



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Nevada**

**Application for 2013
Annual Report for 2011**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Nevada's Assurances and Certifications are signed and filed in the office of the Bureau of Child, Family, and Community Wellness.

Ms. Christine (Christi) Mackie, Deputy Bureau Chief for the Bureau of Child, Family and Community Wellness is identified as the MCH Director for Nevada.

The office is located at:

4150 Technology Way, Suite 210,
Carson City, NV 89706.

Ms. Mackie can be reached at cnmackie@health.nv.gov or at (775) 684-4285.

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 2012; expires January 31, 2015.

E. Public Input

/2012/ Public input on the MCH Block Grant application development was elicited at various public meetings throughout the year in 2010, including meetings of the MCH Advisory Board, MCH regional coalitions, and at subcommittee meetings convened with topic area experts. In order to ensure that any interested public is able to review the application, public notices will be widely disseminated announcing the availability of the draft for review on the Nevada State Health Division website. Public feedback will be collected by an electronic survey mechanism offered on the same website. Public input will be utilized to modify the application as appropriate.*//2012//*

/2013/ Public input on the MCH Block Grant application and report was conducted similar to previous years with the addition of a phased approach for input following the initial draft and subsequent revisions and a large expansion of Nevada's MCH network of stakeholders due to the formation of a rapidly growing statewide MCH Coalition. The coalition membership as well as members of other advisory groups were notified by email of the availability of the application/report and asked to provide feedback. The membership of the coalition as of 7/01/12 includes representation from the following organizations and groups:

Abbott Nutrition

Access to Healthcare Network

Acelero Learning Clark County (Head Start)

Alexander Graham Bell Association (Nevada Chapter)
American Lung Association in Nevada
AMERIGROUP
Baby First Services- HELP of Southern Nevada
Boyd Gaming Corporation
Care Coalition
Care Meridian
Centennial Hills Hospital
Clark County School District
College of Southern Nevada, Dental Hygiene Program
Deaf and Hard of Hearing Advocacy Resource Center
Dignity Health
Family TIES of Nevada
Foundation for Recovery
Head Start Collaboration and Early Childhood Systems Office
Helping Kids Clinic
Immunize Nevada
March of Dimes-Nevada Chapter
MedImmune
Merck Vaccine Division
Nevada Center for Excellence in Disabilities
Nevada Dental Association
Nevada Disability Advocacy & Law Center
Nevada Early Intervention Services
Nevada Governor's Council on Developmental Disabilities
Nevada Health Centers
Nevada Institute for Children's Research & Policy
Nevada Network Against Domestic Violence
Nevada PEP
Nevada Public Health Foundation
Nevada State Health Division
Nevada WIC
Northern Nevada MCH Coalition
NV Hands & Voices
NV State Oral Health Program
NvLEND Executive Committee
NyE Communities Coalition
PACT Coalition
Parents/Caregivers
REACH/Ventanilla
Regional Emergency Medical Services Authority (REMSA)
Renown Regional Medical Center
SAFE House
Sanofi Pasteur
Southern Nevada Immunization and Health Coalition
Southern Hills Hospital and Medical Center
Southern Nevada Health District
Southwest Medical Associates
St. Rose Dominican Hospitals
St. Rose WIC and Barbara Greenspun Women's Center
Stallman Touro Clinic at The Shade Tree
Sunrise Children's Foundation
The Eyecare Center
U. S. Congresswoman Shelley Berkley
UMC - Baby Steps Program
UMC Children's Hospital of Nevada

**Office of United States Senator - Harry Reid
University Nevada School of Medicine, Dept. OB/GYN
University of Nevada Cooperative Extension
UNLV Center for Health Disparities Research
UNLV School of Dental Medicine
UNLV School of Dental Medicine
University of Nevada, Reno
UNR School of Medicine - OB/GYN
Washoe County Health District
WestCare Nevada**

Ongoing feedback during quarterly meetings of the Nevada Maternal and Child Health Advisory Board is solicited to identify activities that support their priority areas, i.e. the Advisory Board has identified full implementation of a PRAMS-like survey as a goal that will increase Nevada's MCH epidemiology capacity and provide useful information for future strategic planning. //2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

MCH Block Grant Needs Assessment Update 2013

Changes in the population strengths and needs in the State priorities:

Nevada MCH populations have not seen significant changes since the last application; however some changes have occurred and should be discussed. Nevada had been one of the fastest growing states in the Nation, with Hispanics representing almost 46% of that growth, however, since the "Great Recession" Nevada has seen population decreases for the first time in a decade. In March 2012, the unemployment rate dropped to 12%, but counties like Lyon and Nye were above 14%, and Nevada leads the nation in unemployment rates (US Bureau of Labor and Statistics [BLS]). Unemployment rates, along with high foreclosure rates, may explain the population decreases in Nevada.

The poor economy in Nevada greatly impacts MCH populations. Many of Nevada's citizens are currently without insurance or now qualify for Medicaid (BLS). Fifty-five (55) percent of adults and 24% of children under 139% of the Federal Poverty Level (FPL) are uninsured in Nevada (Kaiser Family Foundation [KFF]). In January 2012, there were 354,081 persons participating in Food Stamp Program, this is up 27,000 from the year before (KFF). Last year there was a drop in the number of children enrolled in CHIP; these children may have become qualified for Medicaid. Many families in Nevada have lost their homes in this last year, with one (1) in 301 housing units receiving a foreclosure filing in March 2012 (Realtytrac). In addition, ten (10) percent of the population is categorized as non-citizens (KFF), this potentially could put a major strain on the already stressed social services in the state.

Additionally, there has been a downward trend in birth rates overall. In 2011 there were 34,608 births, down from 35,731 births in 2010, which is a decrease of 3.3%. This may be a result of the economy and the loss of population. In 2011, 12,869 of those births were to Hispanic mothers, down from 13,302 births in 2010, which is a 3.3 % decrease. There has also been an overall downward trend in teen births, from 26.7 in 2006 to 18.9 per 1,000 births in 2011, a 41% reduction in rates.

Changes in the State MCH program or system capacity in those State priorities:

Since the last Block Grant application there have been changes to Nevada's MCH program and system capacity. Early in 2012, over 105 individuals attended the initial statewide MCH Coalition meeting and this coalition was officially formed. Public and private organizations representing both the rural and urban communities turned out for the event. MCH provided guidance to the Coalition and Nevada's MCH priority areas were adopted by the Coalition. Currently the MCH coalition is organizing a statewide 2012 MCH Conference in partnership with the statewide immunization conference.

Expansion of the utilization and usability of Nevada 2-1-1, a service launched in 2006 that connects callers with information and referrals and has served more than 260,000 people. An Outreach and Access Committee workgroup was created at the MCH Coalition meeting. The MCH Coalition is also working to develop a Statewide Public Relations and Education Campaign to support MCH Priorities Areas and increase public and provider knowledge and utilization of

"Bright Futures" resource materials.

The MCH Coalition has organized and piloted one Preventative Health Outreach Clinic in Northern and Southern Nevada. The purpose was to increase and expand access to preventative and rehabilitative services, especially for CYHSCN, as well as children enrolled in WIC and/or Head Start programs.

The MCH Coalition plans to complete a root and cause analysis for mental health screening and data collection to identify needs related to mental health provider access. In addition the 2012 MCH Conference will include specific topic(s) on support for mental health screening and data collection to identify needs related to mental health provider access.

With the release of the 2009/2010 CYSHCN survey there have been changes in Nevada's CYSHCNs population. Nevada demonstrated places where there has been improvement and also where there have been decreases. The MCH program is currently working on an evaluation plan for the Nevada Care Coordination model for CYHSCN. The MCH Statewide coalition created the Outreach and Access Committee to address early identification and intervention for CYSHCN. Specific topic(s) on early identification and intervention for CYSHCN will be included at the 2012 MCH Conference.

The Maternal and Child Health Advisory (MCHAB) identified the importance of continuing financial support for the Primary Care Development Center to work with Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/MUP). The MCH Coalitions encourage participation by students and MCH providers for building provider networks. The Nevada State Health Division has partnered with the Nevada System of Higher Education to create student mentorships and internships within MCH. Currently MCH has an intern who will focus efforts on Adolescent Health. Many of these interns come on as full time state employees after the completion of their internship. Nevada is also in the process of exploring alternative staffing.

The Adolescent Health Program, funded through the Patient Protection and Affordable Care Act has begun the implementation phase of the Personal Responsibility Education Program (PREP) and Abstinence programs, in partnership with Planned Parenthood and Huntridge Teen Clinic. The programs have hired one adolescent health program manager, two adolescent health program specialists, and two adolescent health resource analysts. The MCH Statewide coalition activities related to adolescent health include: (1) Create and establish a committee on Adolescent health-systems development; (2) Complete an assessment on the current Adolescent health-systems development; (3) Review National Standards for comprehensive adolescent health system; and (4) Collaborate with existing public and private stakeholders to increase and/or expand School-Based/School-Linked Health Centers.

MCH Statewide coalition activities related to access to prenatal care include: (1) Complete an assessment of pregnant women in Nevada that are not accessing early and adequate prenatal care as well as provider accessibility; and (2) Collaborate with existing public and private stakeholders to increase public knowledge of the importance of early and adequate prenatal care through a Public Relations Campaign.

In April 2011 a MCH epidemiologist was hired and participated in two national specialized trainings within MCH epidemiology. The MCH epidemiologist, along with other activities, has investigated methods for systematic analysis of current MCH epidemiology capacity for Nevada. The MCH epidemiologist has reported to the MCHAB about the regional and racial disparities that exist in Nevada through analysis of birth certificate data. The MCH epidemiologist investigated 2010 birth certificate data to provide an examination of prenatal care in Nevada and this was reported to the MCHAB. In 2010 a pilot project was implemented called Baby BEARS, which was survey designed to mirror PRAMS. Nevada is not a PRAMS state and this pilot was implemented to determine Nevada's capacity to conduct a similar survey. The results of this survey were

delivered to Nevada in late 2011 and the results have been analyzed.

A brief description of ongoing needs assessment activities:

The State MCH program continuously monitors and assesses its priority needs and its capacity to meet those needs. At this time MCH is working on creating a strategic plan for the upcoming Needs Assessment. MCH is putting together a workgroup dedicated to this strategic planning and there will be collaboration with the MCH advisory board, the newly created MCH Statewide Coalition, and all other community partners in this effort. At this time no formal evaluations of the previous Needs Assessment are taking place within MCH. MCH will work closely to form focus groups from MCH Coalition Workgroups. MCH is working on creating a Care Coordination for CYSHCN survey for parents similar to the National Survey to evaluate the effectiveness of programs.

Activities undertaken to operationalize the 5-year Needs Assessment:

The MCH Advisory Board meets quarterly to discuss MCH needs in Nevada and make recommendations for future programs. They are actively monitoring progress on reaching the state priority areas and identifying new trends.

III. State Overview

A. Overview

Nevada's Maternal and Child Health Program is dedicated to improving the health of families, with emphasis on women, infants and children, including Children with Special Health Care Needs, by promoting, assuring and providing health education, prevention activities, quality assurance and health care services. The MCH program has undergone a transformation to streamline processes, integrate programs, and move down the MCH pyramid toward becoming an organization with a stronger public health approach of monitoring, assurance, and policy development.

Nevada is a huge state in land mass. The state is semi-arid, largely mountainous with numerous valleys of primarily north-south orientation. Approximately 83% of Nevada's land area is under the jurisdiction of the Bureau of Land Management; the remaining 17% is under private ownership or state and local jurisdiction. Nevada has thirteen Indian colonies (or reservations) statewide and three military bases.

One of the main challenges to health care delivery in Nevada has been explosive population growth. For 19 consecutive years, Nevada has been the fastest growing state in the nation. Nevada experienced a population growth of 35.1% between 2000 and 2010 (1,998,260 - 2,700,551). Many families moved to Nevada for the prosperity and opportunity associated with a previously rapidly growing economy. Nevada also echoes a nationwide population shift to warmer climates as the population ages and traditional sources of income and employment dwindle in northern states. Regardless of the reason, an increasing population strains overall public health funding. In the case of health, an increased population means increased numbers of people to educate and influence to make good choices.

Nevada's sheer geographical size also increases the difficulty of implementing health related intervention. Nevada is the 7th largest state in the nation, totaling 110,540 square miles. Serving an area this large challenges prevention programs because of the distances involved and the requirements of a diverse population. Nevada has only two areas of dense population, Reno and Las Vegas, located approximately 450 miles apart. The largest populated area of Nevada, Clark County (Las Vegas), currently makes up 72 percent of the total state population. 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 in the service industries, that constitutes a large number of available jobs in these areas. The remainder of Nevada is rural or frontier. In Nevada, the poverty level in rural and urban areas is comparable, but access to many services is severely limited in rural and frontier counties, especially for medical care and health information. The vast distances between communities prohibit many residents from receiving services at all. Rural areas may also lack access to utilities, technology, education, and employment.

Nevada's mobile and transient population and its large geographical size are serious challenges to Nevada's public health delivery system. In addition, Nevada's dependence on tourism creates two public health system challenges; 1) visitors have health and safety concerns that must be addressed by a system with limited fiscal and human resources, and 2) the economic dependence on tourism for state funding creates a fluctuation in available resources during times when the needs of our population may be at their greatest.

Nevada has the largest homeless population, per capita. In 2009, homelessness in Nevada was more than double the national rate (.55% vs. .21%). Because of the lack of affordable housing and rising unemployment, many families are doubling up and living in motels or other temporary housing. Youth living in shelters or those lacking permanent housing face problems enrolling and participating in school. Between 2007 and 2009 Nevada's homeless population grew 15.58% from 12,526 to 14,478. These fluctuating and mobile populations increase the difficulty of

identifying and tracking disease.

The United States Census Bureau expects Nevada to become a minority-majority state in the coming decades. Currently, Nevada's population is comprised of 37.9 percent minority races. In 2006, the estimated racial/ethnic composition of Nevada was 62.2 percent White, 23.2 percent Hispanic/Latino, 6.9 percent African American, 6.3 percent Asian/Pacific Islander and the remaining 1.4 percent Native American or Alaskan Native. The minority population is expected to increase dramatically during the period of the grant and in ensuing years. Hispanic teens are the largest population of pregnant teens with 2,300 teen births in 2007. This coincides with a lack of employment for Hispanics in the current economy: according to Bureau of Labor Statistics, from 2007 to 2010 Hispanics in the Southwest were hardest hit by unemployment, almost double the rate, because of their disproportionate number in the construction industry. The rising cost of gold is putting new life back into some of Nevada's communities with new mines being developed and old mines reopened. Nevada was the leading gold producing state in the country in 2006. Most mines are located in the rural and frontier regions of Nevada, although what effect this has on the regions is not yet clear.

Health Coverage

In addition to the fiscal situation there are many factors that impact the health services delivery system in the state. The extreme rural nature of most of Nevada is one that leads to many challenges in developing a health services delivery system in the state. About 12% of Nevadans live in rural and frontier communities, most of which are remote from urban centers. This is compounded by a lack of providers for both primary and specialty care that is even seen in the most urban communities. MCH collaborates with the Primary Care Office who is responsible for conducting the surveys necessary to establish Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs). HPSAs can be primary care, dental or mental health shortages and have a very high patient to provider ratio. These designations help with the recruitment of providers to underserved areas.

Primary Care Office works closely with a number of key organizations involved in the development of primary care resources throughout the state to address Nevada's shortage of healthcare providers. Their partners include Nevada Health Centers, Office of Rural Health, University of Nevada School of Medicine, Nevada Rural Hospital Partners, Area Health Education Centers, Washoe County Access to Health Care Network, and Clark County Health Access Consortium.

Access to healthcare is a priority for MCH. Nevada's Medicaid and Children's Health Insurance Program are managed the Division of Health Care Financing and Policy. The Nevada Division of Health Care Financing and Policy contracts with two managed care organizations, which provide health care to Medicaid eligible individuals.

Nevada Check Up (the Title XXI State Children's Health Insurance Program) continues to grow as more eligible families learn about program availability. The program benefits children who are not eligible for traditional Medicaid and may not otherwise have access to health care. In 2009 Medicaid provided services to over 510,000 persons. The monthly average of children enrolled in Nevada Check Up for 2008 was 29,075. The complexity arises with the economic downturn and more families are eligible for Medicaid which reduces the need for Nevada Check Up, therefore the expectation is that fewer children will be enrolled in Nevada Check Up and the number of those enrolled in Medicaid will rise in the future.

Designed to help needy families achieve self sufficiency, Temporary Assistance for Needy Families (TANF) in Nevada furnishes financial and support services such as child care, transportation and other services. It is designed to provide temporary assistance for families to care for dependent children in their own homes or in the homes of relative caregivers.

The Maternal and Child Health Program in Nevada, their stakeholders and partners have had many successes and will continue to address efforts to increase healthcare coverage by working together for the population's well-being.

Policy/Legislative Sessions

Nevada is one of only six states that have biennial legislative sessions, and the Nevada Legislature meets for 120 days during each odd-numbered year. This provides NSHD with the opportunity to better identify issues and work with the interim Legislative Committee on Health Care to develop policy and propose legislation to tackle public health needs. However, given the time constraints and constitutional requirements of the biennial sessions, the challenge lies in the workload of Nevada Legislators and the fiscal health of the state, and not all needs can be addressed. Nevada does not have a large federal to state match for funding public health. NSHD has addressed this by working cooperatively with our stakeholders, the district health authorities and rural communities in procuring necessary grant dollars.

With the current economic challenges expected to continue for a period of time, it is expected that NSHD programs will need to show quality cost effective program planning, development and implementation. MCH is well prepared for these expectations.

The MCH Advisory Board has provided direction and guidance on policy issues. Efforts of Nevada's Title V partners, as advocacy voices and educators of the MCH population's public health needs, strengthened outreach and policy development efforts statewide. The MCHAB chair is enthusiastic, knowledgeable and action oriented. Subcommittees have been formed to focus efforts and address needs. The Access to Prenatal Subcommittee works to improve access and increase awareness and knowledge of the issues of prenatal care. The Perinatal Substance Abuse Prevention Subcommittee is looking to expand prevention efforts of alcohol, tobacco and other drugs.

Maternal Health

The Medicaid Managed Care Options make a good faith effort to screen Title XIX and Title XXI pregnant women enrolled in a MCO for maternal high risk factors. The Maternity Risk Screening Form helps identify and meet the need for medical and non --medical services. These services are defined as preventive and or person care services or home health care, substance abuse services, and care coordination services in addition to maternity care. Any identification of high-risk factors will require the Primary Care Provider, Obstetrician provider, registered nurse or licensed practical nurse to refer the woman who is determined to be at risk for preterm birth or poor pregnancy outcome to the MCH's case management where follow up will continue. The Maternity Risk Screen form can be found on the DHCFP website at <http://dhcfp.state.nv.us>. Medicaid reimbursement continues to be a major challenge per conversations with providers. The Title V staff and partners continue to offer information and support to private and public providers including billing and coding education for services that impact state objectives.

Child Health

Recent HEDIS report for Medicaid Managed Care shows significant improvement in rates of Early Periodic Screening Diagnosis Treatment (EPSDT) in Nevada. Community stakeholders have been leaders to increase awareness of families of the benefit available to them.

Participating managed care staff and physician associations have supported education and incentives to providers to comply with the AAP recommended schedules and age-appropriate screening.

Staff and community partners have been active to recruit primary care providers to take the well child online curriculum. The initiative is to promote comprehensive well child and EPSDT exams at <http://www.brightfutures.org/wellchildnevada>. Recent progress has been inclusion of the

curriculum in a Nevada University residency program. Other partners are Family TIES and Nevada 211.

Nevada's Health Officer, Dr. Tracey Green, has brought a group together to view other Bright Futures curriculum to address other childhood issues through provider education and training. Looking forward to a lifetime of health beginning as soon as possible, childhood obesity is a major focus of upcoming strategies for MCH programs. MCH staff partner with schools, afterschool organizations, early childhood education and providers to educate and develop strategies for a healthy lifetime.

Community Input

The Bureau communicates with community partners consistently through many venues, and it is through these conversations and meetings that we are able to assess needs in an ongoing basis. The Nevada Advisory Council for CYSCHN conducted a survey that collected data from 100 families in rural counties, and NSHD Staff meet regularly with two state associations: Nevada Association of Superintendents & the Nevada Association of School Board Trustees. Discussions from these regular interactions have given rise to several pilot projects in school food service, and in 2010, with a Kindergarten Survey. One project is offering healthy snacks and implementing a salad bar. NSHD Staff also coordinate the State Fitness and Wellness Council, which is also interested in school health. It is in this milieu that the following priorities for 2010 from the MCH Needs Assessment were established. The needs assessment initial data collection and focus groups were convened in early 2010. Assessing and revising program direction will be based on continued evaluation of needs. The data establishes priorities and closely complement the HRSA MCHB goals and the MCH Advisory Boards recommendations. They will guide the Bureau's work in the coming years:

1. Increase access to primary care services, providers, facilities, resources, and payor sources among the MCH populations.
2. Increase access to oral health services, providers, facilities, resources, and payor sources among the MCH populations.
3. Increase access to mental health services, providers, facilities, resources, and payor sources among the MCH populations.
4. Create a unified data system and surveillance system to monitor services delivered to the MCH populations.
5. Create "braided" services for CSHCN resources in Nevada including "one-stop-shopping" and "no-wrong-door" models of service delivery.
6. Increase financial coverage and decrease financial gaps for health services among the MCH populations.
7. Decrease the incidence of domestic violence among women of child-bearing age.
8. Decrease the risk factors associated with obesity for children and women.
9. Decrease unintentional injuries among the MCH populations.

/2012/ Upon completion of the initial phase of the Needs Assessment in 2010, priority areas that will guide the Bureau of Child, Family, and Community Wellness and MCH program to address the needs of our target population and reach our federal, state and local goals. They are:

1. Outreach, awareness, navigation and knowledge: Public education regarding preventive services
2. Access to systems of care for Prevention.
3. Continue early identification and intervention for children with special health care needs
4. Support for mental health screening and data collection to identify needs related to mental health provider access
5. Recruitment and retention of healthcare workforce
6. Adolescent health systems development: Comprehensive care for adolescent health, and
7. Access to Prenatal Care.

8. Increase MCH epidemiology capacity. //2012//

In late 2009 an MCH coalition was formed in southern Nevada, this coalition decided their initial priority area was prenatal access to care. The Southern Nevada MCH Coalition, which primarily serves Clark County, elected a chairperson and identified priority activities to address barriers in access to prenatal care. The Maternal and Child Health Coalition of Northern Nevada, which serves the northwest region of the state, established a website (mchcoalitionnn.org) and hosts guest speakers at their monthly meetings. The Southern Nevada MCH Coalition convened a children's summit to promote and generate support.

A prenatal workgroup was also formed from members of the MCH Advisory Board; the first activity was to address access to care issues. The workgroup agreed directing MCH focus to a population based service served a broader, fiscally responsible purpose. Another barrier identified was the length of time for pregnant women to become Medicaid eligible and have identified this issue as a priority.

//2013/ A new statewide Nevada Maternal and Child Health Coalition was formed. The coalition is growing rapidly and has identified activities related to the priority areas. Many of these activities/initiatives are directly tied to performance measures and are detailed in this report. //2013//

Health Equity

The MCH program recognizes the impact of changing demographics in the state, both from the increasing population and the changing race and ethnicity of its citizens. All MCH-funded programs work to address health disparities. Most staff who answer the Information and Referral Lines are bi-lingual. The Bureau makes an effort to recruit bilingual staff. MCH materials are made available in English and Spanish. Oral health surveillance of Head Start children and children in third grade find higher rates of decay in minority children; oral health initiatives work to address these inequities. The teen pregnancy prevention initiatives target the Hispanic populations as they have the highest rate of teen pregnancy. The WIC program is seeking to place clinics in areas frequented by Hispanics and African Americans, and has materials in both English and Spanish. CSHCN materials are in English and Spanish. The PSAP brochures are also in Spanish and English. The MCH program is working with the MCH Coalitions and local community based organizations to reducing infant mortality and low birth weight in minority populations.

Through the State Birth Records Registry MCH programs can link and collect data for improvement in program development. With the assistance of the federal MCHB and state and community partners a project is under way to integrate cultural and linguistic competence into MCH programs. The integration will be in stages and stage II continues in December 2010 with train the trainer workshop that integrates state partners, Health Division and MCH staff and provides tools and direction on integrating Cultural and Linguistic Competence into policy, values, principles and action.

Bureau of Child, Family and Community Wellness programs are collaborating with the Women Infant and Children (WIC) program, providing education and training to parents and staff on health issues. This collaboration further develops communication with diverse populations and offers them resources and services, while building an improved health system of assessment and referral.

Health Care Reform

MCH is working to keep partners informed of all available updates on coverage under health care reform. Questions of pre-existing conditions and high risk pool coverage are of vital concern for children, families and those that serve the special health care needs population. Understanding

health care reform has the potential to change the way programs assist populations and will affect how individuals access healthcare is what drives planning for the future. Staff is committed to improving services, systems and outcomes for the MCH population in Nevada and is planning for the future. One partner is Medicaid and MCH and other partners assist with outreach and enrollment. One role MCH will play is in assisting with resolving any confusion the public has with health care reform and how it affects them, care coordination and navigation through a complex system can be a vital role for MCH.

/2013/ The State of Nevada Department of Health and Human Services (DHHS) was awarded an exchange planning grant from the U.S. Department of Health and Human Services Center for Consumer Information and Insurance Oversight (CCIIO). DHHS submitted a Level One implementation grant application to CCIIO through the Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges, Funding Opportunity Number: IE-HBE-11-004 CFDA 93.525.

Program Integration is one of the 11 exchange establishment core areas as outlined in the exchange implementation grant requirements. To reach this goal, the Exchange and the State Medicaid agency will need to closely partner on systems development and operational procedures.

DHHS promotes the health and wellbeing of Nevadans through the delivery or facilitation of essential services to ensure families are strengthened, public health is protected, and individuals achieve their highest level of self-sufficiency. DHHS is the designated Single State Agency for the Medicaid Program in Nevada. Within DHHS are the Divisions of: 1) Health Care Financing and Policy; 2) Welfare and Supportive Services; 3) Aging Services, Health, Child and Family Services; and 4) Mental Health/Developmental Services. The Division of Health Care Financing and Policy (DHCFP) administers Medicaid and Nevada Check Up. The Nevada Check Up program is Nevada's name for the federal Title XXI benefits administered under the Children's Health Insurance Program (CHIP). DHCFP is responsible for all Medicaid and Nevada Check Up program operations, except for eligibility determination. The responsibility for determining Medicaid eligibility and child support enforcement activities related to medical support are located within the Division of Welfare and Supportive Services (DWSS).

Chapter 439 of the Nevada Act of 2011 created the Silver State Health Insurance Exchange (SSHIX) administrative structure and authorized the seven-member SSHIX Board of Directors (Exchange Board) to perform the duties necessary to develop and operate the SSHIX. There are three non-voting ex officio State executives on the Exchange Board. The Exchange Board is responsible for: 1) creating and administering a State-based health insurance exchange; 2) facilitating the purchase and sale of qualified health plans (QHPs); 3) providing program(s) to help small employers in Nevada enroll employees in QHPs; and 4) performing all other duties required of the SSHIX under the Patient Protection and Affordable Care Act (ACA). The Exchange Board held its first meeting on October 26, 2011; at which time it reviewed and discussed a variety of materials and approved bylaws and job descriptions for an executive director, chief operating officer, and executive assistant.

The ACA, as further defined by proposed regulations, includes a number of responsibilities that apply to state-based health insurance exchanges, many of which the SSHIX needs to coordinate with DHHS, the Nevada Division of Insurance (DOI), and the Governor's Office of Consumer Health Assistance (GovCHA).

As decisions are being made on eligibility, plan management, enrollment, consumer assistance, financial management, and other functions, coordination across agencies is essential for the successful implementation and operations of the SSHIX. Additionally, DHHS has information, resources, and programs that can be leveraged to design and

implement the SSHIX. //2013//

/2012/ In these challenging economic times MCH must continuously reevaluate how to best serve our population in need. Working with federal, state and local partners has never been more critical for our success in the future and for the future of women, children and their families. Resiliency and adaptability to ever changing state need will drive state success. Goals and strategies formed one year may not be appropriate in the next; Nevada's MCH staff is poised for any transition that is needed. As is discussed in MCH capacity and in National and State Performance Measures we are addressing the needs with innovation and dedication. //2012//

//2013/ Increased epidemiology capacity is strengthening Nevada's ability to collect and utilized data to drive program decision-making. State and local efforts are being coordinated to identify barriers to prenatal care access. //2013//

B. Agency Capacity

The Bureau works to leverage its resources to promote and protect the health of the MCH populations it serves including CYSHCN. It does this through partnering and collaborating with multiple agencies and programs, both government and private, across the state. Many of those efforts are described in this Section.

Program authority for Nevada's MCH and CSHCN programs are contained in Nevada Revised Statutes (NRS) and Nevada Administrative Codes (NAC) as follows:

* NRS 442.120-170, inclusive. Designates the department of human resources through the health division to "Cooperate with the duly constituted federal authorities in the administration of those parts of the Social Security Act which relate to maternal and child health services and the care and treatment of children with special health care needs".

* NRS 442.130. Designates DHR as the agency of the state to administer, through the SHD, a MCH program, and to advise the administration of those services included in the program that are not directly administered by it. "The purpose of such a program shall be to develop, extend and improve health services, and to provide for the development of demonstration services in needy areas for mothers and children".

* NRS 442.133. Establishes the Maternal and Child Health Advisory Board. The purpose of the Board is to advise the Administrator of the SHD concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of children.

* NRS 442.140. Authorizes a state plan for MCH.

* NRS 442.180-230. Authorizes the department (DHR) to "administer a program of service for children who have special health care needs or who suffering from conditions which lead to a handicap, and to supervise the administration of those services included in the program which are not administered directly by it."

* NRS 442.190. Authorizes a state plan for children with special health care needs.

* NRS 442.115. Authorizes the State Board of Health (also appointed by the Governor) to adopt regulations governing "examinations for the discovery of preventable inheritable disorders, including tests for the presence of sickle cell anemia". The follow-up for those whose examinations and tests "reveal the existence of such a condition" is described in this statute also. The newborn screening program is placed in the Bureau.

* NRS 442.320-330. Authorizes the establishment of a Birth Defects Registry

* NAC 442. Maternal and Child Health. Establishes regulations for the CSHCN program regarding eligibility, covered conditions and so forth. It establishes the protocol for the taking of blood samples from infants for newborn screening, establishes fees for services of the Bureau of Early Intervention Services' Early Intervention Services, and the nurses of the Bureau of Community Health Services, and defines level of care of hospital neonatal units. It also establishes the provisions for the operation of the Bureau's Birth Defect Registry. AB 136, creating statutory authority for the Oral Health Program and for a 13 member State Oral Health Advisory Committee, was passed during the 2009 legislative session. Note: The 2005 Legislature changed the name of the Department of Human Resources to the Department of Health and Human Services. This change will occur in the coming year. For the purposes of this document, DHR will be used when referring to the Department.

All of the above statutes and regulations impact the operations of Nevada's MCH and CSHCN programs by giving state authority for the programs to the SHD and setting operating regulations into state law. This ensures the programs operate within legal boundaries established and monitored by the state. In addition to the authority for MCH, CSHCN, Newborn Screening and the Birth Defects Registry contained in NRS and NAC, the state budget process also places MCHB's Abstinence Education, SSDI, and Newborn Hearing grants, WIC, Primary Care Organization, the Center for Disease Control and Prevention's (CDC's) Oral Health, Rape Prevention and Injury Prevention grants and the Centers for Medicare and Medicaid Real Choice Systems Change grant within Bureau operations. In FY04 the MCHB funded Early Childhood Comprehensive Systems grant was added. Changes to the bureau operations include the addition of chronic disease prevention programs, Diabetes, Comprehensive Cancer, Breast and Cervical Cancer Early Detection, and Immunization programs, programs that are no longer under the bureau's direction include; WIC, Abstinence, and CMS Real Choice Systems Change grant.

The Bureau seeks to work closely with state's public health community including the Clark County Health District (CCHD), Washoe County District Health Department (WCDHD) and Carson City Health Department to promote the health and well being of the MCH/CSHCN populations in those counties, as well as with the other Bureaus of the SHD. Title V funding provides some support for Community Health Nursing in Nevada's rural and frontier counties. Title V funding supports adolescent health through our community nurses located in the rural and frontier counties and the health districts in southern Nevada Clark County at the Southern Nevada Health District which covers the largest urban county in Nevada, Washoe County Health District, the second largest urban county in Nevada, and Carson City Health District a rural county.

The Bureau is home of a small program that is payor of last resort for the treatment of CSHCN. This program acts as a safety-net provider for eligible individuals who do not meet the eligibility requirements for Medicaid, Supplemental Security Income (SSI which includes Medicaid in Nevada), or Nevada Check Up (Nevada's S-CHIP program), and otherwise meet the eligibility requirements contained in NAC. For covered children the program will pay for specialty and subspecialty care, nutrition and primary care and reconstructive dental care if the child does not have insurance. CSHCN staff refer potential eligible families to Medicaid, SSI, and Nevada Check Up, and follow them until eligibility determination has been made. The Health Division data system has been revised and converted to new software that allows automated data matches with Newborn Screening, the Birth Defects Registry, Medicaid claims, Vital Statistics and Newborn Hearing Screening, and a variety of other state programs. This enables staff to better track what programs and/or initiatives are following the children, services received, etc. The monitoring of eligibility of children referred to Medicaid and Nevada Check Up is now accomplished on-line. Eligibility for the program is currently established at 250% of the Federal Poverty Level, with legal residency in the Nation and Nevada residency required. //2012/ In late 2009 Nevada's CYSHCN program moved to a population based service of care coordination. Now in all but one region in the state, the program has expanded the reach to this population not covered by other payor or referral sources. //2012//

The Bureau used to have a program that paid for prenatal care for eligible women. Redirecting focus to serve more prenatal women, MCH directs support at multiple sources of access for pregnant women, at these locations, each client is screened for social service needs, nutrition needs, domestic violence, substance abuse, and perinatal depression. These community, direct and enabling service providers screen all clients for social service, referring to various community agencies as needed. Early entry into prenatal care is particularly low among Hispanic women. All contracted agencies with the Bureau are to offer bilingual (English and Spanish) service, and have culturally appropriate materials. As part of the services provided by the community based provider the infant born to the covered mother is followed to age one. A medical home will be established for the infant when this service ends on their first birthday. In FY 07, a budget enhancement to expand the above stated services was submitted for inclusion in the Governor's budget; however, this enhancement was not included in the Governor's final budget. /2012/ Nevada will continue to research and identify other resources that may be used to enhance our Maternal and Child Health Campaign. //2012//

Another part of the MCH Campaign is a toll free bilingual (English and Spanish) Information and Referral Line (IRL) that serves as a referral source for pregnancy care statewide. It also provides information for families in need of pediatric care, with referrals to Nevada Check Up, Medicaid, and pediatric providers. /2012/ In late 2009 the toll free number was incorporated into the state's 211 system. This change increased coverage and outreach. //2012// The IRL has been a primary component for signing up women, infants and children for Medicaid and Nevada Check Up as well as referring them and their families to other services such as WIC, immunizations, adoption, substance abuse treatment, a source for dental care, etc. All who call are queried regarding their insurance status. If they do not have or have concerns about it, staff will refer them to Medicaid and/or Nevada Check Up and other resources. /2012/ The CSHCN program moved from a direct service delivery system to one of care coordination. This service is offered through Family Resource Centers. //2012//

/2012/ A third part of the MCH Campaign is an outreach campaign that includes a mass-media campaign, again in both English and Spanish, that educates the public about resources for pregnant women, new parents and children. //2012//The Bureau also now has a toll-free IRL for CSHCN. This new phone number is currently being marketed through a media campaign. It refers callers to services available in the state for CSHCN and their families. This number is 1-866-254-3964.

The Bureau is linked electronically with Medicaid and Nevada Check Up eligibility records in order to check eligibility and prevent duplications. The CSHCN Program does not serve those eligible for Medicaid or Nevada Check Up (unless it is a service such as specialty foods that Medicaid or Nevada Check Up does not pay for). This is possible through NRS, which allows sharing of information between Divisions of the Department of Human Resources and ensures confidentiality of those communications.

The Bureau has a web page where a description of Bureau programs and initiatives may be found and links to web pages either specific to the Bureau such as Oral Health and WIC or relative to MCH such as the Interactive Data Base of the Center for Health Data and Research that is partially supported by the SSDI grant. The Bureau web page is located at <http://health2k.state.nv.us/bfhs/>. /2012/ The new webpage is located at www.health.nv.gov. //2012// Program web pages can be accessed through the Bureau's main web page. The Prenatal web page contains information on how to have a healthy pregnancy, infant care, well child issues, teen pregnancy issues, and many other topics related to maternal and child health. It is one of the most popular web pages on the SHD web-page, receiving several hundred hits a week. A new CSHCN web page was launched in January 2005. It contains links to Medicaid, Nevada Check Up, Food Stamps, SSI, and other programs that might be useful for CSHCN and their families. /2012/ Updates to Health Division webpages are done regularly. //2012//

The Bureau continually works to partner with Medicaid in promoting the health and well-being of Medicaid pregnant women and then their infants. Through contacts between the two agencies and interaction before the Maternal and Child Health Advisory Board (MCHAB) MCH is able to bring concerns about both Medicaid and Nevada Check Up to the attention of the regulatory agency and see them addressed as much as possible. The Bureau continues to look for ways to perform outreach for Nevada Check Up and Medicaid including the contract for the MCH Campaign. Referrals to Nevada Check Up and Medicaid are made through the CSHCN Program, the MCH campaign and WIC, and in FY 06 through the Real Choice Systems Change pilot projects discussed below. /2012/ The Real Choice Systems Change pilot no longer exists, however, continued communication with Medicaid and improving rates of enrollment is a priority for MCH in 2010. //2012//

The Bureau continues to work closely with the University of Nevada School of Medicine (UNSOM). Bureau staff contract with some and otherwise support UNSOM participation in multi-disciplinary clinics for CSHCN that include Cleft/Craniofacial clinics in Reno and Las Vegas. The Bureau Chief and a UNSOM Geneticist are currently working out the details of a Fetal Alcohol Syndrome multi-disciplinary clinic that will first be held in Las Vegas. /2012/ A vision care clinic also in Las Vegas at an Early Intervention site has recently been proposed and is under consideration. //2012//

The Bureau is working very closely with the new Office of Disability Services and Community Based Services which are in DHR Director's office. The Office of Disability Services is working closely with the Real Choice Systems Change project discussed below, particularly on the area of transition of CSHCN to adulthood. It was also the lead on a "211" line for one-stop referrals proposed during the current legislative session and worked with the Bureau to ensure the Bureau's hot lines were appropriately included. This bill did not make it out of session; it was however reintroduced in an omnibus bill that included \$200,000 to implement a 211 line. A committee of representatives from the various DHR Divisions including Health's MCH is currently meeting to begin the development of the line. /2012/ The CYSHCN line was developed and implemented in late 2009. //2012//

Nevada Revised Statutes state that all child care providers must attend a class that covers preventing and recognizing illnesses. In the past, this class has been held only in Clark and Washoe Counties on a regular basis, and Bureau personnel have given the class when possible in the rural counties and parts of Clark County. Most child care providers have not been able to receive this class due to access issues. However, now all community health nurses in the rural counties have been trained by Bureau personnel to teach the "Prevention and Recognition of Illnesses in the Child Care Setting" class. In addition, Southern Nevada Area Health Education Center (AHEC) personnel located in Clark County are being taught the curriculum so that they can service the outlying areas of Clark County. In the near future, this class will be available state-wide and all child care providers should be able to access this class easily. /2012/ This work has been moved to the Head Start State Collaborative Office. MCH attends the leadership planning meetings and a staff member is on the Child Care Licensing Board, for a two year term. //2012//

The continued goal of the State Health Division and Nevada Medicaid is to increase the number of eligible children receiving screening, diagnosis, and necessary treatment services through EPSDT thereby also increasing the number of children appropriately immunized. Through Title V partnerships with the three health districts in Nevada, age appropriate screens are encouraged at all locations as well as with our community health nurses in the rural and frontier counties.

C. Organizational Structure

Nevada's Executive Government is set up with the elected Governor as the Head of State. The current Governor Brian Sandoval is in his first four-year term. Under the Governor are the various Departments that along with Boards and Commissions that make up the Executive Branch, including 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. An org chart of Nevada State Government may be found at <http://www.leg.state.nv.us/Division/Research/Publications/LegManual/2011/StateOrgChart.pdf>

The state public health agency, the State Health Division (SHD), is in the Department of Health and Human Services (DHHS). DHHS also includes the state mental health agency, the Division of Mental Health/Developmental Services (MH/DS); the social services/child welfare agency, the Division of Child and Family Services; Aging and Disability Services; the Medicaid and Nevada Check Up agency in the Division of Health Care Financing and Policy (DHCFP); and the TANF and Child Care Block Grant agency, in Welfare. Mike Willden is the Director of DHHS. Title V works closely with all the Divisions of DHHS to promote MCH priorities and objectives. Nevada Revised Statute 442 designates the Department of Health and Human Services (DHHS) through the State Health Division to administer those parts of the Social Security Act which relate to Maternal and Child Health and the care and treatment of Children with Special Health Care Needs. Within the SHD the MCH and CYSHCN programs are in the Bureau of Child, Family, and Community Wellness.

//2013/ In 2012 the Department of Health and Human Services began merging the SHD and the Division of Mental Health and Developmental Services. They are now under shared Administration. Specific details and MCH program impacts are still being identified. //2013//

The SHD contains 4 bureaus, each headed by a Chief. In addition to the Bureau of Child, Family and Community Wellness are: Health Statistics, Planning, Epidemiology, and Response, Health Care Quality and Compliance, and Public Health and Clinical Services. Richard Whitley, Administrator for SHD was previously Deputy Administrator in the State Health Division. Mr. Whitley received his baccalaureate degree from Willamette University in Oregon, and a Master of Science in Counseling Psychology from Western Oregon State College.

Ms. Marla McDade Williams is the Health Division's Deputy Administrator. Ms. Williams, holds a baccalaureate degree in nursing and a masters in public administration. Ms. Williams previously lead the Bureau of Health Care Quality and Compliance.

The Title V organization chart is attached at III B, Agency Capacity.

The Bureau works very closely with all three of the other Bureaus. It provides funding for Community Health Nurses in Frontier and Rural Area and partners with chronic disease Vital Records works with the SSDI grant and produces the data for the MCH Block Grant application. Title V funds support Early Intervention Services for the CYSHCN population. The Bureau also support the multi-disciplinary specialty clinics held in EIS facilities. New within the bureau are the Chronic Disease programs such as Diabetes and HIV prevention which the MCH program works with most closely with our adolescent population. The Substance Abuse and Prevention and Treatment agency works with the Bureau on its Perinatal Substance Abuse Prevention initiative, particularly focusing on adolescents. The Bureau org chart is attached.

The Bureau of Child, Family and Community Wellness under the SHD Administration is responsible for Title V MCH Block Grant oversight, management and reporting. The Bureau has many programs and initiatives that all work to promote the health and well being of Nevada's families. Deborah Harris has been the Bureau Chief since February 2010.

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 SHD Administrator to two year terms, and two legislators are appointed by the Legislative Counsel. Its composition represents public health, providers, legislators and a consumer who always represents CSHCN. The State Board of Health (SBOH) is a regulatory body that is staffed by the SHD Administrator. Per NRS the MCHAB is advisory to the Administrator of the SHD. They meet 4 to 6 times a year, alternating between Reno and Las Vegas, and more frequently now by videoconference. They respond quickly to issues as they come up and have testified before the Legislature on bills of concern to the Department. The MCH Advisory Board is staffed by the MCH Manager. Under NRS they are charged to advise the Administration of the SHD "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."

/2012/ In 2009 the CYSHCN program for direct service assistance was terminated and in January 2010 a care coordination format was instituted. Through our Family Resource Centers in our largest urban county, Clark County and our rural county, Elko County, care coordination for CYSHCN and their families is provided. MCH believes care coordination is an integral component of comprehensive, quality care provided for CYSHCN. The goal is to locate a medical home for this population and to reduce the stress and frustration to families attempting to navigate the complex healthcare system. The use of care coordination can also reduce the time and effort spent on needless calls and visits that may not meet their needs. In the first year over 70 families were served. MCH is planning for expansion to other regions in the coming years

through additional partnerships.

The Newborn Screening Programs are building capacity within Nevada for workforce competency, laboratory and data infrastructure, quality assurance and sustainability in Nevada. The Health Division and Programs are partnering with our universities and state laboratory in reviewing the challenges and barriers to capacity building.

Once screened and identified through our Newborn Screening Program babies are referred to Early Intervention Services for follow-up with a metabolic pediatrician and geneticist, dietician and developmental specialist as needed for long term follow up. Children seen in these clinic settings are continued through 21 years of age and are provided with direct service delivery and care coordination with financial, social, behavioral and medical care. //2012//

//2012/ The Women's and Early Childhood Section includes the MCH program with CYSHCN care coordination, and Perinatal Substance Abuse Prevention; Women's Health Connection; the breast and cervical cancer early detection program, Newborn Screening and Newborn Hearing Screening programs, and the Rape Prevention and Education Program are also included in this section. The manager of this section is a Health Program Manager II and individual program managers are Health Program Specialists I and II's.

The Oral Health Unit includes a statewide sealant initiative, a fluoride initiative, Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.), Early Childhood Caries prevention, and Oral Health Surveillance. It is funded by CDC and MCH Block Grant. The Oral Health Unit is headed by a Health Program Specialist II who is funded by the MCH grant.

The WIC Program has clinics statewide. It is currently serving approximately 74,000 participants a month. It is funded by USDA and rebates. It is headed by a Health Program Manager II who is funded by the WIC grant. WIC participant numbers seem to have peaked in 2010 with numbers reaching a plateau late in the year. Nevada's Breastfeeding Program is managed through the WIC Program. WIC staff work to improve breastfeeding initiation and duration rates for the state population.

The Primary Care Development Center works to promote access to primary care statewide. It has the Primary Care grant from the Bureau of Primary Health Care, and the HRSA/MCHB funded SSDI program. It is headed by a Health Resource Analyst III who is funded by the Primary Care grant. //2012//

Title V funding is also allocated to Community Health Nursing and Early Intervention Services. Both programs work with the Bureau and provide the reporting required by the block grant. The MCH Director assures the funding is being spent in accordance with federal regulation.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Nevada's MCH/CYSHCN programs are managed through its main office in Carson City, Nevada. Deborah A. Harris served as our MCH Director. Ms. Harris has extensive experience in program management and facilitation. She has worked for over 15 years in state service and comes to MCH in February 2010. Ms. Harris has experience in human resources for public and private entities and has developed and conducted management training. Ms. Harris has facilitated strategic problem identification and has extensive experience in mediation, negotiation and conflict resolution in management. Ms. Harris worked in reorganization and restructuring efforts and has managed health and wellness outreach programs for private and public entities. Ms. Harris has a baccalaureate degree in communication studies from the University of California and a Masters degree in organization management. Ms Harris is a Nevada Certified Public Manager.

/2012/ Christine N. Smith is a Health Program Manager III and oversees the section managers of Women and Children's Wellness and Immunization since July 2010. She will be MCH Director effective July 2011. ***/2013/ Ms. Smith is now known as Christine (Christi) Mackie. //2013//***

/2012/ Ms. JoAnne Malay R.N. M.P.H. managed the Women and Children's Wellness section through July 2011. This position is now open. //2012// ***/2013/ Beth Handler M.P.H. manages the Women, Adolescent and Childhood Wellness section //2013//.***

Deborah Aquino manages the Title V/Maternal and Child Health (MCH) program within the Bureau of Child, Family and Community Wellness in the Nevada State Health Division and serves as the CYSHCN Director. She provides oversight, development and evaluation of the MCH Block Grant and the MCH five-year needs assessment process. Ms. Aquino works cooperatively with other staff of the Division, other agencies and public and private providers to promote MCH services in the state, to identify health needs, issues and gaps in service and develop recommendations to program services. She has extensive experience in health program coordination and evaluation for the Nevada State Health Division, as well as experience managing and team building in the private sector as a former banking manager and in her former roles in the non-profit sector and local government. This experience is useful in managing the MCH program toward building comprehensive, collaboratively-built, community-based systems of care for preventive and primary care services for Nevada's families ensuring that women, infants, children, adolescents, and their families, including children with special health care needs, have access to quality health care.

Muriel Kronowitz, M.A., LPC, currently holds the position of the Perinatal Substance Abuse Prevention (PSAP) coordinator for the Nevada State Health Division. she has more than 25 years of experience developing, implementing and coordinating cutting edge pilot programs in the field of mental health and substance abuse. some of her accomplishments include coordinating the opening of the only therapeutic family court in alaska that addressed FASD, creating and implementing a pilot FASD project at the only women's correctional facility in Anchorage and was the first clinical director for the only residential treatment program for pregnant women and their children in Alaska. Prior to returning to public service she was the clinical director for the private mental health and substance abuse agency.

/2013/ Ms. Kronowitz retired in late 2011. Andrea Rivers, BA, now holds the position of the Maternal and Infant Health Coordinator, covering health issues such as Perinatal Substance Abuse Prevention (PSAP) for the Nevada State Health Division. //2013//

/2012/ Mary Pennington, BA, is the Newborn Metabolic Screening and Newborn Hearing Screening Program Manager. Major responsibilities include administrative and technical coordination of program activities, including policy and procedure development, quality assurance, data development, and fiscal management. Ms. Pennington has more than 17 years experience in Nevada State government managing programs and budgets and building teams to ensure effective and efficient program operation.

/2013/ Andrea Esp, MPH, BS, CHES served as the program coordinator responsible for the Nevada Early Hearing Detection and Intervention (EHDI) Program through June 2011. Job duties include working with both programs to provide assurance of screening, follow-up and assurance of intervention. Additional job duties include development of both the EHDI Programs through collaboration with state hospitals, healthcare providers and non-profit organizations statewide. Ms. Esp has previous experience with statewide screening programs and development of HRSA and CDC competitive and continuation grants. This position is now open. //2013//

Lori Cofano a graduate of the University of Southern California School of Dentistry in Los Angeles, CA and holds a Bachelor of Science in Dental Hygiene. She practices clinical dental hygiene for 19 years prior to joining the Oral Health Program. She has been with the Oral Health

Screening for over eight years as the Fluoridation Specialist and Oral Health Screening Coordinator. Currently she is the Oral health Program Manager. In her capacity as Oral health Screening coordinator she has used the Basic Screening Survey to screen Head Start children, third grade students, and elderly in assisted living facilities. She has developed screening materials and reports that have been used by many other states. She was asked to present information on the BSS at the National Oral Health Conference in 2007. In 2008, she was asked to assist with the Association of State and territorial Dental Directors Basic Screening Survey training materials. The actual training DVD was filmed in Nevada using a Head Start location and a Carson City elementary school as well as several Oral Health Program contacts as actors. She has maintained an excellent working relationship with the Southern Nevada Water Authority and the City of Henderson water treatment staff in Clark County. These are the only facilities in the state that optimally fluoridate community water sources. The Centers for Disease Control and Prevention (CDC) and the ASTDD have honored the water treatment facilities with a State Fluoridation Quality Award for the past six years. The award is based on monthly data sent to the Fluoridation Specialists and entered into the CDC Water Fluoridation Reporting System. She is currently working with the water treatment staff to create an in-state water fluoridation training course. As the acting Oral Health Program Manager she participates in the six regional oral health coalitions and the statewide Oral health Advisory Committee.

//2013/ As of June 2012, Tim Streeper has joined the Nevada Health Division as the Oral Health Program Manager, Mr. Streeper was a research associate at the University of California, San Francisco (UCSF) in the Department of Radiology and Biomedical Imaging. Prior to arrival at UCSF, Mr. Streeper was a Lecturer in the Department of Kinesiology and Health Science at Sacramento State University where he taught undergraduate courses, advised students, and performed committee service. His experience also includes managing a Wellness Program for the State of California, and as a Laboratory Director in an Exercise Physiology lab. Mr. Streeper holds a Master of Science (M.S.) degree in Exercise Physiology from Sacramento State University, and a Bachelor of Science (B.S.) degree in Kinesiology, also from Sacramento State. //2013//

//2012/ Monica Morales M.P.A, currently holds the position of the Wellness and Tobacco Manager for the Nevada State Health Division. She has more than 15 years of experience developing, implementing and coordinating prevention programs targeting at-risk youth, the Latino community, HIV/AIDS prevention, and substance abuse. In addition, she has a background in program evaluation, strategic planning, and fund development. Prior to returning to public service she was a program evaluation manager at a social research firm in California. //2012//

Kelly Y. Langdon, WIC Breastfeeding Coordinator, has her Masters Degree in Public Health and has worked in the public health field for nine years. When Ms. Langdon became a parent she became passionate about the benefits of breastfeeding. She now proudly calls herself a breastfeeding advocate. At the time, the Nevada State Health Division did not have a formal Breastfeeding Program. With help from other colleagues and with the support of our Administrator, the Breastfeeding Program was created. Kelly works with the WIC Program to improve breastfeeding initiation and duration rates for the entire Nevada population. She coordinates and organizes the Breastfeeding Task Force of Nevada, the Carson City Breastfeeding Coalition, and has started a monthly breastfeeding support group in Carson City.

Andrea Rivers, BA, is currently the Injury Prevention program coordinator for the Nevada State Health Division, managing all aspects of this federally funded program. Andrea coordinates the Injury Prevention Task force which meets quarterly. Andrea sits on many injury and trauma related committees and advisory groups. Andrea maintains, performs quality control, assessment and analysis on data from various databases such as mortality, inpatient hospital discharge, trauma and birth. Andrea utilizes appropriate statistical methodologies and software to compile, validate analyze and disseminate health data for grant applications, statistics request and statistical and analytical reports.

/2012/ Due to budget cuts at a national level, the Nevada Injury and Violence Prevention Program did not receive continued funding for state level injury prevention efforts at this time, and the program will officially sunset on July 31, 2011. Steps have been taken to maintain parts of the program developed through other efforts and current Nevada State Health Division programs; this is critical to continue to address injury and violence in Nevada.

Andrea Rivers, BA, will be moving on within the Nevada State Health Division to oversee Rape Prevention and Education and Violence against Women program. Andrea will manage and coordinate all aspects of this federally funded program. Andrea oversees subgrants and contracts put into place utilizing these federal dollars. Andrea will be active with many state and community level entities that have a stake in prevention sexual violence and violence against women. ***/2013/ Deborah Duschesne, BA, joined the Health Division as the Rape Prevention Education Coordinator in April 2012. Deborah received her degree in Behavioral Science from Cal Poly and has worked for the State of Nevada over the last five years. //2013//***

Christine Pool is the Maternal Child Health (MCH) Biostatistician/SSDI Coordinator for the Office of Health Statistics and Surveillance (OHSS). The OHSS houses many critical datasets, including: Behavioral Risk Factor Surveillance (BRFSS), cancer, communicable disease, hospital discharge, STD, HIV, TB, Trauma, Student Height and Weight, Birth Defects and Newborn Screening datasets. Christine maintains, performs quality control oversight and extracts data from various databases such as birth, death, fetal death, infant death, maternal death, abortion, newborn screening and the Birth Defect Registry. She writes syntax to import, clean and manipulate data into proper format for statistical analysis and links/matches databases using both exact and probabilistic matching procedures and software. Appropriate statistical methodologies and software are used to compile, validate, analyze and disseminate health data for grant applications, statistics requests and statistical and analytical reports. Christine uses all of these datasets, linkages, and collaborations to assist with reporting information that supports program planning, policy development and evaluation by Nevadans, legislators, media, and other state and federal organizations. ***/2013/ Jennifer Thompson is currently the Maternal Child Health (MCH) Biostatistician/SSDI Coordinator, assuming all job roles and responsibilities, for the newly renamed Office of Public Health Informatics and Epidemiology (formerly Office of Health Statistics and Surveillance (OHSS)). //2013//***

Gregory Rumbles is a Maternal and Child Health (MCH) funded Management Analyst with the Office of Health Statistics and Surveillance (OHSS). The OHSS houses many critical datasets, including: Behavioral Risk Factor Surveillance System (BRFSS), cancer, communicable disease, hospital discharge, STD, HIV, TB, Trauma, Student Height and Weight, Birth Defects and Newborn Screening datasets. Greg maintains quality control, and performs assessment on extracted data from various databases, with emphasis upon the Birth and Death Registries and Student Height and Weight. Greg utilizes statistical software such as SPSS and SAS to create syntax to import, clean, and manipulate data into proper format for statistical analysis.

Greg assists in the maintenance of the MCH Data Warehouse, coordinating the MCH Block Grant, and when required, the MCH Needs Assessment Project. He collaborates with staff from the Bureau of Child, Family, and Community Wellness on projects related to MCH. Greg links and matches databases using both exact and probabilistic matching procedures and software. Appropriate statistical methodologies and software are applied to compile, validate, analyze and disseminate health data for grant applications, statistics requests, and statistical and analytical reports. Greg uses all of these datasets, linkages, and collaborations to assist with reporting information that supports program planning, policy development and evaluation by Nevadans, legislators, media, and other state and federal organizations. *//2012//*

Brad Towle is the MCH and Newborn Screening data supervisor. Mr. Towle received his BS from San Francisco State University, and has two MAs. He has a MA in Biology from San Francisco State University and a MA in Public Administration from the University of Montana.

/2012/ In 2011, Nevada's Title V program built its workforce capacity by development of some new positions. A fiscal manager was brought directly into the program to help develop, implement, monitor, and control grant-in-aid projects and provide grants management oversight for incoming funding. The fiscal manager helps with site visits and assists in evaluating program effectiveness. **/2013/ Jenni Carducci currently fills the position of the MCH fiscal manager. //2013//**

The MCH epidemiologist position is responsible for developing, reviewing and evaluating program components such as performance measures, data trends for the population we serve, and developing and writing reports for federal, state and local use. This role will help MCH staff to define our efforts. **/2013/ Theresa Bohannon, M.P.H., currently fills the role of the MCH Epidemiologist. Ms. Bohannon received her Master of Public Health degree from the accredited program at the University of Nevada, Reno in May of 2011. Ms. Bohannon has a background in environmental science, earning her Bachelor degree in in 2003. Ms. Bohannon came to the Nevada State Health Division in April of 2011. //2013//**

The Affordable Care Act included funding for State Maternal, Infant and Early Childhood Home Visiting (MIECHV) Programs. Nevada did not have a similar program in place and has utilized the first year to build the program infrastructure and hire staff. Ms. Deborah Aquino serves as the Project Director for Nevada's MIECHV Program. Ms. Aquino oversees the leadership and staff of this new program. Currently, Mr. Perry Smith is serving as the MIECHV Program Manager. //2012//

E. State Agency Coordination

Nevada's Title V leadership works closely with the other members of Nevada's Early Childhood Advisory Council (ECAC). Ms. Aquino is an ex-officio member and participates in the ECAC's work to strengthen state-level coordination and collaboration among various sectors and settings of early childhood programs. The Council adopted the following 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." The membership includes members of various other state agencies, i.e. the Department of Education, the Head Start State Collaboration Office, the Division of Child and Family Services, the IDEA Part C Office, and the Child Abuse Prevention Office as well as a private practice pediatrician, a member of the business community, the current Chair of the Head Start Association and a parent of a young child.

The ECAC has prioritized the following projects:

- 1) Fiscal Mapping project -- To create a funding map of federal, state and private expenditures on programs and services for young children and their families.
- 2) Needs Assessment -- To conduct a statewide assessment of the availability of quality early care and education programs using valid and reliable tools. The report will be used as a baseline for a statewide Quality Rating and Improvement System.
- 3) School Readiness Initiative -- To study the feasibility of developing a state early childhood data collection system. It includes exploring the willingness of local school districts to utilize the same school readiness tool, enabling comparing and contrasting readiness scores between populations and areas.
- 4) Comprehensive Early Childhood Plan -- To develop a plan to provide comprehensive services to children in frontier, rural and urban areas of Nevada so that their health, mental health, parent education, family support and early care and education needs are met to promote children's readiness for school entry.

During 2010, the University of Nevada, Reno's Nevada Center for Excellence in Disabilities

(NCED) was awarded a Leadership Education in Neurodevelopmental and Related Disabilities (LEND) planning grant. Nevada's MCH Program was kept informed and consulted during this process. This initial grant offered Nevada the opportunity to develop an application for a full LEND grant with an anticipated start date of July 2011. The second application was successful and will allow NCED to develop MCH professionals and leaders in their University Center for Excellence in Developmental Disabilities (UCEDD).

The objectives of a UCEDD are:

- 1) advancing the knowledge and skills of all child health professionals to improve health care delivery systems for children with developmental disabilities;
- 2) providing high-quality interdisciplinary education that emphasizes the integration of services from state and local agencies and organizations, private providers, and communities;
- 3) providing health professionals with skills that foster community-based partnerships; and
- 4) promoting innovative practices to enhance cultural competency, family-centered care, and interdisciplinary partnerships.

Through this new interdisciplinary leadership training program, Nevada's infrastructure for Children and Youth with Special Healthcare Needs (CYSHCN) will be re-invigorated and strengthened.

//2013/ Nevada LEND had eleven trainees complete their interdisciplinary leadership training in June 2012. The class included representatives from physical therapy, occupational therapy, pediatric dentistry, pediatrics, education, early childhood special education, psychology, speech, nutrition, social work, and a parent/family representative. The 2013 class has been selected. The thirteen long term trainees include speech-language pathology, social work, behavior analyst, two special education representatives, nutrition, two parents of CYSHCN, child psychiatry, physical therapy, dental hygiene education, psychology and higher education. Leadership projects are conducted in groups by the trainees. One of the leadership projects selected by the 2012 class was increasing state awareness and utilization of the CDC's Learn the Signs, Act Early campaign, enhancing collaborative efforts to improve screening and referral to early intervention services. //2013//

The Bureau partners with the Department of Education and with local (county) school districts around the state on many initiatives around child and adolescent health. These include the Youth Risk Behavior Survey (which includes the Safe and Drug Free School Survey), adolescent health and oral health curriculum for schools. The Bureau also works with Juvenile Probation of the Department of Corrections and the Division of Child and Family Services' foster care programs on teen pregnancy prevention, substance abuse, and injury prevention.

The Bureau works closely with the University of Nevada, School of Medicine (UNSOM). The Birth Defects Registry initiative currently in process will partner with the UNSOM Department of Pediatrics' Geneticists to provide consultation in its development and implementation. Bureau staff contract with some and otherwise support UNSOM participation in multi-disciplinary clinics for CSHCN that include Genetics, and Cleft/Craniofacial clinics in Reno and Las Vegas.

The Oral Health initiative also has many partnerships. The initiative has both a state advisory committee and local regional coalitions. Members of the various coalitions and the state advisory committee include representatives of the State Dental Association, State Dental Hygienists Association, the State Board of Dental Examiners, University of Nevada School of Medicine, the University of Nevada, Las Vegas Dental School, Washoe County District Health Department, Clark County Health District, Tribal Health service providers, consumers, and public and private dental care providers.

//2013/ Nevada MCH leadership began working on a state across-agency team, Expanding

Opportunities. The project vision is that "ALL children in Nevada will receive the necessary comprehensive, coordinated and individualized services and family supports in order to access, participate in, and benefit from high quality, inclusive early care and education opportunities within their communities for optimal development during the critical years from birth through age five". The team includes member representatives from Nevada Center for Excellence, Head Start State Collaboration office, Early Childhood System Office, Washoe Tribe Head Start, Nevada Department of Education, The Children's Cabinet, IDEA Part C office, Nevada PEP, University of Nevada, Las Vegas Department of Educational and Clinical Studies, Early Head Start Grantee, Nevada Child Care and Development, plus federal technical assistance partners. Many of the key components are directly related to supporting the health of young children with disabilities and empowering their families: Parenting Education, Medical Homes and Health Care, Access to Screening, Family Support Services, Family Leadership and Community Engagement and Social-Emotional Development/Mental Health. //2013//

F. Health Systems Capacity Indicators

2013 HEALTH SYSTEMS CAPACITY INDICATORS TREND ANALYSIS

In preparation for the 2013 MCH Block grant, each individual Health Systems Capacity Indicator (HSCI) was examined through trend analysis by the MCH Epidemiologist to determine where the State of Nevada is today and where efforts should be focused in the future year. Each indicator was examined to see if the trend had either IMPROVED, STAYED THE SAME, or DETERIORATED from the previous year and/or years. Then the indicator was compared to the Healthy People 2020 objectives and it was determined if the indicator had either SURPASSED, was CLOSE TO, or was FAR FROM the objective. When possible, the indicator was examined in more detail to determine if there was any trend related to race/ethnicity, region or age groups.

HSCI 01 has IMPROVED since last year; overall there has been an 11% decrease since 2007 in rates. However, Nevada is far from the Healthy People 2020 objective of 18.1 per 10,000 at 30.8 per 10,000. While this trend is improving overall, when looking at this indicator by race, we see that in Nevada, black children are hospitalized at a rate of 67.2 per 10,000. When examined by payer source, 35% of the children were on Medicaid and 31% were Self-Pay. 33% of hospitalizations occurred in winter, 25% in fall, 24% in spring and 18% in summer months.

HSCI 02 trend has DETERIORATED in the last five years; there has been 13.8% reduction since 2007. Nevada is far below the Healthy People 2020 objective of 100%, at 81.7%.

HSCI 03 trend has DETERIORATED since last year, but there has been a 9.7% increase since 2007. Nevada is far below the Healthy People 2020 objective of 100%, at 73%.

HSCI 04 trend has DETERIORATED ; there has been a 9.6% reduction since 2007. Nevada is far below the Healthy People 2020 objective of 77.6% at 61.2%.

HSCI 05A trend has DETERIORATED among both Medicaid and non-Medicaid populations in Nevada. In the last five years there has been a 25% increase of low birthweight infants born to Medicaid mothers and there has been a 10% increase of low birthweight infants for non-Medicaid mothers. Between 2010 and 2011, there was a 21% increase in LBW infants among Medicaid populations, from 7.5% to 9.5%, respectively. Between 2010 and 2011, there was a 12% decrease in LBW infants among non-Medicaid populations, from 8.8% to 7.8%, respectively.

HSCI 05B trend overall has IMPROVED in the last five years for Medicaid populations, but has DETERIORATED for non-Medicaid populations. In the last five years there has been a 5.6% decrease of infant deaths among Medicaid populations and a 12% increase of infant deaths among non-Medicaid populations. Between 2010 and 2011, there was a 41% increase in infant

deaths among Medicaid populations, from 3.1% to 5.3%, respectively. Between 2010 and 2011, there was a 38% decrease in infant deaths among non-Medicaid populations, from 7.9% to 5.7%, respectively.

HSCI 05C trend has DETERIORATED among both Medicaid and non-Medicaid populations in Nevada. In the last five years, there has been a 62% decrease of the percent of infants born to pregnant Medicaid women receiving prenatal care in their first trimester and a 5.8% decrease among non-Medicaid women. Between 2010 and 2011, there was a 10% increase of the percent of infants born to pregnant Medicaid women who accessed prenatal care in their first trimester, from 39.2% to 43.7%, respectively. Between 2010 and 2011, there was a 8.5% decrease among non-Medicaid women who accessed prenatal care in their first trimester, from 66.6% to 61.4%, respectively.

HSCI 05D trend has DETERIORATED for the percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]) for both Medicaid and non-Medicaid populations**. In the last five years, there has been a 26.5% decrease in the percentage of Medicaid women with adequate prenatal care and a 6.7% decrease among non-Medicaid women. Between 2010 and 2011, there was a 9.7% increase among Medicaid women who received adequate prenatal care, from 51.4% to 56.9%. Between 2010 and 2011, there was a 4.5% decrease among non-Medicaid women who received adequate prenatal care, from 65.6% to 62.8%.

**Nevada adopted the CDC 2003 version of the birth certificate form in mid-2009. This enhanced data collection and provides NSHD with more information to make data driven decisions. However, through an examination of 2010 and 2011 birth data, it appears that there may be training issues among some facilities/hospitals in Nevada. It was discovered during analysis that particular hospitals do not accurately report all the prenatal care variables. Without all the variables related to prenatal care (i.e. prenatal care start/end date, total number of visits, etc.), the NSHD statisticians cannot calculate adequate prenatal care for each mother who delivered in the state. For a mother who does not have all prenatal care variables filled out on her birth certificate, she is automatically placed in the "Data Missing/Unknown" category for the Kotelchuck index. When a mother is placed in this category the assumption made is that she did not receive prenatal care. In 2011 (two years after adopting the 2003 birth certificate) there were hospitals where the Kotelchuck index could not be accurately determined because they had not filled out the birth certificate accurately, unknowns reported ranged from 1.1 -- 66.7% for prenatal care. This accounted for 6,779 births for the whole year, which accounts for 19% of all births. If these unknowns are eliminated from the numerator and denominator or assume that all these women received adequate prenatal care, the picture for Nevada changes dramatically. If those unknowns are eliminated, the rate for adequate prenatal care goes up to 79.9% or if we assume all those unknowns received adequate prenatal care the rate goes up to 83.7%. Since the truth lies somewhere in the middle, it is ideal to report adequate prenatal care rate as 79.9% (64.6% -- 83.7%).

HSCI 07A trend has IMPROVED; there has been a 60.2% increase since 2007. Nevada is CLOSE TO the Healthy People 2020 objective of 100% at 96.4%.

HSCI 07B trend has IMPROVED; there has been a 35.8% increase since 2007. Nevada has SURPASSED the Health People 2020 objective of 29.4%, at 54.8%.

HSCI 08 trend has DETERIORATED; there has been a 33.3% reduction since 2007. There is not specific Healthy People 2020 objective. Although there is no specific objective, at 0.3% there appears to be a problem, either in measuring this indicator or somewhere else.

An attachment is included in this section. IIIF - Health Systems Capacity Indicators

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2012/ Nevada's priorities and initiatives are based on the MCH/CSHCN Five-Year Needs Assessments completed in May 2010. " The goals of Nevada's Title V MCH needs Assessment are to determine Nevada's needs for the maternal and child health population and prioritize those needs; assess stakeholder and Nevada State Health Division capacity to address the identified needs; and utilize the findings to strategically address priorities.

As defined in our needs assessment in 2010, a comprehensive and inclusive multi-component process was used that included:

- 1) Data on MCH health indicators collected and analyzed.
- 2) An on-line survey was developed and made widely available for public input on ranking potential needs and recording specific areas of concern.
- 3) MCH and Children and Youth with Special Healthcare Needs focus groups were convened in three geographic regions in the State.
- 4) MCH staff and leaders were asked to rank the State's capacity to address MCH objectives.
- 5) Data results were combined with survey and focus group feedback and presented to the Maternal and Child Health Advisory Board to identify which areas should be targeted as Nevada's current MCH priority needs. The MCH Advisory Board selected the following areas as priorities:
 - a) Outreach, awareness, navigation and knowledge --improve public education regarding healthcare services;
 - b) Access to systems of care for prevention;
 - c) Support for mental health screening and data collection to identify needs related to mental health provider access;
 - d) Continuing early identification and intervention for Children with Special Healthcare Needs;
 - e) Recruitment and retention of healthcare workforce;
 - f) Adolescent health systems development: comprehensive care for adolescent health; and
 - g) Access to prenatal care. //2012//

This process was the initial phase of the ongoing needs assessment with a focus on strategies; specific action steps will be assessed and selected with input from the MCH Advisory Board based on these priorities and their capacity to make changes.

***//2013/ Due to the increased MCH epidemiology capacity, please see the attached trend analysis document that assisted MCH to identify which measures and indicators have changed in the last year and the past five years. Those findings are used to develop to new activities and plans for the coming year. //2013//
An attachment is included in this section. IVA - Background and Overview***

B. State Priorities

/2012/ State priorities identified in 2010 by the 5 year needs assessment from community input were further defined by the MCH Advisory Board. They are:

1. Outreach, awareness, navigation and knowledge: Public education regarding preventive services
2. Access to systems of care for Prevention.
3. Continue early identification and intervention for children with special health care needs
4. Support for mental health screening and data collection to identify needs related to mental health provider access
5. Recruitment and retention of healthcare workforce
6. Adolescent health systems development: Comprehensive care for adolescent health, and
7. Access to Prenatal Care.
8. Increase Nevada's MCH Epidemiology Capacity.

State Performance Measures did not change in 2010 following the needs assessment. Ensuring coordinated preventative care in a medical home with age appropriate screenings continues to be a target for resolution to Nevada's needs. Recruitment and retention of competent workforce to serve the MCH/CYSHCN population remains a federal and state priority.

Nevada will continue to review its needs in the coming years as we evaluate our priorities and ability to address ongoing and new health trends. //2012//

/2013/ State Performance Measures were edited in 2012 in response to guidance received during the federal block grant review process and in order to better align the data collection efforts with identified state priorities. //2013//

An attachment is included in this section. IVB - State Priorities

C. National Performance Measures

Performance Measure 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.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	99	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	51	44	43	54	44
Denominator	51	44	43	54	44
Data Source		Oregon Public Health Lab			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

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.

a. Last Year's Accomplishments

The Nevada Newborn Screening (NBS) Program continued to ensure infants born in Nevada were screened for cystic fibrosis and all current primary conditions and secondary conditions found in the course of screening for core conditions recommended by the Secretary of Health and

Human Services Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children, with the exception of Severe Combined Immunodeficiency (SCID) and Critical Congenital Heart Defect (CCHD). Nevada Revised Statutes (NRS) Chapter 442 requires that newborns receive at least two newborn screenings to ensure that conditions identified on the NBS panel are recognized and treated as early as possible to ensure the best possible medical and developmental outcome for the newborn. While normal weight babies typically receive two screenings, Nevada recently implemented a three-screen process for pre-term, low birth weight, and sick newborns that were admitted to Neo-natal Intensive Care Units (NICU). The Newborn Screening Program continued to ensure that any positive case received necessary services. Positive cases were referred to both the metabolic clinics offered through a contract with Nicola Longo, MD, PhD, and Professor and Chief of Medical Genetics and Pediatrics, University of Utah and to Nevada Early Intervention Services for additional services. The program worked closely with hospitals and healthcare providers to educate the healthcare community about newborn screening issues and provide technical assistance when requested or necessary.

Dr. Donald Buchanan, a board certified neonatologist and pediatrician, was hired to serve as the Medical Director and Senior Physician of the State of Nevada Early Intervention Services clinic in Las Vegas, Nevada. With more than 26 years of service to families in the Las Vegas area, Dr. Buchanan's expertise and knowledge eminently qualified him to become the liaison between the medical community, the newborn screening laboratory and follow-up services, families of newborns identified with inherited and genetic disorders, policy makers, and the general public. Dr. Buchanan was tasked with building stronger relationships with specialists who treat infants and children with conditions identified through newborn screening. Dr. Buchanan worked with the Nevada Early Intervention Developmental Specialists assigned to identifying parental insurance, Medicaid, or uninsured status and to refer parents to services and Children and Youth with Special Healthcare Needs (CYSHCN) resources. Another of Dr. Buchanan's priorities was to work with the Nevada State Health Division to re-energize the Newborn Screening Advisory Committee.

The Newborn Screening Program and Title V funding was used to provide continuing Craniofacial Clinic support to the University of Nevada School of Medicine for services provided to children aged 0-21, including children eligible for Children with Special Health Care Needs, who meet the medical eligibility requirement of cleft palate or other craniofacial anomalies. The MCH funding was used to subsidize a portion of the cost of a clerical support position that was responsible for reporting summary information regarding craniofacial clinics and for documenting referrals to the clinic. Title V also continued its support of CYSHCN care coordination.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In Calendar Year 201, the Nevada NBS program screened approximately 99% of all infants born in the State and approximately 89% of these infants received a second screening			X	
2. The Nevada NBS program supported metabolic specialty clinics for children determined to have a metabolic disorder.		X		
3. The Nevada NBS and CYSHCN programs provided coverage for the diagnosis and treatment of metabolic, endocrine, and hemoglobin disorders.	X	X		
4. The Nevada NBS and CYSHCN programs worked with Nevada Early Intervention Services to ensure that specialty nutrition services provided by registered dietitians were available to families of children born with metabolic and other developmental disorder	X	X		
5. The Nevada NBS program maintained a "registry" of NBS				X

cases.				
6. The newborn screening sample error rate for Calendar Year 2011, based on first specimens that were screened, was 7.15%.			X	X
7. Contract with Dr. Nicola Longo from the University of Utah School of Medicine to conduct quarterly clinics in both Reno and Las Vegas was maintained and will be renewed through June 2014.		X	X	X
8.				
9.				
10.				

b. Current Activities

The NBS Program continues to leverage resources, streamline activities, and increase efficiency. In accordance with direction provided by the 2011 Nevada Legislative Session, NBS is working with the Nevada State Health Laboratory and the University of Nevada School of Medicine to provide newborn screening laboratory and follow-up services in located Nevada in the near future. Technical assistance to help achieve this goal was provided in March by a team led by Brad Therrell from the National Newborn Screening and Genetics Resource Center (NNSGRC).

Nevada is working in conjunction with the Mountain States Genetics Regional Collaborative to finalize the Nevada State Genetics Plan. Focus groups that included a wide range of stakeholders were held in May and the statewide plan is in the draft process. The Newborn Screening Program funded three genetics clinics to eliminate the waiting list that existed for children enrolled in Nevada Early Intervention Services.

NBS provides assistance to families in the ongoing management of disorders identified through the screening process. NBS also continues to provide education regarding proper collection and submission of laboratory specimens to hospitals, commercial laboratories, and medical professionals. NBS maintains its commitment to emphasize the vital importance of newborn screening and promote the goals and program objectives of the NBS Program to parents, healthcare providers, policy makers, and the general public.

c. Plan for the Coming Year

The NBS Program intends to continue to work with the Nevada State Health Laboratory and the University of Nevada School of Medicine to explore the possibility of bringing laboratory and follow-up services for newborn screening to Nevada. Until such time as this occurs, the program will continue to work closely with the contracted laboratory that currently provides those services to Nevada. The program is enhancing its ability to provide short-term follow-up, track those identified in the newborn screening process, and ensure that services are identified for the families of newborns with heritable and congenital disorders.

The program will fund necessary staff positions to provide short-term follow-up and expand the program's ability to provide long-term tracking and follow-up activities. This will include assisting families in the ongoing management of disorders. The program plans to expand education activities relating to the proper submission of laboratory specimens, provide technical support to medical providers regarding medical care for those identified with heritable and genetic disorders, and provide accurate information regarding the purpose of the newborn screening program to policy makers within the state.

The NBS Program intends to re-vitalize the Newborn Screening Advisory Committee as a means to provide expert guidance for the Newborn Screening Program in Nevada. The Newborn Screening Advisory Committee will be expanded and will develop a clear purpose and role with expectations that are clearly defined. Issues that will be addressed include creation of a parent support group for Hemoglobinopathies that will provide an education component, provision of

guidance regarding the addition of metabolic disorders as recommended by the Secretary of Health and Human Services Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children, building partnerships between stakeholders, and reducing loss to follow up.

The Newborn Screening Program plans to focus efforts on providing education and assistance to parents who have a child identified with a disorder and on providing education to high-risk families who plan to have children. In addition, the program plans further work with stakeholders in Nevada to develop family-to-family support services for parents of children identified with a newborn screening-related disorder.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	34996					
Reporting Year:	2011					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	34845	99.6	5	2	2	100.0
Congenital Hypothyroidism (Classical)	34845	99.6	524	12	12	100.0
Galactosemia (Classical)	34845	99.6	13	0	0	
Sickle Cell Disease	34845	99.6	15	14	14	100.0
Cystic Fibrosis	34845	99.6	321	2	2	100.0
Other	34845	99.6	7	7	7	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	34845	99.6	5	5	5	100.0
Glutaric Acidemia Type I	34845	99.6	1	1	1	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	34845	99.6	1	1	1	100.0

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	60	50	50	55	55
Annual Indicator	47.5	47.5	47.5	47.5	64
Numerator					
Denominator					
Data Source		2006 Natl Study	2006 Natl Study	2006 Natl Study	CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	55	60	60	65	65

Notes - 2011

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.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

2006 National Study Data repeated.
Increased outcome objectives to be more in line with the national averages of 57.4% (2006)

a. Last Year's Accomplishments

Nevada continued to be served by critical CYSHCN family support organizations including Family TIES, Nevada's Family Voices affiliate agency, and Nevada PEP, which has served Nevada for over 17 years as the Parent Training and Information Center. Nevada PEP supports family leadership in policy-making decisions at the local and state level to guide the development of meaningful services that are family driven.

Family TIES operates the Nevada Family-to-Family Health Information Center, providing statewide support to families of children and youth with special health care needs. They maintained the CYSHCN toll-free telephone line (1-866-254-3964) providing family-centered, community-based resources and support that is culturally and linguistically competent. Family TIES evaluates client satisfaction and program effectiveness. One tool is their Client Impact Survey for families receiving assistance. A preliminary finding showed that 95% of families reported that they were better able to partner in decision making; 95% reported that they were better able to find and/or learn about community services; and 95% reported more confidence in obtaining health care and services needed. All families reported that services received were useful, very useful or extremely useful.

Nevada Title V continued to refine, based on feedback and evaluation, their care coordination model. It was determined that additional training and emphasis on identification of a medical home, transitioning support and increasing self-efficacy of families needed to be developed. A contract was finalized with a third care coordination provider, Easter Seals, increasing geographical coverage for care coordination services.

Family representatives play integral roles on many of the advisory, program or project and agency leadership teams including, Family TIES, Nevada PEP, University of Nevada, Reno's Leadership Education in Neurodevelopmental Disabilities, Nevada Center for Excellence in Disabilities Consumer Advisory Committee, Nevada Governor's Council on Developmental Disabilities as well as the Maternal and Child Health Advisory Board and regional coalitions.

All MCH contractors and sub-grantees are encouraged to assist their clientele in locating medical homes, accessing public insurance programs (when qualified) and obtaining EPSDT services for their children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Care coordination services for families with CYSHCN provides navigation to emotional, physical, medical and behavioral and financial resources for the family based on individual needs.		X		
2. Feedback from care coordination and information lines are shared with MCH staff and stakeholders to review for strategies for improving family participation.				X
3. State Title V priorities are developed with feedback from parents/caregivers of CYSHCN.				X
4. Collect and disseminate up-to-date information on services and referral sources for families of CYSHCN.			X	
5. Continue to support the inclusion and participation of families in advisory, planning and leadership roles.				X
6. Support parent education and advocacy training.			X	
7.				
8.				
9.				
10.				

b. Current Activities

In addition to continuing activities from the previous year, Nevada MCH leadership began working on a state across-agency team, Expanding Opportunities. The project vision is that "ALL children

in Nevada will receive the necessary comprehensive, coordinated and individualized services and family supports in order to access, participate in, and benefit from high quality, inclusive early care and education opportunities within their communities for optimal development during the critical years from birth through age five". Many of the key components of the project are directly related to supporting the health of young children with disabilities and empowering their families: Parenting Education, Medical Homes and Health Care, Access to Screening, Family Support Services, Family Leadership and Community Engagement and Social-Emotional Development/Mental Health.

In addition the new Statewide Maternal and Child Health Coalition has selected to work on a statewide assessment of the overall services and providers available in Nevada to serve children and adolescents with special health care needs.

c. Plan for the Coming Year

[Trend analysis for future program planning was not available due to changes to the national survey and how this indicator is calculated.]

Nevada Title V will continue to support current activities and identify additional needs and gaps.

New additions to Nevada's CYSCHN team will include the identification of a State Family Contact person, Cathy Robinson, a current staff member who is a parent of a young adult with special health care needs. Ms. Robinson will represent families and will remind us to include their perspective in our internal planning and family outreach efforts.

A new contract position for a CYSCHN Coordinator will be developed to increase our capacity to serve children and youth with special health care needs. Coordinator roles and responsibilities will be established and refined during the first six months. Ultimately, if assessed as beneficial to the state and the CYSCHN population and their families, the coordinator position will be transitioned to a state position.

Performance Measure 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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	55	42	47	51	51
Annual Indicator	41.2	41.2	41.2	41.2	36.8
Numerator					
Denominator					
Data Source		2006 Natl Study	2006 Natl Study	2006 Natl Study	CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	51	51	55	55	55

Notes - 2011

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.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009

This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years) Increased the target objectives to be in line with National averages of 47.1% (2006)

a. Last Year's Accomplishments

Connecting CYSCHN families with a medical home for coordinated, ongoing care has been a goal of our MCH program for many years. Medical home identification and use is promoted at various venues and through working with Nevada's Family Voices chapter; Family Ties and Nevada's Parents Educating Parents organization. Family TIES alone reports that 1,063 families were assisted in accessing a medical home. They also reported that 582 families received assistance in care coordination; 410 received information and/or assistance on child development; 245 families were provided information/assistance on primary care and 176 families received therapy information and resource identification.

The Family-to-Family Health Information Center provided leadership for a Link Up Nevada grant that focuses on quality improvement activities in medical homes for CYSHCN, grant ending 5/31/12. They also interface with the Systems Change Project funded by the Nevada Governor's Council on Developmental Disabilities, which focuses on improving health for people with developmental disabilities across the lifespan. Presentations were made to health providers with information on family-centered Medical Homes at Health Access Washoe County, Nevada Health Centers (Carson City, Elko, Austin, Eureka), Advanced Pediatric Therapies, Indian Health Board, Head's Up Mental Health Clinic and Renown NICU. The Information Center reported that outreach increased referrals from Dr. Johanna Fricke, the only pediatric developmental specialist in Nevada.

Family TIES hosted a topical call, "What is a Medical Home," presented by the National Center on Medical Home Implementation and recruited Dr. David P. Parks as the Nevada Champion for the Medical Home Chapter Champions Program on Asthma.

Expanded knowledge of AAP's Bright Futures guidelines through outreach efforts to clinics and private physicians. Also, provided the Bright Futures family resource materials to communities.

Under the leadership of the Nevada State Health Officer Nevada has developed a School-Based/School-Linked Health Center workgroup to pursue standards for clinic development and operation. The group is including the needs of children with special health care needs in their discussions and will incorporate mental/behavioral health in the recommended services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue work to assure that children identified through newborn metabolic and hearing screenings, as well as through the birth outcomes monitoring have identified a medical home and receive appropriate services.			X	
2. Title V funded health districts refer clients to medical home.			X	
3. MCH information line (Nevada 2-1-1) and CYSHCN line (1-866-254-3964) refer to services including age appropriate screenings and assist families with identifying a medical home. Number of calls are reported to MCH program				X
4. In partnership with Maternal, Infant and Early Childhood Home Visiting, statewide Early Childhood Advisory Council, the local ECACs, regional and statewide MCH coalitions, Title V supports systems development efforts that work to build medical home c				X
5. Implement and assess pilot project to encourage brief mental/behavioral health screenings into primary care physicians' clinics and offices. A core component of the project - identify mental health providers for referrals and follow-up care.		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CYSHCN funded Care Coordination sites are responsible for helping the families they serve identify and work with a Medical Home.

Bright Futures Tool and Resource Kits are being disseminated throughout Nevada, working with the Nevada Maternal and Child Health Coalition to reach providers which include family practice physicians and pediatricians, and mid-level providers. The coalition is also working to distribute Bright Futures' family/caregiver reference and resource materials within local communities with other child health stakeholders.

Implementing and assessing a pilot project to encourage primary care providers to include brief mental/behavioral screenings for children and adolescents (4-18) under their care. This project ended June 30, 2012. An evaluation will be conducted to assess the project process and outcomes.

As part of their contract all Title V funded health districts refer clients to a medical home for ongoing services.

Family TIES will continue its outreach to the medical community including the NICU at Renown, Dr. Fricke, St. Rose Dominican Hospital, Nevada Health Centers. They will produce a physicians

mailing campaign to advance knowledge on the Nevada Family-to-Family Health Information Center and improve family supports and health outcomes for CYSHCN.

c. Plan for the Coming Year

NPM 03 is FAR from the annual performance objective of 51%. The Healthy People 2020 objective is 54.8%, at 36.8% Nevada is far from this objective. The trend has DETERIORATED in the last five years, 12% decrease in trends since 2007, from 41.2 to 36.8%.

Nevada was reported at the lowest end among states for success in meeting this National Performance Measure. It is hoped that recent and ongoing efforts and outreach by the Nevada Maternal and Child Health Coalition, and its broad membership network, will ultimately help Nevada raise the percent of children with special health care needs who receive coordinated, ongoing, comprehensive care within a medical home.

Plans for the coming year include continuing in the current year activities and increasing assessments of projects to review for refinement, expansion, and/or possible elimination. Title V will increase collaboration on public education efforts regarding accessing insurance coverage and the roll-out of the affordable care act benefits, which will hopefully increase CYSHCN access to medical homes.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	64	54	60	62	62
Annual Indicator	53.5	53.5	53.5	53.5	55.2
Numerator					
Denominator					
Data Source		2006 Natl Study	2006 Natl Study	2006 Natl Study	CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	62	70	70	70	70

Notes - 2011

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.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years) Increased the target objectives to be in line with national average of 62.0% (2006 data)

a. Last Year's Accomplishments

Utilization of an on-line application process for Medicaid and SCHIP was piloted within various organizations within the State. Nevada's Access to Healthcare Network was awarded federal funding to increase enrollment in the State's public insurance programs. All Title V MCH and CYSHCN funded programs were asked to assist uninsured clients in identifying and obtaining health care coverage.

The State of Nevada Department of Health and Human Services (DHHS) was awarded an exchange planning grant from the U.S. Department of Health and Human Services Center for Consumer Information and Insurance Oversight (CCIIO). DHHS submitted a Level One implementation grant application to CCIIO through the Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges, Funding Opportunity Number: IE-HBE-11-004 CFDA 93.525.

Chapter 439 of the Nevada Act of 2011 created the Silver State Health Insurance Exchange (SSHIX) administrative structure and authorized the seven-member SSHIX Board of Directors (Exchange Board) to perform the duties necessary to develop and operate the SSHIX. There are three non-voting ex officio State executives on the Exchange Board. The Exchange Board is responsible for: 1) creating and administering a State-based health insurance exchange; 2) facilitating the purchase and sale of qualified health plans (QHPs); 3) providing program(s) to help small employers in Nevada enroll employees in QHPs; and 4) performing all other duties required of the SSHIX under the Patient Protection and Affordable Care Act (ACA). The Exchange Board held its first meeting on October 26, 2011; at which time it reviewed and discussed a variety of materials and approved bylaws and job descriptions for an executive director, chief operating officer, and executive assistant.

The ACA, as further defined by proposed regulations, includes a number of responsibilities that apply to state-based health insurance exchanges, many of which the SSHIX needs to coordinate with DHHS, the Nevada Division of Insurance (DOI), and the Governor's Office of Consumer Health Assistance (GovCHA).

As decisions are being made on eligibility, plan management, enrollment, consumer assistance, financial management, and other functions, coordination across agencies is essential for the successful implementation and operations of the SSHIX. Additionally, DHHS has information, resources, and programs that can be leveraged to design and implement the SSHIX.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Care coordinators assist clients in completing Medicaid/SCHIP			X	

enrollment.				
2. Referrals are made by Title V funded partners to available healthcare coverage including Medicaid/SCHIP or Access to HealthCare Network, a discount health coverage plan.				X
3. Increase knowledge and access to streamlined Nevada Medicaid/SCHIP application process.			X	
4. In collaboration with partners ensure availability of information on the new developments through the Affordable Care Act.			X	
5. Disseminate knowledge of the Silver State Health Insurance Exchange and support consumer (family) voices in development of the SSHIX.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The DHHS has been providing updates to various groups including the Maternal and Child Health Advisory Board and the Nevada MCH Coalition on development of the Silver State Health Insurance Exchange. Title V staff and partners will help to distribute information on the SSHIX to families of children with special health care needs and other MCH populations, as the exchange is developed.

Care coordination sites and other sub-grantees and contractors in the communities continue to address the needs of families with children with special health care needs, including helping them obtain health care coverage.

Results of Nevada’s Kindergarten Health Survey conducted during 2011-12 show that among the population entering Kindergarten there is a decreasing trend in the number of families reporting their child was uninsured, from a high in 2008-09 of 19.1% to 12.3% uninsured during the last survey. In the 2011-12 survey 11.1% of parents reported that lack of insurance was a barrier to accessing health care for their child and 13.1% reported that a lack of money was a barrier.

Improving in this national performance measure is one of the MCH program goals and it is anticipated that national and state initiatives will allow significant progress in the number of children in Nevada with special health care needs whose families have adequate private and/or public insurance to pay for the services they need.

c. Plan for the Coming Year

NPM 04 is FAR from the annual performance objective of 62%. The HP 2020 target is 100%, at 55.2% Nevada is far from the objective.

MCH Staff and funded programs will continue to work on increasing public knowledge of resources for healthcare coverage and services, including the new Silver State Health Insurance Exchange. In coordination with Nevada’s new Maternal, Infant and Early Childhood Home Visiting program, Title V staff will further develop and update broad-based resource identification tools, including information and referral lines, which can be used statewide to assist parents in obtaining coverage.

Performance Measure 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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	80	83	85	90	90
Annual Indicator	82.6	82.6	82.6	82.6	57.2
Numerator					
Denominator					
Data Source		2006 Natl Study	2006 Natl Study	2006 Natl Study	CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	90	90	92	92	92

Notes - 2011

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.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009

This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years) Increased the target objectives to be in line with national average of 89.0% (2006 data)

a. Last Year's Accomplishments

Nevada PEP developed and continued to operate Nevada's Statewide Family Network. Nevada PEP employs family member of children with behavioral health care needs as Family Specialists. Family Specialists can help parents find information, support and resources, provide compassion and understanding of the unique experiences and needs of individual children and families, and assist parents in being advocates for their children and family in accessing support and services

to help them at home, in the community and at school.

Family TIES partners with a number of organizations and agencies to initially understand their programs; share information about community programs with families and identify barriers families have in accessing these services and sharing the barriers with the agencies. During the past year Family TIES assisted over 500 families in navigating systems and accessing community services, including identifying child care, offering parent training and connecting to respite services.

As the Nevada Family to Family Health Information Center and Family Voices State Affiliate, Family TIES continued to reach families across the state and help them access services through direct assistance, broad community outreach and public presentations.

Toll-free information and referral lines continued to be funded through Title V. Staffed with bilingual operators, English and Spanish, the centers offered targeted resources based on the socio-ecological framework that children develop within families, families exist within a community, and the community is surrounded by the larger society, with the intent to serve people based on their individual needs and community resources.

The Nevada Leadership Education in Neurodevelopmental Disabilities (NvLEND) provided training to individuals from a variety of disciplines who are practicing professionals, graduate students, and parents. Trainees were selected who showed promise to assume leadership roles. Trainings conducted through the University of Nevada, helped to chart a course for future collaborations and referrals between providers. The faculty and community professionals leading the trainees included state and national experts in their fields.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain toll-free CYSHCN information and referral line. Information is available via phone, website and text.				X
2. Support inclusion and participation of parent/caregivers of CYSHCN in advisory roles, planning teams and assessment efforts.				X
3. Ensure timely resource information on community services for families of children identified through newborn screening programs and birth outcomes monitoring.			X	
4. Partner with inter-agency projects, for example the school-based health center workgroup, the Technical Assistance Center for Social and Emotional Interventions (TACSEI) and the Department of Education's Expanding Opportunities project, to ensure hea				X
5. Expand care coordination services in the State.		X	X	
6. Family support agencies such as Nevada PEP, and Family TIES are able to sustain their parent training and other supportive services.		X	X	X
7. Strengthen Nevada 2-1-1 information and referral database and outreach.				X
8.				
9.				
10.				

b. Current Activities

NvLEND had eleven trainees complete their interdisciplinary leadership training in June 2012. The class included representatives from PT, OT, pediatric dentistry, pediatrics, education, early childhood special education, psychology, speech, nutrition, social work, and a parent/family representative. The 2013 class has been selected. The thirteen long-term trainees represent speech-language pathology, social work, behavior analyst, two special education representatives, nutrition, two parents of CYSHCN, child psychiatry, PT, dental hygiene education, psychology and higher ed. An additional two candidates have been accepted as medium-term trainees. One of the leadership projects selected by the 2012 class was increasing state awareness and utilization of the CDC's Learn the Signs, Act Early campaign, enhancing collaborative efforts to improve screening and referral to early intervention services.

Title V is actively participating in the inter-agency Expanding Opportunities project, identifying resources, providing guidance and supporting family engagement in components directly related to supporting the health of young children with disabilities and empowering their families.

MCH is working to provide reports on data trends for specific populations with the intention that the findings are routinely used to develop strategic plans to strengthen existing programs and target interventions for increased effectiveness.

c. Plan for the Coming Year

Trend data is not available on the performance measure due to revisions made to the questions since the 2005-06 survey.

In addition to supporting the work in progress, Title V will assess the care coordination service providers for their utilization and knowledge of community-based service systems.

The Nevada MCH Coalition will be contracting with Pamela Hanes, PhD, MSW, to conduct various tasks including completing a statewide assessment of the overall services and providers currently available in Nevada to serve children and adolescents with special health care needs. Ms. Hanes' project will include an analysis to identify needs related to mental health provider access.

Performance Measure 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.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	17	42	45	50	50
Annual Indicator	41.7	41.7	41.7	41.7	31.7
Numerator					
Denominator					
Data Source		2006 Natl Study	2006 Natl Study	2006 Natl Study	CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over					

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	50	50	52	52	52

Notes - 2011

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.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009

This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)

NOTE: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Increased the target objectives to be in line with national average of 41.2% (2006 data)

a. Last Year's Accomplishments

CYSHCN staff will continued to partner with Nevada 2-1-1, Family TIES, and Nevada PEP to assure youth can locate the services they need.

Family TIES provided information and/or assistance to 364 families, including identifying a new healthcare provider to transition out of pediatric services and identifying vocational employment opportunities. In addition, Family TIES supported Teen Councils and Youth Leadership engagement for young adults.

Staff from three Family TIES projects, NVF2F, Link Up Nevada and their VISTA Youth Transition project, worked with several other agencies to address transition issues for YSHCN including the Nevada Special Education Advisory Council, Nevada Department of Education, and People First Chapters. In 2011 Family TIES hosted a Youth Transition Jamboree (Youth Transition Summit). The conference participants gained a greater understanding of the importance and process of

leaving pediatric healthcare for adult services, learning critical steps to ensure a successful transition, strategies for finding those services, and receiving information about local, state, and national health transition resources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Care coordination assists families and individuals up through 21 years of age, including transitioning services.			X	
2. Support transition training for youth and families		X		
3. Family TIES and Nevada PEP maintain information and resources for families on transitions.		X		
4. Collaborate with others to identify current transition activities for assessment and replication of successful programs.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In addition to the above activities, CYSHCN staff are working on the program development for next year's disabilities conference. Transitioning training and resources are being identified to include in the conference.

c. Plan for the Coming Year

NPM 06 is FAR from the annual performance objective of 50% at 31.7%. The trend has DETERIORATED In the last five years. There has been a 32% reduction since 2007, from 41.7 to 31.7%.

Unfortunately, results from the 2009-2010 National Survey of Children with Special Health Care Needs showed a significant decline in the percent of families reporting they received adequate services to transition their youth with special health care needs to all aspects of adult life. In response, Nevada will be seeking technical assistance regarding improving this indicator.

Nevada's Health and Mental Health Divisions will join other agencies, including Family TIES, People First, and Nevada Governor's Council on Developmental Disabilities, to host a statewide conference on disabilities. The program will include a session on Transition issues impacting Youth with Special Healthy Care Needs. Additional useful resources for families will be made available for families and stakeholders at the conference.

Performance Measure 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.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	72	67	69	70	70
Annual Indicator	50.0	45.9	51.1	55.6	61.7
Numerator	37176	34110	48440	52124	102748
Denominator	74316	74382	94846	93767	166429
Data Source		NV Immunization Program	NV Immunization Program	NV Immunization	NV Immunization
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	71	72	73	74	74

Notes - 2011

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."

Notes - 2010

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.

Notes - 2009

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 large increase in the numerator, denominator, and percentage from 2008 is due to the Nevada State regulation requiring all vaccination providers to enter the child's immunization record into WebIZ as of July 2009. Also, the increase between 2008 and 2009 is due to local, state, and health agencies entering in historical immunization records into WebIZ and because of this the data will always be provisional.

a. Last Year's Accomplishments

According to the 2011 Mid-Year National Immunization Survey (NIS), 70% of children aged 19 to 35 months of age were up-to-date on the 4:3:1:3:3:1 series who were living in Nevada. This series includes Varicella. The CDC has not provided data on the series without Varicella since 2008. The NIS is conducted on an annual basis via a random phone survey to determine a child's immunization status. Immunization status is determined from documentation from the parent and their provider.

According to the 2010 National Immunization Survey (NIS), 66% of children aged 19 to 35 months of age were up-to-date on the 4:3:1:3:3:1 series who were living in Nevada. This shows a 4% improvement. Full 2011 data will be released by the CDC in September 2012.

Improvements in vaccination rates in Nevada are being attributed to having a mandatory immunization registry. Immunization registries are confidential, online computerized databases that collect vaccination data on individuals in a specific geographic area, such as a state. Immunization registries are used as a tool to gather vaccination records from multiple providers, and in turn, consolidate the records in one location. Nevada's immunization registry is mandatory. Therefore all vaccinations administered in Nevada must be recorded into the immunization registry. However, people do have the option to opt-out of the immunization registry.

The 4:3:1:3:3:1 series stands for:

4 doses of diphtheria, tetanus, acellular pertussis

3 doses of polio

1 dose of measles, mumps, rubella

3 doses of haemophilus influenza type b

3 doses of hepatitis B

1 dose of varicella.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to education health care professionals on Nevada immunization registry law.		X		
2. Continue to train vaccinators on how to use the immunization registry.				X
3. Continue to educate providers on the immunization schedule.		X		
4. Continue to provide vaccines to providers that are enrolled in the Vaccines for Children program		X		
5. Continue to recruit providers into the Vaccines for Children program.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

For 2012, several activities are being conducted to improve immunization rates in the 19 to 35 month olds throughout Nevada.

- Continue to educate health care professionals on the Nevada immunization registry law;
- Continue to train vaccinators on how to use the immunization registry;
- Continue to educate providers on the immunization schedule;
- Continue to provide vaccines to providers that are enrolled in the Vaccines for Children Program;
- Continue to promote the Vaccines for Children Program to parents; and
- Continue to recruit providers into the Vaccines for Children Program.

c. Plan for the Coming Year

NPM 07 is CLOSE TO the annual performance objective 70% at 61.7%. The trend has IMPROVED in the last five years. There has been a 19% increase since 2007, from 50% to 61.7%. To achieve the annual performance objective, there would need to be a 12% increase in the percent of 19 to 35 months olds who receive immunizations.

For 2013, several activities have been identified to help improve immunization rates in the 19 to 35 month olds throughout Nevada.

- Continue to educate health care professionals on the Nevada immunization registry law;
- Continue to train vaccinators on how to use the immunization registry;
- Continue to educate providers on the immunization schedule;
- Continue to provide vaccines to providers that are enrolled in the Vaccines for Children

Program;

- Continue to promote the Vaccines for Children Program to parents;
- Continue to recruit providers into the Vaccines for Children Program;
- Increase provider education;
- Increase reminder/recalls;
- Collaborate with WIC offices to assess immunization records and vaccinate children who are not up-to-date;
- Collaborate with State office that licenses child care centers to promote the enforcement of immunization laws in child care centers;
- Collaborate with child care centers to assess immunization records and vaccinate children who are not up-to-date; and
- Increase messaging to parents on the importance of vaccinations.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	25	24	24	23	18
Annual Indicator	26.4	25.7	24.1	19.0	19.1
Numerator	1465	1440	1275	1010	986
Denominator	55520	55942	52944	53126	51656
Data Source		Vital Stats	Vital Stats	Vital Stats	Vital Stats
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	17	17	16	16	16

Notes - 2011

Data entered is for 2011. The data is preliminary and will be available in December of 2013.

Notes - 2010

Data entered is for 2010. The data is preliminary and will be available in December of 2012.

Notes - 2009

Data entered is for 2009 and is final.

a. Last Year's Accomplishments

Nevada applied for and was awarded two federal grants aimed at pregnancy prevention by the Administration for Families and Children (ACF); the State Personal Responsibility Program (PREP) grant and the Abstinence Education Grant Program (AEGP). The Nevada State Health Division (NSHD) hired staff for a new adolescent health program including a program manager, a health program specialist, and three health resource analysts. NSHD contracted with Carson City Health and Human Services (CCHHS) to implement a pilot of the evidence-based program "Promoting Health Among Teens, Abstinence Only!" (PHAT!). CCHHS worked with the Nevada Department of Child and Family Services (DCFS) to ensure that youth in foster care were given enrollment priority to prevent unintended pregnancies and exposure to STIs/HIV within this population.

NSHD Women's, Adolescent, and Early Childhood Section Manager, Beth Handler, and the NSHD Adolescent Health Program Manager, Natalie Powell, traveled to Maryland to attend the Family and Youth Services Bureau's First Annual Teen Pregnancy Prevention Conference, Effective Pregnancy Prevention Programming: From Research to Practice, from April 30-May 2, 2012. The conference was the first annual grantee meeting for the State Personal Responsibility Program (PREP) and Abstinence Education Grant Program (AEGP). The CCHHS PHAT! Coordinator, Valerie Cauhape, was also able to attend the annual grantee meeting in Maryland.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nevada awarded State Personal Responsibility Education Program (PREP) grant. (FY2010, FY2011 & FY2012)				X
2. Nevada awarded State Abstinence Education Program (AEGP). (FY2011 & FY2012)				X
3. NSHD hired staff for new Adolescent Health programs.				
4. Staff attended Family and Youth Services Bureau's First Annual Teen Pregnancy Prevention Conference.				X
5. NSHD contracted with Carson City Health and Human Services to implement pilot of evidence-based program "Promoting Health Among Teens, Abstinence Only!" (PHAT!)			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Adolescent Health Staff at the Nevada State Health Division (NSHD) is working on several projects aimed at pregnancy prevention and reducing the rate of birth for teenagers aged 15 through 17 years. Under the State Personal Responsibility Program (PREP), NSHD is working with sub grantees to implement evidence-based programming that educates adolescents on both abstinence and contraception as well as the following adulthood preparation topics; Healthy Life Skills, Healthy Relationships and Adolescent Development. NSHD has a team of health resource analysts working to develop a comprehensive profile of the status of adolescent health in Nevada. The data and accompanying report will be utilized to establish baseline data for pregnancy prevention efforts, to highlight any needs and gaps in existing programming and services, and to

inform future prevention efforts.

Under the Abstinence Education Grant Program (AEGP), NSHD is establishing a program for youth ages 9-12, with preference given to youth in foster care, who are significantly more likely than their peers to become pregnant or to father a child at an early age. NSHD is working with Carson City Health and Human Services (CCHHS) to implement a pilot of the evidence-based program "Promoting Health Among Teens, Abstinence Only!" (PHAT!). Additionally, NSHD is working with the Nevada Broadcaster's Association to develop a statewide media campaign to promote abstinence, and participating in the statewide MCH Coalition.

c. Plan for the Coming Year

NPM 08 is CLOSE TO the annual performance objective of 18 per 1,000 at 18.9 per 1,000 live births for teens. The trend has IMPROVED in the last five years, with a 40% reduction in teen births.

Continue to implement evidence-based programming to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections (STIs), including HIV/AIDS as well as the following adulthood preparation subjects:

- * Healthy relationships, such as positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions.

- * Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects.

- * Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

Continue statewide media campaign for the Abstinence Education Grant Program.

Establish and maintain an interactive adolescent website that provides updates on the Nevada PREP project and resources and information website for teenagers with local, state and national sources.

Expand evidence-based programming to rural areas.

Disseminate the results of the Adolescent Health Profile.

Strategic planning and development of new Adolescent Health programs.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	42	44	38	38	40
Annual Indicator	41	37.5	37.0	37.0	37.0
Numerator			13321	13321	12453
Denominator			36003	36003	33656

Data Source		BSS 2006	BSS 2006	BSS 2006	BSS 2008
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	40	42	42	42	42

Notes - 2011

The Denominator is 33,656.

The 2007 numerator is from the 2006 Basic Screening Survey (BSS). The 2008-2010 numerator is from the survey conducted in those years. For the 2006 survey the denominator for the 2004-2005 school year was used. For the 2008-2009 survey the denominator for the school year 2006-2007 was used. The denominator numbers provided above are the number of third graders enrolled in the school year 2004-2005, 2006-2007 and 2008-2010 in Nevada based on a report that the Department of Education provides.

The 2011 numerator is based upon the Nevada Health Division's Oral Health Program report of 37% from the Basic Screening Survey (BSS) 2008 for all 3rd Graders having received a dental sealant on at least one molar. The 2011 denominator is from the Nevada Department of Education's Statewide NRS 387 303 Report FY2011.

Notes - 2010

The Denominator is 36,003.

Oral Health Surveys are not conducted every year. The 2004 and 2005 numerator is from the 2003 Basic Screening Survey (BSS). The 2006 numerator is from the oral health survey that was conducted in that year. The 2007 numerator is from the 2006 survey. The 2008-2010 numerator is from the survey conducted in those years. For the 2006 survey the denominator for the 2004-2005 school year was used. For the 2008-2009 survey the denominator for the school year 2006-2007 was used. The denominator numbers provided above are the number of third graders enrolled in the school year 2004-2005, 2006-2007 and 2008-2010 in Nevada based on a report that the Department of Education provides.

Notes - 2009

The Denominator is 34,320.

Oral Health Surveys are not conducted every year. The 2004 and 2005 numerator is from the 2003 Basic Screening Survey (BSS). The 2006 numerator is from the oral health survey that was conducted in that year. The 2007 numerator is from the 2006 survey. The 2008-2009 numerator is from the survey conducted in those years. For the 2006 survey the denominator for the 2004-2005 school year was used. For the 2008-2009 survey the denominator for the school year 2006-2007 was used. The denominator numbers provided above are the number of third graders enrolled in the school year 2004-2005, 2006-2007 and 2008-2009 in Nevada based on a report that the Department of Education provides.

a. Last Year's Accomplishments

Nevada has increased coverage of protective sealants to schools through three oral health programs: Future Smiles, Seal Nevada South and the Saint Mary's Sealant Program.

- Future Smiles, a school-based dental sealant program in Las Vegas, provides screenings, child dental prophylaxis, fluoride varnish and oral health education. Future Smiles expanded services to six different schools in Clark County serving 351 students administering a total of 3,221 protective sealants in 2011. Schools include Clark High School and Cunningham, Fay Herron, Hollingsworth, Martinez and Whitney Elementary Schools.

- Seal Nevada South, a school based dental sealant program in Southern Nevada provided screenings, oral health education and protective sealants to three schools: Ira Earl, Vegas Verdes and Wasden Elementary School. Seal Nevada South served 68 students administering a total of 368 protective sealants.

- The Saint Mary's Take-Care-a-Van Sealant Program serves schools primarily in Washoe County. They provide screenings, sealants, fluoride varnish treatments, oral health education, referrals and tracking of children seen. The Saint Mary's Dental Sealant screened 501 school aged children in 2011 and placed 792 sealants on 280 children and applied 472 fluoride varnish treatments.

Combined data for Future Smiles, Seal Nevada South and Saint Mary's for state FY '11 shows that: 699 students received sealants; 4,381 sealants were placed; 19 schools were served; and an average of six sealants was placed per child.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to collaborate with and provide technical support to Saint Mary's, Community Coalition for Oral Health, UNLV School of Dental Medicine, and the College of Southern Nevada on school-based dental sealant programs.				X
2. Continue to provide technical support for school-based dental sealant program planning, implementation, and evaluation.				X
3. Promote sealant placement by Medicaid and Nevada Check Up providers and by the private practice community.			X	
4. Ensure continued support for sealant programs by funding the Oral Health Program Manager position with MCH Block Grant funds.				X
5. Continue to collect, analyze and report data on sealants.				X
6. Utilize data to identify disparities in access to dental disease prevention services including dental sealants.				X
7. Coordinate outreach of community and school-based dental sealant programs to reduce duplication, address gaps and reach target populations.				X
8.				
9.				
10.				

b. Current Activities

- Future Smiles, the Clark County School District, and the Oral Health Program are conducting a longitudinal study compiling information on preventative services, children's attendance, student achievement and potential implications toward improved health and well being.

- Christina Demopoulos, DDS, MHP of the UNLV School of Dental Medicine is collaborating with Future Smiles to revitalize screening, education and sealant services in the South.

- The Saint Mary's Take-Care-a-Van Sealant Program continues to provide their services to targeted 2nd graders.
- Seal Nevada North provides the Miles for Smiles bus to the rurals expanding from Elko into Wells, Jackpot, Battle Mountain, Wendover, Winnemucca, Ely, and McGill. They serve children 18 years of age and younger and services include restorative and preventive care, exams, cleanings, sealants, fluoride treatments, extractions, x-rays, oral health education and fillings. They also assist with enrollment in Nevada Check-Up or Medicaid.
- A surveillance project is being conducted with Head Start Programs statewide in conjunction with the TMCC Dental Hygiene Department and the CSN Dental Hygiene Department. Data collected will include: untreated decay, decay experience/treated decay, Early Childhood Caries, and treatment urgency.
- Clark County Dental Initiative is offering oral health services and education within at-risk schools, community health fairs, Boys & Girls Clubs and family resource centers.

c. Plan for the Coming Year

NPM 09 is CLOSE TO the annual performance objective of 40% at 37%. If using the Healthy People 2020 target of 28.1%, Nevada has SURPASSED this objective. In the last five years the trend has DETERIORATED. There has been an 11% reduction since 2007, from 41 to 37%.

- The Oral Health Program intends to continue to support the .5 FTE Statewide Sealant Coordinator position. The scope of work includes tracking sealant program activities and supporting program development.
- The Oral Health Program will continue offering community and health care provider education on the benefits and potential public health cost savings of providing dental sealant services. The program will also provide technical assistance with data collection and evaluation on existing programs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	2.3	2.2	2	2	1.9
Annual Indicator	2.5	2.3	1.6	1.1	1.1
Numerator	14	13	9	6	6
Denominator	569703	573966	560979	559976	553887
Data Source		ICD 9 codes- Cause of Death	ICD 10 codes- Cause of Death	ICD 10 codes- Cause of Death	ICD 10 codes- Cause of Death
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events					

over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	1.8	1.7	1.6	1.5	1.5

Notes - 2011

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.

Notes - 2010

Data entered is from 2010. 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.

Notes - 2009

Data entered is from 2009. 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.

a. Last Year's Accomplishments

The Injury Prevention Program continued involvement in the Nevada Executive Committee on Traffic Safety, which met several times this year; addressing highway safety in a comprehensive and coordinated manner that involves a variety of federal, state, and local agencies committed to improving highway safety. Continue active participation within in the Seat Belt CEA Team and Nevada Strategic Highway Safety Plan (SHSP).

The Injury Prevention Program continued involvement in the Child Passenger Safety Task Force, organized by the Nevada Office of Traffic Safety Office; providing guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.

Motor vehicle crashes continued to be a priority of Nevada's Injury Prevention Task Force. The Task Force members continued many collaborative prevention efforts regarding motor vehicle crash throughout the State.

The Injury Prevention Program continued collaboration with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, Nevada Department of Public Safety, and the Nevada Office of Traffic Safety, and looked for other opportunities to have a voice at the table.

The Injury Prevention Program continued to collect, analyze and disseminate reports on motor vehicle crash data, providing data to local communities and stakeholders.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Continue collaboration where possible on MVC related activities with other private-public organizations.				X
2. Collection, analysis, and dissemination of data on moto vehicle crash data to local communities and stakeholders upon request.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2011 the Nevada State Health Division was notified by the Centers for Disease Control and Prevention that its application for continued funding through the Core Violence and Injury Prevention Program was approved but would be unfunded for the next five years. Unfortunately, these were the monies used to fully sustain the Nevada Injury and Violence Prevention Program, and the program had to be sunsetted.

Even with the effects of the budget cuts many injury and violence prevention activities are still being conducted throughout the state, including both public and private organizations.

These activities include the Nevada Executive Committee on Traffic Safety, Nevada Strategic Highway Safety Plan (SHSP), and the Zero Fatality, Drive Safe Nevada campaign organized and maintained by the Nevada Department of Transportation.

The Nevada Office of Traffic Safety Office continues to maintain and regular convene the Child Passenger Safety Task Force; providing guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.

The Office of Public Health Informatics and Epidemiology within the Nevada State Health Division continues to collect motor vehicle crash data, providing data to local communities and stakeholders when requested.

c. Plan for the Coming Year

NPM 10 has SURPASSED the annual performance measure of 1.9 deaths per 100,000 children at 1.1 deaths per 100,000 children. The trend has IMPROVED in the last five years, with a 76.6% reudction in rates since 2006.

Health Division program staff will continue to look for opportunities to incorporate injury and violence prevention activities, messages and best practices within existing and funded programs throughout the Health Division.

The Office of Public Health Informatics and Epidemiology within the Nevada State Health Division will continue to collect motor vehicle crash data and providing data to local communities and stakeholders when requested.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	27	32	27	28	28
Annual Indicator	26.5	25.1	25.6	19.8	18.4
Numerator					
Denominator					
Data Source		PedNSS	PedNSS	PedNSS	PedNSS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	28	28	30	30	30

Notes - 2011

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.

Notes - 2010

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.

Notes - 2009

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.

This is just WIC data; Nevada has no other way to capture rates at the infant's 6 month mark. We can ask WIC for it directly, or we can get it from the federal agencies that they send it to: PedNSS. CDC, through the National Immunization Survey, produces a breastfeeding report card for each state that includes process and outcomes indicators.

http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm

CDC through their National Immunization survey conducts it annually.

CDC is by the entire state, we should be able to get clinic data directly from Nevada WIC Program, could be possible to run a report by zip code.

HP 2010 Objective 16-19b, increase to 50% (Baseline: 29% in 1998)

a. Last Year's Accomplishments

The Statewide Breastfeeding Program made huge strides last year and built many relationships across the state. The program completed the following: created and distributed 5,000 Nevada

Breastfeeds 2011 calendars using pictures of Nevada moms and babies, ordered and distributed three types of breast pumps and other breastfeeding accessories to all WIC clinics, revised WIC's breastfeeding policies and procedures, expanded the peer counseling program, held activities for World Breastfeeding Week, and served as a resource for other employers who created lactation rooms at their business.

The Statewide Breastfeeding Program created a statewide breastfeeding website, which now serves as a resource for anything to do with breastfeeding in Nevada. Topics included on the website are: parent resources, employer resources, Business Case for Breastfeeding toolkit, baby-friendly hospital information, state and federal breastfeeding legislation, local coalition information, and breastfeeding news. Visit our website at www.NevadaBreastfeeds.com

The Statewide Breastfeeding Program continued to offer different breastfeeding trainings last year, including Certified Lactation Educator trainings, to WIC staff, nurses and interested community members across the state. Two 45-hour trainings were offered last year: one in Reno and one in Las Vegas, with a total of 150 participants.

WIC's Breastfeeding Peer Counseling Program expanded from \$127,300 to \$658,500 last year. With this increased funding we funded nine local agencies with 36 Peer Counselors participating across the state. We also hired a State Peer Counseling Coordinator who has provided ongoing trainings and technical assistance to all of the Programs.

The Statewide Breastfeeding Program support and collaborate with our local Breastfeeding Coalitions in Northern and Southern Nevada in any way possible.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to offer different breastfeeding trainings, including CLC trainings to WIC staff and nurses across the state.		X		
2. Support any breastfeeding specialist/advocate to take the IBCLC exam.				X
3. Continue to support the local Breastfeeding Coalitions in Northern and Southern Nevada.				X
4. Encourage all birthing hospitals in NV to move towards becoming a Baby-Friendly hospital.				X
5. Produce and distribute 5,000 breastfeeding calendars across the state, in an effort to normalize breastfeeding.				X
6. Maintain our statewide breastfeeding website, which serves as a resource to Nevada residents.				X
7. Direct Nevada WIC's Breastfeeding Peer Counseling Program, statewide.				X
8.				
9.				
10.				

b. Current Activities

The Statewide Breastfeeding Program has continued to offer breastfeeding trainings this year, including a Certified Lactation Educator training to WIC staff, nurses and interested community members across the state. The forty-hour training was offered in March 2012, with a total of 48 participants and was co-sponsored by Renown Regional Medical Center.

The Program contracted with the Breastfeeding Task Force of Nevada to conduct a breastfeeding needs assessment on Nevada's maternity services hospitals. Using this information, the Task Force then produced a comprehensive report on breastfeeding promotion and support in Nevada hospitals. This report was distributed to all hospital administrators and will encourage them to adopt baby-friendly practices for their facility.

The Program produced and conducted a statewide breastfeeding public awareness campaign to

educate the public about Nevada's law that protects a woman's right to breastfeed in public, and to advertise WIC's commitment to support breastfeeding. The campaign included television ads, radio ads, movie theater ads, billboards, posters, bus signage, and website updates.

c. Plan for the Coming Year

NPM #11 is FAR from the annual performance objective of 28%, at 18.4% of mothers who breastfeed their infants. The trend has DETERIORATED in the last five years, with a 44% reduction since 2007.

The Statewide Breastfeeding Program plans to encourage and support Nevada birthing hospitals to adopt Baby Friendly practices and to eventually become Baby Friendly Hospitals.

Nevada WIC will continue to expand/improve their Peer Counseling Program, maintain their breast pump distribution program, promote World Breastfeeding Month in August, and revise breastfeeding policies and procedures, as well as the breastfeeding class curriculums.

The Statewide Breastfeeding Program, through Nevada WIC, will continue to offer different breastfeeding trainings, including CLC trainings and a more basic training, to WIC staff, nurses and interested community members across the state.

The Statewide Breastfeeding Program will continue to support and help build the local breastfeeding coalitions in Reno, Las Vegas and Carson City.

The Statewide Breastfeeding Program has plans to create and distribute a 2013 breastfeeding calendar, continue to work with the state Human Resources Department to implement worksite lactation support in all state office buildings, build relationships with Nevada hospitals and encourage them to adopt breastfeeding friendly practices. The Program will work to include lactation information in the Nevada nursing schools and medical school curriculum, and will work to improve statewide data collection surrounding breastfeeding.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	97	99	99	99	99.5
Annual Indicator	98.8	99.2	98.9	99.8	99.1
Numerator	38744	38232	37205	34433	34263
Denominator	39209	38541	37600	34517	34580
Data Source		EHDI database	EHDI database	EHDI database	EHDI database
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	99.5	99.5	99.5	99.5	99.5

Notes - 2011

From the state Early Hearing Detection & Intervention (EHDI) database.

Notes - 2010

From the state Early Hearing Detection & Intervention (EHDI) database.

Notes - 2009

From the state Early Hearing Detection & Intervention (EHDI) database.

a. Last Year's Accomplishments

The Nevada Early Hearing Detection and Intervention (EHDI) Program worked on a number of issues that affect newborns identified with hearing loss through newborn screening. One of the most difficult issues for the program to address was the shortage of audiologists that routinely treat newborns in Nevada. This results in delays in diagnosis, increased loss to follow-up and creates frustration for parents and healthcare providers. In order to address the issue, the program worked to decrease the hospital referral rate to decrease the burden of conducting unnecessary diagnoses for audiologists, worked with other audiology programs around the nation to recruit audiologists to Nevada, and worked with audiologists currently in Southern Nevada to expand their practice to include pediatric patients.

The program's contracted audiologists worked closely with hospitals statewide to provide training in proper newborn screening techniques. The program provided hospitals with a binder that included an explanation of the goals and objectives of the EHDI program, screening guidelines and technical assistance to improve screening, hospital quality indicator recommendations, strategies for maintaining appropriate referral rates, frequently asked questions, newborn hearing screening scripts, informational brochures for parents, data reporting requirements and standardized forms, and resources including training, contacts, and guidelines for pediatric medical home providers.

The EHDI Program received direct funding through the Centers for Disease Control and Prevention Nevada Early Hearing Detection and Intervention Tracking Program Grant (Project Period 07/01/2008 -- 06/30/2011) and through the Nevada Early Hearing Detection and Intervention -- Information System (ISO Survey Grant (Project Period 07/01/2011 -- 06/30/2016) to develop and maintain a statewide data system to track and monitor progress of newborns identified with hearing loss. The Nevada EHDI Program continued progress toward the development and implementation of the EHDI database in the Newborn Hearing Screening module, a part of the Nevada web-based Birth Registry (WEVRRS) database to allow better tracking and follow-up for referred infants. The EHDI Program also received direct funding through the HRSA Universal Newborn Screening Grant (Project Period 09/01/2002 -- 08/31/2012) to focus on reducing loss to follow-up within the state. The funds focus on the development of more comprehensive education of hospital screeners, nursing staff, parents, and developing audiology referral capacity in Southern Nevada.

The program worked with non-profit organizations around the state including Hands and Voices, the Deaf and Hard of Hearing Advocacy Resource Center and A.G. Bell to develop cooperation and greater communication regarding hearing loss issues. The program worked closely with community partners to create a better referral system for parents of children that have been identified with hearing loss. Finally, the program personalized the Loss and Found Video with Nevada-specific information.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Nevada Newborn Hearing Screening program screens			X	

approximately 99% of infants born in the State.				
2. Families with infants who were referred for further hearing evaluation post hospital discharge are directly referred to Nevada Early Intervention Services.		X		X
3. The Newborn Hearing Screening program works with Early Intervention Services to encourage follow up evaluation for hearing and speech and language development assessment		X		X
4. The Newborn Hearing Screening program works with CYSHCN to offer families assistance with accessing needed services.	X	X		
5. The Newborn Hearing Screening program maintains a "registry" of children who were referred for further hearing evaluation.			X	X
6. A web-based tracking system is being developed to meet the needs of the program.				X
7.				
8.				
9.				
10.				

b. Current Activities

The program worked with Nevada Hands and Voices, the Deaf and Hard of Hearing Advocacy Resource Center, and AG Bell to develop, implement, and enhance existing programs and processes to guide families through the EHDI process and provide education and advocacy for families of children identified with hearing loss. Nevada representation at the annual EHDI Conference was increased to ensure that someone from the state could participate in each break-out session and bring back information to share with the program and all community partners.

In conjunction with Nevada Hands and Voices, the program sponsored SKI-HIGH Training for 45 representatives from school districts and early intervention services in Nevada. The curriculum was developed to serve as a resource for early interventionist and families of infants and young children who are deaf or hard of hearing. The training focuses on family centered services and had last been presented in Nevada 18 years ago.

The EHDI Program continued to expand marketing activities, including development of new brochures, posters and promotional activities, and targeting materials to ensure maximum effectiveness. Grant funding provided a contract audiologist to educate hospital screeners in best practices and appropriate referral and to provide technical assistance to audiologists in pediatric techniques. The program started a workgroup with interested audiologists statewide to develop guidelines for appropriate screening for newborns.

c. Plan for the Coming Year

NPM 12 is CLOSE TO the annual performance objective of 99.5% at 99.1%. There has NOT BEEN A SIGNIFICANT CHANGE in the trend in the last five years, with a 0.3% increase since 2007.

The EDHI Program's database will be updated to include historical information that was previously maintained in an internal database and will include more diagnosis and follow-up information. Follow-up information will also be enhanced by the establishment of a statewide "Guide by Your Side" program, a parental mentorship program developed by the national Hands and Voices Program. Parents with experience navigating through the Nevada newborn screening process will be selected to provide mentoring to parents of newly identified infants with hearing

loss. Mentors will have the ability to contact parents directly, provide educational materials, guidance and resource information, and collect data for the database.

The program plans to continue working with audiologists statewide to perfect the guidelines that will be used to ensure that audiologists treating newborns are aware of the unique challenges that newborn diagnosis presents. Based on answers to a survey, the program will eventually provide a list of audiologists in Nevada that meet the criteria established for "Best Practices" on the Health Division website. Nevada will also work with EHDI-Pals, a program that has been developed nationally, to address similar issues and make the selection of an appropriate audiologist less daunting for parents of newborns with hearing loss.

Nevada will participate in a 17-state Improving Hearing Screening and Intervention Systems (IHSIS) Learning Collaborative. Over the next 18 months, Nevada will work with National Initiative for Children's Healthcare Quality (NICHQ) and other state EHDI programs to test, share, and implement ideas to improve the quality and timeliness of screening, audiologic diagnosis, and entry into intervention. This project uses a Quality Improvement (QI) approach to develop solutions to hearing loss issues that have been identified nationwide. Through participation in previous collaboratives, states have decreased their loss to follow-up, increased parent involvement, improved data systems, and spread ideas that improved the quality of care to newborns with hearing loss and helped ensure that every infant receives the care they need.

The contract audiologist on staff will continue to track and provide follow-up for infants who do not pass their initial screening. This effort includes building stronger relationships with hospitals to provide direct referrals to other audiologists and helping audiologists understand the unique technical aspects of newborn hearing diagnosis. The EDHI Program will continue efforts to provide education and technical assistance to hospitals, medical providers, parents, decision makers, and the general public regarding hearing screening and services available statewide.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	17	16	14	14	15
Annual Indicator	18.8	16.9	16.9	15.6	17.5
Numerator	122018	128670	128670	110400	117196
Denominator	648797	763309	763309	708200	668200
Data Source		GBPCA 2009 Rpt	GBPCA 2009 Rpt	HKFF 2010 State Report	U.S. Census Bureau 2011.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	15	14	14	12	12

Notes - 2011

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/hihist5B.xls>

Notes - 2010

The Henry Kaiser Family Foundation (HKFF) is a primary source for the Great Basin Primary Care Association (GBPCA). The GBPCA annual report for 2010 has not been released, so their primary source HKFF was utilized. Children are calculated for 0-17 years of age.

<http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=30&ind=127&sub=39>

a. Last Year's Accomplishments

Title V began adapting contracts and subgrants to require funded partners to prioritize identifying insurance coverage for any uninsured MCH populations they serve.

Nevada Medicaid/SCHIP piloted an online application process that went very well and will be rolled out statewide. It is hoped that this electronic process will simplify approvals and reduce the turnaround time for families to access public insurance coverage.

In 2010 the Affordable Care Act (ACA) was signed into law. Reforms under the ACA have given Americans new rights and benefits, by helping more children get health coverage, ending lifetime and most annual limits on care, allowing young adults under 26 to stay on their parent's health insurance, and giving patients access to recommended preventive services without cost. Another change that may increase the number of children with insurance coverage is the tax credits being offered for small businesses that provide insurance to employees.

The population impact of these reforms and others to be rolled out through 2014 are still to be determined. Title V staff were tasked with being informed of the timeline for the rollout of ACA components and their potential benefits and requirements.

Title V continues incorporating requirements for funded partners to prioritize identifying insurance coverage for the uninsured MCH populations they reach.

The new Nevada Medicaid/SCHIP online application is being rolled out statewide. It is hoped that this electronic process will simplify approvals and reduce the turnaround time to approve families for public insurance coverage. Title V and other MCH stakeholders are supporting the training of local agency staff (i.e., family resource centers, public health clinics) to assist applicants in preparing for and applying online for Medicaid/SCHIP.

The population impact of the Affordable Care Act (ACA) reforms are still to be determined. Title V staff are keeping informed of the timeline for the rollout of ACA components and their potential benefits and requirements. The impact of the ACA on increasing the proportion of children with health insurance coverage will be monitored and assessed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Incorporate requirements into funded activities that healthcare insurance options are identified and clients who are not currently insured are provided assistance in the application process.		X		
2. Title V staff lead efforts to keep Nevada’s MCH stakeholders informed about the ACA and it’s impacts and benefits for our MCH population				X
3. MCH Epidemiology staff monitors the proportion of the Nevada’s children without access to insurance and assess the contributing factors.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Title V will institutionalize incorporating requirements for funded partners to prioritize identifying insurance coverage for the uninsured MCH populations they reach.

Title V will continue to support the training of local agency staff (i.e., family resource centers, public health clinics) to assist applicants in preparing for and applying online for Medicaid/SCHIP. The population impact of the Affordable Care Act (ACA) reforms are still to be determined.

Title V staff will stay informed and worked with MCH stakeholders in Nevada to increase public knowledge of ACA components and their potential benefits and requirements.

The impact of the ACA on increasing the proportion of children with health insurance coverage will continue to be monitored.

c. Plan for the Coming Year

NPM 13 is CLOSE TO the annual performance objective of 15% at 17.5%. There is no specific HP 2020 objective, but related to Objective 1; Nevada is FAR from the objective of 100%. In the last five years there HAS NOT BEEN A SIGNIFICANT CHANGE in trend. There has been a 7% reduction since 2007, from 18.8 to 17.5%.

Title V will institutionalize incorporating requirements for funded partners to prioritize identifying insurance coverage for the uninsured MCH populations they reach.

Title V will continue to support the training of local agency staff (i.e., family resource centers, public health clinics) to assist applicants in preparing for and applying online for Medicaid/SCHIP. The population impact of the Affordable Care Act (ACA) reforms are still to be determined.

Title V staff will stay informed and worked with MCH stakeholders in Nevada to increase public knowledge of ACA components and their potential benefits and requirements.

The impact of the ACA on increasing the proportion of children with health insurance coverage will continue to be monitored.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	14.5	11	11	10	11
Annual Indicator	12.6	13.8	14.8	14.6	14.3
Numerator					
Denominator					
Data Source		PedNSS tables	PedNSS tables	PedNSS tables	PedNSS tables
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	11	11	10	10	10

Notes - 2011

Using the CDC's 2011 Pediatric Nutrition Surveillance Nevada Summary of Demographic Indicators Children Aged <5 Years Table 2C.

Notes - 2010

Using the CDC's 2010 Pediatric Nutrition Surveillance Nevada Summary of Demographic Indicators Children Aged <5 Years Table 2C.

Notes - 2009

Using the CDC's 2009 Pediatric Nutrition Surveillance Nevada Summary of Demographic Indicators Children Aged <5 Years Table 2C.

a. Last Year's Accomplishments

Reducing the rates of overweight and obesity among children is a priority for Nevada WIC. The baseline in Nevada for FY11 for children with a BMI less than or equal to the 85th percentile is 14.3%. This is only a slight decrease from the previous two years of 14.6% in FY10 and 14.8% in FY09. In Nevada WIC, the evolution of participant-centered services includes a strong nutrition education component working toward influencing healthy eating behaviors as the core of WIC nutrition services. Several trainings have been offered during the past fiscal year to help staff improve skills in approaching clients in a participant-centered manner about topics that influence weight. Advance counselor skills trainings took place in 2011 with WIC certifiers, nutritionists and peer counselors to support this movement along with advance skill trainings for conducting facilitated group discussions with WIC participants.

As nutrition education around obesity prevention and education is a public health concern, Nevada WIC also featured nationally recognized speakers at the Nevada WIC all staff statewide conference in 2011. Experts spoke on the topics of nutrition education and obesity. Specific

sessions included "Tapping into the Power of Influence" presented by Pam McCarthy which focused on using techniques to help move people closer to their desired behaviors, "The Life-Course Perspective in Relation to Maternal, Child, Health Nutrition" and a session by Cathy Carothers titled "Connecting Before Content: Helping WIC Moms Breastfeed which included engaging messages on the powerful health benefits that breastfeeding can provide to both mom and baby.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Host workshops to continue to support and train local agency staff on Participant-centered service skills.		X	X	
2. Host State conference to keep abreast in current nutrition and breastfeeding related topics.		X	X	
3. Engage community partners and stakeholders to promote consistent health related messages in the community.			X	X
4. Focus Groups to gather information from WIC participants regarding WIC services.		X	X	X
5. Reviewing competency based training modules for Nevada's eight week Maternal, Infant and Early Childhood Nutrition class for needed updates.				X
6. Gathering information from WIC clinic staff (stakeholders) regarding support needed to provide effective nutrition assessments and nutrition education.		X		
7.				
8.				
9.				
10.				

b. Current Activities

Nevada WIC was awarded funding to launch a FITWIC campaign to improve health related behaviors of WIC families to reduce the proportion of children 2-5 years of age who are at risk for overweight or obesity. In FY11 Nevada WIC began the program planning phase of the FIT WIC Project now titled "Step Up to Health with Nevada WIC" key messages have been developed around this program slogan:

- S: Step away from the screen
- T: Take a healthy plate
- E: Eat family meals together
- P: Pass on Sugary Beverages
- U: Use your sleep time to recharge
- P: Play with your family

These positive health behavior messages are meant to help staff approach parents by influencing their health related knowledge, attitudes, and behaviors to build healthy WIC families and ultimately decrease childhood obesity. Lesson plans for facilitated group classes and educator tools for individual education sessions have been created to promote these messages. The objective of this campaign is to help build a culture of active, healthy children and to direct young people toward healthy habits to avoid obesity, encompassing actions at the individual, organizational and community level. The campaign is expected to launch August 2012.

c. Plan for the Coming Year

NPM 14 is CLOSE TO the annual performance measure of 11% at 14.3% of children receiving WIC who are at or above 85th percentile. The trend has DETERIORATED in the last five years, with a 12% increase.

Plans are in place for the FITWIC campaign to launch August, 2012 with the plan for the coming year being to launch one of the new health messages every three months by providing in-services at Nevada WIC's local agencies. The span of this campaigns launch will last 18 months as each of the six messages will be highlighted in clinics for the three month period through bulletin boards, tailored nutrition classes that include incentive items, and tools that staff to use for individual education. The three month period will allow the majority of participants to be exposed to each of the six messages.

Also, in the coming year as part of the FITWIC campaign state staff will be working to implement a staff wellness component. The purpose of the staff wellness piece is for both clinic and state staff to be actively engaging in healthy habits that promote a healthy weight to better support the FITWIC initiative with participants. As part of the staff wellness component a healthy behavior tracking system will be initiated as well as a procedure for incentivizing clinic staff for tracking and participating in the worksite wellness program. Finally, for the coming year Nevada WIC would like to strengthen community partnerships to promote healthy lifestyle behaviors by providing resources to community partners and stakeholders in effort to promote consistent health messaging.

Nevada WIC is exploring sending WIC state dietitians and local agency dietitians as well as Breastfeeding Coordinators to the National WIC Association Biennial Nutrition Education and Breastfeeding conference.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	6	6	5	5	5
Annual Indicator	6.6	5.9	6.1	5.0	5.1
Numerator	2727	2286	2292	1800	1789
Denominator	41175	38777	37523	35731	35188
Data Source		vital stat/birth cert	vital stat/birth cert	vital stat/birth cert	vital stat/birth cert
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	5	5	4	4	4

Notes - 2011

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.

Notes - 2010

2010 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 2010 is preliminary. Data will be finalized in December 2012.

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.

Notes - 2009

Data for women who smoked in the last three months of pregnancy is unavailable. Data consists of women who smoked at any time during their pregnancy (numerator) and the number of women who gave birth (denominator).

Data for 2009 is final.

a. Last Year's Accomplishments

MCH worked on a Pregnancy Risk and Monitoring Surveillance (PRAM) pilot; to help assist in identifying behaviors and attitudes of pregnant women and new mothers on smoking during pregnancy and birth outcomes. Nevada is not a designated Centers for Disease Control and Prevention (CDC) PRAMS state; Baby Birth Evaluation and Assessment of Risk Survey (BEARS) was developed for this pilot project.

MCH, under the Prenatal Substance Abuse program supported the 4Ps Plus screening of pregnant women that includes self-reported alcohol, tobacco and other drug use during pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct another Baby BEARS, pregnancy risk and monitoring surveillance survey.				X
2. Coordinate the training of local agency staff on the Tobacco intervention techniques.			X	
3. Continue to advertise the NV QUIT-line throughout the state.			X	
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

Six hundred (600) mothers were sampled in November and December of 2010 for the Baby BEARS pilot project. The sample was derived from birth certificate data and surveys were mailed shortly after birth and it was equivalent to one out of every nine births. It is the understanding of the MCH epidemiologist that there was no selection criterion and this was a straight sample.

Of the total 600 women who were sampled, 357 who were sampled had less than a high school education, with no previous children, 30 years old or younger and received prenatal care after the first trimester. Fifty-seven (57) who were sampled had more than a high school education, no previous children and where 30 years or older. One hundred eighty-six (186) who were sampled were categorized as "others."

In November 2011, the Research Triangle Institute (RTI) provided NSHD-MCH with preliminary data results from the pilot project. Limitations of the pilot project were revealed after preliminary data results were delivered to NSHD.

MCH, has continued under the Prenatal Substance Abuse program supports the 4Ps Plus screening of pregnant women that includes self-reported alcohol, tobacco and other drug use during pregnancy and has expanded to some providers screening at pre-conception health visits. Data analysis is ongoing and is useful in designing prevention programs to reduce the number of women who are using prior to pregnancy.

c. Plan for the Coming Year

NPM 15 is CLOSE TO the annual performance objective of 5% at 5.1% of women who smoked in the last three months of pregnancy. The trend has IMPROVED in the last five years, with a 29% reduction.

Incorporating identified limitations to the first survey, MCH will conduct another Baby BEARS, pregnancy risk and monitoring surveillance survey; to assist in identifying behaviors and attitudes of pregnant women and new mothers on smoking during pregnancy and birth outcomes. Tracking these sources, however specific and/or small, will add to the total picture of pregnant women and smoking in Nevada. Utilizing analysis from the Baby BEARS survey Nevada will continue to determine future activities.

MCH, will continue under the Prenatal Substance Abuse program to support the 4Ps Plus screening of pregnant women that includes self-reported alcohol, tobacco and other drug use during pregnancy and continue to expanded the numbers of providers screening at a womans pre-conception health visit. Data analysis will continue on a ongoing basis and will be used in designing prevention programs to reduce the number of women who are using prior to pregnancy.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	6	6	5	5	5
Annual Indicator	7.8	4.6	6.0	6.0	14.8

Numerator	15	9	11	11	26
Denominator	192576	194035	184637	183031	175516
Data Source		vital stats/ death cert	vital stats/ death cert	vital stats/ death cert	vital stats/ death cert
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	5	5	4	4	4

Notes - 2011

Data entered is from 2011. Data will be available in December, 2013. Data for 2011 is preliminary.

Notes - 2010

Data entered is from 2010. Data will be available in December, 2012. Data for 2010 is preliminary.

Notes - 2009

Data entered is from 2009 and is final.

ICD-10 codes X60-X84, Y87.0 and U03 listed in the underlying cause of death were used to compile the data.

a. Last Year's Accomplishments

The Injury Prevention Program continued to collaborate with the Nevada Office of Suicide Prevention and other identified key partners, including Maternal and Child Health to provide monetary support of a texting crisis call program which was introduced in many middle and high schools throughout Nevada. This program allows teens to text a crisis verses call and involves a live person to respond via text.

In light of the widespread popularity of text messaging among youth, adding stem has added to the capacity for text capacity to current suicide prevention efforts is a natural and necessary progression for any agency providing telephone-based emergency support. The development of this system has added to the capacity of Nevada's schools and communities to provide information, referrals, and crisis intervention in a way that is convenient and preferred by youth.

The Injury Biostatistician continued to collect, analyze, and publish suicide data for the State of Nevada. This data will continue to be shared with the Nevada Office of Suicide Prevention and other stakeholders.

In 2011 the Nevada State Health Division was notified by the Centers for Disease Control and Prevention that its application for continued funding through the Core Violence and Injury Prevention Program was approved but would be unfunded for the next five years. Unfortunately, these were the monies used to fully sustain the Nevada Injury and Violence Prevention Program, and the program had to be sunsetted.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued collaboration with the Nevada Office of Suicide Prevention.	X			
2. Review of data collected by mental health screenings of children and youth to further develop activities.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Suicide Prevention (OSP) has developed a five year strategic plan to eradicate suicide rates in the state of Nevada. Part of their efforts focus on the prevention of youth suicide fatalities and attempts by kicking off a Crisis Text Messaging Center phone line that provides safe and non-judgmental sources of support for youth in any type of crisis. OSP plans to expand its text messaging program in school campuses across Nevada. In order to do so, outreach materials are needed to educate youth on the availability of this resource. Because outreach and education is one component of suicide prevention, OSP is also planning a one-day workshop for mental health professionals on assessing suicide risk, planning treatment, and managing the ongoing care of the at-risk client.

The MCH program worked in partnership with community partner Access to Healthcare (AHN) to provide funds to incentivize providers to include initial mental health screening at no cost to children and youth during a routine visit. This was limited to one age-appropriate screening per calendar year and including patient care funds to pay for an initial mental health visit for those children and youth that screen positive and warranted a referral to a mental health specialist.

c. Plan for the Coming Year

NPM 16 is FAR from the annual performance objective of 5 deaths per 100,000 at 14.8 deaths. There had been an IMPROVING trend until this year; there has been a DETERIORATING trend since last year. There is no specific HP 2020 objective, but related to Objective 1; Nevada has moved to far from the objective of 10.2 suicides per 100,000 at 14.8 suicides per 100,000. Since 2007, there has been a 47% increase in rates of suicides among adolescents. Since last year, there was a 61% increase in the suicide rate. This increase in incidence was discussed with the Suicide Prevention Coordinator of Nevada Office of Suicide Prevention, but no conclusions were reached about this sudden increase in rates. One hypothesis was a relationship between the increase media attention to bullying and the perceived link to suicides.

Continued efforts will focus on the prevention of youth suicide fatalities and attempts by kicking off a Crisis Text Messaging Center phone line that provides safe and non-judgmental sources of support for youth in any type of crisis.

Data collected by the partnership to provide mental health screening during a routine visit will be evaluated to determine effectiveness and outreach. Results will determine continued or additional activities.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	97	97	97	98	97
Annual Indicator	93.2	72.9	84.9	91.4	91.3
Numerator	497	357	406	427	432
Denominator	533	490	478	467	473
Data Source		vital stats/ birth certs	vital stats/ birth certs	vital stats/ birth certs	vital stats/ birth certs
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	97	98	98	99	99

Notes - 2011

Data for 2011 included level 3 only. Data for 2011 is preliminary. Data will be available in December, 2013.

Notes - 2010

Data for 2010 included level 3 only. Data for 2010 is preliminary. Data will be available in December, 2012.

Notes - 2009

Data for 2009 included level 3 only. Data for 2009 is final.

a. Last Year's Accomplishments

Efforts continued to improve the knowledge and awareness of the importance of prenatal care. Our MCH campaign line moved to our statewide toll-free information and referral line, Nevada 211. This offered expanded hours and resources to Nevadans.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue awareness campaigns to bring attention to the need for early and adequate prenatal care in order to identify possible high-risk pregnancies that should be directed to the appropriate facilities.		X		
2. Continue to coordinate activities and efforts of the NV Statewide Maternal and Child Health Coalition.				X

3. Continue partnerships with birthing hospitals and March of Dimes NV Chapter to continue being incorporated in strategies.				X
4.				
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b. Current Activities

The inaugural NV Statewide Maternal and Child Health (MCH) Coalition was conducted and brought together over 100 participants to discuss issues surrounding women and children health in Nevada. A Prenatal Access to Care workgroup was formed and conducts monthly meetings.

Text4baby has been promoted through many of our MCH partners with a lot of success.

Nevada's First Time Motherhood Initiative implemented its marketing campaign. This is a multi-media social marketing strategy that utilized physicians such as obstetricians, gynecologists, pediatrician and nurse practitioners, nurse midwives and certified breast counselors with advice on multiple topics for pregnant women and new parents on resources in Clark County.

Continued partnership with birthing hospitals, March of Dimes NV chapter, MCH coalitions and others were incorporated in strategies to reduce the number of low birth weight infants through early screening and care.

c. Plan for the Coming Year

NPM 17 is CLOSE TO the annual performance objective of 97% at 94.5% of very low birth weight infants delivered at the appropriate facilities. The trend has not seen SIGNIFICANT CHANGE in the last five years, with a 1.4% increase.

Incorporating identified limitations to the first survey, MCH will conduct another Baby BEARS, pregnancy risk and monitoring surveillance survey; to assist in identifying behaviors and attitudes of new mothers on pre-natal care and birth outcomes. Tracking these sources, however specific and/or small, will add to the total picture of the pregnant women in Nevada.

MCH program staff will continue to coordinate activities and efforts of the NV Statewide Maternal and Child Health (MCH) Coalition, as well as continued participation on the Prenatal Access to Care workgroup.

We will continue to identify new partners to help with outreach of text4baby, including a large statewide radio campaign centered on text4baby.

Partnership with birthing hospitals, March of Dimes NV chapter, MCH coalitions will continue to be incorporated in strategies to reduce the number of low birth weight infants through early screening and care.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	76	78	80	85	80
Annual Indicator	64.7	69.4	59.4	56.7	59.0
Numerator	26621	26914	22291	20260	20757
Denominator	41175	38777	37523	35731	35188
Data Source		vital stats/ birth certs	vital stats/ birth certs	vital stats/ birth certs	vital stats/ birth certs
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	80	80	80	80	80

Notes - 2011

Data for 2011 is preliminary. Data will be available in December, 2013.

Notes - 2010

Data for 2010 is preliminary. Data will be available in December, 2012.

Notes - 2009

Data for 2009 is final.

a. Last Year's Accomplishments

Communication continued with MCHAB to further build the coalitions in the north and south. Northern and southern MCH coalitions attended local, state and national events to assist in building their infrastructure and their capacity to address MCH issues.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Build state capacity to conduct Baby BEARS, pregnancy risk and monitoring surveillance survey.				X
2. Continue to coordinate activities and efforts of the NV Statewide Maternal and Child Health Coalition.				X
3. Continue partnerships with birthing hospitals and March of Dimes NV Chapter to continue being incorporated in strategies.				X
4.				
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b. Current Activities

MCH worked on a Pregnancy Risk and Monitoring Surveillance (PRAM) pilot; to help assist in identifying behaviors and attitudes of pregnant women and new mothers on smoking during pregnancy and birth outcomes. Nevada is not a designated Centers for Disease Control and Prevention (CDC) PRAMS state; Baby Birth Evaluation and Assessment of Risk Survey (BEARS) was developed for this pilot project. Six hundred (600) mothers were sampled in November and December of 2010 for the Baby BEARS pilot project.

The inaugural NV Statewide Maternal and Child Health (MCH) Coalition was conducted and brought together over 100 participants to discuss issues surrounding women and children health in Nevada. A Prenatal Access to Care workgroup was formed and conducts monthly meetings.

Text4baby has been promoted through many of our MCH partners with a lot of success.

Nevada's First Time Motherhood Initiative implemented its marketing campaign. This is a multi-media social marketing strategy that utilized physicians such as obstetricians, gynecologists, pediatrician and nurse practitioners, nurse midwives and certified breast counselors with advice on multiple topics for pregnant women and new parents on resources in Clark County.

Continued partnership with birthing hospitals, March of Dimes NV chapter, MCH coalitions and others were incorporated in strategies to reduce the number of low birth weight infants through early screening and care.

c. Plan for the Coming Year

NPM 18 is FAR from the annual performance objective of 80% at 55.6% of infants born to women who received prenatal care in their first trimester. The trend has DETERIORATED in the last five years, with a 16% reduction.

Incorporating identified limitations to the first survey, MCH will conduct another Baby BEARS, pregnancy risk and monitoring surveillance survey; to assist in identifying behaviors and attitudes of new mothers on prenatal care and birth outcomes. Tracking these sources, however specific and/or small, will add to the total picture of pregnant women in Nevada.

MCH program staff will continue to coordinate activities and efforts of the NV Statewide Maternal and Child Health (MCH) Coalition, as well as continued participation on the Prenatal Access to Care workgroup.

The NV Statewide Maternal and Child Health (MCH) Coalition's Prenatal Access to Care workgroup is working on a survey of women who presented in the emergency rooms of Clark County hospitals with no prenatal care.

We will continue to identify new partners to help with outreach of text4baby, including a large statewide radio campaign centered on text4baby.

Partnership with birthing hospitals, March of Dimes NV chapter, MCH coalitions will continue to be incorporated in strategies to reduce the number of low birth weight infants through early screening and care.

D. State Performance Measures

State Performance Measure 2: *The rate (per 1,000 MCH Medicaid population) of Medicaid dental providers.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	2	2	2.1	2.2	2.3
Annual Indicator	1.9	1.9	7.4	7.2	7.2
Numerator	422	405	392	438	462
Denominator	222530	212029	53284	60627	64308
Data Source		NV DHCFP	NV DHCFP	NV DHCFP	NV DHCFP
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	2.4	2.4	2.4	2.4	2.4

Notes - 2011

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.

Notes - 2010

Data is for federal fiscal year 2010.

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.

Notes - 2009

Data is for federal fiscal year 2009.

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.

a. Last Year's Accomplishments

The Nevada Division of Health Care Financing and Policy (DHCFP) continue to provide dental services in Clark and Washoe Counties using a managed care model. Managed care organizations (MCOs) that provide quality health plans in oral health and continually improve quality health care include Medicaid and the Children's Health Insurance Program (CHIP) or more commonly referred, Nevada Check Up.

- Nevada Medicaid is a program that provides quality healthcare services to low income Nevadans who qualify based on federal and state law. Nevada Medicaid does not reimburse an individual; rather, it directly sends payments to the healthcare providers for services utilized by the Medicaid recipient.

- Nevada Check Up is a program designed for families who do not qualify for Medicaid but whose income fall at or below 200% of the federal poverty level. Participants in the Nevada Check Up program are charged a quarterly premium based on income.

Medicaid/Nevada Check Up providers include Health Plan of Nevada and Amerigroup. The majority of members for both Medicaid and Nevada Check Up were children between ages 3 and 14-years of age. Nevada was the first state in the United States to use a State Plan Amendment (SPA) to develop a mandatory Medicaid managed care program.

In addition, Nevada provides a Health Insurance Flexibility and Accountability (HIFA) waiver for uninsured pregnant women who do not qualify for Medicaid. The HIFA waiver program also covers parents, caretaker relatives, and legal guardians of Medicaid- or CHIP-eligible children with a family income below 200% of the federal poverty level, who work for a qualified small employer that has a credible insurance plan.

- In FFY '11 the total number of recipients enrolled in Medicaid included 1,895,873 recipients, of those recipients, 9,661 patients sought oral health services and 2,491 dental sealants were billed (this does not include fee-for-service data)

- In FFY '11 the total number of recipients enrolled in Nevada Check-up included 224,841 recipients, of those recipients, 3,231 patients sought oral health services and 914 sealants were billed (this does not include fee-for-service data)

- In FFY '11 the total number of HIFA recipients was below the minimum 30 cases (for reporting a rate) and therefore sealant data cannot be provided

- During this time there were 1,040 dentists enrolled as Medicaid providers of those, 480 billed for services.

- Medicaid and Nevada Check Up who are contracted by the DHCFP have a ratio of 1:12, dentists to clients

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to collect, analyze and report data on MCH				X

population covered by Medicaid.				
2. Continue to offer support to the Division of Health Care Financing and Policy around policy and recruitment issues.				X
3. Continue to provide support to the regional oral health coalitions in Nevada.		X		X
4. Continue to disseminate information to stakeholders about dentists seeking to serve underserved populations.		X		
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b. Current Activities

- During the 2011 legislative session Medicaid maintained current dental benefits for children. This was significant given current budget issues.
- The Advisory Committee for Oral Health (AC4OH) actively sought Jon Kirwan, PhD from DHCEP to regularly participate in quarterly meetings to discuss current Medicaid and Nevada Check Up issues and to help the committee form more effective strategies in oral health care with target populations
- AC4OH is working with Jon Kirwan, PhD from DHCEP to form a provider work group to correct the Current Dental Terminology (CDT) codes used in Medicaid and make the reimbursement process timelier and more efficient

c. Plan for the Coming Year

- Work with the Primary Care Office to license and bring more providers to Nevada
- Increase the number of dentists enrolled as Medicaid providers who provide services
- Work with local coalitions/committees and DHCEP to streamline Medicaid reimbursement to providers encouraging an increase in oral health providers who take Medicaid

State Performance Measure 3: *The percent of women, ages 18 to 44, who are obese.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	18	17	17	16	16
Annual Indicator	21.9	20.0	22.5	17.7	24.6
Numerator	94783	88875	101025	81114	107104
Denominator	433217	444805	448508	457171	436178
Data Source		BRFSS 2008	BRFSS 2009	BRFSS 2010	BRFSS 2011
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	16	16	16	16	16

Notes - 2009

This data is from Nevada's preliminary 2009 BRFSS report.

a. Last Year's Accomplishments

The Nevada State Health Division's (NSHD), Chronic Disease Prevention and Health Promotion Section (CDPHPS) Wellness Program targeted childhood obesity in both the childcare and school settings. With one third of Nevada's children overweight or obese, the need to focus on improving nutrition and physical activity is a priority. CDPHPS had the following obesity prevention strategies:

Strategy 1-Establish a media campaign for nutrition labeling.

Strategy 1:

Fast Food has become an American way of life and the effects are costing Nevadans their quality of life. In an effort to educate the public on what they are consuming, the Nevada State Health Division's (NSHD) Chronic Disease Prevention and Health Promotion Sections (CDPHPS) embarked on a media campaign to elevate awareness of calories in items consumers were purchasing in chain restaurants. This activity was to establish an environmental change through media campaigns toward the utilization of nutrition labeling, to empower individuals to seek nutritional labeling prior to grocery shopping and dining out. A committee was formed from statewide nutrition interests, for the purpose to strategically plan and develop a media message regarding nutrition labeling. The objective of the media campaign is to help people understand and utilize nutritional labels to make healthy eating decisions.

Initiative Achievements:

In the spring of 2011, a one month television campaign was aired statewide with 1,790,087 impressions in the North, with 36.5% reach of 866,737. In Clark County 2,342,725 impressions with percent of reach 1,155,064. CDPHPS distributed 525 packets with 210 to Northern Nevada (Washoe County and Carson City) and 315 to Clark County (Las Vegas and Henderson). The packets contained a folder with logo, an introduction letter, and a logo window cling. For those restaurants in Washoe County, they also received a thank you note for making the community healthier from the Washoe County Health District. In the winter of 2011/2012, a second television campaign in Northern Nevada was costing \$15,000. There were 3,045 spots of which 1,350 were PSA. There were 2,695,147 impressions with a reach of 37.6% to a total of 1,013,375. The costs to run a campaign in Southern Nevada would have been \$10,000 for 87 spots.

Lessons Learned:

- Timing is everything in relation to the FDA regulations.
- Chains were reluctant to comply without mandates.
- Begin with Restaurant Association as interested partners; they too were waiting for the FDA regulations before joining the committee.
- Include major chains in outreach before beginning campaign. If a few major chains are on board with compliance and promote the campaign, then others will follow.
- Develop campaign strategies: promote websites that provide valid information about the food offered at different restaurants. There are a number of sites available that have the chain information.

The CDPHPS will continue to support nutrition labeling, however as there is no funding for media promotion, it will be up to the Food and Drug Administration (FDA) to promote their final guidance to restaurants and the public.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement a wellness website for Nevada residents and the business sector.			X	
2. Reduce overweight and obesity rates of adults.			X	
3. Increase physical activity.			X	
4. Increase consumption of fruits and vegetables			X	
5.				

6.				
7.				
8.				
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b. Current Activities

This year the Obesity Prevention Program lost 90% of its funding. The Wellness Programs Manager is working on various grant opportunities to identify funding to the program. Nonetheless, these current activities are still taking place:

Wellness Website

Staff is currently working with the Nevada State Governor to design a Wellness website for Nevada residents and the business sector. The website will focus on worksite wellness, school wellness, and citizen wellness. The website is to kick-off early fall.

Media Campaign

The Wellness Manager is working with the Centers for Disease Control to develop a communication plan that promotes physical activity health promotion strategies. This will include a radio or television media campaign that promotes inexpensive ways to be physically active.

c. Plan for the Coming Year

Below are the following goals and strategies the Obesity Prevention Coordinator will focus on for 2013-2014.

- Reduce Overweight & Obesity Rates of adults
 - o Adults will reach healthy weight levels by increasing consumption of fruits and vegetables and physical activity levels
- Increase Physical Activity of children and youth
 - o Children and youth increase physical activity levels by activity engaging in 30 plus minutes of physical activity daily
- Increase Consumption of fruits and vegetables children and youth
 - o Children and youth increase consumption of fruits and vegetables to daily recommended levels
 - o Children and youth will reduce their consumption of sugar to federal recommended levels.
 - o

Due to grant cut backs, the specific activities will be identified based on the level of funding leveraged for these strategies in 2012-2013.

State Performance Measure 5: *The number of public schools (K-12) that have access to a school based health center.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective			10	10	15
Annual Indicator					
Numerator					
Denominator					
Data Source		CIS data			
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016

Annual Performance Objective	15	20	20	20	20
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Notes - 2011

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.

Notes - 2010

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.

a. Last Year's Accomplishments

Goals were articulated of re-establishing relationships with school based health centers.

The Medical State Health Officer worked with the health centers for immunizations and other health areas. Discussed the possibility of implementing the Bright Futures materials in the health centers with the State Medical Health Officer.

A Nevada School-Based Health Summit was held on December 9th, 2011 in Reno, Nevada and school based health centers were incorporated as an activity for the Adolescent Workgroup of the Nevada Statewide Maternal and Child Health Coalition.

A follow-up meeting was held Meeting on Monday, June 4th, 2012, to discuss and draft School Based Health Center (SBHC) standards for Nevada. The development of standards will enhance public and private organizations' applications for competitive funding sources, provide equal access, and standardize delivery of a core list of services and uniform data collection. Existing standards from the states of Oregon and New Mexico were used as a guide as well as information from the state of Louisiana.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. School-Based Health Summit				X
2. Development of School-Based Health Center standards for Nevada				X
3. School-Based Health Care Meeting				X

4. School-Based Health Center Point of Contact established				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The State Medical Health Officer, the NSHD Adolescent Health Program Manager, and the Executive Director of the Southern Nevada Immunization and Health Coalition and Project Lead for the Nevada Statewide Maternal and Child Health (MCH) Coalition are attending the 2012 National School-Based Health Care Convention.

c. Plan for the Coming Year

Finalize School Based Health Center (SBHC) standards for the state of Nevada.

Continued collaboration between the State Medical Health Officer, the MCH Coalition Adolescent Health Working Group, and the NSHD Adolescent Health Program, to advance the goal of development of standardized school-based health care in Nevada.

State Performance Measure 6: *The percent of positive hearing screening newborns who have received additional screening and diagnosis by 3 months.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective			10	15	15
Annual Indicator			3.4	11.3	13.7
Numerator			41	100	75
Denominator			1196	885	547
Data Source		NB hearing database	NB hearing database	NB hearing database	NB hearing database
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	20	10	10	10	10

Notes - 2011

Data for 2011 is from the Newborn Hearing database.

Notes - 2010

Data for 2010 is from the Newborn Hearing database.

Notes - 2009

This is a new State Performance Measure. Data collection began in 2009 for the Newborn Hearing database.

a. Last Year's Accomplishments

The Nevada Early Hearing Detection and Intervention (EHDI) Program began a comprehensive statewide training program to ensure that each hospital understood the importance of accurate testing, appropriate communication with parents, and the importance of accurate completion of the reports required for the internal database that will be incorporated into the Nevada Web-Enabled Vital Records Registry System (WEVRRS). With the development of a statewide database, the scope of loss to follow-up will be efficiently identified and steps can be taken to reduce the number of infants that do not receive timely diagnosis.

Nevada EHDI received direct funding through the Centers for Disease Control and Prevention Nevada Early Hearing Detection and Intervention (EHDI) Tracking, Surveillance and Integration (Project Period 07/01/2008 -- 06/30/2011) and through the Centers for Disease Control and Prevention Nevada Early Hearing Detection and Intervention --Information System (EHDI-IS) Surveillance System (Project Period 07/01/2011 -- 06/30/2016) to develop and maintain a statewide data system to track and monitor progress of newborns identified with hearing loss. Nevada EHDI continued progress toward the development and implementation of the EHDI database in the Newborn Hearing Screening module in WEVRRS to allow improved tracking and follow-up of referred infants. A contracted Project Manager provided the necessary expertise to work effectively with the developer of WEVRRS and representatives from the Nevada Vital Statistics program and the Office of Informatics and Technology to move the database project forward.

Contract audiologists met personally with other audiologists throughout the state to enhance the audiologists' knowledge of the Nevada Early Hearing Detection and Intervention (EHDI) Program and provide technical assistance regarding the unique requirements involved in testing hearing in newborns. Audiologists who routinely diagnose and treat newborns in Nevada is very limited. Therefore, the direct contact between Nevada EHDI contracted audiologists and other audiologists working with infants was essential to provide consistency in testing and to provide better communication with parents.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contracted audiologists disseminated referral forms to hospital staff and increased hospital understanding of the Nevada Early Hearing Detection process and requirements.			X	
2. Maintained sub-grant with Nevada Hands & Voices to provide outreach and education to families of newly screened infants and help ensure that families seek follow-up services.		X		
3. Developed quality assurance procedures to monitor the number of infants screened with potential hearing loss that will need further follow-up.				X
4. Worked with Nevada Early Intervention Services to develop policies that would encourage an increase in the number of specialists working with newborns and young children with potential or diagnosed hearing loss.				X
5.				
6.				
7.				
8.				
9.				

10.				
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b. Current Activities

The Nevada EHDl database in WEVRRS went live this year and allowed the transfer of historical data (from 2010 to the present) to begin in the statewide database. Prior to implementation of the Hearing Module in WEVRRS, there was extensive testing of the system and training of personnel involved with data entry and reporting functions. When all historical data is entered, it will be possible to track diagnostic and follow-up activities effectively and efficiently.

Current information indicates that Nevada has a larger loss to follow-up than national statistics, and the program has begun to send follow-up letters to parents and healthcare professionals to monitor diagnosis and intervention activities. Nevada EHDl has developed letters to parents in both English and Spanish. It has also worked closely with the EHDl Chapter Champion, Dr. Cheryl Robinson, to provide information regarding the Nevada EHDl Program and national EHDl goals and objectives to primary care physicians (PCP) statewide. By enhancing PCP knowledge of the need for early intervention for infants with hearing loss, it is hoped that parents will be encouraged to seek diagnosis and intervention if necessary when their infant has an abnormal screening. The addition of PCP support for the EHDl goal of screening by 1 month of age, diagnosis by 3 months of age, and intervention by 6 months of age will help reduce loss to follow-up.

c. Plan for the Coming Year

Nevada EDHI 's database will continue to be updated to include historical information that was previously maintained in an internal database and will include more diagnosis and follow-up information. Follow-up information will also be enhanced by the establishment of a statewide "Guide by Your Side" program, a parental mentorship program developed by national Hands and Voices. Parents with experience navigating through the Nevada newborn hearing screening process will be selected to provide mentorship and guidance to parents of newly identified infants with hearing loss. Mentors will have the ability to contact parents directly, provide educational materials, guidance and resource information, and collect data for the database.

The program plans to continue working with audiologists and other medical professionals statewide to ensure that audiologists treating newborns are aware of the unique challenges that newborn diagnosis presents and that others in the medical community understand the vital importance of diagnosis and follow-up in suspected cases of hearing loss. Based on answers to a survey, the program will eventually provide a list of audiologists in Nevada that meet the criteria established for "Best Practices" on the Nevada State Health Division website. The contracted audiologist will contact other medical professionals to encourage their support of the 1-3-6 national EHDl guideline for screening, diagnosis, and intervention.

Nevada will work with National Initiative for Children's Healthcare Quality (NICHQ) and other state EHDl programs to test, share, and implement ideas to improve the quality and timeliness of screening, audiologic diagnosis, and entry into intervention. This project uses a Quality Improvement (QI) approach to develop solutions to hearing loss issues that have been identified nationwide. It is hoped that through participation in the collaborative, there will be a reduction in loss to follow-up, increased parent involvement, improved data systems, and improved quality of care to newborns with hearing loss.

The contract audiologist on staff will continue to track and provide follow-up for infants who do not pass their initial hearing screening. This effort includes building stronger relationships with hospitals to provide direct referrals to other audiologists and helping audiologists understand the unique technical aspects of newborn hearing diagnosis. Nevada EHDl will continue efforts to provide education and technical assistance to hospitals, medical providers, parents, decision

makers, and the general public regarding hearing screening and services available statewide.

State Performance Measure 7: *Percentage of children screened for age-appropriate developmental skills and behavioral health levels.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective			15	15	10
Annual Indicator		0.6	0.9	1.4	1.9
Numerator		928	1397	2300	2954
Denominator		150939	154859	158629	157027
Data Source		EIS data	EIS data	EIS data	EIS data
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	10	10	10	10	10

Notes - 2011

Nevada Early Intervention Services serves children birth to three and the above data is reporting for these respective ages. Some children receive ASQ, ASQ-SE, and MCHATs. Autism screening began in 2009. All referred children to NEIS receive a screening.

Notes - 2010

Nevada Early Intervention Services serves children birth to three and the above data is reporting for these respective ages. Some children receive ASQ, ASQ-SE, and MCHATs. Autism screening began in 2009. All referred children to NEIS receive a screening.

Notes - 2009

Nevada Early Intervention Services serves children birth to three and the above data is reporting for these respective ages. Some children receive ASQ, ASQ-SE, and MCHATs. Autism screening began in 2009. All referred children to NEIS receive a screening.

a. Last Year's Accomplishments

Develop funding mechanism for online screening service. Online screenings have been attained at the Early Head Start centers and other locations. Others continue with paper and pencil screening tools. The ASQ remains the prevalent screening tool.

Train community providers to use online screening program for children 6 months to 60 months of age.

Collaborate with pediatrician and family physician professional organizations to orient and train staff to use online developmental and behavioral screening service.

Collaborate with pediatrician and family physician professional organizations to provide coding guidance for appropriate billing of developmental and behavioral screenings of young children.

Community professionals, school districts and parents have been trained in screenings.

During 2010, the University of Nevada, Reno's Nevada Center for Excellence in Disabilities (NCED) was awarded a Leadership Education in Neurodevelopmental and Related Disabilities (LEND) planning grant. Nevada's MCH Program was kept informed and consulted during this process. This initial grant offered Nevada the opportunity to develop an application for a full LEND

grant with an anticipated start date of July 2011. Availability of this resource within Nevada could increase the interdisciplinary teams' awareness and utilization of appropriate developmental screening tools and interventions.

Develop funding mechanism for online screening service. Online screenings have been attained at the Early Head Start centers and other locations. Others continue with paper and pencil screening tools. The ASQ remains the prevalent screening tool.

Train community providers to use online screening program for children 6 months to 60 months of age.

Collaborate with pediatrician and family physician professional organizations to orient and train staff to use online developmental and behavioral screening service.

Collaborate with pediatrician and family physician professional organizations to provide coding guidance for appropriate billing of developmental and behavioral screenings of young children.

Community professionals, school districts and parents have been trained in screenings.

During 2010, the University of Nevada, Reno's Nevada Center for Excellence in Disabilities (NCED) was awarded a Leadership Education in Neurodevelopmental and Related Disabilities (LEND) planning grant. Nevada's MCH Program was kept informed and consulted during this process. This initial grant offered Nevada the opportunity to develop an application for a full LEND grant with an anticipated start date of July 2011. Availability of this resource within Nevada could increase the interdisciplinary teams' awareness and utilization of appropriate developmental screening tools and interventions.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with physician associations to increase awareness of availability of the screens				X
2. Work with Bright Futures Well Child Initiative to increase number of primary care who offer comprehensive well child (including developmental and behavioral screens).				X
3. Increase awareness and visibility of services providing next level of assessments for developmental and behavioral screens.				X
4. Increase visibility of recommended periods of these screens to providers and parents.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Work with physician associations to increase awareness of availability of the screening tools.

Incorporate evidence-based screening tools in the pilot Maternal, Infant and Early Childhood Home Visiting sites.

Increase knowledge and awareness of Bright Futures Guidelines, to increase number of primary care providers who offer comprehensive well child (including developmental and behavioral

screens).

Increase awareness and visibility of services providing next level of assessments for developmental and behavioral screens.

Increase visibility of recommended periods of these screens to providers and parents.

Continue work with the University of Nevada, Reno NCED's University Center for Excellence in Developmental Disabilities.

Through this new interdisciplinary leadership training program, Nevada's infrastructure for Children and Youth with Special Healthcare Needs (CYSHCN) will be re-invigorated and strengthened.

c. Plan for the Coming Year

(placeholder)

Work with physician associations to increase awareness of availability of the screening tools.

Incorporate evidence-based screening tools in the pilot Maternal, Infant and Early Childhood Home Visiting sites.

Increase knowledge and awareness of Bright Futures Guidelines, to increase number of primary care providers who offer comprehensive well child (including developmental and behavioral screens).

Increase awareness and visibility of services providing next level of assessments for developmental and behavioral screens.

Increase visibility of recommended periods of these screens to providers and parents.

Continue work with the University of Nevada, Reno NCED's University Center for Excellence in Developmental Disabilities.

Through this new interdisciplinary leadership training program, Nevada's infrastructure for Children and Youth with Special Healthcare Needs (CYSHCN) will be re-invigorated and strengthened.

State Performance Measure 8: *Percentage of Nevada public school students who are obese and overweight.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective			22	22	22
Annual Indicator	23.2	23.2	24.4	24.4	24.1
Numerator			476	476	478

Denominator			1951	1951	1982
Data Source		YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	22	22	22	22	22

Notes - 2011

Reported data is from 2009. YRBS is done every other year, thus data for 2010 is available in CY 2011.

YRBS only counts High School students, grades 9 through 12.

The performance measure on the block grant form reads “Decrease the percentage of at-risk for overweight and overweight children in Nevada.” we believe it should read “...overweight and obese.....”

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.

Over weight = 13.2 percent and the denominator is 1,982;
 The numerator is $.132 \times 1,982 = 261.6$
 Obese = 10.9% with the same denominator - 1,982.
 The numerator is $.109 \times 1,982 = 216.0$

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 $(478 / 1982) \times 100 = 24.1\%$

Notes - 2010

Reported data is from 2009. YRBS is done every other year, thus data for 2010 is available in CY 2011.

YRBS only counts High School students, grades 9 through 12.

The performance measure on the block grant form reads “Decrease the percentage of at-risk for overweight and overweight children in Nevada.” we believe it should read “...overweight and obese.....”

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.

Over weight = 13.4 percent and the denominator is 1,951;
 The numerator is $.134 \times 1,951 = 261.4$
 Obese = 11.0% with the same denominator - 1,951.
 The numerator is $.110 \times 1,951 = 214.6$

Adding the two numerators together = $214.6 + 261.4 = 476$

Therefore, to fill out the block grant form we used 476 as the numerator and 1951 as the denominator and the percent will automatically be calculated at $(476 / 1951) \times 100 = 24.4\%$

Notes - 2009

YRBS is done every other year, thus data for 2009 is available in CY 2010.

YRBS only counts High School students, grades 9 through 12.

The performance measure on the block grant form reads "Decrease the percentage of at-risk for overweight and overweight children in Nevada." we believe it should read "...overweight and obese....."

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.

Over weight = 13.4 percent and the denominator is 1,951;

The numerator is $.134 \times 1,951 = 261.4$

Obese = 11.0% with the same denominator - 1,951.

The numerator is $.110 \times 1,951 = 214.6$

Adding the two numerators together = $214.6 + 261.4 = 476$

Therefore, to fill out the block grant form we used 476 as the numerator and 1951 as the denominator and the percent will automatically be calculated at $(476 / 1951) \times 100 = 24.4\%$

a. Last Year's Accomplishments

The Nevada State Health Division's (NSHD), Chronic Disease Prevention and Health Promotion Section (CDPHPS) Wellness Program targeted childhood obesity in both the childcare and school settings. With one third of Nevada's children overweight or obese, the need to focus on improving nutrition and physical activity is a priority. CDPHPS had the following obesity prevention strategies:

Strategy 2-Improve nutrition standards among children ages one to five.

Strategy 3-Support the Nevada School Wellness Policy through a State Rating System of Schools.

Strategy 2-Improve nutrition standards among children ages one to five.

Very little movement took place in this goal due to staff turnover and funding. Nonetheless, this year the CDPHPS is coordinating efforts with the Division of Child & Family Services; Bureau of Services for Child Care; Head Start Collaboration and Early Childhood Systems; Child Care and Development Program, Division of Welfare and Supportive Services; and the Nevada Nutrition Assistance Consortium to address childhood obesity in early care and education settings. The goal is to modify regulations in early child care settings around infant feeding, physical activity, and nutrition. A workgroups will be created to develop a work plan to address state regulations, organize provider trainings, and parent education activities around obesity prevention.

Moreover, the Obesity Prevention Program has been working on promoting physical activity and healthy food options in early child care settings and schools. Nevada has increased the number of schools and daycare venues who provide increased physical activity opportunities above 30 minutes by implementing trainings to teachers and child care providers on the importance of physical activity and by distributing Fit Decks. This far, 94 child care venues were training through Vegas PBS and 800 new fit decks were distributed to kindergarten through 12 grade classrooms. In addition, In Lyon County the Healthy Communities Coalition in cooperation with UNCE in Reno, the Lyon County School District and the Boys and Girls Clubs built 8 school hoop houses and one community garden. The food from the hoop houses was distributed to families in need and to the students. Lyon County Healthy Communities also work with Little League to provide healthy snack options to sodas and candy at practice and games.

Strategy 3: Support the Nevada School Wellness Policy through a State Rating System of Schools

In 2011, the CDPHPS developed a rating system and conducted a pilot study to determine the feasibility of this tool. The pilot study was completed in May 2011. It was anticipated that 20 schools would participate in the pilot. Unfortunately, with the heavy workloads on school staff, only four schools, three rural and one urban school, completed the survey and provided feedback.

Initiative Achievements:

Reach of the School Rating System Pilot was two elementary schools (812 students) in Elko County benefited, one in Clark County (111 students) and one in Carson City (2,086 students). The total impact was on 3,009 students

Key Findings, Achievements and Lessons Learned:

Evaluation tool was completed for the School Wellness Rating System by the NSHD. Pilot study was completed and the evaluation report reflected many schools had not implemented their School Wellness Policies, but rather put them on a shelf. With lack of funds, schools had limited ability to implement their School Wellness Policy.

Previously, School Districts, Health Departments, Department of Education (DOE), non profits and NSHD all used various tools to evaluate physical activity and nutrition in schools. In the summer of 2011, through collaboration with the "Partners for A Healthy Nevada", the agencies consolidated a variety of statewide evaluation tools. The group selected one tool to be used statewide as the evaluation tool for school wellness programs to evaluate nutrition and physical activities. The President's Council on Physical Fitness and Nutrition tool was selected.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Complete implementation of a workgroup to improve early child care standards pertaining to obesity prevention.			X	
2. Promote healthy food and physical activities in child care settings and schools.			X	
3. Implement a school wellness rating system in schools.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This year the Obesity Prevention Program lost 90% of its funding. The Wellness Programs Manage is working on various grant opportunities to allocate funding to the program.

Nonetheless, the current activities are still taking place:

Early Child Care and Education Settings Obesity Prevention

A workgroup is currently being established around the prevention of obesity in Early Child Care Settings workgroup. This workgroup will develop recommendations to modify current regulations affecting nutrition, physical activity, and infant feeding in early childcare and education settings. In addition, this workgroup will identify potential trainings for childcare providers and parents pertaining to obesity prevention.

c. Plan for the Coming Year

Below are the following goals and strategies the Obesity Prevention Coordinator will focus on for 2013-2014.

- Reduce Overweight & Obesity Rates of adults
 - o Adults will reach healthy weight levels by increasing consumption of fruits and vegetables and physical activity levels

- Increase Physical Activity of children and youth
 - o Children and youth increase physical activity levels by activity engaging in 30 plush minutes of physical activity daily

- Increase Consumption of fruits and vegetables children and youth
 - o Children and youth increase consumption of fruits and vegetables to daily recommended levels
 - o Children and youth will reduce their consumption of sugar to federal recommended levels.
 - o

Due to grant cut backs, the specific activities will be identified based on the level of funding leveraged for these strategies in 2012-2013.

State Performance Measure 9: *The rate of individuals (per 100,000 populations), aged 13 and over, who expired due to Domestic Violence (DV) or Intimate Partner Violence (IPV).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					
Annual Indicator				0	0
Numerator					
Denominator					
Data Source				AG-DVFRST and Death Certificates	AG-DVFRST and Death Certificates
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	0	0	0	0	0

Notes - 2011

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.

a. Last Year's Accomplishments

Title V and the Nevada Coalition Against Sexual violence in collaboration with the Nevada Network Against Domestic Violence and the Attorney General's Office partnered to improve awareness and education around intimate partner violence prevention. An educational curriculum was developed and workshops and webinars were provided to schools, law enforcement parent groups and through our crisis call centers. Part of our Rape Prevention and Education Program

offered education to middle and high school youth on how to recognize and prevent intimate partner violence.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identifying adjudicated domestic violence fatalities for review.				X
2. Reviewing circumstances of domestic violence related deaths.				X
3. Identifying patterns that lead to fatal outcomes.				X
4. Determining whether reviewed deaths may have been preventable.				X
5. Identifying strategies for prevention of domestic violence related deaths.			X	
6. Developing intervention strategies to reduce fatalities and eliminate ongoing abuse.		X	X	
7. Identifying ways to improve and enhance interagency reporting and communication of Domestic Violence and Intimate Partner Violence.				X
8.				
9.				
10.				

b. Current Activities

In 2011, the Attorney General-Domestic Violence Fatality Review Statewide Team was established as pursuant to NRS 217.475. The purpose of the Attorney General-Domestic Violence Fatality Review Statewide Team (AG-DVFRST) is to review selected cases of domestic violence related deaths in communities where a domestic violence fatality review (DVFR) team does not exist, or if a local team, established pursuant to NRS 217.475, has requested a review by the AG-DVFRST. The Rape Prevention and Education is a member of this newly formed team.

As part of our Rape Prevention and Education Program a partnership has been formed with the Nevada Network Against Domestic Violence (NNADV) to produce and educational/media campaign addressing statutory rape.

c. Plan for the Coming Year

Continued involvement in the newly formed AG-DVFRST. The goals of this group are the following:

Goals and Objectives:

- Identifying adjudicated domestic violence fatalities for review;
 - Reviewing circumstances of domestic violence related deaths;
 - Identifying patterns that lead to fatal outcomes;
 - Determining whether reviewed deaths may have been preventable;
 - Identifying strategies for prevention of domestic violence related deaths, including but not limited to, delivery of agency services and intervention methods;
 - Developing intervention strategies to reduce fatalities and eliminate ongoing abuse;
 - Identifying ways to improve and enhance interagency reporting and communication;
 - Identifying methods, services, and strategies that were used effectively and efficiently;
- and
- Following any and all statutory requirements, including those set forth in NRS 228.495.

We feel the development of this new State Performance Measure (SPM) to yield a tangible result

with the goal of lessening the occurrence of domestic violence fatalities for which Nevada currently ranks number one.

E. Health Status Indicators

2013 HEALTH STATUS INDICATORS TREND ANALYSIS

In preparation for the 2013 MCH Block grant, each individual Health Systems Indicator (HSI) was examined through trend analysis by the MCH Epidemiologist to determine where the State of Nevada is today and where efforts should be focused in the future year. Each indicator was examined to see if the trend had either IMPROVED, STAYED THE SAME, or DETERIORATED from the previous year and/or years. Then the indicator was compared to the Healthy People 2020 objectives and it was determined if the indicator had either SURPASSED, was CLOSE TO, or was FAR FROM the objective. When possible, the indicator was examined in more detail to determine if there was any trend related to race/ethnicity, region or age groups.

HSI 01A is CLOSE TO the Healthy People (HP) 2020 target (7.8%) at 8.2% in 2011. There has been NO CHANGE in trend in the last five years, remaining at 8.2%. To achieve the HP 2020 target, there would need to be a 5% reduction in the percent of live births weighing less than 2,500 grams.

HSI 01B has SURPASSED the HP 2020 target (7.8%) at 6.5% in 2011. However there has been NO CHANGE in trend in the last five years, remaining 6.5%. Nevada has already achieved the HP target, so this indicator may need to be reviewed for a lower objective to reduce the percent of live singleton births weighing less than 2,500 grams.

HSI 02A has SURPASSED the HP 2020 target (1.4%) at 1.3% in 2011. However there has been NO CHANGE in trend in the last five years, remaining at 1.3%. Nevada has already achieved the HP target, so this indicator may need to be reviewed for a lower objective to reduce the percent of live births weighing less than 1,500 grams.

HSI 02B has SURPASSED the HP 2020 target (1.4%) at 1% in 2011. However there has been NO CHANGE in trend in the last year. In the last five years there has been a 10% reduction, from 1.1 to 1%. Nevada has already achieved the HP target, so this indicator may need to be reviewed for a lower objective to reduce the percent of live singleton births weighing less than 1,500 grams.

HSI 03A has SURPASSED the HP 2020 target (36 deaths per 100,000 populations) at 5.8 deaths per 100,000 populations. The trend has IMPROVED since 2007, a 72% reduction, from 10 to 5.8 per 100,000. Nevada has already achieved the HP target, so this indicator may need to be reviewed for a lower objective to reduce the death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

HSI 03B has SURPASSED the HP 2020 target (12.4 deaths per 100,000) at 0.7 per 100,000 populations. The trend has IMPROVED in the last five years, a reduction of 229%. Nevada has already achieved the HP target, so this indicator may need to be reviewed for a lower objective to reduce the death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

HSI 03C has SURPASSED the HP 2020 target (12.4 deaths per 100,000) at 9.8 deaths per 100,000 populations. The trend has IMPROVED in the last five years, there has been a 74% reduction in rates, from 17.1 to 9.8 per 100,000. Nevada has already achieved the HP target, so this indicator may need to be reviewed for a lower objective to reduce the death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

HSI 04A has SURPASSED the HP 2020 target (555.8 hospitalizations per 100,000) at 138.5 hospitalizations per 100,000 in 2011. The trend has DETERIORATED since 2007, an increase of 6.9% in rates, from 129 to 138.5 per 100,000. Nevada has already achieved the HP target, so this indicator may need to be reviewed for a lower objective to reduce the rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

HSI 04B has SURPASSED the HP 2020 target (694.4 per 100,000) at 11.7 injuries per 100,000. The trend has IMPROVED in the last five years, a 27% reduction in rates, from 14.9 to 11.7 per 100,000. Nevada has already achieved the HP target, so this indicator may need to be reviewed for a lower objective to reduce the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

HSI 04C has SURPASSED the HP 2020 target (694.4 per 100,000) at 52.2 injuries per 100,000. The trend has IMPROVED in the last five years, a 43.5% reduction in rates, from 74.9 to 52.2 per 100,000. Nevada has already achieved the HP target, so this indicator may need to be reviewed for a lower objective to reduce the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

HSI 05A has no specific HP 2020 target. The trend has IMPROVED in the last five years, with a reduction of 6% in rates, from 28.2 to 26.5 per 1,000 aged 15 through 19 years with a reported case of chlamydia.

HSI 05B has no specific HP 2020 target. The trend has DETERIORATED in the last five years, with an increase of 7.4%, from 8.8 to 9.5 per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

An attachment is included in this section. IVE - Health Status Indicators

F. Other Program Activities

Nevada's Maternal and Child Health Block Grant continues to provide funding for Early Intervention Services (EIS) to improve services for CYSHCN and early identification. The Bureau also partners with EIS whose clinics provide the site for the Bureau's multidisciplinary clinics in Reno and Las Vegas (metabolic, genetic).

The Bureau continues to maintain toll-free information lines. The first and primary is the MCH Information Line 1-800-429-2669, which can also be reached directly through Nevada's 2-1-1 line. Nevada's CSHCN information and referral line is 1-866-254-3964. Both lines have outreach initiatives and operators who are bilingual, English and Spanish.

The Bureau is partnering with the Department of Health and Human Services' Statewide Headstart Office for implementation of the Early Childhood Comprehensive Systems Development (ECCSD). A statewide Early Childhood Advisory Council has been formed and coordinates activities with existing boards such as the Interagency Coordinating Council and the Maternal & Child Health Advisory Board. Nevada Department of Education Early Child Education and Early Childhood Special Education leaders, a pediatrician, family support organizations, children's mental health providers, higher education early childhood specialists, and child care organizations are also participating. ***//2013/ Several Local Early Childhood Advisory Councils (LECAC) were formed during 2011 and 2012. Plans are under development to support future communities in developing LECACs. //2013//***

G. Technical Assistance

Nevada requests technical assistance in building our adolescent health programs and incorporating these into MCH.

Nevada State Health Division has several new biostatisticians who have expressed a desire to learn more in depth analysis, techniques and planning around Title V and Epi data.

Technical assistance is also welcomed to assess and increase MCH Epidemiology capacity.

/2013/ Nevada Title V programs intend to request technical assistance in the following areas:

- a) Strategic planning for statewide CYSHCN system improvement;***
- b) Youth Transition to Adulthood systems -- Assessment and state plan development with emphasis on support systems that serve minority youth and their families; and***
- c) Developing Life Course Metrics for SSDI and MCH assessment.***

The first two technical assistance requests are in response to results of the 2009/10 National Survey of Children with Special Health Care Needs MCHB Core Outcomes for Nevada. Families in Nevada reported the following:

Outcome #1: CSHCN whose families are partners in shared decision-making for child's optimal health -- 64.0% of Nevada families surveyed this outcome as successfully achieved, in comparison to 70.3% Nationwide. Nevada ranked 50th out of 51 states and the District of Columbia. Nevada results for Outcome #1 by Race/Ethnicity: Hispanic -- 60.4%; White, Non-Hispanic -- 65.0%; Black, Non-Hispanic -- 70.9%; and Other, Non-Hispanic -- 60.8%.

Outcome #2: CSHCN who receive coordinated, ongoing, comprehensive care within a medical home -- 36.8% of Nevada families surveyed this outcome as successfully achieved, in comparison to 43.0% Nationwide. Nevada ranked 47th out of 51 states and the District of Columbia. Nevada results for Outcome #2 by Race/Ethnicity: Hispanic -- 28.9%; White, Non-Hispanic -- 40.1%; Black, Non-Hispanic -- 46.6%; and Other, Non-Hispanic -- 28.6%.

Outcome #3: CSHCN whose families have adequate private and/or public insurance to pay for the services they need -- 55.2% of Nevada families surveyed this outcome as successfully achieved, in comparison to 60.6% Nationwide. Nevada ranked 46th out of 51 states and the District of Columbia. Nevada results for Outcome #3 by Race/Ethnicity: Hispanic -- 48.1%; White, Non-Hispanic -- 54.4%; Black, Non-Hispanic -- 73.1%; and Other, Non-Hispanic -- 58.3%.

Outcome #4: CSHCN who are screened early and continuously for special health care needs -- 69.7% of Nevada families surveyed this outcome as successfully achieved, in comparison to 78.6% Nationwide. Nevada ranked 48th out of 51 states and the District of Columbia. Nevada results for Outcome #4 by Race/Ethnicity: Hispanic -- 62.0%; White, Non-Hispanic -- 74.6%; Black, Non-Hispanic -- 62.9%; and Other, Non-Hispanic -- 70.1%.

Outcome #5: CSHCN who can easily access community based services -- 57.2% of Nevada families surveyed this outcome as successfully achieved, in comparison to 65.1% Nationwide. Nevada ranked 47th out of 51 states and the District of Columbia. Nevada results for Outcome #5 by Race/Ethnicity: Hispanic -- 54.5%; White, Non-Hispanic -- 54.4%; Black, Non-Hispanic -- 74.8%; and Other, Non-Hispanic -- 59.6%.

Outcome #6: Youth with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work, and independence -- 31.7% of Nevada families surveyed this outcome as successfully achieved, in comparison to 40.0%

Nationwide. Nevada ranked 51st out of 51 states and the District of Columbia. Nevada results for Outcome # by Race/Ethnicity: Hispanic -- 9.6%; White, Non-Hispanic -- 43.9%; Black, Non-Hispanic -- 23.4%; and Other, Non-Hispanic -- 19.3%.

Nevada would also like to request technical assistance on developing Life Course Metrics for MCH. This will enhance the ability of MCH and SSDI staff in developing data capacity and linkages with affiliated and complimentary programs. This will be particularly useful in aligning data collection, assessment and activity planning with chronic disease prevention programs and wellness initiatives. //2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	1792466	1752177	1747990		1752177	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	1344350	1314133	1310993		1314133	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	0	0	0		0	
6. Program Income <i>(Line6, Form 2)</i>	0	0	0		0	
7. Subtotal	3136816	3066310	3058983		3066310	
8. Other Federal Funds <i>(Line10, Form 2)</i>	18521626	18521626	12796679		12830824	
9. Total <i>(Line11, Form 2)</i>	21658442	21587936	15855662		15897134	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	1209918	447988	468163		369859	
b. Infants < 1 year old	672175	1091873	993580		877917	
c. Children 1 to 22 years old	537740	525638	552622		525653	
d. Children with	537743	825593	869819		1021314	

Special Healthcare Needs						
e. Others	0	0	0		96349	
f. Administration	179240	175218	174799		175218	
g. SUBTOTAL	3136816	3066310	3058983		3066310	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	0		0		0	
c. CISS	0		0		0	
d. Abstinence Education	194139		0		385546	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	8994681		3013996		10060802	
j. Education	0		0		0	
k. Home Visiting	0		0		1136889	
k. Other						
Early Hearing Detect	0		132000		132985	
HOPWA	0		255631		255681	
PREP	0		0		858921	
ACA Homevisiting	0		911067		0	
Ryan White	8482806		8339054		0	
Ryan White - Sup	0		144931		0	
EDHI	150000		0		0	
First Time Mothers	500000		0		0	
SPNS	200000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	650264	344109	721264		331491	
II. Enabling Services	482055	444331	355452		527082	
III. Population-Based Services	1637007	1102952	606574		1063694	
IV. Infrastructure Building Services	367490	1174918	1375693		1144043	
V. Federal-State Title V Block Grant Partnership Total	3136816	3066310	3058983		3066310	

A. Expenditures

Expenditures

Form 3, State MCH Funding Profile:

In FFY 2010, the Nevada MCH program expended \$1,785,662 in federal funds and \$1,339,247 in state match funds for a total of \$3,124,909. The state match funds are comprised of State General funds \$707,108, and Newborn Screening Fees in the amount of \$632,139. All fees expended by the Metabolic Screening Program for newborn screening activities contribute to the 30% CYSHCN requirement.

In FFY 2012, the Nevada MCH program is budgeting \$3,058,983 in total expenditures. HRSA funds are budgeted at \$1,747,990 and state match funds at \$1,310,993. State general funds account for \$881,541 and Newborn Screening fees make up the balance of the state required match in the amount of \$429,452.

Form 4, Budget Details by Types of Individuals Served (I) and Sources of Other Federal Funds (II):

In FFY 2010, the Nevada MCH Program expended \$587,666 for services to pregnant women. The expended amount is lower than the budgeted amount of \$1,112,846 as a result of programmatic changes that focus more on infants/children and children with special health care needs.

Infants < than 1 year old expenditures in FFY 2010 were \$998,803 and is higher than the budgeted amount of \$769,502; the difference in the budgeted versus expended amounts are the result of programmatic changes that focus more on infants/children and children with special health care needs.

FFY 2010, Children 1 to 22 year old expenditures were \$579,822 and are not significantly different than the budgeted amount of \$537,899.

FFY 2010, Children with Special Healthcare Needs expenditures were \$780,052; the budgeted amount was \$537,899. The difference in budgeted versus expenditures is the result of programmatic changes that focus more on infants/children and children with special health care needs. One of the changes to the Children with Special Health Care Needs program was implementing a care coordination model utilizing family resource centers in Las Vegas and Elko.

Administrative fees expended in 2010 were \$178,566 and comply with the 10% requirement based on the federal award amount of \$1,785,662.

In FFY 2012, the Nevada MCH program is budgeting the following federal and state match funds towards the individuals served requirements:

Pregnant Women -	\$468,163
Infants < 1 year old -	\$993,580
Children 1 to 22 years old --	\$552,622
Children with Special Healthcare Needs --	\$869,819
Administration -	\$174,799

Form 5, State Title V Program Budget and Expenditures by Types of Service:

In FFY 2010, the Nevada MCH program expended \$581,706 towards Direct Health Care Services; \$402,820 for Enabling Services; \$823,396 for Population Based Services; and \$1,316,987 for Infrastructure Building Services. Significant differences between budgeted and expended for Population Based Services and Infrastructure are the result of program changes that concentrate on deliverables that support infrastructure-building activities.

In FFY 2012, the Nevada MCH program is budgeting the following federal and state match funds for types of services:

Direct Health Care Services -	\$721,264
Enabling Services -	\$355,452
Population Based Services -	\$606,574

An attachment is included in this section. VA - Expenditures**B. Budget****Budget**

The total estimated Federal Fiscal Year (FFY) 2012 Maternal Child Health (MCH) budget is \$3,058,983. As required, the state of Nevada's FFY 2012 MCH 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 planning purposes, at \$1,747,990. State matching funds are budgeted at \$1,310,993 and are comprised of State General Funds in the amount of \$881,541. Newborn Screening Fees generated by the Metabolic Newborn Screening Program account for the remaining state match at \$429,452. All fees expended by the Metabolic Screening Program for newborn screening activities contribute to the 30% Children and Youth with Special Healthcare Needs requirement.

As required, FFY 2012 state match funds exceed the required FFY 1989 Maintenance of Effort amount of \$853,034.

For FFY 2012, 30% of the federal Title V allocation (Form 2, Section 1.A) is budgeted for Preventive and Primary care for children and adolescents that equal \$524,397. Additionally, \$524,397 is budgeted for Children and Youth with Special Healthcare Needs and as in prior years, Nevada expects to surpass the 30% minimum.

Administrative costs, (Form 2, Section 1. C) for Federal Fiscal Year 2012 is budgeted at \$174,799. Expenditures will not exceed this amount of 10%.

The remaining 2012 Federal Title V award is directed towards services for pregnant women and postpartum women and infants up to age 1 year as well as other activities supporting MCH populations throughout the state. Direct and population-based 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:

Centers for Disease Control and Prevention

- Oral Health
- Rape Prevention and Education
- Early Hearing Detection
- Diabetes
- Tobacco
- Breast and Cervical Cancer
- Comprehensive Cancer
- Immunization
- HIV Prevention

Preventative Health and Health Services

- Sexual Assault

Health Resources and Services Administration:

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

Ryan White

United States Department of Housing and Urban Development:
HOPWA

The State of Nevada's anticipated FFY 2012 allotments from the above referenced grants are \$12,796,679. All federally funded programs referenced above provide indirect and direct services to the populations served by the Maternal and Child Health Block Grant Program.

Expenditures:

Form 3, State MCH Funding Profile:

In FFY 2010, the Nevada MCH program expended \$1,785,662 in federal funds and \$1,339,247 in state match funds for a total of \$3,124,909. The state match funds are comprised of State General funds \$707,108, and Newborn Screening Fees in the amount of \$632,139. All fees expended by the Metabolic Screening Program for newborn screening activities contribute to the 30% CYSHCN requirement.

In FFY 2012, the Nevada MCH program is budgeting \$3,058,983 in total expenditures. HRSA funds are budgeted at \$1,747,990 and state match funds at \$1,310,993. State general funds account for \$881,541 and Newborn Screening fees make up the balance of the state required match in the amount of \$429,452.

Form 4, Budget Details by Types of Individuals Served (I) and Sources of Other Federal Funds (II):

In FFY 2010, the Nevada MCH Program expended \$587,666 for services to pregnant women. The expended amount is lower than the budgeted amount of \$1,112,846 as a result of programmatic changes that focus more on infants/children and children with special health care needs.

Infants < than 1 year old expenditures in FFY 2010 were \$998,803 and is higher than the budgeted amount of \$769,502; the difference in the budgeted versus expended amounts are the result of programmatic changes that focus more on infants/children and children with special health care needs.

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In FFY 2012, the Nevada MCH program is budgeting the following federal and state match funds towards the individuals served requirements:

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Form 5, State Title V Program Budget and Expenditures by Types of Service:

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In FFY 2012, the Nevada MCH program is budgeting the following federal and state match funds for types of services:

Direct Health Care Services -	\$721,264
Enabling Services -	\$355,452
Population Based Services -	\$606,574
Infrastructure Building Services -	\$1,375,693

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.