

NEVADA STATE HEALTH DIVISION
Bureau of Child, Family and Community Wellness



Nevada Title V
Maternal and Child Health Program

Needs Assessment

Jim Gibbons, Governor

Michael J. Willden, Director
Department of Health and Human
Services

Richard Whitley, MS
Health Division Administrator

Tracey D. Green, MD
State Health Officer

July 2010

Acknowledgement:

This report was made possible through the efforts of many individuals, organizations and agencies. Special thanks to the Nevada State Health Division's Office of Health Statistics and Surveillance for their efforts in collecting, analyzing and reporting the majority of the data indicators reported in the needs assessment.

Please direct any comments or suggestions to:

Deborah Aquino, Manager
Title V Maternal and Child Health Program
Bureau of Child, Family and Community Wellness
Nevada State Health Division
4150 Technology Way, Suite 210
Carson City, NV 89706
Phone: 775-684-3479 Fax 775-684-5998
E-mail: daquino@health.nv.gov

This report is available on the Nevada State Health Division's webpage at:

<http://health.nv.gov/MCH.htm>

Summary

Executive Summary..... 1

Narrative

Title V Maternal & Child Health Overview..... 3

 Background 3

 Mission of HRSA MCHB..... 4

 Nevada Title V Maternal and Child Health Program..... 4

 Nevada Maternal and Child Health Advisory Board (MCHAB) 5

Nevada MCH Needs Assessment 5

 Goals 6

 Process Outline for Conducting Nevada’s Title V MCH Needs Assessment 6

MCH Data 6

 Data Sources and Limitations 6

 Objectives Assessed – by Population Served..... 7

 Pregnant Women and Infants..... 7

 All Women 8

 Children and Adolescents 8

 Children and Youth with Special Healthcare Needs 9

MCH & CYSHCN Focus Groups 10

Nevada Title V MCH Capacity Assessment Results..... 12

Partnership Building and Collaboration Efforts 13

Strengths and Needs of the MCH Population Groups and Desired Outcomes 14

 Survey and Focus Group Background 14

 Childhood Obesity Prevention 15

 MCH Population Findings..... 16

 Pregnant Women, Mothers and Infants 16

Children and Adolescents 17

 Children with Special Healthcare Needs..... 18

Selection of State Priorities..... 20

Conclusion..... 21

APPENDICES:

Appendix A. Supporting Data: Health Systems Capacity Indicators22

Appendix B. Supporting Data: Health & Service Needs for Pregnant Women and Infants27

Appendix C. Supporting Data: Health and Service Needs for Women’s Health 38

Appendix D. Supporting Data: Health and Service Needs for Child and Adolescent Health42

Appendix E. Supporting Data: Health and Service Needs for Children and Youth with Special Health Care
Needs (CYSHCN) 62

Appendix F. Focus Group Invitees.....67

Appendix G. Focus Group Participants Feedback on Process..... 73

Appendix H. Focus Group and Survey Responses..... 84

 Who do you need as partners to address the identified needs?.....85

 What State policies are needed?88

 How can the State support the community policies and practices?91

 Anything else you would like to add.....95

Appendix I. Acronyms 97

Appendix J. Maps 98

 Map 1. Nevada Population and Geography by Rural-Urban Commuting Areas (RUCA)99

 Map 2. Healthcare Resources in Nevada100

 Map 3. Nevada Mileage Diagram101

Summary

In 2010 we celebrate the 75th Anniversary of Congress passing the Social Security Act, which contained the initial key legislation establishing Title V. With the passing of the Social Security Act in 1935, the Federal Government, through Title V, pledged its support of state efforts to extend health and welfare services for mothers and children. Although Title V has been amended over the years, the underlying goal has remained constant: continued improvement in the health, safety, and well-being of mothers and children.

State Maternal and Child Health programs coordinate initiatives that assure access to care; reduce infant mortality; provide and ensure access to prenatal and postnatal care; increase the number of children receiving diagnostic, preventive and treatment services; identify and promote policies that prevent injury and promote wellness; and develop family-centered, community-based systems of coordinated care for Children with Special Healthcare Needs.

Every five years, State Title V agencies are required to conduct needs assessments and to use the findings of the assessment to identify priorities and guide future resource allocation and program planning. 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 (NSHD) capacity to address the identified needs; and utilize the findings to strategically address priorities.

In order to conduct a needs assessment that was comprehensive and inclusive, a multi-component process was used:

- 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.

It is the intention of the MCH Program to transition to an ongoing needs assessment process, whereby more in depth analysis of specific priority areas will be conducted in between the mandated five-year needs assessment, increasing our ability to address the priority areas and enriching our knowledge base in preparation of the mandatory five-year report.

Title V Maternal and Child Health Overview

Background

In 2010 we celebrate the 75th Anniversary of Congress passing the Social Security Act, which contained the initial key legislation establishing Title V. The Title V Federal-State partnership continues to provide, through one of the largest Federal block grant programs, a vital foundation for improving the health of America's families. Each year, States are required to submit an application and annual report for their Maternal and Child Health (MCH) Services Title V Block Grant to the Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA). Every five years State Title V agencies are required to conduct needs assessments and to use the findings of the assessment to identify priorities and guide future resource allocation and program planning.

Mission of HRSA MCHB

The HRSA Maternal and Child Health Bureau improves the health of mothers, children and their families. Authorized under Title V of the Social Security Act, HRSA maternal and child health programs:

- Assure access to quality care, especially for those with low-incomes or limited availability of care.
- Reduce infant mortality.
- Provide and ensure access to comprehensive prenatal and postnatal care, especially for low-income and at-risk women.
- Increase the number of children receiving health assessments and follow-up diagnostic and treatment services.
- Provide and ensure access to preventive and child care services, as well as rehabilitative services for certain children.
- Implement family-centered, community-based systems of coordinated care for children with special healthcare needs.
- Provide assistance in applying for services to pregnant women with infants and children who are eligible for Medicaid.

The Maternal and Child Health Block Grant to States is a public health program that reaches across economic lines to improve the health of all mothers and children. A partnership between HRSA and State Maternal and Child Health programs, State Title V programs use block grant funding to build capacity and systems; conduct public education and outreach; train providers; support services for children with special healthcare needs, newborn screening and genetic services, lead poisoning and injury prevention; and promote health and safety in child care settings.

Nevada's Title V Maternal and Child Health Program

Nevada's Title V Maternal and Child Health (MCH) Program is an interdependent, multi-faceted collaboration between the State of Nevada Health Division and stakeholders throughout Nevada. The goal of the Nevada Title V MCH Program is to improve the health of families, specifically pregnant women, infants, children and adolescents, including Children with Special Health Care Needs. The Program promotes services that are "comprehensive, coordinated, family-centered, community-based, and culturally appropriate" and strives to become an organization with strong public health foundational components of monitoring, assurance and policy development.

Nevada Maternal and Child Health Advisory Board

The Nevada Maternal and Child Health Advisory Board (MCHAB) provides comprehensive advice and guidance to the State Health Division to ensure the enhancement and development of vital services that promote the healthy birth, growth and development of Nevada's children and are supportive of Nevada's families and communities. The Advisory Board is representative of Nevada's population both culturally and geographically while including a broad range of disciplines and interests, including parent representation. During the last legislative session in 2009, Chapter 442 of Nevada Revised Statutes was amended thereby transferring the authority to appoint members of the State Maternal and Child Health Advisory Board from the Governor to the State Board of Health. The Maternal & Child Health Advisory Board consists of nine members appointed by the State Board of Health and two nonvoting members appointed by the Legislative Commission; one who is a member of the Senate and one who is a member of the Assembly.

Nevada Title V MCH Needs Assessment**Needs Assessment Goals**

The goals of Nevada's Title V MCH Needs Assessment include:

- Determining Nevada's needs for the maternal and child health population and prioritize those needs;
- Assessing the capacity of Nevada State Health Division (NSHD) and MCH stakeholders to address the identified needs;
- Strengthen Existing Partnerships and Identify New Partners; and
- Utilizing the findings to develop strategic plans.

Process for Conducting Nevada's Title V MCH Needs Assessment

In order to conduct a needs assessment that was comprehensive and inclusive, a multi-component process was used:

- 1) Data on MCH health indicators were 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 (CYSHCN) 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.

MCH Data**Data Sources and Limitations**

Nevada used data to analyze the significance of factors and effectiveness of efforts to meet MCH Objectives and/or Healthy People 2010 guidelines for these populations. Data, goals, and significance are detailed in the appendices. This Needs Assessment uses a variety of data sources. These have been listed in detail in the appendices with the actual data and any limitations to the data. These limitations are narrow in scope, including, for example: coding issues, preliminary rather than final data, and primary data collection gaps. Data sources used include:

- Nevada Interim Population Projections, 2008
- Medicaid
- Office of Health Statistics
- AFDC/TANF/SCHIP/Food Stamps/WIC
- State juvenile justice files
- Board of Education files
- Linked child health data files
- Nevada State interim population projections
- Census data
- Nevada Health Division Office of Health Statistics and Surveillance data
- Preliminary birth data
- Newborn hearing screening data
- Electronic birth records
- Nevada Early Intervention Services data
- Follow-up data from clinical evaluations
- NICU data
- State birth certificates

-
- Newborn hearing registries
 - Data from tests of otoacoustic emissions and auditory brainstem response
 - State based early hearing detection
 - CDC
 - PedNSS at CDC
 - Nevada State STD surveillance data
 - Nevada State communicable disease registry
 - Nevada Hospital Discharge data
 - Fatal Accident reporting data,
 - US Department of Transportation data
 - Vital Statistics data
 - CDC Pediatric Nutrition Surveillance data
 - HRSA survey of children's health
 - YRBSS
 - Oral health Surveys data
 - Oral health Primary data
 - Children with Special Health Care Needs data

Objectives Assessed – by Population Served

Pregnant Women and Infants (less than one year old)

MCH looked at data for the following goals to identify health and service needs for pregnant women and infants less than one year:

- To increase adequacy of prenatal care utilization
- To reduce proportion of all live deliveries with low birth weight
- To reduce proportion of all live singleton deliveries with low birth weight
- To reduce proportion of all live deliveries with low birth weight
- To reduce the proportion of all singleton deliveries with very low birth weight
- To reduce morbidity associated with hearing impairment through early detection
- To ensure that higher risk mothers and newborns deliver at appropriate level hospitals

-
- To ensure early entrance into prenatal care to enhance pregnancy outcomes
 - To decrease smoking during pregnancy
 - To increase the percentage of mothers who breastfeed their infants at six months of age
 - To reduce number of infant deaths,
 - To reduce the number of perinatal deaths
 - To reduce the number of neonatal deaths
 - To reduce the number of post-neonatal death

All Women

To identify health and service needs for Women's Health (ages 14-44, any status of marriage relationship, parent or non-parent) data was collected to measure progress on the following goals:

- To decrease sexually transmitted disease (chlamydia) rates among women 15-19
- To decrease sexually transmitted disease (chlamydia) rates among women 20-44

Children & Adolescents

To identify health and service needs for Child and Adolescent health progress was measured on the following goals:

- To enumerate the total population of children 0-24 years by age subgroup, race, and ethnicity
- To determine the number/percentage of infants and children ages 0-19 in miscellaneous situations or enrolled in various State programs
- To reduce the number of children in Nevada from birth through 18 who died from unintentional injury
- To reduce the number of non-fatal injuries among children 14 years and younger
- To reduce the number of hospitalizations among children aged 15 years through 24 years due to motor vehicle crashes
- To reduce the number of deaths to children aged 14 years and younger caused by motor vehicle crashes

- To reduce the number of hospitalizations among youth aged 15-24 years due to motor vehicle crashes
- To reduce the proportion of children, ages 2 to 5 years, who are at risk of overweight or obese
- To eliminate self-induced, preventable morbidity and mortality
- To avert all cases of vaccine-preventable morbidity and mortality in children
- To lower the birthrate among teenagers, especially those age 15-17 years
- To prevent pit and fissure tooth decay in school children

Children and Youth with Special Health Care Needs

Assess MCH Bureau Core Outcomes for Children with Special Health Care Needs:

- To increase the proportion of families who are partners in decision making
- To increase coordinated, ongoing, comprehensive care within a medical home for CSHCN
- To increase early screenings for special health care needs
- To increase youth with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work, and independence.

MCH & CYSHCN Focus Groups

A series of seven in-person focus groups in Las Vegas, Reno, and Elko were hosted by the Needs Assessment Team to review and rank needs, discuss resources, and brainstorm solutions. Over two hundred individuals were invited to participate in the Focus Groups, including: Maternal and Child Health Advisory Board Members; Northern Nevada MCH Coalition and the newly formed Southern Nevada MCH Coalition members; key stakeholders including providers, families with children with special health care needs; and affiliated advisory/task forces including the Nevada Advisory Council for CYSHCN; the Perinatal Substance Abuse Prevention Subcommittee; and the five regional Oral Health Coalitions. Approximately one-third of the participants had received the invitation directly from the meeting coordinator. Over half of the attendees had received it two or more times as an email forwarded to them by someone else.

Participants were asked to rank priority needs using an interactive exercise using colored dots. The exercise was well received. Participating in the process encouraged people to meet new MCH stakeholders and encouraged discussion and reflective thinking. Following the prioritization exercise the facilitator organized “round table” discussion groups to brainstorm solutions and clarify priorities. Time was set aside for networking and resource sharing at the end of each session.

Comments on the process were solicited from the participants. One weakness noted was that attendance was lower than hoped for at the focus groups, due to insufficient notice. Suggestions ranged from very broad comments on the myriad of ways that systems could work better to very specific suggestions for primary care providers. Participants overall were satisfied with the

focus groups and the discussion. Many of them had suggestions for additional contacts, some of whom were invited and/or attended other sessions. Please see appendices for detailed lists of invitees and process feedback from participants.

Nevada Title V MCH Capacity Assessment Results

Health Division and stakeholder capacity was evaluated through an online survey of MCH staff and other stakeholders, and qualitative and quantitative data from service providers. Capacity in six areas was assessed at the five stages of program development: 1) The Planning Stage; 2) The Preliminary Action Steps Stage; 3) The Implementation Stage; 4) The Mastery Stage; and 5) the highest level, The Sustainability Stage.

- **OVERALL LEADERSHIP: *Implementation Stage*** – The will and trust for realizing the mission and vision has been established within the Title V/MCH program and key stakeholders and partners.
- **QUALITY IMPROVEMENT: *Implementation Stage*** – A number of quality improvement projects, in partnership with key stakeholders, partners and families are underway.
- **USE OF AVAILABLE RESOURCES: *Preliminary Action Steps Stage*** – The Title V/MCH program is cognizant of available resources, including financial, personnel skill sets and knowledge systems.
- **SERVICE AND COORDINATION: *Preliminary Action Steps Stage*** – Have identified where there are gaps in the provision and coordination of services.
- **PARTNERSHIPS ACROSS PUBLIC AND PRIVATE SECTORS/CONSTITUENCY: *Implementation Stage*** – A number of programs have begun to partner effectively with key public and private sector constituencies.
- **DATA INFRASTRUCTURE: *Preliminary Action Steps Stage*** – The need to establish effective data systems has been communicated across key stakeholders and partners.

Partnership Building and Collaboration Efforts

By the very nature of public health in Nevada, efforts have to be collaborative. The large geographical size of the state, the rural/frontier characteristics of most of the counties, the dense population in the urban counties, a low tax-base, and socially conservative constituency, MCH and others in public health have to rely on each other to create desirable outcomes. Health Division, and its parent organization, Department of Health and Human Services, contain all the elements of public health in Nevada, most of them in the same bureau as MCH, including chronic disease prevention, immunization, vital records and health statistics, and HIV/AIDS. This facilitates an open and collaborative relationship with virtually every aspect of public health in Nevada. In addition to organizations listed in detail in the methodology portions of this text, Health Division currently collaborates and partners with all other State, federal (including HRSA), and county agencies as well as other entities including the universities and community colleges, health districts, numerous community-based programs, individual school districts and the Department of Education, regional coalitions and advisory boards/task forces, tribal organizations, as well as direct service providers and relevant primary care associations, and care access organizations.

All stakeholders and partners were invited to participate in this needs assessment by survey, focus group, or informal discussion. The results of the survey are detailed in the appendices.

Strengths and Needs of the Maternal and Child Health Population Groups and Desired Outcomes**Survey and Focus Group Background**

Surveys and focus groups discussed the following: 1) Who do you need as partners to address the identified needs? 2) What State policies are needed? 3) How can the State support the community policies and practices? 4) Anything else? Not surprisingly for a needs assessment done during the national health care debate, respondents chose health insurance/coverage as a first or second choice for all three populations. The results for Question 1 on partnering did not lead to any clear mandate. General content suggested improvement to systems operation and more effective interactions. The results for Question 2 on state policies also covered a broad range of suggestions. The most implementable of these suggestions related to cost control and coverage, as well as more active policy leadership in the state for public health issues. For Question 3, on state support of community policies and practices, focus groups and survey respondents predictably showed frustration with funding and asked for increased funding by federal and state organizations. The final question, asking for anything else respondents would like to add, clearly indicated frustration with the current fiscal context as well as the feelings common among public health professionals that Nevada could do better as a state in caring for the health of its population. Overall, these comments indicated some areas that will be fruitful for action and other areas that will require a major paradigm shift in state government. Results are listed in the appendices.

Childhood Obesity Prevention

Obesity prevention in children was identified as an area warranting additional assessment by our MCH Needs Assessment Planning Team. The online survey included a question that asked respondents to rank policy change recommendations that could reduce obesity in Nevada's children. The top obesity prevention policies identified were:

1. 71.7% - Ensure that students have appealing, healthy food and beverage choices in
2. 48.3% - Consider requiring standards-based physical education classes taught by certified PE teachers.
3. 44.2% - Improve community design features to encourage physical activity.
4. 41.7% - Keep communities safe and free from crime to encourage outdoor activity.
5. 30.8% - Implement a standards-based health education program taught by teachers certified in health education.

MCH Population Findings

Pregnant women, mothers, infants: (Please see appendices for complete data, goals, objectives, and significance.)

- In Nevada, women not on Medicaid have dramatically higher likelihood of receiving prenatal care in the first trimester and dramatically better prenatal care overall.
- The majority of at-risk populations live in urban areas. A significant number of single parent families use state programs.
- A significant number of woman and children live below the poverty level.
- To carry out the ten essential public health services, Nevada needs more data capacity, collection, and processing infrastructure. For example, Nevada needs better access to key public health data sets.
- Nevada needs to significantly improve the percentage of live born infants who receive adequate prenatal care.
- Nevada needs to significantly improve the rate of women receiving prenatal care.
- Nevada needs to improve the number of low birth rate deliveries
- Nevada does a good job of testing newborns for hearing screening before discharge.
- Nevada needs to significantly improve the percentage of very low birth rate infants being delivered at care-appropriate facilities.
- Nevada's rate of women who smoke during the last three months of pregnancy appears to be improving over rates earlier in the decade.
- Nevada needs to dramatically improve the rate of breastfeeding mothers and increase the data collection on this population.
- Nevada has done a good job of reducing the number of infant deaths and bringing numbers into the healthy people 2010 objectives
- Nevada is also doing a good job of bringing the perinatal birth rate and fetal deaths into range with Healthy People 2010 objectives
- Nevada is doing a good job of reducing the neonatal deaths into the range of health People 2010 objective.

-
- With provisional data, Nevada has exceeded the healthy People 2010 objectives for the number of post-neonatal deaths.
 - Nevada needs to dramatically improve its rates of chlamydia in women.
 - Hispanic and Latino populations have been increasing dramatically.

Children and Adolescents: (Please see appendices for complete data, goals, objectives, and significance.)

- The number of children in Nevada birth through 18 who die from unintentional and intentional injuries seems to be decreasing. Using provisional data.
- The rate of nonfatal injuries for children 14 and younger appears to be improving over the early years of the decade.
- The number of hospitalizations among children 15-24 due to motor vehicle crashes has improved over previous years for the data available.
- Nevada's rates of deaths to children 14 and younger from motor vehicle crashes are better than the Healthy People 2010 objective.
- The number of children 2-5 receiving WIC services who are at risk of overweight or obese has increased slightly.
- The percentage of children engaging in physical activity appears to be improving.
- Students appear to be eating more greens but drinking less milk.
- Nevada's suicide rate exceeds the national average for youth.
- Nevada's rate of alcohol use for youth is higher than the national average.
- Nevada needs to do a better job of vaccinating 19-35 month children.
- Nevada needs to reduce the teen pregnancy rate, especially for Hispanics.

Children with Special Health Care Needs Performance Measures and Current Activities:

(Please see appendices for complete data, goals, objectives, and significance.)

Performance Measure 02: The percentage of CSHCN 0-18 whose families' partner in decision making at all levels and are satisfied with the services they receive. MCH staff increased information dissemination, cultural competency, and family involvement. MCH will be increasing care coordination for CSHCN, increasing cultural competency training to address health disparities, and soliciting feedback from participants.

Performance Measure 03: The percentage of children with special health care needs 0-18 who receives coordinated, ongoing, comprehensive care within a medical home. MCH has been engaging in activities in all pyramid levels of efforts: direct service, enabling, infrastructure building, and population-based. These efforts include increased training for family-centered care, pilot testing, expanding the Bright Futures Initiative, expanding collaborations to develop Nevada's Electronic Birth registry data tracking and collection, and expanding care coordination. MCH will continue to expand the registry, collaborate with Medicaid service providers, and educate rural service providers on comprehensive screenings for their population.

Performance Measure 04: The percentage of children with special health care needs 0-18 whose families have adequate private and/or public insurance to pay for the services they need. MCH has been assisting families in applying for appropriate Medicaid and SCHIP services by providing information and assistance in the application process. MCH is improving cultural competency by language and outreach to the Hispanic and Native American populations. Staff are also seeking to improve access to care and coverage for MCH populations. MCH will continue to improve access to care.

Performance Measure 05: Percent of children with special health care needs 0-18 whose families report that community-based service systems are organized so they can use them easily. Nevada has been improving a point of contact for comprehensive referral and increasing training and collaboration with other services. MCH will be moving toward a coordinated care approach, simplifying the application process, increasing outreach, restructuring grant funds, piloting an online application tool, and forging new partnerships with other groups and agencies.

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. MCH has been working on increasing public assistance access and expanding emphasis on youth transition to adulthood needs. MCH will be building on transition activities based on the work at the University of Florida, expanding connections with targeted programs, and increasing training, especially in rural areas.

Selection of State Priorities

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. MCHAB members, during an open public meeting, discussed the findings: the needs identified, the desired outcomes, any required mandates, and the level of existing capacity. Feasibility was also assessed by the Board. Discussions were held considering areas that it was believed the State has a reasonable opportunity to maintain, modify, or enhance existing interventions, initiatives, or systems that have been successful, or begin new interventions, initiatives, or systems that are expected to result in needed improvements. The MCH Advisory Board selected the following areas as priorities for Nevada:

- Outreach, awareness, navigation and knowledge –improve public education regarding healthcare services;
- Access to systems of care for prevention;
- Support for mental health screening and data collection to identify needs related to mental health provider access;
- Continuing early identification and intervention for Children with Special Healthcare Needs;
- Recruitment and retention of healthcare workforce;
- Adolescent health systems development: comprehensive care for adolescent health; and
- Access to prenatal care.

Conclusion

The State of Nevada Maternal and Child Health Program is required to complete a regular needs assessment in order to provide the best public health care intervention for its populations. This year's needs assessment comes at a valuable time for Nevada. In the current economic climate, Nevada's most vulnerable residents have been facing dramatic financial challenges that result in changes to their standards of care. Nevada's population also has been fluctuating dramatically since the last needs assessment, making addressing these needs more difficult. However, consistent, data-driven, population-based, evidence-based maternal and child health care intervention will continue to bring Nevada's public health concerns into alignment with federal and state health care objectives.

It is the intention of the Nevada MCH Program to transition to an ongoing needs assessment process, whereby more in depth analysis of specific priority areas will be conducted in between the mandated five-year needs assessment, increasing our ability to address the priority areas and enriching our knowledge base in preparation of the mandatory five-year report.

Appendix A. Supporting Data: Health Systems Capacity Indicators

Table 1	Poverty Levels
Table 2	Capacity by Medicaid, Non-Medicaid, and all MCH populations
Table 3	Geographic living area for Nevada’s Children
Table 4	Enrollment in State Programs by Ethnicity
Table 5	Poverty Levels, Ages 0-19
Table 6	Data Set Availability

Goal: To determine the percentage of the State population at 50 percent, 100 percent, and 200 percent of the federal poverty level.

Table 1		
Percent of the State population at various levels of the federal poverty level.		
	Percentage Below	Year
Total Population	2,783,733	2008
Percent Below: 50% of poverty	4.9%	2006
100% of poverty	10.3%	2006
200% of poverty	29.2%	2006
Data Sources and Data Issues:	Census data & Nevada State Interim 2008 population projections.	

Significance: Eligibility for Medicaid, SCHIP and other State programs is in part determined by family income as a percentage of federally defined poverty levels. States have some discretion in determining which groups their Medicaid and SCHIP programs will cover and the financial criteria for Medicaid and SCHIP eligibility.

Goal: To eliminate disparities in pregnancy health outcomes in Medicaid, non-Medicaid, and all populations in the State.

Table 2					
Comparison of health system capacity indicators for Medicaid, Non-Medicaid, and all MCH populations in the state.					
	Year	Data Source	Population		
			Medicaid	Non-Medicaid	All
a) Percent of low birth weight (<2,500g)			8% FFY 09	8% CY 09 Prelim	16
b) Infant death rates per 1,000 live births			6 FFY 09	5.3 CY 09 Prelim	11.3
c) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester			10.2% FFY 09	69.4% CY 09 Prelim	79.6
d) Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck])			10% FFY 09	67.8% CY 08 Prelim	77.8
Data Sources and Data Issues:	Medicaid used federal fiscal year (FFY) and Office of Health Statistics and Surveillance (OHSS) used calendar year (CY).				

Significance: Adverse health outcomes disproportionately affect the poor. Enrollment and participation in the State Medicaid, SCHIP, or other programs (food stamps, WIC, AFDC/TANF) may not eliminate the disparity in pregnancy outcomes by socioeconomic status, race and/or ethnicity. The quality of services provided to pregnant women and their newborns should be evaluated to identify barriers to comprehensive, family-centered, community-based, culturally competent care.

Goal: To determine the number of children in the State aged 0 through 19 years by geographic living area.

Table 3	
Geographic living area for all children aged 0 through 19 years.	
Living in metropolitan areas	677,204
Living in urban areas	692,753
Living in rural areas	11,907
Living in frontier areas	63,340
Total-all children 0-19	768,000
Data Sources and Data Issues:	Nevada State Interim 2008 population projections.

Significance: Child health outcomes and the patterns of utilization of health care services can differ greatly by geographic area of living. Poor families living in metropolitan and urban areas without a regular source of coordinated health services may over utilize emergency services or present as frequent walk-ins to community or public health clinics. Access to care for the poor and under-served in rural and frontier areas is largely dependent on the number of providers available and willing to see the uninsured or accept Medicaid or CHIP. Barriers to quality health care may also include inadequate transport to care and ill-equipped health care facilities.

Goal: To determine number/percentage of infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs.

Table 4		
Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.		
	Total Not Hispanic	Total Hispanic or Latino
0-19 yrs old (population)	508,130	259,870
Percent in household headed by single parent	33%	36%
Data Sources and Data Issues:	AFDC/TANF, Medicaid, SCHIP, food stamp, and WIC files; State juvenile criminal justice and Board of Education files, Linked child health data files. Nevada State Interim 2008 population projections.	

Significance: Adverse health outcomes disproportionately affect infants and children in foster care or in single parent homes. In 1995, 14 million infants and children aged 0 through 18 years lived below the Federal poverty level; 59 percent of these families were single parent families. Leaving high school before graduation can lead to continued poverty and a higher incidence of juvenile arrests. Many infants and children eligible for Medicaid and other State programs are not enrolled. Data linkage of State program files with Medicaid may identify factors associated with State program eligibility without full participation.

Goal: To determine the percentage of all children aged 0 through 19 years at 50 percent, 100 percent, and 200 percent of the federal poverty level.

Table 5		
Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.		
	Total	Year
Total Population	768,000	2008
Percent Below: 50% of poverty	6%	2006
100% of poverty	14%	2006
200% of poverty	38%	2006
Data Sources and Data Issues:	Census data & Nevada State Interim 2008 population projections.	

Significance: Eligibility for Medicaid, SCHIP and other State programs is in part determined by family income as a percentage of federally defined poverty levels. States have some discretion in determining which groups their Medicaid and SCHIP programs will cover and the financial criteria for Medicaid and SCHIP eligibility.

Goal: To assure MCH program and Title V agency access to essential policy and program relevant information from key public health data sets relating to women, children, and families. To demonstrate core MCH data capacity.

Table 6 - Data Set Availability		
	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1-3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
Annual linkage of infant birth and infant death certificates	3	Y
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Y
Annual linkage of birth certificates and WIC eligibility files	1	N
Annual linkage of birth certificates and newborn screening files	3	Y
Hospital discharge survey for at least 90% of in-State discharges	2	Y
Annual birth defects surveillance system	3	Y
Survey of recent mothers at least every two years (like PRAMS)	1	N
1=No, the MCH agency does not have this ability.		
2=Yes, the MCH agency sometimes has this ability, but not on a consistent basis.		
3=Yes, the MCH agency always has this ability.		
Healthy People 2010 Objective: 	No specific Healthy People 2010 Objective. Related Objective 23-5: Increase the proportion of Leading Health Indicators, Health Status Indicators, and Priority Data Needs for which data – especially for select populations – are available at the Tribal, State and local levels.	
Data Sources and Data Issues:	OHSS	

Significance: To carry out the 10 essential public health services, MCH programs need access to relevant program and policy information. This requires basic data capacity on the part of the Title V agency including the ability to monitor health status, to investigate health problems, and to evaluate programs and policies. One measure of this capacity is the availability and use by State MCH programs of key public health data sets related to women, children, and families.

Appendix B. Health & Service Needs for Pregnant Women and Infants (less than 1 year old)

Table 7: Identify health and services for pregnant women and infants (less than 1 year old) 22

Table 8 -- Live births to women (of all ages) enumerated by maternal age and race 22

Table 9 -- Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity 23

Table 10 -- The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.. 23

Table 11-- The percent of live births weighing less than 2,500 grams 24

Table 12 -- The percent of live singleton births weighing less than 2,500 grams..... 24

Table 13 -- The percent of live births weighing less than 1,500 grams 24

Table 14 -- The percent of live singleton births weighing less than 1,500 grams..... 25

Table 15 -- Increase the timeliness of Newborn Hearing Diagnosis to 3 months of age..... 25

Table 16 -- Percentage of newborns who have been screened for hearing before hospital discharge.... 26

Table 17 -- Percent of very low birth weight (VLBW) infants delivered at facilities for high-risk deliveries and neonates 26

Table 18 -- Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester 27

Table 19 -- Percentage of women who smoke in the last three months of pregnancy 27

Table 20 -- The percent of mothers who breastfeed their infants at 6 months of age..... 28

Table 21 -- The infant mortality rate per 1,000 births..... 28

Table 22 -- The perinatal mortality rate per 1,000 births plus fetal deaths 29

Table 23 -- The neonatal mortality rate per 1,000 live births..... 29

Table 24 -- The postneonatal mortality rate per 1,000 births 30

Table 25 -- The ratio of black infant mortality rate to the white infant mortality rate 30



Table 7
Identify health & service needs for Pregnant Women and Infants (less than 1 year old).

Access challenges for pregnant women (ie., finding a provider who accepts Medicaid, etc.)	446.5
Anemia/iron deficiency during pregnancy	13.0
Breastfeeding initiation and duration	102.5
Comprehensive well baby care	241.0
Dental health for women	117.0
Depression (including postpartum depression)	132.5
Domestic and sexual violence screening	95.0
Early and adequate prenatal care	477.0
Environmental toxins exposure	49.5
Folic acid levels during pregnancy	9.0
Genetic counseling	25.5
Health disparities in mothers and infants	137.0
Health insurance/coverage	384.0
Immunizations	157.5
Infant abuse and Neglect	182.5
Infant developmental, social and emotional screening	193.0
Infant injuries (falls, poisoning, drowning)	34.0
Infant mortality	40.0
Infant sleep safety	57.5
Linkage to community resources	141.0
Low birth weight and preterm births	115.0
Male/father involvement in reproductive health and parenting	74.0

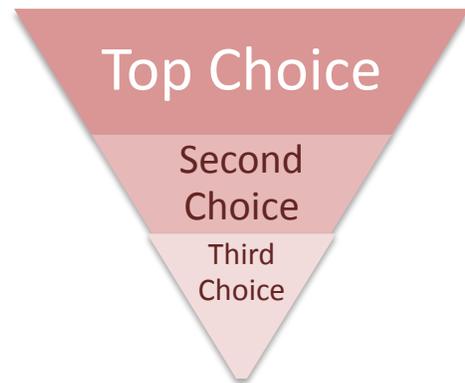


Table 8
Live birth counts to women (of all ages) enumerated by maternal age and race.

Age Groups	Total All Races	White	Black	Native	Asian	NHOPI	>1 Race	Other/Unknown
<15 yrs old	67	54	9	1	2	0	0	1
15-17 yrs old	1,440	1,135	201	18	45	0	0	41
18-19 yrs old	2,752	2,112	413	53	98	0	0	76
20-34 yrs old	29,219	22,950	2,737	401	2,368	0	0	763

Appendix B. Supporting Data: Health and Service Needs for Pregnant Women and Infants

>35 yrs old	5,296	4,053	364	47	693	0	0	139
All Ages	38,774	30,304	3,724	520	3,206	0	0	1,020
Data Sources and Data Issues:	OHSS, Preliminary 2008 birth data. Asian includes Native Hawaiian and Pacific Islander. Did not include unknown age groups.							

Table 9			
Live birth counts to women (of all ages) enumerated by maternal age and Hispanic ethnicity.			
Age Groups	Total Not Hispanic	Total Hispanic or Latino	Ethnicity Not Reported
<15 yrs old	20	43	4
15-17 yrs old	568	826	46
18-19 yrs old	1,375	1,311	66
20-34 yrs old	17,474	11,262	483
>35 yrs old	3,486	1,738	72
All Ages	22,923	15,180	671
Data Sources and Data Issues:	OHSS, Preliminary 2008 birth data. Did not include unknown age groups.		

Goal: To increase the adequacy of prenatal care utilization.

Table 10						
The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.						
Year	2004	2005	2006	2007	2008*	2009*
Percentage	75.9%	69.1%	68.6%	67.1%	67.8%	na
Numerator	26,581	25,667	27,343	27,550	26,207	na
Denominator	35,022	37,133	39,876	41,041	38,642	na
Healthy People 2010 Objective:	Objective 16-16b: Increase to at least 90 percent the proportion of all live born infants whose mothers receive prenatal care that is adequate or more than adequate according to the Adequacy of Prenatal Care Utilization (Kotelchuck) Index.					
Data Sources and Data Issues:	OHSS, Coding issues for Kotelchuck due to data being half electronic & half paper and a change from 1989 standard birth certificate to the 2003. *Data is provisional, rather than final.					

Significance: Adequate prenatal care is an effective intervention that improves pregnancy outcomes, including reducing infant mortality. The two-part (Kotelchuck) Adequacy of Prenatal Care Utilization Index combines independent assessment of the timing of prenatal care initiation and the frequency of visits received after initiation.

Goal: To reduce proportion of all live deliveries with low birth weight.

Table 11						
The percent of live births weighing less than 2,500 grams.						
Year	2004	2005	2006	2007	2008*	2009*
Percentage	8.0%	8.3%	8.3%	8.2%	8.0%	8.0%
Numerator	2,799	3,083	3,335	3,391	3,112	2,950
Denominator	35,146	37,259	40,006	41,175	38,777	36,847
Healthy People 2010 Objective: 	Objective 16-10a: Reduce low birth weights (LBW) to no more than 5 percent of all live births.					
Data Sources and Data Issues:	OHSS, *Data is provisional, as opposed to final.					

Significance: The general category of low birth weight infants includes pre-term infants and infants with intrauterine growth retardation. Many risk factors have been identified for low birth weight babies including: both young and old maternal age, poverty, late prenatal care, smoking, substance abuse, and multiple births.

Goal: To reduce the proportion of all live singleton deliveries with low birth weight.

Table 12						
The percent of live singleton births weighing less than 2,500 grams.						
Year	2004	2005	2006	2007	2008*	2009*
Percentage	6.4%	6.6%	6.4%	6.5%	6.3%	6.4%
Numerator	2,189	2,360	2,488	2,597	2,375	2,309
Denominator	34,165	35,986	38,756	39,895	37,597	35,811
Healthy People 2010 Objective: 	No specific Healthy People 2010 objective. Related to Objective 16-10a: Reduce low birth weights (LBW) to no more than 5 percent of all live births.					
Data Sources and Data Issues:	OHSS, *Data is provisional, as opposed to final.					

Significance: In vitro fertilization has increased the number of multiple births. Multiple births often result in shortened gestation and low or very low birth weight infants.

Goal: To reduce proportion of all live deliveries with low birth weight.

Table 13						
The percent of live births weighing less than 1,500 grams.						
Year	2004	2005	2006	2007	2008*	2009*
Percentage	1.3%	1.3%	1.4%	1.3%	1.3%	1.2%
Numerator	441	478	544	533	490	454
Denominator	35,146	37,259	40,006	41,175	38,777	36,847
Healthy People 2010 Objective: 	Objective 16-10b: Reduce very low birth weight births to no more than 0.9 percent of all live births.					
Data Sources and Data Issues:	OHSS, *Data is provisional, as opposed to final.					

Significance: Very low birth weight births are usually associated with pre-term birth. The primary risk factors for pre-terms births are prior preterm birth, prior spontaneous abortion, low pre-pregnancy weight, cigarette smoking, and multiple births.

Goal: To reduce the proportion of all live singleton deliveries with very low birth weight.

Table 14						
The percent of live singleton births weighing less than 1,500 grams.						
Year	2004	2005	2006	2007	2008*	2009*
Percentage	1.0%	1.0%	1.0%	1.1%	1.0%	1.0%
Numerator	329	365	397	420	363	362
Denominator	34,165	35,986	38,756	39,895	37,597	35,811
Healthy People 2010 Objective: 	No specific Healthy People 2010 objective. Related to Objective 16-10b: Reduce very low birth weights to no more than 0.9 percent of all live births.					
Data Sources and Data Issues:	OHSS, *Data is provisional, as opposed to final.					

Significance: In vitro fertilization has increased the number of multiple births. Multiple births may result in shortened gestation and low or very low birth weight infants.

Goal: To reduce the morbidity associated with hearing impairment by ensuring that children are identified with this condition as early as possible and receive needed treatment or other intervention in a family-centered and timely manner. Receiving diagnosis by three months of age requires audiology capacity and the shortage is what the Nevada Title V and Hand & Voices partnership will address.

Table 15 Increase the timeliness of Newborn Hearing Diagnosis to 3 months of age.						
Year	2004	2005	2006	2007	2008	2009*
Numerator	na	na	na	na	na	41
Denominator	na	na	na	na	na	58
Healthy People 2010 Objective:	 <p>28 general and 28-13. 28 Improve the visual and hearing health of the Nation through prevention, early detection, treatment, and rehabilitation. 28-13 (Developmental) Increase access by persons who have hearing impairments to hearing rehabilitation services and adaptive devices, including hearing aids, cochlear implants, or tactile or other assistive or augmentative devices. 28-14 to 28-17 Developmental Increase the proportion of persons who have had a hearing examination on schedule. Increase the number of persons who are referred by their primary care physician for hearing evaluation and treatment. Increase the use of appropriate ear protection devices, equipment, and practices. Reduce noise-induced hearing loss in children and adolescents aged 17 years and under.</p>					
Data Sources and Data Issues:	Newborn Hearing Screening Program's data system, electronic birth records, Nevada Early Intervention Services data and other follow-up data received from clinical evaluations.*Data is provisional, as opposed to final.					

Significance: While Nevada's Universal newborn hearing screening program is successful with initial screening; follow-up and diagnosis is a challenge. Specialty providers shortages contribute to the need for improvement in this area. Early identification and intervention have lifelong implications for the child's understanding and use of language.

Goal: To reduce the morbidity associated with hearing impairment through early detection.

Table 16 Percentage of newborns who have been screened for hearing before hospital discharge.						
Year	2004	2005	2006	2007	2008	2009
Percentage	na	na	na	98.8%	99.2%	99.0%
Numerator	na	na	na	38,744	38,232	36,372
Denominator	na	na	na	39,209	38,541	36,747
Healthy People 2010 Objective:	 <p>Objective 28-11: Increase the proportion of newborns that are screened for hearing loss by age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services by age 6 months.</p>					

Appendix B. Supporting Data: Health and Service Needs for Pregnant Women and Infants

Data Sources and Data Issues:	State birth certificates, newborn hearing registries, tests of otoacoustic emissions and auditory brainstem responses. Potential data source – State based Early Hearing Detection and Intervention (EDHI) Program Network, CDC.
-------------------------------	--

Significance: The advantages of early detection of hearing impairments are indisputable and include necessary follow-up of free and appropriate enrollment in habilitation and education programs.

Goal: To ensure that higher risk mothers and newborns deliver at appropriate level hospitals.

Table 17 Percent of very low birth weight (VLBW) infants delivered at facilities for high-risk deliveries and neonates.						
Year	2004	2005	2006	2007	2008*	2009*
Percentage	86.6%	95.2%	94.7%	93.2%	72.9%	75.1%
Numerator	382	455	515	497	357	341
Denominator	441	478	544	533	490	454
Healthy People 2010 Objective: 	Objective 16-9: Increase the proportion of very low birth weight (VLBW) infants born at Level III hospitals or sub-specialty perinatal centers to 90 percent.					
Data Sources and Data Issues:	OHSS and listing of NICU facilities. Data greater than or equal to 2008 included level 3 only. Data less than or equal to 2007 included level 2 & 3.*Data is provisional, as opposed to final.					

Significance: Very low birth weight infants are more likely to survive and thrive if they are born/cared for in an appropriately staffed and equipped facility with a high volume of high-risk admissions.

Goal: To ensure early entrance into prenatal care to enhance pregnancy outcomes.

Table 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.						
Year	2004	2005	2006	2007	2008*	2009*
Percentage	67.4%	67.2%	64.3%	64.7%	69.4%	59.4%
Numerator	23,671	25,032	25,721	26,621	26,914	21,875
Denominator	35,146	37,259	40,006	41,175	38,777	36,847
Healthy People 2010 Objective: 	Objective 16-16a: Increase the proportion of pregnant women who receive early and adequate prenatal care beginning in the first trimester of pregnancy to 90 percent.					

Appendix B. Supporting Data: Health and Service Needs for Pregnant Women and Infants

Data Sources and Data Issues:	OHSS, *Data is provisional, as opposed to final.
-------------------------------	--

Significance: Early identification of maternal disease and risks for complications of pregnancy or birth are the primary reason for first trimester entry into prenatal care. This can help ensure that women with complex problems and women with chronic illness or other risks are seen by specialists. Early high-quality prenatal care is critical to improving pregnancy outcomes.

Goal: Decrease smoking during pregnancy.

Table 19 Percentage of women who smoke in the last three months of pregnancy.						
Year	2004	2005	2006	2007	2008*	2009*
Percentage	7.9%	7.7%	6.9%	6.6%	5.9%	6.1%
Numerator	2,779	2,876	2,777	2,727	2,286	2,264
Denominator	35,146	37,259	40,006	41,175	38,777	36,847
Healthy People 2010 Objective: 	Objective 27-6. Increase smoking cessation during pregnancy.					
Data Sources and Data Issues:	OHSS, Data consists of women who smoked at any time of pregnancy. *Data is provisional, as opposed to final.					

Significance: Birth weight is the single most important determinant of a newborn's survival during the first year. Maternal smoking during pregnancy has been directly related to low birth weight.

Goal: To increase the percent of mothers who breastfeed their infants at 6 months of age.

Table 20 The percent of mothers who breastfeed their infants at 6 months of age.						
Year	2004	2005	2006	2007	2008	2009
Percentage	22.7%	23.6%	23.4%	26.5%	25.1%	25.6%
Healthy People 2010 Objective: 	Objective 16-19b: Increase the proportion of mothers who breastfeed their infants at 6 months of age to 50 percent.					
Data Sources and Data Issues:	NV WIC Program is the only source of breastfeeding data available in the State. The NV WIC program sends the raw data extracted from the MIS to the PedNSS at the CDC. The CDC processes the data and reports back only the percentages.					

Significance: Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and

Appendix B. Supporting Data: Health and Service Needs for Pregnant Women and Infants

development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits.

Goal: To reduce the number of infant deaths.

Table 21						
The infant mortality rate per 1,000 births.						
Year	2004	2005	2006	2007*	2008*	2009*
Rate	6.2	5.6	6.5	6.3	5.3	4.7
Numerator	219	209	262	260	207	172
Denominator	35,146	37,259	40,006	41,175	38,777	36,847
Healthy People 2010 Objective:	Objective 16-1c: Reduction of infant deaths (within 1 year) to 4.5 per 1,000 live births.					
Data Sources and Data Issues:	OHSS, *Data is provisional, as opposed to final.					

Significance: All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate, but the rate of decline has slowed in the last 10 years. There is still significant racial disparity, as noted in the Healthy People 2000 Mid-course Review. Rates are much higher in the lower social class and in the lowest income groups across all populations.

Goal: To reduce the number of perinatal deaths.

Table 22						
The perinatal mortality rate per 1,000 births plus fetal deaths.						
Year	2004	2005	2006	2007*	2008*	2009*
Rate	5.2	4.4	5.3	5.7	5.1	4.8
Numerator	182	165	212	229	212	188
Denominator	35,253	37,361	40,127	40,106	41,291	3886
Healthy People 2010 Objective:	Objective 16-1b: Reduce the death rate during the perinatal period (28 weeks of gestation or more to 7 days or less after birth) to 4.5 per 1,000 live births plus fetal deaths.					

Appendix B. Supporting Data: Health and Service Needs for Pregnant Women and Infants

Data Sources and Data Issues:	OHSS, *Data is provisional, as opposed to final.
-------------------------------	--

Significance: Perinatal mortality is a reflection of the health of the pregnant woman and newborn and reflects the pregnancy environment and early newborn care.

Goal: To reduce the number of neonatal deaths.

Table 23 The neonatal mortality rate per 1,000 live births.					
Year	2004	2005	2006	2007*	2008*
Rate	4.2	3.3	4.3	4.0	3.3
Numerator	147	123	174	165	127
Denominator	35,146	37,259	40,006	41,175	38,777

Healthy People 2010 Objective: 	Objective 16-1d: Reduce all neonatal deaths (within the first 28 days of life) to 2.9 per 1,000 live births.
Data Sources and Data Issues:	OHSS, *Data is provisional, as opposed to final.

Significance: Neonatal mortality is a reflection of the health of the newborn and reflects health status and treatment of the pregnant mother and of the baby after birth.

Goal: To reduce the number of post-neonatal deaths.

Table 24 The postneonatal mortality rate per 1,000 births.						
Year	2004	2005	2006	2007*	2008*	2009*
Rate	2.4	2.3	2.2	2.3	2.1	1.3
Numerator	72	86	88	95	80	48
Denominator	35,146	37,259	40,006	41,175	38,777	36,847
Healthy People 2010 Objective: 	Objective 16-1e: Reduce all post-neonatal deaths (between 28 days and 1 year) to 1.5 per 1,000 live births.					
Data Sources and Data Issues:	OHSS, *Data is provisional, as opposed to final.					

Appendix B. Supporting Data: Health and Service Needs for Pregnant Women and Infants

Significance: This period of mortality reflects the environment and the care infants receive. SIDS deaths occur during this period and have been recently reduced due to new infant positioning in the U.S. Poverty and a lack of access to timely care are also related to late infant deaths.

Table 25						
The ratio of black infant mortality rate to the white infant mortality rate.						
Year	2004	2005	2006	2007*	2008*	2009*
Ratio	3.3	2.9	2.5	1.9	na	na
Numerator	19	13.5	16	12.5	na	na
Denominator	5.8	5	6.4	6.6	na	na
Data Sources and Data Issues:	OHSS, Race/ethnicity coding different in death 08 & 09. *Data is provisional, as opposed to final.					

**Appendix C. Health and Service Needs for Women’s Health
(ages 14-44, any status of marriage, relationship, parent or non-parent)**

Table 26 – Identify health and service needs for women’s health (ages 14-44, any status of marriage, relationship, parent or non-parent)..... 31

Table 27 -- The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia 31

Graph 1 – Youth Risk Behavior Survey: Sexual Behaviors 32

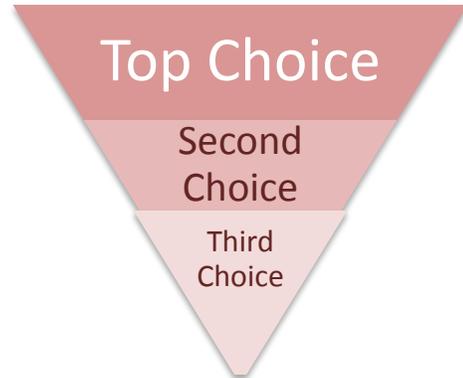
Table 28 -- The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia 32

Graph 2 -- Overweight or Obese Women, ages 18 to 44..... 33

Table 26
Identify health and service needs for Women's Health (ages 14-44, any status of marriage, relationship, parent or non-parent).



Dental care	165.0
Depression/mental health	372.0
Domestic violence	187.5
Health coverage/insurance	599.0
Health disparities	181.0
Nutrition	135.0
OB/GYN providers	190.5
Physical activity	66.0
Poverty	215.5
Preconception health planning/family planning	331.5
Primary preventative	226.0
Sexual violence/assault	120.0
Substance/alcohol use or abuse	236.0
Tobacco use cancer	78.0
Wellness	137.5

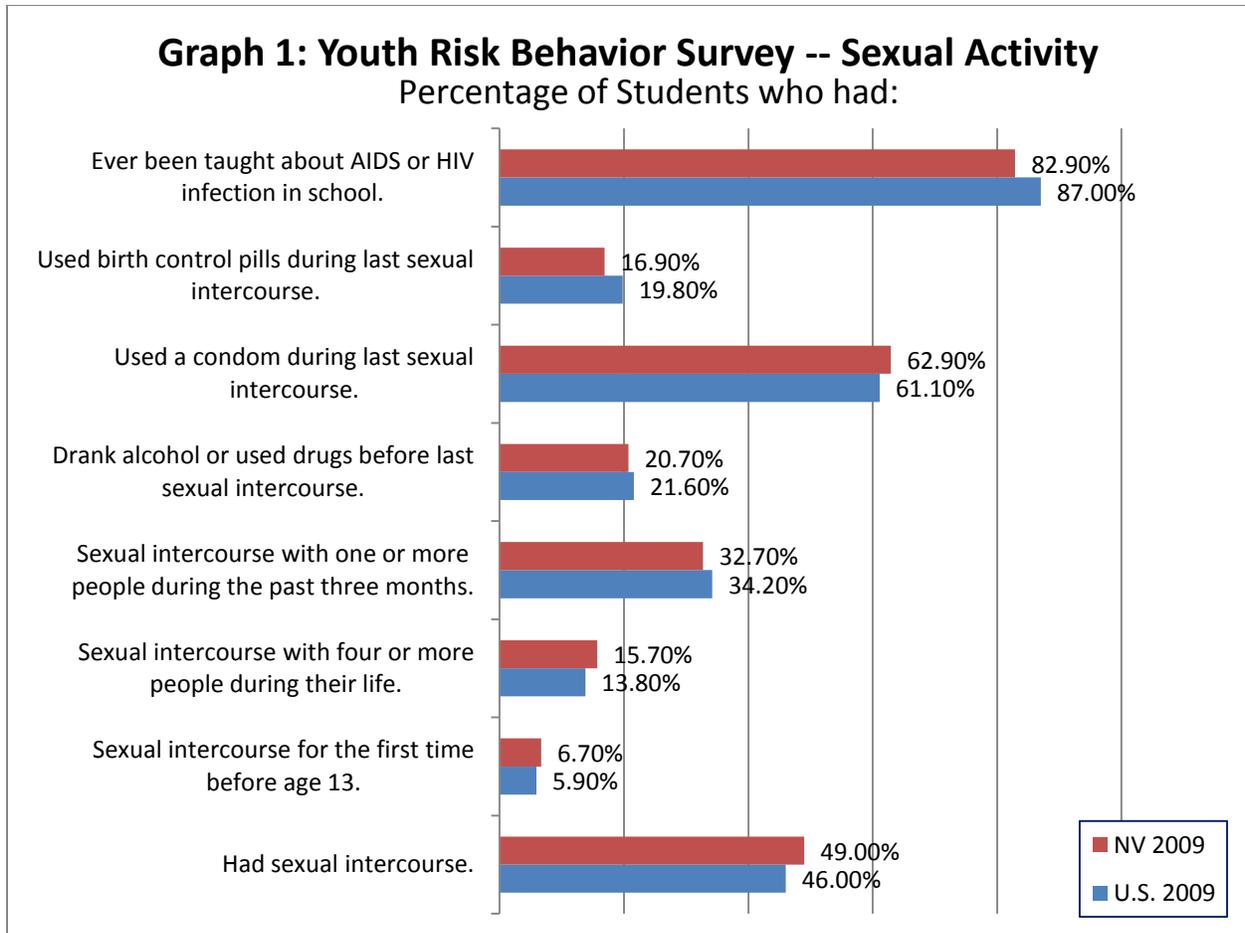


Goal: To decrease the sexually transmitted disease (chlamydia) rates among women aged 15 through 19 years.

Table 27
The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia.

Year	2004	2005	2006	2007	2008	2009
Rate	21.9	22.1	24.1	28.2	28.2	na
Numerator	1,778	1,894	2,154	2,613	2,630	na
Denominator	81,288	85,604	89,472	92,701	93,403	na
Healthy People 2010 Objective:	Objective 25-1: Reduce the proportion of adolescents and young adults with Chlamydia Trachomatitis infections. Objective 25-1a: Reduce the proportion of females aged 15 through 24 years attending family planning clinics to 3.0 percent. Objective 25-1b: Reduce the proportion of females aged 15 to 24 years attending STD clinics to 3.0 percent.					
Data Sources and Data Issues:	State STD Program Surveillance, State Communicable Disease Registry. Nevada State Interim 2006-2008 population projections.					

Significance: In 1997, chlamydia was the most frequently reported communicable disease in the United States. Chlamydia is common in sexually active adolescents and young adults. The highest annual rates are reported in females aged 15 through 19 years.



Goal: To decrease the sexually transmitted disease (chlamydia) rates among women aged 20 through 44 years.

Table 28						
The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia.						
Year	2004	2005	2006	2007	2008	2009
Rate	34.2	37.9	41.6	44.4	44.9	na
Numerator	2,877	3,335	3,820	4,225	4,309	na
Denominator	84,219	87,944	91,885	95,233	95,955	na
Healthy People 2010 Objective:	No specific Healthy People 2010 objective for this age group or gender. Related Objective 25-18: Increase the proportion of primary care providers who treat patients with sexually transmitted diseases and who manage cases according to recognized standards. Related Objective 25-1a: Reduce the proportion of families aged 15 to 24 years attending family planning clinics to 3.0 percent. Related Objective 25-1b: Reduce the proportion of females aged 15 to 24 years attending STD clinics to 3.0 percent.					

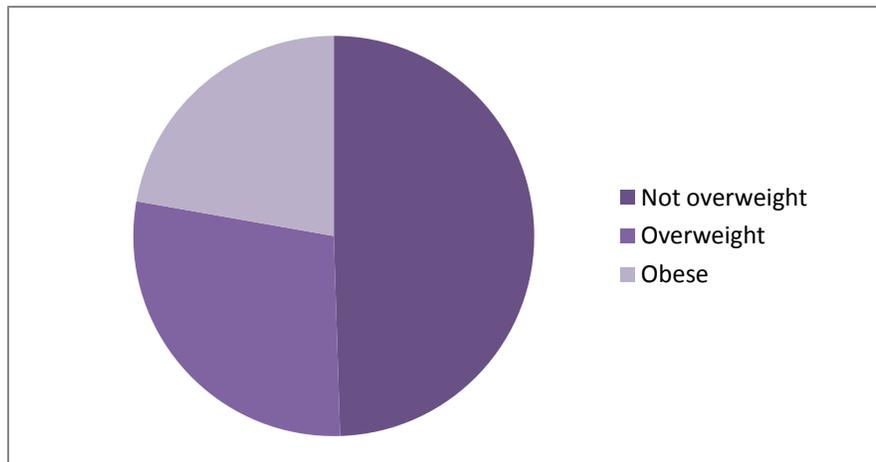
Appendix C. Supporting Data: Health and Service Needs for Women's Health

Data Sources and Data Issues:

State STD Program Surveillance, State Communicable Disease Registry. Nevada State Interim 2006-2008 population projections.

Significance: In 1997, chlamydia was the most frequently reported communicable disease in the United States. Chlamydia is common in sexually active adolescents and young adults. The highest annual rates are reported in females aged 15 through 19 years.

Graph 2 -- Overweight or Obese Women, ages 18 to 44



Significance: As shown in Graph 2, just fewer than half of Nevada women are either overweight or obese. This impacts not only their own health, but the health of their children and families. Data provided by State Division of Health.

Appendix D. Supporting Data: Health and Service Needs for
Child and Adolescent Health

Table 29 – Identify health and services for child and adolescent health
(ages 1 to 21 years old) 34

Table 30 -- Infants and children aged 0 through 24 years enumerated by sub-populations of age group
and race 35

Table 31 -- Infants and children aged 0 through 24 years enumerated by sub-populations of age group
and ethnicity 36

Table 32 -- Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in
various State programs enumerated by race 36

Table 33 -- Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and
race 37

Table 34 -- Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and
Hispanic ethnicity..... 37

Table 35 -- Decrease the percent of children and youth ages birth through aged 18 who die from
unintentional and intentional injuries 38

Table 36 -- The death rate per 100,000 due to unintentional injuries among children aged 14 years and
younger 38

Table 37 -- The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger 39

Table 38 -- The death rate per 100,000 for unintentional injuries among children aged 15 years through
24 years due to motor vehicle crashes 40

Table 39 -- The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged
14 years and younger..... 40

Table 40 -- The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes
per 100,000 children..... 41

Table 41 -- The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15
through 24 years 41

Graph 3 – Youth Risk Behavior Survey: The Percent of Adolescents in Grades 9 through 12 who Reported
Using Tobacco Product in the Past Month **42**

Table 42 -- Percentage of children, ages 2-5 years, receiving WIC services with a Body Mass Index (BMI)
at or above the 85th percentile 42

Appendix D. Supporting Data: Health and Service Needs for Child & Adolescent Health

Table 43 -- Decrease the percentage of at-risk for overweight and overweight children in Nevada public schools 43

Table 44 -- Youth Risk Behavior Survey Dietary Behaviors 43

Table 45 -- The rate (per 100,000) of suicide deaths among youths aged 15 through 19 44

Graph 4 -- Youth Risk Behavior Survey: Injury- Suicide 45

Graph 5 -- Youth Risk Behavior Survey: Unintentional Injury and Violence 46

Graph 6 -- Youth Risk Behavior Survey: Alcohol Use 47

Graph 7 -- Youth Risk Behavior Survey: Drug Use..... 48

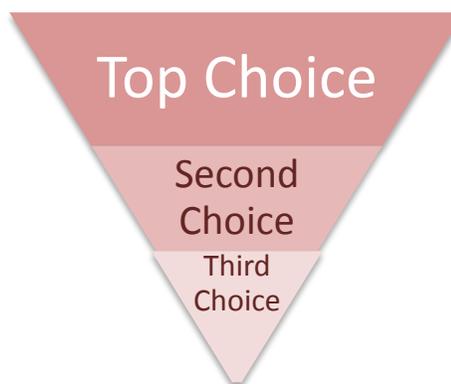
Table 46 -- Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B 48

Table 47 -- The rate of birth (per 1,000) for teenagers aged 15 through 17 years 49

Table 48 -- Percent of third grade children who have received protective sealants on at least one permanent molar tooth 50

Table 49 -- The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age 51

 Table 29 Identify health and service needs for Child and Adolescent Health (ages 1 to 21 years old).	
Acute and infectious diseases	18.0
Alcohol and drug use (also prescription drug abuse)	146.0
Bullying	61.0
Child abuse and neglect	284.0
Child care	72.5
Chronic disease/conditions	31.5
Comprehensive healthcare, well child care	257.5
Dental health	154.5
Developmental, emotional, social screening	204.0
Education	202.5
Environmental hazards	8.0
Family violence	83.5
Gang-related risk	6.5
Health disparities	65.0
Health insurance	258.5
Healthy youth development	70.0
Hearing loss	28.0
Immunizations	101.0
Mental health screening, assessment, and treatment	155.5
Motor vehicle injuries	20.5
Nutrition	102.5
Physical activity	48.5
Obesity	132.0
Poverty	108.0
School readiness	53.5
Sexual Violence	43.0
Sexually transmitted infections (STI) and HIV	98.0
Suicide	44.5
Teen pregnancy and teen birth rate	246.0
Tobacco use	36.0
Unintentional injuries	19.5
Violence (e.g., sexual assault, dating/intimate partner violence, bullying, cyberbullying)	110.0
Vision services	12.0
Wellness	39.0



Goal: To enumerate the total population of children aged 0 through 24 years by age subgroup, race, and ethnicity.

Table 30 Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race.								
Age Groups	Total All Races	White	Black	Native	Asian	NHOPI	>1 Race	Other/ Unknown
0-1 yrs old	40,981	19,413	3,252	503	2,538	0	0	15,275
1-4 yrs old	154,944	71,633	12,470	1,962	11,119	0	0	57,760
5-9 yrs old	188,792	91,960	15,213	2,602	11,604	0	0	67,413
10-14 yrs old	189,249	99,497	16,804	2,745	10,973	0	0	59,230
15-19 yrs old	194,034	102,274	17,307	3,107	11,154	0	0	60,192
20-24 yrs old	199,975	106,654	14,818	2,993	12,832	0	0	62,678
0-24 yrs old	967,975	491,431	79,864	13,912	60,220	0	0	322,548
Data Sources and Data Issues:	Nevada State Interim 2008 population projections. Asian includes Native Hawaiian and Pacific Islander.							

Significance: Demographers predict that, by the end of the year 2000, one of every Americans will be African American, Asian/Pacific Islander, Middle Eastern, or Hispanic. Maternal and Child Health (MCH) professionals and policy makers must develop strategies and programs to address the needs of this growing segment of the population. Data reveals marked variations in morbidity and mortality by race and/or ethnicity. Reaching the goal of eliminating racial and ethnic disparities in health outcomes will necessitate identifying barriers to accessing family-centered, community-oriented, culturally-competent, and comprehensive care for all Americans. Improved collection and use of standardized demographic data will identify high-risk populations and monitor the effectiveness of health promotion and disease prevention interventions targeting these groups.

Goal: To enumerate the total population of children aged 0 through 24 years by age subgroup, race, and ethnicity.

Table 31 Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity.		
Age Groups	Total Not Hispanic	Total Hispanic or Latino
0-1 yrs old	25,706	15,275
1-4 yrs old	97,184	57,760
5-9 yrs old	121,378	67,413
10-14 yrs old	130,019	59,230
15-19 yrs old	133,843	60,192
20-24 yrs old	137,297	62,678

Table 31 Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity.		
Age Groups	Total Not Hispanic	Total Hispanic or Latino
0-24 yrs old	645,427	322,548
Data Sources and Data Issues:	Nevada State Interim 2008 population projections.	

Significance: Demographers predict that, by the end of the year 2000, one of every Americans will be African American, Asian/Pacific Islander, Middle Eastern, or Hispanic. Maternal and Child Health (MCH) professionals and policy makers must develop strategies and programs to address the needs of this growing segment of the population. Data reveals marked variations in morbidity and mortality by race and/or ethnicity. Reaching the goal of eliminating racial and ethnic disparities in health outcomes will necessitate identifying barriers to accessing family-centered, community-oriented, culturally-competent, and comprehensive care for all Americans. Improved collection and use of standardized demographic data will identify high-risk populations and monitor the effectiveness of health promotion and disease prevention interventions targeting these groups.

Goal: To determine number/percentage of infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs.

Table 32 Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race.								
	Total All Races	White	Black	Native	Asian	NHOPI	>1 Race	Other/ Unknown
Number enrolled in WIC								
Year 2004	62.1%	21.6%	12.3%	0.5%	3.5%	n/a	n/a	1.7%
Year 2005	67.3%	19.7%	9.9%	0.4%	2.7%	n/a	n/a	n/a
Year 2006	66.0%	18.0%	8.5%	0.4%	2.4%	n/a	n/a	4.7%
Year 2007	66.7%	17.8%	8.1%	0.6%	2.3%	n/a	n/a	4.5%
Year 2008	65.1%	19.2%	9.1%	0.7%	2.5%	n/a	n/a	3.4%
Year 2009	63.5%	20.4%	9.2%	0.7%	2.9%	n/a	n/a	3.3%
Data Sources and Data Issues:	Data provided from CDC. AFDC/TANF, Medicaid, SCHIP, food stamp, and WIC files; State juvenile criminal justice and Board of Education files, Linked child health data files, Census data.							

Significance: Adverse health outcomes disproportionately affect infants and children in foster care or in single parent homes. In 1995, 14 million infants and children aged 0 through 18 years lived below the Federal poverty level; 59 percent of these families were single parent families. Leaving high school before graduation can lead to continued poverty and a higher incidence of juvenile arrests. Many infants and children eligible for Medicaid and other State programs are not enrolled. Data linkage of State

Appendix D. Supporting Data: Health and Service Needs for Child & Adolescent Health

program files with Medicaid may identify factors associated with State program eligibility without full participation.

Table 33						
Death counts of infants and children aged 0 through 24 years enumerated by age subgroup and race.						
Age Groups	Total All Races	White	Black	Native	Asian	Other/Unknown
0-1 yrs old	259	197	45	0	11	6
1-4 yrs old	67	55	11	0	1	0
5-9 yrs old	21	17	2	0	1	1
10-14 yrs old	37	28	4	0	4	1
15-19 yrs old	110	87	21	1	0	1
20-24 yrs old	201	166	27	0	4	4
0-24 yrs old	695	550	110	1	21	13
Data Sources and Data Issues:	OHSS, Preliminary 2007 death data, 230 cases have not been coded for race. Asian includes Native Hawaiian and Pacific Islander.					

Table 34			
Death counts of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity.			
Age Groups	Total Not Hispanic	Total Hispanic or Latino	Ethnicity Not Reported
0-1 yrs old	178	86	1
1-4 yrs old	45	22	0
5-9 yrs old	13	8	0
10-14 yrs old	27	11	1
15-19 yrs old	85	25	1
20-24 yrs old	149	54	1
0-24 yrs old	497	206	4
Data Sources and Data Issues:	OHSS, Preliminary 2007 death data.		

Goal: To reduce the number of children in Nevada from birth through 18 who died from an unintentional injury.

Table 35						
Decrease the rate of children and youth ages birth through aged 18 who die from unintentional and intentional injuries.						
Year	2004	2005	2006	2007	2008*	2009*
Rate	13.3	10.9	14.0	10.6	9.3	na
Numerator	85	73	91	77	68	na
Denominator	641,218	667,830	697,715	723,176	728,603	na
Data Sources and Data Issues:	OHSS, Nevada State Interim 2006-2008 population projections. *Data is provisional, rather than final.					

Significance: Reducing the number of deaths from unintentional injuries in children will increase the quality of life for children and families. This is a population based and infrastructure-building measure.

Table 36				
The death counts due to unintentional injuries among children aged 14 years and younger.				
2005				
Age Groups	<1	1-4	5-14	Total
Motor Vehicle Accidents (Traffic & Non-Traffic)	-	10	13	24
Poisoning	-	-	-	-
Falls	-	-	-	-
Other Non-transport Accidents	7	-	-	10
Drowning and Submersion	-	10	-	10
Smoke, Fire and Flames	-	-	-	-
Other Land Transport Accidents	-	-	-	-
Firearms	-	-	-	-
Water, Air and Space, and Other Transport Accidents	-	-	-	-
Total	10	22	17	49
2006				
Age Groups	<1	1-4	5-14	Total
Motor Vehicle Accidents (Traffic & Non-Traffic)	-	6	11	21
Poisoning	-	-	-	-

Appendix D. Supporting Data: Health and Service Needs for Child & Adolescent Health

Falls	-	-	-	-
Other Non-transport Accidents	8	-	-	11
Drowning and Submersion	-	5	-	7
Smoke, Fire and Flames	-	-	-	-
Other Land Transport Accidents	-	-	-	-
Firearms	-	-	-	-
Water, Air and Space, and Other Transport Accidents	-	-	-	-
Total	13	17	16	46
2007				
Age Groups	<1	1-4	5-14	Total
Motor Vehicle Accidents (Traffic & Non-Traffic)	-	6	10	16
Poisoning	-	-	-	-
Falls	-	-	-	-
Other Non-transport Accidents	14	5	-	20
Drowning and Submersion	-	8	-	12
Smoke, Fire and Flames	-	-	-	-
Other Land Transport Accidents	-	-	-	-
Firearms	-	-	-	-
Water, Air and Space, and Other Transport Accidents	-	-	-	-
Total	16	22	19	57
Data Sources and Data Issues:	OHSS, Counts less than five have been omitted.			

Goal: To reduce the number of nonfatal injuries among children aged 14 years and younger.

Table 37						
The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.						
Year	2004	2005	2006	2007	2008	2009
Rate	174.5	162.5	141.7	129.0	138.3	na
Numerator	884	855	779	735	794	na
Denominator	506,699	526,084	549,579	569,703	573,966	na
Healthy People 2010 Objective:	No specific Healthy People 2010 objective. Related objective 15-14 (Developmental): Reduce non-fatal unintentional injuries.					
Data Sources and Data Issues:	Nevada Hospital Discharge. Used specific codes and discharge status "Alive" were used to compile the data.					

Significance: Serious non-fatal unintentional injuries account for 84 percent of injury-related hospitalizations and result in an estimated \$108 billion in lifetime medical costs. (A lifetime cost is defined as the total cost of an injury from onset until either complete cure or death. Twenty-eight percent of these lifetime costs due to unintentional injury are attributable to motor vehicle crashes.)

Goal: To reduce the number of hospitalizations among children aged 15 years through 24 years due to motor vehicle crashes.

Table 38			
The death counts for unintentional injuries among children aged 15 years through 24 years due to motor vehicle crashes (traffic & non-traffic).			
Age Group	2005	2006	2007*
15-24 yrs old	88	91	72
Total	88	91	72
Data Sources and Data Issues:	OHSS, *Data is provisional, rather than final.		

Significance: Serious non-fatal unintentional injuries account for 84 percent of injury-related hospitalizations and result in an estimated \$108 billion in lifetime medical costs. (A lifetime cost is defined as the total cost of an injury from onset until either complete cure or death. Twenty-eight percent of these lifetime costs due to unintentional injury are attributable to motor vehicle crashes.)

Table 39					
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger (traffic only).					
Year	2004	2005	2006	2007	2008
Rate	27.8	27.8	23.5	14.9	13.6
Numerator	141	146	129	85	78
Denominator	506,699	526,084	549,579	569,703	573,966
Healthy People 2010 Objective:	 No specific Healthy People 2010 objective by age group. Related objective 15-17: Reduce non-fatal injuries caused by motor vehicle crashes to 1,000 non-fatal injuries per 100,000 population.				
Data Sources and Data Issues:	Nevada Hospital Discharge. Used specific codes and discharge status "Alive" were used to compile the data.				

Significance: Serious non-fatal unintentional injuries account for 84 percent of injury-related hospitalizations and result in an estimated \$108 billion in lifetime medical costs. (A lifetime cost is

defined as the total cost of an injury from onset until either complete cure or death. Twenty-eight percent of these lifetime costs due to unintentional injury are attributable to motor vehicle crashes.

Goal: To reduce the number of deaths to children aged 14 years old and younger caused by motor vehicle crashes.

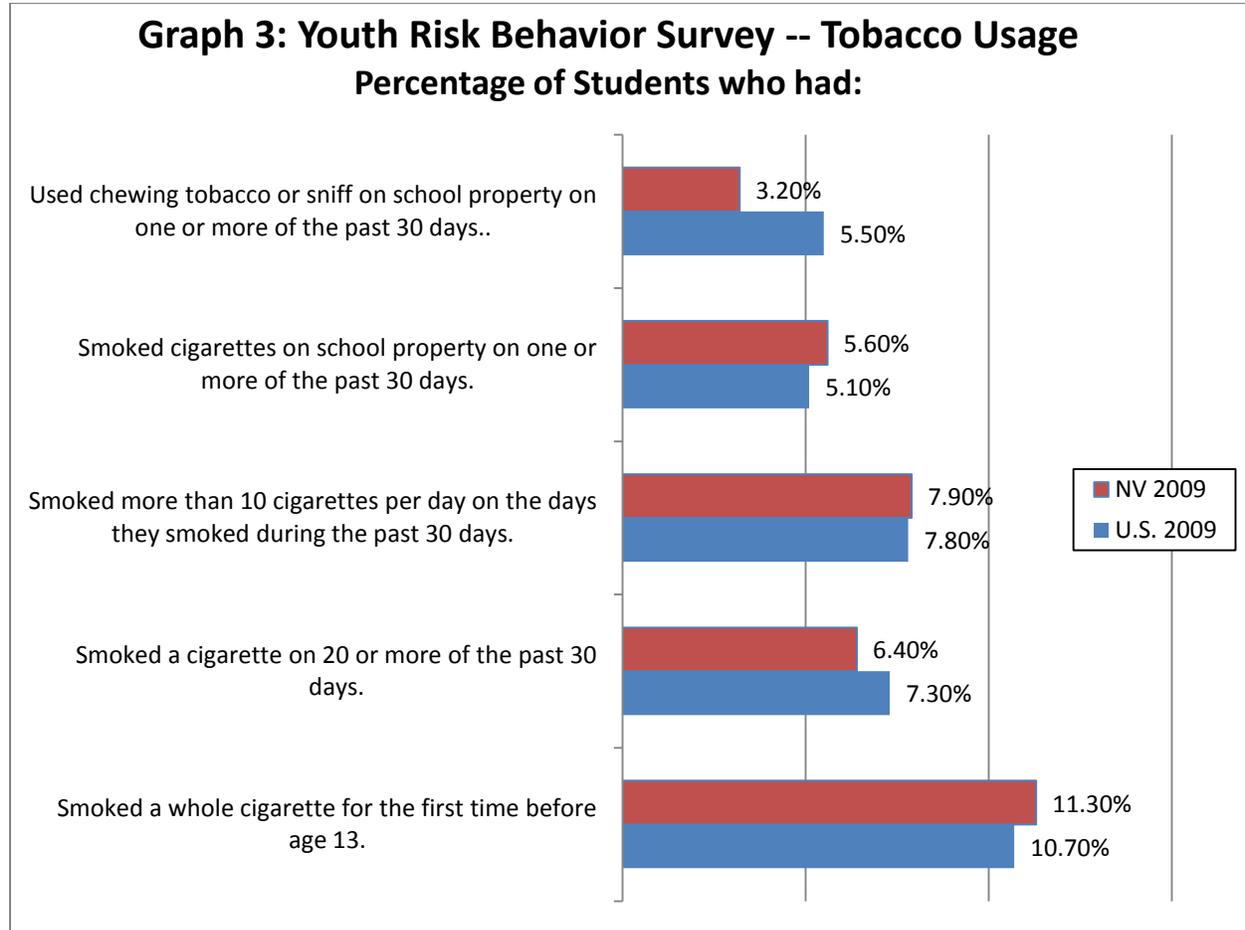
Table 40						
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.						
Year	2004	2005	2006	2007	2008	2009
Rate	4.1	4.2	4.7	2.5	2.3	na
Numerator	21	22	26	14	13	na
Denominator	506,699	526,084	549,579	569,703	573,966	na
Healthy People 2010 Objective:	Objective 15-15: Reduce deaths caused by motor vehicle crashes to 9.0 deaths per 100,000 population.					
						
Data Sources and Data Issues:	Fatal Accident Reporting System (FARS), U.S. Department of Transportation, and Vital Statistics Systems are sources of the data.					

Significance: About 50% of all deaths to children aged 14 years and younger are due to injuries, and around 80% of these are from motor vehicle crashes. Injuries are the leading cause of mortality in this age group and they are the most significant health problems affecting the Nation's children.

Goal: To reduce the number of hospitalizations among youth aged 15 through 24 years due to motor vehicle crashes.

Table 41					
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years (traffic only).					
Year	2004	2005	2006	2007	2008
Rate	109.2	126.0	112.4	74.9	94.7
Numerator	376	455	424	293	373
Denominator	344,470	361,160	377,360	391,047	394,010
Healthy People 2010 Objective:	No specific Healthy People 2010 objective by age group. Related objective 15-17: Reduce non-fatal injuries caused by motor vehicle crashes to 1,000 non-fatal injuries per 100,000 population.				
					
Data Sources and Data Issues:	Numerator: State E-coded hospital discharge data, Denominator: Nevada State interim population projections 2006-2008.				

Significance: Serious non-fatal unintentional injuries account for 84 percent of injury-related hospitalizations and result in an estimated \$108 billion in lifetime medical costs. (A lifetime cost is defined as the total cost of an injury from onset until either complete cure or death. Twenty-eight percent of these lifetime costs due to unintentional injury are attributable to motor vehicle crashes.)



Goal: To reduce the proportion of children, ages 2 to 5 years, who are at risk of overweight or obese.

Table 42						
Percentage of children, ages 2-5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.						
Year	2004	2005	2006	2007	2008	2009
Percentage:	15.9%	16.3%	15.7%	14.5%	13.8%	14.8%
Healthy People 2010 Objective:	Related to Objective 19.3: Reduce the proportion of children and adolescents who are overweight or obese.					
Data Sources and Data	State WIC Data, CDC's Pediatric Nutrition Surveillance System					

Table 42
Percentage of children, ages 2-5 years, receiving WIC services with a Body Mass Index (BMI) at
Issues: (PedNSS), and HRSA's National Survey of Children's Health (NSCH).

Significance: Childhood overweight is a serious health problem in the United States, and the prevalence of overweight among preschool children has doubled since the 1970s. There have been significant increases in the prevalence of overweight in children younger than 5 years of age across all ethnic groups. Onset of overweight in childhood accounts for 25 percent of adult obesity; but overweight that begins before age 8 and persists into adulthood is associated with an even greater degree of adult obesity. Childhood overweight is associated with a variety of adverse consequences, including an increased risk of cardiovascular disease, type 2 diabetes mellitus, asthma, social stigmatization, and low self-esteem.

Table 43 Decrease the percentage of at-risk for overweight and overweight children in Nevada public schools.						
Physical Activity	U.S. 2005	NV 2005	U.S. 2007	NV 2007	U.S. 2009	NV 2009
Percentage of students who were physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes per day on five or more of the seven days before the survey.	35.8%	NA	34.7%	46.2%	37.0%	43.1%

Table 44 Youth Risk Behavior Survey: Dietary Behaviors						
Dietary Behaviors	U.S. 2005	NV 2005	U.S. 2007	NV 2007	U.S. 2009	NV 2009
Percentage of students who described themselves as slightly or very overweight.	31.5%	30.0%	29.3%	28.6%	27.7%	28.5%
Percentage of students who were trying to lose weight.	45.6%	48.6%	45.2%	45.0%	NA	NA
Percentage of students who exercised to lose weight or to keep from gaining weight	60.0%	65.3%	60.9%	63.8%	61.5%	62.5%

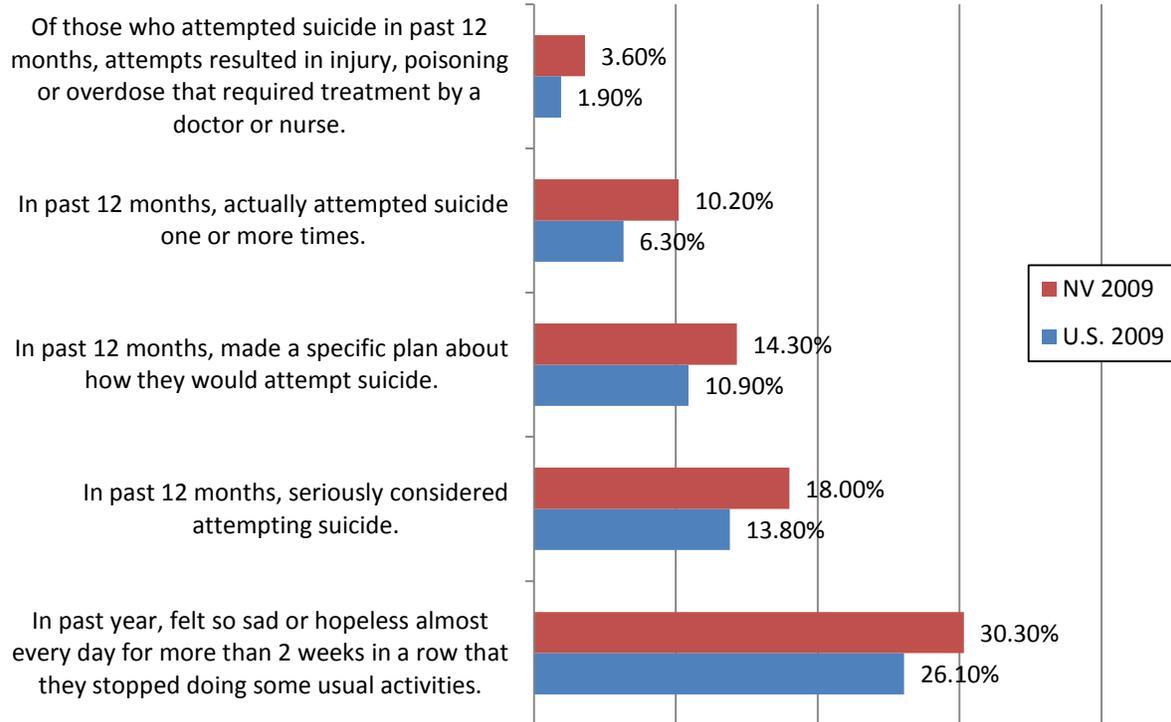
Table 44						
Youth Risk Behavior Survey: Dietary Behaviors						
Dietary Behaviors	U.S. 2005	NV 2005	U.S. 2007	NV 2007	U.S. 2009	NV 2009
during the past 30 days.						
Percentage of students who ate less food, fewer calories, or foods low in fat to lose weight or to keep from gaining weight during the past 30 days.	40.7%	41.0%	40.6%	37.7%	39.5%	35.5%
Percentage of students who went without eating for 24 hours or more to lose weight or to keep from gaining weight during the past 30 days.	12.3%	11.8%	11.8%	11.1%	10.6%	10.6%
Percentage of students who vomited or took laxatives to lose weight or to keep from gaining weight during the past 30 days.	4.5%	7.6%	4.3%	5.0%	4.0%	5.4%
Percentage of students who ate green salad one or more times during the past seven days.	65.6%	65.5%	64.1%	65.4%	63.4%	59.7%
Percentage of students who drank three or more glasses of milk per day during the past seven days.	16.2%	16.6%	14.1%	14.4%	14.5%	12.6%

Goal: To eliminate self-induced, preventable morbidity and mortality.

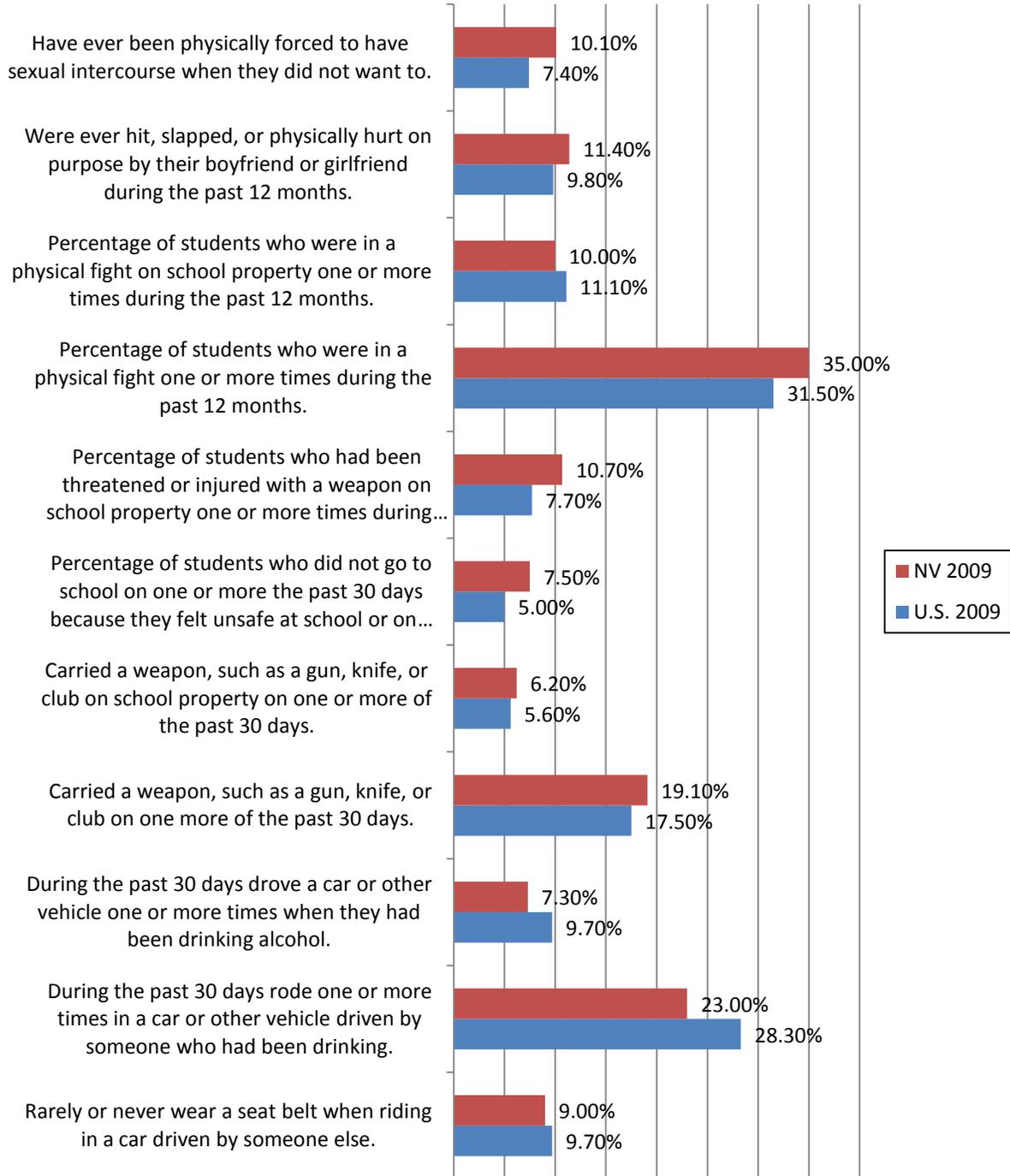
The rate (per 100,000) of suicide deaths among youths aged 15 through 19.						
Year	2004	2005	2006	2007*	2008*	2009*
Rate	11.2	14.1	11.8	7.8	4.6	na
Numerator	19	25	22	15	9	na
Denominator	168,899	177,850	185,872	192,575	194,035	na
Healthy People 2010 Objective: 	Related to Objectives 18-1: Reduce the suicide rate to 6.0 deaths per 100,000 population.					
Data Sources and Data Issues:	OHSS, *Data is provisional, rather than final.					

Significance: Suicide is the third leading cause of death in the United States among youths aged 15 through 19, and in many States it ranks as the second leading cause of death in this population.

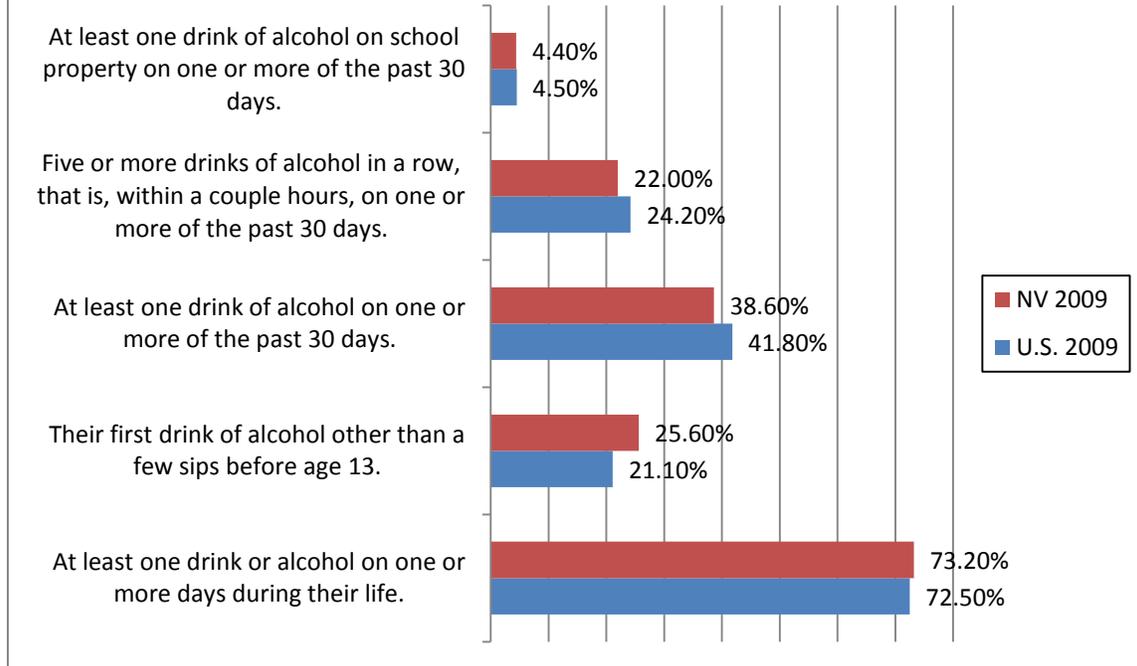
Graph 4: Youth Risk Behavior Survey -- Injury/Suicide
Percentage of Students who:



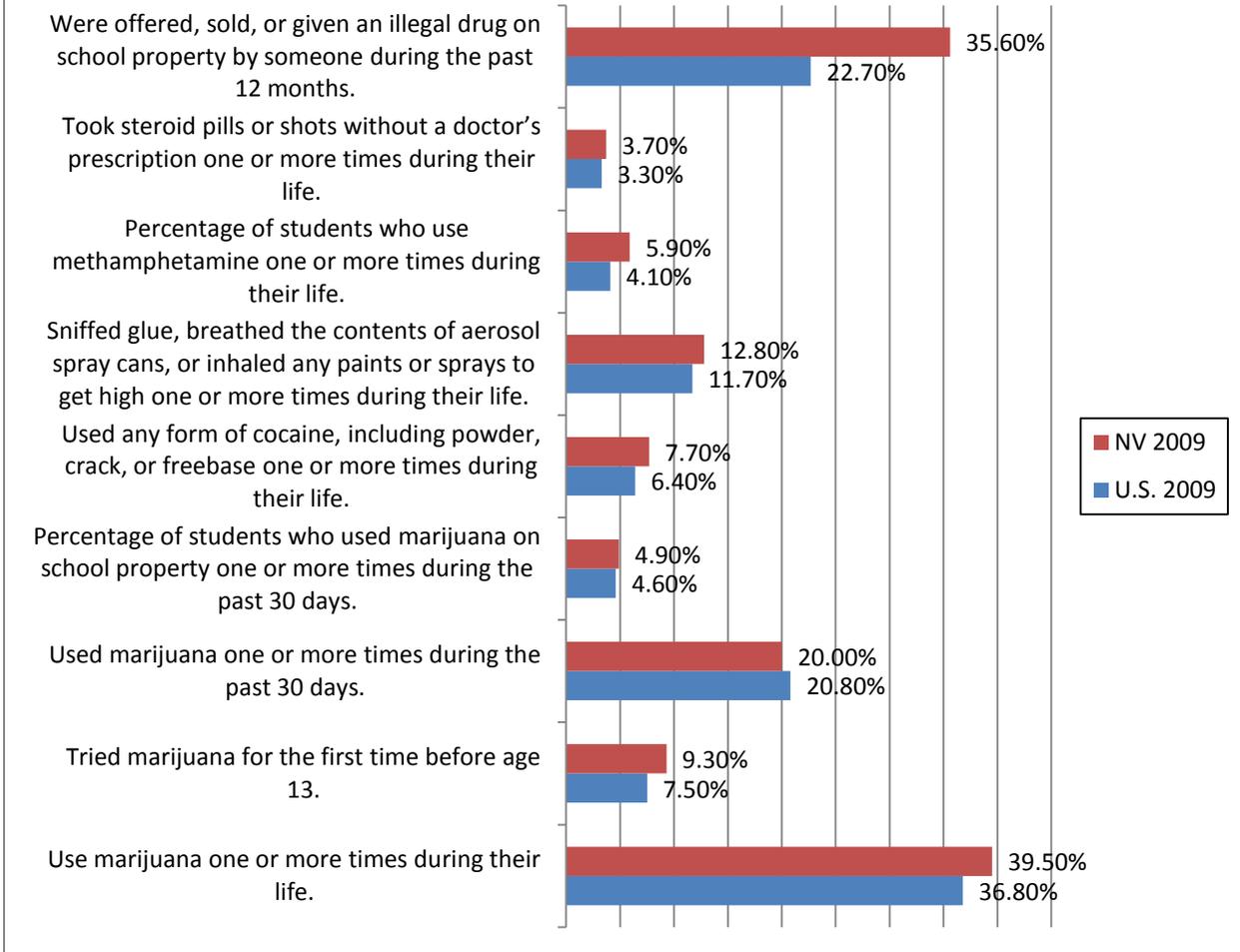
**Graph 5: Youth Risk Behavior Survey --
Unintentional Injury & Violence
Percentage of Student who:**



Graph 6: Youth Risk Behavior Survey -- Alcohol Use
Percentage of Student who had:



Graph 7: Youth Risk Behavior Survey -- Drug Use Percentage of Student who:



Goal: To avert all cases of vaccine-preventable morbidity and mortality in children.

Table 46 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.						
Year	2004	2005	2006	2007	2008	2009
Percentage	52.4%	50.6%	50.6%	50.0%	45.9%	47.1%
Numerator	40,793	37,858	37,788	37,176	34,110	35,652
Denominator	77,790	74,789	74,678	74,316	74,382	75,705
Healthy People 2010 Objective:	Objective 14-24: Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for at least 5 years. Increase the proportion of children aged 19 through 35 months who received all recommended vaccines to 80 percent.					

Table 46 Percent of 19 to 35 month olds who have received full schedule of age appropriate	
Data Sources and Data Issues:	State Immunization Registry, CDC National Immunization Survey, State Vital Records, and Bureau of Census population estimates. 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.

Significance: Infectious diseases remain important causes of preventable illness in the United States despite significant reductions in incidence in the past 100 years. Vaccines are among the safest and most effective preventive measures.

Goal: To lower the birth rate among teenagers, especially those age 15 through 17 years.

Table 47 The rate of birth (per 1,000) for teenagers aged 15 through 17 years.						
Year	2004	2005	2006	2007	2008*	2009*
Rate	26.2	26.4	26.7	26.4	25.7	na
Numerator	1,266	1,353	1,429	1,465	1,440	na
Denominator	48,323	51,274	53,593	55,520	55,942	na
Healthy People 2010 Objective:	Objective 9-7. Reduce pregnancies among females aged 15-17 to no more than 46 per 1,000 females aged 15-17 years.					
Data Sources and Data Issues:	OHSS, Nevada State Interim population from 2006-2008. *Data is provisional, as opposed to final.					

Significance: DHHS is making lowering the rate of teen pregnancies (a major threat to healthy and productive lives) a priority goal in its strategic plan. Teen parenting is associated with the lack of high school completion and initiating a cycle of poverty for mothers.

Goal: To prevent pit and fissure tooth decay (dental caries).

Table 48 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.						
Year	2004	2005	2006	2007	2008	2009
Percentage	32.5%	32.5%	41.0%	41.0%	37.5%	37.5%
Denominator	3,1364	31,364	34,234	34,234	34,320	34,320
Healthy People 2010 Objective: 	Objective 21.8: Increase the proportion of children who have received dental sealants on their molar teeth to 50 percent.					
Data Sources and Data Issues:	This requires primary data collection, such as examination or screening of a representative sample of school children. 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.					

Significance: Dental caries affects two-thirds of children by the time they are 15 years of age. Developmental irregularities, called pits and fissures, are the sites of 80-90% of childhood caries. Sealants selectively protect these vulnerable sites, which are found mostly in permanent molar teeth. Targeting sealants to those at greatest risk for caries has been shown to increase their cost-effectiveness. Although sealants have the potential to combine with fluorides to prevent almost all childhood tooth decay, they have been underutilized. In addition to being an excellent service in preventing tooth decay, sealants may also be a surrogate indicator of dental access, oral health promotion and preventive activities, and a suitable means to assess the linkages that exist between the public and private services delivery system. Public managed sealant programs are usually school-based or school-linked and target underserved children, thus providing entry to other services. It has been stated on several occasions that dental sealants are the oral health equivalent of immunization.

Table 49					
The rate of children hospitalized for asthma per 10,000 children less than five years of age.					
Year	2004	2005	2006	2007	2008
Rate	43.9	46.4	34.6	34.3	42.2
Numerator	752	833	648	667	826
Denominator	171,419	179,563	187,548	194,467	195,925
Healthy People 2010 Objective: 	Objective 24-2a: Reduce hospitalization for asthma in children 0-5 to no more than 25 per 10,000.				
Data Sources and Data Issues:	Nevada Hospital Discharge, Nevada State Interim 2008 population projections.				

Significance: Asthma is one of the few medical problems that may be used to measure the extent to which children are receiving quality disease preventive care and health promotion education. Access to and utilization of appropriate medical care can often prevent severe episodes of asthma. Increased asthma hospitalization rates may be a consequence of inadequate outpatient management and diminished access to a medical home.

Appendix E. Supporting Data: Health & Service Needs for
Children and Youth with Special Health Care Needs (CYSHCN)

Table 50	Identify Health & Service Needs for Children and Youth with Special Health Care Needs – Combined Responses On-Line Survey and Focus Groups
Table 51	Identify Health & Service Needs for Children and Youth with Special Health Care Needs – Only Responses for CYSHCN Focus Group Participants
Chart 1	2005-2006 National Survey of Children with Special Health Care Needs - Nevada Chartbook Page



Table 50
Identify health & service needs for Children and Youth With Special Health Care Needs (CYSHCN).

Access to specialty care and services	118.0
Community-based support for children with behavior disorders	56.5
Condition specific health information	5.5
Dental health for CYSHCN	36.5
Developmental, social, emotional screening	46.5
Early identification of special health care needs	185.5
Early intervention for young children with special health care needs	122.0
Families receive needed services	111.5
Family-Centered care	30.0
Family Violence	18.5
Health care/medical homes	53.0
Health Equity	25.5
Health Insurance	177.5
Home care services	9.5
Knowledge of child development	22.5
Maltreatment or abuse of CYSHCN	32.0
Mental health screening	28.0
Mental health treatment	23.5
Nutrition	11.0
Organized system of care for CYSHCN	21.5
Parents as decision making partners	7.0
Physical activity	6.0
Poverty	25.0
Provider capacity and education to meet the needs of CYSHCN	44.0
Quantify disease prevalence, issues and concerns of the population	4.0
Safe and stable environments for CYSHCN	24.5
Training and family support for children with behavioral issues	54.5
Transition to Adulthood	17.0

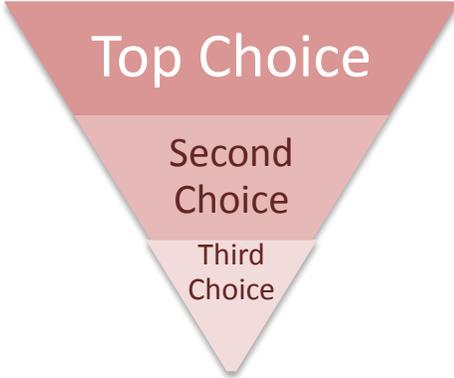




 Table 51 Identify health & service needs for Children and Youth With Special Health Care Needs (CYSHCN). Subset: Responses Received from CYSHCN Focus Groups ONLY.	
Access to specialty care and services	42.0
Community-based support for children with behavior disorders	38.0
Condition specific health information	1.0
Dental health for CYSHCN	12.5
Developmental, social, emotional screening	22.0
Early identification of special health care needs	72.5
Early intervention for young children with special health care needs	54.0
Families receive needed services	37.0
Family-Centered care	3.5
Family Violence	10.0
Health care/medical homes	15.5
Health Equity	21.5
Health Insurance	88.0
Home care services	3.0
Knowledge of child development	9.0
Maltreatment or abuse of CYSHCN	16.5
Mental health screening	19.0
Mental health treatment	2.5
Nutrition	5.0
Organized system of care for CYSHCN	5.0
Parents as decision making partners	4.5
Physical activity	2.5
Poverty	12.5
Provider capacity and education to meet the needs of CYSHCN	17.0
Quantify disease prevalence, issues and concerns of the population	4.0
Safe and stable environments for CYSHCN	10.5
Training and family support for children with behavioral issues	25.5
Transition to Adulthood	8.0

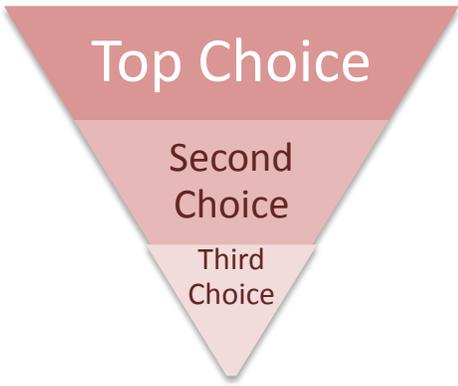


Chart 1

2005/2006 National Survey of Children with Special Health Care Needs

Nevada Chartbook Page

Estimated number of CSHCN: 65,900

Prevalence of CSHCN	State %	Nation %	National Chartbook Indicators	State %	Nation %
Percent of children who have special health care needs	10.4	13.9	Child Health		
CSHCN Prevalence by Age			CSHCN whose conditions affect their activities usually, always, or a great deal	28.5	24.0
Age 0-5 years	6.7	8.8	CSHCN with 11 or more days of school absences due to illness	17.4	14.3
Age 6-11 years	11.1	16.0	Health Insurance Coverage		
Age 12-17 years	13.4	16.8	CSHCN without insurance at some point in past year	17.8	8.8
CSHCN Prevalence by Sex			CSHCN without insurance at time of survey	10.2	3.5
Male	11.8	16.1	Currently insured CSHCN whose insurance is inadequate	37.0	33.1
Female	8.9	11.6	Access to Care		
CSHCN Prevalence by Poverty Level			CSHCN with any unmet need for specific health care services	23.0	16.1
0-99% FPL	8.4	14.0	CSHCN with any unmet need for family support services	6.9	4.9
100-199% FPL	10.6	14.0	CSHCN needing a referral who have difficulty getting it	27.5	21.1
200-399% FPL	10.8	13.5	CSHCN without a usual source of care when sick (or who rely on the emergency room)	7.0	5.7
400% FPL or more	10.9	14.0	CSHCN without any personal doctor or nurse	7.5	6.5
CSHCN Prevalence by Hispanic Origin and Race			Family Centered Care		
Non-Hispanic	12.1	15.0	CSHCN without family-centered care	40.6	34.4
White	12.5	15.5	Impact on Family		
Black	14.5	15.0	CSHCN whose families pay \$1,000 or more out of pocket in medical expenses per year for the child	23.7	20.0
Asian	3.0	6.3	CSHCN whose conditions cause financial problems for the family	23.2	18.1
American Indian/Alaskan Native	14.5	CSHCN whose families spend 11 or more hours per week providing or coordinating child's health care	11.8	9.7
Native Hawaiian/Pacific Islander	11.5	CSHCN whose conditions cause family members to cut back or stop working	27.2	23.8
Multiple Races	10.8	17.9			
Hispanic	5.7	8.3			
Spanish Language Household	3.6	4.6			
English Language Household	10.3	13.1			

Appendix E. Supporting Data: Health and Service Needs for Children and Youth with Special Health Care Needs

MCHB Core Outcomes	State %	Nation %
CSHCN whose families are partners in decision making at all levels, and who are satisfied with the services they receive	47.4	57.4
CSHCN who receive coordinated, ongoing, comprehensive care within a medical home	41.2	47.1
CSHCN whose families have adequate private and/or public insurance to pay for the services they need	53.5	62.0
CSHCN who are screened early and continuously for special health care needs	56.3	63.8
CSHCN whose services are organized in ways that families can use them easily	82.6	89.1
Youth with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work, and independence	41.7	41.2

■ Estimates based on sample sizes too small to meet standards for reliability or precision. The relative standard error is greater than or equal to 30%.

**** Prevalence data only available for States where this minority group makes up at least 5% of total population of children in the State.

Citation: Child and Adolescent Health Measurement Initiative. *2005/2006 National Survey of Children with Special Health Care Needs*, Data Resource Center for Child and Adolescent Health website. Retrieved [06/30/10] from www.cshcndata.org

Appendix F. Focus Group Invitees

Name (Last name, first name)	Reason: Affiliation/Population Representative/Other
Abdulla, Dr. Farooq	MCHAB Interested Parties List
Adelekan, Rachel	St. Vincents
Agnew, Michelle	Nevada Health Centers, Inc.
Aiello, Betsy	NV Check up
Allen, Roswell	CYSHCN Advisory Committee
Anderson, Lynn	Pregnancy Center
Aquino, Deborah	NVHD TitleV/MCH Program
Bacon, Robinette	NVDOE - YRBS
Banghart, Doug	CCHHS
Barlese, Debra	Indian Health Board of Nevada
Barrere, Lisa	MCHAB Interested Parties List
Bartolomeo, Danne	Renown
Bayer, Chris	CASA of Carson City
Becker, Pam	Children's Cabinet & Washoe County Children's Mental Health Consortium
Blower, Jeremy	NVHD Autism Trainer
Bochman, Cammie	CYSHCN Advisory Committee
Boggs, Laura	Rural
Bonaldi-Moore, Lorraine	Orvis School of Nursing
Bond, Bobbette	Culinary Health Fund
Bradley, Jessica	MCHAB Interested Parties List
Buxton, Shauna	MCHAB Interested Parties List
Carlton, Maggie (Senator)	MCHAB, Nevada Senate
Carlton, Rosalynda Paez	No NV MCH Coalition, WCSD
Chakma, Prasanjit	MCHAB Interested Parties List
Chappel, Margot	Head Start State Collaboration/ECCS
Chase, Thomas	Nevada Health Centers, Inc.
Christensen, Angie	WCDHD, Community and Clinical Health Services
Clark, Keith	NV Office of Rural Health
Cofano, Lori	NVHD Oral Health Program
Coger, Laura	Consumer Direct Personal Care
Cohen, Adrina	LCSD - Chief Nurse
Collins, Lyle	NVHD HIV AIDS
Collis, Karen	Community Health Nursing
Cooper, Laura	Community Health Nursing
Costa, Linda	Health Access Washoe County HAWC – (FQHC)
Cote, Marti	DHCFP
Courtney, Jolie	MCHAB, Clark County Dept of Family Services

Cowger, Leslie	MCHAB Interested Parties List
Crandell, Paula	MCHAB Interested Parties List
Crockett, David	WIC
Cunningham, Jennifer	MCHAB, NV PEP, Parent
Curley, Larry	Indian Health Board & Medical Directors
Davis, Tyree DDS	MCHAB, NVRHC, AC4OH
DeGuzman, Dr. Joy	MCHAB, NVRHC
DeLongis, Maureen	Children's Behavioral Health Services
Devon, Carole	CYSHCN Advisory Committee
Dinell, Dan	IDEA Part C
Dixon, Erin	WCHD
Doctor, Susan	PSAP sub-committee
Dr. Bill	MCHAB Interested Parties List
Duarte, Charles	DHCFP
Durbin, Patricia	GBPCA
Durham, Keyth	AC4OH, plus
Dyer, Leanna	CSA Head Start
Ellery, Loren	Indian Health Services
Elquist, Marty	Children's Cabinet CCR&R Coordinator
Erquiaga, Lisa	CYSHCN Advisory Committee
Ezhuthachan, Dr. Rutu	ECAC
Family Resouce Centers of Northeastern Nevada	Family Resource Center
Fellman, Melissa	State Oral Health Program
Fraire, Evelyn	MCHAB Interested Parties List
Franz, Anne	Renown Medical Center
Friel, A. Raylene	Inter-Tribal Council of Nevada - Head Start - Health
Fyfy, Shari	Nevada Early Intervention Services NW
Galata, Roya	Renown Regional Medical Center
Gamet, Traci	St. Mary's Regional Medical Center
Gelford, Jim	Battle Mountain Tribal Health Clinic
Gordon, Karen	So. NV MCH Coalition List
Gorelow, Michelle	March of Dimes
Gray, Lindsey	UNR School of Public Health
Gonzalez, Karen	NVHD - State Oral Health Program + bilingual assistance
Green, Kate	University of Nevada – Center for Excellence
Green, Tracey D	State Health Officer
Grierson, G	So. NV MCH Coalition List
Griffin, Randy	Renown Regional Medical Center
Gumm, Allen & Toni	CYSHCN Advisory Committee IP
Hagerty, Theresa	Nevada Early Intervention Services NW

Hansen, Alicia	NSHD - OHSS
Hanson, Alicia	Nevada Urban Indians
Hardie, Stacy	Washoe County Family Planning Program
Hardy, Brenda	Renown Regional Medical Center
Haro, Eli	Program Coordinator Family to Family Connection
Harrington, Scott	University of Nevada Reno
Harris, Deborah	Bureau of Child, Family & Community Wellness Chief
Helton, Louise	Communities in Schools of Nevada
Herst, Charlene	SAPTA
Hess, Brenda	Family Resource Center
Hiatt, John	PSAP sub-committee
Hiner, D	MCHAB Interested Parties List
Hintin, Jennifer	Family Resource Center
Hixon, Jean	Renown Regional Medical Center
Hogue, Jane	Early Head Start
Holloway, Darrell	Yerington Paiute Tribal Clinic
Hoskins, Melinda	MCHAB Interested Parties List
Huddleston, Michelle	Elko RRC
Hudson, Mason	MCHAB Interested Parties List
Hunter, Candy	MCHAB, WCHD
Hunter, Trianna	So. NV MCH Coalition List
Hyman, Toby	Child Abuse Prevention
James, Sharon	Cultural Liaison for Statewide Children's Mental Health DCFS
John, Jolene	Reno-Sparks Health Center
Johnson, Mike	MCHAB Interested Parties List
Kelly, S	MCHAB Interested Parties List
Khau, Michelle	NVHD
Kidd, Candice	PSAP sub-committee
Kincaid, Robin	CYSHCN Advisory Committee
King, Debbra	Health Division Contractor
Koch, Gale	MCHAB Interested Parties List
Kronowitz, Muriel	NVHD PSAP
Lakes, Quest	Healthy Communities Coalition
Landa, Renee	CSA Head Start
Lang-Catlin, Veronica	MCHAB Interested Parties List
Langdon, Kelly	NVHD Lactation Consultant
Larsen, Dr. Kami	MCHAB
Lee, Meg	Catholic Community Services of Northern Nevada
Less, M	MCHAB Interested Parties List
Lesselles, Tanya	MCH Program - Home Visiting Grant Prep
Lewis, Linda	MCHAB Interested Parties List

Lincicome, Annette	Huntridge Teen Clinic - Dental
Lloyd, Kathie	NVHD
Lottritz, Lisa	WCHD Maternal Child Health Coordinator
Luevano, Valerie	Casa de Vida
Macdonald, Meg	Director of Parents of Preemies Support Group
Malay, Jo	NVHD Early Childhood & Women's Health Section Manager
Manfredi, Alannah	Renown Regional Medical Center
Marineau, Laura	Children's Cabinet
Marlo, Chris	Crowning Moments Childbirth Education
Marsh, Jeanne	MCHAB Interested Parties List
Martin, Darryl	Clark County
Matles, Steve	Indian Health Board of Nevada
Matsunaga-Kirgan, Dr. Marsha	MCHAB
McAdoo, Cathy	PACE Coalition
McBride, Deborah	SAPTA
McDade, Yolanda	Elko
McGaw, Terrence	PSAP sub-committee
McGee, Holly	WCHD
McKinney, Alana	Child Advocates
Mertz, Nicole	Washoe County Health District
Morton, Marilyn	UNCE
Mulvenon, Janelle	NEIS
Nevada Urban Indians	MCHAB Interested Parties List
Neyland, Beverly	former MCHAB chair
Oliver, Debbie	Cleft Advocate
Oliver, Lorraine	CYSHCN Advisory Committee
O'Malley, Marcia	Family TIES
Oman, Johnette	NEIS-NW
Ortega, Angela	CYSHCN Advisory Committee IP
Osburn, Gwen	SNHD, AC4OH
Pacheco, Lisa	UMCSN
Peek, Nova	DHCFP
Pelz, Marina	The Pregnancy Center
Pierce, Peggy (Assemblywoman)	MCHAB, Nevada Assembly
Pittenger, Susan	PSAP sub-committee
Pomi, Julie	WCDHD, Community and Clinical Health Services
Price, Kim	HELP of Southern Nevada
Preston, Leslie	Maple Star - Foster care for children with higher needs
Qualls, Kandy	NVHD MCH & Wellness
Quandt, Linda	Nevada Health Centers - Elko Miles for Smiles

Quilici, Suzanne	Nevada Public Health Foundation
Racoma, Dr. Estela	CYSHCN Advisory Committee
Reavis, S	MCHAB Interested Parties List
Reilly, Jackie	Cooperative Extension
Richardson-Adams, Ellen	Early Intervention Services
Rivers, Andrea	NVHD
Robinson, Cathy	NVHD MCH Program
Rock, Steve	University of Nevada Reno – Center for Excellence
Roller, Christopher	American Heart Association
Rosaschi, Rota	Nevada Public Health Foundation
Rosenberg, Mark DDS	Advisory Committee for Oral Health, Saint Mary's
Rosenberg, TJ	PSAP sub-committee
Rosenthal, Mary	MCHAB Interested Parties List
Rovig, Cari	NV Immunization Coalition
Saleh, Mahasin	UNR School of Social Work
Sanborn, Brenda	Renown Regional Medical Center
Satica, Cheyenne	Renown Regional Medical Center
Schomberg, Nicole	Family TIES of NV
Schott-Bernius, Martha	Nevada Early Intervention Services
Schulz, Fred	Positively Kids
Seals, Kelli	Washoe County Health District Family Planning Program
Serial, Janet	NAACP and Tobacco Prevention
Severens, Anna	PSAP sub-committee
Seward, Erin	NSHD WebIZ
Seymour, Kerry	Cooperative Extension
Sigman-Grant, Madeleine	So. NV MCH Coalition List
Simental, Una	So. NV MCH Coalition List
Simpson, Linda	Volunteers in Medicine
Slater, Margo	Southern Nevada Health District
Slotnick, Nathan	Perinatal Associates of Northern Nevada
Smith, Christi	NVHD IZ Section
Smith, Linda	Opportunity Village
Smith, Shavawn	211/Crisis Call Center
Sorenson, Bonnie	MCHAB, SNHD
Soriano, Franchesca	Early Intervention
Souza, Katherine	Community Chest
Spletter, Amanda	MCHAB, Clark County Dept of Family Services
Stinehart, Jackie	Covering Kids
Stoll, Jennifer	WCDHD, Community and Clinical Health Services
Talley, Bob DDS	AC4OH, NDA
Tanata, Denise	So NV MCH Coalition, Nevada Institute for Children's Research and Policy (UNLV)

Tang, May	So. NV MCH Coalition List
Taylor, Diane	So. NV MCH Coalition List
Todd, Dr. Sherr	Tobacco Free Babies Project/ Operation Tobacco Free NV
Vasquez, Lorraine	PSAP (parent rep)
Victoria	MCHAB Interested Parties List
Villanueva, Michelle	MCHAB Interested Parties List
Walker, Michelle	WIC
Warren, Pam	Child Birth Educator, Mother-Baby Nurse, St. Mary's Regional Medical Center
Webb, Laura	MCHAB Interested Parties List
Weiser, Betty	DHHS Grants Management Unit
Wherry, Mary	NVHD
Whipple, Wendy	DHHS
Whitman, Nancy	Access to Healthcare Network
Widmann, Leigh	CYSHCN Advisory Committee
Williams, Steve	Huntridge Teen Clinic
Winch, George	MCHAB Interested Parties List
Works, Marena	MCHAB, CCHHS
Young, Shelly	FAS (Recommended by Dr. Sher Todd)
Zenteno, Jack	NBS, EHDI
Zumoff, Niki	St. Mary's Regional Medical Center

Appendix G. Focus Group Participants Feedback on the Process

Participants were asked to complete a survey at the end of each focus group. The following questions were asked. Not every participant answered all of the questions and a few participants had to leave early and/or did not complete the survey. This appendix provides a complete listing of responses that were received.

1. Anyone we missed?
2. What was the best part of the focus group(s)?
3. What would you have changed?
4. What is your “primary role” in MCH?

<p>Although we are holding seven separate sessions in three different communities, to the best of your ability, are you aware of anyone or any organization that should have been included, that we may have missed? (Please include their name(s), role(s) and contact information, if available.)</p>
<p>Schools, hospital personnel, Communities in Schools, PACE</p>
<p>Community in schools</p>
<p>Southern Bands Health Clinic 775-738-2252</p>
<p>Southern Bands (IHS) Indian Health Services</p>
<p>Communities in Schools - Terri Clark School of Medicine Outreach Program - Gerald Ackerman Elko Health Consortium (c/o CIS - Terri)</p>
<p>Local health care providers - teachers</p>
<p>Have sent notices out to rural providers coalition – a lot of Elko organizations</p>
<p>Pediatric nurses - teachers physicians Ob/Gyn & Medicaid office rep, political rep (County Manager)</p>
<p>Welfare, DCFS, School District Rep</p>
<p>County Commission(LV) Ready for life working on same (similar issues)</p>
<p>Family court</p>
<p>Southern Nevada Maternal and Child Health Coalition - Denise Ashby, UNLV Sothern Nevada Committee on Youth, Teen Pregnancy Prevention Sub-committee</p>
<p>WIC representatives Head Start representatives Food Bank - "4 Square" representatives Provider - increased physician participation - Ob/Gyn, Peds, Family Practice Mental Health</p>
<p>AHEC</p>
<p>School District, Planned Parenthood & other providers alike</p>
<p>Yes. Unity family services, Olive Crest, Non-profit organizations i.e, (United Way, Help of SN, etc.) Marvie Hill - Director Unity Family Services 702-633-7570</p>
<p>No.</p>
<p>Community / Private physicians, Nurses, Medicaid staff</p>
<p>I don't think anyone was missed, however I do feel more people should have been present</p>

Appendix G. Focus Group Participants Feedback on the Process

Maybe more medical providers
Tiffany Alston, Assistant Director of Family Services for Sunrise Children's Foundation tiffany@sunrisechildrens.org Angie Amica
Jean Reynolds - Principal, John F. Miller Special School
More parents in the groups
Public School Health Education Teachers Providers = Home Health Peds Planned Parenthood
Legislators, educators, school district faculty
Providers - Board Member of Maternal Child Health of Each Hospital within Las Vegas Legislators
Legislators MD's Social Workers Hospitals
FQHC ...NV Health Centers
Child Find, Easter Seals
Local State Agencies, Community Leaders/PEP, Positively Kids, NEIS, Headsup, Easter Seals, Hope Counseling
Yes, Nevada PEP Desert Regional Center Child Find Positively Kids Easter Seals
Child Find
Legislators should have participated! Physicians and social service agencies could have been better represented.
Private Sector. Small Business Association...? Employers with large amounts of employees that are uninsured.
No
Revivals Health & Wellness Council, Director Elaine Brannon Sierra Association of Foster Families - Joe Galata Granparents Raising Grandchildren - David or Emma Love Nevada Afterschool Network (NAN) - Danielle Bauer, Director
High Sierra AHEC NV Rural Hospital Partners UNR Medical & Nursing Clinics Med School Nursing School
No
nope
Baby your Baby Sunrise Prenatal Resources Mom's Clinic (Carson)
OB/GYNS Pregnancy Center Mgr. was invited but didn't attend. Legislators, Board of Health, County Commission. (Per website www.washoecounty.us)
In general I feel more parents/caregivers should have participated.
No
No

The problem here is there is no way to know those who were invited but did not attend
Washoe Children's Mental Health Consortium
NDALC NVPEP
No. And I thought about it a lot beforehand.
Parents - I will forward the survey to the families throughout No. Nevada
Consumers! School District Dir of School Nurses, Dana Balchunas
Did not see rep from local Medical Society/ peds groups/ gyn
Washoe County School District Family Resource Centerws

What was the best part of the focus group(s)?
Discussions / brain storming
Exercise work groups
Discussion Group
Focus on Elko Area Concern
The group discussions The networking info shared
Great discussion ideas - Hearing the different views and realizing some feel more subjects important.
Letting evaluators know of rural differences
Discussion
Very open for discussion. Open to all issues and ideas. I felt our concerns were truly listened to.
Group discussion based on questions
Variety of attendees backgrounds
Sharing ideas Networking Thinking about importance of areas of concern & rating
Long range thinking
Live feedback & discussion group!
Sharing what is needed in community
Group activity

Break-out sessions with one question per group
Discussions and networking
Ideas that were discussed.
Speak to other professionals about important issue, that effect the community.
Different representatives from different organizations
Small group discussions.
Open discussion listening to other perspectives.
Different ideas, question on how meet the needs of families and community
Having Deb Aquino here. Listening to our opinions.
I (heart) the post-its rating system
I enjoyed the discussion during the question/answer session of the group
Getting to put in information to help build up our State policies and future
Getting to network with people from the other agencies and a chance to meet Debbie A
Being able to visually identify others priorities when it comes to children's and women's health care needs.
Good open interaction
Participation of everyone
Group input
Discussions
Identified the needs for CYSHCN. Bringing everybody's ideas to perform services
The collaboration of the different agencies
Smaller group sessions
Discussions
Interaction, planning
Networking with others
Very good discussion on all topics
Networking with other agencies
Open dialogue with other agencies
Networking Identifying the needs
Awareness

Appendix G. Focus Group Participants Feedback on the Process

Nicely moderated to be productive
I enjoyed comparing the afternoon (MCH) focus with the morning (CYSHCN) focus. There was a definite difference.
Discussion among members of group
Group (Large) discussion. Lots of information.
Enough time was allowed for discussion in small - large groups
Information gleaned.
Potential collaboration with others in MCH. Learning about other resources in Reno/Sparks as well as needs.
Networking, sharing ideas
Sharing in small groups
Open, honest discussion
Having the input from people of all different backgrounds.
Sticky notes were great. Discussions within groups.
Hearing everyone's ideas. The sticky notes were great!
Dialogue on system problems
Sharing ideas - with the hope of developing new visions - better service delivery and better outcomes
Great idea sharing
Seeing & meeting everyone Discussing issues Liked the stickys
Talking about real issues that people are going through, throughout Nevada
Excellent networking, stemming from well structured processes.
Working in small groups to answer the questions. I enjoyed the open discussion.
Sharing resources & views
Information / Ideas exchanged
Insight and expertise of group participants
Discussion time - adequate.
The sheets and stickys on wall. Good to give focus group direction.
The rating system - seeing everyone's priorities and learning why. Networking
Priority listing
Networking. Ability to participate and contribute
Hearing what community members think.

What would you have changed about the focus group(s) that would increase its/their impact?
Small group worked out well
Clarify question in depth. (examples)
More awareness to the community of the events.
Rural area challenges identified as an impact on our answers.
Better attendance
More participation
More providers of care - personnel from Drs. offices and hospital. Was disappointed they didn't show.
More participants
More organizations
Great approach
More time to work on subject matter
None
Send out invitations earlier to allow for potential participants a greater chance to plan their schedules to attend.
Like it. Liked the rating system.
Nothing.
Not all topics were addressed our group focused mainly on teen pregnancy
Allow participants to identify issues, topics, obstacles and to develop solution.
Involve more medical professionals (doctors) and legislators.
Nothing at this time.
Pre-write on large poster people's + & - experience related to each topic. Help decrease or channel personal experiences so they (specific instances) don't become the focus.
Nothing, I was just excited to be a part of this group
Maybe more info about what we can do now at our level
N/A
Wasn't clear what we were in for.
none
More advance notice to public to get word out.

Appendix G. Focus Group Participants Feedback on the Process

Invite more people, like physicians, and community support groups leaders
snacks (smiley face) Nothing, very informative
none
Wider participation
Add a teleconference for those who would like to participate but can't attend in person
Have State leaders and community leaders at the table.
Let more people know about this meeting Include physicians
I enjoyed them and wouldn't have changed it.
Present data in advance of having us "vote" in a "vacuum."
More data review prior to starting
N/A
Nothing
More discussion on what follows this focus group ... implementation of ideas.
It was well run
Invite more men to get their feedback. Invite people from public.
Invite parents with CYSHCN.
Data & analysis prior to meeting along with summary of existing work.
I would have appreciated more notice of the focus group meetings. I received an email only a week ago and I was on vacation at the time. I know I could have gotten more folks to attend if I had more time.
Repeat people's questions/comments Difficult to hear at times
Narrowed it down / Keep it focus. People are so passionate and want to add their own piece but if one thing can be changed, the better.
It was extremely well done!
Expand the invite to include more community members
Video conference. Survey of providers (i.e., doctors & nurses). Representation from Senior Citizen leadership.
I liked the analysis off the group rankings (wall charts) and I would have enjoyed more.
Nothing
Added an introduction showing the data. Added information on the State MCH budget for transparency.

Please indicate your Primary Role, as an MCH stakeholder in Nevada: (check only one)	
Response	Other (please specify)
State Agency	
Public Health Personnel	
Tribal Government	
Health Care Provider (medical or mental)	
Health Care Provider (medical or mental)	
Community-Based Organization Employee	
Other (please specify)	Advocate / CASA (Disability)
Community-Based Organization Employee	
Tribal Government	
Parent/Grandparent	
Health Care Provider (medical or mental)	
Health Care Provider (medical or mental)	
Public Health Personnel	
Health Care Provider (medical or mental)	
Health Care Provider (medical or mental)	
Social Services Provider	
Social Services Provider	
Community-Based Organization Employee	
Health Educator	
Parent/Grandparent	
State Agency	
Community-Based Organization Employee	
Social Services Provider	

Appendix G. Focus Group Participants Feedback on the Process

Head Start/Early HS	
School Personnel	
Community-Based Organization Employee	
Community-Based Organization Employee	
Public Health Personnel	
Parent/Grandparent	
Parent/Grandparent	
Other (please specify)	substance abuse provider
Public Health Personnel	
Health Care Provider (medical or mental)	
Other (please specify)	substance abuse
Social Services Provider	
Public Health Personnel	
Community-Based Organization Employee	
Head Start/Early HS	
Social Services Provider	
Public Health Personnel	
Health Care Provider (medical or mental)	
School Personnel	
Public Health Personnel	
Health Educator	
Other (please specify)	CBO Representative
Community-Based Organization Employee	
Health Care Provider (medical or mental)	
Other (please specify)	State coalition
Head Start/Early HS	
Health Care Provider (medical or mental)	
State Agency	
State Agency	
Public Health Personnel	
Community-Based Organization Employee	

Appendix G. Focus Group Participants Feedback on the Process

Community-Based Organization Employee	
University/College Employee	
University/College Employee	
State Agency	
Health Care Provider (medical or mental)	
State Agency	
Parent/Grandparent	
Other (please specify)	Nonprofit for CYSHN
Public Health Personnel	
Health Care Provider (medical or mental)	
State Agency	

Appendix H. Focus Group and Survey Responses

- A. Who do you need as partners to address the identified needs?
- B. What State policies are needed?
- C. How can the State support the community policies and practices?
- D. Anything else you would like to add?



Focus Group and Survey Responses

A. Who do you need as partners to address the identified needs?

	<ul style="list-style-type: none"> ▪ State health division
	<ul style="list-style-type: none"> ▪ DMV can track any SS number, address, photo, and penalty points. Why can't the Division of Health do the same for children?
	<ul style="list-style-type: none"> ▪ doctors, teachers, counselors/social workers, family
	<ul style="list-style-type: none"> ▪ genetic services, MD geneticist through the State
	<ul style="list-style-type: none"> ▪ state, local, city and county
	<ul style="list-style-type: none"> ▪ Those who interface with pregnant and parenting families to connect them to Just in Time Parenting and other Extension resources
	<ul style="list-style-type: none"> ▪ mental health professionals
	<ul style="list-style-type: none"> ▪ education system, health system reform
	<ul style="list-style-type: none"> ▪ the legislators, service providers
	<ul style="list-style-type: none"> ▪ medical community, mental health, early intervention, school districts, health agencies, WIC, Medicaid, insurance,
	<ul style="list-style-type: none"> ▪ Public/private providers, CBO's,
	<ul style="list-style-type: none"> ▪ Primary Care Providers, Mental Health Agencies, etc...
	<ul style="list-style-type: none"> ▪ Health Care Providers & Mental Health Providers
	<ul style="list-style-type: none"> ▪ Excellent educators who can be allowed to talk about sensitive topics without censorship and be able to talk about protection when having sex.
	<ul style="list-style-type: none"> ▪ school district, service and non-profit organizations, community partners, politicians, parents and family support networks
	<ul style="list-style-type: none"> ▪ You need to partner with more than just family ties. Try networking with all the small non profits out there
	<ul style="list-style-type: none"> ▪ State and local political influences.
	<ul style="list-style-type: none"> ▪ medical providers, educational facilities
	<ul style="list-style-type: none"> ▪ healthcare professionals, Department of Health and Human Services: Division of Welfare & Bureau of Family Health Services, pregnant women, and other organizations interested in the welfare of pregnant women
	<ul style="list-style-type: none"> ▪ Counselors, funding, education,
	<ul style="list-style-type: none"> ▪ general public to support to fund prevention efforts
	<ul style="list-style-type: none"> ▪ High Sierra Area Health Education Center, The State Health Division, local health districts, hospitals, and outpatient clinics
	<ul style="list-style-type: none"> ▪ physicians from all specialty groups
	<ul style="list-style-type: none"> ▪ Health Department and DCFS
	<ul style="list-style-type: none"> ▪ community acceptance and support
	<ul style="list-style-type: none"> ▪ more partners for our children and families
	<ul style="list-style-type: none"> ▪ Human Resources Office, Community Health Nurse, DCFS, other Family Resource Centers



Focus Group and Survey Responses

	<ul style="list-style-type: none"> State, county and other local agencies to support and provide needed services to families caring for CYSHN
	<ul style="list-style-type: none"> NEIS, SRC, WCSD, WCDSS
	<ul style="list-style-type: none"> ALL providers some in county but most are not here
	<ul style="list-style-type: none"> Parents, Physicians, providers, teachers,
	<ul style="list-style-type: none"> need to partner across disciplines -- i.e health needs to communication with education and DCFS
	<ul style="list-style-type: none"> Medicaid; Insurance providers; parents/guardians; school districts; public health departments; university systems; community providers
	<ul style="list-style-type: none"> Regulatory agencies, community partners etc.
	<ul style="list-style-type: none"> state legislatures, hospital administration, mental health providers
	<ul style="list-style-type: none"> families, providers, health-personnel, agencies and legislators
	<ul style="list-style-type: none"> Health Insurance/coverage, Comprehensive Health Care/Medical Homes, NEIS, Specialty Care & services for CYSHCN, Prenatal Health, Nutritionist, Social worker, CPS, Dental, Hearing & Vision Health, School, Immunizations, OB/ GYN & Pediatric providers, Dental Health, Mental Health, Environmental Health, Medicaid.
	<ul style="list-style-type: none"> Nevada State Health Division, Local Health Authorities, March of Dimes, Other Voluntary Agencies
	<ul style="list-style-type: none"> Families, state and community service providers, schools
	<ul style="list-style-type: none"> Department of Health and Human Services
	<ul style="list-style-type: none"> grouping by like needs & priorities
	<ul style="list-style-type: none"> lobbyist for the Health Dept.
	<ul style="list-style-type: none"> dental providers ob/gyn for indigent population
	<ul style="list-style-type: none"> Better development of a coalition of providers for these services so that the community is better aware of what is even available. Most discoveries of resources seems to happen by accident
	<ul style="list-style-type: none"> Dentals and OBGYN's who take medicaid
	<ul style="list-style-type: none"> professionals trained regarding in utero a/d exposure
	<ul style="list-style-type: none"> State Health Division, Local County Government, High Sierra Area Health Education Centers, Nevada Rural Hospital Partners
	<ul style="list-style-type: none"> Nevada State Health Division, Division of Child and Family Services, Other Private Mental Health Providers, Insurance Companies, Medicaid, Desert Regional Center
	<ul style="list-style-type: none"> any and all health care professionals and education professionals
	<ul style="list-style-type: none"> education, social services, insurers, medical care organizations, health professional associations (e.g. physicians, nurses, dentists, etc.), health profession education and training programs, legislators, grass roots organizations
	<ul style="list-style-type: none"> Insurance companies (government and private), health care providers, educators, social marketers



Focus Group and Survey Responses

	<ul style="list-style-type: none"> ▪ Local hospitals
	<ul style="list-style-type: none"> ▪ Providers
	<ul style="list-style-type: none"> ▪ In a rural community we access to professional services: medical, mental health, social services.
	<ul style="list-style-type: none"> ▪ State, county and local agencies
	<ul style="list-style-type: none"> ▪ Medicaid, Nevada Check up
	<ul style="list-style-type: none"> ▪ The medical, dental and mental health professionals
	<ul style="list-style-type: none"> ▪ Dental school, MCH, State Board of Dental Examiners, Dental Hygiene Programs, Dental Association, Dental Hygiene Association
	<ul style="list-style-type: none"> ▪ Pediatricians, WIC, Audiologist, Optometrist etc
	<ul style="list-style-type: none"> ▪ Pediatricians and ob/gyns to provide no cost care
	<ul style="list-style-type: none"> ▪ It takes an entire village - legislation to local business
	<ul style="list-style-type: none"> ▪ Community Health Centers
	<ul style="list-style-type: none"> ▪ co-ordination-co-operation-knowledge of each others requirements
	<ul style="list-style-type: none"> ▪ SNHD, State of NV, Politicians, HELP of Southern NV
	<ul style="list-style-type: none"> ▪ everybody that are already involved with women and children health. Let us not reinvent the wheel or duplicate services. funding is so limited and we don't need to divide it into more agencies that require more money for offices, computers etc.
	<ul style="list-style-type: none"> ▪ NVDOE, School Districts, Health Districts
	<ul style="list-style-type: none"> ▪ Finding and Access to Community Resources
	<ul style="list-style-type: none"> ▪ The Early Childhood Advisory Council, the business community, physicians, early childhood mental health professionals, well-informed parents, community members and decision-makers.
	<ul style="list-style-type: none"> ▪ The government and taxpayers.
	<ul style="list-style-type: none"> ▪ More medicaid/check up providers.
	<ul style="list-style-type: none"> ▪ More or EIS, They have a waiting list
	<ul style="list-style-type: none"> ▪ Where to start? Gov't (Federal, State, Local) entities, nonprofits, medical community, for-profits, CBOs...everybody really.
	<ul style="list-style-type: none"> ▪ 1. School District 2. Social service agencies 3. Nevada State Health Division
	<ul style="list-style-type: none"> ▪ The entire state can not longer afford to look away
	<ul style="list-style-type: none"> ▪ PHYSICIANS LOCAL AND SPECIALISTS OUT LOCAL AREA WOULD ALSO NEED TRANSPORTATION SERVICES INSURANCE CO. /MEDICAID
	<ul style="list-style-type: none"> ▪ Feds, state, county and CBOs.
	<ul style="list-style-type: none"> ▪ Networking opportunities to reduce duplication of services
	<ul style="list-style-type: none"> ▪ Governor and legislature
	<ul style="list-style-type: none"> ▪ Pediatricians, Education, Voc Rehab
	<ul style="list-style-type: none"> ▪ case manager, HCP, Nurse, PT, OT, social worker, family and their support
	<ul style="list-style-type: none"> ▪ Specialty Care Providers, State Agencies, Counties, Not for profits



Focus Group and Survey Responses

	<ul style="list-style-type: none"> ▪ Not sure
	<ul style="list-style-type: none"> ▪ legislature, child health/development specialists, mental health professionals
	<ul style="list-style-type: none"> ▪ child care, schools, parents, health professionals, public health all of these at all levels
	<ul style="list-style-type: none"> ▪ Other OB/GYN's to take OB patients ▪ State of Nevada Health assessment, 5 years ▪ Physicians (family & pediatricians) education services for NICU and community Partners, hospitals, doctors ▪ Hospitals, ChildFind, NVPEP ▪ Community health service agencies ▪ Community health clinics ▪ Transportation services ▪ Family; education or health services, child development, extended family (grandparents), accessing services, child development, social services, application help ▪ Schools; pregnant teens, referral services for children/youth ▪ WIC ▪ Health Departments ▪ Support group network for parents, grandparents, extended family, caregivers ▪ Education of care providers (daycare, family, homecare) ▪ Hospitals ▪ Sustainability

B. What state policies are needed?

	<ul style="list-style-type: none"> ▪ policies that state when genetic services are recommended, such as for a positive newborn screening test
	<ul style="list-style-type: none"> ▪ Standards for parenting education and support
	<ul style="list-style-type: none"> ▪ don't know
	<ul style="list-style-type: none"> ▪ leadership on health issues including mandates
	<ul style="list-style-type: none"> ▪ quality child care standards, immunization standards, newborn hearing screening procedures, EPSDT actual screening instrument for development and social emotional
	<ul style="list-style-type: none"> ▪ Funding for clinics, Funding for training, Funding
	<ul style="list-style-type: none"> ▪ Mandatory HIV rapid testing in all drop in births at all the hospitals and hold hosp. accountable if not done properly.
	<ul style="list-style-type: none"> ▪ Access to affordable health insurance coverage
	<ul style="list-style-type: none"> ▪ Allow comprehensive sex education in schools by talking about the reality, trends, using protection as a proactive means to keep self healthy.
	<ul style="list-style-type: none"> ▪ disability insurance, low cost housing, medicaid, mental health counseling
	<ul style="list-style-type: none"> ▪ Adult Protective Services for ALL adults 18+



Focus Group and Survey Responses

	<ul style="list-style-type: none"> ▪ Expedited or presumptive eligibility Medicaid for pregnant women
	<ul style="list-style-type: none"> ▪ Need to research
	<ul style="list-style-type: none"> ▪ fund prevention first-prisons last
	<ul style="list-style-type: none"> ▪ Providing designated and dedicated funding streams
	<ul style="list-style-type: none"> ▪ not sure
	<ul style="list-style-type: none"> ▪ affordable health care for all
	<ul style="list-style-type: none"> ▪ unknown right now but more support
	<ul style="list-style-type: none"> ▪ Policies that mandate funding for education and social services for those groups in need.
	<ul style="list-style-type: none"> ▪ To help in the rural areas more or provide transportation out to these resources.
	<ul style="list-style-type: none"> ▪ Reassessment of funding streams for needs of children; coordination of children's mental health services to bring state into compliance with federal mental health parity act
	<ul style="list-style-type: none"> ▪ I'm not sure where to start at this point.
	<ul style="list-style-type: none"> ▪ teen access to healthcare without parental consent, direction/guidance for healthcare providers on treating minors without parental consent.
	<ul style="list-style-type: none"> ▪ more assistance for families
	<ul style="list-style-type: none"> ▪ Presumptive eligibility pregnant women
	<ul style="list-style-type: none"> ▪ Policy to restore Master Settlement Funds to intended purpose
	<ul style="list-style-type: none"> ▪ System of Care
	<ul style="list-style-type: none"> ▪ Policies that allow for flexibility to leverage and utilize various services from public service agencies.
	<ul style="list-style-type: none"> ▪ MCH-children with special needs policy
	<ul style="list-style-type: none"> ▪ hopefully to be determined by this focus group
	<ul style="list-style-type: none"> ▪ Women and children funding
	<ul style="list-style-type: none"> ▪ funds
	<ul style="list-style-type: none"> ▪ Maybe better direction to the function and ability of the Maternal Child Health Advisory Board
	<ul style="list-style-type: none"> ▪ comprehensive health care
	<ul style="list-style-type: none"> ▪ Policies that would allow funding to cross categories and agencies. Funding that would support peer support and family to family support.
	<ul style="list-style-type: none"> ▪ funding allocation for development and sustainment of services and programs, provider reimbursement, allowing minors direct access to certain services without requiring consent of parent or guardian, restoration of MSA funds for tobacco control and other preventive health services
	<ul style="list-style-type: none"> ▪ Insurance reform and cost containment measures, presumptive and expedited eligibility for Medicaid, provisions for midwife practice (affordable malpractice, collaborating physician or independent practice), physical fitness and nutrition standards for school curriculum, full



Focus Group and Survey Responses

	disclosure of restaurant menu nutritional information, incentives for private providers to take Medicaid - e.g. increase reimbursement rates, complete reimbursement for vaccines
	<ul style="list-style-type: none"> ▪ Health Care for Low Income Pregnant Women ▪ Access to care and providers ▪ Better health coverage ▪ Change in dental regulations. ▪ Policies are known, it takes implementation by stake holders ▪ Adequate funding, medical home program, ▪ i don't know ▪ Presumptive Eligibility, Ban on LAY midwife deliveries ▪ Better, more efficient screening for program eligibility, less paperwork to fill up. ▪ polices to ensure that the needs of the families target are met ▪ Mandated Health Education ▪ healthy Kids exam on admission to kindergarten with all screening tests done ▪ Newborn Screening needs better follow up after diagnosis, parents should be given information including what is available for them to use for the child's diagnosis. Including resources, contacts both community and state resources. This information should also be included on the State's website ▪ All Early Childhood programs should be housed together in a division to streamline administration, services and data collection so that children and families are served more efficiently and effectively. ▪ Are there state policies? Screen all women at birth for alcohol consumption through the new 12 day test. ▪ Mandatory local free access to care asap ▪ Teens need access to "growing up" information, including education and counseling. ▪ Expedite prenatal care for medicaid eligible clients , invest in evidence based programs such as NFP ▪ FASTER RESPONSE TO MEDICAID/ INSURANCE APPLICATIONS FOR CERTAIN TIME CONCERNED HEALTH RELATED INSTANCES, PREGNANCY & SPECIALHEALTHCARE CONDITIONS SUPPORT FOR PHYSICIANS TO PROMOTE NON REFUSAL OF SERVICES BASED ON INSURANCE OR ABILITY TO PAY ▪ Increased use of federal \$ to address need. The state needs to increase taxes slightly to take advantage of funding that is available. ▪ Polices are in place; enforcement of polices and accountability systems haven't been consistently implemented ▪ Access to Health Care (medicaid, SCHIP)meet our federal match to access



Focus Group and Survey Responses

	<p>all available funds to Nevada</p> <ul style="list-style-type: none"> ▪ Sex ed to be more proactive to empower girls to know "what to do if"; parenting classes in high school to empower girls to advocate for their child and to identify and know what to do if they believe their child has a delay (perhaps just defining and identifying the "child find" program), if a child with autism can receive needed therapies and treatment at out of state institutions, why are these same treatments not available to those families willing to keep the child at home? Develop policy that allows children with autism to be provided at home the same therapies they might get at an institution. Some children with autism are being abused by public educators, what mental health services are available to them to help them deal with the abuse? Developing a mental health program for children with significant delays that have been abused. Living with a child with significant autism can destroy "home life", what programs are available to parents to learn how to cope? Develop mental health programs for parents of children with significant disabilities. How are the children with autism's tickets to work being spent, is the current path yielding jobs for them? Develop policy that yields programs to develop skills in children with autism.
	<ul style="list-style-type: none"> ▪ Funding to meet the needs of children with special needs
	<ul style="list-style-type: none"> ▪ Assistance with education and prevention, and tools for providers to implement services
	<ul style="list-style-type: none"> ▪ continued collaboration between MCH and Medicaid
	<ul style="list-style-type: none"> ▪ tax restructure
	<ul style="list-style-type: none"> ▪ access, time from work to participate like wildland firefighters are allowed to leave their state jobs to help.
	<ul style="list-style-type: none"> ▪ Better payment policies ▪ Maternal and child health ▪ Online survey (To be completed asap) ▪ EPSDJ; Early Periodic Screening and Diagnostic Testing ▪ Mandated vision, hearing screening ▪ Provides education ▪ School clinics ▪ Diagnostic timeline of milestones/info/outreach ▪ Need a starting place: mandated policies/ list with branches ▪ DMV insurance tracked but not health ▪ Medicaid specialist at hospital to enroll before leaving hospital ▪ Sex ed policy, prevention ed ▪ Continuity of care, systematic method
<p>C. How can the state support the community policies and practices?</p>	
	<ul style="list-style-type: none"> ▪ Better cooperation of state agencies in different divisions.
	<ul style="list-style-type: none"> ▪ Better collaboration among state agencies especially in separate divisions.



Focus Group and Survey Responses

	<ul style="list-style-type: none"> ▪ promote genetic services
	<ul style="list-style-type: none"> ▪ funding
	<ul style="list-style-type: none"> ▪ By helping disseminate information and by providing a forum for collaboration
	<ul style="list-style-type: none"> ▪ be available, go out and meet with families to see first hand what they are experiencing
	<ul style="list-style-type: none"> ▪ Through partnership, acknowledging the service gaps
	<ul style="list-style-type: none"> ▪ Funding
	<ul style="list-style-type: none"> ▪ Statutes, funding
	<ul style="list-style-type: none"> ▪ Funding for programs
	<ul style="list-style-type: none"> ▪ Being open to the challenges that face our youth today & not just taking a one stand approach that has been practiced for ever. Our society is changing. If we educate our youth starting in grade school about STI, diseases & consequences of exposure to infections, we might see less STI in younger population.
	<ul style="list-style-type: none"> ▪ participate in the communities support efforts
	<ul style="list-style-type: none"> ▪ By listening to advocates more and applying action
	<ul style="list-style-type: none"> ▪ Create and sustain specific services for needs.
	<ul style="list-style-type: none"> ▪ Assist with data collecting/analysis, and be willing to write letters of support and testify in support of policy change
	<ul style="list-style-type: none"> ▪ providing information and personnel when necessary
	<ul style="list-style-type: none"> ▪ fund prevention programs first
	<ul style="list-style-type: none"> ▪ Dedicated funding streams
	<ul style="list-style-type: none"> ▪ get the groups together as one
	<ul style="list-style-type: none"> ▪ to remember our children are living longer
	<ul style="list-style-type: none"> ▪ Funding
	<ul style="list-style-type: none"> ▪ Meet the need with agencies that are not available in the community
	<ul style="list-style-type: none"> ▪ Develop steady funding of state and university services which are not adequately provided or available through the private sector
	<ul style="list-style-type: none"> ▪ By trending changes that occur in the community and implementing policy and /or laws that address them.
	<ul style="list-style-type: none"> ▪ faster approval for Medicaid eligibility. The Medical Review Team takes way too long.
	<ul style="list-style-type: none"> ▪ systems and financial backing
	<ul style="list-style-type: none"> ▪ Dedicated funding streams to assure continuation of programs
	<ul style="list-style-type: none"> ▪ Wraparound Services
	<ul style="list-style-type: none"> ▪ By identifying local community agencies who address the needs of at-risk communities.
	<ul style="list-style-type: none"> ▪ hopefully to be determined by this focus group
	<ul style="list-style-type: none"> ▪ work as a partner instead of as an enemy the southern region
	<ul style="list-style-type: none"> ▪ allow the monies to be available



Focus Group and Survey Responses

	<ul style="list-style-type: none"> Partner better with non profits that cover the same missions to help with maximize both agencies resources to better reach the community
	<ul style="list-style-type: none"> unsure
	<ul style="list-style-type: none"> Secure funding
	<ul style="list-style-type: none"> Look at their policies and really do some changes that will be helpful for families to get what they need in a timely manner.
	<ul style="list-style-type: none"> by listening to the community and valuing their input.
	<ul style="list-style-type: none"> See comments in item C. Also, being open to new and creative approaches, allowing flexibility to allow for innovation and how needs are addressed in each community, respecting the local health authority's legislated authority for all public health matters in their jurisdiction, and accepting that different approaches may be needed for different parts of the state as "one size fits all" approaches may not work for both urban and rural/frontier part areas of the state.
	<ul style="list-style-type: none"> Provide data on standardized outcome measures and develop a strategic plan for all MCH areas with deadlines for action items, compel current programs to do cost analysis on their activities to demonstrate cost effectiveness - scrutinize all existing programs for value based on areas of highest need based on data, provide a method for all stakeholders to communicate electronically in a timely manner, ensure that grants require demonstration of meeting outcome measures, fund only evidence based programs, increase support of private health care through TA and education, SEEK ADDITIONAL RESOURCES FROM GOVERNMENT AND FOUNDATIONS
	<ul style="list-style-type: none"> Continuing Education of Public Health Employees & Providers
	<ul style="list-style-type: none"> Create policies and practices that would benefit the needs of the state.
	<ul style="list-style-type: none"> unknown
	<ul style="list-style-type: none"> funding
	<ul style="list-style-type: none"> more outreach program in the rural areas
	<ul style="list-style-type: none"> Provide data showing the need for services in this population.
	<ul style="list-style-type: none"> Grants to pediatricians and ob/gyn for no-cost care
	<ul style="list-style-type: none"> Funding!
	<ul style="list-style-type: none"> Support local agencies on a cost effective basis rather than buddy system, support agencies with lower overhead
	<ul style="list-style-type: none"> communication
	<ul style="list-style-type: none"> Must change policy of medicaid and ban LAY midwife deliveries
	<ul style="list-style-type: none"> Funding, Funding Funding-Enforcement-check for fraud and abuse of the system
	<ul style="list-style-type: none"> implements more polices and practices that will help families become more advocates and to better understands what their needs are.
	<ul style="list-style-type: none"> Provide expertise and support



Focus Group and Survey Responses

	<ul style="list-style-type: none"> ▪ Enforce AAP guidelines on health care providers in Nevada
	<ul style="list-style-type: none"> ▪ require consistent use of assessment and screening tools for Medicaid reimbursement.
	<ul style="list-style-type: none"> ▪ Foster and empower non-government advocacy--get it organized and efficient rather than ad hoc.
	<ul style="list-style-type: none"> ▪ find out about them and streamline them
	<ul style="list-style-type: none"> ▪ A recognition that prevention is both a conservative value (in that it saves money over the long-term) as well as a progressive value (in that it provides needed supports). What is needed is a philosophical shift that such activities are not "enhancements" but essential services.
	<ul style="list-style-type: none"> ▪ Working together, we could develop state-wide education campaigns for disseminating information to targeted, at-risk populations.
	<ul style="list-style-type: none"> ▪ EDUC ATION MATERIALS FOR OUR COMMUNITY TO DISPERSE AND ACCESS TO MORE LOCAL QUALIFIED CARE GIVERS FOR SPECIAL NEEDS AND PREGNANCY. WILL NEED FUNDING FOR TRANSPORT OF PATIENTS TO NEAREST SPECIALIST
	<ul style="list-style-type: none"> ▪ Provide incentives for promising practice initiatives and practices
	<ul style="list-style-type: none"> ▪ Stop moving your leadership around so frequently. No one knows who they can even reach out to. Individuals need to be in positions long enough to develop expertise and credibility to advocate for the communities they support
	<ul style="list-style-type: none"> ▪ Changes in Sex Education, Mental Health Services for parents of aggressive nonverbal children, a transition program that leads to a job or skill, access to treatment for children and adults with autism.
	<ul style="list-style-type: none"> ▪ Provide funding for education, respite, provide statewide nurse consultants who specialize in care of children with special needs
	<ul style="list-style-type: none"> ▪ Through policy changes to assist in education, training, prevention.
	<ul style="list-style-type: none"> ▪ Not sure
	<ul style="list-style-type: none"> ▪ quit gutting programs that work w/ infants, children, and adults
	<ul style="list-style-type: none"> ▪ more grassroots, offer more in all areas so transportation is not an issue, have exercise options for children and be supported by the school. ▪ Preconception health planning/family planning ▪ Local policy makers ▪ School need to be open to have classes starting since jr high ▪ Nutrition, obesity folic acid, spina bifida ▪ Information ▪ Awareness classes ▪ Linkage between agencies, hospitals, providers ▪ Surveys ▪ Continue with community health nurses ▪ Family planning ▪ Division of health care ▪ Assistance care for undocumented



D. Anything else you would like to add:	
	<ul style="list-style-type: none"> ▪ consistent follow-up ▪ We have too little, little experts, few places to go, no choices ▪ Push to make non-adherent moms more accountable in decreasing their baby's risk for perinatal transmission of disease/s (ie HIV) by ?? ▪ I wish the boxes I am typing my answers in allowed to read what I typed easier. ▪ legislation needs to reflect the needs of the community, not try to control the services provided so that it's harder for individuals to receive the services that they need. ▪ Nevada and Elko need to frequently check why they rank #50th in alot of areas to include mental health. ▪ prevention prevention prevention for safe stable nurturing environments for children! ▪ The need is tremendous ▪ help as our child ages from adult to elderly too. ▪ Poverty, abuse and neglect does not have barrier but the services that is available in some areas do. Some how we need to get more services to the rural areas or provide means or ways for the people to get to them for help. ▪ It all comes down to money ▪ State is to provide easy access to all the lists above (A.) ▪ Health Care for all children and families ▪ There needs to be an information and referral agency who have the ability to direct clients to appropriate services. ▪ There are a large number of families that can not access health care due to their immigration status. There needs to be a way to address that situation so that the children born here in the states into these families have a better chance at life. ▪ We need to become more efficient and accountable to Nevadans for our work - or government mistrust will continue. I'd like to see more partnerships with the private sector if possible. ▪ Monthly or Bi-Annual Meetings of all Community Partners within the newly developed Programs ▪ emphasis on Preventive treatment ▪ Personnel in the Department of Health are not interchangeable and should be given training and support in learning their positions as well as funding them from the state budget ▪ Would like to see greater competition for grants and watch for conflicts of interest or favoritism from state agencies. ▪ We need accessibility, efficiency, affordability with the existing services



Focus Group and Survey Responses

	<ul style="list-style-type: none"> Alcohol Alcohol Alcohol. Nevada runs on it. It is dissolving many unborn brains. We need better statistics/data on what is happening.
	<ul style="list-style-type: none"> create a statewide data base so funding can be found
	<ul style="list-style-type: none"> Utilize technology - social networking for program identified needs; distance learning, collaboration, etc.
	<ul style="list-style-type: none"> There is a need to have nurses with experience work with children with special.
	<ul style="list-style-type: none"> you need buy in from those respected, from professionals to politicians, and today it appears no one cares anymore
	<ul style="list-style-type: none"> State needs to develop plan, based on community input and follow up long term not just per legislative session
	<ul style="list-style-type: none"> Better reimbursement, rates for provider, faster payment, Medicaid
	<ul style="list-style-type: none"> Regulatory insurance commissions

Appendix I. Acronyms Used in This Report

AFDC	Aid for Families with Dependent Children
BSS	Basic Screening Survey
CDC	Centers for Disease Control & Prevention
CSHCN	Children with Special Health Care Needs
CY	calendar year
CYSHCN	Children and Youth with Special Health Care Needs
DHCFP	Division of Health Care Financing & Policy
FFY	federal fiscal year
HIFA	Healthy Insurance Flexibility and Accountability
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
HRSA	Health Resources and Services Administration
LBW	low birth weight
MCH	Maternal and Child Health
MCHAB	Maternal and Child Health Advisory Board (Nevada)
MCHB	Maternal and Child Health Bureau (in HRSA)
MCO	managed care organization
MIS	Management Information System
NV	Nevada
NICU	neonatal intensive care unit
NIS	National Immunization Survey
NSHD	Nevada State Health Division
OB/GYN	Obstetrician / Gynecologist
OHSS	Office of Health Statistics and Surveillance (in the Nevada State Health Division)
PedNSS	CDC's Pediatric Nutrition Surveillance System
STD	sexually transmitted disease
TANF	Temporary Assistance for Needy Families
SCHIP	State Children's Health Insurance Program
SIDS	Sudden Infant Death Syndrome
STI	sexually transmitted infection
VLBW	very low birth weight
WIC	Women, Infants and Children Program
YRBSS	Youth Risk Behavior Surveillance System

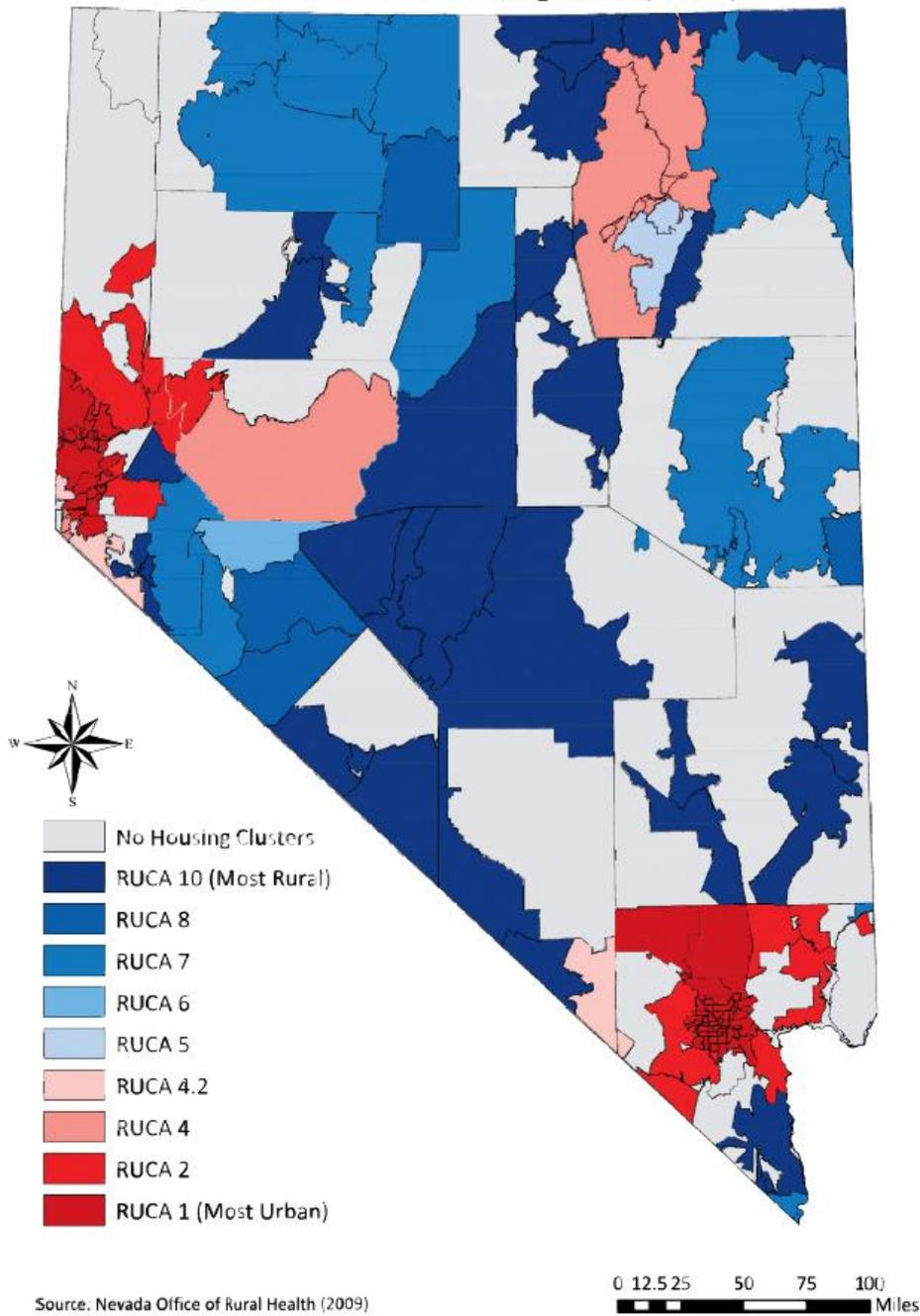
Appendix J. Maps

Map 1: Nevada Population and Geography by Rural-Urban Commuting Areas (RUCA)

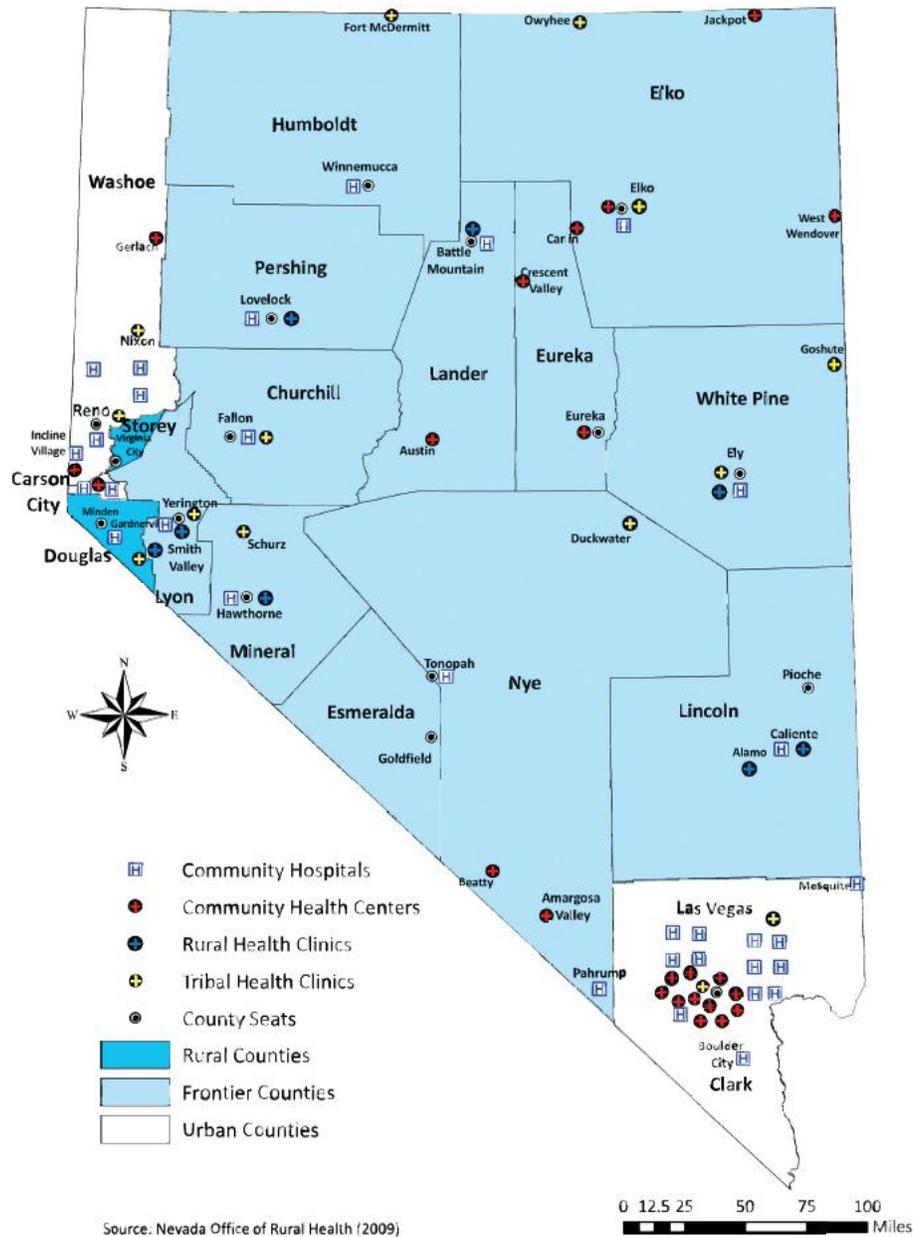
Map 2: Healthcare Resources in Nevada

Map 3: Nevada Mileage Diagram

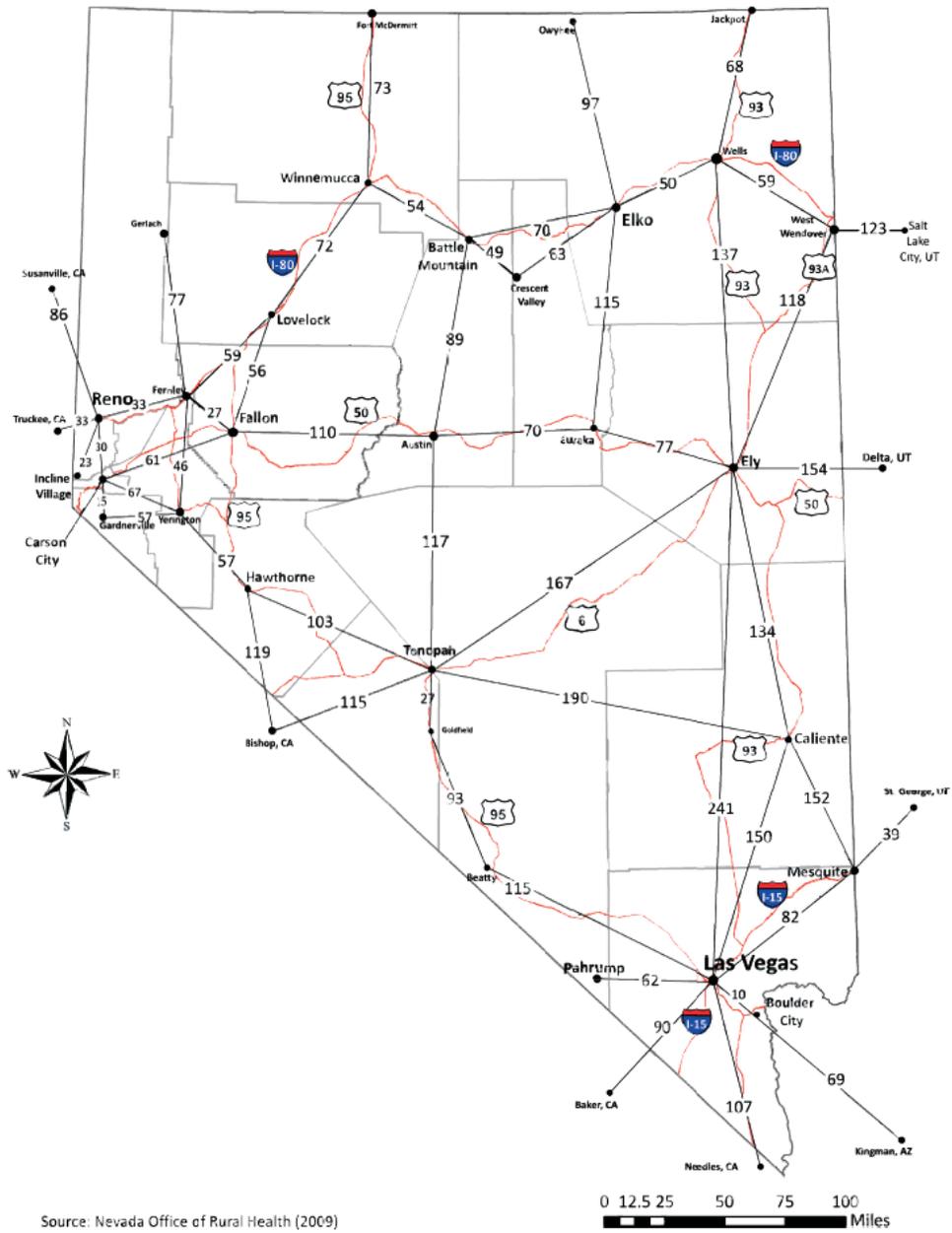
Map 1: Nevada Population and Geography by Rural-Urban Commuting Areas (RUCA)



Map 2: Healthcare Resources in Nevada



Map 3: Nevada Mileage Diagram



Source: Nevada Office of Rural Health (2009)

Summary

In 2010 we celebrate the 75th Anniversary of Congress passing the Social Security Act, which contained the initial key legislation establishing Title V. With the passing of the Social Security Act in 1935, the Federal Government, through Title V, pledged its support of state efforts to extend health and welfare services for mothers and children. Although Title V has been amended over the years, the underlying goal has remained constant: continued improvement in the health, safety, and well-being of mothers and children.

State Maternal and Child Health programs coordinate initiatives that assure access to care; reduce infant mortality; provide and ensure access to prenatal and postnatal care; increase the number of children receiving diagnostic, preventive and treatment services; identify and promote policies that prevent injury and promote wellness; and develop family-centered, community-based systems of coordinated care for Children with Special Healthcare Needs.

Every five years, State Title V agencies are required to conduct needs assessments and to use the findings of the assessment to identify priorities and guide future resource allocation and program planning. 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 (NSHD) capacity to address the identified needs; and utilize the findings to strategically address priorities.

In order to conduct a needs assessment that was comprehensive and inclusive, a multi-component process was used:

- 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.

It is the intention of the MCH Program to transition to an ongoing needs assessment process, whereby more in depth analysis of specific priority areas will be conducted in between the mandated five-year needs assessment, increasing our ability to address the priority areas and enriching our knowledge base in preparation of the mandatory five-year report.