Altarum

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Nevada Title V Maternal and Child Health Block Grant Needs Assessment

2025–2030

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Executive Summary

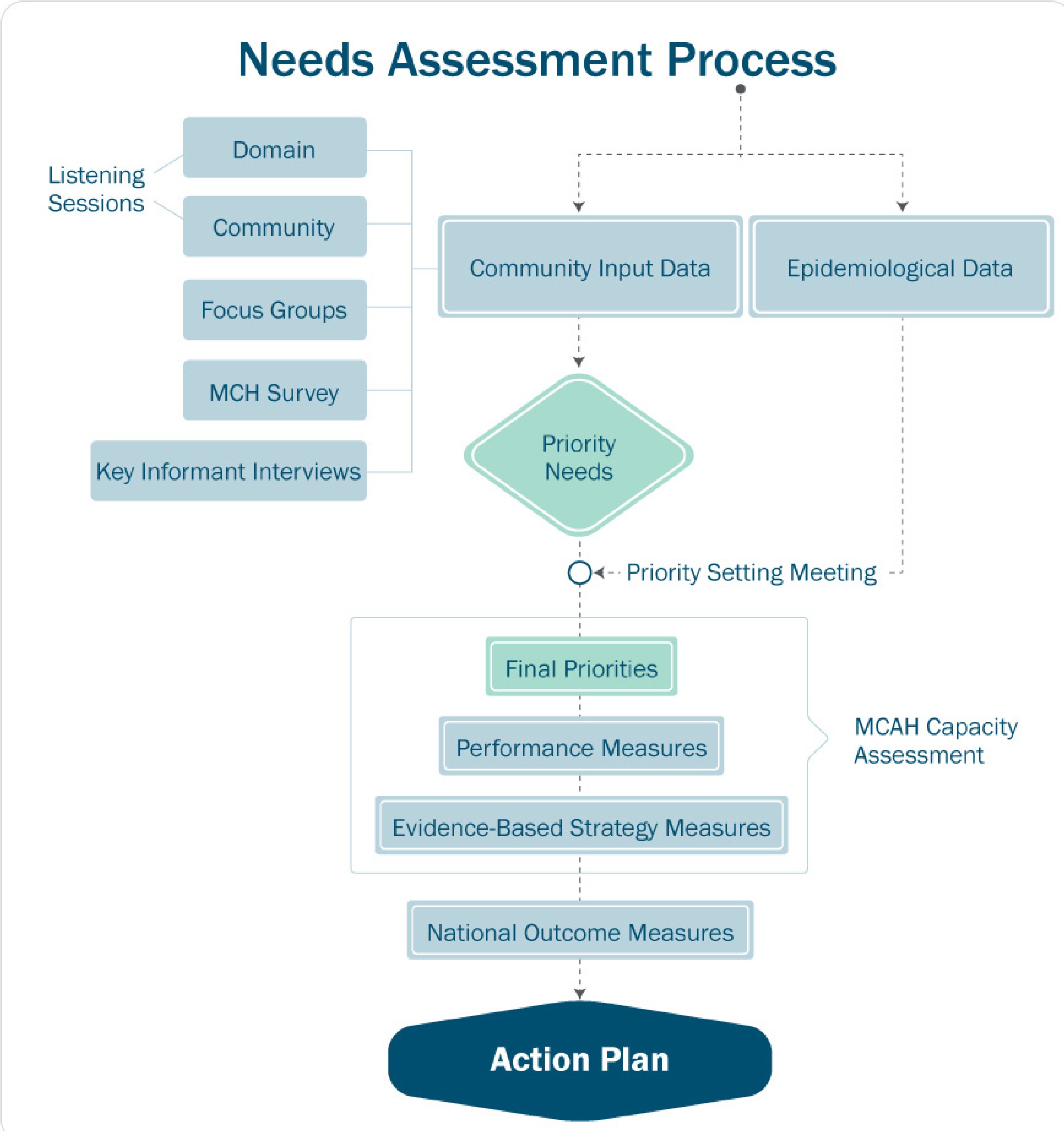
Overview

Nevada's Maternal Child and Adolescent Health (MCAH) Section of the Division of Public and Behavioral Health contracted with Altarum, a non-profit public health consulting and research organization, to assist with Nevada's 2026–2030 Title V Maternal Child Health Block Grant needs assessment. The goal of the needs assessment is to help states determine the current priority needs of their maternal and child populations through both epidemiological (quantitative) and community input (qualitative) data. Based on the needs assessment findings, Nevada identified priority areas, performance measures, evidence-based strategies, and outcomes to guide its work for the next 5 years. Title V supports state efforts to address priority needs across five domains: *Women and Maternal Health; Perinatal and Infant Health; Child Health; Adolescent Health;* and *Children and Youth with Special Health Care Needs (CYSCHN)*.

The needs assessment process **(Exhibit ES.1)** includes:

1. ***Data Collection and Analysis:*** The needs assessment team gathered data through epidemiological sources and community input opportunities to establish the current state of Nevadans' health and well-being and to identify the top priority needs for Nevada's maternal and child populations.
2. ***Priority Setting:*** Priority setting for Nevada's Title V 2026–2030 program occurred through two steps. The process began with obtaining input from the community on current needs and their perspectives on the priorities. The second part of the process involved sharing the needs identified by the community and with meeting participants comprised of MCH policymakers, program administrators, service providers, and community members, who ranked these needs to identify the highest priority in each domain. Nevada MCAH reviewed the final highest ranked priorities to determine final priorities to include in their 5-year Title V action plan.
3. ***Action Plan Development:*** Using needs assessment data and the final priority rankings, Nevada MCAH established one to two priorities per domain. The State then chose national and/or state performance measures, evidence-based strategy measures, and outcomes as part of their 5-year action plan to assess their progress towards meeting selected priority needs.

Exhibit ES.1. Needs Assessment Process



Needs Assessment Process: Data Collection and Analysis

The needs assessment team used state and national epidemiological data to understand the health and well-being of Nevada's MCH populations. To better understand the underlying drivers of observed numbers in the epidemiological data, the needs assessment team engaged Nevadans impacted by and developing MCH programs to share their experiences and expertise. The epidemiological and community data were used to help MCAH make data-informed and community-informed decisions on the key priorities that will direct its Title V activities over the next 5 years.

Data Collection

- ***Epidemiological Data Review:*** The needs assessment team compiled secondary data pertaining to each Title V domain to assess current prevalence, incidence, and trends over time. Data sources included vital records, Pregnancy Risk Assessment Monitoring System (PRAMS), the National Survey of Children's Health, and the Behavioral Risk Factor Surveillance System (BRFSS). The needs assessment team conducted a review of grey literature and peer-reviewed articles to gather additional maternal and child health data available through other research studies. The team found 49 sources meeting inclusion criteria based on timeliness, Nevada-specificity, domain specificity, and overall relevance.
- ***Nevada Maternal Child Health (MCH) Survey:*** The team conducted a survey with a purposeful sample of people across the state. The survey captured the maternal and child health issues of most concern among respondents. The online survey was available in four languages (English, Spanish, Chinese, Tagalog) and had 226 respondents.
- ***Domain Listening Session:*** The team held a virtual listening session on February 28, 2025, with professionals involved in the state public health and social services systems. Participants contributed their perspectives on the priority needs across domains and identified potential and current strategies that address them. The 28 participants represented staff from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), state and county health departments, state epidemiologists, state agencies, as well as CYSHCN parent liaisons.
- ***Key Informant Interviews:*** The needs assessment team interviewed 18 MCH leaders, policy makers, physicians, program directors and staff, and health care administrators to discuss their perspectives and expertise on issues facing the MCH population in Nevada.
- ***Community Listening Sessions:*** Nevadan MCH professionals and people impacted by MCH programs participated in one of four community listening sessions held virtually on March 23, March 25, April 2, and April 3, 2025. Nearly 70 people attended one of the sessions. Participants shared their expertise and experiences as community members and/or as service providers, advocates, OBGYNs, doulas, midwives, and other roles in the MCH system. Participants identified and brainstormed key issues impacting Nevadans across the five domains.
- ***Focus Groups:*** The needs assessment team also conducted focus groups to capture insights from specific populations. Within the month time period available, the team was able to recruit for and conduct two focus groups with Spanish-speaking WIC participants on April 8 and 10, 2025.

Analysis

Analysis of data gathered from the above activities provided information about observed MCH outcomes as well as experiential insights about the key issues impacting Nevada's MCH populations (Exhibit ES.2). In some cases, the information gathered during the different needs assessment activities mirrored each other—for example, epidemiological data or reports from the environmental scan indicated low breastfeeding rates; similarly, community members emphasized breastfeeding as a key MCH issue. In other cases, epidemiological data highlighted health and well-being issues, such as sudden unexplained infant death (SUID), that community members rarely brought up in discussion.

Participants across all community input activities provided insights into the drivers of observed MCH outcomes. For instance, they highlighted the difficulties in accessing care (particularly for people living in rural areas), the lack of knowledge about available services, the need for more supports for parents, the unique challenges of addressing adolescent health needs, and that all these challenges and needs are exacerbated when a family has a child with special health care needs.

Exhibit ES.2. Epidemiological Highlights & Community Input Cumulative Top Priorities in Nevada

Domain	Epidemiological Finding	Community Input Cumulative Top Priorities[1]
Women and Maternal Health	• Higher than national rates of mentally unhealthy days among women of reproductive age (46% vs 40% for aged 18–24, 40% vs 35% for aged 25–44)[a] *(BRFSS, 2022)*. • Decrease in postpartum depression (18% in 2020 to 15% in 2022) *(PRAMS, 2022)*.	• Knowledge of available resources in the community • Mental health services/Substance use • Access to more prenatal and maternal health services • Community health factors • Access to preventive health services
Perinatal and Infant Health	• Top reasons women reported for stopping breastfeeding included they thought they were not producing enough milk (29%), their baby had difficulty latching or nursing (16.9%), breast milk alone did not satisfy their baby (11.8%), they had too many household duties (11.2%), and they felt it was the right time to stop breastfeeding (10.3%) *(Nevada PRAMS 2022)*.	• Need for affordable childcare • Knowledge of available resources in the community • Maternal substance use during and after pregnancy • Need for mental health services • Breastfeeding support
Child Health	• Increase in rates of overweight and obese children (32% in 2020 to 35% in 2023) *(NSCH 2023)*. • Decrease in rates of physical activity[b] among children (15% in 2020 to 13% in 2023) *(NSCH 2023)*.	• Physical health/physical activity • Social media, technology, and screen time • Community health factors • Access to safe and healthy food options • After school and childcare options
Adolescent Health	• Higher percentage of Nevadan adolescents reported feeling sad or hopeless compared to national estimates (42.4% vs 28.5%) *(YRBS 2023)*. • Only 10.4% of adolescents with mental health disorders in Nevada received treatment *(YRBS 2023)*.	• Need for services and resources around sexual and reproductive health • Adverse childhood experiences (ACEs) • Mental health services • Access to educational opportunities and resources • Social media and cyber bullying
CYSHCN	• Decrease in CYSHCN that have adequate and continuous insurance coverage (56,5% in 2020 to 50% in 2023, U.S. estimate in 2023 was 61%) *(NSCH 2023)*. • Decrease in the percent of CYSHCN that report having a medical home (38% in 2020 to 26% in 2023, U.S. estimate in 2023 was 40%) *(NSCH 2023)*.	• Access to appropriate services including specialists and early screening and interventions • Need for caregiver support/navigation • Need to increase workforce • Need for affordable health insurance • Mental health services

[a] 46% of women aged 18–24 and 40% of women aged 25–44 reported 1–13 mentally unhealthy days in the past 30 days compared to 40% and 36% nationally based on 2022 BRFSS data.
[b] Physical activity defined as physically active at least 60 minutes every day

[1] The key priority needs listed reflect the verbatim priorities that emerged from the qualitative analysis and were presented in this way to priority setting participants for voting.

Needs Assessment Process: Priority Setting

The top cumulative priorities that emerged from the community input activities (as listed above), alongside epidemiological data, were given to participants at a *Priority Setting Meeting* held on April 17, 2025. The hybrid virtual and in-person meeting brought together nearly 60 people representing MCH programs, multiple state departments, Nevada communities, social service organizations, and parents. A needs assessment team facilitator guided the group through a process of ranking each priority need against 9 criteria, which could receive a score of 0–5 with 5 indicating a high priority and a possible highest priority score of 45. The needs assessment team tallied and averaged the scores across participants. **Exhibit ES.3** presents the top priorities based on average scores.

Exhibit ES.3. Final Top Priorities by Domain

Women and Maternal Health	Perinatal and Infant Health	Child Health	Adolescent Health	CYSCHN
• Mental health services/ Substance use (score: 36.3) • Access to more prenatal and maternal health services (score: 35.6)	• Need for mental health services (score: 38.6) • Maternal substance use during and after pregnancy (score: 38.3)	• After school and childcare options (score: 38.3) • Community factors that impact health (score: 35.9)	• ACEs (score: 37.1) • Need for services and resources around sexual and reproductive health (score: 37.0)	• Need for affordable health insurance (tied score: 37.3) • Need to increase workforce (tied score: 37.3) • Access to appropriate services including specialists and early screening interventions (tied score: 37.3)

Note: The highest possible score is 45.

Needs Assessment Process: Action Plan Development

After the priority setting meeting, Nevada's MCAH Title V team reviewed the collected data, discussed the top priority needs identified during the priority setting meeting, and determined their final priorities per domain. MCAH then developed a 5-year action plan to address the needs identified. For each priority, the state selected a national or state performance measure, an evidence-based strategy measure, and developed activities the state will implement to address these priorities during the next 5 years **(Exhibit ES.4).**

Exhibit ES.4. Performance Measures and Evidence-Based Strategies

Domain: Women and Maternal Health

Final MCAH Selected Priority Needs	Performance Measures
• Incorporating mental health and substance use screening and referrals into prenatal care • Improving access to prenatal and maternal health services	• ***Universal National Performance Measure Postpartum Visit:*** Percent of women who attended a postpartum checkup within 12 weeks of giving birth; Percent of women who attended a postpartum checkup and received recommended care components • ***State Performance Measure Early Prenatal Care:*** Percent of pregnant women who receive prenatal care beginning in the first trimester

Evidence-Based Strategy Measures

- Percent of WIC and home visiting enrolled families during pregnancy who received at least one postpartum visit.
- Percent of pregnant women enrolled in MIECHV-funded home visiting and WIC programs prenatally who enrolled in prenatal care.

Domain: Perinatal and Infant Health

Final MCAH Selected Priority Needs	Performance Measures
• Increasing access to breastfeeding support • Addressing maternal substance use during and after pregnancy • Reducing infant mortality through safe sleep practices	• ***National Performance Measure Breastfeeding:*** Percent of infants who are ever breastfed; percent of children, aged 6 months–2 years, who were breastfed exclusively for 6 months • ***State Performance Measure Substance Use:*** Percent of women who used substances during pregnancy • ***National Performance Measure Safe Sleep:*** Percent of infants placed to sleep on their backs; percent of infants placed to sleep on a separate approved sleep surface; percent of infants placed to sleep without soft objects or loose bedding; percent of infants room-sharing with an adult

Evidence-Based Strategy Measures

- Percent of Nevada PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends
- Percent of Nevada PRAMS respondents who report they were asked by a provider during their prenatal care visits if they smoked cigarettes or used e-cigarettes, if they were drinking, using illegal substances, or using marijuana.
- Percent of PRAMS respondents who report their infants (under age 1) were laid to sleep in a high-risk sleep position and/or environment

Domain: Child Health

Final MCAH Selected Priority Needs	Performance Measures
• Increasing access to safe and healthy food options • Increasing physical activity	• ***National Performance Measure Food Sufficiency:*** Percent of children, aged 0–11, whose households were food sufficient in the past year • ***National Performance Measure Physical Activity:*** Percent of children, aged 6–11, who are physically active at least 60 minutes per day

Evidence-Based Strategy Measures

- Percent of MIECHV Home Visitors who received training on nutrition and exhibited increased knowledge on food sufficiency and strategies on how to discuss nutrition with families.
- Percent of respondents of the Kindergarten Health Survey (KHS) who report their child exercises for at least 60 minutes per day at least 4–5 times a week.

Domain: Adolescent Health

Final MCAH Selected Priority Needs	Performance Measures
• Increasing screening for ACEs during adolescent well visits • Increasing access to sexual and reproductive health care via adolescent well visits	• ***National Performance Measure Adolescent Well-Visit:*** Percent of adolescents, aged 12–17, with a preventive medical visit in the past year • ***State Performance Measure:*** Rate of Sexually Transmitted Infections in adolescents aged 12–17

Evidence-Based Strategy Measures

- Percent of Medicaid EPSDT eligible adolescents, aged 12–17, who received at least one initial or periodic screen
- Percent of adolescents aged 12–17 who have a well visit through funded partners that provide integrated health services, including being screened for Reproductive Life Planning and provided with client specific education and resources based on individual goals.

Domain: CYSHCN

Final MCAH Selected Priority Needs	Performance Measures
• Increasing access to care via a Medical Home, including addressing health insurance coverage for CYSHCN services	• ***Universal National Performance Measure Medical Home Overall:*** percent of children with special health care needs, aged 0–17, with a medical home

Evidence-Based Strategy Measure

- Percent of northern and rural families who report the family-to-family support in navigation received by a Family Navigator through Family Navigation Network met their needs for transition from pediatric to adult health care.

Conclusion

Information gathered during the needs assessment indicates that where residents live in Nevada (e.g., rural vs. urban settings) impacts their ability to access and receive appropriate and timely services. While Nevada's health and well-being outcomes have improved, work remains to ensure all women, mothers, babies, children, adolescents, CYSHCN, and families reach their full health potential. Focusing MCAH efforts during the next 5 years on issues such as family navigation, medical home, partnerships and collaboration to encourage prenatal care (including addressing substance use and mental health care), breastfeeding support, access to healthy foods, opportunities for physical activity, and adolescent-appropriate health care will help address the underlying factors contributing to Nevadans achieving lifelong health.

NEVADA TITLE V NEEDS ASSESSMENT FINAL REPORT

Introduction

Nevada is comprised of 17 counties and as of the 2020 Census, had a population of 3,104,614 (2020 Decennial Census). A large portion of the state's population (73%; 2,265,461 residents) resides in Clark County, home to Las Vegas, followed by Washoe County (16%; 486,492 residents). The independent municipality of Carson City, home of the capital, has 58,639 residents (2%). While Nevada is one of the most sparsely populated states, the state has experienced significant population growth in the last five years. The US Census Bureau estimates a population percent change from April 2020 to July 2024 of 5%.

The distance between Washoe and Clark counties is 448 miles (approximately 7.5 hours by car); between Washoe and Elko counties is 290 miles (approximately 4.5 hours by car); and between Elko and Clark counties is 433 miles (approximately 7.5 hours by car). Residents in the rural and frontier counties are spread across 95,421 square miles or 86.9% of the state's land mass. Population density ranges from 396 people per square mile in Carson City to 0.27 people per square mile in Esmeralda County. Approximately 90% of Nevada land is publicly owned and administered by federal, state, and Tribal entities, with the remaining 10% privately owned.

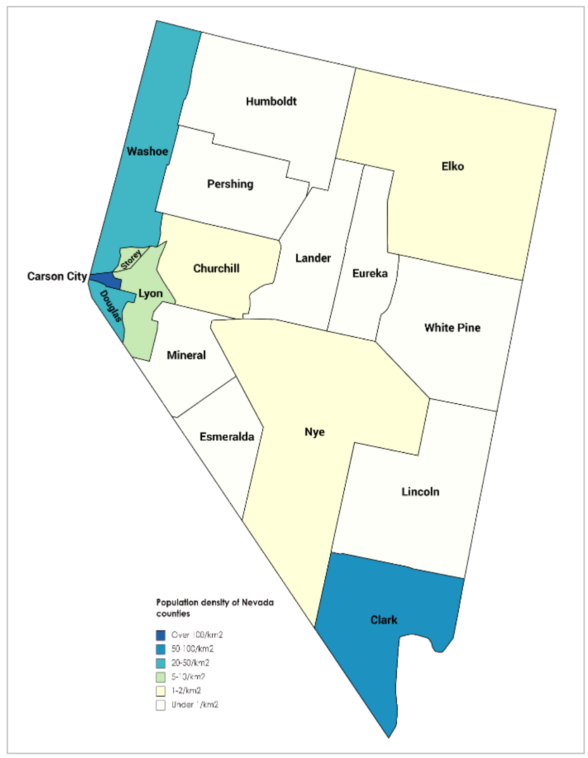


Figure 1. U.S. Census Bureau. (2021). 2020 population and housing state data [Interactive visualization]. census.gov/library/visualizations/interactive/2020-population-and-housing-state-data.html

Given the unique distribution of residents across the state, Nevada faces distinct challenges in accessing care, providing adequate transportation to services, and retaining a robust healthcare workforce. Many communities are located in rural or frontier areas, often hours away from the nearest provider or facility. This geographic spread makes it difficult to ensure timely access to care, particularly for specialized services, and creates additional barriers related to transportation, staffing, and infrastructure. These challenges are further compounded by workforce shortages, which make it difficult to recruit and retain qualified healthcare professionals in underserved areas.

Nevada's Maternal Child and Adolescent Health (MCAH) team contracted with Altarum, a non-profit public health consulting and research organization, to assist with their 2025–2030 maternal and child health needs assessment, which forms part of their Title V Maternal Child Health Block Grant application.

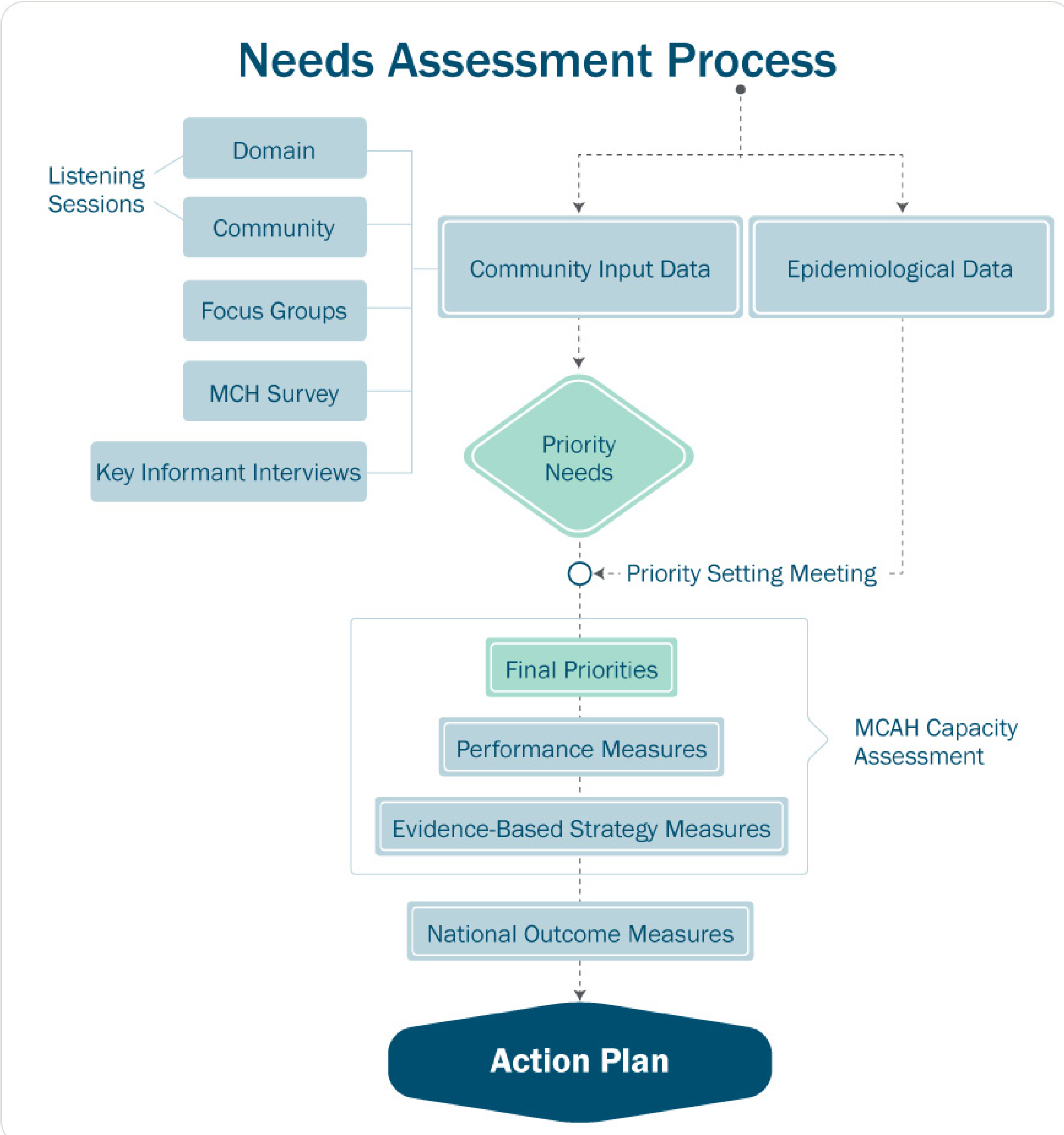
Title V programs focus their efforts on the **five maternal child health (MCH) domains** or populations: **Women and Maternal Health; Perinatal and Infant Health; Child Health; Adolescent Health;** and **Children and Youth with Special Health Care Needs (CYSHCN).**

The goal of the needs assessment was to understand the state of maternal and child health in Nevada and to identify the priority needs or issues impacting the five population domains across the state. To do this, the needs assessment team gathered and analyzed health and well-being information from two types of data:

1. **Epidemiological:** Population-based publicly available data and public health survey data as well as data from research studies.
2. **Community Input:** Themes and insights from communities impacted by programs, medical providers, the public health workforce, social service and advocacy organizations, state and local governmental organizations.

The needs assessment process culminated in a final priority setting meeting that Nevada MCAH used to finalize their top 1–2 priorities for each domain. MCAH used the top priorities to choose the national or state performance measures, evidence-based strategies, and national outcome measures that form their 5-year action plan submitted as part of their block grant application. **Exhibit 1** illustrates the needs assessment process implemented.

Exhibit 1. Needs Assessment Process



Methodology

The Altarum team began the needs assessment process by gathering epidemiological data. Then, the team conducted various primary data collection activities to gather community input. The epidemiological data review assessed prevalence, incidence, and trends in the safety, health, and well-being of the five domain populations in Nevada. The community input, or qualitative activities, provided opportunities to gather in-depth and nuanced information from people impacted by MCH programs and those designing and carrying out programs. The needs assessment team offered multiple opportunities for MCH providers, professionals, and community members to share their perspectives, experiences, and expertise.

Epidemiological Data[2]

The needs assessment team conducted an *Epidemiological Data Review* (**Appendix E**) to obtain and synthesize information from a variety of sources about the health and well-being of Nevadans across the five domains. The needs assessment team reviewed Nevada population-based data from administrative sources and public health surveys, including vital records, Medicaid, Pregnancy Risk Assessment Monitoring System (PRAMS), Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), National Survey of Children's Health (NSCH), and the U.S. Census Bureau's American Community Survey (ACS). Where possible and to add further value and context to the findings, Altarum used the same datasets to compare differences between Nevada and national estimates.

The needs assessment team also conducted an *Environmental Scan* (**Appendix D**) of existing literature (e.g., peer-reviewed, grey) using search criteria to identify more than 75 grey literature and 13 peer-reviewed articles that included additional data to understand prevalence, incidence, and trends of issues impacting MCH populations, service delivery, and outcomes. The team included articles considering the time period of the data, Nevada-specificity, domain-specificity, and overall fit. The Needs Assessment team then reviewed the sources that fit the inclusion criteria (1 peer-reviewed and 48 grey literature articles) for relevant information and summarized findings in the Environmental Scan. The scan provided the team with supporting data from other studies for the needs assessment priorities and measures and helped to fill in existing data gaps.

Community Input Data

The needs assessment team gathered data by conducting multiple community input forums for Nevadans to provide their expertise and experience. The end goal was to obtain a list of the key priority needs by domain from each community input activity. The community input activities included a Domain Listening Session, Community Listening Sessions, *Key Informant Interviews, Focus Groups, and a Maternal Child Health Survey.*

[2] Limitation: In January 2025, federal changes resulted in entire data sets and/or specific data points being modified and/or removed. This loss of access to certain data meant that in some instances, the Nevada Title V Needs Assessment team was unable to conduct quality assurance data checks or to review information as they would have typically or historically done.

Domain Listening Session

The needs assessment team facilitated a virtual Domain Listening Session on February 28, 2025. Nearly 30 participants from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), state and local health departments, epidemiologists, state agencies, as well as CYSHCN parent liaisons attended **(Exhibit 2).** Participants were separated into three groups (Women and Maternal Health + Perinatal and Infant Health; Child Health + Adolescent Health; and CYSHCN) to discuss the needs impacting the domain populations. Using the virtual platform *Mural,* participants virtually posted, said audibly, or typed into the chat their suggestions for the priority needs for each domain on the board. Participants offered information and expertise about communities impacted by MCH programs as well as interventions and ideas for addressing the issues. A notetaker captured what participants discussed. Facilitators grouped similar issues together and defined them into larger caches (i.e., Access to Care). Participants then voted on the most important issues, identifying the top needs (learn more in Findings).

Exhibit 2. Domain Listening Session Participant Organizations

Participants represented the following organizations/departments:

- Adolescent Health and Wellness Program
- Central Nevada Health District
- Chronic Disease Prevention and Health Promotion Section
- Division of Child and Family Services
- Family Navigation Network
- Northern Nevada Public Health (NNPH)
  - NNPH Fetal and Infant Mortality Review Committee
- Division of Public and Behavioral Health Maternal Child Adolescent Health
- Nevada Center for Excellence in Developmental Disabilities
- Rape Prevention and Education Program
- Southern Nevada Health District
- Division of Public and Behavioral Health Tribal Liaison
- WIC
- Nevada Minority Health and Equity Coalition

Key Informant Interviews

Altarum conducted key informant interviews with state leaders, program administrators, policymakers, physicians, MCH social service agency and organization representatives involved in the system serving MCH populations **(Exhibit 3).** Altarum asked key informants about their perspectives on the needs of MCH populations, how the system is helping meet those needs, and where improvements could be made. Altarum developed interview guides **(Appendix C),** and Nevada MCAH identified a list of potential interviewees. The needs assessment team analyzed the priority issues and needs key informants identified and created crosstabulations that provided insight into the frequency of the perceived needs across each domain. Altarum analysts pulled the most frequently reported challenges and needs into a table **(Exhibit 5).**

Exhibit 3. Organizations Represented by Key Informant Interviewees

Key informants represented the following agencies and organizations:

- The Children's Cabinet – Early Childhood
- Dignity Health
- Collaborative Care High-Risk Pregnancy Center, Psychiatry and Addiction Medicine
- Domestic Violence, Sexual Assault and Human Trafficking Division (Attorney General's Office)
- Doula/Midwife/Trauma-Informed Yoga
- EMPOWERED Program, Roseman Medical Group
- University of Nevada, Reno – Family Navigation Network
- NNPH Fetal Infant Mortality Review (FIMR), Public Health Nurse Supervisor
- Nevada Department of Health and Human Services Division of Health Care Financing and Policy
- Nevada Minority Health and Equity Coalition
- Nevada State Medical Association
- Obstetrics and Gynecology Maternal Fetal Medicine
- Safe Babies Court (Reno and Carson Counties)
- Safe Nest Court Advocacy Program

Community Listening Sessions

Altarum hosted and facilitated four virtual community listening sessions. MCAH promoted the forums through their partner organizations, key informants, listservs, and social media channels. The listening sessions were held on March 25 and 27, 2025, and April 2 and 3, 2025. Nearly 70 people attended across all sessions **(Exhibit 4).** Participants discussed issues impacting their health, their community's health, and/or the health of the people they serve across the five domains. Facilitators categorized issues by overarching theme during the session. Participants then voted on the top themes impacting the domain, discussed ways these issues could be addressed, and whether these issues had a different impact across groups and geographies in Nevada.

Exhibit 4. Community Listening Session Participants

Community listening session participants (including community members, community-serving professionals, organization representatives):

- Carson Tahoe Hospital (Behavioral Health)
- Bristlecone Family Resources
- Carson Tahoe Health
- Certified Nurse Midwives and Homebirth Midwives
- Childcare Providers
- Legal Aid (Children's Attorney)
- Children's Cabinet Members
- Eddy House
- Nevada Division of Public and Behavioral Health (Chronic Disease and Health Promotion)
- City of Henderson
- Community Health Alliance
- Community Health Workers
- Community Members
- Doula Trainer and Doulas

- Early Childhood Educators
- Future Smiles
- Healthy Communities Coalition
- IBCLC Breastfeeding Coalition
- Intermountain Health Children's Health and Population Health
- Kids Are Us
- Maternal Health Navigators
- Minority Health Consultants
- Minority Health Equity Coalition Members
- Molina Healthcare
- Nevada Early Intervention Services
- Nevada Health Centers
- Nevada LEND
- Northern Nevada Hopes
- Northern Nevada Maternal Health Coalition
- Northern Nevada Public Health WIC
- PACT
- Parents
- Parents of CYSHCN
- Physicians and OBGYNs
- Fernley Rural Clinics
- Safe Nest
- School of Public Health, Heart and Sol Collective
- Southern Nevada Health District (Congenital Syphilis)
- University of Nevada Reno Extension (Southern Nevada Early Childhood)

Focus Groups

The needs assessment team also conducted focus groups to capture insights from specific groups unrepresented elsewhere. The needs assessment team and Nevada's WIC program worked together to promote and recruit Spanish-speaking WIC participants to participate in a Spanish-language facilitated focus group. Altarum bilingual staff hosted virtual focus groups on April 8 and 10, 2025. Between the two sessions, 24 women participated. They provided their perspectives on issues impacting themselves as parents (including as parents of CYSHCN), pregnant women, and community members. The women lived in various regions of Nevada but were primarily located in Las Vegas. While the other community input opportunities involved ranking and voting of combined priority needs, the focus group participants discussed issues without conducting the voting exercise.

MCH Survey

As a mechanism to gather a wider range of perspectives and validate the community input to date, Altarum designed and fielded a MCH survey for respondents to rate their perceived importance of key themes identified through the listening sessions, interviews, and focus groups. Altarum worked closely with the MCAH team to develop the survey tool. Through this process, MCAH identified two additional topics to include in the survey: 1) Contraceptive methods offered postpartum, and 2) ADHD (diagnosis and medication use, ADHD-related services offered, and barriers to identification/diagnosis). See **Appendix B** for details.

The survey was professionally translated into Spanish, Chinese (simplified), and Tagalog. The survey was web-based and programmed into LimeSurvey, MCAH distributed the survey to reach a wide range of MCH community members. Respondents were asked to provide their informed consent prior to initiating the survey. The survey was available to respondents from March 31 to April 9, 2025. Survey participants responded as an MCH-related professional (professional respondents) or as parents or community members in a non-professional capacity (non-professional respondents).

All survey respondents answered questions about what their top health priorities were across the five domains. Respondents who identified as professionals received questions about their job setting and the services they provide related to ADHD. Respondents who identified as caregivers received questions about their children, discussions about contraception use with their healthcare provider, and ADHD diagnosis and treatment for their children.

Community Input Analysis

Altarum analysts uploaded notes from listening sessions, interviews, and focus groups into NVivo qualitative analysis software and organized them by needs assessment activity type (e.g., domain listening session). Using thematic analysis, which involves the identification of themes that emerge from the data, Altarum analysts developed a preliminary coding framework. The needs assessment team categorized the qualitative data by domain and coded the data by the following themes: *challenges and priorities*, *solutions*, *future considerations*, and *specific areas and populations*. Within these themes, analysts coded sub-themes using inductive analysis. Analysts ran crosstabulations to assess the frequency of the perceived challenges and needs for each domain by data collection activity from highest to lowest. The most frequently mentioned needs were pulled into a table by needs assessment activity. For the MCH Survey, analysts cleaned the data and removed blank or incomplete survey responses and imported the finalized data into IBM SPSS Statistics. Altarum tabulated frequencies to describe the perceived need of each priority from highest to lowest, organized by MCH population domain and survey audience (e.g., professional or community member, English or Spanish speaker). A total of 336 people opened the survey link. After data cleaning and removal of blank responses, there were 226 total responses **(Appendix F).**

Findings

Below, we present findings by domain. Within each domain, we separate findings by epidemiological data and primary community input data collection activities. The epidemiological data provide contextual information about the status of the population’s health and specific conditions impacting Nevada’s population. The findings from community input primary data collection activities offer additional depth and nuance to the statistics and incorporate community experiences and perceptions. The key priority needs that emerged from each of the community input activities alongside the final cumulative top priorities are presented in a table within each domain.

Women and Maternal Health

Epidemiological Data Summary

Overall Well-Being: Metrics from the BRFSS showed decreases in reported general health, diabetes, and high blood pressure among Nevada women. A majority (91.3%) of Nevada women aged 18–24 reported their **general health** as good, very good, or excellent in 2022, a decrease from 94.3% in 2020. Nevada women aged 25–44 reported a larger decrease with 79.7% reporting their general health as good, very good or excellent in 2022 compared to 86.8% in 2020. Among women, the prevalence of **diabetes** increased by about 2% from 9.7% in 2020 to 11.8% in 2023. For **high blood pressure** there was a smaller increase from 29.1% in 2021 to 29.7% in 2023.

Mental Health/Substance Use: Based on data from the BRFSS, the prevalence of **depressive disorders** in women aged 18–24 in Nevada decreased from 35.6% in 2020 to 26.7% in 2022. Conversely, women aged 25–44 experienced an increased prevalence over this same time period from 19.4% in 2020 to 23.3% in 2022. When looking at the number of **mentally unhealthy days** reported by women of reproductive age in Nevada, nearly half (45.7%) reported having 1–13 mentally unhealthy days in the past 30 days based on 2022 data. When specifically looking at PRAMS data on **postpartum depression**, the prevalence was about 15% in 2022, a decrease from 17.6% in 2020.

Based on Nevada PRAMS data, almost 60% of pregnant women in Nevada reported **using substances other than over the counter pain relievers** in 2020. In 2022, this percentage increased to more than 70%. On the other hand, more than 10% of women reported using **marijuana or hash** in 2020, this estimate decreased to 0% in 2022. For those who did use substances during pregnancy, about 11% said they had a current prescription, 1% said they had pain relievers left over from an old prescription, and 6% said they got pain relievers without a prescription. Women who reported **smoking during pregnancy** decreased from 3.6% in 2020 to 2.7% in 2022 while using **e-cigarettes** during this same time-period increased from 0.8% to 2.7% in 2022. Most women (93.3%) reported that a healthcare worker asked them about smoking during a prenatal visit. In addition, environmental scan findings including data from March of Dimes, 2023 and America's Health Rankings, 2025 also identified substance use as a high priority need among women/maternal populations in Nevada.

Access to Care: Nevada Vital Records show a decrease in **prenatal care** initiation during the first trimester between 2020 (78.2%) to 2023 (73.9%). Correlated to the decrease, there was an increase in women initiating prenatal care late or never (3.3% in 2020 versus 4.9% in 2023). Despite lower rates of prenatal care initiation in the first trimester, **maternal mortality** rates in Nevada decreased from 22.4 (per 100,000 live births) in 2017 to 19.2 in 2023. However, the **severe maternal morbidity** rate increased from 60.1 to 89.1 per 10,000 deliveries between 2016 and 2020. Environmental scan findings included data reported by the Department of Health and Human Services in 2022, and a 2023 March of Dimes report that indicated underlying issues in access to prenatal care services related to maternity care deserts and disparate levels of being underserved across race, ethnicity, geography, and age in Nevada.

BRFSS data showed an increase in the percent of Nevada women reporting a **preventive medical visit** from 72.5% in 2020 to 77.7% in 2023. CDC Chronic Health Indicators show that 81.2% of Nevada women reported completing **cervical cancer screening** in 2020. About one-third (62.7%) completed **breast cancer screening** in 2022, a decrease from 69.6% in 2020.

Community Health Factors: Data collected by Feeding America estimated that 14.4% of the Nevada population lived in neighborhoods with low **food access** in 2022. Data from 2020–2022 KIDS COUNT Data Center estimate that 17% of children in Nevada lived in households that were food insecure at some point during the year. Based on 2022 data from the National Survey of Children's Health, 35% of Nevada children lived in a household where **housing** costs were greater than 30% of pretax income, either for rent or mortgage. Percent of women with a recent live birth who experienced housing insecurity in the last year increased from 1.6% in 2020 to 3.6% in 2022 based on Nevada PRAMS data.[3]

Community Input Findings

Needs assessment participants discussed issues impacting women in Nevada: access to care (including a lack of workforce, appropriate care, insurance coverage), substance use (including a lack of screening, referrals, and treatment), and community factors that impact health (such as transportation).

> "I don't think a lot of people know they have access to [services] now."
>
> – Community Input Session Participant

Access to Care: While there are many factors that may impact access to care, participants in the community input activities primarily discussed the physical lack of locations and hours available to access care, the lack of providers to staff locations, and other health factors impacting access to care.

- *Workforce:* Participants discussed the lack of staffing and locations making it difficult to be able to receive health care *when* needed and *where* needed. Participants highlighted ideas to address "maternal health care deserts" such as increasing midwifery options. Participants also suggested that increasing access to doulas and community health workers could lead to better birth and postpartum outcomes. Medical providers expressed that the lack of providers impacts both patient care as well as the mental health of the providers themselves. One noted that increasing the number of physician programs would help alleviate the lack of providers in Nevada and that an effort and investment in medical schools could help impact health outcomes for women throughout Nevada.

> "It takes a while for people to get licensed to provide medical care. Community health workers may help bridge that gap."
>
> – Key Informant

- *Health Insurance:* A lack of health insurance, especially Medicaid, was also mentioned as both a problem and a solution to care access. Needs assessment participants expressed a need for both increased eligibility for Medicaid coverage and a need to help eligible women enroll in Medicaid. Participants across needs assessment activities also discussed the need for improved insurance coverage of Nevadans and gaps in insurance coverage of care. Participants highlighted the issue of Medicaid reimbursements and their impact on the ability of clinics to stay open. *"I can't hire physicians if I can't pay them anything,"* said a key informant.
- *Appropriate Care:* Participants across multiple community input activities brought up the issue that access to existing care is challenging because it does not meet the needs of the people they serve. Participants suggested solutions to such problems as difficulty navigating the system and a lack of flexible hours. Ideas included offering walk-in maternity clinic appointments and having better access to doulas, midwives, and free-standing birthing centers. Physicians also suggested more options for walk-in care or nontraditional care

[3] Limitation: Data from the 2022 Nevada PRAMS survey should be interpreted with caution since this survey only had a response rate of 30.5%, which is under the CDC required response rate threshold of 50% to publish data.

offerings that would help "*women traveling hundreds of miles for care. If they are late or miss their appointment, they must come back [and they aren't able to]*."

- Participants also suggested that the existing workforce needs better training to improve trauma-informed care, better support for moms who use substances, and to meet the needs of non-English speaking clients. *"There are not enough culturally and linguistically congruent providers for populations that exist in Nevada. Or they're not using translators. Patients are having non-consensual medical procedures,"* expressed a doula.

> "Pharmacies are hesitant to fill prescriptions for buprenorphine. The addiction specialist OBs are physically going with patients to the pharmacy to get them to get their MAT [Medication Assisted Treatment] prescription."
>
> – Domain Listening Session Participant

Substance Use and Mental Health: Community input participants expressed concerns about a variety of aspects of substance use, but primarily the system of screening, referrals, and treatment. Barriers to screening included medical providers and patients not bringing up substance use because of stigma, a lack of provider-patient trust, lack of provider training, or lack of provider knowledge on where to refer women wanting or needing substance use help. Participants described the lack of screening leading to challenges in referring women to appropriate treatment and then subsequently receiving treatment.

Providers shared that they struggle to help patients access substance use and mental health services, particularly if their pregnancy is covered by Medicaid. Appointments are "*months and months out causing stress to OBs and their patients*," noted a key informant.

Doctors specializing in providing maternity care to women using substances noted that because providers are not screening for substance use, women are not accessing medications or recovery supports, leading to more newborns experiencing withdrawal and neonatal abstinence syndrome.

"*People don't even go in for prenatal care. A lot are living in unhealthy situations, in poverty, domestic violence, drug use. They're terrified to even engage in the system for their own health care. The only way we're going to be able to help them is if we can get them in. How can we remove the fear that women may be experiencing?"* expressed another key informant.

Participants expressed there is an overall lack of mental health or emotional support for women and moms. Home visiting programs were brought up as both an issue and a solution to addressing substance use and mental health, including helping women navigate the health care and social services systems. Participants shared that while home visiting programs are designed to support moms, potential and eligible families have difficulty accessing or knowing about home visiting programs. Needs assessment participants shared that Nevada home visiting programs have low participation rates.

> "Home visiting programs are underutilized, less than 1% are served. It should be expanded and investigated how to support home visiting with Medicaid and build infrastructure."
>
> – Key Informant

Community Health Factors: All participants brought up issues impacting health and well-being broadly, including the lack of transportation, economic and job instability, quality affordable childcare, paid parental leave, and affordable housing.

> "So much of the issues go hand-in-hand. Addressing transportation as an access issue won't help if you don't have doctors."
>
> – Key Informant

While maternal health outcomes were discussed as being poor, the main issue brought up as a barrier to healthy outcomes for all women was geography. Participants across all community input sessions expressed that women in rural and frontier areas of Nevada were more likely to struggle across all social need areas and have poorer outcomes and opportunities.

Participants also highlighted the uncoordinated care and silos impacting services for women traveling from rural areas to urban areas for specialty care.

Violence: It is important to note that while violence was not a topic that emerged consistently, key informants working in this field and focus group participants highlighted the impacts domestic violence, sex work, sex tourism, trafficking, and sexual violence have on Nevadans. This topic is particularly important since Nevada ranks second in the nation for women experiencing domestic violence, with estimates that nearly 44% of Nevadan women will experience domestic violence in their lifetime.[4] *"It's not feasible to provide for your children here [in rural areas]. People are going into debt just to keep a roof over their heads. Women are stranded and isolated out here without any supports. It drives domestic violence victims back into the hands of their perpetrator because they can't survive,"* explained a key informant about the ongoing cycle of domestic violence.

Exhibit 5 describes the priorities identified in each needs assessment activity for the Women and Maternal Health domain and the cumulative top priority needs.

Exhibit 5. Women and Maternal Health Priorities by Needs Assessment Activity

Cumulative Top 5 Women and Maternal Health Key Priority Needs[5]

Knowledge of available resources in the community
Mental health services/Substance use
Access to more prenatal and maternal health services
Community health factors
Access to preventive health services

Needs Assessment Activity	Key Priority Needs
Domain Listening Sessions	Access to prenatal care Substance use Access to preventive health services Knowledge of available resources in the community
Community listening Sessions	Mental health services Community health factors Knowledge of available resources in the community Daycare options

[4] Domestic Violence by State 2025
[5] The key priority needs listed reflect the verbatim priorities that emerged from the qualitative analysis and were presented in this way to priority setting participants for voting.

Needs Assessment Activity	Key Priority Needs
	Sexual and reproductive health
Focus Groups	Access to culturally competent care Access to healthcare providers and specialists Access to support networks
Key Informant Interviews	Increase workforce Increase outreach and knowledge of services and programs Community health factors Substance use Mental health services
MCH Survey Non-Professional Respondents	Not knowing about available community resources Need for more prenatal and maternal health services Need for more preventative services
MCH Survey Professional Respondents	Need for more prenatal and maternal health services Not knowing about available community resources Need for mental health services

Perinatal and Infant Health

Epidemiological Data Summary

Infant Health: Infant health data showed mixed outcomes with some indicators of infant health improving and others declining. The **infant mortality** rate in Nevada for 2022 was 4.49 (per 1,000 live births), below the national rate of 5.6. However, infant deaths due to **SUID** (sudden unexplained infant death) was 101.1 (per 100,000 live births) compared to the national rate of 92.5 in 2022. The **perinatal mortality rate** in Nevada increased from 5.9 (per 1,000 live births plus fetal deaths) in 2018 to 6.4 in 2021. The **preterm birth rate** in Nevada in 2018 was 10.1 and increased to 11.1 in 2023. About 8% of babies were born **low birth weight** (<2500g) in Nevada based on 2023 data, a decrease from 8.7% in 2018 and below the national estimate of 8.6%. Scores on the **USCDC Maternity Practices in Infant Nutrition and Care (mPINC)** survey for Nevada infants increased from 72 in 2020 to 79 in 2022, slightly below the national average of 81.

Safe Sleep: There were slight changes in data related to safe sleep from 2020 to 2022. Nevada PRAMS showed a slight decrease in the percent of infants **placed to sleep on their back** (75.6% in 2020 to 75.1% in 2022) and infants **placed alone on approved surfaces** (33.2% in 2020 to 31.4% in 2022). There was an increase in the percent of infants laid to sleep in high-risk sleep positions and/or environment (78.0% in 2022 to 79.6% in 2022) but also an increase in the percentage of infants sleeping without soft bedding (39.5% in 2020 to 45.9% in 2022).[3]

Pregnant Women's Health: Compared to national estimates, pregnant women in Nevada had a higher rate of gestational diabetes and gestational hypertension. Based on National Vital Statistics reporting, the rate of **gestational diabetes** per 1,000 live births in Nevada increased from 6.5 in 2016 to 8.0 in 2020. The national estimate for gestational diabetes in 2020 was 7.8. Based on Nevada PRAMS data, rate of **gestational hypertension** in Nevada of 85.8 per 1,000 live births was below the national average of 95.2 in 2023.

Breastfeeding: Data showed a decline in breastfeeding with women reporting multiple reasons why they stopped breastfeeding. The National Immunization Survey-Child Health showed a decline in the percent of Nevada women who reported **initiating breastfeeding** (83.4% in 2018 to 79.3% in 2021) and **exclusively breastfeeding through 6 months** (28.0% in 2018 to 26.1% in 2021). The top reasons women reported for stopping breastfeeding in the 2022 Nevada PRAMS survey included they thought they were not producing enough milk (29%), their baby had difficulty latching or nursing (16.9%), breast milk alone did not satisfy their baby (11.8%), they had too many household duties (11.2%), and they felt it was the right time to stop breastfeeding (10.3%).

Maternal Substance Use: Infants born with **Neonatal Abstinence Syndrome** (NAS) has decreased in recent years. Based on data from the Healthcare Cost and Utilization Project, the rate of infants born with NAS decreased from 7.6 (per 1,000 live births) in 2018 to 5.7 in 2020, below the national estimate of 6.2 in 2020.

Community Input Findings

Access to Care: The struggles Nevadans shared about accessing perinatal and infant care vary—including a lack of providers, a lack of clinics, a lack of clinic offerings that meet the needs of clients, and a lack of community knowledge about services available. Needs assessment participants described issues relating to all of these.

- *Workforce:* A lack of medical workforce in Nevada impacts parents' ability to find pediatricians and medical providers for their infants. One participant suggested increasing "*community or college programming to attract these individuals*." Other participants suggested creation of incentive programs to encourage medical providers to come to Nevada. Participants suggested investing more in doulas, community health workers, and midwives to help bridge gaps in both workforce and available locations and hours of service. Access to care also extended to breastfeeding support, with participants across needs assessment activities highlighting a lack of breastfeeding education and support for moms and babies. Alongside the need for providers, participants brought up the lack of enrollment in Medicaid (a potential barrier to accessing care) and awareness of programs that might help families access care financially.

> "There's a problem, because the children we work with are in foster care, so we are able to access care for the babies. But for their parents, it is so much harder.... How do moms get services?"
>
> – Key Informant

- *Community Health Factors:* Consistently, needs assessment participants brought up isolation, lack of housing, substance use, few resources, lack of health insurance, and difficulty accessing existing resources as critical factors impacting infants and their families. *"[Getting] to appointments is a challenge on a bus in hot weather [even] if you can afford it. [People are] making decisions between food or transportation cost. People may need to walk which is extremely challenging."* While providers might be adequate in urban areas, *"in the rurals and frontier, that doesn't hold true,"* explained a medical provider. *"Even if your clinic is following minimal best practice, care for women with high need perinatal care may still be extremely inadequate."* A comprehensive system was brought up as both an issue and a solution across the needs assessment. "*If we could move things upstream, if we could get a comprehensive team to get involved sooner, we'd reach more people and engage more people,"* said another key informant. Without health care coverage, stakeholders reported that many Nevadans lack the financial resources to pay for care.
- *Appropriate Care:* While needs assessment participants called out a system that is not cohesive, they also said families are unable to access what they need because they don't know the

services exist. *"We have to change the system. We need to get people into the whole system and get everyone to talk because right now the onus is on the person getting the services,"* explained a key informant. This may be especially difficult for pregnant women and new mothers who do not speak English or do not understand the United States' system of care. *"[Providers] need understanding to work with these populations,"* highlighted one key informant.

> "When the systems work in silos, they think if a child has a need, we're focused on the infant, but it's dependent on the mother. [Babies] are dependent on their caregiver—that relational work is missed—people see it as an either or instead of an and—we need to focus on both."
>
> – Key Informant

- *Cyclical Barriers:* Lack of access to perinatal care persists as difficulty accessing pediatric care. In the words of another key informant, "*pediatric clinics have seen a severe decline in pediatric visits in their first year."* While Nevada has done a good job increasing access to health care coverage during pregnancy, providers expressed concerns that "*pregnancy may be the only opportunity that person has to engage with the healthcare system because they don't have the resources. Improving healthcare after pregnancy can be a challenge."*

> "Four out of five of my most recent cases of maternal mortality were suicide or overdose."
>
> – Key Informant

Substance Use and Mental Health: Across all community data collection activities, postpartum mental health and substance use supports for new moms and babies were a major concern. Participants highlighted that substance use and mental health treatment are critical components to the health of not only pregnant women, but postpartum moms and new babies. *"Other issues are not even close to the mental health and substance use needs,"* expressed a key informant.

Access to care and appropriate care extend to substance use and mental health. *"There's not enough mental health providers or group therapy that is community based where people can be together without stigma,"* said one key informant.

Community input session participants also shared that "*overdose risk is higher in postpartum period than during pregnancy,"* emphasizing that screening is important not only during prenatal care but during postpartum.

Exhibit 6. Perinatal and Infant Priorities by Data Source

Cumulative Top 5 Perinatal and Infant Health Key Priority Needs[6]

Need for affordable childcare
Knowledge of available resources in the community
Maternal substance use during and after pregnancy
Need for mental health services
Breastfeeding support

[6] The key priority needs listed reflect the verbatim priorities that emerged from the qualitative analysis and were presented in this way to priority setting participants for voting.

Needs Assessment Activity	Key Priority Needs
Domain Listening Sessions	Childcare for infants Breastfeeding support Mental health services
Community Listening Sessions	Knowledge of available resources in the community Community health factors Access to healthcare services and providers Mental health services Breastfeeding support Childcare and daycare options Substance use
Focus Groups	Access to healthcare services and providers Interpretation services Outreach and knowledge of services Mental health services
Key Informant Interviews	Increase outreach and knowledge of services and programs Substance use Increase workforce Community health factors Mental health
MCH Survey—Non-professional Respondents	Need for affordable childcare Need for breastfeeding support Maternal substance use during and after pregnancy
MCH Survey—Professional Respondents	Need for affordable childcare Maternal substance use during and after pregnancy Need for mental health services

Child Health

Epidemiological Data Summary

Child Mortality: The **child mortality** rate in Nevada has increased in recent years to 19.9 in 2022, from 13.1 in 2020.

Physical Health/Physical Activity: Child health data found an increase in children who are overweight or obese and a decrease in physical activity and immunization rates. The National Survey of Children's Health showed the percentage of Nevada children who are **overweight or obese** has increased from 32.1% from 2019–2020 to 34.6% from 2022–2023. Also, the percentage of Nevada children who are **physically active at least 60 minutes every day** decreased during this time from 14.6% from 2019–2020 to 13.3% from 2022–2023. Almost 90 percent of parents completing the National Survey of Children's Health reported their children in excellent or good health from 2022–2023.The percentage of **children fully vaccinated** by 35 months decreased from 70.0% in 2018 to 60.4% in 2021. Literature from the environmental scan also found that physical health is a challenge among Nevada children.

Community Factors that Impact Health: Children in Nevada experienced **food and housing insecurity** at a higher rate than children in the United States overall, based on Feeding America data. Data collected through Feeding America estimates that about 20.9% of children in Nevada experienced **food insecurity** in 2022 (compared to 18.5% for the United States). This estimate has increased from 19.5% of Nevada children in 2018. The National Survey of Children's Health data estimates about 18.8% of Nevada children experienced housing instability in 2022, compared to the U.S. estimate of 17.0% overall. The percent of children who experienced 2 or more **Adverse Childhood Experiences (ACEs)** has increased in Nevada from 18.1% in 2019–2020 to 19.4% in 2022–2023. These percentages are above the national estimate for 2022–2023 of 17.5% of children who experienced two or more ACEs. About 18.8% of Nevada children experienced **housing instability** in 2022, compared to the U.S. estimate of 17.0% overall.

Education: Based on KIDS COUNT 2018–2022 data, 67% of young children (aged 3 and 4 years) in Nevada are not in **pre-school**. This estimate has increased from the 2013–2017 data estimate of 64%. The National Survey of Children's Health Survey estimates that 86.7% of Nevada children aged 3–5 met the criteria for **school readiness**. There has been an increase in the estimated percentage of children aged 0–5 whose **parent/caregiver read to their children every day** from 29.5% from 2019–2020 to 32.9% from 2022–2023.

Access to Care: According to National Survey of Child Health data, approximately 35% of non-CSHCN (children with special healthcare needs) have a **medical home**. About 71.4% of Nevada children have had a **preventive medical care visit** in the past year and 75.4% a **preventive dental visit**. A little over one-third of Nevada parents reported their children had a **personal doctor or nurse**. A large decrease occurred in **developmental screening** for children aged 9–35 months with 23.8% based on 2022–2023 data compared with 36.9% of children receiving screening based on 2019–2020 data. Literature from the environmental scan cites that data from the Division of Public Health and Behavioral Health State Improvement Plan (2023) and Data Resource Center for Child and Adolescent Health (2022-2023) shows that lack of access to adequate care (i.e., access to usual source of sick care, coordinated, ongoing, comprehensive care, adequate number of pediatricians for children in the state) is a substantial challenge among children in Nevada.

Community Input Findings

> "Proximity is more than just a mileage distance."
>
> – Domain Listening Session Participant

Access to Care: Participants across primary data collection activities were in agreement that access to care and services is a need that impacts nearly all aspects of child health. Participants discussed that "*not every community has all the resources they need*" leaving some areas in Nevada without care or services which can lead to isolation and mental health struggles for families. Community participants identified issues with family access to well child visits as well as to other services needed for healthy growth and development, including childcare. Stakeholders discussed vaccination and the impact of lack of access to care on vaccination rates, as well as parent education about vaccines. With fewer providers and difficulty getting appointments, participants noted that parents are also missing out on opportunities to discuss issues such as development, nutrition, physical activity, and safety with medical providers.

Community Health Factors: When it comes to supporting children, Nevadan community members agreed it starts with supporting their families and communities. Stakeholders emphasized the importance of focusing on family interventions, including in schools, communities, and with childcare providers. Participants highlighted a need for a **"*third space*"** outside of school or work, and home—the concept of an outdoor and/or community space. This also was discussed in terms of its impact on mental health and safety—having a "third space" has a positive impact on communities and overall outcomes, not having it can contribute to poorer outcomes. Participants also included isolation and **mental health** as important components of health and well-being impacted by the communities in which families live, with participants calling for more parental support.

Food, Nutrition, and Physical Activity: Community input session participants brought up **food deserts** and the lack of **access to affordable and health food** for families and children as key issues to child health. Alongside a lack of ability to access nutritious food, needs assessment participants highlighted **a lack of information** on healthy eating or nutrition and physical activity. Participants also discussed **parent education** across a wide range of child health topics, noting that families need and want to know more about how to care for their children. An extension of breastfeeding support highlighted during discussions of previous domains, participants expressed a lack of education and support in general for feeding children from newborns to teenagers.

Screen Time: Needs assessment participants brought up the issue of **"screen time,"** saying that children have too much access to and spend too much time on electronic devices. Participants shared that parents need education about screentime, too. And that when there is a lack of community, childcare, after school programming, and a safe "third space," screens fill in the gaps, to the detriment of Nevada's children.

Exhibit 7. Child Health Priorities by Community Input Activity

Cumulative Top 5 Child Health Key Priority Needs[7]

Physical health/physical activity
Social media, technology, and screen time
Community health factors
Access to safe and healthy food options
After school and childcare options

Community Input Activity	Key Priority Needs
Domain Listening Sessions	Access to care Age-appropriate health literacy Caregiver-centered mental health Relationship focused, trauma-informed health services Access to safe and healthy food options
Community Listening Sessions	Physical health After school and childcare options Community health factors Violence and abuse Mental health services
Focus Groups	Community health factors Social media, technology, and screen time Physical health School, afterschool, and daycare activities
Key Informant Interviews	Knowledge of available resources in the community Community health factors Mental health Childcare services

[7] The key priority needs listed reflect the verbatim priorities that emerged from the qualitative analysis and were presented in this way to priority setting participants for voting.

Community Input Activity	Key Priority Needs
	Early intervention and developmental services
MCH Survey Non-professional Respondents	Overuse of screen time Lack of physical activity Lack of healthy food options
MCH Survey Professional Respondents	Overuse of screen time Lack of access to healthy foods Lack of physical activity

Adolescent Health

Epidemiological Data Summary

Sexual and Reproductive Health: Data on adolescents found that teen birth rates were higher in Nevada than nationwide while the use of condoms and HPV vaccination increased. Nevada had the same teen birth rate as the U.S. average in 2023 (13 per 1,000 females aged 15–19). But the repeat teen birth rate in Nevada for 2023 was 14%, compared to the U.S. estimate of 2%. Adolescents who are sexually active who use **condoms** increased from 49.3% in 2021 to 53.3% in 2023. But there was a decrease in sexually active adolescents reporting use of **other contraceptives** such as birth control pills, IUD, shot, patch, or ring from 30.0% in 2021 to 20.8% in 2023. Based on YRBS data, there has been an increase in the percentage of adolescents (aged 13–17) who received at least one dose of the **HPV vaccine** from 66.0% in 2018 to 76.1% in 2021.

Mental Health/Community Support: Nevada adolescents reported a high rate of feeling sad and hopeless but lower rates of supports including feeling close to others and receiving treatment for mental health disorders. When compared to U.S. estimates (28.5%), YRBS show a higher percentage of Nevadan adolescents (42.4%) reported **feeling sad or hopeless.** A smaller percentage of Nevadan adolescents also reported **feeling close to people at their school** compared to nationwide (35.8% vs 55.3%) and **talking to their parents or other adults** about their problems (23.7% vs 84.0%). Additionally, the proportion of **suicide deaths** among adolescents in Nevada is estimated at 15.1%, compared to the U.S. estimate of 10.6%. For adolescents with mental health disorders in Nevada, only 10.4% received treatment in 2023. This is compared to the national estimate of 17.2% of adolescents with **mental health disorders receiving treatment.** Findings from the environmental scan found, that Nevada ranks last among the 50 states and the District of Columbia in overall youth mental health rankings for 2015, 2020, 2021, and 2022 (Thymianos, et al, 2022). Additionally, data from the Department of Health and Human Services, Bureau of Behavioral Health Wellness and Prevention (2022) found that high school and middle school students report feeling sad or hopeless at the highest rate they have been since 2017. Data from America's Health Rankings in 2020—2022 ranked Nevada as 37th in the nation for teen suicide with 15 deaths due to intentional self-harm per 100,000 adolescents aged 15–19. A Nevada Middle School Youth Risk Behavior Survey Comparison Report from 2019–2021 found that there was an increase in middle schoolers who were bullied electronically from 12% in 2019 to 18% in 2021.

***Substance Use*:** Epidemiologic findings regarding adolescent substance use are varied. Based on YRBS data, there was a decrease in Nevadan adolescent substance use from 2021 to 2023. Use of **alcohol** decreased from 19.4% to 17.6%, **cigarettes** from 3.4% to 2.8%, **nicotine electronic vapor** products from 15.0% to 13.2%, and **marijuana** electronic vapor products from 16.1% to 14.8%. The Nevada 2023 estimates are all below national U.S. estimate for the same year. Findings from the environmental scan found that substance use is a significant challenge among adolescents in Nevada. According to Thymianos, et al, 2022, 6% of youth in Nevada reported a substance use disorder in the past year. Additionally, data from the Department of Health and Human Services, Bureau of Behavioral Health Wellness and Prevention, 2022 found that alcohol use disorder among youth aged 12 and above reached a high in Nevada in 2021 despite high school and middle school students reporting lower use of alcohol or marijuana use.

Community Input Findings

Sexual and Reproductive Health: Participants shared concerns that adolescents may not have equal access to information depending on where they live in Nevada. Participants shared that **sexually transmitted infections (STIs)** in Nevada are high and *"there seems to be a belief that it's okay because they can be treated. Prevention doesn't seem to be a thing. We need to emphasize the dramatic need for prevention and the potential long-term effects of STIs."* Participants discussed the need for **evidence-based comprehensive sex education**, with participants emphasizing that adolescents don't know where to access accurate information that covers the broad spectrum of sexual and reproductive health. Participants shared the need for education on body autonomy, healthy relationships, and consent. Across needs assessment activities, participants shared the impact that misinformation has on the adolescent population in particular. Schools and community groups need to cover education about sexual and reproductive health as well as information about grooming, sexting, harassment, abuse, social media, and trafficking. Key informants also brought up teen dating violence and a lack of adult knowledge of this issue.

> "Sexual risk is influenced by reading level. Information needs to accommodate low adolescent reading levels. And parents struggle to understand sexual health information, too."
>
> – Community Input Session Participant

> "There are lots of broken people. We need to catch them young, and give them the opportunity to thrive."
>
> – Key Informant

Substance Use and Mental Health: Across needs assessment activities, participants shared that adolescents are impacted by substance use and mental health in a variety of ways—both as an ACE experience in their home, their own use of substances, and their own mental health struggles. Participants brought up issues such as body image, suicidal ideation, bullying, and a lack of adult mentors or parental supports. Participants raised the issue of the need for **emotional support resources** within and outside of the school setting and how mental health and substance use are intertwined with other issues such as access to physical activity and extracurricular opportunities. Participants also discussed newer issues such as the ability for people (including adolescents) to buy **drugs online**.

Participants brought up a lack of **resources for parents** in dealing with adolescent needs, especially substance use and mental health. "*Parents are trying to keep children safe, but don't want them on the streets,"* shared a key informant. Another key informant suggested more **mental health providers** and **group therapy options** in schools. This was also suggested as a way to mitigate rural-urban county differences in services available. Schools could also be a place to help middle and high school students learn about risks that can lead to substance use, mental health challenges, sexual violence, and more. *"We need to support children in protecting*

> "In smaller counties, the need for support services is greater."
>
> – Key Informant

themselves and having more control of their rights," stated a key informant. Focus group participants shared struggling to find appropriate services for their adolescent children who are using drugs and coping with their own experiences of domestic violence in the home, when dealing with stigma, language barriers, and navigational challenges.

ACEs: Adolescence is a unique time when many factors considered to be ACEs may be culminating. Needs assessment participants shared that parents need support to address cycles of violence in their home and that adolescent mental health needs are greatly impacted by experiences in their homes. Key informants shared the need for more comprehensive and cohesive methods to reach adolescents struggling with multiple ACEs. Communities need *"wrap-around services, not just social work, but food and coat drives, bringing back universal free lunch, extending services, not just in schools. If you have kids not eating, not sleeping, having to work, so now they're not doing their schoolwork because they're working—wraparound services need to be for everyone. We're ignoring a lot of the at-risk kids."* Needs assessment participants also shared a need to better fund and support the training of those providing the **whole system of supports for children and adolescents**—law enforcement, education, social services, etc. Other key informants brought up that some adolescents are trying to navigate systems themselves, systems that are difficult even for adults to navigate. *"If services are being pulled back or some groups are no longer able to access resources, teenagers are going to be in a bad place because of the issues compounding across all the other areas."* The issue of high rates of **teen suicides** and **teen pregnancy** also came up as issues across the needs assessment activities. Multiple participants shared concerns about **online bullying** and its potential links to suicide. Participants highlighted the need for schools to be well-funded with sufficient staff who are also well-trained to work with adolescents. A parallel to this was the need for healthcare to meet adolescents "where they are at" to help promote life-long health care utilization. Needs assessment participants shared that teens also do not know of safe places to go for their health care or how to access services. Participants also noted a lack of workforce necessary to support adolescent health. Parents also need basic education and there is "*stigma of parents asking for help. Parents are typically going to social media for information*," shared a key informant parent.

Exhibit 8. Adolescent Health Priorities by Community Input Activity

Cumulative Top 5 Adolescent Health Key Priority Needs[8]

Need for services and resources around sexual and reproductive health
ACEs
Mental health services
Access to educational opportunities and resources
Social media and cyber bullying

Community Input Activity	Key Priority Needs
Domain Listening Sessions	Health literacy and reading levels Transition care Sexual and reproductive health ACEs Social media and cyber bullying

[8] The key priority needs listed reflect the verbatim priorities that emerged from the qualitative analysis and were presented in this way to priority setting participants for voting.

Community Input Activity	Key Priority Needs
Community Listening Sessions	Mental health services Sexual and reproductive health Educational resources Substance use Physical health Technology and social media
Focus Groups	Access to educational opportunities Substance use
Key Informant Interviews	Mental health Sexual and reproductive health services Violence and safety Knowledge of available resources in the community Substance use
MCH Survey Non-professional Respondents	Need for services and resources around sexual and reproductive health Cyberbullying ACEs
MCH Survey Professional Respondents	Need for services and resources around sexual and reproductive health ACEs Cyberbullying

CYSHCN

Epidemiological Data Summary

Access to Care: There was a decrease in multiple variables related to access to care for CYSHCN from 2020 to 2023. Based on National Survey of Children's Health data, in 2023, less than half (49.7%) of CYSHCN had **adequate and continuous insurance coverage** a decrease from 56.5% in 2020. The U.S. estimate for CYSHCN having continuous and adequate insurance coverage in 2023 was 61.4%. The percentage of CYSHCN that had a **medical home** decreased to 25.8% in 2023 from 38.4% in 2020. This is compared to the U.S. 2023 estimate of 39.7% of CYSHCN reporting they have a medical home. There has also been a decrease in the percentage of CYSHCN that reported receiving **family-centered care**, from 77.5% in 2020 to 65.2% in 2023. This is compared to the U.S. estimate for 2023 of 81.6% of CYSHCN receiving family-centered care. Data did indicate about a 3% increase in the percentage of Nevada CYSHCN who received **services to prepare for the transition to adult health care** from 8.6% in 2020 to 11.3% in 2023. The literature included in the environmental scan also found that access to a medical home remains a focus nationally and in Nevada for CYSHCN. According to the 2022-2023 NSCH, 25.8% of Nevada's CYSHCN population have care in what is considered a medical home which is significantly less than the national average of 39.7%. The overall percentage of CYSHCN in Nevada slightly increased from 15.4% (about 106,445 children or youth) in 2020 to 16.3% (about 113,245 children or youth).

Mental Health: Indicators related to mental health for CYSHCN showed an increase from 2020 to 2023. Data from the National Children's Health Survey indicates an increase in Nevada CYSHCN who have experienced two or more **ACEs** from 32.7% in 2020 to 37.4% in 2023. Additionally, Nevada CYSHCN who reported being **bullied almost every day** increased from 5.4% in 2020 to 7.7% in 2023.

Community Input Findings

Access to Care: Participants described a system full of struggles. The first struggle is to identify children early, the second is to provide services in a timely way to children who are identified (i.e. with autism), and the third is to help families access specialty care. The system also struggles to support the transition to adult health care services.

Navigation, Coordination, and Referrals: Participants suggested a need for support in **navigating systems**, accessing community services easily, and the difficulties in accessing **specialty services**—both medical specialties and behavioral therapies (i.e. for autism, developmental delay, or neurodivergence). Participants described families of CYSHCN struggling to pay for health care, unable to access transportation, struggling to advocate for their children's care, as well as a lack of paid family caregivers, and difficult transitions between early intervention (IDEA Part C) and special education (IDEA Part B).

Providers, advocates, and parents described a need for improved coordination and referral systems statewide and the impact that this fragmented system has on children and families. This includes medical and educational supports. These issues translate into a lack of services and challenges in accessing the services CYSHCN need.

Educational Services: Access to care issues extended to school and educational services as a particular concern for CYSHCN and their families. Participants shared concerns about "protecting people's rights so 504 [accommodations] and IEPs [individualized education plans] are protected." Another key informant and parent of CYSHCN said, "We need to be better in working on our IEPs and 504s. It is a fight. The amount of work parents do… We shouldn't have to fight so hard." Another key informant shared that CYSHCN should be able to access "prosocial skills, preventive education, resiliency." This may also include access to sexual and reproductive safety, education, and support tailored to the unique needs of CYSHCN.

> "It starts with access—getting into the system. Then once you are in the system, it's navigating the system. Once you figure out where to start, you don't know where to go next. You need an advocate or some kind of support to navigate the system."
>
> – Domain Listening Session Participant

Economic Barriers: Access to care is also impacted by economic barriers and cyclically the economic burden of caring for CYSHCN impacts a family's ability to access care. Caring for CYSHCN impacts a family's economic stability, a parent's ability to work, and their ability to provide and care for all their children. "For families who have no resources, how are they going to access what they need?" expressed a key informant and parent of CYSHCN. Another access to care issue described during the needs assessment was a lack of childcare providers skilled and willing to accept CYSHCN. This in turn impacts a family's ability to work and contributes to economic instability because there is no one to care for their CYSHCN.

Appropriate Care: Medically, key informants shared that CYSHCN may be "sent out of state for care." Participants described the need for health insurance or other funds to cover not only travel, but room and board, when families must access specialty care that is only available in a location a great distance from their home. A new children's hospital opening in Nevada may be able to serve more families in the state, potentially improving access to care.

"Parents shouldn't have to carry 10 plus years' worth of their child's records when going to see a new doctor."

– Domain Listening Session Participant

Families discussed the need for respectful care, culturally and linguistically appropriate care, and workforce development. "We need more training opportunities for providers. They don't have the medical home model because there aren't enough people to create it. We need a collection of providers who are communicating with each other to support the family," said one key informant. Key informants described "a huge gap in specialist care in neurology, ENT, dermatology, genetics, developmental needs. Nevada struggles to recruit and keep providers, which ties into Medicaid reimbursement. In southern Nevada, there is only one neurosurgeon." Health care key informants also said that "changes to managed care are going to affect children with disabilities. These children will not be included and thus would have to do fee for service care."

Key informants also described the added complexity of assuring CYSHCN have access to safety supports and trauma-informed care. For example, if a family is experiencing domestic violence, families may be even more likely to stay in a potentially dangerous or unsafe situation because "*Shelters are not great spaces especially for children with special needs*," shared a key informant.

Mental Health: Families described inaccessible spaces and opportunities for CYSHCN, an added layer and barrier to the issues impacting children and adolescents without special needs. While there is a shortage of wraparound care, extracurricular activities, and social-emotional supports for all Nevadan youth, CYSHCN are at an even greater disadvantage because there are not programs that can accommodate them. Participants also discussed the need for CYSHCN to receive **mental, social-emotional, and behavioral health** in alternate methods—including group settings, peer to peer, and telehealth. Community Input Session participants also described a need for more in-home services for CYSHCN to address social-emotional, behavioral, and mental health needs. Domain Listening Session participants shared that the high costs associated with mental health, stigma in discussing mental health needs, and providers not wanting to take Medicaid or Medicaid denying coverage of mental health services are all detrimentally impacting the health and well-being of CYSHCN and their families.

Not only are CYSHCN themselves struggling to access mental health supports, but their families need **caregivers support**, too. Families described a lack of respite care providers, difficulty in paying for care from family members, a lack of in-home providers and payment systems for in-home providers to maintain the workforce, and the extra mental health needs siblings and parents of CYSHCN have. Families need "*meaningful respite*," shared a Community Input Session participant. *"[We need to] institute practices that support comprehensive care."*

Families described limited options and a lack of system or community opportunities. "*We need more sensory-friendly family outings and bonding activities,*" described a Community Input Session participant. This also impacts mental health for CYSHCN and their families. Domain Listening Session participants shared the need for tailored activities for CYSHCN to support family bonding.

A key informant shared that “state **Medicaid** has started a big initiative around expanding access to services, reducing the number of children who are placed in out-of-home and state residential treatment. There is strong opportunity for partnership and collaboration to move this work forward.”

Exhibit 9. CYSHCN Priorities by Community Input Activity

Cumulative Top 5 CYSHCN Key Priority Needs[9]

Access to appropriate services including specialists and early screening and interventions
Need for caregiver support/navigation
Need to increase workforce
Need for affordable health insurance
Mental health services

Community Input Activity	Key Priority Needs
Domain Listening Sessions	Access to appropriate services Insurance and affordability Workforce Caregiver support/navigation Care coordination and transition
Community Listening Sessions	Access to specialty services and providers Workforce Mental health services Respite and foster support Early screening and intervention Community health factors
Focus Groups	Early screening and intervention
Key Informant Interviews	Increase workforce Access to Care Mental health services Caregiver support
MCH Survey Non-professional Respondents	Need for caregiver support Need for access to specialists Need for affordable health insurance
MCH Survey Professional Respondents	Need for caregiver support Need for access to specialists Need for more coordination between health care providers

[9] The key priority needs listed reflect the verbatim priorities that emerged from the qualitative analysis and were presented in this way to priority setting participants for voting.

Priority Needs, Action Plans, and Title V Capacity

Priority Needs Finalization

MCAH staff, partners, participants in previous needs assessment activities, and identified stakeholders unable to participate in the other primary data collection opportunities were all invited to participate in the Priority Setting Meeting held in-person in Reno and virtually on April 17, 2025. Nearly 60 participants, both in-person and virtually, contributed to the priority setting. The priority setting meeting gave Nevadans the opportunity to review the top priorities identified through the primary data collection activities, as well as the epidemiological data associated with the identified domain areas, and to discuss if the identified priorities were representative of their cumulative knowledge of each domain. The following community and organization representatives participated in the Priority Setting Meeting.

Exhibit 10. Priority Setting Meeting Participants/Organizations

- Autism Treatment Assistance Program
- Carson City Health and Human Services
- Carson Tahoe Health
- Carson Tahoe Medical Center
- Children's Advocacy Alliance
- Community Health Alliance
- City of Henderson
- Department of Children and Families
- Early Hearing Detection and Intervention Program
- Eddy House
- Family Navigation Network
- Future Smiles
- Helping Hands of Vegas Valley
- MCAH
- Molina Health
- Nevada Association of Counties
- Nevada Coalition to End Domestic and Sexual Violence
- Nevada Center for Excellence in Disabilities
- Nevada Department of Behavioral and Public Health (DBPH), Office of State Epidemiology
- Nevada DBPH, Public Health Infrastructure and Improvement
- Nevada Department of Education
- Nevada Department of Health and Human Services, Division of Health Care Financing and Policy
- Nevada Division of Emergency Management
- Nevada Health Centers
- Nevada Hospital Association
- Nevada Minority Health and Equity Coalition
- Nevada State Immunization Program
- Northern Nevada Hopes
- Parents and Community Members
- The Children's Cabinet
- University of Nevada Las Vegas (UNLV)
- UNLV School of Medicine
- UNLV School of Nursing
- UNLV School of Public Health
- Northern Nevada Public Health
- WIC

Altarum developed an agenda and several documents to support attendees in discussing and ranking priorities. All attendees were briefed on the process and findings of the needs assessment before breaking into groups by domain. Each group had a packet of materials including:

1) the cumulative top priorities and the top priorities by each needs assessment community input activity, 2) the current Title V national performance measures, 3) domain-specific summaries of epidemiological data and 4) a priority ranking tool (see below) allowing participants to use a set of criteria to rank potential priorities.

Working in small groups representing each of the five Domains, a facilitator used these tools to guide the group through the priority ranking process by individually assigning a score for each priority area (priority rating criteria are shown below). A notetaker was also present in each group to document group discussions and rationale. Participants were not trying to come to any consensus in their scoring but rather to offer their voice and expertise to the rating process. The final scores across each criterion were tallied and averaged and the final scores were presented back to the whole group. Exhibit 11 provides the priority rating criteria used.

Exhibit 11. Priority Rating Criteria

Criterion	Definition	Rating Scale
Prevalence/ Magnitude	This criterion measures whether this is a substantial problem and whether it has a significant impact on the health and well-being of MCH populations in Nevada.	1= This is not a significant problem or it does not affect very many people 2= This problem affects a small population significantly 3= This problem affects a moderate number of people 4= This problem affects a significant population in certain areas 5= This is a significant, widespread problem
Trend	This criterion considers whether a problem is increasing in magnitude or severity, whether the rate is stable, or whether it may be decreasing.	1= The problem has improved substantially 2= The problem has improved slightly 3= The problem has remained stable 4= The problem has gotten slightly worse 5= The problem has gotten substantially worse
Impact Across the Lifespan	Problem at one life stage has long-term impact in later life and/or problem is a proxy for a set of other related behavioral or social problems.	1= Problem limited to one life stage and is not associated with other problems 2= Problem minimally impacts entire life course and is associated with multiple problems 3= Problem moderately impacts entire life course and is associated with multiple problems 4= Problem severely affects either entire life course or is associated with multiple problems 5= Problem severely impacts entire life course and is associated with multiple problems
Evidence-Based Interventions	This criterion addresses whether there are practical, evidence-based interventions to address the problem which can be implemented by MCAH or its partners.	1= No interventions to address this problem have been implemented or evaluated, or interventions have been shown to be ineffective 2= Interventions exist, but there is no evidence of their effectiveness 3= The evidence on the effectiveness of interventions is mixed 4= There is some evidence of the effectiveness of interventions 5= Well-established evidence-based interventions exist to address this problem

Criterion	Definition	Rating Scale
Health Outcomes	This criterion addresses whether the problem disproportionately affects some people or contributes to disparities in health status for all people. This is intended to address issues that may not appear to have a large prevalence in the population as a whole, but have a substantial impact on others.	1= The problem affects all groups equally 2= Some subgroups may bear the burden of this problem (differences are not statistically significant) 3= One group is significantly overrepresented on this issue 4= Specific subgroups bear the burden of this problem (differences are statistically significant) 5= There are large, statistically significant differences between groups for this problem
Measurable	This criterion addresses whether the problem can be measured and monitored using available data and whether there is a direct relationship between the problem and a National Performance Measure.	1= No data sources are available to measure this problem 2= New data sources could be developed to measure this problem 3= Existing data sources could be modified to measure this problem, at some cost or effort 4= Existing data sources can be easily modified to measure this problem 5= This problem can be measured using existing data sources and definitions and an NPM is associated with the issue
Leadership Support	This criterion addresses whether the State of Nevada currently has the leadership support and interest in addressing this problem, whether it is a priority for key stakeholders, or whether an effort to educate leaders would be effective in making it a priority.	1= This problem is low on the list of leadership priorities 2= Some leaders might be convinced to put effort into this problem 3= An educational effort could be effective in encouraging commitment to this problem 4= An educational effort would definitely be effective in encouraging commitment 5= This problem is a priority for key stakeholders
Stakeholder Support	This criterion addresses whether the stakeholders in this issue (consumers, providers, and partner agencies) support the MCAH's effort to address this problem and would contribute resources to an intervention.	1= Stakeholders do not support this effort 2= Some stakeholders support this effort and would contribute 3= Stakeholders could be convinced to support this effort 4= An effort to educate stakeholders would definitely get them on board 5= This problem is a priority for stakeholders, who would definitely contribute

Criterion	Definition	Rating Scale
Economic Impact	If problem is not addressed the result will be increased monetary costs, e.g., health care and/or social services costs to society and costs to employers, and or loss of productive people because of chronic illness, disability or premature death. The intervention has been shown to be cost-effective.	1= Economic/societal cost is minimal, or the intervention does not save money 2= There is some potential increased costs, or the intervention may save money 3= There is likely to be moderate increased costs or savings to the system 4= There is likely to be substantial increased costs or savings 5= There will be great economic and societal cost or the intervention is clearly cost-effective

Priority Setting Meeting Outcomes (Discussion and Top Priorities)

Once the groups completed discussions and rankings for each criterion and priority need, the facilitator averaged the scores participants gave each criterion and cumulative priority. Each domain then reported out to the larger group the top priorities they identified and any key discussion that took place during their meeting. The highest potential score for each priority was 45.

Women and Maternal Health

This group had participants representing policy makers, providers, advocates, public health workers, and more. Discussion centered extensively on the overlap of so many of the priorities and needs. Participants emphasized how the intersectionality impacts all outcomes for all women across Nevada. To put the top scoring priorities in the context of epidemiological data, based on BRFSS data Nevada had a lower rate of depressive disorder in women of reproductive age (18–44) than the national average in 2022 (27% vs 34% for aged 18–24 and 23% vs 29% for aged 25–44). Overall pregnant women in Nevada reported low use of substances other than over-the-counter pain relievers with almost 60% reporting use in 2020 and over 70% in 2022 on the Nevada PRAMS survey. For access to services, over a quarter of women (26%) do not initiate prenatal care in their first trimester and about 5% initiate care late or never.

The final scoring resulted in the following top priorities:

1. **Mental health services/Substance use (score: 36.3)**
2. **Access to more prenatal and maternal health services (score: 35.6)**
3. Access to preventive health services (score: 32.8)
4. Knowledge of available resources in the community (score: 32.1)
5. Community factors impacting health (score: 31.8)

Perinatal and Infant Health

A range of experienced participants, including WIC staff, midwives, Medicaid administrators, and hospital providers comprised this domain’s reviewers. Participants discussed the high costs of childcare and the hardship it placed on families but also noted that there is little MCAH can do to address this issue within their scope of work. Participants highlighted a barrier to care being Nevada's climate—something not discussed elsewhere during the needs assessment qualitative data collection — saying that people don't want to go to appointments in Las Vegas *"because it's too hot to take an infant out, especially if they have to take multiple bus trips."* Discussion about lack of resource knowledge was surprising to some of the priority setting members, who wondered what the barriers were since so much information is available online. This led participants to discuss issues around health literacy or resources not being presented in a way that meets Nevadans' needs. One of the participants representing the rural areas suggested the issue may be more about the lack of services and access to those services. Participants were very concerned about substance use, discussing it being a top reason for maternal mortality and morbidity.

At the same time, data show that the rate of infants born with NAS decreased in recent years from 7.6 (per 1,000 live births) in 2018 to 5.7 in 2020. Nevada's rate was below the national estimate of 6.2 in 2020. Priority setting participant discussion echoed findings from the community input activities, with participants discussing provider lack of knowledge and comfort with addressing substance use and mental health and women's fears about asking for help. Nevada PRAMS data show the prevalence of postpartum mood disorders in Nevada is higher than the national average at 15% (compared to the U.S. estimate of 13%). Participants discussed the lack of breastfeeding supports, including barriers to becoming a board-certified lactation consultant (IBCLC), and a lack of baby friendly designated hospitals. The rates of women initiating breastfeeding has decreased from about 83% in 2018 to 79% in 2021. Additionally, rates of exclusive breastfeeding have also decreased from 28% in 2018 to 26% in 2022.

The final scores for the top perinatal and infant health priorities were:

1. **Need for mental health services (score: 38.6)**
2. **Maternal substance use during and after pregnancy (score: 38.3)**
3. Breastfeeding support (score: 32.9)
4. Need for affordable childcare (score: 32.6)
5. Knowledge of available resources in the community (score: 31.4)

Child Health

This domain group (comprised of child health and advocacy experts, public health workforce, hospital administration, and government leaders) discussed chronic health issues impacting children's health, including physical activity, obesity, and a lack of access to parks or community spaces. Participants linked these issues with long-term health and well-being outcomes for Nevada's future adult population. *"Obesity leads to lifelong health issues, it's important to teach [about healthy habits] at a young age, kiddos learn based on what they see. [Addressing obesity in children] can prevent health care costs in the future,"* shared a participant. Participants also discussed the complex intersecting factors that impact child health, such as school district policies that take away recess as punishment, focusing on test scores instead of active time, economic situations and work responsibilities of parents making it difficult for children to participate in activities, and the need for both political will and financial support for schools and communities to create a system that supports children to be active. Based on 2023 National Survey of Children's Health (NSCH) data, over one third (35%) of Nevada children were overweight or obese (compared to U.S. estimate of 32%) and only 13% were physically active at least 60 minutes a day (compared to U.S. estimate of 20%).

Along with the issues that not being active leads to, participants highlighted the increase in screentime and technology for children. Technology usage can also lead to issues like cyberbullying and a lack of health literacy may lead Nevadan youth to trust inaccurate information. The many stressors impacting parents and families also impact children and their experiences; priority session participants highlighted the high costs of food and healthy food, a lack of financial stability, lack of childcare leading families to put children in unsafe environments, and a lack of access to SNAP, WIC, and free school lunches. About 20.9% of children in Nevada experienced food insecurity in 2022 (compared to 18.5% for the U.S.). This estimate has increased from 19.5% of Nevada children in 2018.

The top priorities for this domain were:

1. **After school and childcare options (score: 38.3)**
2. **Community factors that impact health (score: 35.9)**
3. Physical health/physical activity (score: 33.4)
4. Social media, technology, and screen time (score: 32.0)

Adolescent Health

Participants, including experts from public health and social service agencies, government organizations, and nonprofits, discussed issues specific to adolescent Nevadans. Main topics included sexual and reproductive health, with participants emphasizing adolescents lack access to education and the ability to navigate unsafe and incorrect information. For example, a participant expressed that a *"lack of education on sexual health and safe sex is a big issue*," explaining an adolescent encounter where a youth told them *"you must put hot sauce on condoms [to prevent pregnancy]."* Participants discussed a lack of education in schools, children missing sex education opportunities because of "opt-in" vs "opt-out" laws, and youths getting their information from social media. Participants also highlighted that HPV vaccination rates are low and there is parental resistance to vaccination because of its relation to sexual health.

Data from the National Immunization Survey show an increase in adolescents 13–17 who receive at least one dose of the HPV vaccine in Nevada, increasing from 66% in 2018 to about 76% in 2022. This rate was still below the U.S. average of 77% in 2023. Participants noted a lack of services for unhoused youth, bullying, and high ACE scores among Nevadan adolescents. Data from the NSCH show Nevada adolescents have a higher percentage of housing instability compared to the national average (19% vs 17%). The pervasiveness of domestic violence was brought up as a factor impacting ACE scores and youth mental health with participants highlighting a need for teacher support in recognizing domestic violence and child abuse in the home, as well as the need for education about consent and boundary setting. Because of their age, adolescents may struggle to seek appropriate resources to address their mental health, and primary care providers may not be trained to support this age group. Based on 2022–2023 NSCH data, only about 10% of adolescents received any treatment or counseling from a mental health professional, compared to the national estimate of 17%, A lack of access to opportunities and resources outside of school as well as the detrimental impacts of social media and cyberbullying (including "sexting") are impacting adolescent health and well-being.

The final priorities for this domain were:

1. **ACEs (score: 37.1)**
2. **Need for services and resources around sexual and reproductive health (score: 37.0)**
3. Mental health services (score: 35.8)
4. Social media and cyber bullying (score: 33.4)
5. Access to educational opportunities and resources (score: 32.9)

CYSHCN

Participants represented autism services, newborn hearing screening, parent navigators, and parents of CYSHCN. Participants discussed how mental health impacts both CYSHCN and their caregivers and that there are two separate and interrelated sets of mental health needs. Participants also discussed the shift from underage care to adult care. Based on 2022–2023 NSCH data, only about 12% of CSHCN in Nevada received services to prepare for transition to adult health care, compared to the U.S. estimate of 22%. Parents shared their unique experiences of diagnosis and trying to access care, including hospice care. Barriers to accessing specialty services included a lack of workforce and insurance coverage. The impact on the parent-child relationship when an unexpected diagnosis occurs and the stress and change in family dynamics were also discussed. Participants shared their knowledge and questions about “medical home” and how this might impact care in the day-to-day experiences of CYSHCN and their families or caregivers. NSCH 2022–2023 data estimates that about 26% of Nevada CYSHCN have a medical home, a decrease from 38% in 2020 and well below the 2023 national estimate of 40%.

The final priorities were as follows:

1. **Need for affordable health insurance (tied score: 37.3)**
2. **Need to increase workforce (tied score: 37.3)**
3. **Access to appropriate services including specialists and early screening interventions (tied score: 37.3)**
4. Mental health services (score: 34.9)
5. Need for caregiver support/navigation (score 33.7)

Action Plans

Once the MCAH reviewed the priorities identified throughout the needs assessment as well as the quantitative data to determine which priorities were most feasible to address and aligned with overall MCH trends. Of note, infant mortality did not emerge during the qualitative needs assessment data collection activities as a key priority or need. However, Nevada MCAH noted the state has higher than national rates of Sudden Unexplained Infant Death (SUID), with 2020 data showing a rate of 101.1 per 100,000 live births compared with 92.5 national rates. This is despite significant improvement in SUID from 2018 when Nevada families experienced a SUID rate of 142.6. As a result, Nevada decided to add this as a priority and continue its work to address infant mortality and SUID.

The 5-year action plan maps each domain's priority need(s) to a state or national performance measure. Each national performance measure must include an evidence-based strategy measure. Per the Health Resources and Services Administration, "these are meant to demonstrate how the Title V program tracks programmatic investments designed to impact the state's performance measures. These measures assess the impact of the selected strategies and activities included in the State Action Plan." This 5-year plan serves as the building blocks of Nevada's work for the next 5 years.

Final priorities, performance measures, and evidence-based strategy measures can be found below in **Exhibit 12.**

Exhibit 12. Mapping Priorities, Performance Measures, and Evidence-Based Strategy Measures

Domain: Women and Maternal Health

Final MCAH Selected Priority Needs	Performance Measures
• Incorporating mental health and substance use screening and referrals into prenatal care • Improving access to prenatal and maternal health services	• ***Universal National Performance Measure Postpartum Visit:*** Percent of women who attended a postpartum checkup within 12 weeks of giving birth; Percent of women who attended a postpartum checkup and received recommended care components • ***State Performance Measure Early Prenatal Care:*** Percent of pregnant women who receive prenatal care beginning in the first trimester
Evidence-Based Strategy Measures • Percent of WIC and home visiting enrolled families during pregnancy who received at least one postpartum visit. • Percent of pregnant women enrolled in MIECHV-funded home visiting and WIC programs prenatally who enrolled in prenatal care.	

Domain: Perinatal and Infant Health

Final MCAH Selected Priority Needs	Performance Measures
• Increasing access to breastfeeding support • Addressing maternal substance use during and after pregnancy • Reducing infant mortality through safe sleep practices	• ***National Performance Measure Breastfeeding:*** Percent of infants who are ever breastfed; percent of children, aged 6 months–2 years, who were breastfed exclusively for 6 months • ***State Performance Measure Substance Use:*** percent of women who used substances during pregnancy • ***National Performance Measure Safe Sleep:*** Percent of infants placed to sleep on their backs; percent of infants placed to sleep on a separate approved sleep surface; percent of infants placed to sleep without soft objects or loose bedding; percent of infants room-sharing with an adult

Evidence-Based Strategy Measures

- Percent of Nevada PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends
- Percent of PRAMS respondents who report they were asked by a provider during their prenatal care visits if they smoked cigarettes or used e-cigarettes, if they were drinking, using illegal substances, or using marijuana.
- Percent of PRAMS respondents who report their infants (under age 1) were laid to sleep in a high-risk sleep position and/or environment

Domain: Child Health

Final MCAH Selected Priority Needs	Performance Measures
• Increasing access to safe and healthy food options • Increasing physical activity	• ***National Performance Measure Food Sufficiency:*** Percent of children, aged 0–11, whose households were food sufficient in the past year • ***National Performance Measure Physical Activity:*** Percent of children, aged 6–11, who are physically active at least 60 minutes per day

Evidence-Based Strategy Measures

- Percent of MIECHV Home Visitors who received training on nutrition and exhibited increased knowledge on food sufficiency and strategies on how to discuss nutrition with families.
- Percent of respondents of the Kindergarten Health Survey (KHS) who report their child exercises for at least 60 minutes per day at least 4–5 times a week .

Domain: Adolescent Health

Final MCAH Selected Priority Needs	Performance Measures
• Increasing screening for ACEs during adolescent well visits • Increasing access to sexual and reproductive health care via adolescent well visits	• ***National Performance Measure Adolescent Well-Visit:*** Percent of adolescents, aged 12–17, with a preventive medical visit in the past year • ***State Performance Measure:*** Rate of Sexually Transmitted Infections in adolescents aged 12–17

Evidence-Based Strategy Measures

- Percent of Medicaid EPSDT eligible adolescents, aged 12–17, who received at least one initial or periodic screen
- Percent of adolescents aged 12–17 who have a well visit through funded partners that provide integrated health services, including being screened for Reproductive Life Planning and provided with client specific education and resources based on individual goals.

Domain: CYSHCN

Final MCAH Selected Priority Needs	Performance Measures
• Increasing access to care via a Medical Home, including addressing health insurance coverage for CYSHCN services	• ***Universal National Performance Measure Medical Home Overall:*** Percent of children with special health care needs, aged 0–17, with a medical home

Evidence-Based Strategy Measure

- Percent of Northern and rural families who report the family-to-family support in navigation received by a Family Navigator through Family Navigation Network met their needs for transition from pediatric to adult health care.

Title V MCAH Capacity

After assessing the needs of the MCH population and identifying the top priorities, performance measures, and strategies, the last piece of the needs assessment process is to assess the needs or capacity of the people and system that serves MCH populations to address the state's identified priorities. To do this, Altarum developed a survey for Nevada MCAH staff and partners responsible for the activities included in their Title V action plans. Through the capacity survey staff identified current capacity and their capacity needs for each priority selected across the five domains. A total of six survey responses were received (5 completed, 1 partial). A complete table of capacity needs assessment responses is in **Appendix G.**

> *"We would we like to expand breastfeeding friendly business but don't have the relationships to do this. Additionally, partnering with Hospitals has been challenging. They are not interested in any breastfeeding initiatives we propose and this is where women need and want breastfeeding support from."*
>
> – Capacity Survey Respondent

Overall, the respondents did not identify capacity needs for the Women and Maternal Health or Perinatal and Infant Health domains. Participants largely felt they had ability to achieve the priorities identified. Where respondents did identify more gaps in their capacity were across the other three domains as described below.

Child Health

Priority: Access to safe and healthy food options. Survey respondents identified some capacity needs related to their identified child health priority. Both respondents identified a need for authority and funding sufficient for functioning at the desired level of performance and formal protocols and guidance for all aspects of the assessment, planning, and evaluation cycle. Respondents were split as to whether they felt they had or needed routine, two-way communication channels or mechanisms with relevant constituencies, and mechanisms for accountability and quality improvement, with one respondent reporting they have these resources and the other reporting they were needed. Respondents left the following comment related to structural resources: "*For funding, given the way Nevada is set up, we just will always have a need for more funding. If we had more money, there would be so many more activities we could try to integrate, but in its current status, we have to work with the money we do get. For quality improvement and evaluations, I feel as though we do not have* *anything set in place to continuously evaluate and improve programs or partnerships. It would be great to create some standardized methods that all program coordinators use to facilitate this*."

Both respondents identified a need for access to timely program and population data from relevant public and private sources. There was a split for adequate data infrastructure with one respondent reporting they had this capacity and another reporting it was needed. One respondent shared the following related to current data and information system capacity:

> "The way Nevada DHHS is set up with having a designated Office of Analytics can create some barriers to timeliness for getting private data. It can take months for one data request to be fulfilled, which is a major barrier for receiving and sharing data to our communities."
>
> "Since one of our strategies is to increase data sharing and capacity, we have knowingly identified some of our capacity needs via that statement. We do have a supportive state environment and desire from most parties to make useful data sharing secure and also easy, however our data infrastructure and access continues to need improvement."

Respondents also identified some organizational relationships that they currently did not have. These included relationships with insurers and insurance oversight stakeholders, non-governmental advocates, funders, and resources for state and local public health activities and businesses. The only competency they were unsure of was the ability to influence the policymaking process. One respondent left the following comment related to this: *"The State team is not able to influence the policymaking process from a lobbying perspective, but we do inform and educate policymakers about existing initiatives and evidence-based strategies we could initiate in Nevada."*

Adolescent Health

Priority: ACEs. Respondents identified a number of structural resource needs related to this priority including: authority and funding sufficient for functioning at the desired level of performance, workforce capacity institutionalized through job descriptions, contract language about skills and credentials, training programs, and routine assessments of capacity and training plans, mechanisms for accountability and quality improvement, and formal protocols and guidance for all aspects of the assessment, planning, and evaluation cycle. Respondents commented they did not have the authority/funding to make headway on some of these, outside of strengthening their relationships with clinical partners. Respondents felt they had a need for adequate data infrastructure as well as organizational relationships with insurers and insurance oversight stakeholders and businesses. Similarly to other priorities, the only competency staff were unsure of was the ability to influence the policymaking process.

CYSHCN

Priority: Need for affordable health insurance. Respondents identified several structural resource needs related to this priority including: Authority and funding sufficient for functioning at the desired level of performance; routine, two-way communication channels or mechanisms with relevant constituencies; workforce capacity institutionalized through job descriptions, contract language about skills and credentials, training programs, and routine assessments of capacity and training plans and Mechanisms for accountability and quality improvement; and formal protocols and guidance for all aspects of the assessment, planning, and evaluation cycle. Staff identified the need for a supportive environment for data sharing and adequate data infrastructure. Respondents also identified some organizational relationships they felt were needed including insurers and insurance oversight stakeholders, non-governmental advocates, funders, and resources for state and local public health activities, businesses, local providers of health, and other services and superstructure of local health operations and state-local linkages. One respondent left the following comment related to organizational relationships *"Assess the relationships to clinics/hospitals independent of data they are required to submit to the state in regard to data sharing. My office cannot lobby interests in a public capacity regarding "State and local policymakers."* The only competency respondents were unsure of was the ability to influence the policymaking process.

Conclusion

Throughout the needs assessment process, Nevadans consistently described similar issues impacting Nevada's MCH populations—the overarching issue of *access to care*. Participants described a system difficult for them to access and navigate and without enough providers to meet their needs. Difficulty accessing care is particularly difficult for those living in rural and frontier areas and for families of children and youth with special health care needs. Participants also emphasized that they don't know about health and social services available to them and if they know about the services, they don't know how to access them. Epidemiologic data corroborate these findings. For example, Nevada vital records showed a decrease in prenatal care initiation from 78% in 2020, to 74% in 2023.[10]

Needs assessment participants shared that while people want to access care and want services and support, they wait months for appointments and must travel many miles to access care and services. They offered the following solutions: make available after-hours and walk-in appointments; increase funding for doulas, community health workers, midwives; establish free-standing birth centers, and incentivize physicians and medical specialists to train and remain in Nevada.

The findings suggest the need to focus MCAH efforts during the next 5 years on family navigation, access to a medical home, prenatal care access through partnerships, access to adolescent well visits, and substance use and mental health integration into maternal and child health care. These efforts will help address the core issues impacting Nevada's MCH populations and support lifelong health for Nevada's mothers, children, and families.

[10] Nevada Electronic Birth Registry System, Count and Percent of Births by Initiation of Prenatal Care and Race/Ethnicity, Aged 15–44, FFY 2023 (10/1/2022–09/30/2023).

Appendix A: 5-Year State Action Plan Table

Women and Maternal Health

Priority Needs	5-Year Objectives	Strategies	Evidence-Based Strategy Measures	National/State Performance Measures	Potential National and State Outcome Measures
Incorporating mental health and substance use screening and referrals into prenatal care	90% of women who attended a postpartum checkup within 12 weeks of giving birth; 70% of women who attended a postpartum checkup and received recommended care components	Increase the number of women who had a postpartum checkup after delivery. Increase postpartum infrastructure.	Percent of WIC and home visiting enrolled families during pregnancy who received at least one postpartum visit.	***Universal National Performance Measure-Postpartum Visit:*** Percent of women who attended a postpartum checkup within 12 weeks of giving birth; Percent of women who attended a postpartum checkup and received recommended care components	***Maternal Mortality:*** Maternal mortality rate per 100,000 live births ***Women's Health Status:*** Percent of women, aged 18–44, in excellent or very good health ***Postpartum Depression:*** Percent of women who experience postpartum depressive symptoms ***Postpartum Anxiety:*** Percent of women who experience postpartum anxiety symptoms
Improving access to prenatal and maternal health services	80% of pregnant women in Nevada will receive their prenatal care beginning in the first trimester	Collaborate with public and private partners to reduce barriers to accessing early and adequate prenatal care. Improve health literacy, including health promotion campaigns and dissemination of health information (including translation/interpretation).	Percent of pregnant women enrolled in MIECHV-funded home visiting and WIC programs prenatally who enrolled in prenatal care.	***State performance measure:*** Early Prenatal Care: percent of pregnant women who receive prenatal care beginning in the first trimester	***Maternal Mortality:*** Maternal mortality rate per 100,000 live births ***Low Birth Weight:*** Percent of low birth weight deliveries (<2,500 grams) ***Stillbirth:*** Stillbirth rate per 1,000 live births plus fetal deaths ***Women's Health Status:*** Percent of women, aged 18–44, in excellent or very good health

Perinatal and Infant Health

Priority Needs	5 Year Objectives	Strategies	Evidence-Based Strategy Measures	National/State Performance Measures	Potential National and State Outcome Measures
Increasing access to breastfeeding support	83% of infants will be ever breastfed by 2030; 25% of infants were breastfed exclusively for 6 months	Increase community awareness and access to education materials that promote evidence-based breastfeeding information and policies. Increase the number or percentage of breastfeeding-friendly businesses. Increase knowledge and access to breastfeeding support services and resources with MIECHV services.	Percent of Nevada PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends.	***National Performance Measure Breastfeeding:*** percent of infants who are ever breastfed; percent of children, aged 6 months–2 years, who were breastfed exclusively for 6 months	***Infant Mortality:*** Infant mortality rate per 1,000 live births ***SUI Mortality:*** Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Addressing maternal substance use during and after pregnancy	Reduce the percent of women who report using tobacco, alcohol, or illicit drugs during pregnancy to 3.6%	Support the Division of Public and Behavioral Health in establishing a Statewide Perinatal Quality Collaborative (PQC) to implement evidence-based strategies to address substance use in women of child-bearing age, pregnant and postpartum (up to 1 year postpartum). Increase partnerships with state and local agencies to address substance use during pregnancy.	Percent of PRAMS respondents who report they were asked by a provider during their prenatal care visits if they smoked cigarettes or used e-cigarettes, if they were drinking, using illegal drugs, or using marijuana.	***State Performance Measure Substance Use:*** percent of women who used substances during pregnancy	***Several Maternal Morbidity:*** Rate of severe maternal morbidity per 10,000 delivery hospitalizations ***Maternal Mortality:*** Maternal mortality rate per 100,000 live births ***Low Birth Weight:*** Percent of low birthweight deliveries (<2,500 grams) ***Preterm Birth:*** Percent of preterm births (<37 weeks gestation) ***Stillbirth:*** Stillbirth rate per 1,000 live births plus fetal deaths ***Perinatal Mortality:*** Perinatal mortality rate per 1,000 live births plus fetal deaths ***Infant Mortality:*** Infant mortality rate per 1,000 live births ***Neonatal Mortality:*** Neonatal mortality rate per 1,000 live births ***Postneonatal Mortality:*** Postneonatal mortality rate per 1,000 live births ***Preterm-Related Mortality:*** Preterm-related mortality rate per 100,000 live births

Priority Needs	5 Year Objectives	Strategies	Evidence-Based Strategy Measures	National/State Performance Measures	Potential National and State Outcome Measures
Reducing infant mortality through safe sleep practices	A) Back sleep position: 68.3% B) Approved sleep surface: 29.5% C) No soft objects/loose bedding: 69.2% D) Room-sharing: 83.2%	Increase staff trainings to home visitors on promotion of safe sleep practices. Partner with Cribs for Kids (C4K) to support providing educational resources to parents and caregivers on the importance of safe sleep behaviors. Promote media campaigns around safe sleep by partnering with public and private partners.	Percent of PRAMS respondents who report their infants (under 1 year of age) were laid to sleep in a high-risk sleep position and/or environment.	***National Performance Measure Safe Sleep:*** percent of infants placed to sleep on their backs; percent of infants placed to sleep on a separate approved sleep surface; percent of infants placed to sleep without soft objects or loose bedding; percent of infants room-sharing with an adult	***Infant Mortality:*** Infant mortality rate per 1,000 live births ***Postneonatal Mortality:*** Postneonatal mortality rate per 1,000 live births ***SUID Mortality:*** Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Child Health

Priority Needs	5 Year Objectives	Strategies	Evidence-Based Strategy Measures	National/State Performance Measures	Potential National and State Outcome Measures
Increasing access to safe and healthy food options	67% of children in Nevada will live in households where food was sufficient in the past year	Increase the number of participants in WIC and SNAP. Increase data sharing and capacity with internal and external partners.	Percent of MIECHV Home Visitors who received training on nutrition and exhibited increased knowledge on food sufficiency and strategies on how to discuss nutrition with families.	***National Performance Measure Food Sufficiency:*** Percent of children, aged 0–11, whose households were food sufficient in the past year	***Overall Health Status:*** Percent of children, aged 0–17, in excellent or very good health ***Flourishing, Young Child:*** Percent of children, aged 6 months–5, who are flourishing ***Flourishing, Child Adolescent:*** Percent of children with and without special health care needs, aged 6–17, who are flourishing
Increasing physical activity	By 2030, 20% of children, aged 6–11, will be physically active for at least 60 minutes per day in Nevada	Increase physical activity for children aged 6–11. Actively collect and monitor changes in physical activity habits for children in Nevada. Promote physical activity for Nevada children aged 6–11.	Percent of respondents of the Kindergarten Health Survey (KHS) who report their child exercises for at least 60 minutes per day at least 4–5 times a week.	***National Performance Measure Physical Activity:*** Percent of children, aged 6–11, who are physically active at least 60 minutes per day	***Overall Health Status:*** Percent of children, aged 0–17, in excellent or very good health ***Child Obesity:*** Percent of children, aged 2–4, and adolescents, aged 6–17, who are obese (BMI at or above the 95th percentile) ***Flourishing, Young Child:*** Percent of children, aged 6 months–5, who are flourishing

Priority Needs	5 Year Objectives	Strategies	Evidence-Based Strategy Measures	National/State Performance Measures	Potential National and State Outcome Measures
					Flourishing, Child Adolescent: Percent of children with and without special health care needs, aged 6–17, who are flourishing

Adolescent Health

Priority Needs	5 Year Objectives	Strategies	Evidence-Based Strategy Measures	National/State Performance Measures	Potential National and State Outcome Measures
Increasing screening for ACEs during adolescent well visits	67% of adolescents, aged 12–17, will have had a preventive medical visit in the past year Healthy People 2030 Goal (AH-01): 82.6%	Increase the awareness of the benefits of preventive medical visits among Nevada adolescents. Increase compliance with AAP guidelines for adolescent screenings to ensure addressing ACEs among providers of adolescent well visits.	Percent of Medicaid EPSDT-eligible adolescents, aged 12–17, who received at least one initial or periodic screen.	***National Performance Measure Adolescent Well-Visit:*** Percent of adolescents, aged 12–17, with a preventive medical visit in the past year	***Overall Health Status:*** Percent of children, aged 0–17, in excellent or very good health ***Adolescent Depression/ Anxiety:*** Percent of adolescents, aged 12–17, who have depression or anxiety ***Adolescent Mortality:*** Adolescent mortality rate, aged 10–19, per 100,000 ***Teen Births:*** Teen birth rate, aged 15–19, per 1,000 females ***Injury Hospitalization—Adolescent:*** Rate of hospitalization for non-fatal injury per 100,000 adolescents, aged 10–19

Priority Needs	5 Year Objectives	Strategies	Evidence-Based Strategy Measures	National/State Performance Measures	Potential National and State Outcome Measures
Increasing access to sexual and reproductive health care via adolescent well visits	Rate of STI infections in aged 12–17 of 500 per 100,000 aged 12–17 Teen birth rate, aged 15–19, per 1,000 females	Reduce barriers to accessing reproductive health services for adolescents aged 12–17. Increase adolescents' prevention of reproductive system cancers.	Percent of adolescents aged 12–17 who have a well visit through funded partners that provide integrated health services, including being screened for Reproductive Life Planning and provided with client specific education and resources based on individual goals.	***State Performance Measure:*** Rate of Sexually Transmitted Infections in adolescents aged 12–17 ***State Performance Measure:*** Teen Pregnancy	***Teen Birth:*** Teen birth rate, aged 15–19, per 1,000 females

CYSHCN

Priority Needs	5 Year Objectives	Strategies	Evidence-Based Strategy Measures	National/State Performance Measures	National and State Outcome Measures
Increasing access to care via a Medical Home, including addressing health insurance coverage for CYSHCN services	35% of children with special health care needs, aged 0–17, will have a medical home	Increase awareness of the importance and benefits of a medical home. Implement elements of the Blueprint for Change. Increase care coordination and access to a medical home among CYSHCN statewide.	Percent of families who report the family-to-family support in navigation received by a Family Navigator through Family Navigation Network reported met their needs for transition from pediatric to adult health care.	***Universal National Performance Measure Medical Home Overall:*** percent of CSHCN, aged 0–17, with a medical home	***CSHCN Systems of Care:*** Percent of children with special health care needs, aged 0–17, who receive care in a well-functioning system ***Flourishing, Young Child:*** Percent of children, aged 6 months–5, who are flourishing ***Flourishing, Child Adolescent:*** Percent of children with and without special health care needs, aged 6–17, who are flourishing ***Overall Health Status:*** Percent of children, aged 0–17, in excellent or very good health

Appendix B: MCH Survey

Introduction

We are asking you to participate in an online survey being conducted by Altarum to help Nevada better understand the priorities for maternal and child health populations. Answers to these questions will be used to help select the State of Nevada's Health Priorities for moms, babies, and their families during 2025–2030.

Your participation in the survey is voluntary and you can stop at any time. We expect 600 participants will take part over a month period. Answering these questions should only take you about 5–10 minutes. Your participation in the survey and your responses will be kept private except to other Altarum project staff and the Allendale Investigational Review Board (IRB) may have access to the records. Answering this survey voluntary and confidential. We will not be able to tell who you are or link you with your answers.

There is no direct benefit to you for participating in this survey. Your participation should be of minimal risk, such as fatigue. If you have any questions, please contact [NAME] and [PHONE] or [EMAIL]. If you have any questions or concerns regarding your rights in participating in this survey, please contact the Allendale Investigational Review Board at [PHONE] or [EMAIL].

Consent

Do you consent with participating in the survey?*

- Yes
- No [Terminate survey]

Please write your name and today's date.

- Name
- Date

About You

1. Please check the box(es) below that best describe you. Select all that apply.

- I am pregnant, was recently pregnant, or hope to be pregnant soon
- I am a caregiver of a child or children
- I am a caregiver of a child or children who needs special services for learning or physical growth
- I am a professional or volunteer working within the maternal and child health sector (i.e., pregnant people, parents/caregivers of children, teens, and/or babies).
- Other, please describe:
- Don't want to say

2. Please select the job setting or job description that best describes your role working with pregnant people, parents/caregivers of children, teens, and/or babies. Select all that apply. [Display if answer to Q1 is “I am a professional or volunteer working within the maternal and child health sector”]
   - Community based organization/non-profit
   - Healthcare professional
   - Local public health professional
   - Nevada Department of Health and Human Services
   - Nevada Department of Education
   - Other state worker
   - Other maternal and child health worker
   - Policymaker
   - Other, please describe:
   - Don’t want to say
3. If you are a caregiver for a child or multiple children, please check their age(s). [Display if answer to Q1 is “I am a caregiver to a child” or “I am a caregiver of a child who needs special services for learning or physical growth”]
   - < 1 years old
   - 1–2 years old
   - 3–5 years old
   - 6–10 years old
   - 11–18 years old
4. During your hospital stay after your baby was born, did a healthcare provider do any of the following things? Check if it happened. [Display if answer to Q1 is “I am a caregiver to a child” or “I am a caregiver of a child who needs special services for learning or physical growth”]
   - Talked with me about birth control methods I can use after giving birth
   - Tied or blocked my tubes
   - Placed an IUD
   - Placed a contraceptive implant in my arm
   - Gave me a contraceptive shot/injection
   - Gave me or prescribed a contraceptive method for me to start later (such as birth control pills, patch, ring)
   - None of these things happened
5. Has a doctor or other health care provider **ever** told you your child has attention-deficit/hyperactivity disorder, or ADHD? [Display if answer to Q1 is “I am a caregiver to a child” or “I am a caregiver of a child who needs special services for learning or physical growth”]
   - Yes
   - No
6. Is this child **currently** taking medication for ADHD? [Display if answer to Q5 is “Yes”]
   - Yes
   - No

7. What ADHD related services do you offer in your practice? Select all that apply. [Display if answer to Q2 is “Healthcare professional” or “Local public health professional” or “Other maternal and child health worker”]

- Diagnose children with ADHD
- Diagnose adults with ADHD
- Treat with stimulant ADHD medication
- Treat with non-stimulant ADHD medication
- Treat with behavior therapy for ADHD
- Other ADHD-related services or referrals
- I do not provide ADHD services

8. Which of the following are your barriers to identification and/or diagnosis of ADHD **in children**? Select all that apply. [Display if answer to Q7 is all answers except “I do not provide ADHD services”]

- My comfort level evaluating these patients
- My knowledge of ADHD
- I don’t have anyone to refer the patient to
- Lack of time to evaluate the patient
- Unable to bill for this type of evaluation
- Family resistance to evaluation/referral
- Other, please describe:
- I do not have barriers to identification and/or diagnosis of ADHD in children

All Nevada People

9. What do you think are the most important health issues that would help Nevada people be healthier? Please select your **top 3.**

- Limited access to health care
- Need for mental health services
- Substance use
- Lack of affordable housing
- Need for culturally competent health care
- Other, please describe:

Women/Maternal Health

10. What are the most important health issues facing women/mothers in Nevada? Please select your **top 3.**

- Need for more prenatal and maternal health services
- Need for more preventive health services
- Substance use
- Not knowing about available community resources
- Need for mental health services
- Other, please describe:

Infant Health (Babies less than 1 year of age)

11. What are the most important health issues facing babies in Nevada? Please select your **top 3**.

- Need for affordable childcare
- Need for breastfeeding support
- Need for mental health services
- Congenital syphilis (syphilis passed to a baby during pregnancy or childbirth)
- Maternal substance use during or after pregnancy
- Other, please describe:

Child Health (Children aged 1–9 years)

12. What are the most important health issues facing children in Nevada? Please select your **top 3**.

- Lack of resources to support age-appropriate health literacy among caregivers
- Lack of physical activity
- Overuse of screen time
- Lack of access to healthy food options
- Need for supports for caregiver mental health
- Other, please describe:

Adolescent Health (Children aged 10–19 years)

13. What are the most important health issues facing adolescents in Nevada? Please select your **top 3**.

- Need for education about sexually transmitted infections
- Need for services and resources around sexual and reproductive health
- Low health literacy
- Cyberbullying
- Adverse childhood experiences
- Other, please describe:

Children with Special Health Needs (Any child between the ages of 0–19 years who need more than routine health care)

14. The issues that impact all children also impact children with special health needs that require more care for their physical, developmental, behavioral, or emotional health than other kids their age. In this section, we are looking for your thoughts on issues that are especially important for children and youth with special health care needs. Please select the **top 3** issues impacting the health of children and youth with special health care needs in Nevada.

- Need for caregiver support
- Need for larger workforce
- Need for affordable health insurance
- Need for more coordination between health care providers
- Need for access to specialists
- Other, please describe:

Demographics

We would like to find out a little more about you to help us understand your perspectives.

15. What is your sex/gender?

- Woman
- Man
- Prefer not to say

16. How old are you?

- <18 years old
- 18–24 years old
- 25–34 years old
- 35–44 years old
- 45–54 years old
- 55–64 years old
- 65+ years old
- I prefer not to say

17. What is your race and/or ethnicity? (select all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Middle Eastern or North African
- Native Hawaiian or Other Pacific Islander
- White
- Other (please describe):
- I prefer not to say

18. What county do you live in?

- Carson City
- Churchill
- Clark
- Douglas
- Elko
- Esmeralda
- Eureka
- Humboldt
- Lander
- Lincoln
- Lyon
- Mineral
- Nye
- Pershing

- Storey
- Washoe
- White Pine
- Other (please describe):

19. What county(ies) do you provide services in (select all that apply)? [Display if answer to Q1 is "I am a professional or volunteer working within the maternal and child health sector"]

- Carson City
- Churchill
- Clark
- Douglas
- Elko
- Esmeralda
- Eureka
- Humboldt
- Lander
- Lincoln
- Lyon
- Mineral
- Nye
- Pershing
- Storey
- Washoe
- White Pine
- Other (please describe):

Thank you for your participation in the survey.

Appendix C: Key Informant Interview Guide

Introduction

Interviewer: *this discussion can be conversational. You do not need to adhere exclusively to the questions as they are written. However, you shouldn't lead the interviewee either and each part of the question needs to be asked.*

Thank you for meeting with me today. We will be talking about issues that impact the health and well-being of Nevada's Maternal Child Health populations. This interview is part of Nevada's needs assessment application to the federal Maternal and Child Health Bureau. This Bureau requires states submit a needs assessment every 5 years as part of their application for the Maternal and Child Health Block Grant, or Title V. Title V provides money to states to meet the needs of pregnant women, mothers, infants, children, adolescents, and children with special health care needs.

The current needs assessment cycle ends in 2025. Nevada contracted with Altarum to help complete their needs assessment for the next 5 years 2025–2030. The needs assessment focuses on 5 areas or domains: Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, and Children and Youth with Special Health Care Needs (CYSHCN).

Here's how we define each domain:

- Women/Maternal Health foc*uses on issues that impact women of childbearing age and mothers in Nevada.*
- Perinatal/Infant Health focuses on issues that impact pregnant women—like prenatal care, labor/delivery and the health of moms and new babies after birth—we think of Infants as a newborn until age 1.
- Child health focuses on issues that impact young children in Nevada—from age 1 to elementary school ages.
- Adolescent health focuses on issues that impact older aged-children—like middle school, high school-aged kids.
- CYSHCN focuses on iss*ues that impact Nevadan children who have special needs—these might be mental health, physical health and behavioral health—children aged 1–21 who need extra supports to be healthy and* well.

The needs assessment process includes collecting, analyzing, and understanding information from surveys, community groups, public health workers, and hearing from people like you. Your knowledge and expertise in issues important to Nevada's maternal and child health population will help us understand Nevada's needs. The information you provide will be included in the overall needs assessment along with other community input. Any direct quotes will not be attributed to you and most information will be included as a summary alongside others.

We are looking for your thoughts about the maternal and child health needs and priorities for Nevada. We aren't looking for specific data from you, but rather your perspective on the state of maternal and child health and the general directions you think Nevada should explore in their work in the next 5 years.

Participation in this interview is voluntary; you are not required to participate. You may refuse to answer any question for any reason and you may stop participating at any time for any reason. If you choose to participate, you will receive a $50 gift card (only offer this to non-state employees).

Needs and Priorities

We’re going to start talking about what the needs and priorities are for the different domain areas in Nevada.

We’ll start with Women/Maternal Health: Women and maternal health –women of childbearing age and mothers in Nevada

Question: What do you think are the biggest needs among this population in Nevada?

Discussion:

Question: How do these needs vary across Nevada?

Discussion:

Question: Which of the needs do you think should be a priority to address in the next 5 years?

Discussion:

Question: What are some things that might impact these priorities in the next year that we need to know about as we try to address them in the next 5 years?

Discussion:

Next, we’re going to talk about Perinatal/Infant Health (you may need to remind the interviewee what that means): Perinatal and infant health—pregnant women, moms and new babies after birth—we think of Infants as a newborn until age 1.

Question: What do you think are the biggest needs among this population in Nevada?

Discussion:

Question: How do these needs vary across Nevada?

Discussion:

Question: Which of the needs do you think should be a priority to address in the next 5 years?

Discussion:

Question: What are some things that might impact these priorities in the next year that we need to know about as we try to address them in the next 5 years?

Discussion:

Now we’ll talk about Child health: Child health—young children in Nevada from age 1 to elementary school ages.

Question: What do you think are the biggest needs among this population in Nevada?

Discussion:

Question: How do these needs vary across Nevada?

Discussion:

Question: Which of the needs do you think should be a priority to address in the next 5 years?

Discussion:

Question: What are some things that might impact these priorities in the next year that we need to know about as we try to address them in the next 5 years?

Discussion:

So moving now to older kids, we'll be discussing Adolescent health: Adolescent health—older aged-children—like middle school, high school aged kids.

Question: What do you think are the biggest needs among this population in Nevada?

Discussion:

Question: How do these needs vary across Nevada?

Discussion:

Question: Which of the needs do you think should be a priority to address in the next 5 years?

Discussion:

Question: What are some things that might impact these priorities in the next year that we need to know about as we try to address them in the next 5 years?

Discussion:

And our last group we want to talk about are those children and youth with special health care needs:

Children and youth with special health care needs—children who have special needs—these might be mental health, physical health and behavioral health—children aged 1–21 who need extra supports to be healthy and well.

Question: What do you think are the biggest needs among this population in Nevada?

Discussion:

Question: How do these needs vary across Nevada?

Discussion:

Question: Which of the needs do you think should be a priority to address in the next 5 years?

Discussion:

Question: What are some things that might impact these priorities in the next year that we need to know about as we try to address them in the next 5 years?

Discussion:

Taking into consideration all the issues we just discussed, we want to dive deeper now into how any maternal child health issues might be impacting different people, groups, or areas of Nevada:

Question: What are some unique needs impacting:

The immigrant, refugee, or asylum-seeking community

Discussion:

Unhoused families and children

Discussion:

The Black community

Discussion:

The Hispanic/Latino/Latinx community

Discussion:

The Tribal Nations

Discussion:

People in rural/frontier Nevada

Discussion:

Asian/Pacific Islander community

Discussion:

Now we're going to look toward the future:

Question: What are some things that might impact the Maternal Child Health populations in the coming years that we need to know about as we develop Nevada's priorities for the next 5 years?

Discussion:

Capacity

Another important part of the needs assessment is seeing if Nevada has the staff, money, and political will to address the needs we've just talked about. We need to consider the capacity, or the strengths and needs of Nevada's Maternal Child Health department, staff, and community partners, to see what the needs are within the system that serves Nevada's maternal child health populations.

Question: What are some capacity challenges the Maternal Child Health system faces in meeting the needs of Nevada's Maternal Child Health populations in the state? In what areas or specialties is the need the greatest? What are the system's greatest strengths in meeting the Maternal Child Health-related needs of Nevadans?

Discussion:

Question: What MCH program partnerships inside and outside of state and federal government programs are meeting Nevada's Maternal Child Health needs? What is missing? What additional partnerships would be helpful?

Discussion:

Recommendations

The last questions are about other recommendations you might have for us as we continue the needs assessment process.

Question: If you were involved in the last needs assessment cycle, or if you have conducted public health needs assessments in other contexts, what lessons have you learned that would help this time around?

Discussion:

Question: What are your recommendations for the needs assessment? (Additional people to interview, groups to include, potential data sources, etc.)

Discussion:

Closing

Thank you for taking the time to meet with me today and to share your thoughts with us. If you think of anything else, please feel free to reach out. The final priorities and needs assessment will be shared at the end of this process. There will also be a public survey that will be sent out, that you are welcome to promote. If you're interested in other aspects of the needs assessment process, please let us know. Thank you very much.

Interviewer: If the key informant has any questions, please feel free to answer as you feel comfortable. If there are questions beyond your comfort or knowledge. please refer them to the team and one of us will get back to the key informant.

Appendix D: Nevada Maternal and Child Health Environmental Scan Memo

Altarum

ENVIRONMENTAL SCAN MEMO | MAY 2025

Nevada Maternal and Child Health Environmental Scan Memo

Background

The Nevada Division of Public and Behavioral Health is conducting a comprehensive needs assessment to inform the development of their State Action Plan for Nevada's Maternal and Child Health (MCH) Block Grant Application. As part of the needs assessment, Altarum supported the state of Nevada with conducting an environmental scan of existing literature. This environmental scan will inform decisions around the prioritized actions for the next five years of the Block Grant and help Nevada's Maternal, Child, and Adolescent Health (MCAH) section assess feasibility, resource requirements, and timeline for prioritized actions and potential areas for larger policy and systems change.

In collaboration with Nevada Division of Public and Behavioral Health, Altarum developed the following research questions to guide the environmental scan:

1. What are the current health outcomes, disparities, and primary needs for mothers, infants, children, and adolescents in Nevada? How do these outcomes vary by demographic factors such as race, ethnicity, and socioeconomic status?
2. What barriers exist to accessing maternal and child health services in Nevada? How effectively are current programs and policies addressing these needs?
3. What key resources, health promotion initiatives, and data sources are available to support maternal and child health efforts in Nevada?

Methodology

Altarum conducted the environmental scan from January to March 2025. The scan included searches of peer-reviewed literature using EBSCO database and searches of grey literature using the first 20 outputs from Google. Analysts conducted searches using the search term combinations in **Exhibit 1**. Article inclusion and exclusion criteria are outlined below.

Exhibit 1. Search Terms

Research Question	Primary Search Term	Secondary Search Term
1. What are the current health outcomes, disparities, and primary needs for mothers, infants, children, and adolescents in Nevada? How do these outcomes vary by demographic factors such as race, ethnicity, and socioeconomic status? 2. What barriers exist to accessing maternal and child health services in Nevada? How effectively are current programs and policies addressing these needs? 3. What key resources, health promotion initiatives, and data sources are available to support maternal and child health efforts in Nevada?	• Maternal health AND • Pregnancy health AND • Postpartum health AND • Prenatal health AND • Perinatal health AND • Infant health AND • Child health AND • Adolescent health AND • Children with special health care needs AND	• Outcomes • Disparities • Equity • Social determinants of health • Mortality • Morbidity • Inequities

Inclusion Criteria

- Dates: Published within the past 10 years. Relevant articles sourced from publication citation lists with earlier publication dates will be included.
- Availability: Subscribed journals: free full text available on EBSCO and/or PubMed.
- Language: English
- Origin: USA, Nevada

Exclusion Criteria

- Dates: Published more than 10 years ago.
- Availability: Full text article unavailable.
- Language: Published in a language other than English.
- Origin: Studies focused outside of the United States and Nevada

Peer Reviewed Literature

Altarum conducted a series of searches in EBSCO using the search term combinations in **Exhibit 1**. Relevance to the environmental scan was based on researcher review of publication titles and abstracts. Publications meeting inclusion criteria based on review of study title and abstract were catalogued in Excel and the manuscript was reviewed in full. Pertinent information from relevant studies were abstracted and analyzed thematically. Studies identified after article review to not meet inclusion criteria were excluded from analysis. Snowball search methods were used to identify citations within publications' cited lists that were of relevance to the scan. In instances where searches returned large numbers of articles, search terms were further refined for specificity and accuracy to the research questions.

Grey Literature

Altarum conducted a series of searches in Google using the search combinations in **Exhibit 1**. The first 20 titles of Google searches were scanned to identify relevant grey literature items (including fact sheets, reports, resources, posters, toolkits, websites, and other materials) that met inclusion criteria. All items meeting inclusion criteria were catalogued in Excel, reviewed in full, and analyzed thematically. Snowball search methods were used to identify citations within publications that were of relevance to the scan.

Data Analysis and Reporting

Altarum reviewed catalogued peer-reviewed and grey literature sources to document their alignment with the research questions in a Microsoft Excel tracking sheet. There were 49 sources deemed relevant and synthesized for this report. Key findings from the scan were summarized for each of the five domains: women/maternal, perinatal/infant, child, adolescent, and children and youth with special health care needs.

Women/Maternal Health

Literature scan findings related to women and maternal health are displayed below. The top priorities referenced in the literature include access to prenatal care services and substance use.

Access to Prenatal Care Services

The Challenge

Access to maternal health services is critical in improving health outcomes for mothers and infants and disparities in access persist. According to the Maternal Mortality and Severe Maternal Morbidity Nevada report, from 2018-2020, Nevada recorded 20 pregnancy-related deaths.[1] Notable disparities are included below.[1]

Mortality rates for Black, non-Hispanic Nevadans were **4.3** times higher than rates for White, non-Hispanic Nevadans (80.7 vs. 18.7) and **5.2** times higher than Hispanic Nevadans (15.4) 2017–2018.

Pregnancy-associated death ratios (per 100,000 live births) were highest for American Indian and Alaska Native non-Hispanic Nevadans at **501.7** and for Black non-Hispanic Nevadans at **199.4** 2020–2021.

The **Maternal mortality rate** for Clark County (35.5) is **3.7** times higher than Washoe County (9.5).

Mortality rates were highest among those 35–39 years (71.9) and **5.4** times higher than those 20–24 years (13.4).

Additionally, Nevada faces significant challenges related to maternity care deserts (areas without access to birthing facilities or maternity care providers). According to the March of Dimes 2023 report:[2]

47.1% of Nevada counties are **maternity care deserts** compared to **32.6%** nationally

Approximately **10%** of women in Nevada **had no birthing hospital within 30 minutes** compared to **9.7%** nationally

15.9% of birthing people received **no or inadequate prenatal care,** exceeding the U.S. rate of **14.8%**

Opportunities and Ongoing Efforts

Telehealth services has been known to equip maternal health providers with the tools to better facilitate care before, during and after pregnancy and has been shown to not only increase but also improve patient engagement and treatment.[2] In Nevada, project ECHO Nevada assists patients and primary care providers in rural settings by offering telehealth consultations by specialty providers to patients in rural and underserved areas.[3] In 2023, project ECHO conducted 264 sessions with attendance by over 3,400 attendees, 14.5% were in attendance from rural Nevada.[3]

Substance Use

The Challenge

Substance use among women of childbearing age presents a significant challenge in Nevada.

In 2022, **18.1%** of Nevada **women of childbearing age** (18-44 years) reported **binge drinking** in the past month, compared to **19.7%** in the U.S.[4]

According to America's Health Rankings, **12.6%** of Nevada **women aged 18-49** reported **misusing prescription psychotherapeutics** (pain relievers, tranquilizers, stimulants or sedatives) **or using cocaine** (including crack), **heroin, hallucinogens, inhalants or methamphetamine** in the past year compared to **10.4%** in the U.S.[5]

Ongoing Efforts

Various substance use treatment initiatives operate across the state, including:

- **Priority admission** for pregnant and post-partum women seeking treatment at any Substance Abuse Prevention and Treatment Agency (SAPTA) funded treatment facility in Nevada.[6] A statewide substance use **hotline** implemented by **Crisis Support Services of Nevada (CSSNV)** is also available in partnership with The Bureau of Behavioral Health Wellness and Prevention.
- **Multidisciplinary care** provided by **Northern Nevada HOPES** to people with alcohol and opioid use disorders.
- Partners with **treatment centers** through Sober Moms, Healthy Babies.[8]
- Resources and services, including with addiction through **Nevada 2-1-1.**[9]
- Substance use prevention and treatment to pregnant and postpartum individuals offered by the **EMPOWERED Program.**[10]
- Medication-assisted treatment for opioid use disorder in pregnant people provided by the **Maternal Opioid Treatment, Health Education and Recovery (MOTHER) Project.**[11]
- Substance use prevention and substance use treatment to pregnant and postpartum individuals through the **Quest Counseling** and **Consulting NAS Program.**[12]

Perinatal/Infant Health

Literature scan findings related to perinatal and infant health are displayed below. The top priorities referenced in the literature include access to care, social determinants of health, and maternal health workforce.

Access to Care

The Challenge

To support new parents, access to adequate care is necessary to improve maternal and infant health outcomes in Nevada.[13]

In 2022, **16.3%** of **individuals who were pregnant** received **inadequate prenatal care** (defined as care beginning in the fifth month of pregnancy or later or having less than 50% of the recommended visits).[14]

In 2023, only **43%** of **infants and toddlers** received coordinated, ongoing, comprehensive **care within a medical home** compared to **51%** of the national average.[15]

In 2023, **10.7%** of **babies** in Nevada were born **preterm** vs. **10.1%** **babies** born **preterm** nationwide. Nevada also saw that **babies with a low birthweight** at **9%** babies compared to **8.2%** nationwide. [15]

Opportunities and Ongoing Efforts

In order to address these gaps in access to care and subsequent health outcomes, United Healthcare Health Plan of Nevada Medicaid collaborated with the Nevada Statewide Maternal and Child Health Coalition to distribute New Mama Care Kits to new parents across the state. [13] These kits included sanitary pads, wipes, breast pads, sanitizers and other essential items to help offer physical comfort, hygiene and alleviate the stress of meeting basic needs during the postpartum period.[13] Through this effort, 1,824 kits have been distributed across the state with 75% of the 1,517 kits distributed in Southern Nevada to people of color.[13]

Social Determinants of Health

Economic and social factors significantly impact maternal and child health outcomes. Mother and babies physical and mental health support provides the foundation for infants' lifelong physical, cognitive, emotional, and social wellbeing.[15] Nonmedical factors that significantly influence health outcomes include income, education level, employment status, housing quality, neighborhood environment, among others.

The Challenge

Families with young children may especially be vulnerable to housing instability.[16]

In Nevada, **housing instability** among **infants and toddlers**, who have moved three or more times since birth, is at **6.2%** vs **2.9%** nationally.[15]

The percentage of **infants and toddlers** who live in **unsafe neighborhoods** in Nevada is **9.6%** vs **5%** nationwide.[15]

Opportunities and Ongoing Efforts

Medicaid programs in the state have implemented new approaches to address housing instability which saw more than 90% of members maintain stable housing and nearly 60% of those who participated in the program and maintained housing were Black.[17] Two of these programs include:

- The Housing Flex Fund: one-time or short-term flexible financial assistance to members experiencing housing instability or homelessness (e.g., assistance with utility bills, payments for security deposits).[17]
- The Family Stabilization Program: a community-based housing assistance organization partnership that offers housing support services and flexible financial assistance to households with children.[17]

Increase Maternal Health Workforce

The Challenge

The preterm birth rate in **Nevada** was **11.1%** in 2023, higher than the rate in 2022.[14]

Preterm birth rates in **Carson City, Lyon, and Nye** worsened from last year with a birth rate of **12.6%, 13%, and 13.4%**.[14]

The preterm birth rate among babies born to **Black birthing people** is **1.3 times higher** than the rate among all other babies.[14]

Opportunities and Ongoing Efforts

However, the state has implemented policies that help support the growth and sustainability of the midwifery workforce including:

- State Medicaid extension to one-year postpartum coverage[14]
- State Medicaid expansion which allows birthing people greater access to preventative care during pregnancy[14]
- State Medicaid program that requires and reimburses for postpartum mental health[14] screening
- State Medicaid doula reimbursement policy[14]

Additionally, Molina Healthcare of Nevada and Birth Collaborative LV were selected to participate in the Institute for Medicaid Innovation National Doula Learning and Action Collaborative, a new multi-state, three-year initiative to increase access to community-based doula services for families of color who have Medicaid health care coverage.[18] Through this initiative, the Nevada team will receive individualized support and resources from IMI and a dedicated national advisory committee to develop sustainable initiatives that will increase access to, and coverage of, doulas for pregnant, birthing, and postpartum individuals enrolled in Medicaid.[18]

Child Health

Literature scan findings related to child health are displayed below. The top priorities referenced in the literature include access to adequate care, mental health services, and physical health.

Access to Adequate Care

Access to adequate care is important for the overall wellbeing and development of children. According to America's Health Rankings Report, Nevada ranks as number 25 in the country with 29.9 number of deaths per 100,000 children ages 1-19.[19] Key factors that can influence the ability to access quality care include consistent access to health insurance coverage. This factor can influence the risk of both health disparities and poor health outcomes.[20]

The Challenge

According to the 2022 - 2023 National Survey on Children's Health (NSCH) access to consistent health insurance coverage among children aged 6-11 years old is lower in Nevada compared to the United States (82.7% vs. 92.6%).[21] Additionally, the rate of medical care visits among children were lower in the state of Nevada compared to the United States. Among 0–5-year-old children, 86.1% had a health care visit in the past 12 months compared to the United States at 90%.[22] Among children aged 6-11 years old, only 78.9% of children had a health care visit compared to 82.7% in the United States.[23]

67.3% of **children** in Nevada have a **usual source of sick care** compared to **75.7%** of **children** in the United States.[23]

In terms of having **coordinated, ongoing, comprehensive care** within a medical home, only **33.9%** of **children** in Nevada have access compared to **45.3%** of **children** in the United States.[24]

This is coupled with only having **59.5** available **pediatricians** available for every **100,000 children** in Nevada.[25]

Opportunities and Ongoing Efforts

Intermountain Health offers patient care at more than 65 clinics across southern Nevada.[26] Most recently, a stand-alone children's hospital in Southern Nevada brings a long-needed need in Las Vegas to help provide comprehensive care for children.[26]

Mental Health Services

The Challenge

Mental health services are critical sources of care, especially among children who need them the most.

According to America's Health Rankings, approximately **15.5%** of **children ages 3-17** were told by a health care provider they have **ADHD, depression, or anxiety problems** or were told by a doctor or educator they have **behavior or conduct problems** between 2022 – 2023.[27]

Despite these rates of mental health needs among children in the state, according to the 2022 – 2023 NCSH survey, **26%** Nevada **children** found it **very difficult to get the mental health treatment or counseling** that was needed compared to **19.5%** of **children** in the United States.[28]

Opportunities and Ongoing Efforts

The 2023 Children's Mental Health Coalition was formed as a grass roots effort of individuals and organizations working together to identify gaps, recommend state level policies, and consolidate strategies. [28] These efforts help address behavioral health provider shortages in both training and retention across the state of Nevada[29] Other efforts include Molina Healthcare funding which aims to support the expansion of adult and child behavioral health services across the care continuum and supporting telehealth solutions to offer training and management support.[30]

Physical Health

The Challenge

According to the 2022 – 2023 NCSH survey, **8.8%** of **children aged 6-11 years old** in Nevada were told by a doctor or other healthcare provider that the child is **overweight** compared to **7.2%** in nationwide.[31]

Additionally, among **children aged 3-5 years old**, **45.3%** of children spend 1 hour or **less per day playing outdoors on weekdays** and **41.6%** on the **weekend** compared to **35.7%** and **22.7%** nationwide.[32]

12.5% children in Nevada spent **0 days engaging in exercise, playing a sport, or other physical activity for at least 60 minutes** compared to **10.8%** nationwide.[33]

Adolescent Health

Literature scan findings related to adolescent health are displayed below. Challenges include mental health, substance use, access to appropriate services, and teen pregnancy.

Access to Care

The Challenge

Nevada ranks high among the states with number of uninsured residents as well as distribution of health care professionals in Nevada—leading to widespread shortages across most types of care—including those serving adolescents. While school-based services can be a mitigator in addressing unmet needs, Nevada had the third lowest availability of school psychologists in 2022 across Mountain West states and the lowest availability of school social workers. Nevada's school mental health workforce operates with a quarter of the recommended number of school psychologists and has just 3% of the recommended number of social workers.[34]

In 2019, **66%** of **middle school** and **71%** of **high school students** in Nevada reported **visiting a dentist in the past year.** [20]

However, racial/ethnic differences exist, with **Hispanic/Latino children** experiencing more **tooth decay/cavities** **(20%)** than their **non-Hispanic** peers (**11.5%** **White children,** **10%** **Black children,** **9%** **Asian children).** [20]

Even compared to the national percentages of **Hispanic/Latino children** with **tooth decay/cavities** **(15%)**, Nevada's **Hispanic/Latino children** fared worse.[20]

Mental Health & Substance Use

The Challenge

Nevada ranks last among the 50 states and the District of Columbia in overall youth mental health rankings for 2015, 2020, 2021, and 2022.[34] Mental health is a critical component of the overall health and wellbeing of Nevada's adolescents.

According to a 2022 Nevada report, the percentage of **high school and middle school students** reporting feeling **sad or hopeless** are all the **highest** they have been since 2017.[35]

Additionally, **alcohol use disorder** among **ages 12 and above** reached a high in Nevada in 2021, despite Nevada **high school and middle school students** reporting **lower use of alcohol or marijuana.**[35]

Nevada ranks **37th** in the nation for **teen suicide**, with Nevada reporting **15 deaths** due to **intentional self-harm** per 100,000 adolescents **ages 15-19**, according to 2020-2022 data[36].

According to Nevada's most recent middle school Youth Risk Behavior Survey, there was an increase in the percentage of **middle schoolers** who were **bullied electronically**—from **12%** in 2019 to **18%** in 2021.[37]

In 2022, Nevada reported nearly **6%** of **youth** with a **substance use disorder** in the past year, ranking the highest among its neighboring Mountain West States (Arizona, Colorado, New Mexico, Utah).[34]

Teen Birth Rates

The Challenge

Births per 1,000 females ages 15-19 have decreased from 50 per 1,000 in 2008 to 14 in 2022.[38] While this is a positive trajectory, Nevada currently ranks 27th in the nation for teen births.

Children and Youth with Special Health Care Needs (CYSHCN)

With approximately 16% of Nevada children considered to have a special health care need,[39] ensuring they are connected with appropriate care and services is critical to their health, wellbeing, and ability to flourish. Literature scan findings related to children and youth with special health care needs are displayed below.

The Challenge

Issues impacting CYSHCN:

- **Medical home:** Medical home remains an area of focus nationally and in Nevada. According to the 2022-2023 NSCH, 25.8% of Nevada's CYSHCN population have care in what is considered a medical home[40]. This is significantly less than the national average of 39.7%.[41] It is also less than the percentage for children without a special health care need, of whom 33.9% have a medical home[40]. The national average is 45.3%.[41]
- **Transition of care for CYSHCN:** As adolescents with special health care needs age, their medical, social, and educational needs change. There is an important focus on transitioning childhood care into adult care for CYSHCN. This "transition of care for CYSHCN" is an important factor in ensuring CYSCHN health and well-being. In 2022-2023, just 11.8% of adolescents with special health needs received transitional care in Nevada[42]. This is roughly half of the national average of 22.3% of transitioning CYSHCN.[43]
- **Flourishing:** A newer Title V outcome measure is "flourishing." This focus is on ensuring all CYSHCN are not only healthy but thriving. Nationally, 35.3% of CYSHCN[44] met the criteria for flourishing, while Nevada CYSHCN were just shy of that at 32.9%.[44]

Opportunities and Ongoing Efforts

According to the 2022 annual report, Nevada's CYSHCN Program "provides resources and support to community agencies serving children ages birth to 21 years. The CYSHCN Program funds a variety of community programs to better serve children and families through a network of federal, state, University, and local community and family-based partners. CYSHCN Program Director and staff participate in community and family-led coalitions and committees, including being an appointee to the Nevada Governor's Council on Developmental Disabilities (NGCDD) and Newborn Screening Program Advisory Board, co-lead on the Nevada Mountain States Regional Genetic Network, Pritzker Foundation Nevada Team, and Healthy Start, and attending the Nevada Early Intervention Interagency Coordinating Council. Nevada's CYSHCN Program continues promotion of the MHP, a virtual resource which provides reliable information about medical conditions, care, and knowledge of valuable local and national services and resources, improving care coordination among children with and without special health care needs. The CYSHCN Program partners with the Nevada Center for Excellence in Disabilities (NCED) Family Navigation Network, Nevada's designated Family to Family Health Information and Education Center, which promotes the MHP, access to health care resources, referrals to adequate insurance coverage, care coordination services, and the CYSHCN toll-free hotline. A program accomplishment is the collaboration with the Rape Prevention and Education (RPE) Program and partners to create a resource on sexual assault prevention for those with developmental disabilities.[45]"

Cross-Cutting/Life Course

Access to insurance coverage and addressing substance use are critical components of maternal and child health in Nevada. The state's Title V MCH Program has implemented various initiatives to tackle these issues, aiming to improve health outcomes for women, infants, and children.

Insurance Status

Ensuring that MCH populations have access to adequate health insurance coverage is a risk factor across MCH population groups in order to receive services.[46] According to the 2020-2021 National Survey on Children's Health, access to consistent and adequate health insurance coverage is lower in Nevada (63.9%) compared to the United States (68.2%).[46] In order to access preventive care an manage health conditions effectively, consistent and adequate insurance coverage is essential.

Substance Use

Substance use during pregnancy poses significant risks to both mothers and infants. From 2018 to 2023, Nevada recorded 181 pregnancy-associated deaths (deaths by any cause while pregnant or within one year of the end of a pregnancy).[47] Of the 55 pregnancy-associated deaths in 2022 and 2023, thirteen were classified as non-transport accidents, a category that includes drug overdoses.[47] Additionally, according to Nevada PRAMS data, marijuana use during pregnancy in 2020 increased by 94% from 2017 to 2020.[45] Nevada's MCH Program is committing to reducing substance use among pregnant women through initiatives like providing resources such as the Substance Use During Pregnancy Provider Toolkit to equip healthcare providers with the necessary tools to support pregnant women in overcoming substance use disorders as well as materials like the CARA Plan of Care Form and provider fact sheets to guide healthcare professionals in creating tailored care plans for pregnant women dealing with substance use issues.[48,49]

Conclusions

This environmental scan revealed disparities and unmet needs across all five domains in Nevada: women/maternal, perinatal/infant, child, adolescent, and children and youth with special health care needs. Key challenges include limited access to care, especially in rural communities, substance use among pregnant women, mental health issues among youth, inadequate prenatal and pediatric care, and shortages in healthcare workforce and infrastructure. These disparities were particularly evident among racial and ethnic minorities. However, despite these challenges, the literature highlighted several promising initiatives such as telehealth innovations, maternal and behavioral health programming, and community partnerships aimed at improving care coordination and access among all populations.

This environmental scan will help provide context for shaping Nevada's Title V MCH State Action Plan as well as informing priority setting and decision-making for programs and policies, identifying opportunities for collaboration and engagement among state and community programs and help guide the allocation of resources.

As part of the five-year Title V MCH needs assessment cycle, this environmental scan will be repeated in 2030, The updated scan will allow Nevada to reassess community needs, review the effectiveness of implemented strategies, identify emerging trends, and refine priorities based on the evolving needs of each domain.

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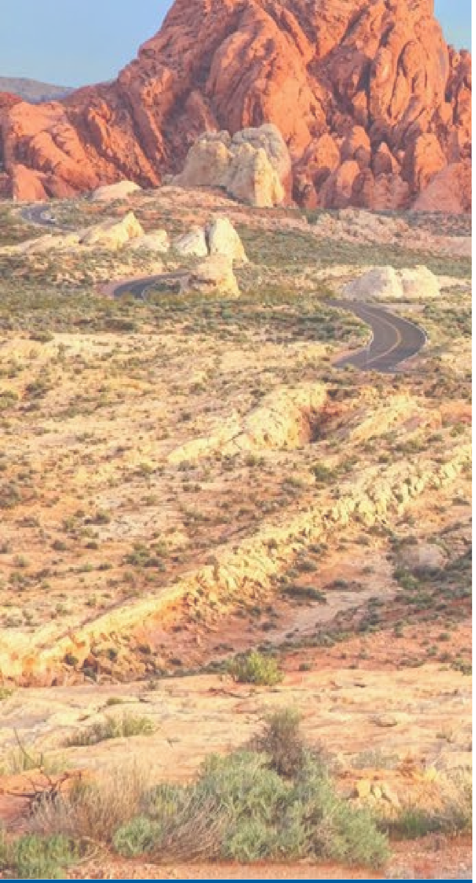
Appendix E: Epidemiological Data Sheets

Nevada Maternal & Child Health Block Grant

5-Year Needs Assessment

April 2025

NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH



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Introduction

Housed within the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), the Title V Maternal and Child Health (MCH) Block Grant funds states to improve the health of mothers, children, and their families. Every five years, the Title V MCH Block Grant requires states to conduct a needs assessment for their MCH population. The needs assessment provides states with the opportunity to reassess the strengths, capacities, emerging issues, and opportunities to improve their MCH policies, systems, and programs. The State of Nevada partnered with Altarum to support its 2025–2030 needs assessment.

To assist in informing the prioritization process of the needs assessment, Altarum conducted a scan and analysis of secondary data as part of a larger environmental scan. The evidence gathered through this scan is intended to provide a contextual starting point to understand current trends, practices, and issues. Additionally, findings from the scan will inform a data-driven understanding of the feasibility, resource requirements, and timeline for recommended actions and potential areas for larger policy and systems change to achieve desired outcomes.

The scan of secondary data included Nevada population-based data from programs and public health surveys as well as publicly available data, such as vital records, Medicaid, Pregnancy Risk Assessment Monitoring System (PRAMS), Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), National Survey of Children's Health (NSCH), and the US Census Bureau's American Community Survey (ACS). Where possible and to add further value and context to the findings, Altarum used the same datasets to compare differences between Nevada and national estimates.

This memo begins with a brief section on the demographics of the state of Nevada and an overview of some key social drivers of health. The findings of the scan are then presented in data sheets, organized by the five domains of Women and Maternal Health, Perinatal and Infant Health, Child Health, Adolescent Health, and Children and Youth with Special Health Care Needs (CYSHCN).

To note, during the development of this memo an executive order was issued that limited access to some publicly available data intended to be included in this memo. Although many general metrics were abstracted prior to the executive order, this did restrict the ability to gather more nuanced or stratified data for metrics of interest, limiting the ability to provide many comparisons across sub-groups. Additionally, data that was abstracted from public datasets could not undergo the planned quality assurance process as they were no longer accessible to be verified at this point in the memo development process.

State Population

Nevada is comprised of 17 counties and as of the 2020 Census, had a population of 3,104,614 (2020 Decennial Census). A large portion of the state's population (73%; 2,265,461 residents) resides in Clark County, home to Las Vegas, followed by Washoe County (16%; 486,492 residents). The county of Carson City, home of the capital, has 58,639 residents (2%). (Find population by county in Appendix A.) While Nevada is one of the most sparsely populated states, the state has experienced significant population growth in the last five years. The US Census Bureau estimates a population percent change from April 2020 to July 2024 of 5%.

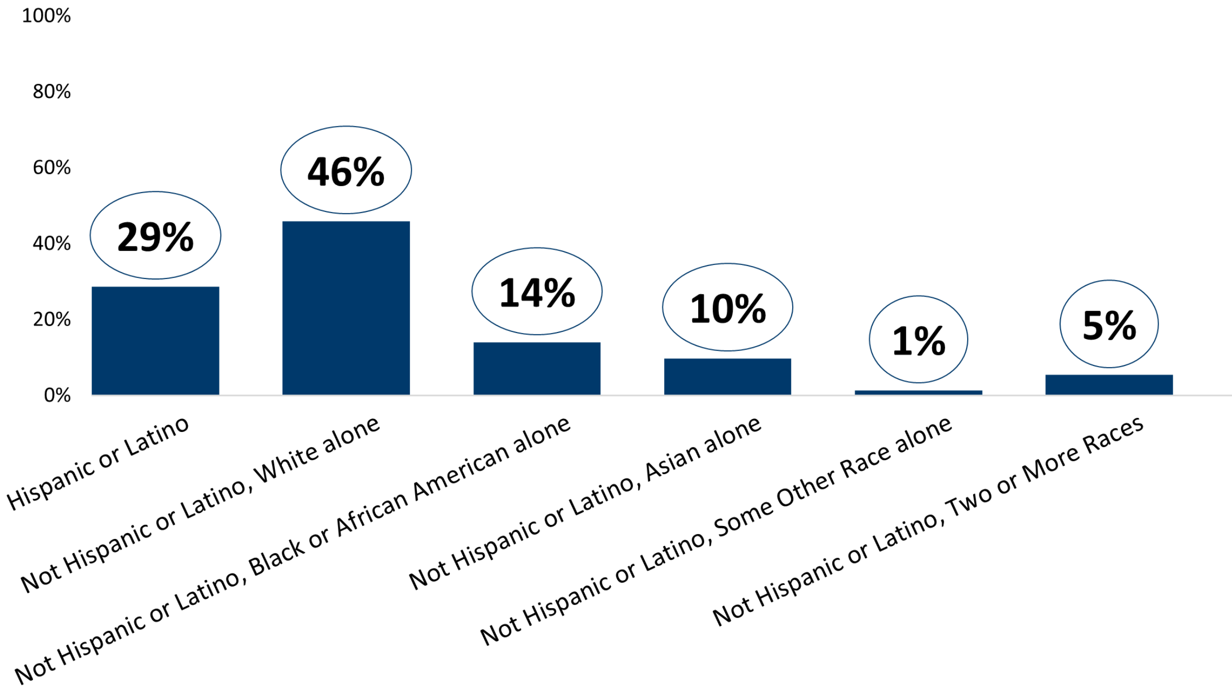
Demographics

This information provides context on Nevada's populations. Table 1 describes the age breakdown of Nevada residents, which roughly mirror the United States general population age groups.

Table 1. Population by Age Group: Nevada 2020

Age Group	Percent of Population
Under 5 years	6%
5 to 19 years	19%
20 to 34 years	20%
35 to 64 years	39%
65 years or older	17%

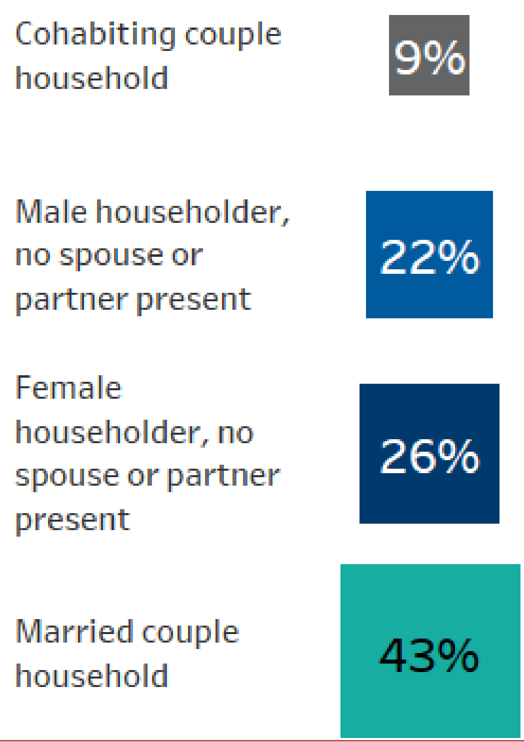
Figure 1. Nevada Population by Race/Ethnicity: 2020



According to 2020 US Census Bureau data, Nevada had the third highest "diversity index" of any state ([2020 US Population More Racially, Ethnically Diverse than in 2010](#)). More than a quarter of the state's population (29%) identified as Hispanic or Latino. Nevada's population is comprised of 50% males and 50% females, and 46% of Nevadan women are of reproductive age (15–49) (2020 US Census).

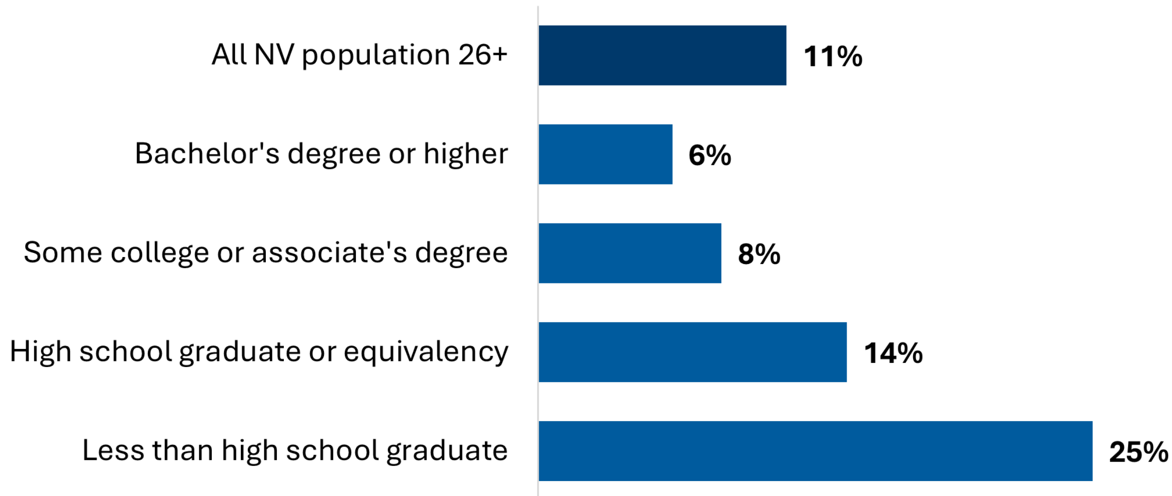
Out of the 1,177,649 households in Nevada, 43% of households were comprised of married couples (Figure 2), and a total of 361,423 (31%) were households with individuals under 18 years old. Out of households with children and youth under 18, 24% were households with a male or female householder with no spouse or partner present.

Figure 2. Nevada Households by Type: 2020



Although 89% of Nevada's civilian noninstitutionalized population reported having health insurance in 2020, insurance rates varied by educational attainment (Figure 3), with a higher percentage of individuals with a bachelor's degree or higher reporting having health insurance (94%) compared to other groups, especially Nevada residents with less than a high school degree (75%).

Figure 3. Percent of Nevada Residents with No Health Insurance, by Educational Attainment: 2020



According to the Centers of Disease Control and Prevention, 32% of adults in Nevada in 2022 had a disability with the most commonly reported disability types being disabilities which impact cognition (16%) and mobility (14%) (US State Profile Data: Adults 18+ Years of Age | Disability and Health Data System (DHDS) | CDC). Based on data from the 2022–2023 National Survey of Children's Health, an estimated 113,245 children in Nevada (16% of Nevada children) had special health care needs based on the CSHCN screener (NSCH 2022–23: Children with Special Health Care Needs Identified with the CSHCN Screener, Nevada).

1 in 3

Adults in Nevada have a disability.

Social Drivers of Health

In addition to income and poverty levels, priority areas related to social drivers of health that impact Nevada residents include:

Food Security

Health Literacy

Air Quality

Supportive Housing

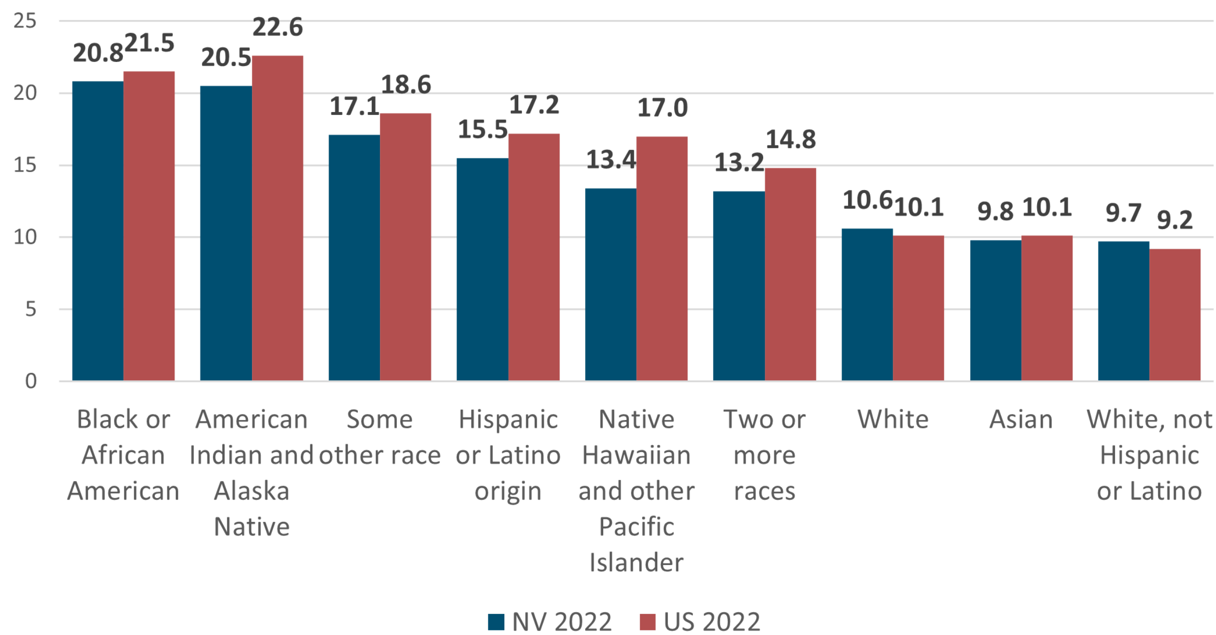
Based on 2022 American Community Survey 5-year estimates, approximately **12.7% of Nevada residents were living below the poverty level.** For the United States, this estimate was 12.5% for 2022.

The per capita income for Nevada residents in 2022 was $37,945. This has increased slightly since the estimate in 2020 of $32,629. For the United States, the per capita income estimate for 2022 was $41,804.

Table 2. Per Capita Income for Nevada Residents in 2022 Varied across Race/Ethnicity Groups

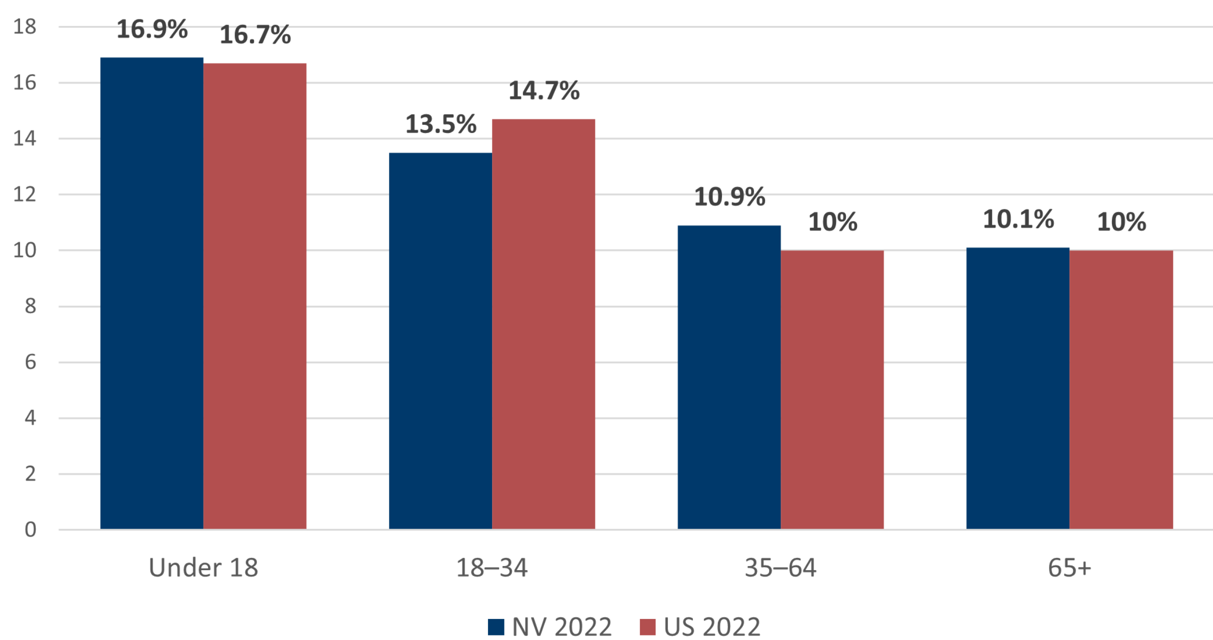
Race/Ethnicity	Income
White, non-Hispanic	$49,467
Asian	$40,679
Native Hawaiian/Other Pacific Islander	$29,409
Black/African American	$28,040
American Indian/ Alaska Native	$26,136
Two or more races	$25,828
Hispanic or Latino	$24,273
Some other race	$22,878

Figure 4. Percent Below Poverty Level by Race/Ethnicity



Nevada residents of a race or ethnicity other than White (9.7%) or Asian (9.8%) had a higher percent living below the poverty level in 2022, with the highest percents seen in the Black/African American (20.8%) and American Indian/Alaska Native (20.5%) populations.

Figure 5. Percent Below Poverty Level by Age



In 2022, Nevada residents under 18 have the highest percentage living below the poverty level at 16.9%, followed by those ages 18–34 at 13.5%.

Food Security

14.4%

Nevada population lived in neighborhoods with **low food access** in 2022

17%

Nevada children lived in **households that were food insecure** in 2020–2022

Based on data collected by Feeding America, in 2020 14.4% of the Nevada population lived in neighborhoods with low food access in 2022. This is compared to 12.8% in 2018. For the US overall in 2022, 13.5% of the US population was estimated to live in neighborhoods with low food access.

Data from 2020–2022 estimate that 17% of children in Nevada lived in households that were food insecure at some point during the year. This is compared to 15% based on 2018–2020 data. For the US overall, 16% of children lived in households that were food insecure based on 2020–2022 data (KIDS COUNT Data Center).

Food security measures include both food insecurity and low food access but also levels of obesity. Based on 2022 Behavioral Risk Factor Surveillance System data for women of reproductive age (18–44) in Nevada, 27% of women 18–24 had obesity and 36.4% of women 25–44 had obesity. Find a comparison to US-level 2022 data and 2020 Nevada estimates in Table 3.

Table 3. Percent of Women of Reproductive Age with a BMI of 30.0 or Higher

Age Group	Nevada 2020	Nevada 2022	US 2022
18–24	19.8%	27.0%	20.5%
25–44	24.2%	36.4%	34.8%

For youth, data from the Nevada Obesity–Annual Report Dec 2022 estimate that 12.3% of youth had obesity in 2019, compared to 14% in 2017.

Health Literacy

Based on 2023 American Community Survey estimates, 70.7% of Nevada residents over the age of 5 spoke English at home, followed by 19.9% speaking Spanish, 5.9% speaking an Asian or Pacific Island language, and 3.5% another language. These estimates are similar to 2020 Nevada data.

Compared to the US overall, Nevada had a lower percentage of the population speaking English at home (70.7% vs 78.0%) and a larger population speaking Spanish at home (19.9% vs 13.4%) and an Asian or Pacific Islander language (5.9% vs 3.5%).

29.3%

Nevada residents spoke a **language other than English** at home

Air Quality

47

Nevada's ranking among the 50 US states on **air pollution**

Environmental factors can also contribute to the health of a community. Air pollution is one metric used to assess the air quality. This metric is measured as average exposure to particulate matter (mixture of solid particles and liquid droplets found in the air such as dust, dirt, soot, or smoke) 2.5 or less. Based on current America's Health Rankings, Nevada ranked 47 out of the 50 states on Air Pollution at 9.8. Air Pollution data for Nevada from 2016–2017 had a measure of 9.7. Thus, the general public in Nevada had higher average exposure of air pollution than those in most other US states.

The overall US measure of average exposure to particulate matter 2.5 or less, based on 2021–2023 data, is 8.6.

Supportive Housing

More than 1/3

of Nevada children lived in households with a **high housing cost burden**

Based on 2022 data, 35% of Nevada children lived in a household with high housing cost burden (i.e., housing costs are >30% of pretax income, either for rent or mortgage). In 2019, this estimate was 33% of Nevada children. This is compared to the 2022 US estimate of 30%.

3.2%

of Nevada children have **experienced homelessness**

Based on 2023 data from the National Survey of Children's Health, Nevada has a higher percent of children who have ever experienced homelessness than the overall US estimate (3.2% vs 2.4%).

3.1%

of Nevada **students were homeless**

In 2022, 3.1% of students enrolled in school were homeless. This is a decrease from 3.8% in 2019 but remains higher than the US estimate based on 2021–2022 data of 2.2% (KIDS COUNT Data Center).

Women & Maternal Health Priorities 2020–2025

609,762

Total Nevada resident women of reproductive age (15–44)
(19.6% of Nevada's total population)*

Improve preconception and interconception health among women of childbearing age

47.5% of women 18–24 and
63.9% of women 25–44
had a preventative visit in the past year in 2023
(compared to 60.4% and 61.5% in 2020)

73.9%
of pregnant women
received prenatal care beginning in their first trimester in 2023
(compared to 78.2% in 2020)

4.9%
of mothers
reported late or no prenatal care in 2023
(compared to 3.3% in 2020)

Reduce substance use during pregnancy

2.7%
of pregnant women
smoked during pregnancy in 2022
(compared to 3.5% in 2020)[+]

93.3%
of PRAMs respondents
reported a prenatal healthcare worker asked if they were smoking cigarettes during pregnancy in 2022[+]
(compared to 91.0% in 2020)

5.6%
of women
who used substances
during pregnancy[+]

*Source: 2020 US Census
+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Women & Maternal Health

Overall Well-Being

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Percent of women of reproductive age (18–44) who reported their general health as good, very good, or excellent	**Age 18–24** 94.3% **Age 25–44** 86.8% (2020)	**Age 18–24** 91.3% **Age 25–44** 79.7% (2022)	**Age 18–24** -3% **Age 25–44** -7.1%	**Age 18–24** 87.9% **Age 25–44** 85.7% (2022)
Prevalence of diabetes in women	9.7% (2020)	11.8% (2023)	+2.1%	11.6% (2022)
Prevalence of high blood pressure in women	29.1% (2021)	29.7% (2023)	+0.6%	30.7 (2021)

Social Drivers of Health

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Percent of persons with recent live birth who experienced housing insecurity in the last year	1.6% (2020)	3.6% (2022)	+2.0%	n/a

Mental Health

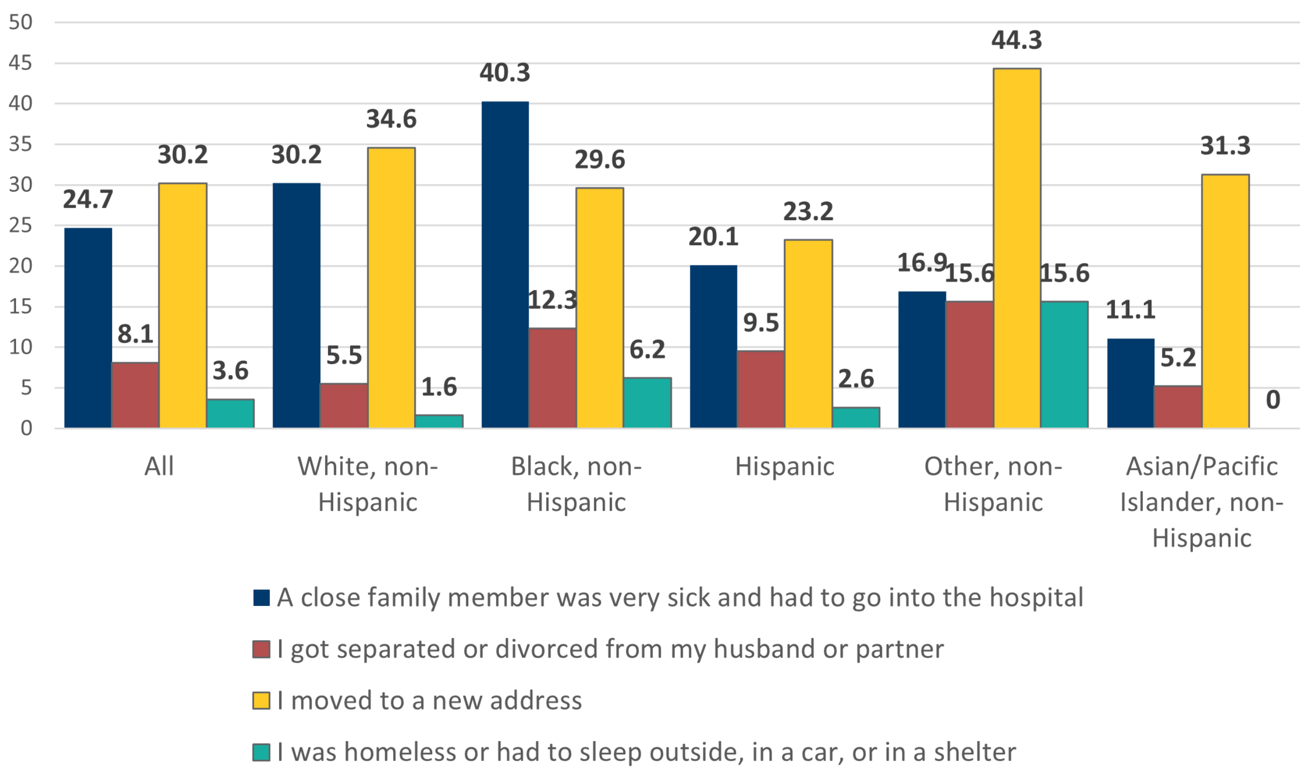
Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Prevalence of depressive disorder in women of reproductive age (18–44)	**Age 18–24** 35.6% **Age 25–44** 19.4% (2020)	**Age 18–24** 26.7% **Age 25–44** 23.3% (2022)	**Age 18–24** -8.9% **Age 25–44** +3.9%	**Age 18–24** 34.2% **Age 25–44** 28.9% (2022)
Average number of mentally unhealthy days reported in the past 30 days in women of reproductive age (18–44)	**Age 18–24** Zero days: 33.3% 1-13 days: 38.8% 14+ days: 27.9% **Age 25–44** Zero days: 46.6% 1-13 days: 33.5% 14+ days: 19.9% (2020)	**Age 18–24** Zero days: 32.9% 1-13 days: 45.7% 14+ days: 21.4% **Age 25–44** Zero days: 40.8% 1-13 days: 40.1% 14+ days: 19.1% (2022)	**Age 18–24** Zero days: -0.4% 1-13 days: +6.9% 14+ days: -6.5% **Age 25–44** Zero days: -5.8% 1-13 days: +6.6% 14+ days: -0.8%	**Age 18–24** Zero days: 29.0% 1-13 days: 40.1 14+ days: 30.9% **Age 25–44** Zero days: 43.0% 1-13 days: 35.8% 14+ days: 21.2% (2022)
Suicide rate per 100,000 women age (15–44)	n/a	0.8 (2023)	n/a	n/a
Prevalence of postpartum mood disorders+	17.6% (2020)	15.1% (2022)	-2.5%	12.7% (2021)

*Measure was a selected NOM/state priority from the previous needs assessment.
+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Spotlight: Stress and Substance Use during Pregnancy

Nevada women reported a range of stressful events occurring 12 months before their pregnancy, with the highest percentage of women reporting a close family member in the hospital or moving to a new address. The percentage of women reporting these events varied by race and ethnicity (Figure 1).

Figure 1. Percent of Nevada Women Who Reporting Stressful Life Events Occurring 12 Months before Pregnancy by Race/Ethnicity, 2022+



+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Overall pregnant women in Nevada reported low use of substances other than over-the-counter pain relievers with almost 60% reporting use in 2020 and over 70% in 2022. Additionally, over 10% of women reported using marijuana or hash in 2020, this estimate decreased to 0% in 2022 (Table 1). For those that did use substances during pregnancy about 11% said they had a current prescription, 1% said they had pain relievers left over from an old prescription, and 6% said they got pain relievers without a prescription.

Table 1. Percent of Women Reporting Use of Substances (Other than Alcohol or Tobacco) During Pregnancy in Nevada, 2020 Compared to 2022+

Substance	NV 2020	NV 2022
Over-the-counter pain relievers such as aspirin, Tylenol®, Advil®, or Aleve®	58.3%	70.4%
Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), codeine	3.9%	6.8%
Adderall®, Ritalin®, or another stimulant	0.6%	0%
Marijuana or hash	10.7%	0%
Synthetic marijuana (K2, Spice)	0%	0%
Methadone, naloxone, subutex, or Suboxone®	0.5%	1.2%
Heroin (smack, junk, black tar, Chiva)	0.5%	0%
Amphetamines (uppers, speed, crystal meth, crank, ice, *agua*)	0.4%	0%
Cocaine (crack, rock, coke, blow, snow, *nieve*)	0%	0%
Tranquilizers (downers, ludes)	0%	0%
Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, bath salts)	0.2%	0%
Sniffing gasoline, glue, aerosol spray cans, or paint to get high (huffing)	0%	0%

+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Preconception/Interconception Health

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Preventative medical visit in the last year*	**Past year** 72.7% **Past 2 years** 13.4% **Past 5 years** 8.0% **5+ years** 5.5% **Never** 0% (2020)	**Past year** 77.7% **Past 2 years** 9.5% **Past 5 years** 7.8% **5+ years** 4.2% **Never** 0% (2023)	**Past year** +5% **Past 2 years** -3.9% **Past 5 years** -0.2% **5+ years** -1.3% **Never** 0	**Age 18–24** **Past year:** 69.7% **Past 2 years:** 15.7% **Past 5 years:** 9.6% **5+ years:** 4.0% **Never:** 1.0% **Age 25–44** **Past year:** 73.3% **Past 2 years:** 13.6% **Past 5 years:** 7.9% **5+ years:** 4.4% **Never:** 0.7% (2022)
Cervical cancer screening	n/a	81.2% (2020)	n/a	82.8% (2020)
Breast cancer screening	69.6% (2020)	62.7% (2022)	-6.9%	73.1% (2022)

*Measure was a selected NOM/state priority from the previous needs assessment.

Pregnancy/Postpartum Health

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Initiating prenatal care during first trimester*	78.2% (2020)	73.9% (2023)	-4.3%	n/a
Initiating prenatal care late or never*	3.3% (2020)	4.9% (2023)	+1.6%	n/a
Unintended pregnancy (indicated did not want pregnancy then or anytime)+	7.8% (2020)	4.3% (2022)	-3.5%	n/a
Dentist visit during pregnancy+	31.4% (2020)	36.9% (2022)	+5.5%	n/a
Maternal mortality rate (per 100,000 live births)	22.4 (2017)	19.2 (2020)	-3.2	32.9 (2021)
Severe maternal mortality rate (per 10,000 deliveries)	60.1 (2016)	89.1 (2020)	+29.0%	88.3 (2020)

*Measure was a selected NOM/state priority from the previous needs assessment.

+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Substance Use

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Smoking during pregnancy*+	3.6% (2020)	2.7% (2022)	-0.9%	5.4 (2021)
Using e-cigarettes during pregnancy+	0.8% (2020)	2.7% (2022)	+1.9%	n/a
Healthcare worker asked about smoking during prenatal visit*+	91.0% (2020)	93.3% (2022)	+2.3%	n/a

*Measure was a selected NOM/state priority from the previous needs assessment.
+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Violence

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Intimate partner violence, violence from family member, or someone else during pregnancy+	**Husband or Partner** 2.2% **Ex-husband of ex-partner** 0.7% **Another family member** 0.9% **Someone else** 0.1%	**Husband or Partner** 3.0% **Ex-husband of ex-partner** 0.4% **Another family member** 0.1% **Someone else** 0.3%	**Husband or Partner** +0.8% **Ex-husband of ex-partner** -0.3% **Another family member** -0.8% **Someone else** +0.2%	n/a

+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Bright Spots

77.7%

of Nevada women had a preventive medical visit in 2023, an increase from 72.5% in 2020

2.7%

of pregnant Nevada women smoked during pregnancy in 2022, a decrease from 3.5% in 2020 and lower than the US estimate of 5.4% in 2021+

9%

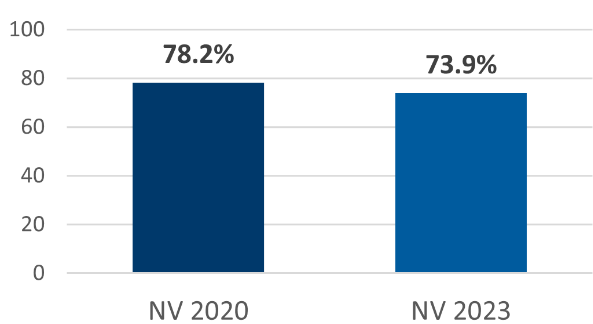
Decrease in the prevalence of depressive disorder in women 18–24 from 35.6 % in 2020 to 26.7% in 2022 (US: 34.2%)

+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Opportunities: Prenatal Care

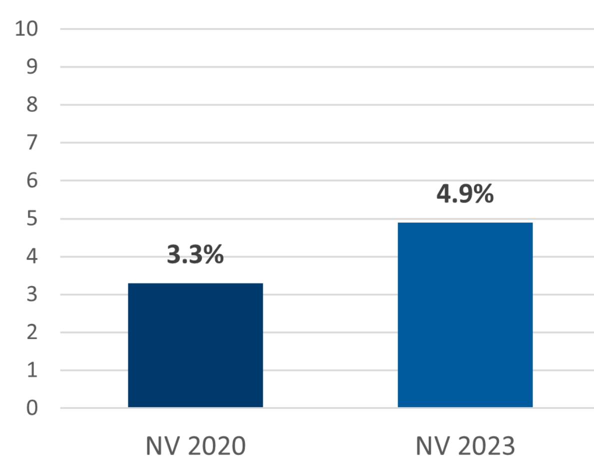
The percent of pregnant Nevada women who initiate prenatal care during the first trimester has decreased since 2020 from over 78% of pregnant women to about 74% in 2023 (Figure 2).

Figure 2: Percent of Pregnant Women Initiating Prenatal Care During the First Trimester



Additionally, the percentage of pregnant women initiating care late or never has increased from 3.3% in 2020 to almost 5% in 2023 (Figure 3).

Figure 3. Percent of Pregnant Women Initiating Prenatal Care Late or Never



Data Sources: Women & Maternal Health

Health Measure	Current Measure	Source: NV	Measure	Source: USA
Percent of women of reproductive age (18–44) who reported their general health as good, very good, or excellent	**Age 18–24** 91.3% (CI: 84.9-97.6) **Age 25–44** 79.7% (CI: 74.5-84.9) (2022)	Behavioral Risk Factor Surveillance System 2022 Prevalence & Trends Data	**Age 18–24** 87.9% (CI: 86.9-89.0) **Age 25–44** 85.7% (CI: 85.1-86.4) (2022)	Behavioral Risk Factor Surveillance System 2022 Prevalence & Trends Data
Prevalence of diabetes in women	11.8% (CI: 8.7–14.8) (2023)	Behavioral Risk Factor Surveillance System 2023 Prevalence & Trends Data	11.6% (CI: 11.3–11.9) (2022)	CDC Chronic Disease Indicators
Prevalence of high blood pressure in women	29.7% (CI: 25.8–33.6) (2023)	Behavioral Risk Factor Surveillance System 2023 Prevalence & Trends Data	11.6% (CI: 11.3–11.9) (2022)	CDC Chronic Disease Indicators
Prevalence of depressive disorder in women of reproductive age (18–44)	**Age 18–24** 26.7% (CI: 14.9-38.4) **Age 25–44** 23.3% (CI: 18.2–28.3) (2022)	Behavioral Risk Factor Surveillance System 2022 Prevalence & Trends Data	**Age 18–24** 34.2% (CI: 32.7-35.6) **Age 25–44** 28.9% (CI: 28.2–29.6) (2022)	Behavioral Risk Factor Surveillance System 2022 Prevalence & Trends Data
Average number of mentally unhealthy days reported in the past 30 days in women of reproductive age (18–44)	**Age 18–24** **Zero:** 33.3 (CI: 21.1-45.5) **1-13:** 38.8 (CI: 25.9-51.7) **14+:** 27.9 (CI:16.7-39.2) **Age 25–44** **Zero:** 46.6 (CI:39.4-53.8) **1-13:** 33.5 (CI:27.0-40.0) **14+:** 19.9 (CI: 14.2–25.7) (2020)	Behavioral Risk Factor Surveillance System 2022 Prevalence & Trends Data	**Age 18–24** **Zero:** 29.0 (CI: 27.4-30.5) **1-13:** 40.1 (CI: 38.6-41.6) **14+:** 30.9 (CI: 29.5-32.3) **Age 25–44** **Zero:** 43.0 (CI: 42.2-43.8) **1-13:** 35.8 (CI: 35.0-36.6) **14+:** 21.2 (CI: 20.5-21.8) (2022)	Behavioral Risk Factor Surveillance System 2022 Prevalence & Trends Data
Suicide rate per 100,000 women (ages 15–44)	0.8 (2023)	NV Title V data	n/a	n/a
Prevalence of postpartum mood disorders⁺	15.1% (2022)	PRAMS 2022–provided by NV	12.7% (CI: 12.2–13.3) (2021)	CDC Chronic Disease Indicators

Health Measure	Current Measure	Source: NV	Measure	Source: USA
Preventative medical visit in the last year	**Within past year** 77.7% (CI:73.9-81.6) **Within past 2 years** 9.5% (CI: 6.7-12.3) **Within past 5 years** 7.8% (CI:5.3-10.4) **5+ years** 4.2% (CI:2.4-6.1) **Never** 0% (2023) Note: sample size too small for age breakdown of NV data	Behavioral Risk Factor Surveillance System 2023 Prevalence & Trends Data	**Age 18–24** **Within past year** 69.7% (CI: 68.2-71.2) **Within past 2 years** 15.7% (CI: 14.6-16.9) **Within past years** 9.6% (CI: 8.6-10.6) **5+ years** 4.0% (CI:3.4-4.6) **Never** 1.0% (CI:0.7-1.2) **Age 25–44** **Within past year** 73.3% (CI: 72.6-74.1) **Within past 2 years** 13.6% (CI:13.1-14.2) **Within past 5 years** 7.9% (CI: 7.5-8.3) **5+ years** 4.4% (CI: 4.1-4.8) **Never** 0.7% (CI: 0.6-0.8) (2022)	Behavioral Risk Factor Surveillance System 2022 Prevalence & Trends Data
Cervical cancer screening	81.2% (CI: 76.7–84.9) (2020)	CDC Chronic Disease Indicators	82.8% (CI: 82.3–83.4) (2020)	CDC Chronic Disease Indicators
Breast cancer screening	62.7% (58.3–67.0) (2022)	Behavioral Risk Factor Surveillance System 2022 Prevalence & Trends Data	73.1% (CI: 71.8–74.5) (2022)	CDC Chronic Disease Indicators
Initiating prenatal care during first trimester	73.9% (2023)	NV Title V Block Grant - NV Vital Records	n/a	n/a
Initiating prenatal care late or never	4.9% (2023)	NV Title V Block Grant - NV Vital Records	n/a	n/a
Unintended pregnancy[+]	4.3% (2022)	PRAMS 2022–provided by NV	n/a	n/a
Dentist visit during pregnancy[+]	36.9% (2022)	PRAMS 2022–provided by NV	n/a	n/a
Maternal mortality rate (per 100,000 live births)	19.2 (2018–2020)	MMRC MM and SMM LCB Report December 28 2022	32.9 (2021)	CDC Maternal Mortality Rates in the United States, 2021
Severe maternal mortality rate (per 10,000 deliveries)	89.1 (2020)	MMRC MM and SMM LCB Report December 28 2022	88.3 (2020)	NV Maternal, Child, and Adolescent Health Data Overview Federally Available Data

Health Measure	Current Measure	Source: NV	Measure	Source: USA
Percent of persons with recent live year who report four or more stressful life events occurring in the 12 months before pregnancy+	Figure 7	PRAMS 2022–provided by NV	n/a	n/a
Percent of persons with recent live birth who experienced housing insecurity in the last year+	3.6% (2022)	PRAMS 2023–provided by NV	n/a	n/a
Smoking during pregnancy+	2.7% (2022)	NV Title V Block Grant–NV PRAMS	5.4% (CI: 5.0–5.8) (2021)	CDC Chronic Disease Indicators
Using e-cigarettes during pregnancy+	2.7% (2022)	PRAMS 2022–provided by NV	n/a	n/a
Healthcare worker asked about smoking during prenatal visit+	93.3% (2022)	NV Title V Block Grant–NV PRAMS	n/a	n/a
Substance use (other than tobacco or alcohol) during pregnancy+	Figure 8	PRAMS 2022–provided by NV	n/a	n/a
Intimate partner violence, violence from family member, or someone else during pregnancy+	**Husband or Partner** 3.0% **Ex-husband or -partner** 0.4% **Another family member** 0.1% **Someone else** 0.3%	PRAMS 2022–provided by NV	n/a	n/a

+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Perinatal and Infant Health Priorities 2020–2025

31,868

Total births in Nevada

(1.0% of Nevada's total population)*

Promote breastfeeding

79.3% infants
who were ever breastfed in 2021
(compared to 83.4% in 2018)

26.1% infants
breastfed exclusively for
6 months in 2021
(compared to 28.0% in 2018)

1.3% PRAMS respondents who
stopped breastfeeding due to
lack of support from family or
friends in 2022[+]
(compared to 2.2% in 2020)

*Source: US Census ACS 5-Year Estimates Public Use Microdata Sample (2023)
+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Promote safe sleep

75.1% infants
placed to sleep on their
backs in 2022[+]
(compared to 75.6% in 2020)

31.4% infants
placed to sleep on a separate
approved sleep surface in 2022[+]
(compared to 33.2% in 2020)

45.9% infants
placed to sleep without soft
objects or loose bedding in 2022[+]
(compared to 39.7% in 2020)

79.6% PRAMS respondents
who reported infants laid to sleep
in high-risk sleep position and/or
environment in 2022[+]
(compared to 78.0% in 2020)

Infant & Perinatal Health

Breastfeeding

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Initiated breastfeeding*	83.4% (2018)	79.3% (2021)	-4.1%	84.1% (2021)
Exclusive breastfeeding through 6 months*	28.0% (2018)	26.1% (2021)	-1.9%	27.2% (2021
Reason to stop breastfeeding: Lack of support from friends/family*+	2.2% (2020)	1.3% (2022)	-0.9%	n/a

*Measure was a selected NOM/state priority from the previous needs assessment.

+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Fetal and Infant Mortality (and Related Measures)

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Infant mortality (per 1,000 live births)	4.64 (2020)	4.49 (2022)	-0.15	5.60 (2022)
Infant deaths due to SUID (per 100,000 live births)	142.6 (2018)	101.1 (2020)	-41.5	92.5 (2020)
Preterm birth rate	10.1% (2018)	11.1% (2023)	+1.0%	10.4% (2023)
Perinatal mortality (per 1,000 live births plus fetal deaths)	5.9 (2018)	6.4 (2021)	+0.5	n/a
Births born low birth weight (<2500g)	8.7% (2018)	8.1% (2023)	-0.6%	8.6% (2022)

Substance use During Pregnancy

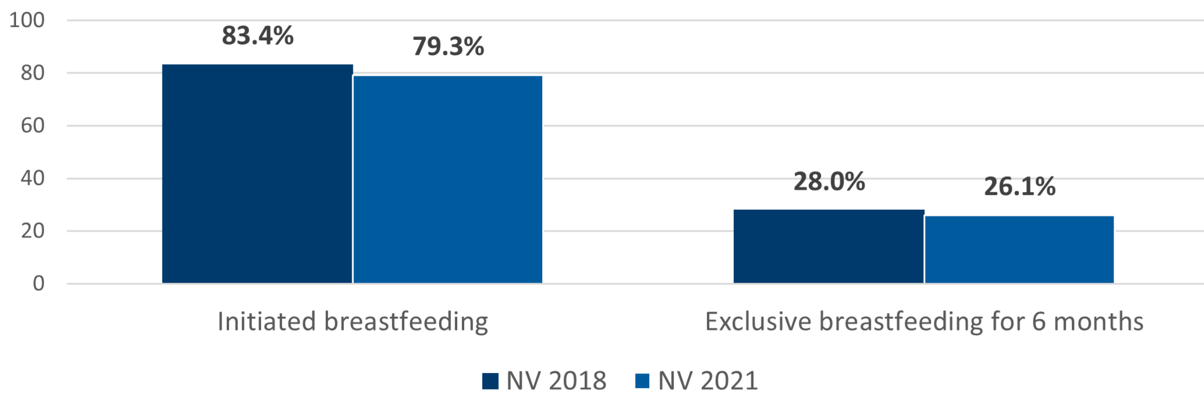
Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Infants born with NAS (per 1,000 live births)	7.6 (2018)	5.7 (2020)	-1.9	6.2 (2020)

Infant Health

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Score on the USCDC Maternity Practices in Infant Nutrition and Care (mPINC) survey	72 (2020)	79 (2022)	+7	81 (2022)

Spotlight and Opportunity: Breastfeeding

Figure 1. Percent of Women Reporting Initiating Breastfeeding and Exclusive Breastfeeding for 6 Months



The percent of mothers in Nevada reporting initiating breastfeeding has decreased from over 83% in 2018 to under 80% in 2021. This is compared to the national 2021 estimate of 84% of women initiating breastfeeding.

A similar trend was seen in mothers reporting exclusive breastfeeding for 6 months. This estimate was 28% in 2018 and decreased to 26% in 2021. This is compared to the national 2021 estimate of 27% of women exclusively breastfeeding for 6 months. Women reported multiple reason to stop breastfeeding. Find a comparison of reported reasons from 2020 and 2022 in Table 1.

Table 1. Reasons Women Stopped Breastfeeding+

Reason	% (2020)	% (2022)
I thought I was not producing enough milk, or my milk dried up	26.1	29.0
Breast milk alone did not satisfy my baby	18.0	11.8
My baby had difficulty latching or nursing	15.7	16.9
My nipples were sore, cracked, or bleeding or it was too painful	9.0	10.2
I thought my baby was not gaining enough weight	8.9	5.3
I had too many other household duties	8.4	11.2
I went back to work	6.3	9.1
I felt it was the right time to stop breastfeeding	5.6	10.3
My baby was jaundiced (yellowing of the skin or whites of the eyes)	5.6	6.4
I got sick or I had to stop for medical reasons	4.0	3.4
I did not have support from family or friends	2.2	1.4
I went back to school	0.6	1.0
My partner did not support breastfeeding	0.0	1.6
Other	10.3	8.1

+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Safe Sleep

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Infants placed to sleep on their backs*+	75.6% (2020)	75.1% (2022)	-0.5%	n/a
Infants placed alone on approved sleep surface*+	33.2% (2020)	31.4% (2022)	-1.8%	n/a
Infants sleeping without soft bedding*+	39.5% (2020)	45.9% (2022)	+6.4%	n/a
Infants laid to sleep in a high-risk sleep position and /or environment*+	78.0% (2020)	79.6% (2022)	+1.6%	n/a

*Measure was a selected NOM/state priority from the previous needs assessment.
+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Pregnant Women Health

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Rate of gestational diabetes (per 1,000 live births)	6.5 (2016)	8.0 (2020)	+1.5	7.8 (2020)
Rate of gestational hypertension (per 1,000 live births) +	n/a	85.8 (2023)	n/a	95.2 (2022)

+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Bright Spots

41.6

Decrease in rate of infant deaths due to SUID (per 100,000 live births) from 2018–2020

85.8

Rate of gestational hypertension (per 1,000 live births) in Nevada compared to 95.2 in the US overall in 2022+

+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Data Sources: Infant & Perinatal Health

Health Measure	Current Measure	Source: NV	Measure	Source: USA
Initiated breastfeeding	79.3 % (+/-5.2%) (2021)	CDC NIS Child Data Results	84.1% (+/-0.9%) (2021)	CDC NIS Child Data Results
Exclusive breastfeeding through 6 months	26.1% (+/- 5.4%) (2021)	CDC NIS Child Data Results	27.2% (+/- 1.0%) (2021)	CDC NIS Child Data Results
Reason to stop breastfeeding: Lack of support from friends/family +	1.3% (2022)	NV Title V Block Grant–NV PRAMS	n/a	n/a
Infant mortality (per 1,000 live births)	4.49 (2022)	CDC Infant Mortality Rates by State	5.6 (2022)	NCHS Data Brief, Number 492, December 2023
Infant deaths due to SUID (per 100,000 live births)	101.0 (2020)	NV Maternal, Child, and Adolescent Health Data Overview Federally Available Data	92.5 (2020)	NV Maternal, Child, and Adolescent Health Data Overview Federally Available Data
Preterm birth rate	11.1% (2023)	CDC Percentage of Births Born Preterm by State	10.4% (2023)	CDC Percentage of Births Born Preterm by State
Perinatal mortality (per 1,000 live births plus fetal deaths	6.4 (2021)	NV Title V Block Grant–NVSS	n/a	n/a
Births born low birth weight (<2500g)	8.1% (2023)	NV Title V Block Grant–Vital Statistics	8.6% (2022)	National Vital Statistics Reports Volume 73, Number 2, April 4, 2024
Infants born with NAS (per 1,000 live births)	5.7 (2020)	NV Maternal, Child, and Adolescent Health Data Overview Federally Available Data	6.2 (2020)	NV Maternal, Child, and Adolescent Health Data Overview Federally Available Data
Score on the USCDC Maternity Practices in Infant Nutrition and Care (mPINC) survey	79 (2022)	CDC mPINC™ State Reports	81 (2022)	CDC mPINC™ National Report
Infants placed to sleep on their backs +	75.1% (2022)	NV Title V Block Grant–NV PRAMS	n/a	n/a
Infants placed alone on approved sleep surface +	28.9% (2022)	NV Title V Block Grant–NV PRAMS	n/a	n/a
Infants sleeping without soft bedding +	42.2% (2022)	NV Title V Block Grant–NV PRAMS	n/a	n/a

Health Measure	Current Measure	Source: NV	Measure	Source: USA
Infants laid to sleep in a high-risk sleep position and /or environment +	76.2% (2022)	NV Title V Block Grant–NV PRAMS	n/a	n/a
Rate of gestational diabetes (per 1,000 live births)	8.0 (CI: 7.7–8.3) (2020)	National Vital Statistics Reports Volume 71, Number 3 July 19, 2022	7.8 (CI: 7.8–7.8) (2020)	National Vital Statistics Reports Volume 71, Number 3 July 19, 2022
Rate of gestational hypertension (per 1,000 live births) +	85.8 (2023)	NV PRAMS	95.2 (2022)	ChildStats: Gestational Hypertension: Rate of women with gestational hypertension by age group, race and Hispanic origin, and metropolitan statistical area status, 2016–2022

+ The 2022 Nevada PRAMS data response rate was 30.5% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.

Child Health Priorities 2020–2025

366,461

Total Nevada residents under 9 years of age
(11.8% of Nevada's total population)*

Increase developmental screening

23.8%
of children (9–35 months)
who received developmental
screening in the past year in 2023
(compared to 36.9% in 2020)

8.9%
Medicaid enrolled children
(9–35 months)
who received developmental
screening in 2023

Promote a medical home

35.4%
of children (0–17 months)
who had a medical home in 2023
(compared to 35.5% in 2021)

*Source: 2020 US Census

Child Health

General Well-Being

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Children 35 months fully vaccinated	70.0% (2018)	60.4% (2021)	-9.5%	72.2% (2021)
Children screened for blood lead levels	4% (2018)	2% (2021)	-2%	11% (2021)
Children screened with elevated blood lead levels	0.6% (2018)	0.4% (2021)	-0.2%	1.3% (2021)
Child mortality rate	13.1 (2020)	19.9 (2022)	+6.8	n/a
Children for whom parents report excellent or very good health	89.2% (2019–2020)	89.8% (2022–2023)	+0.6%	90.0% (2022–2023)

Nutrition and Activity

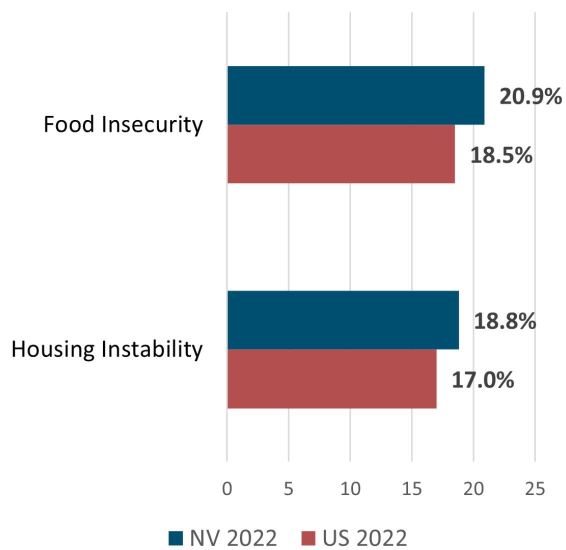
Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Children (age 6–17) currently overweight or obese	32.1% (2019–2020)	34.6% (2022–2023)	+2.5%	32.2% (2022–2023)
Children (age 6–17) who are physically active at least 60 minutes every day	14.6% (2019–2020)	13.3% (2022–2023)	-1.3%	20.0% (2022–2023)

Spotlight: Social Drivers of Health

16.1%

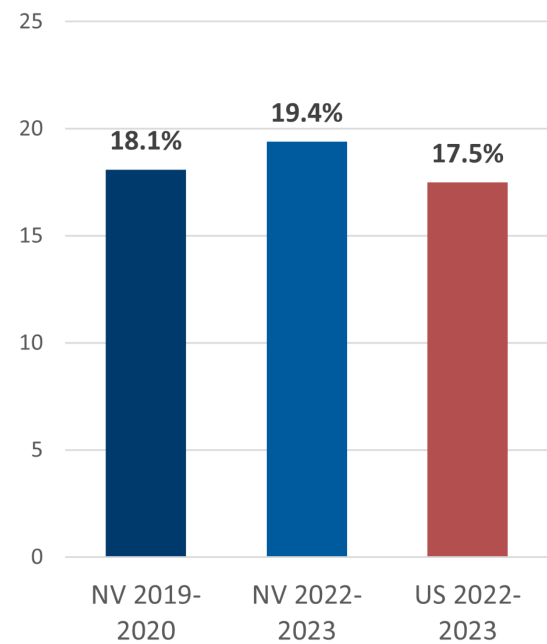
of **Nevada children were living in** poverty in 2023,
this number has decreased from 17.7% in 2018
(compared to 16.0% for the US in 2023)

Figure 1. Percent of Children Experiencing Food Insecurity and Housing Instability, Nevada compared to the US in 2022



Children in Nevada experienced food and housing insecurity at a higher rate compared to children in the US overall. About 20.9% of children in Nevada experienced food insecurity in 2022 (compared to 18.5% for the US). This estimate has increased from 19.5% of Nevada children in 2018. About 18.8% of Nevada children experienced housing instability in 2022, compared to the US estimate of 17.0% overall.

Figure 2. Children Who Experienced 2+ Adverse Childhood Experiences (ACEs)



The percent of children who experienced 2 or more ACEs has increased in Nevada from 18.1% in 2019–2020 to 19.4% in 2022–2023. These percentages are both above the national estimate for 2022–2023 for 17.5% of children who experienced two or more ACEs.

Access to Care/Medical Home

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Children who have a medical home*	**CSHCN** 25.2% **Non-CSHCN** 35.5% (2021–2022)	**CSHCN** 25.8% **Non-CSHCN** 35.4% (2022–2023)	**CSHCN** +0.6% **Non-CSHCN** -0.1%	**CSHCN** 39.7% **Non-CSHCN** 46.8% (2022–2023)
Children who had a preventative medical care visit in the past year	71.7% (2019–2020)	71.4% (2022–2023)	-0.3%	78.7% (2022–2023)
Children (ages 1–17) who had a preventative dental visit in the past year	71.7% (2019–2020)	75.4% (2022–2023)	+3.7%	79.2% (2022–2023)
Children with a personal doctor or nurse	62.0% (2019–2020)	63.2% (2022–2023)	+1.2%	71.8% (2022–2023)

*Measure was a selected NOM/state priority from the previous needs assessment.

Developmental Screening

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Children (ages 9–35 months) who received a developmental screening*	36.9% (2019–2020)	23.8% (2022–2023)	-13.1%	35.6% (2022–2023)

*Measure was a selected NOM/state priority from the previous needs assessment.

Education

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Young children (ages 3 and 4) not in school	64% (2013–2017)	67% (2018–2022)	+3%	54% (2018–2022)
Children (ages 3–5) whose health status meets the criteria for school readiness	n/a	86.7% (2022–2023)	n/a	89.1% (2022–2023)
Children (ages 0–5) whose parents read to them every day	29.5% (2019–2020)	32.9% (2022–2023)	+3.4%	40.4% (2022–2023)
Children (ages 0–5) with ECE needs met	n/a	35.8% (2010)	n/a	n/a
Children (ages 6–12) with ECE needs met	n/a	18.7% (2010)	n/a	n/a

Bright Spots

75.4%

of Nevada children (1–17) had a preventive dental visit in the past year in 2023, an increase from 71.7% in 2020 (US: 79.2%)

3.4%

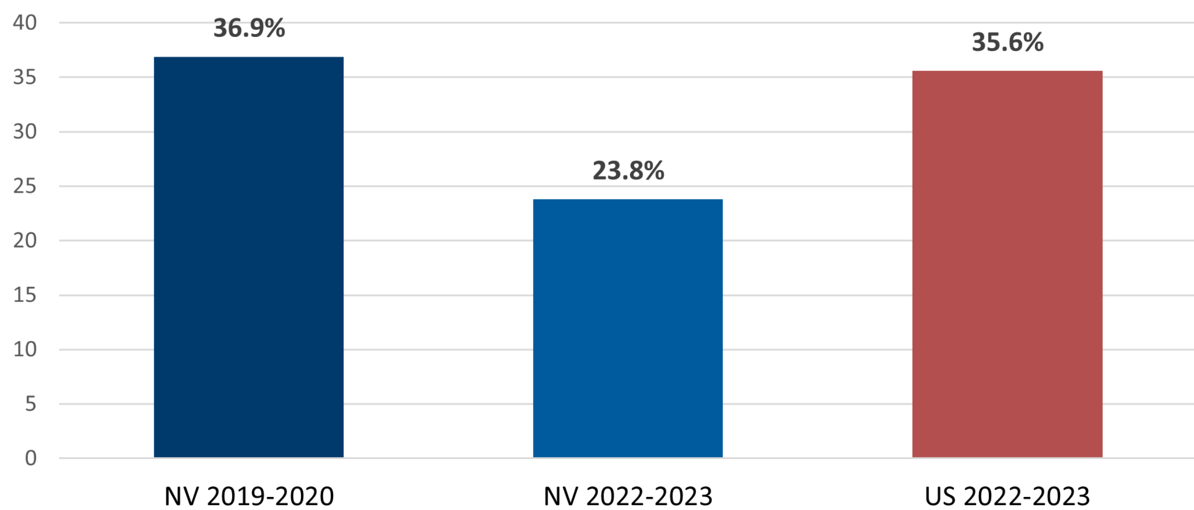
Increase in the percentage of parents who read to their children every day from 29.5% in 2020 to 32.9% in 2023 (US: 40.4%)

Opportunities

The percentage of children (ages 9–35 months) who received a developmental screening has decreased from 36.9% in 2020 to 23.8% in 2023.

This is compared to the overall US estimate of over 35% of children (ages 9–35 months) who received a developmental screening.

Figure 3. Children, Ages 9–35 Months, Who Received a Developmental Screening



Data Sources: Child Health

Health Measure	Current Measure	Source: NV	Measure	Source: USA
Percent of children under 72 months screened for blood lead levels	2% (2021)	CDC Childhood Blood Lead Surveillance: National Data	11% (2021)	CDC Childhood Blood Lead Surveillance: National Data
Percent of children under 72 months screened with elevated blood lead levels	0.4% (2021)	CDC Childhood Blood Lead Surveillance: National Data	1.3% (2021)	CDC Childhood Blood Lead Surveillance: National Data
Child mortality rate	19.9 (2022)	NV Title V Block Grant–NVSS	n/a	n/a
Percent of children for whom parents report excellent or very good health	89.8% (CI: 87.1–92.0) (2022–2023)	National Survey of Children's Health 2022–2023	90.0% (CI: 89.6–90.4) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of children currently overweight or obese, based on BMI (ages 6–17)	34.6% (CI: 30.3–39.2) (2022–2023)	National Survey of Children's Health 2022–2023	32.2% (CI: 31.4–32.9) (2022–2023)	National Survey of Children's Health 2022–2023
Children (ages 6–17) who are physically active at least 60 minutes every day based on parental report	13.3% (CI: 10.8–16.3) (2022–2023)	National Survey of Children's Health 2022–2023	20.0% (CI: 19.4–20.6) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of children 19–35 months who are/are not fully vaccinated	60.4% (CI: 54.4–73.6) (2021) (2019–2020)	CDC ChildVax	70.1% (2018)	CDC ChildVax
Percent of children living in poverty	16.1% (CI: 15.0–17.2) (2023)	KIDS COUNT DATA CENTER	16% (CI: 15.9–16.1) (2023)	KIDS COUNT DATA CENTER
Child food insecurity rate	20.9% (2022)	Feeding America Food Insecurity among the Child Population in Nevada	18.5% (2022)	Feeding America Food Insecurity among the Child Population in the United States
Percent of children (ages 0–17) who experienced housing instability in the past year	18.8% (CI: 15.8–22.2) (2022–2023)	National Survey of Children's Health 2022–2023	17.0% (CI: 16.5–17.5) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of children who experience two or more Adverse Childhood Experience	19.4% (CI: 16.6–22.7) (2022–2023)	National Survey of Children's Health 2022–2023	17.5% (CI: 17.0–18.0) (2022–2023)	National Survey of Children's Health 2022–2023

Health Measure	Current Measure	Source: NV	Measure	Source: USA
Percent of children with and without special health care needs (ages 0–17) who have a medical home	**CSHCN** 25.8% (CI: 19.7–33.0) **Non-CSHCN** 35.4% (CI: 31.8–39.2) (2022–2023)	National Survey of Children's Health 2022–2023	**CSHCN** 39.7% (CI: 38.5–40.8) **Non-CSHCN** 46.8% (CI: 46.1–47.5) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of children who had a preventative medical care visit in the past year	71.4% (CI: 67.8–74.7) (2022–2023)	National Survey of Children's Health 2022–2023	78.7% (CI: 78.2–79.3) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of children (ages 0–17) who had a preventative dental visit in the past year	75.4% (CI: 71.9–78.5) (2022–2023)	National Survey of Children's Health 2022–2023	79.2% (CI: 78.6–79.7) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of children with a personal doctor or nurse	63.2% (CI: 59.5–66.7) (2022–2023)	National Survey of Children's Health 2022–2023	71.8% (CI: 71.2–72.4) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of children (ages 9–35 months) who received a developmental screening using a parent-completed screening tool in the past year	23.8% (CI: 16.7–32.8) (2022–2023)	National Survey of Children's Health 2022–2023	35.6% (33.9–37.2) (2022–2023)	National Survey of Children's Health 2022–2023
Percentage of young children (ages 3 and 4) not in school	67% (2018–2022)	2024 KIDS COUNT DATA CENTER	54% (2018–2022)	2024 KIDS COUNT Data Book
Percent of children (ages 3–5) whose health status meets the criteria for school readiness (on track)	86.7% (CI: 79.2–91.8) (2022–2023)	National Survey of Children's Health 2022–2023	89.1% (CI: 88.2–89.9) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of children (ages 0–5) whose parents read to them every day	32.9% (CI: 27.3–39.0) (2022–2023)	National Survey of Children's Health 2022–2023	40.4% (CI: 39.4–41.4) (2022–2023)	National Survey of Children's Health 2022–2023
Percentage of children (ages 0–5) with ECE needs met	35.8% (2010)	The Economic Impact of Early Care and Education in Nevada	n/a	n/a
Percentage of children (ages 6–12) with ECE needs met	18.7% (2010)	The Economic Impact of Early Care and Education in Nevada	n/a	n/a

Adolescent Health Priorities 2020–2025

400,523

Total Nevada residents 10–19 years of age
(12.9% of Nevada's total population)*

Improve care coordination among adolescents

62.1%
of adolescents (12–17)
with a preventative care visit in the past year in 2023
(compared to 62.1% in 2020)

36%
of Medicaid EPSDT eligible adolescents (12–17)
who received at least one initial or periodic screen in 2023
(compared to 26% in 2020)

Repeat teen birth rate
of **14%** 2023
(compared to 14.3% in 2020)

Teenage pregnancy rate
of **13** per 1,000 females in 2023
(compared to 17 in 2020)

Increase transition of care for adolescents

12.8%
of adolescents (12–17)
who received services to prepare for the transition to adult health care in 2023
(compared to 10.6% in 2020)

*Source: 2020 US Census

Adolescent Health

General Well-Being

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Adolescents (ages 12–17) who report seeing a dentist last year	79.5% (2019–2022)	76.6% (2022–2023)	-2.9%	77.7% (2022–2023)
Adolescent (ages 10–19) death rate (per 100,000)	35.2 (2018)	36.2 (2021)	+1.0%	39.5 (2021)
High school students who have 8 or more hours of sleep on an average school night	21.5% (2021)	18.3% (2023)	-3.2%	23.2% (2023)

Mental Health/Community Support

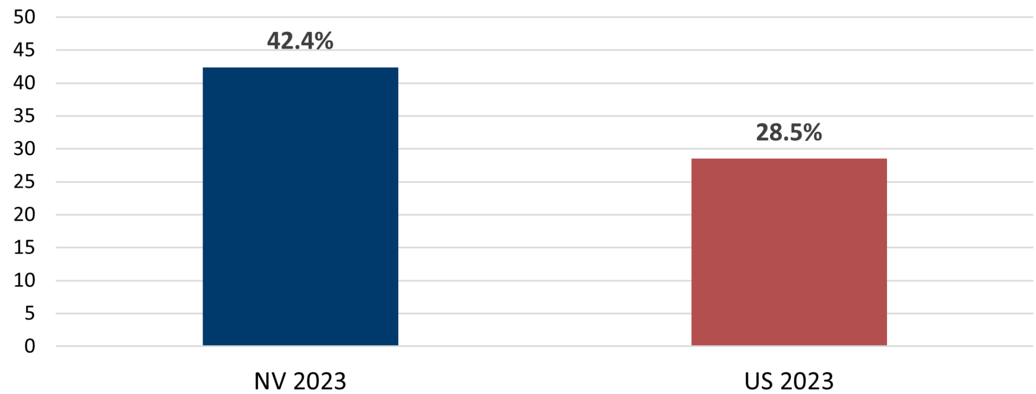
Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
High school students who most of the time/always talked to their parents or other adults in their home about their problems	21.4% (2021)	23.7% (2023)	+2.3%	84.0% (2023)
High school students who most of the time/always felt close to people at their school	30.2% (2021)	35.8% (2023)	+5.6%	55.3% (2023)
Students who report being electronically bullied in the last year	14.8% (2021)	14.4% (2023)	-0.4%	16.3% (2023)
Students who report feeling sad or hopeless almost every day for two or more weeks in a row	46.2% (2021)	42.4% (2023)	-3.8%	28.5% (2023)
Adolescents (ages 12–17) with mental health disorders who receive treatment	11.0% (2019–2020)	10.4% (2022–2023)	-0.6%	17.2% (2022–2023)
Suicide deaths to adolescents	15.2% (2016–2018)	15.1% (2019–2021)	-0.1%	10.6% (2019–2021)

Social Drivers of Health

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Percent of students who report housing instability	n/a	18.8% (2022–2023)	n/a	17.0% (2022–2023)

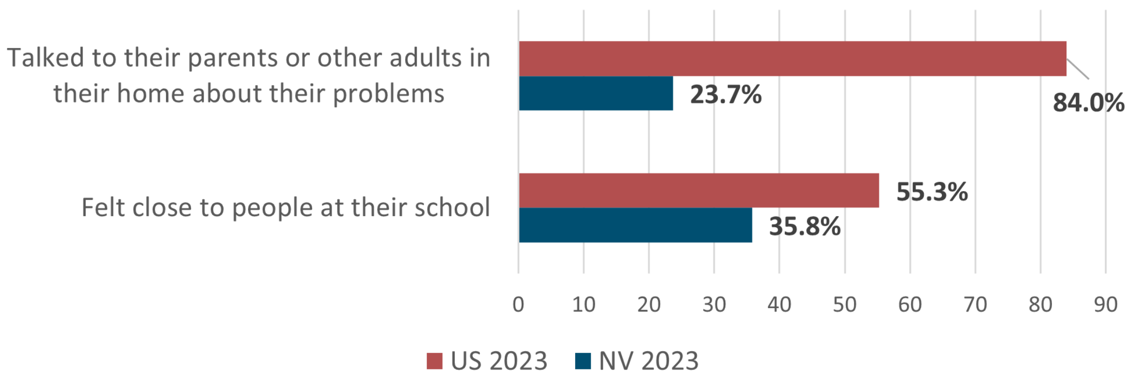
Spotlight: Adolescent Mental Health

Figure 1. Students Who Reported Feeling Sad or Hopeless Almost Every Day for Two or More Weeks in a Row, Nevada Compared to the US in 2023



When compared to US estimates, a higher percentage of Nevadan adolescents reported feeling sad or hopeless. A smaller percent of Nevadan adolescents also reported feeling close to people at their school and talking to their parents or other adults about their problems. Additionally, the proportion of suicide deaths to adolescents in Nevada is estimated at 15.1%, compared to the US estimate of 10.6%.

Figure 2. Percent of High School Students Who Reported the Following Most of the Time or Always



15.1%

of Nevadan suicide deaths were estimated to be adolescents in 2021 (compared to 10.6% in the US overall)

Care Coordination

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Adolescents (ages 12–17) with a preventive medical visit in the past year*	62.1% (2019–2020)	62.1% (2022–2023)	0%	71.4% (2022–2023)
Medicaid EPSDT eligible adolescents (ages 12–17) who received at least one initial or periodic screen*	26% (2020)	36% (2023)	+10%	n/a
Teen birth rate, per 1,000 females*	17 (2020)	13 (2023)	-4	13 (2023)
Repeat teen birth rate*	14.3% (2020)	14.0% (2023)	-0.3%	2.0% (2022)

*Measure was a selected NOM/state priority from the previous needs assessment.

Reproductive Health

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Adolescents (ages 13–17) who receive at least one dose of the HPV vaccine	66.0% (2018)	76.1% (2021)	+10.1%	76.9% (2021)
Adolescents (who are sexually active) who use contraceptives (condoms)	49.3% (2021)	53.3% (2023)	+4.0%	51.9% (2023)
Adolescents (who are sexually active) who use contraceptives (birth control pills, IUD, shot, patch ring)	30.0% (2021)	20.8% (2023)	-9.2%	32.9% (2023)

Safety

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Adolescents who report sexual dating violence	14.0% (2021)	15.5% (2023)	+1.5%	5.9% (2023)

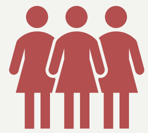
Substance Use

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Students who drank alcohol in the past month	19.4% (2021)	17.6% (2023)	-1.8%	22.1% (2023)
High school students who smoked cigarettes in past 30 days	3.4% (2021)	2.8% (2023)	-0.6%	3.5% (2023)
High school students who used a nicotine electronic vapor product in past 30 days	15.0% (2021)	13.2% (2023)	-1.8%	16.8% (2023)
High school students who used a marijuana electronic vapor product in past 30 days	16.1% (2021)	14.8% (2023)	-1.3%	n/a

Bright Spots: Adolescent Substance Use

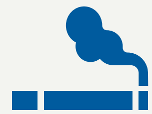
17.6%

of Nevada adolescents reported drinking alcohol in the past month in 2023, a decrease from 19.4% reported in 2021 (US: 22.1%)



13.2%

of Nevada adolescents used a nicotine electronic vapor product in 2023, a decrease from 15.0% reported in 2021 (US: 16.8%)



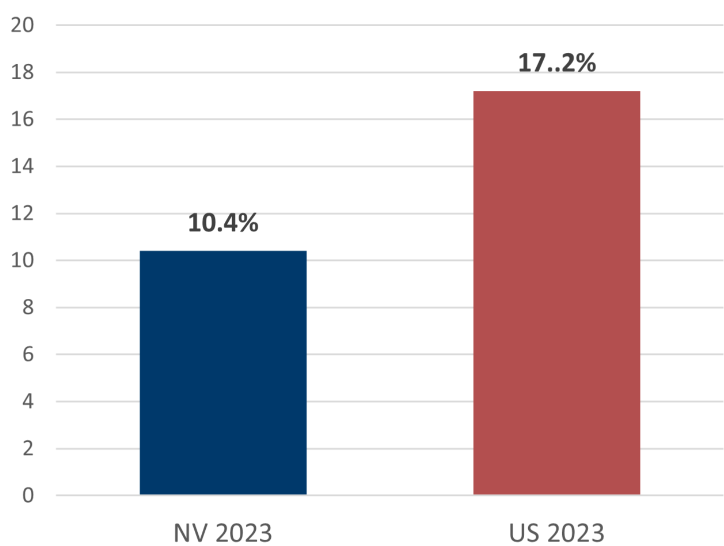
2.8%

of Nevada adolescents reported smoking cigarettes in the past 30 days in 2023, a decrease from 3.4% reported in 2020 (US: 3.5%)

Opportunities: Mental Health Treatment

As highlighted above, Nevada adolescents face multiple mental health challenges. For adolescents with mental health disorders in Nevada, only 10.4% received treatment in 2023. This is compared to the national estimate of 17.2% of adolescents with mental health disorders receiving treatment.

Figure 3. Adolescents, Age 12–17, with Mental Health Disorders Who Receive Treatment



Data Sources: Adolescent Health

Health Measure	Current Measure	Source: NV	Measure	Source: USA
Percent (ages 12–17) who report seeing a dentist (having a dentist appointment) in the last year	76.6% (CI: 71.0–81.5) (2022–2023)	National Survey of Children's Health 2022–2023	77.7% (CI: 76.8–78.6) (2022–2023)	National Survey of Children's Health 2022–2023
Adolescent death rate (ages 10–19) per 100,000	36.2 (2021)	NV Maternal, Child, and Adolescent Health Data Overview Federally Available Data	39.5 (2021)	NV Maternal, Child, and Adolescent Health Data Overview Federally Available Data
Percent of high school students who have 8 or more hours of sleep on an average school night	18.3% (CI: 16.7-19.9) (2023)	2021–2023 Nevada High School YRBS Comparison Report	23.2% (CI: 21.4-25.1) (2023)	Youth Risk Behavior Surveillance System Survey 2023
Percent of high school students who most of the time/always talked to their parents or other adults in their home about their problems	23.7% (CI: 22.0-25.4) (2023)	2021–2023 Nevada High School YRBS Comparison Report	84.0% (CI: 81.2-86.5) (2023)	Youth Risk Behavior Surveillance System Survey 2023
Percent of high school students who most of the time/always felt close to people at their school	35.8% (CI: 33.4–38.1) (2023)	2021–2023 Nevada High School YRBS Comparison Report	55.3% (CI: 52.8-57.8) (2023)	Youth Risk Behavior Surveillance System Survey 2023
Percent of students who report being electronically bullied in the last year	14.4% (CI: 12.8-15.9) (2023)	2021–2023 Nevada High School YRBS Comparison Report	16.3% (CI: 14.2-18.5) (2023)	Youth Risk Behavior Surveillance System Survey 2023
Percent of students who report feeling sad or hopeless almost every day for two or more weeks in a row during the 12 months before the survey	42.4% (CI: 39.9-44.9) (2023)	2021–2023 Nevada High School YRBS Comparison Report	28.5% (CI: 26.7-30.4) (2023)	Youth Risk Behavior Surveillance System Survey 2023
Percent of adolescents (ages 12–17) with mental health disorders who receive treatment	10.4% (CI: 7.6-14.2) (2022–2023)	National Survey of Children's Health 2022–2023	17.2% (CI: 16.6-17.9) (2022–2023)	National Survey of Children's Health 2022–2023

Health Measure	Current Measure	Source: NV	Measure	Source: USA
Adolescent suicide rate per 100,000	15.1% (2019–2021)	NV Maternal, Child, and Adolescent Health Data Overview Federally Available Data	10.6% (2019–2021)	NV Maternal, Child, and Adolescent Health Data Overview Federally Available Data
Percent of students who report housing instability	18.8% (CI: 15.8–22.2) (2022–2023)	National Survey of Children's Health 2022–2023	17.0% (CI: 16.5-17.5) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of adolescents (ages 12–17) with a preventive medical visit in the past year	62.1% (CI: 55.6–68.1) (2022–2023)	National Survey of Children's Health 2022–2023	71.4% (CI: 70.4–72.4) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of Medicaid EPSDT eligible adolescents (ages 12–17) who received at least one initial or periodic screen	36 (2023)	NV Title V Block Grant–CMMS Form 416	n/a	n/a
Teen birth rate	13% (2023)	2024 KIDS COUNT DATA CENTER	13% (2023)	2024 KIDS COUNT DATA CENTER
Repeat teen birth rate	14% (2023)	NV Title V Block Grant	2.0% (2022)	National Vital Statistics Report 73, Number 6
Percent of adolescents (ages 13–17) who receive at least one dose of the HPV vaccine	76.1% (2021)	NV Maternal, Child, and Adolescent Health Data Overview Federally Available Data	76.9% (2021)	NV Maternal, Child, and Adolescent Health Data Overview Federally Available Data
Percent of adolescents who use contraceptives (condoms) (out of adolescents who report having sexual intercourse with an opposite-sex partner during 3 months before the survey)	53.3% (CI: 47.8-58.8) (2023)	2021–2023 Nevada High School YRBS Comparison Report	51.9% (CI: 48.6-55.20 (2023)	Youth Risk Behavior Surveillance System Survey 2023
Percent of adolescents who use contraceptives (birth control pills, IUD, shot, patch ring) (out of adolescents who report having sexual intercourse with an opposite-sex partner during 3 months before the survey)	20.8% (CI: 16.6-24.9) (2023)	2021–2023 Nevada High School YRBS Comparison Report	32.9% (CI: 29.9-36.1) (2023)	Youth Risk Behavior Surveillance System Survey 2023

Health Measure	Current Measure	Source: NV	Measure	Source: USA
Percent of adolescents who report sexual dating violence	15.5% (CI: 13.4-17.6) (2023)	2021–2023 Nevada High School YRBS Comparison Report	5.9% (CI: 5.1-6.8) (2023)	Youth Risk Behavior Surveillance System Survey 2023
Percent of students who drank alcohol in the past month	17.6% (CI: 15.5-19.7) (2023)	2021–2023 Nevada High School YRBS Comparison Report	22.1% (CI: 20.5-23.8) (2023)	Youth Risk Behavior Surveillance System Survey 2023
Percent of high school students who smoked cigarettes during the 30 days before the survey	2.8% (CI: 2.1-3.5) (2023)	2021–2023 Nevada High School YRBS Comparison Report	3.5% (CI: 2.9-4.2) (2023)	Youth Risk Behavior Surveillance System Survey 2023
Percent of high school students who used an electronic vapor product (nicotine) during the 30 days before the survey	13.2% (CI: 11.4-14.9) (2023)	2021–2023 Nevada High School YRBS Comparison Report	16.8% (CI: 15.4-18.2) (2023)	Youth Risk Behavior Surveillance System Survey 2023
Percent of high school students who used an electronic vapor product (marijuana) during the 30 days before the survey	14.8% (CI: 11.4-14.9) (2023)	2021–2023 Nevada High School YRBS Comparison Report	n/a	n/a

Children and Youth with Special Healthcare Needs (CYSHCN) Health Priorities 2020–2025

113,245

Total CYSHCN in Nevada

(3.6% of Nevada's total population)*

Increase transition of care for CYSHCN

11.8%

of adolescents with special health care needs (12–17) who received services to prepare for the transition to adult health care in 2023 (compared to 8.6% in 2020)

Promote a medical home

25.8%

of children with special health care needs (0–17) who had a medical home in 2023 (compared to 38.4% in 2021)

*Source: National Survey of Children's Health 2022–2023

CYSHCN Health

General Well-Being

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Percent/number of CYSHCN in Nevada (based on CSHCN Screener)	15.4% 106,445 (2019-2020)	16.3% 113,245 (2022–2023)	+0.9%	20.8% 15,144,222 (2022–2023)
Percent/number of CYSHCN in Nevada (based on expanded criteria)	n/a	23.8% 164,673 (2022–2023)	n/a	26.2% 19,024,571 (2022–2023)

Mental Health/Community Support

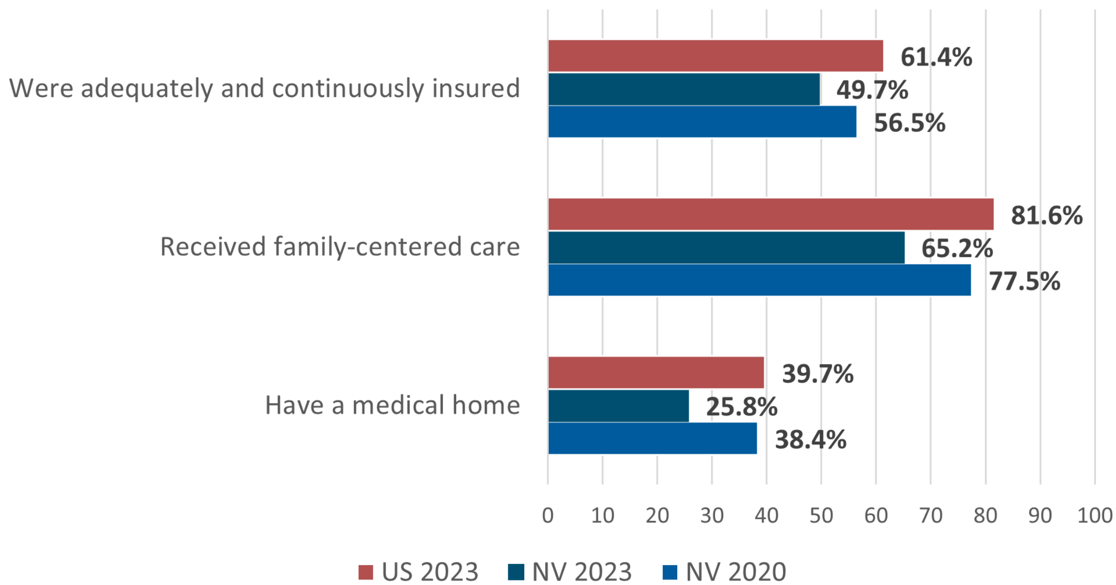
Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
CYSHCN who report being bullied	**1–2 times in past 12 months** 31.9% **1–2 times per month** 10.6% **1–2 times per week** 13.0% **Almost every day** 5.4% (2019–2020)	**1–2 times in past 12 months** 33.8% **1–2 times per month** 10.2% **1–2 times per week** 7.9% **Almost every day** 7.7% (2022–2023)	**1–2 times in past 12 months** +1.9% **1–2 times per month** -0.4% **1–2 times per week** -5.1% **Almost every day** +2.3%	**1–2 times in past 12 months** 31.9% **1–2 times per month** 11.4% **1–2 times per week** 7.9% **Almost every day** 4.6% (2022–2023)
CYSHCN who have experienced two or more Adverse Childhood Experiences	32.7% (2019–2020)	37.4% (2022–2023)	+4.7%	33.8% (2022–2023)

Social Drivers of Health

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
CYSHCN living above the 400% Federal Poverty Limit	26.9% (2019–2020)	23.3% (2022–2023)	-3.6%	31.2% (2022–2023)

Spotlight and Opportunity: Access to Care

Figure 1. CYSHCN Access to Care: Insurance Coverage, Medical Home And Family-Centered Care, Nevada 2020 and 2023 Compared to the US in 2023



In 2023, less than half (49.7%) of CYSHCN had adequate and continuous insurance coverage. This was a decrease from 56.5% in 2020. The US estimate for CYSHCN having continuous and adequate insurance coverage in 2023 was 61.4%. The percent of CYSHCN that reported having a medical home decreased to 25.8% in 2023 from 38.4% in 2020. This is compared to the US 2023 estimate of 39.7% of CYSHCN reporting they have a medical home. There has also been a decrease in the percentage of CYSHCN that reported receiving family-centered care, from 77.5% in 2020 to 65.2% in 2023. This is compared to the US estimate for 2023 of 81.6% of CYSHCN receiving family-centered care.

Bright Spot

+3.2%

Increase in the percentage of Nevada CYSHCN who received services to prepare for the transition to adult health care from 8.6% in 2020 to 11.3% in 2023

Screening and Identification

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Infants screened for genetic conditions at birth	n/a	8.3% (2023)	n/a	n/a
Infants who have newborn hearing testing at birth	96.7% (2020)	96.3% (2022)	-0.4%	97.6%

Access to Care/Medical Home

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
CYSHCN who report having a medical home*	38.4% (2019-2020)	25.8% (2022-2023)	-12.6%	39.7% (2022-2023)
CYSHCN who report having adequate and continuous health insurance coverage in the last year	56.6% (2019-2020)	49.7% (2022-2023)	-6.9%	61.4% (2022-2023)
CYSHCN who receive family-centered care	77.5% (2019-2020)	65.2% (2022-2023)	-12.3%	81.6% (2022-2023)
CYSHCN who did not receive needed medical care	9.0% (2019-2020)	9.2% (2022-2023)	+0.2%	8.4% (2022-2023)

Transition of Care

Health Measure	Previous (Nevada)	Current (Nevada)	Change	Current (US)
Adolescents **with/without** special health care needs (SHCN) (ages 12–17) who received services to prepare for the transition to adult health care*	**With SHCN** 8.6% **Without SHCN** 10.6% (2019–2020)	**With SHCN** 11.8% **Without SHCN** 12.8% (2022–2023)	**With SHCN** +3.2% **Without SHCN** +2.2%	**With SHCN** 22.3% **Without SHCN** 16.5% (2022–2023)

*Measure was a selected NOM/state priority from the previous needs assessment.

Data Sources: CYSHCN Health

Health Measure	Current Measure	Source: NV2	Measure	Source: USA
Percent/number of CYSHCN in Nevada (based on CSHCN Screener)	16.3% (CI: 14.0–19.0) 113,245 (2022–2023)	National Survey of Children's Health 2022–2023	20.8% (CI: 20.4–21.3) 15,144,222 (2022–2023)	National Survey of Children's Health 2022–2023
Percent/number of CYSHCN in Nevada (based on expanded criteria)	23.8% 164,673 (2022–2023)	National Survey of Children's Health 2022–2023	26.2% 19,024,571 (2022–2023)	National Survey of Children's Health 2022–2023
Percent of CYSHCN who report being bullied	**1–2 times in past 12 months** 33.8% (CI: 26.0–42.6) **1–2 times per month** 10.2% (CI: 6.4–16.0) **1–2 times per week** 7.9% (CI: 3.7–16.4) **Almost every day** 7.7% (CI: 3.6–15.9) (2022–2023)	National Survey of Children's Health 2022–2023	**1–2 times in past 12 months** 31.9% (CI: 30.7–33.2) **1–2 times per month** 11.4% (CI: 10.7–12.2) **1–2 times per week** 7.9% (CI: 7.2–8.7) **Almost every day** 4.6% (CI: 4.2–5.1) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of CYSHCN who have experienced two or more Adverse Childhood Experiences	37.4% (CI: 29.6–46.0) (2022–2023)	National Survey of Children's Health 2022–2023	33.8% (CI: 32.6–35.0) (2022–2023)	National Survey of Children's Health 2022–2023
CYSHCN living above the 400% Federal Poverty Limit	23.3% (CI: 17.4–30.5) (2022–2023)	National Survey of Children's Health 2022–2023	31.2% (CI: 30.2–32.2) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of infants screened for genetic conditions at birth	8.3% (2023)	Provided by NV Dept. PH	n/a	n/a
Percent of infants who have newborn hearing testing at birth (vital record births)	96.3% (2022)	CDC Data on Hearing Loss in Children: 2022 Summary of Hearing Screening Among Total Occurrent Births	97.6% (2022)	CDC Data on Hearing Loss in Children: 2022 Summary of Hearing Screening Among Total Occurrent Births
Percent of CYSHCN who report having a medical home	25.8% (CI: 19.7-33.0) (2022–2023)	National Survey of Children's Health 2022–2023	39.7% (CI: 38.5-40.8) (2022–2023)	National Survey of Children's Health 2022–2023

Health Measure	Current Measure	Source: NV2	Measure	Source: USA
Percent of CYSHCN who report having adequate and continuous health insurance coverage in the last year	49.7% (CI: 41.5-57.8) (2022–2023)	National Survey of Children's Health 2022–2023	61.4% (CI: 60.2-62.6) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of CYSHCN who receive family-centered care	65.2% (CI: 56.1-73.3) (2022–2023)	National Survey of Children's Health 2022–2023	81.6% (CI: 80.6-82.7) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of children (CYSHCN) who did not receive needed medical care, per parental report	9.2% (CI: 5.6-14.9) (2022–2023)	National Survey of Children's Health 2022–2023	8.4% (CI: 7.7-9.2) (2022–2023)	National Survey of Children's Health 2022–2023
Percent of adolescents **with and without** special health care needs (ages 12–17) who received services to prepare for the transition to adult health care	**With SHCN** 11.8% (CI: 6.6-20.2) **Without SHCN** 12.8% (CI: 8.6-18.7) (2022–2023)	National Survey of Children's Health 2022–2023	**With SHCN** 22.3% (CI: 20.9-23.8) **With SHCN** 16.5% (CI: 15.7-17.4) (2022–2023)	National Survey of Children's Health 2022–2023

Needs Assessment Key Data Sources

Data Source	Description
US Census	The US census counts each resident of the country, where they live on April 1, every ten years ending in zero. The Constitution mandates the enumeration to determine how to apportion the House of Representatives among the states. Data from the 2020 Census was used for these data sheets.
American Community Survey	The American Community Survey (ACS) is an ongoing survey that provides vital information on a yearly basis about our nation and its people. Information from the survey generates data that help inform how trillions of dollars in federal funds are distributed each year. It is the premier source for detailed population and housing information about our nation. The American Community Survey (ACS) releases new data every year through a variety of data tables that you can access with different data tools.
Behavioral Risk Factor Surveillance System	The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect state data about US residents regarding their health-related risk behaviors, chronic health conditions, health-care access, and use of preventive services. Established in 1984, BRFSS collects data in all 50 states as well as the District of Columbia and participating US territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted telephone-based health survey system in the world.
Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System (PRAMS) is the Pregnancy Risk Assessment Monitoring System. It is a joint surveillance project between state, territorial, or local health departments and CDC's Division of Reproductive Health. PRAMS was developed in 1987 to reduce infant morbidity and mortality by influencing maternal behaviors before, during, and immediately after live birth. The purpose of PRAMS is to find out why some infants are born healthy, and others are not. The survey asks new mothers questions about their pregnancy and their new infant.
Youth Risk Behavior Surveillance System	The Youth Risk Behavior Surveillance System (YRBSS) monitors adolescent health behavior changes over time. It identifies emerging issues, and plans and evaluates programs to support youth health. Overall, it gives the best picture of what is going on at national, state, and local levels. The data is used to inform school and community programs, communications campaigns, and other efforts. The YRBSS captures the health-related behaviors and experiences of American youth.
The National Survey of Children's Health	The National Survey of Children's Health (NSCH) provides rich data on multiple, intersecting aspects of children's lives—including physical and mental health, access to and quality of health care, and the child's family, neighborhood, school, and social context. The National Survey of Children's Health is funded and directed by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB). A revised version of the survey was conducted as a mail and web-based survey by the Census Bureau in 2016, 2017, 2018, 2019, 2020, 2021, 2022 and 2023.
National Vital Statistics System	The National Vital Statistics System (NVSS) provides the most complete data on births and deaths in the United States.
CDC Chronic Disease Indicators	The Chronic Disease Indicators (CDI) provides valuable surveillance data that public health professionals, researchers, and policymakers can use to track chronic diseases and their risk factors at the national and state level. It compiles estimates from various data sources, including surveys, vital records, and administrative data. It uses standardized definitions to allow comparisons at national and state levels.

Data Source	Description
National Immunization Surveys ; CDC ChildVaxView	The National Immunization Surveys (NIS) are a group of phone surveys used to monitor vaccination coverage among children 19–35 months and teens 13–17 years, flu vaccinations for children 6 months–17 years, and COVID-19 vaccination for children and teens in eligible age groups and for adults 18 years and older. The surveys are sponsored and conducted by the National Center for Immunization and Respiratory Diseases (NCIRD) of the Centers for Disease Control and Prevention (CDC) and authorized by the Public Health Service Act. The NIS provides current, population-based, state and local area estimates of vaccination coverage among children and teens using a standard survey methodology. The surveys collect data through telephone interviews with parents or guardians in all 50 states, the District of Columbia, and some US territories.
KIDS COUNT Data Center	The Annie E. Casey Foundation's KIDS COUNT® (LA INFANCIA CUENTA™) is a trusted source of data on children, youth and families.
Feeding America	Since 2011, Feeding America has produced Map the Meal Gap and provided estimates of local food insecurity and food costs to improve understanding of people and places facing hunger and inform decisions that will help ensure equitable access to nutritious food for all.
America's Health Rankings	America's Health Rankings provides an analysis of national health on a state-by-state basis by evaluating a historical and comprehensive set of health, environmental and socioeconomic data to determine national health benchmarks and state rankings.

Note: Additional data not available publicly was requested through the Nevada Department of Health and Human Services.

Appendix A

Table 1. Nevada Population by County, 2020 Census

Nevada County	Population
Churchill	25,516
Clark	2,265,461
Douglas	49,488
Elko	53,702
Esmeralda	729
Eureka	1,855
Humboldt	17,285
Lander	5,734
Lincoln	4,499
Lyon	59,235
Mineral	4,554
Nye	51,591
Pershing	6,650
Storey	4,104
Washoe	486,492
White Pine	9,080
Carson City	58,639

Appendix F: MCH Survey Findings

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Nevada Maternal and Child Health Survey Demographic Findings

April 2025

Prepared for the Nevada Division of Public and Behavioral Health by Altarum

Response Rates by Role

Role	Count (n)	Percent (%)
Non-professional	124	55%
Professional	102	45%

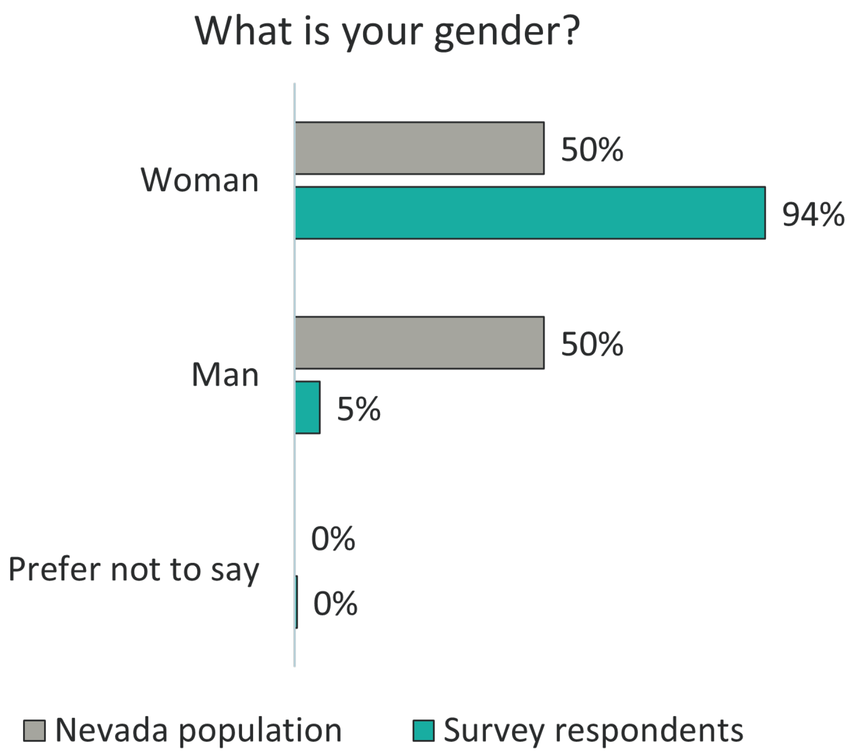
Response Rates by Survey Language

Language	Count (n)	Percent (%)
English	168	74%
Spanish	58	26%

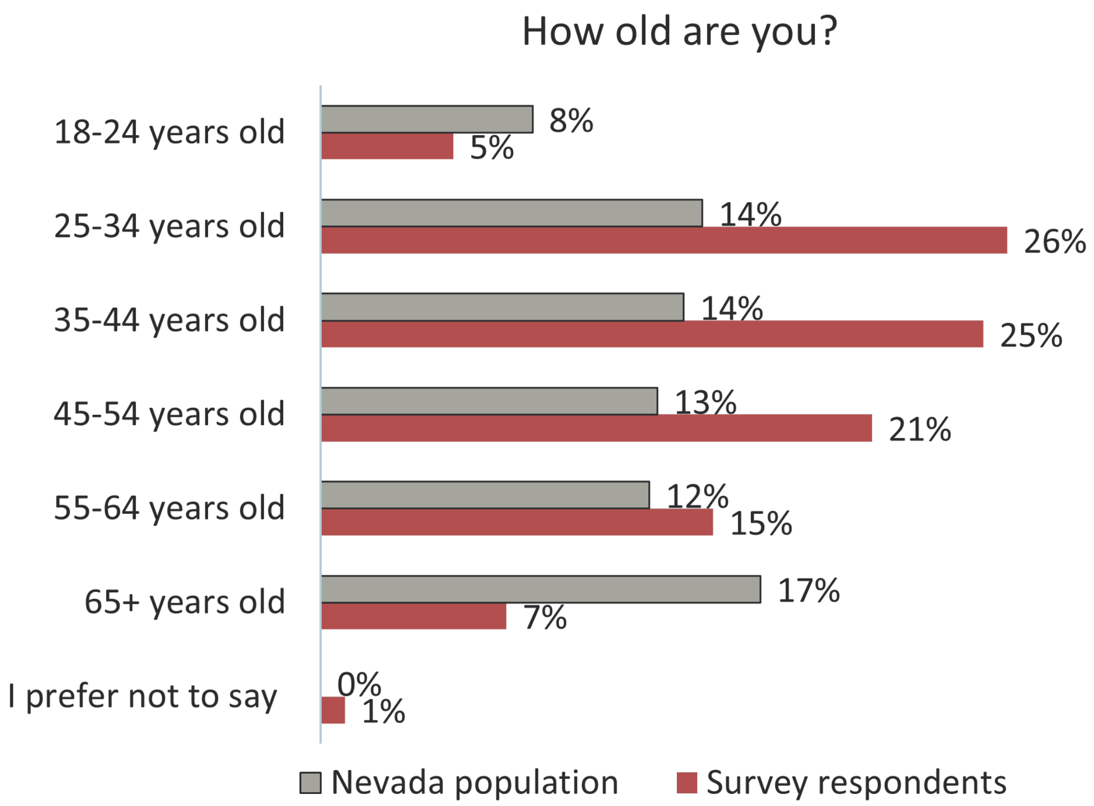
Note: Survey also offered in Chinese and Tagalog but no responses were completed in these languages.
Note: 95% of respondents who identified as being a professional spoke English.

About the Respondents

Nearly all respondents (94%) identify as female, and more than half (51%) are between the ages of 25 and 44 years old.



n= 226

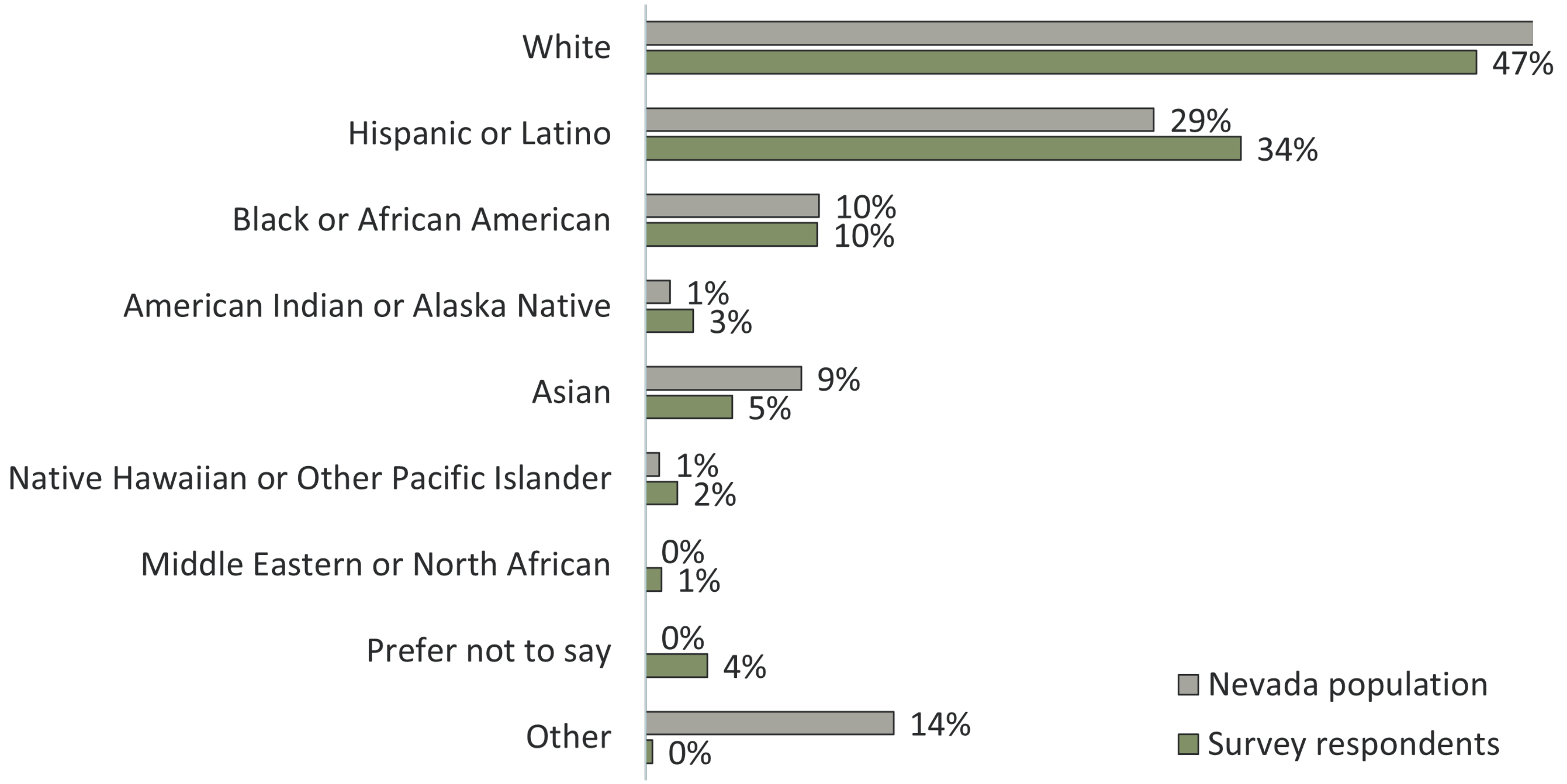


n= 226

Note: Percentages do not add to 100 due to rounding.

Most respondents identify as White (47%) or Hispanic/Latino (34%).

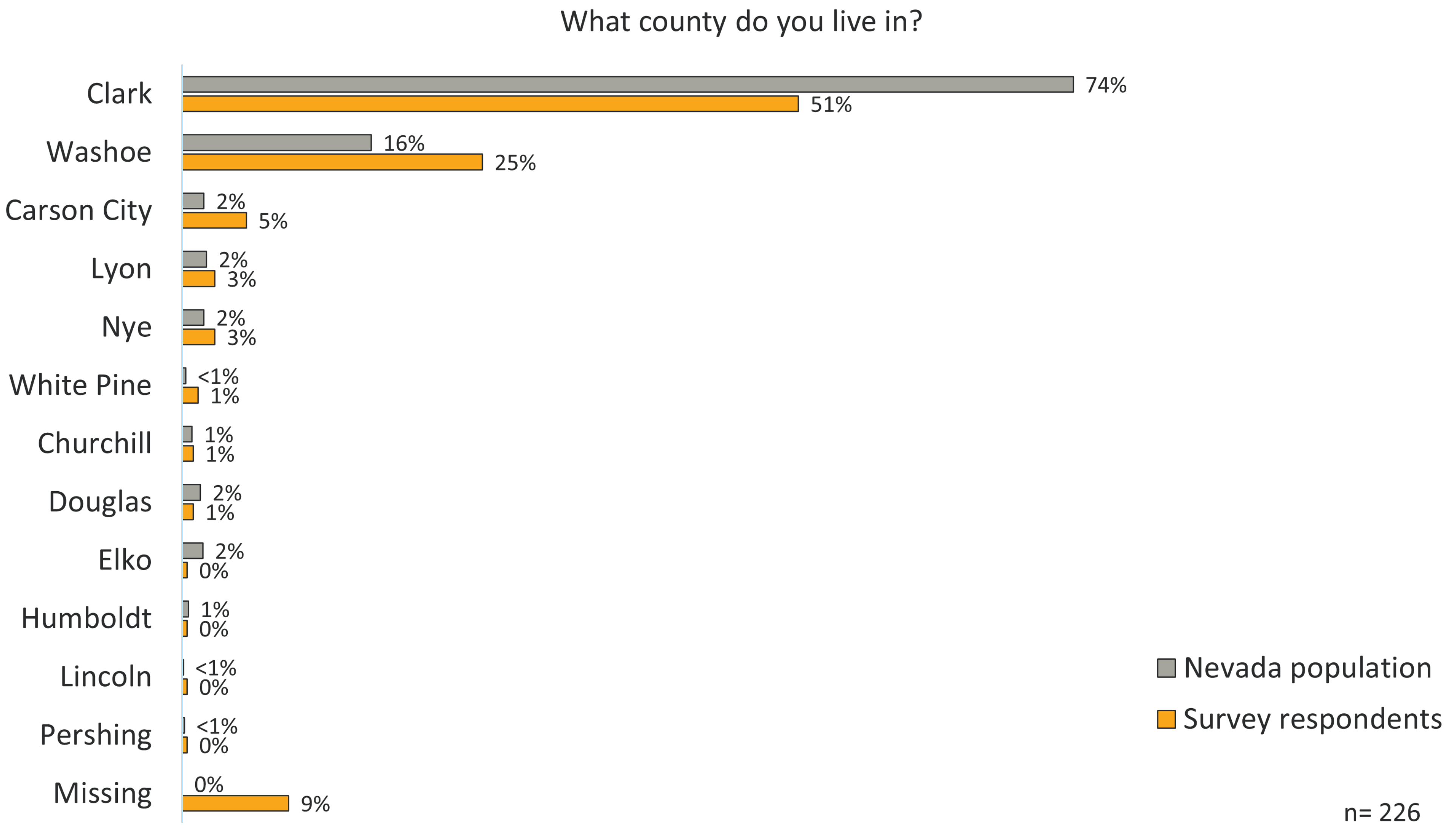
What is your race and/or ethnicity?



Note: Percentages do not add to 100 due to rounding.

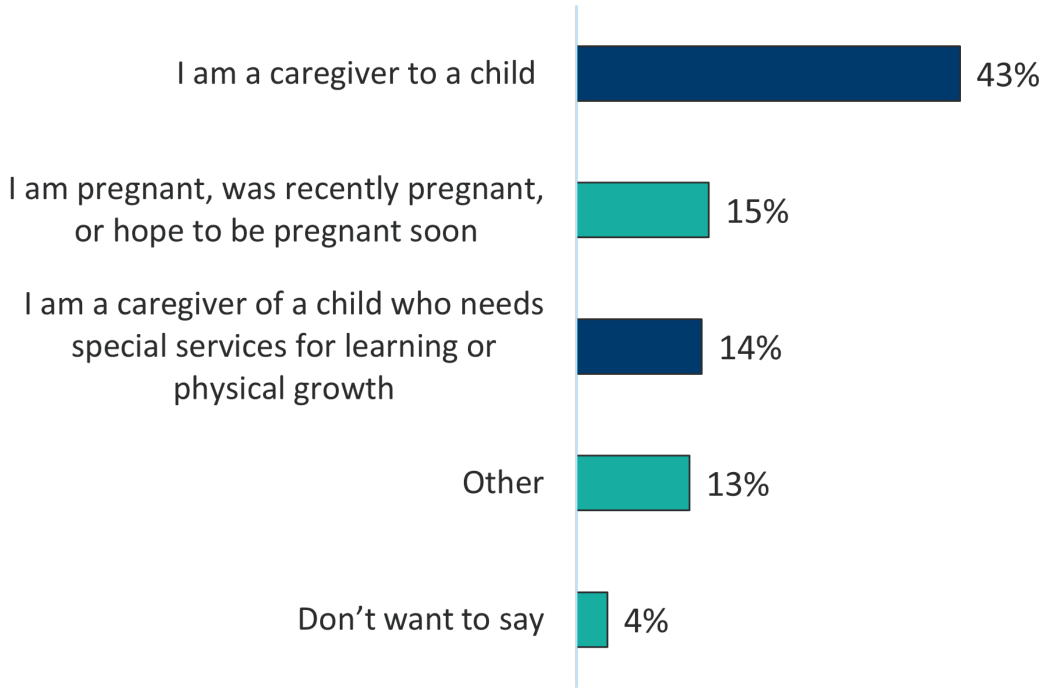
n= 226

Half (51%) of respondents live in the county of Clark.



More than half (57%) of respondents reported being a caregiver to a child and the ages of the child (children) they care for varied.

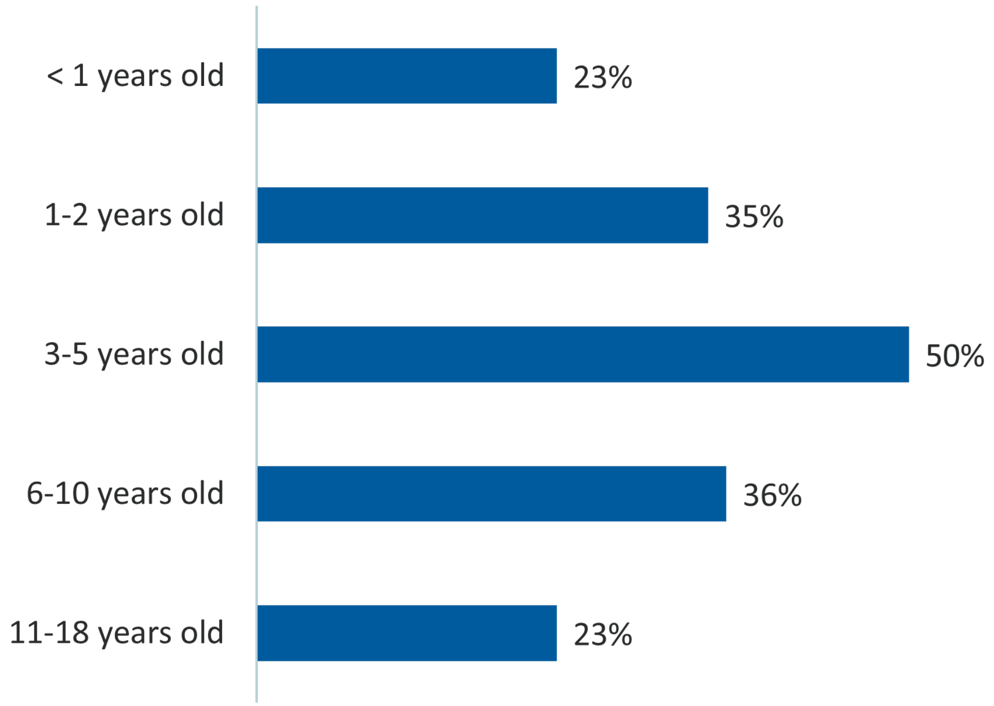
Which best describes you?



Note: Participants could select more than one response; therefore, percentages do not add to 100.

n= 226

If you are a caregiver for a child (children), please check their age(s)

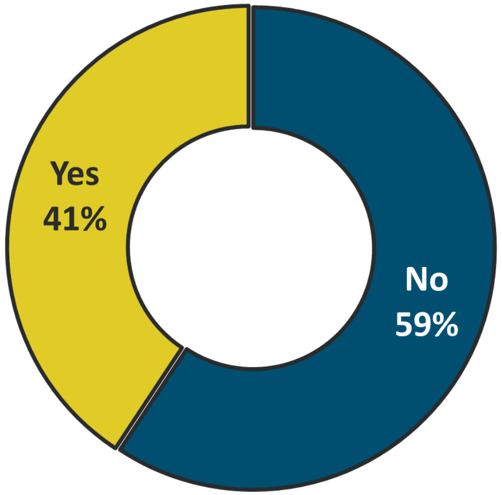


Note: Participants could select more than one response; therefore, percentages do not add to 100.

n= 130

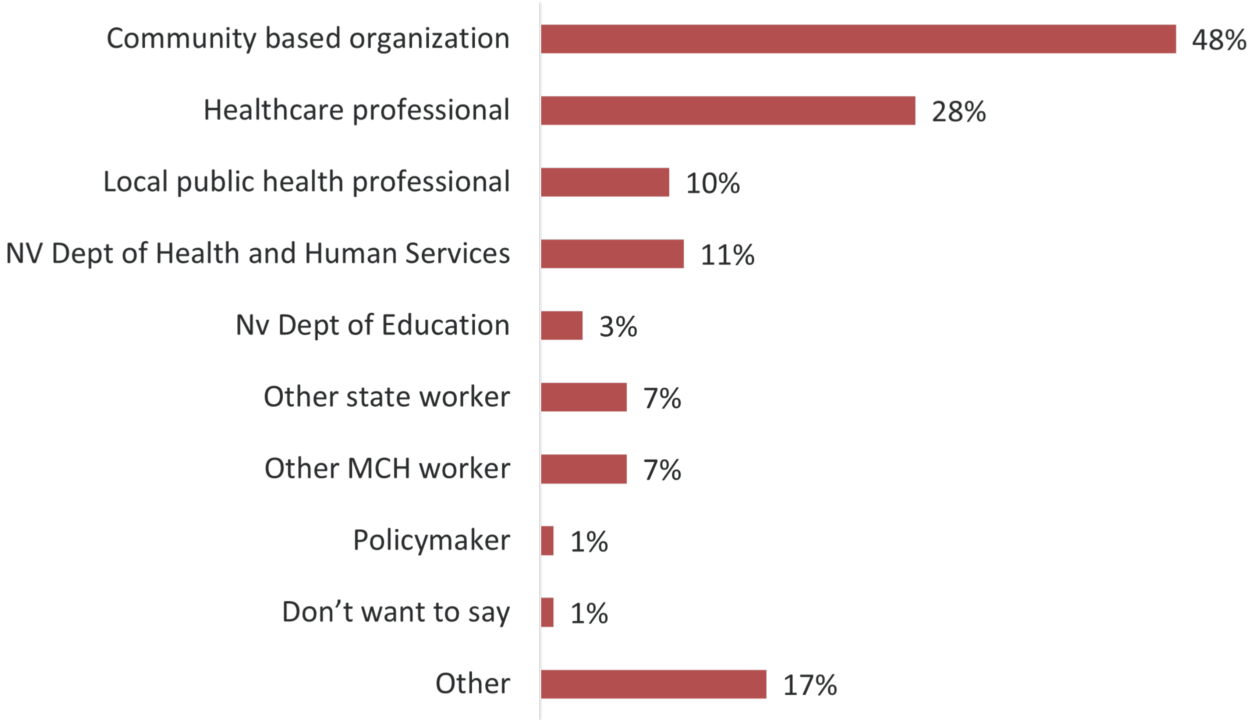
More than one-third (41%) of respondents reported being a professional or volunteer working within the maternal and child health sector. Almost one-half (48%) work or volunteer for a community-based organization.

I am a professional or volunteer working within the maternal and child health sector (i.e., pregnant people, parents/caregivers of children, teens, and/or babies



n= 226

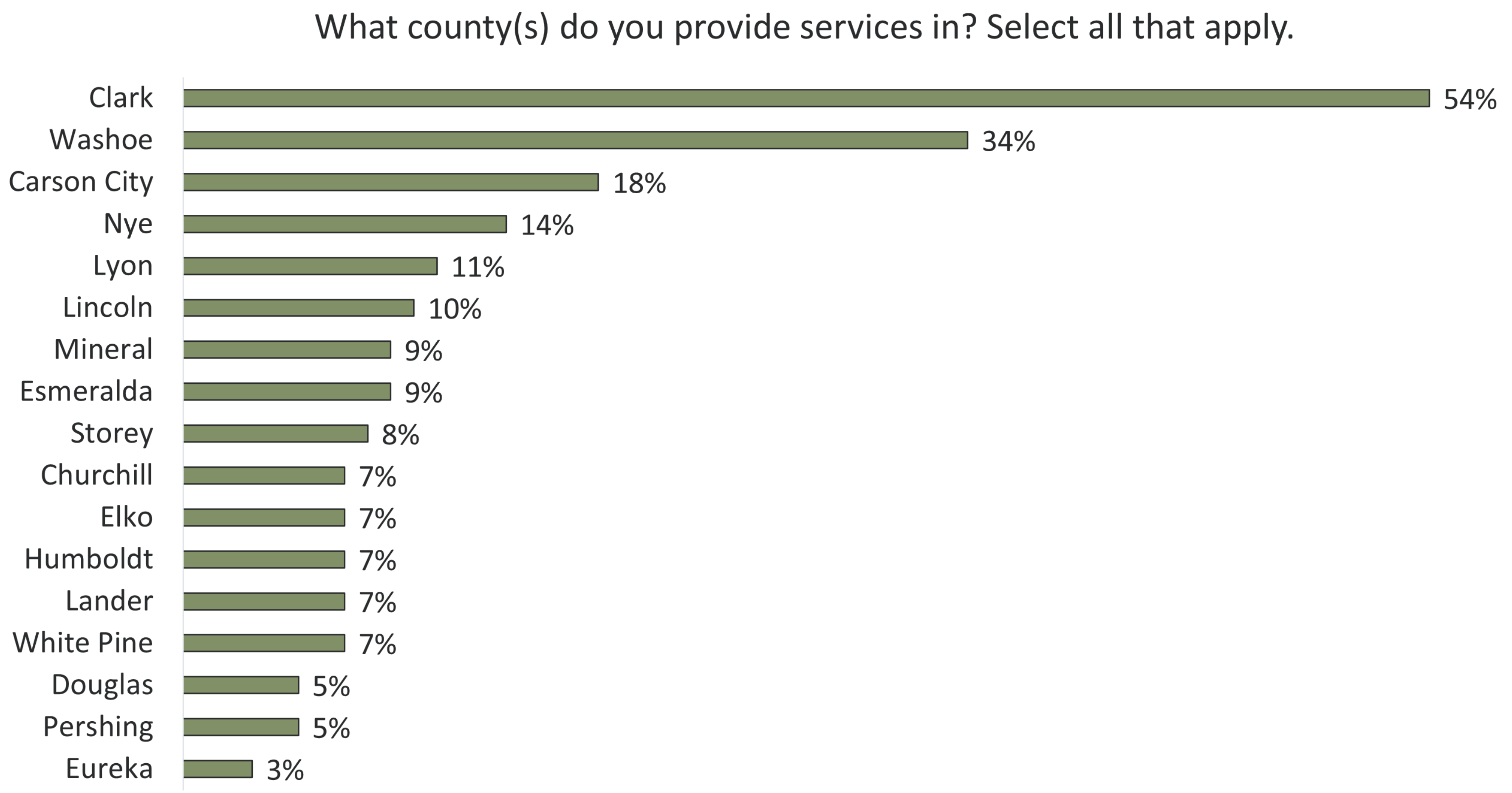
Job setting or description that best describes your role. Select all that apply.



Note: Participants could select more than one response; therefore, percentages do not add to 100.

n= 92

Over half (54%) provide these services in the county of Clark.



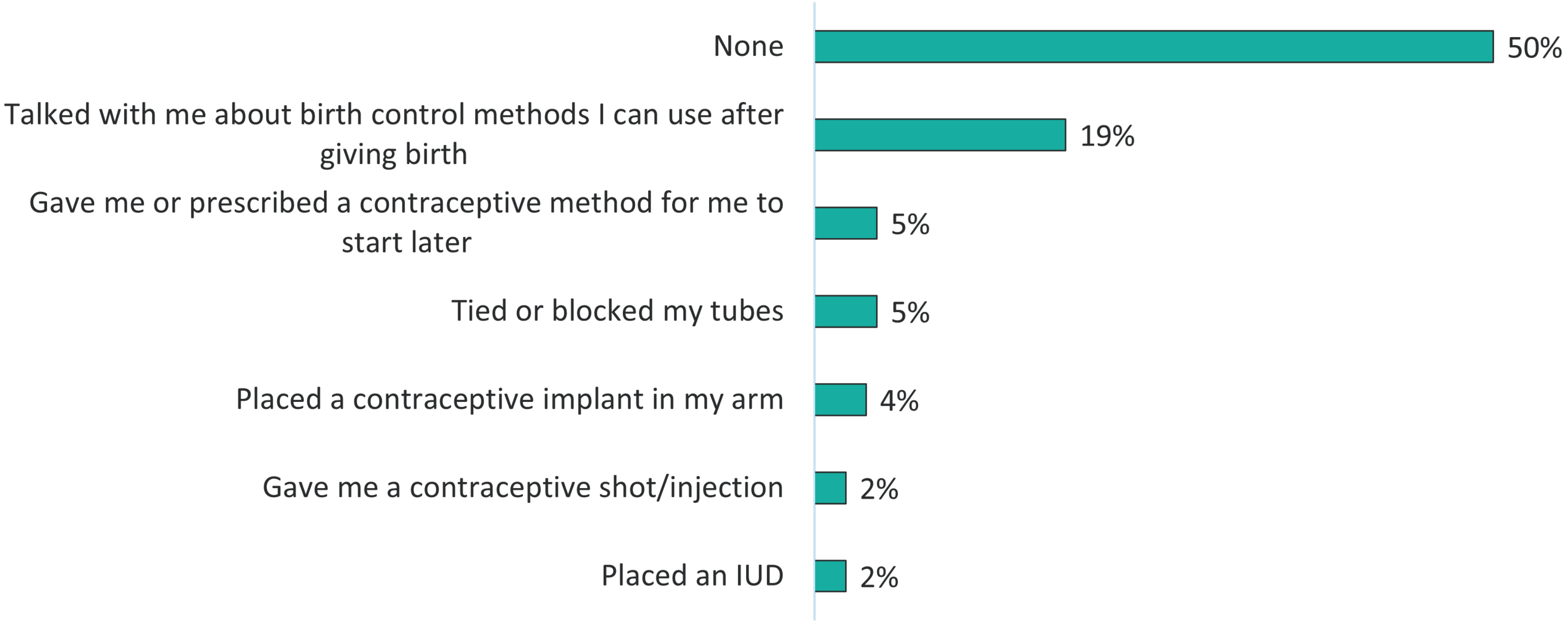
n= 92

Note: Participants could select more than one response; therefore, percentages do not add to 100.

Additional Questions

Half of caregivers (50%) reported their health care provider did not discuss or offer contraception during the hospital stay following the birth of their baby.

During your hospital stay after your baby was born, did a healthcare provider do any of the following things?



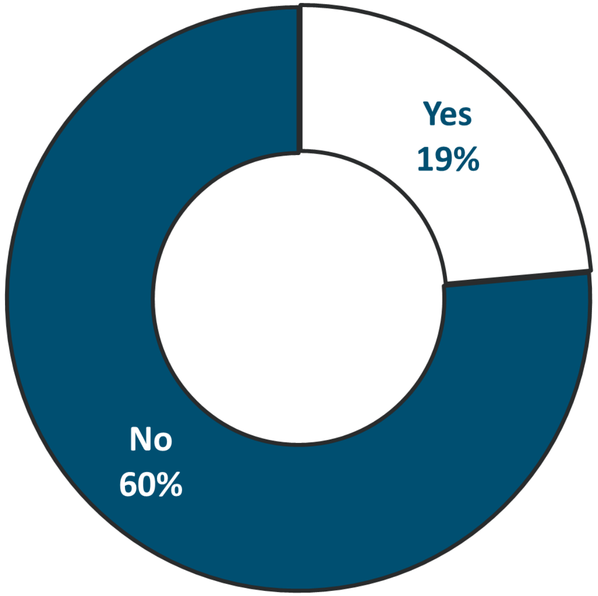
n= 130

Note: Participants could select more than one response; therefore, percentages do not add to 100.

About 19% of caregivers reported having a doctor or healthcare provider tell them their child has ADHD.

One-third (33%) these children are taking medication for ADHD.

Has a doctor or other health care provider ever told you your child has Attention-Deficit/Hyperactivity Disorder, or ADHD?

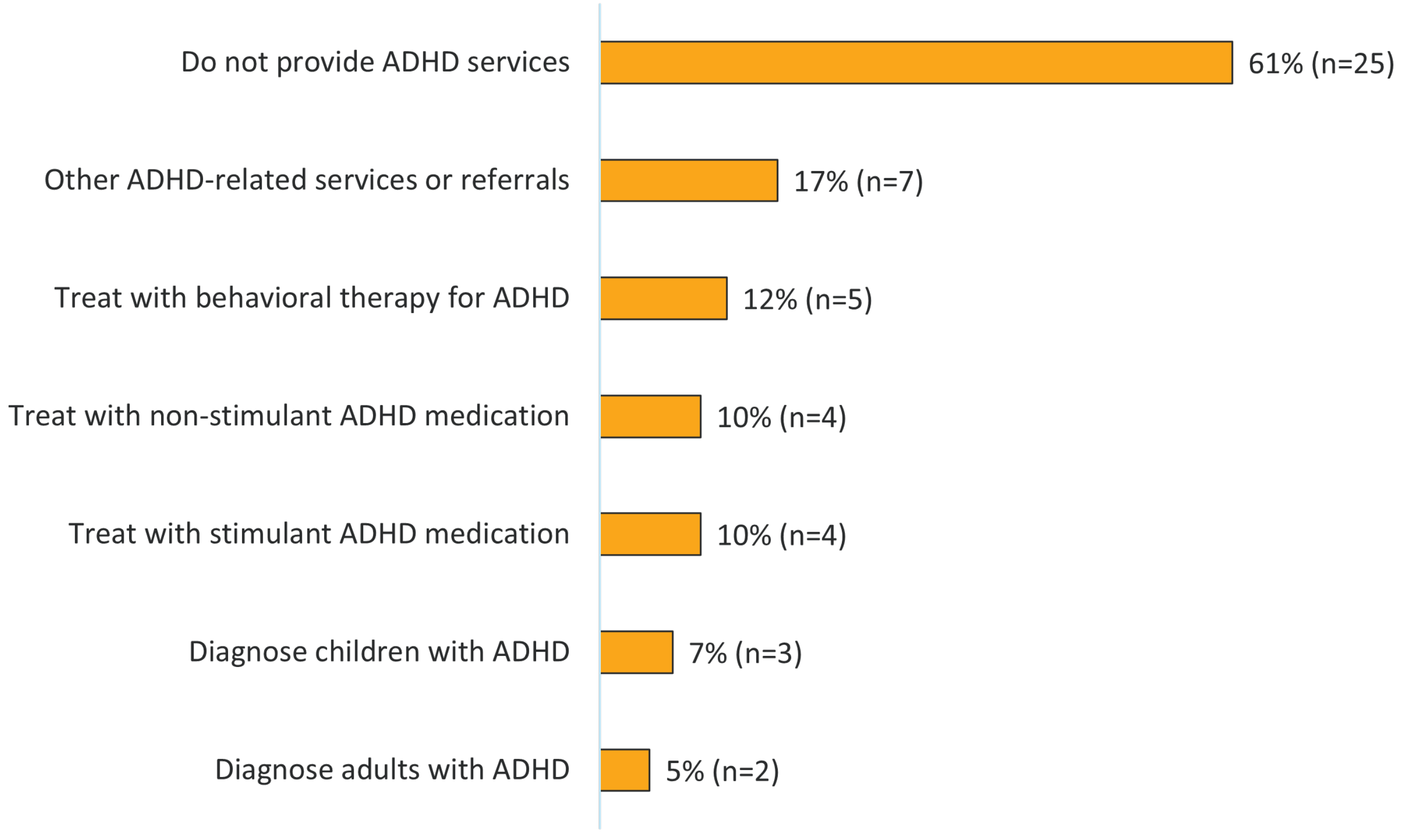


Note: Percentages do not add to 100 due to rounding.

n= 130

A majority of health care providers (61%) do not provide ADHD related services.

What ADHD related services do you offer in your practice?



Providers that diagnose children with ADHD identified the following barriers:

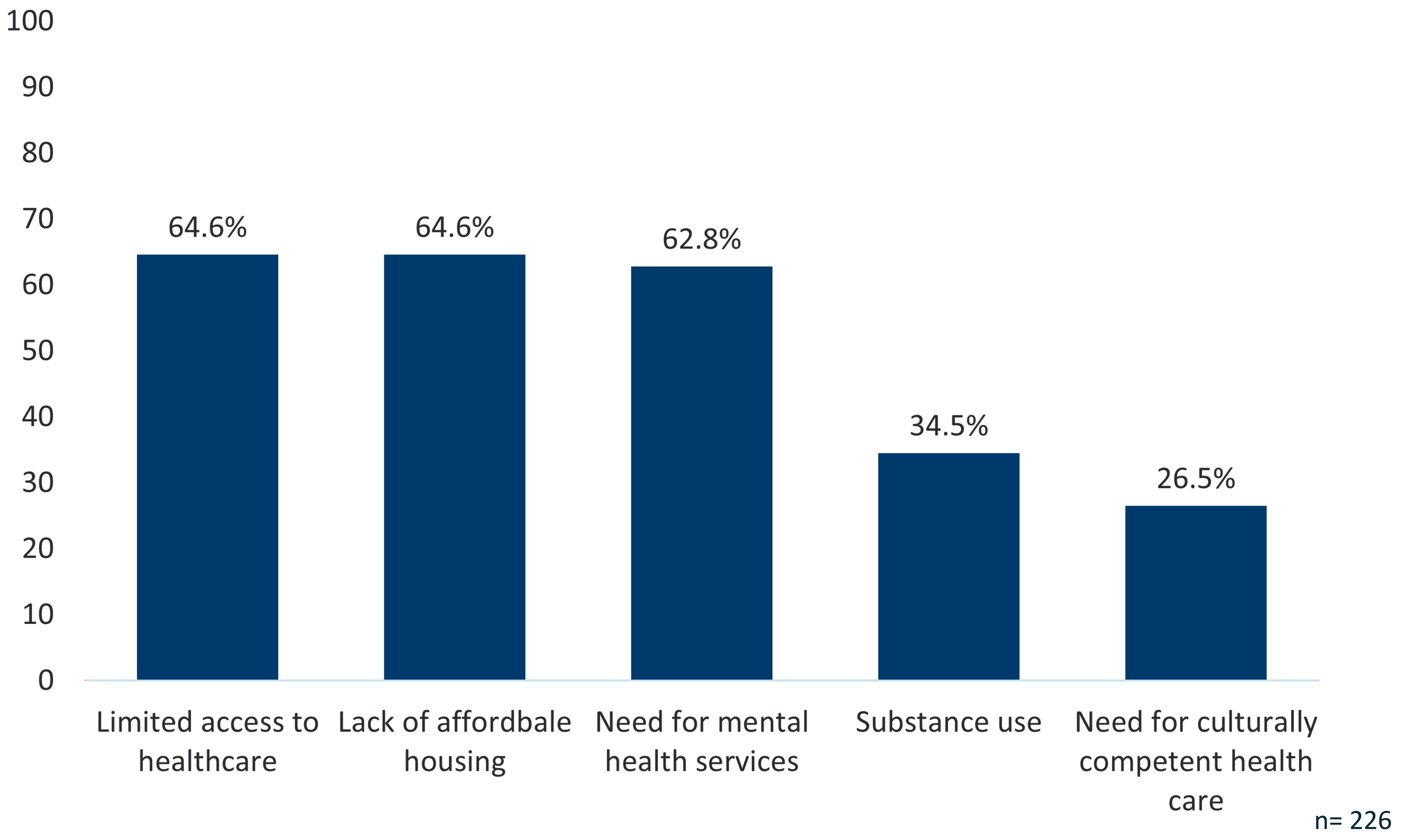
- I don't have anyone to refer patients to (n=1)
- Lack of time to evaluate the patient (n=2)
- Unable to bill for this type of evaluation (n=1)
- Family resistance to evaluation/referral (n=2)
- No barriers (n=4)

Note: Participants could select more than one response; therefore, percentages do not add to 100.

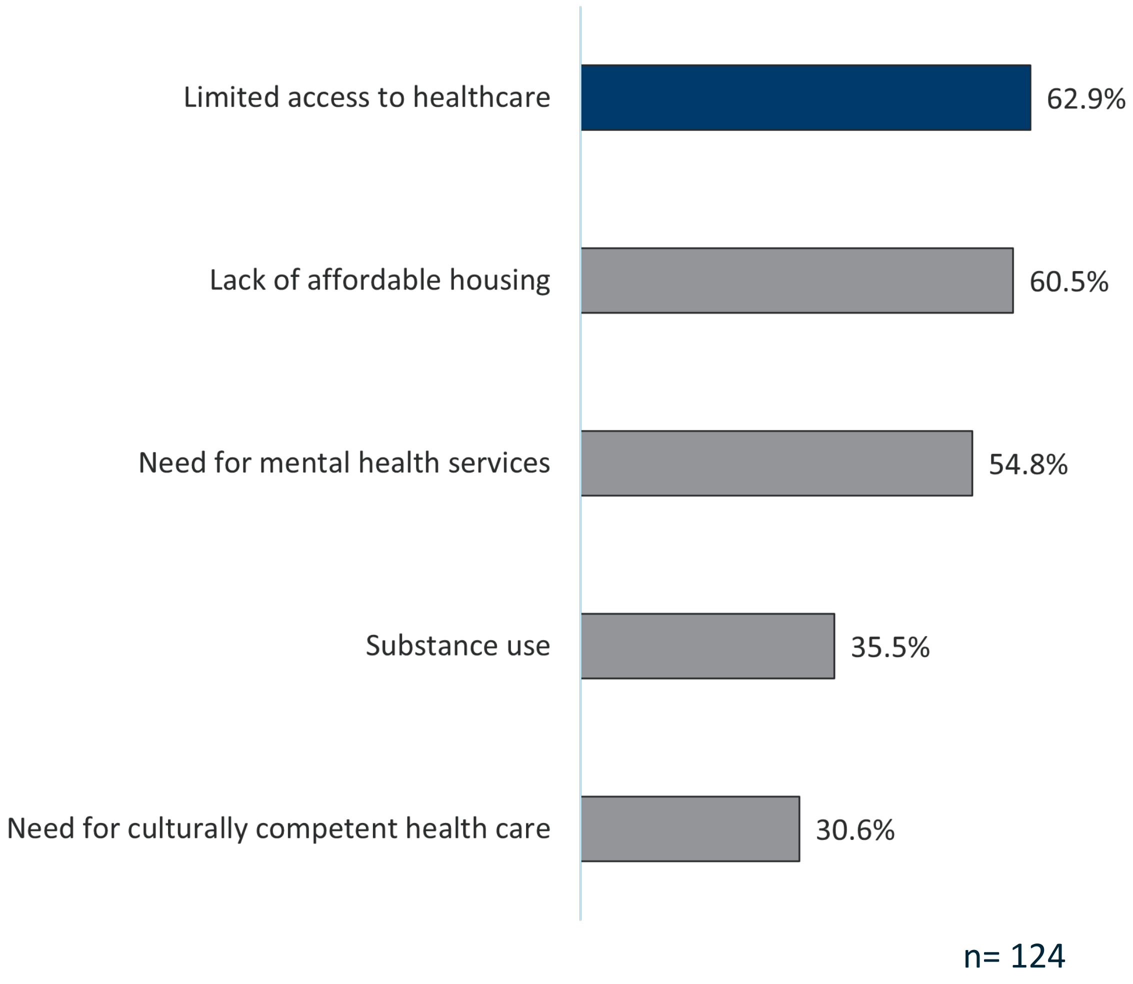
n= 41

Priorities

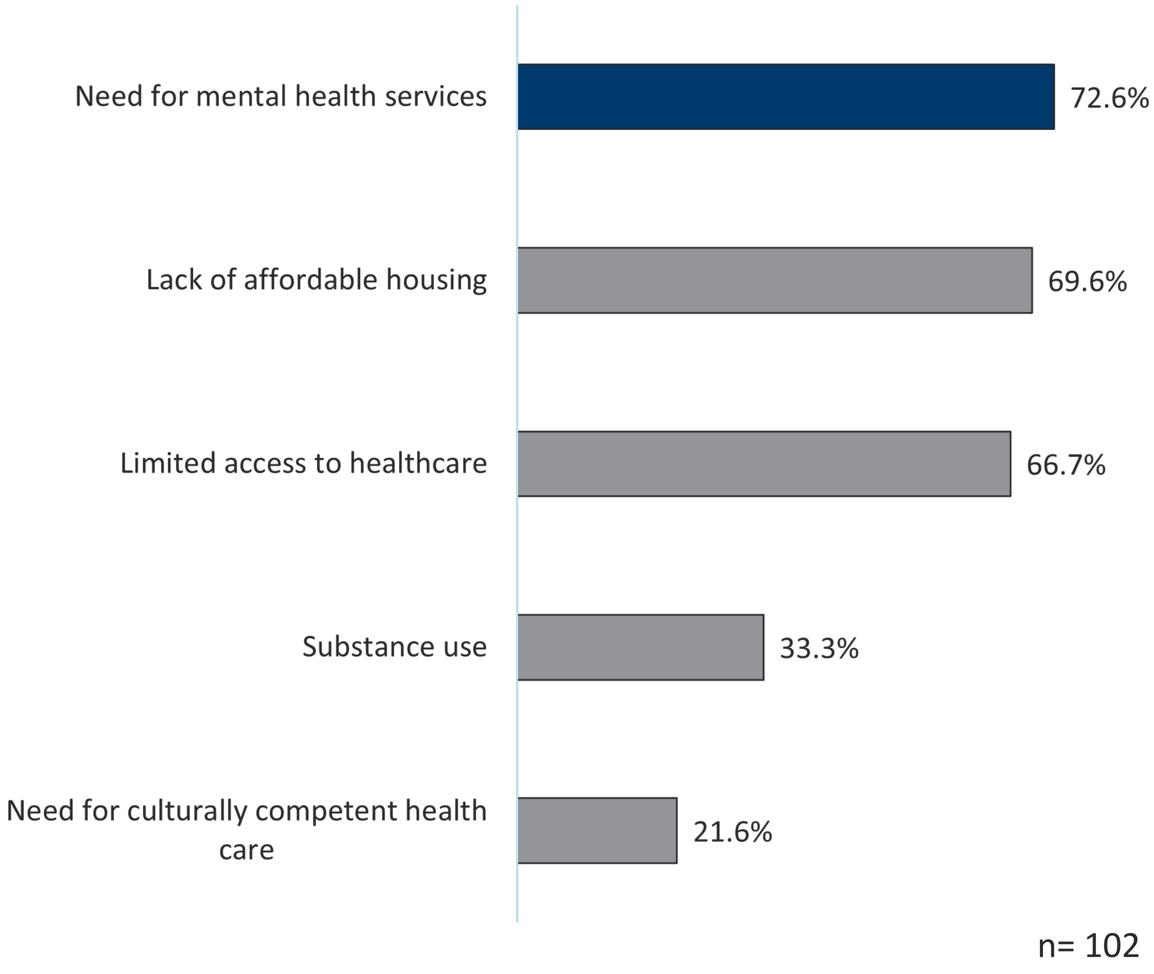
Most respondents (65%) felt that **limited access to healthcare** and **lack of affordable housing** were the most important health issues that would help **all Nevada people** be healthier.



Respondents who were non-professionals felt **limited access to health care** was the most important health issue for **all Nevada people**, while respondents who were professionals felt the need for **mental health services** was the most important.

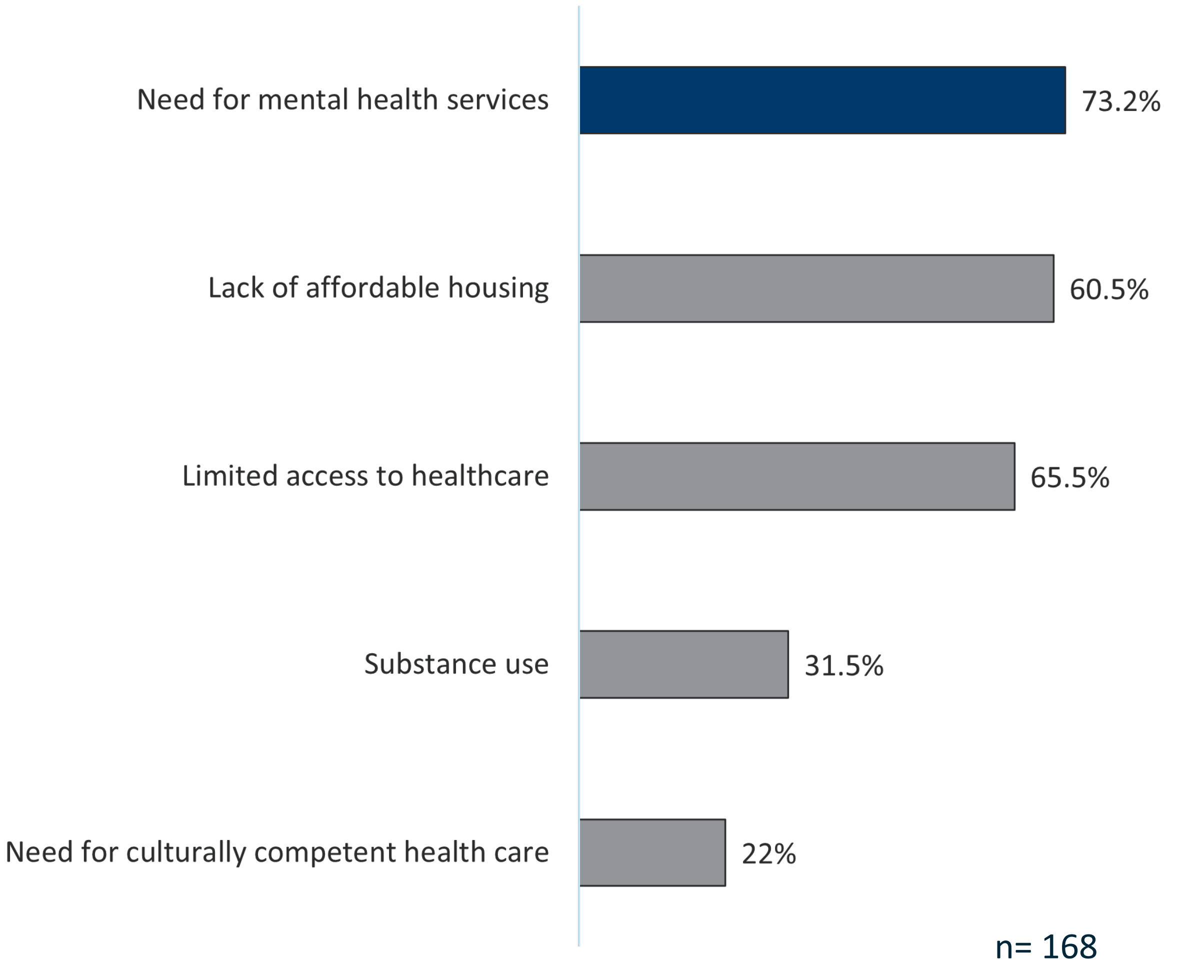


Non-professional

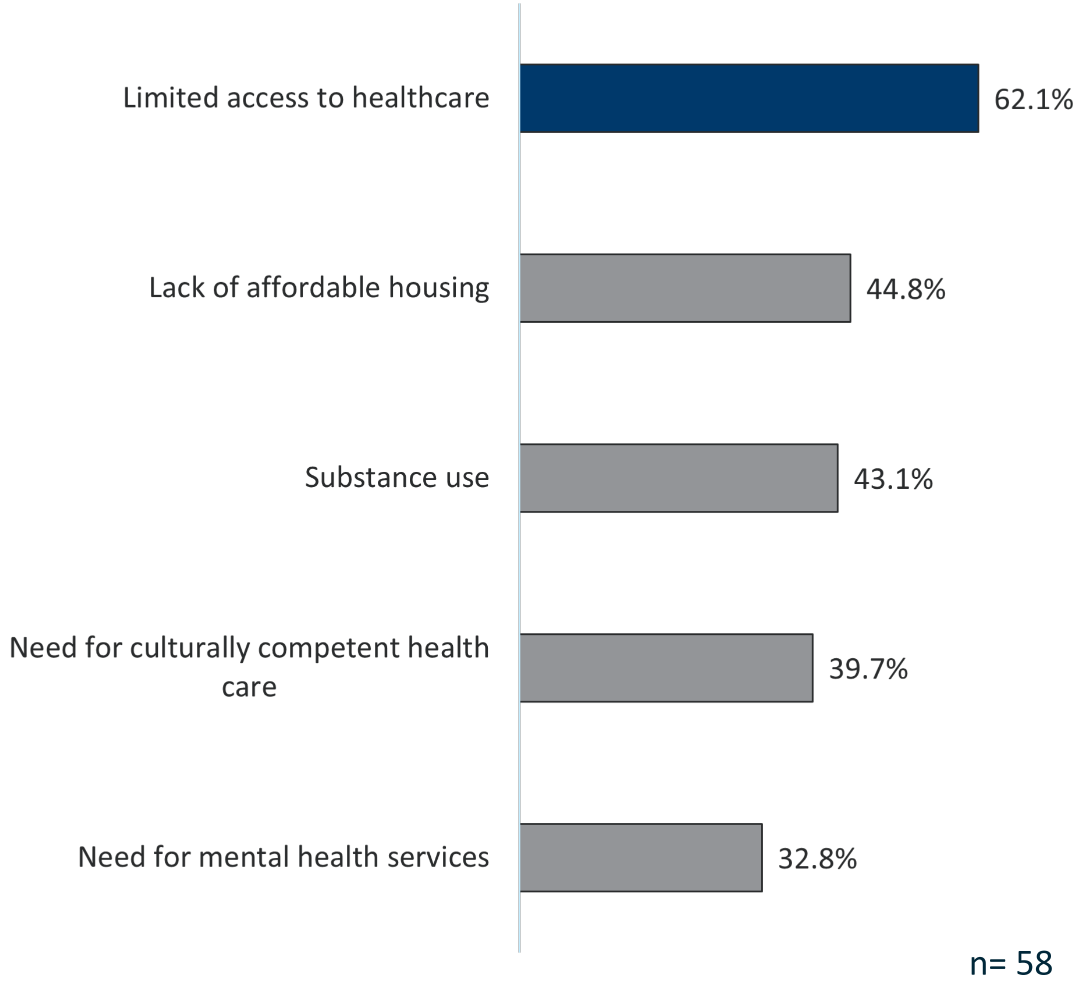


Professional

English speaking respondents felt the need for **mental health services** was the most important health issue for **all Nevada people**, while Spanish speaking respondents felt **limited access to health care** was the most important.



English Speakers



Spanish Speakers

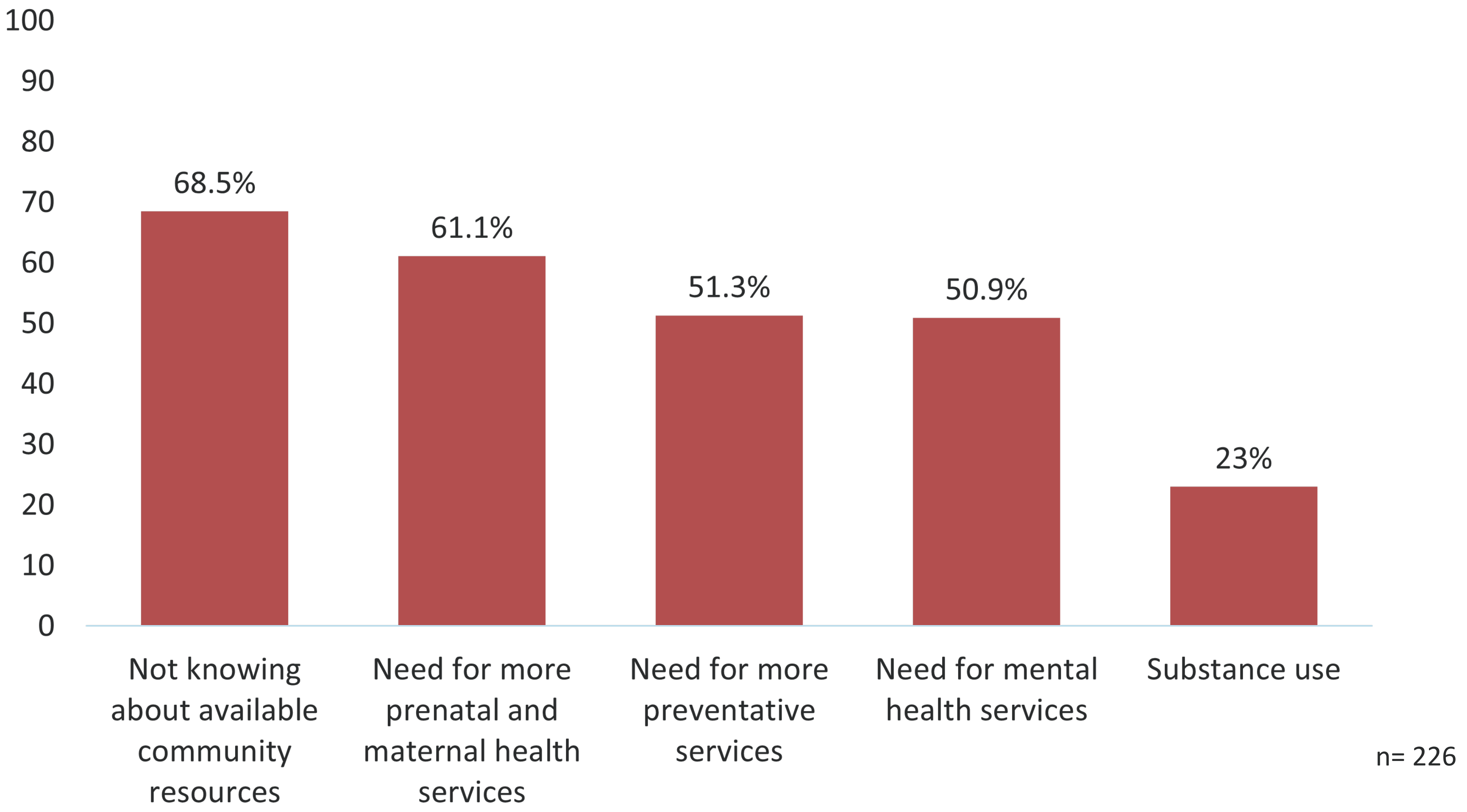
Priorities by Subgroup: **All Nevada People**

Priority	All	Non-professionals	Professionals	English Speakers	Spanish Speakers
Limited access to healthcare	1	1	3	3	1
Lack of affordable housing	2	2	2	2	2
Need for mental health services	3	3	1	1	5
Substance use	4	4	4	4	3
Need for culturally competent health care	5	5	5	5	4

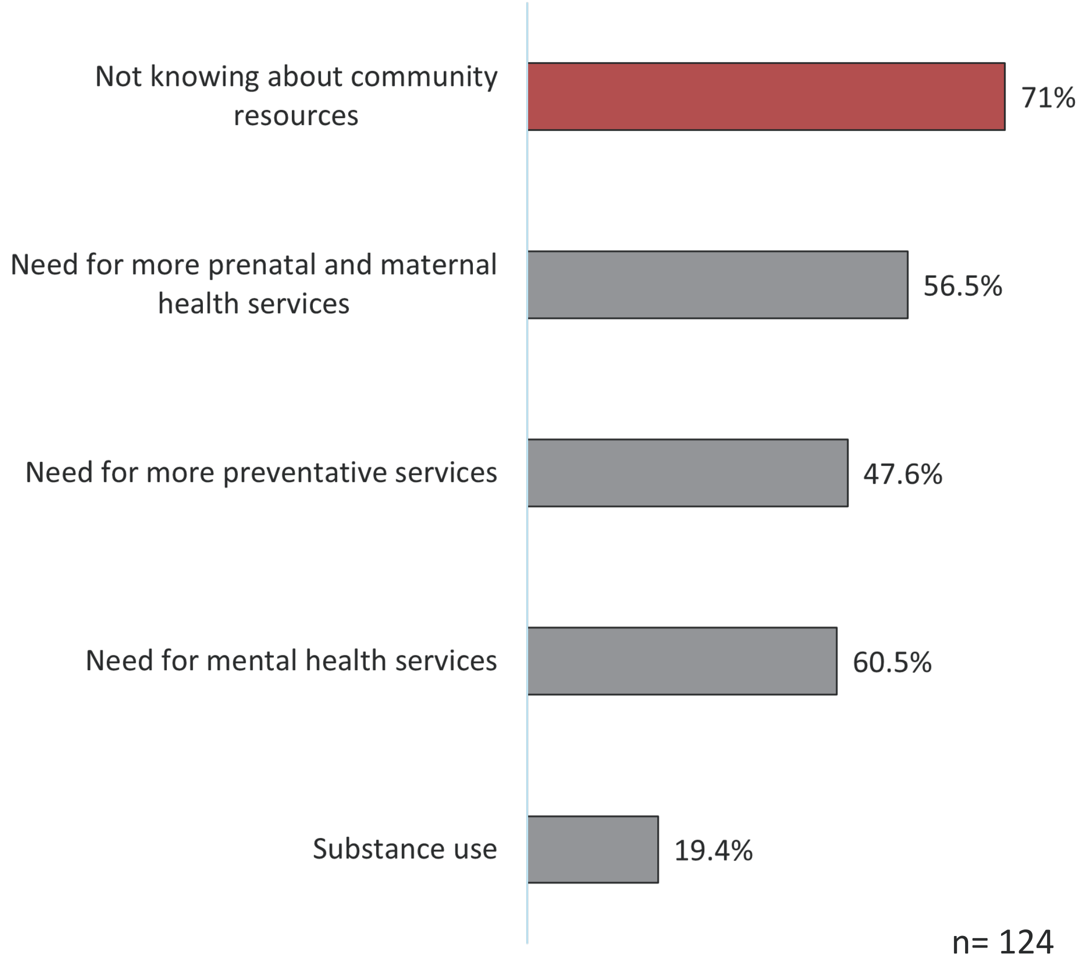
Note: 95% of respondents who identified as being a professional spoke English.

Ranking Scale	1	2	3	4	5

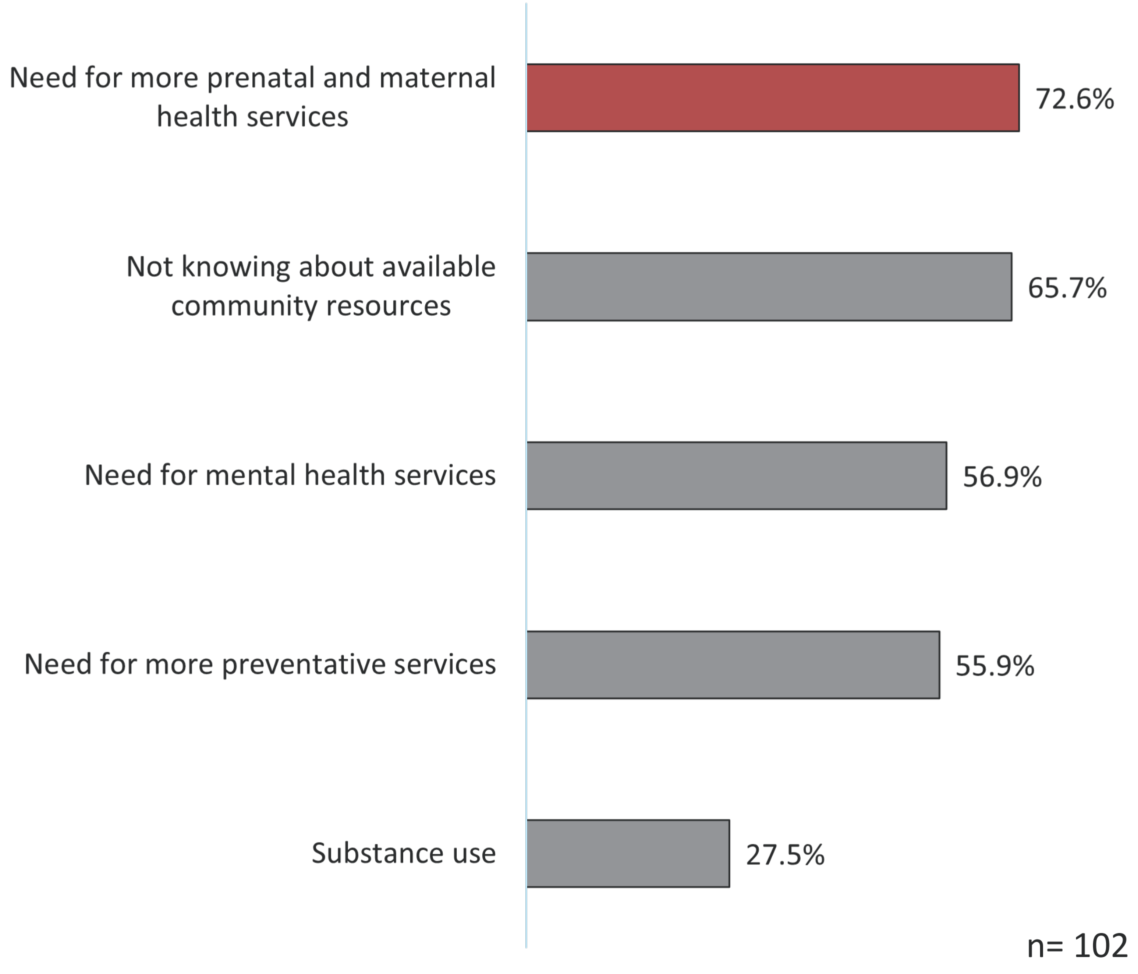
Most respondents (69%) felt that **not knowing about available community resources** was the most important health issue facing **women/mothers in Nevada**.



Most (71%) non-professional respondents felt **not knowing about available community resources** was the most important health issue facing **women/mothers in Nevada**, while most (73%) professional respondents felt the need for **more prenatal and maternal health services** was most important.

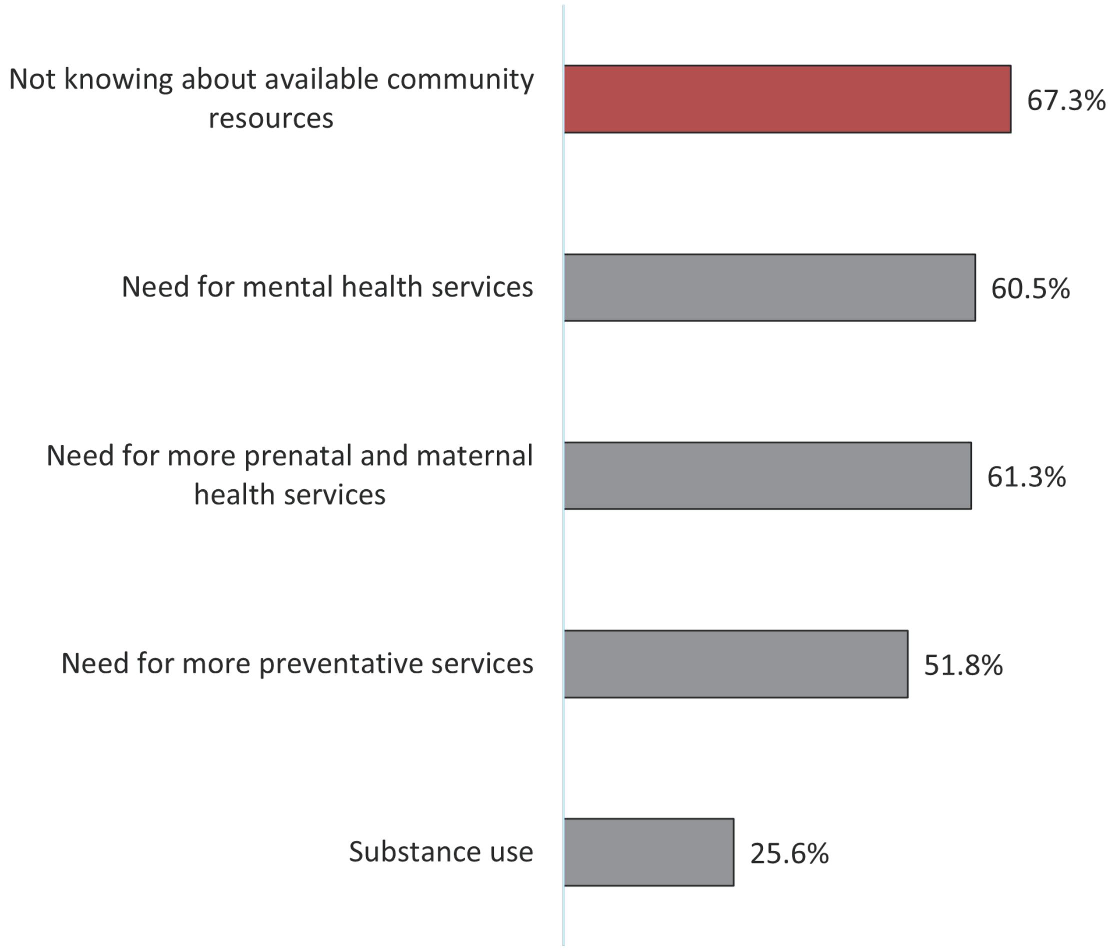


Non-professional



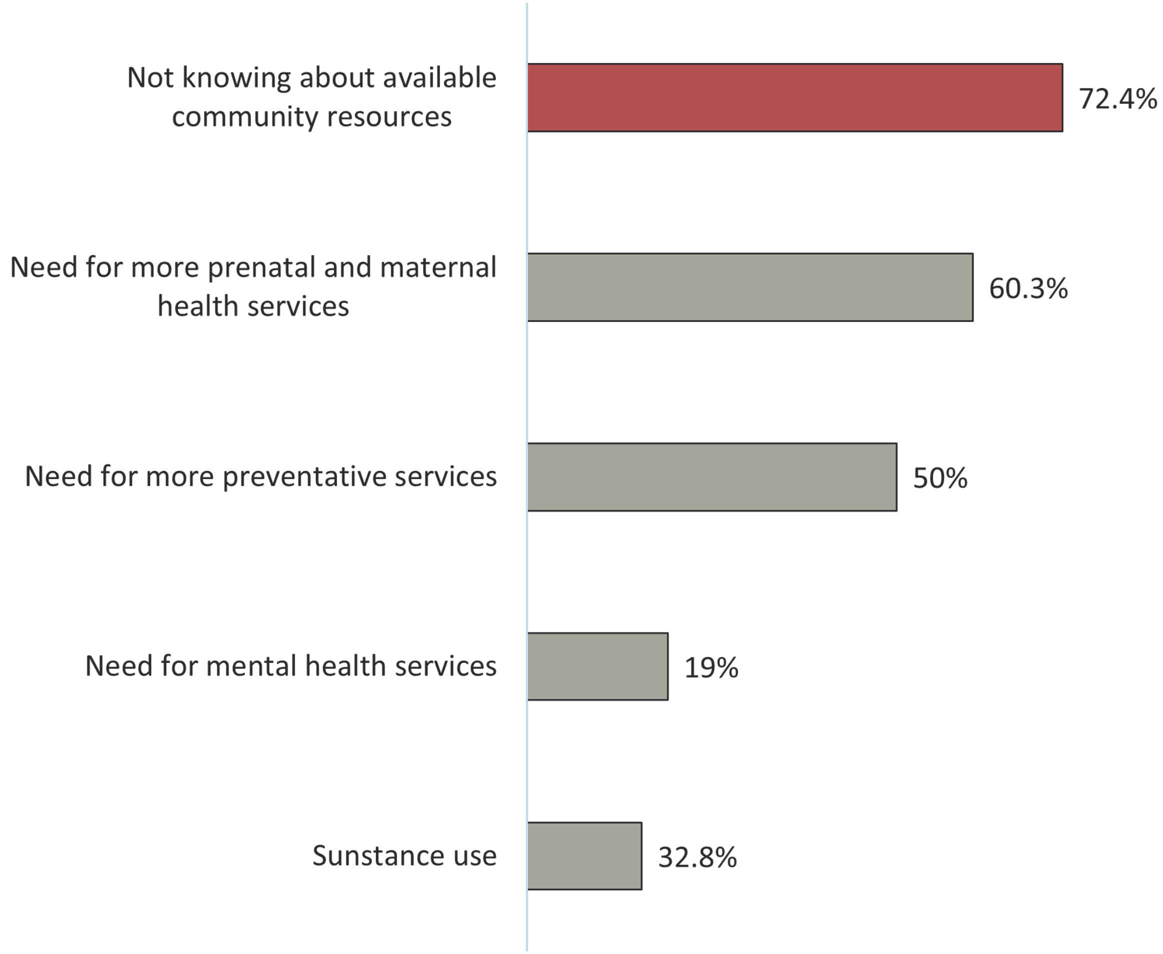
Professional

Both English and Spanish speaking respondents felt **not knowing about available community resources** was the most important health issue facing **women/mothers in Nevada**.



n= 168

English Speakers



n= 58

Spanish Speakers

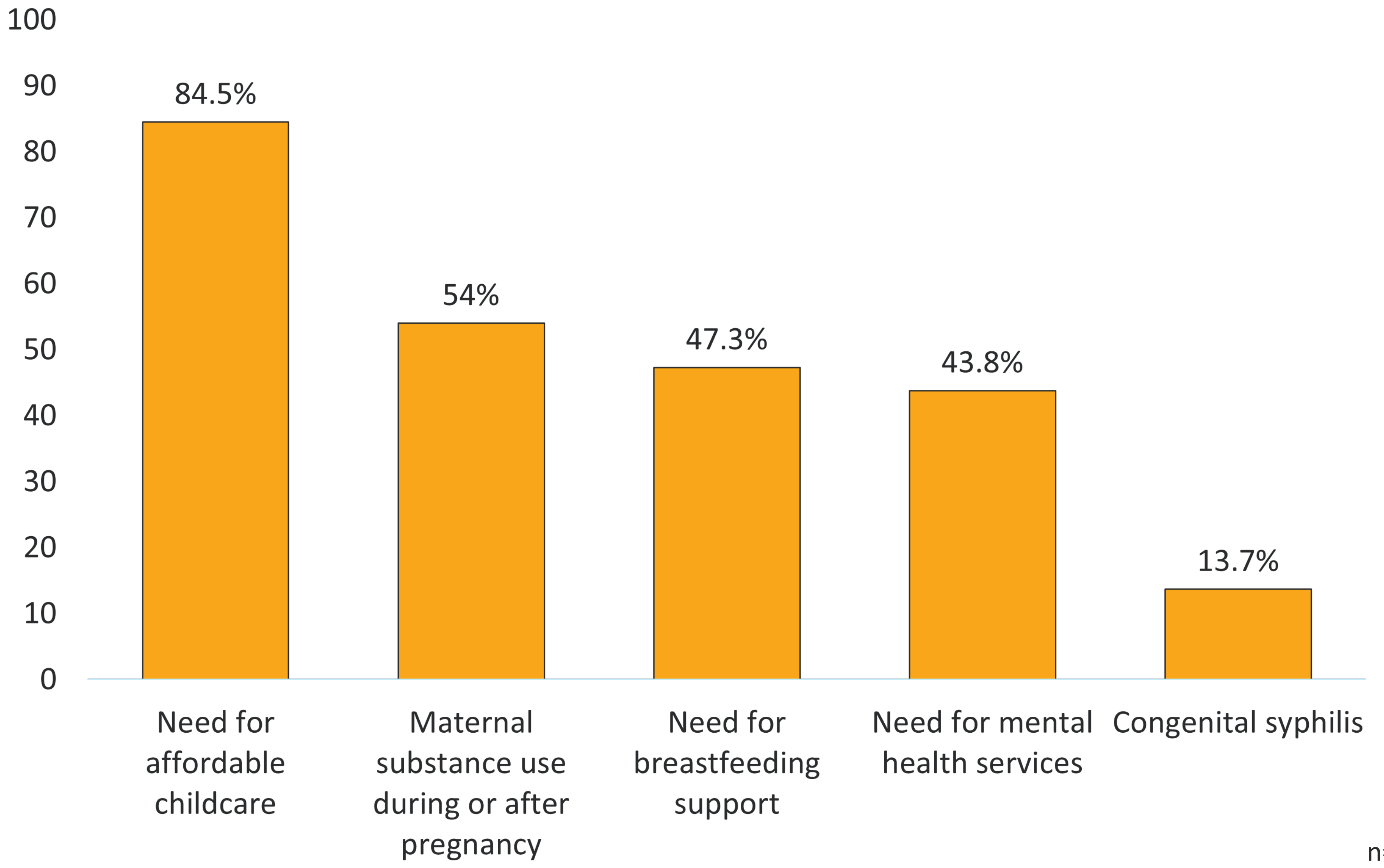
Priorities by Subgroup: Women and Maternal Health

Priority	All	Non-professionals	Professionals	English Speakers	Spanish Speakers
Not knowing about available community resources	1	1	2	1	1
Need for more prenatal and maternal health services	2	2	1	3	2
Need for more preventative services	3	3	4	4	3
Need for mental health services	4	4	3	2	4
Substance use	5	5	5	5	5

Note: 95% of respondents who identified as being a professional spoke English.

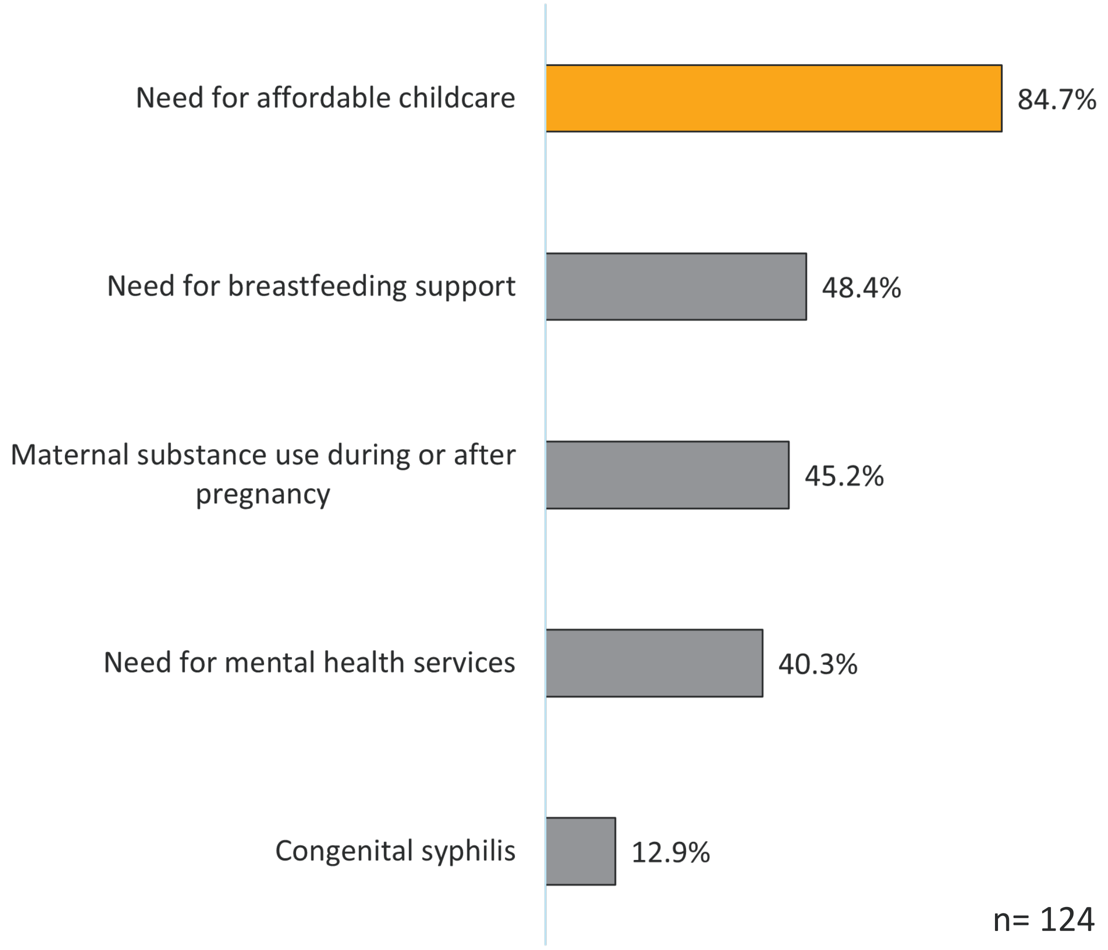
Ranking Scale	1	2	3	4	5

Most respondents (85%) felt the **need for affordable childcare** was the important health issue facing **babies in Nevada**.

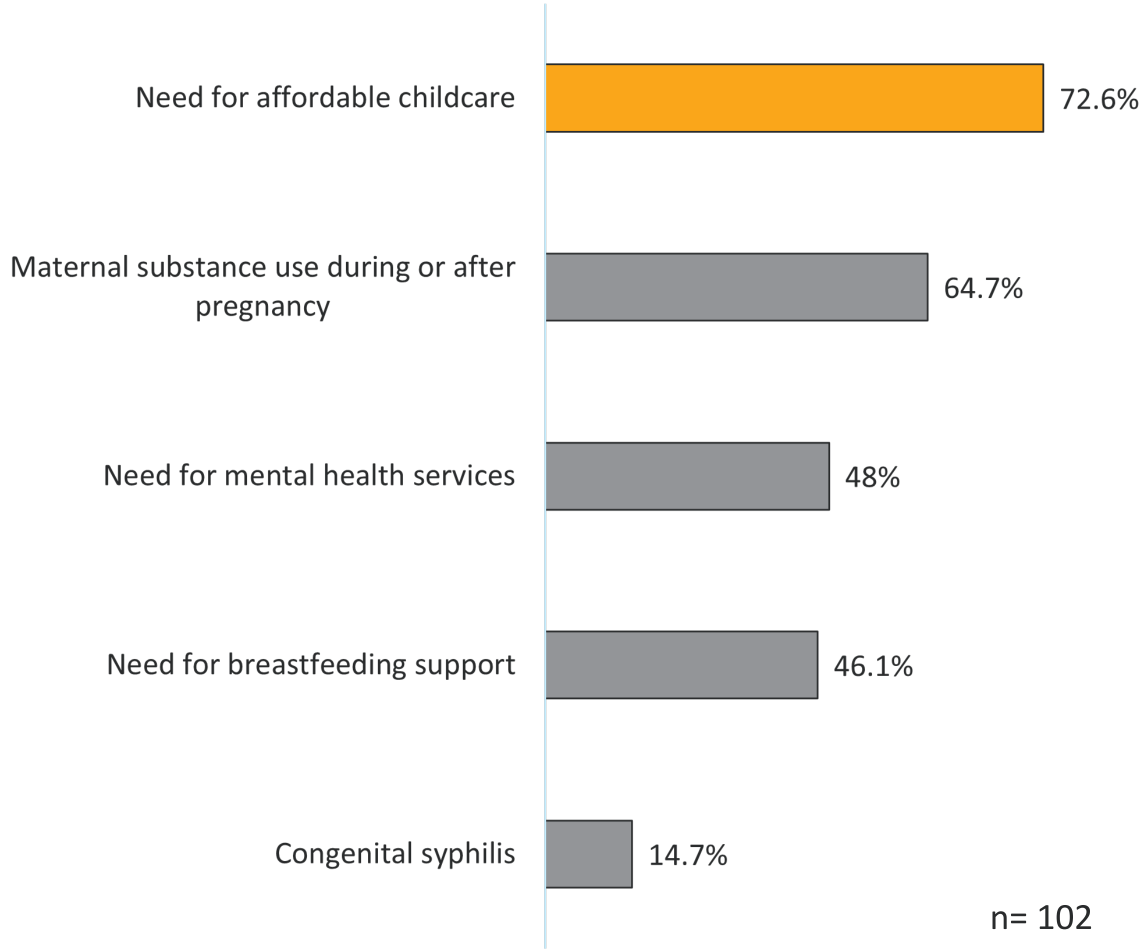


n= 226

Both non-professional and professional respondents felt the **need for affordable childcare** was the most important health issue facing **babies in Nevada.**

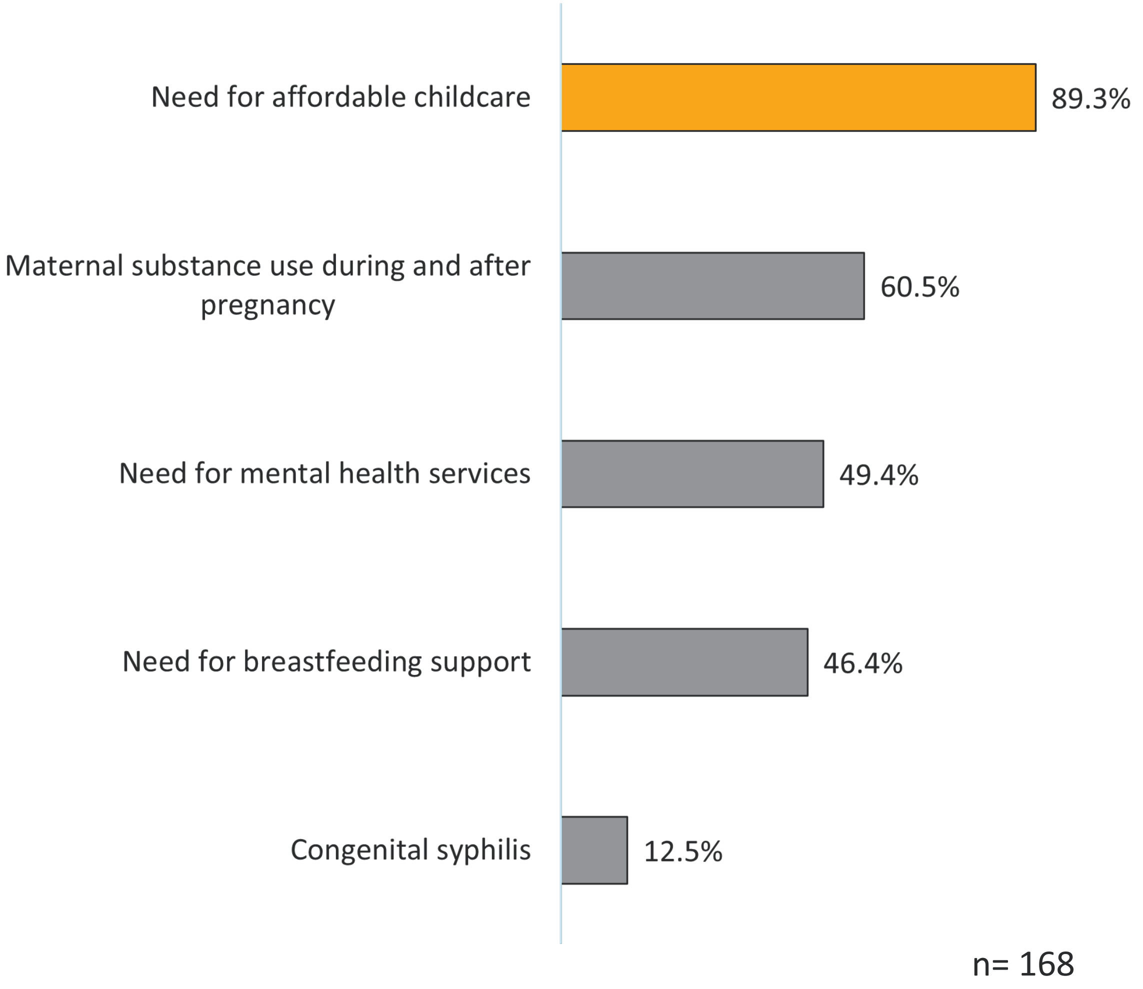


Non-professional

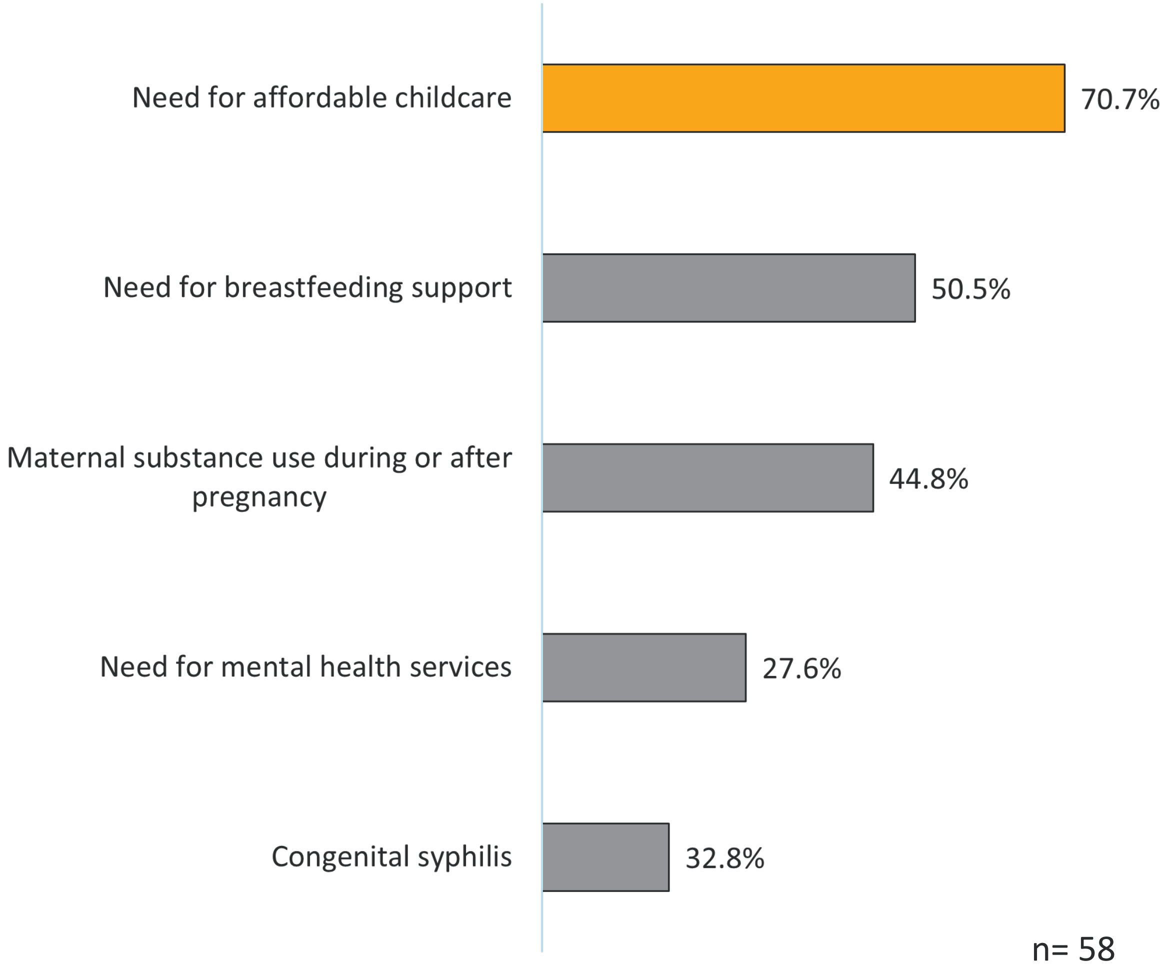


Professional

Both English and Spanish speaking respondents felt the **need for affordable childcare** was the most important health issue facing **babies in Nevada**.



English Speakers



Spanish Speakers

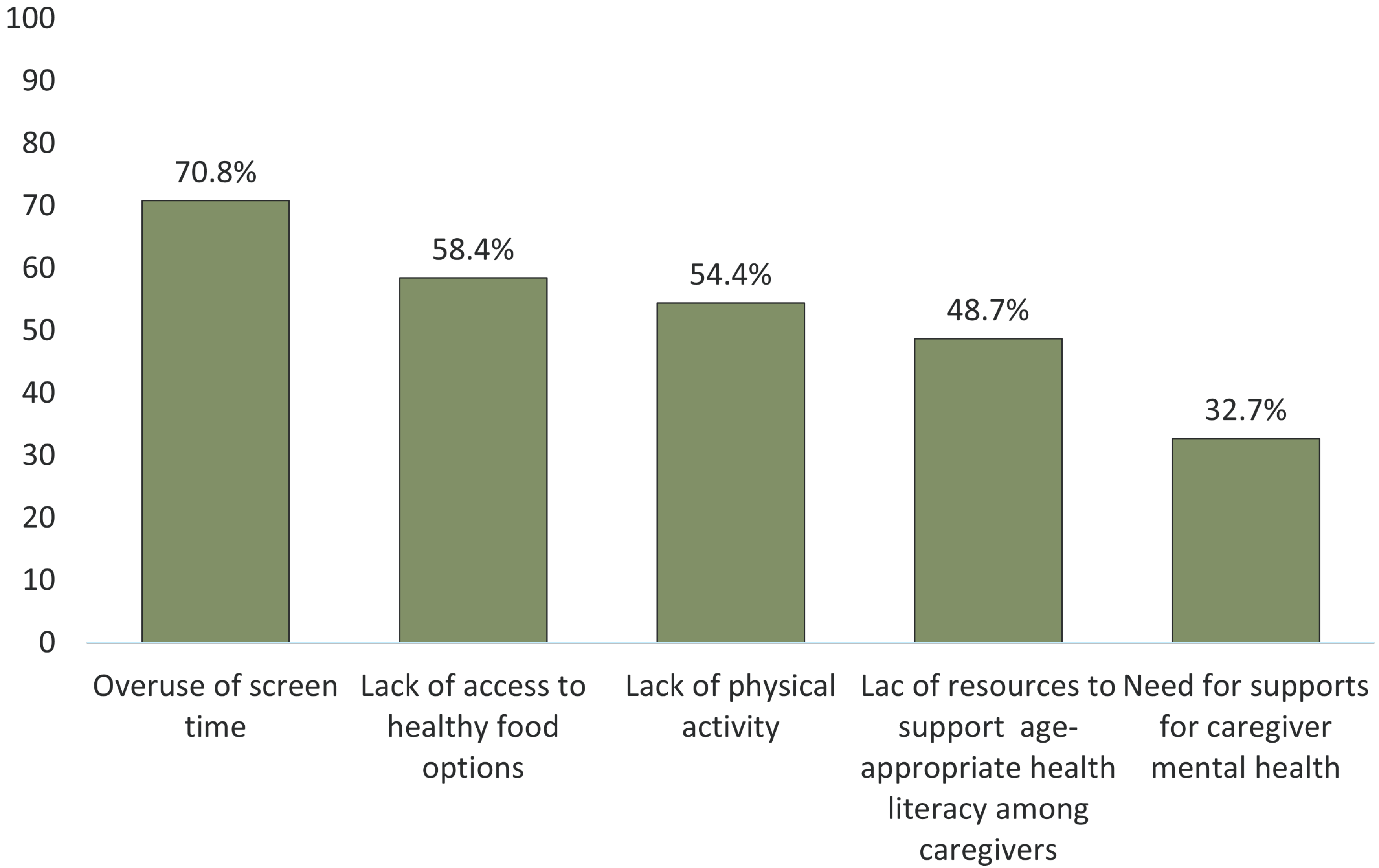
Priorities by Subgroup: Perinatal and Infant Health

Priority	All	Non-professionals	Professionals	English Speakers	Spanish Speakers
Need for affordable childcare	1	1	1	1	1
Maternal substance use during or after pregnancy	2	3	2	2	3
Need for breastfeeding support	3	2	4	4	2
Need for mental health services	4	4	3	3	4
Congenital syphilis	5	5	5	5	5

Note: 95% of respondents who identified as being a professional spoke English.

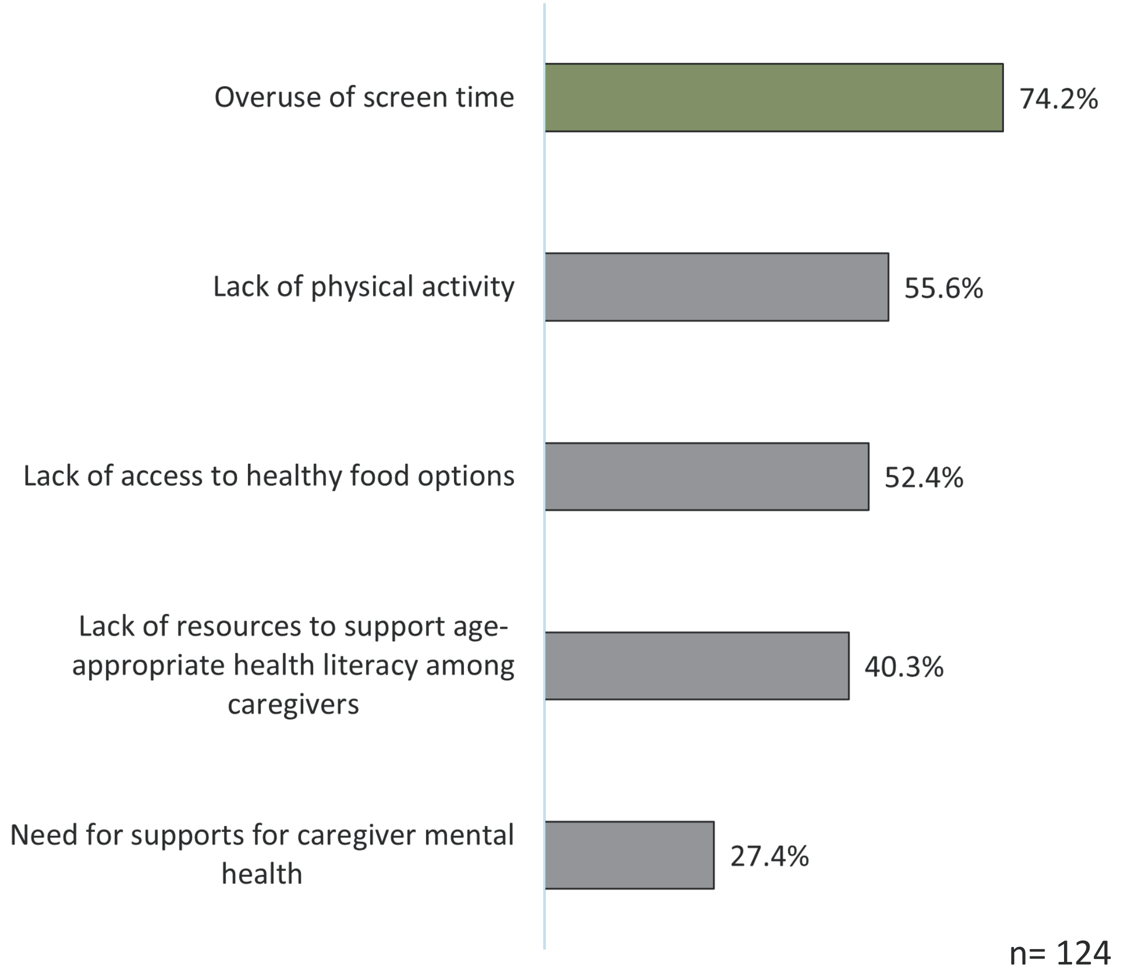
Ranking Scale	1	2	3	4	5

Most respondents (71%) felt that **overuse of screen time** was the important health issue facing **children in Nevada**.

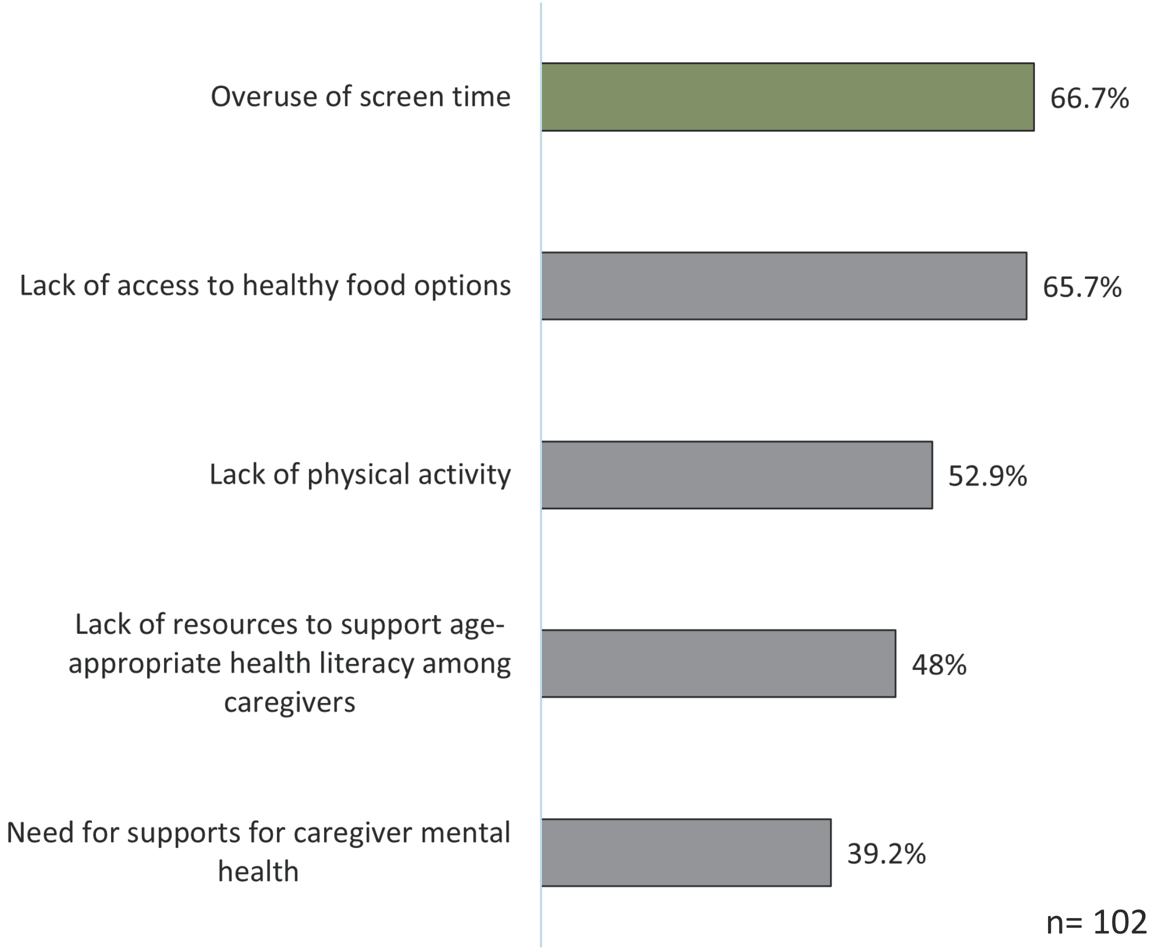


n= 226

Both non-professional and professional respondents felt the **overuse of screen time** was the most important health issue facing **children in Nevada.**

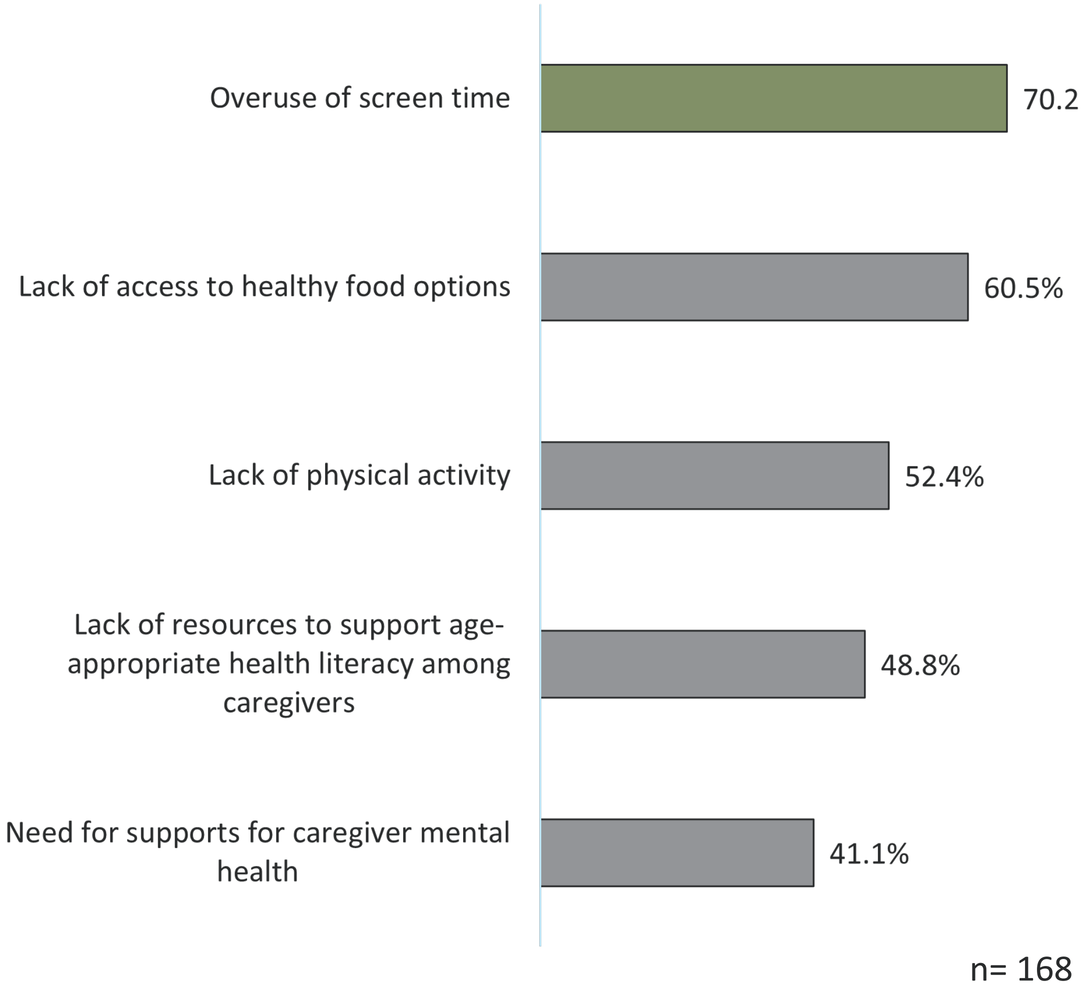


Non-professional

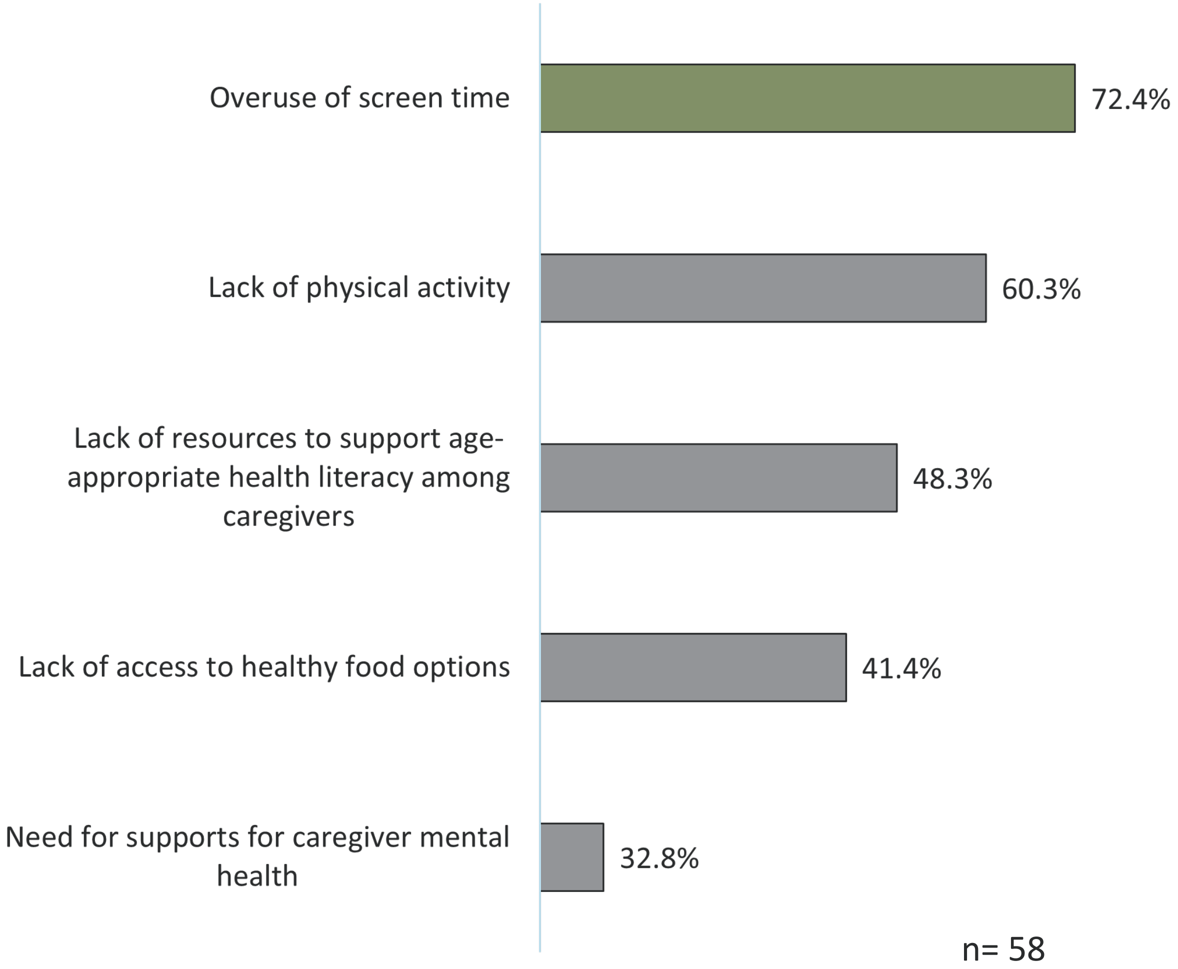


Professional

Both English and Spanish speaking respondents felt that **overuse of screen time** was the most important health issue facing **children in Nevada**.



English Speakers



Spanish Speakers

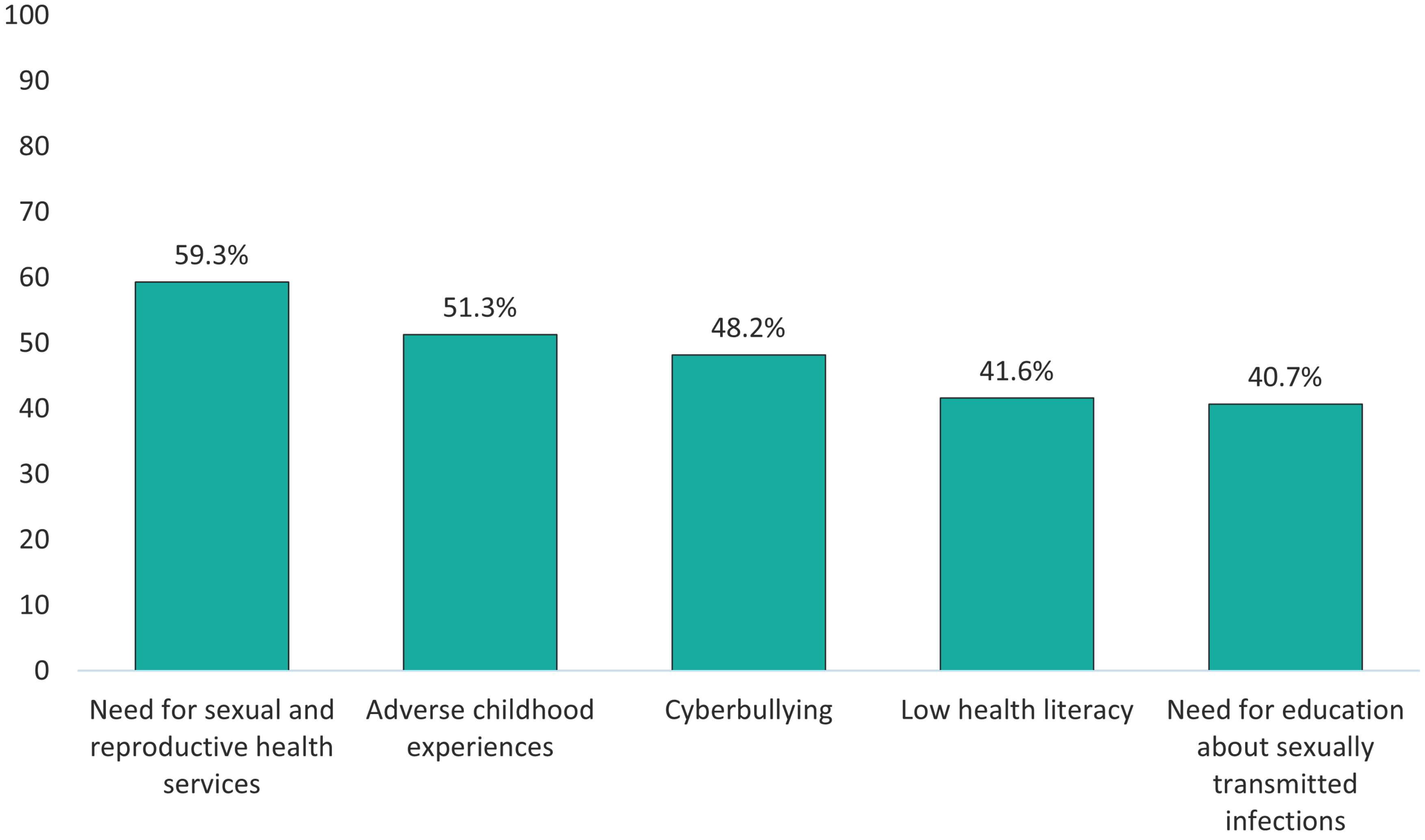
Priorities by Subgroup: Child Health

Priority	All	Non-professionals	Professionals	English Speakers	Spanish Speakers
Overuse of screen time	1	1	1	1	1
Lack of access to healthy food options	2	3	2	2	4
Lack of physical activity	3	2	3	3	2
Lack of resources to support age-appropriate health literacy among caregivers	4	4	4	4	3
Need for supports for caregiver mental health	5	5	5	5	5

Note: 95% of respondents who identified as being a professional spoke English.

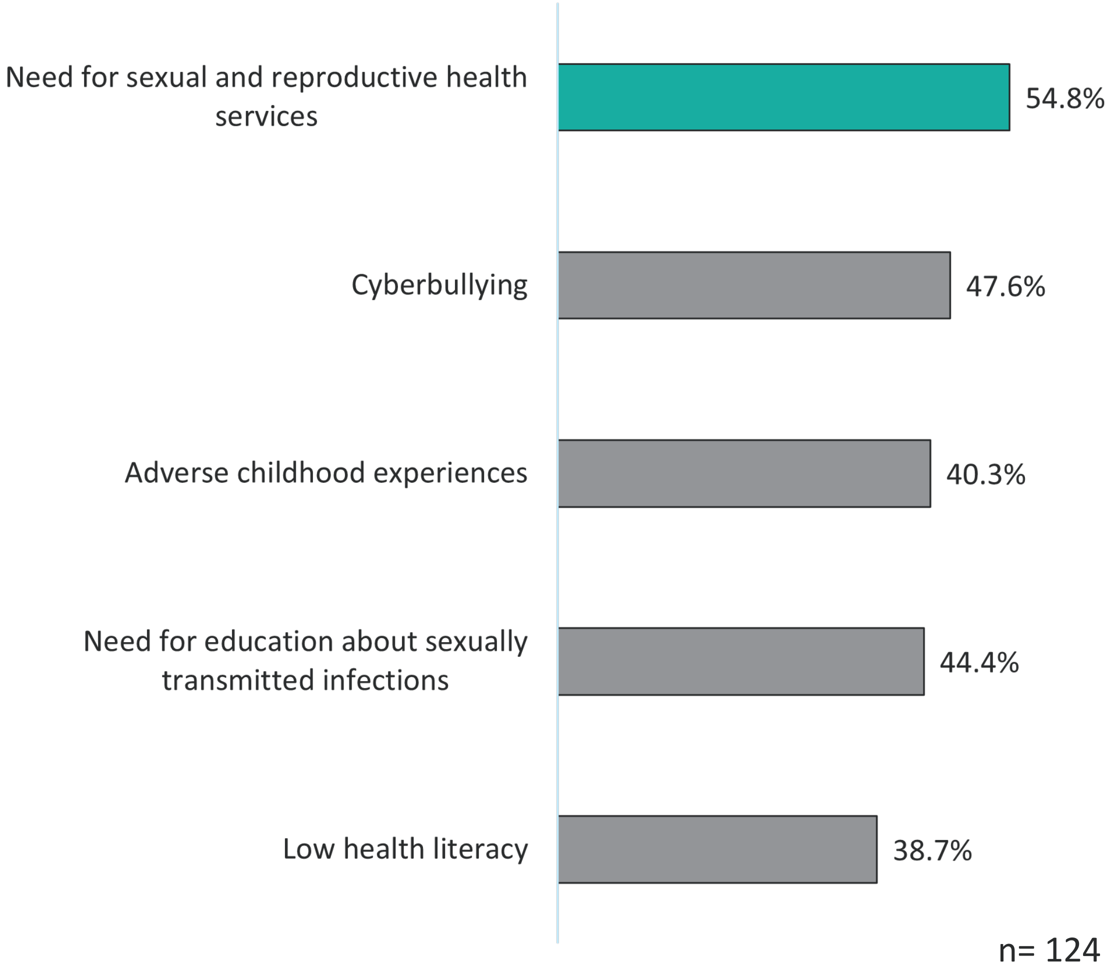
Ranking Scale	1	2	3	4	5

Most respondents (59%) felt that the need for **sexual and reproductive health services** was the important health issue facing **adolescents in Nevada**.

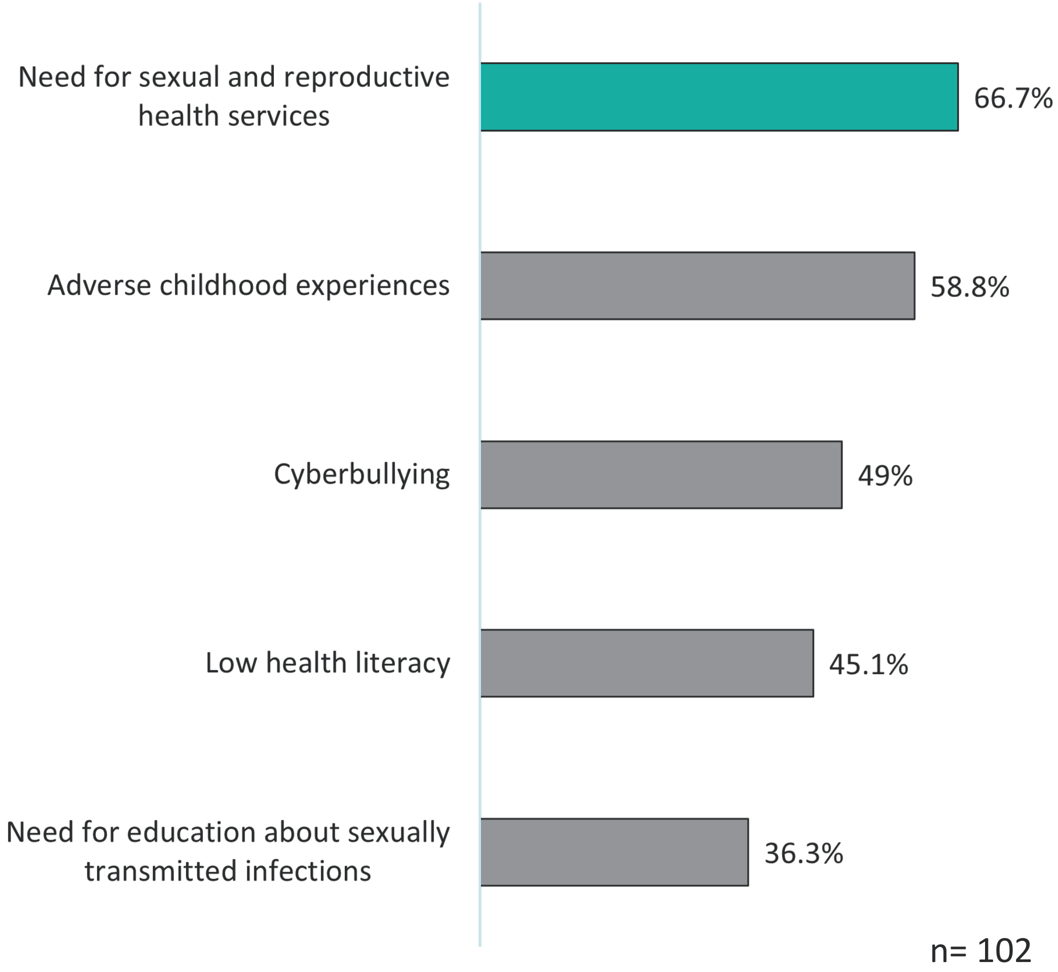


n= 226

Both non-professional and professional respondents felt the need for **sexual and reproductive health services** was the most important health issue facing **adolescents in Nevada.**

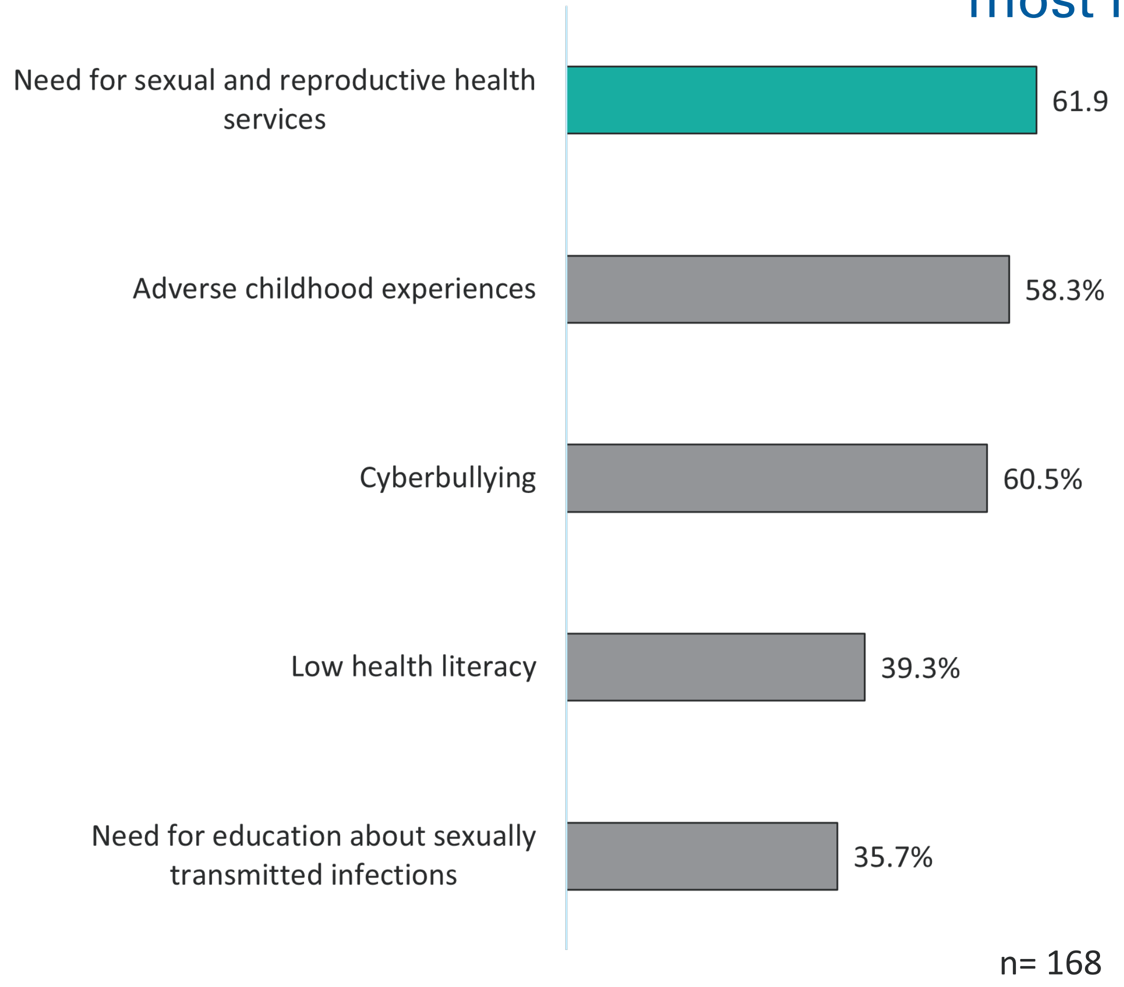


Non-professional

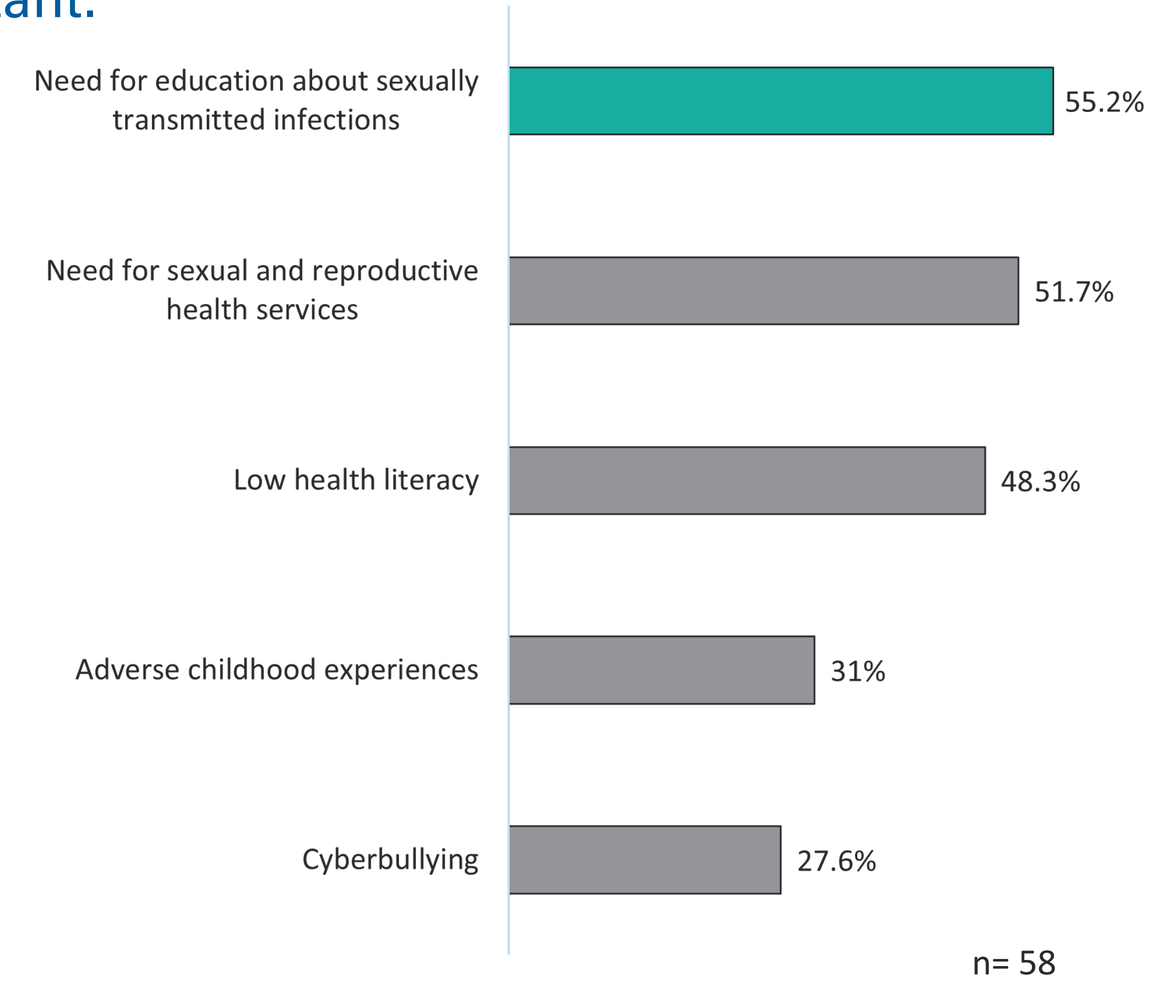


Professional

Most (62%) English speaking respondents felt the need for **sexual and reproductive health services** was the most important health issue facing **adolescents in Nevada,** while Spanish speaking respondents felt the need for **education about sexually transmitted infections** was most important.



English Speakers



Spanish Speakers

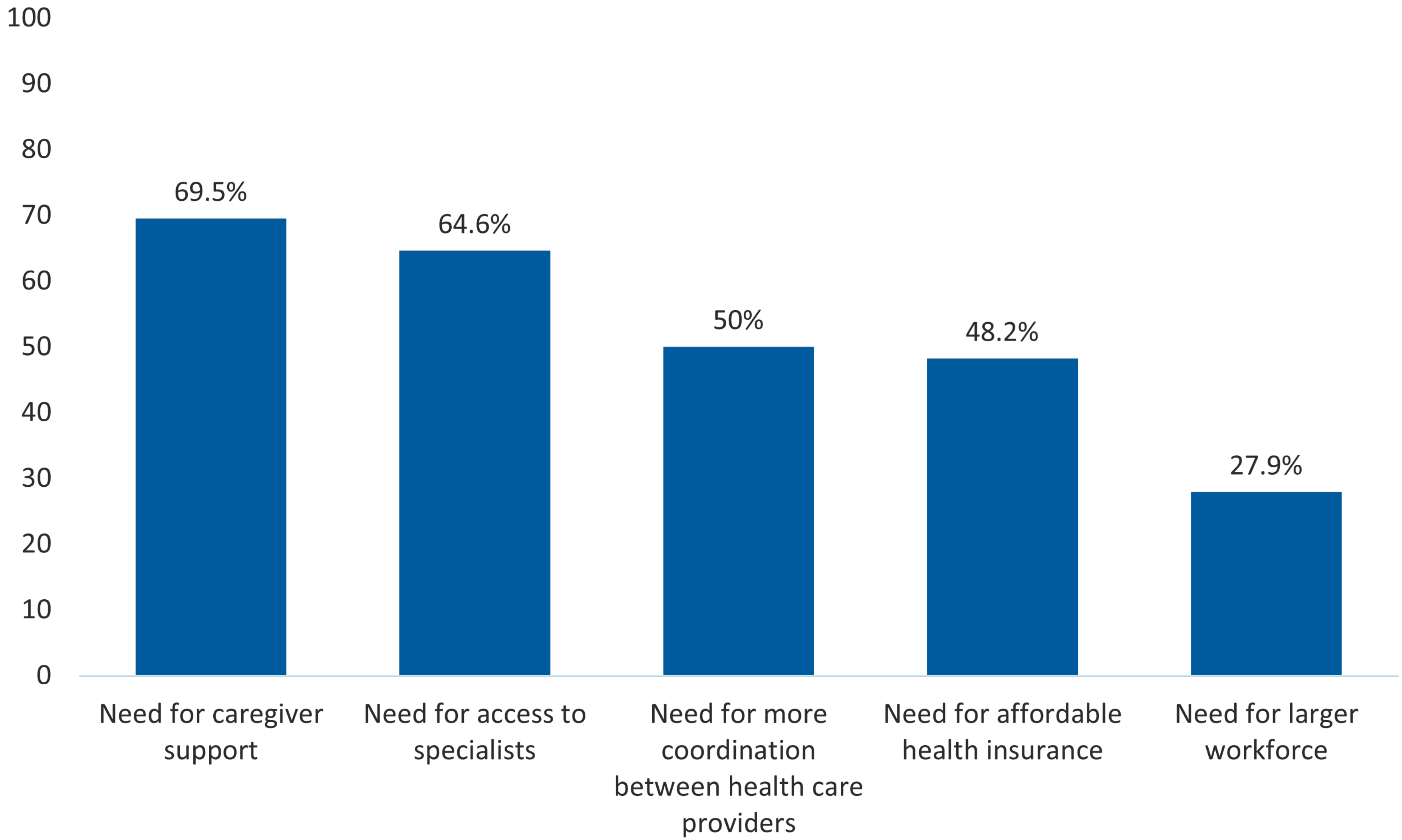
Priorities by Subgroup: Adolescent Health

Priority	All	Non-professionals	Professionals	English Speakers	Spanish Speakers
Need for sexual and reproductive health services	1	1	1	1	2
Adverse childhood experiences	2	3	2	2	4
Cyberbullying	3	2	3	3	5
Low health literacy	4	5	4	4	3
Need for education about sexually transmitted infections	5	4	5	5	1

Note: 95% of respondents who identified as being a professional spoke English.

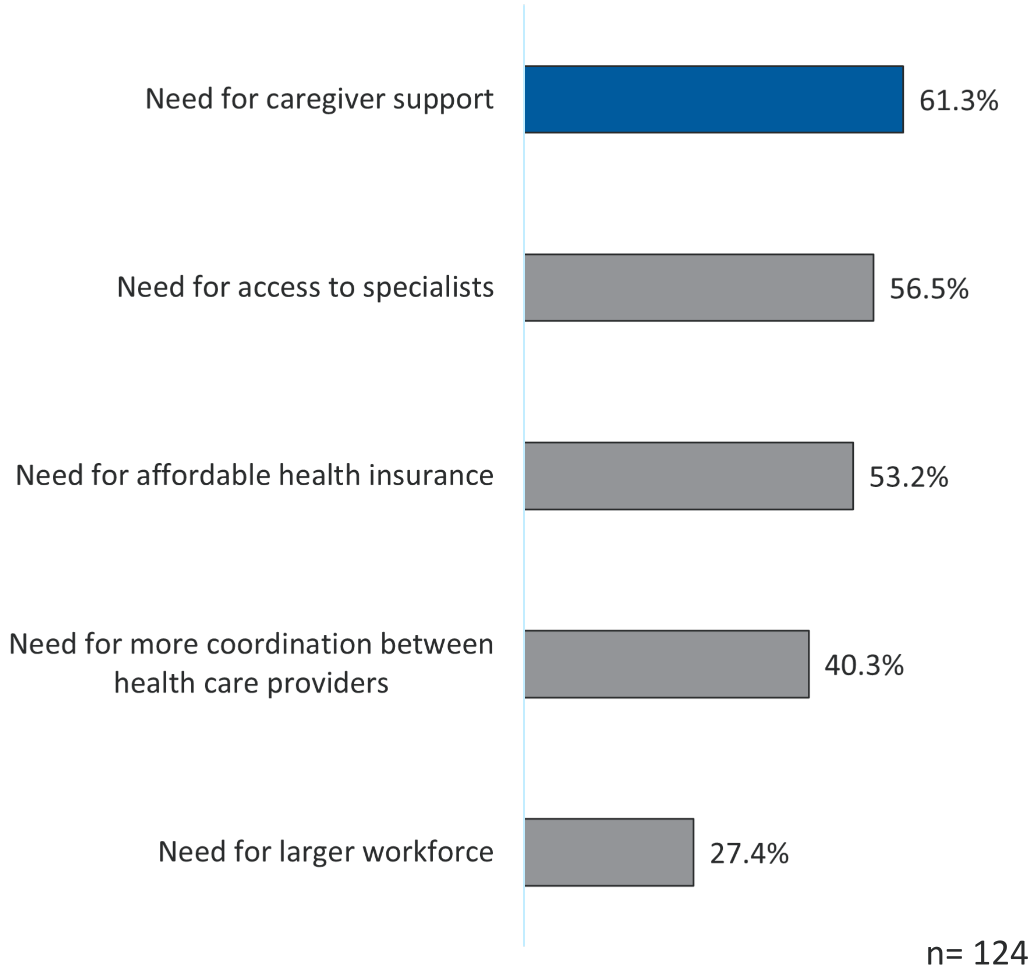
Ranking Scale	1	2	3	4	5

Most respondents (70%) felt that the need for **caregiver support** was the important health issue facing **Children and Youth with Special Health Care Needs (CYSHCN) in Nevada**.

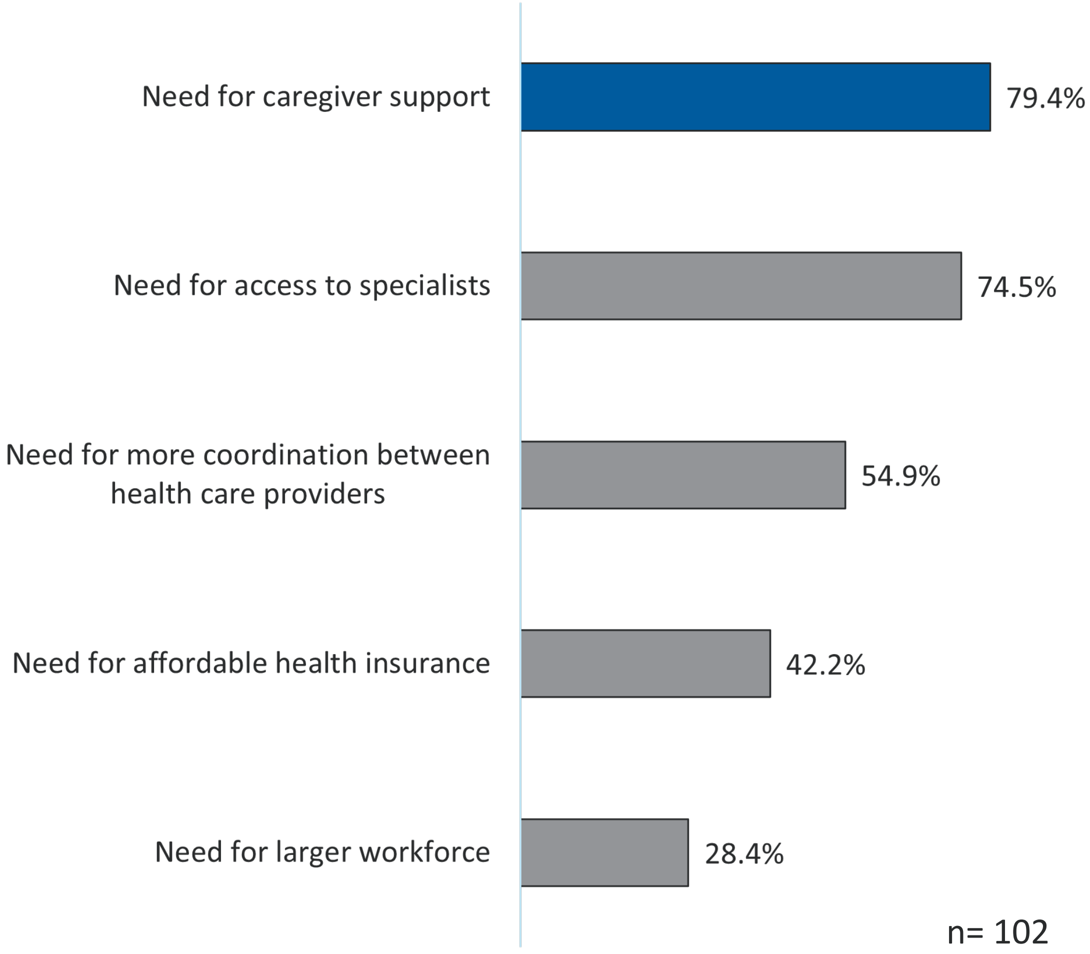


n= 226

Both non-professional and professional respondents felt the **need for caregiver support** was the most important health issue facing **CYSHCN in Nevada.**

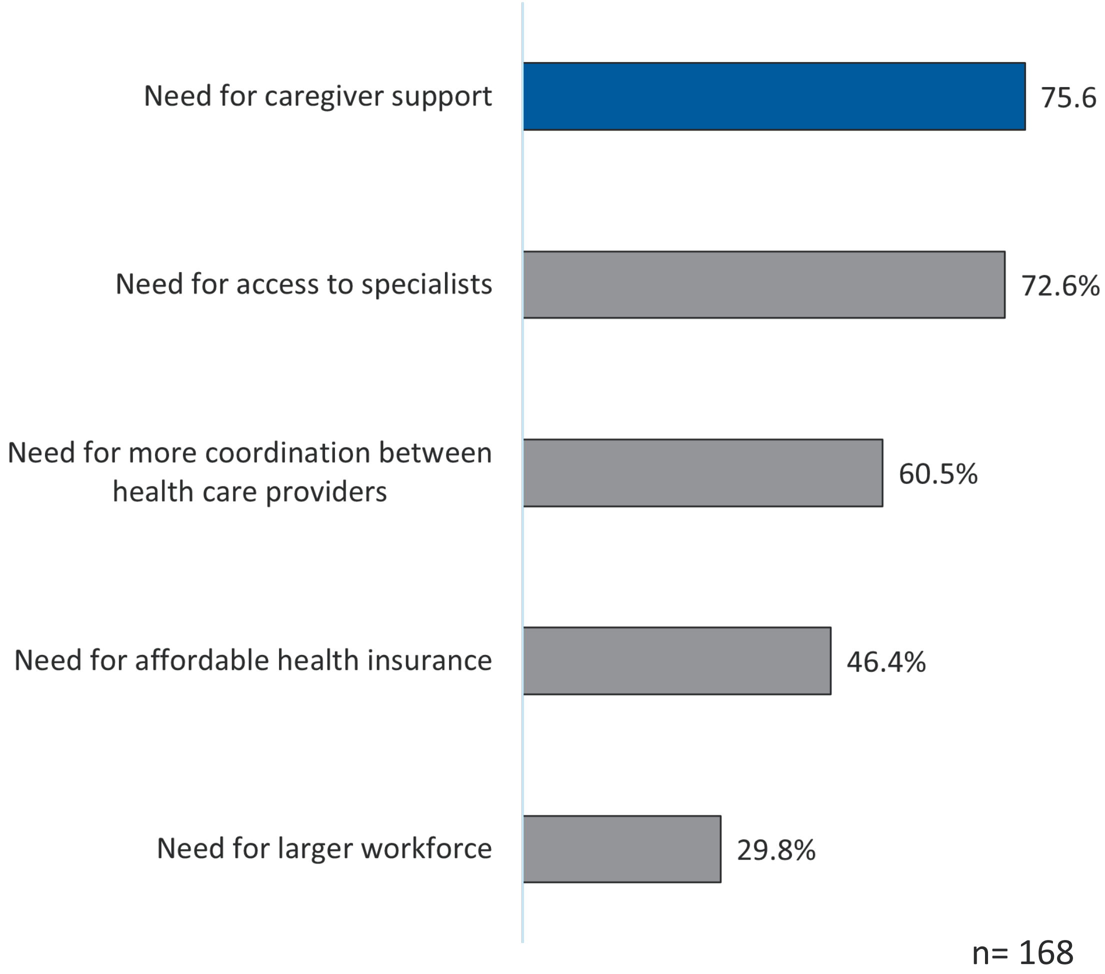


Non-professional

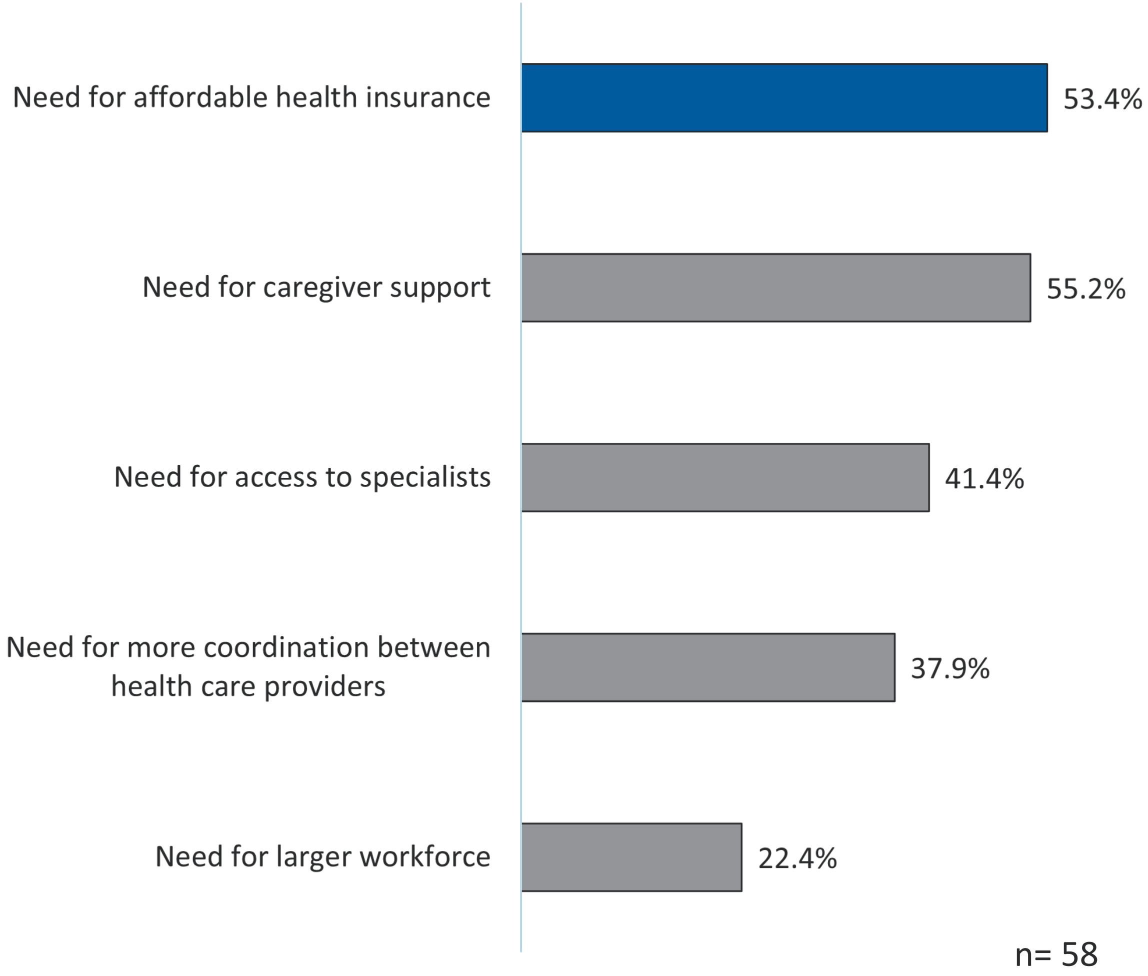


Professional

Most (76%) English speaking respondents felt the need for **caregiver support** was the most important health issue facing **CYSHCN in Nevada,** while Spanish speaking respondents felt the need for **affordable health insurance** was most important.



English Speakers



Spanish Speakers

Priorities by Subgroup: **CYSHCN Health**

Priority	All	Non-professionals	Professionals	English Speakers	Spanish Speakers
Need for caregiver support	1	1	1	1	2
Need for access to specialists	2	2	2	2	3
Need for more coordination between health care providers	3	4	3	3	4
Need for affordable health insurance	4	3	4	4	1
Need for larger workforce	5	5	5	5	5

Note: 95% of respondents who identified as being a professional spoke English.

Ranking Scale	1	2	3	4	5

The End

Appendix G: Capacity Needs Survey Responses, by Domain and Priority

Number of respondents indicating capacity with Have, Need, or Not sure/Doesn't Apply.

Structural Resources

Resources	Women and Maternal Health: Mental Health/ Substance Use *N*=2	Women and Maternal Health: Access to more Prenatal and Maternal Health Services *N*=2	Perinatal and Infant Health: Substance Use *N*=2	Perinatal and Infant Health: Breastfeeding Support *N*=1	Child Health: Access to safe and Healthy Food Options *N*=2	Adolescents Heath: ACEs *N*=1	CYSHCN: Need for Affordable Health Insurance *N*=2
Authority and funding sufficient for functioning	Have= 2	Have= 1	Have= 1	Have= 1	Need= 2	Need= 1	Need= 2
Routine, two-way communication channels with relevant constituencies	Have= 1 Need= 1	Have= 1	Have= 1	Have= 1	Have= 1 Need= 1	Have= 1	Need= 2
Access to up-to-date science, policy, and programmatic information	Have= 1 Not sure/ Doesn't apply= 1	Have= 1	Have= 1	Have= 1	Have=1	Have= 1	Have= 2
Partnership mechanisms	Have= 1	Have= 1	Have= 1	Have= 1	Have=1	Have= 1	Have= 2
Workforce capacity institutionalized through job descriptions, contract language about skills and credentials, training programs, and routine assessments of capacity and training plans	Have= 1	Have= 1	Have= 1	Have= 1	Have=1	Need= 1	Need= 2
Mechanisms for accountability and quality improvement	Have= 1	Have= 1	Not sure/ Doesn't apply= 1	Not sure/ Doesn't apply= 1	Have= 1 Need= 1	Need= 1	Have= 1 Need= 1
Formal protocols and guidance for assessment, planning, and evaluation	Not sure/ Doesn't apply= 1	Not sure/ Doesn't apply= 1	Have= 1	Have= 1	Need= 2	Need= 1	Have= 1 Need= 1

Data Resources

Resources	Women and Maternal Health: Mental Health/ Substance Use *N*=2	Women and Maternal Health: Access to more Prenatal and Maternal Health Services *N*=2	Perinatal and Infant Health: Substance Use *N*=2	Perinatal and Infant Health: Breastfeeding Support *N*=1	Child Health: Access to safe and Healthy Food Options *N*=2	Adolescents Heath: ACEs *N*=1	CYSHCN: Need for Affordable Health Insurance *N*=2
Access to timely program and population data	Have= 1	Have= 1	Have= 1	Not sure/ Doesn't apply= 1	Need= 2	Have= 1	Have= 2
Supportive environment for data sharing	Have= 1	Have= 1	Have= 1	Not sure/ Doesn't apply= 1	Have= 2	Have= 1	Have= 1 Need= 1
Adequate data infrastructure	Have= 1	Have= 1	Have= 1	Not sure/ Doesn't apply= 1	Have= 1 Need= 1	Need= 1	Need= 2

Organizational Relationships

Relationship	Women and Maternal Health: Mental Health/ Substance Use *N*=2	Women and Maternal Health: Access to more Prenatal and Maternal Health Services *N*=2	Perinatal and Infant Health: Substance Use *N*=2	Perinatal and Infant Health: Breastfeeding Support *N*=1	Child Health: Access to safe and Healthy Food Options *N*=2	Adolescents Heath: ACEs *N*=1	CYSHCN: Need for Affordable Health Insurance *N*=2
State health department/agencies/programs	Have= 1	Have= 1	Have= 1	Have= 1	Have= 2	Have= 1	Have= 2
Other relevant state agencies	Have= 1	Have= 1	Have= 1	Have= 1	Have= 2	Have= 1	Have= 2
Insurers and insurance oversight stakeholders	Have= 1	Have= 1	Not sure/ Doesn't apply= 1	Not sure/ Doesn't apply= 1	Need=1 Not sure/ Doesn't apply= 1	Need= 1	Have= 1 Need= 1
Local providers of health and other services	Have= 1	Have= 1	Have= 1	Need= 1	Have= 2	Have= 1	Need= 1 Not sure/ Doesn't apply = 1
Superstructure of local health operations and state-local linkages	Have= 1	Have= 1	Have= 1	Have= 1	Have= 2	Have= 1	Need= 1 Not sure/ Doesn't apply = 1
State and national entities enhancing analytical and program capacity	Have= 1	Have= 1	Have= 1	Not sure/ Doesn't apply= 1	Have= 2	Have= 1	Have= 1 Not sure/ Doesn't apply = 1
State and local policymakers	Have= 1	Have= 1	Not sure/ Doesn't apply= 1	Not sure/ Doesn't apply= 1	Have= 2	Have= 1	Have= 1 Not sure/ Doesn't apply = 1
Non-governmental advocates, funders, and resources	Have= 1	Have= 1	Have= 1	Not sure/ Doesn't apply= 1	Have= 1 Need= 1	Have= 1	Have= 1 Need= 1
Businesses	Not sure/ Doesn't apply= 1	Not sure/ Doesn't apply= 1	Not sure/ Doesn't apply= 1	Have= 1	Need= 1 Not sure/ Doesn't apply= 1	Need= 1	Have= 1 Need= 1

Competencies

Competencies	Women and Maternal Health: Mental Health/ Substance Use *N*=2	Women and Maternal Health: Access to more Prenatal and Maternal Health Services *N*=2	Perinatal and Infant Health: Substance Use *N*=2	Perinatal and Infant Health: Breastfeeding Support *N*=1	Child Health: Access to safe and Healthy Food Options *N*=2	Adolescents Heath: ACEs *N*=1	CYSHCN: Need for Affordable Health Insurance *N*=2
Communication and data translation skills	Have= 1	Have= 1	Have= 1	Have= 1	Have= 2	Have= 1	Have= 2
Ability to work effectively with public and private organizations	Have= 1	Have= 1	Have= 1	Have= 1	Have= 2	Have= 1	Have= 2
Ability to influence the policymaking process	Not sure/ Doesn't apply= 1	Not sure/ Doesn't apply= 1	Not sure/ Doesn't apply= 1	Have= 1	Have= 1 Need= 1	Need= 1	Need= 1 Not sure/ Doesn't apply = 1
Experience and expertise in working with and in communities	Have= 1	Have= 1	Have= 1	Have= 1	Have= 2	Have= 1	Have= 2
Management and organizational development skills	Have= 1	Have= 1	Have= 1	Have= 1	Have= 2	Have= 1	Have= 2
Knowledge and understanding of the state context	Have= 1	Have= 1	Have= 1	Have= 1	Have= 2	Have= 1	Have= 2
Data and analytic skills	Have= 1	Have= 1	Have= 1	Have= 1	Have= 2	Have= 1	Have= 2
Knowledge of MCH and related content areas	Have= 1	Have= 1	Have= 1	Have= 1	Have= 2	Have= 1	Have= 2

Appendix H: Priority Needs, by Domain and Needs Assessment Activity

Table 1. Top 5 Priorities by Data Source and Domain

Data Source	Women and Maternal health	Perinatal and Infant Health	Child Health	Adolescent Health	Children with Special Health Care Needs
Overall	1. Knowledge of available resources in the community 2. Mental health services/Substance use 3. Access to more prenatal and maternal health services 4. Social determinants of health 5. Access to preventive health services	1. Need for affordable childcare 2. Knowledge of available resources in the community 3. Maternal substance use during and after pregnancy 4. Need for mental health services 5. Breastfeeding support	1. Physical health/physical activity 2. Social media, technology, and screen time 3. Social determinants of health 4. Access to safe and healthy food options 5. After school and childcare options	1. Need for services and resources around sexual and reproductive health 2. Adverse childhood experiences 3. Mental health services 4. Access to educational opportunities and resources 5. Social media and cyber bullying	1. Access to appropriate services including specialists and early screening and interventions 2. Need for caregiver support/navigation 3. Need to increase workforce 4. Need for affordable health insurance 5. Mental health services
Domain Listening Sessions	1. Access to prenatal care 2. Substance use 3. Access to preventive health services 4. Knowledge of available community resources	1. Childcare for infants 2. Breastfeeding support 3. Mental health services	1. Access to care 2. Age-appropriate health literacy 3. Caregiver-centered mental health 4. Relationship focused, trauma-informed health services 5. Access to safe and healthy food options	1. Health literacy and reading levels 2. Transition care 3. Sexual and reproductive health 4. ACEs 5. Social media and cyber bullying	1. Access to appropriate services 2. Insurance and affordability 3. Workforce 4. Caregiver support/navigation 5. Care coordination and transition
Community Input Forums	1. Mental health services 2. Social determinants of health 3. Knowledge of available resources in the community 4. Daycare options 5. Sexual and reproductive health	1. Knowledge of available community resources 2. Social determinants of health 3. Access to healthcare services and providers 4. Mental health services 5. Breastfeeding support 6. Childcare and daycare options 7. Substance use	1. Physical health 2. After school and childcare options 3. Social determinants of health 4. Violence and abuse 5. Mental health services	1. Mental health services 2. Sexual and reproductive health 3. Educational resources 4. Substance use 5. Physical health 6. Technology and social media	1. Access to specialty services and providers 2. Workforce 3. Mental health services 4. Respite and foster support 5. Early screening and intervention 6. Social determinants of health

Data Source	Women and Maternal health	Perinatal and Infant Health	Child Health	Adolescent Health	Children with Special Health Care Needs
Focus Groups	1. Access to culturally competent care 2. Access to healthcare providers and specialists 3. Access to support networks	1. Access to healthcare services and providers 2. Interpretation services 3. Outreach and knowledge of services 4. Mental health services	1. Social determinants of health 2. Social media, technology, and screen time 3. Physical health 4. School, afterschool, and daycare activities	1. Access to educational opportunities 2. Substance use	1. Early screening and intervention
Key Informant Interviews	1. Increase workforce 2. Increase outreach and knowledge of services and programs 3. Social determinants of health 4. Substance use 5. Mental health services	1. Increase outreach and knowledge of services and programs 2. Substance use 3. Increase workforce 4. Social determinants of health 5. Mental health	1. Knowledge of available resources in the community 2. Social determinants of health 3. Mental health 4. Childcare services 5. Early intervention and developmental services	1. Mental health 2. Sexual and reproductive health services 3. Violence and safety 4. Knowledge of available resources in the community 5. Substance use	1. Increase workforce 2. Access to Care 3. Mental health services 4. Caregiver support
Priorities Survey – Non-professional	1. Not knowing about available community resources 2. Need for more prenatal and maternal health services 3. Need for more preventative services	1. Need for affordable childcare 2. Need for breastfeeding support 3. Maternal substance use during and after pregnancy	1. Overuse of screen time 2. Lack of physical activity 3. Lack of healthy food options	1. Need for services and resources around sexual and reproductive health 2. Cyberbullying 3. Adverse childhood experiences	1. Need for caregiver support 2. Need for access to specialists 3. Need for affordable health insurance
Priorities Survey – Professional	1. Need for more prenatal and maternal health services 2. Not knowing about available community resources 3. Need for mental health services	1. Need for affordable childcare 2. Maternal substance use during and after pregnancy 3. Need for mental health services	1. Overuse of screen time 2. Lack of access to healthy foods 3. Lack of physical activity	1. Need for services and resources around sexual and reproductive health 2. Adverse childhood experiences 3. Cyberbullying	1. Need for caregiver support 2. Need for access to specialists 3. Need for more coordination between health care providers

Table 2: Women and Maternal Health Top 5 Priorities, Interventions, and Partners, by Data Source

Data Source	Description of Priority	Interventions	Partners
Domain Listening Sessions	1. Access to prenatal care • Difficult to see providers • More walk-in OBs • Maternal health care deserts • Lack of home visiting • Rural areas lack of access to care • Preterm birth rates above average 2. Substance use • Substance use during pregnancy 3. Access to preventive health services • Underperforming well women visits • Insurance coverage barriers 4. Knowledge of available resources in the community	1. Access to prenatal care • Difficult to see providers • Substance use during pregnancy • Walk-in OB visits • Physicians and doulas working together 2. Substance use 3. Access to preventive health services • Increase funding for home visit and telehealth • Increase cultural competence training among medical providers • Bidirectional referral systems for services • Collaborations between agencies with referrals 4. Knowledge of available resources in the community • Community health workers to help with resources—a central point of contact that physicians can refer to • More promotion of STI testing in all populations, especially pregnant people	-

Data Source	Description of Priority	Interventions	Partners
Input Forums	1. Mental health services • Emotional support • Counseling on PPD • Trauma • Support for single moms • Supporting moms who have other children with disabilities 2. Social determinants of health • Public transportation • Housing • Food access • Nutrition education • Income/job stability/Employment case management 3. Knowledge of available resources in the community • Information/education/outreach/resources • Maternal health education 4. Access to daycare options • Childcare/HeadStart • Paid leave options 5. Sexual and reproductive health • Sex education • Access to birth control • STI education	1. Mental health services • Training providers • Trauma-informed clinics and providers • Preconception care (counseling support) • Social determinants of health • Knowledge of available resources in the community • Education to communities within SDOH • Better marketing of programs • Enrollment qualifications • Community based Medicaid enrollment • Accessible resources virtual and in-person/mobile health clinics 2. Daycare 3. Sexual and reproductive health	• Healthy Moms, Healthy Babies

Data Source	Description of Priority	Interventions	Partners
Focus Groups	1. Access to culturally competent care • Need providers who speak Spanish • Need medical interpreters • Patients are not being treated well • Treatment by the public health system is not good and providers are not listening to needs • Not enough information or guidance 2. Access to healthcare providers and specialists • Need help with looking for providers who take uninsured patients • Appointments for x rays and other procedures takes a long time to have available • Not enough providers/long wait times • Specialists not providing care • It is difficult to see the same medical provider as they typically rotate within a clinic • Access to doctors in general • Access to moms who are pregnant is limited if they don't have funds to pay for services • Lack of help to moms who are low income • Pregnancy appointments are expensive • Importance of taking care of children regardless of immigration status of the parent • Access to insurance is limited • Fear of getting sick and having to go to the doctor due to cost and immigration status • Access to gynecologists/pediatricians • Fertility treatments are not a covered service • Cost of medications are high 3. Access to support networks • Lack of support for first time immigrant moms • Social help and information are needed for mothers	-	-

Data Source	Description of Priority	Interventions	Partners
KIIs	1. Increase workforce • Waitlists are long • Few medical providers compared to population size • Timeliness of services • Flexibility in providing services (in person, at home, etc.). • Shortage of providers especially in rural areas • Patients are sent out of state due to workforce shortage • Physician shortage • Specialist shortage (OB/GYN, family practitioners, pediatricians) • Providers are not staying in the state (OB/GYN, pediatricians) • Mental health therapists that are culturally congruent • Doulas that are BIPOC • Certified midwives • Culturally and linguistically congruent providers • More diverse and accessibility to workforce 2. Increase outreach and knowledge of services and programs • How to access services and waitlists • Prior authorizations • Resources to access health insurance • Improve communication and education surrounding maternal health • How to apply for childcare subsidy 3. Social determinants of health • Transportation • Financial instability (wages and low income/inflation) • Affordable housing • Food and nutrition insecurity 4. Substance use • Lack of access to care • Stigma prevents access • Screenings • Substance use women are unhoused 5. Mental health services • Perinatal mood and anxiety disorders • Access to services especially those who have Medicaid • Isolation	1. Increase workforce • Funding to recruit and train providers • Provide fast track certifications as an incentive to enter the field • Incentivize providers to come to the state • Create pathways for funding (Medicaid reimbursement) • Create sustainable living conditions for people who want to pursue long term educational paths • Economic support of doulas to enter the workforce • Senate bill in Washoe county to the medical school to be able to have more fellows into hospitals • Las Vegas Chapter of Chamber of Mothers received funding for affordable childcare and paid parental leave needed to support and develop a more diverse workforce 2. Increase outreach and knowledge of services and programs • Increase CHWs as central person to get resources • Streamline application and enrollment processes • Centralized information of services available • Maternal health task force	• AIMs programs • Opioid settlement funds for task forces and work groups • Family-to-Family (F2F) • Family Navigators • Health districts • Make it Work Nevada • Heart and Sol Collective • Public Health Clinics

Table 3: Infant and Perinatal Health Top 5 Priorities, Interventions, and Partners, by Data Source

Data Source	Description of Priority	Interventions	Partners
Domain Listening Sessions	1. Childcare for infants • Childcare costs 2. Breastfeeding support • Exclusive breastfeeding 3. Mental health services	1. Childcare for infants • Universal low-cost childcare 2. Breastfeeding support • Home visiting • Increase funding for lactation consultations 3. Mental health services Referrals and collaborations between agencies	-

Data Source	Description of Priority	Interventions	Partners
Input Forums	1. Knowledge of available resources in the community • Information about complications during pregnancy • Education, outreach, and support on breastfeeding, PP pregnancy/birth classes • Fathers' education • Education/support for parent-child relationship and social emotional • Resources for young moms and new families • Knowledge of community resources and breastfeeding programs • Support systems 2. Social determinants of health • Transportation • Housing • Food insecurity/nutrition 3. Access to healthcare services and providers • Pediatrics • Postpartum care • Maternal health services • Trauma and consent sensitive care 4. Mental health services • PPD screening and treatment • Mental health resources 5. Breastfeeding support • Breast/chest feeding education and assistance 6. Childcare and daycare options • Quality and affordable quality daycare 7. Substance use	1. Knowledge of available resources in the community • Medicaid enrollment outside of the welfare office • Culturally humble safe sleep • Home visiting 2. Social determinants of health 3. Access to healthcare services and providers • Continued referrals and collaborations between agencies 4. Mental health services 5. Breastfeeding support • Increase funding for lactation consultations 6. Childcare and daycare options • Universal low-cost childcare 7. Substance use	-

Data Source	Description of Priority	Interventions	Partners
Focus Groups	1. Access to healthcare services and providers • Pediatricians and gynecologists 2. Interpretation services • Access to services is difficult when organizations don't have Spanish speaking staff or interpretation services • Families have to bring their own interpreters to appointments 3. Outreach and knowledge of services 4. Mental health services • Need programs that promote mental health wellbeing and provide daycare options	-	-

Data Source	Description of Priority	Interventions	Partners
KIIs	1. Increase outreach and knowledge of services and programs • Resources for families and new moms • Information of resources that is not fragmented • Education about bond building between baby and parent • Parenting classes, lactation education, education on which providers are available • Communication and education from doctors and service providers • Networking 2. Substance use • Stigma when baby is positive for substances at birth • Exposed substances (fentanyl) • Screening and consistent funding for programs • Maternal overdoses • Inadequate facilities to treat drug addictions 3. Increase workforce • Waitlists including for autism evaluation • Prior authorizations • Pediatric services are sent out of state • Obstetricians 4. Social determinants of health • Transportation • Housing insecurity/safe shelter space • Nutrition and food security • Economic stability 5. Mental health • Unaddressed depression • Screening in hospital encounters • Isolation	1. Increase outreach and knowledge of services and programs • Community outreach efforts to help aid in education • Public service/awareness campaign • Collaboratives 2. Substance use • Comprehensive team to get involved sooner (baby positive for substances at birth) • Improve relationship and sense of trust with at risk mothers • Opioid settlement • Increase access to drug addiction programs • Promote use of suboxone and telehealth • Empowered Nevada program • Parent navigators, peers with lived experience • Use of methadone before/after pregnancy • Treating women of reproductive age with opioid use disorder with buprenorphine 3. Increase workforce • Walk-in appointments 4. Social determinants of health • Campaign with reimbursement for travel to medical visits 5. Mental health • Normalization of perinatal mental health/build a community of support	• Postpartum Support International • Nevada Breastfeeding Coalition • Doulas Co Op • WIC • The Fetal Infant Mortality Review (FIMR)

Table 4. Child Health Top 5 Priorities, Interventions, and Partners, by Data Source

Data Source	Description of Priority	Interventions	Partners
Domain Listening Sessions	1. Access to care • Rural areas have limited access to resources and services • Wraparound services • Undocumented populations do not seek our resources • Medicaid funding, CHIP, public charge affect reaching out for services 6. Age-appropriate health literacy • Understanding resources and information • Age-appropriate literature 3. Caregiver-centered mental health • Family interventions 4. Relationship focused, trauma-informed health services 5. Access to safe and healthy food options	1. Access to care • Asset mapping • Interdepartmental communication 2. Age-appropriate health literacy 3. Caregiver-centered mental health 4. Relationship focused, trauma-informed health services 5. Access to safe and healthy food options • Intersectional collaboratives	-

Data Source	Description of Priority	Interventions	Partners
Input Forums	1. Physical health • Healthy lifestyle habits • Screen time and limited activity/more socialization • Hydration • Child obesity • Healthy play 2. After school and childcare options • Access to childcare or Pre-K • School readiness support • After school programs • Cost 3. Social determinants of health • Nutritious foods/food accessibility/food access • Homelessness/housing • Clothing • Adequate sleep 4. Violence and abuse • Safety • Bullying • Domestic violence • Safe home environment/unstable home • Neglect/abuse 5. Mental health services • Access to behavioral health/mental health • Parental and family counseling access • Isolation and increased screen time • Need especially for non-traditional families • Stigma in different cultures	1. Physical health • Caregiver education on screen time and the need for more physical activity • Incorporating nutrition and exercise into childcare • Safe outdoor spaces outside of school/healthy environments • Healthy visits up to 9–12 months for infants 2. After school and childcare options • Accessible childcare/pre-K 3. Social determinants of health • Interventions for nutrition and physical literacy • Affordable healthy food and exercise • Asset mapping 4. Violence and abuse • Safe adult, school-family partnerships 5. Mental health services • Support groups • Family interventions • Culturally sensitive treatments • Community partnerships to leverage relationships with families that are same sex or transgender • Peer support	• Oasis ABA

Data Source	Description of Priority	Interventions	Partners
Focus Groups	1. Social determinants of health • Culture impacts nutrition/eating habits • Nutrition and how to feed children 2. Social media, technology, and screen time • Caregivers need more information about the impact of screen time 3. Physical health • Caregivers need information on how to guide children to be physically healthy/active 4. School, afterschool, and daycare activities • Places where children can learn	-	-

Data Source	Description of Priority	Interventions	Partners
KIIs	1. Knowledge of available resources in the community • Lack of awareness • Misinformation on services that are available • Increase confidence in accessing sources like SNAP and WIC 2. Social determinants of health • Nutrition education and food access (especially families who utilize CHW program, single parents who require childcare) • Housing • Basic needs • Environmental issues • Social issues 3. Mental health • Behavioral health issues • Services for parents of children • To address domestic violence and witness of domestic violence, trauma, ACEs 4. Childcare services • Childcare deserts • Access to quality childcare • High costs of childcare • Meal plans 5. Early intervention and developmental services	1. Knowledge of available resources in the community • Streamline process of gaining knowledge of services • Create a safe space for undocumented families to gain information and access to services • Free legal transportation to gain insight on rights and representation 2. Social determinants of health 3. Mental health • Standardized screening process for children who are with the state or in foster home • Screening opportunities in schools • State allocation of 200–300 million dollars over the next three years to address mental health services for children 4. Childcare services • Universal Pre-K • Support for Early Head Start programs and child readiness for kindergarten programs 5. Early intervention and developmental services	• ECCS grants MCH office • First 5 Nevada • AAP • BeHERE NV • AIM Program • Maria/h program

Table 5. Adolescent Health Top 5 Priorities, Interventions, and Partners, by Data Source

Data Source	Description of Priority	Interventions	Partners
Domain Listening Sessions	1. Health literacy and reading levels • Sexual health risk 2. Transition care • In foster care and aging out process 3. Sexual and reproductive health • Access to sexual health resources, programs, and services • Parental consent required to receive services • High STI rates • STI prevention services needed with emphasis on long-term effects on fertility 4. ACEs • Access to resources • Connections to form relationships 5. Social media and cyber bullying	1. Health literacy and reading levels 2. Transition care • Legislative saving accounts • Baby bonds 3. Sexual and reproductive health 4. ACEs 5. Social media and cyber bullying • Peer support	-

<table>
<tr><th>Data Source</th><th>Description of Priority</th><th>Interventions</th><th>Partners</th></tr>
<tr><td>Input Forums</td><td>1. Mental health services
• Body image/body dissatisfaction
• Suicidal ideation
• Bullying
• Prevention, safety techniques
• Isolation
2. Sexual and reproductive health
• Sexual violence
• Trafficking
• Consent
• STI education and prevention
• Puberty education for all genders
• Health programming in schools/lack of education and awareness
3. Educational resources
• Literacy
• Large student/teacher ratio and schools having capacity to support/workforce in schools
• Quality of education
• Educational pathways supports and opportunities
• Access to additional education/skills training outside of the classroom
4. Substance use
• Education/prevention, safety techniques
• Drugs purchased online
• Vaping
• Peer pressure
5. Physical health
• Sports and clubs/ROTC program funding cuts
• More activities for underprivileged children
• Obesity
• Access to physical activity opportunities
• Food insecurity and nutritious foods
6. Technology and social media
• Digital/online safety
• Screen time</td><td>1. Mental health services
• 1:1 help with children showing behavioral issues
• Emotional support resources within school settings
• Support groups
2. Sexual and reproductive health
• Evidence based comprehensive sex education (including on healthy relationships, body autonomy, puberty, sexual orientation, sexual assault prevention)
3. Educational resources
• Ensure protections for teachers/more teachers and resources in schools
• Education on nutrition and social media/impacts on body image
• Address lack of educational programs in schools
4. Substance use
5. Physical health
• 3rd space including after school activities
• Educational pathways supports and opportunities (including 2nd chance high school)
6. Technology and social media</td><td>-</td></tr>
</table>

Data Source	Description of Priority	Interventions	Partners
Focus Groups	1. Access to educational opportunities • Need more programs that are free or low cost • Caregivers need information on how to enroll adolescents in curricular opportunities 2. Substance use • Drug culture in Nevada, especially with marijuana • Need more programs for substance use among adolescents • Smoking, ecstasy, IV drugs, energy drinks	-	-

Data Source	Description of Priority	Interventions	Partners
KIIs	1. Mental health • Stigma • Teen suicide and suicidal ideation • Parent stress and adolescent mental health issues • Depression • Mental health resources especially those with domestic violence experience (abused or witness) 2. Sexual and reproductive health services • Lack of awareness • Teen pregnancy occurs often • Poor parental support ○ Lack of self-protecting education/control over their sexual rights 3. Violence and safety • Teen dating violence • Lack of knowledge on grooming, trafficking • Teen shelters only support/resource • Parent support needed to address cycle of violence in home or with other children 4. Knowledge of available resources in the community • Resources available (especially for undocumented families) as teens may not be able to navigate system themselves 5. Substance use • Vaping, online drugs	1. Mental health • Suicide prevention and education for those who have access to children • Parental education (social media) • More mental health professionals in schools 2. Sexual and reproductive health services • High-quality information about birth control and fertility (sex education) • Consent-based practices, intimate partner/interpersonal violence, teen pregnancy, and health education • Family planning • Safe spaces to go for sexual health • Health education curriculum in schools (grooming, sexting, internet harassment, social media dangers, child abuse) 3. Violence and safety • Antiviolence curriculum • Domestic violence support through schools • Save Voice program 4. Knowledge of available resources in the community 5. Substance use • Education in schools • Need federal and state funding for programs	-

Table 6. Children with Special Health Care Needs Top 5 Priorities, Interventions, and Partners, by Data Source

Data Source	Description of Priority	Interventions	Partners
Domain Listening Sessions	1. Access to appropriate services • Access to autism assessment • Access to early interventions • Access to OY/PT/SLP • Behavioral healthcare • Cultural and linguistic responsive care • Medical home • Fragmented support for LTSS • Culturally and linguistic responsive care 2. Insurance and affordability • Insurance coverage • Protection of Medicaid coverage • Parental financial support • Co-pays and out of pocket expenses • Access to durable medical equipment • Help paying room and board when traveling to a doctor • Silos between insurance companies 3. Workforce • Few behavioral health providers with limited capacity • Lack of paid family caregivers • Shortages of workforce for home nursing and care attendants 4. Caregiver support/navigation • Increased knowledge to navigate healthcare system • Education on how to advocate for child's care • Parent education • Caregiver mental health support • Lack of respire care • Education and advocacy • Navigating the system/not knowing where to start then once it starts, where to go 5. Care coordination and transition • Smooth transition to adults' services • Smooth transition between EI and special education	1. Access to appropriate services • Respectful care • Autism Diagnostic Observation Schedule 2. Insurance and affordability • Increase state funding/Medicaid reimbursement • Funds for transportation, room and board when traveling to see a doctor • Focus on affordability for care among middle class as well as low-income and Medicaid patients 3. Workforce • Increase workforce across healthcare • Incentives at medical schools for specialty providers to stay in the state • Recruit and train required professionals to address shortages • Workforce support the medical home model 4. Caregiver support/navigation • Community support • Public education • Pay family caregivers • Registry for parents seeking help • Home care nursing reimbursement rates • Advocate or support to navigate the system 5. Care coordination and transition • Coordinated referral system statewide • Bolster and improve referral process • Forms and procedural streamlining • Increase collaboration and cooperation across and between agencies • Warm handoff for transition	-

Data Source	Description of Priority	Interventions	Partners
Input Forums	1. Access to specialty services and providers • Lack of specialty providers • Access to therapies/special medical services • Transition care • Care coordination among providers • Timely care and needs • Specialized care (oral care) • Specialized equipment and devices • Disability resources 2. Workforce • Few dentists that treat CYSHCN • Lack of specialty providers • Trained ECE workforce • Providers • Long wait times • More social workers 3. Mental health services • Limited options for long term placement for behavioral needs • Stigma • Cost of services • Limited providers and facilities 4. Respite and foster support • Lack of foster support for medically fragile • Social-emotional and other support for CYSHCN and their families • Support/respite for both parents and children 5. Early screening and intervention • Early intervention and testing/diagnosis • Affordable testing and screening 6. Social determinants of health • Nutrition • Homelessness/home and family instability	1. Access to specialty services and providers • Expanded coverage to see specialists • Surgery centers that offer anesthesia for dental care 2. Workforce • Recruitment of specialists to Nevada • Provider incentives to practice in Nevada 3. Mental health services • Free Applied Behavioral Analysis support and therapy • Cultural competence in schools and understanding of behaviors and behavioral health visits at school • Emotional support guidance • Peer supports and increase mental health accessibility • Options for long-term placement for behavioral concerns 4. Respite and foster support • Support/respite for both parents and children through educational groups • Support services for families/meaningful respite • Paid parent caregiving for medically fragile 5. Early screening and intervention Social determinants of health	-
Focus Groups	1. Early screening and intervention • The process to diagnose CYSHCN is difficult especially if caregivers don’t have language interpreters or have low literacy levels	-	-

Data Source	Description of Priority	Interventions	Partners
KIIs	1. Increase workforce • Lack of specialty providers and capacity to work with this population (Neurology, Plastic Surgery, ENT, Dermatology, Geneticists, Development needs) • Training opportunities needed • Struggle with recruit and keep providers (especially in rural areas) • Shortage of mental health/behavioral health providers • Shortage of home health workers, Aids, CNAs • Providers that can help transition into adulthood 2. Access to Care • Providers moving to self-pay model because of Medicaid reimbursement • PT, OT, SLT specialists unable to navigate reimbursement system • Northern areas of the state have to travel to other states for services • Provider availability 3. Mental health services • School district only has one psychiatrist to do assessments • Only 1 PEP (Parents Encouraging Parents, Parents Educating Professionals, Professionals Empowering Parents) as a resource 4. Caregiver support • Parents having to stay home and care for child instead of entering the workforce • Paid caregivers support only children over 18	1. Increase workforce • Medical home model with a collection of providers who are communicating with each other • Need organizations to train new providers 2. Access to Care • Intermountain Health building children's hospital (opportunity to support medical home model) 3. Mental health services • State Medicaid started initiative around expanding access to services and reducing number of children placed in and out of home and state residential treatment 4. Caregiver support • Subsidize to designate caregiver (bill SB185)	-