Maternal and Child Health Services Title V Block Grant

Nevada

FY 2026 Application/ FY 2024 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

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July 24, 2025

Shirley Payne, PhD, MPH
Director, Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane Rockville, Maryland 20857

RE: Maternal and Child Health Block Grant Submission. FFY 2026 Application and FFY 2024 Annual Report

Dear Dr. Payne,

The Nevada Division of Public and Behavioral Health, which administers the Title V Maternal and Child Health Block Grant, respectfully submits the Nevada Federal Fiscal Year (FFY) 2026 Application and FFY 2024 Annual Report to the Health Resources and Services Administration.

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

Sincerely,

Vickie Ives

Vickie Ives, MA
Health Bureau Chief and Title V MCH Director
Bureau of Child, Family, and Community Wellness

Bureau of Child, Family and Community Wellness
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ALL IN GOOD HEALTH.

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms",* OMB NO: 0915-0172; Expires: December 31, 2026.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Program Overview

Nevada's Title V Maternal and Child Health (MCH) Program is dedicated to working with diverse public and private partners statewide to improve the health of families. Funded partners implement activities serving women of childbearing age, pregnant women, infants, adolescents, and children, including children with special health care needs (CSHCN). Nevada utilizes Title V MCH funding to collaborate with partners and strengthen community engagement and activities ensuring all MCH populations can access quality health education and preventive services.

Nevada's Title V MCH Program is housed in the Maternal, Child and Adolescent Health (MCAH) Section; Bureau of Child, Family and Community Wellness (CFCW); Division of Public and Behavioral Health (DPBH); Nevada Department of Human Services (DHS). The Nevada Title V MCH Program website can be accessed at: http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/. The Title V MCH Program is committed to funding evidence-based or informed activities and programming to improve the health and wellbeing of the MCH population in Nevada.

Accomplishments and Priorities by Population Domain

Domain: Women/Maternal Health

According to 2023 Behavioral Risk Factor Surveillance System (BRFSS) data, 66.2% of Nevada women ages 18-44 years received a preventive visit in the past year compared to 73.0% of women nationally. Furthermore, according to 2023 National Vital Statistics System (NVSS) data, 76.5% of pregnant women in Nevada received prenatal care beginning in the first trimester, which is just above the national average. This percentage is lower for uninsured women in Nevada, with only 62.2% receiving early prenatal care. The Title V MCH Program partners with statewide and regional MCH coalitions, community-based programs, and public and private partners to increase insurance coverage rates and receipt of timely prenatal care among this population.

Nevada's Title V MCH Program collaborates with partners to identify and reduce modifiable risk factors for improving birth outcomes, including a focus on populations with the highest rates. Partners include Local Health Authorities (LHAs), Division of Health Care Financing and Policy (DHCFP or NV Medicaid), DPBH Office of State Epidemiology (OSE), DPBH Office of Analytics (OoA), Children's Advocacy Alliance, and the Northern Nevada Public Health Fetal Infant Mortality Review (FIMR) Program. In addition, Title V works closely with MCAH programs including the Nevada Maternal Mortality Review Committee (MMRC), Alliance for Innovation on Maternal Health (AIM), and the Nevada Home Visiting (NHV) Program, as well as others.

Twelve partner organizations in eight counties provide critical screenings to women of childbearing age, especially women living in rural and frontier areas and people who live with increased risk. Screenings include those for postpartum depression; Screening, Brief Intervention, and Referral to Treatment (SBIRT); One Key Question campaign; and others. Collaboration with NHV promotes relevant maternal and infant screenings to MCH populations with higher risk. MCAH staff led state-funded statewide reproductive health efforts through the state-funded Account for Family Planning (AFP) Program and share MCH resources with AFP partners. AFP provides family planning, STI, and immunization services to those who would not otherwise be able to access these services.

Domain: Perinatal/Infant Health

According to NVSS, Nevada's percentages for breastfeeding has remained stable, ranging between 77.5% to 81.9% between 2015-2021. In 2023, the most recent data available shows a slight increase, with the percentage of breastfeeding initiation rising slightly to 77.6%. As a comparison, the national average in 2023 for breastfeeding rates is 85.3%. Title V MCH partners with the Nevada Women, Infants, and Children (WIC) Program, MCH coalitions, breastfeeding coalitions, community-based programs, SNAP-Ed, LHAs, the public, and private partners and supports NevadaBreastfeeds.org to increase breastfeeding rates by improving access to breastfeeding supports for new parents, including but not limited to signing up businesses to take the pledge to become breastfeeding friendly.

Northern Nevada Public Health FIMR reviewed 42 cases in FFY2024. Nevada Title V MCH Safe Sleep efforts include funding a statewide Cribs for Kids Program, statewide English and Spanish radio and television media campaigns, and statewide distribution of children's books with safe sleep messages. Cribs for Kids (C4K) distributed 483 Safe Sleep Survival Kits with associated education. The Nevada Title V MCH Program continues Safe Sleep and Injury Prevention education with Indian Health Service clinics. Trainings provided include Infant Safe Sleep and car seat installation. The NHV Program also promotes breastfeeding and safe sleep to participants.

Nevada Title V MCH activities related to decreasing substance use in pregnancy include participation in the AMCHP Promoting Innovation in State MCH Policymaking (PRISM) Learning Community, Association of State and Territorial Health Officials (ASTHO) Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI), Perinatal Health Initiative (PHI) and Nevada Comprehensive Addiction and Recovery Act (CARA) efforts. The MCH Director and CSHCN Director serve on the Core team as well as numerous subcommittees and contributed to educational guides and resources produced by the PHI group and updated the Sober Moms Healthy Babies MCH-funded website with CARA family and provider information.

Domain: Child Health

According to the 2022-2023 National Survey of Children's Health (NSCH), Nevada (23.8%) is significantly below the national average (35.6%) for children ages nine through 35 months who received a developmental screening using a parent-completed screening tool in the past year. This percentage decreased for Nevada from 24.5% in 2021-2022.

Nevada's Title V MCH Program collaborates with public and private partners to improve the rate of children receiving timely developmental screening and increase the number of applicable entities trained in developmental screening.

The Title V MCH-funded Kindergarten Health Survey conducted annually by the Nevada Institute for Children's Research and Policy shows a decrease in the percentage of children receiving a routine medical check-up and a decrease in the percentage of children with a primary care provider. The percentage of children entering kindergarten who had routine medical check-up in the past 12 months decreased from 90.5% in 2022-2023 to 89.3% in 2023-2024. The percentage of children entering kindergarten with a primary care provider decreased from 91.6% in 2022-2023 to 89.6% in 2023-2024.

Domain: Adolescent Health

According to NSCH data, the percentage of adolescents ages 12 to 17 years old in Nevada with a preventive medical visit in the past year (2022-2023) is 62.1%. Comparatively, Nevada is below the national average of 71.4% of adolescents with a preventive medical visit in the past year. To address this, Title V MCH funds social media campaigns through DP Video to promote adolescent well-visits and disseminates educational materials through community partners.

Approximately, one in nine births to a teen (15-19 years old) in Nevada is a repeat teen birth, according to data from the DHS Office of Analytics. To improve teen birth measures, the Nevada Title V MCH Program partners with state and local teen pregnancy prevention programs, NHV, AFP, MCH Coalitions, LHAs, community programs, and private partners to increase access to educational materials, including funding LHAs and rural/frontier Community Health Nurses (CHNs) to provide education and promote awareness of Medicaid coverage of Long Acting Reversable Contraceptives (LARCs) post-partum.

Domain: Children with Special Health Care Needs

All CSHCN should have access to a medical home, but according to the 2022-2023 NSCH, only 25.8% of CSHCN in Nevada do. This is below the national average of 39.7%.

Nevada's CSHCN Program provides resources and support to community agencies serving children ages birth to 21 years. The CSHCN 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. MCH Director and CSHCN Director and staff participate in community and family-led coalitions and committees, including MCH Director 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 CSHCN Director on Early Childhood Comprehensive Systems. Staff also attend the Nevada Early Intervention Interagency Coordinating Council and participate in quarterly meetings with DPBH's Aging and Disability Services Division.

Nevada's CSHCN Program continued promotion of the Medical Home Portal (MHP) during the reporting period; however, the owner of the MPH ceased operations July 2024 after a cyber-attack. During the time Nevada had the MPH, it was a key resource for CSHCN and their families. It was a virtual resource which provided reliable and useful information about medical conditions, care resources, provider look up, and knowledge of valuable local and national services and resources, improving care coordination among children with and without special health care needs. In FFY24, the number of unique users for a partial year was 39,911. The number of MHP website views was 70,517.

The CSHCN Program partners with the Nevada Center for Excellence in Disabilities (NCED) Family Navigation Network (FNN), Nevada's designated Family to Family (F2F) Health Information and Education Center, which promoted the MHP, access to health care resources, referrals to adequate insurance coverage, care coordination services, and the CSHCN toll-free hotline. MCAH also funded vaccine sensory friendly kits for CSHCN.

Nevada's CSHCN Program also manages the Critical Congenital Heart Disease (CCHD) Registry, ensuring Nevada infants are screened for CCHD. The CSHCN and Adolescent Health and Wellness Program (AHWP) are collaborating with NCED to expand resources on health care transition and health literacy.

Domain: Cross-Cutting

Nevada's Title V MCH Program collaborates across systems with the Pregnancy Risk Assessment Monitoring System (PRAMS) to collect data on women who smoke or use substances during pregnancy and secondhand smoke exposure. Survey questions asked about substance use during the respondent's most recent pregnancy. For 2023 births, when asked about prescription pain medication use during pregnancy, 2.6% of respondents said yes. This is a continuous decrease from the 3.9% respondents who reported yes in 2020.

The reported use of substances such as heroin, amphetamines, methamphetamines, cocaine, tranquilizers, hallucinogens, LSD, sniffing gas, and glue or huffing among PRAMS respondents have all remained under 1.0% since 2019. Marijuana and cannabis use during pregnancy has remained steady though concerning given that 8.8% of respondents reported using it in 2023. This is a 43.3% increase from the percentage responding yes in 2017. This percent, however, is down from years 2019 and 2020 with 9.0% and 9.9% of respondents reported use respectively.
*For 2017 and 2018 weighted data, PRAMS had a response rate of 40.6% and 39.4%, respectively, both under the CDC threshold of 50%. Data from years 2019, 2020, 2021, 2022, and 2023 had response rates of 42% ,43%, 34%, 30%, 40% respectively, which were below the CDC threshold of 50% for those years. Therefore, all data should be interpreted with caution.

How Title V Funds Support State MCH Efforts

The federal Title V Maternal and Child Health (MCH) Block Grant plays a vital role in complementing Nevada's state-led efforts to improve the health and wellbeing of mothers, women of childbearing age (15-44), infants, children, including children with special health care needs (CSHCN), and their families. This longstanding federal-state partnership allows Nevada to flexibly respond to emerging health needs while reinforcing a stable public health infrastructure across the state's diverse and often rural geography.

Federal Title V funds significantly augment Nevada's limited state and other non-federal resources to assure the continued delivery of core MCH services, especially for underserved or at-risk populations. Federal dollars have supported gap-filling programs in areas such as Pregnancy Risk Assessment Monitoring System Promotion, MCH Coalition work, Cribs for Kids, Biostatician data support, CSHCN care coordination, youth transition education, and adolescent well-visit education—where state funding alone is insufficient.

By comparing expenditures across federal Title V funding in Nevada shows a targeted investment in enabling services (e.g., care coordination for CSHCN), population-based services (e.g., immunization outreach and home visiting promotion), and infrastructure-building services (e.g., health assessments, strategic planning, and workforce development). These investments have complemented state-supported efforts, complementing these funding streams ensure a continuum of care from programs like health promotion to broader systems level initiatives.

Further, Nevada uses federal Title V resources to build and sustain MCH program infrastructures, supporting staffing, cross-sector partnerships, and data modernization. Title V funds enable staff to engage in comprehensive needs assessments, lead community engagement, and promote family partnerships that are foundational to program design. The grant also supports data surveillance and evaluation tools that inform evidence-based programming across the state.

In the reporting period, federal Title V funds have been instrumental in expanding the reach of MCH services. Without this flexible federal investment, Nevada would be unable to maintain the breadth and impact of its MCH service network. The partnership not only amplifies state capacity, but it also ensures all Nevada families, regardless of zip code, have access to MCH services that protect and promote lifelong health.

Adolescent Wellness – Yoga Haven Success Story

One participant, who was a female high school student, participated in a year-long yoga and mindfulness pilot program at her local middle school. During this pilot program more than 80 percent of students were exposed to trauma-informed yoga and meditation monthly throughout the school year and in addition, a select cohort was exposed to weekly group meditations during lunch. The student shared that during this time she was experiencing alternate family placements due to violence and mental illness in her home. Yoga Haven programming provided a safe place for her to practice introspective reflections, increased her ability to self-advocate and helped her feel more comfortable with her emotions. She described the cohort she was part of weekly as a family and was grateful for how protected the space felt to share and connect deeply with others through meditation and movement.

Maternal and Infant Health – Dignity Health Success Story

During a support group for mothers, the facilitator met a new mom with a baby boy around 10 months old. The parent, new to the area and with limited friends, was very forthright in sharing her feelings of anger and not feeling like herself. She faced several stressors, including her relationship with her co-parent and having another child in a different area under shared custody. During her third session in the group, she expressed interest in emotional self-care after the facilitator inquired about it. The parent was open to the idea of therapy, and recently, she informed the facilitator that she has made an appointment and is scheduled to see a therapist. After the last support group meeting, the parent expressed gratitude and a feeling of hope.

Perinatal Success Story

MCH Director participated in a multiagency team that designed a conference on substance use in pregnancy with key decision-makers in the statewide health community led by DHS. Novel data was shared from the DHS Office of Analytics showing cross agency impacts, gaps, and opportunities for intervention to crucial medical, insurance, community-based organizations, and policy makers to ensure programming and efforts focus on the most important levers to improve health outcomes.

CSHCN Success Story

Partnership between the Title V MCH Program, Nevada State Immunization Program, and the University of Nevada, Reno, Family Navigation Network ensured ongoing supports in the form of Sensory Friendly Vaccination Kit funding support for continued distribution to providers to better serve families of CSHCN and people of childbearing age living with I/DD in immunization contexts when COVID-related funds were unexpectedly federally rescinded, threatening access to these supports in the state.

III.B. Overview of the State

III.B.1. State Description

State Overview

Geography

Nevada is the most mountainous state in the U.S. with over 150 named ranges and several mountain peaks exceeding 11,000 feet. The state has a unique topography, with vast distances separating frontier, rural, and urban communities. With a land mass of approximately 110,000 square miles, Nevada is the 7th largest state by land mass in the U.S. The State Demographer indicates Nevada has three urban counties (Carson City, Clark, and Washoe), three rural counties (Douglas, Lyon, and Storey), and eleven counties designated as frontier (Churchill, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing, and White Pine). The three rural counties also meet “micropolitan” classification due to their proximity to the urban (metropolitan) counties (Carson City and Washoe).

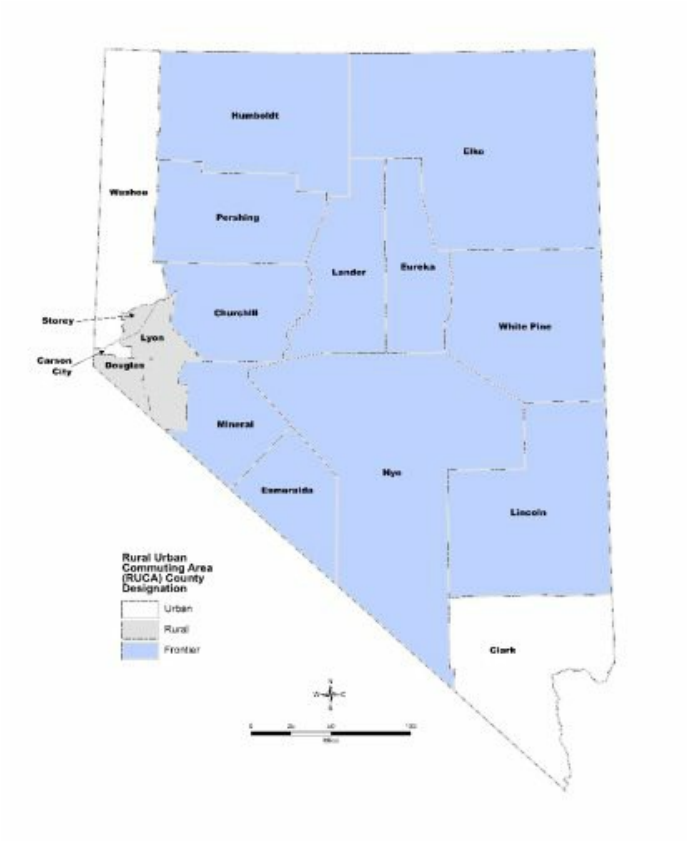


Figure 1. Map of Nevada with Counties

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 federally owned and administered by federal, state, and Tribal entities, with the remaining 10% privately owned. This high distribution of federal land ownership limits state and local governments’ ability to provide MCH services and resources equally across the state. Economic differences, especially in frontier regions, exist due to these challenges.

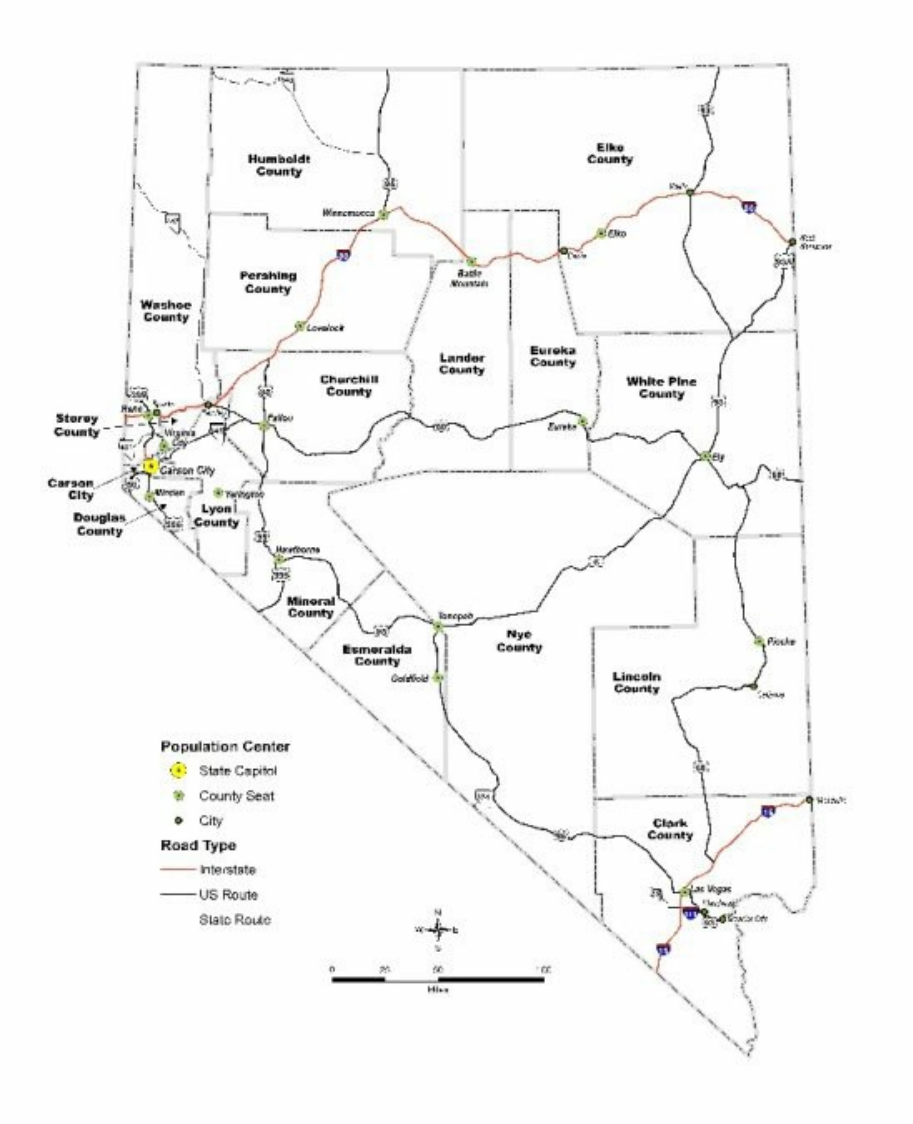


Figure 2. Map of Nevada with Cities

The following images depict Nevada's landscape is remarkably diverse, ranging from the arid desert terrain of the southern region, dominated by the Mojave Desert and iconic features like Red Rock Canyon, to the northern areas where the Great Basin's rugged mountains and expansive valleys create a stark, picturesque contrast. The rural areas of Nevada showcase vast open spaces, dotted with ghost towns and sagebrush plains, offering a sense of solitude and untouched natural beauty. This unique blend of desert, mountains, and open rural land makes Nevada a state of striking and varied landscapes.

Figure 3: Lake Tahoe (Northern Nevada)

Figure 4: Red Rock Desert (Southern Nevada)

Figure 5: Black Rock Desert (Pershing Couty, Rural Nevada), also known as The Playa

Population

In 2024, the Nevada State Demographer's Office and the U.S. Census Bureau estimated Nevada's population at 3,267,467 people. According to the U.S. Census Bureau, Nevada had a population growth of 2.3% from 2023 to 2024 which is similar to the national average. Between 2010 and 2020, Nevada had the fifth-highest percentage growth in the nation (15%, U.S. Census Bureau). While Nevada's population continues to grow, some rural and frontier counties lose population annually. The most densely populated area in the state is Clark County, home to nearly three-quarters (73.4% or 2,398,871 persons) of all Nevada residents (tax.nv.gov). The population in the rural and frontier counties ranges from approximately 1,000 (Esmeralda County) to 59,832 residents (Lyon County) according to the Nevada Rural and Frontier Health Data Book. In 2024, Nevada is home to 209,198 children under the age of 5 years making up 5.4% of the population. Nevadans under 18 years made up 21.5% of the state's

population and 49.5% of the Nevada's population is female, equivalent to the proportion across the U.S. Preliminary data from Nevada Vital Records show there were 32,090 births in Nevada in 2024. Though this is a slight increase from 2023, births rates have been on an overall steady decline trend since 2010.

The U.S. Census Bureau also indicates Nevada is an ethnically diverse state, with over 25% of the state's population in 2024 documented as Hispanic Origin of Any Race. In comparison, Nevada's population is 71.5% White alone, 11% Black alone, 9.7% Asian alone, 1.7% American Indian or Alaska Native alone, 0.9% Hawai'ian and Other Pacific Islander alone, and 5.2% two or more races.

Health concerns for Nevada's diverse MCAH population include physical, reproductive, behavioral, mental, psychosocial, chronic disease concerns, health disparities, and care of CSHCN. Language barriers, access to insurance, structural inequities, and service availability can influence the use of clinics, hospitals, medical providers, and other health care and ancillary services. Nevada Title V MCH-funded partners provide bilingual referrals and resources to community events. Along with providing printed materials, staff link statewide populations to programs providing relevant services.

Healthcare

According to the American Community Survey (ACS), the percent of children under the age of 19 without health insurance in Nevada fell to the state's lowest in 2016 at 7.0% but has slightly increased to 7.5% as of 2023. Nevada is above the national average which is 5.4%. Nevada ranks 49 our 50 states and the District of Columbia. Though the precent of child without health insurance has increased, the Patient Protection and Affordable Care Act (ACA) and Medicaid expansion continue to have a positive effect in Nevada. During the reporting period, over 32,000 infants under the age of one years old were enrolled in Medicaid and 342,670 children aged 1- 21 years were enrolled.

Nevada Medicaid is administered by DHCFP with enrollment administered by DWSS for Medicaid and Nevada Check-Up, Nevada's Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Program. Both Fee for Service (FFS) and Managed Care Organizations (MCOs) operate in Nevada. Rural areas are served by FFS providers and the urban areas of Clark and Washoe counties are served by contracted MCO providers, but rural areas will change to MCO as well as of January 1, 2026.

According to the Nevada Office of Analytics, Nevada had 731,381 individuals enrolled in Medicaid and 40,249 in Nevada Check-Up during the reporting period. Open enrollment for the ACA began in October 2013. There was a significant increase in enrollment from March 2020 to May 2023, due to the passing of the "Families First Coronavirus Response Act", following the declaration of COVID-19 as public health emergency. Since the expiration of the public health emergency in May 2023, Nevada has seen a 16.7% decrease in enrollment as Nevada Medicaid began reassessing eligibility requirements but continue to maintain high numbers. (Monitoring Medicaid Enrollments, Disenrollments, and Renewals in Nevada) Nevada will continue to monitor insurance enrollment data for MCH populations and review related Nevada PRAMS data, as well as monitor Medicaid impacts.

Nevada continues to promote the utilization of EPSDT screenings among Medicaid-eligible children younger than 21 years. Healthy Kids, the Nevada EPSDT Program, reimburses providers for well-child visits for all children enrolled in Nevada Medicaid and Nevada Check-Up. Outreach to providers and families to encourage EPSDT screenings is a continuing effort for the DHCFP and Title V MCH Program. Continued collaboration between DHCFP and Title V MCH includes education and outreach to promote available preventive benefits and EPSDT screenings, particularly as they relate to maternal, child, and infant health, data sharing, School Based Services, School-Based Health Center (SBHC) certification and toolkit distribution, and initiatives to increase well-visits.

Nevadans who are uninsured continue to have difficulty accessing healthcare providers; however, Nevada Health Link (www.nevadahealthlink.com), the online insurance marketplace operated by the state agency, the Silver State Health Insurance Exchange (SSHIX) facilitates and connects eligible Nevadans without insurance to Affordable Care Act Qualified Health Plans and subsidy assistance to help off-set monthly premiums and out-of-pocket costs. In addition, *Access to Healthcare Network* (AHN) offers a medical discount program for members who pay a membership fee to access the discounted provider network and case management services. Participating network providers agree to receive reduced payments to serve AHN members. People in Nevada unable to pay for their health care needs can access limited financial assistance. FQHCs in Nevada provide sliding scale fees for health

care services to all prospective patients, irrespective of citizenship status.

No-cost health care is provided in Northern Nevada through the University of Nevada, Reno, School of Medicine (UNRSOM) *Student Outreach Clinic* operated by medical students. The clinic is operated in cooperation with the Family Medicine Center and UNRSOM and made possible by faculty and community physicians who donate their time. Services include general and acute medical care, gynecological exams, immunizations, and discounted laboratory services. Currently, the Student Outreach Clinic operates four separate clinics: General and Pediatric; Geriatric and Dermatology; Rural Outreach; and Women's.

Volunteers in Medicine of Southern Nevada provides no-cost medical care in southern Nevada. The Kirk Kerkorian School of Medicine at the University of Nevada, Las Vegas (UNLV) clinical practice provides Southern Nevadans with access to a full range of academic medicine faculty physicians delivering clinical patient-focused and collaborative services. The UNLV clinics are open to the public. Further, Rural Access Network events provide oral health, immunizations, and other needed medical services at no cost to people who are medically underserved in Nevada. Title V MCH Program staff support efforts related to CHS/CHNs and routinely share information with the Nevada Hospital Association (NHA), Nevada Rural Hospital Partnership (NRHP), the Nevada Primary Care Association (NVPCA), and the Nevada Rural Health Network.

Employment

According to unemployment data from Bureau of Labor Statistics, in January 2025, Nevada ranked 51st the nation, including the District of Columbia, with an unemployment rate of 5.8% compared to the national average of 4.0% (https://www.bls.gov/web/laus/laumstrk.htm). Previously, the COVID-19 pandemic and subsequent response resulted in a dramatic increase in unemployment for Nevada. The average unemployment rate for Nevada in 2020 was 12.8% compared to the national average of 8.1%. Nevada ranked 50th in the nation for unemployment during 2020. Nevada's unemployment rate recovered from the highest point of 29.5% in April 2020 to 13.0% in September 2020.

Nevada's traditional industries include tourism, gaming, and hospitality; logistics and operations; mining; and agriculture. Other industries including manufacturing, information technology, aerospace and defense, energy, and health care have all historically experienced growth and helped stimulate the economy according to the Nevada Governor's Office of Economic Development (GOED).

For 2024 U.S. Census Bureau data indicate there were approximately 37,000 children (6%) who had at least one parent unemployed. Although this is an increase from 2023 with 33,000 children (5%) who had at least one parent unemployed, currently the rate is significantly higher than before the COVID-19 pandemic started with a rate of 23,000 children (4%) in 2019. There were 92,212 children ages 6 to 12 years old with at least one parent not in the labor force during the year.

Housing

Market forces continue to decrease the availability of affordable rental housing, increasing rates of rent burden for lower income households. According to the National Low-Income Housing Coalition, the 2024 Fair Market Rent in Nevada for a two-bedroom apartment was $1,605. For a household to afford this level of rent without paying more than 30% of their income on housing, the household must earn at least $5,350 monthly or $64,203 annually. The estimated hourly mean renter wage in Nevada is $21.80, at which workers could realistically afford a monthly rent charge of only $1,134. Data related to housing were obtained here: Out of Reach | National Low Income Housing Coalition (nlihc.org).

According to data from County Health Rankings and Roadmaps, 19% of households in Nevada experience severe housing problems, including at least one of the following: overcrowding, high housing costs, or lack of kitchen or plumbing facilities.

Food Security

The 2008 Great Recession affected the economic livelihood of many Nevada families and resulted in a combination of higher levels of food insecurity throughout Nevada's rural, urban, and tribal communities. In subsequent years, government leadership; stronger collaboration among agencies, nonprofits, and providers; as well as additional

federal, state, and private resources and focus, resulted in reducing hunger and food insecurity. Evaluations documented real gains. For example, in 2016, “Nevada was one (1) of 16 states to experience a significant decrease in food insecurity. From 2016-2019, only one (1) in eight (8) Nevadans remained food insecure.”

Unfortunately, in 2020 the coronavirus pandemic (COVID-19) unleashed another cycle of economic devastation upon many Nevada families. The rapid rate at which economic insecurity spread, the nature of the challenges prompted by this public health disaster, and the far-reaching impacts exacerbated existing gaps and revealed new ones within Nevada’s food security ecosystem.

Data from Feeding America, which collects state-level information on hunger, ranks Nevada eighth (8th) nationally among states with the highest projected overall food insecurity rates in 2021 - at 15.2 percent. Overall food insecurity for Nevada in 2022 and 2023 was 14.4% and 15.1% - surprisingly much higher than the 2020 actual of 11%. Very low food security averages for 2021-2023 ranks Nevada eighteenth nationally at 4.9% compared to 2019 actuals of 2.8 percent. Very low food insecurity rates in Nevada have increased roughly 29.2 percent between 2019 and 2021.

In Nevada, 1 in 5 children face hunger and childhood food insecurity remains higher than pre-pandemic rates, 20.9% (2021 and 2022) and 20.0% (2023). In 2021, Nevada ranked second nationally (tied with Hawaii) among states with the highest projected rates of children in very low food insecurity in 2021 (8.1 percent) compared to 6.3 percent in 2019. The rates of children identified as very low food security increased 28.6 percent between 2019 and 2021. While food insecurity may be harmful to individuals of all ages, it can be especially devastating to children. Food insecure children are more likely to repeat a grade in elementary school, experience developmental impairments in areas like language and motor skills and have more social and behavioral problems.

Income

Economic distress indicators such as poverty rate, housing vacancy rate, and percent of adults not working are compared across communities to create the Distressed Communities Index (DCI). According to the Economic Innovation Group 2018-2022 DCI, 13.8% of Nevadans reside in distressed zip codes. Compared to 2018, when four Nevada counties were considered “prosperous” (Douglas, Eureka, Storey, and Washoe), only three met this tier in 2022 (Douglas, Washoe, and Storey). Six counties are considered at higher risk (Eureka, Lander, Lincoln, Pershing, and White Pine). 2022 DCI Interactive Map - Economic Innovation Group (eig.org).

According to the Census, Nevada’s median annual household income (in 2023 dollars), 2019-2023 was $75,561 compared to the nation at $78,538. According to County Health Rankings and Roadmaps, “Income inequality helps measure gaps in household earnings.” Income inequality is measured as the ratio of household income at the 80th percentile to income at the 20th percentile. In Nevada, the ratio is 4.4, meaning that households in Nevada with higher incomes have income 4.4 times that of households with lower incomes. Rate ranges from 2.8 (Lincoln County) to 10.2 (Mineral County) The two largest counties, Clark County and Washoe County, have a ratio of 4.5 and 4.2, respectively.

Nevada’s urban areas struggle with an unusually high cost of living relative to low wages and insecure work associated with service industry tourism economies. The poverty level in rural and urban areas is comparable; however, accessing medical and health care services is severely limited in rural and frontier counties due to geographic access barriers, as well as difficulties in recruiting and retaining providers. This translates into low rates of routine preventive health services being delivered to these regions, such as recommended EPSDT screening and childhood immunizations, and decreased access to preconception health services, including the screening and management of chronic conditions, counseling to achieve a healthy weight, and smoking cessation.

Policy/Legislature

NRS Chapter 442 codifies statutes related to Title V MCH. NRS 442.133 provides the membership and terms of the MCHAB. The MCHAB is comprised of nine members appointed to two-year terms by the State Board of Health, with two legislators appointed by the Legislative Counsel. MCHAB is staffed by the Title V MCH Program Manager and an Administrative Assistant III. MCHAB advises the DBPH Administrator on objectives related to primary care, infant mortality, preventing fetal alcohol syndrome and substance use by pregnant persons, and increasing immunizations. The MCHAB meets at least quarterly. Nevada’s Legislature meets biannually.

State Title V Program Purpose and Design

The Nevada Department of Human Services (DHS) oversees four Divisions, including Child and Family Services (DCFS), Aging and Disability Services (ADSD), Supportive Services (DSS), and Public and Behavioral Health (DPBH). The Nevada Title V MCH Program is part of the Maternal, Child and Adolescent Health (MCAH) Section of the Bureau of Child, Family, and Community Wellness within DPBH. The mission statement of DPBH, "It is the mission of the Division of Public and Behavioral Health to protect, promote and improve the physical and behavioral health of the people of Nevada, equitably and regardless of circumstances, so they can live their safest, longest, healthiest, and happiest life," is the guiding directive for all DPBH programs.

The Title V MCH Program resides within the Bureau of Child, Family and Community Wellness (BCFCW). Within the Bureau are the Maternal, Child and Adolescent Health (MCAH), Women's Infants and Children (WIC), Chronic Disease Prevention and Health Promotion (CDPHP), and Nevada State Immunization Program (NSIP).

Title V Framework

Title V MCH has adopted the "10 Essential Public Health Services to Promote Maternal and Child Health" framework to guide programmatic decision making. This framework best encompasses Nevada's approach to incorporating assessment, policy development, and assurance components into Title V programs. Examples generated from Title V MCH staff of how Nevada promote maternal and child health for each of the essential services are presented below:

Assure the capacity and competency of the public health and personal health workforce to effectively address MCH needs

- Attend conferences, webinars, and other trainings and refreshers to keep current with MCH trends and changes
- Support Project ECHO and webinars to educate providers and community members on MCH topics
- Immediate implementation of new resources and materials to accommodate changes in existing policy

Evaluate effectiveness, accessibility, equity, and quality of MCH services

- Examine access to care barriers and health disparity data
- Evaluate funded partner outcomes through quarterly reporting
- Evaluate partner's commitment to equity
- Needs assessment and public input survey
- Assess language requirements and expand translation services to meet evolving needs

Support research and demonstrations to gain new insights and innovative solutions to MCH problems

- Implement cutting-edge practices such as trauma-informed yoga for youth
- Partner with Nevada System of Higher Education on studies and focus groups
- Collaborative efforts between Rape Prevention and Education Program and Children and Youth with Special Health Care Needs Program to provide awareness on sexual violence prevention for those with disabilities

Promote and enforce legal requirements that protect the health and safety of women, children, and youth

- Provide subject matter expertise and education regarding policies, guidelines, and legislation

Link MCH population to needed health care and supports and assure access to comprehensive, quality systems of care

- Ensure funded partner interventions reach participants equitably
- All resources are culturally appropriate
- Alliance for Innovation on Maternal Health efforts
- School Based Health Center Toolkit
- Family Navigation Network
- Medical Home Portal

Inform, educate, and empower the public and families regarding maternal and child health issues

- Infant safe sleep education
- Sober Moms Healthy Babies website
- Nevada Breastfeeds website
- Adolescent well-visit and insurance coverage campaigns
- Healthcare transition campaigns
- Medical Home Portal campaigns
- Disseminating information on emergent health issues
- Culturally appropriate resources

Mobilize community partnerships among policymakers, providers, the public, and others to identify and solve MCH issues

Partnerships and participation with:

- MCH Coalition
- Mountain States Regional Genetic Network
- Early Childhood Advisory Council
- Medicaid workgroups
- Nevada Primary Care Association
- Regional Tribal Councils
- Nevada Governor's Council on Developmental Disabilities
- Nevada Coalition to End Domestic and Sexual Violence

Provide leadership for planning and policy development to address priority MCH needs

- Maternal and Child Health Advisory Board meetings
- Congenital syphilis action plan efforts
- School Based Health Center Efforts
- Diapering Resource Committee
- Maternal Mortality Review Committee
- Prepare legislative briefs on program activities

Nevada is dedic sizing women, birthing people, infants, and children, inc

- Health education and prevention activities
- Increasing access to health care services
- Developing, and leveraging key partnerships and collaborations
- Planning and implementing program components reaching specific populations in collaboration with community-level partners, coalitions, non-profit organizations, and other state agencies

NPMs, ESMs, and State Performance Measures (SPM) influence Nevada Title V MCH priorities. Nevada's Title V MCH 2025 Needs Assessment demonstrated the need to focus on the following priorities.

- **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
- **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
- **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
- **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
- **Universal National Performance Measure** Medical Home Overall: percent of children with special health care needs, aged 0–17, with a medical home

Nevada Title V MCH Program staff meet weekly to discuss programmatic updates and address the needs of partners, collaborators, and subgrantees. Nevada Title V MCH also remains flexible to adapt to the changing health outcomes for Nevadans. Emerging issues require Nevada Title V MCH staff to stay abreast of evolving MCH healthcare needs.

The 2025 Title V Needs Assessment was composed of six methodologies designed to analyze quantitative data and gathering qualitative input from key partners, families, and community members statewide. Access and key partner

engagement are central throughout the process. Identified needs are prioritized using structured criteria and aligned with national and state performance measures. The results guide strategic planning, program development, and funding decisions for the MCH Block Grant. The following indicators guide the Title V MCH Block grant for the next five-years.

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

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

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

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

Domain: CSHCN

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

III.B.2.b. Organizational Structure

Organizational Structure

Governor Joe Lombardo is Nevada's Governor, currently serving the third year of a four-year term. Nevada DHS is the largest of the State's departments and the Director is appointed by and reports directly to the Governor. The current DHS Director is Richard Whitley, MS. DHS is comprised of four divisions, with multiple stand-alone programs falling under the DHS Director. Divisions include Public and Behavioral Health (DPBH), Aging and Disability Services (ADSD), Child and Family Services (DCFS), and Supportive Services (DSS).

The DPBH Administrator was Cody Phinney, MPH during the reporting period and is currently Dena Schmidt (June 2025). The Community Services Branch of DPBH is led by Deputy Administrator Julia Peek, MHA, CPM. The Bureau of Child, Family and Community Wellness within the Community Services Branch is led by Bureau Chief Vickie Ives, MA. The Bureau includes WIC, NSIP, CDPHP, AFP, and MCAH. The position of Title V MCH Director is held by Vickie Ives and CSHCN Director by Tami Conn. Tami Conn, MPH, one of the CFCW Deputy Bureau Chiefs. MCAH programs include Maternal, Infant, and Early Childhood Home Visiting (MIECHV); Personal Responsibility Education Program (PREP), Rape Prevention and Education (RPE), Sexual Risk Avoidance Education Program (SRAE), Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE) Maternal Mortality, Nevada PRAMS, Early Hearing Detection and Intervention (EHDI), SSDI, Maternal Child Health Advisory Board (MCHAB), Diapering Resources Committee, Nevada Maternal Mortality Review Committee (MMRC), Alliance for Innovation on Maternal Health (AIM), and Account for Family Planning (AFP) and the Title V MCH Program. Ghasi Phillips-Bell, ScD, MS, as the CDC MCH Epidemiology assigned to Nevada supported and strengthened Title V MCH and epidemiology efforts during the reporting period. CSTE Fellow Jordan Lancaster, MPH, joined at the end of the reporting period and supports Title V MCH work. The State Family Delegate position is held by Marcia O'Mailey who is also a Family-to-Family Representative with the Family Navigation Network and provides support to families living with a child with special healthcare needs.

Nevada Revised Statutes (NRS) Chapter 442 details the Title V MCH public health authority of DPBH. The link to NRS Chapter 442 can be found here: http://www.leg.state.nv.us/NRS/NRS-442.html.

The MCAH Section also administers the Maternal Child Health Advisory Board (MCHAB), Diapering Resources Committee, Nevada Maternal Mortality Review Committee (MMRC), Alliance for Innovation on Maternal Health (AIM), and Account for Family Planning (AFP) which are not funded by Title V but are under the supervision of the Title V MCH and CSHCN Directors. The MCAH Section addresses health among the populations served by coordinating efforts with Nevada DHS programs, LHAs, public and private partners, universities, MCH Coalitions, community coalitions, Family Resource Centers, Federally Qualified Health Centers (FQHCs), regional hospitals, and a variety of other traditional and non-traditional partners.

The MCAH Section, as outlined below, lists individuals in the roles during the reporting period and may not reflect current staff (current organizational chart in appendix). The Title V MCH Program was supported by MCH Manager Tasha Cadwallader, MBA, until November 2024; the role is vacant currently. Title V MCH Program fiscal staff include two partially funded Management Analyst II (Thomas Fletcher and Teresa Jarrett) positions and a part-time Accounting Assistant III (Lisa Light). Administrative staff includes Administrative Assistant III and Administrative Assistant IV. The SSDI Manager was held by Max Moskowitz. This position supports MCAH and PRAMS data efforts. Nevada Title V MCH Program staff and topic units include:

- The CSHCN Program Coordinator, Cassius Adams, MS, administers and promoted the Medical Home Portal (MHP), serves family and self-advocates for CSHCN, provides supports for CSHCN, provides and coordinates health education for CSHCN and their families, administers the Critical Congenital Heart Disease (CCHD) Registry, and provides trainings for families and health professionals. Partners working with the CSHCN Coordinator include the University of Nevada, Children's Cabinet Nevada Pyramid Model, Family Navigation Network through NCED, partners providing transition activities for older CSHCN, and Nevada Governor's Council on Developmental Disabilities (NGCDD).
- The Title V MCH Epidemiologist, Colleen Barett, MPH, is responsible for MCH data needs for annual reporting and the five-year needs assessment. Additionally, the MCH Epidemiologist analyzes data and compiles reports for federal, state, and local use, including for the Nevada PRAMS and other MCAH programs. Funding for this position is provided through the Title V MCH Block Grant [0.7 FTE] and CDC PRAMS [0.3 FTE].

- The RPE Coordinator, Chayna Corpuz, collaborates with statewide partners to prevent sexual violence and intimate partner violence among youth and young adults ages 12 to 24 years. Funding for the RPE Coordinator position is provided through the Title V MCH Block Grant [0.25 FTE] and the CDC Nevada Sexual Violence Prevention Grant [0.75 FTE]. The RPE program also receives set-aside funds through the Preventative Health and Health Services Block Grant (PHHSBG) to provide additional related prevention activities.
- The Adolescent Health and Wellness Program (AHWP) Coordinator, which was filled by Eileen Hough, MPH, through April 2024 then Dina Phippen through January 2025, collaborates with community partners on improving access to health insurance, increasing utilization of adolescent well visits and general health and wellness services, including trauma informed yoga, increasing daily physical activity by adolescents, and administering school-based health center Medicaid certification and related technical assistance.
- The Maternal and Infant Health Program (MIP) Coordinator, was vacant during the reporting period. This position collaborates with community partners on a variety of perinatal and interconception care initiatives, including substance use prevention, breastfeeding promotion, injury prevention, perinatal mood and anxiety disorders, safe sleep, and FIMR.
- The Administrative Assistant III was Tierra Sears through June 2024 and is responsible for administrative duties related to the Maternal and Child Health Advisory Board, purchase orders, travel coordination, and other tasks in support of the MCAH Section.

Nevada's Title V MCH activities occur at the local, regional, and statewide levels and MCH cooperates with programs and sections within DPBH supporting women of childbearing age, infants, children, CSHCN, adolescents, and their families. Examples of Title V MCH-funded partners administering programs congruent with the priorities indicated in the 2020-2025 plan include:

- Children's Cabinet Nevada Pyramid Model provides technical assistance and facilitates ECE staff and parent involvement in social emotional Pyramid Model activities.
- Family Navigation Network, Nevada's Family to Family partner, serves CSHCN and supports families and health professionals who work on their behalf providing advocacy, education, training, and other supports including a toll-free hotline.

  NNPH FIMR evaluates elements impacting health in pregnancy and perinatal outcomes, as well as fetal and infant birth outcomes to reduce fetal and infant mortality.
- Money Management/Nevada 211 provides information and referral via https://www.nevada211.org, a toll-free phone number, text support, as well as hosting the Title V MCH toll-free line, supporting the MHP resource sections, and educating on the priority status of pregnant persons at SAPTA-funded treatment centers.
- Nevada Broadcasters Association provides airtime and support for the Sober Moms Healthy Babies (SMHB), PRAMS, and Safe Sleep campaigns. DP Video supports adolescent wellness, transition to adult care, and MHP social media campaigns.
- KPS3 updated the Nevada Breastfeeds website per MCH staff direction.
- Nevada's PRAMS partner is the University of Nevada, Reno (UNR), Center for Surveys, Evaluation and Statistics in the School of Public Health.
- The Statewide MCH Coalition supports website maintenance, disseminates communications, advocates for MCH populations across public and private health entities in Nevada, conducts or refers to maternal mental health trainings, and supports planning with statewide partners for meeting the community needs of diverse populations.
- UNR Nevada Center for Excellence in Disabilities provides training on leadership, advocacy, transition education, and the medical home model for parents of CSHCN.
- Yoga Haven provides trauma-informed yoga to youth who are experiencing health/SDOH disparities. Yoga Haven has provided trauma informed yoga classes to Signs of HOPE as part of the Holistic Healing series. Classes have been useful to clients who are primary victims of sexual violence and their loved ones.
- The Regional Emergency Medical Services Authority (REMSA) led the Cribs 4 Kids (C4K) program in Nevada for the first half of the year. A Tribal specific element in concert with interested Tribal Nations, C4K, Indian Health Services staff, and MCH is funded via the Title V MCH Program to prevent mortality and injury.

The C4K transitioned to Dignity Health for the last half of the year through a request for proposal process after REMSA

- Dignity Health currently operates as the lead agency for the C4K program in Nevada and provides educational resources to parents and caregivers on the importance of practicing safe sleep behaviors with infants to prevent mortality. Dignity Health has continued to work with Tribal Nations for the C4K program and car seat safety.

Program management and fiscal staff meet weekly to discuss and coordinate all Title V MCH activities across Nevada, while program personnel meet weekly to discuss the status of funded program activities and associated outcomes. Program and fiscal goals, potential barriers, training needs, and technical assistance are all topics for discussion and action. Program staff work with community partners to determine the scope of work and budget needed for systems and community-level activities annually in alignment with state MCH priorities. This includes monthly check-in calls and annual site visits to monitor subgrantee program deliverables and fiscal processes.

DHS programs helping to promote Title V MCH priorities in Nevada include: Nevada 211, Office of Consumer Health Assistance, NGCDD, the Office of Health Information Technology, Individuals with Disabilities Education Act (IDEA) Part C Office, Nevada Early Intervention Services (NEIS), the Nevada Office of Minority Health and Equity (NOMHE), DPBH Tribal Liaisons, Nevada Primary Care Office (PCO) which addresses access to health care and identifies workforce shortage areas, Oral Health, CHS/CHNs, DPBH OPHIE, DHS Office of Analytics, Substance Abuse Prevention and Treatment Agency (SAPTA), Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), DCFS, ADSD, Nevada Medicaid, Nevada's Chronic Disease Prevention and Health Promotion (CDPHP) Section, Nevada Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Temporary Assistance for Needy Families located within DSS, and the Nevada State Immunization Program (NSIP).

Nevada's three urban counties have their own health authority: Carson City Health and Human Services (CCHHS), Northern Nevada Public Health (NNPH, Washoe County), and Southern Nevada Health District (SNHD, Clark County). The rural and frontier counties: Humboldt, Elko, Pershing, Lander, Eureka, White Pine, Churchill, Mineral, Esmeralda, Nye, and Lincoln counties that do not have their own health authority are supported by DPBH Office of State Epidemiology (OSE) and the Chief Medical Officer serve as the health authority for those counties. Rural and frontier counties have boards of health and/or a health officer. Additionally, in December 2022, the State of Nevada Board of Health approved the establishment of a Central Nevada Health District and fully implemented services on July 1, 2023. Counties served by Central Nevada Health District (CNHD) include Churchill, Eureka, Mineral, and Pershing. Nevada Community Health Services (CHS) has community health nursing clinics and behavioral health clinics in various rural and frontier counties to provide family planning services, related preventive health services, public health, and infectious disease services.

III.B.3. Health Care Delivery System

III.B.3.a. System of Care for Mothers, Children, and Families

Systems of Care for Mothers, Children, and Families

Access to prenatal care and the time around giving birth varies across counties throughout the state. According to a 2023 March of Dimes report, 47.1% of counties in Nevada are defined as maternity care desserts compared to 32.6% in the U.S. Nevada has 18 birthing hospitals and one birthing center. Only 3 birthing hospitals are located in rural regions of Nevada, and approximately 10% of women had no birthing hospital within a 30-minute radius in 2023.

According to the Nevada State Board of Medical Examiners, and American Medical Association, the number of Obstetricians and Gynecologists (OBGYN) per 100,000 women aged 18 and over in the U.S. is 33 compared to 26.9 for Nevada. An absence of a full-time OBGYN exists in 10 of 17 Nevada counties: Storey, Mineral, Esmeralda, Eureka, Lyon, Humboldt, Nye, and Pershing (Nevada State Board of Medical Examiners, 2024).

The 2024 rate for Nevada Family Medicine physicians per 100,000 population is 27.7 compared to the U.S. rate at 32.2 per 100,000. Additionally, the U.S. rate for Pediatricians was 87.6 per 100,00 persons, and for Nevada, the rate was 52.2 per 100,000 persons. Certified Nurse-Midwives are also underrepresented in Nevada.

The Nevada Health Workforce Research Center is in the Office of Statewide Initiatives at the UNR School of Medicine. According to the 2023 Nevada Health Workforce Research Center's Physician Workforce in Nevada: A Chartbook Report, Nevada ranks 45th for active physicians per 100,000 population, with 233.7 per 100,000. This is lower than the U.S. average of 284.6 per 100,000. In 2023, 2.3 million Nevadans, or 69.7% of Nevada's population, reside in a federally designated primary care Health Professional Shortage Area (HPSA), and 86.9% of Nevada's

population reside in a mental health HPSA. Esmeralda County has no licensed physicians. Nevada needs an additional 189 pediatricians, 250 family medicine physicians, 49 children and adolescent psychiatrists, and 81 OBGYNS to meet national averages.

Over 54% of births in Nevada are financed through Medicaid, reflecting the central role of public insurance in MCH care. Nevada's Medicaid operates under a managed care model in urban counties and fee-for-service will change to MCO in rural/frontier counties in 2026. Nevada Check Up, the state's Children's Health Insurance Program (CHIP) program, provides low-cost coverage for children in families that earn too much to qualify for Medicaid. Title V MCH Block Grant funds are used to support systems-level improvements for Title V MCH priority populations. Nevada collaborates with private insurers, public health districts, and non-governmental organizations to expand access, particularly for preventive and behavioral health services.

Nevada Health Link (www.nevadahealthlink.com) is the online insurance marketplace operated by the state agency, the Silver State Health Insurance Exchange (SSHIX). The marketplace is governed by seven board members and 25 staff members. Four MCOs offer plans on Nevada Health Link: Molina Healthcare of Nevada, SilverSummit Healthplan, Molina Healthcare of Nevada, and Anthem. Carriers are allowed to use telemedicine to meet accessibility requirements. Once enrolled in an MCO, participants are enrolled in the Dental Benefit Administration (DBA), which LIBERTY Dental Plan provides.

Nevada is a Medicaid expansion state and allows more low-income adults to access health insurance. Due to the COVID-19 pandemic, the American Rescue Plan Act (ARPA), signed into law on March 11, 2021, allowed uninsured Nevadans additional opportunities to enroll in health insurance benefits with significant savings. Individuals already enrolled also had the opportunity to take advantage of increased subsidies through the Nevada Health Link marketplace. The Inflation Reduction Act of 2022, signed into law on August 16, 2022, extended the expansion of premium tax credits on Affordable Care Act plans outlined in the ARPA until the end of 2025. Health enrollments were up 3% at the end of the most recent enrollment period (November 1, 2023, through January 15, 2024) from 2023 for a total of 99,312 enrollees according the Silver State Exchange 2024 Fiscal and Operational Report. At the end of 2025, without an additional extension, the maximum income limit of 400% of the FPL will be reinstated resulting to higher subsidy amounts.

According to a Kaiser Family Foundation report (Uninsured Rates for the Nonelderly by Age | KFF), there were still 326,800 uninsured nonelderly residents in Nevada in 2023, a decrease from 342,200 in 2022. Nevada Health Link will continue with outreach efforts targeted at specific uninsured populations and continue to offer certified assisters, licensed brokers, and navigators to provide in-person assistance for people enrolling in the SSHIX. Nevada Title V MCH partners and collaborators will continue to conduct various activities to inform consumers of the benefits of signing up for health insurance. All Nevada Title V MCH funded agencies refer uninsured families to Nevada 211 to obtain health insurance benefits information and distribute brochures outlining steps to access insurance to families of adolescents. Additionally, the Title V MCH Program works closely with other State of Nevada agencies and programs such as, Maternal, Infant, and Early Childhood Home Visiting (MIECHV), Nevada Aging and Disability Services (ADSD), Division of Welfare and Supportive Services (DWSS), Division of Child and Family Services (DCFS), Division of Health Care Financing and Policy (DHCFP), Nevada Office of Minority Health and Equity (NOMHE), Office of Analytics, Office of Suicide Prevention, Nevada State Public Health Laboratory (NSPHL), and Nevada's Governor's Council on Developmental Disabilities (NVDDC).

Nevada continues to address gaps in access statewide through a multi-pronged approach that integrates public health, health care delivery, and community-based supports. Title V MCH plays a central convening and funding role in improving systems for mothers and women of childbearing age (15-44), children, and CSHCN. While challenges remain—especially in provider shortages, rural access, and mental health—opportunities exist in cross-agency integration, telehealth expansion, and innovative payment models to better meet the needs of underserved populations. Nevada remains committed to a systems-oriented, family-centered approach to ensure all women and children receive fair, accessible, and quality health care.

III.B.3.b. System of Services for CSHCN

Systems of Services for CSHCN

Population Served

Nevada's system of services for Children with Special Health Care Needs (CSHCN) supports children and youth with chronic physical, developmental, behavioral, emotional conditions, or socioeconomic conditions who require

services beyond those required by typically developing children. Many of Nevada's CSHCN are covered by Medicaid, live in low-income households, or reside in rural and frontier areas where access to pediatric specialists and coordinated services can be limited. Families of CSHCN often face additional barriers related to transportation, language, provider shortages, access to health specialists and fragmented care delivery.

The National Survey of Children's Health (NSCH) outlines 6 core outcomes that facilitate integrated systems for CSHCN are as follows:

1. Families as partners in decision-making
2. Medical home
3. Adequate health insurance
4. Early and continuous screening
5. Ease of community-based services
6. Transition to adult care

Health Services Infrastructure

The Title V Children with Special Health Care Needs Program, administered through the Nevada Division of Public and Behavioral Health, focuses on building and supporting systems for this population rather than providing direct services. Nevada has limited pediatric specialty infrastructure, with most providers located in urban areas such as Las Vegas and Reno. There is currently no freestanding children's hospital in the state; some urban hospitals have specialized children's hospital areas within their general hospital. Families in rural regions may need to travel long distances or even cross state lines for specialty care. Both rural and urban families often have to go out of state for specialized care and access to pediatric specialists that Nevada does not have.

Pediatric subspecialty shortages remain a critical concern, especially in developmental-behavioral pediatrics, neurology, pulmonology, and genetics. Early Intervention Services (NEIS), operating statewide, provides evaluations and services for infants and toddlers with developmental delays. NEIS is a foundational piece of the early childhood health infrastructure, offering care coordination and access to therapies. Additionally, the Nevada Center for Excellence in Disabilities (NCED) and UNR Family Navigation Network offer key resources, including education, systems navigation, and family leadership development.

Integration of Services

Nevada continues to strengthen integration across health care, behavioral health, education, and social service systems for CSHCN. Medicaid managed care organizations have implemented care coordination models designed to improve outcomes for children with complex conditions. These models focus on person-centered care planning, transition readiness, and connecting families to resources.

The Title V MCH Program collaborates closely with Nevada Medicaid to ensure alignment in services such as Early Periodic Screening, Diagnosis, and Treatment (EPSDT), behavioral health services, and autism supports. Cross-agency collaboration is advancing through partnerships with early intervention (IDEA Part C), schools (Part B), child welfare, juvenile justice, and public health.

The CSHCN Program partners with the Nevada Center for Excellence in Disabilities (NCED), Family Navigation Network (FNN), Nevada's designated Family to Family (F2F) Health Information and Education Center, and the Parent-to-Parent of Nevada's peer-to-peer emotional support program. The FNN are knowledgeable about families with firsthand experience navigating the healthcare system and possess an understanding of the challenges CSHCN and their families face. Other programs in the state that serve as advocacy and provide legal assistance include Nevada PEP, Nevada Disability Advocacy and Law Center, and Nevada Governor's Council on Developmental Disabilities.

Nevada's CSHCN Program promoted Medical Home Portal (MHP), up through July 2024, due to a funded partner's discontinuation of the portal. The CSHCN Program continues to provide resources and support community organizations such as FNN that now fill in the gaps left by the MHP. More details on the CSHCN Program can be found in the CSHCN Narrative.

MCH staff participate in NASHP Behavioral Health and I/DD technical assistance cross agency groups, including those with lived experience; a DME and genetics Medicaid access technical assistance opportunity; statewide child school and health workgroup; ADHD workgroup with CDC and statewide pediatric child psychiatrists; and other opportunities to support CSHCN and their families.

Financing of Services

Medicaid is a primary payer of services for Nevada's CSHCN population, providing essential coverage for primary care, therapies, behavioral health services, and long-term supports through EPSDT and Home and Community-Based Services (HCBS) waivers, as well as School Based Services. Managed care models are used in urban counties, while rural and frontier areas operate under fee-for-service until 2026 when rural MCOs begin. Families often face barriers such as limited provider networks, service delays, lengthy time to process prior authorizations, lack of coverage for necessary durable medical equipment, and out-of-pocket expenses for equipment or therapies not fully covered. Families report the prior authorization process to be complicated, lengthy and riddled with delays and denials, resulting in durable medical equipment or necessary procedures being delayed by months to years. Title V MCH funded partners have worked to educate CSHCN and their families the Katie Beckett waiver to increase their knowledge or resources which can greatly reduce their financial burden related to healthcare.

Key Strategies and Opportunities

Nevada's Title V MCH program has prioritized several initiatives to strengthen the system of care for CSHCN. These include deepening family engagement, improving transition supports for youth moving into adult care systems, and expanding telehealth to mitigate access barriers. Title V continues to support training for providers, and partner with family-led organizations to elevate lived experience and ensure services are responsive to family needs.

Investments in data infrastructure, workforce development, and community-based support are ongoing. With strong collaboration among state agencies, managed care organizations, and nonprofit partners, Nevada remains committed to advancing a coordinated, accessible, and family-centered system of care for all children with special health care needs.

III.B.3.c. Relationship with Medicaid

Relationship with Medicaid

Division of Health Care Finance and Policy (DHCFP) is the state Medicaid agency and collaborates with the Title V MCH program to meet the needs of Nevada's MCH populations. As part of overall Nevada efforts to build systems of care, DHCFP and Title V MCH hold regular quarterly meetings to discuss ways to synchronize program initiatives, highlight gaps, and leverage efforts. The communication between DHCFP and Title V MCH encourages technical assistance, information sharing, and policy-implementation efforts. Efforts include consistent messaging to improve program outreach and enrollment information and MCO quality improvement performance improvement plan updates and awareness of new blood spot panel disorders. MCH staff are heavily involved in School Based Services efforts and have a key role in underutilized school bases heath center certification (no certified in the state currently).

Title V MCH coordinates efforts with partners to increase the percentage of adequately insured Nevadans, especially CSHCN. DHCFP collaborates with partners to identify Medicaid reimbursable services and promotes early identification of referrals of individuals to appropriate services who may be eligible for Medicaid benefits. Each agency has proved a willingness to provide timely information on administrative or fiscal changes impacting children and families. MCH staff highlight gaps, needs, and opportunities to better serve MCH populations in Nevada. Partnership on issues such as breastfeeding supports, doula coverage, CHW coverage, increasing awareness or 12-month postpartum coverage, LARC coverage outside of birth bundled payment, value-based payment models are a few areas of successful partnership. Data sharing is easy and bidirectional, and relationships cross agencies are strong, collaborative, and highly valued. Title V MCH and Medicaid partnerships are active and vital, and each consider the other to be key partners in improving birth outcomes statewide.

DHCFP and Title V MCH implemented a process allowing for Medicaid and other public health data sharing. The data-sharing agreement streamlines critical data acquisition to populate the Title V MCH application and report. Title V and DHCFP partnered with the National Academy for State Health Policy (NASHP) on a learning network regarding medically complex children and Maternal and Infant Health Initiative (MIHI), infant mental health and also home visiting efforts, and currently are participating together in technical assistance related to behavioral health and I/DD, food and housing insecurity, and DME and genetic testing access. Both are in numerous MCH workgroups together in addition to these opportunities.

The Title V MCH staff present information to DHCFP on MMRC efforts and policy efforts to improve maternal health. MMRC information included a review of maternal mortality and severe maternal morbidity incidents and efforts to reduce these incidents in conjunction with a PQC, should the state launch a PQC. MCH staff and Medicaid staff routinely partner on specific information sharing and facilitate information sharing with partners on topics relevant to Title V MCH populations.

III.B.4. MCH Emergency Planning and Preparedness

MCH Emergency Planning and Preparedness

During the prior reporting period, the Nevada Title V program staff were selected to attend cohort two of the AMCHP Emergency Preparedness Response Learning Collaborative (EPR-LC) on a team including the MCH Director, CSHCN Program Coordinator, Public Health Preparedness (PHP) state and LHA staff, and EMS representation.

Title V MCH has continued its efforts in public health preparedness by having all staff complete the Staff completed Incident Command System (ICS) trainings 100, 200, 700 and 800 courses. The Nevada Title V Program is proactive in emergency preparedness planning and coordination with partners at the state and local levels to help center the needs of the MCH population. Quarterly, MCH staff update State PHP's Continuity of Operations Planning (COOP).

Key points in relation to Nevada PHP collaboration efforts continue to include:

1. The state has a written Emergency Ops Plan (EOP), and it is reviewed regularly.
2. The state's EOP specifically consider the needs of the MCH population in the Pediatric Surge Plan and explicitly includes medically affected women, infants, and children.
3. Title V MCH program staff were involved and consulted in the planning and development of the State's Pediatric Surge Plan.
4. Title V Director is included in the State's emergency preparedness planning with the DPBH PHP Section before a disaster since the EPR-LC Team began and this is ongoing, including weekly and response specific activation in Access and Functional Needs statewide workgroup.
5. The Nevada Title V MCH Program needs assessment did not identify PHP as a priority, but lessons learned from Zika MCH communications and family linkage to resources efforts, Mpox resources for youth and families, COVID-19 MCH gaps in relation to agile processes on referral to care and early intervention services and the need for a bidirectional referral system are some of the lessons learned from previous emergency responses. Wildfire and air quality, heat advisory, and flood or earthquake threats as they relate to environmental exposures and planning for MCH issues for pregnant persons, infants and children, including CSHCN are areas in need of development going forward for future disaster or public health emergency planning.
6. The Nevada Title V MCH Program staff participated in the development of pediatric emergency preparedness and response tabletop exercise planning, pediatric plan development, communication plan MCH points of contact identification and were key in introducing CSHCN, sexual assault prevention, breastfeeding and contraception access needs into discussions of tools and strategies to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population in partnership with DPBH PHP staff leads on PHP plan development. It is important to note close relationships between WIC, NSIP, and DPBH PHP.
7. Nevada Title V MCH Program staff have participated in the pediatric surge plans and have emphasized continuity and planning needs for public health programs such as CCHD and EHDI newborn screening, CSHCN beyond durable medical equipment needs and energy continuity with grid disruption, and home visiting needs to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population.
8. MCH measles, Mpox and COVID-19 information sharing focused on infant, CSHCN, child, and pregnant person populations.

9. NGCDD and FNN were provided resources by MCH staff to support their PHP efforts.
10. MCAH amplifies NSIP-led information distribution in relation to immunization. All Bureau sections annually update a Continuity of Operations Plan, including MCAH.

Nevada Title V MCH Program annually assesses PHP opportunities to collaborate and continues to grow MCH integration in EOP efforts; evaluating what is needed in responding to an emerging public health threat or disaster impacting the MCH population is ongoing. Partnerships developed in the EPR-LC identified many future goals for greater MCH integration, data sharing (for example, CDC pregnancy estimator tool utilization), MCH staff training in ISO and PHP emergency response basics. These will continue to be active areas of engagement, as is continuing education and ensuring staff training via webinars on emerging issues and opportunities to best integrate the needs of MCH populations in PHP efforts.

The CSHCN coordinator participated in emergency preparedness training related to integrating access and functional needs into emergency management. This training program consisted of multiple units created to cover core areas of consideration in the event of a public health emergency. During this training, the C-MIST approach was emphasized and is based off of the Federal Emergency Management Agency (FEMA)'s strategic goals of whole community inclusion and conclusions that incorporating the needs of people with access and functional needs into all phases of mitigation, preparedness, response, and recovery programs is a best practice. The C-MIST framework provides an adaptive strategy on how to provide the best support for a variety of common access and functional needs without an emphasis on any specific diagnosis, status, or label.

The components of C-MIST are as follows:

C: Communication – In an emergency, some individuals may experience difficulty with hearing announcements, seeing signs, comprehending communications, or articulating their problems effectively.

M: Maintaining health – Maintaining functional independence in an emergency may require the replacement of essential medications, durable medical equipment, or life-saving equipment in order to reduce or eliminate health deterioration.

I: Independence – Maintain access to necessary mobility devices, assistive technology, vision and communication aids, and service animals.

S: Safety, Support Services, Self-Determination – For an individual, a public health emergency may lead to the loss of caregiver assistance, difficulties in adapting to a new and unfamiliar environment, or increase difficulty with understanding and remembering things. Those who suffer from or are survivors of trauma or abuse may also have additional considerations.

T: Transportation – Some individuals may be unable to operate a motor vehicle due to decreased or impaired mobility caused by age, disability, temporary conditions, injury, or legal constraint.

Through participating in the program, The Title V MCH CSHCN Coordinator learned the distinction between compliance versus commitment to accessibility standards, access and functional needs annexing, people first language, expanded disability definitions, disability law, urban, rural, frontier, and tribal support, inclusive planning, points of access issues in the disaster cycle, strategic, operational, and tactical planning, and partners in plan integration.

Future efforts relate to specific Medicaid data focused collaborations, updating planning for core MCAH services and supports in case of public health emergencies, and continued training for Title V staff.

III.C. Needs Assessment

III.C.1. Five-Year Needs Assessment Summary and Annual Updates

III.C.1.a. Process Description

Needs Assessment

Nevada strives to promote and improve the physical and behavioral health of all Nevadans. The Needs Assessment process aims to engage all MCH community members and partners in the assessment and priority needs selection process. Lastly the Needs Assessment explores approaches to assess the strengths and needs of the MCH population allowing for deeper understanding and more effective programming. The State of Nevada partnered with Altarum to support Nevada's Title V Maternal and Child 2025-2030 Needs Assessment.

The Altarum team began the Needs Assessment process under MCH staff direction 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 Title V MCH domain populations in Nevada. Quantitative data, surveys, key informant interviews, bilingual modalities for sharing feedback, community input, and 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, persons with lived experience and community members to share their perspectives, experiences, and expertise.

Epidemiological Data

The Needs Assessment team conducted an epidemiological data review to obtain and synthesize information from a variety of sources about the health and well-being of Nevadans across the five MCH domains. The Needs Assessment team (including core MCH staff) 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), Kindergarten Health Survey, National Survey of Children's Health (NSCH), U.S. Census Bureau's American Community Survey (ACS), and others. Where possible and to add further value and context to the findings, the same datasets were used to compare differences between Nevada and national estimates.

The Needs Assessment team also conducted an environmental scan 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 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.

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 CSHCN parent liaisons attended (Exhibit 2). Participants were separated into three groups (Women and Maternal Health + Perinatal and Infant Health; Child Health + Adolescent Health; and CSHCN) 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
- Division of Child and Family Services
- Family Navigation Network
- 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
- Southern Nevada Health District
- Division of Public and Behavioral Health Tribal Liaison
- Northern Nevada Public Health
- 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, 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:

- 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
- Family Navigation Network
- 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 CSHCN
- 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 CSHCN), 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).

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 and staff presented to numerous organizations, open meeting law boards, coalitions, Tribal liaisons, etc., to ensure statewide awareness to encourage response rate. 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. The few ADHD related questions related to a separate effort with CDC and statewide Nevada child psychiatrists.

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.

III.C.1.b. Findings

III.C.1.b.i. MCH Population Health and Wellbeing

MCH Population Health and Wellbeing

Below are findings by domain. Within each domain, findings are by epidemiological data and primary community input data collection activities. The epidemiological data provides 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 to the statistics and incorporate community experiences and perceptions. For the full Needs Assessment report and community input findings, please see the supplemental document titled "Final Needs Assessment Report."

Women/Maternal Health

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 **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 disparities among 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.[1]

Perinatal/Infant Health

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) were 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).[1]

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.

Child Health

Child Mortality: The **child mortality** rate in Nevada has increased in recent years from 19.9 in 2022, to 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% in 2020 to 34.6% in 2023. Also, the percentage of Nevada children who are **physically active at least 60 minutes every day** decreased during this time from 14.6% in 2020 to 13.3% in 2022. Almost 90 percent of parents completing the National Survey of Children's Health reported their children in excellent or good health in 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. 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. National Survey of Children's Health data 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. 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% in 2020 to 32.9% in 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.

Adolescent Health

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.[3] 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,[2] 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.

Children with Special Health Care Needs (CSHCN)

Access to Care: There was a decrease in multiple variables related to access to care for CSHCN from 2020 to 2023. Based on National Survey of Children's Health data, in 2023, less than half (49.7%) of CSHCN had **adequate and continuous insurance coverage** a decrease from 56.5% in 2020. The U.S. estimate for CSHCN having continuous and adequate insurance coverage in 2023 was 61.4%. The percentage of CSHCN 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 CSHCN reporting they have a medical home. There has also been a decrease in the percentage of CSHCN 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 CSHCN receiving family-centered care. Data did indicate about a 3% increase in the percentage of Nevada CSHCN 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 CSHCN. According to the 2022–2023 NSCH, 25.8% of Nevada's CSHCN 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 CSHCN 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 CSHCN showed an increase from 2020 to 2023. Data from the National Children's Health Survey indicates an increase in Nevada CSHCN who have experienced two or more **ACEs** from 32.7% in 2020 to 37.4% in 2023. Additionally, Nevada CSHCN who reported being **bullied almost every day** increased from 5.4% in 2020 to 7.7% in 2023.

References & Footnotes

1. 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.

2. Thymianos, K., Cheche, O. K., Beavers, K., Gilbertson, K. M., Saladino, C. J., & Brown, W. E. (2022). *Youth mental health in the Mountain West* (Health Fact Sheet No. 15, pp. 1–4).

III.C.1.b.ii. Title V Program Capacity

III.C.1.b.ii.a. Impact of Organizational Structure

Impact of Organization Structure

The organizational placement of Nevada's Title V program maximizes the program's ability to serve Nevada's MCH populations, and their most pressing needs outlined by the 2025 Needs Assessment. Its placement within MCAH allows the program to partner with adjacent programs that fall under the DBPH and leverage their capabilities to promote and provide services impacting targeted MCH populations.

The Title V MCH Program coordinates efforts with other sections/programs to respond to Nevada's MCH population needs. DPBH Community Health Services (CHS) promotes well visits for women of childbearing age, adolescent preventive medical visits, and health care transition from pediatric to adult care for adolescents and CSHCN. The DPBH Primary Care Office improves health care outcomes through its efforts to coordinate the federal shortage designation process, the J-1 Physician Visa Waiver Program, and other healthcare worker recruitment and retention programs. The CFCW Chronic Disease Prevention and Health Promotion Section provides resources on tobacco prevention, cancer screenings, CVD, and diabetes prevention, Food Security Council, physical activity promotion, and nutritional education. The Nevada State Immunization Program (NSIP) is managed by the Title V MCH and CSHCN Director and co-funds a fiscal position promotes Title V MCH population-related immunizations, including maternal and adolescent vaccines. To further support maternal and infant populations, Title V will continue to coordinate efforts with programs, including Women, Infants and Children (WIC), to promote breastfeeding and safe sleep practices. Access to safe and healthy foods and physical activity were top issues that resulted in the 2025 Needs Assessment.

The Title V MCH Program coordinates efforts with other sections/programs within DPBH through Memoranda of Understanding (MOU). An MOU supports the DHS Office of Analytics (OoA). Title V staff partners with the Office of State Epidemiology to combat emerging issues, including congenital syphilis and increasing sexual transmitted disease screening among adolescents and pregnant women. Additionally, the positioning of the program allows Title V to focus on other specific initiatives relevant to the populations Title V serves including increased care coordination among adolescents and the promotion of a medical home.

In addition, Nevada's Title V and MCAH programs utilize the OoA for comprehensive analysis and special reports to monitor and identify trends related to performance measures and other complex needs. The OoA is under the Department of Human Services and has several biostatisticians with expertise across health sectors that provide data to programs, partners, and the public. Title V programs partner with the OoA on the visualization of MCH health measures on dashboards. The Office of Analytics leads the development and maintenance of these dashboards. Utilization of these tools have allowed evaluation of program effectiveness, target program initiatives, and increase staff and partner capacity in emerging issues. Future collaborations will continue to stress the need for moving beyond descriptive statistics to more complex, predictive analytics.

Some of the challenges faced by the Title V program include not being able to support every potential partner or community organization whose work is consistent with Title V objectives due to scope of PMs and limited funding and staffing constraints.

Title V MCH Program is well positioned to tap into the wide array of additional resources available through adjacent programs, each of which plays an important role overall in health, to work on the continuing and new priority measures selected in the needs assessment.

III.C.1.b.ii.b. Impact of Agency Capacity

Impact of Agency Capacity

The Title V MCH Program functions as a unit within the MCAH Section of CFCW, DPBH and takes a coordinated, systems-based approach to improving MCH health and wellbeing. Title V MCH Program Coordinators work to improve the function of each program unit within Title V MCH. For example, the AHWP Coordinator and CSHCN Coordinator collaborate to improve the number of adolescents who receive preventative well visits. The MCAH Teen Pregnancy Prevention Coordinator and the Sexual Risk Avoidance Education Coordinator both collaborate with the AHWP and CSHCN Coordinators to reduce teen pregnancy and sexual transmitted infections. The MCH Epidemiologist coordinates data requirements with each Title V MCH program unit to enhance reports for internal/external partners and the MCHAB and links MCH to SSDI and PRAMS efforts as part of MCH data efforts led by the MCH and CSHCN Directors. The MCH Director is the CFCW Bureau Chief and is supported by one of the Deputy Bureau Chiefs, Tami Conn, MPH, CSHCN Director. The CSHCN Coordinator works with the MCH and CSHCN Directors and Section Manager to ensure CSHCN and their families and/or caregivers receive the

resources needed to support access to appropriate referrals and health care. In addition, the CSHCN Program coordinates efforts to increase the number of children who have a medical home, leads the critical congenital heart disease (CCHD) registry, and supports transition from pediatric/adolescent to adult health care.

Nevada DPBH Tribal Liaisons and Title V MCH Director and MCAH staff collaborate to share resources to address the needs of MCH populations in Nevada Tribal Nations and support targeted injury prevention efforts. There are 27 federally recognized Tribes of Nevada and DHS has agreements with Tribes. A Tribal Consultation process is established at DHS to guide the work and interactions with federally recognized Tribes in Nevada. Tribal Consultations are held quarterly by DHS.

To support the ongoing communication and trust between Tribal Nations and DHS, the Tribal Liaisons have traveled to all the Tribal Health Clinics to meet face-to-face with the Health Directors, Tribal Council Members, and other tribal organization staff (i.e., Social Service Program Directors). Additionally, to support Tribal partners, the DHS Tribal Liaisons attend all meetings hosted at the Inter-Tribal Council of Nevada (ITCN) and meetings related to Tribal matters, as applicable. Also, with the partnership of other DHS agencies, community events are attended. MCAH staff presented on the MCAH Programs work via the DPBH liaison to share information such as the Five-Year Needs Assessment, reports and opportunities of interest, tailored messaging from federal sources, etc.

Workforce Challenges

Workforce challenges include staffing constraints due to a few vacancies within the MCAH Section, limiting the Title V program ability to operate at full capacity. Additional challenges to retaining qualified health professionals include lengthy hiring process times to fill vacant positions due to human resource processes and salary compensations at the state level are less competitive than what the county or municipal can offer. During staff vacancies, all team members support one another, filling roles ensuring responsibilities are adequately covered.

Agency Capacity Assessment

To assess the needs or capacity of the people and system that serves MCH populations to address the state's identified priorities, 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).

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 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."*

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 DHS is set up with having a designated Office of Analytics can create some barriers to timeliness for getting 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 partners, 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 partners and businesses. Similarly to other priorities, the only competency staff were unsure of was the ability to influence the policymaking process.

Children with Special Health Care Needs

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 partners, on-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.

III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development

Title V Workforce Capacity and Workforce Development

MCH Workforce Development

Nevada's Title V MCH Program maintains workforce capacity to address Title V priorities. Nevada's Title V MCH Program supports 13.21 FTE in various roles and capacities in the DPBH Bureau of Child, Family and Community Wellness (CFCW). Title V funds also support 3.6 FTE DHS/DPBH outside of the Bureau.

Vickie Ives, MA, serves as the CFCW Bureau Chief and MCH Director for Nevada with oversight of the MCAH Section, Women, Infants and Children (WIC), Nevada State Immunization Program (NSIP) and Chronic Disease Prevention and Health Promotion (CDPHP), and the Account for Family Planning. Ms. Ives has over 20 years of experience in policy research, analysis, and evaluation and has worked in MCH since 2011. Ms. Ives also serves on AMCHP's National MCH Workforce Development Center.

Tami Conn, MPH, serves as one of the CFCW Deputy Bureau Chiefs supporting MCAH and NSIP sections and

serves as the CSHCN Director. Ms. Conn has a Bachelor of Science (BS) degree in Biology as well as her MPH and a decade of public health experience with the past seven years in MCH.

Karissa Loper Machado, MPH, is the MCAH Section Manager and oversees all MCAH-related activities. Ms. Loper Machado has a Bachelor of Science in Business Administration as well as her MPH and a decade of public health and social services experience across CFCW and Early Childhood Comprehensive Systems (ECCS) programs.

Funded Staff (full or partial funding)

- Vickie Ives, MA, Health Bureau Chief
- Tami Conn, MPH, Health Program Manager III, Deputy Bureau Chief (0.20 FTE)
- Karissa Machado, MPH, Health Program Manager II, MCAH Section Manager
- Vacant, Health Program Manager I, Title V MCH Program Manager
- Health Program Specialist I (HPS1)
    - Currently Vacant, Maternal and Infant Health Coordinator
    - Allison Gonzalez, MPH, Adolescent Health and Wellness Coordinator
    - Cassius Adams, MS, CSHCN Coordinator
    - Chayna Corpuz, MPH, Rape Prevention and Education Coordinator (0.25 FTE)
    - Currently Vacant, MCH Epidemiologist/PRAMS Lead Coordinator
- Robyn Cunnally, RN, Health Program Specialist II, Nurse Abstractor (0.51 FTE)
- Colleen Barrett, MPH, Health Program Specialist II, SSDI Manager
- Thomas Fletcher (0.75 FTE) and Teresa Jarrett (0.25 FTE), Management Analyst II, Fiscal Services
- Lisa Light, Accounting Assistant III, Fiscal Services (0.50 FTE)
- Tammera Brower, Administrative Assistant IV
- Barbara Bessol, Administrative Assistant III, MCAH Section

Partially or fully funded DHS and DPBH partners include:

- Title V supports a proportion of each of 11 Community Health Nurses, accounting for 1.1 FTE, who provide health promotion and prevention services, care coordination, health education, and outreach to support public health in Nevada's rural and frontier counties.
- Office of Analytics 1.0 FTE Biostatistician and 1.0 FTE Health Resource Analyst II who provides data support across MCAH programs
- Primary Care Office 0.5 FTE Health Resource Analyst

Non-Title V MCH funded key partners within the MCAH Section, CFCW, and other areas of DPBH collaborating on MCH-related activities include:

- Personal Responsibility and Education Program (PREP) and Sexual Risk Avoidance Program (SRAE)
- Early Hearing Detection and Intervention (EHDI) Program
- Nevada Account for Family Planning
- Alliance for Innovation on Maternal Health (AIM)
- Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program
- State Systems Development Initiative (SSDI)
- Nevada WIC
- NSIP
- CDPHP
- Bureau of Behavioral Health Wellness and Prevention (BBHWP)
- CSTE Applied Epidemiology Fellow

MCH Epidemiology Workforce

Nevada's Title V MCH Program supports one (1.0) FTE MCH HPS1 Epidemiologist, one (1.0) FTE Biostatistician II, one (1.0) FTE HRA2 specializing in Geographic Information System (GIS) activities, and the 1.0 FTE SSDI Manager. Title V MCH funds 100% of the HRA2 and Biostatistician, while the MCH Epidemiologist is funded 70% through Title

V MCH and 30% through the PRAMS grant. The SSDI Manager is funded 42% by Title V MCH and 58% by the SSDI grant.

The Office of Analytics, housed within the newly created Nevada Health Authority, provides primary data support for Title V MCH efforts. One Biostatistician II and a GIS specialist assist with complex Title V MCH data requests utilizing advanced Statistical Analysis System (SAS) skills and map requests.

The SSDI Manager works closely with the Title V MCH Unit and assists with data analysis and presentation efforts. The MCH Epidemiologist is responsible for managing, organizing, analyzing, and displaying MCH data. The SSDI Manager performs higher-level data management, PRAMS Management, and systems functions, such as database management.

Improving epidemiological training for both the MCH Epidemiologist and SSDI Manager roles is a priority. Furthermore, with data dashboards becoming more prevalent, gaining more advanced Power BI and dashboarding skills is a priority for the MCH Epidemiologist and SSDI roles, as is building qualitative data capacity and moving beyond descriptive statistics. The SSDI Manager and MCH Epidemiologist are encouraged to seek trainings and conferences that enhance competencies and support Title V MCH activities. In addition, other Title V MCH staff took in-depth Power BI training to support the MCH Epidemiologist in creating future public facing dashboards on specific programmatic topics.

A planned area of change for the epidemiology workforce is to train the MCH Epidemiologist in more advanced SAS skills and improve data access to complete more data analysis within the MCH unit. SAS skills training and increased access to data will help streamline data requests and analyze data in a timelier fashion. As of August 2024, Nevada is hosting a CSTE Applied Epidemiology Fellow, held by Jordan Lancaster, MPH, CPH, in the MCAH section of DBPH. The CSTE Applied Epidemiology Fellow has enhanced data capacity efforts including developing a PRAMS state dashboard as a goal with the Office of Analytics leading the effort, conducting a FIMR evaluation, and analyzing the impact of the COVID-19 pandemic on the Maternal and Infant Population.

State and Division Staff Training

Nevada continues to maintain its Online Professional Development Center (NV eLearn at https://nvelearn.nv.gov) and provide in-person and online classes to employees. DPBH employees are also able to access makinghealthhappen.org via The Larson Institute at the UNR School of Public Health providing access to a range of continuing education topics specific to public health professionals. NV eLearn contains various trainings, including developing and applying logic models for planning, implementing, and evaluating programs, effective techniques for presenting data, and practical methods for making decisions.

DPBH employees meet annual Health Insurance Portability and Accountability Act (HIPAA) and information security training requirements using the Development Center and can use it to further improve job-related skills. Employees value the continuing education offered by MCH trainings to stay current on topical MCH developments in priority areas.

Other workforce development opportunities are provided to staff by various state programs, federal agencies, academic institutions, and professional organizations such as the AMCHP, HRSA/AMCHP Technical Assistance and Regional meetings, and through an assortment of coalitions. Title V MCH staff attend Statewide MCH Coalition sponsored trainings and Project ECHO, federal, and UNR and UNLV topical trainings and are highly encouraged to seek and attend training and conferences to enhance their competencies.

DPBH provides professional development opportunities through a mentorship program by which senior staff provide guidance and career mentorship to new or mid-level employees. Mentors and mentees are matched by interests, goals, and experience of the mentee.

Future Public Health Workforce

The Division of Public and Behavioral Health is an active participant in the academic health department between the state's Department Human Services and the entire University of Nevada, Reno. This formal affiliation aims to increase collaboration and provide mutual benefit in the areas of education, research, service, and practice—where academia informs practice, and practitioners inform academic programs. Specifically, it works to enhance practice-

oriented education and opportunities for students, expand collaboration among university faculty and agency staff, build the evidence base for public health and health care through joint research projects, leverage resources from both institutions, and provide opportunities to develop the current and future workforce.

DPBH hosts undergraduate and graduate students from the Nevada School of Public Health at UNR as part of a student internship program. Students must complete a project that provides a unique service to the organization while giving the student valuable experience working in the public health field. Staff members provide mentorship and a program/project evaluation experience to help advance the future public health workforce. Additionally, the hosting of a CSTE Applied Epidemiology Fellow allows the MCAH Section to bolster data capacity and assist in training the next generation of MCH professionals.

Additionally, DPBH is pursuing Public Health Accreditation Board (PHAB) Accreditation. To achieve accreditation, DPBH has developed a workforce plan to retain and recruit highly qualified, skilled, and robust workforce. DPBH recognizes that an expert workforce is essential to achieving the agency's mission in promoting, protecting, and improving the health of all Nevadans. These Division wide efforts will naturally enhance the Title V MCH Program's capacity as well.

III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

State Systems Development Initiative and Other Title V MCH Data Capacity Efforts

The purpose of Nevada SSDI is to develop, enhance, and expand Nevada Title V MCH data capacity to allow for informed decision making and resource allocation supporting effective, efficient, and quality programming. This project also aims to expand on the linkage of MCH data sets. Nevada SSDI aims to support evaluation activities around NPMs contributing to building the evidence base for the Title V MCH Block Grant. Nevada seeks to enhance surveillance capabilities related to MCH.

Since the formation of Office of Analytics under the Director's Office to consolidate data capacity and facilitate cross-training and data analytics support, Nevada Title V MCH continues to fund a Biostatistician and Health Resource Analyst (HRA) within this group. MCAH funds two additional HRA positions in the Office of Analytics, working with Eary Hearing Detection and Intervention and Nevada Home Visiting. These positions are crucial to members of the MCAH team in increasing MCH data support and analytics capacity, accessing primary data, and generating analyses and reports on behalf of MCAH and MCH, in addition to the work of the MCH Epidemiologist and SSDI coordinator. The Office of Analytics supports public data dashboards that include MCH data points, and Title V MCH have monthly meetings to discuss pending data requests and upcoming projects. Title V MCH also works with Primary Care Office around MCH priorities.

Accomplishments and Barriers

Throughout the reporting period 12/01/2024 to 11/30/2025, the Nevada State Systems Development Initiative (SSDI) Program continued to work on linking data sets for the State Title V Maternal and Child Health (MCH) partner by enhancing connections between programs across the Department of Health and Human Services. Offices collaborated with include the Office of Analytics (OOA), MCH Title V Program, Office of State Epidemiology, Early Hearing Detection and Intervention, and Maternal, Infant, and Early Childhood Home Visiting (MIECHV). The Title V SSDI Manager and the Nevada Biostatistician and Geographic Information System (GIS) Mapping Data Analyst shared statistics for Nevada's Title V MCH State Performance Measures (SPMs).

Building capacity in quantitative, qualitative, and data evaluation capacity is of interest. MCAH added a CDC MCH Assignee in October 2022 who has helped to increase MCH epidemiological capacity for review of congenital syphilis data, evidence-based strategy measures, infant and maternal mortality, ADHD data analysis, and overall support of more robust data capacity. Additionally, MCAH began hosting a Council of State and Territorial Epidemiologist (CSTE) Fellow in August 2024. The CSTE Assignee has supported efforts for Critical Congenital Heart Disease Screen Surveillance, Fetal and Infant Mortality Review (FIMR) Surveillance, the Title V Needs Assessment, and Title Block Grant Reporting.

The MCAH Section manager, MCH Epidemiologist, and newly hired SSDI Manager attended monthly data sharing meetings with the OOA. The MCH Epidemiologist presented on MCH topics around the annual Federally Available Data (FAD) and the MCH Biostatician presented on Maternal Mortality and Severe Maternal Mortality data. Once hired in July 2025, the SSDI Program Manager attended other meetings including, but not limited to, the Maternal Child Health Advisory Board (MCHAB), MCH data sharing meetings, MCH Unit meetings, Title V Block Grant meetings, Nevada Office of Minority Health, and Equity (NOMHE) Advisory Board, and weekly PRAMS. In addition, the MCH Epidemiologist lead Title V Needs Assessment meetings and created MCH Data Workgroup to increase project collaboration and data capacity. The MCH CDC Epidemiologist Assignee and the CSTE Fellow both are a

part of the Nevada Congenital Syphilis Workgroup. The MCH Epidemiologist also attended the Association for Maternal and Child Health Programs (AMCHP) in May 2024 conference and the CityMatch 2025 MCH Epidemiology Training June 2025. The newly hired SSDI Manager will attend the MMRIA User Meeting in August 2025.

Title V MCH faces a few challenges in improving the use of MCH data. Staffing turnover presents issues with keeping staff members trained on data sources. The SSDI Manager was filled for over a year but became vacant in December 2024, then newly hired in July 2025. The MCH Epidemiologist position became vacant in July 2025. The MCAH Deputy Bureau Chief has fulfilled the SSDI Manger position until July2025 and the CDC MCH Assignee, MCH Epidemiologist, CSTE Fellow assisted in expanding MCH data capacity and analysis. Recent efforts have been made to create training guides on the use and implementation of Nevada's data systems.

Goals and Objectives

1. Objective 1.1: Supporting Title V MCH Block Grant program data needs associated with the 5-year Needs Assessment process and the annual needs assessment (NA) update

   2024-2025 Progress: The MCH Epidemiologist assisted in data collections efforts for the 2025 Needs Assessment by facilitating data requests to OOA and coordinating. The newly hired SSDI will lead data collections for the Title V MCH Block Grant for the next five years and support reporting efforts.

2. Objective 1.2: Assisting Title V MCH Block Grant programs with development, selection, refinement, and/or tracking of data and performance measures that are associated with the Title V MCH Block Grant performance measure framework

   2024-2025 Progress: The MCH Epidemiologist worked on refining the scopes of work and data reporting from MCH partners throughout the reporting period to enhance the tracking of data and performance measures. Additionally, the MCH Epidemiologist collaborated with MCAH Section programs to develop a dashboard displaying program performance measures.

3. Objective 1.3: Supporting data needs associated with annual preparation of the Title V MCH Block Grant application/annual report

   2024-2025 Progress: The MCH Epidemiologist supported data collection and reporting needs for the Annual Title V MCH Block grant application and annual report during the reporting period through coordinating data requests to OOA, and MCAH programs. The MCH Epidemiologist also conducted a literature review and gathered additional data relevant to Nevada's MCH population to supplement FAD data. They also attended several TVIS learning lab sessions.

4. Objective 2.1: Strengthening access to data and/or data linkage across the 5-year funding cycle

   2024-2025 Progress: The MCH Epidemiologist attended a PowerBI course during the reporting period to lead the creation of a dashboard displaying performance measures for each of the MCAH programs. Dashboards will also display program information, and the demographics served. Such tracking will allow for continued program evaluation and quality improvement. Furthermore, the MCH Epidemiologist seeks to create a MCH Data work group consisting of epidemiologists and biostatisticians across fields under Nevada Health and Human Services, that work with data involving MCH populations. The MCH Epidemiologist also serves as the Lead PRAMS Coordinator and is working to increase linkages with PRAMS data.

5. Objective 2.2: Collaborating with appropriate state agencies to assure access to and sharing of MCH data

   2024-2025 Progress: The MCH Epidemiologist worked with the OOA Biostatician and GIS Analyst on cross agency data requests including but not limited to MCH data, vital records, environmental data, Critical Congenital Health Disease (CCHD), Early Hearing Detection and Intervention (EHDI), Medicaid, PRAMS, Maternal Mortality and Sever Maternal Morbidity data. During the reporting period the Deputy Bureau Chief and RN Maternal Mortality Review Committee Abstractor both worked on publishing a bi-annual MMRC report and abstract poster presentation.

6. Objective 2.3: Strengthening information exchange and data interoperability

   2024-2025 Progress: The MCH Epidemiologist worked with the OOA Biostatician to aggregate data in meaningful ways and cross-tabulation data and this work will continue through the rest of the reporting period. The

CSTE fellow has collaborated with the OOA to revise Nevada's Critical Congenital Heart Disease Surveillance system and screening tracking. Furthermore, the CSTE Fellow has been working with local health authorities to improve northern Nevadan's Fetal and Infant Mortality Surveillance.

7. Objective 3.1: Assessing the progress of Title V programs, policies, or initiatives in achieving health for all populations

   2024-2025 Progress: The Deputy Bureau Chief and RN MMRC Abstractor aided in evaluating the recommendations of the MMRC to implement recommendations and, reported them in the bi-annual MMRC report that went to the Legislative Counsel Bureau (LCB) for consideration of policy change. This report also contained joint recommendations of the MMRC and Nevada Office of Minority Health and Equity (NOMHE) Advisory Committee. NOHME added valuable expertise for achieving health all Nevadans.

8. Objective 3.2: Integrating social determinants of health (SDoH) metrics to inform Title V programming

   2024-2025 Progress: The MCH Epidemiologist, Title V MCH Manager and MCAH Section Manager met several times in the reporting period to discuss how to incorporate SDoH into the Title V Evidence-Based Measures (ESM) and will continue this work throughout the reporting period.

9. Objective 3.3: Developing workforce and products to drive improved MCH outcomes and achieve health for all populations

   2024-2025 Progress: The SSDI Program has assisted in incorporating new evaluation measures throughout Title V MCH partners. This work is ongoing but is beginning with the roll out of a new application process to receive ongoing MCH funding. Part of this application includes a more in-depth scope of work that incorporates stronger evaluation measures. The application also requires the partner to complete a health plan as part of the completed application and must include one activity demonstrating how they will achieve this goal during the subaward period. The work on improving health outcomes for MCH populations is ongoing.

10. Objective 4.1: Supporting the state to address emergencies and emerging issues/threats

    2024-2025 Progress: The SSDI Program has supported cross agency efforts to decrease rates of congenital syphilis throughout the reporting period. The SSDI Program will continue to support the state for ongoing emergencies and emerging issues and threats, including ongoing work on congenital syphilis; a presentation on this topic was provided at the AMCHP SSDI meeting by Nevada staff.

11. Objective 4.2: Providing support for ongoing data collection, analysis and reporting needs

    2024-2025 Progress: The SSDI Program supports all data collection, analysis and reporting needs across the Maternal, Child, and Adolescent Health Section and will continue efforts in this area.

Significant Changes

The change in staff is the SSDI Program Manager, Max Moskowitz, MPH, who left the position in December 2024. In the interim, the MCAH Deputy Bureau Chief has fulfilled job duties up until July 2025. Colleen Barrett, MPH began the SSDI Program Manager position in July 2025. The Registered Nurse, Robyn Cunnally, is still holding her position. The SSDI Program has not made changes that impact the methodology for achieving goals and objectives. Program will expend the funds from the SSDI Manager vacancy in support of program scope of work.

Plans for the Upcoming Budget Year

The SSDI Program will continue to work on the objectives outlined above. In addition to all objectives work, the major events that will continue to occur in the upcoming budget year is the Title V Block Grant, improving program evaluation, and continuing to support data collection and analysis for the MCAH section.

III.C.1.b.ii.e. Other Data Capacity

Other MCH Data Capacity Efforts

As mentioned previously, Nevada DHS formed a centralized Office of Analytics and Title V MCH funds positions within the group to assist with MCH data capacity efforts.

Nevada PRAMS surveillance has been ongoing since 2017 to collect state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. Title V MCH provides funding to PRAMS to assist in promotional efforts to help increase response rates to the survey and has provided funding in the past for supplemental survey questions. Data has been collected since September 2017, and supplemental questionnaires have been conducted on opioid, disability, and COVID-19 information. Data from PRAMS has been presented to outside partners. Data is also presented at various DBPH Programmatic meetings such as with WIC and Nevada's State Immunization Program. PRAMS data is also utilized for Nevada performance measure reporting on safe sleep and directs Title V programmatic efforts. Nevada's CSTE Applied Epidemiology Fellow is collaborating with the Office of Analytics to launch a PRAMS dashboard which would display key indicators and question stratified by demographic variables.

Additionally, the MCH and CSHCN Directors work as support staff for the MMRC using the Maternal Mortality Review Information Application (MMRIA) data collection system. Every two years, the MMRC is required to submit a biannual data and recommendations legislative report. The CDC MCH Assignee produced an updated infographic shared in presentations to community groups on MMRC key data points and recommendations and MMRC support staff drafted a biennial legislative MMRC report and shared and presented widely. NOMHE Advisory Board were presented to on two occasions on MMRC-related topics and for soliciting recommendations for reporting.

The MCH Epidemiologist and CDC Assignee position maintains the Power BI Data Dashboard, publicly displaying Title V FAD. The dashboard includes Nevada trends, comparisons to national benchmarks, and breakouts by indicators such as demographics and urban-rural residence for all Title V MCH national performance measures and national outcome measures. The dashboard is updated annually in April to coincide with the publication of the updated FAD.

The CSHCN Coordinator is responsible for maintaining the Nevada CCHD Registry. The purpose of the Nevada CCHD Registry is to ensure all children born in Nevada are screened for CCHD at birth and those identified with CCHD receive timely and appropriate medical intervention. The CSHCN Coordinator receives monthly CCHD reports from hospitals, compiles them in a database, and then uses that data for annual reports.

Title V MCH faces a few challenges in improving the use of MCH data. Staffing turnover presents issues with keeping staff members trained on data sources. Still, recent efforts have been made to create redundancy in training on the use and implementation of data systems. Building capacity in quantitative, qualitative, and data evaluation capacity is ongoing. Since MCAH added a CDC MCH Assignee in October 2022 they have helped to increase MCH epidemiological capacity for review of congenital syphilis data, evidence-based strategy measures, infant and maternal mortality, attention deficit hyperactivity disorder (ADHD) data analysis, and overall support of more robust data capacity. Unfortunately, the CDC MCH Assignee was terminated due to the federal reduction in force in 2025. The loss of vital epidemiological training and capacity is currently being felt as all remaining data support is descriptive and lacks predictive analytic capacity.

III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Title V Program Partnerships, Collaboration and Coordination

The MCAH mission is to improve the health and wellbeing of Nevada's pregnant persons, women of childbearing age, infants, children, and youth, including CSHCN, and their families to protect and advance health, safety, and quality of life through the development of partnerships, education, health promotion, and disease and injury prevention. MCAH staff understand active engagement of families, caregivers, and communities are integral to positively impacting the health of MCH populations.

The Title V MCH Program collaborates with a network of partners, collaborators, and agencies to support a systems-based model of delivering public health and enabling services to Nevada's MCH populations. Partnerships include the local Family to Family Health Information Center – Family Navigation Network, state agencies, LHAs, the Nevada System of Higher Education (NSHE), non-profit organizations, MCH Coalitions, community partners, and advocacy groups.

DHS formed an Office of Analytics under the Director's Office to consolidate data capacity and facilitate cross

training and data analytics support. Title V MCH continues to fund a MCH Biostatistician and Health Resource Analyst (HRA) and MCAH has two HRA positions located in the Office of Analytics working with NHV data. These positions are crucial in increasing MCH data support and analytics capacity, accessing primary data and generating analyses and reports on behalf of MCAH and Title V MCH. Title V MCH continues to integrate with SSDI which enhances Nevada Title V MCH data capacity to allow for informed decision making and resource allocation supporting effective, efficient, and quality programming; MCAH created a PRAMS, SSDI, MCH Epidemiology organizational unit to foster cross-training and data supports. The MCH and CSHCN Directors and Office of Analytics Manager meet regularly with staff in relation to MCAH data needs.

The MCH Program plans to enhance evaluation activities around National Performance Measures (NPMs). MCAH PRAMS, MMRC and AIM efforts support enhanced surveillance capabilities benefiting the MCH Program.

Other programs with in DPBH Title V team members with partner to promote and implement Title V MCH priorities in Nevada include: the Office of Analytics, Nevada Home Visiting, EHDI, Teen Pregnancy Prevention (TPP), NGCDD, IDEA Part C Office, NEIS, the NOMHE, PCO, Oral Health, NHV, Community Health Services, Account for Family Planning, Office of Vital Records, ADSD, OSP, OSE, SAPTA, DCFS, CDPHP, WIC, and the Nevada State Immunization Program (NSIP).

The Children's Health Insurance Program (CHIP) provides coverage to low- and moderate-income children. Nevada Medicaid is administered through the DHCFP, with enrollment administered by the DSS for Nevada Check Up, Nevada's CHIPRA of 2009 Program and Medicaid. Both FFS and MCOs operate in the state. Rural areas are served by FFS providers and the urban areas of Clark and Washoe counties are served by contracted MCO providers, but rural areas move to MCOs in 2026. Tribal members can choose FFS or MCOs in urban or rural areas.

DHS and DBPH partner with 27 Tribes across Nevada through a Tribal Consultation Process Agreement to strengthen ties with Tribal Governments. Dignity Health, a Title V MCH partner, is funded by MCH to distribute car seats and provide safe sleep education and safe sleep bundles and injury prevention information as part of the MCH injury prevention pilot developed with key staff at participating Tribal Nations.

Title V MCH partners with WIC, NHV, MCH statewide coalitions, breastfeeding coalitions, community-based programs, LHAs, NSIP, the public, and private partners to increase breastfeeding rates by improved access to breastfeeding supports for new mothers. Breastfeeding campaigns and an MCH-administered website increase awareness, promote breastfeeding services, and normalize breastfeeding in public locations in partnership with WIC staff and the Nutrition Unit Deputy Bureau Chief.

Title V MCH funds the NICRP to conduct an annual health survey of children entering kindergarten, in partnership with all school districts.

Other state and local public and private organizations funded by MCH include Children's Cabinet, NNPH FIMR, University of Utah Medical Home Portal, Nevada 211, Nevada Broadcasters Association, Yoga Haven and Statewide MCH Coalitions. Information and materials disseminated by these partners are required to be accessible and appropriate. Translation support is provided by a service agreement. Children's Cabinet Nevada Pyramid Model provides technical assistance and facilitates ECE staff and parent involvement in social emotional Pyramid Model activities to support developmental screening.

Yoga Haven provides trauma-informed yoga to disproportionately affected youth. The Regional Emergency Medical Services Authority (REMSA), in addition to distributing car seats, provides safe sleep media outreach, and distributes Infant Safe Sleep Survival Kits to families experiencing disadvantage statewide via partners.

Nevada Broadcasters Association is funded to promote Safe Sleep, PRAMS, and Sober Moms Healthy Babies public service announcements (PSAs). The Statewide MCH Coalition is funded to support website maintenance, communication, maternal mental health and other MCH trainings, promote Go Before You Show campaign, and plan conferences for meeting community needs of diverse populations and focusing on specific MCH NPMs.

The Nevada Title V MCH Program will continue collaborations with public and private partners to improve the health of the Nevada MCH populations in areas of need identified by state data, federally available data (FAD), and Needs Assessment feedback.

Efforts to Operationalize the Five-Year Needs Assessment

Efforts to operationalize the Nevada 2020-2025 -Year Needs Assessment include the addition of NPM Safe Sleep (SS) and NPM Transition (TR). NPM SS includes three parts: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding. PRAMS data is used for Evidence-based Strategy Measure (ESM) 5.1 to monitor safe sleep efforts*. The 2020 needs assessment and FAD indicated safe sleep as a priority. Title V MCH efforts to increase the percentages of infants placed in a safe sleep environment include the Cribs for Kids Program through Dignity Health, statewide PSAs on radio and television, all coalitions and funded partners being required to promote safe sleep as a condition of funding, active participation in social media awareness of safe sleep in partnership with DCFS on DHS platforms, FIMR support and MCH staff service in reviews and data to action efforts, joint efforts with the Executive Committee of the Statewide Child Fatality Review (including on increasing provider capacity in relation to child abuse identification), and social media efforts with partners on safe sleep.

NPM TR, Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care, was added due to the needs assessment. Efforts to increase the percentages include partnering with the NCED for transition activities.

Ongoing activities with partners supported NPMs being retained due to the most recent needs assessment. Special attention to areas of disconnect between provider rankings and those of the public and community-based organizations (CBOs) is an area of particular interest with the 5-year needs assessment results. Promoting use of the needs assessment by partners and to help secure other funding has helped inform numerous grant applications. The needs assessment was made publicly available and shared with numerous partners statewide as a resource.

**Nevada PRAMS had a response rate of 43%, 33.6%, 30.5%, and 40.5% in 2020, 2021, 2022, and 2023 respectively, which is under the Center for Disease Control and Prevention (CDC) required response rate threshold of 50%. Interpret data with caution due to response rate.*

III.C.1.b.iv. Family and Community Partnerships

Family Partnership

Nevada Title V MCH staff collaborate with agencies, programs, and organizations at the local and state level to meet the needs of the state's MCH populations and the priorities in the 5-year plan. Nevada Title V MCH reaches families and consumers through these collaborations to receive input and recommendations on developing and implementing the programs provided to Nevada MCH populations. Using the Family Voices four domains of family engagement (commitment, transparency, representation, and impact), this section describes how the Nevada Title V MCH Program engaged families in programmatic initiatives.

Title V MCH aims to collectively enhance the well-being and quality of life for CSHCN while addressing critical areas health access, well-being and quality of life, access to services, and financing services.

Title V MCH funds Family Navigation Network (FNN) as Nevada's primary family partner. Funding FNN began July 2021, and like prior F2F partners funded, host a toll-free hotline and website for families to engage with staff to seek guidance on navigating healthcare systems. FNN employs family navigators and the State of Nevada Family Delegate, Marcia O'Malley, to provide care coordination to families of CSHCN. MCH also funds Nevada Pyramid Model Partnership, formerly known as Technical Assistance Center on Social Emotional Intervention (TACSEI), with Children's Cabinet which passes MCH funds through to Nevada Parents Encouraging Parents (PEP) to support

ECE provider and parent education on recognizing developmental delays.

FNN, along with Nevada Statewide MCH Coalition demonstrated a commitment to family partnership through funded partner activities. The contributions of many organizations to meet the needs of Nevada families include Maternal and Child Health Advisory Board (MCHAB), Nevada Governor's Council on Developmental Disabilities (NGCDD), Rare Diseases Advisory Council, Ryan White program at UNLV, Newborn Screening Advisory Council, ADSD, Early Childhood Advisory Council, and other partners. Nevada Title V MCH staff participated in the Nevada Early Childhood Advisory Council, Children's Advocacy Alliance, Families First, NGCDD and Interagency Coordinating Council, including persons living with intellectual and developmental disabilities and family representatives.

During quarterly MCHAB meetings, members of the public provided feedback and other information related to MCH populations. Furthermore, the Nevada Institute for Children's Research and Policy (NICRP) in partnership with all Nevada School Districts and DPBH conducted an annual health survey of children entering kindergarten. By completing the survey, parents and families provided a voice on the status of Nevada kindergartners. Survey information informed local efforts to improve future programming and the health of Nevadan communities. Nevada's Title V MCH Program funded the survey, partnering with NICRP.

Nevada Title V MCH staff and funded partners also had the support necessary to understand their family partnership role in programmatic activities and a clear understanding of how these activities increase family engagement statewide. Through training provided by HRSA, Family Voices, and other family-centered organizations, Nevada's Title V MCH Program staff and funded partners received evidence-based toolkits and information on assessing and increasing family engagement.

Representation was achieved by focusing efforts on statewide groups, including demographic, socioeconomic, rural/frontier geographical, and rare or complex disease populations. FNN staffs a bilingual (Spanish) hotline for CSHCN and their families. The Children's Cabinet Nevada Pyramid Model Partnership has a Family Engagement Coordinator on staff to facilitate parent involvement, especially for those living in rural areas, in completing developmental screenings for children. Nevada Title V MCH staff also participated in the MSRGN where families with lived experience contribute to expanding genetics services in Nevada. Nevada's current Title V MCH Family Representative, Marcia O'Malley, serves as the Family Resource Coordinator for FNN, and facilitates connections between the Title V MCH team and families in Nevada. The Title V MCH Family Representative attends monthly Title V MCH unit meetings, MCHAB meetings, and the Association of Maternal and Child Health Programs (AMCHP) Conference annually as the Family Delegate, providing input on program goals and activities from the family perspective. Participation in the annual HRSA review process allowed for integration of the family perspective during feedback for the next application year.

Program impact has been measured by assessing current ESMs, listening to partner feedback concerning programmatic activities, working with funded partners to implement strategies to improve family partnership as outlined above, and evaluating how partners contributed to meeting NPMs. Evaluation occurred through a review of quarterly reporting, weekly Title V MCH team discussions, MCH Navigator training, and biweekly or monthly partner check-ins. To improve impact in the application year, Nevada Title V MCH will continue to explore opportunities to engage family leaders in outreach. MCH will also explore broadening the reach of the Family Representative, FNN, and others in engaging more diverse family leaders' input to improve programmatic activities and goals beyond the northern Nevada area to ensure their reach is significant in other parts of the state as their subaward requires.

III.C.1.c. Identifying Priority Needs and Linking to Performance Measures

Identifying Priority Needs and Linking to Performance Measures

MCAH staff, partners, participants in previous needs assessment activities, and identified partners 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, Office of State Epidemiology
- Nevada Department of Behavioral and Public Health, 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 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. For more details on the priority ranking system used, please refer to the supplemental document titled, "Final Needs Assessment Report."

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 show an increase in adolescents 13-who 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 homeless 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 on2022- 2023 NSCH data, only about 10% of adolescents with mental health disorders received treatment, 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)

CSHCN

Participants represented autism services, newborn hearing screening, parent navigators, and parents of CSHCN. Participants discussed how mental health impacts both CSHCN 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 CSHCN and their families or caregivers. NSCH 2022-2023 data estimates that about 26% of Nevada CSHCN 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)

III.D. Financial Narrative

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,236,205	$2,063,585	$2,236,205	$2,222,063
State Funds	$1,677,154	$1,757,910	$1,677,154	$1,677,154
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$3,913,359	$3,821,495	$3,913,359	$3,899,217
Other Federal Funds	$111,476,910	$44,836,700	$65,694,319	$64,441,593
Total	$115,390,269	$48,658,195	$69,607,678	$68,340,810

	2024		2025	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,236,205	$2,118,567	$2,236,205	
State Funds	$1,677,154	$1,588,926	$1,677,154	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$3,913,359	$3,707,493	$3,913,359	
Other Federal Funds	$53,926,817	$64,674,787	$75,417,797	
Total	$57,840,176	$68,382,280	$79,331,156	

	2026	
	Budgeted	Expended
Federal Allocation	$2,450,000	
State Funds	$1,837,500	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$4,287,500	
Other Federal Funds	$66,596,760	
Total	$70,884,260	

III.D.1. Expenditures

III.D.1 Expenditures

Federal Fiscal Year 2024 Application - Expenditure Narrative

In FFY 2024, the Nevada Title V MCH Program expended $2,118,567 in federal funds and $1,588,926 in state match funds for a total of $3,707,493. The state match funds are comprised of $854,897from the State General Fund and $734,028 in-kind contributions from the Nevada Broadcaster's Association. FFY 2023 state match funds expended meet Nevada's maintenance of effort amount of $853,034.

Budgeted vs. Expended by Types of Individuals Served:

The $2,286,437 award received for FFY 2024 was 2.2% higher than the budget of $2,236,205 submitted for FFY 2024. The expended amount of $2,118,567 was 7% lower than the amount received for FFY 2024.

Pregnant Women:

Budget: $255,706
Expended: $273,311
Variance: Expenditures are 7% more than budgeted.
Expenditure sources included but were not limited to:

- Dignity Health and the MCH Coalition, Pregnancy Risk Assessment Monitoring System, Nevada 211, needs assessment, and media campaigns for SoberMomsHealthyBabies.

Infants <1 year old:

Budget: $300,431
Expended: $302,235
Variance: Expenditures are 1% more than budgeted.

Expenditure sources included but were not limited to:

- Fetal infant mortality review in Washoe County, Cribs4Kids, media campaigns for safe sleep, and the Nevada Breastfeeds website.

Children 1 to 22 years old:

Budget: $ 670,862
Expended: $680,835
Variance: Expenditures are 1% more than budgeted.

Expenditure sources included but were not limited to:

- Yoga Haven trauma informed yoga for youth, Carson City Health and Human Services, the needs assessment, adolescent well-visit promotion, and the Nevada Institute for Children's Research and Policy kindergarten health survey.

Children with Special Healthcare Needs:

Budget: $670,862
Expended: $782,312
Variance: Expenditures are 17% more than budgeted

Expenditure sources included but were not limited to:

- The Nevada Medical Home Portal and associated social media campaigns, Family Navigation Network, Nevada Center for Excellence in Disabilities, Nevada 211, Pyramid Model with Children's Cabinet, and the needs assessment.

Others:

Budget: $114,725
Expended: $42,466
Variance: Expenditures are 63% less than budgeted
Expenditure sources included but were not limited to:

- Carson City Health and Human Services, Community Health Services, and Nevada 211.

Administration:

Budget: $223,619
Expended: $37,408
Variance: Expenditures are 83% less than budgeted

Budgeted vs. Expended by Types of Services:

Direct Health Care Services:

Budget: $0
Expended: $0
Variance: No variance

Enabling Services:

Budget: $559,051
Expended: $915,799
Variance: Expenditures are 64% more than budgeted

Public Health Services and Systems:

Budget: $ 1,677,154
Expended: $1,202,768
Variance: Expenditures are 28% less than budgeted

Variance in public health and enabling services are due to the categorization of what public health and enabling services are. Nevada Title V MCH received guidance on what items required recategorization between public health and enabling services which restricted the expenditures for both as well as form 5.

III.D.2 Budget

Federal Fiscal Year 2023 Application – Budget Narrative

The total estimated Federal Fiscal Year FFY 2026 Title V MCH budget is $4,112,500. As required, the state of Nevada's FFY 2026 application budget adheres to the required 3:4 match of three (3) state dollars for every four (4) federal dollars. The federal MCH portion is estimated, for budget purposes, at $2,325,000. State matching funds are budgeted at $1,787,500 and are comprised of State General Funds and in-kind contributions from Nevada State Broadcasters Association. The amount of state funds to be used to support Maternal and Child Health programs in FFY 2026 is shown in the budget documentation of the state application. We assure HRSA the $853,034 maintenance of effort requirement (FFY89 level of state funding) will be satisfied.

For FFY 2026, $784,000, 32% of the federal Title V allocation, is budgeted for Preventive and Primary care of Children and Adolescents. For FFY 2026, $833,000, 34% of the federal Title V allocation, is budgeted for Children and Youth with Special Health Care Needs. Administrative costs for Federal Fiscal Year 2026 are budgeted at $125,000, 5.2% of the MCH allotment. Administrative expenditure will not exceed this amount. The remaining FFY 2026 Federal Title V award is directed towards services for pregnant women, postpartum women, and infants up to age one year as well as other activities supporting MCH populations throughout the state.

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

Other Federal Funds

Nevada's Title V Program is housed in the Bureau of Child, Family, and Community Wellness. The Bureau also administers the following federal grant programs/funding streams totaling $66,596,760 in FFY26. All federally funded programs referenced below provide services to the populations served by the Maternal and Child Health Block Grant Program.

Administration for Children and Families

Sexual Risk Avoidance Education Program (SRAE)
Personal Responsibility Education Program (PREP)

Centers for Disease Control and Prevention

Early Hearing Detection and Intervention (EHDI)
Pregnancy Risk Assessment Monitoring System (PRAMS)
Rape Prevention and Education (RPE)
Preventive Health and Health Services (PHHS) Block Grant
Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees
National Comprehensive Cancer Control Program (NCCCP)
State-Based Diabetes Control Programs and Evaluation of Surveillance Systems
Tobacco Control Programs
Vaccines for Children/Immunizations
National Breast and Cervical Cancer Early Detection (NBCCEDP)
Comprehensive Cancer (NCPR)
WISEWOMAN

Health Resources and Services Administration

Maternal, Infant and Early Childhood Home Visiting Program (MIECHV)
Universal Newborn Hearing Screening
State Systems Development Initiative (SSDI)

United Department of Agriculture

Women, Infants and Children (WIC)

Budget by Types of Individuals Served

In FFY 2026, the Nevada Title V MCH program budgets the following federal and state match funds towards the individuals' served requirements:
Pregnant Women - $540,750
Infants < 1 year old - $622,000
Children 1 to 22 years old - $1,372,000
Children and Youth with Special Healthcare Needs - $1,457,750

All Others – $120,000

Total Budgeted by types of individuals served is $4,112,500 because the administrative costs of $175,000 are excluded in this calculation.

Budget by Types of Services

Nevada no longer allocates funds to direct health care (DHC) services and only budgets for Enabling Services and Public Health Services and Systems. In FFY 2026, the Nevada MCH program plans to allocate federal and state match funds as follows:

Direct Health Care Services - $0
Enabling Services - $1,071,875
Public Health Services and Systems - $3,215,625

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Nevada

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

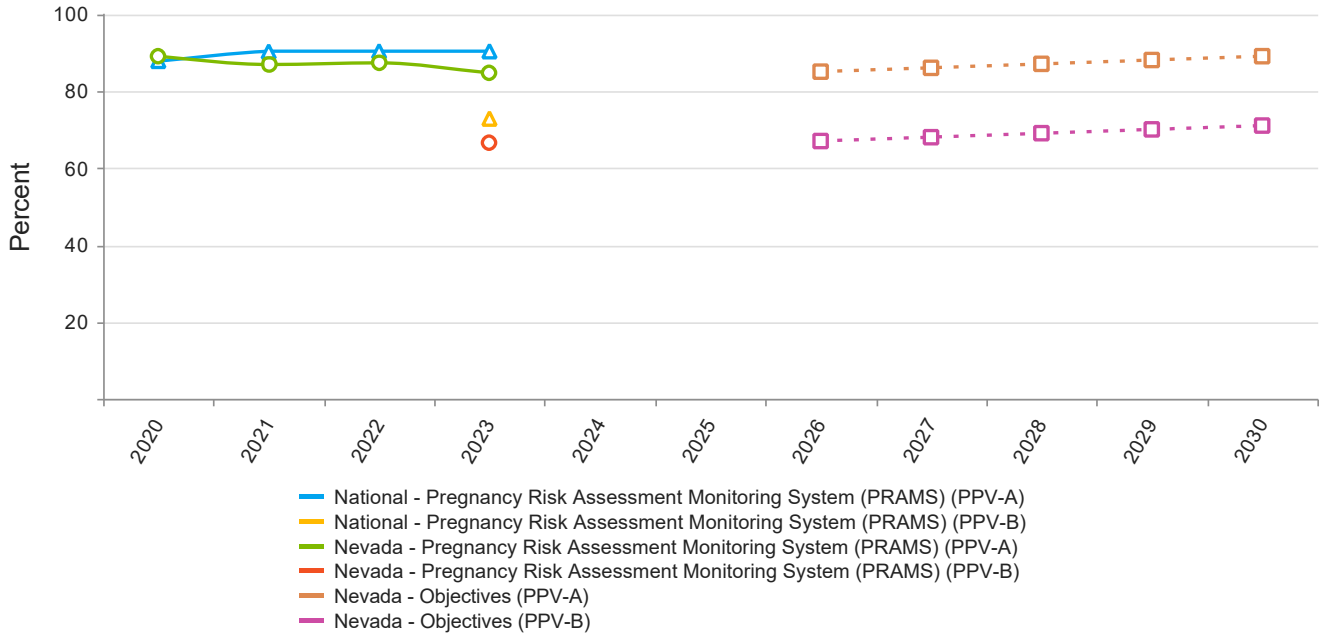
III.E.3 State Action Plan Narrative by Domain

If a Priority Population is selected for an NPM, then this section will display only the data associated with the Priority Population in the charts, data tables, and field notes. Additional NPM data are available in the Form 10 appendix.

Women/Maternal Health

National Performance Measures

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV
Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	84.6
Numerator	24,820
Denominator	29,327
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	85.0	86.0	87.0	88.0	89.0

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	66.5
Numerator	16,261
Denominator	24,466
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	67.0	68.0	69.0	70.0	71.0

Evidence-Based or –Informed Strategy Measures

ESM PPV.1 - Percent of WIC- and home visiting-enrolled families during pregnancy who received at least one postpartum visit

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	100.0	100.0	100.0	100.0

State Performance Measures

SPM 1 - Percent of mothers who reported late or no prenatal care

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective	4	3.5	3.5	4	3.5
Annual Indicator	3.3	2.9	4.3	4.9	8.3
Numerator	1,109	947	1,397	1,521	2,620
Denominator	33,261	32,932	32,475	30,925	31,749
Data Source	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	7.0	6.0	5.0	4.0	3.5

Evidence-Based or –Informed Strategy Measures

None

State Outcome Measures

SOM 1 - Congenital syphilis rate per 100,000 live births

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	244.3
Numerator	77
Denominator	31,514
Data Source	Nevada STI Morbidity Files
Data Source Year	2023
Provisional or Final ?	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	244.0	240.0	230.0	200.0	180.0

SOM 2 - Rate of common immunizations (TDaP, RSV, Flu, COVID-19) in pregnant women per 100,000 live births

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	70.0	71.0	72.0	73.0	74.0

State Action Plan Table

State Action Plan Table (Nevada) - Women/Maternal Health - Entry 1	
Priority Need	
Increase women that receive recommended clinical care components at the post partum visit and appropriate referrals	
NPM	
NPM - Postpartum Visit	
Five-Year Objectives	
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	
Strategies	
Increase the number of women who had a postpartum checkup after delivery	
Enhance/expand postpartum infrastructure	
ESMs	**Status**
ESM PPV.1 - Percent of WIC- and home visiting-enrolled families during pregnancy who received at least one postpartum visit	Active
NOMs	
Maternal Mortality	
Neonatal Abstinence Syndrome	
Women's Health Status	
Postpartum Depression	
Postpartum Anxiety	

State Action Plan Table (Nevada) - Women/Maternal Health - Entry 2

Priority Need

Improve access to prenatal and maternal health services

SPM

SPM 1 - Percent of mothers who reported late or no prenatal care

Five-Year Objectives

80% of pregnant women in Nevada will receive their prenatal care beginning in the first trimester Healthy People 2030 Goal (MICH-08): 80.5%

Strategies

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)
Collaborate with partners to reduce congenital syphilis rates in Nevada

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

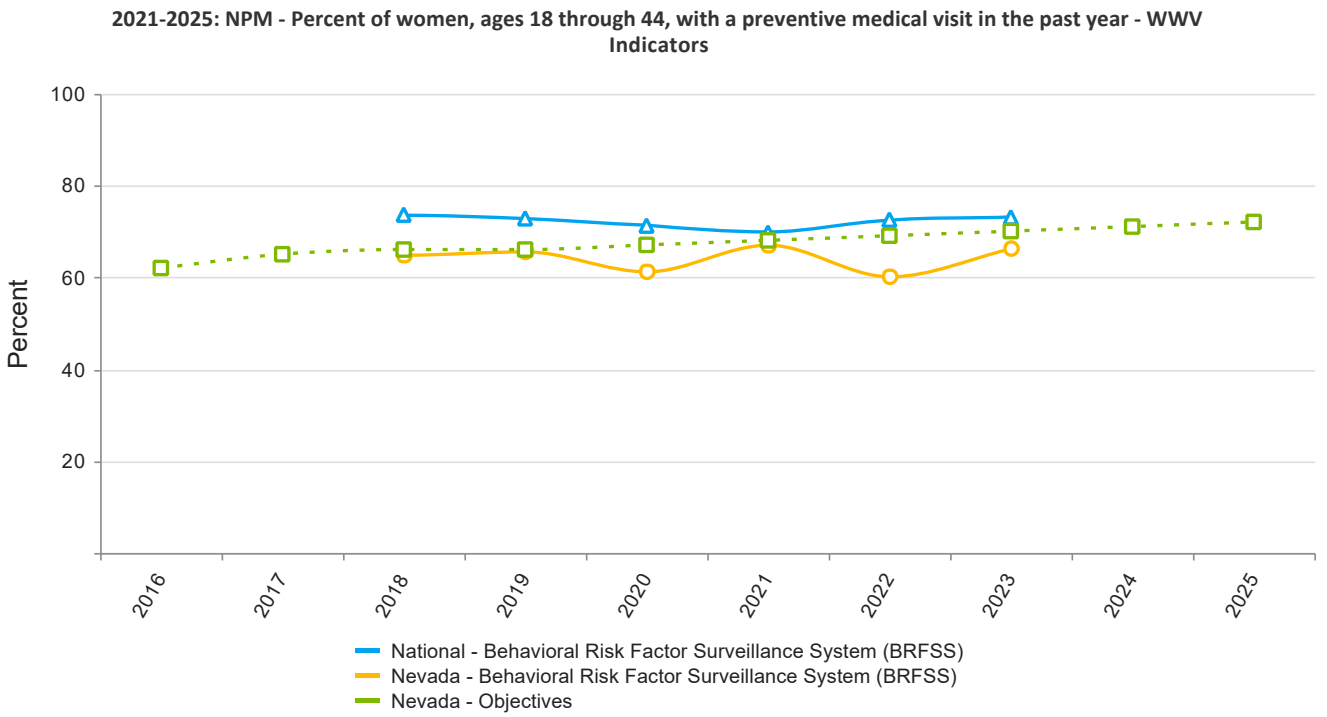
NOMs

Maternal Mortality
Low Birth Weight
Stillbirth
Women's Health Status

SOMs

SOM 2 - Rate of common immunizations (TDaP, RSV, Flu, COVID-19) in pregnant women per 100,000 live births

2021-2025: National Performance Measures

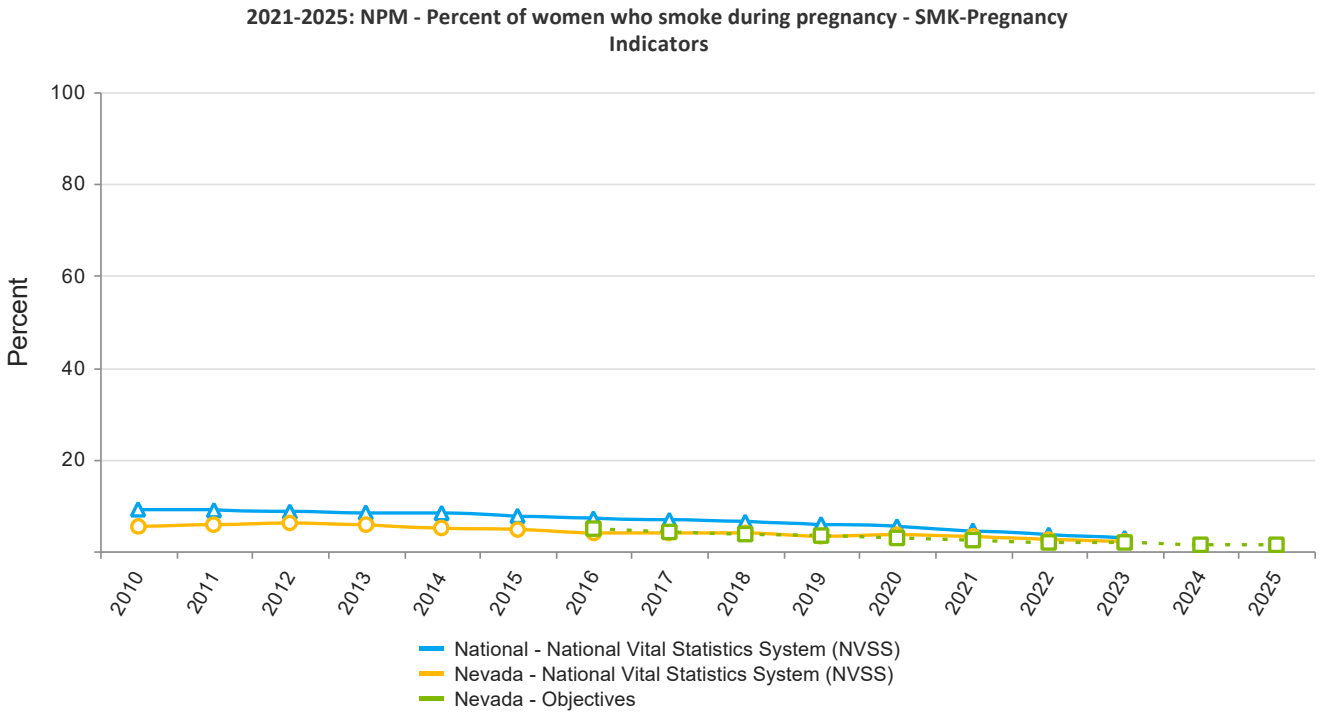


Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	67	68	69	70	71
Annual Indicator	65.6	61	66.8	60.2	66.2
Numerator	350,884	336,911	371,184	334,584	374,048
Denominator	534,782	549,775	555,602	556,095	565,262
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM WWV.1 - Percent of pregnant women who received prenatal care beginning in the first trimester

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	76	77	78	79	80
Annual Indicator	75.4	78.2	78.3	76.6	76.5
Numerator	24,800	25,391	25,922	24,920	23,836
Denominator	32,897	32,463	33,109	32,527	31,148
Data Source	Federally Available Data-NVSS	Federally Available Data-NVSS	Federally Available Data-NVSS	Federally Available Data-NVSS	Federally Available Data-NVSS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Provisional



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	3	2.5	2	2	1.5
Annual Indicator	3.5	3.6	3.3	2.7	2.3
Numerator	1,217	1,209	1,103	900	734
Denominator	34,682	33,260	33,380	32,993	31,574
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2019	2020	2021	2022	2023

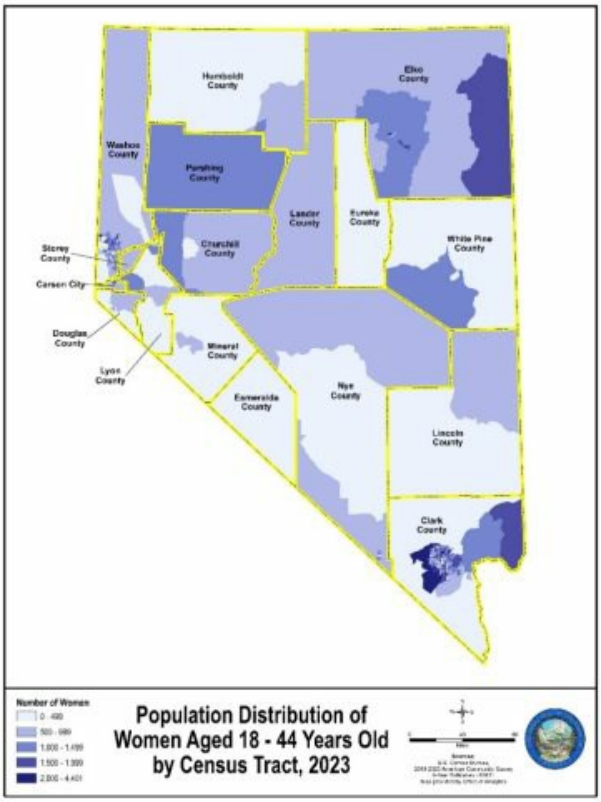
2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM SMK-Pregnancy.1 - Percent of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		92	92	94	95
Annual Indicator	91.9	91	93.7	93.3	89.9
Numerator	30,895	29,302	30,142	29,696	25,978
Denominator	33,607	32,210	32,174	31,812	28,905
Data Source	NV PRAMS	NV PRAMS	NV PRAMS	NV PRAMS	NV PRAMS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Provisional

Women/Maternal Health Report

The Women/Maternal Health report demonstrates how collaboration between agencies, partners, and the Title V Maternal and Child Health (MCH) Maternal and Infant Health Program (MIP) improves the health of Nevadans. The population of women, ages 18 through 44 years old (y.o.) is demonstrated by the Census tract in the map below.



The Nevada Title V MCH Program chose Standardized Measures (SM) for Well-Woman Visits (SM-WWV) and SM-Smoking (SMK)-Pregnancy to improve women and maternal health outcomes. Improving preconception and interconception health among women of childbearing age is a priority need in Nevada. Title V MCH funded partners implement strategies to increase the percentage of women, ages 18 through 44 y.o., with a preventive medical visit in the past year (SM-WWV), reduce the percentage of women who smoke during pregnancy (SM-SMK-Pregnancy), and reduce substance use in women of childbearing age. To address these priority needs all subrecipients share information promoting Nevada 211, the Nevada Tobacco Quitline (NTQ), and the Medical Home Portal (MHP; until its closure in July 2024) as part of their scopes of work. Specific program activities and successes related to these efforts are included below.

As part of the Title V MCH Program, MIP provides technical assistance, resources, and support to private and public agencies serving women ages 18 through 44 y.o. The MIP Coordinator worked closely with these agencies, as well as the Title V MCH Program Manager, Maternal, Child and Adolescent Health (MCAH) Section Manager, State Systems Development Initiative (SSDI) Manager, Centers for Disease Control and Prevention (CDC) MCH Assignee, MCH Epidemiologist, and MCH and Children with Special Health Care Needs (CSHCN) Directors, and CSTE Fellow to improve the health outcomes of women of childbearing age during the reporting period.

Nevada Home Visiting Report

The Nevada Home Visiting (NHV) Program supports agencies and organizations statewide in providing evidence-based home visiting services to pregnant women, mothers, fathers, and caregivers. The program aims to improve maternal and newborn health, enhance school readiness, and reduce child injuries, death, neglect, and abuse.

NHV addresses multiple MCH priorities, including:

- Improving preconception and interconception health
- Promoting breastfeeding
- Increasing developmental screenings
- Reducing teen pregnancy
- Reducing substance use during pregnancy
- Reducing infant mortality
- Increasing adequate insurance coverage for families

The Title V MCH Program collaborates with the NHV Program by sharing educational materials with NHV local implementing agencies. These programs are designed to provide comprehensive, coordinated health and social services, fostering continuous access to screenings and referrals for pregnant women and families with young children.

HIPPY programs (serving families with children aged 2-5 y.o.) help parents engage with their children in daily learning activities to help promote literacy and school readiness. The program fosters language development, problem-solving, logical thinking, and perceptual skills in children. EHS programs serve infants and toddlers under the age of 3 years and pregnant women. PAT serves expectant mothers and families with children up to kindergarten entry providing child development education, health education, activities to build cognitive and motor skills in children, screenings, and parent-child interaction coaching.

Home visiting programs offer a comprehensive set of screenings and referrals, including:

- Developmental and social development screening
- Birth spacing education
- Screening for insurance coverage
- Depression screening (both post-partum and general)
- Screening for domestic violence
- Screening for necessary needs (housing, food, clothing, and utilities)
- Substance misuse screening

Families with identified needs receive referrals and assistance with follow-up appointments and applications.

Agencies implementing NHV programs participate in Continuous Quality Improvement (CQI) efforts using Plan-Do-Study-Act (PDSA) cycles to test small changes aimed at improving service delivery and outcomes. Benchmark data from the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program are shared with the Title V MCH Epidemiologist and relevant staff for evaluation and program improvement.

The Nevada Home Visiting (NHV) Program, in collaboration with its Local Implementing Agencies (LIAs), participates in a core competency certification program through the Essentials of Home Visiting. This professional development initiative includes self-paced coursework designed to build foundational skills and strengthen core competencies.

In 2024, the NHV Program provided vital support to families across the state through its network of Local Implementing Agencies.

During the year, NHV served:

- 400 households
- 448 children
- 10 parents under the age of 17
- 64 pregnant women, including 33 under the age of 21

These figures reflect NHV’s ongoing commitment to supporting families with young children, particularly those facing heightened challenges during pregnancy and early parenthood.

The Nevada Statewide Maternal and Child Health (MCH) Coalition Report

The Nevada Title V MCH-funded Statewide MCH Coalition conducted community outreach and public awareness of the Title V MCH priorities per the direction of MIP and in alignment with select PMs. The Coalition hosted the Policy Center for Maternal Mental Health Annual Forum statewide for the second year, from March 19 – March 20, 2024, by purchasing a group link for coalition members to join virtually. The Coalition continued joining virtual meetings and webinars to conduct outreach and provide continuing education. Many community partners held in-person resource fairs and events that Title V MCH Program staff attended.

Monthly Coalition meetings (17 in total between Southern and Northern Nevada coalitions) continued virtually to best accommodate the most attendees. The Northern NV MCH Coalition held a few hybrid meetings to get more involvement, and they hope to increase the in-person attendance in the new federal fiscal year. The Southern NV MCH Coalition continues to provide at least two in-person meetings with a mixer held after to allow attendees to network.

The Coalition continued to be involved in the community with individual outreach as well as collaborative events that demonstrated support and provided education/resources for breastfeeding, preconception and interconception health, developmental screenings, perinatal mental health, safe sleep, marijuana use during pregnancy, and other statewide resources.

Social Media outlets continued to grow with Facebook totaling 646 page likes and 739 followers. Instagram totaled 1.1K followers and TikTok reached 33 followers. Social posts included awareness and support for the following programs: Sober Moms Healthy Babies (SMHB), Nevada 211, MHP, NTQ, Go Before You Show, Count the Kicks, breastfeeding, safe sleep, lead poisoning information, and several additional community programs and events. The MCH Coalition website saw continued growth throughout the year, totaling 9,620 visitors.

October 2023-September 2024	Facebook Likes	Facebook Followers	Instagram Following	TikTok Following	Website Total Visitors
October	599	678	1021	31	370
November	599	678	1027	31	676
December	601	683	1033	31	428
January	602	685	1047	31	412
February	610	690	1055	32	604
March	614	699	1055	32	694
April	614	700	1058	33	545
May	614	701	1060	33	636
June	613	698	1070	33	592
July	622	707	1094	33	799
August	630	720	1100	33	2919
September	646	739	1143	33	949
Total for Grant Year	**646**	**739**	**1143**	**33**	**9624**

The Coalition was able to promote the program through purchased ads on both Facebook and Instagram for Guide by Your Side (GBYS), Perinatal Mental Health Disorders (PMHD), the Coalition website, and the annual Fall Symposium.

In January 2024, the Southern NV MCH Coalition worked with the Health Plan of Nevada (HPN) to secure a $19,023 sponsorship to provide New Mama Care Kits (NMCK) to mothers in Southern NV and the surrounding rural areas. The Southern NV MCH Coalition distributed the kits to over 26 different community partners. A total of 1,303 kits were distributed statewide (955 in Southern Nevada and 348 in Northern Nevada). Northern NV MCH Coalition also secured a $10,000 sponsorship from HPN to start the NMCK in Northern Nevada and surrounding rural areas.

In February 2024, NV MCH Coalition was awarded an additional $113,771 to provide training to community partners, education and safe sleep bundles to parents and caregivers, and to promote the 12 steps of safe sleep throughout the state. Since receiving these funds, the Coalition has trained 28 new partner staff, distributed 952 safe sleep kits, and distributed 60 car seats to Nevada families through community partners.

In August 2024, NV MCH Coalition amended their subaward to enhance the NMCK for mothers statewide to include diaper bags, breast pumps, breastfeeding essential kits, infant development books, and more. The Southern NV MCH Coalition distributed the kits to over 25 different community partners, and the Northern NV MCH Coalition distributed kits to ten different community partners.

Included as supplement is the distribution tracking of the care kits for FFY2024 (Supporting Document – New Mama Care Kits Distribution).

The NV Statewide MCH Coalition held the annual Fall Symposium, titled “Camp Treasure: Navigating the Deep Sea of Maternal and Child Health,” with both an in-person option in Reno, NV, and a virtual option. Camp Treasure had 213 registered attendees with 145 actual attendees: 76 virtual and 69 in person. The following topics were discussed over eight sessions: Supporting Children Experiencing Violence in the Home, Navigating Family Support with the NCED [Nevada Center for Excellence in Disabilities] Family, All About Syphilis, Social Determinants of Health in Our Communities, Culturally Congruent Doula Care, An Empowered Approach to Supporting Pregnant and Postpartum Individuals Experiencing a Substance Use Disorder, Reflecting on Pregnancy Loss and Birth Experiences, with a keynote discussion on Strength in Struggles, Resilient Mothers and Healthy Futures. This year’s symposium was well received by community members and key partners.

Success Story from Support Group Facilitator:

About five months ago, a new mom joined our support group and showed clear signs of distress. At first, she wasn’t comfortable sharing much of her story and kept her participation brief. By the following week, however, she had opened up more, revealing her struggles. She had recently moved to a new city where she knew no one except her husband. The isolation, combined with managing postpartum anxiety and caring for a special needs child, left her feeling lost and defeated as both a mom and a partner. During her emotional moment of sharing, we reassured her that her feelings were valid and encouraged her to continue attending the group. What I didn’t realize at the time was that she had exchanged numbers with some of the other moms. Soon, she began meeting up with them for outings and building connections outside of the group. Over the next few months, this mom truly blossomed. She gained confidence, found her footing, and even stepped into a leadership role by becoming the group’s substitute instructor after completing training. Today, she has more good days than bad and is fully immersed in the community she helped create with the other moms.

Perinatal Mental Health Disorders and Maternal Mental Health

Title V MCH funding supports a PMHD Coordinator position through Dignity Health to enhance Statewide MCH Coalition efforts. This position works to educate health care professionals and MCH partners about recognizing, assessing, and referring persons to accessible services and resources for PMHD, and promoting emotional and psychological support services to persons diagnosed with PMHD to assist in recovery. The PMHD Coordinator also facilitates a PMHD support group for parents who can receive support, referrals, and information they may need to access additional resources in the community. The PMHD Coordinator renewed her Postpartum Support International (PSI) membership to ensure she is staying current with all updated information, resources and education to support perinatal mental health.

The PMHD Coordinator held 16 trainings for the community. These trainings were held virtually and in-person. Trainings were attended by: University of Nevada, Las Vegas (UNLV) Pediatric Residents, Women, Infant and Children (WIC) Program staff, College of Southern Nevada’s (CSN) Community Health Worker (CHW) students, Well-Rounded Momma, Nevada Division of Child and Family Services (DCFS) staff, and several interested community members. The PMHD Coordinator continued to conduct outreach to organizations including OB/GYN offices, therapists, doulas, the Southern Nevada Health District, local WIC offices, and other local programs. The PMHD Coordinator collaborates with HPN’s Behavioral Health Options to help PMHD families across the state navigate their care and available resources. Additionally, in collaboration with the UNLV Kirk Kerkorian School of Medicine, trainings were provided to current and active pediatricians in Nevada.

The Title V MCH Program continues to promote the Health Resources and Service Administration’s (HRSA) Maternal Mental Health Hotline through website postings and sharing with relevant partners, as well as AWHONN Maternal Warning Signs.

Women’s Health and Wellness Outcomes

The Title V MCH Program continued to participate in efforts to promote reproductive health, family planning, and access to care/services. Staff worked with the Account for Family Planning (AFP) Program, Personal Responsibility

Education Program (PREP), and Sexual Risk Avoidance Education (SRAE) Program, and other key partners to promote informed reproductive choices and education to support reproductive life planning. Quality improvement of Infant Plan of Safe Care processes continued, as did efforts to create robust wraparound care and referrals for patients who are pregnant and using substances. The Title V MCH Program continued efforts to increase NTQ engagement among pregnant women.

Nevada's Alliance for Innovation in Maternal Health (AIM) Program and the Nevada Maternal Mortality Review Committee (MMRC) work to reduce preventable maternal mortality and severe maternal morbidity. Exploration of perinatal quality improvement efforts more broadly continued as a possible space to leverage efforts of perinatal groups. Development of more robust maternal and perinatal data evaluation is pending to present timely key indicators of MCH health. Title V MCH continues to investigate opportunities to expand NHV capacity to serve more families through additional funding streams. The Title V MCH and NHV teams continued to participate in early childhood support and systems building initiatives focused on referral pathway supports and data integration.

Maternal-focused websites, social media and print campaigns, and sponsoring conferences for information sharing and collaboration are ongoing. MCAH staff routinely provide trainings to external partners.

Public Health Clinic Wellness

The Title V MCH Program funded nine public health clinics to improve maternal and women's health among those aged 18-44 y.o. These entities included Carson City Health and Human Services (CCHHS), a local health authority in Northern Nevada, and eight Division of Public and Behavioral Health (DPBH) Community Health Services (CHS) nursing clinics providing services in Nevada's rural areas. Clinic assessments, education, reproductive education, and resources provided were based on nationally accepted standards of practice. All nurses are mandatory reporters and educated in the recognition of patients at risk for human trafficking, neglect, and abuse. Staff are trained in delivery care and trauma-informed care.

Through community events and clinic visits, staff distributed women's health-related materials. Topics encompassed the value of no-cost yearly checkups, reproductive and sexual health (including long-acting reversible contraception), healthy pregnancy outcomes, recommended immunizations, depression, and intimate partner violence. The Title V MCH Program provided resources about GBYS, NTQ, MHP, SMHB, the Pregnancy Risk Assessment Monitoring System (PRAMS), Text4Baby, Nevada Breastfeeds, and Nevada 211.

During clinic visits, SM Well-Woman Visit and NPM Transition were promoted. Individuals were educated on the value of an annual preventive medical visit to align with SM Well-Woman Visit. Those with adolescents in the household were informed about the importance of helping their children transition from pediatric to the adult health care system to address NPM Transition.

Individuals were screened and educated on use of alcohol, tobacco/nicotine, recreational drugs, depression issues or suicidal thoughts, and consequences of intimate partner violence. Referrals were provided for individuals needing services. CCHHS used CAGE, an evidence-based substance/alcohol use screening tool. The acronym is derived from the four questions of the tool: Cut, Annoyed, Guilty, and Eye. CAGE asks about (1) thoughts of cutting down, (2) annoying others or been criticized about their use, (3) feeling bad or guilty about using, and (4) drinking/using substances first thing in the morning to rid hangovers or steady nerves. CCHHS reported an increased patient willingness to accept a treatment referral due to use of the evidence-based tool.

CCHHS provided wellness screenings and education to 858 women. Racial/ethnic groups served were primarily Hispanic (10%) followed by Non-Hispanic White (60%), Non-Hispanic American Indian/Alaskan Native (2%), Non-Hispanic Native (2%), Non-Hispanic Black (2%) and the remaining identifying as other racial groups (24%). Referrals were made for those experiencing depression (18%), for people who used substances, alcohol or nicotine/tobacco (5%) and for women affected by intimate partner violence (3%). All people who used substances were provided with information about the SMHB website.

CCHHS promoted health and wellness messages through community events, clinic digital signage, and social media campaigns. CCHHS reached 900 families through several community events. Individuals driving by or walking into the building could view the promotional campaigns on the signage. Facebook messages promoting yearly well-visits reached 701 people with 1.0% engaged users.

CHS nurses from eight rural clinics provided wellness screenings, preventive information, and referrals. Program funding supported purchases of sexual and reproductive health screenings and the provision of health education during preventive visits. CDC guidelines were used for education to avoid sexually transmitted infections (STIs) and communicable diseases, as well as to develop a treatment protocol. CHS hired a Client Technologies Specialist to improve electronic health record (EHR) reporting capabilities allowing program staff to obtain reliable data. Patagonia's platform does not allow for both billing and reporting on patients receiving more than one service in a single visit. Solutions were implemented allowing for robust data collection. CHS is exploring connecting Power BI to the EHR database creating a replica of the Title V MCH Program reporting figures allowing for ease in completing reports for the next reporting period.

CHS administered 1,007 vaccinations. Of those served, 122 (12.1%) were under one year of age. 510 (50.6%) were between 1-21 y.o., and 375 (37.2%) were between the ages of 22-44 y.o. CHS staff provided 739 preventive screenings. Of those who received preventive screening(s), 218 (29.5%) were 12-17 y.o. and 521 (70.1%) were 18-44 y.o.

CHS Success Story

A young woman (<18 years old) left a message to express how she appreciated both the warmth of the front office and the way she was treated regarding her questions and concerns. She mentioned she was afraid of being ignorant of the process. She was there to initiate birth control but was made to feel okay about not knowing everything, and all her questions were answered. The stories shared show the dedication and quality of care the CHS staff provide to their communities every day.

Sober Moms Healthy Babies Annual Report

The Title V MCH Program continued to update the SMHB website. The goals of the website are to prevent substance use during pregnancy and provide information to women of childbearing age, health care providers, and concerned family and friends. The website provides the substance use helpline number, Nevada 211, Crisis Call Center, the NTQ, and other resources. The website specifies the treatment priority status for pregnant patients at Substance Abuse Prevention and Treatment Agency (SAPTA) funded agencies and the importance of patients identifying if they are pregnant. SAPTA-funded treatment centers must not deny treatment to people unable to pay. All treatment centers listed on the SMHB website are SAPTA-funded.

The website had 3,504 total sessions with 3,015 users, of which 2,085.

Nevada Broadcasters Association conducted television and radio public service announcements in English and Spanish throughout the state to promote the SMHB website, in addition to the distribution of outreach materials and referral cards. The 2024 media campaign had a total of 5,298 TV ads and 29,550 radio ads promoting the SMHB website and the importance of pregnant persons receiving treatment and preventing substance use in persons of childbearing age. All Local Health Authorities (LHAs) and Title V MCH subrecipients promoted SMHB and shared SMHB referral cards; OMNI partners also widely shared the site URL.

To raise awareness on the priority admission of pregnant patients at state-funded treatment centers, the Title V MCH Program disseminated outreach materials promoting the SMHB website. The Title V MCH Program is in contact with state agencies and LHAs which have agreed to help with distribution and promotion.

CCHHS used program funds to endorse pregnant and postpartum women being substance-free through their clinic's digital signage and social media. CCHHS Facebook messages with information about SMHB reached 25,009 individuals.

Program staff participated in Comprehensive Addiction and Recovery Act (CARA) and Neonatal Abstinence Syndrome (NAS) focused efforts and multiple Title V MCH staff serve on the PHI. Program staff also served on numerous subcommittees focused on reduction of substance use in pregnancy and building systems of referral for families with substance exposed infants. Long-Acting Reversible Contraceptives (LARC) and Community Reproductive Engagement Committee Title V MCH Program involvement intersects with substance use prevention efforts, as does engagement on Families First efforts.

The Nevada Title V MCH Program continued to disseminate Spanish and English marijuana awareness materials to partners statewide. These materials were developed in prior funding years in response to Nevada's legalization of medical and recreational marijuana. The Title V MCH Program developed informational resources on marijuana use during pregnancy and breastfeeding, injury prevention, and the harmful effects for children. Efforts to reduce substance misuse in pregnancy and improve interconception care are funded by the Title V MCH Program and include promoting the SMHB website and associated media campaigns and focusing perinatal activities on the reduction of NAS. Title V MCH funded partners promote SMHB through social media and print materials developed by Title V MCH, in addition to the CARA resources (including provider guides and Screening, Brief Intervention and Referral to Treatment (SBIRT) resources), marijuana use and pregnancy information, posters, and marijuana and childhood injury prevention warnings. Informational sheets are distributed widely through the Fetal Infant Mortality Review (FIMR) and LHAs.

Title V MCH Program Tobacco Cessation Report

Nevada chose SM Smoking – Pregnancy to focus on reducing the percentage of women who smoke during pregnancy. All Title V MCH Program funded agencies promoted the NTQ to pregnant individuals and women of childbearing age. CCHHS and CHS clinics provided education and counseling to tobacco users. CCHHS referred 1.6% of all individuals screened (all ages) to the NTQ and promoted the NTQ through the outside digital clinic signage and a Facebook campaign reaching 14,645 individuals with 1.3% engaged users. CCHHS collaborated with health care providers working in behavioral health settings and substance use treatment facilities to educate about NTQ. These collaborations are intended to help a disparate population (with behavioral health conditions and/or substance use) be connected to a Tobacco Quitline resource.

Chronic Disease Prevention and Health Promotion (CDPHP) Tobacco Control Program (TCP) Annual Report

The CDPHP TCP disseminates NTQ promotional material to Nevada providers, WIC clinics, early childhood educators, and Nevada Head Start sites. The promotional materials are given to pregnant and postpartum women who use tobacco. The NTQ continues to provide callers 13 years and older with up to five scheduled personalized, culturally competent coaching sessions, unlimited inbound calls, web and text support, and Nicotine Replacement Therapies (NRTs) at no-cost to callers ages 18 years and older, upon availability. The Pregnancy/Postpartum Program (PPP) offered mothers in Nevada a designated trained coach throughout each session along with incentivized gift cards for each completed counseling call. According to the guidelines of the PPP, each pregnant caller was enrolled before giving birth to ensure eligibility for both programs. PPP provides five coaching sessions during pregnancy and four coaching sessions postpartum, and the same coach administers each session. This allows the parent to focus on their health and the baby, creating longevity for both through cessation. Comprehensive printed educational materials on the benefits of quitting smoking during pregnancy and harmful effects on babies were provided upon each enrollment process.

The NTQ enrolled 1,828 callers during the program period, including five pregnant women. The NTQ offers a no-cost program specializing in helping pregnant women quit smoking. The tailored treatment plan meets their needs by providing intensive behavioral support, including an increased number of coaching calls compared to the general population. As an incentive, gift cards for $5 and $10 are given after scheduled and completed counseling calls. For pregnant and new parents who have quit, additional postpartum support is available to prevent relapses. NTQ uses evidence-based treatment practices to help pregnant smokers quit and remain tobacco-free. Although the call volume was limited, outreach was expanded to community health workers, women's health care providers, WIC clinics, and shared at community events. MCH opportunities to heighten NTQ awareness are being implemented, including promotion by all Title V MCH funded partners.

Partnerships continued to expand with the NTQ as listed: Medicaid Managed Care Organizations, Division Social Services, the MCAH Section, local Tribal health departments, University Medical Center, Nevada Health Centers, Carson Tahoe Hospital, Lyon County Medical Center, Northern Nevada Health Centers, Access to Healthcare Network, and mental health clinics and behavioral health facilities. Established relationships with providers created an opportunity for a health system change through an NTQ e-Referral process specific to patients interested in cessation.

Nevada Maternal Mortality Review Committee (MMRC)

Nevada MMRC statutes are codified in NRS 442.751 through 442.774, inclusive, and the Committee is required to: (1) review incidents of maternal mortality and severe maternal morbidity (SMM) in Nevada; (2) disseminate findings and recommendations concerning maternal mortality and SMM to providers of health care, medical facilities, other interested persons and the public; (3) publish timely reports consisting of data relating to maternal mortality and SMM, descriptions of incidents reviewed by the Committee, and recommendations to reduce maternal mortality and SMM in Nevada. The MMRC meets at least twice annually to review all incidences of maternal mortality in Nevada and address health differences, and to end preventable maternal mortality and SMM.

MCAH supports the MMRC and reports on MMRC and NOMHE Advisory Committee recommendations for the public, clinicians, and policy makers on data-driven MMRC recommendations (e.g., evidence-based practices, screenings, and patient and provider education). Reporting produced by the MMRC support staff will be included in the Title V MCH Block Grant reporting, and health in birth outcomes and maternal domain population health maximization will be key areas of topical intersect in priorities of the MMRC, AIM, Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM), MCAH Section, SSDI Program, and Title V MCH Program. The Title V MCH Program continues to investigate opportunities to create sustained funding for the MMRC as it was passed into law without dedicated state funding. SSDI funds help support MMRC case abstraction staff.

Two key contributing factors to pregnancy-associated maternal mortality are suicide and substance abuse. MCAH has facilitated maternal mortality and severe maternal morbidity presentations to the Maternal Child Health Advisory Board (MCHAB) in concert with the Nevada Department of Human Services (DHS) Office of Analytics and the efforts of the Title V MCH-funded Biostatistician in the Office of Analytics.

Account for Family Planning (AFP)

The Nevada AFP uses state general funds to support reproductive health, vaccine administration, and contraceptive access statewide. These services include, but are not limited to:

- Provision of education concerning family planning
- Referrals for the purpose of family planning
- Distribution of contraceptives, installation of contraceptive devices, and the performance of contraceptive procedures approved by the United States Food and Drug Administration
- The provision of or referral of persons regarding preconception health services and assistance to achieve pregnancy
- The provision of or referral of persons for testing for and treatment of sexually transmitted infections
- The provision of any vaccinations recommended by the Advisory Committee on Immunization Practices of the CDC

While funding is focused on supporting reproductive health and access to reproductive care, AFP also allows funds to be used for immunizations and STI screening and treatment. A mix of LHAs, Universities, community-based organizations, public health clinics, and county partners were awarded funds in the reporting period to implement the goals of AFP. The Reproductive Health Coordinator funded by AFP is situated within the MCAH Section and has worked closely with MCAH data and teen pregnancy prevention staff.

Women/Maternal Domain Accomplishments

Highlights of maternal and women's health efforts include robust substance use in pregnancy prevention efforts and internal and external partner engagement, successful partnerships with NHV to improve dyad outcomes and reproductive health, strong relationships with the LHAs, support of statewide MCH Coalition networks, sustainability of the MMRC, and funding statewide and local conferences for information sharing and workforce development.

Women/Maternal Health Data

SM – Well-Woman Visit- Percent of women, ages 18-44, with a preventive medical visit in the past year

According to the Behavioral Risk Factor Surveillance System, the percent of women, ages 18 through 44 y.o., with a preventive medical visit in the past year in Nevada increased from 60.2% in 2022 to 66.2% in 2023. Nevada is below the US national average of 73.0% for this metric and ranks 47th among 48 states (excluding Kentucky and Pennsylvania which did not have this measure) and the District of Columbia (D.C.). Preventive medical visits for

women in Nevada in 2023 varied across age groups, with those aged 35-44 y.o. having the highest usage (68.3%), followed by 18-24 y.o. (66.6%) and 25-34 y.o. (63.7%). When stratifying by race and ethnicity, Hispanic women had the highest percentage of preventive medical visits (64.4%) compared to non-Hispanic White women (56.2%). Data for other race and ethnicities was not available for this measure.

SM – Smoking – Pregnancy - Percent of women who smoke during pregnancy

According to NVSS data, the percent of women who smoke during pregnancy in Nevada has been steadily declining from 2013 to 2023, from 5.8% to 2.3%. This is significantly lower than the 2023 U.S. national average of 3.0%. Nevada is in the top 30% among the 50 states and D.C. for lowest percentages, ranking 15th for this measure. When 2023 Nevada data is stratified by health insurance, 4.3% of women on Medicaid were found to smoke during pregnancy, compared to 1.4% of those who were Uninsured, 1.0% of those who had other public insurance, and 0.8% of those who had private insurance.

SM – Early Prenatal Care - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data from NVSS show a steady, significant increase for Nevada's percent of pregnant women receiving prenatal care in the first trimester from 2013 to 2023 (68.4% to 76.5%). Nevada's rate is currently lower than the Healthy People 2030 objective of 80.5%. For 2023, Nevada was comparable to the national average (76.1%), and falls in the lower half of states, ranking 30th out of the 50 states and D.C. There are racial/ethnic disparities for timely prenatal care in Nevada. In 2023, non-Hispanic Asian (83.7%) women had the highest prenatal care coverage, followed by non-Hispanic White (81.0%), non-Hispanic multiple race (76.7%), Hispanic (73.6%) and non-Hispanic Black (73.2%). Non-Hispanic Native Hawaiian/Other Pacific Islander (62.6%) and non-Hispanic American Indian/Alaska Native (54.9%) had the lowest percent.

NOM – Severe Maternal Morbidity - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

According to the Healthcare Cost and Utilization Project (HCUP) - State Inpatient Databases (SID), the rate of severe maternal morbidity per 10,000 delivery hospitalizations in Nevada decreased from 73.1 in 2015 Q1-Q3 to 65.2 in 2018. However, Nevada experienced an increase in 2019, with a rate of 84.4 per 10,000 delivery hospitalizations. This increase continued in 2020, to 89.1. Nevada is below average for this measure, ranking 34th compared to 12th in 2018. Nevada's rate of severe maternal morbidity is higher than the 2020 national average of 88.3 per 10,000 delivery hospitalizations. Women 35 y.o. and older had the highest rate (128.3) in 2020, while women aged 20-24 y.o. had the lowest rate (64.4). By race/ethnicity, Non-Hispanic Black persons (130.5) had the highest rate, followed by Non-Hispanic Asian/Pacific Islander (98.2), Other (91.9), Hispanic (82.2), and Non-Hispanic White (79.4). Data is the most up to date as of April 2025.

NOM – Maternal Mortality - Maternal mortality rate per 100,000 live births

The 2019-2023 five-year estimates from NVSS indicate Nevada's maternal mortality rate per 100,000 live births (22.7) is lower than the national rate (23.5). Nevada ranks 20th for this measure. This represents a slight increase from the 2017-2021 estimate of 22.4 per 100,000 live births for Nevada. Even with the five-year estimates, the data should be interpreted with caution, and only limited stratified data exists for Nevada.

NOM – Low Birth Weight – Percent of low birth weight deliveries (<2,500 grams)

Data from NVSS indicates the percentage of low-birth-weight deliveries in Nevada fluctuated between 8.5% and 9.7% from 2016 through 2021. In 2022, the percentage decreased to 9.3%. In 2023, the percentage slightly increased to 9.5%. Nevada has a higher percentage of low-birth-weight deliveries compared to the US national average in 2023 (8.6%). Nevada ranks toward the bottom for this measure, at 41st out of 50 states and D.C. Racial/ethnic differences are apparent. In 2023, non-Hispanic Black (14.6%) women had the highest percent of low-birth-weight deliveries, followed by Native Hawaiian or other Pacific Islander alone (12.9%) or in combination (11.5%). Racial/ethnic groups with percents below the state average of 9.5% in 2023 were Hispanic women (8.9%), American Indian or Alaska Native alone or in combination women (8.8%), and non-Hispanic White women (7.5%).

NOM – Preterm Birth – Percent of preterm births (<37 weeks)

According to NVSS, the percentage of preterm births increased from 10.9% in 2022 to 11.1% in 2023. This is higher than the national average of 10.4%. Nevada ranks near the bottom for highest percent of preterm birth in 2022, at 38th out of 50 states and D.C. Racial/ethnic disparities are apparent. In 2023, non-Hispanic Native Hawaiian or Other Pacific Islander women (17.2%) had the highest percent of preterm births, followed by non-Hispanic Black women (15.0%), non-Hispanic American Indian or Alaska Native women (12.0%), non-Hispanic Asian women (11.9%), non-Hispanic Multiple Race women (11.2%), and Hispanic women (10.6%). Percents for non-Hispanic White women (9.5%) were below the 2023 Nevada average of 10.4%.

Women/Maternal Health Plan for the Application Year

Women's Health and Wellness

Nevada's Title V MCH Program will collaborate with public and private partners, including but not limited to Nevada Medicaid, WIC, and Home Visiting to determine and resolve barriers for women accessing prenatal and/or postpartum care. Promotion of adequate prenatal care will be integrated into their programs in hopes to educate and encourage women to receive adequate prenatal and postpartum care. Furthermore, the Title V MCH Program will strive to improve health literacy related to prenatal/postpartum care and maternal health. In collaboration with partners, the Title V MCH team will translate health information materials to display languages other and English to ensure all Nevadans have access to current health information. The Title V MCH Program will continue to promote the importance of prenatal care and women's well-visits via traditional (e.g., radio) and social media campaigns. Health campaigns will also be translated into several languages based on those most spoken in Nevada. Title V staff will seek out and attend events across the state to promote prenatal/postpartum and maternal health resources available in the state.

As part of ongoing AIM efforts, the hypertension patient safety bundle data will be collected while the obstetric patient safety bundle is launched. Nevada MMRC efforts, including data collection, case review, reporting, recommendations, and development of data to action interventions to reduce preventable maternal mortality and SMM are ongoing. Perinatal quality improvement efforts will continue to leverage the work and recommendations of the MMRC.

Title V MCH Program staff will continue to work with funded partners and community agencies to improve access to yearly well visits. Other areas of focus will include recommended immunizations, tobacco use and cessation, alcohol and substances, healthy nutrition, and emotional health issues. In partnership with the PREP, SRAE, and AFP Programs, the Title V MCH team will continue to promote informed reproductive choices and education to support reproductive life planning. The Title V MCH Program will increase the use of PRAMS data and other cross-section collaborations. Close and frequent communication with Title V MCH funded partners related to emerging MCH population needs will continue for all population domains.

The Title V MCH Program plans to award funds to local health agency partners and the DPBH CHS to promote women and maternal health education and resources to Nevada women and families. Clinical staff serve patients in their community by providing education, counseling, and referrals to additional health/social service resources. Local health agencies reach women through clinic visits and community outreach events. Content shared includes education and resources regarding: the value of no-cost yearly checkups, receiving timely prenatal/postpartum care (e.g., *Go Before You Show,* Maternal Health Warning Signs, etc.), healthy pregnancy outcomes, reproductive health and long-acting reversible contraception, sexually transmitted infections, recommended immunizations, depression, intimate partner violence prevention, the NTQ, Nevada Breastfeeds, Sober Moms, Healthy Babies, and PRAMS.

The Nevada Statewide Maternal and Child Health (MCH) Coalition

The Nevada Statewide MCH Coalition and Title V MCH Program will continue to support critical NPMs related to Title V across population domains. Title V MCH Program staff will continue to attend Coalition meetings and leadership calls. For the 2025-2030 funding cycle, the Nevada Title V MCH Program plans to launch a statewide awareness campaign with the MCH Coalition on the importance of postpartum care. Efforts will include providing resources and education on how to find a provider and make an appointment targeted to reach mothers who are enrolled in Medicaid.

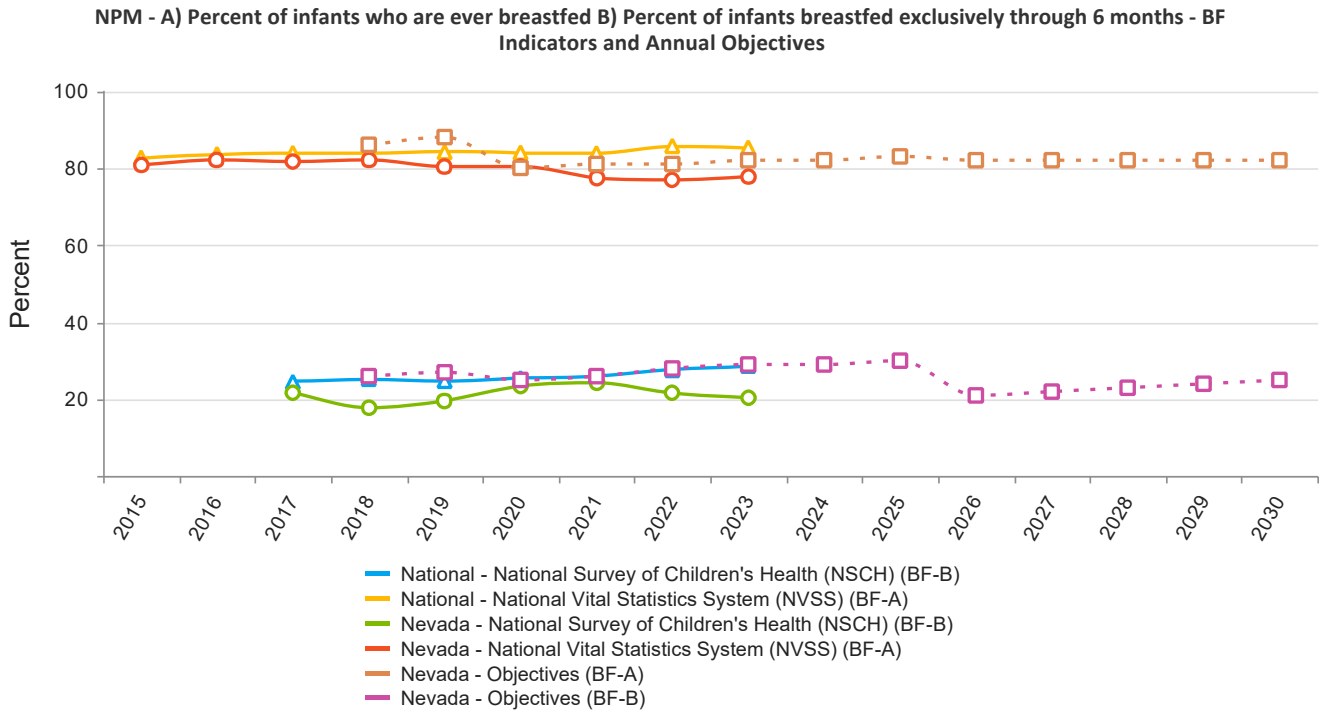
Additionally, the Statewide MCH Coalition website and e-newsletters will continue to be distributed through a variety of community groups to expand outreach and participation from multidisciplinary partners and families. Coalition Listservs and local meetings will continue to disseminate MCH resources to other partners as needed and support PMHD resources. The Coalition will continue to expand distribution of New Mama Care Kits with an emphasis on building partnerships and distributing to more rural communities. The Northern Nevada MCH Coalition will continue to serve as the Community Action Team for the Title V MCH-funded Northern Nevada Public Health Fetal Infant Mortality Review (FIMR) Program.

Nevada MCH Data and Communications

Nevada's Title V MCH Program will investigate robust maternal and perinatal data evaluation across all MCH populations to present timely key maternal and child health indicators. More data indicators will be added to the MCH dashboard to help staff and the public monitor postpartum care access by sociodemographic factors. This information will help focus funded efforts on improving access to and quality of postpartum care among Nevadans. The Title V MCH Program will continue to promote the MCH data dashboard to partners statewide and plan on continued participation of Title V MCH Program staff and leadership in early childhood support and systems building initiatives with a focus on referral pathway supports and data integration.

Title V funds will continue to support public service announcements, websites, social media, digital signage, and print campaigns related to women and maternal health resources and programs, and information sharing and collaboration will be ongoing. Programmatic efforts focused on disparity identification and reduction using data-informed methodologies and evidence-based strategies will continue to be focus areas. Existing cross-program partnerships will continue to help prevent sexual assault and increase education about SV/DV among CSHCN with developmental disabilities.

National Performance Measures



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

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	82	82
Annual Indicator	76.8	77.6
Numerator	24,995	24,082
Denominator	32,527	31,049
Data Source	NVSS	NVSS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	82.0	82.0	82.0	82.0	82.0

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

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2023	**2024**
Annual Objective	29	29
Annual Indicator	21.6	20.3
Numerator	19,094	15,667
Denominator	88,548	77,191
Data Source	NSCH	NSCH
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	21.0	22.0	23.0	24.0	25.0

Evidence-Based or –Informed Strategy Measures

ESM BF.1 - Percent of Nevada PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends

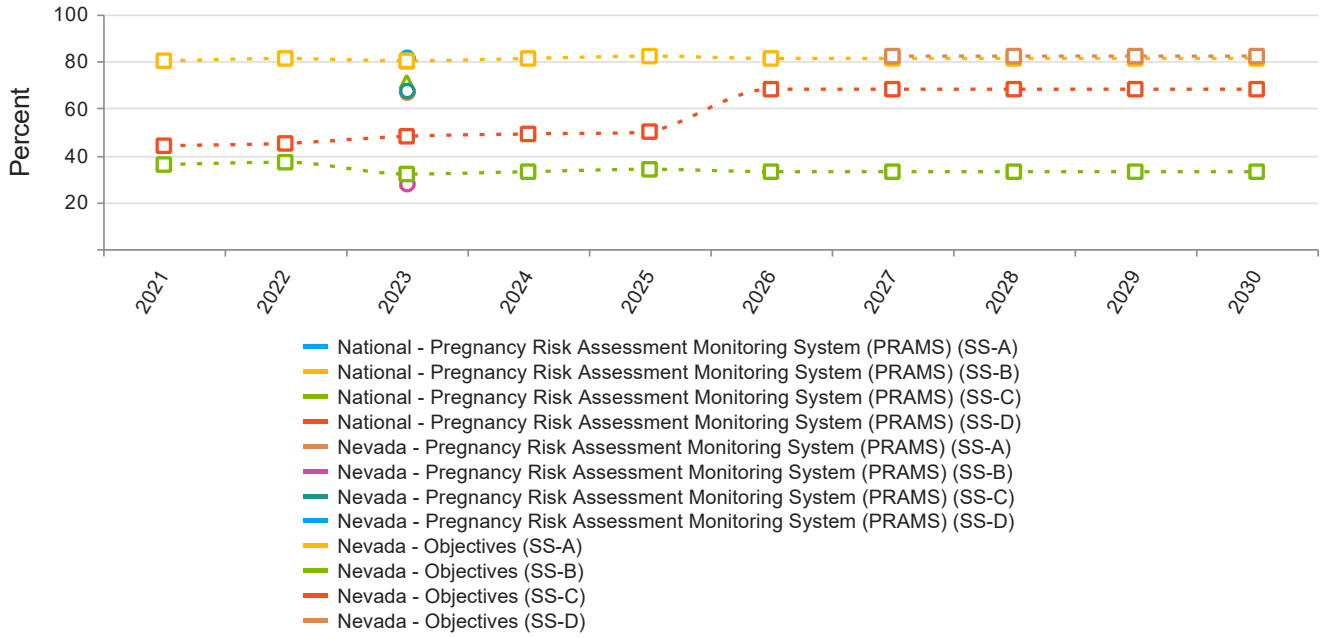
Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		1.5	1.3	2	1.9
Annual Indicator	1.9	2.2	2.3	1.3	0
Numerator	6	6	5	6	0
Denominator	320	272	221	449	556
Data Source	Nevada PRAMS	Nevada PRAMS	Nevada PRAMS	Nevada PRAMS	Nevada PRAMS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	0.0	0.0	0.0	0.0	0.0

NPM - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep - SS

Indicators and Annual Objectives



- National - Pregnancy Risk Assessment Monitoring System (PRAMS) (SS-A)
- National - Pregnancy Risk Assessment Monitoring System (PRAMS) (SS-B)
- National - Pregnancy Risk Assessment Monitoring System (PRAMS) (SS-C)
- National - Pregnancy Risk Assessment Monitoring System (PRAMS) (SS-D)
- Nevada - Pregnancy Risk Assessment Monitoring System (PRAMS) (SS-A)
- Nevada - Pregnancy Risk Assessment Monitoring System (PRAMS) (SS-B)
- Nevada - Pregnancy Risk Assessment Monitoring System (PRAMS) (SS-C)
- Nevada - Pregnancy Risk Assessment Monitoring System (PRAMS) (SS-D)
- Nevada - Objectives (SS-A)
- Nevada - Objectives (SS-B)
- Nevada - Objectives (SS-C)
- Nevada - Objectives (SS-D)

NPM - A) Percent of infants placed to sleep on their backs - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	81
Annual Indicator	66.3
Numerator	18,765
Denominator	28,285
Data Source	PRAMS
Data Source Year	2023

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		80	81	80	81
Annual Indicator	76.8	75.6	77.4	75.1	
Numerator	25,805	23,583	24,230	23,172	
Denominator	33,607	31,184	31,313	30,862	
Data Source	NV PRAMS	NV PRAMS	NV PRAMS	NV PRAMS	
Data Source Year	2019	2020	2021	2022	
Provisional or Final ?	Final	Final	Provisional	Provisional	

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	81.0	81.0	81.0	81.0	81.0

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	33
Annual Indicator	27.5
Numerator	7,906
Denominator	28,795
Data Source	PRAMS
Data Source Year	2023

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		36	37	32	33
Annual Indicator	34.1	33.2	27.9	31.4	
Numerator	10,334	9,888	8,255	9,460	
Denominator	30,290	29,767	29,581	30,153	
Data Source	NV PRAMS	NV PRAMS	NV PRAMS	NV PRAMS	
Data Source Year	2019	2020	2021	2022	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	33.0	33.0	33.0	33.0	33.0

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	49
Annual Indicator	67.2
Numerator	19,532
Denominator	29,061
Data Source	PRAMS
Data Source Year	2023

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		44	45	48	49
Annual Indicator	39.7	39.5	47.2	45.9	
Numerator	12,275	11,956	14,155	13,796	
Denominator	30,901	30,280	30,002	30,081	
Data Source	NV PRAMS	NV PRAMS	NV PRAMS	NV PRAMS	
Data Source Year	2019	2020	2021	2022	
Provisional or Final ?	Final	Final	Provisional	Provisional	

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	68.0	68.0	68.0	68.0	68.0

NPM - D) Percent of infants room-sharing with an adult during sleep - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	81.2
Numerator	23,765
Denominator	29,276
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	82.0	82.0	82.0	82.0	82.0

Evidence-Based or –Informed Strategy Measures

ESM SS.1 - 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

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		72	70	75	73
Annual Indicator	74.6	78	77.7	76.2	81.9
Numerator	25,082	25,122	24,992	24,920	22,703
Denominator	33,607	32,210	32,174	32,689	27,732
Data Source	Nevada PRAMS	Nevada PRAMS	Nevada PRAMS	Nevada PRAMS	Nevada PRAMS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	73.0	72.0	71.0	70.0	69.0

ESM SS.2 - Percent of Nevada PRAMS respondents who report their infants (under 1 year of age) were laid to sleep in a high-risk sleep position and/or environment

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	60.0	60.0	60.0	60.0	60.0

State Performance Measures

SPM 2 - Percent of women who used substances during pregnancy

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	5	4.5	4.5	4	4
Annual Indicator	5.8	6.8	5.5	5.6	4.7
Numerator	1,932	2,246	1,786	1,741	1,507
Denominator	33,261	32,932	32,475	30,925	31,749
Data Source	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	4.0	4.0	4.0	4.0	4.0

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Nevada) - Perinatal/Infant Health - Entry 1	
Priority Need	
Increase breastfeeding rates among mothers.	
NPM	
NPM - Breastfeeding	
Five-Year Objectives	
83% of infants will be ever breastfed by 2030; 25% of infants were breastfed exclusively for 6 months	
Strategies	
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 Maternal, Infant and Early Childhood Home Visiting Services	
ESMs	**Status**
ESM BF.1 - Percent of Nevada PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends	Active
NOMs	
Infant Mortality	
Postneonatal Mortality	
SUID Mortality	

State Action Plan Table (Nevada) - Perinatal/Infant Health - Entry 2

Priority Need

Increase safe sleep practices

NPM

NPM - Safe Sleep

Five-Year Objectives

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%

Strategies

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

ESMs	Status
ESM SS.1 - 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	Active
ESM SS.2 - Percent of Nevada PRAMS respondents who report their infants (under 1 year of age) were laid to sleep in a high-risk sleep position and/or environment	Active

NOMs

Infant Mortality
Postneonatal Mortality
SUID Mortality

State Action Plan Table (Nevada) - Perinatal/Infant Health - Entry 3

Priority Need

Reduce substance use during and after pregnancy

SPM

SPM 2 - Percent of women who used substances during pregnancy

Five-Year Objectives

Reduce the percent of women who report using tobacco, alcohol, or illicit substances, during pregnancy to 3.6%.

Strategies

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 post-partum (up to 1-year post-partum).

Increase partnerships with state and local agencies to address substance use during pregnancy

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

NOMs

Severe Maternal Morbidity

Maternal Mortality

Low Birth Weight

Preterm Birth

Stillbirth

Perinatal Mortality

Infant Mortality

Neonatal Mortality

Postneonatal Mortality

Preterm-Related Mortality

Perinatal/Infant Health Annual Report

As part of the Title V MCH Program, the Maternal and Infant Program (MIP) provides technical assistance, resources, and support to private and public partners serving families and infants. The MIP Coordinator works closely with these partners, as well as the MCH and CSHCN Directors, Title V MCH Program Manager, and MCAH Section Manager to improve infant and maternal health outcomes. The Perinatal/Infant Health report demonstrates how collaboration between partners and MIP accomplishes the state priorities of promoting breastfeeding and safe sleep.

These collaborative efforts include MCAH staff serving on the Newborn Screening Advisory Board and reporting on Critical Congenital Heart Disease (CCHD) efforts including the CCHD Registry maintained by CSHCN in partnership with the Early Hearing Detection and Intervention (EHDI) Program. The EHDI Program and Title V MCH programs work closely together and are co-located in the MCAH Section. Multiple perinatal related presentations were made to the Maternal Child Health Advisory Board (MCHAB) for which Title V MCH Program serve as support staff. Title V MCH provided packets of brochures and MCH information to the DPBH Tribal Liaisons to share with Tribal partners statewide. Close collaboration also occurs between MIP and the Nevada Home Visiting Program and WIC.

Perinatal Health Initiative (PHI) participation by Title V MCH Program (MCH and CSHCN Directors are on the PHI Core Team) was focused on systems building to provide referrals and interventions for women who use substances in pregnancy and substance exposed infants, and state interest in formalizing a statewide perinatal quality collaborative is ongoing as part of these efforts. Screening, Brief Intervention, and Referral to Treatment (SBIRT) education and training was a primary PHI area of focus. MCH participated in a statewide conference focused on gap identification and programs needed in relation to perinatal substance use to leadership across agencies, universities, CBOs, insurers, and others. The Title V MCH Program actively participated in numerous infant and perinatal focused workgroups, conferences, webinars, taskforces, committees, community meetings, provider outreach, hospital presentations, MCH data meetings, and breastfeeding and MCH coalitions. The MCH Director serves on the Association of Maternal Child Health Programs (AMCHP) Board where perinatal and infant health policy is a key area of emphasis, and all key Title V MCH Program participated in AMCHP efforts throughout the reporting period.

Breastfeeding Report

The Title V MCH Program supports the Nevada Breastfeeds website to share key educational resources, policy, and promote the Breastfeeding Welcome Here Campaign. The Nevada Breastfeeds website highlights businesses in Nevada that are breastfeeding-friendly and show their support to breastfeeding persons in Nevada. The goal of this campaign is to encourage more people to choose to breastfeed and breastfeed for longer by recognizing businesses who support a breastfeeding-friendly environment.

The Nevada Breastfeeds website had 4,634 total sessions with 4,406 users, of which 805 were new users.

The Title V MCH Program continued the statewide campaign to improve infant feeding practices and increase community and business support for those choosing to breastfeed. Nevada's Women, Infants, and Children (WIC) Program supported participants by providing free professional lactation services, breast pumps, and an enhanced food package to those breastfeeding. MCH and WIC continue to work with Nevada Medicaid to increase access to breast pumps and lactation support. The collaborative breastfeeding campaign with WIC is designed to increase awareness, promote WIC breastfeeding services, normalize breastfeeding in public locations and recognize breastfeeding-friendly businesses. Resources for CSHCN to support breastfeeding in conditions with craniofacial impacts are also highlighted.

Title V MCH Program staff distributed resources about breastfeeding and posted information on the DPBH website. The Breastfeeding Welcome Here (BFWH) Campaign allowed businesses to receive placards informing patrons breastfeeding is welcomed at the agency. Furthermore, organizations 'taking the pledge' were listed on Nevada Breastfeeds as a breastfeeding-friendly business.

The Title V MCH Program coordinated with the Carson City Planning Division to hang a Breastfeeding Awareness Month Banner on a main street in Carson City, Nevada. The banner was hung from August 12-16th, 2024 to recognize August as Breastfeeding Awareness Month. Staff collaborated with WIC on a breastfeeding proclamation, as well.

Pregnancy Risk Assessment Monitoring System (PRAMS) Report

PRAMS is part of a national effort to reduce infant mortality and adverse birth outcomes. The PRAMS questions cover the period before, during, and shortly after pregnancy. The PRAMS questionnaire packets include a cover letter, a question brochure, and a consent document. If a mother does not respond after three questionnaires are sent, an attempt is made to reach her by telephone. Mothers who complete the survey by mail or telephone are offered a $25 Walmart gift card (funded by PRAMS). PRAMS data is used to monitor the progress of national and state pregnancy and birth-related health measures. PRAMS data is also used to identify and monitor self-reported maternal behaviors and experiences occurring before, during, and shortly after pregnancy among women who deliver live-born infants. Nevada PRAMS started collecting data in September 2017, and a PRAMS-like survey was implemented before PRAMS, Baby Bears.

For birth years 2018-2023, Nevada PRAMS completed full years of data collection of 12 batches each. Weighted data response rates are as follows: 39.4% for 2018 births, 42% for 2019 births, 43% for 2020 births, 34% for 2021 births, and 34% for 2022 births. All response rates have fallen below the CDC-required threshold of 55% for 2018 and 50% for 2019-2022 data. Due to this caveat, the data should be interpreted with caution.

The Title V MCH Program provided funds to cover the costs of printing and distribution of PRAMS survey covers, informational brochures, and posters. The Title V MCH Program has supported efforts to increase the survey response rate by funding a Nevada Broadcasters Association (NBA) campaign with PRAMS television and radio advertisements in both English and Spanish. NBA aired radio advertisements for PRAMS from September 2023 until August 2024.

All Title V MCH subawards include required activities to educate pregnant clients about PRAMS. PRAMS promotional materials are disseminated to appropriate agencies such as posters, brochures, water bottles, ice packs, pens, and tote bags. Carson City Health and Human Services (CCHHS) promoted awareness of the survey through the clinic digital signage and on social media. A month-long campaign allowed patients and people passing by to view PRAMS messages on the outdoor digital signage. The one-month Facebook promotion reached 3,589 individuals with 0.9% engaged users. The Title V MCH Program Manager sits on the PRAMS Steering Committee and the SSDI and Epidemiology staff support PRAMS efforts.

Fetal Infant Mortality Review (FIMR) Report

The Title V MCH Program funded the Northern Nevada Public Health (NNPH, formerly Washoe County Health District) Fetal Infant Mortality Review (FIMR) in which program activities continued, and data was abstracted and entered into the National Fatality Review-Case Reporting System (NFR-CRP) with 47 new cases reported in the reporting period. Four of the included cases were from outside Washoe County yet received medical and other services within Washoe County.

Two comprehensive maternal interviews were conducted during this grant period. Staff successfully contacted several women who were receptive to information about local bereavement and other resources. Many of these women declined full interviews or only answered a limited number of questions due to the grieving process and/or their time constraints. Other barriers for completing maternal interviews continue to be transiency, invalid phone numbers and incomplete information. Interviews are not attempted in cases involving litigation, out of jurisdiction, complex and extenuating circumstances, and patients with comorbidities. Additional obstacles for maternal interviews were staff turnover and training. The FIMR Program is prepared to serve populations with interpreter services provided in multiple languages. Sympathy cards and educational materials are available in both English and Spanish.

The FIMR Case Review Team (CRT) expanded over the last year as staff actively recruited additional members from the community. The CRT welcomed new members from the Community Health Alliance WIC Program, Carson Tahoe

Health, a local midwife practice, and Washoe County Human Services Agency. The CRT is seeking new members from Renown Regional Medical Center, Northern Nevada Sierra Medical Center, The Child Advocacy Center, insurance companies, and mental health clinics due to staffing changes in those organizations. FIMR staff strive to enhance CRT member makeup to improve understanding and address prevention strategies to improve fetal and infant health outcomes. MCH Director is a FIMR member.

The FIMR CRT met a total of ten times and reviewed forty-two cases between October 1, 2023, and September 30, 2024. The FIMR Team typically reviews four cases per meeting. The FIMR Community Action Team (CAT) helps implement recommendations of the CRT through the Northern NV MCH (NNMCH) Coalition. Staff continued to provide FIMR updates at monthly coalition meetings. The NNMCH Coalition held eight meetings during this reporting period. Rebecca Gonzales, NNPH FIMR co-coordinator, and Kelsey Atkins, NNPH WIC Supervisor have co-chaired the NNMCH Coalition during the last year.

FIMR coordinators attended Washoe County Child Death Review meetings every other month. FIMR coordinators also participated in quarterly National Western Region FIMR support calls. FIMR coordinators were actively involved in one Congenital Syphilis Review Board (CSRB) meeting and review of local congenital syphilis cases, which are presented to the FIMR team in the event of a death.

NNPH staff participated in the Join Together Northern Nevada (JTNN) Marijuana Committee and attended one JTNN Prevention committee meeting during the year.

FIMR staff attended the Pregnancy and Infant Loss Support Organization of the Sierras (PILSOS) committee meetings throughout the year and FIMR coordinators also assisted with planning and holding the 13th Annual “Time for Remembrance Event” held on October 15th, 2023, and began planning and preparation for the 2024 event. Staff assisted with planning a PILSOS Professional Conference.

FIMR staff attended several virtual and in-person trainings during this reporting period, including:

- “High Impact Practices to Address Cardiac Conditions and Improve Maternal Health Outcomes” Webinar on December 14, 2023
- National Family Planning and Reproductive Health Association Conference from February 12-14, 2024
- Minor Consent Training on February 28, 2024
- 2024 Maternal Mental Health Forum: “Small Steps and Giant Leaps for Maternal Mental Healthcare” from March 19-20, 2024
- “Our Future Belongs to Us: Amplifying Innovations in Black Maternal Health” Webinar on April 11, 2024
- “Perinatal Loss: Improving Care for Families” Webinar on April 17, 2024
- “At a Crossroads: The Syndemic of Syphilis, Substance Use and Child Welfare During Pregnancy” Webinar on April 18, 2024
- “Equity in Action and Enhancing Equity in Fatality Review Together” from June 3-6, 2024
- “Collaborative Innovations to Strengthen Maternal and Infant Health” Webinar on August 13, 2024
- “Stigma in HIV Prevention and Care” Webinar on August 19, 2024
- 2024 CityMatCH Leadership & MCH Epidemiology Conference from September 8-10, 2024
- Maternal Child Health Fall Symposium on September 20, 2024

Cribs for Kids/Safe Sleep Report

Dignity Health, funded through the Nevada Title V MCH Program, operates as the lead agency for the Cribs for Kids

(C4K) Program in Nevada. C4K provides educational resources to parents and caregivers on the importance of practicing safe sleep behaviors with infants to prevent mortality. Partner agencies participate in train-the-trainer sessions, which include evidence-based, best practice Safe Sleep Education endorsed by the American Academy of Pediatrics (AAP). Safe Sleep Survival Kits for infants are provided to families who cannot afford to purchase a crib for their infant. Safe Sleep Survival Kits are available in English and Spanish, and include:

- Pack n Play (Cribette®)
- Branded SleepSack
- Cribette® Sheet with Safe Sleep Message
- ABCs of Safe Sleep Photo Magnet
- Philips Soothie Pacifier
- Cribs for Kids Step-Down Booklet (educational brochure)
- Sleep Baby Safe and Snug Children's Book

During the reporting period, the C4K Coordinator participated in 30 community-based awareness opportunities, activities, and events. Participation efforts are involved in providing media awareness about C4K and Safe Sleep in English and Spanish, especially during the winter months where sleep-related deaths tend to rise. Being able to hold booths at various locations was effective to spread knowledge about Safe Sleep and the C4K Program. C4K continually participates in MCH Coalition meetings, and local Child Death Review meetings to show support for Safe Sleep in Clark County and across the state. All parties involved are allowed to share resources and events that can benefit C4K outreach efforts.

During community events and the train-the-trainer sessions, the C4K Program shared additional internal MCH agency materials with the public, including Nevada 211, Sober Moms, Health Babies, the Nevada Tobacco Quitline (NTQ), and Medical Home Portal information.

Dignity Health distributed 952 MCH-funded Safe Sleep Survival Kits during the reporting period. Ongoing communication efforts are prioritized to ensure Safe Sleep education and materials are widely distributed and participation in C4K activities continues to increase. Other safe sleep materials were distributed statewide and included binders, posters, brochures, flip charts, and Sudden Unexplained Infant Death (SUID) intake questionnaires. A total of 13,239 educational materials were distributed. Also, 731 initial assessments were completed, and 333 three-month follow-ups were conducted to identify knowledge gaps related to infant safe sleep practices.

The current C4K curriculum includes AAP's 2022 updated safe sleep recommendations. The C4K curriculum also includes updated national statistics through 2020. The statistics are continuously updated to reflect any new updates or changes. The curriculum continues to include a section on how to set up a REDCap account as well as enter data into REDCap. This allows new and old partners to familiarize themselves with the data collecting system.

The C4K Coordinator attends virtual NNMCH Coalition meetings with other MCH key partners and can effectively communicate to help spread the safe sleep message statewide. A robust partner network has been established to share the standardized, evidence-based safe sleep message to the entire state. All partners help to develop and share a unified safe sleep message. During the pandemic, all MCH Coalition meetings became virtual which has led to a higher number of attendees and more safe sleep information dissemination to new MCH partners.

The C4K Coordinator(s) conducted eight Train the Trainer training(s) in FY 2023. Of those, 120 professionals were trained to be safe sleep educators and provided education material such as train-the-trainer binders and flipbooks. C4K continued to communicate with partners to establish the Program in Clark County where the majority of Nevada's population resides. Zoom has continued to allow the C4K Coordinator to reach out to more organizations which need their employees trained, especially when there are only one or two people. The continued use of virtual live meetings (Zoom, Google meets, etc.) allows a broader range of professionals to have access to training, especially those living and working in rural Nevada.

The C4K Program also distributes infant, convertible, and booster car seats statewide. During this grant cycle, 35 seats were distributed within Tribal communities: 16 car seats by Owyhee Community Health Facility and 19 by South Bands Health Center.

Safe Sleep Media Campaign Report

The Safe Sleep Media Campaign ran from October 1, 2023, through September 30, 2024, with English and Spanish radio and television public service announcements statewide. For this funded period, the media campaign had a total of 30,102 total spots aired (24,907 radio advertisements and 5,195 television advertisements). The average return on investment for airtime was 38 to 1 with a 3 to 1 guaranteed return on investment from the Nevada Broadcasters Association.

All local health authorities and other Title V funded partners promote Safe Sleep messaging. The Title V MCH Program works closely with partners across the state. The Statewide Executive Committee to Review Child Fatalities membership includes the MCH Director, working closely with other members to leverage statewide efforts to end preventable infant and child mortality statewide, including Sleep-related SUID. MCH distributes a safe sleep brochure statewide.

Perinatal/Infant Health and Wellness Report

CCHHS and eight nursing clinics within DPBH Community Health Services (CHS) serving Nevada's rural and frontier areas were awarded Title V MCH Program funding to improve perinatal and infant health. Clinic staff provided information about the importance of securing a medical home, being adequately insured, attending postpartum and infant visits, practicing safe sleep, receiving developmental screens, receiving recommended immunizations, breastfeeding, and practicing proper nutrition. Clinic staff distributed immunization schedules to pregnant patients and family members (flu and Tdap cocooning). Title V MCH Program provided materials for CCHHS and CHS to disseminate during clinic visits and outreach events pertinent to safe sleep, Text4Baby, substance use in pregnancy (including marijuana), NTQ, PRAMS, Nevada 211, and the Medical Home Portal. Furthermore, staff promoted Medicaid coding and coverage for long-acting reversible contraceptives immediately postpartum.

CCHHS provided counseling and education to pregnant patients about establishing with an obstetrician, breastfeeding, PRAMS, immunizations, and WIC support services. Patients with a positive pregnancy test or indicated consideration of pregnancy were given materials provided by Title V MCH Program. Content promoted healthy pregnancy outcomes by endorsing Text4Baby, Go Before You Show, NTQ, C4K, being alcohol and substance-free, as well as other pertinent information. Furthermore, 42 pregnant patients were referred to WIC for breastfeeding education and support. The clinic digital signage promoted infant immunizations, Text4Baby, PRAMS, and SMHB. A Text4Baby Facebook campaign reached 12,031 individuals with 1% engaged users.

Nevada 211

Nevada 211, a program of Money Management International, was awarded Title V MCH Program funds to provide access to health and social service information and resources for maternal and child health populations and their families. Enhanced efforts were conducted to ensure pregnant women and their families received a full set of resources for healthy pregnancy and postpartum outcomes. Title V MCH Program funding supports a portion of personnel costs to manage the Nevada 211 website and operate the telephone call center connecting people with needed services. Nevada 211 is a special telephone number and text line providing information and referrals to health and social service organizations. Resources include but are not limited to places to find food, housing, emergency shelter locations, children's services, adoption and foster care, mental health and counseling services, safety for those affected by intimate partner violence, and resources for individuals living with disabilities. Specific services for children include breastfeeding support, diaper programs, childcare and assistance with related expenses, clothing, family support, and respite care.

Nevada 211 has several online data reports. Nevada 211 Counts provides real-time data via an interactive format allowing the viewer to choose specific data categories and time-periods. The Nevada 211 Annual Report categorizes call, chat, and website data.

Nevada 211 call specialists responded to 81,562 inquiries with 2.4% being from someone pregnant or who was residing in the household with someone who was pregnant. Of those callers, 59% were pregnant, with 34.4% in the first trimester, 34.1% in the second trimester, and 31.4% in the third trimester. Most of these callers were non-Hispanic Black (43.2%), followed by Hispanic (28.3%). Additional non-Hispanic comprised of those identifying as

multiple races/or choosing not to respond (16.2%), White (14.0%), Asian (1.5%), Native Hawaiian/Pacific Islander (2.0%), and Native American Native Alaskan (0.7%). Most callers were insured through Medicaid (72.2%) with the largest needs for rental assistance (36.0%) followed by utilities (29.9%), , and food assistance (9.3%).

Pregnant women and new parents were provided with information to help improve maternal and infant health outcomes. Below are the information and referrals made to Title V MCH Program recommended resources:

MCH SPECIFIC INFORMATION PROVIDED	PERCENT
Pregnancy Risk Assessment Monitoring System	12.0%
Cribs for Kids	0.2%
Nevada Tobacco Quitline	0.1%
Sober Moms, Healthy Babies information	0.1%
Perinatal Mental Health Disorder helpline	0.2%

Program staff arranged four training courses for Nevada 211 call specialists to enhance caller's experiences. One session focused on trauma-informed call taking conducted by a human trafficking advocate. Crisis Support Services of Nevada led a discussion about how to deal with emotional and difficult callers. Dignity Health, experts in the field of Perinatal Mental Health Disorders (PMHD), presented allowing call staff to better understand the emotional health impact on birth parents and/or their families affected by PMHD. Title V MCH Program staff provided content about the Medical Home Portal.

Title V MCH Program funded agencies promoted Nevada 211 by providing information to staff and clientele about the value of the service and how to access its resources. CCHHS promoted Nevada 211 through clinic digital signage. All DHS staff include information in their email closings to find help 24 hours a day by dialing 211; texting 898-211; or visiting Nevada 211 website. The Title V MCH Program funded partners are required to register and regularly update program information with Nevada 211.

Nevada 211 Success Story

Nevada 211 Call Specialist response:

I received a call from a mother who said she was calling to get resources for her pregnant daughter. She explained that her daughter is in college and is a full-time student, not currently working, and wanted to know what type of resources may be available to her. I started by asking some questions to find out what her needs were at this time and was able to determine that health insurance was an important need at the time, from there I explained the other benefits she may be able to apply for with the Nevada Division of Welfare and Supportive Services (DWSS), when the mother asked specifically about the TANF program, she was happy that DWSS would also be able to answer those questions and she wouldn't have to be calling numerous places. I was also able to provide referral information for the WIC program. I went over the eligibility requirements and documents that may be required & at the end the mother expressed how thankful she was for us at NV 211 because, although she received a pamphlet with names and numbers, she did not know where to start since she was feeling overwhelmed and just wanted to help her daughter. I was glad that we had the information to help her get started.

Perinatal Immunizations Report

CHS provided immunizations to infants in the rural and frontier regions while providing Title V MCH resources and referrals to care. As many as 157 vaccinations were administered to 122 infants. Although Title V MCH does not fund immunizations, those visits are leveraged and Title V MCH-funded education, resources, and referrals were provided to caregivers.

The HRSA Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and Title V MCH Program funded Nevada Home Visiting (NHV) Program provided education and referral supports promoting timely vaccination for NHV

families and numerous evidence-based screenings and supports to promote healthy pregnancy and infancy for NHV families. MCAH facilitated information sharing on scheduled and catch-up immunizations, COVID, Mpox, and funded sensory-friendly vaccine kits to clinics and providers in partnership with the Southern Nevada Health District, the University of Nevada, Reno, and health care providers.

Congenital Syphilis (CS) Communication Products

In Nevada, CS cases have risen 1,825% from 2014 (n=4) to 2023 (n=77). Southern Nevada Health District consistently has the most counts with 52 cases in 2023, followed by Norther Nevada Public Health (formerly Washoe County Health District) with 22 cases. Although case counts are low in the rural areas, Nevada continues to monitor and evaluate the situation in rural counties.

To promote awareness of this epidemic and mitigation methods, the Title V MCH Program offered and released a number of communication activities and products including 1) an oral presentation entitled “Congenital Syphilis in Nevada” at a WIC local agency staff meeting to 102 attendees, the purpose of which was to inform staff of the public health significance of Syphilis and how the WIC program can help statewide efforts to reduce the incidence by answering client questions about Syphilis using CDC recommended language and working with Disease Investigation Specialists to help people with Syphilis connect to treatment and other services; 2) a Technical Bulletin “CDC Provides New Laboratory Recommendations for Syphilis Testing,” which was distributed to 134 local health authorities, county health officers, and other public health professionals; 3) a comprehensive data report on CS in Nevada to help the state identify missed opportunities for syphilis testing and treatment and is being used as a resource by the State and Medical Epidemiologists to identify areas of need and potential interventions; and, 4) a spreadsheet repository of evidence-supported CS reduction interventions pulled from various sources including original peer-reviewed scientific publications, recommendations from professional organizations (e.g., ASTHO), and guidance from the NV CS Community Action Team. The spreadsheet will allow decision-makers to identify interventions that are readily achievable (given elements such partners and anticipated barriers) and would have the greatest impact based on assigned levels of the Social and Ecological Model.

Perinatal/Infant Domain Accomplishments

MCAH continued to add MCH population-related content to the DPBH website and shared information and resources with partners pertinent to having a healthy pregnancy. MCAH participated in the Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET). Perinatal infant health highlights include active work in relation to substance use disorders (SUD) and pregnancy, newborn screening regulation development. Extensive outreach activities and partnerships supported varied messaging to improve birth outcomes, offer continuing medical education development and provision to prevent preterm birth, and widespread safe sleep messaging and perinatal mortality prevention efforts. The MCH and CSHCN Directors and SSDI Manager serve as support staff for the state MMRC and support Alliance for Innovation in Maternal Health (AIM) Program implementation statewide.

Perinatal/Infant Domain Data

NPM – Breastfeeding – Percent of infants who are ever breastfed

According to NVSS, since 2015, the percent of infants who are ever breastfed in Nevada fluctuated between a low of 76.8% (2022) and high of 81.9% (2016, 2018). The 2023 percent (77.6%) is below the national average of 85.3% in 2023. Nevada ranks near the bottom, 44th out of 50 states and D.C. for the best percentages of this measure.

NPM – Breastfeeding – Percent of infants breastfed exclusively through 6 months

Since 2016-2017, the percent of infants exclusively breastfed through 6 months in Nevada fluctuated between a low of 17.7% (2017-2018) and high of 24.4% (2020-2021) (NSCH). Currently, the percent of infants exclusively breastfed through 6 months in Nevada is 20.3% in 2022-2023. This is below the 2022-2023 national average of 28.7%, and below the Healthy People 2030 objective of 42.4%. Nevada ranks 46t^{h} out of 50 states and D.C. for the best percentages of this measure.

NOM – Preterm Birth – Percent of preterm births (<37 weeks)

According to NVSS, the percent of preterm births increased from 10.9% in 2022 to 11.1% in 2023. This is higher than the national average of 10.4%. Nevada ranks near the bottom for highest percent of preterm birth in 2022, at

38th out of 50 states and D.C. Racial/ethnic differences in percentages are apparent. In 2023, non-Hispanic Native Hawaiian or Other Pacific Islander women (17.2%) had the highest percent of preterm births, followed by non-Hispanic Black women (15.0%), non-Hispanic American Indian or Alaska Native women (12.0%), non-Hispanic Asian women (11.9%), non-Hispanic Multiple Race women (11.2%), and Hispanic women (10.6%). Percents for non-Hispanic White women (9.5%) were below the 2023 Nevada average of 10.4%.

NOM – Infant Mortality – Infant mortality rate per 1,000 live births

According to NVSS, Nevada's infant mortality rate per 1,000 live births markedly decreased from 5.8 in 2021 to 4.5 in 2022. Nevada ranked 12th out of 50 states and D.C, for lowest infant mortality rates. Racial and ethnic differences exist in infant mortality in Nevada. Three-year estimates for 2020-2022 indicate Nevada's Non-Hispanic Black infant mortality rates (8.9) were over twice that of Non-Hispanic Asian (4.1) and Non-Hispanic White (3.5) rates. The Hispanic rate was 4.7. For 2019-2021, no rates were available for Non-Hispanic American Indian/Alaska Native or Non-Hispanic Native Hawaiian/Other Pacific Islander infant population. Three-year infant mortality rate among women with less than high school education (7.2) was the highest, followed by high school graduates (6.0) and women with some college (4.3). Infant mortality rates were lowest in women who were college graduates (2.9).

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

According to the NVSS, since 2017, the sleep-related SUID rate per 100,000 live births in Nevada fluctuated between a low of 81.1 (2017) and high of 142.9 (2018). Except in 2017, SUID rates in Nevada have exceeded those of the nation. In 2022, the SUID rate was 117.5 in Nevada and 100.7 in the nation. From 2022-2022, maternal age group 20-24 years had the highest SUID rate (168.2), compared with 119.5, 83.8, and 77.3 for the 30-34, greater than or equal to 35-years, and 25-29 age groups, respectively. No data for the <20-year age group is available for this three-year period. Non-Hispanic Black women had the highest rate among any race or ethnicity (322.7) and was lowest for non-Hispanic White women (78.6). Hispanic women had a rate of 80.3. No data for other race or ethnicity groups is available for this three-year period.

Perinatal/Infant Health Plan for Application Year

Breastfeeding

Nevada's Title V MCH Program will reach out to childcare providers and other Nevada businesses across the state promoting the Breastfeeding Welcome Here Campaign. Businesses are invited to sign the *Breastfeeding Welcomed Here* pledge to receive a decal to display at their physical sites. The Title V MCH Program will continue to manage and promote the Nevada Breastfeeds website. The Nevada Breastfeeds website will be maintained, and content will be regularly updated and refreshed to ensure relevant and timely information is provided for breastfeeding families and interested collaborators, including information for CSHCN.

Nevada's Title V MCH Program will continue to provide support for the statewide Nevada Breastfeeds website by providing updates and funding ongoing hosting and maintenance costs. Funded partners will be required to collaborate with the Northern and Southern Breastfeeding Coalitions and other Title V MCH partners to help enroll Nevada businesses and childcare providers as breastfeeding-friendly establishments. The Statewide Coalition and Title V MCH team will continue to support critical NPMs related to attending Coalition meetings and leadership calls. Additionally, the Statewide MCH Coalition website and e-newsletters will continue and be distributed through community groups to expand outreach and participation. Promotion of Go Before You Show, Count the Kicks, Text4Baby, Nevada Tobacco Quitline, Nevada Breastfeeds, and other perinatal/infant health resources will also continue.

Title V MCH Program staff will regularly attend Breastfeeding Coalition meetings and support social media postings related to National Breastfeeding Awareness Week. The Breastfeeding banner will be hung across Carson Street in Carson City, Nevada promoting August as National Breastfeeding Awareness Month. Shared promotion of Black Breastfeeding Week and Black Maternal Health Week will continue. The Title V MCH Program will continue to partner with NHV to ensure efforts related to providing breastfeeding resources to home visiting participants continue and will continue to collaborate with Nevada WIC and SNAP-Ed staff. A Medicaid resource page will be added to the site.

Safe Sleep

Results of past Needs Assessments, as well as data for SUID in Nevada, demonstrates the need to continue promoting safe sleep as well as breastfeeding. Therefore, Nevada's Title V MCH Program will continue to include the NPM-Safe Sleep as a performance measure for the 2025-2030 funding cycle. In addition to collaborating with existing partners to promote breastfeeding and safe sleep, the Title V MCH Program will work to establish and fund new partnerships to increase the percent of infants placed to sleep on their backs, on a separate approved sleep surface, and placed to sleep without soft objects or loose bedding.

Title V funded Cribs for Kids (C4K) Program activities will continue in the 2025-2030 funding cycle. Train the trainer sessions will continue to be offered statewide with a focus on providing survival kits to rural areas and Tribal Nations. Additional trainings will be provided as requested. Technical assistance will be provided as needed, along with ongoing support to ensure agencies are collecting and entering mandatory data on three and twelve-month follow-up surveys. Safe Sleep Survival Kits will continue to be distributed through partner agencies statewide.

Nevada's Title V MCH Program will continue Safe Sleep and Injury Prevention education with Tribal Nations at Indian Health Service clinics and continue support for Safe Sleep Survival Kits and car seats in injury prevention efforts among the Tribal population. Tribal health clinics participate in Infant Safe Sleep initiatives, car seat installation, and additional resources will include drowning prevention, tobacco cessation, substance use in pregnancy, car safety, and other Title V MCH Program resources. All class participants are provided materials to enhance healthy outcomes including safe sleep brochures, Nevada Tobacco Quitline, Sober Moms, Healthy Babies, Nevada Breastfeeds, PRAMS, Text4Baby, and Nevada 211.

The Safe Sleep Media Campaign will continue radio and television public service announcements statewide to promote Safe Sleep for infants. Title V MCH Director will continue to be an appointee on the Statewide Executive Committee to Review Child Fatalities and FIMR and will work closely with community partners, local health authorities, and the Division of Child and Family Services (DCFS) to leverage efforts to end preventable infant and child mortality statewide, including SUID.

Substance Use

Title V MCH staff will continue to serve in core team roles for:

- CARA and Perinatal Health Initiative statewide member efforts and quality improvement of Infant Plan of Safe Care processes
- SBIRT policy change and implementation
- Family resource and provider resource development
- Stigma reduction
- MAT utilization, and
- Dyad-centered care

These efforts will continue, as will efforts to create robust wrap around care and referrals for pregnant women who use substances, including to the Nevada Tobacco Quitline. Additionally, the MCAH Section Manager serves in an appointed role on the Advisory Committee for a Resilient Nevada (ACRN) which recommends evidence-based strategies related to substance use and prevention that should be funded with Nevada opioid settlement funds; elevating perinatal/infant and women/maternal health outcomes as priority areas of focus.

State interest in formalizing a statewide perinatal quality collaborative will continue to be explored by Title V MCH Program staff. PRAMS Data to Action reports will include perinatal outcome areas of interest. Cross agency congenital syphilis response and prevention efforts will continue, with a key role for the MCAH Section. Newborn Screening (NBS) Advisory Board and Medicaid policy levers to improve birth outcomes and perinatal concerns will be addressed, as will Public Health Preparedness (PHP) and pediatric planning.

The Title V MCH Program will continue to fund the Sober Moms, Healthy Babies, website to prevent substance use among pregnant women. The public awareness campaign will continue to promote the website and distribution of referral cards and outreach materials. Collaboration with LHAs, PHI, and DPBH Substance Use Prevention, Treatment, and Recovery Services (formerly SAPTA) will ensure substance use in pregnancy materials and resources will be promoted to priority populations. In addition, all LHAs and MCH subgrantees will continue to promote the SMHB website and share SMHB referral cards and the SMHB website will continue to be promoted via public service announcements (PSA) in English and Spanish on radio and television stations statewide.

Title V MCH Program staff will work with partners to develop and maintain a list of treatment centers that receive and treat pregnant women. The list will be available on the SMHB website. Title V MCH Program staff will also work with partners to promote treatment availability for pregnant and postpartum women to increase the number of treatment facilities that designate vacancies to pregnant and postpartum women. Provider and family resources will continue to be added to the SMHB website as new items are developed, and the content will be kept up to date with new resources and a dedicated CARA page. The Title V MCH Program will continue to disseminate marijuana awareness materials to partners statewide.

Nevada Pregnancy Assessment Monitoring System (PRAMS)

PRAMS data will be used to monitor the progress of national and state pregnancy and birth-related health measures. PRAMS efforts will also identify and monitor self-reported maternal behaviors and experiences occurring before, during, and shortly after pregnancy among women who deliver live-born infants. Nevada PRAMS promotional items such as hot/cold packs, reusable water bottles, pens, tote bags, posters and flyers will be provided to OB/GYN offices, pediatricians, vital records, and WIC Clinics across Nevada. PRAMS staff will continue to attend Title V MCH Unit and Block Grant meetings, and Title V MCH Program staff will continue to serve on the PRAMS Steering Committee. All Title V MCH subrecipients will continue to include language in subawards to educate expectant parents about PRAMS. Promotional materials will be disseminated to suitable agencies to help inform Nevadans about PRAMS.

Fetal Infant Mortality Review (FIMR)

The Title V MCH Program will continue funding and serving on the Case Review Team (CRT) of the FIMR Program to reduce fetal and infant mortality in Washoe County. FIMR identifies contributing factors of fetal, neonatal, and postnatal deaths including identification of disparately impacted populations and recommendations to improve outcomes. To identify insurer-specific opportunities to reduce infant mortality gaps and look for opportunities to expand care, FIMR tracks the mother's insurance type during pregnancy and separates categories based on private, Medicaid, and no insurance. FIMR will facilitate ten CRT meetings where at least 40 cases will be reviewed each

FFY. Community Action Team (CAT) updates will be provided at the Northern Nevada MCH Coalition meetings. The CAT will consider implementing objectives and evaluation components for interventions of policy, systems or community changes needed to reduce fetal, neonatal, and postnatal deaths based on case findings, CRT recommendations, and community input.

The CRT will also be actively involved in implementing the birth spacing initiatives and promoting the Go Before you Show and Count the Kicks campaigns in Nevada. The CRT will continue to evaluate mortality reduction strategies, maternal substance use challenges, prevention of premature births, reducing disparities, maternal obesity, identification of cases directly or indirectly linked to COVID-19, and other emerging issues. FIMR staff will continue to participate in statewide MCH Coalition meetings and events, CDR meetings, Western Regional FIMR, and additional community program activities.

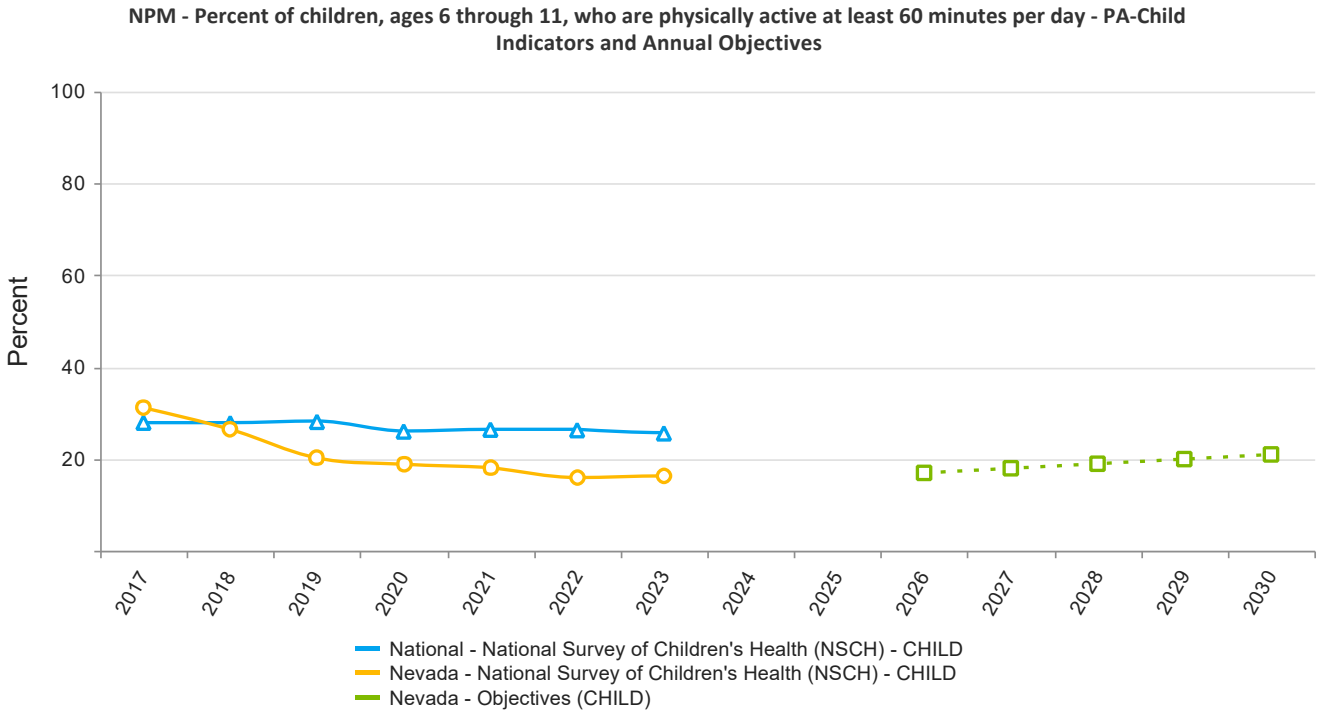
Perinatal/Infant Health and Wellness

The Title V MCH Program plans to award funds to local health agency partners and the DPBH CHS to promote perinatal and infant health among Nevada women and families. Clinic staff will educate parents of infants on the value of securing a medical home, being adequately insured, recommended immunizations, safe sleep, breastfeeding and nutrition, well-child checkups, and reproductive health. Participating local health agencies will promote Medicaid coverage for long-acting reversible contraceptives immediately postpartum, as well as monitor for symptoms of PMAD/PMHD. Clinic personnel will distribute various health-related materials provided by the Title V MCH Program and be encouraged to use digital clinic signage and social media posts to promote infant immunizations, Nevada Tobacco Quitline, Sober Moms, Healthy Babies, PRAMS, Text4Baby, Nevada Breastfeeds, and Nevada 211.

Nevada's Title V MCH Program will continue to partner on perinatal negative outcome reduction efforts and serve on the UNLV supported African American Subcommittee, MMRC and NOHME Advisory Committee report compilation on SMM and MM, and the Vaccine Equity Coalition. AIM implementation and efforts to establish a PQC in the state will continue. The MCH Director and EHDI Program Coordinator will be involved in the Newborn Screening Advisory Board. MCH staff will support ARPA funded efforts to increase the number of disorders on the Nevada blood spot panel by three, as well as support interconnectivity efforts to speed reporting to the Nevada State Public Health Laboratory.

The EHDI and Title V MCH Programs work closely together and are co-located in the MCAH Section. Both programs will explore possible funded efforts in relation to CCHD and EHDI data collection and capacity development, in concert with SSDI and the Office of Vital Records. The CSHCN Director serves on the Nevada ECAC and will continue to center MCH health topics, including but not limited to perinatal health outcomes. The MCAH Section Manager will participate in a Centralized Intake and Referral System (CIRS) workgroup, attend ECAC general and applicable subcommittee meetings, and participate in other MCH related collaborative groups that may be developed throughout the 2025-2030 funding cycle. Many MCH staff are and will continue to be involved in ECCS and other cross agency efforts to improve perinatal/infant and early childhood health outcomes. The MCH Director will continue to participate in appointed roles related to the Nevada Food Security Council, Statewide Executive Committee to Review Child Fatalities, Newborns Screening Council, FIMR, and numerous other initiatives, as well as partner with OSE and the CSTE Fellow on congenital syphilis efforts. The MCH and CSHCN Directors and MCAH Section Manager will continue to participate in PHI and other workgroups.

National Performance Measures



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CHILD	
	2024
Annual Objective	
Annual Indicator	16.3
Numerator	37,800
Denominator	232,452
Data Source	NSCH-CHILD
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	17.0	18.0	19.0	20.0	21.0

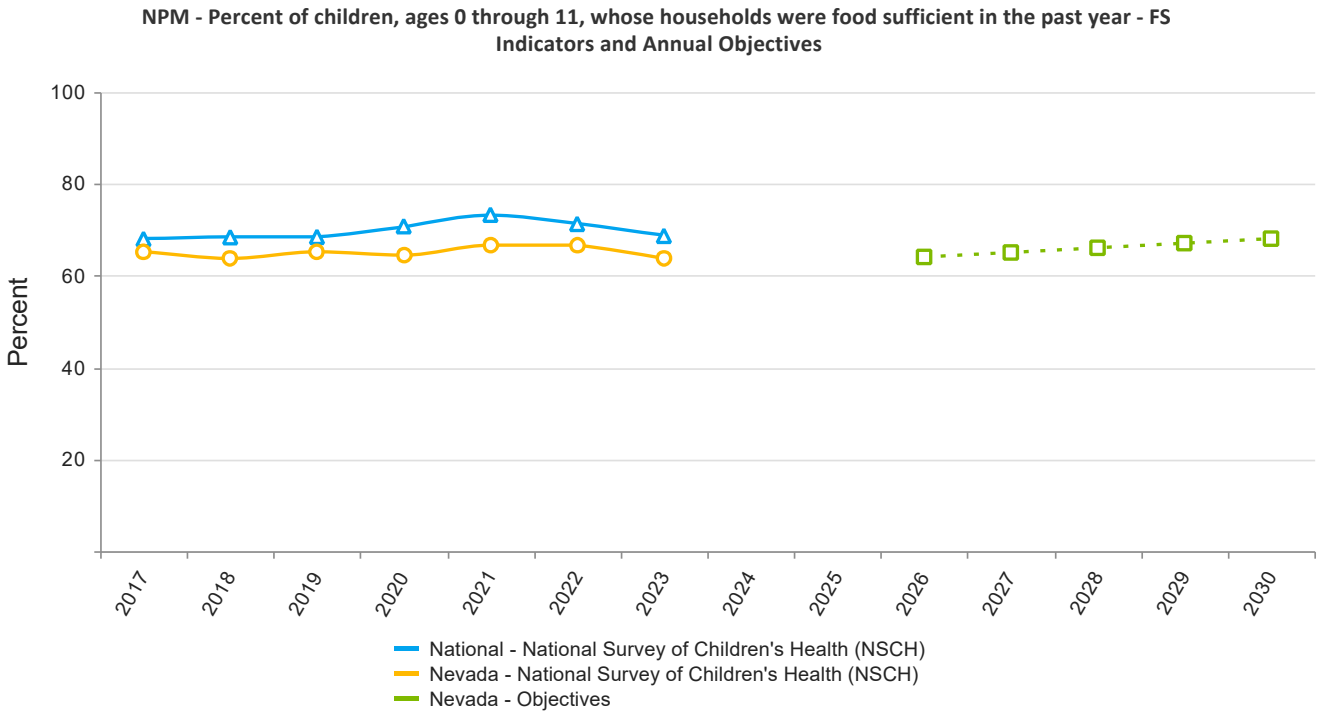
Evidence-Based or –Informed Strategy Measures

ESM PA-Child.1 - Percent of respondents from the Kindergarten Health Survey (KHS) who report their child exercises for at least 60 minutes per day at least 4-5 times a week

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	47.0	48.0	49.0	50.0	51.0



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	63.8
Numerator	275,025
Denominator	431,301
Data Source	NSCH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	64.0	65.0	66.0	67.0	68.0

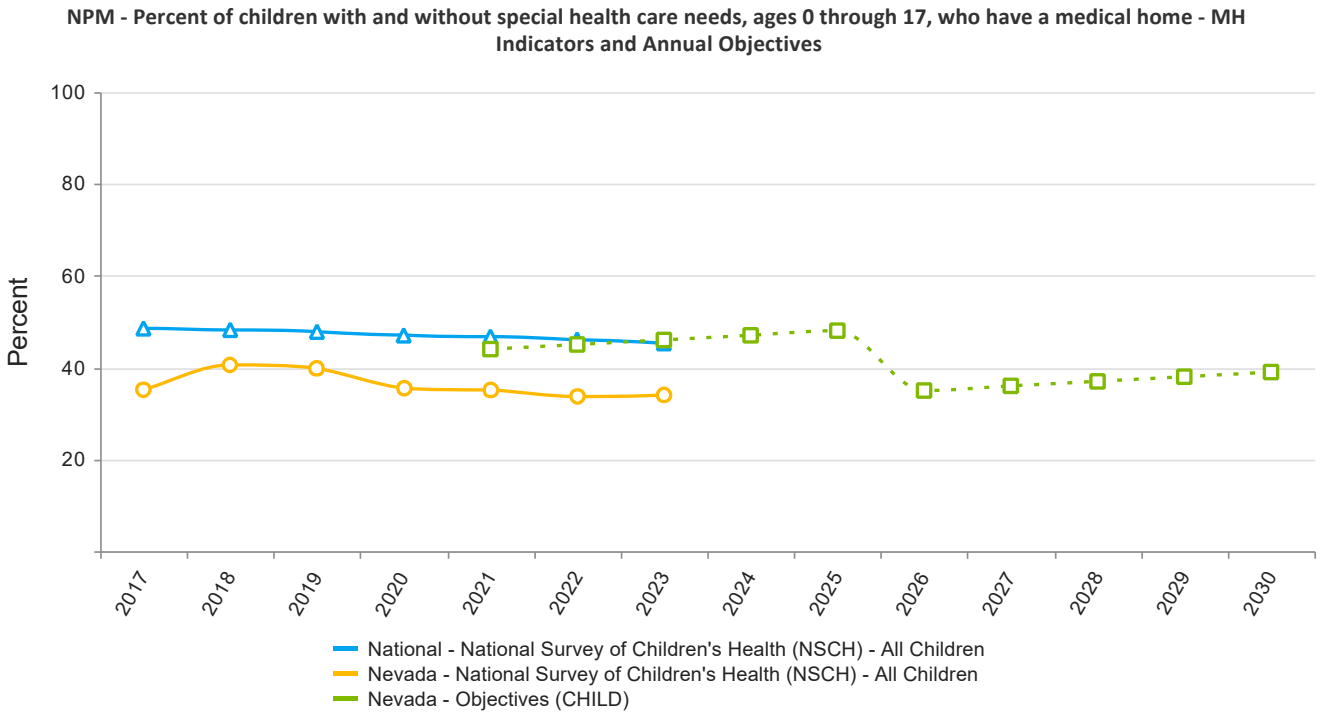
Evidence-Based or –Informed Strategy Measures

ESM FS.1 - Percent of Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Home Visitors who received training on nutrition and exhibited increased knowledge on food sufficiency and strategies on how to discuss nutrition with families

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	100.0	100.0	100.0	100.0



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - All Children					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		44	45	46	47
Annual Indicator	41.8	35.2	34.1	33.8	33.9
Numerator	240,683	203,838	199,127	234,616	233,226
Denominator	576,398	579,646	583,724	693,519	688,978
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-All Children	NSCH-All Children
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	35.0	36.0	37.0	38.0	39.0

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Percent of Nevada Medical Home Portal users who utilize the Services Directory feature to obtain information on providers and community resources.

Measure Status:	Active

State Provided Data			
	2022	2023	2024
Annual Objective			30
Annual Indicator	21.8	28.7	31
Numerator	7,221	13,754	12,550
Denominator	33,184	47,887	40,459
Data Source	Nevada Medical Home Portal Outbound Links Report	Nevada Medical Home Portal Outbound Links Report	Nevada Medical Home Portal Outbound Links Report
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	31.0	31.0	31.0	31.0	31.0

State Action Plan Table

State Action Plan Table (Nevada) - Child Health - Entry 1	
Priority Need	
Increase access to affordable nutritious foods among school aged children	
NPM	
NPM - Food Sufficiency	
Five-Year Objectives	
67% of children in Nevada will live in households where food was sufficient in the past year.	
Strategies	
Increase the number of eligible participants enrolled in WIC and SNAP	
Increase data sharing and capacity with internal and external partners	
ESMs	**Status**
ESM FS.1 - Percent of Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Home Visitors who received training on nutrition and exhibited increased knowledge on food sufficiency and strategies on how to discuss nutrition with families	Active
NOMs	
School Readiness	
Children's Health Status	
Behavioral/Conduct Disorders	
Flourishing - Young Child	
Flourishing - Child Adolescent - CSHCN	
Flourishing - Child Adolescent - All	
Adverse Childhood Experiences	

State Action Plan Table (Nevada) - Child Health - Entry 2

Priority Need

Increase physical activity among school aged children

NPM

NPM - Physical Activity - Child

Five-Year Objectives

By 2030, 20% of children, ages 6 though 11, will be physically active for at least 60 minutes per day in Nevada.

Strategies

Increase physical activity for children ages 6 to 11

Actively collect and monitor changes in physical activity habits for children in Nevada

Promote physical activity for Nevada children ages 6 to 11

ESMs	Status
ESM PA-Child.1 - Percent of respondents from the Kindergarten Health Survey (KHS) who report their child exercises for at least 60 minutes per day at least 4-5 times a week	Active

NOMs

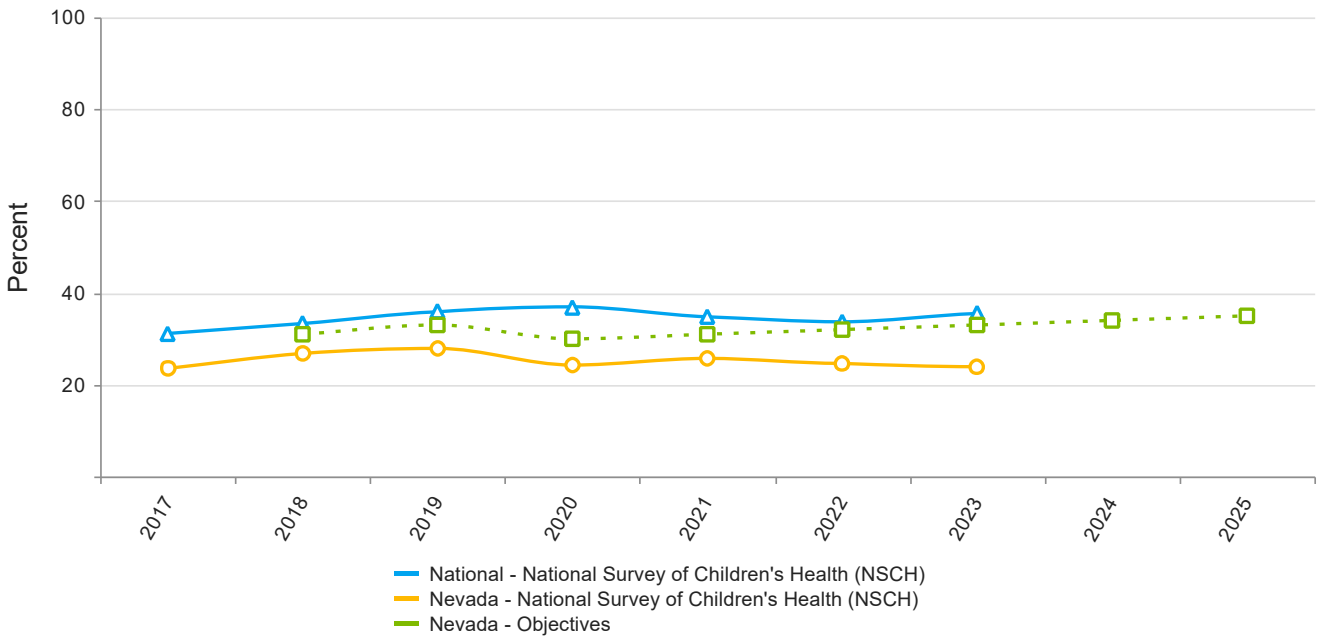
Children's Health Status

Child Obesity

State Action Plan Table (Nevada) - Child Health - Entry 3	
Priority Need	
Promote a Medical Home	
NPM	
NPM - Medical Home	
Five-Year Objectives	
35% of children with and without special health care needs, ages 0-17, will have a medical home	
Strategies	
Increase awareness of the importance and benefits of a medical home and adequate insurance coverage.	
Increase care coordination, adequate insurance coverage, and access to a medical home amongst children ages 0-17 statewide.	
ESMs	**Status**
ESM MH.1 - Percent of Nevada Medical Home Portal users who utilize the Services Directory feature to obtain information on providers and community resources.	Active
NOMs	
Children's Health Status	
CSHCN Systems of Care	
Flourishing - Young Child	
Flourishing - Child Adolescent - CSHCN	
Flourishing - Child Adolescent - All	

2021-2025: National Performance Measures

2021-2025: NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS
Indicators



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	30	31	32	33	34
Annual Indicator	30.6	22.3	21.6	24.5	23.8
Numerator	25,096	16,175	17,977	19,859	16,860
Denominator	82,133	72,622	83,198	80,960	70,804
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

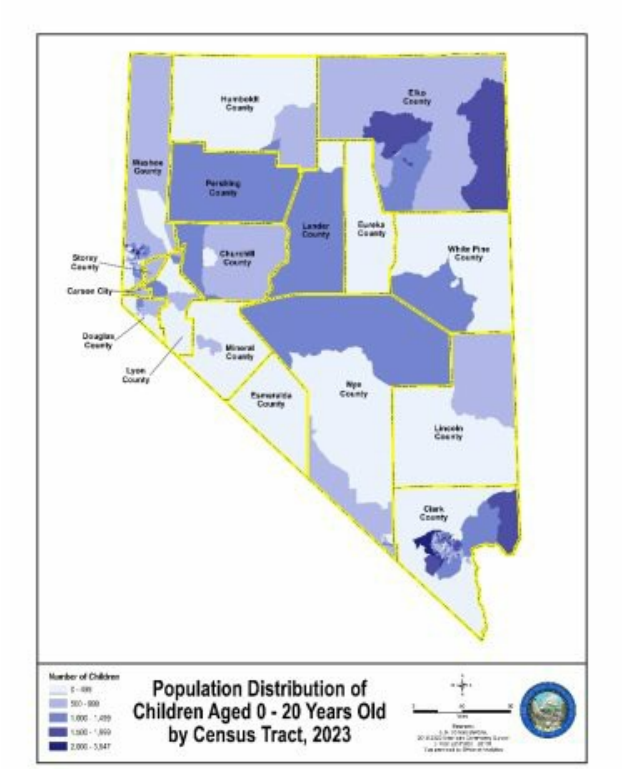
2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM DS.1 - Percent of Medicaid enrolled children, ages 9 through 35 months, who received a developmental screening using a standardized tool.

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	7	8	9	10	11
Annual Indicator	7.5	7.6	8.8	8.9	12
Numerator	3,764	3,780	4,558	4,561	5,870
Denominator	50,481	49,902	51,842	50,970	48,721
Data Source	Nevada Medicaid Data	Nevada Medicaid Data	Nevada Medicaid Data	Nevada Medicaid Data	Nevada Medicaid Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Child Health Annual Report

The Title V MCH Program improves child health outcomes by partnering with families and agencies to help children reach optimal growth, psychological development, and overall health. Child wellness is promoted through developmental screens, partnerships with agencies serving schools and childcare centers, information sharing about the benefits of a medical home, the value of adequate health insurance, and resources regarding childhood immunization schedules, Bright Futures recommendations, Learn the Signs, Act Early (LTSAE), and physical activity recommendations. The population distribution by Census tract for children, ages zero to 20 years, is indicated in the map below.



The Nevada Title V MCH Program selected National Performance Measures for Developmental Screening (NPM DS) and Standardized Measures for Adequate Insurance (SM AI) to improve child health outcomes. Funded partners implemented strategies to increase the percentage of children ages nine through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (NPM DS) and to increase the percentage of children, ages zero to 17 years who are adequately insured (SM AI). Health outcomes should improve when developmental screens are conducted timely and children are adequately insured with consistent health coverage. According to the National Survey on Children's Health (NSCH) 2022-2023 data, 23.8% of Nevada children ages nine through 35 months received a developmental screening using a parent-completed screening tool in the past year compared to 35.6% nationwide. NSCH notes the breakdown for this category as:

- 24.5% of Nevada and 37% Nationwide report consistently insured throughout the past year
- Nevada reports 36.3% are in households with at or greater than 400% above the Federal Poverty Level (FPL), and
- Nationwide data notes 42.3% are at or above the FPL.

Additional efforts to improve child health include collecting survey data about five-year old's for improving early childhood health planning, and referrals made through Nevada 211 call/chat lines and the Nevada Medical Home Portal during the reporting period. Specific program activities and successes are highlighted below.

Developmental Screening

The Nevada Title V MCH Program worked to increase the percentage of children, ages nine through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (NPM DS).

To improve developmental screening, Title V MCH Program funded partners provided over 500 community, parent, and provider education courses statewide concerning developmental milestones and the importance of screening using the Pyramid Model framework. The Pyramid Model is a tiered prevention and intervention framework to avert and address challenging behavior through evidence-based practices. The Pyramid Model consists of four layers:

- The foundation, where systems and policies are developed to ensure an effective workforce can adopt and sustain evidence-based practices
- Tier one, where universal supports for all children occur through nurturing and response relationships and high-quality supportive environments (behavioral needs of about 80% of children)
- Tier two, where prevention through targeted social-emotional strategies is used to prevent problem behaviors (behavioral needs of about 15% of children)
- Tier three, where individualized, intensive interventions comprise the top of the pyramid (required for about 5% of children)

Nevada's Learn the Signs, Act Early (NvLTSAE) milestone checklists help parents set goals related to their child's growth and development, offer parents education about a child's developmental milestones, and provide resources to refer a child when indicated; the EHDI and NHV programs promote LTSAE. NHV provides the Ages and Stages Questionnaire (ASQ) and ASQ-Social Emotional, 3rd edition (ASQ:SE-3) screenings to the families they serve and facilitates resources and referrals to care related to developmental delays. NHV and EHDI share Milestone Moments and NvLTSAE resources with all families they serve in addition to the screenings NHV home visitors provide. Title V MCH works with the NvLTSAE Ambassador and other agencies to promote the program statewide.

Nevada Pyramid Model Partnership Report - The Children's Cabinet

The Title V MCH Program provides funding to the Nevada Pyramid Model Partnership, in collaboration with The Children's Cabinet. Nevada Pyramid Model Partnership is a statewide collaborative initiative to enhance the ability of early care and education (ECE) personnel and families to address the social, emotional, and behavioral needs of all young children birth to five years. Using the Pyramid Model, a tiered prevention and intervention framework to prevent and address challenging behavior through evidence-based practices, Nevada Pyramid Model Partnership provides training and technical assistance (TA) for supporting social emotional competence and addressing challenging behaviors in young children at-risk for or those with identified developmental delays.

The Title V MCH Program funds three Nevada Pyramid Model Partnership staff positions, including the Regional Coordinator (RC), Data and Evaluation Coordinator (D&EC), and Family Engagement Coordinator (FEC). The RC provides leadership, TA and training to local and regional Pyramid Model implementation sites and connects with diverse partners to expand potential sites. The D&EC handles data collection and summarization for the Ages & Stages Questionnaire: Social-Emotional, 2nd edition (ASQ:SE-2) and Pyramid Model evaluation activities. The FEC is a contractual position in collaboration with the statewide nonprofit organization Nevada Parents Encouraging Parents, Parents Educating Professionals, and Professionals Empowering Parents (Nevada PEP).

In addition to Title V MCH funding, The Children's Cabinet expanded the Pyramid Model program during the reporting period through funding from the Child Care and Development Block Grant (CCDBG). The CCDBG supported three childcare provider classroom specialists, one in northern Nevada and two in southern Nevada. The Children's Cabinet's classroom specialists provide childcare providers with resources and coaching around implementing Tier 1 (Universal Promotion) and Tier 2 (Secondary Prevention) teaching strategies. An example of a teaching strategy would be to post a visual schedule for young children to reference, or to intentionally teach friendship skills during circle time. The goal of this support is to reduce the number of children (particularly children receiving childcare subsidy) being asked to leave their childcare programs either temporarily by suspension, or permanently by expulsion. CCDBG funding also supports the statewide Nevada Pyramid Model Partnership Coordinator, Janice Lee (University of Nevada, Reno), to systematically support all elements of the Pyramid Model framework and services across the system with various partners.

The Northern Nevada Coordinator facilitated a preliminary cohort with Family Child Care providers throughout the reporting period. They monitored classrooms implementing the Teaching Pyramid Observation Tool (TPOT) and Teaching Pyramid Infant–Toddler Observation Scale (TPITOS) assessments which will allow for better classroom

level supports.

The Southern Nevada Coordinator engaged in 32 outreach activities during the reporting period. She distributed 559 Nevada Pyramid Model Partnership Program Brochures, 750 Backpack Connection Series, and 779 Pyramid Model Family Partner Brochures. This outreach connected the Coordinator with community partners, families, and childcare centers and providers.

Coordinators attended 18 site-level leadership team meetings and conducted 32 trainings for implementation and demonstration site staff. Coordinators provided most of their coaching focus to Tier 1 (universal) and Tier 2 (prevention) support. Coordinators spent their main coaching hours in these top five categories: leadership team meetings, data collection, problem-solving discussions, data review and TPOT and TPITOS assessments.

Nevada Pyramid Model Partnership sites administered 615 Ages & Stages Questionnaire: Social-Emotional, 2nd edition (ASQ:SE-2) screenings. Statewide, 42 participants attended 10 training sessions. For all participating school district classrooms, a set of materials was provided to support social and emotional skills using the Pyramid Model framework, with most materials provided in English and Spanish. Fact sheets were provided for each family, and some families received additional materials to support their abilities to teach and support their child(ren)'s social and emotional skills at home.

Children's Health and Wellness Outcomes

Nine public health clinics were awarded Title V MCH Program funding help improve children's health and wellness outcomes. These entities included Carson City Health and Human Services (CCHHS) in Northern Nevada and eight rural nursing clinics within DPBH Community Health Service (CHS) providing services in rural and frontier Nevada counties. Clinic nurses provided information about the value of adequate health insurance, age-appropriate developmental screens, overall child wellness, immunization schedules, oral health, and physical activity. Each public health entity refers families with private insurance and Medicaid to primary care providers to establish a medical home with local pediatricians. Families were provided with CDC Milestone Moments booklets or given information on how to access CDC's Milestone Tracker App to monitor their child's development.

Staff distributed child health-related materials at community events and clinic visits. These materials included, but were not limited to, Title V MCH Program resources listed on Nevada 211, the Medical Home Portal, resources regarding health care transition, and child well visit promotion.

CCHHS conducted several child health and wellness clinical support activities. CCHHS distributed 466 vaccination reminder cards for children ages birth to six y.o. and 8,988 to children aged seven – 17 y.o. Childhood immunizations and the Medical Home Portal were endorsed at outreach events and in health promotion marketing campaigns, including clinic digital signage. Child vaccination Facebook messages reached 47,596 people with 1% engaged users.

CHS served children within clinic settings and through community immunization events, administering 510 vaccines to children and youth ages 1-21 y.o. during community point of dispensing sites (PODS). Although Title V MCH does not fund immunizations, those visits are leveraged and Title V MCH-funded education, resources, and referrals were provided to caregivers.

Continuous and Adequate Health Insurance

SM AI efforts were conducted to increase the percentage of children aged zero to 17 y.o. who were continuously and adequately insured. The NSCH 2022-2023 report showed 58.9% of Nevadan children aged zero - seventeen y.o. to be consistently insured throughout the reporting period, compared to 66.5% nationwide. Title V MCH Program and funded partners promoted the value of continuous and adequate health insurance through listservs, brochures, e-newsletters, and social media.

Public health nurses from CCHHS and the DPBH CHS Program provided insurance resources and referrals to uninsured people in Nevada's rural and frontier regions through Nevada Medicaid, Nevada Check Up, and Nevada Health Link. Families not eligible for Medicaid or other insurance were referred to the Access to Healthcare Network (AHN) Medical Discount Plan. Additionally, the NHV Program, co-located with Title V MCH, works directly with families of young children to facilitate completion of insurance enrollment referrals with the aim of increasing adequate insurance coverage.

Nevada Medicaid works in partnership with the U.S. Centers for Medicare & Medicaid Services (CMS) to provide quality

medical care for eligible individuals and families. Services are provided through a combination of traditional Fee for Service (FFS) provider networks and four large contracted managed care organizations (MCOs). Nevada Medicaid partners with the Title V MCH Program for informational and referral resources on the Katie Beckett waiver program, development of the one-sheet on Medicaid coverage for legally present children, and many other SM AI-related efforts. Staff from Nevada Medicaid, DHS, and Title V MCH meet at least quarterly to collaborate and share information focused on MCH populations in the state. Similar quarterly meetings occur with Nevada Early Intervention Services (NEIS) staff and through other cross agency MCH efforts.

Nevada Institute for Children's Research and Policy (NICRP) Kindergarten Heath Survey (KHS)

The Title V MCH Program funds NICRP to conduct an annual health survey of children entering kindergarten in partnership with all school districts statewide. Survey data provides estimates for monitoring MCH indicators and reporting to local, state, and federal entities and policymakers. The desired outcomes are to inform efforts on how to improve future programming for child health.

The Health Status of Children Entering Kindergarten in Nevada (2023-2024 results) is posted on NICRP's website and the agency distributed the report statewide to partners. The Title V MCH Program placed a link to the report on the DPBH website, on documents shared with funded partners, and the information was included in the MCH Coalition and PCO e-newsletters for mass distribution.

NICRP circulated KHS questionnaires to all public elementary schools statewide (paper and electronic). NICRP received 5,514 surveys (20.5% response rate) from parents in 16 of the 17 school districts. All data was weighted (n = 28,871) to derive comparisons on issues representing Clark, Washoe, and Rural counties combined.

- Health Status: Compared to last year, behaviors in the health status category remain steady with minor fluctuations. There was a slight increase in kindergartners being at a healthy weight (51.3% to 52.3%) and underweight (15.6% to 16.3%), whereas those being overweight/obese decreased (33.2% to 31.4%). Kindergartners engaged in 60 minutes of daily physical activity increased (36.7% to 38.6%). There was an increase in those drinking non-diet soda once a day or more (6.7% to 8.0%). Kindergartners exclusively breastfed decreased at one month (49.7% to 49.1%), three months (39.7% to 38.9%), and six months (26.9% to 26.8%), while infants exclusively breastfed at 12 months increased (18.3% to 20.2%).
- Household Income: Compared to last year, households making less than $55,000 per year decreased (45.9% to 44.3%), while those making $55,000 or more per year increased (54.2% to 55.7%).
- Insurance Status: Compared to last year, a slight decrease occurred in kindergartners who were covered by Medicaid (34.3% to 33.9%) and covered by private insurance (47.5% to 44.2%), whereas there was an increase in kindergarteners covered by Nevada Check-Up (4.1% to 4.4%) and those who were uninsured (5.3% to 6.8%).
- Routine Care: Compared to last year, there was a decrease in kindergartners receiving a routine medical check-up (90.5% to 89.3%), having a primary care provider (91.6% to 89.6%), and visiting the dentist (78.9% to 78.2%).
- Barriers to Accessing Health Care: Compared to last year, increases occurred in most categories. Barriers reported included lack of transportation (3.5% to 4.0%), no insurance (5.9% to 6.5%), and money/financial challenges (8.6% to 8.7%). There was a decrease in the barrier of a lack of quality medical providers (7.8% to 7.5%). Less respondents tried to access mental health services (9.0% to 8.0%), though a larger percentage had trouble obtaining them (51.3% to 59.3%).

Children's Behavioral Health

The Title V MCH Program attended child focused social-emotional, behavioral, and mental health meetings through the Nevada Children's Behavioral Health Consortium, the Nevada Department of Education (NDE), and the Nevada Division of Child and Family Services (DCFS). Topics of interest included Medicaid billing updates and policy changes, services assisting CSHCN, activities conducted through the DCFS Systems of Care Grant, and School-Based Mental Health Services.

NDE and DCFS Collaboration Meetings involved active sessions to build the Interconnected Systems Framework for state agencies working on childhood resiliency. Discussions and workgroups focused on compiling a comprehensive document of state programs assisting children in crisis.

School-Based Health Services

The Title V MCH Program provided guidance to agencies interested in setting up school-based health centers (SBHC) by sharing contacts and resources for successful SBHC outcomes. Staff referred SBHC sponsoring agencies with Medicaid billing questions to appropriate staff at Nevada Medicaid. Staff also worked to help educate key partners and policymakers on the differences between SBHCs and School Based Services through Medicaid and met with private and public partners in this space. A SBHC Toolkit was revised and updated and SBHC special interest groups attended by MCH staff.

Child Health Domain Accomplishments

The Title V MCH Program focused on improving the health status of children to reduce negative long-term implications for health, productivity, and longevity. Funded partners dedicated efforts to help children reach optimal physical growth, psychological development, and overall health. Parents/caregivers, providers, and partners received best practice information about age-appropriate developmental screens, the benefits of a medical home, the value of being adequately insured, childhood immunization schedules, and physical activity.

The Health Status of Children Entering Kindergarten in Nevada report showed behaviors in the health status category remaining relatively steady with only slight fluctuations from last year. There were increases in the number of kindergartners receiving a routine medical check-up, having a primary care provider, and visiting the dentist.

MCAH staff assisted in Early Childhood Comprehensive Systems (ECCS)-related efforts to support MCH and ECE systems in Nevada and shared fiscal and program data with key partners, and staff are part of the CIRS workgroup to look at paths to a one stop shop bidirectional referral system for families. MCH Director participated in a NASHP child behavioral health and I/DD technical assistance opportunity led by Nevada Medicaid and including NDE.

MCH staff partnered with NSIP to promote and assist in sensory friendly vaccine kit statewide distribution.

MCH Director serves on the Nevada Executive Committee to Review Child Fatalities and a workgroup focused on increasing child abuse prevention training for providers. Opportunities to leverage efforts and education across systems to prevent child death and injury are core to these efforts.

Child Health Data

NPM – Developmental Screening – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

According to the 2022-2023 NSCH, 23.8% of Nevadan children ages 9 through 35 months received a developmental screening. Nevada is below the 2022-2023 national average of 35.6%, and ranks 49th of the 50 states and D.C.

SM – Smoking – Household – Percent of children, ages 0 through 17, who live in households where someone smokes

The 2022-2023 NSCH found 12.3% of Nevada children aged 0 through 17 live in households where someone smokes. Nevada is comparable to the national average of 11.5% from 2022-2023. Nevada ranks below the median for best or low percentages, 26th out of 50 states and D.C. When stratifying Nevada data by health insurance, households with Medicaid insurance have the highest percentage for someone who smokes at 18.6%, followed by uninsured households (14.9%), and private insurance (8.6%).

SM – Adequate Insurance – Percent of children, ages 0 through 17, who are continuously and adequately insured

According to data from the NSCH, the percent of children who are continuously and adequately insured has remained relatively stable from 62.2% in 2016 to 63.9% from 2020-2021 but decreased to 58.9% in 2022-2023. Nevada's rate of adequately insured children is lower than the national average of 66.5%. Nevada ranks near the bottom for best estimate at 50th out of the 50 states and D.C. Disparities exist in Nevada for this measure. Non-Hispanic Black children have the lowest percentage of continuous and adequate insurance coverage at 51.0%, followed by Non-Hispanic Asian at 54.8%, and Hispanic children at 58.2%. Non-Hispanic White and Non-Hispanic Multiple Race have higher percentages of continuous and adequate coverage, at 62.0% and 61.3%, respectively.

Child Health Plan for the Application Year

Physical Activity

An emerging need identified from the 2025 Needs Assessment is related to children's physical activity. To address this need, the Title V MCH team plans to work over the 2025-2030 funding period to increase the number of children, ages 6 through 11 y.o., who are physically active for at least 60 minutes per day. To track the progress being made for this NPM, the ESM of the percentage of Kindergarten Health Survey (KHS) respondents who report their child exercises for at least 60 minutes per day will be utilized.

Title V will continue to fund partners to conduct surveys regarding children's physical activity behaviors, including the KHS through UNLV's NICRP. This will generate a reliable surveillance system to track physical activity trends among young children in Nevada to inform the Title V Program of progress. Additionally, Title V will collaborate with local health authorities or other funded partners to promote physical activity through awareness and education campaigns to inform Nevada families about the importance of physical activity for children.

The Title V MCH Program will request applications from and fund a community-based organization(s) to provide physical activity opportunities to children, including yoga, meditation, and stress reduction methods to increase skills in social and emotional learning among children ages 6 to 11 y.o. Similar work has been done with the adolescent population in Nevada, and the goal is to expand the program over the 2025-2030 funding cycle to increase physical activity for children.

Food Sufficiency

Access to safe and healthy food options was identified as an emerging priority need for Nevada children in the 2025 Needs Assessment. To address this need, Nevada's Title V MCH Program will implement several coordinated strategies to address food sufficiency across the state. Key efforts will include increasing enrollment in WIC and SNAP, enhancing cross-sector collaboration, and strengthening data capacity related to food access. The MCH Director currently serves on the Nevada Governor's Council on Food Security.

Nevada's Title V MCH Program will partner with WIC, SNAP, and other programs to identify and support eligible families in accessing available benefits. Program staff will also collaborate with NHV and other early childhood programs to promote enrollment in nutrition assistance programs and ensure families are aware of all their options. In partnership with private and public organizations, Title V staff will support community events, training, and outreach efforts that include education on food sufficiency, available federal nutrition programs, and strategies to improve food access, including expanding WIC and SNAP benefit use at farmer's markets.

To support frontline staff, Nevada's Title V MCH team will provide training for home visitors on how to effectively discuss food sufficiency with families during home visits. Finally, to improve data capacity, the Title V MCH Program will strengthen data sharing across agencies, promote coordinated service delivery, and ensure additional Title V staff attend the Nevada Governor's Council on Food Security and regional food security meetings.

Children's Health and Wellness

Nevada's Title V MCH Program will award funds to local health agencies and DPBH CHS which provides care in rural counties to promote child health. Staff will educate parents/caregivers of children on wellness and nutrition topics, the value of securing a medical home and being adequately insured, yearly well-child checkups, immunization schedules, and physical activity. Clinic personnel will distribute various child health-related materials provided by the Title V MCH Program. Partners will promote recommended childhood immunizations, physical activity, and food assistance options using clinic digital signage and social media posts, and MCH staff will cross promote the CDPHP 5-2-1-0 campaign and associated HEALNV website and educational materials statewide.

MCAH staff will continue to assist in Early Childhood Comprehensive Systems (ECCS)-related efforts to support MCH and ECE systems in Nevada and staff are part of the CIRS workgroup to look at paths to a one stop shop bidirectional referral system for families seeking services. The MCH Director will continue to serve on the Nevada Executive Committee to Review Child Fatalities and a workgroup focused on increasing child abuse prevention training for providers. Opportunities to leverage efforts and education across systems to prevent child death and injury remain core to these efforts.

The MCAH Section Manager and other MCH staff will participate in the AMCHP technical assistance opportunity focused on food and housing security, along with staff from other agencies and CBOs.

Nevada Institute for Children's Research and Policy

In partnership with all 17 Nevada School Districts, NICRP will continue to conduct an annual health and behaviors survey of children entering kindergarten with funding from the Title V MCH Program. The Health Status of Children Entering Kindergarten in Nevada annual report will be posted on NICRP's website and distributed to partners statewide. Data results will continue to be used to monitor progress in meeting child health outcomes and to help determine where limited resources should be targeted to make the greatest impact.

Children's Behavioral Health

Nevada Title V MCH staff will continue to attend interconnected systems framework (ISF) social-emotional, behavioral, and mental health collaboration meetings to improve childhood resiliency. Content will include school and community resources ensuring children living with disabilities receive needed educational and emotional supports. The MCH Director will continue to participate in NASHP Medicaid and Department of Education severe mental illness and intellectual and developmental disability (I/DD)-focused efforts, serve on the Nevada Governor's Council on Developmental Disabilities, and work with state providers and CDC specific to ADHD.

School-Based Health Centers (SBHCs) and School Based Services (SBS)

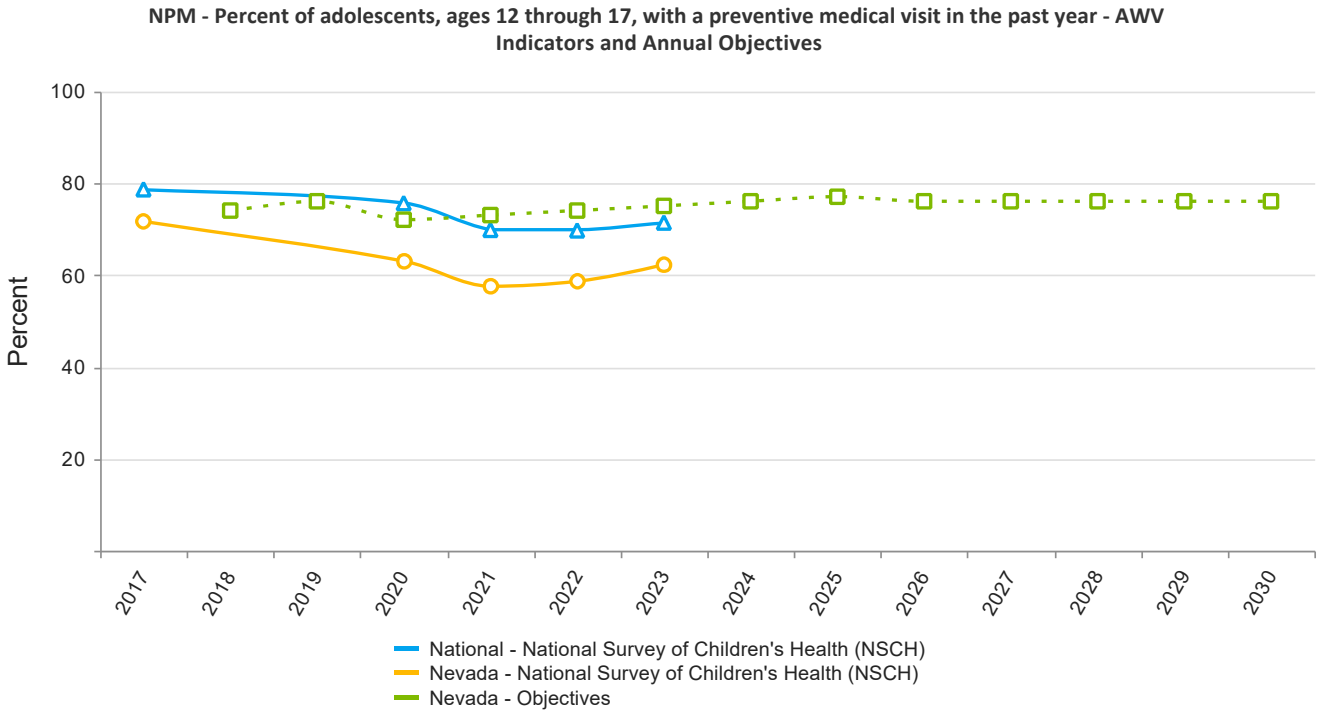
Nevada Title V MCH Program staff will continue to provide the Nevada SBHC Toolkit as well as help increase awareness of Medicaid school-based services. Staff will continue to participate in SBS efforts led by Medicaid and NDE and will try to expand the types of SBS available and increase awareness of SBS opportunities statewide.

Early Childhood Advisory Council (ECAC)

The CSHCN Director will continue to serve in the maternal and child health position on the Nevada ECAC and focus on ensuring health is integrated in ECCS efforts. Various Title V staff will participate in ECAC subcommittees as appropriate to their position. The MCAH Section Manager's experience in ECE and ECAC contexts will continue to inform MCH efforts.

Adolescent Health

National Performance Measures



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	72	73	74	75	76
Annual Indicator	64.5	62.1	58.5	58.6	62.1
Numerator	143,969	142,933	139,135	137,289	143,865
Denominator	223,281	230,016	238,028	234,204	231,846
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	76.0	76.0	76.0	76.0	76.0

Evidence-Based or –Informed Strategy Measures

ESM AWV.1 - Percent of Medicaid EPSDT eligible adolescents, ages 12 through 17, who received at least one initial or periodic screen

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective	26	32	34	36	38
Annual Indicator	31	36	35	36	37
Numerator					
Denominator					
Data Source	Center for Medicare and Medicaid Services Form 416	Center for Medicare and Medicaid Services Form 416	Center for Medicare and Medicaid Services Form 416	Center for Medicare and Medicaid Services Form 416	Center for Medicare and Medicaid Services Form 416
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	39.0	39.0	39.0	39.0	39.0

State Performance Measures

SPM 3 - Rate of STI Infections ages 12-17 years

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	556
Numerator	1,454
Denominator	261,510
Data Source	Nevada STI Morbidity Files
Data Source Year	2024
Provisional or Final ?	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	550.0	525.0	500.0	475.0	450.0

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Nevada) - Adolescent Health - Entry 1	
Priority Need	
Increase referrals and appropriate care for adolescents.	
NPM	
NPM - Adolescent Well-Visit	
Five-Year Objectives	
67% of adolescents, ages 12 through 17, will have had a preventive medical visit in the past year Healthy People 2030 Goal (AH-01): 82.6%	
Strategies	
Increase the awareness of the benefits of preventive medical visits and adequate insurance coverage among Nevada adolescents.	
Increase compliance with AAP guidelines for adolescent screenings to ensure addressing ACEs among providers.	
ESMs	**Status**
ESM AWV.1 - Percent of Medicaid EPSDT eligible adolescents, ages 12 through 17, who received at least one initial or periodic screen	Active
NOMs	
Teen Births	
Adolescent Mortality	
Adolescent Motor Vehicle Death	
Adolescent Suicide	
Adolescent Firearm Death	
Adolescent Injury Hospitalization	
Children's Health Status	
Child Obesity	
Adolescent Depression/Anxiety	
CSHCN Systems of Care	
Flourishing - Child Adolescent - CSHCN	
Flourishing - Child Adolescent - All	

State Action Plan Table (Nevada) - Adolescent Health - Entry 2

Priority Need

Improve access to resources and services around sexual health and reproductive health

SPM

SPM 3 - Rate of STI Infections ages 12-17 years

Five-Year Objectives

500 per 100,000 ages 12-17 years

Strategies

Reduce barriers to accessing reproductive health services for adolescents ages 12-17

Reduce rates of reproductive system cancers among adolescents by increasing access to preventive health visits.

ESMs | Status

No ESMs were created by the State. ESMs are optional for this measure.

NOMs

Teen Births

2021-2025: National Performance Measures

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC
Indicators and Annual Objectives

2021-2025: NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Adolescent Health - All Adolescents

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - All Adolescents					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		13	14	15	16
Annual Indicator	13.5	10.6	8.3	9.8	12.6
Numerator	23,357	18,795	15,091	23,872	30,766
Denominator	173,474	178,069	181,060	243,455	243,933
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-All Adolescents	NSCH-All Adolescents
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM TAHC.3 - Percent of families who report the information received by a Family Navigator through Family Navigation Network met their needs for transition from pediatric to adult health care.

Measure Status:		**Active**	
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			70
Annual Indicator		100	87.6
Numerator		20	198
Denominator		20	226
Data Source		Title V MCH Family Navigation Network	Title V MCH Family Navigation Network
Data Source Year		FFY23	FFY2024
Provisional or Final ?		Provisional	Provisional

2021-2025: State Performance Measures

2021-2025: SPM 3 - Repeat teen birth rate

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	15	14	14	13	13
Annual Indicator	14.3	17	13.2	14	11.7
Numerator	221	233	169	177	144
Denominator	1,543	1,367	1,278	1,262	1,227
Data Source	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

2021-2025: SPM 4 - Teenage pregnancy rate

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	21	20	19	16	15.5
Annual Indicator	16.9	17.7	16.1	19.5	17.3
Numerator	1,758	1,905	1,797	2,219	1,969
Denominator	104,108	107,395	111,285	113,742	114,042
Data Source	NV Vital Records System	NV Vital Records	NV Vital Records	NV Vital Records	NV Vital Records
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Adolescent Health Annual Report

Adolescence is a critical period of discovery and opportunity. Starting around age 10 years old (y.o.), young people learn about and adapt to the world around them, develop relationships, build resilience, and create interests and goals in adolescence which shape their adult lives. Habits and behaviors frequently started during adolescence (healthy weight management, exercise, sexual behavior, nicotine/tobacco, alcohol, substance use, etc.) can impact health outcomes in the short and long term. Mental health disorders and related conditions often surface during adolescence and are best addressed early to ensure optimal health. The Adolescent Health and Wellness Program (AHWP) within the MCAH Section focuses on protective factors to decrease the likelihood of adverse health outcomes.

Program staff selected NPMs Adolescent Well Visit (AWV) and Transition (TR)-All Adolescents and SM Adequate Insurance (AI) to improve adolescent health outcomes. Staff and partners implement strategies to increase the percent of adolescents, ages 12-17 y.o. with a preventive medical visit in the past year (NPM AWV), increase the percent of adolescents with and without special health care needs, ages 12-17 y.o., who received services necessary to make transitions to adult health care (NPM TR-All Adolescents) and increase the percent of children, ages zero-17 y.o. who are adequately insured (SM AI). Health outcomes may improve when young people receive yearly wellness visits, possess health literacy, and are adequately insured.

MCAH staff and funded partners disseminated information and resources on adolescent well-visits, youth-friendly health care, risk screening, transition from pediatric to adult health care, and emotional health and wellbeing to improve adolescent health and wellness outcomes. The materials included, but were not limited to, health and wellness tips, insurance enrollment, self-advocacy, and health literacy. Evidence-based materials were from Bright Futures, Got Transition, Adolescent Health Initiative, National Adolescent and Young Adult Health Information Center, Youth Screening, Brief Intervention and Referral to Treatment, and AMCHP.

Well-Visits

The 2022-2023 NSCH displays 62.1% of Nevadans ages 12-17 y.o., received a preventive health visit, compared to 71.4% nationwide. Efforts to increase preventive medical visits included partnering with outside agencies to increase the percentage of adolescents ages 12-17 y.o. who are adequately insured. The 2022-2023 NSCH data found 57.2% of Nevadans ages 12-17 y.o. had adequate and continuous insurance coverage compared to 63.9% nationwide.

The Affordable Care Act mandates insurance plans cover preventive health services with no out-of-pocket cost to help improve uptake of health screenings addressing physical, emotional, cognitive, and social changes. Well-visit appointments provide substance use screening, behavioral health and depression assessment, reproductive health and STI prevention counseling and screening, administration of age-recommended vaccines, and weight management plans.

Program staff awarded funding to DP Video to create video posts for youth, parents, and caregivers to increase the percent of yearly adolescent well-visits. The campaign messaging was tested by Nevada youth of various socioeconomic and cultural backgrounds, including individuals living with special health care needs. The one-year campaign reached the desired aged audience, racial and ethnic groups, and met both Americans with Disability Act (ADA) and culturally and linguistically appropriate services (CLAS) standards. All content contains video descriptors for individuals who are visually impaired. For the current reporting period, funds were allocated for boosted posts in three additional languages (Swahili, Tagalog, Chinese) alongside English and Spanish posts for the duration of the ad campaign cycle ending September 2024.

- Facebook/Instagram posts consisted of ten video posts (two English, two Spanish, two Swahili, two Tagalog, two Chinese). Paid advertising resulted in 2,203,781 video views, 3,205,600 media impressions, and 925,876 page engagements.

Program staff distributed the operational social media content to funded partners and outside agencies. This provided agencies the opportunity to share messages through their Facebook and X (formerly Twitter) platforms.

The AHWP Coordinator, in collaboration with the Nevada DHS Office of Analytics, developed an infographic during

the reporting period to help increase the number of Medicaid-reimbursed Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits and child/adolescent well-visits occurring in the state. The infographic encouraged providers to change practices, including but not limited to, implementing annual reminder systems and engaging callers during appointment making to turn sports physicals into EPSDT/well-visits. Furthermore, the infographic educated Nevada Medicaid providers about the recent decision allowing payment for a well-visit and sick visit with the same provider on the same day, and prompt clinicians to inform adults on other Medicaid eligibility information. The AHWP disseminated the infographic on the AHWP page on the DPBH website.

Program staff collaborated with Nevada 211 to enhance the child and youth provider list allowing for a user-friendly search by desired clinic locations. Nevada 211 created new list categories and subcategories using a robust provider list supplied by the AHWP Coordinator to be placed on the Nevada 211 website and Nevada 211 Youth App. AHWP ensured MCAH trainings for 211 staff occurred.

Health Care Transition

According to the 2022-2023 NSCH report, 11.8% of CSHCN in Nevada received services necessary to transition into adult health care compared to 22.3% nationwide. For Nevada, this is a decrease from 14.8% reported in 2021-2022. The 2022-2023 NSCH data for non-CSHCN found 12.6% in Nevada received services necessary to transition to adult health care compared to 18.1% nationwide, representing an increase for Nevada of 8.1% from 2020-2021.

The AHWP shared related social media content with funded partners and other community organizations reaching adolescents. This allowed organizations to place the messages on agency Facebook and X (formerly Twitter) platforms. Additionally, program staff shared an animated video, What is Health Care Transition?, with groups focused on serving children and youth with and without special health care needs. This resource, created by Got Transition, was a joint effort developed using young adult input. The Title V MCH Program downloaded English and Spanish materials from Got Transition for adolescents and young adults, and parents and caregivers, and imported Quick Response (QR) codes onto the health care transition materials. Printed handouts were disseminated to partners and at community events.

Public Health Clinic Wellness

Nine public health clinics were awarded Title V MCH Program funding to promote and educate youth and families about adolescent health and wellness. These entities included CCHHS in Northern Nevada and eight rural nursing clinics within DPBH CHS providing services in rural and frontier Nevada counties. The nine public health clinics and Title V MCH Program share commitments to enhance the quality of adolescent visits and increase the number of youth and their families receiving health care transition information. Staff used standards of care from national agencies to enhance service quality. Nurses were trained in person-first inclusive language, congruent care, and adolescent-friendly medical environments. Education and counseling were provided to the individual based on age and life circumstances.

Through clinical settings and community events, staff informed youth about the benefits of being adequately insured, the value of annual well-visits, generated awareness of the transition to adult health care, and educated youth about reproductive and sexual health, immunizations, depression, intimate partner violence prevention, tobacco/nicotine cessation, and healthy eating habits. Title V MCH Program staff provided clinics with materials for dissemination. These included the brochure: Does Your Teen Need Health Coverage? informing about the value of adolescent well-visits and how to apply for health insurance, education on health care transition for youth and young adults as well as parents and caregivers (Got Transition), MHP, and Nevada 211.

During clinic visits, adolescents were screened for risk behaviors, including nutrition and weight management, depression, sexual coercion, alcohol, drug, and tobacco/nicotine use. Nurses encouraged youth to include family in discussions regarding sexual health decisions. Immunizations and community vaccine events were supported by all clinics conducting reminder telephone calls for delayed adolescent age-appropriate vaccinations.

CCHHS provided wellness screenings and education to 83 adolescents. Racial/ethnic groups served were primarily Non-Hispanic White (71%), adolescents who identify as Multiracial or whose race/ethnicity is unknown (14%), Hispanic (8%), Non-Hispanic Black (4%), and American Indian/Alaska Native (2%). Most patients were female (93%) and the remaining seven percent were male. Referrals were made for those experiencing depression (7%), and for those who use substances, alcohol or nicotine/tobacco (1%). CCHHS Implements screenings utilizing the

CAGE screening tool:

C – Cutting Down “Have you ever felt you should cut down on your drinking?”

A – Annoyance by Criticism “Have people ever annoyed you by criticizing your drinking?”

G – Guilty Feelings “Have you ever felt bad about your drinking?”

E – Eye Openers “Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?”

The CAGE screening tool is used to assess alcohol use and CCHHS also leverages the tool to assess a patient’s drug use. Any patient who answers “yes” to any of the 4 questions is provided with referral information and CCHHS staff emphasize the importance of receiving help to those who receive referral information.

The youth-friendly electronic risk assessments, Rapid Adolescent Prevention Screening (RAAPS) and Adolescent Counseling Technologies (ACT) are designed to identify 22 behaviors contributing to social problems, morbidity, and mortality. RAAPS/ACT aided CCHHS in evaluating charting and screening tools within their EHR and adjusting methods to match evidence-based standards of care. For example, charts no longer ask for the number of lifetime partners and now only record greater than four to align with standards of care since more than four partners is considered a high-risk response. The updated chart question resulted in patients not needing to be concerned about being shamed or falsifying numbers. CCHHS discontinued using RAAPS/ACT in FFY24 as the extent of the screening tool was not as relevant for their clinic. Other challenges reported include most patients did not take part in assessments, a lack of smooth data import into the EHR system despite numerous efforts to remedy problems, and unsustainable annual costs.

CCHHS promoted adolescent-focused health and wellness messages through high school classes, community outreach events, printouts, clinic digital signage, and social media campaigns. CCHHS staff were invited into six high school classrooms to share the value of yearly well visits and how youth can take control of their health care. Three outreach events resulted in 94 people being given materials highlighting adolescent well-visits and content from Got Transition on how to transition from pediatric into the adult health care system. Individuals driving by or walking into the CCHHS clinic could view the promotional campaigns on various signage throughout the lobbies. CCHHS Facebook campaigns promoted adolescent well-visits and health care transition. Social media messages reached 701 people with 1% engaged users. Health care transition Facebook posts reached 33,994 individuals with 1% engaged users.

CHS nurses from eight rural clinics provided adolescent wellness screenings, preventive health information, and appropriate referrals. CHS provided wellness screenings and education to 173 adolescents. Title V MCH Program funding supported the provision of sexual and reproductive health education. Referrals were made for those experiencing depression, to those who use substances, alcohol or nicotine/tobacco, and to adolescents affected by intimate partner violence. CDC guidelines were used for education on preventing STIs and communicable diseases and for recommending an appropriate treatment protocol. CHS hired a Client Technologies Specialist to improve EHR reporting capabilities, allowing CHS nurses and other DHS program staff to obtain reliable data. Solutions are being reviewed to enhance robust data collection for the next reporting period. CHS is exploring connecting Microsoft Power BI to their EHR database to create a replica of the Title V MCH Program reporting figures allowing for ease in completing and submitting reports between programs.

CHS Success Story

A female (<18 years old) visited a CHS clinic for STI testing and family planning. She tested positive and was upset. Education, treatment, and an IUD implant were provided, and follow up appointments were scheduled. She followed through with her follow up visits and through some counseling, she has confirmed she is making safer decisions. She is now making better choices with relationships, started a new job, and is going back to school to further her education. Staff even noted the positive change in her appearance and attitude, including appearing happy and determined to be successful in her endeavors.

Trauma-Informed Yoga for Teens

Title V MCH continued funding Yoga Haven to provide trauma-informed yoga, movement, and mindful meditation to disproportionately affected youth in Southern Nevada. Trauma-informed yoga practice helps increase physical

activity, provide resilience, support mindfulness, combat obesity and chronic disease, enhance wellness, and helps mitigate other harmful health outcomes.

The trauma-informed yoga practice provides movement activity, at no cost, in a safe environment for young people experiencing trauma or living in underserved areas in Southern Nevada. Yoga Haven provides inclusive environments to ensure teachers nurture each student's strengths, interests, and talents and honor beliefs, customs, and values.

Yoga Haven provides services to a wide reach of students since the agency operates in Las Vegas, Nevada's largest metropolitan area. Yoga Haven programming focuses on accessible, trauma-informed mindfulness-based movements for the most at-risk adolescents and teaches stress reduction methods to increase skills in social and emotional learning.

Program Successes for FFY24:

- Created of a comprehensive, evidence-based learning manual including recorded tutorials and a supplemental instructional guide on the pre-and-post-test data collection process in English and Spanish.
- Onboarded eight new yoga instructors, bringing the total to 21, a quarter of whom are bilingual in English and Spanish and one in English and Tagalog. All instructors are certified yoga instructors and have completed a 2.5-day trauma informed training course and participate in a continuing education course every six months.
- Yoga classes were held at 10 school sites serving 2,158 pupils in 518 classes. This count is unduplicated and includes 299 pupils who attended multiple classes.
    - Memoranda of Understanding executed with Clark County School District for trauma-informed yoga classes to be conducted in ten Title 1 schools allowing youth residing in low-income neighborhoods to become recipients of the no-cost classes.
- Yoga Haven staff presented at several statewide conferences on adolescent-focused trauma-informed mindfulness programming and have been invited to upcoming community and school events.
- Yoga Haven partnered with Signs of Hope, a local rape crisis center and IPV shelter, to provide no-cost, trauma-informed yoga, meditation, and movement classes to adolescent survivors of sexual violence.

Yoga Haven Success Story

One participant, who was a female high school student, participated in a year-long yoga and mindfulness pilot program at her local middle school. During this pilot program more than 80% of students were exposed to yoga and meditation monthly throughout the school year. In addition, a select cohort was exposed to weekly group meditations during lunch. The student shared that during this time she was experiencing alternate family placements due to violence and mental illness in her home. Yoga Haven programming provided a safe place for her to practice introspective reflections, increased her ability to self-advocate, and helped her feel more comfortable with her emotions. She described the cohort she was part of weekly as a family and was grateful for how protected the space felt to share and connect deeply with others through meditation and movement.

Collaboration with Youth-Serving Agencies

Participation in the National Network of State Adolescent Health Coordinators (NNSAHC), bi-monthly calls with Region IX states, and quarterly calls with Regions VII, IX, and X allowed for resource sharing and engagement with other states. Calls focused on how best to serve adolescents, state policies to include youth in the workforce, challenges and solutions faced by the pandemic, and state program successes. Attendance at several adolescent-focused conferences and webinars and sharing highlights with funded partners and youth-serving agencies across the state occurred.

Information was shared with funded partners and DPBH adolescent-focused programs about upcoming webinars and training, round-table discussions, community events, new publications, and youth-focused materials. Adolescent-focused health information was disseminated through the MCH Coalition and PCO e-newsletters. Topics included but were not limited to Medicaid redetermination due to end of COVID-19 coverage exemptions, emotional and behavioral health, adolescent-centred care, and health care transition from pediatric to adult care.

School-Based Health Centers (SBHC) and School-Based Services (SBS)

The AHWP Coordinator and MCH Director continued work with Medicaid and external partners, including community-based funders, on SBHCs and SBS. Updates were made by the AHWP Coordinator to the SBHC

certification information resources hosted by DPBH. No SBHCs are currently certified with Medicaid nor using the SBHC provider type (PT) billing code. Higher reimbursement rates are available through other PTs. MCH staff engaged in Medicaid and NDE-led efforts to develop a robust SBS infrastructure, billing environment, and growth in the number of participating school districts. Staff consistently work to try to get additional services available within SBSs available at participating school districts.

Pregnant and Parenting Teens

The AHWP partners with agencies serving pregnant and parenting teens to share health education and resources by collaborating with the NHV Program, the Title V MCH MIP, the AFP Program, and Nevada PREP. The NHV Program funds Local Implementing Agencies (LIAs) which provide home visiting services to young parents to improve health outcomes, promote breastfeeding, increase age-appropriate developmental screening, and reduce teen pregnancy and adolescent substance use.

Trauma-Informed Approaches

The 2023 Nevada Youth Risk Behavioral Survey (YRBS) Middle and High School ACEs Special Report reveals the following differences in ACE scores:

- females were more likely to report two or more ACEs than males;
- children qualifying for free or reduced lunches were more likely to report one ACE score or higher;
- students identifying as gay, lesbian, or bisexual were more likely to report higher ACE scores than those identifying as heterosexual, and
- as the number of ACEs increased so did the likelihood of participating in violence, experiencing victimization, sexual and physical dating violence, as well as suicidal ideation.

The 2023 data reflect similar results as the 2019 study with a p-value change for each of these categories being less than 0.05 meaning no statistical significance. The findings of the YRBS indicate the need for prevention and intervention strategies targeting ACEs to reduce mental health consequences into adulthood. Current statewide efforts address ACEs through building resiliency, using trauma-informed approaches, and providing social and emotional support services to children and their families.

Suicide Prevention

While the 2020 Needs Assessment did not list teen suicide as a priority, behavioral health encompasses mental health concerns such as suicide. Strategic partnerships continued to advance public policy around stigma reduction, mandatory training for most school districts, and training for staff and parents. According to NVSS data, the adolescent suicide rate for ages 15-19 y.o. per 100,000 adolescents in Nevada was 8.9 from 2021-2023. Nevada saw a 75% increase in the adolescent suicide rate from 2012 to 2023 and has experienced consistently higher rates compared to the national average.

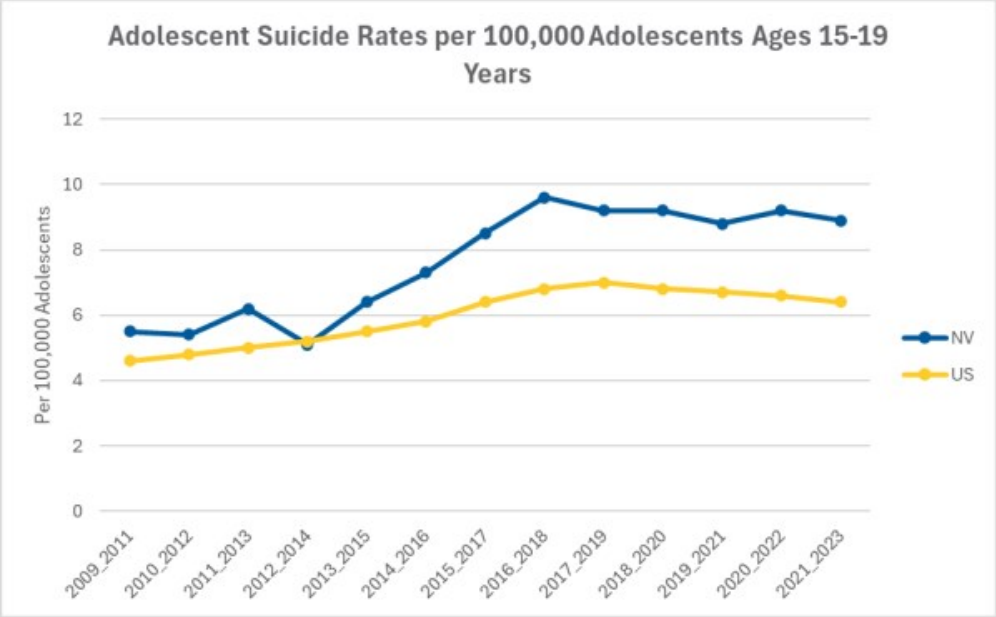


Figure 1: Adolescent suicide rates per 100,000 adolescents ages 15-19 years; Data Source: Federally Available Data, National Vital Statistics Survey (NVSS)

In Nevada, the adolescent suicide rate from 2019 through 2023 was highest for Non-Hispanic Asian teens (12.2 per 100,000 adolescents), followed by Non-Hispanic Black teens (11.4), Non-Hispanic White teens (10.9), and Hispanic teens (6.2). Other racial and ethnic groups for this data are suppressed. Compared to the United States (9.3 per 100,000), Nevada saw a disproportionately higher adolescent suicide rate for adolescents residing in non-metro (or rural) areas at 17.4 per 100,000 adolescents compared to large central metro regions from 2019 through 2023. Adolescent males in Nevada also have higher suicide rates (12.7) compared to females (4.4) between 2019-2023.

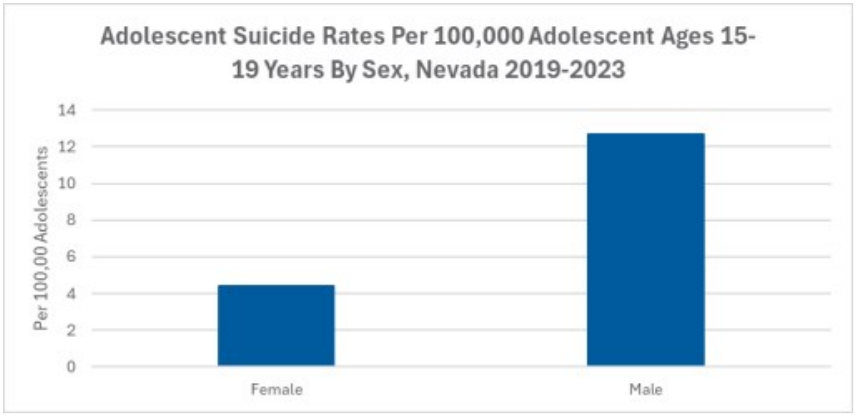


Figure 2: Nevada adolescent suicide rates per 100,000 adolescents ages 15-19 years by sex years 2019-2023; Data Source: Federally Available Data, National Vital Statistics Survey (NVSS)

The 2023 Nevada YRBS Report contains data from students in 6th through 12th grade in regular public, charter, and alternative schools. Students self-report behaviors in six areas of health related to morbidity and mortality. The Emotional Health section contains eight questions to measure mental health risks. The table below outlines the responses from the major areas of concern related to suicide.

2023 Nevada Youth Behavior Health Survey: Emotional Health Questions	Middle School Students	High School Students
Percentage of students who seriously considered attempting suicide during the 12 months before the survey	20.5%	21.0%
Percentage of students who made a plan about how they would attempt suicide during the 12 months before the survey	12.7%	19.8%
Percentage of students who attempted suicide during the 12 months before the survey	7.4 %	11.1%
Percentage of students who attempted suicide that resulted in an injury, poisoning, overdose that had to be treated by a doctor or nurse during the 12 months before the survey	Not asked in middle school survey	2.9%

Teen Pregnancy Prevention (TPP) Programs

The MCAH Section administers two teen pregnancy prevention programs which partner with the AHWP: SRAE and PREP. SRAE-funded agencies educate youth on the benefits of delaying sexual activity to avoid risky behaviors and prevent STIs, including HIV/AIDS. The SRAE and PREP Programs share positive youth development principles. The PREP curricula focus on enhancing adulthood preparation by providing abstinence and comprehensive sex education to prevent pregnancy and STIs, including HIV/AIDS; SRAE focuses on abstinence education and STIs. While Title V MCH Program funds do not directly support TPP Program efforts, the AHWP Coordinator worked closely with SRAE and PREP on cross-cutting efforts to enhance positive youth development, reach youth who live in higher risk settings, prevent teen pregnancy, and avert relationship violence by supporting healthy relationship education. AHWP staff also work closely with the Rape Prevention and Education Program leveraging each others' efforts for overlapping populations of service.

Funded and community partners had access to several documents such as bilingual data factsheets highlighting national, state, and county-specific statistics on teen pregnancy. Additionally, Title V MCH-recommended materials were made available to partners, informing clients about the value of adolescent well-visits and how to apply for health insurance and education about the transition to adult health care, NTQ, MHP, and Nevada 211.

Teen Pregnancy and Repeat Teen Birth Rates

In 2023, according to NVSS, the Nevada teen birth rate was 13.1 births per 1,000 females aged 15–19 y.o., a decrease from 14.0 in 2022. The teen birth rate in Nevada has decreased 57.3% from 2013 and 70.2% from 2009. Nevada has had a higher teen birth rate than the national average since 2013, however, as of 2023 the state has aligned with the national average.

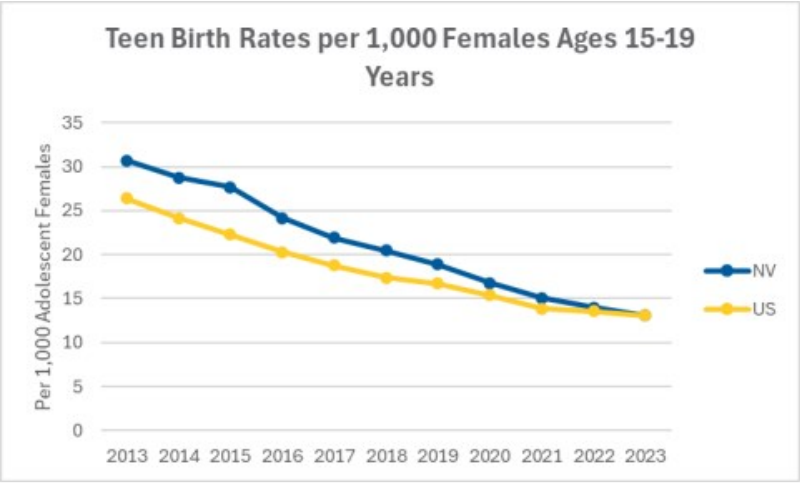


Figure 3: Teen birth rate per 1,000 females ages 15-19 years; Data Source: Federally Available Data, National Vital Statistics Survey (NVSS)

Racial/ethnic and geographic disparities exist in Nevada. In 2023, teen birth rates were higher in the state among

Non-Hispanic Black (23.1 per 1,000 females 15-19 years), Non-Hispanic American Indian or Alaskan Native (16.6), Hispanic (16.5), and Non-Hispanic Native Hawaiian or Other Pacific Islander (16.1) adolescents. The following rates were lower than the state average of 13.1: Non-Hispanic White (7.6), and Non-Hispanic Asian (1.9) adolescents.

The maps below illustrate Nevada's teen pregnancy rate and repeat teen birth rate by mother's residence zip code. Figure 4 reports on teen pregnancy rates and Figure 5 informs on repeat teen birth rates.

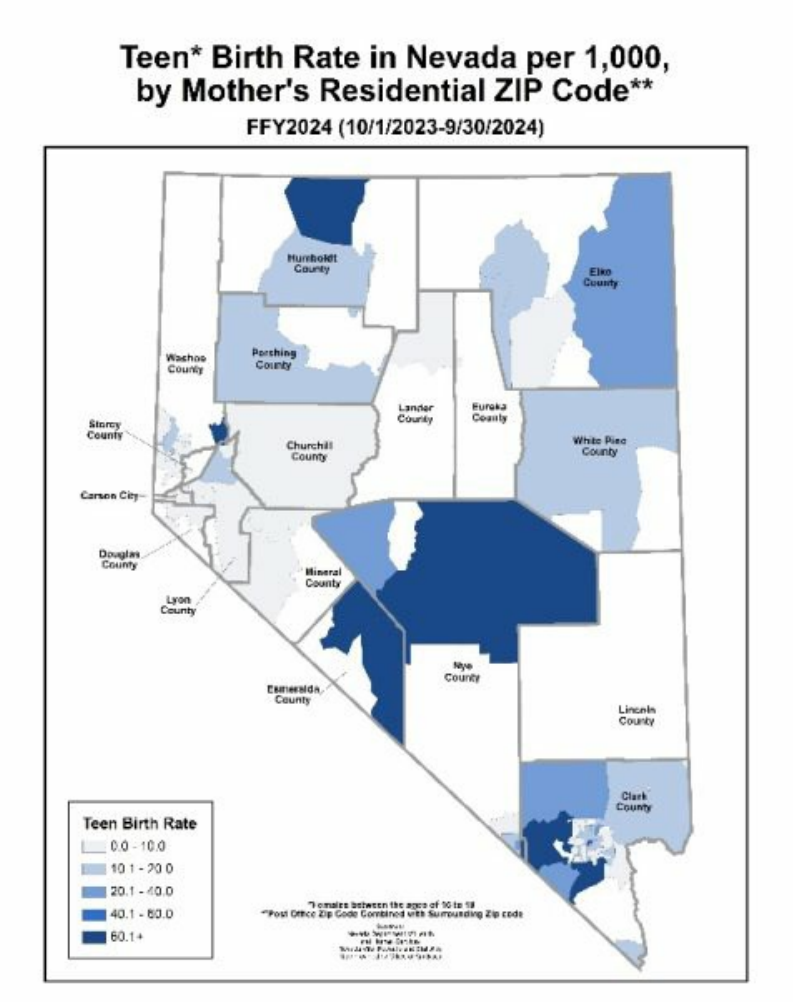


Figure 4: Teen birth rate per 1,000 females ages 15-19 years by residential zip code; Data Source: Nevada Department of Health and Human Services, Nevada Birth Registry and State Demographic Data, Office of Analytics

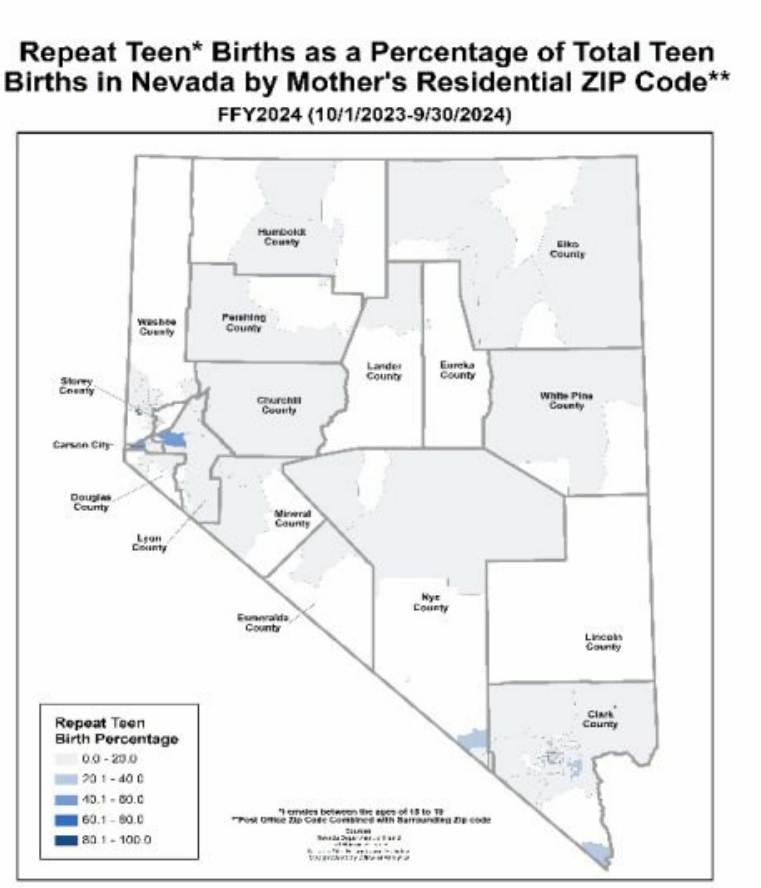


Figure 5: Repeat teen births as a percentage of total teen births by zip code; Data Source: Nevada Department of Health and Human Services, Nevada Birth Registry and State Demographic Data, Office of Analytics

Accomplishments of the Adolescent Health and Wellness Program

Throughout the reporting period, the AHWP successfully promoted public health approaches to protect, promote, and improve adolescent physical, behavioral, emotional, and mental health statewide. Best practices were shared with funded agencies, non-funded partners, and community members on how to serve adolescents through promoting yearly well-visits and health care transition education. Partnerships for insurance information distribution remained widespread statewide and reached far beyond traditional MCH adolescent speres, including engagement of DSS sites for information distribution statewide. The multi-years efforts to narrow the gap in teen birth rates in Nevada as compared to US, while not solely attributable to the AHWP, is a success in that Nevada now matches national rates instead of exceeding them.

Adolescent Health Data

NPM – Adolescent Well-Visit – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

According to the 2022-2023 NSCH, 62.1% of adolescents ages 12 through 17 had a preventive medical visit in the past year. This is significantly below the national average of 71.4%. Nevada ranks last out of the 50 states and D.C. for this measure.

NPM – Transition – All Adolescents Needs Percent of adolescents without special health care needs, ages 12 through 17, who received services to prepare for the transitions to adult health care

According to the 2022-2023 NSCH, 12.6% of adolescents received services to prepare for the transitions to adult

health care in Nevada. Nevada is significantly below the national average of 18.1%, and ranks second to last out of the 50 states and D.C.

NOM – Teen Birth – Teen birth rate, ages 15 through 19, per 1,000 females

According to NVSS data, Nevada's teen birth rate has steadily decreased from 44 per 1,000 in 2009 to 13.1 per 1,000 females in 2023. This represents a 70.2% decrease. Nevada's teen birth rate is now comparable to the national average of 13.1 per 1,000 and ranks 28th for the lowest rate of teen birth out of the 50 states and D.C.

Adolescent Health Plan for the Application Year

Adolescent Well-Visits and Health and Wellness

Nevada Title V MCH Program staff will continue to work with funded partners and community agencies to improve access to annual well visits and promote health care transition materials to providers, youth, and parents/caregivers. To increase the uptake of regular wellness visits among Nevada adolescents, several strategies will be used, including raising awareness about the benefits of preventive medical care and supporting provider adherence to screening guidelines, particularly those that include screening for ACEs. Other areas of focus include recommended adolescent immunizations, sexual behavior and reproductive health education, use of tobacco, alcohol and substances, healthy nutrition and weight management, mental health, and emotional health issues related to depression and suicide.

Outreach with DPBH adolescent-focused programs will identify opportunities to leverage cross-program efforts. Programs will share relevant materials and events crossing over into areas impacting adolescents, such as positive youth development, emotional well-being, intimate partner and dating violence prevention, teen pregnancy, suicide prevention, and cessation of tobacco and substances.

Nevada Title V MCH staff will assess how best to use the DHS Office of Population Affairs Take Action for Adolescents to develop innovative approaches to break down silos, improve systems impacting young people, and identify policies and programs supporting young people to help them thrive. Opportunities will be sought to implement and promote the guiding principles and the Take Action Toolkit, and expand community partnerships with agencies committed to the goals and action steps.

Increase Access to Sexual Health Services and Resources

As a result of the 2025 Needs Assessment, an emerging priority was identified: Nevada teens want access to sexual health education, services, and resources. To track progress on this State Performance Measure, an evidence-based strategy measure will be used that monitors the percentage of adolescents ages 12 to 17 y.o. who receive a well visit through funded partners offering integrated health services. These visits will include screening for Reproductive Life Planning and providing client-specific education and resources aligned with individual goals.

To reduce barriers for teens accessing reproductive health services, the Title V MCH Program will work closely with partners across the state. These efforts will focus on educating adolescents about their ability to obtain reproductive health services, informing families about the importance of these services for adolescent health and wellbeing, and requiring funded partners to promote reproductive health visits and share resources with families. Additionally, the Title V MCH Program aims to prevent reproductive system cancers among adolescents by collaborating with partners to improve HPV vaccination rates statewide and share information on other vaccines administered in adolescence.

Trauma-Informed Yoga for Youth

The Title V MCH Program will request applications from and fund a community-based organization(s) to conduct trauma-informed yoga for adolescents. According to the 2025 Needs Assessment, mental health services and resources appeared in four of five domains and was a top three need for the Adolescent domain. Participating sites will support or provide services to and/or offer programming for students enrolled in Title 1 schools; participants of Communities in Schools of Nevada; and youth who have been exposed to/experienced violence and/or trauma and/or are experiencing social, emotional, or behavioral health challenges. Additionally, funded partners will educate on trauma science, nervous system health, and embodiment practices for individuals working with adolescents, including front-line support workers, care providers, social workers, and teachers.

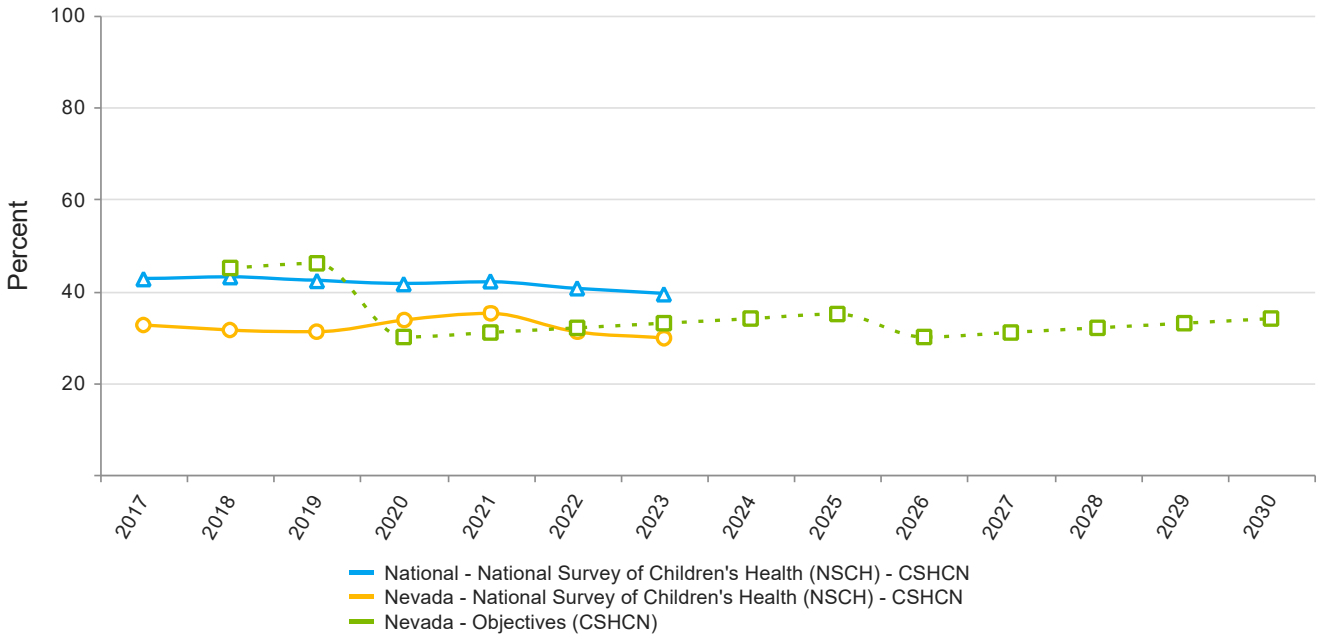
School-Based Health Centers (SBHC) and School-Based Services (SBS)

The AHWP Coordinator and MCH Director will continue to work with Nevada Medicaid and external partners on SBHCs and SBS. MCH staff will remain engaged in Medicaid and NDE-led efforts to develop a robust SBS infrastructure, billing environment, EHR system, and growth in the number of participating school districts. Staff will consistently work to try to get additional services available within SBSs located in participating school districts.

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH Indicators and Annual Objectives



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	30	31	32	33	34
Annual Indicator	30.3	38.4	37.9	25.1	29.9
Numerator	32,151	40,842	41,187	27,992	49,120
Denominator	106,188	106,445	108,746	111,565	164,076
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	30.0	31.0	32.0	33.0	34.0

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Percent of Nevada Medical Home Portal users who utilize the Services Directory feature to obtain information on providers and community resources.

Measure Status:	Active

State Provided Data			
	2022	2023	2024
Annual Objective			30
Annual Indicator	21.8	28.7	31
Numerator	7,221	13,754	12,550
Denominator	33,184	47,887	40,459
Data Source	Nevada Medical Home Portal Outbound Links Report	Nevada Medical Home Portal Outbound Links Report	Nevada Medical Home Portal Outbound Links Report
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

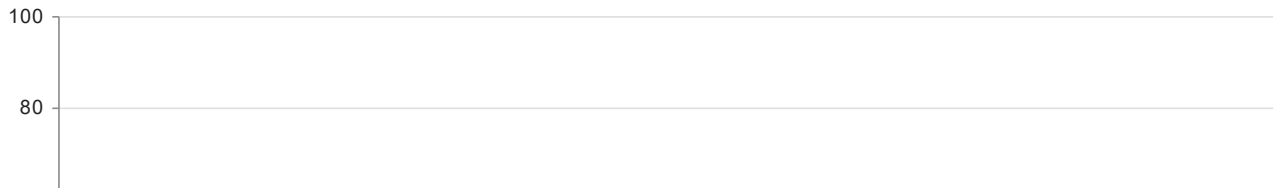
Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	31.0	31.0	31.0	31.0	31.0

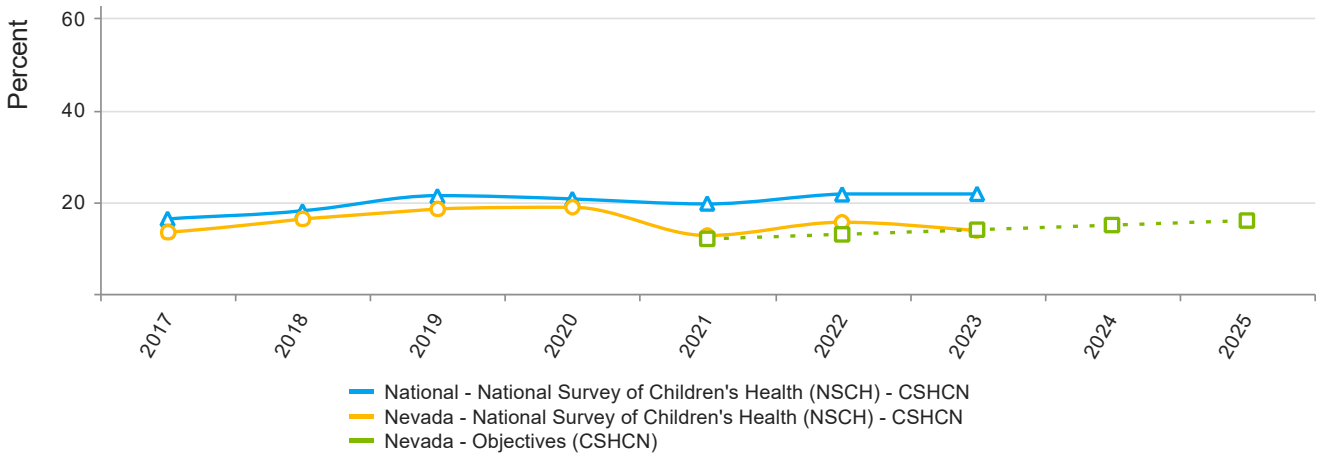
State Action Plan Table

State Action Plan Table (Nevada) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Promote a Medical Home	
NPM	
NPM - Medical Home	
Five-Year Objectives	
35% of children with special health care needs, ages 0-17, will have a medical home	
Strategies	
Increase awareness of the importance and benefits of a medical home and adequate insurance coverage.	
Implement Blueprint for Change	
Increase care coordination, adequate insurance coverage, and access to a medical home amongst CSHCN Statewide.	
ESMs	**Status**
ESM MH.1 - Percent of Nevada Medical Home Portal users who utilize the Services Directory feature to obtain information on providers and community resources.	Active
NOMs	
Children's Health Status	
CSHCN Systems of Care	
Flourishing - Young Child	
Flourishing - Child Adolescent - CSHCN	
Flourishing - Child Adolescent - All	

2021-2025: National Performance Measures

2021-2025: NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC Indicators





2021-2025: 2021-2025: NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		12	13	14	15
Annual Indicator	8.3	8.6	10.4	14.5	14.0
Numerator	3,493	4,204	5,846	7,521	9,985
Denominator	41,899	49,039	56,374	51,963	71,341
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM TAHC.3 - Percent of families who report the information received by a Family Navigator through Family Navigation Network met their needs for transition from pediatric to adult health care.

Measure Status:		**Active**	
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			70
Annual Indicator		100	87.6
Numerator		20	198
Denominator		20	226
Data Source		Title V MCH Family Navigation Network	Title V MCH Family Navigation Network
Data Source Year		FFY23	FFY2024
Provisional or Final ?		Provisional	Provisional

Children with Special Health Care Needs (CSHCN) Annual Report

The Title V MCH Block Grant, through the U.S. Department of Health and Human Services, Health Resources and Services Agency (HRSA) requires at least 30% of Title V funding to be focused on CSHCN.

According to HRSA, CSHCN are defined as: "Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." CSHCN are a diverse group with wide-ranging health concerns, such as chronic and acute conditions, including emotional and behavioral health and low SES.

Nevada's CSHCN Program provides resources and support to community agencies serving children from birth up to age 21 years. The CSHCN Program doesn't fund direct services and focuses on enabling and population health efforts, funding various community programs bridging service gaps and linking families to appropriate resources and providers. This includes developing strategies to better serve children and families through a network of federal, state, and local community and family-based partners.

One of the Child, Family, and Community Wellness (CFCW) Deputy Bureau Chiefs serves as the CSHCN Director. MCH staff use a systems-building strategy by developing relationships with external CSHCN entities, attending innovative training and annual conferences, and participating in community and family-led coalitions and committees. Examples include MCH Director appointment to the Nevada Governor's Council on Developmental Disabilities (NGCDD) and Nevada Newborn Screening Advisory Committee (NSAC), Nevada HRSA Pediatric Mental Health Evaluation Committee, Council on Food Security, and various fatality reviews and technical assistance opportunities. The CSHCN Program Coordinator works closely with the MCAH Section Manager, MCH and CSHCN Director to evaluate if program activities are achieving expectations and to modify these goals when appropriate.

The CSHCN Program Coordinator participates in the Nevada MCH Coalition, Statewide Children's Mental Health Consortia, and the Nevada Early Intervention Interagency Coordinating Council through the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) Part C Office.

Nevada's Title V MCH Program chose NPM Medical Home - Overall, SM Adequate Insurance, and NPM Transition to improve health outcomes among CSHCN. The Title V MCH Program and funded partners implement strategies to increase the percent of children with special health care needs, ages 0 through 17 y.o., who have a medical home (NPM Medical Home - Overall), the percent of children, ages 0 through 17 y.o., who are continuously and adequately insured (SM Adequate Insurance), and the percent of adolescents with special health care needs, ages 12 through 17 y.o., who received services necessary to make transitions to adult health care (NPM Transition).

Medical Home

The Title V MCH Program sought to increase the percentage of CSHCN, ages 0 through 17 y.o., who have a medical home (NPM Medical Home - Overall). According to the NSCH 2022-2023 report, 25.8% of Nevadan children with special health care needs, ages 0 through 17 y.o., have a medical home compared to 39.7% nationwide.

According to the NSCH, 77.3% of CSHCN in Nevada have a usual source of sick care compared to 82.4% nationwide. The Medical Home Model and effective care coordination provide substantial value for CSHCN, families, and clinicians and requires knowledge of conditions, available resources, and relevant service providers. Due to the difficulties of maintaining current medical information and resources for all issues that may arise, families of CSHCN often request more information more often about raising a child with special health care needs, managing conditions, and managing care and navigating the health care system.

The Medical Home Model is aimed at both families and providers. Families are motivated on learning about their child's condition and finding resources. Families will learn technical language and be better able to understand and communicate with health care and allied professionals. Physicians and other providers (therapists, dentists, care coordinators, educators, pediatric and adult subspecialists, etc.) benefit from information about various aspects of caring for CSHCN. Physicians and families sharing information and working together as partners in the Medical Home model will improve outcomes for CSHCN.

Medical Home Portal

Nevada's Title V MCH Program partnered with the University of Utah, Department of Pediatrics (UUDP), School of Medicine, to fund the Medical Home Portal (MHP) which was created to aid CSHCN and their caregivers through the provision of national and local resources such as general practitioners, specialty care, food banks, and rare disease information.

MHP's editorial board was tasked with the review and approval of detailed pages on specific diagnoses and additional information such as ICD-10 codes most associated with a given diagnosis so that both caregivers and clinicians can review pertinent information relevant to their treatment needs. To help caregivers coordinate treatment between multiple providers, MHP built a section on their website which allowed for the creation of a list which can be used to identify all specialists and physicians involved in one's care, and/or a complete list of medications free of charge. To increase awareness, all Title V MCH partners were required to promote MHP as a condition of funding.

To present clinicians and resources relevant to northern, southern, and rural Nevada to website visitors, MHP worked alongside Nevada 211, Nevada's Information and Resource platform, as a primary source of referral information for community and professional service providers serving Nevada's CSHCN population. Once the data is received from NV 211, it is processed by the CSHCN Coordinator and presented on the website.

From October 1, 2023 – July 31, 2024, there were 39,911 MHP unique users (compared to 47,887 in all of FFY 2023) and 70,517 website views (compared to 85,397 in all of FFY 2023). The MHP contained over 500 pages of content and resources, including:

- 56 "Diagnosis Modules" addressing the comprehensive primary care of those conditions
- 41 Newborn Disorder pages addressing primary care response to notification of positive results of newborn screening for those conditions
- Over 7,500 links to other reliable and valuable websites or downloadable information, including components on Sickle Cell Disease (SCD) screening and family resources
- Over 5,700 citations of scientific and other expert literature to provide users with the evidence behind recommendations or to explore topics in greater depth
- Over 3,625 service listings in the directory for CSHCN and their families in Nevada
- New nationwide service directory, including telehealth resources accessible to families living in rural and frontier areas. Nevada's CSHCN Program was the first MHP partner to launch this new feature.

In FFY 2024, there was a 17.4% decrease in website views and 16.7% decrease in unique users compared to FFY 2023 but FFY24 was missing a quarter of data. The Title V MCH Program partnered with DP video to run social media campaigns on Facebook and X [formerly Twitter] to promote MHP across the state. The current reporting period resulted in 5,380,008 impressions and 4,326,068 video plays across a reach of 1,725,420 unique users. MHP was subject to a multitude of changes during the current reporting period. MHP was informed by UUDP that due to a lack of profitability, MHP would need to seek additional funding to continue. MHP subsequently began talks with a potential buyer for MHP. As the possible buyer was assessing the viability of MHP, and different ways to make the MHP sustainable, the website was subject to a cyberattack which severely impacted its primary functionality. For several days, MHP worked with the University of Utah to determine the full scope of the issue and how to fix it. At the conclusion of a full analysis of all known issues, it was determined that the costs associated with repairing MHP were too excessive, and as a result MHP effectively ended its service on July 31, 2024. MHP staff constructed an archived site to maintain the diagnosis modules and other resource pages.

Adequate Insurance

CSHCN are less likely than children without special health care needs to be adequately and continuously insured in Nevada according to NSCH data from 2022-2023. This percentage is 49.7% for CSHCN compared to 60.7% for non-CSHCN. To improve the percentage of CSHCN who are adequately insured, all CSHCN program partners provide insurance application assistance in English and Spanish, referrals to Medicaid and other social service programs, and informational materials on topics such as eligibility criteria and coverage of preventive services.

NCED and Family Navigation Network

The Family Navigation Network (FNN) is located within the Nevada Center for Excellence in Disabilities (NCED) at the University of Nevada, Reno (UNR). FNN serves as Nevada's designated Family to Family Health Information and Education Center. FNN staff provide tailored and informed support and information to CSHCN and their families. FNN provides a bilingual CSHCN toll-free hotline and support to families in their leadership and advocacy journey, while promoting family-centered care and effective family/professional partnerships.

Title V MCH Program staff continue to make progress on understanding the needs of CSHCN and their caregivers to optimize the services and treatment they can receive in Nevada. In addition to managing a toll-free hotline, the funding provided by Title V MCH provides FNN with the means to host and attend community outreach events, attend committee meetings across the state, provide education and referrals, and to train staff, families, and CSHCN. FNN has full-time staff dedicated to translation and interpretation services for Spanish-speaking callers and will assist with step-by-step follow up information regarding care coordination, supportive services, and clinical documentation. FNN is looking for sustainable opportunities to increase the number of languages in which services can be supplied and has recently been looking into their capacity to expand to Tagalog.

Milestones reached during the current reporting period include:

- Finalizing the location site of an upcoming Healthcare Transition summit in addition to guest speakers and sessions offered.
- Increasing their capacity to provide bilingual services.
- Increasing collaborative efforts with other community organizations across the State.
- Appointing a new director.
- Reviewing the process of acquiring durable medical equipment (DME) to help streamline the process.
- Acceptance into a Virginia Family to Family mentorship program.
- Creation and management of an ongoing podcast related to disability and transition related topics.
- FNN generated 40 unique posts on social media.

In FFY 2024, FNN staff attended 40 meetings and events to increase their presence across the state. FNN has developed a partnership with Crossroads, LLC, which is operated by an Elko, NV native. FNN hopes the partnership will help bridge a critical gap between major metropolitan and rural areas of the state and increase the number of services available to rural Nevadans. Because FNN is based in northern Nevada, staff are actively discussing how to have a more definitive presence in southern Nevada and have established ties with The Collaboration Center in the Las Vegas area.

FNN continued to receive cases through their bilingual toll-free CSHCN hotline, the FNN website or via email, and through in-person requests. Of the cases generated this reporting period, 226 calls were family-initiated inquiries and 15 were professional-initiated inquiries. Each of these cases could have multiple topics covered, and a case could involve discussing a certain topic more than once. Discussions occurred regarding:

- Partnering/decision making with providers: 184
- Accessing a medical home: 123
- Financing for needed health services: 1,172
- Early and continuous screening: 179
- Navigating systems/accessing community services easily: 1,428
- Adolescent transition issues: 198
- Other: 41

Nevada's Title V MCH Family Representative, Marcia O'Malley, serves as the Family Resource Coordinator for FNN, and continues to facilitate connections between the Title V MCH team and families across Nevada. The Title V MCH AMCHP Family Representative attends quarterly Maternal and Child Health Advisory Board meetings providing input on program goals and activities from the family perspective. Participation in the annual HRSA review process will again allow for integration of the family perspective during feedback for the next application year.

Family Navigation Network Success Stories

FNN staff report their "Transition Tuesdays" podcast featuring Marcia O'Malley has been a great success and is popular with caregivers and families of CSHCN. Marcia's parent-to-parent resources have been well-recognized and other states have reached out to FNN for additional information. Marcia was also asked to join the Parent-to-Parent national board.

For the current reporting period, FNN received two referrals, each from the parent of a child with a rare genetic disorder. The parents told FNN staff they wanted to be matched with another parent to receive emotional support. Although FNN staff always work to provide those who seek services through their referral system with what they need, in this case there were no Volunteer Support Parents available in Nevada who were suited to be a match. Under these circumstances, FNN staff decided to request a match on the national P2P USA listserv in hopes the match request would be found by a more appropriate match out of state.

However, no positive responses were ultimately received. FNN turned back inwards and identified a member of staff who was particularly knowledgeable about genetics. As the result of her previous and ongoing efforts related to genetics, she was able to identify an appropriate resource in Global Genes, a nonprofit organization dedicated to eliminating the burdens and challenges of rare diseases for parents and families globally, and the parents were appropriately given the resource.

University Center for Autism and Neurodevelopment (UCAN)

The UCAN in the Department of Speech Pathology and Audiology in the University of Nevada, Reno, School of Medicine (UNRSOM) is a multidisciplinary team of professionals concerned with autism and neurodevelopmental impacts in children. The purposes of the UCAN Assessment Team are to provide diagnostic evaluation for children in need and improve differentiation between autism and other neurodevelopmental conditions. The UCAN Team is a diverse group of professionals from different disciplines and agencies throughout Northern Nevada comprised of child psychiatrists, child psychologists, school psychologists, an occupational therapist, a marriage and family therapist, speech language pathologists, and a developmental specialist. The Team provides three extensive assessments per month, as well as follow-up to help families access recommended treatments.

UCAN is associated with the "Nevada Learn the Signs. Act Early" (NvLTSAE) Program, and the Leadership Education in Neurodevelopmental and Related Disabilities (NvLEND) project. The purpose of the NvLEND training project is to improve the health of CSHCN. This is accomplished by preparing trainees from diverse professional disciplines to assume leadership roles in their respective fields and by ensuring high levels of interdisciplinary clinical competence. NvLEND programs across the nation work together to address issues of importance to CSHCN and their families, exchange best practices, and develop shared products.

In conjunction with the NvLTSAE Program, UCAN collaborated with several state, private, and public agencies to disseminate CDC Milestone Moments booklets adapted for Nevada, which included referral information for parents. A new LTSAE Ambassador was appointed, and the sole applicant is also NvLEND-affiliated.

Mountain States Regional Genetics Network

The Nevada Title V MCH Program participated in the Mountain States Regional Genetics Network (MSRGN). Other participating states included Arizona, Colorado, Montana, New Mexico, Texas, Utah, and Wyoming. The MSRGN's primary objective was to increase access to quality care and appropriate genetic expertise to individuals with confirmed or probable genetic condition through a network of genetics clinics, primary care practices, consumer advocates, and state health department resources.

The Nevada team worked diligently for seven years as a part of the MSRGN and completed a multitude of projects to include a genetics-based Project ECHO series in year three, hosting a virtual booth at the Nevada American Association of Pediatrics meeting in year four, the distribution of 1,000 "Red Flags 4 Genetics" handouts and accompanying informational MSRGN magnets for year five, and a grand rounds event for medical providers and families in year six. For the year seven project, the Nevada team worked with UNLV to conduct an evaluation of medical professionals in Nevada to determine the impact of MSRGN's efforts in their service of individuals with genetic disorders and their families.

All regional genetics networks, including the MSRGN, concluded their work on May 31, 2024. The Nevada team participated in an all-state meeting alongside the other partnering states to learn and discuss all the projects each state undertook. To maintain the ability to relay any relevant news or information related to genetics, the Nevada MCH Coalition has accepted former Nevada team members into the coalition and have agreed to let the Nevada team present standing items to the coalition upon request. MCH Staff co-led the Nevada Team.

Pediatric Mental Health Care Access Program

To support CSHCN Program goals specific to mental health, the MCH Director and CSHCN Program Coordinator participate in the Nevada DCFS HRSA Pediatric Mental Health Care Access Program (PMHCAP). PMHCAP uses telehealth strategies such as Mobile Crisis Response teams to expand mental health services for children. The program goals are to:

1. Promote behavioral health integration in pediatric primary care by supporting the development of statewide pediatric mental health telehealth and telephone access program.
2. Provide training and education on the use of evidence-based, culturally and linguistically appropriate telehealth protocols to support the treatment of children and adolescents with behavioral disorders.
3. And serve as a resource for pediatric primary care providers seeing children and adolescents including but not limited to pediatricians, family physicians, nurse practitioners, physician assistants, and case coordinators.

The MCH and CSHCN Directors, Title V MCH Program Manager, and AHWP Coordinator also attend multi-agency child health workgroups.

Critical Congenital Heart Disease Registry

The Title V MCH Program manages the Critical Congenital Heart Disease (CCHD) Registry ensuring Nevada-born infants are screened for CCHD and those diagnosed with CCHD receive timely and appropriate medical care. The Title V MCH Program works in partnership with Nevada birthing hospitals, the Nevada Hospital Association (NHA), and the American Heart Association (AHA) to provide technical assistance, ensure all Nevada birthing hospitals are reporting, and produce an annual CCHD report.

Title V MCH Program staff within the CSHCN Program and Maternal and Infant Program (MIP) are currently exploring the possibility of partnering with state and regional organizations representing Certified Nurse Midwives (CNMs) to include their newborn screenings in the CCHD Registry. The EHDI Program includes CNMs and other types of midwives in their data collection and if the CCHD Registry can accommodate this change, there may be an increase in reportable coverage of CCHD screenings.

Congenital heart defects (CHDs) are malformations of the heart or major blood vessels and the most common type of birth defect. [1] In the US, about 40,000 births per year are affected by CHDs, accounting for 4.2% of all infant deaths.[2] [3] About 25% of infants who have CHDs will be diagnosed with CCHD.[4] CCHD is a life-threatening condition requiring surgical intervention within the first year of life. Fortunately, pulse oximetry screening increases the chances for early diagnosis and detection of CCHD when coupled with routine newborn screening practices.[5] Once detected, many heart defects can be surgically repaired. The State of Nevada worked with the AHA and other partners to implement Nevada Revised Statutes (NRS) 442.680 to address CCHD screenings.

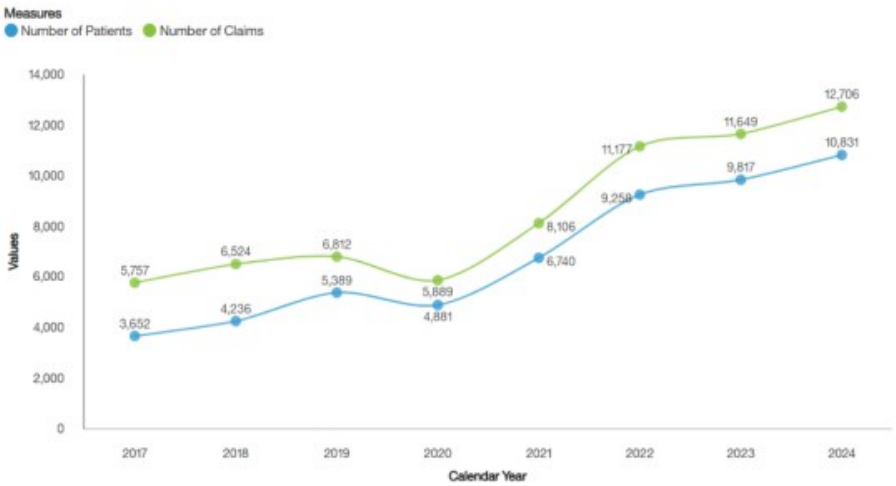
Since July 2015, all hospitals or obstetric centers in Nevada must screen all newborns after 24 hours of birth and prior to 48 hours of life to determine if the newborn suffers from CCHD. The attending physician must report the infant if they have failed the CCHD screening to the DPBH Chief Medical Officer, or a representative thereof, and discuss the condition with those responsible for the infant's care. Working in partnership with Nevada birthing hospitals, NHA, and AHA, the Title V MCH Program has provided technical assistance and ensured all Nevada birthing hospitals are reporting.

The CCHD registry contains monthly counts for the number of screens, number of births, number of failed screens, and percent of failed screens. The registry also includes details on discrepancies in the number of screens and births for the month reported, patient information for failed screenings, and whether the failed screening was found via prenatal detection.

In 2023, the CCHD Registry included a total of 30,737 births. A total of 27,096 (88.15%) were documented as receiving a pulse oximetry screening. Of the 3,641 (11.85%) infants with an incomplete or unknown screening status, 226 passed away, 3,849 were sent to NICU, 1,659 infants received echocardiograms, 25 were confirmed missed screens, 174 were transferred to another facility, and 25 parents or family members declined services for their infants. The confirmed missed screens were all documented as receiving either doctor or family notification from the birthing facility. A total of 47 failed pulse oximetry screenings were reported. There is no funding allocation related to NRS 442.680 and the CCHD registry receives no portion of newborn screening fees or dedicated federal funds.

Amblyopia

According to the Mayo Clinic, amblyopia, colloquially known as a lazy eye, is characterized by diminished vision in one eye resulting from atypical visual development during early childhood. Data on amblyopia is collected and examined for trends by program staff. This data is obtained from Nevada Medicaid claims. For the period from January 2018 to December 2024, the number of patients increased from 4,236 to 10,831.



Developmental Screening

The Title V MCH Program worked to increase the percentage of children ages 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year (NPM Developmental Screening). According to the NSCH 2022-2023 report, 23.8% of Nevadan children ages 9 through 35 months received a developmental screening using a parent-completed screening tool in the past year compared to 35.6% nationwide.

To improve developmental screening, Title V MCH Program partners provided over 100 community, parent, and provider education courses statewide concerning developmental milestones and the importance of screening using the Pyramid Model framework. The Pyramid Model is a tiered prevention and intervention framework to avert and address challenging behavior through evidence-based practices. More information about the Pyramid Model is in the Child Health Annual Report.

The Title V MCH Program purchased Milestone Moments booklets as part of a multi-agency effort for the UCAN located at UNRSOM. This ensures all state LTSAE partners can continue statewide screening and distribution of the LTSAE parental screening tool to increase developmental screenings statewide.

MCH staff participate in a NASHP behavioral health and I/DD focused technical assistance opportunity led by Nevada Medicaid.

Title V MCH provides funding to the Nevada Pyramid Model Partnership for Young Children in partnership with The Children's Cabinet. Nevada Pyramid Model Partnership is a statewide collaborative initiative to enhance the ability of early care and education personnel and families to address the social, emotional, and behavioral needs of all young children birth to five years. Using the Pyramid Model, a tiered prevention and intervention framework to prevent and address challenging behavior through evidence-based practices, Nevada Pyramid Model Partnership provides training and technical assistance for supporting social emotional competence and addressing challenging behaviors in young children at-risk for or those with identified developmental delays.

More information about this partnership with The Children's Cabinet is in the Child Health Annual Report. Overall, statewide, 42 participants attended 10 training events. There are currently 68 sites across the state collecting data.

Nine public health clinics were awarded Title V MCH funding to improve health among children, including CSHCN. These entities include Carson City Health and Human Services (CCHHS) in Northern Nevada and eight DPBH Community Health Services (CHS) nursing clinics providing services in Nevada's rural and frontier areas. Families were provided with CDC Milestone Moments booklets or given information on how to access the CDC mobile app tracker to monitor their child's development.

Children's Cabinet Success Story

At a regional Implementation site, a Family Day event was held where Children's Cabinet staff distributed 60 bags containing Pyramid Model information and resources from the Backpack Series. One member of staff personally connected with each family, offering a brief introduction to Children's Cabinet services. One parent expressed elevated interest in Pyramid Model Family services and was given relevant contact information to follow up via email. As a new school year begins, Children' Cabinet staff remain committed to providing quality assistance to those in need of services.

CSHCN Domain Accomplishments

FNN networked with governmental and community organizations to increase awareness of their toll-free hotline and care coordination services. Nevada was previously awarded a position by the CDC Foundation to support the work of both MCAH and the Immunization Section using time limited COVID funding. Projects leveraged MCH partnerships and NSIP vaccine information and included a project that created sensory friendly vaccination kits. FNN is one of many partners engaged in this effort, as is the Southern Nevada Health District and Nutrition Services Incentive Program. The kits are shared at no cost to help CSHCN and providers support neurodiverse children during vaccination.

Children with Special Health Care Needs Data

NPM – Medical Home - Overall - Percent of children with special health care needs, ages 0 through 17, who have a medical home

According to the 2022-2023 NSCH, the percentage of children in Nevada with special health care needs ages 0 through 17 y.o. who have a medical home in is 25.8%. The national average is 39.7%. Nevada currently ranks last amongst all 50 states and D.C. for NPM Medical Home - Overall. Through new initiatives to implement Blueprint for Change, Title V MCH Program staff are working to facilitate significant improvement in this area.

NPM – Transition - Percent of adolescents with special health care needs, ages 12 through 17, who receive the services necessary to transition to adult care.

According to the 2022-2023 NSCH, the percentage of adolescents in Nevada with special health care needs ages 12 through 17 years who receive services necessary to transition to adult care is 11.8%. Nevada currently falls below the national average of 22.3% and program staff remain actively engaged in healthcare transition efforts.

SM – Adequate Insurance - Percent of children, ages 0 through 17, who are continuously and adequately insured

According to data from the 2022-2023 NSCH, the percentage of children who are continuously and adequately insured in Nevada is 58.9%. This is lower than the national average of 66.5%, and Nevada ranks near the bottom for best estimates at 50th out of the states and D.C. Disparities exist in Nevada for this measure, as CSHCN are less likely to be continuously and adequately insured (49.7%) than children without special health care needs (60.7%).

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[1] Centers for Disease Control and Prevention [CDC]. (2025a). What are congenital heart defects? https://www.cdc.gov/heart-defects/about/index.html
[2] American Heart Association [AHA]. (2025). The impact of congenital heart defects. https://www.heart.org/en/health-topics/congenital-heart-defects/the-impact-of-congenital-heart-defects
[3] CDC. (2024b). Data and statistics on congenital heart defects. https://www.cdc.gov/heart-defects/data/index.html
[4] CDC. (2024). Screening for Critical Congenital Heart Defects. https://www.cdc.gov/heart-defects/screening/index.html
[5] American Academy of Pediatrics [AAP]. (2023). Newborn screening: Critical congenital heart defects. https://www.aap.org/en/patient-care/congenital-heart-defects/newborn-screening-for-critical-congenital-heart-defect-cchd/

Children with Special Health Care Needs (CSHCN) Plan for The Application Year

Nevada's Title V MCH Program serves infants, children, and adolescents through projects funded to increase developmental screening, access to care and the medical home, insurance assistance, health care transition, family support and wraparound services, adaptive and inclusive physical activity, sexual assault prevention for young adults with developmental disabilities, and critical congenital heart disease. The Title V MCH Program also collaborates with regional and out-of-state partners to support projects focused on durable medical equipment (DME), genetic counseling, screening, and child mental health. Future endeavors include increased collaboration with other MCAH Programs, including PRAMS, to improve outreach to families and pregnant women, TPP/RPE to further sexual assault prevention and sexual health efforts, and MIECHV to reach families and women of childbearing age.

The Title V MCH Program will also continue to sustain relationships with state agencies at the Nevada Health Authority (Medicaid, EPSDT, and Katie Beckett Programs); NEIS and the IDEA Part C Office; Nevada Department of Education (DOE; Office of Inclusive Education and Child Find Department); DCFS (Children's Mental Health and Independent Living Programs); Department of Employment, Training, and Rehabilitation (DETR; Bureau of Vocational Rehabilitation); and the Nevada Chapter of AAP. The Title V MCH Program will further improve referrals, and specialized resources for CSHCN and their families in Nevada.

Adequate Insurance

Future efforts within the CSHCN Program will continue promoting insurance application assistance while also focusing on increasing collaboration with the Nevada Health Authority (new state executive agency as of 7/1/2025 which includes NV Medicaid, EPSDT, Katie Beckett, and other programs) and the Nevada Division of Welfare and Supportive Services (DWSS) to improve referrals and thereby, continuous and adequate insurance coverage for Nevadan children.

Family Navigation Network (FNN)

FNN will continue to increase statewide services and the number of individual families and youth with whom they provide information and referrals, build upon community engagement and partnerships previously established to increase the percent of CSHCN with a medical home in Nevada. FNN anticipates serving more families as their statewide presence increases, and staff will continue to facilitate caregiver connection with Medicaid services by receiving Katie Beckett training and through continued collaborative efforts with Katie Beckett staff. FNN will also continue to support the Title V Family Representative. Title V MCH staff will work to support community partner efforts to increase access to Durable Medical Equipment (DME) and support for families in need of genetic counseling and/or resource support.

Social Media Promoting Access to Care

The Title V MCH Program will collaborate with DHS social media efforts to promote the importance of a medical home and adequate insurance coverage for CSHCN and their families. Messages and videos will focus on providers, parents, CSHCN, and caregivers of children with and without special health care needs. Social media outreach will take place through Facebook, Instagram, and Twitter accounts which will provide opportunities to reach those not actively seeking services.

Emergency Preparedness and Response (EPR)

MCAH staff will continue to participate in collaborative efforts and training to enhance the integration of MCH populations in EPR plans. The Public Health Emergency Preparedness (PHEP) Program and MCAH will continue to collaborate and share information and ensure the needs of CSHCN and other MCH populations are included in planning and response. The Nevada Division of Emergency Management Access and Functional Needs (DEM AFN) workgroup includes MCH staff and weekly touchpoints with the MCH Director.

University Center for Autism and Neurodevelopment

Title V MCH funded UCAN to purchase and disseminate Milestone Moments booklets which are being stored and distributed by UNR. A new LEND-affiliated LTSAE Ambassador was appointed and the LTSAE multi-agency team will continue to partner with ADSD, EHDI, WIC, NHV, The Children's Cabinet, UNR FNN and others to promote LTSAE resources.

Blueprint for Change

Nevada's Title V MCH Program is making efforts to implement the HRSA Blueprint for Change framework in its practices to improve the lives of CSHCN across the state. Program staff are working to determine how the work of each relevant agency ties into the critical areas highlighted within the framework.

Nevada Critical Congenital Heart Disease Registry

The Nevada CCHD Registry's goal is to increase the survival of newborns with CHD and to reduce loss to follow-up. The Registry will continue documenting screening of Nevada-born infants for CCHD and that those diagnosed with CCHD receive timely and appropriate medical care. The Title V MCH Program will continue to collect and report data annually and, in conjunction with NHA and AHA, will continue to provide technical assistance to ensure Nevada birthing hospitals report CCHD screenings. New data systems and means of reporting CCHD screenings will be explored and implemented as well. Emerging CCHD data will be evaluated, and updated best practices will be relayed to partnering birthing centers and hospitals across the state.

Amblyopia

Data on amblyopia is collected and examined for trends by program staff. This data is obtained from Nevada Medicaid claims. For the period from January 2020 to December 2024, the number of patients increased from 4,881 to 10,831.

Developmental Screening

Selected community partners will be awarded Title V MCH funds to facilitate developmental screenings using the Pyramid Model framework. The ASQ - SE2 developmental screenings will continue statewide, focusing on Nevada's frontier and rural areas. Online implementation of ASQ - SE2 screenings will be available, along with promoting the Learn the Signs Act Early campaign. Nevada WIC, EHDI, and NHV staff will provide resources to refer a child when indicated. Families will be provided with Milestone Moments booklets in English and Spanish or given information on accessing the CDC mobile app tracker to monitor their child's development.

The Title V MCH Program has been collecting data related to Medicaid recipients and Fetal Alcohol Spectrum Disorder (FASD) diagnosis and cognitive testing. For the years 2023 and 2024 the data remained relatively consistent. The number of Medicaid members with a FASD diagnosis for 2023 was 215 and in 2024 the number was 251. The number of Medicaid members receiving cognitive testing for 2023 was 645 and in 2024 it was 698.

Partnerships

The MCH Director will continue to participate in a cross agency NASHP collaborative with NDE, Nevada Medicaid, and DCFS partners focused on behavioral health and IDD. The Title V MCH Director will continue to serve on the Nevada Governor's Council on Developmental Disabilities, ECAC, various fatality reviews, and Newborn Screening Advisory Board. Efforts will continue to leverage ARPA funding to expand connectivity capacity and increase the number of conditions on the blood spot panel by five by 10/31/2026. Title V MCH staff will continue to participate in standing quarterly meetings with ADSD and Medicaid.

Cross-Cutting/Systems Building Annual Report

Effective Communication and Trainings

During the FFY2024 reporting period, staff were asked to ensure communications were inclusive and met best practice evidence-based standards to reach all MCH populations, including those experiencing highest rates of specific health outcomes tied to NPMs. As directed, awardees reviewed written documents associated with Title V MCH Program funding (e.g., social media campaigns, websites, print materials, etc.). If needed, materials were updated to comply with the key communication principles.

NICRP edited the Health Status of Children Entering Kindergarten Survey to include color blind friendly palettes in tables and figures and the electronic version is remediated allowing individuals who are visually impaired to have full access to the content.

Yoga Haven staff developed a comprehensive, inclusive, evidence-based learning yoga teacher training manual to provide standardized trauma-informed yoga teacher training relevant to Title V MCH populations, especially those with the highest rates of risk for negative health outcomes. Twenty-one instructors were trained from their teaching guide.

CCHHS staff engaged in Spark Trainings provided by the Adolescent Health Initiative to foster a youth-friendly environment. Cultural Responsiveness helped staff identify and discuss key concepts about providing culturally responsive health care to young people and reflect on various cultural norms unique to adolescence. Identifying and Supporting Trafficked Youth aided in exploring ways to identify signs of trafficking and sexual exploitation among youth.

Clinic nurses from CCHHS and the DPBH rural public health nurses participated in a Nevada State Board of Nursing course to comply with Nevada Revised Statutes (NRS) 449.103 requiring all nurses complete a two-hour course before applying for a license renewal.

Dignity Health updated language for the Perinatal Mood and Anxiety Disorders (PMAD) training and are updating the PMAD training to reflect Nevadans more broadly within associated videos. The 2024 MCH Statewide Coalition Fall Symposium included speakers with a broad range of backgrounds to provide a range of experiences to the community. Dignity Health continues to look at what is being done in the community as well as neighboring states to see how they can serve all Nevadans equally with high-quality care.

Nevada 211 Caller Inquiries Across Title V MCH Domains

Nevada 211 report on call volume on topics of special interest to program staff related to infant, child, adolescent, and perinatal health. Of the 2024 inquiries, Title V MCH Program requested data are shown below:

- Suicide Prevention (0.2%)
- Immunization Access (0.4%)
- Car Seat Installation (1.6%)
- Infant Sleep Safety (0.5%)
- Breastfeeding Support (0.1%)
- Childhood Developmental Screen (0.0%)
- Adolescent Bullying/Cyberbullying (0.2%)

Rape Prevention and Education Program

The Rape Prevention and Education (RPE) Program is part of national effort launched by the CDC in response to the Violence Against Women Act of 1994. The Nevada RPE Program focuses on preventing first-time perpetration and victimization of sexual violence by reducing modifiable risk factors and increasing protective health and environmental factors associated with sexual violence. Nevada's RPE Program Coordinator is co-funded through Title V MCH Block Grant and CDC to create a full-time position dedicated to supporting sexual assault and violence prevention. Federally approved strategies reflected the expansion of previous RPE Program work preventing sexual violence through approaches impacting agency professionals, advocates, college campuses, and Las Vegas hospitality personnel.

The Nevada RPE Program, in coordination with grant subrecipients, has worked to implement community prevention strategies. Through these efforts, the RPE program builds and strengthens internal state capacity with programs aimed at risk and protective factors related to violence prevention. The RPE program's reach relates to multiple domains of the Title V MCH program. The RPE Program currently partners with agencies in both Northern and Southern Nevada.

During the reporting period, RPE funded partners continued to include the Nevada Coalition to End Domestic and Sexual Violence (NCEDSV), Signs of HOPE (SOH), and the University of Nevada, Las Vegas (UNLV) and Reno (UNR) campuses. RPE funds activities to support Active Bystander Intervention Training to increase participation in active bystander behavior through education and intervention techniques.

Signs of Hope, formerly known as The Rape Crisis Center, in Southern Nevada, collaborated with the Las Vegas Metropolitan Police Department to educate hospitality staff from Las Vegas bars, casinos, and clubs. The topics focused on the signs of predatory behavior and the part drugs and alcohol play in sexual violence. Signs of Hope assisted entertainment and hospitality venue management in creating policies to avert potentially dangerous situations for staff and patrons. Signs of Hope also has existing partnerships with multiple casino properties in the Las Vegas Metropolitan Area.

A Care Peer Program 45-hour empowerment-based training curriculum was conducted in collaboration with UNLV's Jean Nidetch Women's Center. The interactive modules focused on increasing awareness of community and societal factors leading to sexual violence and harassment and increasing social norms to protect against violence.

Research suggests women with disabilities are more likely to experience domestic violence, emotional abuse, and sexual assault than women without disabilities (Breiding & Armour, 2015). The CSHCN and RPE programs, in conjunction with NCEDSV and CDC Preventive Health and Health Services Block Grant (PHHSBG), continued to provide cross-training workshops for the prevention of relationship abuse in young adults with developmental disabilities to communities in Nevada. NCEDSV continued developing resources and collecting data regarding sexual violence against individuals with disabilities nationwide.

Nationwide, a lack of resources and data has been identified regarding sexual violence against individuals with disabilities. To combat this, NCEDSV developed infographics to increase awareness of local community-based organizations offering sexual assault prevention and survivor services resources. NCEDSV provides links to Access Nevada to promote and increase access for both providers and families to necessary services for CSHCN. NCEDSV built a web page listing resources, policies, and myths regarding sexual violence geared towards those who live with developmental disabilities, parents, caregivers, self-advocates, and service providers.

NCEDSV also continues to develop their workgroup and hold webinars to inform community partners on topics that include intersections with sexual violence and intimate partner violence prevention.

The RPE Program, in coordination with grant subrecipients and other Title V Program Units, was able to maintain local partnerships and continue work implementing community prevention strategies. With these efforts the Nevada RPE Program was able to build and strengthen internal state capacity with programs aimed at risk and protective factors related to violence prevention.

Interorganizational Collaborations

The PCO eNewsletter included multiple articles supporting maternal, child and adolescent health. Informational articles included resources for programs under the PCO such as J-1 Visa Waiver, National Health Service Corps, Certificate of Need, useful trainings/webinars, and opportunities for grant funding. The PCO has also restructured multiple quarterly meetings to create a longer more cohesive quarterly meeting that covers data sharing, recruitment and retention, and shortage designation collaboration. MCH staff also participated in NICRP-led MCH research and data statewide meetings and multiple staff participate in monthly MCAH data meetings with OoA.

Tribal Consultation Process

The Title V MCH Program works closely with the DPBH Tribal Liaison to share information on MCH resources with Tribal partners throughout the state. This includes information on safe sleep and car seat safety Tribal specific efforts in concert with the Cribs for Kids affiliate funded by MCH. Title V MCH staff also attended a session at AMCHP on building Tribal partnerships.

Cross Cutting Domain Accomplishments

The CDC MCH Epidemiology Assignee to Nevada updated and restructured a MCH dashboard in PowerBI, an interactive data visualization software product, based on Federally Available Data (FAD) for state and federal MCH-related indicators. Data from the dashboard are frequently used for Title V reporting, informing partners, and the public, as is an OoA MCH dashboard. All measures are presented overall and stratified by various indicators, including community health factors (e.g., race/ethnicity, education, marital status) and year. Development was completed in December 2024 and became publicly available on February 28, 2025. The dashboard can be accessed here: Nevada Maternal, Child, and Adolescent Health Data Overview of Federally Available Data.

The CDC MCH Assignee built epidemiologic capacity by successfully recruiting 1) a CSTE Fellow for a 2-year assignment in Nevada that started August 2024 and focuses on several projects, 2) a CDC Epidemiology Elective Program (EEP) Fellow for a 6-week assignment that concluded with an updated state's perinatal Hepatitis B protocol in addition to training materials for the state's Immunization Program, and 3) an intern from the Title V MCH Internship Program for a 10-week assignment that ended with nine completed infographics for underperforming national performances measures and interviews with five partners that receive Title V MCH Block funding to obtain context on why selected NPMs are worsening over time or underperforming compared with the nation. This was the first time the Nevada Bureau of Child, Family, and Community Wellness matched with a CSTE Applied Epidemiology Fellow and EEP Fellow.

Cross-Cutting/Systems-Building Plan for the Application Year

Rape Prevention and Education (RPE) Program

The RPE Program will align five-year project activities with the Title V MCH State Action Plan by designing safer environments and fostering economic growth for adolescents and youth. RPE will address shared risk and protective factors through collaborative partnerships within DPBH including Title V MCH, Personal Responsibility Education Program (PREP), and Sexual Risk Avoidance and Education (SRAE) Program, as well as external agencies working with young adult populations. In addition, RPE will expand primary prevention and evaluation efforts and increase community and societal-level changes shown to reduce the occurrence of sexual violence. Goals will focus on increasing the number of community strategies implemented, creating protective environments to protect against violence, and providing opportunities to empower and support adolescents and young people.

Tribal Consultation Process

The Title V MCH Program works closely with the DPBH Tribal Liaisons to share information on MCH resources with Tribal partners throughout the state. This includes information on safe sleep and car seat safety Tribal specific efforts in concert with the Cribs for Kids affiliate funded by MCH.

Public Input and Report

Below are qualitative findings by domain. The findings from community input primary data collection activities offer additional depth to the statistics and incorporate community experiences and perceptions.

Women/Maternal Health

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).

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.
- *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.
- *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.

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.

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.

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.

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.

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.[1]

Perinatal/Infant Health

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. Participants suggested creation of incentive programs to encourage medical providers to come to Nevada. 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.
- *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. A comprehensive system was brought up as both an issue and a solution across the needs assessment. Without health care coverage, partners 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. 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.
- *Cyclical Barriers:* Lack of access to perinatal care persists as difficulty accessing pediatric care. 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."*

Child Health

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.

Community Health Factors: When it comes to supporting children, Nevadan community members agreed it starts with supporting their families and communities. Partners 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.

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.

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.

Adolescent Health

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. 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.

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 brought up a lack of **resources for parents** in dealing with adolescent needs, especially substance use and mental health. 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.

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. 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.

Children with Special Health Care Needs (CSHCN)

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 CSHCN 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 CSHCN need.

Appropriate Care: Medically, key informants shared that CSHCN 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.

Families discussed the need for respectful care, culturally and linguistically appropriate care, and workforce development. 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.

Mental Health: Families described inaccessible spaces and opportunities for CSHCN, 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, CSHCN are at an even greater disadvantage because there are not programs that can accommodate them. Participants also discussed the need for CSHCN 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 CSHCN to address social-emotional, behavioral, and mental health needs.

Not only are CSHCN 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 CSHCN have.

Reference

1. World Population Review. (2024). *Domestic violence by state 2024*. https://worldpopulationreview.com/state-rankings/domestic-violence-by-state

Technical Assistance

Nevada Title V MCH is interested in exploring receiving Technical Assistance (TA) in the following areas:

1. SSDI and MCH integration best practices and staff upskilling

Nevada Title V MCH staff would like to learn more about how Title V MCH Programs integrate SSDI efforts and grow internal data evaluation and qualitative data integration capacity.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - NV_MOU_FY25 SUBMITTED.pdf

V. Supporting Documents

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

Supporting Document #01 - Supporting Document - Needs Assessment Executive Summary.pdf

Supporting Document #02 - Supporting Document - Title V Maternal and Child Health Logic Model.pdf

Supporting Document #03 - Supporting Document - Glossary of Acronyms.pdf

Supporting Document #04 - Supporting Document MCH Staff Training.pdf

Supporting Document #05 - Supporting Document - DPBH-MCAH Interagency Partnerships and Collaborations V2.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - MCAH Org Chart July 2025.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Nevada

	FY 26 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,450,000	
A. Preventive and Primary Care for Children	$ 784,000	(32%)
B. Children with Special Health Care Needs	$ 833,000	(34%)
C. Title V Administrative Costs	$ 125,000	(5.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,742,000	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,837,500	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 1,837,500	
A. Your State's FY 1989 Maintenance of Effort Amount $ 853,034		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 4,287,500	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 66,596,760	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 70,884,260	

OTHER FEDERAL FUNDS	FY 26 Application Budgeted
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 47,697,404
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 552,150
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 472,376
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 169,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 4,535,275
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 174,248
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 464,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 370,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 610,059
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,384,475
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 4,413,691
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 550,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,969,082
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000

OTHER FEDERAL FUNDS	FY 26 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Diabetes Control Programs and Evaluation of Surveillance Systems	$ 900,000

	FY 24 Annual Report Budgeted		FY 24 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,236,205 (FY 24 Federal Award: $ 2,470,662)		$ 2,118,567	
A. Preventive and Primary Care for Children	$ 670,862	(30%)	$ 680,835	(32.1%)
B. Children with Special Health Care Needs	$ 670,862	(30%)	$ 782,312	(36.9%)
C. Title V Administrative Costs	$ 223,619	(10%)	$ 37,408	(1.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,565,343		$ 1,500,555	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,677,154		$ 1,588,926	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 1,677,154		$ 1,588,926	
A. Your State's FY 1989 Maintenance of Effort Amount $ 853,034				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 3,913,359		$ 3,707,493	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 53,926,817		$ 64,674,787	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 57,840,176		$ 68,382,280	

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 52,876,102	$ 49,071,210
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)		$ 499,838
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)		$ 437,602
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs		$ 270,548
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program		$ 384,098
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant		$ 302,295
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)		$ 168,015
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)		$ 792,638
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs		$ 999,508
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations		$ 3,951,115
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)		$ 3,018,223
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants		$ 2,086,690

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease		$ 624,272
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program		$ 524,875
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)		$ 234,355
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)		$ 95,870
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention		$ 204,150
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees		$ 249,757
US Department of Agriculture (USDA) > Food and Nutrition Services > Farmer's Market Nutrition Program	$ 353,775	$ 148,201
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Peer Counseling (BFPC)	$ 696,940	$ 611,527

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Reasons for variance include increased spending on The Blue Print Collaborative focus groups to increase Medical Home Portal traffic as well as associated social media campaigns, Family Navigation Network, and Nevada Center for Excellence in Disabilities healthcare transition work.	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Salary savings were significant and greatly decreased the percentage of Administrative costs expended during this reporting period. These costs are normally 10% or less of the total award.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Nevada

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 301,000	$ 273,311
2. Infants < 1 year	$ 357,000	$ 302,235
3. Children 1 through 21 Years	$ 784,000	$ 680,835
4. CSHCN	$ 833,000	$ 782,312
5. All Others	$ 50,000	$ 42,466
Federal Total of Individuals Served	$ 2,325,000	$ 2,081,159

IB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 239,750	$ 209,781
2. Infants < 1 year	$ 265,000	$ 223,920
3. Children 1 through 21 Years	$ 588,000	$ 495,310
4. CSHCN	$ 624,750	$ 569,347
5. All Others	$ 70,000	$ 71,040
Non-Federal Total of Individuals Served	$ 1,787,500	$ 1,569,398
Federal State MCH Block Grant Partnership Total	$ 4,112,500	$ 3,650,557

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Nevada

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 612,500	$ 915,799
3. Public Health Services and Systems	$ 1,837,500	$ 1,202,768
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 2,450,000	$ 2,118,567

IIB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 459,375	$ 241,148
3. Public Health Services and Systems	$ 1,378,125	$ 1,347,777
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 1,837,500	$ 1,588,925

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Nevada

Total Births by Occurrence: 32,090 **Data Source Year: 2024**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	32,088 (100.0%)	1,021	73	71 (97.3%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Guanidinoacetate Methyltransferase (GAMT) Deficiency	Hearing Loss
Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease
Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Mucopolysaccharidosis Type II (MPS II)
Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy			

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Nevada Early Hearing Detection and Intervention (EHDI) Program	29,202 (91.0%)	824	20	20 (100.0%)
Critical Congenital Heart Disease	27,096 (84.4%)	62	52	34 (65.4%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Once a case is acknowledged by the follow-up coordinator, the primary care physician (PCP) is contacted. If the PCP is incorrect or unknown, the parent is contacted. As soon as contact is made with the PCP, the American College of Medical Genetics Action Sheet, parent information, diagnostic test information, and specialist contact information are sent to the PCP. At the same time, confirmatory testing is recommended. The follow-up coordinator helps organize and guide the PCP and the lab to complete appropriate testing. The reference lab is called again until the diagnostic results are received. If results are normal, they are faxed to the PCP, and the determination is closed. If positive results are confirmed, the PCP is contacted again for applicable treatment information. In metabolic cases, short term and long term follow up coordinate and the case is transferred. Once treatment is received or the infant is scheduled to a metabolic clinic, the determination is closed.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2024**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Nevada Electronic Birth and Death Registry System, Fetal Death, Induced Termination of Pregnancy, Nevada State Demographer, Hospital Emergency Department Billing, and Hospital Inpatient Billing, Calendar Year 2024. Data is preliminary and subject to change.	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2024**
	Column Name:	**Data Source Year Notes**
	Field Note: Calendar Year 2024	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**
	Field Note: Calendar Year 2024 Newborn Screening Report. Data are preliminary and subject to change.	
4.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**
	Field Note: Calendar Year 2024 Newborn Screening Report. Data are preliminary and subject to change.	
5.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**
	Field Note: Calendar Year 2024 Newborn Screening Report. Data are preliminary and subject to change.	
6.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2024**

	Column Name:	**Core RUSP Conditions**
	Field Note: Calendar Year 2024 Newborn Screening Report. Data are preliminary and subject to change. Of the 2 cases not referred for treatment, both were benign and had no symptoms.	
7.	**Field Name:**	**Nevada Early Hearing Detection and Intervention (EHDI) Program - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: Nevada EHDI data uses calendar year 2023 data and are preliminary and subject to change. Due to EHDI data being on 2023 calendar year and Newborn Screening being on 2024 calendar year, the total number of occurrent births used to calculate the percentage of screenings done is not accurate for EHDI data. 2024 calendar year was unable to be obtained for EHDI. Thus, 2023 EHDI data was scaled so that the percentages matched between 2023 and 2024 which slightly changed the actual numbers. For example, 2023 EHDI data had 27,961 screenings out of 30,754 total occurrent births in calendar year 2023= 91%. When adjusting the percentage to 2024 occurrent births (32,090), the total number of screenings inputted was 28,651.	
8.	**Field Name:**	**Nevada Early Hearing Detection and Intervention (EHDI) Program - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: The percentage of presumptive positive screens to 2023 total occurrent births was 2.68% (882). Scaling to 2024 total occurrent births gave 824 which was inputted.	
9.	**Field Name:**	**Nevada Early Hearing Detection and Intervention (EHDI) Program - Total Number Confirmed Cases**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: The percentage of number of confirmed cases to 2023 total occurrent births was 0.06% (20). Scaling to 2024 total occurrent births gave 20 which was inputted.	
10.	**Field Name:**	**Nevada Early Hearing Detection and Intervention (EHDI) Program - Total Number Referred For Treatment**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**

	Field Note: The percentage of number referred to treatment out of the total number of confirmed cases in 2023 was 100.0%. Using the scaled number of confirmed cases to 2024 births (20), the total number referred to treatment that was inputted is 20.	
11.	**Field Name:**	**Critical Congenital Heart Disease - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: Data from 2023 Critical Congenital Heart Disease (CCHD) screening registry. CCHD data uses calendar year 2023 data. The total number of screenings for CCHD was 27,096 screenings out of 31,514 total occurrent births in calendar year 2023= 85.98%. Using 2023 births to make a new ratio (31,514*.8598), the number inputted was 27,096	
12.	**Field Name:**	**Critical Congenital Heart Disease - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: The percentage of presumptive positive screens to 2024 total occurrent births was 0.19% (62). Scaling to 2021 total occurrent births still gave 58 which was inputted.	
13.	**Field Name:**	**Critical Congenital Heart Disease - Total Number Confirmed Cases**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: None	
14.	**Field Name:**	**Critical Congenital Heart Disease - Total Number Referred For Treatment**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: None	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Nevada

Annual Report Year 2024

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	3,959	42.0	0.0	55.0	3.0	0.0
2. Infants < 1 Year of Age	5,725	42.0	0.0	55.0	3.0	0.0
3. Children 1 through 21 Years of Age	27,094	36.0	0.0	55.0	9.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	21,385	38.0	0.0	56.0	6.0	0.0
4. Others	899	15.0	0.0	73.0	12.0	0.0
Total	37,677					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	31,794	Yes	31,794	98.1	31,190	3,959
2. Infants < 1 Year of Age	31,462	Yes	31,462	97.8	30,770	5,725
3. Children 1 through 21 Years of Age	791,453	Yes	791,453	28.4	224,773	27,094
3a. Children with Special Health Care Needs 0 through 21 years of age^	196,152	Yes	196,152	36.9	72,380	21,385
4. Others	2,370,007	Yes	2,370,007	0.1	2,370	899

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2024**

Field Note:
Nevada 211 calls about Pregnancy Risk Assessment Monitoring System (PRAMS) + Dignity Health Prenatal and postpartum mood and anxiety disorder (PMAD) support groups + New Mama Care Kit Distributions + PRAMS responses + Maternal Mortality Review Committee (MMRC) services and refers made to families + Nevada Home Visiting Pregnant person served + Nevada Tobacco Quitline pregnant users

A list of maternal and infant health resources is mailed to all PRAMS sampled participants. We are certain that 561 received this resource. Additionally, during maternal death reviews, referrals for services are given to families members who have lost loved ones.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2024**

Field Note:
Community Health Services (CHS) infant Office Visits + Fetal and Infant Mortality Review (FIMR) cases reviewed + Dignity safe sleep kit distributions + REMSA safe sleep kits distributed + Early Hearing Detection and Intervention (EHDI) failed screens + Nevada Home Visiting screenings + Nevada 211 calls on safe sleep and infant car seat access/installation + Nevada 211 calls on family support services + Critical Congenital Heart Disease (CCHD) failed screens +IZ Sensory Kits distributed

Nevada strives to screen all infants for Congenital Heart Disease. Title V follows up with every infants that has a failed CHD screen and providers referrals and resources. Additionally, during infant death reviews, referrals for services are given to families members who have lost loved ones.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2024**

Field Note:
Kindergarten Health Survey (KHS) responses + Yoga haven trauma informed yoga participants + CHS preventive screens + Carson City Health and Human Services (CCHHS) preventive screens + CHS children vaccinated + Children's cabinet developmental screenings + Nevada 211 calls on childcare + Nevada 211 calls on early childhood education + CCHHS participants reached at community outreach events + Teen Pregnancy Prevention (TPP) Personal Responsibility Education Program (PREP) participants + Sexual Risk Avoidance Education Grant (SRAE) participants + CCHHS vaccine reminder calls + Rape Prevention and Education (RPE) bystander intervention training reach + Account for Family Planning (AFP) clients + Dignity car seat distribution + Community Health Services (CHS) Title V funded clinic immunizations children

Account for family Planning participants include participants under the age of 17 years.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2024**

	Field Note: Family Navigation Network Hotline calls + Nevada Medical Home Portal (MPH) users Family Network Navigation has hotline in which families can call with questions regarding services and resources. Each call generates an intake form that describes the reason for the call and refers and or resources provided.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2024**
	Field Note: CHS adult vaccination + CHS Preventive screens adults	
6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2024**
	Field Note: None	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2024**
	Field Note: Title V supports funds for statewide campaigns on substance use during pregnancy. Data consists of number of Nevada Breastfeed website hits and number of sobermonehealthybabies campaign TV adds have aired on various TV channels.	
2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2024**
	Field Note: Data consists of EHDI number of infant screened	
3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**
	Field Note: Data consists of the number of CCHHS reminder calls + CCHS Adolescent outreach events + Children's Cabinet-educational materials distributed + number of RPE Presentations given across all programs (reach of presentations) + Number of RPE Presentations to Teachers + CCHHS campaign users + NBA Safe sleep Radio and TV adds aired + Teen Insurance Brochures distributed + Preventive Health Services RPE Websites impressions. Data is significantly is lower than previous years due to the discontinuation of adolescent transition campaign adds.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**
	Field Note: Data consists of number MHP Website views + Number Sites trained for Pyramid Model+ Blue Print Collaborative Youth needs assessment participants NBA Sober momshealthybabies radio adds aired + FNN Facebook views + FFN facebook followers, +FNN social media interactions +total reach of attendees at outreach of all rpe partners (NCEDSV, UNR, UNLV, and SOH), rpe related materials (in the form of educational material like brochures and promotional items like swag). Data is significantly lower that last years due to the Medical Home Portal only being available for three quarters of the reporting period.	
5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2024**
	Field Note: Data Consists of number partner (CCHHS) social media campaign users and CCHHS adult outreach events	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Nevada

Annual Report Year 2024

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	32,690	11,685	3,987	12,237	218	2,878	0	0	1,685
Title V Served	30,754	10,447	4,751	11,650	183	2,633	315	0	775
Eligible for Title XIX	14,709	5,258	1,794	5,506	98	1,295	0	0	758
2. Total Infants in State	32,090	11,391	3,915	12,134	212	2,794	0	0	1,644
Title V Served	30,754	10,447	4,751	11,650	183	2,633	315	0	775
Eligible for Title XIX	14,440	5,126	1,762	5,460	95	1,257	0	0	740

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: 2024 Office of Analytics, Vitals – Title V Block Grant All Reports doc. Count and Percent of Births by Race/Ethnicity	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Data from 2023 CDC EHDI Hearing Screening and Follow up Survey	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Data obtained by using percentage of infants eligible for Title XIX from Form 5a (it was listed as 45%) and multiplying by number of total deliveries	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Infants of Nevada Residents 2024 Office of Analytics, Vitals	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Data from 2023 CDC EHDI Hearing Screening and Follow up Survey	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: None	

Form 7
Title V Program Workforce

State: Nevada

Form 7 Entry Page

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	16.81
1a. Total Number of FTEs (State Level)	16.81
1b. Total Number of FTEs (Local Level)	0
2. Total Number of MCH Epidemiology FTEs (subset of A. 1)	4
3. Total Number of FTEs eliminated in the past 12 months	0
4. Total Number of Current Vacant FTEs	3
4a. Total Number of Vacant MCH Epidemiology FTEs	1
5. Total Number of FTEs onboarded in the past 12 months	2.25

B. Training Needs (Optional)	
1	Designing infographics, dashboards, and using other data visualization tools.
2	Using Title V funding to impact community health factors to improve MCH outcomes.
3	
4	

Form Notes for Form 7:

None

Field Level Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Nevada

1. Title V Maternal and Child Health (MCH) Director	
Name	Vickie Ives, MA
Title	Bureau Chief, Bureau of Child, Family, and Community Wellness
Address 1	4150 Technology Way
Address 2	Suite 210
City/State/Zip	Carson City / NV / 89706
Telephone	(775) 684-2201
Extension	
Email	vives@health.nv.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Tami Conn, MPH
Title	Deputy Bureau Chief, Bureau of Child, Family, and Community Wellness
Address 1	4150 Technology Way
Address 2	Suite 210
City/State/Zip	Carson City / NV / 89706
Telephone	(775) 684-4023
Extension	
Email	tconn@health.nv.gov

3. State Family Leader (Optional)	
Name	Marcia O'Malley
Title	Family to Family Representative
Address 1	1664 N. Virginia Street
Address 2	
City/State/Zip	Reno / NV / 89557
Telephone	(883) 427-1673
Extension	
Email	marciao@unr.edu

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

5. SSDI Project Director	
Name	Vickie Ives, MA
Title	Bureau Chief, Bureau of Child, Family, and Community Wellness
Address 1	4150 Technology Way
Address 2	Suite 210
City/State/Zip	Carson City / NV / 89706
Telephone	(775) 684-2201
Extension	
Email	vives@health.nv.gov

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(833) 852-6262

Form Notes for Form 8:

None

Form 9

List of Priority Needs – Needs Assessment Year

State: Nevada

Application Year 2026

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Improve access to prenatal and maternal health services	New
2.	Increase women that receive recommended clinical care components at the post partum visit and appropriate referrals	New
3.	Increase breastfeeding rates among mothers.	Continued
4.	Reduce substance use during and after pregnancy	Revised
5.	Increase access to affordable nutritious foods among school aged children	New
6.	Improve access to resources and services around sexual health and reproductive health	New
7.	Increase referrals and appropriate care for adolescents.	New
8.	Promote a Medical Home	Continued
9.	Increase physical activity among school aged children	New
10.	Increase safe sleep practices	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Nevada

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	89.1	5.3	286	32,084
2019	84.4	5.0	283	33,538
2018	65.2	4.4	223	34,211
2017	69.1	4.5	237	34,302
2016	60.6	4.2	211	34,801
2015	73.1	5.3	189	25,841
2014	85.1	5.0	289	33,979
2013	63.5	4.4	210	33,087
2012	69.3	4.6	230	33,203
2011	63.5	4.4	213	33,541
2010	69.2	4.5	237	34,247
2009	62.0	4.2	223	35,949
2008	66.8	4.2	251	37,568

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SMM - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2023	22.7	3.7	38	167,398
2018_2022	20.4	3.5	35	171,286
2017_2021	22.4	3.6	39	173,849
2016_2020	19.3	3.3	34	176,423
2015_2019	14.5	2.9	26	179,068
2014_2018	9.5	2.3	17	179,857

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM MM - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	13.1	0.4	1,248	95,040
2022	14.0	0.4	1,304	93,069
2021	15.1	0.4	1,384	91,940
2020	16.8	0.4	1,506	89,669
2019	18.9	0.5	1,668	88,483
2018	20.5	0.5	1,800	87,691
2017	21.9	0.5	1,906	86,909
2016	24.2	0.5	2,078	85,963
2015	27.7	0.6	2,369	85,389
2014	28.8	0.6	2,448	85,039
2013	30.7	0.6	2,604	84,892
2012	33.7	0.6	2,863	84,844
2011	36.0	0.7	3,073	85,293
2010	38.9	0.7	3,421	87,849
2009	44.0	0.7	3,879	88,257

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM TB - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	9.5 %	0.2 %	3,016	31,789
2022	9.3 %	0.2 %	3,072	33,190
2021	9.7 %	0.2 %	3,255	33,679
2020	9.0 %	0.2 %	3,022	33,645
2019	8.8 %	0.2 %	3,077	35,066
2018	8.7 %	0.2 %	3,097	35,668
2017	9.1 %	0.2 %	3,265	35,748
2016	8.5 %	0.2 %	3,065	36,251
2015	8.5 %	0.2 %	3,093	36,289
2014	8.3 %	0.2 %	2,972	35,851
2013	8.0 %	0.2 %	2,810	35,028
2012	8.0 %	0.1 %	2,781	34,903
2011	8.2 %	0.2 %	2,906	35,289
2010	8.3 %	0.2 %	2,965	35,931
2009	8.1 %	0.1 %	3,046	37,604

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks gestation) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	11.1 %	0.2 %	3,518	31,780
2022	10.9 %	0.2 %	3,606	33,180
2021	11.2 %	0.2 %	3,779	33,676
2020	10.7 %	0.2 %	3,594	33,637
2019	10.7 %	0.2 %	3,742	35,061
2018	10.1 %	0.2 %	3,616	35,668
2017	10.7 %	0.2 %	3,833	35,741
2016	10.4 %	0.2 %	3,758	36,246
2015	9.9 %	0.2 %	3,609	36,283
2014	10.1 %	0.2 %	3,623	35,845
2013	9.8 %	0.2 %	3,437	34,937
2012	10.4 %	0.2 %	3,598	34,742
2011	10.5 %	0.2 %	3,694	35,187
2010	10.9 %	0.2 %	3,791	34,842
2009	10.8 %	0.2 %	3,981	36,710

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PTB - Notes:

None

Data Alerts: None

NOM - Stillbirth rate per 1,000 live births plus fetal deaths - SB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	7.0	0.5	235	33,428
2021	8.2	0.5	280	33,966
2020	7.7	0.5	260	33,913
2019	6.5	0.4	230	35,302
2018	7.0	0.4	252	35,934
2017	6.8	0.4	244	36,000
2016	7.3	0.5	267	36,527
2015	6.4	0.4	233	36,531
2014	5.7	0.4	207	36,068
2013	6.3	0.4	223	35,253
2012	6.9	0.4	241	35,152
2011	7.0	0.5	250	35,546
2010	6.3	0.4	226	36,160
2009	6.1	0.4	232	37,844

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SB - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.1	0.4	171	33,302
2021	6.4	0.4	217	33,819
2020	6.2	0.4	208	33,779
2019	5.3	0.4	187	35,174
2018	5.9	0.4	210	35,788
2017	5.8	0.4	209	35,866
2016	6.0	0.4	218	36,384
2015	6.1	0.4	222	36,410
2014	6.0	0.4	214	35,958
2013	5.7	0.4	202	35,131
2012	6.0	0.4	209	35,037
2011	6.7	0.4	237	35,433
2010	5.9	0.4	212	36,054
2009	5.8	0.4	220	37,718

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM PNM - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	4.5	0.4	149	33,193
2021	5.8	0.4	194	33,686
2020	4.6	0.4	156	33,653
2019	5.7	0.4	199	35,072
2018	6.1	0.4	219	35,682
2017	5.8	0.4	209	35,756
2016	5.8	0.4	209	36,260
2015	5.2	0.4	188	36,298
2014	5.5	0.4	198	35,861
2013	5.3	0.4	186	35,030
2012	4.9	0.4	172	34,911
2011	5.7	0.4	201	35,296
2010	5.5	0.4	198	35,934
2009	5.8	0.4	219	37,612

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	2.4	0.3	80	33,193
2021	3.4	0.3	113	33,686
2020	2.9	0.3	98	33,653
2019	3.3	0.3	115	35,072
2018	3.6	0.3	129	35,682
2017	3.6	0.3	128	35,756
2016	3.3	0.3	118	36,260
2015	3.3	0.3	119	36,298
2014	3.8	0.3	137	35,861
2013	3.7	0.3	128	35,030
2012	2.9	0.3	102	34,911
2011	3.5	0.3	124	35,296
2010	3.5	0.3	125	35,934
2009	3.9	0.3	146	37,612

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Neonatal - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	2.1	0.3	69	33,193
2021	2.4	0.3	81	33,686
2020	1.7	0.2	58	33,653
2019	2.4	0.3	84	35,072
2018	2.5	0.3	90	35,682
2017	2.3	0.3	81	35,756
2016	2.5	0.3	91	36,260
2015	1.9	0.2	69	36,298
2014	1.7	0.2	61	35,861
2013	1.7	0.2	58	35,030
2012	2.0	0.2	70	34,911
2011	2.2	0.3	77	35,296
2010	2.0	0.2	73	35,934
2009	1.9	0.2	73	37,612

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Postneonatal - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	108.5	18.1	36	33,193
2021	157.3	21.6	53	33,686
2020	121.8	19.0	41	33,653
2019	136.9	19.8	48	35,072
2018	148.5	20.4	53	35,682
2017	148.2	20.4	53	35,756
2016	148.9	20.3	54	36,260
2015	126.7	18.7	46	36,298
2014	186.8	22.9	67	35,861
2013	171.3	22.1	60	35,030
2012	128.9	19.2	45	34,911
2011	167.2	21.8	59	35,296
2010	125.2	18.7	45	35,934
2009	175.5	21.6	66	37,612

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Preterm Related - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	117.5	18.8	39	33,193
2021	121.7	19.0	41	33,686
2020	101.0	17.3	34	33,653
2019	139.7	20.0	49	35,072
2018	142.9	20.0	51	35,682
2017	81.1	15.1	29	35,756
2016	124.1	18.5	45	36,260
2015	88.2	15.6	32	36,298
2014	55.8	12.5	20	35,861
2013	71.4	14.3	25	35,030
2012	85.9	15.7	30	34,911
2011	68.0	13.9	24	35,296
2010	58.4	12.8	21	35,934
2009	93.1	15.7	35	37,612

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-SUID - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	5.7	0.4	183	32,189
2019	5.8	0.4	194	33,683
2018	7.6	0.5	259	34,183
2017	7.6	0.5	261	34,521
2016	8.6	0.5	299	34,861
2015	7.7	0.6	202	26,076
2014	5.6	0.4	193	34,462
2013	5.3	0.4	175	33,311
2012	5.0	0.4	165	33,138
2011	3.5	0.3	118	33,846
2010	2.9	0.3	101	34,549
2009	1.9	0.2	69	36,168
2008	1.6	0.2	62	37,786

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM NAS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness - SR

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	58.2 %	4.0 %	67,153	115,290

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year - TDC

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	15.1 %	1.5 %	99,327	657,226
2021_2022	13.4 %	1.4 %	87,821	654,581
2020_2021	12.6 %	1.2 %	82,296	651,575
2019_2020	14.5 %	1.4 %	94,202	650,843
2018_2019	12.9 %	1.4 %	83,488	647,140
2017_2018	11.7 %	1.5 %	73,414	629,210
2016_2017	13.0 %	1.6 %	80,999	621,345

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM TDC - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	19.8	2.5	65	329,019
2022	19.9	2.5	66	331,871
2021	20.1	2.4	68	337,849
2020	13.1	2.0	45	344,061
2019	17.5	2.3	60	342,924
2018	18.1	2.3	62	341,821
2017	17.3	2.3	59	341,141
2016	20.7	2.5	70	338,564
2015	21.9	2.6	73	333,144
2014	17.8	2.3	59	331,182
2013	18.1	2.3	60	331,294
2012	18.6	2.4	62	332,660
2011	19.5	2.4	65	333,347
2010	19.2	2.4	64	334,050
2009	20.9	2.5	70	334,461

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM CM - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	43.4	3.3	171	393,714
2022	39.2	3.2	154	392,935
2021	36.2	3.0	143	395,272
2020	46.5	3.5	179	385,221
2019	29.9	2.8	114	381,647
2018	35.2	3.1	133	378,120
2017	33.7	3.0	126	373,593
2016	36.3	3.2	133	366,187
2015	38.1	3.2	139	364,784
2014	30.3	2.9	110	362,802
2013	28.8	2.8	104	361,031
2012	29.1	2.8	105	360,693
2011	41.1	3.4	148	359,993
2010	34.2	3.1	125	365,773
2009	36.7	3.2	134	365,053

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021-2023	10.0	1.3	58	577,192
2020_2022	10.1	1.3	57	565,847
2019_2021	8.3	1.2	46	556,360
2018_2020	11.3	1.4	62	548,141
2017_2019	9.7	1.3	53	544,043
2016_2018	11.1	1.4	60	539,074
2015_2017	10.5	1.4	56	534,861
2014_2016	12.0	1.5	64	531,334
2013_2015	12.2	1.5	65	530,795
2012_2014	12.4	1.5	66	531,382
2011_2013	10.4	1.4	55	531,349
2010_2012	11.0	1.4	59	536,826
2009_2011	11.6	1.5	63	541,615
2008_2010	14.1	1.6	77	544,431
2007_2009	17.1	1.8	92	536,460

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 10 through 19 per 100,000 - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	8.9	0.9	105	1,181,921
2020_2022	9.2	0.9	108	1,173,428
2019_2021	8.8	0.9	102	1,162,140
2018_2020	9.2	0.9	105	1,144,988
2017_2019	9.2	0.9	104	1,133,360
2016_2018	9.6	0.9	107	1,117,900
2015_2017	8.5	0.9	94	1,104,564
2014_2016	7.3	0.8	80	1,093,773
2013_2015	6.4	0.8	70	1,088,617
2012_2014	5.1	0.7	55	1,084,526
2011_2013	6.2	0.8	67	1,081,717
2010_2012	5.4	0.7	59	1,086,459
2009_2011	5.5	0.7	60	1,090,819

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Adolescent firearm mortality rate, ages 10 through 19 per 100,000 - AM-Firearm

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	10.8	1.0	128	1,181,921
2020_2022	10.8	1.0	127	1,173,428
2019_2021	10.2	0.9	118	1,162,140
2018_2020	10.5	1.0	120	1,144,988
2017_2019	10.2	1.0	116	1,133,360
2016_2018	10.7	1.0	120	1,117,900
2015_2017	9.7	0.9	107	1,104,564
2014_2016	8.1	0.9	89	1,093,773
2013_2015	6.6	0.8	72	1,088,617
2012_2014	5.3	0.7	58	1,084,526
2011_2013	6.3	0.8	68	1,081,717
2010_2012	6.4	0.8	69	1,086,459
2009_2011	7.2	0.8	79	1,090,819
2008_2010	6.5	0.8	71	1,092,174
2007_2009	8.0	0.9	87	1,081,836

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Firearm - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 - IH-Child

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	149.6	6.3	568	379,765
2019	159.8	6.5	605	378,625
2018	153.3	6.4	579	377,602
2017	136.4	6.0	515	377,591
2016	135.5	6.0	509	375,536
2015	146.7	7.3	406	276,661
2014	164.5	6.7	602	366,044
2013	160.7	6.6	589	366,503
2012	162.0	6.6	597	368,537
2011	173.0	6.8	640	370,022
2010	165.2	6.7	612	370,555
2009	178.9	6.9	665	371,693
2008	157.7	6.5	583	369,783

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Child - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	241.9	7.9	932	385,221
2019	232.9	7.8	889	381,647
2018	214.7	7.5	812	378,120
2017	209.9	7.5	784	373,593
2016	207.3	7.5	759	366,187
2015	216.7	8.9	593	273,588
2014	219.1	7.8	795	362,802
2013	223.2	7.9	806	361,031
2012	211.0	7.7	761	360,693
2011	244.7	8.3	881	359,993
2010	248.0	8.2	907	365,773
2009	264.1	8.5	964	365,053
2008	286.7	8.9	1,036	361,348

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of women, ages 18 through 44, in excellent or very good health - WHS

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	48.9 %	3.6 %	278,907	570,830
2022	48.1 %	3.2 %	268,557	558,349
2021	57.4 %	3.4 %	319,748	556,653
2020	58.0 %	3.2 %	319,423	550,683
2019	46.7 %	2.9 %	255,303	547,246
2018	48.8 %	3.0 %	263,776	540,306
2017	48.4 %	2.9 %	258,523	533,819
2017	48.4 %	2.9 %	258,523	533,819
2016	48.6 %	2.5 %	255,442	525,216
2015	44.2 %	3.1 %	227,267	513,928
2014	48.4 %	3.0 %	244,346	505,050
2013	50.2 %	2.9 %	250,439	498,650
2012	48.5 %	2.2 %	238,735	492,209

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM WHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health - CHS

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	89.8 %	1.3 %	620,475	690,701
2021_2022	89.2 %	1.2 %	619,913	695,273
2020_2021	89.3 %	1.1 %	615,909	689,514
2019_2020	89.3 %	1.3 %	613,431	687,306
2018_2019	90.1 %	1.3 %	617,943	685,746
2017_2018	91.4 %	1.3 %	616,494	674,806
2016_2017	89.2 %	1.4 %	595,833	667,654

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 2 through 4, and adolescents, ages 6 through 17, who are obese (BMI at or above the 95th percentile) - OBS

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	10.3 %	0.2 %	1,625	15,790
2018	11.7 %	0.2 %	2,857	24,429
2016	11.6 %	0.2 %	2,834	24,493
2014	12.0 %	0.2 %	3,237	26,884
2012	12.9 %	0.2 %	3,570	27,649
2010	15.0 %	0.2 %	3,891	25,855
2008	13.8 %	0.3 %	2,528	18,366

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	15.6 %	1.7 %	68,680	439,738
2021_2022	16.0 %	1.6 %	70,242	439,831
2020_2021	17.7 %	1.7 %	76,495	432,636
2019_2020	17.1 %	1.8 %	73,840	431,409
2018_2019	14.8 %	1.8 %	63,085	426,955
2017_2018	18.6 %	2.4 %	78,096	419,110
2016_2017	20.6 %	2.6 %	82,491	400,819

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	11.6 %	1.6 %	3,375	29,046
2022	15.7 %	2.1 %	4,818	30,699
2021	17.3 %	2.2 %	5,383	31,124
2020	18.3 %	2.0 %	5,684	31,048

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPD - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum anxiety symptoms - PPA

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	24.1 %	2.1 %	7,003	29,095

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPA - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 through 11, who have a behavioral or conduct disRecordOrder - BCD

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	6.7 %	1.4 %	15,644	233,773
2021_2022	7.2 %	1.5 %	16,467	229,224
2020_2021	6.0 %	1.3 %	13,712	228,653
2019_2020	7.9 %	2.0 %	18,162	230,951
2018_2019	8.0 %	2.0 %	18,798	236,145
2017_2018	5.4 %	1.3 %	12,719	234,203
2016_2017	5.9 %	1.7 %	13,417	228,257

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM BCD - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 12 through 17, who have depression or anxiety - ADA

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	14.7 %	2.1 %	36,178	245,447
2021_2022	14.9 %	1.9 %	36,557	244,949
2020_2021	14.6 %	1.8 %	34,720	238,543
2019_2020	12.4 %	1.8 %	29,177	234,843
2018_2019	10.3 %	1.6 %	23,412	227,233
2017_2018	11.0 %	1.8 %	24,790	224,749
2016_2017	13.2 %	2.2 %	29,631	225,139

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ADA - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system - SOC

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	11.0 %	2.6 %	18,030	164,076
2021_2022	9.3 %	2.3 %	14,621	156,531
2020_2021	9.6 %	1.9 %	12,031	125,599
2019_2020	10.0 %	2.4 %	14,479	144,207
2018_2019	10.3 %	2.4 %	15,853	153,959
2017_2018	9.8 %	3.0 %	14,215	144,977
2016_2017	11.0 %	2.9 %	16,680	152,160

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 5, who are flourishing - FL-YC

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	77.7 %	2.6 %	149,439	192,441
2021_2022	77.1 %	2.7 %	152,730	198,008
2020_2021	79.6 %	2.6 %	164,005	205,976
2019_2020	81.1 %	2.8 %	167,949	207,083
2018_2019	86.2 %	2.5 %	174,860	202,751

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-YC - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-CA

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	36.0 %	3.8 %	47,735	132,557
2021_2022	35.0 %	3.7 %	42,692	122,022
2020_2021	35.1 %	3.7 %	32,737	93,216
2019_2020	44.0 %	4.6 %	48,439	109,964
2018_2019	47.3 %	4.6 %	57,939	122,444

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-CA - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-Child Adolescent

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	58.6 %	2.3 %	278,214	475,139
2021_2022	60.1 %	2.1 %	280,732	467,333
2020_2021	61.8 %	2.0 %	285,670	462,592
2019_2020	63.6 %	2.2 %	295,857	465,129
2018_2019	69.5 %	2.3 %	323,118	465,183

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-Child Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences - ACE

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	19.1 %	1.5 %	129,170	677,803
2021_2022	20.1 %	1.5 %	135,862	677,164
2020_2021	18.0 %	1.3 %	122,246	680,511
2019_2020	17.4 %	1.4 %	117,509	675,657
2018_2019	19.0 %	1.6 %	126,614	666,654
2017_2018	22.7 %	2.0 %	150,498	662,676
2016_2017	25.3 %	2.0 %	166,182	657,028

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ACE - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Nevada

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	84.6
Numerator	24,820
Denominator	29,327
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	85.0	86.0	87.0	88.0	89.0

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	66.5
Numerator	16,261
Denominator	24,466
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	67.0	68.0	69.0	70.0	71.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	82	82
Annual Indicator	76.8	77.6
Numerator	24,995	24,082
Denominator	32,527	31,049
Data Source	NVSS	NVSS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	82.0	82.0	82.0	82.0	82.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2023	**2024**
Annual Objective	29	29
Annual Indicator	21.6	20.3
Numerator	19,094	15,667
Denominator	88,548	77,191
Data Source	NSCH	NSCH
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	21.0	22.0	23.0	24.0	25.0

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants placed to sleep on their backs - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	81
Annual Indicator	66.3
Numerator	18,765
Denominator	28,285
Data Source	PRAMS
Data Source Year	2023

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		80	81	80	81
Annual Indicator	76.8	75.6	77.4	75.1	
Numerator	25,805	23,583	24,230	23,172	
Denominator	33,607	31,184	31,313	30,862	
Data Source	NV PRAMS	NV PRAMS	NV PRAMS	NV PRAMS	
Data Source Year	2019	2020	2021	2022	
Provisional or Final ?	Final	Final	Provisional	Provisional	

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	81.0	81.0	81.0	81.0	81.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2019 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2020 data is not received until fall 2021). That is why 2019 calendar year was used. For the 2019 PRAMS weighted data, Nevada PRAMS had a response rate of 42%, which is less than the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #49 (In which one position do you most often lay your baby down to sleep now?") which has 3 answer choices, with the option to select only one. Responses were calculated from those who selected "on his or her back."	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2020 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2021 data is not received until fall 2022). That is why 2020 calendar year was used. For the 2020 PRAMS weighted data, Nevada PRAMS had a response rate of 43%, which is less than the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #49 (In which one position do you most often lay your baby down to sleep now?") which has 3 answer choices, with the option to select only one. Responses were calculated from those who selected "on his or her back."	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2021 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2022 data is not received until fall 2023). That is why 2021 calendar year was used. For the 2021 PRAMS weighted data, Nevada PRAMS had a response rate of 34%, which is less than the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #49 (In which one position do you most often lay your baby down to sleep now?") which has 3 answer choices, with the option to select only one. Responses were calculated from those who selected "on his or her back."	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2022 data is not received until fall 2023). That is why 2021 calendar year was used. For the 2021 PRAMS weighted data, Nevada PRAMS had a response rate below the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #49 (In which one position do you most often lay your baby down to sleep now?") which has 3 answer choices, with the option to select only one. Responses were calculated from those who selected "on his	

or her back."

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	33
Annual Indicator	27.5
Numerator	7,906
Denominator	28,795
Data Source	PRAMS
Data Source Year	2023

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		36	37	32	33
Annual Indicator	34.1	33.2	27.9	31.4	
Numerator	10,334	9,888	8,255	9,460	
Denominator	30,290	29,767	29,581	30,153	
Data Source	NV PRAMS	NV PRAMS	NV PRAMS	NV PRAMS	
Data Source Year	2019	2020	2021	2022	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	33.0	33.0	33.0	33.0	33.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2019 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2020 data is not received until fall 2021). That is why 2019 calendar year was used. For the 2019 PRAMS weighted data, Nevada PRAMS had a response rate of 42%, which is less than the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #50 ("In the past 2 weeks, how often has your new baby slept alone in his or her own crib or bed") which has 5 answer choices, with the option to select only one. Percent of infants were calculated from those who selected "Always, often, or sometimes."	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2020 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2021 data is not received until fall 2022). That is why 2020 calendar year was used. For the 2019 PRAMS weighted data, Nevada PRAMS had a response rate of 43%, which is less than the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #50 ("In the past 2 weeks, how often has your new baby slept alone in his or her own crib or bed") which has 5 answer choices, with the option to select only one. Percent of infants were calculated from those who selected "Always, often, or sometimes."	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2021 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2022 data is not received until fall 2023). That is why 2021 calendar year was used. For the 2021 PRAMS weighted data, Nevada PRAMS had a response rate of 34%, which is less than the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #50 ("In the past 2 weeks, how often has your new baby slept alone in his or her own crib or bed") which has 5 answer choices, with the option to select only one. Percent of infants were calculated from those who selected "Always, often, or sometimes."	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2022 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2023 data is not received until fall 2024). That is why 2022 calendar year was used. For	

the 2022 PRAMS weighted data, Nevada PRAMS had a response rate below the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #50 ("In the past 2 weeks, how often has your new baby slept alone in his or her own crib or bed") which has 5 answer choices, with the option to select only one. Percent of infants were calculated from those who selected "Always, often, or sometimes."

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	49
Annual Indicator	67.2
Numerator	19,532
Denominator	29,061
Data Source	PRAMS
Data Source Year	2023

State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		44	45	48	49
Annual Indicator	39.7	39.5	47.2	45.9	
Numerator	12,275	11,956	14,155	13,796	
Denominator	30,901	30,280	30,002	30,081	
Data Source	NV PRAMS	NV PRAMS	NV PRAMS	NV PRAMS	
Data Source Year	2019	2020	2021	2022	
Provisional or Final ?	Final	Final	Provisional	Provisional	

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	68.0	68.0	68.0	68.0	68.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

	Field Note: Data represents 2019 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2020 data is not received until fall 2021). That is why 2019 calendar year was used. For the 2019 PRAMS weighted data, Nevada PRAMS had a response rate of 42%, which is less than the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #52 ("How did your new baby usually sleep in the past 2 weeks?") which has 8 sleep environments with the option to select yes or no for each environment. Percent of infants placed to sleep without soft objects or loose bedding was obtained by those who responded "yes" to "In a crib, bassinet, or pack and play" (choice a) and "no" to all choices b-h.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2020 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2021 data is not received until fall 2022). That is why 2020 calendar year was used. For the 2020 PRAMS weighted data, Nevada PRAMS had a response rate of 43%, which is less than the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #52 ("How did your new baby usually sleep in the past 2 weeks?") which has 8 sleep environments with the option to select yes or no for each environment. Percent of infants placed to sleep without soft objects or loose bedding was obtained by those who responded "yes" to "In a crib, bassinet, or pack and play" (choice a) and "no" to all choices b-h.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2021 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2022 data is not received until fall 2023). That is why 2021 calendar year was used. For the 2021 PRAMS weighted data, Nevada PRAMS had a response rate of 34%, which is less than the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #52 ("How did your new baby usually sleep in the past 2 weeks?") which has 8 sleep environments with the option to select yes or no for each environment. Percent of infants placed to sleep without soft objects or loose bedding was obtained by those who responded "yes" to "In a crib, bassinet, or pack and play" (choice a) and "no" to all choices b-h.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2022 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2023 data is not received until fall 2024). That is why 2022 calendar year was used. For the 2022 PRAMS weighted data, Nevada PRAMS had a response rate below the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #52 ("How did your new baby usually sleep in the past 2 weeks?") which has 8 sleep environments with the option to select yes or no for each environment. Percent of infants placed to sleep without soft objects or loose bedding was obtained by those who responded "yes" to "In a crib, bassinet, or pack and play" (choice a) and "no" to all choices b-h.	

NPM - D) Percent of infants room-sharing with an adult during sleep - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	81.2
Numerator	23,765
Denominator	29,276
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	82.0	82.0	82.0	82.0	82.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CHILD	
	2024
Annual Objective	
Annual Indicator	16.3
Numerator	37,800
Denominator	232,452
Data Source	NSCH-CHILD
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	17.0	18.0	19.0	20.0	21.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 0 through 11, whose households were food sufficient in the past year - FS

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2024
Annual Objective	
Annual Indicator	63.8
Numerator	275,025
Denominator	431,301
Data Source	NSCH
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	64.0	65.0	66.0	67.0	68.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	72	73	74	75	76
Annual Indicator	64.5	62.1	58.5	58.6	62.1
Numerator	143,969	142,933	139,135	137,289	143,865
Denominator	223,281	230,016	238,028	234,204	231,846
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	76.0	76.0	76.0	76.0	76.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	30	31	32	33	34
Annual Indicator	30.3	38.4	37.9	25.1	29.9
Numerator	32,151	40,842	41,187	27,992	49,120
Denominator	106,188	106,445	108,746	111,565	164,076
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	30.0	31.0	32.0	33.0	34.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - All Children					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		44	45	46	47
Annual Indicator	41.8	35.2	34.1	33.8	33.9
Numerator	240,683	203,838	199,127	234,616	233,226
Denominator	576,398	579,646	583,724	693,519	688,978
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-All Children	NSCH-All Children
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	35.0	36.0	37.0	38.0	39.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2021-2025 Needs Assessment Cycle)

State: Nevada

2021-2025: NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	30	31	32	33	34
Annual Indicator	30.6	22.3	21.6	24.5	23.8
Numerator	25,096	16,175	17,977	19,859	16,860
Denominator	82,133	72,622	83,198	80,960	70,804
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		12	13	14	15
Annual Indicator	8.3	8.6	10.4	14.5	14.0
Numerator	3,493	4,204	5,846	7,521	9,985
Denominator	41,899	49,039	56,374	51,963	71,341
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Adolescent Health - All Adolescents

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - All Adolescents					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		13	14	15	16
Annual Indicator	13.5	10.6	8.3	9.8	12.6
Numerator	23,357	18,795	15,091	23,872	30,766
Denominator	173,474	178,069	181,060	243,455	243,933
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-All Adolescents	NSCH-All Adolescents
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	67	68	69	70	71
Annual Indicator	65.6	61	66.8	60.2	66.2
Numerator	350,884	336,911	371,184	334,584	374,048
Denominator	534,782	549,775	555,602	556,095	565,262
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of women who smoke during pregnancy - SMK-Pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	3	2.5	2	2	1.5
Annual Indicator	3.5	3.6	3.3	2.7	2.3
Numerator	1,217	1,209	1,103	900	734
Denominator	34,682	33,260	33,380	32,993	31,574
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2019	2020	2021	2022	2023

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Nevada

SPM 1 - Percent of mothers who reported late or no prenatal care

Measure Status:	Active

State Provided Data	2020	2021	2022	2023	2024
Annual Objective	4	3.5	3.5	4	3.5
Annual Indicator	3.3	2.9	4.3	4.9	8.3
Numerator	1,109	947	1,397	1,521	2,620
Denominator	33,261	32,932	32,475	30,925	31,749
Data Source	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives	2026	2027	2028	2029	2030
Annual Objective	7.0	6.0	5.0	4.0	3.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Late prenatal care is care beginning in the third trimester. Denominator is Nevada resident births aged 15-44 years old.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Late prenatal care is care beginning in the third trimester. Denominator is Nevada resident births aged 15-44 years old.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Late prenatal care is care beginning in the third trimester. Denominator is Nevada resident births aged 15-44 years old.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Late prenatal care is care beginning in the third trimester. Denominator is Nevada residents births aged 15-44 years old.	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Late prenatal care is care beginning in the third trimester. Denominator is Nevada resident births aged 15-44 years old.	
6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Late prenatal care is care beginning in the third trimester. Denominator is Nevada resident births aged 15-44 years old.	

SPM 2 - Percent of women who used substances during pregnancy

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective	5	4.5	4.5	4	4
Annual Indicator	5.8	6.8	5.5	5.6	4.7
Numerator	1,932	2,246	1,786	1,741	1,507
Denominator	33,261	32,932	32,475	30,925	31,749
Data Source	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Substance use during pregnancy includes: smoking, alcohol use and drug use including all mothers who self-reported as having used: cocaine, heroin, illicit drugs, unspecified drugs, marijuana, meth/amphetamines, opiates, and polysubstance (multiple substances). Data are for Nevada residents aged 15-44. 2019 data are preliminary and subject to change.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Substance use during pregnancy includes: smoking, alcohol use and drug use including all mothers who self-reported as having used: cocaine, heroin, illicit drugs, unspecified drugs, marijuana, meth/amphetamines, opiates, and polysubstance (multiple substances). Data are for Nevada residents aged 15-44. 2020 data are preliminary and subject to change.	
3.	**Field Name:**	**2021**

	Column Name:	**State Provided Data**
	Field Note: Substance use during pregnancy includes: smoking, alcohol use and drug use including all mothers who self-reported as having used: cocaine, heroin, illicit drugs, unspecified drugs, marijuana, meth/amphetamines, opiates, and polysubstance (multiple substances). Data are for Nevada residents aged 15-44. 2021 data are preliminary and subject to change.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Substance use during pregnancy includes: smoking, alcohol use and drug use including all mothers who self-reported as having used: cocaine, heroin, illicit drugs, unspecified drugs, marijuana, meth/amphetamines, opiates, and polysubstance (multiple substances). Data are for Nevada residents aged 15-44. 2021 data are preliminary and subject to change.	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Substance use during pregnancy includes: smoking, alcohol use and drug use including all mothers who self-reported as having used: cocaine, heroin, illicit drugs, unspecified drugs, marijuana, meth/amphetamines, opiates, and polysubstance (multiple substances). Data are for Nevada residents aged 15-44. 2021 data are preliminary and subject to change.	
6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Substance use during pregnancy includes: smoking, alcohol use and drug use including all mothers who self-reported as having used: cocaine, heroin, illicit drugs, unspecified drugs, marijuana, meth/amphetamines, opiates, and polysubstance (multiple substances). Data are for Nevada residents aged 15-44. 2024 data are preliminary and subject to change.	

SPM 3 - Rate of STI Infections ages 12-17 years

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	556
Numerator	1,454
Denominator	261,510
Data Source	Nevada STI Morbidity Files
Data Source Year	2024
Provisional or Final ?	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	550.0	525.0	500.0	475.0	450.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
STI includes the following conditions: Gonorrhea, Chlamydia, Primary, Secondary, Early Latent, and Unknown or Late Latent Syphilis. Rates are per 100,000.

Form 10
State Performance Measures (SPMs) (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 3 - Repeat teen birth rate

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	15	14	14	13	13
Annual Indicator	14.3	17	13.2	14	11.7
Numerator	221	233	169	177	144
Denominator	1,543	1,367	1,278	1,262	1,227
Data Source	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2019 data are preliminary and subject to change. Data are for Nevada residents only. Ages 15-19.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 data are preliminary and subject to change. Data are for Nevada residents only. Ages 15-19.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 2021 data are preliminary and subject to change. Data are for Nevada residents only. Ages 15-19.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 2022 data are preliminary and subject to change. Data are for Nevada residents only. Ages 15-19.	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 2023 data are preliminary and subject to change. Data are for Nevada residents only. Ages 15-19	
6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: 2024 data are preliminary and subject to change. Data are for Nevada residents only. Ages 15-19	

2021-2025: SPM 4 - Teenage pregnancy rate

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	21	20	19	16	15.5
Annual Indicator	16.9	17.7	16.1	19.5	17.3
Numerator	1,758	1,905	1,797	2,219	1,969
Denominator	104,108	107,395	111,285	113,742	114,042
Data Source	NV Vital Records System	NV Vital Records	NV Vital Records	NV Vital Records	NV Vital Records
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Teenage Pregnancy Nevada Residents, Ages 15-19. 2019 data is preliminary and subject to change.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Teenage Pregnancy Nevada Residents, Ages 15-19. 2020 data is preliminary and subject to change.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Teenage Pregnancy Nevada Residents, Ages 15-19. 2021 data is preliminary and subject to change.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Teenage Pregnancy Nevada Residents, Ages 15-19. 2022 data is preliminary and subject to change.	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Teenage Pregnancy Nevada Residents, Ages 15-19. 2023 data is preliminary and subject to change.	
6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Teenage Pregnancy Nevada Residents, Ages 15-19. 2024 data is preliminary and subject to change.	

Form 10
State Outcome Measures (SOMs)

State: Nevada

SOM 1 - Congenital syphilis rate per 100,000 live births

Measure Status:	Active

State Provided Data	
	2024
Annual Objective	
Annual Indicator	244.3
Numerator	77
Denominator	31,514
Data Source	Nevada STI Morbidity Files
Data Source Year	2023
Provisional or Final ?	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	244.0	240.0	230.0	200.0	180.0

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
Data presents 2023 calendar year and is preliminary and subject to change.

SOM 2 - Rate of common immunizations (TDaP, RSV, Flu, COVID-19) in pregnant women per 100,000 live births

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	70.0	71.0	72.0	73.0	74.0

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note:	none

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Nevada

ESM PPV.1 - Percent of WIC- and home visiting-enrolled families during pregnancy who received at least one postpartum visit

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: none	

ESM BF.1 - Percent of Nevada PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		1.5	1.3	2	1.9
Annual Indicator	1.9	2.2	2.3	1.3	0
Numerator	6	6	5	6	0
Denominator	320	272	221	449	556
Data Source	Nevada PRAMS	Nevada PRAMS	Nevada PRAMS	Nevada PRAMS	Nevada PRAMS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. 2018 Nevada PRAMS data had a response rate of 39.4% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. Interpret data with caution due to the response rate. Data was gathered from NV PRAMS question #48 (what were your reasons for stopping breastfeeding?) which has a check all that apply response. The response "I did not have support from family or friends" was utilized for this ESM.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

	Field Note: Data represents 2019 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2020 data is not received until fall 2021). That is why 2019 calendar year was used. 2019 Nevada PRAMS data had a response rate of 42% 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 was gathered from NV PRAMS question #48 (what were your reasons for stopping breastfeeding?) which has a check all that apply response. The response "I did not have support from family or friends" was utilized for this ESM.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2020 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2021 data is not received until fall 2022). That is why 2020 calendar year was used. 2020 Nevada PRAMS data had a response rate of 43% 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 was gathered from NV PRAMS question #48 (what were your reasons for stopping breastfeeding?) which has a check all that apply response. The response "I did not have support from family or friends" was utilized for this ESM.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2021 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2021 data is not received until fall 2022). That is why 2021 calendar year was used. 2020 Nevada PRAMS data had a response rate of 34% 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 was gathered from NV PRAMS question #48 (what were your reasons for stopping breastfeeding?) which has a check all that apply response. The response "I did not have support from family or friends" was utilized for this ESM.	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2022 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2022 data is not received until fall 2023). That is why 2022 calendar year was used. 2022 Nevada PRAMS data had a response rate 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 was gathered from NV PRAMS question #48 (what were your reasons for stopping breastfeeding?) which has a check all that apply response. The response "I did not have support from family or friends" was utilized for this ESM.	
6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
2023 Nevada PRAMS data had a response rate 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 was gathered from NV PRAMS question #39 (what were your reasons for stopping breastfeeding?) which has a check all that apply response. The response "My Spouse or partner didn't support breastfeeding" was utilized for this ESM.

ESM SS.1 - 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

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		72	70	75	73
Annual Indicator	74.6	78	77.7	76.2	81.9
Numerator	25,082	25,122	24,992	24,920	22,703
Denominator	33,607	32,210	32,174	32,689	27,732
Data Source	Nevada PRAMS	Nevada PRAMS	Nevada PRAMS	Nevada PRAMS	Nevada PRAMS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	73.0	72.0	71.0	70.0	69.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

	Field Note: Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. 2018 Nevada PRAMS data had a response rate of 39.4% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. Interpret data with caution due to the response rate. High risk sleep positions are defined as not being laid to sleep on the back, using soft bedding, and/or not having a separate approved sleep surface. The following survey questions and responses were used to define high risk: #49 On his or her side, On his or her stomach #50 Sometimes Rarely Never #51 No #52 b. Twin or larger mattress or bed c. Couch, sofa, or armchair d. Infant car seat or swing e. Sleeping sack or wearable blanket f. With Blanket g. With toys, cushions, or pillows, including nursing pillows h. With crib bumper pads	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2019 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2020 data is not received until fall 2021). That is why 2019 calendar year was used. 2019 Nevada PRAMS data had a response rate of 42% 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. High risk sleep positions are defined as not being laid to sleep on the back, using soft bedding, and/or not having a separate approved sleep surface. The following survey questions and responses were used to define high risk: #49 On his or her side, On his or her stomach #50 Sometimes Rarely Never #51 No #52 b. Twin or larger mattress or bed c. Couch, sofa, or armchair d. Infant car seat or swing e. Sleeping sack or wearable blanket f. With Blanket g. With toys, cushions, or pillows, including nursing pillows h. With crib bumper pads	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

	Field Note: Data represents 2020 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2021 data is not received until fall 2022). That is why 2020 calendar year was used. 2020 Nevada PRAMS data had a response rate of 43% 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. High risk sleep positions are defined as not being laid to sleep on the back, using soft bedding, and/or not having a separate approved sleep surface. The following survey questions and responses were used to define high risk: #49 On his or her side, On his or her stomach #50 Sometimes Rarely Never #51 No #52 b. Twin or larger mattress or bed c. Couch, sofa, or armchair d. Infant car seat or swing e. Sleeping sack or wearable blanket f. With Blanket g. With toys, cushions, or pillows, including nursing pillows h. With crib bumper pads	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2021 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2022 data is not received until fall 2021). That is why 2021 calendar year was used. 2021 Nevada PRAMS data had a response rate of 34% 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. High risk sleep positions are defined as not being laid to sleep on the back, using soft bedding, and/or not having a separate approved sleep surface. The following survey questions and responses were used to define high risk: #49 On his or her side, On his or her stomach #50 Sometimes Rarely Never #51 No #52 b. Twin or larger mattress or bed c. Couch, sofa, or armchair d. Infant car seat or swing e. Sleeping sack or wearable blanket f. With Blanket g. With toys, cushions, or pillows, including nursing pillows h. With crib bumper pads	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Data represents 2022 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2023 data is not received until fall 2022). That is why 2022 calendar year was used. 2022 Nevada PRAMS data had a response rate 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.
High risk sleep positions are defined as not being laid to sleep on the back, using soft bedding, and/or not having a separate approved sleep surface. The following survey questions and responses were used to define high risk:
#49 On his or her side, On his or her stomach
#50 Sometimes Rarely Never
#51 No
#52 b. Twin or larger mattress or bed
c. Couch, sofa, or armchair
d. Infant car seat or swing
e. Sleeping sack or wearable blanket
f. With Blanket
g. With toys, cushions, or pillows, including nursing pillows
h. With crib bumper pads

6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
Data represents 2023 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2024 data is not received until fall 2025). That is why 2023 calendar year was used. For the 2023 PRAMS weighted data, Nevada PRAMS had a response rate below the CDC threshold of 50%. Data should be interpreted with caution. High risk sleep positions are defined as not being laid to sleep on the back, using soft bedding, and/or not having a separate approved sleep surface.

ESM SS.2 - Percent of Nevada PRAMS respondents who report their infants (under 1 year of age) were laid to sleep in a high-risk sleep position and/or environment

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	60.0	60.0	60.0	60.0	60.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: None	

ESM PA-Child.1 - Percent of respondents from the Kindergarten Health Survey (KHS) who report their child exercises for at least 60 minutes per day at least 4-5 times a week

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	47.0	48.0	49.0	50.0	51.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: None	

ESM FS.1 - Percent of Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Home Visitors who received training on nutrition and exhibited increased knowledge on food sufficiency and strategies on how to discuss nutrition with families

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: None	

ESM AWV.1 - Percent of Medicaid EPSDT eligible adolescents, ages 12 through 17, who received at least one initial or periodic screen

Measure Status:	Active

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective	26	32	34	36	38
Annual Indicator	31	36	35	36	37
Numerator					
Denominator					
Data Source	Center for Medicare and Medicaid Services Form 416	Center for Medicare and Medicaid Services Form 416	Center for Medicare and Medicaid Services Form 416	Center for Medicare and Medicaid Services Form 416	Center for Medicare and Medicaid Services Form 416
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	39.0	39.0	39.0	39.0	39.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Percentage was obtained from Center for Medicare and Medicaid Services Form CMS-416: Annual EPSDT Participation Report; modified for ages 12-17 only. Percentage was calculated by dividing the "Total Eligibles receiving at least one initial or periodic screen" by "Total individuals eligible for EPSDT."	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Percentage was obtained from Center for Medicare and Medicaid Services Form CMS-416: Annual EPSDT Participation Report; modified for ages 12-17 only. Percentage was calculated by dividing the "Total Eligibles receiving at least one initial or periodic screen" by "Total individuals eligible for EPSDT." The reports needed to provide the data in the document were recreated using CMS's methodology document for the CMS416. A different source was utilized from last year's CMS416 form so there may be some slight variance in data between datasets.	

3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Percentage was obtained from Center for Medicare and Medicaid Services Form CMS-416: Annual EPSDT Participation Report; modified for ages 12-17 only. This data was for FFY 21. Percentage was calculated by dividing the "Total Eligibles receiving at least one initial or periodic screen" by "Total individuals eligible for EPSDT." The reports needed to provide the data in the document were recreated using CMS's methodology document for the CMS416.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Percentage was obtained from Center for Medicare and Medicaid Services Form CMS-416: Annual EPSDT Participation Report; modified for ages 12-17 only. This data was for FFY 22. Percentage was calculated by dividing the "Total Eligibles receiving at least one initial or periodic screen" by "Total individuals eligible for EPSDT." The reports needed to provide the data in the document were recreated using CMS's methodology document for the CMS416.	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Percentage was obtained from Center for Medicare and Medicaid Services Form CMS-416: Annual EPSDT Participation Report; modified for ages 12-17 only. This data was for FFY 22. Percentage was calculated by dividing the "Total Eligibles receiving at least one initial or periodic screen" by "Total individuals eligible for EPSDT." The reports needed to provide the data in the document were recreated using CMS's methodology document for the CMS416. Numerator is 45,312 and denominator is 124,527 = 36.387	
6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Percentage was obtained from Center for Medicare and Medicaid Services Form CMS-416: Annual EPSDT Participation Report; modified for ages 12-17 only. This data was for FFY 24. Percentage was calculated by dividing the "Total Eligibles receiving at least one initial or periodic screen" by "Total individuals eligible for EPSDT." The reports needed to provide the data in the document were recreated using CMS's methodology document for the CMS416. Numerator is 47499 and denominator is 129030 = 36.81	

ESM MH.1 - Percent of Nevada Medical Home Portal users who utilize the Services Directory feature to obtain information on providers and community resources.

Measure Status:	Active

State Provided Data			
	2022	2023	2024
Annual Objective			30
Annual Indicator	21.8	28.7	31
Numerator	7,221	13,754	12,550
Denominator	33,184	47,887	40,459
Data Source	Nevada Medical Home Portal Outbound Links Report	Nevada Medical Home Portal Outbound Links Report	Nevada Medical Home Portal Outbound Links Report
Data Source Year	2022	2023	2024
Provisional or Final ?	Final	Final	Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	31.0	31.0	31.0	31.0	31.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data is obtained from the Nevada Medical Home Portal Google Analytics Outbound Links report which is obtained on a quarterly basis and combined for the final Federal Fiscal year numbers.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data is obtained from the Nevada Medical Home Portal Google Analytics Outbound Links report which is obtained on a quarterly basis and combined for the final Federal Fiscal year numbers. Denominator is the unique users of the Medical Home Portal.	
3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Data source is the number of families who received transition from pediatric care to adult health care coordination and was connected to a provider by the Family Navigation Network out of the total Families who called in for help on transition.	

Form 10

Evidence-Based or -Informed Strategy Measures (ESMs) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM DS.1 - Percent of Medicaid enrolled children, ages 9 through 35 months, who received a developmental screening using a standardized tool.

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	7	8	9	10	11
Annual Indicator	7.5	7.6	8.8	8.9	12
Numerator	3,764	3,780	4,558	4,561	5,870
Denominator	50,481	49,902	51,842	50,970	48,721
Data Source	Nevada Medicaid Data	Nevada Medicaid Data	Nevada Medicaid Data	Nevada Medicaid Data	Nevada Medicaid Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: EPSDT screenings were used for this measure. Data is for federal fiscal year 2019. Data was updated for FFY 2020 Block Grant Application from FFY 2019 Application due to finalized numbers and the acquisition of a more modernized Medicaid data gathering tool from Office of Analytics	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: EPSDT screenings were used for this measure. Data is for federal fiscal year 2020	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: EPSDT screenings were used for this measure. Data is for federal fiscal year 2021. Previous years data were revised due to final data being obtained from Medicaid.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: EPSDT screenings were used for this measure. Data is for federal fiscal year 2022	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: EPSDT screenings were used for this measure. Data is for federal fiscal year 2023 Previous years data were revised due to final data being obtained from Medicaid.	
6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: EPSDT screenings were used for this measure. Data is for federal fiscal year 2023 Previous years data were revised due to final data being obtained from Medicaid.	

2021-2025: ESM TAHC.3 - Percent of families who report the information received by a Family Navigator through Family Navigation Network met their needs for transition from pediatric to adult health care.

Measure Status:		Active	
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			70
Annual Indicator		100	87.6
Numerator		20	198
Denominator		20	226
Data Source		Title V MCH Family Navigation Network	Title V MCH Family Navigation Network
Data Source Year		FFY23	FFY2024
Provisional or Final ?		Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data source is the number of families who received transition from pediatric care to adult health care coordination and was connected to a provider by the Family Navigation Network out of the total Families who called in for help on transition.	
2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Data source is the number of families who received transition from pediatric care to adult health care coordination and was connected to a provider by the Family Navigation Network out of the total Families who called or emailed in for help on adolescent transition.	

2021-2025: ESM WWV.1 - Percent of pregnant women who received prenatal care beginning in the first trimester

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	76	77	78	79	80
Annual Indicator	75.4	78.2	78.3	76.6	76.5
Numerator	24,800	25,391	25,922	24,920	23,836
Denominator	32,897	32,463	33,109	32,527	31,148
Data Source	Federally Available Data-NVSS	Federally Available Data-NVSS	Federally Available Data-NVSS	Federally Available Data-NVSS	Federally Available Data-NVSS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Federally available data (FAD)	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Federally available data (FAD)	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Federally available data (FAD)	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Federally available data (FAD)	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Federally available data (FAD)	
6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Federally available data (FAD)	

2021-2025: ESM SMK-Pregnancy.1 - Percent of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		92	92	94	95
Annual Indicator	91.9	91	93.7	93.3	89.9
Numerator	30,895	29,302	30,142	29,696	25,978
Denominator	33,607	32,210	32,174	31,812	28,905
Data Source	NV PRAMS	NV PRAMS	NV PRAMS	NV PRAMS	NV PRAMS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. 2018 Nevada PRAMS data had a response rate of 39.4% which falls under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. Interpret data with caution due to response rate. Data was gathered from NV PRAMS question #20c, which is a yes/no question.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2019 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2020 data is not received until fall 2021). That is why 2019 calendar year was used. 2019 Nevada PRAMS data had a response rate of 42% which falls under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to response rate. Data was gathered from NV PRAMS question #20c, which is a yes/no question. Numerators and Denominators differ dramatically from 2018 data due to weighted frequencies being utilized	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

	Field Note: Data represents 2020 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2021 data is not received until fall 2022). That is why 2020 calendar year was used. 2020 Nevada PRAMS data had a response rate of 43% which falls under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to response rate. Data was gathered from NV PRAMS question #20c, which is a yes/no question. Numerators and Denominators differ dramatically from 2018 data due to weighted frequencies being utilized	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2021 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2022 data is not received until fall 2023). That is why 2021 calendar year was used. 2021 Nevada PRAMS data had a response rate of 34% which falls under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to response rate. Data was gathered from NV PRAMS question #20c, which is a yes/no question. Numerators and Denominators differ dramatically from 2018 data due to weighted frequencies being utilized.	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2022 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2023 data is not received until fall 2024). That is why 2022 calendar year was used. 2022 Nevada PRAMS data had a response rate under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to response rate. Data was gathered from NV PRAMS question #20c, which is a yes/no question. Numerators and Denominators differ dramatically from 2018 data due to weighted frequencies being utilized.	
6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2023 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2023 data is not received until fall 2024). That is why 2022 calendar year was used. 2022 Nevada PRAMS data had a response rate under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to response rate. Data was gathered from NV PRAMS question #14h, which is a yes/no question. Numerators and Denominators differ dramatically from previous data due to weighted frequencies being utilized.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Nevada

SPM 1 - Percent of mothers who reported late or no prenatal care
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase percent of women receiving prenatal care in first trimester
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 1521 **Denominator:** 29,096
Healthy People 2030 Objective:	No HP 2030 goal for this measure. Nevada's goal is 3
Data Sources and Data Issues:	Electronic Birth Registry System. Goal is Nevada's goal. There is no healthy people 2030 for this measure.
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well-woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing

SPM 2 - Percent of women who used substances during pregnancy
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To reduce the percent of women who report using substances during pregnancy.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 1741 **Denominator:** 29096
Healthy People 2030 Objective:	No HP 2030 objective. Nevada's goal is 4.25
Data Sources and Data Issues:	Nevada Vital Records
Significance:	Optimal health of mother is desired to help provide a healthy foundation for an infant. To reach optimal health, substance free mothers can help achieve a healthier outcome for their babies, potentially avoiding adverse birth outcomes. Awareness and availability of services is crucial to help provide appropriate resources and access to treatment for alcohol, smoking, and drug use. Information sites such as Sober Moms Healthy Babies from the Maternal, Child and Adolescent Health Section and the Substance Abuse Prevention and Treatment Agency (SAPTA) Program provide resources.

SPM 3 - Rate of STI Infections ages 12-17 years
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Reduce the rate of sexually transmitted infections among adolescent ages 12-17 years.
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of STI infections including the following conditions: Gonorrhea, Chlamydia, Primary, Secondary, Early Latent, and Unknown or Late Latent Syphilis among ages 12-17 years **Denominator:** Number of adolescents ages 12-17 years residing in Nevada.
Data Sources and Data Issues:	Data is acquired by the Nevada Office of Analytics EpiTrax tracking and reporting platform. Data for 2024 are preliminary and subject to changes.
Significance:	Although many sexually transmitted infections are preventable and treatable, rates continue to increase and can lead to serious consequences if not they go untreated. Adolsecents and young adults are at increased risk for getting STI's. Contributing factor include initating sexual intercourse at an early age, having multiple sexual partners, failing to use barrier protection consitently and correctly, limited access to testing treatment (2). Increasing access to and use of protection and treatment will help reduce the rate of STI infections among adolescents. 1. Satterwhite, C.L., et al. (2013). Sexually Transmitted Infection Among U.S. Women and Men: Prevalence and Incidence Estimates, 2008. Sexually Transmitted Diseases, 40(3), 187-193. DOI: 10.1097/OLQ.0b013e318286bb53 2. Sexually Transmitted Infections Treatment Guidelines, 2021, Center for Disease Control and Prevention. Retrieved July 15, 2025. https://www.cdc.gov/std/treatment-guidelines/adolescents.htm

Form 10
State Performance Measure (SPM) Detail Sheets (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 3 - Repeat teen birth rate
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of repeat teen births in Nevada.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 177 **Denominator:** 1262
Healthy People 2030 Objective:	Related to Maternal, Infant, and Child Health (MICH) Developmental Objective 16 and Family Planning Objectives FP-8 MICH-16 Increase the proportion of women delivering a live birth who received preconception care services and practiced key recommended preconception health behaviors FP-8.1 Reduce pregnancies among adolescent females aged 15 to 17 years FP-8.2 Reduce pregnancies among adolescent females aged 18 to 19 years
Data Sources and Data Issues:	Electronic Birth Registry System
Significance:	Decreasing repeat teen birth rates is a priority in the state, and account for more than 10% of teen births. Tracking of data to help prevent repeat teen births helps programs across the state see impacts of their programs and the need for continuation of health education their programs need to sustain or develop.

2021-2025: SPM 4 - Teenage pregnancy rate
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of teenage pregnancies in Nevada.
Definition:	**Unit Type:** Rate **Unit Number:** 1,000 **Numerator:** Number of teenage pregnancies **Denominator:** Number of teenage females
Healthy People 2030 Objective:	Related to FP-8 Reduce pregnancies among adolescent females FP-8.1 Reduce pregnancies among adolescent females aged 15 to 17 years FP-8.2 Reduce pregnancies among adolescent females aged 18 to 19 years
Data Sources and Data Issues:	Electronic Birth Registry System Data Note: Abortion data has a one year lag.
Significance:	Reducing teenage pregnancy is a priority in the state. Although teenage pregnancy rates are reducing in Nevada, disparities exist among at-risk populations. Tracking of data to help prevent teenage pregnancies will help programs across the state see the impacts of their programs and the need for continuation of health education.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Nevada

SOM 1 - Congenital syphilis rate per 100,000 live births
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Reduce the rate of infants born with congenial syphilis.
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number infants born with congenital syphilis **Denominator:** Live births
Data Sources and Data Issues:	Nevada Vital Records
Significance:	Congenital syphilis (CS) is a disease that occurs when syphilis infection gets passed to the baby in utero. CS can cause deformed bones, severe anemia, enlarged liver and spleen, jaundice, blindness, deafness, meningitis, and skin rashes. Getting tested and treated for syphilis can prevent serious health complications in both the baby and the parent. However, it is challenging to screen and treat people who do not initiate prenatal care. Syphilis cases in Nevada children have risen 3,750% from 2013 (n=2) to 2023 (n=77). From 2013-2023, CS rates for Nevada increased faster than those for the nation:10-fold for the United States and 33-fold for Nevada. In 2023, Nevada was ranked 6th for highest CS rate (232 cases per 100,000 live births). In comparison, the 2022 national rate was 193 cases per 100,000 live births.

SOM 2 - Rate of common immunizations (TDaP, RSV, Flu, COVID-19) in pregnant women per 100,000 live births
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase the rate of pregnant women that receive common immunizations (TDaP, RSV, Flu, COVID-19).
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Pregnant women who receive common immunizations (TDaP, RSV, Flu, COVID-19). **Denominator:** Live Births
Data Sources and Data Issues:	Nevada Immunization Records
Significance:	Women are able to pass disease protection to their babies during pregnancy when they receive immunizations such as flu, Tdap, RSV, and COVID-19. When pregnant women receive these immunizations, protective antibodies are produced and passed on to the baby, protecting the baby from disease during the first few months of their life.

Form 10

Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Nevada

ESM PPV.1 - Percent of WIC- and home visiting-enrolled families during pregnancy who received at least one postpartum visit NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of women who have at least one postpartum visit</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of WIC and Home Visiting-enrolled families during pregnancy who received at least one postpartum visit</td></tr>
<tr><td>Denominator:</td><td>Number of WIC and Home Visiting-enrolled family during pregnancy</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Nevada's WIC and Home Visiting Program collects data on postpartum care and will be request from program managers annually.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>"MCHBest suggests the strategy of Home Visiting has emerging evidence, alluding to results of utilizing this strategy trend positive. However, further research is warranted to confirm its effects in supporting mothers in obtaining timely postpartum care. State Home Visiting Programs can decrease barries mothers face in receiving adequate postpartum care and can increase the likelihood that mothers will attend postpartum visits (1). Home visiting staff help participants make and attend appointments as well as provide access to community resources. There is evidence to suggest that home visiting programs can improve maternal health and reduce postpartum depression (2,3).

1. Adelson, P., Fleet, J. A., & McKellar, L. (2023). Evaluation of a regional midwifery caseload model of care integrated across five birthing sites in South Australia: Women's experiences and birth outcomes. Women and birth : journal of the Australian College of Midwives, 36(1), 80–88. https://doi.org/10.1016/j.wombi.2022.03.004.
2. Phillips, S. E. K., Celi, A. C., Wehbe, A., Kaduthodil, J., & Zera, C. A. (2023). Mobilizing the fourth trimester to improve population health: interventions for postpartum transitions of care. American Journal of Obstetrics and Gynecology, 229(1), 33–38. https://doi.org/10.1016/j.ajog.2022.12.309.
3. Sama-Miller E, Akers L, Mraz-Esposito A, et al. Home visiting evidence of effectiveness review: Executive summary. Washington, D.C.: Office of Planning, Research and Evaluation (OPRE), Administration for Children and Families (ACF), U.S. Department of Health and Human Services (U.S. DHHS); 2017."</td></tr>
<tr><td>Significance:</td><td>Postpartum care is critical for long-term maternal health and reducing maternal morbidity and mortality. According to Federally Available Data from the Pregnancy Risk Assessment Monitoring System, approximately 90.3% of women in the U.S attend a postpartum check up within 12 weeks after giving birth in 2023. In Nevada only 84.6% of women attend a postpartum check with 12 weeks of giving birth. Women that are uninsured or are enrolled Medicaid are less likely to have adequate postpartum care and be referred to the necessary services. WIC and Home Visiting provide and opportunity to support new mothers and influence their health and well-being.</td></tr>
</table>

ESM BF.1 - Percent of Nevada PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends
NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

Measure Status:	Active
Goal:	Reduce the number of women who stop breastfeeding due to lack of support from family or friends.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of PRAMS respondents who stop breastfeeding due to lack of support from family or friends **Denominator:** Number of PRAMS respondents
Data Sources and Data Issues:	Nevada Pregnancy Risk Assessment Monitoring System; Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2023 calendar year was used. 2023 Nevada PRAMS data had a response rate of 40.5%. Interpret data with caution due to the response rate.
Evidence-based/informed strategy:	According to the MCH Evidence Center, social support in particular father or partner support has been identified as crucial component in increasing successful breastfeeding. One study by found that overall breastfeeding was initiated by 74% of women who's partners attended an educational intervention compared with 41% of women who's partners attended the control (1). In another study looking at the mother's perception of the father's attitude towards breastfeeding, the most common reason for bottle feeding was the mother's perception of the father's attitude, thus indicating education should be given to both parents to increase breastfeeding initiation and duration (2). Nevada participates in programs that promote breastfeeding. Understanding barriers to breastfeeding continuation as measured by this ESM is important when determining if breastfeeding support programs are having an impact on breastfeeding rates. 1. Wolfberg AJ, Michels KB, Shields W, O'Campo P,Bronner Y, Bienstock J. Dads as breastfeeding advocates: results from a randomized controlled trial of an educational intervention. Am J Obstet Gynecol. 2004; 191:708-712. 2. Arora S, McJunkin C, Wehrer J, Kuhn P. Major factors influencing breastfeeding rates: Mother's perception of father's attitude and milk supply. Pediatrics. 2000 Nov;106(5):E67. doi: 10.1542/peds.106.5.e67. PMID: 11061804.
Significance:	Breast milk provides the ideal nutrition for infants. It provides the proper mix of vitamins, protein, and fat to help babies grow. Breastmilk is more easily digested than infant formula, and contains antibodies to help babies fight off viruses and bacteria. Babies who are breastfed exclusively for the first 6 months, without any formula, have fewer health issues. They also have fewer hospitalizations and trips to the doctor., which contributes to reduced healthcare costs for families and systems alike (1,2). 1. Centers for Disease Control and Prevention. (2023). Why it matters. https://www.cdc.gov/breastfeeding/about-breastfeeding/why-it-matters.html 2. Rollins, N. C., Bhandari, N., Hajeebhoy, N., Horton, S., Lutter, C. K., Martines, J. C., ... & Victora, C. G. (2016). Why invest, and what it will take to improve breastfeeding practices? The Lancet, 387(10017), 491–504. https://doi.org/10.1016/S0140-6736(15)01044-2

ESM SS.1 - 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
NPM – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep - SS

Measure Status:	Active
Goal:	Reduce the number of infants (under 1 year of age) who are laid to sleep in a high-risk sleep position and/or environment
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number 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 **Denominator:** Number of PRAMS respondents
Data Sources and Data Issues:	Nevada Pregnancy Risk Assessment Monitoring System; Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2023 calendar year was used. 2023 Nevada PRAMS data had a response rate of 40.5%. Interpret data with caution due to the response rate.
Evidence-based/informed strategy:	Nevada participates in programs that promote safe sleep and provide cribs to families of need. Education on safe sleep practices are including in crib distribution. These programs are proven to be successful in reducing bed sharing, and other safe sleep practices. This ESM allows for the understanding of how safe sleep programs are having an impact on infant safe sleep behaviors.
Significance:	In 2016, the American Academy of Pediatrics (AAP) developed specific recommendations expanding on the importance of sleep position for infants up to 1 year old. To reduce the risk of SIDS, for safe sleep in a supine position (wholly on the back) for every sleep by every caregiver until the child reaches 1 year of age. Side sleeping is not safe and is not advised. Additionally, adding sheets, blankets or other soft objects also increase the change of sleep related suffocation by 16 times compared to babies without soft objects. 1. Sharyn E. Parks, Carla L. DeSisto, Katherine Kortsmit, Jennifer M. Bombard, Carrie K. Shapiro-Mendoza; Risk Factors for Suffocation and Unexplained Causes of Infant Deaths. Pediatrics January 2023; 151 (1): e2022057771. 10.1542/peds.2022-057771

ESM SS.2 - Percent of Nevada PRAMS respondents who report their infants (under 1 year of age) were laid to sleep in a high-risk sleep position and/or environment
NPM – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep - SS

Measure Status:	Active
Goal:	Reduce the number of PRAMS respondents who lay their infants to sleep n a high-risk sleep position or environment
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** PRAMS respondents who report laying their infants on their sides or stomachs and in an environment with loose bedding or soft objects. **Denominator:** All PRAMS respondents
Data Sources and Data Issues:	Nevada Pregnancy Risk Assessment Monitoring System; Data represents calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2023 data is not received until fall 2024), which is why calendar year is used. Nevada PRAMS data has not been able to meet the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data since its inception in the state. Interpret data with caution due to the response rate.
Evidence-based/informed strategy:	Nevada participates in programs that promote safe sleep and provide cribs to families of need. Education on safe sleep practices are including in crib distribution. These programs are proven to be successful in reducing bed sharing, and other safe sleep practices. This ESM allows for the understanding of how safe sleep programs are having an impact on infant safe sleep behaviors.
Significance:	"In 2016, the American Academy of Pediatrics (AAP) developed specific recommendations expanding on the importance of sleep position for infants up to 1 year old. To reduce the risk of SIDS, for safe sleep in a supine position (wholly on the back) for every sleep by every caregiver until the child reaches 1 year of age. Side sleeping is not safe and is not advised. Additionally, adding sheets, blankets or other soft objects also increase the change of sleep related suffocation by 16 times compared to babies without soft objects. 1. Sharyn E. Parks, Carla L. DeSisto, Katherine Kortsmit, Jennifer M. Bombard, Carrie K. Shapiro-Mendoza; Risk Factors for Suffocation and Unexplained Causes of Infant Deaths. Pediatrics January 2023; 151 (1): e2022057771. 10.1542/peds.2022-057771"

ESM PA-Child.1 - Percent of respondents from the Kindergarten Health Survey (KHS) who report their child exercises for at least 60 minutes per day at least 4-5 times a week
NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child

Measure Status:	Active
Goal:	To increase the number of children who are physically active for at least 60 minutes per day
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of KHS respondents who report their child exercises for at least 60 minutes per day at least 4-5 times a week</td></tr><tr><td>**Denominator:**</td><td>Number of KHS respondents</td></tr></table>
Data Sources and Data Issues:	Data will be obtained from the KHS, which is provided by the Nevada Intitute of Children's Research and Policy (NICRP) at the University of Nevada, Las Vegas (UNLV). The NICRP publishes a public-facing annual report detailing the findings of the KHS to inform the public and interested partners.
Evidence-based/informed strategy:	"The percentage of KHS respondents who report that their child is physically active for at least 60 minutes per day serves as an evidence-informed strategy measure that is rooted in national physical activity guidelines. The CDC (1) and U.S. Department of Health and Human Services (DHHS) (2) recommend that children engage in at least 60 minutes of moderate to vigorous physical activity each day to support healthy growth and development, prevent chronic disease, improved mood, and lower risk of obesity. Monitoring this measure through a statewide survey provides important insight into the health behaviors of Nevada children and allows for Title V and related programs to assess progress, identify disparities, and target resources to promote active lifestyles among youth. 1. CDC. (2024). Child Activity: An Overview. Physical Activity Basics. https://www.cdc.gov/physical-activity-basics/guidelines/children.html 2. U.S. Department of Health and Human Services. (2018). Physical Activity Guidelines for Americans, 2nd edition. Washington, DC: U.S. Department of Health and Human Services."
Significance:	"Physical activity is essential for healthy growth and development in children. Regular movement supports physical health, improves emotional well-being, and helps prevent chronic conditions such as obesity, diabetes, and heart disease. For school-aged children, being active daily is linked to better focus, academic performance, and social skills (1). Promoting physical activity among children is a key strategy for improving overall child health and reducing long-term health disparities. 1. CDC. (2025). Health Benefits of Physical Activity for Children. Physical Activity Basics. https://www.cdc.gov/physical-activity-basics/health-benefits/children.html"

ESM FS.1 - Percent of Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Home Visitors who received training on nutrition and exhibited increased knowledge on food sufficiency and strategies on how to discuss nutrition with families
NPM – Percent of children, ages 0 through 11, whose households were food sufficient in the past year - FS

Measure Status:	Active
Goal:	Increase the percent of children who are food sufficient in Nevada
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number 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</td></tr><tr><td>**Denominator:**</td><td>Number of MIECHV Home Visitors who received training on nutrition</td></tr></table>
Data Sources and Data Issues:	Nevada's Home Visiting Program tracks data on staff participating in trainings and will be request from program managers annually. The foreseeable data issues pertain to response rates of pre- and post-surveys for trainings, but will be addressed after training implementation.
Evidence-based/informed strategy:	"The percentage of MIECHV Home Visitors who received training on nutrition and demonstrated increased knowledge of food sufficiency an effective communication strategies aligns with the MCHBest evidence-based strategy of Nutrition Education (1). This training is especially important in Nevada, where the MIECHV program serves high-need populations, as more than 90% of participating households are at or below 200% of the Federal Poverty Guidelines (2). By equipping trusted Home Visitors with the tools and knowledge to support families on topics related to nutrition and food access, families are more likely to receive relevant, culturally responsive, and timeline information that can improve their overall food sufficiency and health outcomes. 1. Association of Maternal & Child Health Programs. (n.d.). Food sufficiency: Nutrition education. MCH Evidence. https://www.mchevidence.org/tools/strategies/details.php?food-sufficiency-02 2. HRSA. (2023). Nevada: Maternal, infant, and early childhood home visiting program FY 2023 formula funding profile. U.S. Department of Health and Human Services. https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/home-visiting/nv.pdf"
Significance:	"Food sufficiency is essential to the healthy growth and development of children. When children have consistent access to nutritious food, they are more likely to succeed academically, develop strong immune systems, and maintain emotional well-being. In contrast, food insecurity is associated with higher risks of chronic health conditions, developmental delays, behavioral issues, and poor academic performance (1). Children in household that lack reliable access to food may also experience increased levels of stress and anxiety, further affecting their health and ability to thrive. By promoting food sufficiency through partnerships and outreach, a stronger foundation for long-term health outcomes and educational attainment can be obtained for Nevada's children. 1. Gundersen, C., & Ziliak, J. P. (2015). Food insecurity and health outcomes. Health Affairs, 34(11), 1830–1839. https://doi.org/10.1377/hlthaff.2015.0645"

ESM AWV.1 - Percent of Medicaid EPSDT eligible adolescents, ages 12 through 17, who received at least one initial or periodic screen
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of adolescents, ages 12 through 17, receiving preventive well visits.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Medicaid EPSDT eligible adolescents, ages 12 through 17, receiving at least one initial or periodic screen</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Nevada Title V/MCH Program</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>According to the Kaiser Family Foundation (1), about 2 in 5 children in Nevada are enrolled in Medicaid. For these children, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides access to preventive health services, including well-visits, developmental and behavioral screenings, and necessary follow-up care. These services are especially critical for adolescents, as they help identify mental health conditions, adverse childhood experiences (ACEs), and emerging physical health concerns early on. This approach aligns with the Youth Health Improvement Initiative featured in AMCHP's Innovation Hub (2), which promotes comprehensive adolescent screening as a best practice. Expanding EPSDT outreach and implementation can strenghten early intervention efforts and support better long-term outcomes for Nevada's youth.

1. KFF. (2025). Medicaid State Fact Sheets. https://www.kff.org/interactive/medicaid-state-fact-sheets/
2. VCHIP. (2016). VCHIP - Youth Health Improvement Initiative. AMCHP. https://amchp.org/database_entry/vchip-youth-health-improvement-initiative/</td></tr>
<tr><td>Significance:</td><td>Adolescents ages 12 to 17 experience rapid physical, emotional, and social development, making this age range a critical time for preventive care. Routine well visits help identify emerging health concerns early, including mental health conditions, substance use, and signs of chronic disease. These visits also offer opportunities for health promotion, and building trust between adolescents and providers. Despite their importance, adolescent well visit rates remain lower than those for younger children (1). Increasing access to and use of preventive well visits supports early intervention. Prioritizing these visits can help improve health outcomes and reduce disparities among youth.

1. NCHS. (2019). Physician Office Visits by Children for Well and Problem-focused Care: United States, 2012. CDC. https://www.cdc.gov/nchs/products/databriefs/db248.htm</td></tr>
</table>

ESM MH.1 - Percent of Nevada Medical Home Portal users who utilize the Services Directory feature to obtain information on providers and community resources.
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Active
Goal:	To increase the percentage of users visiting the Nevada Medical Home Portal website who engage with the website and utilize the Services Directory to obtain information on CSHCN providers and resources.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of users who utilized a link in the Services Directory to navigate to a website for a community provider or community resource. **Denominator:** Number of users of the Nevada Medical Home Portal
Data Sources and Data Issues:	Medical Home Portal Google Analytics quarterly reports are utilized for this ESM.
Evidence-based/informed strategy:	The evidence informed strategy this ESM measures is if expanding a provider alliance has an impact on increasing access to resources within a Medical Home model. This evidence was described as "emerging" and gathered from the MCH Evidence NPM 11 report. This strategy of creating a "one stop shop" model of credible information within the Medical Home Portal is theorized to increase access to providers for CSCN and their caregivers and subsequently result in the formation of a medical home.
Significance:	A Medical Home Portal is a “one-stop shop” credible source of information about children and youth with special health care needs (CSHCN). It is a valuable resource for families, physicians and medical home teams, and other professionals and caregivers. Quantifying the number of users interacting with the Medical Home Portal and utilizing the Services Directory feature allows for a better understanding of the effectiveness of the portal in connecting caregivers to needed CSHCN resources and providers, and translates into how many individuals have a Medical Home.

Form 10

Evidence-Based or -Informed Strategy Measure (ESM) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM DS.1 - Percent of Medicaid enrolled children, ages 9 through 35 months, who received a developmental screening using a standardized tool.
2021-2025: NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Measure Status:	Active
Goal:	To increase the number of children receiving a developmental screenings using a standardized tool.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 4561 **Denominator:** 50970
Data Sources and Data Issues:	Nevada Office of Analytics, Nevada Medicaid
Significance:	Parents Evaluation of Developmental Status (PEDS), Ages and Stages (ASQ-3 and ASQ:SE-2) and Early Language Milestone Screen are the most commonly used standardized developmental screening tool. Collection of this data will allow the Title V MCH Program to track the number of medicaid enrolled children receiving a developmental screening.

2021-2025: ESM TAHC.3 - Percent of families who report the information received by a Family Navigator through Family Navigation Network met their needs for transition from pediatric to adult health care.
2021-2025: NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC

Measure Status:	Active
Goal:	Family Navigation Network (FNN) is Nevada's Family to Family Health Information Center, and works to provide families of CSHCN with resources statewide to assist in better health outcomes, including healthcare transition.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families receiving healthcare transition information from Family Navigation Network who report the information met their needs. **Denominator:** Number of families receiving information on healthcare transition through Family Navigation Network
Data Sources and Data Issues:	Family Navigation Network distributes evaluation surveys to families, and data will be obtained from those responses. Data issues could include low response rate.
Evidence-based/informed strategy:	The strategy this ESM measures is the effectiveness of Title V MCH partnering with Family Navigation Network to create and disseminate tools and resources on health care transition, and if that is translating into helping families and their satisfaction with that assistance. This evidence was accessed through the MCH Evidence Center's NPM 12 evidence report. This strategy influences NPM 12 by creating increased demand among families of CYSHCN to speak with their providers on healthcare transition, and increase their knowledge to advocate for better transition care.
Significance:	This ESM measures overall caregiver satisfaction with Family Navigation Network healthcare transition resources. FNN and Title V MCH are working to develop transition resources and disseminate them widely, so this targeted evaluation allows for an understanding of the effectiveness of these resources and family navigator communication. If the percentage of families satisfied with the assistance they received increases over time, that could indicate that more families of CSHCN feel informed on transition from pediatric to adult healthcare.

2021-2025: ESM WWV.1 - Percent of pregnant women who received prenatal care beginning in the first trimester
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	To increase the percent of women accessing prenatal care in the first trimester.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 22849 **Denominator:** 30925
Data Sources and Data Issues:	Nevada Electronic Birth Registry System
Significance:	Prenatal care access ensures opportunities for the provision of preventive services including screenings, identification of high risk behaviors and nutritional needs, and education for new parents. Prenatal care reduces the risk of pregnancy complications and women who receive prenatal care within their first trimester are more likely to have a healthy birth outcome. Prenatal care visits help monitor maternal and fetal well being throughout pregnancy. Early detection and treatment of potential complications improves chances of healthy pregnancy and healthy infant.

2021-2025: ESM SMK-Pregnancy.1 - Percent of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits
2021-2025: NPM – Percent of women who smoke during pregnancy - SMK-Pregnancy

Measure Status:	Active
Goal:	Reduce the percentage of pregnant women who smoke during pregnancy
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits</td></tr><tr><td>**Denominator:**</td><td>Number of total PRAMS respondents</td></tr></table>
Data Sources and Data Issues:	Nevada Pregnancy Risk Assessment Monitoring System (PRAMS); Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. 2018 Nevada PRAMS data had a response rate of 39.4% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. Interpret data with caution due to the response rate.
Significance:	Tobacco smoke contains a deadly mix of more than 7,000 chemicals; hundreds are harmful, and about 70 can cause cancer. Smoking during pregnancy is a public health problem because of the many adverse effects associated with it. These include intrauterine growth restriction, placenta previa, abruptio placentae, decreased maternal thyroid function, preterm premature rupture of membranes, low birth weight, perinatal mortality, and ectopic pregnancy. Children born to mothers who smoke during pregnancy are at an increased risk of asthma, infantile colic, and childhood obesity. Secondhand prenatal exposure to tobacco smoke also increases the risk of having an infant with low birth weight by as much as 20%. Smoking by women during pregnancy has been shown to increase the risk for Sudden Infant Death Syndrome (SIDS). Providers and public health professionals should provide support mothers to stop perinatal smoking. Public health awareness of the risks associated with smoking and substance use during pregnancy can reach more of the population by mass media. Knowledge of available resources may help reduce the risk of adverse birth outcomes associated with smoking and substance use. Public health initiatives could lead to a decrease in smoking by pregnant women and nonpregnant women of reproductive age by providing access to smoking cessation programs.

Form 11
Other State Data

State: Nevada

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12

Part 1 – MCH Data Access and Linkages

State: Nevada

Annual Report Year 2024

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	More often than monthly	1		
2) Vital Records Death	Yes	Yes	More often than monthly	1	Yes	
3) Medicaid	Yes	Yes	More often than monthly	1	Yes	
4) WIC	Yes	Yes	More often than monthly	1	Yes	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	1	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	More often than monthly	3	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	More often than monthly	12	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: Nevada

Annual Report Year 2024

Form 12 Products And Publications