Maternal and Child Health Advisory Board

MEETING AGENDA

DATE: January 12, 2022, TIME: 3:00 PM

The meeting will be held via teleconference only. **Members of the public who wish to attend and participate remotely are strongly encouraged to do so by utilizing the following meeting link or call-in number:**

CALL-IN NUMBER:+1 (775) 321-6111 ACCESS CODE: 337 918 440#

ONE TAP PHONE NUMBER: +1 775-321-6111,,337918440#

VIDEO CONFERENCE LINK: Click here to join the meeting

If calling in using a cell phone, please remember to mute your phone

Note: Unless a specific time is noted, agenda items may be taken out of order, combined for consideration, and or removed from the agenda at the chairperson's discretion.

1. **Call to order/roll call – Linda Gabor, MSN, RN, Chair**
   Members: Linda Gabor, MSN, RN (Chair), Melinda Hoskins MS, APRN, CNM; Fred Schultz; Marsha Matsunaga Kirgan, MD; Keith Brill, MD; Noah Kohn, MD; Fatima Taylor, M.Ed., CPM; Senator Marilyn Dondero Loop; and Assemblywoman Daniele Monroe-Moreno

2. **Public Comment**
   No action may be taken on a matter raised under this item unless the matter is included on an agenda as an item upon which action may be taken. The Chair of the Maternal and Child Health Advisory Board will place a five (5) minute time limit on the time individuals addressing the Maternal and Child Health Advisory Board.

3. **FOR POSSIBLE ACTION: Approval of draft minutes from the Maternal and Child Health Advisory Board (MCHAB) meeting on May 7, 2021; and the MCHAB Subcommittee meeting on April 9, 2021 – Linda Gabor, MSN, RN, Chair**

   PUBLIC COMMENT

4. **FOR POSSIBLE ACTION: Presentation and possible recommendations to the Division of Public and Behavioral Health regarding Maternal and Child Health (MCH) COVID-19 Data and Resources – Jennifer Thompson, Health Program Manager II, Office of Analytics, Department of Health and Human Services (DHHS)**

   PUBLIC COMMENT

5. **FOR POSSIBLE ACTION: Updates and possible recommendations to the Division of Public and Behavioral Health (DPBH) regarding the Alliance for Innovation on Maternal Health (AIM) and the Maternal Mortality Review Committee (MMRC) – Tami Conn, SSDI Coordinator, Maternal, Child, and Adolescent Health (MCAH), DPBH**

   PUBLIC COMMENT

6. **INFORMATIONAL: Discussion of Nevada Early Hearing Detection and Intervention Program – Perry Smith, Nevada Early Hearing Detection and Intervention Program Coordinator, MCAH, DPBH**

PUBLIC COMMENT

7. **INFORMATIONAL: Presentation on MCH Reports and MCH Updates – Kagan Griffin, MPH, RD, Title V MCH Program Manager, MCAH, DPBH**

PUBLIC COMMENT

8. **FOR POSSIBLE ACTION: Presentation and possible recommendations to the Division of Public and Behavioral Health regarding highlights of the Title V MCH Block Grant Application and Report Federally Available Data (FAD) – Kagan Griffin, MPH, RD, Title V MCH Program Manager, MCAH, DPBH**

PUBLIC COMMENT

9. **FOR POSSIBLE ACTION: Make recommendations for future agenda items – Linda Gabor, MSN, RN, Chair**

PUBLIC COMMENT

10. **FOR POSSIBLE ACTION: Approval of MCHAB meeting dates for 2022 – Linda Gabor, MSN, RN, Chair**
    - **May 6, 2022, 9:00 AM**
    - **August 5, 2022, 9:00 AM**
    - **November 4, 2022, 9:00 AM**

PUBLIC COMMENT

11. **Public Comment**

12. **Adjournment**

NOTICES OF PUBLIC MEETING HAVE BEEN POSTED AT THE FOLLOWING LOCATIONS:

The Nevada Division of Public and Behavioral Health (DPBH) website at http://www.dpbh.nv.gov and will be physically posted at DPBH, First Floor, 4150 Technology Way, Carson City, Nevada, 89706.

The Department of Administration's website at https://notice.nv.gov/

We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the teleconferenced meeting. If special arrangements are necessary, please notify Desiree Wenzel in writing by email (ddwenzel@health.nv.gov), by mail (Maternal and Child Health Advisory Board, Nevada Division of Public and Behavioral Health, 4150 Technology Way, Suite 210, Carson City, NV 89706) or by calling (775) 684-4235 before the meeting date. Anyone who wants to be on the Maternal and Child Health Advisory Board mailing list must submit a written request every six months to the Nevada Division of Public and Behavioral Health at the address listed above.

If you need supporting documents for this meeting, please notify Desiree Wenzel, Division of Public and Behavioral Health, Bureau of Child, Family and Community Wellness, at (775) 434-9150 or by email at ddwenzel@health.nv.gov. Supporting materials are available for the public on the Nevada Division of Public and Behavioral Health Website at www.dpbh.nv.gov.

This body will provide at least two public comment periods in compliance with the minimum requirements of the Open Meeting Law prior to adjournment. Additionally, it is the goal of the Maternal and Child Health Advisory Board to also afford the public with an item-specific public comment period. No action may be taken on a matter raised under public comment unless the item has been specifically included on the agenda as an item upon which action may be taken. The Chair retains discretion to only provide for the Open Meeting Law's minimum public comment and not call for additional item-specific public comment when it is deemed necessary by the chair to the orderly conduct of the meeting.

Written comments in excess of one (1) typed page on any agenda items which requires a vote are respectfully requested to be submitted to the Maternal and Child Health Advisory Board at the below address thirty (30) calendar days prior to the meeting to ensure that adequate consideration is given to the material.

Attachment for Agenda Item #3

MATERNAL AND CHILD HEALTH ADVISORY BOARD
MINUTES
May 7, 2021
9:00 AM

The Maternal and Child Health Advisory Board (MCHAB) held a public meeting on May 7, 2021, beginning at 9:00 A.M. at the following locations:

Call in Number: 1-415-655-0001
Access Code: 187 234 2201
Video: https: https://nvhealth.webex.com/nvhealth/j.php?MTID=m9ed023d2f79a4c74c9dc73901670770c

BOARD MEMBERS PRESENT
Chair Veronica (Roni) Galas, RN
Tyree G. Davis, D.D.S
Melinda Hoskins, MS, APRN, CNM, IBCLC
Linda Gabor, MSN, RN
Fatima Taylor, MEd, CPM
Marsha Matsunaga-Kirgan, MD

BOARD MEMBERS NOT PRESENT
Senator Marilyn Dondero Loop
Assemblywoman Daniele Monroe-Moreno
Noah Kohn, MD
Fred Schultz
Keith Brill, MD

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH (DPBH) STAFF PRESENT
Vickie Ives, MA, Section Manager, Maternal, Child, and Adolescent Health (MCAH), CFCW
Mitch DeValliere, DC, Program Manager, Title V Maternal and Child Health (MCH), MCAH, CFCW
Evelyn Dryer, Program Manager, Maternal, Infant, and Early Childhood Home Visiting (MIECHV), MCAH, CFCW
Tami Conn, Health Program Specialist II, State Systems Development Initiative (SSDI), MCAH, CFCW
Kagan Griffin, MPH, RD, MCH Epidemiologist and Pregnancy Risk Assessment Monitoring System (PRAMS) Lead Coordinator, MCAH, CFCW
Eileen Hough, MPH, Program Coordinator, Adolescent Health and Wellness, MCAH, CFCW
Yesenia Pacheco, Program Coordinator, Rape Prevention and Education (RPE), MCAH, CFCW
Jazmin Sarmiento, Program Coordinator, Personal Responsibility and Education Program (PREP), MCAH, CFCW
Lisa Light, Accounting Assistant III, Immunization Program and MCAH, CFCW
McKenna Bacon, Administrative Assistant IV, Bureau Office Manager, CFCW
Desiree Wenzel, Administrative Assistant III, Office Manager, MCAH, CFCW
Jonathan Figueroa, Administrative Assistant II, MCAH, CFCW
Stephanie Camacho, Administrative Assistant II, MCAH, CFCW
Madisson Jacobs, Administrative Assistant I, MCAH, CFCW
Vanessa Rauch, Program Coordinator, CFCW
Amber Hise, RD, Health Program Specialist I, Maternal and Infant Health Program Coordinator
Marjorie Singh, MCAH and Office of Analytics (OOA), Data and Evaluation Coordinator, Early Hearing Detection and Intervention Program

OTHERS PRESENT

Linda Anderson, JD, Nevada Public Health Foundation
Denise Tanata, JD, Early Childhood Advisory Council (ECCS) Director, The Children's Cabinet
Cachet Wenziger, Biostatistician II, Department of Health and Human Services, Office of Analytics

1. **Call to Order- Roll Call and Introductions**

   Chair Galas called the May 7th meeting to order at 9:04AM.

   Roll call was taken, and it was determined a quorum of the MCHAB was present.

2. **Public Comment**

   A point of order from Ms. Galas; a request was made to move agenda item eight (8) to agenda item four (4) then proceed to agenda items from there.

   Public Comment - None

3. **Approval of draft minutes from the February 5, 2021 and April 9, 2021 meeting – Veronica Galas, RN, BSN; Chair**

   Ms. Gabor asked to have the minutes changed on Page ten (10) of the April 9, 2021 minutes stating she believes Ms. Hoskins was the one to define obstetrics center. Ms. Hoskins and Ms. Galas also agreed.

   TYREE DAVIS ENTERTAINED A MOTION TO APPROVE THE FEBUARY 5 AND APRIL 9, 2021 MEETING MINUTES AS CORRECTED. LINDA GABOR SECONDED THE MOTION WHICH PASSED UNANIMOUSLY

   Public Comment – Chair Galas mentioned a point of procedure that some votes will be verbal, but when the agenda gets to voting for Board officers (agenda item 8), the voting will need to be written and will be done in the chat function. Anyone on the phone will need to email Dr. DeValliere with their vote.

   Dr. DeValliere requested that attendees identify themselves in the chat box.

4. **For Possible Action: Update and possible recommendations on Alliance for Innovation on Maternal Health (AIM) and the Maternal Mortality Review Committee (MMRC) – Vickie Ives, MA, Maternal, Child and Adolescent Health Section Manager, Division of Public and Behavioral Health.**

   Tami Conn presented on the Alliance for Innovation on Maternal Health (AIM) and the Maternal Mortality Review Committee (MMRC). Ms. Conn discussed AIM updates and reported the data REDCap reporting system is complete, and they are planning to launch a kick-off meeting in early June. Starting in August or September, they will be working with hospitals to do one (1) hour learning session webinars for those that sign on to implement the hypertension bundle. Also, the

MMRC April report has been posted online at the Office of Analytics and the MCH websites, and the report covers the whole year of 2020. Ms. Conn mentioned they have sent out a request to fill one member for the MMRC and all applicants have been referred to the Director's Office for consideration for appointment.

Ms. Galas asked for questions from the Board and for the MMRC report websites to be placed in the chat.

No public Comment

5. **For Possible Action: Presentation and possible recommendation on Nevada Strong Start ECCS-Health Integration Health Resources and Services Administration (HRSA) Grant – Denise Tanata, JD, Nevada Strong Start Early Childhood Comprehensive Systems (ECCS) Director, The Children's Cabinet**

Ms. Galas thanked the presenter, Ms. Tanata, and asked for any discussion from the Board.

Ms. Hoskins thanked the presenter for submitting the grant application and stated this is sorely needed in this state.

Ms. Galas stated some clarification might be needed from state staff after this meeting to proceed with Board representation. It is not a usual practice to have a member of the MCHAB Board on an outside committee as a Board representative. A Chairperson may need to be appointed or a formal vote administered, either way clarification is needed to work out the details and the process.

Ms. Gabor stated this is a wonderful program, but she is also not sure how it will work to participate and will need some clarification.

Ms. Conn wanted to clarify the accuracy of the PRAMS data, stating that while the response rate is low based on the Centers for Disease Control and Prevention's (CDC) recommendations, the data is accurate and can still be used.

Ms. Tanata stated she understands the accuracy and wanted to clarify that it was more about getting a better response rate from the community and why they should participate.

Ms. Galas asked who, from this program's leadership, represents those in daycare/childcare ages one (1) through three (3) because those individuals are not yet in school and where is their representation found.

Ms. Tanata stated the Nevada Early Childhood Advisory Council is the governing board, and their focus is on early childhood care, and the Governor' Office appoints them. A large part of their focus is on childcare, early childhood care and education, and healthy development. However, more representation is needed from the health care side. She is looking for support from this group to help better integrate the two.

Ms. Galas asked for comments from the Board or any public comments. Ms. Galas stated hearing interest for participation, but notes they are not prepared to act today and can put this item on as

a future agenda item.

No public comment

6. **For Possible Action: Presentation and possible recommendations on Maternal and Child Health (MCH) COVID-19 Data and Resources – Jen Thompson, Health Program Manager II, Office of Analytics, Department of Health and Human Services**

Cachet Wenzinger presented for Jen Thompson.

Ms. Galas asked for any questions from the Board.

Dr. Davis asked if the data reflects a difference between the first and second vaccine in health outcomes.

Ms. Wenzinger stated she will take all questions now and get them answered by Jen Thompson.

Dr. Davis asked, what the vaccine trends are for those between the ages of twelve (12) to fifteen (15) years of age.

Ms. Gabor asked about how many people are getting the first vaccine but not the second vaccine. She said they are seeing no-shows for the second shot and it would be interesting to see the trends.

Ms. Galas stated Pfizer vaccine is currently in the process of lowering the age of those eligible for the vaccine, potentially conflicting with getting required school vaccines. Once you have had a vaccine of any kind, you must wait 2-weeks before getting another. Ms. Galas recommended encouraging providers to get the word out about delays due to school-related vaccines and the COVID vaccine.

Ms. Galas asked for any other comments from the Board or public comments about the report. Ms. Galas stated that Ms. Wenziger would pass all questions onto Jen Thompson to be answered, and then send an email response to those questions.

No public comment

7. **For Possible Action: Discussion and possible action to draft letter of recommendation to the Division of Public and Behavioral Health (DPBH) Administrator relating to legislation presently before the 81st (2021) Session of the Nevada Legislature regarding maternal and child health including, but not limited to AB 119, AB 192, AB 198, AB 256, and AB 287 – Veronica Galas, RN, BSN; Chair.**

Ms. Galas asked Ms. Gabor or the subcommittee members to share the outcomes of the subcommittee meeting related to legislation.

Ms. Gabor stated that the subcommittee met once and planned to hold a second meeting but did not have a quorum for the second meeting. Three (3) of the bills were discussed and draft letters

to the Administrator included AB 119, AB 192, and AB 287. Other discussions related to AB 198 and AB 256 were held but no letters were provided. AB 189, which expands Medicaid for up to 12 months postpartum is also up for discussion.

Ms. Galas asked Dr. DeValliere to share the letter within the packet for the committee to review.

Ms. Hoskins stated another bill to consider that was not available at the first meeting is SB 420 about a public option, and it includes the expansion of Medicaid for pregnant women.

Dr. DeValliere shared the packet with the draft letter for AB 119.

Ms. Galas thanked the subcommittee for drafting the letters provided and asked the person who drafted the letter to share their information.

Dr. Davis drafted the AB 119 letter and explained the revised provision related to the MMRC. He drafted the letter similar to past letters the Board has written with the "whereas" sections pointing out the most important parts to the bill and the final section summarizing the Board's support of this bill.

Ms. Hoskins indicated restrictions related to getting information from the cancer registry, but this is not addressed in this bill. Ms. Hoskins asked if that information should be included as additional information for the MMRC.

Ms. Gabor asked about the third whereas and if the Advisory Committee of the Office for Minority Health and Equity is able to access confidential information regarding this bill.

Dr. Davis stated they cannot access confidential information due to HIPPA, and certain information is confidential to maintain the well-being of the patient. Dr. Davis asked if it would be advantageous for that information to be available to the Committee. Right now, they are not allowed access to this information and the third whereas is preserving that status. Dr. Davis also stated it is the right of the patient to decide what information is left confidential.

Ms. Hoskins clarified that as a member of the MMRC they have access to confidential information, but the Advisory Committee is not given the same access.

Ms. Ives confirmed the Advisory Committee has access to the report provided to them but not to the actual records.

Ms. Galas discussed drafting an additional whereas based on Ms. Hoskins earlier questions related to adding information for the MMRC and information not available in this bill.

The Board members discussed open meeting law related to the time needed to prepare any additional meetings. An additional subcommittee meeting was suggested if more time is needed to draft the letters. Minutes would need to be provided three (3) days before the meeting and with conflicting schedules, three (3) days would be cutting it close.

AB 192 information was written by Ms. Gabor: Governing testing and support for early syphilis testing and third trimester testing for pregnant persons. The goal is to voice support of early testing in pregnancy. Ms. Gabor provided the references.

Ms. Galas asked for questions or comments from the Board.

No questions or comments regarding AB 192.

AB 287 information about licensure and regulation of free-standing birth centers was written by Ms. Hoskins with references supplied to backup statements.

Dr. DeValliere stated that the backup references were provided in the packet.

Dr. Matsunaga-Kirgan stated this is a controversial issue, and Nevada would benefit from having birthing centers; however, the data are not strong. The medical literature does not have strong evidence available to make the statements in this letter. Dr. Matsunaga-Kirgan supports the bill but not all the statements of the draft letter.

Ms. Hoskins suggested these statements are true for American Association of Birth Centers (AABC) and Commission for the Accreditation of Birth Centers (CABC) birth centers and cited poor outcomes are seen in non-accredited sites. Ms. Hoskins supported the statements as fact and explained that most data regarding free-standing birthing centers are around those not accredited, but the research around accredited birthing centers is sound evidence.

Dr. Matsunaga-Kirgan stated medical research is still not clear and that there is not strong evidence from medical literature. She agreed with supporting birthing centers.

Ms. Galas asked Dr. Matsunaga-Kirgan if the Board needs to change the wording of the whereas or make other changes to support this letter.

Dr. Matsunaga-Kirgan stated she is uncomfortable claiming midwifery has better outcomes than a hospital, and maybe she and Melinda should work together on this section. Dr. Matsunaga-Kirgan indicated she supports this bill but has issues with the wording and evidence of support used to draft this letter.

Ms. Galas asked which specific whereas is the problem.

The Board discussed setting up another meeting to finish the letter in time to be sent out to support these bills. To do this Ms. Gabor stated it would require two (2) meetings, one (1) subcommittee meeting, and another regular Board meeting. Dr. Davis agreed to draft the letter. Dr. DeValliere clarified the bylaws, stating that the Chair (Ms. Galas) can call another meeting and public notice would need to be given. Also, individuals can draft letters individually, but they cannot meet up as a group; an additional meeting would need to be set up. The group recommended finishing by the end of this meeting. The group felt they could at least address AB 119 and AB 192 and try and finish.

Ms. Ives stated that an amendment was made to introduce gender-neutral language; however, the

gender-neutral language left out pregnancy in the MMRC bill.

Ms. Hoskins stated that another revision was being proposed.

Ms. Galas stated the Board could add a whereas statement to AB 119 to read, "Whereas it is understood there is difficulty with obtaining information from the Nevada Cancer Registry and this information would be invaluable to MMRC evaluation processes, and this is not addressed in this bill."

Linda Anderson spoke for a public comment to be reflected in the public minutes. Ms. Anderson stated that including any limitations of the bill with the addition of faults may be seen as opposition. The Board may not want include those comments within the whereas section of the letter.

Ms. Galas stated wording could be added to the to be resolved section including the MCHAB recommendations supporting the revisions to Assembly Bill 119, as it relates to the MMRC. For future consideration, the inclusion of access to the Nevada Cancer Registry data to enhance the MMRC evaluation process may be considered.

A MOTION TO ACCEPT THE AB 119 LETTER WAS MADE BY DR. DAVIS AND WAS SECONDED BY MS. GABOR. THE MOTION WAS APPROVED UNANIMOUSLY.

A MOTION TO ACCEPT THE AB 192 LETTER WAS MADE BY DR. MATSUNAGA-KIRGRAN AND WAS SECONDED BY DR. DAVIS. THE MOTION WAS APPROVED UNANIMOUSLY.

Ms. Galas asked about bill AB 287.

Ms. Gabor asked to include whereas number two (2) with the change to say, "midwifery care licensed and regulated residential-like setting," so it adds licensed and regulated; this has been the established pattern of care endorsed by the American Association of Birth Centers since inception. The sixth (6) whereas the AABC has set evidence-based standards for free-standing birth centers since 1985, and these standards are regularly re-evaluated based on ongoing research and outcomes, which have resulted in excellent outcomes. The last whereas accredited by the CABC since 1985 assures that an accredited facility consistently meets the standard of care for birthing centers.

Dr. Matsunaga-Kirgan mentioned she is comfortable with the changes. Although in the second to the last whereas it says resulted in excellent outcomes as compared to unlicensed and unregulated. She noted the other option is making a statement that the AABC has set evidence-based standards since 1985. These standards are reevaluated based on the outcomes of free-standing birth centers. She suggested not including the statements about the outcomes.

Ms. Galas asked to formulate AB 287 discussion into a motion. Ms. Galas asked for the letter regarding AB 287 to provide for the licensing and regulation of free-standing birthing centers, eliminate whereas number one (1), include whereas number two (2) to say midwifery care in a licensed and regulated facility and the rest of the whereas remain the same, eliminate whereas three

(3) through five (5), revise the whereas on the American Association of Birthing Centers noting the AABC has set the evidence-based standard since 1985 and these standards are regularly evaluated based on the outcomes of free-standing birthing centers, include whereas seven (7), and include the be it resolved.

Dr. Matsunaga-Kirgan mentioned fully supporting the changes, and states that the American College of Obstetrics and Gynecology considers accredited free-standing birthing centers as a safe place to give birth.

Ms. Galas asked if whereas seven (7), as accredited by the CABC since 1985 assures an accredited facility consistently meets the standards of care for birthing centers. She also asked if it should be added to the be it resolved, or should they just add another whereas to what Dr. Matsunaga-Kirgan said.

Dr. Matsunaga-Kirgan recommended the additional whereas and would mention the American College of Obstetricians and Gynecologists (ACOG) support accredited birth centers.

Dr. Matsunaga-Kirgan acknowledged Ms. Hoskins as having invested a great deal of effort in this letter, and that Ms. Hoskins did great work with a lot of data in the document. She stated she thinks this bill is important, and the Board should support it.

DR. MATSUNAGA-KIRGAN MADE A MOTION TO ADD THE AMENDEMENTS, AS STATED, AND MS. GABOR SECONDED THE MOTION. THE MOTION WAS APPROVED UNANIMOUSLY

Dr. Davis asked if the MCHAB is just sending the letter or including the supporting data.

Dr. Matsunaga-Kirgan motions to only include the letter.

Ms. Galas asked Ms. Gabor, is her motion to include only the letter?

Ms. Gabor stated yes, only the letter.

Ms. Galas stated they have a motion on the floor with a second to send just the letter with the amendments of the Board. She thanked everyone for the important work and appreciated the hard work and coming to a consensus. She acknowledged the accomplishment.

DR. TYREE DAVIS MOTIONED TO DRAFT THE LETTER TO THE ADMISTRATOR FOR BILLS AB 119, AB 192, AB 287, AND DR. MATSUNAGA-KIRGAN SECONDED THE MOTION. THE MOTION WAS APPROVED UNANIMOUSLY.

No Public Comment

8. **For Possible Action: Discussion and possible recommendation regarding consideration of new appointees and/ or to renew expiring terms for MCHAB members and elections for Chairperson and Vice Chairperson. Recommendation will be submitted to the Administrator for consideration of submission to the Nevada State Board of Health for consideration of renewal appointment – Veronica Galas, RN, BSN, Chair.**

   Vice Chair, Dr. Tyree Davis and Chair, Veronica Galas will be stepping down from their positions. A new Chair and Vice Chair will need to be elected.

   Ms. Galas stated this item needs discussion and possible recommendations for the consideration of new appointees or the renewal of expiring terms for members of the MCHAB. The Board also needs to hold elections for the Chairperson and Vice-Chairperson to replace the outgoing members. The recommendations will be submitted to the administration of the Nevada State Board of Health for consideration for renewal of appointments. She asked Dr. DeValliere to give the Board an update on where this stands.

   Dr. DeValliere stated MCH staff sent a Doodle poll to see who was interested in staying on the Maternal and Child Health Advisory Board. Of the members who did respond, several indicated they wished to remain on the Board. There are two (2) members who are unable to continue with the Board, Dr. Davis, and Ms. Galas.

   Ms. Galas stated she soon is going to be shifting her position within the Public Health Department in Carson City, so she will no longer be on this Board.

   Dr. Davis stated he will also be taking a different position, and as a result he will not be able to continue on this Board as the Vice-Chair. Dr. Davis mentioned it has been an honor to serve on this Board for over fourteen-years and it has helped him understand the needs of Maternal and Child Health populations and the needs of children with special health care needs.

   Dr. DeValliere stated the MCH staff will draft a memo to notify the Administrator about the members expressing an interest to continue as MCHAB members and about the two vacancies. Staff can also send a notice about the openings to the MCHAB listserv. At this point, anyone with an interest in serving would be able to submit their name and resume. Their interest will be submitted to the Administrator for consideration.

   Ms. Ives mentioned the Administrator selects the appointments and then it goes to the Board of Health to be confirmed, so it would not go back to the Maternal and Child Health Advisory Board.

   Ms. Galas stated thank you, Ms. Ives. Ms. Galas encouraged Dr. Davis to recommend a person with an interest in oral health for this Board, as oral health has always been important. If you have anyone that you can recommend, they would be valuable as far as submissions to this Board.

   Dr. Davis mentioned he might have someone very interested in child mortality, which is very specific to this committee as well.

Ms. Galas stated the entire Board will have the ability to encourage individuals to apply when the position becomes available, and she has not heard of any other members that are unable to continue to serve on the Board. The first thing needed to do is a motion that would request the Administrator put forth the names of the current Board members minus Ms. Galas and Dr. Davis, to the Board of Health for consideration as members of the Maternal and Child Health Advisory Board.

DR. TYREE DAVIS MOTIONS THE MEMBERS THAT ARE STAYING ON THE BOARD BE SUBMITTED TO THE ADMINSRATOR FOR APPROVAL AND MS. HOSKINS SECONDED THE MOTION. THE MOTION WAS APPROVED UNAMIOUSLY.

Dr. DeValliere stated the voting is strictly for the Chair and Vice-Chair.

Ms. Galas stated the next action would be the Board bringing forward a Chair and Vice Chair for election and asked if there was anyone who would like to express an intention to serve as a Chair or Vice-Chair.

Ms. Hoskins stated she would be interested in serving as Vice-Chair.

Ms. Galas stated the Chair or Vice-Chair would be working with Dr. DeValliere on agenda items. The main role is to facilitate these meetings and coordinate the agenda with presentations. The Vice-Chair and Chair can also work with Dr. DeValliere to put their own spin on how it can function in the future. Ms. Galas asked Ms. Gabor if the Chair position is something she in which she would be interested.

Ms. Gabor mentioned she would consider Vice-Chair but because of her travel schedule it would be difficult to be Chair.

Dr. Davis mentioned the Vice-Chair would be there to support her when she had to travel.

Ms. Gabor asked Ms. Hopkins if she would be interested in being the Chair.

Ms. Hoskins stated she has too many other professional commitments. Ms. Hoskins is on the Board of MMRC and Vice President of the Nevada Community of Midwives and has other personal and community-related commitments. Ms. Hoskins stated she is happy to serve on this committee and fill in for now but would not like to be Chair.

Dr. Davis stated if we do not elect a Chairperson, then the Vice-Chair would run the meetings.

Ms. Galas asked if it is possible to elect a Vice-Chair today that would run the next meeting and the next meeting would be to elect the Chair.

Dr. DeValliere displayed the bylaws . Dr. DeValliere stated he does not believe there is any alternative to the bylaws. The members of the MCHAB shall elect a Chairperson and a Vice-Chairperson from among their membership at the second meeting of the biennium, which this is this meeting. Election shall be by a majority of all voting members. Ballots shall be written

unless there is only one nominee for the office. If a majority vote is not received on the first ballot, balloting shall continue until one member receives a majority of the votes. The terms of office for the Chairperson and Vice-Chairperson are in accordance with all other members and shall be for two years with eligibility for reelections. When a vacancy occurs in the office of the Chairperson, the Vice-Chairperson shall assume the office and duties of the Chairperson.

Dr. Matsunaga-Kirgan asked if there are some Board members not on the phone that would be willing to consider running as Chair.

Dr. Davis stated from the standpoint of members that are regularly present. Dr. Brill is another member that they could consider as other members of the Board are more frequently absent for the meetings.

Dr. Matsunaga-Kirgan mentioned Dr. Kohn is a frequent attendee.

Dr. Galas stated Dr. DeValliere did solicit people interested prior to today's meeting. Ms. Galas stated she is not aware if they put forth any interest.

Dr. DeValliere stated the email sent to the MCHAB members was to give them a chance to express continued interest to serve as members; however, none of the members expressed interest in serving as Chair or Vice-Chair.

Ms. Gabor stated she will go ahead and run for Chair with the understanding of patience and support from those that are more experienced.

Ms. Hoskins stated the Board is happy to stand behind Ms. Gabor.

Ms. Galas thanked Ms. Gabor and noted the staff is very helpful.

DR. TYREE DAVIS MOTIONED TO NOMINATE LINDA GABOR FOR CHAIR AND MELINDA HOSKINS FOR VICE-CHAIR OF THE MATERNAL AND CHILD HEALTH ADVISORY BOARD. DR. MARSHA MATSUNAGA-KIRGAN SECONDED THE MOTION. THE MOTION WAS APPROVED UNANIMOUSLY.

Ms. Galas stated in the bylaws that an election is needed unless there is only one nomination for each position, so an election is not necessary. Ms. Galas asked for any further discussion.

Dr. Davis asked to clarify if we do not have to have a written ballot if there is only one nominee for each position.

Ms. Galas stated that was the case according to the bylaws.

MS. GALAS MENTIONED THE MOTION IS APPOROVED. MS. GABOR WILL BE THE CHAIR AND MS. HOSKINS WILL BE THE VICE CHAIR.

Dr. Matsunaga-Kirgan asked if either Ms. Galas or Dr. Davis would be interested in staying on

as a member even though have resigned from Chair and Vice-Chair.

Ms. Galas mentioned she is not clear on timelines. If it is possible, she would submit an application to be a member.

Ms. Gabor asked for clarification that she is an intermittent registered nurse in Washoe Country, not a full-time employee.

Ms. Ives thanked the Chair and Vice-Chair for their incredible service to the committee and noted what an impact they have made for the maternal health populations in this state. The MCH staff is appreciative of their work and the Chair's steady hand to make this Board run smoothly.

Ms. Galas stated a thank you to all and mentioned how dedicated, passionate, and active participants are and noted she appreciated them.

9. INFORMATIONAL: Discussion on MCH Reports and MCH Updates – Mitch DeValliere, DC, Title V MCH Program Manager, Division of Public and Behavioral Health

Dr. DeValliere presented MCH is now part of Promoting Innovation in the State and Territorial MCH Policy Making known as PRISM. It is an effort extending the work of the Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) program. MCH is looking forward to working with the Association of Maternal and Child Health Programs (AMCHP). AMCHP leads many of these efforts and MCH has a great collaboration with them. Dr. DeValliere mentioned the Nevadabreastfeeds.org, website was updated and launched on April 20, 2021.

Ms. Galas thanked Dr. DeValliere for keeping the Board up to date.

No Public Comment

10. Make recommendation for future agenda items – Veronica Galas, RN, BSN, Chair

Ms. Galas asked if anyone has any future agenda items for the August meeting. If not, agenda items can be submitted to Dr. DeValliere thirty (30) days prior to the next meeting. A request was made for more information on the current legislature outcomes. The next meeting will be in August, and the Board would like to know what happened with the current bills they have worked on and what the results were.

Dr. DeValliere stated MCH would usually have a presentation about the application and report for the Title V Block Grant. However, HRSA has extended the deadline to submit the report until after September 1, 2021. With the current situation, they will not be holding a site visit until late September. Dr. DeValliere stated the report will be provided at the MCHAB meeting in November. COVID updates could also be a possible agenda item.

Ms. Galas stated Fatima Taylor's microphone is not working but she is agreeing to the agenda items.

Ms. Galas stated she is curious about the MMRC report that came out. The Board has been so active in MMRC discussions, a presentation of that report may be something of interest. Ms. Galas mentioned there is no vote needed for these agenda items, just possible ideas. She asked if there were any other comments or agenda items. Ms. Galas stated she will move on to public comments if there are no comments or other agenda items. Ms. Galas would like to remind individuals there were two bills AB 189 and SB 420 that were related to expanding Medicaid to women 12 months postpartum. Recommendations did not come about from the MCHAB, but individuals can still show their support, and comments can be made on NELIS.

No Public Comment.

Happy Mother's Day!

Meeting adjourned at 11:54AM.

Attachment for Agenda Item #4

Steve Sisolak
Governor

Richard Whitley
Director

State of Nevada

Department of Health and Human Services

Update on COVID-19 (Coronavirus) within the Maternal Child Health Population

Office of Analytics

Jen Thompson

1/7/2022

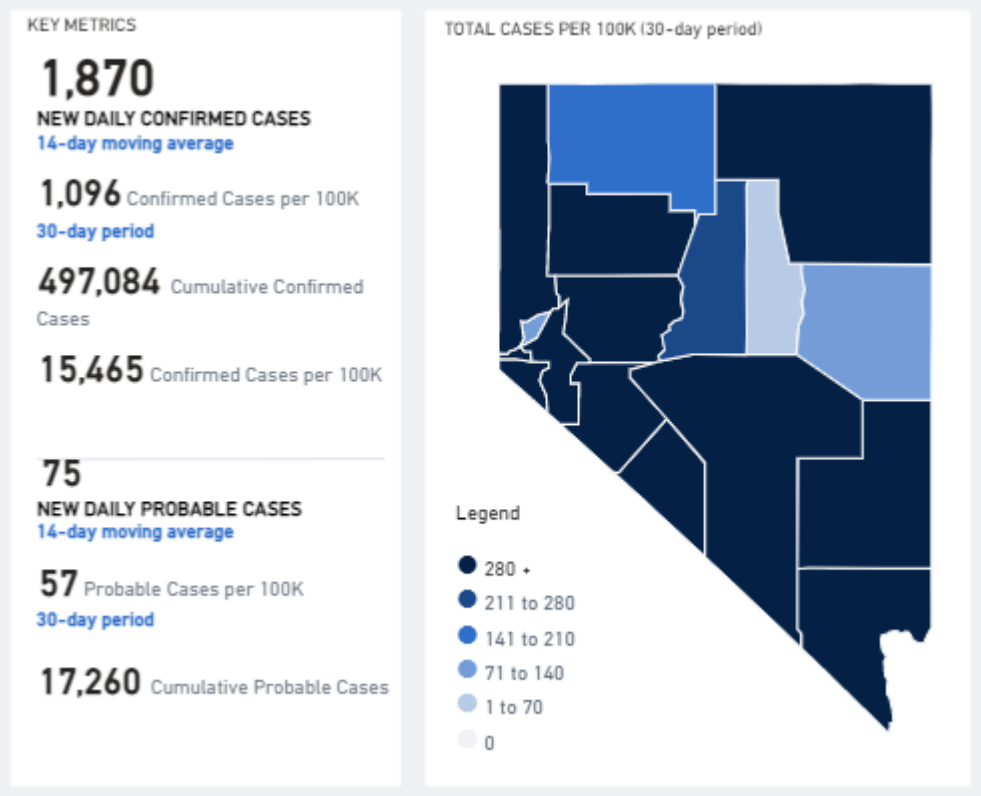
Helping people. It's who we are and what we do.

Technical Notes/Disclaimer

- All data within this presentation are subject to change.
- Small counts have been suppressed.
- Similarly to other states nationally, a significant number of Nevada records are missing demographic information such as, but not limited to Race/Ethnicity, age and gender.

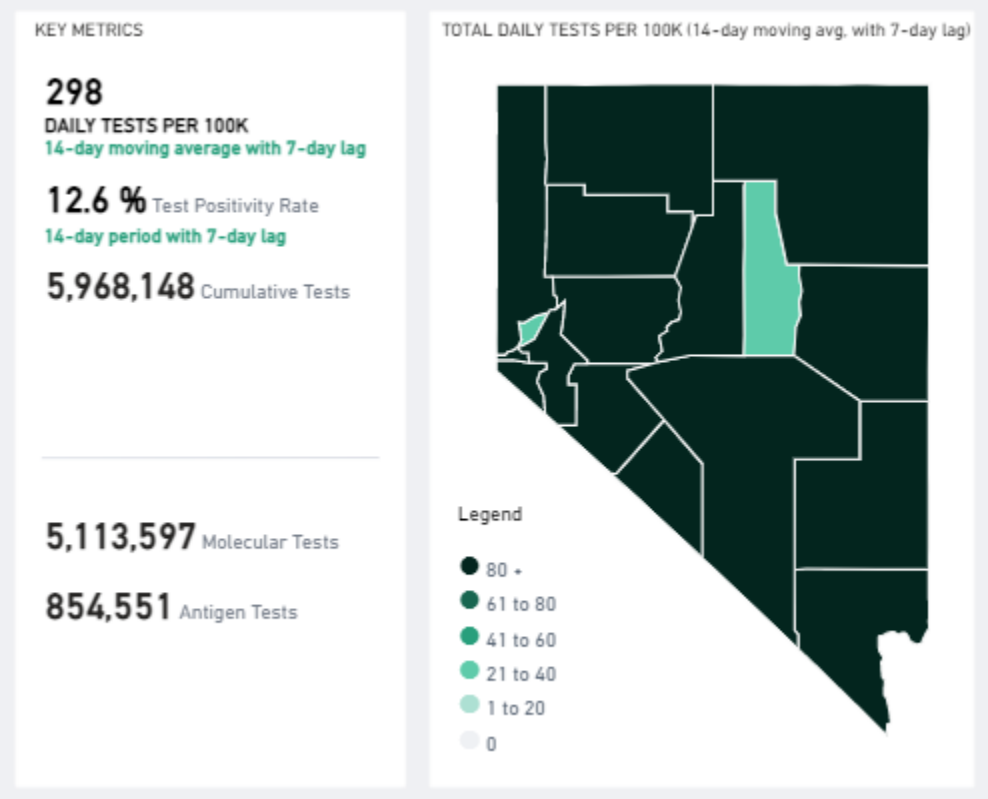
Nevada COVID-19 Data

- Nevada's first COVID-19 case was diagnosed on March 5, 2020
- As of 1/2/22 there were 497,084 confirmed cases of COVID-19 statewide.
- This information is updated daily at https://nvhealthresponse.nv.gov.



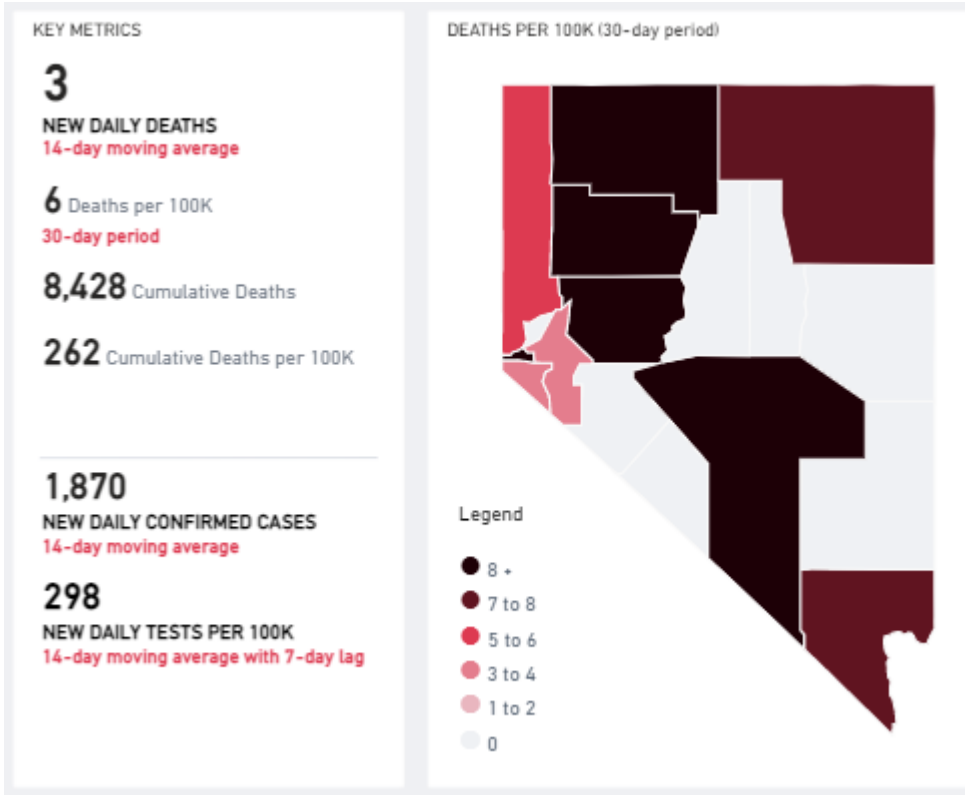
Nevada COVID-19 Data

- As of 1/2/22 there were 5,968,148 COVID-19 tests done statewide.



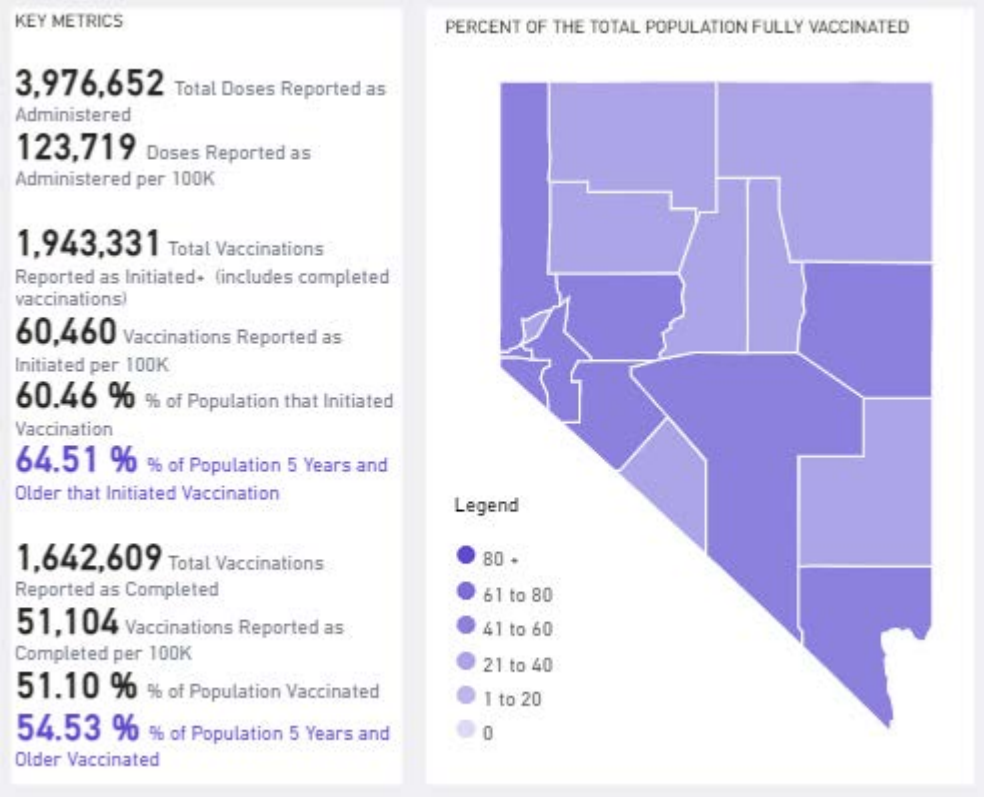
Nevada COVID-19 Data

- As of 1/2/22 there were 8,428 COVID-19 deaths statewide.



Nevada COVID-19 Data

- As of 1/2/22 there were 3,976,652 COVID-19 vaccinations administered statewide.



Demographics for Confirmed Cases

GROUP	CUMULATIVE VACCINES INITIATED	VACCINES INITIATED % (includes completed)
AGE		
<5	0	0.0%
5-11	39,123	2.0%
12-19	181,596	9.3%
20-29	255,895	13.2%
30-39	288,780	14.9%
40-49	290,782	15.0%
50-59	307,603	15.8%
60-69	291,462	15.0%
70+	288,081	14.8%
GENDER		
Female	1,013,822	52.2%
Male	928,301	47.8%
RACE/ETHNICITY		
Hispanic	482,604	26.9%
Non-Hispanic American Indian or Alaska Native	11,018	0.6%
Non-Hispanic Asian/Pacific Islander	165,632	9.2%
Non-Hispanic Black	107,432	6.0%
Non-Hispanic Other Race	368,069	20.5%
Non-Hispanic White	661,910	36.8%

Demographics for Deaths

Group	CUMULATIVE DEATHS	DEATHS %
AGE		
<10	3	0.0%
10-19	9	0.1%
20-29	56	0.7%
30-39	181	2.1%
40-49	511	6.1%
50-59	1,027	12.2%
60-69	1,850	22.0%
70+	4,785	56.8%
GENDER		
Female	3,240	38.5%
Male	5,174	61.5%
RACE/ETHNICITY		
Hispanic	1,694	21.1%
Non-Hispanic American Indian or Alaska Native	75	0.9%
Non-Hispanic Asian/Pacific Islander	870	10.8%
Non-Hispanic Black	826	10.3%
Non-Hispanic Other Race	5	0.1%
Non-Hispanic White	4,551	56.7%

Demographics for Vaccinations

GROUP	CUMULATIVE VACCINES INITIATED	VACCINES INITIATED % (includes completed)
AGE		
<5	0	0.0%
5-11	39,123	2.0%
12-19	181,596	9.3%
20-29	255,895	13.2%
30-39	288,780	14.9%
40-49	290,782	15.0%
50-59	307,603	15.8%
60-69	291,462	15.0%
70+	288,081	14.8%
GENDER		
Female	1,013,822	52.2%
Male	928,301	47.8%
RACE/ETHNICITY		
Hispanic	482,604	26.9%
Non-Hispanic American Indian or Alaska Native	11,018	0.6%
Non-Hispanic Asian/Pacific Islander	165,632	9.2%
Non-Hispanic Black	107,432	6.0%
Non-Hispanic Other Race	368,069	20.5%
Non-Hispanic White	661,910	36.8%

Women of Childbearing Age (15-44)

- As of 1/2/22 there are 132,295 confirmed COVID-19 cases of women within childbearing age.
- Data are from investigations and may be incomplete for many records.

R/E	#	%
AI/AN non-Hispanic	600	0.5%
Asian non-Hispanic	6,241	4.7%
Black non-Hispanic	9,415	7.1%
Hispanic/Latino	42,839	32.4%
NHPI non-Hispanic	1,470	1.1%
Other/Unknown	41,885	31.7%
White non-Hispanic	29,845	22.6%
Total	132,295	100.0%

Age Group	#	%
15-19	16,106	12.2%
20-29	49,254	37.2%
30-39	46,499	35.1%
40-44	20,436	15.4%
Total	132,295	100.0%

Hospitalized	#	%
No	76,668	58.0%
Yes	2,725	2.1%
Unknown	52,902	40.0%
Total	132,295	100.0%

Pregnant Women

- As of 1/02/22 there are 2,794 confirmed cases of pregnant women with COVID-19 in Nevada.
- Data are from investigations and may be incomplete for many records.

R/E	#	%
AI/AN non-Hispanic	14	0.5%
Asian non-Hispanic	152	5.4%
Black non-Hispanic	303	10.8%
Hispanic/Latino	1,140	40.8%
NHPI non-Hispanic	46	1.6%
Other/Unknown	407	14.6%
White non-Hispanic	732	26.2%
Total	2,794	100.0%

Age Group	#	%
<20	113	4.0%
20-29	1,355	48.5%
30-39	1,172	41.9%
40-49	120	4.3%
50-59	17	0.6%
60+	17	0.6%
Total	2,794	100.0%

Hospitalized	#	%
No	2,333	83.5%
Yes	299	10.7%
Unknown	162	5.8%
Total	2,794	100.0%

Children 0-19

- As of 1/02/22 there are 79,914 confirmed cases of COVID-19 in children ages 0-19 in Nevada.
- Data are from investigations and may be incomplete for many records.

R/E	#	%
AI/AN non-Hispanic	448	0.6%
Asian non-Hispanic	3,077	3.9%
Black non-Hispanic	5,598	7.0%
Hispanic/Latino	30,279	37.9%
NHPI non-Hispanic	987	1.2%
Other/Unknown	22,765	28.5%
White non-Hispanic	16,760	21.0%
Total	79,914	100.0%

Age Group	#	%
<1	1,758	2.2%
1-5	11,662	14.6%
6-10	17,362	21.7%
11-15	23,096	28.9%
16-19	26,036	32.6%
Total	79,914	100.0%

Hospitalized	#	%
No	50,888	63.7%
Yes	714	0.9%
Unknown	28,312	35.4%
Total	79,914	100.0%

Gender	#	%
Female	39,713	49.7%
Male	39,691	49.7%
Unknown	510	0.6%
Total	79,914	100.0%

Nevada COVID-19 School Dashboard Data

- This displays the number of COVID-19 cases in Nevada schools (K-12).
- It includes students and staff who were present at their school when they were infectious for COVID-19 (i.e., two days before symptoms presented if symptomatic or two days prior to their specimen that tested positive was collected if asymptomatic).
- This information is updated weekly at [Microsoft Power BI (powerbigov.us)].

County	Student cases	Staff cases	Total cases
Carson City	190	26	216
Churchill	293	18	311
Clark	3,368	535	3,903
Douglas	133	17	150
Elko	757	110	867
Esmeralda	0	0	0
Eureka	33	1	34
Humboldt	275	56	331
Lander	55	3	58
Lincoln	56	17	73
Lyon	243	23	266
Mineral	44	9	53
Nye	311	33	344
Pershing	40	5	45
Storey	10	2	12
Washoe	1,525	303	1,828
White Pine	96	7	103
Total	**7,429**	**1,165**	**8,594**

Total Cases

8,594

Student Cases

7,429

Staff Cases

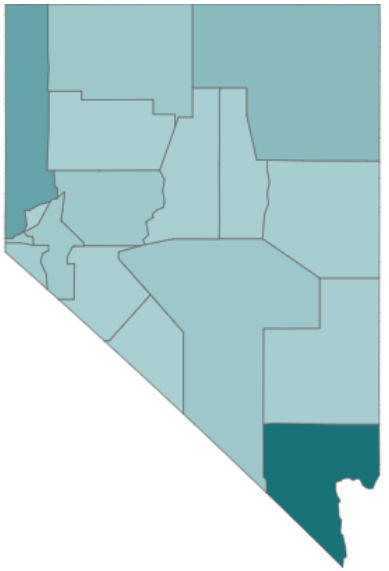
1,165

Current Week

327

Current Month

1,291



Nevada COVID-19 School Dashboard Data

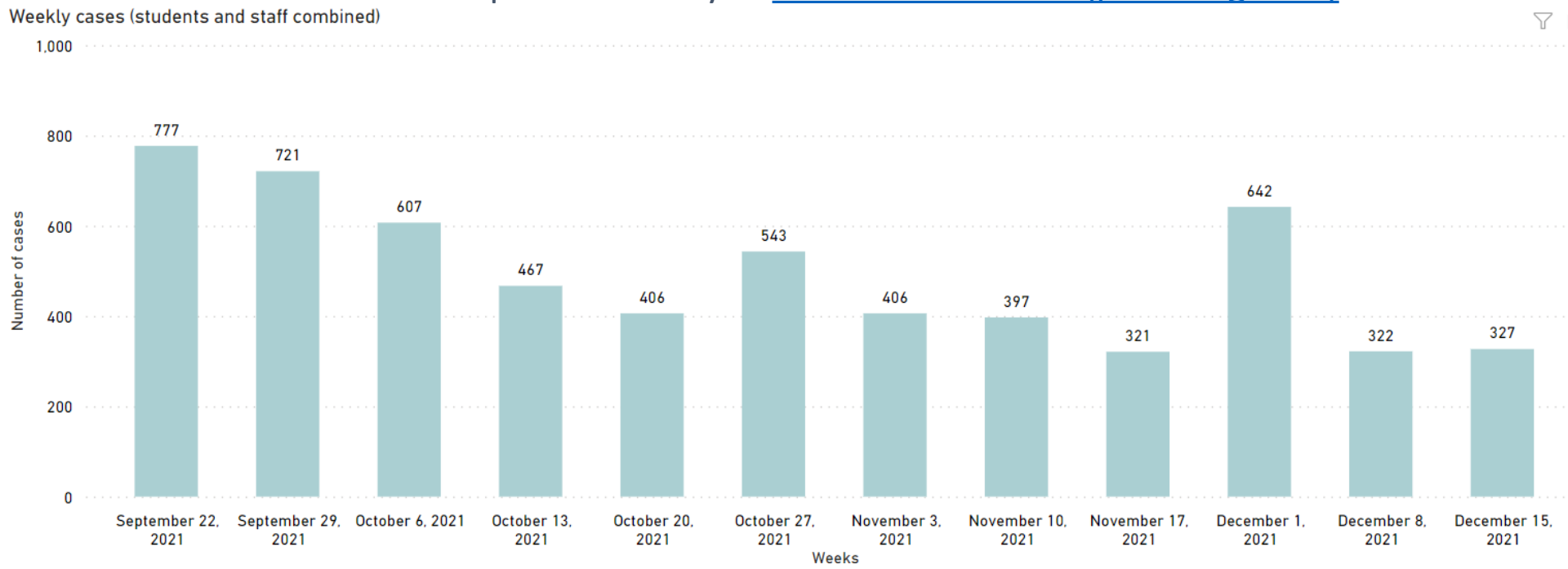
- This displays the school characteristics by name, type, and level.
- This information is updated weekly at Microsoft Power BI (powerbigov.us).

School Type	Number of schools	Student cases	Staff cases	Total cases
Charter	54	815	61	876
District	501	6,337	1,055	7,392
Private	52	276	49	325
Tribal	1	1	0	1
Total	**608**	**7,429**	**1,165**	**8,594**

School Level	Number of schools	Student cases	Staff cases	Total cases
Combined	72	910	91	1,001
Elementary	335	2,563	569	3,132
Elementary-Middle	3	43	7	50
High	87	2,389	255	2,644
Middle	91	1,353	193	1,546
Middle-High	5	106	17	123
Other	12	63	32	95
Rural	3	2	1	3
Total	**608**	**7,429**	**1,165**	**8,594**

Nevada COVID-19 School Dashboard Data

- This displays the COVID-19 case counts (students and staff combined) across schools of Nevada.
- This information is updated weekly at Microsoft Power BI (powerbigov.us).



MIS-C

Multisystem inflammatory syndrome in children (MIS-C)

MIS-C is a serious inflammatory syndrome in children, including some teenagers. This syndrome is rare, but there appears to be an emerging link between children, MIS-C and COVID-19. This link is being researched nationally and there remains a lot to be learned about the connection.

- Prior to the COVID-19 global pandemic, MIS-C symptoms have been monitored via syndromic surveillance within Nevada hospitals, and an MIS-C diagnosis must be reported to the State.

- Between January 1 and December 31, 2021, there were 34 diagnosed MIS-C cases in Nevada. 22 of the diagnosed MIS-C cases also tested positive for COVID-19.

- There were 32 diagnosed cases of MIS-C in 2020.

Comorbidities/Disabilities

- Many states, including Nevada, are struggling to better identify people with disabilities and pre-existing medical conditions within confirmed cases of COVID-19.
- Below is information a disease investigator may ask around pre-existing conditions during the investigation process.
- To date, pregnancy is the most utilized field.

Pre-existing medical conditions?				☐ Yes ■ No ☐ Unknown
Chronic Lung Disease (asthma/emphysema/COPD)	☐ Yes	■ No	☐ Unknown	
Diabetes Mellitus	☐ Yes	■ No	☐ Unknown	
Cardiovascular disease	☐ Yes	■ No	☐ Unknown	
Chronic Renal disease	☐ Yes	■ No	☐ Unknown	
Chronic Liver disease	☐ Yes	■ No	☐ Unknown	
Immunocompromised Condition	☐ Yes	■ No	☐ Unknown	
Neurologic/neurodevelopmental/intellectual disability	☐ Yes	■ No	☐ Unknown	(If YES, specify)
Other chronic diseases	☐ Yes	■ No	☐ Unknown	(If YES, specify)
If female, currently pregnant	☐ Yes	■ No	☐ Unknown	
Current smoker	☐ Yes	■ No	☐ Unknown	
Former smoker	☐ Yes	■ No	☐ Unknown	

Next Steps in Data Collection

- Improved data completeness.
- Better identification of comorbidities through the disease investigation process of confirmed COVID-19 cases.
- Identification on the best way to continually monitor and display comorbidity information within confirmed COVID-19 cases.
    - This may include incorporating comorbidities in existing dashboards as other states have.
        - Georgia: https://dph.georgia.gov/covid-19-daily-status-report
    - Creation of separate and specific dashboards.

Current Data Resources

- Nevada Health Response: https://nvhealthresponse.nv.gov/
- Nevada COVID-19 Facilities Dashboard
- Microsoft Power BI (powerbigov.us)
- CDC COVID-19 Data Tracker
- HRSA COVID-19 Information
- John Hopkins Coronavirus Resource Center

Questions?

Contact Information

Jen Thompson

Health Program Manager

jlthompson@health.nv.gov

For data requests please email us directly at data@dhhs.nv.gov or visit our website at http://dhhs.nv.gov/Office_of_Analytics.

Thank you!

Attachment for Agenda Item #6

Home Page | Part 1: Screening, Diagnostic, and Intervention Data | Part 2: Type and Severity of Hearing Losses | Part 3: Demographics | Final

Part 1: Screening, Diagnostic, and Intervention Data

Screening Data | Diagnostic Data | Intervention Data | Additional Cases Not Reported

Note: Please see the Home Page Tab for additional instructions on completing this tab.

2019 Hearing Screening Data	
Total Occurrent Births* **	34,735
Total Occurrent Births According to Vital Records	34,735
Optional: Total Occurrent Births at Military Facilities According to Vital Records	509
Optional: Total Occurrent Homebirths	574
Overall Documented Screening Results (Most Recent/Final Screen)	
Total Documented as Screened	33,770
Passed (most recent/final screen)	
Total Passed (most recent / final screen)*	33,240
Passed: Before 1 Month of Age	32,610
Passed: After 1 Month of Age	630
Passed: Age Unknown	0
Not Passed (most recent/final screen)	
Total Not Passed (most recent / final screen)**	530
Not Passed: Before 1 Month of Age	481
Not Passed: After 1 Month of Age	44
Not Passed: Age Unknown	5
Detailed Screening Results (if applicable)	
Passed (most recent/final screen)	
Passed initial / No outpatient ‡	*31,951*
No initial ‡ / Passed outpatient	*1*
Passed initial / Passed outpatient	*204*
Referred initial / Passed outpatient	*1,084*
Total Passed (most recent/final screen)*	*33,240*
Not Passed (most recent/final screen)	
Referred initial / No outpatient ‡	*228*
No initial ‡ / Referred outpatient	*0*
Passed initial / Referred outpatient	*3*
Referred initial / Referred outpatient	*202*
Referred initial / straight to diagnostic evaluation	*97*
Total Not Passed (most recent/final screen)*	*530*
No Documented Screening / Undetermined (Most Recent/Final Screen)	
Total Documented as Not Screened	965
Infant Died	70
Non-resident/Moved Out of Jurisdiction	0
Unable to be Screened due to Medical Reasons	56
Parents / Family Declined Services	112
Infant Transferred and No Documentation of Screening	35
Infant Adopted	0
Homebirth	346
Parents / Family Contacted but Unresponsive	3
Please use this dropdown box to indicate the Unresponsive Definition Used †	Old Unresponsive Definition
Unable to Contact	0
Unknown	334
Other	9
Total Occurrent Births* **	34,735

Notes:

† See the HSFS Explanations document for the definitions.

‡ "No initial" includes infants who did not received an initial screening, missed an initial screening or refused an initial screening. "No outpatient" includes infants who did not received an outpatient screening, missed an outpatient screening or refused an outpatient screening.

* The value for the "Total Passed (most recent/final screen)" field in the Overall Documented Screening Results section must match the value for the "Total Passed (most recent/final screen)" field in the Detailed Screening Results section. If there is any difference you will receive a caution message.

** The value for the "Total Not Passed (most recent/final screen)" field in the Overall Documented Screening Results section must match the value for the "Total Not Passed (most recent/final screen)" field in the Detailed Screening Results section. If there is any difference you will receive a caution message.

*** The value for the "Total Occurrent Births" field at the bottom of this table must match the value reported for the "Total Occurrent Births" field at the top of this table. If there is any difference you will receive an error message. If received, please make sure to correct this error before continuing to the next section.

Part 1: Screening, Diagnostic, and Intervention Data

Screening Data | Diagnostic Data | Intervention Data | Additional Cases Not Reported

Note: Please see the Home Page Tab for additional instructions on completing this tab.

2019 Diagnostic Data	
Total Not Passed (most recent/final screen)	530
Documented Diagnostics	
Total with Documented Diagnosis	239
Diagnosed with No Hearing Loss	
Total with No Hearing Loss	185
No Hearing Loss: Before 3 Months of Age	*164*
No Hearing Loss: After 3 Months of Age	*21*
No Hearing Loss: Age Unknown	*0*
Diagnosed with Permanent Hearing Loss	
Total with Permanent Hearing Loss	54
Permanent Hearing Loss: Before 3 Months of Age	*40*
Permanent Hearing Loss: After 3 Months but Before 6 Months of Age	*10*
Permanent Hearing Loss: After 6 Months of Age	*4*
Permanent Hearing Loss: Age Unknown	*0*
No Documented Diagnostics / Undetermined	
Total with No Documented Diagnosis	291
Audiological Diagnosis in Process (Awaiting Diagnosis) *Only applies to infants seen at least one time and have a follow-up appointment scheduled.*	19
PCP/ENT did not Refer Infant for Diagnostic Testing	0
Infant Died	1
Non-resident / Moved Out of Jurisdiction	1
Unable to Receive Diagnostic Testing due to Medical Reasons	0
Parents / Family Declined Services	8
Infant Adopted	0
Parent / Family Contacted but Unresponsive	32
Please use this dropdown box to indicate the Unresponsive Definition Used †	Revised Unresponsive Definition
Unable to Contact	140
Unknown	90
Other	0
Total Diagnosed and Not Diagnosed*	530

Notes:

† See the HSFS Explanations document for the definitions.

* The value for the "Total Diagnosed and Not Diagnosed" field at the bottom of this table must match the value for the "Total Not Passed (most recent/final : at the top of this table. If there is any difference you will receive an error message. If received, please make sure to correct this error before continuing to t section.

Part 1: Screening, Diagnostic, and Intervention Data

Screening Data | Diagnostic Data | Intervention Data | Additional Cases Not Reported

Note: Please see the Home Page Tab for additional instructions on completing this tab.

2019 Early Intervention (EI) Data	
Total with Permanent Hearing Loss*	54
Total with Referral Status	54
Referred to Part C EI	52
Referred to Part C EI: Before 6 Months of Age	50
Referred to Part C EI: After 6 Months of Age	2
Referred to Part C EI: Age Unknown	0
Not Referred to Part C EI	2
Unknown Referral Status	0
Documented EI Services	
Total Enrolled in Part C EI Services	36
Signed IFSP: Before 6 Months of Age	32
Signed IFSP: After 6 Months of Age	4
Signed IFSP: Age Unknown	0
Total Received Part C EI Services	36
Received Part C EI Services: Before 6 Months of Age	27
Received Part C EI Services: After 6 Months of Age	5
Received Part C EI Services: After 6 Months of Age, Due to Family Initially Declining Services	0
Received Part C EI Services: Age Unknown	4
Total from Non-Part C EI Services Only	0
Received Non-Part C EI Services: Before 6 Months of Age	0
Received Non-Part C EI Services: After 6 Months of Age	0
Received Non-Part C EI Services: Age Unknown	0
Monitoring Services Only	
Received Only Monitoring Services	0
No Documented EI Services/ Undetermined	
Total with No Documented EI Services	18
Not Eligible for Part C Services	0
Infant Died	1
Non-resident / Moved Out of Jurisdiction	0
Unable to Receive EI due to Medical Reasons	0
Parents / Family Declined Services	8
Infant Adopted	0
Parent / Family Contacted but Unresponsive	5
Please use this dropdown box to indicate the Unresponsive Definition Used†	Old Unresponsive Definition
Unable to Contact	2
Unknown	2
Other	0
Total with EI Services & No EI Services*	54

Notes:

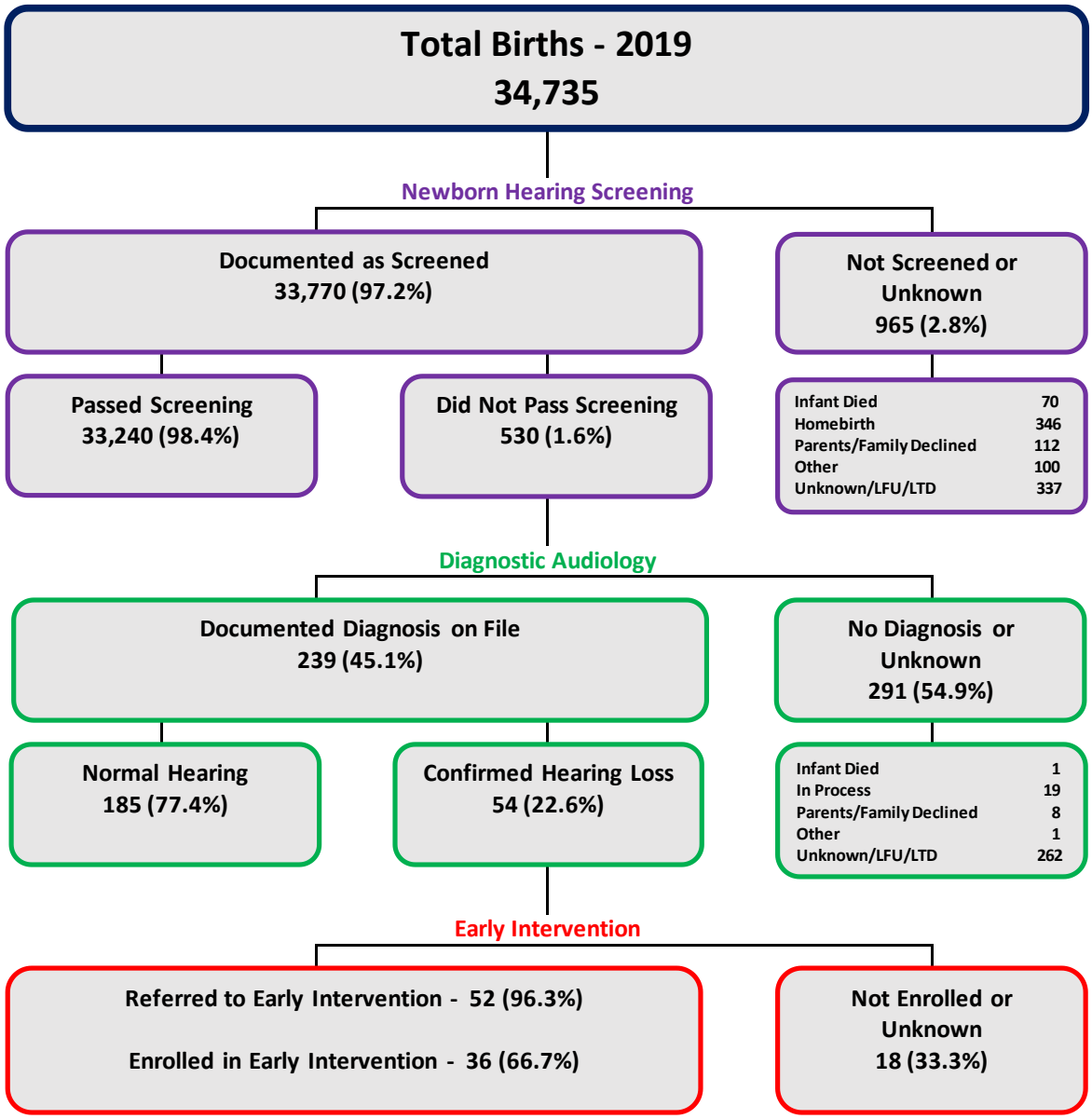
Nevada Early Hearing Detection and Intervention

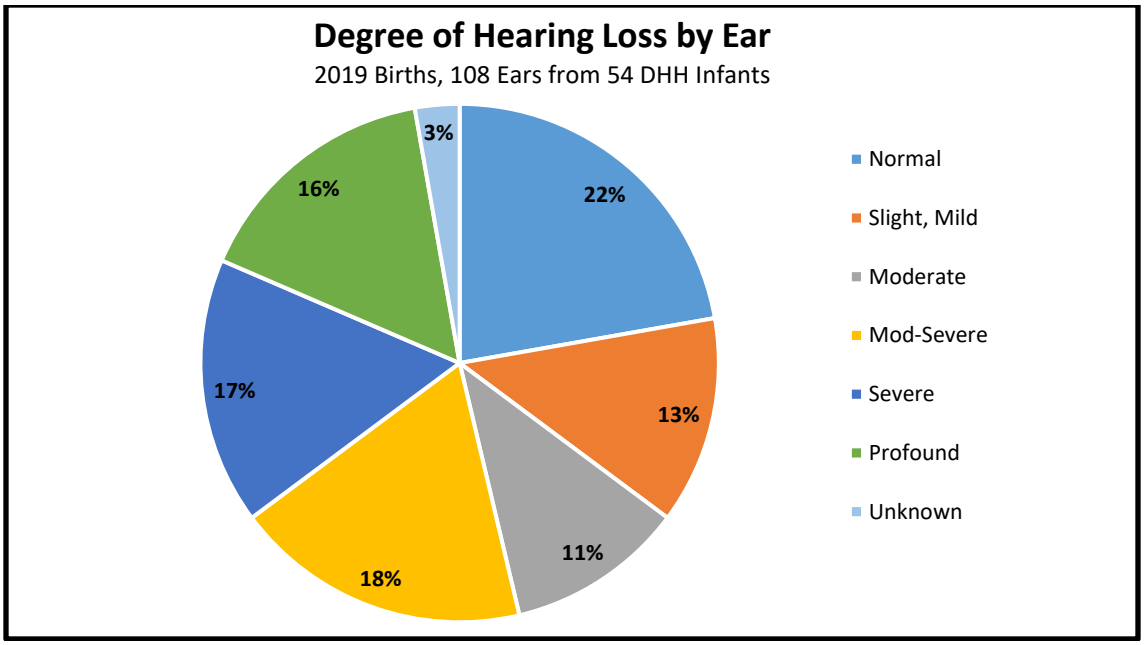
The purpose of the Nevada Early Hearing Detection and Intervention (EHDI) Program is to ensure all children in Nevada are screened for hearing loss at birth and those identified with hearing loss receive timely and appropriate audiological, educational and medical intervention. Nevada EHDI promotes the national EHDI goals and timelines developed by the Joint Committee on Infant Hearing (JCIH) and the Centers for Disease Control and Prevention (CDC).

1 - Before ONE month of Age: Hearing Screening for all babies

3 - Before THREE months of Age: Diagnostic Audiology by an audiologist if baby did not pass hearing screening

6 - Before SIX months of Age: Early Intervention if baby is diagnosed with hearing loss





Resources for More Information about EHDI and EHDI Related Goals:

Nevada Early Hearing Detection and Intervention (EHDI):
http://dpbh.nv.gov/Programs/EHDI/EHDI-Home/

Centers for Disease Control and Prevention (CDC) – Hearing Loss
https://www.cdc.gov/ncbddd/hearingloss/

Health Resources and Services Administration (HRSA) – EHDI:
https://mchb.hrsa.gov/maternal-child-health-initiatives/early-hearing-detection-and-intervention.html

American Academy of Pediatrics (AAP) – EHDI:
https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/Early-Hearing-Detection-and-Intervention.aspx

Joint Committee on Infant Hearing (JCIH):
http://www.jcih.org/

National Center for Hearing Assessment and Management (NCHAM):
http://www.infanthearing.org/

EHDI E-Book
A Resource Guide for Early Hearing Detection and Intervention
http://www.infanthearing.org/ehdi-ebook/index.html

Program Coordinator	Audiology Consultants	Data & Evaluation Coord.	Administrative Assistant
Perry Smith	Diane Miller, Au.D.	Marjorie Singh	Rhonda Buckley
pgsmith@health.nv.gov	dcmiller@health.nv.gov	msingh@health.nv.gov	r.buckley@health.nv.gov

Nevada
Early Hearing Detection and Intervention
2020 Annual Report
Of 2019 data

BUREAU OF CHILD, FAMILY AND COMMUNITY WELLNESS
NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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of families who were contacted but were unresponsive and those whose contact information was inaccurate, disconnected or missing.

Of all infants screened, 530 (1.6%) did not pass the screening. Further audiologic testing identified 185 of the 530 as typical hearing, 54 as deaf and hard of hearing, and the remainder do not have documentation of audiologic testing. Of those with no documented diagnosis, 1 of the infants died; parents or family member declined services for 8 infants; 19 infants were in the process of receiving diagnostic testing, but it had not been completed. The Unknown/Loss to follow-up/Loss to Documentation category is composed of families who were contacted but were unresponsive and those whose contact information was inaccurate, disconnected or missing.

Of the 54 infants with confirmed hearing loss, 52 (96.3%) were referred to Early Intervention Services and 36 (66.7%) are documented as being enrolled in Early Intervention (EI). In Nevada, a diagnosis of any degree of hearing loss is a qualifying diagnosis for EI. Parents may decline enrollment due to the hearing loss being mild, loss is in only in one ear, or travel time commitments to attend EI sessions. Additionally, parent decline through being unresponsive to follow-up from EI services.

Challenges

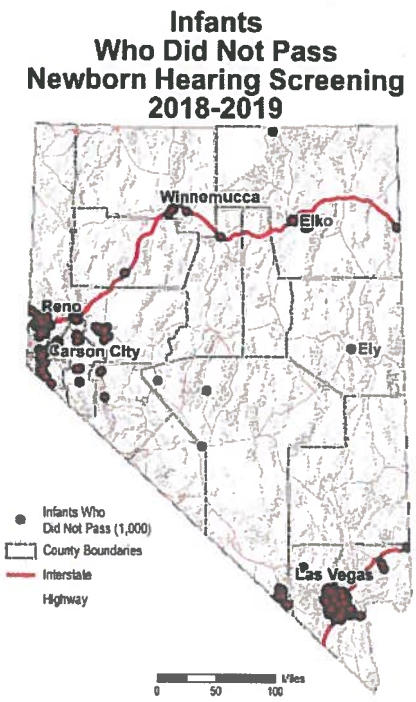
Hearing loss is one of the most common congenital birth defects; if left undetected, hearing impairment in infants can negatively impact speech and language acquisition, academic achievement, and social and emotional development. When diagnosed early however, these negative impacts can be diminished or even eliminated through early intervention.

Ensuring provision of health care services to those affected with hearing loss is challenging due to unique Nevada characteristics such as geography, the distribution of population and infrastructure, and the distribution of medical and support services. The following maps illustrate some of the challenges faced by parents, physicians, hospitals, audiologists, and early intervention staff.

Map 1 – Birthing Facilities

Nevada Birthing Facilities:

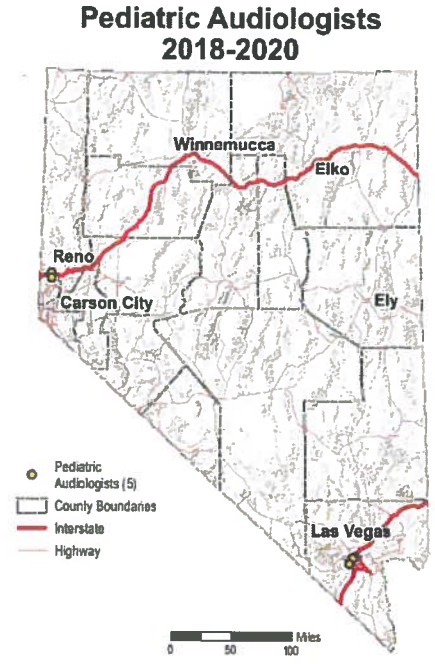
- Banner Churchill Community Hospital
- Carson Tahoe Regional Medical Center
- Centennial Hills Hospital
- Henderson Hospital
- Humboldt General Hospital
- Mike O'Callaghan Federal Hospital
- Mountain View Hospital
- Northeastern Nevada Regional Hospital
- Renown Health
- Saint Mary's Regional Medical Center
- St. Rose Dominican Hospital - San Martin
- St. Rose Dominican Hospital - Siena
- Southern Hills Hospital and Medical Center
- Spring Valley Hospital
- Summerlin Hospital
- Sunrise Hospital & Medical Center
- University Medical Center
- William Bee Ririe Hospital



Map 2 – Failed Newborn Hearing Screens

When birthing facility locations (*Map 1*) and location of failed newborn hearing screens (*Map 2*) are compared, it becomes clear many parents are required to travel many hours back to the hospital if their infant requires a follow-up hearing screen.

The parental travel distance and time burden is accentuated further when observing the location of audiologists (*Map 3*) in relation to the distribution of failed newborn hearing screens (*Map 2*).



Map 3 – Pediatric Audiologists in Nevada

Nevada currently has five pediatric audiology facilities which have both a trained audiologist and the appropriate pediatric equipment to provide service to infants. With so few resources, comes limited capacity and long wait times for time-sensitive diagnostic appointments.

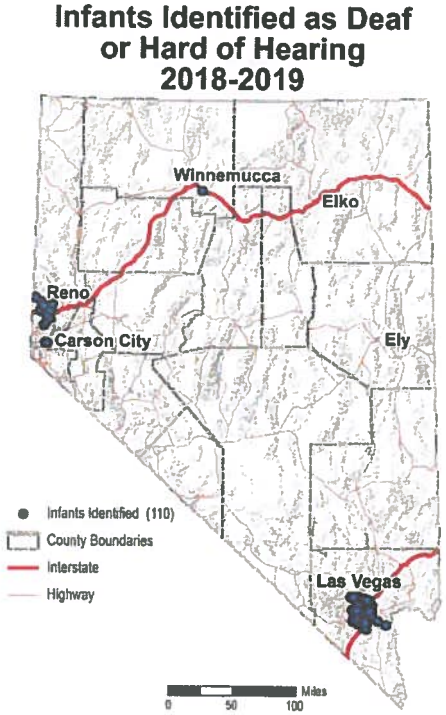
Communities with Pediatric Audiology Facilities:

- Las Vegas
- Reno

It is not uncommon for infant to need more than one diagnostic visit to a pediatric audiologist to complete all diagnostic exams.

Map 4 – Early Intervention Facilities

Early Intervention (EI) Services are also limited with only three communities having trained staff to work with clients who are deaf and hard of hearing. EI services often entail multiple visits per week for infants ages 1-2 months through 3 years of age, and in the years 2018 and 2019 combined, 111 infants were diagnosed as deaf or hard of hearing (*Map 5*).



Map 5 – Infants Identified as Deaf or Hard of Hearing

The cost to travel long distances, multiple times, can be a significant impediment to receiving needed and timely medical or developmental support services not provided locally. The lack of readily accessible services has caused families to move from their homes in rural and frontier locations to in-state metropolitan areas or other states. These unique barriers pose a challenge to parents, physicians, audiologists, early intervention staff, and the NV EHDI program to ensure all infants are screened, receive timely diagnostic audiology services, and are enrolled in early intervention before six months of age.

2019 Statistics

Data presented in this annual report are for the years 2014 through 2019, unless otherwise specified. Each year's EHDI data is considered preliminary until it is reported to the CDC in the annual EHDI Hearing Screening and Follow-up Survey. In 2020, the CDC requested 2018 data. This delay in reporting allows sufficient time for infants to move through the EHDI continuum (screening, diagnosis, and intervention) prior to data being submitted and released to the public.

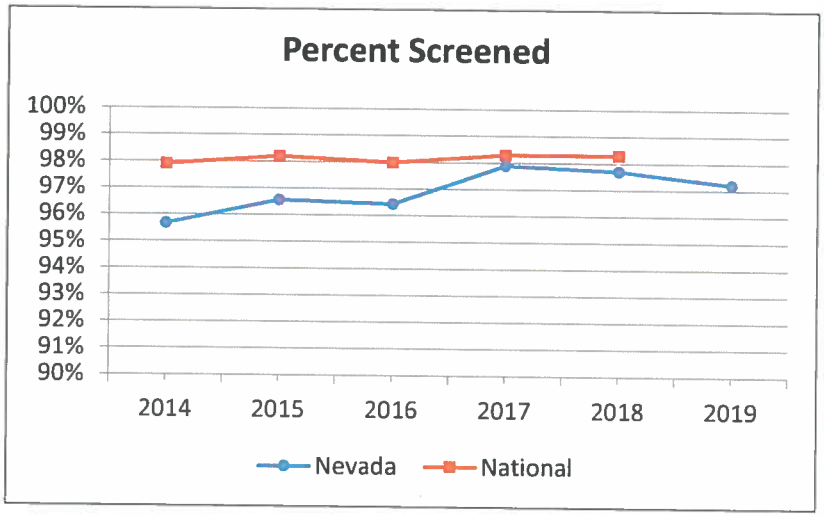


Figure 1 - Total Hearing Screens

Figure 1 – Total Hearing Screens

Nevada's percent screened is slightly below the national average. Chart 1 (page 5) categorizes results and describes reasons for the lack of screen documentation for some infants.

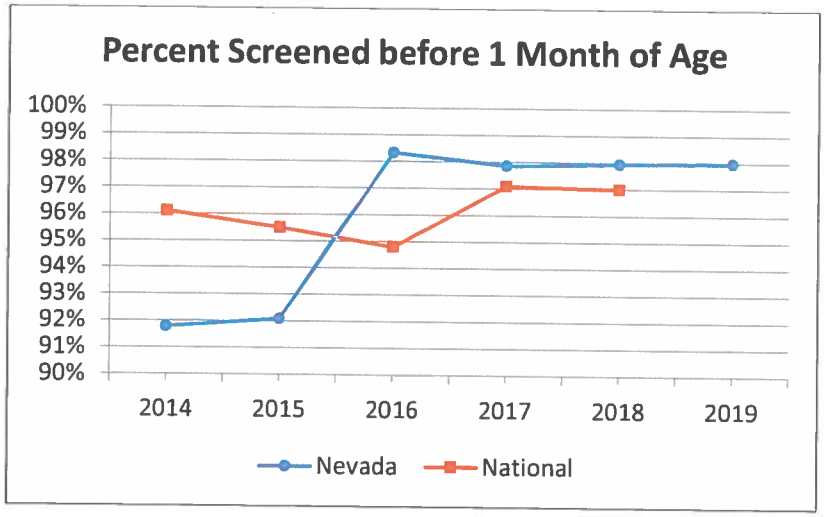


Figure 2 – Percent Screened Before One Month of Age

Figure 2 – Percent Infants Screened Before One Month of Age

The national goal is to screen infants prior to one month of age and refer for audiologic testing those who do not pass the screen. These percentages reflect how well Nevada screens and refers within the one-month benchmark.

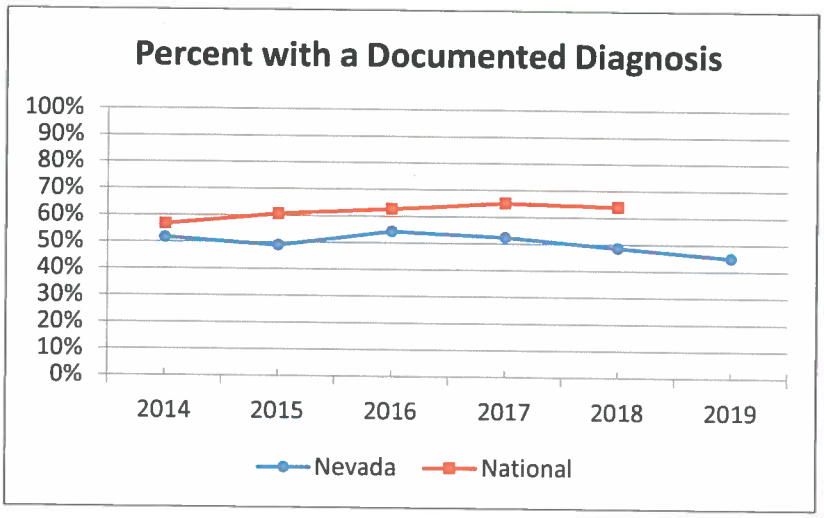


Figure 3 – Percent Infants with an Audiologist's Confirmed Diagnosis

Figure 3 – Percent Infants with an Audiologist's Confirmed Diagnosis

This figure represents those infants who did not pass the hearing screen and whose audiological diagnosis has been reported to Nevada EHDI. These diagnoses include those who are hearing and deaf and hard of hearing. Infants whose diagnostic results have not been reported are included in Figure 5 (page 12)- Lost to Follow-up/Lost to Documentation (LFU/LTD).

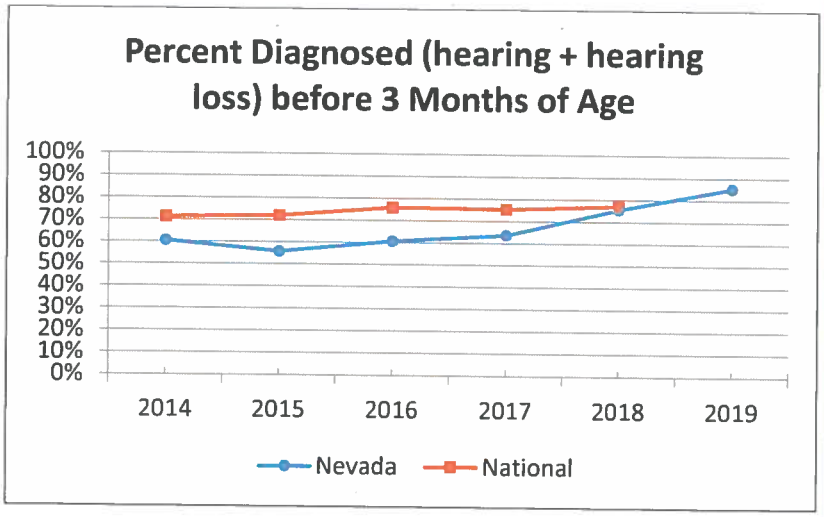


Figure 4 - Infants with a Diagnosis Before Three Months of Age

Figure 4 – Infants with a Diagnosis before Three Months of Age

The JCIH benchmark for infants to receive an audiologic diagnosis is before three months of age. From 2017 to 2019, Nevada has greatly increased the percentage of infants with a diagnoses before three months of age from 63.7% to 85.4%.

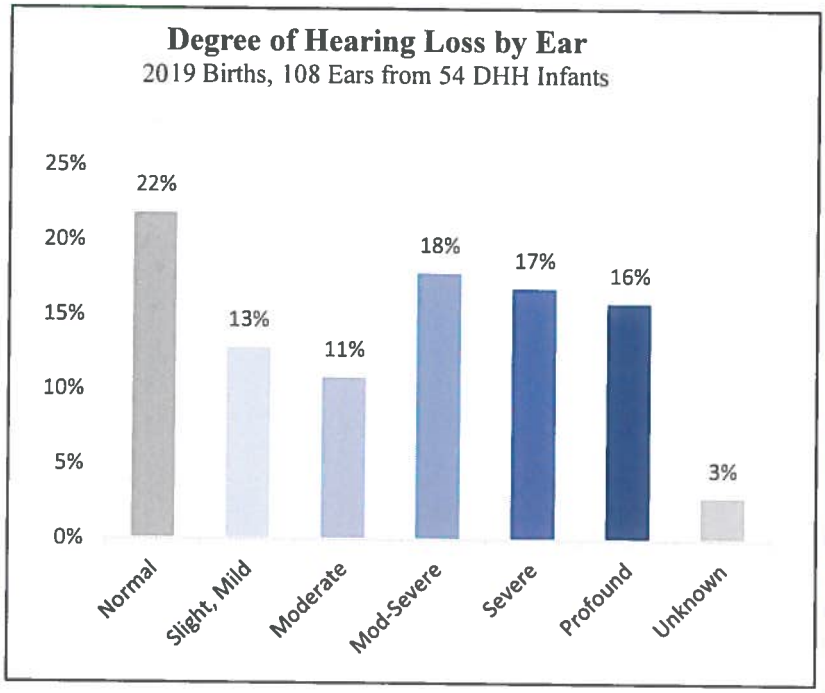


Figure 9 – Degree of Hearing Loss by Ear

Figure 9 – Degree of Hearing Loss by Ear

This figure breaks down the degree of hearing loss for each of the 108 ears tested.
It must be noted these children often have a different degree of hearing loss for each ear.
(54 infants who are D/HH * 2 ears = 108 ears)

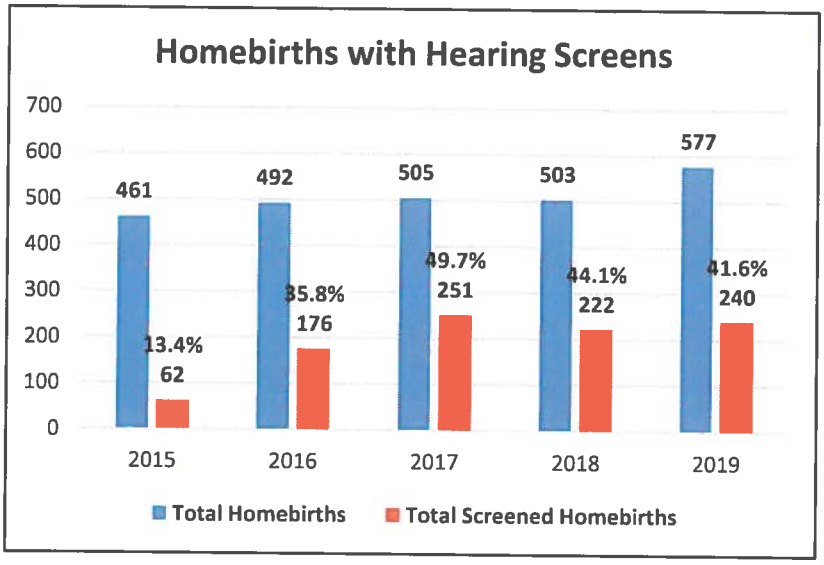


Figure 10 – Homebirths with a Documented Hearing Screen

Figure 10 – Homebirth Infants with a Documented Hearing Screen

Nevada EHDI began a midwife pilot project during 2015 of placing hearing screening equipment in a small number of midwife practices. The project has been a great success and is in the process of expanding.

Attachment for Agenda Item #7

Maternal and Child Health Advisory Board (MCHAB)
November 5, 2021 Update

Domain: Women/Maternal Health

- Increase the percent of women ages 15-44 receiving routine check-ups in the previous year
- Increase the percent of women receiving prenatal care in first trimester

Title V/MCH Program and Partners –

- Community Health Services (CHS) provided preventive education services with a focus on well-care screenings, contraceptives, Sexually Transmitted Infection (STI) screens, immunizations, as well as nutrition, weight, and exercise information. All women presenting for reproductive health visits were screened for domestic violence and behavioral health, as well as depression. Affected women were referred to appropriate providers.
- Carson City Health and Human Services (CCHHS) conducted well visits for 579 women. Referrals were made for 15 women afflicted by domestic violence, 168 with mood disorders, 421 with substance use, and 504 reporting alcohol use were educated about risks of alcohol use with pregnancy. The website https://sobermomshealthybabies.org/ was promoted during clinic visits, especially to pregnant persons living with substance use disorders. CCHHS promoted the website on the clinic digital signage and posted two month-long campaigns on Facebook and reached 3,881 individuals. Staff conducted outreach to 25 local agencies sharing the value of well-visits and information about health care transition. Additionally, both topics were promoted on the clinic digital signage and through social media. Three Facebook posts promoting well visits reached 7,926 individuals and the health care transition messages were viewed by 1,835 parents/caregivers.

Rape Prevention and Education (RPE) Program –

- The Nevada Rape Prevention and Education (RPE) Program is part of a national effort launched by the Centers for Disease Control and Prevention (CDC) in response to the Violence Against Women Act of 1994. It continues through reauthorization and expansion of the original legislation. The RPE Program focuses on preventing first-time perpetration and victimization by reducing modifiable risk factors while increasing protective health and environmental factors to prevent sexual violence. CDC funds the RPE Program, along with sexual violence funds set-aside through Preventive Health the Health Services (PHHS), and the Title V Maternal and Child Health (MCH) Program Block Grant.
- UNLV continued the CARE Peer Program (CPP), an individual/relationship level strategy, and the CARE Campus initiative, a strategy focused on the community level. CPP is an empowerment-based 45-hour training curriculum with interactive modules focused on promoting social norms that protect against violence, such as bystander approaches and healthy relationship/communication components. It is offered to all UNLV students with an outreach emphasis on priority populations of women, female-identified, and LGBTQI students. Graduates of the CPP can become CPP Leaders and are eligible for scholarships, thereby improving both leadership skills and economic stability as they are supported in completing their education.
- CARE Campus continues to focus on revising existing protocols and procedures to identify and respond to intimate partner violence (IPV) for students, faculty, and staff. This work has resulted in tools for tracking and monitoring policy findings over time. Due to the prolonged effects of COVID-19, UNLV has continued with virtual education, outreach, and training.
- Nevada Coalition to End Domestic and Sexual Violence (NCEDSV) has continued working to identify policies and legislative recommendations for increasing gender equity in Nevada to empower and support women and girls. They have connected with various organizations in Nevada working on economic justice issues. NCEDSV held their first Economic Justice

Consortium meeting in August 2021. Some participants of the meeting include Opportunity Alliance, Progressive Leadership Alliance of Nevada (PLAN), Nevada Women's Lobby, Nevada Women's Equity Coalition, Nevadans for the Common Good, Nevada Minority Health and Equity Coalition, Make it Work Nevada, and Make the Road Nevada.

- NCEDSV continues to research statewide economic policies impacting women and girls, such as pay equity, childcare, education, and housing. Also, NCEDSV continues to explore policy initiatives to help identify strategies to operationalize initiatives through changes to existing regulations, codes, and legislation. NCEDSV continues to identify given issues to focus on going forward and has held virtual meetings with key players and interested parties.
- Safe Embrace continues working to assist entertainment and hospitality organizations in northern Nevada to establish and strengthen zero tolerance and sexual harassment policies in the workplace.
- In their work to create protective environments, Safe Embrace has conducted outreach to new partners in the business community, highlighting how they could increase safety for staff and patrons. Since the program's start in late 2019, 23 establishments have MOUs in place and receive information, training, and policy guidance.
- The Rape Crisis Center of Las Vegas (RCCLV) continues to implement the Stay Safe / SAINT program, which is targeted to the hospitality industry. SAINT is a condensed and specific version of Stay SAFE delivered to housekeeping, front desk, and other hospitality staff other than security and food and beverage. While the program was initially put on hold in March due to Nevada's shelter in place order, as businesses reopened, RCCLV held socially distanced and masked trainings promoting safety and security. Through the Stay Safe / SAINT program, RCCLV has worked to institutionalize relationships with MGM Resorts International and Wynn Resorts and seek new partnerships to expand safety practices. In the last year, 30 presentations were given at 7 different properties.
- Additionally, RCCLV continues enhancing prevention efforts concerning Sexual Violence and Intimate Partner Violence during COVID-19 by increasing protective factors. This includes supporting 24-hour crisis response hotlines and improving public health emergency preparedness (PHEP) capabilities through community preparedness and information sharing. Sexual Violence and Intimate Partner Violence Prevention efforts are statewide with a particular focus on rural and frontier counties. COVID-19 funding has been used to specifically benefit populations with disparate burdens of experiencing sexual abuse and intimate partner violence. Due to Nevada's unique geographic distribution of population, 90% of the state's population resides in urban counties. The majority (73%) of the state's population lives in Clark County, 16% in Washoe County, and the remaining 11% in rural and frontier counties. Additionally, a third of Nevadans (33.7%) live in a health professional shortage area (HPSA). This percent is intensified among rural and frontier counties, with 50.6% of rural Nevadans living in an HPSA. The great differences between urban and rural contexts in Nevada highlight unique needs related to HPSAs across the state and the different obstacles many counties face. Nevada's unique geographical landscape, with rural and frontier counties making up most of Nevada's geographical areas, increases the risk of Nevadans experiencing sexual violence and intimate partner violence. Access to health, prevention, and protection services in the U.S. is disparate based on population density: rural areas have less access than urban to domestic violence shelters, physical and mental health professionals, law enforcement, and judicial personnel. Women in rural areas are also nearly twice as likely to be turned away from services because of the insufficient number of community-based health programs and inadequate staffing.
- Additionally, Nevada RPE was awarded CDC COVID-19 Supplemental funding as Nevada's current shelter-in-place restrictions from the COVID-19 pandemic continue and reports of violence

in the home increase in some areas. The Domestic Violence Resource Center in Washoe County, Nevada, has observed a 64% increase in calls to its 24-hour hotline over the past months, a trend consistent with national spikes in domestic violence during COVID-19. Contributing factors for this increase include, but are not limited to, job loss, financial instability, being restricted to home environments, and close proximity to partners and children, which may amplify not only family violence but also diminish the family's ability to engage in constructive communication or coping strategies. The supplemental COVID-19 funding has been used to support crisis response via 24-hour hotlines to increase protective factors during the COVID-19 pandemic and increase protective factors during future state-wide disasters and emergencies by improving public health emergency preparedness (PHEP) capabilities through community preparedness and information sharing.

MCH Coalition (north, south and statewide) –

- The NV Statewide MCH Coalition continues to distribute materials promoting the Go Before You Show campaign, the Nevada Children's Medical Home Portal, Perinatal Mood and Anxiety Disorders (PMAD), Nevada 211, SoberMomsHealthyBabies.org, NevadaBreastfeeds.org and the Nevada Tobacco Quitline. In addition, monthly e-newsletters, educational opportunities, and program updates are provided to coalition members. Social media campaigns promoting maternal, child, and adolescent health continue on Facebook, and Instagram.
- MCH Coalition meetings dates (north, south, and steering committee).
    - North MCH Coalition meetings:
        - April 8, 2021
        - May 13, 2021
        - June 10, 2021
        - August 12, 2021
    - South MCH Coalition meetings:
        - April 13, 2021
        - May 11, 2021
        - June 8, 2021
        - September 14, 2021
    - Steering Committee meetings
        - June 17, 2021
        - August 19, 2021
- From April 2021 to September 2021 both Facebook and Instagram followings have increased.
    - Facebook likes increased from 443 to 480 likes, an increase of 37 likes over six months.
    - Instagram followings increased from 405 to 485 followings, an increase of 80 followings over six months.
    - Instagram posts increased from 273 to 298 posts, an increase of 25 posts over six months.
- The annual MCH Symposium took place virtually on September 10, 2021, due to the COVID-19 pandemic.
    - This year's MCH Symposium "The Great Reset," focused on maternal and adolescent mental health and child development. Approximately 84 individuals attended the symposium.

Nevada Pregnancy Risk Assessment Monitoring System (PRAMS) Program –

- The Pregnancy Risk Assessment Monitoring System (PRAMS) is a joint research project between the Nevada Division of Public and Behavioral Health and the Centers for Disease Control and Prevention (CDC). The purpose is to determine protective factors for healthy, full-term births as well as risk factors for short-term births, babies born with disabilities, and maternal health. To do this, the questionnaire asks new mothers questions about their behaviors and experiences before, during, and after their pregnancy. Each year in Nevada hundreds of babies are born with serious health concerns or disabilities. Many factors in a mother's life may affect her pregnancy and the health of her child and this survey is designed to capture these variables. The overall goal of PRAMS is to reduce infant morbidity and mortality and to promote maternal health by influencing maternal and child health programs, policies, and maternal behaviors during pregnancy and early infancy.
- NV PRAMS continued the disability supplemental questions for 2021 births with MCH Title V Program and State general funds and will switch to opioid supplemental questions in 2022. The disability and opioid supplement will continue to rotate every other year. Data from the survey will inform future data driven MCH efforts.
- Nevada PRAMS received $16,444 from the Council of State and Territorial Epidemiologists (CSTE) to add eleven questions on how the COVID-19 pandemic and response impacted women's pregnancy and birth experiences. These questions began in October 2020, and ran through September 2021, representing 12 months of data collection.
- 2017 Nevada PRAMS data had a response rate of 41% and 2018 data had a response rate of 39%, which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. 2019 weighted data was received in February and had a response rate of 42% which is under the CDC threshold of 50% to publish data. This data should be interpreted with caution due to the response rate.
- Data can be requested via the Office of Analytics at data@dhhs.nv.gov. The primary goal for Nevada PRAMS is to increase response rates moving forward.

Domain: Perinatal/Infant Health

- Increase the percent of children who are ever breastfed
- Increase the percent of children who are exclusively breastfed at 6 months

Title V/MCH Program and Partners –.

- CCHHS reached out to 11 businesses to educate about breastfeeding laws and encourage participation in the Breastfeeding Welcome Here (BFWH) Campaign with three taking the pledge to list themselves as breastfeeding friendly.
- A Pregnancy Risk Assessment Monitoring System (PRAMS) social media campaign promoted the value of participating in the survey to improve prenatal health care in Nevada. These messages only reached 260 since the post was not boosted. Additionally, the clinic promoted PRAMS through the outside digital signage and 21 pregnant women were given PRAMS brochures.
- During clinic visits, staff educated women receiving positive pregnancy test results about breastfeeding. As many as 23 were referred to WIC for support and given information about https://sobermomshealthybabies.org/. Text 4 Baby was promoted on the clinic digital signage and a Facebook campaign reached 2,601 individuals.
- As many as 381 vaccination reminder cards were sent for infants/toddlers four-months through 35-months old in need of recommended vaccines.

Safe Sleep Media Campaign –

April 2021 – August 2021: 1271 Total TV Spots Aired, 3706 Radio Spots Aired

- TV
  - North: 921 English, 55 Spanish
  - South: 228 English, 67 Spanish
- Radio
  - North: 1527 English, 200 Spanish

Safe sleep social media posts in October were completed in partnership with REMSA, the Division of Child and Family Services and MCAH, as was a press release. A Governor's Proclamation on Safe Sleep was released in support of safe sleep awareness.

SoberMomsHealthyBabies.org Media Campaign –

April 2021 – August 2021: 474 Total TV Spots Aired, 2664 Radio Spots Aired

- TV
  - North: 76 English, 54 Spanish
  - South: 275 English, 69 Spanish
- Radio
  - North: 1201 English, 161 Spanish
  - South: 1283 English, 19 Spanish

PRAMS Media Campaign –

April 2021–August 2021: 328 Total TV Spots Aired, 2841 Radio Spots Aired

- TV
  - North: 90 English, 53 Spanish
  - South: 140 English, 45 Spanish
- Radio
  - North: 1314 English, 125 Spanish
  - South: 1281 English, 121 Spanish

Washoe County Health District (WCHD) –

- WCHD continues to review records for the Fetal Infant Mortality Review (FIMR). The Title V MCH Block Grant currently funds all WCHD FIMR efforts.
- There were 2 Case Review Team (CRT) meetings during the reporting period April 1, 2021 to June 30, 2021. Seven cases were presented and discussed. Meetings have been held virtually since COVID-19. The team typically meets monthly, except in June and December. The CRT has reviewed 39 cases this fiscal year so far.
- There were 3 Case Review Team (CRT) meetings during the reporting period July 1, 2021 to September 30, 2021. Nine cases were presented and discussed. Meetings were held virtually since COVID-19 and hybrid in August and September. The CRT has reviewed 9 cases this fiscal year.
- The Washoe County FIMR program has been exploring the "Count the Kicks" fetal movement awareness app and campaign. A recommendation was made by the CRT to support this fetal movement campaign in Nevada. Washoe County FIMR staff met with the Executive Directors of "Count the Kicks" and a local health care insurance company outreach team in March 2021. A campaign launch is happening now and materials are available for providers on the Count the Kicks website.
- The Washoe County FIMR program was recognized in the NCFRP newsletter in June 2021 for advocating for children and pregnant women during COVID-19 pandemic response. They specifically noted how the Washoe County community rallied around pregnant women providing easier access to information and resources for providers and families, encouraging women to continue with prenatal care through PSA's run by local OB offices, and offering of in-services about the latest developments in COVID19 pertaining to pregnant women and children. Link to article: https://www.ncfrp.org/wp-content/uploads/NCFRP_Newsletter_June2021.pdf

- Work with hospital partners to implement Infant Safe Sleep practices and increase awareness by presenting at a minimum of four hospitals per year.
- Distributes Infant Safe Sleep brochures
- Delivered program supplies and equipment including11 car seats, 19,778 brochures, 6 flip charts, and 17 binders,
- Purchased 504 more survival kits to distribute to partners
- Continue to work with partners on 3- and 12-month follow-up surveys
- Continued to promote 211, Nevada Tobacco Quitline and Nevada Children's Medical Home Portal
- Provides safe sleep education and kits and car seats to Tribal partners in injury prevention.

Maternal-Infant Program –

- Critical Congenital Heart Disease (CCHD) data collection is ongoing.
- In June of 2021 Title V MIP launched the updated NeveadaBreastfeeds.org website.
    - This includes maintenance of the site, and the Breastfeeding Welcome Here campaign.
- August was Breastfeeding awareness month, and a banner was placed over Carson Street to support breastfeeding.
- Telehealth pilot by MCAH was accepted as a cutting-edge practice by AMCHP.
- The Nevada Home Visiting partnership continues with MCH.

Substance Use During Pregnancy –

- All Title V subrecipients promote the SoberMomsHealthyBabies.org website
- Title V MCH staff participate in Substance Use workgroups and collaborate with the Substance Abuse Prevention and Treatment Agency (SAPTA) on the Comprehensive Addiction Recovery Act (CARA) initiatives, including Infant Plan of Safe Care, Promoting Innovation in State/Territorial Maternal and Child Health Policymaking (PRISM) Learning Community and Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) efforts.
- All Title V MCH subrecipients promote the website: https://sobermomshealthybabies.org/. CCHHS promoted the website two months on Facebook and reached 3,881 individuals.
- Translation of CARA Family brochure and CARA form were provided by MCAH.

Domain: Child Health

- Increase the percent of children (10-71 months) who receive a developmental screening using a parent-completed screening tool

Title V/MCH Program and Partners –

- Community Health Services (CHS) administered infant and child immunizations in the clinic setting and through community immunization clinics.
- CCHHS works collaboratively with the in-house WIC office whose staff discussed the value for a medical home with 340 individuals. Additionally, Nevada 211 and medical home portal promotional materials were discussed with CCHHS clients and made available in the clinic area. Two Facebook campaigns were run promoting Nevada 211 which reached 4,962 people along with one clinical signage endorsement. CHHS promoted childhood immunizations through the clinic digital signage and a Facebook campaign.
- Nevada Institute for Children's Research and Policy (NICRP) sent 38,836 Kindergarten Health Surveys to all 17 school districts. They distributed 9,000 more than usual since Clark County had higher enrollment numbers than prior years. Efforts were made to include charter schools to reach a more diverse population base.

Child and Adolescent Efforts by Title V MCH staff

- The AHWP Coordinator conducted the final activity from the Children's Healthy Weight CoIIN, led by the Association of State Public Health Nutritionists presenting at a poster session at the annual

conference highlighting a two-month social media campaign conducted this spring. It promoted a series of fact sheets to assist Early Care and Education centers in implementing the Child and Adult Care Food Program (CACFP) which is recommended to help childcare settings improve childhood nutrition, prevent obesity, and address food insecurity.

- The AHWP Coordinator is on the National Center for School Mental Health CoIIN Nevada team led by the Nevada Department of Education (NDE).
- The AHWP Coordinator attended children's mental health meetings such as the Nevada Children's Behavioral Health Consortium and the NDE and Division of Child and Family Services (DCFS) collaboration meetings. Title V MCH and other DPBH staff joined with NDE and DCFS to work on an Interconnected Systems Framework to aid state agencies working on childhood resiliency create a unified resource list and action plan.
- The Teen Pregnancy Prevention Coordinator funded a statewide social media promotion of state resiliency resources and convened partners in disparity reduction trainings while promoting evidence-based curriculum for youth to reduce teen pregnancy, STIs, and promote positive youth development. The campaign reached over 1,575,815 media impressions.
- MCAH staff participate in DCFS' NVPeds Evaluation workgroup in efforts to icrease pediatric mental health resources in the state.

Domain: Adolescent Health

- Increase the percent of adolescents aged 12-17 with a preventive medical visit in the past year
- Increase percent of adolescents with and without special health care needs, aged 12 – 17 who received services necessary to make transitions to adult health care
- Reduce pregnancies among adolescent females aged 15 to 17 years and 18 to 19 years

Title V/MCH Program and Partners –

- CHS provided preventive education services with a focus on well-care screenings, contraceptives, Sexually Transmitted Infection (STI) screens, immunizations, as well as nutrition, weight, and exercise information. Youth presenting for reproductive health visits were screened for domestic violence and emotional/mental problems, as well as depression. Staff were trained on topics pertinent to creating adolescent-friendly clinic environments using best practice resources from the Adolescent Health Initiative (Starter Guide mini toolkits and Spark trainings).
- CCHHS conducted well-visits for 25 adolescents. Referrals were made for 5 youth afflicted by domestic violence, 37 with mood disorders, 54 with substance use, and 49 reporting alcohol use. During clinic visits, 81 youth or family members received health care transition information. Staff conducted outreach to 25 local agencies sharing the value of adolescent well-visits and information about health care transition. Additionally, both topics were promoted on the clinic digital signage and through social media. Two Facebook posts reached 3,504 individuals and one about health care transition was seen by 1,052 youth.
- Urban Lotus Project (ULP) Trauma-Informed Yoga for Youth no-cost courses were completed with 5 agencies hosting in-person classes. COVID-19 necessitated reduced programming and virtual yoga sessions were conducted at three different sites. Yoga teachers taught 179 classes to 1,033 adolescents reaching 332 new students. The Association of Maternal and Child Health Professionals (AMCHP) awarded funding to a Tennessee yoga agency to replicate ULP practices and policies. The AHWP Coordinator and ULP director were trained by AMCHP as coaches and met with the Nashville group regularly to assist them in implementing new policies and practices aligning with ULP.
- DP Video conducted a month-long social media campaign promoting health care transition awareness to youth and parents/caregivers. Six video ads (3 English/3 Spanish) were displayed on Facebook/Instagram. These messages reached 11,709 people with 110,832 media impressions, 7,983 video views, and 336 clicks on the links for additional resources. Six video ads (3 English/3 Spanish) were displayed on Twitter resulting in 95,903 media impressions.

Adolescent Health and Wellness Program (AHWP) –

- All Title V MCH Staff attended a 2.5-day training through the MCH Workforce Development Center. Other partners in attendance included University of Nevada Reno, Nevada Center for Excellence in Disabilities, and the Nevada Primary Care Association. Focus was on system changes pertinent to innovative projects and assessment of efforts. Focal discussions were hold on increasing adolescent well-visits and health care transition awareness/training for professionals.
- Disseminated 34,950 brochures *Does Your Teen Need Health Coverage?* addressing the value of adolescent well-visits and how to apply for health insurance. Of these, 15,625 were in Spanish.
- The AHWP Coordinator serves as a member on the Coalition to Prevent the Commercial Sex Exploitation of Children (CSEC).
- The AHWP and Teen Pregnancy Prevention coordinators are in the Leadership Exchange for Adolescent Health Promotion (LEAHP) learning collaborative which worked on developing Nevada's action plan to support adolescent sexual health policy assessment, expansion, implementation, monitoring, and evaluation. These plans also include ensuring youth have safe and supportive mental and emotional health environments.
- Adolescent focused meetings/conferences attended included:
    - AMCHP virtual annual meeting with most of the focus on how to incorporate health and racial equity into MCH Programs
    - State adolescent health program coordinators regular meetings about program successes and challenges.
    - Racial Equity Learning Community organized by the National Network of State Adolescent Health Coordinators to look at how to improve adolescent programming.
    - Nevada Primary Care Association's Healthy Tomorrows Partnership for Children Youth Advisory Committee.
    -
- Shared the Facebook video posts promoting the value of health care transition awareness created by DP Video with funded partners and outside agencies for placing on their Facebook pages
- Provided the newly released animated video ***What is Health Care Transition? HCT 101*** to adolescent serving groups. This resource created by Got Transition was a joint effort using young adult input
- Obtained resources from https://www.gottransition.org/ to be disseminated to partners and at community events
- Project ECHO attendance at six-session series informing health professionals about the Six-Core Elements of Health Care Transition established by Got Transition.

Domain: Children and Youth with Special Health Care Needs (CYSHCN)

- Increase the percent of children with special health care needs with a medical home
- Increase the percent of children without special health care needs with a medical home
- Increase the number of WIC, Home Visiting, Healthy Start, and other program participants that received information on the benefits of a medical home
- Increase the number of referrals to Nevada's medical home portal
- Increase the percent of children with special health care needs aged 12 through 17 who receive services necessary to make transitions to adult health care

Title V/MCH Program and Partners –

- Nevada Center for Excellence in Disabilities (NCED) hosted 6 University of Nevada, Reno (UNR), Project ECHO series on health care transition. The 34 attendees from six counties learned best practices from Got Transition's six core elements, related resources, and were involved in case-based discussions. The MCH Program provided resources to expand the course opportunity to reach practitioners serving both children with and without special health care needs. A survey collected data on the impact of the Project ECHO series informing about increased knowledge

about health care transition and intention to change clinic policies and practices. Additionally, NCED referred 15 families to the Medical Home Portal.

- The NCED Family Navigation Network became a new partner in July 2021 and supports families of children and youth with special health needs to navigate complex healthcare systems. Family Navigation Network provides free one-to-one support, training, and printed materials to families and the professionals who serve them.
    - During their first quarter as a partner, 12 calls to the hotline were answered. 4 calls were about therapy options, 3 were about school-related issues, 2 were about insurance/payment issues, 1 for college options for a child with a developmental disability, and 2 about the Katie Beckett application.
    - 8 referrals were made for educational advocacy, therapies and paying for services.
    - 100% of staff were trained on the Medical Home Portal and 30% of families were trained.
- A social media campaign ran for Nevada Medical Home Portal during the month of August 2021. The campaign reached over 1,201,524 media impressions on Facebook, Instagram, and Twitter. Facebook and Instagram reached 132,445 people in the specified demographics and had 2,965 link clicks.
- The Family Engagement Coordinator with The Children's Cabinet provides technical assistance and facilities parent involvement in social emotional Pyramid Model (TACSEI) activities. From July 1, 2021, to September 3, 2021, three Technical Assistance trainings with 5 participants were conducted and 7 preschools and daycare centers were contacted and given informational materials. Data collection and evaluation for Pyramid Model activities is ongoing, with 17 sites collecting data. 168 children have received Ages and Stages Questionnaire screenings.

Children and Youth with Special Health Care Needs (CYSHCN) Program –

- Title V MCH staff continued participation in the Pediatric Mental Health Care Access Program (PMHCAP) with the Nevada Division of Child and Family Services (DCFS). PMHCAP uses telehealth strategies like Mobile Crisis Response teams to expand mental health services for children in Nevada. Title V MCH staff recently peer reviewed the Early Childhood Mental Health Brief Development process and protocols initiated by PMHCAP and the Nevada Institute for Children's Research and Policy (NICRP).
- Title V MCH staff presented to the Nevada Governor's Council on Developmental Disabilities (NGCDD) on CYSHCN Programs and provided data and reporting.
- Title V MCH staff distributed 800 Milestone Moments brochures in both English and Spanish to CHS and rural nursing clinics. These brochures detail developmental signs to be aware of during a child's first five years of life.
- Title V MCH staff continue to participate in a joint working group across agencies related to youth mental health.
- Clear masks were widely distributed to statewide school districts to help support youth access to lipreading.

Domain: Cross-Cutting/Life course (activities within this domain are included within each subpopulation above), which include the following objectives:

- Reduce the percent of women who smoke during pregnancy
- Increase the percent of women who call the Nevada Tobacco Quitline for assistance
- Reduce the percent of women using substances during pregnancy
- Reduce the percent of children who are exposed to secondhand smoke
- Increase the percent of adequately insured children
- Increase the percent of callers to Nevada 211 inquiring/requesting health insurance benefits information

Tobacco Cessation –

- All subgrantees continue to promote the Nevada Tobacco Quitline (NTQ). CCHHS and CHS referred tobacco users to the NTQ. CCHHS and CHS counseled self-identified persons who use nicotine with a Brief Tobacco Intervention resulting in 262 referrals to the NTQ due to desire to change smoking/vaping habits. CCHHS posted one NTQ messages on the clinic signage and conducted one Facebook campaign reaching 1,993 individuals.

Adequately Insured Children –

- CCHHS partners with the Division of Welfare and Supportive Services (DWSS) by placing insurance enrollment staff on-site. In-person efforts started up again and 79 individuals sought services. In-reach was conducted through CCHHS clinic staff.

Nevada 211 –

- Nevada 211 received 354 calls/texts from within the MCH population with 90% being pregnant. Referrals were made to the following programs: Medical Home Portal (21), Text 4 Baby (20), Nevada Tobacco Quitline (4), Sober Moms Healthy Babies website (2), and Perinatal Mood and Anxiety Disorder (PMAD) resources (1). PRAMS program information was provided to 3 callers.
- All subgrantees continue to promote Nevada 211.

Title V MCH Program –

- Title V MCH released a public facing Power BI data dashboard that utilizes Federally Available Data to display Nevada data points on performance measures with United States comparisons. Each domain is represented in the dashboard and has interactive graphs and tables that allow for breakdowns by race and ethnicity, insurance status, urban rural residence, and other relevant variables.
- The annual Health Resources and Services Administration (HRSA) site visit to review the Title V Block Grant application for FFY 2022 was conducted on September 29, 2021. This site visit was successful, and Title V MCH members were praised for their effective and numerous community partnerships, commitment to data capacity, involvement in Public Health Preparedness and Planning, and optimization of reach.

Primary Care Office (PCO)

Our Mission

The PCO is an administrative unit of the Nevada Division of Public and Behavioral Health that works to improve the health care infrastructure of Nevada. The PCO supports the Division's mission to promote the health of Nevadans by working to:

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

Programs and Services

The PCO is funded by federal grants from the Health Resources Services Administration (HRSA) to support multiple programs through the following services:

- Complete applications for federal designation of Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas of Populations (MUA/Ps). These designations support eligibility for increased federal funding and recruitment of health care professionals;
- Review applications and provide letters of support for the J-1 Physician Visa Waiver program to bring international medical graduates to underserved areas in Nevada; and
- Review site applications and provide recommendations for the National Health Service Corps loan repayment and scholar programs.

The PCO also engages in the following activities:

- Support primary care workforce development through linkages with education and training, licensure and certification, and recruitment and retention.
- Review applications for certificates of need for construction, or expansion, of facilities providing medical care in counties with less than 100,000 population, or communities with less than 25,000 population in counties with more than 100,000 population.

Oversight

The Primary Care Advisory Council was established in 2008 to enhance oversight of the PCO and the services provided, in an advisory capacity to the Administrator of the Division of Public and Behavioral Health. Creation of the PCAC led to statutory and regulatory changes to ensure compliance with the J-1 Physician Visa Waiver program, under NRS 439A.130-185 and NAC 439A.700-755.

Linkages

The PCO works with many public and private partners to support the health care safety net, including: Nevada Primary Care Association, Federally Qualified Health Centers, Rural Health Centers, Critical Access Hospitals, National Health Service Corps sites, State Office of Rural Health, Nevada Rural Hospital Association, University of Nevada School of Medicine, Western Interstate Commission for Higher Education, Nevada Division of Health Care Financing and Policy, and multiple health professional licensing boards. Facilitated activities include strategic planning for shortage designations, primary care data development and sharing, recruitment and retention strategies, and workforce development.

Contact

Heather Mitchell, Health Resource Analyst, hmitchell@health.nv.gov 775-684-2204; or NV PCO at nvpco@health.nv.gov

PCO Highlights from April-June 2021

- National Health Service Corps (NHSC) outreach activities during this quarter included three virtual visits with Volunteers of Southern Nevada, Pediatric Dentist seeking transfer to Small Smiles encountering licensing issues, and Desert Behavioral Health. Three pediatric/kids dental locations, Planned Parenthood Mar Monte-Fifth Street Health Center, CCBHC-Reno (previously CMS did not approve Medicare for BH) and FirstMed (FQHC- new HR Director Angela Roundtree) new site certifications reviews were completed (the new site certification cycle closed July 1, 2021). These activities increase awareness of the program and subsequent program participation, which leads to increased recruitment and retention of health providers for underserved maternal, pediatric, and adolescent populations. These safety net health care sites serve all patients regardless of ability to pay and represent critical primary care, mental health, and dental access points for maternal, pediatric, and adolescent populations in Nevada.

- Zero Conrad 30 J-1 Visa Waiver applications were reviewed, public hearings were held, and letters of support completed for physicians to practice in Nevada under the Conrad 30 J-1 Visa Waiver program. These doctors serve underserved populations including maternal, pediatric, and adolescent populations in Las Vegas and Reno area. The J-1 program has received fourteen applications this program year.

- The 2nd Quarter (06/23/21) PCO Newsletter (https://conta.cc/2SQj2yt) was published to 480 subscribers and included multiple articles that support maternal, child, and adolescent health. Articles included information regarding shortage designation updates, Nevada 211 Youth App, NV Wellness, Conrad 30, and Project ECHO SBIRT training for Women's Health setting. Announcements for NHSC New Site application cycle https://conta.cc/3wOwUZh; NV Alliance for Innovation on Maternal Health (https://conta.cc/3xBnL5R); Lucia's Story https://vimeo.com/546231005.

- Monthly or Quarterly meetings continue with our safety net partners continued collaboration on data development and sharing, provider recruitment and retention, shortage designations, statewide rational service area plans, and workforce development. PCO Primary Care Needs Assessment completed with stakeholder input with identified priorities of Mental Health, Seniors, and Children and submitted for review to HRSA March 30, 2021 and now approved. The Recruitment and Retention stakeholder would like to work toward data that can show why clinicians either do not come to Nevada or why they leave, next meeting we are looking at bringing in recruitment specialists from the larger health care organizations to let us know how we might support them in those efforts and find out what they feel is needed.

- Certificate of Need approved for Carson Valley Medical Center

- Maternal Child Adolescent Health (MCAH) program specific requests:
    - Provided 2017 HPSA data and maps and 2018 designations list for a time sensitive request.
    - Program Narrative for Title V MCH block grant

If you would like to receive our PCO Quarterly Newsletter, you can sign up online through http://dpbh.nv.gov/Programs/Conrad30/NV_PCO_Newsletter_Sign_Up/ OR constant contact.

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The PCO also engages in the following activities:

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The Primary Care Advisory Council was established in 2008 to enhance oversight of the PCO and the services provided, in an advisory capacity to the Administrator of the Division of Public and Behavioral Health. Creation of the PCAC led to statutory and regulatory changes to ensure compliance with the J-1 Physician Visa Waiver program, under NRS 439A.130-185 and NAC 439A.700-755.

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Contact

Heather Mitchell, Health Resource Analyst, hmitchell@health.nv.gov 775-684-2204; or NV PCO at nvpco@health.nv.gov

PCO Highlights from July - September 2021

- National Health Service Corps (NHSC) outreach activities during this quarter included site certifications for several addiction/behavioral health centers: New Frontier Treatment Center-Fallon; Ridge House, Inc-Reno; The Life Change Center-Sparks and Carson City; Bridge Counseling Associates, Inc-Las Vegas and a Primary Care (PC)/Specialty/OBGYN/Pediatric site - Volunteers in Medicine (VMSN) of So. NV. Planned Parenthood Mar Monte-Fifth St. Health Center was provided technical assistance as they are currently only providing reproductive services and would need to provide women's comprehensive PC services. The following sites are pending approval contingent on the designations that have been proposed for withdrawal re-designated. The recertification cycle closed October 19, 2021. These activities increase awareness of the program and subsequent program participation, which leads to increased recruitment and retention of health providers for underserved maternal, pediatric, and adolescent populations. These safety net health care sites serve all patients regardless of ability to pay and represent critical primary care, mental health, and dental access points for maternal, pediatric, and adolescent populations in Nevada.

- Zero Conrad 30 J-1 Visa Waiver applications were reviewed, public hearings were held, and letters of support completed for physicians to practice in Nevada under the Conrad 30 J-1 Visa Waiver program. These doctors serve underserved populations including maternal, pediatric, and adolescent populations in Las Vegas and Reno area. The J-1 program has received fourteen applications this program year.

- PCO Newsletter (https://conta.cc/3ze5SeA) was published to 479 subscribers and included multiple articles that support maternal, child, and adolescent health. Articles included information regarding sNational Shortage Designation Update (NSDU) project; National Health Service Corps (NHSC) recertification cycle open August 10 – September 28; Suicide Prevention Trainings sponsored by Division of Public and Behavioral Health Office of Suicide Prevention; CASAT Learning-Skills for Psychological Recovery; Maternal and Child Health Title V Federally available data dashboard, Supplemental Nutrition Program for Women, Infants and Children (WIC); US DHHS NOFO in American Rescue Plan funding to reduce burnout and promote mental health among health and public safety workforce and Graduate Medical Education Program to support the training of residents in primary care residency training programs. Additionally an announcement was sent out regarding the Maternal and Child Health Title V Public Input Survey (https://conta.cc/3yPYRjt successfully delivered to 456 subscribers, 61 views, and 7 clicks/shares)

- Monthly or Quarterly meetings continue with our safety net partners continued collaboration on data development and sharing, provider recruitment and retention, shortage designations, statewide rational service area plans, and workforce development. PCO is working with key stakeholders to create a Statewide Rational Service Area Plan using identified priorities of Mental Health, Seniors, and Children and submitted for review to HRSA March 30, 2021, and now approved. The Recruitment and Retention stakeholder would like to work toward data that can show why clinicians either do not come to Nevada or why they leave, next meeting we are looking at bringing in recruitment specialists from the larger health care organizations to let us know how we might support them in those efforts and find out what they feel is needed.

- Maternal Child Adolescent Health (MCAH) program specific:
    - Shared Federal Registrar notice that HRSA seeks public and stakeholder feedback on the proposed Maternity Care Target Area (MCTAs) criteria through November 26, 2021.

If you would like to receive our PCO Quarterly Newsletter, you can sign up online through http://dpbh.nv.gov/Programs/Conrad30/NV_PCO_Newsletter_Sign_Up/ OR constant contact.

July 10, 2021

Medical Home Portal

FFY2021 Q3 REPORT

1. FEATURE UPDATES

Features that have been significantly reworked or updated during the Quarter ending June 30, 2021.

A. Bulk Edits by Category

i. Service Maintainers can now perform bulk edits to text in the Eligibility, Services Provided, and Provider Profile fields of Service Provider records. These bulk edits are available via Service Categories.

B. State Partner Dashboard

i. A State Partner Dashboard was created and added to the Portal Wiki. It can be used as a resource to connect with other partner states and includes ideas for Portal promotion, special projects, and Title V reporting.

2. CONTENT UPDATES

Content that has been published or updated during the Quarter ending June 30, 2021.

A. New Content

i. Clinical

1. *Care of Surgical Wounds in Children*
2. *Pompe Disease (newborn disorder page)*
3. *Sensory Processing/Integration Disorder*
4. *Sleep Disorders & Parasomnias in Children*
5. *3-Methylglutaconic Aciduria (3MGA) (newborn disorder page)*

B. Updated Content

i. Clinical

1. *Asthma module*

2. *Constipation module*
3. *Homocystinuria module*
4. *Attention-Deficit/Hyperactivity Disorder (ADHD) for Educators*
5. *Anxiety Disorders and ADHD issue page*
6. *Disruptive Behavior Disorders and ADHD*

3. GOOGLE ANALYTICS

Google Analytics April 1 – June 30, 2021. Traffic Refined for Quality Segment.

(Percentage change from previous quarter.) [Percentage change from previous year.]

A. Aggregated Subdomains

i. Users: 117,803 (-6.92%) [-0.40%]
ii. Sessions: 134,443 (-9.60%) [-1.77%]
iii. Pageviews: 209,423 (-9.55%) [-2.45%]

B. Nevada

i. Users: 4,929 (-6.14%) [-67.79%]
ii. Sessions: 5,573 (-5.94%) [-73.35%]
iii. Pageviews: 9,811 (-10.56%) [-74.79]

October 5, 2021

Medical Home Portal

FFY2021 Q4 REPORT

1. FEATURE UPDATES

Features that have been significantly reworked or updated during the Quarter ending September 30, 2021.

A. SEO Improvements

i. Worked with an outside consultant to improve the Portal's Search Engine Optimization. These changes will allow Portal pages to come up more frequently and with higher priority in general search engine results. Changes include:

1. *Adding key search terms and phrases to all pages.*
2. *Increasing load times for pages.*
3. *Ensuring pages meet accessibility requirements.*
4. *Adding original photos of children and youth with special health care needs and their families.*

B. New Editorial Board

i. Organized an Editorial Review Board which will advise the Portal on editorial policies, scope, and content. The Board will allow the Portal to offer broader content development, expand contributing authors, and promote the Portal all while maintaining our commitment to be a high-quality and peer-reviewed source of information. We are working toward having the Portal indexed in a National Libraries of Medicine (NLM) database.

2. CONTENT UPDATES

Content that has been published or updated during the Quarter ending September 30, 2021.

A. New Content

i. Clinical

1. *Obsessive-Compulsive Disorder (OCD) module*

2. *Neonatal Opioid Withdrawal Syndrome page*
3. *Somatic Symptom Disorder & Functional Neurologic Disorders page*
4. *Specific Learning Disability page*

B. Updated Content

i. Clinical

1. *Cerebral Palsy module*
2. *Classic Homocystinura newborn disorders page*
3. *Foster Care module*
4. *Neurofibromatosis Type 1 module*
5. *Sickle Cell Disease module*
6. *Spinal Muscular Atrophy module*
7. *Tuberous Sclerosis Complex module*

ii. For Families

1. *Care Notebook page and downloadable PDF*

3. GOOGLE ANALYTICS

Google Analytics July 1-September 30, 2021. Traffic Refined for Quality Segment.

(Percentage change from previous quarter.) [Percentage change from previous year.]

A. Aggregated Subdomains

i. Users: 123,556 (+3.79) [+2.18%]
ii. Sessions: 141,557 (+3.89%) [+3.47%]
iii. Pageviews: 447,570 (+110.85%) [+114.71%]

B. Nationwide

i. Users: 43,195 (-7.80%) [-17.74%]
ii. Sessions: 49,215 (-7.71%) [-16.58%]
iii. Pageviews: 136,614 (+94.93%) [+80.21%]

C. Nevada

i. Users: 9,775 (+81.15%) [+67.97%]
ii. Sessions: 10,974 (+78.73%) [+62.19%]
iii. Pageviews: 37,702 (+246.91%) [+220.62%]

*NV ran a social media campaign in August 2021, which largely accounts for the percent increases shown here compared to the previous quarter and previous year.

Nevada's Pediatric Providers,

Pfizer's BioNTech COVID-19 vaccine has been approved for adolescents ages 12 years and up. It is expected that the minimum age requirement for COVID vaccine administration recommendation will be decreasing to include ages 5 years old to 11 years old in early November. The Nevada State Immunization Program (NSIP) is preparing for this new recommendation and is inviting all pediatric providers in Nevada to enroll in the COVID-19 Vaccine Program. There are many options available for providers to receive smaller quantities of vaccine than the manufacturers minimum dose order. These options include:

- Local redistribution from the NSIP or another enrolled provider
- Vaccine pickup from a Local Health Authority
- Pharmacy pickup from a local pharmacy enrolled in the states Pharmacy Depot Program

If planning to use either of the pickup options, the providers office must have a portable digital data logger as well as a portable cooler that can maintain the vaccines temperature during travel.

In order to enroll in the program, a provider must meet key requirements. These requirements are listed below:

- *Stand-alone refrigerator (no kitchen combination units and no refrigerator units that have any freezer component attached in any way unless there is a compressor for each unit) with a certified digital data logger (state can provide the datalogger [DDL] if one is needed)*
- *Temperatures of the vaccine storage unit must be checked twice a day on business days. Temperature data must be sent to the state every month on the first business day.*
- *Two separate vaccine coordinators must be enrolled for data and vaccine management.*
- *The vaccine coordinators must report the vaccine inventory **daily** to Vaccine Finder. That is every day regardless of provider business hours– Monday thru Sunday per the CDC*
- *Vaccine inventory must be reconciled in NV WEBIZ the first **Friday** of every month.*
- *Vaccine administration must be documented in NV WEBIZ **within 24 hours** of administration.*
- *The COVID-19 vaccines are reactogenic. Provider offices must be prepared, equipped, and trained to handle anaphylaxis in patients.*

For providers interested in enrolling with the state's COVID-19 Vaccine Program, please email your provider name and contact information to DPBH-AVARS@health.nv.gov.

Centers for Disease Control and Prevention

COVID-19 Vaccination for Pregnant People to Prevent Serious Illness, Deaths, and Adverse Pregnancy Outcomes from COVID-19

HAN HEALTH ALERT NETWORK

This is an official CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
September 29, 2021, 12:00 PM ET
CDCHAN-00453

Summary

The Centers for Disease Control and Prevention (CDC) recommends urgent action to increase Coronavirus Disease 2019 (COVID-19) vaccination among people who are pregnant, recently pregnant (including those who are lactating), who are trying to become pregnant now, or who might become pregnant in the future. CDC strongly recommends COVID-19 vaccination either before or during pregnancy because the benefits of vaccination outweigh known or potential risks. As of September 27, 2021, more than 125,000 laboratory-confirmed COVID-19 cases have been reported in pregnant people, including more than 22,000 hospitalized cases and 161 deaths.[1] The highest number of COVID-19-related deaths in pregnant people (n=22) in a single month of the pandemic was reported in August 2021. Data from the COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) in 2021 indicate that approximately 97% of pregnant people hospitalized (either for illness or for labor and delivery) with confirmed SARS-CoV-2 infection were unvaccinated.[2] In addition to the risks of severe illness and death for pregnant and recently pregnant people, there is an increased risk for adverse pregnancy and neonatal outcomes, including preterm birth and admission of their neonate(s) to an intensive care unit (ICU). Other adverse pregnancy outcomes, such as stillbirth, have been reported. Despite the known risks of COVID-19, as of September 18, 2021, 31.0% of pregnant people were fully vaccinated before or during their pregnancy.[3] In addition, there are racial and ethnic disparities in vaccination coverage for pregnant people. Healthcare providers should communicate the risks of COVID-19, the benefits of vaccination, and information on the safety and effectiveness of COVID-19 vaccination in pregnancy. Healthcare providers should strongly recommend that people who are pregnant, recently pregnant (including those who are lactating), who are trying to become pregnant now, or who might become pregnant in the future receive one of the authorized or approved COVID-19 vaccines as soon as possible.

Background

COVID-19 vaccination is recommended for pregnant people. CDC recommends COVID-19 vaccination for all people aged 12 years and older, including people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.[4] CDC recommendations align with those from professional medical organizations serving people who are pregnant, including the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine. Accumulating data provide evidence of both the safety and effectiveness of COVID-19 vaccination in pregnancy. CDC strongly recommends COVID-19 vaccination either before or during pregnancy, because the benefits of vaccination for both pregnant persons and their fetus/infant outweigh known or potential risks. Getting a COVID-19 vaccine can prevent severe illness, death, and pregnancy complications related to COVID-19.

COVID-19 vaccination coverage for pregnant people remains low. Despite recommendations for vaccination, uptake of COVID-19 vaccination by pregnant people has been lower than that of non-pregnant people.[5] In addition, vaccination coverage for pregnant people differs by race and ethnicity, with vaccination coverage being lowest for non-Hispanic Black pregnant people (15.6%) as of September 18, 2021.[3] Although the proportion of fully vaccinated pregnant people has increased to 31.0% (as of September 18, 2021), the majority of pregnant people remain unprotected against COVID-19, and significant disparities exist in vaccination coverage by race and ethnicity.

Pregnant and recently pregnant people with COVID-19 are at increased risk of severe illness, death, and pregnancy complications. Pregnant and recently pregnant people with COVID-19 are at increased risk for severe illness when compared with non-pregnant people. Severe illness includes illness that requires hospitalization, intensive care unit (ICU) admission, mechanical ventilation, or extracorporeal membrane oxygenation (ECMO), or illness that results in death. Although the absolute risk is low, compared with non-pregnant symptomatic people, symptomatic pregnant people have more than a two-fold increased risk of requiring ICU admission, invasive ventilation, and ECMO, and a 70% increased risk of death.[6] Pregnant people with COVID-19 are also at increased risk for preterm birth and some data suggest an increased risk for other adverse pregnancy complications and outcomes, such as preeclampsia, coagulopathy, and stillbirth, compared with pregnant people without COVID-19.[7-10] Neonates born to people with COVID-19 are also at increased risk for admission to the neonatal ICU.[9-11] In addition, although rare, pregnant people with COVID-19 can transmit infection to their neonates; among neonates born to women with COVID-19 during pregnancy, 1–4% of neonates tested were positive by rRT-PCR.[12,13]

Recommendations

CDC recommends urgent action to help protect pregnant people and their fetuses/infants. CDC recommends urgent action to accelerate primary vaccination for people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future. Efforts should specifically address populations with lower vaccination coverage and use approaches to reduce racial and ethnic disparities. CDC recommends ensuring tailored, culturally responsive, and linguistically appropriate communication of vaccination benefits. In addition, pregnant people should continue to follow all recommended prevention measures and should seek care immediately for any symptoms of COVID-19. Healthcare providers should have a low threshold for increased monitoring during pregnancy due to the risk of severe illness.

Recommendations for Public Health Jurisdictions

- Continue and increase efforts to reach and partner with communities to encourage and offer vaccination to people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Leverage resources to promote vaccine equity: COVID-19 Vaccine Equity for Racial and Ethnic Minority Groups.
  - Include focused efforts to increase vaccination coverage in pregnancy among people from racial and ethnic minority groups.
- Encourage healthcare providers to offer and recommend COVID-19 vaccination to their patients and community members who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Work with community partners and employers to make vaccination easily accessible for unvaccinated populations, including those who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Continue to implement additional prevention strategies where SARS-CoV-2 transmission is high and vaccination coverage is low, including in groups at increased risk, such as pregnant people.
- Continue to monitor community transmission and vaccination coverage levels and focus vaccine efforts on populations with low coverage.
- Disseminate and communicate information to key partners about vaccination coverage, risks posed by the highly transmissible Delta variant, and local transmission levels. Partner and share messaging with programs serving pregnant and recently pregnant people.
- Communicate accurate information about COVID-19 vaccines, respond to gaps in information, and confront misinformation with evidence-based messaging from credible sources. For example, there is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.

Recommendations for Healthcare Providers

- Ensure all clinical staff are aware of the recommendation for vaccination of people before and during pregnancy and the serious risks of COVID-19 to pregnant and recently pregnant people and their fetuses/infants.
- Increase outreach efforts to encourage, recommend, and offer vaccination to people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future. A strong recommendation from a healthcare provider is a critical factor in COVID-19 vaccine acceptance and can make a meaningful difference to protect the health of pregnant and recently pregnant people and their fetuses/infants from COVID-19.

- For healthcare providers who see patients who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future:
  - Review patients' COVID-19 vaccination status at each pre- and post-natal visit and discuss COVID-19 vaccination with those who are unvaccinated.
  - Reach out to your patients with messages encouraging and recommending the critical need for vaccination.
  - Remind patients that vaccination is recommended even for those with prior COVID-19 infections. Studies have shown that vaccination provides increased protection in people who have recovered from COVID-19.
  - Support efforts to ensure people receiving the first dose of an mRNA COVID-19 vaccine (i.e., Pfizer-BioNTech, Moderna) return for their second dose to complete the series as close as possible to the recommended interval.
    - Consider a booster dose in eligible pregnant persons.[4]
  - Communicate accurate information about COVID-19 vaccines and confront misinformation with evidence-based messaging from credible sources. For example, there is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.
- Become a COVID-19 vaccine provider and vaccinate patients during their visit. More information can be found at How to Enroll as a COVID-19 Vaccination Provider.

For More Information

- Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States
- COVID-19 Vaccines While Pregnant or Breastfeeding
- COVID-19 Vaccines for People Who Would Like to Have a Baby
- COVID-19 among Pregnant and Recently Pregnant People
- COVID Data Tracker
  - Vaccination Among Pregnant People
  - Data on COVID-19 during Pregnancy: Severity of Maternal Illness
- Toolkit for Pregnant People and New Parents
- Building Confidence in COVID-19 Vaccines

References

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3. COVID Data Tracker. Vaccinations Among Pregnant People. (accessed September 27, 2021)
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5. Razzaghi H, et al. COVID-19 Vaccination Coverage Among Pregnant Women During Pregnancy — Eight Integrated Health Care Organizations, United States, December 14, 2020–May 8, 2021. *MMWR*. 2021:70(24);895–899.
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9. Allotey J, et al. Clinical manifestations, risk factors, and maternal and perinatal outcomes of coronavirus disease 2019 in pregnancy: living systematic review and meta-analysis . *BMJ* 2020;370:m3320. (Published 01 September 2020)
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13. Mullins E, Hudak ML, Banerjee J, et al. Pregnancy and neonatal outcomes of COVID-19: coreporting of common outcomes from PAN-COVID and AAP-SONPM registries . *Ultrasound Obstet Gynecol*. 2021;57(4):573-581. doi:10.1002/uog.23619

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national and international organizations.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HAN Message Types

- **Health Alert:** Conveys the highest level of importance; warrants immediate action or attention.
- **Health Advisory:** Provides important information for a specific incident or situation; may not require immediate action.
- **Health Update:** Provides updated information regarding an incident or situation; unlikely to require immediate action.
- **Info Service:** Provides general information that is not necessarily considered to be of an emergent nature.

###

This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations.

###

Top of Page

Additional Resources

- HAN Archive By Year
- HAN Types
- Sign Up for HAN Email Updates
- HAN Jurisdictions

Page last reviewed: September 29, 2021

Office of Analytics Report: Children Ages 0-24 with Completed 7-Series Vaccination

Comparing December 31 2019, December 31 2020, and December 31 2021

Department of Health and Human Services
Office of Analytics

Children Aged 0-24 Months with Completed 7-Series Vaccinations
Comparing Dec 31, 2019, Dec 31, 2020 and Dec 31, 2021
By Sex, Race, Ethnicity, and Patient County

	2019	2020	2019-2020 % change	2021	2020-2021 % change	2019-2021 % change
Completed	76.8%	77.2%	0.6%	81.4%	5.4%	6%

Sex			
	2019	2020	2021
Female	77.7%	77.9%	82.0%
Male	78.0%	78.2%	82.4%
Unknown	0.8%	1.2%	1.5%

Race			
	2019	2020	2021
American Indian or Alaska Native	83.2%	80.4%	85.5%
Asian	67.7%	66.8%	72.3%
Black or African American	84.6%	83.8%	88.1%
Native Hawaiian or Other Pacific Islander	67.7%	68.0%	71.8%
White	74.7%	75.3%	79.3%
Other	75.2%	76.7%	81.1%
Unknown	76.3%	79.4%	82.2%

Data source: WebIZ Database
Provided by EM on 10/21/21

Department of Health and Human Services
Office of Analytics

County	2019	2020	% change 2019-2020	2021	% change 2020-2021	% change 2019-2021
Carson City	68.4%	75.1%	9.8% ▲	78.9%	5.0% ▲	15.3% ▲
Churchill	86.9%	86.2%	-0.9% ▼	90.2%	4.7% ▲	3.8% ▲
Clark	74.2%	74.7%	0.6% ▲	78.8%	5.6% ▲	6.2% ▲
Douglas	69.8%	74.6%	6.8% ▲	77.9%	4.5% ▲	11.6% ▲
Elko	90.0%	92.9%	3.2% ▲	96.4%	3.8% ▲	7.1% ▲
Esmeralda	100.0%	100.0%	0.0% ▲	100.0%	0.0% ▲	0.0% ▲
Eureka	93.3%	89.5%	-4.1% ▼	92.1%	2.9% ▲	-1.3% ▼
Humboldt	88.7%	86.7%	-2.2% ▼	89.3%	3.0% ▲	0.7% ▲
Lander	86.7%	92.3%	6.5% ▲	95.0%	2.9% ▲	9.6% ▲
Lincoln	82.7%	75.7%	-8.5% ▼	81.1%	7.1% ▲	-2.0% ▼
Lyon	78.1%	82.1%	5.1% ▲	85.4%	4.0% ▲	9.3% ▲
Mineral	89.8%	84.0%	-6.5% ▼	91.4%	8.8% ▲	1.8% ▲
Nye	79.6%	79.5%	-0.2% ▼	84.9%	6.8% ▲	6.6% ▲
Pershing	90.9%	88.8%	-2.3% ▼	95.1%	7.1% ▲	4.6% ▲
Storey	88.9%	100.0%	12.5% ▲	85.7%	-14.3% ▼	-3.6% ▼
Washoe	89.1%	88.5%	-0.6% ▼	92.8%	4.8% ▲	4.2% ▲
White Pine	86.2%	86.7%	0.5% ▲	92.0%	6.2% ▲	6.7% ▲
Other	78.5%	76.1%	-3.0% ▼	80.1%	5.2% ▲	2.0% ▲

Data source: WebIZ Database
Provided by EM on 10/21/21

Attachment for Agenda Item #8

Steve Sisolak
Governor

Richard Whitley
Director

State of Nevada

Department of Health and Human Services

Title V Maternal and Child Health (MCH) Block Grant: Data Updates

Division of Public and Behavioral Health

Kagan Griffin, MPH, RD, Title V MCH Program Manager

11/05/2021

Helping people. It's who we are and what we do.

Overview

- The Federally Available Data (FAD) is provided by the Maternal Child Health Bureau (MCHB) to assist states in reporting the Title V MCH National Outcome Measures (NOMs) and National Performance Measures (NPMs)

- This resource allows state to make comparisons to U.S. and other state data, as well as examine trends

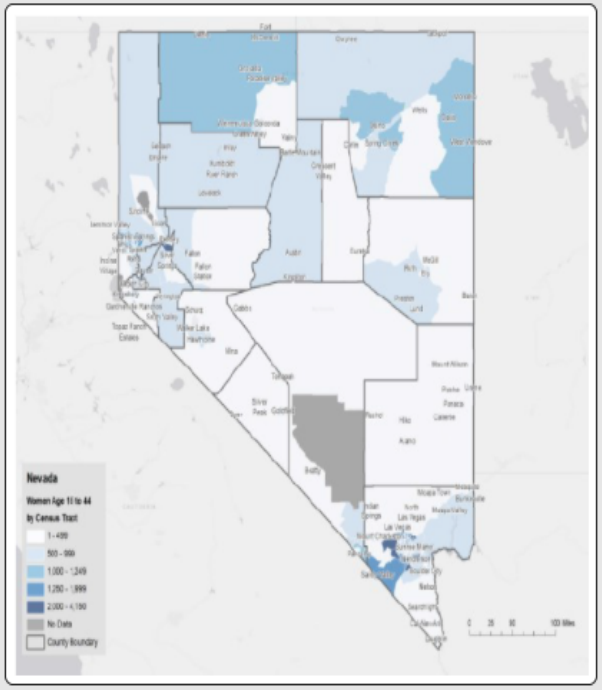
HRSA Maternal & Child Health

Data Dashboard

Maternal Health | Infant/Perinatal Health | Child Health | Children & Youth with Special Health Care Needs | Adolescent Health | Cross Cutting Measures

Maternal Health Overview | Prenatal Care | Morbidity and Mortality | Teen Birth Rate | Smoking During Pregnancy | Cesarean Deliveries | Preventive Medical Care

Maternal Health Measures in Nevada

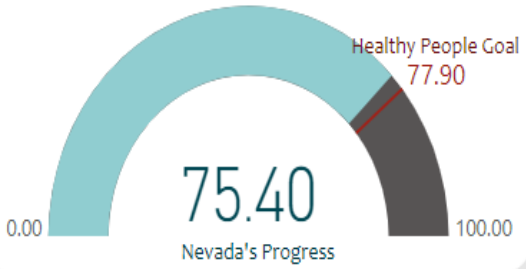


Population of women ages 18-44 in Nevada

Data Source: Office of Analytics

Nevada's progress in meeting Healthy People 2020 Goals

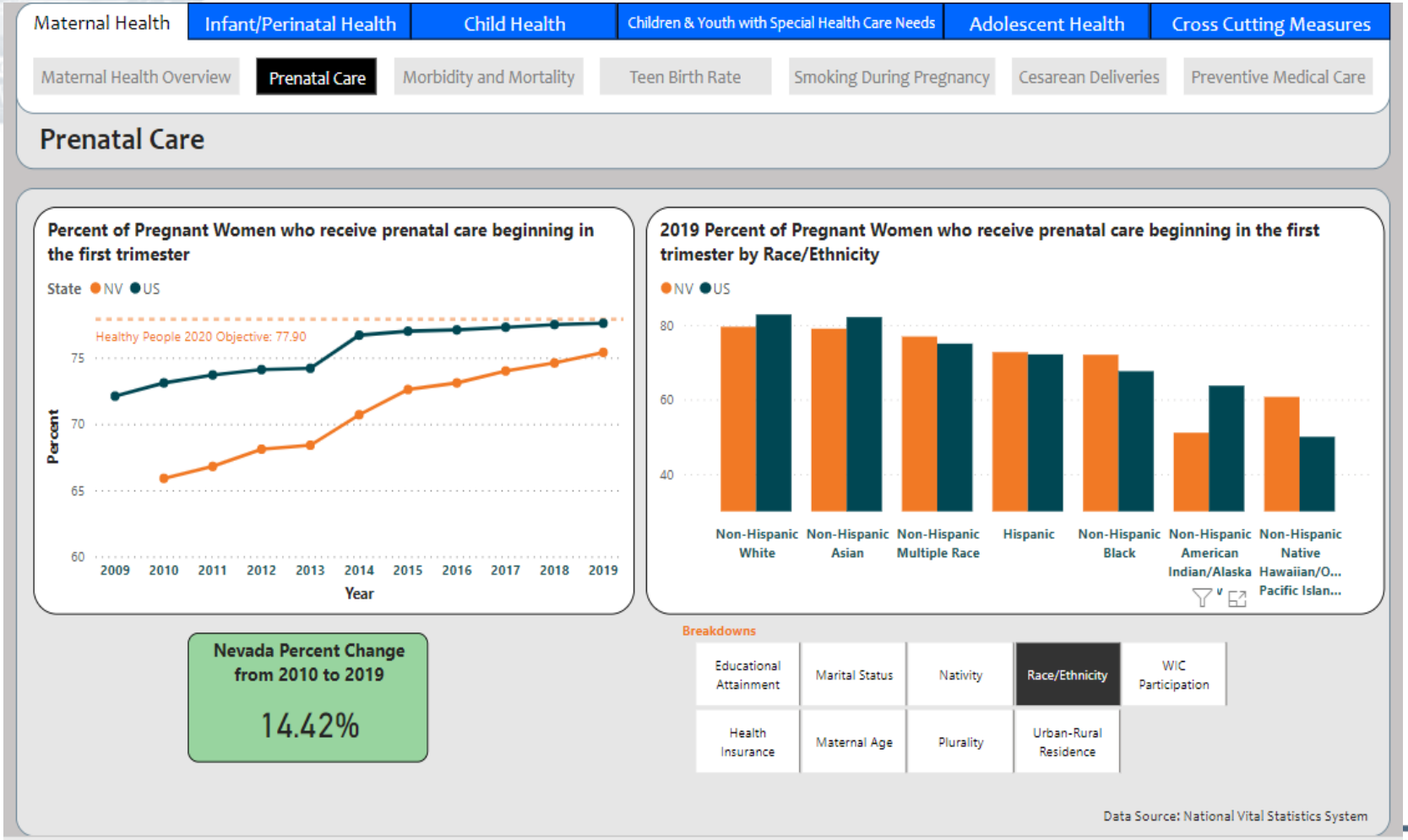
Percent of Women in Nevada who Received Prenatal Care in the First Trimester in 2019



Data Source: National Vital Statistics System

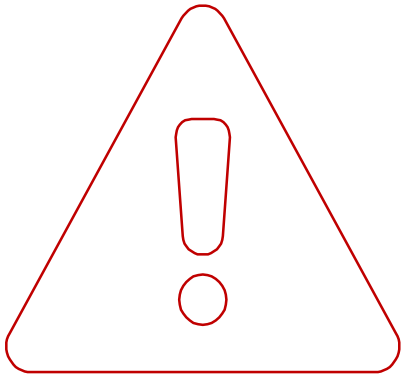
[Link to Data Dashboard]

Data Dashboard

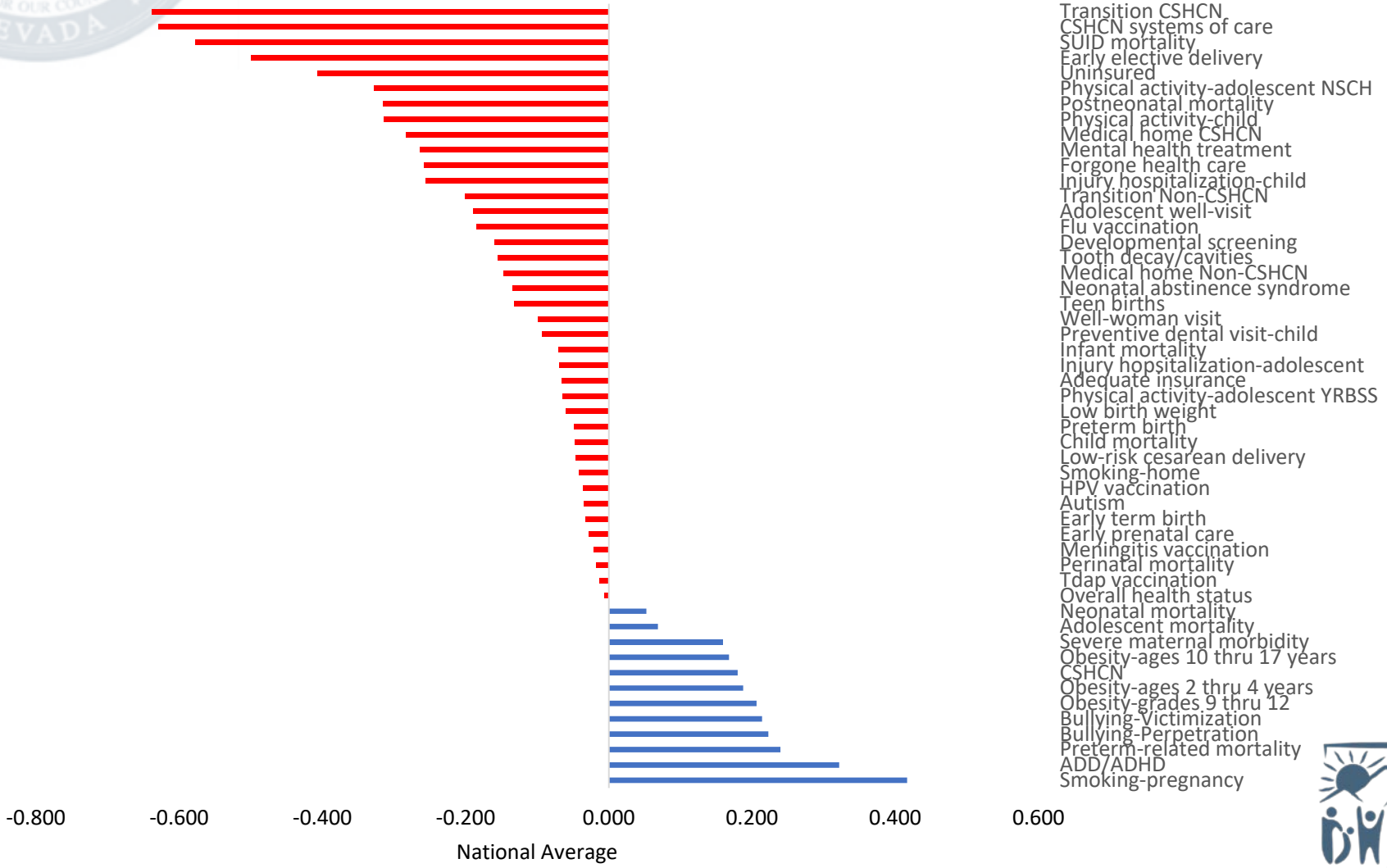


[Link to Data Dashboard]

Nevada Data Trends and Highlights

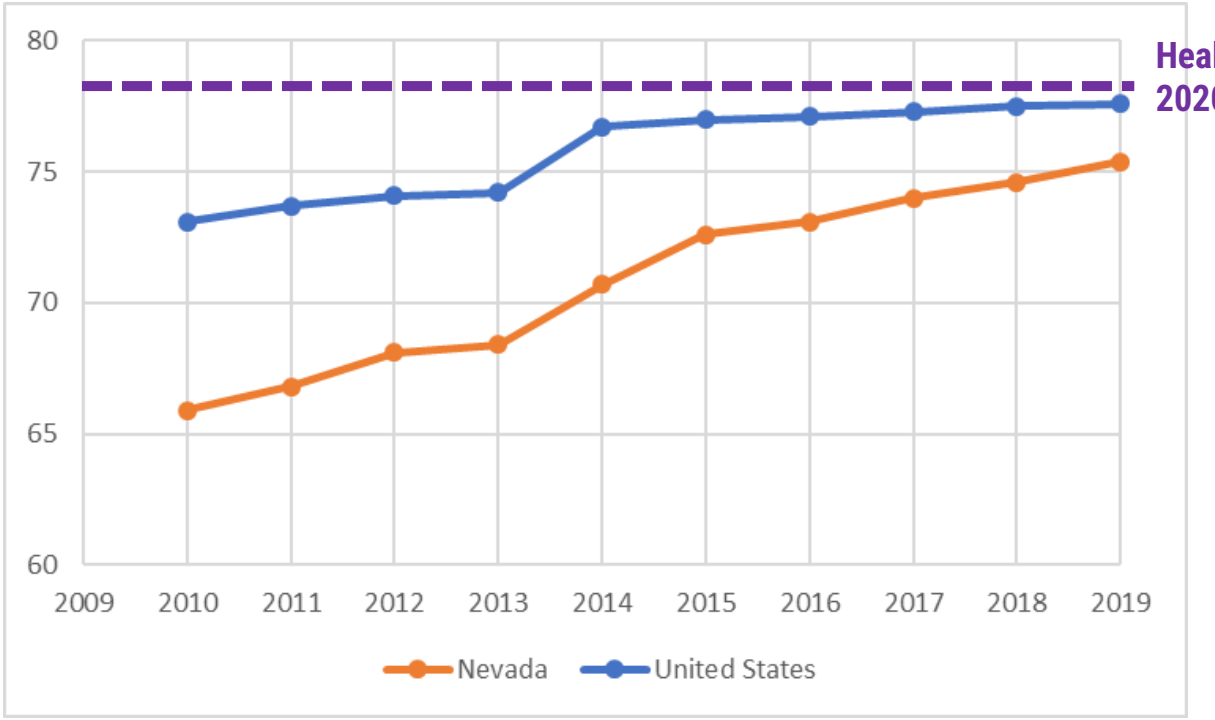


Nevada Maternal and Child Health Indicators



MCH Outcome Measures Positive Trends

NOM 1: Percent Of Women Who Receive Prenatal Care Beginning In The First Trimester

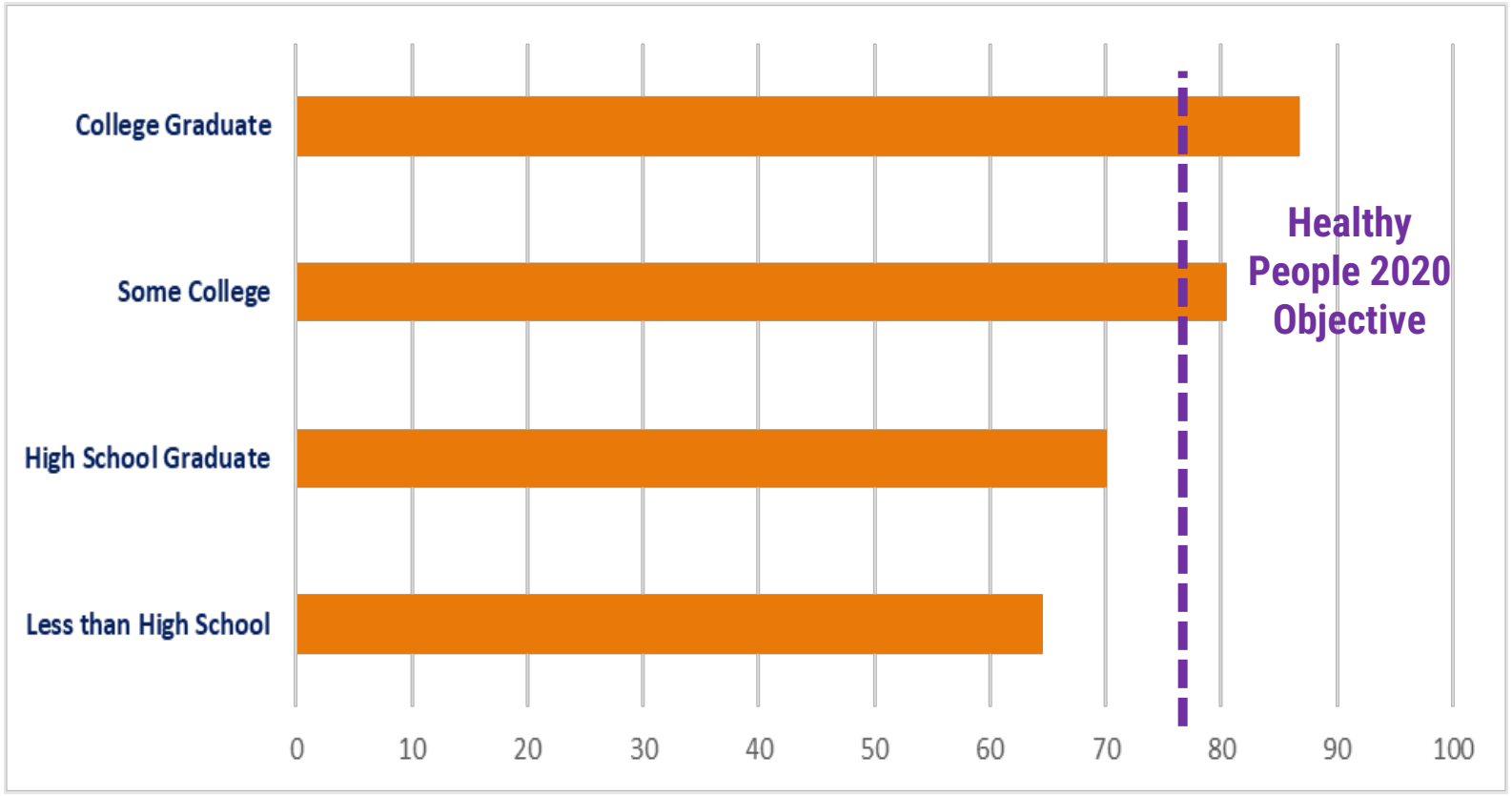


Data Source: National Vital Statistics System (NVSS)

Percent Of Women Who Receive Prenatal Care Beginning In The First Trimester										
	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Nevada	65.9	66.8	68.1	68.4	70.7	72.6	73.1	74	74.6	75.4
United States	73.1	73.7	74.1	74.2	76.7	77	77.1	77.3	77.5	77.6
Healthy People 2020 Objective	77.9									
NV % Change 2010-2019	**+14.42%**									
NV Ranking	**37th** out of 50 states and District of Columbia									

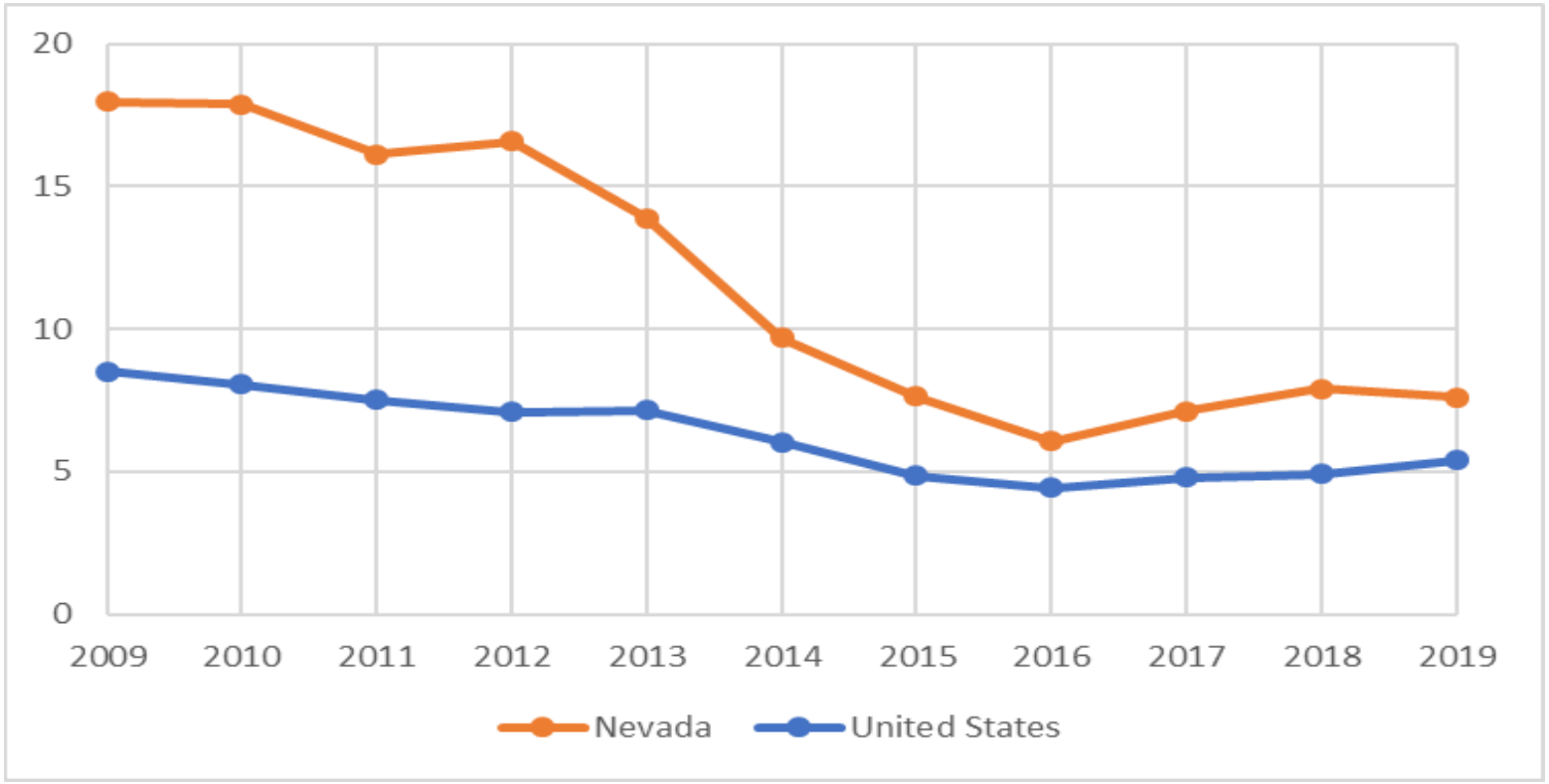
Data Source: National Vital Statistics System (NVSS)

2019 Prenatal Care In The First Trimester By Educational Attainment



Data Source: National Vital Statistics System (NVSS)

NOM 21: Percent Of Children, Ages 0-17, Without Health Insurance



Data Source: American Community Survey (ACS)

Percent Of Children, Ages 0-17, Without Health Insurance											
	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Nevada	17.96	17.86	16.11	16.58	13.89	9.68	7.63	6.06	7.11	7.9	7.6
United States	8.52	8.05	7.5	7.1	7.14	6.02	4.86	4.44	4.79	4.9	5.4
NV % Change 2009-2018	**-57.78%**										
NV Ranking	**45th**										

Data Source: American Community Survey (ACS)

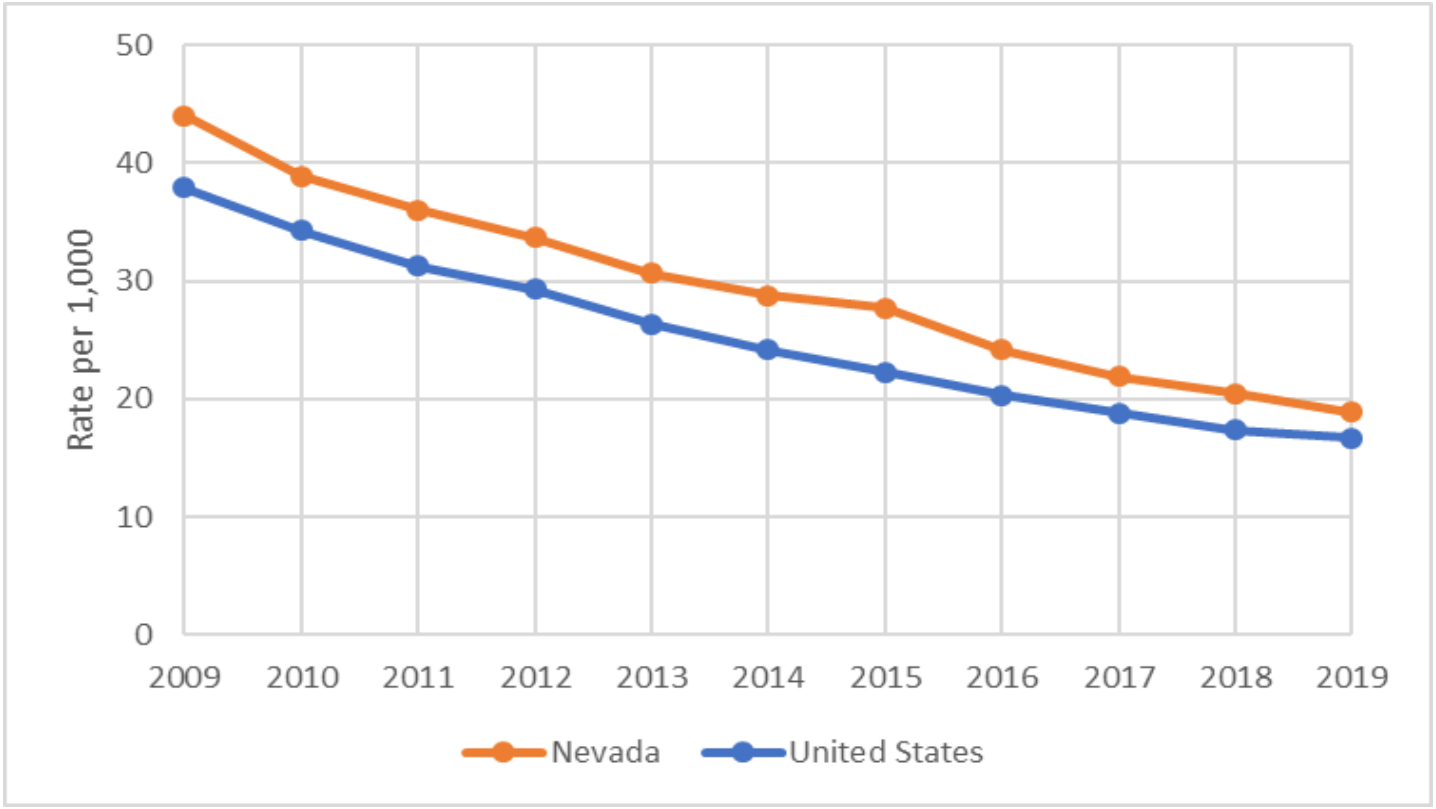
Percent Of Children, Ages 0-17, Without Health Insurance By Race and Ethnicity

	White	Black	Asian	*AI/AN	*API	Multiple Race	Hispanic
2019	4.1	2.2	11.0	2.2	13.1	2.8	12.0
2018	6.2	4.9	5.6	20.9	0	6	10.4
2017	5.3	4.9	7.2	6.5	3.1	4.3	9.8
2016	3.89	4.26	3.03	9.13	3.8	3.5	9.19
Change from 2018-2019							

**AI/AN – American Indian/Alaska Native*
**API - Native Hawaiian/Other Pacific Islander*

Data Source: American Community Survey (ACS)

NOM 23: Teen Birth Rate, Ages 15-19, Per 1,000 Females

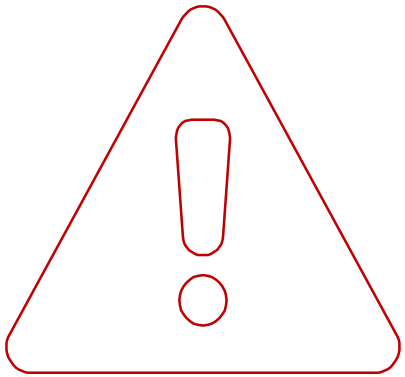


Data Source: National Vital Statistics System (NVSS)

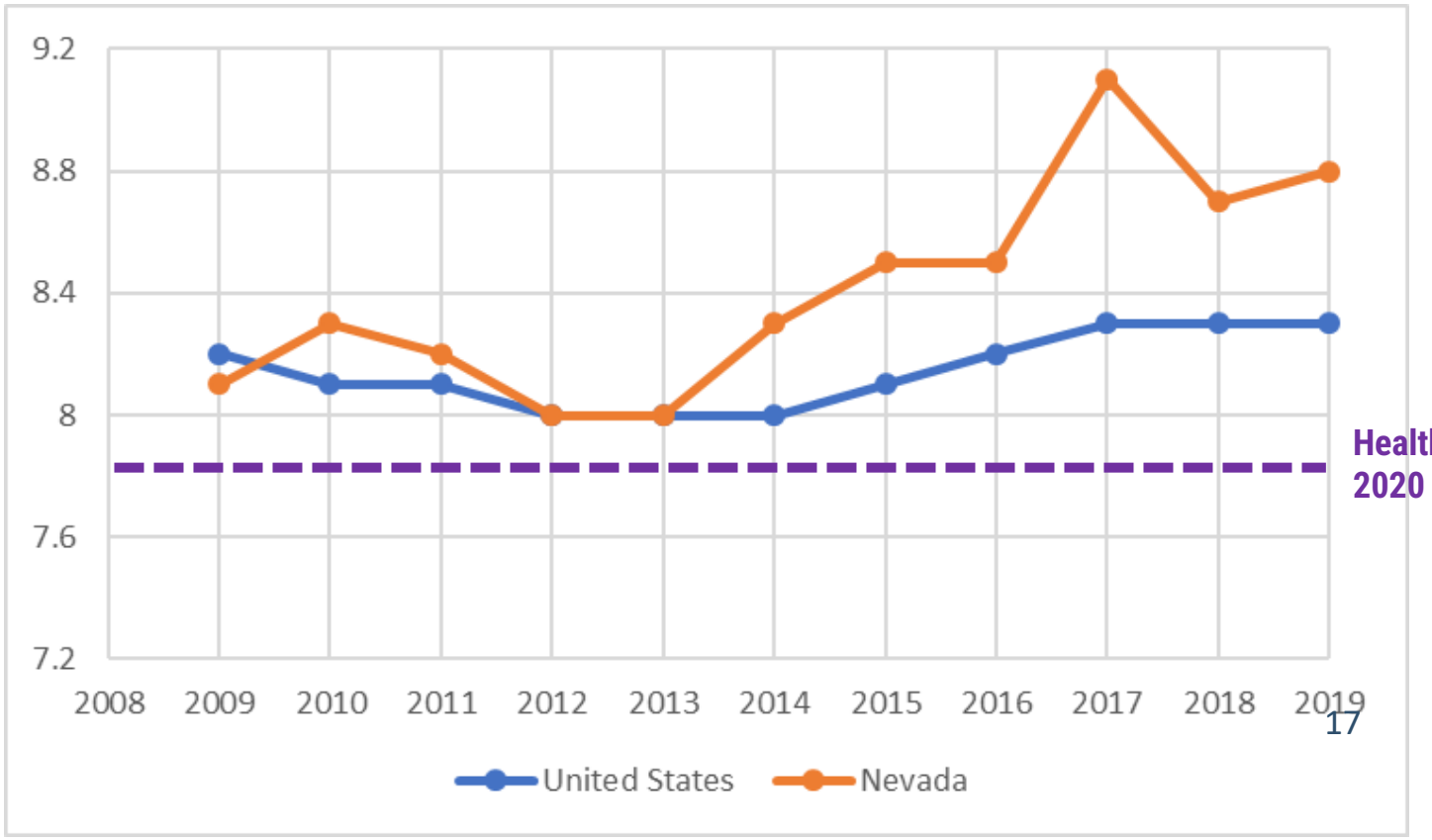
Teen Birth Rate, Ages 15-19, Per 1,000 Females											
	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Nevada	44	38.9	36	33.7	30.7	28.8	27.7	24.2	21.9	20.5	18.9
United States	37.9	34.3	31.3	29.3	26.4	24.2	22.3	20.3	18.8	17.4	16.7
NV % Change 2009-2019	**-57.05%**										
NV Ranking	**34th**										

Data Source: National Vital Statistics System (NVSS)

MCH Outcome Measures Negative Trends



NOM 4: Percent Of Low Birth Weight Deliveries (<2,500 Grams)



Data Source: National Vital Statistics System (NVSS)

Percent Of Low Birth Weight Deliveries (<2,500 Grams)											
	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Nevada	8.1	8.3	8.2	8	8	8.3	8.5	8.5	9.1	8.7	8.8
United States	8.2	8.1	8.1	8	8	8	8.1	8.2	8.3	8.3	8.3
HP 2020 Objective	**7.8**										
NV% Change 2009-2019	**+8.64%**										
NV Ranking	**36th**										

Data Source: National Vital Statistics System (NVSS)

Percent Of Low Birth Weight Deliveries (<2,500 Grams) By Race and Ethnicity

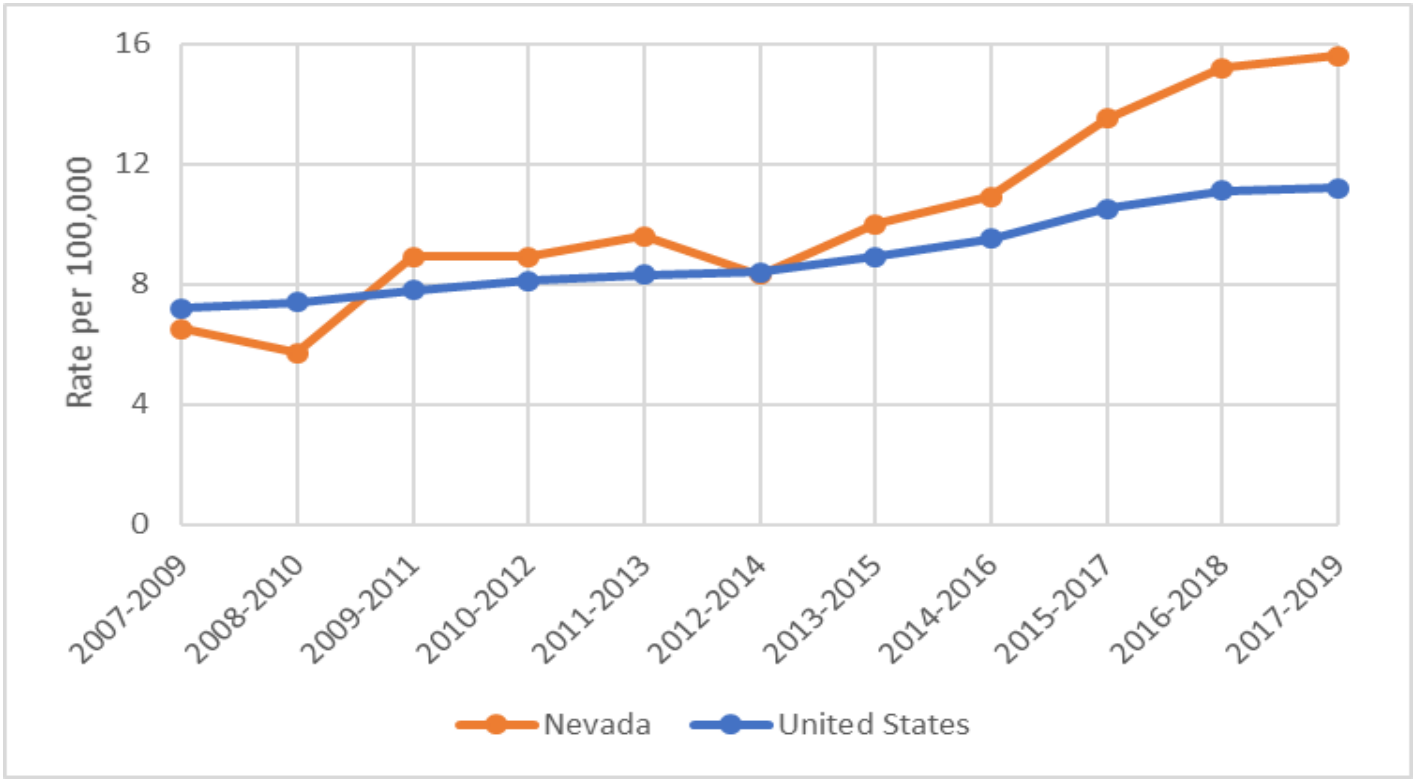
	White	Black	Asian	*AI/AN	*API	Multiple Race	Hispanic
2019	7.6	14.0	10.8	6.1	8.9	9.1	7.7
2018	7.7	12.7	10.2	8.6	10	10.5	7.7
2017	7.9	15.6	9.8	7.9	7.1	10.7	7.9
2016	7.7	14.3	9.1	5.9	11.7	7.8	7.3
Met 2020 HP Objective?							

**AI/AN – American Indian/Alaska Native*

**API - Native Hawaiian/Other Pacific Islander*

Data Source: National Vital Statistics System (NVSS)

NOM 16.3: Adolescent Suicide Rate, Ages 15-19, Per 100,000

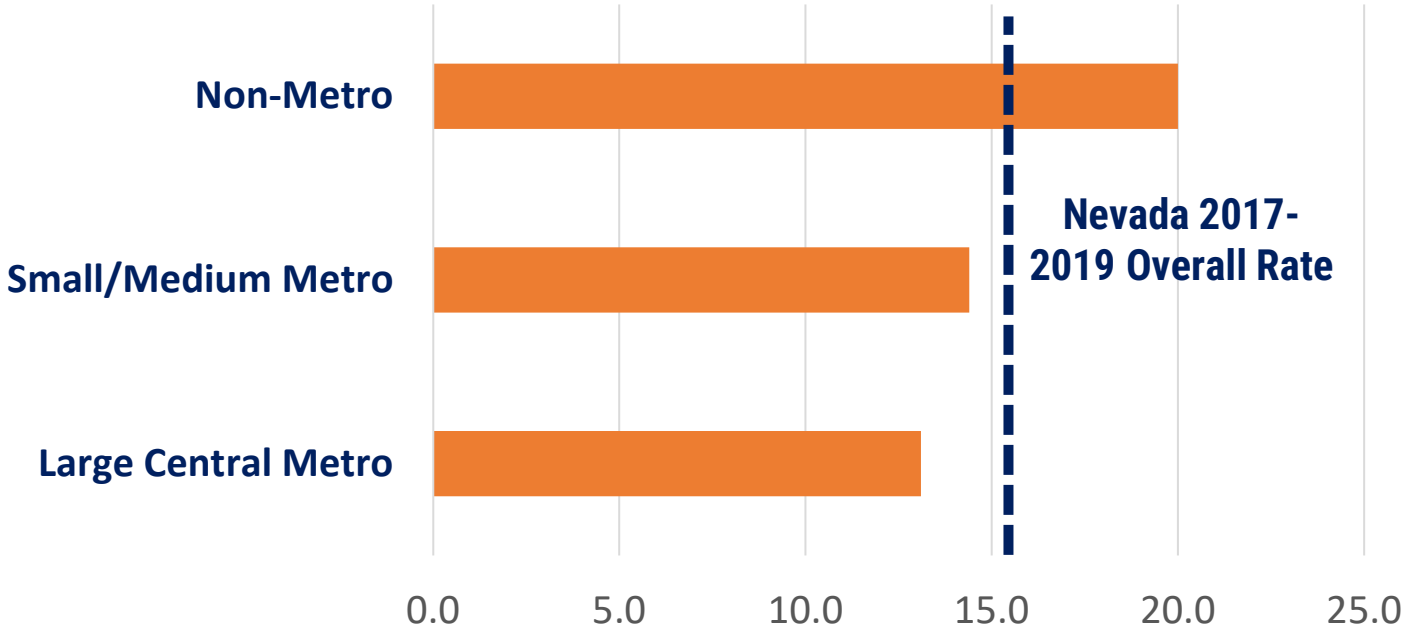


Data Source: National Vital Statistics System (NVSS)

Adolescent Suicide Rate, Ages 15-19, Per 100,000											
	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Nevada	6.5	5.7	8.9	8.9	9.6	8.3	10	10.9	13.5	15.2	15.6
United States	7.2	7.4	7.8	8.1	8.3	8.4	8.9	9.5	10.5	11.1	11.2
NV % Change 2007/2009-2017/2019	**+140%**										
NV Ranking	**35th**										

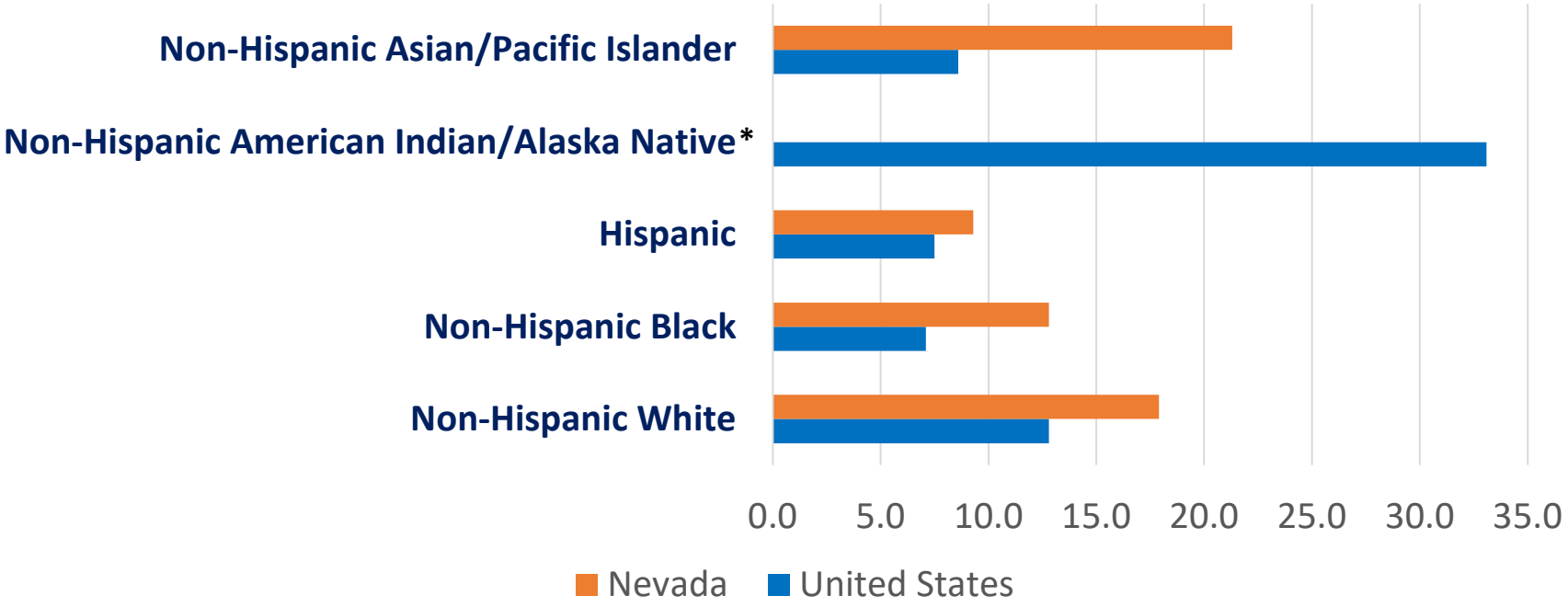
Data Source: National Vital Statistics System (NVSS)

2015-2019 Adolescent Suicide Rate, Ages 15-19, Per 100,000 By Urban/Rural Residence



Data Source: National Vital Statistics System (NVSS)

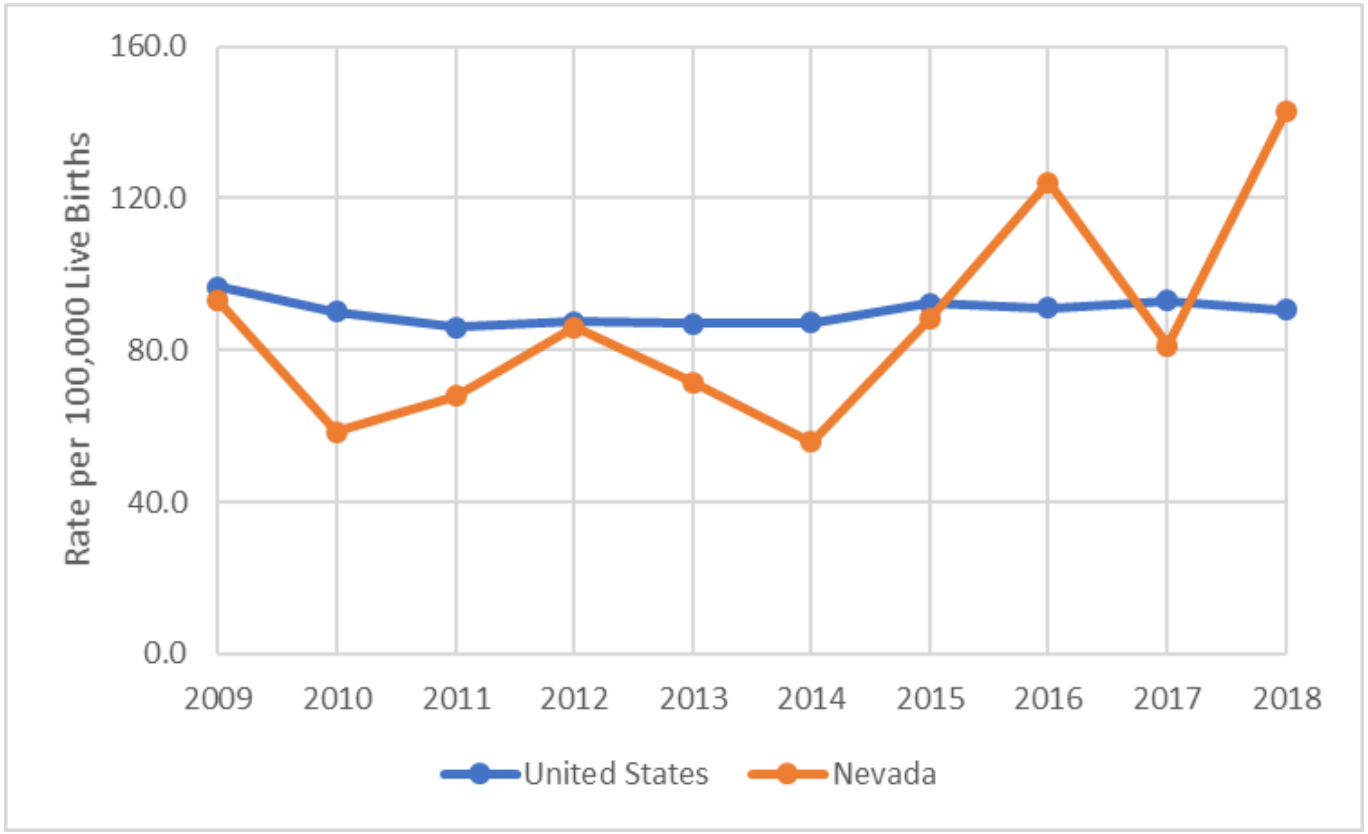
2015-2019 Adolescent Suicide Rate, Ages 15-19, Per 100,000 By Race and Ethnicity



Data Source: National Vital Statistics System (NVSS)

*Nevada data not available

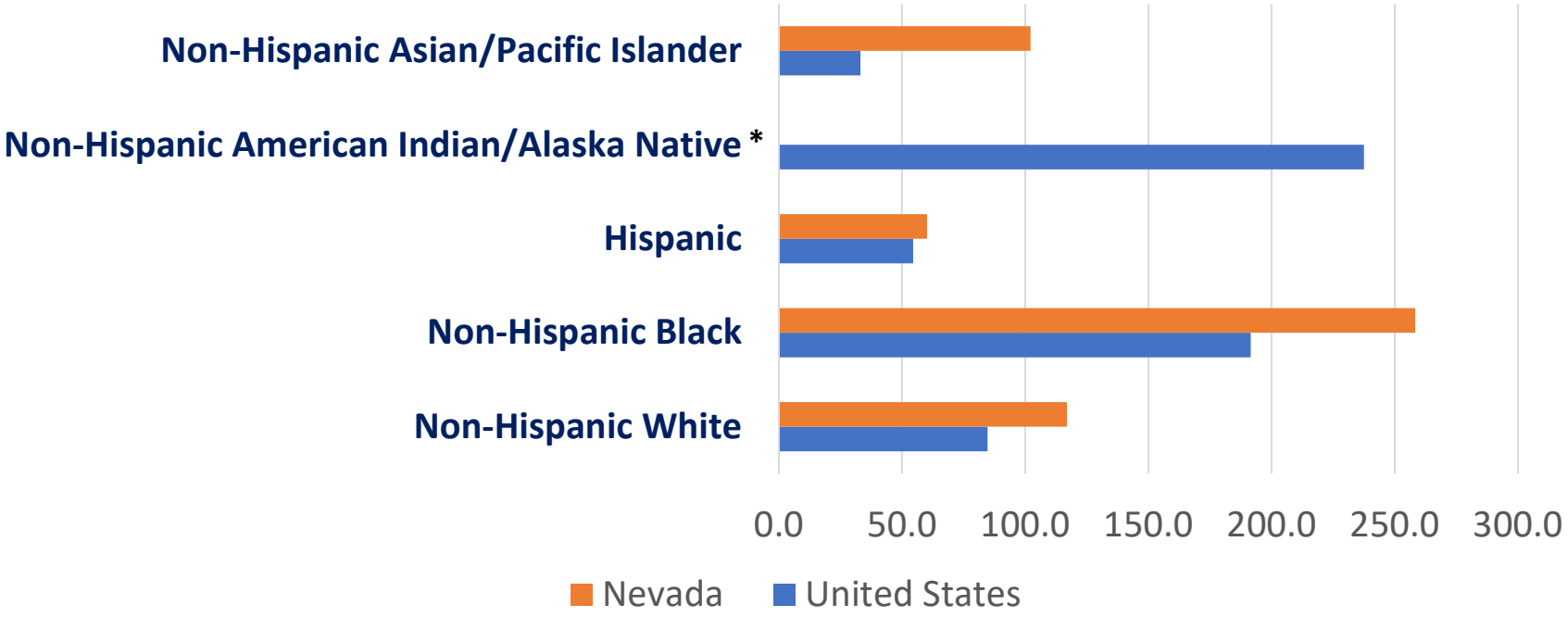
NOM 9.5: Sleep-Related Sudden Unexpected Infant Death (SUID) Rate per 100,000 Live Births



Sleep Related Sudden Unexpected Infant Death Rate (SUID) Rate per 100,000 Live Births										
	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Nevada	93.1	58.4	68.0	85.9	71.4	55.8	88.2	124.1	81.1	142.9
United States	96.7	90.1	86.0	87.4	87.0	87.2	92.2	91.2	93.0	90.6
NV% Change 2009-2018	**+53.49%**									
NV Ranking	39th									

Data Source: National Vital Statistics System (NVSS)

2016-2018 Sleep-Related Sudden Unexpected Infant Death (SUID) Rate per 100,000 Live Births by Race and Ethnicity



Data Source: National Vital Statistics System (NVSS)

*Nevada data not available

Questions?

Contact Information

Kagan Griffin, MPH, RD

Title V MCH Program Manager

kgriffin@health.nv.gov

https://dpbh.nv.gov/Programs/TitleV/TitleV-Home/

Acronyms

- ACS- American Community Survey
- FAD- Federally Available Data
- HP 2020- Healthy People 2020
- MCH- Maternal and Child Health
- MCHB-Maternal Child Health Bureau
- NOM-National Outcome Measure
- NPM-National Performance Measure
- NVSS- National Vital Statistics System