Joe Lombardo
Governor

Laura Rich
Director

DEPARTMENT OF HUMAN SERVICES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Andrea R. Rivers, MS
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

MATERNAL AND CHILD HEALTH ADVISORY BOARD

Meeting Agenda
May 1, 2026
9:00 am to Adjournment

This meeting is a virtual meeting and there is no physical location. The public is invited to attend.
VIRTUAL INFORMATION
Join on your computer, mobile app or room device
Microsoft TEAMS
Meeting ID: 247 478 469 264 59
Passcode: NH3bw7za

Join by phone
+1 775-321-6111, United States, Reno
Phone conference ID: 908 079 202#

NOTICE:

1. Agenda items may be taken out of order;
2. Two or more items may be combined; and
3. Items may be removed from agenda or delayed at any time

1. **CALL TO ORDER/ROLL CALL**
2. **PUBLIC COMMENT**: No action may be taken on a matter raised during the public comment period unless the matter is included on an agenda as an item upon which action may be taken. To provide public comment using the Microsoft Teams application, an individual may raise their hand by clicking the “Raise Your Hand” button (signified by a hand graphic) on the bottom tool bar of the application. To provide public comments telephonically, dial 775-321-6111. When prompted to provide the meeting ID, 908 079 202#. Due to time considerations, comments will be limited to five (5) minutes a person. Members of the public utilizing the call-in (audio only) number may raise their hand by pressing *5. Persons making comments will be asked to begin by stating their name for the record and to spell their last name. Written comments may be submitted by email to Barbara Bessol, bbessol@health.nv.gov.
3. **FOR POSSIBLE ACTION:** Discussion and possible action to approve meeting minutes from February 6, 2026, Maternal and Child Health Advisory Board (MCHAB) meeting
4. **FOR INFORMATION ONLY:** Update on the Nevada Craniofacial Clinic
5. **FOR INFORMATION ONLY: FOR INFORMATION ONLY:** Recommendations for Screening for Domestic Violence and Strangulation in Pregnant, Parenting, and Pediatric Patients
6. **FOR POSSIBLE ACTION:** Data Presentation on Vaccine Coverage and Congenital Syphilis and possible action on recommendations

7. **FOR INFORMATION ONLY:** Presentation on the Nevada Governor's Council on Developmental Disabilities: Down Syndrome Update
8. **For Information Only:** Updates on Maternal and Child Health (MCH) Programs and Alliance for Innovation on Maternal Health (AIM) and Maternal Mortality Review Committee (MMRC)
9. **FOR POSSIBLE ACTION:** Discussion and possible action on recommendations for future agenda items
10. **FOR INFORMATION ONLY:** approved future meeting dates:

    August 7, 2026, at 9:00am

    November 6, 2026, at 9:00am
11. **PUBLIC COMMENT:** No action may be taken on a matter raised during the public comment period unless the matter is included on an agenda as an item upon which action may be taken. To provide public comment using the Microsoft Teams application, an individual may raise their hand by clicking the "Raise Your Hand" button (signified by a hand graphic) on the bottom tool bar of the application. To provide public comments telephonically, dial 775-321-6111. When prompted to provide the meeting ID, 908 079 202#. Due to time considerations, comments will be limited to five (5) minutes a person. Members of the public utilizing the call-in (audio only) number may raise their hand by pressing *5. Persons making comments will be asked to begin by stating their name for the record and to spell their last name. Written comments may be submitted by email to Barbara Bessol, bbessol@health.nv.gov.
12. ADJOURNMENT

NOTICES OF THIS MEETING WERE POSTED AT THE FOLLOWING LOCATIONS:

- The Nevada Division of Public and Behavioral Health website at https://dpbh.nv.gov/Boards/MCAB/Meetings/2025/Maternal_and_Child_Health_Advisory_Board/
- The Department of Administration's website at https://notice.nv.gov.

PHYSICAL POSTING LOCATIONS

- The Nevada Division of Public and Behavioral Health – 4150 Technology Way, Carson City, NV 89706

This body will provide at least two (2) public comment periods in compliance with the minimum requirements of the Open Meeting Law prior to adjournment. Additionally, it is the goal of the MCHAB 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 require a vote are respectfully requested to be submitted to the MCHAB at the below address 30 calendar days prior to the meeting to ensure that adequate consideration is given to the material.

This meeting is a public meeting, recorded and held in compliance with and pursuant to the Nevada Open Meeting Law, pursuant to NRS 241. By Participating, you consent to recording of your participation in this meeting. All voting members should leave their cameras on for the duration of the meeting and refrain from entering any information into the chat function of the video platform.

We are pleased to provide reasonable accommodation for members of the public who are living with a disability and wish to attend the meeting. If special arrangements are necessary, please notify Barbara Bessol in writing by email (bbessol@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 would like to be on the MCHAB mailing

list must submit a written request every six months to the Nevada Division of Public and Behavioral Health at the address listed above.

To join the MCHAB listserv, please follow the directions below to subscribe/unsubscribe to all emails.

Click here to send an email for the MCHAB listserv.

- Include only "subscribe MCHAB" in the body of the email; or
- Include only "unsubscribe MCHAB" in the body of the email.
- Do not include any text in the subject line.

If you need supporting documents for this meeting, please notify Barbara Bessol, Division of Public and Behavioral Health, Bureau of Child, Family and Community Wellness, at (775) 684-4235 or by email at bbessol@health.nv.gov. Supporting materials are available for the public on the Nevada Division of Public and Behavioral Health Website at

https://dpbh.nv.gov/Boards/MCAB/Maternal_and_Child_Health_Advisory_Board_home/ and on the Department of Administration's website at https://notice.nv.gov/.

If at any time during the meeting, an individual who has been named on the agenda or has an item specifically regarding them, including on the agenda is unable to participate because of technical difficulties, please contact Barbara Bessol, Division of Public and Behavioral Health, Bureau of Child, Family and Community Wellness, at (775) 684-4235 or by email at bbessol@health.nv.gov and note at what time the difficulty started to that matters pertaining specifically to their participation may be continued to a future agenda if needed or otherwise addressed.

Please be cautious and do not click on links in the chat area of the meeting unless you have verified that they are safe. If you ever have questions about a link in a document purporting to be from the Maternal and Child Health Advisory Board, please do not hesitate to contact Barbara Bessol, Division of Public and Behavioral Health, Bureau of Child, Family and Community Wellness, at (775) 684-4235 or by email at bbessol@health.nv.gov. Please refrain from commenting in the chat area of the meeting, unless requested to, because minutes are required to be taken of the meeting.

Use of obscenities or other behavior which disrupts the meeting to the extent that orderly conduct is made impractical may result in the forfeiture of the opportunity to provide public comment or removal from the meeting.

MCHAB, DPBH, Attn: Barbara
Bessol 4150 Technology Way,
Suite 210 Carson City, Nevada,
89706

AGENDA ITEM 3

February 6 meeting minutes

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

MATERNAL AND CHILD HEALTH ADVISORY BOARD (MCHAB)

Meeting Minutes

February 6, 2026

9:00 AM until adjournment

This meeting is a virtual meeting and there is no physical location. The public was invited to attend.

VIRTUAL INFORMATION

Join on your computer, mobile app or room device

Microsoft Microsoft TEAMS

Meeting ID: 289 825 272 710 05

Passcode: 3hR7zR3Z

Join by Phone

+1 775-321-6111, United States, Reno

Phone conference ID: 326 490 404#

ATTENDANCE:

Members Present:

- Keith Brill, MD
- Marsha Matsunaga-Kirgin, MD
- Fatima Taylor, M.Ed., CPM
- Elika Nematian, MPH
- Megan Lopez, MS, BS
- Ann DiBiasse, BSN, RN-LC
- Sherri Garland, BSN, RN
- Lora Redmon, BSN, RN, RNC-DB, C-FMC
- Jenna Dykes, MS, BS
- Senator Rochel Nguyen
- Assemblywoman Tracy Brown May

Members Absent:

- No members absent

Staff Present:

- Barbara Bessol, Administrative Assistant III, Maternal, Child and Adolescent Health (MCAH)
- Vickie Ives, MA, Bureau Chief, Child, Family, and Community Wellness (CFCW)
- Alyssa DiBona, Administrative Assistant II, MCAH
- Rachel Marchetti, Health Program Specialist II, MCAH
- Jordan Lancaster, Health Program Specialist I, MCAH
- Sean Watson, Administrative Assistant I, MCAH

DRAFT

- Jazmin Stafford, Health Program Specialist I, MCAH
- Shannon Frazer, Health Program Specialist I, MCAH
- Colleen Barrett, Health Program Specialist II, MCAH
- Tammera Brower, Administrative Assistant IV, MCAH
- Chayne Corpuz, Health Program Specialist I, MCAH
- Cortnee Smith, Health Program Specialist I, MCAH
- Allison Gonzalez, Health Program Specialist I, MCAH
- Karla Rodriguez, Health Program Specialist I, MCAH
- Ryan Spencer, Program Officer, MCAH
- Sarah Rogers, Deputy Bureau Chief, CFCW
- Helina Ashagrie, Health Program Specialist I, MCAH

Guests Present:

- Kelly Forbes, Washe County Safe Babies Court
- Steve Messinger, Nevada Primary Care Association
- Jennifer Bevacqua, Safe Babies, DCFS
- Toni Orr
- Kate Reynolds
- Daniela González Alvarez
- Sabrina Petrel
- Abigail Hatefi
- Gabriela Duarte
- Kelly Verling
- Dr. Gabriela Buccini, UNLV School of Public Health
- Jollina Walker, The Birth Collaborative
- Maria Palapa, UNLV School of Public Health
- Tiffiany Olivas, Children's Cabinet
- Cristina H.

Agenda Item 1

Call to Order and Introduction

The meeting was called to order at 9:01 AM.

Agenda Item 2

First Public Comment Period

No public comment was offered.

DRAFT

Agenda Item 3

FOR POSSIBLE ACTION: Discussion and possible action to approve meeting minutes from the December 19, 2025, Maternal and Child Health Advisory Board (MCHAB) meeting

Chairman Dr. Keith Bill called for a motion to approve the December 19 meeting minutes. Megan Lopez moved to approve the minutes, and Fatima Taylor seconded the motion. The motion passed unanimously.

Agenda Item 4

FOR POSSIBLE ACTION: Discuss and make possible recommendations on upcoming priorities for 2026

Dr. Brill requested clarification on the agenda item. Vickie Ives explained that the item allowed the Board to make recommendations to the Administrator or request additional data for future presentations.

Ms. Taylor requested an update on whether further support is needed for the Craniofacial Clinic.

Ms. Lopez stated she would like to present at the next meeting on improvements to screening and response to domestic violence, with a focus on strangulation in adult and pediatric patients.

Dr. Brill requested data on measles vaccination rates and cases. Ms. Ives confirmed that school and childcare facility data along with current exemption rates are sitting at approximately 6%. The exact figures will be shared along with the measles data at the next meeting.

Ms. Ives noted a raised hand and opened the floor.

Ms. Taylor requested an update from an individual on the DD Council on the portion of NRS 442 legislation regarding the evidence-based resources and information on patients both prenatally and postnatally. Ms. Taylor would also like information on any additional websites that have been created that would have this type of information.

Ms. Ives stated she would contact Kathryn Nielsen, Executive Director of the DD Council.

Dr. Brill requested information on syphilis rates in pregnancy and congenital syphilis.

Ms. Ives shared that syphilis rates remain an urgent concern in Nevada. She noted that legislative measures were recently passed to support efforts in this area; however, a full year of post-implementation data is not yet available to assess changes in screening rates. Once a complete year of data has been collected, it would be helpful to present an analysis of screening trends along with a comprehensive syphilis update. Ms. Ives agreed that as it has been at least a year since the last update on syphilis it would be a good idea to get one scheduled for an upcoming meeting.

Dr. Brill moved to approve the stated priorities. Lora Redmond seconded the motion. The motion passed unanimously.

DRAFT

Agenda Item 5

FOR INFORMATION ONLY: Presentation of the Perinatal Health Initiative (PHI) and the EMPOWERED Program

The Board received a presentation on the Perinatal Health Initiative (PHI) from Abigail Hatefi. The presentation is available in the meeting packet on the DPBH MCHAB Board website.

Ms. Lopez asked whether the initiative includes assessing a history of trauma or current abuse, noting the correlation between substance use and traumatic experiences.

Ms. Hatefi stated that the initiative does not directly interact with clients but does address the importance of creating a stigma-free healthcare environment within its reference guides.

Dr. Brill requested clarification on whether the maternal mortality due to overdose data reflected specific regions, hospitals, providers, socioeconomic groups, or statewide aggregate results. He further noted that providers often focus on physical interventions identified by the Maternal Mortality Review Committee, while mental health factors may be overlooked. He asked whether available data indicates where additional intervention efforts should be directed beyond current screening practices.

Ms. Hatefi responded that the issue is statewide and that one PHI initiative is universal screening to improve data collection. She noted that universal screening is not yet fully implemented and emphasized the value of resources such as roundtable discussions. She added that higher percentages in Clark County likely reflect its larger population.

Dr. Brill asked whether a feedback loop exists to notify obstetricians when a patient dies of an overdose.

Ms. Hatefi agreed with the importance of such a process.

Ms. Ives stated she was not aware of an existing feedback mechanism.

Ms. Hatefi informed the Board that the second scheduled presenter, Dr. Andrea Peterson, was unable to attend; therefore, the EMPOWERED Program presentation was not delivered. The presentation is available in the meeting packet on the DPBH MCHAB Board website.

Agenda Item 6

FOR INFORMATION ONLY: Coordinates Intake Referral System (CIRS) Executive Summary

The Board received a presentation on the Coordinated Intake Referral System (CIRS) Executive Summary from Tiffany Olivas. The presentation is available in the meeting packet on the DPBH MCHAB Board website.

Agenda Item 7

FOR INFORMATION ONLY: Presentations on the University of Nevada, Reno (UNR) Extension and University of Nevada, Las Vegas (UNLV) Early Responsive Nurturing Care for Food Security Programs

DRAFT

The Board received a presentation on the University of Nevada, Las Vegas (UNLV) Interventions to Address Maternal–Child Food Insecurity from Gabriela Buccini. The presentation is available in the meeting packet on the DPBH MCHAB Board website.

The Board also received a presentation on the University of Nevada, Reno (UNR) Healthy Kids, Early Start Program from Elika Nematian. This presentation is available in the meeting packet on the DPBH MCHAB Board website.

Agenda Item 8

FOR INFORMATION ONLY: Updates on Maternal and Child Health (MCH) Programs and Alliance for Innovation on Maternal Health (AIM)/Maternal Mortality Review Committee (MMRC) Updates

Vickie Ives provided updates on three programs: Maternal and Child Health (MCH), the Alliance for Innovation on Maternal Health (AIM), and the Maternal Mortality Review Committee (MMRC).

Ms. Ives reported that the AIM program has onboarded a new hospital. She noted that not all birthing hospitals in the state are currently enrolled and encouraged members to share contacts who may be interested. She expressed appreciation for hospitals participating in both the hypertension and hemorrhage patient safety bundles. With full staffing restored, outreach efforts will continue to increase.

Ms. Ives then provided an update on MMRC. She stated that the Centers for Disease Control and Prevention (CDC) will be conducting a presentation and observation with the MMRC group, which includes MCAH staff, service support staff, and members appointed by the Office of the Director, for a total of 12 members as outlined in statute.

She noted that the biennial report due December 31 will be submitted to the Legislative Counsel Bureau for dissemination to the appropriate committees. MMRC also receives feedback and recommendations from the Commission on Minority Health and Equity that the group may also comment on.

Ms. Ives explained that MMRC conducts case reviews and shared a graphic summarizing findings. She reported that most pregnancy-associated deaths fall under the non-transport accidents category, with 86% attributed to drug overdoses. She noted that variability exists across groups and geographic areas, but the leading causes of death remain consistent among two (2) distinct groups. She provided definitions for pregnancy-associated deaths (death during pregnancy or within one year of the end of pregnancy, regardless of cause) and pregnancy-related deaths (death caused or aggravated by pregnancy).

Ms. Ives reviewed a high-level summary of systems-level, community-level, and provider-level recommendations, highlighting screening for Adverse Childhood Experiences (ACEs), priority access to mental health and substance use treatment for pregnant individuals, and no-cost medication-assisted treatment. She directed members to a QR code linking to the full report and recommendations.

Ms. Ives informed the Board of an upcoming maternal-fetal medicine meeting the week of February 9th, as well as a no-cost maternal mortality focused session hosted by the CDC and the Society for Maternal-Fetal Medicine scheduled for Tuesday, February 10, 2026, from 9:00 a.m. to 12:00 p.m.

DRAFT

Turning to the Maternal and Child Health Title V Block Grant, Ms. Ives noted ongoing collaboration with the Office of Food Security and external partners in food security, housing stability, policy, and technical assistance through AMCHP. She stated that the 2025–2030 priority topics for Title V staff include increasing access to affordable, nutritious foods and increasing physical activity among school-age children.

Ms. Ives reported staffing updates, including the hiring of a Title V Manager and active recruitment for a Maternal Infant Programs Coordinator. She also noted Title V's application to work with Medicaid to strengthen integration between Medicaid and Title V efforts for maternal and child health populations.

Ms. Ives announced an upcoming presentation to the Patient Protection Commission on maternal and child health. She also described a Title V pilot project supporting training for family medicine and pediatric providers in child abuse recognition and certification, noting the limited availability of specialized programs and residencies in this area.

Dr. Brill asked whether there had been any changes in CDC participation or attitudes toward MMRC due to changes in federal administration. Ms. Ives responded that she had not observed any such changes and stated that MMRC continues to receive strong CDC support. She added that while other programs have experienced language or policy changes, MMRC has not.

Ms. Ives stated that school and early childcare facilities are set in statute and regulation; therefore, changes to the federal schedule do not affect state law or state regulations. Ms. Ives also reported no changes in federally funded immunization programs, which continue to purchase and distribute vaccines.

Dr. Brill noted an upcoming meeting of the Joint Interim Health Committee on February 17. Ms. Ives confirmed the date and stated that an email with the meeting link and reference materials would be distributed.

Assemblywoman Tracy Brown-May, Chair of the Interim Committee on Health and Human Services, informed the Board that the February 17 meeting will include a robust agenda focused on maternal, infant, and fetal mortality and health programs.

Agenda Item 9

FOR POSSIBLE ACTION: Discussion and possible action on recommendations for future agenda items

Dr. Brill informed the Board of the upcoming Senate Bill 455 and House Resolution 1061, known as the Protecting Sensitive Locations Act. No motions were made.

Agenda Item 10

FOR INFORMATION ONLY: approved future meeting dates

Dr. Brill noted that the upcoming meeting dates have already been approved and stated that this item served as an informational reminder.

Agenda Item 11

Second Public Comment Period

No public comment was offered.

DRAFT

Agenda Item 12

Adjournment

The meeting was adjourned at 10:48 am.

Minutes were prepared by Alyssa DiBona, Administrative Assistant II, Maternal, Child, and Adolescent Health Section, Bureau of Child, Family and Community Wellness, Nevada Division of Public and Behavioral Health.

DRAFT

AGENDA ITEM 4

Nevada Cleft & Craniofacial Clinic

KIRK KERKORIAN SCHOOL OF MEDICINE | UNLV

Cleft & Craniofacial Clinic Update

Presented to the State of Nevada Advisory Board on Maternal and Child Health

UNLV | SCHOOL OF DENTAL MEDICINE

Program Overview & Early Impact

Clinic Reopening & Care Model

- Reopened in October 2025 utilizing a multidisciplinary care model
- Currently operating 1 clinic per month (first Tuesday)
- Target capacity: ~10 patients per clinic day

Early Feedback & Impact

- High family satisfaction
- Strong appreciation for coordinated, one-stop care
- Increased patient and parent comfort and confidence

Care Model & Patient Experience

Patient Experience Model

- Comprehensive consultation appointments
- Same-day evaluations from full multidisciplinary team
- Ongoing coordination of care with external providers

During Each Visit

- Referrals provided (surgery, specialty care, etc.)
- Follow-up appointments scheduled prior to departure

Care Continuity & Outcomes

- Patients are connected to long-term care pathways
- Each patient leaves with ndividualized care plan, next steps

Capacity & Expanding Access

Patient Demand & Capacity

- On track to serve ~120 patients in year one
- ~850 patients identified through referrals and direct outreach

Key Insight

- Demand significantly exceeds current capacity

Opportunity for Expansion

- Increasing from 1 to 2 clinic days per month could effectively double patient capacity
- What's needed for expansion:
  a. Staff Capacity
  b. Sustained Funding

Team Development & Accreditation

Team Growth & Strategic Focus

- Team has steadily expanded since October 2025

Current Focus

- Strengthening care coordination across specialties
- Enhancing consistency in patient experience and clinical collaboration

Key Priority: National Team Accreditation

- April was the first full month with all required specialists in place
- Next step: Submit accreditation application within 3 months
- Focus on building strong documentation

Operational Progress & Looking Ahead

Progress to Date

- Restoring access to care for patients and families
- Reducing fragmentation through coordinated, team-based care
- Reestablishing a comprehensive multidisciplinary clinic structure

Looking Ahead

- Pursuing national team accreditation
- Expanding team capacity and clinic availability
- Addressing emerging mental health needs through strengthened referral pathways and resource alignment

Questions?

Chelsey Nicol
chelsey.nicol@unlv.edu
(702) 774-2450

AGENDA ITEM 5

SafeNest

Recommendations for Screening for DV and Strangulation in Pregnant, Parenting, and Pediatric Patients

Megan Lopez

SafeNest's VP of One Safe Place

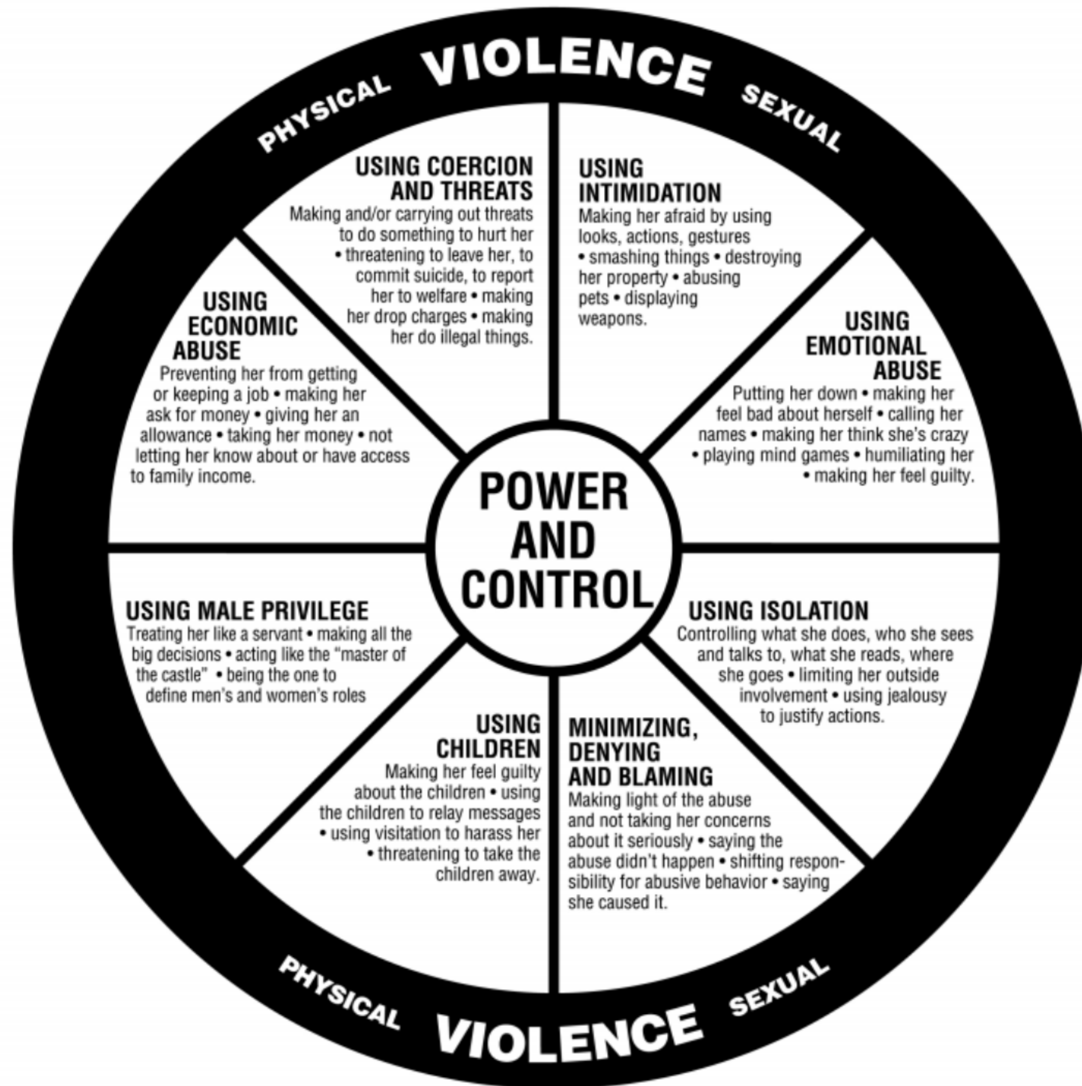
Take care of yourself.

"Abuser" and "victim" terms

Heterosexual relationship examples

SafeNest

What is Domestic Violence?



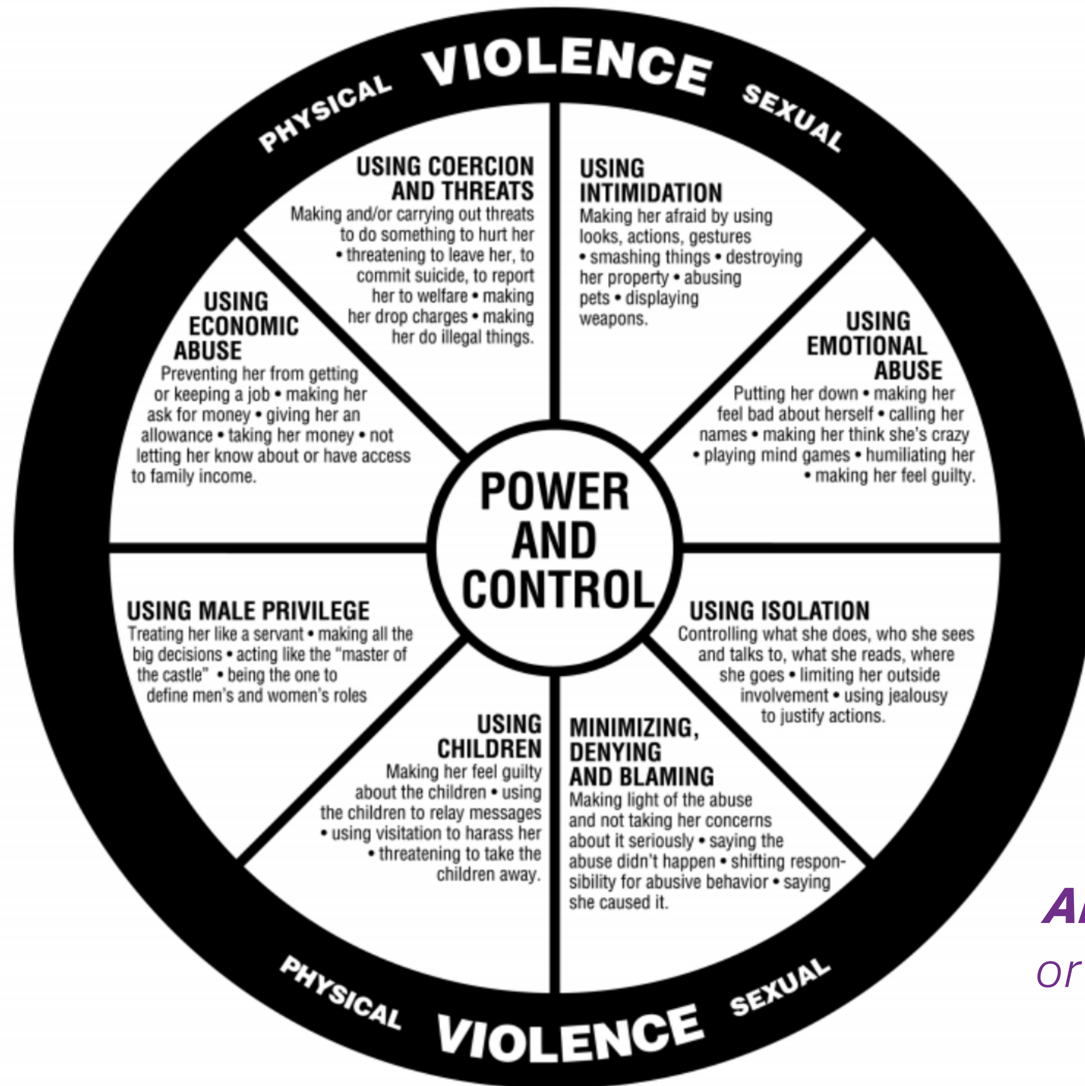
A pattern of behavior in any domestic relationship (intimate partner or family) that is used to gain or maintain **power** and **control** over another person.

United Nations

Source: Domestic Abuse Intervention Project (Duluth, MN)

SafeNest

What is Domestic Violence?



- Child abuse
- Elder/vulnerable adult abuse
- Reproductive coercion
- Spiritual abuse
- Litigation abuse
- Stalking
- Technology abuse

Anything *can be abuse if it's being used to gain or maintain* ***power and control*** *over the victim.*

Source: Domestic Abuse Intervention Project (Duluth, MN)

SafeNest

What is Domestic Violence?

Violence in Relationships

1 in 3 women and **1 in 6 men** experience violence in a relationship in their lifetime

DV Homicides

3 women are murdered by their current or former male intimate partner **every day** in the US

DV Murder-Suicides

On average, there is **1 murder-suicide per day** in the US (not counting those that fail)

95% of perpetrators are men.

Family Annihilation

Since 2020, the rate of family annihilations has increased to **1 every 5 days** in the US.

91% of perpetrators are men.

Mass Shootings

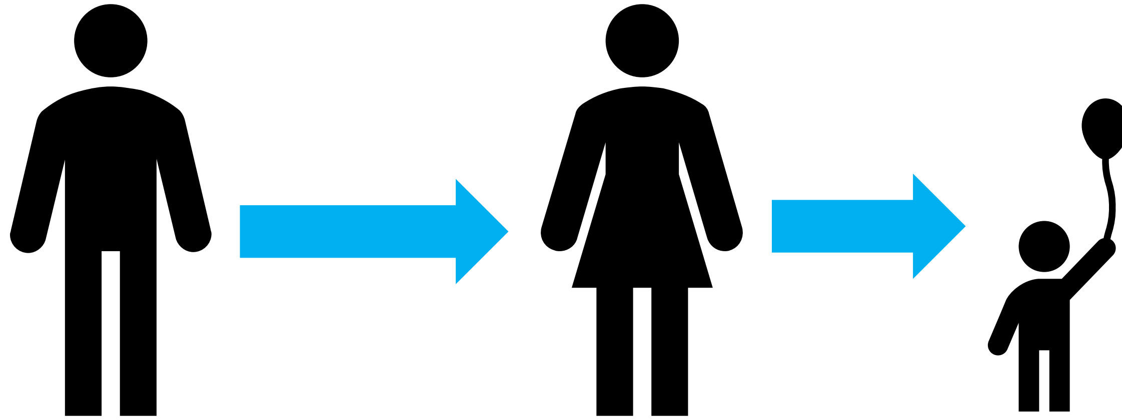
68% of mass shootings are related to DV.

Those whose intended target was the victim of abuse had **higher case fatality rates (84%)**.

Source: CDC, DomesticShelters.org, Indy Star, Gun Violence Archive, Office of the Administration for Children and Families, National Institutes of Health

SafeNest

What is Domestic Violence?



Men who batter their female partners **also abuse the children 30-60%** of the time.

80-90% of victims abuse or neglect **their children**.

- Approximately **15.5 million children witness** DV every year.
- **90%** are direct eyewitnesses.
- In children who grow up with DV, **girls are more likely to become victims** in future relationships and **boys are more likely to become abusers**.
- Teens in abusive relationships are **less likely to report at all**.

Source: National Institutes of Health

SafeNest

What is Domestic Violence?

Three Types of ACEs

ABUSE

Physical

Emotional

Sexual

NEGLECT

Physical

Emotional

HOUSEHOLD DYSFUNCTION

Mental Illness

Incarcerated Relative

Mother treated violently

Substance Abuse

Divorce

BEHAVIOR

Lack of physical activity

Smoking

Alcoholism

Drug use

Missed work

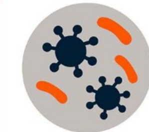
PHYSICAL & MENTAL HEALTH

Severe obesity

Diabetes

Depression

Suicide attempts


STDs

Heart disease

Cancer

Stroke

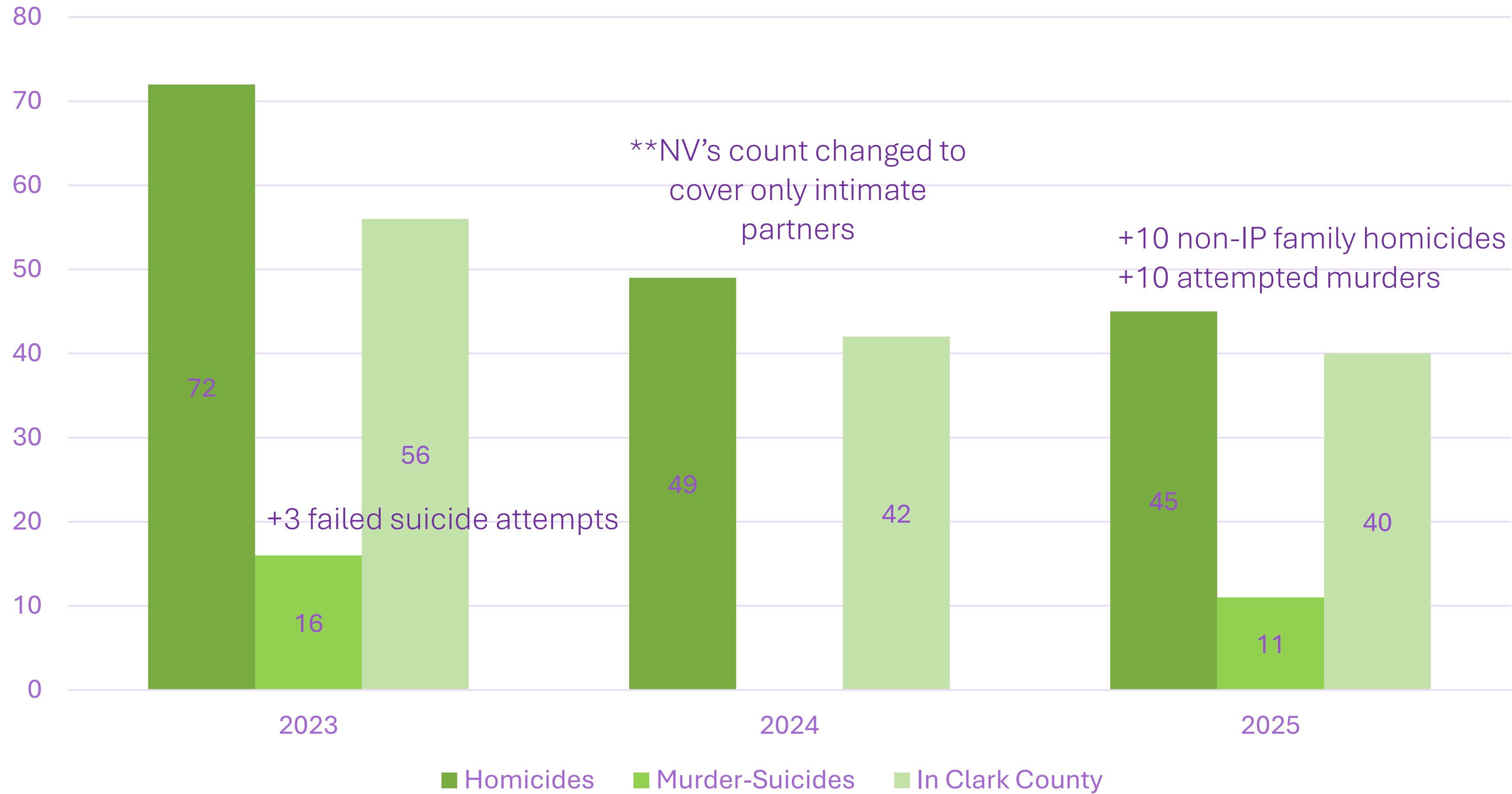
COPD

Broken bones

Source: CDC-Kaiser Permanente Adverse Childhood Experiences (ACEs) Study

SafeNest

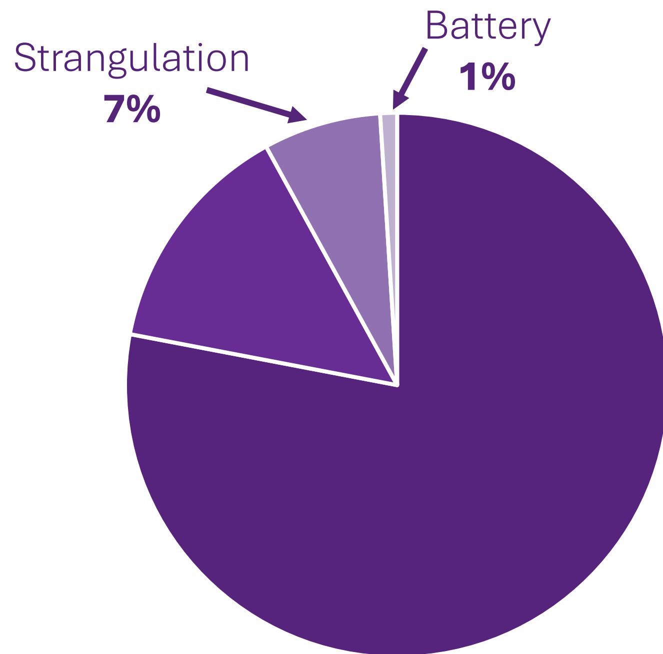
What is Domestic Violence?

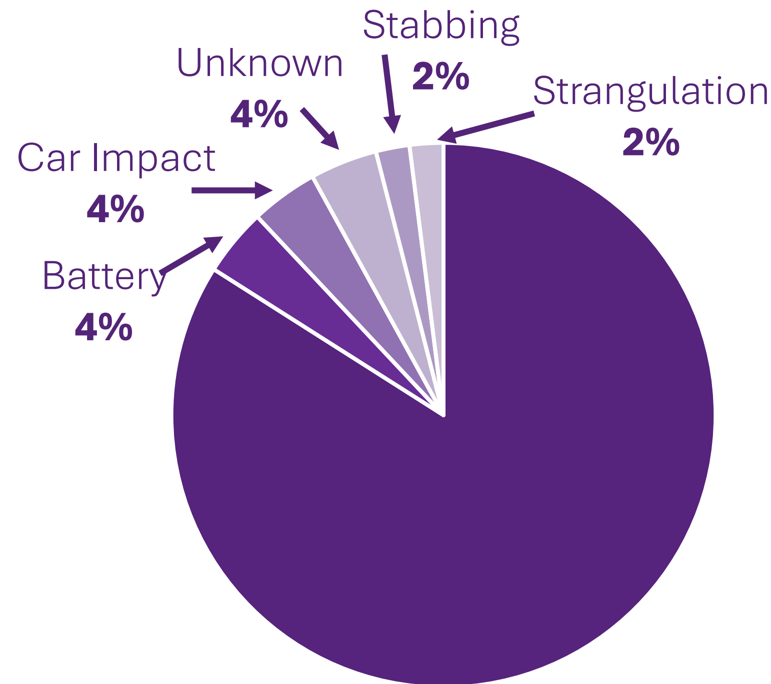


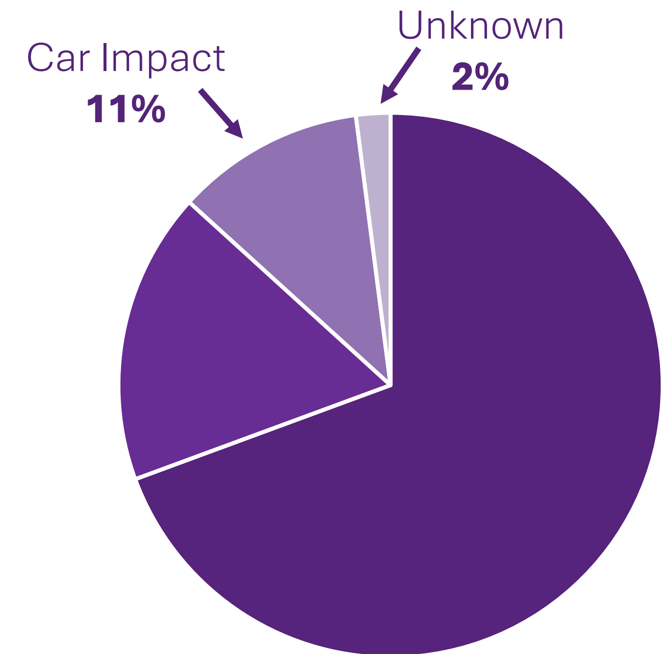
Source: Nevada Coalition to End Domestic and Sexual Violence

SafeNest

What is Domestic Violence?



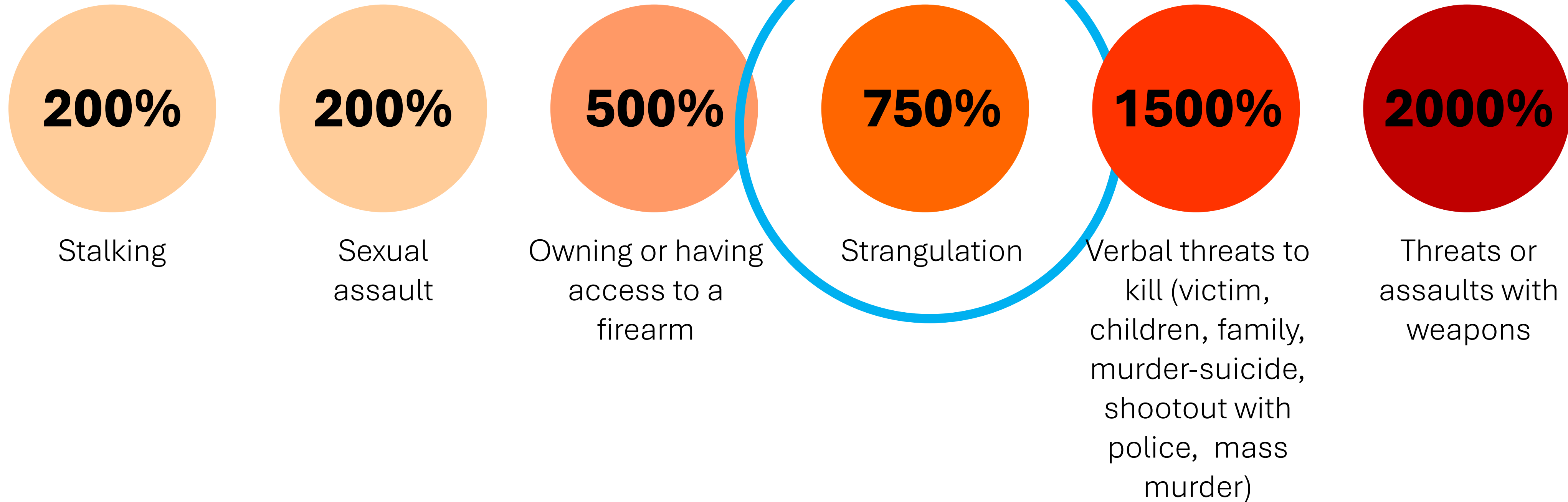




Source: Nevada Coalition to End Domestic and Sexual Violence

SafeNest

What is Domestic Violence?



Source: Dr. Jacquelyn Campbell, developer of the Danger Assessment

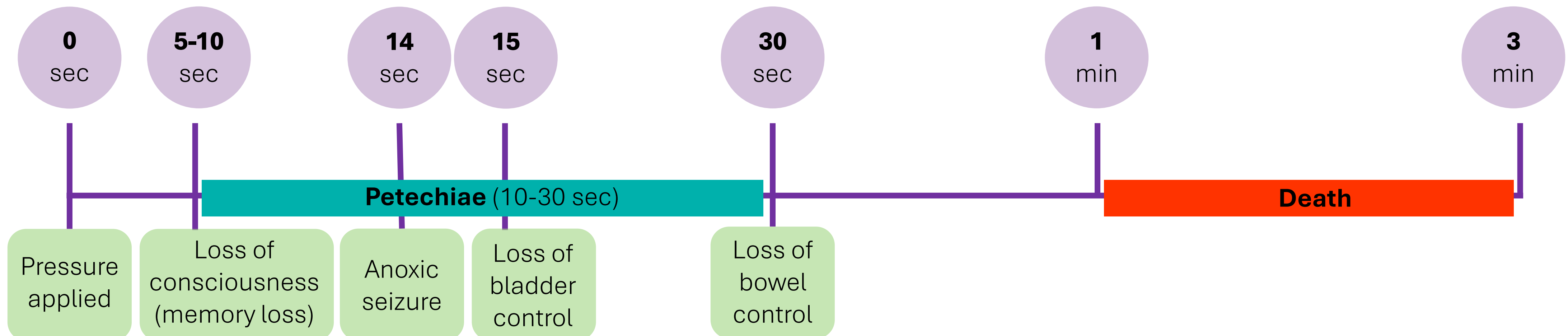
SafeNest

Strangulation

- Only leaves visible bruising/injuries 50% of the time (even in fatal cases)
- Victims can die days/weeks/months after a strangulation incident
- Most victims minimize strangulation because they survived it
- Very little pressure needed to obstruct air and blood flow and leads to death very quickly.

Strangulation is the calling card of a **killer**.

- Gael Strack



Source: Training Institute on Strangulation Prevention

SafeNest

Pregnancy

The **most dangerous times** for a person experiencing violence in their relationship:

Right after **separation** and up to 2 years afterward

77% of DV-related homicides occur upon separation.

During **pregnancy**

Homicide is the leading cause of death for pregnant people in the US, outnumbering deaths from hypertensive disorders, hemorrhage, or sepsis.

Source: Battered Women's Support Services, Harvard T.H. Chan School of Public Health

SafeNest

Pregnancy

Impact on **Pregnant Person**

- Higher likelihood that **pregnancy is unintended** or result of sexual assault
- Increased **bleeding**, anemia
- Increased risk of **mental health issues** (anxiety, depression), leading to increased risk of **smoking and substance use**
- **Poor weight gain** and unhealthy eating patterns
- **Delayed healing** from birth (c-section rupture, forced sex before victim recovers)
- Increased risk of **postpartum depression**
- Increased risk of **homicide and feticide**

77% of pregnant homicide victims are killed in the **first trimester**.

Impact on **Pregnancy**

- **Miscarriage, stillbirth, or premature birth** (unintentional or intentional)
- Spread of **STDs**
- Low **birth weight**
- Toxic **stress**
- Developmental **delays**
- **Eating, nursing, sleeping trouble** for baby
- **Abuse** to baby
- Increased risk of **physical/sexual abuse** later in life

Source: National Resource Center on Domestic Violence, Harvard T.H. Chan School of Public Health, UC San Francisco Health, For Baby's Sake

SafeNest

Intervention

34% Intimate partner violence **victims who seek medical care** for injuries

42% Female DV homicide victims who visited an ED **because of their injuries**

44% Female DV homicide victims who **visited a hospital ED** within 2 years of their murder

53% Female DV homicide victims who had **"battering" in their medical record**

There is **significant opportunity** to intervene within the healthcare system.

Source: National Institutes of Health

SafeNest

Intervention

1

Robust, mandatory training for medical professionals

physicians, MAs, fire/EMTs, nurses, etc.

- During medical/training school
- Recurring annually
- Specific components
  - DV overview
  - Strangulation (adult, pregnant, pediatric)
  - Victim and offender behavior
  - Trauma-informed care
  - ACEs
  - Abortion care as a choice for victims
  - Considerations for unique victims
    - *Racial and/or ethnic minorities*
    - *LGBTQ+ relationships*
    - *Immigrant/limited English populations*
    - *Pregnant minors*

SafeNest

Intervention

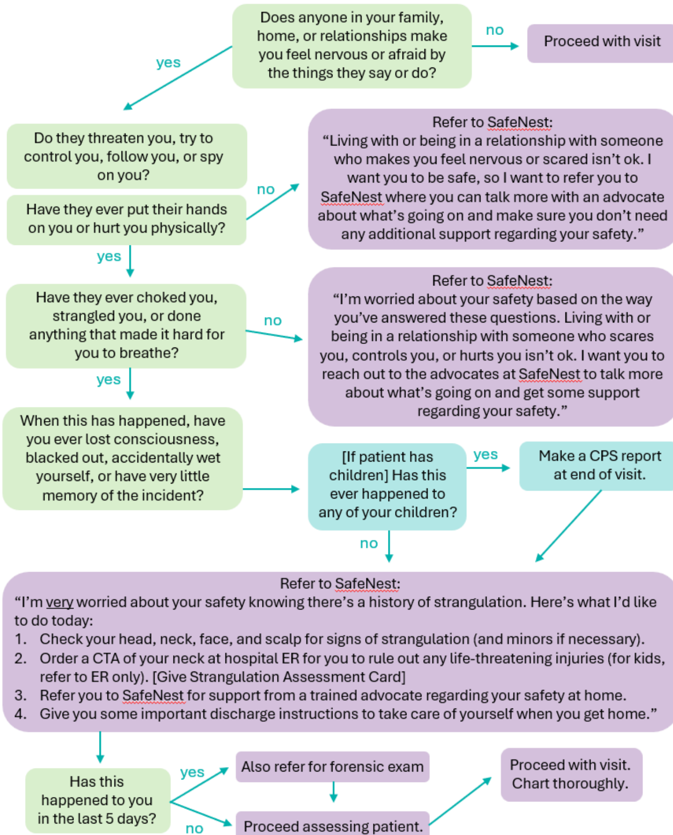
2

Mandatory, trauma-informed screening at **every OBGYN, prenatal, postpartum, and pediatric** appointment

- No one else in room
- Trauma-informed questioning + response
  - Reminder about mandatory reporting
  - Flow chart with trauma-informed language
- Plan if abuser is at appointment
- Standardized recommendations
  - CTA exam at hospital ER
  - Connection to victim service agency
  - Counseling around pregnancy options
  - Child abuse report if victim is minor

SafeNest

Medical Response Packet



Domestic Violence and Strangulation Screening

Non-ED Medical Setting

Patient should be alone in a safe, private area when being screened.

- Does anyone in your family, home, or relationships make you feel nervous or afraid by the things they say or do?
  - no → Proceed with visit
  - yes → Do they threaten you, try to control you, follow you, or spy on you? / Have they ever put their hands on you or hurt you physically?
    - no → Refer to SafeNest: "Living with or being in a relationship with someone who makes you feel nervous or scared isn't ok. I want you to be safe, so I want to refer you to SafeNest where you can talk more with an advocate about what's going on and make sure you don't need any additional support regarding your safety."
    - yes → Have they ever choked you, strangled you, or done anything that made it hard for you to breathe?
      - no → Refer to SafeNest: "I'm worried about your safety based on the way you've answered these questions. Living with or being in a relationship with someone who scares you, controls you, or hurts you isn't ok. I want you to reach out to the advocates at SafeNest to talk more about what's going on and get some support regarding your safety."
      - yes → When this has happened, have you ever lost consciousness, blacked out, accidentally wet yourself, or have very little memory of the incident?
        - → [If patient has children] Has this ever happened to any of your children?
          - yes → Make a CPS report at end of visit.
          - no → Refer to SafeNest

Refer to SafeNest:
"I'm very worried about your safety knowing there's a history of strangulation. Here's what I'd like to do today:

1. Check your head, neck, face, and scalp for signs of strangulation (and minors if necessary).
2. Order a CTA of your neck at hospital ER for you to rule out any life-threatening injuries (for kids, refer to ER only). [Give Strangulation Assessment Card]
3. Refer you to SafeNest for support from a trained advocate regarding your safety at home.
4. Give you some important discharge instructions to take care of yourself when you get home."

- Has this happened to you in the last 5 days?
  - yes → Also refer for forensic exam → Proceed with visit. Chart thoroughly.
  - no → Proceed assessing patient. → Proceed with visit. Chart thoroughly.

StrangulationTrainingInstitute.com

LY PRESENT 50% OF TIME!

SYMPTOMS OF STRANGULATION

SCALP
- Petechiae (tiny red spots)
- Bald spots (from hair being pulled)
- Swelling on the head (from blunt force trauma or falling to the ground)

EARS
- Ringing in ears
- Petechiae on earlobe(s)
- Bruising behind the ear
- Bleeding in the ear

MOUTH
- Bruising
- Swollen tongue
- Swollen lips
- Cuts/abrasions
- Internal Petechiae

NECK
- Redness
- Scratch marks
- Finger nail impressions
- Bruising (thumb or fingers)
- Swelling
- Ligature or Clothing Marks

BREATHING CHANGES
- Difficulty breathing
- Respiratory distress
- Unable to breathe

Intervention

3

More participation in community prevention and prosecution

- Involvement in high-risk and fatality reviews
- Willingness to testify as expert witnesses
- Get more training (for yourself + your staff)
- Formally partner with local victim service agencies

SafeNest

*“**Enhance the survivability and health of infants and persons who are pregnant, are giving birth and have given birth**, and concerning programs to improve the health of preschool children”*

Addressing multiple types of interpersonal violence through comprehensive prevention efforts is critical to supporting maternal and infant health (CDC)

*Objective 2: “reduce the rate of **infant mortality**”*

- Abuse during pregnancy can lead to miscarriage, stillborn birth, low birth weight, and preterm birth
- Women abused during pregnancy are more likely to receive no prenatal care or delay care until later than recommended
- Infants/Children can be and are murdered as part of abuse

*Objectives 3 and 6: “reduce the incidence of **preventable diseases, handicapping conditions** among children, and reduce the need for **inpatient and long-term care services**”*

- Abuse during pregnancy has long-term effects on pregnancy and child once born
- Pregnant person and pregnancy can have life-long complications stemming from STIs and sexual assault
- ACE study shows long-term health impacts on children who experience/witness adverse events, including early death

SafeNest

Objectives 4, 5, and 10: relate to the ***prevention of the consumption of alcohol during pregnancy*** *and subsequent fetal alcohol spectrum disorder*

Abuse during pregnancy increases the risk of substance use/abuse

Objective 11: "assisting the U. of Nevada School of Medicine in ***reviewing, amending, and distributing guidelines****"*

(1) Train doctors and medical professionals more rigorously on presentation, dynamics, warning signs, lethality markers, responses, and interventions for IPV

(2) Mandatory recurring trainings

(3) Consistently and meaningfully screen all patients at every prenatal, postpartum, pediatric, and women's health appointment for DV and strangulation

= **safer and healthier** children, moms, families, and communities

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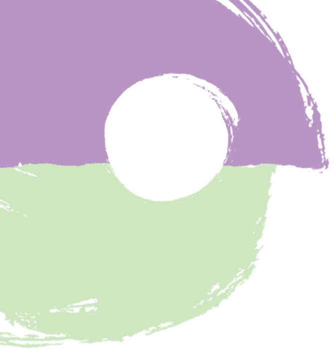


Thank you!

Megan Lopez

VP of One Safe Place

mlop@safenest.org

SafeNest

AGENDA ITEM 6

Office of Analytics & Office of State Epidemiology

NEVADA HEALTH AUTHORITY

Office of Analytics Update

Congenital Syphilis and Childhood Vaccinations Status Update

Jen Thompson

May 2026

NVHA.nv.gov

Reported Cases of Primary & Secondary Syphilis Among Women & Congenital Syphilis (CS), Nevada 2014-2024

Number of Cases

Year	P&S syphilis cases in women	CS cases
2014	23	4
2015	23	8
2016	50	12
2017	75	21
2018	119	34
2019	159	41
2020	150	46
2021	199	45
2022	257	65
2023	163	80
2024	115	58
2025*	58	53

*Data for 2025 are preliminary and subject to change.

Congenital Syphilis 2023 and 2024

- 2023: 80 total cases
  - Three (3) could not be matched to a birth certificate or fetal death certificate
  - Nine (9) were fetal deaths (11.3%)
- 2024: 58 total cases
  - Four (4) could not be matched to a birth certificate or fetal death certificate
  - Eight (8) were fetal deaths (13.8%)

Lowest case count in 4 years, 2021 (n=45)

Rate of Primary & Secondary Syphilis Among Women & Congenital Syphilis, U.S. vs Nevada 2014-2024

Rate of P&S cases among women per 100,000 population (left axis: 0, 5, 10, 15, 20)

Rate of CS cases per 100,000 live births (right axis: 0, 50, 100, 150, 200, 250, 300)

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
US - P&S syphilis rate in women	1.1	1.4	1.9	2.3	3	3.9	4.7	7.3	8.7	8.1	6.9
NV - P&S syphilis rate in women	1.6	1.6	3.4	5.1	7.9	10.4	9.7	12.8	16.3	9.9	7.0
US - CS rate	11.5	12.4	16.2	24.4	34.6	50	59.7	77.9	102.5	107.8	109.6
NV - CS rate	13.9	22	33.1	67.1	86.9	116.9	136.7	133.6	193.0	253.86	180.8

Reported Congenital Syphilis by County
Year to Year Comparison

2023

2024

Washoe County: -19%

Clark County: -57%

Legend

- 401 +
- 301 to 400
- 201 to 300
- 101 to 200
- 1 to 100
- 0

Rates are per 100,000 live births.

General Demographics of CS Cases, Nevada, 2024

Sex

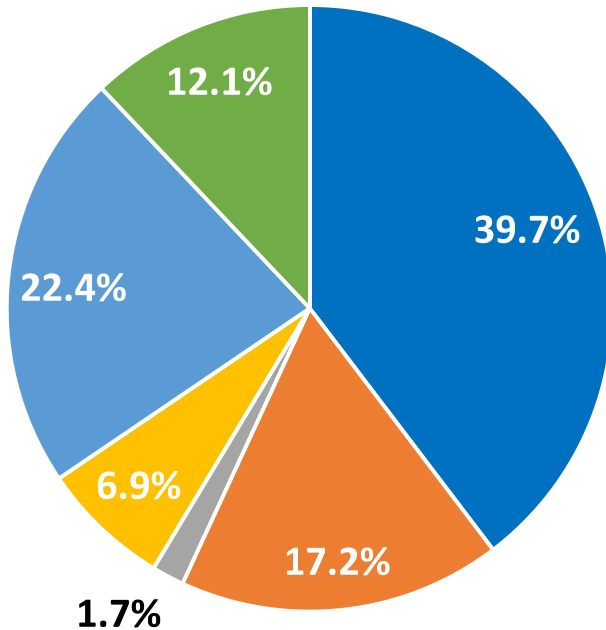
Female:	26	44.8%
Male:	32	55.2%

Birth Weight

<2,500g:	22	37.9%
>=2,500g:	36	62.1%

Gestational Age

<37 Weeks:	18	31.0%
>=37 Weeks:	40	69.0%



- **Non-Hispanic White: 39.7%**
- **Non-Hispanic Black: 17.2%**
- **Non-Hispanic AIAN: 1.7%**
- **Non-Hispanic API: 6.9%**
- **Hispanic: 22.4%**
- **Other/Unknown: 12.1%**

Based on the Mother's Race/Ethnicity

Full term births increased by 8.2% from 2023-2024

Previous Pregnancies: 55.8% 3 or more

Mother's Age at Syphilis Diagnosis, Nevada 2023-2024

	<20	20-24	25-29	30-34	35-39	40-44	Unknown
2023	3.8%	22.5%	36.3%	20.0%	15.0%	1.3%	1.3%
2024	5.2%	8.6%	27.6%	36.2%	20.7%	1.7%	0.0%

There were no mothers age 45+ in both years

Overview of Maternal Characteristics, Nevada 2023-2024

- Stage of Maternal Syphilis at Diagnosis
  - 73% Late Latent or Unknown Stage at Diagnosis (n=101 of 138 cases).
- Trimester of Diagnosis/Testing/Treatment:
  - Nearly ½ the mothers were diagnosed at delivery or post birth (n= 60, 43.5%).
  - Over ½ the mothers were tested at delivery or post birth (n = 76, 55.1%), with 34.1% tested during the 3rd Trimester.
  - Half of the mothers started treatment at delivery or post birth (n= 69, 50.0%).
- Trimester of Prenatal Care (PNC)
  - 58.0% had no information about trimester when PNC began (n=80), of those information was provided 13.8% had care from the 1st trimester.

Maternal Risk Factors
Nevada 2023-2024

Combined Years 2023-2024

- Comorbidities:
  - Chlamydia: 13.0%
  - Gonorrhea: 5.1%
  - HIV Positive: 1.4%
- Drug and/or Alcohol Use: 59.4%
- Sexual Behaviors in the Past 12 Months
  - Sex while under the influence of drugs: 23.9%
  - Sex with anonymous partner: 9.4%
  - More than 4 partners: 3.6%

Supportive Services, 2023

58 (73%) were enrolled in Medicaid

14 Enrolled 6 or Months Prior Date of Birth

50 SNAP

10 TANF

Supportive Services, 2024

35 (60%) were enrolled in Medicaid

8 Enrolled 6 or Months Prior Date of Birth

32 SNAP

6 TANF

Congenital Syphilis Statistical Testing

- Statistically significant associations (Chi-square test) 2023-2024 combined:
  - Race/ethnicity (p-value=0.003) Non-Hispanic Black Mothers
    - % CS
    - % non-CS
  - No Prenatal Care (p-value<0.001):
    - 50.7% CS births
    - 4.6% non-CS births.
  - Low Birth Weight (p-value<0.0001):
    - 32.6% CS
    - 9.5% non-CS births.

Childhood Vaccinations Update

MMR Vaccination Rates by County, 0 to 2 Years of Age

	Carson City	Churchill	Clark	Douglas	Elko	Esmeralda	Eureka	Humboldt	Lander	Lincoln	Lyon	Mineral	Nevada (State)	Nye	Pershing	Storey	Washoe	White Pine
2024	79.9%	80.2%	85.4%	78.0%	88.4%	0.0%	83.3%	84.4%	89.9%	84.8%	82.2%	94.3%	85.8%	84.8%	91.8%	88.0%	89.2%	79.1%
2025	90.0%	83.8%	84.9%	83.6%	86.3%	0.0%	60.0%	85.1%	89.3%	80.6%	85.3%	80.0%	85.4%	80.5%	89.2%	86.4%	87.8%	80.4%

MMR Vaccination Rates by County, 13 to 17 Years of Age

Second Dose recommended
4-6 years of age

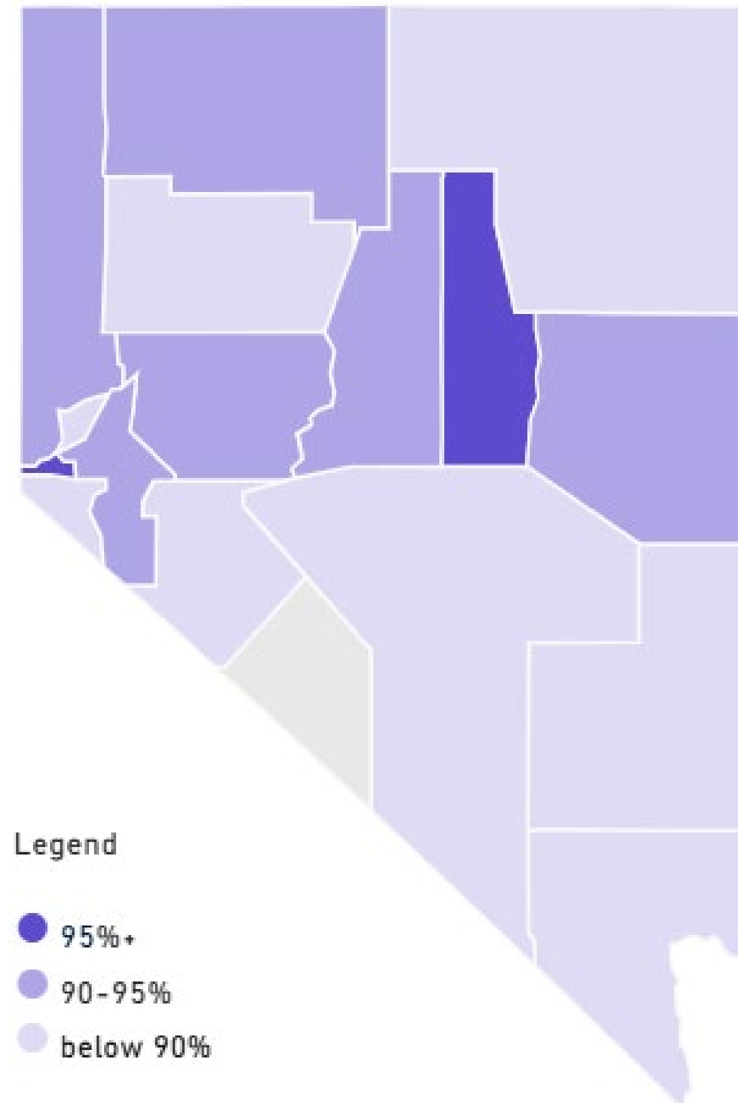
Nevada 83%

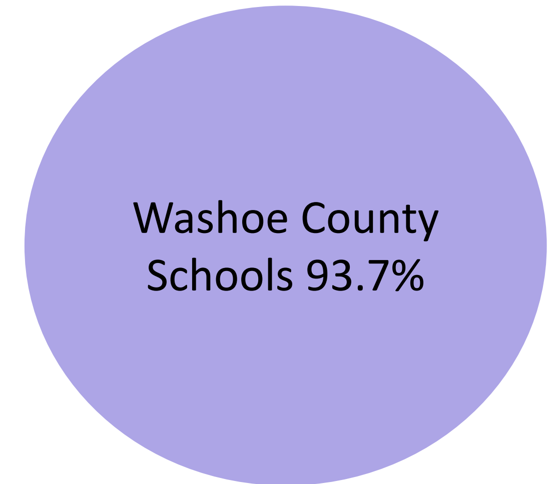
	Carson City	Churchill	Clark	Douglas	Elko	Esmeralda	Eureka	Humboldt	Lander	Lincoln	Lyon	Mineral	Nevada (State)	Nye	Pershing	Storey	Washoe	White Pine
2024	76.6%	88.0%	82.6%	82.3%	87.2%	89.9%	89.9%	88.5%	84.5%	88.6%	81.0%	90.3%	82.9%	77.1%	89.6%	84.6%	84.6%	79.1%
2025	76.3%	86.3%	82.6%	82.0%	86.4%	87.7%	90.3%	87.5%	84.6%	87.2%	80.9%	89.3%	82.9%	78.1%	90.4%	83.3%	85.1%	78.8%

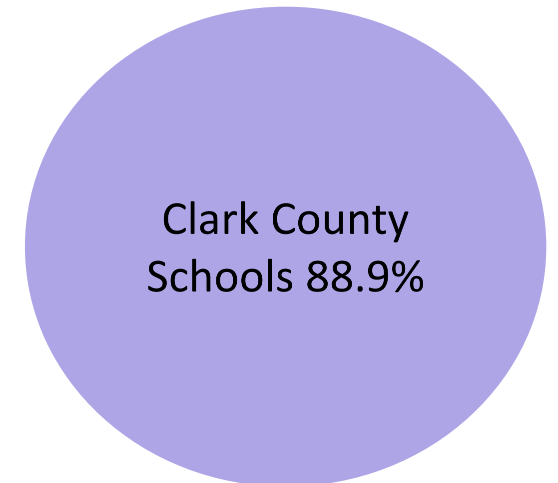
Up To Date (%): 100.0%, 95.0%, 90.0%, 85.0%, 80.0%, 75.0%, 70.0%, 65.0%, 60.0%, 55.0%, 50.0%

Kindergarten School Vaccination

- 2025-2026 School Season
  - Total Vaccinated 89.7%
  - MMR: 89.3%
  - Medical Exemptions: 0.2%
  - Religious Exemptions: 7.3%
- Public Schools
  - Total Vaccinated 91.2%
  - MMR: 91.4%
  - Medical Exemptions: 0.2%
  - Religious Exemptions: 7.1%

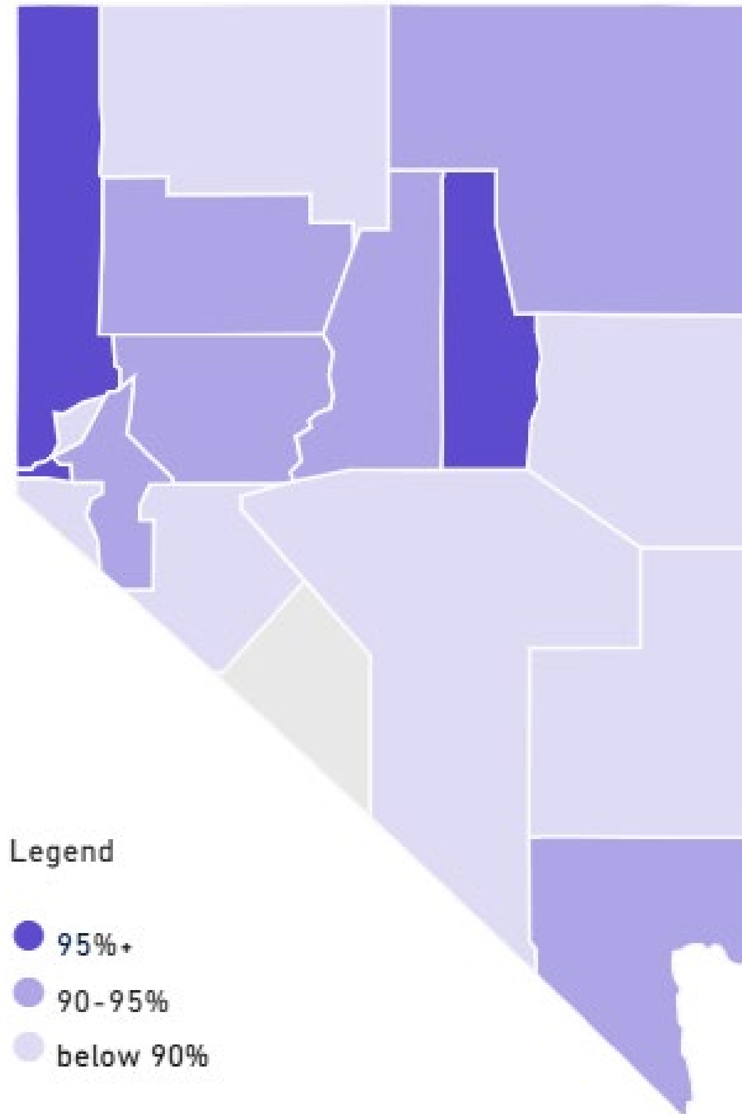


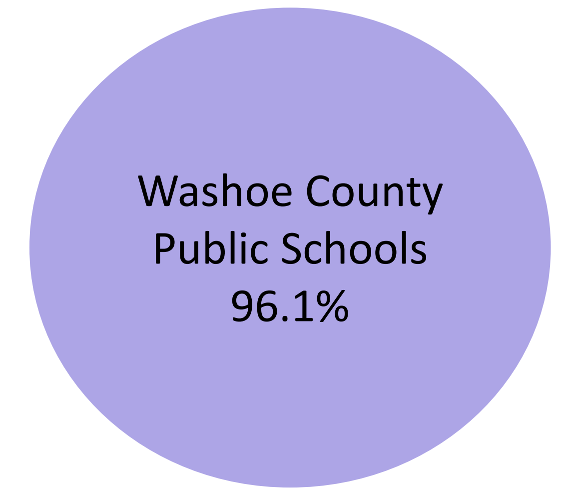


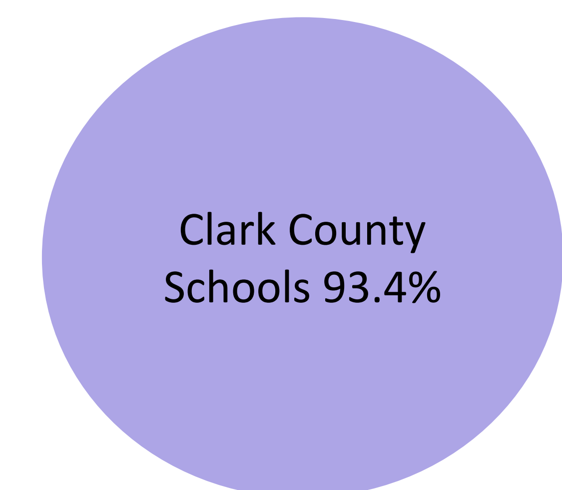


7th Grade School Vaccinations

- 2025-2026 School Season
  - Total Vaccinated 93.5%
  - MMR: 95.8
  - MenACWY: 89.3%
  - Medical Exemptions: 0.1%
  - Religious Exemptions: 5.3%
- Public Schools
  - Total Vaccinated 94.1%
  - MenACWY: 90.2%
  - MMR: 96.4%
  - Medical Exemptions: 0.1%
  - Religious Exemptions: 5.0%

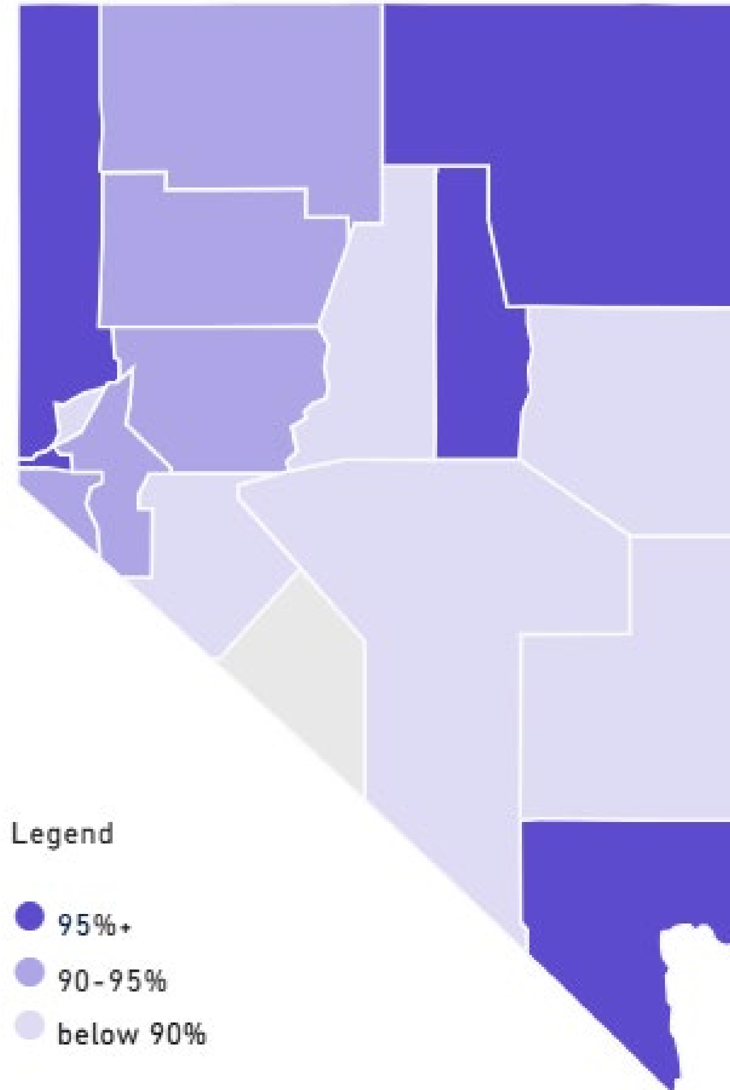






12th Grade School Vaccination

- 2025-2026 School Season
  - Total Vaccinated 95.5%
  - MMR: 97.7%
  - Tdap: 95.8%
  - Medical Exemptions: 0.3%
  - Religious Exemptions: 3.4%
- Public Schools
  - Total Vaccinated 96.3%
  - MMR: 98.1%
  - Tdap: 96.6%
  - Medical Exemptions: 0.2%
  - Religious Exemptions: 3.2%



Washoe County Schools 97.0%

Clark County Schools 95.7%+

Hepatitis B Doses given at Birth
Counts by Year, Nevada Residents 2023-2025

Year	Hepatitis B Vaccine Received						Total
	Yes		No		Unknown		
	Count	%	Count	%	Count	%	
2023	25,316	80.3	5,565	17.7	633	2.0	31,514
2024	24,501	76.4	6,901	21.5	678	2.1	32,080
2025*	19,033	70.7	7,613	28.3	283	1.1	26,929

Data are preliminary and subject to change (as of 12/2025).

Additional Information and Resources

Sexually Transmitted Infections Dashboard

School Screening Dashboard

Direct Inquiries: DATA@DHHS.NV.GOV

Presentation on the Nevada State Immunization Program:

Joint Interim Standing Committee on Health and Human Services – March 31, 2026

Questions?

Contact Information

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Office of Analytics

Measles (MMR) Vaccination Coverage in Nevada: Trends and Spatial Analysis

Richa Chaturvedi, MPH
Epidemiologist, Office of State Epidemiology
May 1, 2026

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

ALL IN GOOD HEALTH.

ABOUT DPBH

MISSION

To protect, promote, and improve the physical and behavioral health and safety of all people in Nevada, equitably and regardless of circumstances, so they can live their safest, longest, healthiest, and happiest life.

VISION

A Nevada where preventable health and safety issues no longer impact the opportunity for all people to live life in the best possible health.

PURPOSE

To make everyone's life healthier, happier, longer, and safer.

ALL IN GOOD HEALTH.

About Nevada OSE

THE OFFICE OF STATE
Epidemiology
NEVADA

- The main goal of the Office of State Epidemiology (OSE) is to prevent and respond to a variety of public health issues through disease surveillance, standardized data collection, meaningful interpretation, statewide standards, and centralized guidance in order to improve health outcomes for our communities.

Purpose of Analysis

Identify geographic areas with lower MMR vaccination rates to guide Local Health Authorities in implementing public health action

- Understand where MMR coverage is low, including areas where there are clusters of low coverage
- Identify geographic gaps in vaccination access
- Identify priority areas by combining coverage with Social Vulnerability Index (SVI)

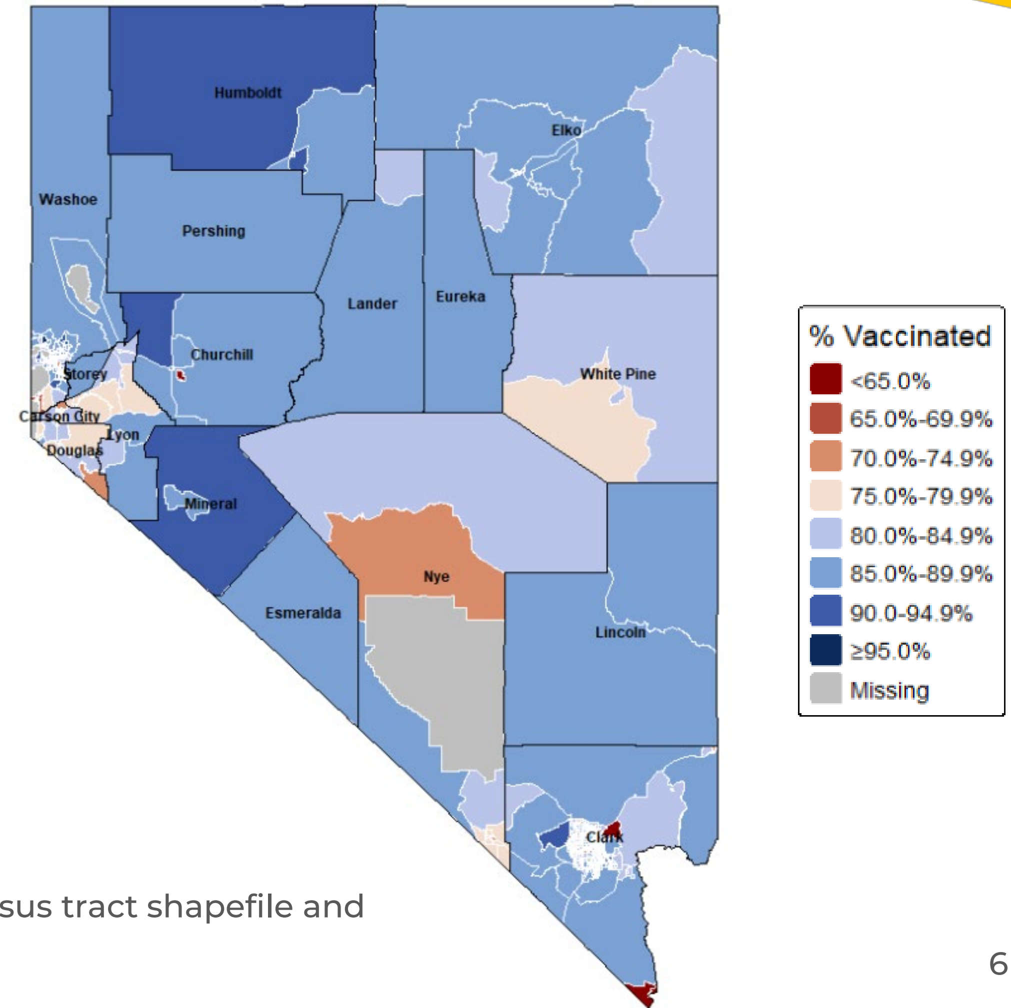
Data & Methods

- Data sources: Nevada State Immunization Registry, U.S. Census Bureau, CDC Social Vulnerability Index
- MMR vaccination data includes data for children (age 2 years) and teens (ages 13-17 years)
- All datasets were harmonized at the census tract level
- MMR vaccination coverage displayed as ranges
  - Coverage of ≤90% is categorized as low

MMR Vaccination Coverage in Nevada Among Children and Teens – 2025

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

- MMR vaccination coverage varies across census tracts
- Several areas fall below the 90% coverage threshold
- Lower coverage observed in both urban and rural settings



Data Source: Nevada's Statewide Immunization Information System (WebIZ)
*Note: A small number of tracts did not match between WebIZ and 2020 census tract shapefile and were treated as missing in the map

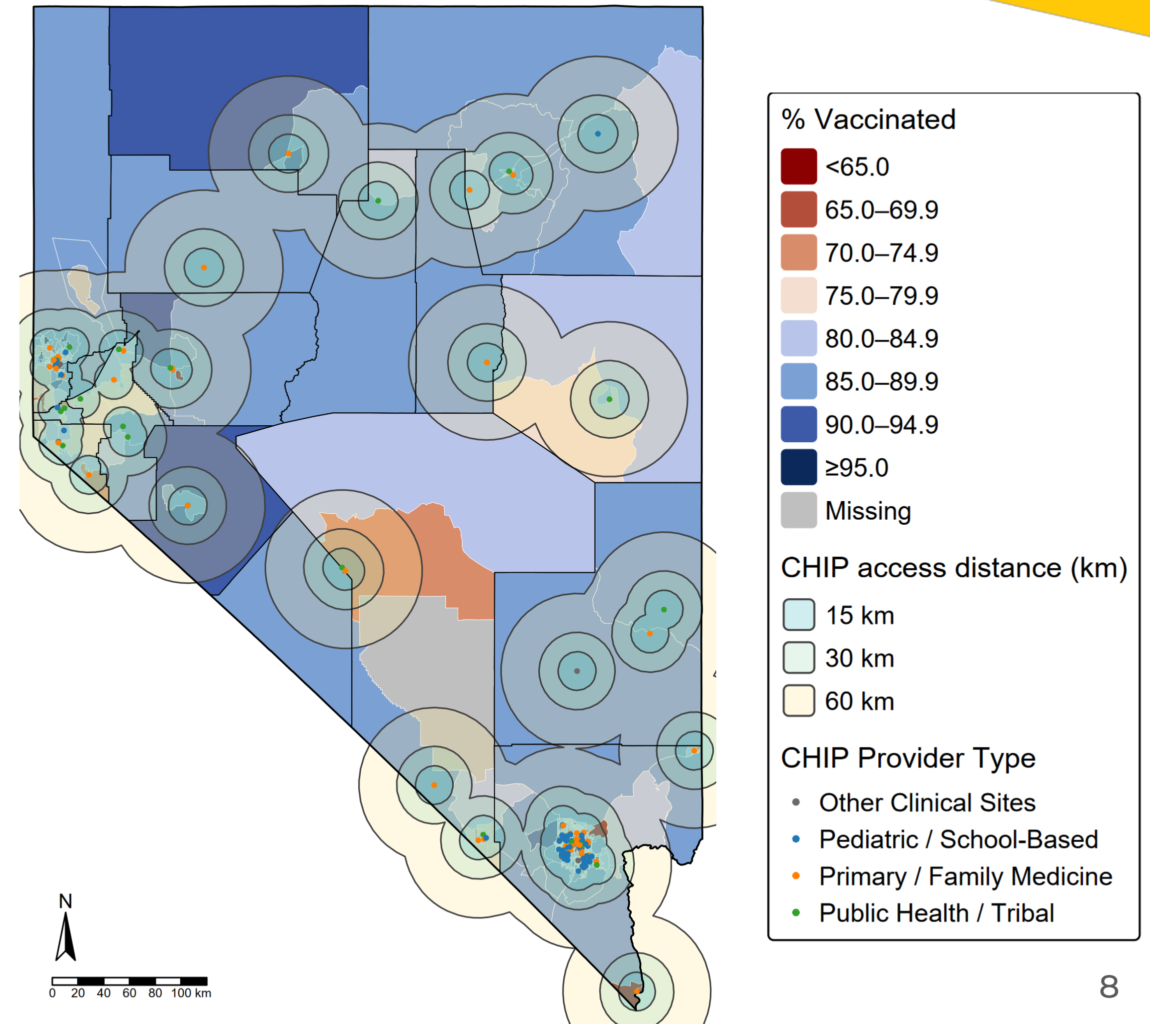
Provider Access Analysis

- Analyzed access to Children’s Health Insurance Program (CHIP) and Vaccination for Children (VFC) providers
- CHIP providers supports access to low-cost health coverage to eligible children
- VFC providers provides vaccines at no cost to children who may otherwise not be vaccinated due to inability to pay
- Provider coverage defined by using 15, 30, and 60 km provider service areas
- The analysis helps identify potential VFC and CHIP desert tract

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Access to CHIP Providers

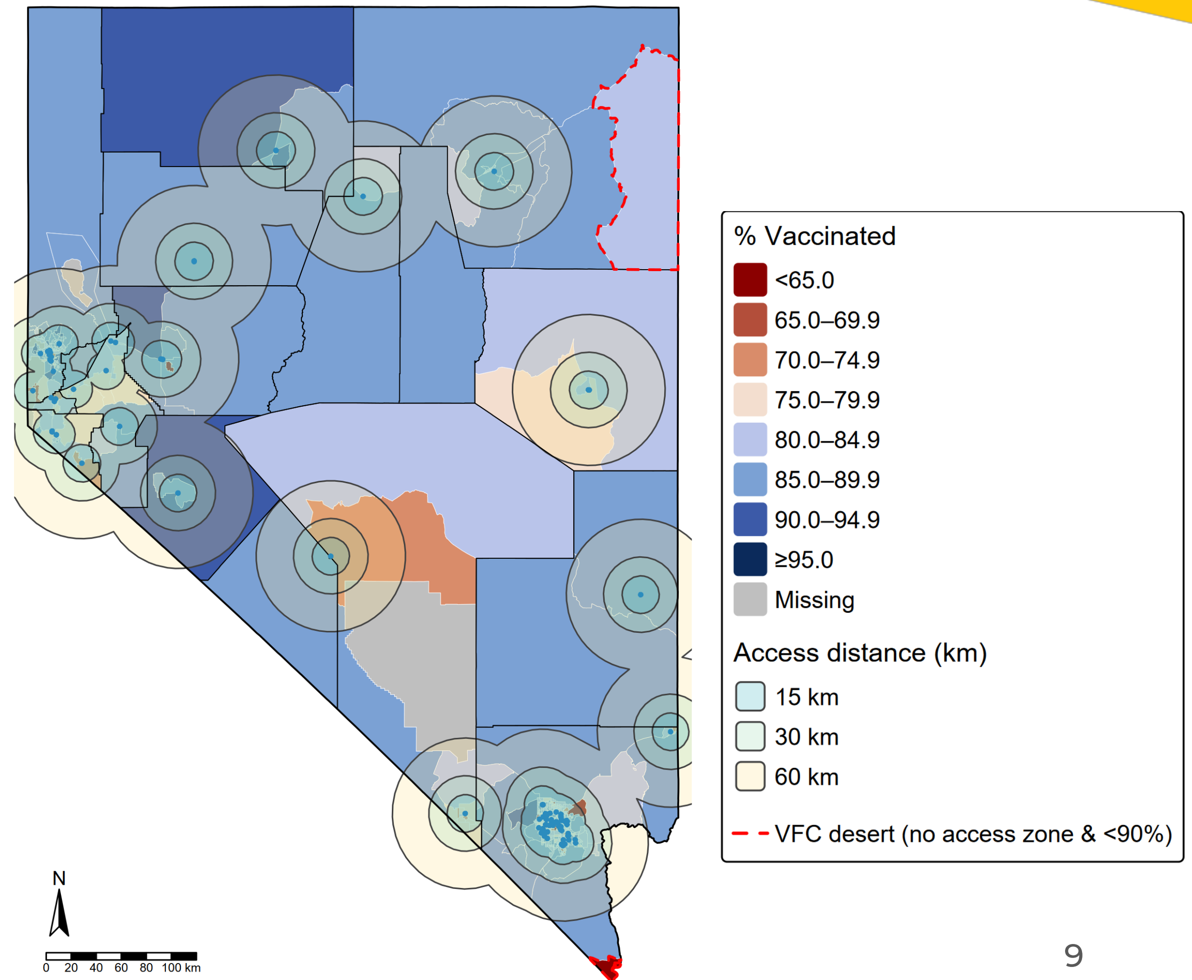
- This map helps assess access to CHIP providers
- All census tracts fall within CHIP provider coverage areas
- Indicates broader geographic CHIP services



Data Source: Nevada's Statewide Immunization Information System (WebIZ)

Access to VFC Providers

- Most census tracts fall within VFC provider coverage areas
- A small number of tracts in Elko and Clark counties were identified as having no provider access
- These tracts also have vaccination coverage of ≤90%



Data Source: Nevada's Statewide Immunization Information System (WebIZ)

Limitations of Provider Access Analysis

- Access gaps may be underestimated as tracts are classified as covered if any portion of the tract overlaps a provider service area
- May mask within-tract variation in access
- Border communities may access providers in neighboring states (not captured)

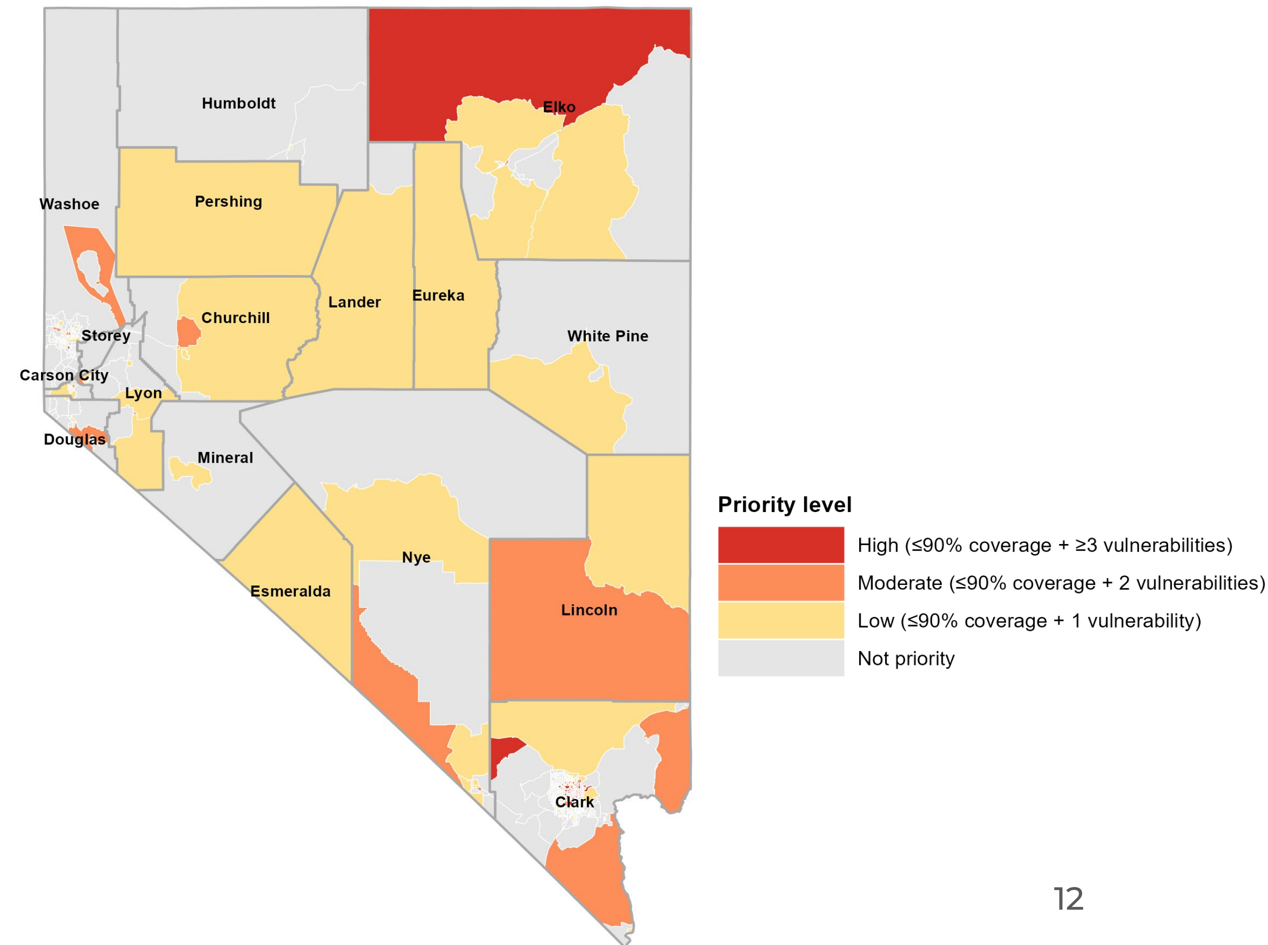
What is Social Vulnerability Index (SVI)?

- Developed by CDC
- Measures community-level vulnerability using U.S. Census data
- Scores range from 0 to 1 (higher values = greater vulnerability)
- Captures four SVI themes:
  - Socioeconomic status
  - Household characteristics
  - Minority status & language
  - Housing & transportation

For this analysis, vulnerability is defined based on number of SVI vulnerabilities (≥ 0.75 across themes) within each tract

Priority Areas Based on Low Vaccination (≤90%) and Social Vulnerability

- Priority areas are tracts with vaccination ≤90% and multiple SVI themes with scores ≥0.75
- High, medium, and low priority is determined based on number of vulnerable themes
- 130 high priority tracts
  - 114 tracts in Clark County
  - 14 tracts in Washoe County
  - One tract in Carson City and Elko County each



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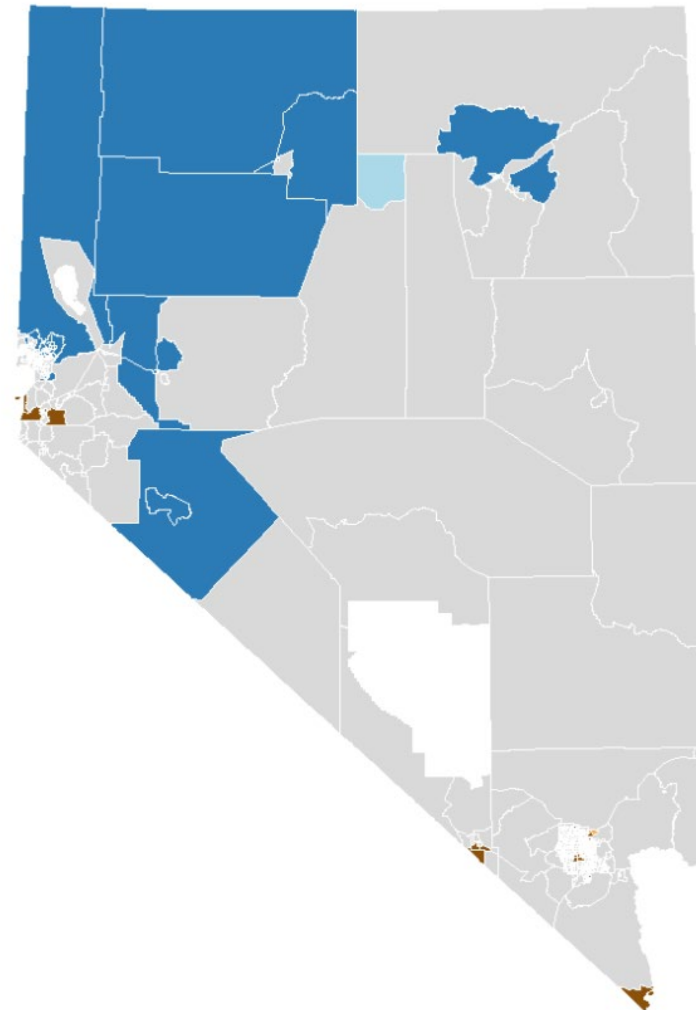
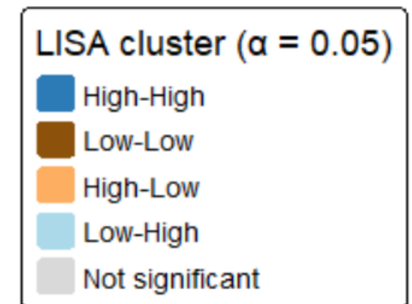
Local Indicators of Spatial Association (LISA) Cluster Analysis

- LISA identifies statistically significant spatial clusters
- Low-coverage clusters (low-low) were limited (6% of Nevada tracts)
- Clusters were localized pockets of lower vaccination coverage

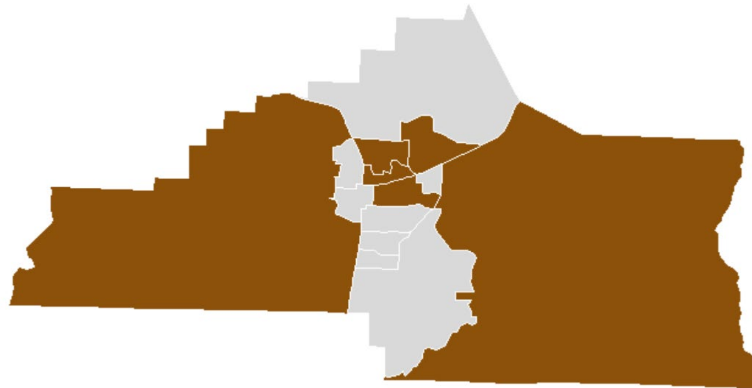
Clusters are defined relative to the statewide average (not the 90% threshold)





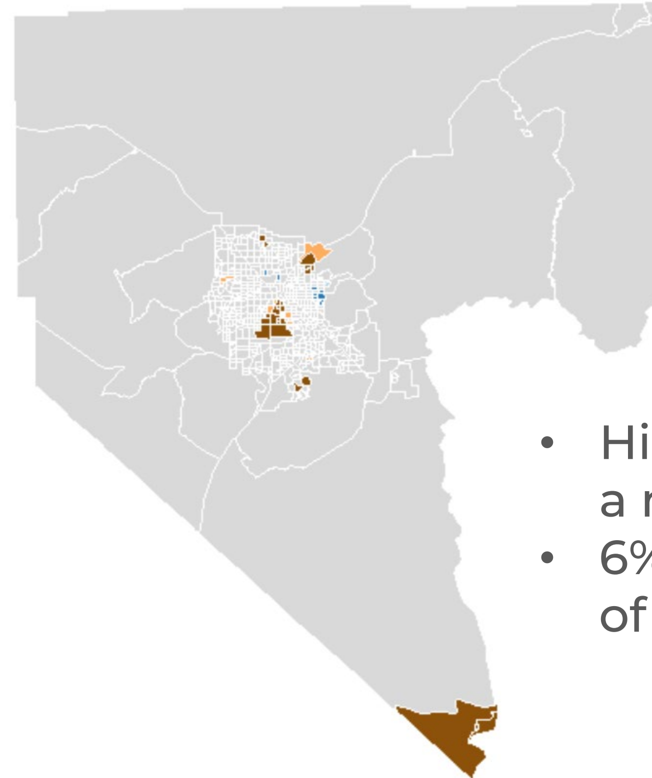
Localized Clustering

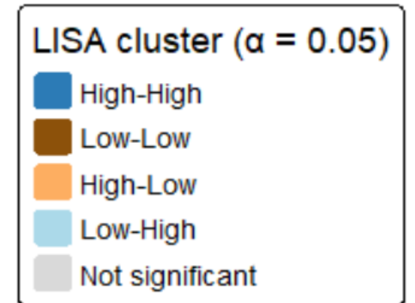
Carson City



- Extensive and concentrated clustering
- 40% of tracts (6 of 15) part of low-low clusters

Clark County





- High number of clusters in a metropolitan county
- 6% of tracts (28 of 535) part of low-low clusters

Key Findings

- Vaccination coverage varies across census tracts in Nevada
- Localized VFC access gaps ("provider deserts") were identified, however, CHIP access appears broadly available at tract level
- Priority areas identified where low coverage overlaps with vulnerability
  - 21% and 10% of all Clark and Washoe county tracts, respectively, were high priority tracts
- Clustering is limited but localized with ~6% of tracts belonging to low-low clusters
  - Low–Low clusters were concentrated in Carson City, Clark County, Washoe County, and Nye County

Public Health Implications

- Meaningful variation at the tract level, indicates localized gaps in coverage, which may reflect differences in vaccine acceptance, access, surveillance, and community-levels of education
- Vulnerability may still limit access even where providers are available
- Clustering indicates localized pockets of need
- Geographically targeted interventions may be more effective than statewide approaches

Next Steps

- Share findings with local health partners
- Identify priority tracts within state jurisdiction for outreach
- Assess barriers to vaccination in priority areas
- Strengthen provider and community partnerships
- Monitor trends and update analysis over time

QUESTIONS?

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

CONTACT INFORMATION

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Office of State Epidemiology
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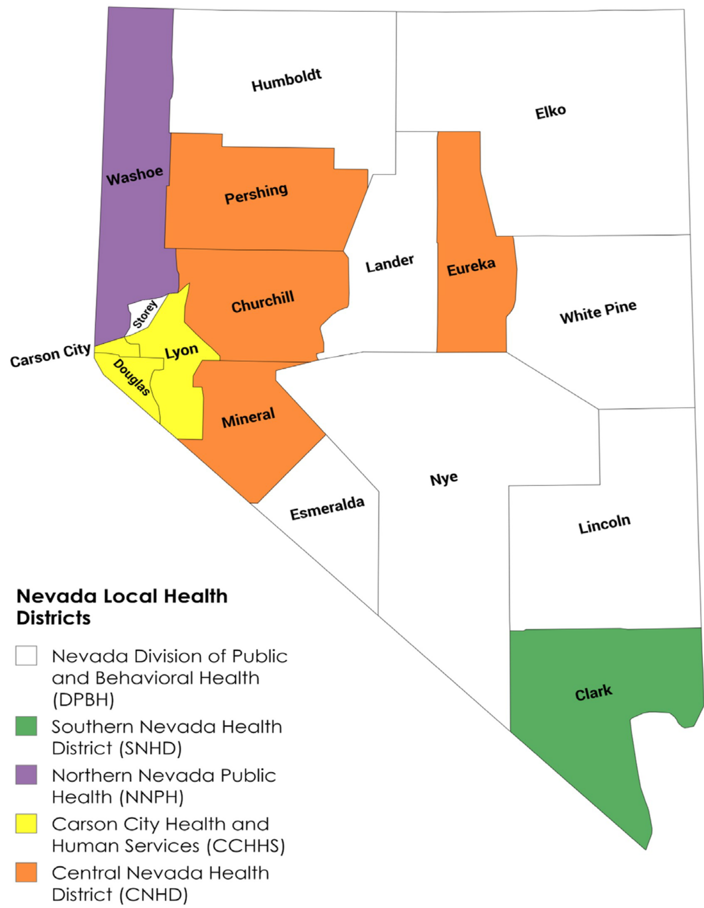
ACRONYMS

- OSE- Office of State Epidemiology
- LHA- Local Health Authority
- SVI- Social Vulnerability Index
- VFC- Vaccines for Children
- CHIP- Children's Health Insurance Program
- LISA- Local Indicators of Spatial Association

NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Local Health Authorities (LHAs)



Health Authorities	Counties
Southern Nevada Health District	Clark
Northern Nevada Public Health	Washoe
Carson City Health & Human Services	Carson City Douglas Lyon
Central Nevada Health District	Churchill Mineral Eureka Pershing
Nevada Division of Public and Behavioral Health (DPBH), Office of State Epidemiology (OSE)	Elko Esmeralda Humboldt Lander Lincoln Nye Storey White Pine

AGENDA ITEM 7

The Nevada Governor's Council

The Down Syndrome Information Act

Catherine Nielsen, Executive Director
Nevada Governor's Council on Developmental Disabilities

What Is the Down Syndrome Information Act?

- Passed in Nevada (2023)
- Requires information at diagnosis
- Ensures accuracy and balance
- Connects families to resources

Where It Lives in Nevada Law

NRS 442

Maternal & Child Health

What Providers Must Do

Provide information at diagnosis

Use evidence-based, current materials

Share balanced perspectives

Offer referrals to support organizations

Why This Matters

- Diagnosis is a critical moment
- Information shapes family perspective
- Reduces fear and misinformation
- Builds connection and support

The Gap This Law Addresses

OUTDATED OR NEGATIVE INFORMATION (HISTORICALLY)

LACK OF RESOURCE CONNECTION

INCONSISTENT PROVIDER PRACTICES

How Our Website Supports the Law

- Centralized, trusted information
- Nevada-specific resources
- Easy access for providers & families
- Supports compliance with AB116

What You'll Find on the Website

CLEAR, ACCESSIBLE INFORMATION

LOCAL ORGANIZATIONS AND SERVICES

REAL-LIFE EXPERIENCES AND PERSPECTIVES

GUIDANCE FOR NEXT STEPS

Alignment with the Law

- ✓ Accurate
- ✓ Balanced
- ✓ Resource-connected
- ✓ Accessible

Closing

Supporting Families from Diagnosis Forward