Maternal and Child Health Services
Title V Block Grant

State Narrative for Nevada

Application for 2010
Annual Report for 2008

Document Generation Date: Tuesday, June 30, 2009

Table of Contents

I. General Requirements 4
A. Letter of Transmittal 4
B. Face Sheet 4
C. Assurances and Certifications 4
D. Table of Contents 4
E. Public Input 4
II. Needs Assessment 6
C. Needs Assessment Summary 6
III. State Overview 7
A. Overview 7
B. Agency Capacity 19
C. Organizational Structure 27
D. Other MCH Capacity 31
E. State Agency Coordination 35
F. Health Systems Capacity Indicators 39
Health Systems Capacity Indicator 01: 40
Health Systems Capacity Indicator 02: 40
Health Systems Capacity Indicator 03: 41
Health Systems Capacity Indicator 04: 42
Health Systems Capacity Indicator 07A: 43
Health Systems Capacity Indicator 07B: 43
Health Systems Capacity Indicator 08: 44
Health Systems Capacity Indicator 05A: 45
Health Systems Capacity Indicator 05B: 45
Health Systems Capacity Indicator 05C: 45
Health Systems Capacity Indicator 05D: 46
Health Systems Capacity Indicator 06A: 46
Health Systems Capacity Indicator 06B: 47
Health Systems Capacity Indicator 06C: 47
Health Systems Capacity Indicator 09A: 48
Health Systems Capacity Indicator 09B: 49
IV. Priorities, Performance and Program Activities 51
A. Background and Overview 51
B. State Priorities 53
C. National Performance Measures 54
Performance Measure 01: 54
Performance Measure 02: 56
Performance Measure 03: 58
Performance Measure 04: 61
Performance Measure 05: 64
Performance Measure 06: 67
Performance Measure 07: 69
Performance Measure 08: 72
Performance Measure 09: 73
Performance Measure 10: 75
Performance Measure 11: 77
Performance Measure 12: 79
Performance Measure 13: 81
Performance Measure 14: 82
Performance Measure 15: 84
Performance Measure 16: 86
Performance Measure 17: 87
Performance Measure 18: 89

D. State Performance Measures 91
State Performance Measure 1: 91
State Performance Measure 2: 92
State Performance Measure 3: 94
State Performance Measure 6: 96
State Performance Measure 9: 97
State Performance Measure 11: 99
State Performance Measure 12: 101
State Performance Measure 13: 103
State Performance Measure 14: 104
E. Health Status Indicators 106
Health Status Indicators 01A: 106
Health Status Indicators 01B: 106
Health Status Indicators 02A: 107
Health Status Indicators 02B: 107
Health Status Indicators 03A: 108
Health Status Indicators 03B: 108
Health Status Indicators 03C: 109
Health Status Indicators 04A: 109
Health Status Indicators 04B: 110
Health Status Indicators 04C: 110
Health Status Indicators 05A: 111
Health Status Indicators 05B: 111
Health Status Indicators 06A: 111
Health Status Indicators 06B: 112
Health Status Indicators 07A: 112
Health Status Indicators 07B: 113
Health Status Indicators 08A: 113
Health Status Indicators 08B: 114
Health Status Indicators 09A: 114
Health Status Indicators 09B: 115
Health Status Indicators 10: 116
Health Status Indicators 11: 116
Health Status Indicators 12: 116
F. Other Program Activities 117
G. Technical Assistance 117
V. Budget Narrative 120
A. Expenditures 120
B. Budget 121
VI. Reporting Forms-General Information 123
VII. Performance and Outcome Measure Detail Sheets 123
VIII. Glossary 123
IX. Technical Note 123
X. Appendices and State Supporting documents 123
A. Needs Assessment 123
B. All Reporting Forms 123
C. Organizational Charts and All Other State Supporting Documents 123
D. Annual Report Data 123

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

/2010/ Nevada's Assurances and Certifications are signed and filed in the office of the Chief of the Bureau of Child, Family, and Community Wellness, Maria Canfielf. Ms. Canfield serves as the MCH Director for Nevada. This office is located at 4150 Technology Way, Suite 101, Carson City, NV 89706. Ms. Canfield can be reached at mcanfield@health.nv.gov or at 775-684-4285. //2010//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

/2010/ The Maternal and Child Health Advisory Board is a Governor appointed board. It is composed of 11 members who represent legislators, pediatricians, mental health providers, dentists, and ob-gyns. The northern urban area, southern urban area and the eastern rural areas are represented. The board annually produces their priority areas. For 2009, they are access to prenatal care, Immunization rates, dental sealants, and access to mental health screenings. See their website at http://www.health.nv.gov/MCH.htm

The MCH board priorities were used to guide the budget and activity changes for the future year plan. The board members were each assigned specific performance measures and worked with state MCH staff to produce the narrative text. In addition community partners and affiliated organizations related to each performance measure were consulted. All board members will review the entire block grant a few weeks prior to the public meeting on July 10 (see attached agenda). Chairs of the Northern Nevada MCH Coalition and the newly formed Southern Nevada MCH Coalition will also attend the public hearing. Special effort was made to invite key stakeholders, affiliated advisory/task forces to the public meeting for more comprehensive views, input, and regional representation. The outreach includes the Nevada Advisory Council for CYSHCN, the Oral Health Coalitions, the MCH Coalitions, and the Youth Action Council.

Public notices were in newspapers as of July 1, 2009 and on the Health Division website. The Public Hearing was held July 10, 2009 during the meeting of the MCH Advisory Board. Written comments were solicited due July 12, 2009. Copies of the application were available by contacting the Bureau of Child, Family, and Community Wellness. Copies continue to be posted at the State Public Library and the Nevada Early Intervention Services in Reno, Las Vegas and Elko and the Health Divison website. This application represents priorities established by the Year 2005 Needs Assessment with annual updates and guidance by the MCH Advisory Board. //2010//

An attachment is included in this section.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2010/ The 2005 Needs Assessment continues to be updated with smaller needs assessments by MCH related grants housed in Title V and by community partners. These are a few of the recent needs assessments reviewed and incorporated by MCH staff: Kindergarten Survey, Head Start Needs Assessment, Southern Nevada Health Districts prenatal population (GIS mapping), Rural Respite for CYSHCN, and others to be mentioned in the remainder of the application. The Oral Health Program has just completed a needs assessment of the oral health of third graders. The data is currently being analyzed but what we already know is that the percent of children with dental sealants decreased from 41% to 37.5%

Surveillance of injury, oral health, low birth weights, pregnant women's substance abuse, continue on a regular basis. (See the online Nevada Interactive Health Databases at http://www.health.nv.gov/NIHDS.htm) In this year, MCH strategic planning sessions and community input pushed the changes to the State Performance Measures to better reflect the findings of the Needs Assessment and subsequent updates.

MCH staff are gearing up for our Five-Year Needs assessment for the next reporting period and are exploring methods to best disseminate the information from the needs assessment, translate it for coalition/community partner use and be prepared for the 2011 Nevada Legislative session.

The county health districts, by request of the MCH Advisory Board submitted their prioritization of the MCH performance measures. (see attached) The MCH Advisory Board used this mini needs assessment to set their priorities which they shared with legislators at a March 12, 2009 event hosted by the Nevada Public Health Foundation. These priorities are also driving the contracts of MCH block grant dollars for the coming year. //2010// An attachment is included in this section.

III. State Overview

A. Overview

MCH Overview

Nevada's Maternal and Child Health Program is dedicated to improving the health of families, with emphasis on women, infants and children, including Children with Special Health Care Needs, by promoting, assuring and providing health education, prevention activities, quality assurance and health care services. This is a year of change for the MCH program. In May 2008, we held our first two-day strategic planning session comprised of all bureau staff (including staff across the entire state), MCH board member representation, Health District representation and community partners. This launched what was to become a focused effort to streamline process, integrate programming, and move more rapidly down the MCH pyramid toward becoming an organization with a strong public health approach of monitoring, assurance, and policy development.

The next step was to participate in a joint 2-day planning session in August with our new bureau members from chronic disease and communicable disease. Our former bureau of Family Health Services merged with the Community Health Services to form our current home, the Bureau of Child, Family, and Community Wellness. Maria D. Canfield is the Bureau Chief and MCH Director. http://www.health.nv.gov/BCFCW.htm ***//2010//***

Geography & Demographics

Nevada is a semi-arid, largely mountainous state with numerous valleys of primarily north-south orientation. The Sierra Mountains form a natural barrier on the west between Nevada and California. The Great Salt Lake Desert isolates eastern Nevada from the population centers of Utah. Approximately 83% of Nevada's land area is under the jurisdiction of the Bureau of Land Management; the remaining 17 % is under private ownership or state and local jurisdiction. Nevada has thirteen Indian colonies or reservations statewide and six military bases located in five counties. As in prior years, Nevada remains the fastest growing state in the nation. In the nine months after the 2000 census was completed Clark County in the south experienced a growth of 90,000, or 6.5% growth to a total population of approximately 1,500,000. According to Census Bureau estimates released April 8, 2004, for the 17th consecutive year Nevada remained the fastest growing state in the Nation. /2010/ In July 2008, Nevada relinquished this status to Utah. //2010//As predicted, most of the growth was in the south, with Clark County gaining more than 200,000 new residents. It is now number 17 on the list of largest U.S. counties, surpassing New York and Philadelphia. Rural Lyon County, in the north, ranked 17th as the fastest growing county per capita in the Nation, also according to Census Bureau figures. No end to Nevada's growth is in sight; the Nevada State Demographer projects Nevada's population will reach 2,442,116 in 2005. In 2004, the State Demographer has estimated Nevada's population reached 2,410,768. Clark County remains the largest in population, with an estimated 1,715,337 or 71% in 2004.

Per the State Demographer, Nevada reached an estimated 2,518,869 in population in 2005, a 4.5 percent increase and more than what was estimated. This is not as much as the 5 percent increase the year before, but still the fastest in the Nation. Per the U.S. Census Bureau figures, Nevada has been the nation's fastest growing state for 19 straight years. The largest increase was in Clark County (Las Vegas) which added 4.7 % or 81,000 people in 2005 for a total of 1,796,380. Washoe County (Reno) reached 396,844. Lyon County, over the hill from Carson City, is one of the fasted growing counties in the nation west of the Mississippi, showing a 9.4 percent growth to nearly 49,000. It will join Carson City and Elko as a Small Metropolitan Area (SMA) in 2006.

//2008// While Nevada has been the fastest growing state in the rate of its population for 19 years from 1987 -- 2005, it was supplanted by Arizona July 1, 2006. It will, however, per the state demographer continue to be the fastest growing state in population growth to 2030, increasing

114.3% from 2000 to 2030, with a 2030 projection of 4,282,102. In 2006 Lyon County achieved over 50,000 in population, at 54,031 estimated. Clark County is estimated at 1,874,837, Douglas County at 51,770, Carson City at 57,701, and Washoe County at 409,085. Elko fell to 48,339. The rising cost of gold is putting new life back into some of Nevada's communities, with new mines being developed and old mines reopened. Nevada was the leading gold producing state in the country in 2006 according to Doug Driesner, mining services director for the Nevada Division of Minerals. What effect this will have on rural county population is not yet clear. The total for the state for 2006 is estimated to be 2,623,050. //2008//

/2009/ While the state demographer reported in April of 2008 the rate of growth in Nevada has slowed due to a weakening economy and housing slump. In 2007 Nevada returned to being the fastest growing state in the Nation according to a July 2007 report of the U.S. Census Bureau. The total population for Nevada in 2007 according to the state demographer was 2,718,337. This included Clark County with a population of 1,954,319 and Washoe County with a population of 418,061; there are four counties with populations over 50,000: Carson City, 57,723; Douglas County, 52,434; Elko County, 50434; and Lyon County, 55,903. //2009//

Nevada's 17 counties comprise an area of 110,540 square miles, making Nevada the seventh largest state in the Nation. Of Nevada's 17 counties, Clark and Washoe are considered urban with approximately 87% of the population; Carson City, Douglas, Elko, Lyon, and Storey counties are rural; and Churchill, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing and White Pine are frontier counties. It should be noted that Carson City and Elko have been designated a Small Metropolitan Area.

Recent Legislative Session

/2010/ We concluded the Nevada Legislative session on June 2, 2009. The biggest areas of change are in the budget deficit and the cuts to balance the budget. MCH staff are reviewing how changes will impact our populations and working with our coalitions to disseminate information and service referrals where needed. New legislation improved service delivery for several programs in our bureau and the Health Division. Efforts by community partners to pass legislative bills that would create an Immunization Advisory Board, funding vaccines for children who are underinsured, and mandatory insurance coverage for immunization and the inclusion of First Dollar coverage, although passed initial rounds through committees, failed in finance sessions. Working with community partners assisted Title V staff to improve working relationships and better understand community needs. This session also allowed for Title V staff to meet with legislators in formal and informal settings. A lead screening bill passed through legislature. Reducing Blood lead levels and eliminating BLL's higher than 10 ug/d. in children, thus meeting two of the nation's Healthy People 2010 objectives. This bill encourages lead screening by providers, follow up and statewide reporting to local health authorities.

The 2009 legislative session came to a close on June 2nd. There were six priority health related changes (see list below) for the upcoming interim Leg Committee on Health Care, that LCB confirmed during the Assembly Health and Human Services Committee meeting this past Sun. For SFY 2010-11, LCB did lose budget and staff, and the interim committee budgets were also reduced significantly, and LCB staff expects to that they will be requesting Exec Branch agencies to help with tech assistance and data for the studies.

1) SB 278 Requiring the Legislative Committee on Health Care to study certain issues concerning the provision of health care (Health Statistics)
2) AB 191 Revises provisions governing certain examinations of the height and weight of pupils (Vital Stats)
3) AB 326 Revises provisions governing controlled substances (abuse of prescribed narcotics) (Multiple DHHS agencies)
4) SB 293 Makes various changes concerning the protection of children (Division of

Child and Family Services)
5) SB 316 Directs the Legislative Committee on Health Care to consider the establishment of a health insurance exchange in Nevada (Primary Care Organization)
6) AB 294 Directs the Legislative Commission to conduct an interim study concerning group homes (Bureau of Licensure and Certification)

//2010//
As with every state, Nevada's MCH program is based on action taken by the biennial Legislature, which approves, sometimes with changes, the Governor's budget for allocating and appropriating funds and establishing their use. State agencies also establish performance measures and workload indicators to reflect the outcomes of their efforts in the coming biennium. In the 2003 Legislature there were two special sessions, which resulted in an increase in the tax base in the state which put it in better shape than in years past. For 2005, state agencies were instructed to construct their budgets for FY06 - FY07 at two times the expended general funds in the base year (FY04). The Bureau's budgets (MCH and WIC) followed this directive with the only changes in funding those to match what is expected in the various grants and fees that come to the Bureau. The change from the MCH Prenatal and Baby Your Baby programs discussed in prior Title V grant years to a Maternal and Child Health Campaign (discussed in III B) was recommended by the Governor and approved by the 2005 Legislature. Generally the Bureau's budgets for the upcoming biennium show no changes from the 2004-2005 biennium, with no gains and no losses. These budgets were closed (approved) on April 21, 2005.

Highlights
/2010/ On a positive note, the recent HEDIS report for Medicaid Managed Care shows significantly improved rates of Early Periodic Screening Diagnosis Treatment (EPSDT) in our state. Community stakeholders have been leaders to increase awareness of families of the benefit available to them. Participating managed care staff and physician associations have supported education and incentives to providers to comply with the AAP recommended schedules and age-appropriate screening. An Informing & Care Coordination pilot is underway (we received HRSA technical assistance and did peer-exchange with Iowa to launch this). The behavioral health coalitions have been instrumental in driving a campaign for standard behavioral health screens to be used in the well child and EPSDT exams. //2010//

/2010/ MCH Staff and community partners have been active to recruit primary care providers to take the well child online curriculum. The initiative is to promote comprehensive well child and EPSDT exams. http://www.brightfutures.org/wellchildnevada/ . Primary care providers are linked to developmental and behavioral health assessment tools and resources; and non-medical referrals and peer-support (via Family TIES fax back forms), Nevada 2-1-1. Recent progress has been inclusion of the curriculum in a Nevada University Residency program. //2010//

Perinatal Substance Abuse Highlights 10/07-9/08

- Proposal award from March of Dimes to hold FASD/Healthy Babies and Children Summit
- First ever Nevada Summit on FASD/Healthy Babies and Children in September 2008 with more than 175 participants (double the anticipated number) and included national expert presentations pro bono.
- Implementation of national pregnancy screening tool (4Ps Plus) with respect to alcohol and other drug use in Reno in May 2008. (Attached data in SPM 11).
- Senator Maggie Carlton, a member of the PSAP subcommittee, sponsored legislation and obtained an appropriation to expand FASD clinics at UNSOM in Las Vegas and implement clinics in Reno.
- Implementation of first FASD diagnostic clinics in Reno.
- Implementation of third party payor (Medicaid) at Reno FASD clinics to build

sustainability.

- Securing funds in collaboration with SAPTA to include two questions on the BRFSS with respect to pregnant women and alcohol and drug use.
- Expansion of PSAP subcommittee membership to include more representation from parents raising FASD children and those serving the Native American community.
- Attendance by invitation only to the national meeting sponsored by SAMSHA and the FASD Center for Excellence.
- Development of FASD tool kits that were distributed statewide for FASD Awareness Day on September 9, 2008, including a proclamation from Governor Gibbons and Carson City Mayor Texiera.

Community Input

/2009/ The Bureau communicates with our communities consistently through many venues, and it is through these conversations and meetings that we are able to assess needs in an ongoing basis. The Nevada Advisory Council for CYSCHN conducted a survey that collected data from 100 families in rural counties, and NSHD Staff meet regularly with two state associations: Nevada Association of Superintendents & the Nevada Association of School Board Trustees. Discussions from these regular interactions have given rise to several pilot projects in school food service, offering healthy snacks and implementing a salad bar. NSHD Staff also coordinate the State Fitness and Wellness Council, who is also interested in school health. //2009// It is in this milieu that the following priorities for 2005 from the MCH Needs Assessment were established. /2010 see additional text below to show the updated priorities with accompanying state performance measures based on interim needs assessment and board recommendations. ***//2010//. They will guide the Bureau's work in the coming year:***

1. Increase access to primary care services, providers, facilities, resources, and payor sources among the MCH populations.

2. Increase access to oral health services, providers, facilities, resources, and payor sources among the MCH populations.

3. Increase access to mental health services, providers, facilities, resources, and payor sources among the MCH populations.

4. Create a unified data system and surveillance system to monitor services delivered to the MCH populations.

5. Create "braided" services for CSHCN resources in Nevada including "one-stop-shopping" and "no-wrong-door" models of service delivery.

6. Increase financial coverage and decrease financial gaps for health services among the MCH populations.

7. Decrease the incidence of domestic violence among women of child-bearing age.

8. Decrease the risk factors associated with obesity for children and women.

9. Decrease unintentional injuries among the MCH populations. /2007/ no change //2007//

The Bureau's performance Measures, which are included in the budget, are as much as possible, based on the findings of the MCH Needs Assessments. For 2006-2007 they include:

1. Percentage of infants born to women receiving prenatal care in the first trimester to promote healthy birth outcomes.

2. Nevada's teen birth rate (per 1,000) among 15-17 year old females.

3. Percent of newborns screened for metabolic disorders and hemoglobinopathies.

4. Percent of newborns screened for newborn hearing.

5. Number of SEARCH and National Health Services Corps primary care provider placements.

6. Percentage of WIC infants partially breastfed.

/2008/ Nevada's legislative process requires agencies to establish performance measures and work load standards for each upcoming biennium budget. It is the Bureau's strategy to use MCH performance measures (reported annually in the block grant) for legislative budget performance measures wherever possible or report on initiatives that address MCH Performance Measures.

The 2007 Legislature had many decisions to make around a state budget that required cuts or if no cuts no growth in order to be balanced. Maternal and Child Health saw only minor cuts, but enhancements mentioned last year for African American birth outcomes, dental sealants, and teen pregnancy prevention was not included in the Governor's budget. The Bureau's performance measures for the 2008-2009 biennium include:

- *Percent of infants born to women receiving prenatal care in the first trimester*
- *Teen birth rate (per 1,000) among 15-17 year olds*
- *Percent of newborns screened for metabolic disorders and hemoglobinopathies*
- *Number of youth who received a teen pregnancy prevention presentation*
- *Number of SEARCH and National Health Services Primary Care provider placements*
- *Number of oral health education classes held*

WIC's performance measures include:

- *Percent of WIC infants partially breastfed*
- *Percent of WIC-eligible clients served*
- *Percent of infants introduced to solid foods at four months of age or older*
- *Total number of women served (pregnant, breastfeeding and postpartum)*
- *Total number of infants served*
- *Total number of infants served //2008//*

/2009/ As this document is written the state is undergoing a major budget crisis. State agencies have had to cut current budgets' general fund 4.5%. This has obviously impacted the programs of the Department of Health and Human Services. State fiscal year 09 will see more cuts. These impacts will be noted throughout this document. //2009/

Compounding Factors

In addition to the fiscal situation there are many factors that impact the health services delivery system in the state. The extreme rurality of most of Nevada is one that leads to many challenges in developing a health services delivery system in the state. About 12% of Nevadans live in rural and frontier communities, most of which are remote (up to 250 plus miles) from urban centers. This is compounded by a lack of providers for both primary and specialty care that is even seen in the most urban communities. MCH supervises the Primary Care Development Center (PCDC), Nevada's Primary Care Organization (PCO). The PCDC is responsible for conducting the surveys necessary to establish Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs). HPSAs can be primary care, dental or mental health shortages and have a very high patient to provider ratio. These

designations help with the recruitment of providers to underserved areas.

PCDC also manages the J-1 Visa program, which places foreign physicians in underserved areas. In FY03 the process for selecting J-1 Visa physicians was changed to give priority to those who serve in a Federally Qualified Health Center or Tribal Health Center, and to not approve any physicians who would be working at a non-primary care site. Currently, of Nevada's 17 counties, 10 in their entirety are Primary Care and Dental HPSAs, and 12 in their entirety are Mental HPSAs. With the exception of Carson City, the rest of the counties are partial HPSAs in all three designations. There are 24 HPSA designations and one MUP. /2007/ There are currently a total of 64 HPSAs, 31 for primary care, 17 for dental health and 16 for mental health. There are now 8 MUAs, 2 MUPs and 2 Governor's Designated Areas. The good news is that 3 areas no longer qualify for underserved status, those of Mesquite, portions of south central Las Vegas, and one in North Las Vegas. //2007//

/2008/ In 2007 there are 61 HPSAs (30 for primary care 10 whole county and 20 partial), 15 for dental health (10 whole county and 5 partial), and 16 for mental health (12 whole county and 4 partial). There are 8 MUAs, 2 MUPs and 2 Governor's Designated Areas. There is one fewer HPSA for primary care, and two fewer HPSAs for dental care. The primary care HPSA that dropped off is low-income East Carson City; the dental HPSAs that dropped off are SW and NE Central Las Vegas. There are currently 38 J-1 Visa physicians practicing in the state and 19 National Interest Waiver. //2008//

These designations help with the recruitment of providers to underserved communities through several programs that PCDC administers. In addition to the J-1 Visa Waiver program, PCDC administers the Student/Resident Experiences and Rotations in Community Health (SEARCH) training program for health care students, and the National Health Service Corps (NHSC). The J-1 Visa program, known as the Conrad 30 program, places foreign medical graduate physicians in medially underserved areas where it is often very difficult to recruit physicians. In FY 05 there are 76 (plus 7 pending) active J-1 physicians practicing throughout Nevada, 94 health care students that have received training through the SEARCH program, and 18 health care professionals that have been placed through the National Health Service Corps.

The PCDC works closely with the Primary Care Association (PCA), the Great Basin Primary Care Association (GBPCA), to promote the placement of health services personnel in underserved areas. It is working with GBPCA in implementing its Statewide Strategic Plan to develop at least 10 new primary care sites over the next five years. It is also working with GBPCA in several community development initiatives around primary care, the largest being in Las Vegas. PCDC also develops sites and places National Health Service Corp (NHSC) and SEARCH providers in clinical and pre-clinical rotations.

PCDC works closely with a number of key organizations involved in the development of primary care resources throughout the state. Included with GBPCA are Nevada Health Centers, Office of Rural Health, University of Nevada School of Medicine, Nevada Rural Hospital Partners, Area Health Education Centers, Washoe County Access to Health Care Network, and Clark County Health Access Consortium. In FY 05 the Washoe County Access to Health Care Network applied for and received for the first time in Nevada a CAP grant to promote access to primary care in Washoe County. This is the first CAP grant for Nevada. /2007/ With the ending of CAP funding the Washoe County Access to Health Care Network has pulled together to continue the activities started under the grant. //2007//

Organizational changes
/2009/ In January of 2008 the PCDC was moved from the Bureau of Family Health Services to the Bureau of Health Planning and Statistics to be part of planning unit being developed by the Department of Health and Human Services. This is further discussed in III C

Organization. //2009//

Health Equity
/2008/Health Disparities
The Bureau recognizes the impact of the changing demographics in the state, both from the increasing population and the changing race and ethnicity of its citizens. All Bureau programs as do those in the Health Division work to address health disparities in all initiatives. These efforts are described through out this document. They include the Maternal and Child Health Campaign, which serves women with no resources for prenatal care; those served are primarily Hispanic. In addition, MCH Campaign staff is working with a coalition of medical providers in southern Nevada which includes the Latin Chamber of Commerce to address disparities in accessing prenatal care. Most of those who answer the Information and Referral line are bi-lingual. The Bureau makes an effort to recruit bilingual staff. MCH Campaign media materials are in English and Spanish. Oral Health surveillance of Head Start children and children in the third grade find higher rates of decay in minority children; oral health initiatives work to address these inequities. The teen pregnancy prevention initiatives target the Hispanic populations as they have the highest rate of teen pregnancy. The WIC program is seeking to place clinics in areas frequented by Hispanics and African Americans, and has all its' materials in both English and Spanish. There are translators in all WIC clinics where necessary. CSHCN materials are in English and Spanish. The PSAP brochures are also in Spanish and English. The MCH Manager is working with the Office of Minority Health and local community based organizations to resurrect the African American initiative on reducing infant mortality and low birth weight for the 2009 Legislative session. //2008//

/2009/ Efforts continue to work with the Office of Minority Health around health disparities. The OHM Manager met with the Maternal and Child Health Advisory board in May 2008 and has engaged their attention about several initiatives she is promoting. As noted elsewhere, she and the Bureau Chief are working together to address the African American birth outcomes by working with community based partners. All efforts described in 2008 continue. //2009//
/2010/As of January 1, 2009 the Nevada State Immunization program was no longer able to provide all of the recommended vaccines for all children in the state. This decision came after lengthy discussions on a twice weekly basis with community leaders. Due to federal and state budget shortfalls the decision to provide vaccines following the Vaccines for Children program began. Through multiple communications, town hall meetings, presentations, electronic mailings and twice weekly teleconferences and mass faxes, a smooth transition occurred. The State Immunization Program has improved its communication with stakeholders in the state due to this transition with many appreciating the transparent communication. Works to improve the State Immunization Registry are under way. With improved data linkages, tracking children can be completed as studies have shown that tracking and scattered record keeping are barriers to up to date immunizations. With our State Birth Records Registry working many MCH programs can link and collect data for improvement in program development.
With the assistance of the federal MCHB and state and community partners a project is under way to integrate cultural and linguistic competence into our MCH programs. The integration will be in stages and stage I begins in June with a contractor to identify critical core team members and develop planning for our strategic plan. //2010//

Health Coverage
Medicaid and the Child Health Insurance Program in Nevada:
Nevada's Medicaid and Children's Health Insurance Program are managed by the Division of Health Care Financing and Policy. The Nevada Division of Health Care Financing and Policy (DHCFP) contracts with two managed care organizations, which provide health care to Medicaid-eligible individuals in Clark County and urban Washoe County. Statewide enrollment in Title XIX Nevada Medicaid is approximately 166,000 and, as of June 2005, 81,861 of these recipients are

enrolled in the managed care plans. Others receive care under Fee-for-Service Medicaid. Participants eligible for full Medicaid benefits pay no co-pays or premiums for covered medically necessary services, regardless of enrollment.

The Nevada Division of Health Care Financing and Policy (DHCFP) contracts with two managed care organizations, which provide health care to Medicaid-eligible individuals in urban Clark County and Washoe Counties. Statewide enrollment in Title XIX Nevada Medicaid is approximately 172,479 and, as of May 2006, 80,110 of these recipients are enrolled in the managed care plans. Others receive care under Fee-for-Service Medicaid. Participants eligible for full Medicaid benefits pay no co-pays or premiums for covered medically necessary services, regardless of enrollment.

Nevada Check Up (the Title XXI State Children's Health Insurance Program) continues to grow as more eligible families learn about program availability. The program benefits children who are not eligible for traditional Medicaid and may not otherwise have access to health care. Currently, Nevada Check Up serves 28,836 children statewide. Of those, 23,715 are enrolled in the contracted managed care plans in Clark County and urban Washoe County. The remaining 5,121 children reside in rural counties and receive care under the Fee-for-Service program. There is no co-pay for covered medical benefits, although families do pay a monthly premium based on income and household size. The 2005 Legislature has assured there will be no cap on Nevada Check Up.

In 2005 Nevada Check Up became a separate Bureau in DHCFP. Previously its management was combined with Medicaid Managed Care's. The Nevada Check Up (the Title XXI State Children's Health Insurance Program) program benefits children who are not eligible for traditional Medicaid and may not otherwise have access to health care. Currently (July 2006), Nevada Check Up serves 27,542 children statewide. Of those, 23,221 are enrolled in the contracted managed care plans in Clark County and urban Washoe County. The remaining 4,321 children reside in rural counties and receive care under the Fee-for-Service program. There is no co-pay for covered medical benefits, although families do pay a quarterly premium based on income and household size.//2007// /2008/ In 2006-2007 Nevada Check Up saw its caseload rise. In May 2007 it was reported that caseload is rising. The program is receiving 2,100 applications a month compared to 1,460 applications a month received last year. Total caseload for May 2007 was 29,409. //2008//

/2009/ In April of 2008 Nevada Check up reported its monthly caseload case load average was 29,444, compared to 28,356 for 2007. A decision to cap Nevada Check Up due to the state's budget crisis was reversed and never implemented. The program reported in April 2008 that the number of applications has stabilized, but the year-to-date monthly average of applications received is 2% below last year's. It is hypothesized that with the downturn in the state's economy more children are winding up on Medicaid. A tracking system is in place to monitor this. //2009//

Other Nevadans who are ineligible for traditional Medicaid but still need assistance obtaining health care may benefit from the recent passage of Assembly Bill 493 by the 2005 Legislature. The legislation allows the Division of Health Care Financing and Policy to apply to the Federal government for a waiver pursuant to the Health Insurance Flexibility and Accountability demonstration initiative. If authorized, the waiver will pave the way for Nevada to provide coverage for medical services or subsidies to three groups: 1) Pregnant women with household incomes between 133 and 185 percent of the Federal Poverty Level; 2) individuals employed by certain small businesses, whose incomes are below 200 percent of the FPL, and 3) low-income individuals who do not qualify for traditional Medicaid but who experience a health crisis that results in unpaid hospital charges exceeding $25,000. The Bureau works closely with the Division of Health Care Financing and Policy to ensure services needed by the MCH populations are provided.

Nevada Assembly Bill 493, passed and approved by the governor in June of 2005 authorized the

Division of Health Care Financing and Policy to apply to the Federal government for a waiver pursuant to the Health Insurance Flexibility and Accountability demonstration initiative. The HIFA waiver was submitted to the Centers for Medicare and Medicaid Services in February of 2006. Language negotiations have pursued with expected approval in August. If authorized, the waiver will pave the way for Nevada to provide coverage for medical services or subsidies to two groups: 1) Pregnant women with household incomes between 133 and 185 percent of the Federal Poverty Level, and 2) individuals employed by certain small businesses, whose incomes are below 200 percent of the FPL. /2008/ The HIFA waiver was approved by CMS. The pregnancy waiver was effective December 1, 2006. It has had a slow start but now has over 100 women so far with 13 infants automatically rolled to Nevada Check Up upon birth. The waiver for individuals employed by small businesses started April 1, 2007, and is experiencing a very slow start. //2008//

/2009/ Due to the state's budget crisis the HIFA waiver was temporarily put on hold early in 2008. It was later reinstated but limited to 200 pregnant women at any given time. The waiver for individuals employed by small businesses was also put on hold and then capped at 100. It is still experiencing a very slow start, with only 3 enrolled in April 2008. //2009// ***/2010/The Medicaid MCO make a good faith effort to screen Title XIX and Title XXI pregnant women enrolled in a MCO for maternal high risk factors. The Maternity Risk Screening Form helps identify and meet the need for medical and non-medical services. These services are defined as preventive and/or curative services and may include, but are not limited to, patient education, nutritional services, personal care services or home health care, substance abuse services, and care coordination services, in addition to maternity care Any identification of high-risk factors will require the PCP, OB provider, RN, LPN or other health care professional to refer the woman who is determined to be at risk for preterm birth or poor pregnancy outcome to the MCO's case management where follow up will continue. The Maternity Risk Screen form can be found on the DHCFP website http://dhcfp.state.nv.us. Medicaid reimbursement continues to be a major challenge per conversations with providers. The Title V staff and our partners continue to offer information and support to private and public providers including billing and coding education for services that impact state objectives. //2010//***

/2010/With cuts to our state budget, many difficult decisions had to be made. With limited funds and a need to stretch resources and meet the needs of our population the MCH program reevaluated the distribution of funds. With input from members of the MCH Advisory Board especially interested in prenatal issues, a Request for Information was sent to community organizations for feedback on the direction of future programs funded by MCH. Feedback requested a population based service delivery. A Request for Proposals will be written and disseminated as an open competition. Centering Pregnancy, Nurse Family Partnership and the First Time Motherhood Grant are currently or will be population based approaches in Perinatal/Maternal health.

Title V representation remains on the Statewide CDR Executive and Administrative Committees. Recently the MCH representative, Injury Prevention Coordinator and CDR representative from Nevada joined together to plan a Safe Sleep Campaign that focuses on prevention while encouraging breastfeeding. These committees work to bring together state and community programs to support leadership, support legislation and reporting //2010//

Temporary Assistance for Needy Families (TANF) in Nevada:
Nevada's TANF Cash Grant program serves 8 population subgroups: Single Parents, 2-Parents, 2-Parents in which One or Both are Incapacitated, Non-Needy Caretakers, Kinship Care program, Non-Qualified Non-Citizens, SSI Households and Family Preservation Program /2007/ (FFP ended June 2005.)//2007//. The last 5 of these categories are "child-only" programs in which only the children of the household are eligible for cash assistance.

In state fiscal year 2004, the average monthly number of total TANF Cash Grants recipients was 24,956, of which 18,644 were children and 6,312 were adults. For state fiscal year 2005 year-to-

date (through March 2005), the monthly average is 22,146, which is an 11.3% decrease from FY04. In 2005 the caseload has decreased from a post-9/11/01 high of 35,122 recipients in May 2002 and is now almost at pre-9/11/01 levels.

Although the continued improvement in Nevada's economy has contributed to the decrease in the TANF caseload since the impact of September 11, 2001, the largest factor has been the Welfare Division's development of strategies to ensure those applying for TANF cash assistance are committed to participating in self-sufficiency programs designed to train and connect recipients to employment.

As an example, under old business operations individuals approved for TANF were scheduled to attend orientation within thirty (30) days of approval to gain a full understanding of what was expected of them in pursuit of self-sufficiency. As a business process improvement, the orientation process was moved to pre-eligibility, allowing all TANF applicants the opportunity to learn what would be expected of them. Surprisingly, approximately 20% of TANF applicants withdraw their applications for cash.

Another business process change required all approved TANF recipients to report for thirty (30) hours of work assignments in the Welfare Office within seven calendar days after approval. When TANF recipients report to the Welfare Office they are assigned non-critical work activities such as paper shredding, photocopying, telephone answering, etc. More importantly, during the thirty hours Welfare Division staff have adequate opportunity to perform a full skills assessment, develop a comprehensive personal responsibility plan, fully address all Child Support issues, identify undisclosed client barriers and establish a long term self-sufficiency plan. Per Welfare, this business process change ended almost as soon as it started. For the rest no change.

Some newly approved recipients fail to complete this requirement and allow their case to be placed in sanction status. Once in sanction status clients are given thirty (30) days to secure program compliance or case closure will occur. When a case is placed in sanction status, the recipient is notified and all future TANF checks are placed in office pick-up status. When the TANF recipient comes to the office to pick up the check they meet with their case worker to address the non-compliance issue and develop a corrective action plan. The aforementioned changes have significantly impacted the number of individuals participating in the TANF cash assistance program in FY04 and FY05 YTD.

The following are details about the individual TANF programs supplied by the Welfare Division:

a. AF - Single Parent Household. This is the typical case; usually a single mom & 2 kids. Payment for a 3 person household = $348.00 per month (p/m). Average family size = 2.83.
b. AI -- Two Parent Household (One or Both Incapacitated). This case will have an adult that is incapable of working due to a serious illness or injury. Payment for a 3 person household = $348.00 p/m. Average family size = 3.40.
c. UP -- Two Parent Household. This case has both adults not working but able to. Payment for a 3 person household = $348.00 p/m. Average family size = 4.34.
d. CON -- Child Only Non-Needy Caretaker Household. This is a case where adult relative(s) of the child(ren) are taking care of him/her/them. Payment for a 3 person household = $535.00 p/m. Average family size = 1.62.
e. COK -- Child Only Kinship Household. This case is similar to CON except that these are normally grandparents aged 62 and over and have court ordered custody of the children. Payments are per child. 0-12 years old receive $534.00 per child. Ages 13 and up receive $616.00 per child. Average family size = 1.65.
f. COA -- Child Only Non-Qualified Non-Citizen Household. This case is typically where the parent(s) are not in the country legally but have children that were born here. Payment for a 3 person household = $348.00 p/m . Average family size = 2.46.
g. COS -- Child Only SSI Household. This case has a parent(s) that is eligible for SSI payments. Payment for a 3 person household = $348.00 p/m. Average family size = 2.05.

h. COF -- Child Only Family Preservation Plan Household. This is a case where a severely handicapped child is kept at home instead of being institutionalized. Payments are per child. Any age = $350.00 per child. Average family size = 1.00. This program is scheduled to be transferred to the Mental Health Division effective 01 July 2005 (SFY06 start). This program was transferred as planned to Mental Health/Developmental Services Division July 1, 2005.

Prior to July 2004 the Kinship program only paid an additional $100.00 per additional child. This was changed starting with July 2004 for a larger payment as stated above.

Average family sizes quoted above are FY2005 year to date.

/2007/ The following are the details for 2005 and 2006 year to date:

a. AF - Single Parent Household. Average family size = 2. 78.
b. AI -- Two Parent Household (One or Both Incapacitated). Average family size = 3. 48.
c. UP -- Two Parent Household. Average family size = 4. 29.
d. CON -- Child Only Non-Needy Caretaker Household. Average family size = 1. 65.
e. COK -- Child Only Kinship Household. Average family size = 1. 62.
f. COA -- Child Only Non-Qualified Non-Citizen Household. Average family size = 2.460.
g. COS -- Child Only SSI Household. Average family size = 1.98.

Average family sizes quoted here for FY2006 year to date.

There have been no changes in the description of the programs or the amount of the cash grants. //2007//

/2008/Temporary Assistance for Needy Families (TANF) in Nevada -- for FY07 YTD (thru 4/07)

Nevada's TANF Cash Grant program currently serves 7 population subgroups: Single Parents, 2-Parents, 2-Parents in which One or Both are Incapacitated, Non-Needy Caretakers, Kinship Care program, Non-Qualified Non-Citizens, and SSI Households The last 4 of these categories are "child-only" programs in which only the children of the household are eligible for cash assistance.

In state fiscal year 2006, the average monthly number of Total TANF Cash Grants recipients was 19,880. For state fiscal year 2007 year-to-date (through April 2007), the monthly average is 17,498, which is an 11.98% decrease over FY06.

Although the stability of Nevada's economy has contributed to the ongoing decrease in the TANF Cash caseload, another factor has been the new Citizenship Verification requirements mandated through the Deficit Reduction Act (DRA), which went into effect July 1, 2006. This mandate has resulted in an increase of TANF Cash denials due to failure to provide required documentation proving citizenship.

Additional DRA requirements with regard to work participation rates have necessitated significant changes in the TANF Cash program, which DWSS will be implementing beginning FY08. It is anticipated that the TANF Cash caseload will continue to decrease in FY08 and FY09 due to these changes.

Details of the individual TANF programs supplied by the Welfare Division:

a. AF - Single Parent Household. This is the typical case; usually a single parent & 2 kids. Payment for a 3 person household = $348.00 p/m. Average family size = 2.79.
b. AI -- Two Parent Household (One or Both Incapacitated). This case will have an adult that is incapable of working due to a serious illness or injury. Payment for a 3 person household = $348.00 p/m. Average family size = 3.34.

c. UP -- Two Parent Household. This case has both adults not working but able to. Payment for a 3 person household = $348.00 p/m. Average family size = 4.21.
d. CON -- Child Only Non-Needy Caretaker Household. This is a case where adult relative(s) of the child(ren) are taking care of him/her/them. Payment for a 3 person household = $535.00 p/m. Average family size = 1.66.
e. COK -- Child Only Kinship Household. This case is similar to CON except that these are normally grandparents aged 62 and over and have court ordered custody of the children. Payments are per child. 0-12 years old receive $534.00 per child. Ages 13 and up receive $616.00 per child. Average family size = 1.66.
f. COA -- Child Only Non-Qualified Non-Citizen Household. This case is typically where the parent(s) are not in the country legally but have children that were born here. Payment for a 3 person household = $348.00 p/m . Average family size = 2.50.
g. COS -- Child Only SSI Household. This case has a parent(s) that is eligible for SSI payments. Payment for a 3 person household = $348.00 p/m . Average family size = 1.86.

Average family sizes quoted above are FY2007 year to date.//2008//

/2009/ Temporary Assistance for Needy Families (TANF) in Nevada -- for FY08 YTD (thru 4/08)

Nevada's TANF Cash Grant program currently serves 10 population subgroups: Single Parents, 2-Parents, 2-Parents in which One or Both are Incapacitated, TANF Loan, TANF Temporary, TANF Self Sufficiency Grant, Non-Needy Caretakers, Kinship Care program, Non-Qualified Non-Citizens, SSI Households. The last 4 of these categories are "child-only" programs in which only the children of the household are eligible for cash assistance.

In state fiscal year 2007, the average monthly number of Total TANF Cash Grants recipients was 17,712, of which 4,110 were adults and 13,602 children. For state fiscal year 2008 year-to-date (through April 2008), the monthly average is 20,943, which is an 18% increase over FY07.

Details of the individual TANF programs supplied by the Welfare Division:

a. TN, (formerly AF) - Single Parent Household. This is the typical case; usually a single parent & 2 kids. Payment for a 3 person household = $383.00 p/m. Average family size = 2.84.
b. TN1, (formerly AI) -- Two Parent Household (One or Both Incapacitated). This case will have an adult that is incapable of working due to a serious illness or injury. Payment for a 3 person household = $383.00 p/m. Average family size = 4.12.
c. TN2, (formerly UP) - Two Parent Household. This case has both adults not working but able to. Payment for a 3 person household = $383.00 p/m. Average family size = 4.31.
d. TL, (Loan) -- Eligible households receive a monthly payment to meet the family's needs until a future anticipated source of income is received. This is not assistance and the expectation is the benefits will be repaid upon receipt of the anticipated income.
e. TP, (Temporary) -- Provides a monthly payment to meet an immediate episode of need and limited to no more than four months per episode. This is not defined as assistance
f. SG, (Self Sufficiency Grant) -- A one-time lump sum payment to help families who would be otherwise eligible for another program to preserve their independence from long-time dependence on Public Assistance and is not considered assistance.
g. CON -- Child Only Non-Needy Caretaker Household. This is a case where adult relative(s) of the child(ren) are taking care of him/her/them. Payment for a 3 person household = $535.00 p/m. Average family size = 1.63.
h. COK -- Child Only Kinship Household. This case is similar to CON except that these are normally grandparents aged 62 and over and have court ordered custody of the children. Payments are per child. 0-12 years old receive $534.00 per child. Ages 13 and up receive $616.00 per child. Average family size = 1.66.
i. COA -- Child Only Non-Qualified Non-Citizen Household. This case is typically where the parent(s) are not in the country legally but have children that were born here. Payment for a 3

person household = $383.00 p/m. Average family size = 2.52.
j. COS -- Child Only SSI Household. This case has a parent(s) that is eligible for SSI payments. Payment for a 3 person household = $383.00 p/m. Average family size = 1.77.

Average family sizes quoted above are FY2008 year to date. //2009//

B. Agency Capacity

The Bureau works to leverage its resources to promote and protect the health of the MCH populations it serves including CYSHCN. It does this through partnering and collaborating with multiple agencies and programs, both government and private, across the state. Many of those efforts are described in this Section.

Program authority for Nevada's MCH and CSHCN programs are contained in Nevada Revised Statutes (NRS) and Nevada Administrative Codes (NAC) as follows:
* NRS 442.120-170, inclusive. Designates the department of human resources through the health division to "Cooperate with the duly constituted federal authorities in the administration of those parts of the Social Security Act which relate to maternal and child health services and the care and treatment of children with special health care needs".
* NRS 442.130. Designates DHR as the agency of the state to administer, through the SHD, a MCH program, and to advise the administration of those services included in the program that are not directly administered by it. "The purpose of such a program shall be to develop, extend and improve health services, and to provide for the development of demonstration services in needy areas for mothers and children".
* NRS 442.133. Establishes the Maternal and Child Health Advisory Board. The purpose of the Board is to advise the Administrator of the SHD concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of children.
* NRS 442.140. Authorizes a state plan for MCH.
* NRS 442.180-230. Authorizes the department (DHR) to "administer a program of service for children who have special health care needs or who suffering from conditions which lead to a handicap, and to supervise the administration of those services included in the program which are not administered directly by it."
* NRS 442.190. Authorizes a state plan for children with special health care needs.
* NRS 442.115. Authorizes the State Board of Health (also appointed by the Governor) to adopt regulations governing "examinations for the discovery of preventable inheritable disorders, including tests for the presence of sickle cell anemia". The follow-up for those whose examinations and tests "reveal the existence of such a condition" is described in this statute also. The newborn screening program is placed in the Bureau.
* NRS 442.320-330. Authorizes the establishment of a Birth Defects Registry
* NAC 442. Maternal and Child Health. Establishes regulations for the CSHCN program regarding eligibility, covered conditions and so forth. It establishes the protocol for the taking of blood samples from infants for newborn screening, establishes fees for services of the Bureau of Early Intervention Services' Early Intervention Services, and the nurses of the Bureau of Community Health Services, and defines level of care of hospital neonatal units. It also establishes the provisions for the operation of the Bureau's Birth Defect Registry. ***/2010/ AB 136, creating statutory authority for the Oral Health Program and for a 13 member State Oral Health Advisory Committee, was passed during the 2009 legislative session. //2010//***
Note: The 2005 Legislature changed the name of the Department of Human Resources to the Department of Health and Human Services. This change will occur in the coming year. For the purposes of this document, DHR will be used when referring to the Department.

All of the above statutes and regulations impact the operations of Nevada's MCH and CSHCN programs by giving state authority for the programs to the SHD and setting operating regulations into state law. This ensures the programs operate within legal boundaries established and monitored by the state. In addition to the authority for MCH, CSHCN, Newborn Screening and the Birth Defects Registry contained in NRS and NAC, the state budget process also places MCHB's Abstinence Education, SSDI, and Newborn Hearing grants, WIC, Primary Care Organization, the Center for Disease Control and Prevention's (CDC's) Oral Health, Rape Prevention and Injury Prevention grants and the Centers for Medicare and Medicaid Real Choice Systems Change grant within Bureau operations. In FY04 the MCHB funded Early Childhood Comprehensive Systems grant was added.

The Bureau seeks to work closely with state's public health community including the Clark County Health District (CCHD), Washoe County District Health Department (WCDHD) and Carson City Health Department to promote the health and well being of the MCH/CSHCN populations in those counties, as well as with the other Bureaus of the SHD. Title V funding supports adolescent health clinics in both Clark and Washoe Counties. Title V funding provides some support for Community Health Nursing in Nevada's rural and frontier counties.

The Bureau is home of a small program that is payor of last resort for the treatment of CSHCN. This program acts as a safety-net provider for eligible individuals who do not meet the eligibility requirements for Medicaid, Supplemental Security Income (SSI which includes Medicaid in Nevada), or Nevada Check Up (Nevada's S-CHIP program), and otherwise meet the eligibility requirements contained in NAC. For covered children the program will pay for specialty and subspecialty care, nutrition and primary care and reconstructive dental care if the child does not have insurance. CSHCN staff refer potential eligible families to Medicaid, SSI, and Nevada Check Up, and follow them until eligibility determination has been made. The Health Division data system has been revised and converted to new software that allows automated data matches with Newborn Screening, the Birth Defects Registry, Medicaid claims, Vital Statistics and Newborn Hearing Screening, and a variety of other state programs. This enables staff to better track what programs and/or initiatives are following the children, services received, etc. The monitoring of eligibility of children referred to Medicaid and Nevada Check Up is now accomplished on-line. Eligibility for the program is currently established at 250% of the Federal Poverty Level, with legal residency in the Nation and Nevada residency required.

The Bureau used to have a program that paid for prenatal care for eligible women. This was discontinued in May of 2004. The Bureau now promotes obstetrical services for low-income, high-risk women through a program called the Maternal and Child Health (MCH) Campaign. The Bureau currently has a contract with a community-based provider in Las Vegas, which serves primarily Hispanic and African American clients. In FY 06 it added a contract with a community based provider in Reno in addition to the one in Las Vegas. Besides prenatal care, each client is screened for social service needs, nutrition needs, domestic violence, substance abuse, and perinatal depression. These community, direct-service providers screen all clients for social service, referring to various community agencies as needed, in addition to providing obstetrical services. Early entry into prenatal care is particularly low among Hispanic women. All contracted agencies with the Bureau are to offer bilingual (English and Spanish) service, and have culturally appropriate materials. As part of the services provided by the community based provider the infant born to the covered mother is followed to age one. A medical home will be established for the infant when this service ends on their first birthday. In FY 07, a budget enhancement to expand the above stated services was submitted for inclusion in the Governor's budget; however, this enhancement was not included in the Governor's final budget. We will continue to research and identify other resources that may be used to enhance our Maternal and Child Health Campaign.

Another part of the MCH Campaign is a toll free bilingual (English and Spanish) Information and Referral Line (IRL) that serves as a referral source for pregnancy care statewide. It is also

provides information for families in need of pediatric care, with referrals to Nevada Check Up, Medicaid, and pediatric providers a service offered through the IRL. Campaign pediatric providers are in Clark and Washoe Counties, and in the rural communities of Armagosa, Austin, Beatty, Elko, Eureka, Gerlach, Hawthorne, Pahrump and Carson City. This number is 1-800-429-2669 (the same number used for Baby Your Baby). The IRL has been a primary component for signing up women, infants and children for Medicaid and Nevada Check Up as well as referring them and their families to other services such as WIC, immunizations, adoption, substance abuse treatment, a source for dental care, etc. All who call are queried regarding their insurance status. If they do not have or have concerns about it, staff will refer them to Medicaid and/or Nevada Check Up and other resources such as the members of GBPCA and the Bureau's MCH Campaign providers and CSHCN program. A third part of the MCH Campaign is an outreach campaign that includes a mass-media campaign, again in both English and Spanish, that educates the public about pregnancy and other related matters. The Bureau has contracted with the Nevada Broadcaster's Association to air both radio and television announcements about the importance of early and continuous prenatal care, information about Medicaid and Nevada Check Up, proper nutrition during pregnancy, and where care may be obtained. This outreach campaign is funded by a contract with DHCFP, Medicaid. For each dollar that the Bureau spends on public education, Medicaid will match it.

The Bureau also now has a toll-free IRL for CSHCN. This new phone number is currently being marketed through a media campaign. It refers callers to services available in the state for CSHCN and their families. This number is 1-866-254-3964.

The Bureau is linked electronically with Medicaid and Nevada Check Up eligibility records in order to check eligibility and prevent duplications. The CSHCN Program does not serve those eligible for Medicaid or Nevada Check Up (unless it is a service such as specialty foods that Medicaid or Nevada Check Up do not pay for). This is possible through NRS, which allows sharing of information between Divisions of the Department of Human Resources and ensures confidentiality of those communications.

The Bureau has a web page where a description of Bureau programs and initiatives may be found and links to web pages either specific to the Bureau such as Oral Health and WIC or relative to MCH such as the Interactive Data Base of the Center for Health Data and Research that is partially supported by the SSDI grant. The Bureau web page is located at http://health2k.state.nv.us/bfhs/. Program web pages can be accessed through the Bureau's main web page. The Prenatal web page contains information on how to have a healthy pregnancy, infant care, well child issues, teen pregnancy issues, and many other topics related to maternal and child health. It is one of the most popular web pages on the SHD web-page, receiving several hundred hits a week. A new CSHCN web page was launched in January 2005. It contains links to Medicaid, Nevada Check Up, Food Stamps, SSI, and other programs that might be useful for CSHCN and their families. It is currently being marketed through a media campaign. /2008/ The SHD web page address has changed to http://health.nv.gov. To reach the Bureau's web page the reader has to start at the SHD web page, and then select the Bureau. From there selection can be made of the program web page. The SHD web page no longer has page selection web addresses. //2008//

The Bureau continually works to partner with Medicaid in promoting the health and well-being of Medicaid pregnant women and then their infants. Through contacts between the two agencies and interaction before the Maternal and Child Health Advisory Board (MCHAB) MCH is able to bring concerns about both Medicaid and Nevada Check Up to the attention of the regulatory agency and see them addressed as much as possible. The Bureau continues to look for ways to perform outreach for Nevada Check Up and Medicaid including the contract for the MCH Campaign. Referrals to Nevada Check Up and Medicaid are made through the CSHCN Program, the MCH campaign and WIC, and in FY 06 through the Real Choice Systems Change pilot projects discussed below.

The Bureau continues to work closely with the University of Nevada School of Medicine (UNSOM). Bureau staff contract with some and otherwise support UNSOM participation in multi-disciplinary clinics for CSHCN that include Genetics, and Cleft/Craniofacial clinics in Reno and Las Vegas. The Bureau Chief and a UNSOM Geneticist are currently working out the details of a Fetal Alcohol Syndrome multi-disciplinary clinic that will first be held in Las Vegas. A vision care clinic also in Las Vegas at a Early Intervention site has recently been proposed and is under consideration.

The Bureau is working very closely with the new Office of Disability Services and Community Based Services which are in DHR Director's office. The Office of Disability Services is working closely with the Real Choice Systems Change project discussed below, particularly on the area of transition of CSHCN to adulthood. It was also the lead on a "211" line for one-stop referrals proposed during the current legislative session and worked with the Bureau to ensure the Bureau's hot lines were appropriately included. This bill did not make it out of session; it was however reintroduced in an omnibus bill that included $200,000 to implement a 211 line. A committee of representatives from the various DHR Divisions including Health's MCH is currently meeting to begin the development of the line.

The Department of Human Resources is the recipient of a three-year Centers for Medicare and Medicaid Services (CMS) $1,385,000 grant to build systems of care for Children with Special Health Care Needs. This is a "Real Choice Systems Change" (RCSC) grant. This DHR grant was placed in the Bureau for implementation. It experienced a delay in implementation which will lead to a fourth year into FFY 06. Its components are a CSHCN Advisory Committee, a CSHCN Needs Assessment, a web page, and 3 pilot projects implementing the findings of the Needs Assessment for CSHCN systems development. The media campaign is currently underway (and is the one marketing the CSHCN web site and IRL.) The Needs Assessment was completed in January 2005 and the Advisory Committee appointed; several meetings have been held. The Advisory Committee has had a subsequent meeting to review the findings of the Needs Assessment and is overseeing the pilot projects that the grant calls for based on the findings of the Needs Assessment. The CSHCN Needs Assessment is a complete in-depth assessment of CSHCN in Nevada to provide a better understanding of the nature and magnitude of challenges facing CSHCN ages birth to 22 and their families in Nevada (e.g., the level of need, amount of services available, amount of services required, service gaps, cultural issues, service duplications, etc.). The data generated by this study will help address CSHCN systems development. Three pilot projects, northern urban, southern urban, and rural, are in the process of being developed and implemented based on the findings of the Needs Assessment. The data generated from the needs assessment will also be used to develop public policy initiatives and demonstration projects to ensure coordinated, family-focused, and community-integrated systems of care for all of Nevada's Children with Special Health Care Needs. This includes family partnership in system planning and service selection, effective supports for CSHCN transitioning to adult life, and better-coordinated care throughout childhood and into young adulthood. This is the piece that is being coordinated with the Office of Disability Services.

The PCDC partners very closely with the Great Basin Primary Care Association and its members to promote access to primary care for all Nevadans including pregnant women, infants, children and adolescents, and CSHCN. In many rural parts of the state as well as in Washoe and Clark Counties GBPCA members are the only providers available for primary care including infant well-child and other care particularly for low income individuals. In 2005 one of its members, Nevada Health Centers, also became a WIC provider in Southern Nevada. In addition, the MCH supported Community Health Nurses of the BCH provide well-child services for infants in the rural counties.

MCH will continue to support Adolescent Clinics in Reno and Las Vegas. These are provided under contract with Washoe County District Health Department (WCDHD) and the Huntridge Teen Clinic in Las Vegas. The Child and Adolescent Health Coordinator will work with the Adolescent Clinics in the coming year to assure they continue to address identified needs. ***/2010/***

The contracts with Washoe County District Health Department (WCDHD) and the Huntridge Teen Clinic in Las Vegas were both discontinued in 2009. //2010//
The MCH Chief serves on DHR's Child Care Advisory Committee, representing the SHD to promote health concerns. The Child Care Steering Committee includes representatives of Health, Welfare, Dept. of Education, Nevada's Community Colleges, University of Nevada, Head Start, Welfare contractors, Consumers, Family to Family Connection, etc. It is charged with advising the Department of Human Resources and the Governor on improving quality and availability of child care for Nevada's children, particularly those services provided to TANF recipients and clients who are receiving transition services from TANF. The MCH Chief is one of 4 state employees on this Committee.

The MCH Chief participates in the Title V-B Steering committee for Family Preservation and Support. The MCH Chief will continue work to ensure MCH concerns are addressed in any changes to Nevada's Title IV-B program. Through the DHR Child Care Advisory Committee, the MCH Chief continues to promote the inclusion of training for care of CSHCN in all training initiatives. The inclusion of CSHCN in all publicly funded child care including those sites receiving assistance with development and training from Welfare is also promoted.

The Bureau continues to work with the Welfare Division for the training of Child Health Care Consultants. The federal grant supporting this initiative which was held by the University of Nevada Reno has ended. Staff is currently contracting with the Area Health Education Center of Southern Nevada, using the Early Childhood Comprehensive Systems (ECCS) grant, to further develop and sustain a Child Health Care Consultant Network in Nevada. In conjunction with this contract, the ECCS program has initiated the training of three trainers for Nevada's Child Health Care Consultant Network. Throughout this next year, the program will be identifying various health care professionals including public health nurses, mental health professionals, developmental specialists, and others to serve as Child Health Care Consultants. In addition, ECCS staff is working with staff from child care licensing agencies to explore the inclusion of Child Health Care Consultants in current licensing policies. Through these efforts, we are working to develop an effective and sustained Child Health Care Consultant Network throughout Nevada.***/2010/ In early 2009 the ECCS grant was moved to the Administrative Office of the Department of Health and Human Services under Head Start State Collaborative Office. The MCH Manager and Title V staff continues to be fundamental partners in building a statewide network of CCHC's. Through collaboration a more diverse purposeful group of partners have joined this initiative providing support and expertise. Recently the ECCS grant was awarded to the HSSCO for another 3 years. Additionally Title V staff collaborated in submission of a proposal for "Project LAUNCH" to SAMSHA and are awaiting outcome. The pilot CCHC project in Clark County is coming to an end and data is collected and will be analyzed and released to our stakeholders soon. //2010//***

Nevada Revised Statutes state that all child care providers must attend a class that covers preventing and recognizing illnesses. In the past, this class has been held only in Clark and Washoe Counties on a regular basis, and Bureau personnel have given the class when possible in the rural counties and parts of Clark County. Most child care providers have not been able to receive this class due to access issues. However, now all community health nurses in the rural counties have been trained by Bureau personnel to teach the "Prevention and Recognition of Illnesses in the Child Care Setting" class. In addition, Southern Nevada Area Health Education Center (AHEC) personnel located in Clark County are being taught the curriculum so that they can service the outlying areas of Clark County. In the near future, this class will be available state-wide and all child care providers should be able to access this class easily.

The 2005 Legislature approved the establishment of an Office of Minority Health effective July 1, 2005, in the DHR Director's office. This has been a goal of the Department for many years. The purposes of the Office are to improve the quality health care services for members of minority groups; increase access to health care services for members of minority groups; and disseminate information to and educate the public on matters concerning health care issues of interest to

minority groups. The Bureau will partner with the new office to address minority health and health disparities in all its efforts.

The Bureau works with all known parent and advocacy groups such as Parents Encouraging Parents (PEP), Family Voices, "Nevada Partners in Policymaking" and the "Nevada Dual Sensory Impairment Project", to discuss available programs and accessing services within the community. Activities have included meetings and panel discussions with consumers in both Reno and Las Vegas to discuss the scope of services covered by Title V programs, as well as developing linkages with other agencies such as Medicaid, Nevada Check Up, Vocational Rehabilitation, Shriner's, and the Department of Education, for access to, and coordination of, services. The meetings included a cross section of consumers, many of whom are adults with disabilities, as well as the parents and foster parents, of children who have a variety of disabilities and needs. This also provided an opportunity to dialog with members of the community and the staff of multiple community agencies. As a result, there is increased communication within a growing network of service organizations and consumers. Family Voices was very prominent in assuring parents of CSHCN input into the MCH Needs Assessment, and will assist with implementing its findings. The CSHCN program now includes information about Family Voices in all its communications with families. All of these agencies and consumers are involved in the development of the Real Systems Change initiative. The Family Voices Director is developing the RCSC media campaign.

/2007/ There has been no change to NRS and NAC since last year or to the information reported above. The Department of Human Resource officially has become the Department of Health and Human Services (DHHS).

The Fetal Alcohol Syndrome multidisciplinary clinic has been developed in partnership with the UNSOM, and is currently being held in Las Vegas. Funds are being sought to hold a similar clinic in Reno. The vision care clinic went on hold when the staff proposing it quit. It is now being revisited by staff to see if the resources are still there and if new partners that have since been identified are able to help.

The 211 line was officially kicked off on February 9, 2006 and in service February 13, 2006. It is not yet statewide. Currently it is available to the metropolitan areas of Washoe County, Carson City, and most of Clark County. Ultimately it will be available statewide. Statewide cellular access to 211 will be available to certain cellular subscribers initially and will become available through other cellular providers as capabilities and service areas are expanded. Unfortunately there are pockets all over rural Nevada where there is no cellular service. Until 211 is fully implemented 1-800 lines such as the Bureau's CSHCN information and referral and line will continue to operate so those who do not have access to 211 can still call toll free for services.

The DHHS Title IV-B Family Preservation and Support Steering Committee is no longer meeting. Its activities have been absorbed by other activities going on in the state including the Child Death Review initiative discussed in IV A Background and Overview.

The DHHS Child Care Committee has not met.

The Office of Minority Health has been established; it is based in Las Vegas. The Bureau's Bureau Chief has been in contact with the new Minority Health Director and enlisted his assistance in the expansion of the MCH Campaign to address African American birth outcomes discussed in the Annual Plan for National Performance Measures (NPM) 15, 17 and 18 and State Performance Measure (SPM) 11. He is building support in the Las Vegas African American community for this enhancement, which will be presented to the 2007 Legislature.

The CSHCN program's eligibility line was transformed into a statewide toll-free CSHCN helpline offering assistance to more families than before. The Health Program Manager from the grant project will continue work for the Bureau of Family Health Services (Title V) programs.

Community-based service providers affiliated with the grant project may be considered for contract work.

There has been an attempt to include more bi-lingual members on the Nevada Advisory Council for CSHCN and producing outreach materials in English and Spanish. The website translation is in a pending status (rudimentary translation available, improved translation in the works). The Native American temporary worker who has been successful with Native American outreach has future Maternal and Child Health funding.

The RCSC Project has segued into a CSHCN systems development project that will combine all the CSHCN systems development efforts under one umbrella. This project is now under an overall CSHCN Coordinator who will manage it and the specialty clinics, BDR, newborn screening, newborn hearing screening, and any other components of the CSHCN system. Through the systems development activities a training for those with potential responsibility for utilization of EPSDT screening will be offered in the fall of 2006. //2007//

/2008/ There hasn't been much change since last year, including no change to NRS or NAC. The MCH Campaign to address African American birth outcomes was not selected to be included in the Governor's budget due to the tightness of the state's budget. The MCH Manager has started conversations with African American community based organizations to lay the groundwork for another effort in the 2009 Legislative session.

A review by the National Center for Newborn Screening lead to the conclusion that in addition to the metabolic clinics the Bureau supports the Bureau needs to add Endocrine and Hemoglobinopathy Clinics also to ensure appropriate follow-up for newborn screening. This is added to the need for a vision clinic. While there is no funding in the next biennium budget for a vision clinic per se, the Bureau is having to rebid its newborn screening contract as this must be done every 4 years. In consultation with SHD Administration it has been determined that when the anticipated fee increase is requested of the State Board of Health, it will include funding for Hemoglobinopathy and Endocrinology clinics as they are part of newborn screening. It is hoped that these clinics will be developed in the coming year.

The name of the Department has officially changed to the Department of Health and Human Services. All phone and fax numbers have remained the same.

The 2007 Legislature appropriated funding to support 25 more fetal alcohol spectrum disorder(FASD) clinics, with 10 more to be added to Las Vegas, 12 in Reno where a separate multidisciplinary team has been developed, and 3 more genetics clinics for Las Vegas. The Las Vegas team determined that the genetics clinics would be used to diagnose birth to three years olds, and the FASD clinics would see children 3 to 18.

The 2-1-1 line is now operational statewide. In addition it received an appropriation of state general fund from the 2007 legislature so will continue to function at least through the 2008-2009 biennium.

The DHHS Child Care Advisory Committee has resumed meeting. It is working in close collaboration with the Bureau's Early Childhood Systems Development initiative and continues to advise the Welfare Division on the policies and procedures for its child care system.

The Health Division is revitalizing the Child Care Health Consultants. An update is given in III E.

The EPSDT meeting was held. As a result there are currently 4 Bureau supported work groups working on various aspects of EPSDT outreach: automatic newborn enrollment; cross system linkages to EPSDT (data); Tribal, FQHC, Local Health Department and MCO coordination; and parent support and education. The work groups include Bureau staff, Medicaid staff and others such as MCO representatives.

//2008//

/2009/ There was no change to the NRS in the past year; the NAC was changed to increase the newborn screening fee from $60.00 to $71.00 per birth. The increased funding allowed the addition of Cystic Fibrosis screening to the screening panel effective May 1, 2008. The Bureau is in the process of developing the Endocrine and Hemoglobinopathy clinics referenced last year and will implement them in the coming year.

As noted in III A the state is undergoing a fairly significant budget crisis. In the first round of budget cuts this year the Bureau lost the funding for the expansion of the fetal alcohol spectrum disorder (FASD) clinics. A settlement negotiated by the State Attorney General over the acquisition of Sierra Health Services, Inc. by United Health Services included restoring the funding to the clinics. As this is written the funding has not yet become available but plans for the clinics continue with the hope they will be implemented in September 2008. This is one time funding.

The DHHS Child Care Advisory Committee is once again not meeting. Its continuation is in jeopardy as other efforts are taking its place, including the development of an Early Childhood Advisory Committee.

The Bureau Chief is working with the Manager of the Office of Minority Health to seek ways to implement the African American birth outcomes initiative that was not approved during the last session. It is very doubtful that such enhancements will be allowed in the coming session and the two programs are looking for ways to involve community members including church communities to address the issue.

Early Periodic Screening, Detection and Treatment (EPSDT) has continued its Title V and Title XIX partnership and has had the following successes:

- getting newborns enrolled in Medicaid/Nevada Check Up before birth
- Resuming notifying families of the EPSDT benefit at enrollment. This had been dropped due to staff turnover.
- Strong MCO involvement in workgroups
- Restoration of a form providers are used to bill for EPSDT
- Networking with community-based organizations including Family TIES, Head Start and other grass-roots organizations to provide notification to parents of the EPSDT benefit.
- Developing a family friendly brochure

Developing the EPSDT toolkit: Website -- www.health.nv.gov

- Ongoing workgroup meetings, such as the Parent Support and Education workgroup.

The Auto Newborn enrollment is the only one that is not continuing as what is left to do is within two state agencies.

The continued goal of the State Health Division and Nevada Medicaid is to increase the number of eligible children receiving screening, diagnosis, and necessary treatment services through EPSDT thereby also increasing the number of children appropriately immunized.

The Nevada State Health Division is taking a much-needed look at its role in public health and how it conducts business. Richard Whitley, the new HD Administrator, has vowed that HD will do business differently, with the Bureau of Family Health Services (BFHS) in the lead. Given this charge, the Bureau of Family Health Services staff, (including MCH Block Grant staff), along with its core partners, engaged in a 2-day strategic planning process at the end of April 2008. The intention of this planning session was to discuss MCH staffs' core competencies, identify community competencies and create new MCH Block grant State performance measures and goals. Staff divided themselves according to MCH Block Grant groups: CSHCN, Child and Adolescent Health and Prenatal and Infant Health. These 3 groups met over the next 6 weeks, working in teams and work-groups to develop cross-program, cross-bureau objectives for the

MCH Block Grant 2009 objectives.

This planning process was invaluable to staff; educating, engaging and empowering them in an unprecedented way. Knowing that the 2010 Needs Assessment is coming up the Health Division is now looking at how to functionally/structurally organize to best situate staff to accomplish new performance measures which based on current data will probably be part of the measures proposed for the next five year period. It is an exciting and dynamic time. BFHS, through the MCH Block Grant, is looking to grow and support local efforts related to the national and state performance measures outlined within the MCHBG. The primary goal is to use MCH money to grow local initiatives that are over time locally-owned and sustained, and then remove the MCH money to grow a different initiative. True to this commitment, BFHS is scrutinizing all vacancies within the MCHBG and looking to see if the way it is structurally organized makes sense for its primary roles of assurance and infrastructure building, or is the funding better utilized at the local level to build community capacity.

Anyone involved in change management knows that this process takes time. Thus, this year is a bridge of cultural change whereby the HD is obligated to this change process with a commitment to our partners to add to their community capacity, in the way our partners envision. The Health Division looks forward to discussing with local health districts and rural community health nurses about their perceived role and the role of the HD. The HD hopes that it is a dynamic dialogue that tells us what the needs are, how to fill them, which agency is leading which aspect of the project, and ultimately together, to improve the health of women and children in Nevada. Activities that are projected to be accomplished in FY 09 are listed in the activities for National and State Performance Measures.
//2009//
//2010//

C. Organizational Structure

/2010/ Nevada's Executive Government is set up with the elected Governor as the Head of State. The current Governor Jim Gibbons, is in his first four-year term. //2010// Under the Governor are the various Departments that along with Boards and Commissions that make up the Executive Branch, including Human Resources, Employment, Rehabilitation and Training, Information Technology, Motor Vehicles, Public Safety, Conservation and Natural Resources, Cultural Affairs, Administration, Personnel, Agriculture, and Business and Industry. The Legislative Branch includes the Senate and Assembly, the Legislative Counsel Bureau and Legislative Committees. The Judicial Branch includes the court system, commissions and the State Board of Pardons. An org chart of Nevada State Government may be found at http://www.leg.state.nv.us/lcb/research/StateOrgChart.pdf.

/2010/ The state public health agency, the State Health Division (SHD), is in the Department of Health and Human Services (DHHS). DHHS also includes the state mental health agency, the Division of Mental Health/Developmental Services(MH/DS); the social services/child welfare agency, the Division of Child and Family Services; Aging; the Medicaid and Nevada Check Up agency, the Division of Health Care Financing and Policy(DHCFP); and the TANF and Child Care Block Grant agency, Welfare. Mike Willden is the Director of DHHS. The org chart for DHHS //2010// may be found at http://hr.state.nv.us/Documents/DHR_904.pdf. The Bureau works closely with all the Divisions of DHR to promote MCH priorities and objectives. /2007/ As previously noted DHR is now the Department of Health and Human Services, DHHS. //2007//

As noted in III.B, Agency Capacity, Nevada Revised Statute 442 designates the Department of Health and Human Services (DHHS) through the State Health Division to administer those parts of the Social Security Act which relate to Maternal and Child Health and the care and treatment of Children with Special Health Care Needs. Within the SHD the MCH and CYSHCN programs are

in the Bureau of Child, Family, and Community Wellness.

/2010/ The SHD contains 5 Bureaus, each headed by a Bureau Chief. In addition to the Bureau of Child, Family, and Community Wellness are are: Licensure and Certification (BLC), Health Planning and Vital Statistics (BHP&VS), Early Intervention Services (BEIS), Health Protection Services (BHS), and Substance Abuse, Prevention and Treatment (SAPTA). Richard Whitley, MA is the Administrator of the SHD, hired in his place in January 2008. Mr. Whitley was previously Deputy Administrator in the State Health Division. Mr. Whitley received his baccalaureate degree from Willamette University in Oregon, and a Master of Science in Counseling Psychology from Western Oregon State College.

The new Deputy Administrator is Mary Wherry, RN, MS. Ms. Wherry became Deputy Administrator in May 2008. Previously she served as Deputy Administrator of the Division of Health Care and Financing where she administered the Medicaid and Nevada Check Up operations. Ms. Wherry holds a baccalaureate degree in nursing from San Jose State University in California and Master of Science degrees in Psychiatric Mental Health Nursing and Health Policy with a Poly Science Certificate from the University of Maryland.

The State Health Officer is Mary Guinan MD & PhD. Dr. Guinan previously served as the health Officer from 1998 to 2002. She currently is Founding Dean of the University of Nevada Las Vegas School of Public Health. Prior to coming to Nevada Dr. Guinan worked at the Centers for Disease Control and Prevention in various scientific and administrative positions for over 20 years. She is certified by the American Board of Internal Medicine, the subspecialty Board of Infectious Diseases and the American Board of Preventive Medicine and Public Health.

The SHD organization chart is attached at III B, Agency Capacity.

The Bureau works very closely with all five of the other Bureaus. It provides funding for Community Health Nurses in Frontier and Rural Area and partners with chronic disease initiatives. //2010//The Center for Health Data and Research in the BHP&VS works with the SSDI grant and produces the data for the MCH Block Grant application and oversees the MCH Needs Assessment process. BADA works with the Bureau on its Perinatal Substance Abuse Prevention initiative, particularly focusing on adolescents. A bill in the 2005 Legislature will move BADA to MH/DS; even should this move occur the Bureau and BADA will continue to collaborate. While the Bureau's Oral Health Unit has the fluoride initiative, BHP has the engineers that monitor the water systems. The Bureau works with BLC on emergency medical services and on Newborn Intensive Care Unit regulations, which they regulate. Finally, the BEIS is collocated with the Bureau and works closely with the CSHCN program and other Bureau initiatives. Title V funds support the BEIS services. The Bureau also supports the multi-disciplinary specialty clinics held in BEIS facilities. The Bureau org chart is attached.

The Bureau of Family Health Services under the SHD Administration is responsible for Title V MCH Block Grant oversight, management and reporting. The Bureau has many programs and initiatives that all go to promote the health and well being of Nevada's families. Judith Wright is the Bureau Chief and MCH Director.

Nevada's MCH Program is advised by a Maternal and Child Health Advisory Board (MCHAB). The MCHAB was first established through an executive order in 1989, and then was established in statute in 1991 by NRS 442.133. It is comprised of 9 individuals appointed by the Governor from a list provided by the SHD Administrator to two year terms, and two legislators appointed by the Legislative Counsel. Its composition represents public health, providers, legislators and a consumer who always represents CSHCN. Per NRS the MCHAB is advisory to the Administrator of the SHD. They meet 4 to 6 times a year, alternating between Reno and Las Vegas, and more frequently now by videoconference. They respond quickly to issues as they come up and have

testified before the Legislature on bills of concern to the Department. They produce a bi-annual report includes a report of their activities for the biennium and recommendations for the coming biennium. This report is placed on the Bureau's web page and some hard copies distributed at the Legislature. The 2005 report is attached to I.E, Public Input, as is noted there. The MCHAB is staffed by the MCH Bureau Chief. Under NRS they are charged to advise the Administration of the SHD "concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of preschool children to achieve the following objectives:

1. Ensuring the availability and accessibility of primary care health services;

2. Reducing the rate of infant mortality;

3. Reducing the incidence of preventable diseases and handicapping conditions among children;

4. Identifying the most effective methods of preventing fetal alcohol syndrome and collecting information relating to the incidence of fetal alcohol syndrome in this state;

5. Preventing the consumption of alcohol by women during pregnancy;

6. Reducing the need for inpatient and long-term care services;

7. Increasing the number of children who are appropriately immunized against disease;

8. Increasing the number of children from low-income families who are receiving assessments of their health;

9. Ensuring that services to follow-up assessments are available, accessible and affordable to children identified as in need of those services; and

10. Assisting the Health Division in developing a program of public education that is required pursuant to NRS 442.385, including, without limitation, preparing and obtaining information relating to fetal alcohol syndrome (FAS);

11. Assisting the University of Nevada School of Medicine in reviewing, amending and distributing (FAS) guidelines it is required to develop pursuant to NRS 442.390; and

12. Promoting the health of infants and mothers by ensuring the availability and accessibility of affordable perinatal services."

The Bureau is also advised, as are other agencies in state government, by the Governor's Youth Advisory Council (GYAC). The GYAC was originally established by Governor Robert Miller in 1995 by executive order and has been continued by Governor Guinn. The GYAC is comprised of 11 youth ages 15 - 21 from statewide, of mixed ethnicities and race. They are staffed by the Bureau's Child and Adolescent Health Manager. For 2006, the GYAC has established as its priorities teen pregnancy prevention, violence prevention, and suicide.

The State Board of Health (SBOH) is a regulatory body that is staffed by the SHD Administrator. As MCH is not regulatory it does not have much activity before the SBOH, but it does go before them to set fees for Newborn Screening and other matters that are contained in the NRS for the Bureau. The Newborn Screening fee increase was approved by the SBOH in September 2003. In 2004 the Bureau partnered with BLC to update the NICU regulations, which were approved by the SBOH on June 25, 2004.

The CSHCN Program has already been described in III.B. Agency Capacity. It pays for treatment for eligible children. The CSHCN program includes Newborn Screening, Newborn Hearing

Screening, and the Birth Defects Registry. These three programs are all required by NRS. The Newborn Screening and Birth Defects Registry programs and the program's supervisor are funded by newborn screening fee revenue. Newborn Hearing is funded by HRSA (this grant will end in 2006 and another has recently been approved). CSHCN also includes the Real Choice Systems Change Grant that is funded by CMS.

The MCH Perinatal and Women's Health program includes the Perinatal Substance Abuse Prevention (PSAP)program, the MCH Campaign, and Domestic Violence, Injury and Rape Prevention programs. Injury and Rape Prevention are funded by CDC. PSAP is funded by state general fund. The supervisor of the unit is funded by Title V, the MCH Block Grant.

The MCH Perinatal and Women's Health and CSHCN Programs are headed by Health Program Specialist IIs.

The Child and Adolescent Health Program addresses teen pregnancy prevention and other initiatives to promote the health and well-being of Nevada's children and adolescents. It includes the Abstinence Only grant now managed by the Administration for Children and Families. It also includes the MCHB Early Childhood Systems Development grant, and with the additional funding from the MCH Block Grant the state received has a component for Early Childhood systems development for ages 6-10. It is headed by a Health Program Specialist II who is funded by Title V, the MCH Block Grant.

The Oral Health Unit includes a statewide sealant initiative, a fluoride initiative, Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.), Early Childhood Caries prevention, Oral Health Surveillance, and is developing an oral health curriculum for primary and secondary education. It is funded by CDC and MCH Block Grant. The Oral Health Unit is headed by a Health Program Specialist II who is funded by the CDC grant. ***/2010/ The oral health curriculum project has been discontinued. //2010//***
The WIC Program has clinics statewide. It is currently serving approximately 46,000 participants a month. It is funded by USDA and rebates. It is headed by a Health Program Manager II who is funded by the WIC grant. WIC expects to reach 60,000 by the end of the next biennium (FY2006-FY2007.

The Primary Care Development Center works to promote access to primary care statewide. It has the Primary Care grant from the Bureau of Primary Health Care, SEARCH from the Bureau of Health Professions and the HRSA/MCHB funded SSDI program. It is headed by a Health Resource Analyst III who is funded by the Primary Care grant.

Specific staff of the Bureau are listed in III D. Other (MCH) Capacity.

Title V funding is also placed as previously mentioned in the Community Health Nursing budget and in Early Intervention Services. Both programs work with the Bureau and provide the reporting required by the block grant. The MCH Bureau Chief assures the funding is being spent in accordance with federal regulation.

/2007/ There will be an election for Governor in November 2006. What effect this election will have on the Bureau's budget and activities remain unknown at this time. Under the current Governor, Governor Guinn, the Bureau has received permission to develop budget enhancements to increase the MCH Campaign and address resources to teen pregnancy prevention. These enhancements are discussed in the Annual Plan. Otherwise budget development instructions are as there were last session, that is two times the base year 2005 for total general fund for the 2008-2009 biennium.

As proposed in the 2005 session, BADA moved to the Mental Health/Developmental Services Division effective July 1, 2007. As noted last year the Bureau and BADA will continue to

collaborate around the issues such as perinatal substance abuse prevention but it will now be across Division lines.

Safe Drinking Water was moved from BHP to the Department of Conservation and Natural Resources (DCNR). The Bureau's Oral Health Program is now working with those engineers in monitoring water systems for fluoride.

The CSHCN Program has the CSHCN Advisory Committee as discussed in III B. This Committee, comprised of parents, advocates and providers, advised on the development of services for CSHCN that are community based, family centered, culturally appropriate and comprehensive. They are advisory to the Administrator of the Health Division. //2007//

BADA moved to Mental Health/Developmental Services Division physically in 2006, with the official move completed July 1, 2007.

There is no change to the GYAC priorities for 2008.

Upon the recommendation of the CSHCN Advisory Council and concurrence of the MCH Advisory Board, the Birth Defects Registry in 2006 was renamed to the Nevada Birth Outcomes Monitoring System. //2008//

//2009//
As noted in III A. the Primary Care Development Center was moved from MCH to Health Planning. It continues to work closely with MCH particularly through the SSDI initiative.

The movement of the PCDC to Health Planning and Statistics has been discussed in III A Overview. As noted it is part of a planning unit being developed with available resources by the Director of DHHS. It continues to provide data for MCH particularly through the State Systems Development Initiative.
//2009//

//2010//
The NV Health Division saw a much-needed re-organization occur in two of its Bureaus. The Bureau of Community Health merged with the Bureau of Family Health Services (many MCH Staff) to become the Bureau of Child, Family and Community Wellness. This is a strategic move to emphasize integrated programming among MCH and Chronic Disease activities. Please see attached organizational chart for details. Maria Canfield is the Bureau Chief and MCH Director, while Debra Wagler is the MCH Manager. The MCH Staff were empowered to completely change how the MCH Block grant funds and initiatives were executed in Nevada. Similarly, MCH Staff are re-engaging the MCH Advisory Board members in their roles: including monitoring, policy setting, and advocacy responsibilities. There has also been a much-needed change in Board member representatives. The MCHAB chose four priority areas for its focus in 2010: dental health sealants, immunizations, mental health and prenatal care/access. MCH Staff also surveyed the three local health districts, as well as each county's community health nurse, for their top three MCH areas, and plan to support these local MCH interests and initiatives as well.
//2010//

An attachment is included in this section.

D. Other MCH Capacity

Nevada's MCH/CYSHCN programs, located in the Bureau, are managed through its main office in Carson City, Nevada. Staff who are located in the Carson City and Las Vegas offices are listed in the attached table along with CVs of program managers.

/2010/ Maria Canfield, Bureau Chief, Child, Family and Community Wellness
She holds an MS in Comprehensive Health Planning from the University of California, Los Angeles from the School of Public Health. In her current position, she is responsible for the following programs: immunizations, sexually transmitted diseases, HIV/AIDS prevention, tuberculosis control, Ryan White, AIDS drug assistance, disease surveillance, hepatitis, women's health connection (breast and cervical cancer screening), comprehensive cancer planning, tobacco control, diabetes prevention, maternal and child health block grant, Women's Infants and Children's Program and office of minority health. She oversees a budget in excess of $100 million with more than 90 FTEs. She has many years of administrative experience that included the redesign of the substance abuse prevention system by creating regional prevention centers (10 geographic areas and two special populations-Native American and Latino using Nevada's 12 funded community-based coalitions as prevention intermediaries while she was the director of the State of Nevada's Substance Abuse Prevention and Treatment Agency (Bureau of Alcohol and Drug Abuse). At different times in her career she has served as an evaluation consultant for the University of California, Davis and Fresno, successfully written awarded grants and assisted communities in their grant writing efforts. During legislative sessions she provides testimony, presents at state and national conferences and is affiliated and/or served on many health associations and boards. //2010//

Debra Wagler, MCH Program Manager, oversees the Maternal and Child Health Advisory Board, manages the MCH budget, and assists staff to create performance-based contracts which include a public health approach to service delivery. She is a social services program developer and evaluator by training, and has been involved in several systems change initiatives and integrated programming to bridge agencies and organizations who serve shared populations. She has lead systems change efforts for the current MCH program to implement a public health approach to programming and for Children and Youth with Special Care Needs lead a medical home initiative, and developed systemic outreach for Healthy Kids-Early Periodic Screening, Diagnosis, and Treatment (EPSDT). Her evaluation, program development, and intercultural communication career has focused on strengthening the well-being of individuals, families and communities by providing leadership, educational resources, training, and evaluation for wellness, health promotion, and disease prevention to build healthier communities. She has facilitated successful working partnerships with diverse personnel who represent community-based organizations, public agencies, or private health agencies. She has directed evaluation and research for state and federal grant funded projects covering topics such as improving children with special health care needs service infrastructure; reducing violence against women and children; and developing interventions for substance abuse, trauma, mental health, diabetes prevention/management, tobacco cessation, and HIV transmission prevention for positives and negatives. Through involvement in these activities, she has had affirmative experiences working in culturally diverse communities with populations of all ages. She has been active in her local and professional community as a member of public health and evaluation professional organizations and is a board member of a local non-profit social justice organization.

Barbara Howe, MCH Nutritionist and NSHD Wellness Section Manager, is a Master's level Registered Dietitian and an International Board Certified Lactation Consultant. The Wellness Section oversees nutrition, physical activity, breastfeeding and tobacco prevention and education efforts in the state. Barbara was elected to the Carson City School Board in 2006 with a simple campaign slogan: "for the health of it". Currently, Barbara is the President of the School Board. She has positioned herself to influence nutrition and physical activity policy and built environments. On numerous occasions, Barbara has shown political and social acumen to entice individuals and groups to cooperate, collaborate and commit all resources available. Also, as a Trustee, Barbara is appointed to several other boards including: the Nevada Association of

School Board Trustees (comprised of trustees from throughout Nevada), the Carson City Parks and Recreation Commission and a local youth wellness council. Barbara is also staff to the Advisory Council for the State Program on Fitness and Wellness, Nevada's clearinghouse for evidence-based programming on health and wellness. Barbara uses all of these associations and organizations to advance the health and wellness of Nevadans.

Judith Wright, is a graduate of the University of Chicago, Chicago, IL. She has been in Public Health since 1978, and MCH specifically since 1989, having formerly served as a WIC Administrative Officer and then CSHCN Director in Montana. She came to Nevada to become Bureau Chief in September 1994. She directly supervises an Administrative Assistant IV, an Accounting Assistant III, and the Bureau's Administrative Services Officer I. She also supervises the managers of CSHCN, the CSHCN Registered Dietitian, Women's Health/Perinatal, PCDC, WIC, Oral Health, Child and Adolescent, and Real Choice Systems Change (RCSC). There is also a bilingual Administrative Assistant I assigned to the Bureau overall. The Administrative Assistant (AA) IV supervises all the clerical staff in the Bureau with the exception of those in PCDC. /2007/ With the Bureau reorganization the CSHCN and the initiatives of the RCSC will go under the CSHCN Coordinator. The Bureau Chief will supervise the now MCH Funded Management Analyst 2 to provide the start of a MCH EPI unit. This will address Priority 4 and SPM 4 (regarding a unified data and surveillance system). //2007// /2008/ The clerical staff have been moved under the supervision of the various program managers, leaving the AA IV with the front desk Administrative Assistant and the MCH Campaign Administrative Assistant. The CSHCN Registered Dietitian has been moved under the supervision of the CSHCN manager. //2008//
Ms. JoAnne Malay R.N. M.P.H. manages the Early Childhood Wellness section which includes the Nevada Center for Genetic and Inheritable Disorders program which houses Newborn Screening, Newborn Hearing and genetics. Additionally the ECW includes the Immunization program, Perinatal Substance Abuse Prevention, the MCH program and the Autism Training and Technical Center recently joined our team. The Early Childhood Wellness section envisions all children have an equal opportunity to obtain their maximum potential through our programs resources and supports. The performance measures we focus on include but are not limited to: NPM 1-7, 12, 13, 15, 17and 18. SPM 1, 6, 11, and 13.

Jack Zenteno is currently responsible for the Nevada Newborn Screening (NBS) Program and the Nevada Early Hearing Detection and Intervention (EHDI) Program. Job duties include working with both programs to provide assurance of screening, follow-up and assurance of intervention. Additional job duties include development of both the NBS and EHDI Programs through collaboration with state hospitals, healthcare providers and non-profit organizations statewide.

Muriel Kronowitz, M.A., LPC, currently holds the position of the Perinatal Substance Abuse Prevention (PSAP) coordinator for the Nevada State Health Division. She has more than 25 years of experience developing, implementing and coordinating cutting edge pilot programs in the field of mental health and substance abuse. Some of her accomplishments include coordinating the opening of the only therapeutic family court in Alaska that addressed FASD, creating and implementing a pilot FASD project at the only women's correctional facility in Anchorage and was the first clinical director for the only residential treatment program for pregnant women and their children in Alaska. Prior to returning to public service she was the clinical director for a private mental health and substance abuse agency.

Lori Cofano, is a graduate of the University of Southern California School of Dentistry in Los Angeles, CA and holds a Bachelor of Science in Dental Hygiene. She practiced clinical dental hygiene for 19 years prior to joining the Oral Health Program. She has been with the Oral Health Program for over eight years as the Fluoridation Specialist and Oral Health Screening Coordinator. Currently she is the acting Oral Health Program Manager. In her capacity as Oral Health Screening Coordinator she has used the Basic Screening Survey to screen Head Start children, third grade students, and elderly in assisted living facilities. She has developed screening materials and reports that have been used by many other states. She was asked to

present information on the Basic Screening Survey at the National Oral Health Conference in 2007. In 2008, she was asked to assist with the Association of State and Territorial Dental Directors (ASTDD) Basic Screening Survey training materials. The actual training DVD was filmed in Nevada using a Head Start location and a Carson City elementary school as well as several Oral Health Program contacts as actors. She has maintained an excellent working relationship with the Southern Nevada Water Authority and the City of Henderson water treatment staff in Clark County. These are the only facilities in the state that optimally fluoridate community water sources. The Centers for Disease Control and Prevention (CDC) and the ASTDD have honored the water treatment facilities with a State Fluoridation Quality Award for the past six years. The award is based on monthly data sent to the Fluoridation Specialist and entered into the CDC Water Fluoridation Reporting System. She is currently working with water treatment staff to create an in-state water fluoridation training course. As the acting Oral Health Program Manager she participates in the six regional oral health coalitions and the statewide Oral Health Advisory Committee.

Randall Figurski, Manager of the MCH Autism Training and Technical Assistance Center, has a Master of Science in Speech-Language Pathology from the School of Medicine, University of Nevada, Reno. Mr. Figurski was a clinical instructor at UNR's School of Medicine in the 1990s where he taught undergraduate and graduate courses in language development and communication disorders. He was the Director of the Scottish Rite Language Disorders Clinic at UNR for three years before moving to the Nevada State Health Division. He is a former President of the Nevada Speech and Hearing Association, the State's professional association of audiologists and speech pathologists. Mr. Figurski has published scholarly articles in peer-reviewed professional publications related to communication disorders in children and adults and has presented at numerous state and national communication disorders conferences. For the past two years, Mr. Figurski has managed the Nevada Health Division's Autism Training and Technical Assistance Center, which is charged with building a professional workforce in Nevada communities and neighborhoods for the early identification and treatment of young children with autism and related disorders. He is an executive board member of Nevada's nonprofit Autism Coalition of Nevada, which represents community parent support and advocacy organizations from across the State. Since the early 1990s, he has consulted with 11 of Nevada's 17 independent school districts to diagnose and assess children with autism spectrum disorders. He has delivered many seminars on screening, evaluation and treatment of communication disorders to special educators, psychologists, occupational therapists and speech-language pathologists working in public and non-public agencies and organizations. Over the years, Mr. Figurski has served more than 300 families living with autism whose children ranged from 18 months to 18 years of age.

Kelly Y. Langdon, Statewide Breastfeeding Coordinator, has her Masters Degree in Public Health and has worked in the public health field for nine years. Almost three years ago, Kelly became a parent and through her own breastfeeding experience became passionate about the subject. She now proudly calls herself a breastfeeding advocate. At the time, the Nevada State Health Division did not have a formal Breastfeeding Program. With help from other colleagues and with the support of our Administrator, the Breastfeeding Program was created. Kelly works with the MCH Program and the WIC Program to improve breastfeeding initiation and duration rates for the entire Nevada population. She coordinates and organizes the Breastfeeding Task Force of Nevada, the Carson City Breastfeeding Coalition, and has started a monthly breastfeeding support group in Carson City.

Andrea Rivers has recently taken over as the Injury Prevention Program Coordinator for the Nevada State Health Division, managing all aspects of this federally funded program. Andrea coordinates the Injury Prevention Task Force which meets quarterly. Andrea currently supervises three people including the new Injury Prevention Biostatistician. Andrea sits on many injury and trauma related committees and advisory groups. Andrea is also responsible for all aspects of the Nevada State Trauma Registry within the Nevada State Health Division. Andrea maintains, performs quality control, assessment and analysis on data from various databases

such as mortality, inpatient hospital discharge, trauma and birth. Andrea utilizes appropriate statistical methodologies and software to compile, validate, analyze and disseminate health data for grant applications, statistics requests and statistical and analytical reports.

Michelle Khau is the MCH Biostatistician/SSDI Coordinator for the Office of Health Statistics and Surveillance. The office houses vital records, communicable diseases, hospital discharge, STD, HIV, TB, Birth Defects and Newborn Screening datasets. Michelle maintains, perform quality control and assessment on and extract data from various databases such as birth, newborn screening and the Birth Defect Registry. Michelle writes syntax to import, clean and manipulate data into proper format for statistical analysis. Michelle maintains the MCH Data Warehouse and Nevada Interactive Health Database System and coordinating the MCH Needs Assessment Project. Michelle collaborates with staff from the Bureau of Child, Family, Community Wellness on projects related to Maternal and Child Health (MCH). Michelle links and matches databases using both exact and probabilistic matching procedures and software. Michelle utilizes appropriate statistical methodologies and software to compile, validate, analyze and disseminate health data for grant applications, statistics requests and statistical and analytical reports. Michelle uses all of these datasets, linkages and collaborations to share the results and advance MCH knowledge towards progression with Nevadans, legislators, media, and other state/federal organizations.

Brad Towle is the MCH and Newborn Screening data person. Mr. Towle received his BS from San Francisco State University, and has two MAs. He has a MA in Biology from San Francisco State University and a MA in Public Administration from the University of Montana. His CV may be found in the attachment to III D.

An attachment is included in this section.

E. State Agency Coordination

As indicated in III.C, the agencies of public health (State Health Division), mental health (Division of Mental Health/Developmental Services), social services/child welfare (Division of Child and Family Services), Medicaid and Nevada Check Up (Division of Health Care Financing and Policy), Aging and TANF and Child Care (Welfare) are located within the Department of Human Resources. The Bureau works closely with all the Divisions of DHR to promote MCH priorities and objectives, described below. (see attached organization chart)

The Bureau works closely with all the Bureaus of the SHD in one manner or another as discussed in III.B and IV.B and IV.C. This includes the Bureaus of Alcohol and Drug Abuse (BADA), Health Planning and Vital Statistics (HP&VS), Health Protection Services (HPS), Community Health (BCH), Licensure and Certification (BLC), and the newest Bureau, the Bureau of Early Intervention Services (BEIS) which joined the SHD in FY04. The main office of BEIS is collocated with the Bureau in Carson City.

The Bureau partners with the Department of Education and with local (county) school districts around the state on many initiatives around child and adolescent health. These include the Youth Risk Behavior Survey (which includes the Safe and Drug Free School Survey), Teen Pregnancy Prevention, and Perinatal Substance Abuse including Fetal Alcohol Syndrome Prevention. It works with the Department of Education on an oral health curriculum for schools. The Bureau also works with Juvenile Probation of the Department of Corrections on teen pregnancy prevention, substance abuse, and injury prevention.

The Bureau is partnering through the MCH Campaign with the Department of Corrections to promote healthy birth outcomes in incarcerated women and good parenting. The Perinatal/Woman's Health Consultant is developing training modules that will be used by Department of Corrections staff, including one on the stages of pregnancy and another on an

infant's health. Modules have also been completed on Postpartum issues and Infant Development.

The 2001 Nevada Legislature passed AB513, which appropriated funds for the development of four long-term strategic plans relating to the health care needs of Nevada residents. The project was lead by a Steering Committee to which four Task Forces report, one of which is for Disabilities. The other Task Forces were for Seniors, Rural Health and Rates.

The Disability plan was charged to "ensure the availability and accessibility of a continuum of services that appropriately meet the basic needs of persons with disabilities in Nevada". Based on this study the 2003 Legislature moved Community Based Services from the Department of Employment, Rehabilitation and Training (DETR) to DHR and also created in DHR a new Office of Disability Services and moved DETR's Traumatic Brain Injury program into it. The Bureau is working very closely with the new Office of Disability Services and Community Based Services. In particular the Office of Disability Services is working closely with the Real Choice Systems Change (RCSC)project discussed in III B.

The RCSC project team has developed an interagency working group to bring all providers of services for the CSHCN population together. This CSHCN Advisory Council's membership includes parents of CSHCN, adolescent CSHCN, advocates, providers, and educators. The Advisory Council serves to guide project activities and to provide a forum for issues of interest to Nevada's CSHCN and their families. The Real Choice program manager acts as a liaison between the Advisory Council and the Children's Disability Subcommittee created as part of the Disability Task Force to assure that project activities are in line with the objectives of Nevada's Strategic Plan for People with Disabilities. While coordination with some agencies is easier than with others, there has been interest in developing a cross-departmental system of care for CSHCN and the RCSC project is working to take advantage of this culture of change.

The Real Choice Project Team has also been attending meetings of and working with the Transition Forum, a subcommittee of the Governor's Council on Rehabilitation and Employment of People With Disabilities. This forum addresses issues inherent to transitioning youth with special health care needs and has formal relationships with DETR and school districts.

The Bureau works closely with the University of Nevada School of Medicine (UNSOM). The Birth Defects Registry initiative currently in process will partner with the UNSOM Department of Pediatrics' Geneticists to provide consultation in its development and implementation. Bureau staff contract with some and otherwise support UNSOM participation in multi-disciplinary clinics for CSHCN that include Genetics, and Cleft/Craniofacial clinics in Reno and Las Vegas. In 2005 the Bureau is working with the geneticist of UNSOM to establish a Fetal Alcohol Syndrome (FAS) multidisciplinary clinic in Las Vegas. Once this clinic is established a plan will be created to have a FAS clinic in the north. The Bureau also works closely with AHEC, whether it is using their expertise to plan and conduct meetings or the partnership with PCDC on rural mental health issues.

The Bureau partners closely with the Clark County Health District (CCHD) and Washoe County District Health Department (WCDHD), which both have MCH programs. A third Health District, Carson City (which is a County), was added late in 2004. There are now three county health departments in Nevada. The remaining 14 counties are served through the SHD. Representatives of the CCHD and WCDHD sit on the Maternal and Child Health Advisory Board and work very closely with the Bureau on MCH issues. /2007/ The CCHD has been renamed to the Southern Nevada Health District (SNHD).//2007//

Through the PCDC the Bureau works very closely with the Great Basin Primary Care Association (GBPCA, the state's PCA) and its members to promote access to primary, dental and mental care for underserved Nevadans. These members include Federally Qualified Health Centers, Tribal Clinics, Rural Health Centers, Nevada Health Centers, etc. The executive director of GBPCA is

the current chairman of the Maternal and Child Health Advisory Board. Nevada Health Centers has just become a WIC provider in southern Nevada.

The WIC Program is in the Bureau and partners with many of the other programs in the Bureau such as Oral Health and Women's Health/Perinatal. In the past year WIC has been turning its state-run clinics over to local community-based organizations who are now partners with WIC. It has also gained additional WIC agencies in Clark and Washoe Counties. As this is written there are state-run clinics in just Douglas,Churchill, Humboldt, and Pershing counties; the rest are run by CBOs that include Family Resource Centers, a Head Start, Nevada Health Centers, and a hospital. A proposal by Pershing County to take over WIC was received in June 2005.

The Teen Pregnancy Prevention initiative works with the various Family Planning organizations in the State, including those services of the Community Health Nurses of BCH and the private organizations in Reno and Las Vegas. In 2004 Nevada was one of several states selected to work together on developing a common Action Plan around Teen Pregnancy, STD, and HIV/AIDS prevention. This initiative is continuing and will continue into FY 06. The Stakeholders Group, as it is called, is now looking at approaching the issues of teen pregnancy, HIV and STD prevention from an adolescent risk reduction perspective. This will be discussed more under National Performance Measure 08.

The Oral Health initiative also has many partnerships. The State Dental Health Consultant (to the CDC grant) is from the University of Nevada Dental School. The initiative has both a state advisory committee and local coalitions in Reno, Washoe, and Lyon counties, with more in process. Members of the various coalitions and the state advisory committee include representatives of the State Dental Association, State Dental Hygienists Association, the State Board of Dental Examiners, UNSOM, the Dental School, consumers, the GBPCA, Washoe County District Health Department, Clark County Health District, Tribal Health, local Churches, a hospital and the State Aging Division. Meetings are usually attended by representatives of other public agencies that include Medicaid and the Nevada Public Health Foundation. /2009/ The Oral Health Program non longer contracts for the services of a State Dental Health Consultant.

Through the partnership the Bureau has with Medicaid and Nevada Check Up, Bureau programs are referral sources for both programs. Bureau staff are able to access the Medicaid data system to confirm Medicaid eligibility or ineligibility when considering eligibility for the CSHCN Program. The Bureau has a contract with Nevada's Division of Health Care Financing and Policy (Medicaid) to provide public education through the Maternal and Child Health Campaign about the importance of early and continuous prenatal care, other pregnancy related issues and infant care. Pregnant women and infants and children are also informed about the Medicaid (including EPSDT) and Nevada Check Up programs and referred to the programs if indicated. In addition, the Real Choice Systems Change project has worked with Medicaid and Nevada Check up staff on an outreach campaign to sign children up for Medicaid and Nevada Check Up, and perform outreach for CSHCN services at the same time. The Bureau's pilot projects for RCSC will work with DHCFP to increase EPSDT usage by Medicaid children, a goal of the grant.

The CSHCN program also uses SSI for a referral. Program regulations require a denial from Medicaid, SSI, and Nevada Check Up for those children whose family income and for SSI the child's condition appear to meet those eligibility criteria.

Through the various programs in the Bureau the Bureau has contact with all the birthing facilities in the State. It works with them on issues such as newborn screening, newborn hearing screening, the Birth Defects Registry, and the MCH Campaign. In 2004 it worked with representatives of all the NICUs in the state to revise the NICU regulations that are in NAC.

Along with moving all Early Intervention Services to the SHD, the Director also moved the Head Start State Collaboration to the Welfare Division with the Child Care Unit. The 2005 session is now moving it to the DHR Director's office. The Bureau has representation on both the Head

Start State Collaboration (the Bureau Chief and Oral Health) and the DHR Child Care Advisory Committee (the Bureau Chief) and ensures that health needs including those of CSHCN are part of every discussion of services. Both the Head Start State Collaboration and DHR Child Care Advisory Committee have similar memberships and frequently have similar agendas items. In June of 2005 it became clear that the Head Start mandate to a strategic plan and the Early Childhood Comprehensive Systems (ECCS) strategic plan are addressing the same populations. The two initiatives are being combined to produce one plan for ECCS that includes Head Start.

As noted in III.B, the Child Care Health Consultant (CCHC) program is in transition due to lack of funding and loss of their lead Child Care Health Consultant trainer. The MCH funded member continues to be available to child care providers for consultation and to train staff in the prevention of illnesses within a child care setting. The Bureau's Early Childhood Comprehensive Systems program is working to continue this program. The CCHC leadership is being transferred from the University of Nevada, Reno, to the Bureau where it is being integrated into the ECCS program. The Bureau is awaiting word on where the training for CCHC trainers (train the trainers) will be in the future. Plans are to send two or three community health nurses from BCH for training as trainers. They will then train all the CHCs as CCHC. This will take care of rural communities. The Welfare Division, Child Care Unit, has agreed to cover the salaries of two nurses who are already trained in Washoe County. This will leave Clark County with a need for CCHC trainers, which will not be addressed until next year.

As previously noted DHR is became the Department of Health and Human Services (DHHS) in 2007.

A Fetal Alcohol Syndrome multidisciplinary clinic has been established in Las Vegas. Plans continue to develop one in the north.

Pershing County is no longer a state run WIC clinic, leaving just Douglas, Churchill and Humboldt counties for the state.

/2010/ The Maternal and Child Health Advisory Board has a new chair, Beverley Neyland, MD, AAP President. The board held a MCH meet & Greet with legislators on March 12, 2009 during session. Their priorities and mission are posted on the Health Division website http://www.health.nv.gov/MCH.htm //2010//

The Oral Health Program convened a one-day coalition building workshop for members of Nevada's oral health coalitions in Las Vegas on June 5, 2006. There are now 6 oral health coalitions in the state, one in Reno, one in Las Vegas, one for rural Carson City and Douglas Counties, a northeast coalition, a central Nevada coalition, and a newly forming one in Churchill, Lyon, Pershing and Storey Counties. Other activities continue as listed.

Unfortunately the plan to address the Child Care Consultants has had to be put on hold due to staff changes.

Collaborations and Coordinations for the Teen Pregnancy Prevention initiative are discussed in the Annual Plan for NPM 8 and SPM 4.

As noted in III D there are no longer state run WIC clinics.

/2010/ The ECCS State Plan is in the process of being completed and will be finished by the end of July 2006. The ECCS Plan was completed and is in the implementation stage. The ECCS program has merged with the statewide Head Start office. The current grant is fully implemented and the new partnership was successful in being awarded a new ECCS grant. A thriving early childhood group is active and prepared a LAUNCH proposal to further support the early childhood activity. //2010//

Funding for additional FAS Clinics was requested during the 2007 Legislative session and was approved. as noted in III B Agency Capacity. This initiative is a partnership between the Bureau, UNSOM, private providers and BEIS.

The Child Care Health Consultant initiative is being revitalized. The Medical Consultant, the ECCS Coordinator and other agency staff went to training in North Carolina in June 2007. They came home with a train the trainer model which they hope to take around the state.

As previously noted the RCSC project ended and segued into MCH supported CSHCN Systems Development. A primary focus now is promoting the use of Medicaid's Early Periodic Screening, Detection and Treatment (EPSDT) for children so that all Medicaid eligible children receive the services they need according to the established periodicity schedule. Due to the tightness of the budget there will be only one pilot project operational in the coming year, the one in Elko. //2008//

/2009/ As with last year there is not much change. As previously noted FASD Clinics will be expanded when the identified funding is finally in hand.

The Child Care Health Consultant continues with new help from the Southern Nevada Health District (Clark County). They will be having community health nurses trained to work in that county.

The Chairman of the MCHAB is now a pediatrician who is with the University of Nevada School of Medicine. She has been the Chapter President for the state AAP.

The MCH Manager is a member of the Lead Team for the Head Start Partnership. As such she represents health, which is a priority for Head Start. The Head Start Partnership meets regularly to discuss how to address the priorities of the program; the lead team meets in the interim to provide guidance to the office. Both the MCH Manager and the Early Childhood Wellness supervisor are Partnership members.

The Bureau Chief continues on the Child Death Administrative Review team; the Medical Consultant continues on the Child Death Executive Committee team.
//2009//

F. Health Systems Capacity Indicators

Introduction

The Center for Health Data and Research (CHDR) is the major provider of data for the MCH Block Grant application. The CHDR systems centralize data from their original sources, clean and standardize the data, and perform linkages to produce the data required for the construction of the different sets of indicators, such as NPMs, SPMs, OMs, SCHIs and HSIMs, required by the application.

There are 30 databases in MCH Data Warehouse which include:

a. Birth data
b. Death data
c. Hospital discharge data
d. WIC
e. Medicaid claims data
f. Census and Demographic data
g. Trauma Registry data
h. Injury data

The CHDR is completing the implementation of the Electronic Death Registry System. The data

are still undergoing quality assurance processes, but CHDR is able to produce some preliminary figures for 2007.

During the last year the CHDR has improved its capability to process more and better public health data. The Death Registry is now electronically managed. The improved quality of the data will increase the reliability and the capability for linkages, thus improve the availability of data.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	44.9	46.4	34.6	34.2	
Numerator	752	833	648	665	
Denominator	167306	179563	187271	194468	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008

Hospital Discharge data for 2008 is not available at this time. Data may be available later in CY 2009.

Narrative:

2009 This specific indicator is obtained from the breakdown by age , from record originated within the Inpatient Hospital Discarge, ICD9 codes 493.0-493.9. The statistics shows a consistent improvement in the indicator.

CSHCN staff are in partnership with the Managed Care Organization and Anthem Blue Shield to raise awareness about the Asthma-Obesity Link for youth. This collaborative brings together Anthem's Obesity Task Force, the Nevada State Health Division, the American Lung Association, and the University of Nevada, Reno. This collaborative is driven by the WellPoint Asthma Initiative and the National Health Promotion Asthma Initiative.

From 2005 to 2006 children less than 5 years of age who were hospitalized for asthma dropped 25%.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	50.8	73.9	97.8		
Numerator	11337	10917	15765		
Denominator	22299	14775	16125		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2007
The data is from Medicaid. The numerator is higher than the denominator because Medicaid has to combine four different data sources to get "patient level" data (Health Plan of Nevada, Anthem ,Nevada Care, and FFS). There are duplicates between the data sources since Medicaid does not require lock-in enrollment period. (i.e. members can bounce between HMOs and FFS from month to month).
Medicaid has no way yet of tracking the duplicates.

The denominator is an unduplicated count directly from Medicaid payment system.

Because percentage is over 100, system does not allow us to input the data so the true counts are listed below:

%= 108.3%
numerator: 17,813
denominator: 16,451

It is the expectation to get a unduplicated number by fall 2008. DHCFP is currently involved in an initiative to import encounter records data from their HMO participants into their claims payment and data warehousing systems. The project is scheduled for completition by fall 2008.

Notes - 2006
The numerator and denominator came from Nevada Medicaid.

Narrative:
The NV Medicaid RACC Unit, provides the data to build this indicator. The numerator is extracted from claims payment databases, that currently does not have the ability to resolve overlaps (duplicated records) and the denominator is extracted from elegibility databases which are unduplicated figures. Thus, the indicator for 2007 is showing a ratio bigger than 1. The Division of Health Care Financing and Policy (DHCFP) is currently involved in an initiative to import encounter records data from their HMOs participants into their claims payment and data warehousing systems. The improvement will allow the system to solve the inconsistancy produced by the overlaps. This project is scheduled for completition by Fall 2008.

HCSM # 2 continues to see an increase. Medicaid managed care continued to have two providers each in northern and southern Nevada. A new HMO contract was negotiated bringing on Anthem Blue Cross to Health Plan of Nevada, which are the two Medicaid (and Nevada Check Up) HMOs in the state. The MCH Campaign's Information and Referral Line (IRL) continues to refer called to providers who will accept Medicaid. The MCH Campaign is a partnership between SHD and Medicaid. Medicaid reported this data.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	37.2	91.7	39.5	65.9	
Numerator	3064	881	456	1271	

Denominator	8238	961	1153	1930	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2007
This data came from Nevada Check Up

Notes - 2006
This data came from Nevada Check Up, which provided data for one quarter of children less than 1 who received at least one screen. The denominator is the average monthly eligible for the same quarter (4th quarter).

Narrative:
The data required to build this indicator for 2007 is provided by the NV Medicaid RACC Unit. The DHCFP is currently undergoing a process of data warehousing and other improvements to increase their data quality and availability.

HCSI # 3 has seen a decrease. This data is from Nevada Check Up. The rates can also be linked to managed care as children in both Reno and Clark County have to belong to the Medicaid managed care agencies in those communities. The Nevada State Legislature has continued to approve increased state funding to match the SCHIP dollars.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	75.9	69.1	68.6	67.1	67.8
Numerator	26581	25667	27343	27550	26207
Denominator	35022	37133	39876	41041	38642
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
Data for 2006 was finalized in CY 2009.

Narrative:
The CHDR is providing the data for the statewide figures. The data is extracted from NV Birth Registry System.
During 2007, the indicator continues showing a slight overall improvement.

HCSM # 4 has seen little overall change, with a rate of 68.4% in 2006 (69.6 in 2005). The 2006 data is not available broken down by Medicaid and non-Medicaid so 2005 data has been used there. As noted in IIII.B, Agency Capacity, the MCH Campaign's message on early and continuous prenatal care will continue in the FY08 -- 09 biennium. The contracts with community-based organizations for care for underserved pregnant women in Las Vegas and Reno will continue in FY 08 and FY 09. The "all" data is from the CHDR data warehouse.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	97.5	30.8	78.4	80.8	
Numerator	95000	43250	151261	154025	
Denominator	97436	140403	193011	190510	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Narrative:
The NV Medicaid RACC Unit provides the data to calculate this indicator. The indicator shows consisten improvement during the last two years.

This data came from Medicaid. Outreach activities are accomplished through the MCH Information and Referral line, the Bureau webpage, and through a Healthy Kids outreach initiative managed by Medicaid. At this point there has been no obvious impact of the Deficit Reduction Act on Medicaid applications.

The CSHCN Systems Change workgroups around EPSDT described in III B are working to promote the use of EPSDT to obtain the services needed by CSHCN and all children who are on Medicaid.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	15.6	26.3	29.7	35.2	
Numerator	5357	7569	8638	10078	
Denominator	34278	28746	29040	28670	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2007
data provided by Medicaid

Narrative:
The data on this indicator is provided by the NV Medicaid RACC. The indicator continue showing improvement.

The Nevada Division of Health Care Financing and Policy has converted the delivery of dental services in the two most populous counties in Nevada (Clark and Washoe) from a fee for service system to a managed care system. This has resulted in a significant increase in the number of dental providers enrolled and the number who actually deliver services to children.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	20.5	20.8	19.0	0.4	
Numerator	1054	1054	1044	22	
Denominator	5140	5077	5486	5674	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2007
The number served is from the Bureau of Early Intervention Services, which is where the CSHCN program serves those on SSI (0-3 yrs old), through early intervention and the multidisciplinary clinics. The denominator is from the U.S. Social Security Administration Office of Policy, SSI Recipients by State and County 2007 for children.

Notes - 2006
The number served is from the Bureau of Early Intervention Services, which is where the CSHCN program serves those on SSI, through early intervention and the multidisciplinary clinics. The denominator is from the U.S. Social Security Administration OFfice of Policy, SSI Recipients by State and County 2006 for chilren.

Narrative:
The numerator is provided by the Bureau of Early Intervention Services, which houses the CSHCN Program serving those 0-3 years old on SSI. The denominator comes from the U.S. Social Secutrity Administration Office of Policy. The denominator is built using the less than 18 years old breakdown, since less than 16 years old is not available. BEIS has no explanation for the drop in numbers of children on SSI served.

As in prior years, the percent of SSI beneficiaries receiving services from CSHCN fluctuates with the number who are being seen by Early Intervention for both Part C services and the multidisciplinary clinics (the numerator). The denominator from SSI (6238) is for children under

18 who are on SSI; a number for those under 16 is not available. Generally, Nevada's MCH Program is getting away from covering direct services and this number is not expected to grow.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)					

Narrative:
The CHDR provides data on the statewide figures. The data is extracted from the Birth Registry System. The NV Medicaid RACC Unit is reporting the data specifically for Medicaid figures. The indicator is built from both sources of data.

HSCI # 5A. The Bureau partners with Medicaid and Nevada Check Up to get underserved women into prenatal care either in to prenatal care through the MCH Campaign or enrolled in Medicaid or Nevada Check Up. Once again low birthweight shows little variation between the two populations. This data comes from the CHDR data warehouse and Medicaid.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births					

Narrative:
The CHDR is completing the implementation of the EDRS and, as expected, the databases are undergoing quality assurance and control to assure the system's reliability. CHDR is providing final dat for 2005 and preliminary data for 2006, 2007 is an Estimated based in the 2003-06 data.

HSCI # 5B. This data is provisional. The CHDR does not have 2006 data yet and this is an estimate. Medicaid data came from Medicaid.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid,***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

non-Medicaid, and all MCH populations in the State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester					

Narrative:
Medicaid 2007 numbers were obtained from HEDIS and provided by the NV Medicaid RACC Unit. They contain data from both HMOs serving Medicaid. Non-Medicaid numbers were provided by CHDR fron the Birth Registry System.

HSCI # 5C. See the note for 5A. In addition Nevada Check Up received a HIFA waiver and raised the income guidelines for coverage of prenatal care for all women to 185% FPL effective December 2006. This will give more women coverage for prenatal care when fully implemented.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					

Narrative:
As reflected in the 5A to 5C, Medicaid 2007 numbers were obtained from HEDIS and provided by the NV Medicaid RACC Unit. They contain data from HMOs serving Medicaid. Non-Medicaid numbers were provided by CHDR fron the Birth Registry System.

HSCI # 5D. See the notes for 5A and 5 C. Efforts to get more women coverage for prenatal care should lead to more women having an adequate number of prenatal visits. This data is from Medicaid and the CHDR.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP**	**YEAR**	**PERCENT OF POVERTY LEVEL**

programs for infants (0 to 1), children, Medicaid and pregnant women.		SCHIP
Infants (0 to 1)	2008	200

Narrative:
There are no changes from 2006 in the poverty levels for eligibility for 2007. The data was obtained from the last update of the Medicaid and SCHIP Elegibility and Payment Manual, available on the Division of Welfare and Supportive Services' Website.

HSCI # 6. This indicator is self explanatory. The information is contained in Medicaid and Nevada Check Up manuals and on their websites. As previously noted, Nevada Check Up raised eligibility for pregnant women over age 18 to 185% FPL. This waiver was implemented December 2006. WIC agencies have been advised of the change and are a referral source for pregnant women who come into the WIC clinics with no source for prenatal care.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2008	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2008	 200

Narrative:
There are no changes from 2006 in the poverty levels for eligibility for 2007. The data was obtained from the last update of the Medicaid and SCHIP Elegibility and Payment Manual, available on the Division of Welfare and Supportive Services' Website.

HSCI # 6B. This data has not changed with the exception of the Nevada Check Up coverage of pregnant women.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

Pregnant Women	2008	200

Notes - 2010
To age 18 pregnant women can get on Medicaid. There is a waiver for women to 185% of poverty for up to 100 women.

Notes - 2010
Pregnant women for SCHIP are eligible only to age 18.

Narrative:
There are no changes from 2006 in the poverty levels for eligibility for 2007. The data was obtained from the last update of the Medicaid and SCHIP Elegibility and Payment Manual, available on the Division of Welfare and Supportive Services' Website.

HSCI # 6C. This data has not changed with the exception of the Nevada Check Up coverage of pregnant women.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2010

Narrative:
The annual linkages of Birth Certificates with Medicaid Elegibility and Pay Claim Files and WIC data are not currently available. However, the processes of improvement that CHDR and DHCFP are currently undergoing will provide the quality and reliability of their data thus, expand their capacity to perform linkages to areas where currently the process in not available. The newborn Screening data from the Oregon Health Sciences Laboratory is again matched with the data from the Birth Registry.

HSCI # 9A. This data comes from the CHDR and Oregon Health Sciences Laboratory. Birth certificates and newborn screening records were again matched (Form 6). The Bureau continues to place the FTE funded by its SSDI grant in the CHDR to work on the data warehouse as it relates to MCH. The Injury Biostatistician is also in the CHDR. These FTEs have direct access to the data bases. State statute does allow surveys such as PRAMS which go back to birth certificates for those to be surveyed but the resources to do such a survey are lacking. WAshoe County District Health Department is instituting Fetal Infant Mortality Review (FIMR) July 2008 using the statute - the state is supporting this effort.

SSDI supports the linking of the following databases:
a. Infant birth
b. Infant death
c. WIC eligibility
d. Newborn screening
e. Newborn Hearing Screening
f. Birth defects registry
g. Medicaid and Nevada Check Up (S-CHIP) eligibility claims
h. Hospital discharge
g. Injury data

The Bureau MCH Analyst is based in Carson City. This new position is currently working on a Nevada Child and Adolescent Profile. She will eventually be responsible for overseeing all MCH data collection.

Nevada's Birth Defects Registry (BDR) is now called the Nevada Birth Outcomes Monitoring System (NBOMS). It is an "active" registry, collecting information primarily from hospital records. NBOMS staff has completed all of CY 2005 and 2006 data collection, giving the State two full years of data, and is half way through 2007data. A report on the 2005 and 2006 data is nearly completion. The FTE for this project is funded by newborn screening fees as directed by the 2003 legislature. He is based in Las Vegas where the majority of state births occur. Effective July 2008 the MCH Analyst and the Nevada Birth Outcomes Monitoring System personnel with be moved organizationally to the CHDR, where with the SSDI personnel they will form a MCH Epidemiology Unit within the CHDR.

The CHDR does not have electronic access to the Pediatric Nutrition Surveillance System (which is collected on WIC clients). This data is sent to CDC for analysis. WIC staff can query the data by contacting CDC.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)

Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2010

Narrative:
This measure is obtained from the Youth Risk behavioral System (YRBS) data accesibility. YRBS is a study conducted by Nevada State Department of Education and CHDR has access to YRBS data through Department of Education.

HSCI -- 9B YRBS. The State Department of Education conducts the Youth Risk Behavior Survey along with the Safe and Drug Free School Survey. It is given to middle and high school students, with some of the questions not appropriate for middle-schoolers left off the questionnaires distributed to them. Nevada is one of the few states that has weighted data so that each school district can have data that is weighted for its local use. The State Department of Education has given the YRBS database to the CHDR. The Child and Adolescent Program is currently asking Nevada's counties for county specific data to help with targeting prevention activities. To date 10 have provided this data.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Nevada's priorities and initiatives are based on the MCH/CSHCN Five-Year Needs Assessments completed in January and May 2005. "Focus groups" were established to publicly discuss the inadequacies and inequalities among the 3 MCH populations in Nevada (pregnant women and infants, children and adolescents, and CSHCN). The focus groups were a tool to build bridges among traditional and non-traditional partners in the community; they were a primary source of information that helped shape the foundation of the Year 2000 Needs Assessment. In an improvement over the 2000 Needs Assessment, the Bureau was able to utilize the data warehouse in the CHDR for Primary and Secondary data sources. No additional surveys needed to be done. Presentations were also made to the Maternal and Child Health Advisory Board and the Governor's Youth Advisory Council, and a statewide video-conferenced public hearing was held to discuss preliminary findings and shape the final outcomes of the Needs Assessment. The persons involved in the Year 2005 Needs Assessment were very vocal, creative, and mindful of the populations they serve. /2009/ /2009/ Through the Bureau's activities and coalitions related to MCH issues we have heard to ongoing needs of our communities and have had the opportunity to adjust our programs and activities to reflect the changing needs of our state. //2009//

/2010/ In response to the bureau's strategic planning, reorganization, and this year's MCH Advisory Board's priorities the Nevada MCH priorities are updated as follows:

The Nevada Maternal and Child Health Advisory board determines the four priority areas to address in
2009 are: a) Prenatal Access, b) Immunization Rates, c) Dental Sealants, and d) Access to Mental Health
Services
• Activities to address the above will range from policy changes for eligibility; rates changes to maintain an
adequate provider network; implementation of best practices; education and awareness campaigns; and
increased availability of data specific to these priority areas.
• Increase access to primary care services, oral health services, and mental health services, with an emphasis
on medical home concepts, online applications, and electronic medical records when possible.
• Create a linked online data collection, surveillance, and reporting system related to services delivered to
the MCH populations.
• Decrease the incidence of domestic violence among women of childbearing age.
• Increase breastfeeding
• Maintain smoke free environments in public places; establish healthy homes initiatives
//2010//

The priorities identified by the Year 2005 MCH Needs Assessment include:

An overarching approach to Nevada's priority needs identified below, continues to be to identify ethnic, gender and age demographics of targeted populations, and use culturally appropriate assumptions and strategies to design and implement initiatives.

1. Increase access to primary care services, providers, facilities, resources, and payor sources among the MCH populations.

2. Increase access to oral health services, providers, facilities, resources, and payor sources among the MCH populations.
3. Increase access to mental health services, providers, facilities, resources, and payor sources among the MCH populations.
4. Create a unified data system and surveillance system to monitor services delivered to the MCH populations.
5. Create "braided" services for CSHCN resources in Nevada including "one-stop-shopping" and "no-wrong-door" models of service delivery.
6. Increase financial coverage and decrease financial gaps for health services among the MCH populations
7. Decrease the incidence of domestic violence among women of child-bearing age
8. Decrease the risk factors associated with obesity for children and women
9. Decrease unintentional injuries among the MCH populations

/2010/ The State Performance Measures have also been updated to:

Increase the percent of women of child-bearing age who receive screening and assistance for domestic violence.
Increase the rate of significant Medicaid dental providers to the Medicaid population of children, youth and pregnant women.
Decrease the percent of women, ages 18 to 44, who are obese.
Decrease the percent of children and youth ages birth through 18 who die from unintentional injuries.
The percent of women (18-44) who feel down or depressed should be decreased.
Increase the number of schools (grades kindergarten to high school) that have access to a school based health center.
Reduce the prevalence of Fetal Alcohol Spectrum Disorders (FASD).
Increase the timeliness of Newborn Hearing Diagnosis to 3 months of age.
Increase the percentage of children screened for age-appropriate developmental skills and behavioral health levels.
Decrease the percentage of at-risk for overweight and overweight children in Nevada public schools. //2010//

Outcome Measures (OM)1 through 5 lead to the issue of achieving a healthy pregnancy and birth outcome. For FY08, the primary efforts of the MCH Program on achieving healthy birth outcomes will be achieved through the Bureau's MCH Campaign and Child and Adolescent Health Programs discussed in III B. The Teen Pregnancy Prevention campaign will continue to work to prevent teen pregnancies, which can lead to low birthweight babies.

For OM 6 the partnerships of Injury Prevention /2008/ and the Child Death Review teams discussed below //2008// will continue to work together to address preventing the deaths of children aged 1-14. The Bureau's Injury Data Surveillance Project produced "An Analysis of the Injury Surveillance Data System in Nevada" in FY 04, which guides the Injury Prevention initiative. The domestic violence and child abuse and neglect activities such as P.A.N.D.A. will continue. /2009/ no change. //2009//

The 2003 Legislative session established a Child Death Review process that involves 2 teams, staffed by DCFS. One team is Executive, on which the Bureau's Women's Health Coordinator sits representing Public Health. It is charged with reviewing child death reports from local teams and making recommendations for state policy changes and outreach campaigns to change behavior. It is comprised of representatives of child death review teams from around the state, public health, vital records, medical personnel, law enforcement, the office of the Attorney General, and a coroner. The other team is Administrative, on which the MCH Chief sits representing Public Health. It is comprised of Administrators from Child Welfare agencies, State agencies of Vital Statistics, Public Health, Mental Health, Public Safety, Child and Family

Services, and Clark and Washoe County Departments of Social Services. The purpose of the Executive team as stated in NRS 323B.403-409 is to review the records of selected cases of deaths of children under 18 years of age in the state; review the records of selected cases of deaths of children under 18 years of age who are residents of Nevada and die in another state; assess and analyze such cases; make recommendations for improvements to laws, policies and practice; support the safety of children; and prevent future deaths of children. The Administrative team shall review the (Executive team's) report and recommendations and respond in writing to the multidisciplinary team within 90 days after receiving the report. An annual report including statistics and recommendations for regulatory and policy changes is to be produced
An attachment is included in this section.

B. State Priorities

/2010/ Driven by the recent reorganization, integrated programming, and staff training/capacity building to use performance measures in their daily tasks, our state performance measures have been updated to the following:

Increase the percent of women of child-bearing age who receive screening and assistance for domestic violence.
Increase the rate of significant Medicaid dental providers to the Medicaid population of children, youth and pregnant women.
Decrease the percent of women, ages 18 to 44, who are obese.
Decrease the percent of children and youth ages birth through 18 who die from unintentional injuries.
Decrease the percent of women (18-44) who feel down or depressed.
Increase the number of schools (grades kindergarten to high school) that have access to a school based health center.
Reduce the prevalence of Fetal Alcohol Spectrum Disorders (FASD).
Increase the timeliness of Newborn Hearing Diagnosis to 3 months of age.
Increase the percentage of children screened for age-appropriate developmental skills and behavioral health levels.
Decrease the percentage of at-risk for overweight and overweight children in Nevada public schools.

These state performance measures were updated to support community interest for addressing current conditions, and reflect the changed priorities. In the past, state performance measures were limited to those for which there was data. Now staff are approaching the choices from which areas need to be addressed. We still lack adequate data, but feel the focus and attention will move us toward monitoring capacity. In some cases, we recognize steps required for data collection will be the primary strategies initiated. Progress will be marked by the development of data resources. For other measures, more sophisticated activities are proposed such as translating existing data into useful forms for our coalitions, policy development, and advocacy in preparation for the 2011 legislative session. (see attached briefs from the MCH Advisory Board) In the 2009 legislative session, the MCH Advisory Board presented a priority packet for each of these areas: Access to Prenatal Care, Immunization Rates, Behavioral Health Assessments/Mental Health, and Dental Sealants. THese are more refined list of state priorities (supported by the national performance measures). The Advisory Board will create their short list of priorities they focus on to develop into community messages and create advocacy movements around their topics.

Data continues to be a challenge, however, the Nevada Interactive Health Databases, http://www.health.nv.gov/NIHDS.htm, and the HRSA Data Resource Center are essential tools. MCH Staff are planning to add to their available data with a potential PRAMS pilot and exploring a data system or surveillance for FASD. //2010//

An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	99	99	99	99	100
Annual Indicator	99.0	98.4	100.0	100.0	100.0
Numerator	34384	35794	49	51	44
Denominator	34730	36377	49	51	44
Data Source					Oregon Public Health Lab
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2006
This is the second year that Nevada has lnked NBS data to birth certificate data. The total births for Nevada is determined from birth certificate records and although this data is fairly complete, there may be a few more late submissions for 2006.

a. Last Year's Accomplishments
Nevada Revised Statutes require that every newborn in the state receive two screens, one before leaving the birthing center, and a second between 5 and 14 days of birth. In 2008 98.3% were screened for 34 disorders and 88.0% received a second screening. During the past year the Nevada Newborn Screening (NBS) Program had a number of accomplishments. In July of 2008 Jack Zenteno began working as the Newborn Screening (NBS) Program Coordinator. Mr. Zenteno has created a development plan for the Newborn Screening Program that will guide future program developments. Oregon Public Health Laboratory (OPHL) received the contract to continue Newborn Screening Program laboratory services through CY 2011, and OPHL will also continue to provide specialists for consultation with Nevada's doctors as well as provide short-term follow-up to the point of confirmation of diagnosis. In 2008 Nevada increased the Newborn Screening fee from $60 to $71 per birth to allow for the inclusion of Cystic fibrosis to Nevada's screening panel. Screening for cystic fibrosis began on May 1, 2008 and to date 3 children have been identified through screening. The Nevada NBS Program continues to provide short-term follow-up including coordination of services between hospitals, laboratories, and primary care physicians to the point of intervention for infants identified with a newborn screening disorder. Hospitals continue to be notified immediately by fax and phone when unacceptable samples are received by OPHL. Because of these efforts the blood sample error rate fell from 40% to less than 10%. The NBS Program has begun contracting with Nicolo Longo from Utah State University to provide clinical metabolic services and phone consultation to primary care doctors. All infants detected with disorders were referred to the Children with Special Healthcare Needs (CSHCN)

Program for additional support, and children in need of metabolic intervention were referred to the state metabolic clinics. NBS funded nutritionists continued to provide nutrition guidance for metabolic cases. In February of 2009 the NBS Program began developing an Advisory Council that will focus on newborn screening issues and guide future program development.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Nevada NBS program screened 98.7% of infants born in the State and 86.4% of these infants received a second screening.			X	
2. The Nevada NBS program supports specialty metabolic clinics for children determined to have a metabolic disorder.		X		X
3. The Nevada NBS and CSHCN programs provide coverage for the diagnosis and treatment of metabolic, endocrine and hemoglobin disorders.	X	X		
4. The Nevada NBS and CSHCN programs work with Early Intervention services to provide specialty nutrition services to families of children born with metabolic and other developmental disorders.	X	X		
5. The Nevada NBS program and CSHCN programs maintain a "registry" of NBS cases.				X
6. All infants detected with an inborn error of metabolism, endocrine, or Hemoglobin disorder are autuomatically referred to the CSHCN program for coverage of physician, laboratory, and nutrition services.	X	X		
7. Cystic fibrosis was added to Nevada's newborn screening panel on May 1, 2008.			X	
8. Funding has been procured to add six new hemoglobin clinics and six new endocrine clinics.	X	X	X	
9. Through training by the program's nurse consultant, newborn screening sample error rate was reduced from 40% to less than 10%.			X	
10. The contract with Dr. Nicola Longo from the Univeristy of Utah School of Medicine to conduct Nevada's metabolic clinics is in effect.		X		

b. Current Activities

The Nevada NBS Program continues to screen children in Nevada for 34 disorders and ensure positive cases receive necessary services within the state. Positive metabolic cases are referred to the metabolic clinics offered through the states' contract with Dr. Nicolo Longo. The Program also continues to work closely with hospitals and healthcare providers to educate the heath care community about the program, and provide education when necessary. This currently includes redesigning the feedback process to hospitals. The program is working with the Nevada Hospital Association to display hospital statistics on the state website. The intent is to make hospital statistics available to the public to ensure accountability and provide citizens of the state more knowledge of hospital activities around the Newborn Screening Program.

c. Plan for the Coming Year

In the coming year the Nevada Newborn Screening Program plans to expand program activities. These activities include integrating the Newborn Screening Program with the EHDI Program to leverage resources, streamline activities, and increase the efficiency of both programs. The Program will work to expand staff positions to provide a more active role in short-term follow-up

and expand the program to provide long-term tracking and follow-up activities. This will include assisting families in the ongoing management of disorders. The program plans to expand education activities around laboratory specimens, program activities, and the purpose of the newborn screening program to healthcare providers around the state. The program also plans to focus efforts on the education of parents planning to have children, and those with a child identified with a disorder. In addition, the program plans to work with parents in Nevada to begin development of family-to-family support services for parents of children identified with a newborn screening related disorder. The NBS Program also plans to focus efforts on the development of the Newborn Screening Advisory Council as a method to provide expert guidance for the program within Nevada. See attached business plan for future Newborn Screening redesign.
An attachment is included in this section.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	58	60	65	60	50
Annual Indicator	54.6	54.6	54.6	47.5	47.5
Numerator					
Denominator					
Data Source					2006 Natl Study
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	50	55	55	57

Notes - 2008
2006 National Study Data repeated

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The Nevada Advisory Council for CYSHCN was active in recommending, developing, and recruiting families to participate in the Rural Respite voucher pilot. The council recommended that in the rural areas, parents needed a voucher system to hire neighbors, friends, or relatives as respite agencies are not available in their areas. An established Respite organization was contracted to oversee the voucher system and offer support/training when needed to families and potential respite givers.

MCH technical assistance with Dr. John Reiss continued. His assistance was focused on parent and provider input from the rurals and foster care. Staff worked with Dr. Reiss to develop new performance measures to test our activities. Additional activities were designed to address parent concerns. They recommended Fact Sheets for the thirty-one disorders covered in the Newborn screening program be available on CSHCN website, the parents of newborns identified in the Nevada Birth Outcome Monitoring System (formerly Birth Defects Registry) be informed in a more timely manner about programs providing monetary and social support. Thus far it has taken an average of 5.6 months from birth to enter case data into the registry compared to 9.1 and 8.1 months in CY 2005 and 2006 respectfully. The technical assistance geared up our program to successfully write the HRSA Systems Integration proposal on medical home and youth health transitioning.

CSHCN staff were active in development, media outreach, and presentations for the inaugural Families First Conference held in Las Vegas, Fall 2007. Dr. Stanley Klein was the keynote. Approximately 375 families attended, 90 presenters, and 100 plus community organizations participated in holding the conference.

Parents were active on the Healthy Kids- EPSDT workgroups. Their input shortened the wait time for newborns to receive their initial series of EPSDT exams. Families and family support organizations were active in the development and piloting of a family-friendly brochure describing the services available through Healthy Kids.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Per the national CSHCN survey, 54.6% of Nevada families partner in decision making at all levels and are satisfied with the services they receive. The Nevada Advisory Council for CYSHCN meetings are covering topics of concern by parents.		X		
2. Staff will continue to strengthen existing relationships with Family TIES and Early Intervention Services and continues to collaborate with the new partners in the office of Disability Services, Mental Health, Special Education and the County Schools				X
3. Family TIES, Nevada PEP and CYSHCN staff continue to provide cross referral for services.		X		X
4. The Nevada Children with Special Health Care Needs Assessment identified the prevailing needs as improvements in the financial application process and the lack of all provider types.		X		X
5. The Bureau has continued the outreach activities in the rural areas.		X		X
6. Parent direction from the Nevada Advisory Council for CSHCN resulted in a Respite voucher subgrant for rural families. The voucher could be used for relatives or friends so it addressed the disparity/lack of respite services in rural areas.		X		
7. Parents were active in the Healthy Kids- EPSDT and designed a family-friendly brochure in English and Spanish. It is distributed by welfare (eligibility), Head Start, Family Resource Centers, Family TIES, and Nevada PEP.				X

8.				
9.				
10.				

b. Current Activities
MCH staff responded to parents' desire for more information on newborn screening disorders. The Nevada website has links to the Oregon Public Health Laboratory "fact sheets" on newborn screening disorders. These fact sheets provide up-to-date information on the 32 disorders on Nevada's newborn screening panel and include information on cause, symptoms, treatment, and outcomes without treatment. An active parent on the Nevada Advisory Council for CYSHCN is leading action to enact a NBS parent run organization focused on newborn screening issues. The Nevada Birth Outcomes Monitoring system (formerly the Birth Defect Registry) program manager will continue to gather and input case data more frequently so parents can be informed of available assistance and support programs in a more timely manner. To increase cultural competency, the state run CYSHCN helpline will be contracted to the state's Family-to-family Health Information Center (Family Voices). This will increase the hours the phone is offered, provide direct linkage to parent support. In addition, the MCH staff are reviewing ways to meaningfully involve Family TIES and Nevada PEP in the Needs Assessment process for 2010. The parent led Interagency Coordination Council (0-3 years) and other parent groups are providing input for the redesign of how Early Intervention Services cross-refers and coordinates services among Newborn Screening, the CYSHCN program, and other needed services for children with developmental delays.

c. Plan for the Coming Year
To increase cultural competency, a contract to deliver the state's CYSHCN helpline by the Family-to-Family Information Center will start after the new State Fiscal Year (July 1, 2009). This will enhance the parent-parent support for the helpline and increase the range of times the help is available. The Nevada Advisory Council for CYSHCN, Hands & Voices, Family TIES, and Nevada PEP will be actively engaged in the upcoming needs assessment process.

2a. Increase family knowledge of supports/resources and family-centered care (based on CYSHCN Needs Assessment) contract with Family-to-family Health Information Center
2b. Redesign of the CYSHCN program; community based contract
2c. Coordinate with EIS for improved transitioning into school system (3-5 years) and early identification of conditions/service enrollment

2d. Coordinate with DETR and InterAgency Transition Board for Youth Health Transitioning work

2e. Increase technical assistance to involve parent lead groups in Needs Assessment process for 2010

2f. (1k.) Coordinate all age appropriate screening under umbrella approaches such as medical home, well child/EPSDT and educate families to seek comprehensive preventive exams and how to pay for services.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	55	55	55	55	42
Annual Indicator	49.1	49.1	49.1	41.2	41.2

Numerator					
Denominator					
Data Source					2006 Natl Study
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45	47	51	54	57

Notes - 2008
This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The following address issues raised during the Medical Home stakeholder meetings facilitated by Dr. John Reiss: a) the CSHCN Advisory Council held meetings on the lack of behavioral screening, the lack of behavioral health services for referral, and outreach for EPSDT, b) the EPSDT workgroups developed the EPSDT family-friendly brochure, addressed cultural competency in family-centered care, c) CSHCN staff worked with the Office of Minority Health to address disparity within the current system, and train staff on social determinants, d) Community leaders were informed by Title V staff of related medical home initiatives to support their work and advance the levels of awareness, e) CSHCN staff facilitated and wrote grant proposals for key stakeholders to fund telemedicine, databases for tracking/monitoring, and care coordination for EPSDT, f) Tribal clinics became more active in the EPSDT workgroups, and are sharing information related to their electronic medical record development with the Federally Qualified Health Center clinics, and h) The EPSDT workgroups facilitated improvements in the transfer of enrollment information among Welfare (eligibility agency) and Medicare (payor of EPSDT) to allow newborns earlier access to preventive screening (EPSDT).
Data collection for the Nevada Birth Outcomes Monitoring system (NBOMS) has been conducted on a more routine basis so parents of children with anomalies are informed of available assistance programs in a more timely manner.
CSHCN staff will continue to refer individuals to the programs that will benefit them the most and assist parents through the application process until eligibility determination is made. The CSHCN program can also provide financial assistance to families while waiting for Medicaid or Nevada Check Up (SCHIP) eligibility. Spanish speaking staff are available in both Carson City and Las Vegas to assist those from the Hispanic community. Program staff work closely with coalitions and organizations; they refer parents to these culturally sensitive organizations for additional information and social support.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN and System Change staff continue to work with Medicaid and Nevada Check Up to develop ways of increasing the number of children eligible for and receiving EPSDT preventive examinations.		X		X
2. Staff are reviewing changes to the CSHCN program, which would allow coverage of primary care for the children/youth who are on the program.	X	X		
3. The CSHCN and System Change team continue to support the Family TIES proposal for medical home technical assistance.				X
4. The Healthy Kids-EPSDT workgroups continue to work with state agencies, and medical providers to ensure services are family-centered and delivered in a culturally sensitive approach.		X	X	
5. The new Indian Health Board has recruited new participation to the Healthy Kids-EPSDT workgroups. Their participation raises health disparity issues regarding policy changes needed for same day multiple-encounters, transportation issues, and referral				X
6. Case data has been entered into the Nevada Birth Outcomes Monitoring System more frequently so parents are contacted and provided with progam information in a more timely manner.		X		
7.				
8.				
9.				
10.				

b. Current Activities

The Bureau would like to expand collaborations to continue the development of the electronic birth registry to enhance tracking on CSHCN. In addition, program staff will increase collaborations with Early Intervention Services and the Bureau of Community Health, Chronic Disease, to improve tracking and follow-up of CHSCN. Staff would also like to explore the possibility of working with Nevada Blind Children's Foundation and Lyons Club to implement Babies Count (vision registry) and develop newborn vision screening. It would also be beneficial this coming year to receive MCH technical assistance to critically evaluate the existing Newborn Screening program and follow-up. Funding was received by community partners to implement three pilot projects (Reno, Las Vegas, rural counties) to do Informing and Care Coordination based on the Iowa delivery system. Implementation will begin July 1, 2008. Additional funding is available to do health provider training using the Georgetown Bright Futures "Well-Child Curriculum," which includes developmental and behavioral health screening. Another small project provides medical tablets for the rural health nurses who conduct EPSDT exams to enter their chart data and be digitally delivered to the home office. Also, the information can be sent directly to the multi-disciplinary team who does the diagnosis for autism and other developmental delays.

c. Plan for the Coming Year

The Bureau is arranging for the CSHCN Family Service Specialist to obtain access (read only) to he NOMADS system which will enable staff to check on Medicaid and Nevada Check Up status of CSHCN and assist with care coordination, enhance referrals, and increase access to care. Additionally, program staff will look into ways of providing physician training for comprehensive screenings that include developmental and behavioral.

CSHCN staff will support the implementation of Family TIES' new HRSA grant with many activities geared to development of medical home capacity. Physician training will occur by a multi-disciplinary team to ensure family-centered care and comprehensive preventive screening is offered by primary care physician practices. Workshops are planned for the National Academy of Family Physicians (NAFP) and the Families First Conferences. Increase Access to care (based on CYSHCN Needs Assessment) by the following:

3a. Pilot test with ACCESS Provider Network for eligible CYSHCN in Washoe county; increase access/primary care/medical home initiative
Performance measures addressed: NPM 3,4,5
Type of service: Direct service

3b. Get 'read only' rights for NOMADS by CSHCN financial assist. Specialist; increased access/care coordination/enhanced referrals
Performance measures addressed: NPM 5, 12
Type of service: Infrastructure building, enabling

3c. Support for FASD outreach and clinics
Performance measures addressed: NPM 1
Type of service: Infrastructure building, population based

3d. Systems Change position shared by office of Disability Services, ADRC, DETR
Performance measures addressed: NPM 5, 6
Type of service: Infrastructure building

3e. (2b.) Open position in CSHCN financial Assistance program, salary savings to a sub-grant with a parent organization for bilingual referral and outreach; increase cultural competency with parent participation
3f. (1m.) Physician training for comprehensive screenings (including developmental and behavioral) and quick guide reminders, such as posters in the exam rooms of when age appropriate screens should occur.
3g. (1k.) Coordinate all age appropriate screening under umbrella approaches such as medical home, well child/EPSDT and educate families to seek comprehensive preventive exams and how to pay for services.
Rural public health nurses will offer more extensive preventive screens including blood lead screening.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	58	60	62	64	54
Annual Indicator	55.4	55.4	55.4	53.5	53.5
Numerator					
Denominator					
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55	57	60	63	66

Notes - 2008
This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
CSHCN staff distributed the Nevada Families (document organizer). The Health Care Access Program (HCAP) built a provider network (physicians, dentists, specialists). Staff referred families who were not eligible to HCAP to join for cash pay, sliding fee medical services. CSHCN program staff partnered with Nevada Covering Kids and Families to assist parents in enroll their children in Nevada Check Up and Medicaid.

Two, new Aging Disability Resource Centers (ADRC) in Clark and Washoe Counties were the product of a grant sponsored by the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS). The ADRC provides a "one-stop" entry point into the long-term support system and assists individuals in need of long-tem support, caregivers, and those planning for future long-term support needs. The ADRC sponsored new online software for completing Nevada Checkup and Medicaid applications.

The Bureau collaborated with the Covering Kids and Families Initiative to simplify and coordinate eligibility policies, practices, and procedures among different coverage programs. Collaborative and coordinated activities are conducted statewide to increase enrolment and retention in Nevada Check Up and Medicaid. The Bureau is working with the Catalyst Center and Family TIES to expand health insurance coverage for children with special healthcare needs, close the gaps faced by uninsured families, and enhance funding for family centered wrap-around services

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Per the national CSHCN survey, 55.4% of Nevada families have adequate private and/or public insurance to pay for the services they need. Partnerships with Great Basin Primary Care are underway.				X
2. CSHCN staff continued to assist families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs and community resources.		X		
3. CSHCN staff provided advocacy for families with private insurance by providing medical information (especially for rare disorders), in order to justify the need and coverage for specific services and supplies.		X		X
4. The MCH information line, CSHCN helpline, and the CSHCN program continues as a referral source for Medicaid and Nevada		X		X

Check Up, as well as for SSI for CSHCN.				
5. Staff continued to address the issues raised during the town hall meetings on Medical Home (Dr. John Reiss, TA last year). Staff attended the Nevada Association of Family Physicians conference and engage spokespersons for medical home and Healthy Kid				X
6. The first draft of the Nevada Birth Outcomes Monitoring system was completed (formerly the Birth Defect registry) with complete CY 2005 and 2006 pooled data.		X		X
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN staff assists families applying for Medicaid and Nevada Checkup (SCHIP) by providing information and referral to appropriate programs for which they are eligible. CSHCN staff review applications and direct families to programs that will benefit them the most and the CSHCN program will continue to provide benefits to families of CSHCN while waiting for enrolment in Medicaid or Nevada Check Up. CSHCN staff in Las Vegas, Carson City and Elko, continue to distribute document organizers to assist families of CSHCN when applying for public assistance and to reduce stress when completing multiple applications. This document organizer is available in English and Spanish. The Nevada Advisory Council will continue to explore the possibilities of a universal on-line application for all health coverage programs. The CSHCN program has Spanish speaking staff in both Carson City and Las Vegas to assist Hispanic families with applications, either by phone or in person, to direct them to the proper program. CSHCN applications are available in both English and Spanish. In addition the program also has an employee in Elko who has a great outreach to the Native American population. The regional Elko Resources for Children website lists rural services and how to obtain their services.
The Bureau will continue to work with the Catalyst Center and Family TIES to enhance funding for family centered wrap-around services increase enrolment and retention in Medicaid and Nevada Check-up.

c. Plan for the Coming Year

CSHCN staff will consider new ways to work with the Access to Healthcare Network which provides an alternative means of obtaining healthcare for individuals who are uninsured and fall within certain income guidelines. Two Reno hospitals and nearly 50 doctors are part of this network. The only qualifications for this program are: must be currently uninsured, must show proof of Nevada residency (such as a bill or rental agreement; legal status is not considered), must have a picture ID, must show proof of income and fall within income guidelines.
These ideas are shared with #3- we will separate based on where there is interest.
Increase Access to care (based on CYSHCN Needs Assessment) by the following:

3a. Pilot test with ACCESS Provider Network for eligible CYSHCN in Washoe county; increase access/primary care/medical home initiative
Performance measures addressed: NPM 3,4,5
Type of service: Direct service

3b. Get ‘read only' rights for NOMADS by CSHCN financial assist. Specialist; increased access/care coordination/enhanced referrals
Performance measures addressed: NPM 5, 12
Type of service: Infrastructure building, enabling

3c. Support for FASD outreach and clinics
Performance measures addressed: NPM 1

Type of service: Infrastructure building, population based

3d. Systems Change position shared by office of Disability Services, ADRC, DETR
Performance measures addressed: NPM 5, 6
Type of service: Infrastructure building

3e. (2b.) Open position in CSHCN financial Assistance program, salary savings to a sub-grant with a parent organization for bilingual referral and outreach; increase cultural competency with parent participation
3f. (1m.) Physician training for comprehensive screenings (including developmental and behavioral) and quick guide reminders, such as posters in the exam rooms of when age appropriate screens should occur.
3g. (1k.) Coordinate all age appropriate screening under umbrella approaches such as medical home, well child/EPSDT and educate families to seek comprehensive preventive exams and how to pay for services.
3h (1j.) Remove CSHCN reimbursement rate from Medicaid reimbursement rate.
3i. (1b). Identify opportunities and expand collaborations to continue development of Nevada's Electronic Birth Registry (EBR) for the purpose of enhanced tracking and data collection.

Nevada's Strategic Plan and Accountability Committee (see attached plan) continues to monitor and provide an advocacy position for person's with disability of all ages. In past years, the Healthy Kids-EPSDT work has accomplished increased compliance with the recommended schedule of visits. In future years, Early Intervention Services, Positive Behavior Supports, and rehabilitative services are areas of focus that support the MCH/CYSHCN population.

An attachment is included in this section.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	78	80	82	80	83
Annual Indicator	75.1	75.1	75.1	82.6	82.6
Numerator					
Denominator					
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	87	90	93	96

Notes - 2008
This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and

the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Title V staff will provide dedicated time, evaluation technical assistance, and support to Family TIES who was recently awarded the HRSA Systems Transformation grant. Work will be dedicated to ensuring all systems (current and being developed) are family-centered, families have input into development, and have a mechanism to voice concerns. Enhanced information delivery and referrals will become available from the Family2Family Information Center, increased cross-referring and cross-training with Nevada 2-1-1 (a statewide Information and Referral system). Additionally, the Aging and Disability Resource Centers are a strong partner in the development of consumer-driven service delivery and systems that serve the lifespan.

Title V staff continue providing support (video-conference or tele-meeting facilities) and technical assistance to the Nevada Advisory Council for CSHCN, the Family 2 Family epilepsy Project Access, Newborn and Epilepsy Learning Collaboratives and two active workgroups for EPSDT.

Title V staff are supporting the development of the next Families First conference to be held in 2009. A large representative committee is formed and the conference plans are in progress. We have secured funding from UCEDD for 2 years of the community run website, and coordinate the local agencies who will be the fiscal, offer child care services, determine the presenter list, etc.

Staff will continued to cross-refer with Nevada 2-1-1 and build referral networks with Family TIES.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Per the national CSHCN survey, 75.1% of families report the community-based service systems are organized so they can use them easily. MCH contracts with the statewide Nevada 2-1-1 system in hopes to expand to a 24 hour 7 day a week system.		X		X
2. CSHCN staff continued to assist families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs and community resources.		X		
3. The MCH information line continues to be a primary component for signing up infants and children for Medicaid and Nevada Check Up. All callers were queried regarding their insurance status.		X		X
4. The Elko regional workgroup has received funding for expanded outreach for CSHCN in the northeast rural and frontier areas of the state. Their regional resource website has english and spanish resources.				X
5. The CSHCN program will work with Nevada Medicaid and Nevada Check Up to increase the number and tracking capacity of CSHCN who receive an EPSDT, or "well child" examination for their child.		X		X
6. The Children with Special Healthcare Needs 2005 Survey indicated that 82.6% of those interviewed said the community-based service systems were orgnaized and could be used easily				X

as compared to the 2000 survey of 75.1%. Staff and the council continue				
7.				
8.				
9.				
10.				

b. Current Activities
Program staff continue to cross-refer with Nevada 2-1-1 and partner with coalitions and organizations that provide training, information and emotional support. Individuals and their families identified through the Birth Outcome Monitoring System (formerly the Birth Defect Registry) will continue to be provided with an informational letter about the CSHCN program. This provides them with a point of contact where they can be directed to the most beneficial program depending on eligibility.

This year, program staff would like to take a more active role in coordinating the community-based organizations working towards a Universal Online Application. Also, if a broad base of financial supporters for Nevada 2-1-1 could be developed and Nevada 2-1-1 could assist families twenty-four hours a day, 7 days a week, then Nevada 2-1-1 would qualify for national certification and federal funding. CSHCN staff would also like to strengthen the collaboration with Aging and Disability Resource Centers (ADRC) Family TIES and the Strategic Planning Accountability Committee (SPAC) to improve the intake process for public assistance programs. In addition, the Bureau would like to work more closely with Great Basin Primary Care, Child Health Policy, and Kids Count to customize data collection. Collaboration with the Aging and Disability Resource Centers as a "no Wrong Door" approach so CSHCN and their families could obtain application assistance.

c. Plan for the Coming Year
The Nevada Advisory Council for CSHCN oversaw a subgrant to RAVE Foundation to provide families with family-driven respite vouchers. An interesting outreach network developed to enroll new families who reside in the rurals and raised attention to how weak the communication pathways are in the rural service sector. The existing referral network was strengthened as more families became aware of services they did not know existed. The council's work enabled the community-based organization offering services to get new funding and serve more rural families in the next 2 years.

CSHCN staff, ACCESS provider network, Covering Kids and Families, and the Strategic Planning Accountability Committee for persons with disability are teaming to pilot an online application tool (modeled after Utah Clicks!). The new HRSA Systems Transformation grant addresses issues of concern to families about how they access services and difficulties maintaining a medical home. Changes within the MCH block grant structure will ease up some funding for new subgrants to enhance community-based services, and offer more bilingual services.
5a. Simplify the complex application process (based on CYSHCN Needs Assessment -see notes in Child and Adolescent NPM 13

5b. Strengthen collaboration with ADRC Family Ties and SPAC to improve the intake processes

5c. Advocate for adequate services for CYSHCN and their families

5d. Work more closely with Great Basin Primary Care, Child Health Policy, and kids count for customized data collection

5e. Capacity to interpret current data into useful format for community based partners

5f. Technical Assistance to community based partners to conduct needs assessment and evaluate their programs

5g. Strengthen role of CYSHCN Advisory Council (i.e. they have new data on the need for respite, family surveys, and have a strong interest in positive behavior support services and behavioral assessments)

5h. Change financing structure of Accustaff (Elko outreach project) to a subgrant to Family TIES, AHEC, or Northeast Nevada Family Resource Center for more community-based supervision/direction of activities.

5i (2d.) Coordinate with DETR and InterAgency Transition Board for Youth Health Transitioning work

5j. (2c.) Coordinate with EIS for improved transitioning into school system (3-5 years) and early identification of conditions/service enrollment

5k (1k.) Coordinate all age appropriate screening under umbrella approaches such as medical home, well child/EPSDT and educate families to seek comprehensive preventive exams and how to pay for services.

5l (1j.) Remove CSHCN reimbursement rate from Medicaid reimbursement rate.

5m. (1g.) Hire full time NS program manager

5n (1f.) Coordinate with EIS for improved follow up (newborn hearing/metabolic screen)

5o (1b.) Identify opportunities and expand collaborations to continue development of Nevada's Electronic Birth Registry (EBR) for the purpose of enhanced tracking and data collection.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	10	11	12	17	42
Annual Indicator	5.8	5.8	5.8	41.7	41.7
Numerator					
Denominator					
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	42	42	45	45	48

Notes - 2008
This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)

NOTE: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
CSHCN program staff continued to provide care coordination of services that include: information/referral; advocacy services for insurance coverage and program eligibility; and access to a variety of community resources. These referrals are increasingly important as youth age out of the CSHCN program. The Nevada Advisory Council for CSHCN provided input and recommendations for transitioning youth. In addition, CSHCN program Staff continued to coordinate efforts with the Developmental Disabilities Council, Vocational Rehabilitation, the Strategic Plan Accountability Committee, Family TIES, Nevada PEP, and the Northern Nevada Transition project at UCEDD. CSHCN staff participated in, and were represented in the Family Ties planning committee for the "Nevada Youth Health Transition Training". CSHCN staff also partnered with Family TIES and Head Start proposal for Grants Management Unit (GMU) funding to conduct a media campaign advertising services for families with CSHCN (unfunded). The activities are being reworked for future grant applications.

One youth with special health care needs was encouraged to join the Governor's Youth Advisory Council; she is now an active participant. Staff conducted outreach among parents and youth with special health care needs for the currently running "Partners in Policy Making" training. Another youth became a member of the Nevada Advisory Council for CSHCN. She has advocacy/policy experience from another state and is an asset.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN program staff counsel parents and youth aging out of the program and assist with referral to adult health care providers.		X		
2. CSHCN program staff provide information for families and youth aging out of the program regarding the change in funding streams for adults.	X	X		
3. CSHCN program staff provide family information regarding IEP for appropriate vocational training of CSHCN.	X	X		
4. CSHCN program staff encourage families to be involved with	X	X		

the educational plan for their child.				
5. PCP and families are given information on adult providers to work with specific conditions.	X	X		
6. PCP and families are given information where community ancillary services may be available.	X	X		
7. The CSHCN systems change team will support the youth health transitioning activities under the new HRSA grant.				X
8.				
9.				
10.				

b. Current Activities

CSHCN program staff will continue to assist eligible families to enroll in public assistance programs that will best address their financial needs and provide information on advocacy services for support and social needs. Youth transition to adulthood will continue to be a priority of the Nevada Advisory Council for CSHCN. CSHCN staff will better coordinate with the Department of Employment, Training and Rehabilitation to address CSHCN youth health transition to adulthood. The Bureau of Family Health Services has partnered with Family TIES of Nevada, Inc. (an affiliate of Family voices) and received a three-year HRSA grant for the project "Link Up Nevada". Family TIES of Nevada with support from CSHCN staff will begin to address the frustration youth have with barriers to receiving health care for their CSHCN and non-health support services, and the lack of attention to the transition needs for youth with disabilities and special health care needs. Youth mentors will be hired in rural locations to aid youth and families with young CSHCN to begin the transition process early. These mentors will be beacons of hope for a successful transition. In addition, the Bureau of Family Health Services is partnering with Family TIES to enhance their on-line training center. This will provide valuable training to health professionals and families who cannot attend the face-to-face workshops.

c. Plan for the Coming Year

In our MCH technical assistance work with Dr. John Reiss, we will build upon the transition activities designed and tested at the University of Florida. Some of the Florida materials developed may be customized for use in Nevada. CSHCN staff will continue to partner with Nevada 2-1-1, Family TIES, and Nevada PEP to assure youth can locate the services they need.

6a. Increase partnering network to become involved in proposed Medical Home and Youth Transitioning work 2008-2011 (new HRSA grant covers many of these areas; However MCH staff time is dedicated to support the successful implementation- D. Wagler; Y. McDade, J. Malay)

6b. (2d.) Coordinate with DETR and InterAgency Transition Board for Youth Health Transitioning work

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	75	75	70	72	67
Annual Indicator	74.5	66.7	69.3	65.4	68.5
Numerator	31160				
Denominator	41826				

Data Source					CDC Natl IZ Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	69	70	71	72	74

Notes - 2008
CDC National Immunization Survey NIS data July 2007 – June 2008
variable 4:3:1:3:3:1†††

Numerator & Denominator information is not available per this survey.

Notes - 2007
This data is from "Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Local Area. U.S. National Immunization Survey, Q3/2006 - Q2/2007

Notes - 2006
This data is from CDC for 2005-2006. Full year 2006 data is not available until around August 31, 2007

a. Last Year's Accomplishments
WIC staff continue to instruct all parents of infants and children to bring their immunization records to every WIC appointment. WIC staff review the records to make sure they are current and if not, refers the family to a site where they can get immunized. Staff check to make sure the immunizations have occurred at the next participant visit, where they are again instructed to bring their immunization records. In rural communities WIC staff give participants a referral form to take to their provider and participant appointments are scheduled on days when immunizations are also available. If needed immunizations can be administered that day.

Beginning June 1st, 2008 WIC clinics in the Las Vegas area will be providing no-cost immunizations to WIC participants. The cost for vaccination supplies and nursing staff are provided by members of the Southern Nevada Immunization Coalition (SNIC).
WIC clinics will offer immunization services once a month by appointment and on a walk-in basis. Nevada Health Center's Cambridge and Martin Luther King WIC clinics will offer immunizations twice a week, as they will provide their own nursing staff.
Title V staff attend local IZ coalition meetings.

All WIC clinics' staff have been trained in utilizing WEB IZ, the web-based immunization registry used in the State of Nevada. Using WEB IZ at the WIC clinics will expedite and improve tracking of immunization records.

Provider Quality Assurance: In 2008, 101 site visits were conducted among the 316 Vaccines for Children (VFC) providers to document appropriate storage, handling, and administration of state supplied vaccine.

Perinatal Hepatitis:
112 infants were delivered by Hepatitis B positive mothers in Nevada in 2007
107 infants were treated at birth with Hepatitis B vaccine and HBIG (Hepatitis B Immune Globulin)

0 infants developed acute Hepatitis B
National Immunization Survey (NIS): Nevada improved its state ranking from 51st to 46th on the most recent NIS for 19-35 mos. olds in the 4:3:1:3:3:1 Series (4 DTAP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to educate healthcare professionals on immunization mandates, schedules and efficacy	X			
2. Continue efforts on linkages of the Immunization Information Registry to the Nevada Birth Records				X
3. Continue to improve Immunization Registry laws to promote use and data entry for improved recordkeeping and tracking of immunizations				X
4. Continue work coaltions and community groups to identify and resolve health issues on barriers to immunizations			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
H1N1: The Immunization Program was included, and played an active role in, the Nevada State Health Division's response to the Novel H1N1 outbreak.
The immunization registry working with the Nevada Birth registry to initiate a medical record at birth will make tracking a child in Nevada and ensuring up to date immunization possible. This link will also provide needed ongoing data for determining needs in Nevada.
MCH staff have worked closely with IZ staff in planning and implmentation of our common goals. Working with our communities and legislators around numerous bill drafts that address childhood health our relationships have strengthed.
Implement registry statute NRS 439.265 adopted by 2007 Legislature and registry regulations adopted at June 20, 2008. The new law and regulation go into effect on July 1, 2009. Efforts continue on provider education, training and marketing plan.

Efforts to expand to northern Nevada education to the WIC clinic staff on the importance of immunization. Staff are trained by local partners and one incentive is an annual awards dinner where WIC clinics are honored for their acheivements.
The immunization coalitions have been invited to the Maternal Child Health Advisory Board as a standing invite. The coalitions have been working with Title V staff to plan and present a Early Childhood Summit that addresses many MCH issues. The summit is in September 2009.

c. Plan for the Coming Year

In 2009 35% of the providers enrolled in the Nevada State Immunization Program will be visited. For those providers who immunize young children, assessments of the immunization status of their patients at age 24 months will be accomplished as part of the VFC site visit. Providers with a rate above 80% will be recognized at the Silver Syringe Awards.

If a vaccine for the Novel H1N1 is developed, the Immunization Registry (WebIZ) will be used to track antiviral distribution as well as vaccine and personal protective equipment dispensed by the state.

Continue to improve immunization coverage ranking. Improve immunization systems and infrastructure through use of ARRA stimulus grant funds.

- • Review, enhance and improve WebIZ infrastructure.
- Upload data from SNHD; develop data sync every 72 hours importing SNHD data into statewide Nevada WebIZ. Troubleshoot and improve data upload with SNHD to complete statewide registry and reduce duplicates created.
- Develop and implement opt-in and opt-out procedures. Currently, children are opt-out and adults are opt-in. Therefore, separate disclosures for children and adults will be needed effective July 1, 2009. Regulation changes per BOH will allow for children and adults to be treated the same as opt-out.
- Develop and implement Countermeasure Response Administration (CRA) pan flu module in WebIZ.
- Develop and implement de-dup process; process to prevent creation of duplicates.
- Explore the development of HL7 messaging or flat-file interface with HMOs/Health Plans in order to populate the registry with historical data.
- Develop and implement GIS mapping project to determine geographical areas in Nevada that have low immunization rates.
- Input historical (legacy) data into WebIZ to increase the number of complete immunization records.
- Connect the State of Nevada, Electronic Birth Registry System to WebIZ. This connection will establish an immunization record into the registry upon a child's birth in Nevada.

MCH and IZ staff will work together with our community partners to determine barriers to up to date immunizations. This partnership will expand to planning, developing and implementing cultural and linguistic competence into our programs, northern and southern Nevada have different cultural, ethical, geographical and political environments that must be explored for effective outreach and education.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	27	26	25	25	24
Annual Indicator	26.7	26.4	26.7	26.4	25.2
Numerator	1266	1353	1429	1465	1440
Denominator	47362	51274	53593	55520	57231
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	24	23	23	23	23

Notes - 2006
Data for 2006 was finalized CY 2009.

a. Last Year's Accomplishments
The Nevada Institute for Children's Research and Policy at the School of Public Health developed a social marketing and evaluation guide and development tool that can be used to assist with teen pregnancy prevention efforts. In addition, WAIT training was initiated in Virginia City, a small rural community in Storey County. The Nevada State Health Division also subgranted $45,000 to the Nevada Broadcaster's Association to produce and air teen pregnancy prevention messages. The Nevada State Health Division also funded the Positive Choices-Positive Futures program through a sub grant to the Area Health Education Center of Southern Nevada.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to support community-based education			X	
2. Continue to support an educational media campaign			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Nevada State Health Division has entered into a new $45,000 subgrant with the Nevada Broadcaster's Association to produce and air abstinence education messages. The Abstinence Education program is also subgranting to Community Chest to provide technical and administrative support to the Nevada Youth Advisory Council (formerly Governor's Youth Advisory Council), which included abstinence education messages. The Health Division also funded the Crisis Pregnancy Center to support the Worth the Wait Program. The Washoe Teen Pregnancy Prevention Coalition conducted several activities as part of Teen Pregnancy Prevention month.

c. Plan for the Coming Year
The Abstinence Education grant will end on June 30, 2009 and planning for future teen pregnancy prevention efforts are pending the receipt of information regarding future funding.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	38	38	40	42	44
Annual Indicator	32.5	33.0	41.0	41.0	37.5

Numerator		10350	13109	13683	12847
Denominator		31364	31973	33372	34258
Data Source					BSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	38	38	40	40	40

Notes - 2007
Children were not resurveyed in 2007. This is an estimate based on prior year (2006).

Notes - 2006
This data is based on a statewide screening of children enrolled in third grade conducted in 2006

a. Last Year's Accomplishments
The Community Coalition for Oral Health (CCOH) in southern Nevada successfully applied for a grant from the Fund for a Healthy Nevada to support implementation of the Seal Nevada South program in Clark County schools. The program was successfully launched in a small group of schools in Henderson, NV. Saint Mary's continued to implement the highly successful Take Care-a-Van dental sealant project in northern Nevada. Saint Mary's has administered this program for over 10 years.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to collaborate with and provide technical support to Saint Mary's, Community Coalition for Oral Health, UNLV School of Dental Medicine, and the College of Southern Nevada on school-based dental sealant programs.			X	
2. Continue to identify target schools.			X	
3. Continue to assist with identification of additional resources for the sealant program.				X
4. Promote sealant placement by Medicaid and Nevada Check Up providers and by the private practice community.			X	
5. Continue to collect, analyze and report data on sealants.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In May 2009, the Oral Health Program entered into a subgrant with CCOH to support a .5 FTE Dental Sealant Coordinator. This has allowed CCOH to expand the number of schools served by the Seal Nevada South program. The Sealant Coordinator provides technical assistance and program coordination, including the submission of grant applications and reports to CCOH's school-based dental sealant program and coordinates with the Saint Mary's sealant program in

northern Nevada for data collection and other technical assistance as requested. The Sealant Coordinator and an MPH student who is currently completing a practicum with the Bureau, are in the process of completing a State Dental Sealant Plan that will be used to guide expansion of existing and implementation of new dental sealant programs in our state.

c. Plan for the Coming Year
The Oral Health Program intends to continue to support the .5 FTE Sealant Coordinator position through a subgrant with CCOH. It intends to continue to explore opportunities to implement new programs in communities which are not currently served.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	2	2.5	2.4	2.3	2.2
Annual Indicator	4.0	4.6	4.7	2.5	
Numerator	20	24	26	14	
Denominator	497677	526084	549579	569704	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2	2	1.9	1.9	1.9

Notes - 2008
PERFORMANCE MEASURE #10
ICD10 Codes are not available at this time for 2008 data. Data may be available later in CY 2009.

Notes - 2006
Data for 2006 was finalized CY 2009.

a. Last Year's Accomplishments
The Injury Prevention Program was involved in the Nevada Executive Committee on Traffic Safety, which was created and formalized, meeting several times a year. The Committee is organized by the Nevada Department of Transportation, with the main goal addressing highway safety in a comprehensive and coordinated manner involving a variety of federal, state, and local agencies committed to improving highway safety.
The Injury Prevention Program was involved in the Child Passenger Safety Task Force, as a result of a recommendation from the Occupant Protection for Children Assessment, organized by the Nevada Office of Traffic Safety Office. The Task Force purpose was to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes. Motor vehicle crashes continued to be a priority of Nevada's Injury Prevention Task Force. The Task Force members continued to collaborate on motor vehicle crash prevention efforts. These

efforts included a PSA made to help push awareness of Nevada currently not having a primary seatbelt law in effect. The PSA was aired in both Northern and Southern Nevada locations.
The Injury Prevention Program became involved with the Nevada Emergency Medical Services for Children Advisory Committee (EMSC), this is part of national effort, and is slowly taking shape within the State of Nevada.
The Injury Prevention Program continued collaborations with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Nevada Office of Traffic Safety.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Injury Prevention Program will continue to be involved in the Highway Safety Summit and the creation of Nevada's Executive Committee on Traffic Safety. The Executive Committee is organized by the Nevada Department of Transportation, and the goal				X
2. The Injury Prevention Program iwill continue to be involved in the Child Passenger Safety Task Force, which is a result of a recommendation made in the Occupant Protection for Children Assessment, and is organized by the Nevada Office of Traffic Safe		X		X
3. The Injury Prevention Program will continue to be involved with the Nevada Emergency Medical Services for Children Advisory Committee.				X
4. The Injury Prevention Program will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Office of Traffic Safety.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Injury Prevention Program (IPP) will continue to be involved in the Nevada Executive Committee on Traffic Safety, which been created, and formalized meeting several times a year. The goal is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies committed to improving highway safety. The IPP will continue an active role in the Child Passenger Safety Task Force, organized by the Nevada Office of Traffic Safety Office. Motor vehicle crashes continue to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue collaboration on motor vehicle crash prevention efforts throughout the State. The IPP will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Nevada Office of Traffic Safety. The IPP will look for continued opportunities to get their name out in public forums to increase awareness of child deaths caused by mother vehicle crashes, and push for tougher legislative reform, such as a mandatory seatbelt law in Nevada. The IPP will continue to collect, analyze and report on motor vehicle crash data. Provide motor vehicle crash data to local communities and stakeholders.

c. Plan for the Coming Year

The Injury Prevention Program plans continued involvement in the Nevada Executive Committee on Traffic Safety, meeting several times a year. Addressing highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies committed to improving highway safety.

The Injury Prevention Program plans continued involvement in the Child Passenger Safety Task Force, organized by the Nevada Office of Traffic Safety Office. Provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.

The Injury Prevention Program plans continued involvement in the Emergency medical Services for Children Advisory Committee.

Motor vehicle crashes will continue to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue collaboration efforts regarding motor vehicle crash prevention efforts throughout the State.

The Injury Prevention Program will continue collaboration with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, Nevada Department of Public Safety, and the Nevada Office of Traffic Safety.

The Injury Prevention Program will be continuing to collect, analyze and disseminate reports on motor vehicle crash data. Providing data to local communities and stakeholders.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			25	27	32
Annual Indicator		22.7	23	26.5	25.1
Numerator					
Denominator					
Data Source					WIC data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	27	28	29	30	31

Notes - 2008

NV WIC Program is the only source of breastfeeding data available in the State. The NV WIC program sends the raw data extrated from their MIS to the PedNSS at the CDC. The CDC processes the data and reports back only the percentages, NV WIC program does not know the value of numerator and denominator used. Currently, the MIS uses regional parameters to calculate programatic indicators that are not fully compatible with CDC's, thus the MCH uses the PedNSS data to ensure consistancy in the report.

Perf. Obj. This was a new reporting measure in 2005. Progress toward the projected objectives are not met. A review for more realistic objectives were made this year. This is a new program, had major organizational shifting, new staff and activities are underway but need time to get a foothold for outcome indicators to change greatly.

Notes - 2007
NV WIC Program is the only source of breastfeeding data available in the State. The NV WIC program sends the raw data extrated from their MIS to the PedNSS at the CDC. The CDC processes the data and reports back only the percentages, NV WIC program does not know the value of numerator and denominator used. Currently, the MIS uses regional parameters to calculate programatic indicators that are not fully compatible with CDC's, thus the MCH uses the PedNSS data to ensure consistancy in the report.

Notes - 2006
The data from CDC PedNSS is for WIC 2006. The only breastfeeding data at six months Nevada has is WIC data.

a. Last Year's Accomplishments
With the new WIC Breastfeeding Coordinator hired breastfeeding was more of a focus in FY 08 rather than something that is handled along with other duties.

Three major areas of focus for FY 08 were centered upon to continue increasing the breastfeeding knowledge base among clinic staff to facilitate promotion and education; Initiate community partnerships and developments with key stakeholders to improve awareness and community support of breastfeeding families; Continued participation in and the provision of technical support to the Breastfeeding Taskforce of Nevada in efforts to establish more resources and support for breastfeeding within Nevada.

Other areas of focus included: The support and expansion of the breastfeeding peer counseling program; Procurement and provision of single-user electric breast pumps for eligible participants; Provision of updated educational and promotional materials for clinic use; and Continued development of polices and guidelines for breastfeeding promotion and education.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to offer different breastfeeding trainings, including CLC trainings to WIC staff and nurses across the state.		X		
2. Support any breastfeeding specialist/advocate to take the IBCLC exam				X
3. Continue to lead and support the Breastfeeding Task Force of Nevada (BFTN).				X
4. Assist the BFTN to conduct an Ethics Training to be held for physicians across the state.				X
5. Work with State Human Resources Departments to implement worksite lactation support in all state office buildings.			X	
6. Encourage all labor and delivery hospitals in NV to move towards becoming a Baby-Friendly hospital.				X
7. Work with partners to include breastfeeding curriculum in Nevada nursing and medical school curriculum.				X
8. The State BF Coordinator will gain clinical hours needed to be eligible to take the IBCLC exam.				X
9.				
10.				

b. Current Activities

In addition to the WIC BF Coordinator, a Statewide BF Coordinator position was created, paid 50% MCH Block Grant and 50% WIC. This combined funding source allows the position to improve BF rates among WIC and non-WIC participants. The Statewide BF Program completed the following: received a grant from the Office on Women's Health to develop a worksite lactation education and community support program for working mothers breastfeeding their baby, purchased breastfeeding books that were distributed to every public library, OB/GYN, Pediatrician, La Leche League Group, and WIC Clinic in Nevada, offered three different BF trainings, two of which were CLC trainings, and 30 Multi-User Electric Breast Pumps were purchased for the University Medical Center (UMC) NICU in Las Vegas. This purchase has already tripled the number of NICU babies receiving breast milk at UMC. The Statewide Breastfeeding Program is now playing an active leadership role in the Breastfeeding Task Force of Nevada and it created an employee Lactation Room in the HD's main office building. The Coordinator is working with the Human Resources Department to expand this service to other state offices. The Nevada WIC Program started a new breast pump program by ordering Single User Electric Breast Pumps and additional Mult-User Electric Breast Pumps and manual breast pumps. The Nevada WIC Program updated all BF policies and procedures and expand the BF Peer Counseling Program.

c. Plan for the Coming Year

The Statewide BF Program will continue to offer different BF trainings, including CLC trainings, to WIC staff and nurses across the state. The program will also encourage and support any breastfeeding advocate to sit for the IBCLC exam. The Nevada WIC Program will create an atmosphere to make breastfeeding promotion and support and priority for all WIC clinics. The Statewide BF Program will continue to lead and support the BF Task Force of Nevada in any way possible, work with the Task Force to implement the goals and objectives of a mini-grant they received from the United States BF Committee (USBC) for an Ethics in BF Training to be held for physicians across the state. These trainings are scheduled to be held in fall 2009.

The Statewide BF Program will continue to work with the state Human Resources Department to implement worksite lactation support in all state office buildings, will build relationships with Nevada hospitals and encourage them to adopt BF friendly practices. Some more progressive hospitals will be encouraged to meet the requirements to become Baby Friendly, which includes staff training on breastfeeding for physicians and nurses. The Program will work to include lactation information in the Nevada nursing schools and medical school curriculum, will work to improve statewide data collection surrounding breastfeeding. The Statewide BF Coordinator will gain the clinical hours needed for her to be eligible to take the exam to become an International Board Certified Lactation Consultant.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	94	95	97	97	99
Annual Indicator	92.5	96.2	96.7	98.8	
Numerator	31815	35116	37834	38744	
Denominator	34384	36485	39122	39209	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99	99	99	9	

a. Last Year's Accomplishments

In the past year the Nevada EHDI Program has had a number of accomplishments. For 2008 the Program received a second grant through the Centers for Disease Control and Prevention to expand EHDI activities. This grant will allow the Nevada EHDI Program to focus on developing a system to track and follow-up with children that have referred from the hospital screen. The Nevada EHDI Program has purchased a database and is in the process of developing implementing the system. This system will be a secure, web-based reporting system that operates as a module of the Nevada Electronic Birth Registry. The system will allow the program to collect individual and demographic data, track infants at each step of the EHDI process, and help reduce the number of children in Nevada lost to follow-up or lost to documentation within the state.

The Nevada EHDI Program has been working with parents and professionals to develop a Nevada chapter of Hands and Voices. The purpose is to expand parent-to-parent support within the state, provide education to parents and professionals, and serve as a non-biased source of information for parents of children identified with hearing loss. In addition, in 2008 the Nevada EHDI Program was invited to attend the National Initiative for Children's Healthcare Quality (NICHQ) Learning Collaborative. This was an opportunity for the program to collaborate with other state as well as federal agencies to identify best practices that can be implemented in Nevada. This has allowed the EHD I program to streamline program activities and identify better methods to assure follow-up up for children statewide.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Nevada EHDI Program is currently working on a number of issues. One of the most difficult issues for the program to address is the shortage of audiologists in Southern Nevada. This results in delays in diagnosis, increased loss to follow-up and creates frustration for parents and healthcare providers. In order to address the issue the program is working in three areas; working to decrease the hospital referral rate to decrease the burden on audiologists, working with audiology programs around the nation to recruit audiologists to Nevada, and working with audiologists currently in Southern Nevada to expand their practice to include pediatric patients. The Nevada EHDI Program plans to continue the development and implementation of the EHDI database to allow for the tracking and follow-up for referred infants. The program is working with non-profit organizations around the state including Hands and Voices, the Deaf and Hard of

Hearing Advocacy Resource Center and A.G. Bell to create cooperation and unity around hearing loss issues and create a system of referral for parents of children that have been identified with hearing loss. The Program is also working to receive an additional HRSA grant to focus on reducing loss to follow-up within the state. If received, the funds will be focused on the hiring of a contract audiologist that will be responsible for educating hospital screeners and nursing staff, and helping develop audiology capacity in Southern Nevada.

c. Plan for the Coming Year

In the coming year the Nevada EHDI Program plans to continue development through the expansion of staff to provide data entry and reminder phone calls to parents of referred infants. Staff will also be utilized as Help Desk Personnel for the EHDI database. Program staff plan to begin active recruitment for audiologist from graduate programs around the nation. This will include travel to graduate programs to provide information booths and distribute literature. It also includes providing flyers and literature to a number of graduate programs. Program staff are also working to purchase screening equipment for State Health Districts and diagnostic equipment for audiologists willing to work with pediatric patients. The program plans to work with Nevada Hands and Voices to develop the Guide by Your Side Program which will work to shuttle families through the EHDI Process and provide education and advocacy for families of children identified with hearing loss. The Nevada EHDI Program also plans to expand marketing activities around the program. This includes development of new brochures, posters and promotional activities, and targeting materials to ensure maximum effectiveness. If grant funding comes available the program will also hire a contract audiologist to educate hospital screeners in best practices and appropriate referral, and work to train audiologists in pediatric techniques.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	18	18	17	17	16
Annual Indicator	17.7	18.6	17.9	18.8	
Numerator	105473			122018	
Denominator	595895			648797	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	14	14	13	13	

Notes - 2007

2007 indicator is from the U.S. Bureau Current Population Survey 2007 (new source of data for 2007)

Notes - 2006

This data is from GBPCA based on a study by Decision Analytics using 2006 population estimates.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

c. Plan for the Coming Year

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			15	14.5	11
Annual Indicator		15.8	15	12.6	13.8
Numerator					
Denominator					
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	11	10	10	9	9

Notes - 2008
Using the 2008 Pediatric Nutrition Surveillance
Nevada Summary of Demographic Indicators Children Aged <5 Years
Table 2C

Notes - 2007

This data is from the Centers for Disease Control Pediatric Nutrition Surveillance System for WIC. It is reported as 85% - 95% and >95%. What is reported here is the > 95% rate.

Notes - 2006
This data is from CDC's PedNSS for WIC 2006.

a. Last Year's Accomplishments
In FY 08 we continued with the initiatives from FY 07. In addition the areas of focus were planning for the implementation of (Value Added Nutrition Assessment) VENA and Emotional Based Learning within the WIC clinics. WIC participants will be more involved in goal setting and facilitating discussions of their nutritional needs. The goal is to make the WIC experience more valuable for the participants and therefore promote behavior change. Along with the emotional based aspect to promote behavior change new educational materials were utilized in the clinics to promote the importance of a healthy weight.

The second area of focus was the idevelopment of the interactive CPA Training Modules. The plan is full implementation in FY08, as mentioned an instructor led child nutrition course was part of the training to cover proper eating practices for children with emphasis on a healthy weight.

The State also took the initiative to develop lesson plans for implementation in the WIC clinics to educate on the seriousness and prevalence of overweight and obesity, the importance of physical activity and proper meal planning.

Lastly, our revised Health/Nutrition Information forms were fully utilized in the WIC clinics, the revised forms enhanced the assessment process allowing CPAs to clearly determine risks for becoming overweight which allowed for the proper education and follow-up to occur.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Train local WIC Agency staff to perform motivational interviewing and participant centered education.				X
2. Provide training to local WIC Agency staff, physicians and stores around the new WIC Food Package				X
3. Use the Fruits and Veggies More Matters logo and brand to help market increased fruit and vegetable intake among WIC families.			X	
4. Continue the educational marketing campaign of "Moooooove over to reduced-fat milk" through WIC clinics targeting 2-5 year old WIC children.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Nevada State Health Division's WIC Nutrition Education Coordinator is now certified by the American Dietetic Association in Childhood and Adolescent Weight Management. This training and learned expertise will guide the development of training for all WIC Local Agency staff in 2010.
In preparation for the new WIC Food Package (details in Plan for Coming Year) the State WIC

Program has started an educational campaign with clients entitled "Mooooove Over to Reduced Fat Milk" and is targeting families with 2-5 year old children.
Lastly, the State WIC Program developed and distributed activity classes to the local agencies to help them promote indoor activities within WIC families. (Let's Have a Ball, Bowling Game and Ball in the Basket)

c. Plan for the Coming Year
VENA -- Nevada WIC Program is striving to train the local agency staff to perform motivational interviewing and participant-led behavioral decision-making. Basically, a shift from "speaking to the eligibility code" to "speaking to the family" and assessing readiness for change.

New WIC Food Package - The new WIC food package will begin October 1, 2009 and should be much more compatible with decreasing childhood obesity. The new food package will include fruits and vegetables, only allow low-fat milk, include whole grain and provide less juice, cheese and eggs. This is a huge change and will hopefully result in big improvements on the growth grids for Nevada's overweight WIC kids. In addition, the Nevada WIC Program intends to use the Fruits and Veggies More Matters ™ as the marketing message for the new WIC Food Package that includes fruits and vegetables.

The NV WIC Program is also partnering with the Nevada SNAP Partner Network (State Nutrition Action Plan) to promote breakfast.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			7	6	6
Annual Indicator		7.6	7.0	6.6	5.9
Numerator		2771	2738	2727	2286
Denominator		36479	39260	41175	38777
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5	5	4	4	4

a. Last Year's Accomplishments
The Maternal and Child Health Campaign contracted with community-based obstetrical providers. The Bureau's two contracted vendors provided full-service obstetrical care to high-risk, low income pregnant women in urban areas. They continued to screen the women seen in their clinics for substance abuse including tobacco use, and referred those who smoke to sources that would help them quit. The MCH Campaign Information and Referral Line referred callers to smoking cessation resources. The Nevada Tobacco Users Helpline sent pregnant women

information on health risks to their babies by tobacco smoke.

Rural Nevada Community Health nurses received "Tobacco Brief Intervention" training for their smoking population.

In May 2008 the Health Division and the Children's Triangle Institute under the leadership of Dr. Ira Chasnoff collaborated to implement an evidence based pregnancy screening tool at two sites in northern Nevada. The 4P's Plus, administered by trained staff, addresses tobacco use as part of the interview. This information is collected into a national data system and will provide the State of Nevada Health Division and providers' prevalence and incidence rates.

The Health Division, through a CDC Tobacco Cessation and Control Program grant, partnered with health district to serve a diverse population of women, children, minorities, uninsured and those on Medicaid through bilingual staff members. The Health Division has information on its website about pregnancy and smoking: http://health.nv.gov.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate the training of all local agency WIC Staff on the Tobacco Brief Intervention techniques, partnering with Nevada Tobacco Free Babies Project (Dr. Sher Todd)		X		X
2. Continue to support and fund local health districts Tobacco Cessation and Prevention efforts through NV's CDC Tobacco funds, including prenatal clients.				X
3. Continue to advertise the NV QUIT-line throughout the state.			X	
4. Coordinate with the State Prenatal Substance Abuse Prevention Coordinator to improve data collection for this measure.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Based on data from Nevada Interactive Health Data Base, the number of pregnant women who smoked between the ages of 15 and 30 is approximately 9 percent for the state of Nevada. However, the rate of women who smoke during pregnancy in the rural and frontier areas of Nevada, have a prevalence rate that is twice the state average. NV's activities include Tobacco Brief Intervention(TBI) workshops, a four hour training conducted by Dr. Sher Todd of Operation Tobacco Free Babies that provides the behavioral interviewing skills for health professionals to conduct the 5 A's at every encounter: Ask, Advise, Assess, Assist, and Arrange TBI was conducted for all Community Health nurses (20) in the state to provide them with the skills to engage with their pregnant, smoking clients. In April 2009, 1800 letters and smoking cessation tool kits were sent out to physicians across the state encouraging them to advise their smoking patients to quit. Operation Tobacco Free Babies is a program which is funded by Master Settlement dollars, where Dr. Sher Todd offers tobacco cessation counseling and referral to all pregnant women who arrive for prenatal care. Dr. Todd not only counsels the pregnant woman but the whole family on the risks of tobacco use, secondhand and third-hand smoke. This program has been in operation for at least 4 years.

Southern Nevada Health District screens all of their prenatal clients.

c. Plan for the Coming Year
NSHD will increase collaboration between the CDC Tobacco Prevention and Education Program and the State WIC Program. Through this new line of communication, Nevada Tobacco Free Babies Project (Dr. Sher Todd) will be training local WIC agencies in the Brief Intervention techniques, (explained previously) TBI will be conducted for all WIC staff across the state(approximately 200) to enable them to advise and refer their pregnant, smoking clients. Nevada passed legislation that will braid the MSA Tobacco dollars to the CDC Tobacco Prevention and Education Program, and planning for this local lead agency initiative will be underway in SY 2010. Whenever possible, emphasis on tobacco cessation for pregnant and lactating women will be emphasized, increasing the impact of this performance measure.

Under the Prenatal Substance Abuse program is the 4Ps Pregnancy screening that includes tobacco use data that will be useful. The project has screened more than 2,000 women in northern Nevada in 2009 and collaboration of this data with the CDC Tobacco program and MCH Staff will definitely occur.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6	14	7	6	6
Annual Indicator	11.5	14.1	11.8	7.8	
Numerator	19	25	22	15	
Denominator	165297	177850	185872	192576	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5	5	5	5	5

Notes - 2008
ICD10 Codes are not available at this time for 2008. The data may be available later in CY 2009.

Notes - 2006
Data for 2006 was finalized CY 2009.

a. Last Year's Accomplishments
The attempted and completed suicide rate in Nevada remained one of the worst in the nation.

The Injury Prevention Program collaborated with the newly formed Nevada Office of Suicide Prevention. In addition the Office of Suicide Prevention was added as a member agency on the

Injury Prevention Task Force.
The Injury Biostatistician continued to collect and analyze suicide data for the State of Nevada.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Injury Prevention Program performs data surveillance on suicides throughout the State of Nevada				X
2. The Injury Prevention Program will continue to collaborate with the Crisis Call Center of Northern Nevada.			X	X
3. The Injury Prevention Program will continue to collaborate with the Nevada Office of Suicide Prevention.		X		X
4. The Injury Prevention Program will look for ways to help partners in funding their teen suicide prevention efforts.				X
5. The Primary Care Development Center will continue to designate Mental Health HPSAs, MUPS and MU				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Data Surveillance of Suicides in Nevada will continue.
The Injury Prevention Program will continue collaboration with the Nevada Office of Suicide Prevention and other key partners paying particular attention to youth suicides, including the prospect of potential funding three thirty second TV commercials regarding youth suicide developed in part by the recently expired Garret lee Smith Grant obtained by our partners as Southern Nevada Health District.
The Injury Biostatistician will collect and analyze suicide data for the State of Nevada, publishing a data report in 2009 on the topic of suicide. All data analyzed and published will be shared with the Nevada Office of Suicide Prevention.

c. Plan for the Coming Year
The Injury Prevention Program will continue to collaborate with the Nevada Office of Suicide Prevention and other identified key partners.
The Injury Prevention Program will continue to look for ways to help support key partners on youth suicide efforts.
The Injury Biostatistician will continue to collect, analyze, and publish suicide data for the State of Nevada. This data will continue to be shared with the Nevada Office of Suicide Prevention.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	95	95	95	97	97

Annual Indicator	86.6	95.2	94.7	93.2	95.7
Numerator	382	455	515	497	469
Denominator	441	478	544	533	490
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	97	98	98	99	99

Notes - 2006
Data for 2006 was finalized CY 2009.

a. Last Year's Accomplishments
The Maternal and Child Health Campaign continued to contract with two providers, one each in Reno and Las Vegas, to see women who have no resources including Medicaid to pay for prenatal care, including being a facility for high-risk infants. The MCH information and referral line (1-800-429-2669) continued available to all women and families who may need information regarding neonatal care. As noted previously the 2007 Legislature approved the continuation of the MCH Campaign for the 2008-2009 biennium.
In FY07 Nevada Check Up had approved a HIFA waiver to increase its eligibility for prenatal care for women over 18 to 185%. In the first 3 months 100 women entered the program. WIC is a referral source for this program as its income eligibility is also 185%. Pregnant women who do not qualify for Medicaid (whose eligibility income level is 133%) are automatically referred to Nevada Check Up. Women on both Medicaid and Nevada Check up work with providers who will ensure they deliver in a high risk facility if one is needed. The HIFA Waiver is discussed in III A Overview.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue outreach and public awareness to available prenatal services		X	X	
2. Work with coalitions and community partners to identify and resolve barriers to early access to prenatal care		X		X
3. Continue to collect, analyze and report on birth outcomes to community groups, coalitions and stakeholders				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All activities with the MCH Campaign continue. The northern vendor is looking at ways to improve the number of retention of women who enter the program. The southern health districts implemented the Nurse Family Partnership initiative to first time mothers which address the need

for prenatal care in these women. Nurse Family Partnership model programs are evidence based. The model in the south has had much success with 17 women giving birth to full term babies. These women were some of the youngest in the nation using this model.
Planning activities have began with

The Bureau and the Health Division will continue to partner with organizations to address the issue of prenatal care to improve birth outcomes and to provide prenatal care to the communities in greatest need.

c. Plan for the Coming Year
Plans for the coming year includes continued work on the First Time Motherhood/New Parents grant collaboration with our community partner. This initiative includes public awareness around early access to prenatal care and where these services are located. A needs assessment has been completed and in the coming year the media campaign will begin. Studies have shown geographical areas with the highest rate of no prenatal care in Clark County, our largest urban county, and outreach will focus on this area.
Title V staff continue to build relationships with providers through the Nevada Chapter of the American Academy of Pediatrics, Academy of Family Practitioners and the Nevada Hospital Association. Title V provide information, resources and support to these organizations.
Within the Health Division Title V staff work with the Bureau of Licensing and Certification (BLC)to ensure facilities are up to date on policy and practice. IN the coming year Title V will expand its outreach to BLC by providng education on MCH related practices such as Newborn Screening and Newborn Hearing. Reaching providers through area health education centers will be reviewed as a means of continuing education to healthcare professionals.
Our MCH campaign line will move to our statewide toll-free information and referral line, Nevada 211 (see attached). This will offer expanded hours and resources to our populations.
Support from Title V funding will be expanded to a diverse population based service that will include education, outreach, training and evaluation.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	77	80	74	76	78
Annual Indicator	74.4	67.2	64.3	64.7	66.8
Numerator	26157	25032	25721	26621	25914
Denominator	35147	37259	40006	41175	38777
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	85	85	85	85

Notes - 2006
Data for 2006 was finalized CY 2009.

a. Last Year's Accomplishments
The Bureau continued to contract with the two obstetrical centers as part of the Maternal and Child Health (MCH) Campaign, to provide full obstetrical services to low-income, high-risk pregnant women who are not eligible for Medicaid or Nevada Check-Up. Both the vendors from Southern and Northern Nevada maintain current programs.

The Bureau continues to maintain a toll-free, statewide health line where women and families can access information regarding a variety of issues, including where to obtain prenatal care and social/mental health services. Outreach included FQHC's in our state that offer prenatal and obstetric services, as well as health districts screening , referral and educating pregnant women on early access.

OUr MCH Advisory Board continued to support early access to prenatal care as a priority area. Community leaders and legislators make up the coposition of board members. Outreach and education continued on the importance of early access of prenatal care.
MCH and Local organizations work with ethnically and culturally diverse groups to extend outreach of services and resources. Partners include United Way of Southern Nevada, Latin Chamber of Commerce and faith based organizations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue outreach and education to women of childbearing age on the importance of early prenatal care		X		
2. Continue to provide outreach and public awareness on life course perspective through partners, grandparents and family members		X		
3. continue to collect, analyze and report on prenatal access to community groups and organizations				X
4. Build, support and provide technical assistance to MCH coalition in southern Nevada to address prenatal issues				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Efforts continue on development of a southern MCH coalition of local healthcare providers, businesses, and organizations to form an alliance towards the goal of maternal and women's health issues including increasing early access to prenatal care throughout our state.
The northern Nevada MCH coalition, which partners with diverse community partners and our Health Division, is focusing on prenatal awareness and education.
Discussions on measures to improve the number of pregnant women receiving prenatal care in the first trimester focused on a need for improving physician reciprocity, legislative changes to nursing regulations regarding midwives, and working with the university system to develop mid-level practitioners. A state mandate that would provide presumptive eligibility through Medicaid did not pass through our legislative session. Our communities state that waiting for Medicaid eligibility is a barrier to early access to prenatal care. Our coalitions are addressing this issue and will work with stakeholders.

c. Plan for the Coming Year
Our MCH campaign line will be moved to our statewide toll-free information and referral line. This will expand the access and scope of the MCH line. MCH provides outreach and awareness on this transition. MCH staff are working with communities on outreach and the most effective method to reach our populations. Through focus group and key informant interviews with the First Time Motherhood Grant, we have learned communities most trust community partners. MCH will use communites to reach the population and assist in development of the messaging. Community driven strategies that are evidence based will be supported by MCH and have shown to reduce infant mortality and low birth weight babies.

Title V staff will continue to work with the MCH Advisory Board to address issues of access to prenatal care. The board will implement lessons learned from technical assistance received from MCHB this year. Title V staff have been designated to work with members of the MCHAB to assist with any needs in regards to MCH related issues. This relationship has improved our communication with our board members. Title V subject matter experts have worked with board members to address focus areas in a smaller workgroup which allows for an effective means of communication that is later shared with the larger group. The board members provide guidance on their subject matter to the Title V staff.

D. State Performance Measures

State Performance Measure 1: *Increase the percent of women of child-bearing age who receive screening and assistance for domestic violence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	10	10	10	15	15
Annual Indicator	7.7	5.7	6.0	5.6	3.9
Numerator	38229	30288	30015	28982	19546
Denominator	497955	528027	498297	515208	503840
Data Source					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	15	15	15	15	15

Notes - 2008
Data from Title V funded pregnancy clinics and Nevada Network Against Domestic Violence women aged 18-44years. Denominator is state demographers projection of women.

a. Last Year's Accomplishments
Staff continues
d to collaborate with the Attorney General's Council for the Prevention of Domestic Violence. Bureau staff will continue to partner with the Nevada Network Against Domestic Violence on the Health Care Standards team to have domestic violence screening become standard throughout the state. In addition, the Bureau continues the statewide, toll-free Maternal and Child Health Line for callers needing referral to a social service agency in their area and the screening of clients who receive prenatal care through the providers of the MCH Campaign. Opportunities to partner with other organizations allowed for education on our states domestic violence screening practices to various groups, both in our state and nationally.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to partner and support efforts of statewide domestic violence prevention advocacy groups and organizations			X	
2. Continue to disseminate information and materials to coalitions, community groups and healthcare professionals			X	
3. Continue to serve on committees that offer education to healthcare professionals on screening women of child bearing age for domestic violence.			X	
4. Ensure screening of women of childbearing age in all Title V funded programs				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Building collaboration with organization on domestic violence prevention. Building relationship with child death review groups and injury prevention to address behaviors that lead to domestic violence and and reducing recidivism among families.

c. Plan for the Coming Year
Staff will continue to build collaborations with organizations in the coming year. Staff will continue to partner with Nevada Network Against Domestic Violence to train healthcare professionals on domestic violence screening. Our MCH Campaign vendors will continue to screen for domestic violence for women who come in for prenatal care.
Provide technical assistance on performance measures to organizations on domestic violence. Support the statewide domestic violence organization in its interventions and strategies on reducing domestic violence.

State Performance Measure 2: *Increase the rate of significant Medicaid dental providers to the Medicaid population of children, youth and pregnant women.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			1.9	2	2
Annual Indicator		1.8	1.5	1.9	
Numerator		298	344	422	
Denominator		167271	235066	222530	
Data Source					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.1	2.2	2.3	2.4	

Notes - 2006
Medicaid data is not yet available, but Medicaid made great strides in opening up dental care for Medicaid clients in2006. This is an estiamte.

a. Last Year's Accomplishments

The Nevada Division of Health Care Financing and Policy (DHCFP) continued to provide dental services in Clark and Washoe Counties using a managed care model. Due to budget challenges, the DHCFP did not implement its plans to expand the HMO model into an additional five counties. Both Managed Care Organizations (MCO) contracted by the DHCFP were able to exceed the ratio of dentists to clients required by their contracts.

Health Access Washoe County (HAWC) Community Health Center agreed to provide administrative oversight for a new community-based dental clinic in Silver Springs. This allowed the clinic to overcome what had been a significant operational barrier. Saint Mary's continued to be a significant provider of dental services to Nevada's Medicaid, Check Up, and uninsured populations in Washoe County. Nevada Health Centers continued to be one of the primary safety-net dental provider in Las Vegas as is the University of Nevada, Las Vegas School of Dental Medicine. Nevada Health Centers was also the only safety-net dental provider in Elko and the rural counties surrounding Elko County. In addition to Nevada Health Centers, Huntridge Teen Clinic and Paradise Park Children's Dental Clinic provided safety-net dental services in Clark County.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to collect, analyze and report data on the MCH population covered by Medicaid.				X
2. Continue to offer support to the Division of Health Care Financing and Policy around policy and recruitment issues.				X
3. Continue to provide support to the six regional oral health coalitions in Nevada.		X		X
4. Continue to disseminate information to stakeholders about dentists seeking to serve underserved populations.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Nevada Division of Health Care Financing and Policy (DHCFP) continues to provide dental services in Clark and Washoe Counties using a managed care model and both Managed Care Organizations (MCO) contracted by the DHCFP continue to exceed the ratio of dentists to clients required by their contracts. The DHCFP implemented a new $600 a year annual cap on dental services for Nevada Check Up clients. In addition, it eliminated orthodontic coverage for these clients. However, the recently passed federal SCHIP legislation has required the DHCFP to reinstate these benefits.

All of the safety-net dental providers mentioned above continue to provide dental services.

c. Plan for the Coming Year

Health Access Washoe County will be opening a new clinic in Virginia City which will include dental services. This will bring the number of dental clinics operated by HAWC to four (two in Reno, one in Silver Springs, and one in Virginia City).

State Performance Measure 3: *Decrease the percent of women, ages 18 to 44, who are obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			18	18	17
Annual Indicator		19.7	23.0	21.9	20.0
Numerator		104021	98268	94783	88875
Denominator		528027	426760	433217	444805
Data Source					BRFSS 2008
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	17	16	16	16	16

Notes - 2007
This data is from Nevada's preliminary 2007 BRFSS report.

Notes - 2006
This data is from Nevada's final 2006 BRFSS report.

a. Last Year's Accomplishments
The CSHCN Program had a nutritionist on staff who provided education and counseling to parents with CSHCN.

The MCH Wellness Program Manager worked with Medicaid to begin a system of payment for Registered Dieticians, who would have billed Medicaid directly for three hours per year of medical nutrition therapy for women of child-bearing age and children through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. The federal agency overseeing Medicaid informed the HD that Medicaid dollars could not be used unless Registered Dietitians (RDs) were licensed in Nevada, which they were/are not. The MCH Staffer worked with a state senator to introduce legislation on licensure. In an unforeseen way, the American Dietetic Association moved in a threatened to come and testify against the bill draft because they were not consulted. The Nevada Dietetic Association, under pressure from the national organization, asked the state senator to withdraw her bill draft. This project is dead for now and the HD is in mourning.

The Medical Consultant working with statewide partners addressed women's health issues throughout the lifespan and educated the public on nutrition and physical activity through events and programs.

The MCH Wellness Program Manager is also on the Carson City School Board and worked closely with school nurses and lunch programs in each district to promote healthy lifestyles. All Nevada elementary schools received supplies of the "Eagle Series" books on nutrition; additional books will be distributed as the need arises. The MCH Wellness Manager also worked with school nurses to determine what health related data is collected at the local school level and the availability of this data to the Health Department.

Child Care Health Consultants were trained with 2 hours of nutrition and healthy menus in the child care setting. The CCHC's provided education to both the child care providers and parents. Child Care Health Consultants are community health nurses

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with Human Resource Departments, both public and private sector, providing technical assistance on implementation of worksite wellness initiatives, this also includes lactation support in the worksite.				X
2. Assist the WIC Program and the ITCN WIC Program in implementing the more healthful WIC Food package in Fall 2009.		X		
3. Continue to support local health districts' wellness initiatives.				X
4. Work with the Advisory Council for the State Program on Fitness and Wellness to showcase evidence-based wellness practices.				X
5. Continue to work to expand school and community gardens and Farmer's Markets throughout Nevada.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Health Division supports its local health districts in their chronic disease and prevention activities, with obesity reduction and prevention a key activity. See www.gethealthyclarkcounty.org and www.gethealthywashoe.com . The Advisory Council for the State Program on Fitness and Wellness used its state resources to develop a webpage that will act as a Nevada clearinghouse for program related to fitness and wellness, www.fitfirstnevada.org (still investigating a host server) National efforts, like Bike to Work Week/Women's Health Week were promoted and supported inside and outside the HD. In a rather new initiative, the HD is assisting the University of Nevada Las Vegas in some local Las Vegas-area research around the physical activity built environment.

Washoe County School District has an award-winning employee wellness program that is marketed to other Nevada employers. The MCH Wellness Program Manager worked to support school and community gardens and the expansion of Farmer's Markets. Lastly, taking its role-modeling seriously, the HD opened its own, on-site fitness center room and lactation room for staff of the Technology Way office.

c. Plan for the Coming Year

Most women in this age bracket are busy at school, working, raising their children, and perhaps all three. Health initiatives need to capture them in an environment where they already are. The MCH Wellness Program Manager will target these women at their worksites. In partnership, work with the HD Frontier and Rural Community Health Program to implement one employee wellness program within their region (for a total of 10 employers). The Health Division's Human Resources Manager is also arranging for wellness staff to provide technical assistance to both public and private Human Resource staff to help facilitate more workplace wellness initiatives. This also includes lactation support for breastfeeding women returning to work, helping decrease obesity in women of child bearing age. Also, through CDC initiatives and training, the HD will integrate state-level Wellness Program Activities with state level Chronic Disease Program Activities to further impact obesity rates.

An attachment is included in this section.

State Performance Measure 6: *Decrease the percent of children and youth ages birth through 18 who die from unintentional injuries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			5	5	5
Annual Indicator	13.3	10.9	14.0	9.7	
Numerator	85	73	98	70	
Denominator	641220	667830	697715	723177	
Data Source					
Is the Data Provisional or Final?				Provisional	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5	5	5	5	5

Notes - 2008
ICD10 Codes are not available at this time for 2008. The data may be available later in CY 2009.

Notes - 2006
Data for 2006 was finalized CY 2009.

a. Last Year's Accomplishments
The Injury Prevention Program became involved in the Child Passenger Safety Task Force, as a recommendation made from the Occupant Protection for Children Assessment, organized by the Nevada Office of Traffic Safety Office. The Task Force provided guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.
The Injury Prevention Program continued its involvement in the Washoe County SAFE KIDS Coalition. The Coalition is committed to the prevention of childhood injury in Northern Nevada.
The Injury Prevention Program became involved with the Nevada Emergency Medical Services for Children Advisory Committee.
The Injury Prevention Program continued to employ a half-time Biostatistician responsible for improving data collection and analysis of injuries in Nevada, including childhood injuries.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Injury Prevention Program will continue to facilitate an Injury Prevention Task Force providing guidance to the State with a goal of decreasing the number of childhood injuries and deaths.				X
2. The Injury Prevention Program will continue to collaborate with coalitions committed to the prevention of childhood injuries throughout Nevada.				X
3. The Injury Prevention Program employs a half-time Biostatistician who's continued responsibility is improving data collection and analysis of injuries in Nevada, including childhood				X

injuries				
4. The Injury Prevention Program has potentially identified funds to carry out a public education campaign to reduce unintentional injuries to children.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Injury Prevention Program will be continuing its involvement in the Child Passenger Safety Task Force. The purpose of the Task Force is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.
Continued involvement will continue with the Nevada Emergency Medical Services for Children Advisory Committee.
A half-time Biostatistician is employed by the Injury Prevention Program who is responsible for improving data collection and analysis of injuries in Nevada, including childhood injuries.

c. Plan for the Coming Year
The Injury Prevention Program will continue involvement with identified key partners including the Child Passenger Safety Task Force, Nevada Emergency Medical Services for Children Advisory Committee, and identify other key partnerships throughout Nevada to become involved with to help decrease the number of childhood injuries and deaths from unintentional injuries.
The Injury Prevention Program will continue to employ a half-time Biostatistician who will be responsible for improving data collection and analysis of injuries in Nevada, including childhood injuries.

State Performance Measure 9: *Increase the number of schools (grades kindergarten to high school) that have access to a school based health center.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective					

Notes - 2007
Clark County is the only county in Nevada that has schools with SBHC. Currently only 3 elementary schools are equipped with these centers. We currenlty are awaiting for the # of children k-6 who are enrolled in school based heatlh centers (numerator). Some of these centers have only been in operation for 6 months because they were lacking medical directors.

Therefore, we do not have reliable data to report for the numerator.

The denominator is 148,773. This data came from NV Annual Reports of Accountability provided by NV Dept of Education.

a. Last Year's Accomplishments
Nevada changed this performance measure slightly, FROM, the percent of children kindergarten - grade 6 who have access, TO, the number of schools that have access to a school based health center kindergarten-high school)

The was a new performance measure for Nevada and much staff time was focused on learning what was happening and what was being planned. The MCH Staffer learned a great deal and brought partners together to facilitate needed expansion.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance and support to existing school-based health centers.				X
2. Provide technical assistance to Carson City School District to open a school based health center in 2009.				X
3. Invite Communities in Schools to address the Nevada Assocation of School Board Trustees at their annual conference in November 2009.				X
4. Send a Nevada Representative to the National Assembly of School Based Health Centers' annual conference for training.				X
5. Utilize existing Nevada kindergarten health parent survey data to drive the top health service priorities in each location of a school-based health center.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Nevada will change this performance measure in two ways: the percent of children who have access to a school based health center becomes simply the number of school based health centers, and secondly, the region isexpands to all of the counties in Nevada.

There are currently 6 school based health centers in Nevada,
3 in Las Vegas operated by the Federally Qualified Health Center, Nevada Health Centers (NVHC): CP Squires Elementary School, Roy Martin Middle School, and Valley High School, and 2 by Communities in Schools (CIS): Cunningham and Reynaldo Martinez Elementary Schools. There is also a SBHC at Basic High School in Henderson that is operated through grants and by the Nevada State College Nursing administration. Clark County School District, the fifth largest district in the United States, added a FTE in the District Office to facilitate the smooth operation of these facilities on their campuses, showing commitment and sustainability for the performance measure. All of Nevada's school-based health centers are based in southern Nevada.

c. Plan for the Coming Year

Communities in Schools of Southern Nevada plans to open 3 additional clinics in the Las Vegas area in the coming years. CIS feels that 6 clinics in the metropolitan Las Vegas area will provide coverage to all of the targeted/disparate populations. CIS has also expressed interest in expanding to Northern Nevada, with Carson City School District being the most likely school district to add the next clinic. In addition, Elko County School District will be approached by MCH Staff about the interest in a clinic at one of their Elko area schools. CIS will be invited to address the Nevada Association of School Board Trustees at their annual meeting in November. Nevada will look closely at the CDC's Coordinated School Health Program and move towards its' guidance to enhance its funding opportunities.

Carson City School District is now in the process of completing a needs assessment that includes surveying parents, staff, community members and middle/high school students.
The District Office has already committed the use of a modular building at its Eagle Valley Middle School, and CIS is interested in overseeing the operations of this clinic.

Additionally, a Nevada Representative will attend the National Assembly of School Based Health Centers annual conference in Florida this summer to learn more about this new performance measure.

Data from the first and second years of a parent Kindergarten Health Survey will be used to see what health services are lacking as children enter into the school system. This information will be shared with our school based health center partners.

An attachment is included in this section.

State Performance Measure 11: *Reduce the prevalence of Fetal Alcohol Spectrum Disorders (FASD).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					35
Annual Indicator				346.7	
Numerator				26	
Denominator				75	
Data Source					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	32	30	28	25	

Notes - 2007
This initiative started May 19,2008. Data is for 6 weeks.

a. Last Year's Accomplishments
Continuation of work from the Perinatal Substance Abuse Prevention Program (PSAP) include for direct services: screening, diagnosing, and referring from our Title V funded FASD clinic and our MCH partners in Las Vegas at UNSOM. During this time period 35 children were diagnosed with a waiting list of approximately 80 children. With the support and guidance from the PSAP subcommittee, Senator Carlton secured additional funds during the 2007 legislative session or UNSOM to address the long waiting list and establish an FASD clinic in Reno.
With respect to standards development, the 4Ps Plus pregnancy screening for infrastructure building in our Title V funded pregnancy clinics and MCH stakeholders in northern Nevada was implemented in May of 2008. More than 1200 women were screened with education/brief intervention strategies. To continue to strengthen infrastructure and in collaboration with the

Substance Abuse Prevention and Treatment Agency (SAPTA), two BRFSS questions were included for the first time . Attendance at the annual national conference for FASD state coordinators continues to support policy development with respect to strengthening infrastructure.
Q1) In the month before you knew you were pregnant, how much beer, wine, or liquor did you usually drink per week? - Number of drinks, - Don't know/not sure, - Refused
Q2) Upon learning you were pregnant, about how many days per week did you have at least one drink of any alcoholic beverage?

1. Did not drink
2. Every day
3. 3 to 6 days a week
4. 1 or 2 days a week
5. Less than 1 day a week

Data will be available in 2010.
Enabling services included the first FASD Summit held in Carson City. More than 175 people attended from the medical, educational, social service and community sectors. The March of Dimes awarded the PSAP proposal to fund this event. Additionally, health education presentations and materials for MCH coalitions, the State Epidemiology Work group and SAPTA coalitions and community organizations.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implementation of monthly FASD diagnostic clinic in northern Nevada	X			
2. Medicaid consultation, collaboration and establishment of reimbursement category for FASD claims		X		
3. Creation of monthly clinic data reporting forms that provide profiles of mother and children				X
4. Implment 4Ps Plus pregnancy screening of all pregnant women and those suspected of being pregnant at pregnancy clinics, FQHC's and Rural Health Clinics.			X	X
5. Outreach preveention efforts to rural and frontier Nevada communities		X		
6. FASD prevention summit in 2008 in Northern Nevada			X	
7. Development and distribution of FASD Awreness Day toolkits to coaltions and consortiums throughout Nevada		X		X
8. Develop and distribute FASD brochures in English and Spanish	X			
9.				
10.				

b. Current Activities
Continuation of work from the Perinatal Substance Abuse Prevention Program include direct services: screening, diagnosing, and referring from our Title V funded FASD clinic and our MCH partners in Las Vegas at UNSOM. In October of 2008 Reno FASD diagnostic monthly clinic work began at the Mojave Child, Adult and Family Center. To sustain the clinics in the north and south with third party payor sources, meetings were held with Medicaid to work out the billing. Thus far, the Reno FASD clinic has been successful with reimbursement fees to continue the clinics beyond the appropriated amount. For this reporting period the Las Vegas FASD clinic has diagnosed 22 children with a waiting list of 38 children. The Reno clinic has diagnosed 26 children and a waiting list of 37 children.
Enabling services included health education/prevention presentations and educational materials road to trip to community organizations, coalitions and health providers in four rural communities

in northern Nevada. Mobilization of communities to acknowledge FASD Awareness Day on 9/9/09. This was a collaborative effort with the Tobacco Prevention and Immunization program. Additionally, multiple events are planned for July for Dr. Chasnoff, Title V HRSA grant to return to Nevada with presentations at MCH partner sites.
Standards development efforts continued with the 4Ps Plus pregnancy screening for infrastructure building in our Title V funded pregnancy clinics and MCH stakeholders in northern Nevada.
An attachment is included in this section.

c. Plan for the Coming Year
Increase prevention efforts to rural and frontier communities in Nevada. Implementation of 4P's Plus pregnancy screening in Clark County in the south. Develop targeted prevention strategies with collaborative community partners. Statewide FASD Awareness Day collaborations with coalitions, consortiums and community groups and agencies who serve women of child bearing age.
If sucessful in being awarded the FAS Surveillance Grant from HRSA in partnership with Arizona, planning, development and implementation of an FAS Surveillance in Nevada.

Continue enabling services in form of education materials and future prevention presentations in rural communities including collaboration with Indian Health Services, SAPTA and MCH coalitions.
Continuation of work from the Perinatal Substance Abuse Prevention Program (PSAP) include for direct services: screening, diagnosing, and referring from our Title V funded FASD clinic and our MCH partners in Las Vegas and Reno. Las Vegas will be instituting third party Medicaid bilking to sustain services. Provide education/prevention to MCH coalitions, SEW, SAPTA and allied providers. Seek funding streams for FASD Summit in Southern Nevada.
Continued standards development efforts with the 4Ps Plus pregnancy screening for infrastructure building in our Title V funded pregnancy clinics and MCH stakeholders in northern Nevada. Expansion of 4Ps to southern Nevada. Prevalence infrastructure building if CDC grant awarded to University of Arizona School of Medicine. Redesign strategic plan for PSAP subcommittee, revise by-laws and expand membership. Review BRFSS data to guide prevention strategies.
Membership and active participation in National Prevention Network that assists in developing and implementing FASD prevention strategies using materials, presentations.

State Performance Measure 12: *Increase the timeliness of Newborn Hearing Diagnosis to 3 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective					

a. Last Year's Accomplishments

In the past year the Nevada EHDI Program has had a number of accomplishments. For 2008 the Program received a second grant through the Centers for Disease Control and Prevention to expand EHDI activities. This grant will allow the Nevada EHDI Program to focus on developing a system to track and follow-up with children that have referred from the hospital screen. The Nevada EHDI Program has purchased a database and is in the process of developing implementing the system. This system will be a secure, web-based reporting system that operates as a module of the Nevada Electronic Birth Registry. The system will allow the program to collect individual and demographic data, track infants at each step of the EHDI process, and help reduce the number of children in Nevada lost to follow-up or lost to documentation within the state.

The Nevada EHDI Program has been working with parents and professionals to develop a Nevada chapter of Hands and Voices. The purpose is to expand parent-to-parent support within the state, provide education to parents and professionals, and serve as a non-biased source of information for parents of children identified with hearing loss. In addition, in 2008 the Nevada EHDI Program was invited to attend the National Initiative for Children's Healthcare Quality (NICHQ) Learning Collaborative. This was an opportunity for the program to collaborate with other state as well as federal agencies to identify best practices that can be implemented in Nevada. This has allowed the EHD I program to streamline program activities and identify better methods to assure follow-up up for children statewide.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Disseminate fax referral forms to hospital staff and increase their understanding of their process			X	
2. Hands & Voices outreach to families of newly screened newborns		X		
3. Quality Assurance and monitoring of the numbers screened with need for further followup				X
4. Policy development to increase the number of specialists in our state.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Nevada EHDI Program is currently working on a number of issues. One of the most difficult issues for the program to address is the shortage of audiologists in Southern Nevada. This results in delays in diagnosis, increased loss to follow-up and creates frustration for parents and healthcare providers. In order to address the issue the program is working in three areas; working to decrease the hospital referral rate to decrease the burden on audiologists, working with audiology programs around the nation to recruit audiologists to Nevada, and working with audiologists currently in Southern Nevada to expand their practice to include pediatric patients. The Nevada EHDI Program plans to continue the development and implementation of the EHDI database to allow for the tracking and follow-up for referred infants. The program is working with non-profit organizations around the state including Hands and Voices, the Deaf and Hard of Hearing Advocacy Resource Center and A.G. Bell to create cooperation and unity around hearing loss issues and create a system of referral for parents of children that have been identified with hearing loss. The Program is also working to receive an additional HRSA grant to focus on reducing loss to follow-up within the state. If received, the funds will be focused on the hiring of a

contract audiologist that will be responsible for educating hospital screeners and nursing staff, and helping develop audiology capacity in Southern Nevada.

c. Plan for the Coming Year
Nevada now has an active Hands & Voices chapter. They are engaging parents and working with service providers to develop family-centered outreach and referrals for diagnosis.

In the coming year the Nevada EHDI Program plans to continue development through the expansion of staff to provide data entry and reminder phone calls to parents of referred infants. Staff will also be utilized as Help Desk Personnel for the EHDI database. Program staff plan to begin active recruitment for audiologist from graduate programs around the nation. This will include travel to graduate programs to provide information booths and distribute literature. It also includes providing flyers and literature to a number of graduate programs. Program staff are also working to purchase screening equipment for State Health Districts and diagnostic equipment for audiologists willing to work with pediatric patients. The program plans to work with Nevada Hands and Voices to develop the Guide by Your Side Program which will work to shuttle families through the EHDI Process and provide education and advocacy for families of children identified with hearing loss. The Nevada EHDI Program also plans to expand marketing activities around the program. This includes development of new brochures, posters and promotional activities, and targeting materials to ensure maximum effectiveness. If grant funding comes available the program will also hire a contract audiologist to educate hospital screeners in best practices and appropriate referral, and work to train audiologists in pediatric techniques.

State Performance Measure 13: *Increase the percentage of children screened for age-appropriate developmental skills and behavioral health levels.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective					

a. Last Year's Accomplishments
This performace measure is new this year.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1.				
2.				
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Providing developmental, behavioral and autism screenings for children 18 months to 60 months of age through community screening events and phone/email screening project.
- Developed and maintaining database program of children receiving developmental, behavioral and autism screenings.
- Researching online options for developmental and behavioral screening service.
- Researching funding options for online developmental and behavioral screening service.

c. Plan for the Coming Year

- Develop funding mechanism for online screening service.
- Contract with publisher of online screening program to establish online screening program.
- Train community providers to use online screening program for children 6 months to 60 months of age.
- Collaborate with pediatrician and family physician professional organizations to orient and train staff to use online developmental and behavioral screening service.
- Collaborate with pediatrician and family physician professional organizations to provide coding guidance for appropriate billing of developmental and behavioral screenings of young children.

State Performance Measure 14: *Decrease the percentage of at-risk for overweight and overweight children in Nevada public schools.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					
Annual Indicator				23.2	
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	22	22	22	22	22

Notes - 2008
State Performance Measure #14
Date for 2008 is not available because the YRBS is done every other year. Data for 2009 will be available in CY 2010.

Notes - 2006
State Performance Measure #14
Date for 2006 is not available because the YRBS is done every other year. Data for 2007 will be available in CY 2008.

a. Last Year's Accomplishments
This performace measure is new this year.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Wellness Section Manager will attend the CDC's BEAT Institute training around the built environment, including schools				X
2. Develop and provide comprehensive training to every school wellness coordinator in Nevada. Plans include 5 modules and monitoring of the web-based training.		X		X
3. Continue to support the training and resource needs of Nevada Public School Nurses.		X		X
4. Work with the Alliance for a Healthier Generation on school-based wellness and prevention initiatives.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Nevada's Advisory Council for the State Program on Fitness and Wellness sponsored registration and travel for 75 school nurses to attend the National School Nurses' Association's School Nurse Childhood Obesity Prevention and Education (known as SCOPE) training in Las Vegas in April 2009. The Council also paid for the development of a children's "Fit for Life" web page that will provide education and resources to Nevada's students. The MCH RD worked with the NV Department of Transportation and the NV Superintendent's Association to increase the number of school district's that applied for Safe Routes to Schools monies from NDOT.
Many schools in Clark County hosted family fitness and nutrition nights events to set the stage for parental involvement in school wellness Councils and parental involvement in providing healthy foods for their children and making physical activity a family a priority.

An attachment is included in this section.

c. Plan for the Coming Year
MCH Nutritionist will attend the CDC's BEAT Institute (Built Environment Assessment Training) in June 2009. Working closely with local school district staff, she will be able to articulate the needed changes to the built school environment as it relates to nutrition and physical activity in SY 2010.
Through a graduate intern project, the potential of an inter-district "cooperative buying club" that would enhance purchasing power and draw food distributors with more nutritious food choices for the school districts will be investigated. (new trucks bringing healthier food to the delivery docks at schools)
UNLV Sports Education Leadership, NV's State Superintendents' Association and NV's Action for Health Kids are working cooperatively to provide training to every School Wellness Coordinator (650 total). National experts will be brought to Nevada, videotaped by the Las Vegas PBS Station, and 650 CDs will be made and distributed. NAFHK will provide personal follow-up and tracking Based on feedback provided by the Nevada school superintendents, the training will be delivered using electronic and web-based technology. The trainings have been conceptualized as 5 sequential 50 minute modules. Based on the known reticence of school personnel and administrators to dedicate scarce resources and time to health and wellness, modules 1, 2, and 3

have been conceptualized with the need to increase knowledge and persuade school policy makers that an investment in a child's health is an investment in their academic achievement and that coordinated school health can be easily incorporated into the daily systems of school life. These modules will be video-based productions that will be made available on line and will have an assessment mechanism so that school completion may be monitored. Modules 4 and 5, are live webinars that will be delivered live through the partnership between Action for Healthy Kids and The Alliance for a Healthier Generation. Additionally, one district representative will receive additional training to add support and assistance to schools as they endeavor to create healthier school environments for Nevada's K-12 school children. Participation and completion in all 5 modules will be monitored through the development of a web site that will function as an access and delivery point for the trainings and also record and post school completion accordingly.
Once the Nevada Healthy School project develops the training modules, there must be a way to allow easy registration, evaluation and tracking of the schools' wellness progress.
Proposed: Website
This site could be housed in the Department of Education, Health and Human Services or outsourced to third party such as Nevada Action for Healthy Kids/National Action for Healthy Kids.

- Register school, school administrator and wellness coordinator
- Insure training modules are completed
- House method for Wellness Coordinators to log progress for evaluation purposes

E. Health Status Indicators

Introduction

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.0	8.3	8.3	8.2	8.0
Numerator	2799	3083	3335	3391	3112
Denominator	35147	37259	40006	41175	38777
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
Data for 2006 was finalized CY 2009.

Narrative:

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	6.4	6.3	6.4	6.5	6.3
Numerator	2189	2360	2488	2597	2375
Denominator	34167	37259	38756	39895	37597
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
Data for 2006 was finalized CY 2009.

Narrative:

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.3	1.3	1.4	1.3	1.3
Numerator	441	478	544	533	490
Denominator	35147	37259	40006	41175	38777
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
Data for 2006 was finalized CY 2009.

Narrative:

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.0	1.0	1.0	1.1	1.0
Numerator	329	365	397	420	363
Denominator	34165	37259	38756	39895	37597
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
Data for 2006 was finalized CY 2009.

Narrative:

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	9.4	9.3	11.1	11.2	
Numerator	47	49	61	64	
Denominator	497677	526084	549579	569704	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2008
ICD10 Codes are not available at this time for 2008. The data may be available later in CY 2009.

Notes - 2006
Data for 2006 was finalized CY 2009.

Narrative:

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.0	4.6	3.3	1.8	
Numerator	20	24	18	10	
Denominator	497677	526084	549579	569704	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2008
ICD10 Codes are not available at this time for 2008. The data may be available later in CY 2009.

Notes - 2006
Data for 2006 was finalized CY 2009.

Narrative:

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	22.0	24.4	23.3	14.8	
Numerator	74	88	88	58	
Denominator	336900	361160	377360	391047	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2008
ICD10 Codes are not available at this time for 2008. The data may be available later in CY 2009.

Notes - 2006
Data for 2006 was finalized CY 2009.

Narrative:

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	232.5	162.5	141.7	164.5	
Numerator	1157	855	779	937	
Denominator	497677	526084	549579	569704	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	

Notes - 2008
ICD10 Codes are not available at this time for 2008. The data may be available later in CY 2009.

Narrative:

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	18.1	35.2	25.3	16.1	
Numerator	90	185	139	92	
Denominator	497677	526084	549579	569704	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
ICD10 Codes are not available at this time for 2008. The data may be available later in CY 2009.

Notes - 2006
Data for 2006 was finalized CY 2009.

Narrative:

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	97.1	145.9	121.1	83.6	
Numerator	327	527	457	327	
Denominator	336900	361160	377360	391047	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
ICD10 Codes are not available at this time for 2008. The data may be available later in CY 2009.

Notes - 2006
Data for 2006 was finalized CY 2009.

Narrative:

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	20.2	13.1	14.1	16.8	16.7
Numerator	1612		1259	3236	3216
Denominator	79608		89473	192575	192575
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.4	5.4	6.6	6.0	6.2
Numerator	3103		3056	5975	6146
Denominator	418348		462416	999293	999293
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
This is an estimate from the state STD program.

Narrative:

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	0							
Children 1 through 4	0							
Children 5 through 9	0							
Children 10 through 14	0							
Children 15 through 19	0							
Children 20 through 24	0							
Children 0 through 24	0	0	0	0	0	0	0	0

Notes - 2010

Narrative:

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1			
Children 1 through 4			
Children 5 through 9			
Children 10 through 14			
Children 15 through 19			
Children 20 through 24			
Children 0 through 24	0	0	0

Notes - 2010

Narrative:

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live	**Total All**	**White**	**Black or African**	**American Indian or**	**Asian**	**Native Hawaiian**	**More than one race**	**Other and Unknown**

births	Races		American	Native Alaskan		or Other Pacific Islander	reported	
Women < 15	0							
Women 15 through 17	0							
Women 18 through 19	0							
Women 20 through 34	0							
Women 35 or older	0							
Women of all ages	0	0	0	0	0	0	0	0

Notes - 2010

Narrative:

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15			
Women 15 through 17			
Women 18 through 19			
Women 20 through 34			
Women 35 or older			
Women of all ages	0	0	0

Notes - 2010

Narrative:

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	0							
Children 1	0							

through 4								
Children 5 through 9	0							
Children 10 through 14	0							
Children 15 through 19	0							
Children 20 through 24	0							
Children 0 through 24	0	0	0	0	0	0	0	0

Notes - 2010

Narrative:

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1			
Children 1 through 4			
Children 5 through 9			
Children 10 through 14			
Children 15 through 19			
Children 20 through 24			
Children 0 through 24	0	0	0

Notes - 2010

Narrative:

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19									
Percent in household									

headed by single parent									
Percent in TANF (Grant) families	2.0	63.0	27.0	2.0	2.0	0.0	5.0	1.0	2008
Number enrolled in Medicaid									
Number enrolled in SCHIP									
Number living in foster home care									
Number enrolled in food stamp program									
Number enrolled in WIC									
Rate (per 100,000) of juvenile crime arrests									
Percentage of high school drop-outs (grade 9 through 12)									

Notes - 2010
TANF data is from the Welfare Division; Demographis from the Health Division.

Narrative:

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19				
Percent in household headed by single parent				
Percent in TANF (Grant) families				
Number enrolled in Medicaid				
Number enrolled in SCHIP				
Number living in foster home care				
Number enrolled in food stamp program				
Number enrolled in WIC				
Rate (per 100,000) of juvenile				

crime arrests				
Percentage of high school drop-outs (grade 9 through 12)				

Notes - 2010

Narrative:

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	
Living in urban areas	
Living in rural areas	
Living in frontier areas	
Total - all children 0 through 19	0

Notes - 2010

Narrative:

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	
Percent Below: 50% of poverty	
100% of poverty	
200% of poverty	

Notes - 2010

Narrative:

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	
Percent Below: 50% of poverty	
100% of poverty	
200% of poverty	

Notes - 2010

Narrative:

F. Other Program Activities

Nevada's Maternal and Child Health Block Grant continues to provide funding for Early Intervention Services. The Bureau also partners with BEIS whose clinics provide the site for the Bureau's multidisciplinary clinics in Reno and Las Vegas (metabolic, genetic, etc.).

The Nevada WIC Program's Electronic Benefit Transfer (EBT) initiative is on hold as this document is written. USDA is assessing the value of the system and whether or not Nevada should go statewide, stay at 70% usage, or go back to paper. The EBT (smart) card is very popular with the WIC clinics, participants and partners. Participants only procure those foods that their families need, and can go as often as they like to the grocery store as they are not tied to purchasing everything that is listed on a voucher on one visit to the store. Clinics like the paperless aspects; staff can serve more people in a given time period than with a paper voucher. Vendors like it as it has eliminated checker problems and bill backs. They are also reimbursed overnight as opposed to getting paid in the several weeks it takes for paper. As previously mentioned WIC is a program of the Bureau's and under the supervision of the MCH Chief.

The Bureau continues to have three toll-free information lines. The first and primary is the MCH Campaign's 1-800-429-2669. In 2006 it had 1,077 calls. The second line is the CSHCN line, 1-866-254-3946. It had 1,302 calls in 2006. The third and final line is the WIC line, 1-800-8 NEV WIC. It is now being answered in the Bureau. All three lines are marketed. They are all bilingual, English and Spanish. They all tie into the State's 2-1-1 line.

The State in the next biennium is putting several resources together to develop a system for autism screening and referral for all children. The 2007 Legislature appropriated Two million dollars to DHHS for an advisory committee and to allocate to families to help them with the expenses of having a child with autism. The Health Division is charged with developing the system; the project is located in the Administrator's Office. The Bureau is working with this development as it is a logical partnership for the Early Childhood Comprehensive Systems Development (ECCSD) initiative and the CSHCN Information and Referral Line. The Bureau will take the calls that come in from the autism media campaign (and other sources), forward an intake form by e-mail to the autism office who will send out an Ages and Stages questionnaire for parents/guardians to complete and return. The office will score it and be in charge of follow-up. The Bureau is also working with the autism office through the ECCSD project to get the screening tool widely distributed, with the state goal of screening all children at age 18 months (or older).

G. Technical Assistance

Medical Home.

An extension to the current consultation by Dr. John Reiss--University of Florida, Institute for Child Health Policy is requested. The extension will continue the work begun to assist the Title V CSHCN staff with development of medical homes for all CSHCN (through partnerships with family and community based organizations) and to measure/monitor on-going progress. This effort is to support the MCHB priority of subspecialty capacity building and improving service delivery to

children from communities with limited access to comprehensive care.

Dr. Reiss worked with the Title V staff from May 2007 to September 30, 2007 to initiate medical home development consultation in 3 key areas of Nevada. Dr. Reiss and Title V staff visited key stakeholders in Reno/Carson City, Las Vegas, and Elko to discuss topics related to medical home development, family-centered care, the relationship of the existing CSHCN program to services, and local data collection/reporting. One of the resounding conclusions from these indepth discussions were the number of barriers in Nevada to achieving the basic level of medical "homeness." Discussions pursued methods to share limited resources, improve cross-organization communication, involve families in the decision-making, and improve education to providers and families on non-traditional ways to achieve services that are accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and delivered in culturally competent environment.

This TA extension request will focus on means to overcome the obstacles in Nevada to medical home development (limited number of primary care providers, severe lack of specialty care, extreme mobility of the residents, and geographic distances to services). Proposed activities are to educate parents and providers about alternative methods to achieve a medical home, such as use of tele-medicine, electronic health records, involving non-traditional providers, i.e., Family Resource Center staff, social workers, community health nurses, and parent support organizations. Devise means to broadly disseminate these messages. With Dr. Reiss' consultation, Title V staff assist key stakeholders in implementation of these ideas. Also, stronger partnering across state agency and community-based organizations is expected from the activities planned. From the increased partnering, more systematic data sharing will be an intended outcome. Activities already planned are a medical home presentation to an expected 400 families of CSHCN at the fall "Families First" conference, November 16 and 17, 2007 in Las Vegas, Nevada and a listserv for providers to share success and discuss barriers to implementation.

/2010/ Staff continued the work begun from the Medical Home technical assistance to continue the Nevada Medical Home Listserv, initiate a Bright Futures Well Child Online Curriculum training (a joint venture among the University public health school, Family TIES, Medicaid, and Title V.) Staff are working with foster care staff to begin addressing the lack of medical home components in their system. //2010//

EPSDT.
/2009/Technical Assistance was received in 2008 for EPSDT. Medicaid staff and Title V staff has peer-exchange with Iowa. This has resulted in a new project in Nevada. We are implementing an Informing and Care Coordination pilot. It is a statewide pilot with information and referral, limited care coordination provided to all chidren newly enrolled in Medicaid and Nevada Check Up (SCHIP). It is funded by a state minigrant and is time limited. Data collected from the pilot is being used to submit an NIH proposal to continue the same work. Title V staff are working with Kay Johnson, Johnson Consulting and John T. Richards, Georgetown University to improve language in our Title V - Medicaid Interagency Agreement. The consultants are assisting us to look at additional ways to finance the Informing project in the future. //2009// This TA has resulted in an Informing and Care Coordination pilot extended into Year 2. It is statewide and hopes to expand the organizations involved in making the informing calls. The pilot has helped work out data sharing issues with Welfare and Medicaid, produced data to enhance two National Institutes of Health proposals, and strengthened the working relationship among DHHS agencies. As calls are made to families, we get objective feedback on how we can improve communication to newly enrolled families, are making more providers and families aware of the social services available, and increasing public knowledge on the information and referral networks such Nevada 2-1-1 and the Family-to-family Health Education Center.

Cultutal Competency.

Nevada once again requests cultural competency training. The local source identified in prior years may not still be available, but given problems with the National Center in years past that is not an option for the state.
/2010/ Cultural Competency Technical Assistance is received. The first planning session with consultant Suganaya Socklingham will occur in June. //2010//

New TA Requests for 2010.
/2010/ Nevada has a wide variety of technical assistance requests, please see Form 15 for details. In general, Nevada would like to interact with the University of South Florida for some general systems capacity issues, to learn how to fully define the context and purpose of the upcoming needs assessment. More specifically, Nevada's Technical Assistance and Training Center on Autism is looking to the Association of Maternal Child Health Programs' State Public Health Coordinating Center for Autism (STHCCA), to provide technical assistance on
• Standards for care coordination • Materials and strategies for rural/hard to reach populations • Materials for Hispanic families • Engagement of advisory groups • Strategies around training providers • Best practices around reimbursement. Within breastfeeding support, Nevada wishes to learn from the Oregon Nursing Mother's Council how it interacts with the State WIC Program, how it is funded, and who its partners are. Our Prenatal Substance Abuse Prevention Program is very interested in developing a partner-driven strategic 5-year plan, and is looking to Alaska for assistance in this area. In the area of School Health, Nevada would like to learn from the CDC what the next steps are to move Nevada into obtaining the Coordinated School Health funding at the next FOA. Specific to data, Nevada State Health Division has several new biostatisticians who have expressed a desire to learn more in depth analysis, techniques and planning around Title V and Epi data.
/2010//

V. Budget Narrative

A. Expenditures

Form 3, State MCH Funding Profile shows FY 2007 MCH expenditures amounted to $1,835,626 with the appropriate expenditure match of state funds adhering to the required 3-4 match of three (3) state dollars for every four (4) federal dollars. The State expenditure amount was $1,376,719 for a total of $3,212,345. The MCH budget for FY 2007 was $3,608,709, so expenditures were $396,364 less than budget, or 11.0% of the budgeted amount. The expenditure variance is partially explained by holding the $150,000 amount as carry forward for expenditures projected for future years.
Other federal funds expended during FY 2007 amounted to $43,516,956. This compares with the budgeted amount of $49,207,697 for a shortfall of expenditures by 11.6%. For FY 2007 the total budget under the guidance of the MCH Chief was $52,816,406 and expenditures under the guidance of the MCH Chief amounted to $46,729,301. The total expenditure variance under the guidance of the MCH Chief of $6,087,105 was due to WIC expenditures not approaching budgeted levels and approximately $246,400 in MCH expenditure activities.

Form 4, Budget Details By Types of Individuals Served provides the detail for budget expenditure variances by population served. Pregnant Women included budgeted expenditures of $1,432,657 and actual expenditures amounted to $1,360,409 in FY 2007. The budget expenditure variance for Pregnant Women is $72,249, or 5.0% below the amount budgeted. Expenditures for the Pregnant Women population included newborn screening expenditures. Federal expenditures for Pregnant Women amounted to $223,059 or 12.2% of federal funds expended in FY 2007.

Form 4 for FY 2007 for Children 1 to 22 Years Old included budgeted expenditures of $920,220 and actual expenditures amounted to $713,344. The budget variance for this group is a decrease of $206,876, or 22.5% below the amount budgeted. The budget variance is due to a transition of budgeting methodology from straight-line expenditures by population group to attempting a more accurate estimation of the amount expenditures projected for future years. The current methodology is based on percentage expenditures from the year of expenditures currently being reported. Federal expenditures for Children 1 to 22 Years Old amounted to $628,129, or 34.3% of federal funds expended in FY 2007.

Form 4 for FY 2007 for Children with Special Health Care Needs included budgeted expenditures of $1,058,192 and actual expenditures amounted to $942,878. The budget variance for this group is a decrease of $115,314, or 10.9% below the amount budgeted. The budget variance is due to a transition of budgeting methodology from straight-line expenditures by population group to attempting a more accurate estimation of the amount expenditures projected for future years. The current methodology is based on percentage expenditures from the year of expenditures currently being reported. Federal expenditures for Children with Special Health Care Needs amounted to $788,724, or 43.0% of federal funds expended in FY 2007.

Form 4 for FY 2007 for Administrative costs, included budgeted expenditures of $197,640 and actual expenditures amounted to $195,714. The budget variance for this group is a decrease of $1,926, or 1.0% below the amount budgeted. No budget variance explanation is needed for this group. The $195,714 was less than the 10% threshold for Administrative expenditures per grant guidance.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Direct Health Care Services for FY 2007 included budgeted expenditures of $934,656 and actual expenditures amounted to $876,987. The budget variance for this group is a decrease of $57,669, or 6.2% below the amount budgeted. Federal expenditures for Direct Health Care Services amounted to $472,201, or 25.7% of federal funds expended in FY 2007.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Enabling Services for FY 2007 included budgeted expenditures of $700,090 and actual expenditures amounted to $795,828. The budget variance for this group is an increase of $95,738, or 13.7% above the amount budgeted. The budget variance is due to a transition of budgeting methodology from straight-line expenditures by population group to attempting a more accurate estimation of the amount expenditures projected for future years. The current methodology is based on percentage expenditures from the year of expenditures currently being reported. Federal expenditures for Enabling Services amounted to $545,198, or 29.7% of federal funds expended in FY 2007.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Population-Based Services for FY 2007 included budgeted expenditures of $1,515,657 and actual expenditures amounted to $1,002,136. The budget variance for this group is a decrease of $513,521, or 33.9% below the amount budgeted. The budget variance is due to a transition of budgeting methodology from straight-line expenditures by population group to attempting a more accurate estimation of the amount expenditures projected for future years. The current methodology is based on percentage expenditures from the year of expenditures currently being reported. Federal expenditures for Population-Based Services amounted to $280,833, or 15.3% of federal funds expended in FY 2007.

Form 5, State Title V Program Budget and Expenditures By Type of Service, Infrastructure Building Services for FY 2007 included budgeted expenditures of $458,306 and actual expenditures amounted to $548,359. The budget variance for this group is an increase of $90,053, or 19.6% above the amount budgeted. The budget variance is due to a transition of budgeting methodology from straight-line expenditures by population group to attempting a more accurate estimation of the amount expenditures projected for future years. The current methodology is based on percentage expenditures from the year of expenditures currently being reported. Federal expenditures for Infrastructure Building Services amounted to $537,394, or 29.3% of federal funds expended in FY 2007.

B. Budget

Next year's budget, Federal Fiscal Year (FFY) 2010 MCH application budget adheres to the required 3:4 match of three (3) state dollars for every four (4) federal dollars. The federal MCH portion is estimated, for budget planning purposes at $1,792,997. The 75% state MCH match, budgeted at $1,344,748 is comprised of fees generated by the Newborn Screening program. The total FFY 2010 MCH budget is $3,137,745. As required, the FFY 2010 MCH budget exceeds the required FFY 1989 Maintenance of Effort amount of $853,034. As with previous years, the actual match will likely exceed the budgeted match as more fees are generated for each birth. All fees are expended for newborn screening activities (contributing to the 30% CYSHCN requirement).

For FY 2010, 30% of the federal Title V allocation (Form 2, Section 1.A) is budgeted for Preventive and Primary care for children and adolescents that equals $537,899. We expect as in prior years to surpass the 30% minimum. Working with our MCH Advisory Board members and county health district representatives, we are in the process of issuing new contracts for services. In the past, most contracts were for direct services and had been renewed up to 14 years in some cases. Nevada MCH is working to allocate the dollars to current priorities and budget the activities to more proportionally meet the MCH pyramid recommendations. We are decreasing the amount of Direct Care Services proportionally, designing the next in quantity to be Enabling Services, increasing the amount of Population-Based Services, and building our base of Infrastructure building services. Our short term goal will be an improved diamond shape, with more public health functions being added over time. In the past, direct health care services have been primary care and oral health oriented, as these represent two significant unmet needs for children and adolescents. While, we still consider these important areas, the function of how the MCH dollars will be used is shifting. For example, money may be contracted to address the same

areas, but to include monitoring and quality assurance, advocacy, and policy development activities. The MCH Advisory board is increasing their advocacy role and will be quarterly monitors of the MCH contracted dollars. This is part of the shift to move toward a public health approach emphasizing prevention and primary care to improve health outcomes for children and adolescents. In the current year, the MCH AB developed their priority areas: Access to prenatal care, Immunization rates, Dental sealants, and access to mental health services (standard behavioral health screens). Projects in FFY 2010 are being designed to address their priorities and manage as many areas of need as possible.

For FFY 2010, 30% of the federal Title V allocation (Form 2, Section 1.B) is budgeted for Children with Special Health Care Needs and their families in the amount of $537,899. We expect as in prior years to surpass the 30% minimum. Nevada MCH is in the process of redesigning their health coverage program for CYSHCN and reviewing how the dollars are used for Early Intervention Services. MCH staff, the Interagency Coordinating Council, and the Nevada Advisory Council for CYSHCN are involved in the redesign. In the past, direct services have been provided by Nevada Early Intervention Services and through health professionals, such as pediatric ophthalmologists and physical therapists who are under contract to the CYSHCN program. In FFY 2009 all these services were provided through the Nevada Early Intervention Services in Reno and Las Vegas and CSHCN staff based in Carson City.

For FFY 2010, Administrative costs, Form 2, Section 1. C $179,299 is budgeted. Expenditures will not exceed this amount of 10%. For FFY 2010, the remaining federal Title V award is directed towards services for pregnant women and postpartum women and infants up to age 1 year; and designing other activities directed to MCH populations statewide. Direct and population-based services are provided through contracts with local agencies, including health districts and community based non-profit agencies. Requests for Information are out to the community to assist in rewriting the new contracts' competitive process and scope of work.

Last year's note indicated Nevada's MCH unexpended grant balance of $150,000, was "basically expended as planned over the current 2007-2008 biennium." However, it shows up in the budgeted amount again. As the dollars were previously expended, the budget line item will zero out this year. Nevada's Title V Maternal and Child Health Block grant is fully budgeted for a two year period, through the Legislative process for the 2010-2011 biennium.

Other federal funds administered by the MCH Chief in addition to the Maternal and Child Health Title V Block Grant Program include a United States Department of Agriculture (USDA) grant for the state WIC program; Abstinence-Only Education, and State Systems Development Initiative grants funded by MCHB; Oral Health, Rape Prevention and Education, Early Hearing Detection and Injury Prevention grants from CDC; and Sexual Assault Prevention from PHHS. Other federal grants include Early Childhood Comprehensive Systems, and Newborn Hearing Screening that provide different services to the populations served by the Maternal and Child Health Block Grant Program in accordance with approved grant proposals.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.