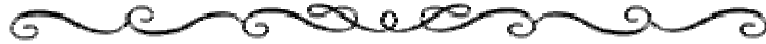

Maternal and Child Health Services Title V Block Grant

State Narrative for Nevada

Application for 2009
Annual Report for 2007

Document Generation Date: Tuesday, July 15, 2008

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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

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Nevada's Assurances and Certifications are signed and filed in the office of the Chief of the Bureau of Family Health Services, Judith Wright. Ms. Wright serves as the MCH Chief for Nevada. This office is located at 3427 Goni Road, Suite 108, Carson City, NV 89706. Ms. Wright can be reached at jwright@health.nv.gov.

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; expires May 31, 2009.

E. Public Input

Oportunity for public input on the 2009 MCH Block Grant application and 2007 Annual Report after required public notices was provided on June 27, 2008, at two sites. One hearing was held in the north in the Bureau of Family Health Services Carson City, and the other teleconferenced to Las Vegas at the Desert Regional Center at the same time. The Public Hearing was held on the same day and place as a meeting of the MCH Advisory Board. Written comments were solicited due July 10, 2007. Notice of preparation of the grant, the date and places of the public hearings, and an invitation for comment was published in newspapers on June 11, 2008 in Reno, Las Vegas and Elko and were sent to individuals on the Maternal and Child Health Advisory Board mailing list. Copies of the proposed grant were available by contacting the Bureau and the NEIS in Reno, Las Vegas and Elko. Copies were sent to members of the MCHAB and those who requested them including the state's MCH Coalitions who were asked to promote its review. It was also posted on the Bureau's website. This application represents priorities established by the Year 2005 Needs Assessment including extensive public comment through the Needs Assessment process, ongoing surveillance of programs in the Bureau, and the meetings of the MCHAB.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

There is no change to the findings of the 2005 Needs Assessment. Surveillance of injury, oral health, pregnant women's substance abuse, etc. have continued to support the priorities established then. Copies of the surveillance documents may be found under the specific program on the Bureau's website. The Bureau's website may be reached by going to http://health.nv.gov and selecting the Bureau of Family Health Services. From there selection can be made of the program web page. In this year several State Performance Measures were changed to better reflect the findings of the Needs Assessment and subsequent updates. This is more fully described in the Annual Report.

III. State Overview

A. Overview

There are many factors that impact the health delivery system in Nevada. The State Health Division seeks to improve the health and well being of all Nevadans through a myriad of programs and activities. In addition its priorities include building the public health infrastructure in the state, eliminating waiting lists for Early Intervention, and addressing bioterrorism. Within this context the Maternal and Child Health (MCH) program focuses on the well being of the MCH populations of women and infants, children and adolescents, and Children with Special Health Care Needs (CSHCN), and their families, addressing in particular those priorities identified in the MCH 2005 Needs Assessment. In Nevada, the MCH Title V Program is located in the Bureau of Family Health Services (Bureau) in the State Health Division. The Bureau serves as Nevada's MCH Agency.

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.

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. 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 15th 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.

/2007/ Nevada continues to be the fasted growing state in the Nation. 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. //2007//

//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.

It is in this milieu that the following priorities for 2005 from the MCH Needs Assessment were established. 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//

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. 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 were 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//

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//

/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//

/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 who come 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 it materials in both English and Spanish. There are translators in all WIC clinics where necessary. CSHCN materials are in English and Spanish. 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 around 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//

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.

/2007/ 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. //2007//

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.

/2007/ 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.

/2007/ 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. //2007// /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//

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. /2007/ 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. //2007//

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. /2007/ Per Welfare, this business process change ended almost as soon as it started. For the rest no change. //2007//

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. /2007/ no change //2007//

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). /2007/ This program was transferred as planned to Mental Health/Developmental Services Division July 1, 2005. //2007//

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 CSHCN. It does this through partnering and collaborating with a myriad of 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.

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.

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.

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

C. Organizational Structure

Nevada's Executive Government is set up with the elected Governor as the Head of State. The current Governor is Kenny Guinn, now in his second four-year term, which expires in January 2007. 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.

The state public health agency, the State Health Division (SHD), is in the Department of Human Resources (DHR). DHR 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 DHR. The org chart for DHR 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 Human Resources 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 CSHCN programs are in the Bureau of Family Health Services.

The SHD contains 7 Bureaus all headed by a Bureau Chief. In addition to the Bureau of Family Health Services they include Community Health (BCH), Licensure and Certification (BLC), Health Planning and Vital Statistics (BHP&VS), Early Intervention Services (BEIS), Health Protection Services (BHS), and Alcohol and Drug Abuse (BADA). Alex Haartz, MPH, is the Administrator of the SHD. Mr. Haartz received his MPH from Tulane University. Prior to coming to the SHD he was with the San Diego County Department of Health providing public health education. He began his career with the SHD with the Bureau, and is an advocate for MCH. The State Health Officer is Dr. Bradford Lee. Dr. Lee came to the SHD from the United States Air Force, where he served for more than 29 years. His medical degree is from Howard University, College of Medicine; his Juris Doctorate is from the University of the Pacific McGeorge School of Law. The SHD organization chart is attached at III B, Agency Capacity.

The Bureau works very closely with all six of the other Bureaus. It provides funding for Community Health Nurses in BCH and partners with BCH on chronic disease initiatives. 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.

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//

/2008/ Jim Gibbons was elected Governor in November 2006. He is in his first four-year term. Otherwise there is no change from 2007.

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

Dr. Lee retired June 1, 2007. His replacement has not yet been hired.

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.

Alex Haartz resigned from his position as Administrator of the Health Division. Richard Whitely, MS was 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.

Dr. Lee's replacement has not yet been hired. In the interim the State Health Division has contracted with Mary Guinan, MD, Ph.D., as acting Health Officer. 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 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 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//

D. Other MCH Capacity

Nevada's MCH/CSHCN 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.

Judith Wright, Bureau Chief, 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//

Gloria Deyhle, RN, Health Program Manager II, CSHCN Manager, got her nursing degree from Mount Sinai Hospital School of Nursing. She has been CSHCN Manager since 1990, having previously worked as a Medicaid Services Specialist in the Welfare Division. The CSHCN Program staff also includes a contractor for newborn hearing (the grant ends in 2006), a Health Program Specialist I for the Birth Defects Registry, one Family Service Specialist II and an Administrative Assistant I for the payment portion of the program. /2007/ Gloria retired June 2, 2006. At this time the position of CSHCN Manager is vacant. It will be the supervisor of the entire CSHCN program including those efforts formerly funded by CMS through the RCSC project. The newborn hearing screening position is currently vacant; it will be revisited in the new fiscal year when the new grant is received. //2007// /

/2008/ The new CSHCN Manager is Brad Towle. 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. The CSHCN Program now includes the CSHCN program, Newborn Screening, Newborn Hearing Screening, Nevada Birth Outcomes Monitoring System, CSHCN Registered Dietitian, and Systems Change. The Newborn Hearing position has been filled by Jack Zenteno. Mr. Zenteno has a BS in Biology from the University of Nevada Reno and 54 semesters from the University of Nevada School of Medicine in Pharmacy. //2008//

Cynthia Huth, CNM, Health Program Specialist II, Women's Health/Perinatal Coordinator, received her MS in Nursing/Midwifery from the University of Utah. She was a practicing midwife until 1996 when she came to work for the Bureau as a Perinatal Nurse Consultant. This unit includes two Health Program Specialist Is for Perinatal Substance Abuse Prevention and Injury/Rape Prevention. There is one contractor /2007/ FTE //2007// bilingual Administrative

Assistant I assigned to this program for the MCH Campaign and a .5 FTE Administrative Assistant I for Injury Prevention. /2007/ This position will become the medical consultant to the Bureau when the Bureau is reorganized. //2007//

/2008/ The Bureau underwent some reorganization when both the nurses in the Bureau retired (the CSHCN Manager and the Women's Health Consultant) in 2006. Given the problems with recruiting nurses it was decided to turn the Women's Health Consultant into a Medical Consultant for the Bureau and designate that one a nurse's position. The CSHCN Manager is no longer required to be a nurse. The programs for the MCH Prenatal and Women's Health programs (the MCH Campaign, PSAP, and Domestic Violence, Injury and Rape Prevention) were moved under the Child and Adolescent Health Program which was renamed Maternal, Child and Adolescent Health. The Medical Consultant now consults with all the programs in the Bureau.

The Medical Consultant position has been filled by Jo Malay, RN, MPH. Ms. Malay is working with the CSHCN program on medical issues including newborn screening along with other duties. Ms. Malay has received an Associate Degree in Nursing from Truckee Meadows Community College and a BS and MPH from the University of Nevada Reno. She is a Registered Nurse. Her CV may be found in the attachment to III D. The .5 FTE Administrative Assistant for Injury (who was also .5 FTE for PCDC) has been eliminated due to a lack of workload.//2008//

Mark Hemmings, Health Resource Analyst III, PCDC Manager, received his Masters from Central Michigan University (Extension), Honolulu, Hawaii. Before becoming manager of the PCDC in 2002 he was a Health Resource Analyst in the Bureau of Health Planning and Statistics. PCDC includes a Health Resource Analyst I for SEARCH, a Health Resource Analyst II for NHSC, a Health Resource Analyst II for SSDI, and 1.5 Administrative Assistants Is. /2007/ There is 1 FTE Administrative Assistant in PCDC now. //2007// /2008/ Mark Hemmings, the Primary Care Manager retired in 2006; a recruitment has lead to the hiring of Rhonda Smoot, MPH, who started September 4, 2007. Ms Smoot received her MPH from Oregon State University. This position is funded by the Primary Care grant and the MCH Block Grant. //2008// ***/2009/ As previously noted the Health Resource Analyst 3 has been moved to the Bureau of Health Planning and Statistics. The position is no longer under MCH. //2009//***

Steve Kepp, Administrative Services Officer I, received his MBA from Nova Southeastern University in Florida. Before coming to the SHD in 1998 he worked for a Construction company in Wyoming. ***/2009/ Steve Kepp has resigned and this position is currently vacant. A recruitment is underway. //2009//***

Kyle Devine, Health Program Specialist II, received his MSW from University of Nevada Reno, and is the Bureau's Child and Adolescent Coordinator. Prior to coming to the State he worked for Lassen Diversified Management of Susanville California in charge of their Tobacco Control initiative. This unit includes three Health Program Specialist Is, for Early Childhood Systems Development birth to five, Childhood Systems Development ages six to ten, and Abstinence-Only. It has an Administrative Assistant I assigned to it. /2007/ This position took over rape and injury prevention, the MCH Campaign, and Perinatal Substance Abuse Prevention when the Bureau was reorganized. This would include the 2 HPS Is. //2007// /2008/ Abstince-Only funding has ended and the initiative no longer exists in the Bureau. The HSP I position is currently vacant. //2008// ***/2009/ Kyle Devine transferred in May 2008 to Health Preparedness and is no longer with the Bureau. This position is currently vacant. The Bureau is still awaiting final disposition of the Abstinence-Only grant. //2009//***

Christine Forsch, Health Program Specialist II, Oral Health Program Manager, is a graduate of Kennedy Western University, and a Registered Dental Hygienist (RDH). Prior to becoming the Oral Health Program Manager, she served as the State's Oral Health lead as a contractor in the Bureau. /2007/ Ms. Forsch has changed her name back to her maiden name and is now Chris Wood. She was recently elected president-elect of the Association of State and Territorial Dental Directors. //2007//. /2008/ In April 2008, she was installed as President of ASTDD. //2008// In

addition the Oral Health Program has a Biostatistician, a half-time Health Educator, two half-time RDH contractor educators, a contracted half-time collaboration specialist and a contracted half-time time evaluator. There is an Administrative Assistant II assigned to it. /2007/ One of the half-time RDH contractors is now a .75 FTE. //2007//

Debra Wagler, Health Program Manager I, Real Choice Systems Change, received her MA from California State University. She also has a MA from Nanyang Technological in the Republic of Singapore. The RCSC initiative also has a Management Analyst II, and an Administrative Assistant I assigned to it. /2007/ This program has been moved to the block grant for continued systems development. The MA II is being moved to form the beginning of a MCH EPI unit for the Bureau. Ms. Wagler will continue working on CSHCN Systems Development. //2007//

/2008/ The MCH Epi position has been filled by Silvia Giancontieri. Ms. Giancontieri has a BS in Statistics from the Universidad Regiomontana (Monterrey, N.L. Mexico) and a MBA in Strategic Planning from the Universidad Autonoma de Chihuahua (Chihuahua, Mexico). She also has a diploma in medical coding and insurance reimbursement from the Northern Nevada Career College. During the 2007 session the Bureau also received an FTE for a Public Service Intern (PSI) which will be part of the MCH Epi Unit. This position is funded by newborn screening fees. It can be filled starting October 1, 2007.//2008// ***/2009/ The PSI position has been filled by Angel Stachnik, a MPH candidate at the University of Nevada Reno School of Public Health. Her term ends in August when a new PSI will be recruited. Each PSI serves for six months. //2009//***

Doug Schrauth, Health Program Manager II, WIC Manager, is a graduate of Cal-State University in Hayward, CA. Before coming to be WIC Manager in 2002 he was SHD Internal Auditor. The State WIC Office has a Health Program Specialist II Registered Dietitian, a Management Analyst II, a Computer Services Technician II, an Accounting Assistant and an Accounting Technician. There is an Administrative Assistant III assigned to it for vendor monitoring and training. WIC now has an office in Las Vegas, which has a Health Program Specialist I breastfeeding Coordinator, and will have a Health Program Specialist I trainer. The Las Vegas office has a contracted Administrative Assistant. It will house the Birth Defects Registry HPS I when that vacancy is filled. /2007/ Doug has now moved to a Health Resource Analyst 1 position in the PCDC. The new WIC Program Manager is David Crockett. David has a BS from The Citadel (Charleston, SC, and a MS from the University of Utah in Management. He has also had training from the U.S. Air Force while he was in the military. He comes to WIC from the Bureau of Community Health Services AIDs Program, where he was a HPS II. His CV is in the attachment to this chapter. The HPS 1 Trainer for Las Vegas position has been filled. //2007//

In 2003 the WIC program released a Request for Application for WIC agencies who would take over state run clinics in the rural counties (the urban counties Washoe and Clark were already served by contracted agencies). This RFA was completed and a second one released that has been left open. The goal is to have the state WIC office get out of providing direct services and assume a solely management role. At this time only four rural counties have state-run WIC clinics, Douglas, Humboldt, Churchill and Pershing. The remainder have been turned over to locally community-based organizations that include Family Resource Centers and Head Start. There are also additional contractors in Clark and Washoe Counties. Additionally, WIC is on task to convert WIC benefits to Electronic Benefit Transfer (EBT). It has added contracted staff to work on the conversion. It has also added a contractor to help with vendor monitoring and a contractor to help with financial management of the program, for a total of 4 WIC contractors. WIC is currently undergoing a reengineering study to help it determine its configuration after conversion from state to locally run clinics and the impact of EBT on the caseload. This study is due this summer. WIC currently has 26.79 FTEs, but this will change in the coming year. /2007/ The contractor for financial management is now an FTE Accountant 2; the Vendor monitor, based in Las Vegas, is also now an FTE. There are now only 3 state-run WIC clinics,Douglas, Humboldt and Churchill. WIC has also added 3 Health Program Specialist 1s, 1 in Carson City and 2 in Las Vegas. It is currently studying its configuration to address the conversion from

manual checks to Electronic Benefit Transfer cards for WIC benefits. In the coming year more computer support staff will probably be added. With the conversion of all but 3 WIC clinics to private providers WIC now has 19.77 FTEs, 10 of them in the state office and 5 in Las Vegas. In this past year WIC opened a state office in Las Vegas. When hired the breast feeding coordinator will be based there.//2007//

/2008/ The last 3 WIC clinics have been turned over to private providers. This has lead to WIC clinics co-located with other services in an area. WIC clinics are now co-located with a Head Start, in a Family Resource Center, in an Obstetric Center in a Federally Qualified Health Center, etc. No longer having WIC clinics for direct services has freed the state WIC staff to concentrate on technical assistance, monitoring, and quality assurance. Two Administrative FTEs that were in the former state clinics have been moved to the State WIC office. One is based in Carson City and the other in the Las Vegas office. One half-time Administrative Aide was lost during the legislative session as it had been vacant for over two years. The breast feeding coordinator has been hired for WIC and is based in Las Vegas. Keyonie James who started in March 2007 is a graduate of Michigan State University with a major in Women's Studies. //2008// ***/2009/ WIC reached close to 62,000 participants in May 2008. //2009//***

/2007/
The Birth Defects Registry Health Program Specialist 1 position has been filled by Prasanjit Chakma. Mr. Chakma graduated from Chittagong Medical College, Bangladesh, with a MBBS in Medicine. He then completed an MPH at the University of Wales College of Medicine, Cardiff, Wales. He is currently working on a MS at California State University. He is based in Las Vegas. He is housed with the Cancer Registry in Las Vegas.

Outside of WIC the Bureau has an additional 40.26 FTEs. The Bureau also has several temporary employees filling positions in Oral Health, CSHCN, and WIC. Several of these will be converted to FTEs in the future, perhaps the coming year. //2007//

/2009/ The Nevada Birth Outcomes Monitoring System staff is now co-located with the Bureau WIC staff and the Office of Minority Health, in Las Vegas. //2009//

/2008/ Total MCH staff in 2007 is 39.26 for MCH and 19.26 for WIC (all of them for the state office). There also remain contracted temporary employees in Oral Health, CSHCN, and WIC. //2008//

/2009/ Total MCH staff is 46, of which 15 are WIC, with several others who work for MCH in the Center for Health Data and Research. There continue to be contracted temporary employees for CSHCN, Oral Health and WIC. Of the staff 7 plus 1 temporary employee are based in las Vegas, 1 temporary employee in Elko, and the rest in Carson City. //2009//

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.

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.

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.

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

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

The Chairman of the MCHAB is now an obstetrician who is a prior chairman of the Nevada chapter of ACOG.

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

The ECCS State Plan is in the process of being completed and will be finished by the end of July 2006.

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.

The RCSC project continued the projects detailed above. It has continued collaboration with other activities going on in the State around disability services, including the Governor's 10 year Strategic Plan for People with Disabilities. It supported a conference on the Olmstead Decision in Reno and again in Las Vegas in March 2006 which brought together most of the state players in the disability field. It is currently working with other CMS grantees and other interested agencies in the state to submit a proposal to CMS for a Systems Transformational grant. Development of the 2-1-1 system is ongoing.

For the rest there is no change. //2007//

/2008/ There is not much change from 2007. As noted in III D there are no longer state run WIC clinics.

The ECCS Plan was completed and is in the implementation stage.

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 Bureau's Chief 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 Bureau Chief and the Oral Health Manger 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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	44.2	44.9	46.4	34.6	34.3
Numerator	730	752	833	648	667
Denominator	165242	167306	179563	187271	194467
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:

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	44.9	50.8	73.9	97.8	
Numerator	8919	11337	10917	15765	
Denominator	19876	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	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.

Notes - 2005
Data for this indicator is from 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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	39.5	37.2	91.7	39.5	65.9
Numerator	5541	3064	881	456	1271
Denominator	14035	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?				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).

Notes - 2005
This measure is from the Nevada Check Up web page for July 1, 2005, the number on the program. The number served is reported from the program.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	80.5	75.9	69.1	68.4	67.0
Numerator	26957	26581	25667	26762	26949
Denominator	33468	35022	37133	39132	40203
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	Provisional

Notes - 2005
final data updated in 2008

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	90	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	Final

Notes - 2005
Data for this measure was provided by Medicaid.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	15.7	15.6	26.3	29.7	35.2
Numerator	6517	5357	7569	8638	10078
Denominator	41429	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	Final

Notes - 2007
data provided by Medicaid

Notes - 2005
Data for this measure was 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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	20.5	20.5	20.8	19.0	0.4
Numerator	953	1054	1054	1044	22

Denominator	4653	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?				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)	2007	payment source from birth certificate	9.3	4.9	8.2

Notes - 2009
Medicaid data was provided by the Nevada Medicaid RACC Unit.
Non-medicaid data was provided by the CHDR, extracted from the Nevada Birth Registry System

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	2007	payment source from birth certificate	3.8	5.9	4.9

Notes - 2009
Medicaid data was provided by the Nevada Medicaid RACC Unit.
Non-medicaid data was provided by the CHDR, extracted as interim from the Nevada Electronic Death Registry System

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, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	8.4	74.9	64.7

Notes - 2009
Medicaid data was provided by the Nevada Medicaid RACC Unit, extracted from HEDIS. The figures include both HMOs: HPN and Anthem
Non-medicaid data was provided by the CHDR, extracted from the Nevada Birth Registry System

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])	2007	payment source from birth certificate	73.9	66.7	67

Notes - 2009
Medicaid data was provided by the Nevada Medicaid RACC Unit, extracted from HEDIS. The figures include both HMOs: HPN and Anthem.
Non-medicaid data was provided by the CHDR, extracted from the Nevada Birth Registry System

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)	2007	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**
Infants (0 to 1)	2007	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)	2007	 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)	2007	 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	2007	185
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	2007	185

Notes - 2009
Nevada's S-CHIP covers pregnant women under 18 at 200% FPL. Under its HIFA waiver it will cover 200 women a year older than 18 for pregnancy at 185% FPL.

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	3	No
Annual linkage of birth certificates and WIC eligibility files	3	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 - 2009
The state has the statutory authority but not the resources.

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 - 2009

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.

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

Eight State Performance Measures were developed from the nine priorities to complement the 18 National Performance Measures. The eight are:

1. The percentage of women of childbearing age who receive screening and assistance for domestic violence should be increased.

2. Access to preventive oral health services for the Medicaid population of children and youth

should be increased.

3. Obesity among women ages 18 to 44 will be decreased.

4. Teen pregnancy birth rates among Hispanic adolescents ages 15-17 should be reduced.

5. All infants born in the state will have a newborn hearing screening prior to discharge from the hospital.

6. The percent of children and youth ages birth through aged 18 who die from unintentional injuries should be decreased.

7. Increase the ratio of primary care providers to the number of children and youth ages birth to twenty-one and women of child bearing age.

8. The percent of children ages birth to twenty-one including CSHCN and women of child bearing age who have access to mental health services, regardless of the ability to pay, should be increased.

/2007/ There has been no change to Nevada's Priorities or State Performance Measures. The State Performance Measures were established as sentinel measures for the priorities, with the proviso that there be data available for them. //2007// /2008/ no change //2008//

/2009/ Several State Performance Measures have been deleted and new ones added this year. The deleted ones are:

4) Teen pregnancy birth rates amoung Hispanic adolescents should be reduced. Community members felt this measure identified a population that is already included in NPM 8 and want it dropped.

5) Newborn Hearing Screening. This one is a duplicate of NPM 12.

7) Ratio of primary care providers to the MCH populations. With the loss of the PCDC the Bureau has been unable to collect the data for this measure and will be revisiting it in the future.

New Measures include:

9) The percent of children kindergarten-grade six who have access to a school based health center in Clark County should be increased.

10) Percent of CYSCHN program enrollees with follow-up visits from a nutritionist should be increased.

11) The percent of pregnant women and those who are suspected of being pregnant who are screened for Alcohol, Tobacco and Other Drugs (ATOD) should be decreased. //2009//

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.

B. State Priorities

Nine priorities were identified by the Nevada Year 2005 MCH Needs Assessment.
They include:

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.

The priorities are fully discussed in the Needs Assessment.

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	2003	2004	2005	2006	2007
Annual Performance Objective	99	99	99	99	99
Annual Indicator	99.6	99.0	98.4	100.0	100.0
Numerator	33036	34384	35794	49	51
Denominator	33168	34730	36377	49	51
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
	2008	**2009**	**2010**	**2011**	**2012**
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.

Notes - 2005
For the first time this number is from a match of newborn screen records and birth certificates.

a. Last Year's Accomplishments
Nevada mandates two screens, one before leaving the birthing center, and another about two weeks of life. Out of the 40,703 births in Nevada (CY 2007), 98.05% were screened for 31 disorders and 86.4% received a second confirmatory screening. The SHD continued to contract with the Oregon Public Health Laboratory (OPHL) to provide "expanded" Tandem Mass Spectrometry testing. In addition to providing laboratory screening, the OPHL provided metabolic, endocrine, and hemoglobin consultants who interfaced with Nevada physicians concerning positive cases. Parents were provided with double kits so each child born in Nevada is screened twice; therefore, reducing the chance of "missed" cases. The SHD continued to contract with a Metabolic Geneticist to provide ongoing clinical consultation to children born with metabolic disorders and women of children with PKU and other metabolic conditions. The Metabolic Geneticist also consulted by phone with any physician in the state; this consultation was a provision of the contract. All infants detected with an inborn error of metabolism, endocrine or hemoglobin disorder were automatically referred to the Children with Special Health Care Needs (CSHCN) program for coverage of needed physician, laboratory, and nutrition services. CSHCN referred these babies to the Early Intervention clinics for a full developmental assessment. MCH funded nutritionists based in the Early Intervention clinic provide ongoing nutrition guidance to metabolic cases.

Brad Towle (the new CSHCN program director) cleaned birth defect data, and created queries to report aggregate data in categories required by CDC. He has also developed a database to help program support staff record and track pertinent referral information and types of phone calls received.

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 process has begun to contract Dr. Nicola Longo from the Univeristy of Utah School of Medicine to conduct Nevada's metabolic clinics.		X		

b. Current Activities

As a result of the RFP process, the Oregon Public Health Laboratory (OPHL) was awarded the contract for laboratory services. OPHL also provides specialists for consultation with Nevada's doctors and provides short-term follow-up until confirmation of diagnosis. Birth registration fees were increased on April 15, 2007 and cystic fibrosis testing was added to Nevada's screening panel May 1, 2008. In addition, this fee increase provided for six new hemoglobinopathy and endocrine clinics. Program staff sent certified letters to the physician concerning infants needing initial or subsequent screens. Hospitals were notified immediately by fax and phone when unacceptable samples were received by OPHL; training has also been provided to reduce the number of unacceptable samples. Since training began, the blood sample error rate fell from 40% to less than 10%. The SHD contracted with a Metabolic specialist to provide clinical services and to provide phone consultation to primary care doctors. All infants detected with disorders were automatically referred to the Children with Special Healthcare Needs (CSHCN) Program for additional support if needed. MCH funded nutritionists continued to provide nutrition guidance for metabolic cases.

c. Plan for the Coming Year

Nevada will continue to contract with the Oregon Public Health Laboratory (OPHL) to screen for 32 different disorders with the addition of cystic fibrosis. Positive cases will be automatically referred to the metabolic clinics; birthing facilities will be contacted immediately by phone and fax in cases of unsatisfactory blood spot samples and; letters will be sent to primary care physicians in cases where no satisfactory screen has been received by OPHL or no repeat screen received

after an abnormal screen. Nevada will continue to require two newborn screens for each child born in Nevada. This coming year Dr. Nicola Longo from the University of Utah will be conducting Nevada's metabolic clinics. He is now in the process of receiving licensure for Nevada and a contract is being negotiated. He will hold six clinics in Las Vegas, five in Reno and one at a location to be determined. Nevada will continue to hold ten Fetal Alcohol Syndrome Disorder clinics in Las Vegas. Funding was procured to hold twenty-five additional FASD clinics; some of these additional clinics will be in Reno. In addition, Nevada will continue to hold 28 genetics clinics in Las Vegas and Reno this year. With the increase in birth registration fees this year 12 new clinics will be provided, six for hemoglobinopathies and six for endocrine disorders. This year, program staff will partner more closely with specialty clinic personnel to facilitate the follow-up of individuals receiving services from these clinics. In addition, the program's nurse consultant will continue to provide training to Nevada's birthing facilities to reduce the sampling error rate. Nevada's contract with OPHL includes access to a case management system. This system, provided by Neometrics, is being converted to a web-based system which will allow newborn screening staff to access OPHL case notes and contact information for Nevada doctors. In addition, the system will automate the process of sending out follow-up letters to primary care doctors. This system should be up and running in the fall of 2008.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	55	58	60	65	60
Annual Indicator	54.6	54.6	54.6	54.6	47.5
Numerator					
Denominator					
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	50	50	50	55	55

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.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The Nevada CSHCN Needs Assessment identified the two prevailing needs in Nevada as the simplification of the financial application process and the lack of physicians and specialty providers.

The Real Choice Systems Change (RCSC) program (since the grant ended, now referred to as Systems Change for CSHCN) continued to emphasize the maintenance and strengthening of existing partnerships with private, public, and community agencies statewide and improving access to services for CSHCN. In addition to the survey that was developed to gather public input, public input was gathered on a regular basis at rural Elko and Reno. Health program specialist attended coalition meetings and health fairs to present the CSHCN application process.

During the peak of the RCSC media campaign, the average number of helpline calls per month was 122 (the 2005 average was 67 and in 2004 was 41). Stakeholders thought that the media spots and website contributed to the community awareness of CSHCN issues

The Nevada Advisory Council for CSHSN supported the successful People First Respectful Language Bill SB491 (BDR 297) in the 2007 legislative session.

The Nevada CSHCN program received MCH technical assistance with Dr. John Reiss in May 07. Part of his assistance was focused on relevant local data collection, reporting and more parent input for decision making. He visited with parent groups in two state regions to hear how parents perceive the CSHCN program, their expectations of services, and their understanding of the relevance of Medical Homes for their family.

A launching event for Health Kids, EPSDT was held September 7, 2006 to bring together stakeholders and determine priorities to address what would make the most impact to increase the number of children receiving the Healthy Kids benefit. Stakeholders included the Medicaid MCOs, the primary care safety-net providers, the 3 local county health departments, the Intertribal Council of Nevada, parent organizations, Washoe Legal Services, and other state agencies including the Department of Health and Human Services Directors Office and the Division of Child and Family Services. Out of some 26 topics that were identified during the workshop, four workgroups were formed to address 4 categories -- Parent Support & Education, Tribal/Federally Qualified Health Centers/Local Health Department/MCO, Cross-linkages, and Auto Newborn Enrollment. The Parent group's purpose is to support parents in their role through education, motivation, and knowledge of how to use the health system. The Tribal/FQHC/LHD/MCO work group's purpose is to build provider capacity and work through credentialing issues. The Auto newborn group was to streamline enrollment notification and reduce the time between birth and Medicaid enrollment. The Cross linkage group was formed to address the problem of multiple case managers that a special needs child might have depending on how many services the child receives.

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, such as beha		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 CSHCN 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		X		X

the financial application process and the lack of all provider types.				
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 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 on 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.

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 Health Kids.

c. Plan for the Coming Year

In the coming year program staff plan to provide a webpage link to direct people 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. 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. Through education and close collaboration with local coalitions staff will continue to emphasize increasing family knowledge of available support, resources, and family-centered care. To increase cultural competency, program staff will explore the possibility of supporting a parent organization for bilingual referral and outreach through a subgrant. In addition, the Bureau will be looking at ways to include support for Family TIES and Nevada PEP to guide the Needs Assessment process for 2009. Program staff will gather input from parents who use the Nevada 2-1-1 and provide feedback to the organizations to make the referral process more family-centered, and Improve coordination with Early Intervention Services to ease children age 3 into the school system.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	50	55	55	55	55
Annual Indicator	49.1	49.1	49.1	49.1	41.2
Numerator					
Denominator					
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	42	42	42	45	45

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.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
CSHCN staff continued to assist families applying for Medicaid and Nevada Check Up (SCHIP) by providing information and referral to appropriate programs. CSHCN program staff assisted parents through the application process and followed them until an eligibility determination was made. Parents of CSHCN identified through the Nevada Birth Outcomes Monitoring System (NBOMS) were mailed informational letters.

The MCH information line continued to be a primary component for signing up infants and children for Medicaid and SCHIP. If they did not have coverage, staff refered them to Medicaid and/or Nevada Check Up. The Bureau experienced a drop in caseload most likely due to changes in Medicaid when the asset test was dropped in July 1, 2004, and more children became eligible for Medicaid.

In an effort to reduce stress for families with CSHCN program staff developed a document organizer to assist families completing multiple applications. The document organizer, (Nevada Family: Access for All) is available in English and Spanish. Feedback indicates that the organizer shortens the application process by reducing the number of times a family has to return with missing documents.

The Nevada Advisory Council for CSHCN recommended the use of a universal online application for all health coverage programs such as Utah Clicks! There was also legislative activity discussing an online application for Medicaid and Nevada Check Up (SB 311; thebill died)

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. The Systems Change program and needs assessment provided needed support to identify data sources that expand to all children, as well as provided state planners with useful information to determine where increased efforts need to be.				X
3. 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		
4. The CSHCN and System Change team continue to support the Family TIES proposal for medical home technical assistance.				X
5. 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 way..		X	X	
6. 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
7. 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		
8.				
9.				
10.				

b. Current Activities

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.

c. Plan for the Coming Year
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.

The Bureau would also 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.

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. 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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	56	58	60	62	64
Annual Indicator	55.4	55.4	55.4	55.4	53.5
Numerator					
Denominator					
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	54	54	54	56	56

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.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
CSHCN staff continued to assist families applying for Medicaid and Nevada Check Up (SCHIP) by providing information and referral to appropriate programs. CSHCN program staff assisted parents through the application process and followed them until an eligibility determination was made. Parents of CSHCN identified through the Birth Outcomes Monitoring System (BOMS) were mailed informational letters.

The MCH information line continued to be a primary component for signing up infants and children for Medicaid and SCHIP. If they do not have coverage, staff refer them to Medicaid and/or Nevada Check Up. The Bureau experienced a drop in caseload most likely due to changes in Medicaid when the asset test was dropped on July 1, 2004, and more children became eligible for Medicaid.

The CSHCN helpline offered referral and advice for callers to locate health coverage.

In an effort to reduce stress for families with CSHCN program staff developed and a document organizer to assist families completing multiple applications. The document organizer, (Nevada Family: Access for All) is available in English and Spanish. Feedback indicated that the organizer shortens the application process by reducing the number of times a family has to return with missing documents.

The Nevada Advisory Council for CSHCN recommended the use of a universal online application for all health coverage programs such as Utah Clicks! There was also legislative activity this session discussing an online application for Medicaid and Nevada Check Up (SB 311) (which died).

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 Check Up, as well as for SSI for CSHCN.		X		X
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 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

c. Plan for the Coming Year
CSHCN staff will continue to assist 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.

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.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	75	78	80	82	80
Annual Indicator	75.1	75.1	75.1	75.1	82.6
Numerator					
Denominator					
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	83	83	83	86	86

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.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
CSHCN staff maintained lists of local support groups, pharmacy providers, and providers of other ancillary services and supplies to assist families. CSHCN staff also kept abreast of eligibility criteria for Medicaid, Nevada Check Up, WIC, and Federally Qualified Health Centers in order to provide appropriate referrals.

The RCSC project evaluation team conducted key stakeholder consumer interviews to solicit input on experiences with the system of support and services for CSHCN. One of the recommendations was to supplement the National Children's CSHCN survey, currently administered every five years through the State and Local Area Integrated Survey (SLAITS).

FACT sheets and "Goto" bookmarks were created to assist families and providers to use the Healthy Kids--EPSDT benefit. Informational sheets were printed explaining that diabetes nutritional consultation can be provided by the CSHCN program. The Healthy Kids workgroup, which brings together representatives from local healthcare entities, provided recommendations that may help increase the number of people using screening benefits.

In Elko (rural Nevada), there was increased attention placed on early developmental screening and surveillance. They were recently awarded a grant by Trust Fund for a Healthy Nevada to reprint locally developed outreach resource materials and the Elko regional website of resources.

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. Staff have written 5 proposals, which include financial support to expand the statewide Nevada 2-1-1 system to a 24		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 System Change and CSHCN team support and cross referr to the Nevada 2-1-1 information and referral system, the family 2 family information center, and the Aging and Disability Resource Centers.		X		X
7. 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 as compared to the 2000 survey of 75.1%. Staff and the council continue				X

8.				
9.				
10.				

b. Current Activities
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.

c. Plan for the Coming Year
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 Rsource 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.

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 referal 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

(modelled 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.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	6	10	11	12	17
Annual Indicator	5.8	5.8	5.8	5.8	41.7
Numerator					
Denominator					
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	42	42	42	45	45

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.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure. This data is SLAITS data that the State has no control over.

a. Last Year's Accomplishments
All CSHCN program eligible cases received 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. Partnerships with Aging and Disability Resources, and the Department of Rehabilitation and Training enhanced the referral options.

Staff also involved the Nevada Advisory Council for CSHCN in recommendations on strategies for transitioning youth in Nevada.Many of their recommendations focused attention on the needs of youth with mental health issues. Existing services are not adequate and long term changes are needed. A proposal was written for this population and work is initiated to partner with the juvenile

system and foster care. The CSHCN website also includes information for youth and young adults; links for recreation and social activities were updated. CSHCN staff partnered with Family TIES to promote their Youth Health Transitioning conference and an online training based upon content from the conference is now available.

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 the educational plan for their child.	X	X		
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 systems change and CSHCN team works with the Office of Disability Services to ensure an action plan for the transition of youth to adult services is created.			X	
8. The CSHCN systems change team will support the youth health transitioning activities under the new HRSA grant.				X
9.				
10.				

b. Current Activities

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.

c. Plan for the Coming Year

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. 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.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	78	75	75	70	72
Annual Indicator	74.4	74.5	66.7	69.3	65.4
Numerator		31160			
Denominator		41826			
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	67	69	70	71	72

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

Notes - 2005
This data is from CDC for 2005 data.

a. Last Year's Accomplishments
NPM 7. Percent of 1- 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. FY07: 65.4
This measure is population based.

Nevada's Immunization Program (in BCH), in conjunction with immunization coalition partners, continued their statewide initiative started in 2006 called NV'r Miss a Shot. NV'r Miss a Shot is a statewide immunization initiative that has both consumer and health care provider components. Radio and outdoor bus advertising run in both Northern and Southern Nevada -- the message is give your kids a shot at life by immunizing. Health Care provider components include educational elements and immunization tools.

This initiative includes the Protect and Immunize Nevada's Kids (PINK) portfolio that contains immunization, health and safety information, and is designed to maintain and organize immunization and health records for the child from birth through college. It is given to new parents prior to discharge from the hospital.

The strong link between immunizations and WIC continued as explained in the current year narrative.

The MCH Referral line continues to be a resource for access to immunization services for callers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Referral of callers to the MCH Campaign Line to immunization resources will continue.		X		
2. The partnership between immunizations and WIC to promote immunizations in WIC clinics will continue.		X		
3. Women participating in the MCH Campaign will be given information on immunizations and encouraged to have the immunization periodicity schedule completed for their infants.		X		
4. The Bureau will continue funding Community Health Nurses in rural counties, who provide well child visits including immunizations.		X		
5. Utilize a Child Care Health Consultant for coalitions for Immunizations		X		
6. Assist the Bureau of Community health with its Immunization Program through promotion and education.		X		
7. Collaborate with communities (health districts, coalitions, Family Resource Centers) for their immunization efforts.		X		
8. Coordinate with the Oral Health program for Immunization Week activities.		X		
9.				
10.				

b. Current Activities
NV'r Miss a Shot continues as does the MCH Referral Line.

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.

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.

c. Plan for the Coming Year
All previously described activities will continue in 2009. Web IZ, the immunization registry, continues to expand to private providers. Efforts in Las Vegas WIC will be studied for implementation in Reno.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	30	27	26	25	25
Annual Indicator	27.5	26.7	26.4	26.4	25.9
Numerator	1257	1266	1353	1415	1440
Denominator	45749	47362	51274	53593	55520
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	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	24	24	23	23	23

Notes - 2005
Final data- updated in 2008

a. Last Year's Accomplishments
Nevada's teen pregnancy prevention initiative involved work with community organizations through the Nevada Statewide Coalition Partnership, a network of prevention coalitions located in ten of Nevada's seventeen counties, and through the continuation of the Governor's Youth Advisory Council, which identified teen pregnancy prevention as one of its top three priorities.

There is one abstinence sub grantee, the Area Health Education Center of Southern Nevada. They continued to work on reaching parents of adolescents in Clark County using the Positive Choices, Positive Futures program, focusing on the Hispanic Population.

Materials in the Teen Pregnancy Prevention Resource Center continue to be made available to community organizations and other interested parties. The State Health Division maintains the State Teen Pregnancy Prevention website: http://health.nv.gov.

Staff continued to seek other opportunities to work collaboratively with various communities within communities that can include racial/ethnic groups, migrant families, youth with special health care needs, youth in foster care, and run away and homeless youth.

Six radio non-commercial sustaining announcements (NCSA) created in English and Spanish continue to air throughout Nevada. The Bureau, through the Abstinence Grant, continued to provide updated educational media and materials to the state's 17 school districts.

The Bureau supports two adolescent health clinics, onef each in Las Vegas and Reno.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support of community coalitions and organizations (including ones emphasizing minority populations) by making federal Abstinence Education funds available for contracts for programs.		X		
2. Continuation of a statewide media campaign with Nevada Broadcasters Association promoting sexual abstinence.			X	
3. Continue supporting workshops for parents of adolescents, teaching them the importance of healthy sexuality through the development of an Adolescent Health Technical Assistance Center.		X		
4. Develop a Plain Talk program in Nevada targeting North Las Vegas		X		
5. Continue maintenance of TPP webpage and resource center		X		
6. Continue collaborating with other programs to promote the integration of teen pregnancy prevention with HIV and STD prevention efforts		X		
7. Continue supporting teen health clinics in Washoe and Clark Counties.		X		
8. Create an Adolescent Health Technical Assistance Center to provide guidance for pregnancy, STDs, rape prevention and other risky behaviors in adolescents that is available to the public.		X		
9.				
10.				

b. Current Activities

The main activities for Nevada's teen pregnancy prevention initiative have been supported by the state's Abstinence Education Program, funded through the Administration on Children and Families. The funding for this program has been tenuous as it is being authorized in three to six month time frames, making it hard to do any long term planning. At the current time, this funding is only authorized through June 30 of 2008.

The Abstinence Education Coordinator was transferred to another Health Division program, leaving the program director to administer the program. This year the program director worked with Southern Nevada Area Health Education Center to support the application of Positive Choices Positive Futures in Las Vegas and Reno. This program supported the Sexual Health Youth Summit in collaboration with the Department of Education. This summit targets school

health educators, school nurses, and school administrators to give them the latest information on best practices. Educational materials for local school districts and school nurses were procured upon request. In addition to these Abstinence activities, he continued to work with local organizations by giving technical assistance including information on the "Plain Talk" program that community based organizations in the Las Vegas area would like to apply in targeted communities.

The Bureau continues supporting the operation of two adolescent health clinics in Northern and Southern Nevada.

c. Plan for the Coming Year

The main activities for Nevada's teen pregnancy prevention initiative have historically been supported by the state's Abstinence Education Program, funded through the Administration on Children and Families. If it does not receive authorization for extended legislative authority, then the program will cease on June 30, 2008.

If the Abstinence Education Program ceases, the Health Division will no longer have funds to support National Performance Measure #8. However, MCH staff will attempt to provide limited technical assistance to outside organizations regarding teen pregnancy prevention as time and funding allow.

If funding of the Abstinence grant continues, funds will be made available to community organizations to support teen pregnancy prevention efforts. This may include working collaboratively with the STD and HIV programs to establish an Adolescent Health Technical Assistance Center to duplicate evidence based programs throughout the state. In addition, these programs may also support bringing the "Plain Talk" program to Nevada.

The Bureau will continue supporting the operation of two adolescent health clinics in Northern and Southern Nevada.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	43	38	38	40	42
Annual Indicator	32.5	32.5	33.0	41.0	41.0
Numerator			10350	13109	13683
Denominator			31364	31973	33372
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	44	46	47	48	49

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

Notes - 2005
Children were not resurveyed in 2005. This is an estimate based on prior year.

a. Last Year's Accomplishments
Three organizations administered school-based dental sealant programs in Nevada last year. They were Saint Mary's which primarily served schools in Washoe County, the Community College of Southern Nevada (CCSN), now renamed as the College of Southern Nevada (CSN), which primarily served schools in Clark County, and Nevada Health Centers, which primarily served schools in rural northeastern Nevada. CCSN and Nevada Health Centers programs were funded through a HRSA State Oral Health Collaborative Systems grant. As a result of these efforts, the percent of children with at least one dental sealant on a permanent molar increased from 33 percent to 41 percent.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to assist community-based programs with grant applications to support sealant programs.			X	
2. Continue to provide technical support for school-based dental sealant program planning, implementation, and evaluation.			X	
3. Promote sealant placement by Medicaid and Nevada Check Up providers and by the private practice community.			X	
4. Continue to collect, analyze and report data on sealants.				X
5. Ensure continued support for sealant programs by funding the Oral Health Program Manager position with MCH Block Grant funds		X		
6. Provide train-the trainer and in-service training on oral health screening and appropriate referral to community health and school nurses, and other health care providers.		X		
7. Offer oral health education for Children with Special Health Care Need providers		X		
8.				
9.				
10.				

b. Current Activities
In 2008, the state continues to support school-based dental sealant programs through the provision of technical support. It assists with identifying target schools, obtaining county school district support, identification of primary contacts within each school, development of uniform data collection measures, analysis of data, and evaluation of process, output, and outcome measures. However, the Health Resources and Services (HRSA) State Oral Health Collaborative Systems (SOHCS) grant that supported two of the three school-based dental sealant programs in Nevada ended in August 2008 and the grant was not refunded. The program in northeastern Nevada was discontinued and the program in southern Nevada significantly reduced the number of children served.

c. Plan for the Coming Year
In May 2008, with technical support from the Oral Health Program, the Community Coalition for Oral Health (CCOH), the oral health coalition in Clark County, applied for and was awarded a

Fund for a Healthy Nevada (Tobacco Settlement dollars) grant in the amount of $100,000 a year for two years to support the school-based dental sealant program in southern Nevada. This funding will allow the program in southern Nevada to serve even more children than it did when it was funded by HRSA. In 2009, the Oral Health Program will continue to provide technical support for planning, implementation, and evaluation of school-based dental sealant programs. It will also continue to assist the regional oral health coalitions with locating resources to support school-based dental sealant programs.

The Oral Health Program is currently in the last year of the Centers for Disease Control and Prevention (CDC) grant that supports the vast majority of the program's infrastructure and capacity. It is in the process of applying for a new grant, however funding is only available to support 15 states and it is anticipated that all the states and the territories will apply. To mitigate the loss of capacity that will occur if the program is not refunded by the CDC, the Nevada State Health Division has made the decision to support the Oral Health Program Manager's salary through the MCH block grant. This will ensure that the State will continue to maintain some oral health capacity even if the Oral Health Program is not refunded.

If the Oral Health Program is awarded a new grant, it will be able to undertake the third statewide Basic Screening Survey (BSS) of children enrolled in third grade to determine the percent of children who have ever experienced tooth decay, the percent with untreated decay, and the percent of children with dental sealants. It will continue to provide significant support to the regional oral health coalitions that support school-based oral health programs on a community level. It will continue to be able to provide data for school-based dental sealant program planning, resource development, and evaluation. If it is not, the program will loose substantial capacity to support school-based dental sealant programs.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	3	2	2.5	2.4	2.3
Annual Indicator	4.3	4.0	4.6	3.3	3.9
Numerator	21	20	24	18	22
Denominator	483936	497677	526084	549579	569703
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	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	2.2	2	2	1.9	1.9

Notes - 2007
2007 data for the denominator was provided by the Nevada CHDR.
Due to The Electronic Death Registry is now in the final step of implementation, breakdowns by cause of death are not yet available, the numerator reported was estimated using the methodology "percentages rolling", based in the 2003-06 data.

Notes - 2006
This is an estimate as death data is not yet available.

a. Last Year's Accomplishments
The Injury Prevention Program applied for and received funding through the Centers for Disease Control and Prevention to continue Nevada's Injury Prevention Program for five more years. The program will now be funded through July 31, 2010. The Injury Prevention Program performs data surveillance on Motor Vehicle Crashes of children aged 14 yfears and younger.

The Nevada State Health Division's Injury Prevention Task Force oversees Nevada's injury prevention initiative. Members of the task force include: representatives from the Department of Education, Nevada Department of Transportation, the SHD BLC Emergency Medical Services (EMS), Bureau of Health Planning and Statistics, Southern Nevada Health District, Washoe County District Health Department, SAFE KIDS Clark County, SAFE KIDS Washoe County, Indian Health Services, Office of Suicide Prevention, and the Nevada Office of Traffic Safety.

The Injury Prevention Program is 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 Safety. The Task Force meets monthly and its purpose is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.

The Injury Prevention Program is also involved in the Nevada Executive Committee on Traffic Safety. This Committee is organized by the Nevada Department of Transportation, and the goal of the is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.

The Injury Prevention Program has and 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.

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 Motor Vehicle Crashes of children aged 14 years and younger.				X
2. The Injury Prevention Program was 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.			X	
3. The Injury Prevention Program is also involved in the Child Passenger Safety Task Force whose purpose is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.		X		
4. The Injury Prevention Program is and 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 is involved in the Nevada Executive Committee on Traffic Safety, which has already been created, and formalized and meets several times a year. This Committee is organized by the Nevada Department of Transportation, and the goal is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.

The Injury Prevention Program will continue its involvement in the Child Passenger Safety Task Force, which was a result of a reccommendation made in the Occupant Protection for Children Assessment, and is organized by the Nevada Office of Traffic Safety Office. 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.

Motor vehicle crashes continue to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue to collaborate on motor vehicle crash prevention efforts.

c. Plan for the Coming Year
The Injury Prevention Program will be involved in the Nevada Executive Committee on Traffic Safety, which has already been created, and formalized and meets several times a year. This Committee is organized by the Nevada Department of Transportation, and the goal is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.

The Injury Prevention Program will continue its involvement in the Child Passenger Safety Task Force, which was a result of a recommendation made in the Occupant Protection for Children Assessment, and is organized by the Nevada Office of Traffic Safety Office. 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.

Motor vehicle crashes continue to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue to collaborate on motor vehicle crash prevention efforts.

The Injury Prevention Program is and 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.

MCH Block grant monies will potentially be used to subgrant to communities (subgrant to hospitals, local Safe Kids Coalitions, etc.)

The Injury Prevention Program will train Child Safety Seat Technicians throughout the state, so there are more trained professional performing child seat checks.

The Injury Prevention Program will continue to collect, analyze and report on motor vehicle crash data. Provide motor vehicle crash data to local communities

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				25	27
Annual Indicator			22.7	23	26.5
Numerator					
Denominator					
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	32	35	38	40	40

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.

Notes - 2005
This data from CDC is for 2004. The 2005 data will not be available until October 2006.

a. Last Year's Accomplishments
In FY 07 initiatives for FY 06 continued. In FY 07 a WIC breastfeeding coordinator was finally hired and started in the spring of 2007. Work continued on the breastfeeding peer counselor project, and the program realized the addition of a new agency in southern Nevada to administer the Peer Counselor program. This year two Peer Counselors attended a regional Le Leche League conference along with the State lactation consultant. Both parties acquired continuing education credits for their attendance.

The Nevada WIC program instituted some key policy updates to its breastfeeding promotion policies in the WIC policy manual. These updates require that agency's be more accountable for their management of the electric breast pump program.

The program renewed its partnership with the Breastfeeding Taskforce of Nevada by providing strategic guidance and technical support to the 15 year old organization to see the realization of its continued growth and development within the state. The WIC breastfeeding coordinator along with the State lactation consultant is involved in planning and steering activities with the taskforce.

CLC training opportunities continued for WIC staff showing interest and dedication to breastfeeding education, promotion and support in the clinic. These opportunities were utilized by WIC staff at 3 agencies.
State training for WIC staff on breastfeeding promotion and education, and breast pump issuance continued for FY 07 for 4 (four) agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support and guide the four regional breastfeeding coalitions to faciliate environmental and policy changes in hospitals and worksites		X		
2. Data will be disseminated to consultants etc. to target activities in identified areas.				X
3. WIC continues to promote breastfeeding and providing breastfeeding education by lactation specialists and breast pumps in clinics statewide.		X		
4. WIC supports the breastfeeding "peer counselor" program.		X		
5. WIC networks with other lactation consultants and healthcare providers statewide to promote breastfeeding.		X		
6. Incorporate breastfeeding training in upcoming Child Care Health Consultants training		X		
7. Work with the CHDR to determine a solid population-based indicator and other evaluation tools for breastfeeding.				X
8.				
9.				
10.				

b. Current Activities
The Nevada WIC program was granted an OA (Operational Adjustment) from USDA to host a lactation specialist training for State WIC staff. This training is expected to take place in fall 08 with a focus on improving the breastfeeding competencies of the State WIC staff.

The Nevada WIC office in Las Vegas, through the Breastfeeding Coordinator has begun to see growth in community partnerships and development through her service as a board member on the Breastfeeding Taskforce of Nevada. This has resulted in awareness by the Sunrise Children's Foundations Early Head Start program, La Leche Leagues of Las Vegas and surrounding areas, and a limited number of local hospitals, about the breastfeeding support services that WIC provides.

The WIC Breastfeeding Coordinator continues to provide technical assistance to the Breastfeeding Taskforce of Nevada through her guidance on the Taskforce Board of Operations.

Significant improvements have been made to the Breastfeeding Peer Counselor program. Most specifically in the way local agencies recruit, track and provide services to participants in the program. In addition, for the first time since the inception of the program, the State Agency is tracking enrollment into the BFPC program in order to gauge more successfully participation rates.

Policy changes were made to focus more specifically on prenatal breastfeeding education and establishing guidelines for recognition of advanced breastfeeding education/training.

c. Plan for the Coming Year
Supporting and expanding the breastfeeding Taskforce of Nevada as an active statewide breastfeeding coalition along with expanding and supporting the four regional breastfeeding coalitions as they enter hospitals and worksites.

Plans are in development for a partnership with Nevada System of Higher Education for a Certified Lactation Educator in the schools of nursing, along with offering continuing education credits at the community college level. The Bureau is working to strengthen the MCH learning

tracks at the Schools of Public Health and continue to train family practice residents in breastfeeding basics.

In addition other plans include:

Incorporate breastfeeding education in upcoming Child Care health Consultants training. Add breastfeeding promotion activities to our Title V funded prenatal care centers.

Increase breastfeeding education in the workplace as part of the workplace wellness initiatives, using HRSA's toolkit entitled "The Business Case for Breastfeeding". In addition to this develop and provide employer recognition programs for worksite lactation programs. Open dialogue with birthing facilities to adopt Breastfeeding Friendly Hospital Initiative designation.

Work with the State's Bureau of Health Planning and Statistics to determine a population based indicator and other evaluation tools around state data collection.

Improve the state's workplace in supporting breastfeeding environments to include space and an electric pump in all the health divisions with the assistance of the MCH Breastfeeding Coordinator, and seek funding to add more IBCLCs in our state.

The four major areas of focus for the Nevada WIC Breastfeeding Promotions functional area will encompass: increasing the presence of the Breastfeeding Coordinator in other parts of the State through the provision of in-services and trainings in the local agencies; improving the function of Local Agency Breastfeeding Coordinators to strengthen promotion and education efforts at their local agencies by the introduction of bi-monthly, or quarterly nutrition education and promotion conference calls and in-services; improving the delivery of breastfeeding nutrition education through the introduction of lesson plans, appropriate videos and other educational tools; and procuring updated educational and promotional breastfeeding handouts for WIC participants.

Other areas of focus will include: the increasing the initiation and duration numbers of breastfed babies in WIC which will result in a six month duration rate of 30%, up from 26.5% in the 2007 PedNSS report.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	85	94	95	97	97
Annual Indicator	94.3	92.5	96.2	96.7	98.8
Numerator	30958	31815	35116	37834	38744
Denominator	32834	34384	36485	39122	39209
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	99	99	99	99	9

a. Last Year's Accomplishments
In the last year the Nevada Early Hearing Detection and Intervention (EHDI) program worked to improve outcomes for infants with hearing loss. Areas of focus included working to decrease missed screens, increasing the program's ability to track and follow-up with referred infants, enhancing the states capacity to diagnose infants with hearing loss, and increasing parent-to-parent support activities.

Last year, the Nevada EHDI program worked to identify and resolve issues related to missed screens. This included holding meetings with staff at three hospitals responsible for the majority of missed screens and changing hospital procedures when necessary. Through these efforts the program decreased the number of missed screens by 44.5 percent between 2006 and 2007. The program also worked with non-profit groups and parents around the state to educate healthcare providers on the importance of detecting hearing loss early.

The Nevada EHDI program also worked to change referral procedures from hospital screens to diagnostic assessments. This includes ensuring hospitals complete a second screen before hospital discharge and, more importantly, a direct referral process between hospitals and Nevada Early Intervention Services (NEIS). This was done to address two major issues within the state; the dramatic shortage of audiologists willing to work with pediatric patients and the number of infants lost to follow-up. To accomplish this, the EHDI program helped NEIS purchase diagnostic equipment for Northern and Southern Nevada and worked with hospitals to train screeners on appropriate referral procedures.

In addition, the EHDI program purchased a data system that will dramatically improve the programs ability to track and follow-up with infants referred from the hospital screen. The database is a web-based system that will be compatible with Nevada's proposed Electronic Birth Registry (EBR). The data system will be available to the EHDI program, each state birthing hospital, and early intervention clinics around the state. This system will allow the EHDI program to track infants referred from the hospital screen, collect demographic information, identify and track infants with risk factors for late-onset hearing loss, and allow the program to collect and analyze statistical information.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Nevada Newborn Hearing Screening program screens 98.8% of infants born in the State.			X	
2. Families with infants who were referred for further hearing evaluation post hospital discharge are directly referred to Nevada Early Intervention Services.		X		X
3. The Newborn Hearing Screening program works with Early Intervention Services to encourage follow up evaluation for hearing and speech and language developmental assessment.		X		X
4. The Newborn Hearing Screening program works with CSHCN to offer families assistance with accessing needed services.	X			
5. The Newborn Hearing Screening program maintains a 'registry" of children who were referred for further hearing evaluation.			X	X
6. Staff have begun working with the National Initiatives for Children's Healthcare Quality (NICHQ) Learning Collaborative to identify issues and implement change.			X	X

7. A web-based tracking database has been purchased and is being developed meet the needs of the program.			X	X
8.				
9.				
10.				

b. Current Activities
The Nevada EHDI program addressed a number of issues. Starting in May of 2008 the program began working with the National Initiatives for Children's Healthcare Quality (NICHQ) Learning Collaborative to increase the program's ability to identify issues and implement change. Using the Collaborative's method of small tests of change the program has begun to identify methods that will reduce loss to follow-up, increase parent knowledge of the EHDI program and the need to screen infants early, and streamline policies and procedures. The EHDI program is also working to increase family-to-family support efforts through the state. To accomplish this, a sub-grant has been provided to parents and professionals to start a Nevada chapter of Hands and Voices. Work began in February of 2008 and it is expected that Hands and Voices will have an advisory board and begin operations by fall 2008.

Program staff also worked to develop the purchased data tracking system to meet the needs of the program. This included developing necessary fields for hospitals, early intervention clinics, and the EHDI program. Fields include relevant screening and demographic data, and also screens for late-onset hearing loss risk factors and diagnosis specific information including the extent of hearing loss and ear specific information

c. Plan for the Coming Year
Program staff plan to improve tracking and follow-up and enhance its role in assuring appropriate services for infants with hearing loss. Plans include enhancing collaborations with hospitals to ensure appropriate screenings, re-screenings, and referrals. Program staff also plan to enhance collaborations with other state screening and education programs to enhance education of parents at pre-natal classes, increase education of healthcare providers, and educate the general public in issues related to hearing loss. In addition, staff plan to enhance collaborations with bordering states including Memorandums of Agreement to share data and decrease loss to follow-up from infants crossing state borders.

Much of the next years work will focus on the continued development and implementation of the hearing screening data system. Once development is completed the system needs to be implemented in each state hospital and early intervention clinic. This will require working with Information Technology personnel at each site as well as training screeners and diagnostic personnel. The hearing screening data system has been developed as a module for the state Electronic Birth Registry (EBR). Though development of the EBR has begun, further development is on hold due to state budget cuts. In the next year EHDI staff will work with other state, and local programs that need access to this system to finish its implementation and ensure future data systems are compatible and information can be shared between programs. Success will enhance the programs ability to track infants through multiple programs which is vital since Nevada has a highly transient population. Standardized policies and procedures will also be developed for the EHDI program, state birthing hospitals, and early intervention clinics, to streamline program operations and ensure program sustainability.

Program staff also applied for a second grant through the Centers for Disease Control and Prevention. If funding is received operations can be dramatically expanded. This will include development of Regional Coordinators in Northern and Southern Nevada to increase collaborations with hospitals and parent groups and work more directly with hospitals that fall below best practice standards for the program. It will also involve increasing funds to community groups to increase parent-to-parent support efforts and increase training healthcare professionals

in the need to identify infants with hearing loss early.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	19	18	18	17	17
Annual Indicator	19.1	17.7	18.6	17.9	18.8
Numerator	110568	105473			122018
Denominator	578890	595895			648797
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	16	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.

Notes - 2005
this is an estimated measure

a. Last Year's Accomplishments
There is still no cap on Nevada Check Up. Nevada Check Up received a HIFA waiver in FY 07 that expands coverage of pregnant women to 185%. A change made along with the waiver is efforts to make the infant automatically enrolled in Nevada Check Up at birth. The EPSDT changes discussed in NPM 2 -- 5 are also looking at coordination between Medicaid and Nevada Check Up, so that a child who is over income for Medicaid is automatically referred to Nevada Check Up.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Bureau will continue to support the expansion of Nevada Check Up		X		
2. Continue to prepare the data needed for designations for HPSAs, MUPS and MUAs				X
3. The MCH Information and Referral Line will continue to refer to Medicaid and Nevada Check Up		X		

4. The Maternal and Child Health Advisory Board will continue to have updates from Medicaid and Nevada Check Up and encourage their expansion.		X		
5. Continue the EPSDT workgroups to ensure Medicaid coverage of all needed services for children.		X		
6. Develop a way to take a more active role in coordinating the community based organizations who are working toward a Universal Online Application.		X		
7. Take a more active role in the support and development of ACCESS to Healthcare Nework and Southern Nevada ACCESS to assure health care coverage of uninsured/undocumented families and lessen the emergency room burden.		X		
8.				
9.				
10.				

b. Current Activities
The Bureau will continue all the activities described above, all of which serve to ameliorate the shortage of medical providers in the state and promote the application of low-income families for Medicaid and Nevada Check Up and other resources that will promote the health of Nevada's children.

c. Plan for the Coming Year
BFHS staff will facilitate and mobilize Great Basin Primary Care, Covering Kids and Families, and the state Primary Care Development Center to form a united front and shared message to raise awareness about the severe shortage of providers in the state of Nevada. Community organizations report instances of willing providers who move from another state, pay $2,500 for the licensing process, are denied licensing (lose the fee) and move back out of the state. Policy changes are needed for reciprocal licensing and to address other barriers to practicing in Nevada. The Physician Associations will be engaged to accurately describe the additional support needed to retain the practicing medical providers in the state

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				15	14.5
Annual Indicator			15.8	15	12.6
Numerator					
Denominator					
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	11	11	10	10	9

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.

Notes - 2005
This data from CDC analysis of WIC data is from 2004. 2005 data will not be available until October 2006.

a. Last Year's Accomplishments
Data for FY07 - 85% - 95% = 14.5% ; >95th percentile = 12.6%. Data is from CDC's PedNSS for WIC 2007.

In FY 07, practices from FY 06 are continued regarding screening for overweight and obesity, assigning the appropriate risk codes, referring to the dietitian and facilitating nutrition education.

In FY 07 the State WIC program has revised the Child Health/Nutrition Information Questionnaire to include several specific questions regarding the child's eating habits as well as activity level. The Health/Nutrition Assessment forms are currently being piloted at three WIC locations in the State. Also, the State of Nevada is in the process of implementing comprehensive, interactive CPA Training Modules that include an instructor led class regarding child nutrition with a focus on proper eating practices and healthy weight. New educational materials have been reviewed and ordered regarding the promotion of physical activity and healthy eating.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC will continue PedNSS to monitor the percent of WIC children at or above the 85th percentile for Body Mass Index				X
2. VENA will continue to be implemented with targeted nutrition education that is culturally appropriate for staff and clients		X		
3. WIC staff trained to provide effective education to clients with overweight children.		X		
4. The WIC Nutrition Education Coordinator will work with the University of Reno post-bachelorate dietetic interns to create a WIC staff training program that provides WIC paraprofessionals the tools to address counseling WIC familes about weight.		X		
5. The HD will train the Child Care Health Consultants in improving the health and safety in child care settings with topics including the benefits of breastfeeding, the importance of healthy eating, physican exercise and menu planning.		X		
6.				
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b. Current Activities
In FY 08 we are continuing with the initiatives from FY 07. In addition the areas of focus will be the implantation 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 will be utilized in the clinics to promote the importance of a healthy weight.

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

The State will also take 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 will be fully utilized in the WIC clinics, the revised forms will enhance the assessment process allowing CPAs to clearly determine risks for becoming overweight which will allow for the proper education and follow-up to occur.

c. Plan for the Coming Year

In addition to our initiatives from FY08 the State of Nevada will provide an in-service training to all local agency staff on "Approaching Parents with Childhood Obesity". The in-service is to help staff understand the best ways to approach parents with a child that is overweight. This will help staff become more understanding of how the client feels and what type of motivational state they may be in so as not to push the parent and create resistance or denial. This in-service will present different approaches for the staff to use, to best serve each individual family's needs.

Another initiative will be to use tools from Fit WIC to develop and implement a physical activity class. Participants will leave the classroom with a jump rope and a handout with various games that use the jump rope and other ideas on how to increase family activities in their daily lives. The physical activity messages will be reinforced by the use of a bulletin board in all local agencies along with a special feature on our staff newsletter pertaining to physical activity.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				7	6
Annual Indicator			7.6	7.0	6.6
Numerator			2771	2738	2677
Denominator			36479	39260	40332
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	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	6	5	5	4	4

Notes - 2005
This data comes from the Bureau of Health Planning and Statistics, CHDR. Data for women who smoked in the last three months of pregnancy is unavailable. Data consists of women who smoked at any time during their pregnancy (numerator) and the number of women who gave birth (denominator).

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

The PSAP campaign continued working with private and public agencies to educate the public about the dangers of tobacco, alcohol and drug use during pregnancy. In November 2006 the state passed a ballet initiative that bans smoking in all restaurants and bars where food is served, slot machine sections of grocery and convenience stores, and at video arcades, shopping malls, school and day care centers in the state with the exception of those in casinos. Compliance with the law has been almost universal, with only a few bars being cited for non-compliance. In addition state law requires that venues that serve alcohol post a warning sign on the dangers of drinking during pregnancy. As there is a link between drinking and smoking pregnant women in these facilities are reminded of the need for healthy behaviors during their pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH Campaign will continue to contract with providers north and south for prenatal care that includes smoking cessation interventions		X		
2. Partner with other public and private agencies to conduct media campaigns regarding pregnancy and smoking			X	
3. The MCH Information and Referral Line will continue to refer callers to smoking cessation opportunities as will the Health Division's Tobacco Users Helpline.		X		
4. The Health Division web site including the Bureau will continue to have smoking during pregnancy information and referrals for smoking cessation.		X		
5. Evaluate what impace the prenatal packets sent from the tobacco cessation hotline have on the pregnant women's smoking habits.				X
6. The Oral Health program continues to screen for tobacco use and oral cancers, and traing nursing students about the relationship to oral health and pregnancy.		X		
7. Develop additional smoking cessation partners through WIC clinics, planned parenthood and the MCH supported adolescent health clinics and the Family Nurse Partnership.		X		
8.				
9.				
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b. Current Activities

The Maternal and Child Health Campaign continues to contract with community-based obstetrical providers. The Bureau's two contracted vendors provide full-service obstetrical care to high-risk, low income pregnant women in urban areas. They continue to screen the women seen in their clinics for substance abuse including tobacco use, and referring those who smoke to sources that can help them quit. The MCH Campaign Information and Referral Line continue to refer callers to smoking cessation resources. The Nevada Tobacco Users Helpline sends 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 partners 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.

c. Plan for the Coming Year

The MCH Campaign contract will continue in the next year. The campaign will look to expand its reach to a more diverse population through a multifaceted approach, including written information, coalition building, and our community partners for outreach and education.

The Bureau's Oral Health partners will provide limited screening for tobacco use and oral cancers. Nursing students are being trained about the relationship of pregnancy and oral health with preterm births. Prenatal providers will continue to be kept abreast on perinatal issues, including smoking cessation, folic acid consumption, nutritional information, HIV screening and treatment, immunizations during pregnancy and infections during pregnancy, including oral infections from caries and periodontal disease.

The Health Division's statistics show that the rural and frontier areas of Nevada have a prevalence rate of smoking during pregnancy that is higher than the urban areas in Nevada, with our Title V rural community nurse partners now trained in tobacco interventions will have an opportunity to interact with smokers in a medical/clinical setting.

The Bureau plans to expand smoking cessation partners through the State and Tribal WIC programs, Planned Parenthood and several MCH support teen health clinics in northern and southern Nevada.

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	2003	2004	2005	2006	2007
Annual Performance Objective	7	6	14	7	6

Annual Indicator	13.2	11.5	14.1	11.3	11.9
Numerator	21	19	25	21	23
Denominator	159580	165297	177850	185872	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?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	6	5	5	5	5

Notes - 2007
2007 data for the denominator was provided by the Nevada CHDR.
Due to The Electronic Death Registry is now in the final step of implementation, breakdowns by cause of death are not yet available, the numerator reported was estimated using the methodology "rolling of percentages", based in the 2003-06 data.

Notes - 2006
This is 2005 data. The CHDR does not have 2006 data as it is converting to an electronic death certificate. At this time there is only 3 or 4 months of 2006 data available. CHDR indicates they do not think there is much if any change between 2005 and 2006. 2006 data will be available next year.

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 collaborates with the newly formed Nevada Office of Suicide Prevention. In addition the Office of Suicide Prevention has been added as a member agency on the Injury Prevention Task Force.

The Injury Biostatistician will continue 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 is and will continue to collaborate with the Crisis Call Center of Northern Nevada.		X		
3. The Injury Prevention Program is and will continue to collaborate with the Nevada Office of Suicide Prevention.		X		
4. The PCDC in BHP& S will continue to designate Mental Health HPSAs, MUPS and MUAs.		X		
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
The Data Surveillance of Suicides in Nevada will continue through 2008.

The Injury Prevention Program will continue to collaborate with the Nevada Office of Suicide Prevention.

The Injury Biostatistician will continue to collect and analyze suicide data for the state of Nevada. This data is shared with the Nevada Office of Suicide Prevention.

c. Plan for the Coming Year
Activities for 2008 will continue in 2009. Funding identified for communities through the changes of the strategic planning process will be a possibity for suicide prevention activities through the Injury Prevention Task Force.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	95	95	95	95	97
Annual Indicator	89.8	86.6	95.2	98.1	97.1
Numerator	388	382	455	515	495
Denominator	432	441	478	525	510
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	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	97	97	98	98	99

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. Provide prenatal care for women without resources in Reno and Las Vegas that includes access to a NICU		X		
2. Promote early entry into prenatal care for all women in NV through the MCH Campaign		X		
3. Continue to monitor the percent of low birth weight infants delivered at facilities for high-risk neonates to evaluate efforts and plan further initiatives.				X
4. Continue looking for resources to expand the MCH Campaign to rural communities		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

All activities of 2007 were continued in 2008. As previously noted the MCH Campaign and all its components were funded through June 30, 2009. Unfortunately an enhancement to expand the campaign to a rural community was not approved. Other options for rural communities continue to be explored.

c. Plan for the Coming Year

All activities with the MCH Campaign will continue. The northern vendor is looking at ways to improve the number of retention of women who enter the program. In northern and southern health districts will be implementing the Nurse Family Partnership initiative to first time mothers which will address the need for prenatal care in these women. Nurse Family Partnership model programs are evidence based.

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.

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	2003	2004	2005	2006	2007
Annual Performance Objective	76	77	80	74	76
Annual Indicator	75.5	74.4	67.2	64.2	64.7
Numerator	25362	26157	25032	25199	26080
Denominator	33605	35147	37259	39260	40332
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	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	78	80	85	85	85

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 will maintained current programs.

The Bureau continued to conduct an educational campaign to make women aware of the need for early and continuous prenatal care. This included a poster and bus shelter campaign in English and Spanish. In addition, brochures were continued to be produced and disseminated throughout southern Nevada and local Hispanics engaged to determine how to better educate the community. Medicaid matches all educational funding 1:1. The Bureau will continued 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.

The effectiveness of the educational campaign was evaluated, providing valuable information to guide future strategies to making the program even more effective.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue sponsoring a public education campaign regarding the need for early prenatal care,			X	
2. Continue distribute brochures and other printed materials at clinics, health fairs on early prenatal care,			X	
3. Collaborate with providers to offer prenatal care to pregnant women regardless of their ability to pay,		X		
4. Provide prenatal care to low-income pregnant women through contracted agencies.		X		
5. Continue to collaborate with Mediciad for the MCH Campaign Information and Referral Line which can refer callers to prenatal care in their community.		X		
6. Provide support to the newly opened free prenatal clinic in North Las Vegas.		X		
7. Incorporate preconception/life course perspective in all HD Health Promotion activities.		X		
8.				
9.				
10.				

b. Current Activities
The Bureau is continuing 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 conduct an educational campaign to make women aware of the need for early and continuous prenatal care. This includes a poster and bus shelter campaign in English and Spanish. Brochures continue to be produced and disseminated throughout southern Nevada and local Hispanics are engaged in our groups and are helping us to better educate the community. Medicaid matches all educational funding 1:1. An MCH coalition in southern Nevada is forming and are addressing prenatal care issues.

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.

The effectiveness of the educational campaign will continue to be evaluated, providing valuable information to guide future strategies to making the program even more effective. The Bureau has met with members of local organizations, healthcare providers, and legislators to address the issue of prenatal care; this group is actively working on measures to improve early prenatal access.

c. Plan for the Coming Year

Further develop an MCH coalition of state and 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 our Health Division is focusing on prenatal awareness and education. A southern Nevada coalition is in development and is working with local area physicians and legislatures to address the issue of prenatal care. The Bureau is actively working with these partners to expand awareness and education in a preconception and lifespan health approach for women and families.

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.

Our Bureau is working to enhance the MCH Media Campaign by providing reader friendly materials, directing outreach to the population through trusted members of the community, such as faith based organizations and community organizations that serve these diverse populations with culturally competent communications and resources.

D. State Performance Measures

State Performance Measure 1: *The percent of women of child-bearing age who receive screening and assistance for domestic violence should be increased.*

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	18	10	10	10	15
Annual Indicator	0.1	0.1	0.1	0.1	0.1
Numerator	35814	38229	30288	30015	28982
Denominator	484433	497955	528027	498297	515208

Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	15	15	15	15	15

a. Last Year's Accomplishments
Bureau staff collaborated with the Nevada Network Against Domestic Violence on presenting domestic violence screening tools to nursing and medical schools.

The Bureau continued to have the statewide, toll-free Maternal and Child Health Line available for callers needing referral to a social service agency in their area. The staff person who was the Health Division's contact to the Attorney General's Council for the Prevention of Domestic Violence retired. Her replacement has made contact to rebuild this relationship. The MCH Campaign vendors continued to screen and refer for domestic violence for all those who come in for prenatal care.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue promoting the statewide domestic violence health screening protocols,				X
2. Collaborate with the Nevada Network Against Domestic Violence in conducting on-going training classes to health care providers,		X		
3. Collaborate with the medical and nursing schools to adopt and teach their students the statewide screening protocols,			X	
4. Collaborate with a variety of agencies to educate the public about domestic violence,			X	
5. MCH serves on the Nevada Attorney General’s Domestic Violence Prevention Council,		X		
6. Select health care related objectives from the completed Needs Assessment and begin fulfilling those objectives.				X
7.				
8.				
9.				
10.				

b. Current Activities
Staff continues 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 will continue 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.

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.

State Performance Measure 2: *The rate of significant Medicaid dental providers to the Medicaid population of children, youth and women of childbearing age (15-44) should be increased.*

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

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				1.9	2
Annual Indicator			1.8	1.5	1.9
Numerator			298	344	422
Denominator			167271	235066	222530
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	2	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.

Notes - 2005

a. Last Year's Accomplishments
In 2007, the Nevada Division of Health Care Financing and Policy (DHCFP), which administers Medicaid and Nevada Check Up, the Nevada SCHIP plan, rolled out dental managed care in Washoe County, the second most populous county in Nevada. The expansion was initiated based on very positive outcomes from the implementation of dental managed care in Clark County, the most populous county in the state. The Oral Health Program facilitated discussion between DHCFP, the private practice dental community, and safety-net providers through the regional oral health coalitions. These discussions helped ease concerns and increased acceptance of the managed care concept within the dental community.

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 provide technical support to the Medicaid Advisory Committee.				X
3. Continue to provide support to the six regional oral health coalitions in Nevada.				X
4. Continue to support recruitment of dental providers to serve underserved populations through participation on the Western Interstate Commission on Higher Education Health Care Access Program Advisory Board.				X
5. Continue to facilitate communication between Medicaid, the HMOs, the Nevada Dental Association, private practice providers, and dental safety-net providers.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
In 2008 Medicaid dental services in Clark and Washoe County continue to be delivered through a managed care model. In the middle of the year, one of the Managed Care Organizations, Anthem Blue Cross Blue Shield changed their dental third-party administrator from WellPoint to Doral. In order to continue to provide dental services to Anthem Blue Cross Blue Shield clients, dental providers had to re-credential with Doral. In addition, Doral immediately enacted a 25% cut in reimbursement to providers. The end result has been that the number of Medicaid providers has decreased. The DHCFP had intended to implement managed care in an additional five counties; Carson City, Churchill, Douglas, Lyon, and Nye Counties. Due to the recent budget cuts, this expansion will most likely be deferred.

The Oral Health Program has continued to facilitate discussions between DHCFP, the managed care organizations, the Nevada Dental Association, the private practice community, and safety-net dental providers through the regional oral health coalitions. The outcome of these regular, ongoing discussions has resulted in greater understanding amongst the stakeholders and increased attempts to address each others concerns.

c. Plan for the Coming Year
The Oral Health Program is currently in the last year of the Centers for Disease Control and Prevention (CDC) grant that supports the vast majority of the program's infrastructure and capacity. It is in the process of applying for a new grant, however funding is only available to support 15 states and it is anticipated that all the states and the territories will apply. To mitigate the loss of capacity that will occur if the program is not refunded by the CDC, the Nevada State Health Division has made the decision to support the Oral Health Program Manager's salary through the MCH block grant. This will ensure that the State will continue to maintain some oral health capacity even if the Oral Health Program is not refunded. The program will continue to attempt to facilitate discussions between DHCFP, the managed care organizations, the Nevada Dental Association, the private practice community, and safety-net providers.

State Performance Measure 3: *The percent of obese women ages 18 to 44 should be decreased.*

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				18	18
Annual Indicator			19.7	23.0	21.9
Numerator			104021	98268	94783
Denominator			528027	426760	433217
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	17	17	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 HD encouraged the establishment of behavioral-based weight management programs throughout the state, and used existing MCH programs as a referral base. The Bureau workied with existing local obesity coalitions to identify current referral resources and key local clinical organizations willing to establish behavioral-based weight management programs, over 10 weeks in duration (especially Lifesteps and Shapedown).

The HD provided program information and support to identified organizations to become licensed providers of behavioral-based weight management programs. The Bureau utilized the public health marketing strategy to educate partners (WIC, Head Start, School Nurses, Medicaid, Cooperative Extension, Family Resource Centers, county health districts, contract Registered Dietitians, and the media among others), on current behavioral-based weight management programs in their local areas and encourage partners to refer obese NV women 18-44 and their families to existing programs.

In addition, the HD promoted and supported the "National Fruits and Vegetables Program" (formerly called the "5 A Day" fruit and vegetable campaign) for NV communities. Targeted places included supermarkets, restaurants, day care centers, hospitals 84 and school districts. Work with state-level NDOT personnel to begin dialogue for the need to create safe routes for pedestrian and bicyclists to facilitate daily increased physical activity in communities throughout NV.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC will implement VENA to address cliented center nutrition education that is culturally appropriate.		X		
2. Staff will work with existing obesity coalitions to provide technical assistance and resources		X		
3. Work with existing local obesity coalitions to identify current referral resources and key local clinical organizations willing to establish behavioral-based weight management programs.				X
4. Provide program information and support to identified organizations to become licensed providers of behavioral-based weight management programs.				X
5. Utilizing public health marketing strategy, educate existing partners on current behavioral-based weight management programs and encourage partners to refer obese NV women 18-44 and their families to existing programs and newly formed programs.		X		
6. Promote and support the “National Fruits and Vegetables Program” campaign in NV communities.				X
7. Work with state-level NDOT personnel to create safe routes for pedestrian and bicyclists to facilitate daily increased physical activity in communities throughout NV.			X	
8. Establish contact and provide nutrition counseling to parents of CSHCN who are at high risk for obesity.	X			
9. The hd will work with the newly formed Nevada Fitness and Wellness Council to provide best practice/evidence based workplce wellness programs to recommend to Nevada		X		

employers.				
10.				

b. Current Activities
The CSHCN Program has a nutritionist on staff who continues to provide education and counseling to parents with CSHCN.
The CSHCN nutritionist will continue to work with Medicaid to begin a system of payment for Registered Dieticians, who will bill Medicaid direct for three hours per year of medical nutrition therapy for children through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

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

The CSHCN staff nutritionist is on the Carson City School Board and is working closely with school nurses and lunch programs in each district to promote healthy lifestyles. All Nevada elementary schools have now received supplies of the "Eagle Series" books on nutrition; additional books will be distributed as the need arises. The CSHCN nutritionist is also working 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 are being trained with 2 hours of nutrition and healthy menus in the child care setting. The CCHC's will provide education to both the child care providers and parents. Child Care Health Consultants are community health nurses

c. Plan for the Coming Year
As the National Fruits and Vegetables Program Coordinator for Nevada, the CSHCN nutritionist will continue to coordinate with the University of Reno Cooperative Extension, Action for Healthy Kids, schools, hospitals, and daycare centers, to plan and participate in trainings, and distribute educational materials. The CSHCN staff nutritionist will continue to be involved in the creation of safe routes for pedestrians and bicyclists to facilitate daily increased physical activity in communities throughout NV.

The Child Care Health Consultants will provide education to parents and child care providers on nutrition and physical activity, along with screenings using the Early Periodic Screening and Diagnosis Treatment program.

The Bureau will support local wellness initiatives such as Southern Nevada Health District's "Get Healthy Clark County" and Wahoe County District Health Department's "Get healthy Washoe". The Bureau will work to capture women in an environment where they are located, such as workplaces, understanding busy women may not have time to go to classes or gyms. The Bureau will work towards a culture of wellness throughout a woman's lifespan. Staff will begin implementing workplace wellness by training community health nurses and developing a toolkit. Bureau staff will assist the nurses to develop this tool.
The Nevada State Health Division will support and work to build the state employee wellness activitys and program. The HD will work with the newly formed Nevada Fitness and Wellness Council to provide best practic/evidence based workplace wellness programs to Nevada employees.

State Performance Measure 6: *The percent of children and youth ages birth through aged 18 who died from unintentional injuries should be decreased.*

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				5	5
Annual Indicator	12.2	13.3	10.9	12.0	12.2
Numerator	76	85	73	84	88
Denominator	625350	641220	667830	697715	723176
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	5	5	5	5	5

Notes - 2007
2007 data for the denominator was provided by the Nevada CHDR.
Due to The Electronic Death Registry is now in the final step of implementation, breakdowns by cause of death are not yet available, the numerator reported was estimated using the methodology "percentages rolling", based in the 2003-06 data.

Notes - 2006
As noted on NPM 16 the CHDR is converting to electronic death certificates and 2006 data is not available at this time and will not be until sometime next year. The CHDR feels there has not been a great change in the data from 2005.

a. Last Year's Accomplishments
The Injury Prevention Program applied for and received funding through the Centers for Disease Control and Prevention to continue Nevada's Injury Prevention Program for five more years. The program will now be funded through July 31, 2010.

The Nevada State Health Division's Injury Prevention Task Force oversees Nevada's injury prevention initiative. Members of the task force include: representatives from the Department of Education, Nevada Department of Transportation, the SHD BLC Emergency Medical Services (EMS), Bureau of Health Planning and Statistics, Southern Nevada Health District, Washoe County District Health Department, SAFE KIDS Clark County, SAFE KIDS Washoe County, Indian Health Services, Office of Suicide Prevention, and the Nevada Office of Traffic Safety.

The Injury Prevention Program is 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 Safety. The Task Force meets monthly and its purpose is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.

The Injury Prevention Program is also involved in the Nevada Executive Committee on Traffic Safety. This Committee is organized by the Nevada Department of Transportation, and the goal of the is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.

The Injury Prevention Program is and 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.

Motor vehicle crashes continue to be a priority of Nevada's Injury Prevention Task Force. The

Task Force members will continue to collaborate on motor vehicle crash prevention efforts.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Injury Prevention Program has a Task Force to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes,				X
2. The Injury Prevention Program will collaborate with the Washoe County SAFE KIDS Coalition. The Coalition is committed to the prevention of childhood injury in Northern Nevada,				X
3. The Injury Prevention Program employs a full-time Biostatistician who is responsible for improving data collection and analysis of injuries in Nevada, including childhood injuries,				X
4. The Injury Prevention Program will continue to collaborate with the Task Force is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.				X
5. The Injury Prevention Program will seek funding sources to carry out public education campaigns to reduce unintentional injuries to children.				X
6. Continue to work with Chid Death Review teams to identify priorities and focus initiatives for available funding.		X		X
7. Address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.			X	X
8.				
9.				
10.				

b. Current Activities
The Injury Prevention Program is involved in the Nevada Executive Committee on Traffic Safety, which has already been created, and formalized and meets several times a year. This Committee is organized by the Nevada Department of Transportation, and the goal is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.

The Injury Prevention Program will continue its involvement in the Child Passenger Safety Task Force, which was a result of a recommendation made in the Occupant Protection for Children Assessment, and is organized by the Nevada Office of Traffic Safety Office. 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.

Motor vehicle crashes continue to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue to collaborate on motor vehicle crash prevention efforts.

The Injury Prevention Program is and 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.

c. Plan for the Coming Year
The Injury Prevention Program will be involved in the Nevada Executive Committee on Traffic Safety, which has already been created, and formalized and meets several times a year. This Committee is organized by the Nevada Department of Transportation, and the goal is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies that are committed to improving highway safety.

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Motor vehicle crashes continue to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue to collaborate on motor vehicle crash prevention efforts.

The Injury Prevention Program is and 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.

MCH Block grant monies will potentially be used to subgrant to communities (subgrant to hospitals, local Safe Kids Coalitions, etc.)

The Injury Prevention Program will train Child Safety Seat Technicians throughout the state, so there are more trained professional performing child seat checks.
The Injury Prevention Program will continue to collect, analyze and report on motor vehicle crash data and provide motor vehicle crash data to local communities

State Performance Measure 8: *The percent of women (18-44) who feel down or depressed should be decreased.*

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				30	30
Annual Indicator			55.1	42.8	51.0
Numerator			290954	187963	238537
Denominator			528047	439213	467389
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	29	28	28	28	28

Notes - 2007
Weighted percentage of women (18-44) who answered their mental health was not good at least 1 day during the past 30 days. (BRFSS)

Notes - 2005
The annual number here is the weighted percentage from BRFSS for all women ages 18-44 who answered feeling down or depressed at least 1 day during the last 30 days.

a. Last Year's Accomplishments
Current activities to address this new state performance measure include: continued collaboration with the State Suicide Prevention Coordinator and Southern Nevada Suicide Prevention Trainer/Facilitator. The Bureau continues to attend the Suicide Prevention Coalition.

A statewide toll-free suicide prevention hotline continues to operate, and some Nevada based organizations continue to have extensive websites with links to resources for those suffering with suicidal ideation.

In addition, the Bureau of Family Health Services continues to contract with obstetrical providers. All providers must screen for perinatal depression, and refer women as needed to appropriate services. The providers keep a list of services available in their area to discuss with the woman if needed.

The Health Division continues to address other issues that may lead to depression, such as domestic violence, sexual violence, and chronic diseases. The Bureau is currenly identifying an individual who will continue representation on the Attorney General's Domestic Violence Prevention Council.

DHHS Child Death Review Administrative and Executive Teams worked on a Suicide Checklist to be used at the site of a suicide and approved it in June 2006.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Serve on the Suicide Prevention Coalition			X	
2. Contract with direct health care providers to screen for perinatal depression, and ensure MCH Campaign providers are screening and referring.		X		
3. Continue with sexual assault prevention activities,			X	
4. Collaborate with Nevada Network Against Domestic Violence to provide training to health care providers,		X		
5. Inform, educate and empower the public about chronic disease prevention,			X	
6. Continue to establish mental health HPSAs, MUPs and MUAs to promote services in underserved areas for those who need them.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Bureau continues to have representation on the DHHS Child Death Review Administrative and Executive Teams, which consider suicide as one of their charges. The Child Death Teams in June 2006 approved a Suicide Checklist to be used at the site of a suicide by responders proposed by the state's Suicide Prevention Coordinator and with the help of members of the team it has been sent statewide to police, coroners, etc. The task in 2008 will be to assess its use. It is hoped that there will be good data coming in that will enable the teams working with the Suicide Prevention Coordinator can make recommendations and perhaps allocate funds to address some of the findings from the data. One of the questions, for example, is whether or not the victim assessed mental health services prior to committing suicide. If so what happened? The Suicide Checklist has been posted on the DHHS website and has been picked up by other states.

The statewide suicide prevention hotline will continue to operate, and some Nevada based organizations will continue to have extensive websites with links for those suffering from suicidal thoughts.

The MCH Campaign providers will continue to screen women for depression, postpartum depression, etc. and are on the look out for those whose mental health appears to be at risk. The providers have referral resources should a woman be so identified. The Bureau will continue to have a representative on the Attorney General's Council for the Prevention of Violence.

c. Plan for the Coming Year
The statewide suicide prevention hotline will continue to operate, and some Nevada based organizations will continue to have extensive websites with links for those suffering from suicidal thoughts.

The MCH Campaign providers will continue to screen women for depression, postpartum depression, etc. and are on the look out for those whose mental health appears to be at risk. The providers have referral resources should a woman be so identified. The Bureau will continue to have a representative on the Attorney General's Council for the Prevention of Violence.

State Performance Measure 9: *The percent of children kindergarten - grade six who have access to a school based health center in Clark County should be increased.*

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2008	**2009**	**2010**	**2011**	**2012**
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
This is a new measure this year the goal is to show the percent of children that use or have access to school based health centers. Health based school centers can address the issues of ongong care, difficulties or delays in obtaining needed health care, provide screenings for oral health, mental health, and special needs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**

1. Pilot a School Based Health Center that will address chronic disease in children.		X		
2. coordinate with School Nurses and Community Nurses for more seamless referral and assurance the children receive needed services (follow-up on referrals, etc.)		X		
3. Collaborate with community partners to raise awareness of families and providers (medical, childcare, and social) about the currently available preventive screens and how to receive them.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Currently there are four school based health centers all located in southern Nevada. Operated by Communities in Schools in Southern Nevada is Health Access located at Reynaldo Martinez Elementary School in North Las Vegas.

Operated by Nevada Health Centers
C.P. Squires Elementary (this is the only SBHCs that's actually located inside the school)
Ray Martin Middle School (Ray Martin School-based
Valley High School

Operated by Nevada State Coolege
Basic High School in old Henderson

These four school based health centers will provide us data on children's health and screenings. The Bureau will provide technical assistance to the centers as needed.

c. Plan for the Coming Year
Continue developing partnerships with "communities in Schools", develop publicly available materials, and seek new grant funding. The Bureau and its partners will continue to develop care plan templates that can be customized to the schools' preferences. This can include addressing policy change to ensure students are able to carry their inhalers and other prescription medications as needed for their daily health care and how to
collaborate with community partners to raise awareness of families and providers about the currently available preventive screens and how to receive them.

State Performance Measure 10: *Percent of CSHCN program enrollees with follow-up visits from a nutritionist should be increased.*

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator					10.2
Numerator					23
Denominator					226
Is the Data Provisional or Final?					Final

	2008	2009	2010	2011	2012
Annual Performance Objective	25	50	75	100	100

Notes - 2007
Data is from CSHCN program

a. Last Year's Accomplishments
This is a new measure developed to track the number of CSHCN followed by a nutritionist.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide a list of referrals from the CSHCN program to the program's nutritionist for follow up.			X	
2. Provide education to parents on nutrition for the child with special health care needs			X	
3. Support families through education to provide care in the home for the child with special health care needs		X		
4. Provide continued coordinated care for child between nutritionist, healthcare provider and parents			X	
5. Monitor referral follow up through a tracking system (paper) of children in the CSHCN program				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Currently the CSHCN staff gives a list of referrals to the CSHCN program to our nutritionist who reviews the referrals by hand to determine follow up needs. The nutritionist then follows up with the clients who are in need of follow up for coordinated care and the ability to teach parents how to care for their child at home. The nutritionist educates parents on needs which are especially critical for the child with metabolic disorders possibly minimizing the devastating effects of disease.

c. Plan for the Coming Year
The establishment of systems of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care are essential for effectively fostering and facilitating activities to (1) reverse of slow the progress of chronic and disabling conditions among children; (2) minimize the complications and impact of chronic disabling conditions among children; (3) strengthen the ability of families to care for children with actual or potential chronic and disabling conditions; (4) enable children with more serious conditions to remain in the home and community-based living arrangements rather than in institutional settings, and (5) increase the emphasis on the range of services offered to CSHCN in Nevada during the shift away from direct medical (only) intervention.

State Performance Measure 11: *The percent of pregnant women and those who are suspected of being pregnant who are screened for Alcohol, Tobacco And Other Drugs (ATOD) and referred in Reno, NV should be decreased.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator					34.7
Numerator					26
Denominator					75
Is the Data Provisional or Final?					Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	35	32	30	28	25

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

a. Last Year's Accomplishments
This is a New Measure - the initiative started in 2008.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Hold regularly scheduled Leadership team meetings to address any concerns that may have surfaced at the two implementation sites		X		
2. Train additional providers who serve the target population on how to implement the 4P's Plus and deliver prevention messages.		X		
3. Implement the 4P's Plus at additional Reno agencies/providers of services to the target population after they have been trained.		X		
4. Work to implement screenings in southern Nevada and the rural hospitals to make this a statewide effort		X		
5. Provide demographics and profiles of women to target prevention efforts				X
6. Provide a quarterly analysis of the data collected for collaborative partners and the Maternal Child Advisory Board that reflects progress in the reduction of at risk pregnancies with respect to alcohol, drugs and tobacco use.				X
7.				
8.				
9.				
10.				

b. Current Activities
Current Year: There is national recognition that Nevada has one of the highest high-risk behaviors related to alcohol, tobacco and other drugs coupled with a high rate of teen pregnancy. To address these concerns and collect needed data, the Nevada State Health Division (NSHD) has collaborated with Dr. Ira Chasnoff to implement pregnancy screening in Northern Nevada with grant funds he received from the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services and sponsored by the Maternal and Child Health Bureau (MCHB). The overall goal of the project is to prevent alcohol use by pregnant women, to promote screening for alcohol use in the context of primary prenatal care, and to identify children affected by prenatal alcohol exposure and link them to appropriate early services. A leadership team was formed and they developed a plan in the North to screen all pregnant women and women who suspect they may be pregnant using the evidence based 4P's Plus screening tool. A number of other states have been using this tool, including our neighbor state

California. After several days of planning consensus was reached to implement screenings at Renown Pregnancy Center and Health Access Washoe County (HAWC -- a federally qualified health center) because of the population they serve.

c. Plan for the Coming Year

In early May 2008 Dr. Chasnoff returned to Reno and spent several days training critical staff at both centers in how best to administer the 4P's Plus with implementation formally occurring on May 19 2008 at the two designated sites with the trained staff. The two centers together serve the majority of pregnancies in Washoe County. Primary prevention occurs at the time of each screening. All women who are screened are educated about the dangers of using ATODs during pregnancy. Those women whose responses point to at risk pregnancies are referred for additional services depending upon the level of assessed risk that the 4P's Plus has indicated. A copy of each screening is sent to the Chasnoff Children's Research Triangle and entered into a data base that will provide information that will guide the state and stakeholders in developing effective prevention strategies and assisting in presenting the need for funding to address capacity issues. It is expected that as these prevention efforts continue that the number of referrals to additional services for at risk pregnancies will decrease. This initiative will continue into 2009, with data being collected on each screening and outcomes monitored.

All of the activities reflect the primary goal of this performance measure; to prevent alcohol use by pregnant women and to screen for alcohol and other drug use in the context of primary prenatal care. The leadership team will resolve any concerns about the progress of the implementation with an eye towards expanding the screenings at additional sites in the North with trained staff. The Health Division and Dr. Chasnoff will continue to collaborate and plan for pregnancy screening in Southern Nevada contingent upon his grant being funded. The lessons learned in the North will be valuable for implementation in the South.

E. Health Status Indicators

BG2007 IV E Health Status Indicators

The Bureau has initiatives which address Health Status Indicators 1A (percent of live births weighing less than 2500 grams), 1B (the percent of singleton births weighing less than 2500 grams), 2A (percent of live births weighing less than 1500 grams), and 2B (percent of live singleton births weighing less than 1500 grams) as well as 7A and 7B (Live births to women of all ages) enumerated by maternal age, race and ethnicity) through its MCH Campaign discussed in III B, NPM 15, NPM 17, NPM 18, SPM 1 and SPM 7. Through these measures the effectives of initiatives addressing healthy birth outcomes are monitored. As discussed earlier in this document changes made with the dropping of the Medicaid asset test, the establishment of the MCH Campaign through approval by the 2005 Legislature and subsequently the 2007 Legislature for the FY08-09 Biennium, and the raising of the poverty level for coverage of prenatal care by Nevada Check Up to 185% FPL. are as yet unevaluated as they are too new to have produced any data. As a proposed enhancement to address African American birth outcomes was not approved for the coming Biennium, the Bureau has begun discussions with the African American community in Reno and Las Vegas to see if portions of the planned enhancement can be developed with community resources. This is a priority for 2008.

The Bureau has an injury prevention grant funded by CDC that has a biostatistician who produces the data such as that of 3A (the death rate per 100,000 due to unintentional injuries among children aged 14 years and younger), 3B (the death rate per 100,000 for unintentional

injuries among children aged 14 years and younger due to motor vehicle crashes), 3C (the death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years), 4A (the rate per 100,00 of all nonfatal injuries among children aged 14 years and younger) 4B (the rate per 1000,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger), 4C (the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years) and 8A and 8B (Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity). As previously noted the CHDR is converting to electronic death certificates and death data for 2006 is not available for analysis at this time. The Injury Prevention initiative is described in National Performance Measure 10. Information on the Injury Prevention initiative may be found at http://health.nv.gov, then the Bureau of Family Health Services then Injury. There 2 reports prepared under the biostatistician may be found, one on the use of surveillance in injury prevention and another surveillance report on Nevada injuries. Preventing infant deaths is also a goal of the MCH Campaign.

The Bureau of Community Health (BCH) has the Sexually Transmitted Disease Prevention program and has supplied this data for 5A and 5 B, the rates of Chlamydia. They have initiatives that address adolescents and women of child bearing age, including the BCH Community Health Nursing which has Family Planning Grants and can do testing of STDs.

The demographic data of 6A and 6b just emphasizes how Nevada continues to grow. The impact of growth has been noted in the Overview (III A) and throughout this document.

For 9A and 9B, Demographic Data, individual programs are under the governance of different portions of state government. The Bureau oversees WIC which as previously noted continues to experience growth, reaching over 50,000 participants a month in May of 2006. The Bureau partners with the Division of Health Care Financing and Policy, the Welfare Division, the Department of Education and others to get this data, and works with every one of them to promote the health and well being of Nevada's children. These partnerships are detailed throughout this document.

For HSI 10, 11 and 12, the Bureau watches the population and economic status of residents of the state in all its programs, from projecting potential WIC participants to identifying where to target outreach activities.

The Health Status Indicators are but a small portion of the data the Division collects through the Center for Health Data and Research. Data plays a clear role in soliciting grants, building programs, and evaluation through all Bureau programs.

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

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.

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.

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

This FY 2009 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 $1,837,036. The state MCH match, budgeted at $1,377,777 is comprised of State General Fund dollars and fees generated by the Newborn Screening program. The total FY 2009 MCH budget is $3,214,813. As required, the FY 2009 MCH budget complies with the FY 89 Maintenance of Effort amount. This amount represents $853,034.

For FY 2009, 34.8% of the federal Title V allocation is directed to Form 2, Section 1.A, Preventive and primary care for children and adolescents that amounts to $640,681. Direct services provided under Section A are primary care and oral health oriented, as these represent two significant unmet needs for children and adolescents. Services are provided through a community based non-profit agency (Huntridge Teen Clinic in Clark County) and a teen clinic sponsored by Washoe County. In addition to direct services, Component A includes funding for the continued development of core public health/infrastructure activities including oral health and teen pregnancy prevention to ensure appropriate and continued services to children and adolescents.

For FY 2009, 43% of the federal Title V allotment is directed towards Children with Special Health Care Needs, Form 2, Section 1.B are Children with Special Health Care Needs and their families. This amounts to $789,421. Services funded under this component are primarily enabling services and are designed to be family-centered, community based, culturally appropriate and comprehensive. Direct services are provided through several mechanisms: through the Nevada Early Intervention Services and through health professionals, such as pediatric ophthalmologists

and physical therapists who are under contract to the CSHCN program and the CSHCN treatment program. In FY 2008 all these services are provided through the Nevada Early Intervention Services in Reno and Las Vegas and CSHCN staff based in Carson City.

For FY 2009, Administrative costs, Form 2, Section 1. C Administrative costs, will not exceed $183,703, which is 10% of the current period grant request total. For FY 2009, the remaining federal Title V allotment is directed towards services for pregnant women and postpartum women and infants up to age 1 year. The allotment budgeted for services is $223,231. The individuals to be served are pregnant and postpartum women and infants up to age 1 year statewide. Services are designed to be family-centered, community based, culturally appropriate and comprehensive. Direct services are provided through contracts with local agencies, including health districts and community based non-profit agencies. In addition, funding includes the continued development of core public health/infrastructure activities. The integration of perinatal substance abuse services including prevention of fetal alcohol syndrome into routine perinatal services received by all pregnant women is an example of the core public health activities to be continued in FY 2009. A newly proposed breastfeeding initiative of the American Academy of Pediatrics will be supported through this component. Also included is the State's Newborn Screening program, which screens almost every infant born in the state for inborn errors of metabolism and hemoglobinopathies. The mandated newborn hearing screening passed during the State's 2002 Legislature (those born at hospitals with over 500 births) will be part of the program. Follow-up for the identified children is included in Component B.

Overall, allocation of MCH dollars across Components A, B, & C is based upon unmet health care needs identified in the Year 2000 Five Year MCH Needs Assessment and subsequent studies. The state assures a fair and equitable method of distributing funds based upon identified needs.

Nevada's MCH unexpended grant balance, as reported in last year's application, was basically expended as planned over the current 2007-2008 biennium. The goal was to leave approximately $150,000 in unexpended grant balance at the end of the upcoming biennium and this goal was met in FY 2007. Nevada's Title V Maternal and Child Health Block grant has been fully budgeted through the Legislative process for the 2008-2009 biennium and this is no longer possible in 2009.

Other federal funds administered by the MCH Chief besides 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.