



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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1.4 Overview of the State

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 with a 1999 population of 1,967,850.

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 85% of the population; Carson City, Douglas, Elko, Lyon, and Storey counties are rural; and Esmeralda, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing and White Pine are frontier counties. It should be noted that Carson City was designated a Small Metropolitan Area in 2000. A map of the counties may be found in Appendix A, Supporting Documents.

Nevada as a state is projected to face a fiscal downturn in the next 10 years. For this reason Governor Kenny Guinn has instructed state agencies to prepare budgets for the next biennium (2002-2003) with no increase in funding nor any rate increases. Budgets are in essence in very few cases being prepared with no increases of any kind; Maternal and Child Health (MCH) is no exception. As always, the Governor's budget will be finished sometime around September 1, 2000 (after agency submission to the governor by August 15, 2000) and will then go to the Legislative Council Bureau for development of the Legislative budget. The Legislative session that begins in February 2001 will establish the biennium budget that begins on July 1, 2001, which will be official upon signature by the Governor. In this scenario MCH expects no changes in current priorities or initiatives for 2001 as they were approved by the 1999 Legislature. These priorities and initiatives are based on the MCH Five-Year Needs Assessment completed in February 1996 and subsequently updated. They 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. The teen pregnancy rates, particularly those of minorities, should be reduced.
2. The use of tobacco, alcohol, marijuana and other drugs among adolescents should be reduced.
3. The rate of child abuse and neglect should be reduced.
4. The incidence of Fetal Alcohol Syndrome should be reduced.
5. All women should have access to prenatal and postpartum services, which include medical and dental care, regardless of ability to pay.
6. The incidence of low and very low birthweight babies should be reduced.
7. Children with Special Health Care Needs in the state should have access to specialty and subspecialty services, including care coordination.
8. Children with Special Health Care Needs in the state should have access to quality day care, baby sitting and pre-school services.
9. The incidence of Early Childhood Caries in Nevada's children should be reduced.
10. Every child in Nevada ages zero to twenty-one should have a home for primary care, including dental care.

The Needs Assessment submitted with this application will guide the planning in coming years as far as funding allows. As will be seen, the findings of this current Needs Assessment, with the exception of those around mental health, will not lead to significant changes in the priorities or initiatives of Nevada's MCH Program, including Children with Special Health Care Needs (CSHCN). Included in the Needs Assessment beginning on page 31 is a discussion of the effects of poverty, non-citizenship, racial and ethnic disparities in health status, geography, urbanization and private sector impacts on the delivery of services for the MCH population.

Managed Care in Nevada:

Managed Care in Nevada continues to have low market penetration, with 20.1 % overall as of December 1999. Of this 18.2% is Commercial, 33.6% Medicare, and 84.1% Medicaid enrollment. As managed care for the Medicaid population was fully implemented in 1999, the 84% penetration represents a 148% increase since December 1998 when it was fully implemented. Dental services continue to not be included in Nevada's Health Maintenance Organization (HMO) benefit packages, but rather remain fee-for-service. As of December 1999 there were 9 licensed HMOs in Nevada as predicted. There were 98 provider organizations (PPOs), a small increase from the 93 of a year ago.

Nevada 3Check Up:

By May 1, 2000, Nevada 3Check Up, Nevada's Child Health Insurance Program, reached a milestone of 10,000 children enrolled in the program and receiving health services. By June 1, 2000, Nevada Check Up had 11,164 children enrolled and receiving health services. The program is entering a new phase of administration and organization, in which a targeted outcome-based marketing and outreach program will play a prominent role in achieving maximum enrollment and participation in the children's health insurance program.

Among immediate changes to the program were a rapid elimination of an application backlog, reassessment of staff function and allocation of staffing resources, a reinstatement of a state programs and community partners Marketing and Outreach Advisory Team, investigation of instituting a "premium lock box" contract with the state's bank to collect the quarterly premium payment, and the submission of a State Plan Amendment to the Health Care Financing Administration (HCFA) to: (1) waive cost sharing (i.e., Nevada Check Up quarterly premiums) for American Indians and Alaska Natives; (2) change the re-determination process from annual to rolling, providing ongoing eligibility for 12 months after the date of a child's most recent enrollment; and (3) remove the six month residency requirements prior to a child's eligibility.

To complement the planning and implementation of a renewed marketing and outreach plan, Nevada intends to submit a State Plan Amendment to HCFA to: (1) increase the administrative cap from 10% to 15% based on health care expenditures; (2) base the 10% administrative cap on federal monies allocated to the state per federal fiscal year; or, (3) remove marketing/outreach from the administrative cap and base it on 1% of the available federal monies allocated to the state per federal fiscal year.

Temporary Assistance for Needy Families (TANF):

Nevada saw the loss of TANF assistance for many families in January 2000 when they reached the 24-month limitation established by Nevada policy. An audit report of the Welfare Division dated February 23, 2000, notes the Welfare Division does not have information readily available to determine the extent in which employment and training programs help welfare clients become self-sufficient, and thus did not have an adequate mechanism to track what happens to clients who leave TANF. The Welfare Division developed a plan to survey and track former clients of its New Employees of Nevada (NEON) training and employment program. A study by the University of Nevada consisting of a monthly survey requested by the Welfare Division began in the spring of this year for those individuals who have left TANF during the previous month. This survey of randomly selected clients is performed at 3, 6, 12, 18, and 24-month intervals after they leave TANF assistance. As this study has just started a report is not yet available. Welfare is also in the process of consolidating its computer systems in order to improve its ability to track clients' and former clients' progress. Between the survey and the computer systems the State including MCH hopes to have a clearer picture of what is happening to former clients who have left TANF.

In spite of the dropping off of families due to the 24 month limitation, Nevada saw its Welfare rolls rise more than 6% during April 2000 to 16,421 recipients from a low of 15,487 in March 2000. This rise was mirrored in Food Stamps and Medicaid. It is not clear at this time whether the rise is a trend; it is being watched closely by Welfare Division and MCH officials. The officials note however that the number of TANF recipients is no where near the record high point in caseload in March 1995, when Nevada had 42,703 people on what was then Welfare.

Nevada's long-term decline in Welfare/TANF rolls is attributed in part to the state's strong

economy with record low rates of unemployment and welfare reform efforts that include child care dollars that exceed TANF dollars for families in transition and job retention initiatives for those going off TANF.

Additional information regarding an overview of the state including its priorities is included in the Five-Year Needs Assessment beginning on page 31. The Needs Assessment also includes information regarding the extent to which poverty, racial and ethnic disparities in health status, geography, urbanization, and private sector affect the provision of Title V services in Nevada. It is not repeated here.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

Nevada's MCH and CSHCN program are both administered through the Bureau of Family Health Services (Bureau) in the Nevada State Health Division (SHD). The SHD is part of the larger Department of Human Resources, part of the Executive branch of Nevada state government. Governor Kenny Guinn, elected by a popular vote of the state, as head of the Executive branch, appoints both the Director of DHR, Charlotte Crawford, and the Administrator of the SHD, Yvonne Sylva. See Appendix B, Supporting documents, for organization charts for the Bureau, SHD and DHR.

Program authority for Nevada's MCH and CSHCN is 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 and MCH prenatal programs 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’s Special Children’s Clinics, 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 discussed in the Annual Plan on page 182.

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 and the Birth Defects registry contained in NRS and NAC, the state budget process also places Abstinence Education, WIC, MCHB's and the Center for Disease Control and Prevention's (CDC's) Fluoride grants, and CDC's Birth Defects and Injury Prevention grants within the Bureau operations discussed in the Annual Plan beginning on page 154.

1.5.1.2 Program Capacity

The Bureau seeks to work closely with state's public health community including the Clark County Health District (CCHD) and Washoe County District Health Department (WCDHD) 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 provides support for WCDHD, CCHD and Community Health Nursing Services of the Bureau of Community Health Services. In Washoe County funding supports the MCH program of home visiting for women and infants and an adolescent health clinic. In Clark County funding supports an adolescent health clinic including an oral health initiative. Title V funding provides some support for Community Health Nursing in Nevada's rural and frontier counties. Additional details are provided in the Annual Plan beginning on page 154.

In the spring of 2000, the SHD Primary Care Development Center (PCDC) was moved organizationally to the Bureau. This is reflected in the organization chart found in Appendix B. This move has provided the opportunity to more closely integrate MCH with primary care activities than even what was accomplished in the past. The MCH Chief is working very closely with the new PCDC Supervisor and has gained, for example, greater knowledge of the data available or in process through PCDC. New ways to partner with PCDC and the primary care community are being identified with regularity, such as linking up FQHCs with potential partners previously unidentified in their communities to promote access to care. The state has a Covering

Kids grant from Robert Woods Johnson through the Great Basin Primary Care Association (GBPCA). The Bureau is working with GBPCA to ensure that every opportunity to partner and promote access to Medicaid and Nevada 3 Check Up by eligible children is taken.

The Bureau has been seeking for sometime to build the MCH data system. In the past year the Birth Defects Registry has become operational and is in the process of linking with birth certificates and newborn screening. With the Bureaus of Health Planning and Statistics and Disease Control and Intervention Services the Bureau is a partner in a grant application to MCHB for HRSA CFDA #93.110U regarding "Data Utilization and Enhancement". The intent of the application is to continue to link data bases to track health status indicators and continue to add data bases to the SHD interactive web-based data base initiated through the Maternal and Child Health Internet-Query Module (MatCHIIM) and INPHO the past two years. In addition, the SHD has requested support from the Department of Energy for the Birth Defects Registry to track birth defects that might have been caused by activities of potentially radioactive sites like Yucca Mountain in southern Nevada. This initiative will also link with the activities of the State Systems Development Initiative (SSDI) which currently is focused on the MCH Needs Assessment and data assessment (now also a part of the Bureau through PCDC). The discussion of the MCH Needs Assessment methodology beginning on page 40 provides more detail on the SSDI activities as they relate to the plan for the management information system (MIS) to get good, reliable data for MCH.

The Baby Your Baby (BYB) campaign continues to support an Information and Referral Line (IRL) , a multi-media information campaign, and a network of prenatal care and pediatric providers. It is a partnership between SHD, Medicaid and private sponsors. Providers agree to accept Medicaid, Nevada 3 Check Up, and MCH Prenatal as well as have a sliding fee scale for those who do not qualify for assistance. In 1999 the IRL had 8,664 calls. A total of 12,452 individuals received services through BYB in 1999 including those who did not call the IRL but had heard of BYB and self-referred. The Bureau's database Resource Directory (The Family Health Services Resource Directory) currently has over 2000 listings which are used for BYB and any other referral that comes into the Bureau, including those for Perinatal Substance Abuse and

Teen Pregnancy. The BYB campaign is particularly targeting Hispanic and African American groups. The campaign is discussed on page 156 in the Annual Plan.

The Bureau is home of small programs that are payors of last resort for the treatment of CSHCN and prenatal care for pregnant women. These programs act as safety-net providers for eligible individuals who do not meet the requirements for Medicaid, Supplemental Security Income (SSI which includes Medicaid in Nevada), or Nevada 3Check Up, and otherwise meet the eligibility requirements contained in NAC. For those children who are CSHCN eligible the program will also pay for primary care. For those pregnant women who are eligible the program will pay for dental care and other services deemed necessary to produce a healthy birth outcome. It does not cover labor and delivery. For those children who are SSI eligible the program supports services at the Bureau's Special Children's Clinics (SCCs) in Reno and Las Vegas including the multidisciplinary clinics and other services that are not covered by Medicaid such as specialty foods required by some children with metabolic disorders. More information on the SCCs is provided in the Annual Plan on page 180.

The Bureau receives a monthly list from Nevada 3Check up and a microfiche listing from Medicaid which enables Bureau staff to check the eligibility status of program applicants. The SHD and Division of Health Care Financing and Policy (DHCFP) have an agreement that outlines information sharing and cross referral between the agencies. A separate agreement covers the BYB program which is a partnership between Medicaid (in DHCFP) and the SHD, as well as private sponsors. With the development of the Birth Defects Registry and the MCH data system a new agreement between DHCFP and SHD will be negotiated to include provisions to cooperate and collaborate on data collection and exchange, outreach efforts, enabling services and quality assurance. Bureau staff consult regularly with DHCFP staff to promote access to services for CSHCN covered by Medicaid and Nevada 3 Check Up, particularly specialty and subspecialty care.

The Bureau's BYB IRL serves as a referral source for families in need of pediatric care, with referrals to Nevada 3 Check Up, Medicaid, and pediatric providers a service offered through the

IRL. The Bureau’s Special Children’s Clinics (SCC) staff work to ensure children seen at the clinics covered by Medicaid Managed Care and Nevada 3 Check Up are receiving the services they need including primary care. In 1999 BYB made 993 referrals to pediatric providers.

CSHCN and their families continue to be served with case management/care coordination through the SCCs, the multidisciplinary specialty clinics and the Carson City office. The Carson City office primarily focuses care coordination services on children with complex conditions who are covered by the CSHCN Program and those identified through newborn screening. SCC services are for those children served through Early Intervention.

Bureau staff continue to provide training statewide to improve the knowledge, skills and abilities of providers serving the MCH population. Such training includes preconceptual counseling, care of the infant and Early Childhood Caries prevention. The training is discussed in the Annual Plan beginning on page 158.

Finally, the Bureau now 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 Baby Your Baby and WIC or relative to MCH such as MatCHIIM (discussed in the Annual Plan). The Bureau web-page is located at <http://health2k.state.nv.us/BFHS/>.

1.5.1.3 Other Capacity

Nevada’s MCH/CSHCN programs, located in the Bureau, are managed through its main office in Carson City, Nevada. The following staff are located in the Carson City office:

Employee	Number of FTEs	Job Title/Responsibility
Judith Wright	1	Bureau Chief/ MCH Chief
Gloria Deyhle	1	Health Program Specialist

		II/CSHCN Coordinator
Cynthia Huth	1	Health Program Specialist II/MCH Perinatal Coordinator
Wade Greenlee	1	Education & Information Officer/Child & Adolescent Coordinator
Barry Lovgren, Frank Sakelarios,	2	Health Program Specialist I, Perinatal Substance Abuse and Injury Prevention
Vacant, Dennis Murphy	2	Education and Information Officers/Teen Pregnancy Prevention, and Baby Your Baby
Stephanie Gibbs	1	Administrative Services Officer/Fiscal and MCH Data
Wei Yang*	1	Biostatistician/MCH Data
Sally Macaskill	1	Supervising Health Resource Analyst/Primary Care
Roger Pelham	1	Health Resource Analyst II, Primary Care
Mary Anne Maliwat	1	Health Resource Analyst II, SSDI MCH Data, Primary Care
Vacant	1	Health Resource Analyst I, Primary Care
Tami Terstege	1	Management Assistant III/Office Manager
Various	9.5	Clerical, Technical and Accounting support staff

*Dr. Yang is in the Bureau of Health Planning and Statistics, SHD.

Two contractors, both Health Educators with one a Registered Dental Hygienist, currently staff the Bureau's Oral Health Unit. They are funded by Title V. One contractor is working on the Teen Pregnancy Prevention initiative, funded by the Abstinence-only grant. A request to turn the Abstinence-only contract into a Full Time Employee (FTE) (classified) is currently in process.

The Bureau Carson City office also contains the state Special Supplemental Food Program for Women, Infants and Children (WIC) staff, a total of 9 FTEs including the Health Program Manager II WIC, 2 Registered Dietitians, a Management Analyst II, and clerical, technical and accounting support staff. Additional state staff including 3 Registered Dietitians and program

support staff are located in WIC clinics in Nevada’s 15 rural and frontier counties. (WIC services in Clark and Washoe counties are provided through contracts with the SHD).

Out-stationed personnel, supported by Title V, are reflected in the following table:

Employee	Number of FTEs	Job Titles/Responsibilities/Location
Karen Cummings	1	Health Program Manager III, Special Children’s Clinic (SCC) Las Vegas
Various	34.5 + contractors	Professionals SCC Las Vegas (Social Workers, Psychologists, Registered Dietitians, Speech, OT, PT, Physicians, Audiologists, Parent Consultant)
Various	12	Clerical and Administrative support, SCC – Las Vegas
Peg Hellman	1	Health Program Manager III, SCC Reno
Various	25 + contractors	Professionals SCC Reno (Social Workers, Psychologists, Registered Dietitians, Speech,OT,PT, Physicians, Audiologists, Parent Consultant)
Karon Felten, Peggy Nipp	1	CSHCN Registered Dietitians (job sharing)
Various	7	Clerical and Administrative support, SCC – Reno
Various	3	Community Health Nurses, Rural Counties in BCHS

In addition, a Bureau contractor is working on the Birth Defects Registry in Las Vegas. A request to turn the contract into an FTE has been approved and hiring is in process. Both the SCCs have special needs parents on staff to provide assistance and support to the families served by the clinics.

Biographies of managers may be found in Appendix C. There is a total of 130.25 FTEs and contractors in the Bureau.

1.5.2 State Agency Coordination

As indicated on the organization charts found in Appendix B, the agencies of public health (SHD), mental health (Division of Mental Health/Developmental Services), social services/child welfare (Division of Child and Family Services), Medicaid and Nevada 3 Check Up (Division of Health Care Financing and Policy) are located within the Department of Human Resources. The Bureau works closely with all the Divisions of DHR to promote MCH priorities and objectives. Particular initiatives are discussed in the Annual Plan beginning on page 154.

The Bureau works closely with all the Bureaus of the SHD in one manner or another as discussed in the Needs Assessment beginning on page 31. This includes the Bureaus of Alcohol and Drug Abuse (BADA), Disease Control and Intervention Services (BDCIS), Health Planning and Statistics (HP&S), Health Protection Services (HPS), Community Health Services (BCHS), and Licensure and Certification (BLC).

The Bureau partners with the Department of Education on many initiatives around child and adolescent health. These include the Youth Risk Behavior Survey, Teen Pregnancy Prevention, and Perinatal Substance Abuse including Fetal Alcohol Syndrome Prevention. These initiatives are discussed in the Annual Plan beginning on page 154. The Bureau also works with Juvenile Probation of the Department of Corrections on teen pregnancy, substance abuse, and injury issues.

As in years pass the Bureau has not been very successful in partnering with the Vocational Rehabilitation, Rehabilitation, Community Based Services, and Development Disabilities Planning Council of the Department of Employment, Rehabilitation and Training (DETR) in spite of a recent partnering on youth workforce initiatives. This relationship may change for the better as the newly appointed (as of June 19, 2000) Director of DETR was formerly the Administrator for Welfare and before that Administrator of SHD. The coming year will see what changes this appointment will bring.

The Bureau continues to work closely with the University of Nevada School of Medicine (UNSOM). As noted in last year's application the MCH Chief has been part of the interview team for faculty positions that work closely with MCH. The Birth Defects Registry initiative is partnering 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, Diabetes, Endocrinology, Gastroenterology, Pulmonology and Cleft/Craniofacial clinics in Reno and Las Vegas. The multi-disciplinary clinics are more fully discussed in the Annual Plan on page 180. UNSOM pediatric residents rotate through SCC-Las Vegas giving them a hands-on experience in working with CSHCN in need of Early Intervention services.

As noted in Section 1.5.1.2 the Bureau is now the home of the PCDC. It partners closely with the Clark County Health District and Washoe County District Health Department, which both have MCH programs, as well as the Bureau of Community Health Services in Nevada's rural and frontier counties which provide public health services in those counties as they do not have local public health agencies.

Universal Newborn Hearing Screening:

The Bureau, DCFS' Early Intervention program and Part C/Early Intervention (located in the office of the Director, DHR) are working with a task force of the Part C Interagency Coordinating Council (ICC) to promote Universal Newborn Hearing Screening in Nevada. A description of this initiative may be found in the Annual Plan on page 185.

II. REQUIREMENTS FOR THE ANNUAL REPORT

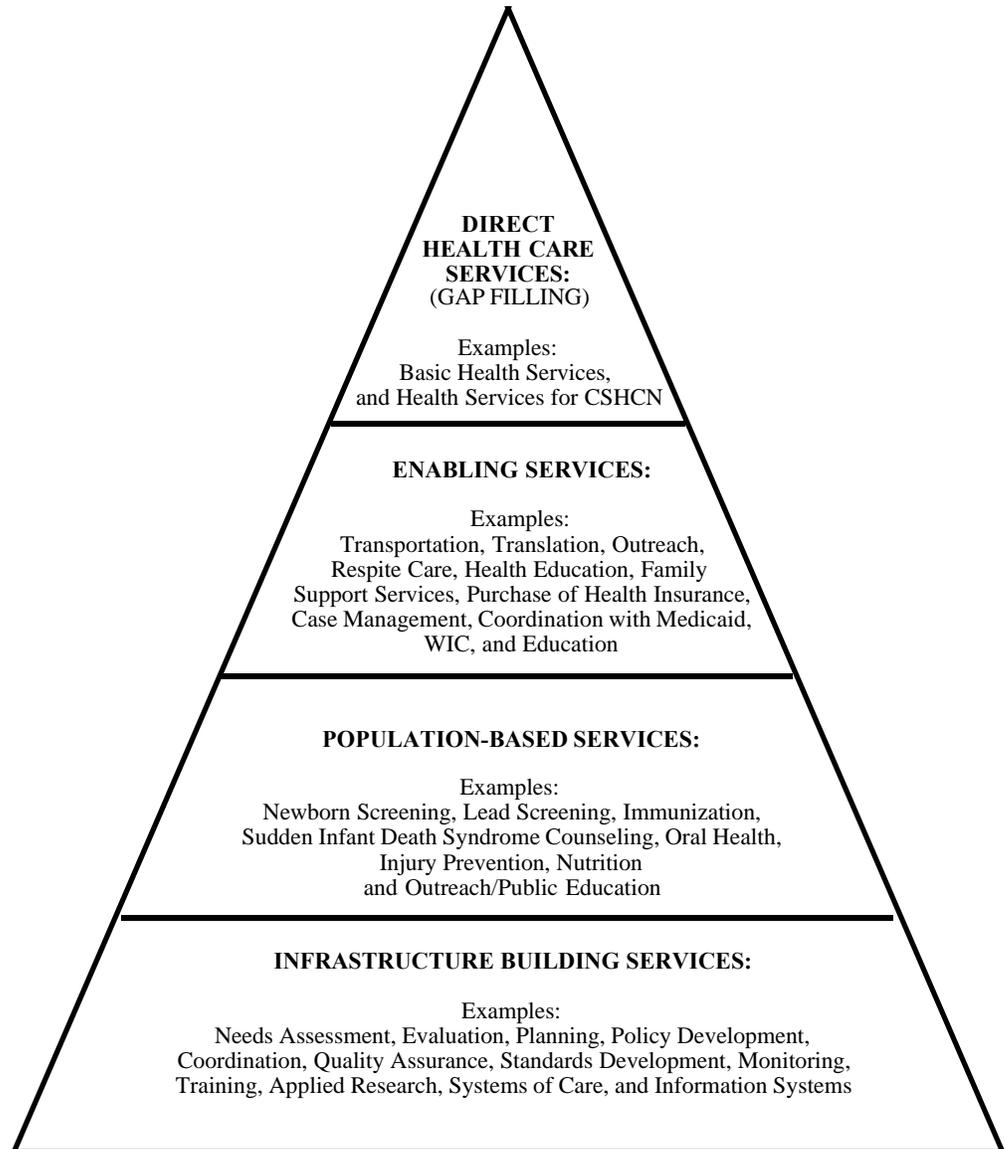
2.1 Annual Expenditures

See Form 3, State MCH Funding Profile, page SD3.1; Form 4, Budget Details by Types of Individuals Served, page SD4.1; and Form 5, State Title V Programs Budget, page SD5.1.

There is no significant variation between what was budgeted for FY99 and what was expended, or between fiscal year expended funds columns with the exception that carry-ver funds were not expended as planned in FY99 but in FY2000.

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



2.2 Annual Number of Individuals Served

See Form 6, Number and Percentage of Newborns and Others Screened, page SD6.1; Form 7, Number of Individuals Served (Unduplicated) Under Title V, page SD7.1; Form 8, Deliveries and Infants served by Title V and Entitled to Benefits Under Title XIX, page SD8.1; and Form 9, MCH Toll-Free Telephone Line Reporting, page SD9.1.

2.3 State Summary Profile

See Summary, Form 10, page SD 10.1.

2.4 Progress on Annual Performance Measures

Data reported is for Fiscal Year 1999 unless otherwise noted.

P01. Percent of SSI Beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program. FY99: 19.8%

Children with SSI automatically qualify for Medicaid in Nevada and therefore do not qualify for most CSHCN assistance. SSI eligible children receive Title V supported services at the SCCs. In addition they may receive support for medical specialty foods if they have an inborn error of metabolism as Medicaid does not cover that service. The clinics provide community-based, family-centered early intervention services, are the site of multidisciplinary medical specialty clinics, and assist families with inborn errors of metabolism obtain medical specialty foods and formulas. Past surveys have demonstrated a 16-20% SSI eligibility for those children served at the clinics. Using an estimate of 20% to include those SSI eligible children seen at the multidisciplinary clinics, and the December 1999 SSI report on the number of SSI eligible children in Nevada, 19.8% of SSI beneficiaries less than 16 years of age have been estimated to have received re-habilitative services from the CSHCN Program in FY99.

P02: The degree to which the State CSHCN Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients. FY99 Score = 9

The children that Nevada's CSHCN Program reports for this performance measure are those children who are found eligible for CSHCN Program coverage of specialty and subspecialty treatment, and/or are seen at the SCCs and the multidisciplinary specialty clinics. For those children who do meet program eligibility, the program will cover all 9 services listed in P02. The coverage of home health care is minimal, as is care coordination outside of the SCCs; all the other services are covered up to program limitations as found in NAC. Specialty and subspecialty evaluations and follow-up are provided through the multidisciplinary specialty clinics. Unless eligible for CSHCN assistance, children who are seen at the SCC would need coverage of some of the listed services through other sources, such as Medicaid or private insurance. Title V does support services provided by the SCCs for early intervention children as follows: occupational therapy and physical therapy services; speech, hearing and language services; nutrition services; care coordination; and early intervention services.

P03: The percent of CSHCN in the State who have a "medical/health home". FY99: 84.6%

The Nevada CSHCN program can only track those CSHCN who are either eligible for assistance with payment of their treatment and other services, and/or seen at the multidisciplinary medical specialty clinics. Based on a CSHCN data system report, 84.6% have some kind of primary care coverage based on insurance status. It can not be determined whether this meets the criteria for a "medical home" as described in the performance measure. Children who are served by CSHCN may have a medical home as the CSHCN Program will pay for it if the child does not have insurance. Developing methodologies to count and track CSHCN in Nevada is a priority for the SSDI grant in the coming year.

P04: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies. FY99: 99.8%

Nevada continues to have one of the top programs for Newborn Screening in the Nation. From year to year, 99.8% of Nevada's newborns are screened for PKU, hypothyroidism, galactosemia and hemoglobinopathies, as well as for biotinidase deficiency and maple syrup urine disease. In addition, 85 – 88% of newborns receive a second confirmatory screening. Data is obtained through State vital statistics (birth certificates) and Newborn Screening records.

P05: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B. FY99: 71%

The goal of 75% for immunizations in FY99 was established in consultation with the Immunization Program manager of the Bureau of Disease Control and Intervention Services. Factors impacting lack of achievement of the immunization goal include Nevada's rapidly growing population, and the availability of resources and sites for immunizations. An identified issue was the lack of return for the final series of immunizations after age 1. The 1997 legislature authorized one-time funding for a central registry to link the Immunization Program, WIC clinics and other public providers. A report on this effort is included in the Annual Plan on page 155. Funding to support the data system was also been obtained through a Robert Wood Johnson Foundation "All Kids Count" grant, as well as United States Department of Agriculture funding for the WIC clinics. Finally, an INPHO three-year grant has been obtained to link private providers. With the data system, it will be possible to assess a child's immunization status and refer those in need of vaccinations or provide the vaccination on the spot, depending on the site. Title V supported immunization services at Community Health Services and Washoe County Health District clinics in FY99. The FY2001 goal has been set in consultation with the Immunization Program. Efforts to reach the goal are discussed in the Annual Plan.

P06: Rate of birth (per 1,000) for teenagers aged 15 through 17 years. CY99: 35.3 per 1,000.

CY99 was the fourth year of Nevada's Teen Pregnancy Prevention Action Plan. Per the Plan, resources were directed to assisting Community Action Teams (CATs) in Community Needs Assessments, planning and implementation, depending on where the CATs were in their efforts. Data is from Bureau of Health Planning and Statistics records.

P07: Percent of third grade children who have received protective sealants on at least one permanent molar tooth. FY99: 37.32%

The Bureau has conducted a weighted statewide study for FY 00 and is estimating that the figures are also appropriate for FY99 as they were collected during the 1999-2000 school year. This data was collected with the assistance of St. Mary's Hospital of Reno and Miles for Smiles of UNSOM-Las Vegas, both of whom have dental vans that visit schools in their target areas to provide dental services. St. Mary's area of study included rural counties as well as rural areas of Washoe County. Schools were selected for SES status as well as location.

P08. The rate of deaths to children aged 1 - 14 caused by motor vehicle crashes per 100,000 children . FY99: 5.2 per 100,000

The data for this performance measure is from State vital statistics provided by the Bureau of Health Planning and Statistics. The SHD is increasing its efforts in intentional and unintentional injury prevention. It is now the recipient of a CDC Injury Prevention grant.

P09. Percentage of mothers who breastfeed their infants at hospital discharge. FY99: 52.6 %

This data is WIC data from the Pediatric Nutrition Surveillance System. Approximately half, or 52.6 %, of WIC mothers breastfeed upon discharge from the

hospital in 1999. Breastfeeding is a major WIC initiative. An FTE to be devoted entirely to breast feeding promotion is currently requested through the State's Interim Finance process. WIC remains the primary promoter of breastfeeding in Nevada.

P10. Percentage of newborns who have been screened for hearing impairment before hospital discharge. FY99: 14.7 %

Nevada saw a change in its in 1999 with the initiation of newborn hearing screening in the two largest hospital in Reno through the efforts of Pediatrix, a national pediatric provider network. In 2000 one of the smaller hospitals in Las Vegas served by Pediatrix implemented universal newborn hearing screening. Finally, in the spring of 2000 Medicaid began paying for newborn hearing screening for all eligible infants, not just those in an NICU.

P11. Percent of CSHCN in the State CSHCN program with a source of insurance for primary and specialty care. FY99: 51%

Data for this performance measure is from the CSHCN data system and estimates of the state population of CSHCN. For FY99, 51% of the children in the CSHCN program had health insurance. Children on Medicaid are not included in this estimate as they are not included in the State CSHCN program except through the SCCs. Nevada Medicaid does not identify children as CSHCN unless they are on SSI. All children on SSI have Medicaid. If they were included in this calculation it would skew the data as the total number of CSHCN served by Medicaid is not known.

P12. Percent of children without health insurance. FY99 estimate: 19.6 %

This data is based on a marketing study done by Great Basin Primary Care Association, which demonstrated 19.6% of children under 18 were not covered by any private or public health insurance. The number of children under 18 was obtained from Nevada Health Division Vital Statistics.

P13. Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. FY99: 90.0%

Medicaid of DHCFP provides data for this performance measure.

P14. The degree to which the State assures family participation in program and policy activities in the State CSHCN Program. FY99: Score of 10.

See the Annual Plan, page 185 for an assessment of current family participation in program and policy activities in the State CSHCN Program. This is not an area in the control of MCH.

P15. Percent of very low birth weight live births. FY99: 1.2%

Data for this performance measure comes from State vital statistics. MCH affects this performance measure through public health education measures such as BYB, provider education, and other initiatives, which are described in the Annual Plan.

P16. The rate (per 100,000) of suicide deaths among youths aged 15 – 19. FY99: 11.4 per 100,000

Data reported for this performance measure comes from State vital statistics. The 1999 Youth Risk Behavior Survey (YRBS) reports 20% of Nevada's high school students have seriously considered suicide during the past 12 months. This is a 2% drop from the 1997 YRBS of 22%. Sixteen percent planned how they would commit suicide, a 1% increase from the 1997 YRBS. Twenty-seven percent attempted suicide, a 19% increase from the 1997 report. The attempted and completed suicide rate in Nevada is one of the worst in the Nation. Youth suicide is a multifaceted issue in which MCH can have some affect, but which requires a statewide collaborative effort to address. Such a collaborative must address the internal and external forces influenced by culture and environment that contribute to teen suicide. Dr. John Fildes of the Trauma Division, UNSOM, working with the University Medical Center of Las

Vegas, obtained a CDC grant for a Suicide Prevention Center to be located in Las Vegas. Unfortunately this Center is looking primarily at elder suicide, also a major concern in Nevada. MCH is working to change this focus to include efforts around prevention of youth suicide. Working with the staff of the Center will be one of the focuses of the new Child and Adolescent Health and Injury Prevention Coordinators.

As a state, Nevada is beginning to take a greater role in promoting the mental health of its children. MCH is supporting this effort in every way it possibly can. Primary MCH efforts involve promoting intended and healthy pregnancies, promoting healthy lifestyles and acceptance of personal responsibility, participation in the steering committees for Family Preservation and Support and Child Care, and access to health care and other services for Nevada's MCH populations. As part of the Fundamental Review currently being conducted under Governor Guinn, a proposal to end the bifurcation of adult and child mental health services, currently in the Divisions of Child and Family Services and Mental Health/Developmental Services is under consideration and may be addressed in the 2001 Legislative Session. Mental Health has been identified as one of the MCH Five-Year Needs Assessment's priorities.

P17. Percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates. FY99: 75.4%

Data for P17 has come from State vital statistics. Since 1990, Nevada has seen an increase in the number of Level III hospital facilities in both Clark and Washoe Counties, where 85% of Nevada's population reside. In addition, MCH promoted the BYB campaign throughout the state to encourage all pregnant women to enter prenatal care in the first trimester, thus receiving assessments for adverse birth outcomes and appropriate intervention.

MCH continued to work with the Primary Care Development Center to promote access to obstetrical services in rural communities, but they remain a challenge for

some parts of the state where a woman must travel over 100 miles for obstetric care. All perinatologists in the state were and are providers for the MCH prenatal program.

P18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. FY99: 77.3 %

Data for performance measure P18 has come from State vital statistics. Through factors that include the BYB campaign and increased availability of obstetric services, Nevada has seen its rate of entry into prenatal care in the first trimester increase from 68% in 1991 to 77.3 % in 1999, an 13.6 % improvement.

SP1. The degree to which CSHCN in the State have access to case management and other enabling services. FY99 60.2%

This SP is assessed as in P02, (the degree to which the State CSHCN Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients) and as described in the Annual Plan on page 181. At this time case management services provided for CSHCN is available only through the SCCs, multidisciplinary specialty clinics, and for seriously involved cases in the CSHCN Program clientele. Case management in this case are those services which assure access to services in addition to specialty and subspecialty care, such as transportation, translation, referral to other services such as WIC, Medicaid and/or Nevada 3Check Up, SSI, representation at IEPs and so forth.

SP2. The degree to which Children with Special Health Care Needs in the State have access to specialty nutrition services FY99: 100%

Specialty nutrition services are defined as those services provided by registered dietitians who have been trained and/or mentored in the nutrition needs of special needs children. Through the CSHCN Registered Dietitians (RDs) nutrition services are available for all CSHCN in the state. A survey of 16 of Nevada's 17 school districts is currently being conducted to identify who are the children in Nevada's

public schools who need specialty nutrition services.(Only one rural school district has declined participation). Data will be available by the end of the year. The CSHCN RDs are working on developing a network of RDs statewide who will have the resources available to them including consultation with the CSHCN RDs as needed. For example, they are currently working with a nutritionist in Pershing County who just had two children with Cerebral Palsy move into the school district. Finally they are working with Medicaid to obtain payment for nutrition services provided through the diabetes clinics sponsored by UNSOM in the north and south.

SP3. The birth rate (per 1,000) for Hispanic teenagers aged 15 – 17. FY99: 110.7 per 1,000

This data comes from State vital statistics. It recognizes the need to concentrate efforts on addressing the Hispanic teen pregnancy rate, which is double the state average.

SP4. The percent of children ages 1 - 5 at risk for Early Childhood Caries (ECC). FY99: 27.2 %

SP4 was monitored for FY 99 as in FY98 through WIC Data which uses the new WIC nutrition risk factor, # 419, developed by the Institute of Medicine to identify WIC children at risk of ECC as a risk factor. The FY99 rate is slightly higher than FY 98 as it was the first full year of use of the new nutrition risk factor codes.

SP5. The rate of hospital discharge per 100,000 youth for intentional injury. FY99: 148.8 per 1,000

For this year national rates are used. This data will be available from hospital discharge data and the Crash Outcome Data Evaluation Systems (CODES) Project described in the Annual Plan on page 177. This state performance measure is important as intentional injury can be a factor in unsafe lifestyles of children including suicide and in child abuse and neglect.

SP6. The percent of children in the State who have a medical home, including a dental home. FY99: 80.6%

This SP is monitored with the assistance of DHCFP and National statistics. It will assist MCH efforts with outreach. MCH will also use data collected on use of Medicaid, Nevada 3Check Up, and HEDIS, to assess use of primary and preventive care for Nevada's children.

SP7. Percent of pregnant and postpartum women who use alcohol, tobacco and/or other drugs (ATOD). FY99: 23.5 %

The percentage of women who consume alcohol, tobacco and other drugs has been calculated based on an independent study by Cristman Associates. The study was statewide and included a survey of birth mothers for a three week period from all 15 birthing hospitals in Nevada. This finding includes the total percentage of women who smoked, drank alcohol or took illegal drugs during pregnancy. It does not mean that the women did all three or even two during pregnancy. There may or may not have been combined usage of alcohol, tobacco and drugs.

SP8. The degree to which the Nevada MCH Prenatal program supports or pays for prenatal care, including dental care, not otherwise accessible to its clients. FY99: 1.5%

The data for the numerator for this measure is produced by the current MCH data system, which produces an unduplicated count. The denominator comes from State vital statistics. Nevada's MCH Prenatal Program remains a safety-net for women who do not meet Medicaid eligibility or otherwise have access to third party payor support for their pregnancy.

SP9. Percent of pregnancies that are intended. FY99: 48.8

This data came from an independent study by Cristman Associates, who were contracted by the Nevada Health Division. The survey gathered data from a

representative sample of mothers delivering infants throughout the year because of the randomness of the sampling technique used.

SP10. The rate of substantiated child abuse and neglect. FY99: 7.1 per 1,000

This data was based on the # of *substantiated* cases from the Division of Child & Protective Services, and Nevada Health Division, Vital Statistics. It should be noted that the numbers differ substantially from the past two years. The past two years inadvertently reported the number of *reported* cases of child abuse and neglect, not the number of *substantiated* cases. This year's measure is a more accurate reflection of the substantiated cases, and is similar to the number reported in the 1998 Kids Count Data Book. A "case" is a substantiated report - it may have one child or three children per "case". One child may be involved in three or more "cases" per year.

2.5 Progress on Outcome Measures

OM1 through OM5: all but one National Outcome Measure leads to the issue of achieving a healthy pregnancy and birth outcome. For FY99, the primary effort of the MCH Program on Outcome Measures 01 through 05 continued to be achieved through the Bureau's MCH Perinatal Program and Child and Adolescent Health Programs. Through the BYB campaign, residents of the state were educated on the importance of early and continuous prenatal care. Residents of the most populous counties had access to prenatal care regardless of their ability to pay. Training of providers in new information that affects birth outcomes such as Strep B and periodontal disease continued in FY99. The State has achieved Outcome Measure 01 with an infant mortality rate of 6.4 per 1,000 in 1999. The State has a very small minority of African Americans, and for this reason Outcome Measure 2 rates vary significantly from year to year due to a difference of one or two infant deaths. For 1999 the rate was 11.8 per 1,000, and the ratio 2.0. The State has achieved Outcome Measure 03 with a rate of 3.77 per 1,000 but not Outcome Measure 04 with a rate of

2.6 per 1,000. Outcome Measure 05 is monitored for progress in reducing perinatal mortality with a 1999 rate of 10.1.

OM6: the child death rate in Nevada for FY99 was 24.4 per 100,000 children ages 1. Nevada's efforts addressing child death rates have not been the responsibility or under the control of Nevada's MCH. Nevada's MCH, however, has been involved in State efforts and in FY2000 has assumed a greater role with the initiation of the Injury Prevention initiative address in the Annual Plan. There are Child Death Review Teams in Clark and Washoe Counties, and a State Team formed under the leadership of the Division of Child and Family Services. The SCC - Las Vegas manager continues as Co-Chairman of the Clark County team. The goal of the teams is to analyze causes of death and develop recommendations to address the causes. Nevada's MCH Chief will also continue participation in the Title IV-B Steering Committee for Family Preservation and Support. All of these efforts together should affect Nevada's child death rate.

III. REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 YEAR 2000 STATE OF NEVADA FIVE YEAR NEEDS ASSESSMENT OF THE MATERNAL CHILD HEALTH POPULATION

If you want one year of prosperity, grow grain. If you want ten years of prosperity, grow trees.

If you want one hundred years of prosperity, grow people.

--Ancient Chinese Proverb

EXECUTIVE SUMMARY

Nevada is a state on the verge of discovering what Public Health can do to increase the capacity of its healthcare systems: providing outreach to underserved and/or minority populations, diversifying resources, providing primary care access to all populations, providing preventive

and health education to all ages, and much, much more. If we look to our flagship public health states like Massachusetts, Minnesota, and Washington, Nevada can utilize their historical perspectives to predict what it can look like within 10-15 years, as well as, design a system that promotes prevention, incorporates education, and provides age, medical, and culturally-appropriate services to its populations. The potential is staggering. It is important that Nevada knows the strengths and weaknesses in its healthcare systems to promote growth in our state.

As the Nevada State Health Division (SHD) prepared to assess the needs of the Nevada MCH population, various methods were used to promote collaboration between state agencies, health entities, Community Based Organizations (CBOs), parents, youth groups, and the three MCH populations. The State held work and focus groups, a statewide video-conferenced public hearing, distributed surveys, and made essential presentations to the Maternal and Child Health (MCH) Advisory Board and the Governor's Youth Advisory Council that focused on the three MCH populations – women and children < 1, children ages 1-9 and adolescents ages 10-21, and Children with Special Health Care Needs (CSHCN) during the course of four months.

Among the work and focus groups, public hearing, surveys, and advisory boards recommendations were ten common priority areas that encompass all of the three MCH populations: additional medical personnel, quality oral/dental healthcare, unified data and surveillance systems, domestic violence, healthcare access, insurance, and financial gaps, health education, self-esteem and behavior modification, mental health services and providers, and enabling services. These ten priority areas are to be the focus areas for the Bureau of Family Health Services (BFHS) and all partnering organizations during the next five years (2000-2005); the priority areas helped determine the ten Nevada State-Negotiated Performance Measures for 2000-2005 as well.

Nevada Five Year MCH Needs Assessment Recommendations for 2000-2005

Ten Priority Areas

- ◆ Address the need for additional medical personnel among the three MCH populations in the State of Nevada (Direct Health Care Services)
- ◆ All three MCH populations should have access to quality oral/dental health (Enabling Services)
- ◆ Create a unified data system and surveillance system to monitor services delivered to the three MCH populations (Infrastructure Building Services)
- ◆ Create “braided” services and “one-stop shopping” for CSHCN resources in Nevada (Direct Health Care, Enabling, Population-Based, and Infrastructure Building Services)
- ◆ Decrease the incidence of domestic violence among women of child-bearing age (Population-Based Services)
- ◆ Increase healthcare access and address insurance and financial gaps among the three MCH populations (Population Based Services)
- ◆ Increase the amount of health education available for the three MCH populations and providers (Enabling and Population-Based Services)
- ◆ Increase the amount of innovative programs that address self-esteem and behavior modification in children 1-9 and adolescents 10-21 (Enabling and Population-Based Services)
- ◆ Increase access to mental health services, providers, facilities, resources, and payor sources among the three MCH populations (Enabling Services)
- ◆ Increase the amount of outreach and enabling services available for the three MCH populations (Enabling Services)

The following are the needs assessment recommendations for the Nevada State-Negotiated Performance Measures:

Ten State-Negotiated Performance Measures

- ◆ The percent of domestic violence screening among women of child-bearing age and their children should be increased (Population-Based Services)

- ◆ The percent of women, children, and youth (ages birth to 21) who have access to preventive oral services and dental care, regardless of ability to pay, should be increased (Enabling Services)
- ◆ The number of health education programs that target children 1-9 should be increased (Enabling Services)
- ◆ The rate of child abuse and neglect should be reduced (Population-Based Services)
- ◆ The number of health education, support systems and programs that address self-esteem in children 1-9 and adolescents 10-21 should be increased (Enabling Services)
- ◆ Teen pregnancy rates among adolescents 15-19 should be reduced, with emphasis on minority populations (Population-Based Services)
- ◆ Access to specialty and subspecialty services, and care coordination available to CSHCN should be increased (Enabling Services)
- ◆ Access to enabling services that assist in CSHCN care coordination, respite care, outreach, transportation, case management, and coordination with Medicaid, Nevada 3Check Up, or purchase of health insurance should be increased (Enabling Services)
- ◆ The percent of children and youth (ages zero to twenty one) and women of child-bearing age who have homes for primary medical care, regardless of ability to pay, should be increased (Population Based Services)
- ◆ The percent of children and youth (ages zero to twenty one), women of child-bearing age, and CSHCN who have access to mental health services, regardless of ability to pay, should be increased (Enabling Services)

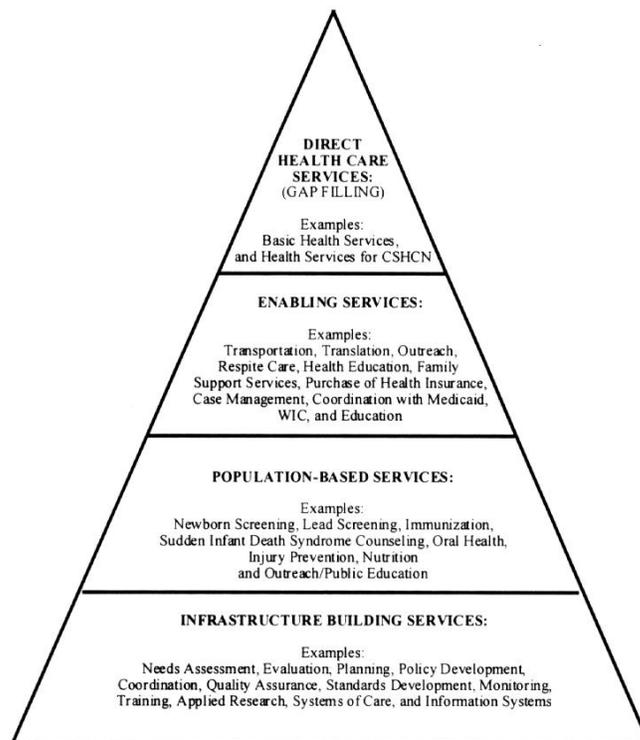
The areas with the most glaring deficiencies for the three MCH populations, and perhaps the state as a whole are: oral/dental healthcare, mental health services, and access to primary care services. Delineated throughout the document by population and need are other areas that have been underprovided and/or lacking in years past. Recommendations to begin the process of addressing each one of these needs are also outlined within the needs assessment, thereby providing the SHD, BFHS, and partnering agencies with a preliminary plan they can build on; it is important to note that these recommendations are not set in stone, and that adaptation is key to making the right plan for each specific population and community.

Overall, there is a lack of communication and fragmentation of services between policy-makers, state agencies, health systems, tribal health systems, and between some public and private providers in the State of Nevada. It is essential to educate policy-makers who make funding decisions on local, state, and national levels to help forge the path necessary to building up and strengthening the current public health system and propelling Nevada into the future.

INTRODUCTION

As Nevada's Public Health state continues to evolve, it will be shown that the state is slowly making its way down the hierarchy of the Maternal and Child Health (MCH) Services Pyramid. As the BFHS moves away from traditional direct health care services, it will be shown that the communities are in great need of enabling and population-based services. In order to provide acceptable, accessible, accountable, affordable, quality services and programs to children, adolescents, and women, the Federal Maternal Child Health Bureau (MCHB) initiated the Maternal and Child Health State Systems Development Initiative (MCHSSDI). Included in this initiative is the preparation of a State Maternal Child Health Needs Assessment. Every five years each state must prepare a statewide needs assessment that identifies the need for: preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children and adolescents; and overall services for CSHCN. To conduct the Nevada MCH Five Year Needs Assessment, the SHD employed both primary and secondary data collection strategies: work and focus groups, surveys, presentations, and data analysis. Throughout the process, the focus was on the BFHS main mission – *to improve the health of Nevada's families with emphasis on women, infants, and children by promoting, assuring, and providing health education, prevention activities, quality assurance, and access to health care services*. Parents were consulted for their opinions as well, based upon the premise that families are the true experts when it comes to identifying and describing their mother's and children's needs.

The BFHS administers programs, projects, and initiatives such as: Children and Adolescent Health Program including Abstinence Works (abstinence education focused on young children), an injury prevention program, and teen pregnancy prevention; Children with Special Health Care Needs (CSHCN) including two multidisciplinary Special Children’s Clinics; an oral health initiative; newborn screening; perinatal program including Baby Your Baby (BYB) and a substance abuse prevention program; and Special Supplemental Food Program for Women, Infants, and Children (WIC). According to the MCHB (Nevada Title V Snapshot 1997), Nevada spent 70.1% of its expenditures on direct health care and enabling services, 18.3% on population-based services, and 11.6% on infrastructure building services. Comparatively speaking, the National snapshot shows 46.5% of expenditures in direct health care services, 25% on enabling services, 14.1% on population-based services, and 14.4% on infrastructure building services. The needs assessment will show that the SHD must move away from encumbering most of its funds in direct health care and move more towards enabling services, population-based services, and infrastructure building.



As the SHD prepared to assess the needs of the Nevada MCH populations, various methods were used to promote collaboration between state agencies, health entities, CBOs, parents, youth groups, and the three MCH populations. Work and focus groups, surveys, and a public hearing were created to give ample opportunity to all populations to provide the SHD with their advice and needs. In addition, oral input was given at the meetings of the Nevada State Maternal and Child Health Advisory Board and the Nevada Governor's Youth Advisory Council. The State held work groups during the course of two months that focused on the three MCH populations – women and children < 1, children ages 1-9 and adolescents ages 10-21, and CSHCN. Each work group was conducted in one rural and two urban locations, for a total of twelve workgroups. These workgroups were convened in order to have agencies and groups other than the SHD address and evaluate Nevada's approach to the MCH service pyramid consisting of direct health care, population based, enabling, and infrastructure building services. In addition, surveys were given to the work group members, parents, and other agencies that were not able to participate in the work group process. A secondary mailing of the first survey was done to include school nurses and follow-up on the first mailing. From the work groups came a second survey that focused on the parents of CSHCN. Interest in this survey produced a CSHCN parent focus group.

Among the work and focus groups, public hearing, surveys, and advisory boards recommendations were ten common priority areas that encompass all of the three MCH populations: additional medical personnel, quality oral/dental healthcare, unified data and surveillance systems, domestic violence, healthcare access, insurance, and financial gaps, health education, self-esteem and behavior modification, mental health services and providers, and enabling services. Within these ten recommendations are four comprehensive approaches that should be addressed among all the priority areas: within the next five years address inadequately funded medical and social services and the need for identification of Federal and State funds to develop these resources; acculturation and cultural competency issues should cut across all services provided; address the elimination of health disparities among all racial and ethnic minorities, and development of a more holistic approach in addressing service needs. The population of CSHCN stood out with the most deficiencies; from personal services for the parents and children, to accessing appropriate providers and care in the State of Nevada. It is

an additional overall recommendation of the needs assessment that the SHD take a closer look at the needs of the CSHCN population by focusing attention on physician access and the attainment of better and timely services.

3.1.1 NEEDS ASSESSMENT PROCESS

NEEDS ASSESSMENT PROCESS

History – Nevada 1995 MCH Five Year Needs Assessment

(Excerpts from 1995 Needs Assessment)

In December 1994, the BFHS began the 1995 needs assessment process. Lead staff was designated, as well as, a workgroup to represent the public and private sectors, state and local government, CBOs, and consumers. Twenty-three individuals comprised the MCH needs assessment workgroup. This was a new process for Nevada that set a pattern for the inclusion of diverse sectors of the MCH community to help identify the scope of unmet MCH need in Nevada. Through the course of the next twelve months, the work group identified the issues to be addressed in the needs assessment, designed and conducted surveys of identified populations, reviewed the findings of the surveys and identified pertinent data, and came to consensus on the recommendations.

The 1995 needs assessment created these four main recommendations for the years 1995-2000:

I. General Maternal and Child Health

Every pregnant woman and child age 0-21 is entitled to a medical home for primary care, including dental care. Construct a plan that pursues universal access to preventive and episodic health care, but develop it concurrently with financial sources that assure accessibility. Move away from the one doctor-one patient model. Aim for culturally competent community-based programs that include enabling services such as

transportation, baby-sitting and interpretation, and promote public-private partnerships.

II. Pregnant women and infants

Every pregnant woman in Nevada is entitled to a medical home. Construct a plan that pursues universal access to perinatal care, from pre-conception to delivery and post-partum care, but develop it concurrently with financial sources that assure accessibility. Move away from the one doctor-one woman model. Aim for culturally competent community-based programs that include enabling services such as transportation, baby-sitting and interpretation, and promote public-private partnerships. Prevention of low birthweight infants is a priority.

III. Children and Adolescents

Every child from 0-21 is entitled to a medical home for primary care, including dental care. Construct a plan that pursues universal access to preventive and episodic health care, but develop it concurrently with financial sources that assure accessibility. Move away from the one doctor-one child model. Aim for family centered, culturally competent community-based programs that include enabling services such as transportation, baby-sitting and interpretation, and promote public-private partnerships.

IV. Children with Special Health Care Needs

In addition to a medical home for primary care, that includes dental care, every special needs child from age 0-21 is entitled to a medical home for their specialty care. All services must be developed concurrently with financial sources that assure accessibility. Each child and his/her family are entitled to case management. Services should be family centered, culturally competent community-based programs that

include enabling services such as transportation, baby-sitting, day care, preschool, and interpretation. Services should build on public-private partnerships.

New Needs Assessment Methodology – Year 2000-2005

In February 2000, the BFHS began a new needs assessment process. The purposes of the Year 2000 Nevada MCH Needs Assessment are to improve Nevada's MCH outcomes and its performance measurement data collection process. The project's two main goals are: 1) develop a replicable process for conducting the Five Year MCH Needs Assessment and implement the process and 2) develop a system for the routine and on-going tracking of Nevada's progress on the MCH performance measures and apply it to six indicators.

Key features of the Year 2000 needs assessment process included the development of a "core group" whose membership included the Project Director, Project Coordinator, Chief of the BFHS, Chief of the Bureau of Health Planning and Vital Statistics, the State Biostatistician, and representatives from the Washoe and Clark County Health Districts. The core group was charged with reviewing the needs assessment outline, assisting the project coordinator with additional data collection, and making suggestions or additions to the final product. The project coordinator was the main staff person that worked and compiled all the components of the needs assessment. "Workgroups" were established to publicly discuss the inadequacies and inequalities among the three MCH populations in Nevada. The Project Coordinator and selected BFHS staff had primary responsibility for conducting the workgroup process. The workgroups were a tool to build bridges among traditional and non-traditional partners in the public health community; they were a primary source of information that helped shaped the foundation of the needs assessment. In addition, two surveys were distributed and one focus group was held for the CSHCN population. CSHCN was selected for the focus group because BFHS staff noticed a deficiency in participation in the workgroups from parents, and used the focus group as a forum for parents to give additional concepts to the needs assessment. As the surveys were returned, they indicated a need for more detailed information on this population. Presentations were also made to the MCH State Advisory Board, the Governor's Youth Advisory Council, and a statewide

videoconferenced public hearing were held to discuss the preliminary findings and shape the final outcomes of the needs assessment.

The SHD employed both primary and secondary data sources to provide the necessary information to assess the needs of the three MCH populations; most of the tabular data came from other bureaus within the SHD. The two surveys were part of a primary data collection strategy that sampled various state agencies, health entities, CBOs, parents, and youth groups that work with or are a part of the three MCH populations. These surveys are referenced in the text of the needs assessment, as well as Appendices D and E. Additional primary data collection came from phone calls to the project coordinator from concerned parents, work and focus group participation, presentations before public meetings of the Nevada State MCH Advisory Board and the Governor's Youth Advisory Council, and the videoconferenced public hearing. The referenced secondary data sources were from both Federal and State data and are listed in the endnotes. Limitations within the primary data may be from survey response bias, recall bias, and/or coding error in data entry.

The Workgroups

The collaborative workgroups for the three MCH populations met within a two-month period to discuss what they saw in their public or private agencies, communities, or personal perceptions as being the areas in which the SHD should address its efforts for the years 2000-2005 in identifying inequities and inadequacies of care within each specific population. Each workgroup was made up of invited participants who regularly collaborate with the SHD; however, additional participants were invited from organizations in which historically minimal to no collaborative work is done as well, e.g., members of the Great Basin Primary Care Association, Nevada Public Health Foundation. A definitive effort was taken to invite parents and various ethnic and minority agencies to participate as well.

Response to the work group process was excellent for the women and children < 1, children (ages 1-9), and CSHCN workgroups; however, the adolescent (ages 10-21) work groups were poorly

attended. The noticeable deficiencies were a lack of parental participation in all of the workgroups and a noticeable lack of total participation in the adolescent workgroups. Although many of the invited workgroup members were also parents, this lack of representation was mostly due to the time of the meetings (morning/afternoon). Participants were asked to invite anyone who was interested in commenting on the Nevada MCH services to participate in the needs assessment process. Evaluation after the completion of the workgroups indicated that the SHD did not invite the correct people to the workgroups, too many directors of agencies were invited, and not enough coordinators of programs were invited. In addition, medical and social providers indicated a lack of time to participate in the workgroup process, but did send in the agency/parent survey.

There were three workgroups for each MCH population with meetings in Reno, Las Vegas, and a defined rural area:

Population	Reno	Las Vegas	Rural Area
Women and children < 1	√	√	Winnemucca
Children 1-9	√	√	Fallon
Adolescents 10-21	√	√	Fallon
Children with Special Health Care Needs	√	√	Elko

In each area of Nevada, the population-specific workgroup members met once for approximately four hours to list, listen to, and discuss the needs they saw in their urban or rural settings with BFHS staff and the Project Coordinator. The workgroup’s intense work ethic and belief in the populations they serve prompted SHD to produce a second mailing of the agency-focused survey to school nurses and identified parents. The second mailing had a very low response rate, too negligible to report on. The workgroups identified multiple areas of concern within the three MCH populations, but were given the profound task of distinguishing only five or six priority areas within each population that the BFHS should focus on for the next five years. These identified priority areas of concern are as follows (these priorities are in no particular order):

Women and Children < 1
Reno/Sparks, Las Vegas, Winnemucca

- ◆ Decrease the incidence of domestic violence among women of child-bearing age and increase education of providers to respond to and treat domestic violence
- ◆ Increase the amount of health education for available for women of child bearing age and their providers
- ◆ Increase healthcare access to diverse medical homes and address financial gaps and insurance barriers to the provider and the child
- ◆ Increase access to mental health services, providers, facilities, resources, and payor sources available in the state to women and children < 1
- ◆ All women of child-bearing age and children < 1 should have access to quality oral/dental healthcare
- ◆ Increase the amount of outreach and other enabling services to women and children < 1

Children 1-9
Reno/Sparks, Las Vegas, Fallon

- ◆ Increase the amount of innovative educational programs targeting behavior modification in children 1-9
- ◆ Increase healthcare access to diverse medical homes, address financial gaps and insurance barriers to the provider and the child
- ◆ Increase the amount of outreach and other enabling services to children 1-9
- ◆ Increase the amount of mental health providers, facilities, resources, payor sources, and social services to children 1-9
- ◆ All children 1-9 should have access to quality oral/ dental healthcare

Adolescents 10-21

Reno, Las Vegas, Fallon, Governor's Youth Advisory Council

- ◆ Increase the amount of innovative programs that address self-esteem in adolescents 10-21
- ◆ Increase the amount of health education classes available to adolescents 10-21, especially age and grade appropriate sex and abstinence education
- ◆ Increase the amount of parental involvement in the lives of adolescents 10-21
- ◆ Reduce the incidence of violence among adolescents 10-21
- ◆ Reduce the incidence of substance abuse among adolescents 10-21
- ◆ Reduce deaths and injuries caused by alcohol and drug- related motor vehicle crashes among adolescents 10-21

Children with Special Health Care Needs

Reno/Sparks, Las Vegas, Elko, Focus Group

- ◆ Create “braided” services and “one-plan” for CSHCN resources and services in Nevada
- ◆ Increase the amount of enabling services, especially family support and respite care for the CSHCN population
- ◆ Increase the amount of health education and training available for parents and providers in the CSHCN population
- ◆ Increase access to mental health services, providers, facilities, resources, and payor sources among the CSHCN population
- ◆ Increase the amount of appropriate providers (namely specialists) and create a provider-specialist linkage in Nevada for the CSHCN population
- ◆ All CSHCN should have access to quality oral/dental healthcare

Ten Recommended Priority Areas

Among the above recommendations are ten common priority areas that encompass the three MCH populations. Within these ten areas are four comprehensive approaches that should be

used: within the next five years address inadequately funded medical and social services and the need for identification of Federal and State funds to develop these resources; acculturation and cultural competency issues should cut across all services provided; address the elimination of health disparities among all racial and ethnic minorities, and development of a more holistic approach in addressing service needs. The CSHCN population was singled out with the scarcest resources from respite and personal services for the parents and children to accessing appropriate providers and adequate medical care in the state.

Recommendations – Ten Priority Areas

- ◆ Address the need for additional medical personnel among the three MCH populations
- ◆ All three MCH populations should have access to quality oral/dental health
- ◆ Create a unified data system and surveillance system to monitor services delivered to the three MCH populations
- ◆ Create “braided” services and “one-stop shopping” for CSHCN resources in Nevada
- ◆ Decrease the incidence of domestic violence among women of child-bearing age
- ◆ Increase healthcare access and address insurance and financial gaps among the three MCH populations
- ◆ Increase the amount of health education available for the three MCH populations and providers
- ◆ Increase the amount of innovative programs that address self-esteem and behavior modification in children 1-9 and adolescents 10-21
- ◆ Increase access to mental health services, providers, facilities, resources, and payor sources among the three MCH populations
- ◆ Increase the amount of outreach and enabling services available for the three MCH populations

Four Comprehensive Approaches to Address the Recommendations

- ◆ Within the next five years address inadequately funded medical and social services and the need for identification of Federal and State funds to develop these resources
- ◆ Acculturation and cultural competency issues should cut across all services provided
- ◆ Address the elimination of health disparities among all racial and ethnic minorities
- ◆ Develop a more holistic approach in addressing the service needs of women and children < 1 children 1-9, adolescents 10-21, and CSHCN

Interestingly, in addition to identifying priority areas of concern, the workgroups took the opportunity to brainstorm various efforts they could collaborate on amongst each other and/or with the SHD to address these problems. Throughout the needs assessment, there will be suggestions for solutions from the workgroups to address certain priority areas.

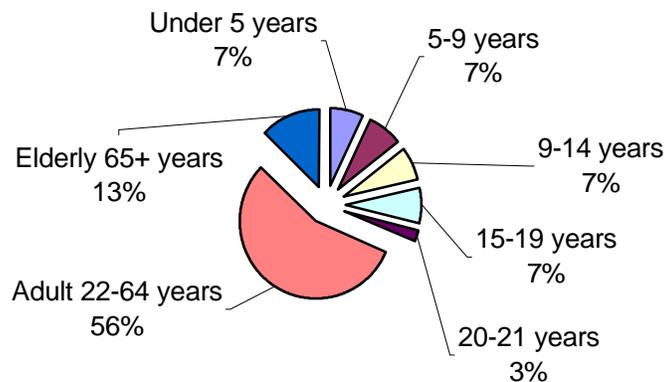
3.1.2 NEEDS ASSESSMENT CONTENT

3.1.2.1 OVERVIEW OF THE NEVADA MATERNAL CHILD HEALTH POPULATION'S HEALTH STATUS

Throughout the needs assessment, the effects of poverty, non-citizenship, racial and ethnic disparities in health status, geography, urbanization and private sector impacts on the delivery of services for the Nevada MCH population are discussed.

National statistics from Child Health USA (1999) indicate that in 1998, the 84 million children through the age of 21 in the United States represented 31.4% of the total population. Since 1990, the number of children under 5 years of age has increased by 0.6%. The number of children ages 5-19 years has increased by 10.7%. Through the year 2000, the proportion of children through the age of 21 is projected to remain between 31.5% and 31.6% (U.S. Bureau of the Census).

U.S. Resident Population by Age Group: July 1, 1998
Source: U.S. Bureau of the Census



As a people it is our personal and civic duty to raise, protect, educate, clothe, and feed our children to become productive members of society. Through the needs assessment's collection of primary and secondary data, Federal and State data, the accomplishments of the work and focus groups, presentations before the MCH State Advisory Board and the Governor's Youth Advisory Council, and the videoconferenced public hearing it has been confirmed that Nevada does not make its services for women, children, and adolescents a priority. According to the Governor's Youth Advisory Council, state focus on the adolescent population has been lacking for too many years, and we need to develop new and savvy initiatives to address the issues that are being faced by our teens. It is time that Nevada concentrates on its women, children, and adolescents.

Federal and State statistics demonstrate a needed change in focus regarding the minority populations that have increased in number during Nevada's population explosion. Some key examples come from Kids Count and Nevada Kids Count (Annie E. Casey Foundation 1998, 1999, 2000), Nevada ranked 36th among the 50 states and the District of Columbia on the well-being of children. The Annie E. Casey Foundation tracks the status of children by using a method that evaluates the benchmarks of child well-being.

Highlights from this document (note that the scale is 1-51, 51 being "worst"):

- ◆ Nevada ranks 11th in the percent of children in poverty; however, this ranking has remained unchanged from 1985-1996.
- ◆ Nevada ranks 37th in the rate of teen deaths by accident, homicide, and suicide; the rate increased 4% from 1985-1996.
- ◆ Nevada ranks 42nd in the teen birth rate in Nevada; it has increased 35 % from 1985-1996.
- ◆ Nevada ranks 45th in the nation on the percentage of children under age 18 without health insurance.
- ◆ Nevada ranks 46th in the nation on the immunization rate of two year olds.
- ◆ Nevada ranks 51st in the percentage of teens who are high school dropouts; Nevada has the nation's highest percentage of teenage residents who are high school dropouts.

According to Nevada Vital Statistics, from 1990 to 1998, Nevada was the fastest growing state in the nation, and Las Vegas was the fastest growing metropolitan area in both Nevada and the nation. The statistics show a 56% increase in the total population, and notable increases in the minority populations (54.5% Asian American/Pacific Islander (AAPI), 66.6% Black/African American, 93.6% Hispanic/Latino, and 59.0% Native American). The 1990 Nevada population of 1,201,833 grew to 1,874,760 in 1998, and is projected to surpass two million by 2000 (approximately 2,034,010). The vast majority of growth has been by in-migration. The Las Vegas and Reno metropolitan areas contain more than four out of every five of the state's residents. In Clark County alone, there was a 70.7% rise in population from 1990-1998, Washoe County shows a 24.9% increase, and in the rural/frontier counties there was a 41.5% increase (SHD January 2000).

Nevada Population, 1990-1998											
Source: Nevada Bureau of Health Planning and Vital Statistics											
Year	Gender			Race/Ethnicity					County/Region		
	Total	Male	Female	White	Black	Native	AAPI	Hispanic	Washoe	Clark	Rural
1990	1,201,833	611,882	589,951	947,328	76,638	17,499	35,950	124,418	254,667	741,459	205,707
1991	1,297,910	660,212	637,698	1,019,575	83,517	18,953	38,855	137,010	262,260	820,804	214,846
1992	1,343,940	683,000	660,940	1,052,047	87,242	19,684	40,216	144,752	265,660	856,339	221,941
1993	1,398,760	710,216	688,544	1,091,058	91,597	20,552	41,853	153,700	271,770	898,008	228,982
1994	1,494,230	757,982	736,248	1,161,359	98,708	22,028	44,673	167,461	282,630	971,658	239,942
1995	1,582,389	801,935	780,454	1,225,482	105,460	23,408	47,231	180,808	294,290	1,036,290	251,809
1996	1,688,140	854,685	833,455	1,302,715	113,511	25,063	50,259	196,592	306,810	1,115,940	265,390
1997	1,740,897	880,533	860,364	1,338,599	118,102	25,944	51,699	206,552	308,579	1,163,207	269,111
1998	1,874,760	947,726	927,034	1,422,838	127,669	27,830	55,555	240,868	318,050	1,265,590	291,120

Some very common measurements collected by state vital statistics offices around the nation and the world are key indicators to the growth, development, and maturity of a state's population and its public health influence. As the nation moves forward to address the Presidential initiative to eliminate health disparities among racial and ethnic minorities in the United States, we can use these measurements to begin the planning process of attending to these needs. Among these measurements are many MCH core performance measurements: birth rate, infant mortality rates, low birth weight incidence, very low birth weight incidence, access to pre-natal care, and teen pregnancy rates. By knowing these rates and taking note of trends in populations, we can begin the elimination of health disparities among all races and ethnicities.

Birth Rate

The age mix of Nevada's population varies from the nation as a whole by having a higher share of people in the age groups between 25-45 (note that women of child-bearing age range from ages 14-44. From 1990 to 1998, the mix in ethnicity has become more statistically noticeable, and the fastest growing ethnic group in the state is of Hispanic origin.

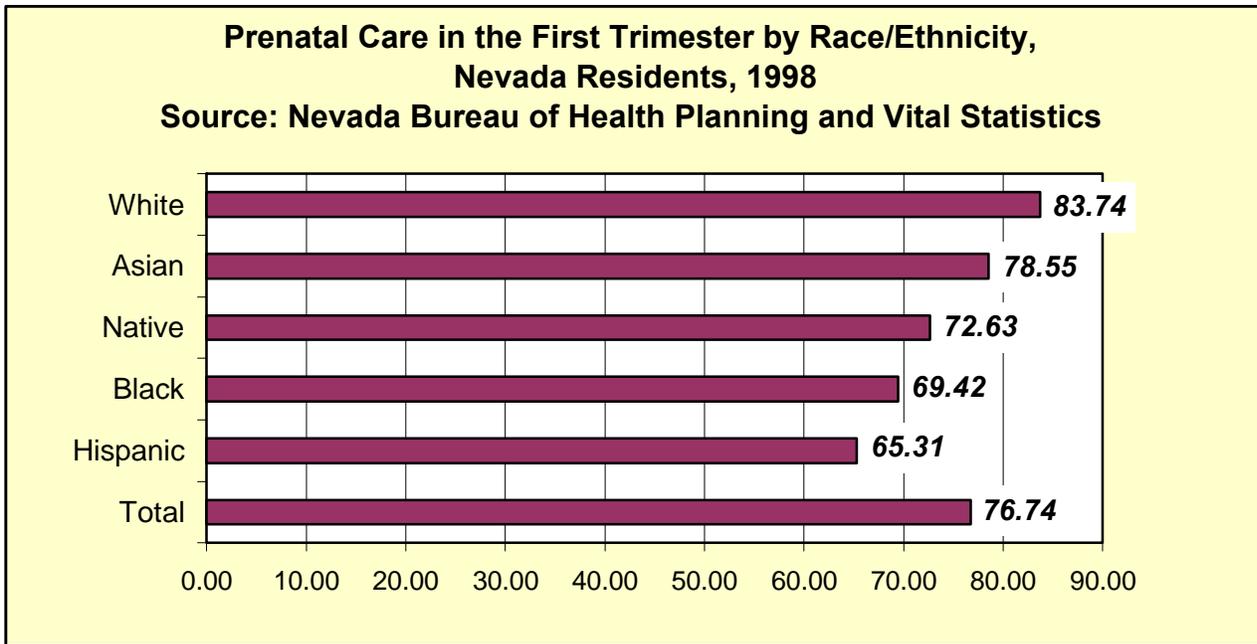
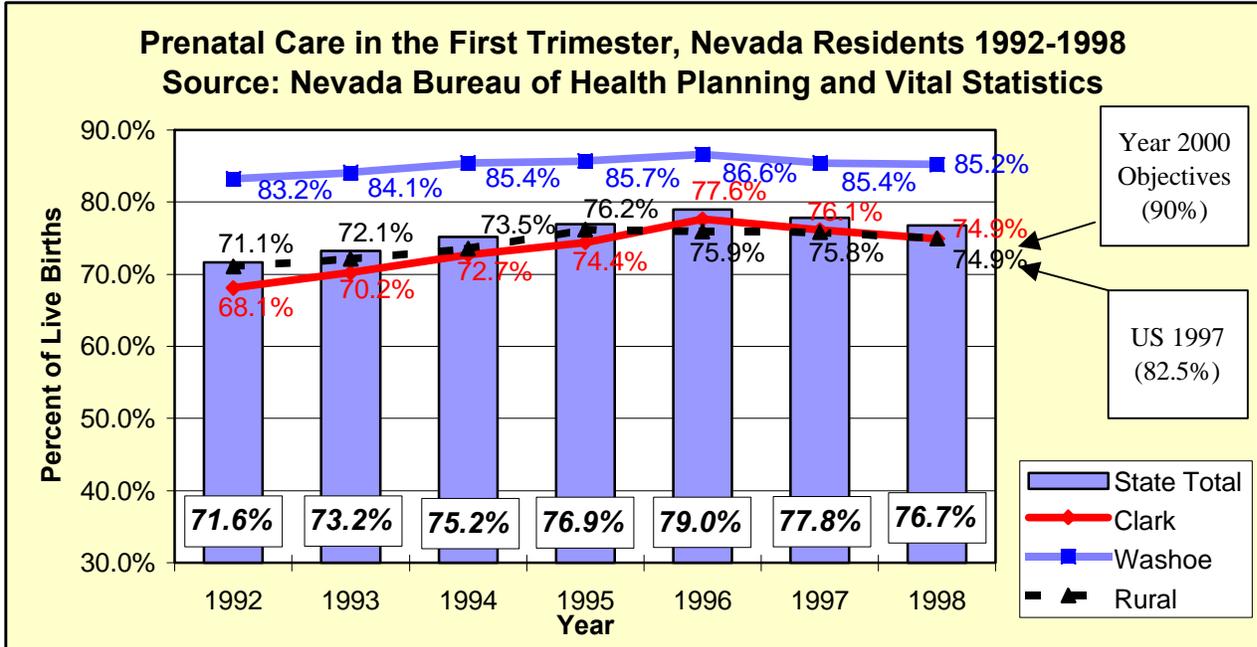
Nevada experienced an increasing birth rate from 1985 to 1990, with a slight increase from 1996-1997, followed by a moderate decrease in the rate through 1998. The crude birth rate for Nevada residents was 15.1 per 1,000 population, while the Hispanic ethnic group had a crude birth rate (36.2 per 1,000 population).

Births by Age of Mother and Race/Ethnicity Nevada Residents, 1998							
Source: Nevada Bureau of Health Planning and Vital Statistics							
Age of Mother	White	Black	Native	AAPI	Hispanic	Unknown/Others	Total
0-14	13	12	0	1	43	3	72
15-17	512	173	27	36	541	13	1,302
18-19	1,087	257	47	85	859	16	2,351
20-24	3,689	692	110	291	2,662	71	7,515
25-29	4,554	520	107	479	2,401	79	8,140
30-34	3,409	338	68	406	1,426	63	5,710
35-39	1,622	129	23	212	565	44	2,595
40-44	308	34	3	56	120	7	528
45+	22	2	0	3	3	1	31
Unknown	8	2	0	1	10	10	31
Total	15,224	2,159	385	1,570	8,630	307	28,275

Births by Age of Mother, Nevada, 1992-1998														
Source: Nevada Bureau of Health Planning and Vital Statistics														
Age of Mother	1992		1993		1994		1995		1996		1997		1998	
	Number	%												
0-14	59	0.26	64	0.28	57	0.24	73	0.29	74	0.28	77	0.29	73	0.25
15-17	976	4.34	1,093	4.81	1,218	5.03	1,241	4.93	1,259	4.83	1,374	5.09	1,310	4.57
18-19	1,756	7.81	1,862	8.20	1,939	8.00	2,110	8.38	2,129	8.18	2,193	8.13	2,384	8.32
20-24	6,507	28.93	6,452	28.41	6,799	28.06	6,740	26.77	6,951	26.69	7,058	26.17	7,613	26.58
25-29	6,692	29.75	6,424	28.29	6,891	28.44	7,151	28.41	7,520	28.88	7,771	28.81	8,243	28.77
30-34	4,497	19.99	4,688	20.64	4,918	20.30	5,217	20.72	5,326	20.45	5,449	20.20	5,791	20.22
35-39	1,681	7.47	1,796	7.91	2,025	8.36	2,171	8.62	2,337	8.97	2,502	9.28	2,632	9.19
40-44	306	1.36	307	1.35	358	1.48	446	1.77	408	1.57	518	1.92	538	1.88
45+	7	0.03	9	0.04	18	0.07	23	0.09	25	0.10	21	0.08	31	0.11
Unknown	12	0.05	16	0.07	3	0.01	3	0.01	12	0.05	8	0.03	32	0.11
Total	22,493	100.00	22,711	100.00	24,226	100.00	25,175	100.00	26,041	100.00	26,971	100.00	28,647	100.00

Pre-natal Care

The rate of prenatal care in the first trimester increased from 71.6% in 1992 to 79% in 1997 followed by a decrease in rates in 1997 (77.8 %) and in 1998 (76.7%). The Hispanic population had the lowest number accessing prenatal care in the first trimester, even though they have the highest crude birth rate.

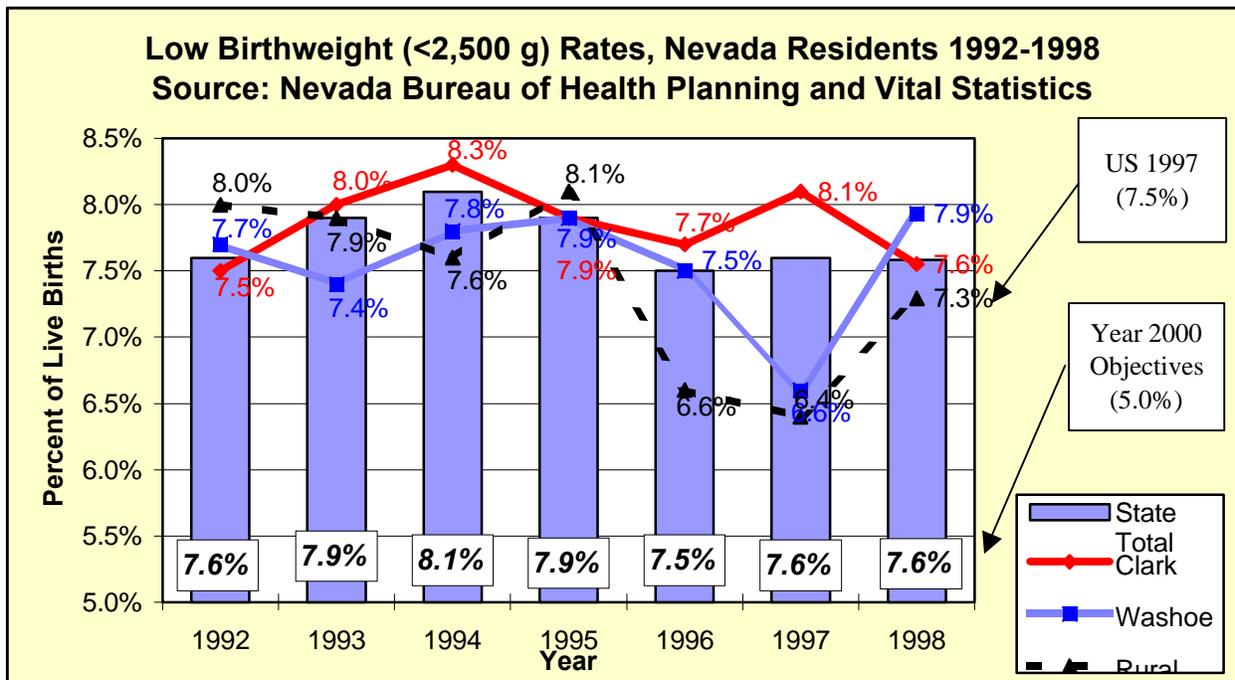


Low Birth Weight

National statistics indicate that in 1997, 291,154 babies (7.5% of all live births) were of low birth weight, weighing less than 2,500 grams, or about 5.5 pounds, at birth. The percentage of low birth weight births rose from a low of 6.8% in 1985 to 7.5% in 1997. Low birth weight increased among white mothers from 6.2% to 6.5%. Although the rate of low birth weight is still more than twice as high among infants born to Black/African American women (13.0%), the rate has been

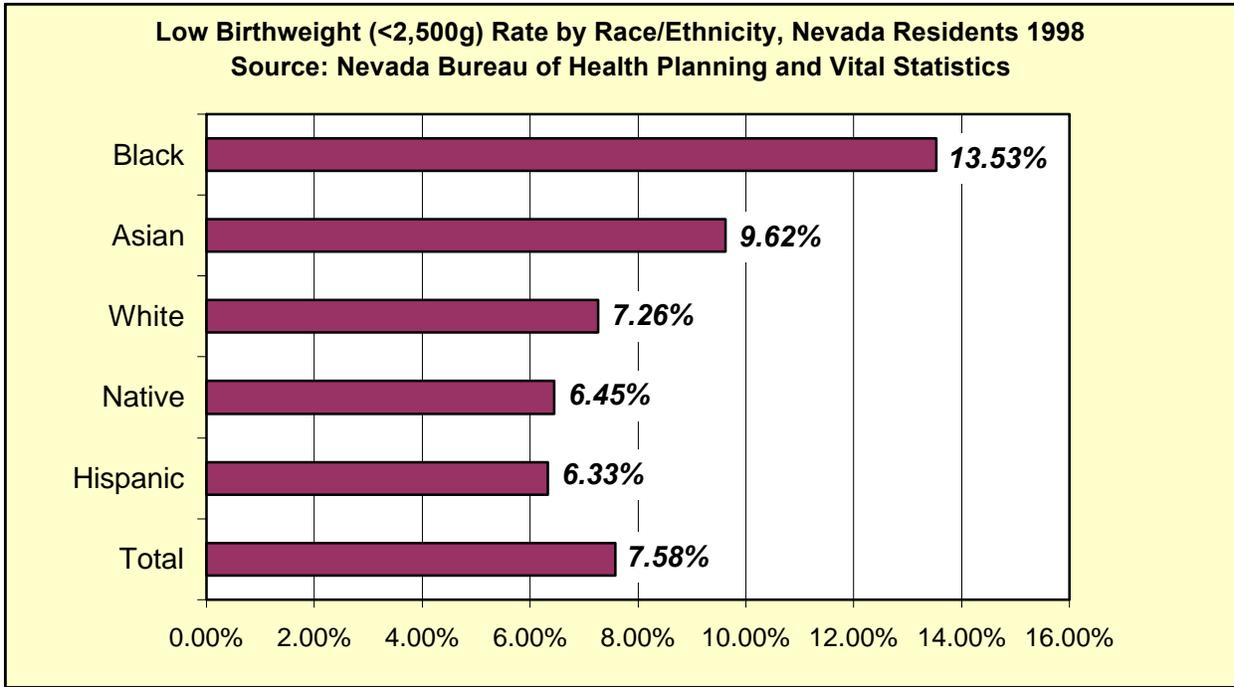
dropping since 1992. Low birth weight is the factor most closely associated with neonatal mortality. Low birth weight infants are more likely to experience long-term disabilities or to die during the first year of life than are infants of normal weight. In 1997, 12.1% of infants born to smokers were of low birth weight, compared with 7.1% of births to nonsmokers. The nearly twofold differential has been observed since 1989 between both Black/African American and white infants. Other factors associated with increased risk of low birth weight include poverty, low level of educational attainment and minority status (Child Health 1999).

In Nevada, the incidence of low birthweight babies was 7.6% in 1998, with no changes from the previous year. Although Blacks/African Americans improved the overall rate from 14.1% in 1997 to 13.5% in 1998, they still had the highest low birthweight rate among race/ethnic groups.



Low Birthweight Percent by Race/Ethnicity Nevada Residents, 1998
Source: Nevada Bureau of Health Planning and Vital Statistics

	White	Black	Native	AAPI	Hispanic	Other/ Unknown	Total
Very Low Birth Weight (<1500g)	166	63	5	26	91	0	351
Adjusted Number	166	63	5	26	91		351
Percent	1.08	2.89	1.28	1.64	1.04		1.24
Low Birth Weight (<2500g)	1,112	294	25	152	550	10	2,143
Adjusted Number	1,117	295	25	153	553		2,143
Percent	7.26	13.53	6.45	9.62	6.33		7.58
Live Births	15,224	2,159	385	1,570	8,630	307	28,275
Adjusted Number	15,204	2,182	380	1,587	8,725		28,275



Teen Pregnancy

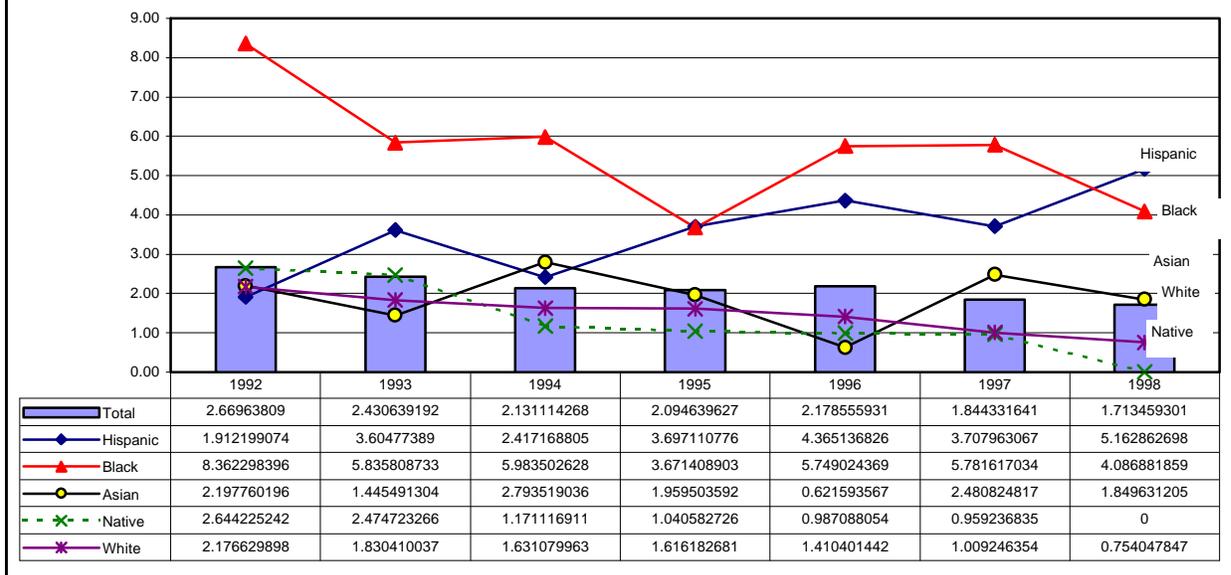
Nationally, Nevada has the highest teenage birthrates between the ages of 15-19. Nevada Vital Statistics reports that teen pregnancy rates in Nevada have been decreasing during the past seven years for all teenage groups (10-14, 15-17, 18-19). According to the Nevada Bureau of Health Planning and Vital Statistics, in 1992 the pregnancy rates were 2.7, 62.4, and 158.9 per 1,000 respectively, while in 1998, the rates decreased to 1.7, 48.7, and 129.8 per 1,000 respectively.

Teen Pregnancy (10-14 yrs) by Race/Ethnicity Nevada Residents, 1998
Source: Nevada Bureau of Health Planning and Vital Statistics

	Hispanic	White	Black	Native	AAPI	Unknown	Total
Live Births	43	13	12	0	1	3	72
Adjusted Number	44.87	13.57	12.52	0.00	1.04		72.00
Rate(1/1000)	4.73	0.30	2.30	0.00	0.58		1.13
Abortion	1	18	7	0	2	8	36
Adjusted Number	1.29	23.14	9.00	0.00	2.57		36.00
Rate(1/1000)	0.14	0.51	1.65	0.00	1.43		0.57
Fetal Death	0	0	1	0	0	0	1
Adjusted Number	0.00	0.00	1.00	0.00	0.00		1.00
Rate(1/1000)	0.00	0.00	0.18	0.00	0.00		0.02
Pregnant	44	31	20	0	3	11	109
Adjusted Number	48.94	34.48	22.24	0.00	3.34		109.00
Rate(1/1000)	5.16	0.75	4.09	0.00	1.85		1.71
Population*	9,479	45,726	5,443	1,162	1,804		63,614

Note: Rates have been adjusted for unknown race/ethnicity. *Age Specific Female Population.

Teen Pregnancy (10-14yrs) by Race/Ethnicity Nevada Residents, 1992-1998
Source: Nevada Bureau of Health Planning and Vital Statistics

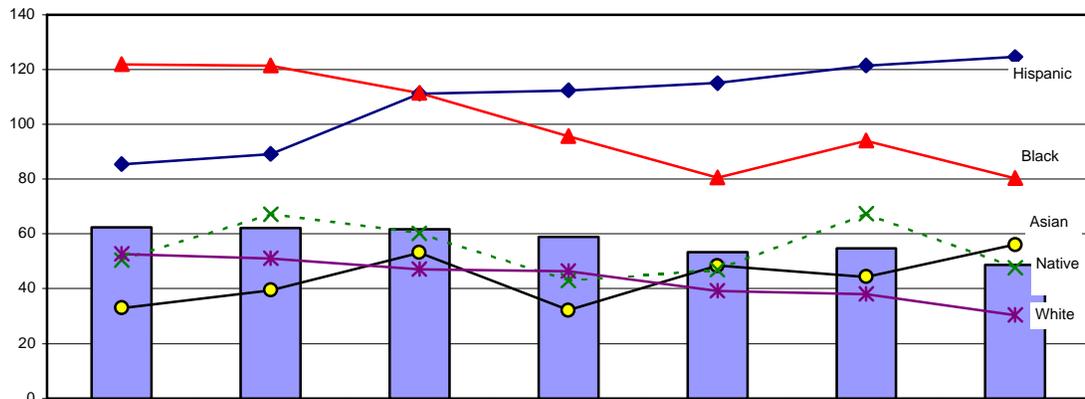


Teen Pregnancy (15-17 yrs) by Race/Ethnicity Nevada Residents, 1998
Source: Nevada Bureau of Health Planning and Vital Statistics

	Hispanic	White	Black	Native	AAPI	Unknown	Total
Live Births	541	512	173	27	36	13	1,302
Adjusted Number	546.46	517.16	174.74	27.27	36.36		1,302.00
Rate(1/1000)	109.93	19.71	58.02	42.61	34.05		36.23
Abortion	23	217	43	1	19	131	434
Adjusted Number	32.94	310.82	61.59	1.43	27.21		434.00
Rate(1/1000)	6.63	11.84	20.45	2.24	25.48		12.08
Fetal Death	4	4	6	0	0		14
Adjusted Number	4.00	4.00	6.00	0.00	0.00		14.00
Rate(1/1000)	0.80	0.15	1.99	0.00	0.00		0.39
Pregnant	568	733	222	28	55	144	1,750
Adjusted Number	618.93	798.72	241.91	30.51	59.93		1,750.00
Rate(1/1000)	124.51	30.44	80.31	47.67	56.12		48.70
Population*	4,971	26,242	3,012	640	1,068		35,933

Note: Rates have been adjusted for unknown race/ethnicity. *Age Specific Female Population.

Teen Pregnancy (15-17 yrs) by Race/Ethnicity Nevada Residents, 1992-1998
Source: Nevada Bureau of Health Planning and Vital Statistics



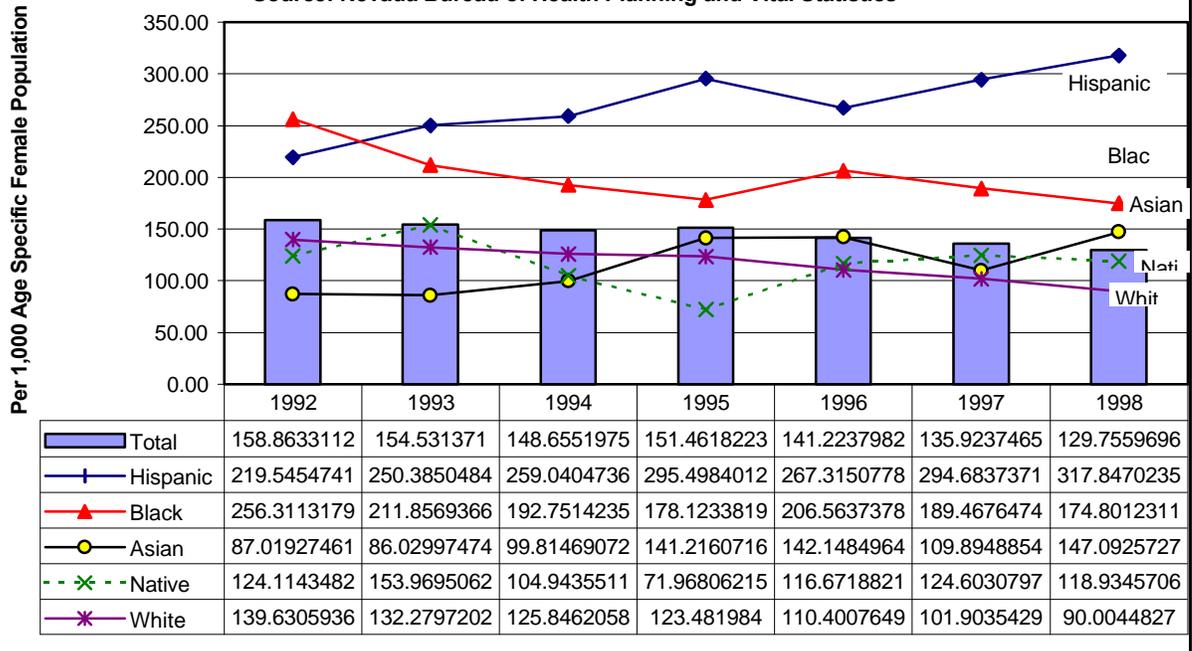
	1992	1993	1994	1995	1996	1997	1998
Total	62.39084876	62.25165563	61.80558171	58.96088733	53.30402189	54.67155038	48.70175048
Hispanic	85.49278983	89.12738603	111.2506656	112.3605901	115.0358128	121.4682406	124.5079493
Black	121.9369691	121.3799269	111.4078668	95.69205003	80.6076664	94.03132995	80.31386285
Asian	32.98521167	39.47619316	53.17499891	32.13631929	48.4091971	44.37318801	56.11564312
Native	50.54043373	67.23367683	60.29393754	42.96093096	46.90786181	67.31996963	47.67278954
White	52.66805741	51.12471775	47.10789561	46.38277679	39.27548032	38.03710916	30.43683929

Teen Pregnancy (18-19 yrs) by Race/Ethnicity Nevada Residents, 1998
Source: Nevada Bureau of Health Planning and Vital Statistics

	Hispanic	White	Black	Native	AAPI	Unknown	Total
Live Births	859	1,087	257	47	85	16	2,351
Adjusted Number	864.89	1,094.45	258.76	47.32	85.58		2,351.00
Rate(1/1000)	285.44	65.39	133.93	112.40	114.72		102.82
Abortion	44	319	60	0	18	166	607
Adjusted Number	60.56	439.08	82.59	0.00	24.78		607.00
Rate(1/1000)	19.99	26.23	42.75	0.00	33.21		26.55
Fetal Death	1	8	0	0	0	0	9
Adjusted Number	1.00	8.00	0.00	0.00	0.00		9.00
Rate(1/1000)	0.33	0.48	0.00	0.00	0.00		0.39
Pregnant	904	1,414	317	47	103	182	2,967
Adjusted Number	963.08	1,506.41	337.72	50.07	109.73		2,967.00
Rate(1/1000)	317.85	90.00	174.80	118.93	147.09		129.76
Population*	3,030	16,737	1,932	421	746		22,866

Note: Rates have been adjusted for unknown race/ethnicity. *Age Specific Female Population.

Teen Pregnancy (18-19 yrs) by Race/Ethnicity Nevada Residents, 1992-1998
Source: Nevada Bureau of Health Planning and Vital Statistics

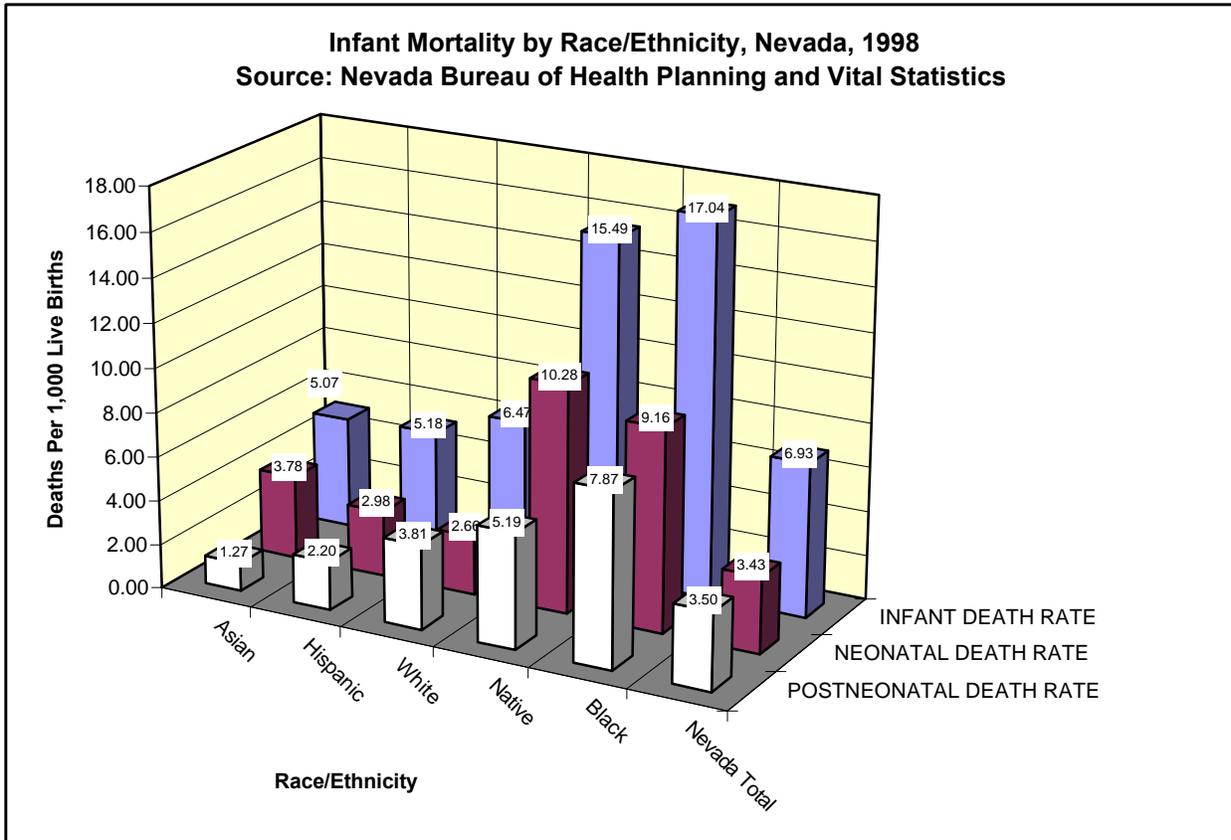
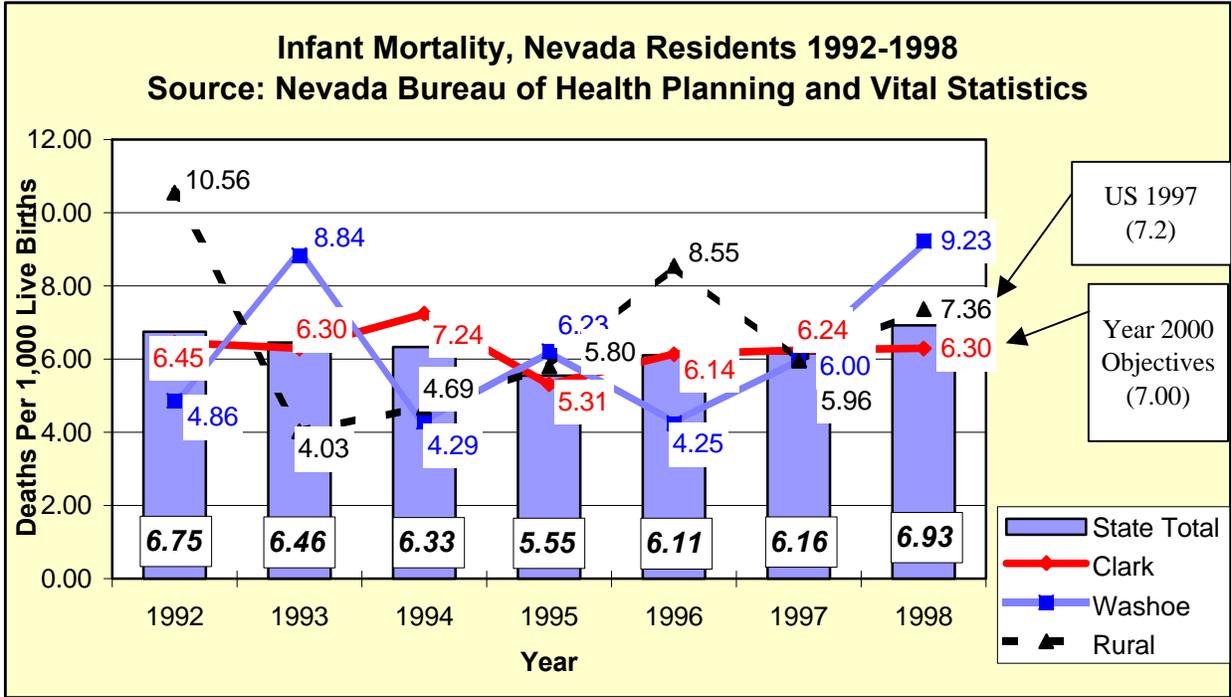


Infant Mortality

In 1998, Nevada's infant mortality rate was 6.9 per 1,000 live births. Although it was below the national year 2000 objectives of 7.0 per 1,000, the rate reversed the trend of decreasing since 1992 and became the highest year in Nevada during the past seven years. Washoe County (from 6.0 to 9.2) as a region and Black/African American (from 13.6 to 17.0) as a race/ethnicity group contributed heavily to this increase in rate. Among the race/ethnicity groups, Blacks/African Americans had the highest infant mortality rate at 17.0, followed by Native American at 15.5, while AAPI had the lowest rate at 5.1 per 1,000 live births.

Infant Mortality by Race/Ethnicity Nevada Residents, 1998							
Source: Nevada Bureau of Health Planning and Vital Statistics							
	White	Black	Native	AAPI	Hispanic	Other/ Unknown	Total
Neonatal	41	20	4	6	26	0	97
Adjusted Number	41.00	20.00	4.00	6.00	26.00		97.00
Rate(1/1,000)	2.66	9.16	10.28	3.78	2.98		3.43
Post Neonatal	58	17	2	2	19	1	99
Adjusted Number	58.59	17.17	2.02	2.02	19.19		99.00
Rate(1/1,000)	3.81	7.87	5.19	1.27	2.20		3.50
Infant	99	37	6	8	45	1	196
Adjusted Number	99.51	37.19	6.03	8.04	45.23		196.00
Rate(1/1,000)	6.47	17.04	15.49	5.07	5.18		6.93
Live Births	15,224	2,159	385	1,570	8,630	307	28,275
Adjusted Number	15,391	2,183	389	1,587	8,725		28,275

Note: Rates has been adjusted for unknown race/ethnicity.



THE WORKGROUP PROCESS

Over a two-month period, each workgroup met separately with SHD staff and the project coordinator in the cities of Reno, Las Vegas, Elko, Fallon, and Winnemucca. They listened to presentations regarding the needs assessment and the particular population the workgroup was asked to focus on; and they discussed and deliberated the status of current, future, and needed services, programs, and initiatives targeting the three MCH populations in Nevada. Among the twelve workgroups, hundreds of priority areas were identified and many themes emerged. These groups stressed their concern time and again about the lack of age-, cultural, and movingly-appropriate services offered by the SHD, State, non-profit, and private agencies around the state, as well as the various health systems. Not only did they define problems, but they also suggested solutions. Each group was given the difficult task of recommending five or six priority areas from the hundreds they suggested for the MCH Needs Assessment; these priorities are where the SHD should focus their efforts for the next five years (2000-2005).

WOMEN AND CHILDREN UNDER THE AGE OF 1

Women and Children < 1 Reno/Sparks, Las Vegas, Winnemucca
<ul style="list-style-type: none">◆ Decrease the incidence of domestic violence among women of child-bearing age and increase education of providers to respond to and treat domestic violence◆ Increase the amount of health education for available for women of child bearing age and their providers◆ Increase healthcare access to diverse medical homes and address financial gaps and insurance barriers to the provider and the child◆ Increase access to mental health services, providers, facilities, resources, and payor sources available in the state to women and children < 1◆ All women of child-bearing age and children < 1 should have access to quality oral/dental healthcare

- ◆ Increase the amount of outreach and other enabling services to women and children < 1

Domestic Violence – Direct Health Care and Population-Based Services

Domestic violence is a health issue of epidemic proportions in the United States. It was carved out of the priority areas as a topic in which health education, mental health, and healthcare access intersect. Domestic violence must be addressed in conjunction with family and child abuse, as well as chemical dependency/abuse. The role of the State is to promote awareness of domestic violence as a public health disease, assist families through the social aspects of domestic violence, and educate the public as a support infrastructure for abused women and children – these are all crucial to addressing this priority area. Provider education regarding recognition and treatment of domestic violence victims and aggressors is also needed in Nevada. The needs assessment recommends universal domestic violence screening for women seeking prenatal care, training of professionals in domestic violence awareness and local resources, better reporting and data sources, and tracking systems for victims are key to addressing this measure.

Studies have suggested that the majority of domestic violence victims do not discuss the violence with anyone. However, many will see a health care provider in some capacity for regular exams, specific health problems, or for the care of children and/or other dependants. Working in conjunction with other systems and domestic violence advocates, health care professionals are in a unique position to respond to victims and their children (FVPF 2000). It is very important to victims of domestic violence that medical records are kept confidential so that insurer discrimination does not occur.

Health Education – Enabling Services

Health education is a very large and multi-disciplinary area to address; it has been extracted from enabling services because of its permeation of nearly all areas of health. Health education for providers and consumers is the key concern. The work groups believe that there is not enough information in various forms (aural, visual, tactile) for the population of Nevada.

Information clearinghouse(s)

There are no comprehensive information clearinghouses in Nevada that persons requiring public health education in the form of brochures, visual, audio, referral, training, etc. can access. Clearing houses specific to different programs exist throughout the state, but there is no communication between these offices or a centralized location for public access. The needs assessment recommends a comprehensive clearinghouse location be established, with outreach provided to the public on how to access the information.

Pre- and Post-natal care

For young women and new mothers, information regarding pre- and post-natal care, pregnancy, baby care, developmental milestones, fetal alcohol syndrome, and fetal alcohol effects are of primary concern. Nevada must increase the number of women who access early pre-natal care. According to a recent evaluation of the Baby Your Baby (BYB) campaign, the most common reasons for women not accessing pre-natal care sooner were that they did not perceive any complications in their pregnancy, were afraid, had no money or insurance, did not know they were pregnant, and/or did not know where to get pre-natal care (SHD 2000). The most common concern among BYB providers was that they are not receiving timely compensation for the services they give to the BYB consumers.

There are a few successful pre-natal programs in Nevada that may serve as templates for other rural, frontier, or urban areas. For example, the Fallon Tribal Health Center has an innovative pre-natal program: a shared baby shower and birthing program with the local hospital. BYB is successful at helping pregnant women access pre-natal care; however additional contracts to rural areas for BYB providers are needed.

The needs assessment recommends that the State address the gap of services between hospital and home for new mothers. There should be a balance created between the two

educational services to ensure a healthy pregnancy and child, because pre-natal care lasts nine months or less, but raising a child takes years. Teens and teenage parents need additional help in learning to raise their children and future children; the needs assessment recommends that child-nurturing classes in the schools be taught within the health curriculum and mandated by the Department of Education for all students.

Healthcare Access – Direct Health Care and Population-Based Services

Healthcare access is addressed within three areas: medical homes, provider availability, and financial access.

Medical Homes

Increased healthcare access to diverse types of medical homes and addressing financial gaps and insurance barriers to the provider and child is a priority that touches all three MCH populations. Providing access in non-traditional places is an innovative means of creating access to those populations who rarely use traditional forms of medical homes. Diversity in population means diversity in need. The needs assessment recommends that differences among the health needs of the growing ethnic populations of Nevada can be best addressed by the creation of a Minority Health Office which would assist CBOs in providing outreach to diverse populations. Cultural competency is core to addressing the growing needs of the different populations and developing diverse medical homes. The State must make great strides in providing culturally competent care to all of its populations, whether age-, medical-, or ethnic-related.

Additional providers

There is an intrinsic need for additional healthcare practitioners in the State. The need spans from primary care to specialists especially in the area of pediatrics. In Nevada the difficulty with recruiting physicians are the medical and dental licensing boards, which are some of the most difficult in the nation, and the lack of desire by practitioners to practice

in rural and frontier areas. For pre-natal care, BYB has been a successful initiative, however, recruitment of rural providers and retention of urban providers continues to need to be addressed to provide mothers with a central source to accessing pre-natal care.

Financial barriers

Barriers for why women do not access prenatal care early are: payment for additional tests during pregnancy, and difficulty in Medicaid enrollment. There is a strong need to not only educate women to enroll in Medicaid and health insurance early, but also to provide assistance with the process. According to a recent evaluation of the BYB Campaign, 30% of women cited no money or insurance as one of the most common reasons for not getting pre-natal care sooner (BYB 2000).

Mental Health –Population-Based Services

There is a lack of mental health focus and services in Nevada among the three MCH populations. It is the recommendation of the needs assessment that resources must first be developed and then provider and consumer education regarding diagnosis, treatment, and use of services may ensue. The legislature must address the inadequacy of this area of health and delineate financial resources to tackle the lack of appropriate services.

Oral/Dental Health – Population-Based Services

Oral/dental health is another need in Nevada and nationally, clearly evidenced by the May 2000 Surgeon General's Report on Oral Health. Among women and children under age one, the American Academy of Periodontology and several seminal studies have indicated that periodontal diseases represent a previously unrecognized and clinically significant risk factor for low birth weight as a consequence of either preterm labor or preterm premature rupture of membranes (Offenbacher, Katz, Fertik, et. al., 1996). This priority area is discussed more in depth for all MCH populations on pages 74 and 116 and below.

Dental home access and barriers

Low-income women and children have trouble accessing providers who will take fee for service (FFS), Medicaid, or uninsured clients. According to a recent General Accounting Office report, national survey data showed that in 1996 poor children and adults across the United States visited the dentist at about half the rate of their higher-income counterparts – numbers that have stayed relatively unchanged since 1977 (GAO 2000). Additional barriers to finding a dental home are the strict Nevada Board of Dental Examiners' guidelines which are not friendly to those persons who would like to practice in Nevada.

Outreach – Enabling and Population-Based Services

Outreach is placed within enabling and population-based services in the MCH services pyramid. Enabling services include: transportation, translation, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC, and education. Population-based services include: newborn screening, lead screening, immunization, Sudden Infant Death Syndrome (SIDs), counseling, oral health, injury prevention, nutrition, and outreach/public education. It is the recommendation of the needs assessment that there is need for additional outreach for the homeless and pregnant women, runaway children, battered women and their children, and undocumented persons. The State can best address these problems by increasing social services to homeless, battered women, and runaway shelters. Rural communities stress the importance of direct and frequent communication with the State regarding infrastructure building, e.g., needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring training, applied research, development of systems of care, and development of information systems.

CHILDREN AGES 1-9

Children 1-9 Reno/Sparks, Las Vegas, Fallon
<ul style="list-style-type: none">◆ Increase the amount of innovative educational programs targeting behavior modification in children 1-9◆ Increase healthcare access to diverse medical homes, address financial gaps and insurance barriers to the provider and the child◆ Increase the amount of outreach and other enabling services to children 1-9◆ Increase access to mental health services, providers, facilities, resources, payor sources, and social services to children 1-9◆ All children 1-9 should have access to quality oral/ dental healthcare

Innovative Educational Programs Targeting Behavior Modification – Enabling and Population-Based Services

Health education among children ages 1-9 was taken a step farther than pamphlets and lectures to include preventive education. It is recommended that behavior modification methodology (definition – behavior change through effective prevention education techniques, these are meant to be used over a lifetime and incorporated before bad habits set in) within this age group is the most recent and effective technique of incorporating preventive instructions and interventions in their daily lives. Educating parents and schoolteachers to reinforce prevention practices is the key to behavior modification. It is the recommendation of the needs assessment that elementary school health classes, provider, and parents utilize behavior modification tools to address disease prevention, safety, violence, physical activity and nutrition, drug and alcohol abuse, etc. A means of increasing preventive education for parents and children is to target them in places where they are often together. Group education versus one-on-one education is a means of promoting prevention practices among the entire family, and providing for continual reinforcement of behaviors. Nevada also has a need for additional entities to provide education to parents, not only the health care agencies. Partnerships between managed care organizations, hospitals, and

state/county agencies need to be strengthened to provide population-based services. Non-traditional partners such as churches and private employers need to see the value of becoming partners to better meet the needs of the State as a whole.

Healthcare Access and Financial Barriers – Direct Health Care and Enabling Services

As was said above, increased healthcare access to diverse types of medical homes and addressing financial gaps and insurance barriers to the provider and child is a priority area that touches all of the three MCH populations. Increasing the percentage of children in the state who have medical homes continues to be a priority as it has been in the past. The need for school-based health centers in Nevada has become a pressing one as certain behaviors and practices among our children and teens become more prevalent, i.e., lowered age of sexual introduction, violence, teen pregnancy, etc. It is the recommendation of the needs assessment that the State address conservative attitudes thwarting the introduction of school-based health centers in Nevada elementary and high schools. One of the best ways to address the lack of medical homes and health insurance barriers for children and teens is to put one in their schools (Kaplan, Brindis, et. al. 1999). The Kaplan and Brindis study concluded that independent of insurance status and other confounding variables, underserved minority children with school-based health center access have better healthcare access and use than children without school-based health center access, signifying that school-based health centers can be an effective component of health delivery systems for these children. The recommendation of the needs assessment is to conduct a pilot study for school-based health centers in various communities.

The Balanced Budget Act of 1997, Medicaid, Nevada 3Check Up, and Covering Kids

The Balanced Budget Act of 1997 enacted the State Children's Health Insurance Programs (SCHIP). At the time, it was hoped that these programs would substantially improve access to and use of primary care by children (NEJM 1998). Authorization of this program reflected a growing appreciation of the role of health insurance in determining children's

access to needed health care (Newacheck et. al., 1998). Numerous studies have demonstrated that children's insurance status is an independent predictor of their use of health care. Uninsured children have fewer visits to physicians than their insured counterparts (Wood et. al. 1990, Holl et. al. 1995, Currie and Gruber 1996), and they are more likely than insured children to go without any contact with a physician in a given year (Holl et. al 1995, Kogan et. al. 1995, Aday et. al. 1993, Lieu et. al 1992, Newacheck 1992), to receive inadequate prevention services (Mustin et. al. 1988, Ettner 1996), and to be without a usual source of health care (Holl et. al 1995, Lieu et. al. 1992, Newacheck et. al. 1996). They are also less likely than insured children to be seen by physicians when they have symptoms of a variety of illnesses for which office visits are warranted (Stoddard et. al. 1994).

Poor children with Medicaid coverage were more likely than those without Medicaid to have a usual source of primary care and to receive primary care within an appropriate time interval. However poor children with Medicaid were less likely than children living above the poverty line to receive primary care in physician's offices and more likely to lack continuity of care between usual sources of primary and sick care. Children receiving primary care at community clinics compared with children receiving care at physician's offices were more likely to receive sick care at a different location than where they receive primary care and also more likely to identify and emergency department as their usual source of sick care. While Medicaid does improve access to care for poor children, it does not ensure them access to the same locations and continuity of care as that available to other children. Recent changes in the Medicaid program may address some of these inequities, but others are likely to remain. Medicaid is associated with improvements in access to care and use of services. However, there remains room for improvement when Medicaid is judged against private health insurance. The Balanced Budget Act of 1997 contains several Medicaid provisions that could stimulate further improvements in access to care for poor children (St. Peter et. al. 1992, Newacheck et. al 1998).

Nevada 3Check Up is Nevada's answer to the SCHIP. In 1998, the Federal government provided funding to Nevada for 43,000 children to have health insurance. Estimation of the number of uninsured children in the state is approximately 112,000. This information comes from a study based on 1999 data funded by the Great Basin Primary Care Association, *Nevada-Specific Estimates of the Uninsured*. According to the Bureau of Health Planning and Vital Statistics, today there are approximately 634,500 children (ages 0-21, including number of CSHCN) in the state. If 112,000 children are uninsured, then 17.65% of Nevada's children have no form of health coverage. To aid in its recruitment of children into Nevada 3Check Up, the State uses a study by the Urban Institute, the American Association of Retired Persons, and Families USA that shows approximately 27,000 uninsured children in Nevada. According to the Nevada 3Check Up Program, only 17,000 of these children were eligible.

Data from a study done by the University of Nevada-Las Vegas in 1997 showed that 19.6% of children under 18 were not covered by any private or public health insurance. The number of children under 18 was obtained from the Bureau of Health Planning and Vital Statistics. This is the same data source that has been used the past three years to determine need. The Nevada Insurance Commission does not keep data on this subject.

By May 1, 2000, Nevada 3Check Up enrolled 10,000 children in the program and they received health services. By June 1, 2000, Nevada 3Check Up had 11,164 children enrolled and receiving health services. According to a memorandum recently released by the Health Resources and Services Administration (HRSA), as of May 31, 2000, thirteen states are not fulfilling the statutory requirement for supporting outstationed eligibility workers (OEWs) in Federally Qualified Health Centers (FQHCs) to facilitate SCHIP and Medicaid enrollment. Nevada is one of the thirteen states. OEWs are a key component in maximizing enrollment in SCHIP, Medicaid, and other public assistance programs; however, survey results at HRSA indicate that despite the guidance articulated in the 1990 Federal Law [42 U.S.C. 1396a(a)(55)], many states are not providing the required fiscal support for OEWs in FQHCs.

Covering Kids was established in May 1998 to assist in enrolling children into Nevada 3Check Up by establishing community based coalitions. To date, coalitions have been established for the rural areas of the State as a whole, and in the north, south. The process has been slow and according to data from Nevada 3Check Up, Covering Kids has assisted in enrolling only 17 of the 52 referrals from May 1999 to May 2000. This knowledge begs the question of whether the enrollment process, the providers, the parents, or Nevada 3Check Up is the barrier.

It is the suggestion of the needs assessment that enrollment forms and eligibility rules be reassessed to increase the recruitment and retention of children eligible for Medicaid or Nevada 3Check Up.

Outreach – Enabling and Population-Based Services

Outreach and enabling services for children addressed in the needs assessment are tied to health education, health access and insurance barriers, and other support services. It is the recommendation of the needs assessment that a promotion of collaborative agency, school, and parent task forces and coalitions that address the need for particular types of health education in the schools should be created over the next five years. Coalitions can increase education to parents regarding Medicaid changes and HMO services available for children, develop simpler/easier curricula, brochures, handbooks, etc. that will empower parents to seek the necessary care for their children, expand existing programs – health, education, social services, etc., and increase preventive education. Preventive education for parents of young children includes: parental knowledge of knowing “when” to take your child/ren to the physician, parent education to have their child/ren assessed for developmental milestones, and promoting increased interaction between the child, parent, and child care provider. Special care to educate the teen, transient, homeless, and/or Temporary Assistance to Needy Families (TANF) parent(s) regarding medical and physician access is important to the retention of children enrolled in Medicaid or Nevada 3Check Up. The needs assessment recommends that outreach must be extended to children who are not enrolled in schools, especially the homeless and transient populations.

Nutrition

Health education focusing on nutrition is key to reducing the proportion of overweight children, those with eating disorders, and promoting proper nutrition habits. Multiple issues regarding good nutrition in our schools can be resolved by extending lunch times; most are too short to promote good nutrition habits. Schools have decreased lunch periods, as well as decreased recess periods to keep children from “getting into trouble,” however the backlash is poor nutrition and lack of physical fitness. It is the recommendation of the needs assessment that dietician and parent-led coalition groups address the lack of nutrient-rich foods in the lunch programs, as well as the lack of recess and appropriate physical education programs in our schools. Nevada has several initiatives addressing nutrition among young children; e.g. the University of Nevada School of Medicine, Pediatrics Department – Las Vegas has received a grant to address overweight children, Head Start, and the WIC program at the SHD.

Cultural competency in nutrition is a rarely discussed topic in our public schools. Introducing different types of foods is a means of educating about different cultures, as well as, teaching our children to become more global in perspective and diverse in their food choices. In addition, there is a growing problem of obese children in the Native American communities. Proper nutrition as a means of prevention is a key to addressing this problem.

Physical education

Good nutrition and physical education go hand in hand. According to the workgroups, parents, and other agencies, the opportunity for physical activity for children has decreased over the years. In addition, elementary, middle school, and high school physical education classes make participation optional. It is the recommendation of the needs assessment that the State address the need for better and required physical education

classes, increase the opportunities for physical activity for all children, and promote school health among all schools in Nevada.

Sex education

There is a tremendous need for abstinence and sex education in our elementary schools. Urban and rural school districts in Nevada have little or no sex education. According to the Governor's Youth Advisory Council (YAC), the SHD Abstinence Works program has had some measurable success at reaching young children. An evaluation component that tests young people's retention of the concepts conveyed during the Abstinence Works curriculum is distributed the day after the program. Educational efforts and programs like Abstinence Works are essential to promoting preventive life skills to young people across the state.

Safety education

According to a recent report from the Nevada Department of Motor Vehicles and Public Safety, Office of Traffic Safety, from 1996 to 1998 children who could not drive (ages 0-14) represented approximately 7.4% of the population, but 4.6% of the fatalities in the state. The needs assessment recommends identification and/or creation of programs that increase the use of safety belts and the correct installation of car seats directed at parents for children be made available around the state. Continuous support of ongoing media campaigns targeting drinking and driving are important to safety education. It is important to note that safety education goes beyond motor vehicle accidents and incorporates other forms of preventable injury, the BFHS is beginning to focus on injuries and will provide health education on this subject.

Self-esteem

Children ages 1-9 are in need of self-esteem programs. This is evidenced by parents and social service agencies who attended the work groups. These programs should provide age-appropriate educational efforts, as well as good role models for children this age. Promotion of critical thinking skills and assisting in goal formation and achievement of those goals at this age level allows children to develop skills that will last them a lifetime. Self-esteem in young children of ethnic descent is another important initiative. It is the recommendation of the needs assessment that efforts that focus on immigrant, refugee, first-generation, and/or children of minority descent will require the assistance of ethnic CBOs and building up self-esteem in the adult populations as well. Various templates around the nation exist to address the concerns of minority children, who not only have the problems of this particular age group, but the problems faced by their ethnicity as well. Addressing self-esteem in young people is a means of preventing future medical or social problems.

Mental Health and Social Services –Population-Based Services

Mental health disorders are as real, common, and treatable in children as they are in adults. The Federal Center for Mental Health Services (CMHS) estimates that as many as one in five children will experience a diagnosable mental, emotional, or behavioral disorder before the age of eighteen. One in ten may actually have a serious emotional disturbance so severe it disrupts a child's ability to function socially, academically, or emotionally. Left untreated, childhood mental disorders can lead to school failure, substance abuse, and involvement with the juvenile justice system or even suicide. Tragically, nearly two-thirds of the children and adolescents with mental health problems do not receive the care they need. Children and families in need of mental health services often

encounter several barriers, including a lack of accessible services, underfunded public health systems, and stigma. Insurance plans, HMOs, and Medicaid also pose barriers to children who need help, often offering little or no mental health benefit or not covering long-term or more complex problems. Many families end up trapped between the public and private health sectors, leaving an estimated 11 million children and adolescents uninsured and often untreated. Healthcare providers can be a part of the solution, because they are often a family's gateway to health and medical information (NMHA 2000).

For example, services for Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE) children, who have multiple mental and physical disabilities, need providers who can properly diagnose and treat FAS/FAE children and services that fit the symptoms of FAS/FAE once diagnosis is complete are completely lacking.

Treatment for child abuse and maltreatment victims is lacking in Nevada as well. There is a strong need for preventive education directed at parents and childcare givers regarding child abuse. Provider education showing the correlation between the incidence of domestic violence and child abuse will enable caregivers to recognize that in situations of domestic violence, the children may be abused as well. The strain on social services regarding current and future caseloads is predictable; it is the recommendation of the needs assessment to educate and train medical health care professionals to recognize domestic violence and child abuse cases to assist social services. Hotlines, safehouses, and shelters could serve as triage for victims of violence and/or abuse and refer their clients to health care professionals who in turn refer to social services.

Attention Deficit Hyperactivity Disorder (ADHD) has been in the news lately with much speculation surrounding the over diagnosis of such cases. More research needs to be done to address the growing needs of Nevada's ADHD children, whether correctly or incorrectly diagnosed.

The lack of and the need for anger management within children is an often discussed topic as well, and needs to be addressed by providing appropriate mental health services to these children to educate them, as well as, protect them from harming themselves and others. Conflict resolution skills taught to current and future educators, parents, and children are a means of preventing violence in our homes and schools.

Oral/ Dental Health – Population-Based Services

Throughout the needs assessment process, the findings regarding oral/dental health have been similar for all age groups in the MCH population. The needs assessment recommends that these oral/dental health areas be addressed for all populations:

- ◆ Address the stringent requirements of the Nevada Dental Board for out-of-state dentists who want to practice in Nevada
- ◆ Increase funding to recruit and retain more oral/dental health services and providers
- ◆ Use the dental programs in Reno and Las Vegas to provide pro bono, fee for service, reduced fee services (hygienists, future dental school, dental van, etc.)
- ◆ The dental programs should be more active in the rural areas
- ◆ Address the need for more dental health education brochures, speakers, preventive education classes, etc. for school age children
- ◆ Address the lack of dental providers who accept Medicaid patients, or only accept a few Medicaid recipients per year
- ◆ Address the need for population preventive measures – examples, health education efforts, fluoride in drinking water, sealants for school age children, etc.

ADOLESCENTS AGES 10-21

Adolescents 10-21

Reno, Las Vegas, Fallon, Governor's Youth Advisory Council

- ◆ Increase the amount of innovative programs that address self-esteem in adolescents 10-21
- ◆ Increase the amount of health education classes available to adolescents 10-21, especially age and grade appropriate sex and abstinence education
- ◆ Increase the amount of parental involvement in the lives of adolescents 10-21
- ◆ Reduce the incidence of violence among adolescents 10-21
- ◆ Reduce the incidence of substance abuse among adolescents 10-21
- ◆ Reduce deaths and injuries caused by alcohol and drug- related motor vehicle crashes among adolescents 10-21

The Centers for Disease Control and Prevention (CDC) compiles data from State Youth Risk Behavior Surveys every year; in 1999, the six leading causes of death and disease among youth were:

1. Behaviors that result in unintentional or intentional injuries
2. Tobacco use
3. Alcohol and drug use
4. Sexual behaviors that result in HIV infection, other sexually transmitted diseases (STDs), and unintentional pregnancies
5. Dietary behaviors
6. Physical inactivity

These risk areas were discussed thoroughly throughout the needs assessment process, with recommendations to the State to expand its Child and Adolescent Program activities and increase participation from other state agencies, CBOs.

Self-Esteem – Population-Based Services

During the workgroups, advisory boards, and survey research, a general theme from the groups was raised regarding the need to raise youth self-esteem, and general mental health. With the advent of violent situations like Columbine, other school shootings around the nation, and the Oklahoma City bombing, parents, educators, health care providers, service providers, etc. are concerned about the mental well-being of our youth. Mental status affects everything one does, despite age. As these young people are experiencing and dealing with their biological changes and the revolutionary changes in the world they live in, they are mentally unprepared to deal with all the transformation going on around them. As a people, we have allowed the status quo of adolescence to perpetuate, and we do not address the needs of our youth as a community, state, or nation unless something atypical happens, i.e., the recent uprising of school shootings. Similar to most problems, we medicate to heal, instead of uncovering the problem and educating ourselves and others to prevent it from happening again.

There are very few survey methodologies that ask measurable questions about self-esteem. For example, the Nevada Youth Risk Behavior Survey does a very good job measuring behaviors that result in unintentional and intentional injuries, tobacco use, alcohol and other drug use, sexual behaviors and health related outcomes, dietary behaviors, and physical activity. However, the questions only measure health behavior, not the motives behind young people's health behavior. Mental health professionals using the Diagnostic and Statistical Manual of Mental Disorders (DSM) survey methodology can measure mental health status; however this data is typically confidential, therefore, we have little population-specific data for the mental health of our youth. A prerequisite for effective responsiveness to a problem is understanding. Threats to the health and well-being of young people in the past generation have shifted from primarily biological etiologies to a far more complex, interweave of sociological, psychological, and biological factors. Simultaneously it is clear that the promotion of adolescent health and the successful reduction of health-compromising behaviors best emanate from community-based, developmentally and culturally grounded interventions buttressed by the appropriate flow of both encouragement and material resources from national levels (Resnick 1996). For communities to respond to shifting

and often complex sources of threat to the health and well-being of young people, they must be provided with valid, timely data that allow them to identify, prioritize, mobilize, and act upon urgent health and social issues. A powerful source of such data is the periodic assessment of the adolescent population (Resnick 1996).

The importance of good mental health is indicated in studies coming from the University of Minnesota. A sense of spirituality, as well as low family stress (referring to poverty, unemployment, substance use, and domestic violence) function as protective factors. Measures of caring and connectedness surpassed demographic variables such as two parent versus single parent family structure as protective factors against high risk behaviors. Interventions for at-risk youth must critically examine the ways in which opportunities for a sense of belonging may be fostered, particularly among youth who do not report any significant caring relationship in their lives with adults (Resnick et. al. 1993). Studies regarding adolescents with chronic conditions show that they typically do less well than adolescents without chronic conditions; however having a disability is not the most influential factor on emotional well-being. Family-connectedness is of fundamental importance for adolescent's emotional health (Wolman et.al 1994).

Nevada has little to no Nevada-specific research regarding its youth. The needs assessment recommends that the State undertake research studies, both long and short-term cohort studies, to address the needs of all of its MCH populations. There is an obvious need for Nevada-specific research, and collaborative partners can produce vital, seminal studies to address the health of the adolescent population. The needs assessment has uncovered multiple issues facing Nevada youth, and if addressed can help generate innovative, preventive programs to which youth would be more receptive. Many of these suggestions came from the Governor's Youth Advisory Council:

Future concept

- ◆ Address the problems youth have regarding no future concept and the sense of hopelessness regarding their future
- ◆ Assist youth in future planning
- ◆ Address the reasons why youth believe there is no value to life

- ◆ Address the reasons youth believe that they will not grow old
- ◆ Address the concept of invincibility

Self-control

- ◆ Address paranoia that youth have about their selves, peers, etc.
- ◆ Address low self-esteem in youth
- ◆ Address control issues in youth – wanting to control situations, people, or things around them, as well as self-control

Respect

- ◆ Youth want respect from peers and adults – create programs that involve youth and parents and promote respect
- ◆ Create programs that educate adults on how to really listen to kids
- ◆ Promote programs that cultivate learning about the different cultural beliefs of our youth and how they use these beliefs to deal with problems
- ◆ Promote programs that help youth deal with death and dying
- ◆ Promote programs that discuss loyalty
- ◆ Promote peace rallies in schools

Sadness

- ◆ Create youth hotlines that address multiple issues
- ◆ Reduce the proportion of children and youth with disabilities who are reported to be sad, unhappy, or depressed
- ◆ Encourage youth to seek help if they are sad, and educate parents, teachers, etc. to recognize signs of sadness

Violence

- ◆ Promote school violence awareness
- ◆ Encourage discussion about violence and educate students to recognize signs of violent, or aberrant behavior

The needs assessment uncovered many innovative solutions and programs that can begin to address the needs of our Nevada youth and raising their self-esteem. These solutions may not all be new, but they do need to occur in higher frequency:

- ◆ Encourage extracurricular activities
- ◆ Need for positive role models
- ◆ Teach self-determination
- ◆ Need for a holistic approach that includes spirituality, harmony, well-being, etc. in addressing youth and family needs
- ◆ Address acculturation issues

Health Education – Enabling and Population-Based Services

Part of Nevada’s health education efforts includes the Governor’s Youth Advisory Council (YAC). The YAC was established in March 1996 to advise the Governor, SHD, and other agencies on issues of concern to Nevada’s youth. The YAC is a diverse mix of students across Nevada representing both urban, frontier, and rural populations, as well as varying levels of high school and college education. This vocal group has an advocacy and health education group that speaks to young children about abstinence, called Abstinence Works. They speak mainly to younger groups because they are the targeted audience for abstinence and delaying onset of sexual activity. The YAC articulated many issues that need to be addressed within the school system, citing examples that not only impact high school students, but grade and middle school students as well. The following examples are their primary concerns, and the prevalence data comes from the 1999 Nevada Youth Risk Behavior Survey (YRBS):

Sex education

- ◆ Increase the amount of school health education, targeting preventive behaviors
- ◆ Increase the amount of education for abstinence and sex, birth control, sexually transmitted diseases/infections, and sexual responsibility in the middle and high schools
- ◆ Address the needs of teenagers who do get pregnant and promote responsibility to teen parents – In 1998, Nevada had the highest teen pregnancy rate in the nation (now 4th).
- ◆ Reduce the teen pregnancy rate for females aged 15-19
- ◆ Reduce the number of cases of HIV infection among adolescents and young adults
- ◆ Reduce the proportion of young people with chlamydia trachomatis infections

In 1999, 51% of Nevada high school students had sexual intercourse at least once in their life, an 8.5% increase over 1997. 7% of students report that they had sexual intercourse for the first time before the age of 13, and 37% had sexual intercourse in the past three months. The proportion of sexually active youth who abstained from sexual activity during the past three months (28%) remained unchanged since 1995. Among students who have had sexual intercourse, only 15% indicated that neither they nor their partners used any method of birth control the last time they had sexual intercourse, a 10% improvement over 1997 and a move toward the goal of 90% use of contraception. However, 7.5% of students reported that they have been pregnant or have gotten someone pregnant, a 25% increase from 1997 (NV YRBS 1999).

Nutrition, obesity, and physical activity

- ◆ There is a need for any type of preventive health education in the schools
- ◆ Teens would like general education regarding the characteristics of adolescence
- ◆ Programs need to be created to address obesity, and to reduce the proportion of children and adolescents who are overweight or obese
- ◆ Increase the proportion of young persons who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion

Approximately 13% of high school students are at risk for becoming overweight and roughly 6% are overweight according to calculations of body mass index from self-reported height and weight (NV YRBS 1999). The prevalence of overweight adolescents more than doubled from 5% in the late 1970s to 11% between 1988 and 1994 (Troiano 1998). Obesity acquired during childhood or adolescence may persist into adulthood, increasing later risk for chronic conditions such as diabetes, heart disease, high blood pressure, stroke, some types of cancer, and gall bladder disease (PHS 1988). In addition, children and adolescents often experience social and psychological stress related to obesity (Rotatori and Fox 1989). Obesity in adolescence has been related to adverse psychological and social consequences (Dietz 1998). Studies have shown high rates of body dissatisfaction and dieting among adolescent females with many engaging in unhealthy weight control behaviors, such as fasting, and self-induced vomiting (French and Jeffery 1994, Serdula, et. al., 1993, Story, et. a, 1993, and Whitaker, et. al., 1989). The following data are from the Nevada 1999 YRBS:

- ◆ 13% of Nevada high school students are at risk for becoming overweight based on calculations of body mass index from self-reported height and weight
- ◆ More than half of Nevada high school students (56%) felt they were about the right weight
- ◆ 42% of Nevada high school students were trying to lose weight, and 18% were trying to gain weight
- ◆ During the 30 days preceding the survey, well over half (61%) of Nevada high school students exercised to lose weight or to keep from gaining weight
- ◆ During the 30 days preceding the survey, 12% of Nevada high school students went without eating for 24 hours or more to lose weight or to keep from gaining weight

Suicide

Nationally, suicide is the third leading cause of death among youth aged 15-24 and the second leading cause of death among white males in that age group (NCHS 1995). Since 1950, the suicide rate for persons aged 15-24 has tripled (NCHS 1995, DHHS 1994). Attempted

suicide is also considered a lethal health event; it is a proven risk factor for future completed suicide and a potential indicator of other health problems such as substance abuse and depression (ADAMHA 1989). Nevada's suicide rate for youth aged 15-19 ranged from 15.4-22.1 per 100,000 during 1981-1991 (NV YRBS 1999). In any given year, the state's suicide rate for this age group was between 1.5-2.4 times the national rate, leading to consistent annual ranking among the top ten states with the highest rates of teen suicide (Quon 1995). The rate of attempted suicide by Nevada teens also is twice the national average (LA Times 1994). The following statistics are from the Nevada 1999 YRBS:

- ◆ During the 12 months prior to the survey, 28% of Nevada high school students felt so sad and hopeless almost every day for two weeks in a row that they stopped doing some usual activities
- ◆ 20% of Nevada high school students seriously considered attempting suicide during the year prior to the survey
- ◆ During the year prior to the survey, 16% of Nevada high school students made a plan about how they would attempt suicide
- ◆ Approximately 9% of Nevada high school students actually attempted suicide one or more times during the year prior to the survey
- ◆ Among students who attempted suicide during the year preceding the survey, more than one fourth (27%) required treatment by a doctor or nurse

The needs assessment recommends these areas be addressed:

- ◆ Educate the community to recognize the symptoms of suicide
- ◆ Teach the community how to prevent suicide
- ◆ Promote the recruitment and use of in-school mental health and peer counselors for students
- ◆ Create education programs and seminars that address the need to recognize symptoms of suicide among peers

Parental Involvement – Population-Based Services

Every child has a right to be raised by an educated parent – this does not mean the parent needs a traditional, degreed education, but that s/he should be aware of the services available to them and their child/ren to promote a better relationship between them. Indicative of their age, adolescents typically blame parents and in return, parents self deprecate. Programs should be set up to address the needs of married and single parents. Today’s youth and parents continually ask for parental involvement. The needs assessment recommends that the SHD, schools, other agencies, and other interested parties should collaborate on a parental involvement campaign to address the need for increased, better, and timely chats, activities, and situations that increase the opportunities for parents and children to interact. Creative seminars that assist and teach parents how to address their child’s needs should be dispersed throughout the state by addressing Parent-Teacher Associations (PTAs).

In addition, parents and teachers should raise their expectations of what they believe is important for kids to learn; e.g., sex education is very important to young people, and they believe that it should be incorporated into the curriculum, instead of a class that requires parental consent. In 1999, 87% of high school students were taught about HIV infection and AIDS in school, however, this number is not indicative of how many students received complementary sex education; the two are not synonymous (NV YRBS 1999). Parent education and tolerance of the current health issues facing today’s adolescents are just as important as educating youth.

For all adolescents, positive emotional development is associated with a strong sense of self (e.g., body image) as well as family cohesion and support (Wolman et. al 1994). This finding underscores the centrality of family (and adults) as a source of caring and belonging, providing an arena of comfort that is indispensable to adolescent emotional well-being. Even though the development of autonomy and the process of individuation of the growing person characterize adolescence, teenagers perceive family cohesion as highly desirable (Feldman et. al. 1988), and this quality of the family is considered to be compatible with autonomy in adolescence (Gavazzi and Sabatelli 1990).

Violence – Population-Based Services

Violence is a very serious subject to discuss in any day and age, but especially during a time in which seemingly harmless students can walk into their schools and brandish weapons killing or injuring those who step into their line of sight or path. Firearm violence is one of the most serious threats to the health of adolescents in the United States. In 1992, 667 youth ages 10-14 and 4484 youth ages 15-19 were killed by firearms (Fingerhut 1992). Among adolescents aged 15-19, firearm deaths outnumber deaths from any disease category and rank second only to motor vehicles among causes of injury-related deaths. Within some demographic areas and subgroups, firearm deaths surpass deaths from any other cause (CDC 1994). Violence has a wide and variable definition, from personal to public violence, allowing for interpretations of types of violence, although all forms of inflicted violence are bad. Inability to properly manage anger among our youth has inflated to a lack of personal competencies of communicating with parents, siblings, peers, teachers, etc., thereby promoting a lack of communication or hurtful behavior between these groups as well. The needs assessment recommends that a series of seminars addressing anger be incorporated into the curriculum in schools, particularly addressing:

- ◆ Prevention education: address social environment factors of maltreatment (home, school, social groups, etc.) – work with families and youth together
- ◆ Isolation
- ◆ Dealing with confrontation
- ◆ Impulsive anger
- ◆ Date rape, sexual assault/violence in relationships
- ◆ Anger, physical fighting, weapon carrying
- ◆ Maltreatment of children (incest, brutality, etc.)
- ◆ Dealing with the after effects of brutality, homicide, etc.
- ◆ Substance abuse (tobacco, alcohol)
- ◆ Riding with a drunk driver
- ◆ Homicides

- ◆ Physical fighting among adolescents
- ◆ Weapon carrying by adolescents

Approximately 9 out of 10 homicide victims in the United States are killed with a weapon or some type, such as a gun, knife, or club (Baker, et. al., 1992). Homicide is the second leading cause of death among all youth aged 15-24 and the leading cause of death among Black/African American youth in the same age group (NCHS 1995). During adolescence, homicide rates increase 15 times, from a negligible rate of 1.5 per 100,000 in youth aged 14 to 20.3 per 100,000 in youth age 15-24 (NCHS 1997). Non-fatal violence, e.g., fighting, often preceded fatal violence among young persons (O'Carroll and Smith 1988). Nearly 60% of adolescents report at least one episode of dating violence (Avery-Leaf, et. al., 1997), while 20% report they have experienced forced sex (Davis, et. al., 1993). Forced sex has been associated with suicide and with alcohol and drug use (Hartman and Burgess 1993, Erikson and Rapkin 1991). Firearms markedly elevate the severity of the health consequences of violent behavior (Rosenberg, et. al., 1992). The following statistics come from the Nevada 1999 YRBS:

- ◆ 18% of Nevada high school students carried a weapon such as a gun, knife, or club during the 30 days prior to the survey
- ◆ 5% of Nevada high school students stayed home from school at least once during the month preceding the survey because they felt they would be unsafe at school or on the way to or from school
- ◆ 9% of Nevada high school students were threatened or injured with a weapon at school in the preceding year
- ◆ Approximately 34% of Nevada high school students were in a physical fight at least once during the prior 12 months
- ◆ 4% of Nevada high school students were injured at least once in a physical fight in the year prior to the survey and had to be treated by a doctor or nurse
- ◆ Approximately 14% of Nevada high school students were in a physical fight on school property at least once during the year prior to the survey

- ◆ More than one in ten Nevada high school students reported having been hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend in the past year
- ◆ One in ten Nevada high school students reported being forced to have sexual intercourse when they did not want to

Substance Abuse – Enabling and Population-Based Services

The 1999 YRBS suggests that a relatively small number of preventable behaviors, such as drinking alcohol and driving, failing to wear seat belts, and engaging in unprotected intercourse, contribute greatly to causes of morbidity and mortality among youth and young adults. These behaviors are usually established during youth, continue into adulthood, and are often interrelated. Tobacco use is considered the chief preventable cause of death in the United States (DHHS 1994) accounting for more than one of every five deaths (CDC 1991).

Cigarette Smoking, Smokeless Tobacco, and Cigars

Smoking is associated with heart disease; cancers of the lung, larynx, mouth, esophagus, and bladder; stroke; and chronic obstructive pulmonary disease (DHHS 1994). In addition, there is evidence that cigarette smokers are more likely to drink alcohol and use marijuana and cocaine as compared to non-smokers (CDC 1991), and smoking has also been found to be related to poor academic performance. Oral cancer occurs more frequently among smokeless tobacco users than nonusers and may be 50 times as frequent among long-term snuff users (PHS 1986). Cigar smoking has been associated with cancers of the oral cavity, larynx, esophagus, and lung with chronic obstructive lung disease (PHS 1986).

Nationally over one million teenagers begin smoking each year (DHHS 1994). In Nevada, increases in adolescent smoking have been apparent since 1991. The proportion of youth who have ever tried smoking has risen at all grade levels, and by grade twelve, nearly 16%

of students smoke every day (Soule and Sharp 1997). The following tobacco, smokeless tobacco, and cigar-use prevalence data comes from the 1999 Nevada YRBS:

- ◆ 69% of Nevada high school students have tried smoking cigarettes
- ◆ 27% of Nevada high school students smoked a whole cigarette for the first time before age 13
- ◆ One in three Nevada high school students smoked cigarettes on one or more of the 20 days preceding the YRBS
- ◆ 22% of Nevada high school students smoked two or more cigarettes on the days they smoked
- ◆ Fewer than one-fourth (21%) of students who smoked during the 20 days prior to the survey usually got their cigarettes by purchasing them in a store such as a convenience store, supermarket, or gas station
- ◆ 49% of Nevada students who bought cigarettes in a store during the 20 days preceding the survey were not asked to show proof of age
- ◆ During the 30 days prior to the survey, 17% of Nevada students smoked cigarettes on school property
- ◆ 24% of high school students in Nevada have smoked at least one cigarette every day for thirty days at some point in their life
- ◆ 34% of Nevada high school students have tried to quit smoking cigarettes
- ◆ During the 30 days prior to the survey, 10% of Nevada high school students used chewing tobacco
- ◆ 6% of high school students in Nevada used chewing tobacco or snuff on school property during the 30 days prior to the survey
- ◆ One in five Nevada high school students smoked cigars, cigarillos, or little cigars on one or more of the days in the month preceding the survey

The data indicates the need for increased education and prevention efforts by the SHD, Department of Education, media, other agencies, etc. to address the problem of tobacco in our grade and high schools. Other drugs such as marijuana, cocaine, crack, inhalants,

methamphetamines, etc. should also be included in a comprehensive substance abuse education program. In addition, parents and teachers should also be educated to recognize the signs of substance abuse among youth. The needs assessment recommends programs and education efforts addressing:

- ◆ Tobacco, smokeless tobacco, cigars, marijuana, cocaine, crack, methamphetamines, inhalants, etc.
- ◆ Increase education and awareness among parents and teachers
- ◆ Gas, whiteout, markers, fingernail polish, rubber cement, aerosols, lighter fluid

Alcohol and Drug-Related Motor Vehicle Crashes – Enabling and Population-Based Services

Between 1996 and 1998, teens involved in alcohol and drug-related fatal crashes in Nevada have increased by 36.3%; in Clark County, the rate has increased by 140.0%. Between 1996 and 1998, teens involved in fatal crashes have increased by 35.5%; in Clark County the rate increased by 77.2%. Between 1996 and 1998, teens 15-19 represented 6.3% of the population, yet were 10.6% of the fatalities (DMVPS 1999). Reducing deaths and injuries caused by alcohol and drug-related motor vehicle accidents has been a longstanding performance measure among maternal and child health bureaus across the nation. It is the recommendation of this needs assessment that different approaches to addressing education of teenagers regarding drinking and driving be discussed. According to the Governor's YAC, Nevada has had a lack of age-, cultural, and movingly appropriate initiatives for youth. The YAC states that the hesitancy to change programs stems from fear and conservative attitudes from adults within the state. The needs assessment recommends that continued measures to address alcohol and drug-related vehicle crashes begin by addressing these areas:

- ◆ Reduce deaths and injuries caused by alcohol and drug-related motor vehicle crashes
- ◆ Reduce the amount of persons impaired while driving
- ◆ Reduce the proportion of young people who report that they rode with a driver who had been drinking alcohol (in the last 30 days)

- ◆ Increase use of safety belts
- ◆ Increase awareness regarding designated drivers

Alcohol is a major contributing factor in approximately half of all homicides, suicides, and motor vehicle crashes, which are the leading causes of death and disability among young people (CDC 1991). Heavy drinking among youth has been linked conclusively to physical fights, destroyed property, and trouble with law enforcement authorities (PHS 1991). Marijuana use, poor academic performance, and multiple sex partners have also been correlated with heavy drinking (Wechsler, et. al. 1995). Data from the Nevada 1999 YRBS strongly indicate a need to address the abuse of alcohol among youth:

- ◆ 81% of Nevada high school students have had at least one full drink of alcohol during their lifetime
- ◆ 38% of Nevada high school students had their first drink of alcohol before the age of 13
- ◆ 49.5% of Nevada high school students have used marijuana at least once in their life
- ◆ 16% of Nevada high school students tried marijuana prior to the age of 13
- ◆ More than one out of every ten Nevada high school students (13%) has used some form of cocaine at least once during his/her lifetime
- ◆ Approximately one in five Nevada high school students (19%) has sniffed glue, breathed the contents of aerosol spray cans, or inhaled paint or spray to get high on at least one occasion
- ◆ During the twelve months preceding the survey, less than a third (31%) of Nevada high school students had someone offer, sell, or give them an illegal drug on school property
- ◆ During the 30 days prior to the survey, 35% of Nevada high school students rode in a car or other vehicle with a driver who had been drinking alcohol
- ◆ 17% of Nevada high school students drove a car or other vehicle when they had been drinking alcohol during the 30 days preceding the survey

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Children with Special Health Care Needs Reno/Sparks, Las Vegas, Elko	
◆	Create “braided” services and “one-stop shopping” for CSHCN resources in Nevada
◆	Increase the amount of outreach services, especially family support and respite care for the CSHCN population
◆	Increase the amount of health education and training available for parents and providers in the CSHCN population
◆	Increase access to mental health services, providers, facilities, resources, and payor sources among the CSHCN population
◆	Increase the amount of appropriate providers and create a provider-specialist linkage in Nevada for the CSHCN population
◆	All CSHCN should have access to quality oral/dental healthcare

Children with Special Health Care Needs Services and Resources in Nevada – Enabling, Population-Based, and Infrastructure Building Services

In the past Nevada’s CSHCN population has been so small, the financially responsible method of securing services for the population was to send them to California to receive needed services. Nationally and statewide, this group of children represents a statistically small number, although the number grows in size depending on how “special need” is defined. The American Academy of Pediatrics adopted the definition MCHB created for CSHCN: children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also requires health and related services of a type or amount beyond that required by children generally (AAP 1998). The numbers of children may be small, but their use of medical services far outnumbers that of healthier children.

Parents, public and private employees, and state staff all agree that CSHCN have great difficulty navigating the misaligned Nevada health system. Multiple assistance agencies, coalitions, and

advocacy groups have cropped up in recent years employing paid and volunteer parents of special needs children to assist other special needs parents in steering through the Nevada system. The needs assessment recommends that the following areas for CSHCN need to be addressed by the SHD, other state agencies that work with CSHCN, and the school districts:

- ◆ Special Children’s Clinic (SCC) releases children without adequate preparation of families – there is no smooth transition, families are sent their children’s files with no human follow-up
- ◆ Address the gap in services for children who are released from SCC to their enrollment in school (ages 3-5 or 6)
- ◆ Develop a universal minimum standard of care for CSHCN so that all children are receiving adequate services in the state; develop one plan for the child that is adopted by all agencies that provide services to CSHCN
- ◆ School district Individual Education Program (IEP) doesn’t adequately address and provide for the regression of a child
- ◆ Create “braided” services, “one-stop shopping” for CSHCN medical and social resources: assistance in filling out enrollment forms for services and/or health insurance; a hotline to provide parents with information to navigate the Nevada healthcare system; a child-specific information center, that has publications for parents and providers (resource directory, website, brochures on conditions, etc), etc.
- ◆ Recruit and retain more medical specialists, qualified home care providers, and qualified mental health providers

Within the resources and services available to CSHCN is the subject of medical homes and healthcare access. Assuring a medical home for CSHCN is extremely critical because of the variable disorders that they may have. As was said above, increased healthcare access to diverse types of medical homes and addressing financial gaps and insurance barriers to the provider and child is a priority area that touches all of the three MCH populations. Increasing the percentage of children in the state who have medical and dental homes continues to be a priority as it has been in the past. In addition to providing diverse forms of medical homes is also making available appropriate medical coverage for the extensive needs of CSHCN.

Outreach – Enabling and Population-Based Services

For CSHCN and their parents, outreach services are crucial to their utilization of the minimal medical and social services available to them in Nevada. Not all families are financially capable of maintaining the high costs of raising their special needs child/ren, and depend on public services to supplement their needs. Transportation, translation, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, and WIC are just a few of the enabling services CSHCN parents need.

The needs assessment recommends that the State develop the following services within their organizations to provide long term enabling support to CSHCN parents:

- ◆ Services for parents to maintain emotional health, e.g., respite care
- ◆ Behavioral intervention education for parents
- ◆ Educate parents regarding accessing, navigating, and knowing what is available in the Nevada system
- ◆ Certification for those who care for “medically fragile” children
- ◆ Systematic case management that ALL providers follow
- ◆ Create a centralized information source, hotline, interpretation and translation services for parents and providers
- ◆ Expand and enhance family resource centers – use for advocacy in CSHCN populations
- ◆ Establish an ombudsperson for health care issues pertaining to the MCH populations

Health Education and Training for Parents and Providers – Enabling and Population-Based Services

As it was discussed among the other MCH populations, health education is a very large and multi-disciplinary area to address. Health education for providers and consumers is the key concern of the needs assessment. It is important that providers know the resources available to them, as well as to

parents. Having a central clearinghouse that providers can refer to, as well as refer parents to is fundamental in this day and age, because the amount of health education brochures, pamphlets, programs, etc. available is tremendous. The work groups believe that there is not enough Nevada-specific information available in various forms (aural, visual, tactile) for the population of Nevada. The needs assessment recommends the following health education efforts for the CSHCN population, parents, and providers:

- ◆ Increased continuing education (CE) opportunities for CSHCN providers
- ◆ Create basic provider and service guidelines and standards for those serving the CSHCN population
- ◆ Increase education to parents regarding caring for their special needs child/ren
- ◆ Create awareness among parents and providers of the CSHCN resources in their communities and state
- ◆ Increase the number of preventive education programs for CSHCN to be taught during school
- ◆ Develop mechanisms or education efforts that assist families – better case management system (clearinghouse system of info for CSHCN – for example, Family Voices is creating a CSHCN national clearinghouse)

Mental Health – Population-Based Services

Mental health services for the CSHCN population are a more complex set of services to coordinate. Because of the wide variety of disorders that this population may have, these services range as broadly as the disorders. From the work and focus groups it was noted that there was a lack of qualified mental health providers and sufficient mental health resources to work with their children's condition(s). The needs assessment recommends that the resources must first be developed, and then provider and consumer education regarding the diagnosis, treatment, and use of these services can ensue. The legislature must address the inadequacy of this area of health and delineate financial resources to tackle the lack of appropriate services.

Provider-Specialist Linkage – Direct Health Care, Enabling, Population-Based, and Infrastructure Building Services

Throughout the work and focus group process, and written in the surveys, the lack of an existing provider-specialist linkage in Nevada was described in great detail. The most common complaint among CSHCN parents is the lack of appropriate providers to accurately diagnose their child/ren. If the SCC inaccurately or cannot diagnose the child/ren, parents who cannot afford other physician diagnoses often have to wait until their child/ren is/are school age to get another diagnosis; this time by the school district, which provides a more limited selection of providers and is usually unacceptable to parents. CSHCN parents reiterated throughout the needs assessment process the lack of choice in providers in Nevada due to a limited amount of specialists, e.g., geneticists, dysmorphologists, pediatric neurologists, behavioral specialists, pediatric developmental specialists, etc.; medical board barriers for specialists who want to come and practice in Nevada; lack of recruitment and retention of specialists by the State; in rural areas, it is costly to fly in appropriate physicians to see a small number of children; lack of networking among providers – health care professionals are unaware of the social providers in their area; and a lack of appropriate payor sources to assist parents in paying for the expensive services and treatments needed by their child/ren.

The requirements of a child with special needs are usually individual; for example, autistic children may have varying degrees of autism, as well as other health disorders; children with fetal alcohol syndrome (FAS) or fetal alcohol effects (FAE) may suffer varying degrees of their disorder as well. It is important that these children are seen by qualified health providers who can accurately diagnose the disorders, refer parents to appropriate social and educational services, and provide follow-up to the children throughout their lifetime.

Paying for the care of a special needs child can propel a middle class family into bankruptcy, and many families have one parent stay at home to care for the child/ren, as well as keep their yearly income to a minimum to allow them to qualify for state assistance – Medicaid. In a state like Nevada that has a large, lower educated workforce, not all families can afford to be a one-income family, and often fall short of qualifying for any state assistance. Parents with autistic

children have little to no insurance coverage for their child/ren, because categorical diagnoses put autism in a mental health category that is mostly uncovered by Nevada insurance agencies. The Katie Beckett program does cover autism in their services, but they cannot cover all the children in Nevada because their services are limited as well.

Education of providers and parents of appropriate services available to their child/ren is a necessary part of linkage. Collaborative work should be continued between agencies to bolster social services to the children, their parents, and the providers. Developing the community to care for children with special needs is an educational benefit for us all. The needs assessment recommends the following deficiencies be addressed:

- ◆ Increase the amount of qualified home care providers through certification programs at community colleges, etc.
- ◆ Educate providers and parents of available resources in their community and state
- ◆ Recruit local health care providers (e.g., physical therapists) to do home visiting
- ◆ Develop a University of Nevada School of Medicine-based TRAVELING developmental pediatrician available statewide (based in Reno and Vegas – the State, UNSOM, and the communities can subsidize travel, clinic fees, etc.)
- ◆ Increase physician compliance to see CSHCN
- ◆ Increase the amount of available crisis-intervention services for CSHCN
- ◆ Increase the amount of therapy services available to CSHCN

Oral/Dental Healthcare – Population-Based Services

As discussed throughout the needs assessment, oral/dental healthcare is a priority area that touches all three MCH populations. For CSHCN, it is important to note that dental care can be an excruciatingly difficult medical appointment for a special needs child. Oftentimes, the child will not understand or comply with the dental provider, and may hurt him/herself or the provider. Special care must be taken with CSHCN. Dental providers must be aware of the risk and be educated on how to care for CSHCN.

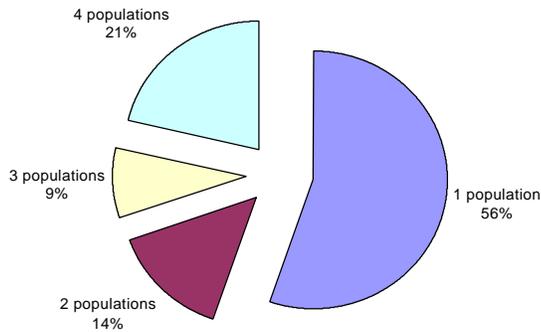
SURVEY RESEARCH

To provide some recent data regarding services being offered to and used by the three MCH populations, a survey was created to address agencies/parents (state agencies, CBOs, schools, community health services, and other health entities, see Appendix E). The survey measured the number of MCH populations agencies serve, current and future services, goals and objectives of agencies, data collection, impact of changes in financing care, types of providers available in communities, and types of providers and services needed in communities. The sample of respondents was a well-rounded mix of medical and social service agencies; however, there was a very small parental response to the survey. Limitations of the survey included: the questions were very agency oriented (e.g., goal development, services provided, data collection, etc.) and not applicable to all parents unless they worked in the medical or social services field. This discrepancy was noticed midway through the process, and a second survey was put into development.

During the survey and workgroup process, it was noted that CSHCN parents were not represented in the data collection. A second survey was produced to address the needs of CSHCN and their parents (see Appendix D). The survey measured what types of special health care needs exist in Nevada, various enabling services needed by the child/ren and parent(s), difficulties encountered when accessing services, various methods of payment available for healthcare services, types of specialists seen by this population, medical home, insurance coverage, respite care, and child/day care access. This survey had a low response rate, but the qualitative information received can be generalizable to the small Nevada CSHCN population. A notable benefit of the survey and the work and focus groups is the creation of an alliance between many CSHCN service providers and the SHD. Limitations of the parent survey include: power was not calculated to estimate the number of needed responses for the survey and CSHCN parents may not have had enough time to fill out the survey (this was indicated by multiple phone calls made to the project coordinator throughout and after the needs assessment process).

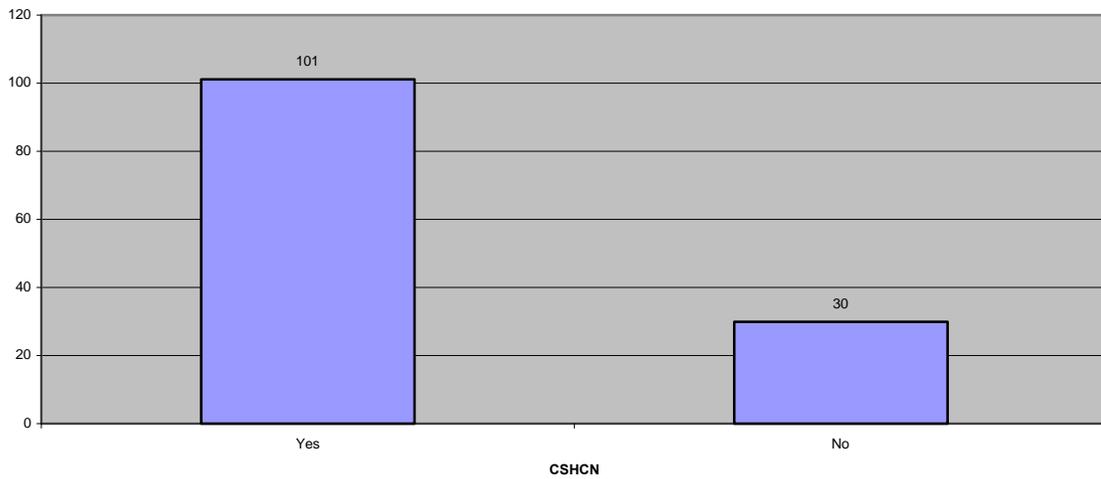
The initial provider/parent survey was sent to 173 various agencies, schools, and parents around the State (2 were returned to sender and 2 providers refused to answer), 111 surveys were returned, providing the SHD with a 65.7% response rate.

How many different types of populations does your agency serve?
N = 111



The second survey focusing on CSHCN parents was sent to 518 families around the state (27 were returned to sender), 131 surveys were returned, providing SHD with a 26.7% response rate (due to a low response rate, this data is may not be wholly representative of the CSHCN population, although some qualitative data is generalizable to the CSHCN population).

**Do you have a child with special health care needs?
N = 131**



The data collected from the surveys addresses the MCH pyramid, and will be discussed throughout sections 3.1.2.2 – 3.1.2.5.

3.1.2.2 and 3.1.2.3 DIRECT HEALTH CARE AND ENABLING SERVICES

DIRECT HEALTH CARE AND ENABLING SERVICES

Historically the BFHS has combined direct and enabling services for the MCH populations, expending approximately 70.1% of its monies to these two categories. The SCC provides direct health care services and is funded by the BFHS, therefore, we can extrapolate that the majority of funding does go to direct health care services. As indicated throughout the needs assessment, enabling services are of great concern to the population, and it is the recommendation of the needs assessment that the BFHS begin to separately track these two services areas.

Financial Access

Managed Care

Managed Care in Nevada continues to have low market penetration, with 20.1 % overall as of December 1999; 18.2% is Commercial, 33.6% Medicare, and 84.1% Medicaid enrollment. Managed care for the Medicaid population was fully implemented in 1999; the 84.1% penetration represents a 148% increase since December 1998. This is largely due to the fact that managed care for the Medicaid population is mandatory in Clark County which houses the State's largest population. Dental services are not included in Nevada's HMO benefit packages, and remain fee-for-service. As of December 1999 there were 9 licensed HMOs in Nevada, and 98 Preferred Provider Organizations (PPOs), a small increase from the 93 in 1998.

Nevada 3Check Up

By May 1, 2000, Nevada 3Check Up had 10,000 children enrolled in the program and receiving health services. By June 1, 2000, Nevada 3Check Up had 11,164 children enrolled and receiving health services. The program is currently entering a new phase of administration and organization, innovative targeted outcome-based marketing and outreach programs will begin to play a prominent role in achieving maximum enrollment and participation in the SCHIP in the near future.

Among immediate changes to the program were a rapid elimination of an application backlog, reassessment of staff function and allocation of staffing resources, a reinstatement of state programs and the community partners Marketing and Outreach Advisory Team, investigation of instituting a "premium lock box" contract with the state's bank to collect the quarterly premium payment, and submission of a State Plan Amendment to the Health Care Financing Administration (HCFA) to: 1) waive cost sharing (i.e., Nevada 3Check Up quarterly premiums) for American Indians and Alaska Natives; 2) change the re-determination process

from annual to rolling, thereby providing ongoing eligibility for 12 months after the date of a child's most recent enrollment; and 3) remove the six month residency requirements prior to a child's eligibility.

To complement the planning and implementation of a renewed marketing and outreach plan, Nevada intends to submit a State Plan Amendment to HCFA to: 1) increase the administrative cap from 10% to 15% based on health care expenditures; 2) base the 10% administrative cap on Federal monies allocated to the State per Federal fiscal year; or, 3) remove marketing/outreach from the administrative cap and base it on 1% of the available Federal monies allocated to the State per Federal fiscal year (information from a Year 2000 memorandum from Nevada 3Check Up).

Temporary Assistance for Needy Families

Nevada saw the loss of Temporary Assistance to Needy Families (TANF) for many families in January 2000 when they reached the 24-month limitation established by Nevada policy. An audit report of the Welfare Division dated February 23, 2000, notes that the Welfare Division does not have information readily available to determine the extent in which employment and training programs help welfare clients become self-sufficient, and thus did not have an adequate mechanism to track what happens to clients who leave TANF. The Welfare Division developed a plan to survey and track former clients of its New Employees of Nevada (NEON) training and employment program. A study by the University of Nevada consisting of a monthly survey requested by the Welfare Division began in the spring of 2000 for those individuals who have left TANF during the previous month. This survey of randomly selected clients is performed at 3, 6, 12, 18, and 24-month intervals after they leave TANF. This study has just started a report; therefore the information is not yet available. Welfare is also in the process of consolidating its computer systems in order to improve its ability to track clients' and former clients' progress. Between the survey and the computer systems the State hopes to have a clearer picture of what is happening to former clients who have left TANF.

In spite of the release of families due to the 24-month limitation, Nevada saw its Welfare rolls rise more than 6% during April 2000 to 16,421 recipients from a low of 15,487 in March 2000. This rise was mirrored in Food Stamps and Medicaid. It is not clear at this time whether the rise is a trend; Welfare Division officials are watching it closely. The official note is that the number of TANF recipients is no where near the record high point in caseload in March 1995, when Nevada had 42,703 people on what was then Welfare. Nevada's long-term decline in Welfare/TANF rolls is attributed in part to the state's strong economy with record low rates of unemployment and welfare reform efforts that include childcare dollars that exceed TANF dollars for families in transition and job retention initiatives for those going off TANF.

Survey Data

The first agency/parent survey sent to Nevada agencies, parents, other provider organizations, schools, etc. asked questions regarding the impact of financing care publicly, privately, or self-funded among the three MCH populations. The second CSHCN survey addressed how CSHCN parents finance care for their child's and whether there were providers in their area who accepted various forms of payment. Both of these surveys address access to healthcare and health-related services from the perspectives of financial access, cultural acceptability, availability of prevention and primary care services, and availability of specialty care services when needed.

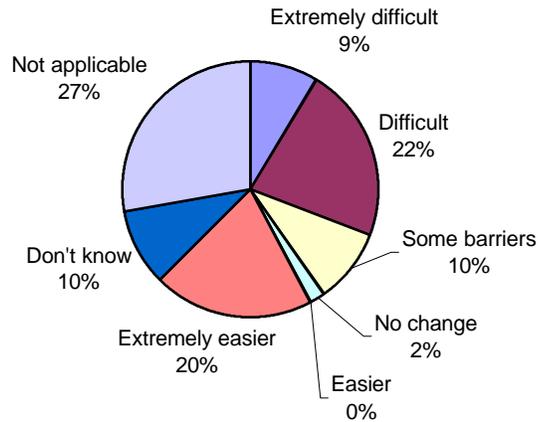
Agency/Parent Survey

Using a Likert scale (Extremely difficult, difficult, some barriers, no change, easier, extremely easier, don't know), respondents answered questions regarding the impact changes in financing healthcare has had upon them personally and/or their organizations. For some groups who do not provide medical or social services billable to a third party, these questions were not applicable to them.

Managed Care

Respondents were asked to describe the impact that the move to managed care delivery systems has had on service delivery and availability of services delivered by their agency to the MCH populations that they serve. 31% of the 111 respondents felt that managed care has made their service delivery and availability extremely difficult or difficult. However, 20% believe that this system has made their work extremely easier.

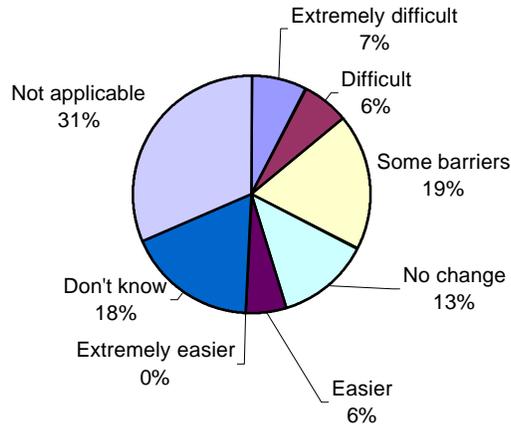
Describe the impact that the move to managed care delivery systems has had on service delivery and availability of services delivered by your agency to this population
N = 111



Medicaid

31% of the respondents to the agency/parent survey do not bill Medicaid. However among those that do, 13% found the system extremely difficult or difficult, 19% indicated barriers of some kind, and 13% found that there has been no change in the agency delivered services from the impact of the shift in Medicaid coverage over the last five years.

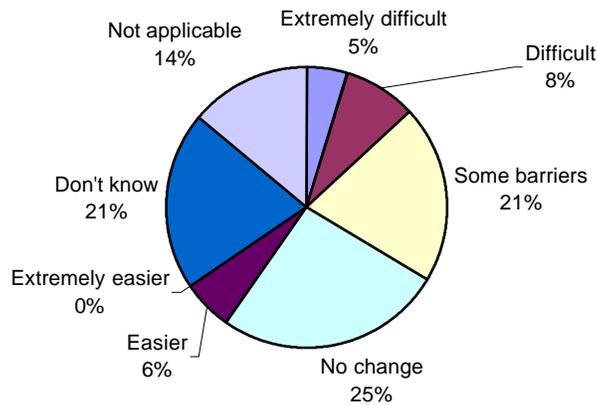
Describe the impact that the shift in Medicaid coverage over the last five years has made on financial barriers to care and services delivered by your agency to this population.
N = 111



Welfare

With the changes in welfare eligibility, enrollment of individuals and families on TANF, and the recent rolling off of TANF families, it was predicted that the survey would indicate the difficulty or confusion agencies, healthcare organizations, CBOs, etc. are having with all the changes. 13% indicated some form of difficulty, 21% faced some barriers, and 21% did not know how the welfare changes affected them. Surprisingly, 25% indicated that they noticed no change at all.

Describe the impact that welfare reform has had on service delivery and availability of services delivered by your agency to this population.
N = 111

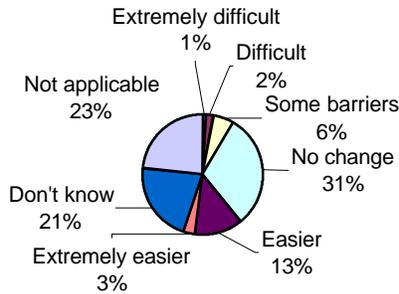


Nevada 3Check Up

Noted throughout the Children ages 1-9 workgroups was a concern regarding Nevada 3Check Up and its slow enrollment of eligible children into its insurance system. Knowing that the program has enrolled only a small amount of uninsured children, it was predicted that the survey would point out that Nevada 3Check Up has had a very small impact upon agency services. 31% of respondents indicated that Nevada 3Check Up had no impact upon their services.

Describe the impact that Nevada Check Up has had on service delivery and availability of services delivered by your agency to these populations.

N = 111

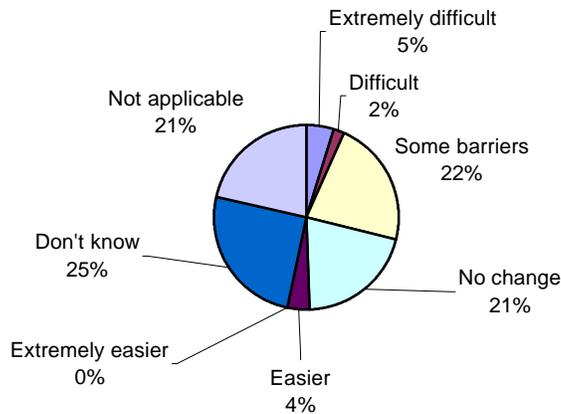


Other Financial Changes

In addition to changes in welfare, managed care, Medicaid, and Nevada 3Check Up are additional shifts in Supplemental Security Income (SSI), eligibility changes for CSHCN, and other changes in financial access (private insurance, risk pools, etc.). Survey respondents were asked to describe any influence these modifications made on service delivery. 7% reported difficulty of some type, 22% reported some barriers, 21% indicated no change, 4% stated that these changes made services delivery easier, and 25% didn't know how the changes impacted them.

Describe the impact that other changes in financial access has had on service delivery and availability of services delivered by your agency to this population.

N = 111

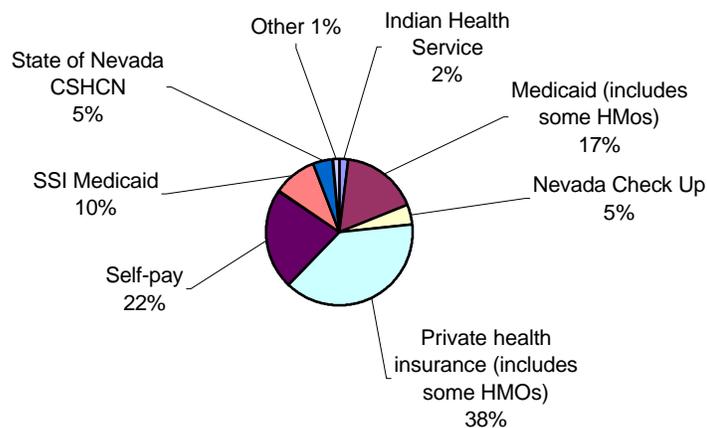


One note of caution regarding interpretation of the choices “don’t know” and “not applicable,” it was noted during the survey analysis that respondents interchanged these two answers, therefore the data reported in these categories is mixed.

CSHCN Parent Survey

CSHCN parents use a variety of modes of financing care for their children. During the workgroups, some playfully called it “creative financing of care.” In Nevada, CSHCN parents use one or more of the following to finance care for their children: Indian Health Service, Medicaid (including some HMOs), Nevada 3Check Up, private health insurance (including some HMOs), self-pay/cash, SSI, State of Nevada CSHCN program, Shriner’s Hospital). A very important interpretation of the data for financing CSHCN care is that the types of payment sources are very few. 38% of families have private insurance that helps finance the necessary care for their child/ren, however nearly 42% require some form of public assistance to afford the care needed. It should be recognized that CSHCN may need services even though they are not receiving them resulting from lack of knowledge, limited provider availability, or other financial and nonfinancial barriers to care (Stanton, et. al., 1991). An important interpretation to add to a lack of access and availability of appropriate providers and services for CSHCN is that parents would have limited means of financing care, even if it were to become readily available in Nevada.

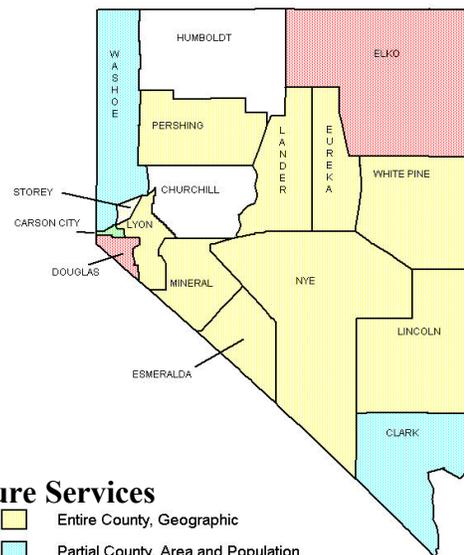
**What forms of payment do you use to pay for your child's special care?
N = 131**



Availability of Care

The Primary Care Development Center (PCDC) of the SHD, collects data on 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 (e.g., 1 primary care physician: 3000 people, 1 dentist to 4000 people); nine of Nevada's seventeen counties are primary care HPSAs. MUAs and MUPs exist within HPSAs. These Federal designations help place needed primary care professionals in underserved areas. The following is an example indicating the locations of Nevada's Primary Care HPSAs:

Primary Care HPSAs in Nevada, 1999



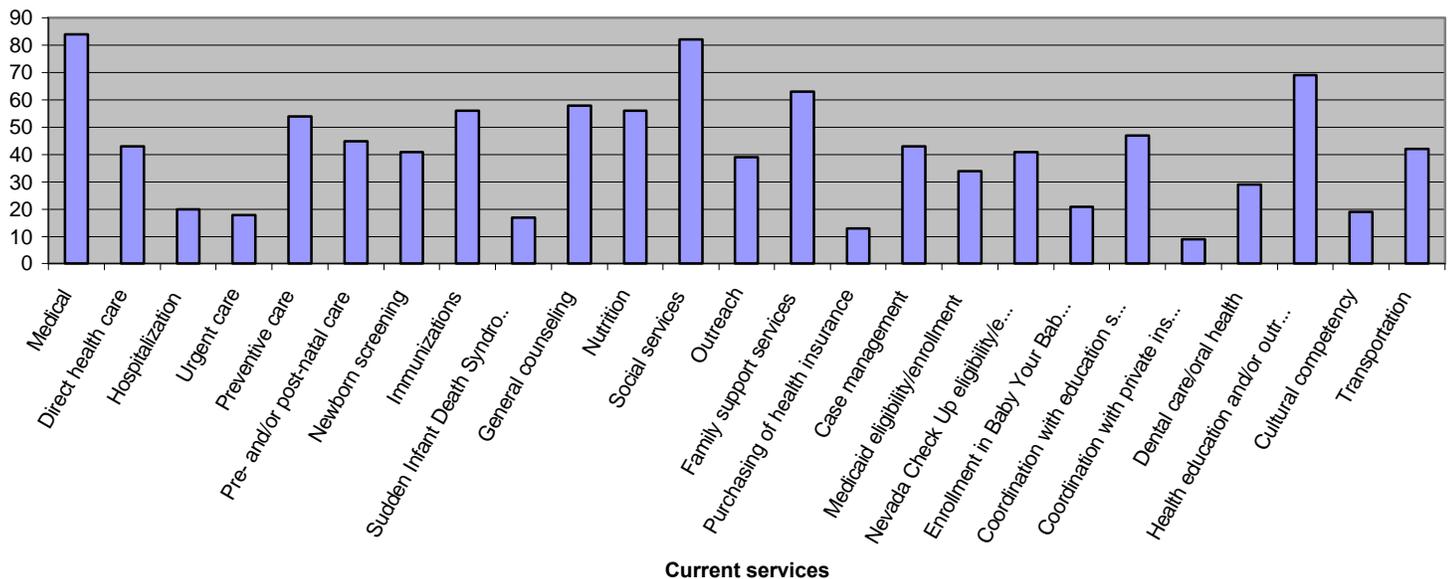
Current and Future Services

- Entire County, Geographic
- Partial County, Area and Population
- Partial County, Area
- Partial County, Population

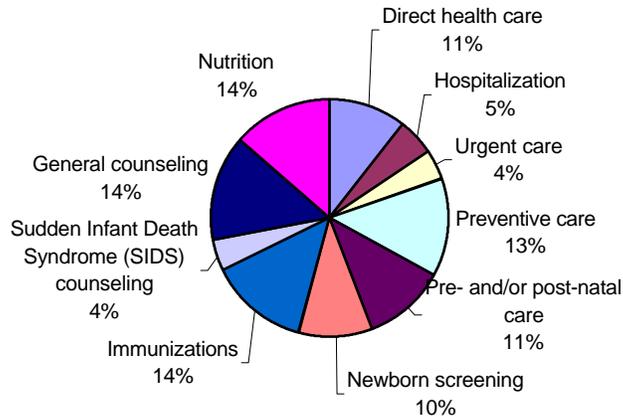
Data from the agency/parent survey shows us the types of services available to the three Nevada MCH populations. Agencies were asked what general services they provide for the populations they serve, as well as what types of service they plan to offer in the future. Of the 111 respondents, 75.7% provide medical services and 73.9% provide social services (note from the percentage rates that some of the respondents were parents, and not applicable to the data regarding services). Interesting findings from this survey question are:

- ◆ 11% provide some form of pre-natal counseling, and 4% assist women in enrolling in the BYB program
- ◆ 7% of the respondents provide translation and interpretation services to their populations; however, there is a lack in diversity of languages offered. Mostly Spanish and Tagalog (Filipino dialect) are offered, one organization offers Chinese, and a few organizations make use of the AT&T translation line
- ◆ 20% assist with enrolling families into purchasing health insurance (3%), Medicaid enrollment (7%), Nevada 3Check Up (8%), coordinate with private health insurance enrollment (2%)

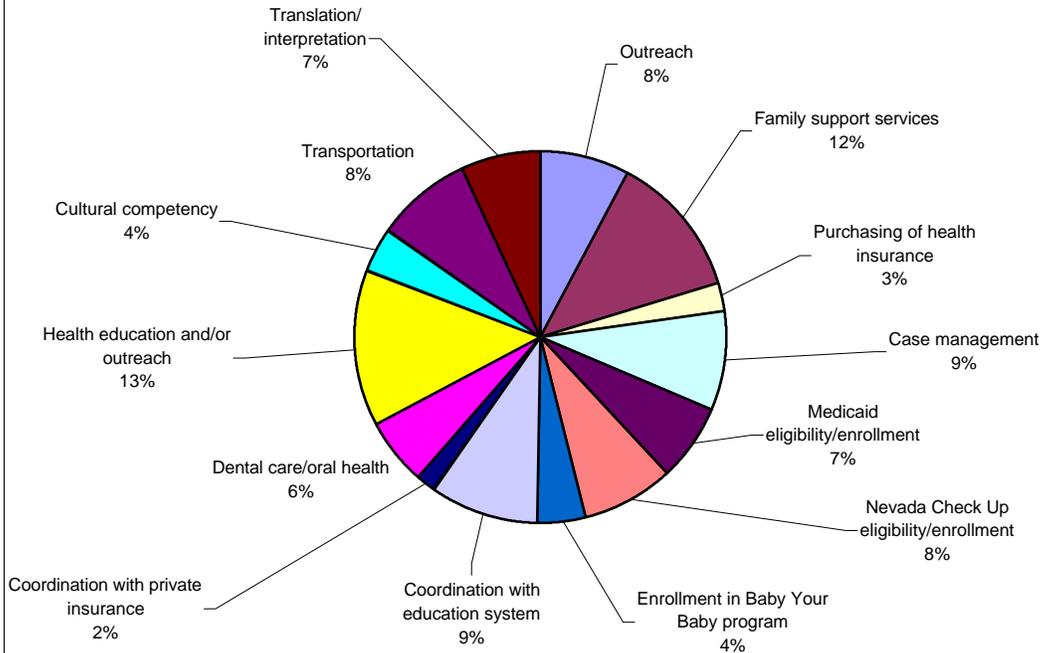
**What types of services does your organization provide for this population?
N = 111**



Current Medical services



Current Social Services



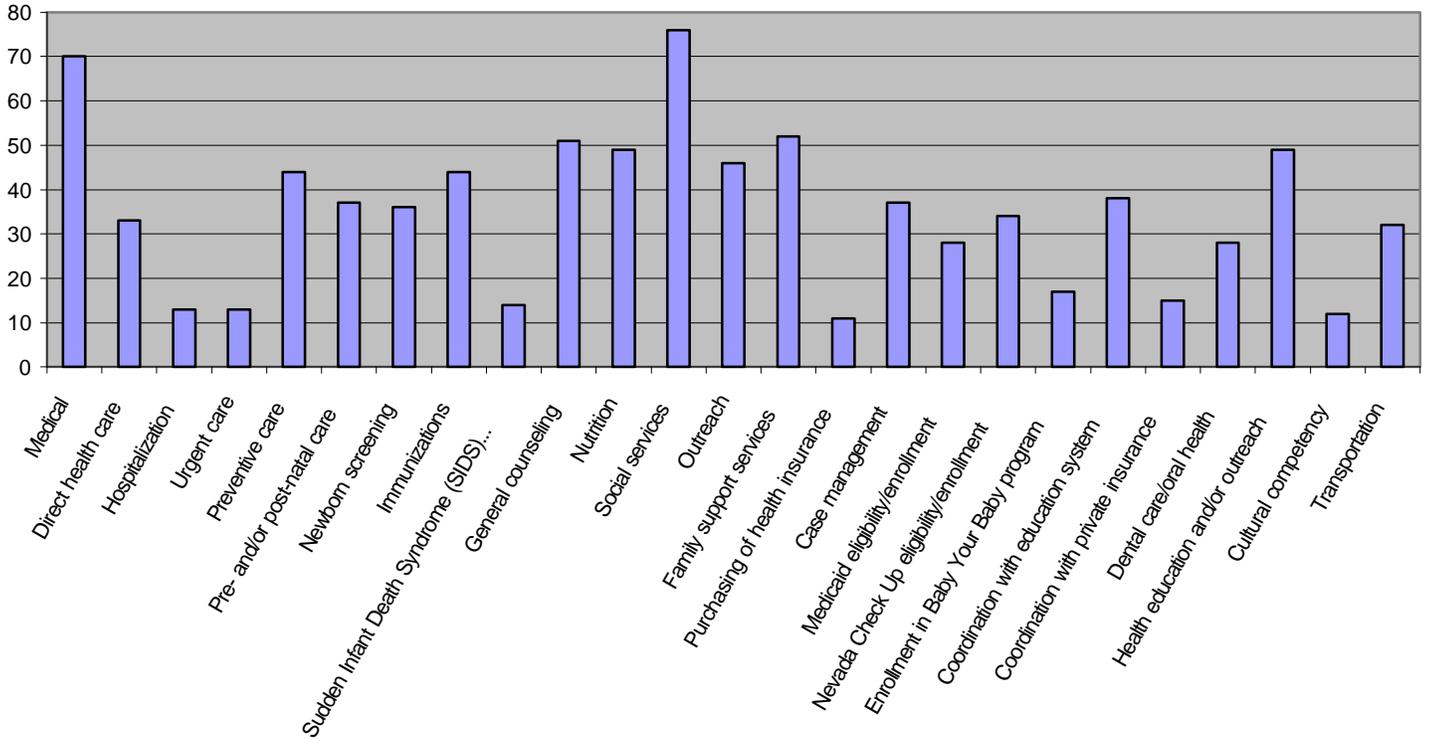
Shortages in Care

As discussed throughout the needs assessment, there is a shortage of both primary care and specialty providers in Nevada who provide diverse types of services. Most notable are the shortages in physician specialist care for CSHCN, oral/dental healthcare providers, mental health providers, nurse practitioners, nutritionists, community nursing services, visiting nurses, and physical and occupational therapists. The agency/parent survey asked respondents what types of services they planned to offer in the future and what services they lacked in their communities. There was very little difference between current and future services to be offered by these communities. Explanations given for the slight differences are:

- ◆ Current funding will not support additional services
- ◆ The infrastructure does not support additional services
- ◆ Providers are working at full capacity and are unable to take on additional workloads
- ◆ There is not enough support staff to assist providers
- ◆ There may be duplication of services and effort by agencies, but there is no communication or network among agencies to promote collaboration
- ◆ Lack of communication with and support from SHD

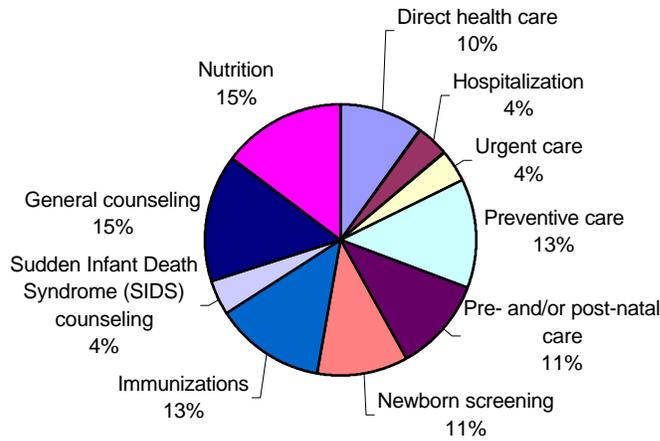
Only one notable difference between current and future services was in outreach and enabling services. Only a few agencies plan to offer additional health education, transportation services, and coordination with private insurance.

**What types of services does your organizations plan to offer this population in the future?
N = 111**

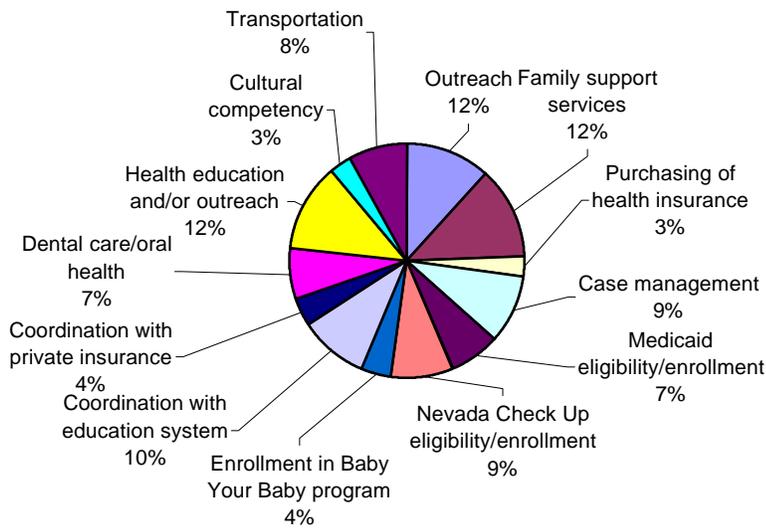


Future Services

Future Medical Services



Future Social Services

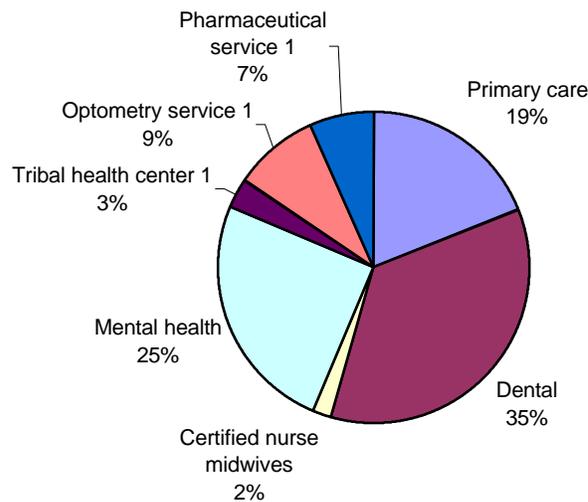


Provider shortages

Agencies/parents were asked to give information about the types of providers needed most by their communities. The three areas of most need agree with the workgroup and advisory board response, as well as the CSHCN survey – oral/dental healthcare, mental

health, and primary care. 35% of respondents indicated a need for oral/dental healthcare providers, 25% need access to mental health services and providers, and 19% need more primary care providers. According to 1999 data from the Primary Care Development Center, approximately 28% of Nevada’s population is underserved. This percentage is calculated using primary care provider ratios, and federal and state data.

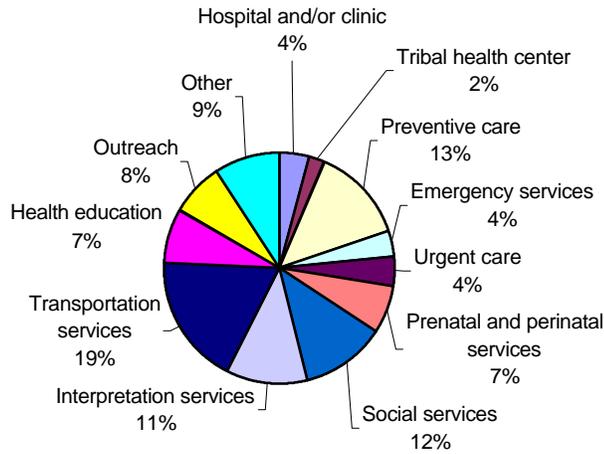
Which of the following providers does your community need most?
N = 111



Service shortages

Enabling services are in most demand in communities around Nevada. The agent/parent survey indicated a strong need for transportation services (19%), preventive care and education (13%), social services (12%), translation (11%), additional outreach (8%), health education (7%), and prenatal/perinatal services (7%). The workgroup process also reported these deficiencies in enabling services. Obviously, this is an area of great concern for all providers that Nevadans receive important services supplemental to direct health care services.

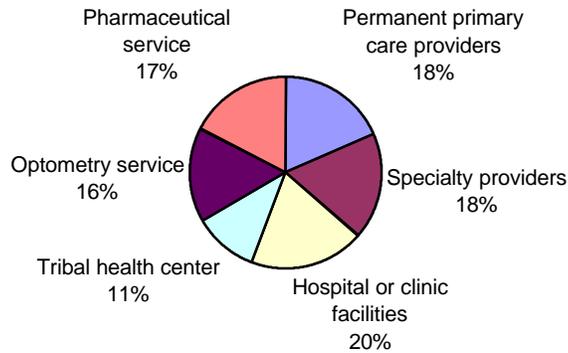
**What types of services do you need most in your community?
N = 111**



Services Linkages

36% of the agency/parent survey respondents indicated that they have access to both permanent primary care and specialty providers, 20% have hospital and clinic facilities, 17% have pharmaceutical services, 16% have optometry services, and 11% have Tribal Health Centers. This information is indication of a strong foundation upon which CBOs, schools, medical facilities, agencies, and the SHD can build stronger direct healthcare, enabling, population-based, infrastructure building services and systems within the communities. However, in the previous section, it was indicated that the areas of most need within the primary and specialty provider areas are dental/oral healthcare, mental health, and primary care.

Which of the following do you have in your community?
N = 111



3.1.2.4 Population Based Services

Need

The workgroups, surveys, and advisory boards indicated that the greatest population-based services needs are in oral/dental health and public education. Dental care has not been focused on by the state as a whole. This is demonstrated by a lack of a State dental office, difficulty in recruiting and retaining dental providers, and lack of access to dental healthcare by lower socio-economic populations.

Nevada has a strong public education media presence (television and radio), including the BYB program, WIC program, and drinking and driving. However, there are many programs offered by the SHD that do not have the financial means or the initiative to incorporate a media campaign as part of their education efforts. It is important that the population of Nevada knows what services are offered directly or indirectly through the SHD. The needs assessment recommends a stronger overall media (print, visual, and audio) presence, more education seminars and available speakers to travel around the state, and the appointment of a Health Education and Communications Officer who assists the SHD in media concerns.

Oral/Dental Health

In June 2000, the U.S. Surgeon General's Office released the first-ever oral health report entitled: *Oral Health in America: A Report of the Surgeon General*. This report alerts Americans to the full meaning of oral health and its importance to general health and well-being. This report describes dental and oral diseases affecting some population groups in the US as a "silent epidemic." This burden of disease restricts activities in school, work, and home, and often significantly diminishes the quality of life. Those who suffer the worst oral health are found among the poor of all ages, with poor children and poor older Americans particularly vulnerable. Members of racial and ethnic minority groups also experience a disproportionate level of oral health problems. Individuals who are medically compromised or who have disabilities are at greater risk for oral diseases, and in turn, oral diseases further jeopardize their health (DHHS 2000).

Oral health means much more than healthy teeth. It means being free of chronic oral-facial pain conditions, oral and pharyngeal (throat) cancers, oral soft tissues lesions, birth defects such as cleft lip and palate, and scores of other diseases and disorders that affect the oral, dental, and craniofacial tissues, collectively known as the craniofacial complex. New research is pointing to associations between chronic oral infections and heart and lung diseases, stroke, and low birth weight, premature births. Associations between periodontal disease and diabetes have long been noted. This report assesses these associations and explores mechanisms that might explain the oral-systemic disease connections (DHHS 2000).

Oral diseases are progressive and cumulative and become more complex over time. They can affect our ability to eat, the foods we choose, how we look, and the way we communicate. These diseases can effect economic productivity and compromise our ability to work at home, at school, or on the job. Health disparities exist across population groups at all ages. Over one-third of the US population (100 million people) has no access to community water fluoridation. Over 108 million children and adults lack dental

insurance, which is 2.5 times the number who lack medical insurance (DHHS 2000). The following are highlights of the Surgeon General's report of oral health data for children:

- ◆ Dental caries (tooth decay) is the single most common chronic childhood disease – 5 times more common than asthma and 7 times more common than hay fever.
- ◆ Over 50% of 5-9 year old children have at least one cavity or filling, and that proportion increases to 78 percent among 17 year olds.
- ◆ There are striking disparities in dental disease by income. Poor children suffer twice as much dental caries as their more affluent peers, and their disease is more likely to be untreated. These poor/non-poor differences continue into adolescence. One out of four children in America is born into poverty, and children living below the poverty line (annual income of \$17,000 for a family of four) have more severe and untreated decay.
- ◆ Unintentional injuries, many of which include head, mouth, and neck injuries are common in children.
- ◆ Intentional injuries commonly affect the craniofacial tissues.
- ◆ Professional care is necessary for maintaining oral health, yet 25% of poor children have not seen a dentist before entering kindergarten.
- ◆ Medical insurance is a strong predictor of access to dental care. Uninsured children are 2.5 times less likely than insured children to receive dental care. Children from families without dental insurance are 3 times more likely to have dental needs than children with either public or private insurance. For each child without medical insurance, there are at least 2.6 children without dental insurance.
- ◆ Medicaid has not been able to fill the gap in providing dental care to poor children. Fewer than 1 in 5 Medicaid-covered children received a single dental visit in a recent year-long study period. Although new programs like SCHIP may increase the number of insured children, many will still be left without effective dental coverage.
- ◆ The social impact of oral diseases in children is substantial. More than 51 million school hours are lost each year to dental-related illness. Poor children suffer nearly 12 times more restricted-activity days than children from higher-income families. Pain

and suffering due to untreated disease can lead to problems in eating, speaking, and attending to learning.

The barriers to oral health include lack of access to care, whether because of limited income or lack of insurance, transportation, or the flexibility to take time off from work to attend to personal or family needs for care. Individuals with disabilities and those with complex health problems may face additional barriers to care. Sometimes too, the public, policymakers, and providers may consider oral health and the need for care to be less important than other health needs, pointing to the need to raise awareness and improve health literacy (DHHS 2000).

All Americans can benefit from the development of a National Oral Health Plan to improve quality of life and eliminate health disparities by facilitating collaborations among individuals, health care providers, communities, and policymakers at all levels of society, and by taking advantage of existing initiative. Everyone has a role in improving and promoting oral health. Together we can work to broaden public understanding of the importance of oral health and its relevance to general health and well-being, and to ensure that existing and future preventive, diagnostic, and treatment measures for oral disease and disorders are made available to all Americans (DHHS 2000). The Surgeon General's Office has produced a framework for action that the SHD may utilize to create a more specific plan for its populations:

- ◆ Change perceptions (public, policymakers, and health providers) regarding oral health and disease so that oral health becomes an accepted component of general health.
- ◆ Accelerate the building of the science and evidence base and apply science effectively to improve oral health.
- ◆ Build an effective health infrastructure that meets the oral health needs of all Americans and integrates oral health effectively into oral health.
- ◆ Remove known barriers between people and oral health services.

- ◆ Use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.

(The following are excerpts from the December 1999 Review of the Nevada Oral Health Program. Please note the Nevada Oral Health Unit is currently housed in the BFHS)

Although the SHD does not have an oral health program as an identifiable organizational unit, promotion of oral health is an implicit goal of the agency. Since 1992, SHD has been aware of the need for services, providers, and data on oral/dental health in Nevada. At that time, a comprehensive survey of the oral health status of children and youth in Nevada was conducted. This survey included assessments of dental caries experience, oral hygiene status, presence of sealants, and questionnaire data on socio-economic status (SES), and tobacco use in the home. The study used methodology developed by the National Institute of Dental and Craniofacial Research (NIDCR) in a stratified statewide sample of 764 first and sixth grade Nevada schoolchildren, and resulted in a 100-page publication summarizing findings and providing recommendations for oral health policy. The shortcomings of the 1992 youth survey are that the information has become outdated with the major demographic shift in population during the last decade, and no similar data are available for adults or special populations (ASTDD 1999).

In 1999, the SHD directed a self-study evaluation of the State's oral health program, based on *Guidelines for State and Territorial Oral Health Programs* developed by the Association of State and Territorial Dental Directors (ASTDD). The purposes of the evaluation were to provide SHD with an internal assessment of the State oral health program, including an evaluation of current program components and activities; as well as, identify strategies for supporting ongoing activities and determining new directions for the oral health program based on the needs of the State. Although there is no SHD budget category for oral health, dental Medicaid expenditures totaled more than \$12 million in 1998, indicating a continuing need for oral health services for many Nevadans (ASTDD 1999).

The ASTDD review uncovered the following shortcomings and made recommendations for the core public health components (assessment, policy, and assurance) of the Nevada Oral Health Program (excerpts from the ASTDD 1999 Review):

Assessment of oral health status, needs, and determinants

Shortcomings

- ◆ Findings of the 1992 youth survey are becoming outdated as the State has undergone major demographic shifts during the past decade. No similar data area available for adults or special populations.
- ◆ An integrated data system that incorporates oral health data as part of a statewide surveillance system needs to be developed.
- ◆ Without a State Office of Oral Health there is no infrastructure to assure continuing data collection efforts at periodic intervals.

Recommendations

- ◆ Mobilize support for an updated oral health status survey that will reflect Nevada's current demographic makeup.
- ◆ Develop strategies to identify and collect existing secondary data on oral health status, needs, and determinants from a variety of sources within and outside of the department.
- ◆ Identify partners within the State to explore incorporating oral health information into the existing epidemiological data systems.
- ◆ Consult with oral health program directors in neighboring states to determine how other programs have addressed problems and issues in assessment of oral health status and determinants; identify strategies that would be appropriate for use in Nevada.

Policy Development

Shortcomings

- ◆ Although the SHD Oral Health Action Plan includes meaningful objectives and recommendations, implementation strategies remain to be developed; the lack of a State Office of Oral Health is a serious shortcoming in this regard, and the absence of a fully qualified State Dental Director means that the SHD has no one who can assume full leadership responsibility in the interests of oral health in the State.
- ◆ Lack of resources and program infrastructure compromise the SHD's ability to address the oral health problems identified in the Action Plan, and limit the effectiveness of potential partnerships.
- ◆ Lack of legislative support for an Office of Oral Health presents a major obstacle to the implementation of the Action Plan.
- ◆ The current Action Plan was developed as a one-time ad hoc effort; no strategic planning infrastructure exists through which planning and policy development activities can be pursued on a continuing basis.

Recommendations

- ◆ Using the existing Action Plan and the planned Oral Health Initiative as examples and resources, identify and recruit advocacy partnerships within Nevada's oral health and public health communities to work towards the establishment of an Office of Oral Health within the SHD; without an Office of Oral Health and a state dental director, the remaining recommendations will be difficult or impossible to implement.
- ◆ Using existing and new partnerships, establish a statewide oral health planning committee to periodically review existing plans, policies, and objectives on a regular and continuing basis
- ◆ Develop a formal oral health strategic plan with operational objective, priorities, and implementation strategies, and timelines for key objectives.

Assurance

Shortcomings

- ◆ The absence of a State Office of Oral Health has constrained the ability of the SHD to implement the assurance recommendations of the 1998 Oral Health Action Plan.
- ◆ Not all of Nevada's dentists accept Medicaid patients.
- ◆ Only one of Nevada's community health centers currently provides oral health care.

Recommendations

- ◆ The establishment of a State Office of Oral Health remains an essential long-term objective if assurance initiatives are to be fully implemented as recommended in the Governor's 1998 Oral Health Action Plan; in the interim the State should continue to seek assistance through partnerships and coalitions, and strive to build a constituency in support of establishing an Office of Oral Health in the near future.
- ◆ The SHD should continue to monitor the progress of implementation of water fluoridation in Clark County, and should mobilize efforts to maintain a strong health education and promotion presence in that locality.
- ◆ The State should work with appropriate partners to identify and remove barriers to provider participation in the dental Medicaid program, and to encourage the provision of dental care in all of the State's community health centers.

The needs assessment recommendations concur with the findings of the ASTDD review of the Nevada Oral Health Program. Additional recommendations include:

- ◆ Reduce dental caries and increase the number who receive protective sealants
- ◆ Education for consumers regarding dental health care for their children

- ◆ Increase education to the parents to reinforce basic oral health practices – teeth brushing, check-ups
- ◆ Address the lack of access to dental healthcare for lower socio-economic, uninsured populations
- ◆ Increase the number of dentists in rural areas who accept Medicaid, provide pro bono services, fee-for-service, other payment methods, Nevada 3Check Up, etc.
- ◆ Increase/recruit more dental providers to the State
- ◆ Address the Nevada Dental Board requirements that make it difficult for out-of-state dentists to practice in Nevada

Health Education

Health education is a very large and very vague area to address; it has been extracted from enabling and population-based services because of its permeation of nearly all areas of health. Health education for providers and consumers is the key concern. The work groups believe that there is not enough Nevada-specific information in various forms (aural, visual, tactile) for the population. State agencies, HMOs, hospitals, social service agencies, community-based organizations, and so forth, can partner together to produce public health strategies to address the need for health education. It is important that education efforts identify persons at risk for unhealthy behaviors and link them with appropriate services. This identification process can be outlined by those entities that participate in the strategic planning process of health education materials, seminars, etc. In addition, there are no comprehensive information clearinghouses in Nevada that persons requiring health education in the form of brochures, visual, audio, referral, training, etc. can access. It is the suggestion of the needs assessment that one be created and that the SHD develop a public health library that will include an information clearinghouse (in-house and web-based).

Mental Health

Mental health services are in great need among the three MCH populations. Over the next five years, it is important that access to mental health services, providers, and resources be increased for all populations. The needs assessment recommends that the resources must first be developed and then provider and consumer education regarding the diagnosis, treatment, and use of these services can ensue. The legislature must address the inadequacy of this area of health and delineate state financial resources to tackle the lack of appropriate services.

Screening

Screening for particular health discrepancies in the three MCH populations was addressed by the workgroups and surveys. The following are some examples of screening in Nevada that need to be created, implemented, or increased.

Women and Children < 1

- ◆ Increase the number of children who receive immunizations at all stages, most importantly non-school age children
- ◆ Create universal domestic violence screening for women seeking prenatal care

Children 1-9

- ◆ Increase the proportion of primary care providers who routinely refer or screen children for impairments and other developmental milestones
- ◆ While screening mothers for domestic violence, screen children for signs of abuse and/or neglect

Adolescents 10-21

- ◆ Create and promote universal self-esteem evaluations among youth

CSHCN

- ◆ Increase the proportion of primary care providers who routinely refer or screen children for impairments and other developmental milestones

Immunizations

Another area of great concern among the healthcare providers in Nevada is immunizations. 75% of our two year olds are covered by their “4, 4, 3, 1” immunizations (DTaP, Hib, Haemophilus/influenzae, and MMR). Tribal Health Facilities and some private practices around the state expressed concern about not knowing who has received immunizations and oftentimes do not give or double-up on immunization dosages. The Nevada State Immunization Registry is fully functioning, and all of the health departments around the state are connected to the SHD system, except Clark County Health District. Many private providers around the state are using the registry as well and providing information to the Western Governor’s Association’s Health Passport interface. It is important that Tribal Health Facilities, as well as other private practices around the state support the Nevada State Immunization Registry to ensure timely, proper, and documented immunizations of our children.

State Involvement and Coordination

The SHD, mental health (Division of Mental Health/Developmental Services), social services/child welfare (Division of Child and Family Services), Medicaid and Nevada 3Check Up (Division of Health Care Financing and Policy) are located within the Department of Human Resources (DHR). BFHS works with the Divisions of DHR to promote MCH priorities and objectives. BFHS also works with the bureaus of the SHD in one manner or another (data analysis and collection, referral, policy analysis, etc). This includes the Bureaus of Alcohol and Drug Abuse (BADA), Disease Control and Intervention Services (BDCIS), Health Planning and Vital Statistics (BHPVS), Health Protection Services (BHPS), Community Health Services (BCHS), and Licensure and Certification (BLC).

In the Spring of 2000, the SHD Primary Care Development Center (PCDC) was moved organizationally into the BFHS. This move has provided the opportunity to more closely integrate MCH with primary care activities than was accomplished in the past. PCDC is the home of the MCH SSDI grant that provides the BFHS needs assessment and surveillance of BFHS performance measures. The BFHS chief is working very closely with the new PCDC manager and has gained greater knowledge of the data available or in process through PCDC. New ways to partner with PCDC and the primary care community are being identified with regularity, such as linking Federally Qualified Health Centers (FQHC) with potential partners previously unidentified in their communities to promote access to care. Nevada also has a Covering Kids grant from the Robert Wood Johnson Foundation (RWJF) through the Great Basin Primary Care Association (GBPCA). The BFHS is working with GBPCA to ensure that every opportunity to partner and promote access to Medicaid and Nevada 3Check Up for eligible children is made.

BFHS seeks to work closely with Nevada's public health community including the Clark County Health District and Washoe County District Health Department to promote the health and well-being of the MCH populations in those counties. Title V funding provides support to Washoe and Clark Counties and Community Health Services (BCHS). In Washoe County funding supports the MCH program of home visiting for women and infants and an adolescent health clinic. In Clark County funding supports an adolescent health clinic including an oral health initiative. Title V funding provides some support for Community Health nursing services in Nevada's rural and frontier counties. Community Health Services in Nevada's rural and frontier counties provide public health services to those counties that do not have local public health agencies.

BFHS has not been very successful in partnering with Vocational Rehabilitation, Community Based Services, and the Development Disabilities Planning Council of the State Department of Employment, Rehabilitation and Training (DETR) despite a recent partnering on youth workforce initiatives. This relationship may change for the better; the newly appointed (June 19, 2000) Director of DETR was formerly the Administrator for Welfare and before that Administrator of SHD. The coming year will see what changes this appointment will bring.

BFHS receives a monthly list from Nevada 3Check up and a microfiche listing from Medicaid that enables BFHS staff to check the eligibility status of program applicants. The SHD and the Division of Health Care Financing and Policy (DHCFP) have an agreement that outlines information sharing and cross referral between the agencies. A separate agreement covers the BYB program that is a partnership between Medicaid and the SHD, as well as, private sponsors. With the development of the Birth Defects Registry and the MCH data system a new agreement between DHCFP and SHD will be negotiated to include provisions to cooperate and collaborate on data collection and exchange, outreach efforts, enabling services and quality assurance. A BFHS contractor is working on the Birth Defects Registry in Las Vegas. Both the SCCs have special needs parents on staff to provide assistance and support to the families served by the clinics.

BFHS continues to work closely with UNSOM. The MCH chief has been part of an interview team for faculty positions that work closely with MCH. The Birth Defects Registry initiative is partnering with the UNSOM Department of Pediatrics' geneticists to provide consultation in its development and implementation. BFHS staff contracts with and supports UNSOM participation in multi-disciplinary clinics for CSHCN that include genetics, diabetes, endocrinology, gastroenterology, pulmonology and cleft/craniofacial clinics in Reno and Las Vegas. UNSOM residents rotate through SCC-Las Vegas giving them a hands-on experience in working with CSHCN in need of Early Intervention services.

The BYB campaign continues to support Information and Referral Line (IRL), a multi-media information campaign and a network of prenatal care and pediatric providers. Providers agree to accept Medicaid, Nevada 3 Check Up, and MCH Prenatal funding, as well as, have a sliding fee scale for those who do not qualify for assistance. In 1999 the IRL had 8,664 calls. A total of 12,452 individuals received services through BYB in 1999 including those who did not call the IRL but had heard of BYB and self-referred. The Bureau's BYB IRL serves as a referral source for families in need of pediatric care, with referrals to Nevada 3Check Up, Medicaid, and pediatric providers a service offered through the IRL. The Bureau's SCC staff work to ensure children seen at the clinics covered by Medicaid managed care and Nevada 3Check Up are receiving the services they need including primary care. In 1999 BYB made 993 referrals to pediatric providers. The BFHS database

Resource Directory (The Family Health Services Resource Directory) currently has over 2000 listings that are used for BYB and any other referrals that come into the Bureau, including those for Perinatal Substance Abuse and Teen Pregnancy. The BYB campaign is particularly targeting Hispanic and Black/African American groups.

BFHS is home to small programs that pay for the treatment of CSHCN and prenatal care for pregnant women. These programs act as safety-net providers for eligible individuals who do not meet the requirements for Medicaid, SSI (which includes Medicaid in Nevada), or Nevada 3Check Up. For those children who are CSHCN eligible, the program will also pay for primary care including dental care. For those pregnant women who are eligible, the program will pay for dental care and other services deemed necessary to produce a healthy birth outcome; it does not cover labor and delivery. For those children who are SSI eligible the program supports services at the SCCs in Reno and Las Vegas including the multidisciplinary clinics and other services that are not covered by Medicaid such as specialty foods required by some children with metabolic disorders. It should be known that this funding is very limited, and often runs out before the end of the fiscal year.

CSHCN and their families continue to be served with case management/care coordination through the SCCs, the multidisciplinary specialty clinics and the Carson City office. The Carson City office primarily focuses case management services on children with complex conditions who are covered by the CSHCN Program and those identified through newborn screening. SCC services are for those children served through Early Intervention. The Carson City office also contains the state Special Supplemental Food Program for Women, Infants and Children (WIC).

Other Population-Based Programs

Nevada has one of the top programs for Newborn Screening in the nation. From year to year, 99.8% of Nevada's newborns are screened for phenylketonuria (PKU), hypothyroidism, galactosemia and hemoglobinopathies, as well as for biotinidase deficiency and maple syrup urine disease. In addition, 85-88% of newborns receive a second confirmatory screening. Data is obtained through State vital statistics (birth certificates) and Newborn Screening records.

In 1999, Nevada saw a change with the initiation of newborn hearing screening in the two largest hospitals in Reno through the efforts of Pediatrix, a national pediatric provider network. In Year 2000 one of the smaller hospitals in Las Vegas served by Pediatrix has implemented universal newborn hearing screening. During Spring 2000, Medicaid began paying for newborn hearing screening for all eligible infants, not only those in neo-natal intensive care units (NICU). BFHS, Department of Children and Family Service's (DCFS) Early Intervention program, and Part C/Early Intervention are working with the Interagency Coordinating Council (ICC) to promote Universal Newborn Hearing Screening in Nevada.

3.1.2.5 INFRASTRUCTURE BUILDING SERVICES

Need

Nevada-specific Research

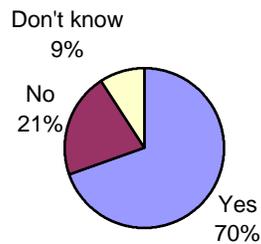
Nevada must continue to publish Nevada-specific research regarding its changing populations. The needs assessment findings are impetus for the SHD to undertake its own studies to address the needs of all of its populations. There is an obvious need for Nevada-specific research, and collaboration between State agencies, and the private sector to produce collaborative studies to address the health of all persons in Nevada. Without data generalizable to the population, we cannot properly and specifically address the needs of Nevada's rural, frontier, and urban populations.

Information Systems

Data collection and the development of information systems at State and community levels are important in the electronic age. Keeping up with the latest electronic methods of data collection, analysis, and transmission are difficult in a world where funding often drives the types of computer systems housed in offices. Unfortunately, not all healthcare systems are

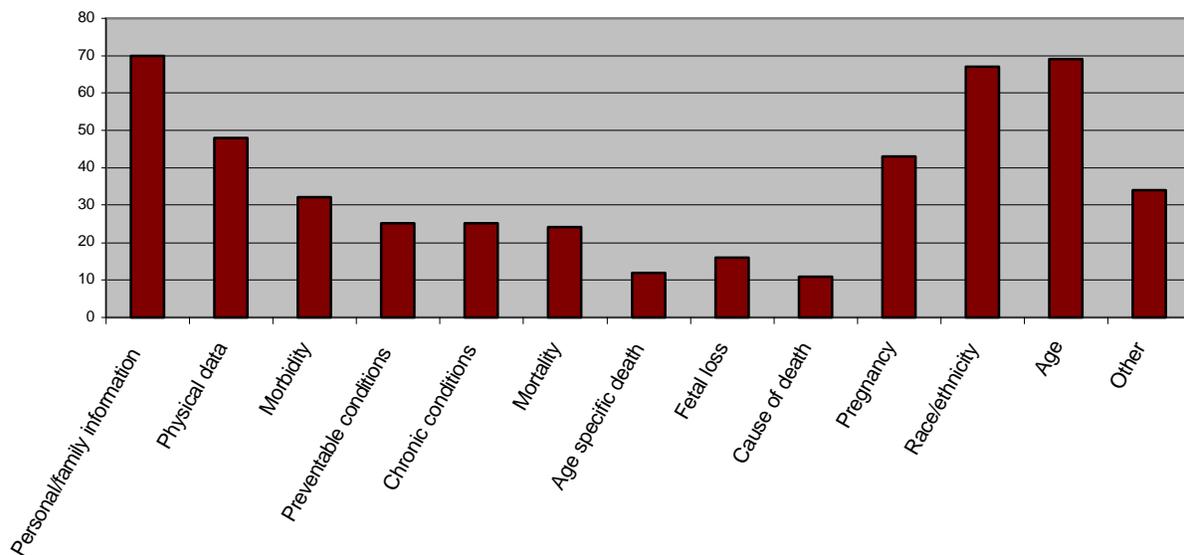
able to keep up with the most recent versions of software and hardware available; therefore, some systems are further ahead or further behind than others. Uniformity of data collection is possible, however, uniformity of data storage and transmission may not be. SHD must work to develop a statewide surveillance system for performance indicators. The workgroups and surveys indicated a large amount of diverse types of data collected by the agencies, and a willingness to share this confidential data to help continue, create, plan, and promote existing and future SHD programs and projects. The agencies indicated a strong need for SHD to bolster their data collection systems by assisting in helping them develop their surveillance systems, data collection methods, interpreting data analysis, and providing support in grant writing. Among the polled agencies, 70% do collect some form(s) of data.

Do you uniformly collect information/data on these populations?
N = 111



Among the various forms of data collected are: personal/family information, physical data, morbidity and mortality data, pregnancy, race/ethnicity, age, socio-economic status, substance abuse, disability status, lifestyle, income, etc.

What type(s) of information do you collect for the populations you serve?
N = 111



BFHS has wanted to build up the MCH data system for quite some time. In the past year the Birth Defects Registry has become operational and is in the process of linking with birth certificates and newborn screening. With the Bureaus of Health Planning and Vital Statistics and Disease Control and Intervention Services, BFHS is a partner in a grant application to the MCHB for “Data Utilization and Enhancement.” The intent of this application is to link databases to track health status indicators, with the hope of adding additional databases to the SHD interactive internet database initiated through the Maternal and Child Health Internet-Query Module (MatCHIIM) during the past two years. In addition, the SHD has requested support from the Department of Energy (DOE) for the Birth Defects Registry to track birth defects that might have been caused by activities of nuclear sites, e.g., Yucca Mountain in southern Nevada; this initiative links with the activities of MCH SSDI.

Agencies also utilize this data to help form their goals and objectives for the populations they serve (63% of respondents). Not all the agencies surveyed draw on the BFHS State-Negotiated Performance Measures, Healthy People 2000 or 2010 goals, or other Federal measurements to formulate their goals and objectives (34% use Federal or State measurements, 20% do not, and 46% did not know what they use).

Focus on Minority Populations

Diversity among the health needs of the growing ethnic populations of Nevada can be best addressed by the creation of an Office of Minority Health at SHD. Cultural competency is core to addressing the growing needs of the different populations and developing diverse medical homes; the State must make great strides in providing culturally competent care to all of its populations, whether age-, medical-, or ethnic-related. This includes the need for additional and diverse personnel throughout the healthcare delivery system.

Local Delivery Systems

Nevada needs to continue work to increase the capacity of its healthcare systems, provide outreach to underserved populations, diversify resources, provide preventive and health education to all ages, and much, much more. If we look to our flagship public health states like Massachusetts, Minnesota, and Washington, Nevada can utilize their historical perspectives to predict what it can look like within 10-15 years, as well as, design a system that promotes prevention, incorporates education, and provides appropriate services to its populations.

A prime example of the need for a better healthcare system is the Las Vegas area. The city faces many challenges due to the immense growth in population during the last decade. A lack of providers, growing numbers of uninsured and working poor, minimal county support, and little financial resources to provide for the most basic needs of all the residents of the Las Vegas area contribute to the problem. The Federal Government has taken an interest in the Las Vegas area, and is looking to provide community development within the public health model to provide infrastructure-building services to create access to health care services and providers. There is a need for local government to take ownership for health planning activities and work to bring all parties to a common table.

Existing Systems and Collaborative Mechanisms

BFHS works with the Divisions of DHR to promote MCH priorities and objectives. BFHS also works with the Bureaus of the SHD in one manner or another (data analysis and collection, referral, policy analysis, etc). To provide better and more comprehensive services to the population of Nevada, the different Bureaus must promote more collaborative efforts with other State agencies, CBOs, and the primary, secondary, and university education systems.

With the move of PCDC into the BFHS, the opportunity to more closely integrate MCH with primary care activities has been created. It is important that PCDC continues to provide services to all of Nevada's populations, as well as, collaboratively work with other Bureaus in the SHD. New ways to partner with PCDC and the primary care community are being identified with regularity, such as linking FQHCs with potential partners previously unidentified in their communities to promote access to care.

BFHS seeks to work closely with Nevada's public health community including the Clark County Health District and Washoe County District Health Department to promote the health and well-being of the MCH populations in those counties. Title V funding provides support to Washoe and Clark Counties and BCHS. BFHS continues to work closely with UNSOM. BFHS has had little success in partnering with Vocational Rehabilitation, Community Based Services, and the Development Disabilities Planning Council of the DETR despite a recent partnering on youth workforce initiatives. It is important to forge relationships among all State agencies to provide a more unified effort in supporting Nevada's populations.

Preventive and Primary Care Services for Women and Children < 1

BFHS plans to continue and grow its programs focusing on women and children under age one, i.e., BYB, newborn screening, perinatal substance abuse prevention program, oral health initiatives, WIC, and an injury prevention program. Outlined within the section entitled “Women and Children < 1” is a more detailed look at this population, current and future services, as well as recommendations for improving the system for this population.

Preventive and Primary Care Services for Children and Adolescents

BFHS plans to continue and grow its programs focused on children ages 1-9, i.e., immunizations, injury prevention, oral health initiatives, and Abstinence Works. Outlined within the sections entitled “Children ages 1-9” and “Adolescents ages 10-21” are more detailed looks at this population, current and future services, as well as recommendations for improving the system for this population.

Preventive and Primary Care Services for CSHCN

BFHS has taken notice of preliminary data regarding needed additional focus on the CSHCN population, their parents, and providers. Outlined within the section entitled “Children with Special Health Care Needs” is a more detailed look at current and future services for CSHCN, as well as recommendations for improving the system in which this small population revolves.

Coordination Efforts

BFHS coordinates with Medicaid to monitor the Nevada 3Check Up Program. Now that BFHS has partnered with PCDC, it can monitor the efforts of Covering Kids through the Great Basin Primary Care Association. It is the recommendation of the needs assessment that BFHS evaluate the Nevada 3Check Up and Covering Kids Programs. BFHS partners coordinate with SSI and Ryan White through referral systems by healthcare and social service providers.

The Reno and Las Vegas SCCs provide social services, special education programs, early intervention programs, mental health programs, and developmental disabilities programs to infants and children up to age three. At school-age, these children are evaluated by the school districts. Of grave importance are the children between age three and school age (5-7) and what services they may or may not be receiving. There are no coordination efforts for CSHCN this age. The PCDC has made connections with the State Developmental Disabilities Planning Council, which will hopefully provide some answers, collaborative projects, and open doors to other organizations that will help provide a team to produce a strategic plan to address the needs of CSHCN. For children who are not CSHCN, BFHS needs to increase its participation in coordination efforts within the school (primary, secondary, and university) health programs. These programs serve all of the ages within the MCH populations.

The MCH SSDI grant now falls under the auspices of BFHS with the recent acquisition of PCDC. WIC is also within the BFHS organizational plan. These two, large programs have and will continue to work in conjunction with the efforts of BFHS, as well as provide services within the SHD and Nevada as necessary.

BFHS is partnered with the major healthcare systems around Nevada – both public and private. In addition, they also have partnerships with the State chapter of the American Academy of Pediatrics (AAP), the American College of Obstetrics and Gynecology (ACOG), and various family and parent advocacy organizations (e.g., Family Voices, Nevada Parent Network). BFHS should promote collaborative research, program, and projects with these partners to further the work of all the organizations.

CSHCN

BFHS is fortunate to have a Bureau Chief who has a CSHCN/Early Intervention background and a CSHCN program manager who has a nursing and Medicaid

background. Both of these women have promoted relationships among other state agencies, CBOs, healthcare entities, and advocacy groups to crusade the needs of CSHCN. Because of the wide variation of needs among the CSHCN population, multiplicity of diagnosis, and lack of funding, this program has provided a great deal to the small population it serves. However, as the CSHCN population grows, this small program is noticing deficiencies, both personnel and financial, in its current mode of service. Parents, advocacy groups, and small organizations are coming forward with concerns regarding the ability of the BFHS, SCC, and other partnering organizations to provide sufficient services to their children. The BFHS recognizes that there is a growing service need, however financial and personnel resources are the keys to providing for the needs of this population. BFHS staff recognizes the great difficulty in recruiting and retaining specialists for CSHCN, however there is very little they can do to resolve this problem. Making appropriate services and healthcare providers to special needs children and their parents in rural and frontier communities is proving just as difficult as providing services for urban CSHCN.

BFHS works with advocacy groups (e.g., Family Voices) who are in better communication with community-based systems like the Family Resource Centers. BFHS should strive for better communication among all its coordinating agencies. Working with community level services is also lacking within the BFHS. Once CSHCN are released from the SCC, little follow-up is done to address their needs. It is the recommendation of the needs assessment that BFHS develop a CSHCN Advisory Board who can keep them apprised of changes in community organizations, as well as informing them of the services offered by CBOs.

Development and Implementation of Assessment, Policy, and Assurance – the Core Public Health Functions

The BFHS concentrates 70.1% of its efforts on direct health care and only 11.6% on infrastructure building services. It can be extrapolated, that very little is done regarding

continuous quality improvement, development of community-based systems, implementation of standards of care, guidelines, monitoring of program effectiveness, and approaches to evaluation of care. During the needs assessment process, it was found that most communities have taken the initiative to develop their own programs and initiatives without the assistance of the SHD or BFHS. Some of these programs are highly creative and successful in the populations they serve. The project coordinator observed that there are many programs the SHD and BFHS are not aware of within Nevada, and it is important that a survey be sent to communities to take an inventory of these programs, projects, and resources so that the MCH populations may know what resources are available to them.

PRIORITY NEEDS

Throughout the needs assessment process, the project coordinator heard and observed themes within the recommendations from the workgroups, surveys, advisory boards, and public hearing. Within the themes are solutions in the form of methodologies, procedures, and global thought processes. The persons involved in any portion of the needs assessment process were very vocal, creative, and mindful of the populations they serve. These men and women represent an intricate thread that tie MCH services together in Nevada. All through the assessment, the effects of poverty, non-citizenship, racial and ethnic disparities in health status, geography, urbanization and private sector impacts on the delivery of services for the Nevada MCH population are discussed. Money, open-mindedness, and tolerance are the keys to implementing the recommendations of the Nevada Five Year MCH SSDI Needs Assessment. In order to properly address the needs of Nevada's MCH populations over the next five years, ten priority areas from the needs assessment were utilized to create Nevada's ten State-Negotiated Performance measures. From these performance measures, six

indicators of development will be tracked by the MCH SSDI surveillance system that is housed in the PCDC. These indicators will provide data to the MCHB who tracks the progress of the various MCH programs and regions in progressing towards their goals and objectives. The following is a summary of the ten priority areas and the recommendations of the Nevada Five Year (2000-2005) MCH SSDI Needs Assessment:

Nevada Five Year MCH Needs Assessment Recommendations for 2000-2005

Recommendations – Ten Priority Areas
◆ Address the need for additional medical personnel among the three MCH populations in the State of Nevada (Direct Health Care Services)
◆ All three MCH populations should have access to quality oral/dental health (Direct Health Care and Population-Based Services)
◆ Create a unified data system and surveillance system to monitor services delivered to the three MCH populations (Infrastructure Building Services)
◆ Create “braided” services and “one-stop shopping” for CSHCN resources in Nevada (Direct Health Care, Enabling, Population-Based, and Infrastructure Building Services)
◆ Decrease the incidence of domestic violence among women of child-bearing age (Population-Based Services)
◆ Increase healthcare access and address insurance and financial gaps among the three MCH populations (Enabling Services)
◆ Increase the amount of health education available for the three MCH populations and providers (Enabling and Population-Based Services)
◆ Increase the amount of innovative programs that address self-esteem and behavior modification in children 1-9 and adolescents 10-21 (Enabling and Population-Based Services)
◆ Increase access to mental health services, providers, facilities, resources, and payor sources among the three MCH populations (Direct Health Care and Population-Based Services)
◆ Increase the amount of outreach and enabling services available for the three MCH populations (Enabling Services)

Four Comprehensive Approaches to Address the Recommendations

- ◆ Within the next five years address inadequately funded medical and social services and the need for identification of Federal and State funds to develop these resources
- ◆ Acculturation and cultural competency issues should cut across all services provided
- ◆ Address the elimination of health disparities among all racial and ethnic minorities
- ◆ Develop a more holistic approach in addressing the service needs of women and children < 1, children 1-9, adolescents 10-21, and CSHCN

Measurable objectives for State-negotiated performance measures

The following are the needs assessment recommendations for the Nevada State-Negotiated Performance Measures:

- ◆ The percent of domestic violence screening among women of child-bearing age and their children should be increased (Population-Based Services)
- ◆ The percent of women, children, and youth (ages birth to 21) who have access to preventive oral services and dental care, regardless of ability to pay, should be increased (Enabling Services)
- ◆ The percent of health education programs that target children 1-9 should be increased (Enabling Services)
- ◆ The rate of child abuse and neglect should be reduced (Population-Based Services)
- ◆ The percent of health education, support systems and programs that address self-esteem in children 1-9 and adolescents 10-21 should be increased (Enabling Services)
- ◆ Teen pregnancy rates among adolescents 15-19 should be reduced, with emphasis on minority populations (Population-Based Services)
- ◆ Access to specialty and subspecialty services, and care coordination available to CSHCN should be increased (Enabling Services)
- ◆ Access to enabling services that assist in CSHCN care coordination, respite care, outreach, transportation, case management, and coordination with Medicaid, Nevada 3Check Up, or purchase of health insurance should be increased (Enabling Services)

- ◆ The percent of children and youth (ages zero to twenty one) and women of child-bearing age who have homes for primary medical care, regardless of ability to pay, should be increased (Population Based Services)
- ◆ The percent of children and youth (ages zero to twenty one), women of child-bearing age, and CSHCN who have access to mental health services, regardless of ability to pay, should be increased (Enabling Services)

CONCLUSION

Throughout the needs assessment process, deficiencies, strategies, and solutions were offered to the Project Coordinator to address the needs of the three MCH populations. There is an array of ongoing and changing needs, but limited financial and human resources to address them. The 10 State-Negotiated performance measures identified by the process make a very small dent in the short-run, however in the long-run, they will provide the State with a stable foundation upon which to further build public health services for women and infants, children and adolescents, and children with special health care needs.

Long-run solutions that will assist the SHD, BFHS, and all other coordinating agencies were identified throughout the document. The best of these solutions are outlined here:

- ◆ The State must increase funding to the SHD.
- ◆ There are no comprehensive information clearinghouses in Nevada that persons requiring health education in the form of brochures, visual, audio, referral, training, etc. can access. A public health library should be created in the State that will include an information clearinghouse (in-house and web-based).
- ◆ Differences among the health needs of the growing ethnic populations of Nevada can be best addressed by the creation of an Office of Minority Health at SHD that can assist CBOs in providing outreach to diverse populations.
- ◆ Mental health resources must first be developed and then provider and consumer education regarding diagnosis, treatment, and use of services may ensue. The legislature must address

- ◆ The BFHS should develop a CSHCN Advisory Board who can keep them apprised of changes in community organizations, as well as informing them of the services offered around the State and nation.
- ◆ The needs assessment recommends that the State undertake research studies, both long and short-term cohort studies, to address the needs of all of its MCH populations. There is an obvious need for Nevada-specific research to produce collaborative studies to address the health of its population.

These suggestions are only the beginning of a prosperous Public Health system in the State of Nevada.

3.2 Health Status Indicators

See Forms C2.1, C2.2, and C3.1 pages C2.1, C2.2 and C3.1 in Supporting Documents for the Health Status Indicators, and Forms SD D1 through SD D2.8, pages SD D1 through SD D2.8 in Supporting Documents for the Developmental Health Status Indicators.

The MCH Chief and MCH Biostatistician are working together to identify resources for the Developmental Health Status Indicators. Data initiatives discussed on page 11 have been identified as potential resources. It is anticipated that the state will be able to complete some if not most of the Developmental Health Status Indicators in the coming years, particularly when census data becomes available.

3.2.1 Priority Needs

Throughout the needs assessment process, the project coordinator heard and observed themes within the recommendations from the workgroups, surveys, advisory boards, and public hearing. Within the themes are solutions in the form of methodologies, procedures, and global thought processes. The

persons involved in any portion of the needs assessment process were very vocal, creative, and mindful of the populations they serve. These men and women represent an intricate thread that tie MCH services together in Nevada. All through the assessment, the effects of poverty, non-citizenship, racial and ethnic disparities in health status, geography, urbanization and private sector impacts on the delivery of services for the Nevada MCH population are discussed. Money, open-mindedness, and tolerance are the keys to implementing the recommendations of the Nevada Five Year MCH SSDI Needs Assessment. In order to properly address the needs of Nevada's MCH populations over the next five years, ten priority areas from the needs assessment were utilized to create Nevada's ten State-Negotiated Performance measures. From these performance measures, six indicators of development will be tracked by the MCH SSDI surveillance system that is housed in the PCDC. These indicators will provide data to the MCHB who tracks the progress of the various MCH programs and regions in progressing towards their goals and objectives. The following is a summary of the ten priority areas and the recommendations of the Nevada Five Year (2000-2005) MCH SSDI Needs Assessment:

Nevada Five Year MCH Needs Assessment Recommendations for 2000-2005

Recommendations – Ten Priority Areas

- ◆ Address the need for additional medical personnel among the three MCH populations in the State of Nevada (Direct Health Care Services)
- ◆ All three MCH populations should have access to quality oral/dental health (Direct Health Care and Population-Based Services)
- ◆ Create a unified data system and surveillance system to monitor services delivered to the three MCH populations (Infrastructure Building Services)
- ◆ Create “braided” services and “one-stop shopping” for CSHCN resources in Nevada (Direct Health Care, Enabling, Population-Based, and Infrastructure Building Services)
- ◆ Decrease the incidence of domestic violence among women of child-bearing age (Population-Based Services)
- ◆ Increase healthcare access and address insurance and financial gaps among the three MCH populations (Enabling Services)
- ◆ Increase the amount of health education available for the three MCH populations and providers (Enabling and Population-Based Services)
- ◆ Increase the amount of innovative programs that address self-esteem and behavior modification in children 1-9 and adolescents 10-21 (Enabling and Population-Based Services)
- ◆ Increase access to mental health services, providers, facilities, resources, and payor sources among the three MCH populations (Direct Health Care and Population-Based Services)
- ◆ Increase the amount of outreach and enabling services available for the three MCH populations (Enabling Services)

Four Comprehensive Approaches to Address the Recommendations

- ◆ Within the next five years address inadequately funded medical and social services and the need for identification of Federal and State funds to develop these resources
- ◆ Acculturation and cultural competency issues should cut across all services provided
- ◆ Address the elimination of health disparities among all racial and ethnic minorities
- ◆ Develop a more holistic approach in addressing the service needs of women and children < 1, children 1-9, adolescents 10-21, and CSHCN

Measurable objectives for State-negotiated performance measures

The following are the needs assessment recommendations for the Nevada State-Negotiated Performance Measures:

- ◆ The percent of domestic violence screening among women of child-bearing age and their children should be increased (Population-Based Services)
- ◆ The percent of women, children, and youth (ages birth to 21) who have access to preventive oral services and dental care, regardless of ability to pay, should be increased (Enabling Services)
- ◆ The percent of health education programs that target children 1-9 should be increased (Enabling Services)
- ◆ The rate of child abuse and neglect should be reduced (Population-Based Services)
- ◆ The percent of health education, support systems and programs that address self-esteem in children 1-9 and adolescents 10-21 should be increased (Enabling Services)
- ◆ Teen pregnancy rates among adolescents 15-19 should be reduced, with emphasis on minority populations (Population-Based Services)
- ◆ Access to specialty and subspecialty services, and care coordination available to CSHCN should be increased (Enabling Services)

- ◆ Access to enabling services that assist in CSHCN care coordination, respite care, outreach, transportation, case management, and coordination with Medicaid, Nevada 3Check Up, or purchase of health insurance should be increased (Enabling Services)
- ◆ The percent of children and youth (ages zero to twenty one) and women of child-bearing age who have homes for primary medical care, regardless of ability to pay, should be increased (Population Based Services)
- ◆ The percent of children and youth (ages zero to twenty one), women of child-bearing age, and CSHCN who have access to mental health services, regardless of ability to pay, should be increased (Enabling Services)

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

See Form 2, SD2.1; Form 3, page SD 3.1; Form 4, page SD 4.1; and Form 5, page SD 5.1.

3.3.2 Other Requirements

This FY2001 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 \$2,053,725.00 and is based upon \$1,545,737.00 in FY2001 allocation and an anticipated carryover of \$507,988.00 from the FY99 allocation. The state MCH match, budgeted at \$1,159,303.00 is comprised of State General Fund dollars and fees generated by Newborn Screening. The state MCH match is for the current year allocation as the state match for the carryover was expended during the current fiscal year. The total FY2001 MCH budget is \$3,213,028.00. As required, the FY2001 MCH budget complies with the FY 89 Maintenance of Effort amount. This amount represents \$853,034.00.

For FY2001, 30.0% of the federal Title V allocation is directed to Section A of Form

2, Component B, preventive and primary care for children and adolescents that amounts to \$463,722.00. Direct services provided under Component B are primary care and oral health oriented, as these represent two significant unmet needs for children and adolescents. Services are provided through community based, non-profit agencies, Federally Qualified Health Centers, as well as through the health districts. In addition to direct services, Component B 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 FY2001, 30.0% of the federal Title V allotment is directed towards Children with Special Health Care Needs, Section B Form 2, Component C. The allotment budgeted for Component C services amounts to \$463,722.00. The individuals to be served under Component C are children with special health care needs and their families. Services funded under this component are primarily direct services and are designed to be family-centered, community based, culturally appropriate and comprehensive. Direct services are provided through several mechanisms: through the Special Children's Clinics and through health professionals, such as the pediatric ophthalmologists and physical therapists who are under contract to the CSHCN program and the CSHCN treatment program.

For FY2001, Administrative costs, Section C Form 2, will not exceed \$154,572, which is 10% of the current period grant request total. For FY2001, the remaining federal Title V allotment is directed towards services for pregnant and postpartum women and infants up to age 1 year. The allotment budgeted for services is \$463,722.00. 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 contract with local agencies, including health districts and community based non-profit agencies. In addition to direct services, 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 FY2001. Also included is the State's Newborn Screening program, which screens almost every infant born in the state for inborn errors of metabolism hemoglobinopathies. Follow-up for identified children is included in Component C.

Overall, allocation of MCH dollars across Components A, B, & C is based upon unmet health care needs identified by the Year 2000 Five-Year MCH Needs Assessment. 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, is being expended in two primary areas over the FY2000/2001 biennium. Approximately half has gone to support an oral health prevention initiative, which is described in the Annual Plan on page 169. The other half has gone to the SCCs to support community-based, family centered early intervention services. The goal is to leave approximately \$150,000 in unexpended grant balance at the end of the upcoming biennium.

Other federal funds administered by the MCH Chief besides the Maternal and Child Health Title V Block Grant Program include a USDA grant for the state WIC program, abstinence-only education funded by Title V, carry-over fluoride education funded by the Maternal and Child Health Bureau, and Fluoride, Birth Defects Registry and Injury Prevention grants from CDC. The other federal grants provide different services to the populations served by the Maternal and Child Health Block Grant Program in accordance with the approved grant proposals.

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

Figure 4
PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) 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.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
The percent of domestic violence screening among women of child-rearing age and their children should be increased.			X				X
The percent of women, children and youth ages birth to 21 who have access to preventive oral services and dental care regardless of ability to pay should be increased.		X			X		
The number of health education programs that target children 1 – 9 should be increased.		X				X	
The rate of child abuse and neglect should be reduced.			X				X
The number of health education, support systems and programs that address self-esteem in children 1 – 9 and adolescents 10 – 21 should be increased.		X				X	
Teen pregnancy rates among adolescents 15-19 should be reduced, with emphasis on minority populations.			X				X
Access to specialty and subspecialty services available to CSHCN should be increased.		X			X		
Access to enabling services that assist CSHCN in care coordination, respite care, outreach, transportation, case management, and coordination with Medicaid, Nevada 3Check Up or purchase of health insurance should be increased.		X			X		
The percent of children and youth ages birth to twenty-one and women of child bearing age who have homes for primary medical care, regardless of ability to pay, should be increased.			X		X		
The percent of children and youth ages birth to twenty-one, women of child- bearing age, and CSHCN who have access to mental health services, regardless of ability to pay, should be increased.		X			X		

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
 IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.1.1 Five Year Performance Objectives

See Form 11, page SD 11.

3.4.2 State "Negotiated" Five Year Performance Measures

See Forms 16, beginning on page 16.1, for detail.

The following State Performance Measures were selected beginning FY 2001 based on the findings of and priorities established by the FY2000 MCH Needs Assessment.

SP 11. The percent of domestic violence screening among women of child-bearing age and their children should be increased (Population-Based Services)

SP 12. The percent of women, children, and youth (ages birth to 21) who have access to preventive oral services and dental care, regardless of ability to pay, should be increased (Enabling Services)

SP 13. The number of health education programs that target children 1-9 should be increased (Enabling Services)

SP 14. The rate of child abuse and neglect should be reduced (Population-Based Services)

SP 15. The number of health education, support systems and programs that address self-esteem in children 1-9 and adolescents 10-21 should be increased (Enabling Services)

SP 16. Teen pregnancy rates among adolescents 15-19 should be reduced, with emphasis on minority populations (Population-Based Services)

SP 17. Access to specialty and subspecialty services available to CSHCN should be increased (Enabling Services)

SP 18. Access to enabling services that assist CSHCN in care coordination, respite care, outreach, transportation, case management, and coordination with Medicaid, Nevada 3Check Up or purchase of health insurance should be increased (Enabling Services)

SP 19. The percent of children and youth (ages zero to twenty one) and women of child-bearing age who have homes for primary medical care, regardless of ability to pay, should be increased (Population Based Services)

SP.20 The percent of children and youth (ages zero to twenty one), women of child-bearing age, and CSHCN who have access to mental health services, regardless of ability to pay, should be increased (Enabling Services)

3.4.2.1 Development of State Performance Measures

See page 31 for the FY 2000 MCH Needs Assessment. All State Performance Measures for the next five years are based on the findings of this latest Needs Assessment.

3.4.2.2 Discussion of State Performance Measures

See the Needs Assessment beginning on page 31 for a discussion of the State Performance Measures. Level of placement in the Pyramid of State Negotiated Performance Measures is reflected in Figure 4 on page 152. All 10 State Performance Measures relate to the 10 State priorities listed on pages 145 to 146 and National Outcome Measures

3.4.2.3 Five Year Performance Objectives

See Form 11, National performance Measures, page SD 11.

3.4.2.4 Review of State Performance Measures

No information is included at this time of grant submission.

3.4.3 Outcome Measures

See Form 12, Outcome Measures, page SD 12.

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]

4.1 Program Activities Related to Performance Measures

All National Performance Measures (P) and State Performance Measures (SP):

Nevada has chosen to write this Annual Plan by population and then by level of the pyramid. Staff have determined many of the State's MCH/CSHCN initiatives for each population level have components at two or more levels of the pyramid.

Within these caveats the following Annual Plan has been prepared.

Pregnant Women, Mothers and Infants

P5 Immunizations, and SP19 Access to Care: Nevada's MCH-supported immunization efforts are primarily *Population-Based Services, with some Direct Services*.

Nevada's MCH Program will continue to participate in State immunization initiatives through its WIC Program and BYB, and through the Community Health Services offices in the rural counties, as well as the contract support for Washoe County District Health Department which includes immunizations.

Nevada WIC continues its immunization link with the State's Immunization Program in the SDH Bureau of Disease Control and Intervention Services and Medicaid. By the end of 1999 almost all WIC clinics were integrated into the State immunization registry as planned. This was accomplished with a United States Department of Agriculture and a Robert Wood Johnson Foundation's "All Kids Count" grant. This allows for less missed opportunities since WIC clinics now have the ability to do real time searches of children immunization records. Approximately 90% of all WIC clinics are now part of the SHD Wide Area Network. Depending on the location of the WIC clinic, they will be able to send a family to a nurse to obtain needed immunizations on site, or will refer the family to a site for immunizations. The WIC manager, the Bureau of Community Health Services Chief, and the MCH Chief continue to make co-location of WIC clinics and Community Health Services (CSH) offices a priority in the rural CHS clinics. WIC clients in Washoe County will also be able to keep track of their immunizations by way of the Health Passport Project (HPP) smart-card . The smart-cards were launched in Washoe County in June 2000. MCH

funding also supports immunizations offered in the CHS offices as well as in the MCH supported Washoe County District Health Department clinics. Finally, the Nevada WIC hot-line number (1-800-8 NEV WIC) is the number given for information with the Nevada Broadcaster's PSA campaign for immunizations.

Staff of the PCDC are meeting with state immunization staff of BDCIS to discuss integrating information. Under discussion is using the Center's map-info, geocoding and census tract information to provide data by census tract on immunization rates. Data provided could then be used to assist with planning strategies in identified targeted areas to raise immunization rates.

Baby Your Baby:

Baby Your Baby continues to promote immunizations through its bilingual multi-media campaign, particularly during April's Immunization Month. Public Service Announcements in both the north and south provide information regarding immunizations and where they can be obtained. The Baby Your Baby Information and Referral Line will also continue to provide information to callers on where to obtain immunizations.

P15 Very Low Birth Weight; P17 Very Low Birth Weight Deliveries; P18 Prenatal Care 1st Trimester; SP11, Domestic Violence, SP 19 Access to Care

Components of the MCH Perinatal initiative to promote healthy birth outcomes include:

BYB:

Through the Baby Your Baby campaign, Nevada's MCH will continue to support and promote a network of prenatal providers who will serve pregnant women regardless of ability to pay. In FY2001 the effort to recruit providers, particularly rural providers will continue. BYB will continue the statewide bilingual multi-media campaign to encourage early entry into prenatal care and promote healthy behaviors during pregnancy. Callers to the BYB Information and Referral Line (IRL) will continue to

receive information regarding sources for coverage of prenatal care as well as to any other referrals requested by the caller. The multi-media campaign and staffing of the IRL are both provided in English and Spanish. The most recent evaluation of the program indicated BYB is reaching minority populations at a greater rate than their representation in the general population. BYB will continue to assess its impact on African American and Hispanic women and target the multi-media campaign to them.

The BYB web-page (www.state.nv.us/health/byb) contains information on Nevada's Baby Your Baby Campaign, how to have a healthy pregnancy, infant care, well child issues, teen pregnancy issues, and many other topics related to maternal and child health.

The BYB campaign is primarily *Enabling and Population Based Services*.

MCH Prenatal:

MCH Prenatal will continue to pay for prenatal care for women who meet eligibility criteria as listed in NAC. This is currently established at 250% of the Federal Poverty Level, with legal residency in the Nation and Nevada residency required. This component of the MCH Prenatal program is *Direct Services*.

Standards:

The MCH Perinatal program will continue standards development and information options. In addition to HIV voluntary counseling and testing, the MCH Prenatal program is assuring providers have information on new research regarding birth outcome, such as the affect of Strep B, periodontal disease and Bacterial Vaginosis. The Bureau database discussed in Section 1.5.1.2 will continue to be developed to include information on services of interest to pregnant women and their families, and the general public. These are *Infrastructure Building and Enabling Services*.

Continuing Education Workshops:

The Bureau of Family Health Services has taken a leading role in developing and presenting continuing education workshops for health care providers throughout the state. These are *Infrastructure Building* and *Enabling Services*. Below are the classes that have been developed or presented in the past year and plans so far for the coming year:

Folic Acid

At the annual state meeting of all WIC personnel in Nevada, a presentation on the importance of Folic Acid both before and during pregnancy was given. There were approximately 100 people who attended this meeting.

Preconception Counseling

Three separate classes on Preconception Counseling have been held during 1999-2000 and will continue to be available in 2001. This class provides information on the areas of health that should be discussed with all childbearing age women and their partners, including reproduction and fertility (preventing unintended pregnancy), body weight, nutrition, genetics, infectious diseases, drugs, medical history, high risk behaviors, environmental issues, male issues and breastfeeding. One class was held in Las Vegas, one in Reno and one in the rural Nevada, Winnemucca. Approximately 70 nurses and social workers attended the workshops.

Care of the Infant - What's a parent to do?

Seventy-Six (76) nurses, social workers and WIC personnel have attended this course in 1999. It has been given in locations throughout Nevada. This class covers infant development, nutrition and common illnesses. Another class is scheduled in July 2000 in Las Vegas, NV.

Fetal Alcohol Syndrome and Drug Addicted Babies: Their Special Needs

In this class, participants learn about the principals of teratology and developmental toxicology, the susceptible stages of fetal development, specific illegal drugs, and the medical and social management of the drug exposed infant. This class has just recently

been developed and has been given one time in Las Vegas. Forty-Six people attended the first class.

The Stages of Pregnancy and Fetal Development

This four-hour continuing education class has just recently been developed. It is scheduled to be presented for the first time in October 2000.

Folic Acid Council:

The Bureau is partnering with the March of Dimes and other organizations to educate the public about the need for women of childbearing age to take Folic Acid. The council has received a \$10,000 grant from the March of Dimes to disseminate information to the public. This will be done through private health care providers' offices, WIC clinics, schools and possibly other avenues. Follow-up to evaluate the effectiveness of this effort will also be done.

Access to Prenatal Care:

The Bureau will continue its efforts to work with agencies to promote access to prenatal care including those whose services target high risk Hispanic and African American Women. The Economic Opportunity Board (EOB) serves areas of Las Vegas and North Las Vegas with high minority populations. The MCH contract with EOB provides support for appropriate obstetric services for their clients. It has WIC clinics on site. Through PCDC MCH will work with Rural Health Centers of Southern Nevada as they develop clinics, particularly those in Las Vegas replacing Community Health Centers of Southern Nevada, to include the provision of prenatal care in their services. In addition, MCH will continue to provide funding for Community Health Nursing (CHN) services in Nevada's 15 rural counties. The CHNs provide pregnancy testing and family planning services as well as referrals to BYB and MCH Prenatal in their clinics. These are *Direct* and *Enabling Services*.

As reported last year, the Bureau and St. Mary's Hospital of Reno received a grant supported through a collaborative effort between the American College of Nurse-Midwives and the Maternal and Child Health Bureau to hold a conference on MCH issues. The purpose of the MCH Providers Partnership is to promote cooperative efforts and enhance communication between the MCHB and MCH providers' membership organizations serving pregnant women and children that will ultimately improve the health status of all pregnant women and infants through improved MCH health care services and systems.

The conference, which took place on September 24, 1999 in Reno, brought together key stakeholders that included hospital representative, clinic representatives, public health, Medicaid and private practice health care providers. Unexpected accomplishments included physicians from the urban area networking with a physician from the rural area of Nevada and learning of the tremendous barriers rural physicians face. In addition, there is no "peer review" in rural areas. As a result, physicians from urban areas of the state associated with UNSOM offered to review charts of rural physician's performance. In addition, the UNSOM and the Nevada Chapter of the American College of Obstetricians and Gynecologists (ACOG) recently had a meeting to bring together health care providers throughout the state to discuss specific measures that are being investigated to help alleviate the shortage of obstetrical providers in the rural areas. This initiative is a direct result of the MCH Providers Partnership initiative; the Bureau will continue to support this effort in the coming year. These are *Infrastructure Building* and *Enabling Services*.

Perinatal Substance Abuse Prevention:

The Bureau continues its initiative in Perinatal Substance Abuse Prevention (PSAP). This is an *Infrastructure Building* initiative. Elements of the initiative that will be addressed in FY2001 are as follows:

The PSAP initiative activities over the course of the next year will be developed and coordinated through the PSAP and Fetal Alcohol Syndrome (FAS) Subcommittees of the Maternal and Child Health Advisory Board (MCHAB). The PSAP Subcommittee addresses perinatal substance abuse prevention overall, while the FAS Subcommittee is more narrowly focused upon efforts directed towards prevention of alcohol-related birth defects. Some activities over the course of the next year will be those mandated by the 1999 legislation (Senate Bill 197) which created the FAS Subcommittee:

1. Assisting the Health Division in developing a program of FAS-prevention public education which provides information to both the general population and to target populations identified as being at high risk of alcohol use during pregnancy, and which provides school personnel with FAS screening and referral materials.
2. Evaluating the effectiveness of the Health Division's FAS-prevention public education program.
3. Determining, and report to the MCHAB, the most effective means of preventing alcohol-related birth defects and of conducting FAS surveillance in Nevada.
4. Developing and promoting guidelines for prevention of alcohol use during pregnancy and for increasing substance abuse treatment utilization by women of childbearing years.
5. Developing with the University of Nevada School of Medicine model continuing education curricula regarding alcohol-related birth defects and promoting the availability and distribution of these curricula.
6. Reviewing Health Division statistics regarding the incidence of alcohol-related birth defects.

Some elements of the above will be expanded beyond alcohol-related birth defects. The PSAP Subcommittee will be identifying the most effective means of preventing abuse of alcohol and other drugs (not just alcohol) during pregnancy including prevention of initiation of alcohol, tobacco and other drugs use by youth and determining means of implementing primary prevention of such perinatal substance abuse. Grant funding is being sought to implement the FAS-prevention public

education program required by NRS in the larger context of a perinatal substance abuse prevention public education program.

During the course of the next year both Subcommittees will be addressing matters of public policy relating to perinatal substance abuse, such as whether there should be a legal requirement for drinking establishments to post notices warning women of the dangers of alcohol use during pregnancy. In addition, both Subcommittees are partnering with the Nevada Chapter of the March of Dimes in seeking funding from National March of Dimes for a perinatal substance abuse prevention initiative which would provide substance-abuse screening training to health care providers and would provide outreach to pregnant substance abusing women.

The PSAP Initiative will also address identification and coordination of resources in Nevada for prevention of, intervention for, and treatment of perinatal substance abuse and for enhancing protective factors for substance-affected children.

Finally, to provide for a more accessible and up-to-date PSAP Resource Center, instead of relying upon hard-copy documents and materials the Center will be re-developed to consist almost entirely of a directory of Internet resources related to perinatal substance abuse with a brief description of each site.

Prevention of Perinatal Transmission of HIV:

The Bureau in collaboration with the Bureau of Disease Control and Intervention Services is taking the lead in developing a plan to reduce the perinatal transmission of HIV. So far the proposed plan includes developing and implementing standards of care, professional training, public awareness campaign and outreach to those women who are at risk for transmitting the HIV virus to their unborn child, as well as a look-back study to see why women with HIV/AIDs do not enter prenatal care. The target date for implementation is the year 2000. A meeting will be held later in the summer of 2000 to start planning, identify funding and so forth.

Domestic Violence:

Through the BCHS, which is partially supported by MCH, the SHD is participating in a statewide initiative to prevent domestic violence. BCHS has a protocol entitled “Domestic Violence Policies and Procedures” which is followed in all BCHS clinics. The protocol includes use of the RADAR screening card for interviewing, a procedures for documentation and referral, and designation of the clinics as “Safe Havens”. RADAR stands for: **R**outinely screen all patients; **A**sk direct questions; **D**ocument your findings; **A**ssess patient safety; and **R**eview options and referrals. Labels indicating the clinic is a “Safe Haven” are to be placed in a conspicuous place for all clients to visualize. The protocol references Domestic Violence: Handbook for Victims and Professionals, published by the Nevada Commission for Women, as the policies and procedures for domestic violence in BCHS clinics.

Unintended Pregnancy:

This issue remains a high priority for the Bureau. It continues to be addressed in the classes beginning on page 157. Through the BYB campaign, news stories on TV about this problem and the need for all women of childbearing age who are sexually active to take precautions against unintended pregnancy have aired. Bureau efforts seek to make medical professionals aware that for women who may in a domestic violence situation or taking illicit drugs, the risk of unintended pregnancy is higher. They are encouraged to counsel their clients about this issue.

P9 Breastfeeding:

Nevada’s Breastfeeding initiative is based in the WIC program. Breastfeeding is a National priority for WIC. Nevada’s WIC program has lactation counselors, some of whom are bilingual, who are available for all breastfeeding WIC clients. As previously noted the Bureau is seeking a dedicated Breastfeeding Coordinator for WIC to provide full-time support for this initiative. This is an *Enabling Services* initiative.

P12 Children Without Insurance; P13 Medicaid Eligible Children, SP19 Access to Care

The implementation of Nevada 3 Check Up and Medicaid enrollment is being closely monitored by the Bureau including the Primary Care Development Center. The BYB pediatric campaign is also a source of information. The multi-media component encourages families to seek a Medical Home for their children and provide public health education on the value of primary and preventive care. The multi-media campaign is using *Bright Futures* to guide the content of the multi-media campaign. Callers to the IRL for pediatric information are referred to Medicaid and Nevada 3Check Up for coverage of care and to BYB pediatric providers in their community. Providers who have signed up for the BYB Pediatric campaign have also agreed to see children, including infants, regardless of a family's ability to pay. Sliding and/or discounted fee schedules have been established for cash-pay clients. The BYB Pediatric campaign is *Enabling and Population Based Services*. Monitoring of insurance status and access to Medicaid and Nevada 3Check Up are *Infrastructure Based*.

Finally, PCDC will continue to promote access to care for underserved children including infants.

Children and Adolescents

P5 Immunizations; P12 Children Without Insurance; P13 Medicaid Eligible Children, SP19 Access to Care.

The initiatives described above under P5, P12, P13 and SP9 for Infants are also applicable to children and adolescents.

Nevada 3 Check Up and Medicaid managed care:

As discussed in Section 1.5.1.2, the SHD including the Bureau is in close contact with staff of Medicaid and Nevada 3Check Up. The MCHAB continues to watch very closely Nevada's changing health care system and implementation of Medicaid managed care and Nevada 3 Check Up. The Bureau continues to look for ways to perform outreach for Nevada 3 Check Up and Medicaid. Referrals to Nevada 3Check Up and Medicaid are made through the BYB campaign and WIC.

Adolescent Clinics:

MCH will continue to support Adolescent Clinics in Reno and Las Vegas. These are provided under contract with Washoe County District Health Department and Clark County Health District. 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 CHNs also continue to be a source for child and adolescent services.

These are *Direct* and *Enabling Services*.

BYB Pediatric Campaign:

The BYB pediatric component is modeled on the prenatal campaign. As already noted, it includes the IRL, a multi-media campaign based on *Bright Futures*, a web-page, and a network of pediatric providers willing to see children regardless of a family's payment status. In addition to providers in Las Vegas and Reno, BYB has recruited rural pediatric providers in Elko, White Pine, Eureka, Carson City, Nye, Humboldt, Lander, Mineral and rural portions of Washoe Counties. The BYB campaign is *Enabling* and *Population Based Services*.

MCH standards development will also continue to address the health of children and adolescents, looking at what adolescents should know about health and health care by

specific ages and by graduation. Through the Interagency Group for Teen Pregnancy Prevention the Bureau partnered with the Department of Education to produce the 1999 Youth Risk Behavior Survey in FY2000. The Bureau is working with the Department of Education on plans for the 2001 Youth Risk Behavior Survey which will be combined with the Safe and Drug Free School Survey. Support for the printing of the report in FY 2000 came from the Abstinence-only grant. This is *Infrastructure Building Services*.

Child Care:

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. A state plan for child care has been approved by the DHR Director and will be the basis for Committee activities in FY2001.

P6 Teenage Birth Rate and SP16 Teen Pregnancy rates:

Teen Pregnancy Prevention:

Community Action Teams (CATs) to address Teen Pregnancy Prevention (TPP) in their communities have now been formed and remain active in approximately 30 communities with more under development. Eight target youth of Hispanic, African American or Native American ethnicity, with 3 focusing specifically on African American males. The communities represented by the teams vary in their nature – counties, cities and towns, school zones, zip codes, Enterprise areas, and racial and ethnic communities. The Bureau continues to provide technical assistance and support to the teams on an ongoing basis, including a monthly newsletter for CAT leaders

which includes information on the National Campaign to Prevent Teen Pregnancy, the state's activities, new programs, and potential funding sources. The Bureau also helps the teams identify local, state and federal funding sources, such as the MCHB Abstinence Grant. Five teams have received Title V's Abstinence-only Education funding as they have identified activities that meet the requirements of that grant.

With support from the Abstinence-only Education grant the Bureau is partnering with the Nevada Public Health Foundation's Title XX Family Life Demonstration Project to train parents statewide in the various issues in teen maturation and how to talk with their children. The Curriculum used is *Positive Choices, Positive Futures - Helping Parents Help Teens*. Teams are offered this training to be part of their sponsored activities. The Bureau is offering this training in rural communities; the Foundation is offering a train the trainer component in Washoe and Clark Counties. The Foundation and the Bureau are coordinating to ensure the same information is presented statewide with no duplication.

The state's Teen Pregnancy Prevention Initiative was originally designed to be a four year initiative, beginning in 1996. In December 1999 a new five year plan was released entitled "Teen Pregnancy Prevention in Nevada – Meeting the Challenge of the New Millennium: The current Action Plan has 6 main components:

- State Leadership. State Leadership is to include a web-page, which has been developed at www.state.nv.us/health/teen, the development and distribution of public education materials on teen pregnancy quarterly, continuation of the Governor's Youth Advisory Council (already accomplished), ongoing recruitment, training and support for CATs, and an evaluation process for the TPP initiative.
- Community Action Teams: CATs will promote themselves and their activities in their communities; they will revisit their community needs assessment to see if it

needs changing; following this review they will begin (or continue) to implement their TPP project.

- **Community Involvement:** Community members throughout the state shall be increasingly aware of the state's challenges in preventing TPP. They shall support Nevada's laws pertaining to statutory sexual seduction and child support enforcement.
- **Family Involvement.** Parents need to learn to communicate with teens on cultural beliefs, values, expectations and TPP; youth must make a commitment to TPP that goes beyond abstinence or contraception; parents and other adults such as the CATs need to invite youth to participate in the development and implementation of programs targeting youth, such as TPP.
- **Male Involvement.** A committee is being formed to collaborate with the State Team in identifying strategies to promote male involvement and responsibility in TPP that can include media campaigns specifically targeting males and programs for adolescent males. The committee's membership will include adult and adolescent males from diverse racial and ethnic backgrounds.
- **Communities within Communities.** A task force will be developed to work with specific populations on TPP such as racial or ethnic populations. The task force will work collaboratively to examine current prevention efforts, while identifying areas requiring expanded or additional efforts.

As with Perinatal Substance Abuse, additions are constantly being made to the Teen Pregnancy Prevention Resource Center. Materials in this Center are available to CATs and other interested parties upon request. Links to other appropriate Internet sites will be added to the web-page.

The Interagency Group for Teen Pregnancy Prevention continues to collaborate on an ongoing basis. Members include staff of the Health Division, Nevada Public Health Foundation, Welfare, Medicaid's MOMS/EPSTD, Department of Education's Health and Welfare team, Mental Health and Developmental Services (MH/SD), the Division of Child and Family Services and Aging. The primary activity of this group continues to be promoting May as Teen Pregnancy Prevention Month. Through group efforts May 2000's observance included: full page advertisements received from the National Campaign to Prevent Teen Pregnancy in major newspapers in Reno and Las Vegas as well as a full page advertisement featuring Grant Hill in the Reno paper during the week of state Basketball tournaments (held in Reno); a statewide media contest promoting abstinence in middle and high school students conducted with nice donated prizes for the winners; and a meeting of the Governor's Youth Advisory Council with Governor Guinn. The group will continue to meet plan May 2001's observance, and to look for ways to collaborate on teen pregnancy prevention. These performance measures are *Population Based*.

P7 Sealants, SP 12 Access to Preventive Oral Health Services and Dental Care, and SP13 Health Education Programs:

As a move to an oral public health infrastructure for Nevada, an Oral Health Unit was created within the Bureau in 1999. It is noted on the organization chart found in Appendix B. The Bureau's Oral Health Unit is focusing on several major initiatives. Its activities are based on the recommendations of "An Oral Health Action Plan for Nevada" dated February 1998. The Oral Health Action Plan stated: "The Oral Health office will develop and implement a statewide public health dental program with a prevention focus." Prevention of dental disease is the goal of the Oral Health Unit.

Due to action of the 1999 Legislature, the SHD through the Bureau was mandated to spend Nevada's MCH carry-over on an oral health initiative with a prevention focus such as sealants or an oral health education campaign. The Legislative authorization provides funding for oral health initiatives with a prevention focus.

To accomplish the Legislative mandate, several projects are underway which address oral health prevention. A request for proposal (RFP) process was used to solicit proposals for the use of the funds in addition to an Early Childhood Caries prevention project that was already in development. Under the terms of the Legislative mandate, all proposals for use of the MCH carry-over funds had to be approved by the MCH Advisory Board and the Legislature's Interim Finance Committee (IFC). This approval process was completed with approval of the RFP proposals by the MCH Advisory Board in October and the IFC in November 1999. All projects are approved to the end of the biennium June 30, 2001. All these projects are *Enabling* and *Infrastructure*.

The largest of the projects is the Early Childhood Caries (ECC) prevention initiative. While in prior years Nevada's efforts to prevent ECC were primarily addressed in WIC clinics, since 1999 a comprehensive ECC prevention initiative has been under way. After many meetings of interested stake holders in 1999 that included EOB, UNSOM, Bureau and other staff, it began as a multi-faceted pilot project in Las Vegas, with many partners committed to delivering the same message regarding ECC prevention and healthy teeth at multiple sites and opportunities. Originally set up to be conducted in EOB's Head Start, WIC, and Prenatal Care clinics, it has grown to include both the Clark County Health District and Washoe County District Health Department, Early Head Starts north and south, Medicaid MOMS program which serves pregnant women, Family to Family Connection offices (a set of office around the state that act as resource centers for families), UNSOM Dental Program, Blue Cross/Blue Shield Foundation's Miles for Smiles, Family Resource Centers, and BCHS' Community Health Nurses. The list of participants keeps growing as word of the project spreads and it has in essence become statewide.

The purpose of the project is to develop a community-based, culturally appropriate oral health promotion program that will lead to changes in those behaviors that lead to

ECC. The goal of the ECC project is the promotion of good oral health in pregnant women and children to age two of targeted parents and caregivers served by the project partners. The project is based on the ongoing research on the effect of poor oral health in pregnancy on birth outcomes and the transmission of dental disease from one person to another such as from mother to child. The message delivered at all sites seeks to change behaviors in the target population to:

1. Value good oral health in their children and themselves
2. Understand the reasons to have good oral health even for the primary teeth in children.
3. Implement feeding practices that nurture healthy teeth, including baby teeth.
4. Understand the benefits of routine and ongoing dental care.

The first step of the project was to develop a SOCO (Single Overriding Communication Objective) and a curriculum to be used by all the partners. The original workgroup that came together at EOB established “Healthy Smile Healthy Child” as SOCO and an accompanying logo was produced (Appendix F, Supporting Documents) in English and Spanish. Promotional items and posters with the logo have been obtained. Information on ECC projects in other states was researched and collected. Phillip Weinstein, Ph.D., University of Washington School of Dentistry, Seattle, one of the authors of “Early Childhood Caries: A Team Approach to Prevention and Treatment” consulted with the team through the development of the project. Materials were collected from the National Center for Education in Maternal and Child Health Oral Health Unit, from various state dental offices, and from participating agencies. Focus groups and key informant interviews conducted in both English and Spanish were held with WIC and Head Start Parents to ask a series of set questions around feeding and nurturing, value of primary teeth and so on. Finally, from all the gathered information a curriculum was developed that is to be used by all the partners in their interactions with the target population. It includes information on ECC, and brief lessons and handouts. Each Section focuses on a particular age: prenatal, 1 month, 3 months, 6 months, 9 months, 12 months, 18 months and 24

months. It also includes a listing of those programs for each area that will see low income clients for dental services, including those that accept Medicaid or Nevada 3 Check Up. The curriculum has been translated into Spanish.

The project is now at the training on curriculum implementation point. Oral Health Unit staff have developed a Power-Point presentation that also includes the “Lift the Lip” video produced by the University of Washington to teach providers how to screen for ECC. Training participants also receive a manual that includes masters of the handouts that can be photocopied and then given to the clients of the providers. Training will continue as there is interest. Once training is completed staff are to implement the curriculum. Over the next year the Oral Health Unit will help with the implementation and be available for consultation as needed. An evaluation as yet unformulated will be developed, perhaps a survey of parents to see if there is a change in oral health knowledge and any reported change in behavior.

All state WIC offices continue their emphasis on ECC prevention. Over the next year they will all be trained in the ECC curriculum.

By unscientific report, ECC has been identified as a major oral health problem for Nevada’s children.

Four additional projects were approved for use of the MCH carry-over funding:

1. St. Mary’s Benefit and Foundation. This project proposes sealant and fluoride varnish placement and prevention education using St. Mary’s Take Care-A-Van. The van, outfitted as a dental clinic, typically visits schools in the area around Reno for the placement of sealants and other oral health services. Geographic locations served by this project include Washoe county, Fallon, Fernley, Hawthorne, Silver Springs and Carson City. This project is a partnership between St. Mary’s Benefit and Foundation, Health Access Washoe County (a FQHC), Washoe County District Health Department, CSA Head Start of Reno, University

of Nevada Reno Early Head Start, Washoe County School District, Truckee Meadows Community College Dental Hygiene program and the Northern Nevada Dental Society. This project is using the ECC curriculum as part of its prevention education.

2. Huntridge Teen Clinic, Las Vegas, NV. Preventive dentistry including sealants and application of topical fluoride along with oral health education of clients served by the clinic is the goal of this project. The Huntridge Teen Clinic is one of the two adolescent clinics funded by MCH discussed on page 165. It serves children ages 12 – 18. This funding enhances a dental component.
3. Southern Nevada Dental Hygienist’s Association. This project is to conduct a study of child indices, care provider’s survey and oral health behavior modification working off Blue Cross/Blue Shield Foundation’s Miles for Smiles van (outfitted as a dental clinic) with Clark County schools, targeting kindergarten classes.
4. Clark County Health District. Oral health/prevention education for clients of the District. This project also uses the ECC curriculum. It addresses children from birth to age 4. In addition to the ECC curriculum it will address finger and thumb sucking, dental emergencies, and high calcium foods and healthy snacks for the children ages 2 – 4 (already addressed in the ECC curriculum for birth to two). Services will be provided at the District’s Child Health Conference clinics, provided at 30 community setting in Clark County by the District’s Public Health Nurses (PHNs). Services provided at the Child Health Conferences include:
 - Counseling: good health and parenting practices are discussed with parents
 - Screening: mental and physical developments are measured and recorded

- Referrals: to other agencies/providers if abnormalities or problems are observed
- Immunizations: childhood immunizations are given as needed.

The District will also integrate oral health activities into their ongoing projects with EOB for immunizations, Child Health Conference clinics, and as a referral source for EOB Head Start; collaboration with UNSOM on daily rounds of perinatal, obstetric and pediatric floors at University Medical Center resulting in referrals to District PHNs for home visits; and the District's 3 WIC clinics. The District will be available to teach the ECC curriculum to other WIC agencies in the County including Sunrise Hospital.

As there is additional funding in the second year of the biennium for the oral health prevention initiative, a new RFP has been prepared and offered for projects still to be completed by June 30, 2001.

The SHD has also been the recipient of a MCHB Fluoride grant. Although this grant has officially ended the Fluoride initiative continues. The fluoride tap was turned on in Clark County on March 1, 2000, but legislation allowing the fluoridation requires a popular vote to keep it in November. Oral Health Unit staff have been and continue to work with coalitions for Fluoridation in Clark County to promote a successful vote. In addition, the Bureau is pursuing CDC funding to both help with the equipment needed by the Clark County Water District to fluoridate and to also promote fluoridation of other Nevada communities. A web-page for fluoridation and oral health is under development.

The Oral Health Unit is pursuing the implementation of a Prevent Abuse and Neglect through Dental Awareness (PANDA) project in Nevada. Contact with Dr. Lynn Mouden, regarding implementation of PANDA in Nevada, has been made. Delta Dental has been contacted and has committed to participating and has pledged a

donation to the project. Other significant players including DCFS, the Nevada Dental Association and Nevada Dental Hygiene Association have been contacted. A key Nevada Legislator who is a dentist has been approached to be a key-note speaker at a child abuse seminar. The Executive Director of the Nevada Dental Association has expressed a preference to partner on a local rather than a state level, with seminars and training to be held in Reno, Las Vegas, and Elko. As PANDA is developed the Bureau will look to doing training as the Nevada Dental Association requested.

The Oral Health Unit worked with Nevada Broadcasters' Association and local newspapers in English and Spanish to promote February as oral health month. In addition BYB media campaigns north and south focused on oral health for the first quarter of 2000. These activities will be repeated in the coming year.

Oral Health Unit staff are working with Medicaid staff in the north to promote participation of local dental providers in Medicaid and Nevada 3Check Up. An informational brochure to simplify participation in the DHCFP programs has been produced and is being distributed. Oral Health Unit staff will continue to work on this endeavor.

The staff are also working with a coalition in Northern Nevada to seek a Community Access Program (CAP) grant. It would be used to assist communities and their safety-net providers in developing integrated health care delivery systems that serve the uninsured. Members of the coalition include St. Mary's Hospital, Great Basin Primary Care Association, and Western Interstate Commission for Higher Education. They would like to see the funds used for workforce development. The plan is to plan for the grant now and submit next year.

Primary Care Development Center continues to work to identify Dental Health Professional Shortage Areas and to promote the placement of dentists in underserved areas. There is now a Public Health Service dentist at HAWC in Reno.

For FY2000, a study was undertaken previously described on page 23 to determine the rate of sealants on third graders in Nevada.

P8 Child Deaths due to Motor Vehicles; P16 Youth Suicide Rate; SP15, Children's Self-Esteem, SP20, Access to Mental Health Services.

Injury and Violence Prevention:

The SHD through the Bureau is now the recipient of an Injury Prevention grant from CDC. With the grant a core injury prevention program will be developed. Staff were hired and started work May 30, 2000. A state level, multidisciplinary task force has been established. The initiative's plan for the coming year is to use the planning model developed through the Safe States Initiative: data collection and analysis; program design; implementation, and evaluation; coordination and collaboration; technical support and training; and public policy.

An Injury Prevention Action Plan will be developed using Nevada-specific, community mobilization process previously used for public health topics. The staff and task force will first identify existing data sources and analysis performed previously. Additional data needs will also be identified. Then, a series of community meetings will be conducted to identify additional partners for this project, as well as existing resources and programs. Based on the results of the data collection and analysis, the input of communities, and the results of program review and evaluation, the task force will develop a core injury prevention program and a list of existing resources within the state. This information will be disseminated through the Action Plan.

Members of the task force to date include representatives from the Department of Education, Nevada Department of Transportation's Traffic Safety Unit, the SHD Bureau of Licensure and Certification's Emergency Medical Services (EMS), Bureau of Health Planning and Statistics, the Trauma Institute of UNSOM, Department of Tourism, and Department of Employment, Training and Rehabilitation.

The Bureau continues to participate in the Region IX Injury Prevention Network (IPN) and the Governor's Bicycle Advisory Board through its Child and Adolescent Coordinator. Additionally, the Health Division's representative to the Governor's Bicycle Advisory Board (GBAB) represents the GBAB on the Statewide Transportation Technical Advisory Committee on Traffic Safety. The Bureau, along with the Bureaus of Health Planning and Statistics (BHP&S) and Licensure and Certification (BLC) through its EMS unit is also collaborating with UNSOM's Trauma Institute under the direction of Dr. John Fildes. The Institute is the recipient of several grants, including a trauma grant, and the Emergency Medical Services for Children grant, which supports the development of a data warehouse. Named the Crash Outcome Data Evaluation Systems (CODES) Project, it will also link with Vital Statistics maintained by BHP&S, Uniform Hospital Discharge Data Set containing UB 92s, and EMS through BLC. The CODES Project is funded by the National Highway Transportation Safety Administration. One of the goals of the project is to standardize outpatient data collection and develop a statewide registry that includes a uniform pre-hospital EMS system and data from the state's Trauma Registry. The state's Trauma Registry is located in BHP&S. This collaboration will increase data surveillance and provide data that can be used by MCH to develop injury prevention initiatives that target the MCH populations. All these activities will be incorporated into the Injury Prevention initiative. This is *Population and Infrastructure Building Services*.

The Governor's Youth Advisory Council (YAC) is addressing violence, including school violence. The issue was first discussed at the YAC's May 21, 1999 meeting. There the Council established a subcommittee to begin looking at violence in Nevada, and survey what other projects are taking place across the Nation. The subcommittee and the Council will consider the potential implementation of these projects in Nevada. From this the Council will then develop an Action Plan with recommendations for consideration by policy makers. The 1999 Legislature also created a Commission on School Safety and Juvenile Violence, with the directive to study the issue and report to

the FY2001 Legislature. To date the Commission is recommending that all violence in schools be reported to the local police. The Council's work will be provided to this commission. An almost new YAC will begin efforts for FY01 in July with the sitting of the new Council (with 7 out of 10 new members).

SP14, Child Abuse and Neglect, SP15 Children's Self-Esteem and SP20 Access to Mental Health Services:

See pages 160 to 161 for a discussion of the Bureau's PSAP activities current and planned for FY 2000, including those targeting youth. It is a well-known fact that smoking, alcohol consumption, and other drug use, begun during childhood or adolescence, leads to increased rates of consumption and addiction in adulthood. The Bureau is also part of an interagency Comprehensive School Health Initiative, lead by the Department of Education, which, among other issues, is looking at alcohol, tobacco and other drugs (ATOD) use in Nevada schools. As noted on page 164 it is working with the Department of Education to produce the biannual Nevada Youth Risk Behavior Survey and Safe and Drug Free Schools study that assess ATOD use and its co-occurrences with other adverse behaviors. Nevada's Attorney General continues to make prevention of youth access to tobacco a priority and has received national recognition for this effort. The SHD is the recipient of a Legacy America Foundation grant. The YAC will be asked to take leadership of this initiative.

Research has demonstrated that much of the adverse behaviors, lack of self-esteem and mental health concerns seen in children comes from abuse and neglect. The Bureau will continue its activities addressing abuse and neglect that include prevention of unintended pregnancy, perinatal substance abuse prevention, and promotion of access to care including care for CSHCN, all of which have been identified as risk factors for abuse and neglect.

The Bureau will follow-up on classes held in September 1999 in Reno and Las Vegas on "The Visual Diagnosis of Physical Child Abuse". This training used a slide program with accompanying literature produced by the American Academy of Pediatrics to train providers to recognize child abuse when they see it. The Bureau and DCFS partnered to bring in an expert speaker for the two classes, with DCFS providing the funding for the speaker.

The Oral Health Unit is pursuing a statewide PANDA project as described on page 174. Under this project dental providers will be trained in how to identify abuse and the mandated reporting requirements.

The Bureau's Injury Prevention initiative will devote the coming year to conducting a needs assessment to identify those areas of intentional and unintentional injury to target. Working with a state task force, a series of community meetings will be conducted to identify additional partners for this project, as well as existing resources and data sources. It will also identify resource and data need, and analyze the results. From the analysis an Action Plan will be developed. The risk of abuse and mental health in injury will be addressed in the study and any findings in the Action Plan.

The MCH Chief will continue participation on 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. These initiatives are *enabling* and *population based*.

Children with Special Health Care Needs (CSHCN)

P1 SSI Children Rehabilitation; P2 CSHCN Program Pays for Care; P3 CSHCN with a Medical Home; P11 CSHCN with Insurance; SP17 Access to Specialty and Subspecialty services for CSHCN and SP18 CSHCN Access to Case Management/Care Coordination and other Enabling Services.

Most of Nevada's Title V funding for CSHCN is used to support services at the Bureau's Special Children's Clinics in Reno and Las Vegas. The SCCs serve as regional centers providing comprehensive, family-centered, community based, culturally appropriate, multidisciplinary, early intervention diagnostic, treatment and follow-up services for families with children who have known or suspected developmental delays or are at risk of becoming developmentally delayed in the areas of cognition, communication, physical development, social/emotional development and adaptive skills. Although the clinics occasionally serve children up to age 21, children birth through age two receive priority. Clinic staff include pediatricians, clinical social workers, psychological developmental counselors, speech pathologists, audiologists, registered dietitians, physical and occupational therapists, Spanish language interpreters and parent resource coordinators.

The clinics are the sole providers of assessment and follow-up services for local neonatal intensive care unit (NICU) nurseries. They are also the provider of multidisciplinary specialty clinics, which are held periodically throughout the year, including those for Genetics, Metabolics, Pulmonary, Diabetes, Cleft/Craniofacial, Gastrointestinal, and NICU follow-up. Due to funding these clinics vary in the ages they can serve, from the SCC population only for the Pulmonary clinic to children to age 21 for Cleft/Craniofacial. Through FY2001 the Bureau will continue to examine the caseloads of the specialty clinics and adjust them as funding allows. As previously noted, the only place Nevada's Title V supports children who are on SSI is for early intervention services at the SCCs and multidisciplinary clinics. These services remain *Direct and Enabling Services*.

With the exception of the services provided by the SCCs, case management is minimally provided through the multidisciplinary specialty clinics and by the CSHCN Manager in complex cases on an as needed basis.

As noted on page 12 the Bureau's CSHCN Program serves as a "payor of last resort" and safety-net for Nevada's CSHCN. The Program will pay for treatment for CSHCN who meet eligibility standards as contained in NAC. This includes an income limitation of 250%, proper residency, and a condition that can be ameliorated. A denial of eligibility for Medicaid, SSI and/or Nevada 3 Check Up must first be obtained for those children whose family incomes meets the eligibility requirements of those programs. Nevada's CSHCN Program does not cover catastrophic conditions. For covered children the program will pay for specialty and subspecialty care, and primary care and dental care if the child does not have insurance.

CSHCN Respite and Child Care

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. In addition, DHR is the recipient of a Map to Inclusive Care Grant, and the MCH Chief is a member of the MAP Subcommittee which reports to the ICC and the DHR Child Care Advisory Committee. "Map to Inclusive Child Care" promotes the inclusion of children with disabilities and other special needs in child care. It is unclear at this time where the MAP initiative will go in FY 2001, but it will continue. In FY2000 it provided training on child care for special needs children at a meeting of the Nevada Association for the Education of Young Children and promoted inclusion.

SCC staff Reno and Las Vegas are working with local child care providers to provide early intervention services at their sites. Respite and child care providers are also trained to provide early intervention services when SCC staff are not present. This successful initiative is a start in moving the SCCs to Natural Environments as required by Part C of the Individuals with Disabilities Education Act. Funding has been obtained from the state's Part C grant to continue this project in FY2001.

CSHCN Data Needs:

The MCH Year 2000 Needs Assessment has sought to more definitively define the percentage of CSHCN who have a medical home but this is a difficult task as data is very scanty. The CSHCN data system has been revised with additional fields to collect information on a child's primary care provider, if any. The SSDI project will identify 6 performance measures to study more closely and it is anticipated that CSHCN data will be one of the six. The Birth Defects Registry will provide a basis for CSHCN collection as it develops.

Birth Defects Registry:

The SHD through the Bureau is the recipient of a CDC funded Birth Defects Registry (BDR) project that will provide data on children in Nevada with birth defects. The data collected in the registry will be used to analyze, develop and implement initiatives to prevent birth defects, such as Neural Tube Defects (NTDs) and Fetal Alcohol Syndrome, and to develop initiatives to provide follow-up for affected children and their families. The project will begin in Las Vegas with the central data collection in the Bureau's Carson City office. In FY 2000 the SHD achieved passage of implementing NRS and NAC. A data system to collect BDR information was obtained and installed. It still has some problems to work out. Efforts are underway to link Newborn Screening and Birth Certificates with the BDR system. A contractor has begun collecting information in the hospitals in Las Vegas that will be entered into the data system once it is operational. As previously noted a proposal to change the contract to an FTE is before the IFC at this time. Geneticists of the UNSOM and staff of the March of Dimes are consulting with the project as it is developed and implemented. MCH Prenatal has implemented and will continue into FY2000 a folic acid campaign to prevent NTDs. Plans for FY2001 in addition to the collection of records is the establishment of a SHD protocol for access and use of the BDR data to ensure confidentiality and other requirements under NRS are met.

Nutrition Services:

In FY2001 the Bureau will continue the development of specialty nutrition services. This initiative is housed in the SCC-Reno but services are available statewide.

Activities planned for FY 2001 include:

- Pursuing financial resources in school districts to fund trained dietitians to provide nutrition services in the various communities for CSHCN.
- Continued distribution of a Resource Manual they have developed in conjunction with the needs assessment screening form to allow appropriate Nutrition Intervention be done in communities with high-risk children.
- Continued identification of dietitians in rural and urban communities to provide nutrition services and to utilize the CSHCN Nutritionists for consultation. Once identified, the CSHCN Nutritionists provide training for services for CSHCN and women of child bearing age with metabolic disorders and provide the manual.
- Act as statewide coordinators for a nationwide video teleconference on nutrition sponsored by University of Alabama.
- Continue annual training for University of Nevada Reno dietetic interns and senior medical students in nutrition for special needs populations.
- Educate family physicians and pediatricians of available, trained resources for referral.
- Begin planning for Year 2002 CSHCN Workshop at joint Nevada/California annual dietetic association meeting. Will coordinate with Region IX leaders on this project.

The Needs Assessment for statewide public school nutrition screening noted on page 27 will be completed in FY 2000 and analysis of the data and report performed in FY2001. The purpose of this project is to identify those school-aged children with special health care needs who have ongoing nutritional risk factors who are enrolled in the public school districts. Once identified, program development can progress to provide appropriate intervention for these children. A side benefit of this process is a count and classification of CSHCN in Nevada's school districts.

This initiative is primarily *Enabling* and *Infrastructure Services*. There are some *Direct* services provided on an intermittent basis in special cases.

At this time the CSHCN care initiatives are *Infrastructure Building* as well as *Enabling*.

P4 Newborn Screening:

An extensive Newborn Screening program has been developed in Nevada. The program relies on rapid notification of positive results and follow-up test results as appropriate. As there is no metabolic specialist in the state, consultation to the program and providers in the state is obtained through a contract with Oregon Health Sciences University for Dr. Robert Steiner. Under this contract Dr. Steiner also provides metabolic clinics in Reno and Las Vegas for all children zero to twenty-one with metabolic disorders, and for women of child bearing age with PKU (or any other metabolic disorder where this service may be needed) who are considering pregnancy or are pregnant. The CSHCN Nutritionists, SCC Nutritionists, and nutritionists who are part of the network being developed by the CSHCN Nutritionists are available to provide case management and consultation on an on-going basis to individuals affected statewide and their providers, whether health care, school-based, or whomever else the family authorizes.

Through the Nutritionists at the SCCs, families receive assistance with obtaining the medical specialty foods and formulas required by affected family members. The clinics will order the foods for the families through the Bureau budget, thus obtaining them at wholesale cost, and have them direct shipped by UPS to the family regardless of where they live in the state. The family's insurance is then billed for whatever costs can be recovered. Families may also order directly but then pay retail cost.

This initiative is *Enabling* and *Population Based Services*.

P10 Newborn Hearing Screening:

As noted on page 17 in Section 1.5.2 the MCH Chief, and Part C Early Intervention staff of DCFS and the Director's office are working with a Subcommittee of the ICC to promote Universal Newborn Hearing Screening (UNHS) in Nevada. Members of the Subcommittee including the state Early Intervention staff, Audiologists from UNSOM and SCC-Las Vegas, pediatricians who are interested in the issue, and community advocates. With the advent of universal newborn hearing screening in Reno and most recently in one hospital in Las Vegas and Medicaid coverage of the test noted on page 24, a start has been made to eventually lead to such screening becoming a standard of care in Nevada. Confirmatory testing for those children identified through the screening is usually performed at the SCCs, which are the only sites in the state for public supported access to the appropriate staff and equipment in the state. Early Intervention services for children with confirmed hearing deficits are provided by the state's Early Intervention programs found in the SCCs and DCFS.

The Early Intervention community in Nevada is monitoring the Reno and Las Vegas initiative very closely for its outcomes, and will look for opportunities to promote such screening in other communities in the state in the 2001 Legislature. The Bureau submitted a grant proposal to MCHB to support this initiative that was approved but not funded. Funding is now available from CDC and the Bureau is looking into pursuing this funding. A state legislator has been identified who will introduce a bill in the 2001 Legislative Session to mandate UNHS. The legislator is working with the Subcommittee in this effort. This initiative is *Enabling, Population Based and Infrastructure Building*.

P14 CSHCN Family Involvement:

Nevada's MCH has put in place several initiatives to ensure parent participation. The only state staff are the Resource Parents in each of the SCCs and representation on the Maternal and Child Health Advisory Board.

The Resource Parents provide valuable input into the functioning of the SCCs, and act as liaisons with other parents on an as-needed basis. The Resource Parent in Reno, for example, was instrumental in organizing SCC parents into a 501-C (3) non-profit organization called "Friends of Special Children". Friends of Special Children have been very active in assisting with the development of a multidisciplinary diabetes clinic in Reno, and Natural Environment day care options.

The Bureau works with parent and advocacy groups such as "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 3 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 dialogue 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. Nevada Partners in Policy Making were very prominent in assuring parents of CSHCN input into the MCH Needs Assessment, and have pledged to assist with implementing its findings.

Efforts to include parents in the Five-Year Needs Assessment are described in the Needs Assessment beginning on page 31.

4.2 Other Program Activities

There have been no major changes from last year's application in this area.

All activities of Nevada MCH are included one way or the other in performance measures and are recorded within Section 4.1. If they are not included, they are not addressed by Nevada MCH. This includes purchase of health insurance, and applied research, all listed in the Pyramid. As previously noted, WIC is part of MCH.

There has been no change in Nevada's three toll-free hot-lines. The first MCH/CSHCN toll-free number is 1-800-992-0900. The second and primary line is Baby Your Baby's, 1-800-429-2669. In CY 1999 the BYB IRL had 8,664 calls. The third line is part of the WIC/Immunizations/Medicaid promotion discussed on page 155. Its number is 1-800-8 NEV WIC. All three lines are widely marketed. The BYB and WIC lines are included in multi-media bilingual campaigns.

It has previously been stated that Health, Nevada 3 Check Up and Medicaid work very closely together on many initiatives, including BYB and teen pregnancy prevention. The Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) and Nevada 3 Check Up are resources for eligible Nevada CSHCN. The MCH program is a referral source for Medicaid and ultimately EPSDT and Nevada 3Check Up through BYB, the SCCs, WIC, and so forth.

Medicaid and Nevada 3Check Up providers are included in the BYB referral network. See the Annual Plan for a discussion of the BYB providers. All callers to the IRL are referred to Medicaid and/or Nevada 3Check Up if it is deemed appropriate. This represents most callers as those contacting the IRL frequently do not have coverage of their prenatal or pediatric care.

Nevada MCH directly supports Family Planning in its Adolescent Clinics in Reno and Las Vegas, through the Bureau of Community Health Services in the BCHS clinics,

the Comprehensive School Health Programs initiative, and the non-profit agencies in Clark and Washoe Counties. The primary focus of this collaboration is teen pregnancy prevention.

Lead Screening:

The MCH Chief is the state contact for blood lead issues. The Bureau of Health Protection Services completed an extensive study of childhood lead poisoning in Clark and Washoe Counties in March 1996. That study concluded “It is the unanimous opinion of the Study Committee that childhood lead poisoning does not represent a significant present risk to urban Nevada children”. It went on to state that any further study could perhaps look at rural areas of the state where there has been mining. The Study Committee noted that no legitimate need has been identified to support the costs associated with the development and maintenance of a formal blood lead registry in Nevada. The CHNs of BCHS, who are partially supported by MCH, act as the contact for any incidents of blood lead identified in their counties and have an established protocol to deal with it as have Washoe County district Health Department and Clark County Health District. These are few and far between and more often that not involve children (and adults) who have move to Nevada from other states. Three or 4 children a year might be identified through Medicaid’s EPSTD screening. The state has concluded there is no risk level in the state that warrants a blood lead initiative.

MCH has been written into the Department of Employment, Training and Rehabilitation’s Office of Community Based Services’ Traumatic Brain Injury (TBI) Grant, the Nevada Cares Project. MCH is to help with: the design and conduct of a statewide needs assessment; formulation of research elements and strategic planning recommendations for the development of a State Action Plan; development of prevention strategies for children and adolescents stemming from intentional and unintentional injuries; modification of the Nevada Trauma registry; and development of health status indicators for young survivors of TBI. The new injury prevention

coordinator will ensure coordination of the Bureau's injury prevention initiative with the TBI initiative.

Family Preservation and Support is addressed on page 179. MCH collaboration with family members is addressed on page 184.

4.3 Public Input [Section 505(a)(5)(F)]

Oral public input on the block grant application after required public notice was obtained at a time set aside on June 23, 2000, at two sites. Public comment was also solicited throughout the Needs Assessment process. One hearing on the application was held during the regularly scheduled meeting of the MCH Advisory Board in Reno, and the other in Las Vegas in the SCC conference room. Written comment was also solicited, due by July 6, 2000. Notice of preparation of the grant, the date and places of public hearings, and an invitation for comment was published in newspapers in Reno on June 16, 2000 and in Elko and Las Vegas on June 20, 2000. Copies of the proposed grant were available by contacting the Carson City Office and at the SCCs. Only one comment was received, and that was a question asking why access to genetic services was not identified as one of the state's 10 priorities. The response was that although it was mentioned in the surveys, it was never identified in the work groups or anywhere else in the process as a priority, and is included in the priority for access by CSHCN to specialty and subspecialty services. This application represents priorities established by the Year 2000 needs Assessment including extensive public comment through the Needs Assessment process and the meetings of the MCH Advisory Board.

4.4 Technical Assistance [Section 509 (a)(4)]

Nevada's priority for technical assistance in the coming year continues to be cultural competency training for MCH/CSHCN staff and others who work with MCH. Such training should be a follow-up to the training offered in 1999 through the National Center for Cultural Competency. This is priority number 1.

Nevada MCH continues to have an overriding program need for good, reliable, comprehensive data. Whether this involves increased personnel with analytical skills, an MCH data system, linking with other data systems, monitoring the affect of managed care on CSHCN, etc., the need is critical. Technical Assistance for FY2001 in the area of data systems development and performance indicators is Nevada's second priority. The Bureau requests recommendations of a provider for this priority.

All requested TA would help Nevada's MCH/CSHCN program continuing development.

V. SUPPORTING DOCUMENTS

Glossary

GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [*Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. (*Title V Sec. 501(b)(4)*)

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (*For budgetary purposes*) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. (*For planning and systems development*) - Those children who have or are at increased risk for a chronic physical,

developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. **State Program Collaboration with Other State Agencies and Private Organizations.** States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.
2. **State Support for Communities.** State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.
3. **Coordination of Health Components of Community-Based Systems.** A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.
4. **Coordination of Health Services with Other Services at the Community Level.** A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining: 1)

What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden

Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors

tend to be intermediate term. Risk factor results should answer the question, “Why should the State address this risk factor (i.e., what health outcome will this result support)?”

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State’s required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State’s Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State’s Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State’s Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant’s* funds (carryover from the previous year’s MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO’s, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under “Infrastructure Building”, “Population Based Services”, “Enabling Services” and “Direct Medical Services”.

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect.

3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification

and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file

the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

Appendix A: Map of Nevada Counties, page 207

Appendix B: Organization Charts of Department of Human Resources, State Health Division, and Bureau of Family Health Services, pages 209 through 211

Appendix C: Curriculum Vitae

- Judith Wright, Bureau Chief/MCH Chief, page 212
- Wei Yang, Biostatistician, page 213
- Stephany Gibbs, Administrative Services Officer, page 215
- Wade Greenlee, Child and Adolescent Coordinator, page 216
- Gloria Deyhle, CSHCN Manager, page 217
- Cynthia Huth, MCH Perinatal Manager, page 218
- Maryanne Maliwat, SDDI Coordinator, page 220
- Salli Macaskill, PCDC Manager, page 222

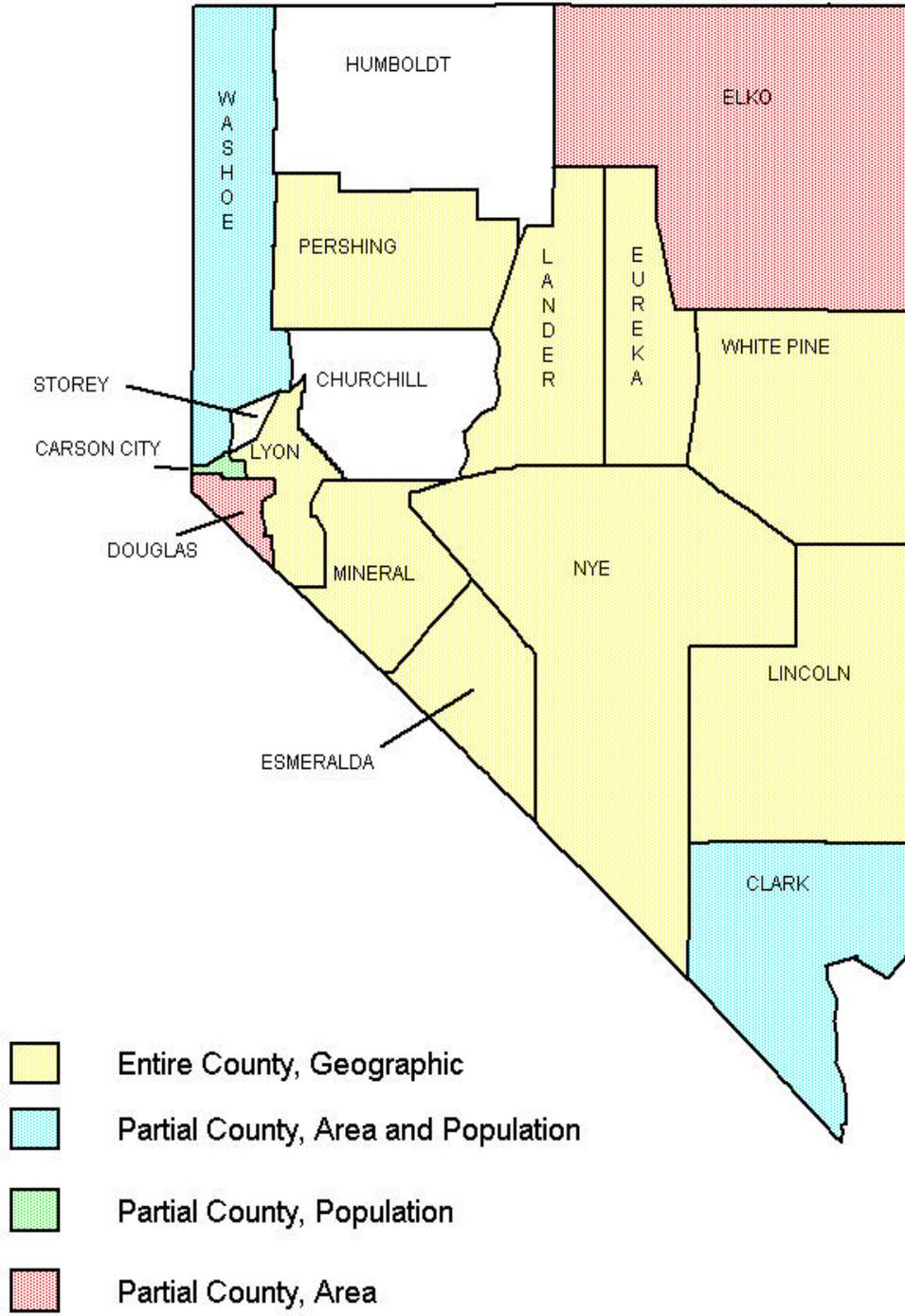
Appendix D: Parent/Consumer Survey, page 224

Appendix E: Needs Assessment Worksheet/Survey, page 228

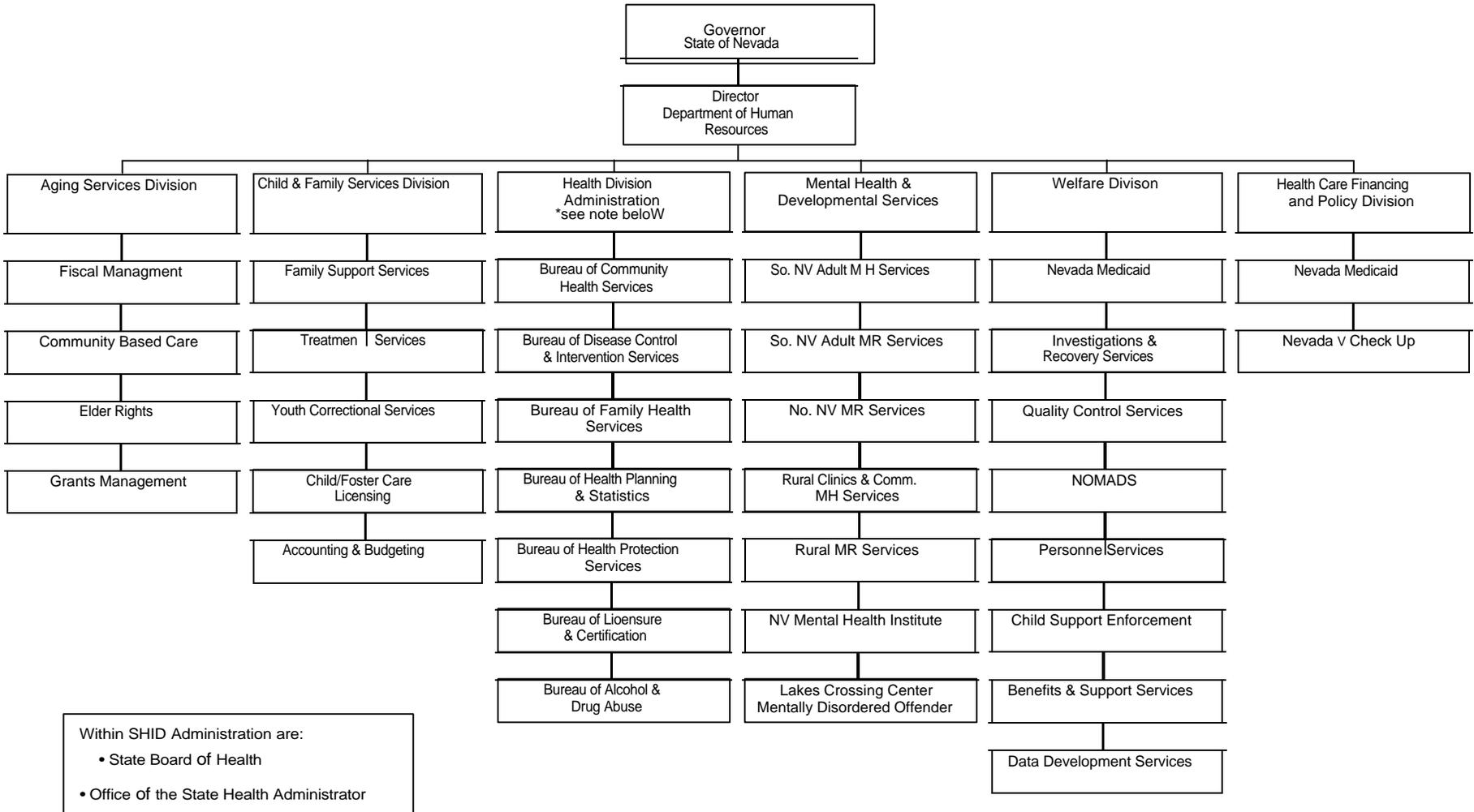
Appendix F: Oral Health Initiative Logo, page 235

Appendix A

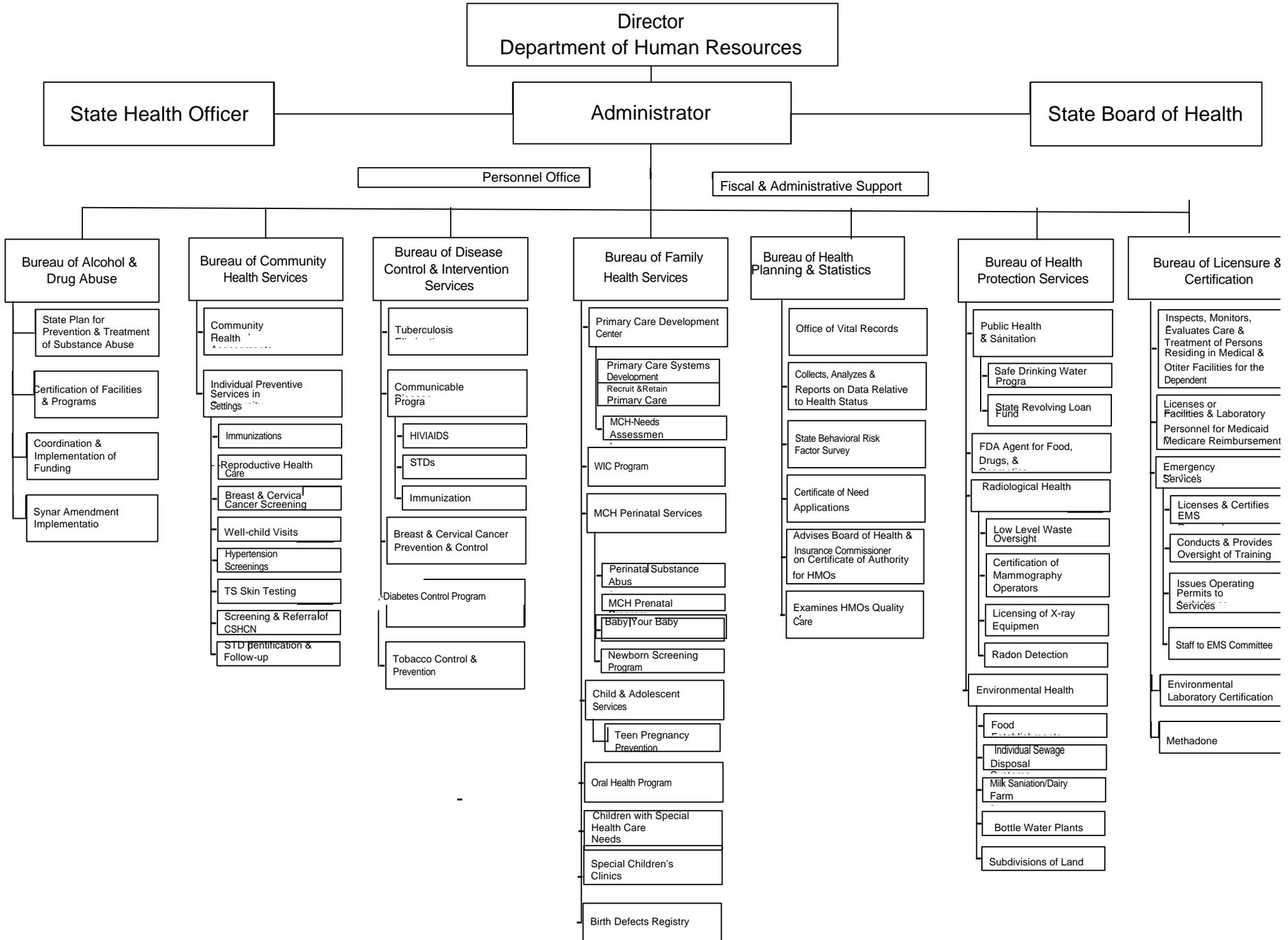
Primary Care HPSAs in Nevada, 1999



Nevada Department of Human Resources Organization Chart

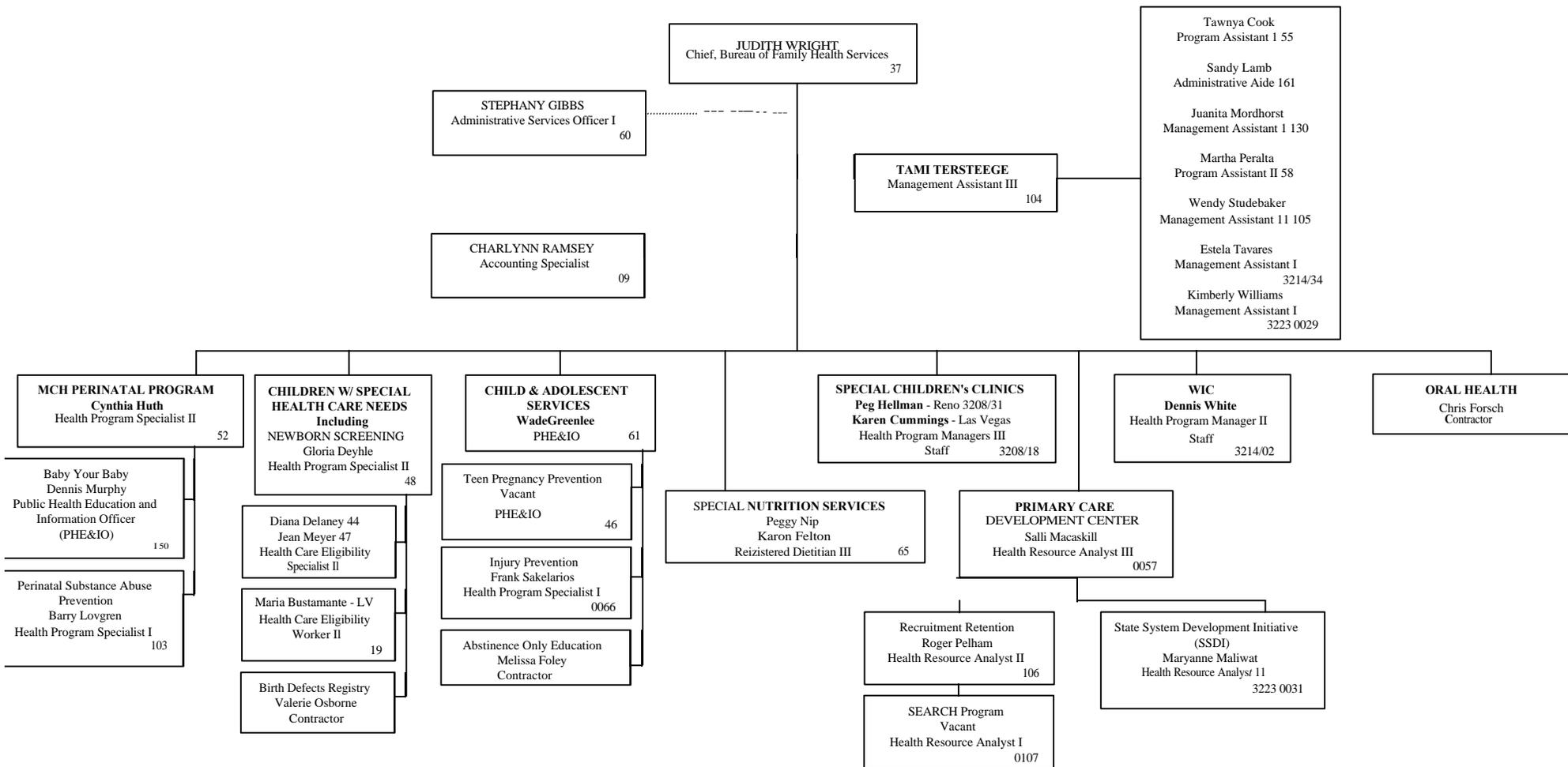


NEVADA STATE HEALTH DIVISION, 2000



Nevada State Health Division
Bureau of Family Health Services

*All in 3222 unless otherwise noted



Approved

JUDITH MCCROCKLIN WRIGHT

Curriculum Vitae

Education

- College: University of Chicago, Chicago IL
Bachelor of Arts, Oriental Languages and Civilizations, 1967
- Graduate Work: George Peabody College for Teachers (now Vanderbilt), Nashville, TN
Bachelor of Arts equivalent and Graduate work in Elementary Education
with an emphasis on Early Childhood, 1967 - 1968

Professional Experience

September 1994 - Present. Bureau Chief, Family Health Services, Nevada State Health Division, Carson City, NV. Overall responsibility for supervisory, administrative and professional duties in planning, directing, implementing and evaluating the Nevada Maternal and Child Health Program, including Children with Special Health Care Needs, MCH Perinatal, WIC, Child and Adolescent, Oral Health and Newborn Screening services. Direct responsibility for the Title V, the Maternal and Child Health Block Grant, needs assessment, application, implementation and reporting. E-mail: jwright@govmail.state.nv.us.

January 1989 - August 1994. Program Manager, Children's Special Health Services, Family/Maternal and Child Health Bureau, Montana Department of Health and Environmental Sciences (MDHES), Helena, MT. Perform supervisory, administrative and professional duties in directing, planning, implementing and evaluating the state program for Children with Special Health Care Needs. SSI liaison for Title V.

1984 - December 1989. Program Specialist, Special Supplemental Food Program for Women, Infants and Children (WIC), Family/Maternal and Child Health Bureau, MDHES, Helena, MT. Responsible for implementation and management of WIC certification system; monitoring and technical assistance to local agency staff; assisting in development and writing of program policies and procedures; and analysis of state and local agency budgets and expenditures.

1980 - 1984. Administrative Assistant, Laboratory/Management Division, MDHES, Helena, MT. Administrative responsibilities in the management of the DHES public health and environmental health laboratories including fiscal oversight, inventory control and supervision of support staff.

Additional Experience

1989 - 1994. MDHES representative to the Montana Interagency Coordinating Council for PL 102-119 (Part H of the Individuals with Disabilities Education Act) to represent MCH interests on the Council. Vice-Chair 1991-1992, Chair 1992 - 1993.

1985 - 1994. Trustee (elected), Helena School District # 1, Helena, MT.

WEI YANG

Bureau of Health Planning and Statistics
Nevada State Health Division
505 E. King Street, Room 102
Carson City, Nevada 89701
Tel: (775) 684-4182
e-mail: yangw@govmail.state.nv.us

EDUCATION

- Ph.D.** Environmental Epidemiology, University of Nevada, Reno, Nevada, 1996
Major: Epidemiology, Minor: Biostatistics
- M.S.** Public Health Nutrition, University of Nevada, Reno, Nevada, 1994
- M.D.** (Equivalent -- US Medical Board Exam Eligible) Public Health, Nanjing Medical College, Nanjing, China, 1984

OTHER TRAINING:

Graduate Studies (Ph.D. Program)

Public Health, Two Quarters, Oregon State University, Corvallis, Oregon, 1991.

Advanced Training Program

Biostatistics/Epidemiology, 5 Months, Tongji Medical University, Wuhan, China, 1986.

Clinical Medicine Internship

Internal Medicine and Pediatrics, 6 Months, Luhe County Hospital, Nanjing, China, 1983.

PROFESSIONAL EXPERIENCE

State Biostatistician Present Nevada State Health Division	10/1996 - Carson City, Nevada
Adjunct Professor , Environmental Epidemiology University of Nevada, Reno	09/1997 - Present Reno, Nevada
Research Scientist , Environmental Epidemiology University of Nevada, Reno & Washoe County District Health Department	05/1994 - 10/1996 Reno, Nevada
Research Assistant , Nutritional Epidemiology University of Nevada, Reno	05/1992 - 05/1994 Reno, Nevada
Physician/Epidemiologist/Resident Physician , Occupational Medicine Jiangsu Institute of Occupational Medicine	08/1984 - 09/91 Nanjing, China

SELECTED PUBLICATIONS

- Chen, L., Jennison, B.L., **Yang, W.**, and Omaye, S.T. 2000. Elementary School Absenteeism and Air Pollution. *Journal of Inhalation Toxicology*. In press.
- Chen, L., **Yang, W.**, Jennison, B.L., and Omaye, S.T. 2000. Air particulate pollution and hospital admissions for chronic obstructive pulmonary disease in Reno, Nevada. *Journal of Inhalation Toxicology*. 12:281-298, 2000.
- Carns, D.E., EeJan, E., **Yang, W.**, Greenway, J., Le, K. 1999. Personal Health Choices: Nevada State Hospital Patient Discharge Analysis, 1994-1998. Eleventh Edition. *Publication of Center for Public Data Research, University of Nevada Las Vegas and Nevada State Health Division*. October, 1999. Las Vegas, Nevada.
- Hemmings, M. and **Yang, W.** 1999. Nevada Report on Cancer 1991-1997. *Nevada State Health Division Publications*. March, 1999. Carson City, Nevada.
- Yang, W.** and Lusak, S. 1999. Nevada Vital Statistics 1996 and 1997. *Nevada State Health Division Publications*. January, 1999. Carson City, Nevada.
- Yang, W.**, Jennison, B.L., and Omaye, S.T. 1998. Cardiovascular Disease Hospitalization and Ambient Levels of Carbon Monoxide. *Journal of Toxicology and Environmental Health*. 55:101-112.
- Yang, W.** 1998. Personal, Social and Economic Costs of Smoking. *American Health Today*. 98 (1): 17.
- Yang, W.**, Jennison, B.L., and Omaye, S.T. 1998. Ambient Carbon Monoxide (CO) Levels and Cardiovascular Disease Hospitalization. *Toxicological Sciences*. 98:42 (1) :s253.
- Yang, W.** 1998. Smoking-Attributed Mortality, Morbidity, and Economic Costs in Nevada. *Nevada State Health Division Publications*. January, 1998. Carson City, Nevada.
- Yang, W.** and Omaye, S.T. 1997. Heterocyclic Amines (HCA) and Asian High Temperature Cooking: Cancer and Bacterial Mutagenicity. *Environmental and Nutritional Interactions*. 97:1:191-211.
- Hemmings, M. and **Yang, W.** 1997. Healthy People 2000: Nevada Year 2000 Health Objectives. *Nevada State Health Division Publications*. July, 1997. Carson City, Nevada.
- Yang, W.**, Jennison, B.L., and Omaye, S.T. 1997. Air Pollution and Emergency Room Visits for Asthma in Reno, Nevada. *Journal of Inhalation Toxicology*. 97:9:pp15-29.
- Yang, W.** and Read, M. 1996. Dietary Pattern Changes among Asian Immigrants. *Journal of Nutrition Research*. 96:16(8):pp.1277-1293.
- Yang, W.**, Jennison, B.L., and Omaye, S.T. 1996. Air Pollution and Health Effects in Northern Nevada. *Epidemiology*. 96:7:s100.

Stephany Gibbs
Administrative Service Officer I

Education

Bachelor of Science Degree in Business Administration, University of Nevada, Reno
Major: Accounting
Honors: Phi Kappa Phi Honor Society

Certificates

Certified Public Accountant
Certified Government Financial Manager

Related Work Experience

Administrative Service Officer I

State of Nevada Health Division
June 2000 to Present

As an Administrative Service Officer I am responsible for fiscal monitoring for the Bureau of Family Health Services and the Bureau of Community Health Services. My duties include monitoring expenditures for compliance with state budget laws and with federal grant provisions. I assist program managers with fiscal aspects of grant requests and contract procurement. Finally, I am responsible for the preparation of the state biennial budget request for both bureaus.

Deputy Legislative Auditor

State of Nevada Legislative Counsel Bureau
May 1990, to June 2000

As a Deputy Legislative Auditor I was responsible for conducting performance audits in accordance to governmental auditing standards. The primary focus of most audits was economy and efficiency of an agency or program. The audit process included testing and analyzing control systems; reviewing state and federal laws and regulations, and agency policies and procedures; analyzing fiscal activity to identify revenue sources and uses, trends, and fluctuations; and analyzing the agency's strategic plan including mission, goals, objectives, inputs, outcomes, and performance indicators.

Audit scope and objectives include areas general to all state agencies and areas specific or unique to an agency. General areas include purchasing, asset inventory control, payroll, and personnel. Specific areas include grant management and federal reporting, and contract procurement, fiscal monitoring, and analysis of deliverables.

Staff Accountant

Freeman and Williams, CPAs
September 1988, through April 1990

As a staff accountant my duties included financial auditing corporations, non-profit entities, and local governments; performing financial reviews and compilation reports; and preparing federal tax reports for individuals, corporations, partnerships, sole proprietors, trusts, and not-for-profit entities.

Staff Accountant

Leonard M. Faike, CPA
January 1986, through August 1988

My job duties included preparing federal tax reports, financial compilation reports, and bookkeeping.

Wade Greenlee, Health Education and Information Officer

CURRICULUM VITAE

Office Address

Health Division
BFHS
505 E. King St. Rm. 200
Carson City, NV 89701
(775) 684-4052
E-mail: wgreenle@govmail.state.nv.us

Post-Secondary Education

Bachelor of Science Degree, 1988
Bemidji State University
Specialization: Education
Minor: Math, Psychology

Graduate Education

Nova Southeastern University
Specialization: Educational Administration

Honors and Awards

High school Salutatorian
George C. Marshall Award

Work Experience

- Teacher, mathematics
Clark County School District, 1988-1998
- Teacher, social studies
Carson City School District, 1999-2000
- Child and Adolescent Coordinator
Nevada State Health Division, Bureau of Family Health Services, May 2000 to present

Professional Service and Volunteer Work

Committee member, Shadow Hills Baptist Daycare Center, Las Vegas, NV
Coach and Umpire, Little League Baseball, Las Vegas, NV and Carson City, NV

Curriculum Vitae

Gloria M. Deyhle, R.N.

Education

The Mount Sinai Hospital School of Nursing – 1962 – 1965 - Registered Nurse
5 East 98th Street
New Your, New York

Columbia University - 1966 – 1968
100 West 116th Street
New York, New York

Experience

Nevada State Health Division - 1990 – Present

1990-1999 – MCH Nurse Consultant

1999 – Present – CSHCN Manager – Health Program Specialist II

Children with Special Health Care Needs Program

Newborn Screening Program Coordinator

Genetics Program

Birth Defects Registry

Duties: Policy Development and Implementation

Claims Reimbursement

Cost/Benefit Analysis

Nevada State Welfare Division – 1981 – 1990

1981 – 1990 - Medicaid Services Specialist

Duties: Early, Periodic, Screening, Diagnosis and Treatment Program

Home Health Services

Outpatient Services – Office, Ambulatory surgery

Policy Development and Implementation

Surveillance and Utilization Review Coordinator

Procedure File Conversion and Maintenance

Computer Conflicting Procedure Edits – CPT and ICD codes

Claims Processing and Reimbursement

Claims Adjudication

Oversight of Peer Review Organization activities

Hospital Cost Reports

Cost Analysis

Disability Determinations

Long Term Care Regulations and Review

Clark County Health District – 1980 – 1981

Assistant Coordinator – Home Health Services

Public Health Nurse – Clinics

Instructor – Clark County Social Services – Homemaker/Health Aide Program

Registered Nurse – 1966 – 1980

Public Health Nurse – New York

Head Nurse – Delivery Room

Head Nurse – Emergency Room

Head Nurse - Intensive Care Unit

Staff Nurse - Operating room, NICU, Burn unit, Med/Surg, Neuro-surgery, Orthopedics, and

Rehabilitation unit.

CYNTHIA C. HUTH, RNC, MSN, CNM
984 SUNVIEW DRIVE
CARSON CITY, NV 89705
(775) 267-4363

SUMMARY OF QUALIFICATIONS:

- ◆ Certified Nurse-Midwife/OB-GYN Nurse Practitioner
- ◆ Excellent communication skills
- ◆ Developed and presented continuing education classes on maternal/child health issues for health care professionals
- ◆ Computer skills: Word 7.0, Windows NT, Access 7.0, Power Point, Internet

EDUCATION:

- ◆ 1995 - University of Utah, MS Nursing/Nurse Midwifery
- ◆ 1991 - University of California Los Angeles, OB/GYN Nurse Practitioner certificate
- ◆ 1980 - University Nevada Las Vegas, BS Nursing
- ◆ 1974 - University Nevada Las Vegas, AA Nursing

PROFESSIONAL EXPERIENCE:

11/96 - Present: NV State Health Division, State of Nevada, Carson City, NV

Perinatal Nurse-Consultant

Authoring, developing and conducting continuing education classes for health care providers, at various sites throughout the state of Nevada. Development of perinatal protocols for use within the obstetrical community and the Maternal/Child Health (MCH) Prenatal Program. Perform medical record review for appropriateness of care/authorization of services for the MCH Prenatal Program.

Review of nursing and medical research articles for incorporation into a variety of policies and programs. Oversee the "Baby Your Baby" Campaign, including working with the media to develop Public Service Announcements (PSAs), recruit health care providers and develop brochures and booklets on prenatal and infant care, and oversee Perinatal Substance Abuse including Fetal Alcohol Syndrome Prevention initiative. Liaison on perinatal issues for the bureau to community organizations. Writing and applying for available grants. Full supervision of two professional employees and one clerical employee.

8/96 - 11/96: NV State Health Division, State of Nevada, Lovelock, NV

OB-GYN Nurse Practitioner/ Community Health Nurse

Full scope community health nursing, including family planning, sexually transmitted disease (STD) diagnosis and treatment, immunizations, and well-child exams. Limited prenatal care.

1/94 - 7/96: Eastern NV Medical Group, Ely, NV

Certified Nurse-Midwife/OB-GYN Nurse Practitioner

Complete antepartum, intrapartum and postpartum care. Gynecological and well child exams. Preceptor, including performance evaluation, nurse practitioner and nurse-midwifery students.

9/89 - 12/93: NV State Health Division, State of Nevada, Ely, NV

Community Health Nurse/ OB-GYN Nurse Practitioner

Full scope community health nursing, including family planning, sexually transmitted disease (STD) diagnosis and treatment, immunizations, and well-child exams. Expansion of duties to OB/GYN Nurse Practitioner in June 1991. Preceptor new community health nurses, orienting them to clinic procedures.

9/87 - 9/89: Sierra Health Services, Las Vegas, NV

Utilization Review Nurse

Review of medical records to determine appropriateness of care.

1981 - 1988: Saint Rose Dominican Hospital, Henderson, NV

Staff Nurse/Charge Nurse/Supervisor (PT, FT & Temp.)

Worked in all areas of full-scope hospital, including medical/surgical unit, emergency department, and intensive care unit as a staff nurse, charge nurse and house supervisor.

NATIONAL ACCREDITATION:

- ◆ American College Nurse-Midwives Certification (Certified Nurse-Midwife)
- ◆ National Certification Corporation (OB/GYN Nurse-Practitioner)

PROFESSIONAL INVOLVEMENT & CURRENT MEMBERSHIPS:

- ◆ American College of Nurse-Midwives
- ◆ Maternal Child Health Coalition
- ◆ Member of the Nevada State Board of Nursing Advanced Practitioner of Nursing Subcommittee (Term 3/97 - 3/00).

MASTERS' DEGREE PROJECT:

- ◆ "Teaching Resources, Including Barriers And Facilitators, For Distance Education"

NEVADA NURSING LICENSE: RN06848

Maryanne O. Maliwat, M.P.H.

610 E. Proctor St, # 6
Carson City, Nevada 89701-4282

Phone: 775.841.2161, FAX: 734.448.0926
Email: mmaliwat@netzero.net

PROFESSIONAL EXPERIENCE

HEALTH RESOURCE ANALYST II, Nevada State Health Division, Carson City, Nevada, 2000-present
Responsible for coordinating the Maternal and Child Health State Systems Development Initiative (MCHSSDI). <http://www.state.nv.us/health/primary/>

- Coordinated and wrote the Five Year Needs Assessment (2000-2005) for the Bureau of Family Health Services.
- Created survey instruments and evaluation tools.
- Designed and maintained the surveillance system for the MCH State-Negotiated performance measures.
- Provided data and policy analysis to the Nevada State Health Division and various partners.
- Worked on minority health issues within the State of Nevada.
- Maintained program web-page.

STUDENT WORKER, Minnesota Department of Health, Minneapolis, Minnesota, 1997-1999
Responsible for project management and development, and assisting in the management of the Minnesota State Refugee Health Program. <http://www.health.state.mn.us/divs/dpc/adps/refugee/refugee.htm>

- Represented the Refugee Health Program to the community, local and state social service agencies, county public health agencies, HMOs, hospitals, and state governmental agencies.
- Presented epidemiological study findings before local and state public health meetings, and conferences.
- Reviewed, evaluated, and assisted in the planning and writing of local, state, and national grants.
- Created innovative parent survey instruments, monitored pilot testing, and coordinated survey distribution.
- Designed and analyzed surveys for county public health agencies and public health nursing services.
- Coordinated and co-authored public materials outlining the Domestic Refugee Health Assessment.
- Analyzed, researched, and reviewed various Federal policies for the Refugee Health Program.

GRADUATE RESEARCH ASSISTANT, University of Minnesota, Minneapolis, Minnesota, 1996-1998
Responsible for researching technological advances in biology and mathematics for the development of a collaborative, web-based national clearinghouse to be used by professors and students in small universities, colleges, and community colleges. <http://www.gen.umn.edu/research/currtran/proj.html>

- Collaborated in an Annenberg/Corporation for Public Broadcasting sponsored research project.
- Performed research of technologically advanced teaching techniques used to transform educational curricula.
- Maintained database of collaborative efforts.
- Co-authored and edited papers on curricular transformation in biology for local, state, and national publication.
- Presented study findings at Minnesota State Conferences.

RESEARCH ASSISTANT/INTERN, National Institutes of Health, Bethesda, Maryland, 1995

Responsible for assisting administrators with the creation of a multimillion-dollar comprehensive health clinic targeted towards adolescents and young adults.

- Created patient funding, phone, and contact databases for use by Multicultural Adolescent Community Initiative (MACI) administrators, patients, government agencies, etc.
- Analyzed, reviewed, and evaluated policies on HIV/AIDS patient funding, i.e. Medicare, Medicaid, Hill-Burton Funds, Social Security, Welfare, Food Stamps, Housing, AIDS drugs, Ryan White C.A.R.E. Act and Unit Cost.

FELLOW, The Washington Center for Internships and Academic Seminars, Washington DC, 1995

LABORATORY TECHNICIAN/CARL ALBERT INTERN, Oklahoma State Bureau of Investigation, Oklahoma City, OK, 1994-1995

EDUCATION

Master of Public Health, Public Health Administration, 1998

University of Minnesota, Minneapolis, Minnesota

Emphases in health management, policy, epidemiology, international health, adolescent and family health

Bachelor of Science in Biology, 1995

Oklahoma City University, Oklahoma City, Oklahoma

PUBLICATIONS

Minnesota Refugee Health Assessment Brochure,

<http://www.health.state.mn.us/divs/dpc/adps/refugee/brochure.htm>

Health Guide for Refugees in Minnesota,

http://www.health.state.mn.us/divs/dpc/adps/images/Refugee/h_gdbook.pdf

Nevada MCH Five Year Needs Assessment, currently being published

PROFESSIONAL ACTIVITIES

1997-present American Public Health Association

1997-present Public Health Student Caucus – positions held – Membership Chair, Program Chair

1995-present Mentoring

1997-1999 National Asian Pacific American Women’s Forum, Minnesota chapter – position held – Membership Chair

1997-1999 Filipino American Women’s Network, Minnesota chapter

1997-1999 Minnesota Refugee and Immigrant Consortium – positions held – Co-chair

1997-1999 Minnesota Refugee and Immigrant Task Force

-SALLI VANNUCCI MACASKILL-

EDUCATION: University of Washington, Seattle, Washington, Graduate Certificate in Public Health, MPH Program - 1999.

University of Nevada, Reno, Nevada, Bachelor of Arts, Social Health Resources, Health Education Concentration – 1988

Bachelor of Science, Nursing – 1992

Critical Care Certified Training, UC Davis Medical Center, Davis, CA – 1992

Coalition Building, Pediatric Institute of Health, Norfolk, VA - 1996

EXPERIENCE:

Nevada State Health Division (NSHD), Bureau of Family Health Services, Primary Care Development Center (PCDC). Supervising Health Resource Analyst III. 4/00 to present. Responsibilities include supervision of the PCDC including the Primary Care Cooperative Agreement, National Health Services Corps Fellowship Network and the Maternal and Child Health State Systems Development Initiative.

NSHD, Bureau of Health Planning and Vital Statistics, Health Resource Analyst II. - 10/98 to 4/00

Responsibilities include HMO regulation and monitoring of HMO activities including providing technical assistance to public and private entities regarding healthcare resources, utilization of data, demographic and health status information, health planning information and health care policy review; review of HMO applications for new licensure or expanded service areas to determine quality, availability and accessibility of healthcare services. Also State Trauma Registry coordinator including monitoring of hospital trauma, developing regulatory requirements, coordinating contracts with involved agencies, and data collection.

NSHD, BUREAU OF DISEASE CONTROL AND INTERVENTION SERVICES (BCDIS) – 6/97 to 10/98, Nevada Diabetes Control Project Manager

Function as manager for all aspects of the program. Responsibilities include; the oversight of all program operations, budget preparation and management, the facilitation and development of the Diabetes Advisory Council, and evaluating and implementing new approaches to diabetes control.

NSHD, BDCIS, Immunization Coordinator – 2/95 to 6/97

Responsible for coordinating actions within the state to increase Nevada's immunization status through assessment, research and direct coordination of activities in the rural areas and health districts.

Washoe County District Health Department (WCDHD), Community and Clinical Health Services
- 7/93 to 2/95 Reno, Nevada Immunization Action Plan Coordinator

Responsible for increasing immunization levels in Washoe County through community outreach and education, private and public partnership networking, and direct service delivery. Other duties included assessing community levels for immunization needs and coordinating clinics accordingly. Job entailed working closely with "Immunization team" to meet immunization needs of county through vaccine management, vaccine protocol writing, rash illness and vaccine-preventable disease investigation, enforcing vaccine exemption and disease reporting laws.

WCDHD 2/93 TO 7/93 Reno, Nevada Community Health Nurse

Direct care and education of district clientele in the home setting. Responsible for assessing the status of individuals and families regarding maternal-child health, adult health and disease prevention.

LICENSURE

Registered Nurse, Nevada

ORGANIZATIONS

Etta Sigma Gamma: Professional Honary for Health Educators
Nevada Public Health Association, President-Elect

COMPUTER SKILLS

Microsoft Word programs, Excel, Harvard Graphics, Access., Power Point.

PUBLICATIONS/PRESENTATIONS

"Quarterly HMO Profile Industry Report", Dec 1998 through Jan 2000, State Health Division

"Social Marketing, Promoting your Program for Effective Health Strategies", sponsored by Nevada's Nutrition Support Network. Reno, NV, November 20, 1997

"Partners in Prevention", Alaska WIC Coordinators Annual Meeting, August, 1996, Juneau, Alaska

"WIC IMMUNIZATION INTEGRATION", MARCH 13, 1996, ANNUAL STATE WIC CONFERENCE, LAS VEGAS, NV

"WIC Immunization Integration Study", May 17th, 1995, paper presentation, 29th National Immunization Conference, Los Angeles, CA

"Evaluating Social-Marketing Campaigns," September 17, 1999, paper presentation, University of Washington, Seattle.

AWARDS

Even Tough Guys Immunize: Food and Consumer Service Administrator's Citation May 1996 for participation in multi-aceted marketing campaign Nevada WIC, Immunization, and Medicaid.

4 If you have difficulty getting services, what kind of problems do you encounter (check all that apply for each condition)?

	Asthma	Behavior problems	Diabetes	Heart Condition	Hearing Disorder	Mental Retardation	Seizures	Vision Disorder	Other (Please list)
Inability to pay									
No transportation in my area									
Physician is not available when necessary									
Service(s) not available in my area									
There is no physician available who is comfortable with my child's condition in my area									
There is no physician who will accept Medicaid in my area									
Other (please list):									

5 How do you pay for your child's special care (check all that apply for each condition)?

	Asthma	Behavior problems	Diabetes	Heart Condition	Hearing Disorder	Mental Retardation	Seizures	Vision Disorder	Other (Please list)
Indian Health Service									
Medicaid (includes some HMOs)									
Nevada Check Up									
Private health insurance (includes some HMOs)									
Self-pay									
SSI Medicaid									
State of Nevada CSHCN									
Other (please list):									

6 What specialists does your child see (check all that apply for each condition)?

Asthma	Behavior	Diabetes	Heart	Hearing	Mental	Seizures	Vision	Other
--------	----------	----------	-------	---------	--------	----------	--------	-------

	problems	Condition	Disorder	Retardation	Disorder	(Please list)
General pediatrician						
Geneticist						
Pediatric cardiologist						
Pediatric endocrinologist						
Pediatric neurologist						
Psychologist						
Registered dietician						
Other (please list):						

7 Where does your child receive medical care (check all that apply for each condition)?

	Asthma	Behavior problems	Diabetes	Heart Condition	Hearing Disorder	Mental Retardation	Seizures	Vision Disorder	Other (Please list)
Clinic									
Emergency room									
Physician's office									
Public health (Well Child check-ups)									
Other (please list):									

8 How well does your insurance cover your child/ren's medical expenses?

- Very good
- Good
- Not good
- Don't know

9 Are you in need of respite care for your child/ren?
Yes, please tell us how you will use your respite time:

No

10 Do you have access to child/day care for your child/ren?

Good access
 Limited access
 No access
 Do not use child/day
 care

11 How old is/are your child/ren (please list)?

Child 1	Child 2	Child 3	Add additional children

12 What is the ethnicity of your child (check all that apply)?

Child 1	Child 2	Child 3	Add additional children
African American	African American	African American	
Asian/Pacific Islander	Asian/Pacific Islander	Asian/Pacific Islander	
Caucasian	Caucasian	Caucasian	
Hispanic/Latino	Hispanic/Latino	Hispanic/Latino	
Native American	Native American	Native American	
Other (please list):	Other (please list):	Other (please list):	

13 What is your zip code?

**MATERNAL AND CHILD HEALTH STATE
SYSTEMS DEVELOPMENT INITIATIVE
(MCH SSDI)
NEEDS ASSESSMENT
WORKSHEET** Appendix E

INSTRUCTIONS: Thank you for participating in the Maternal and Child Health State Systems Development Initiative's Five Year Needs Assessment. Your input is extremely valuable to us; try to answer each question as thoroughly as possible. Feel free to add additional comments throughout the worksheet, as well as add additional pages as necessary.

IF YOU ARE A CONSUMER OF THESE SERVICES, ANSWER THE QUESTIONS IN TERMS OF YOUR USE OF THE SERVICES. IF YOU FEEL THAT YOU ARE NOT THE RIGHT PERSON TO COMPLETE THIS SURVEY, PLEASE GIVE IT TO THE APPROPRIATE PERSON.

The worksheets will be collected and housed at the Nevada State Health Division. **ALL INFORMATION IS CONFIDENTIAL;** your personal information and answers will only be shared with staff working on the needs assessment. A final report will be created and mailed to you and/or your organization. When completed, please send or fax to:

Maryanne O. Maliwat, MPH
Nevada State Health Division
Primary Care Development Center
505 E. King St., Room 203
Carson City, NV 89701-3711
Phone: 775.684.4220

Fax: 775.684.4046

Email: mmaliwat@govmail.state.nv.us

Please list the name(s) of the person(s) filling out this worksheet.

Name(s): _____

Title: _____

Agency/Organization: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

1. Please indicate below which population(s) you serve:

- Women and children >1
- Children ages 1-9
- Adolescents 10-21
- Children with Special Health Care Needs (CSHCN)

WHEN ANSWERING THE FOLLOWING QUESTIONS, PLEASE KEEP IN MIND THE POPULATIONS YOU SERVE.

2. What types of services does your organization provide for this population (check all that apply)?

- Medical
 - Direct health care
 - Hospitalization
 - Urgent care
 - Preventive care
 - Pre- and/or post-natal care
 - Newborn screening
 - Social services
 - Outreach
 - Family support services
 - Purchasing of health insurance
 - Case management
 - Medicaid eligibility/enrollment
 - Dental care/oral health
 - Health education and/or outreach
 - Cultural competency
 - Transportation
 - Translation/Interpretation services (list languages): _____
 - Other (please explain): _____
- Immunizations
 - Sudden Infant Death Syndrome (SIDS) counseling
 - General counseling
 - Nutrition
 - Nevada Check Up eligibility/enrollment
 - Enrollment in Baby your Baby program
 - Coordination with education system
 - Coordination with private insurance

3. What types of services does your organization plan to offer this population in the future (check only those that your organization will implement within the next 5 years)?

- Medical
 - Direct health care
 - Hospitalization
 - Urgent care
 - Preventive care
 - Pre- and/or post-natal care
 - Newborn screening
 - Social services
- Immunizations
 - Sudden Infant Death Syndrome (SIDS) counseling
 - General counseling
 - Nutrition

- Outreach
- Family support services
- Purchasing of health insurance
- Case management
- Medicaid eligibility/enrollment
 - Dental care/oral health
 - Health education and/or outreach
 - Cultural competency
 - Transportation
 - Translation/Interpretation services (please list languages): _____
- Other (please explain): _____

4. Does your organization set health service goals and objectives for this population?

- Yes
- No (go to question 7)
- Don't know (go to question 7)

5. Are these health service goals and objectives built from Federal (Healthy People 2000 and 2010) and State performance measures?

- Yes
- No
- Don't know

6. What are the health service goals and objectives in your organization for this population (add attachments if necessary)?

7. Do you uniformly collect information/data on this population?

- Yes
- No (go to question 12)
- Don't know (go to question 12)

8. What type of information do you collect on this population (check all that apply)?

- Personal/family information
- Physical data
- Morbidity
- Preventable conditions
- Chronic conditions
- Mortality
 - Age specific death
 - Fetal loss
 - Cause of death
 - Pregnancy
- Race/ethnicity
- Age
- Socio-economic status (SES)
- Other (please list): _____

9. What can your organization do to promote the collection of valid, reliable, and reportable data (add attachments if necessary)?

10. Describe the impact that the shift in Medicaid coverage over the last five years has made on financial barriers to care and services delivered by your agency to this population (add attachments if necessary).

- Extremely difficult
 - Difficult
 - Some barriers
 - No change
 - Easier
 - Extremely easier
 - Don't know
 - Not applicable
- Comments: _____

11. Describe the impact that the move to managed care delivery systems has had on service delivery and availability of services delivered by your agency to this population (add attachments if necessary).

- Extremely difficult
 - Difficult
 - Some barriers
 - No change
 - Easier
 - Extremely easier
 - Don't know
 - Not applicable
- Comments: _____

12. Describe the impact that welfare reform has had on service delivery and availability of services delivered by your agency to this population (add attachments if necessary).

- Extremely difficult
 - Difficult
 - Some barriers
 - No change
 - Easier
 - Extremely easier
 - Don't know
 - Not applicable
- Comments: _____

13. Describe the impact that other changes in financial access (private insurance, risk pools, State insurance programs, child health initiatives) has had on service delivery and availability of services delivered by your agency to this population (add attachments if necessary).

- Extremely difficult
 - Difficult
 - Some barriers
 - No change
 - Easier
 - Extremely easier
 - Don't know
 - Not applicable
- Comments: _____

14. Describe the impact that Nevada Check Up has had on service delivery and availability of services delivered by your agency to this population (add attachments if necessary).

- Extremely difficult
 - Difficult
 - Some barriers
 - No change
 - Easier
 - Extremely easier
 - Don't know
 - Not applicable
- Comments: _____

15. Which of the following do you have in your community (check all that apply)?

- Permanent primary care providers
- Specialty providers
- Hospital or clinic facilities
- Tribal Health Center
- Optometry service
- Pharmaceutical service

16. Which of the following providers does your community need most (check top three choices)?

- | | |
|---|---|
| <input type="checkbox"/> Primary care | <input type="checkbox"/> Certified nurse midwives |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Specialty (please list): _____ | <input type="checkbox"/> Tribal Health Center |
| _____ | <input type="checkbox"/> Optometry service |
| _____ | <input type="checkbox"/> Pharmaceutical service |
| _____ | |

17. What types of services do you need most in your community (check top three choices)?

- Hospital and/or clinic
- Tribal Health Center
- Preventive care
- Emergency services
- Urgent care
- Prenatal and perinatal services
- Social services
- Interpretation services
- Transportation services
- Health education
- Outreach
- Other (please list): _____

18. What type of support or guidance do you need or would like to receive from the Nevada State Health Division that is not provided (add attachments if necessary)?

19. If you have any comments or other information you would like to share with us, please use the space below or add additional pages.

THANK YOU!

Appendix F



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- 5.4 Core Health Status Indicator Forms follow page SD C1
- 5.5 Core Health Status Indicator Detail Sheets page SD C1
- 5.6 Developmental Health Status Indicator Forms page DS HS1
- 5.7 Developmental Health Status Indicator Detail Sheets page SD D1
- 5.8 All Other Forms page SD 2.1
- 5.9 National “Core” Performance Measure Detail Sheets page SD 11
- 5.10 State "Negotiated" Performance Measure Detail Sheets page SD 16
- 5.11 Outcome Measure Detail Sheets page SD 12