Nevada State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Improve preconception and interconception health among women of childbearing age	Increase the percent of women, ages 18 through 44, receiving a preventive medical visit in the past year to 70% by 2025 Increase the percent of women receiving prenatal care in first trimester to 80% by 2025	Collaborate with public and private partners to provide women, ages 18 through 44, with information on the benefits available to link them to appropriate health care coverage options Collaborate with public and private partners to engage (through outreach) and educate (e.g. website, materials, etc.) women, ages 18 through 44, communities, and health care professionals, regarding women's health, including early prenatal care and screenings Collaborate with public and private partners to conduct training focused on rape and sexual assault prevention Partner to conduct and/or fund survey activities that ask questions regarding pre and interconception care Collaborate with MCH Coalition and other partners to improve health literacy, including health promotion campaigns and dissemination of health information (including translation/interpretation) Collaborate with public and private partners to conduct data collection, surveying, and other activities to improve maternal health and birth outcomes Collaborate with public and private partners to provide women, ages 18 through 44, communities and health care professionals with information to reduce disparity in perinatal outcomes	ESM WWV.1 - Percent of pregnant women who received prenatal care beginning in the first trimester	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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					NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
Reduce substance use during pregnancy	Reduce the number of women who smoke during pregnancy to 1.5% by 2025 Reduce the percent of children ages 0-17 who live in households where someone smokes to 13% by 2025 Increase the percent of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits to 97% by 2025 Reduce the percent of women using substances during pregnancy to 3.5% by 2025	Collaborate with public and private partners such as The Tobacco Control Program (TCP) and Medicaid to promote smoking cessation programs. Disseminate educational materials to partners for statewide distribution and engage partners through outreach to encourage promotion of smoking cessation resources Collaborate with public and private partners to improve outcomes related to substance use Collaborate with public and private partners to conduct data collection, surveying, and other activities to improve maternal health and birth outcomes, including continuation of Nevada PRAMS	ESM SMK-Pregnancy.1 - Percent of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits	NPM - Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-Pregnancy	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

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					NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Improve preconception and interconception health among women of childbearing age	Increase the percent of pregnant women/new mothers receiving prenatal care in first trimester to 76%.	Collaborate with public and private partners to engage (outreach) and educate (e.g. website, materials, etc.) women, ages 18 through 44, communities, and health care professionals, regarding women's health, including early prenatal care and screenings.		SPM 1: Percent of mothers who reported late or no prenatal care	
Reduce substance use during pregnancy	Reduce the percent of women who used substances during pregnancy to 3.5% by 2025.	Collaborate with public and private partners to promote use of the State's Tobacco Quitline for pregnant women and new mothers. Disseminate educational materials to partners for statewide distribution. Collaborate with public and private partners to improve outcomes related to substance use		SPM 2: Percent of women who used substances during pregnancy	
	Increase the percentage of women who receive a postpartum check up within twelve weeks of giving birth	Collaborate with public and private partners to provide postpartum women with information on the importance of attending a postpartum visit.	No ESMs were created by the State. ESMs were optional	NPM - A) Percent of women who attended a postpartum checkup within	This NPM was newly added in the 2025 application/2023 annual report. The list of associated

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	from 85.95% to 90% by 2025. Increase the percentage of women who received recommended care components by 5% for each component by 2025.	Collaborate with the MCH Coalition and other partners to imprve health literacy, including health promotion campaigns relating to the importance of postpartum care. Disseminate educational materieals to partners for statewide distribution and engage partners through outreach to encourage promotion of postpartum care.	for this measure in the 2025 application/2023 annual report.	12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Promote Breastfeeding	Increase the percent of children who are ever breastfed to 87% by 2025 Increase the percent of children who are exclusively breastfed at 6 months to 30% by 2025 Decrease the percent of PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends to 0.5% by 2025	Partner with MCH Coalition and MCH stakeholders on activities and website postings to increase awareness, community-wide support and business education of breastfeeding, safe sleep, etc. (includes FIMR) Collaborate with public and private partners such as WIC, faith-based and breastfeeding coalitions, community based programs, and local health authorities to improve access to breastfeeding supports for new mothers Collaborate with public and private partners to conduct data collection, surveys, and other activities to improve breastfeeding rates Collaborate with public and private partners to proved website maintenance and updates to...	ESM BF.1 - Percent of Nevada PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Promote Safe-Sleep	Increase the percent of infants placed to sleep on their backs to 84% by 2025. Increase the percent of infants placed to sleep on a separate approved sleep surface to 40% by 2025. Increase the percent of infants placed to sleep without soft objects or loose bedding to 48% by 2025.	Provide staff support and training to home visitors on promotion of safe sleep practices Collaborate with public and private partners to conduct data collection, surveys, and other activities to understand current safe sleep practices Collaborate with public and private partners to promote safe sleep resources to the community such as media campaigns Collaborate with Cribs for Kids (C4K) to support providing educational resources to parents and caregivers on the importance of safe sleep behaviors	ESM SS.1 - Percent of PRAMS respondents who report their infants (under 1 year of age) were laid to sleep in a high-risk sleep position and /or environment	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

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				during sleep (Safe Sleep) - SS	
Child Health					
Increase developmental screening	Increase the percent of children, ages 9 through 35 months, who receive a developmental screening using a parent-completed screening tool to 35% by 2025	Collaborate with public and private partners to communicate the importance of developmental screenings, including referral to appropriate health professionals Collaborate with Title V MCH public and private partners, families of CYSHCN, and providers to conduct outreach to educate individuals, families and communities regarding the benefits of the medical home portal for CYSHCN Collaborate with Title V MCH partners to train providers on the parent-completed screening tool Collaborate with public and private partners on community events, trainings and other events/activities which include information about the importance of developmental screenings Collaborate with Title V MCH partners to promote use of the Medical Home Portal to provide resources for families and health care providers	ESM DS.1 - Percent of Medicaid enrolled children, ages 9 through 35 months, who received a developmental screening using a standardized tool.	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Promote a Medical Home	Increase the percent of children with special health care needs with a medical home in the past year to 53.3% by 2025 Increase the percent of children without special health care needs with a medical home in the past year to 54.8% by 2025 Increase the number of WIC, Home Visiting, and other program participants that received information on the benefits of a medical home by 20% by 2025	Partner to support the utilization of Medical Home Portal including awareness, professional development, Nevada 2-1-1 activities, etc. Partner to identify and conduct outreach to CYSHCN groups, including families to promote the availability and benefits of Medical Home Portal	***Inactive -*** *ESM MH.1 - Number of Nevada Medical Home Portal website views.* ESM MH.2 - Percent of Nevada Medical Home Portal users who utilize the Services Directory feature to obtain information on providers and community resources.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very

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	Increase the number of unique users of Nevada's medical home portal to 9,000 by 2025				good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Adolescent Health					
Improve care coordination among adolescents	Increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 77% by 2025 Reduce pregnancies among adolescent females, ages 15 to 19, to 16 pregnancies per 1,000 by 2025 Reduce repeat birth rate among adolescent females, ages 15 to 19, to 12 repeat births per 1,000 by 2025	Collaborate with public and private partners to provide adolescents, ages 12 through 17, with information on the benefits available and link them to appropriate health care coverage options Collaborate with public and private partners to conduct outreach, education, and eligibility assistance to promote utilization of family planning and link women to appropriate health services, vaccinations, screenings (breast and cervical cancer, substance use/misuse, behavioral/mental health, postpartum depression, etc.), LARC, and use of 1-key question Collaborate with public and private partners on activities focused on teen pregnancy prevention, bullying, rape and sexual assault prevention, suicide, and other factors that negatively impact health Coordinate with partners and local health authorities to enhance the quality of adolescent clinic environments	ESM AWV.1 - Percent of Medicaid EPSDT eligible adolescents, ages 12 through 17, who received at least one initial or periodic screen	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly

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					NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly

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					NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Increase transition of care for adolescents and CYSHCN	Increase percent of children with special health care needs ages 12 through 17, who received services necessary to transition from pediatric to adult health care to 16% by 2025 Increase percent of children without special health care needs ages,12 through 17, who received services necessary to transition from pediatric to adult health care to 17% by 2025	Coordinate with partners and local health authorities to improve the messaging of transition care. Collaborate with public and private partners to provide adolescents, ages 12 through 17, with information on the benefits available and link them to appropriate health care coverage options Conduct health transition trainings among health care providers to support transition efforts and gather information regarding changes in knowledge, practices, and policy.	***Inactive -*** *ESM TR.1 - Percent of participants reporting a change in knowledge who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition* ***Inactive -*** *ESM TR.2 - Percent of participants reporting intent to change practices or policies who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition* ESM TR.3 - Percent of families who report the information received by a Family Navigator through Family Navigation Network met their needs for transition	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

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			from pediatric to adult health care.		
Improve care coordination among adolescents	Reduce repeat birth rate among adolescent females, ages 15 to 19, to 12 repeat births per 1,000 by 2025.	Collaborate with the Sexual Risk Avoidance Education (SRAE) Program and the State Personal Responsibility Education Program (PREP). Collaborate with community partners on educational campaign focused on decreasing teen pregnancy and repeat pregnancy.		SPM 3: Repeat teen birth rate	
Improve care coordination among adolescents	Reduce pregnancies among adolescent females, ages 15 to 19, to 16 pregnancies per 1,000 by 2025	Collaborate with the State Sexual Risk Avoidance and Education (SRAE) Program and the State Personal Responsibility Education Program (PREP) on positive youth development, Sexually transmitted infection (STI) reduction and teen pregnancy reduction. Collaborate with community partners on resource sharing related to decreasing teen pregnancy.		SPM 4: Teenage pregnancy rate	
Children with Special Health Care Needs					
Promote a Medical Home	Increase the percent of children with special health care needs with a medical home in the past year to 35% by 2025 Increase the percent of children without special health care needs with a medical home in the past year to 50% by 2025 Increase the number of WIC, Home Visiting, and other program participants that received information on the benefits of a medical home by 20% by 2025 Increase the number of unique users of Nevada's medical home portal to 9,000 by 2025	Partner to support the utilization of Medical Home Portal including awareness, professional development, Nevada 2-1-1 activities, etc. Partner to identify and conduct outreach to CYSHCN, including families, with the greatest need (e.g. racial/ethnic group, payer, rural/urban) regarding availability and benefits of Medical Home Portal	***Inactive -*** *ESM MH.1 - Number of Nevada Medical Home Portal website views.* ESM MH.2 - Percent of Nevada Medical Home Portal users who utilize the Services Directory feature to obtain information on providers and community resources.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the

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					past year (Forgone Health Care, Formerly NOM 25) - FHC
Increase transition of care for adolescents and CYSHCN	Increase the percent of children with special health care needs ages, 12 through 17, who received services necessary to make transitions from pediatric to adult health care to 16% by 2025	Coordinate with partners and local health authorities to improve the messaging about transition from pediatric to adult care to youth with and without special health care needs. Collaborate with public and private partners to provide children with special health care needs and their families with information on the benefits available and link them to appropriate health care coverage options Conduct health transition trainings among health care providers to support transition efforts and gather information regarding changes in knowledge, practices, and policy.	***Inactive -*** *ESM TR.1 - Percent of participants reporting a change in knowledge who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition* ***Inactive -*** *ESM TR.2 - Percent of participants reporting intent to change practices or policies who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition* ESM TR.3 - Percent of families who report the information received by a Family Navigator through Family Navigation Network met their needs for transition from pediatric to adult health care.	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC