# Nevada State Action Plan Table 2024 Application/2022 Annual Report

| Priority Needs | Strategies | Objectives | National and State Performance Measures | Evidence-Based or –Informed Strategy Measures | National and State Outcome Measures |
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| **Women/Maternal Health** | | | | | |
| Improve preconception and interconception health among women of childbearing age | 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<br><br>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<br><br>Collaborate with public and private partners to conduct training focused on rape and sexual assault prevention<br><br>Partner to conduct and/or fund survey activities that ask questions regarding pre and interconception care<br><br>Collaborate with MCH Coalition and other partners to improve health literacy, including health promotion campaigns and dissemination of health information (including translation/interpretation)<br><br>Collaborate with public and private partners to conduct data collection, surveying, and other activities to improve maternal health and birth outcomes<br><br>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 | Increase the percent of women, ages 18 through 44, receiving a preventive medical visit in the past year to 70% by 2025<br><br>Increase the percent of women receiving prenatal care in first trimester to 80% by 2025 | NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year | ESM 1.1: Percent of pregnant women who received prenatal care beginning in the first trimester | NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations<br><br>NOM 3: Maternal mortality rate per 100,000 live births<br><br>NOM 4: Percent of low birth weight deliveries (<2,500 grams)<br><br>NOM 5: Percent of preterm births (<37 weeks)<br><br>NOM 6: Percent of early term births (37, 38 weeks)<br><br>NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths<br><br>NOM 9.1: Infant mortality rate per 1,000 live births<br><br>NOM 9.2: Neonatal mortality rate per 1,000 live births<br><br>NOM 9.3: Post neonatal mortality rate per 1,000 live births<br><br>NOM 9.4: Preterm-related mortality rate per 100,000 live births |

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| | | | | | NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy<br><br>NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations<br><br>NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females<br><br>NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth |
| Reduce substance use during pregnancy | Collaborate with public and private partners such as The Tobacco Control Program (TCP) and Medicaid to promote smoking cessation programs.<br><br>Disseminate educational materials to partners for statewide distribution and engage partners through outreach to encourage promotion of smoking cessation resources<br><br>Collaborate with public and private partners to improve outcomes related to substance use<br><br>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 | Reduce the number of women who smoke during pregnancy to 1.5% by 2025<br><br>Reduce the percent of children ages 0-17 who live in households where someone smokes to 13% by 2025<br><br>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<br><br>Reduce the percent of women using substances during pregnancy to 3.5% by 2025 | NPM 14.1: Percent of women who smoke during pregnancy | ESM 14.1.1: 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 | NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations<br><br>NOM 3: Maternal mortality rate per 100,000 live births<br><br>NOM 4: Percent of low birth weight deliveries (<2,500 grams)<br><br>NOM 5: Percent of preterm births (<37 weeks)<br><br>NOM 6: Percent of early term births (37, 38 weeks)<br><br>NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths<br><br>NOM 9.1: Infant mortality rate per 1,000 live births |

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| | | | | | NOM 9.2: Neonatal mortality rate per 1,000 live births<br><br>NOM 9.3: Post neonatal mortality rate per 1,000 live births<br><br>NOM 9.4: Preterm-related mortality rate per 100,000 live births<br><br>NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births<br><br>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health |
| Improve preconception and interconception health among women of childbearing age | 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. | Increase the percent of pregnant women/new mothers receiving prenatal care in first trimester to 76%. | SPM 1: Percent of mothers who reported late or no prenatal care | | |
| Reduce substance use during pregnancy | Collaborate with public and private partners to promote use of the State's Tobacco Quitline for pregnant women and new mothers.<br><br>Disseminate educational materials to partners for statewide distribution.<br><br>Collaborate with public and private partners to improve outcomes related to substance use | Reduce the percent of women who used substances during pregnancy to 3.5% by 2025. | SPM 2: Percent of women who used substances during pregnancy | | |
| **Perinatal/Infant Health** | | | | | |
| Promote Breastfeeding | 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) | Increase the percent of children who are ever breastfed to 87% by 2025 | NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed | ESM 4.1: Percent of Nevada PRAMS respondents who stopped breastfeeding | NOM 9.1: Infant mortality rate per 1,000 live births<br><br>NOM 9.3: Post neonatal mortality |

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| | 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<br><br>Collaborate with public and private partners to conduct data collection, surveys, and other activities to improve breastfeeding rates<br><br>Collaborate with public and private partners to proved website maintenance and updates to... | Increase the percent of children who are exclusively breastfed at 6 months to 30% by 2025<br><br>Decrease the percent of PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends to 0.5% by 2025 | exclusively through 6 months | due to a lack of support from family or friends | rate per 1,000 live births<br><br>NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births |
| Promote Safe-Sleep | Provide staff support and training to home visitors on promotion of safe sleep practices<br><br>Collaborate with public and private partners to conduct data collection, surveys, and other activities to understand current safe sleep practices<br><br>Collaborate with public and private partners to promote safe sleep resources to the community such as media campaigns<br><br>Collaborate with Cribs for Kids (C4K) to support providing educational resources to parents and caregivers on the importance of safe sleep behaviors | Increase the percent of infants placed to sleep on their backs to 84% by 2025.<br><br>Increase the percent of infants placed to sleep on a separate approved sleep surface to 40% by 2025.<br><br>Increase the percent of infants placed to sleep without soft objects or loose bedding to 48% by 2025. | NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding | ESM 5.1: 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 | NOM 9.1: Infant mortality rate per 1,000 live births<br><br>NOM 9.3: Post neonatal mortality rate per 1,000 live births<br><br>NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births |
| **Child Health** | | | | | |
| Increase developmental screening | Collaborate with public and private partners to communicate the importance of developmental screenings, including referral to appropriate health professionals<br><br>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<br><br>Collaborate with Title V MCH partners to train providers on the parent-completed screening tool<br><br>Collaborate with public and private partners on community events, trainings and other events/activities which include information about the importance of developmental screenings | 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 | NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year | ESM 6.1: Percent of Medicaid enrolled children, ages 9 through 35 months, who received a developmental screening using a standardized tool. | NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)<br><br>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health |

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| | Collaborate with Title V MCH partners to promote use of the Medical Home Portal to provide resources for families and health care providers | | | | |
| Promote a Medical Home | Partner to support the utilization of Medical Home Portal including awareness, professional development, Nevada 2-1-1 activities, etc.<br><br>Partner to identify and conduct outreach to CYSHCN groups, including families to promote the availability and benefits of Medical Home Portal | Increase the percent of children with special health care needs with a medical home in the past year to 53.3% by 2020<br><br>Increase the percent of children without special health care needs with a medical home in the past year to 54.8% by 2020<br><br>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<br><br>Increase the number of unique users of Nevada's medical home portal to 9,000 by 2025 | NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home | ***Inactive -*** *ESM 11.1: Number of Nevada Medical Home Portal website views.*<br><br>ESM 11.2: Percent of Nevada Medical Home Portal users who utilize the Services Directory feature to obtain information on providers and community resources. | NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system<br><br>NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling<br><br>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health<br><br>NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year |
| **Adolescent Health** | | | | | |
| Improve care coordination among adolescents | 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<br><br>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<br><br>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 | Increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 77% by 2025<br><br>Reduce pregnancies among adolescent females, ages 15 to 19, to 16 pregnancies per 1,000 by 2025<br><br>Reduce repeat birth rate among adolescent females, ages 15 to 19, to 12 repeat births per 1,000 by | NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. | ESM 10.1: Percent of Medicaid EPSDT eligible adolescents, ages 12 through 17, who received at least one initial or periodic screen | NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000<br><br>NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000<br><br>NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000<br><br>NOM 17.2: Percent of children with |

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| | Coordinate with partners and local health authorities to enhance the quality of adolescent clinic environments | 2025 | | | special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system<br><br>NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling<br><br>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health<br><br>NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)<br><br>NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza<br><br>NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine<br><br>NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine<br><br>NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine |

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| | | | | | NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females |
| Increase transition of care for adolescents and CYSHCN | Coordinate with partners and local health authorities to improve the messaging of transition care.<br><br>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<br><br>Conduct health transition trainings among health care providers to support transition efforts and gather information regarding changes in knowledge, practices, and policy. | 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<br><br>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 | NPM 12: 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 | ***Inactive -*** *ESM 12.1: 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*<br><br>***Inactive -*** *ESM 12.2: 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*<br><br>ESM 12.3: 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. | NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system |
| Improve care coordination | Collaborate with the Sexual Risk Avoidance Education (SRAE) Program and the State Personal Responsibility Education Program (PREP). | Reduce repeat birth rate among adolescent females, ages 15 to 19, | SPM 3: Repeat teen birth rate | | |

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| among adolescents | Collaborate with community partners on educational campaign focused on decreasing teen pregnancy and repeat pregnancy. | to 12 repeat births per 1,000 by 2025. | | | |
| Improve care coordination among adolescents | 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.<br><br>Collaborate with community partners on resource sharing related to decreasing teen pregnancy. | Reduce pregnancies among adolescent females, ages 15 to 19, to 16 pregnancies per 1,000 by 2025 | SPM 4: Teenage pregnancy rate | | |
| **Children with Special Health Care Needs** | | | | | |
| Promote a Medical Home | Partner to support the utilization of Medical Home Portal including awareness, professional development, Nevada 2-1-1 activities, etc.<br><br>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 | Increase the percent of children with special health care needs with a medical home in the past year to 35% by 2025<br><br>Increase the percent of children without special health care needs with a medical home in the past year to 50% by 2025<br><br>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<br><br>Increase the number of unique users of Nevada's medical home portal to 9,000 by 2025 | NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home | ***Inactive -*** *ESM 11.1: Number of Nevada Medical Home Portal website views.*<br><br>ESM 11.2: Percent of Nevada Medical Home Portal users who utilize the Services Directory feature to obtain information on providers and community resources. | NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system<br><br>NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling<br><br>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health<br><br>NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year |
| Increase transition of care for adolescents and CYSHCN | 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.<br><br>Collaborate with public and private partners to provide children with special health care needs and their families with information on the benefits | 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 | NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition | ***Inactive -*** *ESM 12.1: Percent of participants reporting a change in knowledge who completed the Project* | NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system |

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| | available and link them to appropriate health care coverage options<br><br>Conduct health transition trainings among health care providers to support transition efforts and gather information regarding changes in knowledge, practices, and policy. | | to adult health care | *ECHO online course using Got Transitions Six-Core Elements of Health Care Transition*<br><br>***Inactive -*** *ESM 12.2: 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*<br><br>ESM 12.3: 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. | |