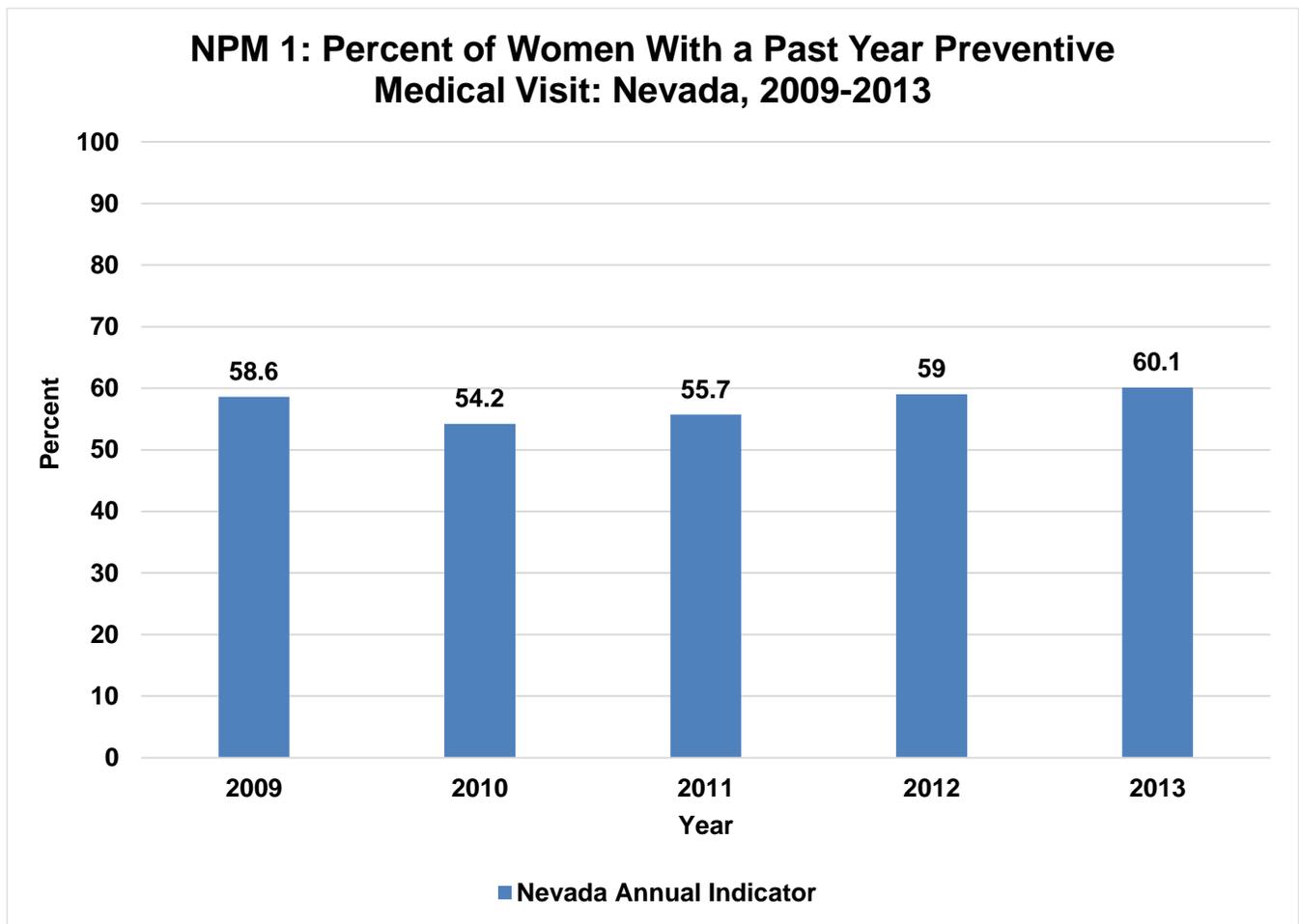


Nevada Maternal and Child Health Block Grant FY 2016 Application /FY 2014 Report

National Performance Measures

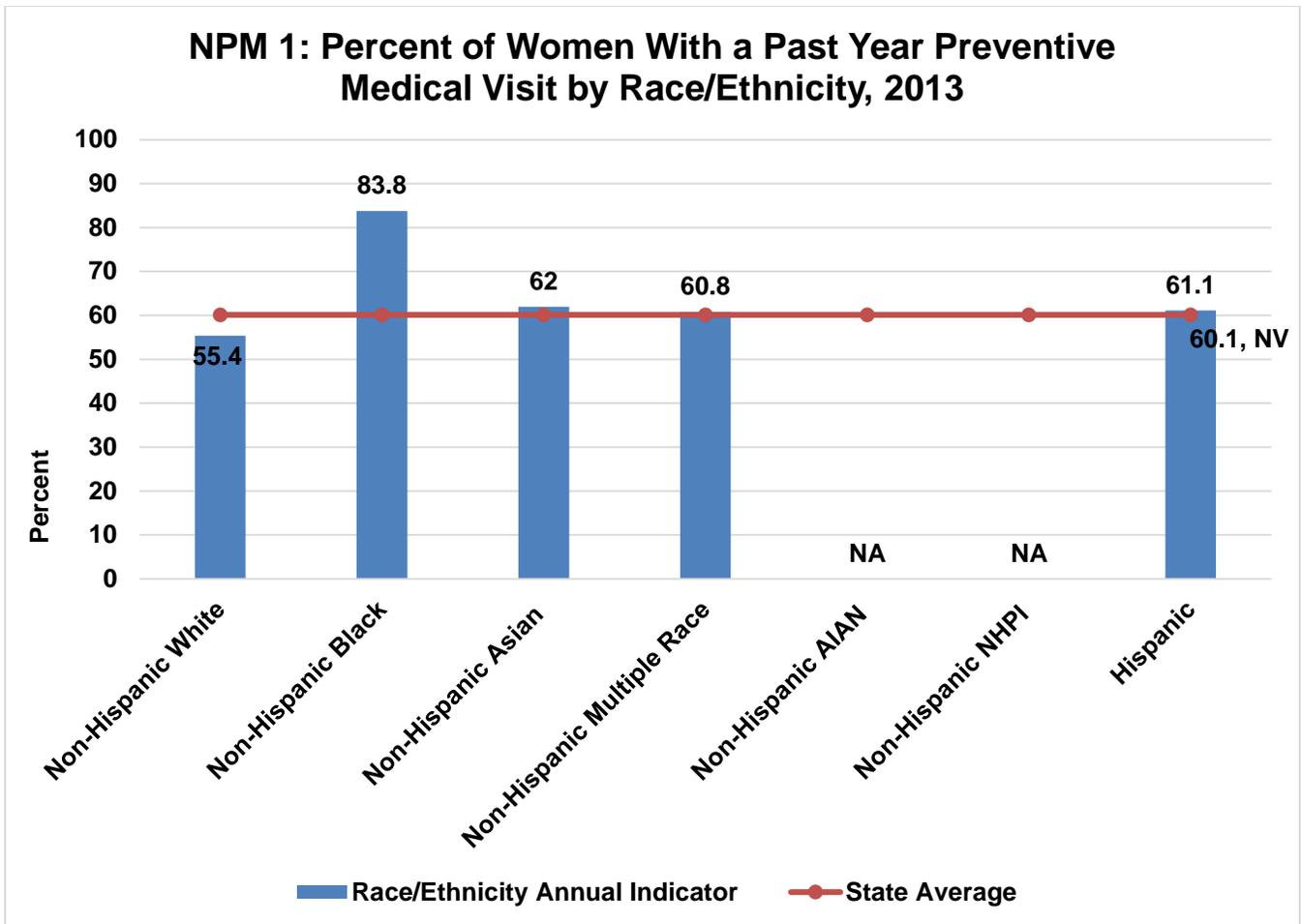


National Performance Measure (NPM) 1 has seen an increase of preventive medical visits by women in Nevada since 2010. This measure is related to two HP 2020 developmental objectives (MICH 16.1 and AHS 7.0) aimed at increasing the percentage of women delivering a live birth who discussed preconception health with a health care worker prior to pregnancy and increasing the proportion of persons who receive appropriate clinical preventive services.

Source: BRFSS, 2009-2013

Data note (FAD Resource Document):

In 2011, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. The weighting methodology also changed in 2011. Therefore, estimates from 2009 and 2010 may not be comparable to subsequent estimates. The estimates, numerators, and denominators presented are weighted to account for non-response and to reflect state population totals by various demographic characteristics. Standard errors account for the complex survey design.

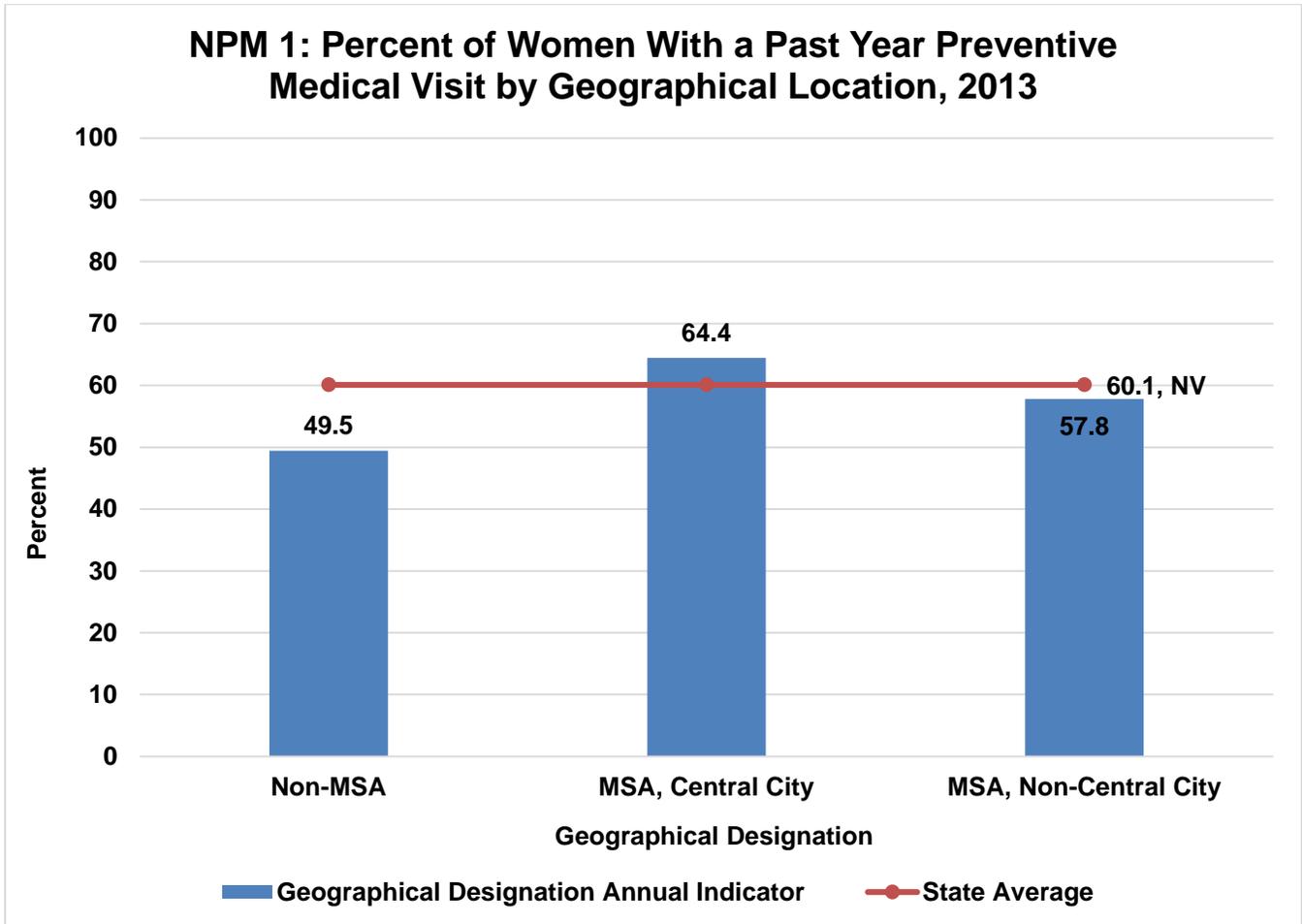


For NPM1, in 2013 women in Nevada of Non-Hispanic Black, Non-Hispanic Asian, Non-Hispanic Multiple Race, and Hispanic race/ethnicity, surpass the state annual indicator of 60.1 percent past year preventive medical visits.

Source: BRFSS, 2013

Data note (FAD Resource Document):

In 2011, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. The weighting methodology also changed in 2011. Therefore, estimates from 2009 and 2010 may not be comparable to subsequent estimates. The estimates, numerators, and denominators presented are weighted to account for non-response and to reflect state population totals by various demographic characteristics. Standard errors account for the complex survey design.

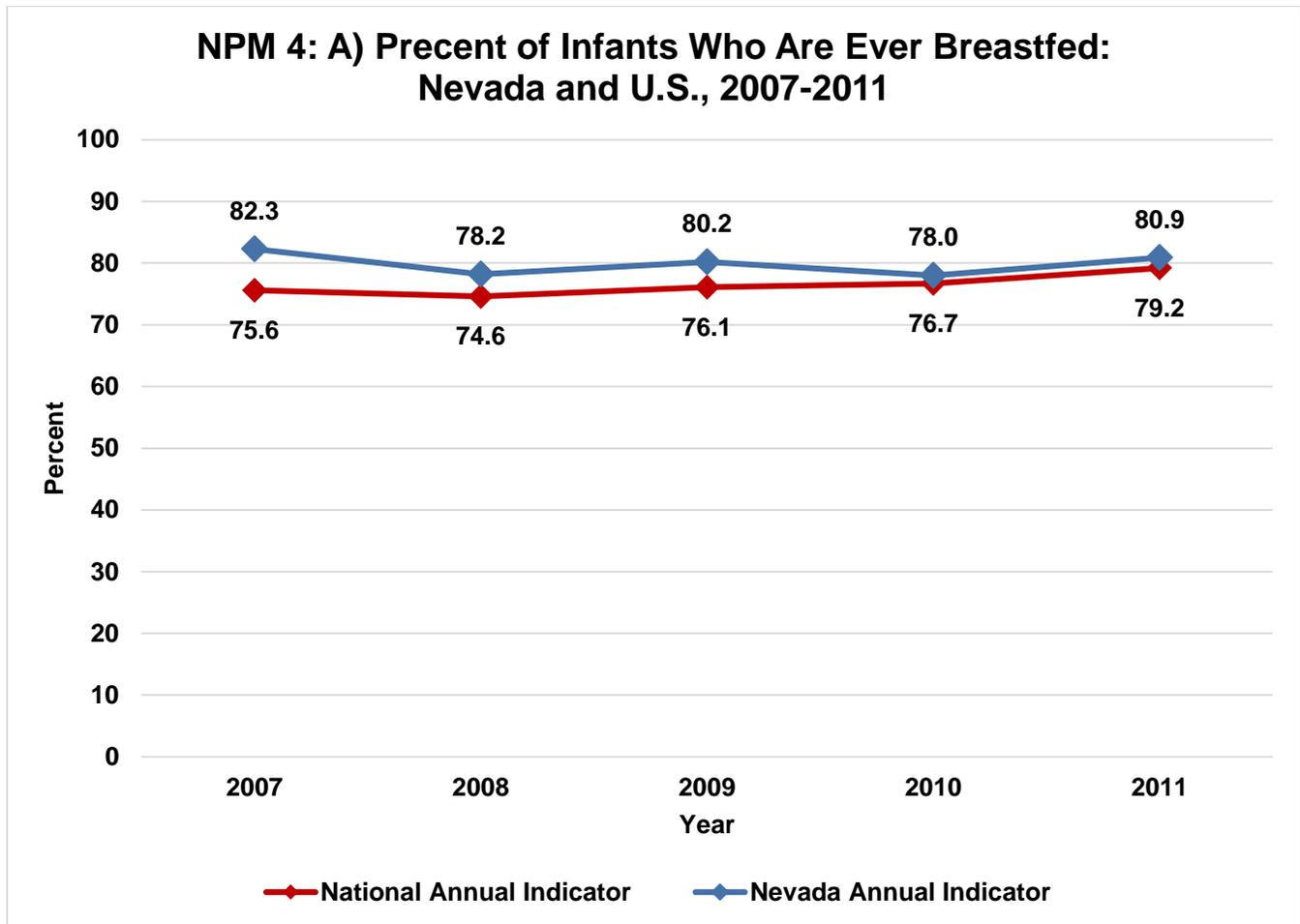


In Nevada during 2013, women who lived in a Metropolitan Statistical Area/Central City were more likely to receive a past year medical visit. Women in this geographical designation were the only population to exceed the state annual indicator of 60.1% at 64.43%.

Source: BRFSS, 2013

Data note (FAD Resource Document):

In 2011, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. The weighting methodology also changed in 2011. Therefore, estimates from 2009 and 2010 may not be comparable to subsequent estimates. The estimates, numerators, and denominators presented are weighted to account for non-response and to reflect state population totals by various demographic characteristics. Standard errors account for the complex survey design.

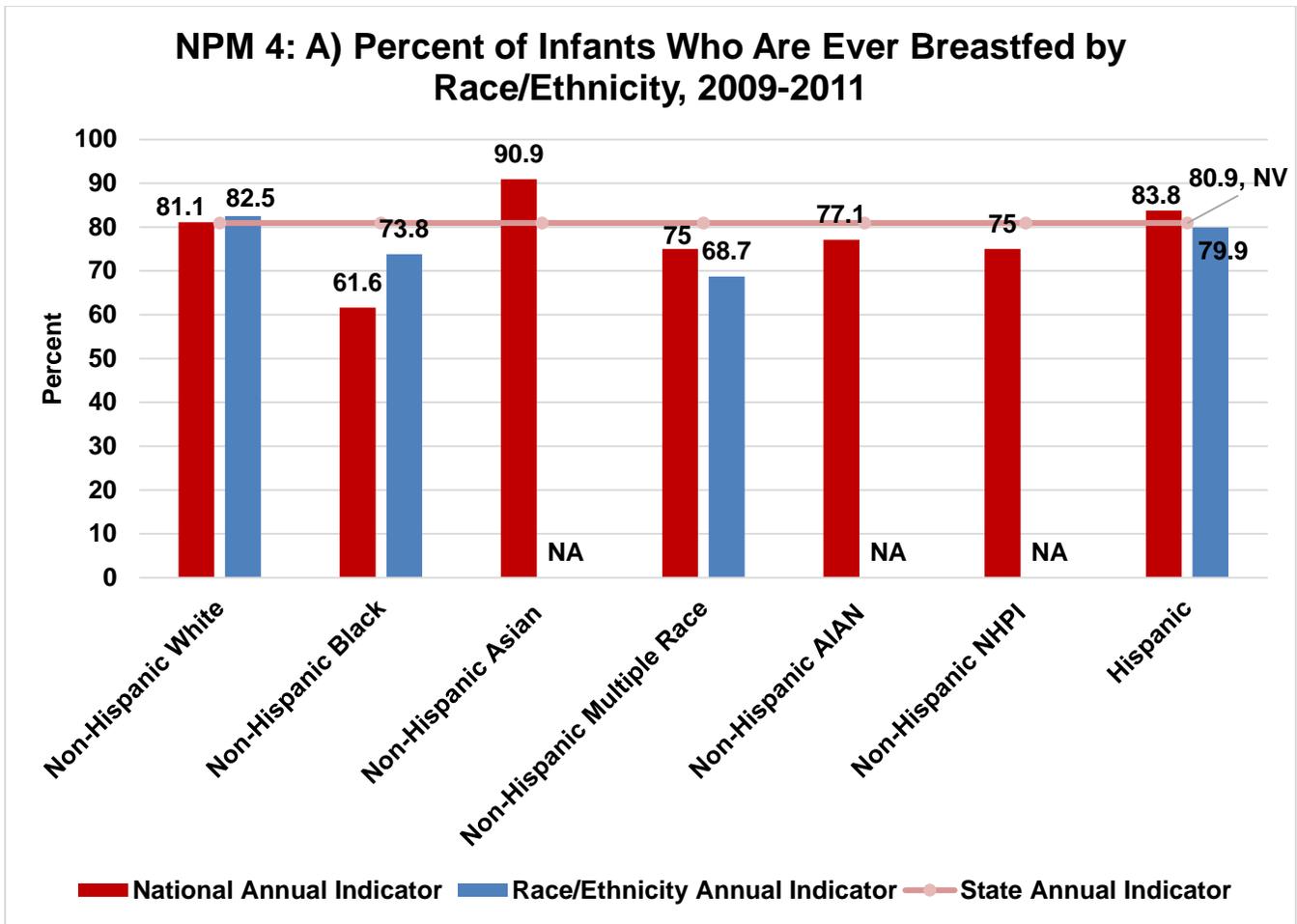


Nevada is above the national annual indicator for percent of infants ever breastfed across all years 2007 through 2011. The goal of NPM 4 is to increase the number of infants breastfed. Related to MICH objective 21.1, the HP 2020 target is 81.9%. Nevada missed this mark in 2011, but came within 1% of the target goal. The next two figures describe the 2009-2011 data by race/ethnicity and geographical location.

Source: National Immunization Survey (NIS), 2007-2011

Data note (FAD Resource Document):

Starting with 2009 births, the survey switched from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates from 2007 and 2008 may not be comparable to subsequent estimates. Weighted numerators and denominators will be provided in subsequent updates.

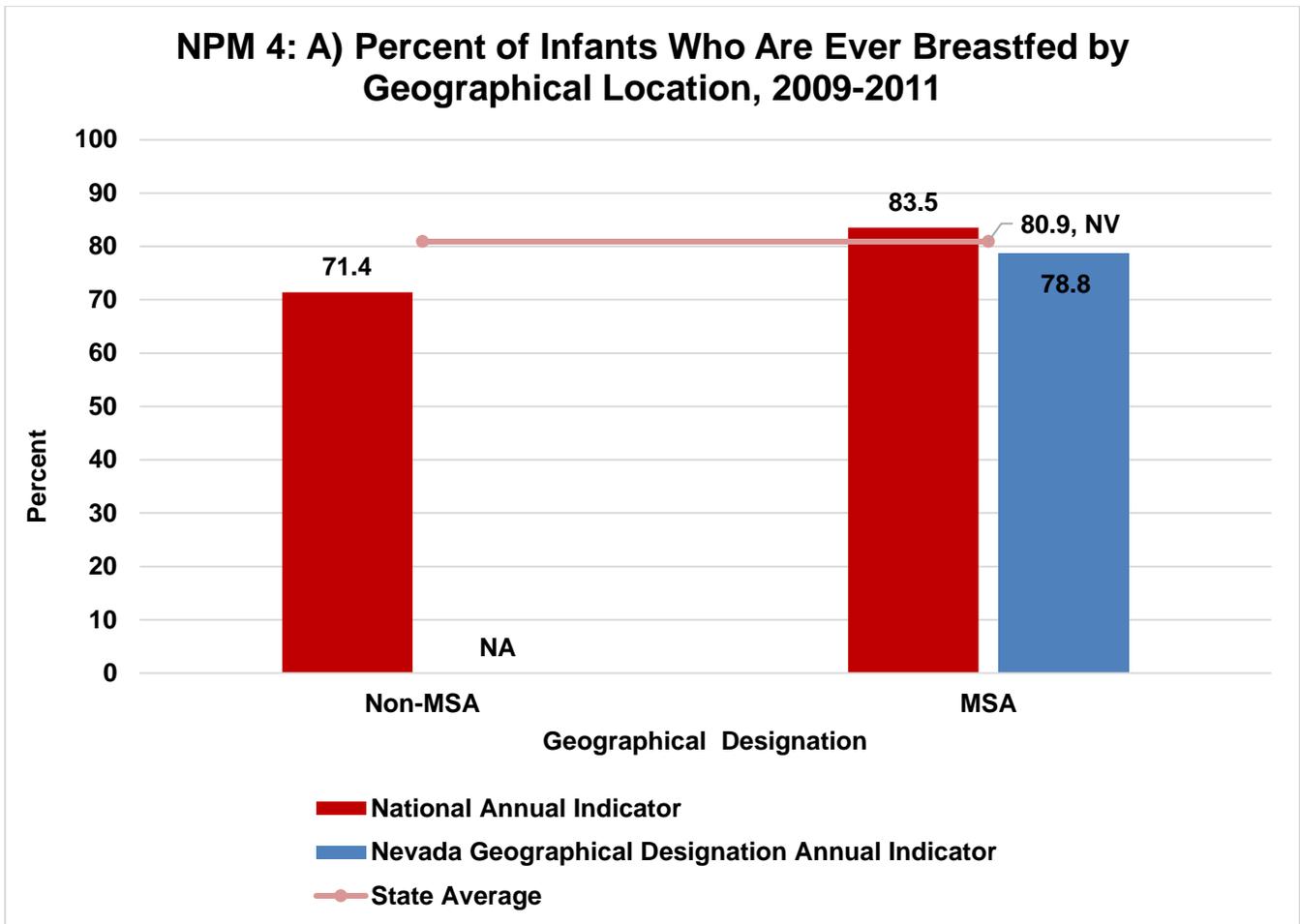


For 2009-2011 totals, only Non-Hispanic White, exceeded the HP 2020 target of 81.9% during the years 2009 to 2011. All other populations were below both the HP 2020 target goal and the state annual indicator of 80.9%.

Source: National Immunization Survey (NIS), 2009-2011

Data note (FAD Resource Document):

Starting with 2009 births, the survey switched from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates from 2007 and 2008 may not be comparable to subsequent estimates. Weighted numerators and denominators will be provided in subsequent updates.

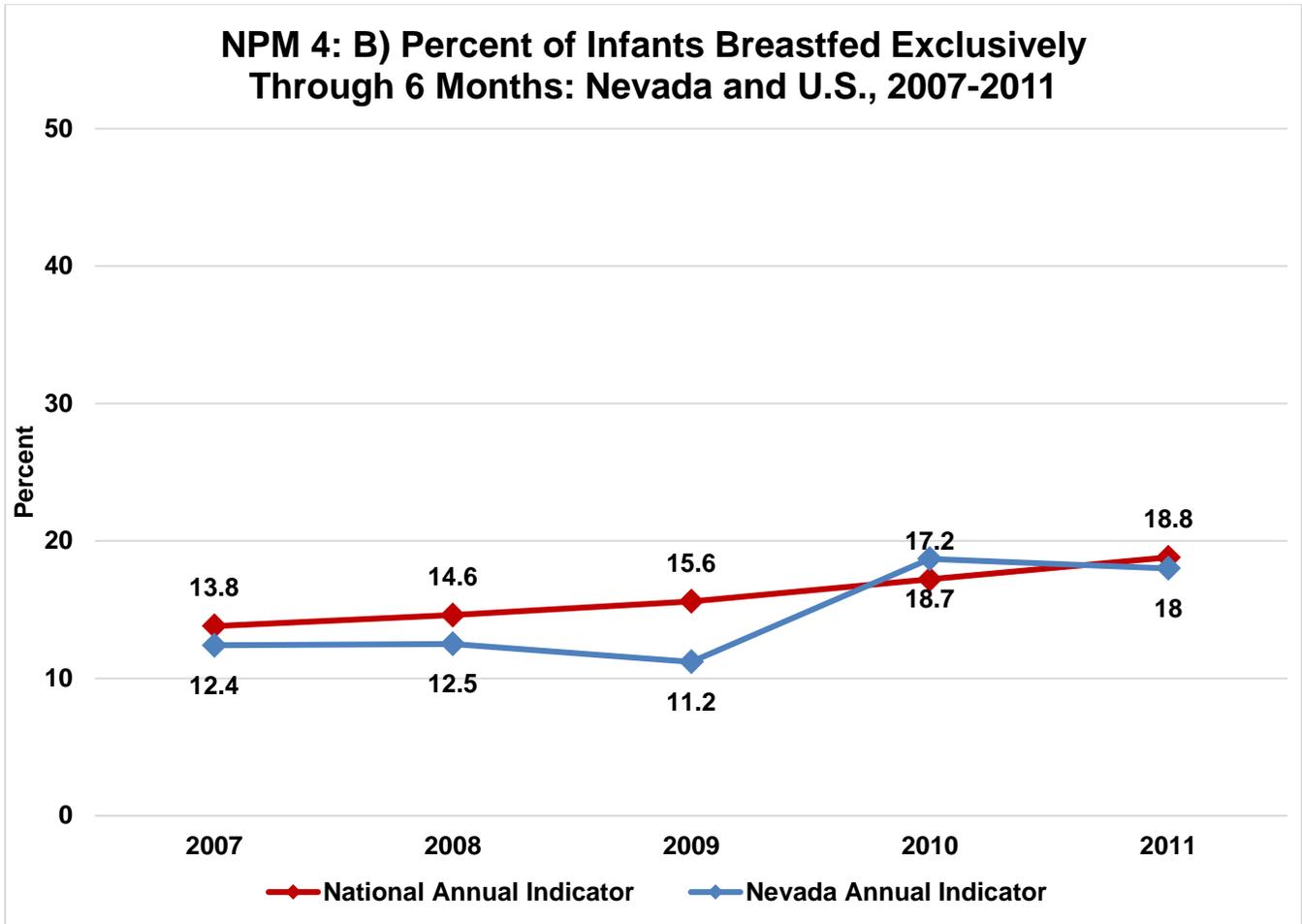


During 2009 to 2011 Nevada infants living in Metropolitan Statistical Areas were more likely to have ever been breastfed than infants living in non-MSAs.

Source: National Immunization Survey (NIS), 2009-2011

Data note (FAD Resource Document):

Starting with 2009 births, the survey switched from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates from 2007 and 2008 may not be comparable to subsequent estimates. Weighted numerators and denominators will be provided in subsequent updates.

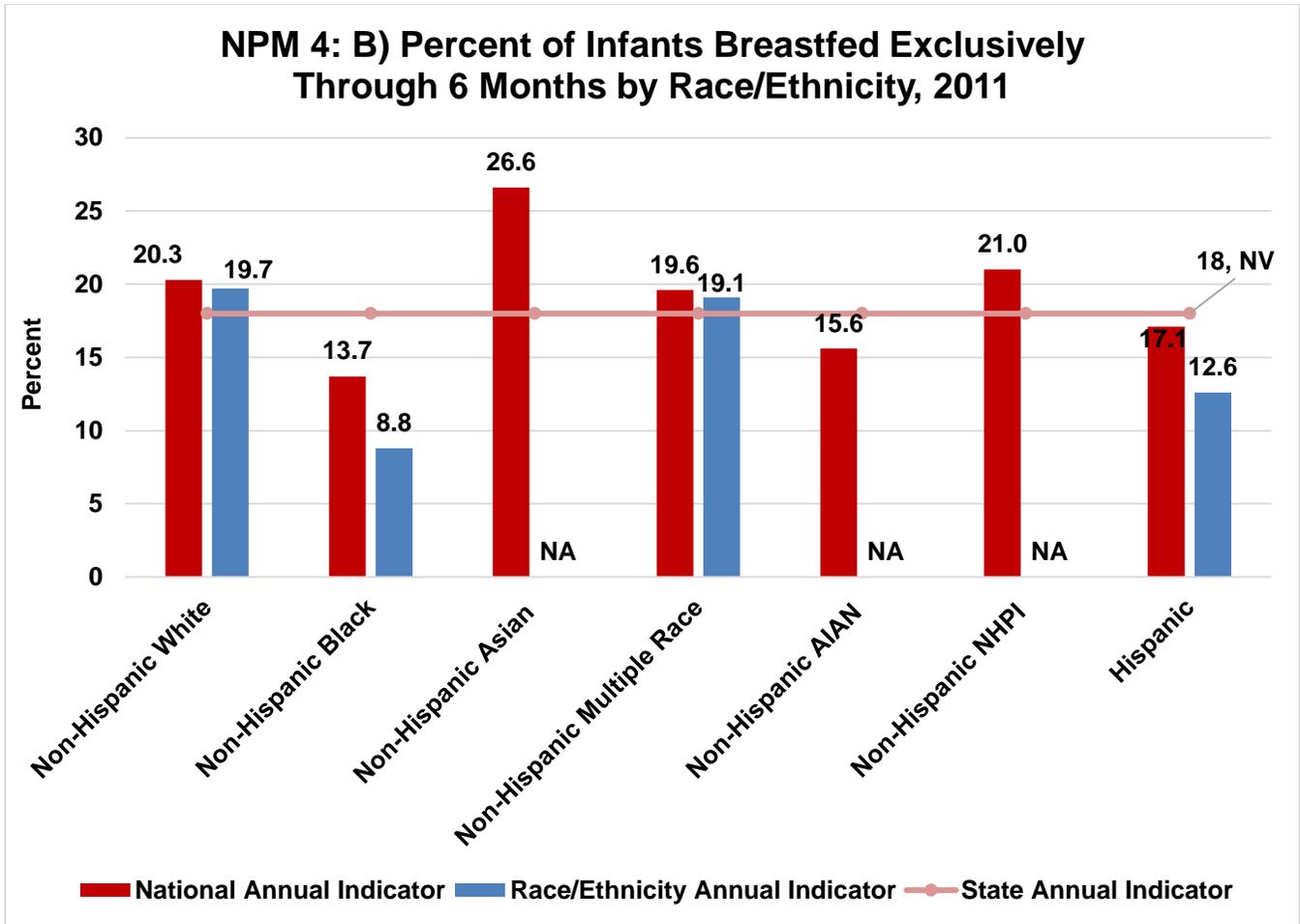


Only once in the five year span (2007-2011) did Nevada surpass the National Annual Indicator for children exclusively breastfed through 6 months of age. NPM 4 is related to MICH objective 21.5, which seeks to increase the proportion of children exclusively breastfed through 6 months. The HP 2020 target is now 25.5%. Nevada's annual indicator significantly increased by 45 percent from 12.4% in 2007 to 18% in 2011.

Source: National Immunization Survey (NIS), 2007-2011

Data note (FAD Resource Document):

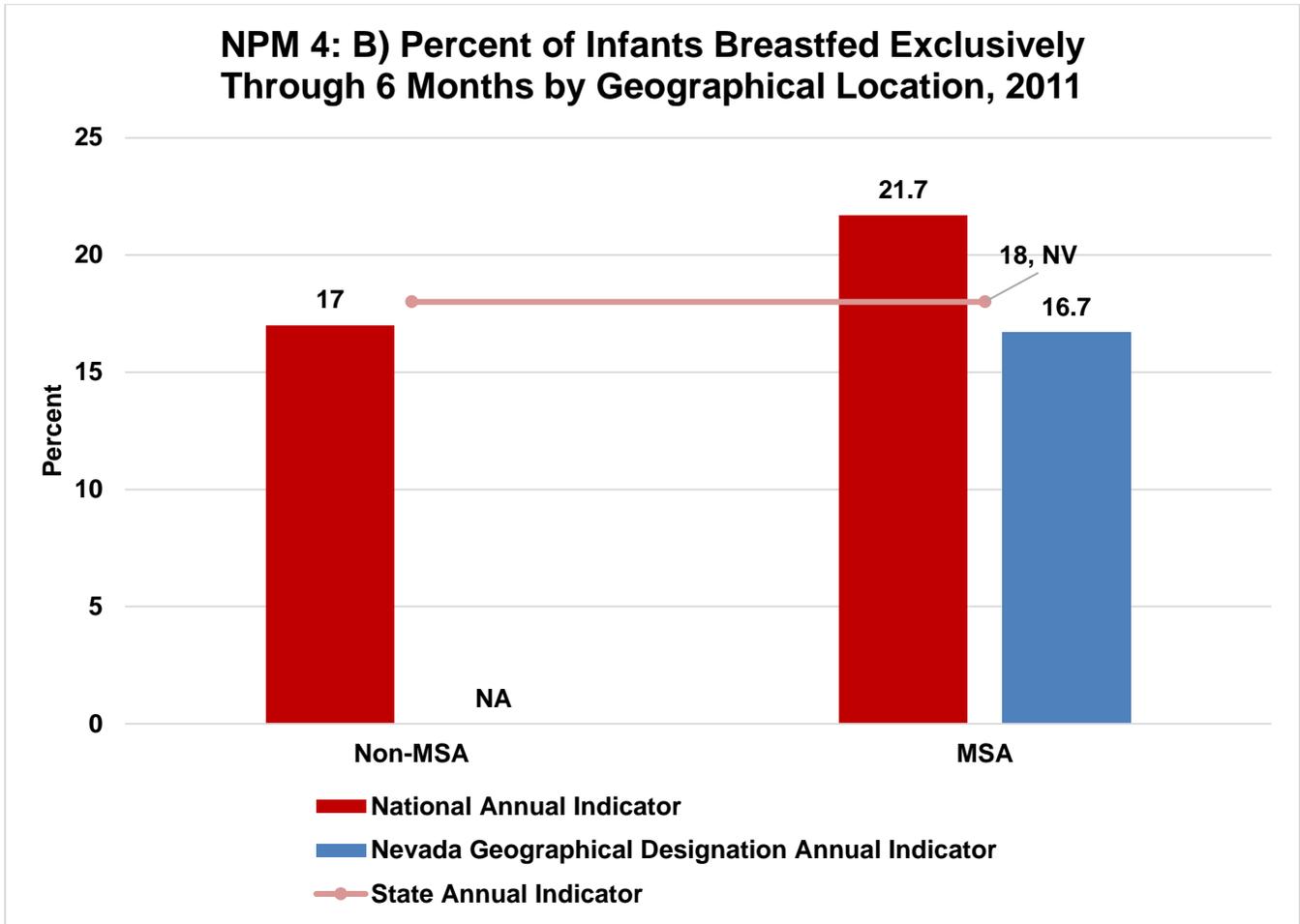
Starting with 2009 births, the survey switched from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates from 2007 and 2008 may not be comparable to subsequent estimates. Weighted numerators and denominators will be provided in subsequent updates.



Non-Hispanic White and non-Hispanic population of multiple race surpassed the state annual indicator in 2011 in the percent of infants who were breastfed exclusively at 6 months of age. Nevada’s annual indicator does not meet the HP 2020 objective and indicates areas of possible improvement to focus on.

Source: National Immunization Survey (NIS), 2009-2011

Data note (FAD Resource Document): Starting with 2009 births, the survey switched from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates from 2007 and 2008 may not be comparable to subsequent estimates. Weighted numerators and denominators will be provided in subsequent updates.

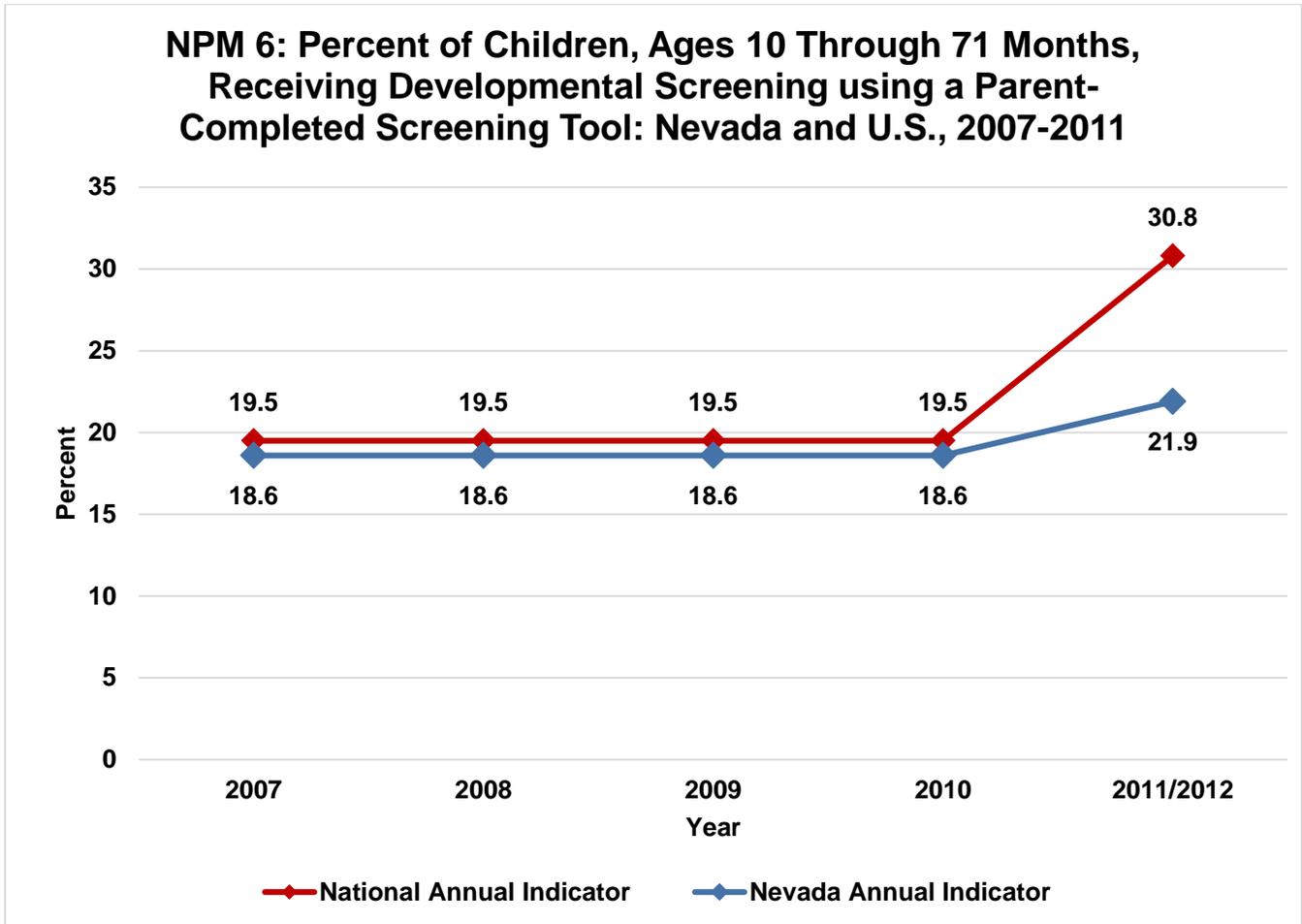


Though infants in MSAs surpassed the rest of the State for being exclusively breastfed at 6 months, nationally both MSA and Non-MSA populations are below the HP 2020 target of 25.5%.

Source: National Immunization Survey (NIS), 2009-2011

Data note (FAD Resource Document):

Starting with 2009 births, the survey switched from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates from 2007 and 2008 may not be comparable to subsequent estimates. Weighted numerators and denominators will be provided in subsequent updates.

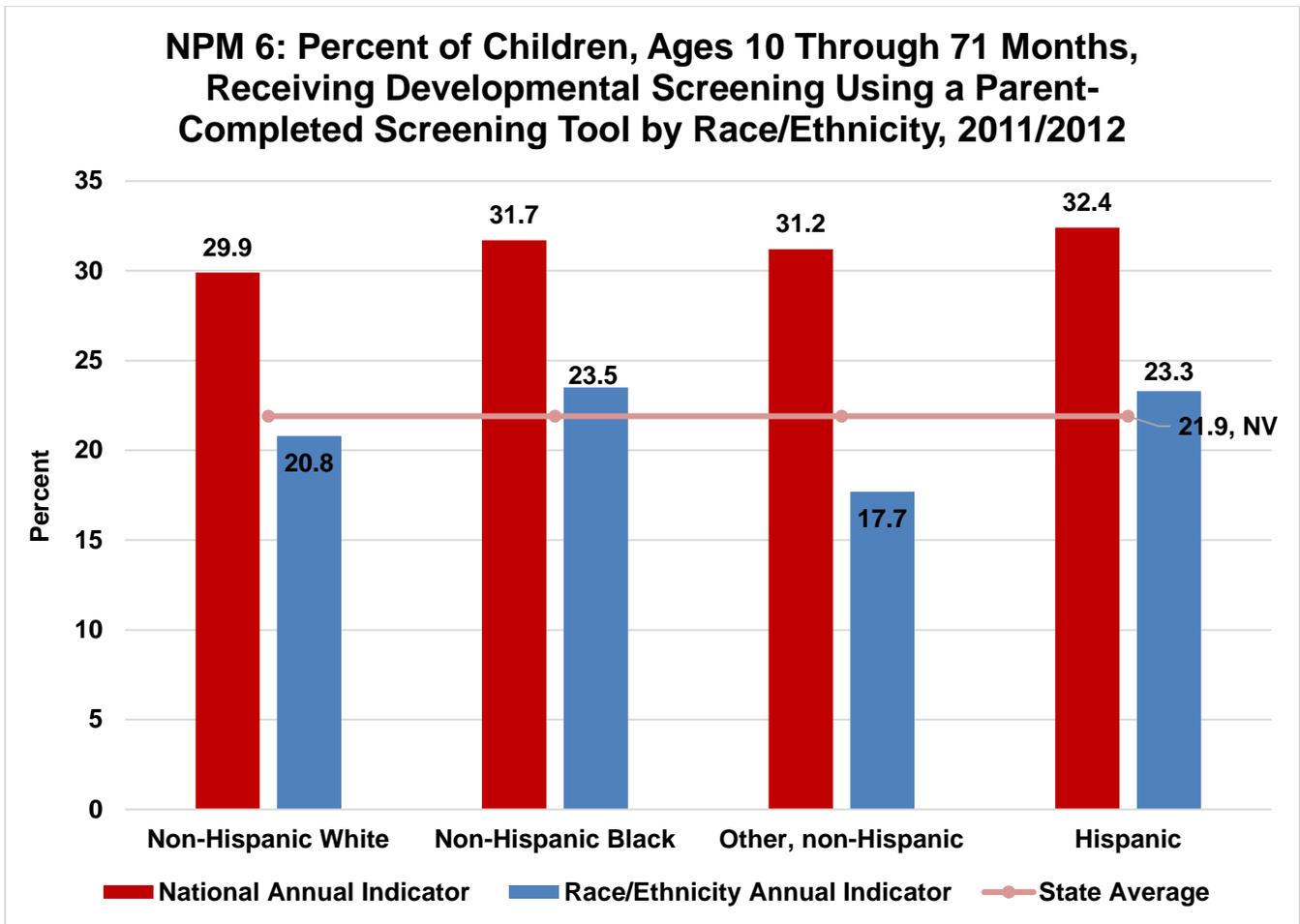


The goal of NPM 6 is to increase the number of children who receive developmental screening. This goal is related to the MICH objective 29.1 to increase the number of children (aged 10-35 months) who have been screened for Autism Spectrum Disorder and other developmental delays. The HP 2020 target for MICH 29.1 is 24.9%. The difference in age groupings should be taken into consideration: HP includes ages 10-35 months and the NPM includes ages 10-71 months.

Source: National Survey of Children's Health (NSCH), 2007-2011/2012

Data note (FAD Resource Document):

Developmental screening measure was added in 2007 and data are only available at two time points. In 2011/2012 the survey changed from landline-only sample to a dual-frame sample including landlines and cell phones. Estimates may not be comparable over time. Numerators and denominators are weighted to account for the probability of select.

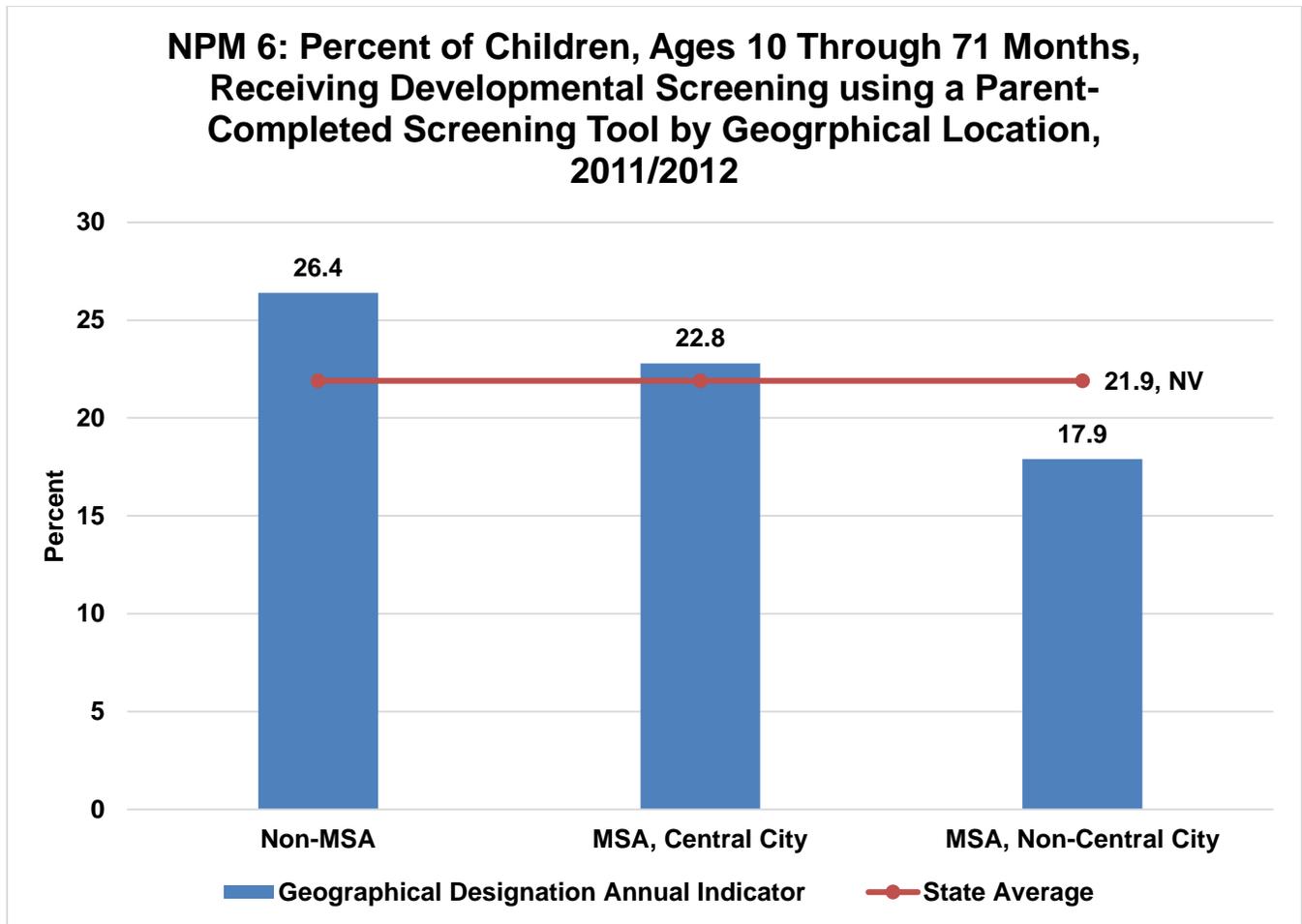


Only two of Nevada's populations, Non-Hispanic Black and Hispanic, exceeded the state annual indicator for 2011-2012. None of Nevada's populations came within 5% of their national cohorts and none of Nevada's populations met the 24.5% target of HP 2020.

Source: National Survey of Children's Health (NSCH), 2011/2012

Data note (FAD Resource Document):

Developmental screening measure was added in 2007 and data are only available at two time points. In 2011/2012 the survey changed from landline-only sample to a dual-frame sample including landlines and cell phones. Estimates may not be comparable over time. Numerators and denominators are weighted to account for the probability of select.

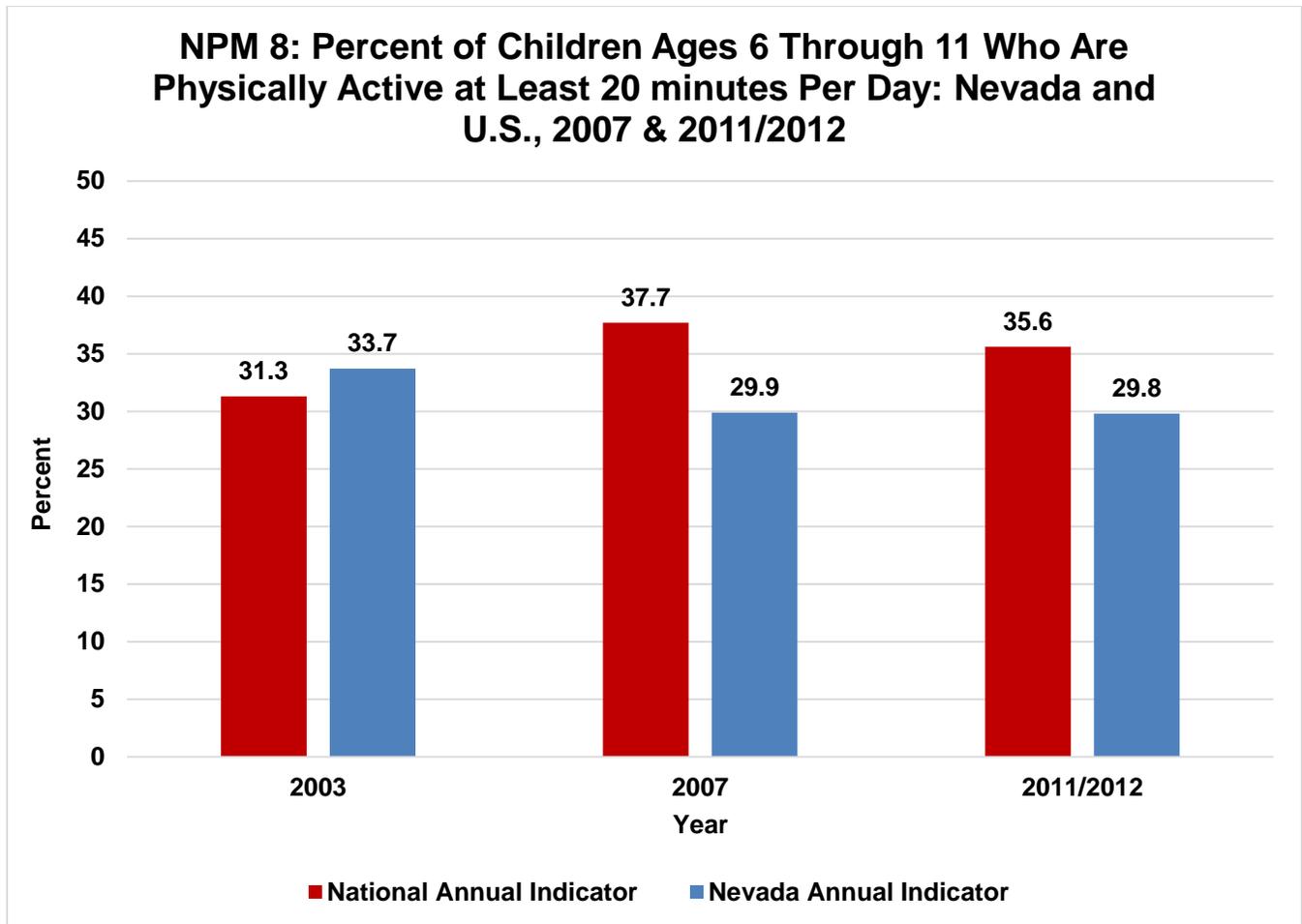


In 2011/2012, Nevada children living in Non-MSA geographical designations met and surpassed the HP 2020 target of 24.5% for receiving a developmental screening using a parent-completed screening tool and the state annual indicator. Children ages 10-71 months living in MSA, non-central city had the lowest percent at 17.9%, lower than the state annual indicator as well as the HP 2020 objective.

Source: National Survey of Children's Health (NSCH), 2011/2012

Data note (FAD Resource Document):

Developmental screening measure was added in 2007 and data are only available at two time points. In 2011/2012 the survey changed from landline-only sample to a dual-frame sample including landlines and cell phones. Estimates may not be comparable over time. Numerators and denominators are weighted to account for the probability of select.

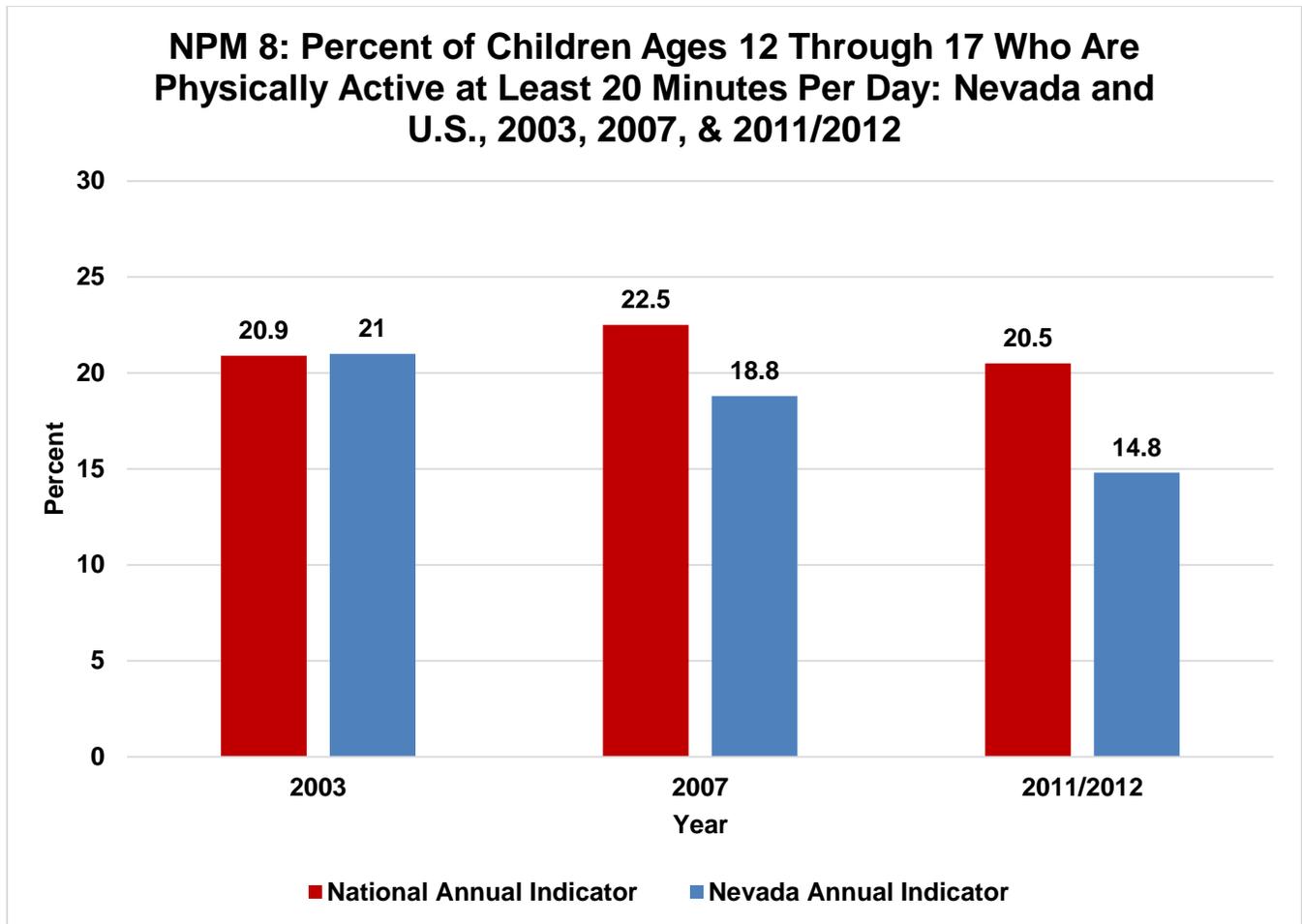


In 2011/2012, 29.8 percent of children ages 6 to 11 in Nevada were physically active for at least 20 minutes per day compared to 35.6 percent nationally.

Source: National Survey of Children's Health (NSCH), 2003-2011/2012

Data note (FAD Resource Document):

The revised NSCH will capture physical activity of at least 60 minutes per day with baseline NSCH data reflecting at least 20 minutes per day. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time.

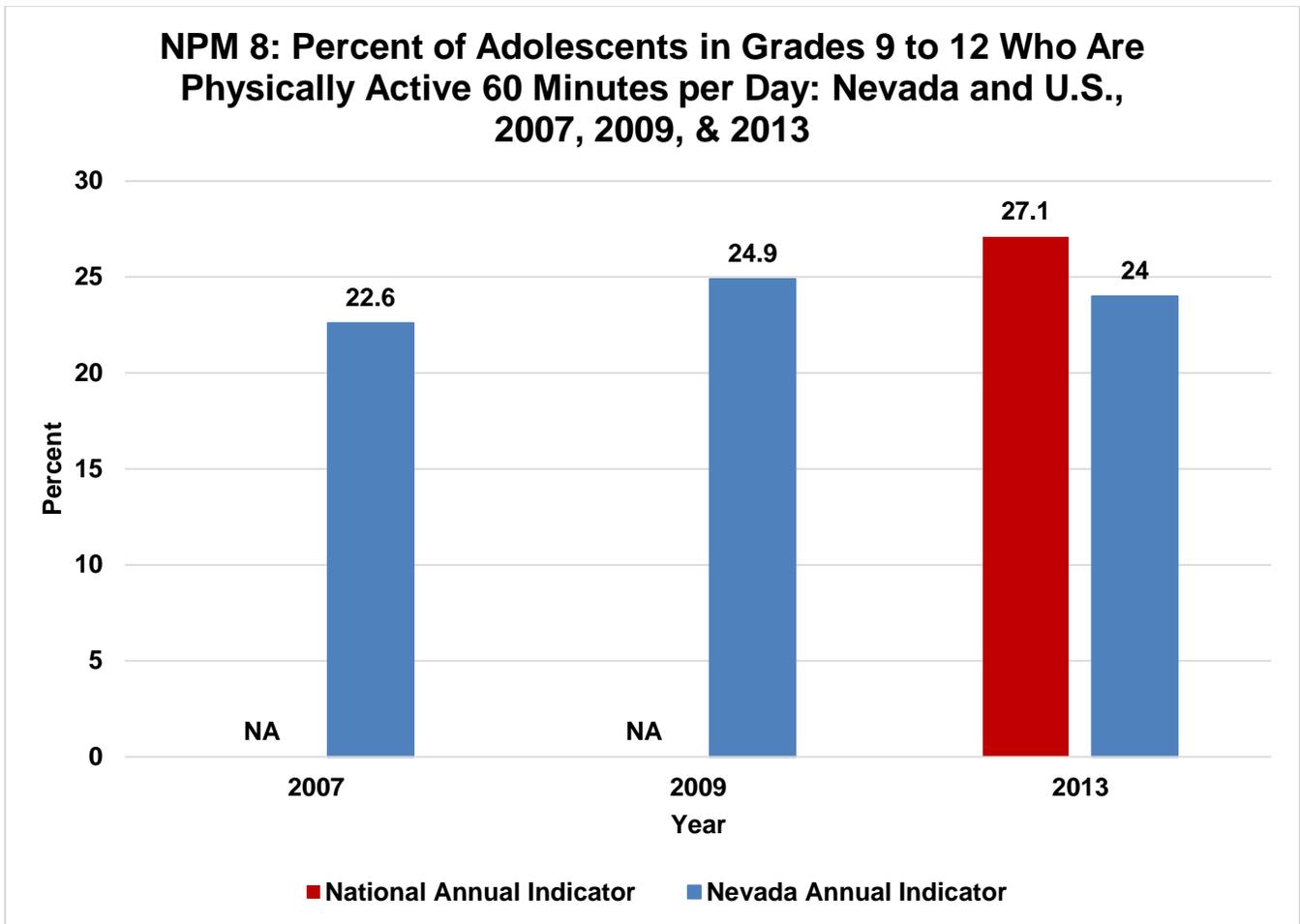


The percent of children aged 12 to 17 physically active for at least 20 minutes decreased from 21% in 2003 to 14.8% in 2011/2012. The National Survey of Children's Health (NSCH) changed from a landline-only sample to a dual-frame sample including landlines and cell phones in 2011-2012 and this is a factor to consider when interpreting the trend data. In subsequent surveys, NSCH will change the question wording to read 60 minutes of physical activity instead of 20 minutes.

Source: National Survey of Children's Health (NSCH), 2003-2011/2012

Data note (FAD Resource Document):

The revised NSCH will capture physical activity of at least 60 minutes per day with baseline NSCH data reflecting at least 20 minutes per day. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time.

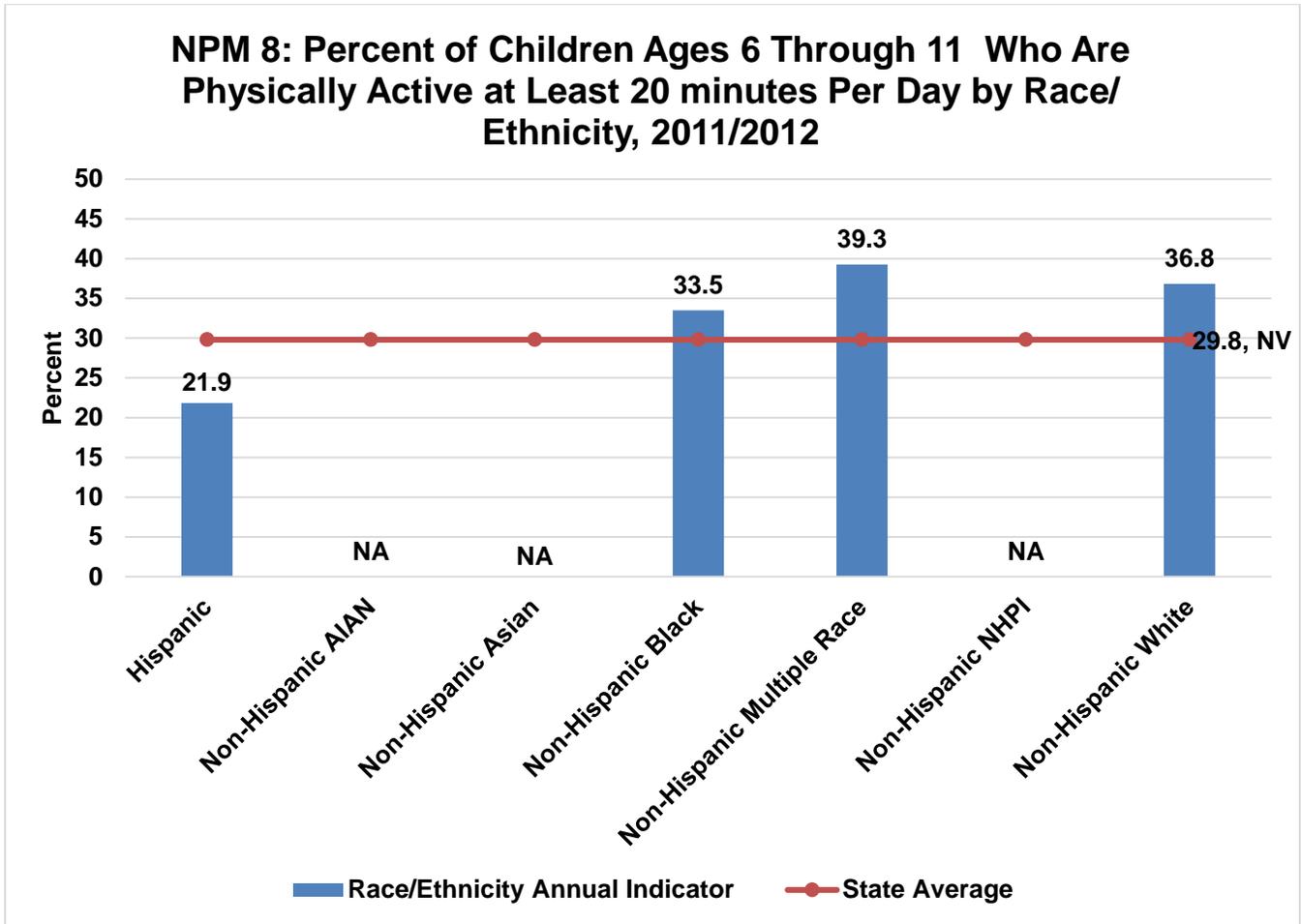


Nevada adolescents grades 9 through 12 had a slight increase in the percent of adolescents who are physically active 60 minutes per day, from 22.6% in 2007 to 24% in 2013. In 2013, the nation reported a higher percent of adolescents physically active 60 minutes per day at 27.1% compared to Nevada at 24%.

Source: Youth Risk Behavior Surveillance System (YRBSS), 2007-2013

Data note (FAD Resource Document):

YRBSS data are self-reported by students in grades 9 through 12. The estimates, numerators, and denominators presented are weighted to account for the probability of selection and non-response, and are adjusted to reflect the total population of high school students by sex, grade, and race/ethnicity for the United States and for each state.

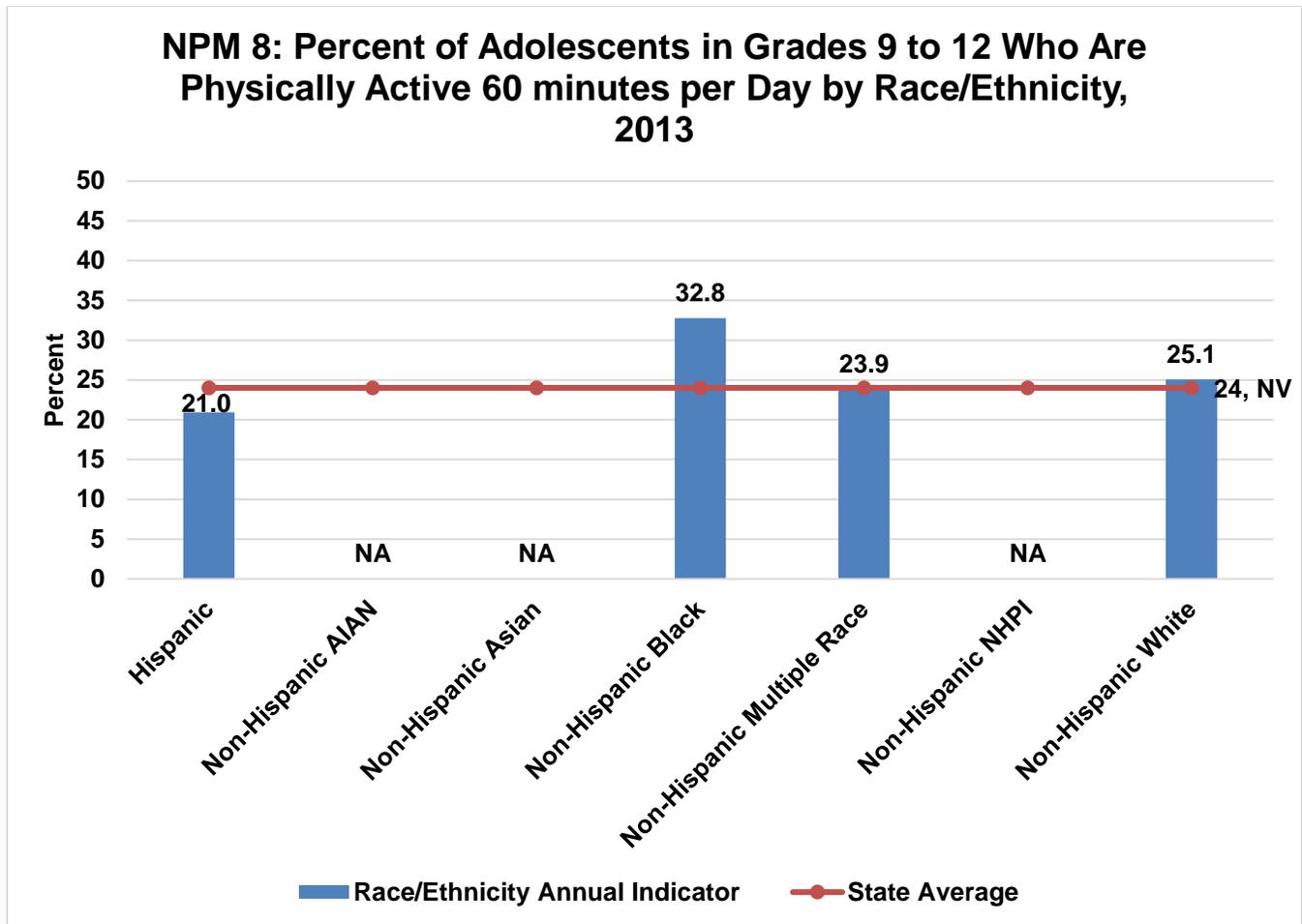


Non-Hispanic Black, Non-Hispanic Multiple race and non-Hispanic White children ages 6 to 11 years exceeded the State Annual Indicator for physical activity at least 20 minutes a day.

Source: National Survey of Children’s Health (NSCH), 2011-2012

Data note (FAD Resource Document):

The revised NSCH will capture physical activity of at least 60 minutes per day with baseline NSCH data reflecting at least 20 minutes per day. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time. The numerators and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children by state.

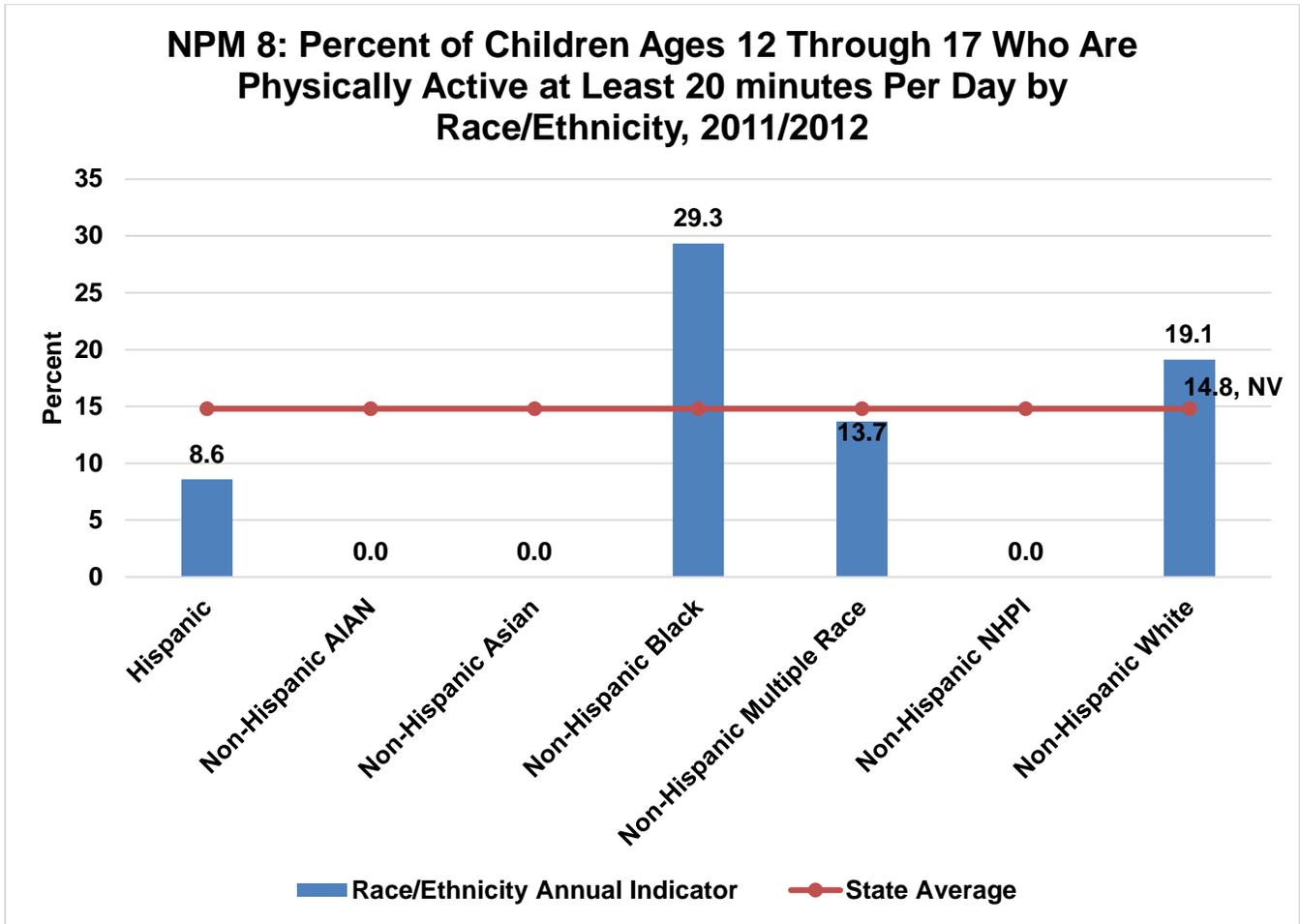


In 2013, Non-Hispanic Black adolescents in grades 9 to 12 had the highest rates of physical activity in the state. In the same year, Non-Hispanic Black and Non-Hispanic White adolescents in grades 9 to 12 exceeded the State Annual Indicator of 24% for 60 minutes of physical activity per day.

Source: National Survey of Children's Health (NSCH), 2011-2012

Data note (FAD Resource Document):

The revised NSCH will capture physical activity of at least 60 minutes per day with baseline NSCH data reflecting at least 20 minutes per day. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time. The numerators and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children by state.

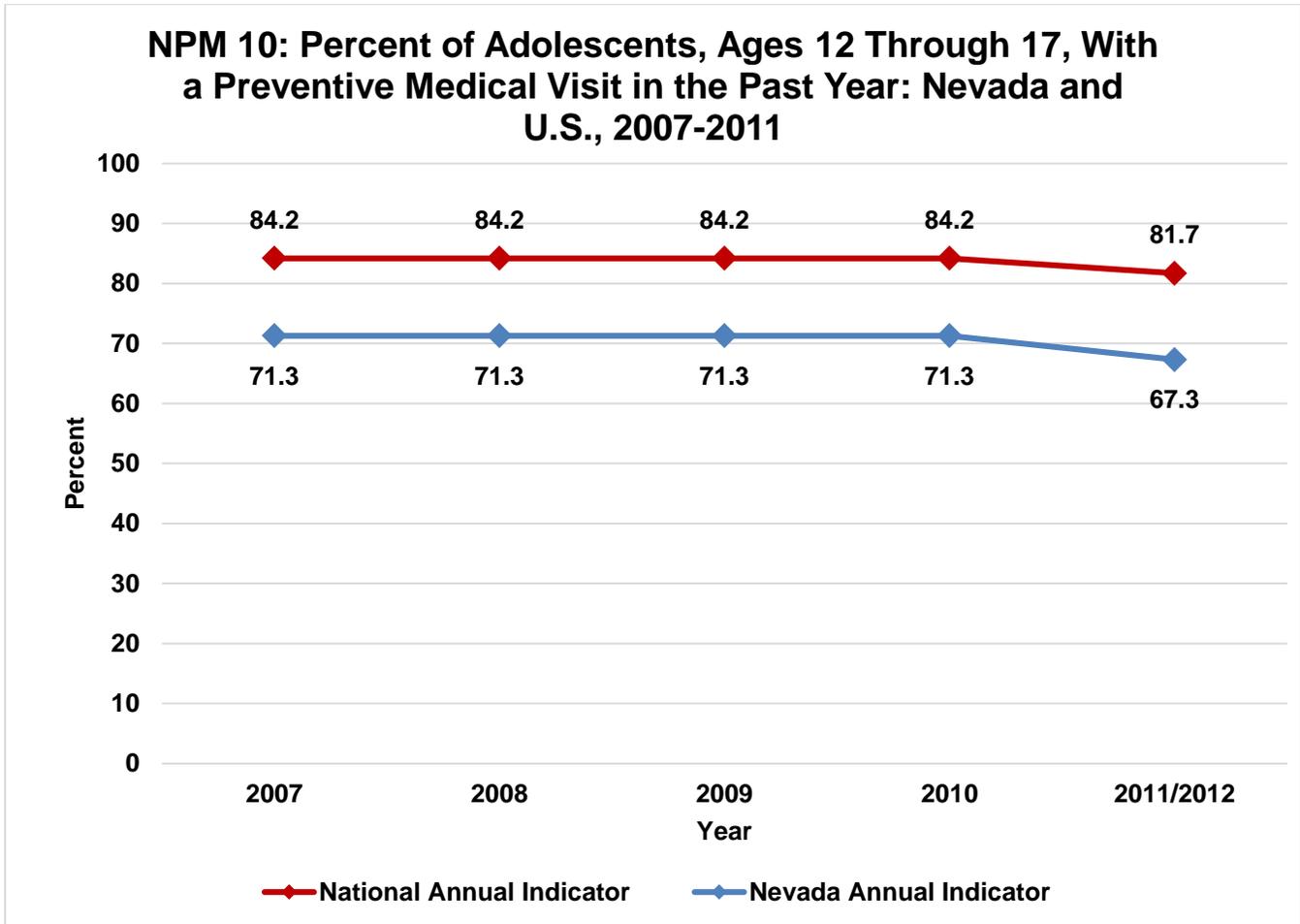


In Nevada, both the Non-Hispanic Black and the Non-Hispanic White populations for children and adolescents aged 12 to 17 years exceeded the State Annual Indicator for physical activity of at least 20 minutes a day in 2011/2012.

Source: National Survey of Children’s Health (NSCH), 2011/2012

Data note (FAD Resource Document):

The revised NSCH will capture physical activity of at least 60 minutes per day with baseline NSCH data reflecting at least 20 minutes per day. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time. The numerators and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children by state.

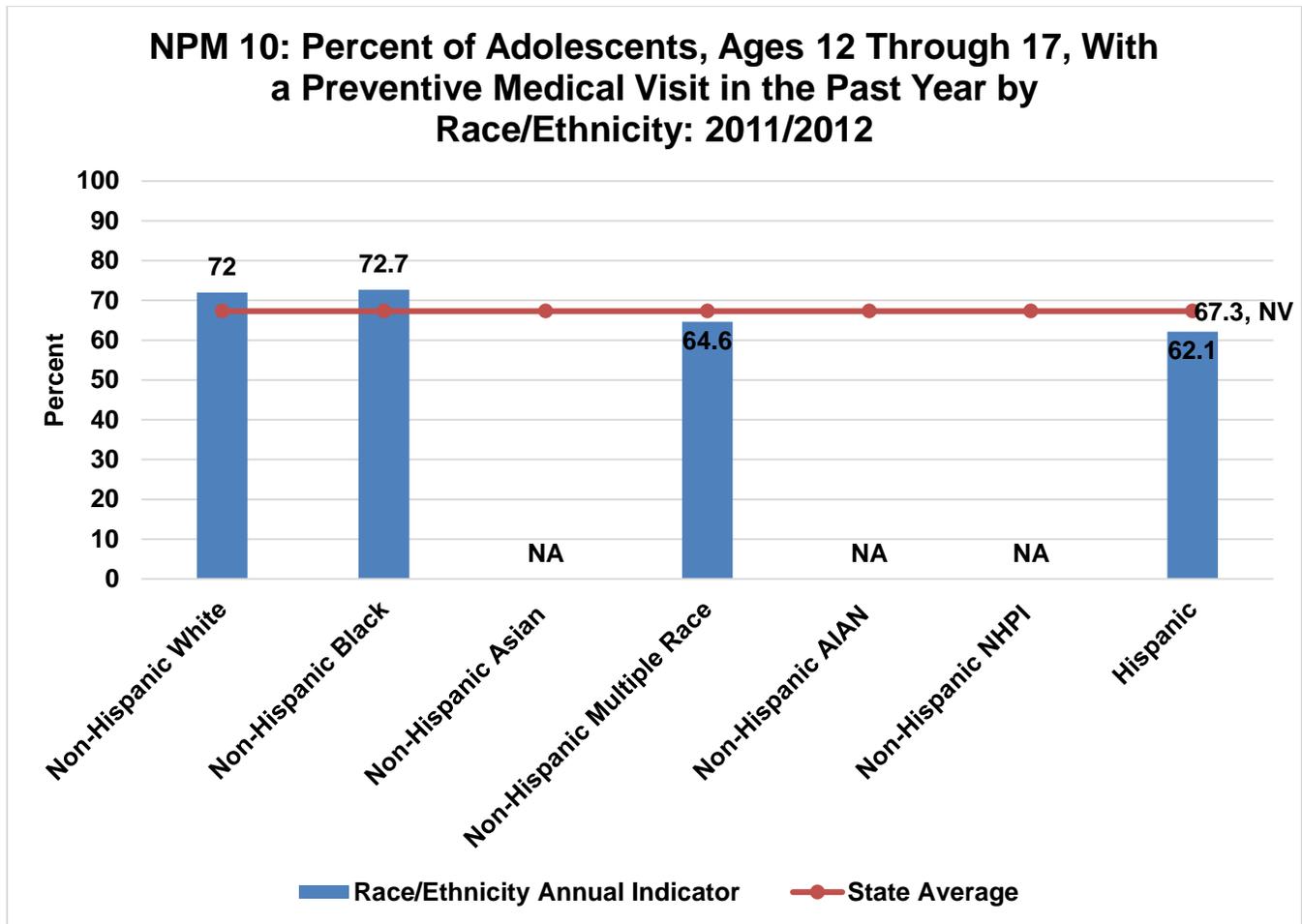


In 2007 through 2010, the percent of Nevada adolescents who had received a preventive medical visit in the past year stayed steady. In 2011/2012, the percent declined by 6 percent to 71.3% in 2010. Nevada did not meet the National Annual Indicator or the HP 2020 target of 75.6% across these years. The HP 2020 target is related to Adolescent Health (AH) Objective 1.

Source: National Survey of Children's Health (NSCH) 2007-2011

Data note (FAD Resource Document):

Starting with 2009 births, the survey switched from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates from 2007 and 2008 may not be comparable to subsequent estimates. Weighted numerators and denominators will be provided in subsequent updates.

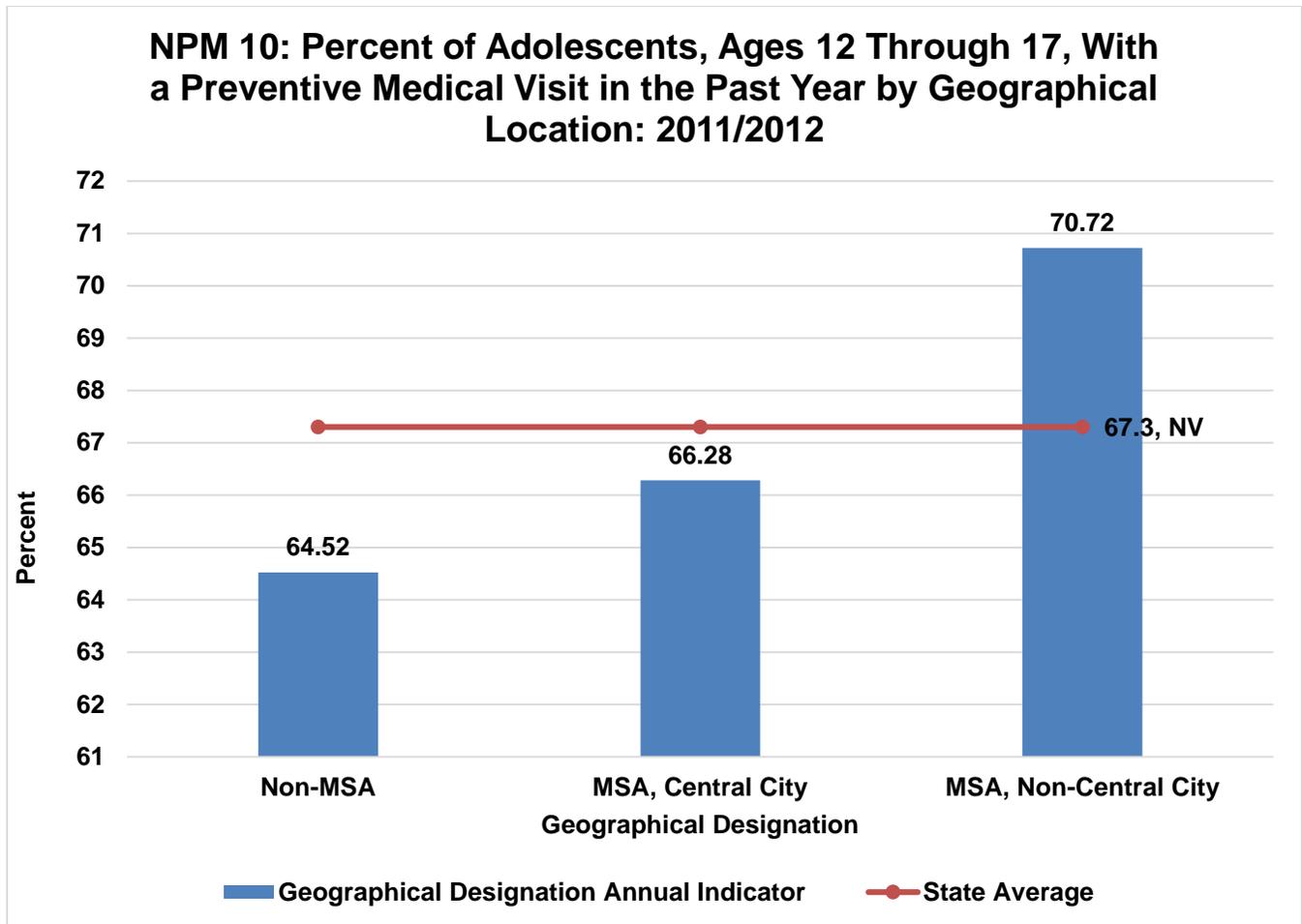


In 2011/2012 Non-Hispanic Black and Non-Hispanic White adolescents aged 12 to 17 in Nevada surpassed the State Annual Indicator for percent receiving a past year preventive visit. These numbers did not meet the National Annual Indicator or the HP 2020 target of 75.6%.

Source: National Survey of Children's Health (NSCH), 2011/2012

Data note (FAD Resource Document):

Starting with 2009 births, the survey switched from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates from 2007 and 2008 may not be comparable to subsequent estimates. Weighted numerators and denominators will be provided in subsequent updates.

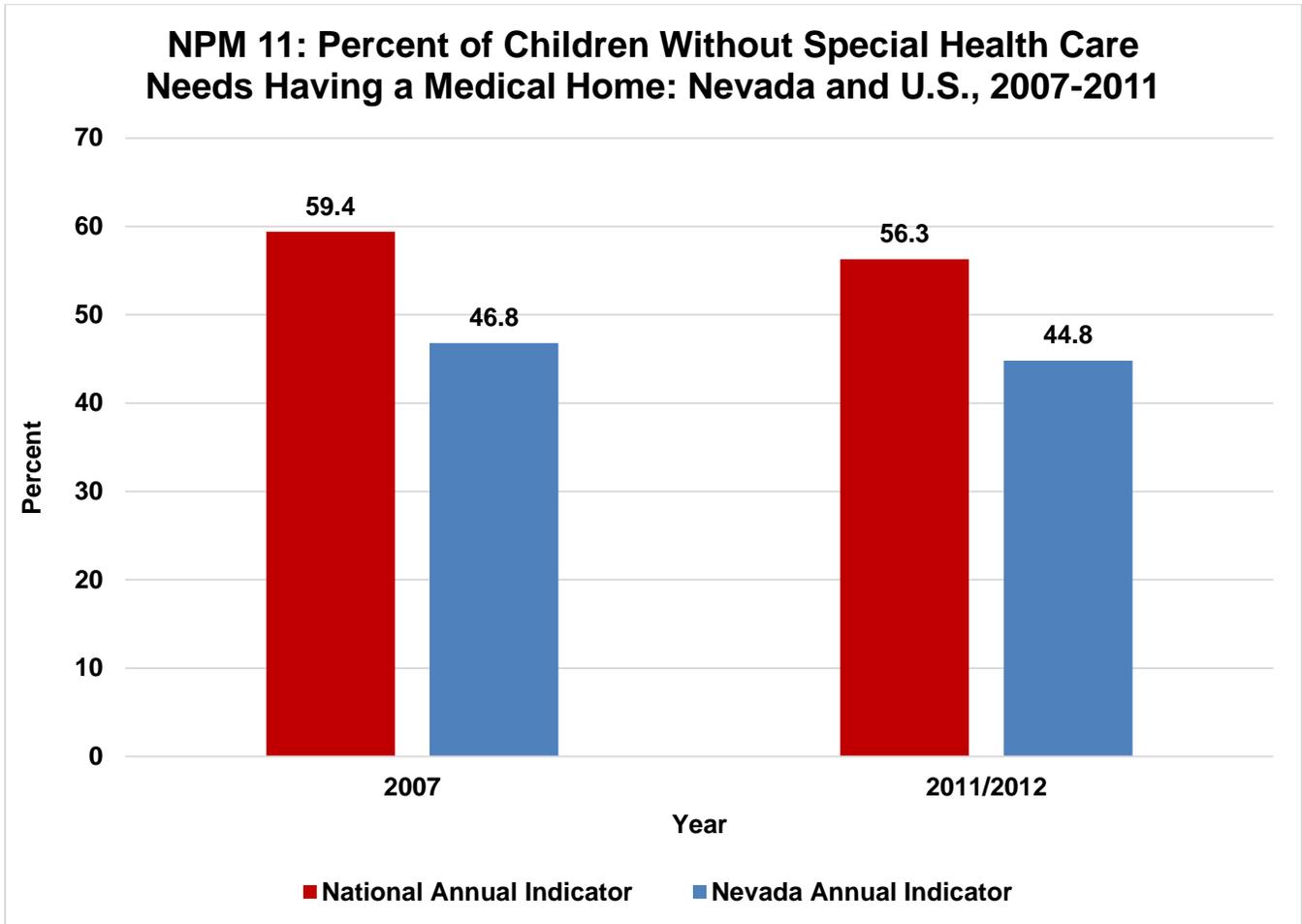


In 2011/2012, Nevada Adolescents living in an MSA, Non-Central City geographical designation were the most likely to have received a preventive medical visit in the last year. However, the 70.72% of adolescents in this geographical designation receiving this type of care are still below the HP 2020 target of 75.6%.

Source: National Survey of Children's Health (NSCH), 2011/2012

Data note (FAD Resource Document):

Starting with 2009 births, the survey switched from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates from 2007 and 2008 may not be comparable to subsequent estimates. Weighted numerators and denominators will be provided in subsequent updates.

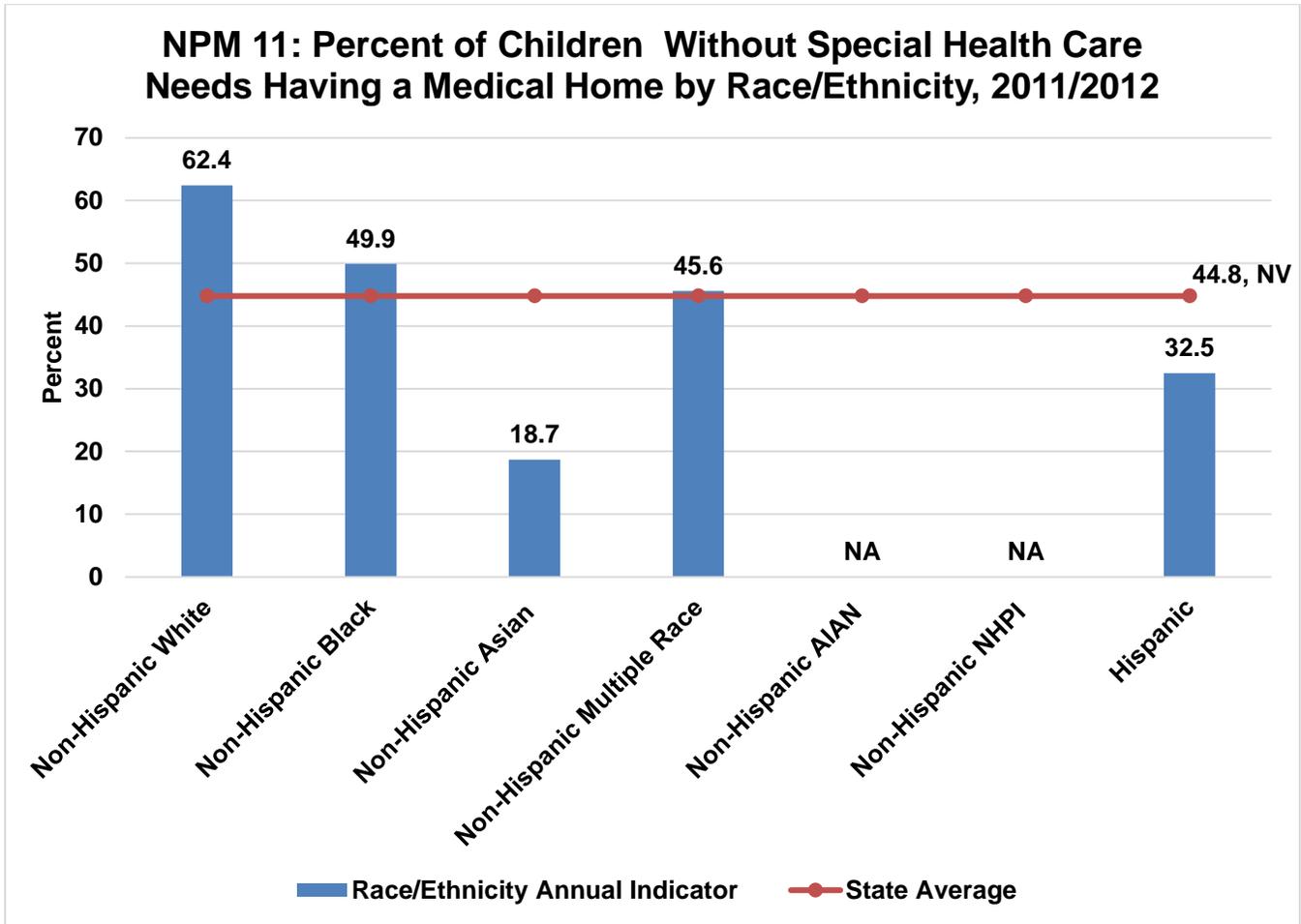


The percent of children without special health care needs who had access to a medical home in Nevada was below the National Annual Indicator in both 2007 and 2011/2012. The HP 2020 target (related to MICH Objective 30.1 to increase the proportion of children who have access to a medical home) is 63.3%. Both the National Annual Indicator (56.3%) and the Nevada Annual Indicator (44.8%) for 2011/2012 are below this target.

Source: National Survey of Children's Health (NSCH) - NONCSHCN, 2007 & 2011/2012

Data note (FAD Resource Document):

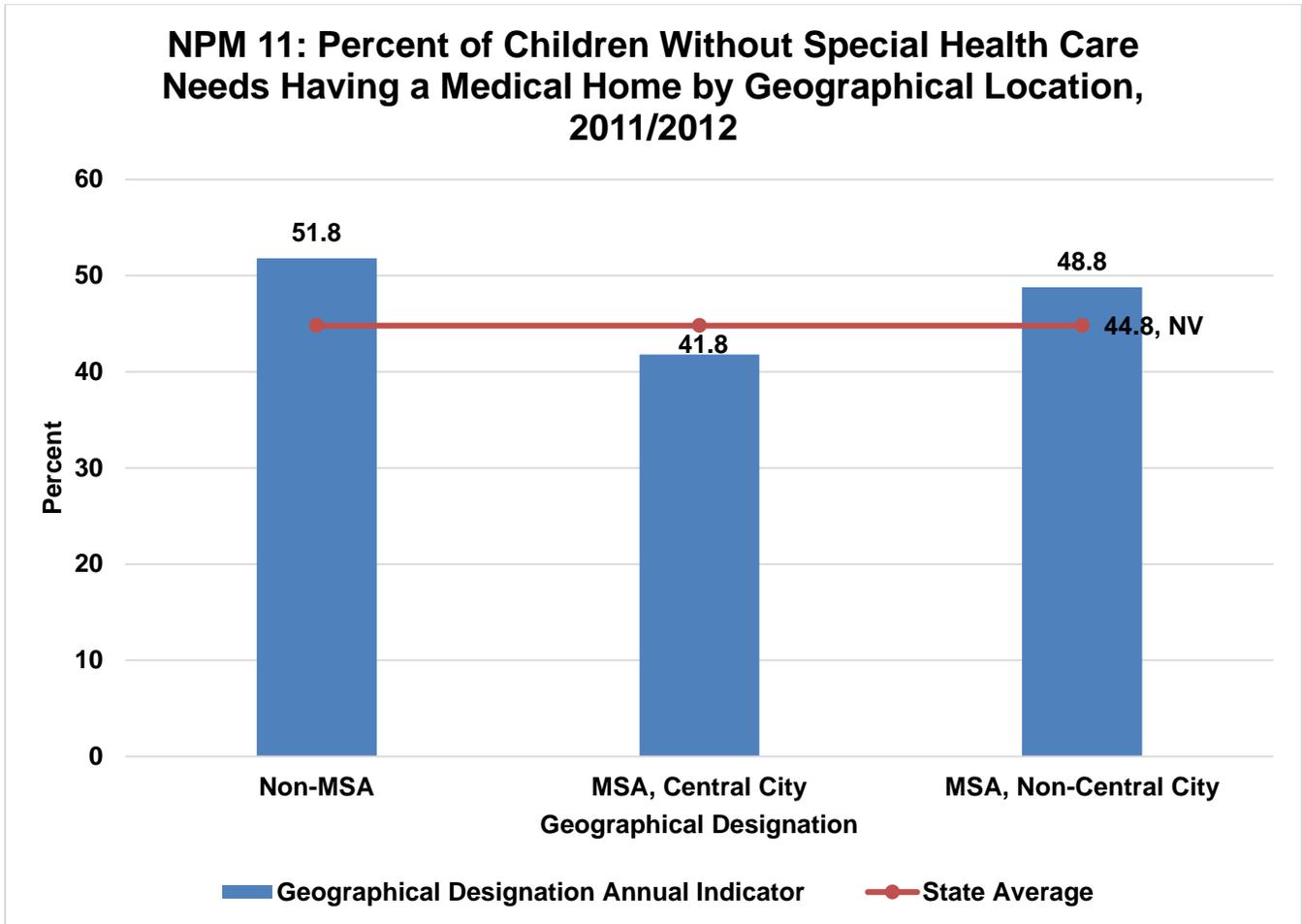
Medical Home items were substantially revised in 2007 and are only comparable at two time points. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time.



Non-Hispanic White, Non-Hispanic White and non-Hispanic Multiple Race populations exceeded the 2011/2012 State Annual Indicator for children without special healthcare needs who have access to a medical home. However, none of these populations met the HP 2020 target of 63.3%.

Source: National Survey of Children's Health (NSCH) - NONCSHCN, 2011/2012

Data note (FAD Resource Document): Medical Home items were substantially revised in 2007 and are only comparable at two time points. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time.

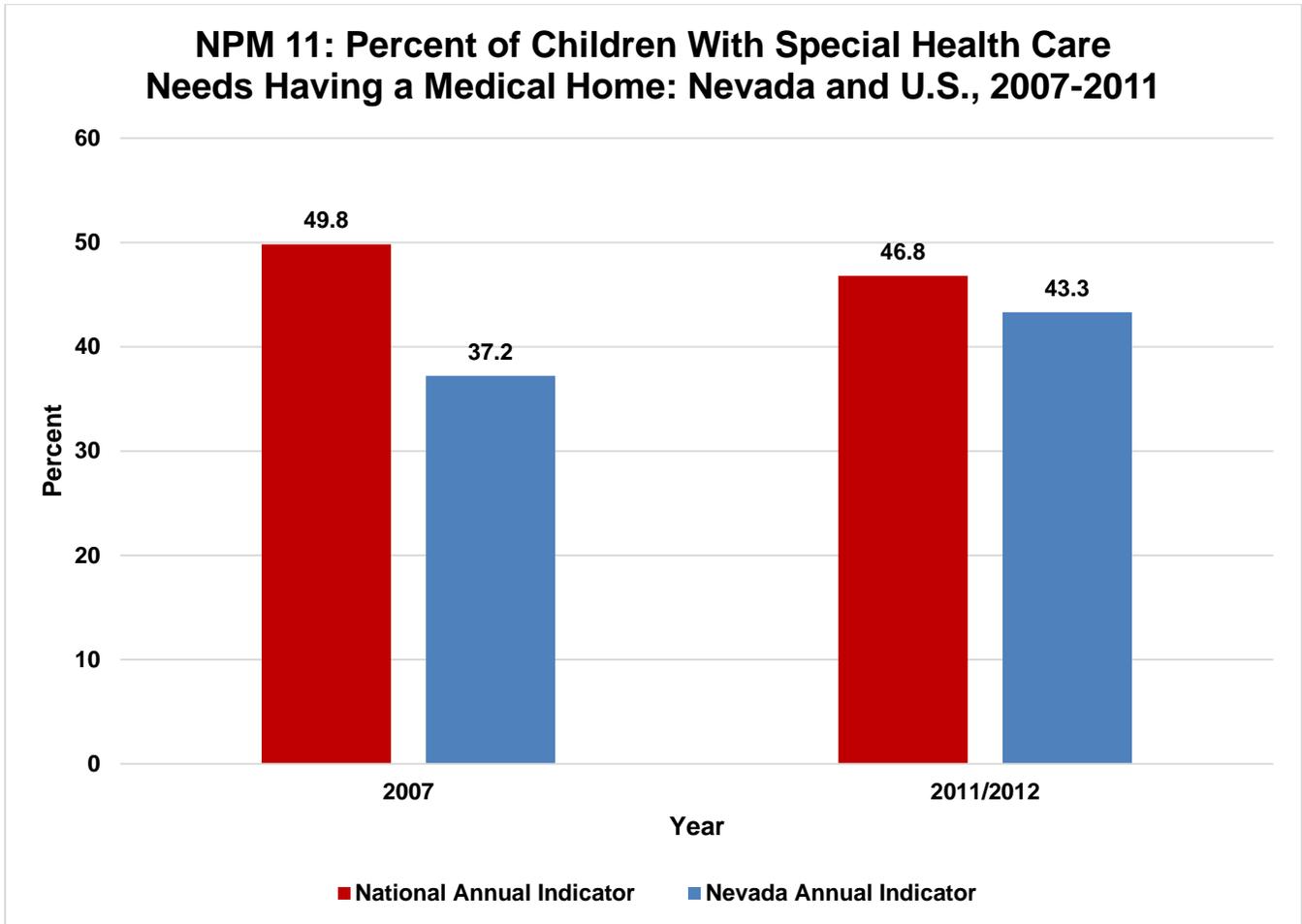


Children without special health care needs in Non-MSA and MSA, Non-Central City geographical designations were more likely to have access to a medical home than children in MSA, Central City. However, none of these groups met the HP 2020 target in 2011/2012.

Source: National Survey of Children's Health (NSCH) - NONCSHCN, 2011/2012

Data note (FAD Resource Document):

Medical Home items were substantially revised in 2007 and are only comparable at two time points. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time.

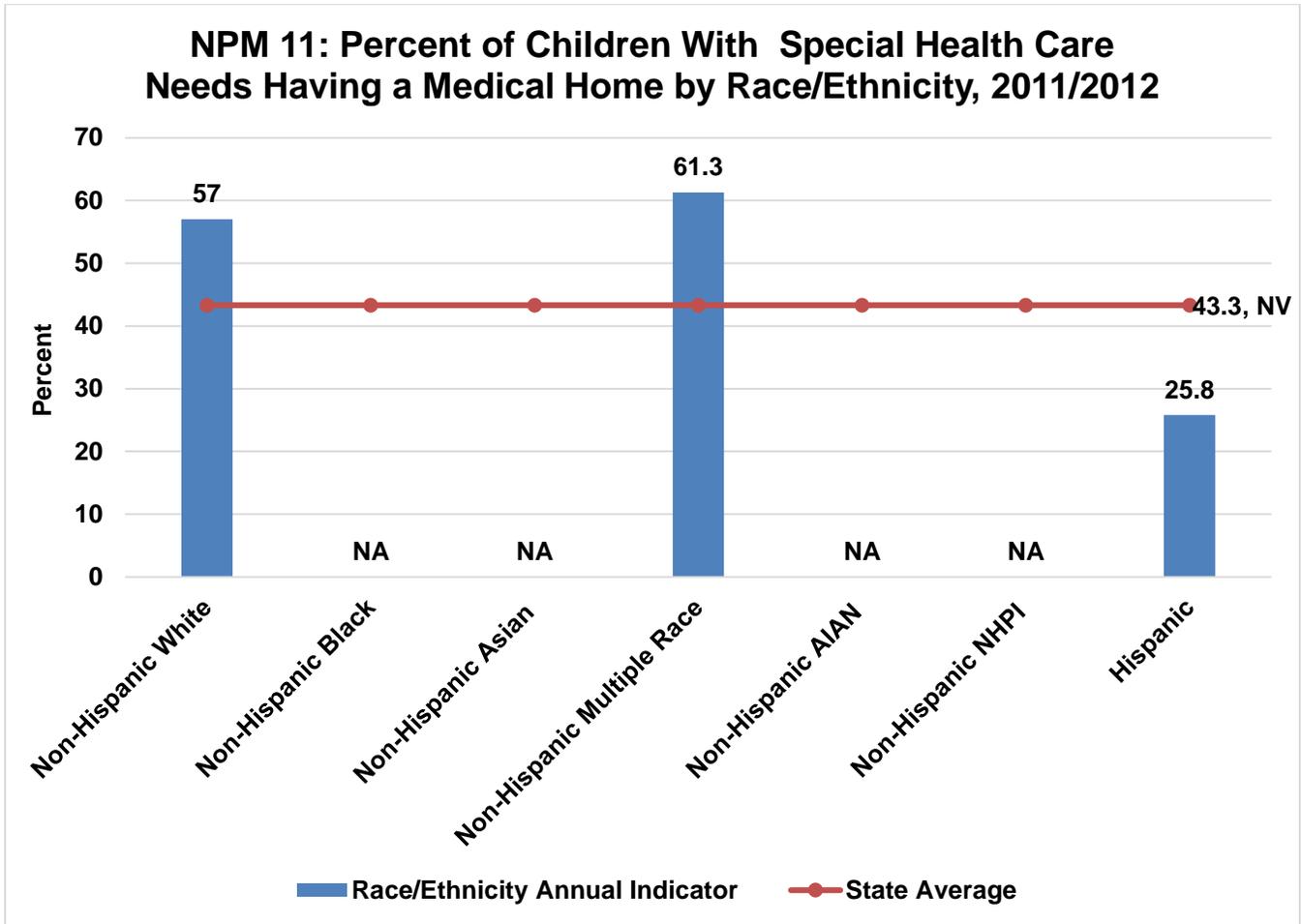


In 2007 and 2011/2012, the percent of children with special health care needs with access to a medical home in Nevada was below that of the nation. The HP 2020 target is 54.8% (related to MICH 30.1), which neither Nevada nor the National Annual Indicator met in 2011/2012.

Source: National Survey of Children's Health (NSCH) – CSHCN, 2007 & 2011/2012

Data note (FAD Resource Document):

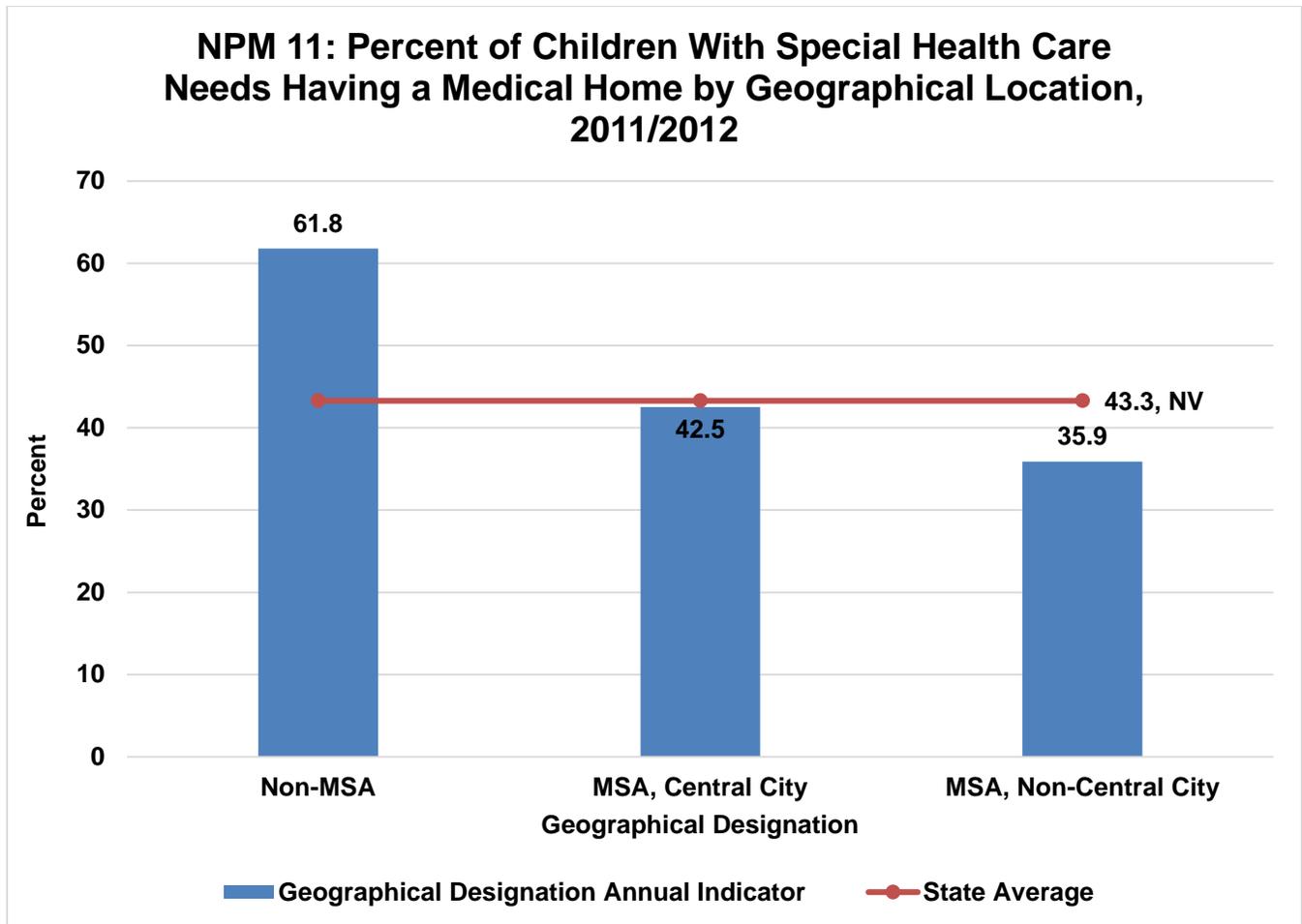
Medical Home items were substantially revised in 2007 and are only comparable at two time points. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time.



In 2011/2012, Non-Hispanic White and Non-Hispanic Multiple Race children with special health care needs were more likely to have a medical home compared to other race/ethnic groups in the state. Both of these populations exceeded the State Annual Indicator (43.3%) and the HP 2020 target of 54.8%.

Source: National Survey of Children's Health (NSCH) – CSHCN, 2011/2012

Data note (FAD Resource Document):
 Medical Home items were substantially revised in 2007 and are only comparable at two time points. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time.

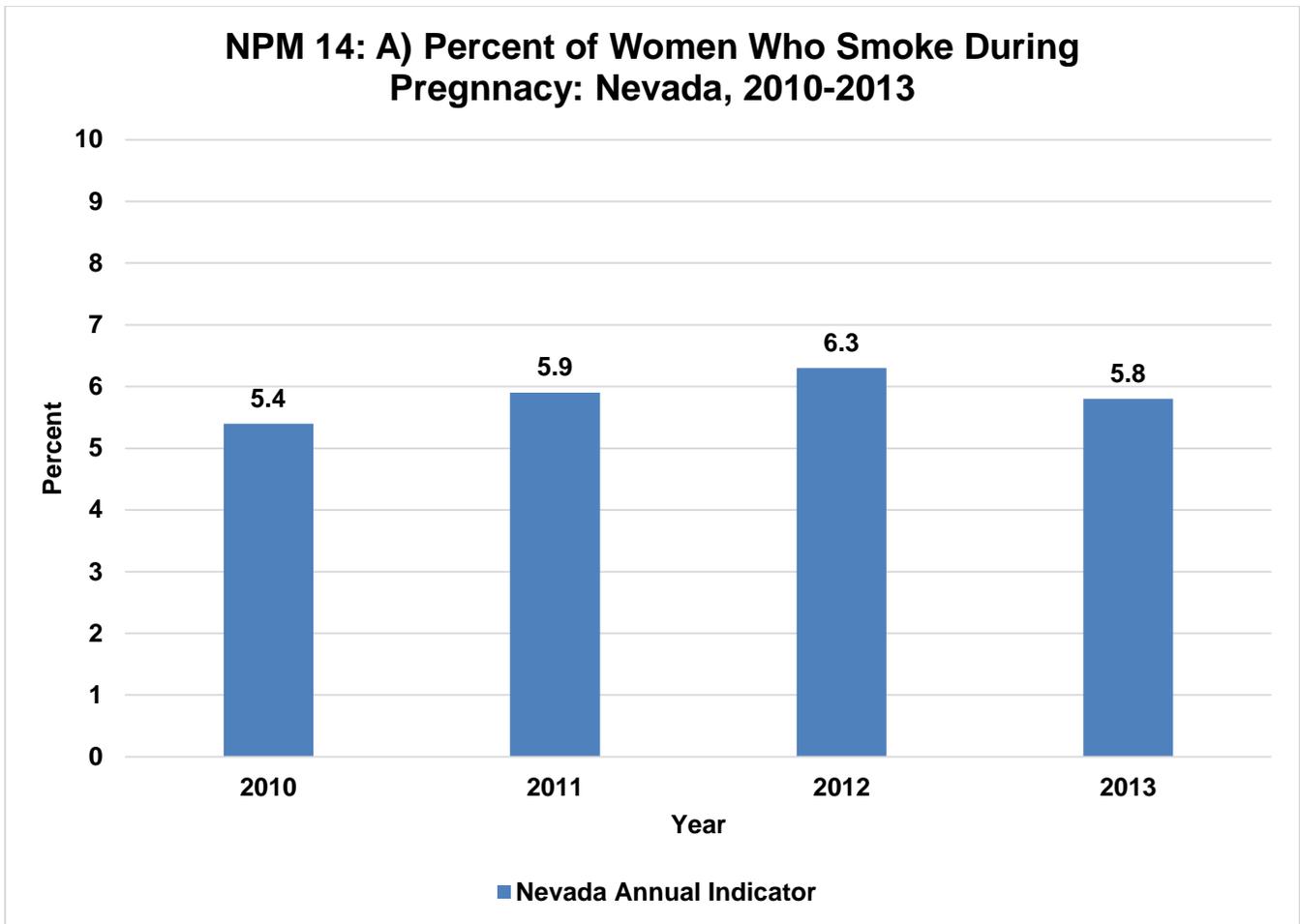


In 2011/2012 children with special health care needs living in a Non-MSA geographical designation in Nevada were more likely to have access to a medical home than children living in other geographical designations. The Non-MSA population was the only one to meet and surpass the HP 2020 target of 54.8%.

Source: National Survey of Children's Health (NSCH) – CSHCN, 2011/2012

Data note (FAD Resource Document):

Medical Home items were substantially revised in 2007 and are only comparable at two time points. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time.

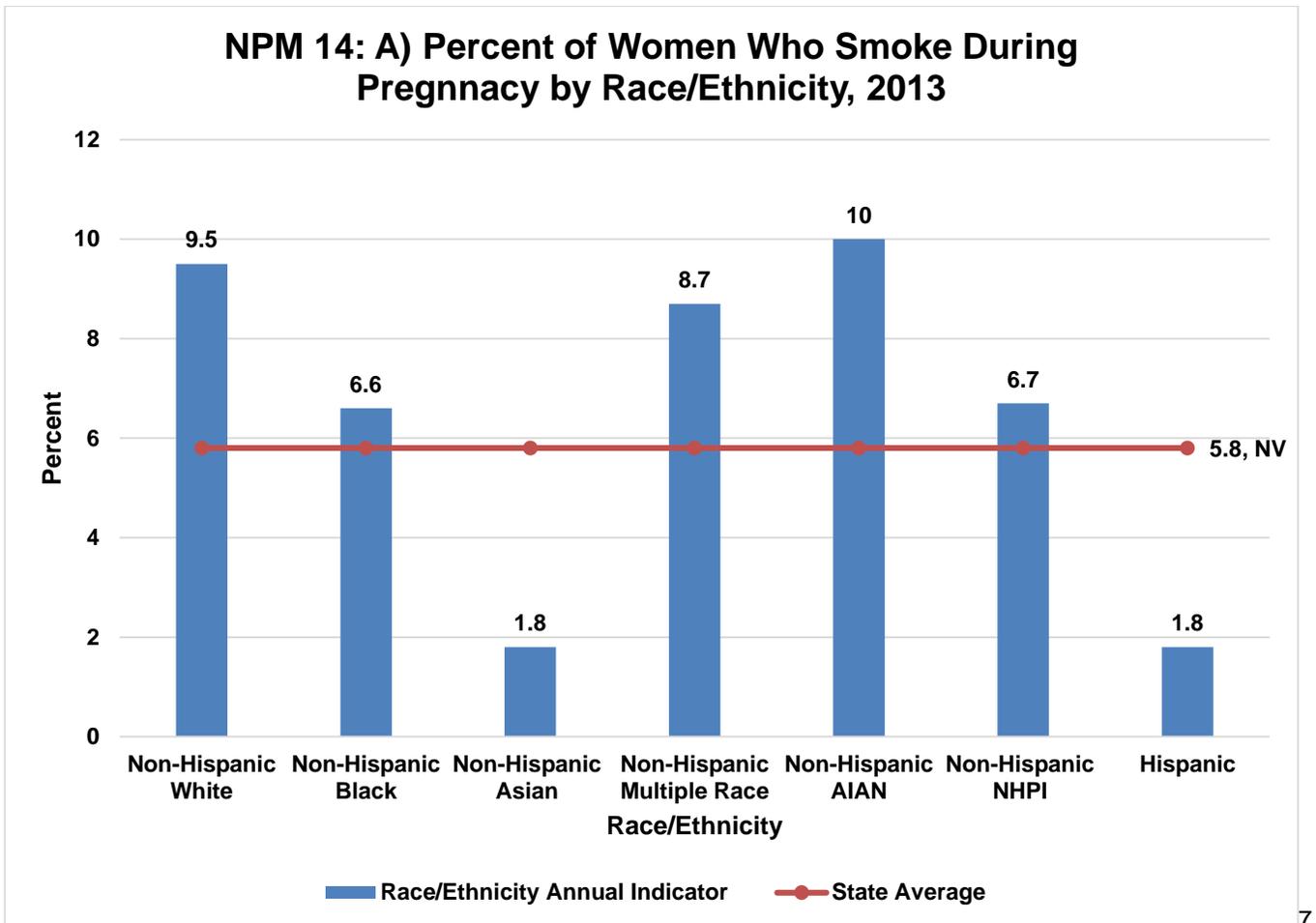


The goal of NPM 14 A is to decrease the number of women who smoke during pregnancy. The HP 2020 target related to this NPM seeks to increase smoking cessation during pregnancy (TU 6), and to reduce children aged 3 to 11 years exposed to secondhand smoke (TU 11.1). Since 2010, the percent of women who smoke during pregnancy gradually increased peaking at 6.3% in 2012 but declined by 8 percent to 5.8% in 2013.

Source: National Vital Statistics System (NVSS), 2010-2013

Data note (FAD Resource Document):

Tobacco use in pregnancy was modified in the 2003 revision of the U.S. Standard Certificate of Live Birth and is only available for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Michigan does not collect tobacco use in a manner consistent with the 2003 revision and is excluded from the national file. Overall U.S. estimates by year are not comparable due to the addition of states over time that have implemented the 2003 revision. Trends within a state after the 2003 revision are comparable.



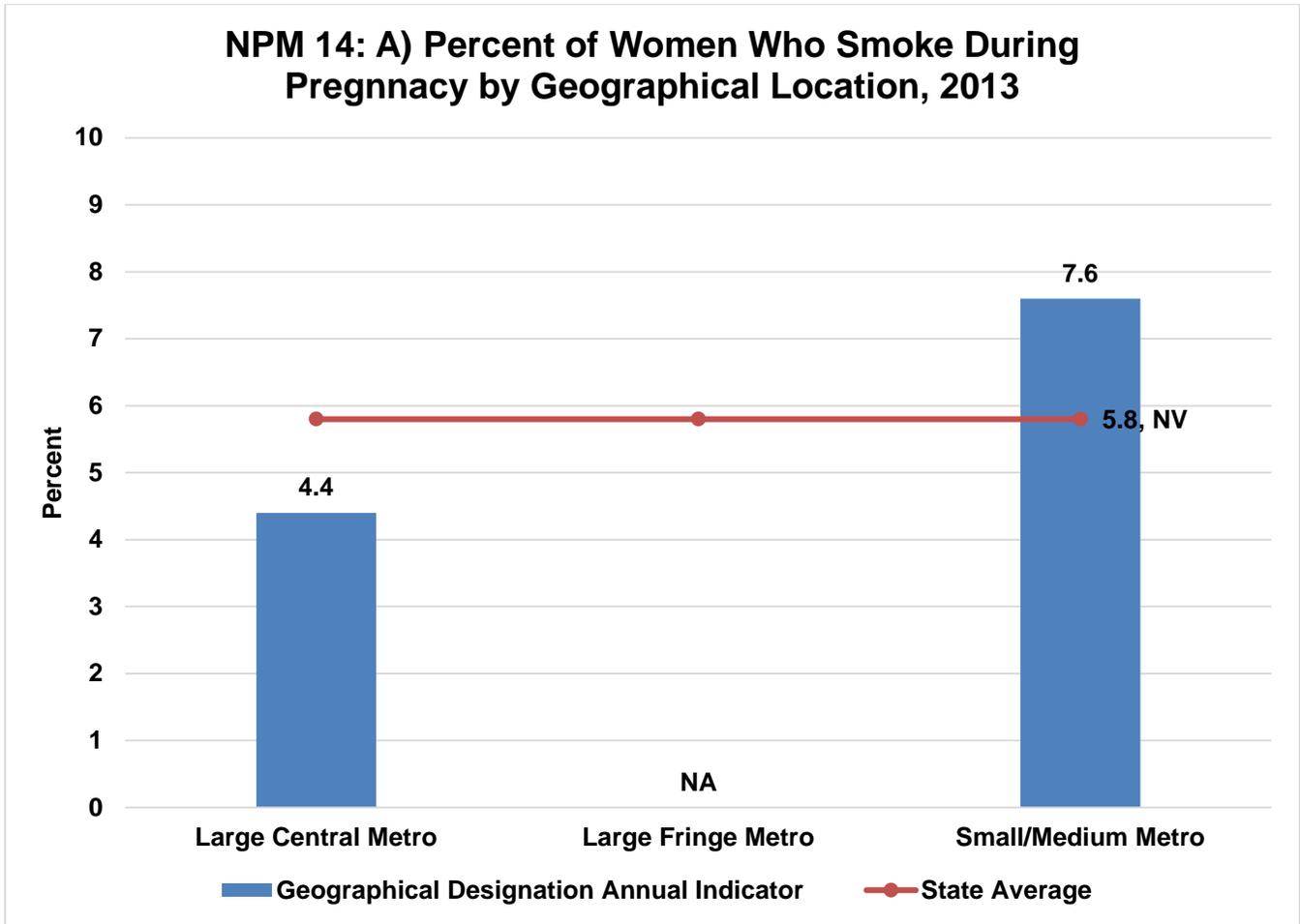
AIAN: American Indian/Alaskan Native ; NHPI: Native Hawaiian/Pacific Islander

In 2013, Hispanic and Non-Hispanic Asian women in Nevada had the lowest rates of smoking during pregnancy. In the same year, non-Hispanic American Indian/Alaska Native and Non-Hispanic White pregnant women had the highest smoking rates in the state.

Source: National Vital Statistics System (NVSS), 2013

Data note (FAD Resource Document):

Tobacco use in pregnancy was modified in the 2003 revision of the U.S. Standard Certificate of Live Birth and is only available for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Michigan does not collect tobacco use in a manner consistent with the 2003 revision and is excluded from the national file. Overall U.S. estimates by year are not comparable due to the addition of states over time that have implemented the 2003 revision. Trends within a state after the 2003 revision are comparable.

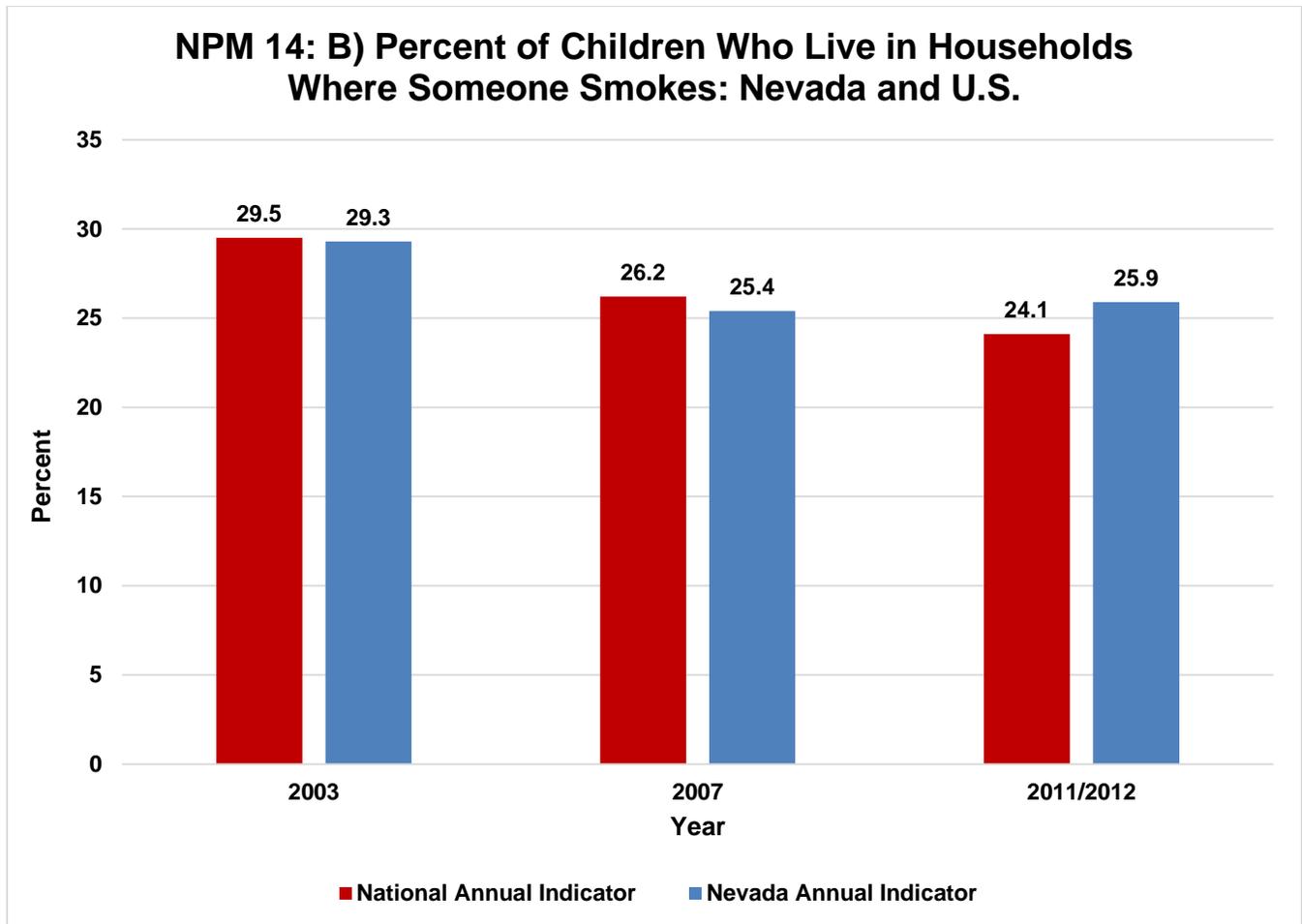


In 2013, women living in the small/medium metro geographical areas were more likely to smoke during pregnancy compared to women living in large central Metro areas of the State.

Source: National Vital Statistics System (NVSS), 2013

Data note (FAD Resource Document):

Tobacco use in pregnancy was modified in the 2003 revision of the U.S. Standard Certificate of Live Birth and is only available for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Michigan does not collect tobacco use in a manner consistent with the 2003 revision and is excluded from the national file. Overall U.S. estimates by year are not comparable due to the addition of states over time that have implemented the 2003 revision. Trends within a state after the 2003 revision are comparable.

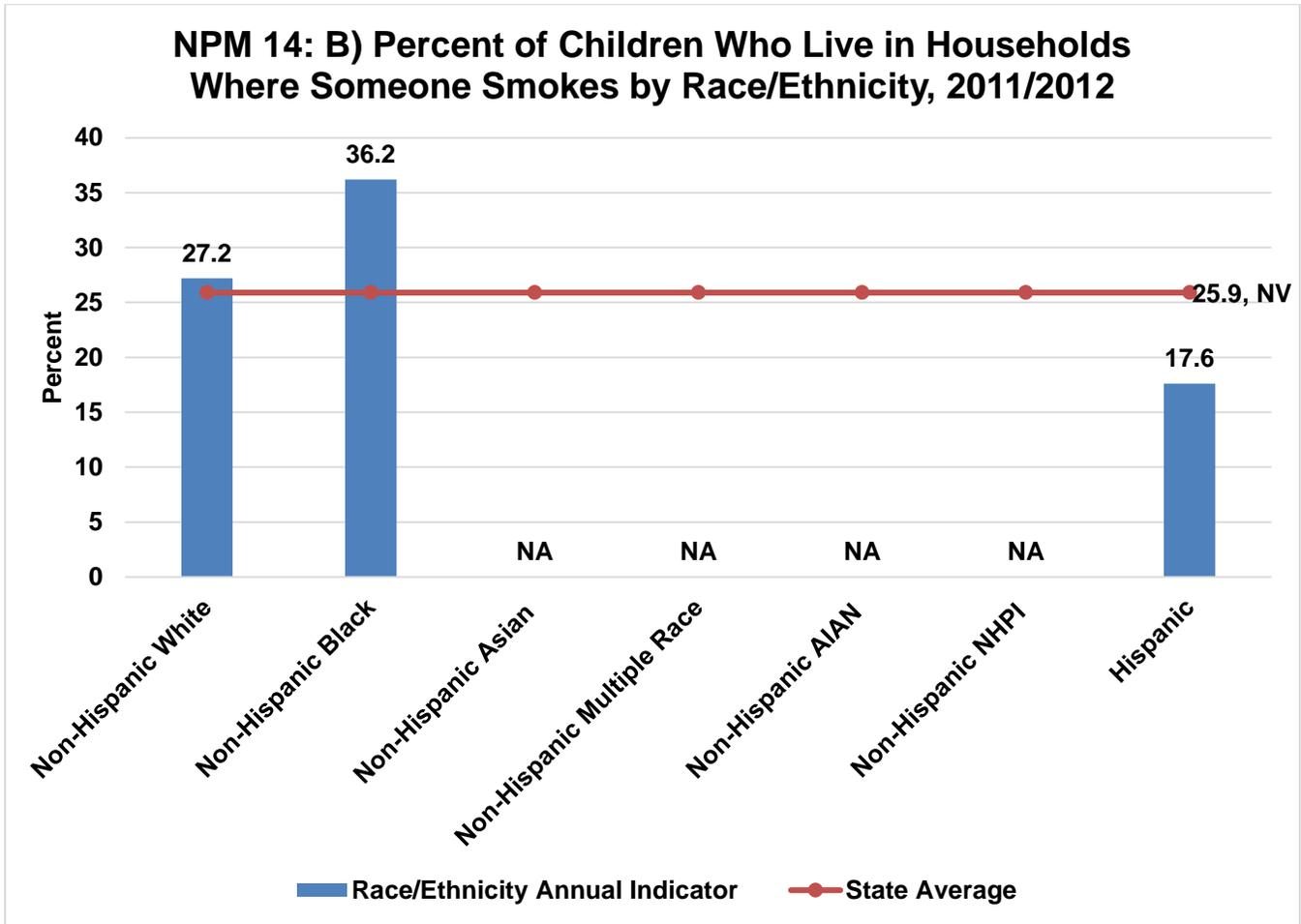


Nationally, there has been a decrease in the number of children who live in households where someone smokes. Nevada saw a decrease from 2003 to 2011/2012, though 2011/2012 is slightly higher than in 2007. The NPM 14 B goal is to decrease the number of households where someone smokes. The HP 2020 targets related to Tobacco Use (TU) Objectives TU 6, TU 11.1, and Respiratory Diseases (RD) Objective 7.5 do not directly correlate with this data.

Source: National Survey of Children's Health (NSCH), 2003, 2007, 2011/2012

Data note (FAD Resource Document):

In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time.

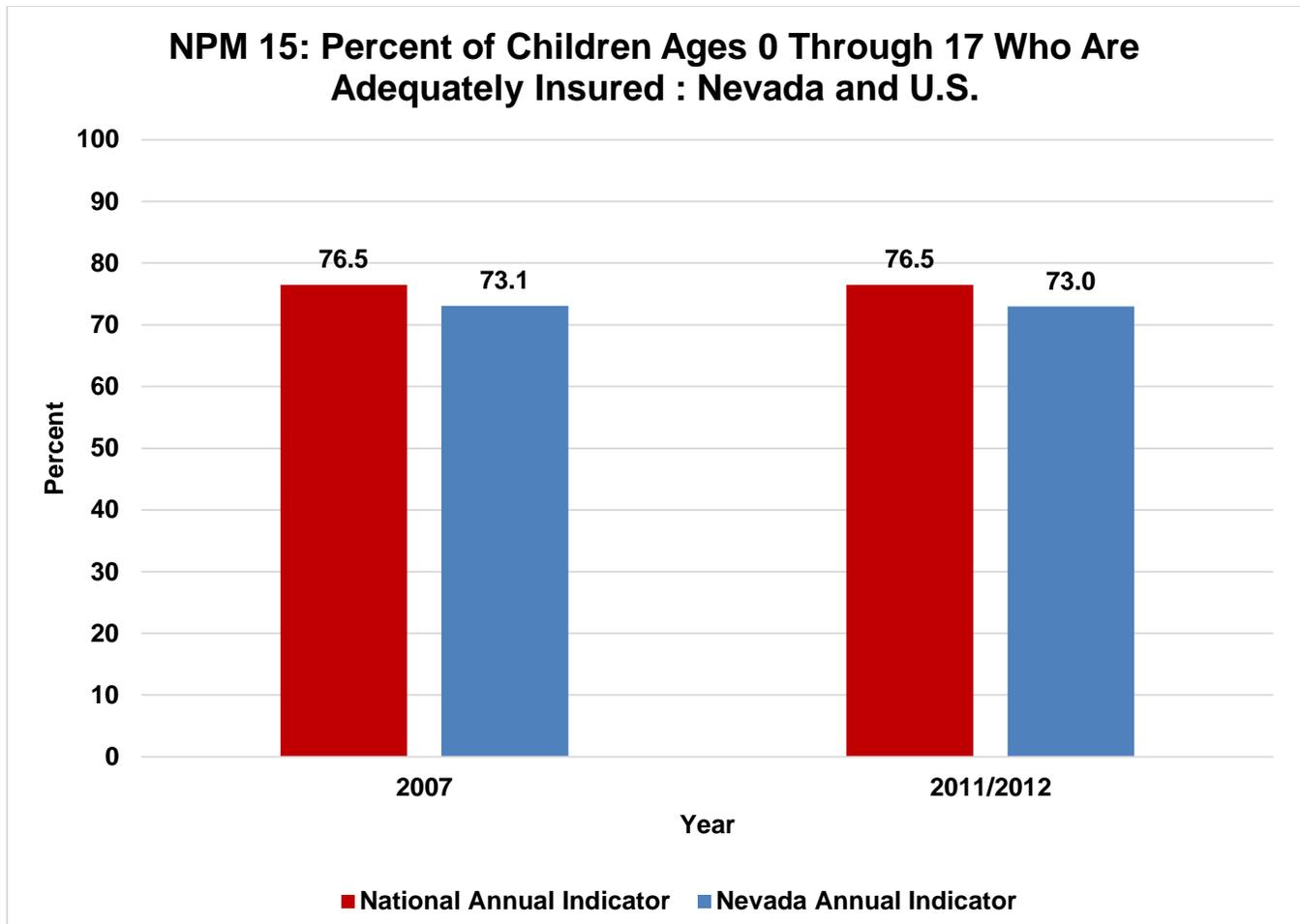


In 2011/2012, Non-Hispanic White and Non-Hispanic Black children were more likely to live in a household where someone smokes in Nevada. Both of these populations had a higher percent than the State Annual Indicator (25.9%) and the National Annual Indicator (24.1%).

Source: National Vital Statistics System (NVSS), 2011/2012

Data note (FAD Resource Document):

In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time.

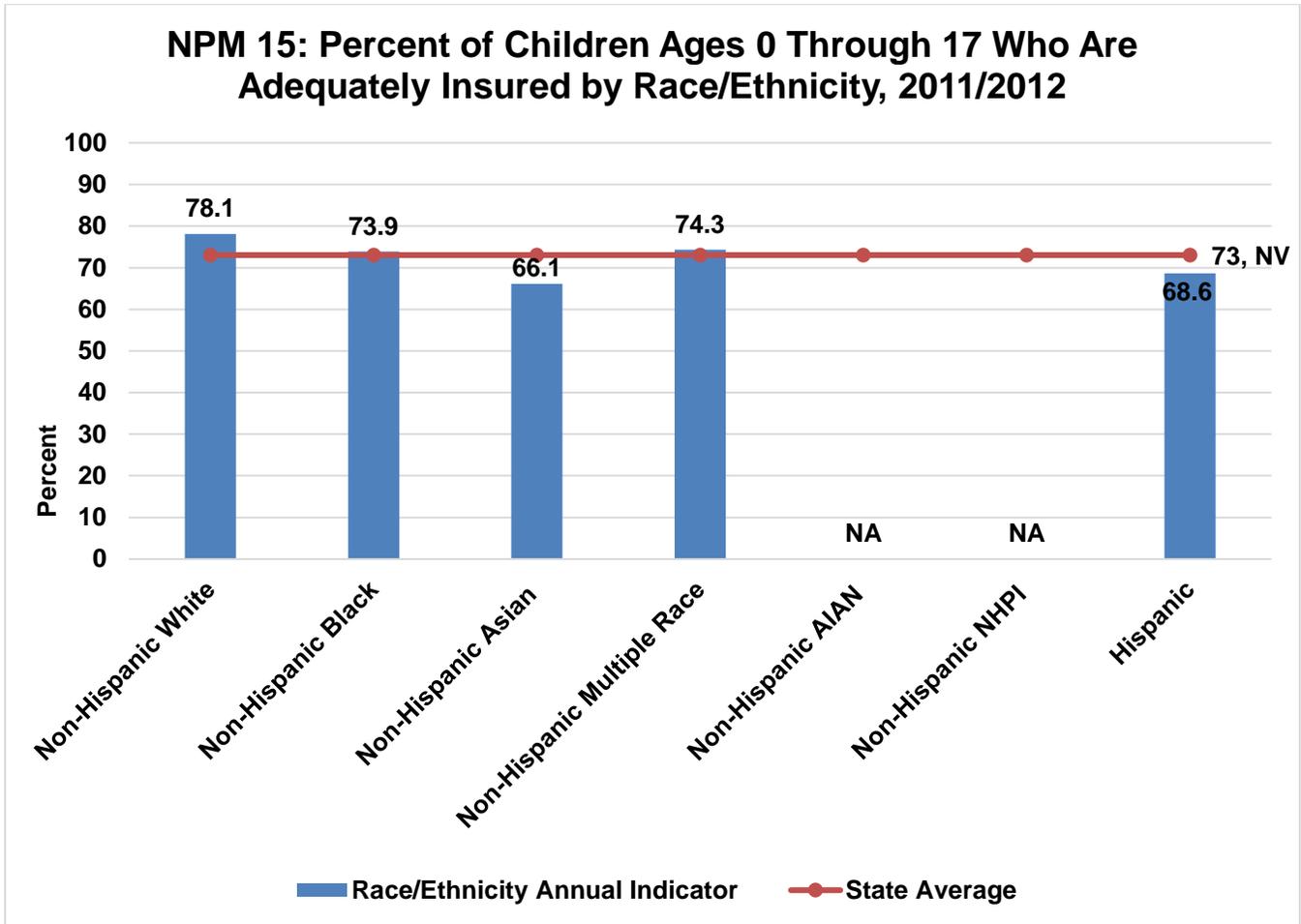


The goal of NPM 15 is to increase the number of children who are adequately insured. The Access to Health Services (AHS) Objective 1 (increase proportion of persons with health insurance) and AHS Objective 6 (reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines) are related to the HP 2020 but have not been assigned a target. In 2007 and 2011/2012 the percent of Nevada children who were adequately insured was less than that of the Nation.

Source: National Survey of Children's Health, 2007 & 2011/2012

Data note (FAD Resource Document):

Survey items on insurance adequacy were added in 2007 and are only available at two time points. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time. The numerators and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children by state. Standard errors account for the complex survey design. Certain categories of race/ethnicity (American Indian/Alaska Native, Asian, and Native Hawaiian/Other Pacific Islanders), parental educational attainment (Some College, College), and urban/rural residence were obtained from restricted access files at the National Center for Health Statistics' Research Data Center and were suppressed to protect confidentiality if the unweighted numerator was less than 5.

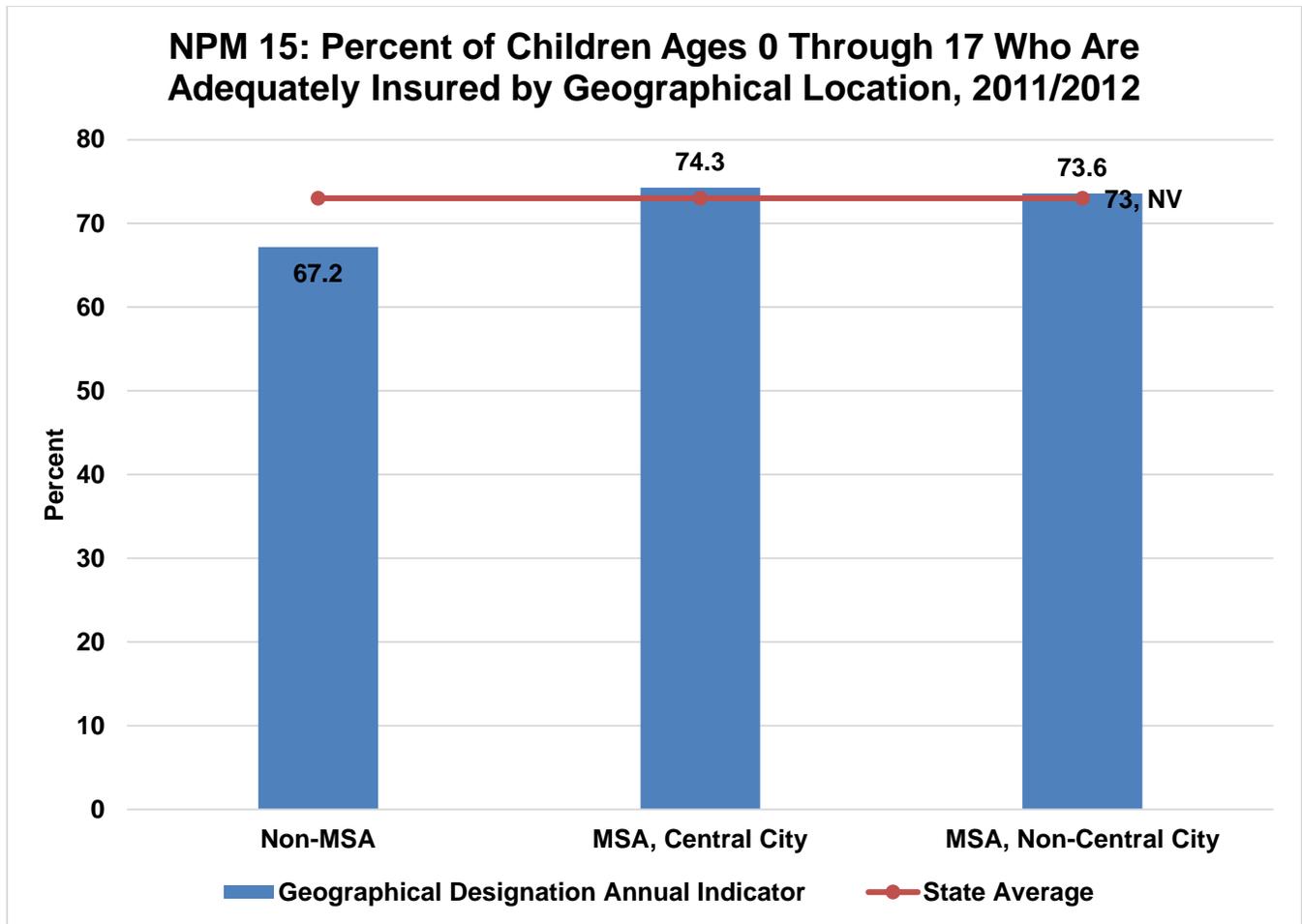


In 2011/2012, Non-Hispanic White, Non-Hispanic Black and Non-Hispanic multiple race children met and exceeded Nevada’s Annual Indicator of 73% for children with adequate health insurance.

Source: National Survey of Children’s Health, 2011/2012

Data note (FAD Resource Document):

Survey items on insurance adequacy were added in 2007 and are only available at two time points. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time. The numerators and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children by state. Standard errors account for the complex survey design. Certain categories of race/ethnicity (American Indian/Alaska Native, Asian, and Native Hawaiian/Other Pacific Islanders), parental educational attainment (Some College, College), and urban/rural residence were obtained from restricted access files at the National Center for Health Statistics’ Research Data Center and were suppressed to protect confidentiality if the unweighted numerator was less than 5.



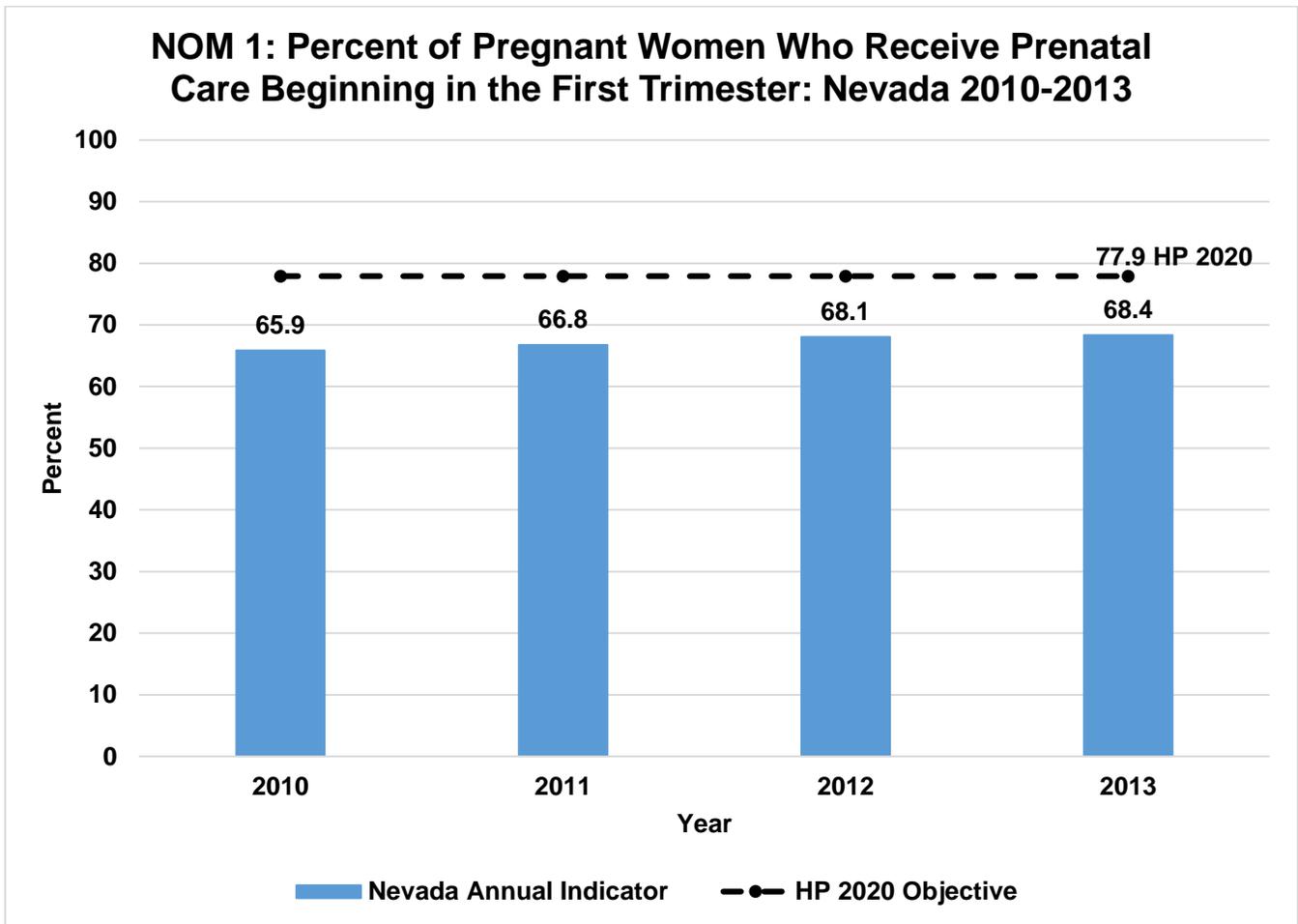
In 2011/2012 children in Nevada living in Non-MSA geographical designation were the least likely to have adequate health insurance compared to children living in MSA, central city and MSA, non-central city.

Source: National Survey of Children's Health, 2011/2012

Data note (FAD Resource Document):

Survey items on insurance adequacy were added in 2007 and are only available at two time points. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time. The numerators and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children by state. Standard errors account for the complex survey design. Certain categories of race/ethnicity (American Indian/Alaska Native, Asian, and Native Hawaiian/Other Pacific Islanders), parental educational attainment (Some College, College), and urban/rural residence were obtained from restricted access files at the National Center for Health Statistics' Research Data Center and were suppressed to protect confidentiality if the unweighted numerator was less than 5.

Nevada Maternal and Child Health Block Grant FY 2016 Application /FY 2014 Report National Outcome Measures

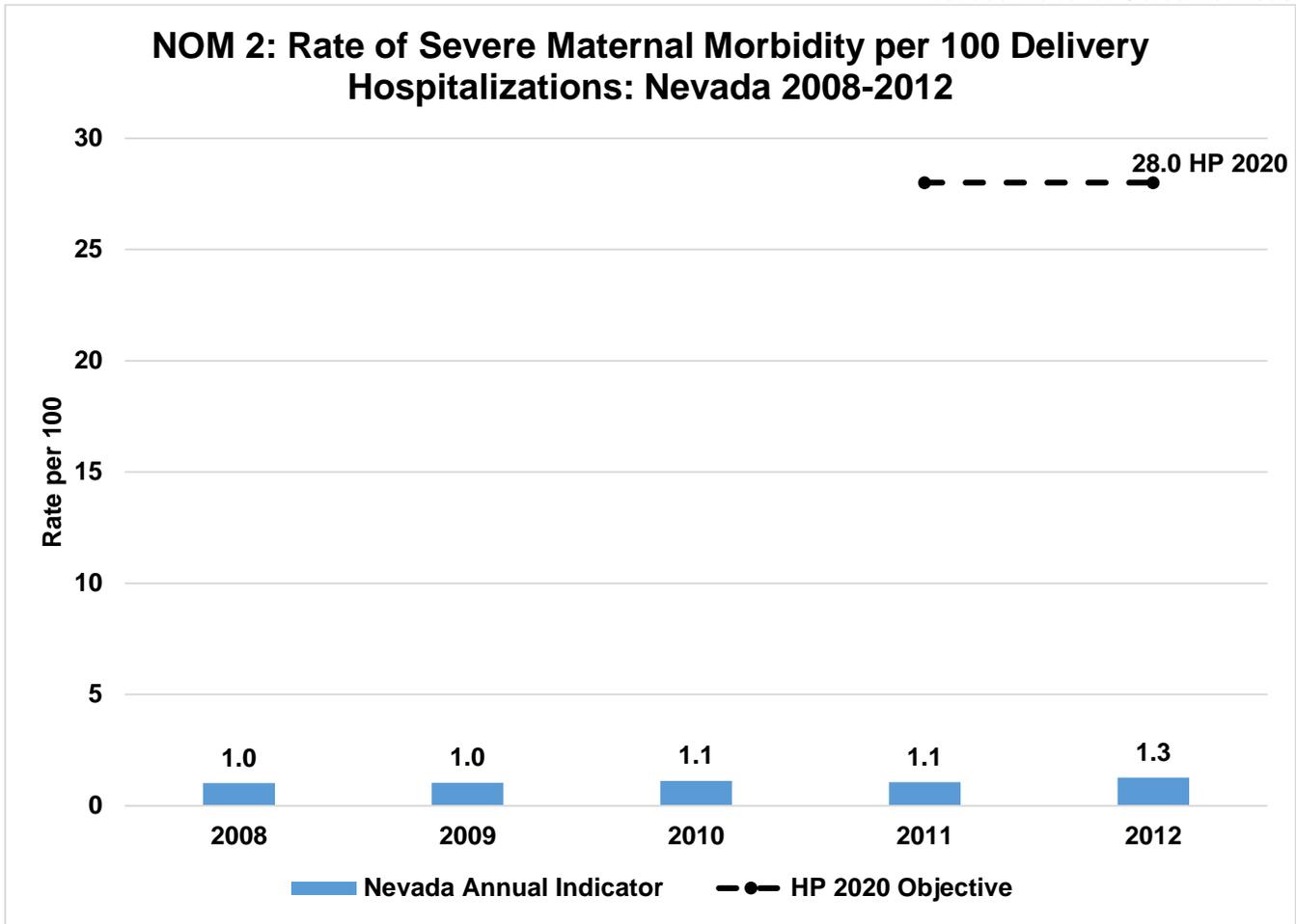


NOM 1: Nevada did not meet HP 2020 Objective (MICH 10.1) of 77.9% for National Outcome Measure #01. Since 2010, the percent of women receiving prenatal care beginning in the first trimester has gradually improved and increased from 65.9% in 2010 to 68.4% in 2013.

Source: NVSS, 2010-2013.

Data notes (FAD Resource Document)

Prenatal care utilization was modified in the 2003 revision of the U.S. Standard Certificate of Live Birth and is only available for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Overall U.S. estimates by year are not comparable due to the addition of states over time that have implemented the 2003 revision. Trends within a state after the 2003 revision are comparable. County metro status is not available for territories.

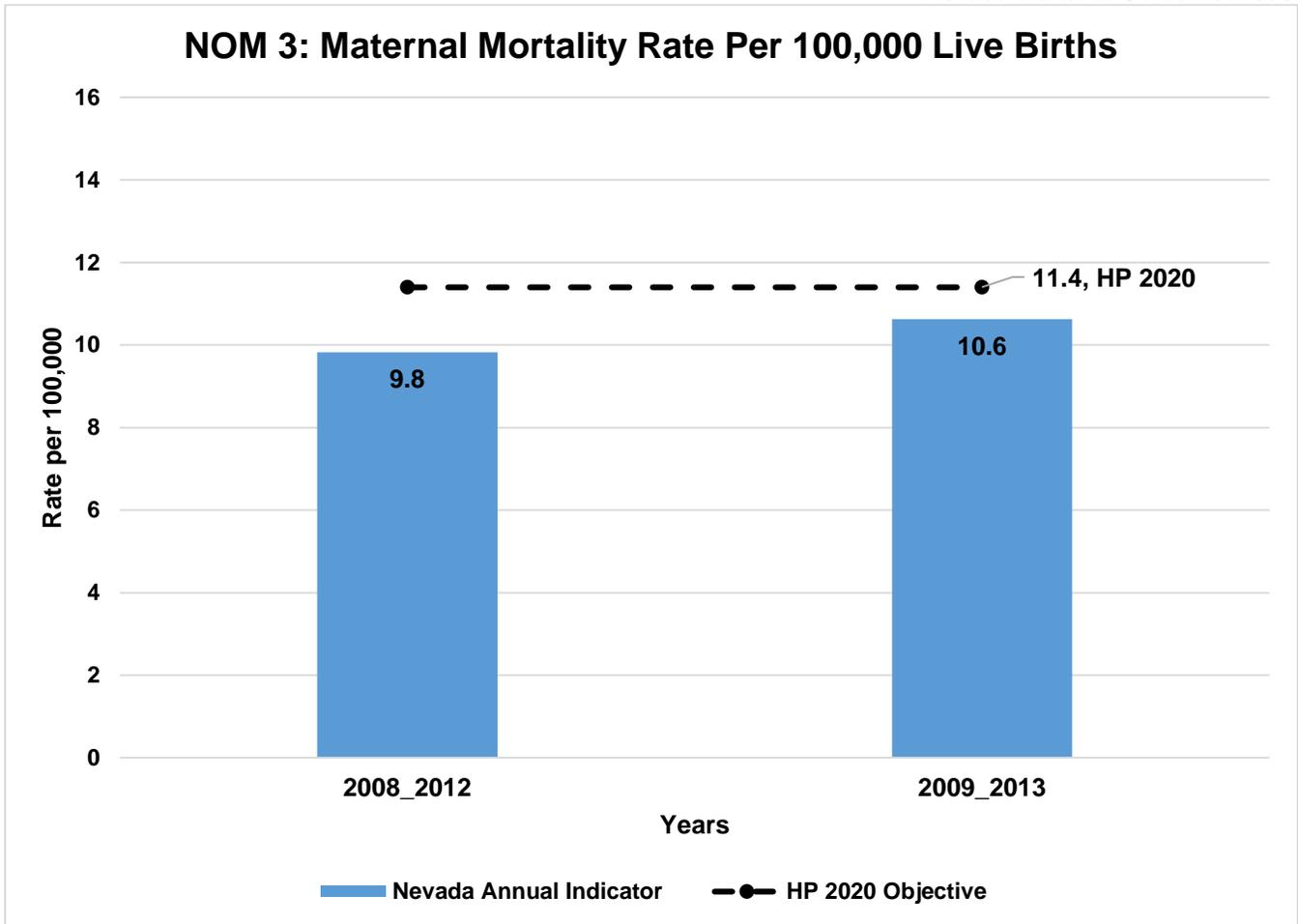


NOM 2: Since 2008, the rate of severe maternal morbidity per 100,000 delivery hospitalizations in Nevada has remained well below the 2020 Objective (MICH 6) of 28%. The HP 2010 target was 24 per 100.

Source: State Inpatient Database (SID)

Data Notes:

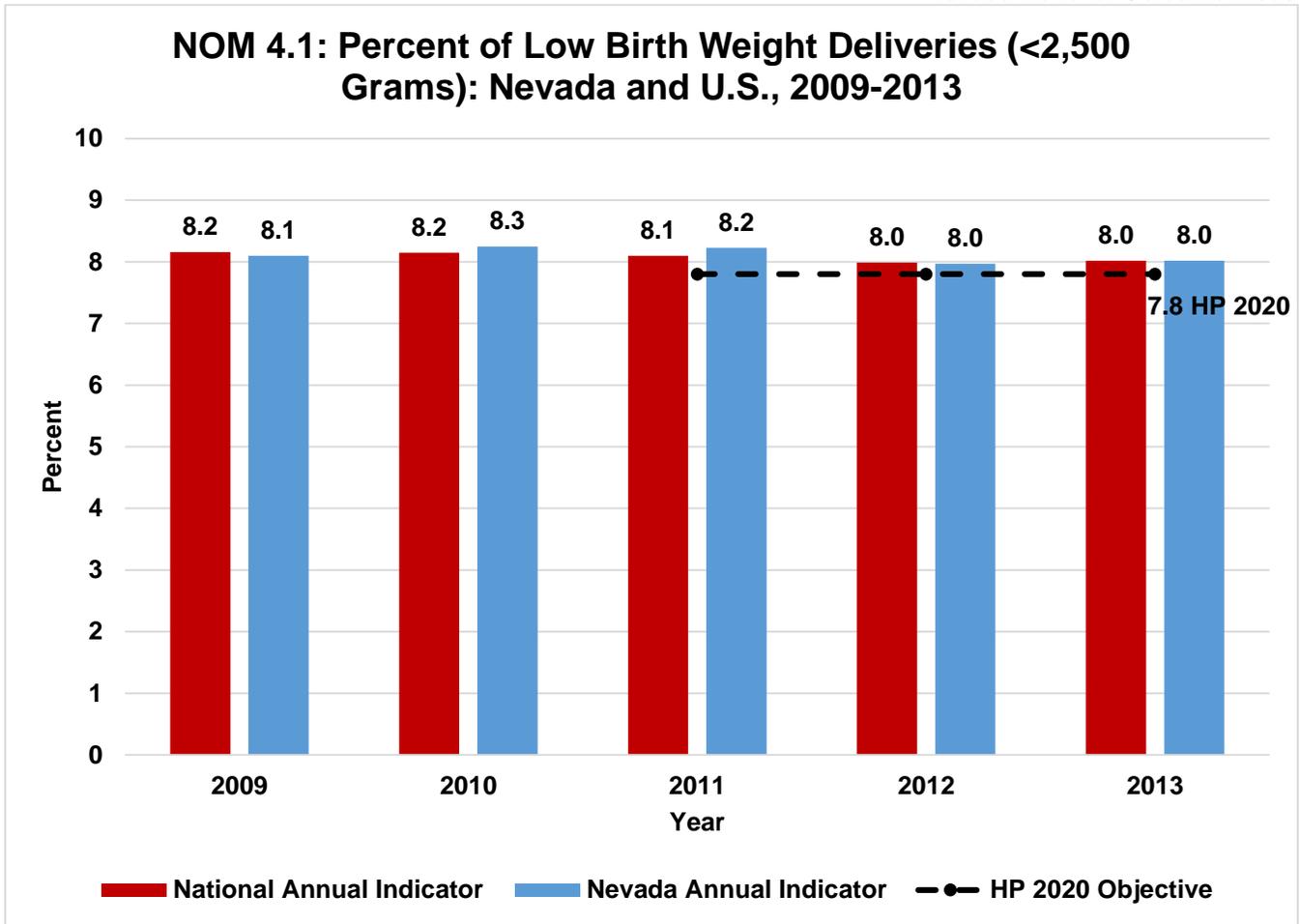
This measure follows the CDC-developed definition of severe maternal morbidity identified from hospital discharge procedure and diagnosis codes that indicate a potentially life-threatening condition or maternal complication (Callaghan et al, 2012). Specific ICD-9-CM diagnosis and procedure codes are available at <http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/SevereMaternalMorbidity.html>. In 2009, the code for acute renal failure changed from 584.8 to 277.88. In 2010, a new code was added for major puerperal sepsis (670.2). With the exception of hospitalizations with in-hospital mortality, transfer, or severe complications identified by procedure codes (e.g., hysterectomy, blood transfusion, ventilation), cases of severe maternal morbidity identified by diagnostic codes were reclassified as hospitalizations without severe maternal morbidity if they had an implausibly short length of stay (<90th percentile calculated separately for vaginal, primary, and repeat cesarean deliveries). Delivery hospitalizations were identified by diagnosis codes for an outcome of delivery, diagnosis-related group delivery codes, and procedure codes for selected delivery-related procedures (Kuklina et al, 2008). Estimates refer to state residents and out-of-state hospitalizations to state residents were included where possible (if hospitalization state provided data to AHRQ). Federal, rehabilitation, and psychiatric hospitals were excluded from calculations. For more information about the State Inpatient Databases (SID), please visit <http://www.hcup-us.ahrq.gov/sidoverview.jsp> Callaghan WM, Creanga AA, Kuklina EV. Severe maternal morbidity among delivery and postpartum hospitalizations in the United States. *Obstet Gynecol.* 2012 Nov;120(5):1029-36. Kuklina EV, Whiteman MK, Hillis SD, Jamieson DJ, Meikle SF, Posner SF, et al. An enhanced method for identifying obstetric deliveries: implications for estimating maternal morbidity. *Matern Child Health J* 2008;12:469-77.



NOM 3: During 2008-2012 and 2009-2013, Nevada’s maternal mortality rate has remained below the HP 2020 Objective (MICH 5) target of 11.4 maternal deaths per 100,000 live births. The HP 2010 target was 3.3 maternal deaths per 100,000 live births. Years were combined in order to make the data reliable.

Source: NVSS, 2008-2013.
 * Numbers should be interpreted with caution, indicator <20.

Data notes (FAD Resource Document):
 Ascertainment of maternal deaths was modified by a pregnancy checkbox in the 2003 revision of the U.S. Standard Certificate of Death and is only reported for the 31 states and DC that had implemented the 2003 revision or, in the case of MD, had a comparable checkbox item as of January 1, 2009 for reporting of five-year maternal mortality rates (2009-2013). Five-year estimates are necessary for many states due to the small number of maternal deaths. Overall U.S. estimates by year are not comparable due to the addition of states over time that have implemented the 2003 revision. Trends within a state after the 2003 revision are comparable; however, changes are mitigated with five-year data where each estimate shares 80% (4/5) of the data with the next estimate. Standard statistical tests that assume independence should not be used when comparing overlapping 5-year estimates; significance will be exaggerated without accounting for dependence.

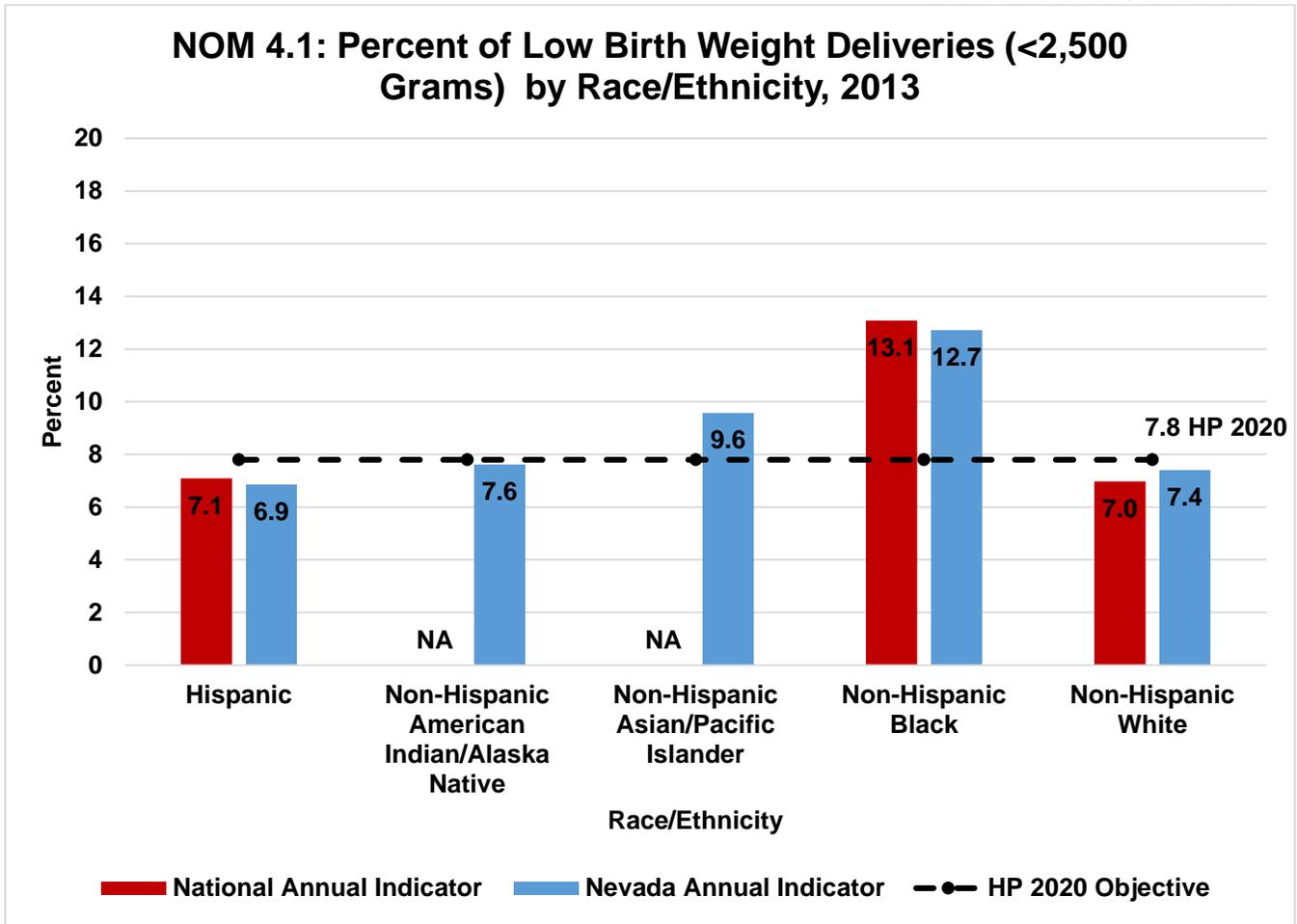


NOM 4.1: Over the years 2009-2013, Nevada’s percent of low birth weight deliveries remained close to the national annual indicator. However, this National Outcome Measure remained above the HP 2020 Objective (MICH 8.1) of 7.8%. The HP 2010 target was 5%. The next figure shows the 2013 data by race/ethnicity.

Source: NVSS

Data notes (FAD Resource Document):

Follows NCHS birth weight edits to replace as unknown if outside of 227-8165 grams or grossly incompatible with both the obstetric estimate and LMP-based estimate of gestational age. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Urban/rural residence is not available for territories.

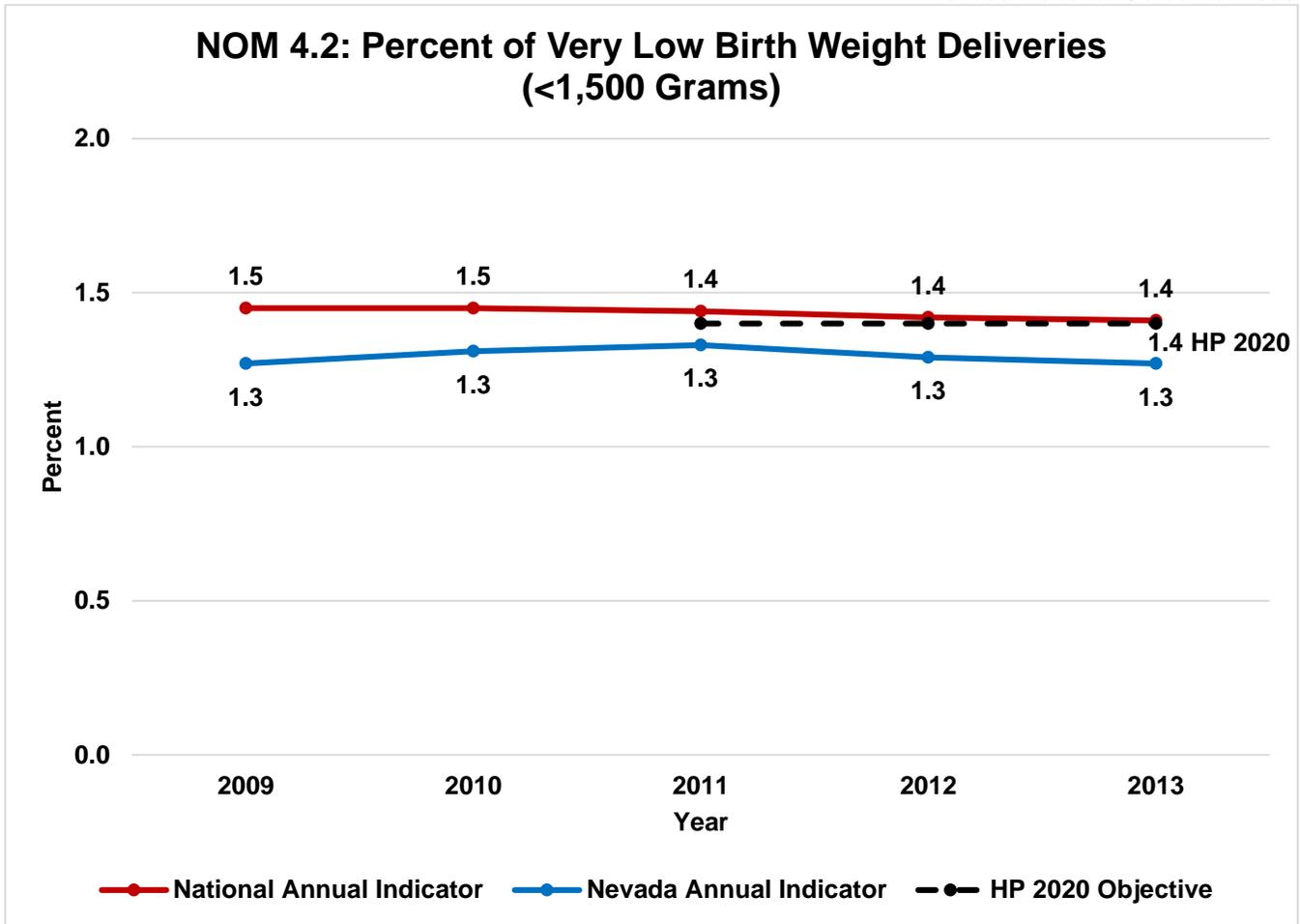


NOM 4.1: In 2013, Non-Hispanic Black (12.7%) and Non-Hispanic Asian/Pacific Islander (9.6%) infants were the only race/ethnic group in Nevada above the HP 2020 Objective (MICH 8.1) of 7.8%.

Source: NVSS

Data notes (FAD Resource Document):

Follows NCHS birth weight edits to replace as unknown if outside of 227-8165 grams or grossly incompatible with both the obstetric estimate and LMP-based estimate of gestational age. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Urban/rural residence is not available for territories.

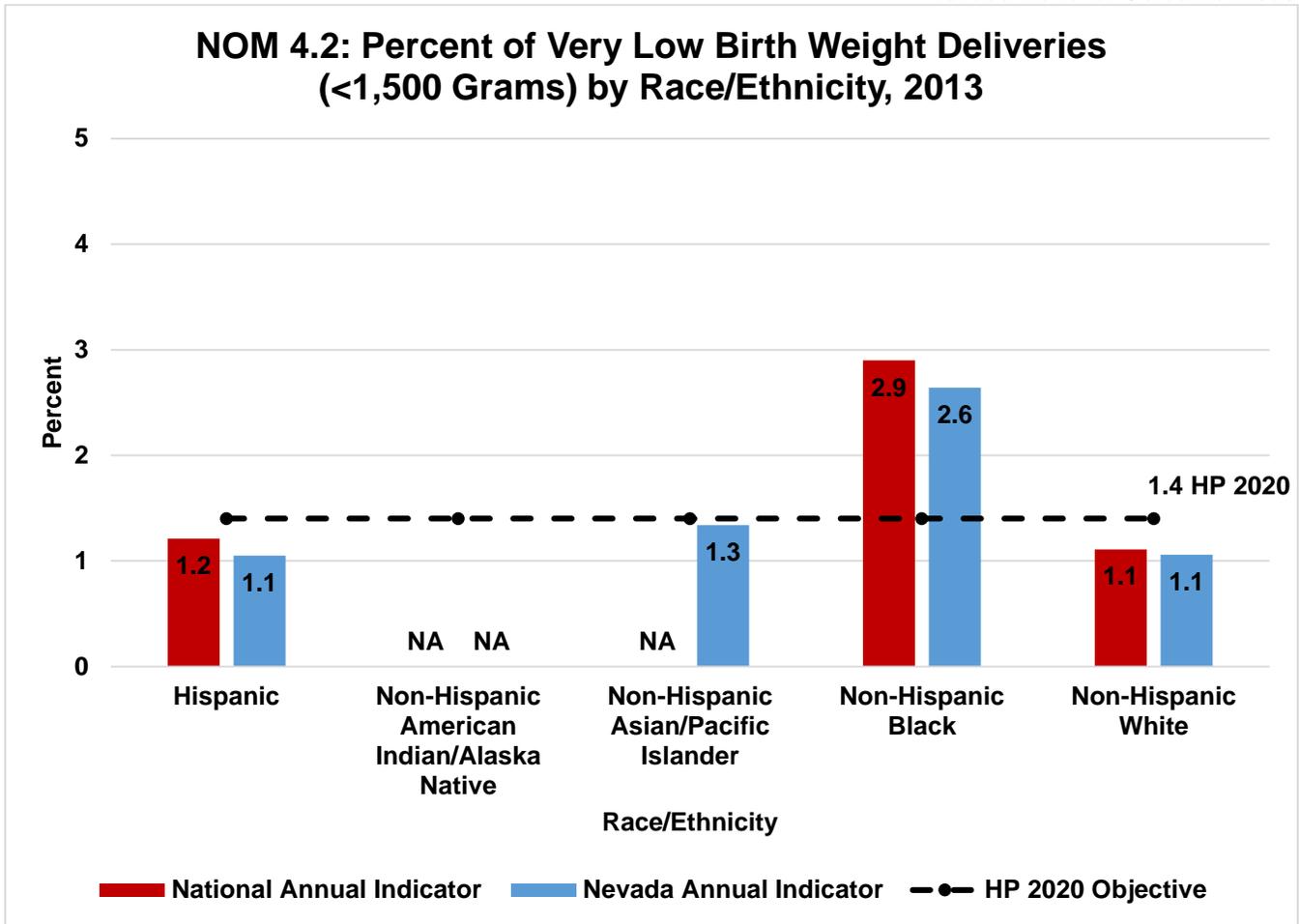


NOM 4.2: Since 2009, the percent of very low birth weight deliveries (<1,500 Grams) in Nevada has remained below the National Annual Indicator as well as the HP 2020 Objective (MICH 8.2) of 1.4%. The next figure describes NOM 4.2 across race/ethnicity. The HP 2010 target was 0.9%.

Source: NVSS Final Birth Data:2009-2013

Data Notes (FAD Resource Document):

Follows NCHS birth weight edits to replace as unknown if outside of 227-8165 grams or grossly incompatible with both the obstetric estimate and LMP-based estimate of gestational age. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Urban/rural residence is not available for territories.

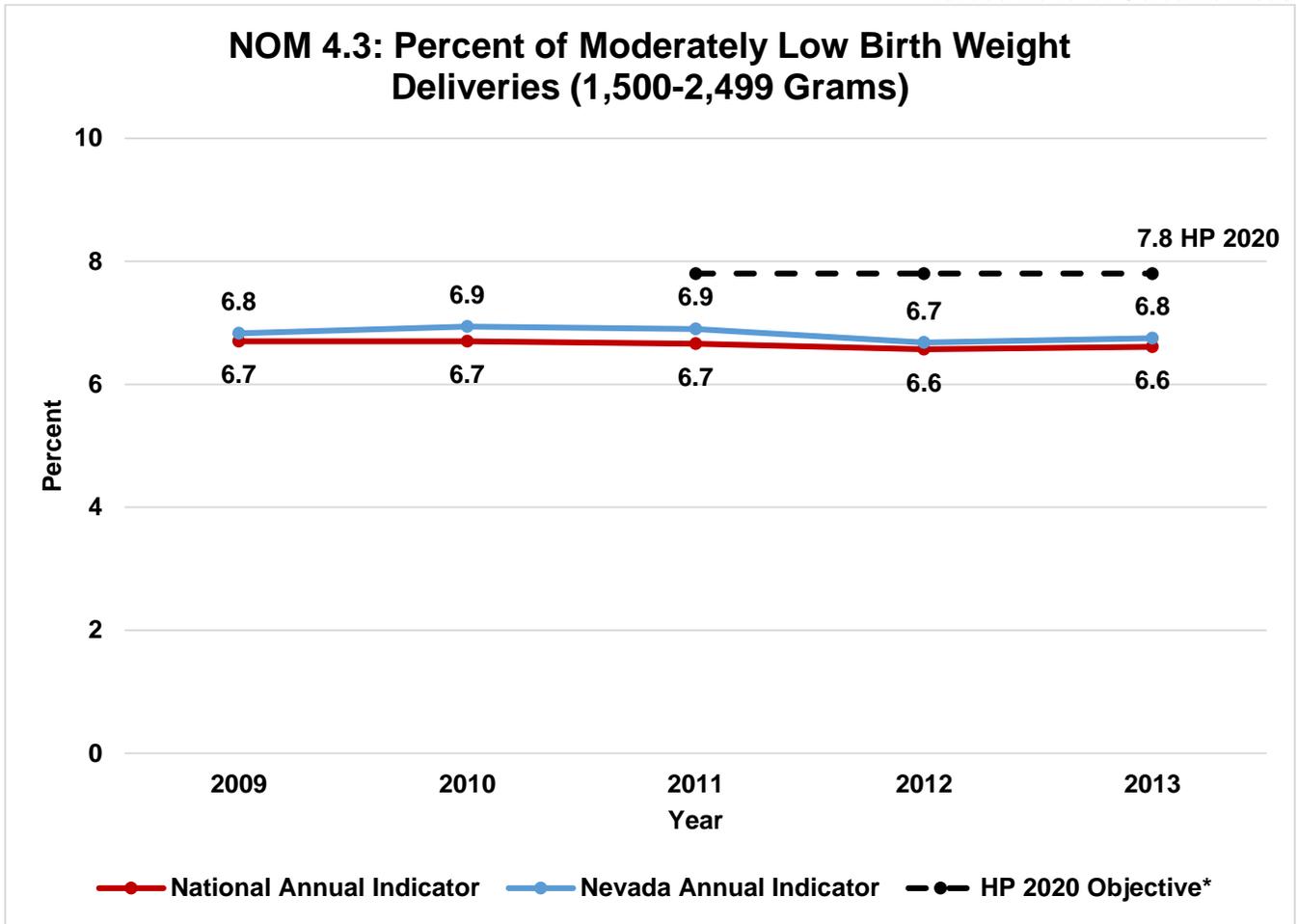


Similar to the national rates, Non-Hispanic Black infants had the highest percentage of very low birth weight in the State. This rate is also higher than the HP 2020 Objective of 1.4%.

Source: NVSS Final Birth Data: 2009-2013

Data Notes (FAD Resource Document):

Follows NCHS birth weight edits to replace as unknown if outside of 227-8165 grams or grossly incompatible with both the obstetric estimate and LMP-based estimate of gestational age. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Urban/rural residence is not available for territories.

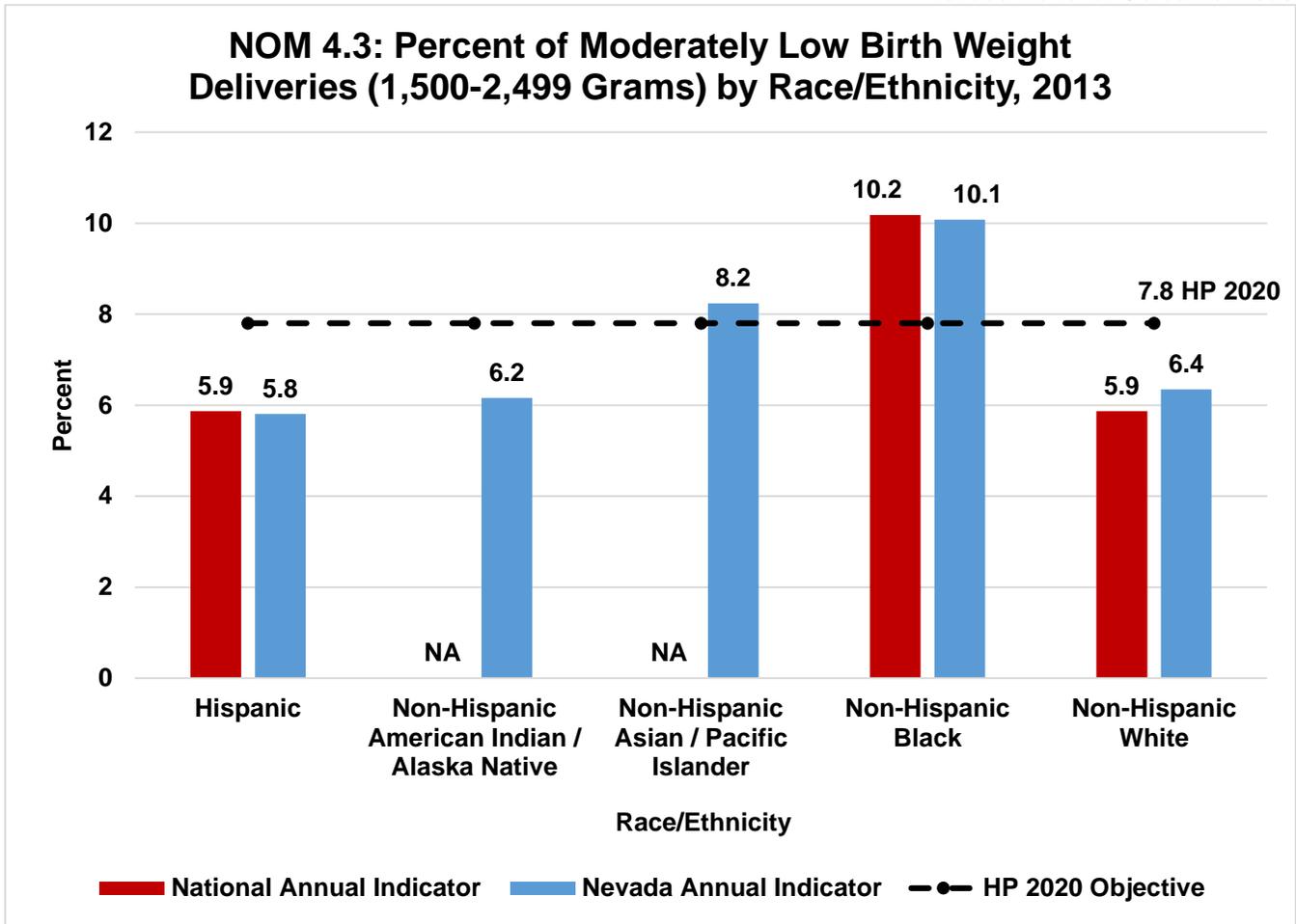


NOM 4.3: Similar to the national rates, the percent of moderately low birth weight deliveries in Nevada is below the HP 2020 Objective (MICH 8.1) of 7.8%. The next figure describes the percent of moderately low birth weight deliveries by race/ethnicity. There was no HP 2010 target for this outcome measure.

Source: NVSS 2009-2013

Data notes (FAD Resource Document):

Follows NCHS birth weight edits to replace as unknown if outside of 227-8165 grams or grossly incompatible with both the obstetric estimate and LMP-based estimate of gestational age. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Urban/rural residence is not available for territories.

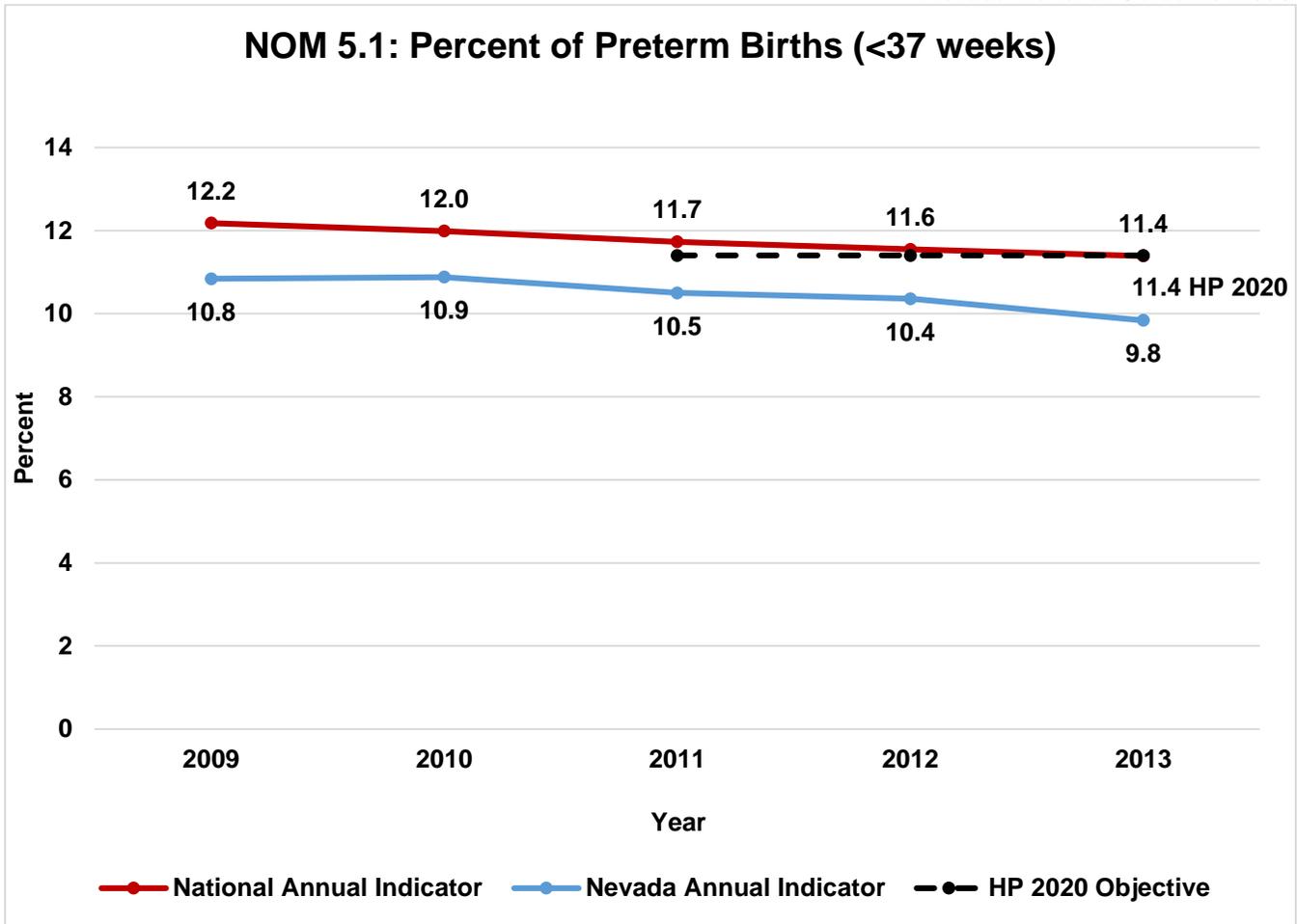


NOM 4.3: In 2013, Non-Hispanic Asian/Pacific Islander and Non-Hispanic Black were the only race/ethnic groups that did not meet the HP 2020 Objective (MICH 8.1) of 7.8%.

Source: NVSS 2009-2013

Data notes (FAD Resource Document):

Follows NCHS birth weight edits to replace as unknown if outside of 227-8165 grams or grossly incompatible with both the obstetric estimate and LMP-based estimate of gestational age. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Urban/rural residence is not available for territories.

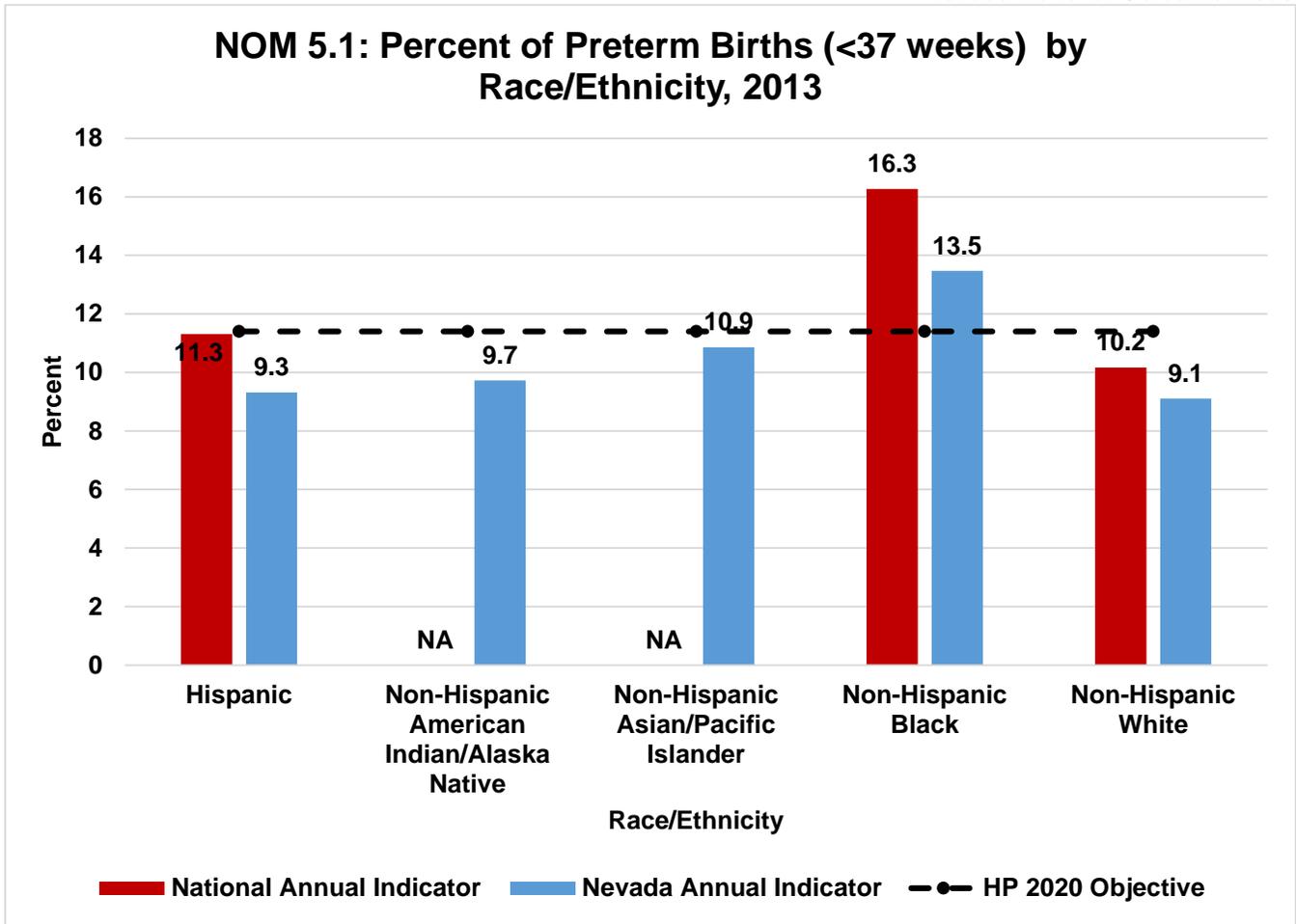


NOM 5.1: Since 2009, the percent of preterm births (<37 weeks) in Nevada has consistently remained below both the National Annual Indicator and the HP 2020 Objective (MICH 9.1) of 11.4%. The HP 2010 target was 7.6%. The figure below shows 2013 data by Race/Ethnicity.

Source: NVSS 2009-2013 Births: Final Data

Data notes: (FAD Resource Document)

Based on obstetric/clinical estimate of gestation, following NCHS edits to replace as unknown if outside of 17-47 weeks. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Urban/rural residence is not available for territories.

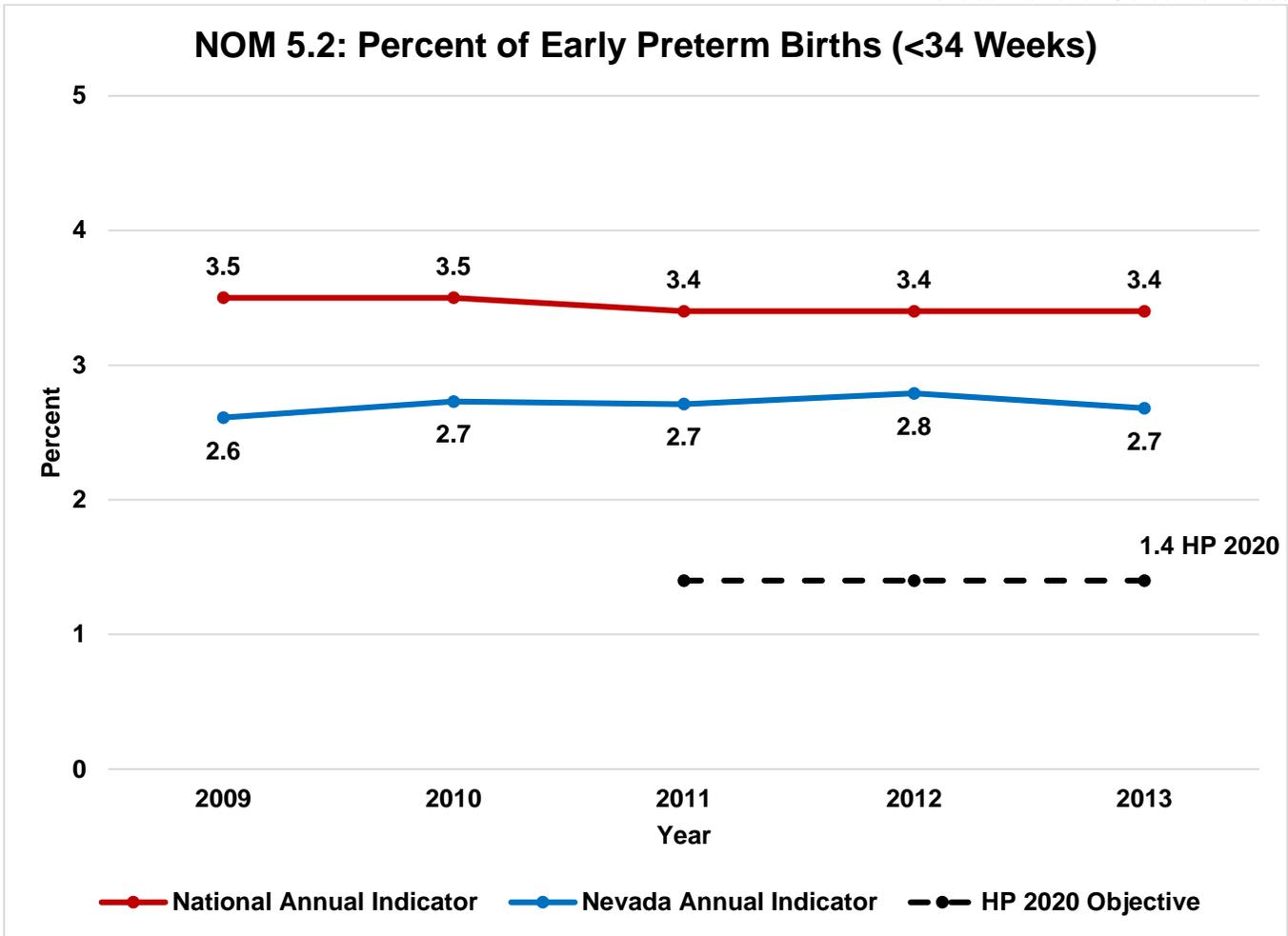


NOM 5.1: In 2013, Non-Hispanic Black was the only population that did not meet the HP 2020 Objective (MICH 9.1) of 11.4% in Nevada.

Source: NVSS 2009-2013 Births: Final Data

Data notes: (FAD Resource Document)

Based on obstetric/clinical estimate of gestation, following NCHS edits to replace as unknown if outside of 17-47 weeks. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Urban/rural residence is not available for territories.

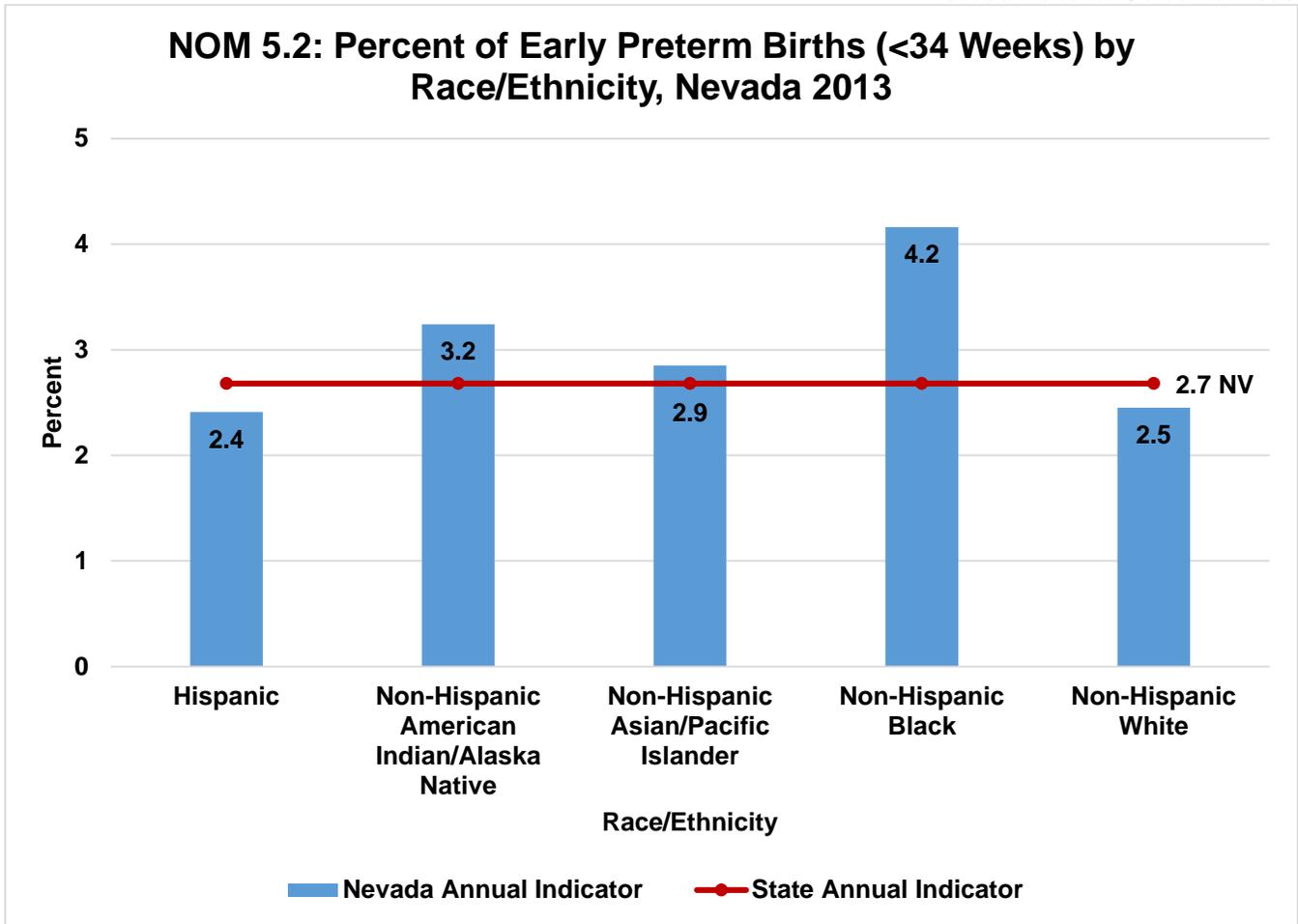


NOM 5.2: Since 2009, the percent of Early Preterm Births (<34 Weeks) in Nevada is below the national average but above the HP 2020 objective of 1.4%. Previously the HP 2010 target was 1.1% for live births less than 32 weeks of gestation. The next figure describes the 2013 data by Race/Ethnicity.

Source: NVSS Death Records

Data notes (FAD Resource Document):

Based on obstetric/clinical estimate of gestation, following NCHS edits to replace as unknown if outside of 17-47 weeks. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Urban/rural residence is not available for territories.

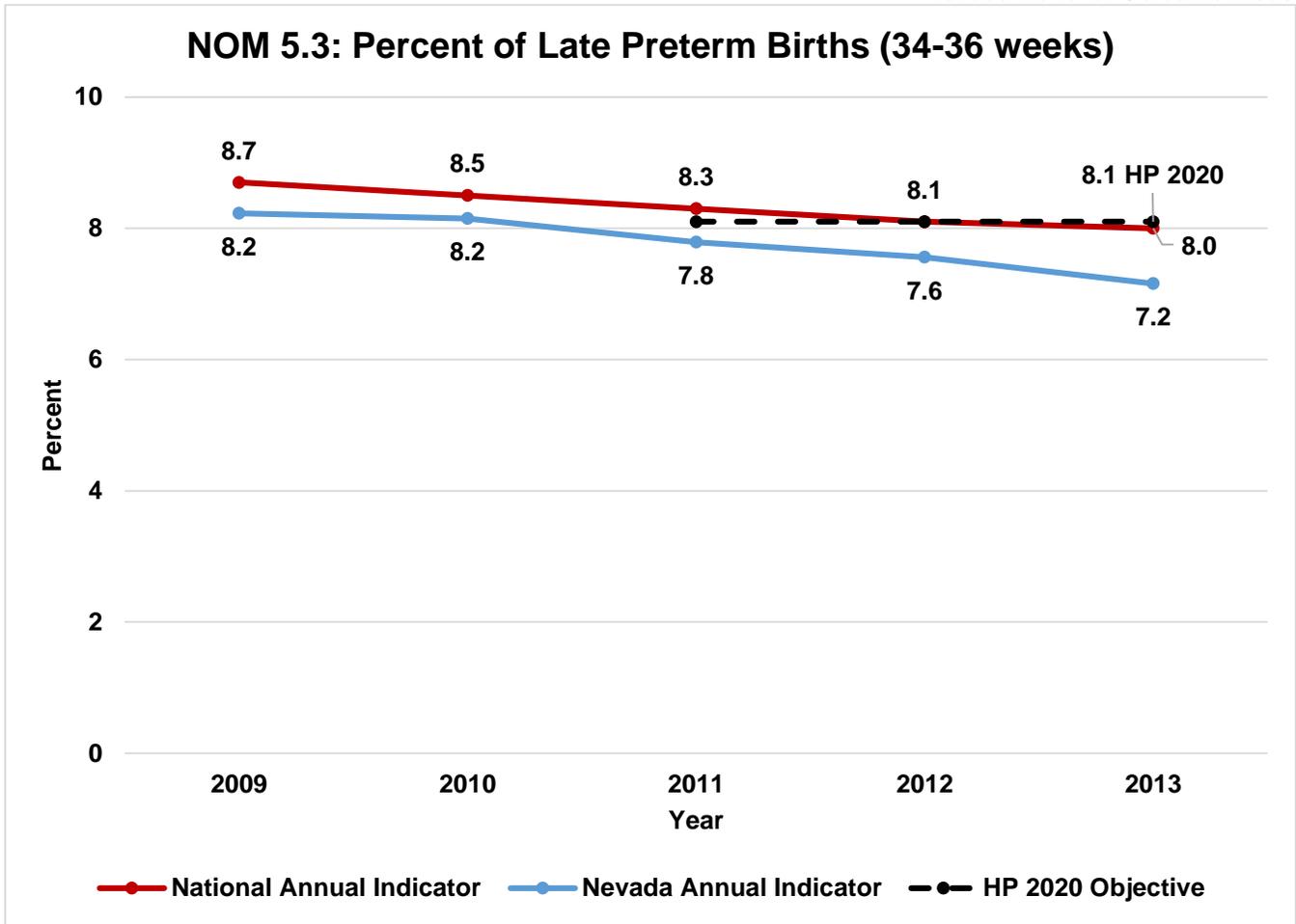


NOM 5.2: In 2013, the percent of early preterm births (<34 weeks) in Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native and Non-Hispanic Asian/Pacific Islander, was higher than the state average. Non-Hispanic White and Hispanic infants were below the state average.

Source: NVSS Death Records

Data notes (FAD Resource Document):

Based on obstetric/clinical estimate of gestation, following NCHS edits to replace as unknown if outside of 17-47 weeks. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Urban/rural residence is not available for territories.

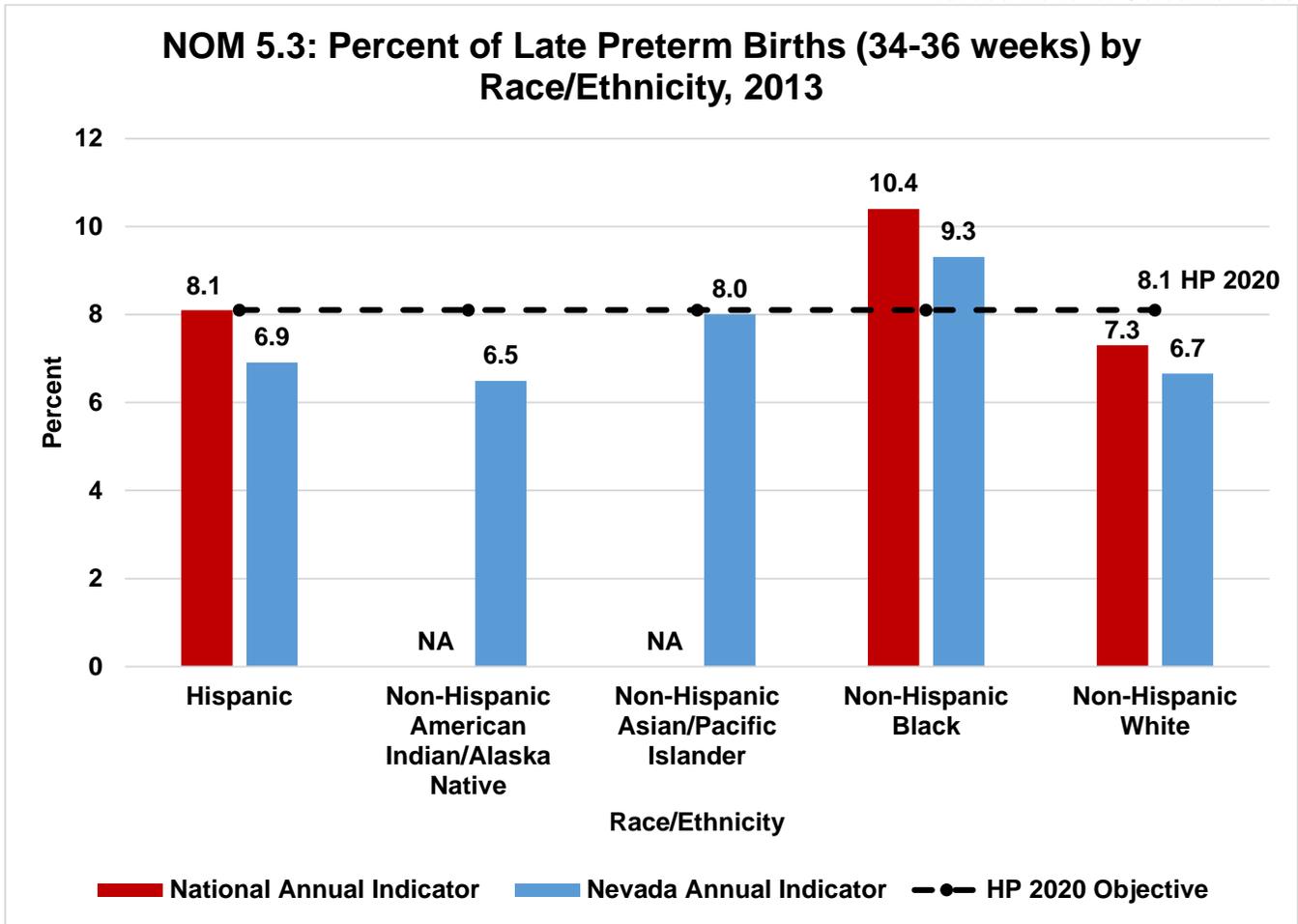


NOM 5.3: Since 2009, the percent of late preterm births (34-36 weeks gestation) in Nevada has remained below the national average and also met and surpassed the HP 2020 Objective (MICH 9.2) of 8.1%. The HP 2010 had a target of 6.4% for live births at 32-36 weeks of gestation. Both the National and the State Annual Indicator have been gradually declining over the years. . The next figure describes the 2013 data by Race/Ethnicity.

Source: NVSS

Data notes (FAD Resource Document):

Based on obstetric/clinical estimate of gestation, following NCHS edits to replace as unknown if outside of 17-47 weeks. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Urban/rural residence is not available for territories.

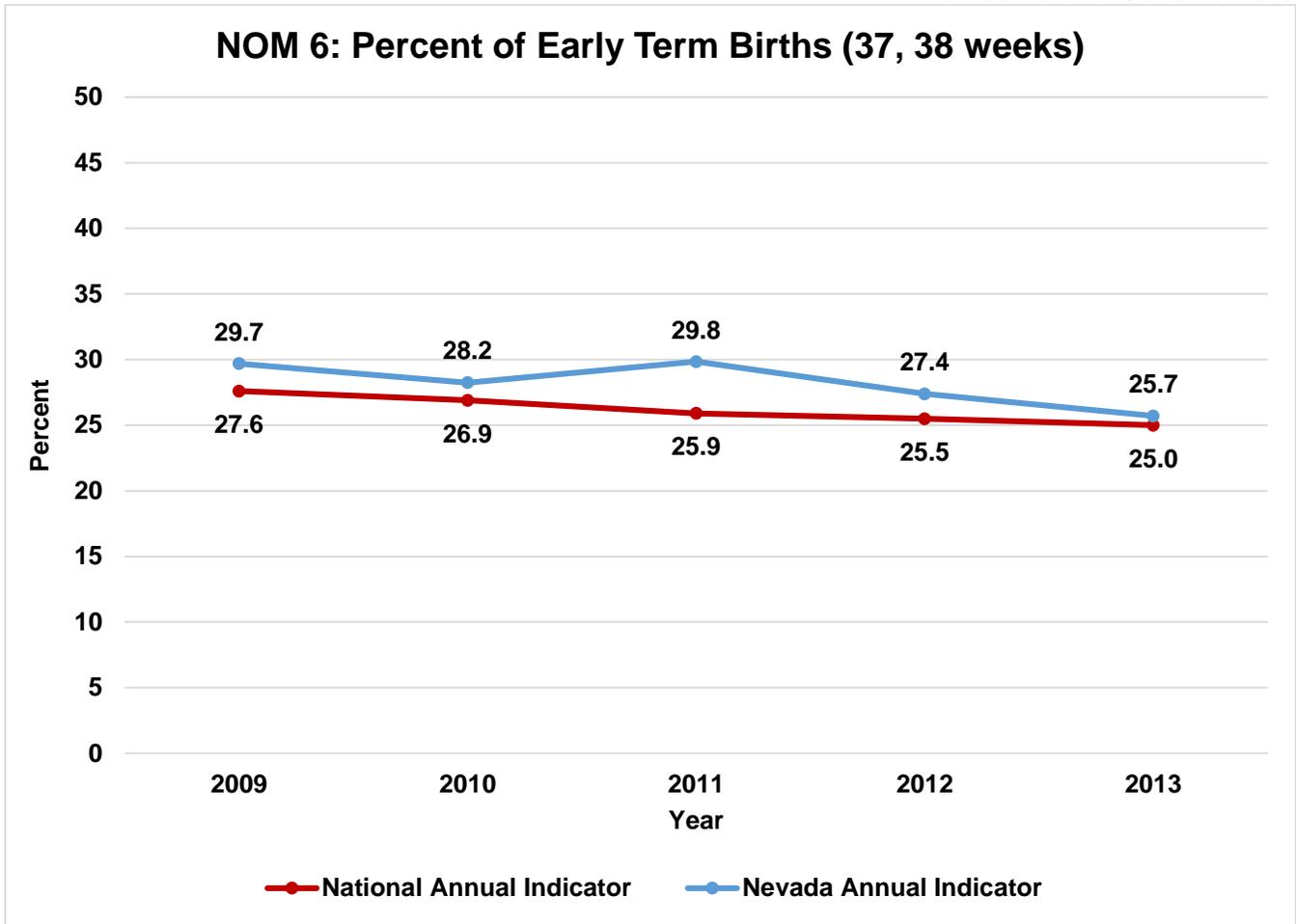


NOM 5.3: In 2013, Non-Hispanic Blacks had the highest percent of late preterm births (34-36 weeks) both in Nevada and nationally. This population did not meet the HP 2020 Objective (MICH 9.2) of 8.1%. All the other race/ethnic groups in the State were well below the HP 2020 objective.

Source: NVSS 2013

Data notes (FAD Resource Document):

Based on obstetric/clinical estimate of gestation, following NCHS edits to replace as unknown if outside of 17-47 weeks. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. Urban/rural residence is not available for territories.



NOM 6: From 2009 to 2013, the percent of early term births (37-38 weeks) in Nevada has been higher than the national average. There is no HP 2020 Objective for this measure.

Source: NVSS

Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 41 states, DC, Guam, Puerto Rico, and Northern Marianas Islands that had implemented the 2003 revision as of January 1, 2013. County metro status is not available for territories.

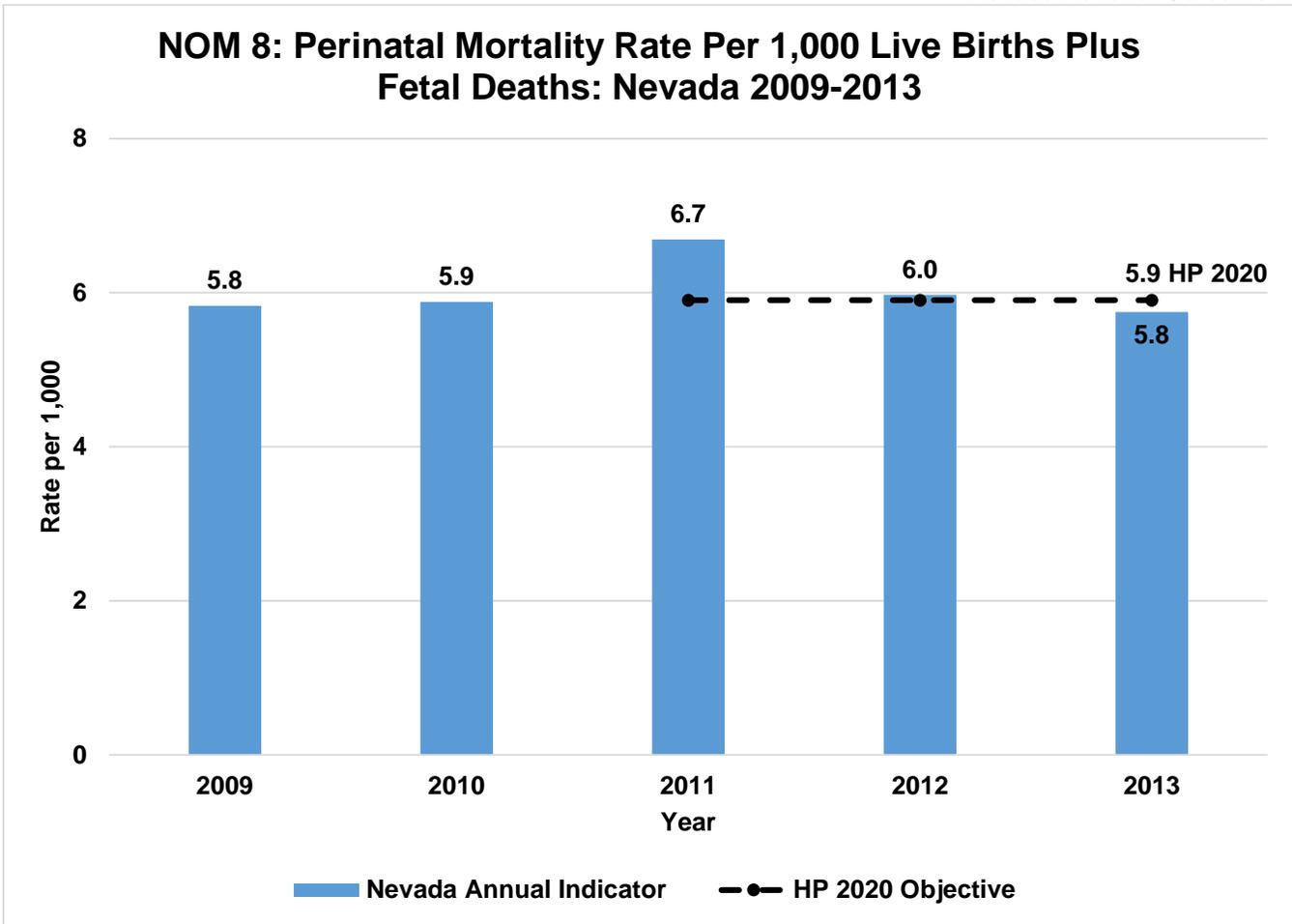
NOM 7: Percent of Non-Medically Indicated Early Elective Deliveries.

Federally Available data indicate that Nevada's Annual indicator for 2013/Q2-2014/Q1 is 6.0%. The results of non-medically indicated early elective deliveries were based on a shorter time period than required for reporting. There is no HP 2020 Objective for this measure.

Source: CMS Hospital Compare

Data notes (FAD Resource Document):

Indicator data reflect all births in Medicare-certified hospitals (virtually all U.S. hospitals excluding critical access hospitals). Standard errors, numerators, and denominators are not available; hospital births are often sampled and are not weighted when forming total estimates for states and the US overall. Indicator data are available for download with hospital-specific detail at <https://data.medicare.gov/data/hospital-compare> (PC_01 within Timely and Effective Care)

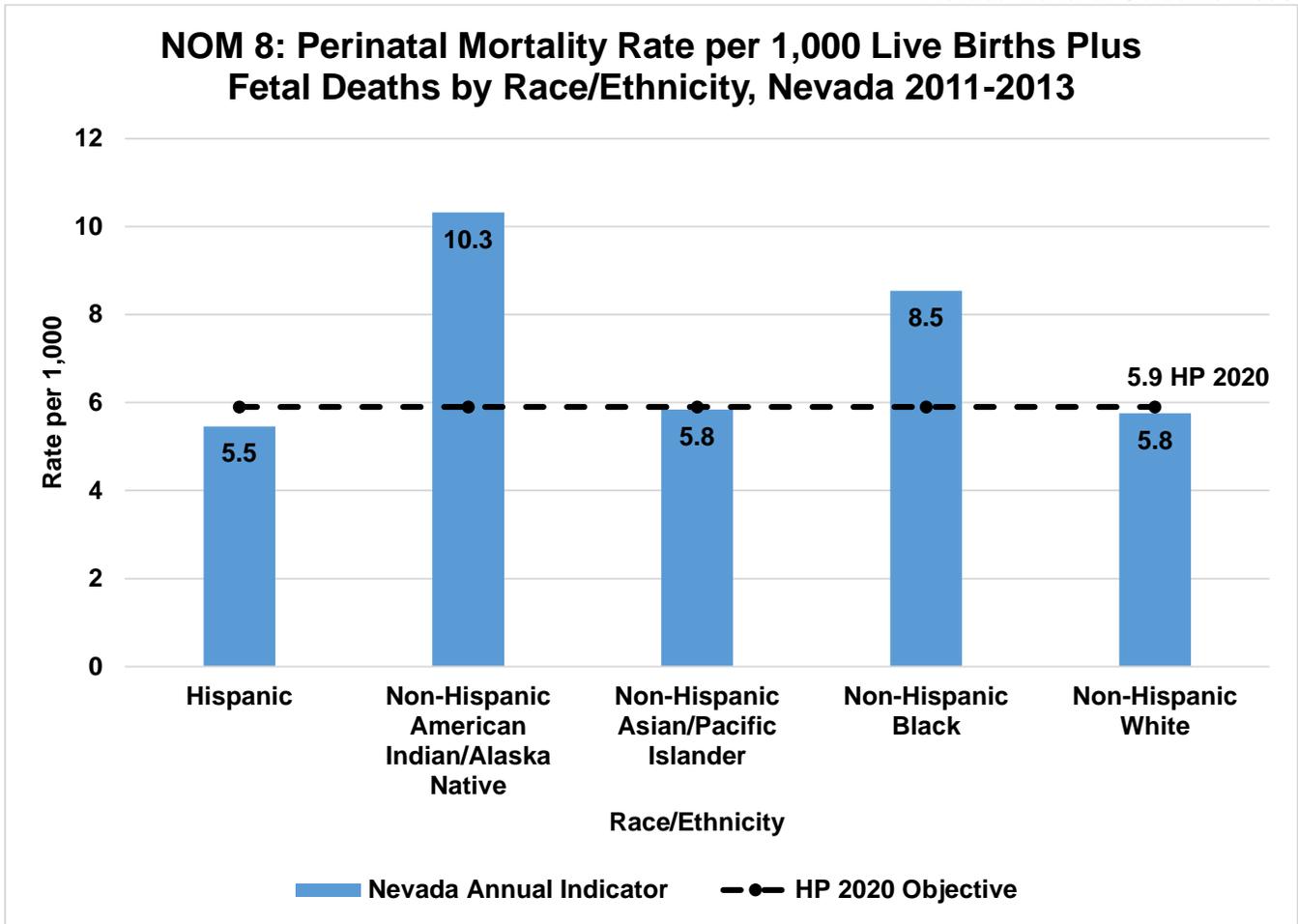


NOM 8: From 2009-2013, the perinatal mortality rate in Nevada remained the same, peaking at 6.7 (per 1,000 live births plus fetal deaths) in 2011 and declining to 5.8 in 2013. Nevada was below the HP 2020 Objective (MICH 1.2) of 5.9 in 2013. The HP 2010 target was 4.5 per 1,000 live births plus fetal deaths. The next figure describes the 2013 data by Race/Ethnicity.

Source: NVSS

Data notes (FAD Resource Document):

This measure uses the traditional LMP-based estimate of gestation to determine fetal deaths, live births, infant deaths at 28+ weeks' gestation. Fetal deaths with missing or not stated gestational age that were presumed to be 20+ weeks were proportionally distributed to <28 and 28+ weeks. NCHS will be issuing future guidance for incorporating the obstetric estimate in fetal and perinatal mortality statistics; it is more complicated given that the flag for analyzing deaths with a stated or presumed gestational age of 20+ weeks is based on LMP. Early neonatal deaths are weighted to account for deaths that were unable to be linked to a birth certificate in a given state or territory. Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Urban/rural residence is not available for territories. Puerto Rico does not report race/ethnicity on fetal death certificates.

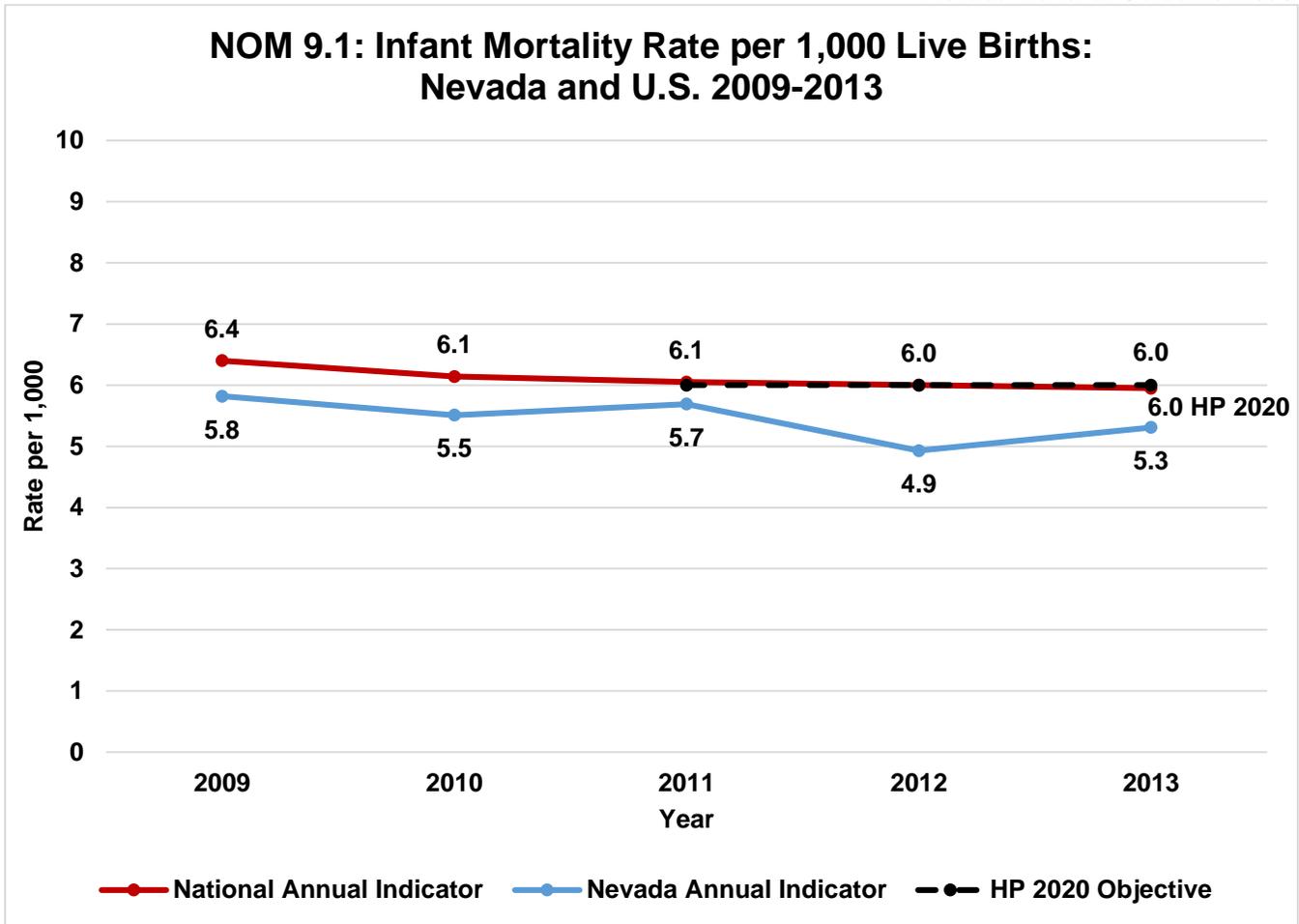


NOM 8: In 2011-2013, Non-Hispanic American Indian/Alaska Native and Non-Hispanic Black had the highest perinatal mortality rate in Nevada. These were the only two populations that did not meet the HP 2020 (MICH 1.2) target of 5.8.

Source: NVSS

Data notes (FAD Resource Document):

This measure uses the traditional LMP-based estimate of gestation to determine fetal deaths, live births, infant deaths at 28+ weeks' gestation. Fetal deaths with missing or not stated gestational age that were presumed to be 20+ weeks were proportionally distributed to <28 and 28+ weeks. NCHS will be issuing future guidance for incorporating the obstetric estimate in fetal and perinatal mortality statistics; it is more complicated given that the flag for analyzing deaths with a stated or presumed gestational age of 20+ weeks is based on LMP. Early neonatal deaths are weighted to account for deaths that were unable to be linked to a birth certificate in a given state or territory. Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Urban/rural residence is not available for territories. Puerto Rico does not report race/ethnicity on fetal death certificates.

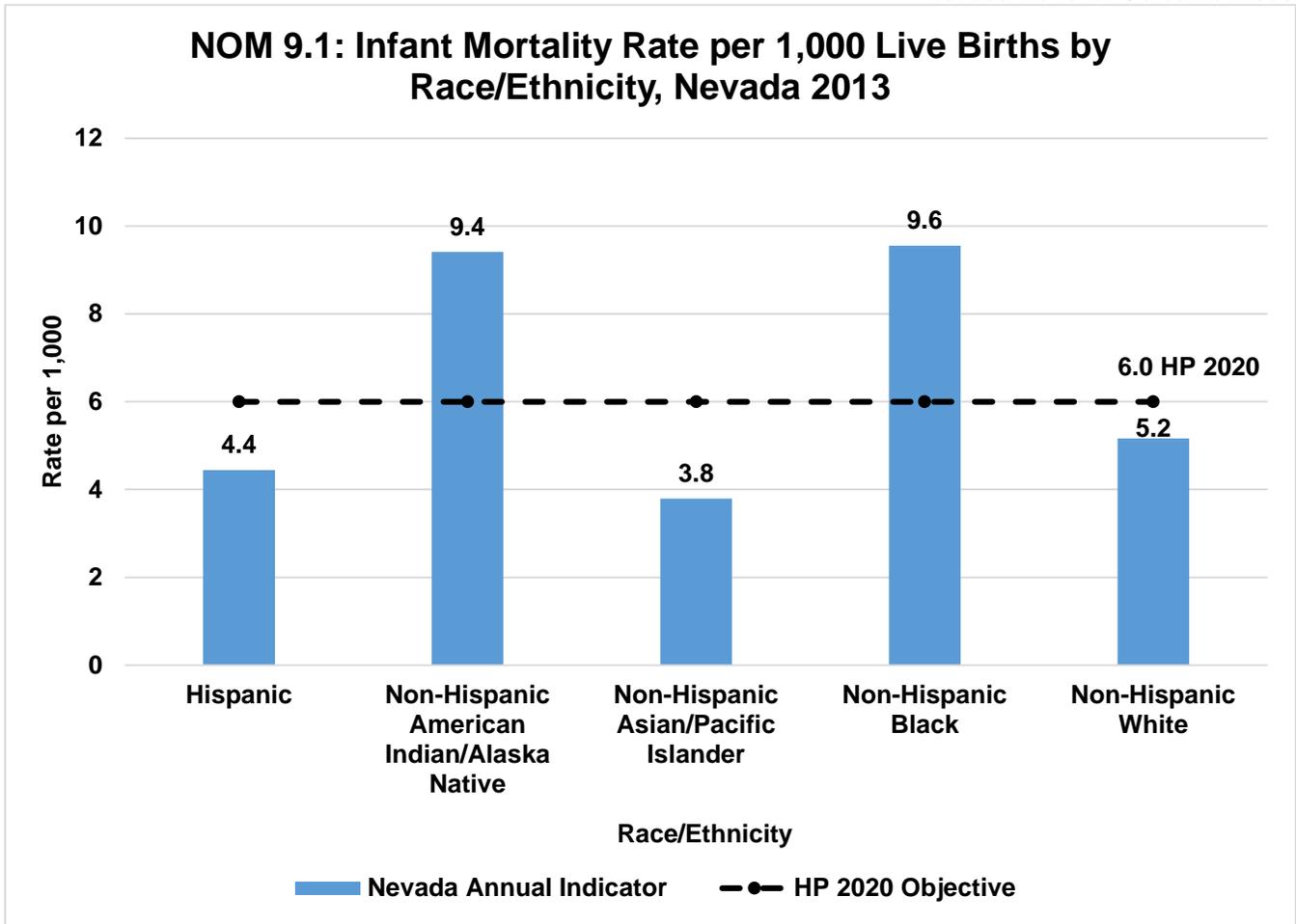


NOM 9.1: From 2011-2013, Nevada’s Infant Mortality Rate (IMR) has remained below the national average and surpassed the HP 2020 Objective (MICH 1.3) of 6.0 infant deaths per 1,000 live births. The HP 2010 target was 4.5 infant deaths per 1,000 live births. The next figure shows Nevada’s IMR by Race/Ethnicity.

Source: NVSS Death Records
NCHS Data Brief – Infant Mortality.

Data notes (FAD Resource Document):

Infant deaths are weighted to account for deaths that were unable to be linked to a birth certificate in a given state or territory. Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 33 states, DC, and Puerto Rico that had implemented the 2003 revision as of January 1, 2010. Urban/rural residence is not available for territories. Unlinked data are used for American Samoa and the Northern Marianas Islands since linked data are unavailable; therefore no stratifiers are available as race/ethnicity data were highly incomplete in the mortality file.

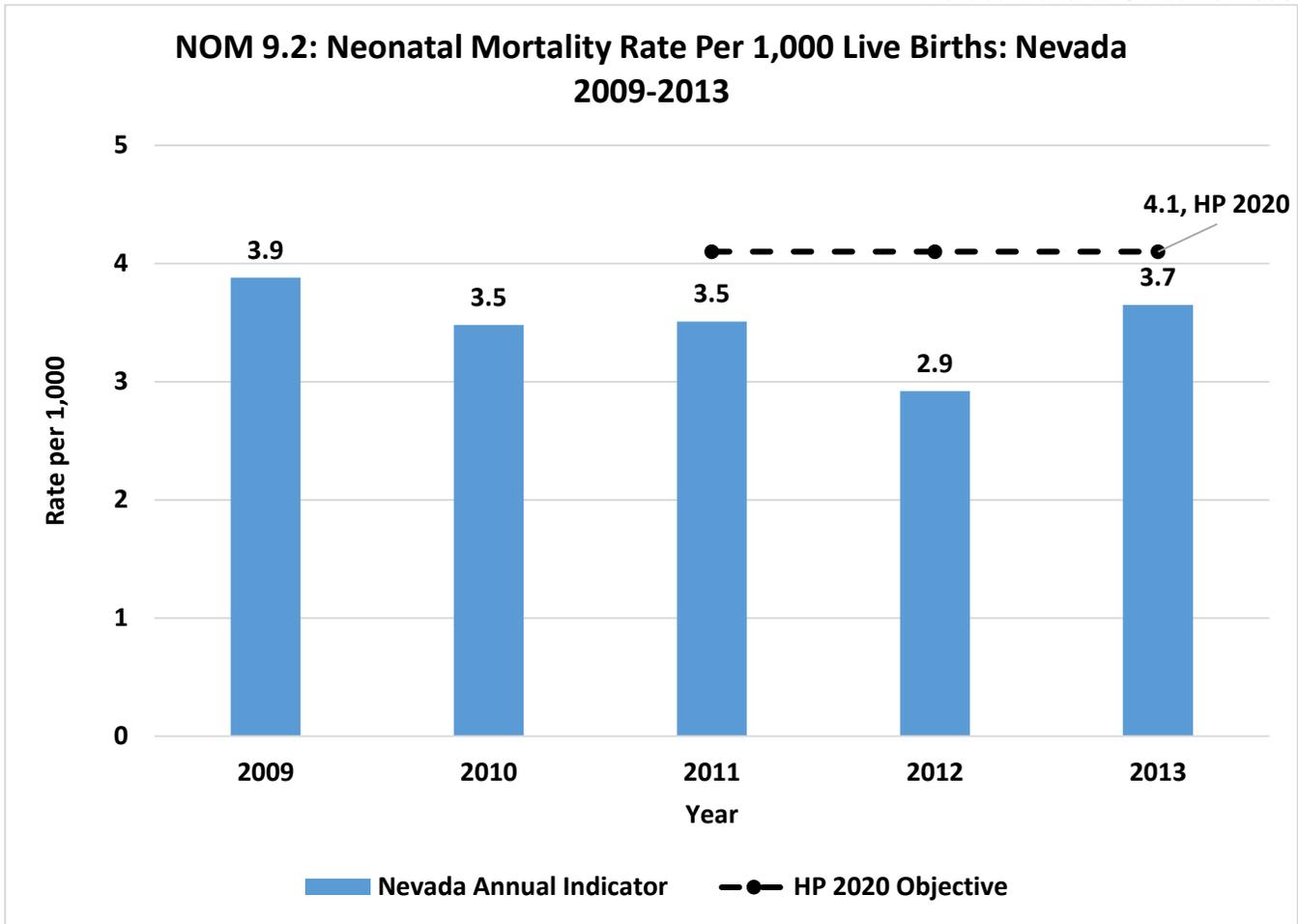


NOM 9.1: In 2013, Non-Hispanic Black and Non-Hispanic American Indian/Alaska Native infants in Nevada were more likely to die before their first birthday than Non-Hispanic White, Non-Hispanic American Indian/Alaska Native and Hispanic infants. In addition, Non-Hispanic Black (9.6) and Non-Hispanic American Indian/Alaska Natives (9.4) were the only race/ethnic groups in the State that did not meet the HP 2020 objective of 6.0 infant deaths per 1,000 live births in 2013. ,

Source: NVSS Death Records
NCHS Data Brief – Infant Mortality.

Data notes (FAD Resource Document):

Infant deaths are weighted to account for deaths that were unable to be linked to a birth certificate in a given state or territory. Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 33 states, DC, and Puerto Rico that had implemented the 2003 revision as of January 1, 2010. Urban/rural residence is not available for territories. Unlinked data are used for American Samoa and the Northern Marianas Islands since linked data are unavailable; therefore no stratifiers are available as race/ethnicity data were highly incomplete in the mortality file.

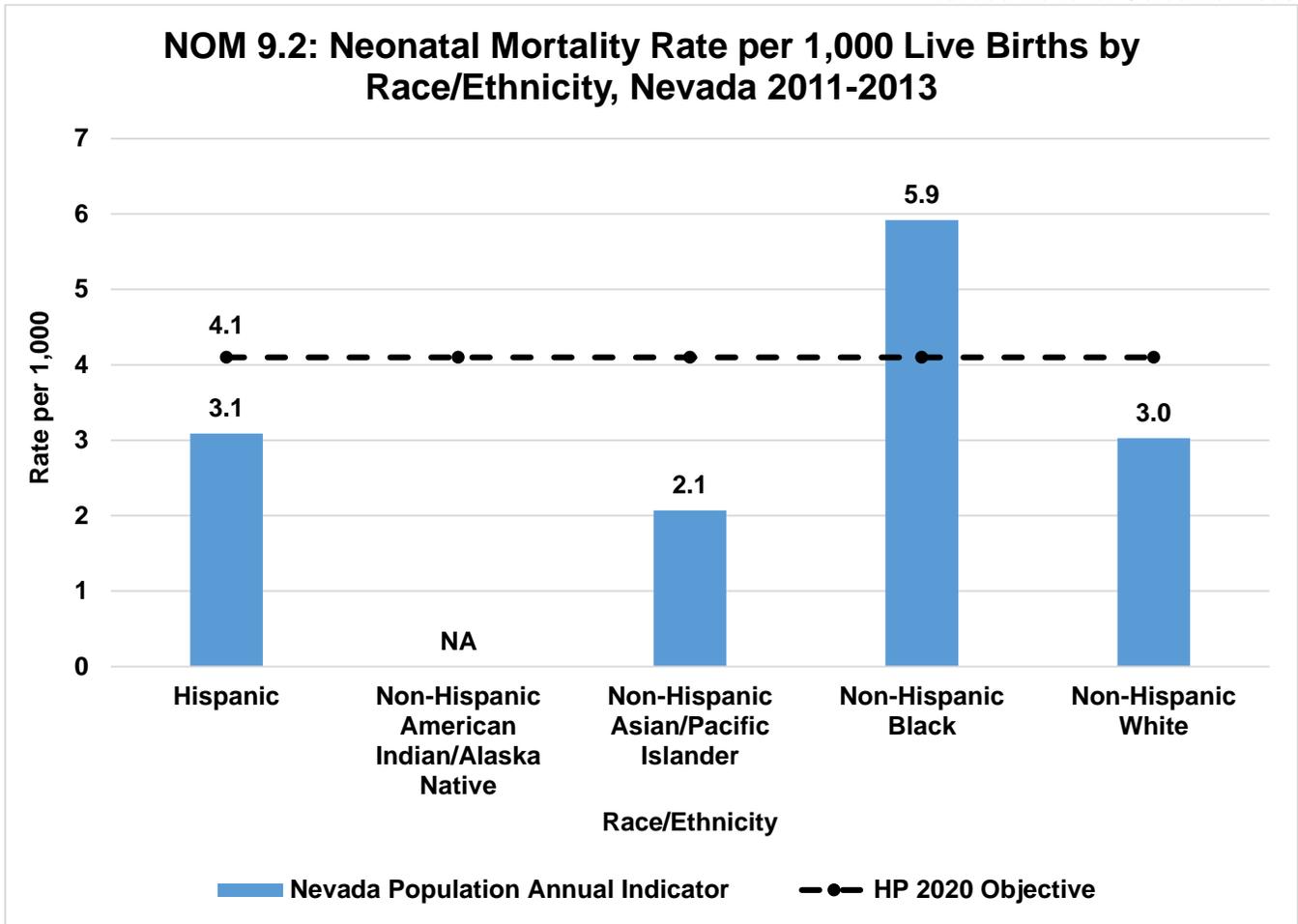


NOM 9.2: From 2011-2013, the neonatal mortality rate (per 1,000 live births) in Nevada has remained below the HP 2020 Objective (MICH 1.4) of 4.1 neonatal deaths per 1,000 live births. The HP 2010 was 2.9. The HP objective seeks to reduce the occurrence of neonatal deaths within the first 28 days of life. The next figure shows the 2013 data by Race/Ethnicity.

Source: NVSS

Data Notes (FAD Resource Document):

Infant deaths are weighted to account for deaths that were unable to be linked to a birth certificate in a given state or territory. Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 33 states, DC, and Puerto Rico that had implemented the 2003 revision as of January 1, 2010. Urban/rural residence is not available for territories. Unlinked data are used for American Samoa and the Northern Marianas Islands since linked data are unavailable; therefore no stratifiers are available as race/ethnicity data were highly incomplete in the mortality file.

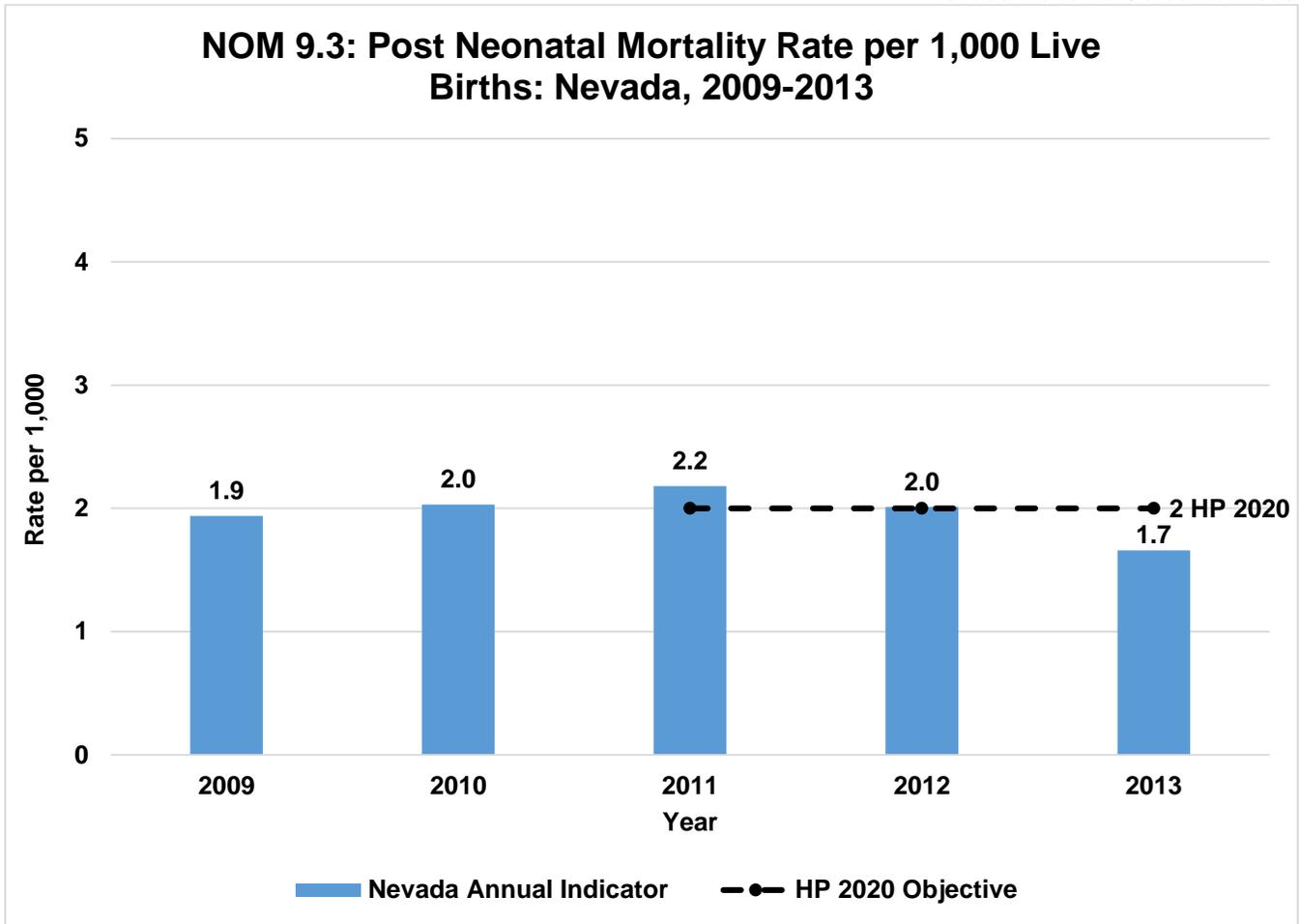


NOM 9.2: From 2011-2013, Non-Hispanic Blacks in Nevada had the highest neonatal mortality rates at 5.9 neonatal deaths per 1,000 live births. In addition, Blacks were the only race/ethnic group that did not meet the HP 2020 Objective (MICH 1.4) of 4.1.

Source: NVSS

Data Notes (FAD Resource Document):

Infant deaths are weighted to account for deaths that were unable to be linked to a birth certificate in a given state or territory. Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 33 states, DC, and Puerto Rico that had implemented the 2003 revision as of January 1, 2010. Urban/rural residence is not available for territories. Unlinked data are used for American Samoa and the Northern Marianas Islands since linked data are unavailable; therefore no stratifiers are available as race/ethnicity data were highly incomplete in the mortality file.

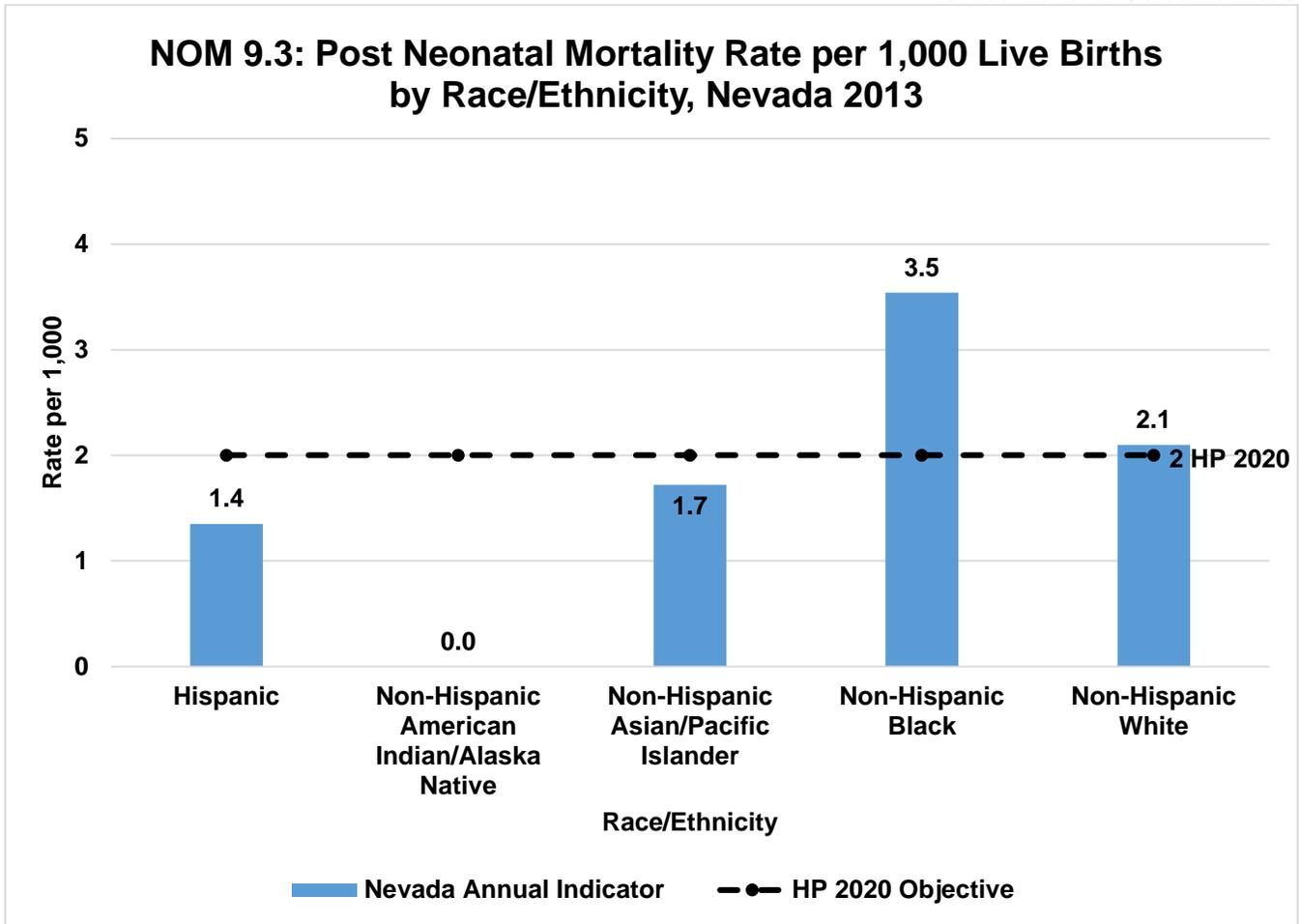


NOM 9.3: The post neonatal mortality rate (per 1,000 live births) in Nevada has gradually declined from 1.9 in 2009 to 1.7 in 2013. In 2013, this indicator was below the HP 2020 Objective (MICH 1.5) of 2 post neonatal (between 28 days and 1 year) deaths per 1,000 live births. The HP 2010 target was 1.2. The next figure shows the 2013 data by Race/Ethnicity.

Source: NVSS

Data Notes (FAD Resource Document):

Infant deaths are weighted to account for deaths that were unable to be linked to a birth certificate in a given state or territory. Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 33 states, DC, and Puerto Rico that had implemented the 2003 revision as of January 1, 2010. Urban/rural residence is not available for territories. Unlinked data are used for American Samoa and the Northern Marianas Islands since linked data are unavailable; therefore no stratifiers are available as race/ethnicity data were highly incomplete in the mortality file.

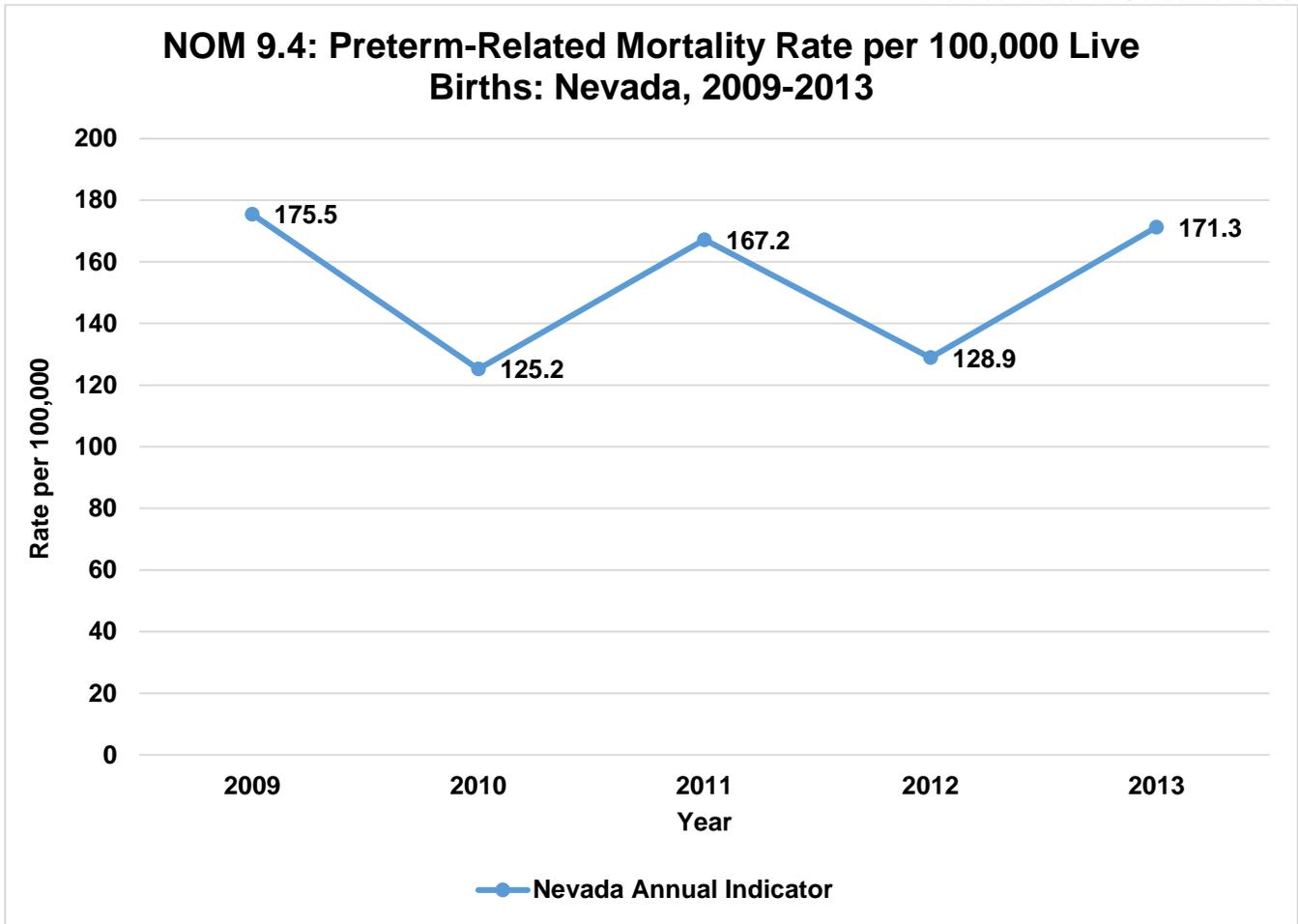


NOM 9.3: In 2013, Non-Hispanic Blacks had the highest post neonatal mortality rate in Nevada at 3.5 per 1,000 live births. In the same year, both Non-Hispanic Blacks and Non-Hispanic Whites did not meet the HP 2020 objective of 2.0. All the other race/ethnic groups in the State were well below the HP 2020 objective.

Source: NVSS

Data Notes (FAD Resource Document):

Infant deaths are weighted to account for deaths that were unable to be linked to a birth certificate in a given state or territory. Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 33 states, DC, and Puerto Rico that had implemented the 2003 revision as of January 1, 2010. Urban/rural residence is not available for territories. Unlinked data are used for American Samoa and the Northern Marianas Islands since linked data are unavailable; therefore no stratifiers are available as race/ethnicity data were highly incomplete in the mortality file.

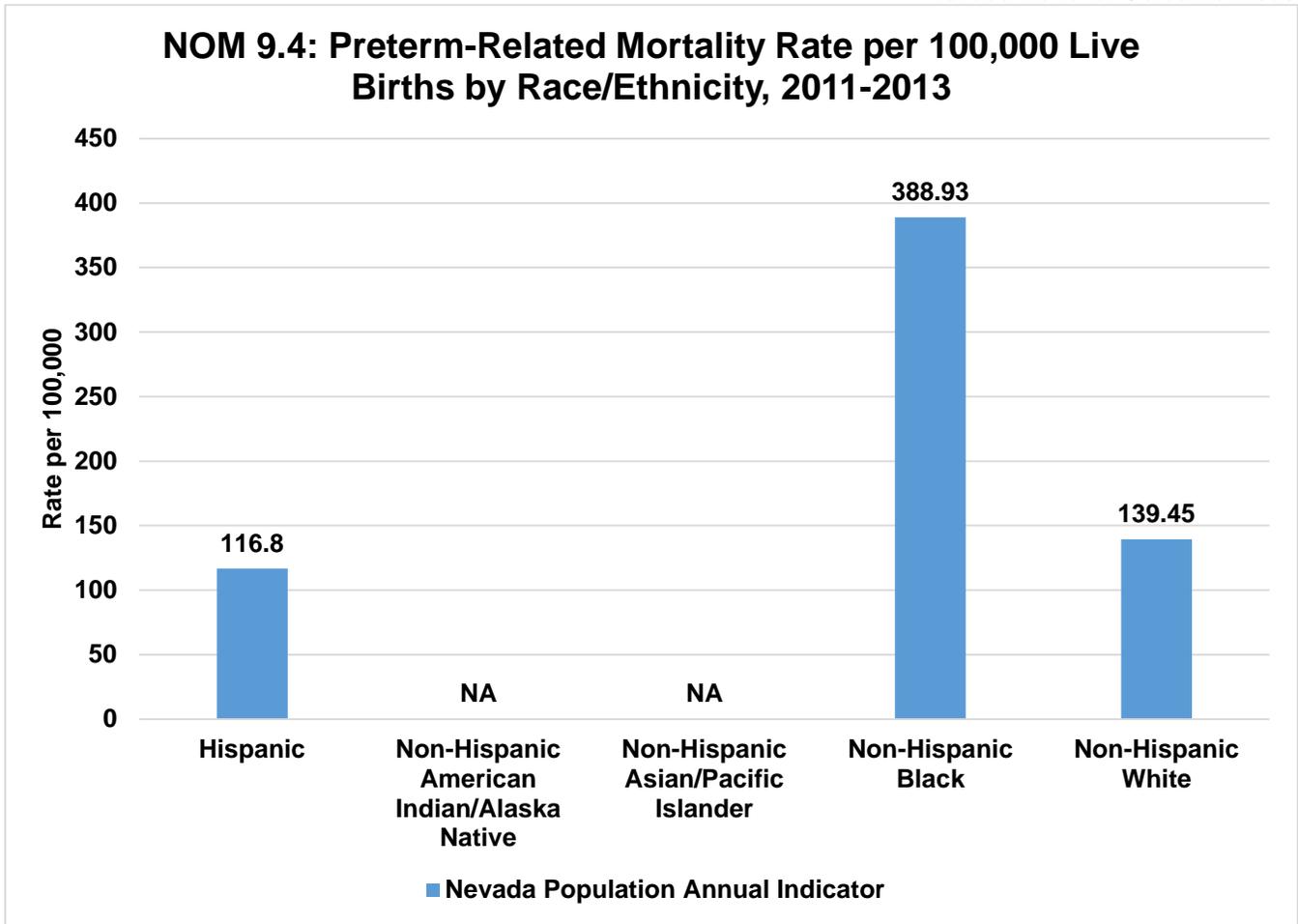


NOM 9.4: From 2009-2013, the preterm related mortality rate (per 1,000 live births) in Nevada had a see-saw effect with rates declining in one year only to go up in the next. There is no HP 2020 objective associated with this national outcome measure. The following figure describes the 2011-2013 data by Race/Ethnicity.

Source: NVSS

Data Notes (FAD Resource Document):

Follows the CDC definition of preterm-related cause if 75% or more of infants whose deaths were attributed to a cause were born at less than 37 weeks of gestation, and the cause of death was a direct consequence of preterm birth based on a clinical evaluation and review of the literature. Preterm-related causes of death are further restricted to preterm infants when determining preterm-related deaths. Gestational age was based on the obstetric/clinical estimate. This measure provides a conservative estimate of the preterm contribution as indirect causes are not included and many non-specific causes of death (e.g. other perinatal conditions) have a high percentage of deaths to preterm infants but lack etiologic specificity. Infant deaths are weighted to account for deaths that were unable to be linked to a birth certificate in a given state or territory. Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 33 states, DC, and Puerto Rico that had implemented the 2003 revision as of January 1, 2010. Urban/rural residence is not available for territories.

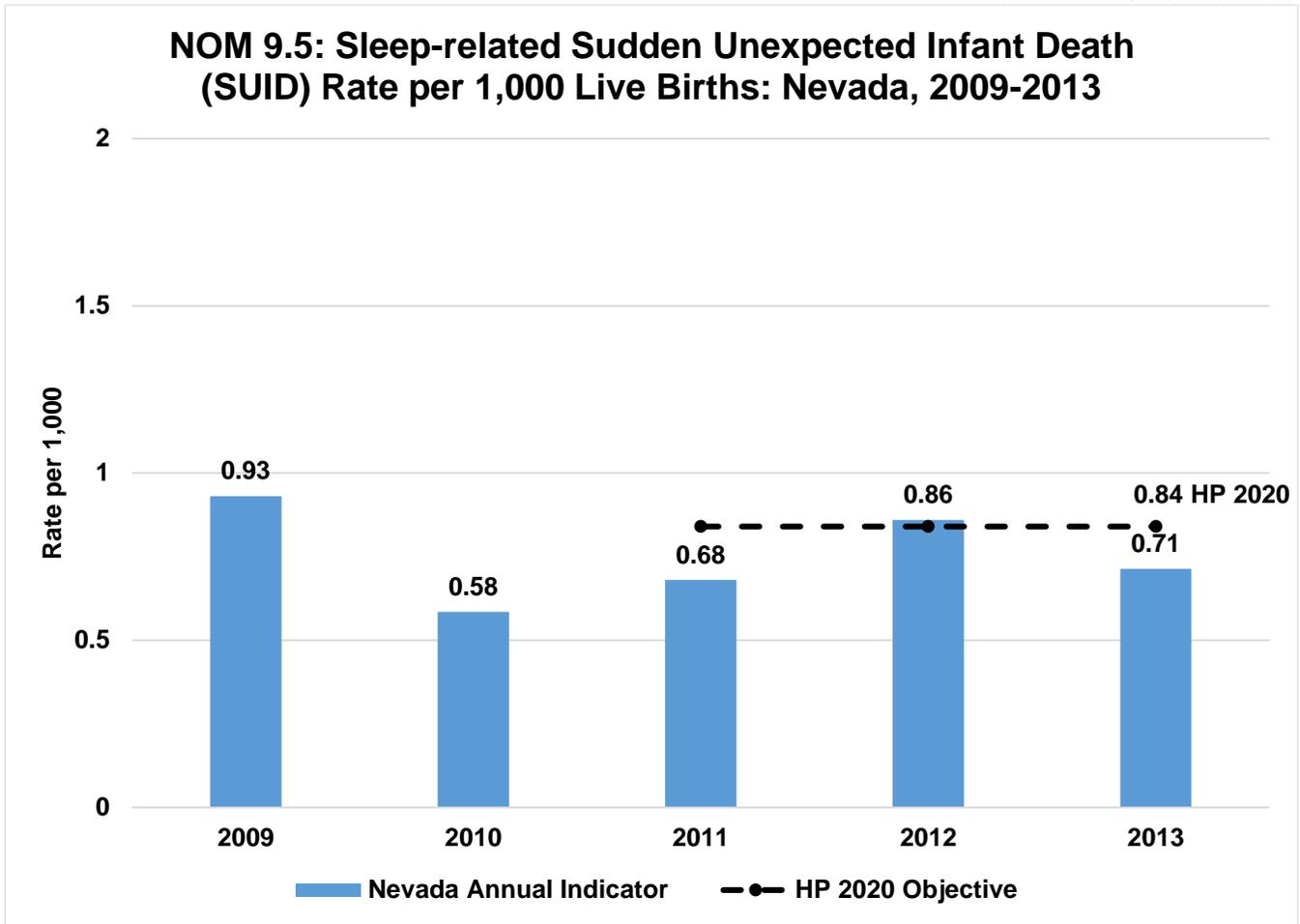


NOM 9.4: During 2011 to 2013, Non-Hispanic Blacks had the highest preterm-related mortality at 388.93 per 100,000 live births in Nevada. Preterm related deaths among Non-Hispanic Blacks were more than three times that of Hispanics and more than two and a half times that of Non-Hispanic Whites. There is no HP 2020 Objective related to this measure.

Source: NVSS

Data Notes (FAD Resource Document):

Follows the CDC definition of preterm-related cause if 75% or more of infants whose deaths were attributed to a cause were born at less than 37 weeks of gestation, and the cause of death was a direct consequence of preterm birth based on a clinical evaluation and review of the literature. Preterm-related causes of death are further restricted to preterm infants when determining preterm-related deaths. Gestational age was based on the obstetric/clinical estimate. This measure provides a conservative estimate of the preterm contribution as indirect causes are not included and many non-specific causes of death (e.g. other perinatal conditions) have a high percentage of deaths to preterm infants but lack etiologic specificity. Infant deaths are weighted to account for deaths that were unable to be linked to a birth certificate in a given state or territory. Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 33 states, DC, and Puerto Rico that had implemented the 2003 revision as of January 1, 2010. Urban/rural residence is not available for territories.

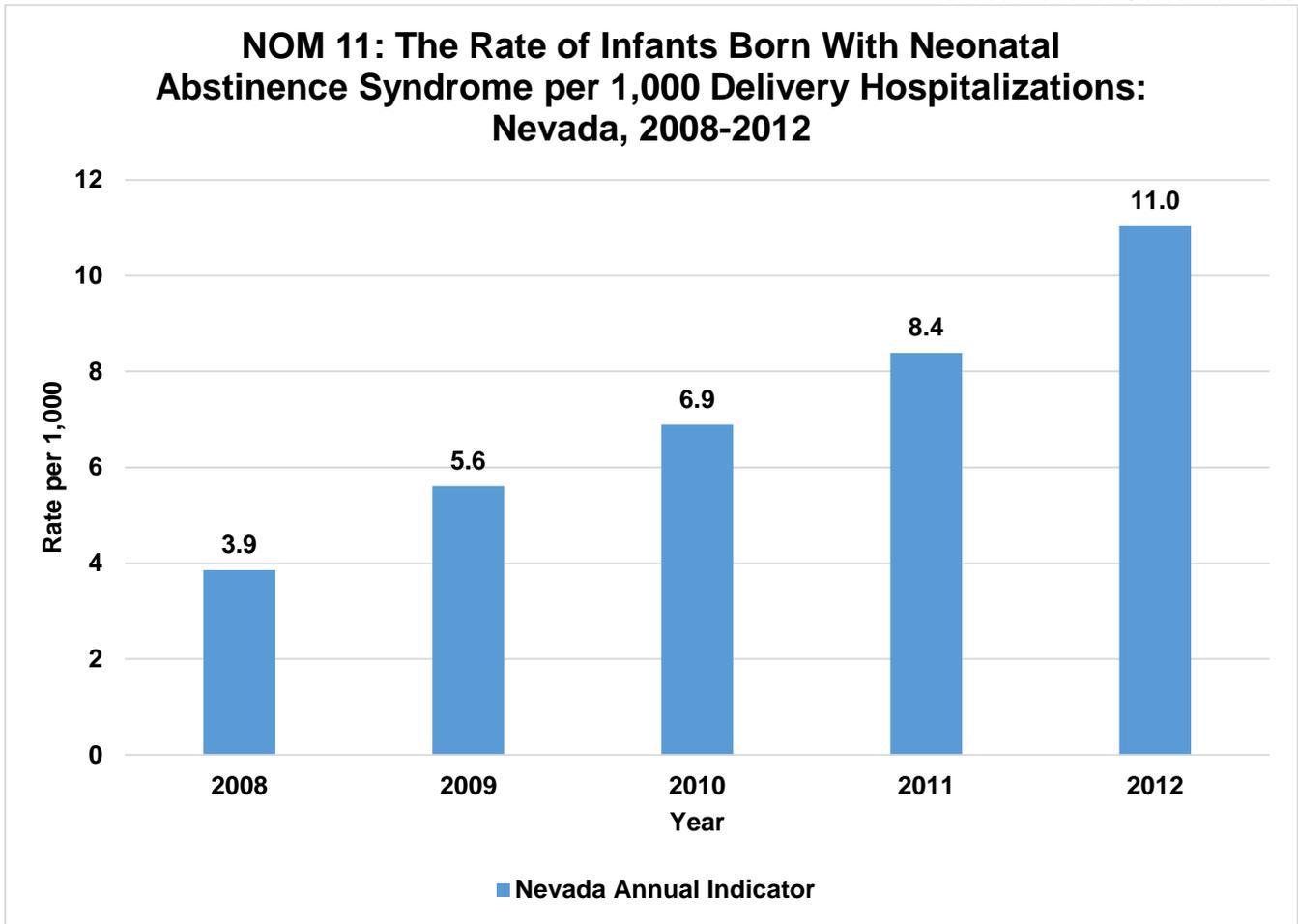


NOM 9.5: Sleep-related sudden unexpected infant death (SUID) rate per 1,000 live births in Nevada was below the HP 2020 objective of 0.84 infant deaths per 1,000 live births in 2011 and 2013. The HP 2010 target was 0.25 deaths per 1,000 live births.

Source: NVSS

Data Notes:

Infant deaths are weighted to account for deaths that were unable to be linked to a birth certificate in a given state or territory. Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Stratifiers that were modified or newly added on the 2003 revision (i.e., maternal education, delivery payment source, prenatal WIC participation) are only reportable for the 33 states, DC, and Puerto Rico that had implemented the 2003 revision as of January 1, 2010. Urban/rural residence is not available for territories. Unlinked data are used for American Samoa and the Northern Marianas Islands since linked data are unavailable; therefore no stratifiers are available as race/ethnicity data were highly incomplete in the mortality file.

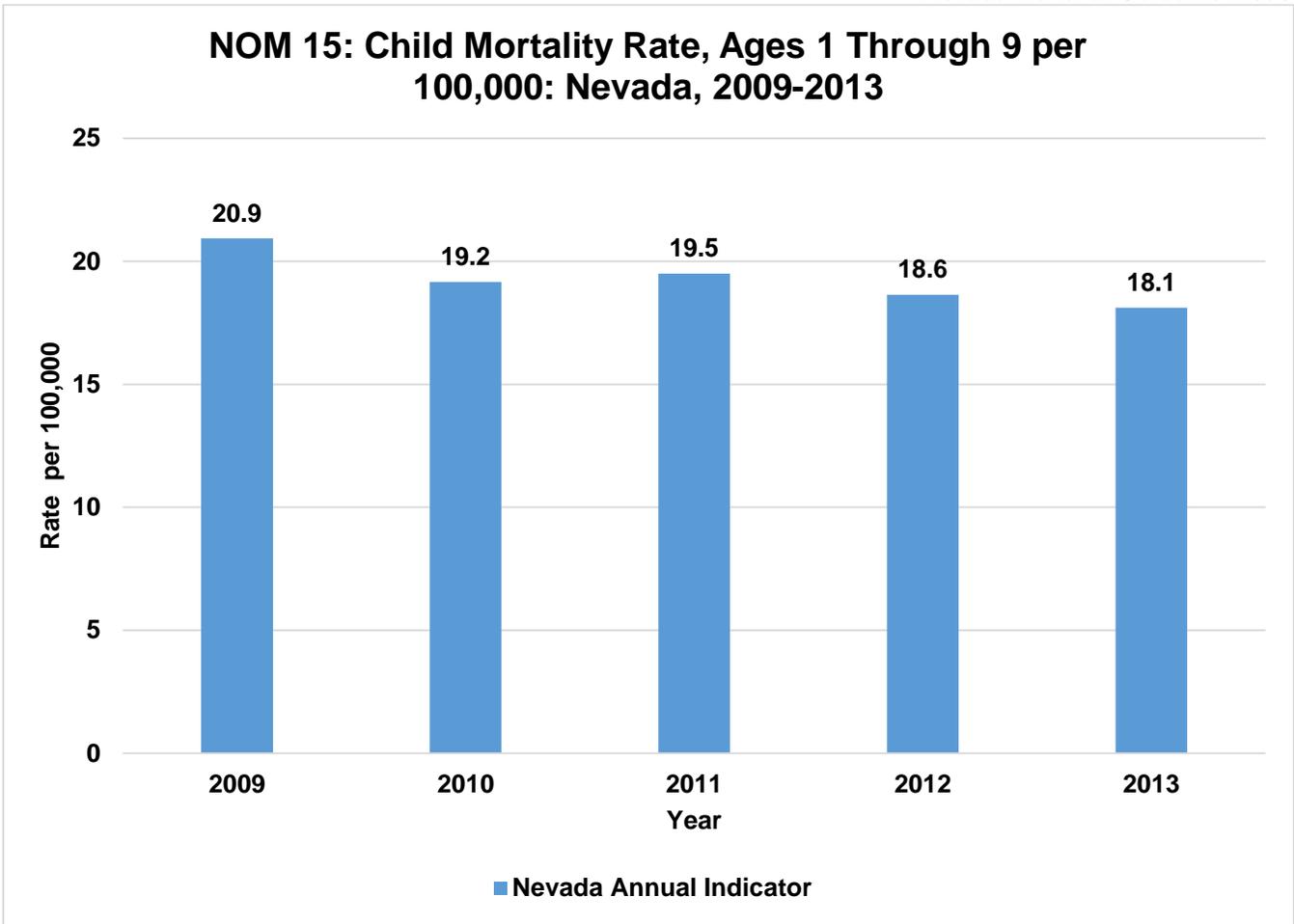


NOM 11: Nevada has seen a consistent increase in the rate of infants born with neonatal abstinence syndrome since 2008. The HP 2020 (MICH 11.4) objective target is 100% of pregnant females ages 15-44 reporting abstaining from illicit drugs in the last 30 days and targets to reduce the rate of infants born with drug dependency.

Source: State Inpatient Database (SID)

Data notes (FAD Resource Document):

Cases of neonatal abstinence syndrome were identified by ICD-9-CM diagnosis codes 779.5 (drug withdrawal syndrome in newborn) and/or 760.72 (noxious influences affecting fetus or newborn via placenta or breast milk, narcotics). The use of multiple codes may significantly increase previous estimates of neonatal abstinence syndrome. Delivery hospitalizations were identified by diagnosis codes for an outcome of delivery, diagnosis-related group delivery codes, and procedure codes for selected delivery-related procedures (Kuklina et al, 2008). Estimates refer to state residents and out-of-state hospitalizations to state residents were included where possible (if hospitalization state provided data to AHRQ). Federal and rehabilitation hospitals were excluded from calculations. Overall U.S. estimates by year may not be comparable due to the different states included in any given year. Certain states did not provide race and/or ethnicity data and are excluded from U.S. totals by race/ethnicity (LA, MN, MT, ND, NE, WV).

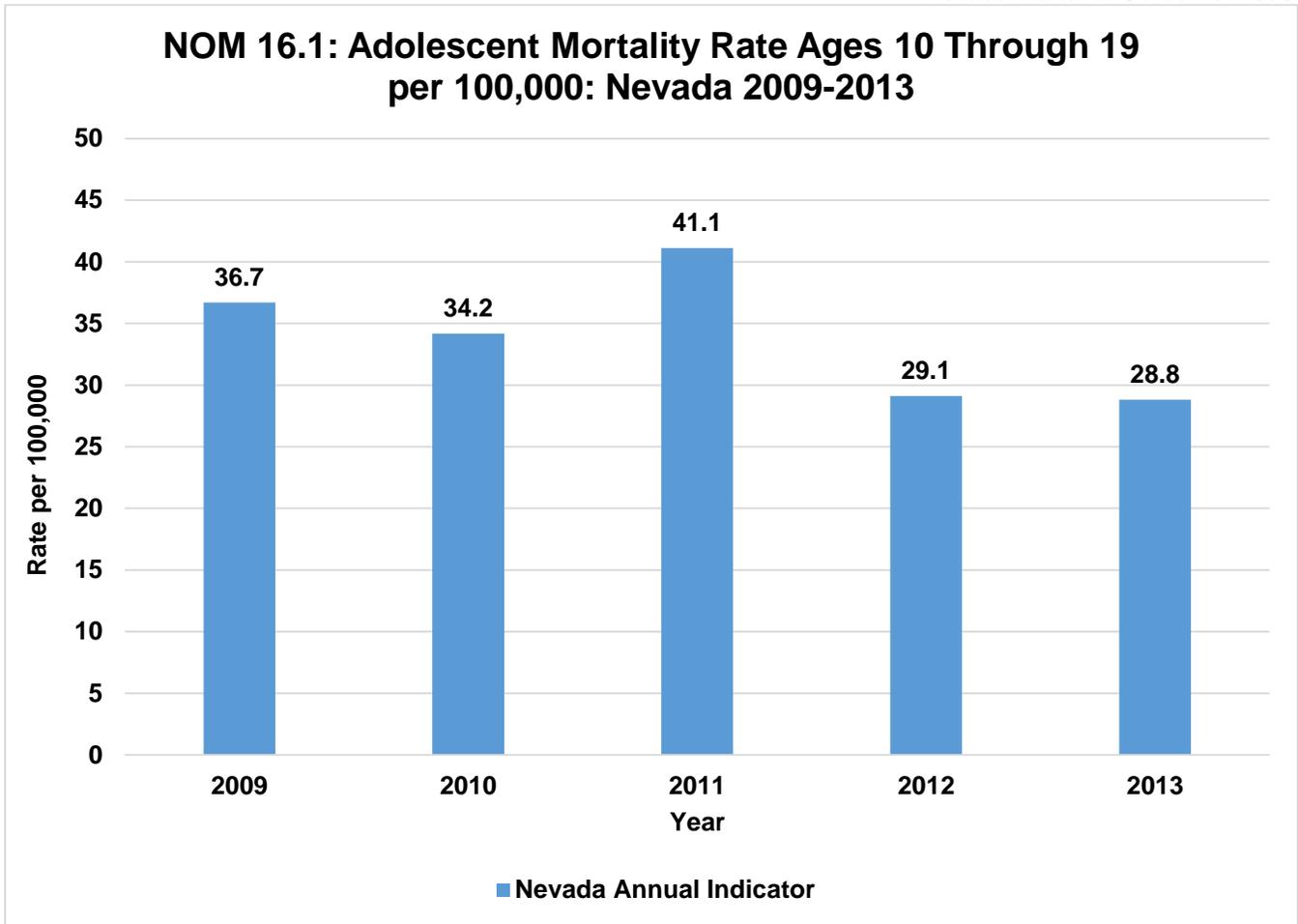


NOM 15: From 2009-2013, child mortality rate in Nevada has declined by 13 percent from 20.9 in 2009 to 18.1 in 2013. The goal of MICH Objectives 3.1 and 3.2 is to reduce deaths among children ages 1 to 4 years (target 25.7 per 100,000) and 5 to 9 years (target 12.3 per 100,000) respectively.

Source: NVSS Mortality File

Data notes (FAD Resource Document):

Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Urban/rural residence and race/ethnicity denominators are not available for territories.

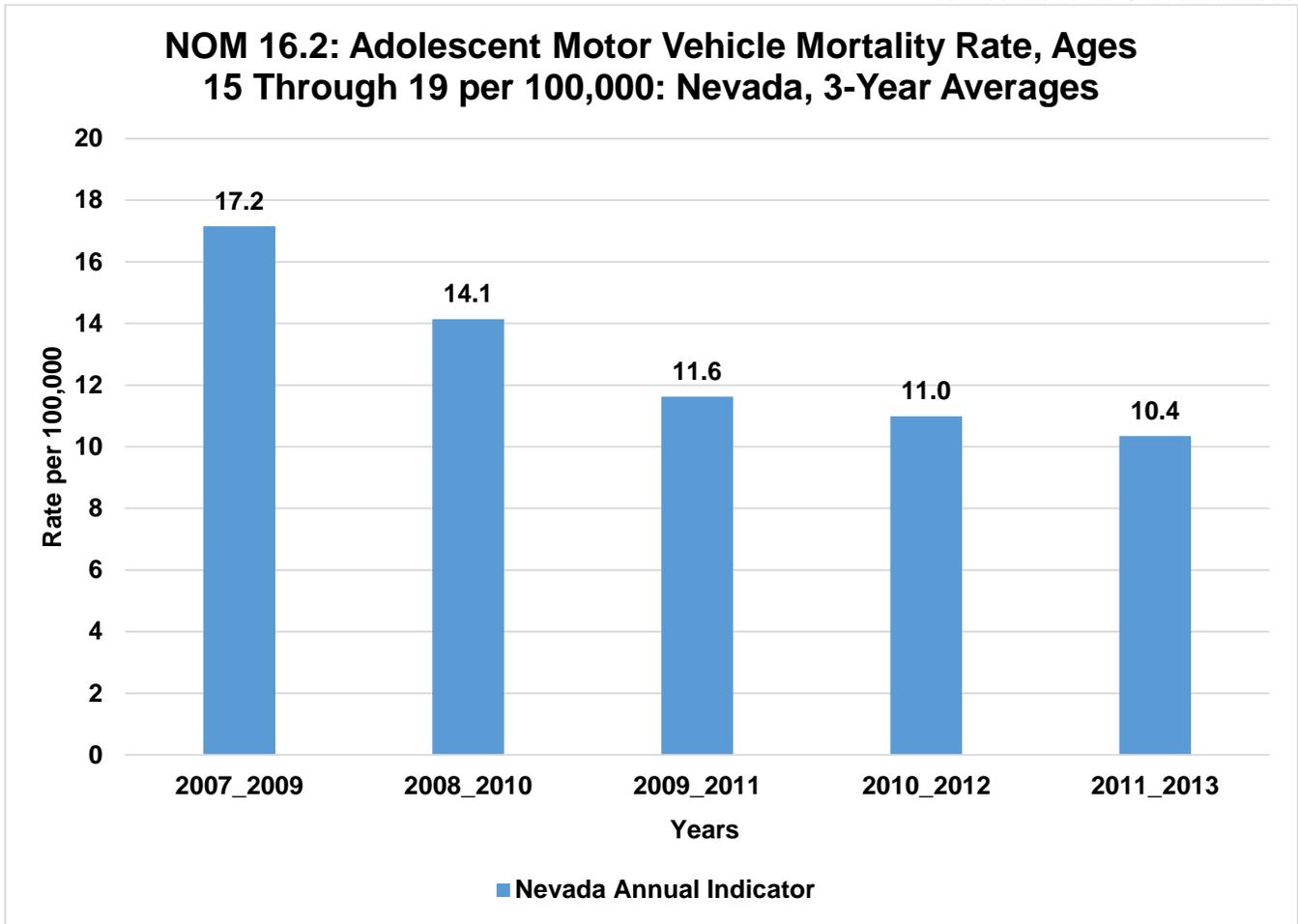


NOM 16.1: Nevada’s mortality rate for adolescents aged 10-19 declined by 22 percent from 36.7 (per 100, 000) in 2009 to 28.8 in 2013. This indicator is related to two HP 2020 objectives: MICH 4.1 sets the target for adolescents aged 10 to 14 years at of 15.2 deaths per 100,000 and MICH 4.2 sets the target for adolescents aged 15 to 19 years at 54.3 deaths per 100,000.

Source: NVSS Mortality File

Data notes (FAD Resource Document):

Estimates by stratifiers are calculated with three-year data to improve precision and reportability. Urban/rural residence and race/ethnicity denominators are not available for territories.

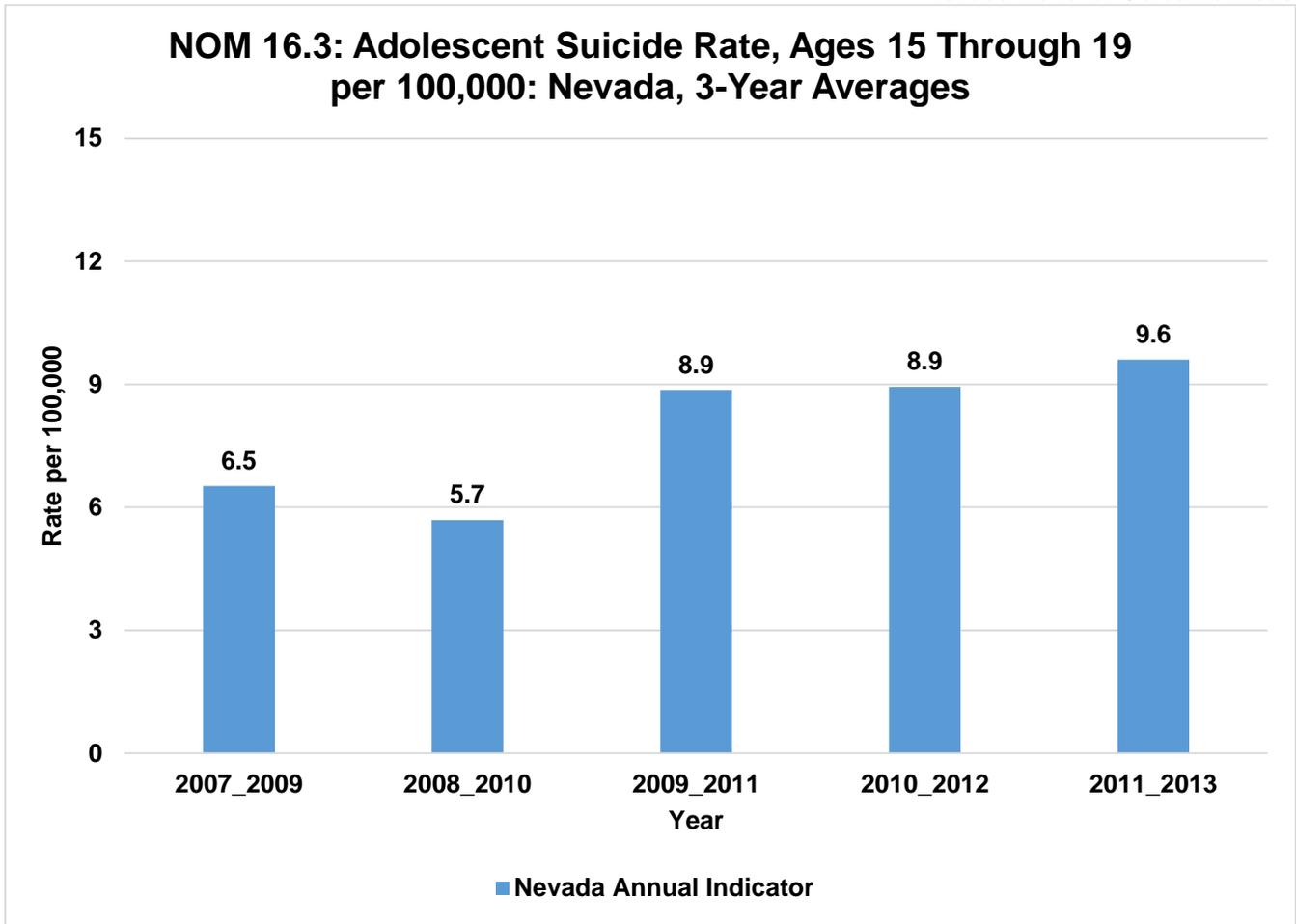


NOM 16.2: Motor Vehicle deaths among adolescents aged 15-19 has been declining in Nevada over the years. This indicator is related to HP 2020 Objective IVP-13 and the target is 12.4 deaths per 100,000. Nevada's three-year averages for 2009-2011, 2010-2012, and 2011-2013 met and surpassed this target.

Source: NVSS Mortality File

Data notes (FAD Resource Document):

Due to the relatively small number of deaths, total estimates are shown with three-year data while estimates by stratifiers are shown with five-year data. However, trends are mitigated with three-year data where each estimate shares 67% (2/3) of the data with the next estimate. Standard statistical tests that assume independence should not be used when comparing overlapping 3-year estimates; significance will be exaggerated without accounting for dependence. Urban/rural residence and race/ethnicity denominators are not available for territories.

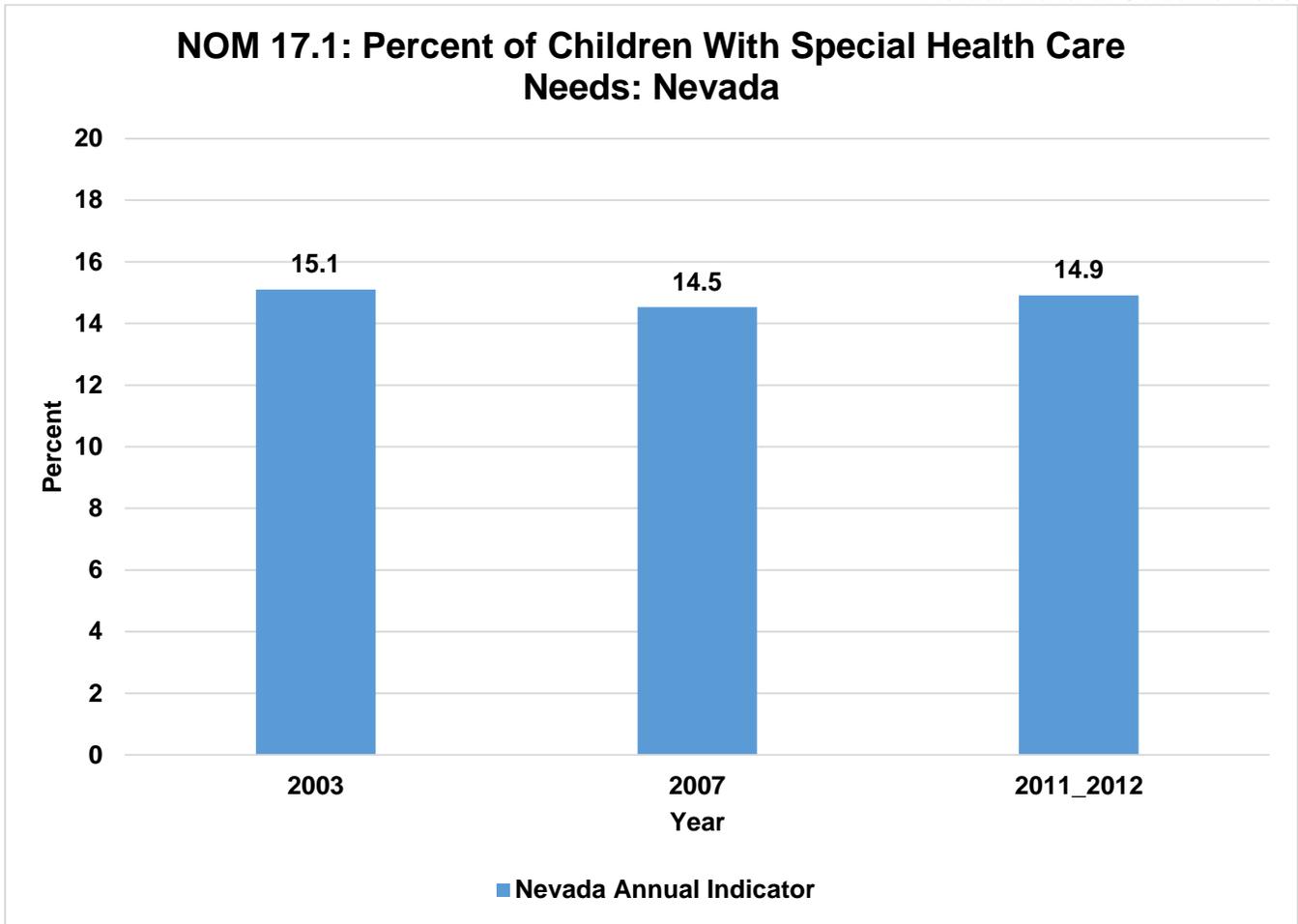


NOM 16.3: The three-year averages indicate that Nevada’s adolescent suicide rates are not improving. This indicator is related to two Mental Health and Mental Disorders (MHMD) Objectives 1 (reduce the suicide rate, target 10.2 suicides per 100,000 population) and 2 (reduce suicide attempts by adolescents, target: 1.7 suicide attempts per 100).

Source: NVSS Mortality File

Data notes (FAD Resource Document):

Due to the relatively small number of deaths, total estimates are shown with three-year data while estimates by stratifiers are shown with five-year data. However, trends are mitigated with three-year data where each estimate shares 67% (2/3) of the data with the next estimate. Standard statistical tests that assume independence should not be used when comparing overlapping 3-year estimates; significance will be exaggerated without accounting for dependence.

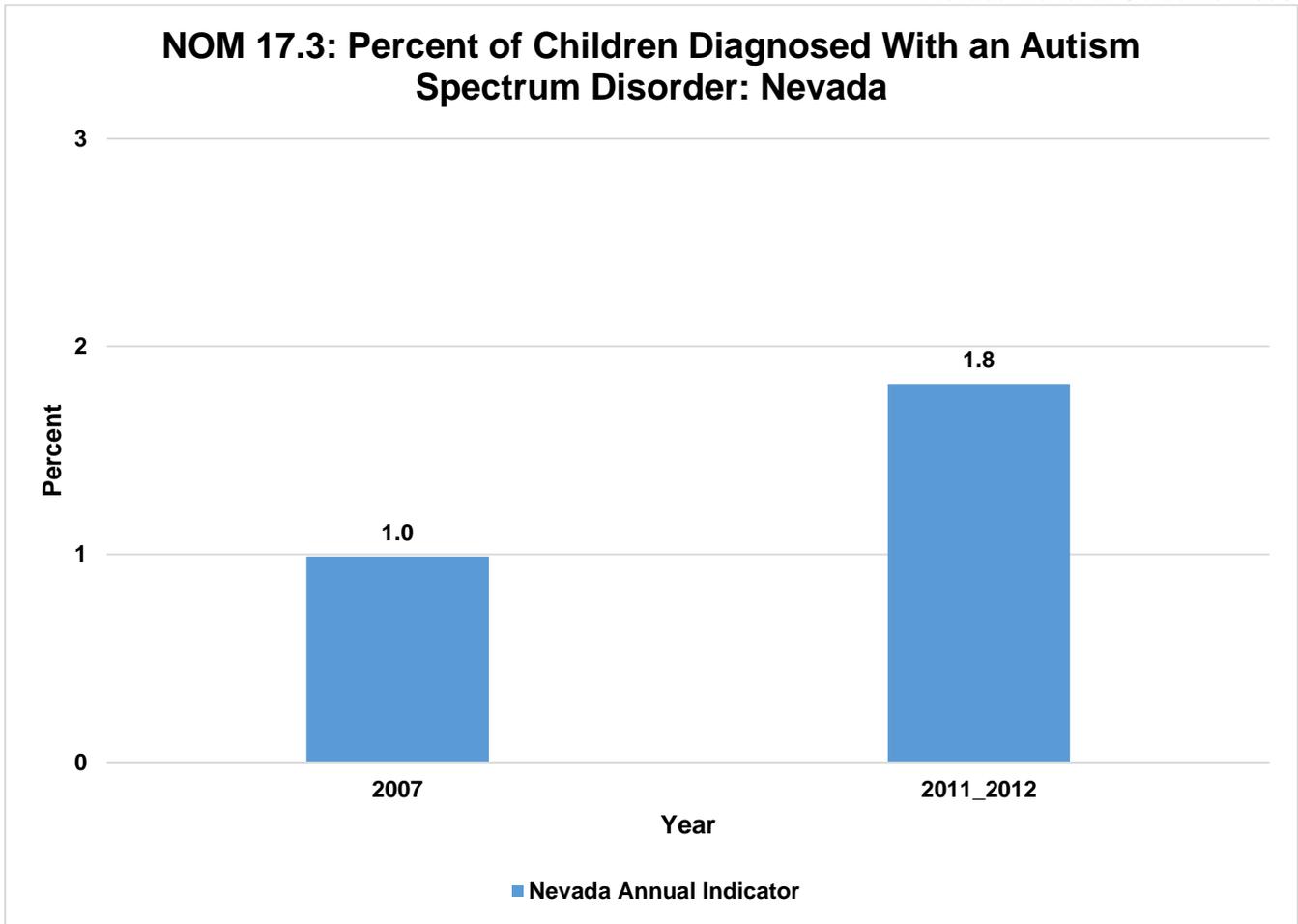


NOM 17.1: The percent of children with special health care needs (CSHCN) in Nevada has remained about the same since 2003. The prevalence of CSHCN in Nevada is similar to that of the nation which was between 12-18% over the same time period. This indicator tracks the percent of children and youth with special health care needs, autism spectrum disorder (ASD), and attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD).

Source: National Survey of Children's Health (NSCH)

Data notes (FAD Resource Document):

In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time. The estimates, numerators, and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children by state. Standard errors account for the complex survey design. Certain categories of race/ethnicity (American Indian/Alaska Native, Asian, and Native Hawaiian/Other Pacific Islanders), parental educational attainment (Some College, College), and urban/rural residence were obtained from restricted access files at the National Center for Health Statistics' Research Data Center and were suppressed to protect confidentiality if the unweighted numerator was less than 5.

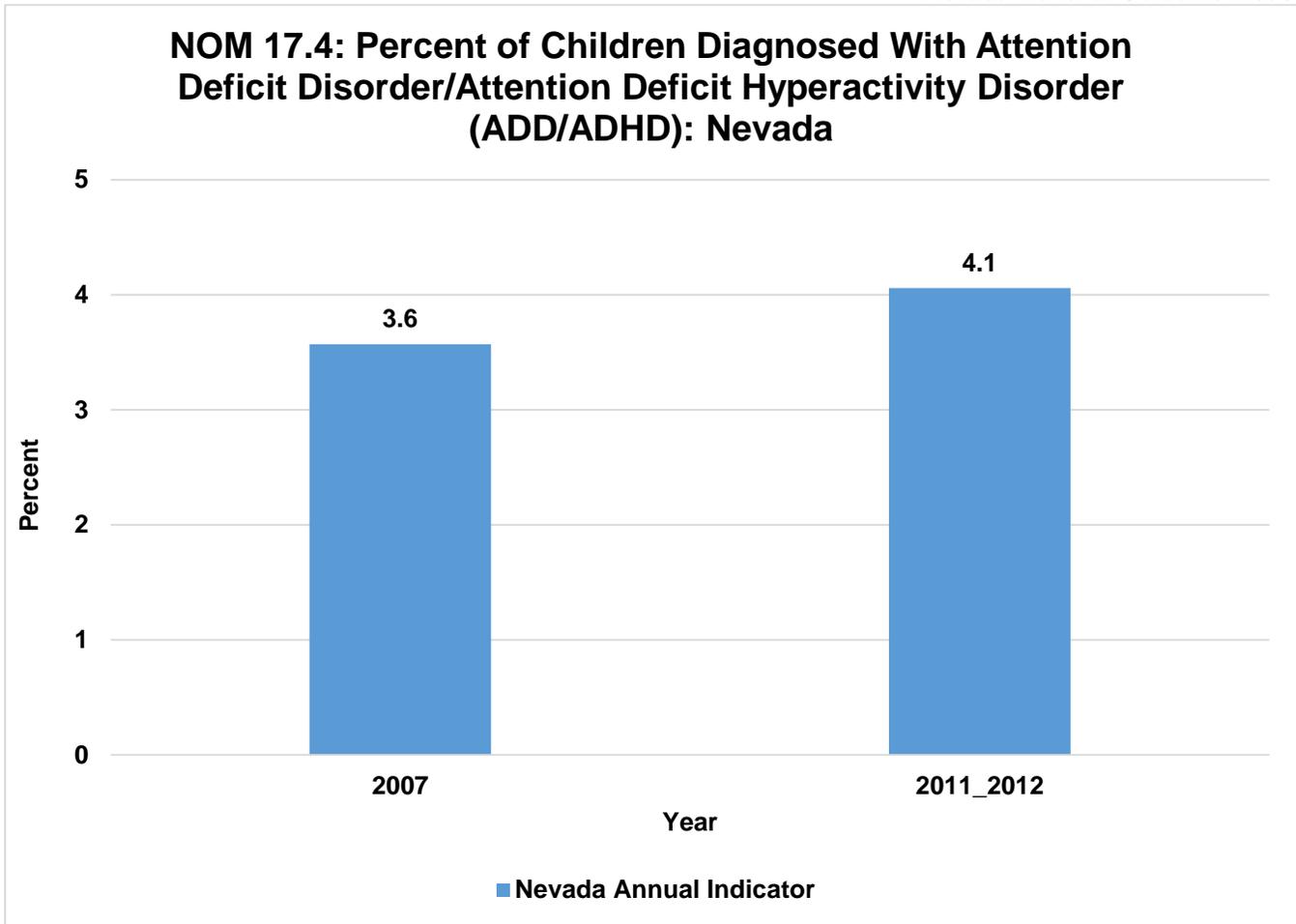


NOM 17.3: There was no significant change in the percent of children diagnosed with an Autism Spectrum Disorder in Nevada between 2007 and 2011-2012. There is no HP 2020 Objective for this indicator.

Source: NSCH

Data notes (FAD Resource Document):

The survey items on current chronic conditions were added in 2007 and are only available at two time points. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time. The estimates, numerators, and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children by state. Standard errors account for the complex survey design. Certain categories of race/ethnicity (American Indian/Alaska Native, Asian, and Native Hawaiian/Other Pacific Islanders), parental educational attainment (Some College, College), and urban/rural residence were obtained from restricted access files at the National Center for Health Statistics' Research Data Center and were suppressed to protect confidentiality if the unweighted numerator was less than 5.

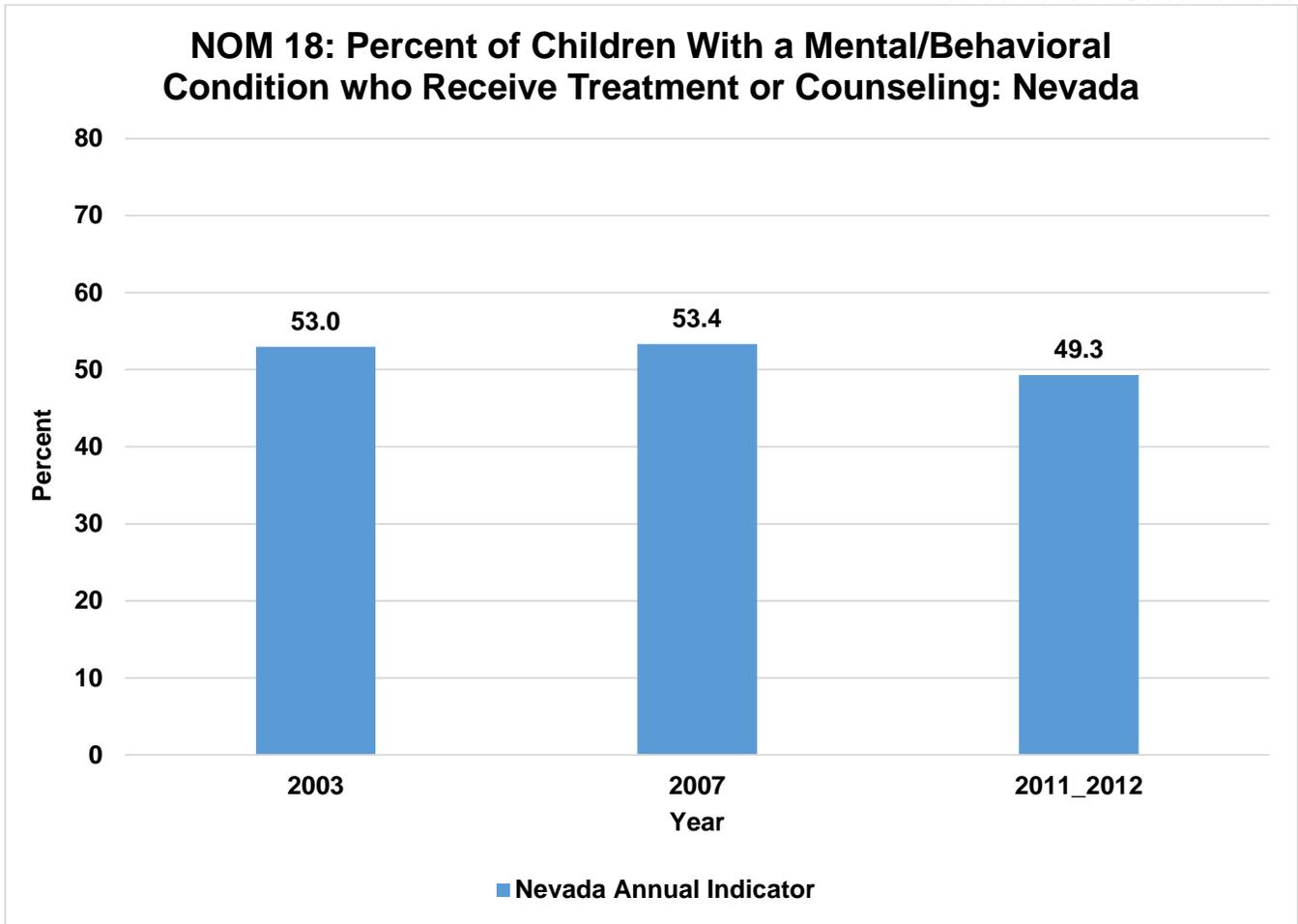


NOM 17.4: The percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) in Nevada increased by 14 percent from 3.6% in 2007 to 4.1% in 2011/2012. The National Survey of Children's Health changed the methodology (from a landline-only sample to a dual-frame sample including landlines and cell phones) in 2011/2012 and this factor should be considered when interpreting this data. There is no HP 2020 Objective for this indicator.

Source: NSCH

Data notes (FAD Resource Document):

The survey items on current chronic conditions were added in 2007 and are only available at two time points. In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time. The estimates, numerators, and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children by state. Standard errors account for the complex survey design. Certain categories of race/ethnicity (American Indian/Alaska Native, Asian, and Native Hawaiian/Other Pacific Islanders), parental educational attainment (Some College, College), and urban/rural residence were obtained from restricted access files at the National Center for Health Statistics' Research Data Center and were suppressed to protect confidentiality if the unweighted numerator was less than 5.

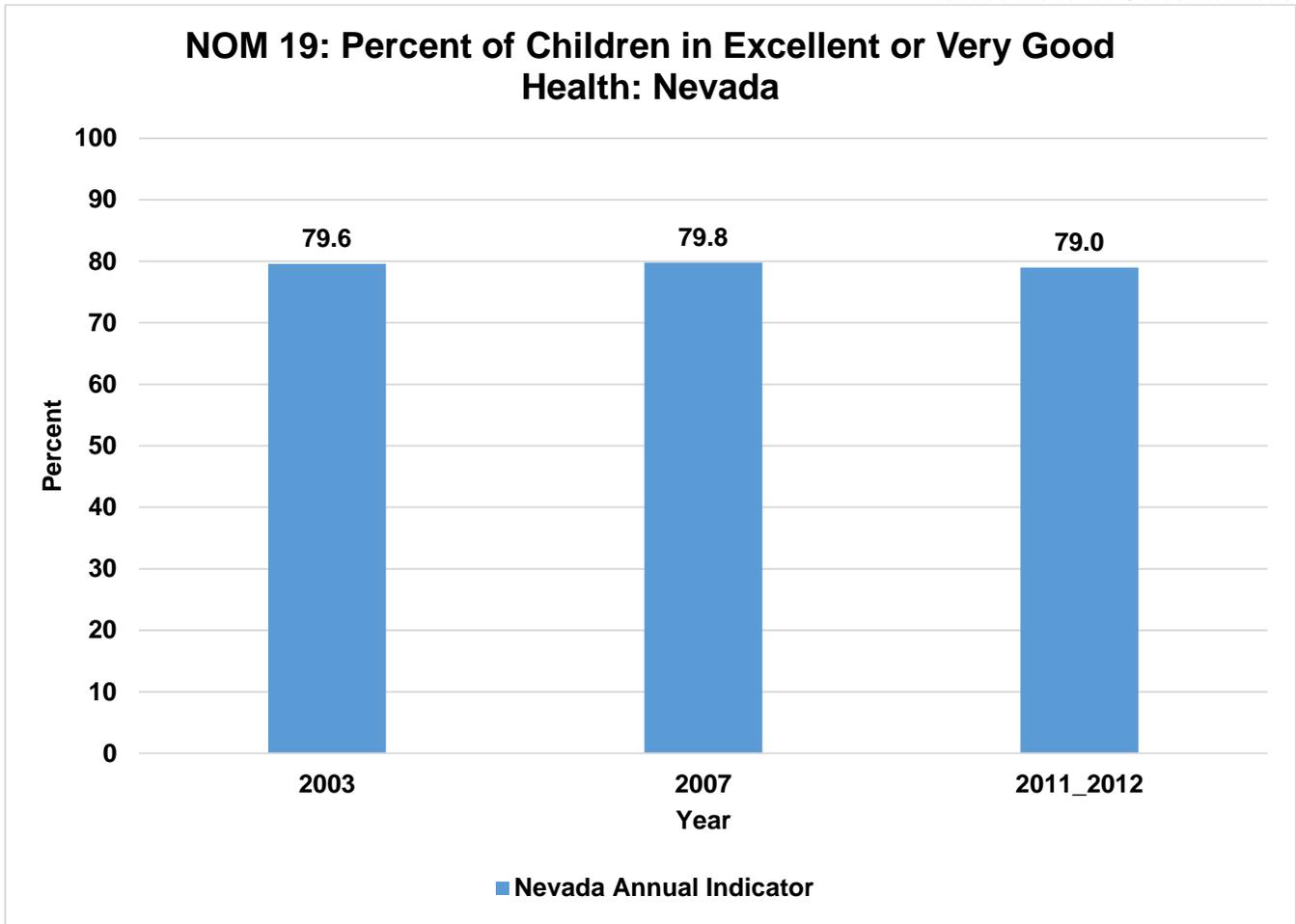


NOM 18: The percent of children with a mental/behavioral condition who receive treatment or counseling in Nevada remained steady in 2003 and 2007 but declined to 49.3% in 2011/2012. This outcome measure is related to MHMD Objective 6 and the HP 2020 target is 75%. Nevada is far below the target.

Source: NSCH

Data notes (FAD Resource Document):

In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time. The estimates, numerators, and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children by state. Standard errors account for the complex survey design. Certain categories of race/ethnicity (American Indian/Alaska Native, Asian, and Native Hawaiian/Other Pacific Islanders), parental educational attainment (Some College, College), and urban/rural residence were obtained from restricted access files at the National Center for Health Statistics' Research Data Center and were suppressed to protect confidentiality if the unweighted numerator was less than 5.

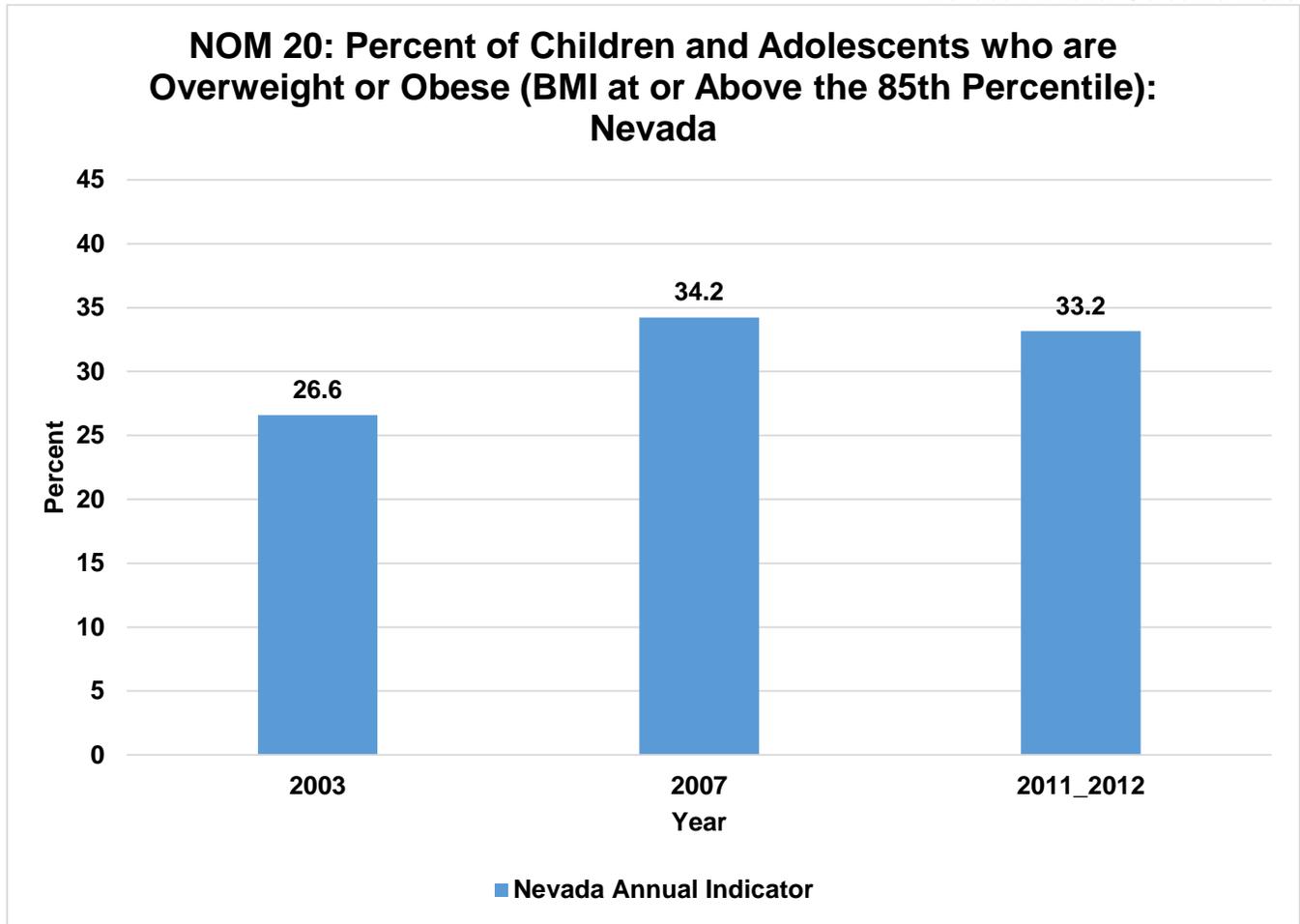


NOM 19: The percent of children in excellent or very good health in Nevada remained constant in 2003, 2007 and 2011/2012. There is no HP 2020 Objective for this goal.

Source: NSCH

Data Notes (FAD Resource Document):

In 2011-2012, the survey changed from a landline-only sample to a dual-frame sample including landlines and cell phones. Therefore, estimates may not be comparable over time. The estimates, numerators, and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children by state. Standard errors account for the complex survey design. Certain categories of race/ethnicity (American Indian/Alaska Native, Asian, and Native Hawaiian/Other Pacific Islanders), parental educational attainment (Some College, College), and urban/rural residence were obtained from restricted access files at the National Center for Health Statistics' Research Data Center and were suppressed to protect confidentiality if the unweighted numerator was less than 5.

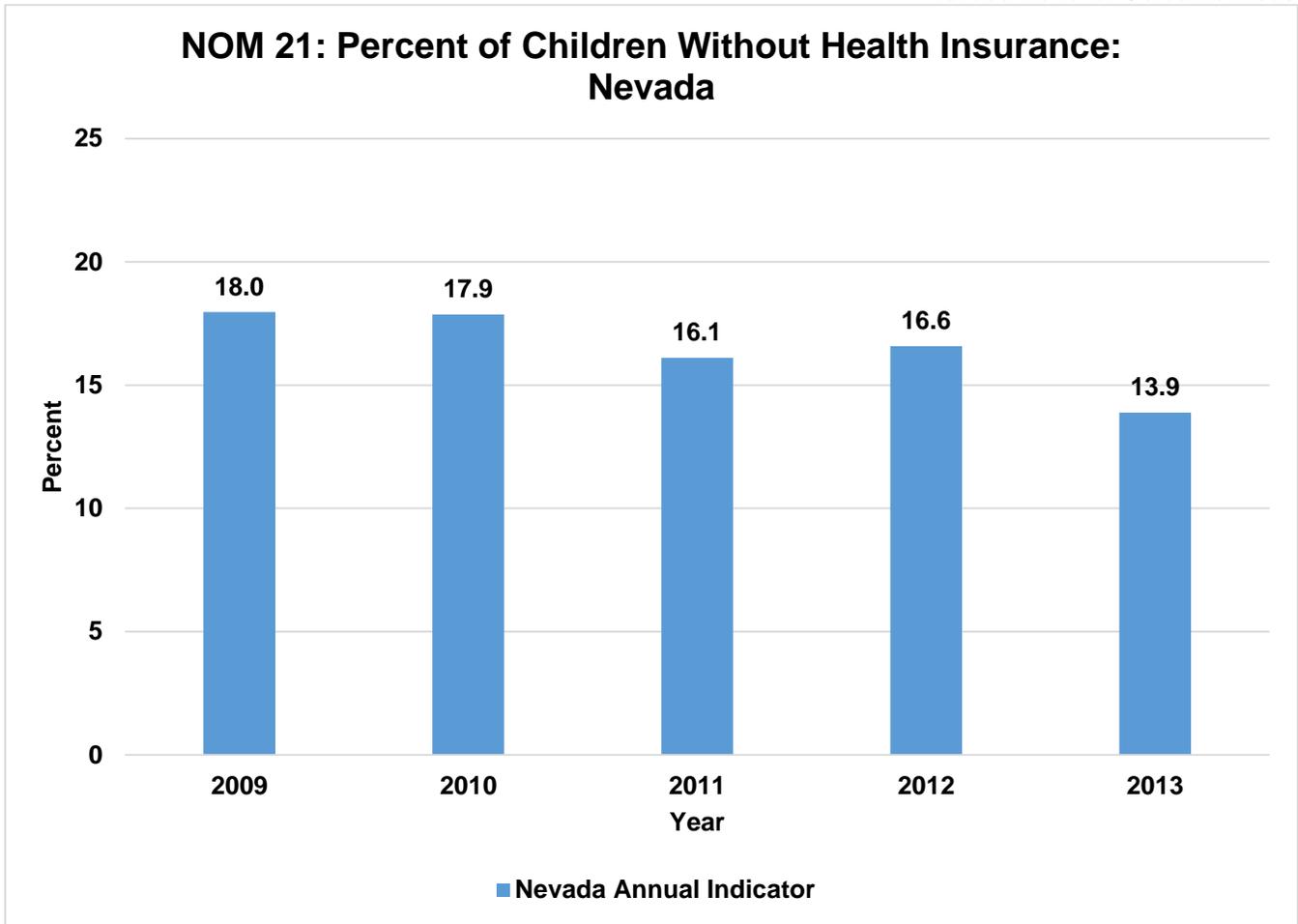


NOM 20: The percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) increased by 25 percent from 26.6% in 2003 to 33.2% in 2011/2012. The Healthy People 2020 target of 14.5% is related to two Nutrition and Weight Status objectives, NWS 10.4 (reduce the proportion of children and adolescents aged 2 to 19 years who are considered obese, and NWS 11 (prevent inappropriate weight gain in youth and adults).

Source: WIC (children 2 to 4 years), NSCH (parent report, children 10 to 17 years) and YRBSS (adolescent report, grades 9-12)

Data notes (FAD Resource Document):

Data are from the Women Infants and Children Participant and Program Characteristics file (WIC PC). WIC PC is a biennial census that includes participants who are certified to receive WIC benefits between April 1 and April 30 in 2012. Children's anthropometric measurements were taken by trained staff during required routine clinic visits. Weight was reported to the nearest 1/4 pound and height to the nearest 1/8 inch. This measure reflects sex-specific BMI-for-age \geq the 85th percentile on the CDC growth charts among WIC participants ages 2-4. Children with missing or biologically implausible height, weight, and BMI were excluded. Biological implausible z-scores are defined as height-for-age < -5.0 or > 5.0 , weight-for-age < -5.0 or > 8.0 , and BMI-for-age < -4.0 or > 8.0 . Trend data will not be available for this year's release. Data were analyzed by the Epidemiology and Surveillance Team of CDC's Obesity Prevention and Control Branch.



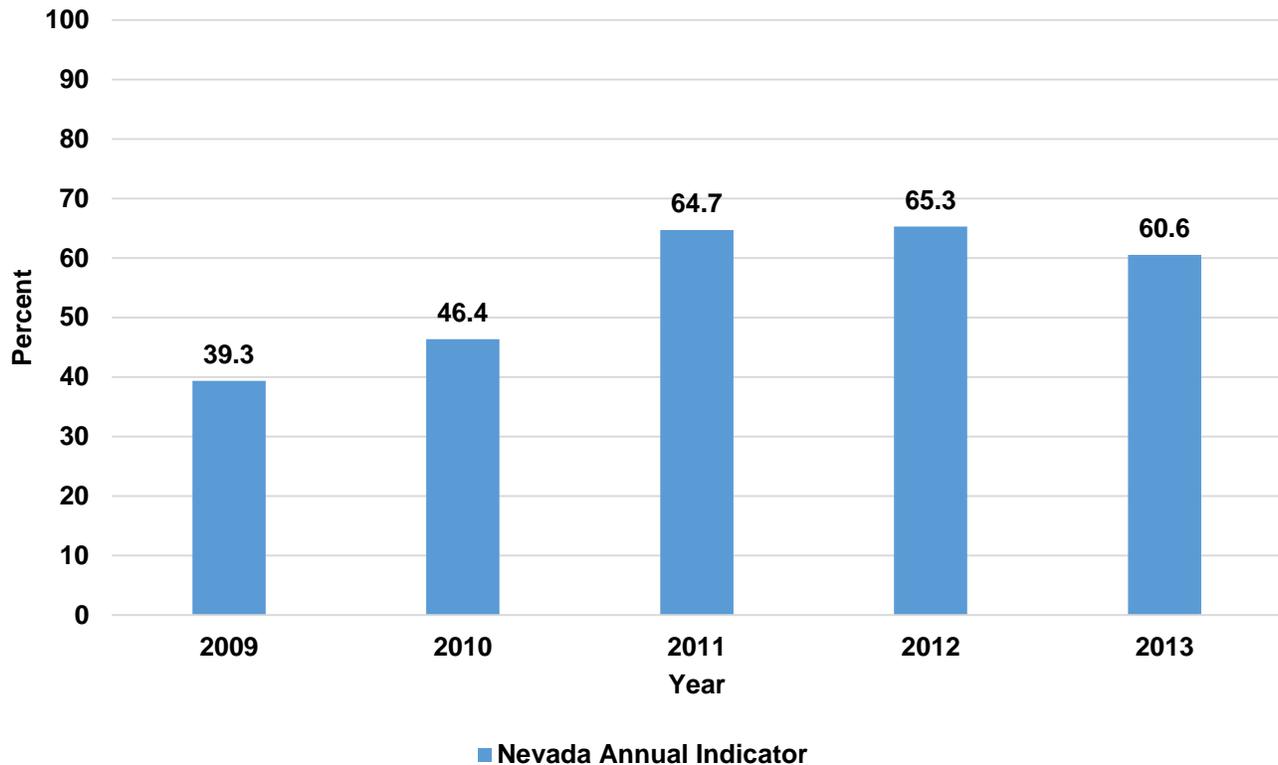
NOM 21: The percent of children without health insurance in Nevada significantly declined by 23 percent from 18% in 2009 to 13.9% in 2013. This indicator is related to HP 2020 access to health services objective 1 (increase proportion of persons with health insurance) and the HP 2020 target is 100%. More children are expected to get health insurance coverage with the Affordable Care Act implementation and Medicaid expansion in our State.

Source: American Community Survey (ACS)

Data Notes (FAD Resource Document):

The estimates, numerators, and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the population of U.S. children by state. Standard errors were estimated with the replicate weight method recommended by the US Census Bureau.

NOM 22.1: Percent of Children Ages 19 Through 35 Months, Who Have Received the 4:3:1:3(4):3:1:4 Series of Routine Vaccinations: Nevada, 2009-2013

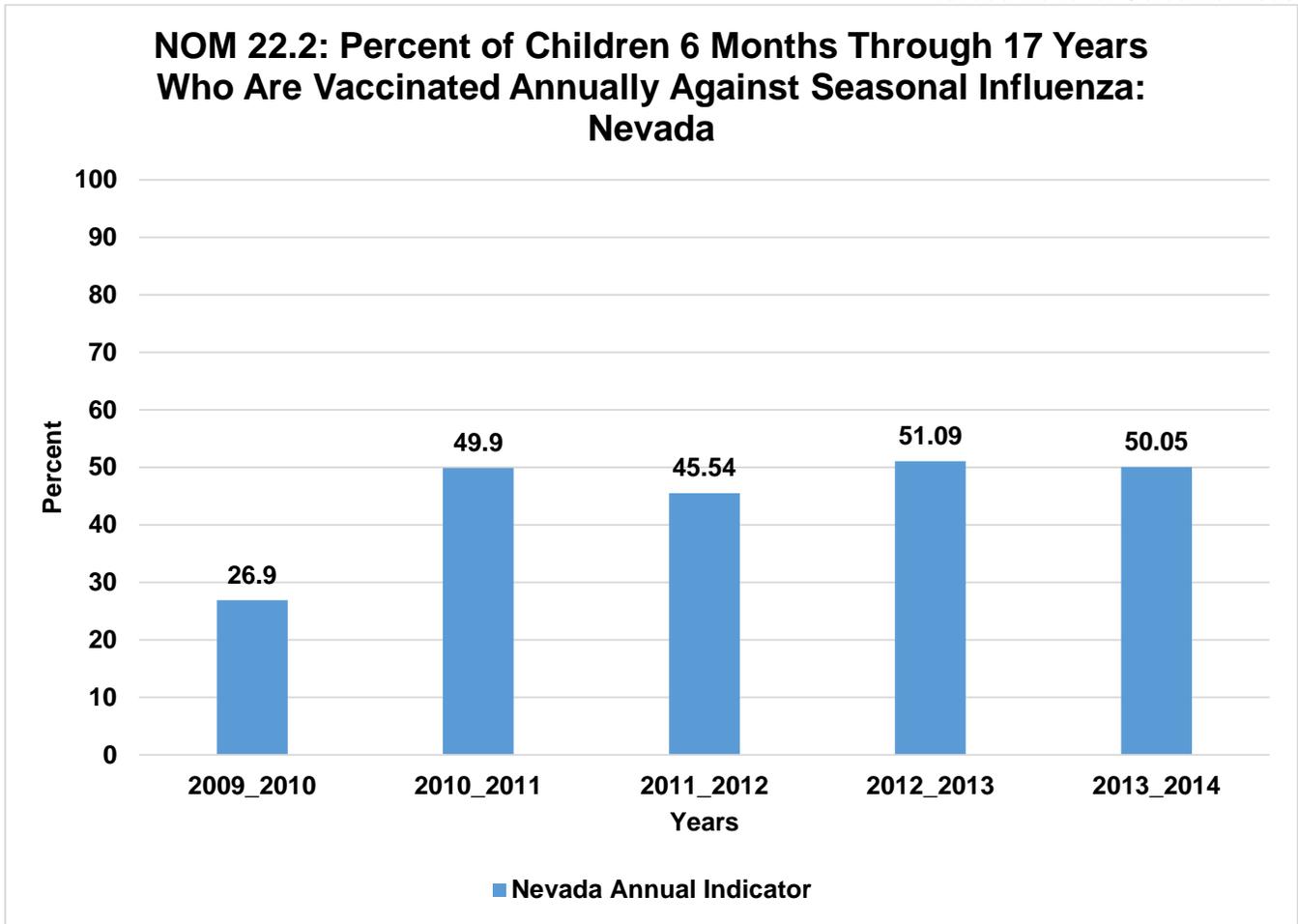


NOM 22.1: The percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations in Nevada peaked at 65.3% in 2012 but declined by seven percent to 60.6% in 2013. This indicator is related to the HP 2020 objective 8.0 (Immunization and Infectious Disease (IID)) to increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine. The target is 80% and Nevada is far below the HP 2020 objective.

Source: National Immunization Survey (NIS)

Data Notes (FAD Resource Document):

The estimates, numerators, and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children. Standard errors account for the complex survey design. Estimates by demographic stratifiers rely on three-year data to improve precision and reportability. Data users should, however, be aware that estimates from combined years of NIS data represent an average over multiple years. Although combining multiple years of NIS data will yield a larger sample size for estimation areas and states, the composition of the population in a geographic area may change over time, making interpretation of the results difficult. Furthermore, if vaccination administration schedules or vaccination coverage changes over time, the estimate of vaccination coverage for the combined time period applies to a hypothetical population that existed at the middle of the time period, making interpretation of the results more difficult. Given the use of independent samples in the NIS, it is also possible that a child could appear in more than one public-use data file. MSA status and Medicaid/CHIP insurance are not collected in territories.



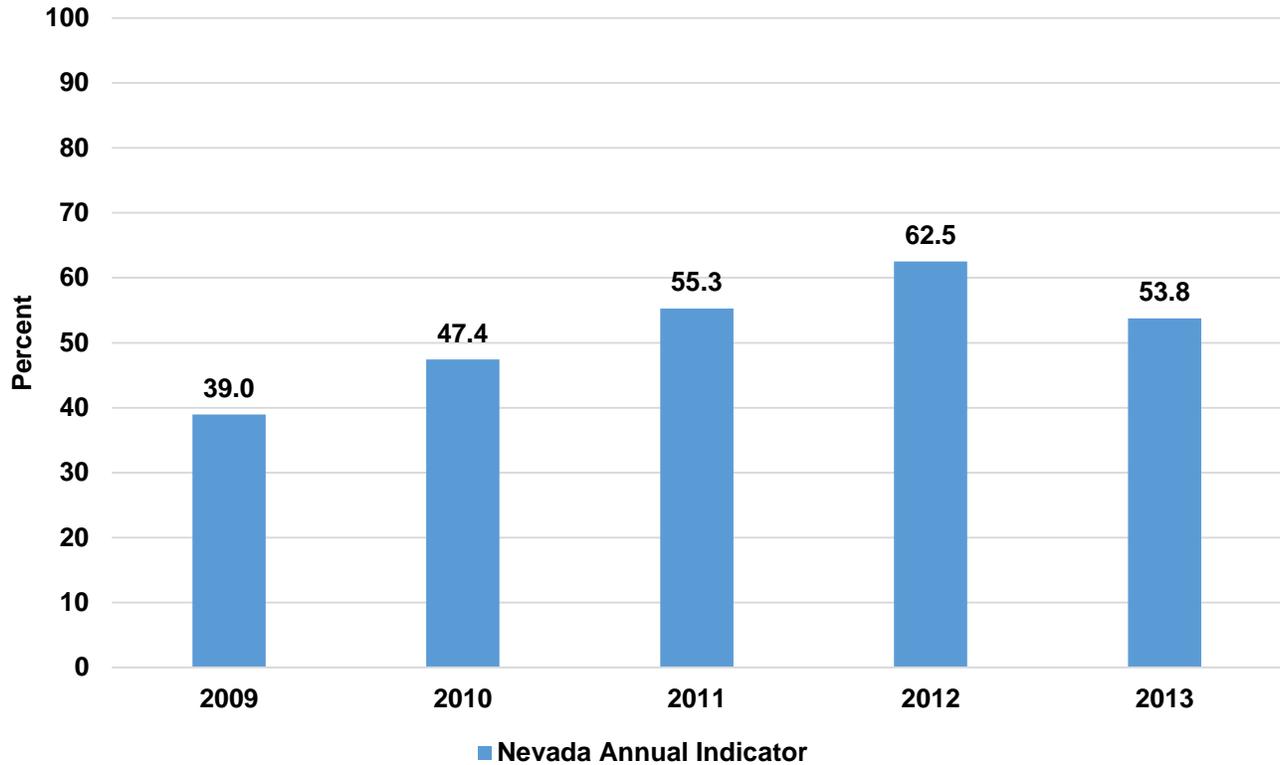
NOM 22.2: Nevada is far below the HP 2020 goal of 70% in the percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza.

Source: NIS

Data Notes (FAD Resource Document):

Coverage estimates are for persons interviewed September through June for 2010-11 and 2011-12, and October through June for 2009-10, 2012-13 and 2013-14; and who reported being vaccinated August through May for 2009-10, 2010-11 and 2011-12, and July through May for 2012-13 and 2013-14. Kaplan-Meier survival analysis was used to determine the cumulative influenza vaccination coverage (≥1 dose). Month of vaccination was imputed for respondents with missing month of vaccination data. The estimates, numerators, and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children. Standard errors account for the complex survey design.

NOM 22.3: Percent of Adolescents, Ages 13 Through 17, Who Have Received at Least One Dose of the HPV Vaccine: Nevada Females, 2009-2013

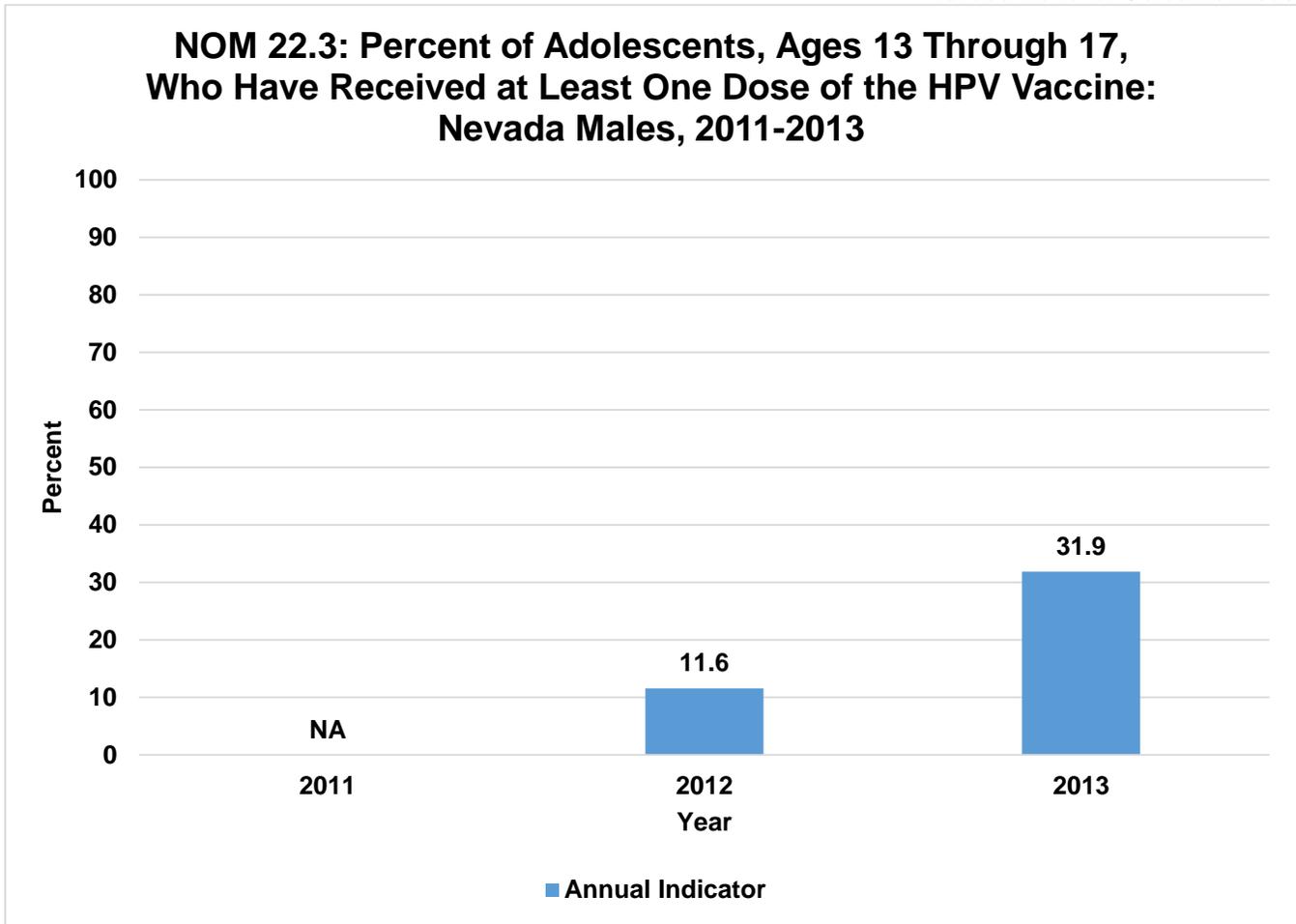


NOM 22.3: The percent of female adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine in Nevada peaked at 62.5% in 2012 but declined by 14 percent to 53.8% in 2013. This outcome measure is related to HP 20250 objective IID 11.4 (increase vaccination coverage level of 3 doses of HPV vaccine for females by age 13 to 15 years) and the target is 80%. The age group tracked by this indicator is 13-17 years.

Source: NIS

Data notes (FAD Resource Document):

The estimates, numerators, and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children. Standard errors account for the complex survey design. Estimates by demographic stratifiers rely on three-year data to improve precision and reportability. Data users should, however, be aware that estimates from combined years of NIS data represent an average over multiple years. Although combining multiple years of NIS data will yield a larger sample size for estimation areas and states, the composition of the population in a geographic area may change over time, making interpretation of the results difficult. Furthermore, if vaccination administration schedules or vaccination coverage changes over time, the estimate of vaccination coverage for the combined time period applies to a hypothetical population that existed at the middle of the time period, making interpretation of the results more difficult. Given the use of independent samples in the NIS, it is also possible that a child could appear in more than one public-use data file. While HPV was licensed for use in males in 10/2009, a routine recommendation for use in boys was not published by the Advisory Committee on Immunization Practices until 2011. Given this, US national and state level HPV coverage for males is only reported for 2011-2013. MSA status and Medicaid/CHIP insurance are not collected in territories.

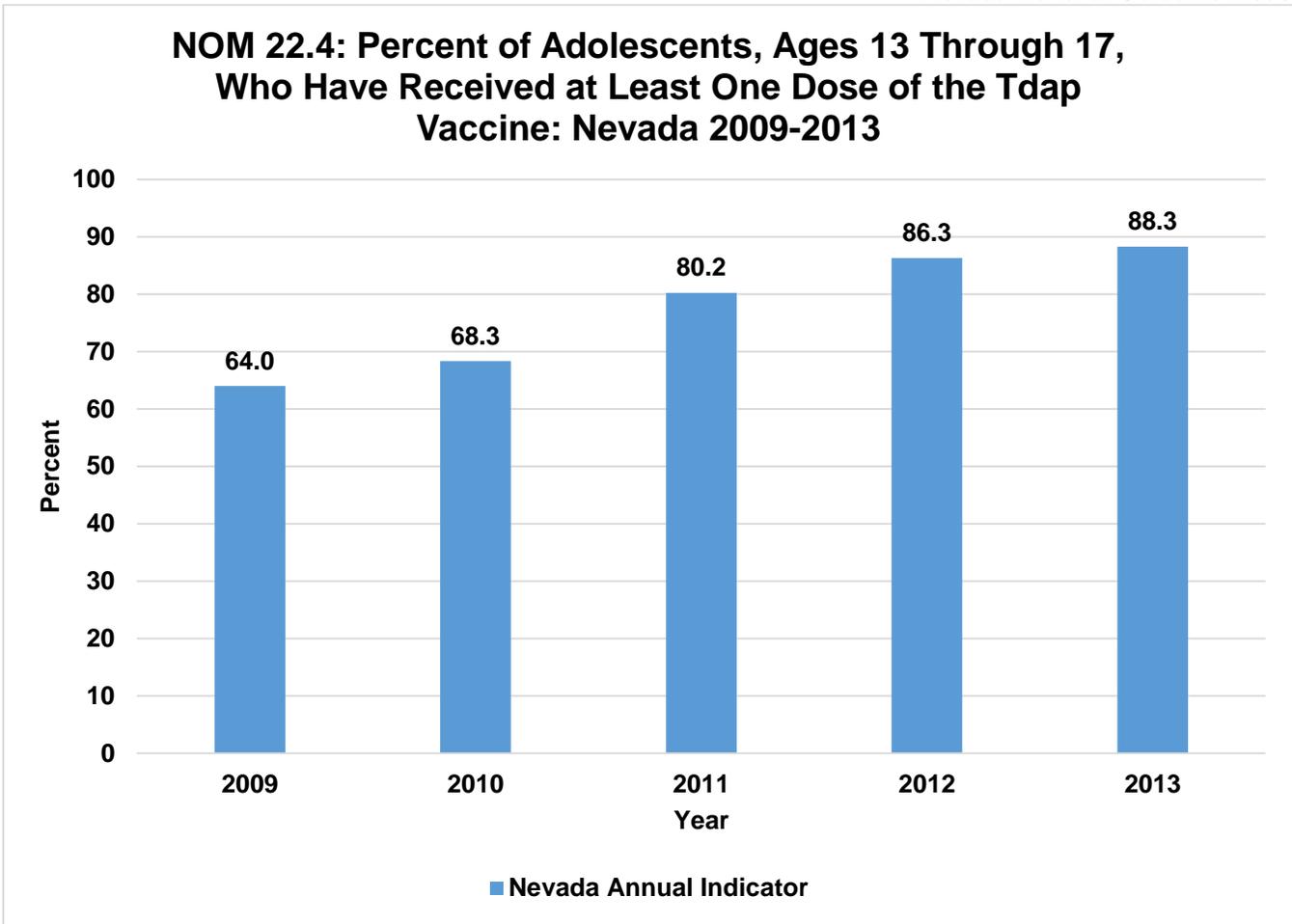


NOM 22.3: The percent of male adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine in Nevada significantly increased from 11.6% in 2012 to 31.9 in 2013. Similar to national trends, male adolescents are less likely than female adolescents to get the HPV vaccine.

Source: NIS

Data notes (FAD Resource Document):

The estimates, numerators, and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children. Standard errors account for the complex survey design. Estimates by demographic stratifiers rely on three-year data to improve precision and reportability. Data users should, however, be aware that estimates from combined years of NIS data represent an average over multiple years. Although combining multiple years of NIS data will yield a larger sample size for estimation areas and states, the composition of the population in a geographic area may change over time, making interpretation of the results difficult. Furthermore, if vaccination administration schedules or vaccination coverage changes over time, the estimate of vaccination coverage for the combined time period applies to a hypothetical population that existed at the middle of the time period, making interpretation of the results more difficult. Given the use of independent samples in the NIS, it is also possible that a child could appear in more than one public-use data file. While HPV was licensed for use in males in 10/2009, a routine recommendation for use in boys was not published by the Advisory Committee on Immunization Practices until 2011. Given this, US national and state level HPV coverage for males is only reported for 2011-2013. MSA status and Medicaid/CHIP insurance are not collected in territories.

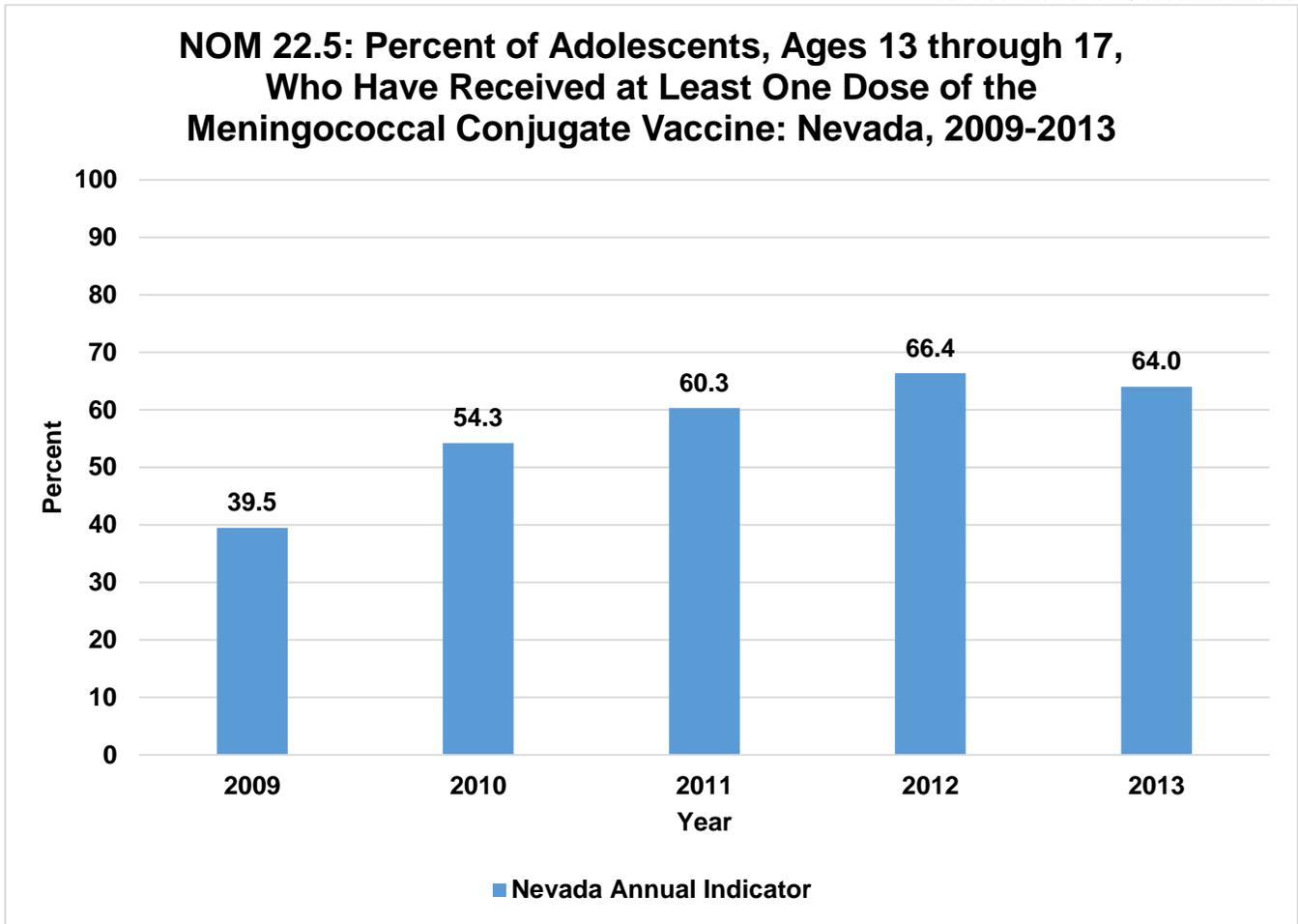


NOM 22.4: The percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine in Nevada significantly increased by 38 percent from 64.0% in 2009 to 88.3% in 2013. This outcome measure is related to IID 11.1, increase the vaccination coverage of 1 Tdap booster by age 13 to 15 years and the HP 2020 target is 80%. Nevada met this objective in 2011 and surpassed it in 2012 and 2013.

Source: NIS

Data Notes (FAD Resource Document):

Measure reflects adolescents ages 13 through 17 years who received at least one dose of Tdap vaccine on or after their 10th birthday. The estimates, numerators, and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children. Standard errors account for the complex survey design. Estimates by demographic stratifiers rely on three-year data to improve precision and reportability. Data users should, however, be aware that estimates from combined years of NIS data represent an average over multiple years. Although combining multiple years of NIS data will yield a larger sample size for estimation areas and states, the composition of the population in a geographic area may change over time, making interpretation of the results difficult. Furthermore, if vaccination administration schedules or vaccination coverage changes over time, the estimate of vaccination coverage for the combined time period applies to a hypothetical population that existed at the middle of the time period, making interpretation of the results more difficult. Given the use of independent samples in the NIS, it is also possible that a child could appear in more than one public-use data file. MSA status and Medicaid/CHIP insurance are not collected in territories.



NOM 22.5: The percent of adolescents, ages 13 through 17, who have received at least one dose of the Meningococcal Conjugate Vaccine in Nevada peaked at 66.4% in 2012 but declined to 64.0% in 2013. This outcome measure is related to the HP 2020 IID 11.3 and the target is 80%. Nevada has not met this goal since implementation in 2011, despite a rise in vaccination coverage since 2009.

Source: NIS

Data Notes (FAD Resource Document):

The estimates, numerators, and denominators presented are weighted to account for the probability of selection, non-coverage, non-response, and adjusted to reflect the non-institutionalized population of U.S. children. Standard errors account for the complex survey design. Estimates by demographic stratifiers rely on three-year data to improve precision and reportability. Data users should, however, be aware that estimates from combined years of NIS data represent an average over multiple years. Although combining multiple years of NIS data will yield a larger sample size for estimation areas and states, the composition of the population in a geographic area may change over time, making interpretation of the results difficult. Furthermore, if vaccination administration schedules or vaccination coverage changes over time, the estimate of vaccination coverage for the combined time period applies to a hypothetical population that existed at the middle of the time period, making interpretation of the results more difficult. Given the use of independent samples in the NIS, it is also possible that a child could appear in more than one public-use data file. MSA status and Medicaid/CHIP insurance are not collected in territories.