

2017

# Children's Legislative Briefing Book



*A collaborative effort between:*



Children's  
Advocacy  
ALLIANCE

Nevada Institute For Children's Research & Policy

**NICRP**

Agenda Item V B (EDUCATION)  
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# 2017 Children’s Legislative Briefing Book

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Southern Nevada Health District  
The University of Nevada Las Vegas Mental and Behavioral Health Coalition

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***"There can be no keener revelation of a society's soul than the way in which it treats its children."***

***— Nelson Mandela, Former President of South Africa***

*The purpose of this Legislative Briefing Book is to provide a snapshot of some of the most pressing issues facing Nevada's children in order to assist advocates and policymakers in creating positive changes to improve the lives of Nevada's children. While this book will not cover all of the issues our children face, it is intended to highlight some of the areas in which state policy might have an impact, particularly in the areas of education, health, and safety. This book is a compilation of statistics and policy recommendations from across the state, with contributions from practitioners, agencies, organizations, individuals and others who work with and advocate for the well-being of children in Nevada. Special Issue briefs are included in several of the areas to highlight topics of special interest, including specific recommendations for policy change at the state level. In addition, this book is aligned with the 2016 Nevada Children's Report Card which grades the State of Nevada on specific indicators in each of these areas. It is important to note that there are instances where Nevada's indicator has improved, but our rank has gone down (due to other state's improving more than Nevada). Because the grades are based on Nevada's rank, this may result in a lower grade, despite improvements on the indicator.*

*Diligent efforts need to be made during the 2017 Legislative Session to improve policies, procedures and services for Nevada's children. While we have seen improvement in some areas, Nevada has continually been ranked as one of the most deficient states when it comes to statistics regarding children and social policy. Given the current economic strains on our state, it is vitally important to focus on preventing cuts to necessary programs while looking ahead to see what improvements can be made. Although most advocates and policymakers would like to create policies that provide immediate results, it is important to realize that effective social change takes time. As such, emphasis should be placed on developing quality, comprehensive systems and implementing evidence-based preventive strategies.*

*Thank you for your support – together we can improve the lives of all of Nevada's children!*

*Denise Tanata  
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# 2016 NEVADA CHILDREN’S REPORT CARD

## State Overall Grade: D

The Children’s Report Card is published biennially, and highlights where Nevada ranks in comparison to other states in regard to child development indicators and behaviors. The information is compiled by the Children’s Advocacy Alliance (CAA) utilizing current national data and statistics and provides a platform in which to effectively advocate for policy changes that benefit Nevada’s children and families.

The Children’s Report Card is a useful tool that can help strengthen the systems that support the well-being of Nevada’s children and their families. It also provides insight to help identify potential policy changes and updates that can keep kids safe and help them grow. It is important to note that there are instances where Nevada’s indicator has improved, but our rank has gone down (due to other state’s improving more than Nevada). Because the grades are based on Nevada’s rank, this may result in a lower grade, despite improvements on the indicator.

\*Economic Well-Being is a new section in the 2016 Report Card and reflects additional indicators that impact Health, Safety and Education.

### 2016 Summary of Grades

#### HEALTH: D

Access to Health Care	F-
Prenatal/Infant Health	C-
Immunizations	D
Childhood Obesity	B-
Dental Health	F
Mental Health	F
Sexual Health	D+

#### SAFETY: D+

Child Maltreatment	C-
Youth Homelessness	D
Juvenile Violence	D+
Child Deaths & Injuries	C-
Substance Abuse	C-

#### EDUCATION: F

School Readiness	F
Student Achievement	F
High School Completion	F
Funding	F

#### \*ECONOMIC WELL-BEING: D-

Employment	D-
Housing	D
Poverty	C-
Income	F+

How Grades are Determined: By State Ranking (Where Available)

1-3 = A+	11-13 = B+	21-23 = C+	31-33 = D+	41-43 = F+
4-7 = A	14-17 = B	24-27 = C	34-37 = D	44-47 = F
8-10 = A-	18-20 = B-	28-30 = C-	38-40 = D-	48-51 = F-

# Education

## 2017

“A good education helps us make sense of the world and find our way in it.”

- Mike Rose

### Education Overview

1. School Readiness
2. Student Achievement
3. High School Completion
4. Funding

## EDUCATION OVERVIEW

### Nevada Children's Report Card Grade: F

Investing in quality education affords our children with critical skills and tools to provide for themselves and for their future families by increasing their ability to create opportunities for employment, reducing the spread of communicable diseases, reducing mother and infant mortality, and improving overall health. Additionally, an increase in the years of education our youth receive has been shown to lower the rate at which youth enter the criminal justice system in adulthood.<sup>1</sup>

In 2015, the Governor proposed and the Nevada State Legislature passed nearly 30 bills aimed at improving Nevada's education system. These included expansion of full-day kindergarten and Zoom schools, establishment of Victory schools, reorganization of the Clark County School District and numerous other policies aimed at improving the infrastructure and quality of education in Nevada. While the results of these reforms remain to be seen, Nevada's education system remains largely underfunded and thus struggles to prepare all students to be successful in their endeavors post high school.

There are several areas within education which need improvement and contribute to the Overall Children's Education Grade of F, which the state received on the 2016 Children's Report Card. Details in each of these areas are provided in the sections below in addition to recommendations to make improvements in the state. These areas include:

1. **School Readiness**
2. **Student Achievement**
3. **High School Completion**
4. **Funding**

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<sup>1</sup> "The State of America's Children® 2014 Report." Children's Defense Fund, n.d. Web. 30 Aug. 2016. <<http://www.childrensdefense.org/library/state-of-americas-children/>>.

# 1. SCHOOL READINESS

## Nevada Children’s Report Card Grade: F

The school readiness grade is based on preschool enrollment, availability, and spending per capita. Nevada is currently ranked 50<sup>th</sup> in the nation for preschool enrollment with only 32.8% of 3- and 4-year olds enrolled. Of the 32.8% of enrolled students, only 12% are enrolled in state preschool, special education or Head Start programs.<sup>2</sup> Low enrollment is due in part to state spending on preschool, which is currently \$46.35 per capita in Nevada, compared to the national average of \$773.63.<sup>3</sup>

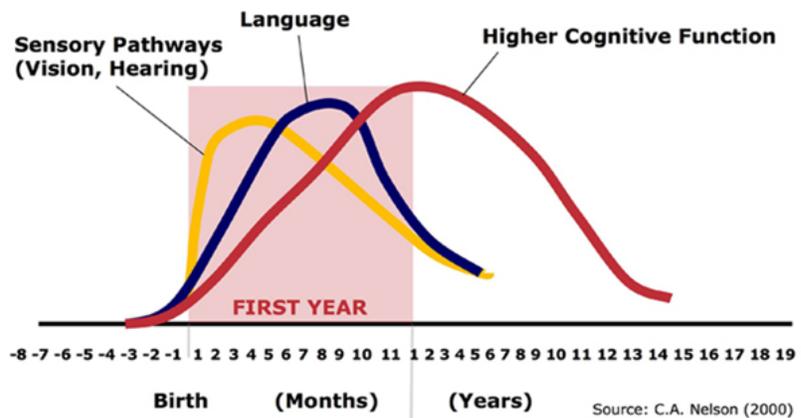
Every child in Nevada deserves the opportunity to enter school ready to learn. Nevada is in need of a comprehensive early childhood system that supports families by making sure they have high quality options for their children’s early care and learning—whether their children spend their days at home, in formal child care, or with family and friends. Providing children with the right start will lead to less intervention and remediation in later grades – ultimately resulting in increased rates of graduation and success in adulthood.

Experiences during the first five years of a child’s life are crucial to their development and can be indicative of future success due to early brain development and growth. For example, in the first few years of a child’s life, 700 new neural connections are formed every second. These connections are dependent upon an interaction of genes as well as the child’s environment and are the base structures which all future learning, behavior, and health are dependent upon.<sup>4</sup>



Center on the Developing Child  
HARVARD UNIVERSITY

### Human Brain Development Neural Connections for Different Functions Develop Sequentially



Given that a child’s development is quite extensive during the first few years of life, it is vital that they are exposed to high quality early learning experiences.

<sup>2</sup> The National Institute for early Education Research, “The State of Preschool 2015”  
<http://nieer.org/sites/nieer/files/2015%20Yearbook.pdf#/1/> (2015)

<sup>3</sup> Ibid.

<sup>4</sup> Center on the Developing Child-Harvard University, “Five Numbers to Remember About Early Childhood Development”  
[http://developingchild.harvard.edu/resources/multimedia/interactive\\_features/five-numbers/](http://developingchild.harvard.edu/resources/multimedia/interactive_features/five-numbers/)

“Several decades of research clearly demonstrate that high quality; developmentally appropriate early childhood programs produce short- and long-term positive effects on children's cognitive and social development. Specifically, children who experience high-quality stable child care engage in more complex play, demonstrate more secure attachments to adults and other children, and score higher on measures of thinking ability and language development. High quality child care can predict academic success, adjustment to school, and reduced behavioral problems for children in first grade. Studies demonstrate that children's success or failure during the first years of school often predicts the course of later schooling. A growing body of research indicates that more developmentally appropriate teaching in preschool and kindergarten predicts greater success in the early grades.”<sup>5</sup>

**“The first five years have so much to do with how the next 80 turn out.”**

- Bill Gates Sr., Co-Chair of the Bill and Melinda Gates Foundation

## **RECOMMENDATIONS FOR IMPROVEMENT:**

- *Increase access to high quality early childhood education for all children - birth through kindergarten - in Nevada.*
  - *Increase state funding toward subsidy programs. Currently Nevada is only serving 4% of the eligible population. The high cost of early childhood education programs is a barrier in the community. Increases in subsidy would increase access for Nevada's most vulnerable children.*
  - *In addition, current market rates should be used to determine subsidy reimbursements. The Child Care Development and Block Grant (CCDBG) mandates that states review the current market rate every two years, but does not require states to set the reimbursement rate based on the results. Nevada must legislatively mandate setting the reimbursement rate to the most recent market rate every two years to ensure equal access to quality early childhood education programs.*
- *Continue to support investments in programs that assess quality of care, such as the Silver State Stars Quality Rating Improvement System.*
  - *Require childhood subsidies to be used at child care programs participating in the Nevada Silver State Stars Quality Rating and Improvement System (QRIS) to ensure children are receiving high quality care. Currently, child care subsidies may be used at any licensed program and, in some instances, unlicensed homes. These programs may do more harm than good to a child's development if they do not promote a safe and enriching environment.*

*Additional information is available in the Early Education and Care Imperatives for Nevada developed by the Nevada Education for the Association of Young Children.<sup>6</sup>*

<sup>5</sup> The National Association for the Education of Young Children, “A Call for Excellence in Early Education,” <http://www.naeyc.org/policy/excellence>

<sup>6</sup> Nevada Association for the Education of Young Children 2017 Public Policy Agenda <https://nevaeyc.org/policy/>

## SCHOOL READINESS – SPECIAL ISSUE

### Child Care Background Checks

In Nevada, any individual working at a licensed child care facility must pass a comprehensive background and personal history check. They must also complete a child abuse and neglect screening through the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child (CANS Check). The personal history and background check is used to determine if an individual has any federal or state convictions of the following crimes:

- (a) Murder, voluntary manslaughter or mayhem;
- (b) Any other felony involving the use of a firearm or other deadly weapon;
- (c) Assault with intent to kill or to commit sexual assault or mayhem;
- (d) Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
- (e) Abuse or neglect of a child or contributory delinquency;
- (f) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;
- (g) Abuse, neglect, exploitation, isolation or abandonment of older persons or vulnerable persons, including, without limitation, a violation of any provision of NRS 200.5091 to 200.50995, inclusive, or a law of any other jurisdiction that prohibits the same or similar conduct; or
- (h) Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property within the immediately preceding 7 years.<sup>7</sup>

The CANS check shows any cases of abuse and neglect that have been substantiated by a child welfare agency within the state of Nevada, not all of which lead to a criminal conviction. This potentially allows an individual from another state, who has a substantiated instance of abuse or neglect, to move to Nevada and work with children in a child care facility. The state currently has no mechanism to do a CANS check for the states that the individual has previously lived.

#### Substantiated Abuse or Neglect

The findings are classified as “Substantiated,” meaning that a report made pursuant to NRS 432B.220 was investigated and that credible evidence of the abuse or neglect exists.

To help remedy this issue, the Child Care and Development Block Grant (CCDBG) – Congressionally reauthorized in 2014 – requires all states to conduct additional background, personal history and CANS checks for all employees of a licensed child care facility in each state where such staff member has resided during the preceding 5 years.

<sup>7</sup> "NRS: CHAPTER 432A - SERVICES AND FACILITIES FOR CARE OF CHILDREN." N.p., n.d. Web. 30 Aug. 2016. <<https://www.leg.state.nv.us/nrs/NRS-432A.html>>.

The reauthorized CCDBG also requires background and personal history checks and CANS checks for license-exempt providers caring for children on Nevada's child care subsidy program. Additionally, it allows for state discretion relating to individuals who have a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug. According to the Office of Child Care – An Office of the Administration for Children and Families – the law provides flexibility for States in regard to individuals disqualified due to a felony drug offense. The State, at its option, may allow for a review process through which the State may determine an individual still eligible for employment.<sup>8</sup>

## **Recommendations:**

Nevada should take the necessary steps to come into compliance with CCDBG background check requirements. This includes:

- Require child care licensing to complete full state and federal background and personal history checks, as well as state based child abuse and neglect registry checks in Nevada and each state where such staff member resided during the preceding 5 years, as applicable for every licensed provider and all license-exempt providers who participate in Nevada's child care subsidy program.
- Review current regulations related to individuals who have a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug. Pending review, create a process through which the State may determine if an individual is eligible for employment at a licensed child care facility.

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<sup>8</sup> "CCDF Reauthorization Frequently Asked Questions." Office of Child Care: An Office for the Administration for Children & Families, n.d. Web. 30 Aug. 2016. <<http://www.acf.hhs.gov/occ/resource/ccdf-reauthorization-faq>>.

## SCHOOL READINESS – SPECIAL ISSUE

### Child Care Subsidies

In 2014, the Child Care and Development Block grant (CCDBG) – also known as the Child Care Development Fund – was reauthorized for the first time since 1996. Historically, the CCDBG aimed to reduce the high financial burden of child care on working parents by providing a subsidy to offset a portion of the costs.

- The average cost of care in licensed centers in Nevada ranges from \$10,324 for an infant to \$8,792 for preschoolers (age 3-5).<sup>9</sup>
- A single parent with an infant and preschooler making \$1,674.17 a month (100% of poverty) would have to spend 95% of the parent’s income on center-based care. If the same family received child care subsidy, the parent would receive an average assistance amount of \$14,105 (\$7,930 for infants and \$6,175 for preschoolers – based on current reimbursement rates). This would still require the single parent to cover the \$5,011 difference, which is 25% of their annual income.
- A family with an infant and preschooler making \$4,041.67 a month (200% of poverty) would have to spend 39% of their income on center-based care for their children.<sup>10</sup>

In Nevada, child care subsidies are provided to families with children – up to age 12 – living in poverty – up to 85% of Nevada’s median income. There are two types of subsidies provided to families, mandatory and discretionary. Mandatory subsidies are provided to children who have a parent participating in the New Employees of Nevada (NEON) Program; the state is required to provide subsidies to all NEON families who apply. Discretionary subsidies are provided to all other eligible at-risk families based upon available funding. Since its reauthorization, the CCDBG has broadened its

focus to not only assist parents with funding, but also to ensure the children who receive the subsidies attend high quality early learning programs. To accomplish this, the reauthorization added many new – and largely unfunded – mandates. These mandates include issues related to safety, quality improvements, eligibility requirements, general processes, and payments. Overall, the following four mandates will largely affect the State’s child care subsidy program going forward:

#### Cost Comparisons

- \$61,081: Median Family Income (with children under the age of 18)
- \$10,324: Annual average cost for infant center care in Nevada
- \$8,792: Annual average cost for preschool center care in Nevada
- \$6,943: Average annual cost of UNLV/UNR tuition for an in-state undergraduate student

<sup>9</sup> Calculation provided from the Children’s Cabinet 2015 Child Care Market Price & Referral Survey, unpublished data.

<sup>10</sup> According to the 2015 Federal Poverty Guidelines, <http://ccf.georgetown.edu/wp-content/uploads/2015/01/2015-Federal-Poverty-Guidelines.pdf>

## I. Protection for Working Parents

Under the Protection for Working Parents mandate, there was a renewed focus on ensuring stability for children and families receiving subsidy. The act:

- Extends the timeframe in which a family is re-determined for eligibility from 3-months to 12-months (Sec. N.i.i)<sup>11</sup>
- Requires the state, during the redetermination period, to take into account parents irregular fluctuations in earnings (Sec. N.i.ii)<sup>12</sup>
- Establishes – before termination of benefits – a graduated phase-out of care for families whose income does not exceed 85% of the state median income (Sec. N.i.v).<sup>13</sup>

Each of these mandates ensures that once a family qualifies for care they will continue to receive a portion of the subsidy in perpetuity.

## II. Payment Practices

The Payment Practices mandate works to alleviate stress on providers who serve children receiving subsidy assistance. This mandate requires the state to amend the way it calculates a provider's reimbursement rate. Prior to the reauthorization, Nevada reimbursed a provider based on the number of days that a child actually attended. This placed additional strain on a provider, as they dedicate a slot to the child whether or not they actually attended. The new mandate requires:

The State... to implement enrollment and eligibility policies that support the fixed costs of providing child care services by delinking provider reimbursement rates from an eligible child's occasional absences due to holidays or unforeseen circumstances such as illness. (Sec. S.ii)<sup>14</sup>

By tying reimbursement payment rates to days scheduled, child care subsidy payments will become more predictable for providers. And as a result, hopefully increasing the number of quality providers who will accept subsidy reimbursements.

## III. Payment Rates

Nevada currently sets its provider reimbursement rates at 2004 market rate levels. This has forced many families receiving subsidy to use lower quality – and often times cheaper – care; as they could not afford to cover the difference between what subsidy would pay and what quality child care costs. To remedy this problem, the new mandate requires:

The State... to certify that payment rates for the provision of child care services... are sufficient to ensure equal access for eligible children to child care services that are comparable to child care services in the State. (Sec. 4.A.i)

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<sup>11</sup> "S.1086 - 113th Congress (2013-2014): Child Care and Development Block Grant Act of 2014." *Congress.gov*. N.p., n.d. Web. 30 Aug. 2016. <<https://www.congress.gov/bill/113th-congress/senate-bill/1086>>.

<sup>12</sup> *Ibid.*

<sup>13</sup> *Ibid.*

<sup>14</sup> *Ibid.*

To comply with this new requirement, Nevada may be required to update its reimbursement rates from 2004 market rates to the most current rates.<sup>15</sup> The following table shows the needed daily increase in subsidy payments per child if market rates are updated.

CHILD CARE CENTERS		Washoe	Clark	Car-Doug	Rural
<b>Infants</b>	Current Reimb Rate (2004)	\$35.00	\$31.00	\$29.00	\$27.00
	12-2015 75th Percentile Rate	\$43.59	\$48.00	\$39.19	\$35.75
	2015 / 2004 Rate Difference	\$8.59	\$17.00	\$10.19	\$8.75
<b>Toddlers</b>	Current Reimb Rate (2004)	\$30.00	\$28.00	\$24.00	\$22.00
	12-2015 75th Percentile Rate	\$39.58	\$42.00	\$35.85	\$32.50
	2015 / 2004 Rate Difference	\$9.58	\$14.00	\$11.85	\$10.50
<b>Pre-K</b>	Current Reimb Rate (2004)	\$26.00	\$23.00	\$24.00	\$22.00
	12-2015 75th Percentile Rate	\$34.00	\$39.87	\$31.50	\$36.00
	2015 / 2004 Rate Difference	\$8.00	\$16.87	\$7.50	\$14.00

During the month of September 2015, Nevada provided child care subsidies to 3,210 families which allowed a total of 5,711 children to attend child care. This was done at a cost of \$1,967,341.91 for the month. If Nevada would have paid 2015 market rates for the same month and served the same number of children and families, it would have cost the state approximately \$2,826,648 – an increase of \$859,306. Over the course of a year, for Nevada to increase the child care market rates to 2015 rates and serve the same number of families it would cost an additional \$10.3 million dollars.

#### IV. Compliance with State Licensing Requirements

The reauthorized CCDBG grant also set a new requirement for the state to certify that license-exempt child care providers who serve children on subsidy are not endangering the health, safety, or development of the children they serve (Sec. F.ii).<sup>16</sup> To satisfy this requirement, the state must now conduct background checks and on-site inspections for all providers receiving subsidy. This requirement will create the need for

<sup>15</sup> On June 13, 2016, the Administration for Children and Families of the U.S. Department of Health and Human Services sent a letter to the Nevada Department of Health and Human Services saying, "They continue to be concerned that Nevada's rates may not allow for equal access." [https://www.acf.hhs.gov/sites/default/files/occ/nevada\\_stplan\\_pdf\\_2016.pdf](https://www.acf.hhs.gov/sites/default/files/occ/nevada_stplan_pdf_2016.pdf).

<sup>16</sup> "S.1086 - 113th Congress (2013-2014): Child Care and Development Block Grant Act of 2014." *Congress.gov*. N.p., n.d. Web. 30 Aug. 2016. <<https://www.congress.gov/bill/113th-congress/senate-bill/1086>>.

approximately 10 new staff members and additional resources to conduct the checks and inspections statewide at a cost of over \$560,000 annually.<sup>17</sup>

## **Recommendations:**

These four new – largely federally unfunded – mandates have placed further strain on Nevada’s child care subsidy program. Prior to the implementation of these mandates, Nevada only served 3.21%<sup>18</sup> of its eligible population. Without a substantial investment in the program, Nevada will serve even less of its working families. These same families will then continue to struggle to provide for their children while spending up to 39% of their income, solely, on child care. Some families may also choose to leave the workforce altogether, causing additional strains on Nevada economy and other social safety net programs such as Supplemental Nutrition Assistance Program (SNAP), Homelessness and Urban Development (HUD) program, and the Temporary Assistance for Needy Families (TANF) program.

Specific recommendations include:

- Provide additional funding to increase the percentage of eligible children served by subsidies, including those children under 13 years of age who live at or below 75% of Nevada’s median income in single-earner moms, single-earner dads or dual earner households to allow them to work, seek employment, or attend school/vocational training.
- Require childhood subsidies to be used at child care programs participating in the Nevada Silver State Quality Rating and Improvement System (QRIS) to ensure children are receiving high-quality care. Currently, child care subsidies may be used at any licensed program and, in some instances, unlicensed homes. These programs may do more harm than good to a child’s development if they do not promote a safe and enriching environment.
- Ensure that child care subsidies are available for biological and foster families to support the need for high quality care for parents/foster parents who work or are in school. The low subsidy reimbursement rate and requirement for foster parents to pay the overage places additional burdens on these families. Kinship caregivers are also being denied eligibility from receiving both child-only TANF and child care subsidies for their relative’s children they are fostering.

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<sup>17</sup> Estimates provided by Children’s Cabinet and Las Vegas Urban League.

<sup>18</sup> Calculation provided from the Children’s Cabinet 2015 Child Care Market Price & Referral Survey, unpublished data.

## SCHOOL READINESS – SPECIAL ISSUE

### Child Care Tax Credits

In Nevada, over 63% of children ages 0-5 live in families where all available parents are in the workforce. These working parents face the challenge of finding quality childcare they can afford. Currently, the average annual cost of child care in licensed centers in Nevada ranges from \$10,324 for an infant to \$8,791 for preschoolers (age 3-5). These high costs cause a significant financial burden to working families, especially those in poverty. Today, a family with an infant and preschooler making \$4,041.67 a month (200% of poverty) would have to spend 39% of their income on center-based care for their children.<sup>19</sup> The high cost of child care is due to it being a market driven service: providers offer services for a price; consumers choose among those services and pay the price.<sup>20</sup>

- The average child care center generates 87% of its revenue from parent tuition, while the average institution of higher education generates only 35% from tuition and fees.<sup>21</sup>

This causes lower-income families to use the cheaper and often times lower quality care that they can afford.

To help reduce this financial burden, Nevada provides child care subsidies to families with children up to age 12 living in poverty up to 85% of Nevada's median income. Unfortunately, Nevada currently serves only 3.21% of these eligible low-income families – the lowest percentage in the nation – due to a lack of statewide investment.<sup>22</sup> This has caused many parents to leave the workforce or enroll their children in cheaper and often lower quality care.

Another opportunity to increase investments in early learning programs outside of additional state investments is through tax credits. According to the Partnership for America's Economic Success, "Allocating funds via the tax system affords the opportunity to use an already existing infrastructure to administer resources. Indeed, the Internal Revenue Service (IRS) is uniquely qualified to administer a universal, income-related, market-based benefit such as ECE financial incentives." There are many benefits to using tax credits as an early childhood education financing strategy. Tax credits are: part of a familiar system, non-stigmatizing, relatively stable and non-controversial, and conducive to the use of nontraditional ECE funding streams.<sup>23</sup>

<sup>19</sup> According to the 2015 Federal Poverty Guidelines, <http://ccf.georgetown.edu/wp-content/uploads/2015/01/2015-Federal-Poverty-Guidelines.pdf>

<sup>20</sup> Stoney, Louise, and Anne Mitchell. *Using Tax Credits to Promote High Quality Early Care and Education Services #2* (n.d.): n. pag. Partnership for America's Economic Success, 20 Nov. 2007. Web. <[http://www.earlychildhoodfinance.org/downloads/2007/StonMitch\\_UsingTaxCreditsPromoteServices\\_2007.pdf](http://www.earlychildhoodfinance.org/downloads/2007/StonMitch_UsingTaxCreditsPromoteServices_2007.pdf)>.

<sup>21</sup> Stoney, Louise, and Anne Mitchell. "Can We Use Tax Strategies to Help Finance Early Care and Education?" *Early Childhood Finance*, n.d. Web. 30 Aug. 2016. <[www.earlychildhoodfinance.org/.../TaxStrategiesCall\\_Resources\\_2006.doc](http://www.earlychildhoodfinance.org/.../TaxStrategiesCall_Resources_2006.doc)>.

<sup>22</sup> Calculation provided from the Children's Cabinet 2015 Child Care Market Price & Referral Survey, unpublished data.

<sup>23</sup> Blank, Susan, and Louise Stoney. *Tax Credits for Early Care and Education: Funding Strategy for a New Economy* (2011): n. pag. Web. <[http://opportunities-exchange.org/wp-content/uploads/OpEx\\_IssueBrief\\_Tax\\_Final1.pdf](http://opportunities-exchange.org/wp-content/uploads/OpEx_IssueBrief_Tax_Final1.pdf)>.

There are four types of tax credits that could be used to support early learning:<sup>24</sup>

1. Consumer Tax Credits – a direct reduction in the tax liability of an individual who purchases (consumes) a particular product or service. Consumer tax credits can function as market-based strategy to reinforce a merit good.
2. Business Investment Tax Credits – a direct reduction in the tax liability of a sole proprietor or corporation to offset cost of investing in the business.
3. Contribution and Community Investment Tax Credits – reduces the tax liability of an individual or business that makes a contribution to, or investment in, another business. These tax credits are typically used to raise revenue for non-profit entities and/or businesses that produce a merit good.
4. Job Development/Occupational Tax Credits - accrued to employees who work in a targeted industry who are eligible for special tax breaks.

### **Recommendations:**

It is our recommendation that Nevada create child care tax credits for businesses that either provide or give support to their employees around early learning resources or donate to an established early childhood development fund.<sup>25</sup> These early childhood tax credits should be:<sup>26</sup>

- System Building – the strategy should be integrated with the Nevada’s Quality Rating and Improvement System and child care subsidies and advance the state’s larger ECE system building approach.
- Accessible to Taxpayers – the tax credit should be easy to use, and it should be refundable – or if not, the taxpayer should be able to apply some or all of it to taxes owed in the future tax years.
- Financially Rewarding – the percentage of the tax credit, the state’s aggregated allocation for the credit, and the amount of eligible expenses should be significant enough to promote participation.
- Trackable – the tax credit should produce measurable results that are collected and promoted year after year.

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<sup>24</sup>Stoney, Louise, and Anne Mitchell. *Using Tax Credits to Promote High Quality Early Care and Education Services #2* (n.d.): n. pag. Partnership for America's Economic Success, 20 Nov. 2007. Web.

<sup>25</sup> Without a state-income tax, providing tax credits to parents and/or employees would be a difficult option.

<sup>26</sup> Blank, Susan, and Louise Stoney. *Tax Credits for Early Care and Education: Funding Strategy for a New Economy* (2011): n. pag. Web. <[http://opportunities-exchange.org/wp-content/uploads/OpEx\\_IssueBrief\\_Tax\\_Final1.pdf](http://opportunities-exchange.org/wp-content/uploads/OpEx_IssueBrief_Tax_Final1.pdf)>.

## **SCHOOL READINESS – SPECIAL ISSUE**

### **License Exempt Child Care**

Parents have many options when looking for child care for their children. In Nevada, there are five different types of child care providers. These include state-based care (state preschool programs), family home care (5-6 non-related children), group home care (7-12 non-related children), child care center (13 or more children), and license-exempt providers (1-4 non-related children). When a parent sends their children to a licensed provider – state-based, family home, group home or center based – they have the assurance that every individual in the facility has received a complete personal history, background, and child abuse and neglect checks. These checks ensure that individuals are not allowed to work with children if they have a record of the following:

- (a) Murder, voluntary manslaughter or mayhem;
- (b) Any other felony involving the use of a firearm or other deadly weapon;
- (c) Assault with intent to kill or to commit sexual assault or mayhem;
- (d) Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
- (e) Abuse or neglect of a child or contributory delinquency;
- (f) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;
- (g) Abuse, neglect, exploitation, isolation or abandonment of older persons or vulnerable persons, including, without limitation, a violation of any provision of NRS 200.5091 to 200.50995, inclusive, or a law of any other jurisdiction that prohibits the same or similar conduct; or
- (h) Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property within the immediately preceding 7 years.

License-exempt providers (unless they receive child care subsidy funding) are not subject to these requirements. Thus, leaving the potential for individuals with a history of sexual, physical abuse or neglect of a child, among other crimes, to be left alone with these children – placing them in harm's way. A 2005 study, *Fatalities and the Organization of Child Care in the United States, 1985–2003*, found that licensed child care may also offer safer care as a result of child care licensing's many safety requirements such being required to lock up hazardous supplies, cover electrical outlets, and take basic safety courses.<sup>27</sup>

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<sup>27</sup> Wrigley, Julia, and Joanna Derby. "Fatalities and the Organization of Child Care in the United States, 1985-2003." *American Sociological Review* 70 (2005): n. pag. Web. <<http://www.asanet.org/sites/default/files/savvy/images/members/docs/pdf/featured/Oct05ASRWrigleyDreby.pdf>>.

Additionally, Nevada’s Department of Health and Human Services’ Child Care Licensing Program does not have the ability to provide oversight or access fines for providers violating child care regulations and statutes – apart from requesting a law enforcement agency to charge the provider with a misdemeanor. From 2013- 2015, Child Care Licensing responded to 68 complaints for providers serving too many children while operating a license-exempt child care.<sup>28</sup> Of these 68 complaints, 18 of these complaints were substantiated – the providers were serving more than their allotted 4 children – with 5 being repeat offenders.<sup>29</sup> Apart from notifying the providers that they are breaking the law, there is nothing else Child Care Licensing can do. This gives license-exempt providers’ little incentive to come into compliance with current law and places the children at a higher risk of injury or death.

### **Recommendations:**

1. Require all child care providers that receive monetary compensation for their services to receive a background check through the State of Nevada’s Child Care Licensing Program (in the Division of Public & Behavioral Health, Department of Health & Human Services) if they regularly provide care for fewer than five non-relative children, without the presence of parents, outside the child’s home.
  - “Regularly” is defined differently by different states. We do not want to be overly burdensome for people helping friends temporarily. For example, one state defines “regularly” as more than 6 hours a day 4 days a week for more than 3 consecutive weeks.
  - Background checks should also be required for all employees and volunteers that provide direct care, as well as every resident age 18 or older living in the provider’s place of business.
  - Background checks must be updated at least once every five years.
  - A person may not provide child care for compensation to non-related children in Nevada if the if they do not pass a complete personal history and background check and a Child Abuse and Neglect check.
2. Authorize the Child Care Licensing Program (DPBH, DHHS) to impose an administrative fine upon license-exempt providers caring for more than the allowed number of children (this enforces the current law). They should be able to impose a fine for any violation, including for providers who lack a current background check and those caring for more than the allowed number of children in the license-exempt category.

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<sup>28</sup> In total, Child Care Licensing responded to 100 complaints regarding unlicensed child care facilities serving too many children. 32 of these complaints found that the individual was not providing child care in their home.

<sup>29</sup> Numbers compiled by the Children’s Advocacy Alliance via Child Care Licensing complaint reports.

## SCHOOL READINESS – SPECIAL ISSUE

### Quality Rating Improvement Systems (QRIS)

*A QRIS is a systematic approach to assess, improve, and communicate the level of quality in early care and school-age programs. Similar to rating systems for restaurants and hotels, QRIS awards quality star ratings to early care and school age programs that meet a set of defined program standards. These systems provide an opportunity for States to increase the quality of care for children, increase parents' understanding and demand for higher quality care, and increase professional development of child care providers. A QRIS can also be a strategy for aligning components of the early care and school-age system for increased accountability in improving quality of care.<sup>30</sup>*

To help incentivize child care providers to improve their quality, in July 2013, Nevada launched the Nevada Silver State Stars Quality Rating and Improvement System (QRIS). The QRIS was created to establish a standard to measure and improve the quality of early childhood programs and educate families, providers, and the community.<sup>31</sup> As of May 2016, a total of 147 centers have applied to participate in the program. By participating, centers receive: technical assistance (TA) and training from coaches who develop a quality improvement plan for the centers; visit from their coach for up to 10 hours per month to evaluate progress, provide onsite TA and train staff; a one-time initial quality improvement grant (\$4,000 - \$8,500) based upon licensed capacity; advancement bonus at renewal; and eligibility for increased child care subsidy rates of 6, 9, or 12% depending on their final star rating level.

The star ratings are awarded based upon an onsite quality assessment and documentation in four quality categories: Policies & Procedures, Administration & Staff Development, Health & Safety, and Families & Community.<sup>32</sup>

<b>Star Level Definitions</b>	
	<b>HIGHEST QUALITY</b> (Far exceeds high quality)
	<b>QUALITY PLUS</b> (Exceeds high quality standards)
	<b>QUALITY</b> (Meets high quality standards)
	<b>PROGRESSING STAR</b> (Approaching high quality standards)
	<b>RISING STAR</b> (Committed to quality improvement)
	<b>NO RATING</b> (Program has chosen not to participate in the QRIS)

As of May 2016, forty-two centers throughout Nevada were rated with the Silver State Stars QRIS. More than 50% of the centers that participated in the QRIS program were able to improve their care and become quality early learning programs. While the programs that are at two-stars are still working to meet high quality standards, it should be noted that two-star

<sup>30</sup> National Child Care Information Center, 2009. QRIS definition and statewide systems. <http://nccic.acf.hhs.gov/pubs/qrs-defsystems.html>.

<sup>31</sup> *Vision / Mission*. Nevada Silver State Stars QRIS, n.d. Web. 30 Aug. 2016. <<http://www.nvsilverstatestars.org/mission-and-vision>>.

<sup>32</sup> Note: The QRIS star level definitions are currently under review and may undergo revisions in 2017.

programs are still going above and beyond minimum requirements required by Child Care Licensing.

Number and Percentage of Centers Receiving Each Star Level Rating		
May 2016		
Five Stars	7	17%
Four Stars	4	10%
Three Stars	11	26%
Two Stars	19	45%
One Star	1	2%
Total Number of rated Centers	42	100%

The Silver State Stars QRIS is continuing to work with child care providers to improve the quality of care in Nevada. Prior to 2016, Silver State Stars QRIS work focused on improving the quality of licensed child care providers. This quality initiative has since been expanded and now includes rating scales for Family Child Care and public pre-K programs. Currently, the Silver State Stars QRIS is working to include the Tribal Model child care. This expansion is helping families gain access to high quality care for their children in Nevada. Unfortunately, the ability of programs to participate is limited due to lack of funds. As of May 2016, there is a wait list of 50 centers to become part of the Silver State Stars QRIS program.

### Recommendations:

Nevada currently lacks the appropriate resources for full participation in QRIS for all types of child care providers. Statewide expansion should be implemented on a gradual basis, with continued assessment, evaluation and improvement to further refine the process. Further funding is needed to increase the number of participating licensed child care centers, family child care, licensed exempt, district model and tribal child care. Efforts should also be made to include appropriate resources for marketing and outreach to ensure that parents are aware of and understand the star rating system. Upon statewide implementation, direct alignment between QRIS and child care subsidy reimbursements will ensure that state funds are being used both efficiently and effectively to provide the highest level of quality care and education to our state’s most vulnerable children.

*Adapted from the Nevada Silver State Stars Website, <http://www.nvsilverstatestars.org/>*

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## SCHOOL READINESS – SPECIAL ISSUE

### High Quality Workforce for High Quality Early Learning

In Nevada, 63.6% of children have all available parents in the workforce.<sup>33</sup> This, combined with an improved understanding of the positive impacts of high-quality early learning, have caused an increased demand for high-quality, affordable child care and early education programs. Children are rapidly developing and learning in their first five years of life, laying the foundation for later success. During this time, it is crucial that children be exposed to high quality early learning experiences to increase their achievement in school and beyond. Research indicates that the most critical component of child care quality is the teacher-child relationship.<sup>34</sup> As Nevada builds the necessary infrastructure to increase early education services, it is important that a comprehensive plan is created to help support and train teachers.

Currently, most professionals within the early learning workforce earn low wages, often, regardless of their training or level of education. Some individuals within the early childhood education (ECE) community are making at or near the Federal poverty line and qualify for welfare programs. These low wages make it difficult for individuals in this work to take care of their own families

**Wages for Early Childhood Care and Education Professionals in Nevada\***

Licensed Center Wages**	Average Starting	Average	Median Reported to NV Registry
<b>Aids</b>	\$8.20	\$8.65	\$9.50
<b>Teachers</b>	\$9.96	\$10.75	\$11.00
<b>Directors</b>	\$15.53	\$17.53	\$14.00

\*"2014 Demographics: Early Education & Care & Out of School Programs." *The Children's Cabinet* (n.d.): n. pag. Web. <<http://www.childrencabinet.org/wp-content/uploads/2014-Demographics-Report.pdf>>.

\*\*Excludes Head Start & Pre-K Wages

Overall, such low pay limits the ability of this growing field of education to entice and retain staff-especially those with higher levels of education. The limited supports to provide livable wages and development programs lead to an increased turnover which is costly to programs. In 2014 in Nevada, the turnover rate for center-based staff was 16%.<sup>37</sup> This turnover can have an impact on children's learning. Research illustrates that children benefit from being enrolled in centers with lower turnover.<sup>38</sup> This stability allows for children to engage in increased positive

<sup>33</sup> "2014 Demographics: Early Education & Care & Out of School Programs." *The Children's Cabinet* (n.d.): n. pag. Web. <<http://www.childrencabinet.org/wp-content/uploads/2014-Demographics-Report.pdf>>.

<sup>34</sup> Shonkoff, Jack P., and Deborah Phillips. *From Neurons to Neighborhoods the Science of Early Childhood Development*. Washington, D.C.: National Academy, 2000. Print.

<sup>35</sup> "2014 Demographics: Early Education & Care & Out of School Programs." *The Children's Cabinet* (n.d.): n. pag. Web. <<http://www.childrencabinet.org/wp-content/uploads/2014-Demographics-Report.pdf>>.

<sup>36</sup> Excludes Head Start & Pre-K Wages

<sup>37</sup> "2014 Demographics: Early Education & Care & Out of School Programs." *The Children's Cabinet* (n.d.): n. pag. Web. <<http://www.childrencabinet.org/wp-content/uploads/2014-Demographics-Report.pdf>>.

<sup>38</sup> "High-Quality Early Learning Settings Depend on a High-Quality Workforce." Department of Education & Department of Health and Human Services, 2016. Web. 30 Aug. 2016. <<http://www.acf.hhs.gov/ecd/high-quality-early-learning-settings-depend-on-a-high-quality-workforce>>.

interaction and activities with their teachers. On the opposite end, a child enrolled in a center with high staff turnover can see negative effects with their social-emotional and behavioral development. High staff turnover can influence the overall program culture and have an impact on the quality of services.

There is a national and local push to increase the quality of care and education being provided in early learning centers. With this push, there have been calls for higher educated teachers in ECE classrooms. In Nevada, the Nevada Ready!

Preschool Development Grant requires a minimum of a bachelor's degree in ECE to qualify to teach in a grant funded classroom.

Unfortunately, there is a very limited quantity of early learning professionals with higher levels of education and this is unlikely to change unless the annual earnings for these teachers increase.

Child care and early learning programs, unlike K-12 education programs, rely on fees and tuition from families to operate their early learning centers. The average center generates 87% of its revenue from parent tuition, while the average institution of higher education generates only 35% from tuition and fees.<sup>39</sup> Unless centers increase their fees and tuition, limiting access to the most at-risk children and families, there is no way for these centers to increase the wages of their employees or provide incentives for obtaining higher levels of education. To assist with higher wages, the state needs to increase financial support for child care and early learning professionals. Without the state's intervention, early learning professionals will remain at or close to the poverty line and have no incentive to increase their educational attainment, unless it is to leave the ECE workforce.

Licensed Child Care-Highest Educational Attainment	
Less than a High School Diploma	42%
High School Diploma	19%
Some College	19%
Associate's Degree-ECE	3%
Associate's Degree-Other	3%
Bachelor's Degree-ECE	3%
Bachelor's Degree-Other	8%
Postgraduate Degree-ECE	1%
Postgraduate Degree-Other	2%

### Recommendations:

Nevada needs to increase financial support for child care and early learning professionals. The state should subsidize teachers' monthly wages to help lift the early learning professionals out of poverty and attract new talent to the career path. To help encourage educational attainment, the state can tier the wage subsidies based on level of education or professional development.

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<sup>39</sup> Stoney, Louise, and Anne Mitchell. "Can We Use Tax Strategies to Help Finance Early Care and Education?" Early Childhood Finance, n.d. Web. 30 Aug. 2016. <[www.earlychildhoodfinance.org/.../TaxStrategiesCall\\_Resources\\_2006.doc](http://www.earlychildhoodfinance.org/.../TaxStrategiesCall_Resources_2006.doc)>.

## 2. STUDENT ACHIEVEMENT

### Nevada Children's Report Card Grade: F

The student achievement grade is based upon 4<sup>th</sup> grade reading scores, 8<sup>th</sup> grade math scores, and postsecondary participation. Although there are multiple assessments to measure the reading and math indicators, the NV Children's Report utilizes the National Assessment of Educational Progress (NAEP) in effort to assess how Nevada compares with other states. According to the 2015 NAEP, the percentage of 4<sup>th</sup> graders who are proficient at reading has declined from 34% in 2013 to 29% in 2015. Similarly, 8<sup>th</sup> graders proficient in math declined from 30.3% to 26.1% in 2015. Nevada remains near the bottom of both rankings, 45<sup>th</sup> for reading and 42<sup>nd</sup> for math.<sup>40</sup> Nevada ranks 50<sup>th</sup> overall for postsecondary participation, with just 40.1% of young adults enrolled in postsecondary education or with a degree, compared to the national average of 55.2%.<sup>41</sup>

As discussed in the previous section, student achievement is dependent on the quality of care prior to primary school enrollment as well as within primary school. According to the U.S. Department of Education (2011), first-time kindergartners' fall reading skills differed based on their primary care arrangements in the year prior to entering kindergarten. Specifically, children who had not received any non-parental care on a regular basis and those whose primary care arrangement was home-based with a relative had lower fall reading scores than children who attended home-based nonrelative care, attended center-based care, or had multiple care arrangements. These patterns emerged for math abilities as well.

Learning to read and write are essential skills to be successful in school and in life. It is imperative that students are provided an opportunity to achieve their full potential during their early and primary years in order to ensure the likelihood they graduate from high school. When our schools lack the resources to properly educate our students, the community at large will experience the related negative outcomes.

#### **RECOMMENDATIONS FOR IMPROVEMENT:**

- *Continue support for additional professional development for teachers at all grade levels to increase their ability to offer quality instruction to students.*
- *Reduce classroom sizes in all grades so teachers have more time to dedicate to individualized student improvement.*
- *Increase funding for all schools in order to increase pay for quality teachers. It is important to keep qualified teachers in the classroom.*
- *Ensure that children receive supports early by providing high quality early education programs so that children enter school ready to learn.*
- *Continue programs that support at-risk youth with additional support in reading & math.*

<sup>40</sup> "Nevada State Highlights 2016." (2016): n. pag. Education Week, 26 Jan. 16. Web. <<http://www.edweek.org/media/ew/qc/2016/shr/16shr.nv.h35.pdf>>.

<sup>41</sup> Ibid.

### 3. HIGH SCHOOL COMPLETION

#### Nevada Children's Report Card Grade: F

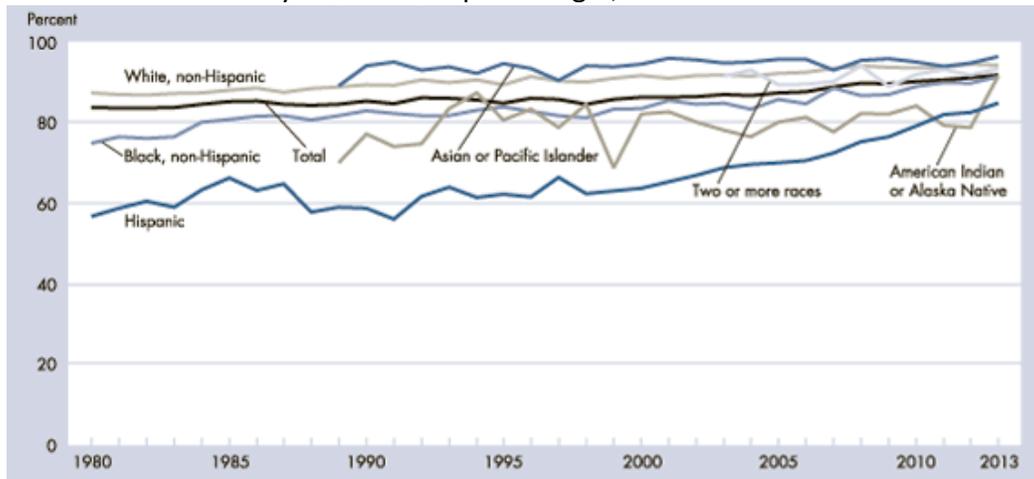
The high school completion grade is based upon high school dropouts (teens age 16 to 19 who are not in school and have not yet graduated), as well as high school graduation rates.

Nevada's dropout rate is 4%<sup>42</sup>, ranking Nevada 15<sup>th</sup> (with 21 other states) in 2014 – showing steady improvement with the highest ranking yet seen in Nevada.

In order to grade Nevada by national rank, data for the high school graduation indicator is based upon the class of 2012 – which was 60%.<sup>43</sup> However, more recent data from the Nevada Department of Education shows a cohort graduation rate of 70.77% for the class of 2015, showing steady improvement over the past several years.<sup>44</sup>

The percentage of young adults ages 18–24 with a high school diploma or an equivalent credential is a measure of the extent to which young adults have completed a basic prerequisite for many entry-level jobs and for higher education. The graph below shows high school diploma attainment by race across the country.

Percentage of young adults ages 18–24 who have completed high school by race and Hispanic origin, 1980–2013<sup>45</sup>



Much like the graph above, Nevada has deep disparities in graduation rates. Students who are Black or Hispanic have a graduation rate of 55.5% and 66.7% in Nevada, respectively, thus showing that Nevada's trend mirrors that which is occurring across the US.<sup>46</sup>

<sup>42</sup> "Teens Ages 16 to 19 Not in School and Not Working." *KIDSCOUNT Data Center from the Annie E. Casey Foundation*. N.p., n.d. Web. 30 Aug. 2016. <<http://datacenter.kidscount.org/>>.

<sup>43</sup> "Nevada State Highlights 2016." (2016): n. pag. Education Week, 26 Jan. 16. Web. <<http://www.edweek.org/media/ew/qc/2016/shr/16shr.nv.h35.pdf>>.

<sup>44</sup> "Nevada Report Card" Nevada Department of Education, <http://www.nevadareportcard.com/>

<sup>45</sup> "America's Children in Brief: Key National Indicators of Well-Being, 2016." *Childstats.gov*. N.p., n.d. Web. 30 Aug. 2016. <[http://www.childstats.gov/americaschildren/ed\\_fig.asp#ed4](http://www.childstats.gov/americaschildren/ed_fig.asp#ed4) (2015)>.

<sup>46</sup> "Nevada Report Card" Nevada Department of Education, <http://www.nevadareportcard.com/>

In addition, there are other groups who have disparate graduation rates including those eligible for free or reduced price lunch (52.32%), English Language Learners (26.36%), and those with an Individualized Education Program (22.71%).<sup>47</sup>

According to a report by the National Dropout Prevention Center, there are many factors that influence the dropout rate which include: chronic or mental illness, early marriage, low occupational aspirations, need for autonomy, sexual involvement, pressures to seek employment, change in educational services or placement, school dissatisfaction, having siblings that dropped out, and substance abuse.<sup>48</sup> Each of these factors represents a point of intervention that can be targeted to reduce risk associated with high school dropouts in Nevada.

Identifying and addressing the reasons Nevada's students drop out will help improve overall graduation rates. Reducing the dropout rate is also advantageous for the State. Individuals lacking a high school diploma are more likely to face unemployment, rely on government cash assistance, food stamps, and housing assistance, and to cycle in and out of the prison system.<sup>49</sup> Research conducted by Dr. Tiffany G. Tyler and Dr. Sandra Owens from the University of Nevada, Las Vegas suggests that increasing the 2010 graduation rate by half would result in Nevada seeing gains of \$64,844,808 in earnings, \$155,366,635 in vehicle and home purchases, 405 new jobs supported, and receiving \$53,317,331 in lost revenue.<sup>50</sup> This evidence shows that high school completion is not simply a concern for the school systems, but for the community overall.

#### **RECOMMENDATIONS FOR IMPROVEMENT:**

- *Increase funding to support additional professional development for teachers at all grade levels to increase their ability to offer quality instruction to students.*
- *Reduce classroom sizes in all grades so teachers have more time to dedicate to individualized student improvement.*
- *Increase funding for all schools in order to increase pay for quality teachers. It is important to keep qualified teachers in the classroom.*
- *Increase support services for youth and families to address other factors associated with low graduation and dropout rates including youth homelessness, poverty, physical, mental and behavioral health needs, and participation in high risk behaviors.*

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<sup>47</sup> Ibid.

<sup>48</sup> Hammond, C., Linton, D., Smink, J., & Drew, S, "Dropout Risk Factors and Exemplary Programs. Clemson, SC: National Dropout Prevention Center, Communities in Schools, Inc" (2007) <http://dropoutprevention.org/resources/major-research-reports/dropout-risk-factors-and-exemplary-programs-a-technical-report/>

<sup>49</sup> Tyler, T. G. and Owens, S., e edited by Dmitri N. Shalin., "High School Graduation and Dropout Rates," [http://cdclv.unlv.edu/healthnv\\_2012/index](http://cdclv.unlv.edu/healthnv_2012/index) (2012)

<sup>50</sup> Tyler, T. G. and Owens, S., e edited by Dmitri N. Shalin., "High School Graduation and Dropout Rates," [http://cdclv.unlv.edu/healthnv\\_2012/index](http://cdclv.unlv.edu/healthnv_2012/index) (2012)

## 4. FUNDING

### Nevada Children’s Report Card Grade: F

The funding grade is based on the amount of money allocated per pupil in the state, as well as student-teacher ratios. Per pupil expenditures are calculated for grades pre-kindergarten through 12<sup>th</sup> grade in public elementary and secondary education.<sup>51</sup> In Nevada, actual per pupil expenditures for the 2013-2014 fiscal year were \$8,414 compared to \$11,000 nationally.<sup>52</sup> Nevada’s ranking of 46<sup>th</sup> in this category has changed little since the last report card. Nevada’s low per pupil expenditure causes high student-teacher ratios. Nevada ranks 47<sup>th</sup> in the nation for student-teacher ratios with an average ratio of 20.6 compared to 16.1 nationally.<sup>53</sup> In 2015, Nevada’s Legislature voted to change Nevada’s funding formula which could increase the state’s ranking in future years.

The changes to the funding formula took constructive steps to modernize *The Nevada Plan for School Finance* – which was first created in 1967 – through the passage of Senate Bill 508. The bill:<sup>54</sup>

- Adjusted the method used to conduct the student enrollment count;
- Revised and repealed the hold harmless provision;
- Clarified the basic support guarantee;
- Made revisions to the equity allocation model;
- Required the state to implement or phase-in weighted funding for special education, English language learners, at-risk (high poverty), and gifted and talented (GATE);
- Created a contingency account for special education services;
- Made changes to the special education placement Interagency Panel;
- Mandated kindergarten pupils to be fully funded to support full day kindergarten for all students; and
- Changed requirements for the biennial budget submittal.

#### **RECOMMENDATIONS FOR IMPROVEMENT:**

- Nevada should make a larger contribution to the education of our children by increasing the base per pupil expenditure.
- Nevada should revise the funding formula to incorporate funding for preschool students.

<sup>51</sup> The per pupil amount used in this analysis takes into consideration categorical funds allocated to education and the funding from the Nevada funding formula.

<sup>52</sup> “Public Education Finances: 2014” U.S. Census Bureau, <http://census.gov/content/dam/Census/library/publications/2016/econ/g14-aspef.pdf>

<sup>53</sup> Glander, Mark. *Selected Statistics from the Public Elementary and Secondary Education Universe: School Year 2013-14. First Look* (n.d.): n. pag. National Center for Educational Statistics. Web. <<http://nces.ed.gov/pubs2015/2015151.pdf>>.

<sup>54</sup> Nevada Legislative Website, 78<sup>th</sup> Legislative Session. Senate Bill 508. [http://www.leg.state.nv.us/Session/78th2015/Bills/SB/SB508\\_EN.pdf](http://www.leg.state.nv.us/Session/78th2015/Bills/SB/SB508_EN.pdf)

## FUNDING – SPECIAL ISSUE

### Funding for Pre-K Education

The first five years of a child’s life are crucial to their overall development, making this a critical point for strategic investments. Research shows that preschool is an effective early intervention method that creates lasting academic and social impact. Long-term studies of varying preschool programs have found significant benefits including:<sup>55</sup>

- Higher levels of verbal, mathematical, and intellectual achievement;
- Greater success at school, including less need for special education, less grade retention, and higher graduation rates;
- Lower unemployment and higher earnings;
- Better health outcomes;
- Less welfare dependency;
- Lower rates of crime; and
- Greater government revenues and lower government expenditures.

For Nevada’s most at-risk students, high quality early childhood education can be the difference between entering kindergarten ready to learn or entering 18 months behind their affluent peers.<sup>56</sup> The benefits of preschool go beyond the classroom and into adulthood. The positive impact of preschool for an individual translates to a large return on investment (ROI) for society. Children who attend preschool are less likely to need costly services, such as an extra year of schooling, welfare assistance, or a jail bed. Additionally, children who attend preschool are more likely to be employed and have a higher salary - enabling them to contribute greater earnings to the community. Some communities have seen a ROI as high as \$7 for every dollar invested in Pre-K.<sup>57</sup>

Despite the proven benefits of investment into high quality early childhood education programs, Nevada has limited funds for the state preschool program. Even with the changes made to the funding formula in 2015, the Nevada Plan does not guarantee funding for early childhood education for non-special education students. The Nevada State Preschool Program is currently funded by external categorical dollars allowing it to be easily reduced or eliminated. The State has yet to increase funding for this external categorical program but has instead

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<sup>55</sup> Lynch, G. Roberts. 2004. “Exceptional Returns: Economic, Fiscal, and Social Benefits in Early Childhood Development.” Economic Policy Institute [http://www.unicef.org/lac/spbarbados/Finance/Global/exceptional\\_returns\\_ECD\\_2004.pdf](http://www.unicef.org/lac/spbarbados/Finance/Global/exceptional_returns_ECD_2004.pdf)

<sup>56</sup> “Kindergarten Readiness” Early Edge California. <http://www.earlyedgecalifornia.org/our-issues/kindergartenreadiness/index.html>

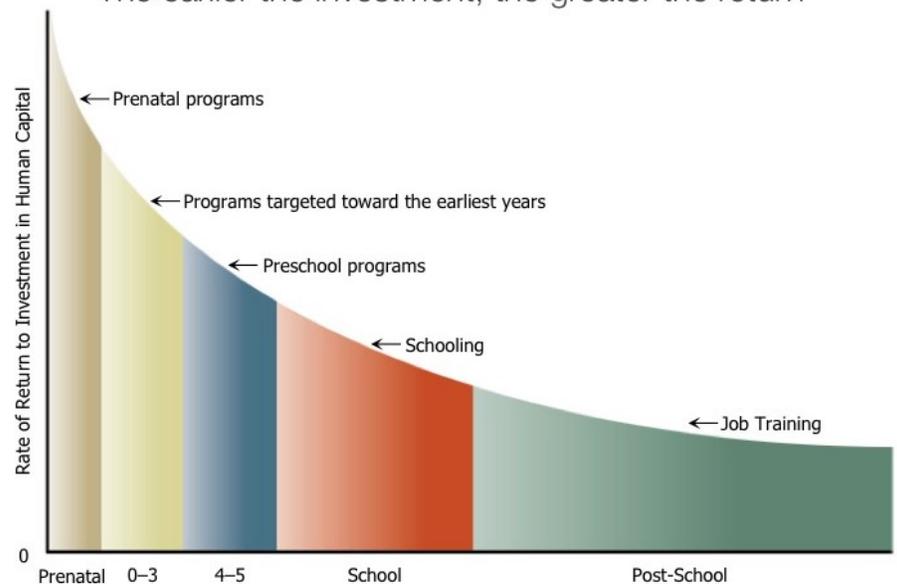
<sup>57</sup> Heckman, James, Seong Hyeok Moon, Rodrigo Pinto, Peter A. Savelyev, and Adam Yavitz. 2009. “The rate of return to the Highscope Perry Preschool Program.” *Journal of Public Economics*, Vol. 94, pp. 114-128. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3145373/>

decreased funding. In 2001, the Nevada State Preschool Program was funded at 3.5 million dollars and today it is funded at 3.3 million dollars. Currently, Nevada ranks 42<sup>nd</sup> for state spending per capita among states that offer preschool programs, investing \$46.35 per child compared to the national average of \$773.63.

Fortunately, the Nevada State Preschool Program has had indirect funding to help increase access for young children.

During the 2015 Legislative Session, the legislature did increase funds to Zoom Schools, created the Victory Schools program and approved the match requirement for the Preschool Development Grant. While Nevada has not directly taken steps to increase state preschool funding, these investments will help to increase access to preschool programs; but, they are also not guaranteed from year to year. These categorical investments are steps in the right direction, but Nevada needs to start looking at long-term, sustainable funding for its preschool programs.

The earlier the investment, the greater the return



Source: James Heckman, Nobel Laureate in Economics

### **Recommendation:**

In order to stabilize funding and increase access to the Nevada Preschool Program, the Nevada Plan should be revised to include per pupil funding for preschool programs. In addition to funding for preschool students, Nevada needs to ensure they are also providing funds to create space for additional classrooms, as well as to support to train and retained qualified early childhood teachers.

### **For more information on this topic, please contact:**

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# Children's Health

“To keep the body in good health is a duty, otherwise we shall not be able to keep our mind strong and clear.”

- Buddha

## Children's Health Overview

1. Access to Healthcare
2. Prenatal and Infant Health
3. Immunizations
4. Childhood Obesity
5. Dental Health
6. Mental Health
7. Sexual Health

## **CHILDREN'S HEALTH OVERVIEW**

### **Nevada Children's Report Card Grade: D**

Every child in Nevada should have the opportunity to grow up healthy, from the prenatal period through young adulthood.

To be healthy, children and families need:

- High quality and on-time prenatal care.
- Access to high quality, affordable health care, including oral health and mental health.
- On-time, recommended childhood immunizations.
- Access to food that supports good nutrition, including an adequate supply of fruits and vegetables.
- Communities that provide a safe place to run and play, offering ample opportunities for physical activity.
- Access to information to make healthy decisions regarding nutrition, physical activity, chronic disease prevention, avoidance of risky behaviors and overall well-being.

Every child deserves a healthy start in life and access to quality health care. Neglecting a child's basic health care needs can contribute to health problems and higher costs as they grow. It is also important that children receive necessary on-time, affordable care. Too often, families forego preventative care and treatments due to lack of medical coverage and the high cost of care.

There are several areas of children's health which need improvement and contribute to the Overall Children's Health Grade of D, which the state received on the 2016 Children's Report Card. Details in each of these areas are provided in the sections below in addition to recommendations for improvement in the state. These include:

- 1. Access to Health Care**
- 2. Prenatal and Infant Health**
- 3. Immunizations**
- 4. Childhood Obesity**
- 5. Dental Health**
- 6. Mental Health**
- 7. Sexual Health**

# 1. ACCESS TO HEALTHCARE

## Nevada Children’s Report Card Grade: F-

For the Nevada Children’s Report Card, the access to health care grade includes the percentage of children without health insurance (Nevada ranks 48<sup>th</sup>),<sup>58</sup> those who have a quality medical home (Nevada ranks 50<sup>th</sup>),<sup>59</sup> and patient to provider ratios, in which Nevada ranks 48<sup>th</sup>.<sup>60</sup> While all of these indicators are key to ensuring access to quality healthcare, those children with adequate health insurance are far more likely to receive the preventative care necessary for healthy development.

The rates of uninsured children in the nation continue to decline. However, despite this decline, Nevada continues to rank in the bottom states when it comes to providing healthcare insurance coverage for children. Approximately 10% of Nevada’s children have no healthcare insurance coverage, which is nearly double the national rate of 6%.<sup>61</sup> There are also disparities in healthcare insurance coverage, seen both in the nation and in our state. Hispanic children are the most likely group in the nation to be uninsured with an average of 9.7% in 2014. In Nevada, 13.3% of children who are Hispanic are uninsured which, despite being a significant improvement from the previous year, is still the 9<sup>th</sup> highest percentage in the country.<sup>62</sup> Additionally, Nevada law still requires a 5 year wait period for lawfully residing immigrant children – delaying access to health insurance coverage for thousands of children in Nevada.

States with the Highest Uninsured Rates <sup>63</sup>		
	2013	2014
National	7.1%	6.0%
Alaska	11.6%	11.4%
Texas	12.6%	11.0%
Arizona	11.9%	10.0%
Nevada	14.9%	9.6%
Utah	9.5%	9.4%

<sup>58</sup> Alker, Joan and Chester, Alisa. Children’s Health Insurance Rates in 2014: ACA Results in Significant Improvements Oct. 2015. <http://ccf.georgetown.edu/wp-content/uploads/2015/10/ACS-report-2015.pdf>

<sup>59</sup> “NSCH Profiles” Data Resource Center for Child & Adolescent Health. <http://childhealthdata.org/browse/snapshots/nsch-profiles?geo=30&rpt=16>

<sup>60</sup> “2015 State of Physician Workforce Data Book. Center for Workforce Studies. November 2015. [http://members.aamc.org/eweb/upload/2015StateDataBook%20\(revised\).pdf](http://members.aamc.org/eweb/upload/2015StateDataBook%20(revised).pdf)

<sup>61</sup> Alker, Joan and Chester, Alisa. Children’s Health Insurance Rates in 2014: ACA Results in Significant Improvements Oct. 2015. <http://ccf.georgetown.edu/wp-content/uploads/2015/10/ACS-report-2015.pdf>

<sup>62</sup> Schwartz, Sonya, Chester, Alisa, Lopez, Steven, Vargas Poppe, Samantha. Historic Gains in Health Coverage for Hispanic Children in the Affordable Care Act’s First Year. <http://ccf.georgetown.edu/wp-content/uploads/2016/01/CCF-NCLR-Uninsured-Hispanic-Kids-Report-Final-Jan-14-2016.pdf>

<sup>63</sup> Alker, Joan and Chester, Alisa. Children’s Health Insurance Rates in 2014: ACA Results in Significant Improvements Oct. 2015. <http://ccf.georgetown.edu/wp-content/uploads/2015/10/ACS-report-2015.pdf>

Good health is key for academic achievement. Children with healthcare insurance, who have greater access to regular medical care, have an easier time focusing during class, participate more in activities and are not absent from school as often. Access to healthcare insurance will save the lives of many children. In 2008, one of the leading causes of natural child deaths in the nation was a treatable chronic illness. Of the children who die every year, it is estimated that roughly 37.8% of them could have been saved if they had health insurance.<sup>64</sup> In addition, children who are born underweight because of various causes such as lack of prenatal care and pre-birth stress, have an 80% chance of being in a special needs program in school.<sup>65</sup>

“Unless someone like you cares  
a whole awful lot, nothing is going  
to get better. It’s not.”  
– Dr. Seuss

As we improve health insurance coverage rates, it is important to note that access to healthcare does not end with an insurance card. Having adequate medical providers is also key to ensuring access to appropriate medical care for children. As indicated above, Nevada ranks 48<sup>th</sup> in patient to provider ratios at a rate of 69.8 per 100,000 providers.<sup>66</sup> To attract and retain providers, Nevada should further support medical education initiatives, revise reciprocity protocols and update Medicaid reimbursement rates to reflect actual provider costs.

#### **RECOMMENDATIONS FOR IMPROVEMENT:**

- *Continue to expand outreach programs to increase enrollment among eligible children and families in Medicaid and Nevada Check Up programs.*
- *Continue to implement the Affordable Care Act in full, while developing outreach to the community to educate the public on its provisions and effects.*
- *Increase providers and medical services in Nevada to increase access to care.*
- *Revise Medicaid reimbursement rates to better support provider costs, enabling more providers to accept Medicaid patients.*
- *Review reciprocity policies for various types of medical providers to encourage experienced providers to come to Nevada.*
- *Remove the 5 year waiting period for lawfully residing immigrant children to enroll in Nevada Check Up.*

<sup>64</sup> Abdullah, Zhang, Lardaro, Black, Colombani, Chrouser, Pronovost, & Chang (2010). Analysis of 23 million US hospitalizations: uninsured children have higher all-cause in-hospital mortality. *Journal of Public Health*, 32(2), 236-244.  
<http://www.ncbi.nlm.nih.gov/pubmed/19875420>

<sup>65</sup> Nevada Business Summit on Early Childhood Investments. Nevada Institute for Children’s Research and Policy;  
[nic.unlv.edu/files/NBS%20on%20Early%20Childhood%20Investment.pdf](http://nic.unlv.edu/files/NBS%20on%20Early%20Childhood%20Investment.pdf)

<sup>66</sup> “2015 State of Physician Workforce Data Book. Center for Workforce Studies. November 2015.  
[http://members.aamc.org/eweb/upload/2015StateDataBook%20\(revised\).pdf](http://members.aamc.org/eweb/upload/2015StateDataBook%20(revised).pdf)

## ACCESS TO HEALTHCARE - SPECIAL ISSUE

### Emergency Albuterol Inhalers

According to the National Heart, Lung, and Blood Institute, asthma affects people of all ages, but it most often starts during childhood.<sup>67</sup> Just over 1 out of 12 children in the United States have been diagnosed with asthma.<sup>68</sup> The effect of asthma is compounded by Nevada's dry climate, dust & quick temperature changes – resulting high asthma rates. In Nevada, Asthma is the most common medical condition for children entering kindergarten and 24% of high schoolers reported having asthma.<sup>69</sup> In total, an estimated 4,036 Nevadan children have been diagnosed with asthma.<sup>70</sup> While in school, these children with asthma, whether diagnosed or undiagnosed, are at-risk of having an asthmatic attack. In 2010, 3 out of 5 children who have asthma had one or more asthma attacks in the previous 12 months.<sup>71</sup> The symptoms include<sup>72</sup>:

- Coughing
- Wheezing
- Chest Tightness
- Shortness of breath

These attacks can be mitigated by the use of an albuterol inhaler. But without an inhaler, depending on the severity of the attack, these children's symptoms may worsen and become a life-threatening emergency. In 2015, there were a total of 10,301 visits to a Nevada emergency room where Asthma was the principle diagnosis – includes child and adult visits.<sup>73</sup> Unfortunately, children do not always have an inhaler available for use. This may be due to them being undiagnosed, not owning an inhaler, leaving it at home, or because it is broken, or empty. The lack of owning inhalers also disproportionately affects minority children and children living in poverty. According to the Nevada State Asthma Control Plan:

“Minority children and children in poverty have a greater burden from asthma compared with white, more socioeconomically advantaged children, and the

#### Asthma in Nevada

- 7.5% of kindergarteners in Nevada reported having asthma.
- 24% of high school students in Nevada reported having asthma.
- 20% of children in the U.S. have reported having one or more asthma attacks in the previous 12 months.

<sup>67</sup> “Who Is at Risk for Asthma” National Heart, Lung, and Blood Institute. <https://www.nhlbi.nih.gov/health/health-topics/topics/asthma/atrisk>

<sup>68</sup> “Asthma Facts” Center for Disease Control and Prevention. <http://www.cdc.gov/nchs/fastats/asthma.htm>

<sup>69</sup> “Nevada State Asthma Control Plan.” Department of Health and Human Services: Division of Public and Behavioral Health.

<sup>70</sup> Moonie S, Lucas JA. Nevada 2011-2014 Childhood Asthma Prevalence Statewide Report. University of Nevada, Las Vegas and Nevada Division of Public and Behavioral Health, Nevada State Department of Health and Human Services. April 2016

<sup>71</sup> “Asthma Statistics” American Academy of asthma & Immunology <http://www.aaaai.org/about-aaaai/newsroom/asthma-statistics>

<sup>72</sup> “Asthma Signs” National Heart, Lung, and Blood Institute. <https://www.nhlbi.nih.gov/health/health-topics/topics/asthma/signs>

<sup>73</sup> Moonie S, Lucas JA. Nevada Emergency Room – Asthma as Principle Diagnosis. University of Nevada, Las Vegas and Nevada Division of Public and Behavioral Health, Nevada State Department of Health and Human Services. April 2016

same children are less likely to receive adequate treatment and to have family or community support for their asthma management.”

To improve access to asthma medications in schools, the American Lung Association made the following recommendations<sup>74</sup>:

- State and local officials must educate all school personnel on existing laws and policies, and clarify expectations for their implementation.
- Schools, asthma advocates and healthcare providers must facilitate parent and caregiver engagement in the management of their child’s asthma at school.
- School districts must implement standardized protocols and instruments for the assessment of a student’s readiness to self-carry.
- Schools must provide access to back-up medication using standing orders for quick-relief medication.

Access to emergency albuterol inhalers provides a safe guard for children who do not have access to an inhaler. This legislation would be similar to Senate Bill 453, passed in 2013, which: allowed for a physician to issue an order for auto-injectable epinephrine to a public or private school; required for public schools to obtain an order from a physician or osteopathic physician for auto-injectable epinephrine to maintain the drug at the school; allowed a school nurse or other designated employee of the public or private school, as applicable, who has received training in the storage and administration of auto-injectable epinephrine to possess and administer auto-injectable epinephrine to a pupil on the premises of the school during the school day who is reasonably believed to be experiencing anaphylaxis; and require training in the storage and administration of epinephrine to be provided to designated employees of a public or private school.<sup>75</sup>

### **Recommendations:**

- Mandate schools to provide access to back-up albuterol inhalers using standing orders for quick-relief medication to be administered by a trained professional within the school. Training should include assessment for use of inhaler vs. epinephrine.
- Require school districts to implement standardized protocols and instruments for the assessment of a student need for an emergency inhaler.
- Work with pharmaceutical companies to reduce the fiscal burden on school districts purchasing the medication.
- Establish protections from liability for schools and medical providers writing the prescriptions.

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<sup>74</sup>“Improving Access to Asthma Medication in Schools” American Lung Association  
<http://www.lung.org/assets/documents/asthma/improving-access-to-asthma.pdf>

<sup>75</sup>“Senate Bill 453” 77<sup>th</sup> Nevada Legislative Session  
<http://www.leg.state.nv.us/Session/77th2013/Reports/history.cfm?billname=SB453>

## ACCESS TO HEALTHCARE - SPECIAL ISSUE

### CHIPRA for Lawfully Residing Immigrant Children

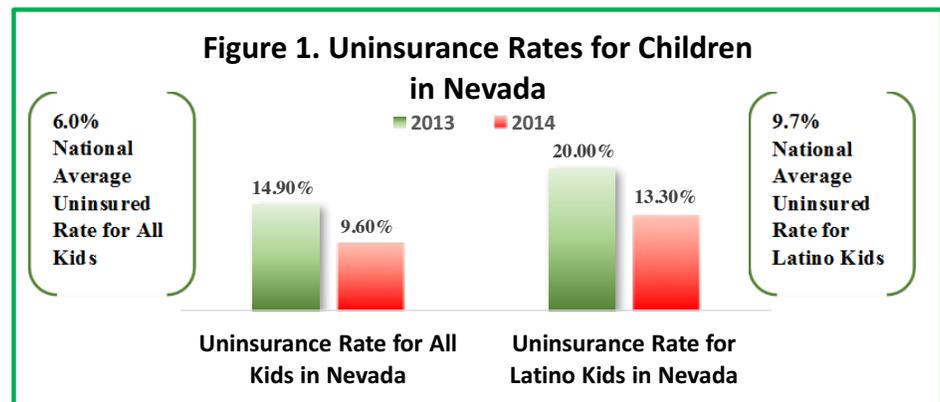
Nevada has made great strides in covering children in the last few years. Uninsurance rates for all children fell from 14.9% in 2013 to 9.6% in 2014 for all children, and from 20% in 2013 to 13.3% in 2014 for Latino children (see Figure 1). However, uninsurance rates still remain much higher than the national average of 6% for all kids and 9.7% for Latino kids in 2014.

To continue making gains in health coverage levels for children, Nevada has an opportunity to draw down federal funds to provide health coverage to lawfully residing children who are currently ineligible. In Nevada, only a very specific group of “qualified” immigrant children are currently eligible for Nevada Check Up (the State’s children’s health insurance program)<sup>76</sup> and most have to wait 5 years before they become eligible. However, § 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows states to cover lawfully

residing immigrant children without a 5 year waiting period. This means that lawfully residing immigrant children in Nevada would be able to receive coverage enabling them to access vital medical care as soon as they are enrolled. Accepting the CHIPRA option could potentially help 7,000

uninsured children living in Nevada. To-date, 31 states including the District of Columbia have taken up the CHIPRA option to lift the 5-year waiting period (see Figure 2).

CHIPRA § 214 allows Nevada to draw down federal funds to provide coverage to lawfully residing children who reside in families with incomes below 200% of federal poverty level (FPL). In Nevada, federal funding would cover 98.45 of the cost of Nevada Check Up (the States children’s health insurance plan) through FY 2017. In addition to the very limited fiscal impact that covering these children would likely have on the state, there is evidence that take-up of the CHIPRA option leads to improved health outcomes for low-income immigrant children. A 2014 study published in the Journal *Health Affairs* found that immigrant children’s coverage



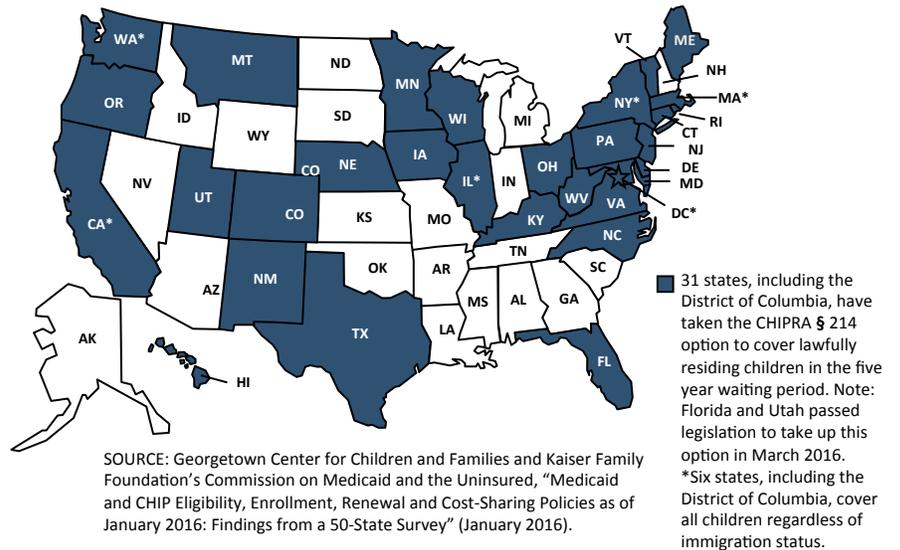
<sup>76</sup> The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA / welfare reform) of 1996 restricted immigrants eligibility for Medicaid and CHIP to a narrow group of qualified immigrants, many of whom have to wait five years before becoming eligible for coverage.

rates increased by 24.5% in the states that had taken the CHIPRA option compared to states that had not and these states also reported fewer instances of unmet health care needs.<sup>77</sup>

**Potential Fiscal Implications:**

Removing the 5-year waiting period for legally residing immigrant children would result in a nominal cost to the state due to the 98.45% federal funding match for Nevada. Estimates show that if Nevada elects the CHIPRA § 214 option for children, it will cost the state between \$150,000 and \$300,000 per year.<sup>78</sup> However, the cost to the State may be even lower when considering the amount Nevada already spends on Emergency Medicaid for children who are currently ineligible based on immigration status.

**Figure 2: States Providing Coverage to Lawfully Residing Children**



**Recommendations:**

Nevada should remove the 5-year waiting period for legally residing immigrant children in order to provide Medicaid and Nevada Check Up to more children in the state.

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<sup>77</sup> Brendan Saloner, Neel Koyawala, and Genevieve M. Kenney. “Coverage for Low-Income Immigrant Children Increased 24.5 Percent in States that Expanded CHIPRA Eligibility.” *Health Affairs* 33 (5): 832-839.  
<sup>78</sup> Estimate provided by the Georgetown University Center for Children and Families July 14, 2016.

## 2. PRENATAL and INFANT HEALTH

### Nevada Children’s Report Card Grade: C-

The prenatal, infant, and child health grade is based upon the number of pregnant women receiving late or no prenatal care, infant mortality rates, and the percentage of low birth weight babies in Nevada. Nevada has improved in infant and child mortality rates, decreasing from 5.72% to 5.1%, increasing in rank from 18<sup>th</sup> in 2014 to 13<sup>th</sup> in 2016. Low birthweight babies also showed a slight improvement, dropping from 8.2% to 8% in this reporting period. The most significant statistical improvement was the percentage of women receiving late or no prenatal care, which dropped from 11% in 2012 to 9% in 2014.<sup>79</sup>

Prenatal care refers collectively to the health services a pregnant woman receives before a baby’s birth. Studies have shown that prenatal care is important as potential problems that may endanger the mother or her baby are more likely to be discovered and treated before birth. It is recommended that a woman begins prenatal care in her first trimester and continues her prenatal visits on a regular basis until delivery.<sup>80</sup> Babies born to mothers who received no prenatal care are 3 times more likely to be born at a low birth weight and 5 times more likely to die than those whose mothers received prenatal care.<sup>81</sup>

According to the Centers for Disease Control and Prevention, preterm birth is the birth of an infant before 37 weeks of gestation. Preterm births cost the U.S. health care system more than \$26 billion in 2005.<sup>82</sup> In Nevada in 2013, 12.6% of infants were born preterm and this rate has only declined slightly since 2003 when the rate was 13.6%.<sup>83</sup> During the final stages of pregnancy, infants are going through the final stages of organ development which includes the development of the brain, lungs, and liver. If delivered early, the infant could experience complications including organ failure, breathing problems, developmental delays, and are at a higher risk for infant mortality.

According to the March of Dimes, low birthweight is when a baby is born weighing less than 5 pounds, 8 ounces. While infants with a low birthweight may not experience any complications, it can cause serious, immediate health conditions such as respiratory distress, bleeding in the brain, patent ductus arteriosus (a congenital heart defect), as well as long term health conditions such as diabetes, heart disease, high blood pressure, metabolic syndrome, and obesity. Major risk factors for low birthweight include prematurity, inadequate maternal nutrition, and smoking.<sup>84</sup> In Nevada in 2015, 8.0% of infants were born at a low birthweight

<sup>79</sup> Kids Count, “Births to Women Receiving Late or No Prenatal Care,” <http://datacenter.kidscount.org/data/tables/11-births-to-women-receiving-late-or-no-prenatal-care?loc=1&loct=2#detailed/1/any/false/36,868,867,133,38/any/265,266> (July 2015)

<sup>80</sup> “Prenatal Care and Infant Mortality in Nevada,” <http://cdclv.unlv.edu/healthnv/prenatalcare.html> (November 5, 2004)

<sup>81</sup> Office on Women’s Health, U.S. Department of Health and Human Services, “Prenatal care fact sheet,” <http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.html?from=AtoZ>

<sup>82</sup> Center for Disease Control and Prevention, “Preterm Birth,” <http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PretermBirth.htm> (October 30, 2014)

<sup>83</sup> March of Dimes, “Peristats,” [http://www.marchofdimes.org/Peristats/pdflib/999/pds\\_32\\_3.pdf](http://www.marchofdimes.org/Peristats/pdflib/999/pds_32_3.pdf) (May 30, 2014)

<sup>84</sup> March of Dimes, “Your premature baby,” <http://www.marchofdimes.org/baby/low-birthweight.aspx#> (October 2014)

which is a decrease from the previous reporting period, but represents an increase from 7.2% in 2003.<sup>85</sup>

## **RECOMMENDATIONS FOR IMPROVEMENT:**

- *Maternal and child health services for prenatal care through the postpartum period need to be expanded and made more accessible for all parents including parents with diverse backgrounds and/or those who are economically challenged.*
- *While efforts have been made to establish additional medical schools in Nevada, as well as reciprocity for licensure, Nevada needs to continue to support efforts to train and retain medical providers locally to increase access and availability, especially for specialty care providers.*
- *Increase outreach efforts and programs that provide educational and referral services to families to increase participation in preventative care practices and other necessary services.*
- *Support efforts to improve education and outreach about family planning and interconception care as well as early identification of pregnancy and enrollment in early prenatal care.*

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<sup>85</sup> America's Health Rankings, United Health Foundation, "Low Birthweight," <http://www.americashealthrankings.org/Measures/Measure/NV/birthweight> (2016)

## ***PRENATAL and INFANT HEALTH - SPECIAL ISSUE***

### **Diaper Assistance for Families**

The cost of diapers places a huge financial burden on Nevada’s most at-risk families. Infants, on average, use about 240 diapers per month which costs a family – assuming they can purchase in bulk - approximately \$78 per month. A two parent family with an infant making \$2,226.64 a month (133% of poverty)<sup>86</sup> would spend 3.5% of their monthly income on diapers. For families receiving public assistance, this cost is compounded by the fact that diapers are labelled as a luxury item, resulting in them not being covered by TANF (Temporary Assistance for Needy Families), Food Stamps (SNAP Program), or WIC (Special Supplemental Nutrition Program for Women, Infant, & Children).

A study by Yale University<sup>87</sup> found that 30% of mothers reported that they were unable to afford to change their child’s diapers as often as they would like. To “stretch” the use of diapers many families reported reusing diapers –removing the diapers, dumping out the excrement and then placing the soiled diaper on the infant – or leaving the soiled diapers on longer than they should. This practice leads to negative health outcomes for the child – such as urinary tract infections (UTIs) – sometimes resulting in chronic UTIs – and severe diaper dermatitis (diaper rash). A lack of diapers also directly affects the mental health of mothers. The same Yale study found, “diaper need was more likely among mothers [identified as having] some form of mental health need”.

The use of cloth diapers is not an option for many low-income working families. For these families the ability to send their infant to child care often requires providing disposable diapers to the facility.<sup>88</sup> Low income families also struggle with washing and drying the disposable diapers, as washing machines and dryers are not always available for use in their housing units.

### **Cloth Diapers**

The use of cloth diapers is not an option for many families as:

- Child Care Facilities typically will not accept cloth diapers (due to health and sanitary reasons) and require parents to provide a supply of disposable diapers.
- Washing machines and dryers are a luxury that many low-income families cannot afford.
- Coin-laundromats do not allow cloth diapers (due to health and sanitary reasons)

<sup>86</sup> According to the 2015 Federal Poverty Guidelines, <http://ccf.georgetown.edu/wp-content/uploads/2015/01/2015-Federal-Poverty-Guidelines.pdf>

<sup>87</sup> “Diaper Need and Its Impact on Child Health” *Pediatrics: Official Journal of the American Academy of Pediatrics*. <http://pediatrics.aappublications.org/content/pediatrics/early/2013/07/23/peds.2013-0597.full.pdf>

<sup>88</sup> NRS 432a and NAC 432a do not prohibit the use of cloth diapers in child care facilities. Many facilities have this requirement out of convenience, health, and sanitary reasons.

These families then cannot wash and dry the diapers at coin-laundromats as they do not allow for the washing and drying of cloth diapers due to health and sanitary reasons.

Families who can afford to purchase diapers suffer from price inequality – low income families pay upwards of two to three times the price of diapers compared to middle to high income families. This is largely due to their inability to purchase diapers in bulk at big-box stores or through the internet– due to a lack of transportation, cash flow or credit. These families are also burdened by the sales tax they pay on diapers. In Nevada, the lowest sales tax rate is 6.850%. This tax provides an additional burden on a necessity good for families, as they pay more than \$60 a year in taxes for diapers alone.

## Sales Tax on Diapers

According to a 2014 Fifty State Survey on the Sales Tax Treatment of Diapers by the National Diaper Bank Network:

- Twelve states do not have a sales tax on diapers.
  - o Five of which do not have a sales tax in general.
  - o The other seven states have exempted diapers from their tax.

### Recommendations:

- Create a child diaper fund to provide diapers to women with infants participating in the Women, Infant, and Children (WIC) program. This fund would provide a monthly \$50 credit for participants to purchase diapers for their infant. In fiscal year 2015, there was an average of 17,415 infants in Nevada participating in WIC.<sup>89</sup>
- Remove the state sales tax on diapers. This would provide all working families with a relief from paying taxes on a necessary good.<sup>90</sup>
- Encourage convenience stores and businesses in low-income neighborhoods to sell diapers in bulk.

### For more information on this topic, please contact:

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[www.caanv.org](http://www.caanv.org)

<sup>89</sup> "WIC Program Statistics and Data" United States Department of Agriculture: Food and Nutrition Service.

<http://www.fns.usda.gov/pd/wic-program>

<sup>90</sup> There is an estimated 105,970 children ages 0-2 living in Nevada (2015 American Community Survey). Assuming all of these families spend \$78 per month on diapers – \$936 annually – the potential lost net tax revenue is \$6.8 million a year (64.12 x 105,970).

### 3. IMMUNIZATIONS

#### Nevada Children's Report Card Grade: D

The immunizations grade focuses on the percentage of children receiving recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines by age 19 to 35 months. Considered by many to be our society's greatest healthcare achievement, childhood immunizations provide a preventative measure against a variety of once common diseases such as polio, measles, pertussis, meningitis, and many more. Nevada children have lower immunization rates than their nationwide counterparts and Nevada parents have reported difficulties in ensuring their children receive all CDC recommended doses of vaccines. In 2015, 67.7% of Nevada's children ages 19 to 35 months received the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines compared to 71.6% nationwide. Nevada ranks 37<sup>th</sup> in the percentage of children who receive their recommended immunizations by age 19 to 35 months.<sup>91</sup>

#### ***Nevada WebIZ***

Nevada's Immunization Information System (IIS), Nevada WebIZ, continues to see positive results from the implementation of Nevada Revised Statute (NRS) 439.265. As of July 2016, there are:

- 1,442 Providers
- 2,969 Clinics
- 14,739 Users
- 3,327,027 Patient Records
- 35,109,391 Vaccinations

However, there are still providers not using Nevada WebIZ to its fullest capacity. Accurate, timely, and complete widespread use of Nevada WebIZ would reduce unnecessary immunizations; provide better data to identify Nevada's vaccination gaps, especially during periods of outbreak; provide access for patient reminder/recall; facilitate patient use of the Nevada WebIZ Public Access Portal; and help providers better manage immunization inventory and administration within their practice.

#### ***Challenges with Implementation of ACA***

The changing health care marketplace continues to create challenges for immunization delivery in Nevada and across the country. Physicians in private practice continue to experience great economic pressure as vaccine costs rise and reimbursement rates shrink. Also, as the number of recommended vaccines has increased, some providers simply cannot afford to stock the increased inventory. As a result, more private offices are no longer administering all vaccines and end up referring their patients

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<sup>91</sup> America's Health Rankings, United Health Foundation, <http://www.americashealthrankings.org/NV> (2016)

to local public health and Federally Qualified Health Center (FQHC) sites. Privately insured Nevadans also utilize these clinics for convenience, because access to a primary care physician can be limited due to the inability to quickly get appointments. Ranking at 51<sup>st</sup>, Nevada has the lowest per capita public health funding expenditures in the U.S. at \$4.10, while the median per-capita expenditure is \$33.50.<sup>92</sup> Unfortunately, due to this and other factors, health districts and public health clinic sites are facing budget strains and personnel cuts at the same time their patient loads are increasing.

### **Medicaid Expansion**

Nevada's Medicaid expansion has been immensely successful; however, Nevada is already functioning within a physician shortage environment. Ranked as 47<sup>th</sup> in terms of physician to population ratio, Nevada needs more than 2,900 new doctors to catch up with the national rate of physicians per capita.<sup>93</sup> Many existing physicians are reluctant to see patients covered by Medicaid (or to accept new patients covered by Medicaid) due to low reimbursement rates, which is also taxing the public health and FQHC sites. Medicaid-covered vaccines are supplied to children through the Vaccines for Children (VFC) Program and only the administration fees are reimbursable. The Centers for Medicare and Medicaid Services' (CMS) cap for Nevada's administration fee is \$7.80/dose<sup>94</sup> and \$22.57/dose is the maximum allowable VFC admin fee for non-Medicaid covered children.<sup>95</sup> It is important to note that providers cannot refuse to vaccinate a VFC-eligible child with VFC vaccine due to the parent/guardian's inability to pay the vaccine admin fee. Nevada's immunization leadership and stakeholders continue to express concern about the fragmentation of the vaccine delivery system.

### **RECOMMENDATIONS FOR IMPROVEMENT:**

- *Increase accurate and timely use of Nevada WebIZ statewide in order to reduce unnecessary immunizations and facilitate accurate coverage assessments.*
- *Increase availability and affordability of public and private vaccines for children in Nevada.*
- *Increase incentives for doctors to accept children covered by Medicaid to increase the availability of providers for these children.*
- *Increase providers and medical services in Nevada to increase access to care.*

<sup>92</sup>"Investing in America's Health: A State-By State Look At Public Health Funding and Key Health Facts 2016". Trust for America's Health <http://healthyamericans.org/assets/files/TFAH-2016-InvestInAmericaRpt-FINAL.pdf>

<sup>93</sup>"Physician Workforce in Nevada: 2016 Edition" UNSOM Health Policy Report. [http://medicine.nevada.edu/Documents/unsom/statewide/reports/Physician\\_Workforce\\_in\\_Nevada\\_2016\\_Edition\\_-\\_March\\_2016\\_-\\_FINAL.pdf](http://medicine.nevada.edu/Documents/unsom/statewide/reports/Physician_Workforce_in_Nevada_2016_Edition_-_March_2016_-_FINAL.pdf)

<sup>94</sup> "Nevada Medicaid and Nevada Check Up Pharmacy Manual" Catamaran [https://www.medicaid.nv.gov/Downloads/provider/NV\\_Pharmacy\\_Manual.pdf](https://www.medicaid.nv.gov/Downloads/provider/NV_Pharmacy_Manual.pdf)

<sup>95</sup> "RIN 0938-AQ63" A Rule by the Centers for Medicare & Medicaid Services. Federal Registry <https://www.federalregister.gov/articles/2012/11/06/2012-26507/rin-0938-aq63#t-2>

## 4. CHILDHOOD OBESITY

### Nevada Children's Report Card Grade: B-

The childhood obesity grade is based on the percentage of children between the ages 10 and 17 whose Body Mass Index (BMI) is at or above the 85<sup>th</sup> percentile (15% overweight and 12.2% obese), the percentage of 9th-12th grade students not physically active 5 days per week for 60+ minutes (49%), and the percentage of children who do not consistently eat vegetables (7.2%). The rate of unhealthy bodyweight among children and adolescents in the US has tripled since the 1980s. For the first time in more than 100 years, children's life expectancy is declining due to an increase in obesity. Children who are overweight or obese are at a significantly higher risk for developing other serious health conditions including diabetes, heart disease, and hypertension.

American obesity is becoming an epidemic that cost more than \$147 billion in medical expenses in 2008. In Nevada, the prevalence of obesity in children continues to increase in all age categories, including 2-4 year olds (42.7% increase from 1989-2011) and 10-17 year olds (50% increase from 2004-2011).<sup>96</sup> Children who are obese are more likely to have a shortened lifespan and develop a variety of health problems, including hypertension, high cholesterol, liver disease, orthopedic problems, sleep apnea, asthma and more often, type 2 diabetes. They are also predisposed to be obese in adulthood. Research indicates that physically active and fit children tend to have better academic achievement, better school attendance, and fewer disciplinary problems. Children who get regular exercise may have improved concentration and cognitive functioning.<sup>97</sup>

- 12.2% of Nevada high school students are obese and 15% are overweight.<sup>98</sup>
- 31.5% of kindergarten students in Nevada were found to be overweight or obese.<sup>99</sup>
- 18% of 4<sup>th</sup>, 7<sup>th</sup> and 10<sup>th</sup> graders in Nevada are overweight and 20% are obese.<sup>100</sup>

In Nevada, physical education is not required in elementary schools, and even though it is a requirement for high school graduation, many children seek and are granted waivers.

<sup>96</sup> <http://stateofobesity.org/states/nv/>

<sup>97</sup> Trost S., "Active Education: Physical Education, Physical Activity and Academic Performance. A Research Brief," Princeton, NJ: Active Living Research, a National Program of the Robert Wood Johnson Foundation. (Summer 2009), Available from [www.activelivingresearch.org](http://www.activelivingresearch.org)

<sup>98</sup> "2015 Nevada Youth Risk Behavior Survey," (February 2016) <http://dhs.unr.edu/chs/research/yrbs>

<sup>99</sup> Nevada Institute for Children's Research and Policy, "Summary of Findings: Health Status of Children Entering Kindergarten: Results of 2014-2015 (Year Seven) Nevada Kindergarten Health Survey," (2015) [http://nic.unlv.edu/files/KHS%20Year%207%20Report\\_Final\\_.pdf](http://nic.unlv.edu/files/KHS%20Year%207%20Report_Final_.pdf)

<sup>100</sup> "BMI Summary Report and Recommendations; Nevada State Health Division," (2010) <http://www.leg.state.nv.us/Interim/75th2009/Exhibits/HealthCare/E052610C.pdf>

Substitutions are allowed for others, including online courses where there is no way to know if physical activity is actually being incorporated.

## **RECOMMENDATIONS FOR IMPROVEMENT:**

- *Enforce state and local school wellness policies at the school level.*
- *Increase the number of physical education minutes in schools. The consensus recommendation is 150 minutes per week in elementary schools and 250 minutes per week in middle schools.*
- *Reduce the number of physical education waivers and substitutions.*
- *Increase opportunities for physical activity and healthy eating in after-school and child care settings.*
- *Increase the number of public places including worksites, parks, recreation and community centers that offer healthy vending options.*
- *Increase availability of affordable healthy food options in communities, particularly communities within designated 'food deserts' and in low-income communities.*
- *Ensure development of a sustainable, well connected regional trail systems for physical activity, recreation and active transport.*
- *Increase the number of schools that are participating in Safe Routes to Schools programs, which will encourage more active transport for children to and from school.*
- *Support the adoption of Complete Streets<sup>101</sup> policies and the adoption of Complete Streets elements into local planning documents at the state, regional and local levels in order to make the environment safer for active transport.*
- *Support adoption of nutrition standards and/or menu labeling efforts in restaurants, movie theaters and other locations that serve meals and snacks so that parents can make informed and healthy choices about what to feed their children when out.*
- *Dedicate sustainable funding to support evidence-based obesity prevention efforts both in schools and in communities.*
- *Reinstate BMI Surveillance in schools so that childhood obesity rates can be monitored. This was the only source of actual measurement of BMI in Nevada and it expired in 2015.*

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<sup>101</sup> For more information on the Complete Streets policy, see: <http://www.smartgrowthamerica.org/complete-streets>

## **CHILDHOOD OBESITY - SPECIAL ISSUE**

### **Body Mass Index (BMI) Survey**

Obesity is among the greatest public health challenges of our time. According to the Center for Disease Control and Prevention (CDC), more than one third of the U.S. population is obese; which puts those individuals at risk for a number of medical conditions, including heart disease, stroke, type 2 diabetes, and cancer.<sup>102</sup> Together with being overweight, obesity is estimated to be the second leading preventable cause of death killing about 300,000 Americans each year.<sup>103</sup> In addition to these health concerns, obesity places a huge economic burden on the state. In 2006, the estimated cost associated with treating overweight and obesity in Nevada was \$337 million.<sup>104</sup>

An even more alarming trend is the growing prevalence of childhood obesity. From 1980 to 2012, obesity rates for children more than tripled. Childhood obesity causes numerous physical and mental health problems including heart disease, type 2 diabetes, asthma, sleep apnea, depression and low self-esteem, which could also have a negative effect on children's learning abilities and academic performance.<sup>105</sup> Obese children and adolescents are also more likely to become obese adults, which further increases the impact of this growing epidemic.<sup>106</sup>

The latest Nevada Kindergarten Health Study (2014-2015) conducted by the Nevada Institute for Children's Research and Policy within the UNLV School of Community Health Sciences found that 31.5% of children entering kindergarten are already overweight or obese.<sup>107</sup> As these rates continue to increase and threaten the quality of life of individuals, leaders in all levels of government seek ways to reverse the trends. In 2010, the United States Surgeon General Regina M. Benjamin called for a nationwide grassroots effort to prevent obesity, focused not only on personal choices and behaviors, but also on the characteristics of social and physical environments. In her message, she highlighted the role of schools, among other settings, as playing a critical role in preventing obesity and encouraged the implementation of school programs promoting physical activity and healthy nutrition.<sup>108</sup> One of the latest approaches in addressing obesity that has gained national attention is the body mass index measurement of students in schools.

<sup>102</sup> "Adult Obesity Facts" Centers for Disease Control and Prevention <http://www.cdc.gov/obesity/data/adult.html>

<sup>103</sup> "Obesity: Facts, Figures, Guidelines" <https://www.wvdhhr.org/bph/oehp/obesity/mortality.htm>

<sup>104</sup> "Strategic Plan for the Prevention of Obesity in Nevada. Nevada State Health Division Bureau of Community Health. September 2006. [http://www.getthehealthywashoe.com/fb\\_files/reports\\_obesity\\_plan.pdf](http://www.getthehealthywashoe.com/fb_files/reports_obesity_plan.pdf)

<sup>105</sup> "Obesity Facts" Centers for Disease Control and Prevention <http://www.cdc.gov/healthyschools/obesity/facts.htm>

<sup>106</sup> Ibid

<sup>107</sup> Nevada Institute for Children's Research and Policy, "Summary of Findings: Health Status of Children Entering Kindergarten: Results of 2014-2015 (Year Seven) Nevada Kindergarten Health Survey," (2015) [http://nic.unlv.edu/files/KHS%20Year%207%20Report\\_Final\\_.pdf](http://nic.unlv.edu/files/KHS%20Year%207%20Report_Final_.pdf)

<sup>108</sup> Ibid.

Body mass index (BMI) is estimated as a person's weight divided by their height squared (BMI = kg/m<sup>2</sup>, or BMI = lb/in<sup>2</sup> \* 703). While BMI is not a direct measure of body fat, it does correlate with body fat, and is widely used to estimate a person's risk of weight-related health problems. There are other, more sophisticated measures, of body fat, such as skinfold thickness measurement, underwater weighing, computerized tomography (CT) and magnetic resonance imaging (MRI), but they are much more invasive and expensive to administer.<sup>109</sup> BMI is the most basic and most common way of measuring body fat that is also inexpensive and easy to calculate. Despite its limitations, BMI has shown results comparable to the most accurate measures available, and has been proven to predict higher risk of chronic disease and early death.<sup>110</sup>

On June 30, 2015, the requirement for school districts to collect the height and weight data from a representative sample of Nevadan students in 4<sup>th</sup>, 7<sup>th</sup>, and 10<sup>th</sup> grades sunset. This information was used to calculate the average BMI for students across the state and was used for a variety of purposes, including:

- Describing trends in weight status over time;
- Identifying demographic groups at higher risk of obesity;
- Increasing awareness on the extent of obesity among youth;
- Driving improvements in public policy and practice, as well as services aimed at preventing and treating obesity;
- Monitoring the effects of new and existing programs; and
- Measuring progress towards achieving specific goals.

Without this information, Nevada may struggle to qualify and compete with other states when applying for federal funding or philanthropic grants. Many grant awards, such as those funded by the Centers for Disease Control and Prevention (CDC), increasingly require proof that their resources are making a positive impact on public health. This would put further strains on Nevada, which, according to a Trust for America's Health and Robert Wood Johnson Foundation report, ranked 31<sup>st</sup> in the nation for the amount of funding received by the CDC.<sup>111</sup>

Some of the grants that have been awarded to Nevada in the past, which used BMI data to apply for funds, include:

- CDC grant funding the Communities Putting Prevention to Work (CPPW) initiative designed to tackle obesity and tobacco use throughout 50 different communities in Nevada;<sup>112</sup>
- The Partnerships to Improve Community Health (PICH) grant (\$2,650,555) awarded to the Southern Nevada Health District to drive down chronic diseases in Clark County;<sup>113</sup>

<sup>109</sup> "Measuring Obesity" Harvard T.H. Chan: School of Public Health <https://www.hsph.harvard.edu/obesity-prevention-source/obesity-definition/how-to-measure-body-fatness/>

<sup>110</sup> "Why Use BMI?" Harvard T.H. Chan: School of Public Health <https://www.hsph.harvard.edu/obesity-prevention-source/obesity-definition/obesity-definition-full-story/>

<sup>111</sup> "Shortchanging America's Health" Robert Wood Johnson Foundation <http://www.rwjf.org/en/library/research/2010/03/shortchanging-america-s-health.html>

<sup>112</sup> [http://www.cdc.gov/nccdphp/dch/programs/communitiesputtingpreventiontowork/communities/profiles/both-nv\\_clark-county.htm](http://www.cdc.gov/nccdphp/dch/programs/communitiesputtingpreventiontowork/communities/profiles/both-nv_clark-county.htm)

<sup>113</sup> "Newsroom" Southern Nevada Health District <http://southernnevadahealthdistrict.org/news14/092514-snhd-awarded-2-mil-to-drive-down-disease-in-clark-county.php>

- \$1.3 million grant received by the Lincy Foundation that was used mainly to fund the Healthy Schools Program, which aims to improve schools in the areas of nutrition, physical activity and staff wellness.<sup>114</sup>

Although we do not currently have an exact estimate of the total cost associated with school-based BMI measurements in the state of Nevada, we anticipate that all costs would far outweigh the benefits of implementing the program. For example, in 2014, Nevada Wellness issued a report on the BMI Data Collection Status in Nevada for the period between 2011 and 2012 (during that time only two counties, Washoe and Clark, conducted BMI measurements and only on a sample of students). The report provided the following estimate annual costs associated with BMI data collection: \$128,554 for equipment (one-time cost), \$116,999 for labor (including salaries and training), and \$870 for materials, for an initial cost of \$246,423.<sup>115</sup> Deducting the one-time cost of equipment, the average yearly cost would be \$117,879.

### Recommendations:

The Nevada Legislature should mandate the annual collection of BMI data in school for surveillance purposes. We also recommend that legislators ensure the following elements:

- **Anonymity** – Students’ data must be collected, analyzed, and interpreted anonymously, and without sharing individual children’s weight status to avoid potential negative outcomes, such as a privacy breach, bullying, or lowering of students’ self-esteem.
- **Privacy** – Height and weight measurements must be taken in private and by a trained technician to ensure that children do not suffer any adverse effects in the process.
- **Opting-out** – Parents must be notified in advance about the measurements taking place in schools and also be given an opportunity to opt their children out of the program if they wish do not want their child to participate.

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<sup>114</sup> “State Reports: Progress in the Health Schools Program Nevada 2012” Alliance for a Healthier Generation [https://schools.healthiergeneration.org/\\_asset/xk4xez/](https://schools.healthiergeneration.org/_asset/xk4xez/)

<sup>115</sup> “BMI Data Collection In Nevada School Districts” Chronic Disease Prevention and Health Promotion: Obesity Prevention Program <http://dpbh.nv.gov/uploadedFiles/dpbhngov/content/Boards/CWCD/Meetings/2014/Exhibit%20C%20BMI%20Data%20Collection%20Nevada%20School%20Districts.pdf>

## 5. DENTAL HEALTH

### Nevada Children’s Report Card Grade: F

The dental health grade is based upon preventative dental health care visits of 9<sup>th</sup> to 12<sup>th</sup> graders in Nevada. Nevada ranks 29<sup>th</sup> in the nation for the percentage of 9-12<sup>th</sup> grade students who have had a preventative dental care visit within the past year. Currently, 68.9% of students have had a dentist visit in the past year, less than the national average of 74.4% reported for 2015, but up slightly from 68.3% in 2013 for Nevada.

Oral health plays a significant role in overall health and wellbeing. It is intimately related to the health of the entire body and plays a vital role in overall physiology. Mounting evidence has shown infections in the mouth such as periodontal gum disease to increase the risk of heart disease, increase the risk of premature labor, and disrupt the ability of the body to regulate blood sugar for people living with diabetes.<sup>116</sup> The far-reaching effects of oral health demonstrate the enormous importance of proper oral and preventative health care for people of all ages.

According to the 2012 Burden of Oral Disease in Nevada report, Nevadans experience many oral diseases in greater number than their national counterparts. The 2008 Third-Grade “Healthy Smile, Happy Child” report found that more than 65% of Nevada’s third-grade students have tooth decay in comparison to just 53% nationwide.<sup>117</sup> Further, significantly more adolescents in Nevada suffer with untreated tooth decay than their national counterparts (28% vs. 18%). These effects are compounded by the fact that many Nevadans report experiencing barriers in accessing proper preventative dental care. As many oral diseases are progressive and become more difficult to manage over time, there exists a great need to improve access to preventative and regular dental care for children across all of Nevada.

#### **RECOMMENDATIONS FOR IMPROVEMENT:**

- *Develop and fund outreach and education programs to promote good dental hygiene among children, as well as appropriate preventative dental visits.*
- *Ensure that dental care is adequately covered under Medicaid and Nevada Check-Up, with reimbursement rates that reflect provider costs.*

<sup>116</sup> “The Burden of Oral Disease in Nevada,” <http://nsla.nevadaculture.org/statepubs/epubs/31428002984595-2012.pdf> (April 2012)

<sup>117</sup> Oral Health Publication – Nevada State Health Division, “Healthy Smile, Happy Child” (2008) [http://dphh.nv.gov/uploadedFiles/dphhngov/content/Programs/OH/Oral\\_Health\\_Program\\_Reports/Burdenoforaldisease2008.pdf](http://dphh.nv.gov/uploadedFiles/dphhngov/content/Programs/OH/Oral_Health_Program_Reports/Burdenoforaldisease2008.pdf)

## 6. MENTAL HEALTH

### Nevada Children’s Report Card Grade: D-

The mental health grade is based upon rates of mental health treatment, suicide attempts, and teen suicide rates. Nevada ranks 49<sup>th</sup> in the nation for overall rates of youth mental health treatment in which children received needed mental health treatment or counseling in the past 12 months. While Nevada’s attempted suicide rank dropped from 16<sup>th</sup> in 2013 to 30<sup>th</sup> in 2015, with a significant increase in attempts – 10.7% in 2015 compared to 6.8% in 2013 – our actual suicide rate has gone down from 3.88 to 2.29 (per 100,000 children age 0-18), increasing our rank from 36<sup>th</sup> to 16<sup>th</sup>.

The World Health Organization lists mental illness as the single most common cause of disability in young people worldwide. Despite this fact, Nevada has cut its mental health funding budget by 28.1% since 2009 and has one of the lowest per capita rates of mental health funding in the nation.<sup>118</sup> Mental health is an essential part of children’s overall health, with extensive influence on children’s physical health and their ability to succeed in school, work, and society.<sup>119</sup> In spite of a growing nationwide need for age appropriate and evidence-based mental health interventions for children, funding for children’s mental health continues to decline.

- Half of lifetime mental health disorders start by age 14.<sup>120</sup>
- In the US, 20% of youth ages 13-18 live with a mental health condition.<sup>121</sup>
- In 2014-2015, in Nevada, 4.9% of children served through the State Mental Health Agency (SMHA) met the federal definitions of a serious emotional disorder (SED) while also having a substance abuse diagnosis.<sup>122</sup>
- It is estimated that only 7% of youth who need services receive appropriate help from mental health professionals.<sup>123</sup>

It is of great importance to appropriately address mental health issues in childhood and early adolescence as many disorders have life-long effects. These include not only psychological effects, but great economic costs for families, schools, communities, and the state. While this

<sup>118</sup> National Alliance on Mental Illness State Advocacy, “State Statistics: Nevada” (2010) <https://www2.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93507>

<sup>119</sup> The State of America’s Children,” <http://www.childrensdefense.org/child-research-data-publications/data/2014-soac.pdf> (2014)

<sup>120</sup> National Institute of Mental Health Release of landmark and collaborative study conducted by Harvard University, the University of Michigan and the NIMH Intramural Research Program (release dated June 6, 2005 and accessed at [www.nimh.nih.gov](http://www.nimh.nih.gov)).

<sup>121</sup> “Mental Health Facts: Children & Teens” National Institute of Mental Illness <http://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf>

<sup>122</sup> Nevada 2015 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System SAMHSA Uniform Reporting System (URS) Output Tables 2015 SAMHSA Uniform Reporting System (URS) Output Tables

<sup>123</sup> American Psychological Association, “Children’s Mental Health,” <http://www.apa.org/pi/families/children-mental-health.aspx>

economic burden is great, the life-long effects of undiagnosed mental health disorders are far-reaching and forever affect the ability of young people to establish healthy interpersonal relationships, succeed in school, and become a part of the work force. In addition, research shows that “the high rate of comorbidity between drug use disorders and other mental illnesses argues for a comprehensive approach to intervention that identifies and evaluates each disorder concurrently, providing treatment as needed.”<sup>124</sup>

Nevada consistently has one of the highest youth suicide rates in the country.<sup>125</sup> In 2014, suicide was the second leading cause of death for 15 to 24 year old Nevadans, with a rate of 15.02 suicides for every 100,000 youth. The national average rate for the same age group was 11.55 per 100,000.<sup>126</sup> Comparing youth ages 10-24, Nevada ranks just above the national average of 8.51 with a Nevada rate of 10.50 per 100,000. The Nevada Youth Risk Behavior Survey (YRBS) for 2015 found that 17.7% of high school students had seriously considered attempting suicide, 15.8% of high school students made a suicide plan, and 9.8% of high school students actually attempted suicide.<sup>127</sup> According to the Clark County Children’s Mental Health Consortium Annual Plan, all school children need access to screening and universal behavioral health promotion activities. The findings from the assessments in each system point to the need to develop a system that supports children and families in a way to avoid entrance into public service systems, such as child welfare, juvenile justice and special education.<sup>128</sup> By providing public education environments that support wellness through behavioral health promotion activities, many children could avoid deeper involvement in the public service systems.

All children have the right to live healthy lives and deserve access to appropriate and effective mental health care. It is important to address the tremendous amount of unmet need and improve the state of children’s mental health care in Nevada. Mental health promotion within communities and schools as well as screening for early detection of youth who are at risk for suicide are working and are imperative to preventing youth from attempting and taking their own lives.

#### **RECOMMENDATIONS FOR IMPROVEMENT:**

- *Accelerate efforts to promote awareness and help-seeking behaviors among youth in the education system, as well as screening and early intervention to identify behavioral health disorders before there is a crisis.*

<sup>124</sup> National Institute of Drug Abuse Research Report Series. Comorbidity: Addiction and Other Mental Illnesses. NIH Publication Number 10-5771 Revised September 2010

<sup>125</sup> Nevada Office of Suicide Prevention

<sup>126</sup> “Web-based Injury Statistics Query and Reporting System, 2014 Data,” <http://www.cdc.gov/injury/wisqars/> (2014)

<sup>127</sup> 2015 Nevada High School Youth Risk Behavior Survey Report <http://dhs.unr.edu/Documents/dhs/chs/yrbs/2015-YRBS-Reports/2015-Nevada-HS-YRBS-Final.pdf>

<sup>128</sup> Clark County Children’s Mental Health Consortium, “10 Year Strategic Plan.” (2010) <http://dcfs.nv.gov/uploadedFiles/dcfsnv.gov/content/Meetings/CCCMHC%20Status%20Report%202015%20EXPANDED-FINAL-2-23-15.pdf>

- *Identification and treatment of substance abuse must be included in any effort to improve mental and behavioral health issues.*
- *Universal screening for suicide risk and substance abuse should also be routine in all primary care, hospital care (especially emergency department care), behavioral health care, and crisis response settings (e.g., help lines, mobile teams, first responders, crisis chat services). Any person who screens positive for possible suicide risk should be formally assessed for suicidal ideation, plans, availability of means, presence of acute risk factors (including history of suicide attempts), and level of risk.*
- *Public health and behavioral health organizations should assure staff working with persons at risk of suicide have been appropriately trained and possess requisite skills.*
  - *All persons identified as at risk of suicide by primary care practices and clinics, hospitals (especially emergency departments), behavioral health organizations and crisis services should have a collaboratively designed safety plan prior to release from care. Persons with suicidal risk leaving intervention and care settings should receive follow-up contact from the provider or caregiver.*
- *Continue to increase mental health promotion in schools, such as social and emotional learning along with suicide prevention strategies that need to be implemented for elementary, middle, and high school students. Strategies in the education system need to be tailored to target audiences by gender, race, disability, and sexual orientation.*
- *Suicide prevention training is needed in the foster care, juvenile justice and child welfare systems to address the large numbers of youth with depression and suicidal ideation.*
- *Mobile crisis assessment needs expansion to ensure crisis response, family stabilization, and continuity of care for youth who are identified as at-risk or who have previously attempted suicide.*
- *Build up the workforce in all parts of Nevada, especially in rural regions, so there is local ability to provide appropriate mental health resources.*
  - *Address mental health licensure by requiring reasonable and transparent licensure reciprocity for mental health providers in order to expand the available workforce.*
  - *Support greater use of technology to enhance access to mental health services, especially in areas where transportation is problematic, such as the rural regions of our state.*
- *Support youth to succeed as adults. Develop, fund and implement system-level policies coupled with successful strategies to help youth with mental health needs transition to postsecondary education, employment, and independent lives.*

## 7. Sexual Health

### Nevada Children's Report Card Grade: D+

The sexual health grade encompasses many factors such as teen birth rate, sexual activity, condom use, any birth control use, and sexually transmitted disease (STD) rates. With 12.4% of Nevada's high school students not using any type of birth control, Nevada ranks 14<sup>th</sup> out of the 33 states reporting this information. This directly affects the teen birth rate of 29 births per 1,000 females ages 15 to 19 and ranks Nevada 38<sup>th</sup> in the nation – an average of five births higher than the national average. Nevada ranks 28<sup>th</sup> out of 38 states reporting information for condom use. With regard to STD rates, Nevada ranks toward the middle for chlamydia (22<sup>nd</sup>) and gonorrhea (26<sup>th</sup>), but has seen a sharp increase in syphilis from 9.7 (per 100,000 15 to 24 year olds) in 2011 to 25.1 in 2014, ranking Nevada 50<sup>th</sup> in the nation.<sup>129</sup>

Every school district in Nevada is currently required to teach some sex education (NRS 389.065), but standards vary across the state.<sup>130</sup> As of January 2012, national standards exist for sexuality education, as they do for math and reading. Including sex education standards in our health standards and curriculum ensures our youth receive consistent, medically-accurate, factual information to make informed decisions.

- Teen childbearing cost Nevada taxpayers at least \$68 million in federal, state, and local dollars in 2010. Between 1991 and 2010 there were 73,470 teen births in Nevada, costing taxpayers a total of \$1.5 billion over that period.<sup>131</sup>
- Nevada has made some progress and the teen birth rate in Nevada declined 62% between 1991 and 2014 saving taxpayers millions of dollars.<sup>132</sup>
- Young people (ages 15-24) are particularly affected, accounting for half (50 percent) of all new STIs.<sup>133</sup>
- Nevada's HIV infection rate ranks 24<sup>th</sup> in the United States, with a rate of 16.4 cases per 100,000 individuals compared to the national rate of 13.9 cases per 100,000.<sup>134</sup>
- STIs place a significant economic strain on the U.S. healthcare system. CDC conservatively estimates that the lifetime cost of treating eight of the most common STIs contracted in just one year is \$15.6 billion.<sup>135</sup>

<sup>129</sup> Please see Appendix: Report Card Sources

<sup>130</sup> Clark County School District "Sex Education Curriculum Information," <http://www.ccsd.net/students/sex-ed-info.php> (November 2014)

<sup>131</sup> "Nevada Data" The National Campaign to prevent Teen and Unplanned Pregnancy <http://thenationalcampaign.org/data/state/nevada>

<sup>132</sup> Ibid.

<sup>133</sup> "Incidence, Prevalence, and Cost of Sexually Transmitted Infections in the United States. CDC Fact Sheet. <http://www.cdc.gov/std/stats/sti-estimates-fact-sheet-feb-2013.pdf>

<sup>134</sup> "Surveillance Report: Diagnosis of HIV Infection in the United States and Dependent Areas, 2014." Centers for Disease Control and Prevention. <http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-us.pdf>

<sup>135</sup> "Incidence, Prevalence, and Cost of Sexually Transmitted Infections in the United States. CDC Fact Sheet. <http://www.cdc.gov/std/stats/sti-estimates-fact-sheet-feb-2013.pdf>

- In a 2008 study, young people who received evidence-based, age-appropriate and medically accurate sexuality education used significantly fewer acts of violence toward a dating partner by the end of Grade 11.<sup>136</sup>
- Among sexually active boys, those who received evidence-based, age-appropriate and medically accurate sexuality education were more likely to practice safe sex 2.5 years later (i.e., always use a condom).<sup>137</sup>
- Teens who received evidence-based, age-appropriate and medically accurate sexuality education were 50% less likely to experience pregnancy than those who received abstinence-only education.<sup>138</sup>

Widespread support exists for balanced, evidence-based sex education in Nevada. A January 2013 poll conducted in the state showed that 67% of Nevadans agree with the policy of “teaching sex education in schools, including age-appropriate discussions of birth control options.”<sup>139</sup>

#### **RECOMMENDATIONS FOR IMPROVEMENT:**

*Some level of sex education is currently required in Nevada schools, but the curriculum is not consistent across the state. Policies should be implemented so that all school districts offer\* consistent evidence-based, age-appropriate and medically accurate sexuality education curriculum that will include:*

- *Reproductive and sexual anatomy and physiology, including biological, psychosocial and emotional changes that naturally occur.*
- *Accurate information on AIDS/HIV and STI prevention, testing and treatment as well as contraception, with an emphasis on refraining from sex as the most effective way to prevent pregnancy and sexually transmitted infections.*
- *Development of interpersonal and life skills to help students develop healthy relationships and make responsible decisions about sexuality and sexual behavior.*
- *Inclusion and acceptance of individuals regardless of race, gender, gender identity, religion, sexual orientation, ethnic or cultural background or disability.*
- *Identification and prevention of domestic and dating violence, sexual abuse and legal, medical and counseling resources available.*
- *Awareness and understanding to prevent participation or exploitation of sexually explicit material over the internet and other media platforms.*

*\*This recommendation still maintains that parents would be able to make decisions about their children’s participation in this coursework, without penalty.*

<sup>136</sup> CAMH Centre for Prevention Science. The Fourth R: Relationship Based Violence Prevention. 2008. <http://youthrelationships.org>

<sup>137</sup> CAMH Centre for Prevention Science. The Fourth R: Relationship Based Violence Prevention. 2008. <http://youthrelationships.org>

<sup>138</sup> “Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S.” <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3194801/>

<sup>139</sup> Third Eye Strategies (2012). Nevada Voter Opinions July through December 2012. Produced and distributed by the State Capacity & Innovation Foundation.

# Safety

“Safety and security don’t just happen, they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear.”

- Nelson Mandela, Former President of South Africa

## Children’s Safety Overview

1. Child Maltreatment
2. Youth Homelessness
3. Juvenile Violence
4. Child Deaths and Injury
5. Substance Abuse

## **Children’s Safety Overview**

### **Nevada Children’s Report Card Grade: D+**

In 2015, over 669,000 children under the age of 18 years old lived in Nevada.<sup>140</sup> Each of these children deserve to be safe and secure, but often lack the skills to protect and care for themselves. For this reason, it is the responsibility of the parents, guardians, and the community to ensure the safety of all our children and youth. Factors such as poverty, low educational attainment, substance abuse, and domestic violence can all have an impact on children’s safety – resulting in abuse and neglect, homelessness, juvenile violence, preventable injuries and sometimes fatalities. Ensuring that children, and their families, have appropriate access to key resources is essential to improving the safety of children and youth in Nevada.

Children’s safety can mean a variety of things, but for the purpose of this briefing book, the areas of child safety are narrowed to the following five areas that need improvement and contribute to the Overall Children’s Safety Grade of D+, which the state received on the 2016 Children’s Report Card. Details in each of these areas are provided in the sections below in addition to recommendations for improvement in the state. These factors include:

- 1. Child Maltreatment**
- 2. Youth Homelessness**
- 3. Juvenile Violence**
- 4. Child Injury and Death**
- 5. Substance Abuse**

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<sup>140</sup> “American Fact Finder” United States Census Bureau <http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>

# 1. Child Maltreatment

## Nevada Children’s Report Card Grade: C-

The child maltreatment grade is based on the number of children who had substantiated experiences of maltreatment which include physical abuse, sexual abuse, and neglectful maltreatment. Nevada remained relatively stable in overall maltreatment, going from 19<sup>th</sup> in 2012 to 15<sup>th</sup> in 2014.<sup>141</sup> For physical, sexual, and neglectful maltreatment, Nevada ranked 45<sup>th</sup>, 17<sup>th</sup>, and 27<sup>th</sup>, respectively.<sup>142</sup> This contributed to Nevada’s 2016 ranking of 31<sup>st</sup> in the nation for foster care placement, in which an average of 5 children were removed from their homes and placed in foster care per 1,000 children.<sup>143</sup>

### Nevada State Child Welfare Information for July 2014 - June 2015

	July 2014 - June 2015			
	Clark County	Washoe County	Rural Counties	Total Statewide
<b>Total New Referrals</b>	21,068	5,680	3,803	30,551
<b>Information Only</b>	8,866	3,319	2,294	14,579
<b>Differential Response or Investigation Initiated</b>	768	228	434	1,430
<b>Total Closed Investigations</b>	11,434	2,033	1,075	14,542
<b>Substantiated</b>	2,258	612	149	3,019
<b>Unsubstantiated</b>	8,479	1,187	576	10,242

Data has been provided by Nevada Division of Child and Family Services.

In Nevada in 2014, just over 40% of child maltreatment cases were children under the age of 5. The majority of child maltreatment cases include neglect (approximately 76.9%) and physical abuse (approximately 35.6%), and a smaller percentage are due to sexual abuse (approximately 4.7%).<sup>144</sup> However, instances of sexual abuse are more likely to go unreported therefore the prevalence is likely much larger. For instance, it is estimated that one in four girls and one in six boys will be the victim of child sexual abuse by the time they are 18 years old, however, 87% never report their abuse.<sup>145</sup>

<sup>141</sup> “Child Maltreatment 2014,” <http://www.acf.hhs.gov/sites/default/files/cb/cm2014.pdf> (2014)

<sup>142</sup> “The State of America’s Children,” <http://www.childrendefense.org/child-research-data-publications/data/2014-soac.pdf> (2014)

<sup>143</sup> Kids Count, “Children 0 to 17 Entering Foster Care,” <http://datacenter.kidscount.org/data/tables/6268-children-0-to-17-entering-foster-care#ranking/2/any/true/868/any/1562> (July 2014)

<sup>144</sup> Division of Child & Family Services Nevada, “Nevada Context Data,” [http://dcfs.nv.gov/uploadedFiles/dcfsvgov/content/Tips/Reports/Nevada\\_Context\\_Data.pdf](http://dcfs.nv.gov/uploadedFiles/dcfsvgov/content/Tips/Reports/Nevada_Context_Data.pdf)

<sup>145</sup> Division of Child & Family Services Nevada, “Task Force on the Prevention of Sexual Abuse of Children,” <http://dcfs.nv.gov/uploadedFiles/dcfsvgov/content/Tips/Reports/SB258%20Report.pdf> (2014)

Child abuse and neglect creates a tremendous burden on society, in both social and economic terms. Abused or neglected children suffer from much higher likelihoods of mental health problems, perpetuation of abuse, suicide, homelessness, teen pregnancy, addiction, and crime.<sup>146</sup> To reduce instances of abuse and neglect, Nevada's child welfare system works to protect children by providing support and services to them and their families. Through this support and services, the child welfare system strives to preserve the child's family. Unfortunately, sometimes staying in the care of their parents is not always in the best interest of the child. As a last resort the child is removed from the family and placed into foster care. Overall, Nevada tends to make the determination for removal more often than 30 other states, ranking 31<sup>st</sup> in the nation, with an average of 5 per 1,000 children.<sup>147</sup> In December of 2015, just over 3,000 children were in out-of-home placements. In Nevada in 2016, children that were removed from their home had an average stay in foster care of 13 months in Clark and Washoe Counties and 19 months in rural counties.<sup>148</sup> Nevada's Child Welfare System needs to continue to work to identify mechanisms and policies that can be put in place to promote family preservation. Entering into the foster care system should not be the answer to permanently escaping abuse and neglect; rather, the root causes of abuse or neglect should be addressed and the child welfare system redesigned to focus more on family-centered child welfare service and prevention.<sup>149</sup>

#### **RECOMMENDATIONS FOR IMPROVEMENT:**

- *Ensure that adequate resources are in place to provide children and families with the services needed to safely prevent removals and ensure timely reunifications.*
- *Ensure that foster families are appropriately trained to be sensitive to diverse youth (including those of different races and sexual orientations) and develop appropriate screening practices and checkpoints to ensure the youth are residing in a healthy environment while in foster care.*
- *Establish new and expand existing in-home prevention and intervention services for families at risk, including but not limited to parent-child interaction therapy, nurse-family partnerships, and counseling services.*
- *Include parent representatives in the decision making process by requiring inclusion on state-level advisory and oversight groups, as appropriate.*

<sup>146</sup> Zimmerman, F., Mercy, J. A Better Start: Child Maltreatment Prevention as a Public Health Priority. *Zero to Three (J)*, v30 n5 p4-10 May 2010

<sup>147</sup> See Appendix: Report Card Data Sources

<sup>148</sup> Division of Child & Family Services Nevada, "Data Book,"

[http://dcfs.nv.gov/uploadedFiles/dcfsnv.gov/content/Home/features/Data\\_Book\\_April\\_2016%20\(2\).pdf](http://dcfs.nv.gov/uploadedFiles/dcfsnv.gov/content/Home/features/Data_Book_April_2016%20(2).pdf)

<sup>149</sup> *Community We Will* Brief: <http://nic.unlv.edu/files/CommunityWeWillBusinessCase.pdf>

## CHILD MALTREATMENT - SPECIAL ISSUE

### TANF for Fictive Kin Providers

When a child is removed from his/her home, the child welfare agency must identify and notify all other adult relatives within the fifth degree of consanguinity of the child.<sup>150</sup>

When blood relatives are not willing or able to take the child, the preference for placement is then given to fictive kin – those who have a family-like tie to the child.

Relatives and fictive kin caregivers provide kinship care, which allows a child to grow to adulthood in a family environment and maintain connections to their family, community and identity<sup>151</sup>.

Kinship caregivers differ from foster parents because they are “unlicensed” when they first accept children into their home, which means they are not entitled to the financial support that non-kin foster parents receive.

For most kinship caregivers, having a child placed in their care can become financially burdensome: many of these caregivers are retired and living on fixed incomes; more than one-third are already living at the poverty line<sup>152</sup>; and some may be in poor health<sup>153</sup>.

In Nevada, there are two main sources of financial support for qualified kinship families.

1. **Title IV-E of the Social Security Act** –Relative and fictive kin families may become licensed as foster parents and receive the same foster care reimbursement that non-kin foster parents receive. The process is managed by the child welfare agency and can take months, leaving many families struggling to pay the bills while they are working to become licensed while caring for the new children in their home.
2. **Temporary Assistance for Needy Families (TANF)** – During the time relatives are working to become licensed, many families may be eligible for a smaller form of financial support from the TANF grant offered through the Division of Welfare and Supportive Services (DWSS). Child- only TANF, also known as Non-Needy Relative

In Nevada, the FY2014 monthly average number of children in Foster Care was 4,955.

- 36% of children in foster care in Nevada live in a kinship placement.
- 68% of foster children living in a kinship placement are in an unlicensed home.
- Between 20-30% of kinship placements are with a fictive kin caregiver.

<sup>150</sup> “Fostering Connections to Success and Increasing Adoptions Act of 2008” <https://www.gpo.gov/fdsys/pkg/PLAW-110publ351/pdf/PLAW-110publ351.pdf>

<sup>151</sup> Child Welfare League of America [CWLA] & Generations United [GU], 2011

<sup>152</sup> Nelson et al., 2010; Alliance for Children’s Rights, 2014.

<sup>153</sup> Sakai, Lin, & Flores, 2011; Stein et al, 2014

Caregiver TANF<sup>154</sup>, is available to individuals caring for dependent children,<sup>155</sup> other than their own biological children, who meet specified conditions. These include:

- I. Providing proof of relation to the child(ren) by birth, marriage or adoption within the 5<sup>th</sup> degree of consanguinity<sup>156, 157</sup>.
- II. Proof the biological parents do not reside in the home<sup>158</sup>, or if they are in the home, have been declared by the court to be mentally or physically incapable of caring for children<sup>159</sup>.
- III. The gross household income must not exceed 275% of the Federal Poverty Guidelines for household size<sup>160</sup>.

Due to a lack of coordinated information for families, an application process that can be complicated, and the stigma families may feel is associated with applying for a welfare benefit; few eligible households receive the child-only TANF grants<sup>161</sup>. In addition, there are policies that prevent some kinship families from accessing the TANF grant at all.

- Paternal relatives may find they are unable to receive help if the biological father is not listed on the child's birth certificate<sup>162</sup>.
- If the caregiver does not share a blood relationship to all kinship children in their home, the case will be denied for the children with whom there is a blood relationship because the sibling set is considered an assistance unit<sup>163</sup>.
- Relatives must also agree to have child support enforcement officers pursue the biological parents for child support to repay the state<sup>164</sup>, a requirement that deters some families.
- Due to relationship requirements, fictive kin families are not eligible for any financial support from TANF.
- Finally, even if the family meets all the criteria to apply, some relative families are denied at the welfare office, potentially related to the fact that child-only applications are relatively rare. Relative families would often have to request an appeal to correct the decision.

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<sup>154</sup> NV DWSS Manual 1010.2.3 Non-Needy Relative Caregiver A Non-Needy Relative Caregiver (NNRC) is a relative, other than a legal parent, who is not requesting assistance for themselves and only requesting assistance for a relative child(ren). Only one non-parent caregiver may be included as a needy caregiver and they must be a relative of specified degree (see manual section A-300). See manual section A-2600 for eligibility requirements and C-140 for payment amounts.

<sup>155</sup> NV DWSS Manual 323 DEPENDENT CHILD

<sup>156</sup> NV DWSS Manual 321 CAREGIVER

<sup>157</sup> NV DWSS Manual RELATIONSHIP

<sup>158</sup> NV DWSS Manual 1010.2 TANF Cash Programs

<sup>159</sup> NV DWSS Manual 330 WHO IS INCLUDED

<sup>160</sup> NV DWSS Manual A 2620.1.1

<sup>161</sup> Mauldon, Speigman, Sogar, & Stagner, 2012; Nelson, 2010; AECF, 2012

<sup>162</sup> NV DWSS MANUAL 323.3 Children Living With Relatives of the Biological Father

<sup>163</sup> NV DWSS MANUAL A 2630.2

<sup>164</sup> NV DWSS MANUAL 1600 PURPOSE, 1610 ASSIGNMENT OF SUPPORT, 1611 GOOD CAUSE FOR NON-COOPERATION WITH CSEP

**Recommendations:**

1. Expand child-only TANF to allow payments to fictive kin caregivers of children in foster care who meet all other requirements. Based on the number of children per fictive kin placement, the financial impact would be between \$127K and \$225K per month.<sup>165</sup>
2. Ensure child welfare workers are informed of the child-only TANF program so that relative families are encouraged to apply when they first get placement of a child. Increase the number of TANF training hours for welfare eligibility specialists, with a focus on child-only TANF.

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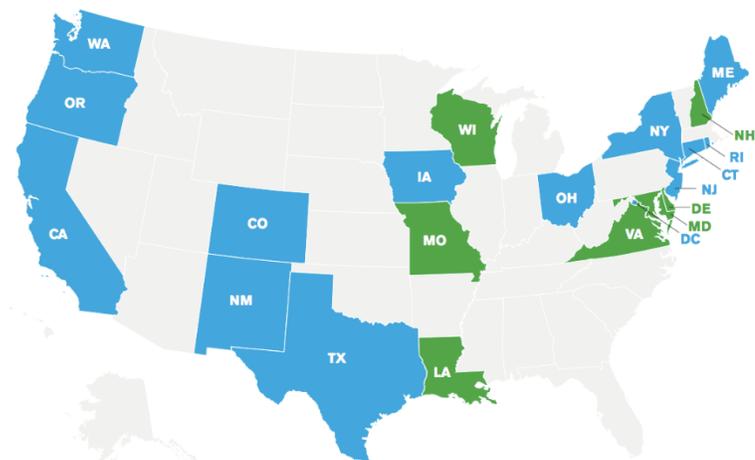
<sup>156</sup> One child per placement: (Total number of children in foster care\*.36 kinship placements)\*.3 fictive placements \*\$417. Two children per placement: [(Total number of children in foster care\*.36 kinship placements)\*.3 fictive placements]/2 \*\$476

## CHILD MALTREATMENT- SPECIAL ISSUE

### LGBTQ Youth in Out-of-Home Care

According to the *National Coming Out Day: Youth Report*, seven percent of lesbian, gay, bisexual, transgender and questioning/queer (LGBTQ) youth who are out to their families indicated that their families are “not at all accepting” of their sexual identity.<sup>166</sup> For some of

these youth, the lack of acceptance they face may result in abuse and/or neglect from their parents – resulting in LGBTQ young people being overrepresented in foster care. The lack of acceptance also places these youth at an increased risk of homelessness – increasing the chances of interactions with the juvenile justice system. According to The Center for American Progress, homeless gay and transgender youth are more likely to resort to criminal behaviors, such as drug sales, theft, or “survival sex,” which put them at risk of arrest and detainment. These youth are also at an increased risk of detainment for committing crimes related to homelessness, such as violating youth curfew laws and sleeping in public spaces.”<sup>167</sup> However, few states have laws and policies in place designed to protect them from discrimination and ensure that providers are trained on LGBTQ competencies.



**States with Foster Care Non-Discrimination Laws or Policies Inclusive of Sexual Orientation and Gender Identity**

- |                |                  |
|----------------|------------------|
| 1. California  | 8. New Mexico    |
| 2. Colorado    | 9. New York      |
| 3. Connecticut | 10. Ohio         |
| 4. DC          | 11. Oregon       |
| 5. Iowa        | 12. Rhode Island |
| 6. Maine       | 13. Texas        |
| 7. New Jersey  | 14. Washington   |

**States with Foster Care Non-Discrimination Laws or Policies Inclusive of Sexual Orientation Only**

1. Delaware
2. Louisiana
3. Maryland
4. Missouri
5. New Hampshire
6. Virginia
7. Wisconsin

Source: Human Rights Campaign White Paper *LGBTQ Youth in the Foster Care System*

- A survey of youth in foster care found that nearly 1 out of 5 (19.1%) of LA-based foster youth are LGBTQ and the percentage of youth in foster care who are LGBTQ is between 1.5 and 2 times that of youth living outside of foster care.<sup>168</sup>
- LGBTQ youth represent just 5% to 7% of the nation’s overall youth population, yet they

<sup>166</sup> “Growing Up LGBT in America: NCOD Report” Human Rights Campaign <http://www.hrc.org/youth/download-the-report/#.V6uz4mXMyFJ>

<sup>167</sup> “The Unfair Criminalization of Gay and Transgender Youth”: Center for American Progress <https://www.americanprogress.org/issues/lgbt/report/2012/06/29/11730/the-unfair-criminalization-of-gay-and-transgender-youth/>

<sup>168</sup> Human Rights Campaign: White Paper *LGBTQ Youth in the Foster Care System* <http://www.hrc.org/resources/lgbt-youth-in-the-foster-care-system>

compose 13% to 15% of those currently in the juvenile justice system.<sup>169</sup>

Even though LGBTQ youth are overrepresented in foster care, only 14 states have foster care laws and policies that are inclusive of sexual orientation and gender identity, and seven have laws and policies that include sexual orientation only<sup>170</sup>. Currently, Nevada does not have any inclusive non-discriminatory laws or policies.

To tackle these issues, foster care and juvenile justice agencies need to ensure that all employees are properly informed and trained to meet the needs of LGBTQ youth.

Without these types of laws, policies and trainings in place, Nevada's LGBTQ youth face the prospect of neglect, discrimination and abuse within the very systems charged to protect them. Inappropriate placements and a lack of understanding of the needs of LGBTQ youth also endanger their health and safety as they are at increased risk of physical violence, substance abuse, unsafe sex, homelessness and even suicide.

### **Recommendations:**

1. Require all providers, staff, foster parents and direct care staff (those who work directly with youth in out-of-home settings, including child welfare and juvenile justice) to complete at least 8 hours of initial training regarding working with LGBTQ youth and at least 4 hours annually thereafter. These trainings may be integrated with other trainings, but must include specific components addressing the needs of LGBTQ youth.
2. Ensure that "gender" and "sex" are defined as the gender identity of the youth in out-of-home placement (not their sex assigned at birth) in all relevant sections of the NRS and NAC.
3. Require the Nevada Division of Child and Family Services (DCFS) to develop placement protocols in both Child Welfare and Juvenile Justice that address appropriate placement of youth based on their gender identity. These protocols must be developed with the consultation and input of key stakeholders, including: current and/or former LGBTQ foster youth and/or youth from juvenile justice; representatives from child welfare and juvenile justice agencies in Nevada; representatives from the LGBTQ community; legal counsel, including children's attorneys; juvenile and/or family court representatives; child advocates; and others deemed appropriate by DCFS.
4. Establish a Bill of Rights for youth in the juvenile justice system, similar to the Nevada Foster Youth Bill of Rights (NRS 432.500 – 432.550). Include reference for cross over

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<sup>169</sup> "The Unfair Criminalization of Gay and Transgender Youth": Center for American Progress  
<https://www.americanprogress.org/issues/lgbt/report/2012/06/29/11730/the-unfair-criminalization-of-gay-and-transgender-youth/>

<sup>170</sup> Human Rights Campaign: White Paper LGBTQ Youth in the Foster Care System <http://www.hrc.org/resources/lgbt-youth-in-the-foster-care-system>

youth who are also in the child welfare system to clarify which rights apply when they are placed within the juvenile justice system.

5. Require the Nevada Division of Child and Family Services to establish a grievance and/or complaint process for all youth in out-of-home care that allows them to file a grievance and/or a complaint related to their rights (Foster Youth Bill of Rights and/or Bill of Rights for youth in the juvenile justice system) with an individual or entity that is not directly responsible for their care, but has the authority to investigate and seek remedies, as appropriate, on behalf of the youth.
6. Require that all youth in out-of-home placements receive a copy of their rights, including the process for filing complaints and/or grievances as established by DCFS per the recommendation above.

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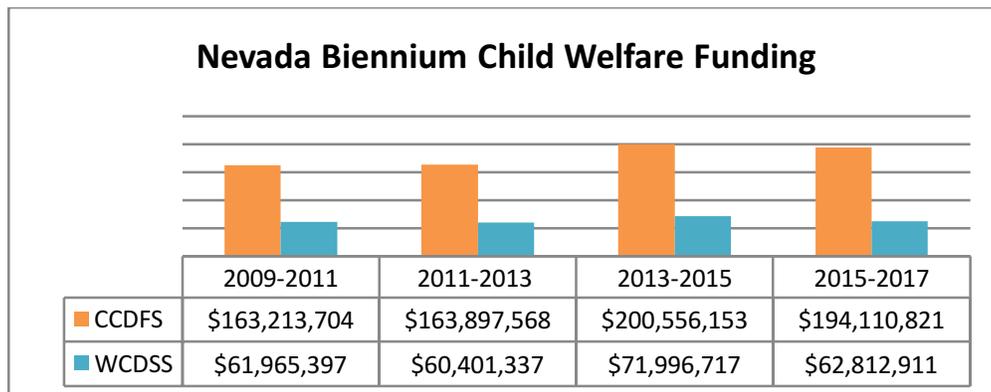
## CHILD MALTREATMENT - SPECIAL ISSUE

### Child Welfare Funding

In 2011, Nevada revised the child welfare funding structure for the two urban county child welfare agencies, Clark County Department of Family Services (CCDFS) and Washoe County Department of Social Services (WCDSS).<sup>171</sup> The new structure provides the counties with an annual capped block grant which de-categorized the General Fund appropriation for the purpose of child welfare integration. The purpose of the change was to provide flexible funding to allow agencies to redirect child welfare funding to meet the needs of the children and families in their communities.<sup>172</sup> The block grant is divided into two allocations:

- (1) A base allocation for the biennium which is based on the total state General Fund appropriated for the previous biennium.
- (2) The second allocation would include the estimated cost attributable to projected caseload growth for the adoption assistance program.

Overall, grant funding is supported by federal, state, and local funds. During the 2015-2017 biennium, Nevada allocated over \$256.9 million to CCDFS and WCDSS; more than half of which – \$132.2 million – came from the Nevada General Fund.<sup>173</sup>



The intent is for child welfare agencies to use these funds to provide a complete system of care to children and families. According to the Child Welfare Information Gateway, “this approach is based upon the principles of interagency collaboration; individualized, strengths-based care practices; cultural competence; community-based services; accountability; and full participation of families and youth at all levels of the system. A centralized focus of systems of care is building the infrastructure needed to result in positive outcomes for children, youth, and

<sup>171</sup> “SB 447” 76<sup>th</sup> Nevada Legislative Session <http://leg.state.nv.us/Session/76th2011/Reports/history.cfm?ID=1086>

<sup>172</sup> “Child Welfare Budget” State of Nevada: Governor’s Finance Office <http://budget.nv.gov>

<sup>173</sup> Child Welfare for CCDFS and WCDSS for the 2009-2011 and 2011-2013 Biennium only include Integration Funding. Integration Funding was provided to CCDFS and WCDSS to support child welfare services in Clark County and Washoe County that were transferred to DFS as part of the child welfare integration. This budget supports child welfare services that include substitute care, foster care, licensing services, adoption services, Interstate Compact on the Placement of Children (ICPC), and Intensive Family Services.

families.”<sup>174</sup> To provide this type of care, CCDFS and WCDSS need appropriate funding to ensure adequate investigations, case management, family supports and other related services.

In 2012, just one year after the revision of the funding structure, Nevada ranked 38<sup>th</sup> in the nation in per capita spending on child welfare at \$22.09.<sup>175</sup> This overall spending has remained relatively flat since 2012 – largely due to the block grant structure. In a review of federal block grant programs, the Center on Budget and Policy Priorities found that “a block grant’s basic structure makes them especially vulnerable to funding reductions over time... As a result, the funds are used in diffuse ways and their impact is hard to document. Often, it is difficult even to track in detail how the money is used. That, in turn, makes it easier for policymakers seeking resources for their own priorities to look to block grants for savings, and has made block grants particularly vulnerable to funding freezes for years on end.”<sup>176</sup>

### **Recommendations:**

To ensure that Nevada is funding CCDFS and WCDSS at appropriate levels to provide effective and efficient child welfare services, a study should be conducted to provide an analysis of:

- The current block grant structure to the local child welfare agencies. Specifically, asking if this structure is appropriate/sufficient to support the needs of the child welfare agencies and if there are other structures that may be more appropriate.
- Potential funding sources to support child welfare. Determining what other sources of funding are available to support child welfare that NV is not currently receiving.
- All funding sources (local, state, federal, and potentially private) that support the broad child welfare system. Besides funding specifically directed toward child welfare agencies, the system itself is reliant upon many other social programs and systems including funding for medical care, mental health, substance abuse, education, juvenile justice, child care and other social service/welfare programs. The study should review how these systems are aligned to ensure appropriate support services for children and families.

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<sup>174</sup> “Systems of Care” Child Welfare Information Gateway <https://www.childwelfare.gov/pubPDFs/soc.pdf>

<sup>175</sup> Calculated from comparing the 2012 Casey Child Welfare Financing Survey with 2012 Census population estimates. <http://www.childwelfarepolicy.org/maps/single?id=345> <https://www.census.gov/popest/data/state/totals/2012/>

<sup>176</sup> <http://www.cbpp.org/sites/default/files/atoms/files/11-19-15bud.pdf>

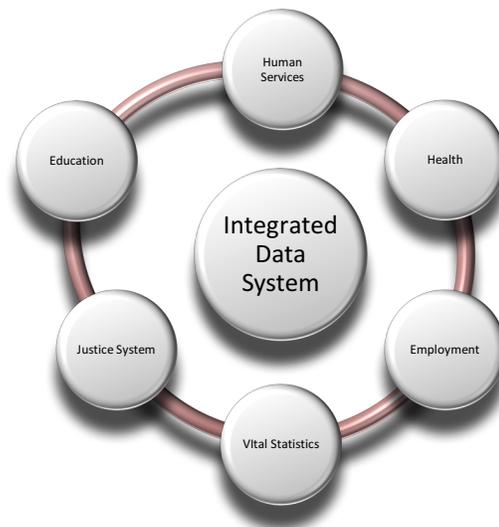
## CHILD MALTREATMENT - SPECIAL ISSUE

### Child Welfare Data System

***“Entities and communities should endeavor to provide a holistic, comprehensive, and integrated experience for children, youth, and families seeking support and receiving services.” – Child Welfare League of America<sup>177</sup>***

Children who enter the child welfare system often cross over into other systems of care.

- A child who is abused/neglected is 55% more likely to be arrested as a juvenile;<sup>178</sup>
- More than 20% of children who leave foster care experienced housing problems within two years of leaving;<sup>179</sup>
- Former foster children are more likely to become homeless, incarcerated, or dependent on state services.<sup>180</sup>



For example, in Clark County, children who enter the child welfare system would have their information entered into the Unified Nevada Information Technology for Youth (UNITY) data system and the National Youth in Transition Database (NYTD). If he/she then receives welfare services, they would be entered into the CACTUS System and the Nevada Operations of Multi-Automated Data System (NOMADS). If they go through the court system they will get entered into Odyssey, and through the juvenile justice system into the Family Tracking, Reporting and Automated Case Support (FamilyTracs) system. If that child becomes homeless or receives homelessness services, they would be entered into the Homeless Management Information System (HMIS) and if they receive workforce aid they would be entered into the Southern Nevada Workforce Connections data reporting system (NVTrac). Additionally, they would still be tracked by the School District and by health care services. Without being able to see what services/resources a child has already received, the service providers operate with blinders which may result in a lack of appropriate services, duplication of services and a lack of efficiency among all agencies. Additionally, many of these systems are old and lack the capacity to input, store and/or report data necessary for these agencies to make timely and appropriate decisions for these youth.

<sup>177</sup> Child Welfare League of America, *National Blueprint for Excelling in Child Welfare* p. 70

<sup>178</sup> Center for Juvenile Justice Reform <http://cjjr.georgetown.edu/pdfs/Fall%2008%20NCJFCJ%20Today%20feature.pdf>

<sup>179</sup> “Pathways to and From Homelessness and Associated Psychosocial Outcomes Among Adolescents Leaving the Foster Care System” American Public Health Association <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2707485/>

<sup>180</sup> Lips, Dan “Foster Care Children Need Better Educational Opportunities” Heritage Foundation [http://www.heritage.org/research/reports/2007/06/foster-care-children-need-better-educational-opportunities#\\_ftn10](http://www.heritage.org/research/reports/2007/06/foster-care-children-need-better-educational-opportunities#_ftn10)

This problem could be alleviated with the creation of an integrated data system. Integrated data systems are data systems that “integrate individual-level data from multiple administrative agencies on an ongoing basis. These systems may exist for jurisdictions at various levels, including states, counties, and cities. Records in these systems may include those from human services (such as child welfare, income supports, and child care subsidies), health, employment, vital statistics, justice system and education.”<sup>181</sup> They could be accessed by participating entities and would include securely exchanged information that protects privacy and confidentiality. This would allow the organizations to quickly look up their client, see their personal information, which would be automatically populated, and see what services their clients have used or are currently using. Having an integrated data system would lead to “an increased knowledge and communication among agencies, resource sharing and reduction of duplicated efforts, greater specialization, and an improved image with clients and the community.”<sup>182</sup> Using an integrated data system would provide substantial benefits to the clients by offering “referrals to more and a wider range of services, improved access, and improved case management,”<sup>183</sup> while also saving time for clients and providers.

### **Recommendations:**

The Nevada Legislature should conduct a feasibility study to look at the viability of an integrated data system with community input. CAA also recommends the integrated system include the following key design elements:

1. Collect information from multiple service providers, which will provide greater coordination.
2. The power of available technology should be leveraged to the fullest. For example, back-end systems should support robust, bidirectional information exchange, and automatically populate appropriate information into a record that follows the child through a continuum of care and over time.
3. Information must be exchanged securely, in a manner that protects privacy and confidentiality, and the tools must support the specific designation of individuals authorized to see specific portions of the record (i.e. granular data segmentation and role-based access), among other protections.
4. Electronic records generated must be able to extract and summarize important information, and to include historical information to provide an accurate and complete client record.
5. Electronic records should be designed with consumer-facing features, such as patient portals and pre-visit questionnaires, as well as links to available tools that can feed critical information into the record, such as remote monitoring devices.<sup>184</sup>

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<sup>181</sup> Hende, Leah, Coulton, Claudia, Kingsley, G. Thomas “Connecting People and Place: Improving Communities through Integrated Data Systems. [http://neighborhoodindicators.org/sites/default/files/publications/final\\_concept\\_paper\\_nnp\\_ids.pdf](http://neighborhoodindicators.org/sites/default/files/publications/final_concept_paper_nnp_ids.pdf)

<sup>182</sup> Urban Institute. [http://www.urban.org/UploadedPDF/coordination\\_FR.pdf](http://www.urban.org/UploadedPDF/coordination_FR.pdf)

<sup>183</sup> Ibid.

<sup>184</sup> “Electronic Information Exchange Elements that Matter for Children in Foster Care” SPARC: State Policy Advocacy & Reform Center <http://childwelfaresparc.org/wp-content/uploads/2014/07/15-Electronic-Information-Exchange-Elements-that-Matter-for-Children-in-Foster-Care.pdf>

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## 2. YOUTH HOMELESSNESS

### Nevada Children's Report Card Grade: D

The youth homelessness grade is based upon accompanied youth (children under 18 with their families), unaccompanied youth (youth who are not part of a family with children during their episode of homelessness), and unsheltered youth (youth who stay in places not meant for human habitation, such as the streets, abandoned buildings, vehicles, or parks).<sup>185</sup>

Youth homelessness is a devastating and growing problem in Nevada. In 2012-2013, 23,790 children experienced homelessness throughout Nevada, a 15% increase over the prior year.<sup>186</sup> In 2014, the National Center on Family Homelessness ranked Nevada 44<sup>th</sup> in the United States for overall child homelessness based on a composite score reflecting Nevada's extent of child homelessness, child well-being, risk for child homelessness, and state planning and policy efforts. Nevada's state policy and planning efforts in particular were ranked 47<sup>th</sup> in the country, pointing to a serious need for focused policy work around youth homelessness in our state. Research shows that children who experience homelessness with their families are often hungry, sick, and scared, struggle to attend and succeed in school, and are likely to develop mental health problems as a result of being exposed to high levels of stress, violence, and uncertainty.

Unaccompanied homeless youth – youth who experience homelessness on their own without their families – find themselves in even more danger. In 2015, the State of Nevada had the fourth highest number of unaccompanied homeless youth under age 25 (2,310 youth) and the second highest number of unaccompanied homeless children under age 18 (825 youth) residing in our state on an average night.<sup>187</sup> Illustrating Nevada's severe lack of age-appropriate beds and services for this population, in 2015, Nevada had the highest rate of unaccompanied homeless youth living unsheltered of any state in the country, with 87.5% of identified unaccompanied homeless youth under 25 living on our streets unsheltered at the time of the count.<sup>188</sup> In fact, in 2015, though 2,310 unaccompanied youth experienced homelessness in Nevada on an average night, only 231 beds throughout Nevada's homeless services system were devoted to homeless youth.

Youth often become homeless due to inter-related factors of family breakdown, economic insecurity, and/or residential instability.<sup>189</sup> Family breakdown is the most common contributing factor to youth becoming homeless on their own: many youth leave home after enduring years of sexual, physical, and/or emotional abuse, neglect, parental substance abuse, and rejection. Homeless youth find themselves in different situations and require distinct resources from homeless adults because young people enter into homelessness with little or no work experience or life skills, and are often forced into dropping out of school as a result of their homelessness. They also experience higher levels of criminal

<sup>185</sup> U.S. Department of Housing and Urban Development, 2015, Annual Homeless Assessment Report (AHAR) to Congress, <https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf>

<sup>186</sup> National Center on Family Homelessness at American Institutes for Research, 2014, "America's Youngest Outcasts: A Report Card on Child Homelessness," <http://www.air.org/sites/default/files/downloads/report/Americas-Youngest-Outcasts-Child-Homelessness-Nov2014.pdf>

<sup>187</sup> U.S. Department of Housing and Urban Development, 2015, Annual Homeless Assessment Report (AHAR) to Congress, <https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf>

<sup>188</sup> U.S. Department of Housing and Urban Development, 2015, Annual Homeless Assessment Report (AHAR) to Congress, <https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf>

<sup>189</sup> National Coalition for the Homeless, 2008

victimization, including sexual exploitation and labor trafficking. Racial and ethnic minorities and LGBTQ youth are also overrepresented among the homeless youth population, pointing to a need for culturally competent and diverse services.

Youth homelessness has dangerous consequences for both the youth experiencing homelessness and their communities. According to the National Alliance to End Homelessness, one out of every three teens on the streets will be lured into prostitution within 48 hours of leaving home<sup>190</sup>. Every day homeless youth spend on the streets increases their likelihood of engaging in substance abuse, developing mental and physical health problems, contracting sexually transmitted infections, experiencing unwanted pregnancies, committing and becoming victims of crimes, getting involved in gangs, dropping out of school, and becoming homeless adults. Homeless youth are vulnerable to forming complicated relationships with our education, health, welfare, and criminal justice systems, creating costly and long-term problems for themselves and their communities.

Limited federal resources are not enough to provide housing and services to Nevada's homeless youth and many local and state-level funders and policymakers are simply unaware of the extent and severity of youth homelessness in our state. Through building awareness, collaboration, and devoting concentrated resources to age-appropriate, evidence-based service offerings, we can not only turn individual lives around, but save significant long-term costs. Numerous studies have shown that providing unaccompanied homeless youth with appropriate housing interventions is significantly cheaper and more effective than serving youth through the child welfare or juvenile justice systems.<sup>191</sup>

### **Recommendations for Improvement:**

- Create a statewide plan for responding to and ending youth homelessness.
- Build awareness and collaboration among systems that interact with high-risk and homeless youth, including homeless services, public education, juvenile justice, and child welfare.
- Develop a coordinated community response to youth homelessness.
- Increase resources for the proactive prevention of youth homelessness, including family counseling.
- Devote larger portions of general funding and the creation of specific funding streams to support culturally competent youth-focused homeless service offerings, including drop-in centers, emergency shelter, transitional housing, rapid re-housing, and permanent supportive housing developed specifically to respond to youths' unique needs and developmental stage.
- Increase targeted outreach and crisis intervention to at-risk and homeless youth.
- Devote resources to human trafficking prevention and intervention services within homeless youth programs.
- Require public school districts to create formal plans on addressing youth homelessness in schools.
- Reduce barriers for unaccompanied homeless youth to access high quality education, including higher education.
- Mitigate barriers around access to quality health care and Medicaid for unaccompanied homeless youth.
- Advance data collection, analysis, and research around youth homelessness.

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<sup>190</sup> National Alliance to End Homelessness, <http://www.endhomelessness.org/>

<sup>191</sup> National Partnership to End Youth Homelessness; National Network for Youth

### 3. JUVENILE VIOLENCE

#### Nevada Children's Report Card Grade: D+

The juvenile violence grade is based upon high school violence, weapons on school property, dating violence, fear of violence, and juvenile justice. In 2015, 8.5% of Nevada's high school students felt unsafe attending school, ranking 30<sup>th</sup> in the nation. Furthermore, Nevada ranked 7<sup>th</sup> out of 33 states with data for students reporting to have brought a weapon to school (3.7%), and 11<sup>th</sup> in the nation for the percentage of students who have been in a fight on campus (6.8%).<sup>192</sup> The threat of violence at school directly disrupts the ability of students to achieve success in school and increases the need for medical care. The effects of violence at school are far reaching however, and affect not only fellow students, but also the school and community as a whole. To ensure children receive the education they need, schools must be both safe learning and teaching environments.

In addition to violence at school, many of Nevada's youth experience both physical and sexual dating violence. In 2015, Nevada ranked 22<sup>nd</sup> out of 36 reporting states for physical dating violence and 22<sup>nd</sup> out of 30 reporting states for sexual dating violence with 9.6% of individuals experiencing physical violence and 11.5% experiencing sexual violence. Youth often experience violence in dating and relationships when one person tries to maintain power and control over the other through verbal, physical, emotional, or sexual abuse. Teenagers may tend to accept and conform to sexual stereotypes in greater numbers than adults, and mistake controlling behavior as signs of caring or love. For these reasons, youth are a population particularly susceptible to intimidation and control through violence.<sup>193</sup>

The challenges faced by Nevada's youth in regards to juvenile violence can be seen further in the number of individuals involved with the state's juvenile justice system. In 2013, Nevada ranked 37<sup>th</sup> in the nation in the number of youth residing in juvenile detention, correctional and/or residential facilities with 201 children per 100,000; well above the national average of 173 per 100,000. The economic burden of juvenile justice involvement is great and has long lasting effects on the social services of the community.<sup>194</sup>

Juvenile violence is widespread in the United States, and violence against youth is the second leading cause of death for young people between the ages of 15 and 24 nationwide. It affects not only youth, but the overall health of the community. It can increase health care costs, decrease property values, and disrupt social services in addition to the economic burdens of juvenile justice detention. There exists a great need to adequately address and prevent all aspects of juvenile violence in order to improve the overall health of our children and our community as a whole.

<sup>192</sup> Centers for Disease Control and Prevention <http://www.cdc.gov/mmwr/volumes/65/ss/pdfs/ss6506.pdf> (June 2016)

<sup>193</sup> See Appendix: Report Card Sources.

<sup>194</sup> "Youth Residing in Juvenile Detention Correctional and/or Residential Facilities." *KIDS COUNT Data Center from the Annie E. Casey Foundation*. N.p., n.d. Web. 30 Aug. 2016. <<http://datacenter.kidscount.org/>>.

## **RECOMMENDATIONS FOR IMPROVEMENT:**

- *School districts in the state of Nevada should create school wide prevention and intervention strategies to increase school safety that include ongoing staff development and training, fostering school-law enforcement partnerships, instituting school-based links with mental health and social service agencies, and fostering school, family, and community involvement.*<sup>195</sup>
- *Increase prevention efforts related to reducing teen dating violence which may include increasing access to evidence-based programs about healthy relationships offered in schools and other youth serving organizations. In addition, more information is needed to educate children on the harms of recruitment into prostitution by pimps as sex trafficking is a serious problem in Nevada.*
- *Youth that become involved in the juvenile justice system, during incarceration and while on probation, need access to adequate resources and treatment to assist in rehabilitation and to prevent recidivism.*
- *Courts need to use structured decision making processes and tools in order to reduce racial and ethnic disparities in juvenile justice processing.*
- *All juvenile justice data should be generated by gender, race and ethnicity in order to monitor the implementation of effective decision making processes and to track the reduction of disparities in the system.*

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<sup>195</sup> National Criminal Justice Reference Service, "School Policies and Legal Issues Supporting Safe Schools," <https://www.ncjrs.gov/pdffiles1/ojdp/book2.pdf> (September 2002)

## 4. CHILD INJURY AND DEATH

### Nevada Children’s Report Card Grade: C-

The child deaths and injury grade is based on non-natural child deaths or those that were a result of an unintentional or intentional injury. Unintentional injuries include things that are often referred to as “accidents”. These include motor vehicle or traffic accidents, drowning, poisoning or overdose, suffocation, fire, etc. Unintentional injuries are the leading cause of hospitalization and death for children ages 1-18 years, both nationally and in Nevada.<sup>196</sup> In 2014 in Nevada, the number of deaths due to injury for children ages 0-17 years was 17.8 per 100,000, which is slightly over the national average of 14 deaths per 100,000.<sup>197</sup>

It is important to note that the leading causes of death for children are different depending on the age group. For example, younger children are more likely to be injured in non-motor vehicle related accidents, while older children are more likely to be injured in motor vehicle accidents. In fact, infants under one year of age most frequently die from injuries related to unsafe sleep positioning that causes asphyxia, while children ages 1-4 years are the group most at risk for drowning. Older children – those between 5 and 17 – are most commonly the victims in motor vehicle accidents.

According to the 2013 Child Death Review Report for Nevada<sup>198</sup>, the leading cause of death for children is non-motor vehicle accidents which specifically include suffocation, drowning, gunshot wounds, and poisoning/overdose which is consistent with the national data. Listed below are the counts and percentages of 2013 child deaths by manner and cause in Nevada (excluding natural and undetermined causes):

- Non-motor vehicle accidents – 50.0% (n=52)
  - Asphyxia (n=22)
  - Drowning (n=9)
  - Drug Exposed Infant (n=6)
  - Fall (n=4)
  - Overdose (n=3)
  - Gunshot Wound (n=1)
  - Weapon (n=1)
  - Poisoning (n=1)

<sup>196</sup> Children’s Safety Network. “2013 Nevada State Fact Sheet,” <http://www.childreissafetynetwork.org/sites/childreissafetynetwork.org/files/Nevada%202013%20State%20Fact%20Sheet.pdf>

<sup>197</sup> Center for Disease Control and Prevention, “Fatal Injury Data,” <http://www.cdc.gov/injury/wisqars/fatal.html> (August 29, 2014)

<sup>198</sup> Nevada Division of Child and Family Services, “2013 Child Death Review Report for Nevada”, [http://dcfs.nv.gov/uploadedFiles/dcfsvgov/content/Tips/Reports/2013%20Statewide%20Child%20Death%20Report%20\(final\).pdf](http://dcfs.nv.gov/uploadedFiles/dcfsvgov/content/Tips/Reports/2013%20Statewide%20Child%20Death%20Report%20(final).pdf)

- Fire (n=1)
- Other (n=4)
  
- Motor vehicle accidents – 16% (n=17)
  - Driver (n=6)
  - Passenger (n=6)
  - Pedestrian (n=5)
- Homicide – 19% (n=20)
- Suicide – 14% (n=15)

The common theme with all of these deaths is that they are preventable. Many of these deaths may have been prevented by providing education about risk factors and improving supervision for the children and youth at the time of the incident that led to their death. Recommendations to improve prevention efforts are listed in the section below.

#### **RECOMMENDATIONS FOR IMPROVEMENT:**

- *Continue to support the activities of child death review teams and increase funding designated for prevention activities.*
- *Support efforts related to improving firearm safety and restricting access to firearms from children and youth.*
- *Support and promote existing efforts to eliminate child drowning incidents by supporting consistent policy regarding barriers to residential swimming pools and supporting education about drowning prevention.*
- *Support programs that provide training for parents and caregivers of infants on safe sleep practices as well as those that ensure families have safe sleep spaces for infants by providing low or no cost cribs.*
- *Support efforts to provide substance abuse treatment to pregnant women.*

## ***CHILD INJURY AND DEATH - SPECIAL ISSUE***

### **Safe Haven**

Safe Haven, also known as Protection of Children from Abuse and Neglect (NRS 432B.630), allows parents to safely surrender their baby if they can no longer care for him/her. This law protects infants from being injured or otherwise harmed due to unsafe and illegal abandonment by providing distressed parents a safe, anonymous option for surrender of their infant.

In the event that parents bring a child to a Safe Haven site and wish to remain anonymous:

- The law requires that the Safe Haven site to take possession of the child, no questions asked.
- The Safe Haven site should then ensure the receipt of immediate medical care needed, report the child's surrender to law enforcement (if the Safe Haven site is not a law enforcement agency) and then report the surrender to the local child welfare agency.
- The Child Welfare Agency then completes its protocol for surrendered infants with no information on the parents.
- Once the Child Welfare Agency determines this to be a Safe Haven surrender, they will proceed with termination of parental rights in order to prepare the infant for adoption. In accordance with the law, proper notification of the hearing for the termination of parental rights must be provided. When names of the birth parents are known, they are included in the public notice. However, if parents have surrendered their child anonymously (i.e. does not provide a name or any other identifying information at the time of surrender) there is no identifying information to publish, thus protecting the identity of the biological parents throughout the process.

Recently, parental anonymity has been an issue for mothers who give birth in a hospital and immediately surrender the child at the hospital under the Safe Haven Law; as the language of NRS 432B.60 does not explicitly protect a mother's anonymity. This is due to the identifying information for medical and billing purposes that is collected from the mother during her admission to the hospital for delivery. Currently when Safe Haven is invoked:

- Custody of the child is transferred to the Child Welfare Agency and as the legal custodian of the child, all medical records for the baby are given to the Child Welfare Agency. **These records also include identifying information for the mother because information on her pregnancy and delivery are pertinent to the health care of the infant.**
- This identifying information on the mother is provided to the Child Welfare Agency regardless of the mother's intent to anonymously surrender the child under the Safe Haven Law.
- Once the identity of the mother is known to the Child Welfare Agency, they are required to contact and notify her and any other named parent (father) regarding all proceedings

to terminate parental rights, if they have not already completed paperwork to voluntarily terminate their rights.

This can be problematic for mothers who invoke Safe Haven with a wish or need to remain anonymous in an effort to protect their own safety or the safety of the child from violence or other repercussions if their identity is known – going against the purpose of the law. Safe Haven is intended to prevent parents from “dumping” infants unsafely, so they can remain anonymous while ensuring the infant is in a safe place – no questions asked. This should also apply to parents who choose to deliver safely, in a hospital.

### **Recommendations:**

Enact the following amendments to the Safe Haven law to ensure our children are being properly protected:

- Clarify the language of this law to better protect the mother’s anonymity by prohibiting the release of any identifying information on the mother acquired by a hospital or EMS service for the purpose of medical care or billing to the Child Welfare Agency upon surrender under Safe Haven.
  - This clarification in the law provides additional protection for parents and will ensure that parents in crisis feel comfortable using this law knowing that no matter which type of Safe Haven location they choose to surrender with, their identities will be protected if they so wish. This change will eliminate a potential barrier for parents in using this law and will further protect babies from unsafe and illegal abandonment.
- Clarify that a baby voluntarily delivered to a Safe Haven provider, including after the birth of a child within a hospital, by a parent of the baby who does not express an intent to return and fulfills all other Safe Haven criteria, (less than 30 days old, free of obvious abuse, etc.) will also be considered a Safe Haven surrender and processed as such.
  - This proposed change will ensure that parents who responsibly leave their baby with the hospital under the assumption of the baby’s safety, without invoking the Safe Haven Law specifically, are not charged with illegal abandonment.
- Ensure that any other biological parents, who are not present or did not participate in the delivery of the baby but their identity is known, is afforded due process and is publicly notified of the hearing to terminate parental rights.
  - This affords protection to biological parents who may be unaware of the decision of the mother to surrender the baby under the Safe Haven Law.

\*Adapted from the Safe Haven Work Group: Hospital 1-pager.

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## **CHILD INJURY AND DEATH - SPECIAL ISSUE**

### **Health & Safety Requirements for Recreation Programs**

Recreation programs are an important industry for Nevada’s children and families. Many parents enroll their child in a sports team, summer camp, dance classes, art lessons or after-school programs. These programs often provide unique educational and social experiences for children. For many parents these programs provide an additional form of after school care that allows them to work. They also help parents foster new skills or expertise for their child.

In Nevada, there are multiple types of recreation programs that offer supervision of children which include:

- **Out-of-school recreation program-** a recreation program operated or sponsored by a local government in a facility which is owned, operated or leased by the local government and which provides enrichment activities to children of school age.<sup>199</sup>
- **Out-of-school-time program-** a program, other than an out-of-school recreation program, that operates for 10 or more hours per week, is offered on a continuing basis, provides supervision of children who are of the age to attend school from kindergarten through 12<sup>th</sup> grade and provides regularly scheduled, structured and supervised activities where learning opportunities take place.<sup>200</sup>
- **Seasonal or temporary recreation program-** a recreation program that is offered to children for a limited time or duration and may include, without limitation:
  - A special sports event, which may include, without limitation, a camp, clinic, demonstration or workshop which focuses on a particular sport;
  - A therapeutic program for children with disabilities, which may include, without limitation, social activities, outings and other inclusion activities;
  - An athletic training program, which may include, without limitation, a baseball or other sports league and exercise instruction; and
  - Other special interest programs, which may include, without limitation, an arts and crafts workshop, a theater camp and dance competition.<sup>201</sup>

Out-of-school recreation programs are governed by NRS 423A.600-650 – requiring background checks of staff and well as health and safety requirements to ensure the well-being of children and youth who participate in these programs. However, neither out-of-school-time programs nor seasonal or temporary recreation programs have to meet these basic safety requirements, potentially endangering children.

To ensure the safety of Nevada’s children, out-of-school-time programs and the seasonal or temporary recreation programs should be required to meet the same requirements as out of

<sup>199</sup> Nevada Revised Statute 432A.0277 <https://www.leg.state.nv.us/nrs/NRS-432A.html>

<sup>200</sup> Nevada Revised Statute 432A.0278 <https://www.leg.state.nv.us/nrs/NRS-432A.html>

<sup>201</sup> Nevada Revised Statute 43A.029 <https://www.leg.state.nv.us/nrs/NRS-432A.html>

school recreation programs as stated in NRS 423A.600-650. These requirements include, but are not limited to, the following:

- Requirements for the site where program is operated:
  - Complies with applicable law and regulations concerning safety standards;
  - Complies with applicable law and regulations concerning health standards;
  - Has a complete first-aid kit accessible on site;
  - Has an emergency exit plan posted on-site in a conspicuous place; and
  - Has not less than two staff members on-site and available during the hours of operation who are certified and receive annual training in the use and administration of first aid, including, without limitation, cardiopulmonary resuscitation.
- **Requirements for staff of program:**
  - A background and personal history check; and
  - A child abuse and neglect screening through the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child established by NRS 432.100 to determine whether there has been a substantiated report of child abuse or neglect made against the staff member.
- **Requirement for number of participants in the program:**
  - Does not exceed a ratio of one person supervising every 20 participants; and
  - Will not cause the facility where the program is operated to exceed the maximum occupancy as determined by the State Fire Marshal or the local governmental entity that has the authority to determine the maximum occupancy of the facility.
- **Required components of program:**
  - An inclusion component for participants who qualify under the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101 et seq.;
  - Regular restroom breaks; and
  - Nutrition breaks.

In addition, these programs should be required to maintain certain records for participants and to submit reports of inspections of facilities where programs operate. By adopting the requirements for out-of-school-time programs and the seasonal or temporary recreation programs, families would know their children are in healthy and safe environments with positive adult supervision.

### **Recommendations:**

Require out-of-school-time programs and the seasonal or temporary recreation programs to meet the same health and safety requirements as out of school recreation programs as stated in NRS 423A.600-650. Additionally, Nevada should impose a civil penalty on a person who operates a program and fails to comply with such requirements.

### **For more information on this topic, please contact:**

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## 5. SUBSTANCE ABUSE

### Nevada Children's Report Card Grade: C-

In 2015, Nevada and other state high school students were surveyed and reported their drug and substance abuse. Compared to the other states, Nevada fares very well in the percentage of high school students who smoke cigarettes (7.5%) or use smokeless tobacco (5.1%), ranking 2<sup>nd</sup> and 4<sup>th</sup> respectively. However, those who use any type of tobacco has significantly increased from 14.8% to 30.4%, dropping our ranking from 2<sup>nd</sup> to 15<sup>th</sup>. This may be due to the growing popularity of electronic vapor products, also, known as e-cigarettes. Results from the 2012 National Youth Tobacco Survey (NYTS) indicate that more than 1.78 million middle and high school students nationwide tried e-cigarettes. E-cigarettes do not just emit “harmless water vapor.” Secondhand e-cigarette aerosol (incorrectly called vapor by the industry) contains nicotine, ultrafine particles and low levels of toxins that are known to cause cancer. Exposure to fine and ultrafine particles may exacerbate respiratory ailments like asthma and constrict arteries.<sup>202</sup> According to the CDC, more than half (51.1%) of the calls to poison centers due to e-cigarettes involved young children 5 years and under.<sup>203</sup> The 2012 NYTS found that 76.3% of middle and high school students who used e-cigarettes within the past 30 days also smoked conventional cigarettes.<sup>204,205</sup> This raises concerns that e-cigarettes may be an entry point to conventional tobacco products.

With regards to alcohol consumption, Nevada ranked 26<sup>th</sup> in the nation with 33.5% of Nevada high school aged youth reported currently drinking alcohol on a regular basis. In addition, 64.8% reported having had at least one drink in their life.<sup>206</sup> Nevada's rate of treatment for alcohol use among persons aged 12 or older with alcohol dependence was lower than the national rate from 2008 to 2012. Among persons aged 12 or older with alcohol dependence, approximately 9,000 individuals received treatment from 2008 to 2012, representing only 4.2% of the populations reporting alcohol dependence.

Nevada ranks among the worst states for most drug use except heroin and marijuana (where Nevada ranks 18<sup>th</sup> of 32 and 20<sup>th</sup> of 36 reporting states), ranking 23<sup>rd</sup> of 27 states for ecstasy use, 19<sup>th</sup> of 29 states for methamphetamine use, 30<sup>th</sup> of 32 states for prescription drug use, and 15<sup>th</sup> out of 29 for inhalant use.<sup>207</sup> Evidence suggests that the younger the age of a person's

<sup>202</sup> Americans for Nonsmokers' Rights, “Electronic Smoking Devices and Secondhand Aerosol,” <http://no-smoke.org/pdf/ecigarette-secondhand-aerosol.pdf> (2014)

<sup>203</sup> Centers for Disease Control and Prevention, “Notes from the Field. Calls to Poison Centers for Exposures to Electronic Cigarettes — United States, September 2010–February 2014,” (April 4, 2014)

<sup>204</sup> Centers for Disease Control and Prevention, “Electronic Cigarette Use Among Middle and High School Students — United States, 2011–2012,” (September 6, 2013)

<sup>205</sup> Legacy, “Tobacco Fact Sheet, Electronic Cigarettes,” <http://www.legacyforhealth.org/content/download/582/6926/file/LEG-FactSheet-eCigarettes-JUNE2013.pdf> (May 2014)

<sup>206</sup> “Nevada High School Youth Risk Behavior Survey 2015,” [nccd.cdc.gov/youthonline/App/Results.aspx?LID=NV](http://nccd.cdc.gov/youthonline/App/Results.aspx?LID=NV) (2015)

<sup>207</sup> Center for Disease Control and Prevention, “Youth Risk Behavior Surveillance – United States, 2015,” <http://www.cdc.gov/mmwr/volumes/65/ss/pdfs/ss6506.pdf> (June 10, 2016)

onset of drug use, the higher the likelihood of the person's later development of addiction will be.<sup>208</sup> For these reasons, it is important to appropriately address substance abuse issues in adolescents with age-appropriate prevention, intervention, and treatment measures. In addition, research shows that "the high rate of comorbidity between drug use disorders and other mental illnesses argues for a comprehensive approach to intervention that identifies and evaluates each disorder concurrently, providing treatment as needed."<sup>209</sup>

## **RECOMMENDATIONS FOR IMPROVEMENT:**

- *Given the rise in the use of e-cigarettes by youth, Nevada needs stronger policies that prohibit minors from possessing and using e-cigarettes.*
- *Improve/enhance and increase substance abuse treatment options for youth, especially ages 14-17.*
- *Accelerate efforts to promote awareness and help-seeking behaviors among youth, as well as screening and early intervention in schools to identify both substance abuse and mental and behavioral health disorders before there is a crisis.*
  - *Identification and treatment of mental and behavioral health must be included in any effort to improve substance use or abuse.*
  - *Universal screening for substance abuse and suicide risk should also be routine in all primary care, hospital care (especially emergency department care), behavioral health care, and crisis response settings (e.g., help lines, mobile teams, first responders, crisis chat services). Any person who screens positive for possible suicide risk should be formally assessed for suicidal ideation, plans, availability of means, presence of acute risk factors (including history of suicide attempts), and level of risk.*
- *Require pharmacies to include information with prescriptions about the dangers of using prescription drugs for recreational purposes.*
  - *In addition, require pharmacies to include importance of securing and tracking prescription drugs as well as information about options for proper disposal of unused prescriptions drugs.*

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<sup>208</sup> National Institute on Drug Abuse, "Preventing Drug Abuse: The best Strategy," <http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preventing-drug-abuse-best-strategy> (July 2014)

<sup>209</sup> National Institute of Drug Abuse Research Report Series. Comorbidity: Addiction and Other Mental Illnesses. NIH Publication Number 10-5771 Revised September 2010

# Appendix

## 2017

Indicator	Grade	Rank	Stat	Stat year	Change*	Source
<b>Health Insurance-</b> The percentage of children without health insurance.	F-	48	9.60%	2014	↓ (-7%)	Center For Children and Families - <i>Health Coverage for Children and the Uninsured - 2014*</i> . Center For Children and Families. N.p., n.d. Web. 19 Aug. 2016.
<b>Medical Home-</b> Children who have a medical home that is accessible, continuous, comprehensive, family centered, coordinated and compassionate	F-	50	44.60 %	2011-2012	↔ (0.0)	National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 08/19/16 from www.childhealthdata.org.
<b>Patient Provider Ratios-</b> Active Primary Care Physicians per 100,000 Population by Degree Type	F-	48	69.8	2014	↔ (+0.4)	Association of American Medical Colleges- <i>2015 State Physician Workforce Data Book Center for Work Studies November 2015</i> ." Association of American Medical Colleges. N.p.n.d. Web. 19 Aug. 2016.
<b>Prenatal Care-</b> Births to Women Receiving Late or No Prenatal Care	F	43	9.00%	2014	↓ (-2%)	Kids Count Data Center- <i>Births to Women Receiving Late or no Prenatal Care.</i> Kids Count Data Center. N.p.n.d. Web. 19 Aug. 2016.
<b>Infant/Child Mortality-</b> # per 1,000 (infant deaths < 1 year per # live births)	B+	13	5.10%	2015	↓ (-0.62)	America's Health Rankings United Health Foundation- <i>Infant Mortality Nevada</i> " America's Health Rankings United Health Foundation. N.p.n.d. Web. 19 Aug. 2016.
<b>Low Birth Weight-</b> Percentage of infants weighing less than 2500 grams (5 pounds, 8 ounces) at birth	C+	23	8.00%	2015	↔ (-0.2%)	America's Health Rankings United Health Foundation- <i>Low Birth Weight Nevada</i> " America's Health Rankings United Health Foundation. N.p.n.d. Web. 19 Aug. 2016.
<b>Immunizations-</b> Percentage of children aged 19 to 35 months receiving recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines.	D	37	67.7%	2015	↑ (+7.1%)	America's Health Rankings United Health Foundation- <i>Immunizations Nevada</i> " America's Health Rankings United Health Foundation. N.p.n.d. Web. 19 Aug. 2016.
<b>Physical Fitness-</b> 9-12 grade students not physically active 5 days per week, 60+ minutes)	B+	8	49%	2015	↑ (+6%)	Center for Disease Control and Prevention- <i>Physical Fitness &gt;=5 days Data Tables- Nevada, High School Youth Risk Behavior Survey, 2015</i> ." Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Obesity-</b> (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts)	B+	8	12.2%	2015	↑ (+0.8)	Center for Disease Control and Prevention- <i>Obesity Data Tables- Nevada, High School Youth Risk Behavior Survey, 2015</i> ." Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Overweight-</b> (>= 85th percentile but <95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts)	C+	15	15%	2015	↔ (+0.4%)	Center for Disease Control and Prevention- <i>Overweight Data Tables- Nevada, High School Youth Risk Behavior Survey, 2015</i> ." Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Nutrition-</b> 9-12 grade students who did not eat vegetables during the 7 days before the survey	C+	19	7.2%	2015	↑ (+0.8)	Center for Disease Control and Prevention- <i>No Vegetable Eating Data Tables- Nevada, High School Youth Risk Behavior Survey, 2015</i> ." Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Mental Health Treatment-</b> Received needed mental health treatment or counseling in the past 12 months	F-	49	49.3%	2011/12	↔ (0.0)	National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 08/19/16 from www.childhealthdata.org
<b>Attempted Suicide-</b> Percentage of Nevada high school students who attempted suicide	F+	30	10.70%	2015	↑ (+4.9%)	Center for Disease Control and Prevention- <i>Attempted Suicide Data Tables- Nevada, High School Youth Risk Behavior Survey, 2015</i> ." Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Suicide-</b> Suicide Rate Ages 0-18	B-	16	2.29%	2014	↓ (-1.59%)	Center for disease Control and Prevention- <i>Suicides Ages 0-18 Nevada 2014 - WISQARS Fatal Injury Reports 1999-2014</i> . Center for disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.

<b>Preventive Care-</b> Percentage of high school students who did not see a dentist.	D	29	31.1%	2015	↓ (-0.6%)	Center for Disease Control and Prevention- <i>Oral Health Care Data Table-Nevada, High School Youth Risk Behavior Survey, 2015</i> " Center for Disease Control and Prevention. N.p..n.d. Web. 19 Aug. 2016.
<b>Teen Birth Rate-</b> # of births for teens age 15 to 19 per 1000 females	F+	38	29.00%	2014	↓ (-4%)	Kids Count Data Center- <i>Total Teen Births</i> " Kids Count Data Center. N.p..n.d. Web. 19 Aug. 2016.
<b>Sexual Activity-</b> Currently sexually active	B-	12	27.00%	2015	↓ (-2.2%)	Center for Disease Control and Prevention- <i>Sexual Activity Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> " Center for Disease Control and Prevention. N.p..n.d. Web. 19 Aug. 2016.
<b>Condom Use-</b> Condom use during last sexual intercourse	C+	28	46.30%	2015	↓ (-12.7%)	Center for Disease Control and Prevention- <i>Condom Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> " Center for Disease Control and Prevention. N.p..n.d. Web. 19 Aug. 2016.
<b>No birth control use-</b> HS students who did not use any method to prevent pregnancy during last sexual intercourse	C+	14	12.40%	2015	↓ (-3.6%)	Center for Disease Control and Prevention- <i>No Birth Control Use</i> " <i>Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> " Center for Disease Control and Prevention. N.p..n.d. Web. 19 Aug. 2016.
<b>Chlamydia (STD Rate)-</b> rate 15-24 year olds per 100,000	C+	22	2019.6	2014	↑ (+53.5)	Center for Disease Control and Prevention- <i>Chlamydia (STD Rate) NCHHSTP Atlas</i> " <i>Center for Disease Control and Prevention</i> . N.p..n.d. Web. 19 Aug. 2016.
<b>Syphilis (STD Rate)-</b> rate 15-24 year olds per 100,000	F-	50	12.40%	2015	↑ (+15.4)	Center for Disease Control and Prevention- <i>Syphilis (STD Rate) NCHHSTP Atlas</i> " <i>Center for Disease Control and Prevention</i> . N.p..n.d. Web. 19 Aug. 2016.
<b>Gonorrhea (STD Rate)-</b> rate 15-24 year olds per 100,000	C-	26	369.1	2014	↑ (+64.5)	Center for Disease Control and Prevention- <i>Gonorrhea (STD Rate) NCHHSTP Atlas</i> " <i>Center for Disease Control and Prevention</i> . N.p..n.d. Web. 19 Aug. 2016.
<b>Foster Care Placement-</b> # of children removed & placed in foster care, per 1,000 children under age 18 in population	D+	31	5%	2014	↔ (0.0)	Kids Count Data Center- <i>Children Foster Care Placement</i> " Kids Count Data Center. N.p..n.d. Web. 19 Aug. 2016.
<b>Maltreatment-</b> Total child maltreatment victims rate per 1,000 of the population under age 18	B	15	6.50%	2014	↓ (-1.7%)	U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2016). Child maltreatment 2014
<b>Physical Maltreatment-</b> Percentage of child victims	F	45	36.4%	2013	↑ (+2.4%)	Children's Bureau- <i>Maltreatment: Maltreatment Types of Child Victims Child Welfare Outcomes Report Data</i> "U.S. Department of Health & Human Services Children's Bureau
<b>Sexual Maltreatment-</b> Percentage of child victims	B	17	5.3%	2013	↔ (+0.4%)	Children's Bureau- <i>Maltreatment: Maltreatment Types of Child Victims Child Welfare Outcomes Report Data</i> "U.S. Department of Health & Human Services Children's Bureau
<b>Neglect-</b> Percentage of child victims	C	27	75.6%	2013	↔ (0.0)	Children's Bureau- <i>Maltreatment: Maltreatment Types of Child Victims Child Welfare Outcomes Report Data</i> "U.S. Department of Health & Human Services Children's Bureau
<b>Accompanied Youth-</b> Share of Homeless Families in the US	B+	12	0.00%	2015	↔ (-0.4%)	The U.S. Department of Housing and Urban Development Office of Community Planning and Development- <i>The 2015 Annual Homeless Assessment Report (AHAR) to Congress</i> " The U.S. Department of Housing and Urban Development Office of Community Planning and Development. N.p..n.d. Web. 19 Aug. 2016.
<b>Unaccompanied Youth-</b> Estimates of Unaccompanied Homeless Children and Youth	F	47	2,310.0	2015	↑ (+ 388)	The U.S. Department of Housing and Urban Development Office of Community Planning and Development- <i>The 2015 Annual Homeless Assessment Report (AHAR) to Congress</i> " The U.S. Department of Housing and Urban Development Office of Community Planning and Development. N.p..n.d. Web. 19 Aug. 2016.
<b>Unsheltered Youth-</b> % of Unaccompanied Children and Youth who were Unsheltered	F-	50	87.5%	2015	↑ (+0.6%)	The U.S. Department of Housing and Urban Development Office of Community Planning and Development- <i>The 2015 Annual Homeless Assessment Report (AHAR) to Congress</i> " The U.S. Department of Housing and Urban Development Office of Community Planning and Development. N.p..n.d. Web. 19 Aug. 2016.

<b>High School Violence-</b> NV HS students reported involvement in fighting on school property)	B	11	6.8%	2015	↔ (0.0)	Center for Disease Control and Prevention- <i>Physical Fighting at School Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Weapons on school property-</b> NV HS students reported to have carried a weapon on school property)	B+	7	3.7%	2015	↔ (+0.4)	Center for Disease Control and Prevention- <i>Weapon Carrying at School Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Dating Violence-</b> Physical Violence	D+	22	9.6%	2015	↓ (-1.3%)	Center for Disease Control and Prevention- <i>Dating Violence Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Dating Violence:</b> Sexual Violence	F	29	11.5%	2015	↓ (-0.7)	Center for Disease Control and Prevention- <i>Dating Violence Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Fear of Violence-</b> NV HS students who felt unsafe attending school in the past 30 days)	F+	30	8.5%	2015	↓ (-2.6%)	Center for Disease Control and Prevention- <i>Fear of Violence Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Juvenile Justice-</b> Persons under age 21 detained, incarcerated, or placed in residential facilities.	D	37	201	2013	↓ (-45)	Kids Count Data Center- <i>Youth Residing in Juvenile Detention, Correctional and/or Residential Facilities.</i> ” Kids Count Data Center. N.p.n.d. Web. 19 Aug. 2016.
<b>Child Deaths-</b> All Injury Deaths and Rates per 100,000 Ages 0 to 5	C	25	17.78	2014	↔ (+0.09%)	Center for disease Control and Prevention- <i>Child Deaths, All Intents, Ages 0-18 Nevada 2014 – WISQARS Fatal Injury Reports 1999-2014</i> ” . Center for disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Road Traffic injuries and Deaths-</b> Transport Deaths All transportation related deaths and rates per 100,000 Ages 0-18	B	13	4.3	2014	↑ (+0.76%)	Center for disease Control and Prevention- <i>Road Traffic Injuries Ages 0-18 Nevada 2014 – WISQARS Fatal Injury Reports 1999-2014</i> ” . Center for disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Road Traffic injuries and Deaths-</b> Transport Deaths All transportation related deaths and rates per 100,000 Ages 0-18	B	13	4.3	2014	↑ (+0.76%)	Center for disease Control and Prevention- <i>Road Traffic Injuries Ages 0-18 Nevada 2014 – WISQARS Fatal Injury Reports 1999-2014</i> ” . Center for disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Drowning-</b> Drowning Deaths Drowning Deaths and Rates per 100,000 Ages 0 to 18	D-	25	1.44	2013	↓ (-0.14)	Center for disease Control and Prevention- <i>Drownings Ages 0-18 Nevada 2013 – WISQARS Fatal Injury Reports 1999-2014</i> ” . Center for disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Alcohol-</b> Nevada high school students who currently drank alcohol	D	26	33.50 %	2015	↓ (-1%)	Center for Disease Control and Prevention- <i>Current Alcohol Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Cigarettes-</b> Nevada high school students who have ever smoked any of a cigarette	C+	13	33.30 %	2015	↓ (-7.1%)	Center for Disease Control and Prevention- <i>Ever Cigarette Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Cigarettes-</b> Nevada high school students who currently use cigarettes	A+	2	7.50%	2015	↓ (-2.8%)	Center for Disease Control and Prevention- <i>Current Cigarette Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Smokeless Tobacco-</b> Current smokeless tobacco use	A	4	5.10%	2015	↔ (+0.1%)	Center for Disease Control and Prevention- <i>Current Smokeless Tobacco Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Any Tobacco-</b> Use any form of tobacco	C+	15	30.40 %	2015	↑ (+15.6%)	Center for Disease Control and Prevention- <i>Use any form of Tobacco Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Drugs-</b> Nevada high school students that have used methamphetamines at least once in their lives	C-	19	3.80%	2015	↓ (-30.2%)	Center for Disease Control and Prevention- <i>Methamphetamine Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Drugs-</b> Nevada high school students have used any form of cocaine	F+	27	6.60%	2015	↓ (-1.1%)	Center for Disease Control and Prevention- <i>Cocaine Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Drugs-</b> Current marijuana use	C-	20	19.30 %	2015	↑ (+0.6%)	Center for Disease Control and Prevention- <i>Current Marijuana Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Drugs-</b> Ever used inhalants	C+	15	7.70%	2015	↓ (-2.6%)	Center for Disease Control and Prevention- <i>Inhalant Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.

<b>Drugs- Ever used ecstasy</b>	F+	23	7.30%	2015	↓ (-3.9%)	Center for Disease Control and Prevention- <i>Ecstasy Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Drugs- Ever used heroin</b>	C-	18	2.70%	2015	↓ (-0.6%)	Center for Disease Control and Prevention- <i>Heroin Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Drugs- Ever took prescription drugs without a doctor's prescription</b>	F	30	18.50 %	2015	↓ (-0.9%)	Center for Disease Control and Prevention- <i>Prescription Drug Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2015</i> ” Center for Disease Control and Prevention. N.p.n.d. Web. 19 Aug. 2016.
<b>Pre-K Enrollment- Percentage of 3 and 4 year olds enrolled in preschool</b>	F	50	32.8%	2014	↑ (+1.1%)	National Institute for Early Education Research (NIEER)- <i>The State of Preschool 2015</i> ” National Institute for Early Education Research (NIEER). N.p.n.d. Web. 19 Aug. 2016.
<b>Pre-K Availability- Enrollment of 3- and 4-year-olds in State Pre-K. Preschool Special Education and Federal and State Head Start</b>	F	47	12%	2014-2015	↑ (+1.1%)	National Institute for Early Education Research (NIEER)- <i>The State of Preschool 2015</i> ” National Institute for Early Education Research (NIEER). N.p.n.d. Web. 19 Aug. 2016.
<b>Pre-K Spending- State spending on pre-k programs per capita</b>	F	42	\$46.35	2014-2015	↑ (+\$1.76)	National Institute for Early Education Research (NIEER)- <i>The State of Preschool 2015</i> ” National Institute for Early Education Research (NIEER). N.p.n.d. Web. 19 Aug. 2016.
<b>4th Grade Reading- Percent of 4th Grader's Reading Scores Proficient and above</b>	F	45	29.0%	2015	↓ (-5%)	Education Week Research Center- <i>Nevada-State Highlights 2016 Education Week Quality Counts 2016 Called to Account: New Directions in School Accountability</i> ” Education Week Research Center N.p.n.d. Web. 19 Aug. 2016.
<b>8th Grade Math- Percent of 8th Grader's Math Scores Proficient and Above</b>	F	42	26.1%	2015	↓ (-4.2)	Education Week Research Center- <i>Nevada-State Highlights 2016 Education Week Quality Counts 2016 Called to Account: New Directions in School Accountability</i> ” Education Week Research Center N.p.n.d. Web. 19 Aug. 2016.
<b>Postsecondary Participation- Young adults enrolled in postsecondary education or with a degree</b>	F	50	40.1%	2014	↓ (-0.5)	Education Week Research Center- <i>Nevada-State Highlights 2016 Education Week Quality Counts 2016 Called to Account: New Directions in School Accountability</i> ” Education Week Research Center N.p.n.d. Web. 19 Aug. 2016.
<b>High School Dropout Rate- youth of high school age who are not attending</b>	F+	42	6.0%	2014	↓ (-1%)	Kids Count Data Center- <i>Teens Ages 16 to 19 Not in School and Not High School Graduates</i> ” Kids Count Data Center. N.p.n.d. Web. 19 Aug. 2016.
<b>High School Graduation Rate- Graduation Rates</b>	F	51	60.0%	2012	↓ (-2.7)	Education Week Research Center- <i>Nevada-State Highlights 2016 Education Week Quality Counts 2016 Called to Account: New Directions in School Accountability</i> ” Education Week Research Center N.p.n.d. Web. 19 Aug. 2016.
<b>Money per Pupil- PreK to 12th public actual expenditures)</b>	F	46	\$8,414	2014	↑ (+\$191)	Educational Finance Branch- <i>Public Education Finances: 2014 Economic Reimbursable Surveys Division Reports</i> ” U.S. Department of Commerce Economics and Statistics Administration” N.p.n.d. Web. 19 Aug. 2016.
<b>Pupil to Teacher Ratio- PreK and 12th public student-teacher ratio - students per teacher</b>	F	47	20.6	2013-2014	↔ (-0.2)	Glander, Mark National Center for Education Statistics- <i>Selected Statistics from the Public Elementary and Secondary Education Universe: School Year 2013-2014</i> ” U.S. Department of Education. N.p.n.d. Web. 19 Aug. 2016.
<b>Employment- Children whose parents lack secure employment</b>	D	33	32%	2014	↓ (-2%)	Kids Count Data Center- <i>Children Whose Parents Lack Secure Employment</i> ” Kids Count Data Center. N.p.n.d. Web. 19 Aug. 2016.
<b>Employment- Unemployment Rate Of Parents</b>	D-	38	6%	2014	↓ (-1%)	Kids Count Data Center- <i>Unemployment Rates of Parents</i> ” Kids Count Data Center. N.p.n.d. Web. 19 Aug. 2016.
<b>Income- Teens ages 16-19 not attending school and not working</b>	F+	40	3%	2014	↓ (-2%)	Kids Count Data Center- <i>Teens ages 16-19 not Attending School and not Working</i> ” Kids Count Data Center. N.p.n.d. Web. 19 Aug. 2016.
<b>Income- Low-Income Working Families With Children</b>	F+	41	26%	2014	↑ (+2%)	Kids Count Data Center- <i>Low-Income Working Families with Children</i> ” Kids Count Data Center. N.p.n.d. Web. 19 Aug. 2016.
<b>Poverty- Children in Poverty (100 percent poverty)</b>	C-	29	22%	2014	↓ (-1%)	Kids Count Data Center- <i>Children in Poverty (100 percent poverty)</i> ” Kids Count Data Center. N.p.n.d. Web. 19 Aug. 2016.
<b>Poverty- Children In Extreme Poverty (50 Percent Poverty)</b>	C	24	10%	2014	↔ (0.0)	Kids Count Data Center- <i>Children in Extreme Poverty (50 Percent of Poverty)</i> ” Kids Count Data Center. N.p.n.d. Web. 19 Aug. 2016.
<b>Housing- Children living in households with a high housing cost burden</b>	D	42	37	2014	↓ (-2%)	Kids Count Data Center- <i>Children Living in Households with a High Cost Burden</i> ” Kids Count Data Center. N.p.n.d. Web. 19 Aug. 2016.
<b>Housing- Children In Low-Income Households With A High Housing Cost Burden</b>	D+	29	63	2014	↓ (-3%)	Kids Count Data Center- <i>Children in Low-Income Households with a High Housing Cost Burden</i> ” Kids Count Data Center. N.p.n.d. Web. 19 Aug. 2016.



## Children's Advocacy Alliance

The Children's Advocacy Alliance (CAA) is a community-based nonprofit organization that serves as an independent voice for Nevada's children and families by advocating for improved policies, practices and laws related to children's health, safety and school readiness.

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## Nevada Institute for Children's Research and Policy

The Nevada Institute for Children's Research and Policy (NICRP), located within the School of Community Health Sciences at the University of Nevada Las Vegas, is a not-for-profit, non-partisan organization dedicated to improving the lives of children through research, advocacy and other specialized services.

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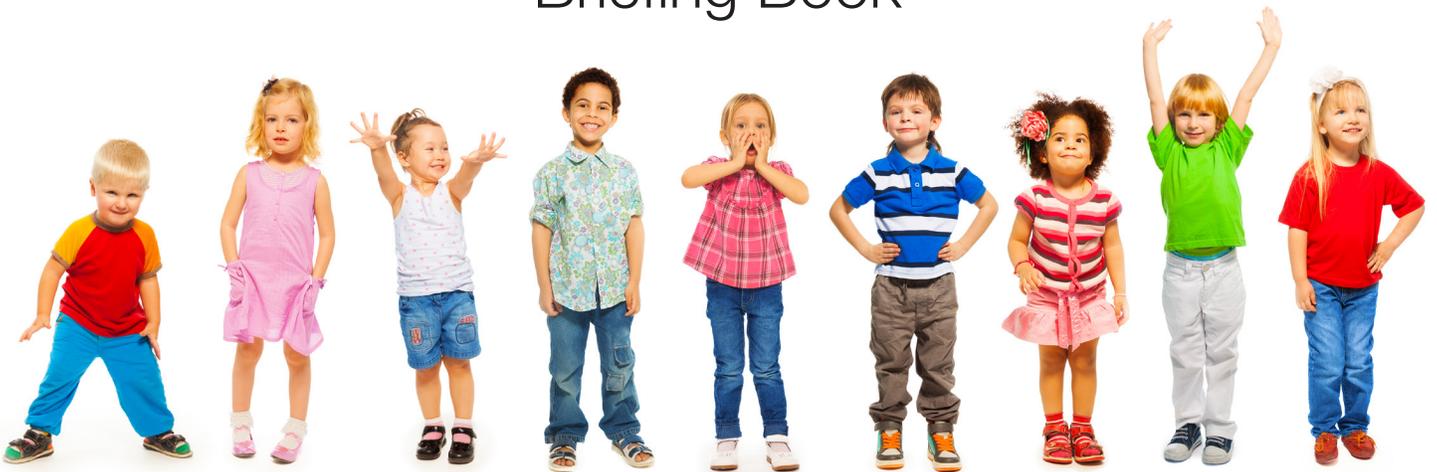
## Nevada Institute for Children's Research and Policy

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