2013

2013 Children’s Legislative Briefing Book

Nevada Institute for Children’s Research and Policy

Children’s Advocacy Alliance

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2013
Children’s
Legislative
Briefing Book

A collaborative effort between:

Nevada Institute For Children’s Research & Policy

Children’s Advocacy A L L I A N C E
One Hundred Years from now
It will not matter what kind of car I drove,
What kind of house I lived in,
how much money was in my bank account
nor what my clothes looked like.
But the world may be a better place because
I was important in the life of a child.

- Author Unknown
“We may not be able to prepare the future for our children, but we can at least prepare our children for the future.”

— Franklin D. Roosevelt

The purpose of this Legislative Briefing Book is to provide a quick snapshot of some of the most pressing issues facing Nevada’s children in order to provide advocates and policymakers with a stepping stone in creating positive changes to improve the lives of Nevada’s children. While this book will not cover every issue facing our children, it is intended to highlight some of those where state policy may have an impact, covering issues in education, health, safety and security, and the juvenile justice system.

Diligent efforts need to be made during the 2013 Legislative Session to improve policies, procedures and services for Nevada’s children. Nevada has continually been ranked as one of the poorest 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 we can improve upon. Although most advocates and particularly policymakers would like to create policies that will provide immediate positive feedback, it is important to realize that effective social change takes time. As such, much emphasis should be placed on developing quality, comprehensive systems and implementing evidence-based preventive strategies to researched-based risk indicators.

This book is intended to be 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.

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School Readiness
Ensuring Our Children Enter School Ready to Learn

Every child in Nevada deserves the opportunity to enter school ready to learn. Our goal is to create a comprehensive early childhood system in Nevada 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 childcare, or with family and friends.

We know that 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. In Nevada, over 57% of children ages 0-5 live in families where all available parents are in the workforce. The average annual cost of child care in a licensed center in Nevada ranges from $8,987 for an infant to $7,340 for preschoolers (age 3-5). The average individual income is $38,334. Only 39 of the 448 licensed child care centers in Nevada are accredited programs.

“Although education and the acquisition of skills is a lifelong process, starting early in life is crucial. Recent research...has documented the high returns that early childhood programs can pay in terms of subsequent educational attainment and in lower rates of social programs, such as teenage pregnancy and welfare dependency.”

- Ben Bernanke, Chairman of the Federal Reserve Board
Quality – Professional Development

Policy Issue: Nevada lacks a sufficient number of highly qualified and trained early childhood professionals needed to ensure that young children, particularly from low-income families, receive the level of high quality, developmentally appropriate instruction that will promote school readiness.

Background:
Early childhood education is more than child care – nearly 80% of the physical growth of the brain occurs in the first 5 years of life, making this a critical period for establishing a solid foundation for future development. 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.

- There are nearly 236,000 children ages 0-5 in the State of Nevada – more than half (about 61%) of these children have all parents in the labor force.
- Only one quarter of the infant-toddler classrooms in NV are rated as having reached minimal quality.¹
- Only 4.69% of all licensed child care programs (9% of centers and 1% of family child care) in Nevada are accredited by a national accrediting organization.
- For directors, the minimal requirement is a CDA credential (which may be waived)², while most other states require a CDA credential and up to 4,000 hours of experience or a bachelor’s degree.
- Only 10.63% of the licensed child care workforce in Nevada has an associate’s degree in ECE or higher. The vast majority of child care providers have a high school diploma (67.11%) and less than 30% of the workforce has an associate’s degree or higher, regardless of the field of study.³

A high quality system of early childhood care and education relies on a highly qualified workforce. Nevada has some of the lowest standards and qualifications for early childhood professionals in the country. Enhancing qualifications and training requirements, beginning with Directors, will assist in improving the quality of programs.

¹ Nevada Early Childhood Advisory Council, Assessment of Center-Based Quality 2011-12.
² NAC 432A.300 - http://www.leg.state.nv.us/NAC/NAC-432A.html#NAC432ASec300
³ Children’s Cabinet, Inc.
Policy Recommendations:

Director Qualifications:
Add a provision in NRS which outlines the mandatory minimum qualifications of a Director of a child care facility to include a minimum age of 21, a minimum of 1,000 verifiable hours in an administrative position or a course/training in business administration, an application to the Nevada Registry, updated annually, and:

1. An Associate’s Degree or higher in early childhood education, plus 1,000 hours of experience in an early childhood learning center;
2. An Associate’s Degree or higher in any field with 15 or more credits in early childhood education or related courses, plus 2,000 hours of experience in an early childhood learning center;
3. High School Diploma, or GED (with administrator approval), with 15 or more credits in early childhood education or related courses, plus 3,000 hours of experience in an early childhood learning center;
4. CDA with preschool or infant/toddler endorsement (as appropriate), including at least 12 or more credits in early childhood education or related courses and 4,000 hours of experience in an early childhood learning center; OR
5. A combination of education and experience which, in the judgment of the Administrator of the Health Division, is equivalent to that required by section 1, 2, 3 or 4 above.

Implementation:
• All current Directors would have until December 2015 to meet current minimum qualifications or request a waiver, with appropriate documentation, to the Administrator of the Health Division.
• All new Directors would be required to meet minimum qualifications upon enactment.

Teacher Training Requirements:
Increase training hours for teachers in child care facilities according to the following schedule:
• At least 15 hours each year through December 2013 (current requirement);
• At least 18 hours each year through December 2014;
• At least 21 hours each year through December 2015; and
• At least 24 hours each year beginning January 2016 and thereafter.

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Quality – Silver State Stars QRIS

Policy Issue: Nevada’s Silver State Stars Quality Rating Improvement System (QRIS), which is designed to establish a structure and accountability system for ensuring the provision of high quality early childhood education in Nevada, currently lacks the appropriate resources for statewide implementation.

Background:
Quality Rating Improvement Systems (QRIS) are being developed across the country to improve the quality of early childhood education programs. These systems have been developed to provide a more objective way to assess quality in a facility providing childcare. Currently, there are Quality Rating Improvement Systems (QRIS) in 26 states or local jurisdictions in the United States and the remaining 25 states are in the process of developing a QRIS. Each of these systems varies slightly in its requirements and protocols, but all have the goal of improving the quality of early childhood education.

The Silver State Stars QRIS Pilot Project, which started in 2009, is the first QRIS in Nevada and has been developed and implemented by the Nevada Office of Early Care and Education in collaboration with the University of Nevada Cooperative Extension (UNCE) and the Nevada Institute for Children’s Research and Policy (NICRP). A pilot project to test and refine the program processes was conducted from 2009 to 2011 and the program is now being implemented on a voluntary basis in Clark County.

- To date, 30 centers have participated in the process of assessment to test the star rating system.
- All centers have been assigned a star rating of 1, which indicates that a center is licensed in good standing. In order to be assigned a higher rating, centers must attend an orientation to the program and enroll in the process.
- Centers are provided with coaching and grant funds to help improve programming and learning environments to help them to receive a higher star rating.
- Planned for 2013 is an evaluation which will examine the relationships between star ratings and outcomes for children enrolled in those centers, which will provide valuable data about the efficacy of Nevada’s QRIS program and will be one of the first evaluations of its kind in the country.

Policy Recommendations:
- Implement statewide expansion on a gradual basis, with continual assessment, evaluation and improvement to further refine the process.
• Support efforts to include appropriate resources for marketing and outreach to ensure that parents are aware of and understand the star rating system.
• Upon statewide implementation, align QRIS and child care subsidy reimbursements to 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.

<table>
<thead>
<tr>
<th>Nevada Silver State Stars Quality Rating Improvement System (QRIS) for Early Childhood Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Star] Center is licensed in good standing.</td>
</tr>
<tr>
<td>![Two Stars] Center is licensed in good standing, accepts child care subsidies, AND staff are engaged in quality improvements, having met at least 4 quality indicators.</td>
</tr>
<tr>
<td>![Three Stars] Center is licensed in good standing, accepts child care subsidies, has better than average group size and teacher to child ratios, has scored a minimum of 3 (out of 7) on a quality assessment, AND has met at least 8 quality indicators. Director is at least a 3.1 on the career ladder.</td>
</tr>
<tr>
<td>![Four Stars] Center is licensed in good standing, accepts child care subsidies, has better than average group size and teacher to child ratios, has scored a minimum of 4 (out of 7) on a quality assessment, AND has met at least 12 quality indicators. Director is at least a 4.2 on the career ladder.</td>
</tr>
<tr>
<td>![Five Stars] Center exceeds all of the requirements above and is accredited by the National Association for the Education of Young Children or the National Early Childhood Program Accreditation. Director is at least a 5.2 on the career ladder.</td>
</tr>
</tbody>
</table>

Centers that participate in Silver State Stars QRIS demonstrate and document quality indicators above licensing regulations. It should be understood advancing from Star Level 1 to subsequent levels is an accomplishment that takes a significant amount of time and effort.

A complete list of required criteria for each star level, including quality indicators, is available at www.nvsilverstatestars.org.

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**Accessibility & Affordability – Child Care Subsidy Programs**

**Policy Issue:** Recent cuts to Nevada’s child care subsidy program have left many families without the appropriate resources to provide high quality early childhood programs for their children. Furthermore, the failure of the State to utilize current market rates to determine subsidy reimbursement amounts has created a financial burden on these providers, as well as the families that they serve.

**Background:**
Families of all income levels, not just families in poverty, struggle with the cost of childcare. The child care subsidy program promotes family economic self-sufficiency by assisting with the high cost, providing both short- and long-term benefits on the economy. Short term, subsidies contribute to the economy by enabling parents to go to work as well as support child care providers who use the subsidy money to operate their business and maintain their own employment. Long term, subsidies provide equal access to quality child care opportunities so children are prepared for school and for life.

The Federal and State dollars that support the Child Care Development Fund (CCDF) subsidy currently serve families in poverty or children in the foster care system, but recent cuts have put pressure on these important sources of family support.

- Prior to February 1, 2009, working families earning 240% of poverty could qualify for assistance with 20% of their child care costs.
- Today, a single mom with an infant and preschooler making $1820 a month (118% of poverty) would not qualify for subsidy. This same mother would have to spend 79% of her income on center-based child care for her children.
- 26.76% (119,400) of all Nevada’s children under the age of 13 live below 200% of poverty and have all available parents in the workforce.
- Nevada’s subsidy program currently only serves 6.27% of children in this eligible population.

Access to quality care is also limited due to the State’s subsidy reimbursement rate currently being set on 2004 market rates. Only 3 states have reimbursement rates that are set on older
market rates. The Federal Register (1998) specifically states that a “biennial market rate survey (be) relied upon to determine that the rates provided are sufficient to ensure equal access.”

- In Clark County, the reimbursement rate for center-based preschool care only represents 4.04% of the available market.
- To access care outside of what the state will reimburse, parents must pay the overage between the State’s maximum reimbursement rate and providers’ actual market rate. For center-based preschool care in Clark County, the difference between the state maximum rate and the 2011 75th percentile rate is $12.53 a day.
- This overage alone is 22% of income for a single mom with a preschooler living at 100% of poverty. Because higher quality child care is often times more expensive than lower quality care, families on the subsidy program are being forced to use care that they can afford due to the increased responsibility to cover the overage.

Policy Recommendations:
- Increase the percentage of eligible children served by subsidies, including those children under 13 years old who live below 200% poverty in single-earner moms, single-earner dads or dual earner households.
- Require current market rates be used to determine subsidy reimbursements. The Child Care Development and Block Grant Act (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 resetting the market rate at every two years to ensure equal access to quality, early childhood education programs.

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4 Schulman & Blank, 2011
5 Pg. 39986

Quality early education for at-risk children can produce an annual rate of return as high as 16% - higher than most stock portfolios. It should be at the top of any state’s economic development agenda.

- Art Rolnick, Senior Vice President, Federal Reserve Bank of Minneapolis
Infrastructure and Systems – Data

Policy Issue:
Nevada needs to develop a comprehensive early childhood education system that supports the ability of all children in Nevada to enter kindergarten ready to learn. The two major components of systematic change identified by this effort are: the need for and adoption of a common kindergarten entry assessment; and the development of a coordinated data system that links pre-kindergarten (pre-K) to K-12.

Background:
Assessing the readiness of children to enter school is a crucial step in understanding what children need to succeed both in school and in life. Kindergarten entry assessments not only assist teachers in utilizing curriculum and aligning instruction to the needs of the children, it also assists in identifying what gaps exists in ensuring that children enter kindergarten ready to learn.

The Nevada Early Childhood Advisory Council (NECAC) conducted a needs assessment that revealed that up to half of school difficulties and failures is already apparent by the time children start school, and that there is a consensus among Nevada educators regarding the need for a statewide, comprehensive kindergarten readiness assessment tool which measure child’s readiness for school across five connected domains:

- Physical Development and Health
- Social and Emotional Development
- Approaches to Learning
- Language and Early Literacy Development
- Cognition and General Knowledge

Moreover, an early childhood data system is needed to drive program quality and improve school readiness once children enter the system. Measuring young children’s educational progress and readiness to enter school during their Pre-K years will assist in:

- Providing information on teacher and program effectiveness
- Identifying students who would benefit from intervention and other services
- Informing local and state policy and program improvement decisions.

“\[quote\]
The success of modern economies depends in part on well-educated and adaptable workers who are capable of learning new skills so that they remain competitive in a continually changing global market.\[quote\]

- James Heckman, Ph.D., Nobel Memorial Prize in Economic Sciences Winner

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6 Information drawn from the Children’s Advocacy Alliance policy brief on School Readiness and Kindergarten Entry Assessment, February 2013.
Policy Recommendations:

- Adopt a state definition of school readiness that incorporates the five domains of early childhood development which are critical to early learning and long term success.
- Identify and implement a common kindergarten entry assessment to assist in providing a picture of what incoming kindergartners can do, so their teachers can design instruction that builds on children’s strengths. The data generated will not only assist teachers, but will also inform policy and help target state resources to improve school readiness on a statewide level and set common expectations for what all preschoolers should learn.
- Implement a Coordinated Early Childhood Data System that will facilitate linkage of state K–12 data systems with early learning, postsecondary education, workforce, social services and other critical agencies and develop governance structures to guide data collection, sharing and use and allow the tracking of progress for each child in Nevada.

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Children’s Health

Ensuring Good Health for Our Children

Every child in Nevada should have the opportunity to grow up healthy, from the prenatal period all the way through their teen years.

To be healthy, children and families need:

- 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.
- High quality, and on-time, prenatal care.

Nothing is as important as a healthy start in life. Every child should be able to count on good health care 365 days a year, but kids can’t insure themselves. Neglecting their basic health care needs can multiply health problems and costs as these kids grow into adults. Just as it’s our responsibility to educate every child, kids also need our help to be sure they have appropriate care – right when they need it. And families need the peace of mind knowing that childhood bumps and bruises won’t turn into life-long health problems, and medical emergencies won’t drive families into bankruptcy.

Percentage of American children ages 0–17 covered by health insurance at some time during the year by type of health insurance, 1987–2010

Source: childstats.gov
Access to Healthcare

Policy Issue: Nevada currently ranks last in the nation when it comes to providing health coverage for children. Over 16% of Nevada’s children have no health coverage, which is more than double the national rate of 7.5%.

An unprecedented opportunity exists to dramatically improve health insurance coverage for Nevada children at limited cost.

Background:
In Nevada, 82% of children with health insurance see a doctor while only 56% of uninsured children receive the benefit of similar medical attention, and uninsured children are ten-times more likely to lack much-needed medical care. Good health is key for academic achievement. Children with 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 health insurance will save the lives of many children. In 2008, one of the leading causes of natural child deaths 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. 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.

<table>
<thead>
<tr>
<th>States with Highest Uninsured Rates(^8)</th>
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<tbody>
<tr>
<td>Nevada</td>
<td>16.2%</td>
</tr>
<tr>
<td>Texas</td>
<td>13.2%</td>
</tr>
<tr>
<td>Arizona</td>
<td>12.9%</td>
</tr>
<tr>
<td>Florida</td>
<td>11.9%</td>
</tr>
<tr>
<td>Alaska</td>
<td>11.8%</td>
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Significant progress has been made across the nation in reducing the rate of uninsured children\(^9\), yet Nevada continues to lag behind, partly driven by the failure to fund outreach and enrollment for Medicaid and the Nevada Check Up program, the state-provided health

\(^8\) Georgetown University Health Policy Institute, Center for Children and Families. “Uninsured Children 2009-2011: Charting the Nation’s Progress.”

insurance for children of low-income families, despite the fact that the Federal Government pays for 70% of the program’s costs.

With the Federal Government promising to pay 100 percent of the cost for three years if Nevada extends its Medicaid program to low-income, uninsured adults – a policy which is estimated to include 25,000 parents of low-income children – and with the ongoing implementation of the nationwide Affordable Care Act, an unprecedented opportunity exists to dramatically improve health insurance coverage for Nevada children at limited cost.

**Policy Recommendations:**

- Extend Medicaid program to low-income, uninsured adults, taking advantage of the available, and unused, federal subsidy.
- Develop and fund 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.

*When children are hospitalized, those without health insurance are 60% more likely to die than those who are insured.*

- Center on Budget and Policy Priorities, Improving Children’s Health, 2007

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Childhood Obesity

Policy Issue: 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. Overweight and obese children are at a significantly higher risk for developing other serious health conditions including diabetes, heart disease, and hypertension.

Background:
Obesity prevalence in Nevada’s children has increased by 29% since 2003. Obese children are more likely to have a shorter 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. American obesity is becoming an epidemic that cost more than $147 billion in medical expenses in 2008.

- 11% of Nevada High School students are obese. 10
- 13% of Nevada High School students are overweight. 11
- 35.5% of kindergarten students in Nevada were found to be overweight or obese. 12
- According to BMI data collected, 18% of 4th, 7th and 10th graders in Nevada are overweight and 20% are obese. 13
- In Nevada, PE is not required in elementary schools, and even though it is a requirement for graduation, many kids seek and are granted waivers and substitutions are allowed for others, including online courses where there is no way to know if physical activity is actually being incorporated.

Policy Recommendations:
- Strengthen statewide and local school wellness policies to increase access to healthy foods and increase opportunities for physical activity at schools. Currently within the state school wellness policy there is a requirement for 30 minutes of physical activity, but most school districts allow for the passing time between periods to count for this activity time.
- Increase the number of Physical Education minutes in schools. The consensus recommendations 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

10 2009 Nevada YRBS
11 2009 Nevada YRBS
13 BMI Summary Report and Recommendations; Nevada State Health Division, 2010
• 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\(^\text{14}\) policies and the adoption of Complete Street elements into local planning documents at the state, regional and local levels in order to make the environment safer for active transport.

• Support 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.

• Continue BMI Surveillance in schools so that we can monitor current childhood obesity rates in our state. Nevada requires height and weight measurements to be taken in schools, but the requirement expires after the 2015 school year.

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\(^{14}\) For more information on the Complete Streets policy, see: [http://www.smartgrowthamerica.org/complete-streets](http://www.smartgrowthamerica.org/complete-streets)
CPR Education in Schools

Policy Issue: In the 2013 Legislative Session the American Heart Association and the American Red Cross are working with partners in the EMS and public safety communities to pass legislation that will create a requirement for Nevada schools to provide psychomotor skills based CPR education to all children prior to graduation.

Background:
Cardiopulmonary Resuscitation (CPR) is used to save the lives of victims of sudden cardiac arrest (SCA). Studies show that states with a higher percentage of citizens that have been educated in CPR have higher SCA survival rates, and that CPR education in schools will dramatically increase both the percentage of citizens who know CPR and subsequently the survival rates of SCA victims.

- Currently, less than 8% of victims of SCA outside of a hospital will survive. This is due in part to the low percentage of bystanders that know and/or are willing to use CPR.
- For every one minute that an SCA victim does not receive CPR or AED assistance, their chances of survival decrease 10%.
- Recent data shows that only 2.9% of Nevadans know CPR.
- As of the 2009 school year, 36 states had a law or curriculum standard encouraging CPR training in schools. Six states have passed legislation requiring CPR education for
Currently, less than 8% of victims of sudden cardiac arrest (SCA) outside of a hospital will survive.\textsuperscript{15}

Moreover, legislation is being considered on the Federal level – the Josh Miller Hearts Act – that would provide federal support for CPR education in schools.

**Policy Recommendations:**
Establish psychomotor skill based CPR education in schools between the 7\textsuperscript{th} and 12\textsuperscript{th} grades according to AHA recommendations:

- Compression only or “hands only” CPR is the preferred method, which does not require mouth to mouth resuscitation.
- Lessons which allow time for students to practice in class and can take place in one class period, whether in health education or otherwise.
- Considered as a graduation requirement so that all children graduating from Nevada schools will have learned this life-saving skill.

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\textsuperscript{15} All information comes from the American Heart Association, CPR in Schools Fact Sheet and FAQ Documents
Newborn Screening

**Policy Issue:** The March of Dimes, American Heart Association, American Academy of Pediatrics, the American College of Cardiology and Save the Babies are partnering on a national level to ensure that all states require screening for newborn critical congenital heart defects (CCHD).

**Background:**
Some babies born with a heart defect appear healthy at first and can be sent home with their families before their heart defect is detected. It has been estimated that about 300 infants with an unrecognized CCHD are discharged each year from newborn nurseries in the United States. These babies are at risk for having serious complications within the first few days or weeks of life and often require emergency care.¹⁶

Newborn screening using pulse oximetry can identify some infants with a CCHD before they show signs of a CCHD. Once identified, babies with a CCHD can be seen by cardiologists and can receive specialized care and treatment that could prevent death or disability.

- Congenital heart defects account for nearly 30% of infant deaths due to birth defects
- In the United States approximately 7,200 babies are born each year with CHHD. These babies usually require surgery or catheter intervention within the first year of life.
- CCHDs can potentially be detected using pulse oximetry screening, which is a test to determine the amount of oxygen in the blood and pulse rate.
- Pulse oximetry screening is most likely to detect seven of the CCHDs. These seven main screening targets are:
  - Hypoplastic left heart syndrome
  - Pulmonary atresia (with intact septum)
  - Tetralogy of Fallot
  - Total anomalous pulmonary venous return
  - Transposition of the great arteries
  - Tricuspid atresia
  - Truncus arteriosus

¹⁶ Information in this brief comes from The Centers for Disease Control and Prevention, Screening for Critical Congenital Heart Defects Fact Sheet; the American Heart Association, CCHD Facts; and March of Dimes CCHD FAQ document.
The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC) is charged with advising the Secretary of the U.S. Department of Health and Human Services (DHHS) in areas relevant to heritable conditions in children, particularly newborn screening. In September 2010, SACHDNC voted to recommend adding critical congenital heart disease (CCHD) to the Recommended Uniform Screening Panel, and the Secretary adopted the addition of CCHD to the panel in September 2011.

- Following this recommendation, parent groups and newborn patient advocate organizations began to push for requirements for CCHD screening in states.
- As of December 2012 seven states have passed such requirements, with at least 30 others (including Nevada) working towards a requirement.

**Policy Recommendations:**

Require that all birthing centers in Nevada screen all newborns for CCHD using pulse oximetry, with a provision to allow for a new method if the screening technology changes over time.

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Teen Pregnancy Prevention

Policy Issue: Nevada consistently has one of the highest teen pregnancy rates in the country. Teens who received comprehensive sex education were 50 percent less likely to experience pregnancy than those who received abstinence-only education.

Background:
Every school district in Nevada is currently required to teach sex education (NRS 389.065) and school districts update curricula every two years, including the sex education curriculum. As of January 2012, national standards exist for Sexuality Education, as they do for math and reading. The creation of Sex Ed standards ensures that it will be considered a core competency in our school systems.

- Nevada consistently has one of the highest teen pregnancy rates in the country.
- Comprehensive Sex Education will save taxpayers money in the long run. Teen childbearing cost Nevada taxpayers at least $84 million in federal, state, and local dollars in 2008. Between 1991 and 2008 there were more than 66,000 teen births in Nevada, costing taxpayers a total of $1.3 billion over that 17 year period.
- The average annual cost associated with a child born to a mother 17 and younger is $3,040 in the state of NV.
- Nevada’s teen birth rate currently ranks 10th in the US, with a rate of 53.5 births per 1,000 young women ages 15-19 compared to the national rate of 41.5 births per 1,000.
- Nevada’s HIV infection rate ranks 10th in the United States, with a rate of 18.9 cases per 100,000 individuals compared to the national rate of 19.5 cases per 100,000.
- According to the CDC, one in four sexually active teen girls will acquire an STD.
- Teaching young people about healthy relationships and ways to avoid dating violence can reduce physical dating violence and sexual dating violence by 60%.
- Teens who received comprehensive sex education were 50 percent less likely to experience pregnancy than those who received abstinence-only education.
- Nearly half of the 19 million new STDs each year are among young people (15–24 years).

Widespread support exists for comprehensive 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.”

According to the Guttmacher Institute: California’s “teen pregnancy rate declined by 52% between 1992 and 2005, the steepest drop registered by any state over that period – and far larger than the national decline of 37%.” Experts credit this record decline to California’s aggressive and evidence-based comprehensive sexuality education and access to contraception. On the other hand, the National Campaign to Prevent Teen and Unplanned Pregnancy found no strong evidence that abstinence-only programs delayed initiation of sex, hastened the return to abstinence, or reduced number of sexual partners. It did find that two-thirds of the comprehensive Sex Ed programs reviewed had positive behavioral effects on individuals, such as decreasing rates of unprotected sex, delaying the initiation of sex, and reducing the number of sexual partners.
Policy Recommendations:
Sex Education is currently required in Nevada schools, but the curriculum is not consistent across the state. To address the current realities our students are facing, legislation should be passed that would require all school districts to offer a comprehensive, age-appropriate and medically accurate sexuality education curriculum that will include:

- Reproductive and sexual anatomy and physiology, including biological, psychosocial and emotional changes that accompany maturation
- Accurate information on AIDS/HIV and STD prevention, testing and treatment as well as contraception, with an emphasis on abstinence as the most effective way to prevent pregnancy and sexually transmitted diseases
- 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 violence and 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

Structure and Administration:
- Parents would be allowed to have their children “opt-out” of this coursework without penalty.
- This legislation maintains the existing community Sex Education advisory boards, with one change: each member of the committee, including student representatives, shall have one vote.  
- These courses may be taught by an educational professional, health care provider, educator, teacher or school nurse who has demonstrated a competency in comprehensive, age-appropriate and medically accurate sexuality education.
- The State Board of Education adopts standards for content and performance in school courses of study. This legislation adds: the health (or science) standards will include regularly updated standards of content and performance pursuant to NRS 389.065 which requires comprehensive, age-appropriate, medically accurate instruction on human sexuality, healthy relationships, and sexual responsibility.

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Widespread support exists for comprehensive Sex Education in Nevada.

17 The present legal statute is NRS 389.065, which can be found at [http://leg.state.nv.us/NRS/NRS-389.html](http://leg.state.nv.us/NRS/NRS-389.html)
Children’s Safety
Ensuring Our Children are Safe and Well

In FY11, over 7,200 children in Nevada were in foster care – more than 68% were returned to their birth family within one year and 13% returned home within 7 days. This staggering phenomenon suggest that if our community had a stronger array of critical family support services, and a community ethic of investing in children and families before crisis hits, many children could remain safely with their parents, instead of entering foster care or ending up on the streets. Studies have shown that we can save taxpayer dollars and increase our return on investment by re-directing the exorbitant costs of foster care into child abuse prevention and family support services.

Child abuse and neglect costs United States taxpayers approximately $103.8 billion each year, with a mere 25 percent of these costs attributable to child welfare services themselves. The remaining 75 percent of costs ($70.7 billion) consist of indirect costs to society and involvement with other social services systems, such as the health care and criminal justice systems. Child abuse and neglect costs each Nevada household roughly $95, for a statewide total of $79 million, every year.

To ensure the safety and well-being of our children, and their families, we must:

- Engage a broad, diverse and deep coalition of community members in identifying and developing a shared vision for child and family wellbeing in our community.
- Collect data and conduct research on best practices to develop a comprehensive system for preventing child abuse and neglect and providing necessary care and services for children and families in the system.
- Revise and update laws affecting child welfare to ensure that they are consistent with federal laws and to ensure the appropriate level of services for children and families in the system.
- Ensure that the use of psychotropic medications among children and youth in the child welfare system are monitored, tracked and appropriately prescribed to meet the health needs of the child.
- Ensure that appropriate services are available to ensure the safety and well-being of youth and young adults who are involved in sex trafficking in our State.
- Review and revise the funding structure in Nevada that supports prevention services for children and families at risk of becoming involved with child welfare and for those who are currently involved with child welfare.
Nevada’s Child Welfare System

Policy Issues:
Nevada’s child welfare system, like many others, are not adequately organized or resourced to prioritize prevention and reduce the rate of entry into the foster care system.

Background:
Child abuse and neglect creates 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. The child welfare system thus grew around the attempt to solve or at least mitigate these problems, protecting the children in the community and ensuring their chance to thrive as healthy, hopeful children. Nevada’s child welfare system is, like others in the country, comprised of many agencies and community groups, and a primary tool to protect the children from adult abuse and neglect is to remove them from their families into foster care.

However, although foster care has no doubt saved many children from dangerous environments, and removal of at-risk, abused, or neglected children into foster care may seem like a logical first choice, the long term effect is not always the best.

- In Nevada, more than 68% of the children who come into foster care are returned to their birth family within one year.
- 13% of those who enter the child protective system return home 7 days or less.

With these statistics, clearly entering into the foster care system is not always a permanent escape; rather, the root causes of abuse or neglect should be addressed and the child welfare system redesigned to focus more on family-focused child welfare service, focusing on prevention.18

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18 See the Community We Will brief for further information.
Policy Recommendations:

- 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.
- Revise NRS 432B.393(4) to include a definition of the reasonable efforts standard that is: culturally appropriate, available and accessible within the specified timeframe, and are designed to meet the specific needs of the family to provide a safe and stable home for their children.
- Revise NRS 432B.393’s waiver of reasonable efforts provisions to ensure that waivers are only allowed for the most severe cases of abuse or neglect and that the court must review and approve an agency request to waive reasonable efforts.
- Establish procedures for child welfare agencies to protect children and youth in the child welfare system from identity theft, and credit checks conducted at specific intervals for every child in the child welfare system.
- Ensure that adequate resources are in place to provide children and families with the services needed to safely prevent removals and ensure timely reunifications.

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“Our nation’s overreliance on foster care fails to address the conditions that lead to child removal, devastate families, strain state and local budgets, and contribute to long-term outcomes for children, families and communities.”
– Casey Family Programs
Sexually Exploited Children

Policy Issues:

*Treatment and Services for Sexually Exploited Children* - Nevada is a major destination for juvenile prostitution but there are no services available to treat the children who are sexually exploited by the consumers of the sex trade. The 2013 Legislative Session should address the critical lack of resources to fund services for these children.

*Criminalization of Victims* - Under the federal Trafficking Victims Protection Act (TVPA) all persons under the age of 18 involved in prostitution are federally designated as victims. Currently, under Nevada law these victims are arrested, detained and adjudicated as juvenile delinquents.

*Stronger Prosecution of Consumers* - Nearly a fifth of the children detained for prostitution are under 16 and not yet legally old enough to consent to any sexual activity in Nevada. There needs to be a new focus on the enforcement of this serious crime which is being committed by the tens of thousands of men purchasing sexual services from children each year. The legislature should recognize that purchasing sexual services from children is a more serious crime than purchasing sex from adults and warrants a different charge.

Background:

Since the Department of Justice’s 2007 assessment of domestic minor sex trafficking in Las Vegas and the FBI’s identification of trafficking hot spots, Nevada has been in the national eye for our response. Las Vegas is a major destination for children being trafficked domestically in the United States. Some of the key findings from these reports were: there is a complete lack of prevention programs for at-risk children in the sexualized environment of Las Vegas; prostituted children are being identified as victims but are treated as delinquents; there are inadequate prosecutions of the men purchasing sexual services from these children; and, there is a critical lack of safe and appropriate services or programs for prostituted children.

**THE MOST URGENT NEED IS TREATMENT AND APPROPRIATE PLACEMENTS FOR THESE SEXUALLY EXPLOITED CHILDREN.**

The primary reason these victims are being held in juvenile detention longer than other youth is the lack of alternative secure placements. In addition, there is a lack of programming for sexually exploited children. Treatment that can address the multiple traumatic needs of these children is lacking both in detention and in the community at large. Children sexually exploited through prostitution have unique needs. For example, these children often require intensive intervention to break the traumatic bond that they have with their pimps. These children have a variety of urgent care needs including medical care and trauma counseling that are best addressed in a therapeutic environment that is safe and secure. Intermediate needs may include housing placement, educational assessment, continued counseling, mentoring and other wrap-around services.
The Juvenile Courts, District Attorneys, and Public Defenders are collaborating to develop programming for sexually exploited children. These agencies in partnership with non-profit community partners like the Sojourn Foundation have led to new initiatives like the Clark County Family Court position of a Sexually Exploited Youth Court Administrator. This position, however, is hampered by the lack of resources for victims. Non-profit organizations are hoping to partner with government to create safe houses and programs that will support these sexually exploited children in transitioning out of prostitution and into healthy adulthood.

- In Las Vegas between August 2005 and December 2010, 551 children (534 girls and 5 boys) were prosecuted for prostitution or prostitution-related offenses through Judge W. Voy’s dedicated commercial sexual exploitation court. Although these children are now federally defined as victims they are still treated as delinquents.
- Law enforcement records kept since 1994 show that an annual average of 150-200 children have been adjudicated in Clark County for prostitution related offenses.
- National estimates are that over 150,000 children are prostituted every year.
- National and local research has shown that the majority of children exploited through prostitution have experienced sexual abuse or neglect in the home. These children are in need of services that currently do not exist.

Even though record high numbers of children have been arrested for prostitution, far fewer men have been prosecuted for abusing them as either pimps or as consumers. The lack of serious consequences for purchasing sexual services from juveniles leaves this form of exploitation unchecked and uncurbed.

**Policy Recommendation(s):**

- Fund important and necessary services for victims, which are in critical need.
- Address the legal treatment of sexually exploited children in the State. Contrary to the federal designation (TVPA) of children who are sexually exploited through prostitution as victims, Nevada is adjudicating these victims as juvenile delinquents.
- Highlight the seriousness of the offence of taking advantage of these children and the necessity to step up enforcement against the consumers. The demand for prostitution fuels the trafficking of sexually exploited children. In order to reduce the demand for children, consumers must be prosecuted.

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19 STOP Program
20 NISMART
Child Death Review Teams (CDRTs)

Policy Issue: The Child Death Review Teams, which investigate child deaths in Nevada, have two state-level oversight groups – the Administrative Team and the Executive Committee – that have redundant functions and should be combined into one state-wide effort.

Background:
The primary object of child welfare and its partnering systems such as justice, public health, and law enforcement, is to ensure the safety and well-being of children in the State of Nevada. The child death review (CDR) process is an unfortunate and necessary component of achieving this goal. Deaths of children occur while children are in the care of their natural families, adoptive parents, foster parents, and day care providers to name a few. NRS 432B establishes child death review teams (CDRTs) at the State, regional, and local levels. These teams must review child deaths and make recommendations to improve policies and practices.

One of the goals of child death review teams (CDRTs) is to prevent future deaths from occurring by learning from those unfortunate instances. Currently, there are three different types of review teams in the State of Nevada, which includes five regional CDRTs: Clark, Pahrump, Elko, Fallon, and Washoe; and two state-wide oversight groups: The Administrative Team and the Executive Committee. Information sharing flows to and from each of the three different types of teams to ensure the fidelity of recommended policies, trainings, and practices. At the state level a considerable amount of overlap exists between the Administrative Team and the Executive Committee. To promote efficiency and streamline the review and response process the two teams should be combined into one state-wide effort.

Per NRS 432B.405-506 Regional Child Death Review Team consists of a representative of child welfare, law enforcement, medical, district attorney’s office, any school involved with the case, the coroner’s office, and any other stakeholders from organizations concerned with the death of the child; and the functions include:

- Review selected cases of child deaths involving children under the age of 18;
- Review selected cases of child deaths of children under 18 that are residents of Nevada, but die in other States;
- Evaluate and analyze such cases;
- Recommend improvements to laws, policies and practices;
- Enhance mechanisms to facilitate the safety of children; and
- Prevent future child deaths.
Per NRS 432B.408 Administrative Team consists of child welfare administrators of agencies, and agencies responsible for vital statistics, public health, mental health and public safety; and the functions include:

- Review the report and recommendations set forth by CDRTs and respond back within 90 days of receiving the report.

Per NRS 432B.409 Executive Committee consists of representatives from child welfare, vital statistics, law enforcement, public health and the Office of the Attorney General; and the functions include:

- Preparation of annual reports that include statistics and recommendations;
- Responsibility for the Review of Death of Children Account that is used to fund particular activities related to the review of child deaths;
- Provide training and assistance to regional CDRTs; and
- Determines who will be members of the Administrative Team

The overlapping responsibilities entail multiple meetings and similar discussions at the statewide-level. This translates into the inability of the two teams to nimbly respond to child deaths. An example of unnecessary steps that foreclose efficiency is when CDRTs forward approved preventative initiatives to the Administrative Team, which ultimately lands with the Executive Committee for review. This information could go directly to the Executive Committee. Another example of inefficiency is when CDRT performance reports are prepared annually and must be presented to multiple grouped stakeholders including both the Administrative Team and Executive Committee.

**Policy Recommendations:**

- Amend NRS.432B to combine the Administrative Team and the Executive Committee to streamline the state level structure of the child death review teams. This will focus the process of reviewing cases and promote consistency and expediency of review.
- Ensure adequate representation of local stakeholders and those from rural regions in particular in the combined team, ensuring that the team does not have an overrepresentation of administrators.

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Assembly Standing Committees

Commerce and Labor
Bobzien, Kirkpatrick, Bustamante Adams, Carlton, Daly, Diaz, Frierson, Healey, Horne, Ohrensall, Ellison, Grady, Hansen, Hardy, Livermore

Education
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Legislative Operations and Elections
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Government Affairs
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Revenue & Economic Development
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