
Health Status of Children Entering Kindergarten in Nevada



Results of the 2021-2022 (Year 14) Nevada Kindergarten Health Survey

This project was completed in collaboration with the following:

All Nevada County School Districts
Nevada School District Superintendents
Nevada Division of Public and Behavioral Health

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Nevada Institute For Children's Research & Policy

NICRP

University of Nevada, Las Vegas
School of Public Health

The Nevada Institute for Children's Research and Policy (NICRP) is a not-for-profit, non-partisan organization dedicated to advancing children's issues in Nevada.

As a research center within the UNLV School of Public Health, NICRP is dedicated to improving the lives of children through research, advocacy, and other specialized services.

NICRP's History: NICRP started in 1998 based on a vision of First Lady Sandy Miller. She wanted an organization that could bring credible research and rigorous policy analysis to problems that confront Nevada's children, but she did not want to stop there; Miller wanted to transform our research into meaningful legislation that would make a real difference in the lives of Nevada children.

NICRP's Mission: Our mission is to conduct community-based research that will guide the development of programs and services for Nevada's children. For more information regarding NICRP research and services, please visit our website at <https://nic.unlv.edu>

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EXECUTIVE SUMMARY

To gather data on the health status of children entering the school system and to better track student health status, the Nevada Institute for Children’s Research and Policy (NICRP), in partnership with Nevada School Districts, and the Nevada Division of Public and Behavioral Health, conducted a health survey of children entering kindergarten in Nevada. The goals of this study were to:

- Longitudinally quantify the health status of children as they enter school,
- Identify specific areas for improvement to potentially increase academic success, and
- Provide local information to policymakers to guide decisions that affect children’s health.

In the fall of 2021, NICRP distributed questionnaires to almost all public elementary schools in the state. The survey had an overall response rate of **23.3 percent**, with a total of 7,058 surveys received from parents/guardians in 16 of the 17 school districts in Nevada. One rural county did not return any surveys. The data herein are weighted ($n = 30,198$) to derive comparisons on issues that represent the following regions of the state: Clark County, Washoe County, and Rural Counties combined. Comparisons to previous years are also included. The following tables contain some of the key findings of the survey. Arrows are included in the tables to indicate the direction of the percent change from previous years.

Health Status: Compared to last year, the percentage of kindergartners identified as being at a healthy weight and being overweight or obese increased while the percentage of kindergartners identified as being underweight decreased. The percentage of kindergartners that drink diet soda once a day or more increased while the percentage of kindergartners that never drink diet or non-diet soda and drink non-diet soda once a day or more decreased. The percentage of kindergartners that were exclusively breastfed at one, three, and six months decreased while the percentage of kindergartners that were exclusively breastfed at twelve months increased.

	2020-2021	2021-2022	% Change	
Weight Status				
Underweight	19.5%	16.2%	-16.9%	▼
Healthy	48.6%	50.7%	+4.3%	▲
Overweight/Obese	31.9%	33.1%	+3.8%	▲
Physical Activity				
7 days per week of 60-minutes of physical activity	37.4%	37.7%	+0.8%	▲
Consumption of Non-Diet Soda				
Never drink non-diet soda	71.6%	69.6%	-2.8%	▼
Drink non-diet soda once a day or more	7.5%	7.3%	-2.7%	▼
Consumption of Diet Soda				
Never drink diet soda	88.3%	86.3%	-2.3%	▼
Drink diet soda once a day or more	2.9%	3.8%	+31.0%	▲
Infant Feeding Behaviors				
Breastfed Only – One Month	53.1%	52.2%	-1.7%	▼
Breastfed Only – Three Months	42.6%	41.4%	-2.8%	▼
Breastfed Only – Six Months	28.8%	27.6%	-4.2%	▼
Breastfed Only – Twelve Months	17.9%	19.1%	+6.7%	▲

EXECUTIVE SUMMARY

Household Income: Compared to last year, the percentage of households making less than \$25,000 per year and households making \$55,000 or more per year decreased, while the percentage of households making \$25,000 - \$54,999 per year increased.

	2020-2021	2021-2022	% Change	
Household Income				
Less than \$25,000 per year	18.3%	16.9%	-7.7%	▼
\$25,000 - \$54,999 per year	26.8%	31.5%	+17.5%	▲
\$55,000 or more per year	54.9%	51.8%	-5.6%	▼

Insurance Status: Compared to last year, the percentage of uninsured children and children covered by Medicaid increased, while the percentage of children covered by private insurance and Nevada Check-Up decreased.

	2020-2021	2021-2022	% Change	
Insurance Status				
Uninsured	5.4%	5.9%	+9.3%	▲
Private Insurance	54.7%	48.8%	-10.8%	▼
Medicaid	27.5%	32.3%	+17.5%	▲
Nevada Check-Up	5.4%	5.2%	-3.7%	▼

Routine Care: Compared to last year, the percentage of children receiving a routine medical check-up slightly increased, while the percentage of those having a primary care provider and those visiting the dentist slightly decreased.

	2020-2021	2021-2022	% Change	
Routine Care				
Had a routine medical check-up in last 12 months	86.8%	88.4%	+1.8%	▲
Have a primary care provider	92.0%	90.6%	-1.5%	▼
Have been to a dentist in past 12 months	76.1%	78.0%	-2.5%	▼

Access to Health Care: Compared to last year, the percentage of respondents reporting lack of transportation, insurance, quality medical providers, and money/financial resources as barriers to accessing health care decreased. In contrast, although a smaller percentage of respondents tried to access mental health services this year as compared to last year, a larger percentage had trouble obtaining them.

	2020-2021	2021-2022	% Change	
Barriers to Accessing Health Care**				
None	80.0%	82.7%	+3.4%	▲
Lack of Transportation	3.2%	2.6%	-18.8%	▼
Lack of Insurance	6.9%	5.8%	-15.9%	▼
Lack of Quality Medical Providers	6.5%	6.1%	-6.2%	▼
Lack of Money/Financial Resources	10.4%	6.8%	-34.6%	▼
Have tried to access mental health services	8.1%	7.3%	-9.9%	▼
Had trouble obtaining mental health services***	44.1%	47.4%	+7.5%	▲

**Since respondents could select more than one barrier, totals may exceed 100%.

***Only refers to respondents who answered that they had tried to access mental health services.

For more detailed information about our survey questions, please see Appendix B of the full report.

Data for specific counties and schools may also be available upon request.

Please contact NICRP at (702) 895-1040 for additional information.

INTRODUCTION

Health plays an important role in academic achievement and is pivotal in determining long-term educational outcomes (Shaw et al., 2015; Suhrcke & de Paz Nieves, 2011). However, the connection between education and health is not straightforward. The relationship is complicated due to a myriad of social issues that can impact both components and is related to disparities rooted in a child's earliest experiences. Determining factors may include one's housing and neighborhood features, as well as access to services, health status, and where one falls on the socio-economic ladder (Ellen & Glied, 2015; Suhrcke & de Paz Nieves, 2011). Studies have found that disadvantages in these determining factors account for inequities that persist through the lifecycle into adulthood (Suhrcke & de Paz Nieves, 2011).

Does poor health lead to lower educational attainment or is the converse true? The answer is complex as "poor health not only results *from* lower educational attainment, it can also *cause* educational setbacks and interfere with schooling" (Center on Society and Health, 2014, p. 6). How does this impact children? Chronic absenteeism can be caused by chronic illness and mental health conditions along with multiple other factors (Allen et al., 2018). Frequent school absenteeism can have negative effects on academic performance which include high school and college graduation rates (Allen et al., 2018). Chronic absenteeism can prevent children from reaching important learning milestones and has been correlated with lower graduation rates, which can lead to poor outcomes later in life (U.S. Department of Education, 2019). It is estimated that, nationally, more than 8 million students are chronically absent each year (Attendance Works, 2022). Studies examining rates of absenteeism have found rates to be highest among the economically disadvantaged and those living in high poverty areas (Balfanz & Byrnes, 2012; Jacob & Lovett, 2017). Children with health conditions living in low-income communities may have limited access to health care and may not always receive the medical care needed to attend school regularly (Balfanz & Byrnes, 2012). Implementation of the Affordable Care Act helped improve health insurance coverage through the Medicaid expansion. A study examining the impact of Medicaid on long-term educational attainment found that children who can access Medicaid while they are young have higher rates of academic success (Cohodes et al., 2014). The benefits of Medicaid on academic achievement are highest among those who complete high school, attend college, and/or obtain a 4-year degree (Cohodes et al., 2014).

The first years of life are predictive of future success. The Brookings Institute's Social Genome Model measures children's success in life across five stages: early childhood, middle childhood, adolescence, transition into young adulthood, and adulthood (Sawhill & Karpilow, 2015). Through their research, they found that success in each stage is highly dependent upon success during earlier stages (Sawhill & Karpilow, 2015). For instance, "a child who is ready for school at age five is nearly twice as likely as one who is not, to complete middle school with strong academic and social skills" (Sawhill & Karpilow, 2015, p. 3). The first 8 years of life are instrumental to a child's success (Centers for Disease Control & Prevention [CDC], 2022b). Brain development depends on a variety of factors including proper nutrition in pregnancy, exposure to toxins, and the child's experiences with people and the world (CDC, 2022b). Cognitive development is the process of learning to think and reason, which can begin as early as 0-1 years old and continue up to late adolescence (CDC, 2021; Cincinnati Children's, 2020).

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Children between the ages of 6-12 think in concrete ways which include combing, separating, ordering, and transforming objects and actions (Cincinnati Children's, 2020). Children need to be nurtured and supported during these formative years and protected from extreme stress to avoid long term consequences (CDC, 2022b). Early and ongoing assessment and intervention efforts are needed to continue to improve long-term outcomes for Nevada's children.

COVID-19 has had a profound impact on the world and our nation, causing stress and uncertainty, and affecting the lives of children and families. Due to the changes in their environment and the increased isolation, children were left with social, emotional, and developmental impacts, as families faced unemployment or working from home, loss of loved ones, health challenges and lack of access to services such as mental health treatment, food, housing, and childcare (Office of the Surgeon General [OSG], 2021; Rabinowicz et al., 2020). Many of America's children still face major challenges such as increased rates of distress, anxiety, depression, and trauma-related mental health diagnoses, as well as behavioral reactions including higher inattention-hyperactivity, irritability, sleep problems, and clinging (OSG, 2021; Meade, 2021). Children need the support of parents, caregivers, and teachers to provide them with safe and supportive environments to overcome these challenges.

The health status of our children is vital to the future success of Nevada. Thus, NICRP has partnered with the state's 17 school districts, the Nevada Division of Public and Behavioral Health (DPBH), and several other community partners since 2008 to conduct an annual health survey of Nevada's children as they enter kindergarten. The purpose of this survey is to longitudinally quantify the health status of children as they enter school, identify specific areas for improvement to potentially increase academic success, and provide local information to policymakers and community organizations to make informed programmatic, system-level, decisions.

METHODOLOGY

The Kindergarten Health Survey (KHS) used in this study was created in 2008 in partnership with the Clark County School District and the Southern Nevada Health District and has been administered on an annual basis. The survey was intended to provide a general understanding of the overall health status of children when they enter school. The original short questionnaire was developed in both English and Spanish and consisted of 22 questions. Small revisions to the survey have been considered each year and are based on feedback obtained from a variety of organizations and coalitions statewide. Due to changes in the survey, data for all items presented in this report may not be available for all previous years. The current version of the one-page survey consists of 37 questions (12 demographic questions and 25 questions related to health and early childhood environments) and continues to be printed double-sided to provide the survey in both English and Spanish.

At the beginning of Fall 2021, questionnaires were distributed to kindergarten teachers in all public elementary schools in the state. Parents/guardians that chose to participate either turned the survey into the school office, their child's teacher, or mailed it directly to NICRP.

INTRODUCTION

NICRP staff followed-up with each school to ensure receipt of materials or to answer questions regarding the survey. Schools that indicated they did not receive the materials were asked if they still wanted to participate. If they indicated yes, the surveys were mailed or delivered again. Additionally, follow-up calls were made in mid-October and November to schools that had not yet submitted surveys. During the follow-up calls, NICRP staff attempted to verify if the schools distributed the surveys to parents/guardians and if the schools had any questions or problems with the distribution and collection of the surveys. In some cases, these phone calls reminded the schools to distribute the surveys or submit completed surveys.

Once surveys were received by NICRP, each survey was assigned a unique identification number by NICRP staff to aid in the tracking of survey responses. All survey responses were analyzed using IBM SPSS Statistics for Windows, Version 28.0. County frequencies were weighted to adjust for student responses. The weights were scaled so that the weighted count of students reflects each county's officially reported unaudited enrollment of schools that were sent surveys for the year of this report (State of Nevada Department of Education [NDE], 2021). The only schools not included were those that are online only or state charter schools that were not sent surveys. Therefore, the surveys received from the 7,058 respondents represent all public kindergarten students in the state of Nevada. Weighted estimates are representative for all kindergarten students in the state of Nevada, as well as for Clark County, Washoe County, and Rural Counties combined. Data presented in this report does not always total 100 percent due to the procedures used to round the data.

LIMITATIONS TO THE STUDY

As in all research studies, there are limitations to the data collected. First, all information contained in this report was self-reported by each parent or guardian. The information provided relied on the memory and honesty of the survey respondents. Second, while all the surveys received were included in the analyses, it is important to note, when reading the percentages presented, not all respondents answered all questions. All percentages calculated for this report are based on the total weighted number of people answering the question, rather than the total number of people who completed the survey. Third, the KHS data include children who attend public kindergarten and some Nevada State Charter schools that agreed to participate. Therefore, it does not represent all children of kindergarten age statewide. However, based on the number of 5-year-olds who were projected to reside in the state of Nevada in 2021 (approximately 38,948 children) (Nevada State Demographer, 2022) and the number of children who were enrolled in public kindergarten (34,641) (NDE, 2021), it appears that only 8.9 percent of children may not attend public kindergarten.

SURVEY RESULTS

Presented in the figures below are the basic frequencies (counts and percentages) of responses for all questions included in the survey. Cross-tabulations were also calculated for selected variables to provide additional information on specific topics. In addition, the 2021-2022 data were compared across counties (Clark, Washoe, and Rural Counties combined) for the current data collection period (See Appendix A, Table 10.1) with data from the previous years (2 years in the text, and three years in Appendix A, Table 10.2). All data presented after the response rates are weighted data.

1 RESPONSE RATES

Each school district involved in the study provided NICRP with the estimated number of kindergarten students enrolled in their district for the 2021-2022 school year. Based on these estimates, 39,734 surveys were distributed to participating schools. At the end of the data collection period (April 2022), 7,058 surveys were returned to NICRP for a **response rate of 17.8 percent**. Response rates for each school district (Table 1.1) ranged from 0 percent in Lander County to 54.1 percent in Storey County.

Table 1.1 Survey Response Rate by School District

School District	# Surveys Distributed	# Surveys Returned	Response Rate
Carson City	600	181	30.2%
Churchill County	240	89	37.1%
Clark County	31,701	4,210	13.3%
Douglas County	350	122	34.9%
Elko County	780	216	27.7%
Esmeralda County	20	1	5.0%
Eureka County	27	8	29.6%
Humboldt County	200	1	0.5%
Lander County	100	0	0.0%
Lincoln County	60	13	21.7%
Lyon County	650	255	39.2%
Mineral County	50	14	28.0%
Nye County	362	125	34.5%
Pershing County	55	19	34.5%
Storey County	37	20	54.1%
Washoe County	4,402	1,743	39.6%
White Pine County	100	41	41.0%
<i>All Districts</i>	39,734	7,058	17.8%

In addition, NICRP calculated a response rate based on the number of surveys returned and the number of kindergarteners enrolled within each school district, including the Nevada State Public Charter School Authority (SPCSA) schools that chose to participate, by obtaining the unaudited enrollment numbers for each school district from NDE (2021, Table 1.2). This information was used to calculate how much of the actual kindergarten sample was surveyed.

This NDE unaudited enrollment response rate was compared to the survey distribution response

RESPONSE RATES

rate based on the number of surveys distributed by each school district. For the school districts that returned surveys, the difference in the NDE unaudited enrollment response rate and the survey distribution response rate ranged from 0.1 percent (Humboldt County) to 7.8 percent (White Pine County). The overall response rate for the unaudited enrollment response rate and the survey distribution response rate varied by 5.5 percent where in the past it was closer to 4 percent. Further review indicates that the Clark County data are largely responsible for this increase. In the past few years, the difference between the requested surveys and unaudited enrollments in Clark County was approximately 4 percent; however, this year it was almost 7 percent. Given the size of the Clark County school district and the abnormally large increase in the number of surveys requested, this difference alone accounts for the discrepancy with the NDE Unaudited Enrollment Response Rate. Therefore, for this survey year, the NDE Unaudited Enrollment **Response Rate of 23.3 percent** is a better measure of the survey response rate.

Table 1.2 Kindergarten Unaudited Enrollment and Response Rate by School District

School District	NDE Unaudited Enrollment	# Surveys Distributed Requested	NDE Unaudited Enrollment Response Rate	Survey Distribution Response Rate
Carson City	504	600	35.9%	30.2%
Churchill County	253	240	35.2%	37.1%
Clark County	22,212	31,701	20.2%	13.3%
Douglas County	359	350	34.0%	34.9%
Elko County	725	780	29.8%	27.7%
Esmeralda County	9	20	11.1%	5.0%
Eureka County	22	27	36.4%	29.6%
Humboldt County	244	200	0.4%	0.5%
Lander County	81	100	0.0%	0.0%
Lincoln County	68	60	19.1%	21.7%
Lyon County	620	650	41.1%	39.2%
Mineral County	55	50	25.5%	28.0%
Nye County	397	362	31.5%	34.5%
Pershing County	61	55	31.1%	34.5%
Storey County	33	37	60.6%	54.1%
Washoe County	4,552	4,402	39.2%	39.6%
White Pine County	84	100	48.8%	41.0%
<i>All Districts</i>	30,279	39,734	23.3%	17.8%

Note. The unaudited enrollment numbers for each district only include public schools that were sent survey, include SPCSA charter schools that are located within their respective districts.

SURVEY PARTICIPATION BY SCHOOL DISTRICT

Figure 1.1 illustrates the participation of Washoe, Clark, and all Rural Counties combined. A total of 7,058 surveys were utilized for analysis with parents/guardians completing 59.6 percent of those surveys in Clark County, 24.7 percent in Washoe County, and 15.7 percent in the Rural Counties. This year, Clark County contributed a larger percentage of the surveys (59.6%) as compared to last year (41.7%) and both Washoe County and the Rural Counties contributed smaller percentages (Washoe: 24.7% v 25.3%; Rural Counties: 15.7% v 33.0%).

RESPONSE RATES

Figure 1.1 Survey Participation by School District, Unweighted

2021-2022 n = 7,058

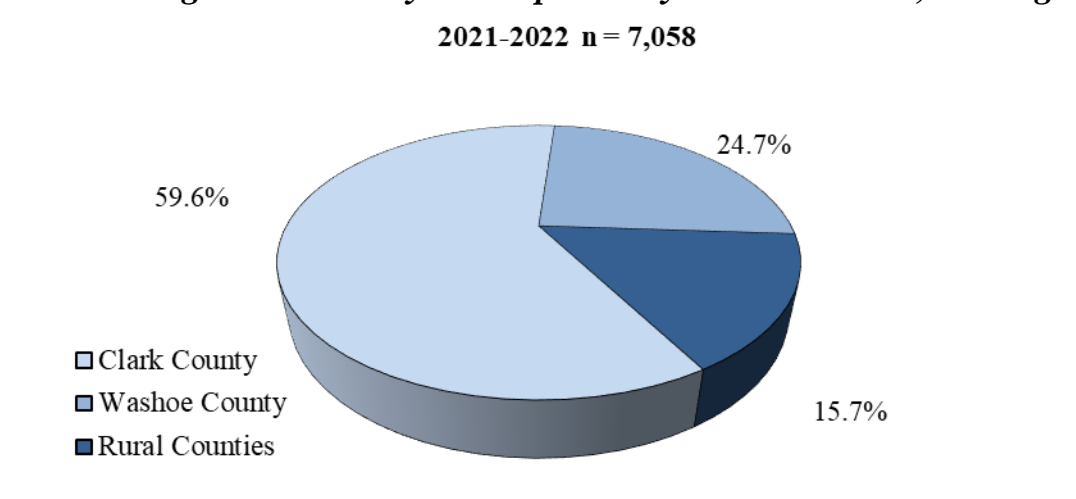
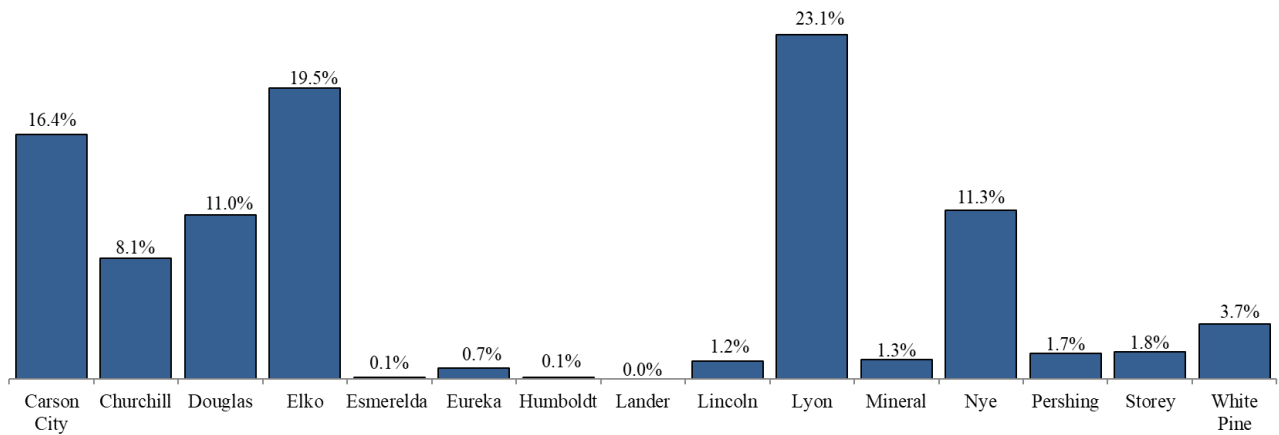


Figure 1.2 Illustrates county-specific participation for *only* Rural Counties, representing 15.7 percent of the total respondents.

Figure 1.2 Survey Participation Among All Rural Counties, Unweighted

2021-2022 n = 1,105



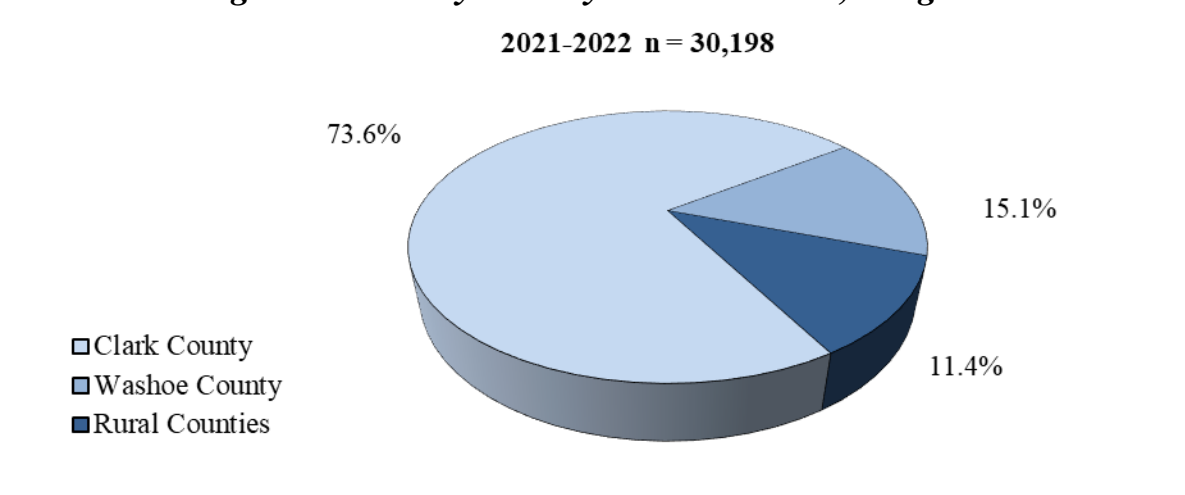
2 DEMOGRAPHICS

The survey was created to be one page in length, with one side printed in English and the reverse side printed in Spanish. Of the 7,058 respondents who returned surveys, 90.3 percent completed the English version and 9.7 percent completed the Spanish version.

WEIGHTED DATA

Please note that all data provided from this point on are weighted to be representative of the regions of the state and the state as a whole. Therefore, the responses received from the 7,058 respondents represent 30,198 kindergarten students. Figure 2.1 below demonstrates that after weights are applied, the distribution of the data mirrors that of the actual distribution of kindergarten students by region and the state overall.

Figure 2.1 Survey Data by School District, Weighted



Parents/guardians were asked to respond to questions regarding their annual household income and their child's gender, race/ethnicity, and preschool setting before entering kindergarten. Data for each of these questions are presented in Figures 2.2 through 2.6 below, with all percentages calculated using the total number of completed responses rather than the total number of returned surveys.

GENDER

Among the kindergarten students for which gender was reported, the distribution included a larger percentage of females (50.3%) than males (49.6%).

FAMILY DEMOGRAPHICS

The average age of the child's mother was 33.93 ($SD = 6.78$), and the average age of the child's father was 36.39 ($SD = 7.65$). The average number of adults living in a household was 2.12 ($SD = 0.94$) and ranged from zero to nine adults. The number of children living in a household

DEMOGRAPHICS

averaged 2.49 ($SD = 1.18$) and ranged from zero to 12 children. Of the parents/guardians that responded to the question, 27.8 percent indicated that they are a single parent or guardian.

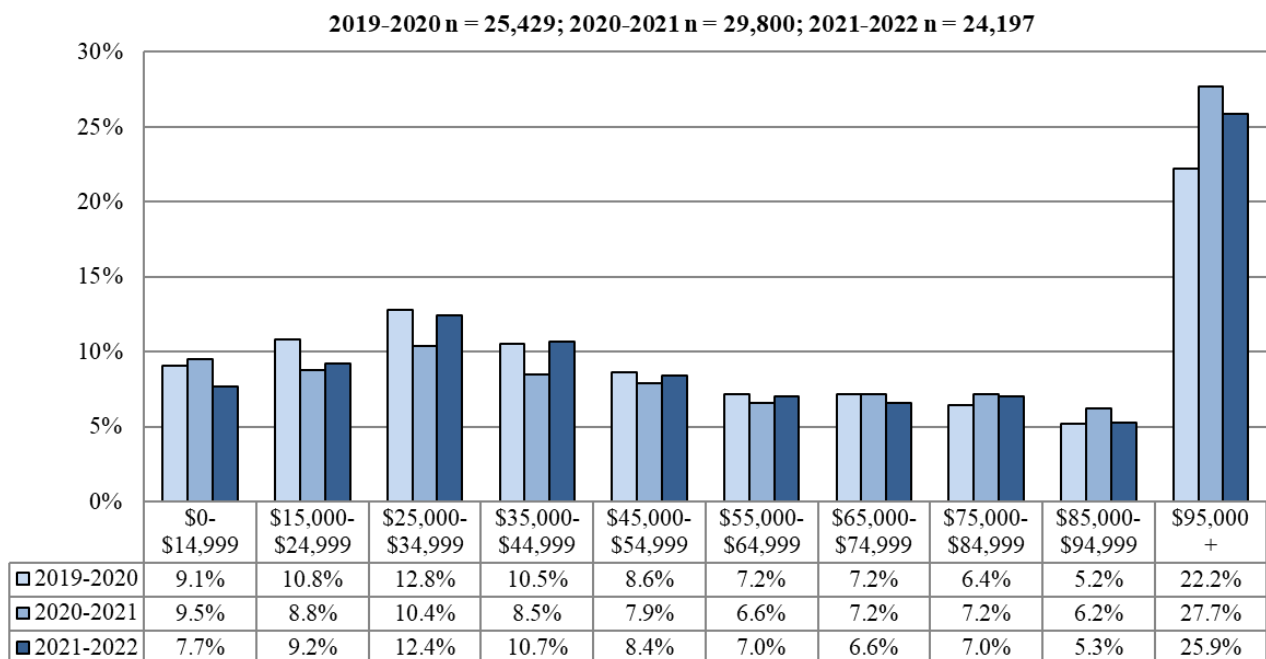
ANNUAL HOUSEHOLD INCOME AND HOUSING TENURE

According to the U.S. Census Bureau (2021), the 2021 median household income in Nevada was \$65,686. This median income represents the middle value of a distribution and is the best measure of central tendency to reduce the impact of outliers (very high or very low incomes) in the distribution. In the current study, 55.4 percent of respondents reported an annual household income less than \$65,000 (See Figure 2.2).

Compared to previous survey years:

- The percentage of families with an annual household income between \$15,000 and \$64,999 increased this year as compared to last year and the percentage of families with an annual household less than \$15,000 decreased (See Appendix A, Table 10.2).
- The percentage of families with an annual household income of \$65,000 or more decreased this year as compared to last year.

Figure 2.2 Annual Household Income by School Year



Housing and neighborhoods are key components to a child’s growth and development. In the United States, the availability of rental housing has decreased, causing the rate of rental properties to increase. Lower income families and families with limited resources may face significant barriers to finding stable, healthy housing in such a competitive market. Housing instability is associated with a greater risk of fair or poor health of children and their caregivers and of maternal depressive symptoms (National Low-Income Housing Coalition, 2018). Housing can affect children’s health outcomes in many ways. Poor housing is associated with higher risks of symptoms for depression, anxiety, and aggression from elementary school through young

DEMOGRAPHICS

adulthood. Children in kindergarten living in poor quality homes are more likely to receive lower readiness scores compared to children who have stable housing (Gaitán, 2019). Households behind on rent had increased odds of fair and/or poor caregiver health, maternal depressive symptoms, child lifetime hospitalizations, fair and/or poor child health, and household material hardships. Families with multiple moves and a history of homelessness had similar adverse caregiver and child health and hardship outcomes (Sandel et al., 2018). Research on the impact of homeownership on child health and development outcomes has consistently demonstrated that children whose parents own the house they grow up in are more likely to finish high school (Coley et al., 2014; Yun, & Evangelou, 2017), have higher reading skills, have fewer emotional and behavioral problems (Coley et al., 2014), have higher earnings (Cooper & Luengo-Prado, 2014), and have a lower reliance on welfare as adults (Harkness & Newman, 2003). Therefore, a question was added to the survey to assess homeownership.

Responses to housing tenure indicate 52.0 percent of children live in rental housing and 48.0 percent live in owner-occupied housing. Upon further examination, income and racial disparities exist for housing tenure. With regards to income, approximately 59.8 percent of the individuals who rent earn less than \$45,000 a year while only 18.3% of individuals who own earn less than \$45,000 a year. With regards to race, **79.0 percent of individuals who identified as African American/Black live in rental housing** compared to 35.0 percent of individuals who identified as Caucasian and 37.6 percent of those who identified as Asian. A large percentage of those who identified as Native American/Alaskan Native (67.7%) also rent, followed by Hispanic/Latino (63.0%), Pacific Islander (57.6%), Mixed Race (54.4%), and Other (39.3%).

COVID-19 had a large impact on housing, especially for those with low-incomes (Opportunity Finance Network [OFC], 2022). Many tenants are facing job loss and income loss that affect their ability to pay for rent, buy food, or access health care (OFC, 2022). Individuals in Low-Income Housing Tax Credit (LIHTC) financed affordable housing face immediate challenges, as they are forced to pay the full amount of rental payments, yet many of these properties will not be able to provide their usual services or pay for the increased cost of cleaning and sanitizing due to losses in revenue, which places these people at risk for losing their housing (OFC, 2022). One study found that eviction and foreclosure rates have doubled, with Black and Hispanic households having reported higher evictions and higher rates of rent/mortgage delinquency and delayed bill payments than White households (Chun & Grinstein-Weiss, 2020).

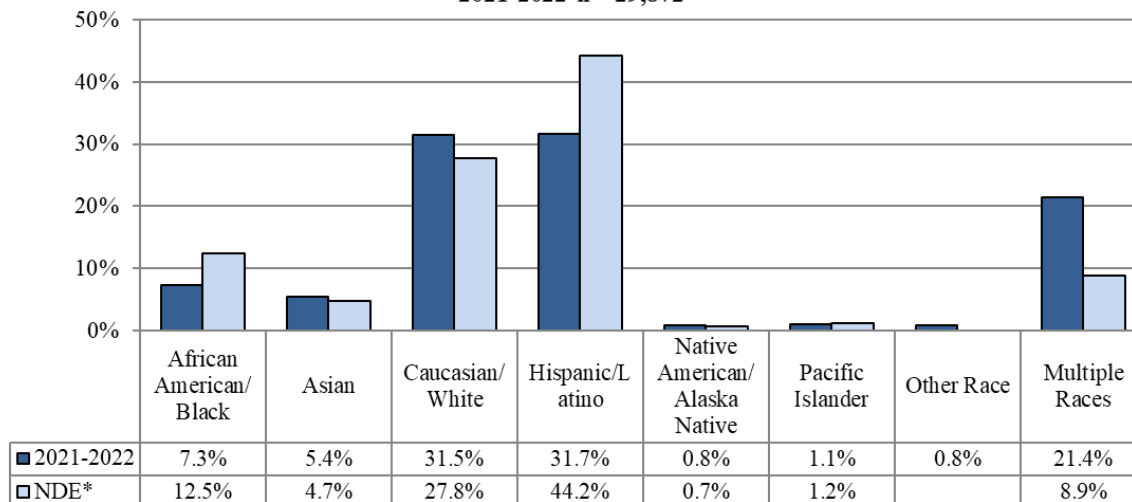
RACE/ETHNICITY

Race and ethnicity data were compared to the most recent data available from the NDE kindergarten student demographic profiles. Compared to the racial demographics of kindergarten students attending public schools in Nevada, KHS survey respondents included fewer Hispanic and African American/Black participants (12.5 and 5.2 percentage points respectively) and more multiple race and Caucasian participants (12.5 and 3.7 and percentage points respectively) (See Figure 2.3). It is important to note that NDE does not provide an option for “other,” while the KHS does provide this as an option.

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Figure 2.3 Child's Race/Ethnicity

2021-2022 n = 29,872



Source: State of Nevada Department of Education. (2021). *2021-2022 School Year Number of Students Receiving Educational Services as of 10/01/2021*. [Excel] Retrieved from https://doe.nv.gov/DataCenter/Enrollment_Data/

When comparing race/ethnicity across counties for the 2021-2022 school year (See Appendix A, Table 10.1), there are larger percentages of kindergarteners who are African American/Black, Asian, Pacific Islander, and Multiple Race in Clark County as compared to Washoe County and the Rural Counties. There are also larger percentages of kindergarteners who are Asian in Washoe County compared to the Rural Counties. There is a larger percentage of kindergarteners who are Native American/Alaskan Native in Rural Counties than in Clark County and Washoe County.

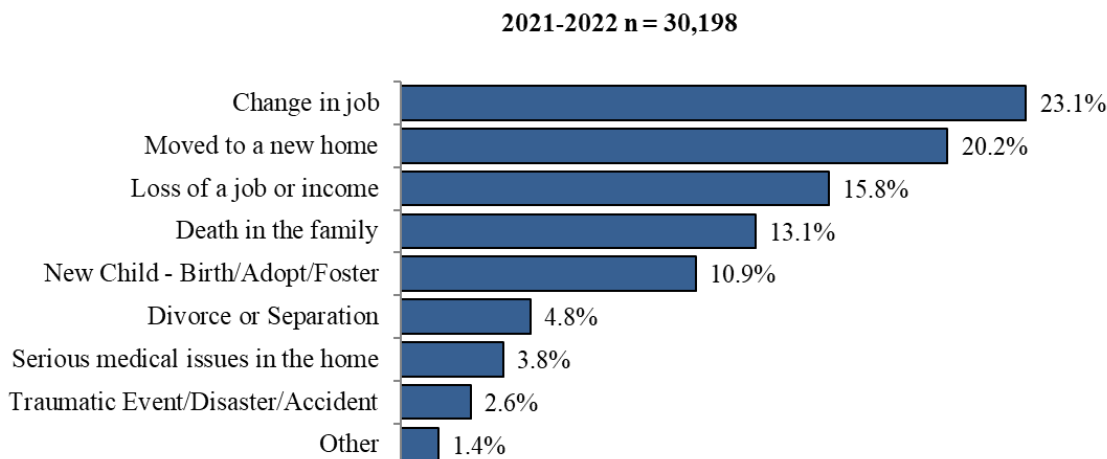
FAMILY ENVIRONMENT

Early childhood experiences shape a child’s emotional and psychological health. Significant life events, even when positive, may still be stressful for a family. According to Harvard University’s Center on the Developing Child, exposure to stressful events can be overcome if there are supportive relationships to help children cope (Center on the Developing Child, 2016; Cohen, 2017). Manageable stress alongside emotional support is referred to as positive stress, which can be beneficial to the development of coping skills (Center on the Developing Child, 2016). However, stress can develop into toxic stress for children facing prolonged or frequent adversity with a lack of supportive relationships to act as a buffer, leading to negative outcomes and a disruption in a child’s physiological response (Center on the Developing Child, 2016). Children in adverse environments during their formative years may experience long-term consequences (Cohen, 2017; Masarik & Conger, 2017; Sciaraffa et al., 2018). Adults with more adverse experiences during their younger years have an increased risk for “heart disease, diabetes, substance abuse, and depression well into the adult years” (Center on the Developing Child, 2016, p. 12). Given the impact that significant life events can have on a child and their family, respondents were asked if they had any significant life experiences over the last year.

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Almost two-thirds of the KHS respondents indicated they had experienced at least one significant life event (64.9%) in the past year. The most common life event was a change in job (23.1%), followed by a move to a new home (20.2%) (See Figure 2.4).

Figure 2.4 Life Events



Note. Respondents were able to select multiple categories. Therefore, the total percent within each year might exceed 100.

Respondents were able to write in “other” life events they experienced. Common “other” life events included pregnancy, a parent not living at home (e.g., due to deployment or incarceration), new family members moving in, a parent going back to school, and custody issues.

NUTRITION

Numerous families experience food insecurity, defined as an inability to consistently provide nutritious food in a socially acceptable way (Beckwith et al., 2020). In 2018, an estimated 128,160 children faced food insecurity in Nevada alone. Families that face food insecurity tend to make up for the lack of nutritious food through unhealthier, energy-dense foods (Lee et al., 2018). Research theorizes a lack of nutritional food may lead to the development of unhealthy lifestyles such as overeating. Furthermore, transitions into food insecurity are associated with anxiety and depressive symptoms and significantly worse health status outcomes compared to consistently food-secure children (Kimbrow & Denney, 2015).

Due to potential health impacts of food insecurity on a child, starting in Year 14, respondents were asked if they had experienced food insecurity over the last year.

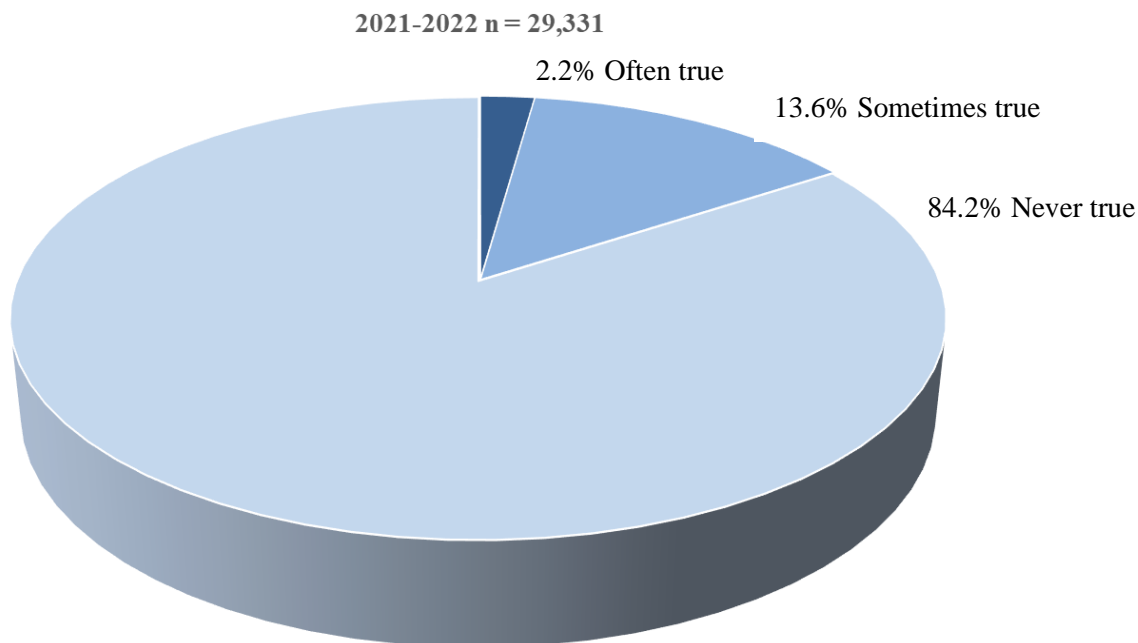
Within the past 12 months, **15.8 percent of respondents** indicated that it was often true (2.2%) or sometimes true (13.6%) that their food didn’t last and they didn’t have money to buy more.

DEMOGRAPHICS

When comparing data across counties:

- A larger percentage of respondents in Clark County indicated that it was sometimes or often true that they ran out of food and did not have money to buy more (17.1%) than in the Rural Counties (14.2%) and Washoe County (10.5%).

Figure 2.5 Food Didn't Last and Didn't Have Money for More



HOUSEHOLD SMOKING

In the US, more than 16 million people live with health conditions caused by smoking (CDC, 2018). Smoking can lead to chronic disability and contribute to diseases of the heart, cancers, strokes, and chronic lower respiratory diseases, all of which can cause preventable deaths (CDC, 2018). The impacts of smoking extend to those who are exposed to secondhand smoke. In the US, exposure to secondhand smoke accounts for 41,000 deaths among nonsmoking adults and 400 infant deaths annually (CDC, 2018).

In babies, secondhand smoke increases the likelihood of death due to Sudden Infant Death Syndrome (SIDS, CDC, 2022c). In young children, it increases the risk of lung problems, ear infections, and severe asthma (CDC, 2022c). The two most common places of secondhand smoke exposure for babies, children, and teens are their own home and family vehicle (CDC, 2022d). The combination of secondhand smoke and resulting health outcomes increases the risk of children missing school compared to those who remain unexposed. One study found that children with one or more adult smokers in the home had between 1.06 and 1.54 more days of missed school than children living with adults who do not smoke (Levy et al., 2011). Another study found that those who lived with a smoker were approximately 1.50 times more likely to report that they sometimes, often, or very often missed school due to illness (Merianos et al., 2018).

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Due to the stay-at-home order issued during COVID-19, children were at an increased risk of being exposed to secondhand smoke, especially with higher rates of stress and anxiety leading to more tobacco consumption in the households (Okereke et al., 2021). Okereke and colleagues analyzed results from a 2020 online tobacco survey and found that the presence of children in the household did not deter people from smoking indoors; in fact, 63.5 percent of households in the U.S. with at least one daily smoker allowed smoking indoors during the stay-at-home orders, with 57.4 percent of households including children (Okereke et al., 2021).

The current survey assessed young children’s exposure to secondhand smoke by asking if there were individuals in the home who smoked and if smoking was allowed in the home. As seen in Table 2.1, 12.6 percent of children live in a home with a household smoker, while just over one percent allow smoking in the home.

Table 2.1 Percent of Children in Households that Smoke

SMOKER IN HOUSEHOLD <i>n</i> = 28,942	SMOKING ALLOWED IN THE HOME <i>n</i> = 28,256
12.6%	1.1%

PRESCHOOL SETTING

Respondents were asked to indicate the type of preschool setting their kindergartener attended in the past twelve months, if any (See Figure 2.6).

Compared to previous years’ data:

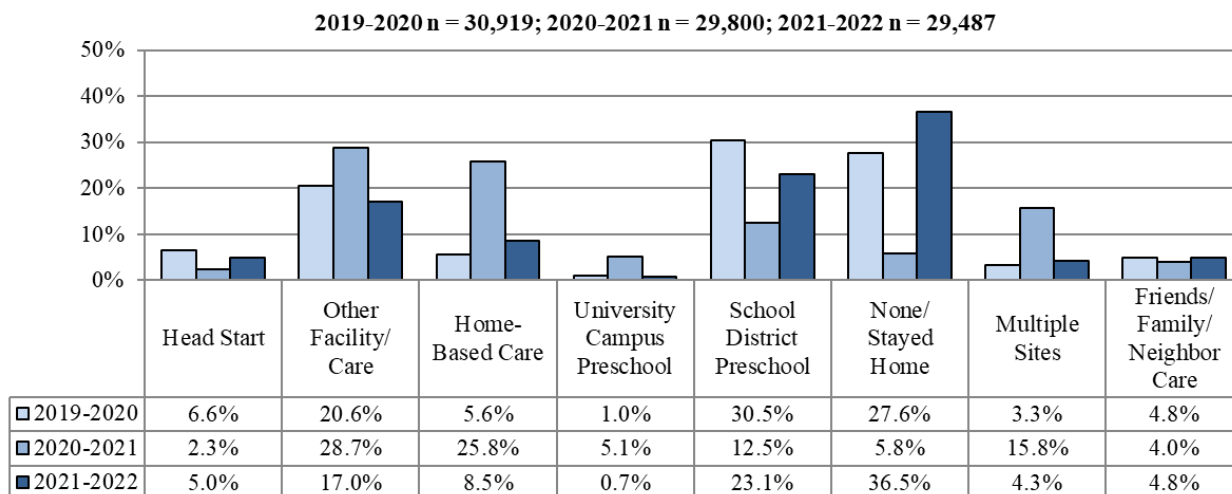
- The percentage of children who did not attend preschool dramatically increased from 5.8% last year to 36.5% this year.
- Participation in Head Start, school district preschool, and friends/family/neighbor care increased this year as compared to last year.
- As seen in Figure 2.6, participation in the different preschool settings this year is similar to participation in 2019-2020. This likely reflects a “return to normal” following the impacts of COVID-19 on the 2020-2021 survey results.

When comparing the 2021-2022 data across counties (See Appendix A, Table 10.1):

- A larger percentage of children attended home-based programs in Clark County (9.6%) as compared to the Rural Counties (6.4%) and Washoe County (5.1%).
- A smaller percentage of children attended Head Start in Clark County (4.4%) as compared to Washoe County (6.0%) and the Rural Counties (7.4%).
- A smaller percentage of children attended school district preschool in Washoe County (19.3%) as compared to Clark County (23.9%) and the Rural Counties (23.4%).

DEMOGRAPHICS

Figure 2.6 Child's Type of Preschool Setting During Last Twelve Months



Average Hours of Preschool Attendance

Data from 2019 indicates that of children five years of age and younger who were not enrolled in kindergarten, 59 percent were in at least one weekly nonparental care arrangement, 62 percent were attending daycare or prekindergarten, 38 percent were being taken care of by a relative, and 20 percent were cared for in a private home (National Center for Education Statistics, 2021). Thus, it is important to understand how preschool environments affect children's overall well-being. Some of these effects, positive or negative, might be correlated with the time spent in non-parental care. Therefore, in addition to the type of preschool setting, the survey assesses the amount of time children spend in the preschool setting.

Results shown in Table 2.2 indicate that 40.4 percent of parents/guardians have their child at home during the week, 36.3 percent have their child in someone else's care for 20 hours or fewer per week, 19.2 percent have their child in someone else's care 21-40 hours per week, and only 4.0 percent have them in someone else's care more than 40 hours a week.

When comparing the results across counties (See Appendix A, Table 10.1):

- A larger percentage of children were in care more than 20 hours a week in Washoe County (33.6%) as compared to Clark County (21.5%) and the Rural Counties (20.8%).

Table 2.2 Average Preschool Hours of Attendance

0 HRS	1-4 HRS	5-10 HRS	11-15 HRS	16-20 HRS	21-30 HRS	31-40 HRS	41+ HRS
40.4%	9.3%	12.9%	7.9%	6.2%	7.5%	11.7%	4.0%

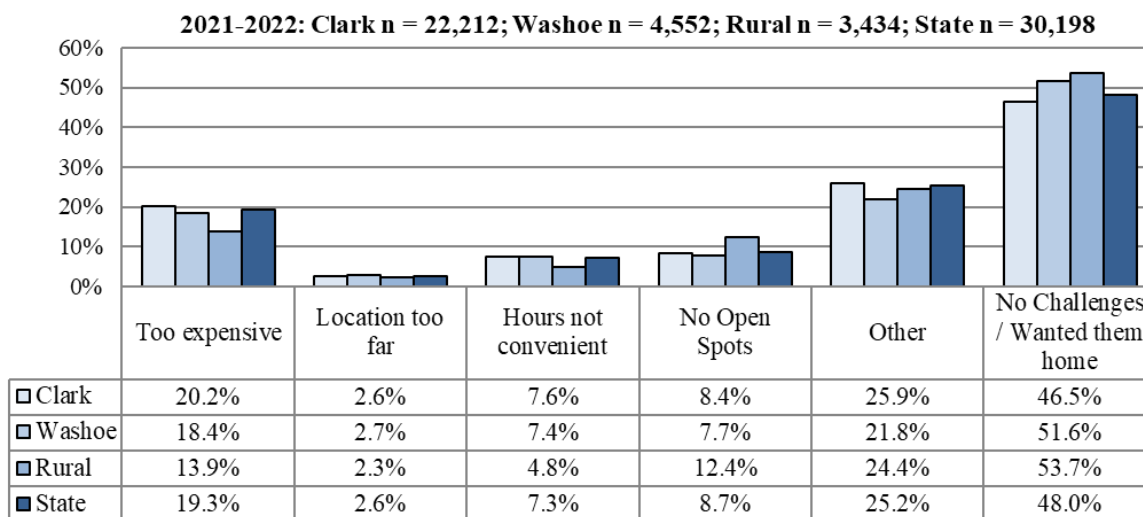
Note. n = 28,765

DEMOGRAPHICS

Barriers to Preschool Attendance

The KHS captures information about barriers that prevent preschool enrollment in order to identify effective strategies to increase access for families who wish to enroll children in preschool. When asked to select reasons why their child did not attend preschool or attend the preschool of their choice, the most common reason was cost (See Figure 2.7). In addition to the response options provided, respondents were able to write in other reasons why their child did not attend preschool or go to their preferred preschool. Among those who wrote in an “other” barrier, the most common barriers included COVID-19, not meeting the income requirement, lack of transportation, and difficulties related to online learning.

Figure 2.7 Reasons Why a Child Did Not Attend Preschool



Note. Respondents were able to select multiple categories

Parents/guardians were also asked whether they would place their child in full-time versus part-time preschool if given the option. More than half of parents/guardians (57.9%) indicated that they preferred full-time preschool and 41.2 percent indicated that they would prefer their child to attend preschool offered by the school district.

READING TO YOUNG CHILDREN

Reading to a child enhances cognitive development, language acquisition, and stimulates learning (Children’s Bureau, 2017). Variations in socioeconomic status are correlated with differences in language outcomes (Fernald et al., 2013). Children’s exposure to oral language is significantly lower in families with incomes below the federal poverty level (Fernald et al., 2013). This lack of exposure can result from multiple factors, including lack of books in schools and at home, poor motivation from parents to assist children in developing an interest in reading (Mohammed & Amponsah, 2018), parents using shorter sentences and fewer diverse words, and parents having lower reading comprehension (Neuman et al., 2018). Lack of exposure to oral language may result in delayed language and literacy development, and these delays are often notable once children enter kindergarten (Fernald et al., 2013). This disparity in early life puts a child behind just as they are starting school and is a predictor of later academic achievements and

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failures (Fernald et al., 2013). As a result of these important findings, the KHS captures information about how often children were read to in the home.

In 2021-2022, 25.1 percent of children were read to every day in the past week and 3.2 percent of children were not read to at all in the past week. When comparing KHS survey data with national and statewide data on reading, a larger percentage of our sample was read to four to six days of the week than the national and state averages and smaller percentages of our sample were read to zero days, one to three days, and every day as compared to both the national and state samples (See Table 2.3).

Table 2.3 Comparison of Reading Frequency per Week

	0 Days	One to Three Days	Four to Six Days	Every Day
Nationwide	7.5%	37.7%	18.2%	36.6%
Nevada	7.6%	45.1%	17.7%	29.5%
KHS Data	3.2%	33.6%	38.1%	25.1%

Source: Child and Adolescent Health Measurement Initiative. (2020). 2019-2020 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services. Health Resources and Services Administration (HRSA). Maternal and Child Health Bureau (MCHB). Retrieved from [www.childhealthdata.org].

Figures 2.8 and 2.9 depict the frequency of reading by race/ethnicity and household income and illustrate the following:

- A larger percentage of Caucasian children were read to daily (38.0%) as compared to children of other races/ethnicities.
- Hispanic and Native American/Alaska Native children trailed behind the most in terms of being read to daily.
- Among those with a household income of \$15,000 or more, the percentage of children read to daily increased with household income. Among households with an income less than \$15,000, a larger percentage of children were read to daily as compared to children in households making between \$15,000 and \$44,999.

When comparing results across counties (See Appendix A, Table 10.1):

- A larger percentage of children were read to daily in the past week in Washoe County (29.4%) as compared to Clark County (24.5%) and the Rural Counties (23.4%).
- A larger percentage of children were not read to in the past week in the Rural Counties (3.9%) as compared to Clark and Washoe County (both 3.2%).

DEMOGRAPHICS

Figure 2.8 Reading Frequency by Child's Race/Ethnicity

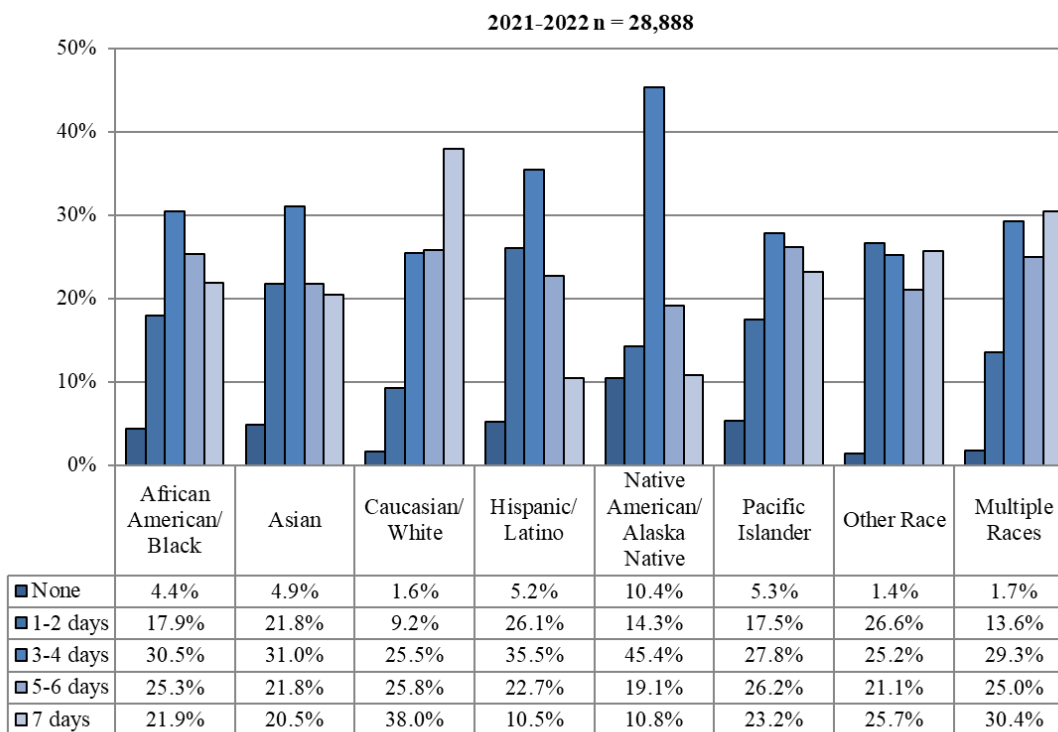
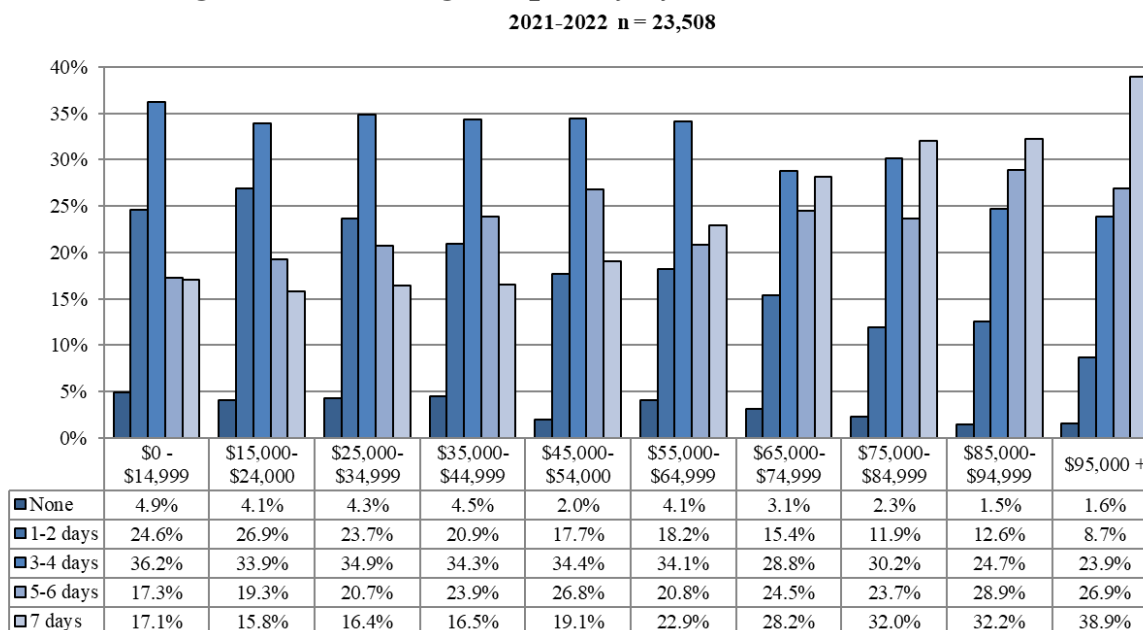


Figure 2.9 Reading Frequency by Household Income



3 INSURANCE STATUS

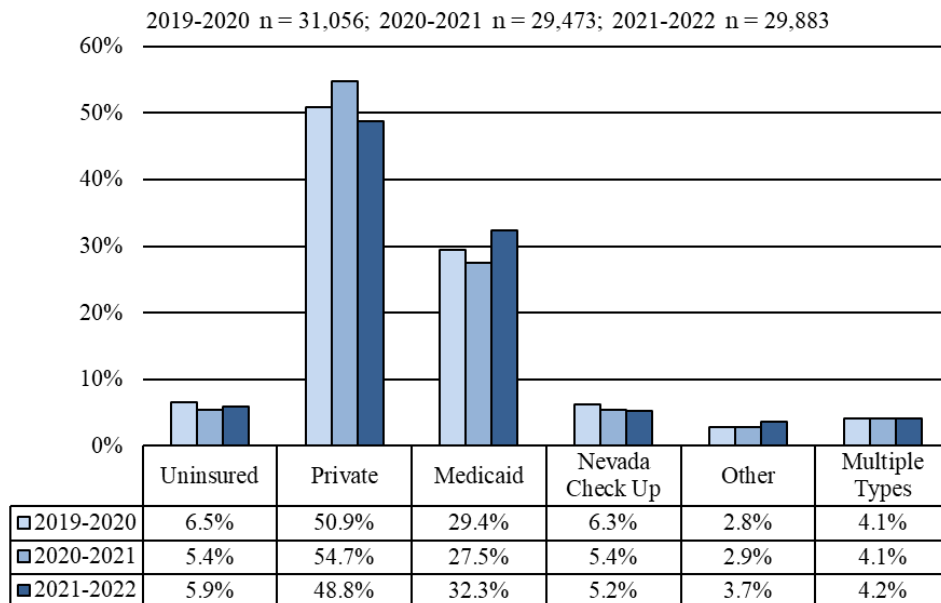
Nevada has consistently placed near the bottom of national rankings for the percent of children covered by health insurance. In the United States, 4.3 million children (5.6%) under the age of 19 are without health coverage (Bunch & Bandekar, 2021). Nevada was ranked 49th in the U.S. in 2021, with 8.6 percent of children reported as not having health insurance (Georgetown University Center for Children & Families [CCF]), 2022.

A correlation exists between children’s health insurance status and access to health care services. Research shows that uninsured children are less likely to have access to the care they need and are more likely to have poorer health outcomes as compared to insured children. For example, parents of uninsured children are more likely to report that their child has an unmet health need (Flores et al., 2017; Alker & Pham, 2018). Nevada was ranked 48th when compared nationally across five dimensions of health: health care access and affordability, prevention and treatment, avoidable hospital use and cost, equity, and healthy lives (Radley et al., 2019). Changes in health insurance status could be affected by COVID-19, as more than seven million people lost their employer-sponsored health insurance due to individual layoffs and layoffs of their dependents (Fronstin & Woodbury, 2020).

HEALTH INSURANCE STATUS OF KINDERGARTEN STUDENTS

In the current study, respondents were asked to specify their child’s current health insurance coverage (See Figure 3.1).

Figure 3.1 Child’s Health Insurance Status by School Year



INSURANCE STATUS

Overall, 94.2 percent of respondents reported that their child had some type of health insurance while 5.9 percent of respondents stated that their child had no coverage.

Of the health insurance options:

- Slightly less than half (48.8%) of the respondents indicated that their kindergartener had private health insurance.
- There were 37.5 percent of respondents that indicated that their kindergartener had public health insurance (either Medicaid or Nevada Check Up, the state's Children's Health Insurance Program (CHIP)).

A small percentage of individuals indicated that their child either had "other" insurance (3.7%) or multiple types of insurance (4.2%). When possible, "other" responses were re-coded into existing categories. For those that remained in the other category, some included Indian Health Service coverage, medical sharing or discount plans, or insurance providers listed as providing both private and public insurance, so it was not possible to determine their appropriate categorization.

CHIP enrollment increased 3.42 percent as of July 2021 compared to June 2020 (Center for Medicaid & CHIP Services [CMCS], 2020; CMCS, 2022). According to the American Academy of Pediatrics (AAP, 2021), approximately 38.3 million children in the U.S. (51%) were enrolled in CHIP or Medicaid in January 2021. It is important to ensure the children covered by public insurance have equal access to quality care, as insurance coverage does not always result in equal access to care (Story et al., 2014). Large disparities in access to care remain based on the type of health insurance (Bisgaier & Rhodes, 2011; Cossman et al., 2014). Children with public insurance are more likely to have reduced access to care compared to children with private insurance (Alexander, & Currie, 2017).

Increasing Access to Insurance through Nevada Health Link (Silver State Health Insurance Exchange)

Due to regulations of the Affordable Care Act (ACA), in October of 2013, Nevada began its health exchange program, the Silver State Exchange, better known as Nevada Health Link. The KHS survey captured respondents' participation in that program for their children and found:

- The percent of respondents that reported they or someone else had applied for insurance through the exchange for their child decreased this year (14.3%) as compared to last year (57.1%). However, this appears to be a "return to normal" following COVID-19 as the percent is similar to that reported in 2019-2022 (14.0%).
- Of the children for whom insurance was applied for through the exchange, 85.9 percent were approved (See Appendix A, Table 10.1).

INSURANCE STATUS

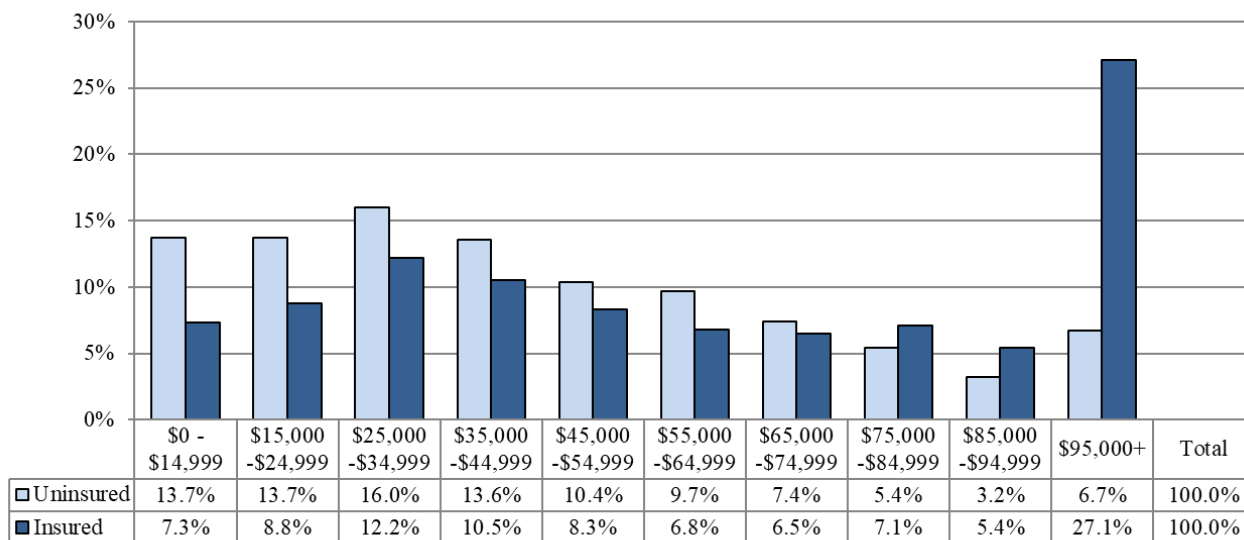
ANNUAL HOUSEHOLD INCOME AND INSURANCE STATUS

The ACA drastically increased the number of insured children, however gains made under ACA have been declining in recent years (Alker & Roygardner, 2019). The effect is most pronounced in low to middle income families (See Figure 3.2).

- 27.4 percent of children who are uninsured reside in households with an annual income of less than \$25,000.
- 67.4 percent of children who are uninsured live in a household with an annual income of less than \$55,000.

Figure 3.2 Child's Insurance Status by Annual Household Income

2021-2022: Uninsured n = 1,398; Insured n = 22,664; Total n = 24,062



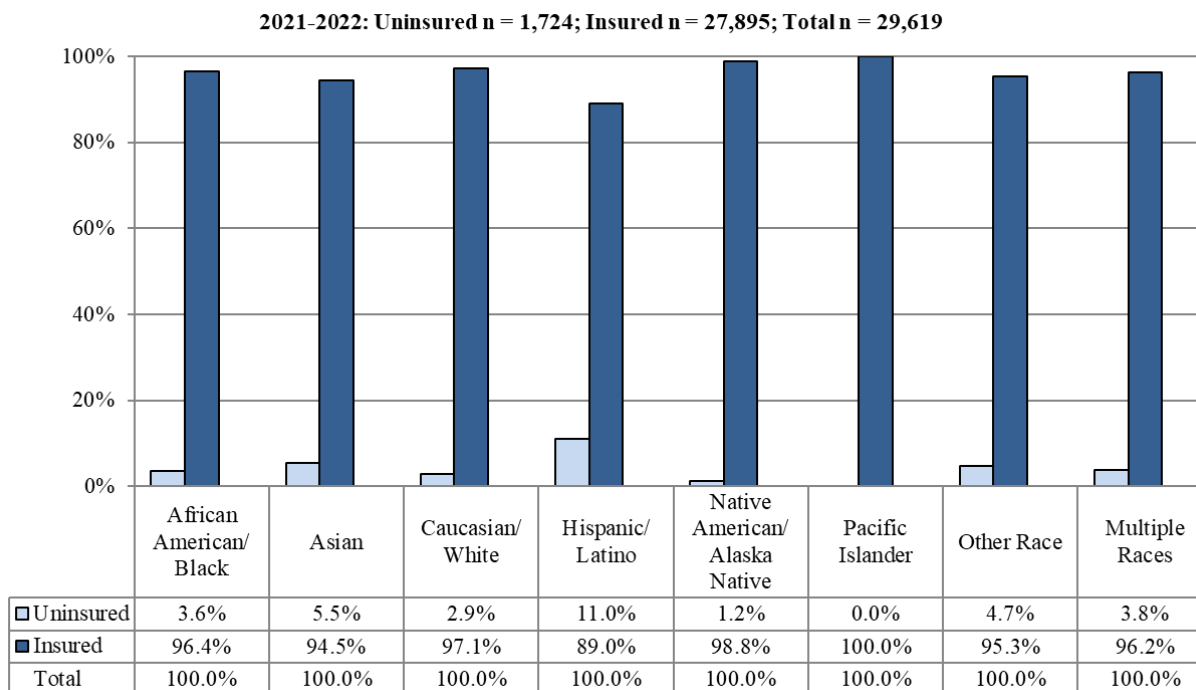
Race/Ethnicity and Insurance Status

Figure 3.3 illustrates the relationship between race/ethnicity and insurance status.

- The largest percentage of children without insurance were those identified as Hispanic (11.0%), which far surpassed the next largest percentages which include children identified as Asian (5.5%) and “Other Race” (4.7%).

INSURANCE STATUS

Figure 3.3 Child's Insurance Status by Child's Race/Ethnicity



Research suggests that in Nevada and across the United States, Hispanic populations are much more likely to be uninsured than Caucasian populations (Kaiser Family Foundation, 2019). Approximately 18.3 percent of Hispanic individuals of all ages across the country are uninsured and 9.5 percent of Hispanic children are uninsured (Keisler-Starkey & Bunch, 2021). States with a high proportion of non-US born Hispanic residents, such as Nevada, are expected to experience an increase in this rate. Although many of these children are eligible for public health insurance, enrollment is likely not growing due to fewer enrollment outreach efforts, elimination of the penalties for not having health coverage, language and literacy challenges, and persistent fears surrounding public charge policy (Artiga et al., 2020).

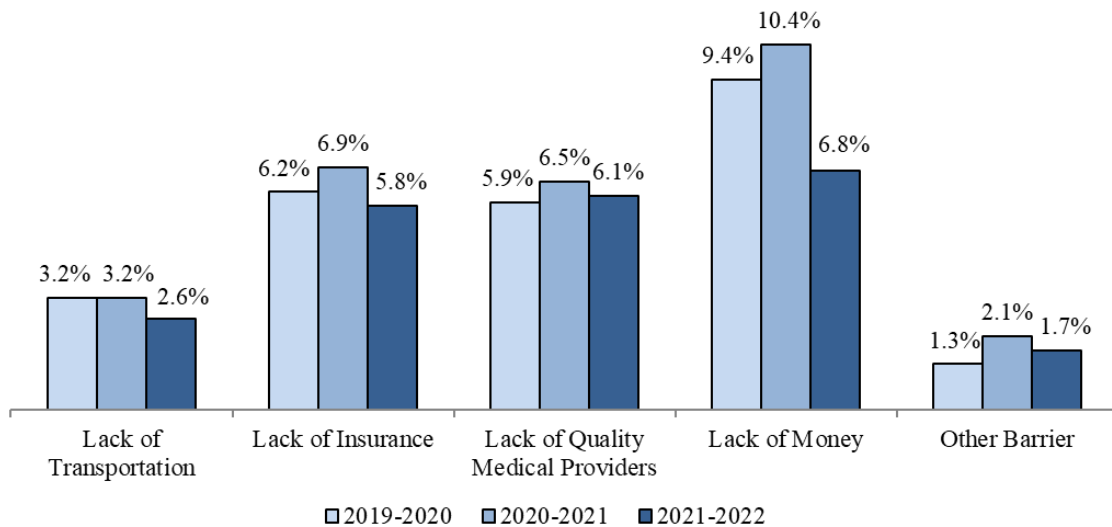
4 ACCESS TO HEALTH CARE

BARRIERS TO ACCESSING HEALTH CARE

When asked about accessing health care for their child, **17.3 percent of respondents reported experiencing at least one barrier**. Of the barriers presented to respondents (See Figure 4.1), the most commonly selected was “lack of money.”

Figure 4.1 Types of Barriers When Accessing Health Care for Child

2019-2020 n = 30,282; 2020-2021 n = 29,800; 2021-2022 n = 29,160



Note. Respondents were able to select multiple categories, therefore, the total percent within each year might exceed 100.

Of all respondents experiencing one or more barriers to accessing health care:

- 80.6 percent reported having health insurance (31.7% Private, 35.6% Medicaid, 4.9% Nevada Check-Up, and 8.4% Other/Multiple)
- 64.4 percent reported an annual household income of less than \$55,000.

The two most common “other” barriers provided by respondents, accounting for 65.1 percent of all of the “other” responses, included trouble getting an appointment and insurance specific barriers.

KNOWLEDGE REGARDING ACCESSING SUPPORT SERVICES

A question was added to the 2013-2014 survey to determine if parents/guardians know how to access support services and programs to meet their family’s needs. This survey question included the examples of food/bills, parent classes, and support groups.

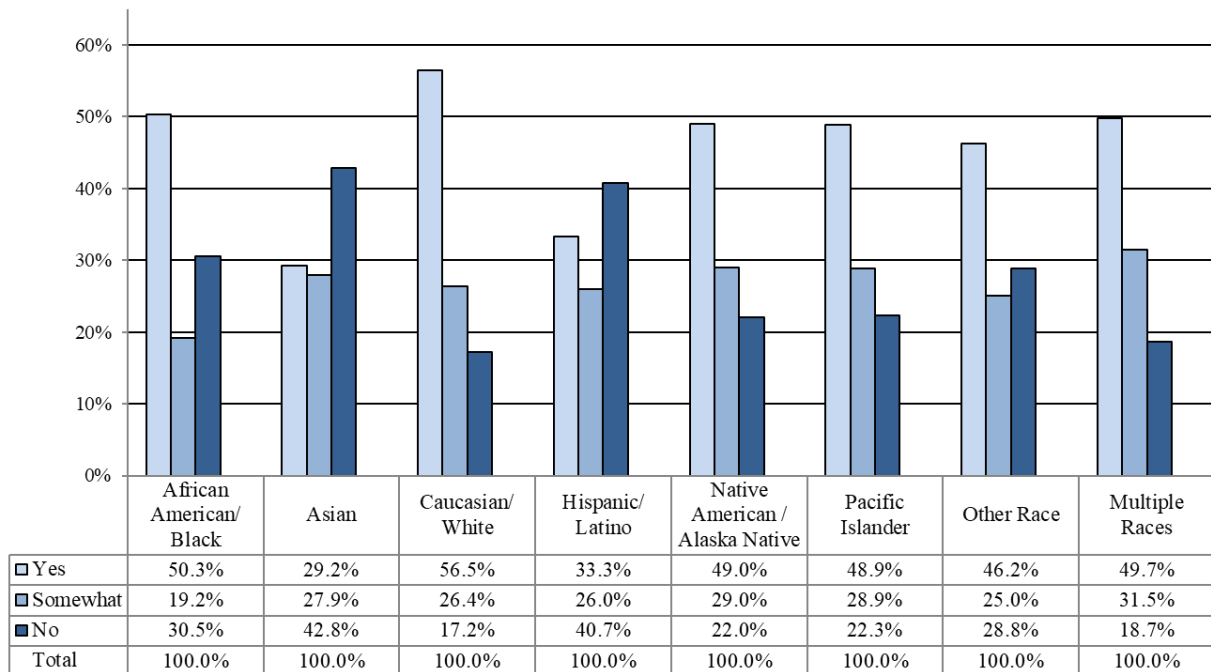
ACCESS TO HEALTH CARE

Overall, 28.1 percent of respondents reported that they did not know how to access support services and 26.7 percent were somewhat aware of how to access support services. Respondents in Clark County (42.9%) were less likely to know how to access services than those in the Rural Counties (48.7%) and Washoe County (54.2%).

When exploring knowledge regarding accessing support services and race/ethnicity, results indicate that parents/guardians of children identified as Asian or Hispanic have less knowledge about accessing support services than the other groups.

Figure 4.2 Knowledge of Access to Support Services by Child's Race/Ethnicity

2021-2022: African American/Black n = 2,142; Asian n = 1,582; Caucasian/White n = 9,307;
 Hispanic/Latino n = 9,255; Native American/Alaska Native n = 241; Other n = 212;
 Pacific Islander n = 305; Multiple n = 6,266



5 ROUTINE CARE

Access to routine medical care services is a major factor contributing to a child's health status. Routine care includes basic health care services such as immunizations, vision screenings, and well-child visits. Nevada ranked 49th in the U.S. in 2021 for the proportion of children without health insurance, with 8.6% of children lacking coverage (CCF, 2022). Children without health insurance are more likely to forego routine care than insured children. The 2019-2020 National Survey of Children's Health found that 85.4 percent of children that do not have a medical home are uninsured, compared to 57 percent that have private health insurance and 69 percent that have Medicaid. In addition, 64.5 percent of children that do not have someone the parent thinks of as their personal doctor or nurse were uninsured compared to 34.8 percent of those that were insured (Child and Adolescent Health Measurement Initiative, 2020).

Having access to regular primary care services or a medical home is a key indicator of children's overall health status. Studies have shown that having access to usual care has been associated with better health and reduced health disparities, and that children without a regular source of care are nine times more likely to be hospitalized for a preventable problem (Cecil et al., 2016; Huntley et al., 2014; Pourat et al., 2015; Witt et al., 2017). Primary care providers (e.g., physicians, physician's assistants, nurses) offer a medical home where children can receive basic care services including annual check-ups and immunizations. Children who see the same pediatrician regularly have better health status as compared to those who do not have access. Having a pediatrician increases successful screenings during check-ups and decreases emergency room visits (Snyder, 2020).

ROUTINE CARE FOR KINDERGARTEN STUDENTS

Current survey results show that 88.4 percent of kindergarteners had at least one routine medical check-up in the twelve months preceding the survey. Similarly, 90.6 percent of parents/guardians reported that their child had a primary care provider (See, Figure 5.1).

Compared to 2020-2021 data:

- A slightly smaller percentage of children have a primary care provider this year (90.6%) as compared to last year (92.0%) (See Appendix A, Table 10.1).
- A slightly larger percentage of children had a routine check-up this year (88.4%) as compared to last year (86.8%) (See Appendix A, Table 10.1).

Health insurance can be a factor in accessing care. In the current sample, 93.4 percent of children with health insurance have a primary care provider while 45.4 percent of children without insurance have a primary care provider (See Figure 5.2).

ROUTINE CARE

Having a primary care provider is related to whether a child has had a routine check-up in the past twelve months (See Figure 5.3). In the current sample,

- Of the children that had a routine check-up, 5.8 percent did not have a primary care provider.
- Of the children that had not had a routine check-up in the last year, 36.3 percent did not have a primary care provider.

Figure 5.1 Child's Routine Check-Up and Presence of Primary Care Provider

2021-2022: Check-Up n = 29,463; Primary Care Provider n = 29,409

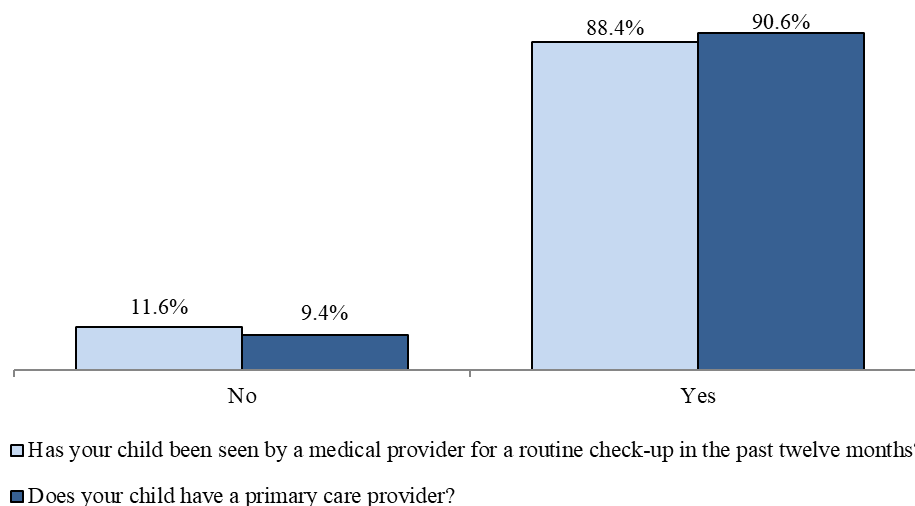
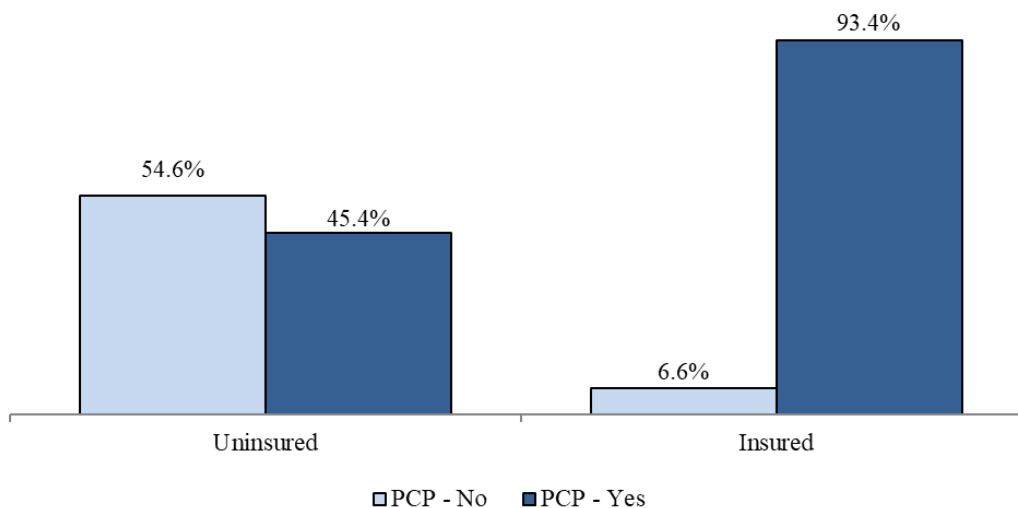


Figure 5.2 Presence of Primary Care Provider by Child's Insurance Status

2021-2022: Uninsured n = 1,644; Insured n = 27,575; Total n = 29,219

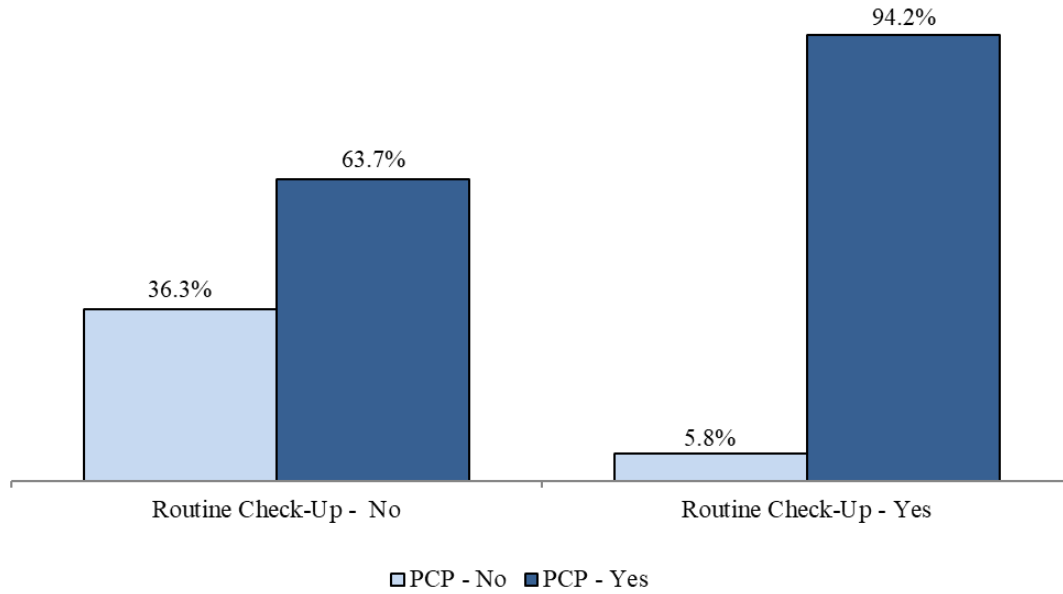


Note. PCP – Primary Care Provider; Percentages are calculated out of the number within each PCP category.

ROUTINE CARE

Figure 5.3 Child's Routine Check-Up by Presence of Primary Care Provider

2021-2022: No PCP n = 2,690; Has PCP n = 26,297; Total n = 28,987



Note. PCP – Primary Care Provider; Percentages are calculated out of the number within each PCP category.

6 MEDICAL CONDITIONS

Approximately 15% of Nevada’s children have special health care needs (Child and Adolescent Health Measurement Initiative, 2020). Treatment for these children may be expensive and can require a team of medical care providers, led by a primary care physician, devoted to the treatment and maintenance of their conditions. Thus, quality health insurance coverage is vital for children with special health care needs, as it improves their chances of having ongoing care and treatment.

TYPES OF MEDICAL CONDITIONS

According to the 2019-2020 National Survey of Children’s Health (2020) in Nevada, 15.4 percent of children aged zero to 17 have special health care needs and only 10.3 percent receive care in a well-functioning system. The criteria for children to be designated as having a special health care need includes both the child’s experiences and consequences due to a medical, behavioral, or other health condition, and the fact that the condition has persisted for 12 months or longer. Unfortunately, only 62.4 percent of Nevada’s children with special health care needs, aged zero to 17, had adequate and continuous insurance in the past year (Child and Adolescent Health Measurement Initiative, 2020).

According to this year’s survey results, **31.8 percent of respondents reported that their child had a medical condition** (See Figure 6.1).

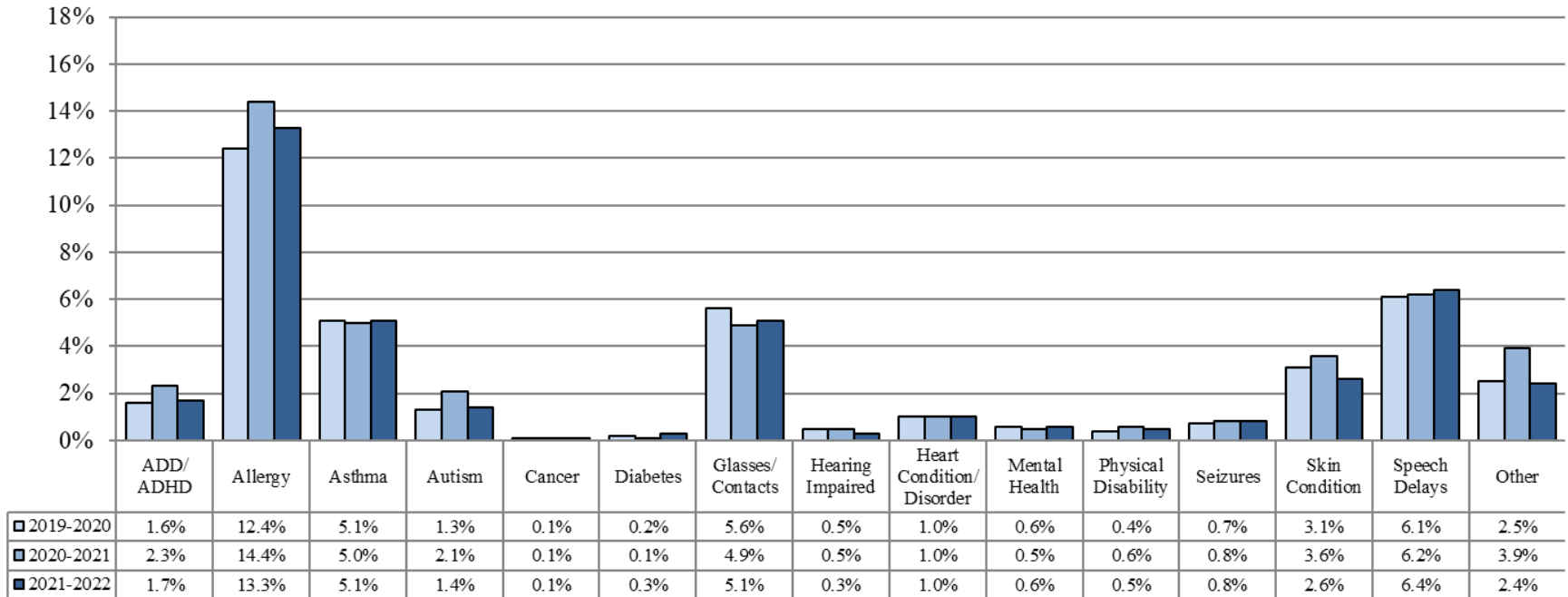
- The most common medical condition reported was allergies (13.3%), followed by speech delays (6.4%), asthma (5.1%), and glasses/contacts (5.1%).

Of the respondents that reported their child had a medical condition, 2.4 percent indicated that their child had an “other” health condition not listed on the survey. The most common conditions, accounting for 45.2 percent of the “other” conditions, included genetic conditions, urinary tract issues, lung/breathing issues, blood disorders, brain conditions, thyroid issues, and sensory disorder.

MEDICAL CONDITIONS

Figure 6.1 Types of Medical Conditions in Children

2019-2020 n = 28,095; 2020-2021 n = 28,522; 2021-2022 n = 26,775



Note. Respondents may select multiple categories; therefore, the total percent within each year may exceed 100%.

MEDICAL CONDITIONS

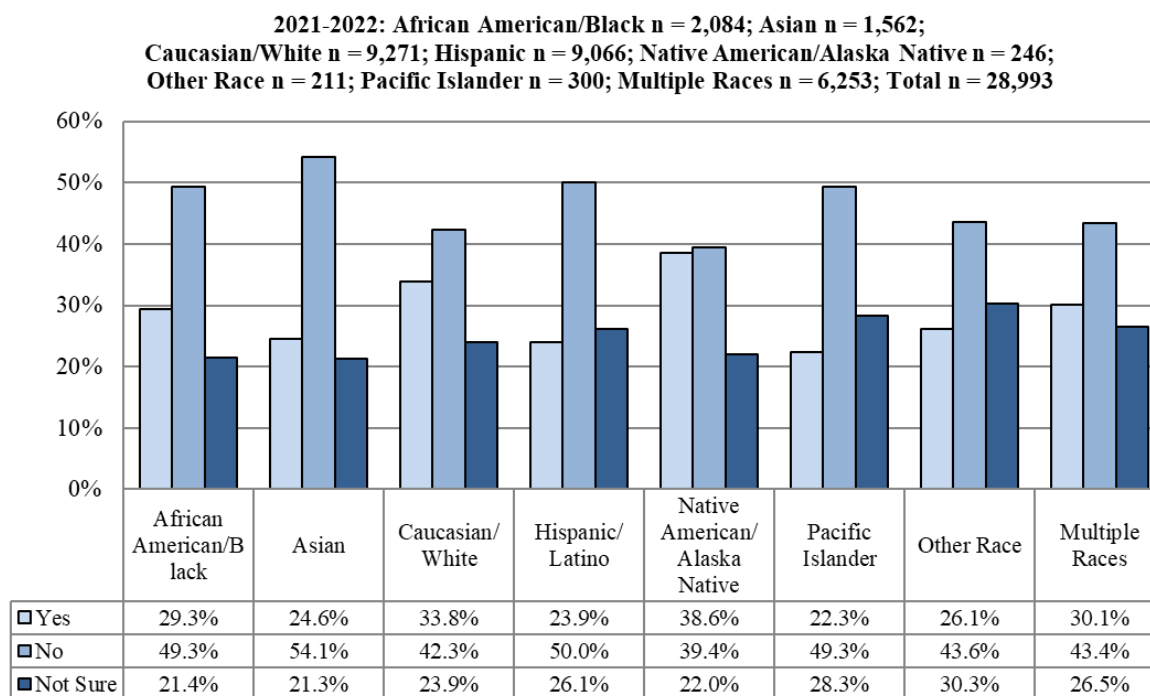
DEVELOPMENTAL SCREENING

Developmental screening is a method used by childcare providers (e.g., mental health providers, pediatricians, and childcare professionals) to assess whether a young child has delayed mental or physical development. Early identification of developmental delay coupled with the initiation of intervention programs may contribute to greater academic and social success throughout a child’s life (Sawhill & Karpilow, 2015; Vitrikas et al., 2017). Many children with developmental disabilities are not identified until they have entered kindergarten or later, causing the child to miss out on crucial years of intervention (CDC, 2020b). Therefore, a question on the current survey asked respondents whether or not their child had received a developmental screening in the twelve months prior to the survey.

Of all respondents who answered this question, 46.1 percent reported that their child did not have a developmental screening and 24.9 percent reported that they were unsure if their child had a screening. When exploring differences among counties, more respondents in Washoe County (32.0%) reported that their child had a developmental screening as compared to the Rural Counties (30.1%) and Clark County (28.2%) (See Appendix A, Table 10.1).

When exploring race/ethnicity differences in screening (See Figure 6.2), results indicate that the largest percentage of children that received a developmental screening were Native American/Alaska Native and the smallest percentage of children that received a screening were Pacific Islander.

Figure 6.2 Developmental Screening by Child's Race/Ethnicity



7 DENTAL CARE

Routine dental care is also important to a child’s health and daily functioning. Children without access to regular dental care are more likely to experience dental problems such as dental cavities and tooth abscesses. Poor oral health is consistently related to worse academic performance regardless of factors such as age, sex, household income, and type of health insurance (Guarnizo-Herreño et al., 2019; Ruff et al., 2018). Children with oral health problems are more likely to miss more than three or six school days compared to children without oral health problems (Guarnizo-Herreño et al., 2019).

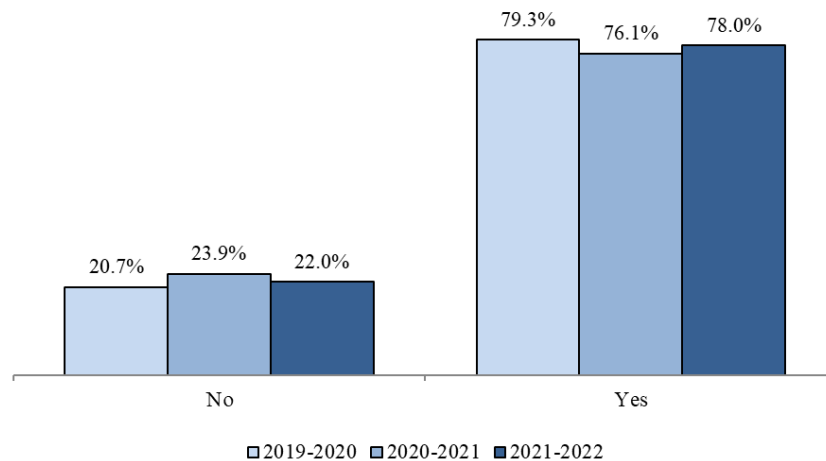
Research indicates that uninsured children are much more likely to have unmet dental needs (e.g., teeth cleanings) and to have had fewer dental visits compared to children who are insured. Further, children who are privately insured have fewer unmet dental needs and more dental visits on average than children who are publicly insured (Zhou et al., 2017). Duffy and colleagues (2018) found that uninsured children were at an increased risk for untreated dental carries (22%) compared to children with private insurance (8.9%). Additionally, 41.7 percent of children that did not receive any type of dental care in a 12-month period were uninsured, while 17.8 percent were insured (Child and Adolescent Health Measurement Initiative, 2020).

DENTAL CARE OF CHILDREN ENTERING KINDERGARTEN

According to Stanford Medicine Children’s Health (2022), a child’s first dental visit should be at 12 months of age or six months after the first tooth comes in. In the current study, 22.0 percent of survey respondents indicated that their kindergartener had not seen a dentist in the past twelve months, which is a slight decrease from last year (23.9%) (See Figure 7.1).

Figure 7.1 Child's Dental Visit

2019-2020 n = 29,542; 2020-2021 n = 27907; 2021-2022 n = 28,108



8 MENTAL HEALTH

Many of Nevada's children have mental health conditions that require specialized treatment. It is important that these children have regular access to mental health services. This is particularly true for young children entering the elementary school system. Nationally, 7.7 million children and teens have at least one treatable mental health disorder, yet only half of these children receive treatment from a mental health care professional. State-level practices and policies may play a role as to why children do not receive needed treatment (Whitney & Peterson, 2019). In Nevada, 21 percent of children aged three to seventeen years have at least one mental health condition and only 40.2 percent of these children have received counseling or treatment (Child and Adolescent Health Measurement Initiative, 2020). Without access to mental health care providers to manage and treat their conditions, children with mental health conditions are more likely to experience learning difficulties and developmental delays (Baker et al., 2010; Scott et al., 2016).

Learning difficulties and developmental delays will likely have been further exacerbated by COVID-19, as children faced new challenges with virtual instruction in their familial environment. Families might have experienced increased stress due to job loss, placing themselves and their families at risk as an essential worker, food insecurity and/or housing insecurity, and struggling to find childcare, all factors that can affect the overall well-being of children (American Psychological Association, 2020). It was reported that 65 percent of parents with children aged 5-7 felt that the pandemic made the 2019-2020 school year extremely stressful, and parents reported higher levels of stress related to the pandemic than non-parents (American Psychological Association, 2020). Children were physically isolated from their peers and might not have fully understood the reasoning behind the social restrictions and safety precautions in place, further exacerbating their stress (Nevada Division of Child and Family Services [DCFS], 2020). In addition, children might have experienced grief from losing loved ones or family members more often due to COVID-19 (DCFS, 2020).

The survey results indicate that **7.3 percent of respondents have tried to access mental health services for their children**, which is a slight decrease from 2020-2021 data (8.1%).

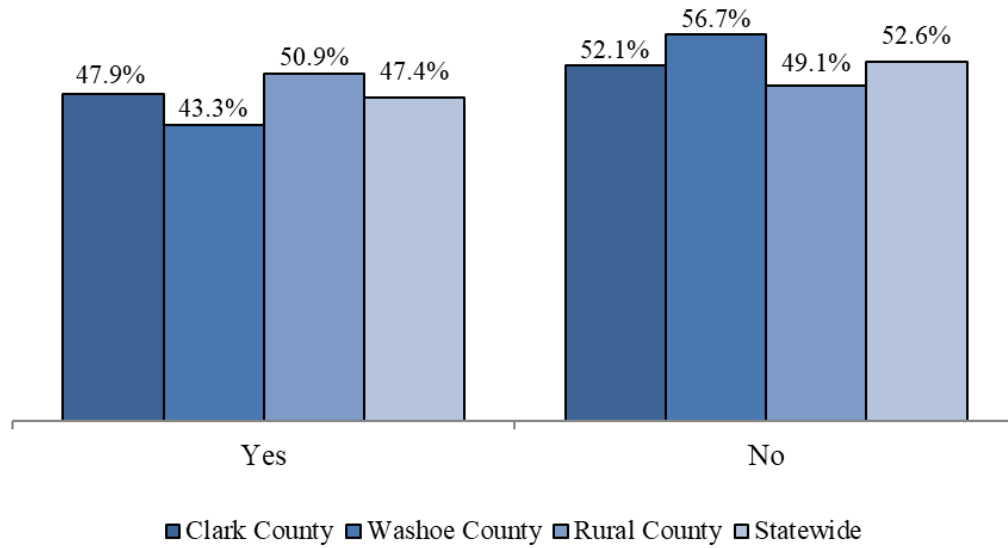
Of the 7.3 percent that attempted to access services, 47.4 percent reported having trouble obtaining the services, a slight increase from the previous survey year (44.1%).

- When examining this percentage across counties, those in Rural Counties reported more trouble obtaining services (50.9%) than those in Clark (47.9%) or Washoe County (43.3%) (See Figure 8.1).
- The most common barriers provided by respondents regarding accessing mental health services, from most to least common, included: lack of providers, insurance specific barriers, and long wait times.

MENTAL HEALTH

Figure 8.1 Trouble Obtaining Mental Health Services by County

Clark n = 1,388; Washoe n = 374; Rural n = 222; Statewide n = 1,984



Note. Percent only for those who tried to access services

9 WEIGHT AND HEALTHY BEHAVIORS

In the past three decades, the prevalence of childhood obesity in the U.S. has more than doubled in children and tripled in adolescents (Sanyaolu et al., 2019). Research suggests a significant link between high Body Mass Index (BMI) values and type 2 diabetes (Ganz et al., 2014; Abbasi et al., 2017). Therefore, monitoring children’s weight has become an important tool for analyzing potential health problems.

In our survey design, parents/guardians are asked to write-in their child’s height and weight information so that a BMI value can be calculated for each child with valid height and weight responses. BMI values were calculated using the standard formula employed by the CDC and other health agencies:

$$BMI = [(Weight\ in\ pounds) / (Height\ in\ inches)^2] * 703$$

However, to increase the validity of the data, several strict guidelines were implemented for the calculation of BMI. First, if the respondent reported that the child was under the age of four or over the age of six, they were excluded from the analyses, as it is unlikely that kindergarteners would be outside of this age range. Age is an important factor because it is used to determine weight status category and is strongly correlated with height. Second, if a child’s reported height was outside of the 95th percentile for the average height of four to six-year-olds (CDC, 2000), the child was excluded from the analysis. Finally, if a child’s weight was reported to be under 20 pounds, the child was excluded from the analysis. The inclusion criteria resulted in 12,821 (42.5 percent of the entire sample) kindergarteners with a valid BMI value.

Once BMI was calculated, each child in the sample was assigned a weight status category based on CDC standards, which uses a child’s age, gender, and BMI percentile. Table 9.1 outlines the BMI percentile ranges for each weight status category.

Table 9.1 Weight Status Categories by BMI Percentile Ranges

Weight Status Category	BMI Percentile Range
Underweight	BMI less than the 5 th percentile
Healthy Weight	BMI from the 5 th percentile to less than the 85 th percentile
Overweight	BMI from the 85 th percentile to less than the 95 th percentile
Obese	BMI equal to or greater than the 95 th percentile

Source: Centers for Disease Control and Prevention. (2022a). *About child & teen BMI*. Retrieved from https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

WEIGHT AND HEALTHY BEHAVIORS

For the purpose of this study, NICRP used ten different weight status formulas: one formula for females and one for males for each of the following ages: 4.0, 4.5, 5.0, 5.5, and 6.0. Table 9.2 outlines the calculations used to determine the weight status categories.

Table 9.2 Weight Status Category Calculations Based on BMI Values

Females				
Age	Weight Status Category			
	Underweight	Healthy Weight	Overweight	Obese
4.0	0 < BMI < 13.725	13.725 <= BMI < 16.808	16.808 <= BMI < 18.028	BMI >= 18.028
4.5	0 < BMI < 13.614	13.614 <= BMI < 16.760	16.760 <= BMI < 18.084	BMI >= 18.084
5.0	0 < BMI < 13.527	13.527 <= BMI < 16.796	16.796 <= BMI < 18.240	BMI >= 18.240
5.5	0 < BMI < 13.465	13.465 <= BMI < 16.906	16.906 <= BMI < 18.486	BMI >= 18.486
6.0	0 < BMI < 13.428	13.428 <= BMI < 17.083	17.083 <= BMI < 18.808	BMI >= 18.808
Males				
Age	Weight Status Category			
	Underweight	Healthy Weight	Overweight	Obese
4.0	0 < BMI < 14.043	14.043 <= BMI < 16.935	16.935 <= BMI < 17.842	BMI >= 17.842
4.5	0 < BMI < 13.932	13.932 <= BMI < 16.852	16.852 <= BMI < 17.829	BMI >= 17.829
5.0	0 < BMI < 13.845	13.845 <= BMI < 16.839	16.839 <= BMI < 17.927	BMI >= 17.927
5.5	0 < BMI < 13.781	13.781 <= BMI < 16.891	16.891 <= BMI < 18.118	BMI >= 18.118
6.0	0 < BMI < 13.739	13.739 <= BMI < 17.003	17.003 <= BMI < 18.389	BMI >= 18.389

Source: Centers for Disease Control and Prevention (2001). Data Table of BMI-for-age Charts.

Retrieved from http://www.cdc.gov/growthcharts/html_charts/bmiagerev.htm

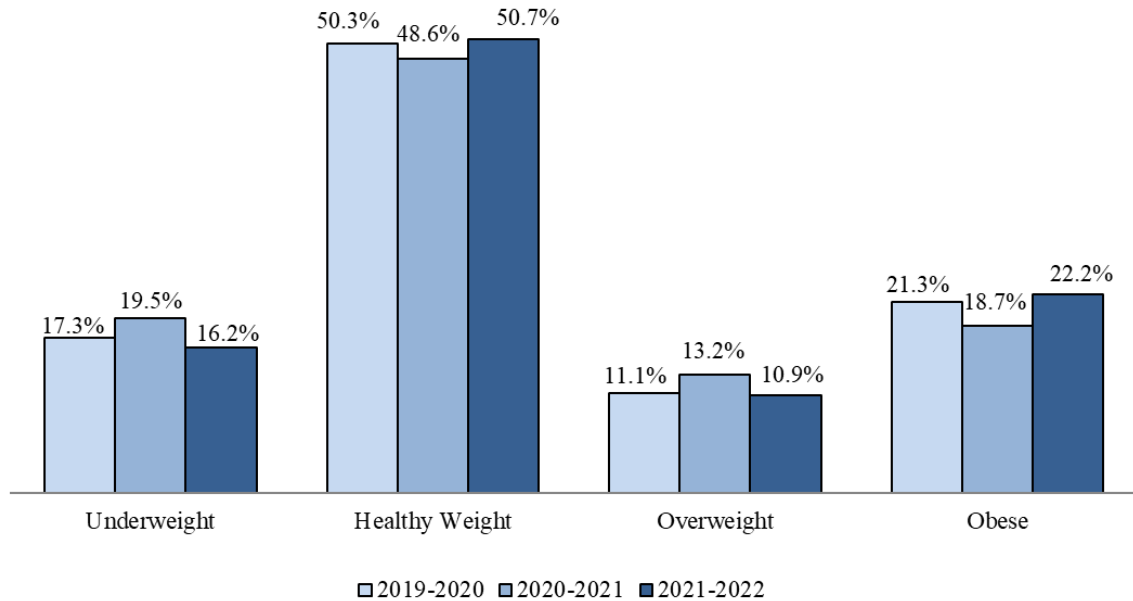
Based on the calculated BMI for this year's sample, slightly more than half (50.7%) of the children were categorized as being a healthy weight which is a slight increase from last year (48.6%) (See Figure 9.1). However,

- **16.2 percent of children were underweight**
 - The Rural Counties had a smaller percentage of children that were underweight (11.4%) as compared to Clark County (16.5%) and Washoe County (18.2%) (See Appendix A, Table 10.1).
- **10.9 percent of children were overweight**
 - The Rural Counties had a smaller percentage of children that were overweight (9.0%) as compared to Clark County (10.8%) and Washoe County (12.5%) (See Appendix A, Table 10.1).
- **22.2 percent of children were obese**
 - The Rural Counties had a larger percentage of children that were obese (24.2%) as compared to Clark County (21.7%) and Washoe County (23.0%) (See Appendix A, Table 10.1).

The percentage of children that were overweight and underweight decreased this year as compared to last year, while the percentage of children at a healthy weight and children that were obese increased.

Figure 9.1 Child's Weight Status Category

2019-2020 n = 13,550; 2020-2021 n = 13,342; 2021-2022 n = 12,821

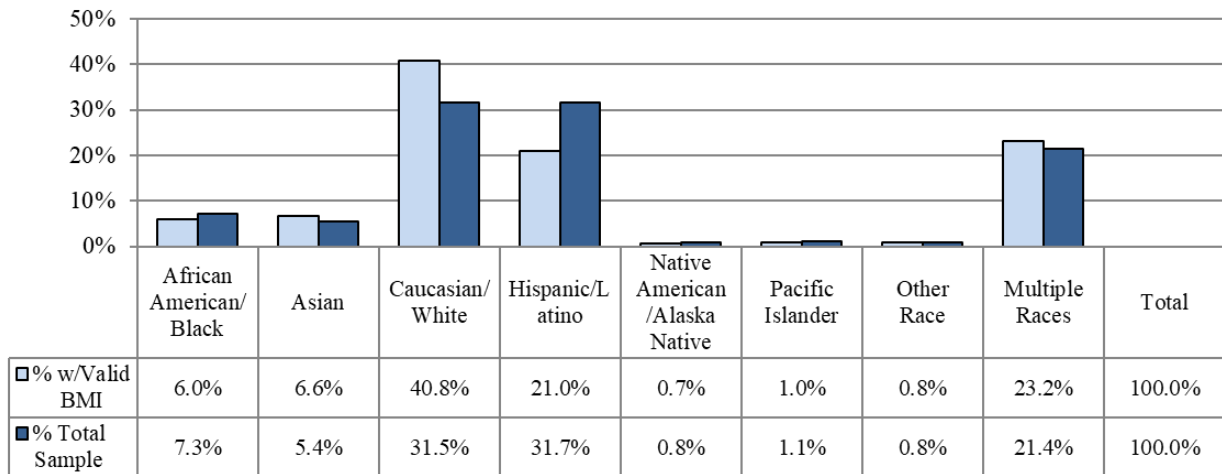


When comparing each child’s race/ethnicity with their BMI, there are some differences in distributions across weight status categories for each race/ethnic group. It is important to note that the total number of respondents included in this race/ethnicity analysis is less than those in the above statistics on valid BMIs within the sample because some respondents did not provide information on race/ethnicity.

The distribution of race/ethnicity for children with valid BMIs varies slightly from the racial/ethnic demographics of the survey sample as a whole, with the greatest discrepancy being the percentage of Hispanic children with valid BMI data. Though respondents who reported their child as Hispanic comprised 31.7 percent of the total sample, Hispanic children comprised only 21.0 percent of those with a valid BMI. Figure 9.2 illustrates the race/ethnicity data for children with a valid BMI.

Figure 9.2 Race/Ethnicity of Participants with a Valid Body Mass Index

2021-2022 n = 12,813

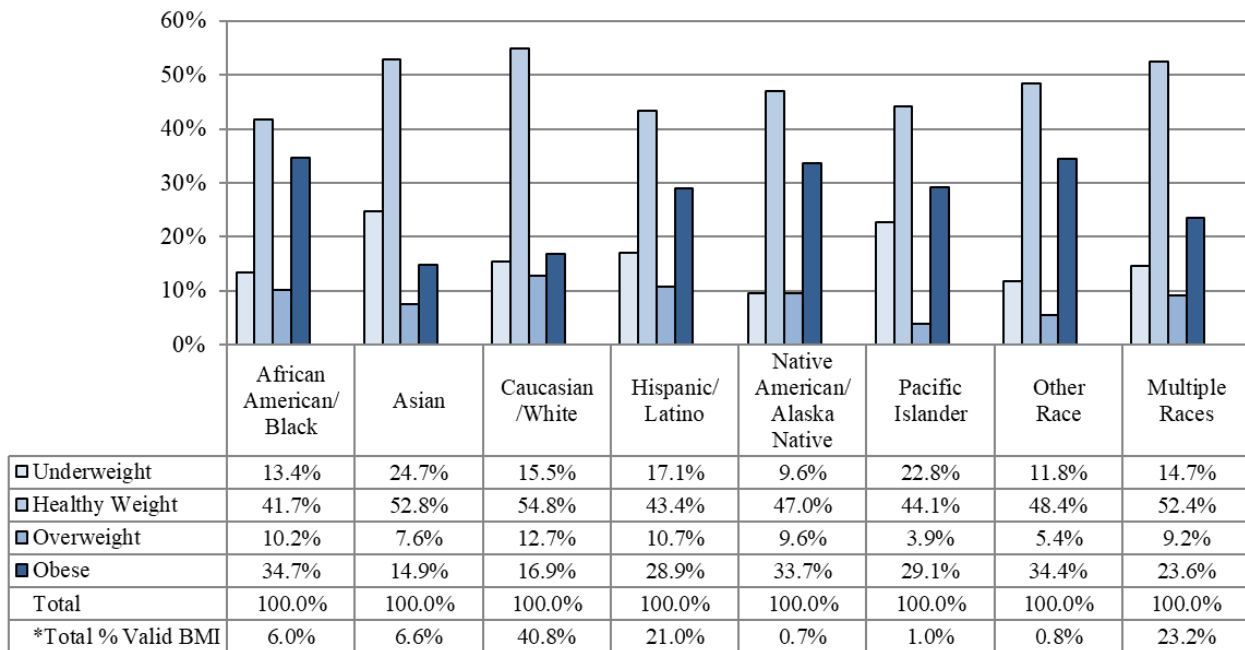


As seen in Figure 9.3, the differences in BMI across racial/ethnic groups indicate the following:

- The largest percentage of children that were obese were African American/Black children (34.7%), followed by children that were identified as being an “Other Race” (34.4%), and Native American/Alaska Native children (33.7%).
- The largest percentage of children that were underweight were Asian (24.7%) and the smallest percentage of children that were obese were also Asian (14.9%).
- The largest percentage of children that were at a healthy weight (54.8%) and that were overweight were Caucasian (12.7%).

Figure 9.3 Child's Weight Status Category by Child's Race/Ethnicity

2021-2022 n = 12,761



Note. *Indicates percentages are calculated out of the total number of Valid BMI responses in each race/ethnicity category.

BEHAVIORS RELATED TO HEALTHY WEIGHT IN YOUNG CHILDREN

Explanations for obesity in young children are related to several behavioral factors, including level of physical activity, television viewing, time spent playing video games, and diet. According to the CDC, physical inactivity can lead to energy imbalance, increase risks of cardiovascular diseases, increase the risk of developing type 2 diabetes, lead to low bone density, and increase the risk of multiple types of cancers. Approximately 24% of children 6-17 years old are participating in at least 60 minutes of physical activity everyday (CDC, 2020c). Therefore, the KHS assessed the frequencies of the following behaviors among children entering kindergarten: physical activity, TV viewing time, video game usage, and the consumption of juice, non-diet, and diet soda.

Physical Activity

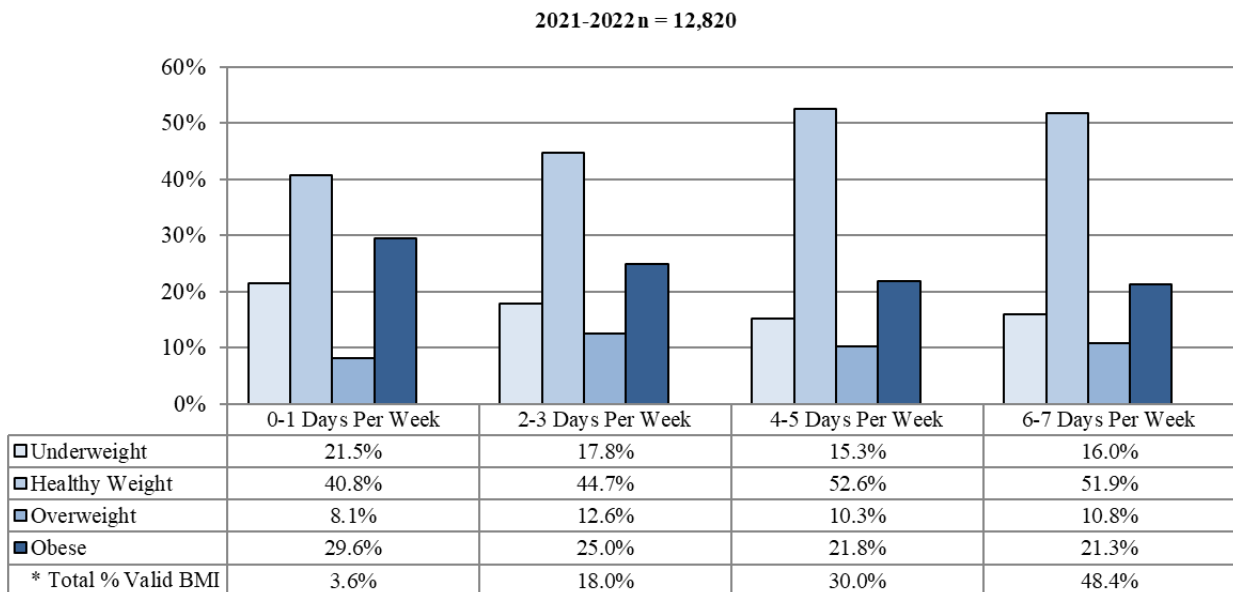
Parents/guardians were asked to report the number of days per week their child is physically active for at least 60 minutes. For those that responded, **almost half (48.4%) indicated that their child was physically active six to seven days a week for at least sixty minutes and 3.6 percent indicated that their child was not active during the week.**

WEIGHT AND HEALTHY BEHAVIORS

Figure 9.4 illustrates the relationship between weight status category and amount of physical activity.

- A very small percentage of children with a valid BMI were reported to engage in physical activity zero to one day a week (3.6%) and 18.0 percent reported activity two to three days per week.
- Overall, as days of physical activity per week increased, kindergarteners were less likely to be in the obese weight category.
- Children that were physically active less often (zero to three days per week) were more likely to be obese, as compared to children that were physically active throughout the week (four to seven days per week).

Figure 9.4 Child's Weight Status Category by Amount of Physical Activity per Week



Note. *Indicates percentages are calculated out of the total number of valid BMI responses in each category.

To gain a better understanding of the barriers that parents/guardians face regarding providing physical activities for their children, after indicating how many days a week their child was active, they were asked to indicate barriers to being more physically active. The most common barriers, accounting for 88.0 percent of the responses, included: the weather, lack of time and/or a busy work schedule, poor air quality, COVID-19, asthma or the child's health, and lack of outdoor space, a yard, or parks nearby. Please note the response categories were not mutually exclusive; respondents were allowed to list multiple barriers.

Television Viewing and Use of Electronic Devices

In the current study, more than half of respondents (57.1%) reported that their child spends two to three hours in front of a TV or electronic device watching TV, videos, or playing video games on an average weekday. On the weekend, more than half of children (53.7%) spend two to three hours in front of a TV or electronic device.

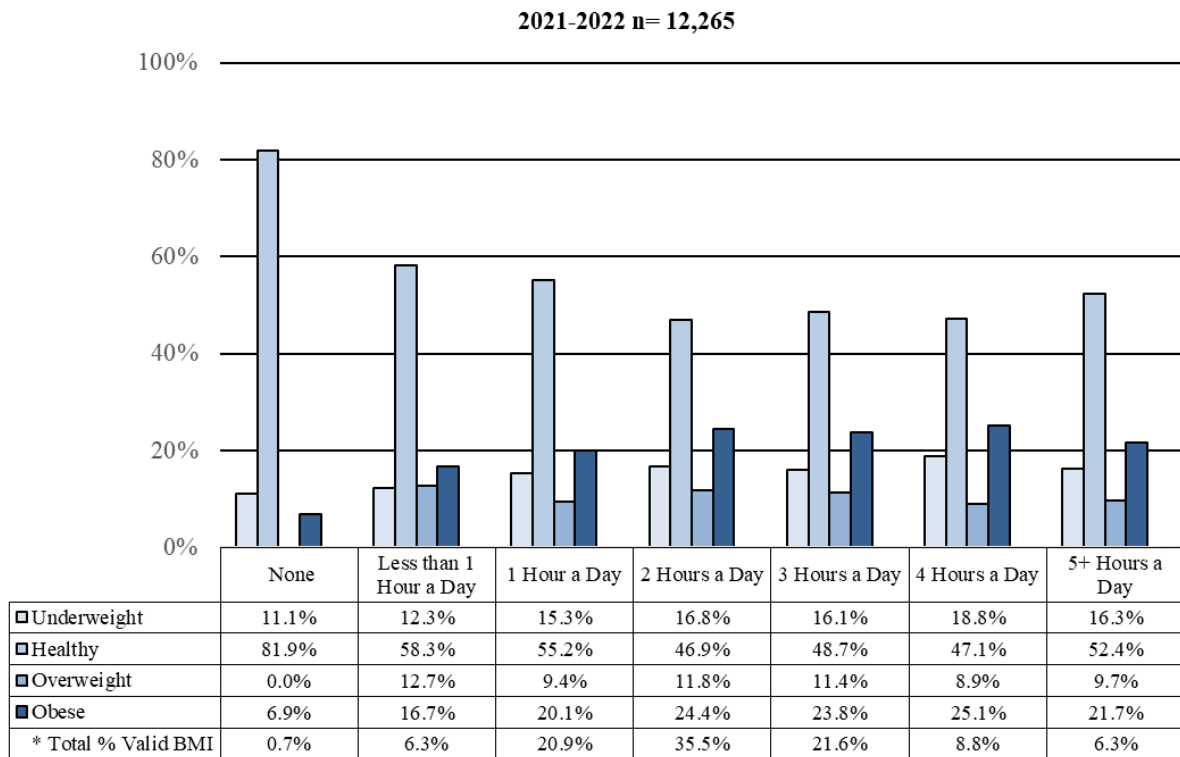
WEIGHT AND HEALTHY BEHAVIORS

Table 9.3 Number of Hours Spent on Electronic Devices

	Average Weekday	Weekend
None	0.7%	0.6%
Less than 1 hour	6.3%	2.7%
1 hour	20.9%	9.6%
2 hours	35.5%	26.9%
3 hours	21.6%	26.8%
4 hours	8.8%	18.4%
5 or more hours	6.3%	14.9%

When examining the relationship between average number of hours that a child spends in front of a TV or electronic device on an average weekday and BMI (See Figure 9.5), as TV viewing and the use of electronic devices increases to two hours a day, the likelihood of a child being obese also increases. The largest percentage of children that are at a healthy weight do not watch TV or use electronic devices on an average weekday (81.9%).

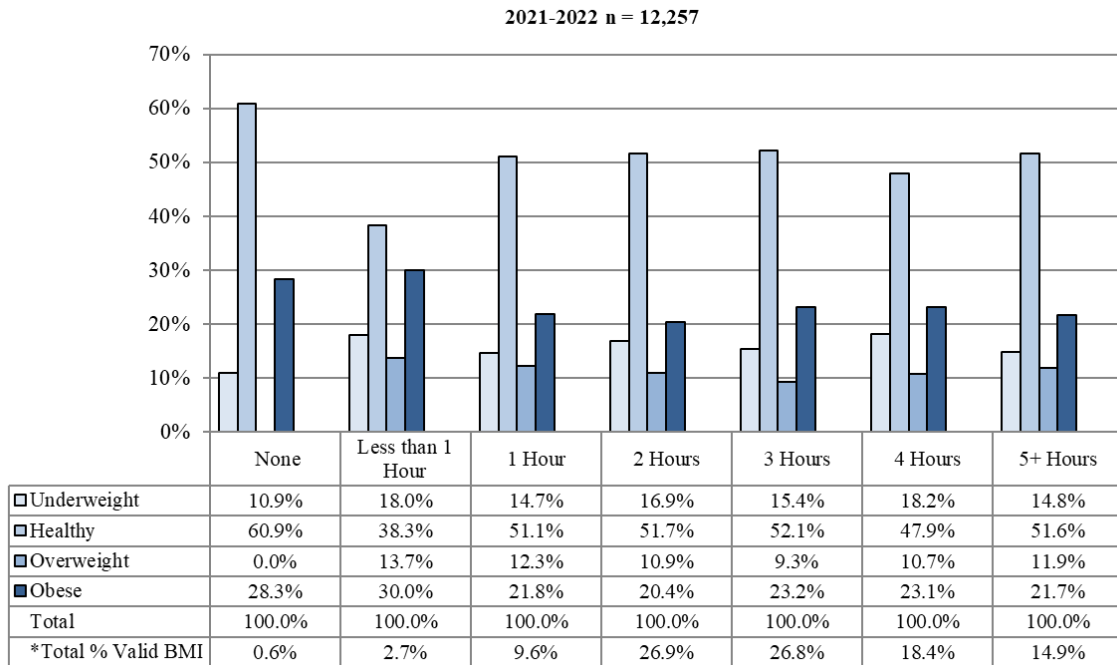
Figure 9.5 Child's Weight Status Category by Hours Spent on Electronic Devices on an Average Weekday



WEIGHT AND HEALTHY BEHAVIORS

Similarly, when examining the relationship between the average number of hours that a child spends in front of a TV or electronic device on the weekend and BMI (see Figure 9.6), the largest percentage of children that are at a healthy weight do not watch TV or use electronic devices on an average weekend (60.9%).

Figure 9.6 Child's Weight Status Category by Hours Spent on Electronic Devices on an Average Weekend



Soda Consumption: Non-Diet Soda

According to the 2021 Nevada High School Youth Risk Behavior Survey (YRBS) Report, 14 percent of youth in Nevada drank a can, bottle, or glass of non-diet soda/pop at least one time per day in the seven days prior to administration of the survey (Anderson et al., 2022), which was below the 2019 national average of 15.1 percent (Merlo et al., 2020). To determine similar activity in children entering kindergarten, this same question on soda consumption was added to the survey starting in the 2011-2012 school year.

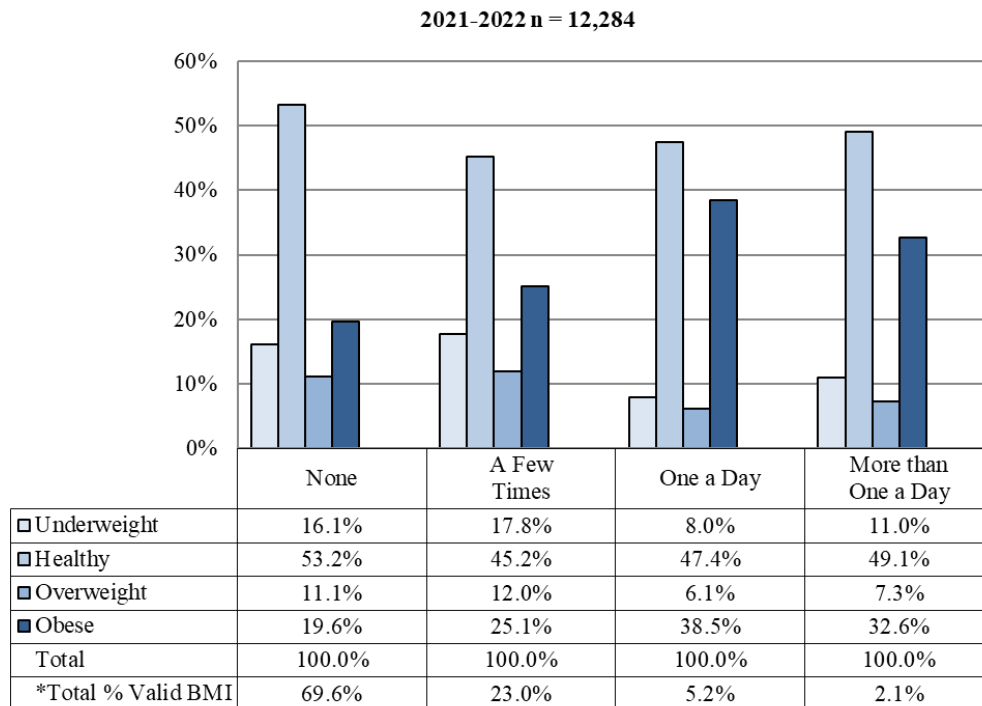
This year's results indicate that:

- The majority of children either did not drink any non-diet soda (69.6%) or drank some a few times per week (23.0%).
 - The percentage of children who did not drink any non-diet soda is smallest in Clark County (69.1%) and is slightly larger in the Rural Counties (70.9%) and Washoe County (71.4%) (See Appendix A, Table 10.1).
- A total of 5.2 percent of respondents reported that their child drank non-diet soda once a day and 2.1 percent indicated that their child drank non-diet soda more than once a day.
- A larger percentage of children in Clark County (7.6%) drank at least one non-diet soda a day, as compared to children in Washoe County (6.8%) and the Rural Counties (6.0%) (See Appendix A, Table 10.1).

WEIGHT AND HEALTHY BEHAVIORS

Figure 9.7 illustrates children’s weight status category by the number of non-diet sodas consumed in one week. Of the respondents with kindergarteners having a valid BMI, most reported that their child had less than one non-diet soda a day (92.6%). The largest percentages of children in the obese category drank one or more non-diet sodas a day (71.1%).

Figure 9.7 Child's Weight Status Category by Number of Non-Diet Sodas Consumed in a Week



Note. *Indicates percentages are calculated out of the total number of valid BMI responses in each category

Soda Consumption: Diet Soda

Similarly, the survey asked the parents/guardians to indicate the level of their kindergartener's consumption of diet soda products in the past seven days.

Results indicate that:

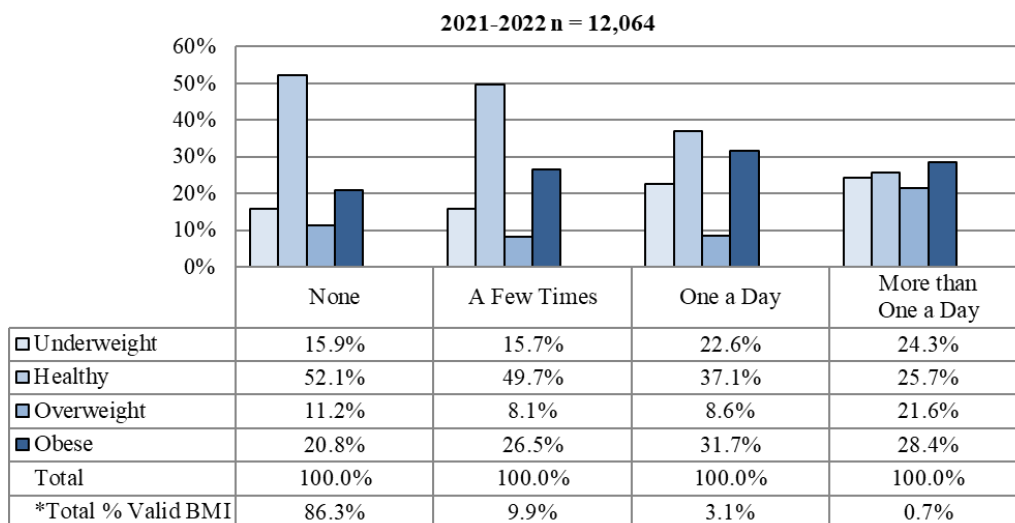
- The majority of children in the current study did not drink any diet soda (86.3%).
 - The percentage of children who did not drink any diet soda was smallest in the Rural Counties (79.6%) as compared to Washoe (86.2%) and Clark County (87.4%) (See Appendix A, Table 10.1).
- A total of 9.9 percent reported that their child drank diet soda a few times a week, 3.1 percent reported daily consumption, and 0.7 percent reported consumption of more than once a day.
 - In Washoe County, a larger percentage of children drank diet soda a few times a week (10.9%) as compared to children in the Rural Counties (10.1%) and Clark County (9.7%).

WEIGHT AND HEALTHY BEHAVIORS

- A much larger percentage of children in the Rural Counties reportedly drank diet soda once a day (9.8%) as compared to children in Washoe (2.3%) and Clark County (2.2%) (See Appendix A, Table 10.1).

When looking at children’s weight status categories by the number of diet sodas drank in one week, it appears that the percentage of children at a healthy weight decreases with the increase in diet soda consumption. However, it is difficult to project a relationship given that so few of the respondents reported their child drank diet soda either once a day or more than once a day. Therefore, these results should be used with caution (see Figure 9.8).

Figure 9.8 Child's Weight Status Category by Number of Diet Sodas Consumed in a Week



Note. *Indicates percentages are calculated out of the total number of valid BMI responses in each category.

Juice Consumption

Parents and childcare providers often perceive fruit juice as a healthy alternative to sodas and other sugary beverages for children. There has been an increase in the consumption of fruit juices by children over the past 30 to 40 years as well as the variety of types of juices available for purchase (Wojcicki & Heyman, 2012). The low levels of fiber and high sugar content of these products, even in 100 percent fruit juice, raise health issues for children (Heyman & Abrams, 2017; Wojcicki & Heyman, 2012). Research shows that excessive consumption of fruit juice among children contributes to obesity (Shefferly et al., 2016; Wojcicki & Heyman, 2012).

This year’s results indicate that:

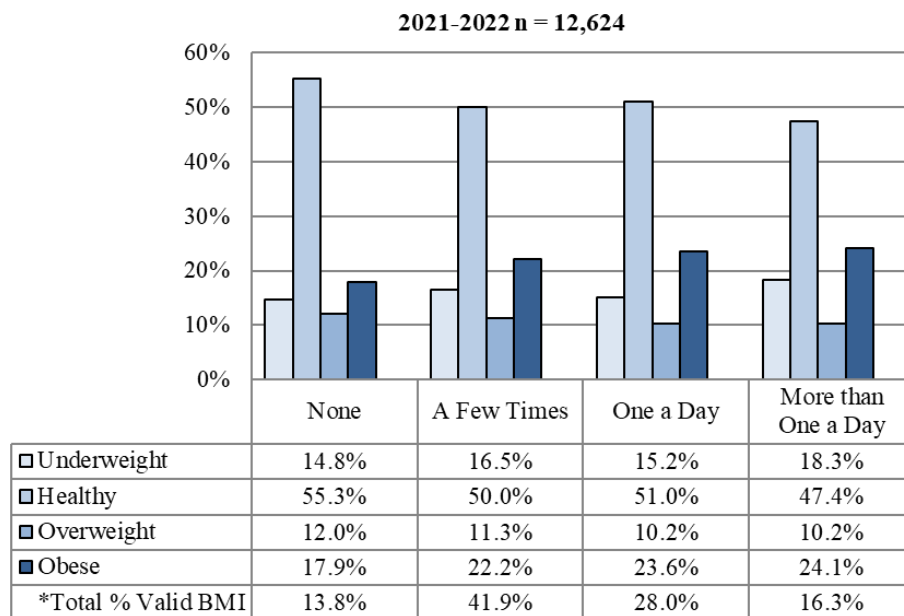
- The majority of children drank juice a few times a week (41.9%) or once a day (28.0%).
 - A larger percentage of children in Clark County drank juice once a day or more (46.1%) as compared to children in the Rural Counties (43.8%) and Washoe County (35.8%) (See Appendix A, Table 10.1).

WEIGHT AND HEALTHY BEHAVIORS

- Overall, 13.8 percent reported that their child did not drink juice.
 - A larger percentage of children in Washoe County did not drink juice (18.7%) as compared to children in the Rural Counties (13.1%) and Clark County (12.9%) (See Appendix A, Table 10.1).

When comparing children’s weight status category to the number of juice drinks consumed in one week, it appears that an increase in juice consumption is related to an increase in obesity (See Figure 9.9). However, it is difficult to project a relationship given the sample size of respondents in each category. Thus, results should be interpreted with caution.

Figure 9.9 Child's Weight Status Category by Number of Juice Drinks Consumed in a Week



Note. *Indicates percentages are calculated out of the total number of valid BMI responses in each category.

Infant Feeding Behaviors

Breastfeeding has been shown to have many health benefits for both the lactating person and the child. Breastfeeding has been associated with reduced risk of cancer, diabetes, obesity, and postpartum depression in the lactating person, and improved cognitive development and reduced risk of cancer, ear infections, gastrointestinal issues, allergies, SIDS, obesity, hypertension, cardiovascular disease, hyperlipidemia, and diabetes in the child (Binns et al., 2016; U.S. Department of Health and Human Services [US DHHS], 2011).

Starting in 2007, the CDC began issuing annual Breastfeeding Report Cards that provide both national and state-level data. According to the 2020 report card, Nevada is below the national average for babies who have ever been breastfed (US =84.1%; NV =81.8%), below the national average for exclusive breastfeeding at six months (US =25.6%; NV =21.7%), and below the national average for exclusive breastfeeding at three months (US =46.9%; NV =40.9%) (CDC, 2020a).

The Healthy People 2030 breastfeeding objectives aim to increase the proportion of infants who are breastfed at one year (54.1%), and exclusively breastfed through six months of age (42.4%) (US DHHS, 2021a; US DHHS, 2021b). According to the 2021-2022 KHS survey, 35.8 percent of incoming kindergartners were breastfed at twelve months with 19.1 percent being exclusively breastfed. At six months, 27.6 percent of children were exclusively breastfed.

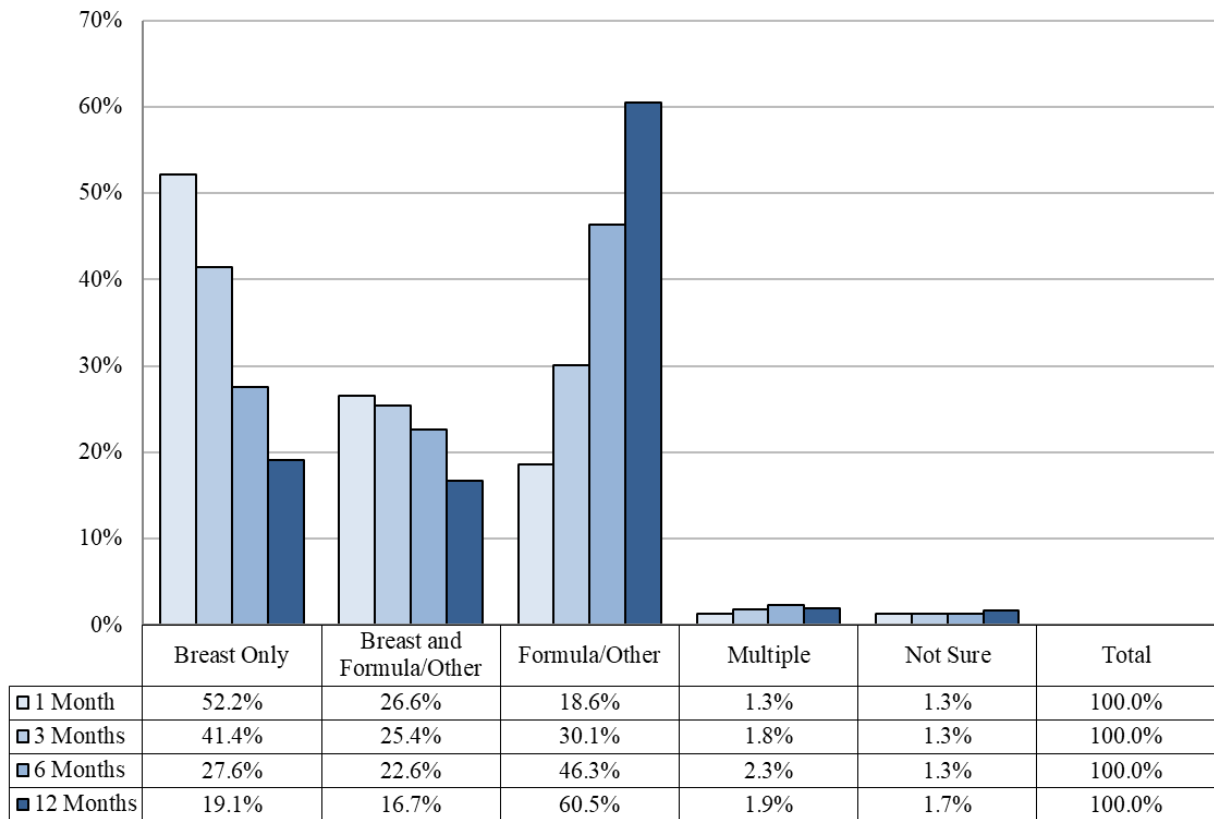
It is important to note that there are many reasons why a child may not receive breast milk exclusively during the first six months such as low milk supply, trouble latching, or a plugged duct (US DHHS Office on Women's Health, 2011). In 2021-2022, of those who wrote in barriers to breastfeeding, the most frequently cited barriers, from most to least common, included lack of milk production, difficulties with latching, and work or school.

WEIGHT AND HEALTHY BEHAVIORS

As seen in Figure 9.10, 52.2 percent of respondents indicated that their child was breastfed exclusively at one month old.

Figure 9.10 Infancy Feeding Habits

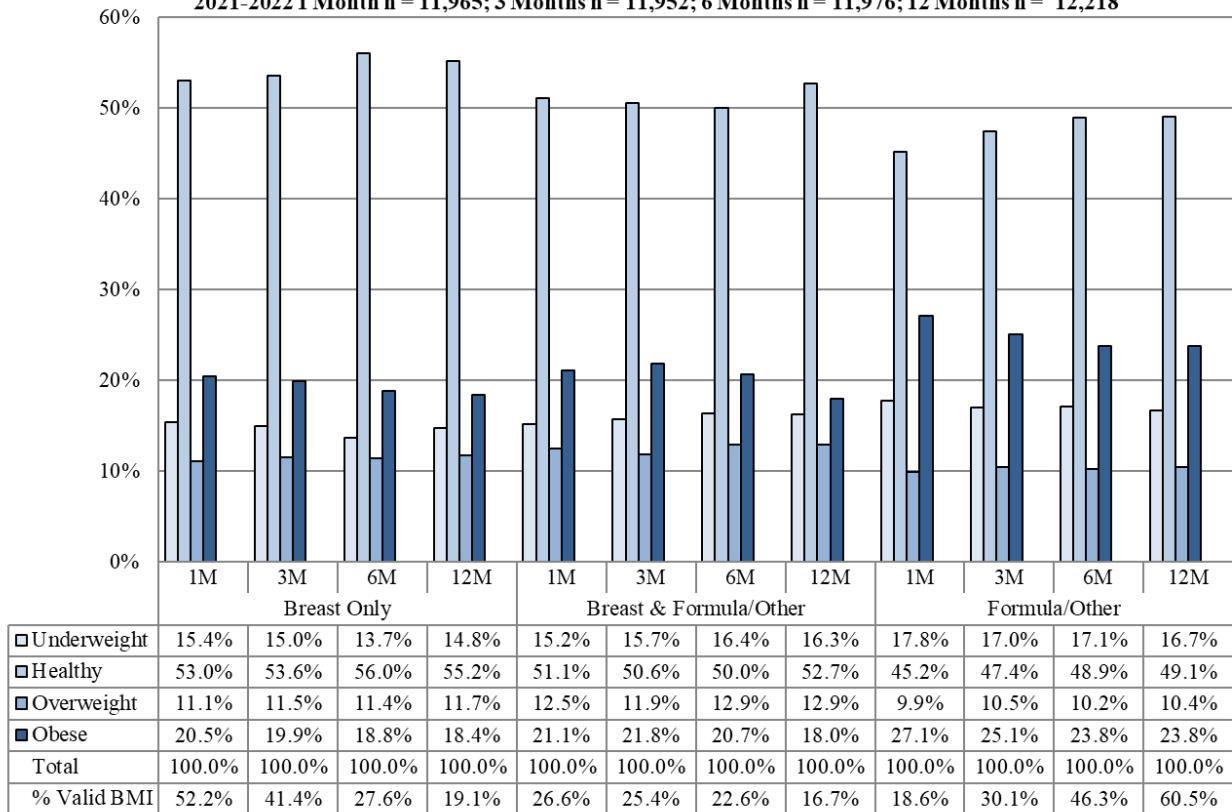
2021-2022 1 month n = 26,821; 3 months n = 26,876; 6 months n = 27,023; 12 months n = 27,824



The literature shows a link between breastfeeding and preventing obesity. Certain types of bacteria that help to prevent obesity are more likely to be present in babies that drink breast milk (McCarthy, 2018). Infants who were given breast milk from a bottle did have lower rates of obesity at 12 months; however, the lowest rates of obesity were seen in infants who received breast milk directly from the breast for the first three months of their life (McCarthy, 2018). Figure 9.11 illustrates child weight status categories by infant feeding behaviors. There are slightly larger percentages of children in the healthy weight category among those that were exclusively fed breast milk at all time points as compared to those that were fed both breast milk and formula/other or formula/other only.

Figure 9.11 Child Weight Status Category by Infancy Feeding Habits

2021-2022 1 Month n = 11,965; 3 Months n = 11,952; 6 Months n = 11,976; 12 Months n = 12,218



Note. Respondents were also given the response option to indicate Not Sure and some selected multiple responses. However, for the purposes of this graph, those response options were not included because of the low number of responses in each of those categories.

APPENDIX A. COMPARISON OF SURVEY RESULTS

SUMMARY OF 2021-2022 WEIGHTED SURVEY RESULTS BY COUNTY

Table 10.1 below outlines the percentages of responses for the 2021-2022 school year survey results by Clark County, Washoe County, and the Rural Counties. Not all respondents answered every question on the surveys that were returned. All percentages calculated are based on the total weighted number of people answering the question, rather than the total number of people who completed a survey. In addition, percentages are represented by county(ies); therefore, percentages will total 100 percent within each county category and not across all county categories.

Table 10.1 Summary of 2021-2022 Weighted Survey Results by County

Survey Indicator	State (Percent)	Clark County (Percent)	Washoe County (Percent)	Rural Counties (Percent)
<i>Survey Participation</i>	--	73.6	15.1	11.4
<i>Demographic Information</i>				
<i>Gender of Kindergartener</i>				
Male	49.6	49.4	53.0	46.7
Female	50.3	50.6	47.0	53.3
Other	0.0	0.0	0.0	0.0
<i>Race/Ethnicity of Kindergartener</i>				
African American/Black	7.3	9.5	1.7	1.0
Asian	5.4	6.5	3.0	1.1
Caucasian	31.5	25.8	46.6	48.5
Hispanic	31.7	32.9	28.7	28.2
Native American/ Alaska Native	0.8	0.6	0.7	2.9
Pacific Islander	1.1	1.2	0.7	0.3
Other Race	0.8	0.9	0.4	0.3
Multiple Races	21.4	22.6	18.2	17.7
<i>Single Parent or Guardian</i>	27.8	28.5	25.2	26.2
<i>Average # of Children in Household</i>	2.49	2.47	2.47	2.63
<i>(Standard Deviation)</i>	(1.18)	(1.18)	(1.14)	(1.21)
<i>Average # of Adults in Household</i>	2.12	2.15	2.02	2.00
<i>(Standard Deviation)</i>	(0.94)	(0.96)	(0.88)	(0.79)
<i>Average Age of Mother/Guardian</i>	33.93	34.07	34.26	32.54
<i>(Standard Deviation)</i>	(6.78)	(6.72)	(6.42)	(7.45)
<i>Average Age of Father/Guardian</i>	36.39	36.57	36.83	34.62
<i>(Standard Deviation)</i>	(7.65)	(7.57)	(7.41)	(8.23)

Table 10.1 continued

APPENDIX A. COMPARISON OF SURVEY RESULTS

Survey Indicator	State (Percent)	Clark County (Percent)	Washoe County (Percent)	Rural Counties (Percent)
<i>Annual Household Income of Survey Respondents</i>				
\$0-\$14,999	7.7	8.0	6.4	7.8
\$15,000-\$24,999	9.2	9.8	7.6	7.0
\$25,000-\$34,999	12.4	13.1	9.4	11.8
\$35,000-\$44,999	10.7	11.2	9.5	8.5
\$45,000-\$54,999	8.4	8.5	7.6	9.0
\$55,000-\$64,999	7.0	6.8	6.2	9.4
\$65,000-\$74,999	6.6	6.1	6.9	9.4
\$75,000-\$84,999	7.0	6.9	6.4	8.6
\$85,000-\$94,999	5.3	5.1	6.3	5.2
\$95,000+	25.9	24.6	33.6	23.3
<i>Housing Tenure</i>				
Renter-Occupied	52.0	53.4	46.0	50.9
Owner-Occupied	48.0	46.6	54.0	49.1
<i>Household Smoking</i>				
Someone in household smokes	12.6	11.9	10.5	19.8
Smoking allowed in home	1.1	1.2	0.7	1.1
<i>Family Events</i>				
None	35.1	33.8	43.4	32.2
Moved to a new home	20.2	19.9	16.9	26.0
Job Change	23.1	22.2	23.3	28.7
Divorce or Separation	4.8	4.6	5.7	5.6
Loss of job or income	15.8	18.0	9.0	10.2
New Child - Birth/Adopt/Foster	10.9	9.8	9.8	19.1
Serious Medical issues in the home	3.8	3.9	2.7	4.8
Death in the family	13.1	13.7	10.7	12.0
Traumatic Event/Disaster/Accident	2.6	2.5	2.6	3.3
Other	1.4	1.3	1.7	1.9
<i>Not Enough Food</i>				
Often true	2.2	2.4	1.6	1.8
Sometimes true	13.6	14.7	8.9	12.4
Never true	84.2	82.8	89.4	85.8

APPENDIX A. COMPARISON OF SURVEY RESULTS

Table 10.1 continued

Survey Indicator	State (Percent)	Clark County (Percent)	Washoe County (Percent)	Rural Counties (Percent)
<i>Type of School Child Attended in the Past 12 Months</i>				
None/Stayed at Home	36.5	37.3	30.9	38.4
Friends/Family Care	4.8	4.9	4.7	4.8
Home-Based	8.5	9.6	5.1	6.4
School District Preschool	23.1	23.9	19.3	23.4
University Campus Preschool	0.7	0.5	1.1	1.6
Head Start	5.0	4.4	6.0	7.4
Other Facility/Center	17.0	15.2	28.2	14.0
Multiple	4.3	4.2	4.8	4.0
<i>Average Preschool Hours of Attendance</i>				
0 Hours	40.4	41.4	34.8	41.7
1-4 Hours	9.3	10.0	6.5	8.4
5-10 Hours	12.9	13.6	10.4	11.5
11-15 Hours	7.9	7.8	6.9	10.4
16-20 Hours	6.2	5.7	7.9	7.3
21-30 Hours	7.5	6.9	10.0	7.6
31-40 Hours	11.7	11.0	17.6	9.0
More than 40 Hours	4.0	3.6	6.0	4.2
<i>Reasons Children Did NOT attend preschool (percentage only of those who stayed home or were in the care of friends/family/neighbors)</i>				
No Challenges / Wanted them home	36.5	37.3	30.9	38.4
Too expensive	19.3	20.2	18.4	13.9
Too far	2.6	2.6	2.7	2.3
Hours not convenient	7.3	7.6	7.4	4.8
No open spots	8.7	8.4	7.7	12.4
Other	25.2	25.9	21.8	24.4
<i>If they could have attended, would they have attended part-time or full time? (percentage only of those who stayed home or were in care of friends/family/neighbors)</i>				
Full Time	57.9	57.3	61.6	57.0
Part Time	28.2	28.8	24.7	28.7
No preschool	13.9	13.9	13.7	14.3
<i>If they could have attended, what type of facility would you have placed your child in? (percentage only of those who stayed home or were in care of friends/family/neighbors)</i>				
Home-Based	19.1	18.5	13.9	28.4
Facility/Center	39.7	38.6	54.3	29.6
School District Preschool	41.2	43.0	31.8	42.0

APPENDIX A. COMPARISON OF SURVEY RESULTS

Table 10.1 continued

Survey Indicator	State (Percent)	Clark County (Percent)	Washoe County (Percent)	Rural Counties (Percent)
<i>Number of Days During the Past Week that Someone Read to Child</i>				
None	3.2	3.2	3.2	3.9
1 day	5.2	5.0	6.1	5.7
2 days	11.8	12.0	11.9	10.1
3 days	16.6	16.5	17.3	15.8
4 days	13.8	13.6	14.8	13.6
5 days	18.9	19.6	12.8	21.9
6 days	5.4	5.6	4.5	5.5
7 days	25.1	24.5	29.4	23.4
<i>Health Insurance Status and Access to Health Care</i>				
<i>Applied for insurance for child using Nevada Health Link</i>	14.3	14.6	12.8	14.6
<i>Yes, child was approved</i>	85.8	87.3	84.4	78.3
<i>Health Insurance Type</i>				
Uninsured	5.9	6.1	5.4	5.0
Private	48.9	47.5	56.8	47.2
Medicaid	32.3	32.9	25.8	36.3
Nevada Check-Up	5.2	5.6	4.1	3.7
Other	3.7	3.5	4.3	3.7
Multiple Types	4.2	4.4	3.5	4.2
<i>Kindergartener Does NOT Have a Primary Care Provider</i>	9.4	9.0	9.1	12.0
<i>Types of Barriers Experienced When Trying to Access Health Care</i>				
Lack of Transportation	2.6	3.0	1.6	2.0
Lack of Insurance	5.8	6.0	4.6	5.9
Lack of Quality Medical Providers	6.1	6.2	3.2	9.0
Lack of Money/Financial Resources	6.8	7.2	3.6	8.6
Other Barriers	1.7	1.8	1.4	1.8
<i>Know how to access support services</i>	45.2	42.9	54.2	48.7
<i>Difficulties Accessing Mental Health Services for Kindergartener (percentage only for those who tried to access services)</i>	47.4	47.9	43.3	50.9
<i>Routine Care and Health of Kindergartener</i>				
<i>Has Not Had Routine Check-Up in the Last Year</i>	11.6	11.8	10.3	12.7
<i>Has Not Visited a Dentist in the Last Year</i>	22.0	24.6	13.7	16.6

APPENDIX A. COMPARISON OF SURVEY RESULTS

Table 10.1 continued

Survey Indicator	State (Percent)	Clark County (Percent)	Washoe County (Percent)	Rural Counties (Percent)
<i>Types of Medical Conditions Seen in Kindergarteners</i>				
None	68.2	69.1	70.5	59.1
ADD/ADHD	1.7	1.5	1.8	3.0
Allergies	13.3	13.7	10.2	14.8
Asthma	5.1	4.2	4.3	12.4
Autism	1.4	1.4	1.5	0.9
Cancer	0.1	0.1	0.3	0.1
Diabetes	0.3	0.3	0.1	0.5
Glasses/Contacts	5.1	5.0	5.0	5.4
Hearing Aid/Impairment	0.3	0.2	0.0	0.1
Heart Condition/Disorder	1.0	0.9	0.7	1.6
Mental Health Condition	0.6	0.6	0.7	0.6
Physical Disability	0.5	0.6	0.3	0.2
Seizures	0.8	0.9	0.4	0.7
Skin Condition	2.6	2.6	2.8	2.6
Speech Delays	6.4	6.1	7.2	7.9
Other Condition	2.4	2.2	2.5	3.0
<i>Received a Developmental Screening in past 12 months</i>	29.0	28.2	32.0	30.1
<i>Weight and Health Behaviors</i>				
Underweight	16.2	16.5	18.2	11.4
Healthy Weight	50.7	50.9	46.3	55.4
Overweight	10.9	10.8	12.5	9.0
Obese	22.2	21.7	23.0	24.2
<i>Number of Days per Week that Child Has at Least 60 Minutes of Physical Activity</i>				
None	1.0	1.2	0.7	0.7
1 Day	2.7	2.1	1.1	8.3
2 Days	6.3	7.4	3.8	2.8
3 Days	12.3	13.8	9.7	6.8
4 Days	12.6	13.5	10.4	9.2
5 Days	18.5	18.9	18.7	16.0
6 Days	8.8	8.8	9.6	7.7
7 Days	37.7	34.4	46.1	48.5

APPENDIX A. COMPARISON OF SURVEY RESULTS

Table 10.1 continued

Survey Indicator	State (Percent)	Clark County (Percent)	Washoe County (Percent)	Rural Counties (Percent)
<i>Hours of TV or Electronics on an Average Weekday</i>				
None	0.7	0.7	0.5	0.6
Less than 1	6.3	6.0	6.4	7.8
1 Hour	20.8	20.8	21.1	20.6
2 Hours	35.5	35.4	38.9	31.4
3 Hours	21.6	21.1	19.9	27.6
4 Hours	8.8	9.3	7.5	7.4
5 Hours or More	6.3	6.6	5.7	4.6
<i>Hours of TV or Electronics on an Average Weekend</i>				
None	0.6	0.5	0.6	0.9
Less than 1	2.7	2.4	4.1	2.8
1 Hour	9.6	9.0	12.3	10.3
2 Hours	26.9	25.5	35.3	25.4
3 Hours	26.8	26.8	26.1	27.5
4 Hours	18.4	19.9	13.5	15.3
5 Hours or More	14.9	15.8	8.2	17.7
<i>Number of Times Per Week the Kindergartener Drinks Non-Diet Soda</i>				
None	69.6	69.1	71.4	70.9
A Few Times	23.0	23.3	21.7	23.1
Once a Day	5.2	5.4	5.2	4.2
More Than Once a Day	2.1	2.2	1.6	1.8
<i>Number of Times Per Week the Kindergartener Drinks Diet Soda</i>				
None	86.3	87.4	86.2	79.6
A Few Times	9.9	9.7	10.9	10.1
Once a Day	3.1	2.2	2.3	9.8
More Than Once a Day	0.7	0.7	0.6	0.5
<i>Number of Times Per Week the Kindergartener Drinks Juice</i>				
None	13.8	12.9	18.7	13.1
A Few Times	41.9	40.9	45.5	43.1
Once a Day	28.0	28.4	24.5	30.4
More Than Once a Day	16.3	17.7	11.3	13.4

APPENDIX A. COMPARISON OF SURVEY RESULTS

Table 10.1 *continued*

Survey Indicator	State (Percent)	Clark County (Percent)	Washoe County (Percent)	Rural Counties (Percent)
<i>Infancy Eating Habits at One Month</i>				
Breast Only	52.2	48.8	63.1	59.3
Breast and Formula/Other	26.6	28.7	21.0	20.5
Formula/Other	18.6	19.9	13.1	17.7
Multiple	1.3	1.3	1.6	1.0
Not Sure	1.3	1.3	1.3	1.5
<i>Infancy Eating Habits at Three Months</i>				
Breast Only	41.4	38.9	49.7	46.1
Breast and Formula/Other	25.4	26.3	24.4	21.3
Formula/Other	30.1	31.7	22.5	29.6
Multiple	1.8	1.8	2.1	1.5
Not Sure	1.3	1.3	1.2	1.5
<i>Infancy Eating Habits at Six Months</i>				
Breast Only	27.6	26.7	34.7	24.0
Breast and Formula/Other	22.6	23.0	22.8	19.6
Formula/Other	46.3	47.0	38.1	52.3
Multiple	2.3	2.1	3.2	2.8
Not Sure	1.3	1.3	1.3	1.3
<i>Infancy Eating Habits at Twelve Months</i>				
Breast Only	19.1	18.5	24.0	16.7
Breast and Formula/Other	16.7	16.9	18.4	13.4
Formula/Other	60.5	61.0	53.3	66.4
Multiple	1.9	1.7	2.6	2.1
Not Sure	1.7	1.8	1.6	1.4

APPENDIX A. COMPARISON OF SURVEY RESULTS

COMPARISON OF SURVEY RESULTS BY YEAR

Table 10.2 below outlines the percentages of responses from the three most recent school year surveys (2019-2020, 2020-2021, and 2021-2022). Please note that for each survey year, not all respondents answered every question. All percentages calculated are based on the total weighted number of people answering the question, rather than the total number of people who completed a survey. In addition, the percentages for Table 10.2 represent percentages by year; therefore, for each response category, percentages will total 100 percent within each year and not across all years.

Table 10.2 Comparison of Survey Results by Year

Survey Indicator	2019-2020 (Year 12) (Percent)	2020-2021 (Year 13) (Percent)	2021-2022 (Year 14) (Percent)
<i>Survey Participation by School District</i>			
Clark County	71.7	72.5	73.6
Washoe County	16.4	17.8	15.1
Rural Counties	11.9	9.7	11.4
<i>Demographic Information</i>			
<i>Gender of Kindergartener</i>			
Male	49.4	52.3	49.6
Female	50.6	47.4	50.3
Other	0.0	0.2	0.0
<i>Race/Ethnicity of Kindergartener</i>			
African American/Black	7.0	5.3	7.3
Asian	--	--	5.4
Caucasian	35.1	43.1	31.5
Hispanic	31.1	23.3	31.7
Native American/Alaska Native	1.0	0.7	0.8
Pacific Islander	--	--	1.1
Other Race	0.8	0.8	0.8
Multiple Races	18.9	21.1	21.4
<i>Single Parent or Guardian</i>	26.8	24.7	27.8
<i>Average # of Children in Household</i>	2.53	2.50	2.49
<i>(Standard Deviation)</i>	(1.21)	(1.45)	(1.18)
<i>Average # of Adults in Household</i>	2.15	2.14	2.12
<i>(Standard Deviation)</i>	(0.92)	(1.09)	(0.94)
<i>Average Age of Mother/Guardian</i>	33.77	34.99	33.93
<i>(Standard Deviation)</i>	(6.84)	(6.47)	(6.78)
<i>Average Age of Father/Guardian</i>	36.20	37.36	36.39
<i>(Standard Deviation)</i>	(7.62)	(8.10)	(7.65)

APPENDIX A. COMPARISON OF SURVEY RESULTS

Table 10.2 Continued

Survey Indicator	2019-2020 (Year 12) (Percent)	2020-2021 (Year 13) (Percent)	2021-2022 (Year 14) (Percent)
<i>Annual Household Income of Survey Respondent</i>			
\$0-\$14,999	9.1	9.5	7.7
\$15,000-\$24,999	10.8	8.8	9.2
\$25,000-\$34,999	12.8	10.4	12.4
\$35,000-\$44,999	10.5	8.5	10.7
\$45,000-\$54,999	8.6	7.9	8.4
\$55,000-\$64,999	7.2	6.6	7.0
\$65,000-\$74,999	7.2	7.2	6.6
\$75,000-\$84,999	6.4	7.2	7.0
\$85,000-94,999	5.2	6.2	5.3
\$95,000 +	22.2	27.7	25.9
<i>Housing Tenure</i>			
Renter-Occupied	53.8	46.2	52.0
Owner-Occupied	46.2	53.8	48.0
<i>Household Smoking</i>			
Someone in household smokes	15.1	13.1	12.6
Smoking allowed in home	1.3	1.2	1.1
<i>Family Events</i>			
Moved to a new home	22.5	17.5	20.2
Job Change	21.5	24.8	23.1
Divorce or Separation	5.7	5.9	4.8
Loss of job or income	9.6	28.6	15.8
New Child - Birth/Adopt/Foster	10.4	10.1	10.9
Serious Medical issues in the home	4.4	6.8	3.8
Death in the family	9.2	12.7	13.1
Traumatic Event/Disaster/Accident	2.1	4.9	2.6
Other	1.9	6.1	1.4
<i>Type of School Child Attended in the Past 12 Months</i>			
None/Stayed at Home	27.6	5.8	36.5
Friends/Family Care	4.8	4.0	4.8
Home-Based	5.6	25.8	8.5
School District Preschool	30.5	12.5	23.1
University Campus Preschool	1.0	5.1	0.7
Head Start	6.6	2.3	5.0
Other Facility/Care	20.6	28.7	17.0
Multiple	3.3	15.8	4.3

APPENDIX A. COMPARISON OF SURVEY RESULTS

Table 10.2 Continued

Survey Indicator	2019-2020 (Year 12) (Percent)	2020-2021 (Year 13) (Percent)	2021-2022 (Year 14) (Percent)
<i>Average Hours of Preschool Attendance</i>			
0 Hours	30.9	18.1	40.4
1-4 Hours	9.7	3.5	9.3
5-10 Hours	14.7	24.4	12.9
11-15 Hours	10.5	14.1	7.9
16-20 Hours	6.3	12.6	6.2
21-30 Hours	10.0	9.3	7.5
31-40 Hours	13.1	13.1	11.7
More than 40 Hours	4.8	4.9	4.0
<i>Reasons Children Did NOT attend preschool*</i>			
No Challenges / Wanted them home	47.0	34.5	36.5
Too expensive	27.9	18.7	19.3
Too far	4.5	2.8	2.6
Hours not convenient	11.2	5.9	7.3
No open spots	13.2	7.6	8.7
Other	9.2	8.0	25.2
<i>If they could have attended, would they have attended part-time or full time?</i>			
Full Time	56.1	57.8	57.9
Part Time	31.8	32.3	28.2
<i>If they could have attended, what type of facility would you have placed your child in?</i>			
Home-Based	15.4	12.6	19.1
Facility/Center	36.1	36.6	39.7
School District	48.5	50.9	41.2
<i>Number of Days During The Past Week that Someone Read to Child</i>			
None	2.6	2.6	3.2
1 day	4.7	5.0	5.2
2 days	9.5	8.1	11.8
3 days	14.3	14.6	16.6
4 days	13.3	12.0	13.8
5 days	19.2	17.7	18.9
6 days	7.5	4.8	5.4
7 days	29.0	35.2	25.1

APPENDIX A. COMPARISON OF SURVEY RESULTS

Table 10.2 Continued

Survey Indicator	2019-2020 (Year 12) (Percent)	2020-2021 (Year 13) (Percent)	2021-2022 (Year 14) (Percent)
<i>Health Insurance Status and Access to Health Care</i>			
Applied for insurance for child using Nevada Health Link	14.0	57.1	14.3
Yes child approved. % only of those who selected yes to applied for insurance using Nevada Health Link	83.0	83.1	85.9
<i>Health Insurance Type</i>			
Uninsured	6.5	5.4	5.9
Private	50.9	54.7	48.8
Medicaid	29.4	27.5	32.3
Nevada Check-Up	6.3	5.4	5.2
Other	2.8	2.9	3.7
Multiple Types	4.1	4.1	4.2
<i>Race/Ethnicity of Uninsured Kindergartener</i>			
African American/Black	2.7	2.8	3.6
Asian	--	--	5.5
Caucasian	4.3	4	2.9
Hispanic	10.6	10.9	11.0
Native American/Alaska Native	5.3	7.4	1.2
Pacific Islander	--	--	0.0
Other Race	12.4	9.6	4.7
Multiple Races	4.3	2.7	3.8
<i>Annual Household Income of Uninsured Kindergarteners</i>			
\$0-\$14,999	14.1	14.7	13.7
\$15,000-\$24,999	13.3	16.9	13.7
\$25,000-\$34,999	14.8	18.6	16.0
\$35,000-\$44,999	12.6	11.9	13.6
\$45,000-\$54,999	11.3	9.4	10.4
\$55,000-\$64,999	8.1	4.4	9.7
\$65,000-\$74,999	6.7	6.8	7.4
\$75,000-\$84,999	4.6	4.7	5.4
\$85,000-94,999	4.6	5.9	3.2
\$95,000 +	9.9	6.8	6.7
<i>Kindergartener Does Not Have a Primary Care Provider</i>	10.7	8.0	9.4

APPENDIX A. COMPARISON OF SURVEY RESULTS

Table 10.2 Continued

Survey Indicator	2019-2020 (Year 12) (Percent)	2020-2021 (Year 13) (Percent)	2021-2022 (Year 14) (Percent)
<i>Types of Barriers Experienced When Trying to Access Health Care</i>			
Lack of Transportation	3.2	3.2	2.6
Lack of Insurance	6.2	6.9	5.8
Lack of Quality Medical Providers	5.9	6.5	6.1
Lack of Money/Financial Resources	9.4	10.4	6.8
Other Barriers	1.3	2.1	1.7
<i>Knows how to access support services</i>	44.9	50.2	45.2
<i>Difficulties Accessing Mental Health Services for Kindergartener</i>	40.0	44.1	47.4
<i>Routine Care and Health Status of Kindergartener</i>			
<i>Kindergartener Has NOT Had Routine Check-Up In Past Year</i>	9.4	13.2	11.6
<i>Kindergartener Has NOT Visited Dentist in Past Year</i>	20.7	23.9	22.0
<i>Types of Medical Conditions Seen in Kindergarteners</i>			
ADD/ADHD	1.6	2.3	1.7
Allergies	12.4	14.4	13.3
Asthma	5.1	5.0	5.1
Autism	1.3	2.1	1.4
Cancer	0.1	0.1	0.1
Diabetes	0.2	0.1	0.3
Glasses/Contacts	5.6	4.9	5.1
Hearing Aid/Impairment	0.5	0.5	0.3
Heart Condition/Disorder	1.0	1.0	1.0
Mental Health Condition	0.6	0.5	0.6
Physical Disability	0.4	0.6	0.5
Seizures	0.7	0.8	0.8
Skin Condition	3.1	3.6	2.6
Speech Delays	6.1	6.2	6.4
Other Condition	2.5	3.9	2.4
<i>Received a Developmental Screening in past 12 months</i>	31.3	31.2	29.0
<i>Kindergartener's Weight Status</i>			
Underweight	17.3	19.5	16.2
Healthy Weight	50.3	48.6	50.7
Overweight	11.1	13.2	10.9
Obese	21.3	18.7	22.2

APPENDIX A. COMPARISON OF SURVEY RESULTS

Table 10.2 Continued

Survey Indicator	2019-2020 (Year 12) (Percent)	2020-2021 (Year 13) (Percent)	2021-2022 (Year 14) (Percent)
<i>Number of Days per Week that Child Has at Least 60 Minutes of Physical Activity</i>			
None	1.2	1.6	1.0
1 Day	1.9	1.7	2.7
2 Days	6.1	7.5	6.3
3 Days	11.8	14.7	12.3
4 Days	12.5	11.5	12.6
5 Days	18.8	18.5	18.5
6 Days	8.7	7.2	8.8
7 Days	39.0	37.4	37.7
<i>Number of hours spent in front of a TV or electronic device watching TV, videos, or playing video games - Average Weekday</i>			
None	1.0	0.7	0.7
Less than 1	9.3	5.3	6.3
1 Hour	26.5	14.2	20.9
2 Hours	34.3	29.0	35.5
3 Hours	18.6	7.1	21.6
4 Hours	5.6	15.0	8.8
5 Hours or More	4.6	28.6	6.3
<i>Number of hours spent in front of a TV or electronic device watching TV, videos, or playing video games - Average Weekend</i>			
None	0.6	1.2	0.6
Less than 1	3.9	5.0	2.7
1 Hour	12.6	8.7	9.6
2 Hours	29.8	26.4	26.9
3 Hours	26.3	25.5	26.8
4 Hours	16.2	16.1	18.4
5 Hours or More	10.6	17.2	14.9
<i>Number of Times Per Week the Kindergartener Drinks Non-Diet Soda</i>			
None	69.2	71.6	69.6
A Few Times	23.8	20.9	23.0
Once a Day	5.1	4.0	5.2
More Than Once a Day	1.9	3.5	2.1

APPENDIX A. COMPARISON OF SURVEY RESULTS

Table 10.2 Continued

Survey Indicator	2019-2020 (Year 12) (Percent)	2020-2021 (Year 13) (Percent)	2021-2022 (Year 14) (Percent)
<i>Number of Times Per Week the Kindergartener Drinks Diet Soda</i>			
None	88.8	88.3	86.3
A Few Times	8.7	8.8	9.9
Once a Day	2.1	1.9	3.1
More Than Once a Day	0.5	1.0	0.7
<i>Number of Times Per Week the Kindergartener Drinks Juice</i>			
None	14.4	18.5	13.8
A Few Times	41.2	45.5	41.9
Once a Day	27.8	22.9	28.0
More Than Once a Day	16.6	13.1	16.3
<i>Infancy Eating Habits at One Month</i>			
Breast Only	51.4	53.1	52.2
Breast and Formula/Other	25.8	26.0	26.6
Formula/Other	19.9	18.3	18.6
Multiple	1.4	0.4	1.3
Not Sure	1.5	2.3	1.3
<i>Infancy Eating Habits at Three Months</i>			
Breast Only	39.3	42.6	41.4
Breast and Formula/Other	25.9	25.8	25.4
Formula/Other	32.2	29.2	30.1
Multiple	1.3	0.5	1.8
Not Sure	1.4	2.0	1.3
<i>Infancy Eating Habits at Six Months</i>			
Breast Only	25.8	28.8	27.6
Breast and Formula/Other	21.5	23.3	22.6
Formula/Other	49.4	45.0	46.3
Multiple	2.0	0.8	2.3
Not Sure	1.4	2.2	1.3
<i>Infancy Eating Habits at Twelve Months</i>			
Breast Only	17.6	17.9	19.1
Breast and Formula/Other	17.0	19.5	16.7
Formula/Other	62.1	59.3	60.5
Multiple	1.4	0.5	1.9
Not Sure	1.8	2.8	1.7

APPENDIX B. SURVEY INSTRUMENT



Kindergarten Health Survey

DEAR PARENT OR GUARDIAN: This survey has been designed by the Nevada Institute for Children's Research and Policy at the University of Nevada Las Vegas, in partnership with the State of Nevada Department of Health and Human Services, and the local county school districts. The information from this survey will be used to help understand the health of children entering kindergarten this year. You have been asked to participate because you have a child entering kindergarten. Your responses to this survey will be confidential. All information from this survey will be used to discuss children's health on a group level, not on an individual level. Please check this box if this information can be used for research.

Name of elementary school: _____

Your HOME zip code: _____

Do you Rent your home or Own your home

Are you a single parent/guardian? Yes No

Total # of children(0-17) in your household: _____

Total # of adults in your household (18+): _____

Age of child's mother/guardian: _____

Age of child's father/guardian: _____

Annual household Income: (check one)

\$0-\$14,999

\$15,000-\$24,999

\$25,000-\$34,999

\$35,000-\$44,999

\$45,000-\$54,999

\$55,000-\$64,999

\$65,000-\$74,999

\$75,000-\$84,999

\$85,000-\$94,999

\$95,000 +

Does anyone in your household smoke? Yes No

Is smoking allowed in your house? Yes No

Have you experienced any of the following events in the last 12 months? (check all that apply)

Change in job Moved -new home/city/country

Divorce or separation New Child—Birth/Adopt/Foster

Death in the family Serious medical issues in the home

Loss of a job or income Traumatic Event/Disaster/Accident

Other major event (specify): _____

COVID-19 NONE

Please answer the following questions for the child that will be enrolled in kindergarten this year.

- Child's age: _____
- Child's gender: Male Female Other
- Child's weight: _____ pounds
- Child's height: _____ ft. _____ in. (12in = 1ft)
- Child's race / ethnicity:
 - African American/Black Hispanic / Latino
 - Asian Pacific Islander Native American / Alaska Native
 - Caucasian/White Other (please specify): _____
- Please select the type of medical insurance your child currently has: (Check all that apply)
 - Medicaid Private (Employer/Union)
 - Nevada Check-Up Other _____
 - NONE/Uninsured
- Have you or someone else: Applied for Medicaid or other health plan for your child through the Silver State Exchange/NV Health Link? Yes No Not Sure
If yes, was your child approved? Yes No Not Sure
- Does your child have a primary care provider (regular doctor, nurse practitioner, or physician's assistant)? Yes No
- In the past 12 months has your child visited a: Medical provider for a routine check-up (not an illness)? ... Yes No
Dentist? _____ Yes No
- Please select any medical conditions listed below that your child has: (Check all that apply)
 - ADD / ADHD Heart Condition/Disorder
 - Allergies Mental Health Condition
 - Asthma Physical Disability
 - Autism Seizures
 - Cancer Skin Condition
 - Diabetes Speech Delays
 - Hearing Aid/Impairment Vision Impairment /Glasses / Contacts
 - Other (specify) _____ NONE
- Please check which one best describes what your child drank at each time point:

	Breast Only	Breast & Formula/Other	Formula/Other	Not Sure
1 Month (check one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Months (check one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Months (check one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 Months (check one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List barriers to breastfeeding: _____
- Has your child had a developmental screening (like the Ages and Stages Questionnaire) in the past 12 months? Yes No Not sure
- Do you know where or how to access support services and programs in your community to meet your child's/ family's needs? (e.g. food/bills, parent classes, support groups, etc.) Yes Somewhat No
- Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Often true Sometimes true Never true
- Please select any barriers you have experienced when accessing health care for your child: (check all that apply)
 - Lack of transportation Lack of insurance
 - Lack of good medical providers Lack of money
 - Other (specify): _____
 - NONE
- Have you ever tried to get mental or behavioral health services for your child? Yes No
If yes, have you had trouble getting services? No Yes (explain) _____
- In general, how many days a week does your child do at least 60 minutes of physical activity? (circle one)

0	1	2	3	4	5	6	7
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List barriers: _____

- On an average weekday, about how many hours does this child usually spend in front of a TV or electronic device (e.g. computers, cell phones, handheld video games) watching TV, videos, or playing video games? (circle one)

None	Less than one	1	2	3	4	5+
------	---------------	---	---	---	---	----

- On an average weekend, about how many hours does this child usually spend in front of a TV or electronic device (e.g. computers, cell phones, handheld video games) watching TV, videos, or playing video games? (circle one)

None	Less than one	1	2	3	4	5+
------	---------------	---	---	---	---	----

- During the past 7 days, how many times did your child drink a can, bottle, or glass of...

	None	A few times	Once a Day	More than Once a Day
Non-diet soda or pop (check one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet soda or pop (check one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit Juice (check one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- During the past 7 days, how many days did you or someone in your family/ house read to your child? (circle one)

0	1	2	3	4	5	6	7
---	---	---	---	---	---	---	---

- What type of pre-school did your child attend most often in the past 12 months? (check one)
 - Friends/Family/Neighbor care Home-based
 - School District/Charter Pre-school University/College Campus Pre-school
 - Head Start Other Facility/Center
 - NONE / Stayed home
- On average, how many hours per week did your child attend preschool?
 - Zero 1-4 5-10 11-15 16-20 21-30 31-40 41+
- If your child did not attend preschool OR if they did not attend the school you preferred, hours preferred, ect, what were some of the reasons? (check all that apply):
 - Too expensive Location too far Hours not convenient No open spots
 - Other _____
 - None (No challenges or I wanted to keep them home)
- What preschool options would have or did best fit your needs?
 - 1) (check one) Full time Part-time No Preschool
 - 2) (check one) home based facility/center based School District

PLEASE RETURN THIS SURVEY TO YOUR CHILD'S TEACHER BY OCTOBER 29, 2021

Thank you for your participation.
TEACHERS: Please return the survey to your school's front office, or mail to:
NICRP, Kindergarten Health Survey, 4700 Maryland Parkway, Box 453064, Las Vegas, NV 89119
For Questions/Concerns Contact: Amanda Haboush-Deloye 702-895-1040 Amanda.Haboush@unlv.edu

APPENDIX B: SURVEY INSTRUMENT



Cuestionario de Salud de Kinder

ESTIMADO PADRE DE FAMILIA O GUARDIAN: La siguiente encuesta ha sido diseñada por el Nevada Institute for Children's Research and Policy en la Universidad de Nevada Las Vegas, en colaboración con el Centro de Salud del Sur de Nevada y los Distritos Escolares del Condado local. La información adquirida de esta encuesta se utilizará para ayudar a comprender la salud de los niños que comienzan la escuela preescolar este año. Se le ha pedido participar porque usted tendrá un niño comenzando la escuela preescolar. Sus respuestas a esta encuesta serán confidenciales. Toda la información obtenida de esta encuesta será utilizada para discutir la salud de los niños a nivel de grupo, no individual. Por favor, aquí si esta información se puede utilizar para la investigación.

Nombre de la escuela primaria: _____
 Código postal de su CASA: _____

¿Usted? Renta su casa o es Propietario de su casa
 Es usted padre/tutor soltero? Sí No

Total de niños(as) (0-17) viviendo en su casa: _____
 Total de adultos (18+) viviendo en su casa: _____

Edad de la madre/tutor del niño: _____
 Edad del padre/tutor del niño: _____

Ingreso anual del hogar (seleccione uno)
 \$0 -\$14,999
 \$15,000 -\$24,999
 \$25,000 -\$34,999
 \$35,000 -\$44,999
 \$45,000 -\$54,999
 \$55,000 -\$64,999
 \$65,000 -\$74,999
 \$75,000 -\$84,999
 \$85,000 -\$94,999
 \$95,000 +

¿Alguien en su hogar fuma? Sí No
 Está permitido fumar en su casa? Sí No

Ha experimentado cualquiera de los siguientes eventos en los últimos 12 meses? (seleccione todas las que apliquen)

<input type="checkbox"/> Cambio en el trabajo	<input type="checkbox"/> Se mudó/mudó hogar/ciudad/pais
<input type="checkbox"/> Divorcio o separación	<input type="checkbox"/> Nuevo niño(a)—Nacimiento/Adopción / Acogimiento temporal
<input type="checkbox"/> Muerte en la familia	<input type="checkbox"/> Acogimiento temporal
<input type="checkbox"/> Pérdida de un trabajo o ingresos	<input type="checkbox"/> Graves problemas médicos en el hogar
<input type="checkbox"/> Otro evento importante (especifique) : _____	<input type="checkbox"/> Evento traumático / desastre / accidente
<input type="checkbox"/> COVID-19	<input type="checkbox"/> NINGUNO

Por favor conteste las siguientes preguntas sobre el niño(a) que será inscrito en el kinder este año.

- Edad del niño(a): _____
- Sexo del niño(a): Masculino Femenino Otro
- Peso del niño(a): _____ libras
- Estatura del niño(a): _____ ft. _____ in. (12in. = 1 ft.)
- Etnicidad del Niño(a)
 Afro Americano / Negro Hispano / Latino
 Asiático Islaño Pacífico Nativo Americano / Nativo de Alaska
 Caucásico/Blanco Otro (especifique): _____
- Por favor seleccione el tipo de seguro médico que su niño(a) tiene actualmente. (seleccione todas las que apliquen)
 Medicaid Privado (Empleador/Unión)
 Nevada Check-Up Otro _____
 NINGUNO/No asegurado
- ¿Usted o alguien más:
 Aplico para Medicaid/otro plan de salud para su niño(a) a través del Silver State Exchange/NV Health Link? Sí No No se
 En caso que si, ¿fue su niño aprobado? Sí No No se
- ¿Su niño(a) tiene un proveedor médico primario (doctor regular, enfermera o asistente médico)? Sí No
- En los últimos 12 meses su niño(a) ha visto a un:
 Proveedor médico para un chequeo de rutina (no para una enfermedad) Sí No
 Visto a un dentista Sí No
- Por favor, seleccione todas las condiciones medicas que tenga su niño(a):
 ADD/ADHD Condición del corazón
 Alergias Condición de Salud Mental
 Asma Discapacidad física
 Autismo Convulsiones
 Cáncer Condición de la piel
 Diabetes Retrasos en el habla
 Oído/Discapacidad Auditiva Debilitación de la visión/ Lentas/ de Contacto
 Otro (especifique) _____ NINGUNO
- Por favor, seleccione que mejor describe lo que bebió su niño(a) en cada etapa:

	Solo Pecho	Pecho y Formula/Otro	Formula/ Otro	No Se
Un Mes (elige uno)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Meses (elige uno)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Meses (elige uno)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 Meses (elige uno)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Lista de barreras al amamantar:
 ¿Su niño(a) ha tenido una evaluación del desarrollo (como el Cuestionario de Edades y Etapas) en los últimos 12 meses?
 Sí No No Se
- ¿Sabe usted dónde o cómo acceder servicios y programas de apoyo en su comunidad para satisfacer las necesidades de sus niños/familia? (e.g. asistencia de gasto en alimentos, clases de padres, grupos de apoyo, etc.)
 Sí Un Poco No
- En los últimos 12 meses, la comida que compramos simplemente no duró y no teníamos dinero para obtener más.
 A menudo cierto A veces cierto Nunca es cierto
- ¿Se ha enfrentado con obstáculos en el acceso de salud para su niño (a)? (seleccione todas las que apliquen)
 Falta de transportación Falta de aseguranza
 Falta de proveedores médicos de calidad Falta de dinero
 Otro (especifique): _____
 NINGUNO
- ¿Alguna vez ha tratado de obtener servicio de salud mental o de comportamiento para su niño(a)? Sí No
 En caso que si, ¿ha tenido problemas para obtener los servicios?
 No Si (especifique) _____
- En general, ¿Cuántos días a la semana su niño(a) hace por lo menos 60 minutos de actividad física? (círcule uno)
 0 1 2 3 4 5 6 7
 Lista barreras: _____
- En un día de la semana normal, ¿cuántas horas suele pasar su niño frente a un televisor o dispositivo electrónico (por ejemplo, computadoras, teléfonos celulares, videojuegos portátiles) viendo televisión, videos o jugando videojuegos? (círcule uno)
 Ninguna Menos de una 1 2 3 4 5 +
- En un fin de semana normal, ¿cuántas horas suele pasar su niño frente a un televisor o dispositivo electrónico (por ejemplo, computadoras, teléfonos celulares, videojuegos portátiles) viendo televisión, videos o jugando videojuegos? (círcule uno)
 Ninguna Menos de una 1 2 3 4 5 +
- Durante los últimos 7 días, cuántas veces bebió su niño(a) una botella o vaso de...

	Ninguno	Algunas veces	Una vez al día	Más de una vez al día
¿Soda regular o pop? (elige uno)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
¿Soda de dieta o pop? (elige uno)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
¿Jugo de fruta? (elige uno)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Durante los últimos 7 días, cuántas días usted o alguien en su familia/casa le leyó a su niño(a)? (círcule uno)
 0 1 2 3 4 5 6 7
- ¿A que tipo de escuela preescolar atendió su niño(a) mas a menudo en los últimos 12 meses? (seleccione uno)
 Al cuidado de Amigo/Familiar/Vecino Preescolar Basada en Casa
 Preescolar del Distrito Escolar Preescolar de la Universidad
 Head Start Otro Centro
 Ninguna/Parque en la Casa
- En promedio, cuántas horas por semana asistió su niño(a) al preescolar?
 Cero 1-4 5-10 11-15 16-20 21-30 31-40 41+
- Si su niño(a) no asistió al preescolar, o si no asistió al preescolar su preferido, ¿cuáles fueron algunas de las razones? (seleccione todas las que apliquen):
 Demasiado caro Localización demasiado lejos Horas no convenientes
 No hay espacios abiertos Otro _____
 Ninguno, sin retos o quería mantenerlo(a) en casa
- ¿Cual opciones que más preferiría or que más prefiere?
 1) (seleccione uno) tiempo completo tiempo parcial

POR FAVOR DEVUELVA ESTE CUESTIONARIO AL MAESTRO(A) DE SU NIÑO(A) ANTES DEL VIERNES, OCTUBRE 29, 2021

Gracias por su participación.
 TEACHERS: Please return the survey to your school's front office, or mail to: NICKRP, Kindergarten Health Survey, 4700 Maryland Pkwy, 453064, Las Vegas, NV 89119
 Preguntas? Contactar a: Amanda Haboush-Deloye 702-495-1040 Amanda.Haboush@unlv.edu

APPENDIX C. REFERENCES

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