



2026-2031 Southern Nevada Community Health Improvement Plan

Presenter:

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Division of Disease Surveillance and Control

April 27, 2026

Overview

2025 Community Health Assessment (CHA) Overview

- MAPP 2.0 Framework
- Prioritization

2026-2031 Community Health Improvement Plan

- Methodology
- Steering Committee
- Top Priorities Selected
- Goals & Objectives Overview

Conclusion & Next Steps

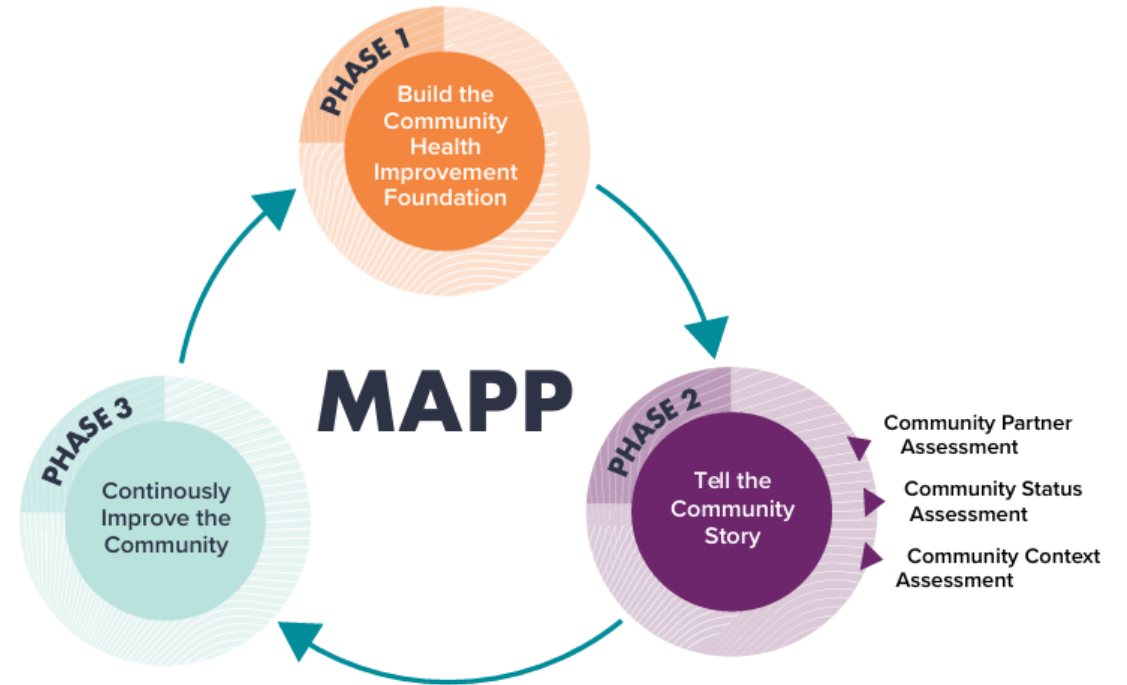
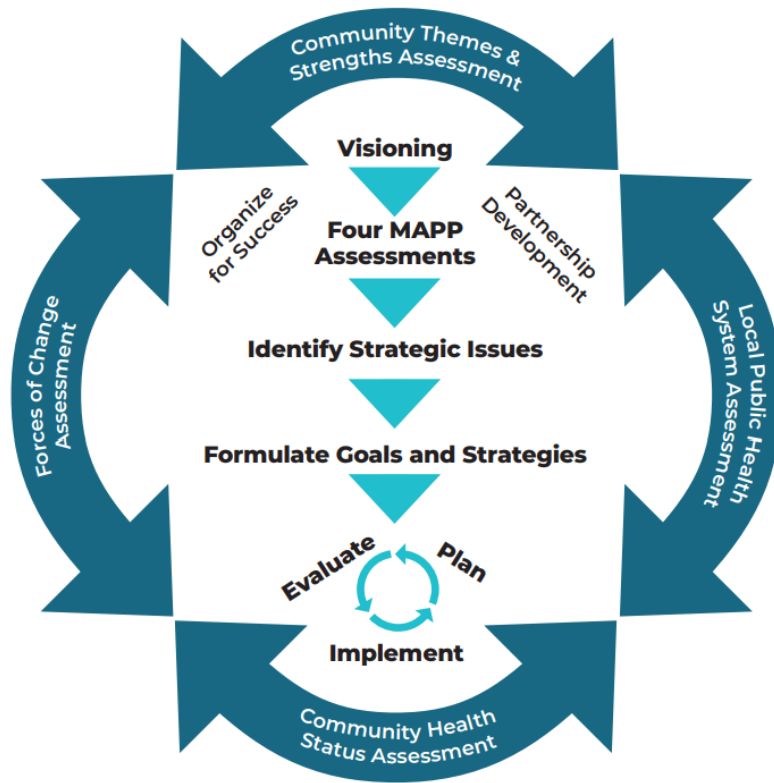
- CHIP Report Release – Early June 2026
- [HealthySouthernNevada.org](https://www.healthySouthernNevada.org)
- Join the Steering Committee/Implementation Workgroup

MAPP 2.0 Framework

2001

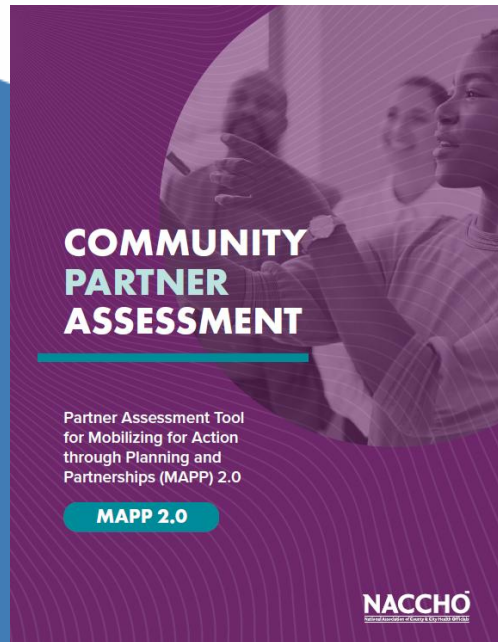
Undergone updates

2023

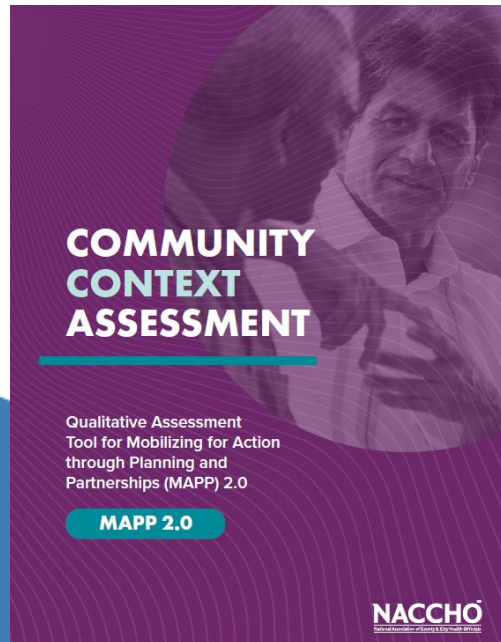


Community Health Assessment (CHA) Components

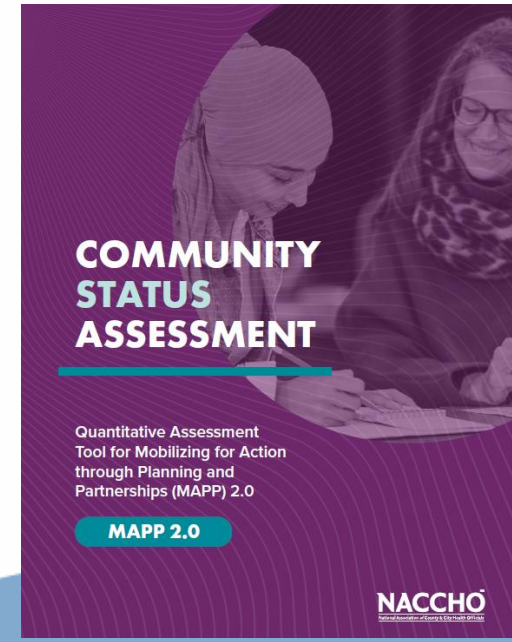
Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 Framework



Community Partner Assessment (CPA)



Community Context Assessment (CCA)



Community Status Assessment (CSA)

2025 Community Health Assessment Report

Click [here](#) to view the full report!



Full CHA Report is available on HSN website:

<https://www.healthysouthernnevada.org/>

The Southern Nevada Health District (SNHD) collaborated with multiple community organizations and individuals to conduct a Community Health Assessment (CHA). This CHA identifies the community's health-related needs and strengths as well as resources available to address and improve health outcomes.

The CHA's intended purpose is to provide an overview of the health information and seeks to identify target populations who may be at an increased risk of poor health outcomes. Findings from the CHA are used to guide the development of a Community Health Improvement Plan (CHIP). The CHIP will direct and guide the development of SNHD's and other community partners' activities through the next three to five years. SNHD and community partnerships have assessed the health status of the community as well as community behaviors and conditions. Where available this CHA examines the health status of Clark County and compares it to the state-wide as well as national health indicators.

Community Health Assessment Methodology

Developed by the National Association of County and City Health Officials (NACCHO), the Mobilizing Action through Planning and Partnerships (MAPP) framework is a community-driven strategic planning process that aims to improve community health. This formal assessment, adopted by the CHA Steering Committee, consisted of four assessments that have gathered primary and secondary, qualitative and quantitative data. The three assessments were:

- Community Partner Assessment (CPA)
- Community Status Assessment (CSA)
- Community Context Assessment (CCA)

Please view the full assessment report findings below:

+ Community Partner Assessment (CPA)

+ Community Status Assessment (CSA)

+ Community Context Assessment (CCA)

2025 Community Health Prioritization



April 30, 2025

- Facilitated by Southern Nevada Health District with 195+ participants
- Reviewed Community Health Assessment findings: Community Partner, Community Context, and Community Status Assessments
- Priority areas selected based on:
 - Inclusion in multiple assessments
 - Population impact & costs
 - Effect on quality/length of life
 - Feasibility of interventions
 - Comparison to national benchmarks
- 155 attendees ranked issues by magnitude, severity, and intervention effectiveness
- Hanlon Method used to identify top 4 priorities
- Results will guide the 2026–2031 Community Health Improvement Plan (CHIP)

2026-2031 Community Health Priorities

1

ACCESS TO CARE

2

CHRONIC DISEASE

3

PUBLIC HEALTH FUNDING

4

SUBSTANCE USE

What is the CHIP?

The purpose of the CHIP is to serve as a community-driven blueprint informed by data from the Community Health Assessment (CHA). It outlines shared goals, strategies, and actions to improve population health, reduce health inequities, and coordinate efforts across community partners. The four priority areas were selected through a large, community-wide prioritization meeting and provide direction for the work moving forward. Southern Nevada Health District (SNHD) serves as the primary coordinator of the planning process by convening partners and facilitating collaboration; however, it is not the sole lead for implementing each initiative, though it may serve as the lead in areas where appropriate.

Mission, Vision, and Values

Each priority workgroup developed its own mission, vision, and values statements to reflect the unique focus of its area. Together, these individual statements were integrated into the overall mission, vision, and values below, which represent the shared commitment and guiding principles of the CHIP Steering Committee.

Mission

To improve health and quality of life in Southern Nevada by strengthening access to quality healthcare, reducing the burden of chronic disease, addressing substance use through prevention and recovery support, and advancing sustainable public health funding through community collaboration.

Vision

A healthier, safer, and more resilient Southern Nevada where all people have equitable access to care, prevention resources, and supportive services that empower individuals and communities to thrive.

Values

Southern Nevada's Community Health Improvement Plan is guided by:



EQUITY
Ensuring fair access to care and resources for all populations

COLLABORATION

Building strong partnerships to drive shared solutions



COMPASSION
Supporting individuals with dignity, respect, and understanding

PREVENTION

Prioritizing early intervention, education, and wellness



SUSTAINABILITY
Strengthening long-term public health funding and systems

INNOVATION

Using evidence-based and creative approaches to improve outcomes



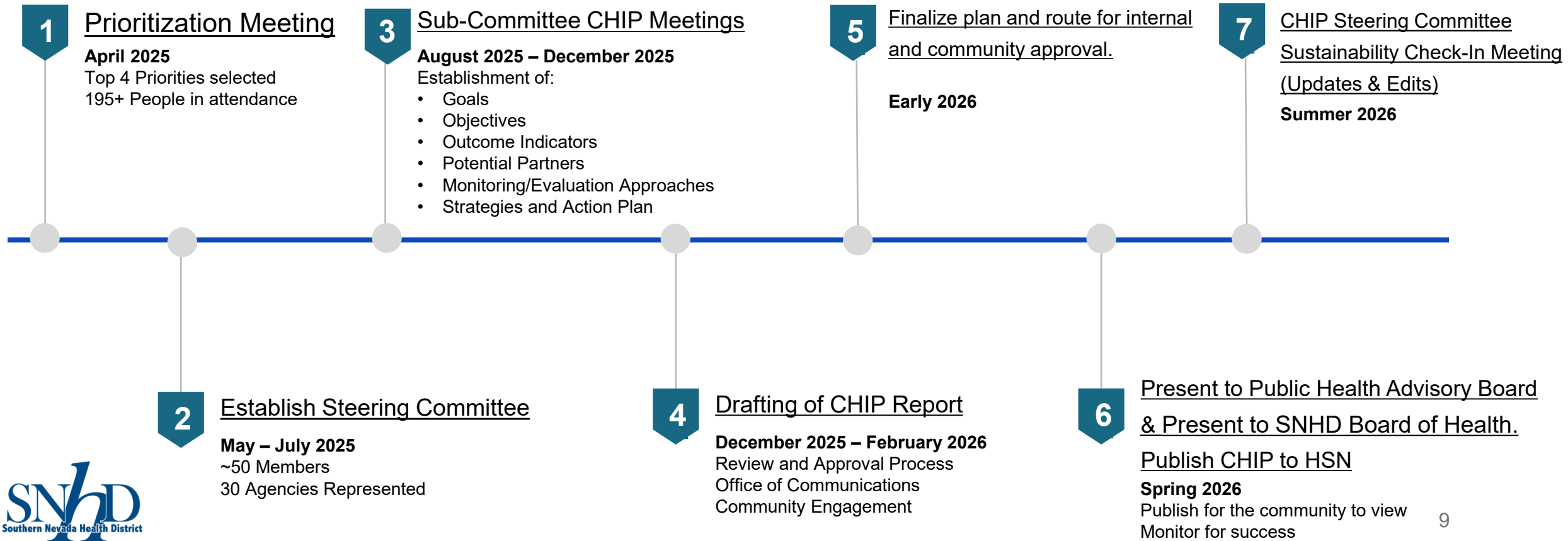
ACCOUNTABILITY
Promoting transparency and data-driven decision-making

RECOVERY SUPPORT

Recognizing recovery as possible and supporting lifelong well-being



2026-2031 CHIP Process Timeline



Steering Committee & Workgroups

Chronic Disease

Co-Chairs

Amineh Harvey
Angel Garcia-Saavedra

Collaborators

Courtney Taber
Elika Nematian
Jennifer Young
Katy Oestman
Kimberly Pozucek
Malcolm Ahlo
Mateo Marquez
Rayleen Earney
Samantha Bojorquez
William Bendik

Access to Care

Co-Chairs

Julie Tousa
Ian Imperial

Collaborators

Amy Levin
Gwendolyn Greene
Holly Lyman
Laura Sida
Regina De Rosa
Siddharth Raich
Tamera Travis
Will Rucker
Xavier Foster

Public Health Funding

Co-Chairs

Emma Rodriguez
Amanda Brown

Collaborators

Eileen Colen
Liz Morris
Marcia Blake
Rich Hazeltine
Ryan Kelsch
Tina Dortch
Trinh Dang-Mai
Xurong Liu

Substance Use

Co-Chairs

Jessica Johnson
Jamie Ross

Collaborators

Bethany De Los Reyes
Charles Winston
Chris Reynolds
Jeremiah Zablon
Jose Partida Corona
Liz Morris
Rebecca Cruz-Nanez
Ron Schnese
Sherra McGowan
Toluwanimi Babarinde

Contributing Organizations

Alzheimer's Association
Anthem Nevada Medicaid
City of Henderson
Comagine

Daybreak Consulting
Dignity Health
Foundation for Recovery
Helping Hand of Vegas Valley
Intermountain Health
NAMI Southern Nevada
YMCA of Southern Nevada

Nevada Homeless Alliance
Nevada Office of Minority Health
and Equity
PACT Coalition
Partida Corona Medical Center
Renaissance Behavioral Health
University of Nevada, Reno
Extension

Regional Transportation Commission
of Southern Nevada
Select Health
Southern Nevada Health District
Southern Nevada Health Consortium
The Center
Three Square
University of Nevada, Las Vegas



Selected Priorities



ACCESS TO CARE

Access to care refers to the ability of individuals to obtain the health services they need—when they need them—without barriers. This includes having affordable, timely, and culturally appropriate medical, mental health, and preventive services available in one’s community. Access to care is essential for preventing disease, managing chronic conditions, and improving overall health outcomes. Without timely and affordable care, people are more likely to experience worsened health, avoidable hospitalizations, and increased health disparities, especially in underserved populations.



CHRONIC DISEASE

Chronic diseases are long-term health conditions that typically progress slowly and persist over time, often for the rest of a person’s life. Common examples include heart disease, diabetes, and cancer—many of which are influenced by lifestyle factors like diet, physical activity, and tobacco use. Chronic diseases are a leading cause of death, and prioritizing them allows for prevention, early detection, and management. Focusing on chronic disease can improve health outcomes and extend life expectancy across populations.



PUBLIC HEALTH FUNDING

Public health funding is the financial support provided by governments, organizations, or institutions to protect and improve the health of communities. It supports different programs and services such as disease prevention, health education, emergency, preparedness, and access to care—which aim to reduce health risks and improve population well-being. Adequate funding supports essential services, preparedness and response, and health equity efforts targeting underserved and at-risk populations. Investing in public health infrastructure strengthens community health and resilience.



SUBSTANCE USE

Substance use refers to the use of drugs or alcohol, whether occasional, regular, or problematic. While some use may be moderate, misuse can lead to serious health issues, including addiction, mental health challenges, and overdose. Substance use is an important community health issue because it affects not only individuals, but also families, public safety, and local resources. Addressing it through prevention, treatment, and support helps create a healthier, safer, and more resilient community.

Access to Care

Goals & Objectives

Goal 1 Improve Access to Reliable Transportation Infrastructure

Objective 1.1: Mobility-Dependent Populations

By December 2031, decrease transportation wait-list times for lower-income residents, individuals with disabilities, and refugees in high-need ZIP codes by expanding enrollment in transportation assistance programs and improving coordination.

Objective 1.2: Public Transportation-Dependent Populations

By December 2031, increase capacity and access in transportation programs (RTC vouchers, Dignity Health referrals) among older adult residents and public transit-reliant populations through tracking utilization, addressing policy barriers, and including senior and mobility-impaired voices.

Objective 1.3: Households With Limited or No Vehicles

By December 2031, expand transportation outreach for households without vehicles, increasing successful service linkages through refugee organization partnerships and multilingual outreach. Limited mobility independence, those relying on accessible transportation, and zero-vehicle households.

Goal 2 Strengthen Healthcare Provider Support During Credentialing

Objective 2.1: Reduce Credentialing Delays

By December 2031, reduce provider credentialing processing time from 90+ days to 30 days by collaborating with Medicaid, Managed Care Organizations (MCOs), and Health Care Finance to streamline workflows and revise policies.

Objective 2.2: Support Underserved Patient Access

By December 2031, increase the number of credentialed providers serving underserved patients through assistance with applications and removal of administrative barriers.

Goal 3 Increase Knowledge and Diversify Community Resource Information Distribution

Objective 3.1: Expand Community Resource Engagement

By December 2031, Access to Care CHIP Workgroup organization representatives will attend at least 25 events per year to promote resource access and track referrals.

Objective 3.2: Diversify Outreach Methods and Improve Community Insight

By December 2031, introduce at least five new outreach strategies (translated materials, digital tools, social media, text systems, pop-up booths) to increase resource access.

Chronic Disease

Goals & Objectives

Goal 1

Decrease the prevalence of cardiovascular disease among African Americans/Hispanic 35+ (prevention) and Older Adults 65+ (management)

Goal 2

Decrease the prevalence of diabetes among adults 18+, African American, Hispanics, living in underserved areas in Clark County.

Objective 1.1:

By Spring 2027, increase referrals to organizations providing Chronic Disease Self-Management Education (CDSME).

Objective 1.2: Promote Get Healthy Clark County resource guide

By June 30, 2027, increase the utilization of the Office of Chronic Disease Prevention and Health Promotion's (OCDPHP) Health and Wellness resource guide among African American and Hispanic adults 35+ and older adults 65+ by promoting the guide at a minimum of 10 community-based locations annually.

Objective 2.1: Diabetes prevention & management enrollment

By December 31, 2031, increase enrollment of priority-population residents into diabetes prevention and diabetes self-management programs (e.g., Diabetes Prevention Program (DPP), (Diabetes Self-Management Education (DSME), Prediabetes 101 classes, Mind, Exercise, Nutrition, Do-It! (MEND), Build Healthy Families) by 20%, using a baseline established by June 30, 2027, through program review.

Objective 2.2: Provider-driven referrals & culturally responsive navigation

By December 31, 2028, increase provider-initiated referrals to diabetes programs for the priority population by implementing referral workflows with Primary Care Physicians (PCP), CHWs, and community partners (including Intermountain, UNLV School of Medicine, and SNHD), and providing culturally responsive navigation support.

Objective 2.3: Referrals to DPP/DSME & related programs

By December 31, 2031, increase annual referrals of African American and Hispanic adults 35+ and older adults 65+ to evidence-based cardiovascular and diabetes prevention/management programs (including DPP, DSME, Pathways Programs, and Comagine Compass-tracked programs) by at least 25%, based on a baseline established through audits completed by June 30, 2027.

Chronic Disease Cont'd

Goals & Objectives

Goal 3

Strengthening communication and collaboration among organizations that serve residents experiencing chronic diseases (especially cardiovascular disease and diabetes).

Objective 3.1: Cross-promotion of listservs

By December 31, 2027, establish a shared cross-promotion system among at least 10 chronic disease service organizations by linking and promoting one another's listservs.

Objective 3.2: Vendor & community event promotion

By June 30, 2027, establish a collaborative vendor-sharing and event-promotion system to ensure that at least 30 diabetes and cardiovascular disease service providers receive timely notifications about community events (including the Diabetes & Heart Disease Block Party), vendor opportunities, and free/low-cost community classes such as "With Every Heartbeat There's Life."

Objective 3.3: Community of Practice

By September 30, 2026, establish a Chronic Disease Community of Practice that convenes quarterly, with a baseline of membership and collaboration indicators established by March 2027, to strengthen coordination among providers and increase shared resources and best practices.



Public Health Funding

Goals

Goal 1

Increase, maintain, or optimize existing public health resources to support the ongoing implementation, monitoring, and community engagement efforts of the CHIP.

Objective 1.1:

By December 2031, collaborate with community partners to conduct a comprehensive landscape and market analysis to identify existing funding streams, funding gaps, or emerging opportunities across Access to Care, Chronic Disease and Substance Use.

Objective 1.2:

By December 2031, develop, publish, and annually update a Funding Resource Toolkit that consolidates grant-writing resources, state match opportunities, and funding opportunities relevant to Access to Care, Chronic Disease, and Substance Use.

Objective 1.3:

By December 2031, design and implement a matchmaking system that identifies partner capabilities, aligns complementary strengths across organizations, and facilitates teaming for funding opportunities in Access to Care, Chronic Disease, and Substance Use.

Goal 2

Maintain or increase sustainable public health funding to support and strengthen public health capacity and social determinants of health in Southern Nevada.

Objective 2.1:

By December 2031, maintain state per-capita public health funding and pursue increases to strengthen public health capacity in Southern Nevada.



Substance Use

Goals

Goal 1

Expand and improve access to evidence-based prevention programs for pre-K to 24-year-olds who live in Clark County

Objective 1.1

By December 2031, conduct a countywide community landscape analysis of prevention programming in Clark County K-12 schools and use findings to expand evidence-based programs to at least 10 more schools.

Objective 1.2

By December 2031, implement training for at least 200 teachers, counselors, and primary care providers on risk factors for substance use/mental health concerns and on referral pathways, resulting in an increase in early referrals to school or community services.

Objective 1.3

By December 2031, increase access to substance use prevention programming for Clark County college students by adding or enhancing prevention services at a minimum of two higher-education campuses.

Goal 2

Reduce Clark County overdose deaths through prevention and education

Objective 2.1

By December 2031, expand naloxone availability to at least 50 easy-to-access community locations (e.g., libraries, rec centers, cultural centers, nonprofits, etc.)

Objective 2.2

December 2031, engage 5,000 residents and educate 1,000 staff at community sites on overdose response, naloxone use, or stigma reduction in identified high-risk ZIP codes.

Objective 2.3

Complete a review of current state laws, propose at least one policy recommendation by 2027.



Substance Use Cont'd

Goals

Goal 3

Improve access to substance use treatment and care for people who live in Clark County

Objective 3.1

By December 2031, increase Clark County's detox and treatment capacity, including stimulant use disorder treatment at carceral settings, community settings, and medical/hospital settings.

Objective 3.2

By December 2031, ensure that 75% of substance use treatment programs routinely offer or refer for Human Immunodeficiency Virus (HIV)/ Hepatitis C virus (HCV)/ Sexually transmitted infections (STIs) testing.

Objective 3.3

By December 2031, eliminate Medicaid prior authorization for buprenorphine and increase the number of pharmacies and clinics offering MOUD, supported by a public directory of dispensing locations.

Goal 4

Address mental health and substance use disorder intersections for people of Clark County

Objective 4.1

By December 2031, increase awareness for people who live in Clark County to know when and how to use 988 through a countywide, multilingual awareness campaign, a peer-to-peer text campaign, and/or a targeted narrow-cast campaign in high-need community locations.

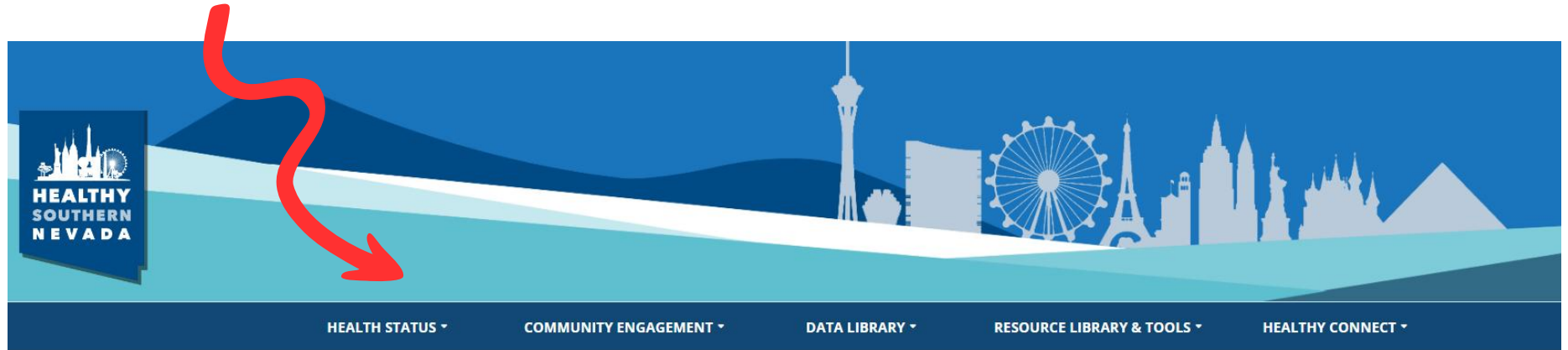
Objective 4.2

By December 2031, increase awareness of existing trauma-informed and co-occurring disorder response training and support access to the training for at least 500 Clark County first responders, including law enforcement, Emergency Medical Technicians (EMTs), fire personnel, healthcare workers, and Community Health Workers (CHWs).



CHA/CHIP Reports and Tracking

www.HealthySouthernNevada.org



Next Steps

01

Join the
Implementation
Workplan Group!



02

Stay Tuned: Final
CHIP report
release date - Early
June 2026

03

Implement Action
Plan, Provide
Progress Updates &
Tracking on HSN
Website Dashboard

THANK YOU
to everyone involved!



Acknowledgements

The Southern Nevada Community Health Improvement Plan (CHIP) was developed through the dedication and collaboration of numerous agencies, service providers, and community partners committed to improving health outcomes across the region. Through a coordinated workgroup process, participants identified priority health issues, assessed gaps in existing programs and policies, reviewed evidence-based practices, and developed strategies aimed at advancing health equity and strengthening community systems. The Southern Nevada Health District extends sincere appreciation to all members of the CHIP Steering Committee for their time, expertise, and leadership. We would like to recognize these individuals and thank them for their dedication to this process.

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Steering Committee by Workgroup

Chronic Disease

Co-Chairs
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Angel Garcia-Saavedra

Collaborators

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Jennifer Young
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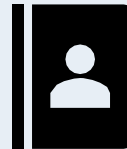
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Select Health
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Southern Nevada Health Consortium
The Center
Three Square
University of Nevada, Las Vegas
University of Nevada, Reno Extension
YMCA of Southern Nevada

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Dr. Anilkumar Mangla
Victoria Burris
Southern Nevada District Board of Health
SNHD Public Health Advisory Board

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