

## County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

# 2024 Southern Nevada County Health Rankings & Roadmaps

Wednesday, March 20, 2023

9 AM – 11 AM

Virtual - WebEx

*A collaboration between:*



Nevada Department of  
Health and Human Services  
DIVISION OF PUBLIC AND  
BEHAVIORAL HEALTH



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# *Welcome!*

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*Maria Azzarelli, EMHA, CHES*

*Manager, Office of Chronic Disease Prevention and Health Promotion*

*Acting Director Community Health Division*

*Southern Nevada Health District*





# Agenda

## County Health Rankings & Roadmaps

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## Southern Nevada County Health Rankings



Location: Virtual; WebEx

(<https://snhd.webex.com/snhd/j.php?MTID=mf6168cb168213cce474c47ea56dbfe28>)

Date: Wednesday, March 20, 2024

Time: 9:00 – 11:00 AM

### Agenda Items:

9:00 AM – 9:05 AM	Welcome & Opening Remarks Maria Azzarelli, EMHA, CHES, Manager, Office of Chronic Disease Prevention and Health Promotion, Acting Director Community Health Division, Southern Nevada Health District
9:05 AM – 9:30 AM	County Health Rankings Data & Interpretations John Packham, PhD, Associate Dean Office of Statewide Initiatives, University of Nevada, Reno School of Medicine
9:30 AM – 9:45 AM	Update on Southern Nevada Health District Community Health Improvement Plan Carmen Hua, MPH, CHES, Health Educator, CHA/CHIP Coordinator, Division of Disease Surveillance & Control, Southern Nevada Health District
9:45 AM – 10:00 AM	Overcoming Barriers and Building a Better Future: Enhancing Access to Care through the Deflection Program in Nye, Esmeralda, and Lincoln Counties DJ Mills, Director of Mental Health and Deflection Programs, Nye Communities Coalition
10:00 AM – 10:15 AM	Combating Heart Disease in the Heart of the Community Amineh Harvey, MPH, Health Educator, Office of Chronic Disease Prevention and Health Promotion, Southern Nevada Health District
10:15 AM – 10:30 AM	RTC of Southern Nevada: Programs & Initiatives Daniel Fazekas, Manager of Transportation Planning, Regional Transportation Commission (RTC) of Southern Nevada
10:30 AM – 10:50 AM	From Analysis to Action: Strategies for Chronic Disease Prevention Benjamin Ashraf, PhD, MPH, CHES, Epidemiologist, Department of Epidemiology, Southern Nevada Health District Brandon Delise, MPH, Senior Epidemiologist, Department of Epidemiology, Southern Nevada Health District
10:50 AM – 11:00 AM	Questions & Closing Remarks



Nevada Department of  
Health and Human Services  
IMPROVING PEOPLE AND  
PROTECTING HEALTH



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# 2024 Nevada County Health Rankings and Roadmaps

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**Presented and Prepared by:**

**John Packham, PhD**

Associate Dean, Office of Statewide Initiatives

University of Nevada, Reno School of Medicine

Policy Director, Nevada Public Health Association

March 20, 2023



# County Rankings Project Partners

- Carson City Health and Human Services
- Central Nevada Health District
- Nevada Department of Health and Human Services
- Nevada Public Health Association
- Nevada Public Health Foundation
- Nevada Public Health Institute
- Northern Nevada Public Health
- Office of Statewide Initiatives, UNR School of Medicine
- Robert Wood Johnson Foundation
- Southern Nevada Health District
- UNLV School of Public Health
- UNR School of Public Health
- University of Wisconsin Population Health Institute

# 2024 Measures and Data Sources

**Health Data**

The annual data release provides a revealing snapshot of how health is influenced by where we live, learn, work, and play. The snapshots provide communities a starting point to investigate where to make change.

[Read our 2024 National Findings Report](#)

## Find Data by Location

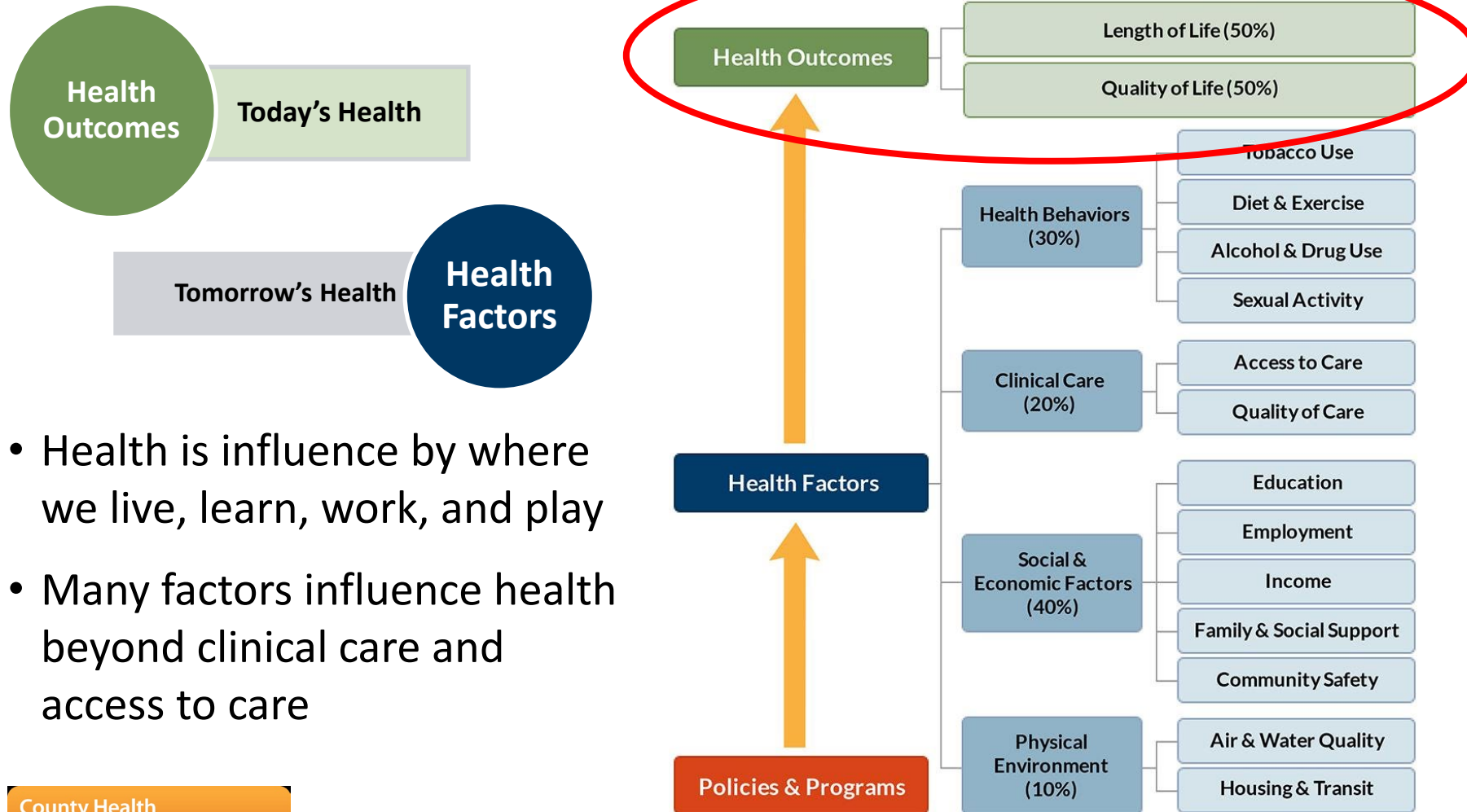
Enter your state, county, or ZIP Code

Search



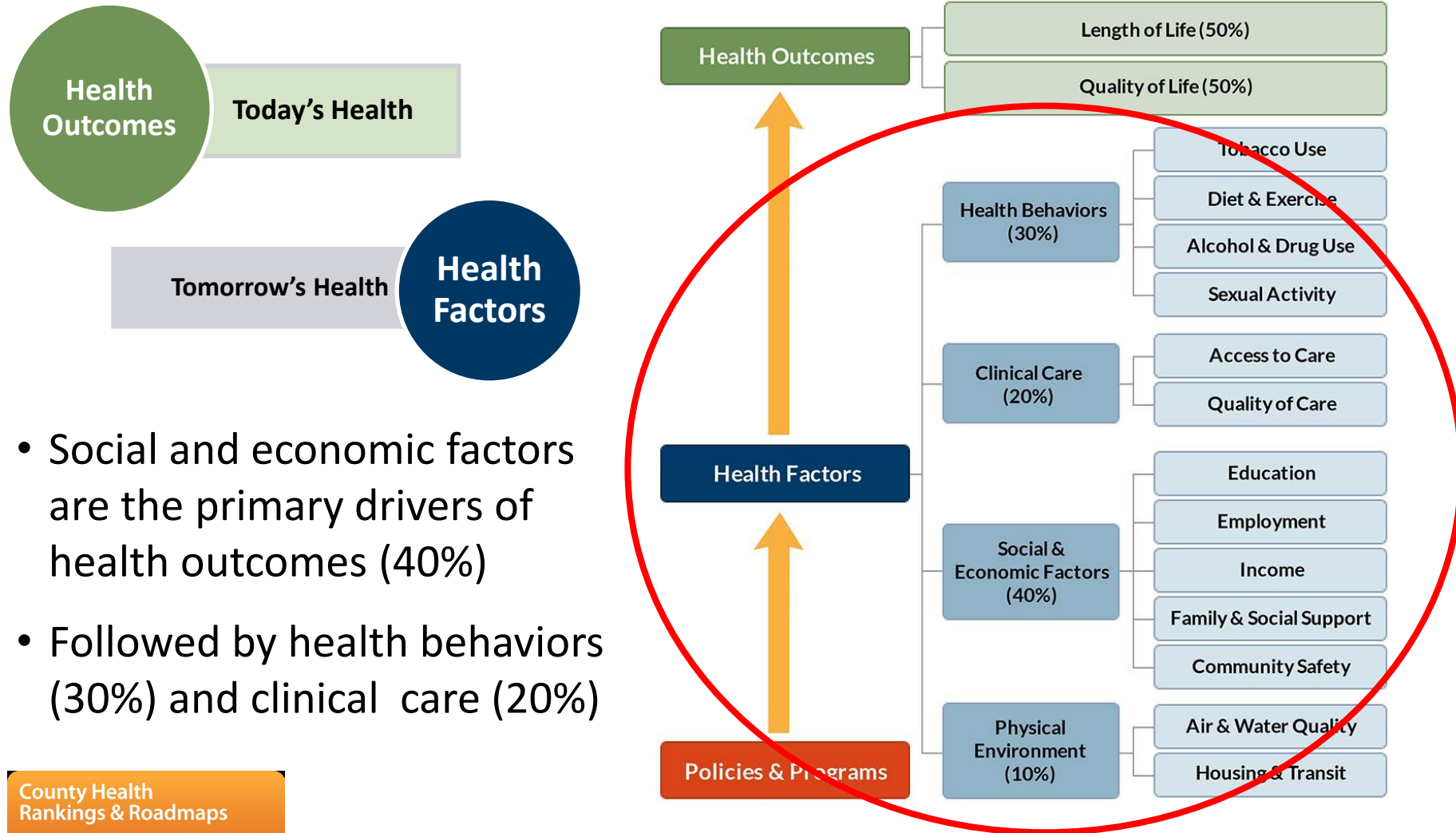
[www.CountyHealthRankings.org](http://www.CountyHealthRankings.org)

# Two Sets of Rankings – Health Outcomes



- Health is influenced by where we live, learn, work, and play
- Many factors influence health beyond clinical care and access to care

# Two Sets of Rankings – Health Factors



- Social and economic factors are the primary drivers of health outcomes (40%)
- Followed by health behaviors (30%) and clinical care (20%)



# 2024 Nevada Health Outcomes Rankings

1. Douglas (1)\*

2. Pershing (2)

3. Washoe (5)

4. Clark (9)

5. White Pine (8)

6. Elko (4)

7. Lyon (8)

8. Lincoln (11)

9. Storey (7)

10. Churchill (6)

11. Carson City (10)

12. Humboldt (3)

13. Eureka (NR)

14. Lander (14)

15. Nye (13)

16. Mineral (15)

Not ranked – Esmeralda

(\*) Ranking in 2010

Note: Eureka County was not ranked in 2010

# 2024 Nevada Health Factors Rankings

1. Douglas (1)\*

2. Storey (2)

3. Washoe (3)

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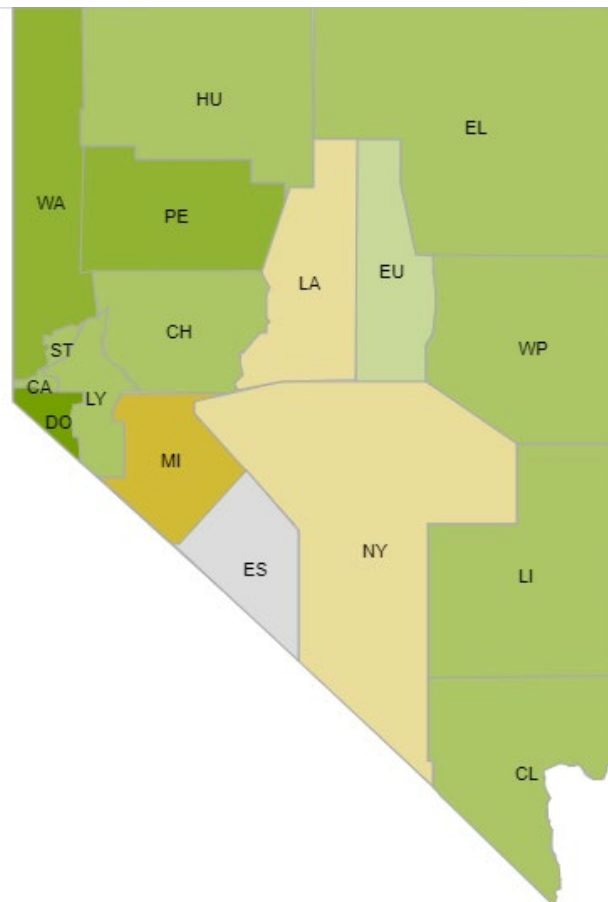
16. Nye (13)

Not ranked – Esmeralda

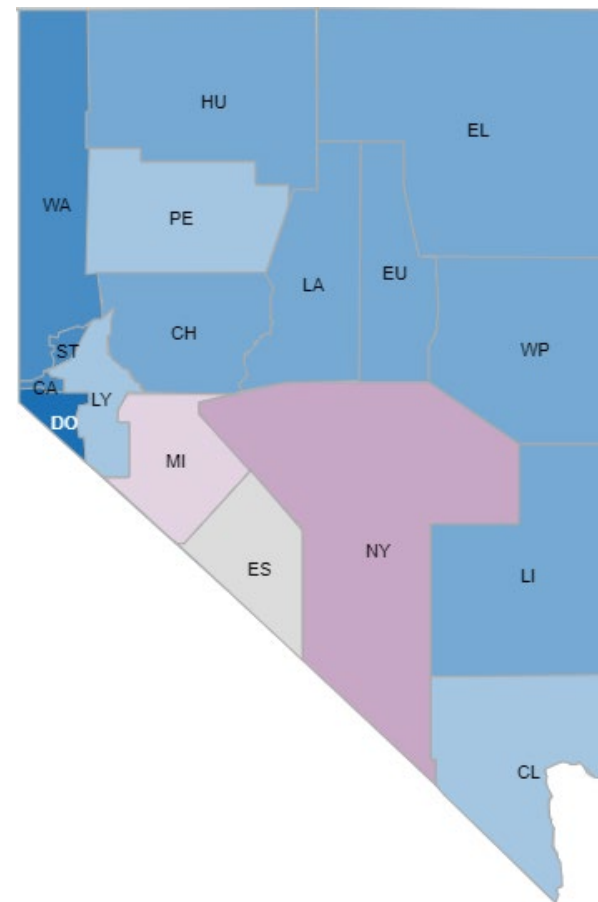
(\*) Ranking in 2010

Note: Eureka County was not ranked in 2010

# Health Outcomes and Factors Rankings – 2024



LEAST HEALTHY IN US HEALTHIEST IN US



LEAST HEALTHY IN US HEALTHIEST IN US

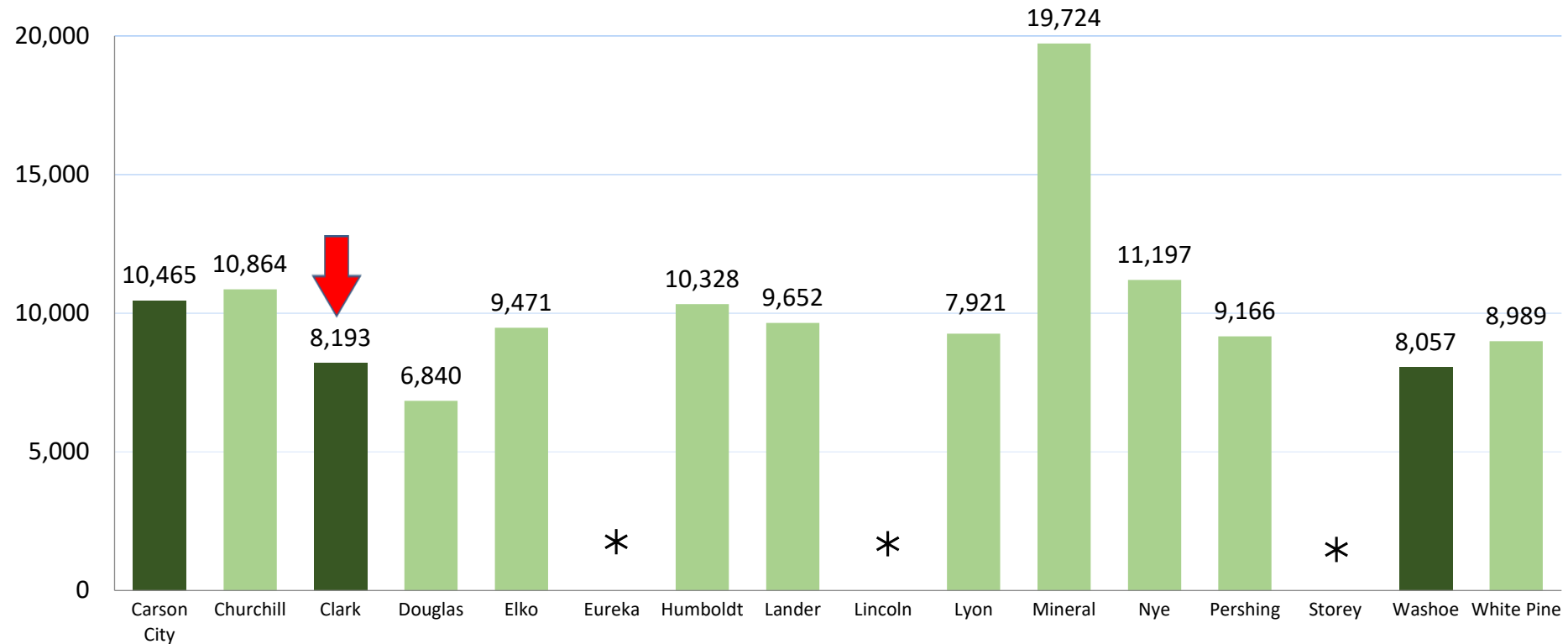
# Health Outcomes – Premature Death

Years of potential life lost before the age of 75 per 100,000 population

US Average = 8,000 years

Nevada Average = 8,317 years

Nevada Range = 6,840 to 19,724 years



Source: National Center for Health Statistics – Mortality Files (2019-2021).

\* = Unreliable data, no estimate provided

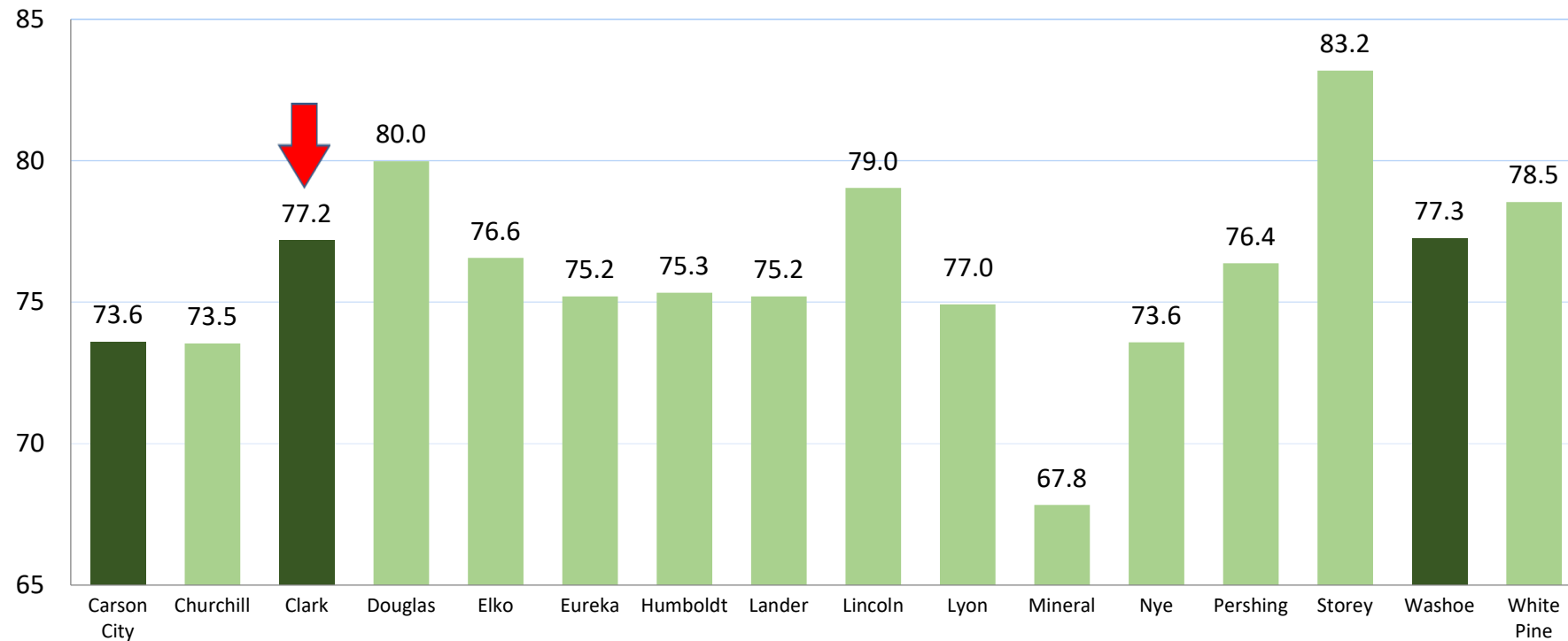
# Health Outcomes – Life Expectancy

Average number of years a person can expect to live

US Average = 78.5 years

Nevada Average = 77.0 years

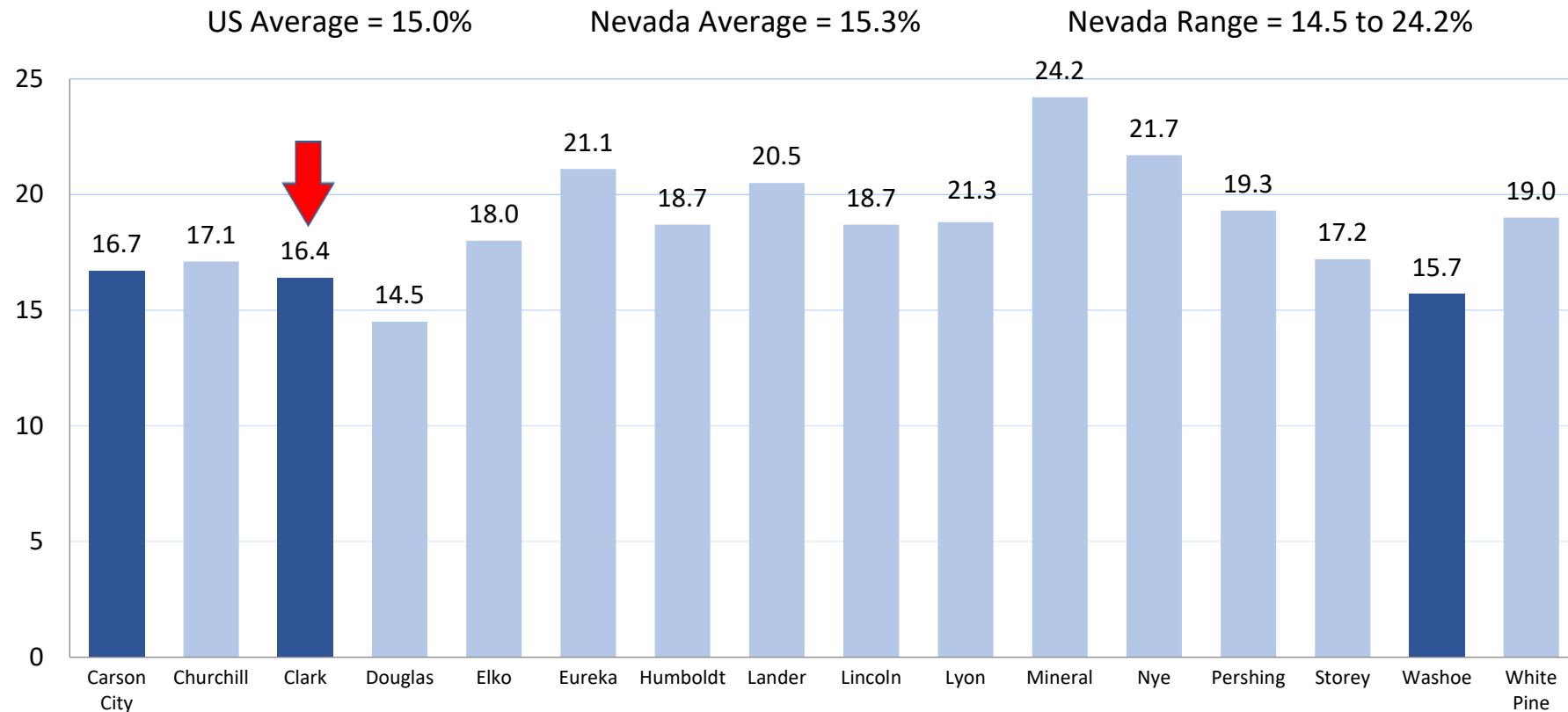
Nevada Range = 67.8 to 83.2 years



Source: National Center for Health Statistics – Mortality Files (2019-2021).

# Health Behaviors – Adult Smoking

Percentage of adults who are current smokers

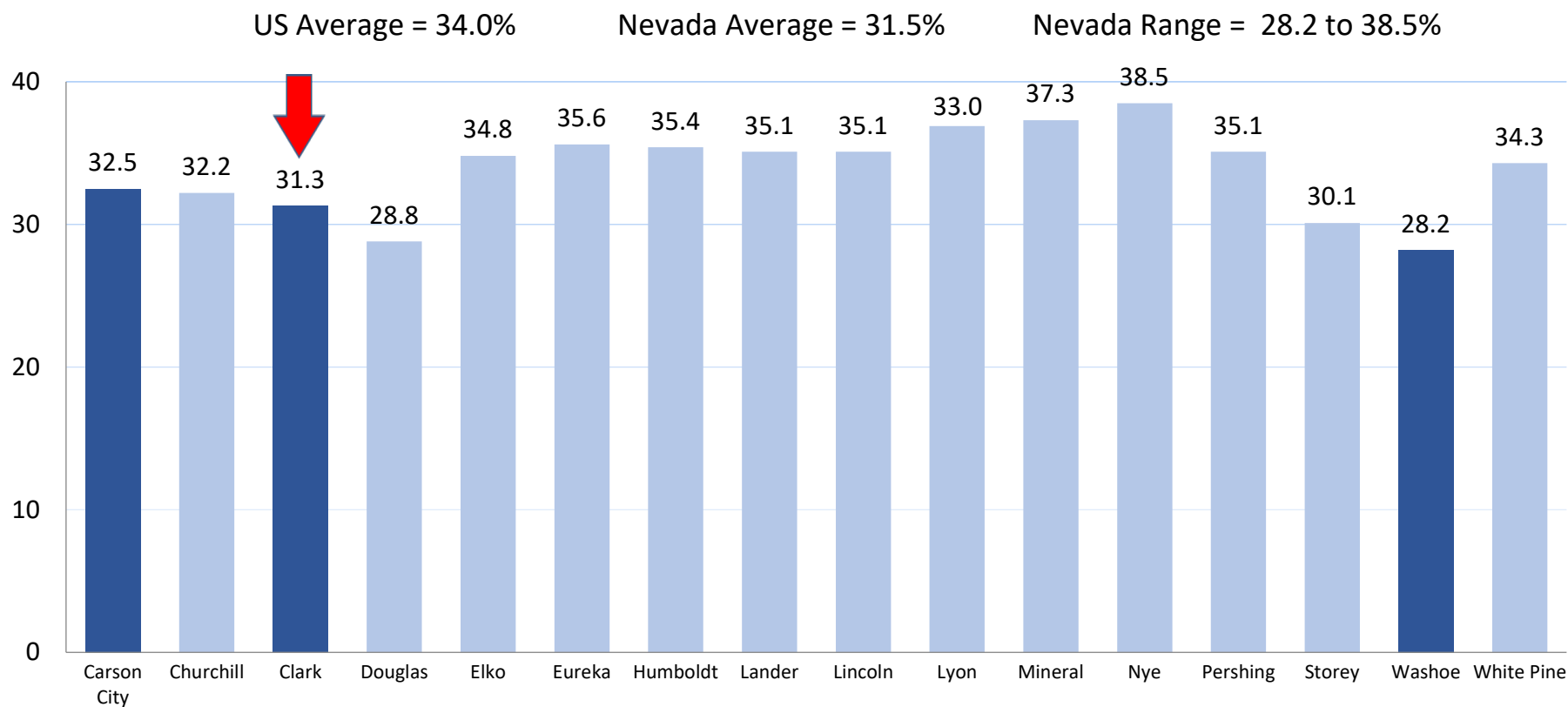


Source: Behavioral Risk Factor Surveillance System (2021).



# Health Behaviors – Adult Obesity

Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m<sup>2</sup>



Source: Behavioral Risk Factor Surveillance System (2021).

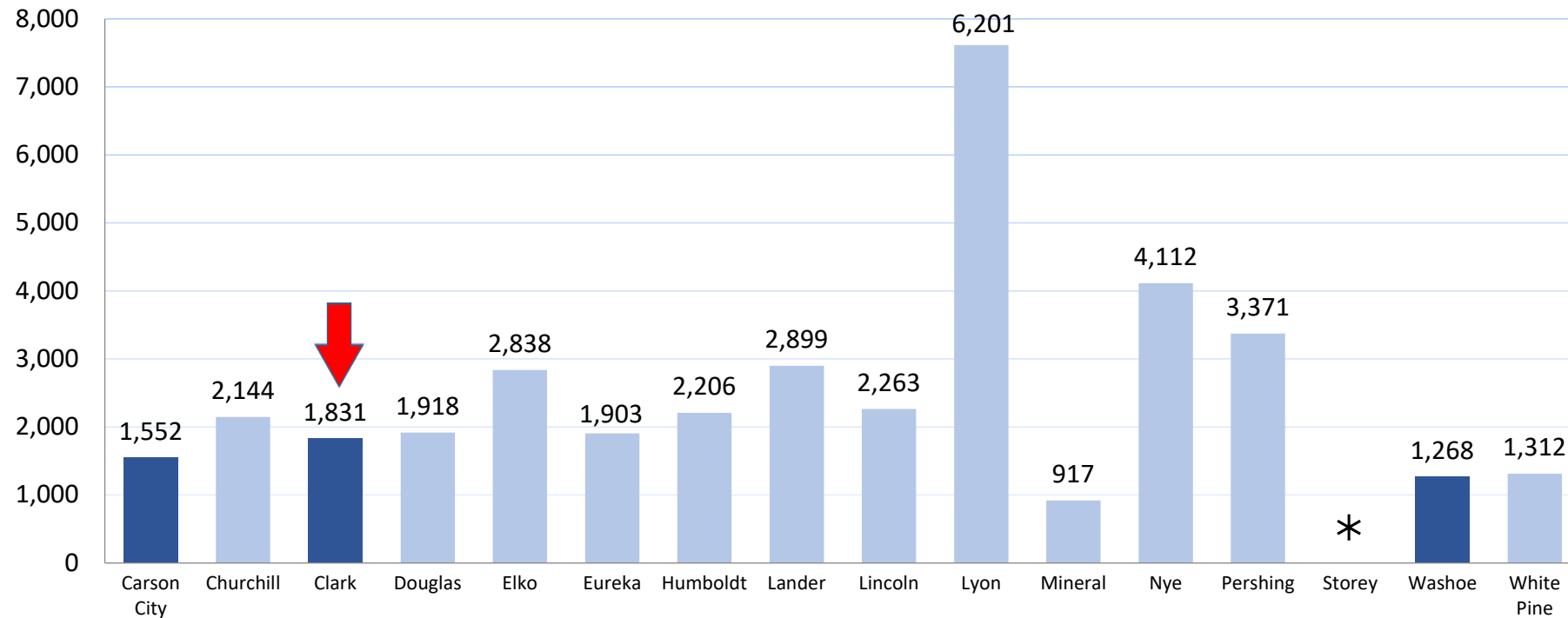
# Clinical Care – Primary Care Physicians

Ratio of population to primary care physicians

US Average = 1,330:1

Nevada Average = 1,763:1

Nevada Range = 904:1 to 6,573:1



Source: Area Health Resource File/American Medical Association (2021).

\* = No primary care physicians in Storey County in 2021

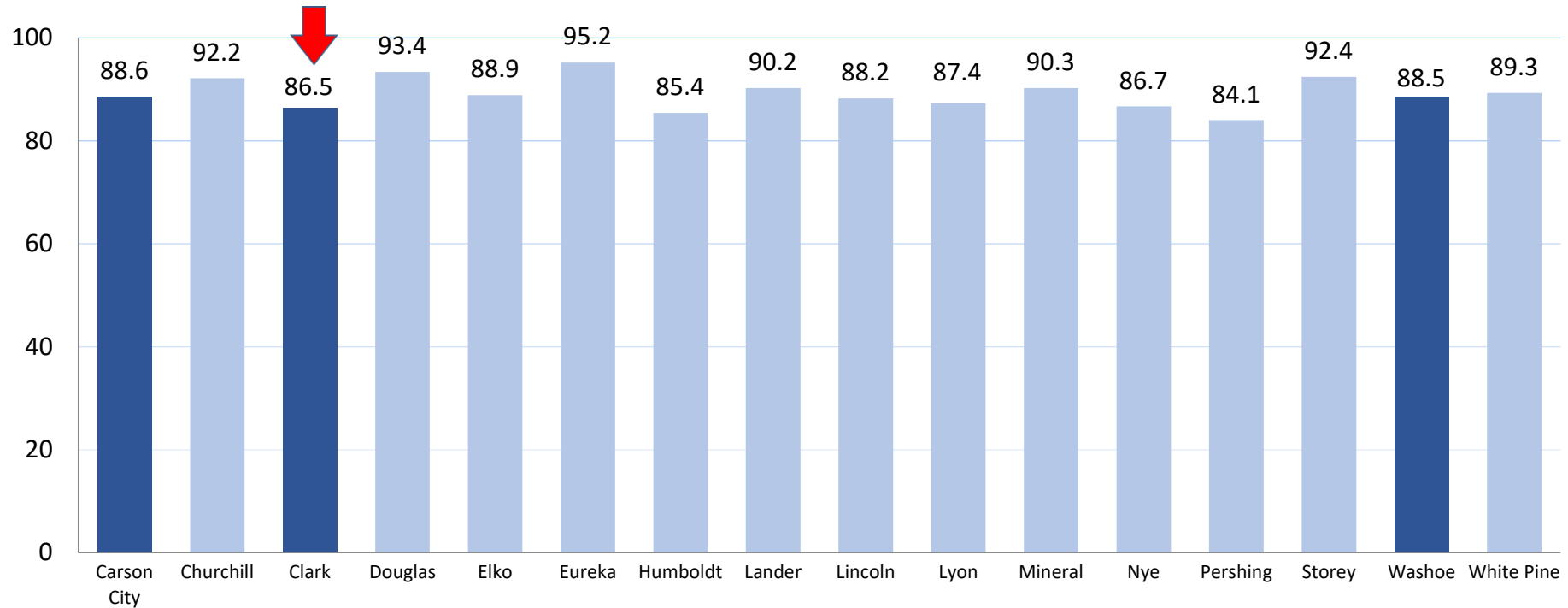
# Social and Economic – High School Completion

Percentage of adults ages 25 and over with a high school diploma or equivalent

US Average = 89.0%

Nevada Average = 87.2%

Nevada Range = 78.1 to 95.2%



Source: American Community Survey, Five-year Estimates (2018-2022)

# Comparisons with Peer Counties

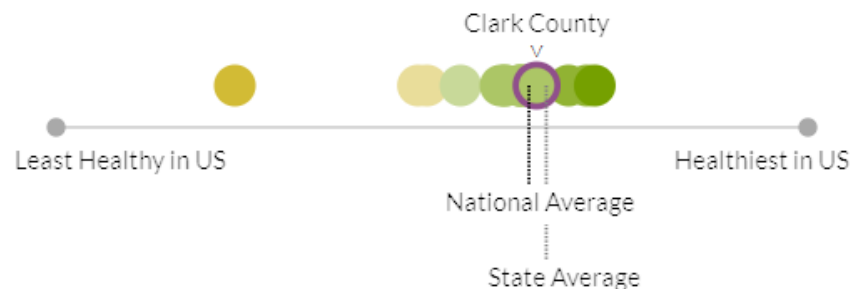
	Clark, NV Remove Location <input type="button" value="x"/>	Salt Lake, UT Remove Location <input type="button" value="x"/>	Oklahoma, OK Remove Location <input type="button" value="x"/>	Maricopa, AZ Remove Location <input type="button" value="x"/>
Health Outcomes				
Length of Life	Clark, NV	Salt Lake, UT	Oklahoma, OK	Maricopa, AZ
Premature Death <input type="button" value="📈"/>	8,200	6,600	10,200	8,000
Quality of Life	Clark, NV	Salt Lake, UT	Oklahoma, OK	Maricopa, AZ
Poor or Fair Health	19%	13%	20%	15%
Poor Physical Health Days	4.3	3.6	3.6	3.4
Poor Mental Health Days	5.5	5.5	5.6	5.2
Low Birthweight	9%	8%	9%	7%
Health Factors				
Health Behaviors	Clark, NV	Salt Lake, UT	Oklahoma, OK	Maricopa, AZ
Adult Smoking	16%	9%	17%	14%
Adult Obesity	31%	31%	38%	31%
Food Environment Index	7.8	8.7	7.6	8.3
Physical Inactivity	25%	19%	28%	22%
Access to Exercise Opportunities	95%	92%	94%	92%
Excessive Drinking	14%	17%	13%	18%

# Clark County 2024 Recap

## Clark County Health Outcomes

Health Outcomes tell us how long people live on average within a community, and how much physical and mental health people experience in a community while they are alive.

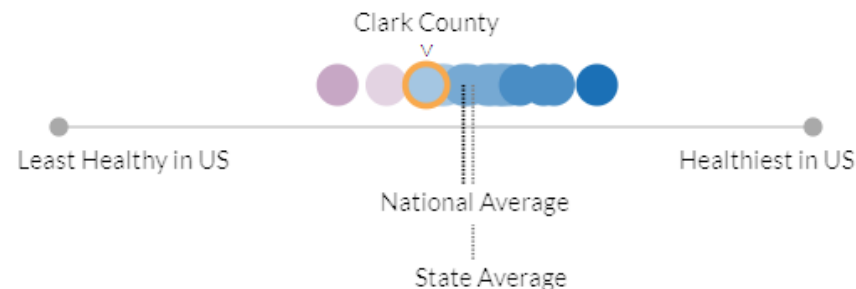
**Clark County is faring worse than the average county in Nevada for Health Outcomes, and about the same as the average county in the nation.**



## Clark County Health Factors

Many things influence how well and how long we live. Health Factors represent those things we can improve to live longer and healthier lives. They are indicators of the future health of our communities.

**Clark County is faring worse than the average county in Nevada for Health Factors, and worse than the average county in the nation.**



County Health  
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# Clark County 2024 Recap

## Areas of Strength

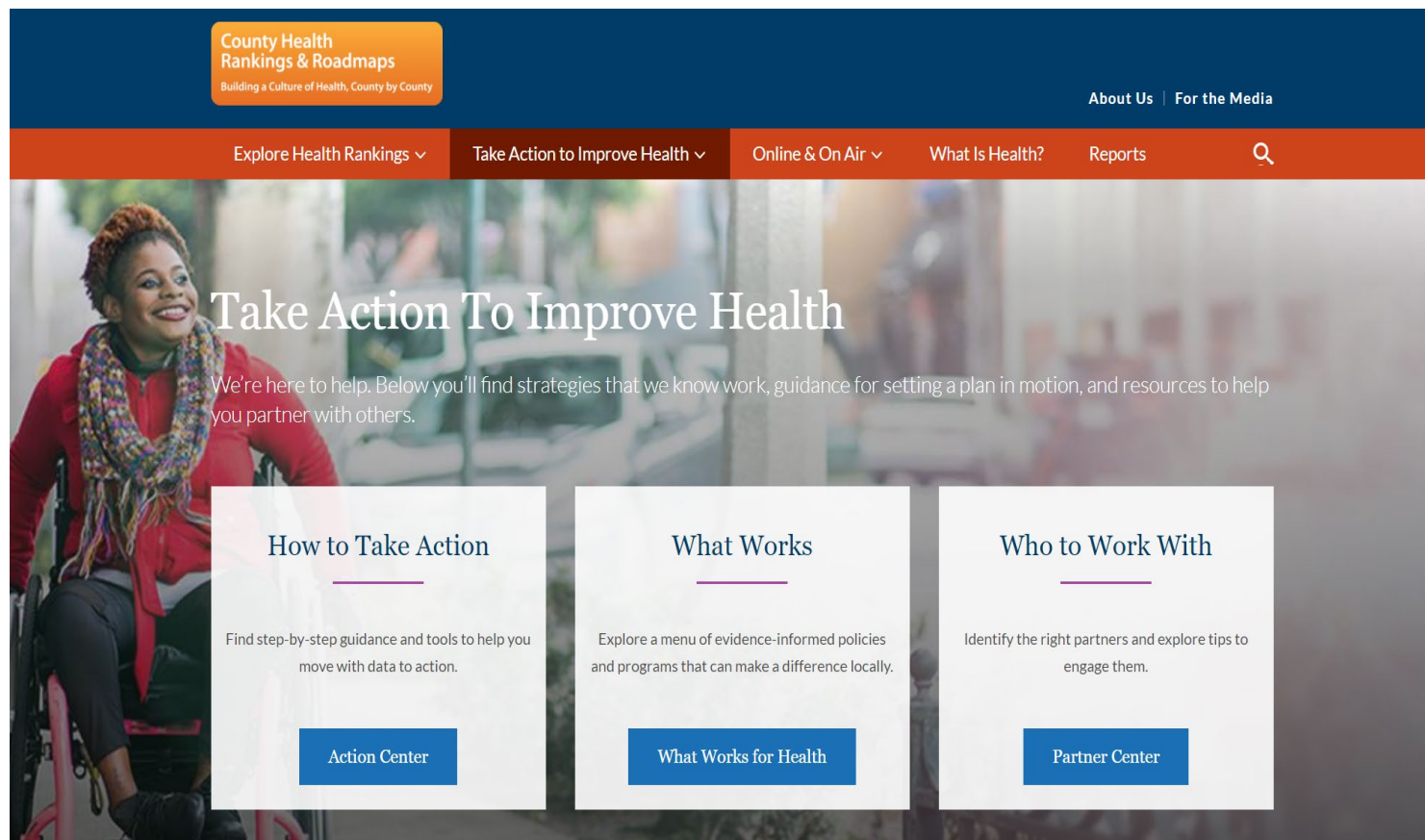
- Premature death estimates
- Access to exercise opportunities
- Injury death rate
- Air pollution – particulate matter
- Population-to-provider ratios

## Opportunities for Improvement

- Sexually transmitted infections
- Mammography screening
- Children in poverty
- Uninsured rate
- Adult obesity
- Flu vaccinations



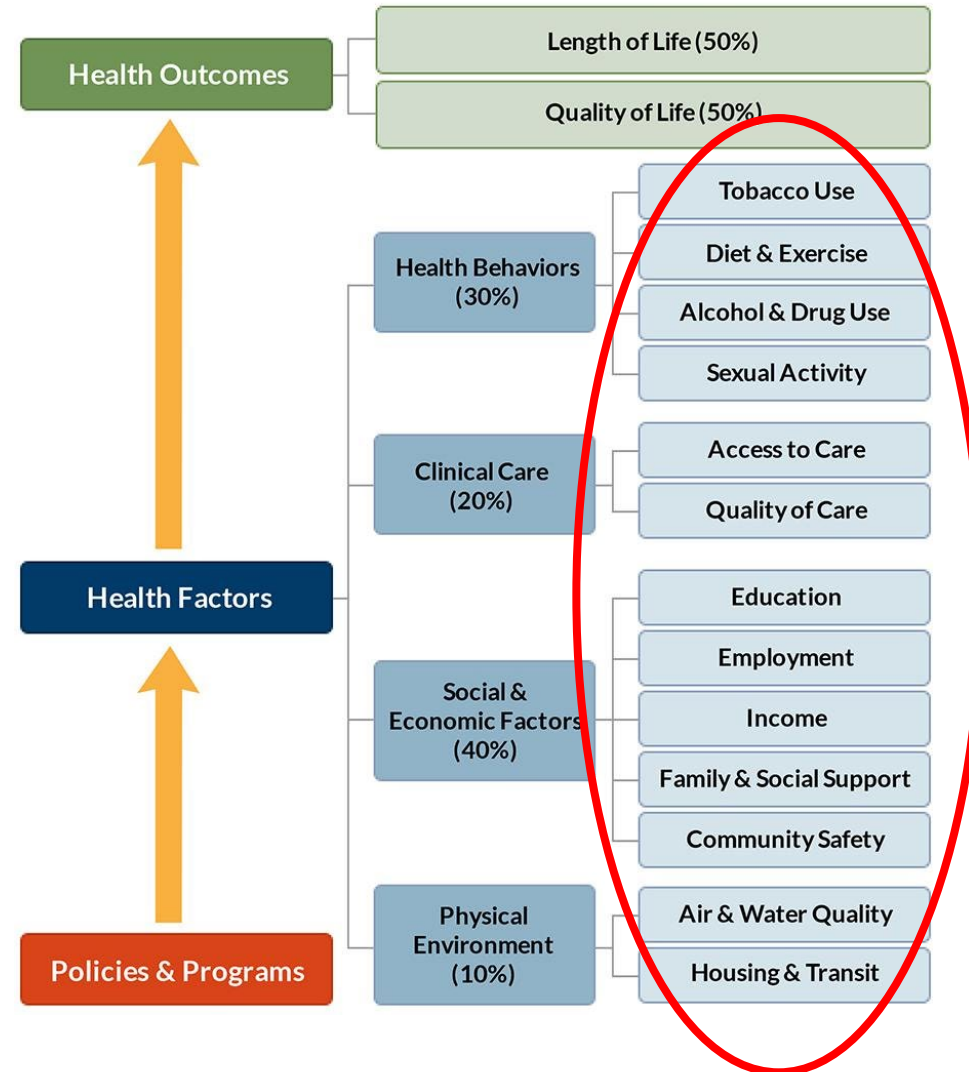
# Policies and Programs to Improve Health



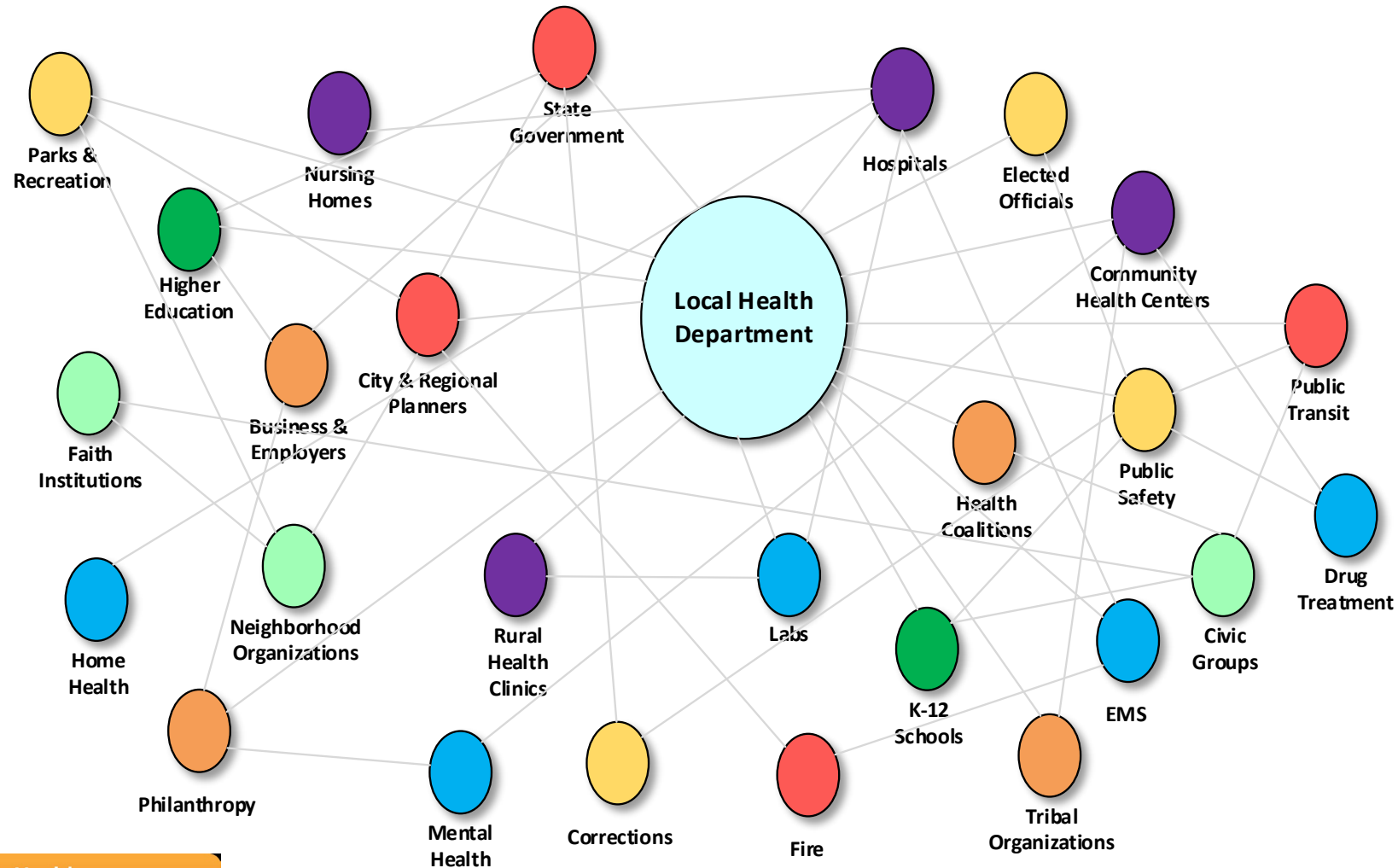
[www.countyhealthrankings.org/take-action-to-improve-health](http://www.countyhealthrankings.org/take-action-to-improve-health)

# Upstream Policies and Strategies to Improve Health

- Tobacco and e-cigarette use
- Food deserts (and swamps)
- Housing and zoning policy
- Transit, complete streets policy
- Injury and violence prevention
- Family and social supports
- Income supports, living wages
- Jobs and employment policy
- Health workforce development



# Public Health System Partners



# Explore the Rankings Data!

## Health Data

The annual data release provides a revealing snapshot of how health is influenced by where we live, learn, work, and play. The snapshots provide communities a starting point to investigate where to make change.

[Read our 2024 National Findings Report](#)

### Find Data by Location

Enter your state, county, or ZIP Code

Search



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



## County Health Rankings & Roadmaps

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# *Update on Community Health Improvement Plan in Southern Nevada*

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*Carmen Hua, MPH, CHES  
Health Educator, CHA/CHIP Coordinator  
Division of Disease Surveillance & Control  
Southern Nevada Health District*



# Overview Outline

## MAPP Framework

- Overview

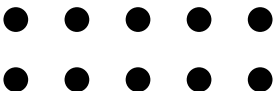
## 2022-2025 Community Health Improvement Plan

- Southern Nevada CHIP Goals
- Healthy Southern Nevada Website
- Healthy Connect

## Priority Area Update

- Chronic Disease
- Access to Care
- Transportation
- Funding

## Next Steps



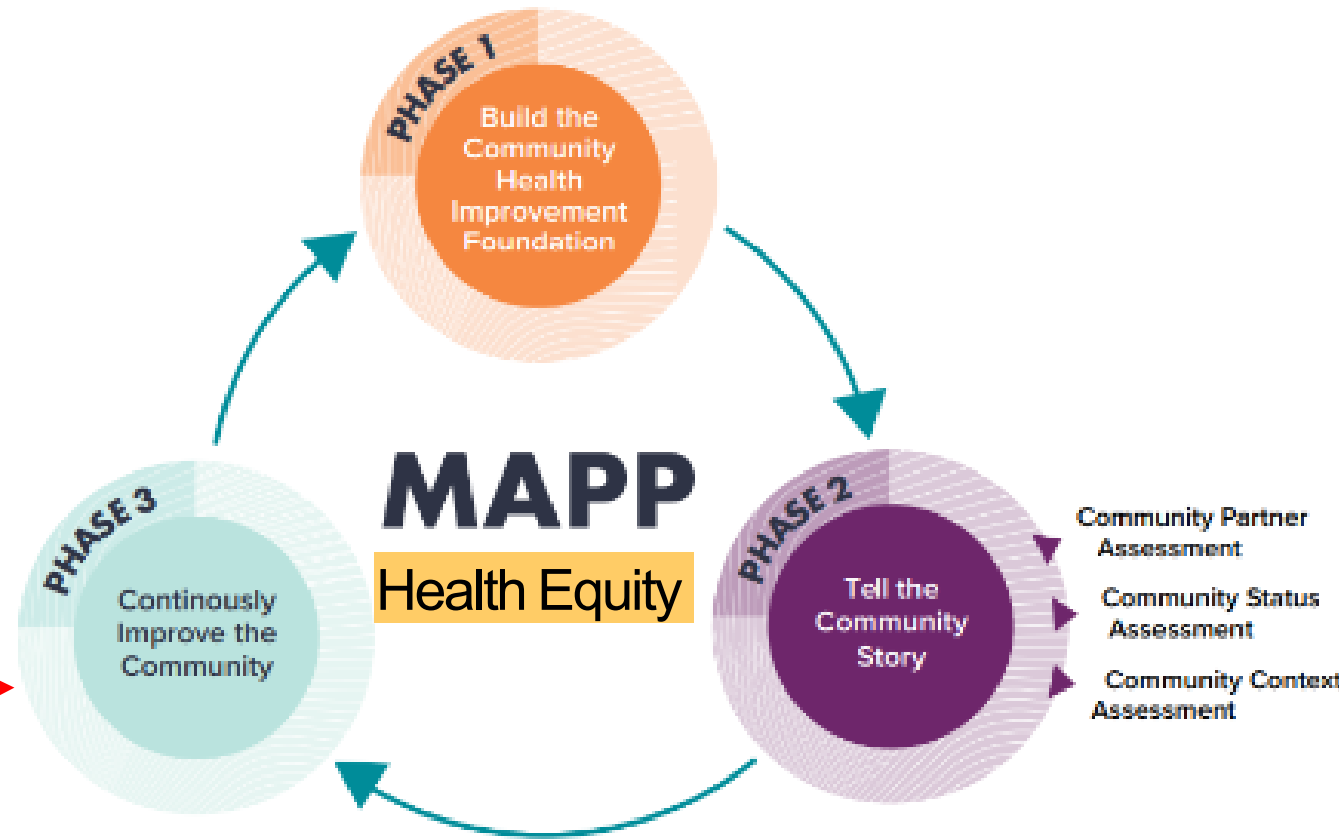
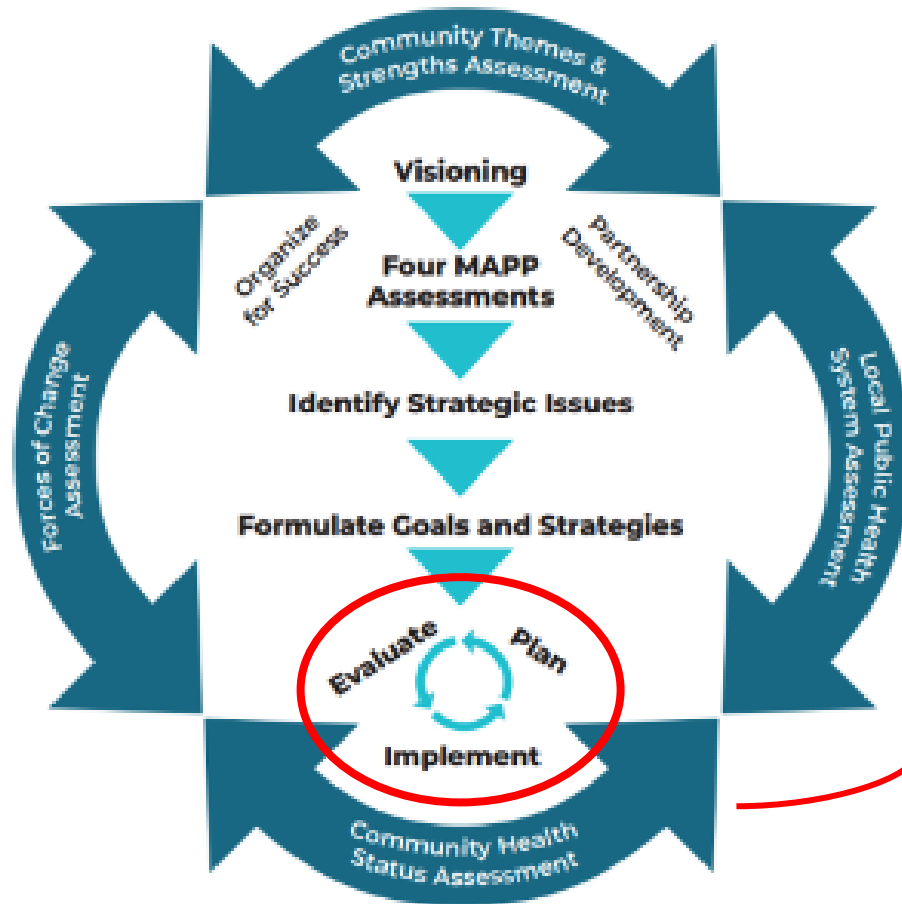


# MAPP 2.0 Framework

2001



2023



# CHIP Goals: Guiding the process



Create an **inclusive community health improvement plan** for Southern Nevada



Ensure and enhance **opportunities for participation of cross-sector stakeholders** to improve community health



**Have a clear roadmap** to collaboratively address inequities while expanding community partnership



**Address root causes** of prioritized health issues and inequities



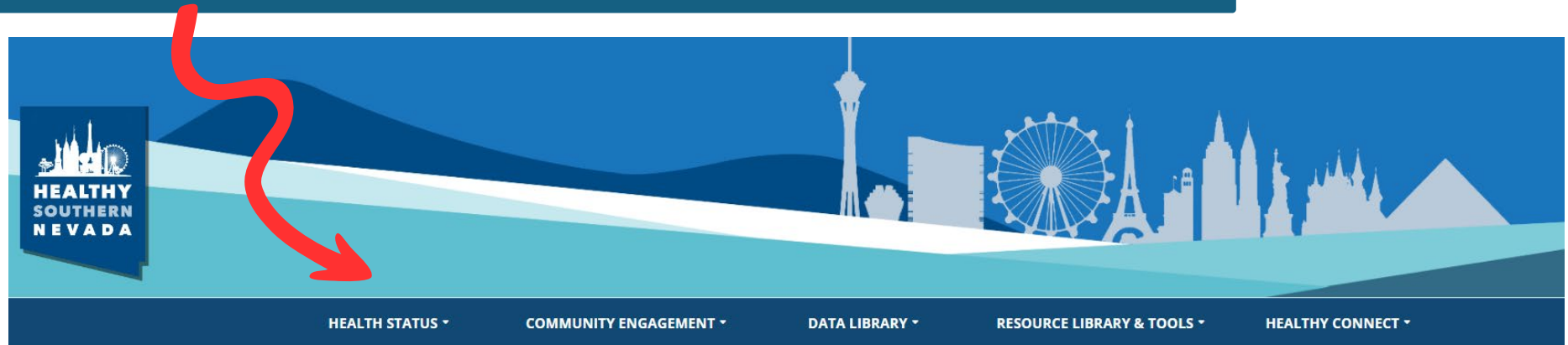
**Utilize data to increase the impact** of strategies



Ensure **CHIP is health-inclusive of health equity** for all populations and making sure no efforts are duplicated

# CHIP Progress Updates

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



## 2022–2025 Southern Nevada Community Health Improvement Plan

**Click here to  
go to the report**





# Healthy Connect Newsletter



## What Is Healthy Connect?

Welcome to the first edition of the Healthy Connect newsletter!

The primary purpose of this newsletter is to inform the community about developments related to the **Community Health Improvement Plan (CHIP)** and keep partners up to date about exciting community partner news and events.

The four priority areas of the CHIP are:  
1) Chronic Disease 2) Access to Care 3) Transportation and 4) Public Health Funding.

The Healthy Connect newsletter will provide quarterly updates on the progression of the CHIP action plan in the community as well as connect community members. Please utilize this platform to feature your important work in the community and connect with others to emphasize that we are "Healthy People in a Healthy Southern Nevada."



WWW.HEALTHYSOUTHERNNEVADA.ORG | HEALTHYCONNECT@SNHD.ORG

Volume 1, Issue 1



## Focus on the Community

Welcome to the second edition of the Healthy Connect newsletter!

We heard your feedback and wanted to highlight community events occurring in Southern Nevada while providing regular updates on the Community Health Improvement Plan.

- A Community Health Improvement Plan Steering Committee meeting was held in August to provide updates on ongoing

progress that has been occurring in the community. [Check out the progress here.](#)

- Access to Care is one of four identified priority areas and recent goals and objectives have focused on the LGBTQ+ community. **October is LGBTQ+ History Month** and we will be highlighting a community organization and their available resources in this edition of our newsletter.



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Volume 1, Issue 2



# Healthy Connect Events Calendar

[HEALTH STATUS ▾](#)[COMMUNITY ENGAGEMENT ▾](#)[DATA LIBRARY ▾](#)[RESOURCE LIBRARY & TOOLS ▾](#)[HEALTHY CONNECT ▾](#)

< August 2023 > + ADD EVENT

Submit your own event  
Or email  
HealthyConnect@SNHD.org

🔍 Search

👤 Sign In

📅 Add To Calendar ▾

📅 Month View ▾

Previous

Categories

Organizers

Tags

Venues

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
				4:00pm UMC Wellness Center Woman's Support Group	10:00am Overdose Prevention Training	
6	7	8	9	10	11	12
				8:00am 2023 Southern NV Substance Misuse and Overdose Prevention Summit	8:00am Special Back-to-School Immunization Clinic	
13	14	15	16	17	18	19
					8:00am Interdisciplinary Symposium on Parkinson's Disease: Research, Innovation, and Technology	
20	21	22	23	24	25	26
			11:30am 988 Suicide & Crisis Lifeline Workshop Lunch & Learn	10:00am Free Workshop: Identifying & Coping with PTSD 5:00pm Veterans Advocacy Council Monthly Community Coalition Meeting		
27	28	29	30	31		
				4:00pm International Overdose Awareness Day Event		



# 2022-2025 Priority Areas

## Southern Nevada Community Values

- ✓ Community Engagement
- ✓ Health
- ✓ Education
- ✓ Environment

## 2022-2025 CHIP Priority Areas

### Priority Area 1: Chronic Disease



The CHIP chronic disease subcommittee recognized smoking, and tobacco use in general, as an important determinant of multiple chronic diseases and identified **tobacco control efforts as a key mechanism for reducing the burden of chronic disease** in the Southern Nevada community.



### Priority Area 2: Access to Care



Promoting health equity through access and utilization of care is important as everyone has the right to be healthy. Health should not depend on the ZIP code, economic status, or an individual's heritage, religion, and/or sexual orientation. **Having access to care helps address disparities and it is the first step in creating a more equitable health system** that improve the physical, social, and mental health for everyone in the community.



### Priority Area 3: Transportation



**Reliable access to transportation can help increase employment rates, access to healthy foods, access to health care providers and facilities, and access to parks and recreation for a healthy lifestyle.** The CHA identified the high cost of transportation, lack of access to transportation, and insufficient transportation funding as key areas to address.



### Priority Area 4: Funding



Increasing public health funding is a necessary first step to improving key determinants of health such as reducing high unemployment rates, addressing high health care and transportation costs, increasing limited public resources, and improve opportunities to pursue educational goals. **Accessible and transparent public health funding will facilitate the adoption and timely implementation of community health programs and services.**



# Chronic Disease

## Southern Nevada Community Values

- ✓ Community Engagement
- ✓ Health
- ✓ Education
- ✓ Environment

## Priority Area 1: Goals

### Goal 1:

**Decrease the prevalence of heart disease** among those identified (Non-Hispanic Black/African American, 65 and Older, by ZIP Codes).



**Objective 1.1:** By December 2025, advocate for and attempt to secure **increased funding for tobacco control** to CDC recommended **funding levels** as well as other chronic disease programs.



### Goal 2:

**Decrease the prevalence of lower respiratory disease** among those identified (Non-Hispanic Black/African American, 65 and Older, by ZIP Codes).



**Objective 2.1:** By December 2025, implement CDC or national **model policy and law for secondhand smoke protection**.



**Objective 2.2:** By December 2025, **decrease smoking prevalence** in the non-Hispanic Black/African American, 65 and older, and geographic area.



### Goal 3:

**Decrease the prevalence of cancer** among those identified (Non-Hispanic Black/African American, 65 and Older, by ZIP Codes).



**Objective 3.1:** By December 2025, **decrease tobacco-related cancers** for non-Hispanic Black/African-American, 65+, and those living in specific geographic areas.





# Priority Area 1: Chronic Disease



## Goal 1: Decrease the prevalence of heart disease among those identified (Non-Hispanic Black/ African American, 65 and Older, by ZIP Codes)



Objective 1.1: By December 2025, advocate for and attempt to secure increased funding for tobacco control to CDC recommended funding levels as well as other chronic disease programs.



Action Step: Meet with Legislators to raise awareness and justify need for additional funding.



Action Step: Promote existing tobacco programs and the connection to reduced chronic disease.



Action Step: Identify funding priorities, best practices, and potential collaborations with local and statewide partners.



Completed



In progress



Not started



## Goal 2: Decrease the prevalence of lower respiratory disease among those identified (Non-Hispanic Black/African American, 65 and Older, by ZIP Codes)



Objective 2.1: By December 2025, implement CDC or national model policy and law for secondhand smoke protection.



Action Step: Develop educational materials for distribution to legislators that share the model policies and the disproportionate impact of those policies on communities of color.



Action Step: Develop a tracker for model policy implementation



Action Step: Identify populations or communities not covered by tobacco policy.



Action Step: Meet with decision makers to promote and encourage secondhand smoke protection by creating smoke-free law/policies



Action Step: Review current model policies and the applicability for the state of Nevada



# Access to Care

## Southern Nevada Community Values

- ✓ Community Engagement
- ✓ Health
- ✓ Education
- ✓ Environment

## Priority Area 2: Goals

### Goal 1:

**Increase access to care in identified target populations** by Access to Care Subcommittee (i.e., LGBTQ+, and uninsured and undocumented populations)



**Objective 1.1:** By December 2025, increase primary care centers **providing mental health services in "medical deserts"** for **uninsured populations** including undocumented and LGBTQ+ persons.



### Goal 2:

**Increase patient confidence** in choosing primary care physicians with assistance of care coordinators.



**Objective 2.1:** By December 2023, increase the number of healthcare providers **documenting sexual orientation and gender identity on intake forms**.



### Goal 3:

**Fewer undocumented and LGBTQ+ individuals will access emergency departments (ED)** for non-urgent health problems.



**Objective 3.1:** By December 2025, create or adapt a **comprehensive cultural responsiveness training** focusing on LGBTQ+ and undocumented communities.

**Objective 3.2:** By December 2025, **increase medical staff trained** with the cultural response training.



# Priority Area 2: Access to Care



## Goal 1: Increase access to care in identified target populations by Access to Care Subcommittee (i.e., LGBTQ+, and uninsured and undocumented populations)



Objective 1.1: By December 2025, increase primary care centers providing mental health services in "medical deserts" for uninsured populations including undocumented and LGBTQ+ persons.



Action Step: Work with institutions of higher education to identify ZIP codes and data for underserved populations.



Action Step: Identify and document medical deserts in Southern Nevada



Action Step: Identify local, regional, and state level funding opportunities to support construction of new primary care facilities.



Action Step: Increase the total number of mental health professionals in the State by supporting individuals seeking licensure through free supervision.

✔ Completed    ➤ In progress    ✖ Not started



## Goal 2: Increase patient confidence in choosing primary care physicians with assistance of care coordinators



Objective 2.1: By December 2023, increase the number of healthcare providers documenting sexual orientation and gender identity on intake forms.



Action Step: With assistance of community partners, create a list of guidelines and revise intake forms.



Action Step: Implement training to collect data on indicators within medical communities.



Action Step: Provide office resources to indicate support for LGBTQ+ and undocumented communities



Action Step: Survey communities to document facilities data collection processes.

✔ Completed    ➤ In progress    ✖ Not started



## Goal 3: Fewer undocumented and LGBTQ+ individuals will access emergency departments for non-urgent health problems



Objective 3.1: By December 2025, create or adapt a comprehensive cultural responsiveness training focusing on LGBTQ+ and undocumented communities.

# Transportation

## Southern Nevada Community Values

- ✓ Community Engagement
- ✓ **Health**
- ✓ Education
- ✓ Environment

## Priority Area 3: Goals

### Goal 1:

**Increase awareness of transportation options** that facilitate access to basic needs and services.



**Objective 1.1:** By December 2024, **explore the expansion of Three Square's Golden Groceries** program to include low-income populations of all ages.



**Objective 1.2:** By December 2024, **promote awareness of existing programs** such as Silver STAR and Silver Rider to eligible riders, and **promote the expansion of on-demand transportation services** for low-income communities lacking access to essential services.



### Goal 2:

**Increase availability of general transportation resources** available to the community.



**Objective 2.1:** By December 2023, help **identify funding opportunities to consider new transit fare policies** for improved affordability and access.



**Objective 2.2:** By December 2025, **increase the number of available transportation resources** available to the community.





# Priority Area 3: Transportation



## Goal 1: Increase awareness of transportation options that facilitate access to basic needs and services



Objective 1.1: By December 2024, explore the expansion of Three Square's Golden Groceries program to include low-income populations of all ages.



Action Step: Confirm interest with service providers



Action Step: Identify new resources for expansion



Action Step: Pilot test service



Objective 1.2: By December 2024, promote awareness of existing programs such as Silver STAR and Silver Rider to eligible riders, and promote the expansion of on-demand transportation services for low-income communities lacking access to essential services.



Action Step: Confirm interest with service provider



Action Step: Identify new resources for expansion



Action step: Develop potential service routes



Action Step: Co-develop transportation service pilot

✓ Completed    > In progress    ✗ Not started



## Goal 2: Increase availability of general transportation resources available to the community



Objective 2.1: By December 2023, help identify funding opportunities to consider new transit fare policies for improved affordability and access.



Action Step: Identify interested community partners



Action Step: Develop task force



Action Step: Co-develop and submit funding application



Action Step: Expand access to existing reduced transit fare programs



Objective 2.2: By December 2025, increase the number of available transportation resources available to the community.

# Funding

## *Southern Nevada Community Values*

- ✓ Community Engagement
- ✓ Health
- ✓ Education
- ✓ Environment

## *Priority Area 4: Goals*

### *Goal 1:*

Increase the Nevada public health system's **readiness and ability to respond to the health needs of the community.**



**Objective 1.1:** By December 2024, increase the community's **understanding and awareness about the importance of public health funding.**



**Objective 1.2:** By December 2025, Advocate for the government (federal, state, local) to **increase the total amount of per capita funding** dedicated to the public health system.



# Priority Area 4: Public Health Funding



## Goal 1: Increase the Nevada public health system's readiness and ability to respond to the health needs of the community



Objective 1.1: By December 2024, increase the community's understanding and awareness about the importance of public health funding.



Action Step: Conduct surveys and town hall meetings to understand community knowledge, beliefs, and perceptions about public health funding.



Action Step: Present results and action plan to community organizations



Action Step: Identify top priorities for public health spending within and across communities.



Action Step: Partner with state senators/assembly-people that want to increase the per capita funding and support via legislation.



Action Step: Provide support and partner with the Governor's Office/Nevada Public Health Association (NPHA)/National Association of Counties (NACO)/community partners that advocate for funding.



Objective 1.2: By December 2025, Advocate for the government (federal, state, local) to increase the total amount of per capita funding dedicated to the public health system.



Action Step: Identify potential community partners



Action Step: Identify potential bill sponsors



Action Step: Identify Federal Legislator to partner with for funding.



Action Step: Draft bill language



Action Step: Develop and implement advocacy plan and Track Bill



Completed



In progress



Not started

# Priority Area Comparisons throughout Nevada

	STATE PRIORITIES										
	ACCESS TO HEALTH CARE			MENTAL HEALTH AND SUBSTANCE USE			SOCIAL DETERMINANTS OF HEALTH			PUBLIC HEALTH INFRASTRUCTURE	
RELATED LOCAL PRIORITIES	ACCESS/HEALTH EQUITY	HEALTH CARE WORK-FORCE	BEHAVIORAL HEALTH WORK-FORCE	CHILDREN'S BEHAVIORAL HEALTH	CRISIS RESPONSE	SUBSTANCE USE DISORDER	FOOD SECURITY	HEALTH LITERACY	AIR QUALITY/CLIMATE CHANGE	HOUSING / SUPPORTIVE HOUSING	FUNDING, PUBLIC UNDERSTANDING/AWARENESS
SOUTHERN NEVADA HEALTH DISTRICT	X	X (new facilities in medical deserts)	X				X (transportation)	X			X (funding, public understanding/awareness)
NORTHERN NEVADA PUBLIC HEALTH	X	X	X	X	X		X (access to healthy food)			X (affordable rental housing)	

\*Carson City Health and Human Services had not published a recent CHIP at the time of publication.

# Next Steps

01

Continuously  
Implement Action  
Plan from 2022-2025  
into the Community

02

Progress Updates  
& Tracking on HSN  
Website  
Dashboard

03

Continue  
community  
partnership and  
engagement –  
Healthy Connect!



# SNHD Reaccreditation Update



## Year 1

- QI project submitted to fulfill our annual report 3/31/2023

## Year 2 & 3

- Year 2 annual report submission 3/19/2024, Year 3 in 2025
- Demonstrated how we encourage innovation with reference to the Public Health Vending Machines shifting from harm prevention to harm reduction including needles and hygiene kits

## Year 4

- Provides SNHD an opportunity to mock upload the full accreditation package for a non-punitive review in 2026

## Year 5

- Upload any upgrades from year 4 for our next 5-year accreditation; Due: 3/31/2027

# THANK YOU!

## **Presenter Contact:**

Carmen Hua, MPH, CHES®

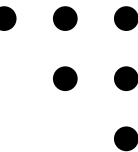
Health Educator | CHA/CHIP Coordinator

Division of Disease Surveillance and Control

Email: [huac@SNHD.org](mailto:huac@SNHD.org)

PH: 702-759-1209

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



# *Overcoming Barriers and Building a Better Future: Enhancing Access to Care through the Deflection Program in Nye, Esmeralda and Lincoln Counties*

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*DJ Mills*

*Director of Mental Health and Deflection Programs  
NyE Communities Coalition*



OVERCOMING BARRIERS AND BUILDING A BETTER FUTURE:  
ENHANCING ACCESS TO CARE  
THROUGH THE DEFLECTION PROGRAM  
IN NYE, ESMERALDA, AND LINCOLN COUNTIES



**DJ Mills**  
**NyE Communities Coalition**

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# INTRODUCTION

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- **The Nye & Lincoln County Teams**
- **Deflection vs Diversion**
- **Nye County - FASTT & MOST Programs**
- **Lincoln County - FASTT & MOST Lite Programs**
- **Esmeralda County - \*Coming Soon\***

# CLIENTS & CHALLENGES

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## **Criminogenic Risk Factors:**

- Criminal History
- Education, Employment, and Financial
- Family and Social Support
- Neighborhood Problems
- Substance Abuse
- Peer Associations
- Criminal Attitudes and Behavioral Patterns:

## **Common Responsively Factors:**

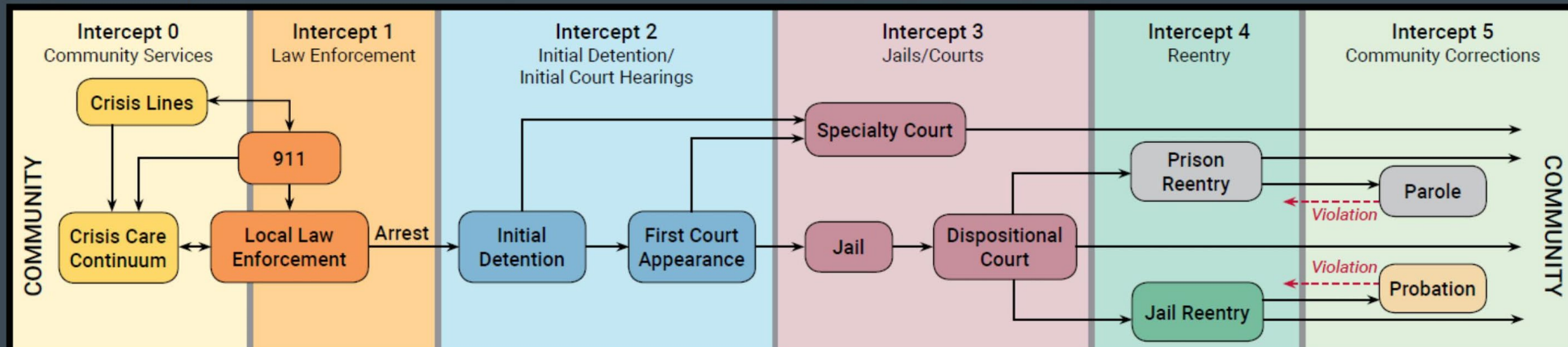
- Transportation
- Housing
- Mental Health
- Medical Needs
- Low Intelligence / Cognitive Delay
- Motivation to Change
- Veterans

## **Barriers**

- Complexity of Clients' Needs
- Limited Availability of Services
- Staffing Challenges
- Stigma / Privacy
- Accessible Housing
- Transportation
- Paperwork / Identification Requirements
- Unpredictable Releases
- Court Required Program / Residency



## The Sequential Intercept Model



## Key Issues at Each Intercept

## Intercept 0

Mobile crisis outreach teams and co-responders. Behavioral health practitioners who can respond to people experiencing a behavioral health crisis or co-respond to a police encounter.

Emergency Department diversion. Emergency Department (ED) diversion can consist of a triage service, embedded mobile crisis, or a peer specialist who provides support to people in crisis.

Police-friendly crisis services. Police officers can bring people in crisis to locations other than jail or the ED, such as stabilization units, walk-in services, or respite.

## Intercept 1

Dispatcher training. Dispatchers can identify behavioral health crisis situations and pass that information along so that Crisis Intervention Team officers can respond to the call.

Specialized police responses. Police officers can learn how to interact with individuals experiencing a behavioral health crisis and build partnerships between law enforcement and the community.

Intervening with super-utilizers and providing follow-up after the crisis. Police officers, crisis services, and hospitals can reduce super-utilizers of 911 and ED services through specialized responses.

## Intercept 2

Screening for mental and substance use disorders. Brief screens can be administered universally by non-clinical staff at jail booking, police holding cells, court lock ups, and prior to the first court appearance.

Data matching initiatives between the jail and community-based behavioral health providers.

Pretrial supervision and diversion services to reduce episodes of incarceration. Risk-based pre-trial services can reduce incarceration of defendants with low risk of criminal behavior or failure to appear in court.

## Intercept 3

Treatment courts for high-risk/high-need individuals. Treatment courts or specialized dockets can be developed, examples of which include adult drug courts, mental health courts, and veterans treatment courts.

Jail-based programming and health care services. Jail health care providers are constitutionally required to provide behavioral health and medical services to detainees needing treatment.

Collaboration with the Veterans Justice Outreach specialist from the Veterans Health Administration.

## Intercept 4

Transition planning by the jail or in-reach providers. Transition planning improves reentry outcomes by organizing services around an individual's needs in advance of release.

Medication and prescription access upon release from jail or prison. Inmates should be provided with a minimum of 30 days medication at release and have prescriptions in hand upon release.

Warm hand-offs from corrections to providers increases engagement in services. Case managers that pick an individual up and transport them directly to services will increase positive outcomes.


## Intercept 5


Specialized community supervision caseloads of people with mental disorders.


Medication-assisted treatment for substance use disorders. Medication-assisted treatment approaches can reduce relapse episodes and overdoses among individuals returning from detention.


Access to recovery supports, benefits, housing, and competitive employment. Housing and employment are as important to justice-involved individuals as access to behavioral health services. Removing criminal justice-specific barriers to access is critical.


## Best Practices Across the Intercepts

 Cross-systems collaboration and coordination of initiatives. Coordinating bodies improve outcomes through the development of community buy-in, identification of priorities and funding streams, and as an accountability mechanism.

 Routine identification of people with mental and substance use disorders. Individuals with mental and substance use disorders should be identified through routine administration of validated, brief screening instruments and follow-up assessment as warranted.

 Access to treatment for mental and substance use disorders. Justice-involved people with mental and substance use disorders should have access to individualized behavioral health services, including integrated treatment for co-occurring disorders and cognitive behavioral therapies addressing criminogenic risk factors.

 Linkage to benefits to support treatment success, including Medicaid and Social Security. People in the justice system routinely lack access to health care coverage. Practices such as jail Medicaid suspension vs. termination and benefits specialists can reduce treatment gaps. People with disabilities may qualify for limited income support from Social Security.

 Information-sharing and performance measurement among behavioral health, criminal justice, and housing/homelessness providers. Information-sharing practices can assist communities in identifying super-utilizers, provide an understanding of the population and its specific needs, and identify gaps in the system.

# OVERCOMING CHALLENGES

## Key Lessons

- Importance of Skilled Case Managers
- Building Strong Inter-agency Relationships
- Transportation Solutions
- Developing Beneficial Services
- Connecting With Clients Pre-release
- Client Screening
- Employment Needs
- Individualized Case Plans
- Soft Accountability





# CONCLUSION

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## Nye County

- Full-Time Social Security Benefits Specialist
- Jail-Based Case Manager
- Criminogenic Needs Curriculum Teacher
- Community-Based Case Manager
- Crisis Response Capabilities
- Transportation Services
- Barrier Removal Funding
- Statewide Collaboration Creating a Handbook for Post-Arrest Diversion (FASTT Model)
- Peer Services
- VJO Detention Center Access

## Lincoln County

- Access to Mobile Case Manager
- Reentry Planning from Incarceration
- Covering Travel Costs for Treatment
- Overcoming Technology Barriers
- Criminogenic Risk Curriculum: One-on-One Teaching
- Assistance with Applications
- NAMI Warmline

# WHATS NEXT?

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## LOOKING TOWARDS THE FUTURE

- Mobile Outreach Safety Teams in Nye County & Lincoln County - offering crisis stabilization and deflection from law enforcement, when possible, with law enforcement collaboration
- Lincoln Deflection / Diversion Transportation Assistance
- Prosecutor Collaboration for Case Management Supervision
- Esmeralda County Deflection Diversion
- Nye County Virtual Crisis Care Partnership with NAMI

# THANK YOU

**DJ Mills**

**Director of Mental Health & Deflection Programs**

775-727-9970 ext 208

[dj@nyeccc.org](mailto:dj@nyeccc.org)

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

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## County Health Rankings & Roadmaps

Building a Culture of Health, County by County

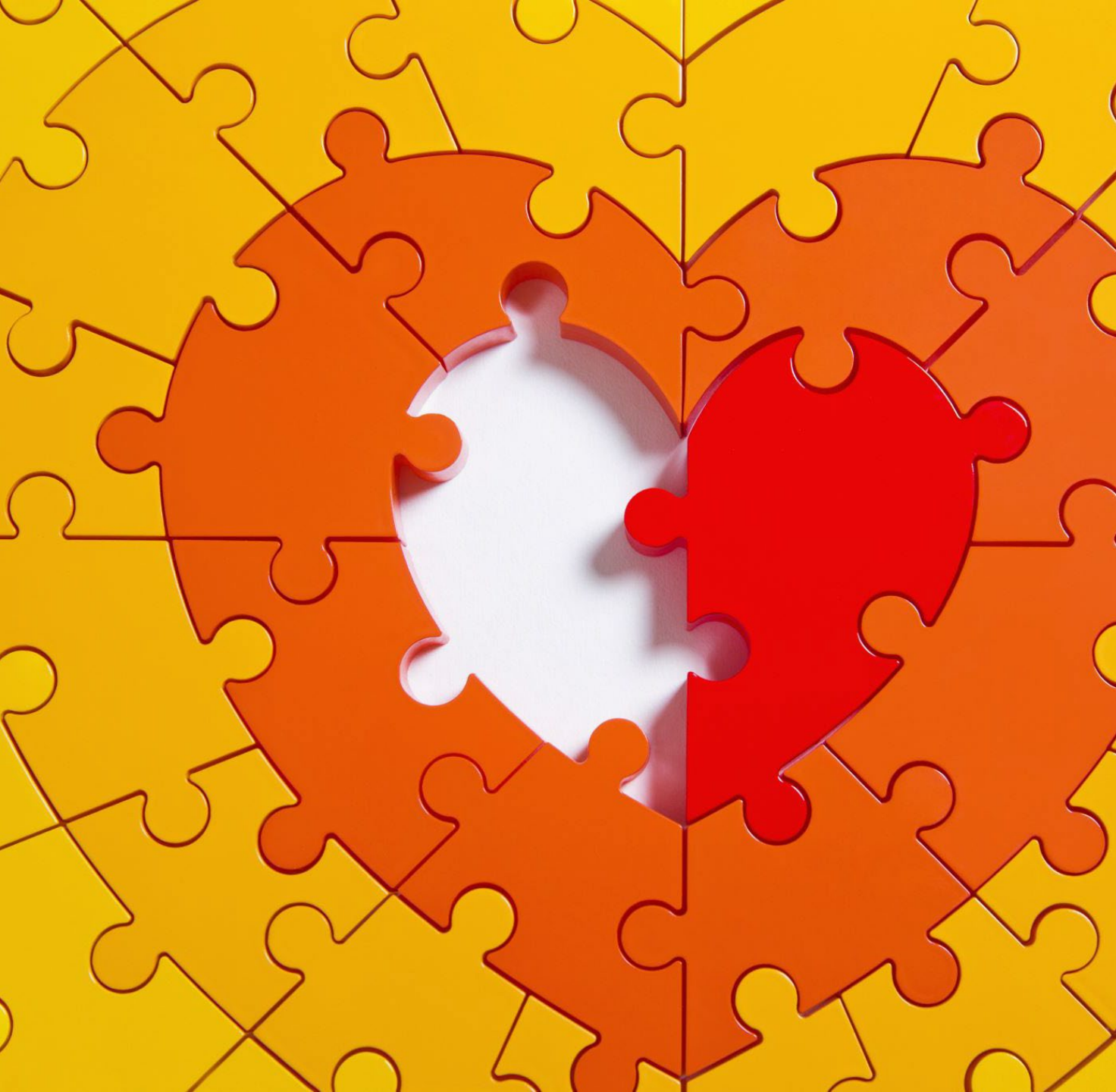
A Robert Wood Johnson Foundation program

# *Combating Heart Disease in the Heart of the Community*

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*Amineh Harvey, MPH  
Health Educator  
Office of Chronic Disease Prevention and Health  
Promotion Southern Nevada Health District*





# Combating Heart Disease in the Heart of the Community

Date: March 20, 2024

Presented By: Amineh Harvey, MPH  
Office of Chronic Disease Prevention and Health Promotion

Email: [harveya@snhd.org](mailto:harveya@snhd.org)

# Burden of Hypertension in the AA Community

## Both

- Hypertension develops earlier in life and more severe organ damage.
- High rates of death and disability from uncontrolled hypertension and Cardiovascular disease.

## Men

- Lower rates of hypertension treatment and control (medication adherence).
- Less physician interaction compared to black women (distrust in providers).
- 46% are diagnosed with some form of CVD.
- 45% aged 20 and older have hypertension.

## Women

- African American women are 60 percent more likely to have high blood pressure, as compared to non-Hispanic white women.
- Only 52 percent of African-American women are aware of the signs and symptoms of a heart attack





# Why the barbershop?

- Non-traditional clinical setting
- Culturally appropriate implementation site
- Vehicle for health promotion/education
- Pillar of the African American Community
- Barbers serve as community leaders
- Effective peer-based messaging approach



**1 IN 3** ADULTS HAS  
**HIGH BLOOD PRESSURE**

High blood pressure increases your risk for heart disease and stroke. No matter your age, take steps to lower your risk. Get your blood pressure checked today.

**BARBERSHOP HEALTH OUTREACH PROJECT**  
*Take it beyond the chair!*

*Your barber can help ease the pressure!*

**SNHD**  
Southern Nevada Health District

[www.gethealthyClarkCounty.org](http://www.gethealthyClarkCounty.org)  
GET MOVING, GET BETTER, GET YOURS GOVING.

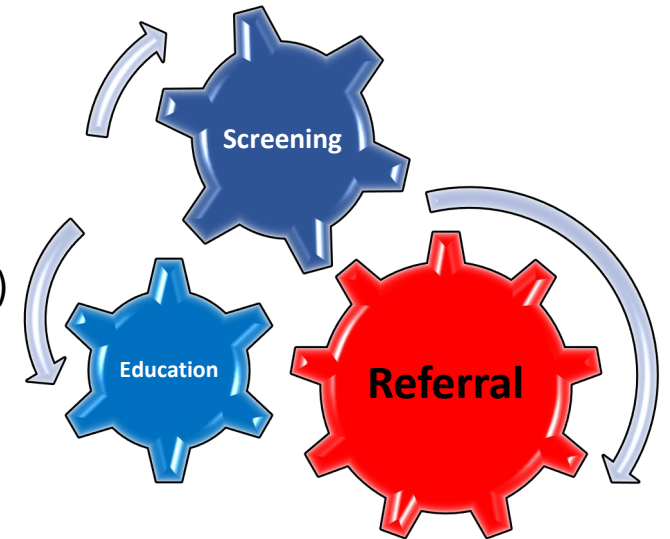
This publication was supported by the Nevada State Division of Public and Behavioral Health through Grant Number 1 NUS8DP006538-01-00 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor Centers for Disease Control and Prevention.

LEARN MORE AT [GETHEALTHYCLARKCOUNTY.ORG](http://GETHEALTHYCLARKCOUNTY.ORG)

# Barbershop Initiative

## Taking the Barbershop Experience Beyond the Chair

- To empower black men to adopt healthier lifestyle choices and reduce their risk for heart disease and stroke, SNHD partnered with three black-owned barbershops to create the **Barbershop Health Outreach Project (BSHOP)**. Since inception in 2018, the initiative has expanded its partnership with a total of 11 barbershops and introduced the program in the beauty salons using the BSHOP model with a total of 4 salons.
- **Trained volunteers/partners**
  - Eta Eta Eta Chapter of Chi Eta Phi Nursing Sorority
  - Nevada State College of Nursing
  - Southern Nevada Black Nurses Association
  - Nevada Faith and Health Coalition Community Health Workers (CHWs)
  - Lay Community Volunteers
- **Funding**
  - SNHD
  - Funded by the NV Division of Public and Behavioral Health
  - Blood pressure cuffs donated by American Heart Association
  - Low-cost intervention – volunteers, community partnerships, in-kind support

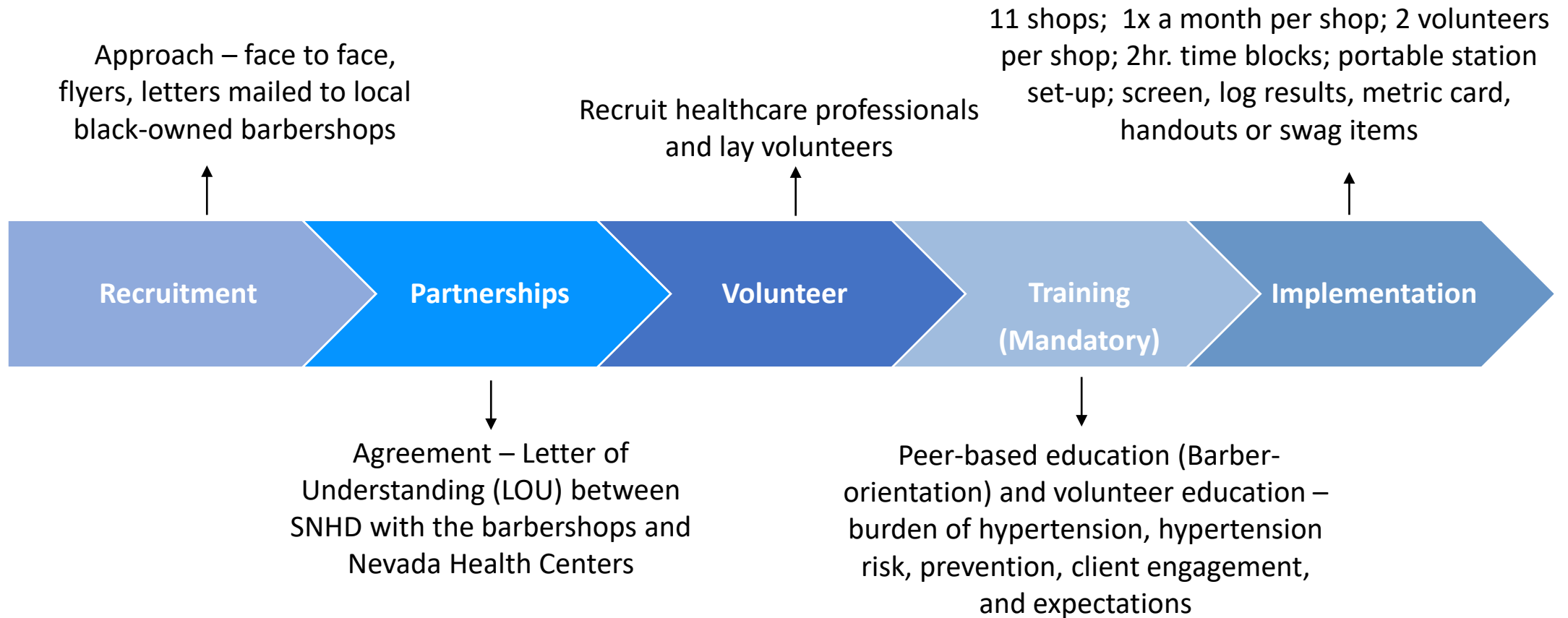






# The Intervention

# BSHOP Intervention Process







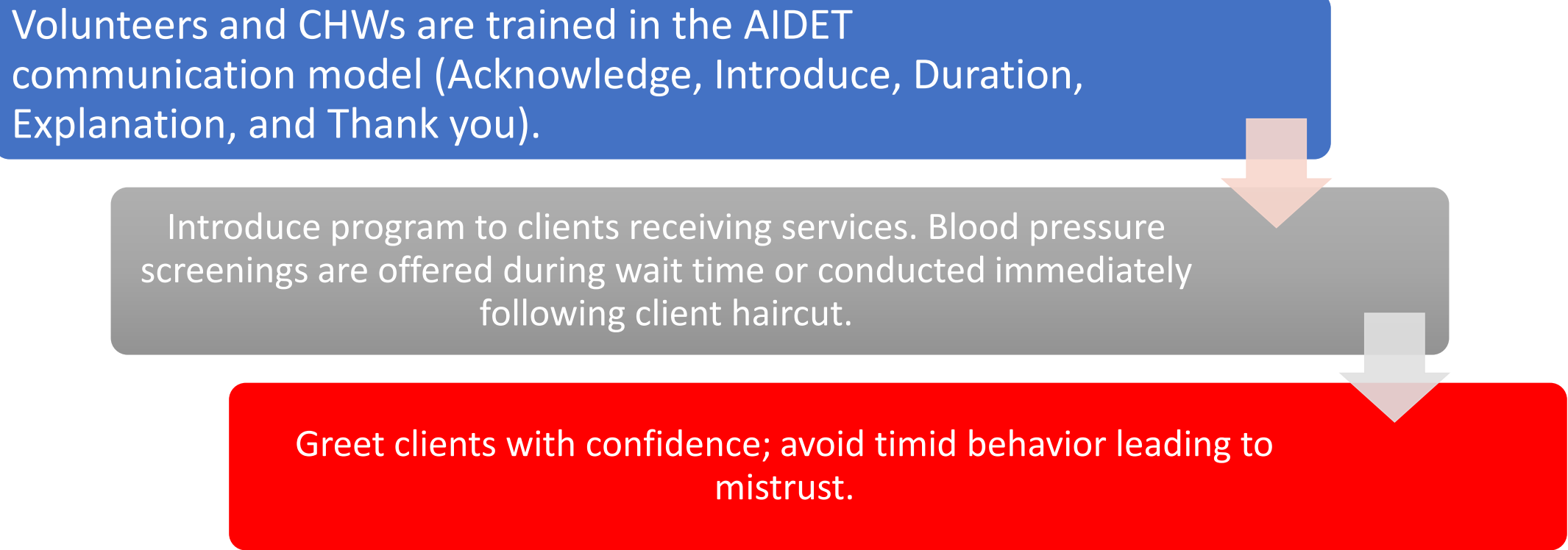
# The Barbershop Experience “More than a haircut”

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# Client Engagement

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Volunteers and CHWs are trained in the AIDET communication model (Acknowledge, Introduce, Duration, Explanation, and Thank you).



```
graph TD; A[Volunteers and CHWs are trained in the AIDET communication model (Acknowledge, Introduce, Duration, Explanation, and Thank you).] --> B[Introduce program to clients receiving services. Blood pressure screenings are offered during wait time or conducted immediately following client haircut.]; B --> C[Greet clients with confidence; avoid timid behavior leading to mistrust.];
```

Introduce program to clients receiving services. Blood pressure screenings are offered during wait time or conducted immediately following client haircut.

Greet clients with confidence; avoid timid behavior leading to mistrust.

## What's the **BIG DEAL** about controlling my blood pressure

### Small changes make a **HUGE** difference:

Even one lifestyle change I make for my health...	can decrease my blood pressure by small amounts	and small decreases in blood pressure result in <b>huge</b> health benefits.
Walking 30 minutes, five days a week	can decrease blood pressure <b>10 points</b>	<b>Every 5 points decrease in blood pressure reduces</b> ♦ risk of stroke by <b>34%</b> ♦ risk of heart attack by <b>21%</b>
Losing 5–10 lbs. of weight	can decrease blood pressure <b>5 points</b>	
Quitting tobacco (call 1-800-QUITNOW)	can decrease blood pressure <b>5–10 points</b>	<b>Every 3 points decrease in blood pressure reduces</b> ♦ risk of stroke by <b>8%</b> ♦ risk of heart attack by <b>5%</b>
Limiting sodium (salt) to 1,500 mg. per day	can decrease blood pressure	



CDH 345-288 October 2015

Healthy Communities  
Washington  
Public Health  
HEALTHIER WASHINGTON

## STOP HEART DISEASE BEFORE IT STARTS

Heart disease will affect **1 IN 2 ADULTS** IN THE U.S. Most of the time, **HEALTHY HABITS CAN PREVENT IT**

**WHAT YOU CAN DO:**  
BUILDING A STRONG FOUNDATION

Go to [CardioSmart.org/Prevention](http://CardioSmart.org/Prevention) to learn more about making healthier choices.

## PREDIABETES?

### Prediabetes Risk Test

- How old are you?  
Less than 40 years (0 points)  
40–49 years (1 point)  
50–59 years (2 points)  
60 years or older (3 points)
- Are you a man or a woman?  
Man (1 point) Woman (0 points)
- If you are a woman, have you ever been diagnosed with gestational diabetes?  
Yes (1 point) No (0 points)
- Do you have a mother, father, sister, or brother with diabetes?  
Yes (1 point) No (0 points)
- Have you ever been diagnosed with high blood pressure?  
Yes (1 point) No (0 points)
- Are you physically active?  
Yes (0 points) No (1 point)
- What is your weight status?  
(see chart at right)

Write your score in the box.







































Height	Weights (lbs.)
4'10"	119-142 143-190 191+
4'11"	124-147 148-197 198+
5'0"	128-152 153-203 204+
5'1"	132-157 158-210 211+
5'2"	136-163 164-217 218+
5'3"	141-168 169-224 225+
5'4"	145-173 174-231 232+
5'5"	150-179 180-239 240+
5'6"	155-185 186-246 247+
5'7"	159-190 191-254 255+
5'8"	164-196 197-261 262+
5'9"	169-202 203-268 269+
5'10"	174-208 209-277 278+
5'11"	179-214 215-285 286+
6'0"	184-220 221-293 294+
6'1"	189-226 227-301 302+
6'2"	194-232 233-310 311+
6'3"	200-239 240-318 319+
6'4"	205-245 246-327 328+
	(1 Point) (2 Points) (3 Points)

Adapted from Bang et al., Ann Intern Med 100:775-780, 2004.  
Original algorithm was validated without gestational diabetes as part of the model.

### If you scored 5 or higher:

You're likely to have prediabetes and are at high risk for type 2 diabetes. However, only your doctor can tell for sure if you do have type 2 diabetes or prediabetes (a condition that precedes type 2 diabetes in which blood glucose levels are higher than normal). Talk to your doctor to see if additional testing is needed.

Type 2 diabetes is more common in African Americans, Hispanic/Latino, American Indians, Asian Americans and Pacific Islanders.

Higher body weights increase diabetes risk for everyone. Asian Americans are at increased diabetes risk at lower body weights than the rest of the general public (about 15 pounds lower).



### LOWER YOUR RISK

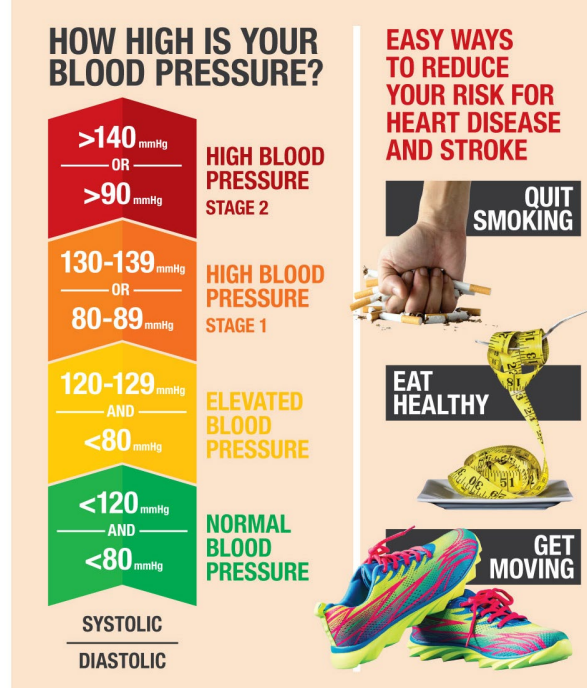
Here's the good news: it is possible with small steps to reverse prediabetes, and these measures can help you live a longer and healthier life.

If you are at high risk, the best thing to do is contact your doctor to see if additional testing is needed.

Visit [GoToPrediabetes.org](http://GoToPrediabetes.org) for more information on how to make small lifestyle changes to help lower your risk.

# Outreach Resources





# KNOW YOUR NUMBERS

Your **BLOOD PRESSURE**, **BLOOD SUGAR**, and **CHOLESTEROL** numbers

## Diabetes Self-Management Classes

Dignity Health / Nevada Quality & Technical Assistance Center  
Free diabetes self-management programs are available in English and Spanish. Stanford curriculum, 6 sessions each.  
► (702) 616-4914 or [www.nvhealthyliving.org](http://www.nvhealthyliving.org)

Healthy Living Institute at UMC  
Free diabetes self-management classes, Stanford curriculum, 6 sessions each.  
► (702) 383-7353 (SELF) or <https://www.umcn.com/healthy-living-institute>

Nevada Diabetes Association  
Visit the statewide diabetes resource directory to find information about kids camps, support groups, classes, and resources.  
► 1-800-379-3839 or [www.diabetesnv.org](http://www.diabetesnv.org)

Southern Nevada Health District  
Free diabetes workshops are available using the US Diabetes Conversation Maps.  
► (702) 759-1270 or [www.gethealthyclarkcounty.org](http://www.gethealthyclarkcounty.org) or email [gethealthyclarkcounty.org](mailto:gethealthyclarkcounty.org)

Please call first to ask about class costs, schedules and requirements because information may change.

## Diabetes Prevention Classes

Dignity Health / Nevada Quality & Technical Assistance Center  
► (702) 616-4914 or [www.nvhealthyliving.org](http://www.nvhealthyliving.org)

Find a listing of CDC-recognized Diabetes Prevention Programs near you:  
► [https://nccd.cdc.gov/DOT\\_DPP/Registry.aspx](https://nccd.cdc.gov/DOT_DPP/Registry.aspx)

The Road to Diabetes Prevention Program  
is a free online program developed by the Southern Nevada Health District.  
Participate at your own pace.  
► [www.gethealthyclarkcounty.org/training/diabetes](http://www.gethealthyclarkcounty.org/training/diabetes)

[www.gethealthyclarkcounty.org](http://www.gethealthyclarkcounty.org)  
Southern Nevada Health District  
Prevent. Promote. Build. Thrive.



### DIET

The National Institutes of Health (NIH) has found that you can help lower your blood pressure by following the Dietary Approaches to Stop Hypertension (DASH) diet. This diet is rich in fruits, vegetables, and low-fat dairy foods, and is low in saturated and total fat.

SERVINGS PER DAY*	
Grain products	6 to 8
Vegetables	4 to 5
Fruits	4 to 5
Low-fat dairy products	2 to 3
Protein, poultry, and fish	6 or less
Legumes (beans, lentils)	4 to 5/wk.
Nuts	2 to 3
Seeds	5 or less/wk.

\*Based on a diet of 2,000 calories a day

### KNOW YOUR SCOPE

Keeping track of your blood pressure can help you avoid a heart attack or stroke. And it can help you know when to call your doctor. If you are taking medicine for your blood pressure, which is as common as high blood pressure, you should know your blood pressure numbers. Your blood pressure numbers can vary greatly depending on what you eat, what you drink, and the time of day you take your medicine.

### BLOOD PRESSURE CHANGES

SYSTOLIC	DIASTOLIC	Category
<120	<80	Normal
120-129	80-89	Elevated
130-139	80-89	High Blood Pressure Stage 1
>140	>90	High Blood Pressure Stage 2

### BLOOD PRESSURE Recorder

POCKET PAL

Educational Materials



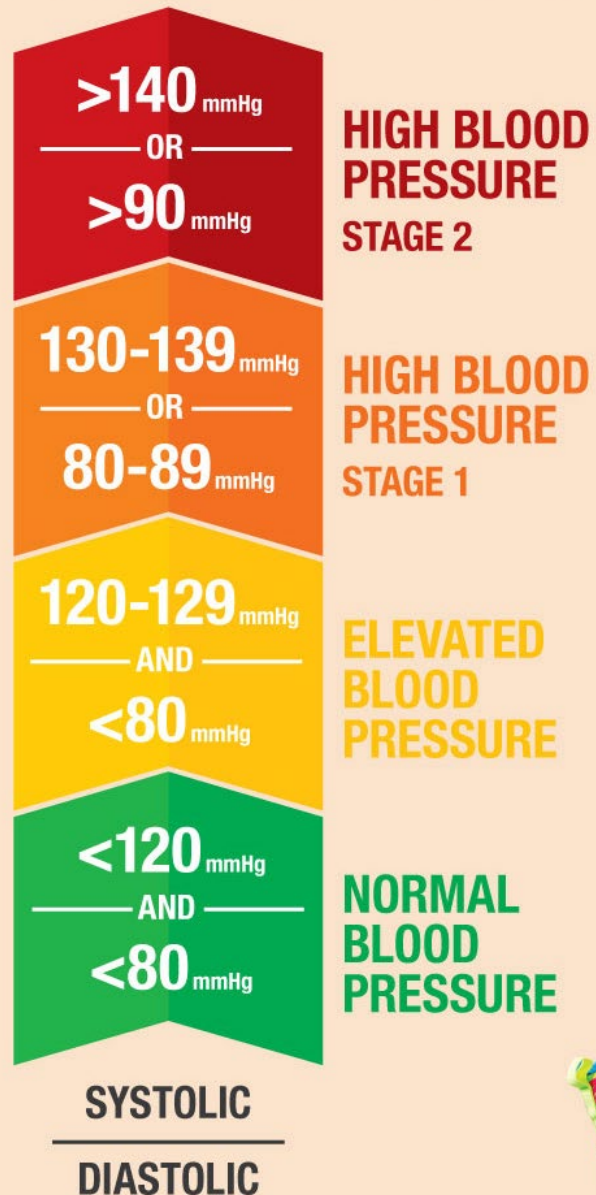
# BSHOP Program Outcomes

- Number of Screening Events: 216
- Number of Participants Screened: 2,016

**\*\*Barriers:** screening events cancelled due to lack of volunteer coverage and COVID-19 pandemic (2020-2021 Year 3)



# HOW HIGH IS YOUR BLOOD PRESSURE?



**EASY WAYS  
TO REDUCE  
YOUR RISK FOR  
HEART DISEASE  
AND STROKE**

**QUIT  
SMOKING**



**EAT  
HEALTHY**



**GET  
MOVING**

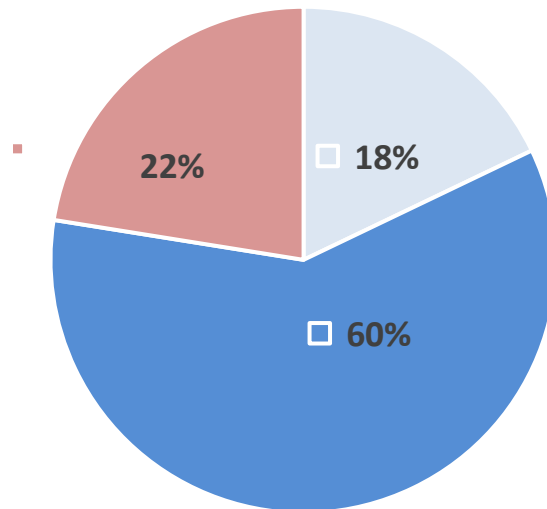


## Average Blood Pressure Reading

132/90mmHg (Stage 2 HTN)

# BSHOP Outcomes

Referrals



■ Clinic ■ Quitline ■ Diabetes



# MARKETING AND PROMOTION

## Barbershop Signage



Care about your  
**HEART**  
like you care about your  
**HAIR**

Your hair may change, but your heart will stay with you forever if you take care of it.

**FREE BLOOD PRESSURE CHECKS**

FAIR KUTZ JUNE 8 3PM-5PM	MASTERPIECE #2 JUNE 9 10AM-1PM	BLADE MASTERS JUNE 16 10AM-1PM
--------------------------------	--------------------------------------	--------------------------------------

[www.gethealthyclarkcounty.org](http://www.gethealthyclarkcounty.org)  
GET MOVING. BE SAFE. EAT BETTER. LIVE TOBACCO-FREE.

**BARBERSHOP HEALTH OUTREACH PROJECT**  
Take it beyond the chair!

FOR MORE INFORMATION, TALK TO YOUR BARBER

## Social Media Ads

- RJ Takeover
- Web Banner
- Facebook/IG
- Black Image Magazine



Get to the  
**HEART**  
of the matter

Every 43 seconds someone in the United States has a heart attack, and every four minutes someone dies from a stroke.

Do you know the warning signs?

- Chest discomfort, including uncomfortable pressure, squeezing, fullness or pain.
- Discomfort in other upper body areas, including one or both arms, the back, neck, jaw or stomach.
- Shortness of breath that occurs with or without chest discomfort.
- Breaking out in a cold sweat, nausea or lightheadedness.

Take action to improve your heart health. Sign-up for a **FREE** Blood Pressure Self-Monitoring Program offered at the YMCA of Southern Nevada. To enroll, contact Lindsey Edmond (702) 839-4901 or email [ledmond@lasvegasyymca.org](mailto:ledmond@lasvegasyymca.org).

Learn more about how to keep your heart healthy at [GetHealthyClarkCounty.org](http://GetHealthyClarkCounty.org)

**SNHD** [www.gethealthyclarkcounty.org](http://www.gethealthyclarkcounty.org)  
GET MOVING. BE SAFE. EAT BETTER. LIVE TOBACCO-FREE.

This publication was supported by the Nevada State Division of Public and Behavioral Health through Grant Number 1 A050P000138-01 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor the CDC.

## Bus Stop Ad



Care about your  
**HEART**  
like you care about your  
**HAIR**

Your hair may change, but your heart will stay with you forever — if you take care of it.

The Southern Nevada Health District is partnering with local beauty shops to raise awareness about the risk for heart disease and stroke in women by offering:

- Blood pressure screenings
- Health education
- Referrals to health care providers

**Did you know?**

- Of African-American women ages 20 and older, 49 percent have heart disease.
- Only 1 in 5 African-American women believes she is at risk.
- Only 52 percent of African-American women are aware of the signs and symptoms of a heart attack.

**BEAUTY SHOP HEALTH OUTREACH PROJECT**  
Healthy beyond your hair!

[www.gethealthyclarkcounty.org](http://www.gethealthyclarkcounty.org)  
GET MOVING. BE SAFE. EAT BETTER. LIVE TOBACCO-FREE.

**SNHD** Southern Nevada Health District

For more information about the Beauty Shop Health Outreach Project, contact Aminiya Harvey at [harveya@snhd.org](mailto:harveya@snhd.org)

This publication was supported by the Nevada State Division of Public and Behavioral Health through Grant Number 1 A050P000138-01-00 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor the Centers for Disease Control and Prevention.


## KCEP Power 88.1 Radio Ad




HIGHER ACTIVITY, LOWER BLOOD PRESSURE

[www.gethealthyclarkcounty.org](http://www.gethealthyclarkcounty.org)  
GET MOVING. BE SAFE. EAT BETTER. LIVE TOBACCO-FREE.

**SNHD**



Care about your  
**HEART**  
like you care about your  
**HAIR**

Your hair will change, but your heart will stay with you forever- if you take care of it. February is American Heart Month. Heart disease and stroke is the No. 1 killer in women, and stroke affects African-Americans at an alarmingly higher rate. To learn more about heart disease in women visit [www.gethealthyclarkcounty.org](http://www.gethealthyclarkcounty.org)

**SNHD** **BEAUTY SHOP HEALTH OUTREACH PROJECT**  
Healthy beyond your hair!

# Shots at the Shop Initiative

- Established to combat COVID-19
- Barbers served as 'Key Messengers'
- Developed a campaign to address vaccine hesitancy







## SHOP Talk to commemorate Men's Health Month





# Project Expansion

Identify new outreach locations (2)

Integrated social determinants of health screening assessment

Collaborated with BSHOP partner's 'Health is Wealth Tour' hosting 'Move to the Beat Walks'

Expand 'Shop Talk' in Beauty Salons using the BSHOP Shop Talk Model





## Program Sustainability

- Blood Pressure Screening Stations
- Self-Administered FREE screenings
  - Available for public use
- Steps on how to accurately measure BP
  - Heart Education & Resources
  - **Locations:**
    - Executive Cuts
    - Blade Masters
    - Master Barbering Galo





Thank you!



## *RTC of Southern Nevada: Programs & Initiatives*

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*Daniel Fazekas, AICP  
Manager of Transportation Planning  
Regional Transportation Commission (RTC) of  
Southern Nevada*







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# RTC of Southern Nevada Transportation Initiatives Update

Southern Nevada County Health Rankings & Roadmaps

Wednesday, March 20, 2024

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# Regional Transportation Commission of Southern Nevada



Public Transit



MPO/Regional  
Planning



Roadway  
Funding



Traffic  
Management



Bicycling







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# Urban Heat

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# Understanding & Addressing Urban Heat in Southern Nevada





## 2 INVESTING IN COMPLETE COMMUNITIES

Complete Communities are those where jobs, housing, transportation, and community amenities combine to create places that support economic opportunity and health for all people, regardless of income level.

1. Stabilize and strengthen existing neighborhoods through placemaking improvements.
2. Encourage an adequate supply of housing characterized by a range of price, income, density, ownership, and building types.
3. Support access to healthcare facilities, healthy food, parks, and community services.
4. Improve neighborhood safety and protect residents from the harmful effects of pollution and hazardous materials.
5. Promote resource-efficient land use and development practices.

## 3 INCREASING TRANSPORTATION CHOICE

Southern Nevada's current land use patterns are auto-centric, requiring that most people have access to a car to meet their day-to-day transportation needs. Southern Nevadans support having additional transportation options in the Valley, including expanded bus service and potentially light rail. Walking and biking become viable options for more people as safety is improved and land use patterns allow easy access to common destinations.

1. Develop a modern transit system that is integrated with vibrant neighborhood and employment centers, better connecting people to their destinations.
2. Connect and enhance bike and pedestrian facilities throughout the region.
3. Support the regional economic development strategy through integrated investments in transportation and urban development.
4. Develop a safe, efficient road network that supports all transportation modes.



## NEXT STEPS

- Continue public outreach to review and strengthen the plan. Continued engagement efforts will assess support for the principles proposed in the plan, gather additional ideas and engage stakeholders who will be critical in its implementation.
- Plan implementation will require changing land use and development patterns to support environmental and economic sustainability and to increase opportunity for all residents. Local jurisdictions will need to collaborate on an ongoing basis to make regulatory, legislative, operational, cultural and fiscal changes.
- Create indicators dashboard. To monitor our progress, we will develop a set of key indicators to monitor which will help confirm we are moving in the right direction.
- Opportunity site analysis. Southern Nevada Strong is creating realistic, implementable transit-oriented development strategies for four opportunity sites within the Valley. These strategies will identify opportunity for new development and changes to the transportation system that reflects the Regional Plan vision.

For more information and ways to get involved, visit [SouthernNevadaStrong.org](http://SouthernNevadaStrong.org)

SouthernNevadaStrong.org | SNRPC.org | 240 Water St., P.O. Box 50050 MSC 15 | Henderson, NV 89008-5050



## WHAT IS SOUTHERN NEVADA STRONG?

Southern Nevada Strong is a community-driven planning effort that seeks to develop regional support for long-term economic success and stronger communities by integrating reliable transportation, quality housing for all income levels, and job opportunities throughout Southern Nevada. This project is funded by a \$3.5 million dollar grant from the US Department of Housing and Urban Development. These funds provided the resources to conduct in-depth research and extensive community outreach to analyze issues facing our community and propose collaborative solutions. The resulting Regional Plan outlines valley-wide goals and presents a set of agreed-upon strategies that local governments can select from to implement the regional vision. This At-A-Glance document summarizes the Regional Plan and illustrates through the Vision Map how the regional vision can be implemented through coordinated land use and transportation planning.

## WE WILL ACHIEVE OUR REGIONAL VISION BY FOCUSING ON:

### 1 IMPROVING ECONOMIC COMPETITIVENESS AND EDUCATION

Southern Nevadans want access to a wide range of well-paying jobs and quality education. The Regional Plan seeks to create conditions for a variety of economic, housing, and transportation options that meet the demands of a skilled workforce and can attract quality employers to the region. These strategies will also help support education by improving the physical environment around schools.

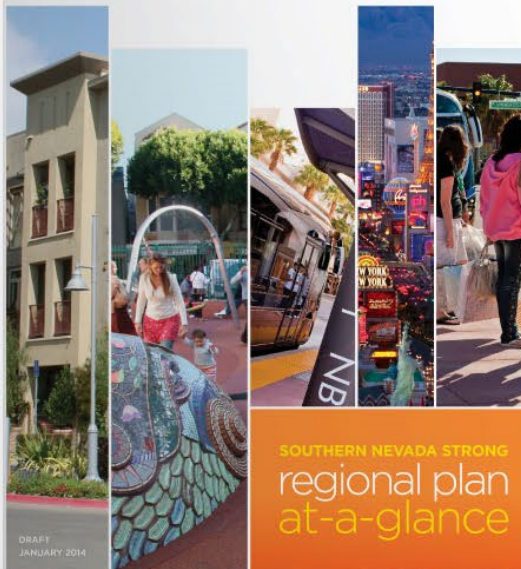
To increase collaboration between the state government, local governments and the region's higher education institutions to high economic development and education efforts.

Support the educational system and learning environments through thoughtful land use and transportation planning.

For more information, please visit [SouthernNevadaStrong.org](http://SouthernNevadaStrong.org)

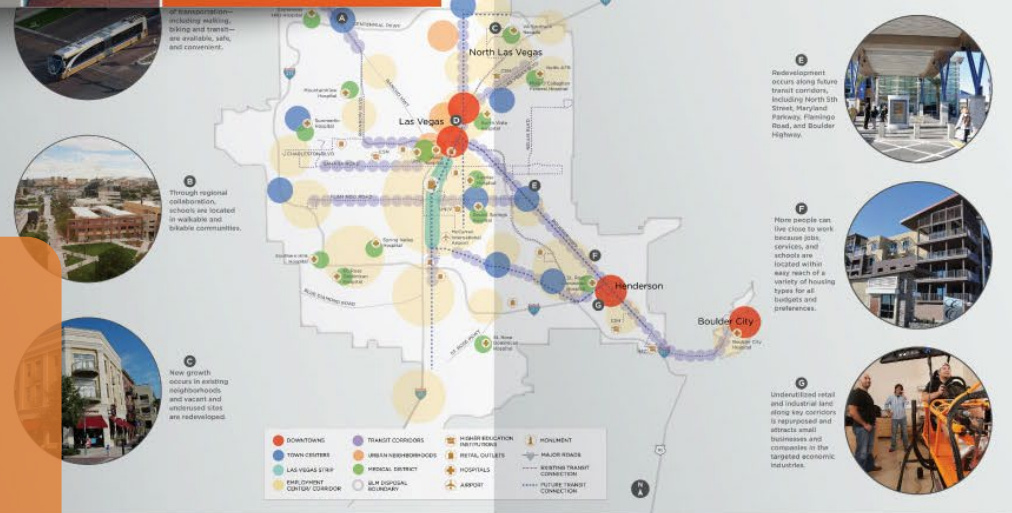


## A COMMUNITY GUIDE TO ACHIEVING A STRONGER SOUTHERN NEVADA



## SOUTHERN NEVADA STRONG regional plan at-a-glance

DRAFT JANUARY 2014



1 The region's downtowns provide a variety of jobs and services for local residents, dense housing combined with vibrant commercial centers, and new employment and workforce development opportunities.



2 Redevelopment occurs along future transit corridors, including North Las Vegas, Henderson, and Boulder City.



3 Here people can live close to work because jobs, services, and schools are located within easy reach of a variety of housing types for all budgets and preferences.



4 Underutilized retail and industrial land along key corridors is reimagined and attracts small businesses and companies in the targeted economic industries.



# Southern Nevada Strong

our valley's blueprint



# 100-degree days in Southern Nevada

72

100-degree days



1970

97

100-degree days



2020

115

100-degree days



2070

# Negative impacts



**water supply**



**infrastructure**



**air quality**

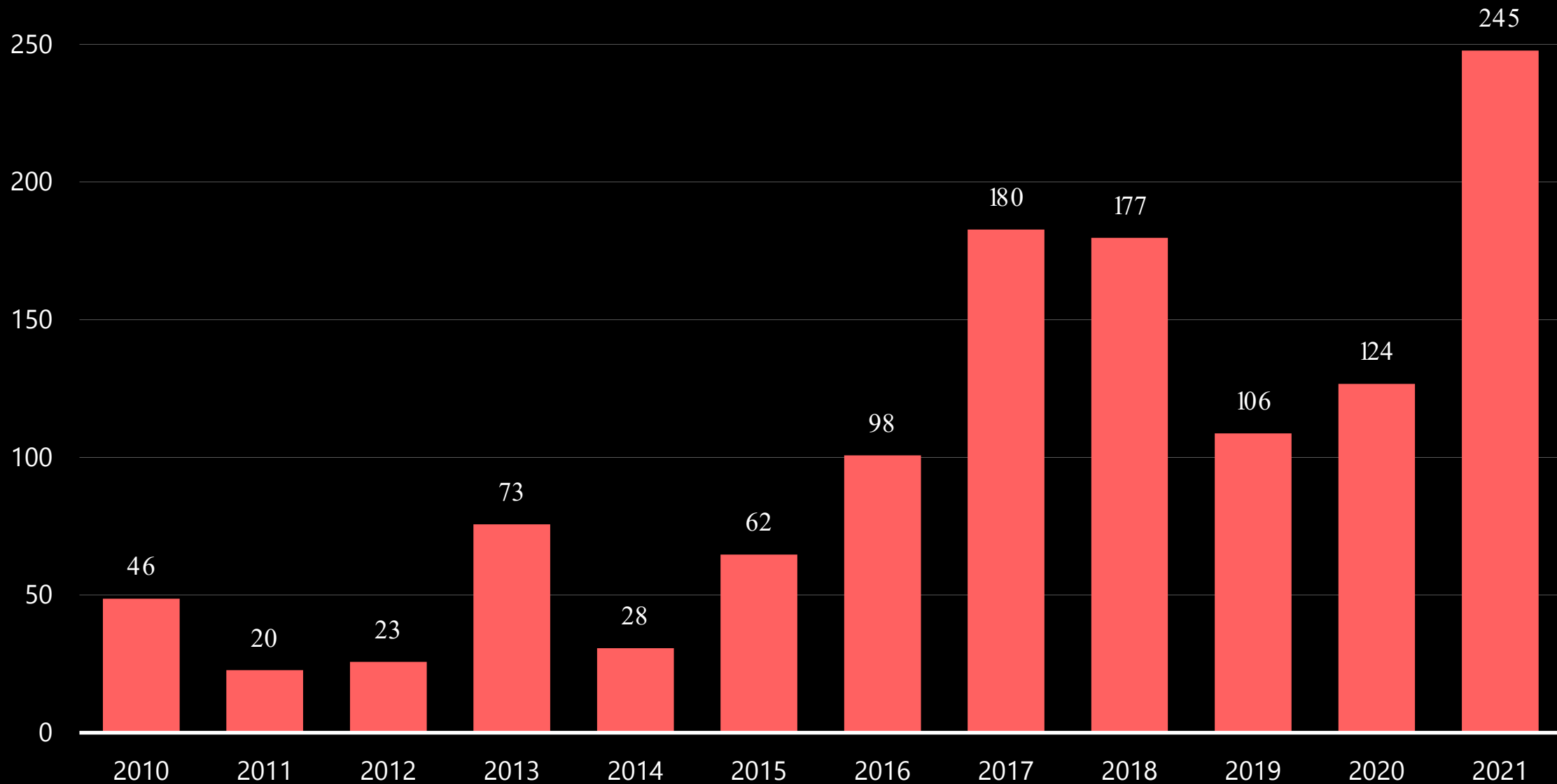


**tourism**

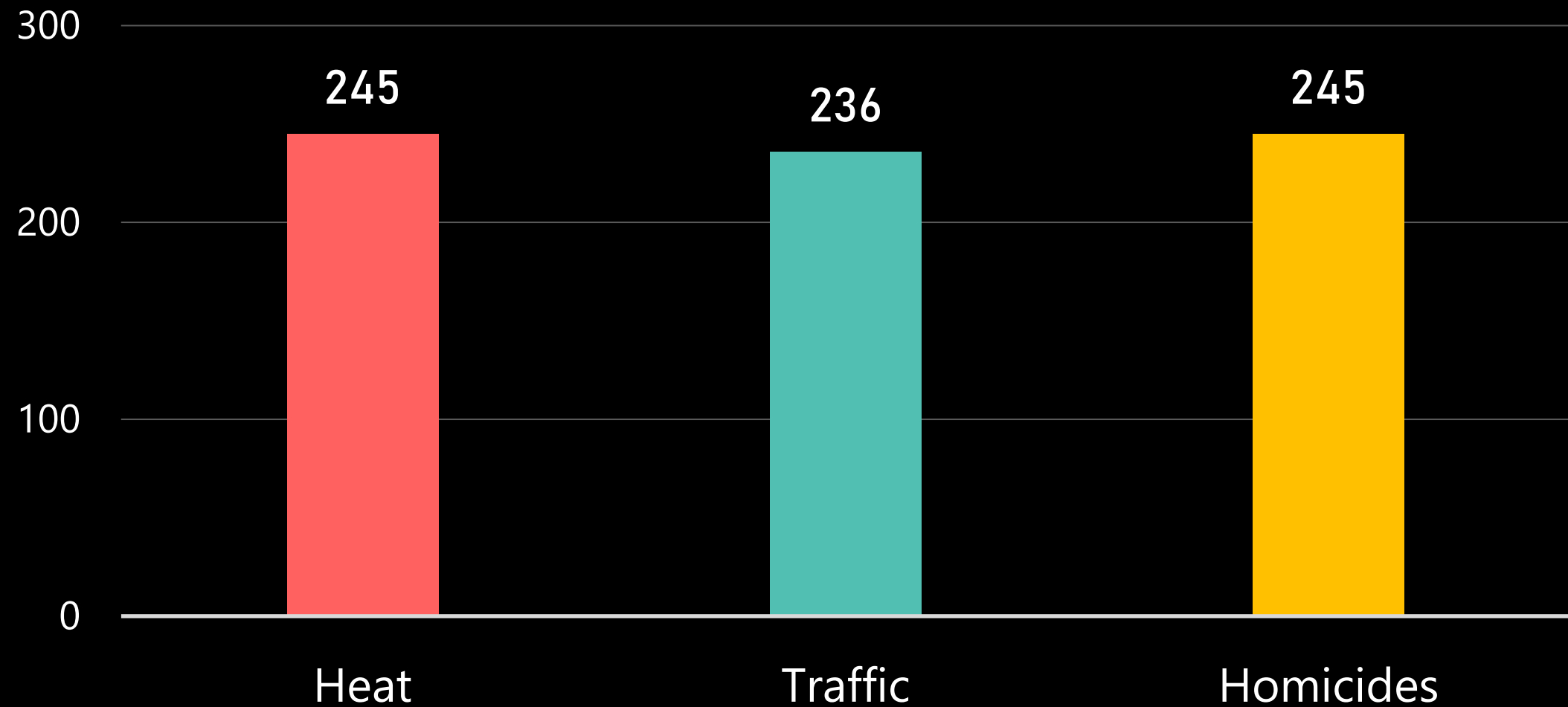


**health**

# Heat-related fatalities in Southern Nevada



# Fatalities in Southern Nevada (2021)



# Extreme Heat Vulnerability Analysis (2021)



## Exposure

- elevation
- temperature
- vegetated land cover
- developed land/impermeable surfaces
- air conditioning
- mobile homes



## Adaptive Capacity

- educational attainment
- race (non-white)
- unsheltered homeless
- disability
- limited english proficiency
- poverty
- vehicleless households



## Sensitivity

- isolated seniors
- older adults (50+)
- cardiovascular disease
- respiratory disease
- diabetes

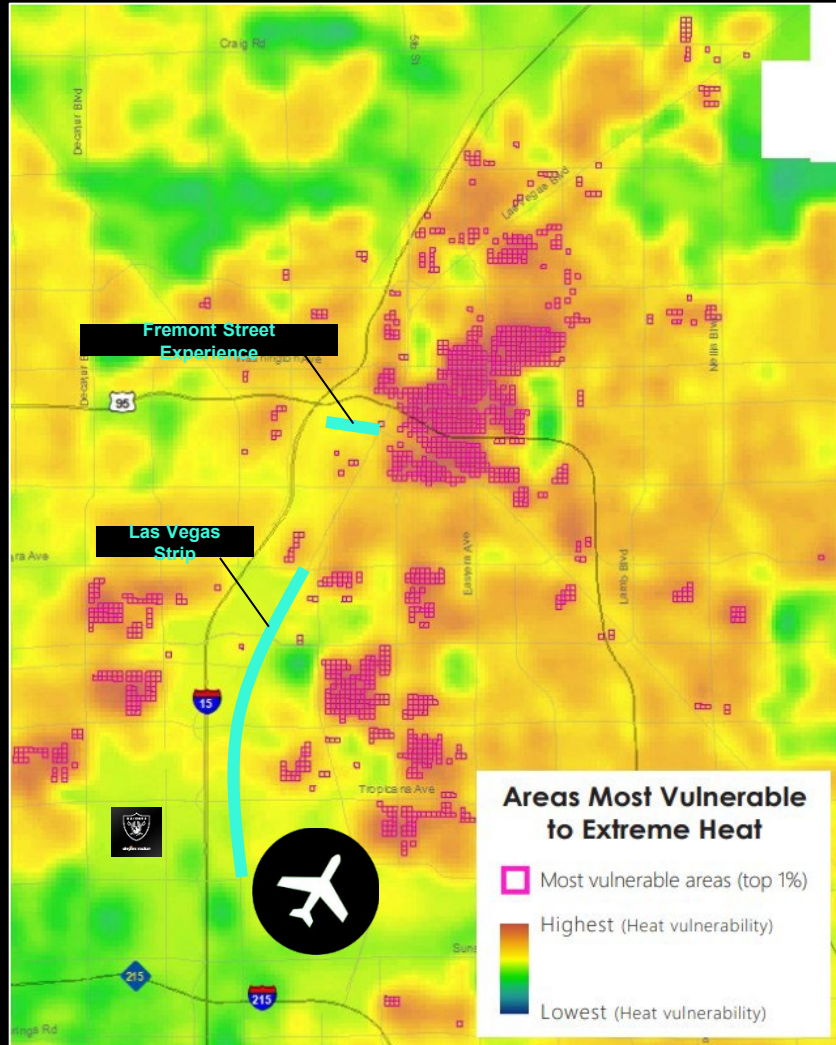


# Extreme Heat Vulnerability Analysis (2021)



[www.rtcsonv.com/extremeheat](http://www.rtcsonv.com/extremeheat)

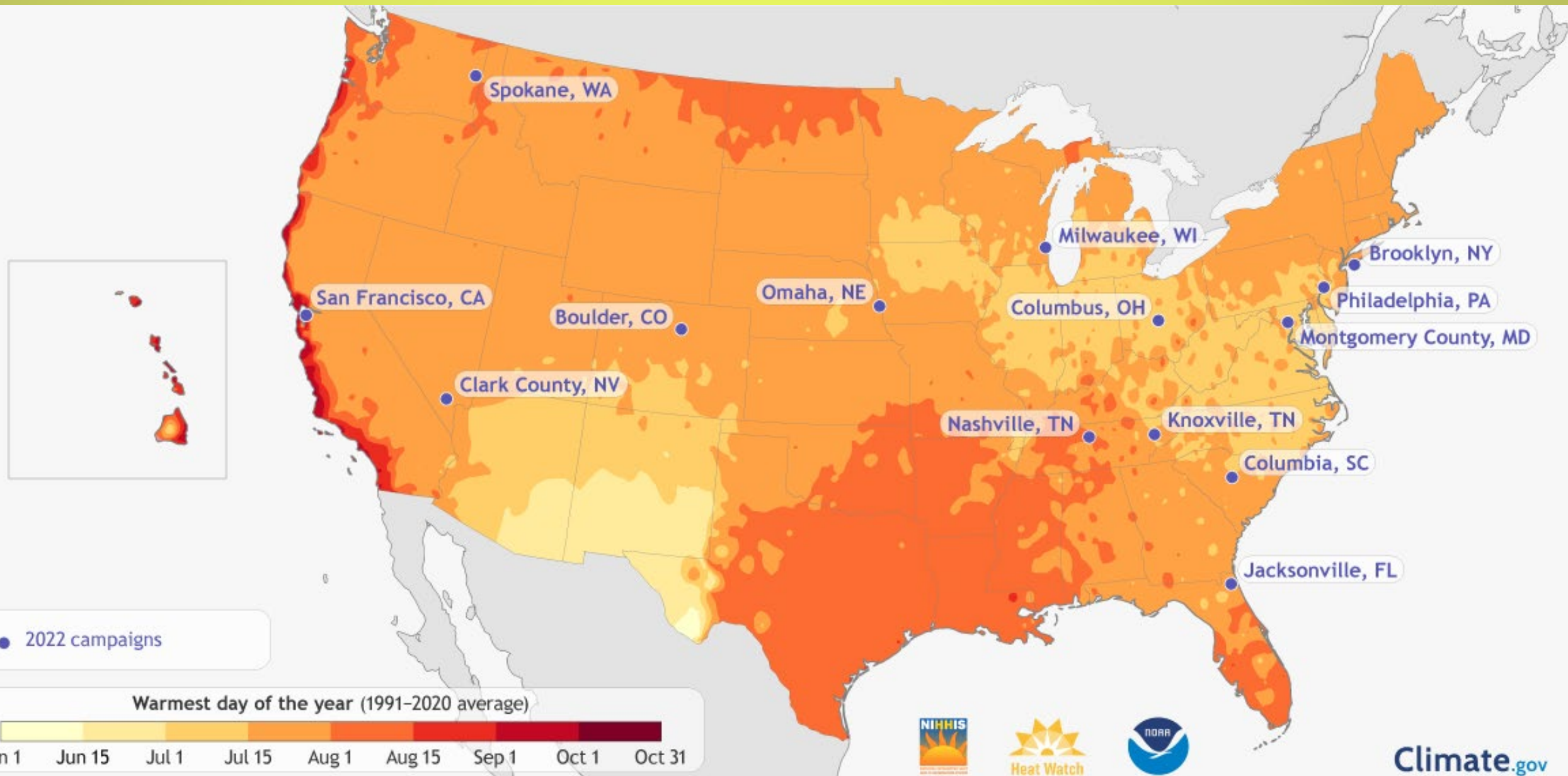
# Extreme Heat Vulnerability Analysis (2021)



## Areas Most Vulnerable to Extreme Heat

- Concentrated in urban core and east side
- Older neighborhoods/housing
- Communities of color (esp. Hispanic/Latinx and Black/African American)
- Household income: \$31,000
- Lower elevation (naturally hotter than western half of region)

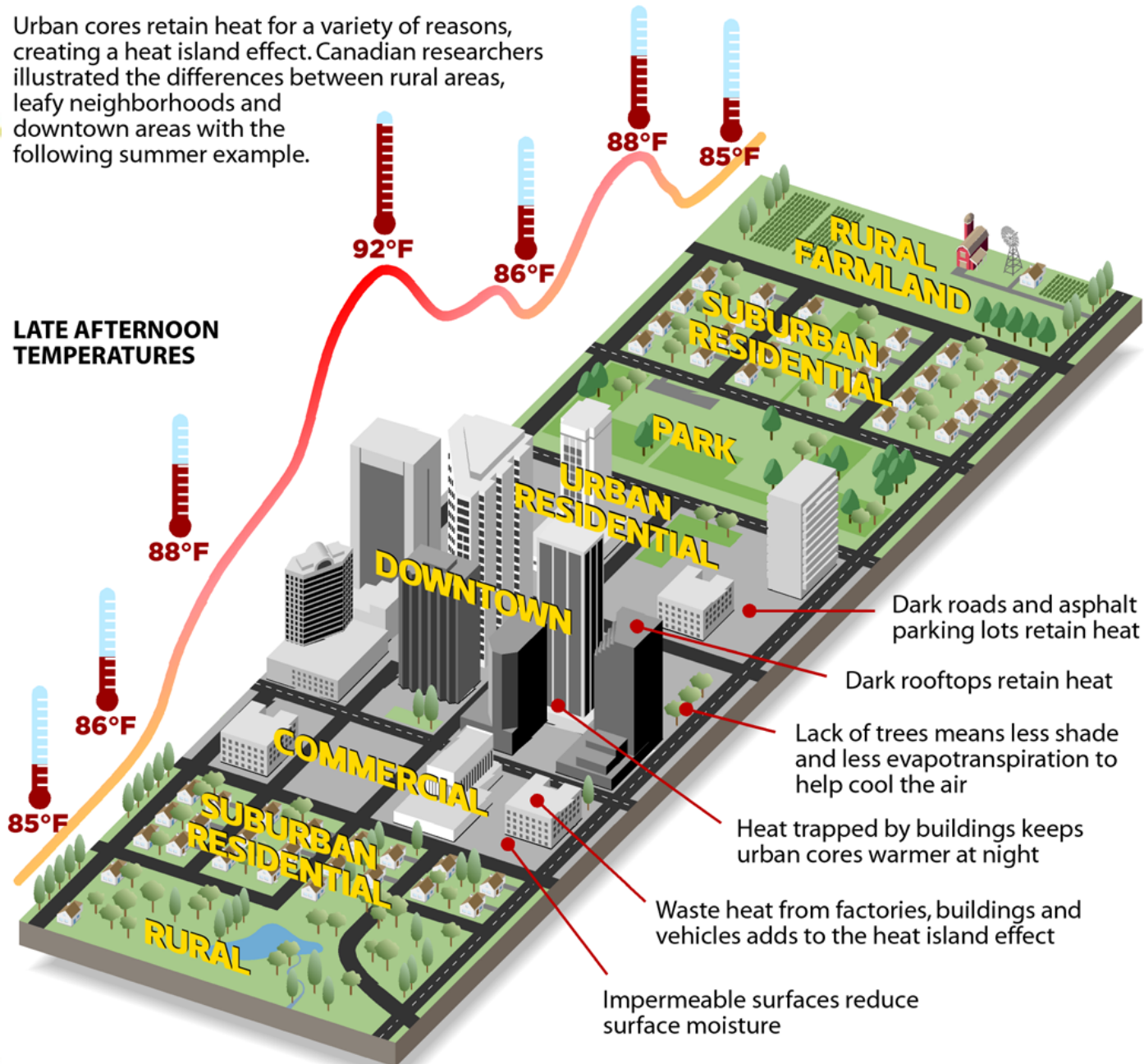
# NOAA 2022 UHI Mapping Campaign Locations



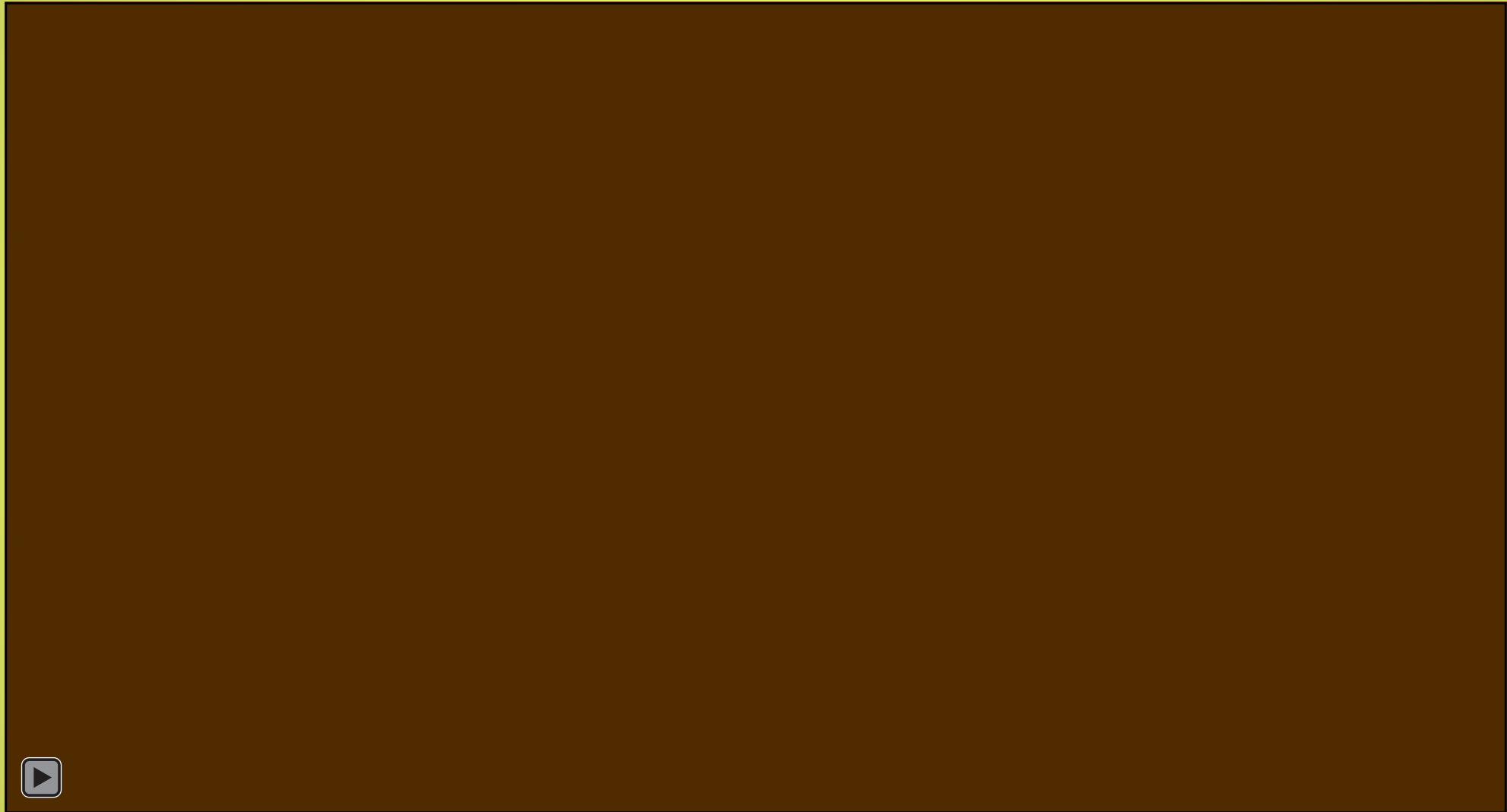


# Urban Heat Island Effect

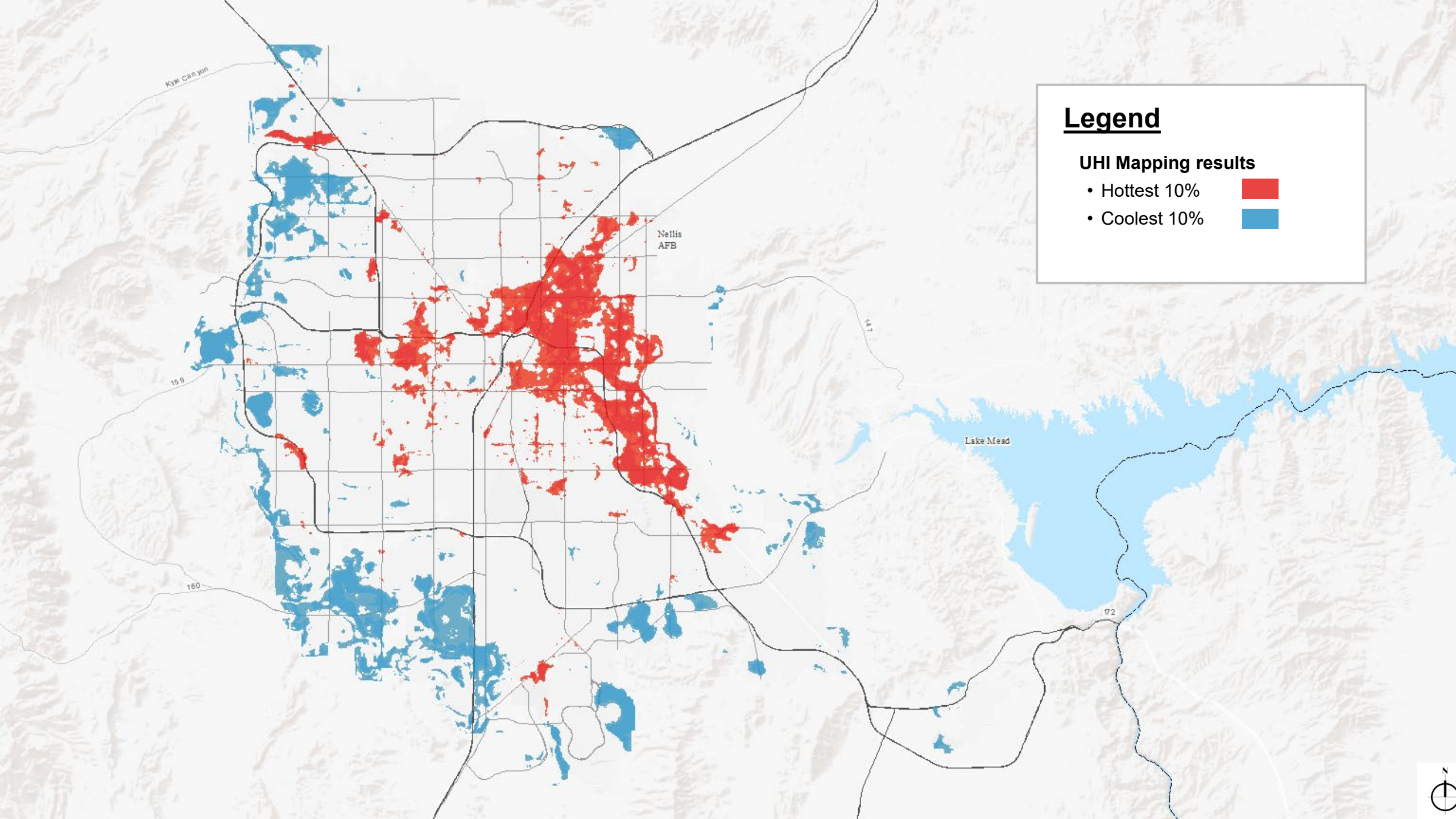
Urban cores retain heat for a variety of reasons, creating a heat island effect. Canadian researchers illustrated the differences between rural areas, leafy neighborhoods and downtown areas with the following summer example.



# UHI Mapping Results



[www.rtcshv.com/heatmap](http://www.rtcshv.com/heatmap)













# Addressing Urban Heat

(through transportation planning)



**Route Planning  
Restoration**



**Reconnecting  
Communities**



**Areas of Persistent  
Poverty**





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# Bicycle and Pedestrian Planning

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2021

# Nevada Assembly Bill 343

requires an action plan for performing walk audits



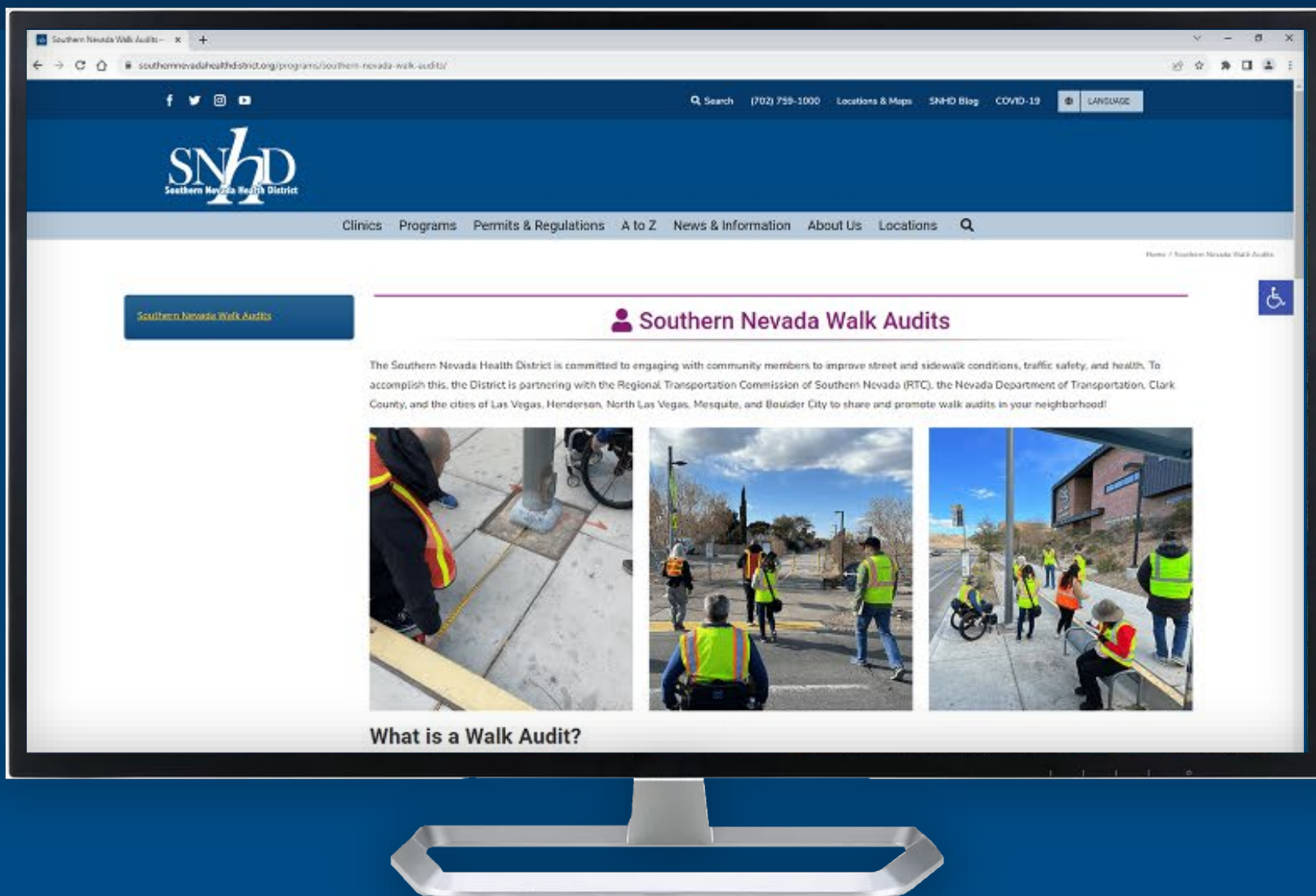


# What is a Walk Audit?





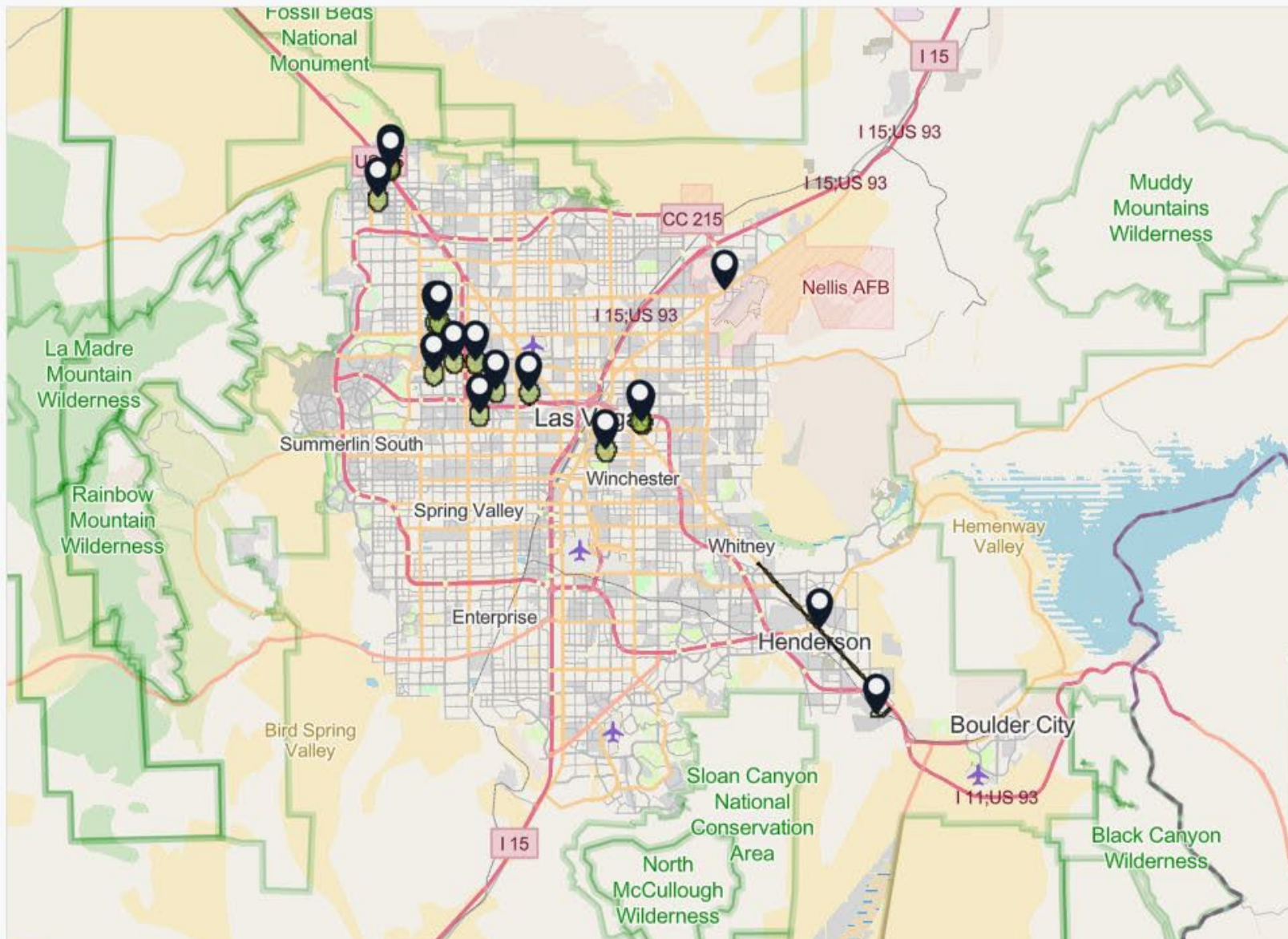
Past walk audits  
performed by the RTC







# Southern Nevada Walk Audit Log



Map data © OpenStreetMap contributors, Microsoft, Facebook, Inc. and its affiliates, Esri Community Maps co... Powered by Esri

## Walk Audit Log

College Area Livable Centers audit  
in Henderson  
Recorded - February 16th, 2023

Safe Routes To School audit in Las Vegas  
Recorded - July 25th, 2023

Safe Routes To School audit in Las Vegas  
Recorded - August 17th, 2023

Safe Routes To School audit in Las Vegas  
Recorded - August 22nd, 2023

Safe Routes To School audit in Las Vegas  
Planned - September 2023



Planned  
19

Recorded  
4





# Next steps





## EXISTING BIKE SHARE SYSTEM



# BIKE SHARE

**25**  
stations

**100**  
classic bikes

**10**  
electric bikes

Launched in  
**Oct 2016**













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# Upcoming RTC Grant Projects

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Regional Transportation Commission





# Route Planning Restoration Program

FTA | *Route Planning Restoration Program*

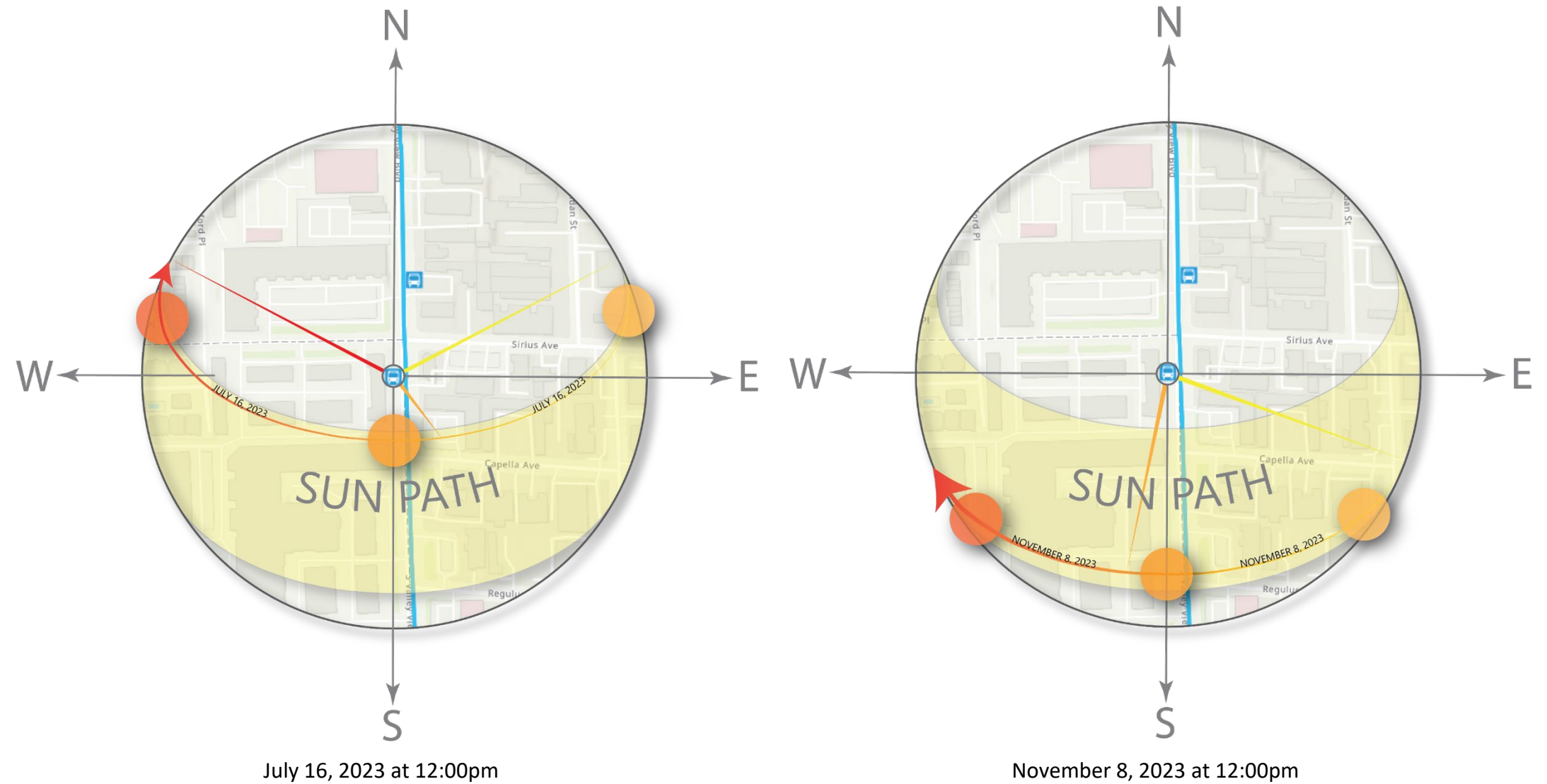




# SUN STUDY: Elevation Angles

Southbound VALLEY VIEW after SIRIUS

Stop #: 2943







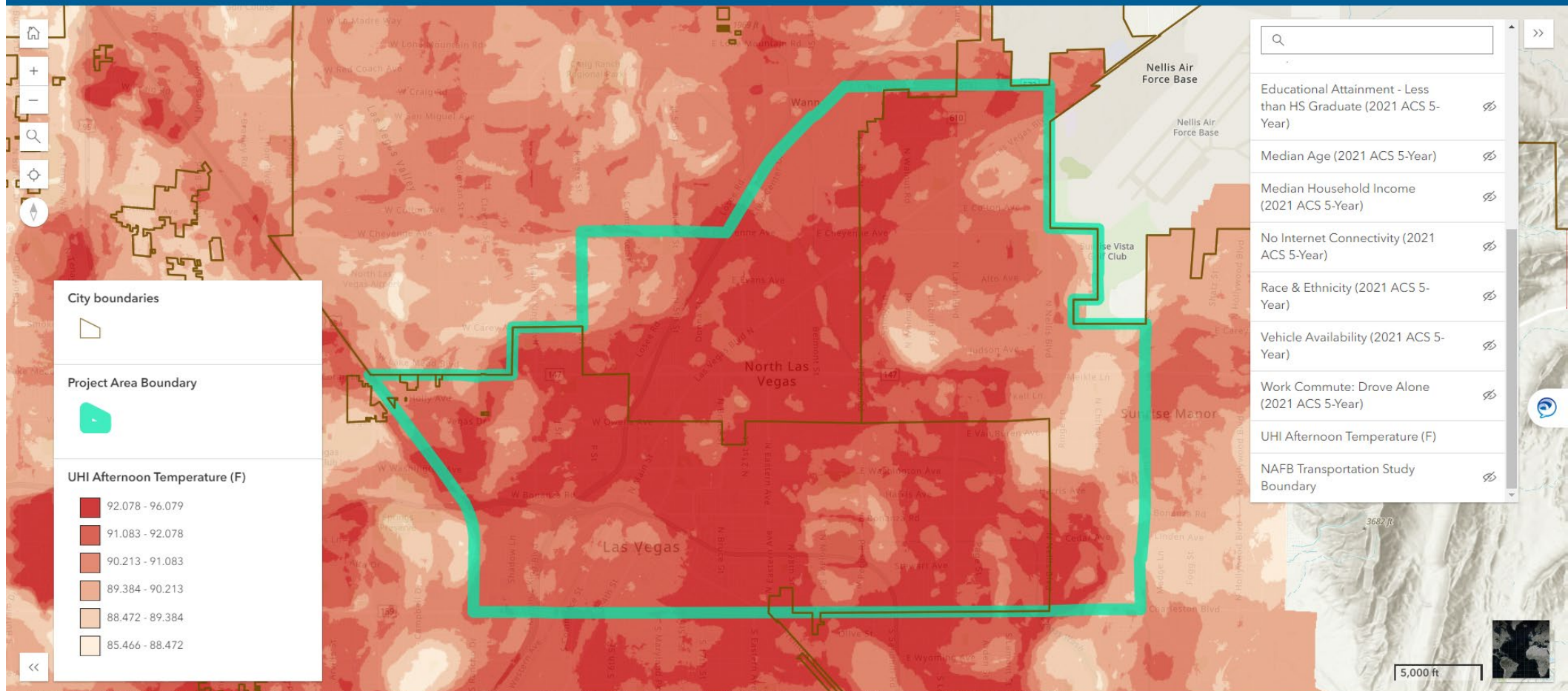
# Equitable Access to Mobility Action Plan

FTA | *Areas of Persistent Poverty (AoPP) Program*



# Study Area

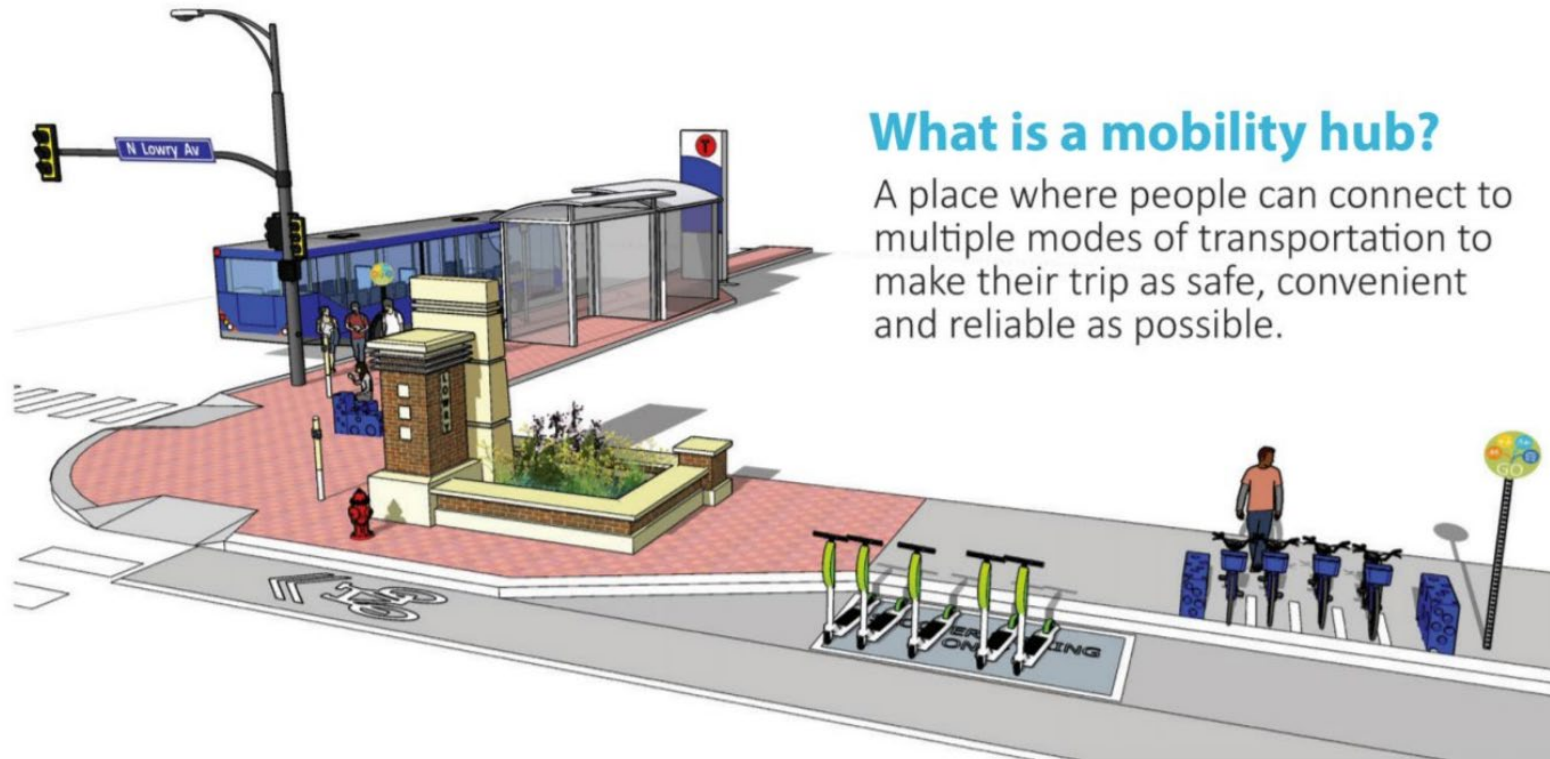
## RTC AoPP Study Area - Equitable Access to Mobility Action Plan



Esri, NASA, NGA, USGS, FEMA | Clark County Dept of Aviation, California State Parks, Esri, TomTom, Garmin, SafeGraph, GeoTechnologies, Inc, METI/NASA, USGS, Bureau of Land Management, EPA, NPS, USDA, USFWS

Powered by Esri

# Mobility Hubs



## What is a mobility hub?

A place where people can connect to multiple modes of transportation to make their trip as safe, convenient and reliable as possible.



# Mobility Hubs



# Mobility Hubs





# Mobility Hubs







**Mobility hubs  
(design & locations)**

+



**Transit stop  
enhancements**

+



**Complete Streets  
improvements**





**RTC**

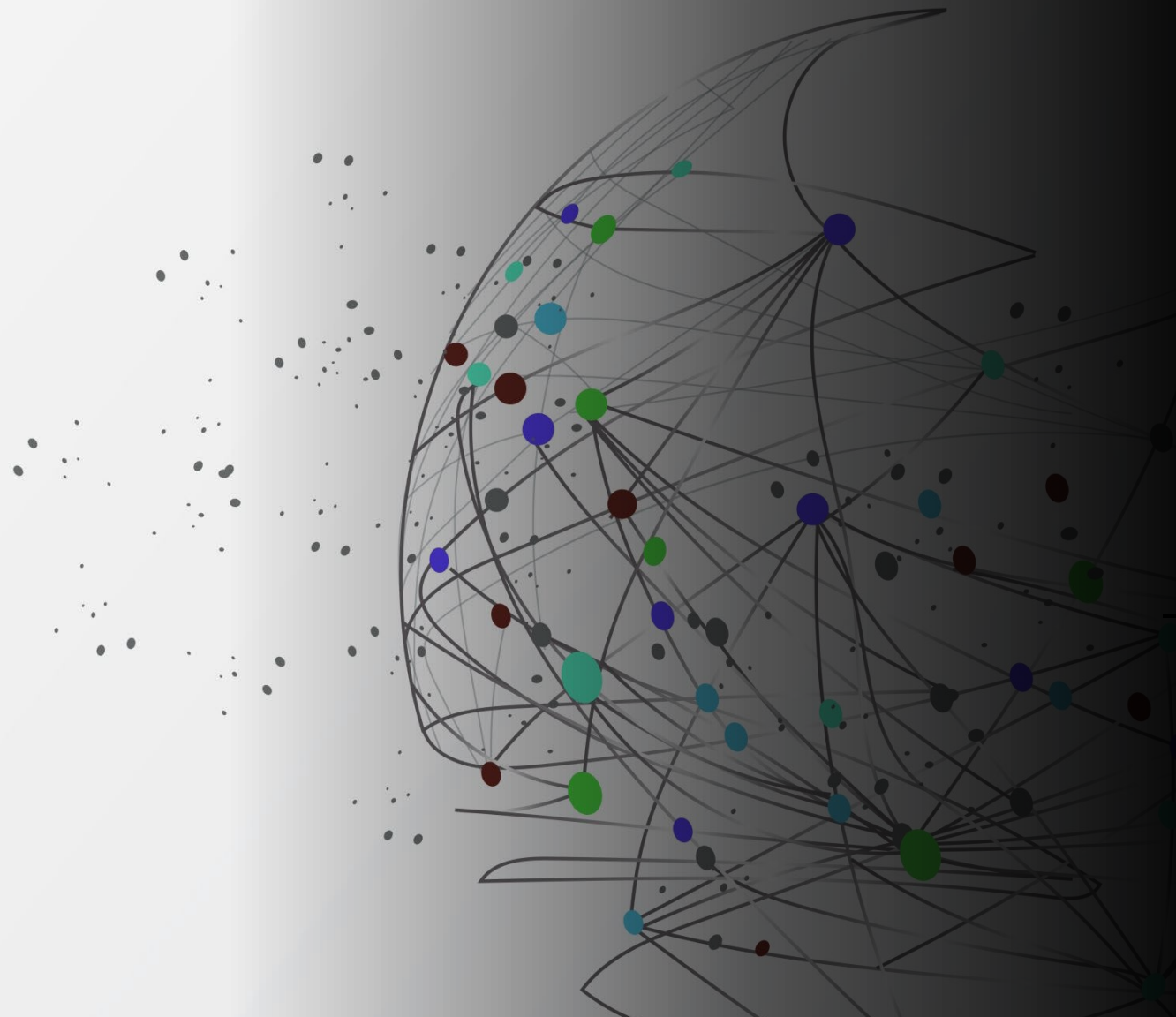


## *From Analysis to Action: Strategies for Chronic Disease Prevention*

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*Benjamin Ashraf, PhD, MPH, CHES, Epidemiologist  
Brandon Delise, MPH, Sr. Epidemiologist  
Department of Epidemiology  
Southern Nevada Health District*



An abstract graphic on the left side of the slide. It features a dark, semi-transparent sphere composed of a complex network of thin, grey lines. Scattered across the surface of this sphere are numerous small, colored dots in shades of blue, green, red, and black. Some of these dots are larger than others, suggesting different levels of importance or activity within the network. The sphere is set against a dark background, with a lighter, hazy area on the far left edge of the slide.

# From Analysis to Action: Strategies for Chronic Disease Prevention

Benjamin Ashraf, Ph.D., MPH

Brandon Delise, MPH



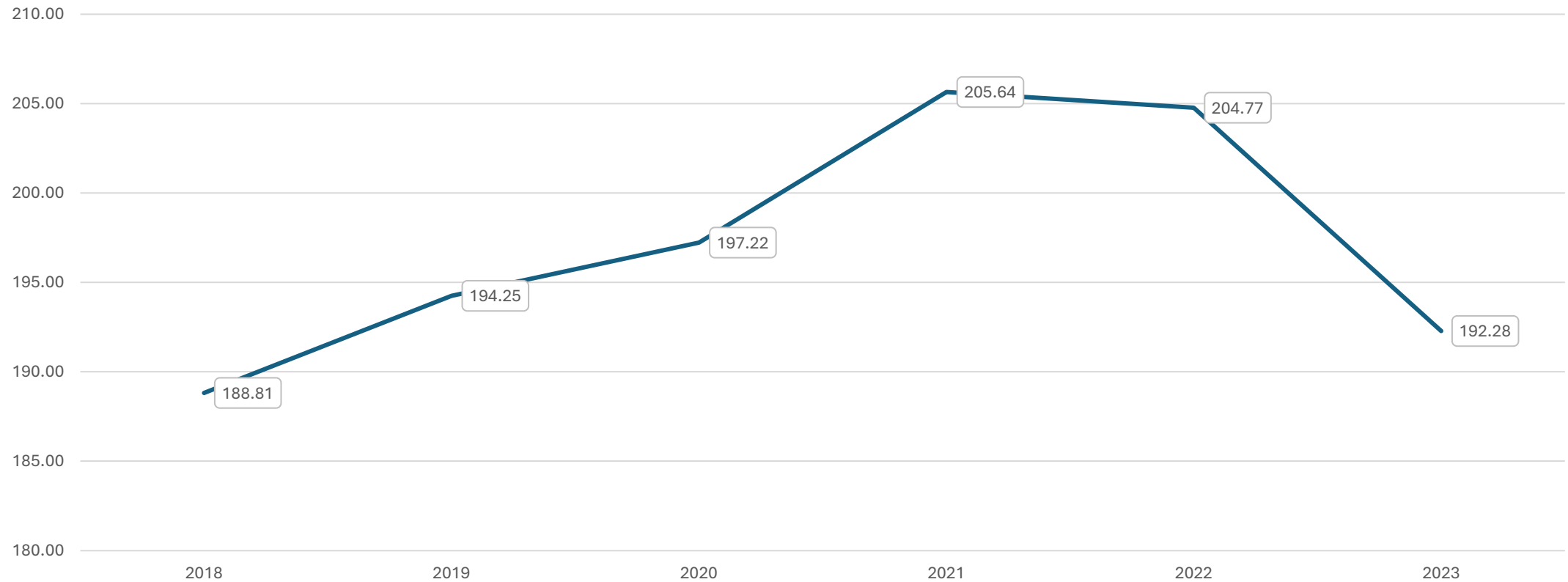


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## What is Heart Disease?

- Heart disease has been the leading cause of death in the United States since 1921.<sup>4</sup> Risk factors include high blood pressure, high cholesterol, smoking, diabetes, overweight and obesity, unhealthy diet, physical inactivity, and excessive alcohol use.<sup>1</sup>
- Heart disease encompasses various conditions, with coronary heart disease being the most common in the United States, characterized by narrowing of the blood vessels that carry blood to the heart. This can lead to chest pain, heart attacks, heart failure, and arrhythmias.<sup>1</sup>

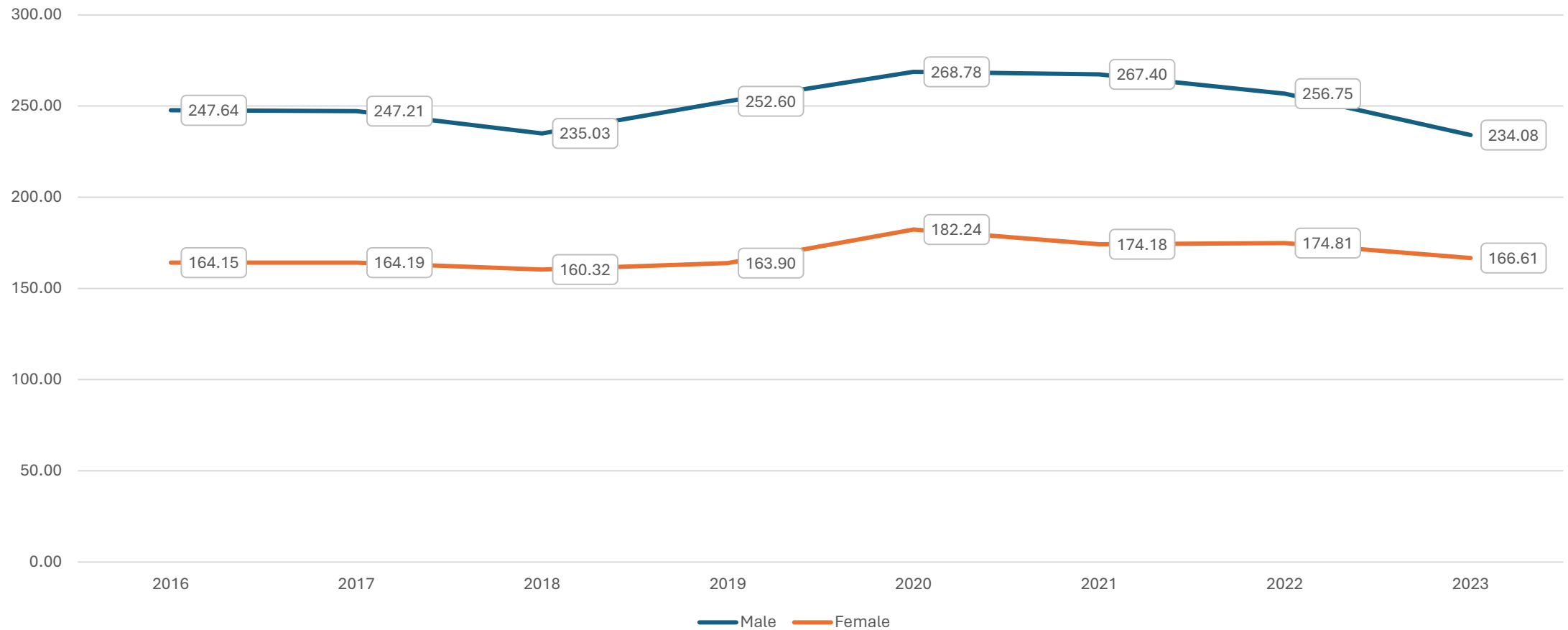
# Heart Disease Age Adjusted Death Rate per 100,000 Clark County Residents, 2018-2023



Data Source: SNHD's Electronic Death Registry System. Current as of 03/06/2024. 2023 data are preliminary and subject to change.



# Heart Disease Crude Death Rate per 100,000 Clark County Residents by Gender, 2016-2023

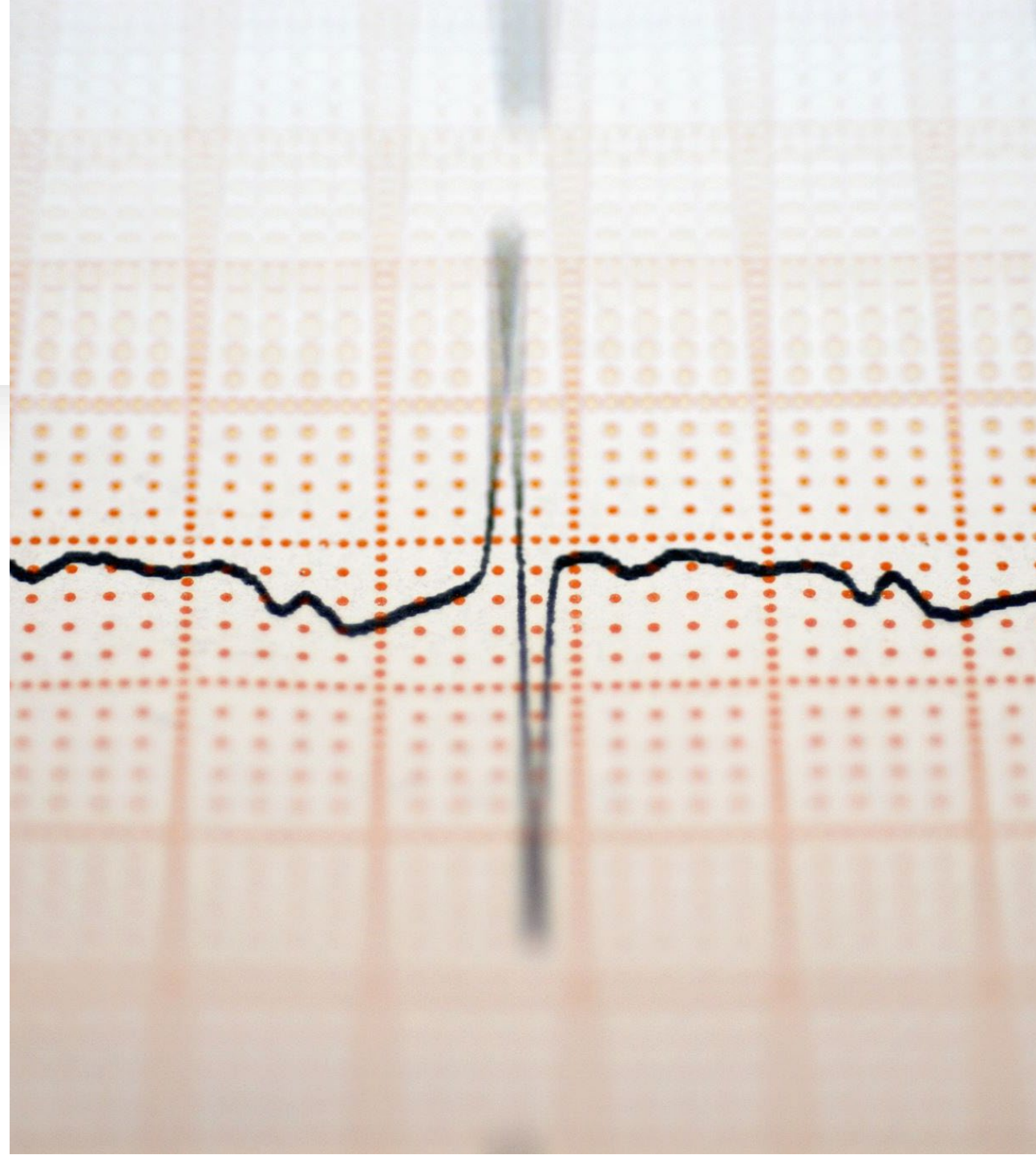


Data Source: SNHD's Electronic Death Registry System. Current as of 03/06/2024. 2023 data are preliminary and subject to change.

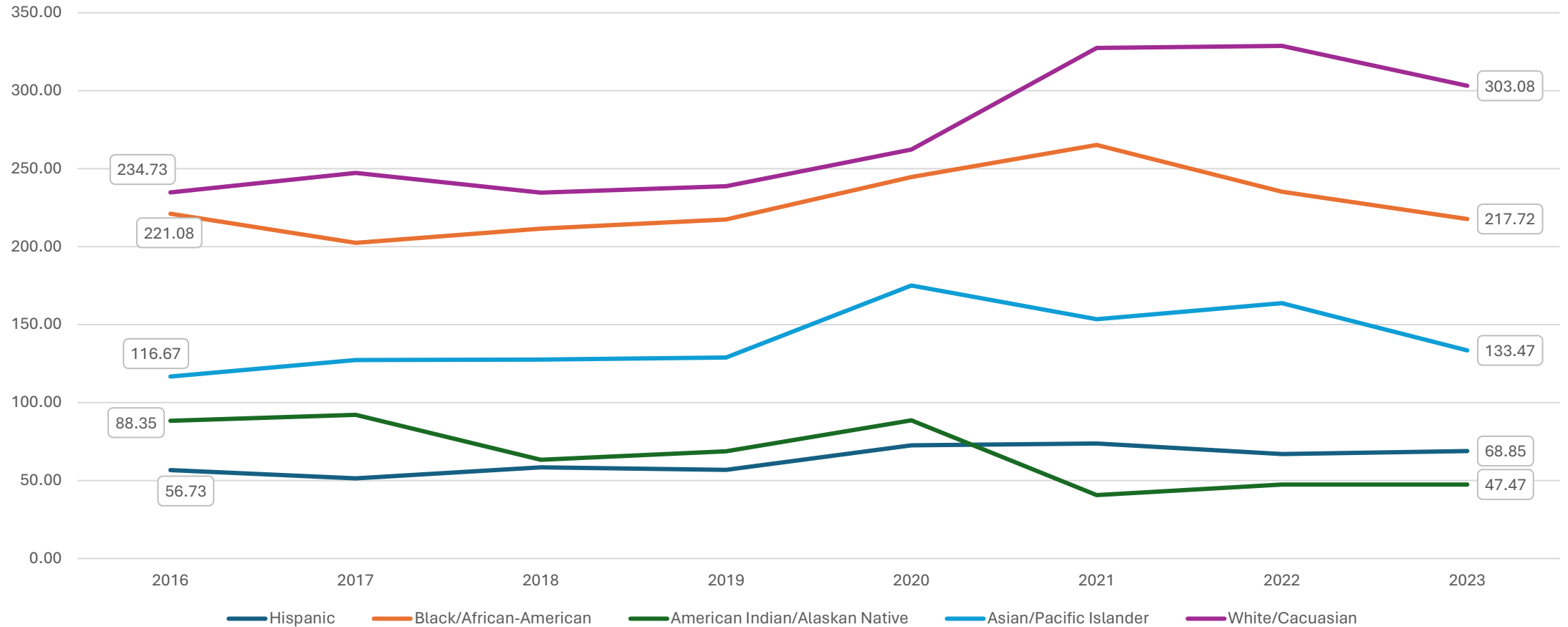
# Heart Disease Deaths: Gender Descriptive Statistics

- From 2016 to 2023, heart disease death rates decreased nearly 5% among Clark County males and increased nearly 2% among Clark County females.
- The heart disease death rate among Clark County males is consistently higher than Clark County females from 2016-2023, in line with gender differences in heart disease deaths nationally.

Data Source: SNHD's Electronic Death Registry System. Current as of 03/06/2024. 2023 data are preliminary and subject to change.



# Heart Disease Crude Death Rate per 100,000 Clark County Residents by Race/Ethnicity, 2016-2023



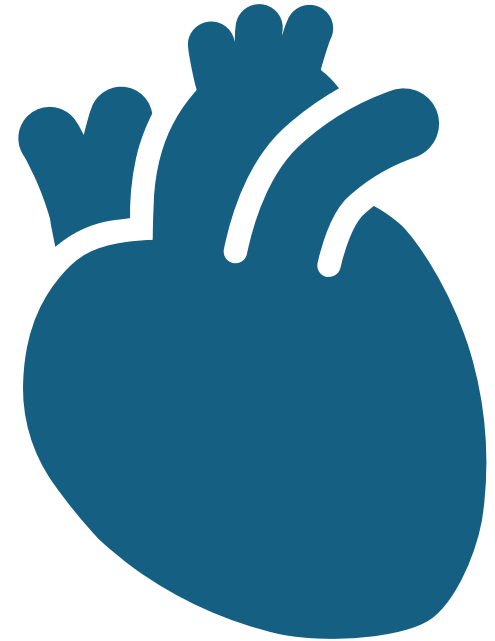
Data Source: SNHD's Electronic Death Registry System.  
Current as of 03/06/2024. 2023 data are preliminary and  
subject to change.



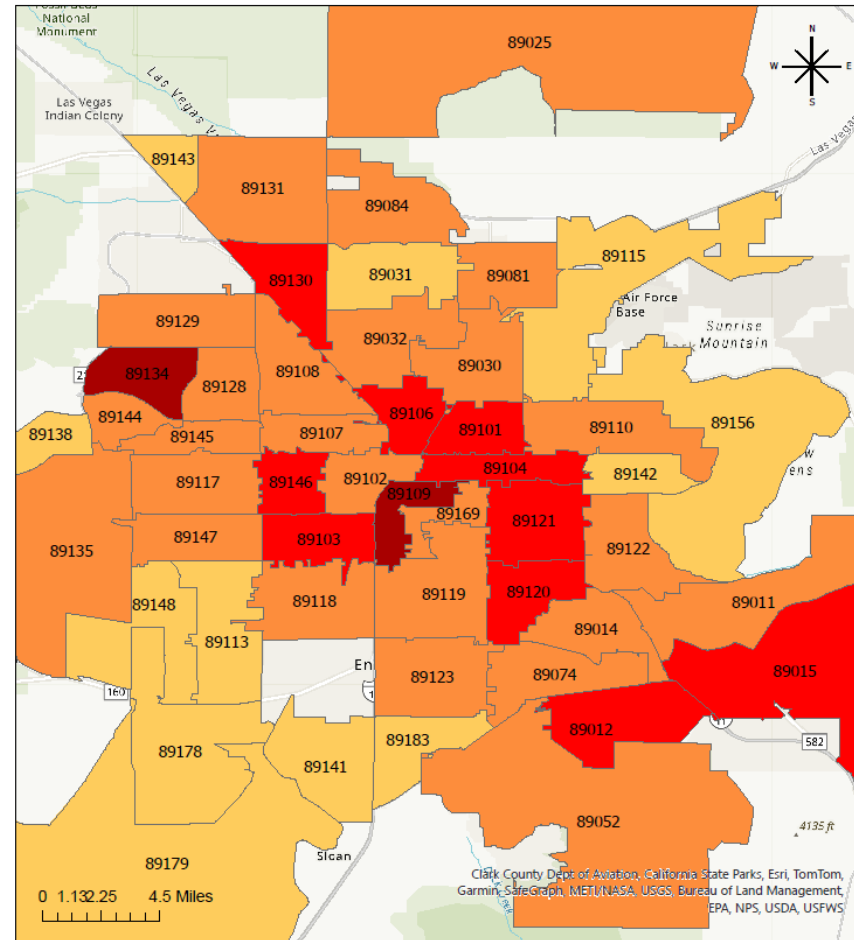
# Heart Disease Deaths: Race/Ethnicity Descriptive Statistics

- There is an increase in the death rate among all ethnicities, except American Indians/Alaskan Natives and Black/African-Americans, from 2016 to 2023.
  - The largest increase from 2016-2023 took place among Clark County residents who were White.
- There are disparities in the number of heart disease deaths among different ethnic groups.
  - Notably among Whites and Blacks/African-Americans.

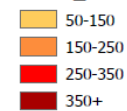
Data Source: SNHD's Electronic Death Registry System. Current as of 03/06/2024. 2023 data are preliminary and subject to change.



Heart Disease Death Rate per 100,000 Clark County Residents, 2023



crude\_rate2023



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# Heart Disease Deaths: Resident ZIP Code Descriptive Statistics

- The resident ZIP codes experiencing the largest increase in crude death rates due to heart disease from 2018-2023 were observed in:
  - 89081 (99.3%)
  - 89027 (71.6%)
  - 89138 (69.7%)
  - 89146 (59.8%)
  - 89144 (54.9%)

Note: ZIP codes with numerators less than 5 and/or denominators less than 100 were excluded.

Data Source: SNHD's Electronic Death Registry System. Current as of 03/06/2024. 2023 data are preliminary and subject to change.





# The Relationship Between Smoking and Heart Disease

For smokers themselves:

- Smoking causes one of every four deaths from CVD<sup>1</sup>
  - Increase the buildup of plaque in blood vessels
  - Lower “good” cholesterol (HDL)
  - Cause thickening and narrowing of blood vessels

For those exposed to second-hand smoke:

- Exposure at home or at work increase risk of:
  - Heart Disease (25–30%)<sup>1</sup>
  - Strokes (20–30%)<sup>1</sup>
- Interferes with the normal functioning of the heart, blood, and vascular systems
- Brief exposure can damage the lining of blood vessels and cause your blood to become stickier

# However, There is Good News

- A majority of Nevada residents who smoke or who use tobacco are interested in quitting tobacco
  - Nevada reported a state specific prevalence of 85.2 individuals (80.7–89.7) between 2018 – 2019<sup>2</sup>
- A majority of Nevada residents who smoke or who use tobacco are interested in:
  - Use of cessation counseling and/or medications to quit - 25.5 individuals (17.3–33.7)<sup>2</sup>
  - Use of cessation medications to quit - 23.9 individuals (16.1–31.7)<sup>2</sup>



# How Can We Address This Problem?

- Comprehensive approach is needed
  - Interventions addressing prevention and cessation of tobacco use are needed
- Such strategies will not only promote cardiovascular health, but also assist with the prevention of future cardiovascular events<sup>3</sup>
- Community based strategies are a key for success
  - Such approaches can help guide and improve the effectiveness of smoking cessation programs.<sup>5</sup>
- Economic evaluations of community-based tobacco cessation activities have shown them cost-effective.<sup>6</sup>





# Strategies for Improvement Moving Forward

- Continued work and funding are needed to address tobacco prevention and other chronic diseases associated with CVD
- Interventions should use a variety of approaches to address this problem
  - Community involvement in these projects needs to occur early in the process
- Future interventions should involve consistent cost effectiveness analysis to support their continued use or their respective need for adaption

# References

- 1) CDC.GOV  
[https://www.cdc.gov/tobacco/basic\\_information/health\\_effects/heart\\_disease/index.htm#:~:text=Smoking%20can%3A&text=Raise%20triglycerides%20\(a%20type%20of,to%20the%20heart%20and%20brain](https://www.cdc.gov/tobacco/basic_information/health_effects/heart_disease/index.htm#:~:text=Smoking%20can%3A&text=Raise%20triglycerides%20(a%20type%20of,to%20the%20heart%20and%20brain)
- 2) Cornelius ME, Wang TW, Jamal A, et al. State-Specific Prevalence of Adult Tobacco Product Use and Cigarette Smoking Cessation Behaviors, United States, 2018-2019. *Prev Chronic Dis.* 2023;20:E107. Published 2023 Nov 23. doi:10.5888/pcd20.230132
- 3) Carroll AJ, Labarthe DR, Huffman MD, Hitsman B. Global tobacco prevention and control in relation to a cardiovascular health promotion and disease prevention framework: A narrative review. *Prev Med.* 2016;93:189-197. doi:10.1016/j.ypmed.2016.10.004
- 4) Martin, S. S., Aday, A. W., Almarzooq, Z. I., Anderson, C. A. M., Arora, P., Avery, C. L., Baker-Smith, C. M., Barone Gibbs, B., Beaton, A. Z., Boehme, A. K., Commodore-Mensah, Y., Currie, M. E., Elkind, M. S. V., Evenson, K. R., Generoso, G., Heard, D. G., Hiremath, S., Johansen, M. C., Kalani, R., ... Palaniappan, L. P. (2024). 2024 heart disease and stroke statistics: A report of US and Global Data from the American Heart Association. *Circulation*, 149(8). <https://doi.org/10.1161/cir.0000000000001209>
- 5) Sheikhattari P, Apata J, Kamangar F, et al. Examining Smoking Cessation in a Community-Based Versus Clinic-Based Intervention Using Community-Based Participatory Research. *J Community Health.* 2016;41(6):1146-1152. doi:10.1007/s10900-016-0264-9
- 6) Reisinger SA, Kamel S, Seiber E, Klein EG, Paskett ED, Wewers ME. Cost-Effectiveness of Community-Based Tobacco Dependence Treatment Interventions: Initial Findings of a Systematic Review. *Prev Chronic Dis.* 2019 Dec 12;16:E161. doi: 10.5888/pcd16.190232. PMID: 31831106; PMCID: PMC6936666.

## County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

### *Questions and Closing Remarks*

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## County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

# Thank you for attending!

