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:

SNHD Southern Nevada Health District

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

School of Public Health
Making Health Happen

NEVADA PUBLIC HEALTH INSTITUTE

NNPH

LARSON INSTITUTE
HEALTH IMPACT AND EQUITY

CARSON CITY
HEALTH & HUMAN SERVICES

CNHD
CENTRAL NEVADA HEALTH DISTRICT

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Welcome!

Maria Azzarelli, EMHA, CHES
Manager, Office of Chronic Disease Prevention and Health Promotion
Acting Director Community Health Division
Southern Nevada Health District

SNHD
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

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2024 Nevada County Health Rankings and Roadmaps

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

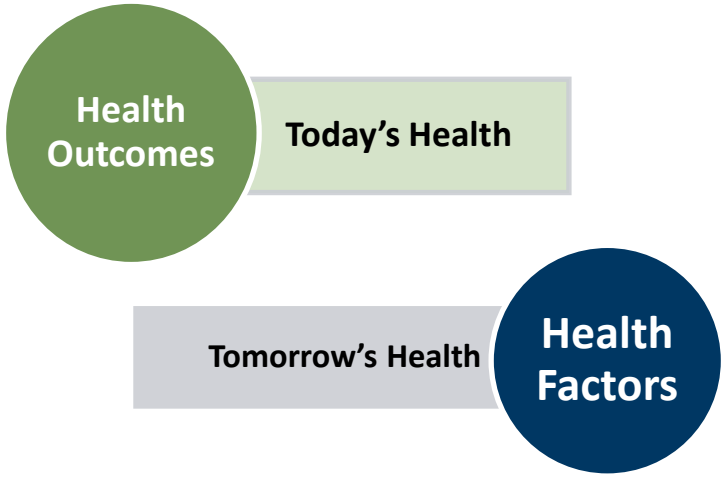
County Rankings Project Partners

- 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

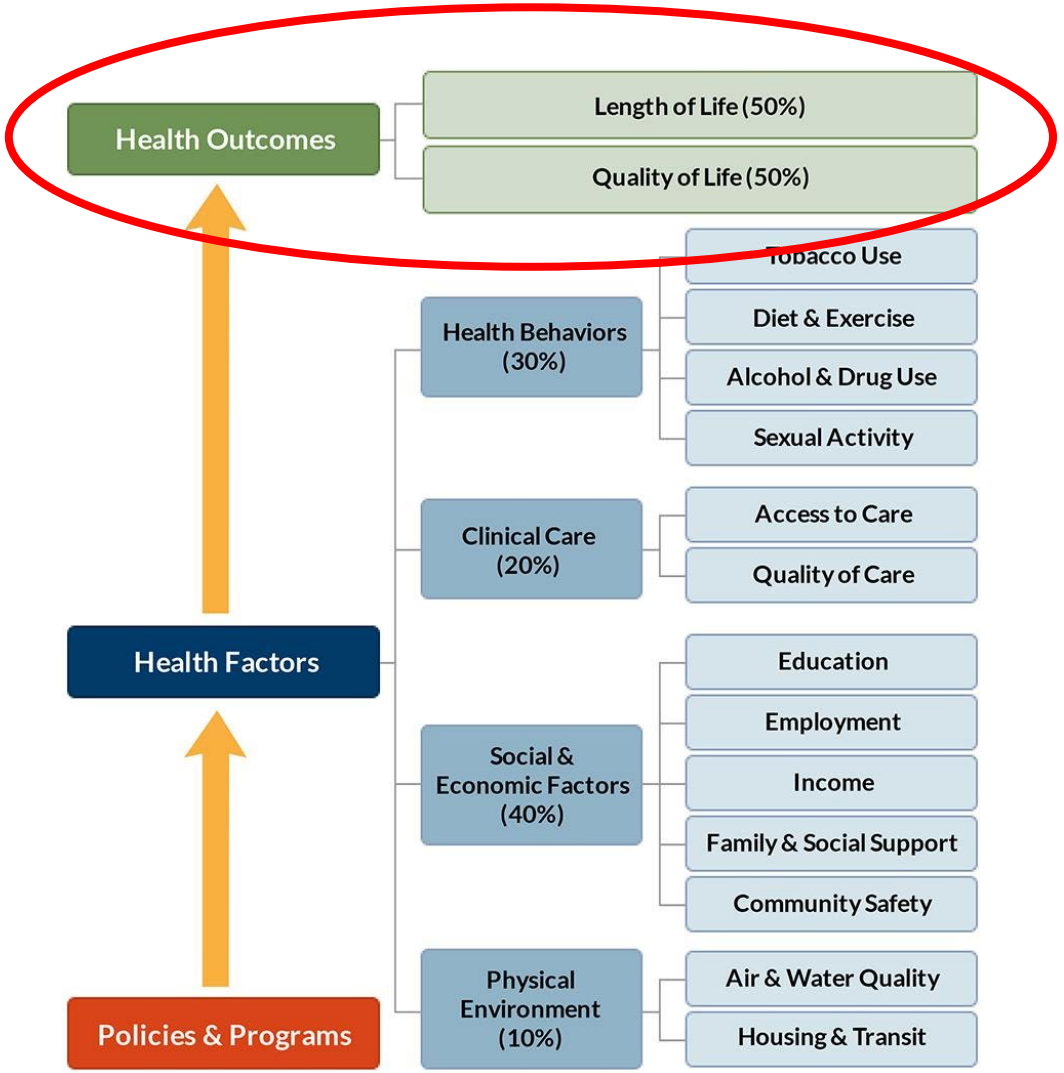
2024 Measures and Data Sources

www.CountyHealthRankings.org

Two Sets of Rankings – Health Outcomes



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



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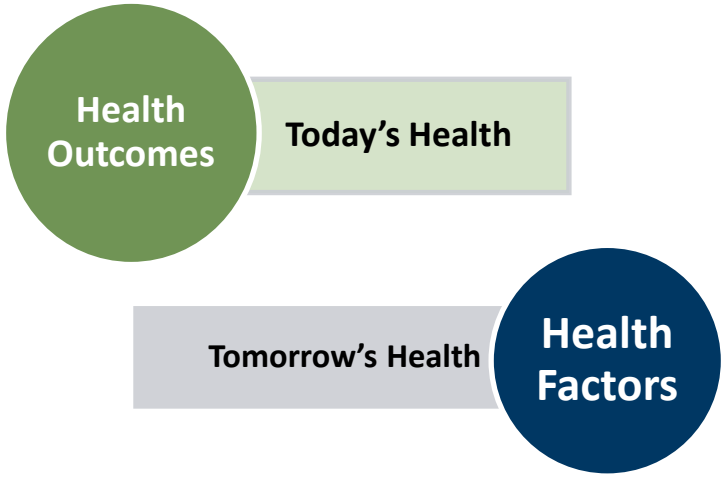
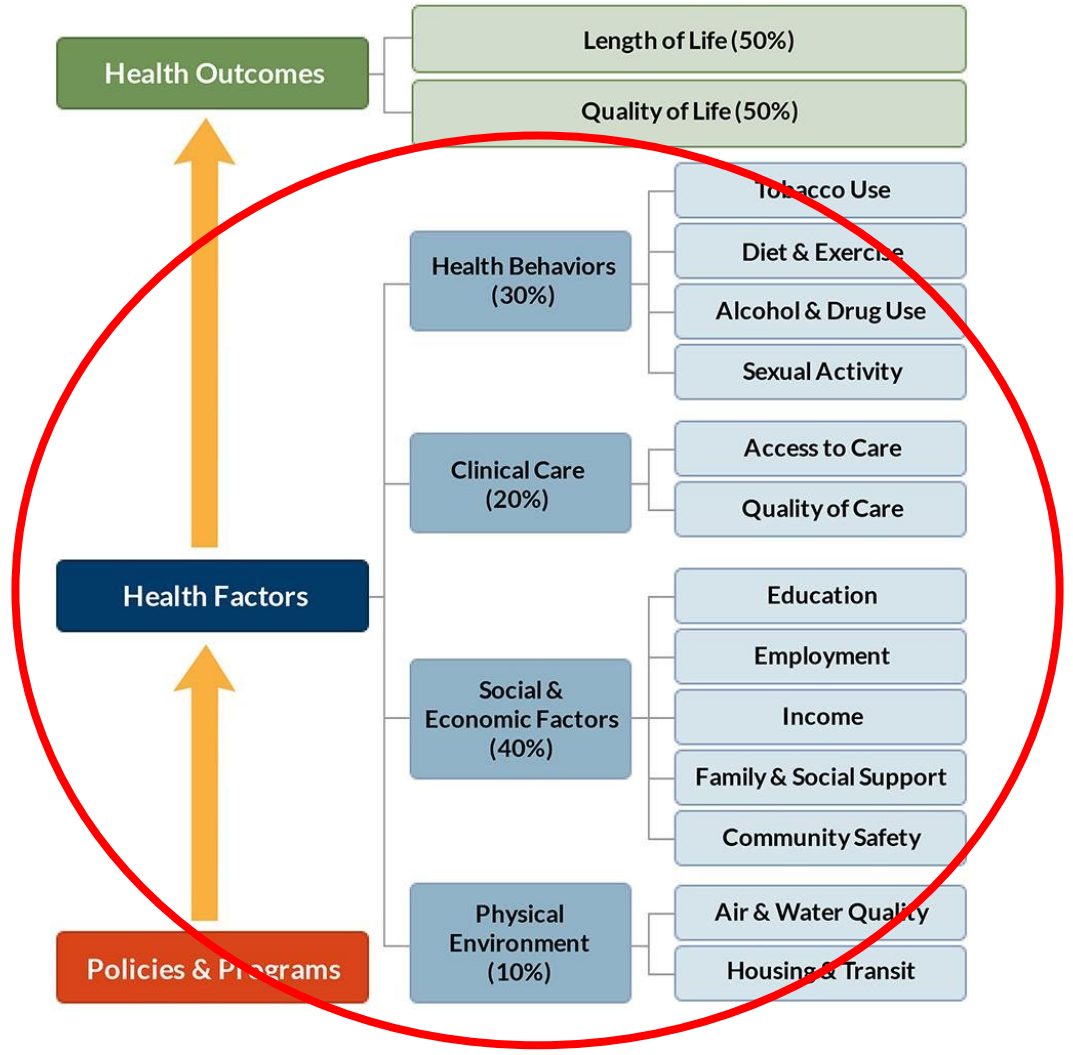
Two Sets of Rankings – Health Factors





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

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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

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2024 Nevada Health Factors Rankings

1. Douglas (1)*
2. Storey (2)
3. Washoe (3)
4. Carson City (8)
5. Elko (6)
6. White Pine (5)
7. Eureka (NR)
8. Churchill (7)
9. Lander (9)
10. Lincoln (4)
11. Humboldt (10)
12. Pershing (14)
13. Lyon (12)
14. Clark (11)
15. Mineral (15)
16. Nye (13)

Not ranked – Esmeralda

(*) Ranking in 2010

Note: Eureka County was not ranked in 2010

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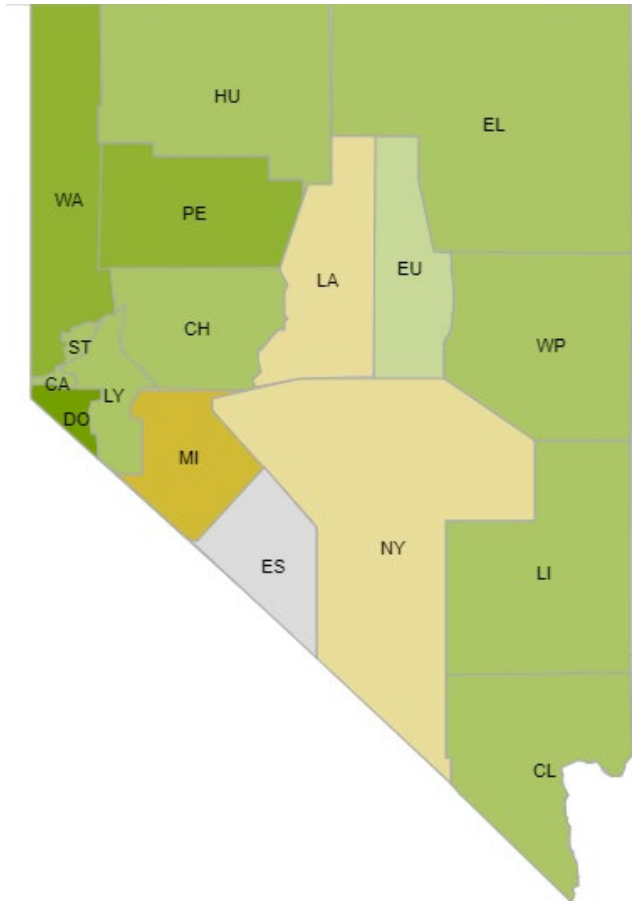
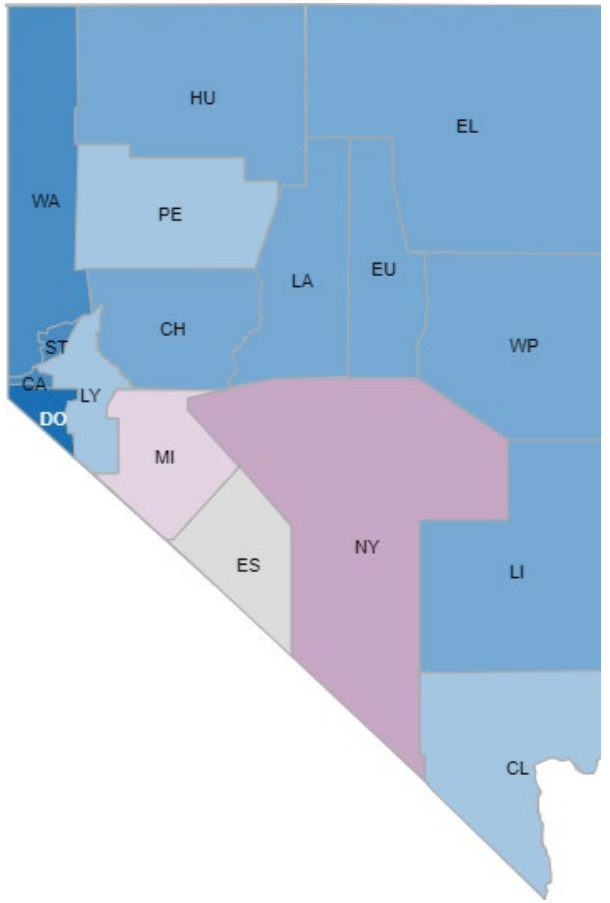
Health Outcomes and Factors Rankings – 2024



LEAST HEALTHY IN US HEALTHIEST IN US



LEAST HEALTHY IN US HEALTHIEST IN US

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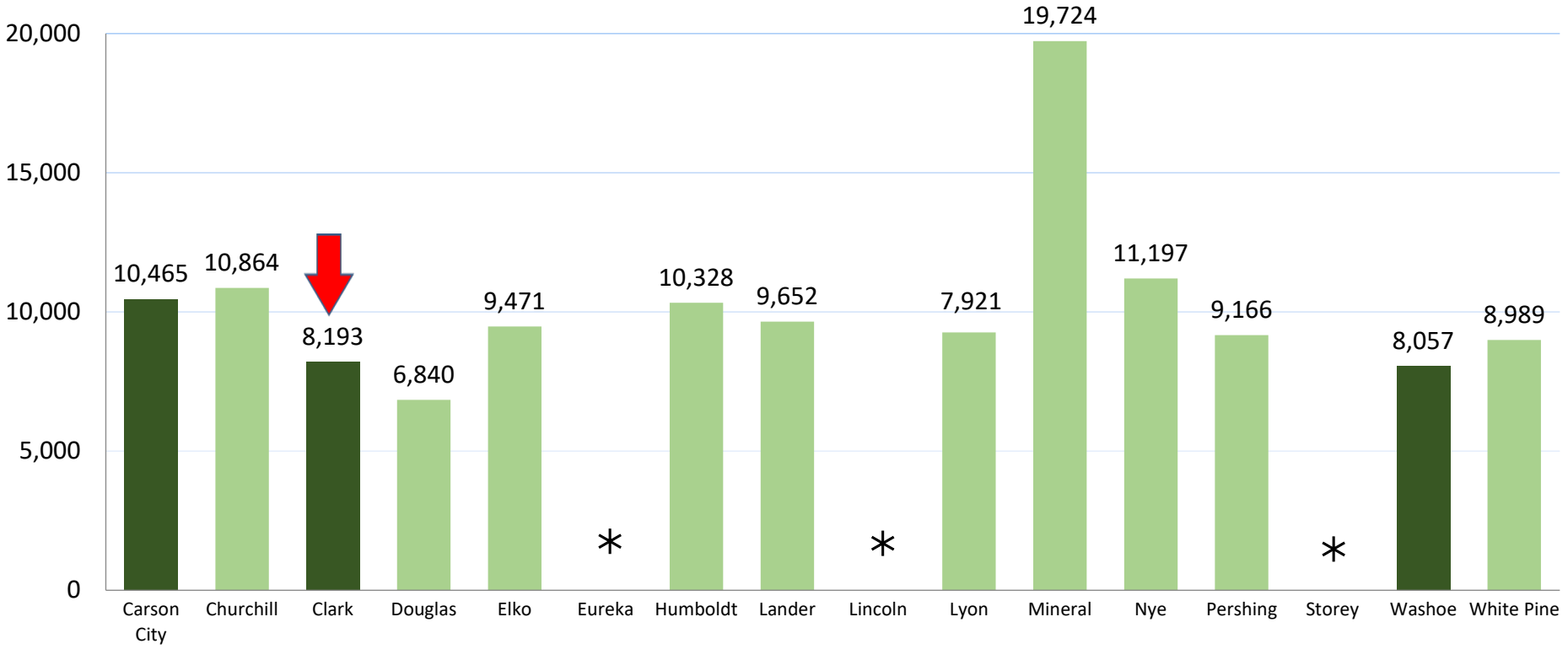
Health Outcomes – Premature Death

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

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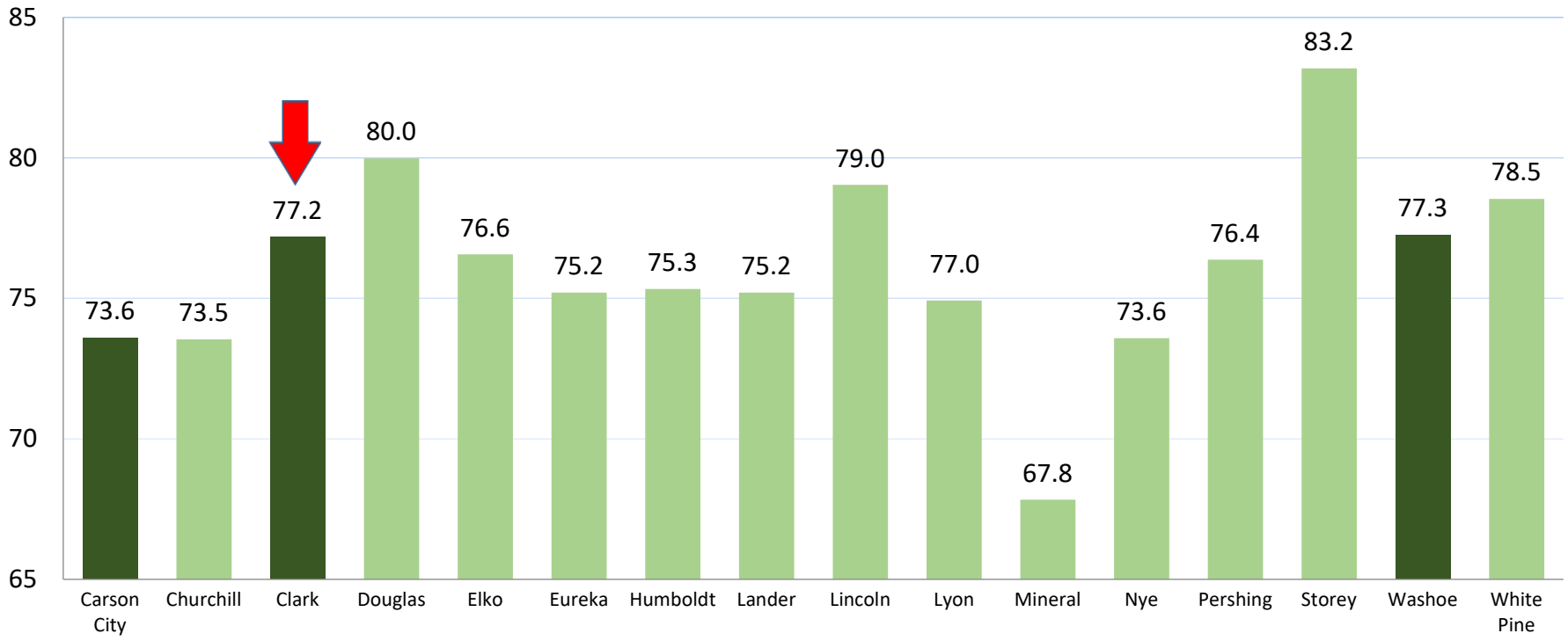
Health Outcomes – Life Expectancy

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).

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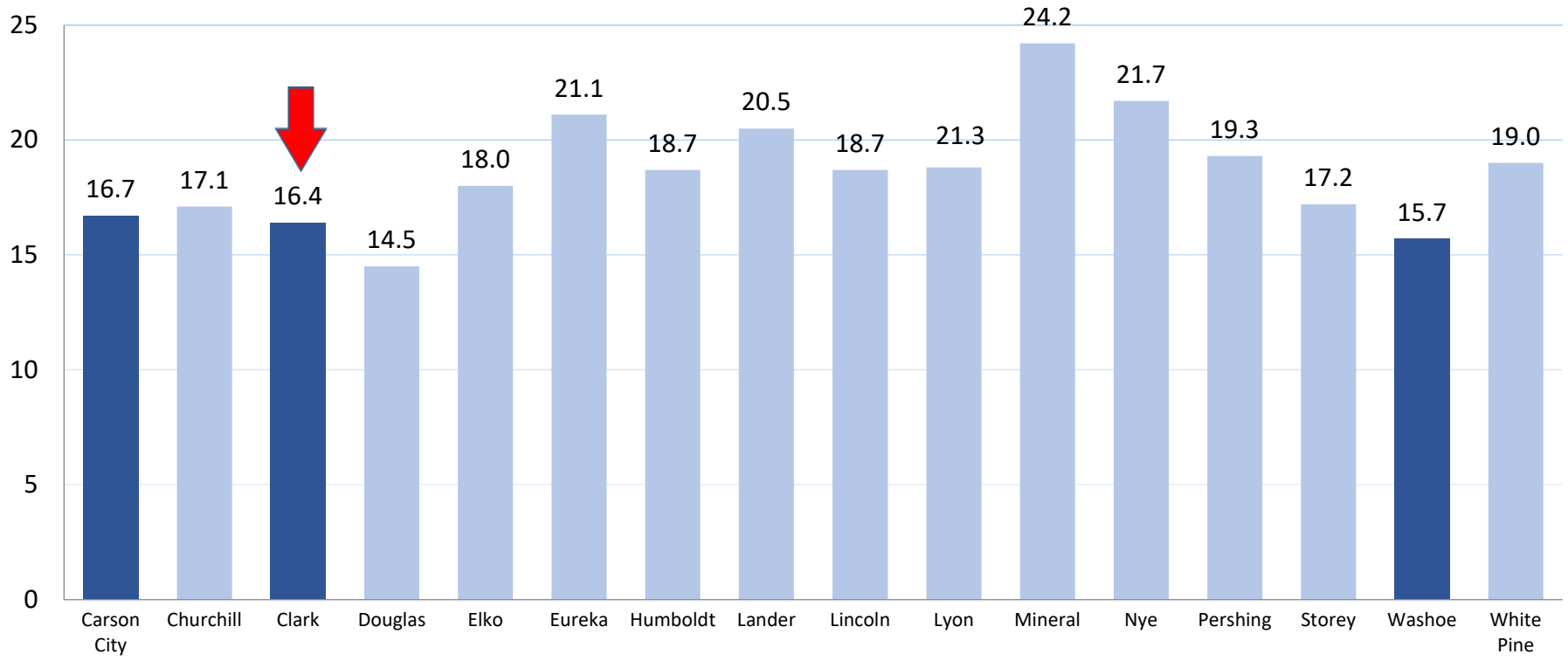
Health Behaviors – Adult Smoking

Percentage of adults who are current smokers

US Average = 15.0% Nevada Average = 15.3% Nevada Range = 14.5 to 24.2%



Source: Behavioral Risk Factor Surveillance System (2021).

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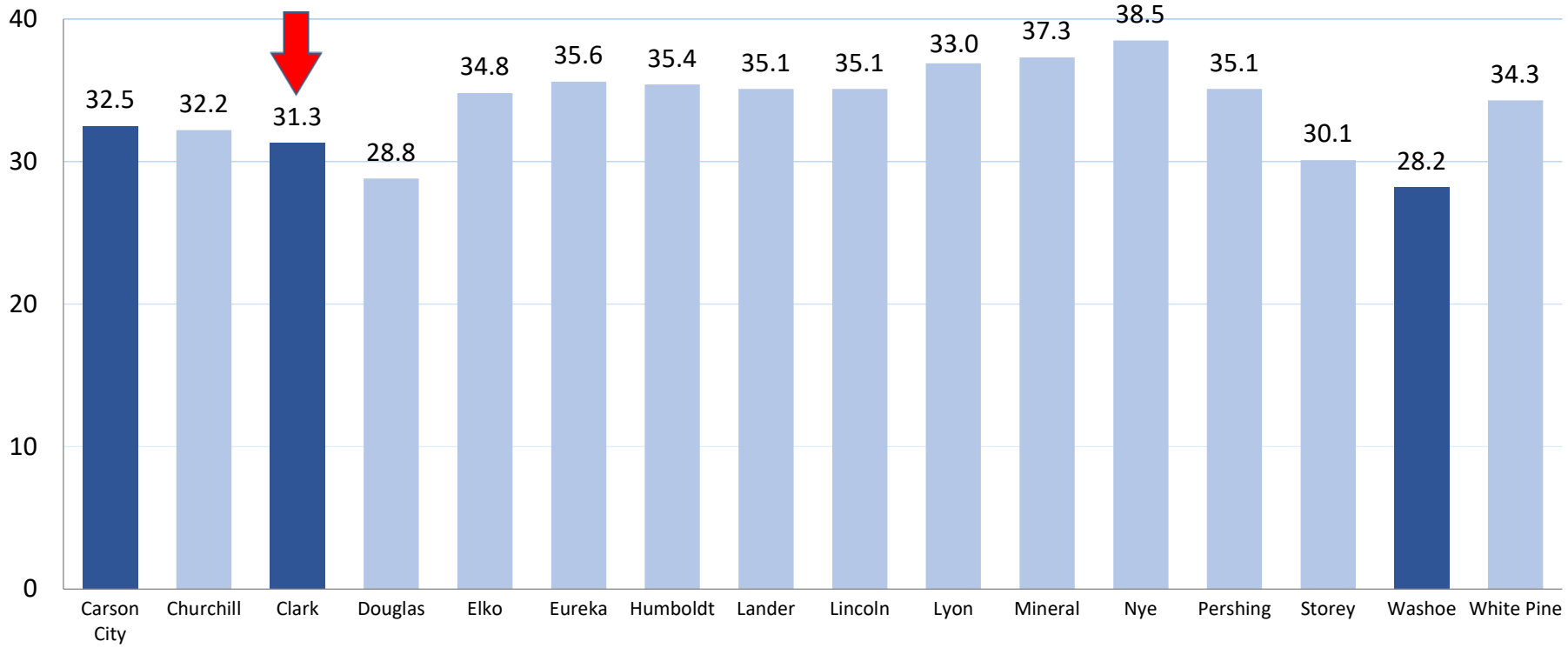
Health Behaviors – Adult Obesity

Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2

US Average = 34.0% Nevada Average = 31.5% Nevada Range = 28.2 to 38.5%



Source: Behavioral Risk Factor Surveillance System (2021).

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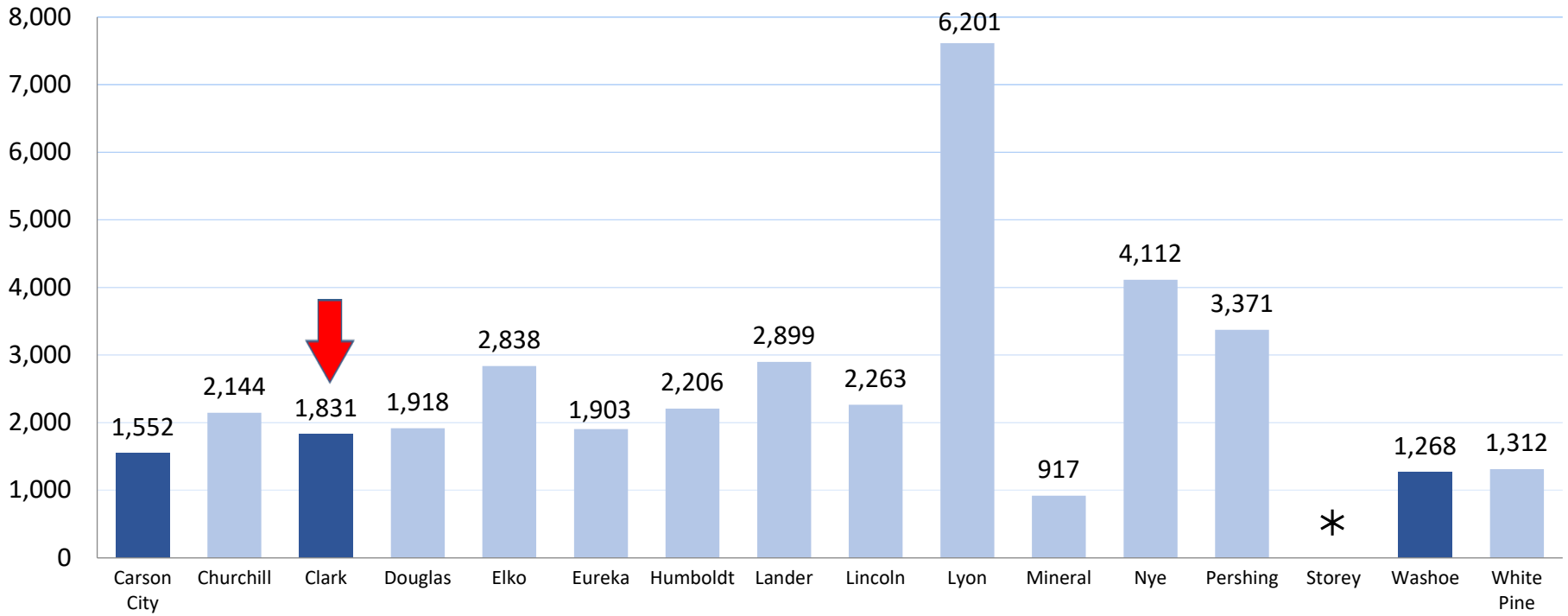
Clinical Care – Primary Care Physicians

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

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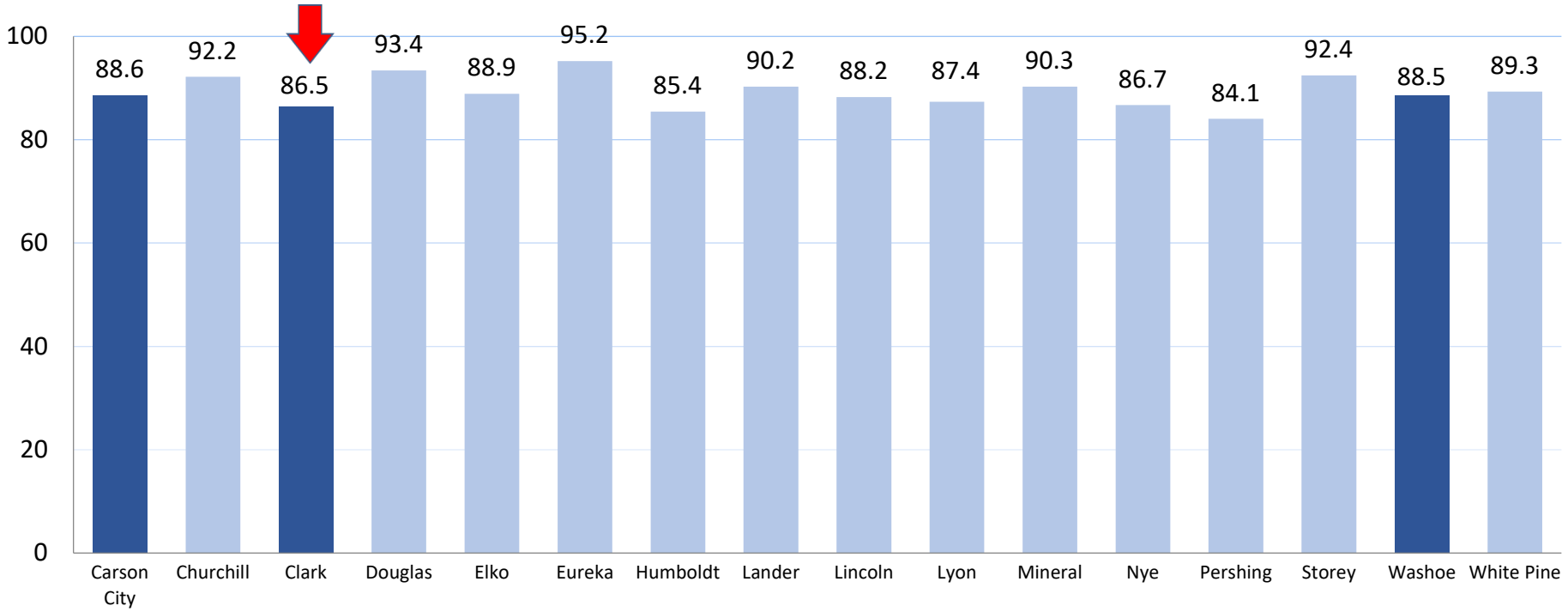
Social and Economic – High School Completion

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)

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Comparisons with Peer Counties

	Clark, NV	Salt Lake, UT	Oklahoma, OK	Maricopa, AZ
	Remove Location	Remove Location	Remove Location	Remove Location
Health Outcomes				
Length of Life	Clark, NV	Salt Lake, UT	Oklahoma, OK	Maricopa, AZ
Premature Death	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%

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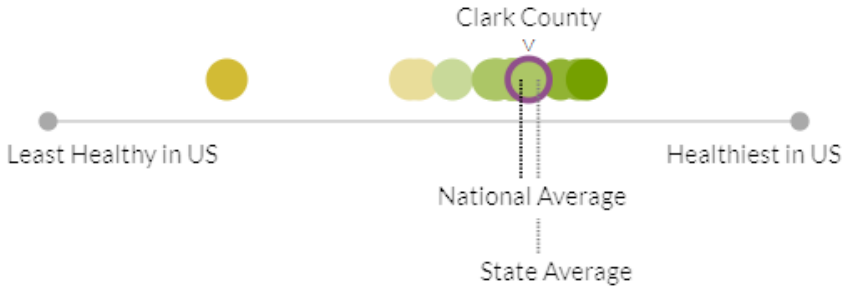
Clark County 2024 Recap

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.

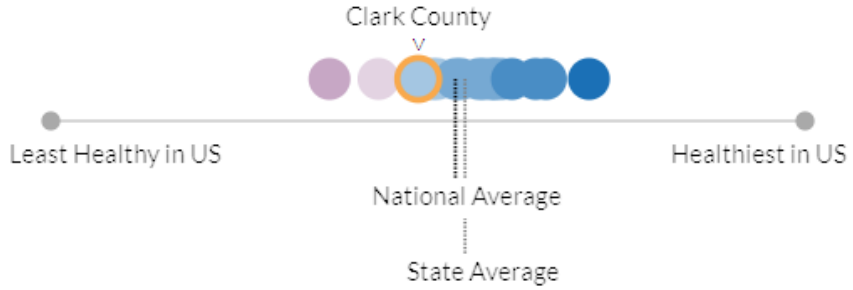
Clark County is faring worse than the average county in Nevada for Health Outcomes, and about the same as the average county in the nation.



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.



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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

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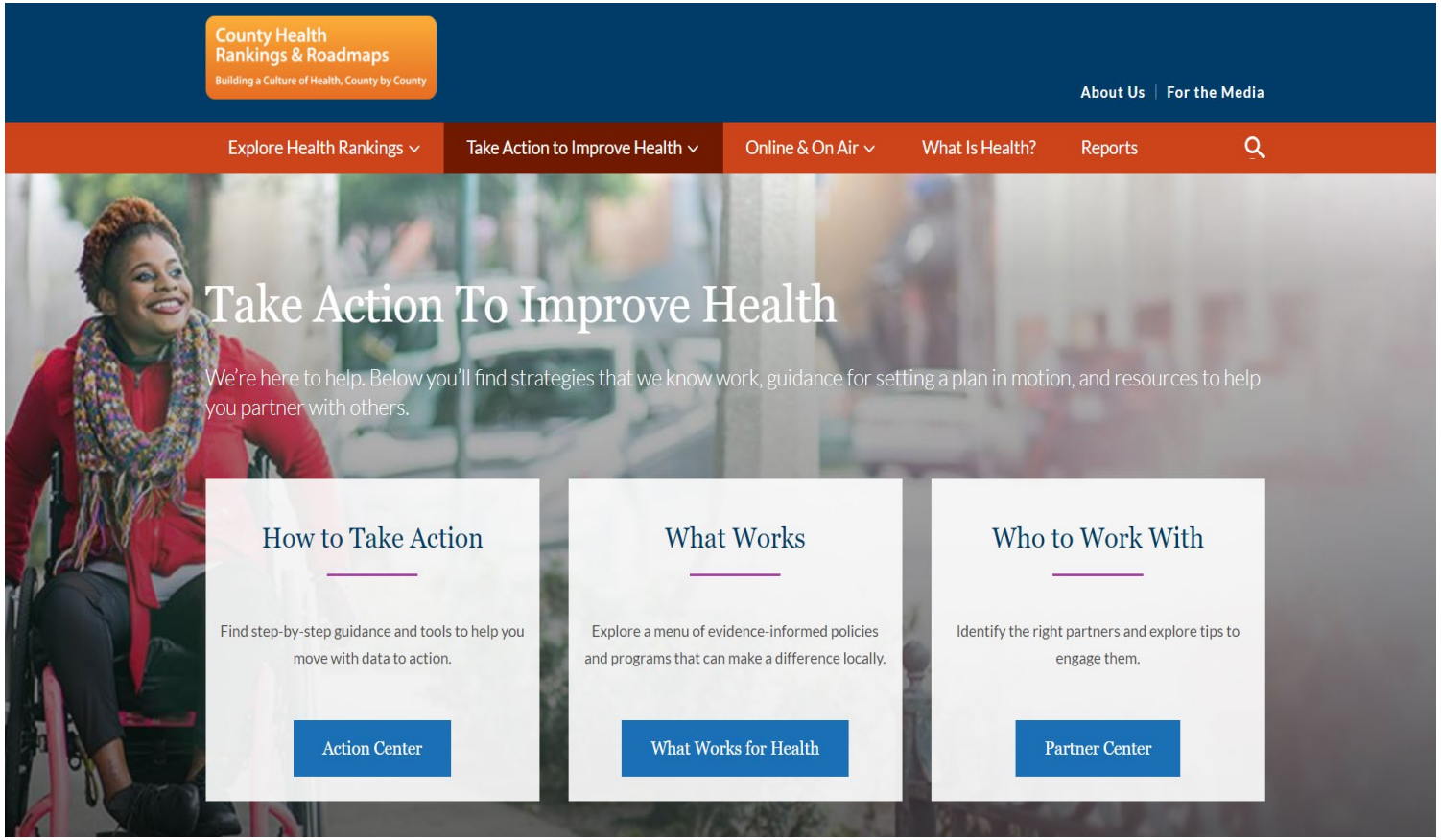
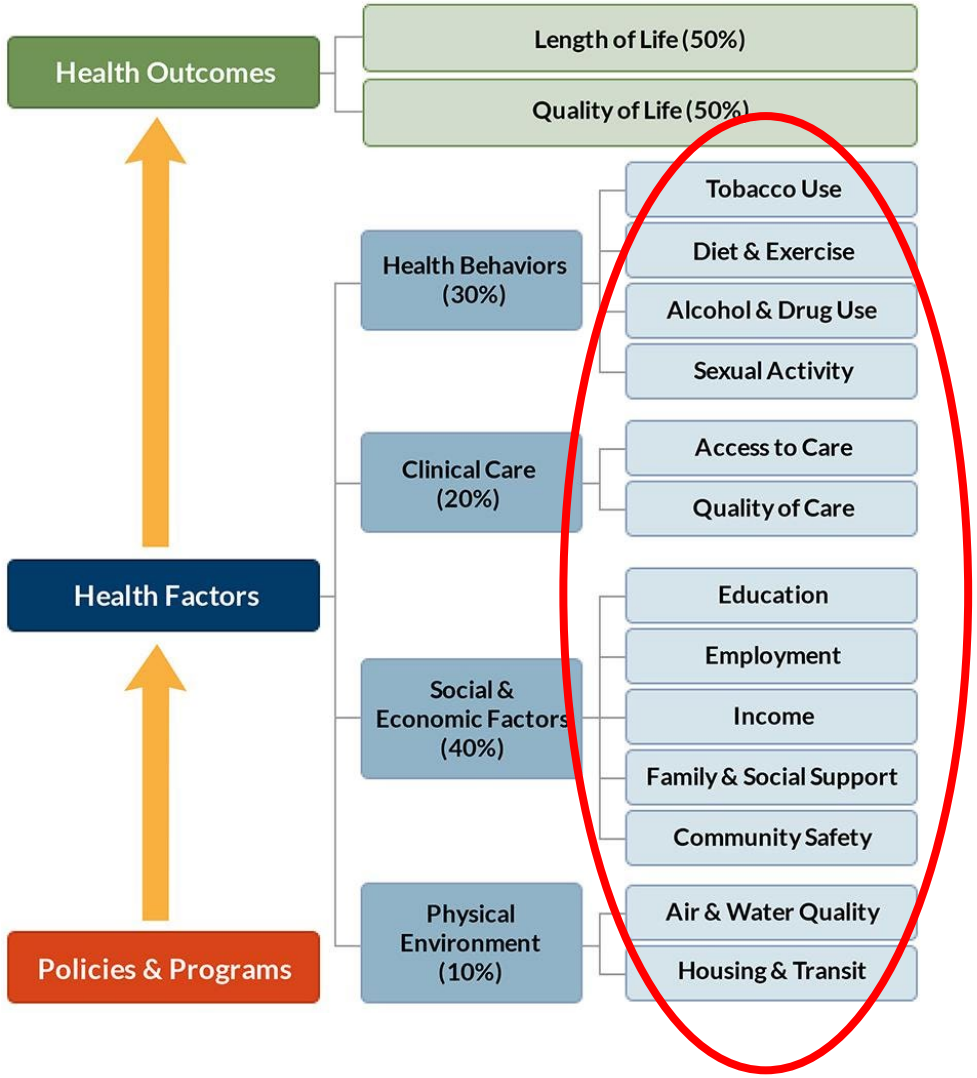
Policies and Programs to Improve Health



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



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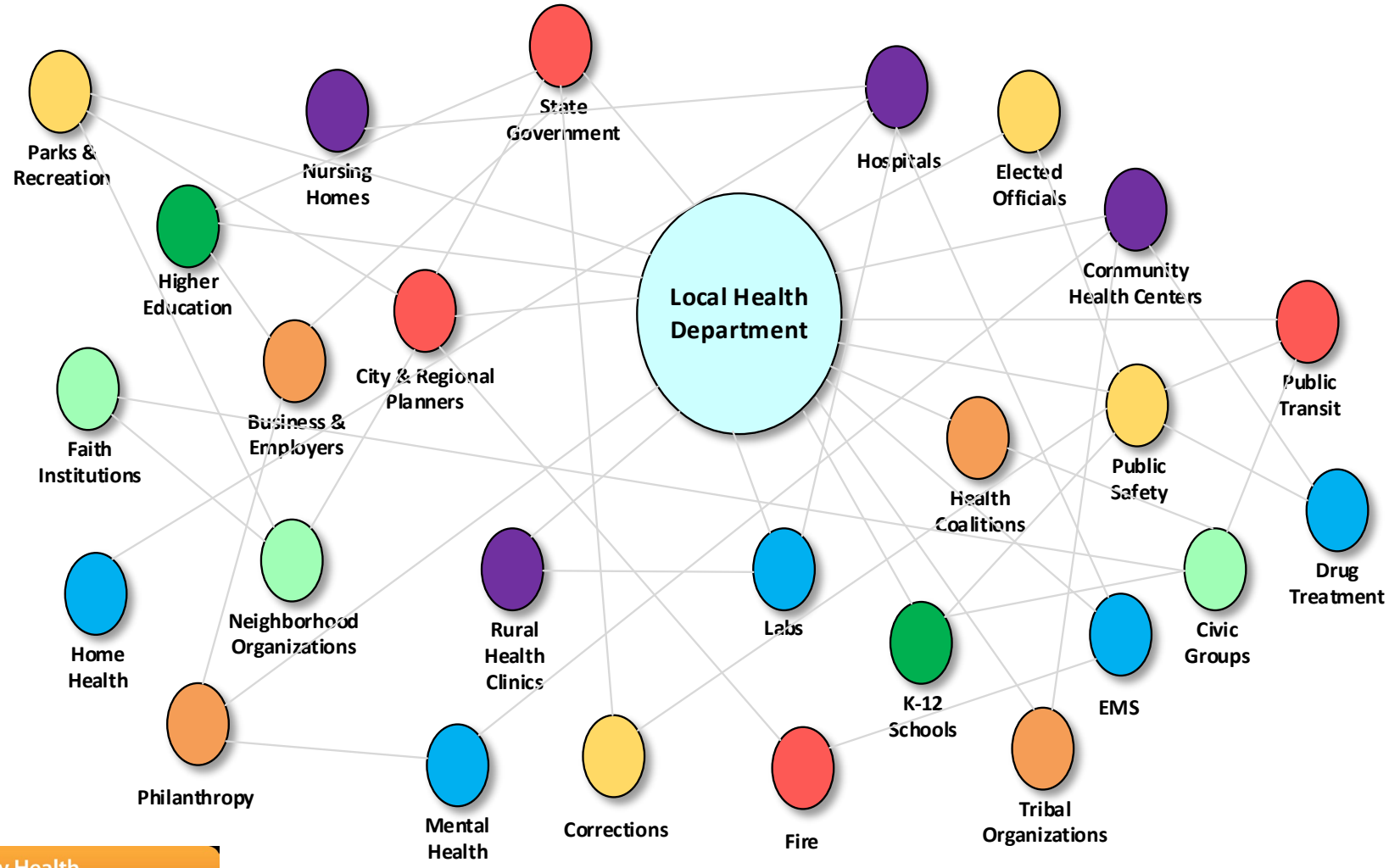
Public Health System Partners



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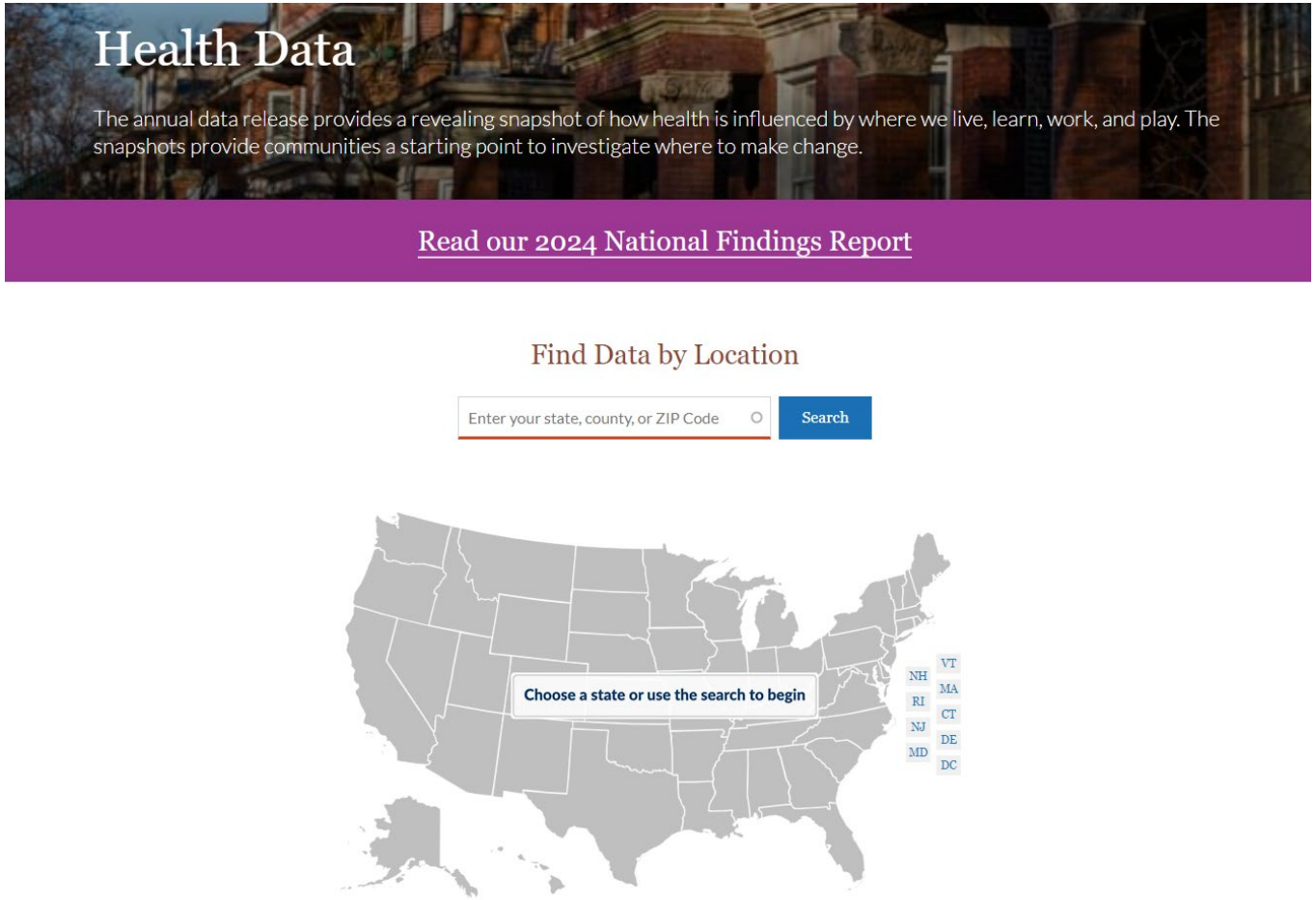
Explore the Rankings Data!



www.CountyHealthRankings.org

County Health Rankings & Roadmaps

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Update on Community Health Improvement Plan in Southern Nevada

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

SNHD 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

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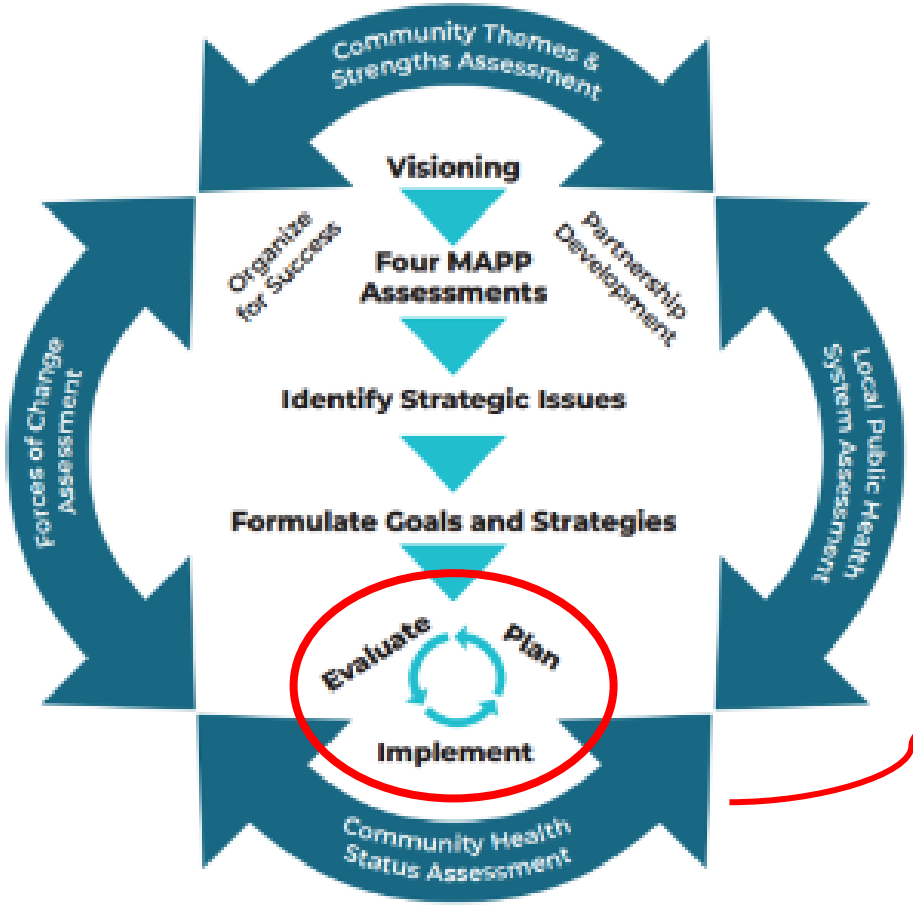
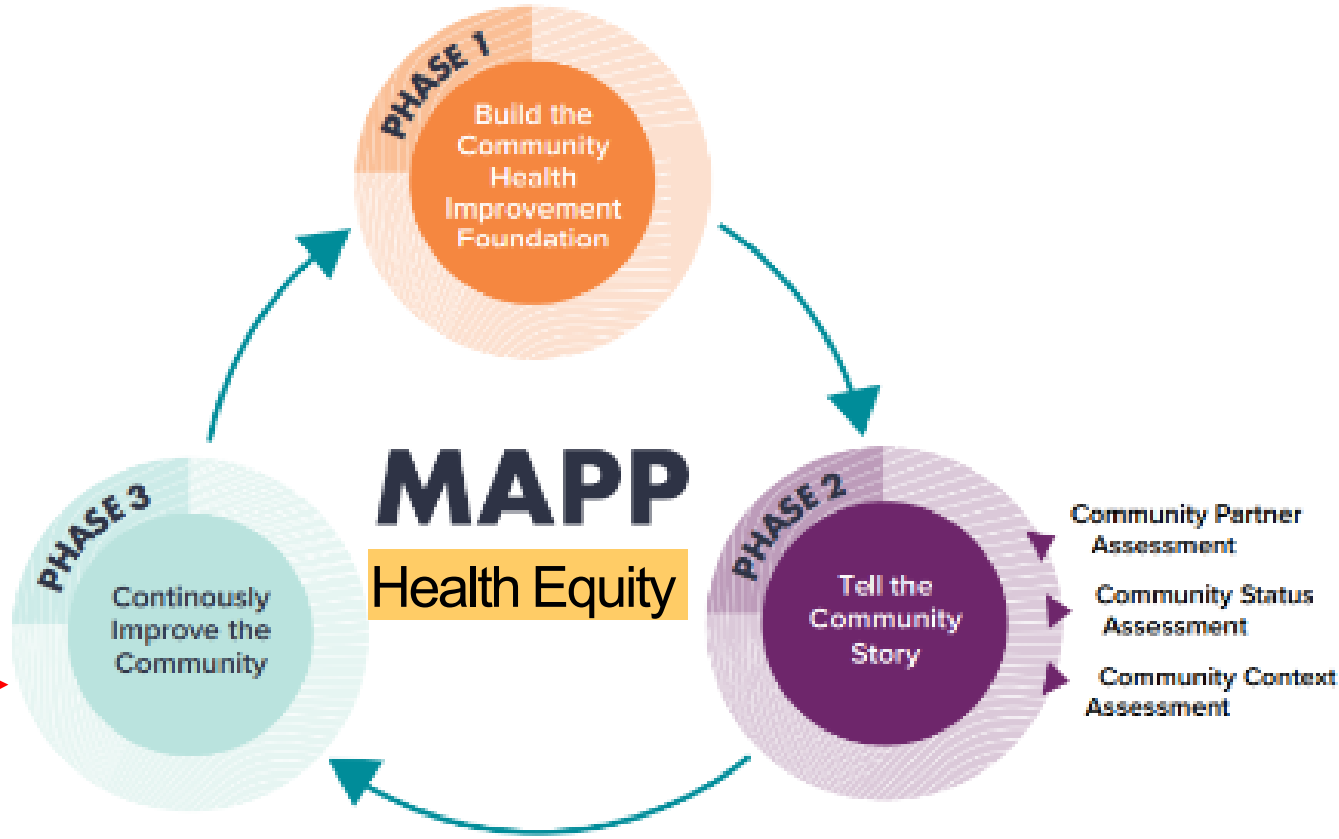


2023



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*

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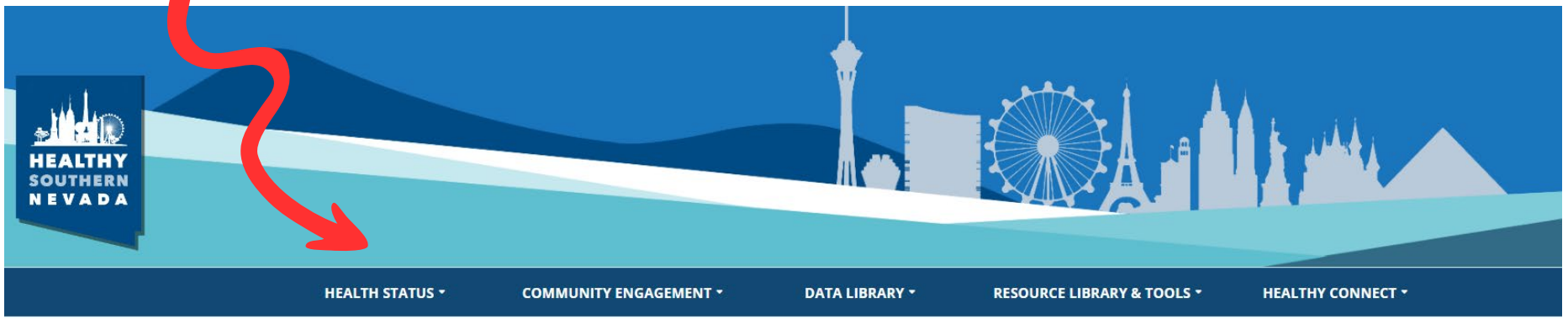
CHIP Progress Updates

www.HealthySouthernNevada.org



Healthy Connect Newsletter


Healthy Connect

VOLUME 1, ISSUE 1 | JULY 2023

PRESENTED BY SNHD

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."

Get to know CHIP

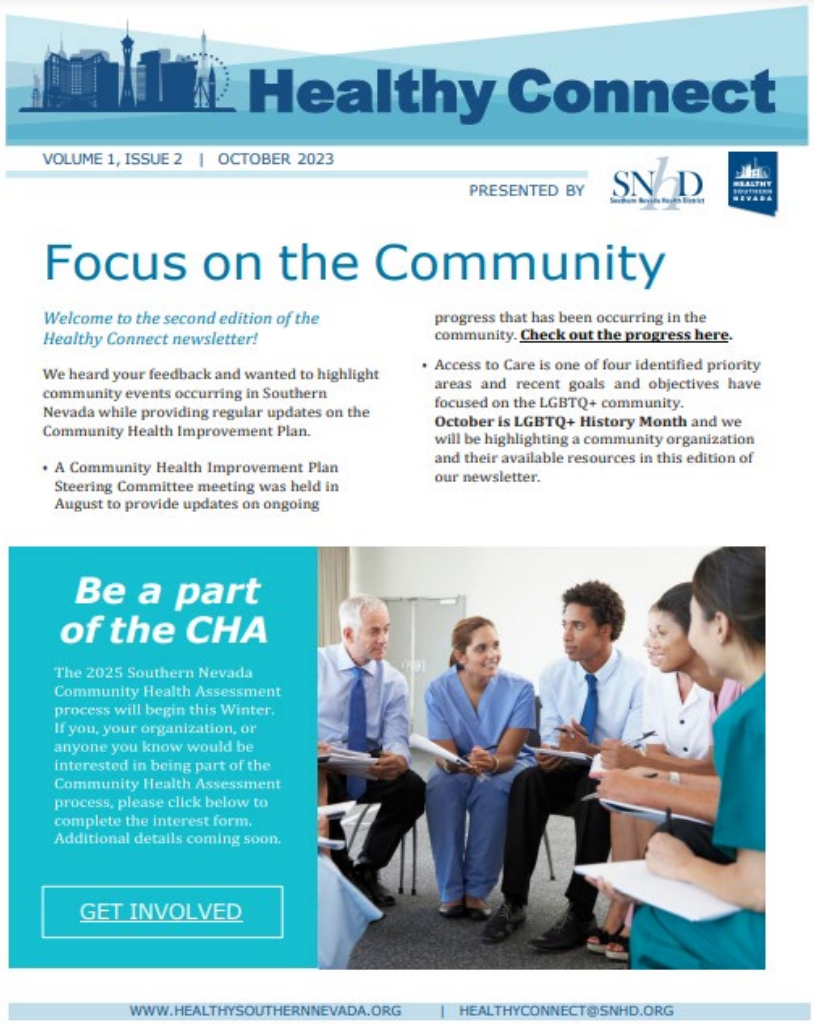
The 2022-2025 Southern Nevada Community Health Improvement Plan was published in January 2023.

Click below to download a copy of the CHIP and read about our priorities for a healthy Southern Nevada.

DOWNLOAD CHIP

WWW.HEALTHYSOUTHERNNEVADA.ORG | HEALTHYCONNECT@SNHD.ORG

Volume 1, Issue 1


Healthy Connect

VOLUME 1, ISSUE 2 | OCTOBER 2023

PRESENTED BY SNHD

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.

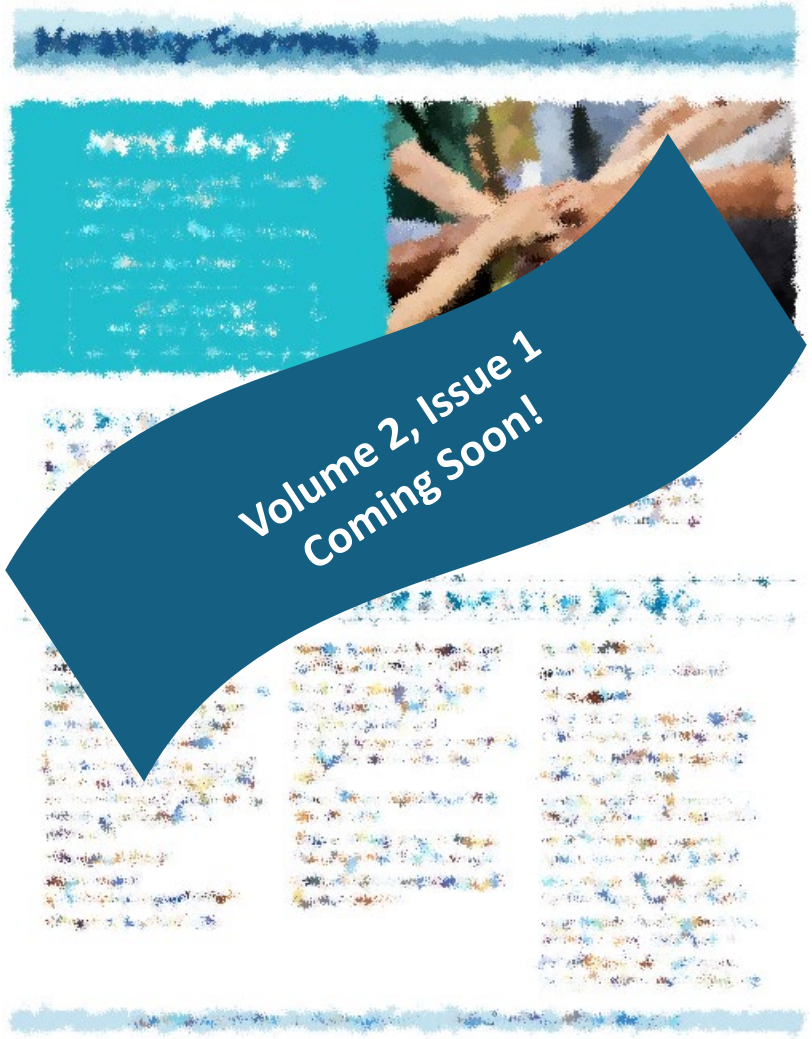
Be a part of the CHA

The 2025 Southern Nevada Community Health Assessment process will begin this Winter. If you, your organization, or anyone you know would be interested in being part of the Community Health Assessment process, please click below to complete the interest form. Additional details coming soon.

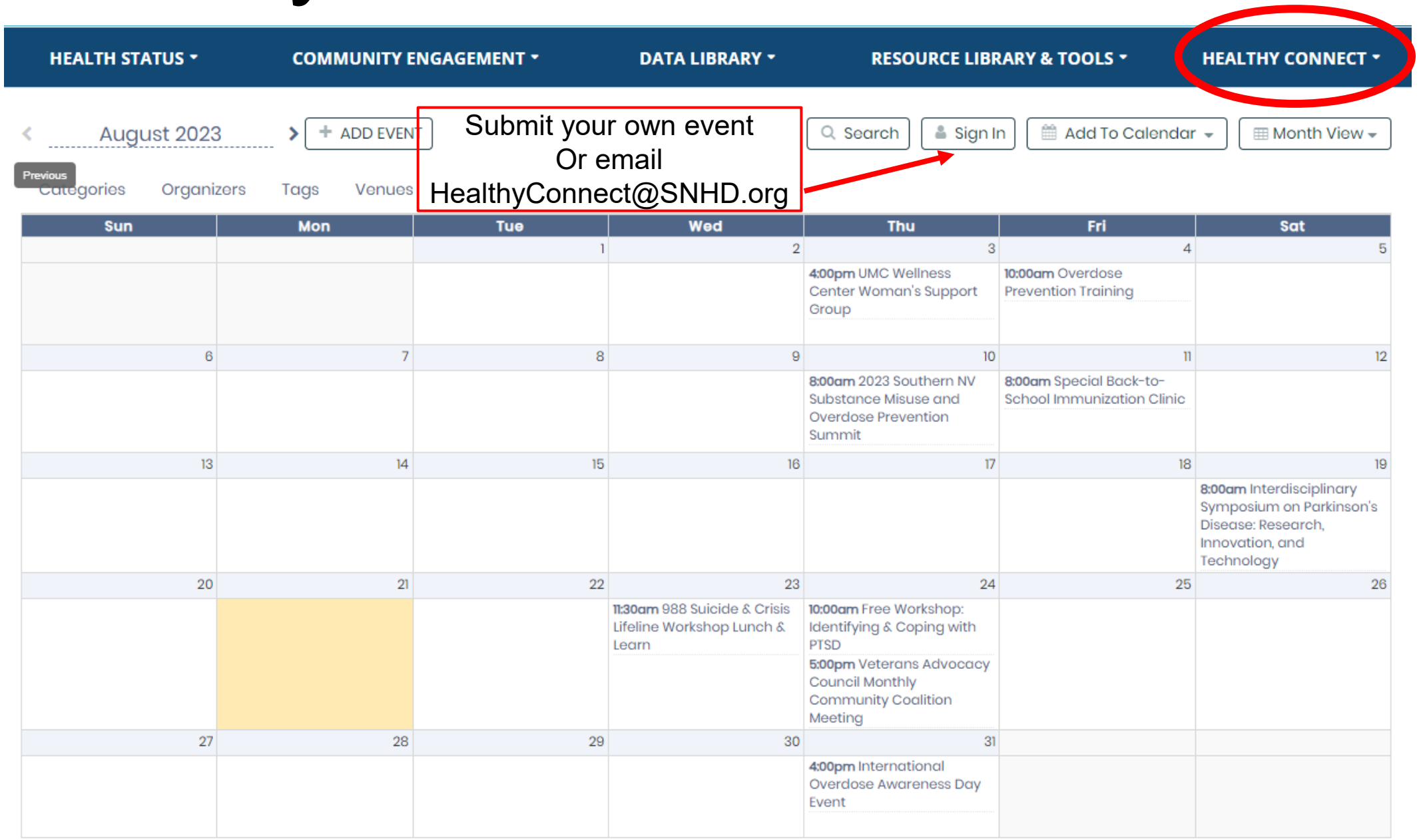
GET INVOLVED

WWW.HEALTHYSOUTHERNNEVADA.ORG | HEALTHYCONNECT@SNHD.ORG

Volume 1, Issue 2



Healthy Connect Events Calendar



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.

SNHD Southern Nevada Health District

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

- In progress — Objective 1.1: By December 2024, increase the community's understanding and awareness about the importance of public health funding.
- Not started — Action Step: Conduct surveys and town hall meetings to understand community knowledge, beliefs, and perceptions about public health funding.
- Not started — Action Step: Present results and action plan to community organizations
- Not started — Action Step: Identify top priorities for public health spending within and across communities.
- Completed — Action Step: Partner with state senators/assembly-people that want to increase the per capita funding and support via legislation.
- In progress — Action Step: Provide support and partner with the Governor's Office/Nevada Public Health Association (NPHA)/National Association of Counties (NACO)/community partners hat advocate for funding.
- Not started — 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.
- Completed — Action Step: Identify potential community partners
- Completed — Action Step: Identify potential bill sponsors
- In progress — Action Step: Identify Federal Legislator to partner with for funding.
- In progress — Action Step: Draft bill language
- In progress — 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 UNDERSTAND-ING/ 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.

Source: Nevada Division of Public and Behavioral Health (2024). *Silver State Health Improvement Plan 2023-2028*. Retrieved from https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/About/2023-28-SSHIP-23-28-Final1.pdf

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
PH: 702-759-1209
www.healthysouthernnevada.org

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

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

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

INTRODUCTION

- **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

Criminogenic Risk Factors:

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

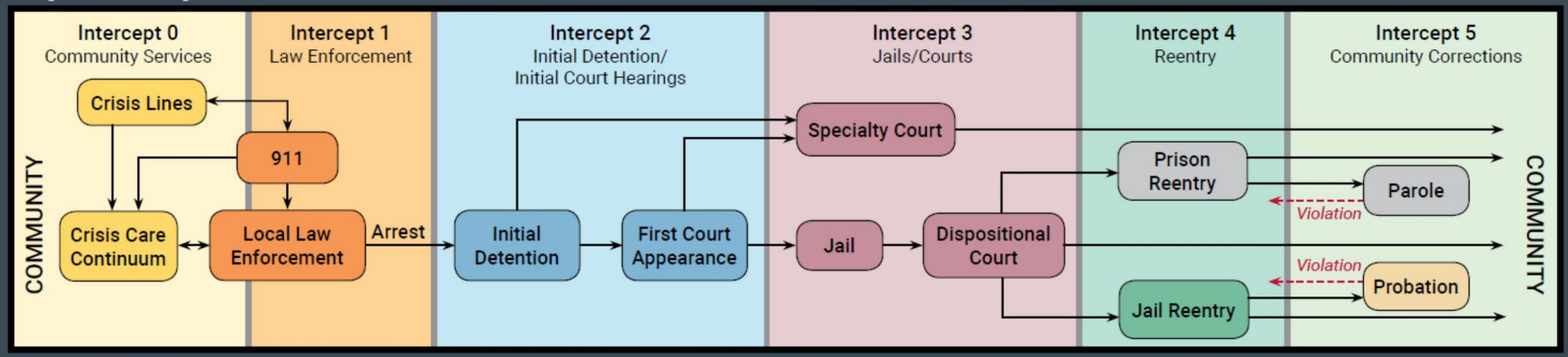
Common Responsively Factors:

- 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

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?

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@nyecc.org

www.nyecc.org

County Health Rankings & Roadmaps

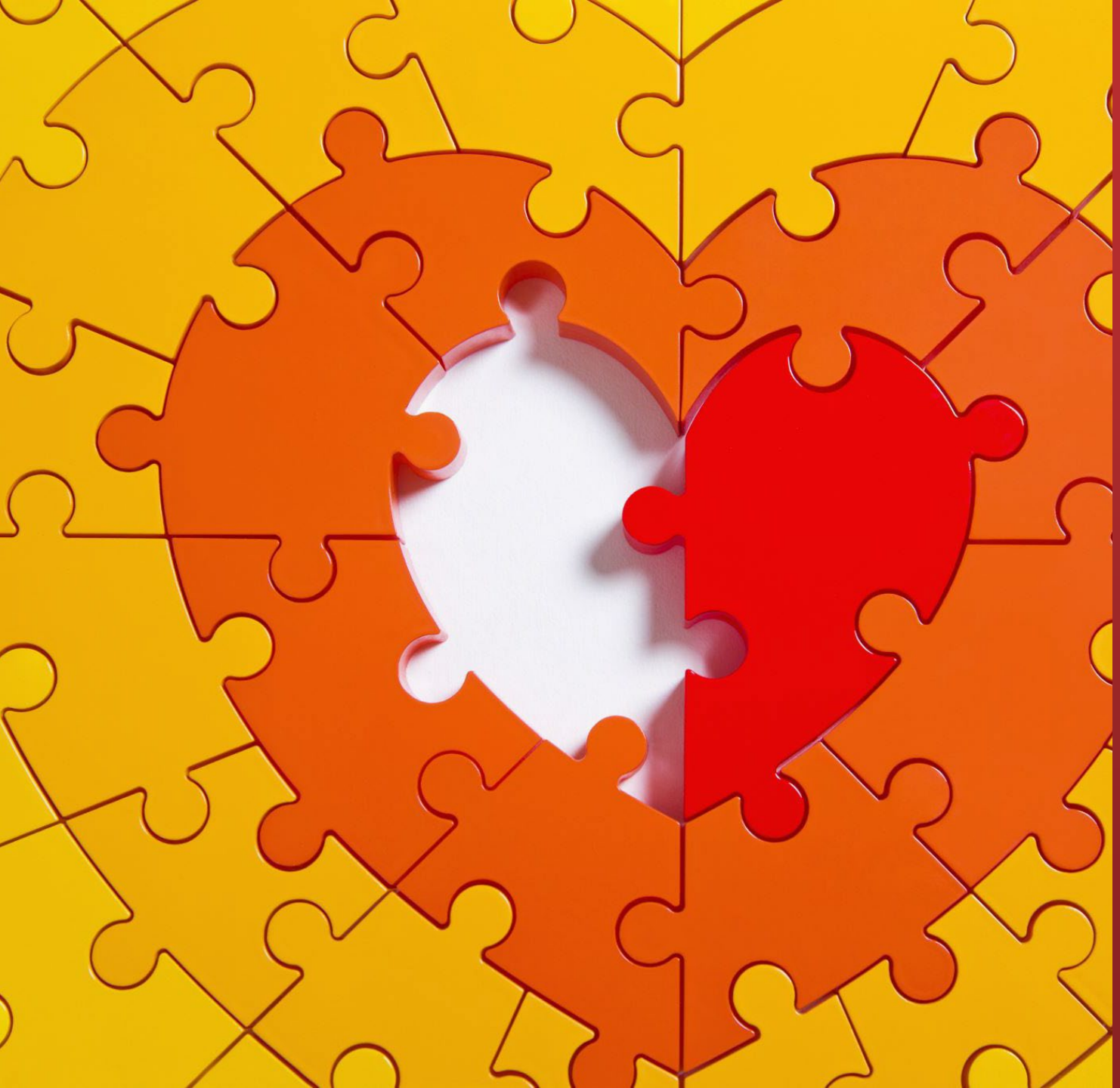
Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

Combating Heart Disease in the Heart of the Community

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

SNHD
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

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

American Heart Association, 2017

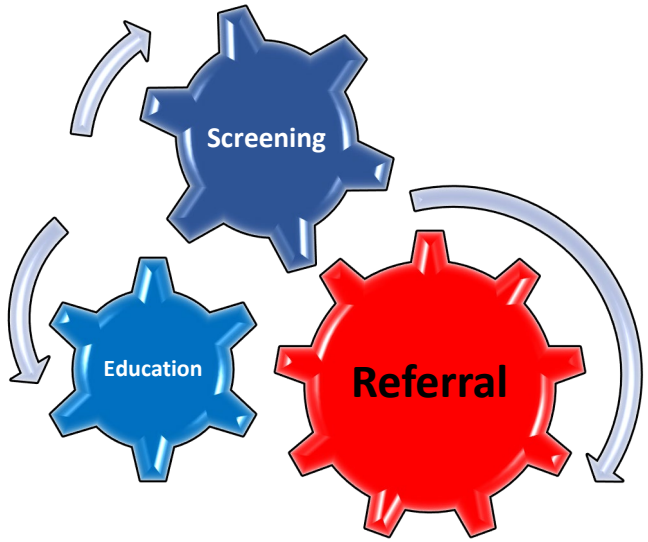
Why the barbershop?

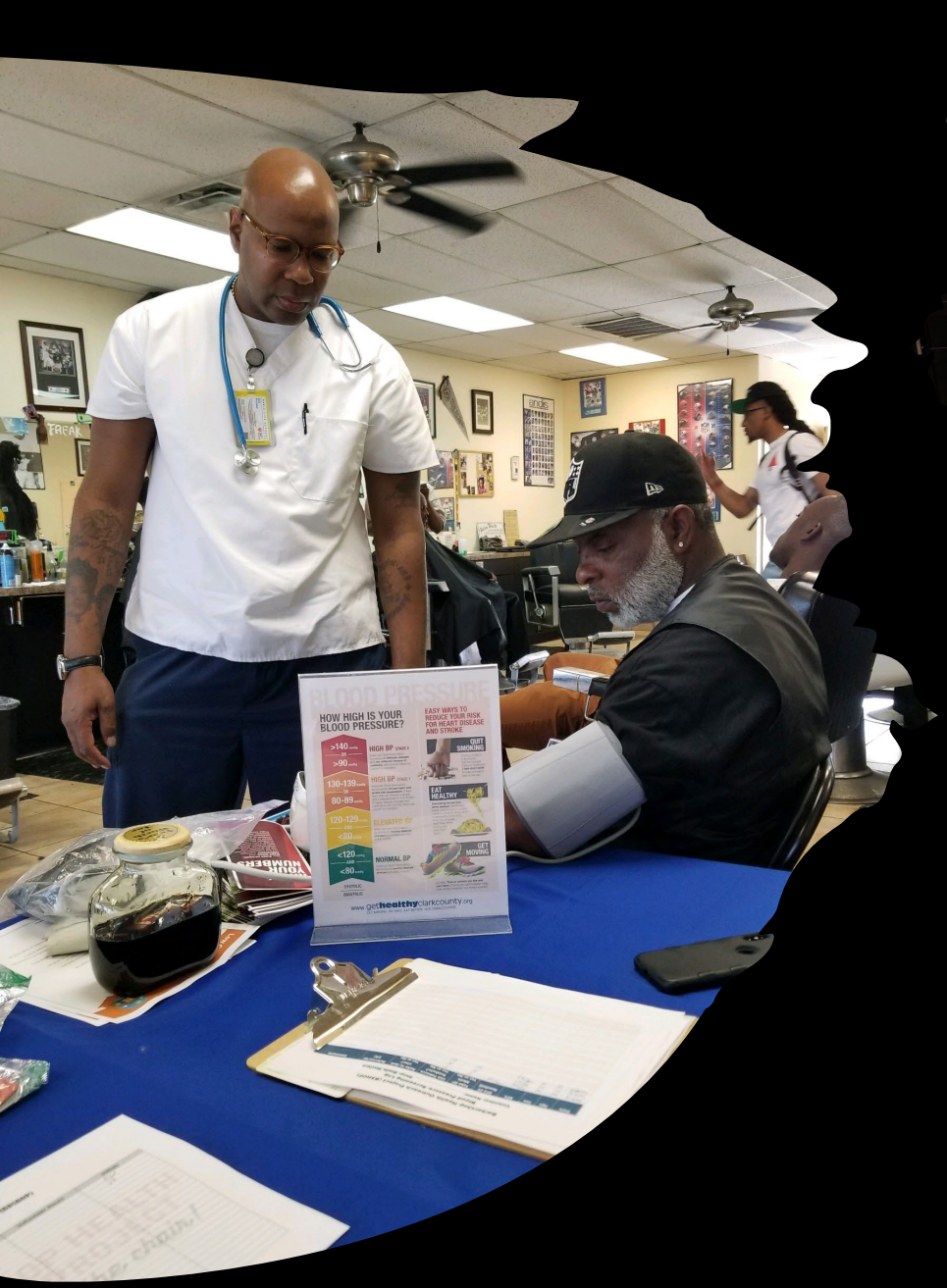
- Non-traditional clinical setting
- Culturally appropriate implementation site
- Vehicle for health promotion/education
- Pillar of the African American Community
- Barbers serve as community leaders
- Effective peer-based messaging approach

Barbershop Initiative

Taking the Barbershop Experience Beyond the Chair

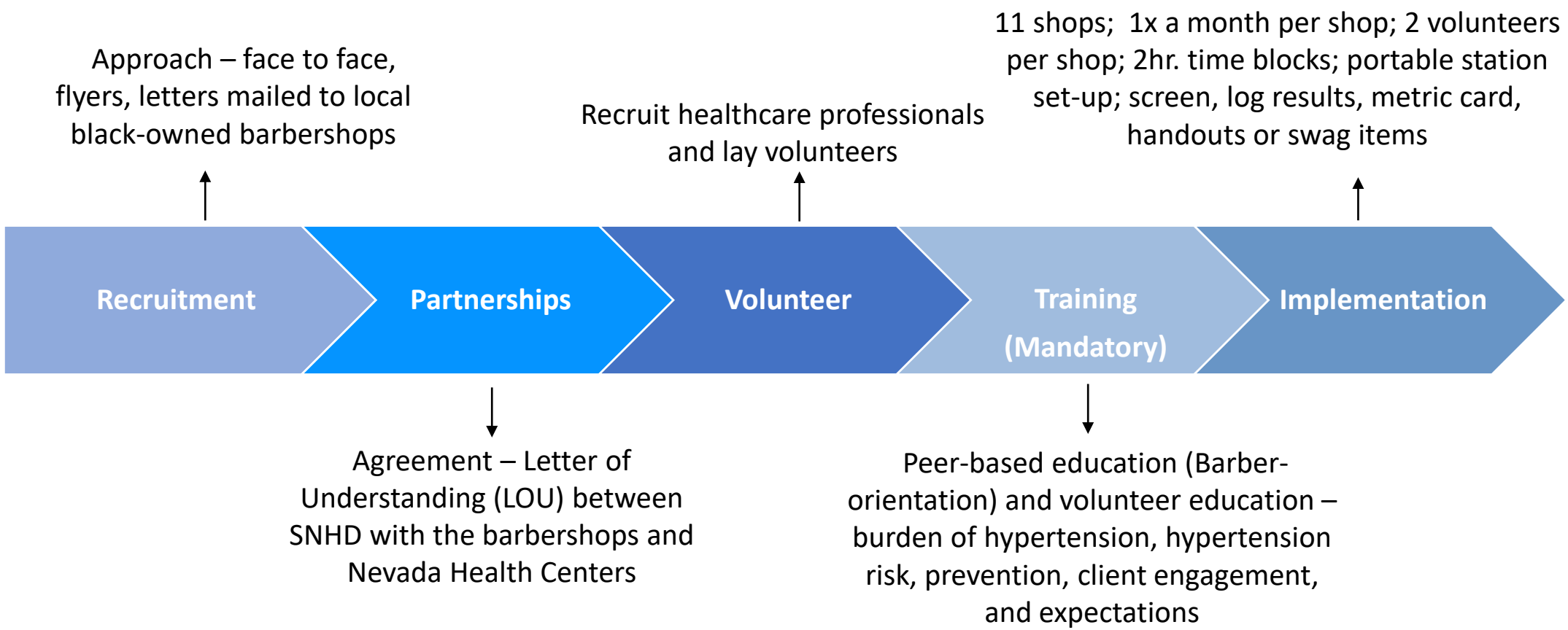
- To empower black men to adopt healthier lifestyle choices and reduce their risk for heart disease and stroke, SNHD partnered with three black-owned barbershops to create the **Barbershop Health Outreach Project (BSHOP)**. Since inception in 2018, the initiative has expanded its partnership with a total 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”

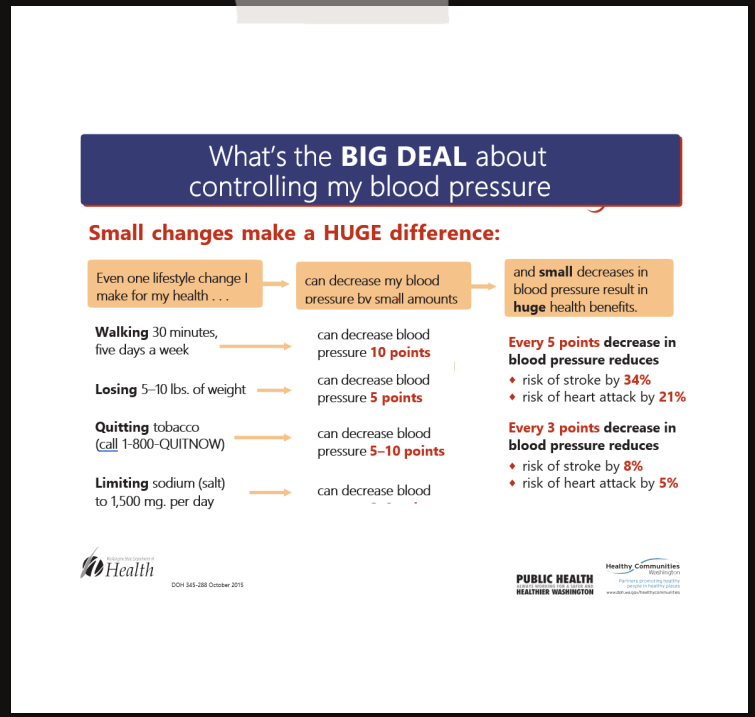
Client Engagement

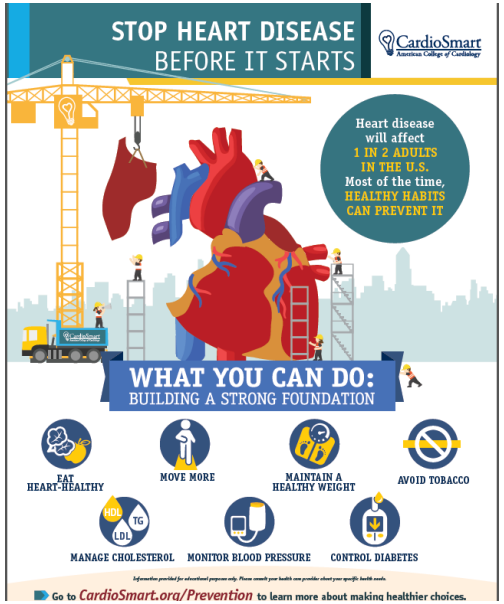
Volunteers and CHWs are trained in the AIDET communication model (Acknowledge, Introduce, Duration, Explanation, and Thank you).

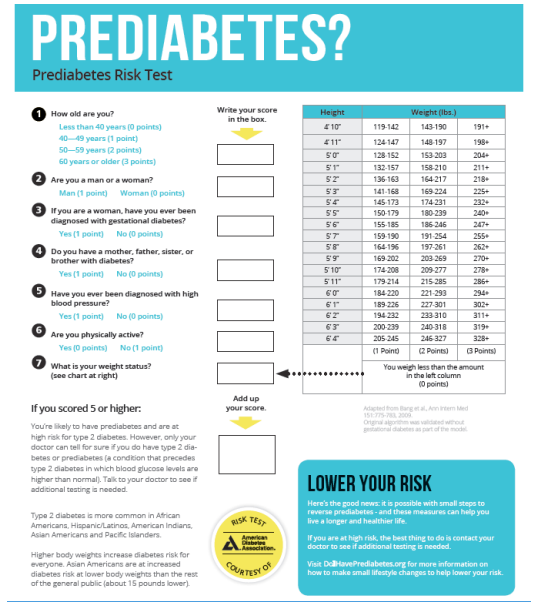
Introduce program to clients receiving services. Blood pressure screenings are offered during wait time or conducted immediately following client haircut.

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

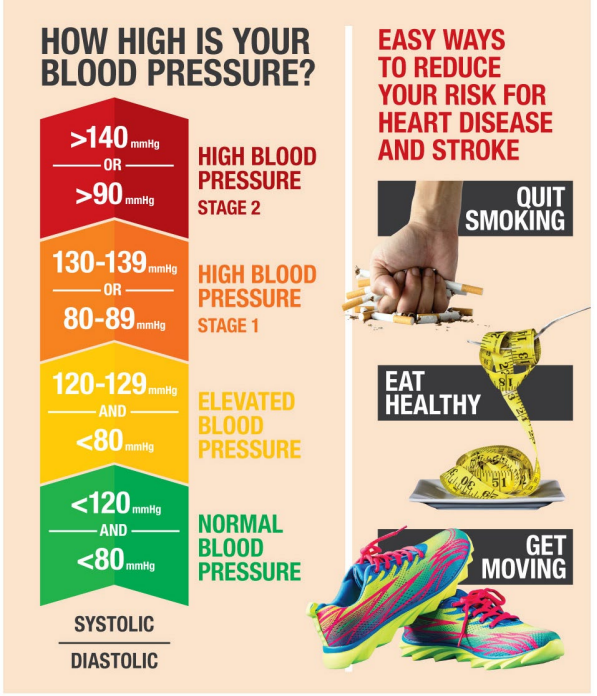
Volunteers include: CHWs, Temp. Outreach Workers, Nurses, Healthcare professionals and lay community members

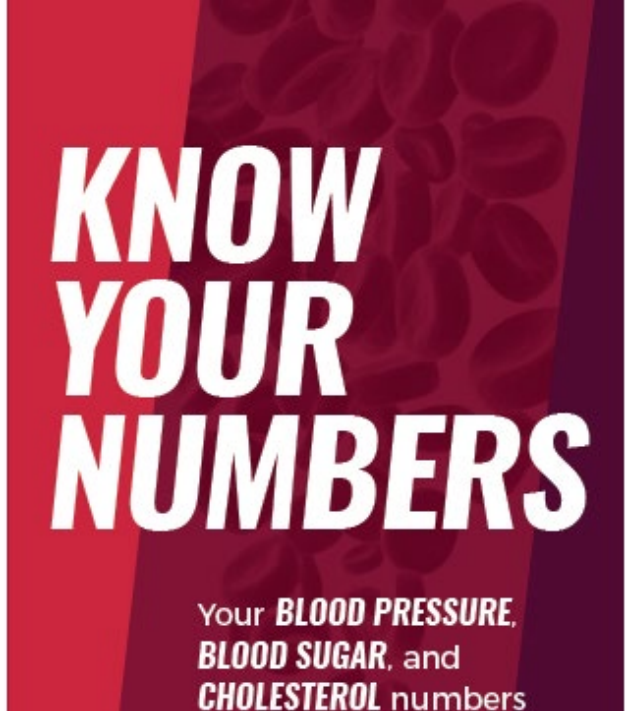


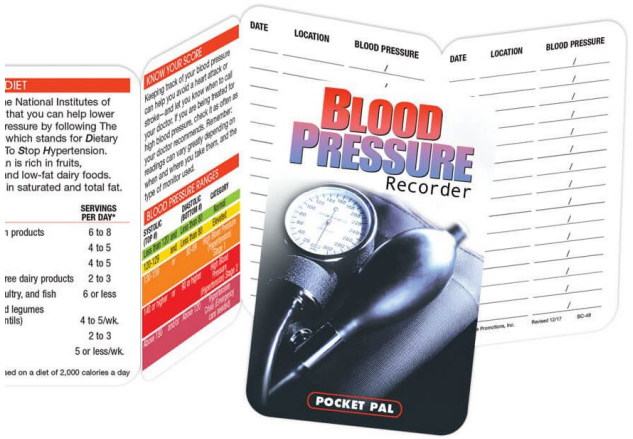




Outreach Resources





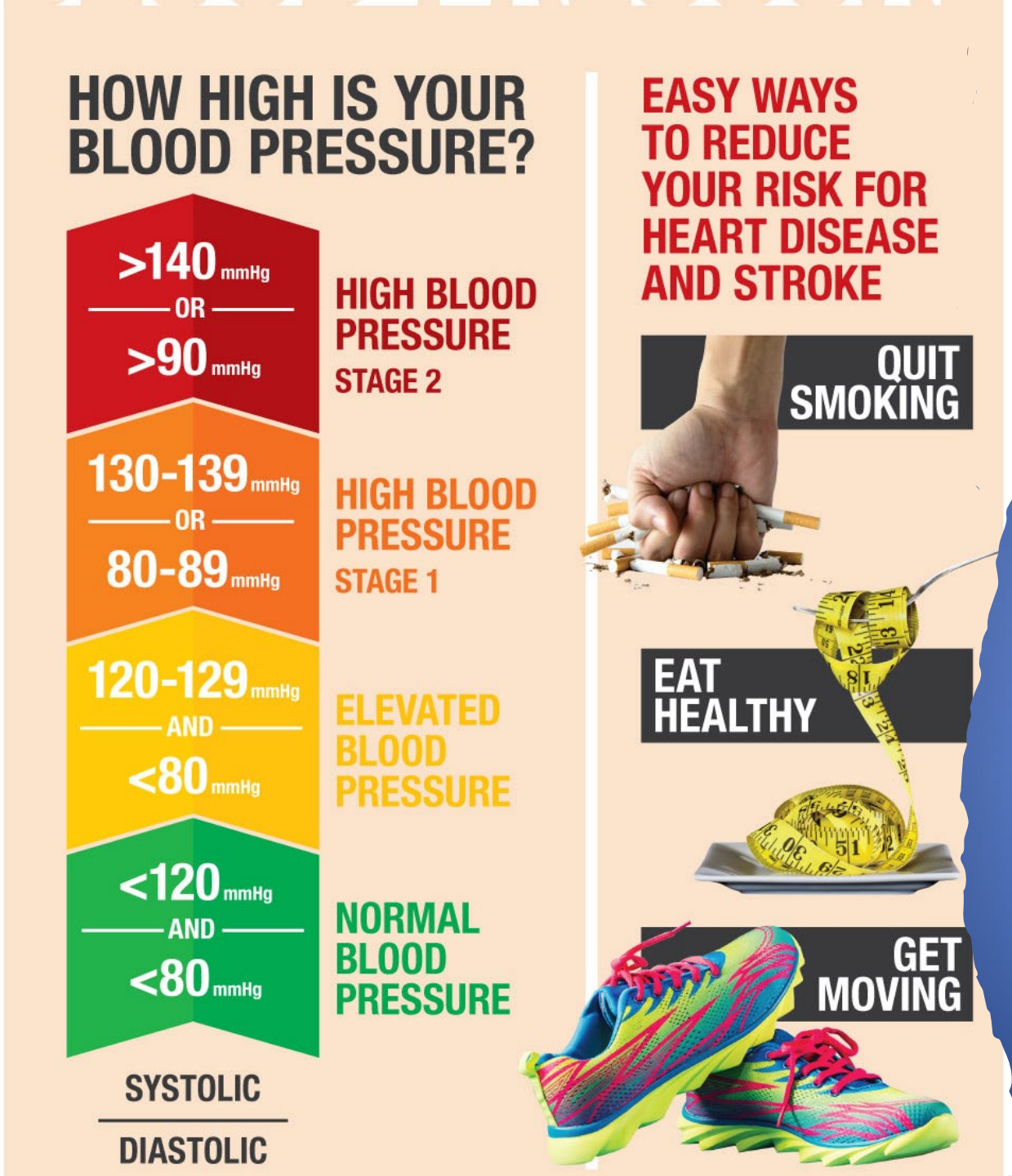


Educational Materials

BSHOP Program Outcomes

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

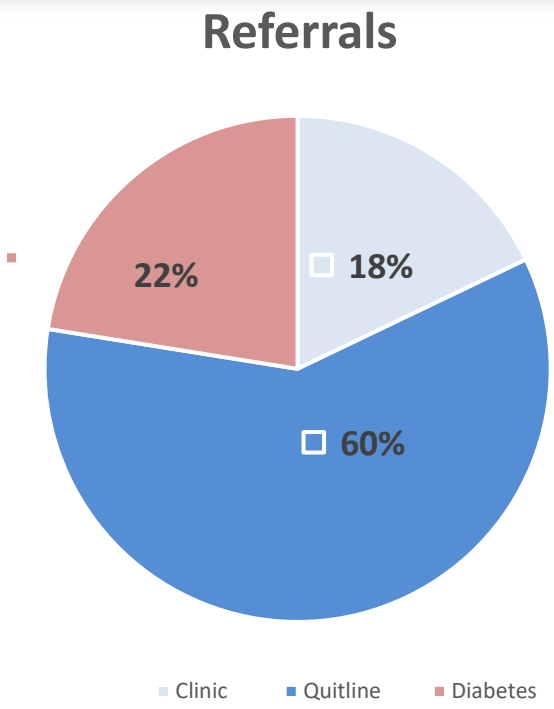
****Barriers**: screening events cancelled due to lack of volunteer coverage and COVID-19 pandemic (2020-2021 Year 3)



Average Blood Pressure Reading

132/90mmHg (Stage 2 HTN)

BSHOP Outcomes



MARKETING AND PROMOTION

Barbershop Signage

KCEP Power 88.1 Radio Ad

Social Media Ads

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

Bus Stop Ad

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


BARBERSHOP HEALTH
OUTREACH PROJECT
Take it beyond the chair!
www.gethealthyclarkcounty.org


BARBERSHOP HEALTH
OUTREACH PROJECT
Take it beyond the chair!

Thank you!

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

RTC of Southern Nevada: Programs & Initiatives

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

RTC of Southern Nevada Transportation Initiatives Update

Southern Nevada County Health Rankings & Roadmaps

Wednesday, March 20, 2024

Regional Transportation Commission of Southern Nevada

Public Transit

MPO/Regional Planning

Roadway Funding

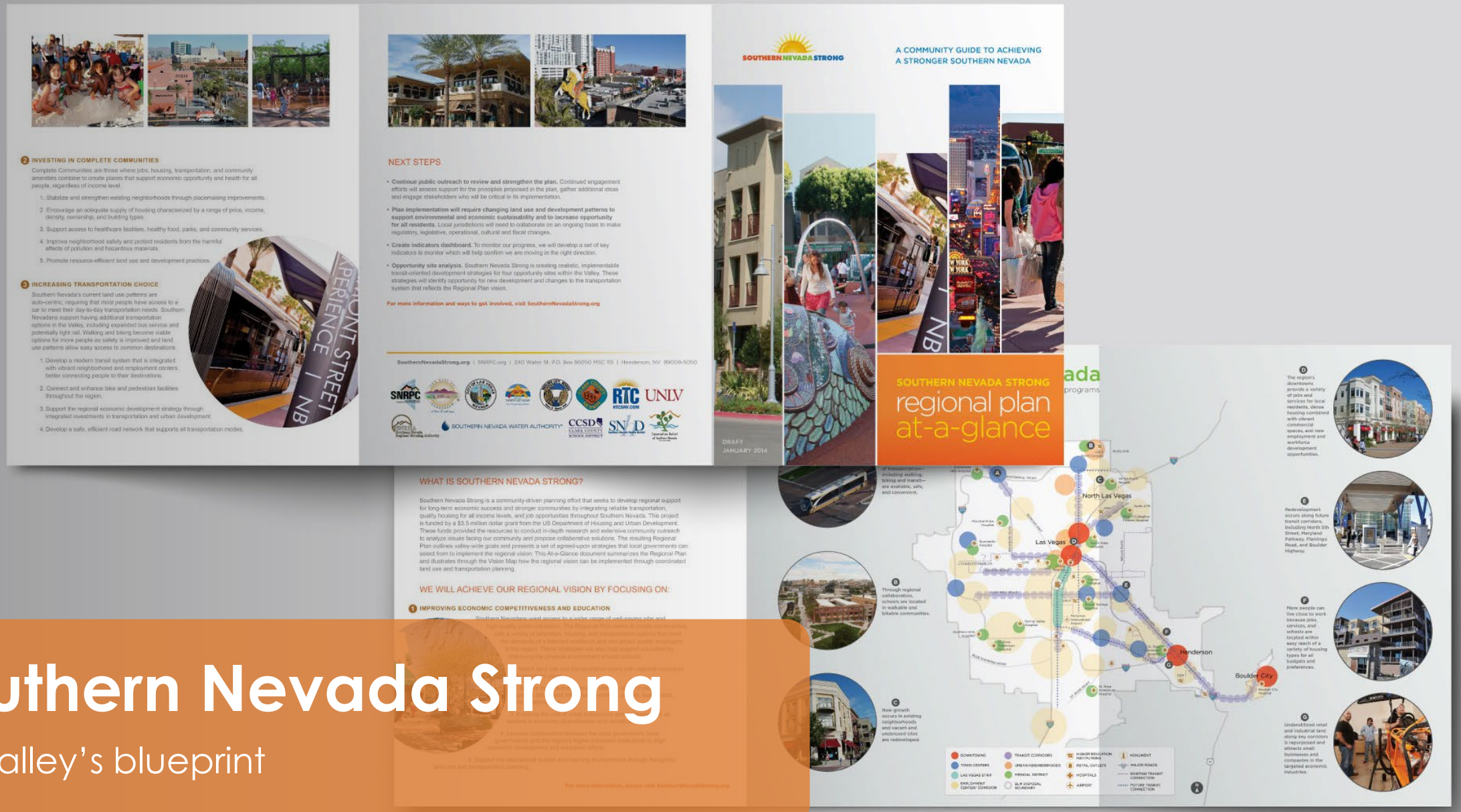
Traffic Management

Bicycling

RTC

Urban Heat

Understanding & Addressing Urban Heat
in Southern Nevada



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

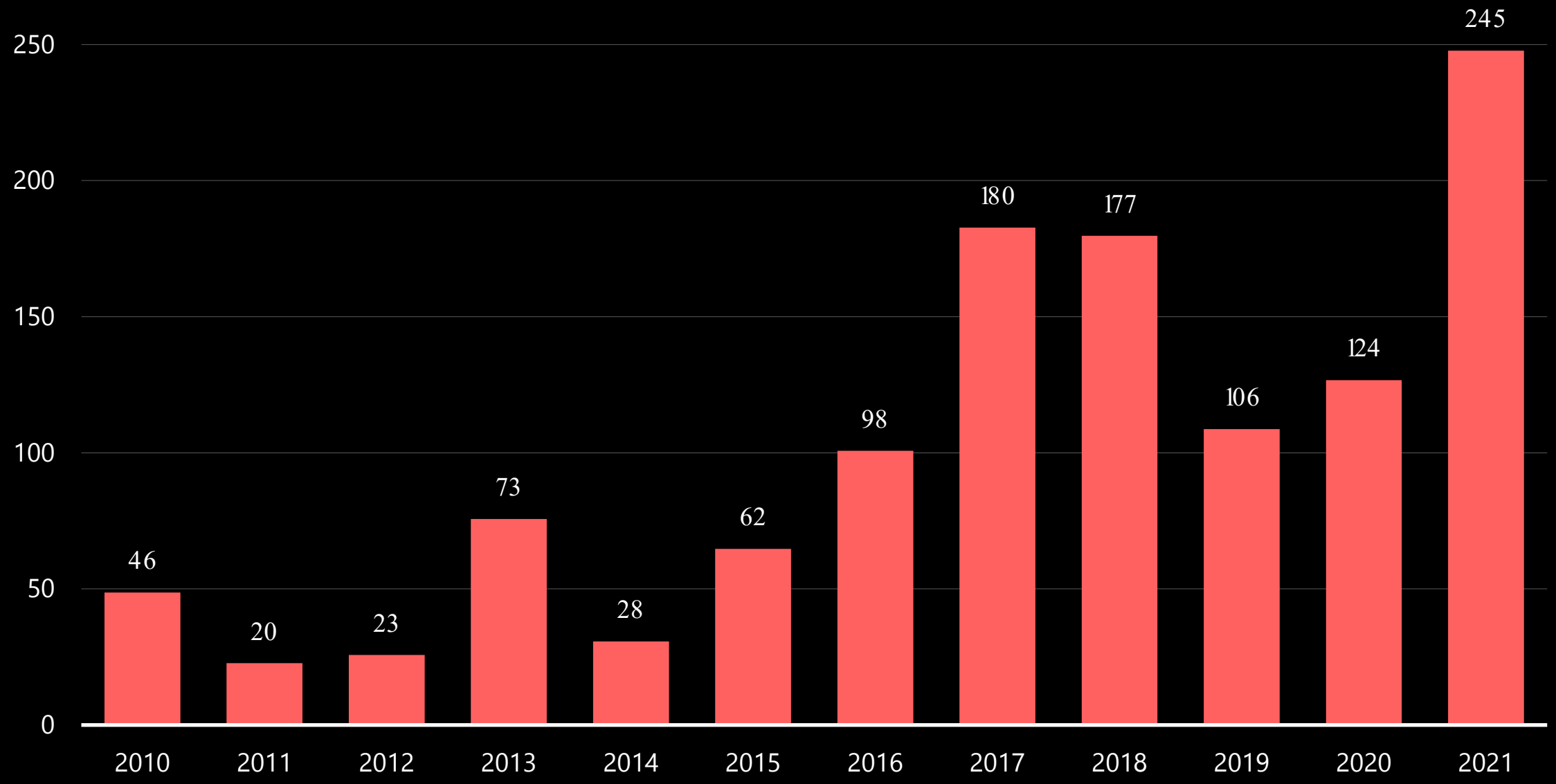
infrastructure

air quality

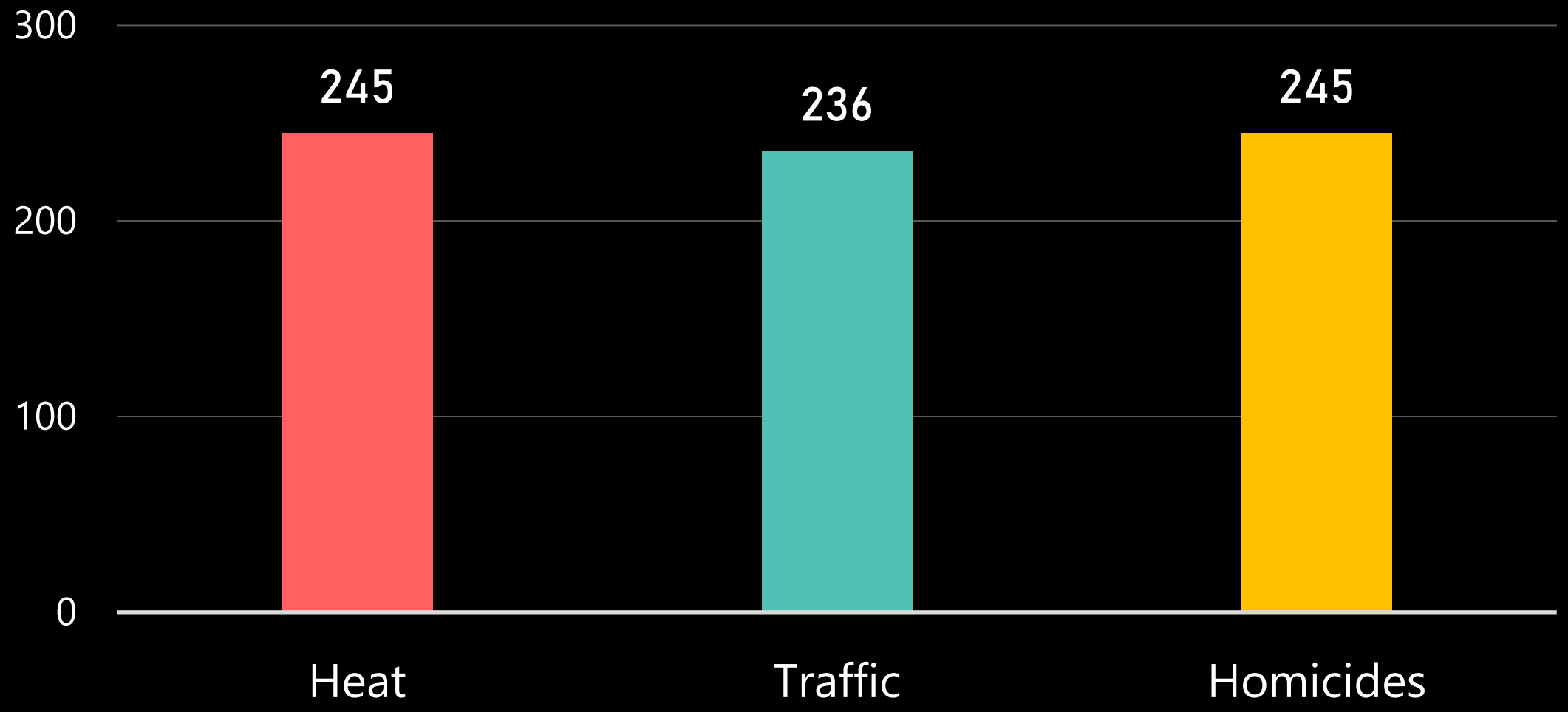
tourism

health

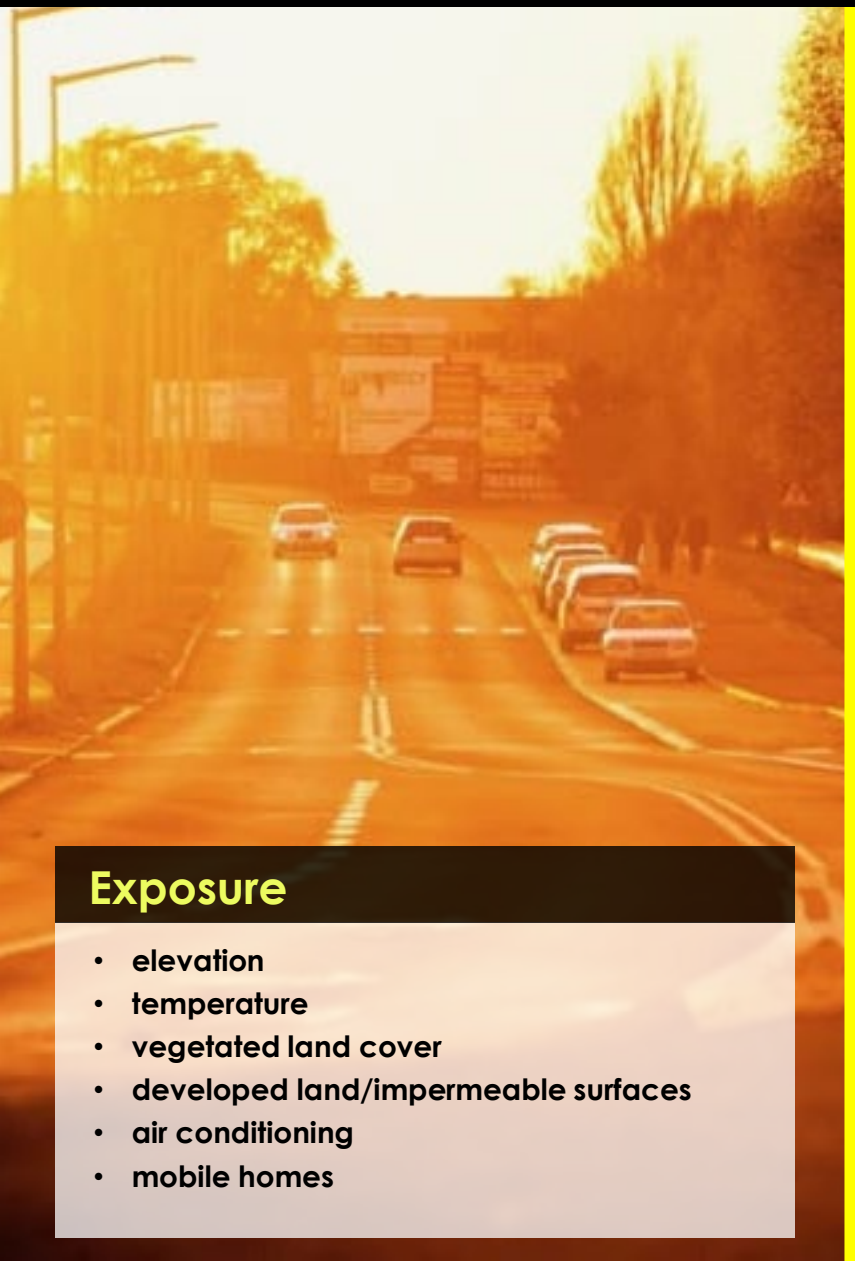
Heat-related fatalities in Southern Nevada



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

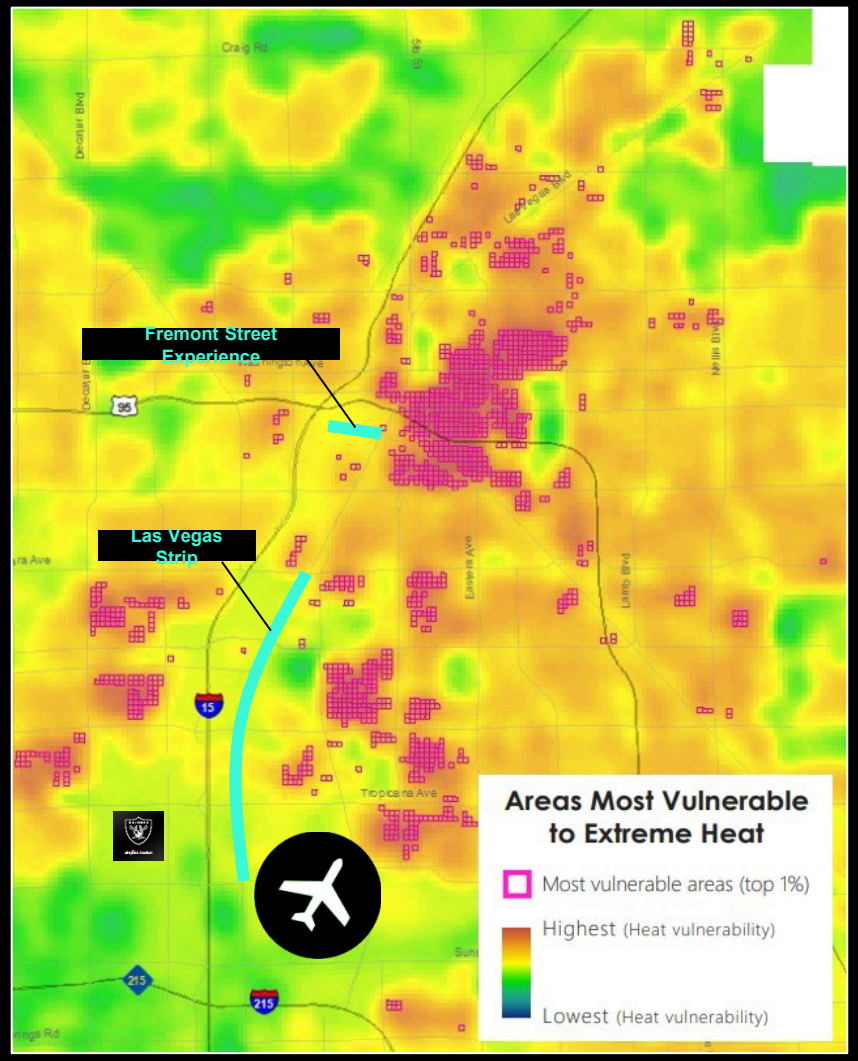
Sensitivity

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

Extreme Heat Vulnerability Analysis (2021)

www.rtcsnv.com/extremeheat

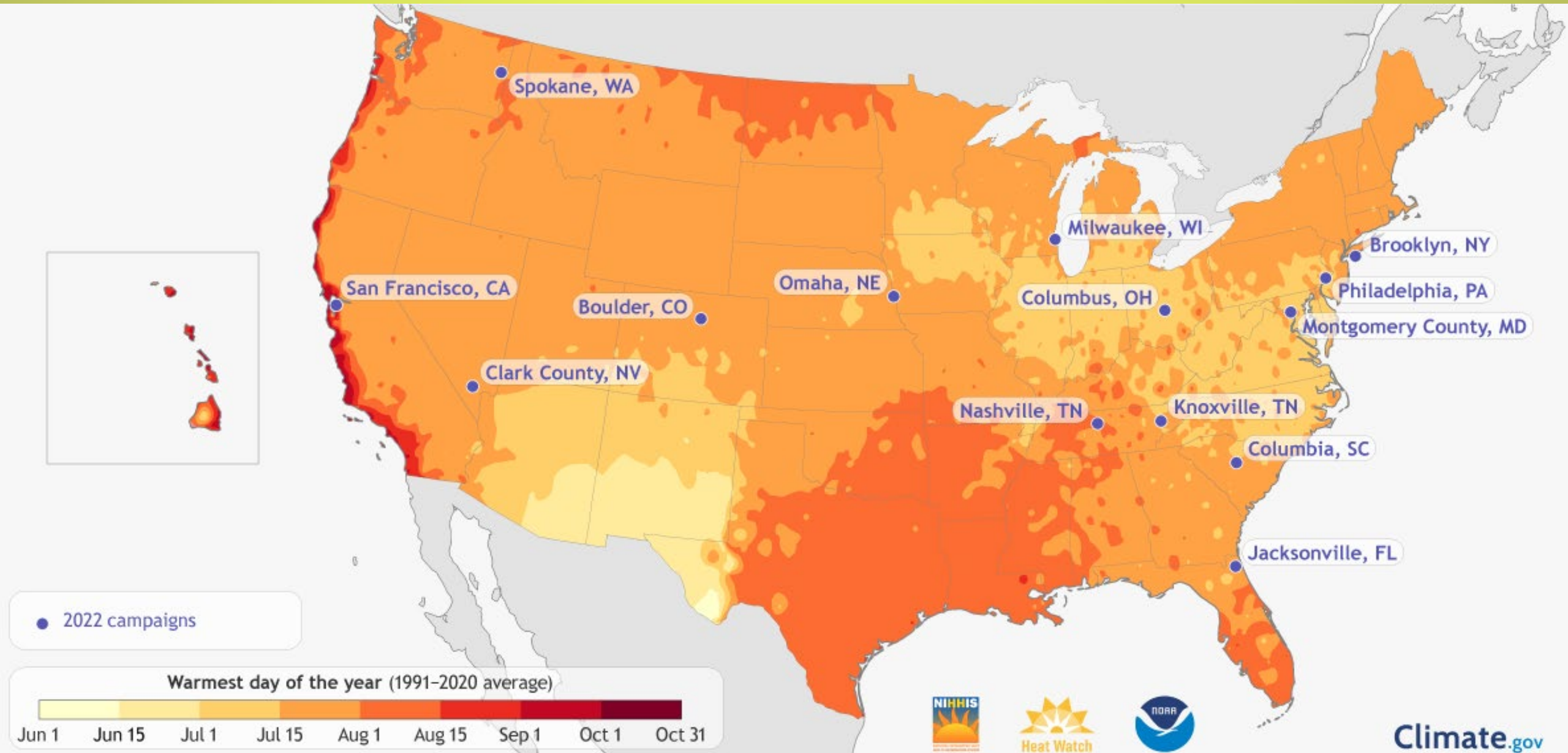
Extreme Heat Vulnerability Analysis (2021)



Areas Most Vulnerable to Extreme Heat

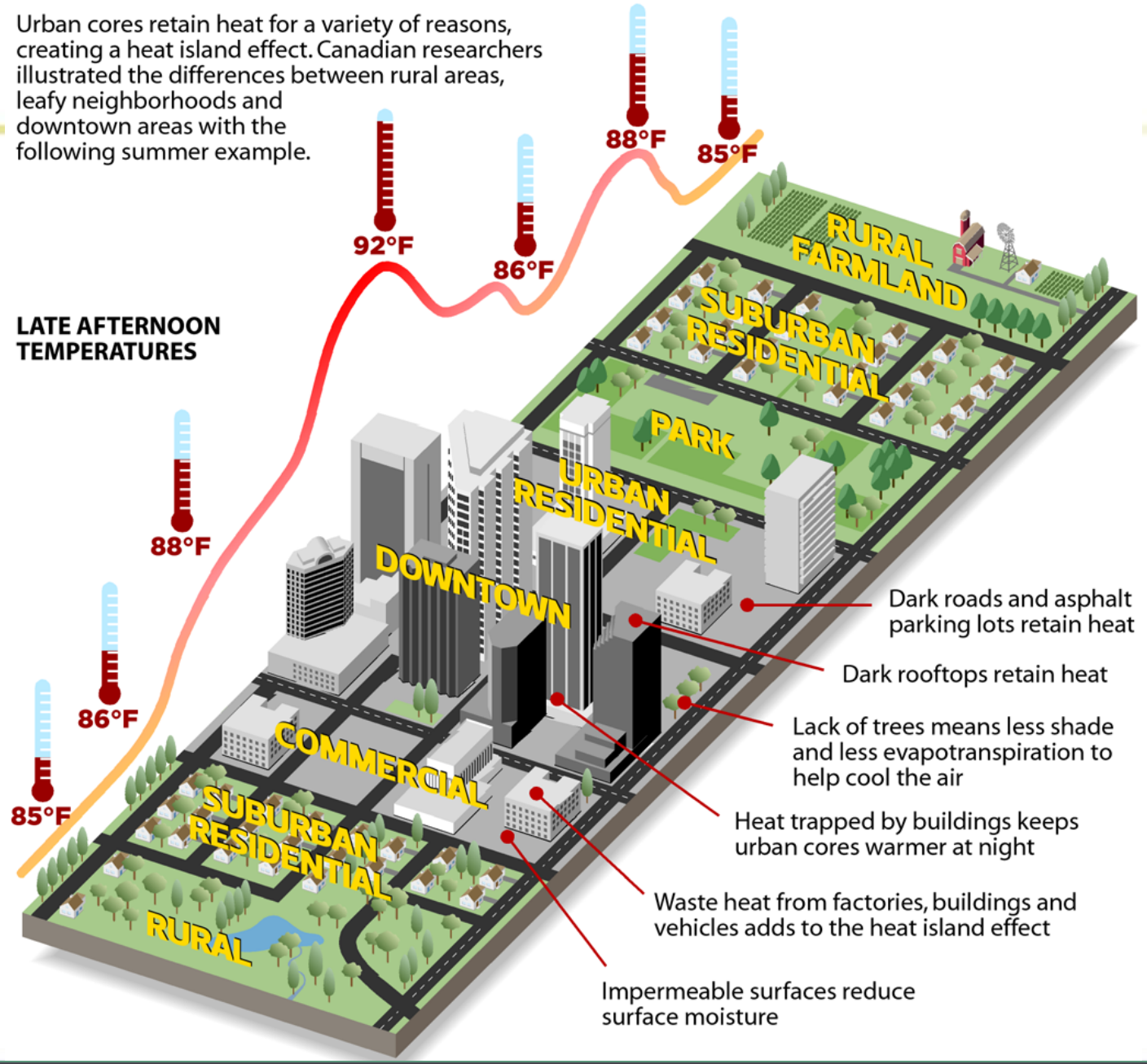
- Concentrated in urban core and east side
- Older neighborhoods/housing
- Communities of color
  (esp. Hispanic/Latinx and Black/African American)
- Household income: $31,000
- Lower elevation
  (naturally hotter than western half of region)

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.

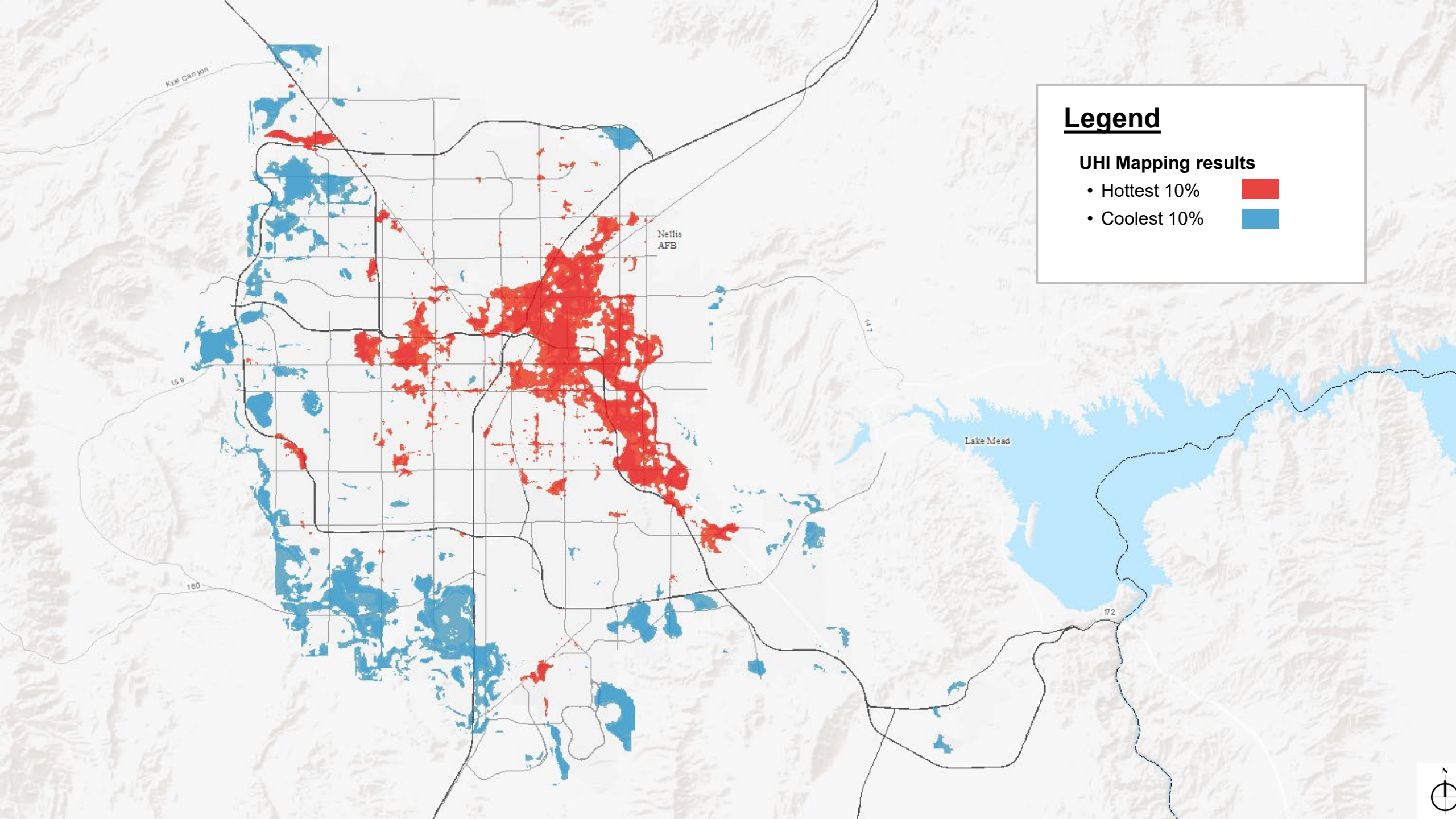


SOURCE: D.S. Lemmen and F.J Warren, Climate Change Impacts and

PAUL HORN / InsideClimate News

UHI Mapping Results

www.rtcsnv.com/heatmap


Legend
UHI Mapping results
• Hottest 10%
• Coolest 10%
Nellis AFB
Lake Mead
Kyle Canyon
159
160
147
172


15607

Addressing Urban Heat

(through transportation planning)

Route Planning Restoration

Reconnecting Communities

Areas of Persistent Poverty

Bicycle and Pedestrian Planning

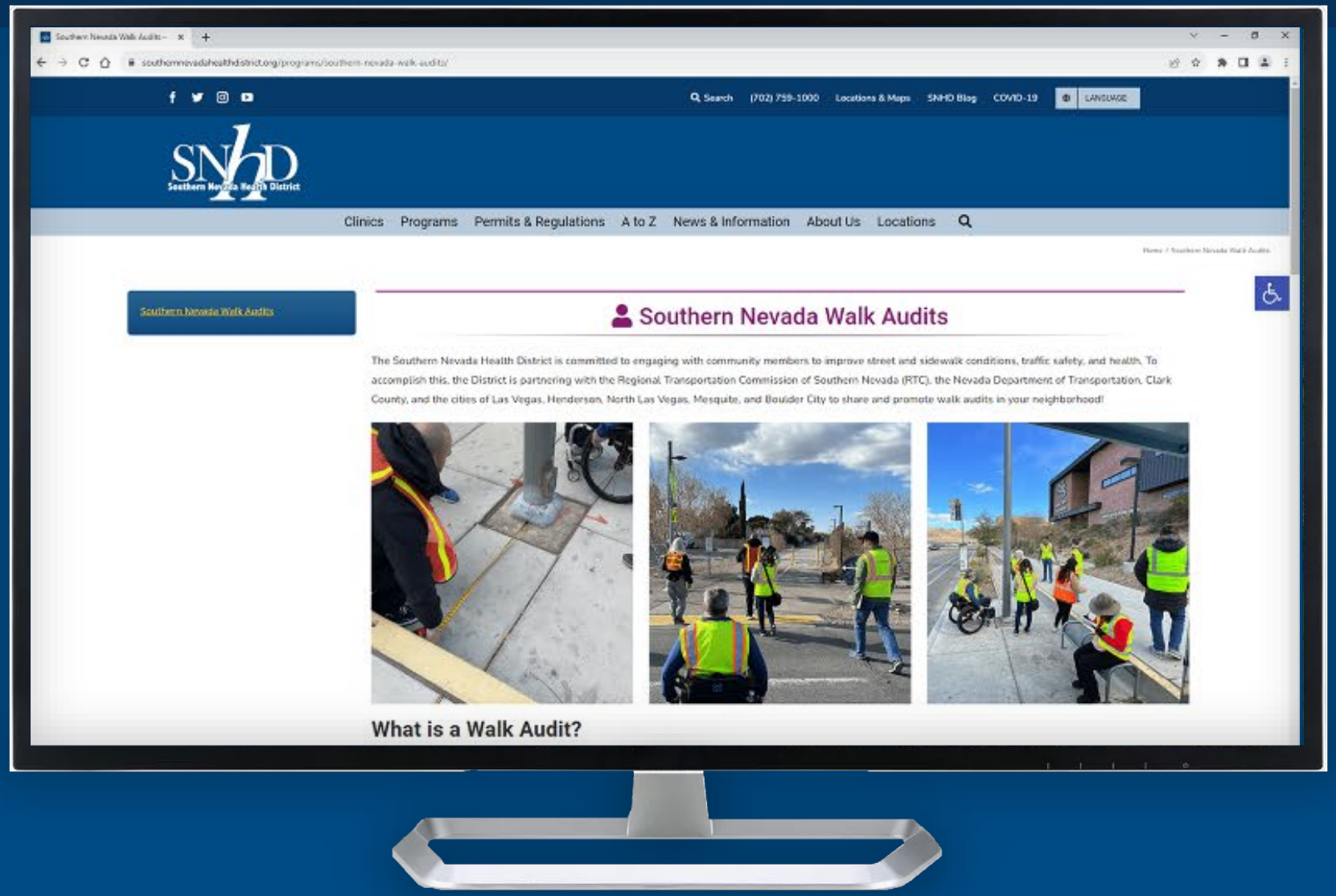
2021

Nevada Assembly Bill 343

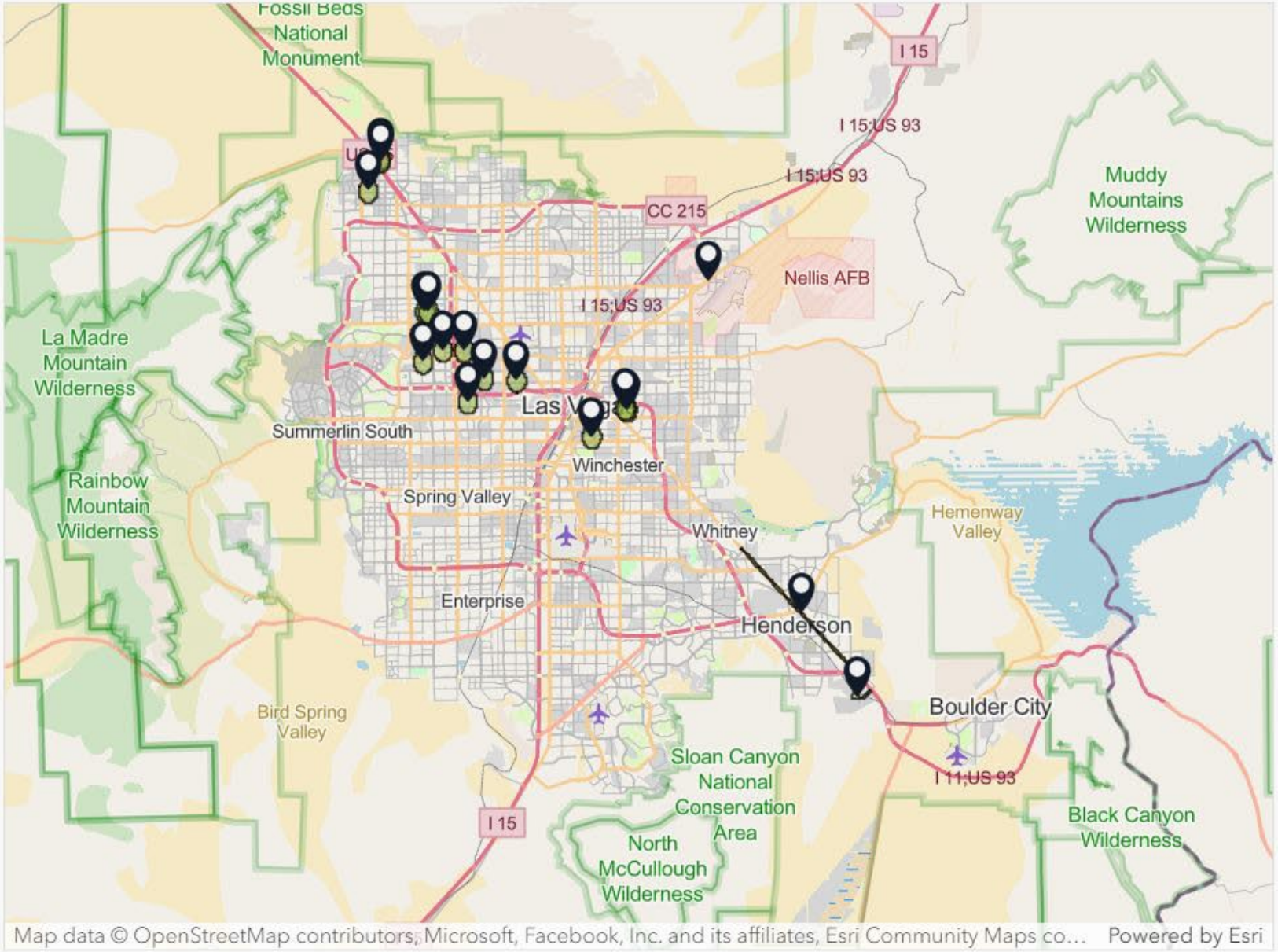
requires an action plan for performing walk audits

What is a Walk Audit?

Past walk audits performed by the RTC


Southern Nevada Walk Audits
southernnevadahealthdistrict.org/programs/southern-nevada-walk-audits/
Search
(702) 759-1000
Locations & Maps
SNHD Blog
COVID-19
LANGUAGE
SNHD
Southern Nevada Health District
Clinics
Programs
Permits & Regulations
A to Z
News & Information
About Us
Locations
Southern Nevada Walk Audits
Southern Nevada Walk Audits
The Southern Nevada Health District is committed to engaging with community members to improve street and sidewalk conditions, traffic safety, and health. To accomplish this, the District is partnering with the Regional Transportation Commission of Southern Nevada (RTC), the Nevada Department of Transportation, Clark County, and the cities of Las Vegas, Henderson, North Las Vegas, Mesquite, and Boulder City to share and promote walk audits in your neighborhood!
What is a Walk Audit?

Southern Nevada Walk Audit Log



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


RTC
Share

EXISTING BIKE SHARE SYSTEM

BIKE SHARE

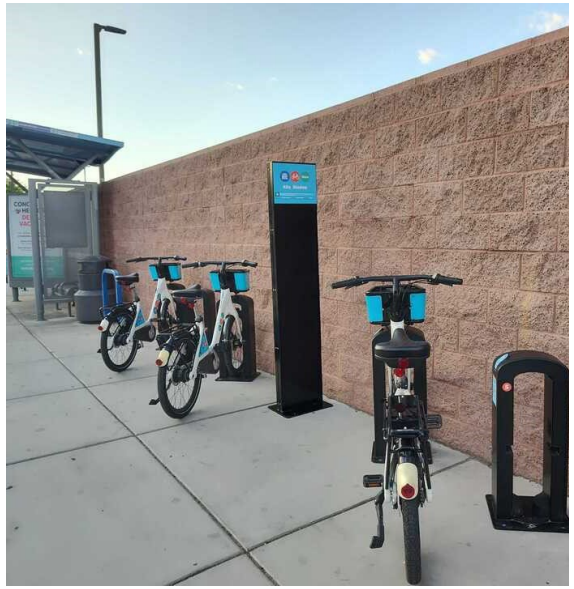
25
stations

100
classic bikes

10
electric bikes

Launched in
Oct 2016


RTC
Share



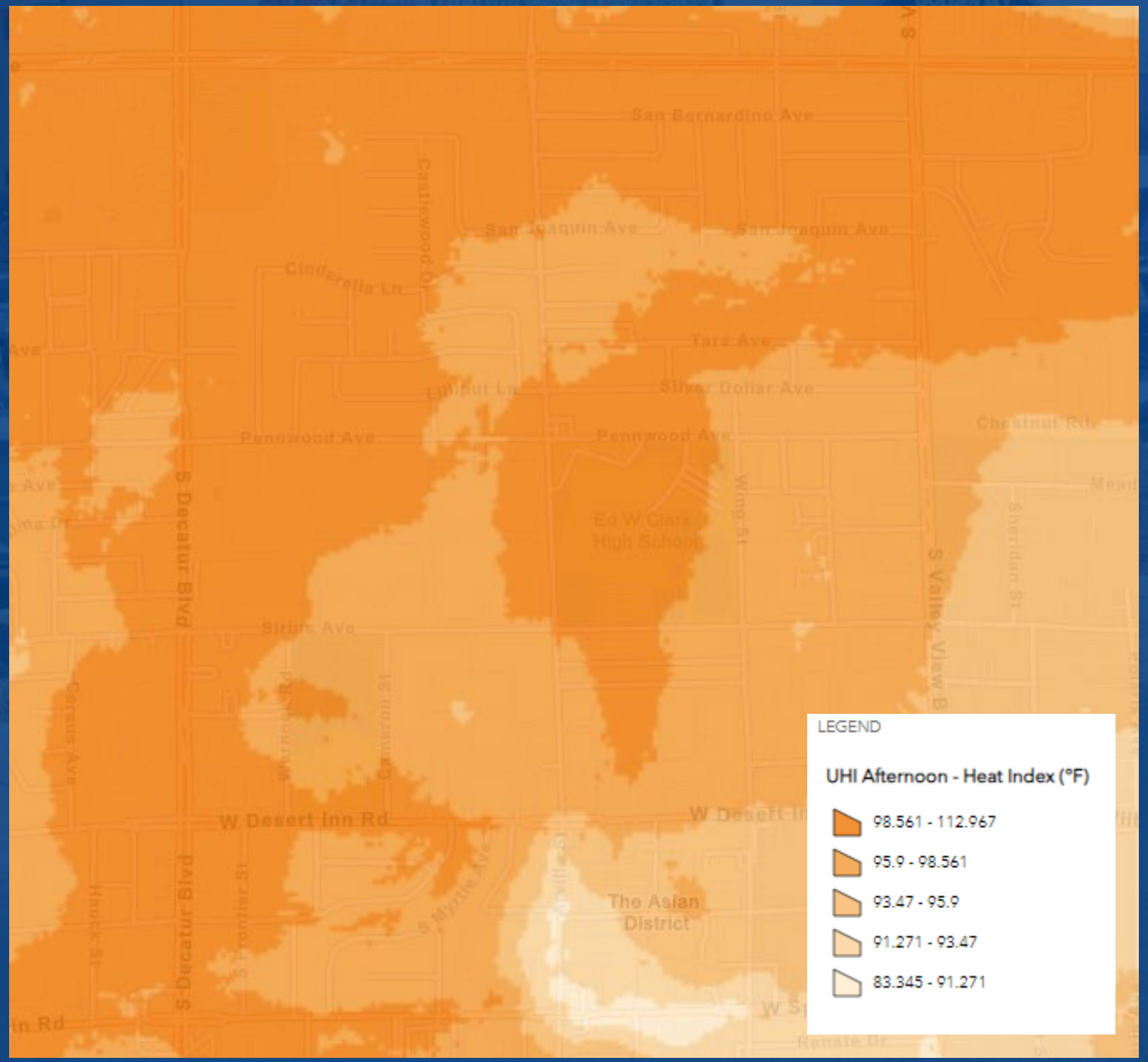

RTC
Wellness Way
Ride at a discoun


RTC
RTC TRANSIT
BRIDGER AVE

Upcoming RTC Grant Projects

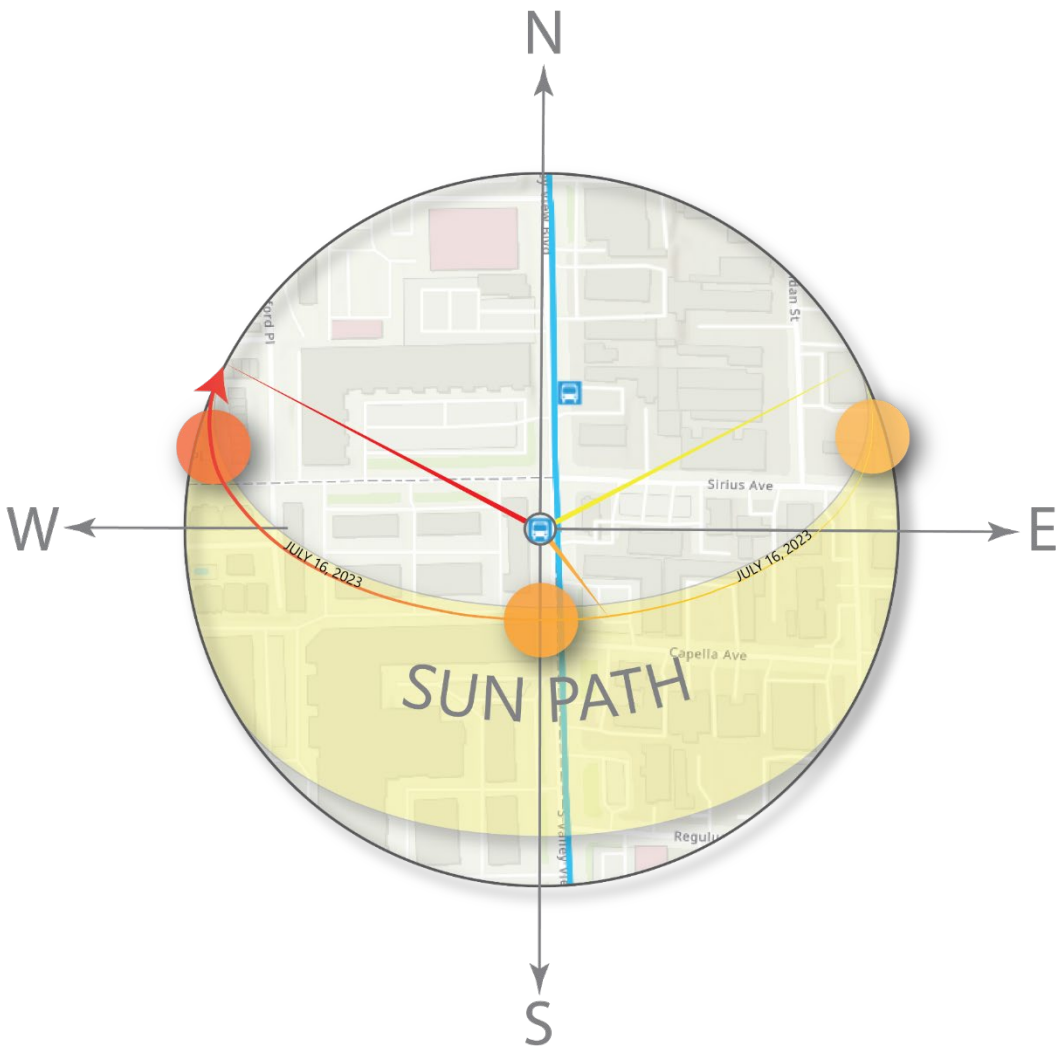
Route Planning Restoration Program

FTA | *Route Planning Restoration Program*

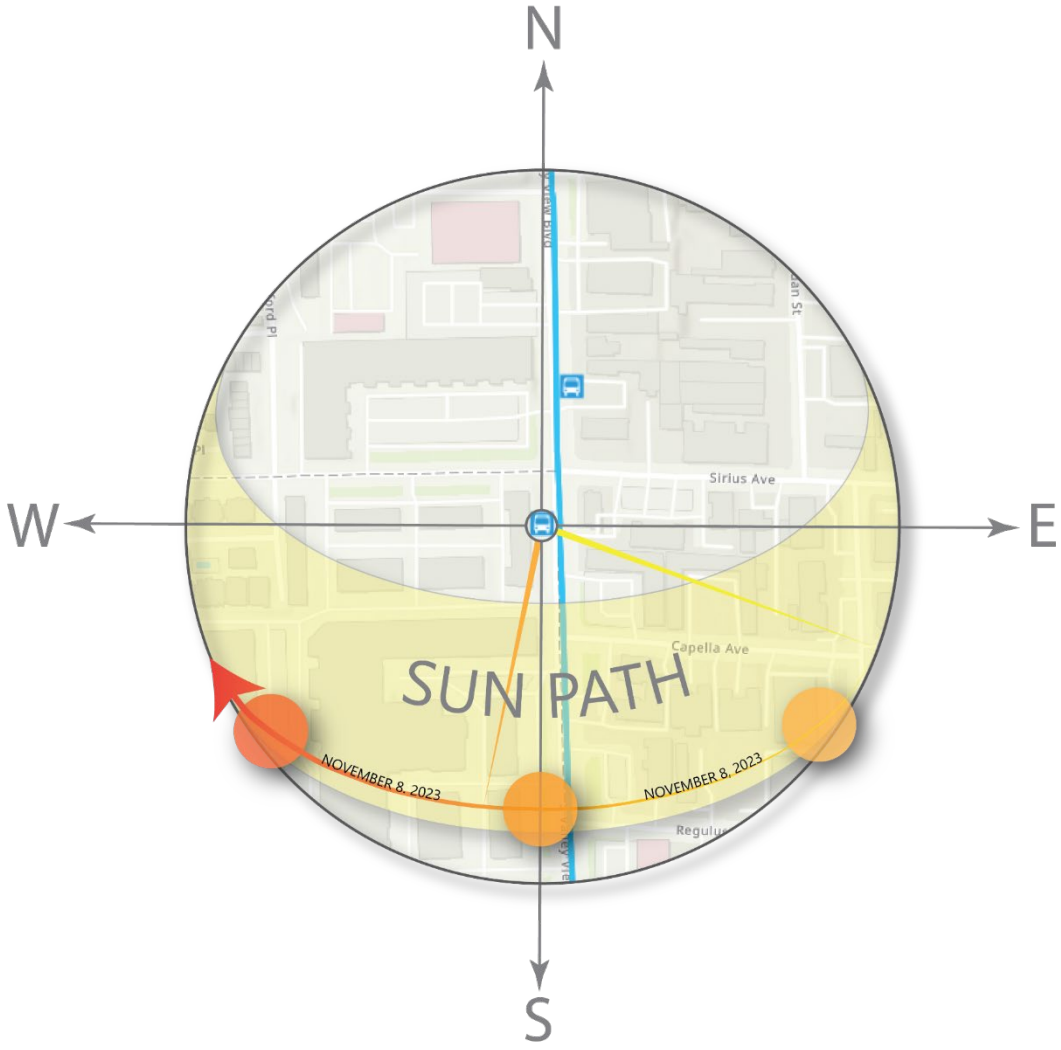

San Bernardino Ave
San Joaquin Ave
Cinderella Ln
Tara Ave
Silver Dollar Ave
Pennwood Ave
Chestnut Rd
Ed W Clark High School
S Decatur Blvd
Sirius Ave
W Desert Inn Rd
The Asian District
S Valley View Blvd
LEGEND
UHI Afternoon - Heat Index (°F)
98.561 - 112.967
95.9 - 98.561
93.47 - 95.9
91.271 - 93.47
83.345 - 91.271

SUN STUDY: Elevation Angles

Southbound VALLEY VIEW after SIRIUS
Stop #: 2943



July 16, 2023 at 12:00pm

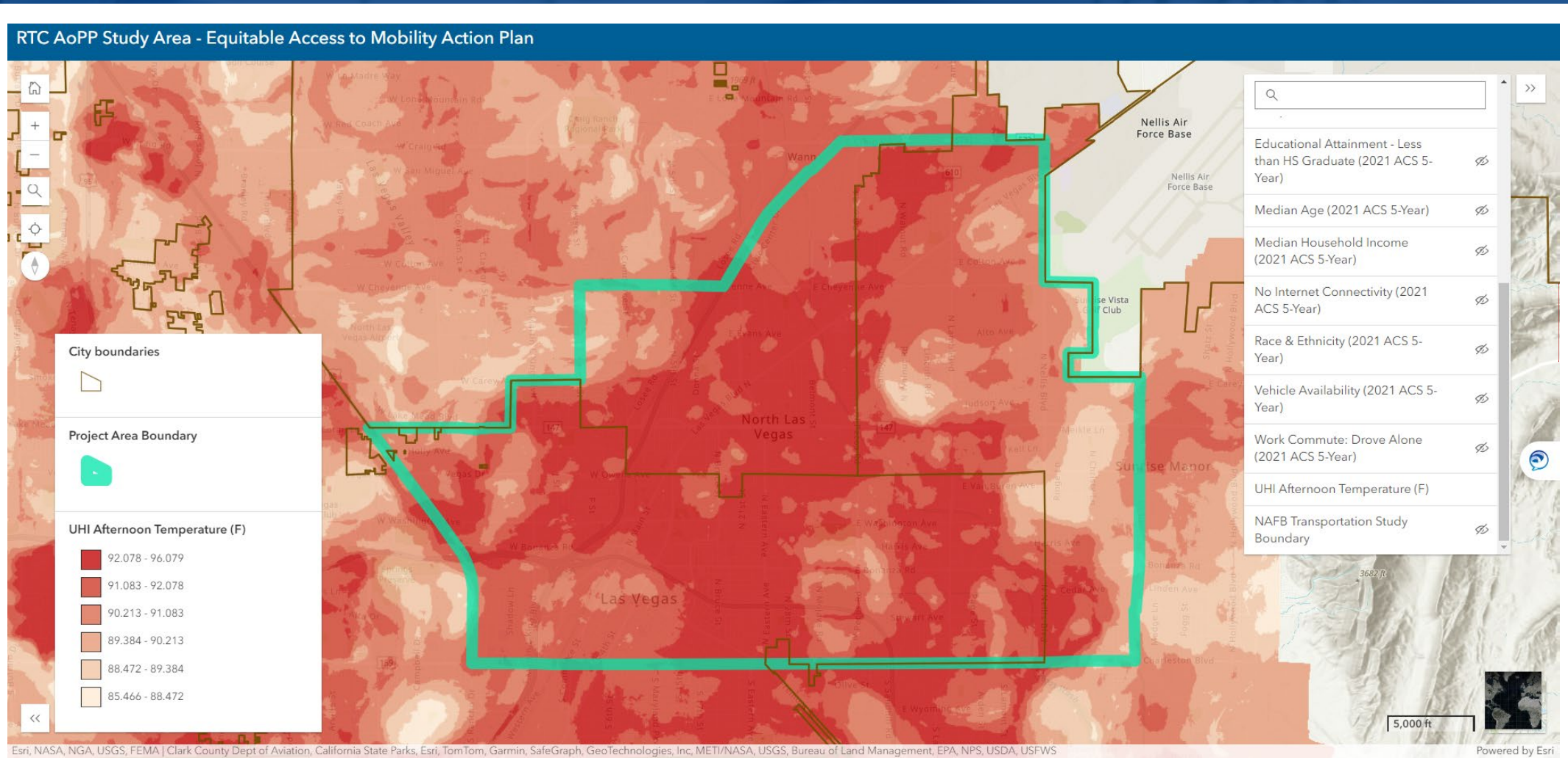


November 8, 2023 at 12:00pm

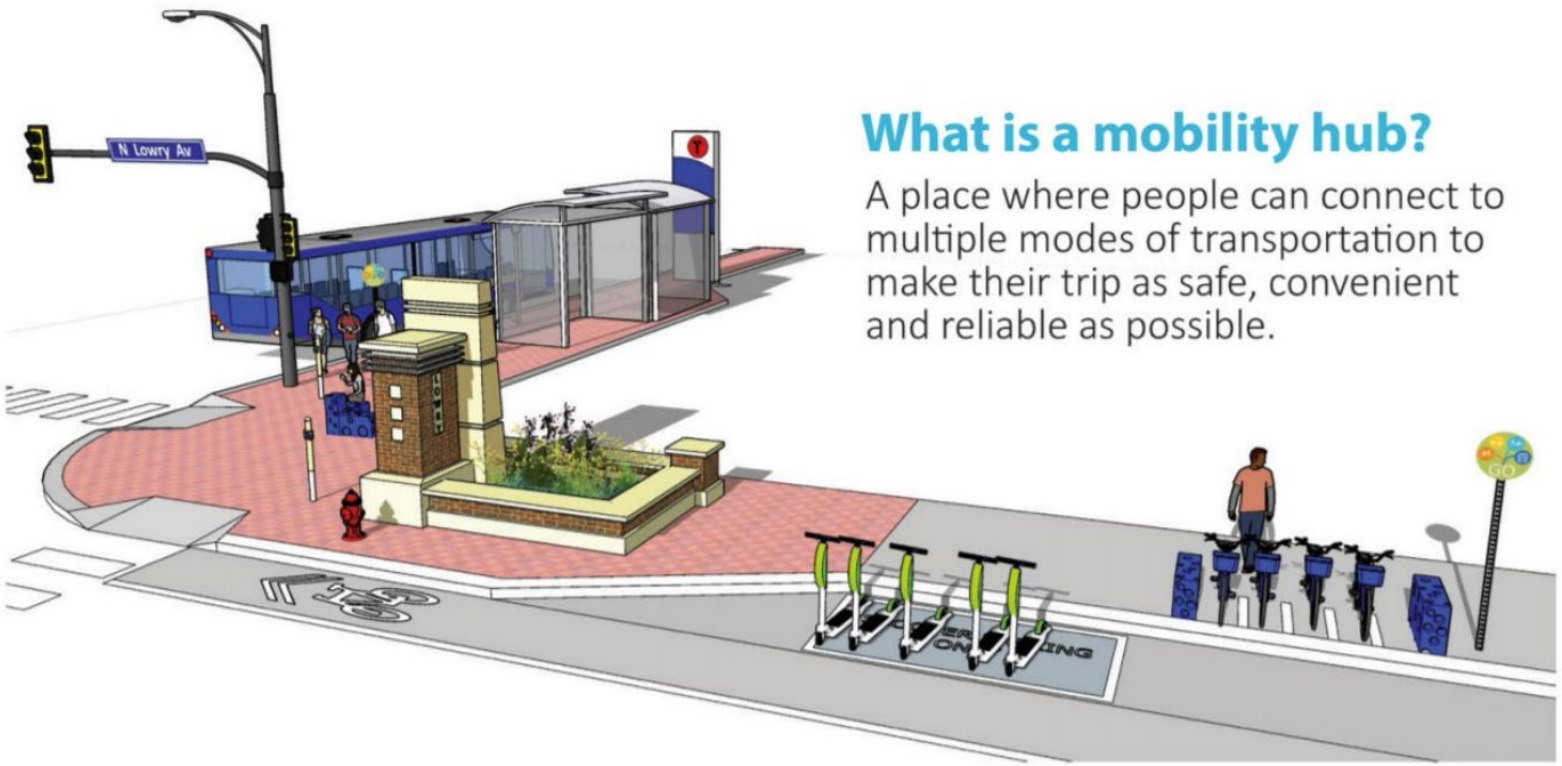
Equitable Access to Mobility Action Plan

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

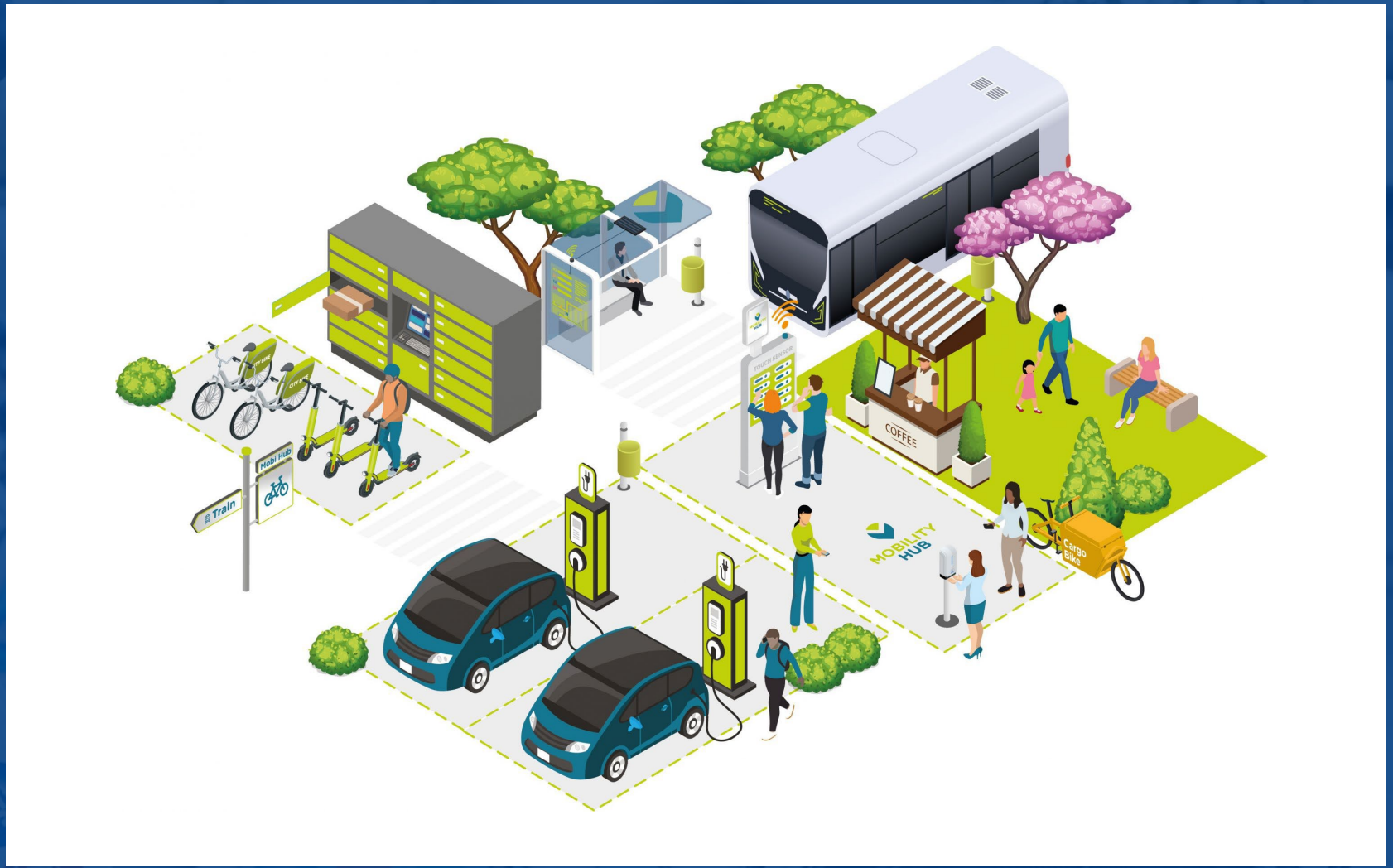
Study Area


RTC AoPP Study Area - Equitable Access to Mobility Action Plan
City boundaries
Project Area Boundary
UHI Afternoon Temperature (F)
92.078 - 96.079
91.083 - 92.078
90.213 - 91.083
89.384 - 90.213
88.472 - 89.384
85.466 - 88.472
Educational Attainment - Less than HS Graduate (2021 ACS 5-Year)
Median Age (2021 ACS 5-Year)
Median Household Income (2021 ACS 5-Year)
No Internet Connectivity (2021 ACS 5-Year)
Race & Ethnicity (2021 ACS 5-Year)
Vehicle Availability (2021 ACS 5-Year)
Work Commute: Drove Alone (2021 ACS 5-Year)
UHI Afternoon Temperature (F)
NAFB Transportation Study Boundary
Nellis Air Force Base
North Las Vegas
Las Vegas
5,000 ft
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



Mobility Hubs



Mobility Hubs

Mobility Hubs

Mobility hubs
(design & locations)

+

Transit stop
enhancements

+

Complete Streets
improvements


RTC

County Health Rankings & Roadmaps

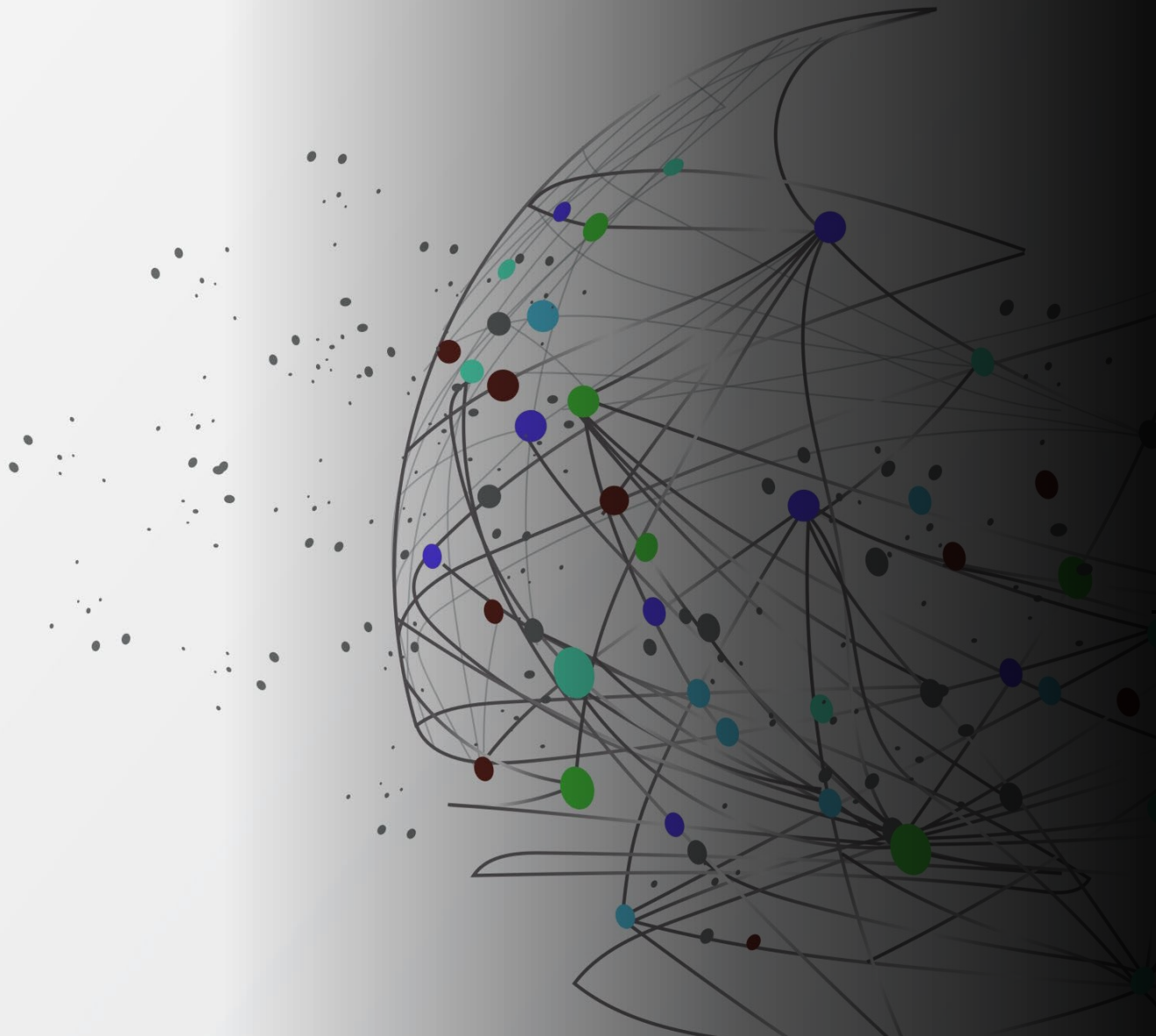
Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

From Analysis to Action: Strategies for Chronic Disease Prevention

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

SNHD
Southern Nevada Health District



From Analysis to Action: Strategies for Chronic Disease Prevention

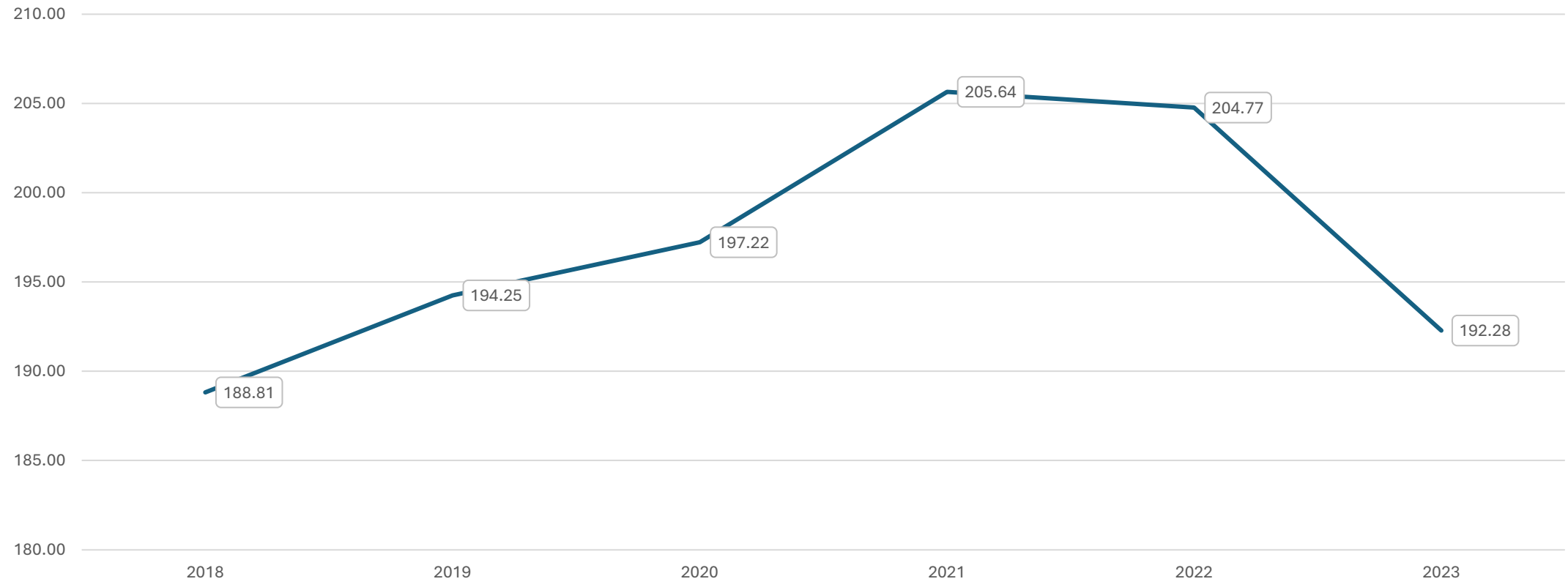
Benjamin Ashraf, Ph.D., MPH

Brandon Delise, MPH

What is Heart Disease?

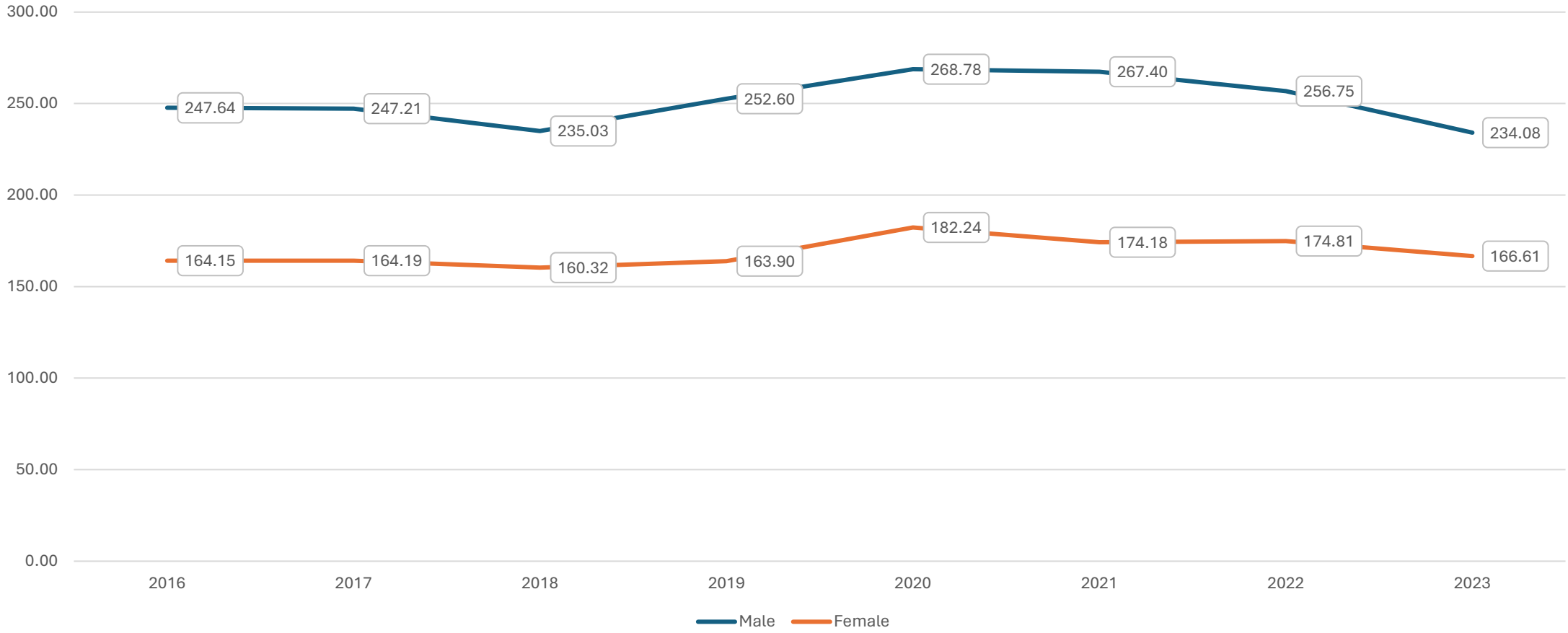
- Heart disease has been the leading cause of death in the United States since 1921.[4] Risk factors include high blood pressure, high cholesterol, smoking, diabetes, overweight and obesity, unhealthy diet, physical inactivity, and excessive alcohol use.[1]
- Heart disease encompasses various conditions, 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. [1]

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

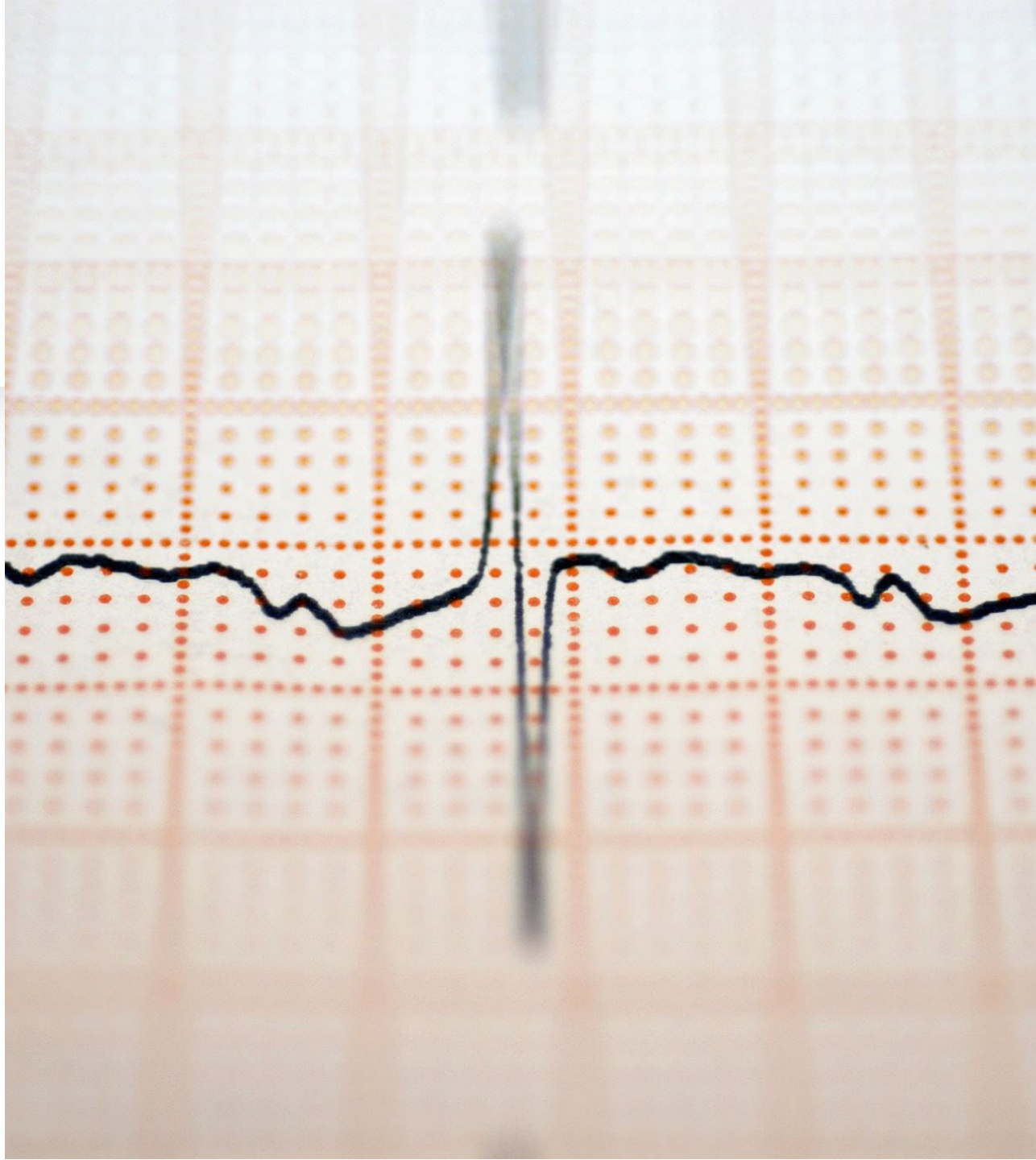


Data Source: SNHD's Electronic Death Registry System. Current as of 03/06/2024. 2023 data are preliminary and subject to change.

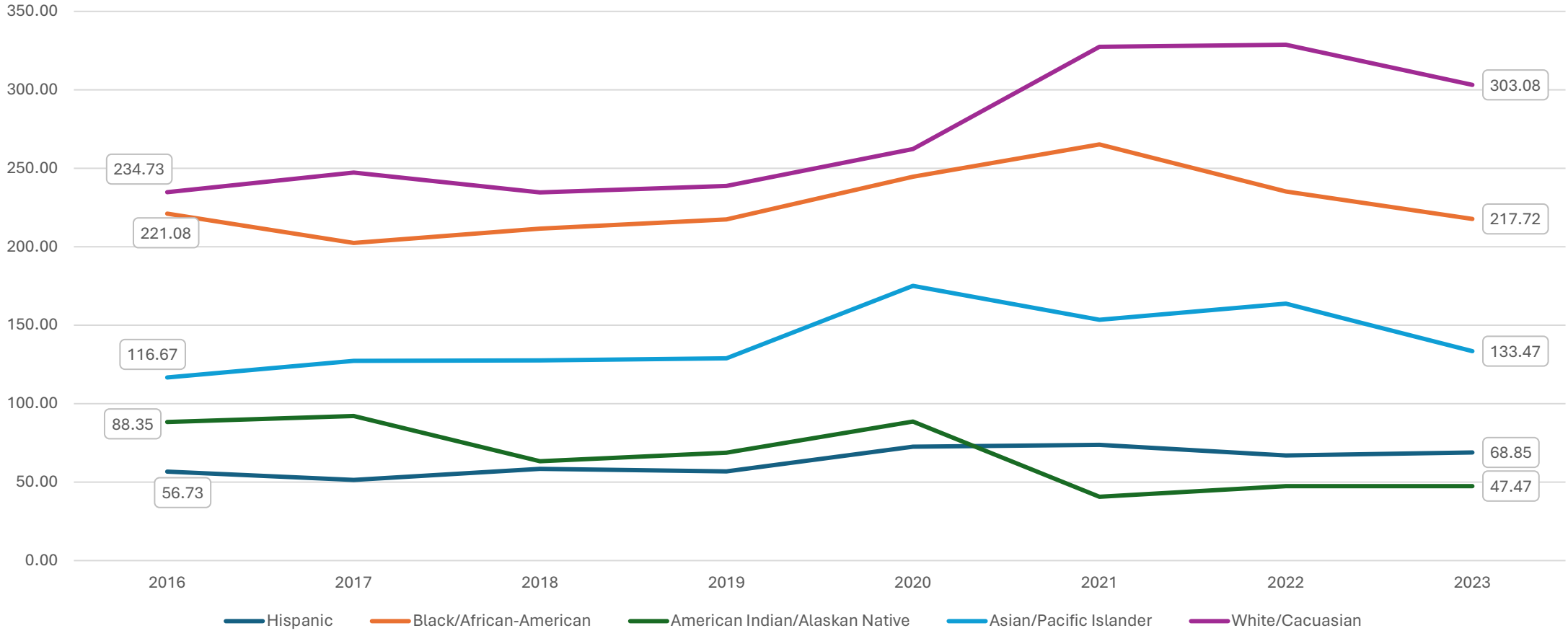
Heart Disease Deaths: Gender Descriptive Statistics

- 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.



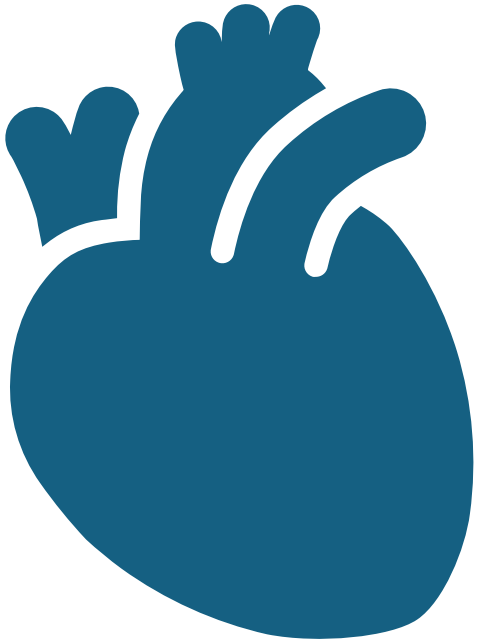
Heart Disease Crude Death Rate per 100,000 Clark County Residents by Race/Ethnicity, 2016-2023



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

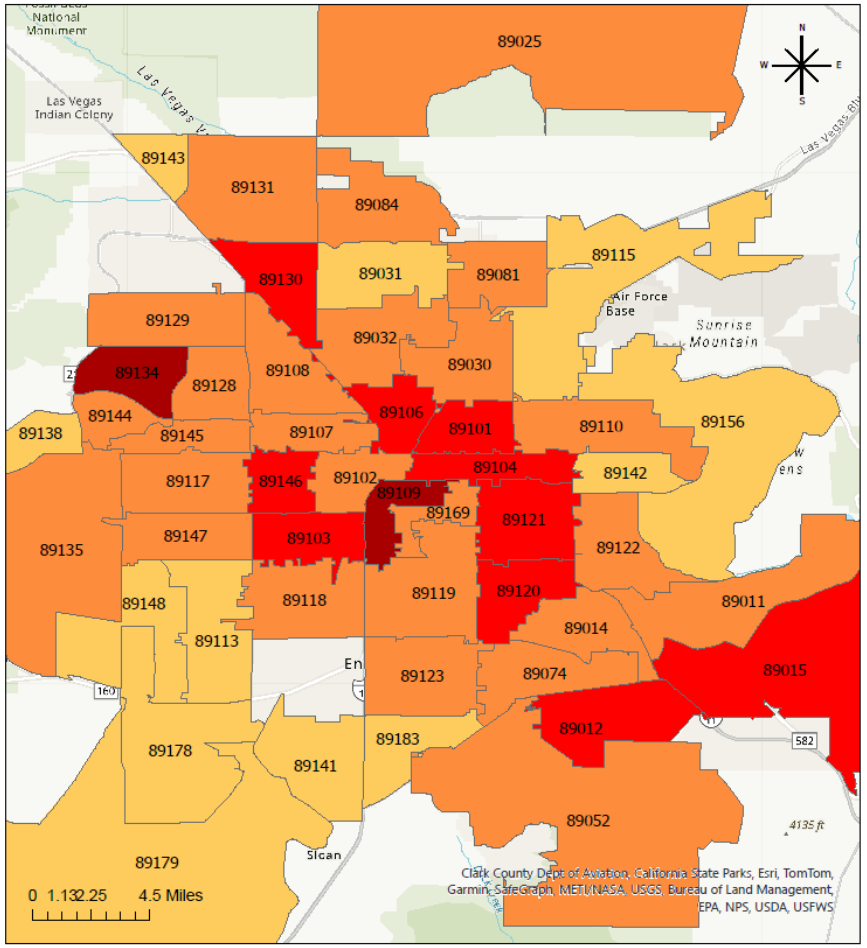
Heart Disease Deaths: Race/Ethnicity Descriptive Statistics

- 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



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: 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[1]
  - Increase the buildup of plaque in blood vessels
  - Lower “good” cholesterol (HDL)
  - Cause thickening and narrowing of blood vessels

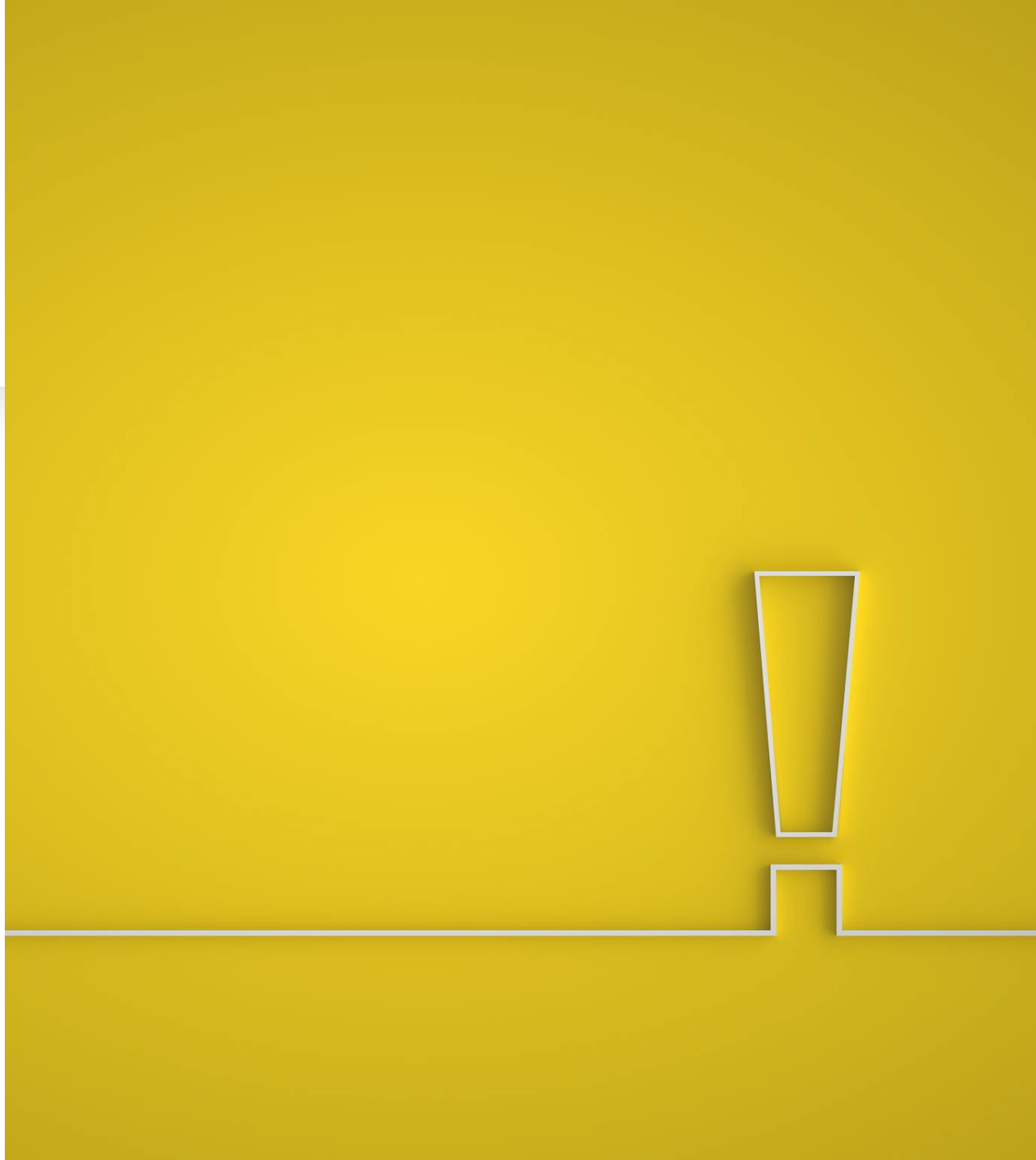
For those exposed to second-hand smoke:

- Exposure at home or at work increase risk of:
  - Heart Disease (25–30%)[1]
  - Strokes (20−30%)[1]
  - 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[2]

- 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)[2]
  - Use of cessation medications to quit - 23.9 individuals (16.1–31.7)[2]



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[3]
- Community based strategies are a key for success
  - Such approaches can help guide and improve the effectiveness of smoking cessation programs.[5]
- Economic evaluations of community-based tobacco cessation activities have shown them cost-effective.[6]

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

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

SNHD Southern Nevada Health District

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

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Thank you for attending!

Southern Nevada Health District

Nevada Department of Health and Human Services
Division of Public and Behavioral Health

School of Public Health
Making Health Happen

Nevada Public Health Institute

NNPH

Larson Institute
Health Impact and Equity

Carson City Health & Human Services

CCHD
Central Nevada Health District