Access to Quality Health Services

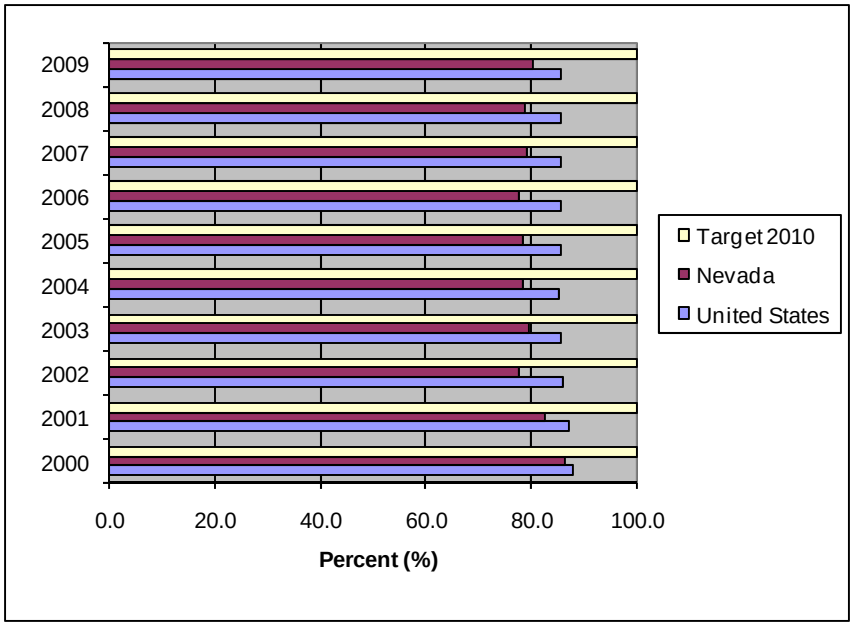
Improving access to quality health care is critical in eliminating health disparities and increasing the quality of life for all Nevadans. In particular, improved access to clinical preventive services such as screening tests and immunizations can reduce the number of preventable diseases and conditions. According to the Centers for Disease Control and Prevention (CDC), it is estimated in the first half of 2009, in the United States, 43.6 million people (14.8 percent) of all ages were uninsured and 6.8 million children (9.3 percent) were

Healthy People 2010 Objective (1-1): Increase the proportion of persons with health insurance.

Healthy People 2020 Objective AHS HP2020-1: Increase the proportion of persons with health insurance.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
80.5	85.6	100.0	100.0	Fluctuating

Proportion of Persons with Health Insurance, Nevada Residents and United States, BRFSS Data, 2000 - 2009.*

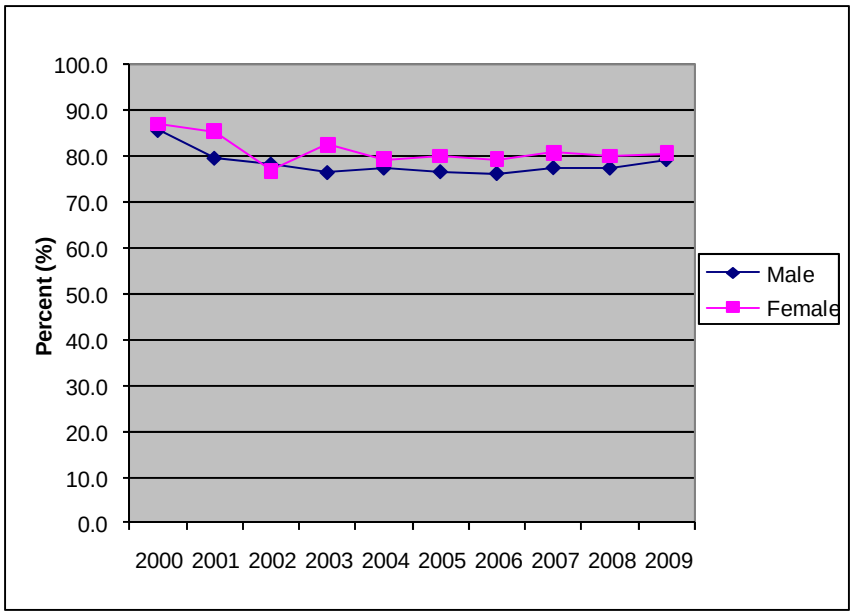


In 2010 it is estimated that 1 in 6 working age adults in America are uninsured.[1]

From 2004 to 2009, the percentage of persons with health insurance within the United States was steady around 85 percent, at 85.6 percent in 2009. In Nevada, during the same period, the state averaged 80 percent of people had health insurance.

*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of Persons with Health Insurance, Nevada Residents by Gender, BRFSS Data, 2000 - 2009.*



As of February 2009, approximately 1.7 million men have lost employer-provided health insurance from their jobs nationally, compared to approximately 396,800 women.[2]

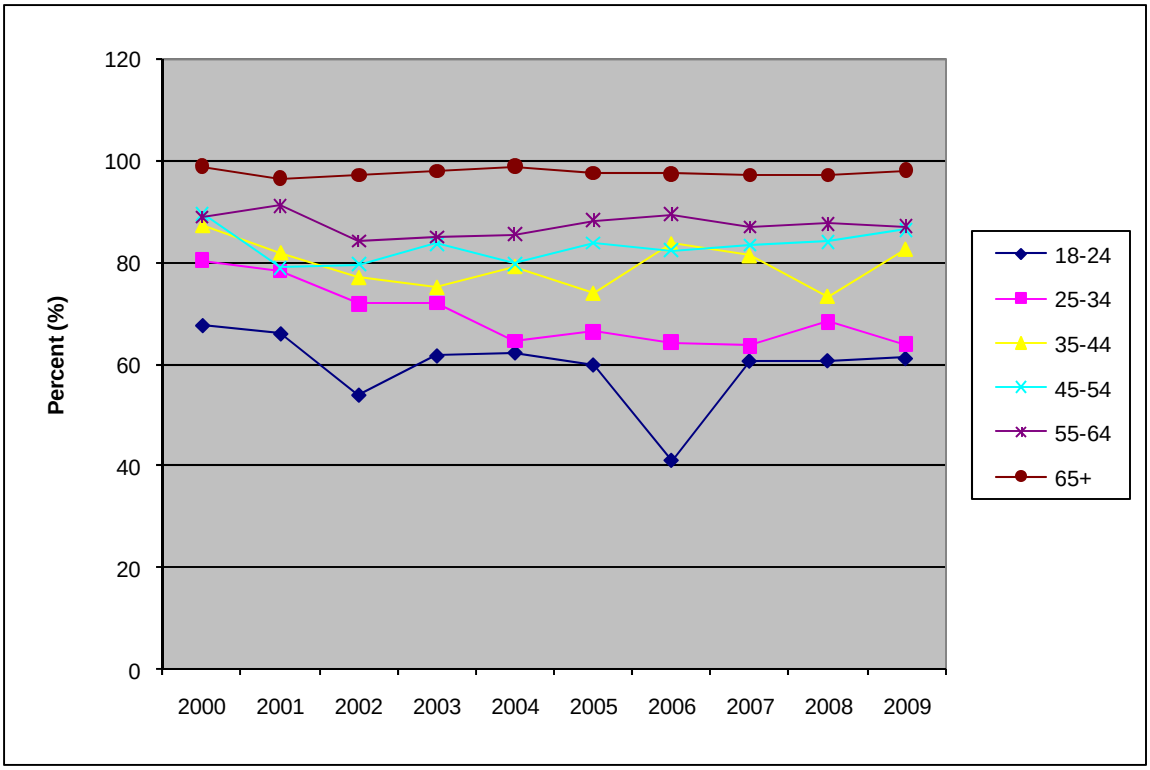
From 2003 to 2009, there was a slightly higher proportion of Nevada females with health insurance than Nevada males.

Proportion of Persons with Health Insurance, Nevada Residents by Race/Ethnicity, BRFSS Data, 2000 - 2009.*

Whites had a higher proportion of people with health insurance than all other race/ethnic groups in the reported years. While Hispanics had the lowest proportion of people with health insurance among all race/ethnic groups.

*These percentages are weighted to survey population characteristics.

Proportion of Persons with Health Insurance, Nevada Residents by Age, BRFSS Data, 2000 - 2009.*



From 2000 to 2009, Nevada residents, 65 years and older, consistently had the highest proportion of people reporting that they have health insurance. Nevada residents who are 18 to 24 years old consistently had the lowest proportion of people reporting that they have health insurance.

*These percentages are weighted to survey population characteristics.

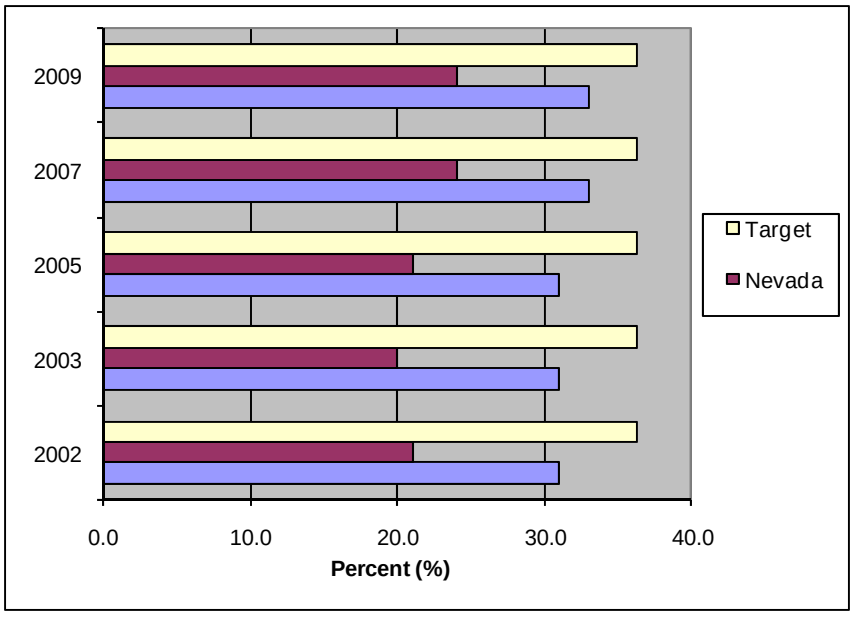
Adolescent Health

During the transition from childhood to adulthood, adolescents establish patterns of behavior and make lifestyle choices that affect both their current and future health. Adolescents and young adults are adversely affected by serious health and safety issues such as motor vehicle crashes, violence, substance use, and sexual behavior. They also struggle to adapt behaviors that can decrease their risk of developing chronic diseases in adulthood, behaviors such as eating healthy, engaging in physical activity, and choosing not to use tobacco. Environmental factors such as family, peer group, school, and community characteristics also contribute to the challenges that adolescents face.[1]

Healthy People 2020 Objective AH HP2020-5.3.1: Increase the percentage of students whose reading skills are at or above the proficient achievement level for their grade- 4th Grade.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
24.0	33.0	N/A	36.3	Improving

Percentage of 4th Grade Students Whose Reading Skills Are At or Above Proficient, Nevada Residents and United States, 2002, 2003, 2005, 2007, 2009.*

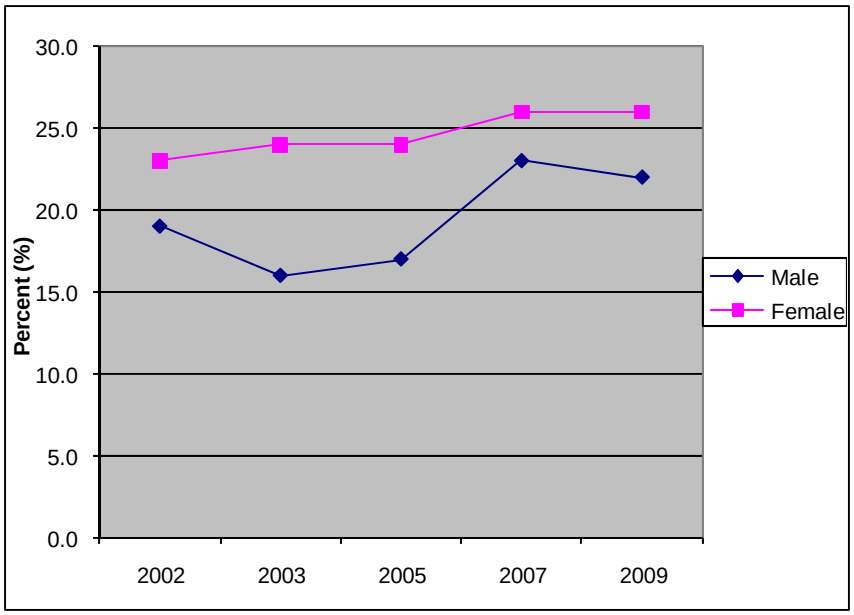


The percentage of 4th grade students who are considered “at or above proficient” was lower in Nevada than in the United States from 2002 to 2009. Neither region has met the Healthy People 2010 target of 36.3 percent.

The National Assessment of Educational Progress (NAEP) grade 4 reading achievement levels correspond to the following scale points: Below basic, 207 or lower; Basic, 208-237; Proficient, 238-267; Advanced, 268 or above.

*Nevada and U.S. data are from U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, National Assessment of Educational Progress (NAEP). Individual county data are not available.

Percentage of 4th Grade Students Whose Reading Skills Are At or Above Proficient, Nevada Residents by Gender, 2002, 2003, 2005, 2007, 2009.*

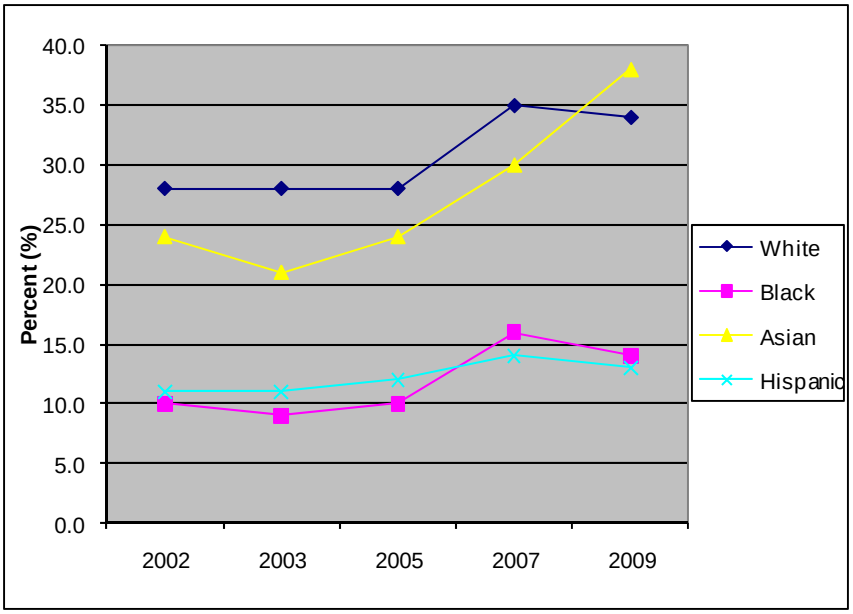


From 2002 to 2009, female 4th grade Nevada students have had a higher percentage of students with proficient reading scores than Nevada 4th grade male students.

The National Assessment of Educational Progress (NAEP) grade 4 reading achievement levels correspond to the following scale points: Below basic, 207 or lower; Basic, 208-

Percentage of 4th Grade Students Whose Reading Skills Are At or Above Proficient, Nevada Residents by Race/Ethnicity, 2002, 2003, 2005, 2007, 2009.*

There was an overall increase in the percentage of Nevada 4th grade students who were proficient in reading in all race/ethnicity groups from 2002 to 2009. In general, White and Asian Nevada residents had the highest percentage of 4th grade student who were proficient in reading, while Black and Hispanic Nevada residents had much lower percentages.



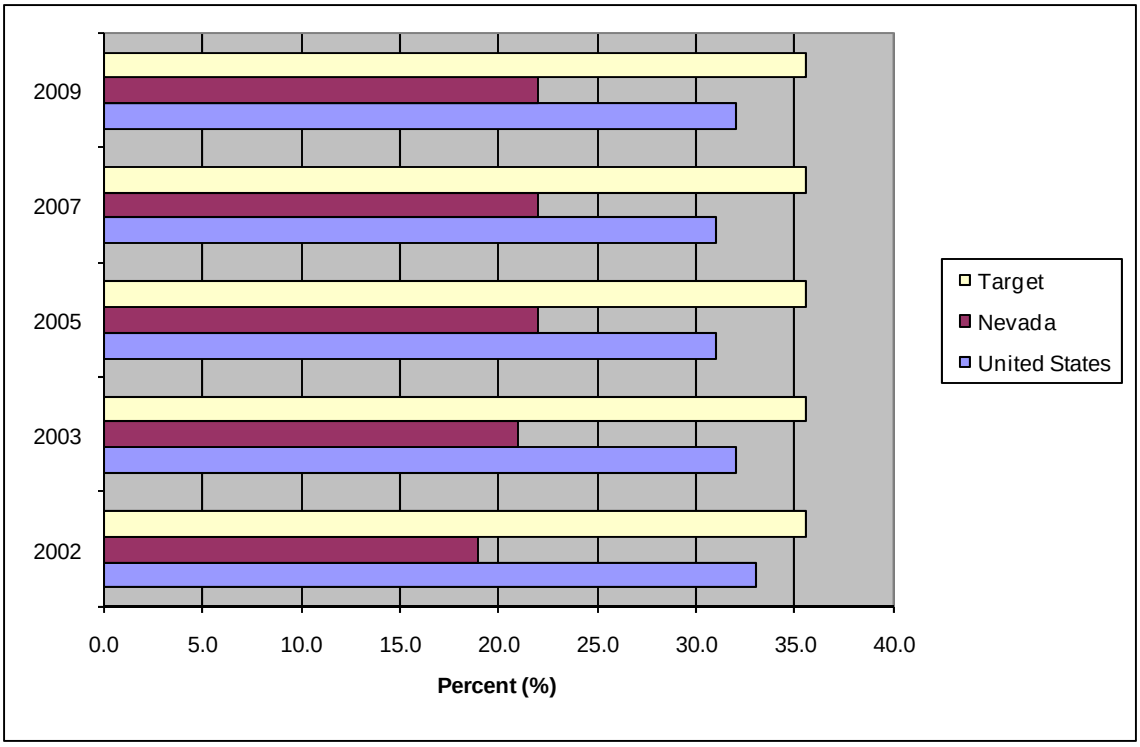
The National Assessment of Educational Progress (NAEP) grade 4 reading achievement levels correspond to the following scale points: Below basic, 207 or lower; Basic, 208-

*Nevada data are from U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, National Assessment of Educational Progress (NAEP). Individual county data are not available.

Healthy People 2020 Objective AH HP2020-5.3.2: Increase the percentage of students whose reading skills are at or above the proficient achievement level for their grade- 8th Grade.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
22.0	32.0	N/A	35.6	Fluctuating

Percentage of 8th Grade Students Whose Reading Skills Are At or Above Proficient, Nevada Residents and United States, 2002, 2003, 2005, 2007, 2009.*

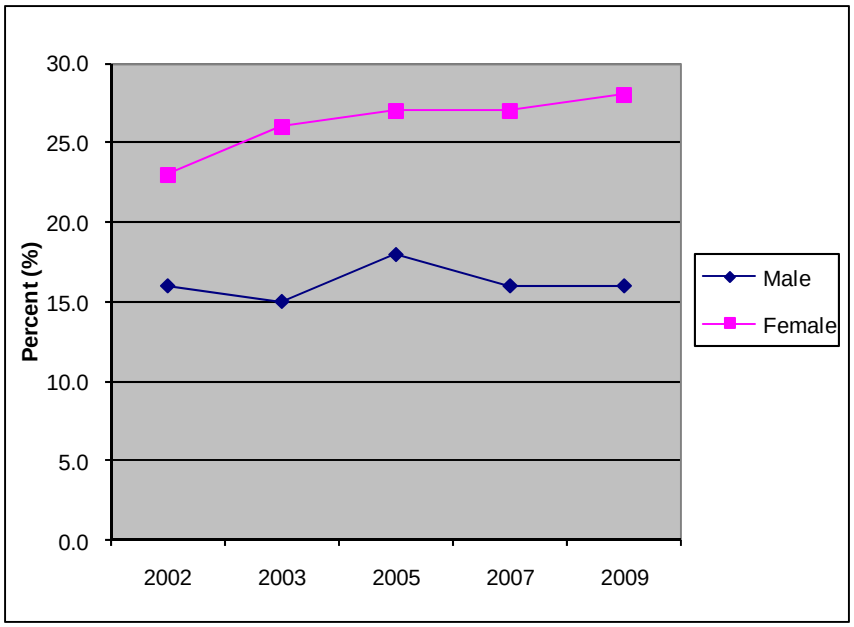


The National Assessment of Educational Progress (NAEP) grade 8 reading achievement levels correspond to the following scale points: Below basic, 242 or lower; Basic, 243-280; Proficient, 281-322; Advanced, 323 or above.

The percentage of 8th grade students who were considered “at or above proficient” was lower in Nevada than in the United States from 2002 to 2009. Neither region met the Healthy People 2010 target of 35.6 percent.

*Nevada and U.S. data are from U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, National Assessment of Educational Progress (NAEP). Individual county data are not available.

Percentage of 8th Grade Students Whose Reading Skills Are At or Above Proficient, Nevada Residents by Gender, 2002, 2003, 2005, 2007, 2009.*

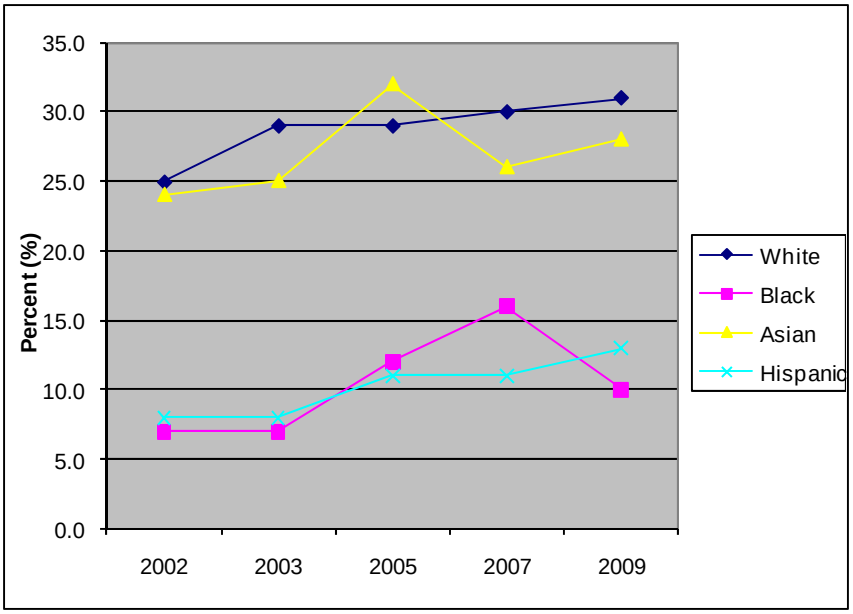


From 2002 to 2009, female 8th grade Nevada students had a higher percentage with proficient reading scores that Nevada 8th grade male students.

The National Assessment of Educational Progress (NAEP) grade 8 reading achievement levels correspond to the following scale points: Below basic, 242 or lower; Basic, 243-280; Proficient, 281-322; Advanced, 323 or above.

Percentage of 8th Grade Students Whose Reading Skills Are At or Above Proficient, Nevada Residents by Race/Ethnicity, 2002, 2003, 2005, 2007, 2009.*

There was an overall increase in the percentage of Nevada 8th grade students who were proficient in reading in all race/ethnicity groups from 2002 to 2009. In general, White and Asian Nevada residents had the highest percentage of 8th grade student who were proficient in reading, while Black and Hispanic Nevada residents had much lower percentages.



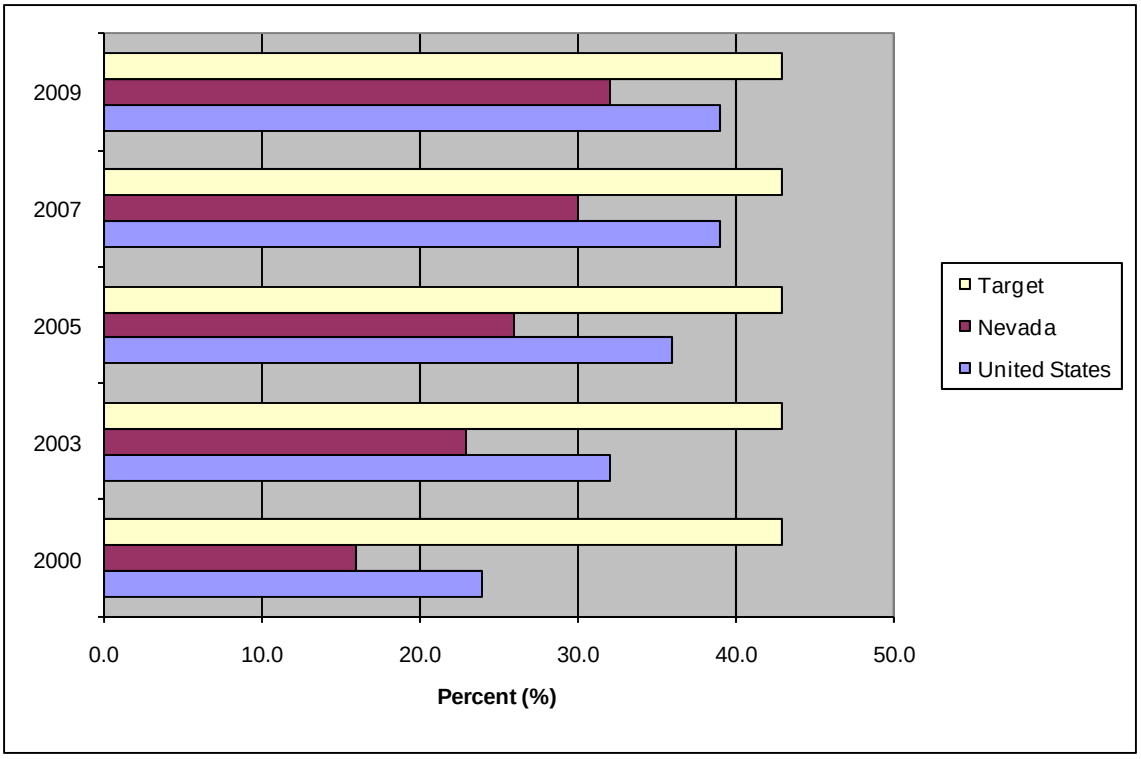
The National Assessment of Educational Progress (NAEP) grade 8 reading achievement levels correspond to the following scale points: Below basic, 242 or lower; Basic, 243-280; Proficient, 281-322; Advanced, 323 or above.

*Nevada data are from U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, National Assessment of Educational Progress (NAEP). Individual county data are not available.

Healthy People 2020 Objective AH HP2020-5.4.1: Increase the percentage of students whose mathematical skills are at or above the proficient achievement level for their grade- 4th Grade.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
32.0	39.0	N/A	43.0	Improving

Percentage of 4th Grade Students Whose Mathematics Skills Are At or Above Proficient, Nevada Residents and United States, 2000, 2003, 2005, 2007, 2009.*



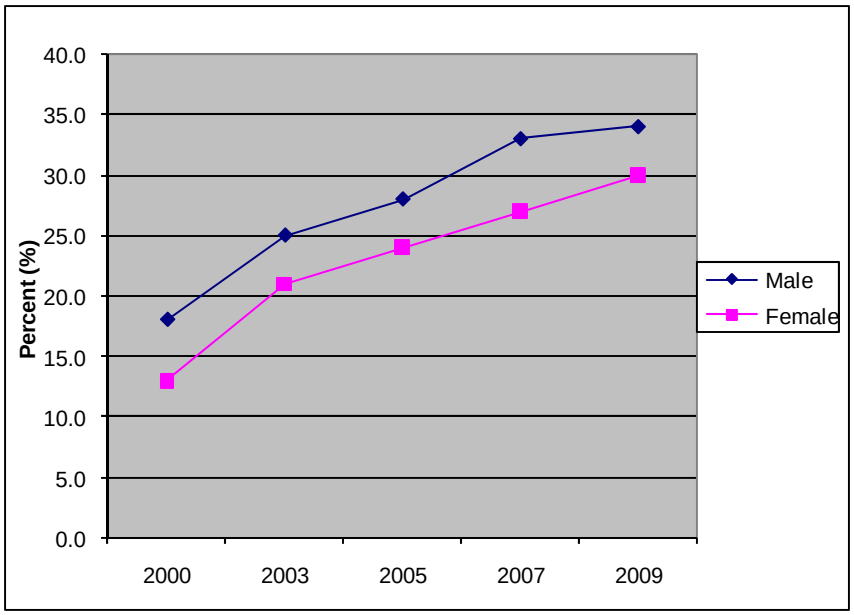
The National Assessment of Educational Progress (NAEP) grade 4 math achievement levels correspond to the following scale points: Basic, 239 and below; Proficient, 240 and above.

The percentage of Nevada 4th graders who are proficient in reading increased from 2000 to 2009. At 32.0 percent in 2009, Nevada had a lower percentage of reading proficient 4th graders than the nation (39.0 percent). Neither Nevada nor the nation have met the Healthy People 2020 target of 43.0 percent.

In 2009, the average mathematic proficiency score of 4th grade students in Nevada was 235. This was lower than the average score of 239 for public schools in the nation.[2]

*Nevada and U.S. data are from U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, National Assessment of Educational Progress (NAEP). Individual county data are not available.

Percentage of 4th Grade Students Whose Mathematics Skills Are At or Above Proficient, Nevada Residents by Gender, 2000, 2003, 2005, 2007, 2009.*



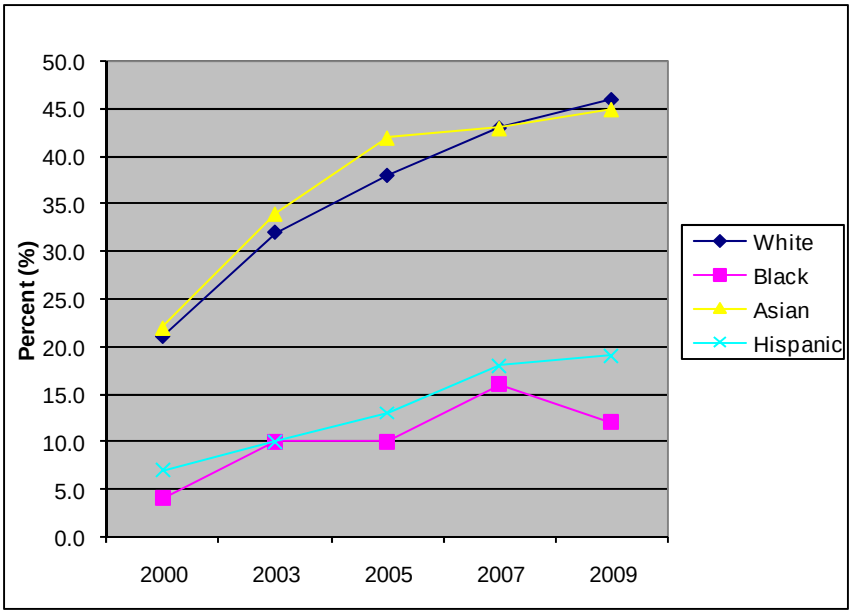
The percentage of 4th grade Nevada students who are proficient in Mathematics increased from 2000 to 2009 for both genders. Nevada's male students were consistently higher than Nevada's female students.

The National Assessment of Educational Progress (NAEP) grade 4 mathematic achievement levels correspond to the following scale points: Basic, 239 and below; Proficient, 240 and above.

Percentage of 4th Grade Students Whose Mathematics Skills Are At or Above Proficient, Nevada Residents by Race/ Ethnicity, 2000, 2003, 2005, 2007, 2009.*

The percentage of 4th grade Nevada students who are proficient in Mathematics increased from 2000 to 2009 for all race/ethnicity groups.

In general, White and Asian Nevada residents had the highest percentage of 4th grade student who are proficient in mathematics, while Black and Hispanic 4th grade Nevada students had much lower percentages.



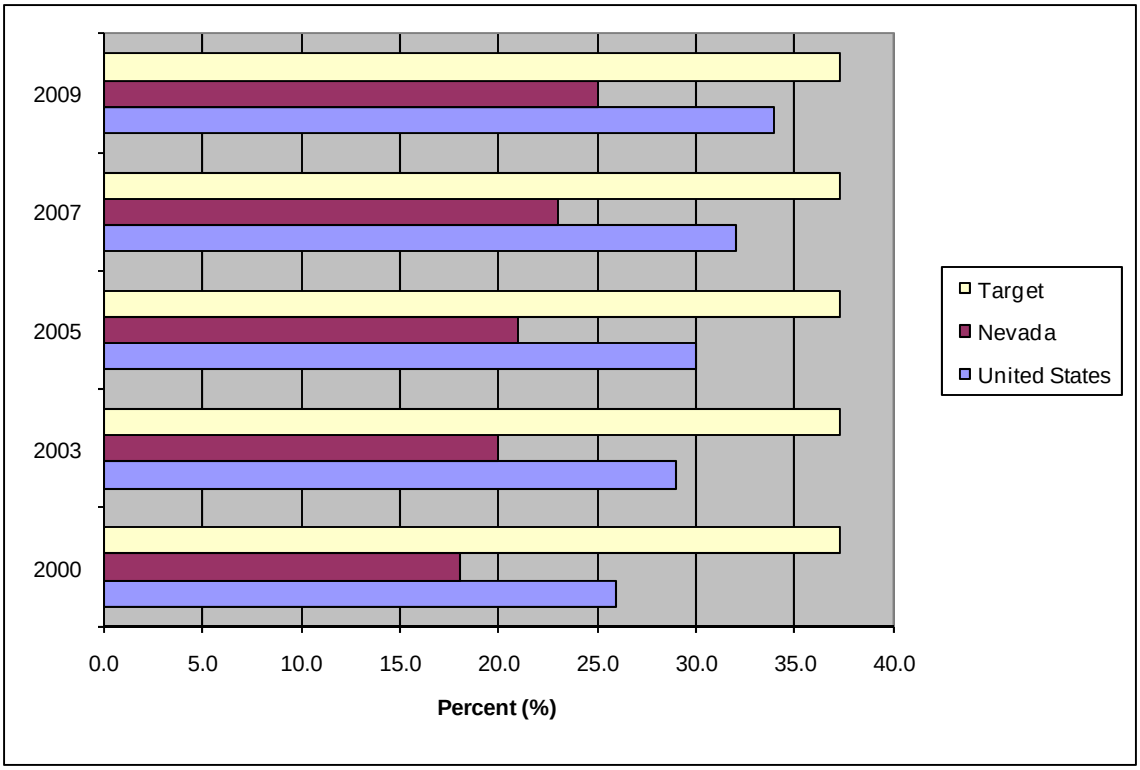
The National Assessment of Educational Progress (NAEP) grade 4 math achievement levels correspond to the following scale points: Basic, 239 and below; Proficient, 240 and

*Nevada data are from U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, National Assessment of Educational Progress (NAEP). Individual county data are not available.

Healthy People 2020 Objective AH HP2020-5.4.2: Increase the percentage of students whose mathematical skills are at or above the proficient achievement level for their grade- 8th Grade.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
25.0	34.0	N/A	37.3	Improving

Percentage of 8th Grade Students Whose Mathematics Skills Are At or Above Proficient, Nevada Residents and United States, 2000, 2003, 2005, 2007, 2009.*



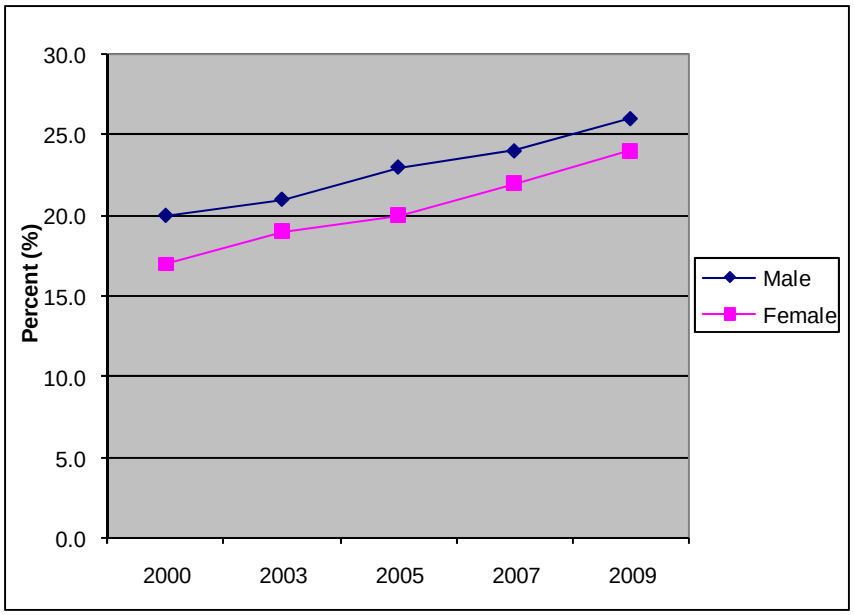
The National Assessment of Educational Progress (NAEP) grade 8 math achievement levels correspond to the following scale points: Basic, 239 and below; Proficient, 240 and above.

The percentage of Nevada 8th graders who are proficient in reading increased from 2000 to 2009. At 25.0 percent in 2009, Nevada had a lower percentage of reading proficient 8th graders than the nation (34.0 percent). Neither Nevada nor the nation met the Healthy People 2020 target of 37.3 percent.

In 2009, the average mathematic proficiency score of 8th grade students in Nevada was 274. This was lower than the average score of 282 for public school students in the nation.[2]

*Nevada and U.S. data are from U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, National Assessment of Educational Progress (NAEP). Individual county data are not available.

Percentage of 8th Grade Students Whose Mathematics Skills Are At or Above Proficient, Nevada Residents by Gender, 2000, 2003, 2005, 2007, 2009.*



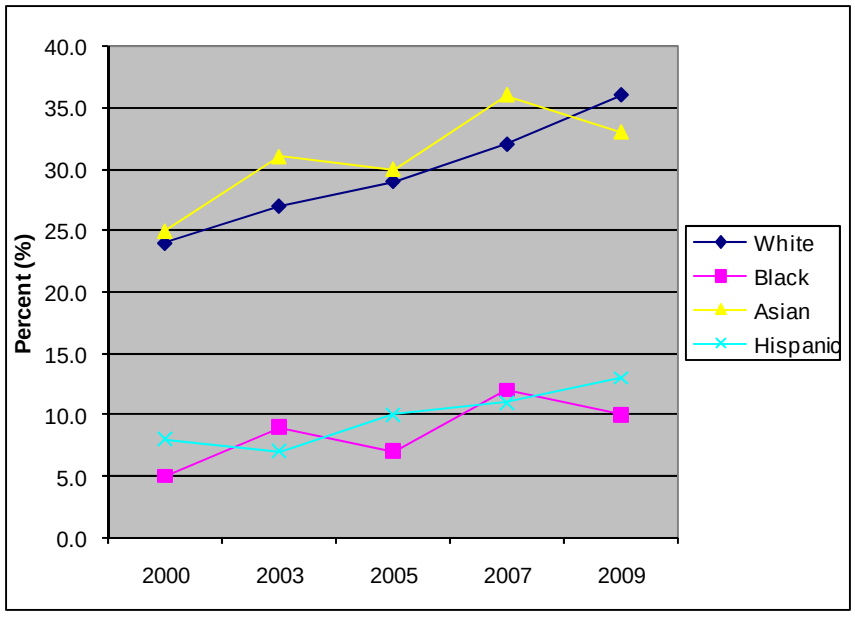
The percentage of 8th grade Nevada students who are proficient in Mathematics increased from 2000 to 2009 for both genders. There has consistently been a higher percentage of Nevada 8th grade male students with proficient or better mathematics skills than Nevada 8th grade females.

The National Assessment of Educational Progress (NAEP) grade 8 math achievement levels correspond to the following scale points: Basic, 239 and below; Proficient, 240 and above.

Percentage of 8th Grade Students Whose Mathematics Skills Are At or Above Proficient, Nevada Residents by Race/ Ethnicity, 2000, 2003, 2005, 2007, 2009.*

The percentage of 8th grade Nevada students who are proficient in Mathematics increased from 2000 to 2009 for all race/ethnicity groups.

In general, White and Asian Nevada residents have had the highest percentage of 4th grade student who are proficient in mathematics, while Black and Hispanic 4th grade Nevada students have had much lower percentages.



The National Assessment of Educational Progress (NAEP) grade 8 math achievement levels correspond to the following scale points: Basic, 239 and below; Proficient, 240 and above.

*Nevada data are from U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, National Assessment of Educational Progress (NAEP). Individual county data are not available.

Arthritis, Osteoporosis, and Chronic Back Conditions

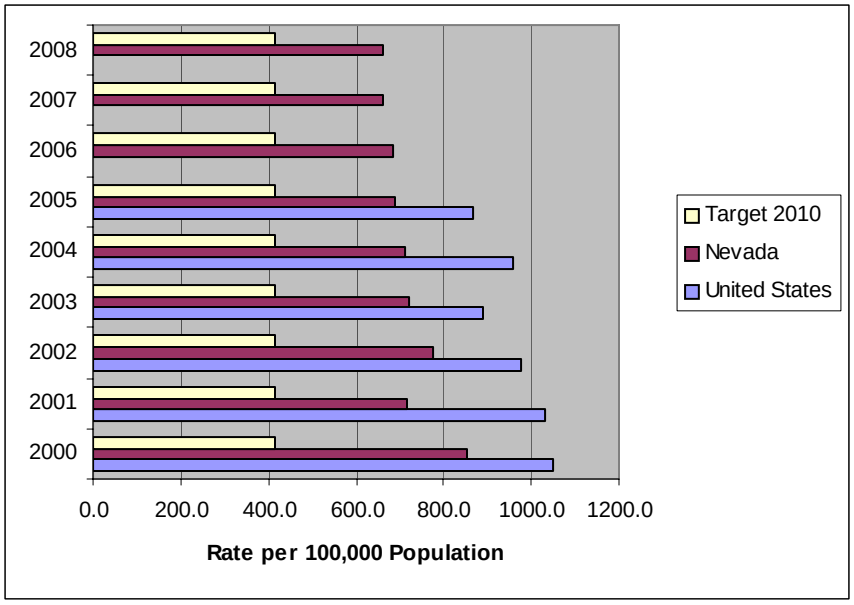
The term *arthritis* is used to describe more than 100 rheumatic diseases and conditions that affect joints, the tissues which surround the joint, and other connective tissue. Common symptoms include pain, aching, stiffness, and swelling in or around the joints. Early diagnosis and appropriate management are especially important for people with inflammatory arthritis. Injury prevention, physical activity, and weight control can lower a person's risk for arthritis. According to the Centers for Disease Control and Prevention (CDC),[1] arthritis is the leading cause of disability in the United States, limiting activities of more than 19 million adults.

Healthy People 2010 Objective (15-28): Reduce hip fractures among females and males aged 65 and older.

Healthy People 2020 Objective AOCBC HP2020-11: Reduce hip fractures among older adults.

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
663.1 (females)	868.0 (females)	416.0 (females)	741.2 (females)	Improving

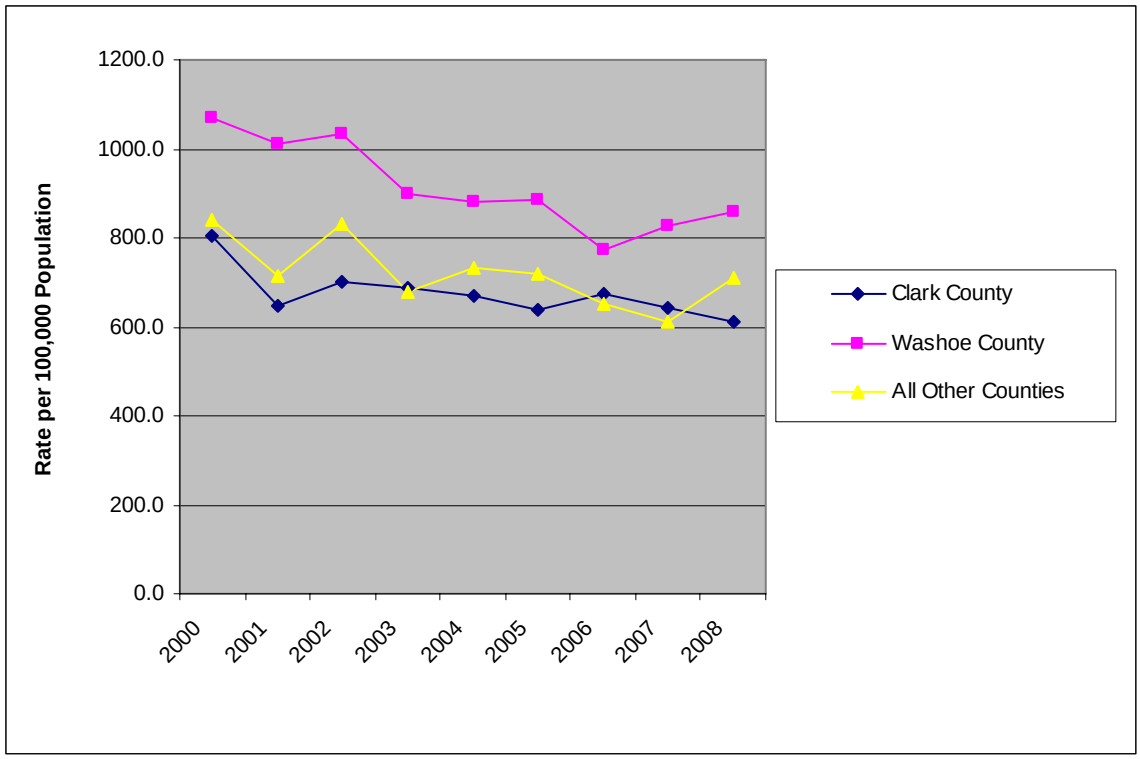
Hospitalization Rate for Hip Fractures Among Females Aged 65 Years and Older, Nevada Residents and United States, 2000 - Most Current Data.*



Hip fractures are associated with substantial morbidity and mortality; approximately 15-20 percent of patients die within one year of fracture.[2] In both Nevada and the nation, the hospitalization rate for hip fractures among females has declined slightly over the decade.

*The Nevada data are from Nevada Inpatient Hospital Discharge (NIHDD). The U.S. data are from the National Hospital Discharge Survey (NHDS).
Note: See appendix for additional information.

Hospitalization Rate for Hip Fractures Among Females Aged 65 Years and Older, Nevada Residents by County/Region, 2000 - 2008.*

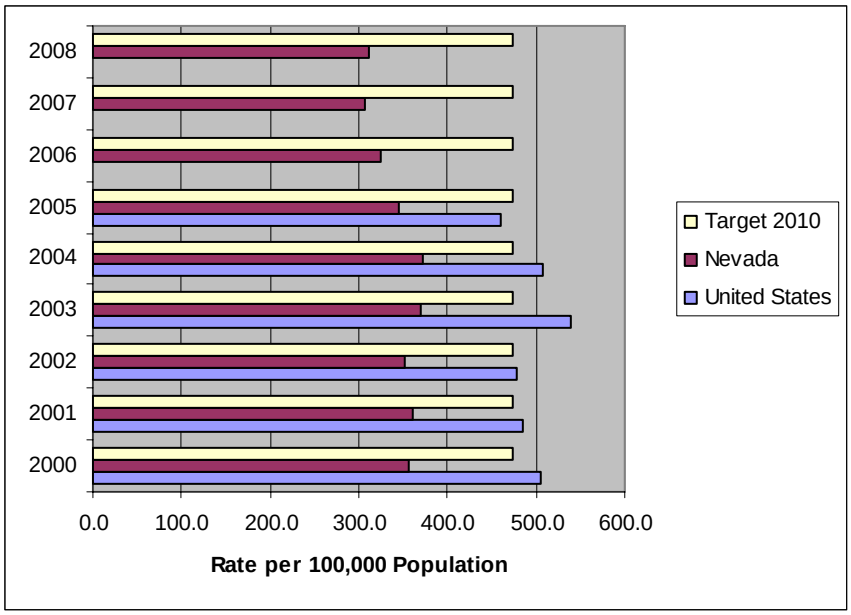


Most hip fractures occur in elderly individuals as a result of minimal trauma, such as a fall from standing height.[2] Washoe County had a higher hospitalization rate among females, aged 65 and older, for hip fractures than any other region from 2000 to 2008.

*The Nevada data are from Nevada Inpatient Hospital Discharge (NIHDD).

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
310.2 (males)	459.4 (males)	474.0 (males)	418.4 (males)	Surpassed

Hospitalization Rate for Hip Fractures Among Males Aged 65 Years and Older, Nevada Residents and United States, 2000 - Most Current Data.*

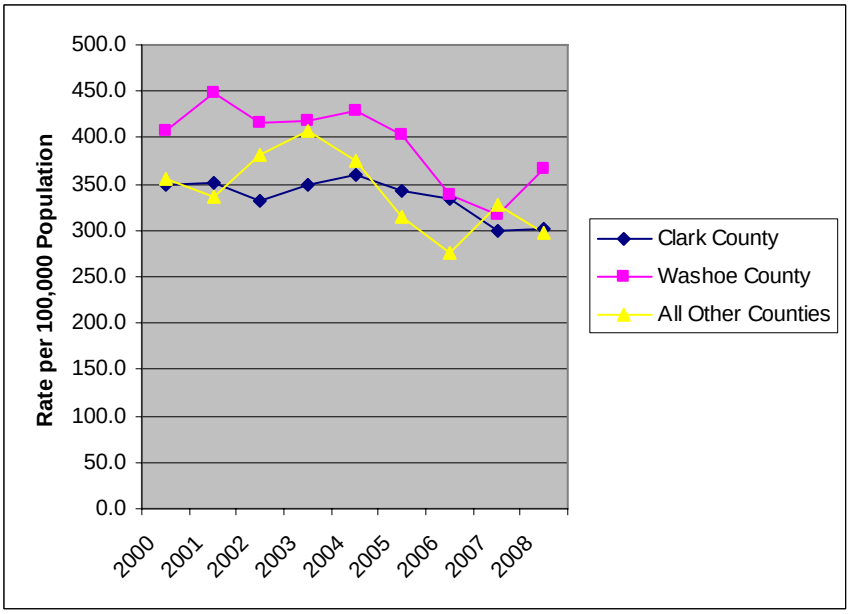


Increasing age, cognitive impairment, decreasing bone mass, decreasing depth perception, decreased mobility, dizziness, and a poor/fair self-perceived state of health are all linked to increasing likelihood of sustaining a fall and thus a possible hip fracture.[2]

The hospitalization rate for hip fractures among males, aged 65 and older, declined in Nevada from 2000 to 2008. While the national rate fluctuated and remained higher than the state rate.

Specific characteristics in men have been evaluated to determine the relationship to hip fracture; smoking, tall stature, stroke, and dementia were found to increase the risk of hip fracture,[4] while non – work-related physical activity and high BMI were found to be protective.[2] Washoe County's hospitalization rate for hip fractures among males, aged 65 and older, was higher than any other region in Nevada over the decade.

Hospitalization Rate for Hip Fractures Among Males Aged 65 Years and Older, Nevada Residents by County/Region, 2000 - 2008.*



*The Nevada data are from Nevada Inpatient Hospital Discharge (NIHDD). The U.S. data are from the National Hospital Discharge Survey (NHDS).
Note: See appendix for additional information.

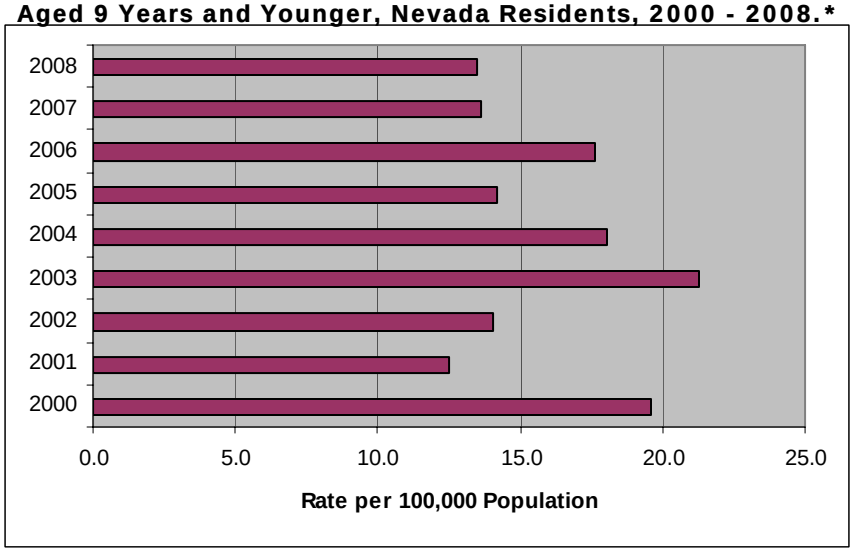
Blood Disorders and Blood Safety

Blood disorders, such as sickle cell disease, anemia, and hemophilia, affect millions of people each year in the United States, cutting across the boundaries of age, race, sex, and socioeconomic status. Men, women, and children of all backgrounds live with the complications associated with these conditions, many of which are painful and potentially life-threatening. With proper preventive actions and early intervention, many of these disorders and their complications could, to a large extent, be eliminated.[1]

Healthy People 2020 Objective BDBS HP2020-2: Reduce hospitalization for sickle cell disease among children aged 9 years and younger. Moved from HP 2010 16-21.
NOTE: This objective was removed from the final HP 2020 release.

Most Recent NV Value (2008)	U.S.	HP 2010 Target	HP 2020 Target	Progress Towards Targets
13.5		N/A	N/A	N/A

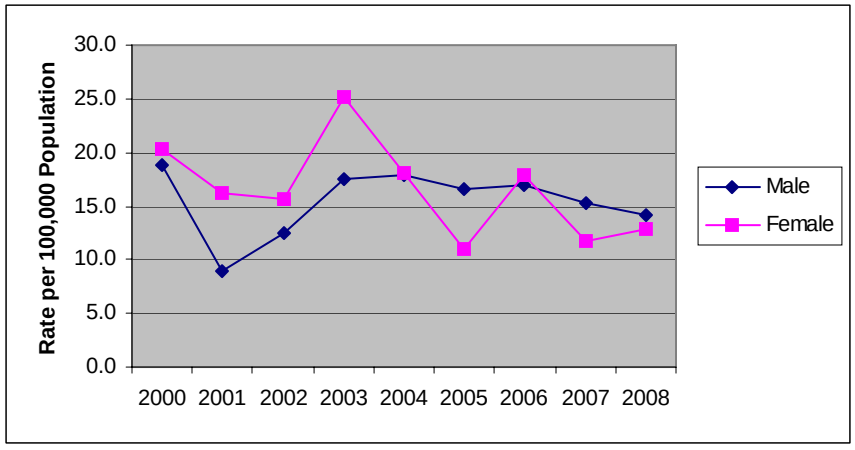
Hospitalization Rate for Sickle Cell Disease Among Children Aged 9 Years and Younger, Nevada Residents, 2000 - 2008.*



Sickle cell disease (SCD) is an inherited disease of red blood cells that produces abnormal hemoglobin, the protein found in red blood.[2] The hospitalization rate for sickle cell disease among children, aged 9 years and younger, fluctuated from 2000 to 2008.

In the U.S., SCD effects around 72,000 people, most of whose ancestors came from Africa.[2] In the five-year period from 2003 to 2007, there were 49 infants born with SCD in Nevada.[1] Hospitalization rates for sickle cell disease among children, aged 9 years and younger, fluctuate for both males and females in Nevada.

Hospitalization Rate for Sickle Cell Disease Among Children Aged 9 Years and Younger, Nevada Residents by Gender, 2000 - 2008.*



*The Nevada data are from Nevada Inpatient Hospital Discharge (NIHDD).
Note: See appendix for additional information.

Cancer

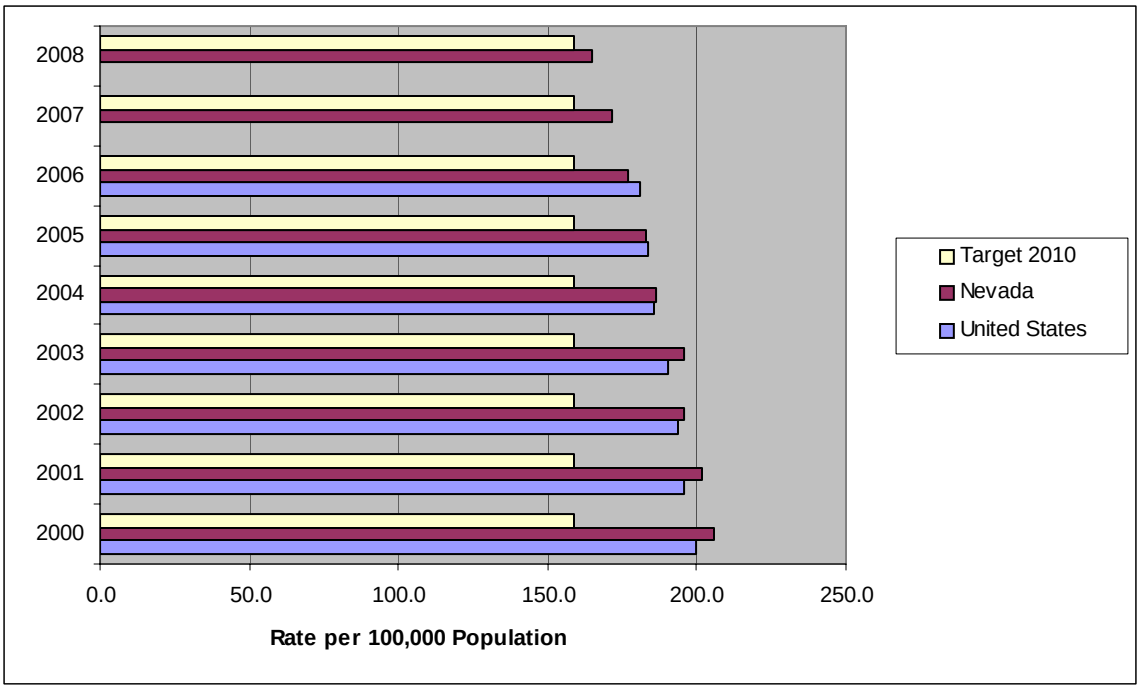
Cancer is the second leading cause of death in the United States and Nevada. According to the American Cancer Society the lifetime probability of developing cancer is 1 in 2 for men, and 1 in 3 for women. Cancer is attributed to causing over 4 million years of potential life lost in the U.S. Approximately two thirds of all cancers are caused by lifestyle, i.e. smoking, obesity, poor nutrition, and inadequate nutrition. Lifestyle contributes to roughly one third of all cancer deaths.[1]

Healthy People 2010 Objective (3-1): Reduce the overall cancer death rate.

Healthy People 2020 Objective C HP2020–1: Reduce the overall cancer death rate.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
164.9	180.7	158.6	160.6	Improving

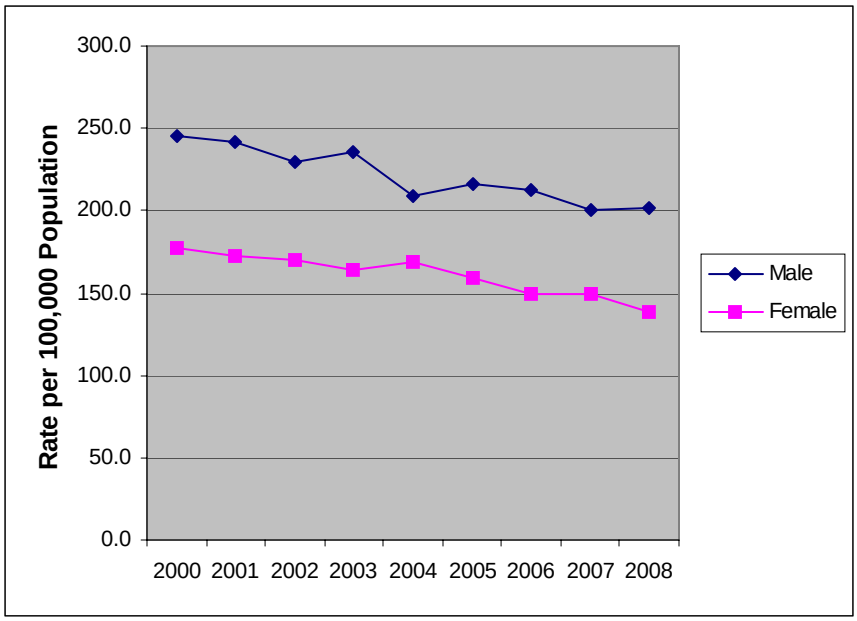
Age-Adjusted Overall Cancer Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*



While Nevada did not meet the 2010 target from 2000 to 2008, there was a decreasing trend in the overall cancer death rate. Nevada had a lower overall cancer rate than the United States in the reported years. Neither the state, nor the nation, reached the Healthy People 2010 target.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age Adjusted Overall Cancer Death Rate, Nevada Residents by Gender, 2000 - 2008.*



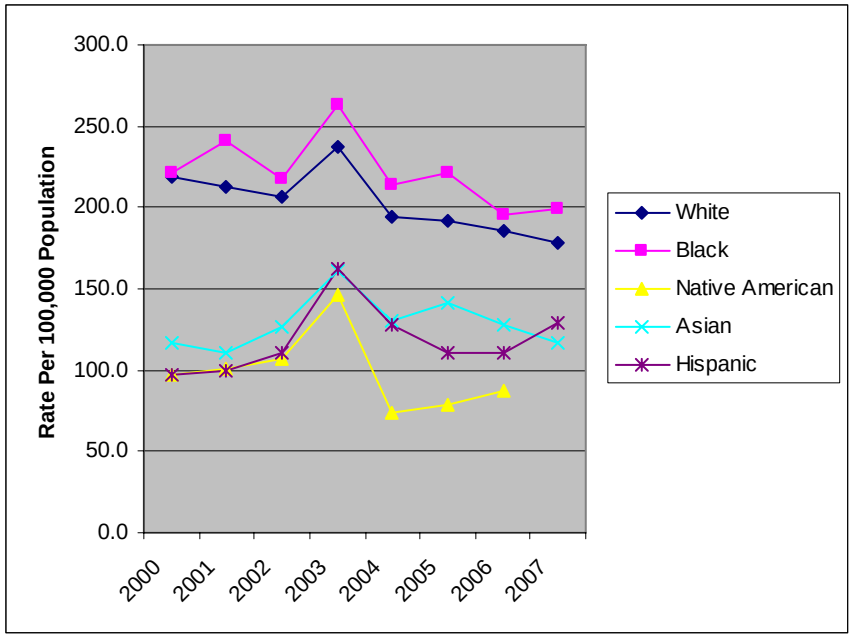
There was a decreasing trend in Nevada's overall cancer death rate among both genders from 2000 to 2008.

Nevada males had a higher overall cancer mortality rate than Nevada females.

Age-Adjusted Overall Cancer Death Rate, Nevada Residents by Race/Ethnicity, 2000 - 2007.*

The extent to which genetic variations cause disease in ethnic groups, such as African American, Hispanic and Asian Americans, is far less understood than that of Whites.[2]

Black Nevada residents had higher overall cancer mortality rates than any other racial/ethnic group in Nevada, followed by White Nevada residents from 2000 to 2007.



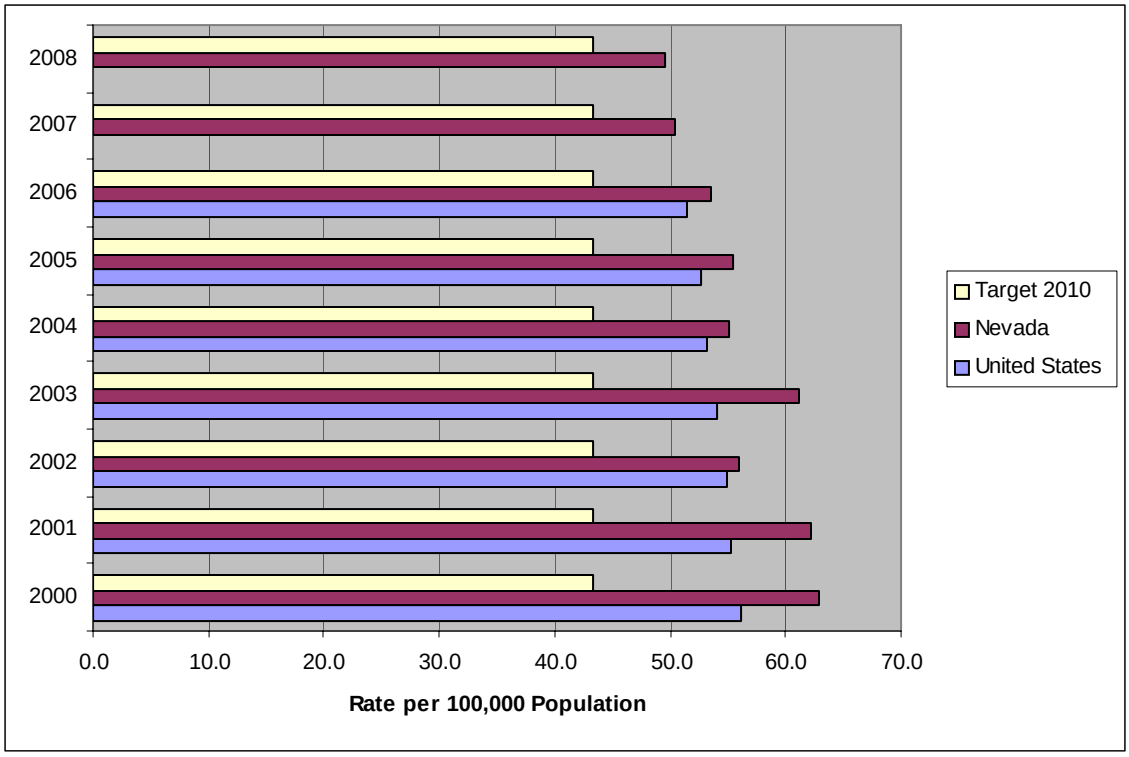
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for age group and county breakdowns.

Healthy People 2010 Objective (3-2): Reduce the lung cancer death rate.

Healthy People 2020 Objective C HP2020-2: Reduce the lung cancer death rate.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
49.5	51.5	43.3	45.5	Improving

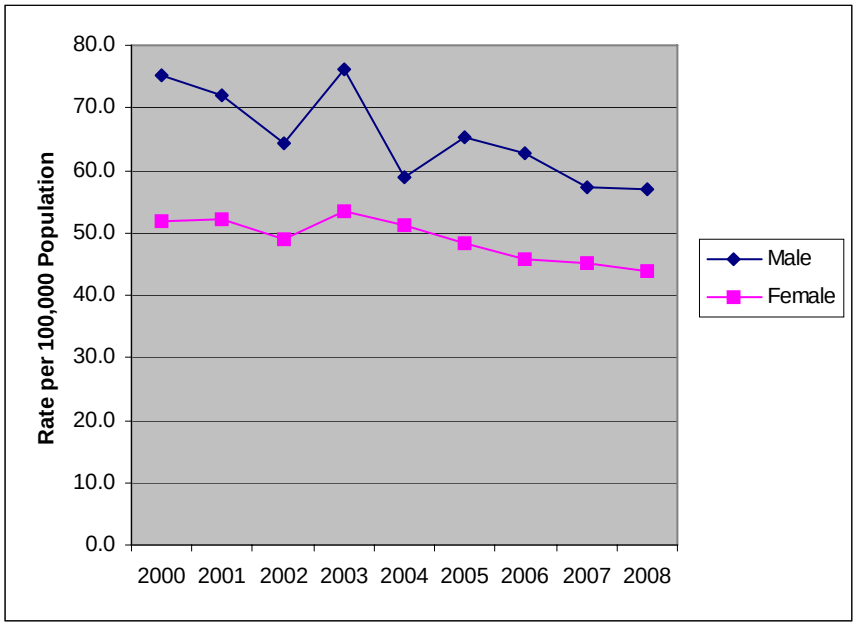
Age-Adjusted Lung Cancer Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*



While Nevada's lung cancer deaths decreased overall from 2000 to 2008, they were still above the national average in 2006. Both the United States and Nevada had lung cancer mortality rates that were higher than the Healthy People 2010 target over the decade.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Lung Cancer Death Rate, Nevada Residents by Gender, 2000 - 2008.*



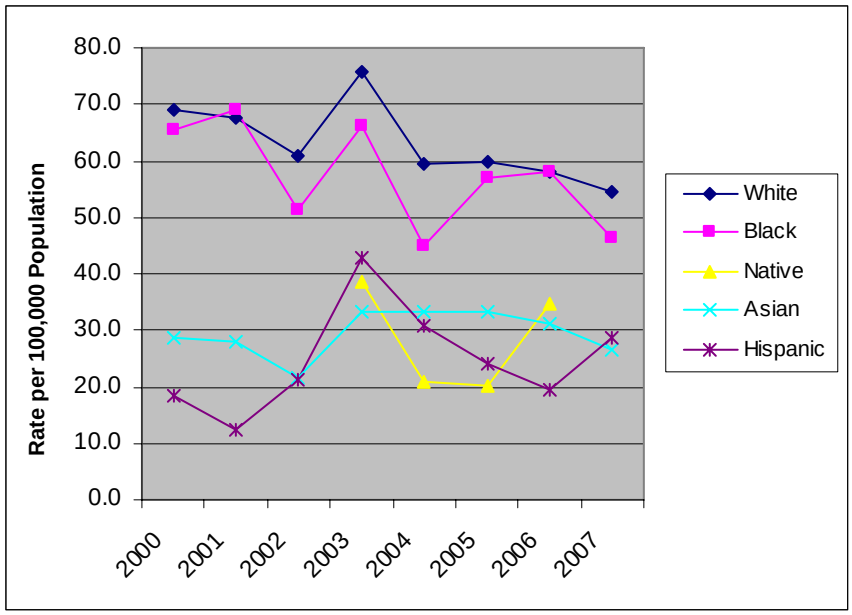
In 2007, the leading type of cancer deaths were lung and bronchus cancer, for both men (31 percent) and women (26 percent).[2]

In 2008, a higher number of males (57.1 per 100,000) died from lung cancer than females (43.9 per 100,000) in Nevada.

Age-Adjusted Lung Cancer Death Rate, Nevada Residents by Race/Ethnicity, 2000 - 2007.*

Studies on genetic variation in different ethnic groups and how these variations affect susceptibility to cancer, cardiovascular disease and other diseases which have a genetic component to their etiology are ongoing.[2]

More Whites and Blacks died from lung cancer than other racial/ethnic groups in Nevada from 2000 to 2007.



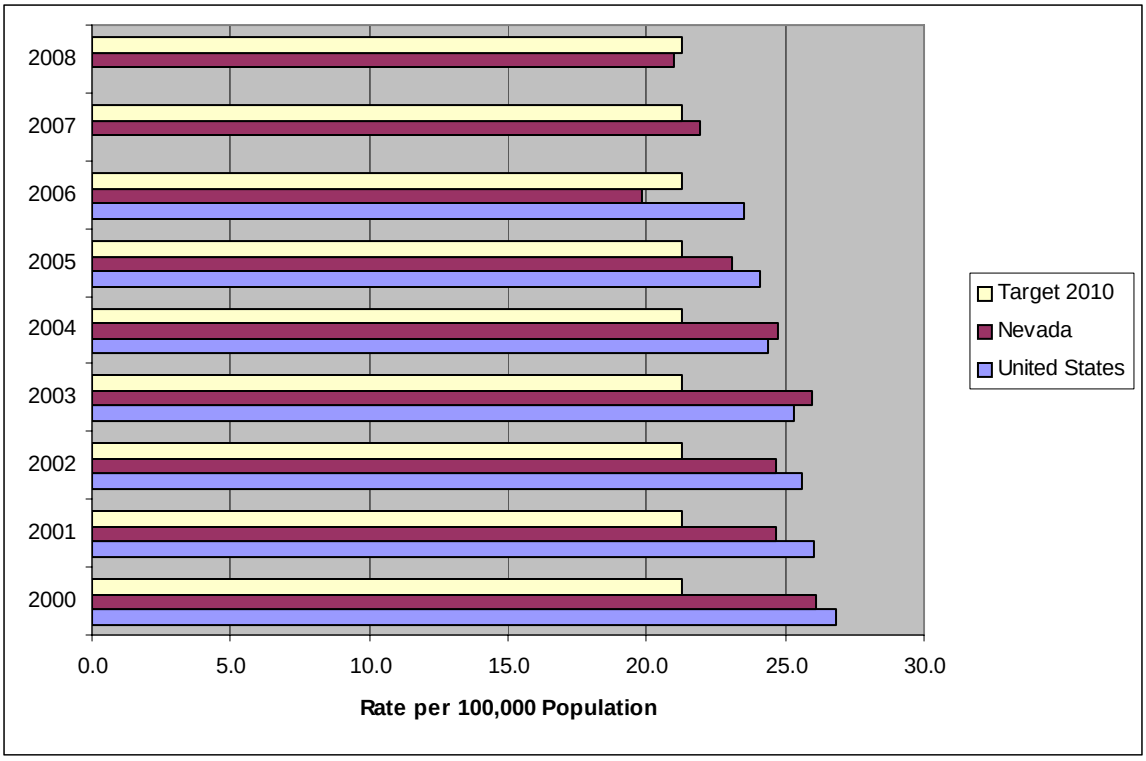
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.

Healthy People 2010 Objective (3-3): Reduce the breast cancer death rate.

Healthy People 2020 Objective C HP2020-3: Reduce the female breast cancer death rate.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
21.0	23.5	21.3	20.6	Achieved

Age-Adjusted Female Breast Cancer Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*

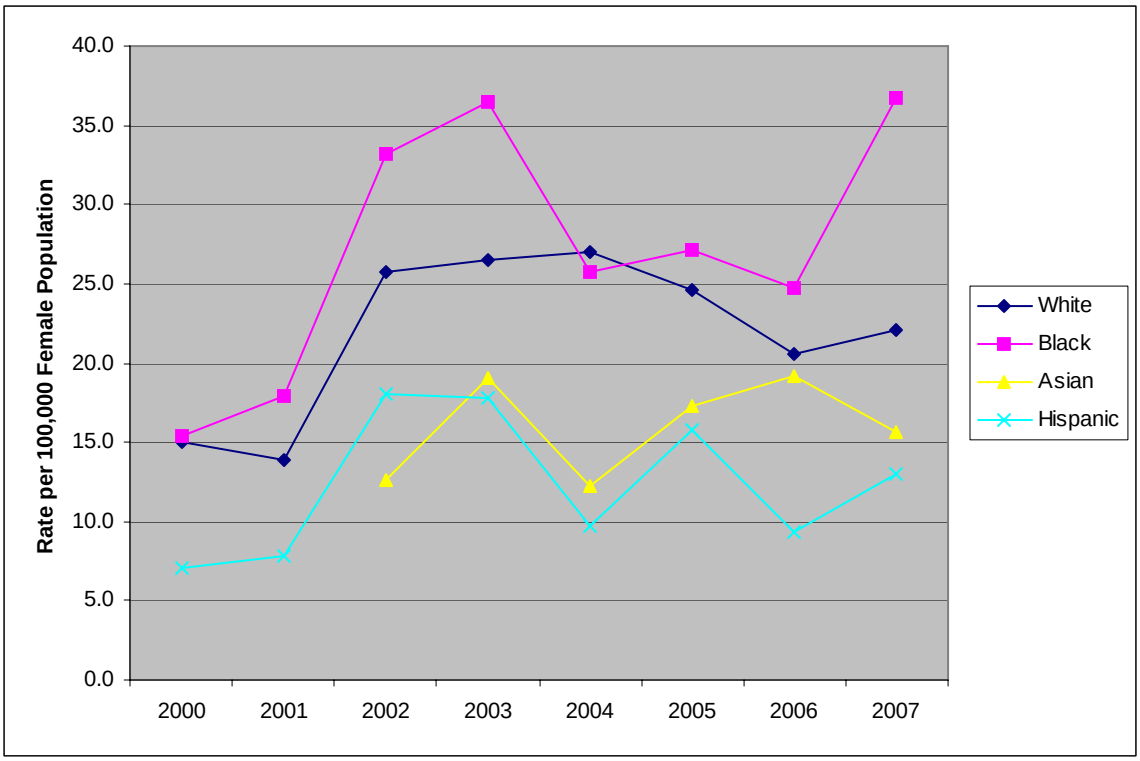


Breast cancer mortality rates decreased in both Nevada and the nation from 2000 to 2008. In 2006 and 2008, Nevada met the Healthy People 2010 target.

Many factors are linked to breast cancer risk. Some of these factors affect risk a great deal and others by only a small amount. Some risk factors you can't change. Being a woman and getting older increase your chances of getting breast cancer. Other factors you may be able to change. For instance, leading a healthy lifestyle can help reduce your risk of breast cancer.[3]

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Female Breast Cancer Death Rate, Nevada Residents by Race/ Ethnicity, 2000 - 2007.*



Black and White Nevada females had a higher rate of breast cancer death than Asian or Hispanic females in 2000 through 2007.

Nationally, White women have higher rates of postmenopausal breast cancer compared to Black women.[4]

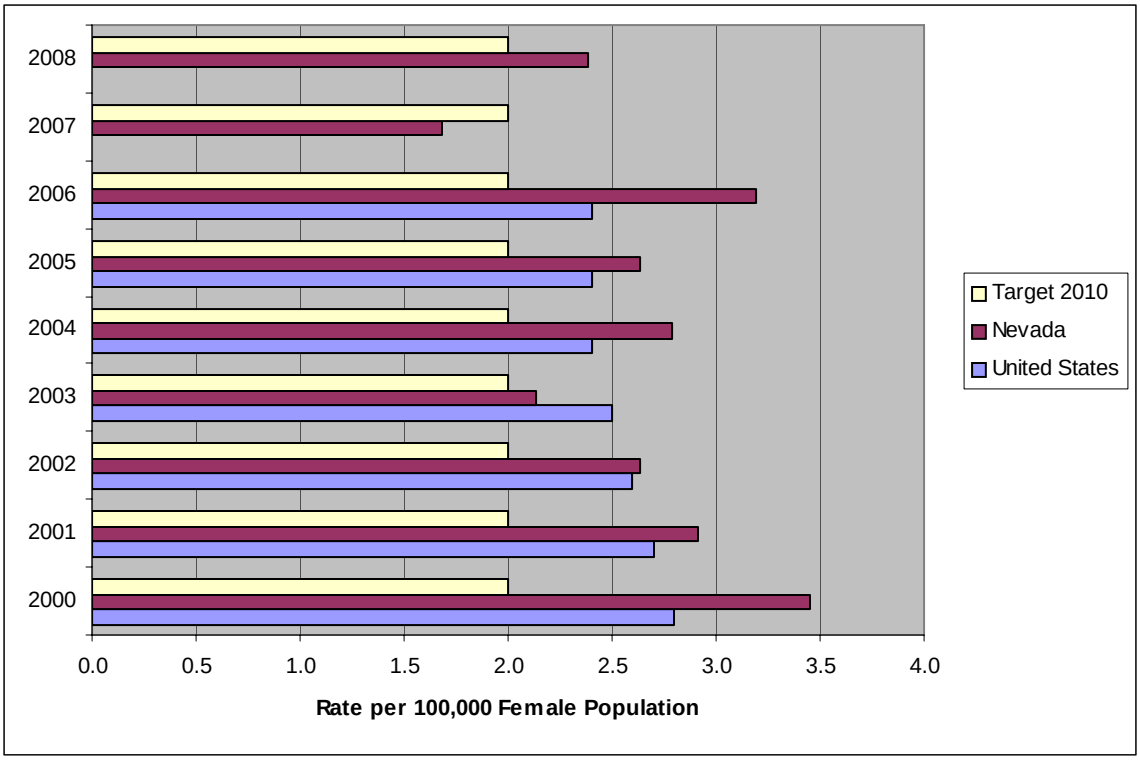
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group for the years 2000-2008 or for the Asian race/ethnicity group for the years 2000-2001 due to small counts.

Healthy People 2010 Objective (3-4): Reduce deaths from cancer of the uterine cervix.

Healthy People 2020 Objective C HP2020-4: Reduce deaths from cancer of the uterine cervix.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
2.4	2.4	2.0	2.2	Fluctuating

Age-Adjusted Uterine Cervix Cancer Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*

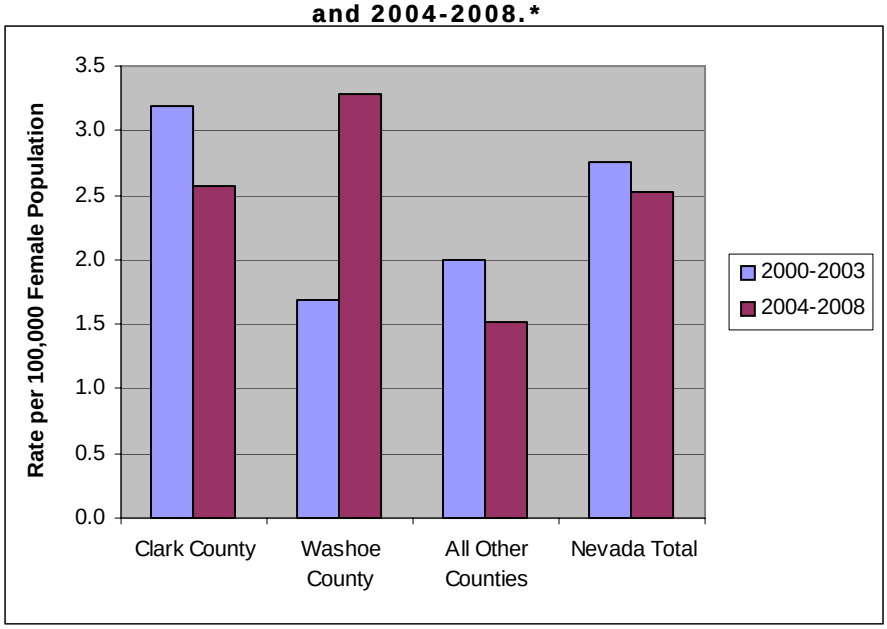


It is estimated that 43,470 women in the United States will be diagnosed and 7,950 women will die of cancer of the corpus and uterus, nitric oxide synthase (NOS) in 2010. From 2003-2007, the median age at diagnosis for cancer of the corpus and uterus, NOS was 62 years of age.[5]

Nationally, uterine cervix cancer mortality rates decreased from 2000 to 2006. In Nevada, the rate has fluctuated. In 2007, Nevada met the Healthy People 2010 target.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Aggregated Age-Adjusted Uterine Cervix Cancer Death Rate, Nevada Residents by County/Region, 2000 - 2003 and 2004-2008.*

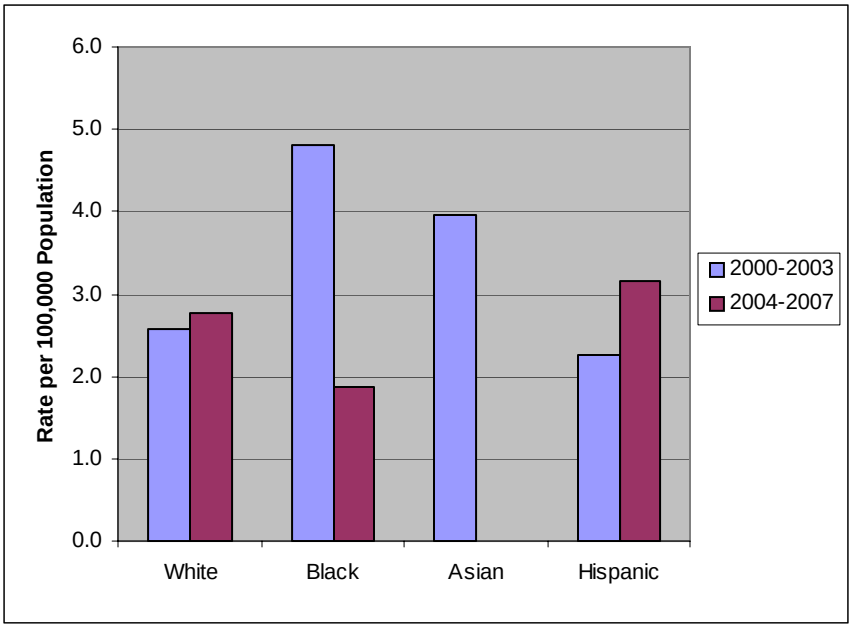


For the combined years 2004 through 2008, Washoe County had the highest rates of uterine cervix cancer mortality of all Nevada's regions.

Aggregated Age-Adjusted Uterine Cervix Cancer Death Rate, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004-2007.*

In the United States, from 2003-2007, the median age at death for cancer of the corpus and uterus, was 72 years of age.[5]

For the combined years 2000 through 2003, Black and Asian females had the highest rates of uterine cervix cancer mortality in Nevada.



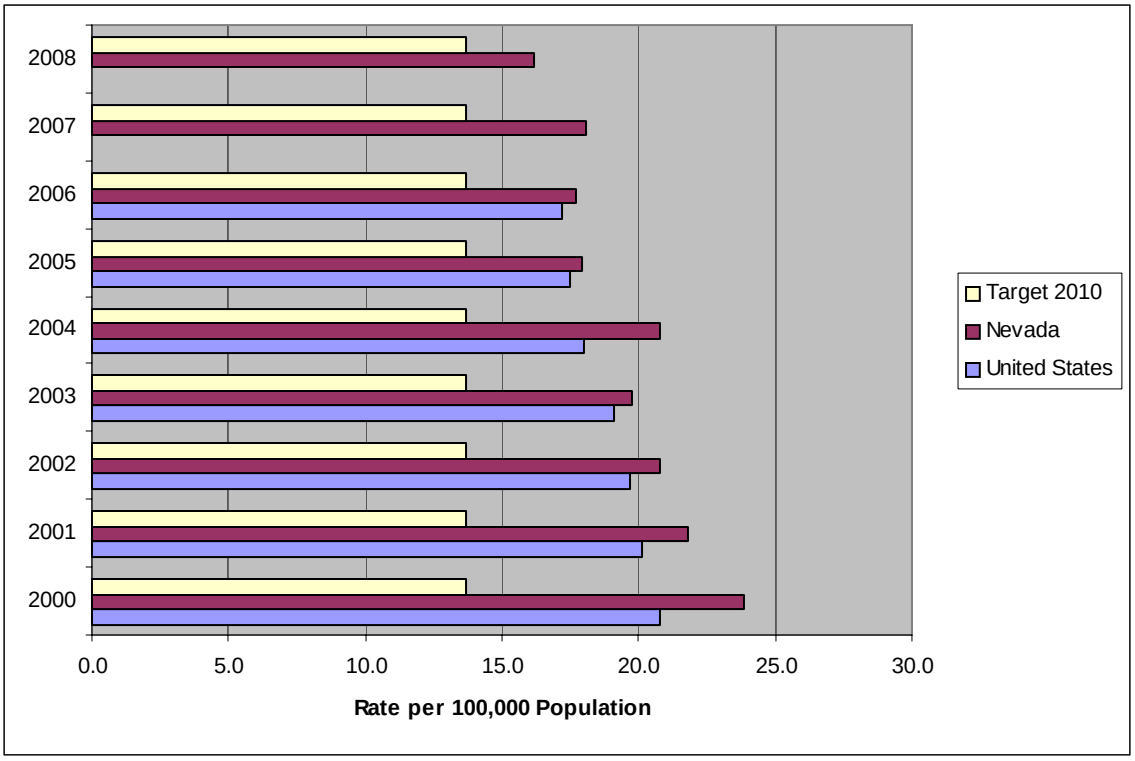
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group for the years 2000-2008 or for the Asian race/ethnicity group for the years 2004-2007 due to small counts.

Healthy People 2010 Objective (3-5): Reduce the colorectal cancer death rate.

Healthy People 2020 Objective C HP2020-5: Reduce the colorectal cancer death rate.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
16.1	17.6	13.7	14.5	Improving

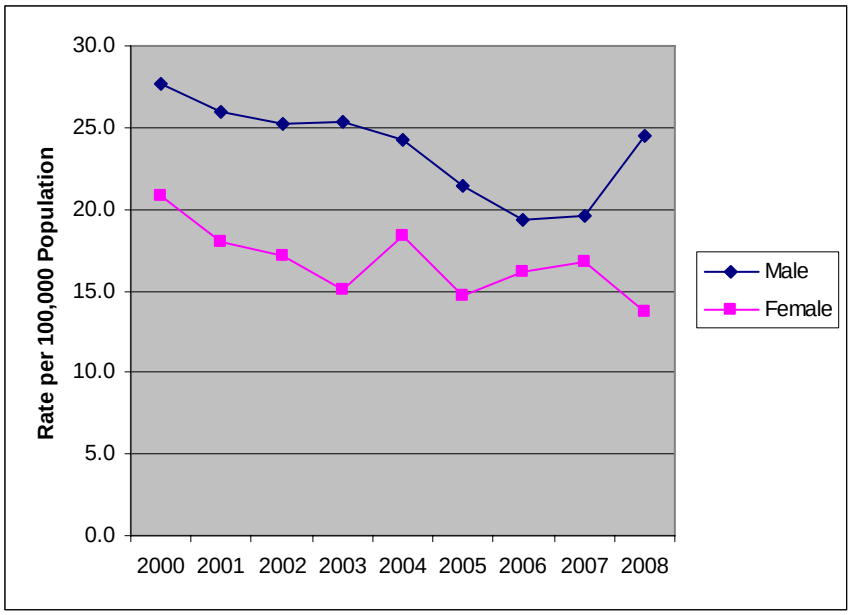
Age-Adjusted Colorectal Cancer Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*



Colorectal cancer mortality rates for both Nevada and the United States have declined over the decade. Neither the state, nor the national rate, had met the Healthy People 2010 target.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Colorectal Cancer Death Rate, Nevada Residents by Gender, 2000 - 2008.*



Based on U.S. rates from 2005-2007, 5.1 percent (or 1 in 20) of men and women born today will be diagnosed with cancer of the colon and rectum at some time during their lifetime.[6]

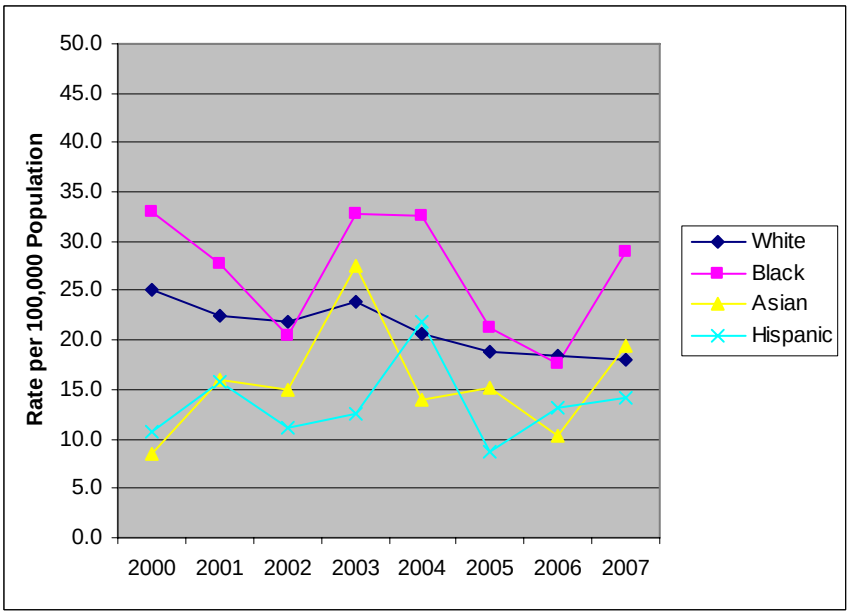
After a seven year period of decline, males in Nevada had shown an increase in colorectal cancer deaths in 2008.

The colorectal cancer death rate among females in Nevada decreased from 2000 to 2008.

Early stage colorectal cancer does not usually have symptoms; screening is necessary to detect colorectal cancer in its early stages.[1] Advanced disease may cause rectal bleeding, blood in the stool, a change in bowel habits, and pain in the lower abdomen.[1]

In Nevada, Blacks had a higher rate of colorectal mortality than any other racial/ethnic group for six of the past eight years.

Age-Adjusted Colorectal Cancer Death Rate, Nevada Residents by Race/Ethnicity, 2000 - 2007.*



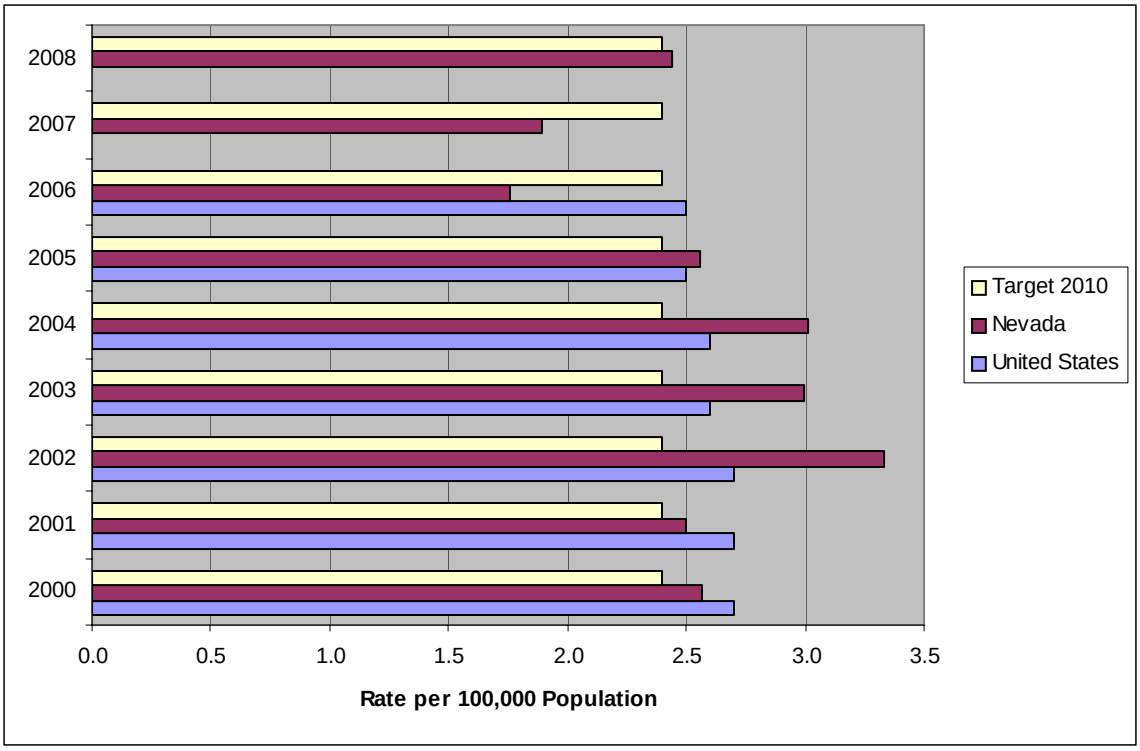
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group due to small counts.

Healthy People 2010 Objective (3-6): Reduce the oropharyngeal cancer death rate.

Healthy People 2020 Objective C HP2020-6: Reduce the oropharyngeal cancer death rate.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
2.4	2.5	2.4	2.3	Achieved

Age-Adjusted Oropharyngeal Cancer Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*

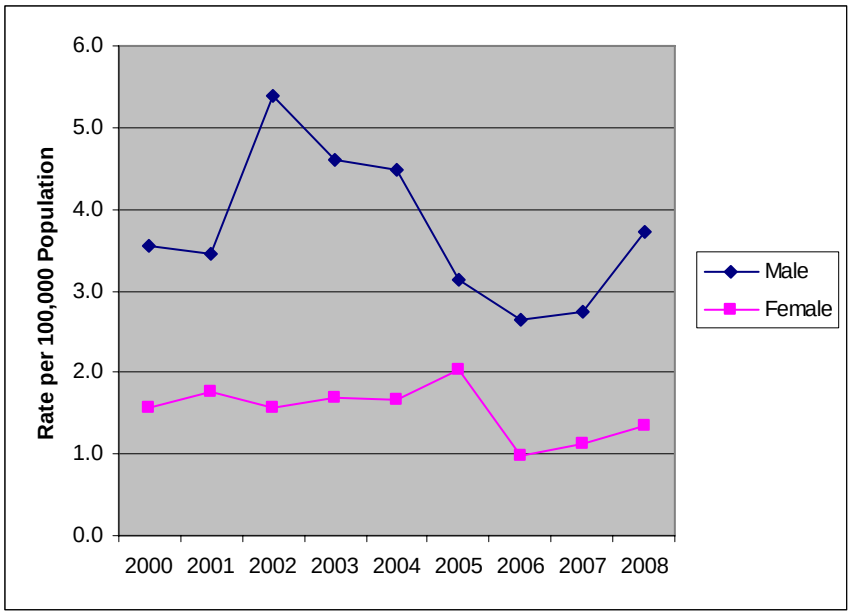


Known risk factors for oropharyngeal cancer include all forms of smoked and smokeless tobacco products and excessive consumption of alcohol. Many studies have reported a synergism between smoking and alcohol use, resulting in more than a 30-fold increased risk in individuals who both smoke and drink heavily.[7]

While Nevada met the Healthy People 2010 target in 2006 and 2007 and nearly met the Healthy People 2010 target in 2008, the oropharyngeal cancer mortality rate has fluctuated. The national rate has decreased over the decade.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Oropharyngeal Cancer Death Rate, Nevada Residents by Gender, 2000 - 2008.*



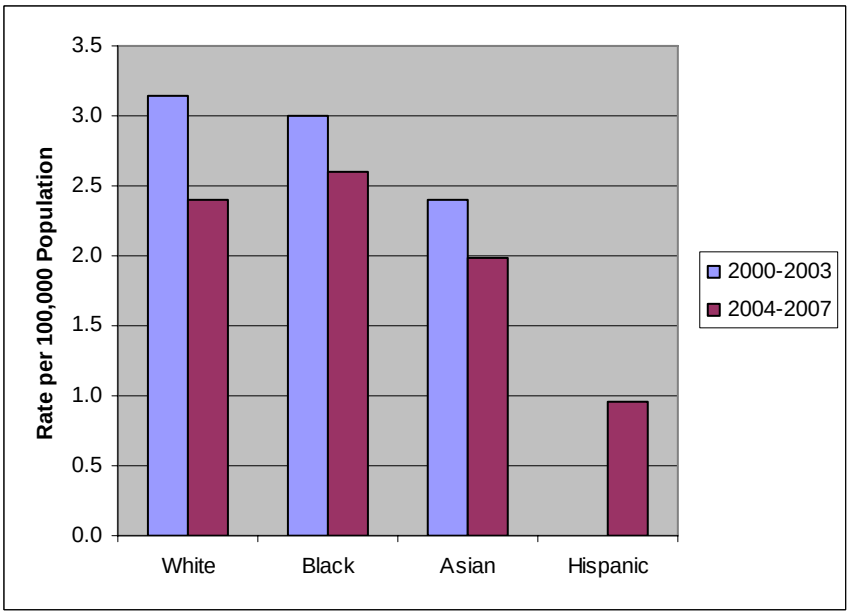
Nationally, an estimated 7,880 deaths from oral cavity and pharynx cancer are expected in 2010.[8] Death rates have decreased by more than 2 percent per year since 1980 in men and since 1990 in women.[8]

Nevada males had a higher rate of oropharyngeal cancer deaths than Nevada females from 2000 to 2008.

Cancer can affect any part of the oral cavity, including the lip, tongue, mouth, and throat.[8] Dentists and primary care physicians can detect premalignant abnormalities and cancer at an early stage, when they are most curable.[7]

Whites and Blacks had higher rates of oropharyngeal cancer mortality than other racial/ethnic groups in Nevada.

Aggregated Age-Adjusted Oropharyngeal Cancer Death Rate, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2007.*



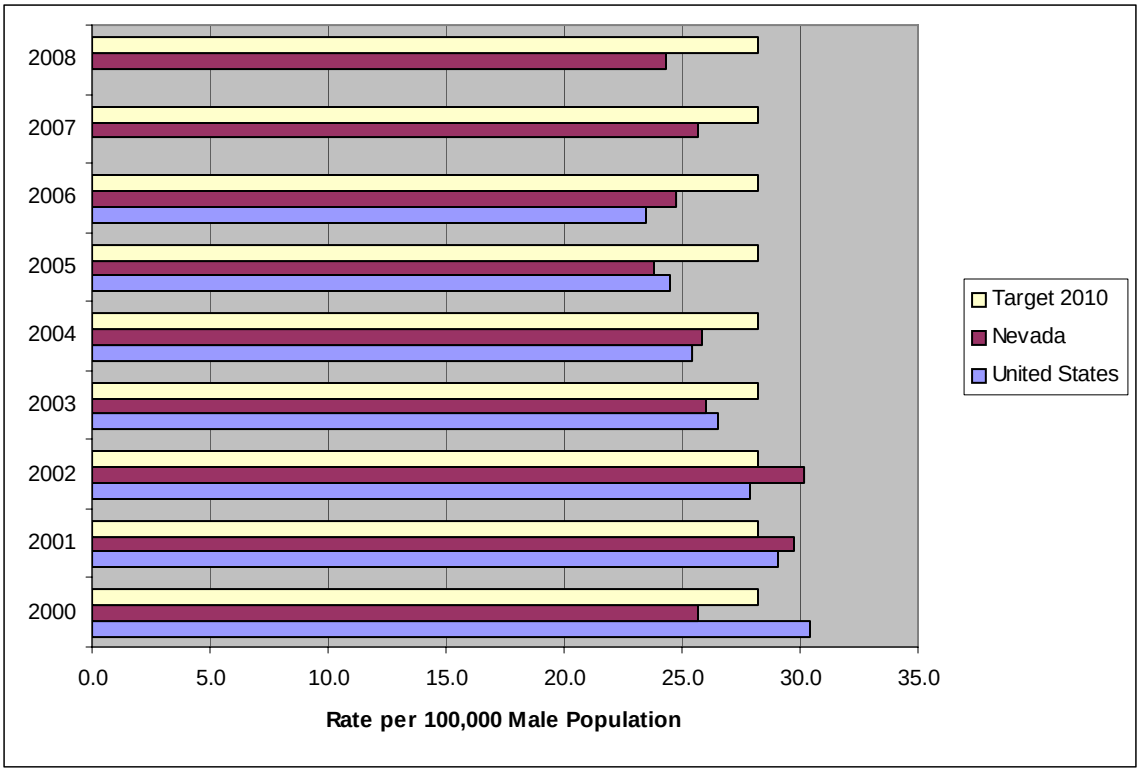
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group for the years 2000-2008 or for the Hispanic race/ethnicity group for the years 2004-2007 due to small counts.

Healthy People 2010 Objective (3-7): Reduce the prostate cancer death rate.

Healthy People 2020 Objective C HP2020-7: Reduce the prostate cancer death rate.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
24.3	23.5	28.2	21.2	Surpassed

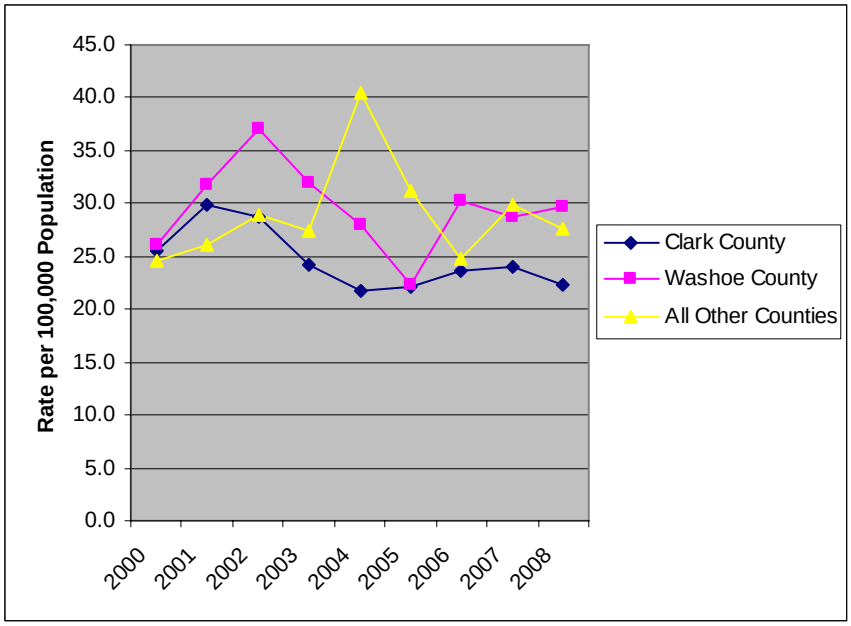
Age-Adjusted Prostate Cancer Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*



Both national and Nevada prostate cancer mortality rates have shown a slight decrease over the decade. The state rate met the Healthy People 2010 target from 2003 to 2008, and the U.S. rate met the Healthy People 2010 target from 2002 to 2008.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Prostate Cancer Death Rate, Nevada Residents by County/Region, 2000 - 2008.*

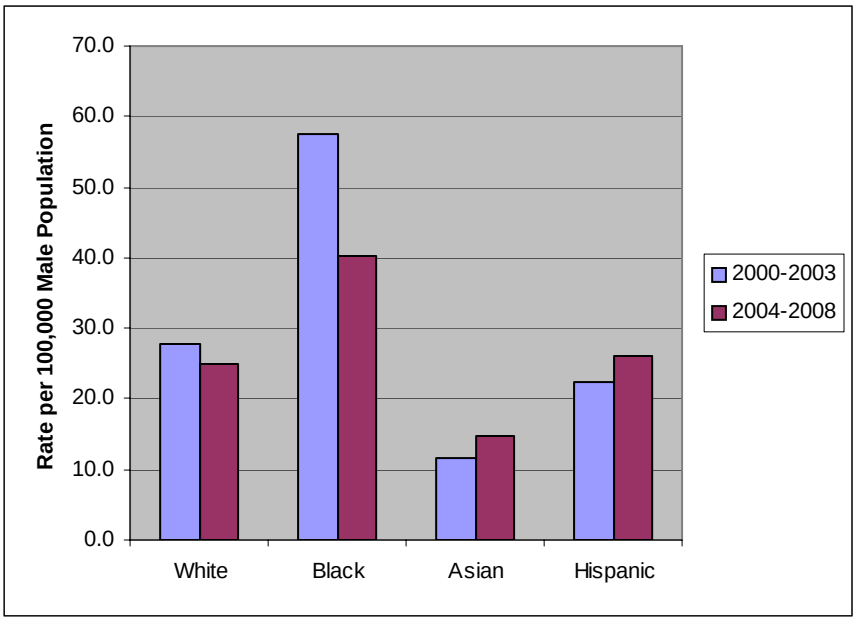


Some prostate cancers can grow and spread quickly, but most prostate cancers grow slowly. Autopsy studies show that many men who died of other diseases also had prostate cancer that hadn't yet produced symptoms. 70 percent to 90 percent of the men had cancer in their prostate by age 80, but in many cases neither they nor their doctors knew they had it.[9]

In Nevada, Clark County had the lowest prostate cancer mortality rate in the state from 2003 to 3008.

In Nevada, Black males had a higher rate of prostate cancer mortality than any other racial/ethnic group, over twice that of males in other race/ethnicity groups for the combined years 2000 through 2003. This rate, among Black males, did decrease in the combined years 2004 through 2008. Asian males had the lowest rate of prostate cancer death in the state.

Aggregated Age-Adjusted Prostate Cancer Death Rate, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2007.*



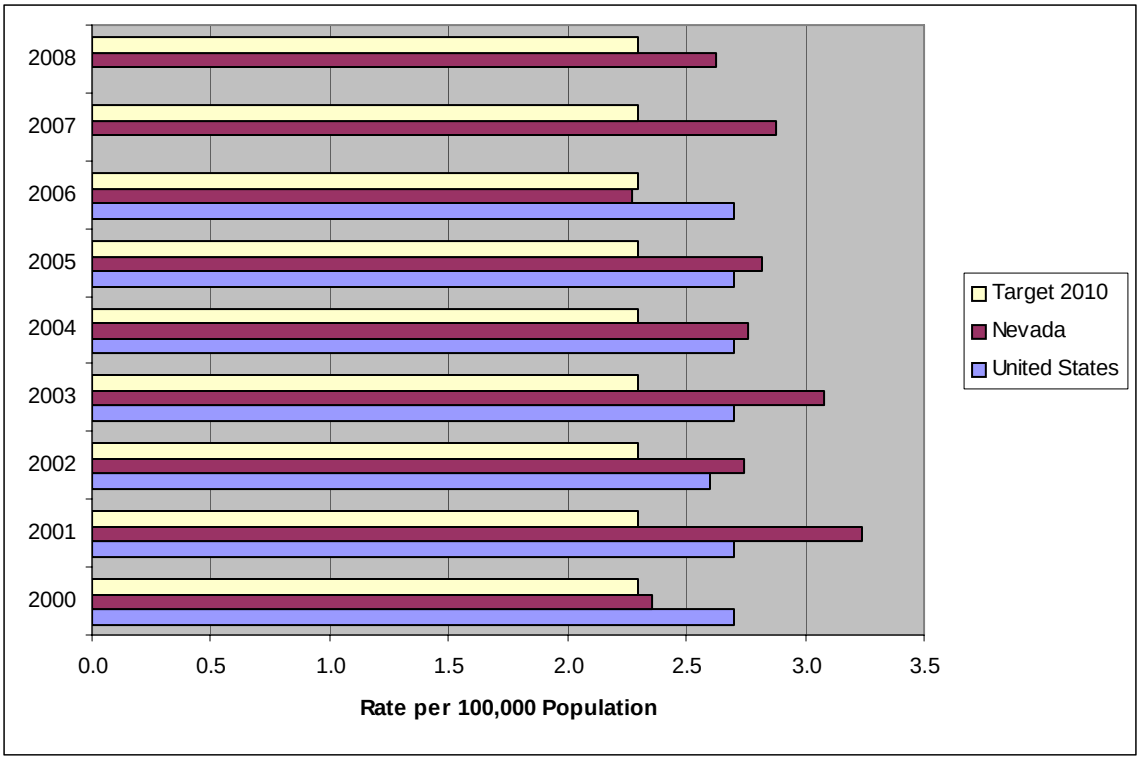
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group due to small counts.

Healthy People 2010 Objective (3-8): Reduce melanoma cancer.

Healthy People 2020 Objective C HP2020-8: Reduce the melanoma cancer death rate.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
2.6	2.7	2.3	2.4	Fluctuating

Age-Adjusted Melanoma Cancer Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*

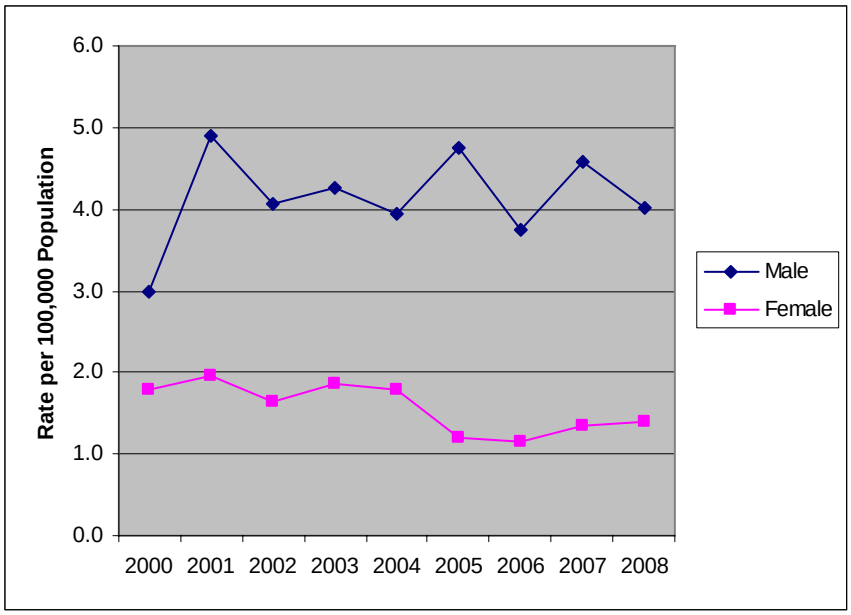


In 2006, Nevada met the Healthy People 2010 target for melanoma cancer mortality. The state rate has fluctuated over the decade. The U.S. rate has remained steady. Nevada did not meet the Healthy People 2010 rate in either 2007 or 2008. The national rate did not meet the Healthy People 2010 rate this decade.

Exposure to the sun's ultraviolet (UV) radiation is a known cancer risk factor. Because more than half of a person's lifetime skin damage from sun exposure occurs by the age of 18, educating parents, caregivers, and children is critical. To reduce the risk of skin cancer stay out of the sun between 10:00 a.m. and 4:00 p.m. and wear protective clothing, including a wide brimmed hat and sunglasses. Sunscreen with a minimum sun protection factor (SPF) of 15 should be used.[10]

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

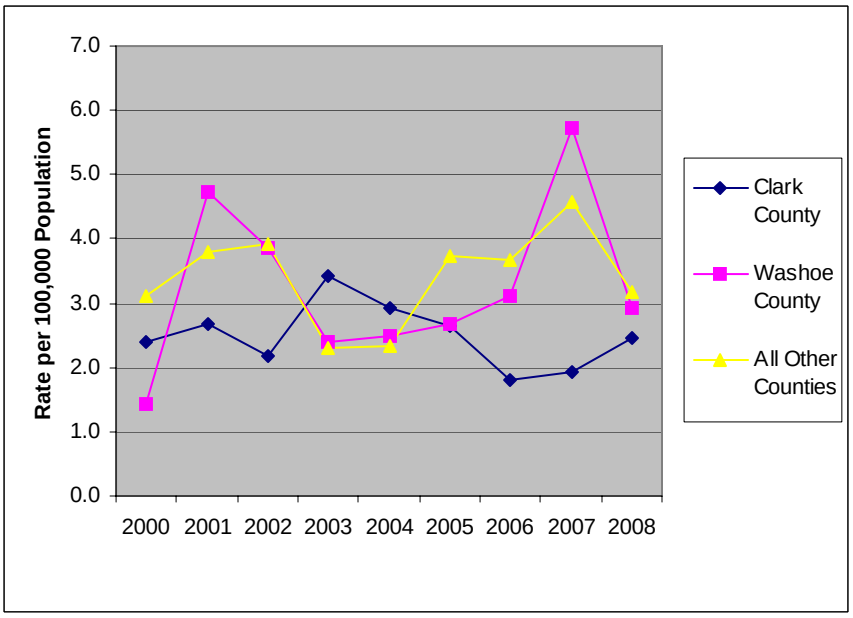
Age-Adjusted Melanoma Cancer Death Rate, Nevada Residents by Gender, 2000 - 2008.*



In Nevada, males had a melanoma cancer mortality rate which is much higher than that of females, some years over twice as high, from 2000 to 2208.

Skin cancer is the most common of all cancers. Melanoma accounts for less than 5 percent of skin cancer cases, but it causes most skin cancer deaths. The number of new cases of melanoma in the United States has been increasing for at least 30 years.[10]

Age-Adjusted Melanoma Cancer Death Rate, Nevada Residents by County/Region, 2000 - 2008.*



Overall, the lifetime risk of getting melanoma is about 1 in 50 for Whites, 1 in 1,000 for Blacks, 1 in 200 for Hispanics.[10]

Melanoma cancer mortality rates fluctuated in all of Nevada's counties over the decade.

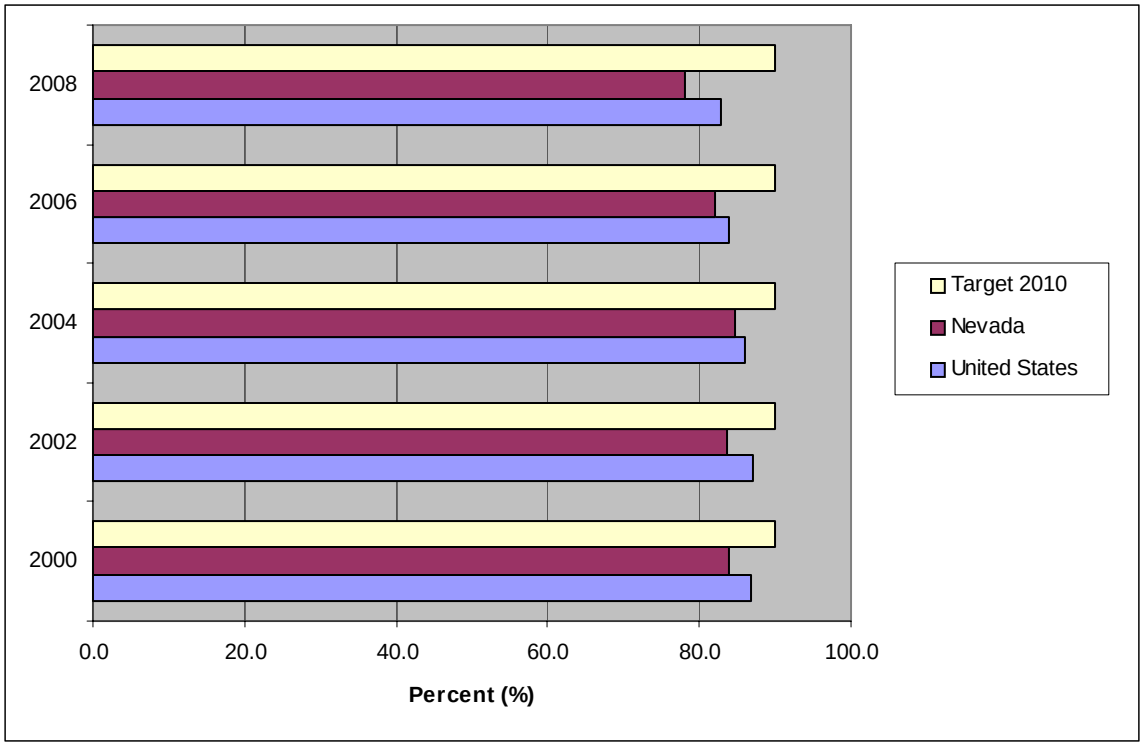
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.

Healthy People 2010 Objective (3-11b.): Increase the proportion of women aged 18 years and older who have had a Pap test in the preceding three years.

Healthy People 2020 Objective C HP2020-15: Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
78.2	82.9	90.0	93.0	Worsening

Proportion of Women Aged 18 and Older Receiving a Pap Test within Three Years, Nevada Residents and United States, BRFSS Data, 2000, 2002, 2004, 2006, 2008.*

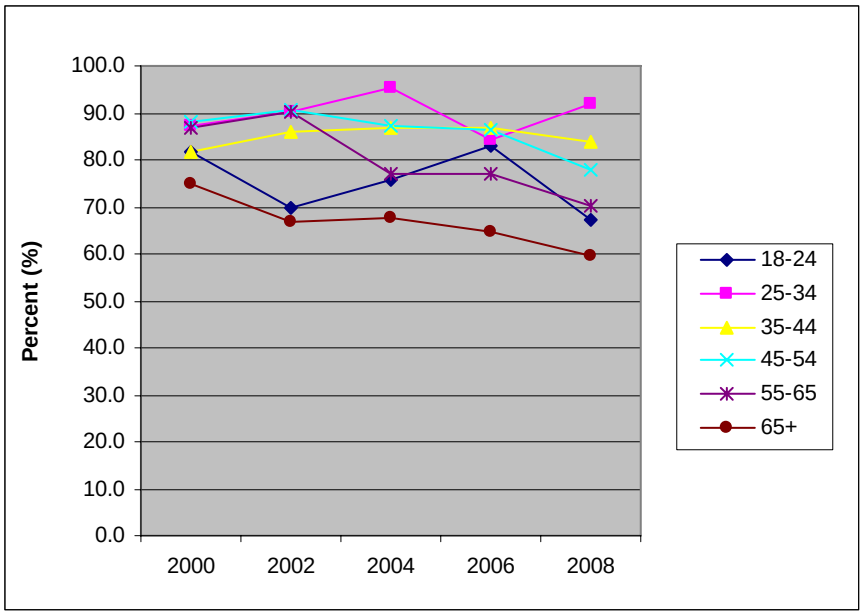


The proportion of women aged 18 years and older who received a pap smear test within the past three years in both the Nevada and U.S. decreased from 2000 to 2008. Neither met the Healthy People 2010 target of 90.0 percent.

The American Cancer Society's most recent estimates for cancer of the uterine corpus (body of the uterus) in the United States for 2010 are: About 43,470 new cases of cancer of the uterine corpus will be diagnosed, about 1,200 of these cases will be uterine sarcomas. About 7,950 women in the United States will die from cancer of the uterine corpus during 2010. Incidence rates of uterine sarcoma cancer have been decreasing since 1998. Death rates from uterine sarcoma have been stable since 1992.[1]

*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of Women Aged 18 and Older Receiving a Pap Test within Three Years, Nevada Residents by Age, BRFSS Data, 2000 , 2002, 2004, 2006, 2008.*



A Pap smear is a microscopic examination of the cells scraped from the cervix. It can detect cancerous or even precancerous conditions of the cervix.[11]

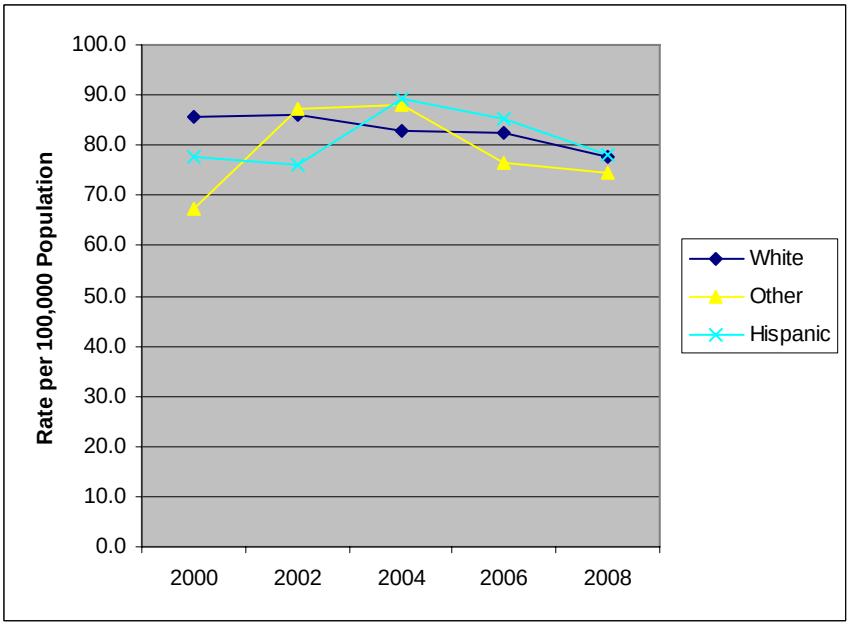
In Nevada, 25 to 34 year old females tend to had the highest proportion of women having received a pap test within the last 3 years from 2000 to 2008. Females aged 65 years and older had the lowest proportion during these years.

Women should have a Pap test at least once every 3 years, beginning 3 years after they begin to have sexual intercourse, and no later than age 21.[11]

An estimated 4,210 deaths from cervical cancer are expected in 2010.[1]

The proportion of White, Hispanic, and Other race Nevada adult females who have received a pap test within the past three years decreased from 2004 to 2008.

Proportion of Women Aged 18 and Older Receiving a Pap Test within Three Years, Nevada Residents by Race/Ethnicity, BRFSS Data, 2000, 2002, 2004, 2006, 2008.*



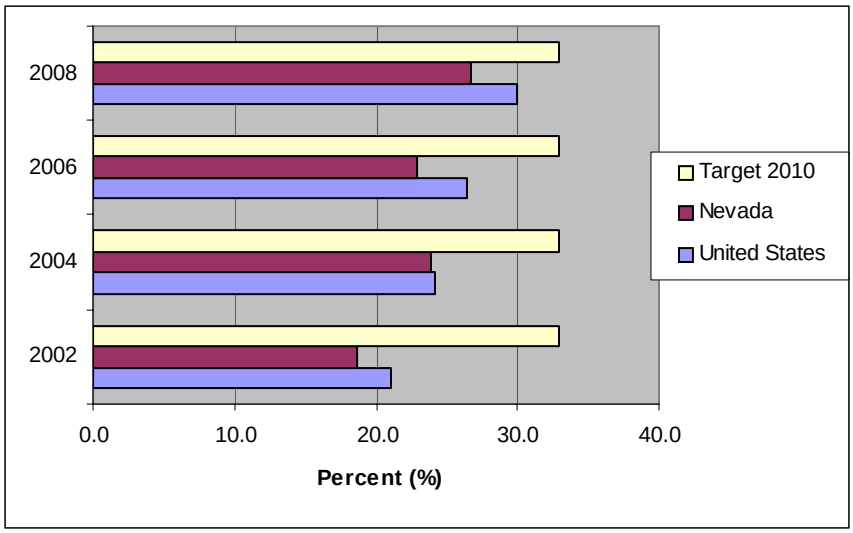
*These percentages are weighted to survey population characteristics.
Note: Data for the Black race/ethnicity group are not available, due to less than 50 respondents, and is not included in the Other race/ethnicity group.

Healthy People 2010 Objective (3-12a.): Increase the proportion of adults aged 50+ who have had a fecal occult blood test in the preceding two years.

Healthy People 2020 Objective C HP2020-16: Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
26.7	30.0	33.0	70.5	Improving

Proportion of Adults Aged 50+ Who Have Had A Fecal Occult Blood Test Within the Preceding 2 Years, Nevada Residents and United States, BRFSS Data, 2002, 2004, 2006, 2008.*

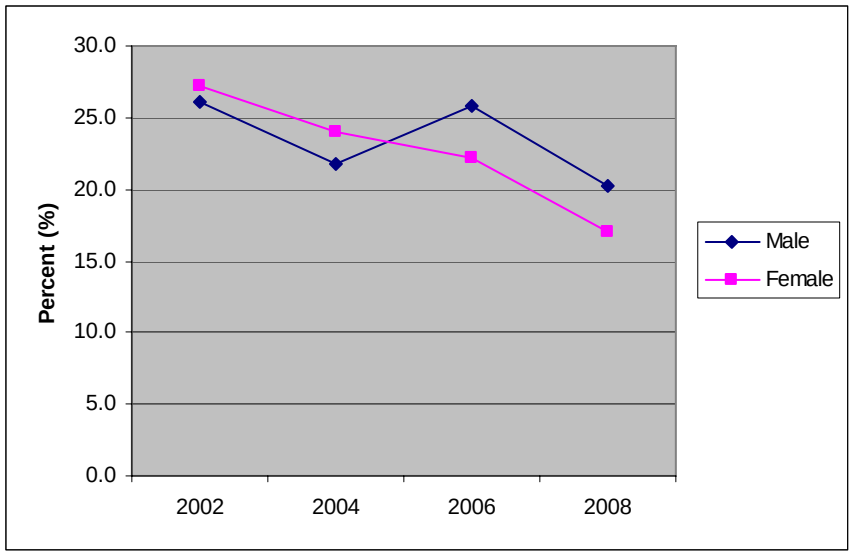


Nevada did not surpassed the Healthy People 2010 target for adults who have had a fecal occult blood test within the preceding two years from 2002 to 2008, but did improve (BRFSS). The proportion of adults 50 years and older who have had a blood stool test within the last two years nationally also did not to meet the Healthy People 2010 target.

Fecal occult blood is a test for microscopic traces of blood in the feces (stool). A positive test is usually an indication to do a colonoscopy.

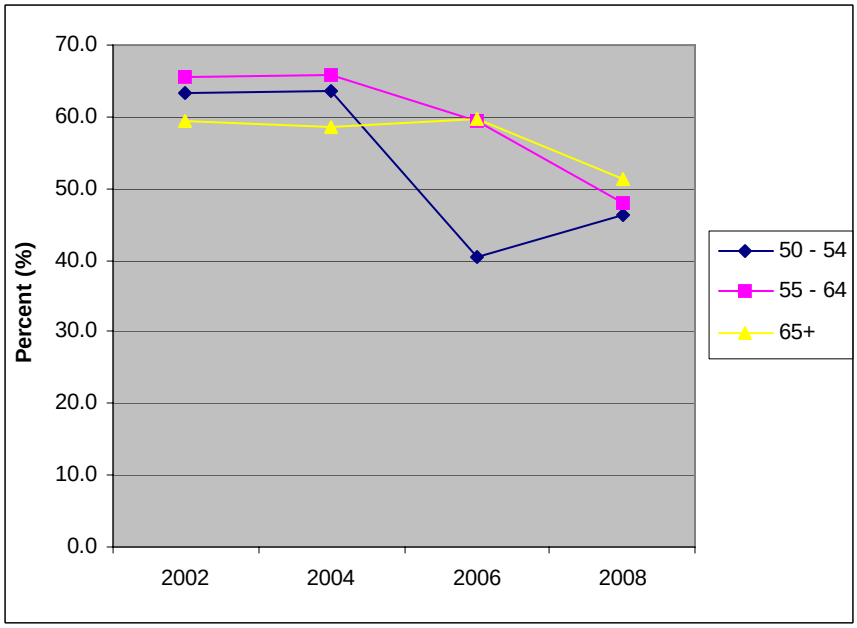
The proportion of both male and female Nevada residents aged 50 years and older who have had a fecal occult blood stool test within the preceding two years decreased from 2002 to 2008.

Proportion of Adults Aged 50+ Who Have Had A Fecal Occult Blood Test Within the Preceding 2 Years, Nevada Residents by Gender, BRFSS Data, 2002, 2004, 2006, 2008.*



*These percentages are weighted to survey population.
Note: See appendix for additional information.

Proportion of Adults Aged 50+ Who Have Had A Fecal Occult Blood Test Within the Preceding 2 Years, Nevada Residents by Age, BRFSS Data, 2002, 2004, 2006, 2008.*

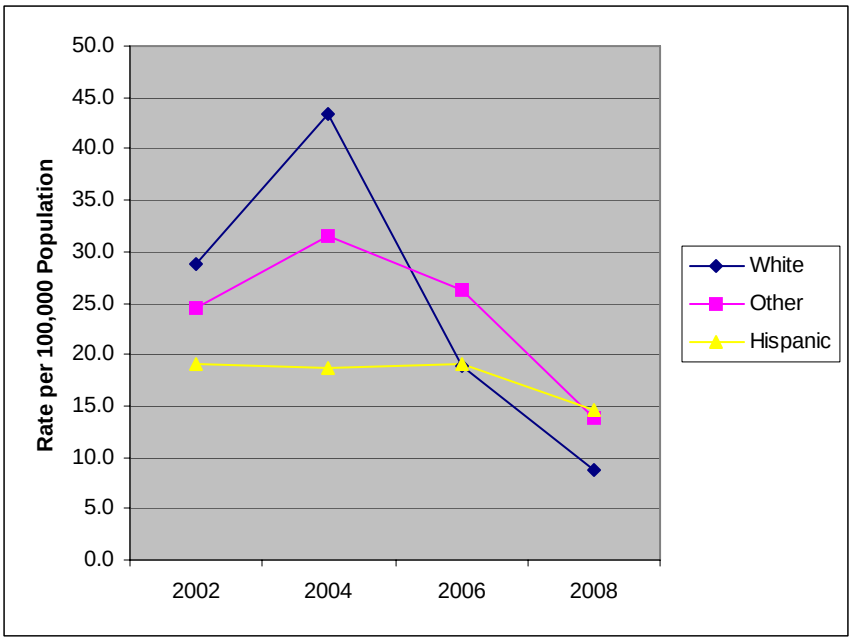


The proportion of Nevada adults who had received a fecal occult blood stool test within the past two years decreased overall in all age groups older than 50 years, from 2002 to 2008.

In 2008, 51.4 percent of Nevada adults aged 65 and older had received a fecal occult blood stool test within the past two years, 47.9 percent of Nevada adults aged 55 to 64 had received a fecal occult blood stool test within the past two years, and 46.4 percent of Nevada adults aged 50 to 54 had received a fecal occult blood stool test within the past two years.

Proportion of Adults Aged 50+ Who Have Had A Fecal Occult Blood Test Within the Preceding 2 Years, Nevada Residents by Race/Ethnicity, BRFSS Data, 2002, 2004, 2006, 2008.*

The proportion of Nevada adults who had received a fecal occult blood stool test within the past two years decreased in all three race/ethnicity groups from 2004 to 2008.



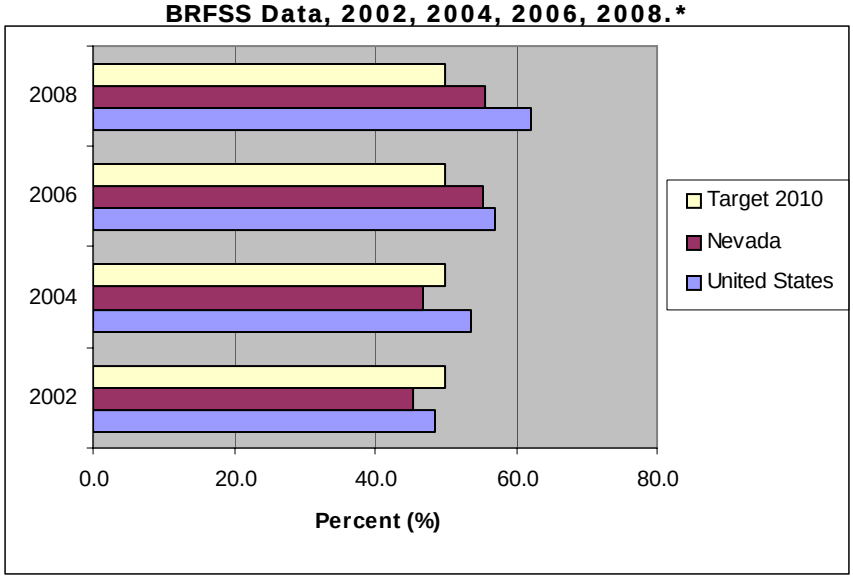
*These percentages are weighted to survey population.
Note: Data for the Black race/ethnicity group are not available, due to less than 50 respondents, and is not included in the Other race/ethnicity group.

Healthy People 2010 Objective (3-12b.): Increase the proportion of adults aged 50+ who have ever had a sigmoidscopy or colonoscopy.

Healthy People 2020 Objective C HP2020-16: Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
55.7	62.2	50.0	70.5	Surpassed

Proportion of Adults Aged 50+ Who Have Ever Had a Sigmoidscopy or Colonoscopy, Nevada Residents and United States, BRFSS Data, 2002, 2004, 2006, 2008.*

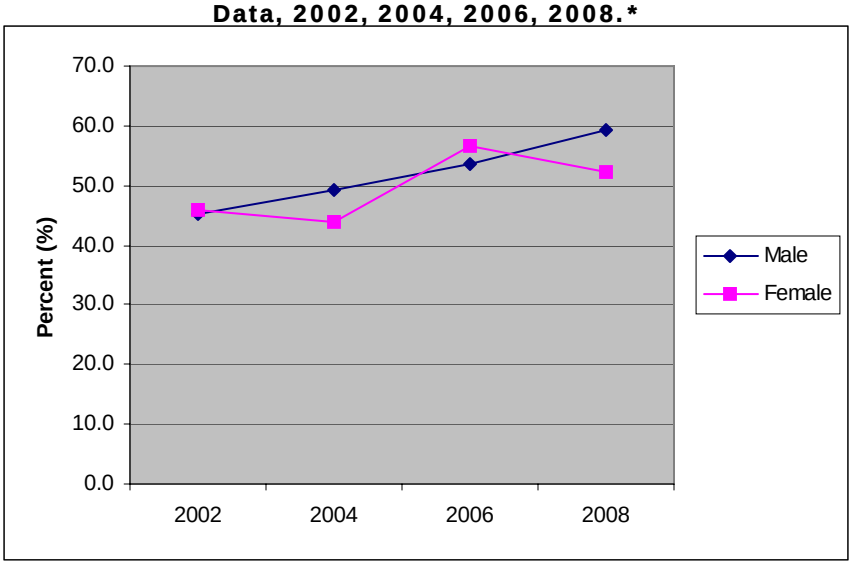


A sigmoidscopy is the minimally invasive medical examination of the large intestine from the rectum through the last part of the colon. A colonoscopy is the endoscopic examination of the colon and the distal part of the small bowel with a charge coupled device (CCD) camera or a fiber optic camera on a flexible tube passed through the anus. It may provide a visual diagnosis and grants the opportunity for biopsy or removal of suspected lesions.[12]

In 2006 and 2008, the proportion of adults aged 50 and older who had ever had a sigmoidscopy or colonoscopy in both Nevada and the nation surpassed the Healthy People 2010 target.

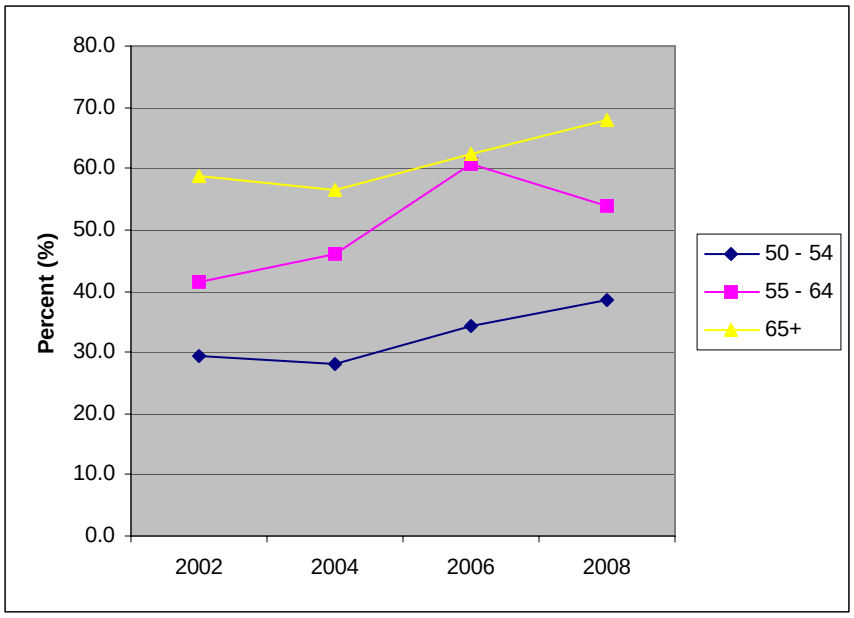
The proportion of both male and female Nevada residents aged 50 years and older who have had a sigmoidscopy or colonoscopy increased from 2002 to 2008.

Proportion of Adults Aged 50+ Who Have Ever Had a Sigmoidscopy or Colonoscopy, Nevada Residents by Gender, BRFSS Data, 2002, 2004, 2006, 2008.*



*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of Adults Aged 50+ Who Have Ever Had a Sigmoidscopy or Colonoscopy, Nevada Residents by Age, BRFSS Data, 2002, 2004, 2006, 2008.*



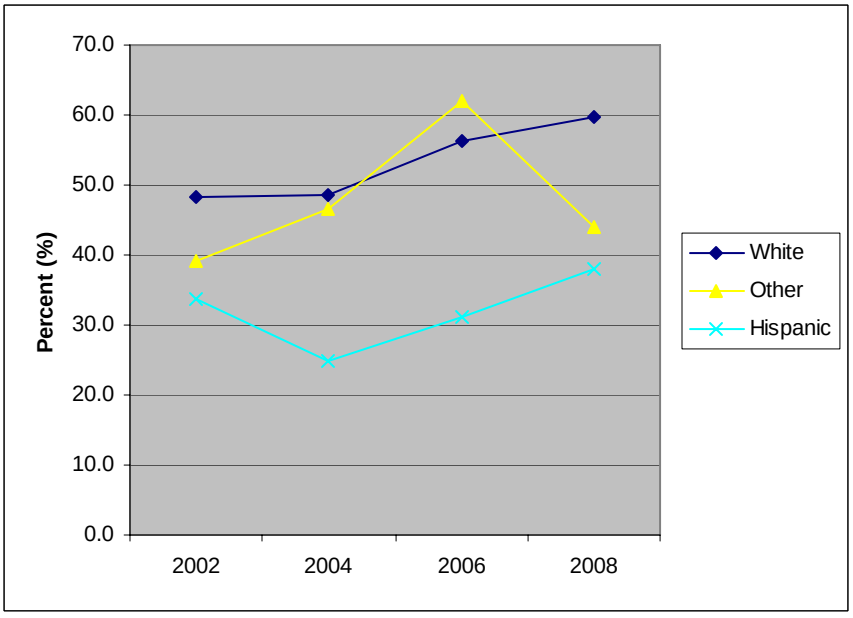
Conditions that call for colonoscopies include gastrointestinal hemorrhage, unexplained changes in bowel habit and suspicion of malignancy. Colonoscopies are often used to diagnose colon cancer, but are also used to diagnose inflammatory bowel disease.[12]

In Nevada, adults aged 65 years and older, had the highest proportion of people ever receiving a sigmoidscopy or colonoscopy from 2002 to 2008. Adults aged 50 to 54 years, had the lowest proportion.

In Nevada, Whites had the highest proportion of people who had received a sigmoidscopy or colonoscopy in 2008.

Due to the high death rates associated with colon cancer and the effectiveness and low risks associated with colonoscopy, it is now a routine screening test for people 50 years of age or older. Subsequent rescreenings are then scheduled, based on the initial results found, with a five to ten year recall being common for colonoscopies that produce normal results. Patients with a family history of colon cancer are often first screened during their teenage years.[12]

Proportion of Adults Aged 50+ Who Have Ever Had a Sigmoidscopy or Colonoscopy, Nevada Residents by Race/Ethnicity, BRFSS Data, 2002, 2004, 2006, 2008.*



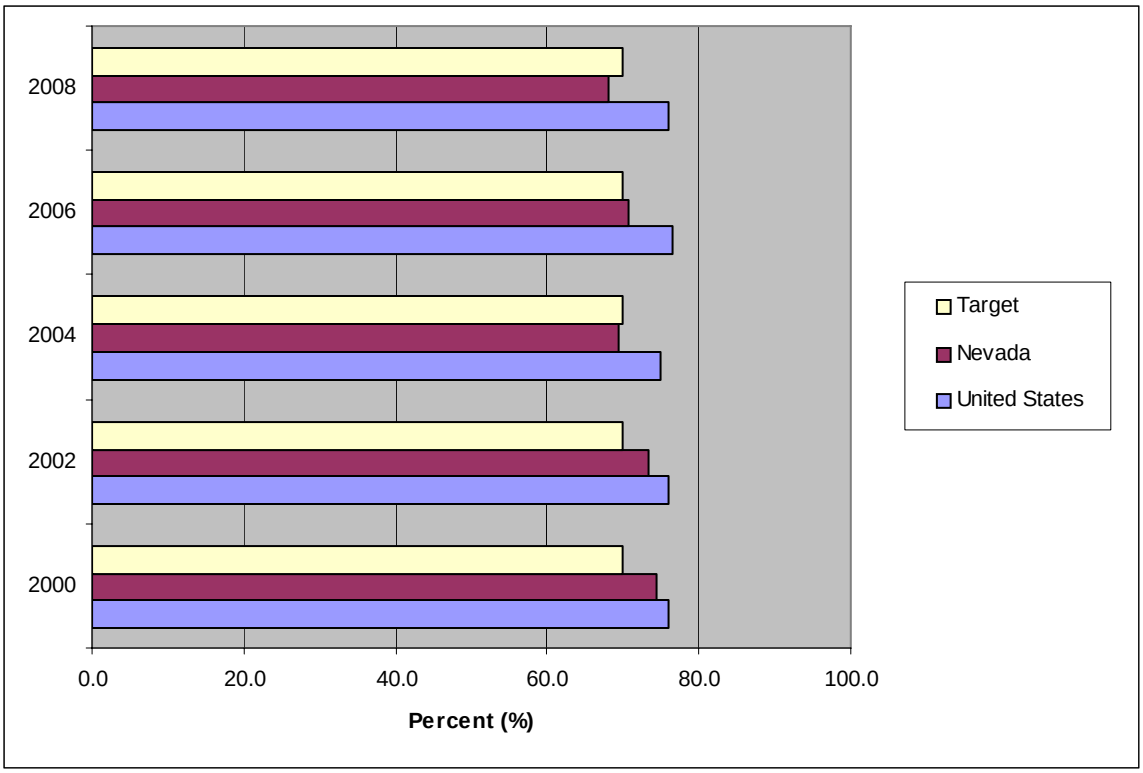
*These percentages are weighted to survey population characteristics.
Note: Data not available for the Black race/ethnicity group due to small counts and is not included in the Other race/ethnicity group.

Healthy People 2010 Objective (3-13): Increase the proportion of women aged 40+ who have had a mammogram in the preceding two years.

Healthy People 2020 Objective C HP2020-17: Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
68.0	76.0	70.0	81.1	Worsening

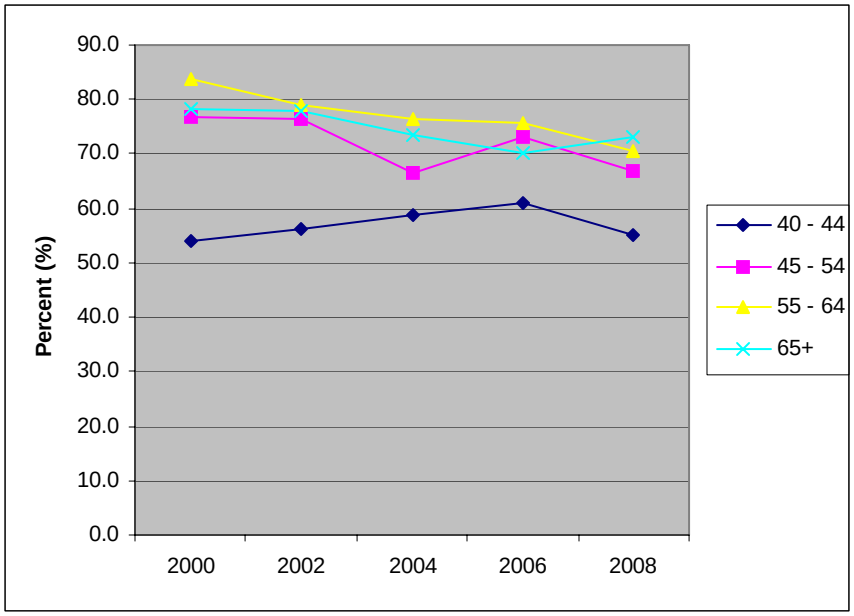
Proportion of Women Aged 40+ Who Have Had A Mammogram in The Preceding 2 Years, Nevada Residents and United States, BRFSS Data, 2000, 2002, 2004, 2006, 2008.*



The proportion of Nevada adults aged 40 years and older who had received a mammogram in the past 2 years decreased from 2000 to 2008. In 2000 and 2002 Nevada had surpassed the Healthy People target of 70.0 percent, at 74.4 percent and 73.3 percent respectively. In 2008 this proportion had decreased to 68.0 percent.

*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of Women Aged 40+ Who Have Had A Mammogram in The Preceding 2 Years, Nevada Residents by Age, BRFSS Data, 2000, 2002, 2004, 2006, 2008.*

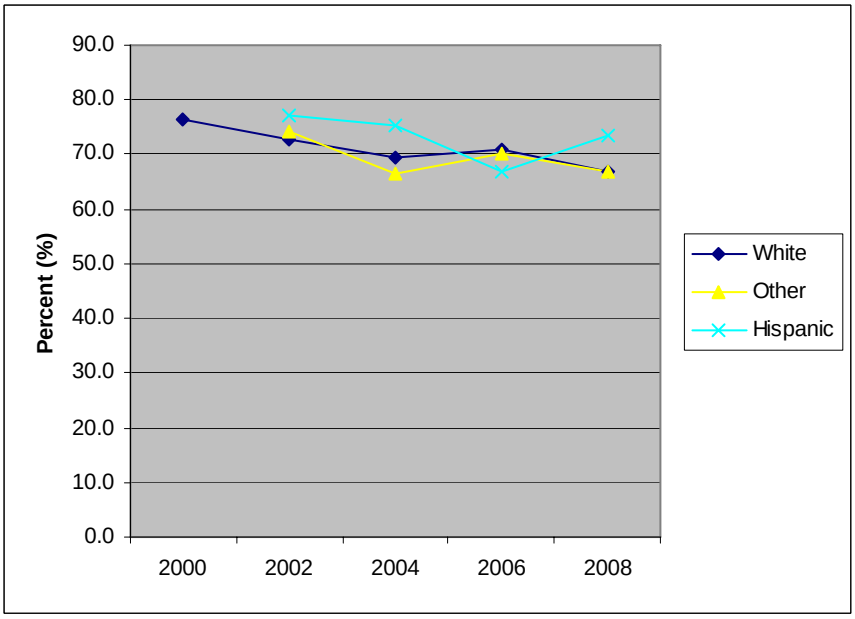


In Nevada, the number of females who had had a mammogram in the preceding two years decreased from 2000 to 2008 for all age groups and race/ ethnicities.

The American Cancer Society's most recent estimates for breast cancer in the United States are for 2010:

- About 207,090 new cases of invasive breast cancer will be diagnosed in women.
- About 54,010 new cases of carcinoma in situ (CIS) will be diagnosed (CIS is non-invasive and is the earliest form of breast cancer).
- About 39,840 women will die from breast cancer.[13]

Proportion of Women Aged 40+ Who Have Had A Mammogram in The Preceding 2 Years, Nevada Residents by Race/ Ethnicity, BRFSS Data, 2000, 2002, 2004, 2006, 2008.*



*These percentages are weighted to survey population characteristics.
Note: Data are not available for the Black race/ethnicity group due to small counts and is not included in the Other race/ethnicity group.
Note: Data are not available for the Other and Hispanic race/ethnicity groups for 2000 due to small counts.

Diabetes

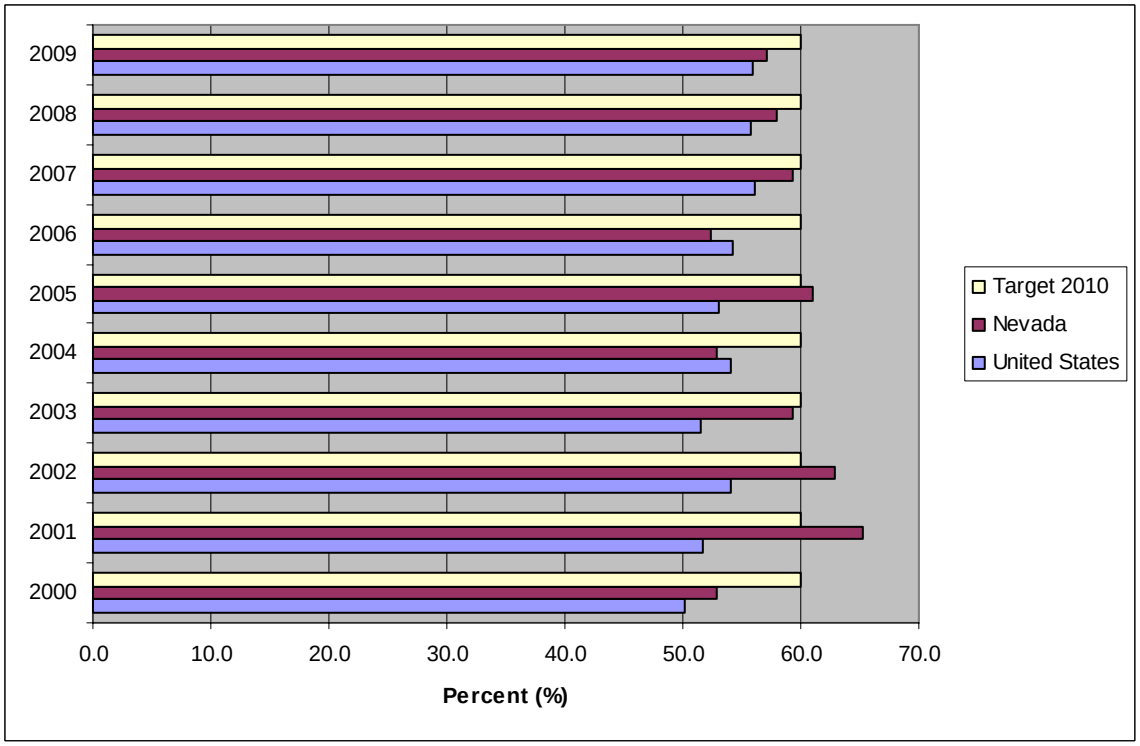
Diabetes is the seventh leading cause of death in the United States. Individuals with diabetes are at greater risk for heart disease, stroke, high blood pressure, blindness, kidney disease, disease of the nervous system, amputations, and dental disease. In 2007, an estimated 23.6 million people or 7.8 percent of the population had diabetes. Diabetes prevalence in the U.S. is likely to increase for several reasons. A large segment of the population is aging. Hispanic/Latinos and other minority groups are at an increased risk and make up the fastest-growing segment of the U.S. population. And Americans are increasingly overweight and sedentary. The CDC projects that the prevalence of diagnosed diabetes in the U.S. will increase 165 percent by 2050.[1]

Healthy People 2010 Objective (5-1): Increase the proportion of persons with diabetes who receive formal diabetes education.

Healthy People 2020 Objective D HP2020-14: Increase the proportion of persons with diabetes who receive formal diabetes education.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
57.2	55.9	60.0	62.5	Fluctuating

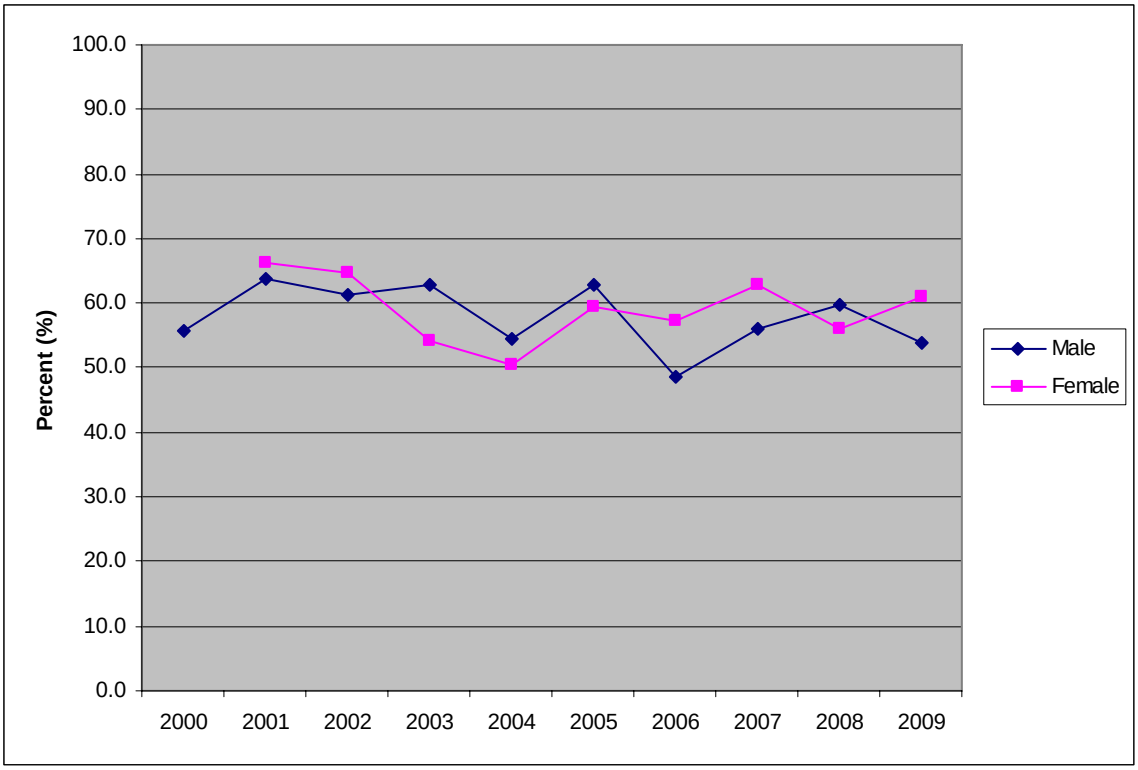
Proportion of Persons With Diabetes Receiving Formal Diabetes Education, Nevada Residents and United States, BRFSS Data, 2000 - 2009.*



Nevada's proportion of persons receiving diabetes education has not consistently reached the Healthy People 2010 target. Nevada, however, had higher proportions of people with diabetes that have ever received diabetes education than the U.S. from 2007 to 2009.

*These percentages are weighted to survey population.
Note: See appendix for additional information.

Proportion of Persons With Diabetes Receiving Formal Diabetes Education, Nevada Residents by Gender, BRFSS Data, 2000 - 2009.*



The proportion of persons with diabetes in Nevada who have received formal diabetes education fluctuated from 2000 to 2009 for both males and females, hovering around 60 percent for both genders.

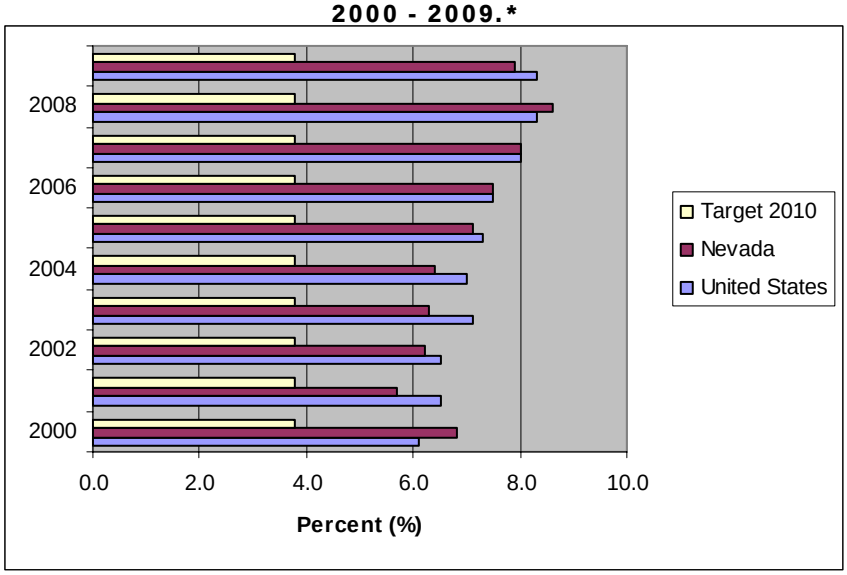
*These percentages are weighted to survey population.
Note: Data for the female gender group are not available for 2000 due to small counts.

Healthy People 2010 Objective (5-3): Reduce the overall rate of diabetes that is clinically diagnosed.

Healthy People 2020 Objective D HP2020-1: Reduce the annual number of new cases of diagnosed diabetes in the population.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
8.5**	8.3**	N/A**	N/A**	Worsening

Proportion of Persons with Clinically Diagnosed Diabetes, Nevada Residents and United States, BRFSS Data, 2000 - 2009.*



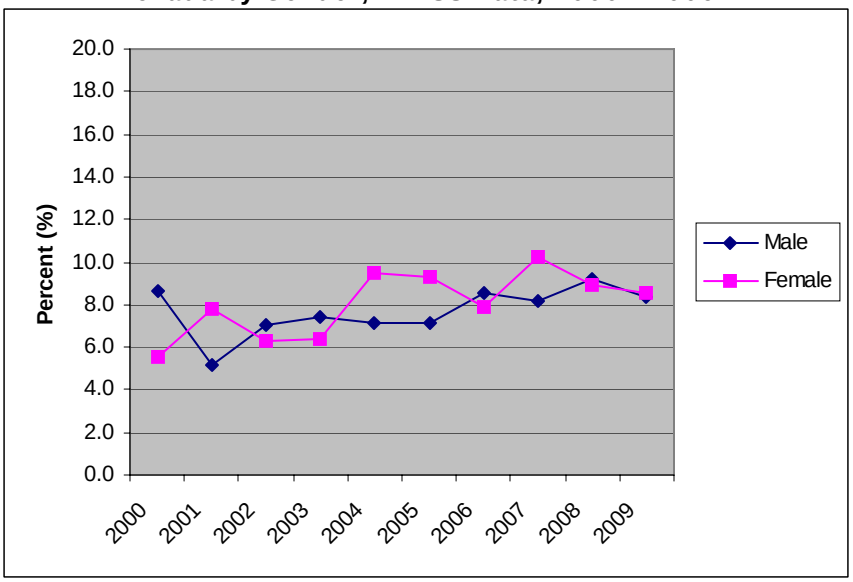
Diabetes is a serious, costly, and increasingly common chronic disease that can cause devastating complications that often result in disability and death.[2]

The proportion of persons with diabetes increased in both the state and the country from 2000 to 2009. Neither region met the Healthy People 2010 target.

The proportion of persons with clinically diagnosed diabetes fluctuated in Nevada males from 2000 to 2009, at 8.7 percent in 2000 and 8.3 percent in 2009.

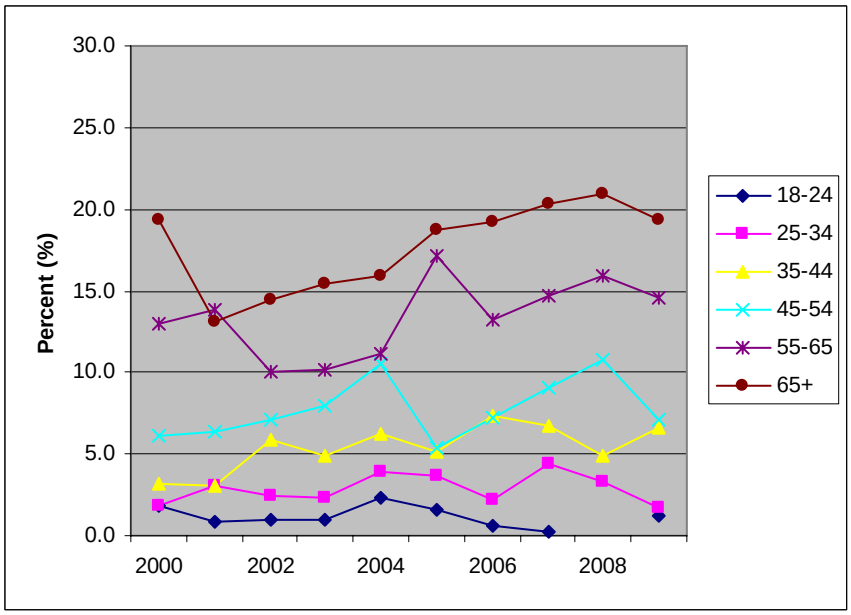
Among Nevada females, the proportion of clinically diagnosed diabetes increased from 5.6 percent in 2000 to 8.5 percent in 2009.

Proportion of Persons with Clinically Diagnosed Diabetes, Nevada by Gender, BRFSS Data, 2000 - 2009.*



*These percentages are weighted to survey population.
**The available data is not in line with reporting methodology used for the Healthy People targets.
Note: See appendix for additional information.

Proportion of Persons with Clinically Diagnosed Diabetes, Nevada Residents by Age, BRFSS Data, 2000 - 2009.*



The total prevalence of diabetes in 2005 was 20.8 million people diagnosed with diabetes, that was 7 percent of the entire U.S. population.[2]

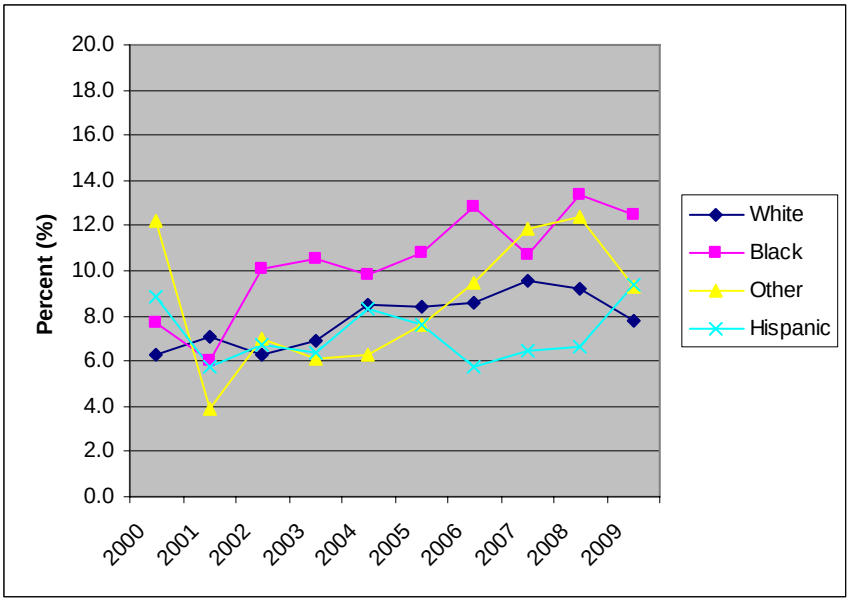
Approximately 176,500 children and adolescents and an estimated 217,467 adults in Nevada have diabetes in 2007.[3]

In Nevada, adults aged 65 years and older had the highest proportion of people with diagnosed diabetes in the past decade.

In Nevada, Blacks and Other racial/ethnic groups had the highest proportion of people with diagnosed diabetes from 2000 to 2009.

Clinically-based reports and regional studies suggest that type 2 diabetes, although still rare, is being diagnosed more frequently in children and adolescents, particularly in American Indians, African Americans, and Hispanic/Latino Americans.[2]

Proportion of Persons with Clinically Diagnosed Diabetes, Nevada Residents by Race/Ethnicity, BRFSS Data, 2000 - 2009.*



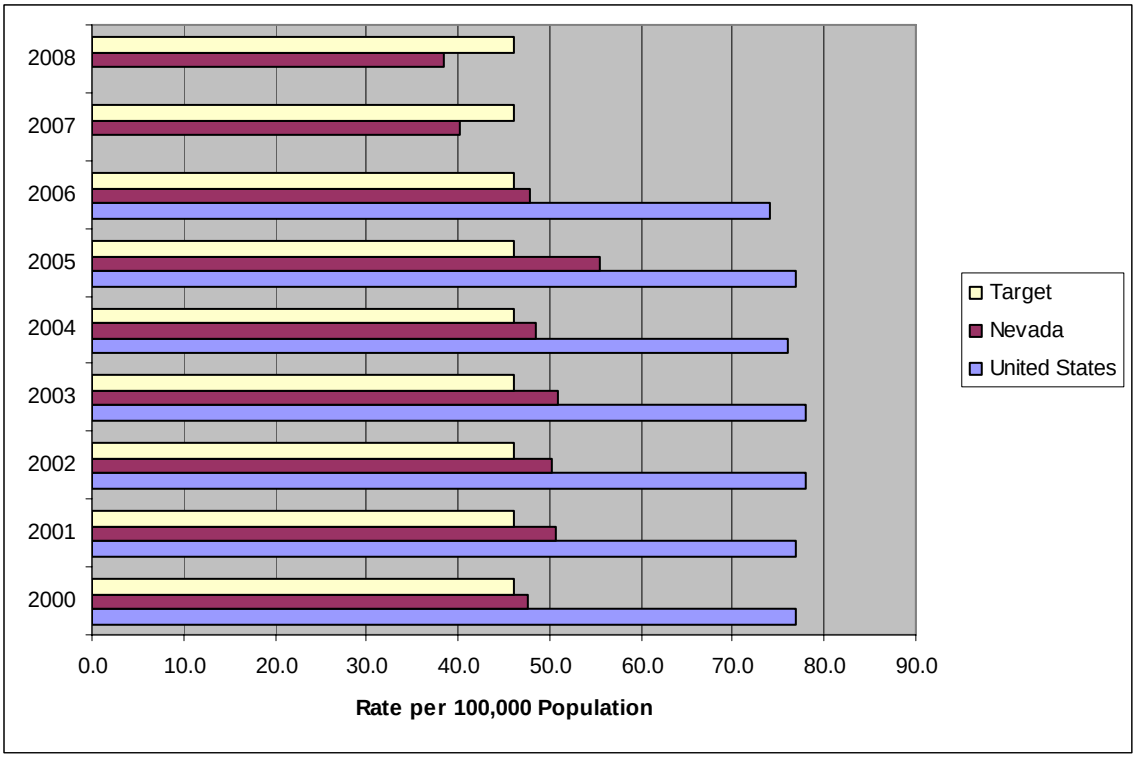
*These percentages are weighted to survey population.
**The available data is not in line with reporting methodology used for the Healthy People targets.

Healthy People 2010 Objective (5-5): Reduce the diabetes death rate.

Healthy People 2020 Objective D HP2020-3: Reduce the diabetes death rate.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
38.5	74.0	46.0	65.8	Surpassed

Age-Adjusted Diabetes Related Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*

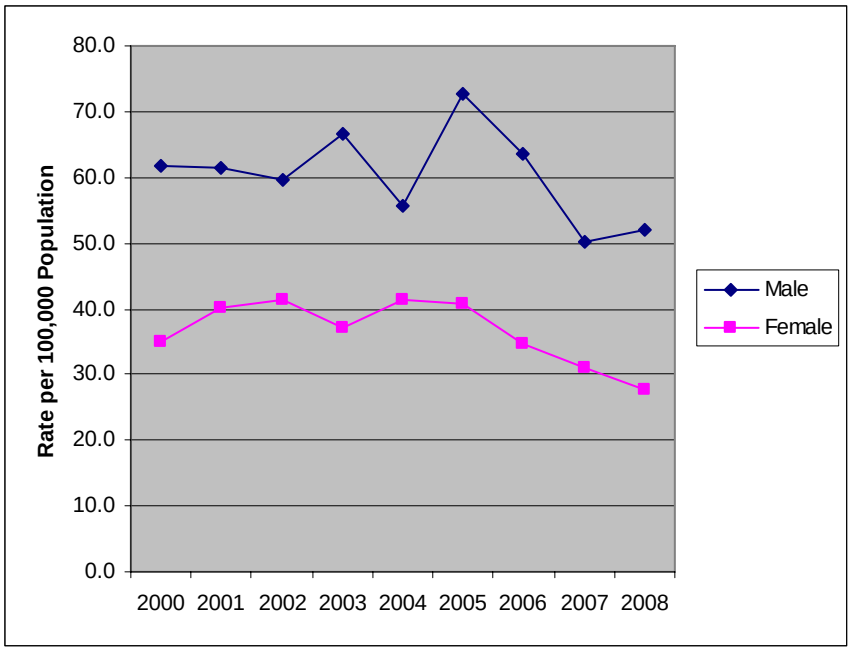


Diabetes is likely to be underreported as a cause of death. Studies have found that only about 35 percent to 40 percent of decedents with diabetes had it listed anywhere on the death certificate and only about 10 percent to 15 percent had it listed as the underlying cause of death.[2]

Nevada surpassed the Healthy People 2010 target for diabetes mortality from 2007 to 2009. The nation had not met the Healthy People 2010 target as of 2006. The national rate was relatively unchanged from 2000 to 2006, while the state rate decreased from 2006 to 2009.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada are not final and are subject to change.
Note: See appendix for additional information.

Diabetes-Related Death Rate, Nevada Residents by Gender, 2000 - 2008.*



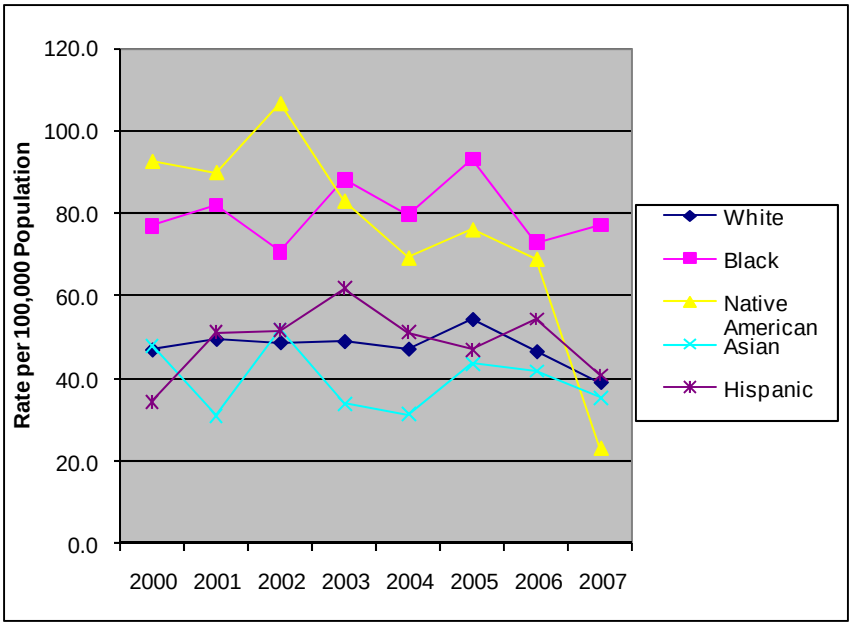
The diabetes mortality rate decreased for both genders in Nevada from 2000 to 2008.

The diabetes death rate for Nevada males was consistently higher than the rate for Nevada females from 2000 to 2008.

Diabetes-Related Death Rate, Nevada Residents by Race / Ethnicity, 2000 - 2007.*

From 2003 - 2007, Blacks had a higher diabetes mortality rate than any other racial or ethnic group in Nevada.

The diabetes death rate for Blacks increased in 2008, while the rates for all other race/ethnicities decreased.



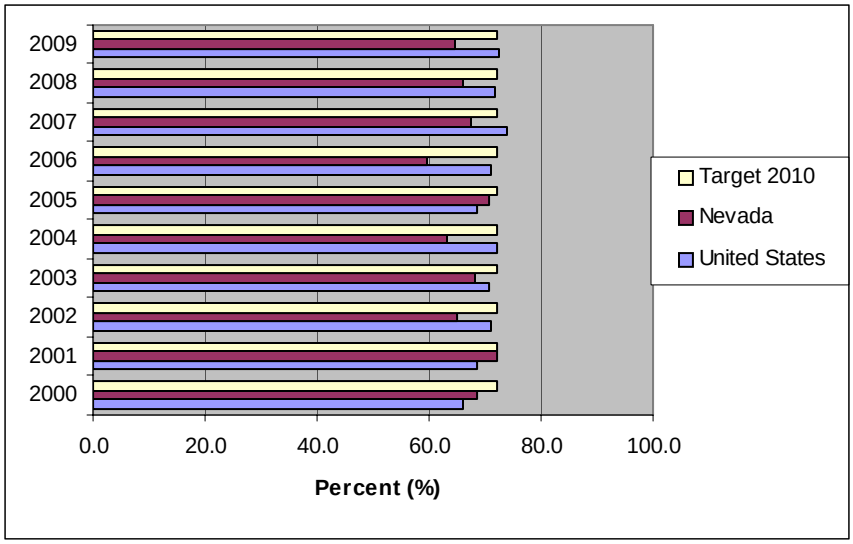
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada are not final and are subject to change.

Healthy People 2010 Objective (5-12): Increase the proportion of adults with diabetes who have had a glycosylated hemoglobin measurement at least two times a year.

Healthy People 2020 Objective D HP2020-11: Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement at least twice a year.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
64.6	72.4	72.0	71.1	Fluctuating

Proportion of Adults with Diabetes Who Have Had a Glycosylated Hemoglobin Measurement at Least Two Times a Year, Nevada Residents and United States, BRFSS Data, 2000 - 2009.*

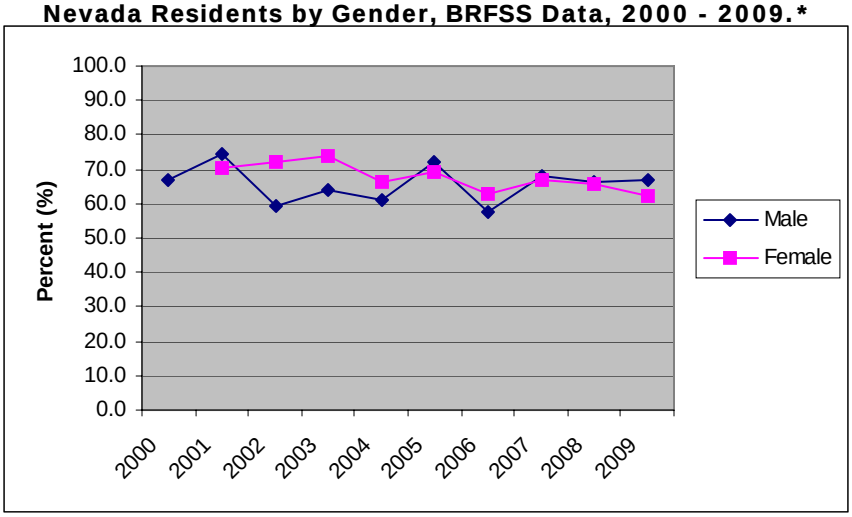


Complications from diabetes include: Eye disease and blindness, Skin and dental problems, Feet and amputations, Stroke, Gastrointestinal problems, Heart disease, Sexual concerns, Kidney disease, Neuropathy, Psychosocial complications.[2]

Both the national and state proportion of adults with diabetes who have had a glycosylated hemoglobin measurement at least twice a year have not met the Healthy People 2010 target.

Proportion of Adults with Diabetes Who Have Had a Glycosylated Hemoglobin Measurement at Least Two Times a Year, Nevada Residents by Gender, BRFSS Data, 2000 - 2009.*

The proportion of persons with diabetes who have had a glycosylated hemoglobin measurement at least twice per year fluctuated in Nevada for both genders from 2000 to 2009, at 66.6 percent and 62.1 percent for males and females respectively in 2009.



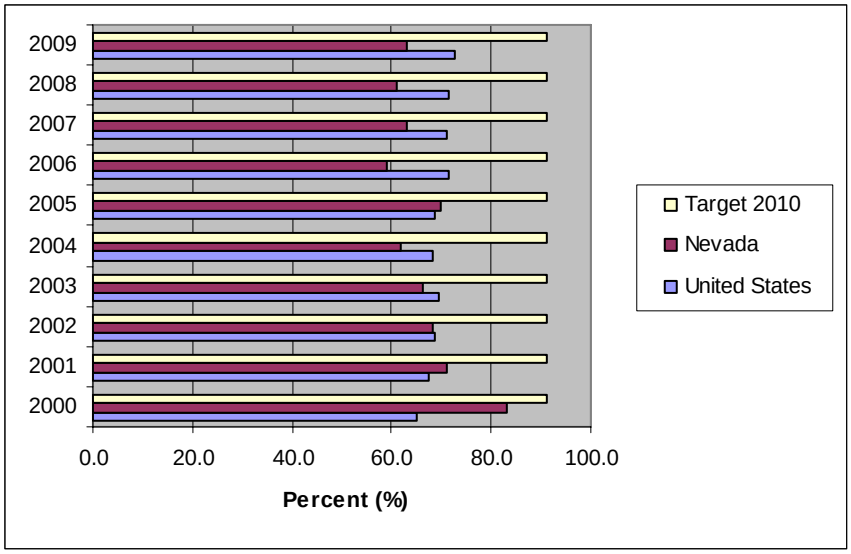
*These percentages are weighted to survey population.
Note: Data for the female gender group are not available for 2000 due to small counts.
Note: See appendix for additional information.

Healthy People 2010 Objective (5-14): Increase the proportion of adults with diabetes who have had at least an annual foot examination.

Healthy People 2020 Objective D HP2020–9: Increase the proportion of adults with diabetes who have had at least an annual foot examination.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
63.2	72.6	91.0	74.8	Worsening

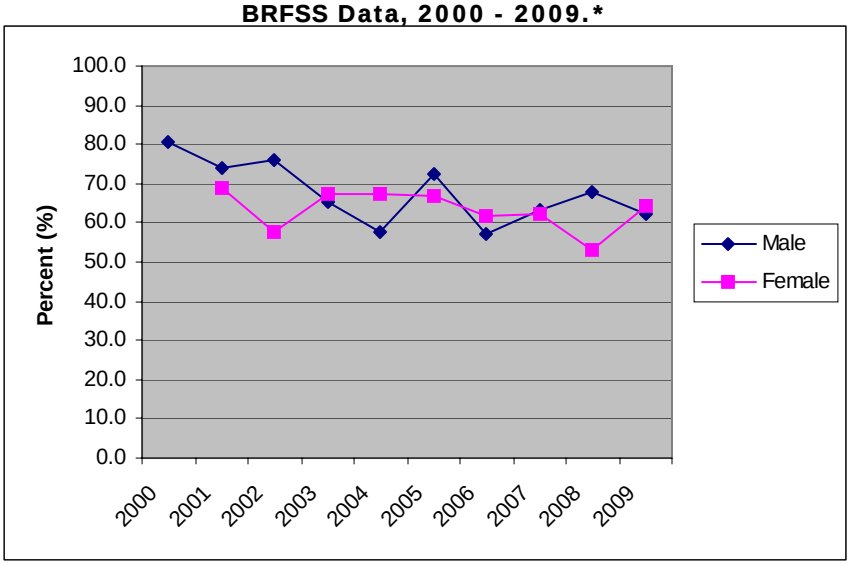
Proportion of Adults with Diabetes Who Have Had at Least an Annual Foot Examination, Nevada Residents and United States, BRFSS Data, 2000 - 2009.*



The proportion of Nevada adults with diabetes who have had an annual foot examination decreased from 2000 to 2009. The national rate slightly increased from 2000 to 2009. In 2005, 45 percent of lower extremity amputations are performed on patients with a primary diagnosis of diabetes (2005 BRFSS).

Diabetes is a costly disease in Nevada. Costs for diabetes health care and related treatments run about $167 million annually.[3]

Proportion of Adults with Diabetes Who Have Had at Least an Annual Foot Examination, Nevada Residents by Gender, BRFSS Data, 2000 - 2009.*



The proportion of Nevada adults with diabetes who have had at least one annual foot exam decreased overall from 2000 to 2009 for both males and females.

*These percentages are weighted to survey population.
Note: Data for the female gender group are not available for 2000 due to small counts.
Note: See appendix for additional information.

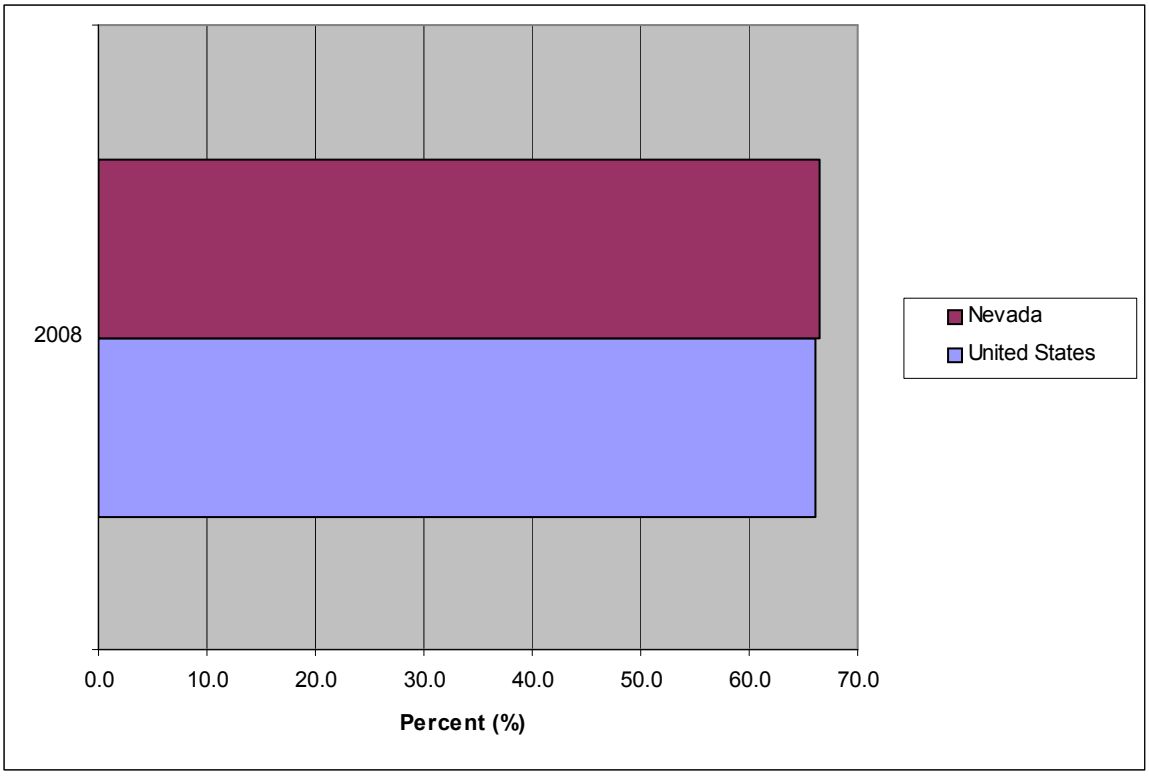
Early and Middle Childhood

During a child's early and middle childhood, they will experience many changes in their life. Some of these changes include forming the foundation for learning, well being, and social awareness in developing independence from families. It is important for the child to develop healthy cognitive functions and emotional abilities, as well as to establish healthy behaviors to carry on throughout their aging process.[1]

Healthy People 2020 Objective EMC HP2020-4: Increase the proportion of elementary, middle, and senior high schools that require school health education.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
66.5	66.1	N/A		

The Proportion of Schools With A Health Education Curriculum That Addresses All Eight National Standards For Health Education, Nevada Residents and United States, SHPPS Data, 2008.*



In 2008, more than 66 percent of schools in Nevada had a health education curriculum that addressed all eight national standards for health education.[2] This proportion nationally was closely trailing that in Nevada in 2008, at 66.1 percent and 66.5 percent respectively.

*The Nevada and U.S. data are from the Centers for Disease Control and Prevention (CDC), School Health Policies and Protection Study (SHPPS), School Health Profiles 2008. Individual county data is not available.

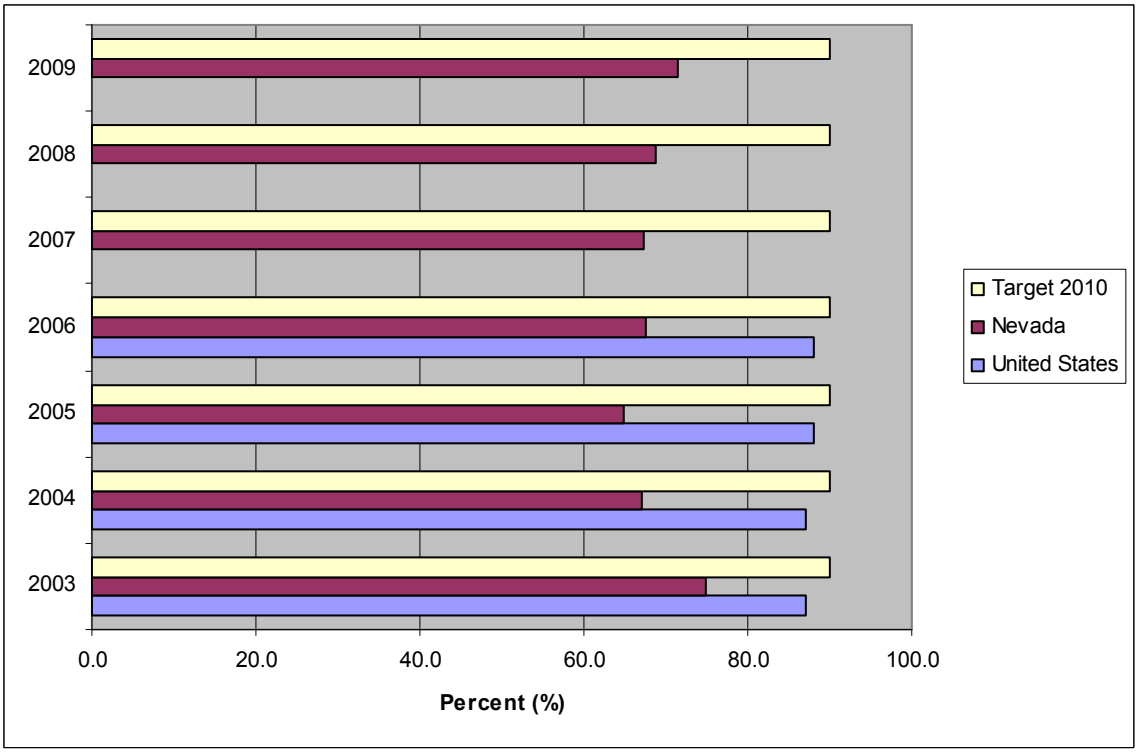
Education and Community-Based Programs

The national dropout rate over the years 2000 to 2007 was 10.75 percent and Nevada's was approximately 5.6 percent, and that is based on Kids Count-UNLV reports for the years 2000—2007. These reports were based upon a community survey taken by the U.S. Census Bureau. Nevada's rapid growth and migratory population are factors in Nevada's dropout rate. In 2007, Nevada's dropout rate was reported as 'the worst in the nation'.[1]

Healthy People 2020 Objective ECBP HP2020-6: Increase the proportion of the population that completes high school education.

Most Recent NV Value (2009)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
71.4	88.0	90.0	97.9	Fluctuating

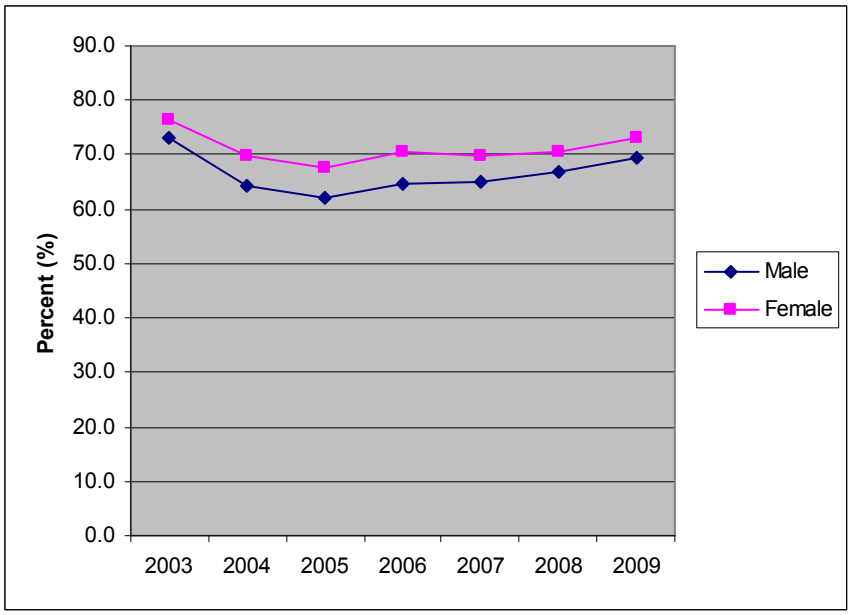
Proportion of the Population Who Completes High School, Nevada Residents and United States, 2003 - Most Current Data.*



From 2003 to 2009, the proportion of Nevada residents who complete high school was consistently lower than that proportion nationally and the Healthy People 2010 target of 90.0 percent. However, the proportion of Nevada residents who complete high school increased from 2007 to 2009.

*The Nevada data are from the Nevada Annual Reports of Accountability. U.S. data are from the Current Population Survey (CPS), U.S. Department of Commerce, Bureau of the Census.
Note: Nevada and U.S. data are from two different data sources and thus may not be comparable.
Note: See appendix for additional information.

Proportion of the Population Who Completes High School, Nevada Residents by Gender, 2003 - 2009.*

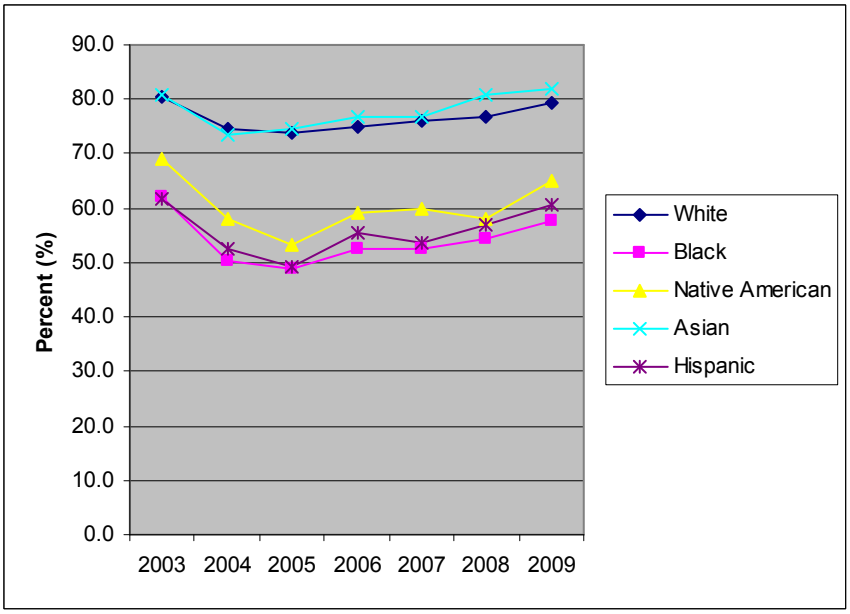


In Nevada, a higher proportion of females completed high school than males from 2003 to 2009. The proportion of Nevada residents who complete high school increased since 2005 for both genders.

Proportion of the Population Who Completes High School, Nevada Residents by Race/Ethnicity, 2003 - 2009.*

From 2003 to 2009, the proportion of Whites and Asians who completed high school was 15 to 20 percent higher than other racial/ethnic groups in Nevada.

Blacks and Hispanics have the highest percentage of high school dropouts.[2]



*The Nevada data are from the Nevada Annual Reports of Accountability.

Family Planning

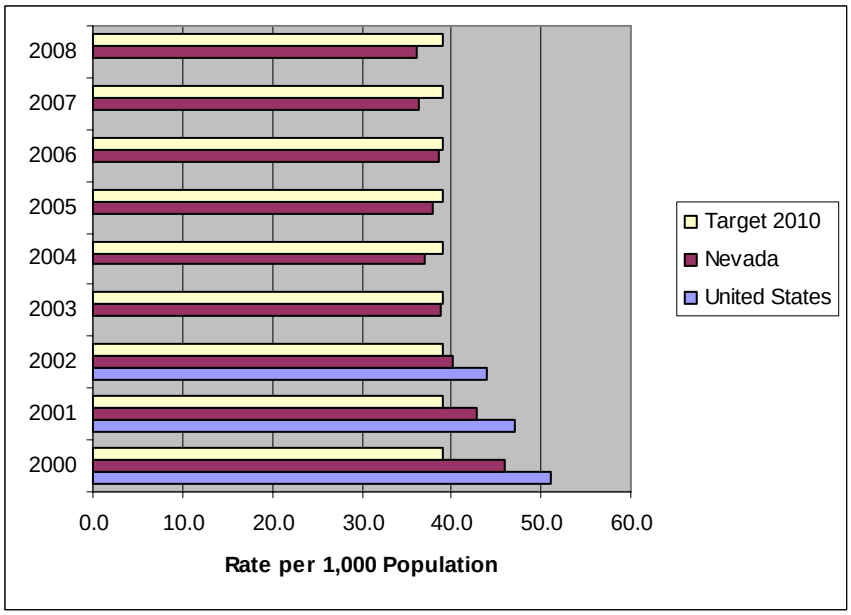
The United States has a considerably higher rate of teen pregnancy than most other developed countries. In 2006, there were 435,436 births to mothers aged 15–19 years in the United States, a birth rate of 41.9 per 1,000. Teen mothers face higher rates of preterm birth, have higher rates of low birth weight babies, and neonatal death. Teen mothers are more likely to drop out of school, and more likely to live in poverty and be dependent on public programs. The cost to U.S. taxpayers for adolescent pregnancies is estimated to be $9 billion a year (CDC, 2009).[1]

Healthy People 2010 Objective (9-7): Reduce pregnancies among adolescent females.

Healthy People 2020 Objective FP HP2020–8: Reduce pregnancies among adolescent females, aged 15-17 and aged 18-19.

Most Recent NV Value (2008)	U.S. (2002)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
36.1	44.0	39.0	36.2	Surpassed

Adolescent Pregnancy Rate Among Females Aged 15 to 17 Years, Nevada Residents and United States, 2000 - Most Current Data.*

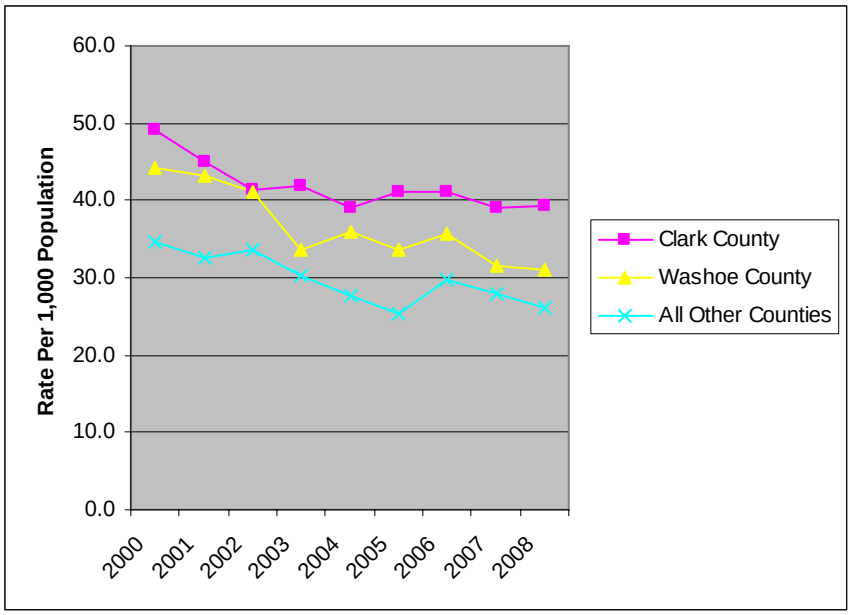


The Nevada adolescent pregnancy rate among females aged 15 to 17 years, decreased from 2000 to 2008. The state rate was consistently lower than the reported national rate and was lower that the Healthy People 2010 target, of 39.0, from 2003 on.

The national rate for the same indicator for the last three reported years (2000, 2001, & 2002) also decreased.

*These rates are per 1,000 female age specific population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Births.
Note: 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Adolescent Pregnancy Rate Among Females Aged 15 to 17 Years, Nevada Residents by County/Region, 2000 - 2008.*

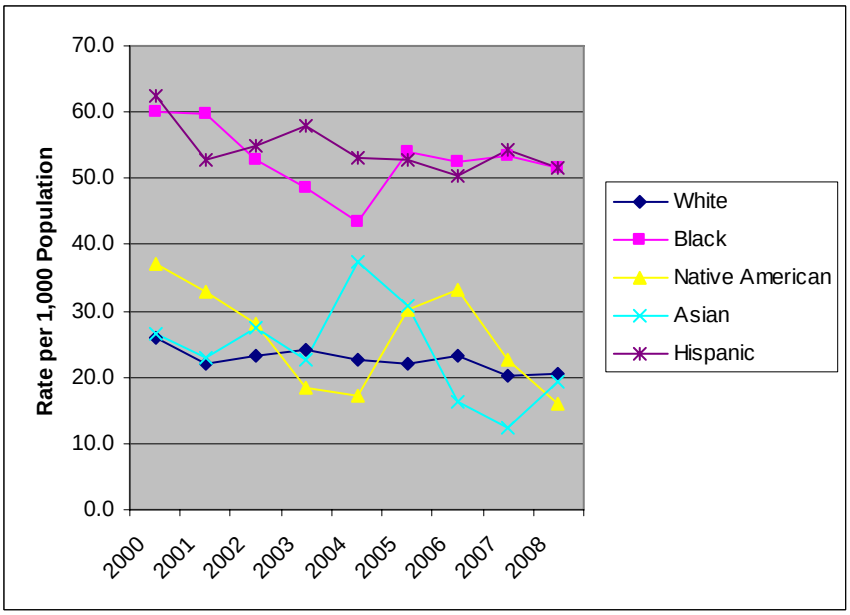


Counties with higher populations may have a corresponding increase in their adolescent pregnancy rates among females aged 15 to 17, when compared with counties of less dense populations.

Clark County had the highest adolescent pregnancy rate among females aged 15 to 17 years, in Nevada from 2000 to 2008.

Adolescent Pregnancy Rate Among Females Aged 15 to 17 Years, Nevada Residents by Race/Ethnicity, 2000 - 2008.*

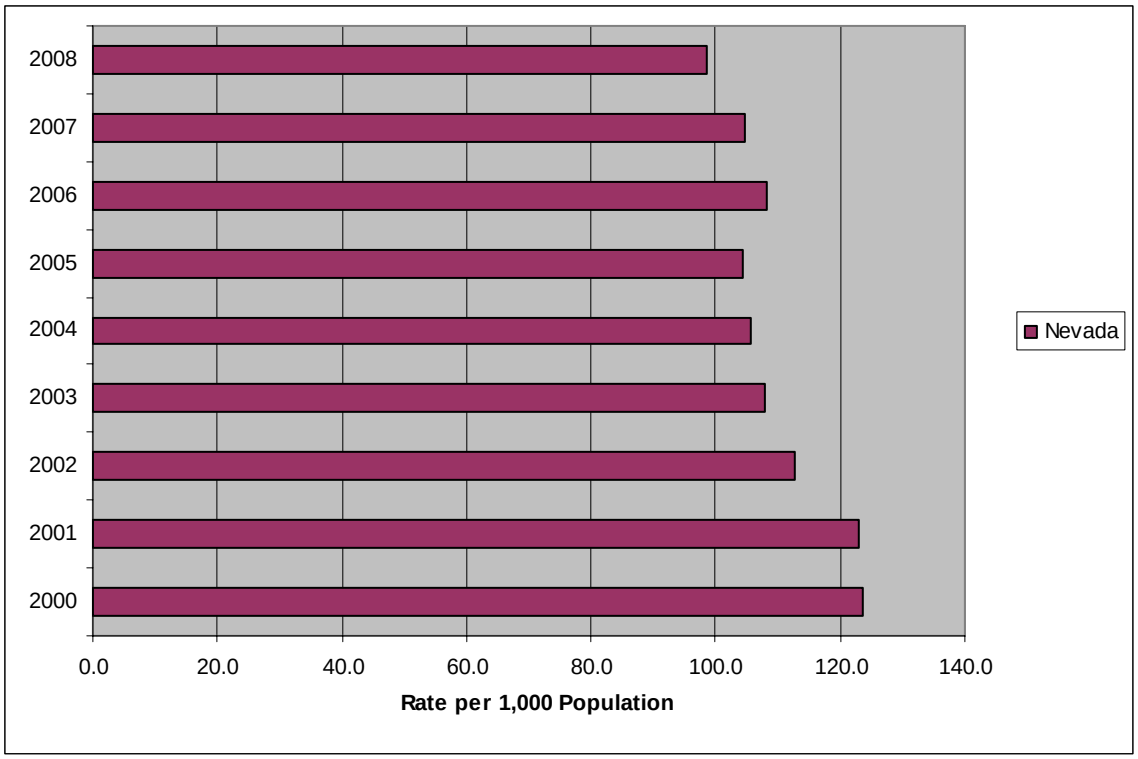
Black and Hispanic females aged 15 to 17 years consistently had a higher rate of adolescent pregnancy than other racial groups in Nevada over the years 2000 to 2008.



*These rates are per 1,000 female age specific population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2008 Nevada data are not final and are subject to change.

Most Recent NV Value (2008)	U.S.	HP 2010 Target	HP 2020 Target	Progress Towards Targets
98.7	N/A	N/A	105.9	N/A

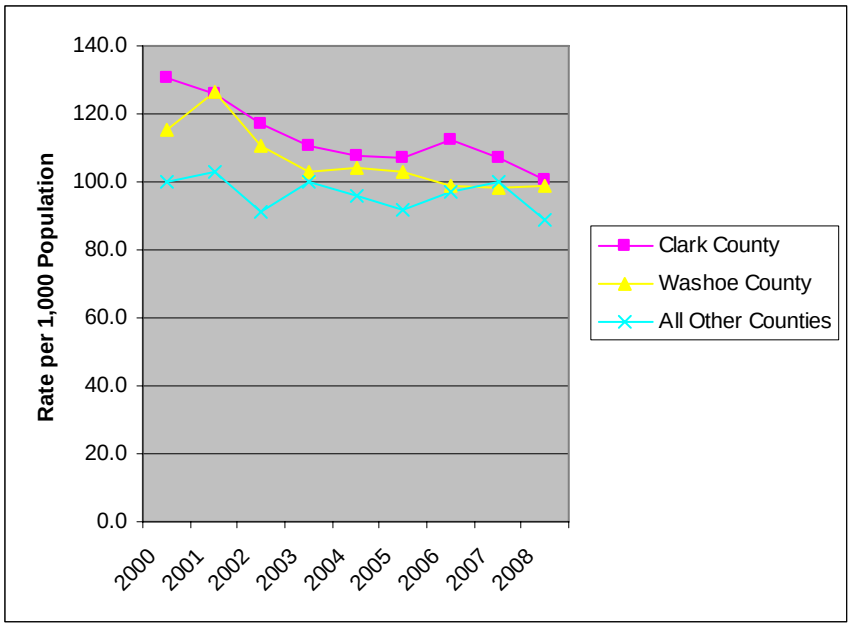
Adolescent Pregnancy Rate Among Females Aged 18 to 19 Years, Nevada Residents, 2000 - 2008.*



The Nevada adolescent pregnancy rate among females age 18 to 19 years, decreased from 2000 to 2008, at 98.7 percent in 2008.

*These rates are per 1,000 female age specific population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

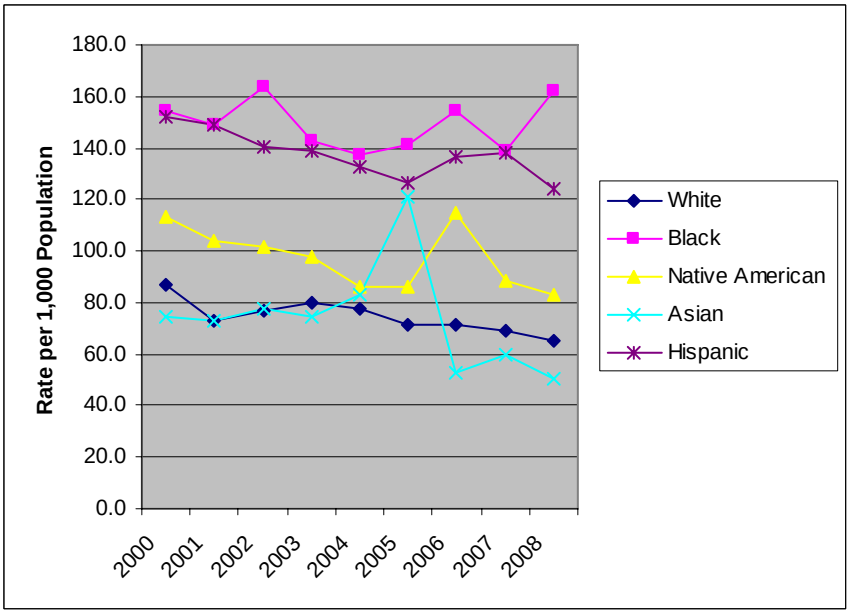
Adolescent Pregnancy Rate Among Females Aged 18 to 19 Years, Nevada Residents by County/Region, 2000 - 2008.*



The rates of adolescent teen pregnancy among 18 and 19 year olds declined in all Nevada regions over the last nine years.

Adolescent Pregnancy Rate Among Females Aged 18 to 19 Years, Nevada Residents by Race/Ethnicity, 2000 - 2008.*

Blacks and Hispanics had higher rates of adolescent pregnancy among females aged 18 and 19 than all other racial/ethnic groups in Nevada from 2000 to 2008.



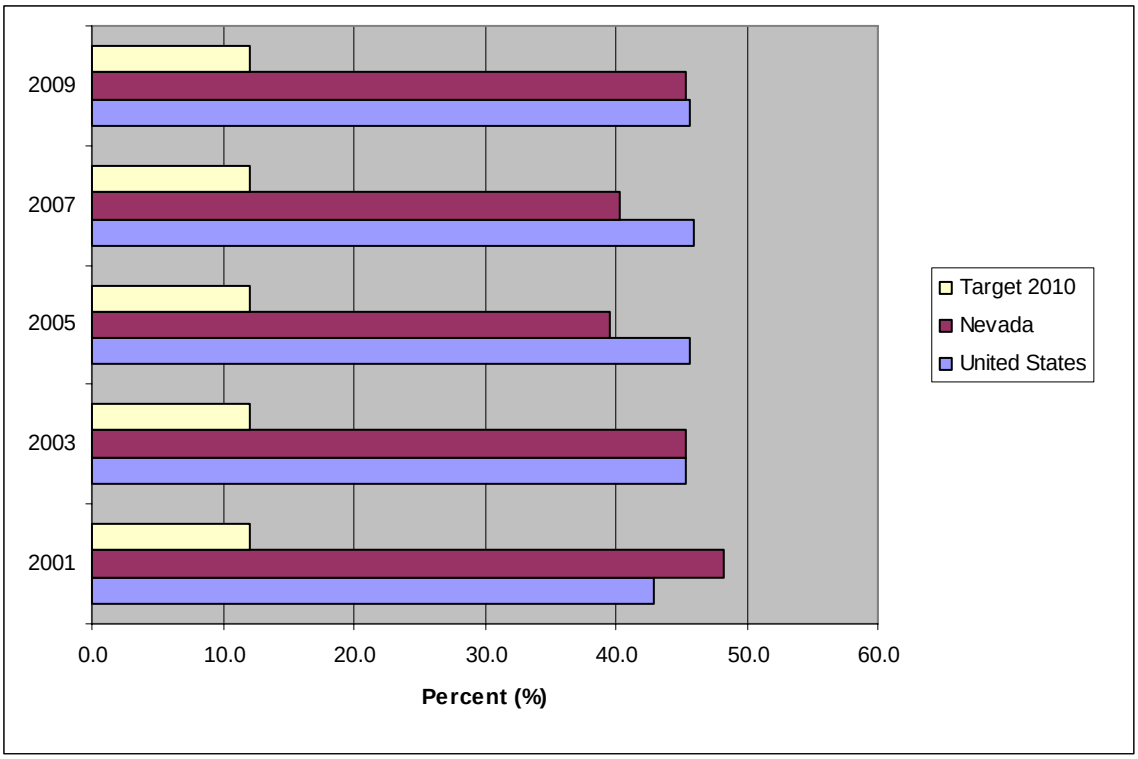
*These rates are per 1,000 female age specific population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2008 Nevada data are not final and are subject to change.

Healthy People 2010 Objective (9-8a.): Increase the proportion of females who have never engaged in sexual intercourse before age 15.

Healthy People 2020 Objective FP HP2020–9.3: Increase the proportion of female adolescents aged 15 years and under who have never had sexual intercourse.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
45.0	46.0	12.0**	91.2	Fluctuating

Proportion of Female Adolescents, Grades 9-12, Who Have Ever Had Sexual Intercourse, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

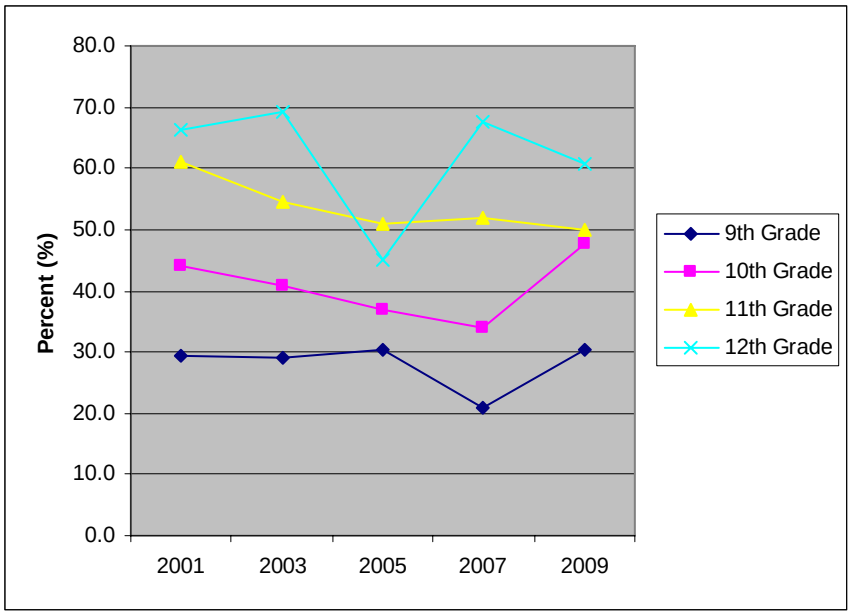


The proportion of Nevada female adolescents in grades 9 through 12 who have ever had sexual intercourse fluctuated from 2001 to 2009, at 45.0 percent in 2009.

From 2001 to 2009, over 40 percent of female adolescents in Nevada reported having sexual intercourse.[2]

*Individual county data are not available.
**The Healthy People 2010 target was changed to represent the proportion of females who have ever engaged in sexual intercourse, rather than females who have never engaged in sexual intercourse.

Proportion of Female Adolescents, Grades 9-12, Who Have Ever Had Sexual Intercourse, Nevada Residents by Grade, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

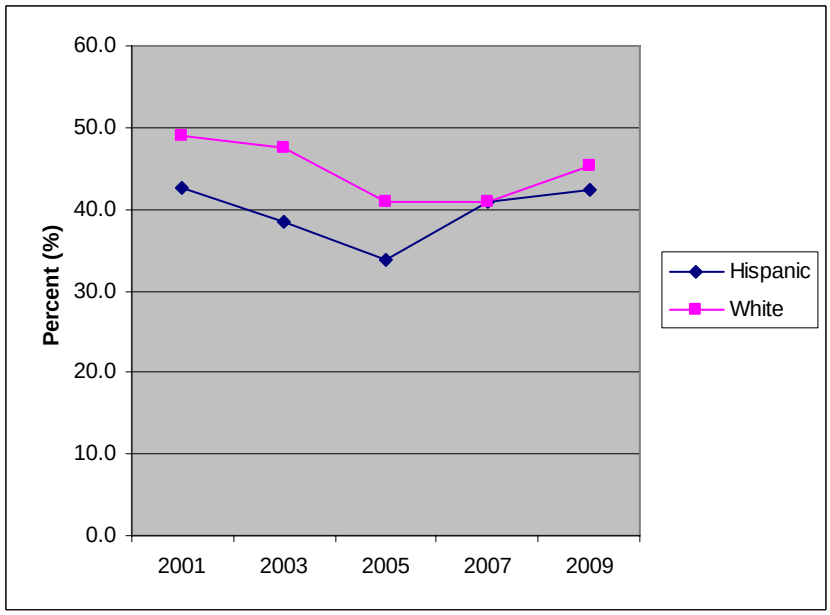


According to the Youth Risk Behavior Surveillance System (YRBS), in 2009, 61 percent of females in the 12th grade had reported having sexual intercourse in the state.[2]

Approximately half of the females in the 10th and 11th grades have had sexual intercourse, and 31 percent of the 9th graders have reported having sexual intercourse.[2]

Proportion of Female Adolescents, Grades 9-12, Who Have Ever Had Sexual Intercourse, Nevada Residents by Race/ Ethnicity, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

From 2001 to 2005, there was a decrease in the proportion of White and Hispanic female adolescents who reported ever having sexual intercourse. From 2005 to 2009, the proportion of adolescents engaging in sexual intercourse has increased for both White and Hispanic females in Nevada.



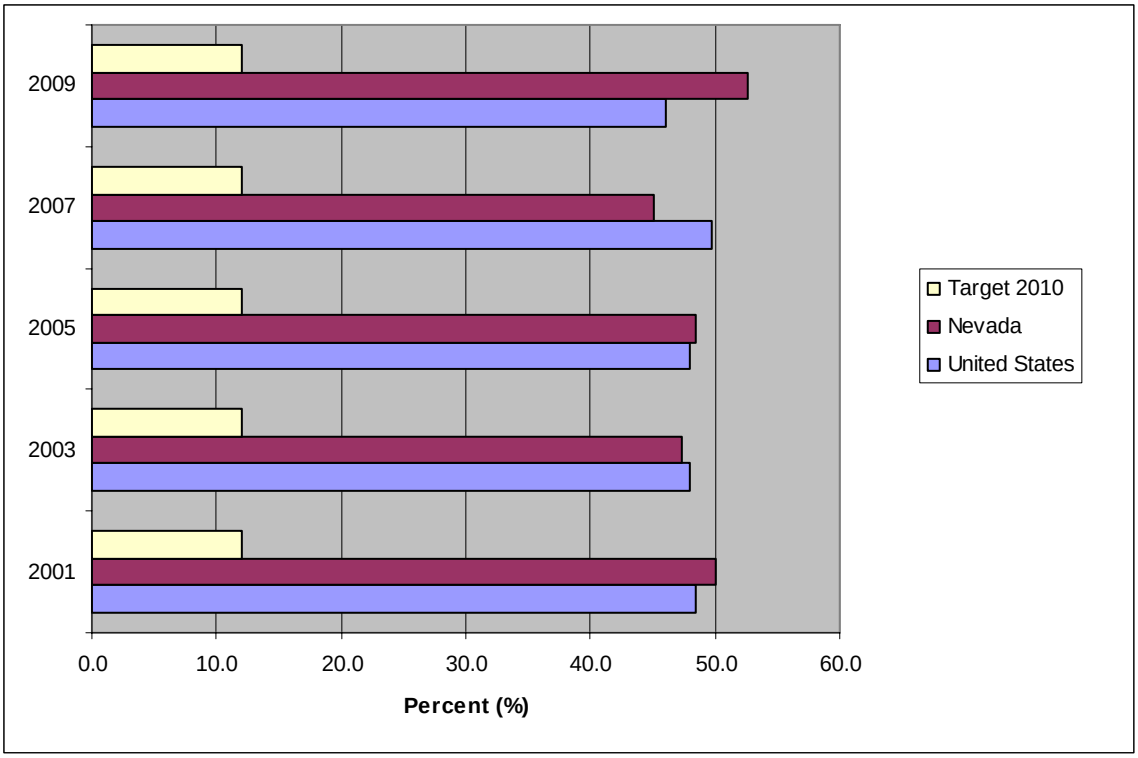
*Individual county data are not available.
Note: Data are not available for Black and Other race/ethnicity groups due to <100 respondents for those subgroups.

Healthy People 2010 Objective (9-8b.): Increase the proportion of males who have never engaged in sexual intercourse before age 15.

Healthy People 2020 Objective FP HP2020–9.4: Increase the proportion of male adolescents aged 15 years and under who have never had sexual intercourse.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
53.0	46.0	12.0**	90.2	Fluctuating

Proportion of Male Adolescents, Grades 9-12, Who Have Ever Had Sexual Intercourse, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

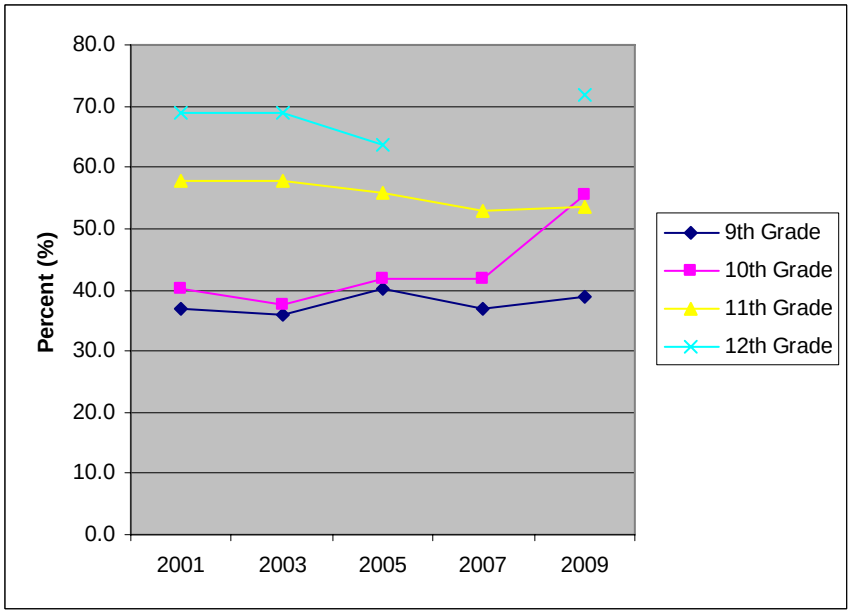


The proportion of Nevada male adolescents, grades 9 through 12, who have ever had sexual intercourse fluctuated from 2001 to 2009, at 53.0 percent in 2009.

From 2001 to 2009, over 45 percent of male adolescents, grades 9 through 12, in Nevada have reported having sexual intercourse.[2]

*Individual county data are not available.
**The Healthy People 2010 target was changed to represent the proportion of males who have ever engaged in sexual intercourse, rather than males who have never engaged in sexual intercourse.

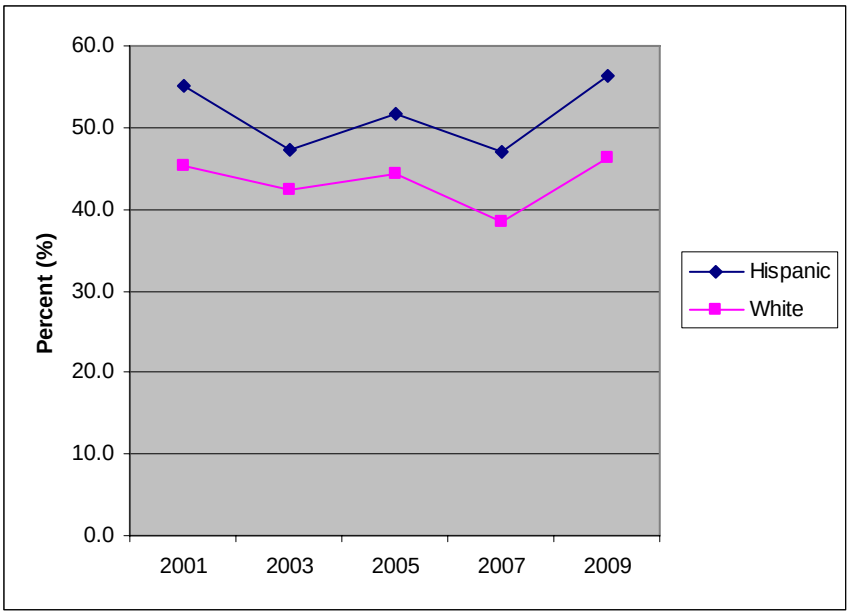
Proportion of Male Adolescents, Grades 9-12, Who Have Ever Had Sexual Intercourse, Nevada Residents by Grade, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



According to the Youth Risk Behavior Surveillance System (YRBS), in 2009, 72 percent of males in the 12th grade had reported having sexual intercourse in Nevada.[2]

Proportion of Male Adolescents Who Have Ever Had Sexual Intercourse, Grades 9-12, Nevada Residents by Race/ Ethnicity, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

In Nevada, during 2009, over 40 percent of White male adolescents and over 50 percent of Hispanic male adolescents, reported ever having sexual intercourse.[2] Reliable counts were not available for the other racial/ethnic groups.



Data not available in 2007 for 12th grade, <100 respondents for the subgroup.

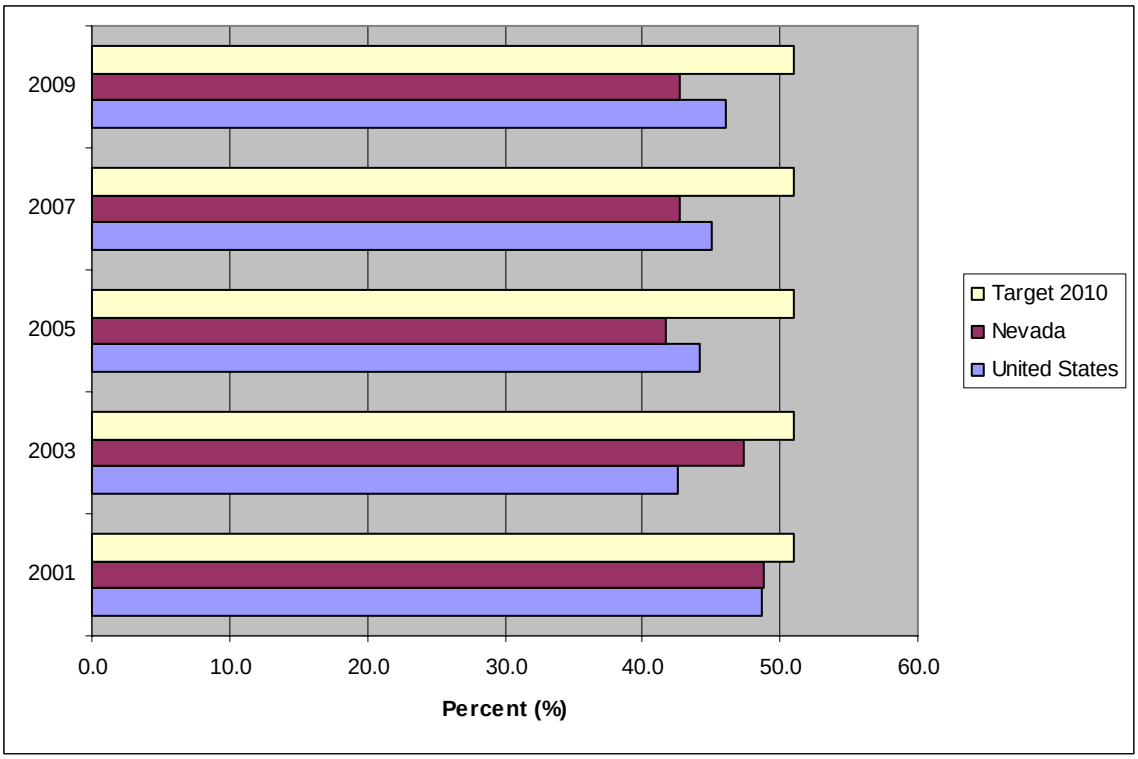
*Individual county data are not available.
Note: Data are not available for Black and Other race/ethnicity groups due to <100 respondents for those subgroups.
Note: Data are not available for 12th grade group for the year 2007 due to <100 respondents.

Healthy People 2010 Objective (9-10e.): Increase the proportion of female adolescents aged 15 to 17 years who used a condom at last intercourse.

Healthy People 2020 Objective FP HP2020-10.3: Increase the proportion of sexually active females aged 15 to 19 years who used a condom at last intercourse.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
42.7	46.1	51.0**	58.1	Improving

Proportion of Female Adolescents Who Did Not Use a Condom During Last Sexual Intercourse, Grades 9-12, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



From 2001 to 2009, in Nevada, over 40 percent of female adolescents, grades 9-12, did not use a condom during their last sexual intercourse. The national percentage is slightly higher.[2]

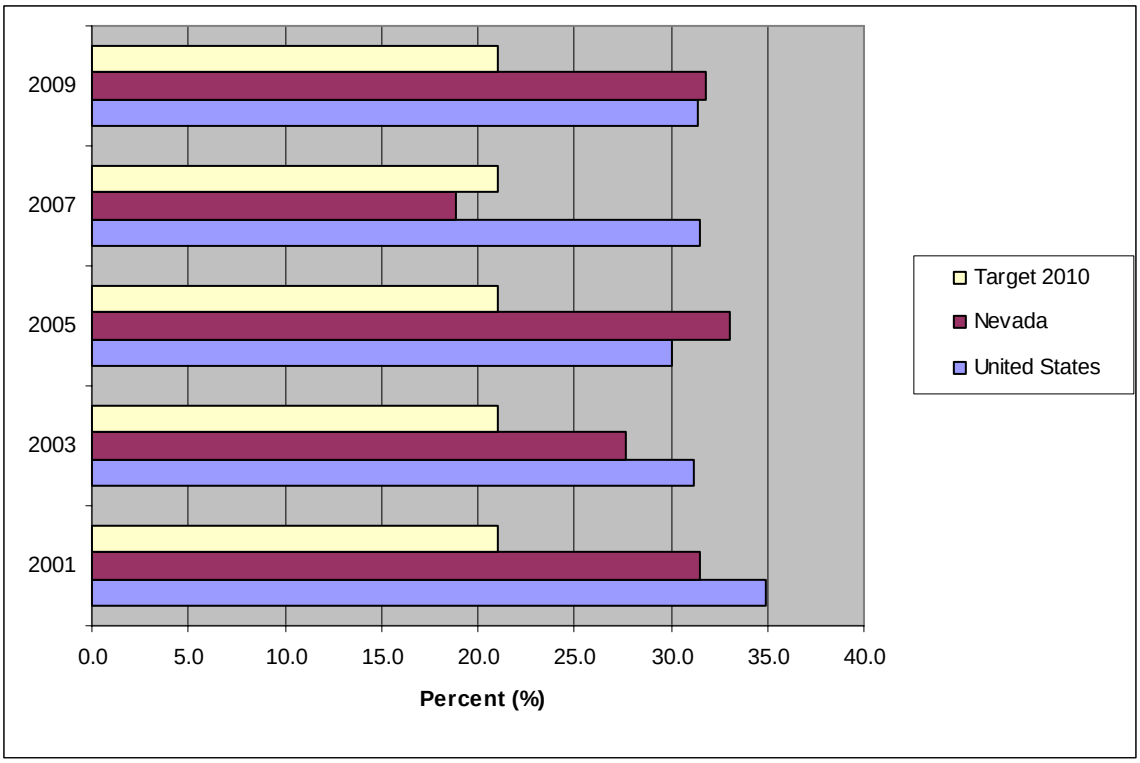
*Individual county data are not available. Race/ethnicity and grade data are not available due to <100 respondents from those subgroups.
**The Healthy People 2010 target was changed to represent the proportion of females who did not use a condom during last sexual intercourse, rather than females who used a condom during last sexual intercourse.

Healthy People 2010 Objective (9-10f.): Increase the proportion of male adolescents aged 15 to 17 years who used a condom at last intercourse.

Healthy People 2020 Objective FP HP2020-10.4: Increase the proportion of sexually active males aged 15 to 19 years who used a condom at last intercourse.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
31.8	31.4	21.0**	85.7	Fluctuating

Proportion of Male Adolescents, Grades 9-12, Who Did Not Use a Condom During Last Sexual Intercourse, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.**



According to the Youth Risk Behavior Surveillance System (YRBS), in 2009, 32 percent of male adolescents in Nevada did not use a condom during their last sexual intercourse.[2]

Nationally, the percentage of male adolescents, grades 9-12, not using a condom decreased from 2001 to 2009. Nevada's percentage fluctuated from 2001 to 2009. The Healthy People 2010 target was met by the state in 2007.

*Individual county data are not available. Race/ethnicity and grade data are not available due to <100 respondents from those subgroups.
**The Healthy People 2010 target was changed to represent the proportion of males who did not use a condom during last sexual intercourse, rather than males who used a condom during last sexual intercourse.

Food Safety

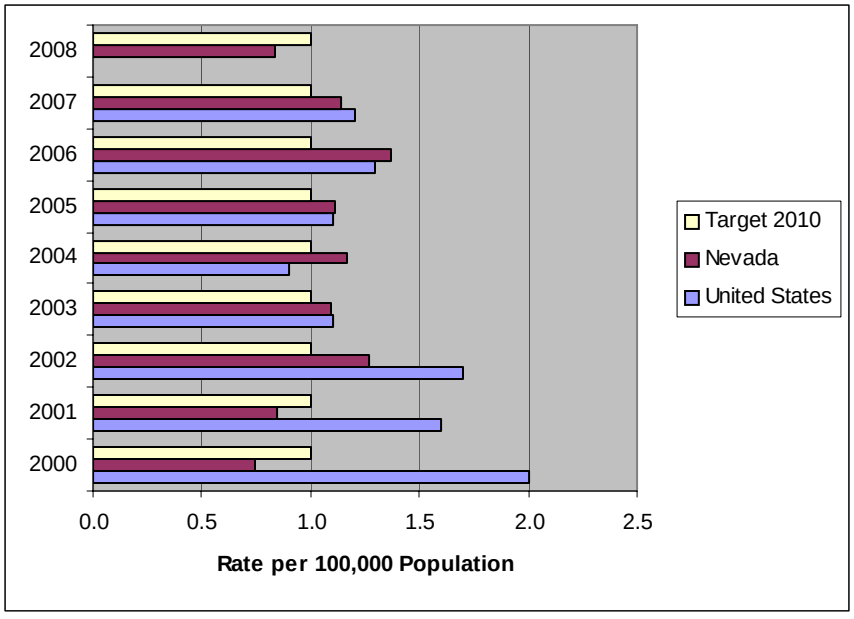
Foodborne disease is caused by consuming contaminated foods or beverages. The most commonly recognized foodborne infections are those caused by the bacteria *Campylobacter jejuni,* Salmonella, Listeria monocytogenes, Toxoplasma, E.Coli 0157:H7, and by a group of viruses called calicivirus, also known as the Norwalk virus. An estimated 76 million cases of foodborne disease occur each year in the United States. The great majority of these cases are mild, although some cases are more serious. The CDC estimates that there are 325,000 hospitalizations and 5,000 deaths related to foodborne diseases each year.[1] The most severe cases tend to occur in the very old, the very young, and those who have an illness already which reduces their immune system function.

Healthy People 2010 Objective (10-1b.): Reduce infections caused by key foodborne pathogens, Escherichia Coli 0157:H7.

Healthy People 2020 Objective FS HP2020-1.2: Reduce infections caused by key pathogens transmitted commonly through food, Shiga toxin-producing *Escherichia coli* (STEC) O157:H7.

Most Recent NV Value (2008)	U.S. (2007)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
0.8	1.2	1.0	0.6	Achieved

Rate of Reported Cases of Escherichia Coli 0157:H7, Nevada Residents and United States, NEDSS Data, 2000 - Most Current Data.*



Foodborne disease rates fluctuated in Nevada and declined in the United States From 2000 to 2008 and 2007 respectively.

Irrespective of the surveillance system, many cases of foodborne illness are not reported because the ill person does not seek medical care, the health care provider does not obtain a specimen for diagnosis, the laboratory does not perform the necessary diagnostic test, or the illness or laboratory findings are not communicated to public health officials.[1]

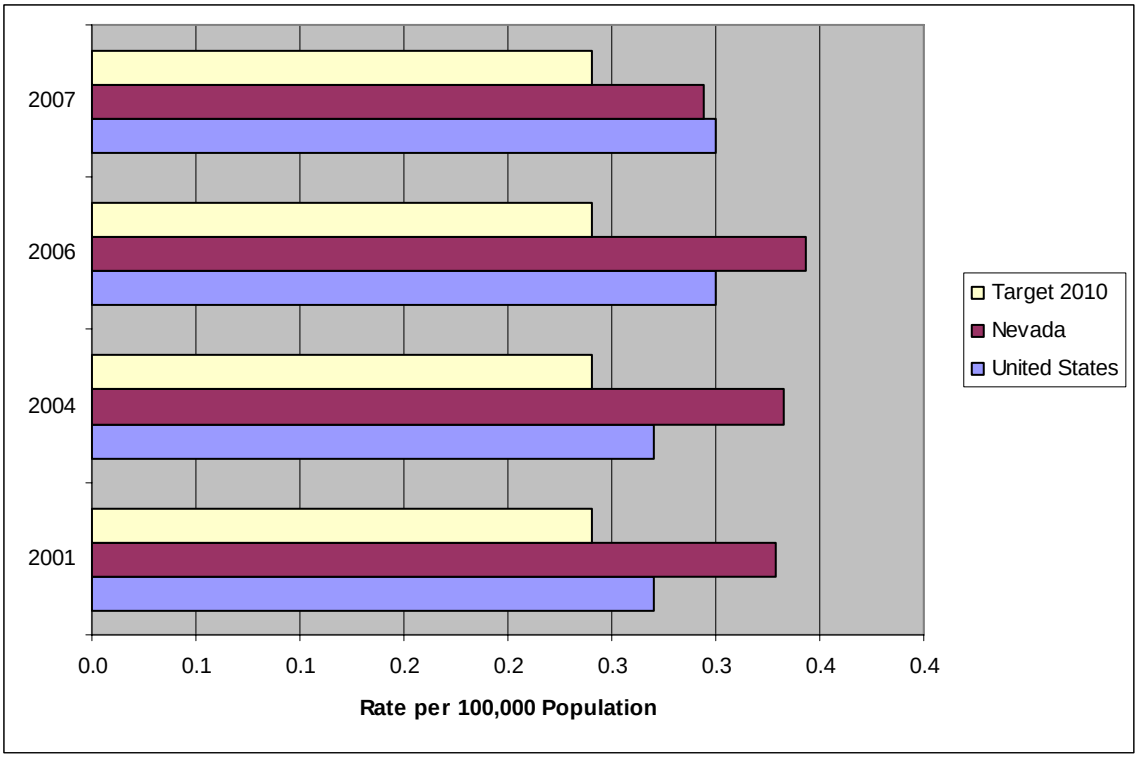
*The Nevada data are from the National Electronic Telecommunications System for Surveillance (NETSS) from 2000 to date for Clark County and for the years 2000 to 2004 for all other counties. The Nevada data are from the National Electronic Diseases Surveillance System (NEDSS) for 2005 to date for all other counties except Clark County. U.S. data are from the National Electronic Diseases Surveillance System (NEDSS).
Note: See appendix for additional information.

Healthy People 2010 Objective (10-1c.): Reduce infections caused by key foodborne pathogens, Listeriosis.

Healthy People 2020 Objective FS HP2020-1.3: Reduce infections caused by key pathogens transmitted commonly through food, *Listeria Monocytogenes.*

Most Recent NV Value (2007)	U.S. (2007)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
.29	.30	.24	.2	Fluctuating

Rate of Reported Cases of Listeriosis, Nevada Residents and United States, NEDSS Data, 2001, 2004, 2006, 2007.*



Neither Nevada, nor the nation, met the Healthy People 2010 target in the reported years.

Listeriosis is a serious infection caused by eating food contaminated with bacteria called Listeria monocytogenes. Persons with listeriosis usually have: fever, muscle aches, nausea or diarrhea. If the infection spreads to the nervous system, the following symptoms may occur: headache, stiff neck, confusion, loss of balance, and convulsions. Symptoms may occur within as few as three days to as many as 70 days after consumption of contaminated food.[2]

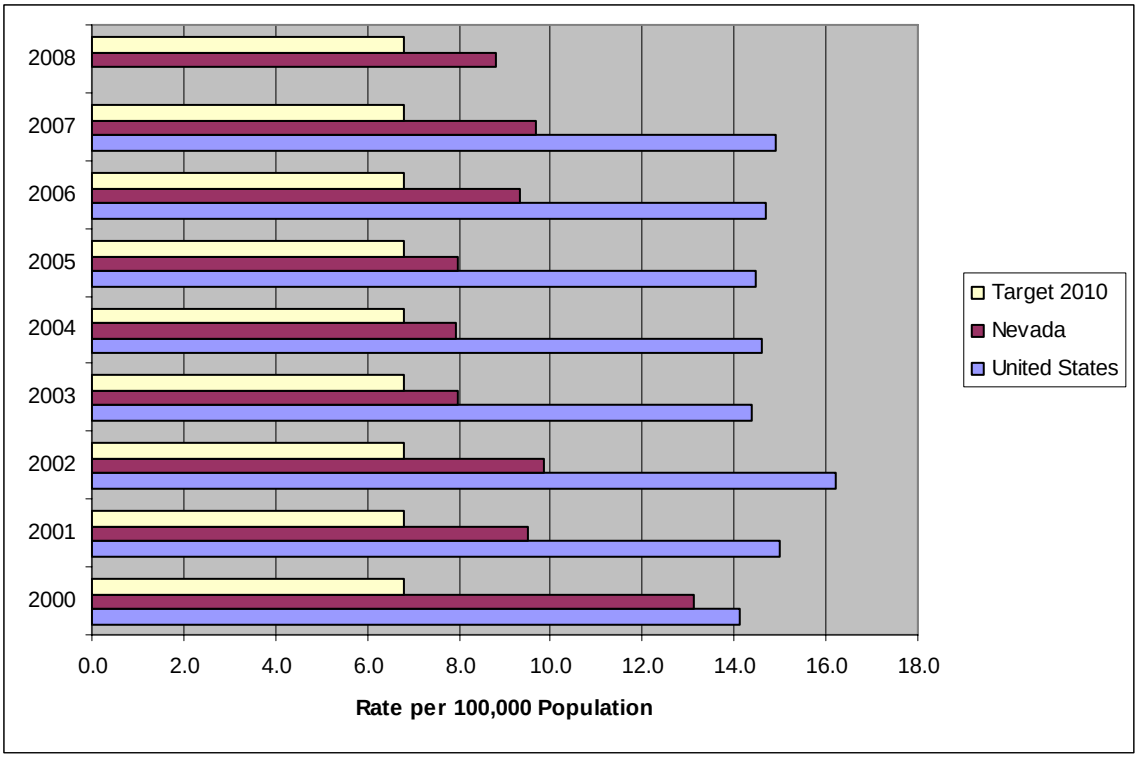
*The Nevada data are from the National Electronic Telecommunications System for Surveillance (NETSS) from 2000 to date for Clark County and for the years 2000 to 2004 for all other counties. The Nevada data are from the National Electronic Diseases Surveillance System (NEDSS) for 2005 to date for all other counties except Clark County. U.S. data are from the National Electronic Diseases Surveillance System (NEDSS).
Note: See appendix for additional information.

Healthy People 2010 Objective (10-1d.): Reduce infections caused by key foodborne pathogens, Salmonella.

Healthy People 2020 Objective FS HP2020-1.4: Reduce infections caused by key pathogens transmitted commonly through food, *Salmonella species.*

Most Recent NV Value (2008)	U.S. (2007)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
8.8	14.9	6.8	11.4	Fluctuating

Rate of Reported Cases of Salmonella, Nevada Residents and United States, NEDSS Data, 2000 - Most Current Data.*



Both Nevada and the U.S. had rates above the Healthy People 2010 target for reported cases of salmonella in the reported years. According to the CDC more than 200 known diseases are transmitted through food. The causes of foodborne illness include viruses, bacteria, parasites, toxins, metals, and prions. The symptoms of foodborne illness range from mild gastroenteritis to life-threatening neurologic, hepatic, and renal syndromes. In the United States, foodborne diseases have been estimated to cause 6 million to 81 million illnesses and up to 9,000 deaths each year.[3]

*The Nevada data are from the National Electronic Telecommunications System for Surveillance (NETSS) from 2000 to date for Clark County and for the years 2000 to 2004 for all other counties. The Nevada data are from the National Electronic Diseases Surveillance System (NEDSS) for 2005 to date for all other counties except Clark County. U.S. data are from the National Electronic Diseases Surveillance System (NEDSS).
Note: See appendix for additional information.

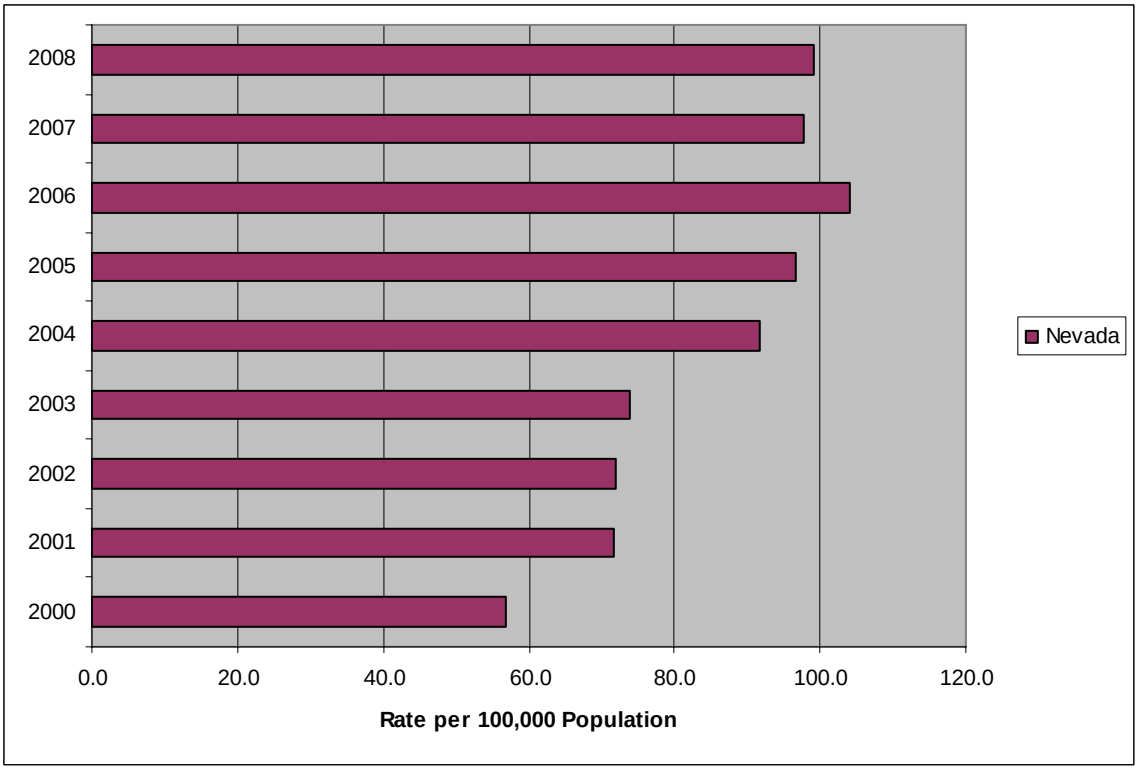
Health Care-Associated Infections

Health Care-Associated Infections (HAI) contribute significantly to hospital morbidity and mortality. It is estimated in the U.S. there are roughly 1.7 million infections and 99,000 deaths per year due to HAI.[1] HAIs are among the leading causes of preventable deaths in the U.S. Additionally, the financial burden attributed to HAIs cost the health care system up to $31.5 billion in excess health care expenditures (70 percent preventable infections).[2]

Healthy People 2020 Objective HAI HP2020-2: Reduce invasive methicillin-resistant Staphylococcus Aureus (MRSA) infections.

Most Recent NV Value (2008)	U.S.	HP 2010 Target	HP 2020 Target	Progress Towards Targets
98.4		N/A	6.56	N/A

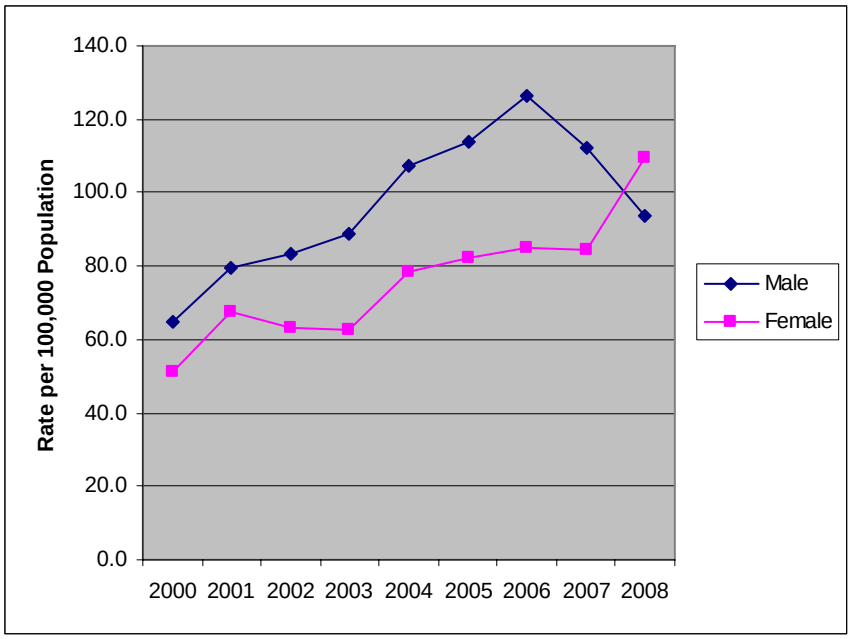
Age Adjusted Hospitalization Rate of Invasive Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections, Nevada Residents, 2000 - 2008.*



MRSA stands for methicillin resistant Staphylococcus aureus, a bacterium that has developed a resistance to most antibiotics commonly used for staphylococcus infections.[3] In Nevada, the rate of MRSA infections almost doubled from 2000 to 2008. During the years 2007 to 2008 the rate of MRSA infections was 98.4 per 100,000 people.

*The Nevada data are from the Nevada Inpatient Hospital Discharge Database (NIHDD).
Note: See appendix for additional information.

Age adjusted Hospitalization Rate of Invasive Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections, Nevada Residents by Gender, 2000 - 2008.*



In 2006, Males had a 30 percent higher rate of MRSA infections than females in Nevada. MRSA most often spreads from person to person by direct contact. For example, in medical settings MRSA is spread most commonly from patient to patient by health care workers' hands.[3]

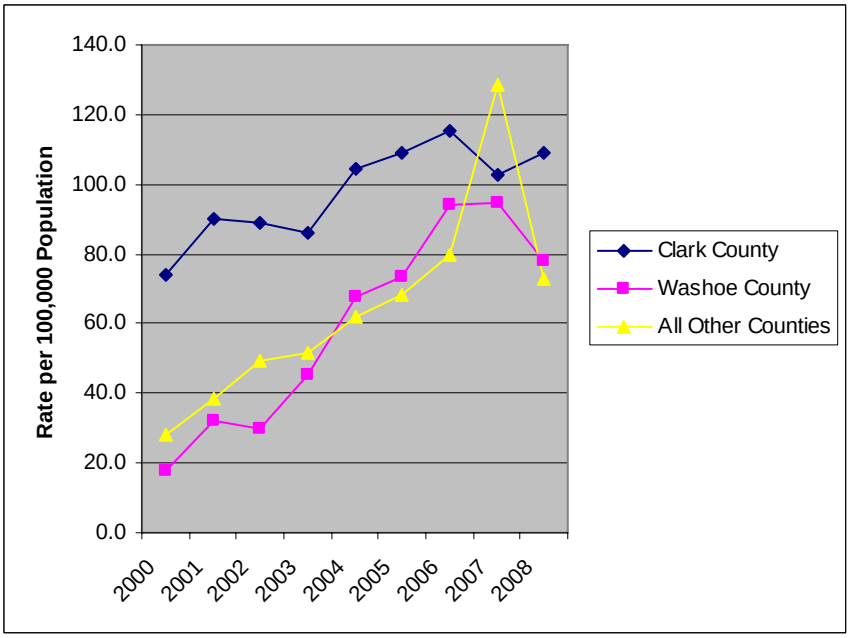
The most effective way to prevent the spread of infection is by proper hand washing, i.e. lathering with soap and water for at least 20 seconds and rinsing with warm water.[3]

In 2008, females had a higher rate of MRSA infections than males in Nevada.

Infections caused by MRSA are very difficult to treat. Typically, MRSA infections are treated intravenously with an antibiotic called vancomycin. The side effects of this drug may be quite severe, especially in older or immunodeficient patients. Patients with invasive devices such as catheters, nasogastric or gastrostomic tubes, or with intravenous lines are much more prone to infections, including MRSA.[3]

In general, Clark County has reported a higher rate of MRSA than the rest of the state's regions. MRSA rates for all three regions increased from 2000 to 2008.

Age adjusted Hospitalization Rate of Invasive Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections, Nevada Residents by County/Region, 2000 - 2008.*



*The Nevada data are from the Nevada Inpatient Hospital Discharge Database (NIHDD)
Note: See appendix for age-group and additional county breakdowns. Race/Ethnicity data is not available.

Heart Disease and Stroke

Heart disease is the leading cause of death for both men and women in the United States and Nevada. In 2006, 631,636 people died of heart disease in the U.S. Of the deaths that year, 26 percent or more than one in every four deaths were caused by heart disease. Several medical conditions and lifestyle choices can increase the risk for heart disease, including high cholesterol, high blood pressure, diabetes, cigarette smoking, overweight and obesity, poor diet, physical inactivity and alcohol use.[1]

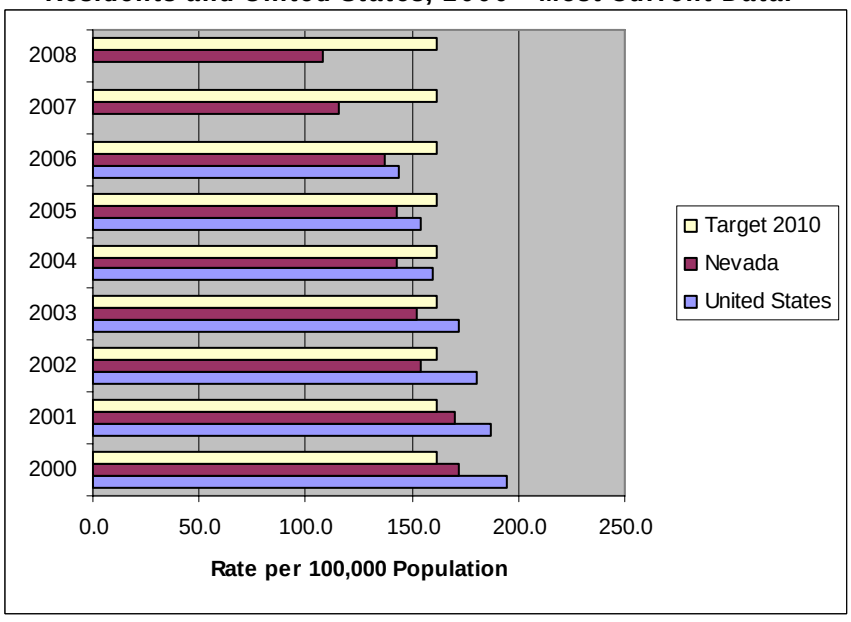
Stroke is the third leading cause of death after heart disease and cancer in the United States. Approximately 137,000 Americans die of stroke every year.[1] A stroke occurs when a clot blocks the blood supply to the brain or when a blood vessel in the brain bursts. Stroke can cause death or significant disability, such as paralysis, speech difficulties, and emotional problems. In 2005, nearly 1.1 million stroke survivors reported difficulty performing basic activities of daily life.[1]

Healthy People 2010 Objective (12-1): Reduce coronary heart disease deaths.

Healthy People 2020 Objective HDS HP2020-2: Reduce coronary heart disease deaths.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
107.8	144.0	162.0	100.8	Surpassed

Age-Adjusted Coronary Heart Disease Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*

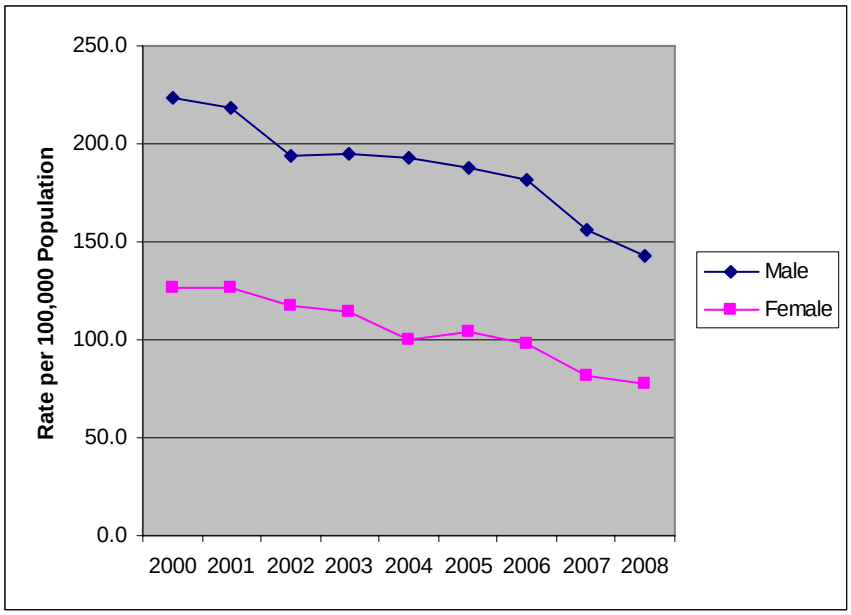


Cardiovascular disorders represent one of the greatest challenges confronting modern health care. The estimated toll in human life and economic cost, combined with the inestimable effects on quality of life for individuals and families, transcends all gender, racial, ethnic, and socioeconomic groups.[2]

Coronary heart disease mortality decreased this decade in both Nevada and the U.S. From 2004 to 2008, both the national and state rates surpassed the Healthy People 2010 target.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Coronary Heart Disease Death Rate, Nevada Residents by Gender, 2000 - 2008.*



The signs of a heart attack are:[2]

- Chest discomfort
- Discomfort in areas of the upper body
- Shortness of breath
- Other symptoms such as sweating, nausea, and light-headedness

The following additional signs should be considered when assessing heart attack risk for women:[2]

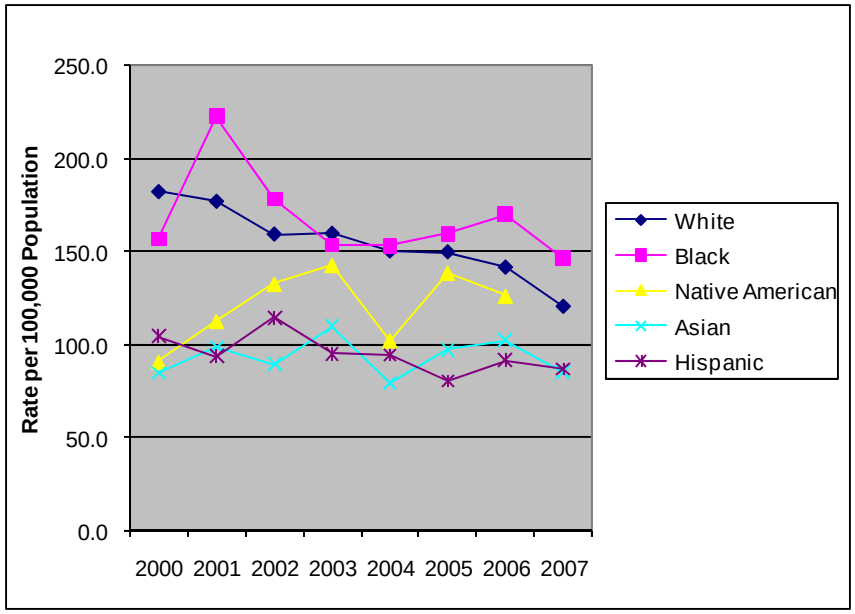
- Unusual tiredness
- Trouble sleeping
- Problems breathing
- Indigestion
- Anxiety

In Nevada, men had over twice the coronary heart disease mortality rate of women from 2000 to 2008. Rates fro both genders decreased this decade.

In Nevada, White men and Black females had the highest prevalence rates for coronary heart disease and myocardial infarction.[2]

The mortality rates per 100,000 for Blacks in general, both nationally and in Nevada, show a significantly higher rate when compared to Whites. The majority of research shows that Blacks have both a higher prevalence and mortality rate when compared to Whites.[2]

Age-Adjusted Coronary Heart Disease Death Rate, Nevada Residents by Race/Ethnicity, 2000 - 2007.*



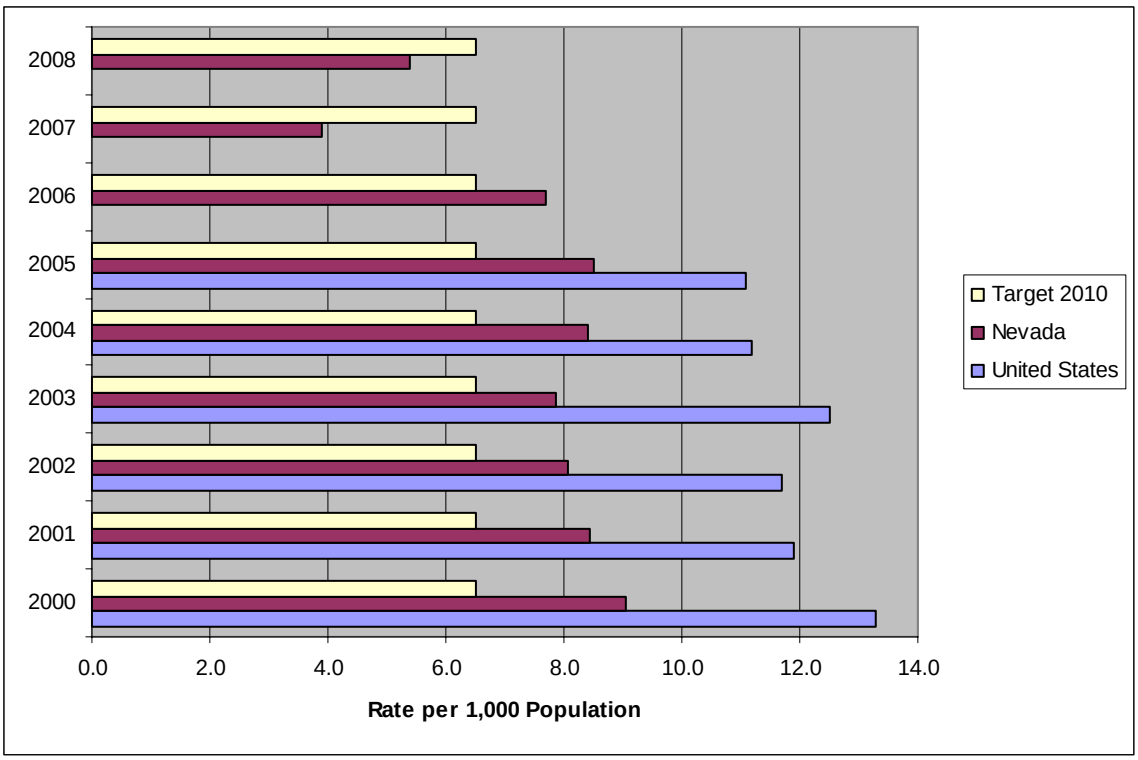
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for age group, county, and additional race/ethnicity breakdowns.

Healthy People 2010 Objective (12-6a.): Reduce the rate of hospitalizations of older adults aged 65 to 74 years with congestive heart failure.

Healthy People 2020 Objective HDS HP2020-24.1: Reduce the rate of hospitalizations of older adults aged 65 to 74 years with heart failure as the principal diagnosis.

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
5.4	11.1	6.5	8.8	Surpassed

Rate of Hospitalizations of Older Adults Aged 65 to 74 Years With Congestive Heart Failure, Nevada Residents and United States, 2000 - Most Current Data.*



Over the last decade, Nevada has maintained a lower hospitalization rate for congestive heart failure than the national average. Nevada also surpassed the Healthy People 2010 target for this indicator in 2007 and 2008.

Public education is a critical component of any effective intervention strategy for heart disease and stroke prevention programs. Human behavior is always one of the most difficult aspects in addressing any issue. For many motivation for change will only occur after a significant life-altering event. However, there are a number of individuals, if given adequate information and useful suggestions for change, will attempt to alter and adjust behaviors and lifestyle.[2]

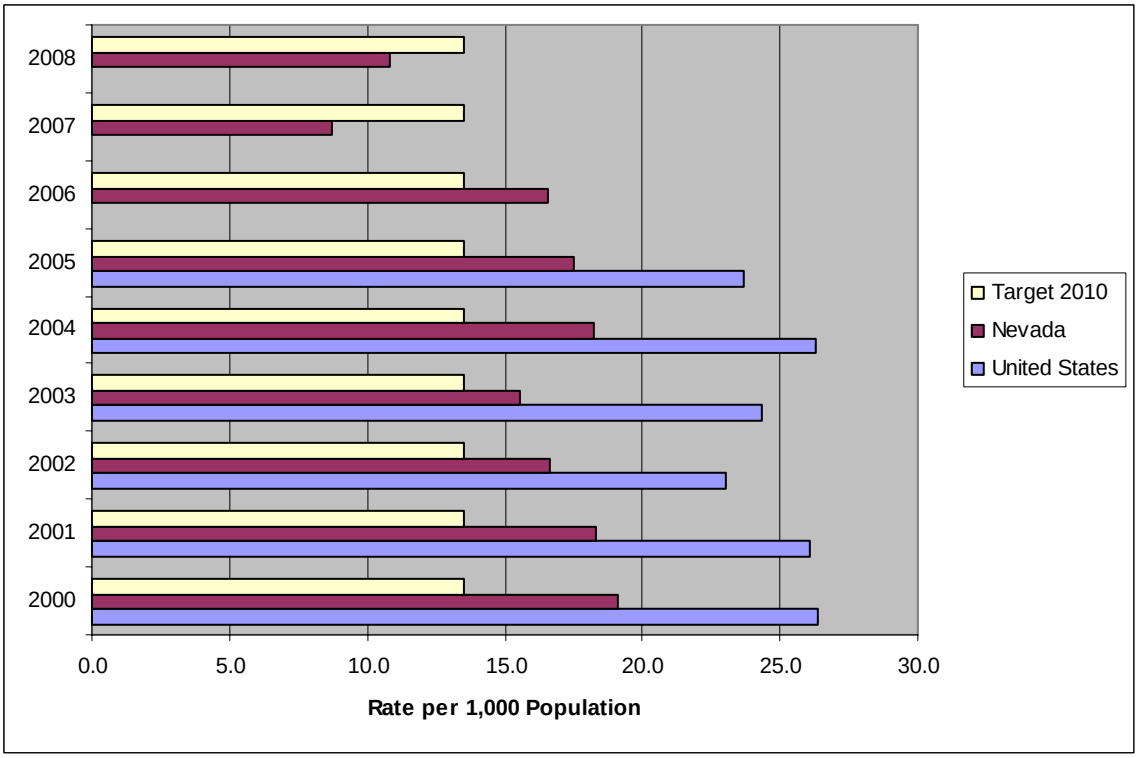
*The Nevada data are from Nevada Inpatient Hospital Discharge (NIHDD). The U.S. data are from the National Hospital Discharge Survey (NHDS).
Note: See appendix for additional information.

Healthy People 2010 Objective (12-6b.): Reduce the rate of hospitalizations of older adults aged 75 to 84 years with congestive heart failure.

Healthy People 2020 Objective HDS HP2020-24.2: Reduce the rate of hospitalizations of older adults aged 75 to 84 years with heart failure as the principal diagnosis.

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
10.8	23.7	13.5	20.2	Surpassed

Rate of Hospitalizations of Older Adults Aged 75 to 84 Years With Congestive Heart Failure, Nevada Residents and United States, 2000 - Most Current Data.*



From 2007 to 2008, Nevada surpassed the Healthy People 2010 target for hospitalizations of adults, aged 75 to 85 years with congestive heart failure.

Genetics and family history weigh into the risk factors. As with all disease, the basic genetic materials provided at birth can predispose future pathological process. The key in this discussion is the term predisposition. Some individuals are more likely to be at risk for certain diseases, but that does not condemn them to a statistical certainty. A number of events and behaviors contribute to an individual life. A person's health is as much a matter of choices as it is genetics. Some elements of risk cannot be eliminated, but the effects can be reduced through educated and informed decisions combined with acceptance of responsibility for outcomes.[2]

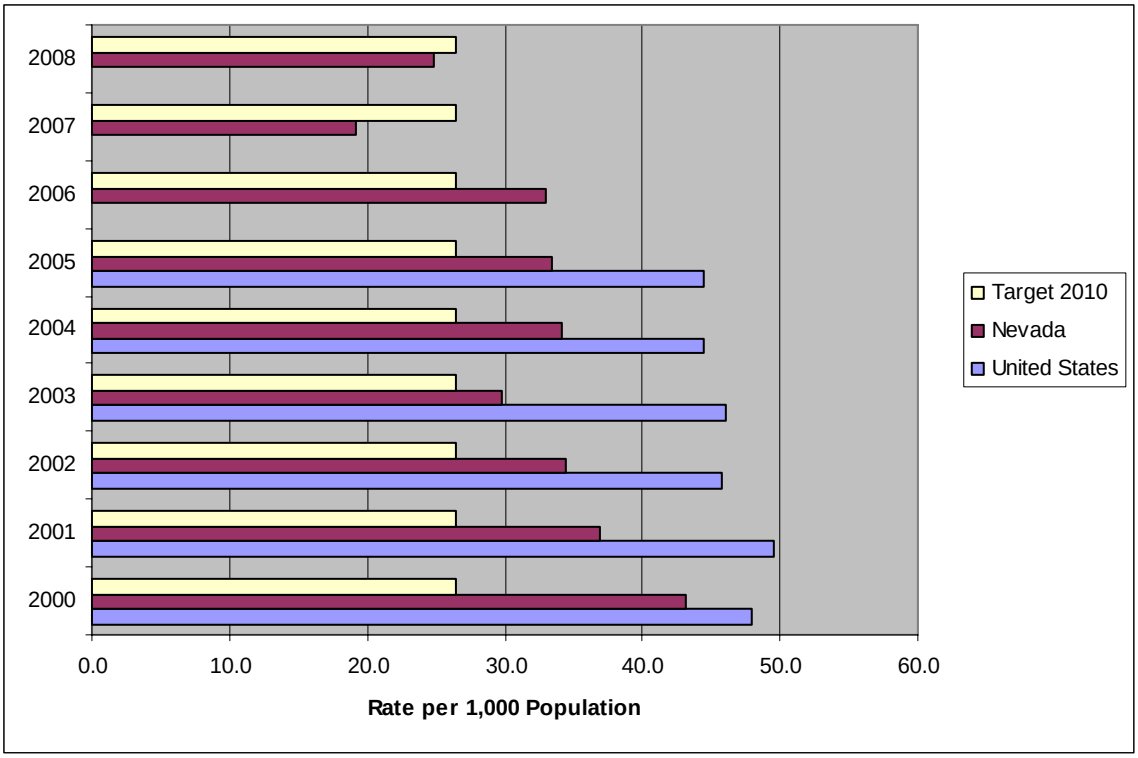
*The Nevada data are from Nevada Inpatient Hospital Discharge (NIHDD). The U.S. data are from the National Hospital Discharge Survey (NHDS).
Note: See appendix for additional information.

Healthy People 2010 Objective (12-6c.): Reduce the rate of hospitalizations of older adults aged 85 years and older with congestive heart failure.

Healthy People 2020 Objective HDS HP2020-24.3: Reduce the rate of hospitalizations of older adults aged 85 years and older with heart failure as the principal diagnosis.

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
24.8	44.5	26.5	38.6	Surpassed

Rate of Hospitalizations of Older Adults Aged 85 Years and Older With Congestive Heart Failure, Nevada Residents and United States, 2000 - Most Current Data.*



Nevada met the Healthy People 2010 target for hospitalization rate of adults, aged 85 years and older, with congestive heart failure from 2007 to 2008.

Some of the key components to successful disease prevention and management are quality health care combined with adequate resources. Community health centers provide a venue for the proper management of a variety of disorders, including high blood pressure, adequate monitoring of lab values, support for tobacco cessation, and other primary care services that are critical to the success of any health system and direct intervention services for cardiovascular diseases. In addition, the health care infrastructure must be functional and sufficient to meet the needs of all individuals, in all geographic locations.[2]

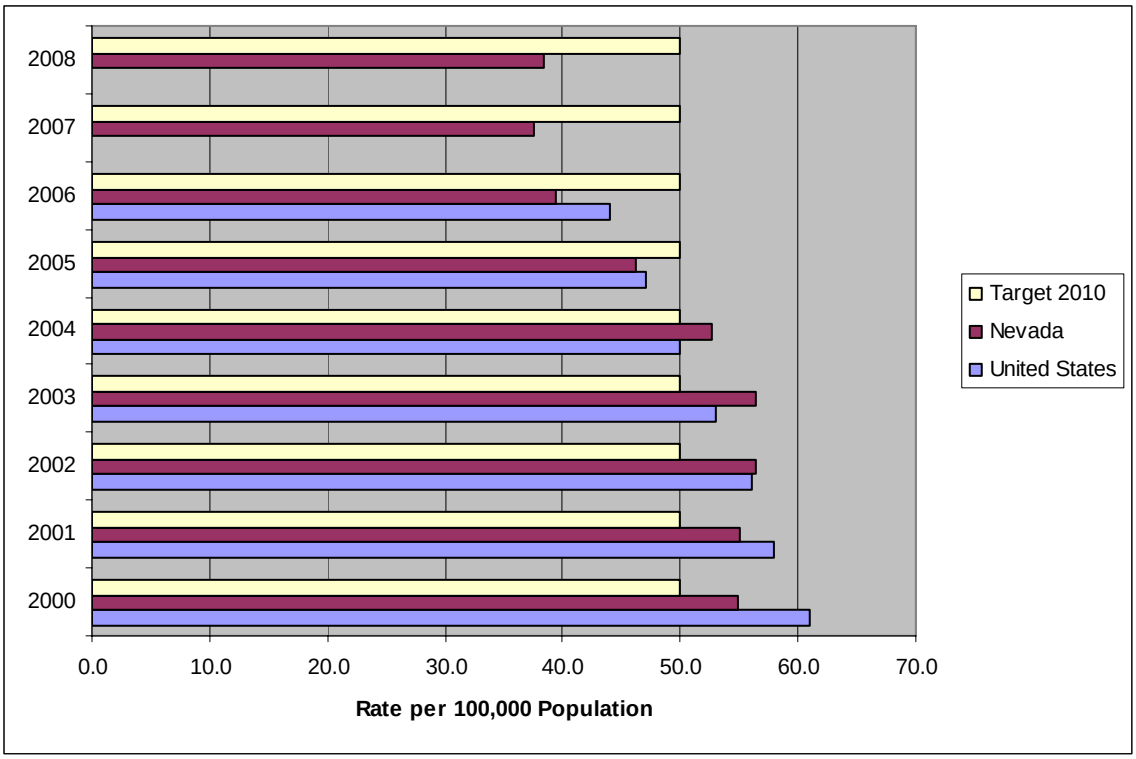
*The Nevada data are from Nevada Inpatient Hospital Discharge (NIHDD). The U.S. data are from the National Hospital Discharge Survey (NHDS).
Note: See appendix for additional information.

Healthy People 2010 Objective (12-7): Reduce stroke deaths.

Healthy People 2020 Objective HDS HP2020-3: Reduce stroke deaths.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
38.4	44.0	50.0	33.8	Surpassed

Age-Adjusted Stroke Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*

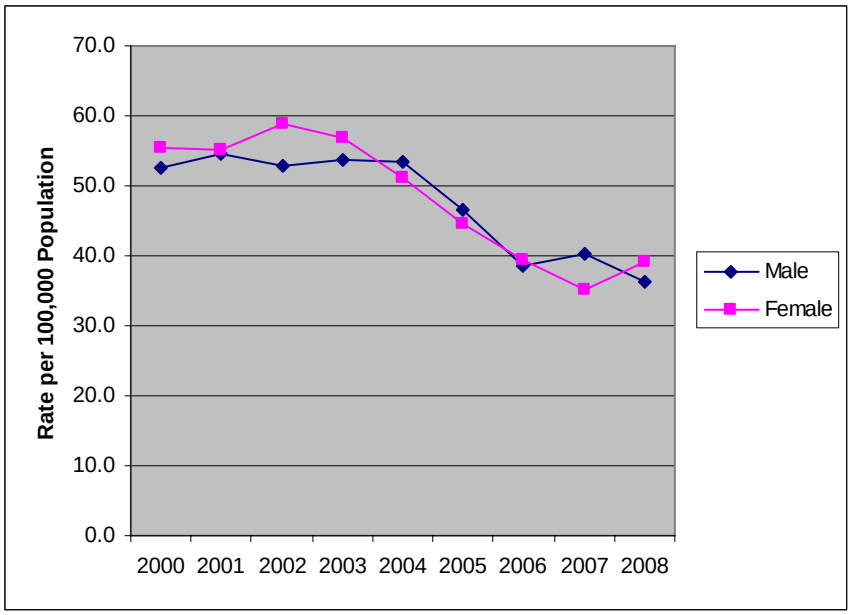


From 2005 to 2008, Nevada surpassed the Healthy People 2010 target for stroke death rate. The stroke rate death rate decreased in Nevada and the United States in the reported years, 2000 to 2008 and 2000 to 2006 respectively.

The issue of cost is frequently a topic of discussion regarding the development of services and the overall feasibility for program development or expansion. In 2005, the United States paid $394 billion for costs related to heart disease and stroke. This does not include the human toll in lives or the devastating cost related to quality of life that millions of people throughout the country face on a daily basis. The cost of prevention, related to community health centers, could save billions of dollars in health care costs and dramatically improve the quality of life for millions suffering from the effects of cardiovascular disease.[2]

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Stroke Death Rate, Nevada Residents by Gender, 2000 - 2008.*



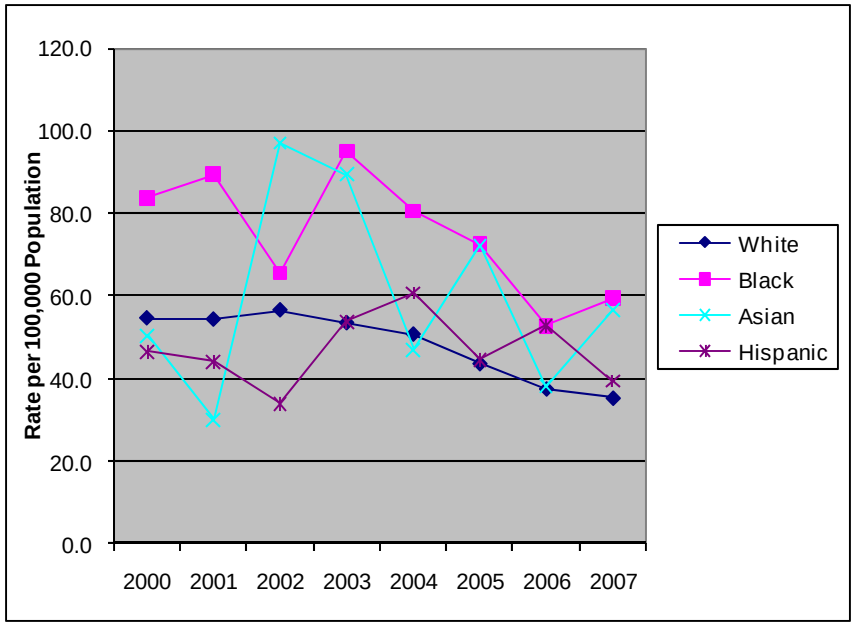
In 2004, 2005, and 2007 Nevada males had a higher stroke death rate than Nevada women.

In general, stroke death rates decreased in both genders from 2000 to 2008.

Age-Adjusted Stroke Death Rate, Nevada Residents by Race/ Ethnicity, 2000 - 2007.*

In 2003 all race/ethnic groups in Nevada reached their highest stroke death rate. This rate decreased overall for all race/ethnic groups in Nevada from 2003 to 2007.

Blacks and Asians had the highest stroke mortality rates of any racial/Ethnic group in the state in 2007.



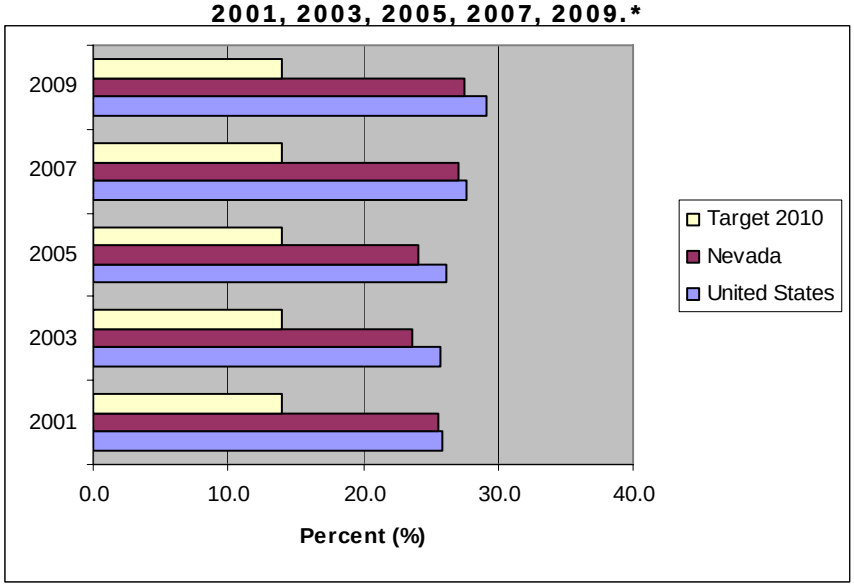
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for Native American race/ethnicity group due to small counts. See appendix for age group, county, and additional race/ethnicity breakdowns.

Healthy People 2010 Objective (12-9a.): Reduce the proportion of adults with high blood pressure.

Healthy People 2020 Objective HDS HP2020-5.1: Reduce the proportion of adults with hypertension.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
27.5	29.2	14.0	26.9	Worsening

Proportion of Adults with High Blood Pressure, Nevada Residents and United States, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*

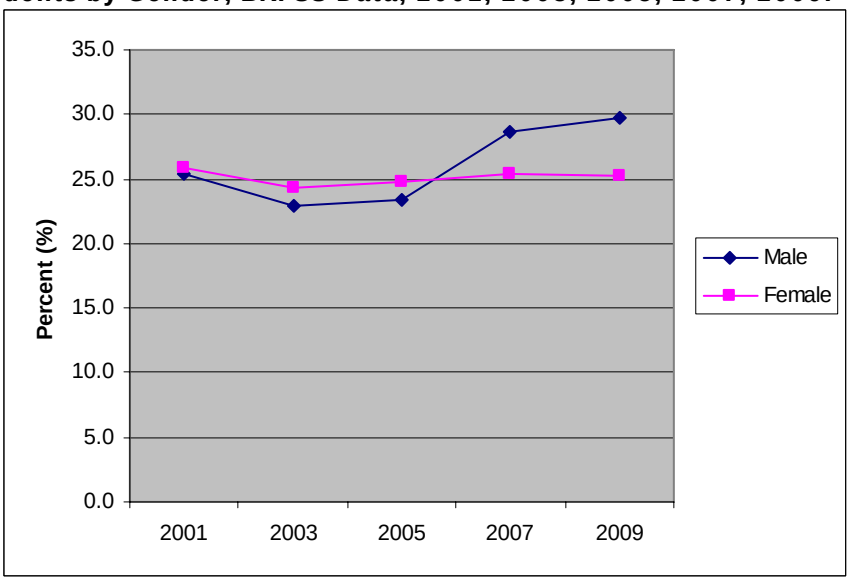


High blood pressure, or hypertension, is one of the most significant conditions considered in evaluating heart disease. High blood pressure has a number of causes, but the salient point is that high blood pressure affects the cardiovascular system. High blood pressure also must be taken into consideration regarding stroke. The possibility of both ischemic and hemorrhagic strokes is increased with elevated blood pressure.[2]

The proportion of Nevada adults who have high blood pressure was higher than the Healthy People 2010 target, but lower than the proportion of adults in all of the United States who have high blood pressure from 2001 to 2009.

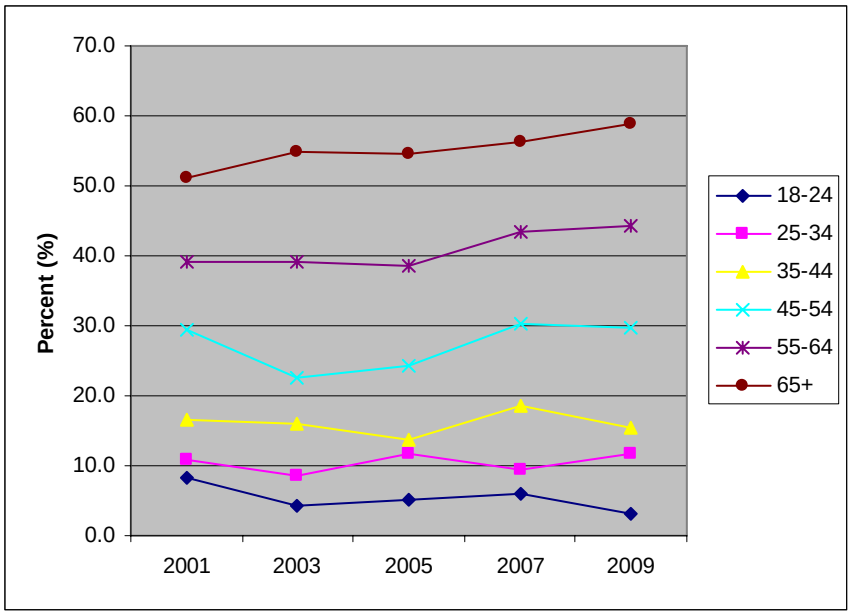
There was an increase in the proportion of Nevada males who have high blood pressure from 2001 to 2009, however this increase was seen in Nevada's female population.

Proportion of Adults with High Blood Pressure, Nevada Residents by Gender, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of Adults with High Blood Pressure, Nevada Residents by Age, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



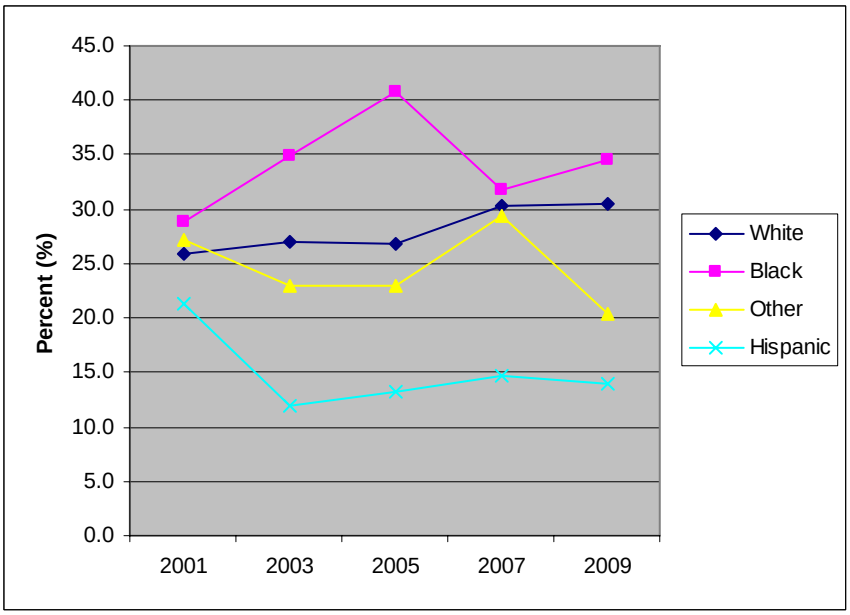
Nevada adults, aged 65 years and older, are at the highest risk for high blood pressure. In general, the risk of having high blood pressure increases with age.

Decreasing systolic blood pressure 12-13 mm Hg over four years can reduce risk for coronary heart disease by 21 percent and stroke by 37 percent. Overall, this could reduce cardiovascular disease mortality rate by 25 percent, and total mortality rate by 13 percent.[2]

High blood pressure, also referred to as hypertension, can cause a number of cardiovascular complications including cardiomyopathy (enlarged heart), heart failure, cerebrovascular disease (stroke), exacerbation of aneurysms, as well as number of other complication in the renal and other systems. High blood pressure accounts for approximately six percent of all deaths related to cardiovascular disease.[2]

BRFSS data indicates that from 2001 to 2009, Blacks had the highest risk for high blood pressure and Hispanics had the lowest risk among Nevada adults.

Proportion of Adults with High Blood Pressure, Nevada Residents by Race/Ethnicity, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



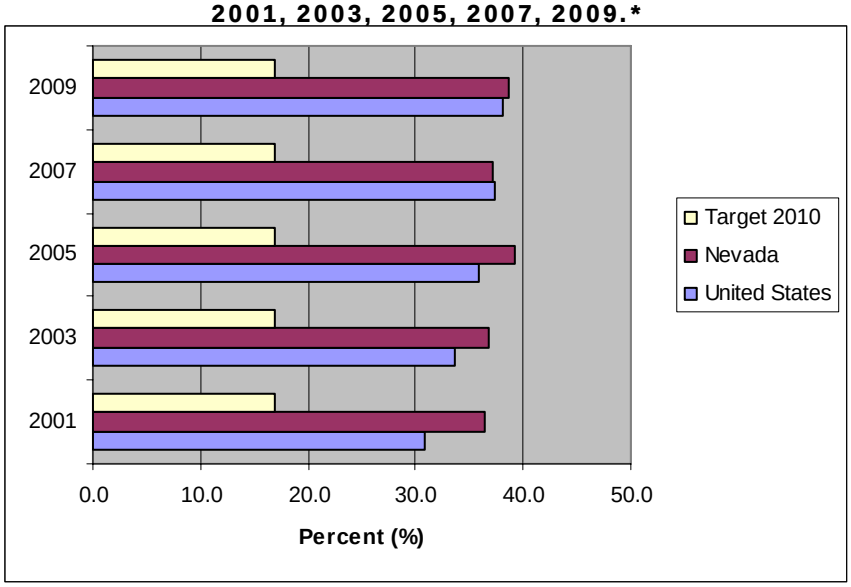
*These percentages are weighted to survey population characteristics.

Healthy People 2010 Objective (12-14): Reduce the proportion of adults with high blood cholesterol levels.

Healthy People 2020 Objective HDS HP2020-7: Reduce the proportion of adults with high total blood cholesterol levels.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
38.6	37.5	14.0	13.5	Fluctuating

Proportion of Adults with High Cholesterol Levels, Nevada Residents and United States, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*

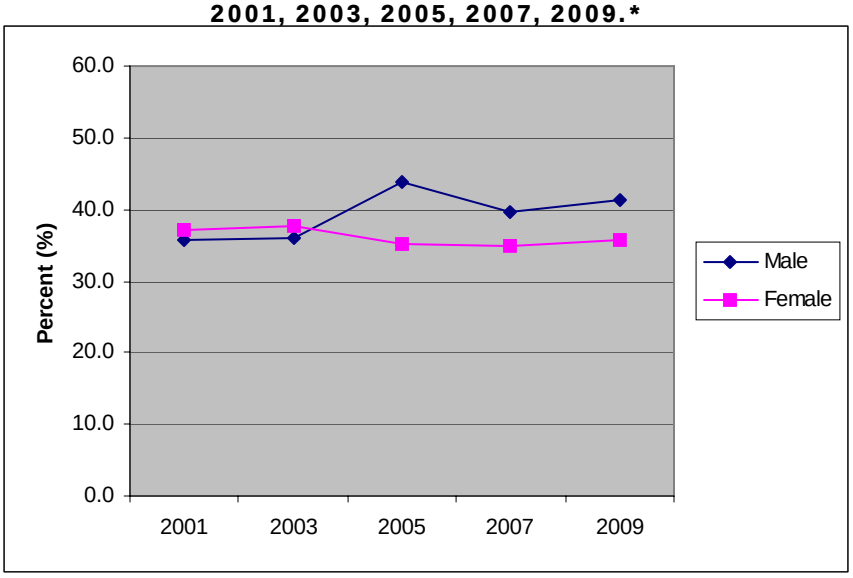


Elevated blood cholesterol levels are of concern in risk assessment for cardiovascular disease. Cholesterol becomes a problem when the liver over-produces or excessive amounts are ingested from dietary sources. An estimated decrease of 10 percent in serum cholesterol could potentially decrease the incidence of heart attacks and stroke by 30 percent.[2]

In 2009, 38.2 percent of Nevada adults had high cholesterol, this is higher than the Healthy People 2010 target of 14.0 percent. Neither the United States, nor Nevada, had met the Healthy People 2010 target in 2009.

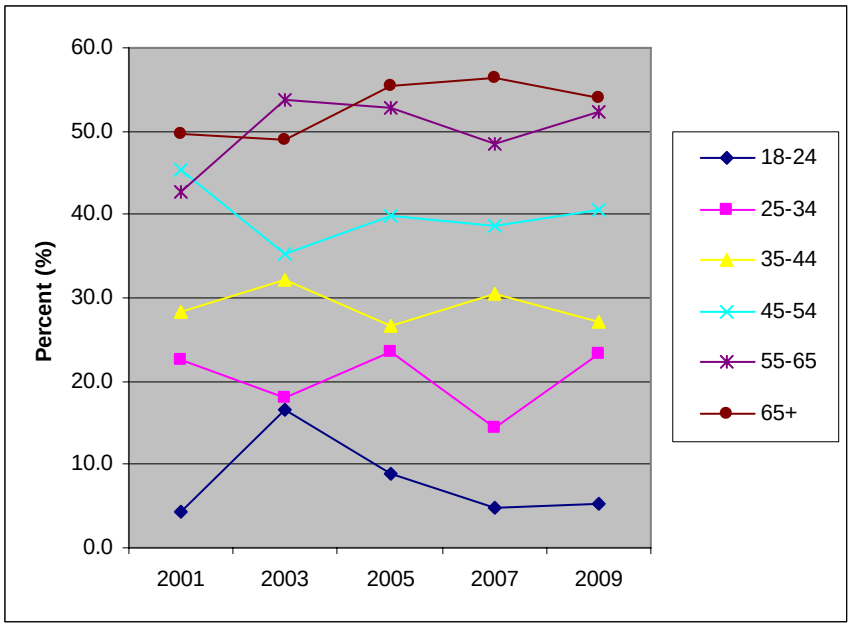
From 2005 to 2009 there had been a higher proportion of Nevada males with high cholesterol than Nevada Females.

Proportion of Adults with High Cholesterol Levels, Nevada Residents by Gender, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of Adults with High Cholesterol Levels, Nevada Residents by Age, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*

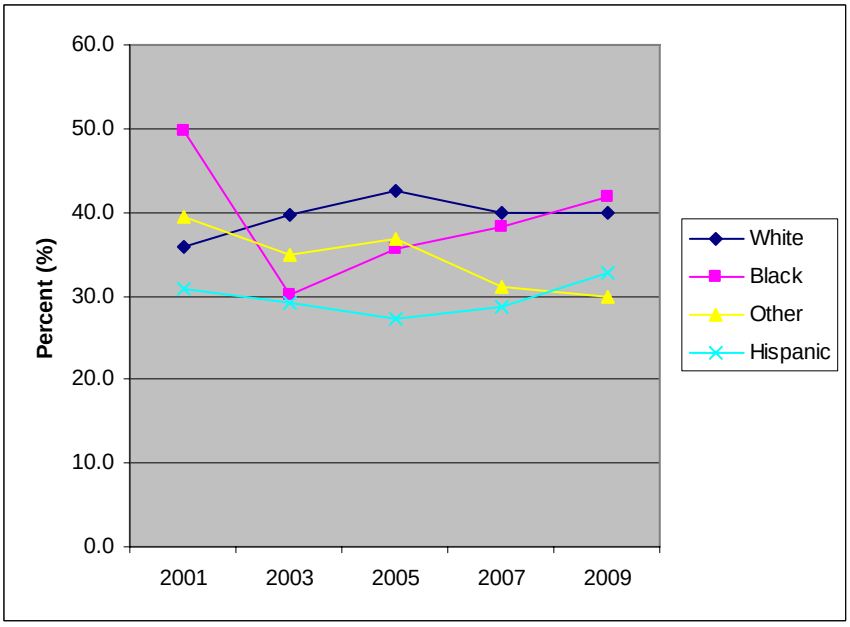


The risk of high cholesterol levels among Nevada adults increases with age.

Healthy behaviors, including a diet low in saturated fats, and regular physical activity can lower cholesterol levels.

Obesity, a condition of excessive weight and body fat, has been associated with higher levels of serum LDL cholesterol and triglycerides. Individuals considered obese are at greater risk for cardiovascular disease, stroke, as well as diabetes and other chronic disease.[2]

Proportion of Adults with High Cholesterol Levels, Nevada Residents by Race/Ethnicity, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



The Black population in Nevada had the highest risk for high cholesterol and the Hispanic population had the lowest risk among Nevada residents in 2009.

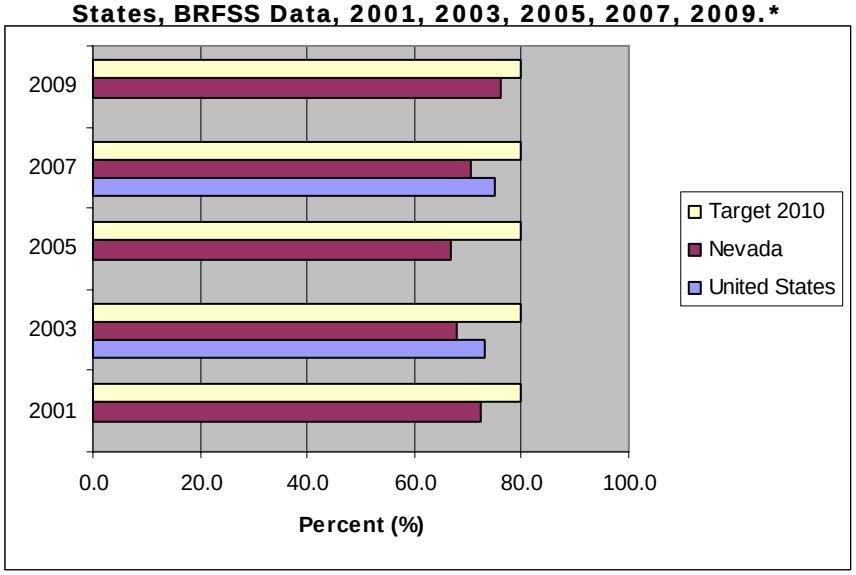
*These percentages are weighted to survey population characteristics.

Healthy People 2010 Objective (12-15): Increase the proportion of adults having had their blood cholesterol checked within the preceding 5 years.

Healthy People 2020 Objective HDS HP2020-6: Increase the proportion of adults having had their blood cholesterol checked within the preceding 5 years.

Most Recent NV Value (2009)	U.S. (2007)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
76.8	75	80.0	82.1	Improving

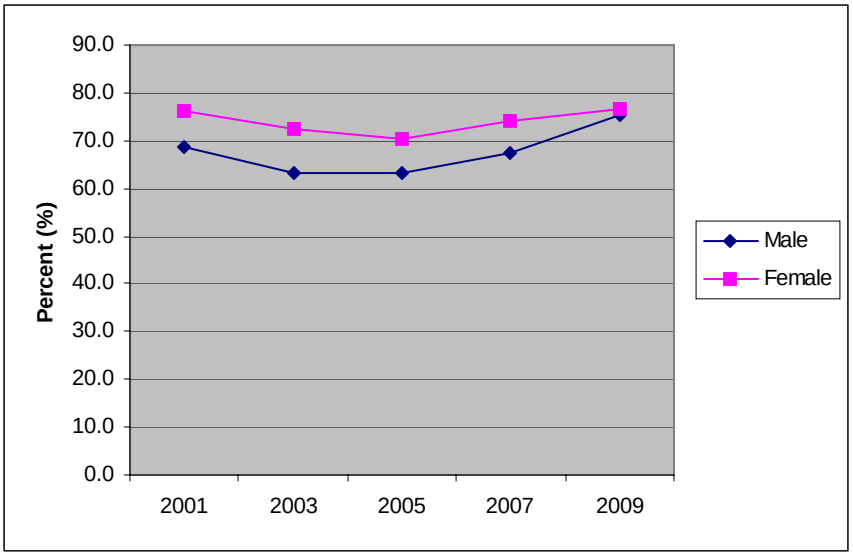
Proportion of Adults Having Their Blood Cholesterol Checked Within the Preceding 5 Years, Nevada Residents and United States, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



Neither Nevada, nor the U.S., met the Healthy People 2010 target for the percentage of adults having their blood cholesterol checked within the preceding five years in the reporting period. The proportion of adults having had their blood cholesterol check in the past five years improved from 2001 to 2009 for both regions.

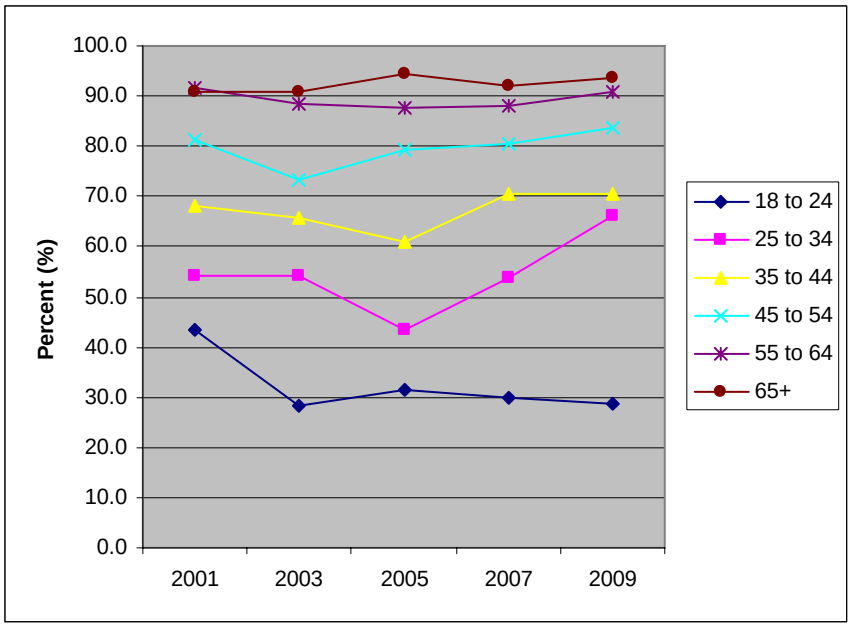
Proportion of Adults Having Their Blood Cholesterol Checked Within the Preceding 5 Years, Nevada Residents by Gender, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*

The proportion of Nevada females having had their blood cholesterol checked within the past five years was above the proportion of Nevada males having had their blood cholesterol checked within the past five years from 2001 to 2009. The difference in these proportions, however, has decreased.



*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of Adults Having Their Blood Cholesterol Checked Within the Preceding 5 Years, Nevada Residents by Age, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*

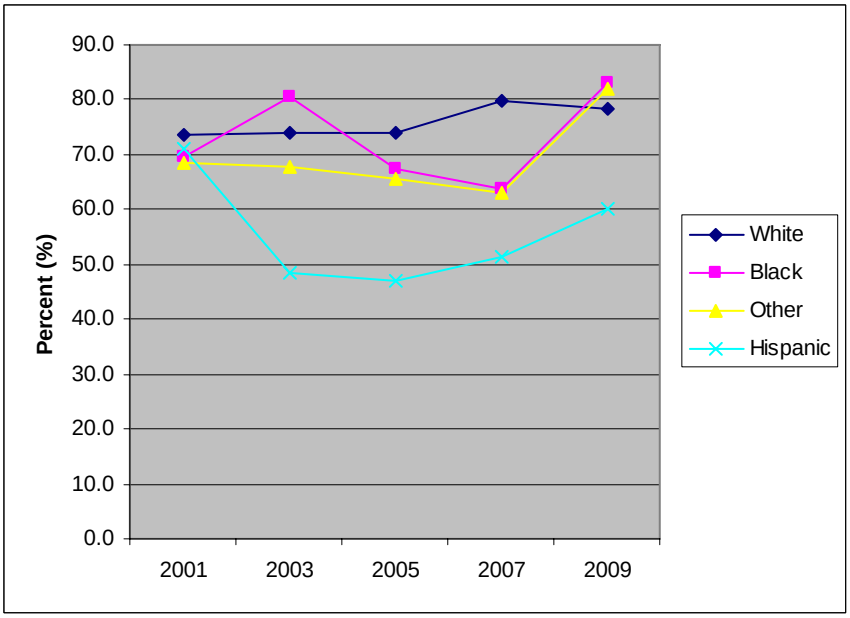


Becoming aware of high cholesterol levels via a blood cholesterol check can prolong life. Early intervention increases the potential for a positive medical outcome, thus decreasing the long-term effects of disease including morbidity, mortality, and cost, and quality of life.[2]

In Nevada, from 2001 to 2009, adults aged 65 and older had the highest proportion of people having their blood cholesterol checked within the preceding five years. 18 to 24 year olds had much lower proportions of adults having their cholesterol checked in the past 5 years.

The provision of adequate health care coverage and high quality insurance programs are an important component to good health. Health care coverage should include both prevention and treatment components in order to provide a comprehensive approach to disease identification and management. Exclusion of either component in the coverage profile leaves gaps in the disease management process, ultimately marginalizing the overall quality and effectiveness of health care services.[2]

Proportion of Adults Having Their Blood Cholesterol Checked Within the Preceding 5 Years, Nevada Residents by Race/ Ethnicity, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



In 2009, Hispanics were 20 percent less likely to have had their blood cholesterol checked in the last five years than other race/ethnicity groups in Nevada over the reported years.

*These percentages are weighted to survey population characteristics.

Human Immunodeficiency Virus (HIV)

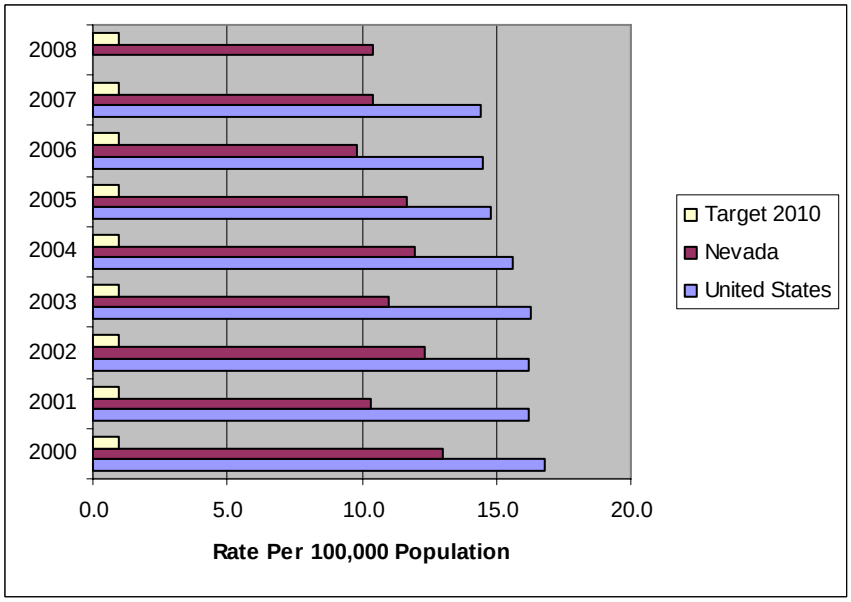
At the end of 2006, an estimated 1.1 million persons in the United States were living with diagnosed or undiagnosed HIV/AIDS. In 2007, there were approximately 42,655 new HIV infections, with the highest proportion among African Americans, despite the fact that they account for only 12 percent of the U.S. population.[1] Since the epidemic began in the U.S. in 1981, 565,927 people have died of AIDS.[2]

Healthy People 2010 Objective (13-1): Reduce AIDS among adults and adolescents.

Healthy People 2020 Objective HIV HP2020-1: Reduce acquired immune deficiency syndrome (AIDS) among adults and adolescents.

Most Recent NV Value (2008)	U.S. (2007)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
10.4	14.4	1.0		Improving

Reported AIDS Cases, Nevada Residents and United States, 2000 - Most Current Data.*



The rate of reported AIDS cases in both Nevada and the U.S. decreased from 2000 to 2008.

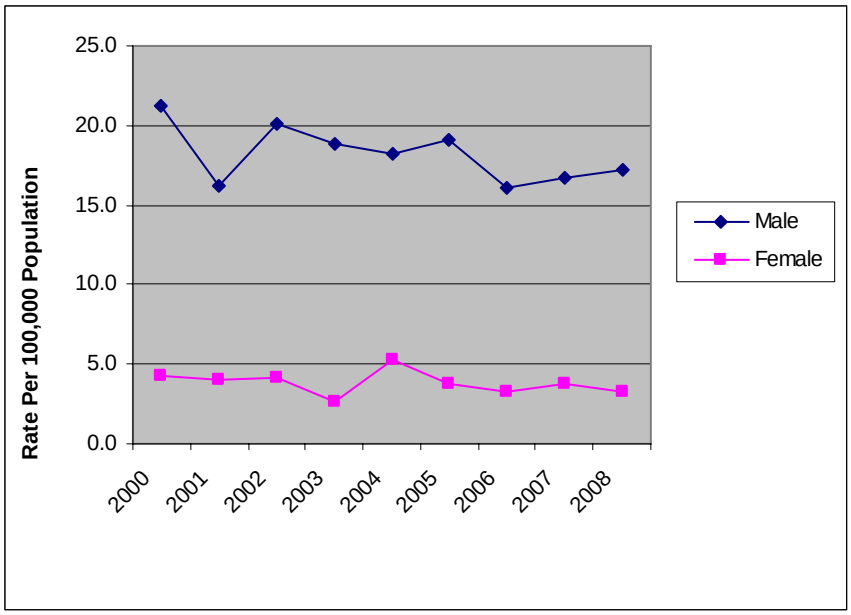
In 2007, Nevada had four less reported AIDS cases per 100,000 compared to the national average.

Neither the state, nor the nation, reached the Healthy People 2010 target for reported AIDS cases this decade, 1.0 per 100,000 people.

21 percent of those infected with HIV are unaware of their infection.[2]

*The Nevada data are from the Enhanced HIV/AIDS Reporting System (eHARS), and the U.S. data is from the HIV/AIDS Reporting System, Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
Note: See appendix for additional information.

Reported AIDS Cases, Nevada Residents and by Gender, 2000 - 2008.*

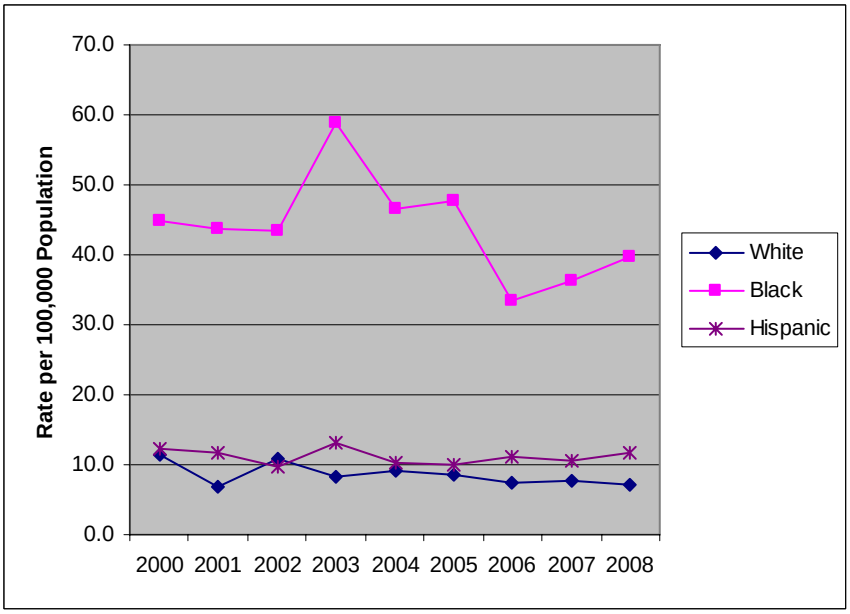


From 2000 to 2008, males had a higher rate of reported AIDS cases than females in Nevada.

Reported AIDS Cases, Nevada Residents by Race/Ethnicity, 2000 - 2008.*

Blacks had the highest rate of AIDS cases in Nevada from 2000 to 2008.

The rate of reported cases of AIDS among Whites and Hispanics in Nevada were similar from 2000 to 2008.



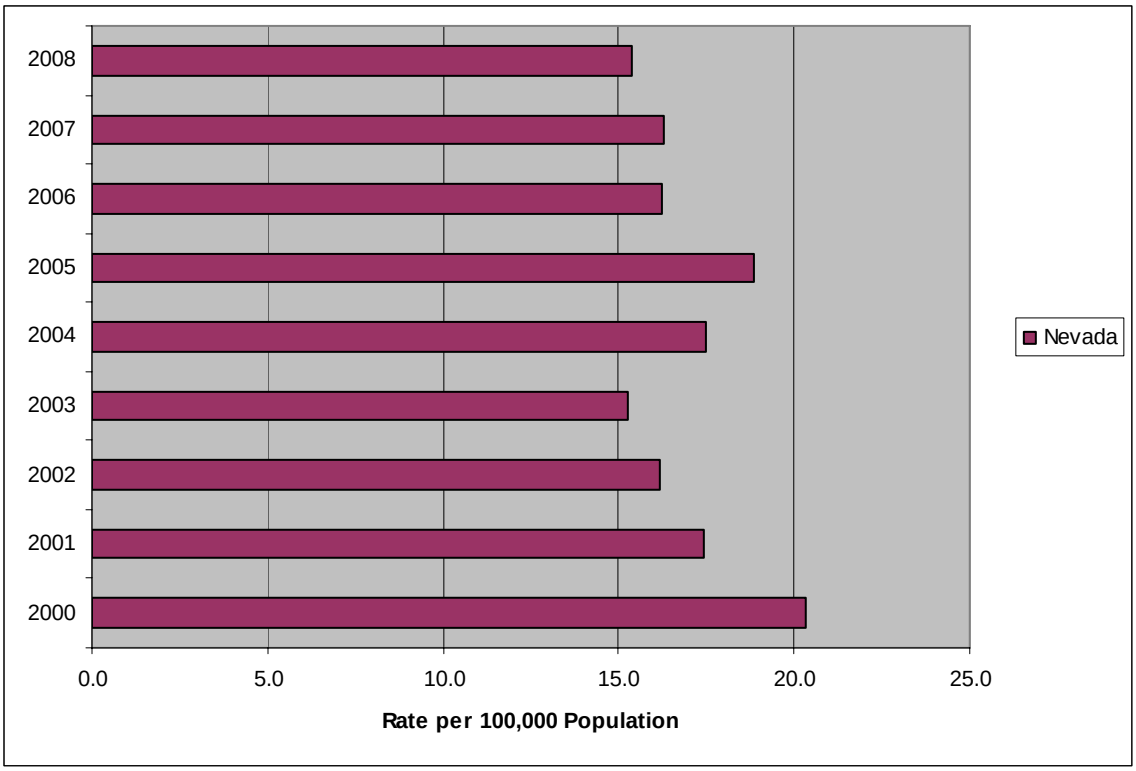
*The Nevada data are from the Enhanced HIV/AIDS Reporting System (eHARS).
Note: Data not available for Native American race/ethnicity or Asian race/ethnicity groups due to small counts.

Healthy People 2010 Objective (13-5): Reduce the number of new cases of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) diagnosed among adults and adolescents.

Healthy People 2020 Objective HIV HP2020-4: Reduce the number of new AIDS cases among adults and adolescents.

Most Recent NV Value (2008)	U.S.	HP 2010 Target	HP 2020 Target	Progress Towards Targets
15.4		N/A	13.0	N/A

Reported New Cases of HIV/AIDS, Nevada Residents, 2000 - 2008.*

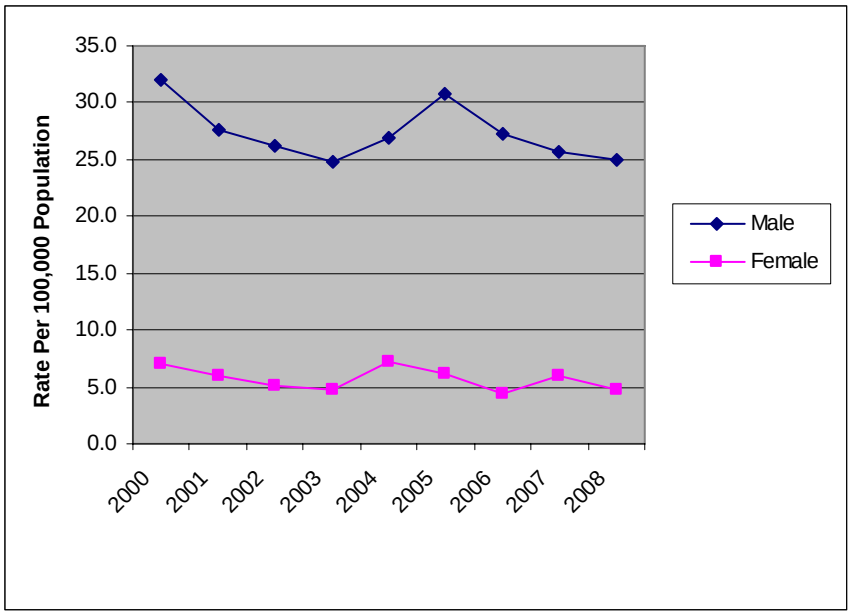


Reported new cases of HIV/AIDS decreased in Nevada from 2000 to 2008.

Each year, approximately 16-22 million persons in the U.S. are tested for HIV. In 2002, an estimated 38 percent to 44 percent of all adults had been tested for HIV. In 2007 approximately 1 in 5 (21 percent) or 232,700 of those tested did not know they were infected with HIV.[3]

*The Nevada data are from the Enhanced HIV/AIDS Reporting System (eHARS).
Note: U.S. data are not included because it is reported as counts and thus it is not comparable.
Note: See appendix for additional information.

Reported New Cases of HIV/AIDS, Nevada Residents by Gender, 2000 - 2008.*

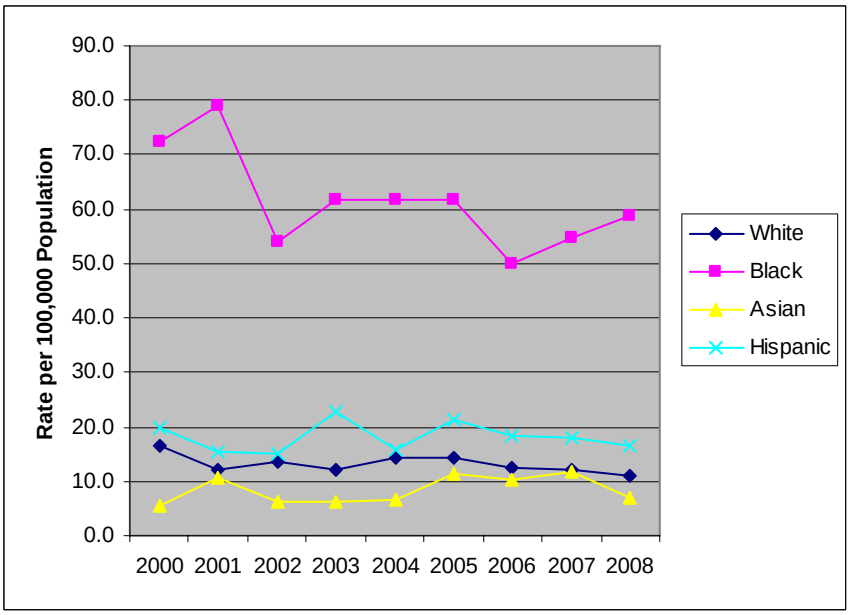


From 2000 to 2008, Nevada males had a higher rate of newly reported HIV/AIDS cases than Nevada females.

Reported New Cases of HIV/AIDS, Nevada Residents by Race/ Ethnicity, 2000 - 2008.*

In 2008, the rate of new cases of HIV/AIDS among Nevada Blacks was nearly 60 per 100,000, compared to 11 per 100,000 among Nevada Whites.

Hispanics consistently had the second highest rate of new cases of HIV/AIDS while Asians consistently have the lowest rate of all race/ ethnicity groups in Nevada from 2000 to 2008.



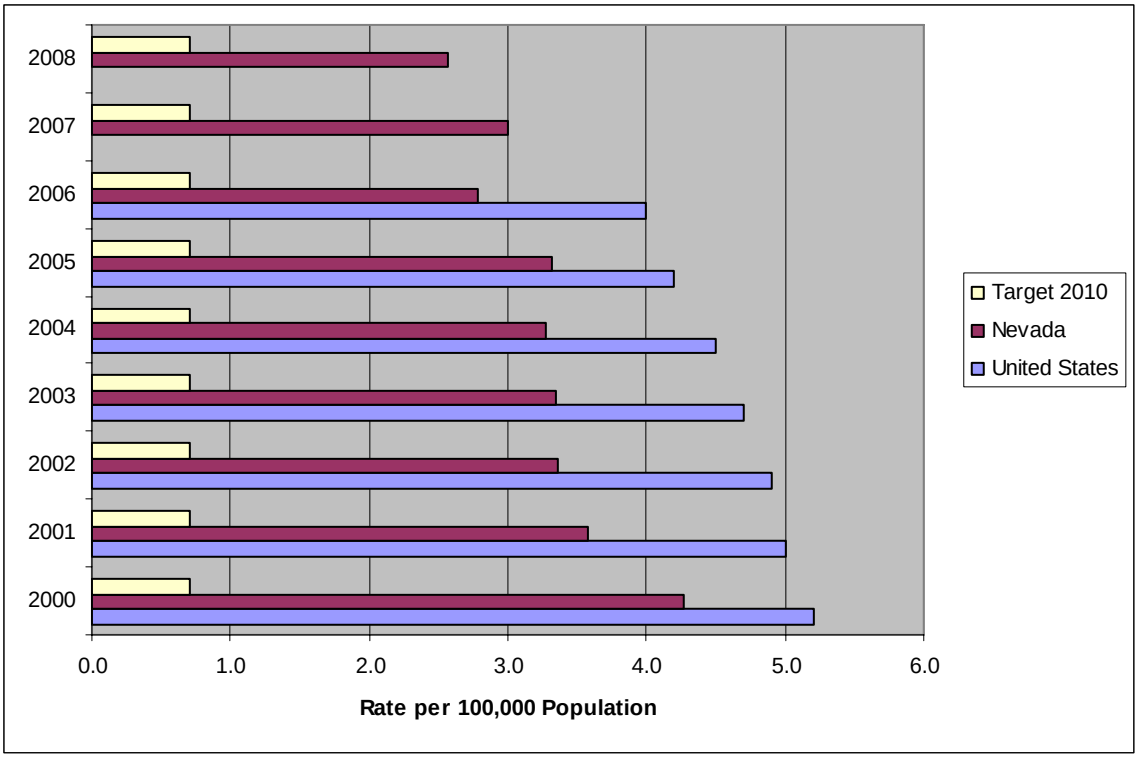
*The Nevada data are from the Enhanced HIV/AIDS Reporting System (eHARS).
Note: Data not available for Native American race/ethnicity group due to small counts.

Healthy People 2010 Objective (13-14): Reduce the deaths from HIV infection.

Healthy People 2020 Objective HIV HP2020-12: Reduce deaths from HIV infection.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
2.6	4.0	0.7	3.3	Improving

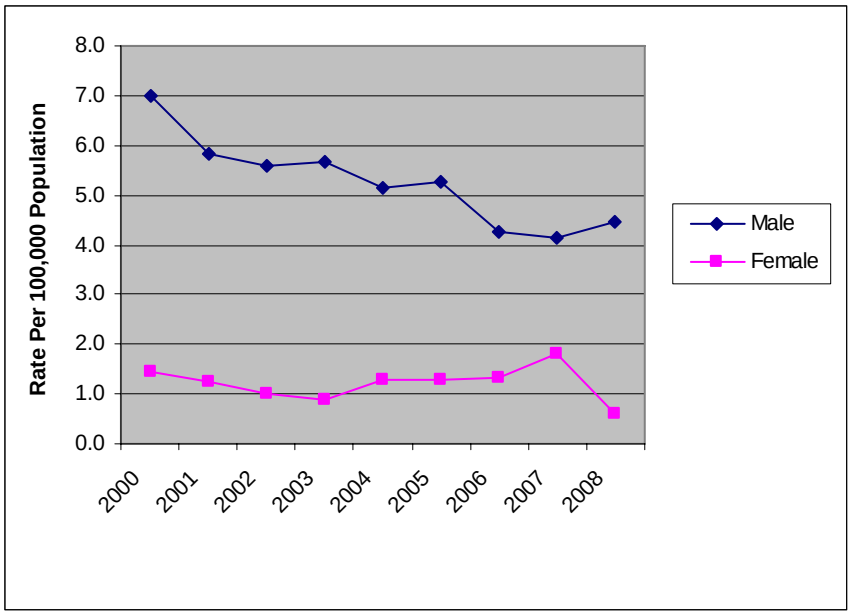
Age-Adjusted HIV Infection Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*



In 2000, the HIV infection death rate in Nevada was 4.3 per 100,000, and in 2008 the rate was 2.6 per 100,000. The HIV infection mortality rates for both Nevada and the United States decreased over the reporting period.

*These rates are age-adjusted to the year 2000 U.S. standard population. The Nevada data is from the Nevada Vital Statistics Records, and the U.S. data is from the National Vital Statistics System– Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

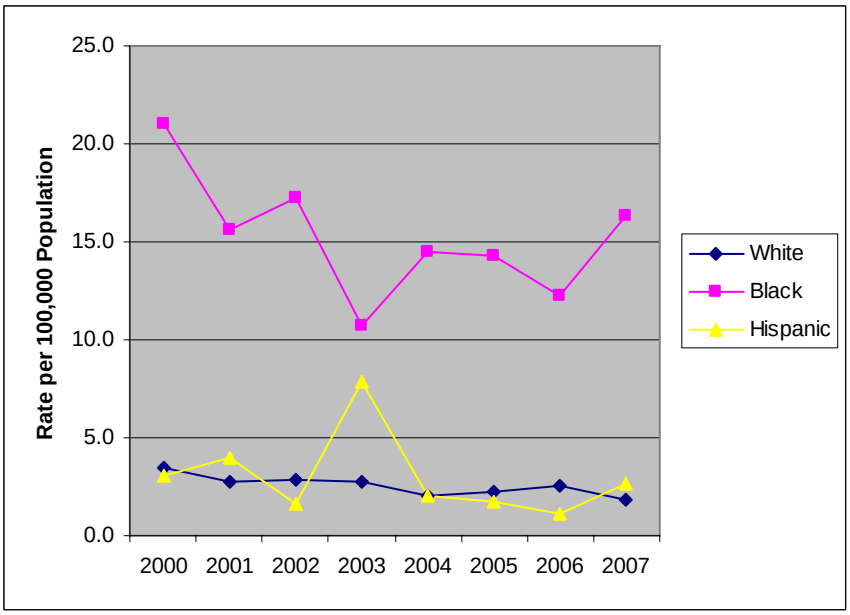
Age-Adjusted HIV Infection Death Rate, Nevada Residents by Gender, 2000 - 2008.*



From 2000 to 2008, the HIV infection death rate among males in Nevada steadily declined. The HIV infection rate for males was still almost four times that of females in the state in 2008.

Age-Adjusted HIV Infection Death Rate, Nevada Residents by Race/Ethnicity, 2000 - 2007.*

From 2000 to 2008, the rate of HIV infection deaths was highest among Blacks in Nevada.



*These rates are age-adjusted to the year 2000 U.S. standard population. The Nevada data is from the Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for Native American or Asian race/ethnicity groups due to small counts.

Immunization and Infectious Diseases

Immunization is a proven tool for controlling and eliminating life-threatening infectious diseases. Immunization is estimated to avert over 2 million deaths each year.[1] Vaccine-preventable disease levels are at or near record lows. Most infants and toddlers have received all recommended vaccines by age 2, although many under-immunized children remain, leaving the potential for outbreaks of disease. Many adolescents and adults are under-immunized as well, missing opportunities to protect themselves against diseases such as Hepatitis B, influenza, and pneumococcal disease.[2]

Healthy People 2010 Objective (14-1): Reduce or eliminate cases of vaccine-preventable diseases.

Healthy People 2020 Objective IID HP2020-1: Reduce or eliminate cases of vaccine-preventable diseases.

1.1. Congenital rubella syndrome (children aged 1 or under)
1.2 Serotype b cases of Haemophilus influenzae (Hib) invasive disease (children aged 5 years or under)
1.3 Hepatitis B (persons aged 2 to 18 years)
1.4 Measles
1.5 Mumps
1.6 Pertussis (children aged 1 or under)
1.7 Pertussis among adolescents aged 11 to 18 years
1.8 Acute paralytic poliomyelitis (wild-type)
1.9 Rubella
1.10 Varicella

Reported Cases of Vaccine Preventable Diseases, Nevada Residents, NEDSS/NETSS Data, 2000 - 2009.*

IID HP2020-1: Cases of Vaccine Preventable Diseases. (Trend Data: 2000 - Most Current Data)										
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Cogenital Rubella Syndrome in Children Aged 1 or Under	0	0	0	0	0	0	0	0	0	0
Stereotype b Cases of Haemophilus Influenza in Children Aged 5 Years or Under	0	<5*	<5*	0	<5*	<5*	0	0	0	<5*
Measles	10	<5*	<5*	0	0	0	0	<5*	<5*	<5*
Mumps	6	<5*	6	5	<5*	<5*	5	12	6	<5*
Pertussis in Children Aged 1 or Under	8	7	20	21	16	24	16	10	13	7
Pertussis Among Adolescents aged 11 to 18 Years	<5*	<5*	8	<5*	10	7	15	5	<5*	<5*
Acute Paraytic Poliomyelitis (Wild-Type)	0	0	0	0	0	0	0	0	0	0
Rubella	0	0	0	0	0	0	0	0	0	0
Varicella	0	<5*	0	0	0	6	10	<5*	5	17

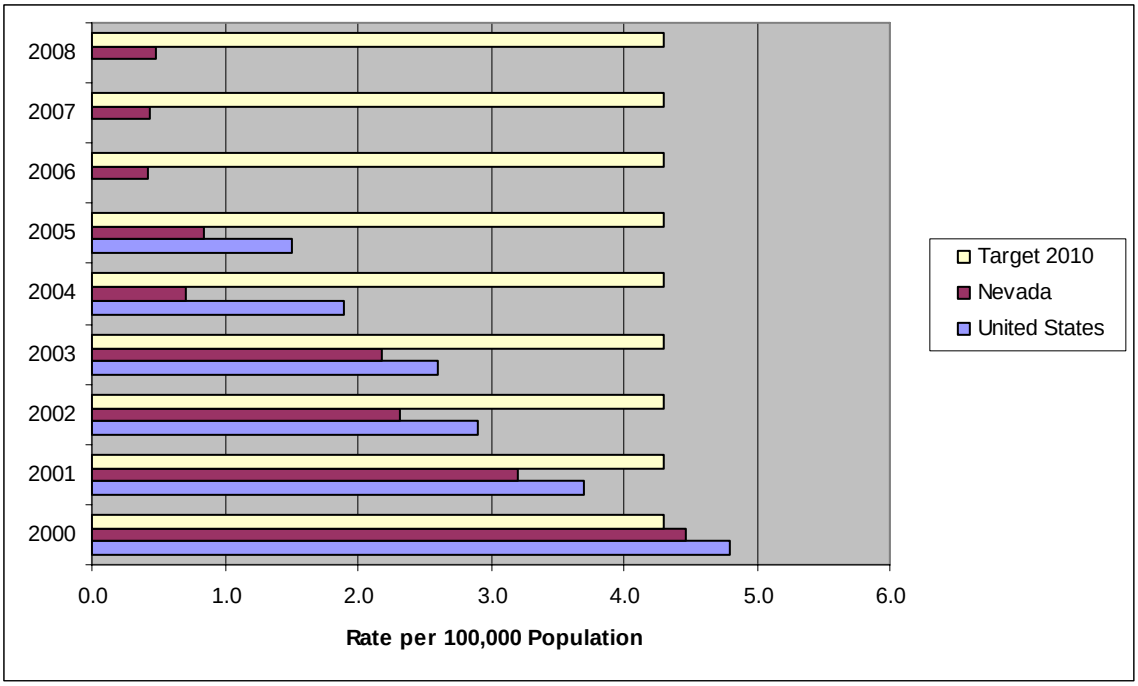
*The Nevada data from 2000 to 2004 are from the National Electronic Telecommunications System for Surveillance (NETSS) and Nevada date from 2005 to present are from the National Electronic Disease Surveillance System (NEDSS), except for Clark County data which are from the National Electronic Telecommunications System for Surveillance (NETSS) from 2000 to present.
Note: These specific age groups were chosen because they are considered 'high risk' age groups and are targeted for elimination via vaccination.
Note: See appendix for additional information.

Healthy People 2010 Objective (14-6.): Reduce new cases of Hepatitis A.

Healthy People 2020 Objective IID HP2020-23: Reduce Hepatitis A.

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
0.5	1.5	4.3	0.3	Surpassed

Rate of Reported New Cases of Hepatitis A, Nevada Residents and United States, NEDSS/NETSS Data, 2000 - Most Current Data.*

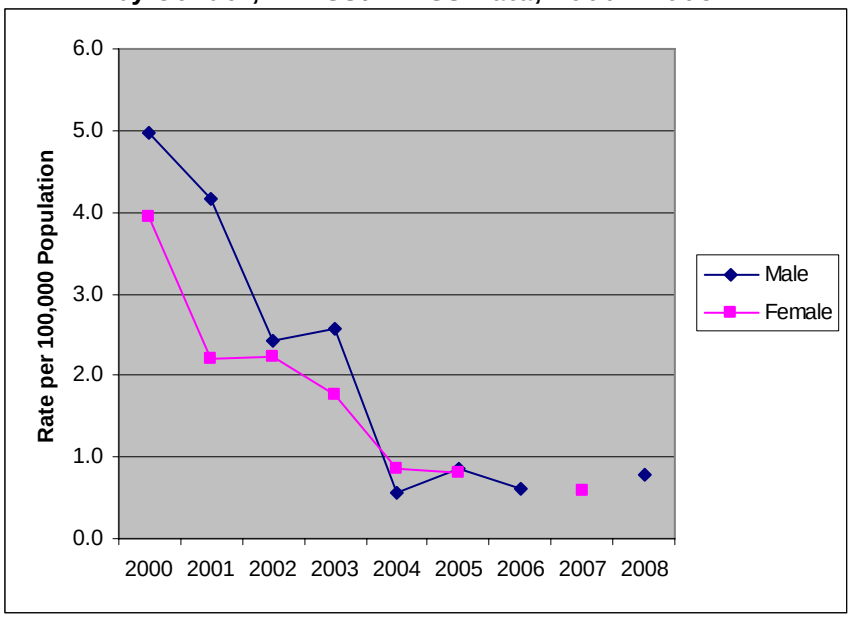


Nevada had a consistently lower rate of new cases of hepatitis A than the national rate from 2000 to 2008. Nevada surpassed the Healthy People 2010 target for reducing the number of new cases of hepatitis A to 4.3 per 100,000 people from 2001 to 2008.

Anyone can get hepatitis A. This disease is caused by the hepatitis A virus that results in inflammation of the liver. Hepatitis A was formerly known as infectious hepatitis. This virus is found in the feces (stool) of infected persons and is usually spread by the fecaloral route. The virus may be spread by food prepared or handled by an infected person who does not wash their hands carefully, via water contaminated with human feces, the consumption of raw oysters, close intimate contact (household or sexual), and by changing the diaper of an infected child.[3]

*The Nevada data from 2000 to 2004 are from the National Electronic Telecommunications System for Surveillance (NETSS) and Nevada date from 2005 to present are from the National Electronic Disease Surveillance System (NEDSS), except for Clark County data which are from the National Electronic Telecommunications System for Surveillance (NETSS) from 2000 to present.
Note: These specific age groups were chosen because they are considered 'high risk' age groups and are targeted for elimination via vaccination.
Note: See appendix for additional information.

Rate of Reported New Cases of Hepatitis A, Nevada Residents by Gender, NEDSS/NETSS Data, 2000 - 2008.*



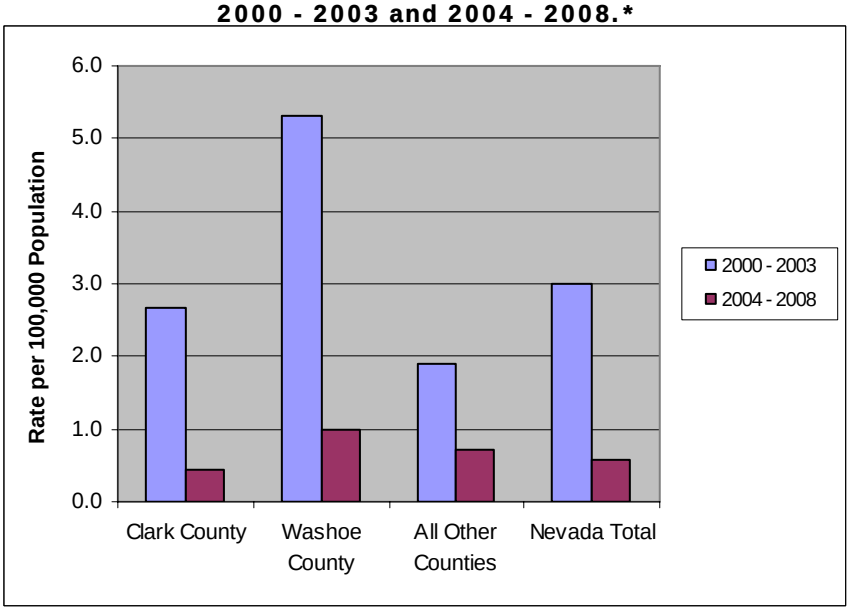
Both males and females are equally at risk for hepatitis A infection. Usually the first symptoms appear at about one month, but can develop anytime between two and six weeks after exposure to the virus. After one infection, a person cannot get hepatitis A again. However, there are five types of viral hepatitis, and infection with hepatitis A will not protect against other types of hepatitis.[3]

The Nevada trend shows overall decreases in the number of reported new cases of hepatitis A from 2000 to 2008 for both genders.

In all regions of the state, rates of reported new cases of hepatitis A declined over the past five years. Washoe County reported the highest rate of hepatitis A between 2000 and 2008.

There is no specific treatment for hepatitis A. Bed rest is generally all that is needed. Infected persons should also avoid alcohol, drugs, or medicines (including aspirin and Tylenol). Most people feel batter after one to two weeks. People are most infectious in the two weeks before their symptoms appear and remain infectious about a week after jaundice presents.[3]

Aggregated Rate of Reported New Cases of Hepatitis A, Nevada Residents by County/Region, NEDSS/NETSS Data, 2000 - 2003 and 2004 - 2008.*



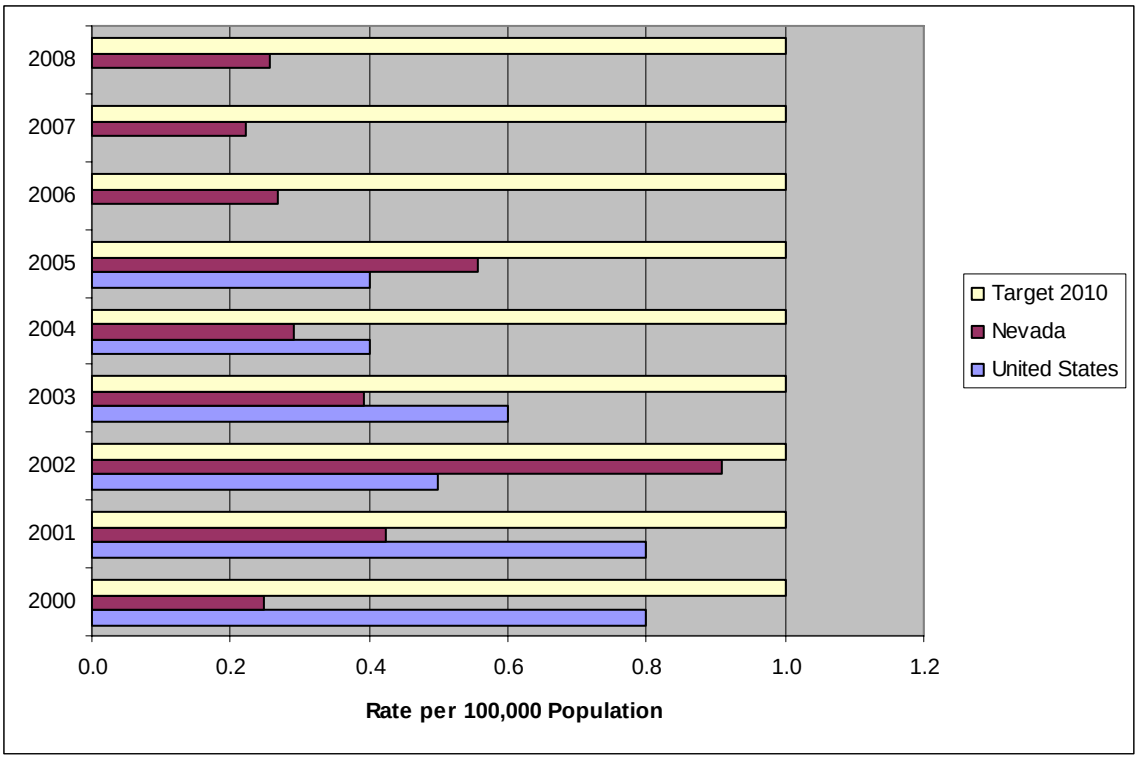
*The Nevada data from 2000 to 2004 are from the National Electronic Telecommunications System for Surveillance (NETSS) and Nevada date from 2005 to present are from the National Electronic Disease Surveillance System (NEDSS), except for Clark County data which are from the National Electronic Telecommunications System for Surveillance (NETSS) from 2000 to present.
Note: These specific age groups were chosen because they are considered 'high risk' age groups and are targeted for elimination via vaccination.
Note: Data not available for Female 2006 or Male 2007 due to small counts.
Note: Race/ethnicity and age group data are not available.

Healthy People 2010 Objective (14-7): Reduce new cases of meningococcal disease.

Healthy People 2020 Objective IID HP2020-3: Reduce meningococcal disease.

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
0.3	0.4	1.0	0.3	Surpassed

Rate of Reported New Cases of Meningococcal Disease, Nevada Residents and United States, NEDSS/NETSS Data, 2000 - Most Current Data.*

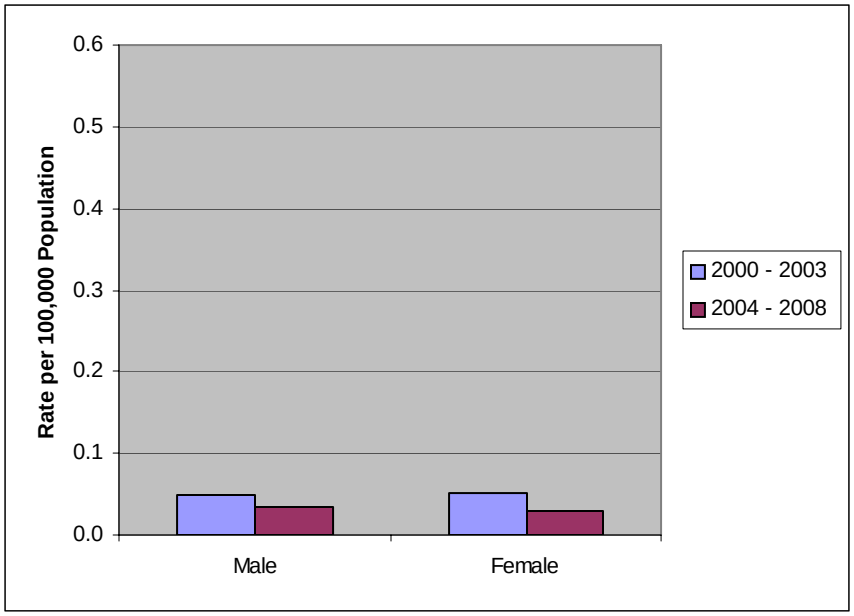


Nevada's rate of Meningococcal Disease fluctuated from 2000 to 2008, remaining lower than the Healthy People 2010 target.

Meningococcal Disease is a bacterial infection caused by the bacterium, Neisseria meningitides. This is one of many organisms that infects the blood and the tissues covering the brain and spinal cord (meninges). The disease is relatively rare, and more cases occur during the spring and winter months.[4]

*The Nevada data from 2000 to 2004 are from the National Electronic Telecommunications System for Surveillance (NETSS) and Nevada date from 2005 to present are from the National Electronic Disease Surveillance System (NEDSS), except for Clark County data which are from the National Electronic Telecommunications System for Surveillance (NETSS) from 2000 to present.
Note: These specific age groups were chosen because they are considered 'high risk' age groups and are targeted for elimination via vaccination.
Note: See appendix for additional information.

Aggregated Rate of Reported New Cases of Meningococcal Disease, Nevada Residents by Gender, NEDSS/NETSS Data, 2000 - 2003 and 2004 - 2008.*



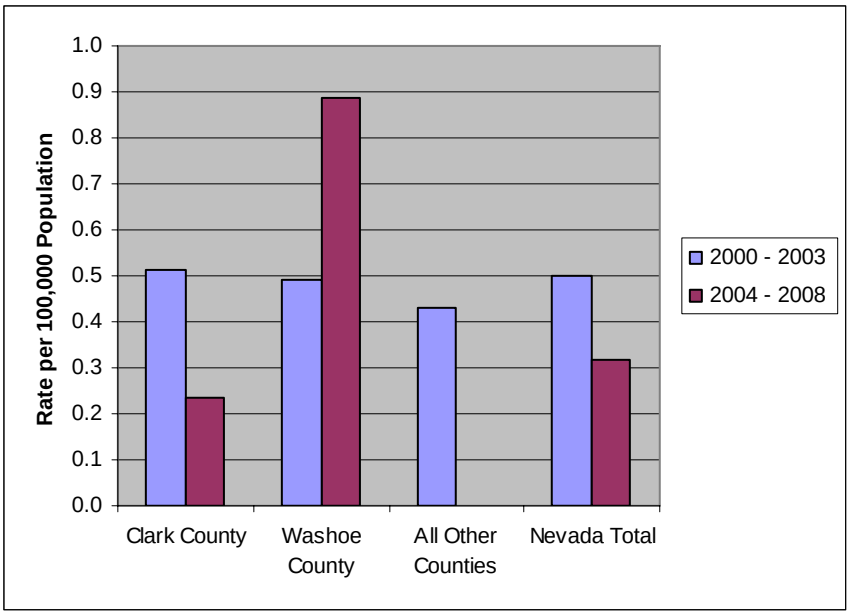
Anyone can get meningococcal disease. It is more common in infants, children, and young adults. The disease is more prevalent in places where there are crowded living conditions. Meningococcal disease spreads by contact with mucus or droplets from the nose and throat of the infected person.[4]

Nevada rates for the disease decreased from 2000 - 2003 to 2004 - 2008 for both males and females.

Nevada's most populated counties had higher rate of meningococcal disease than "All Other Counties" in the combined years 2000 - 2003. The rate of new cases of meningococcal disease increased in Washoe County in the combined years 2004 through 3008.

People with colds or influenza-like symptoms should be careful to cover their mouths and noses with tissue when sneezing and coughing, and remember to wash their hands frequently. There are several types of Neisseria Meningitidis and infection with one type does not provide immunity to others.[4]

Aggregated Rate of Reported New Cases of Meningococcal Disease, Nevada Residents by County/Region, NEDSS/NETSS Data, 2000 - 2003 and 2004 - 2008.*



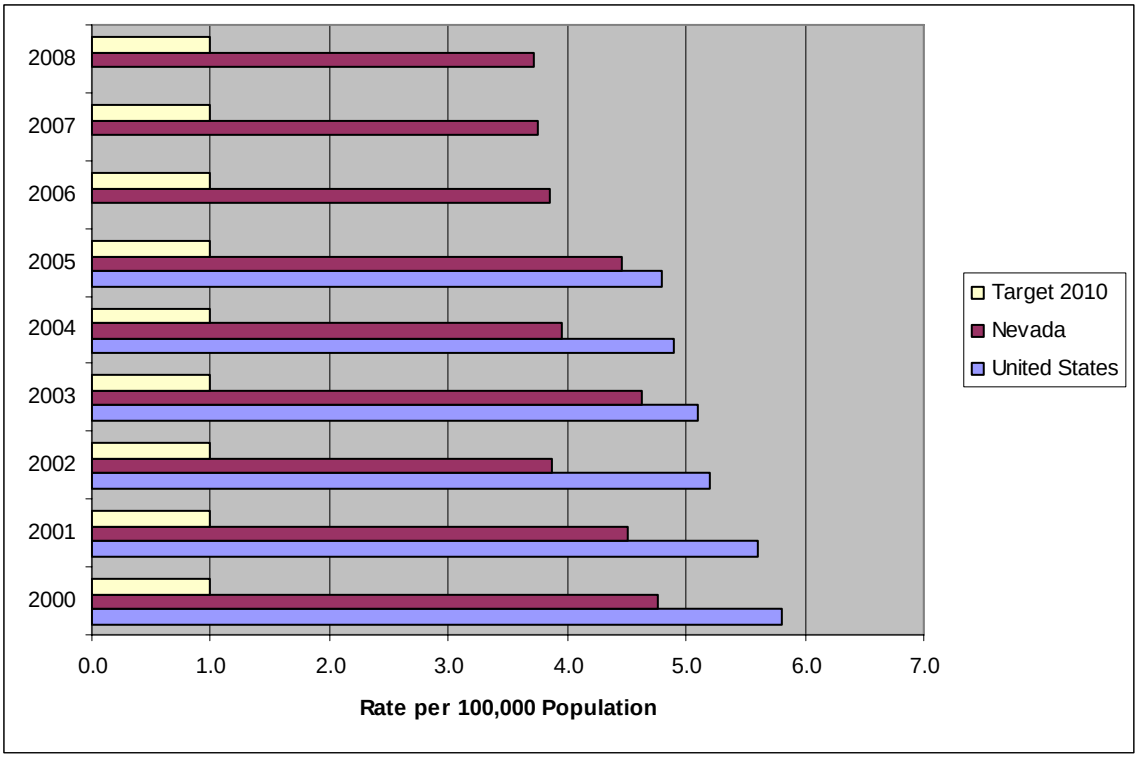
*The Nevada data from 2000 to 2004 are from the National Electronic Telecommunications System for Surveillance (NETSS) and Nevada date from 2005 to present are from the National Electronic Disease Surveillance System (NEDSS), except for Clark County data which are from the National Electronic Telecommunications System for Surveillance (NETSS) from 2000 to present.
Note: These specific age groups were chosen because they are considered 'high risk' age groups and are targeted for elimination via vaccination.
Note: Race/ethnicity and age group data are not available.

Healthy People 2010 Objective (14-11): Reduce new cases of tuberculosis.

Healthy People 2020 Objective IID HP2020-29: Reduce tuberculosis (TB).

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
3.7	4.8	1.0	1.0	Improving

Rate of Reported New Cases of Tuberculosis, Nevada Residents and United States, TIMS Data, 2000 - Most Current Data.*



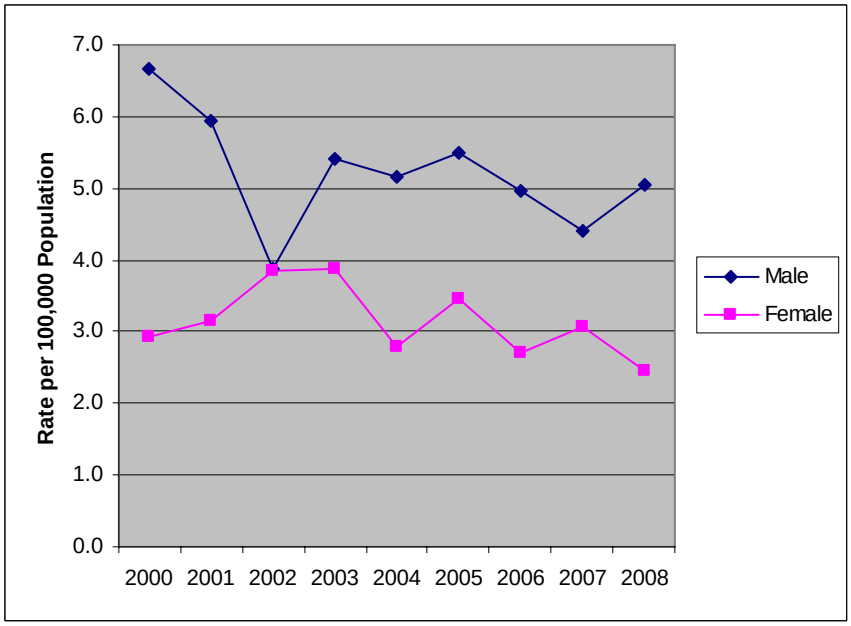
Nevada's rate of tuberculosis (TB) was consistently lower than the national rate from 2000 through 2005. Nevada's rate decreased from 2005 to 2008, however, neither the state nor the U.S. have met the Healthy People 2010 target of 1.0 per 100,000 people.

Nationally, tuberculosis rates have experienced a steady decline while Nevada rates have remained relatively constant. *Mycobacterium tuberculosis* (TB) causes disease in over one hundred residents of Nevada annually, infecting an estimated eight hundred more with the bacterium that causes tuberculosis, and placing Nevada as the 16th highest state in the nation for TB cases per population in 2008.

TB is a disease caused by bacteria called Mycobacterium tuberculosis. The bacteria usually attack the lungs, but TB can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal.[5]

*The Nevada and U.S. data are from the Tuberculosis Information Management System (TIMS).
Note: See appendix for additional information.

Rate of Reported New Cases of Tuberculosis, Nevada Residents by Gender, TIMS Data, 2000 - 2008.*



In keeping with the nation, males 45 years and older had TB case rates approximately twice of those as women of the same age. See the complete national TB report at:

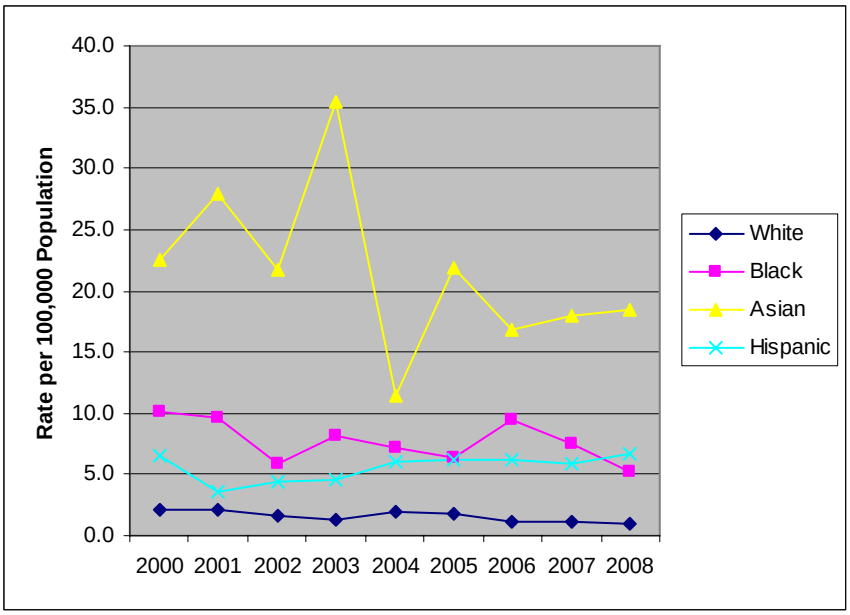
http://www.cdc.gov/tb/statistics/reports/2009/pdf/report2009.pdf

Asians had a higher prevalence of tuberculosis than any other racial group in Nevada from 2000 to 2008.

In Nevada approximately 80 percent of all reported TB occurred in racial and ethnic minorities. From 2003 through 2009, the three countries of birth contributing the majority to Nevada's TB case rate were: 34 percent from the United States, 24 percent from the Philippines, and 20 percent from Mexico. For more Nevada TB information see:

http://www.health.nv.gov/CD_HIV_TBProgram.htm

Rate of Reported New Cases of Tuberculosis, Nevada Residents by Race/Ethnicity, TIMS Data, 2000 - 2008.*



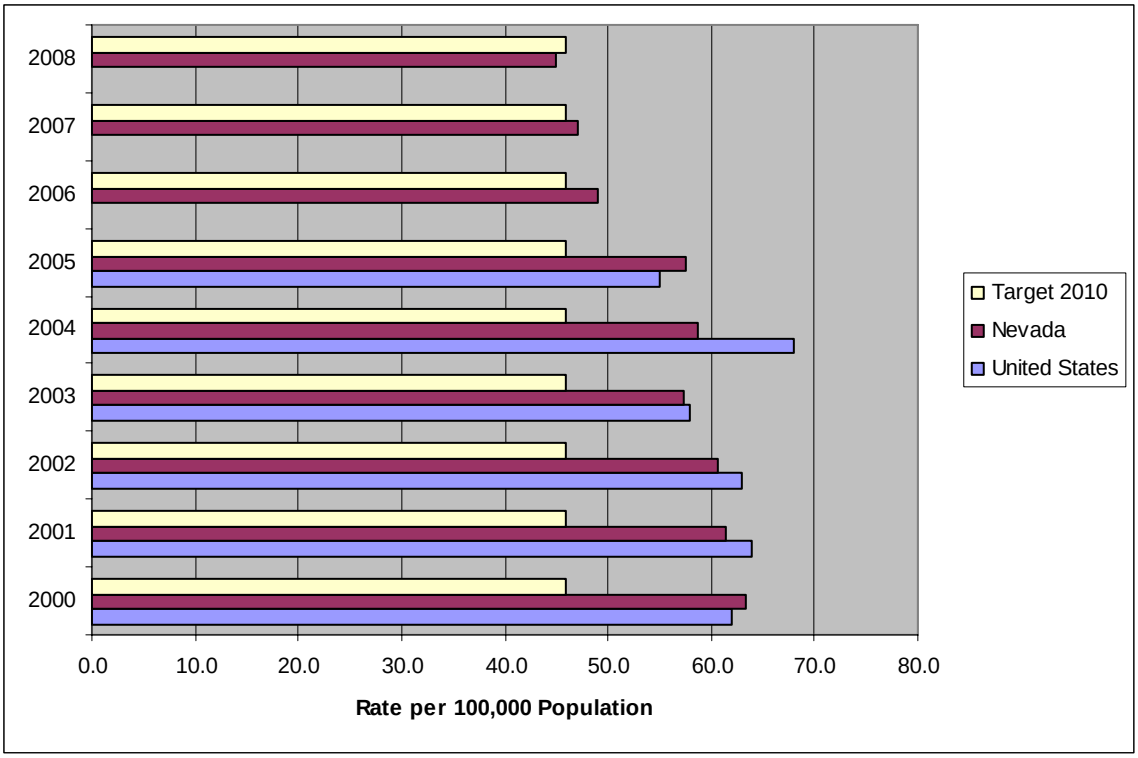
*The Nevada and U.S. data are from the Tuberculosis Information Management System (TIMS).
Note: Data not available for the Native American race/ethnicity group due to small counts.

Healthy People 2010 Objective (14-17): Reduce hospitalization caused by peptic ulcer disease in the United States.

Healthy People 2020 Objective IID HP2020-10: Reduce hospitalization caused by peptic ulcer disease in the United States.

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
45.0	55.0	46.0		Achieved

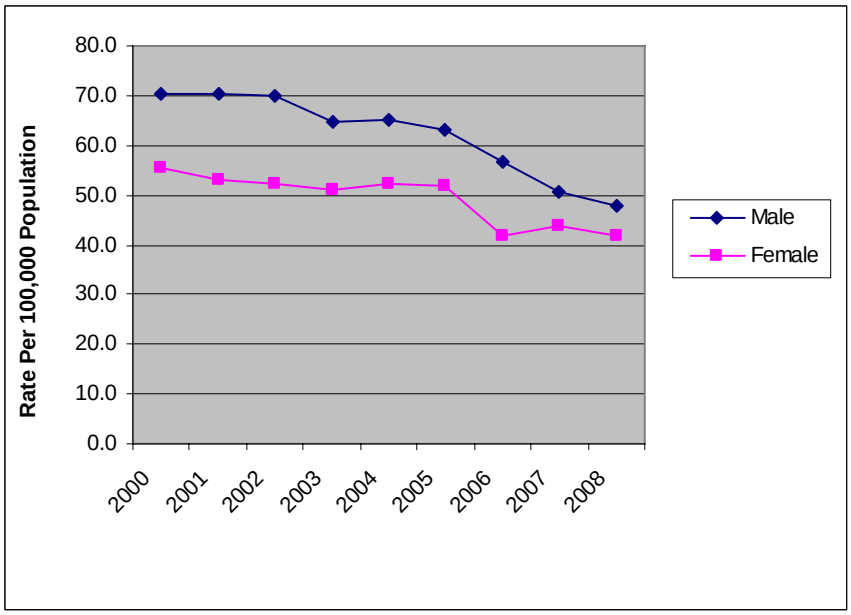
Age-Adjusted Rate of Hospitalizations for Peptic Ulcer Disease, Nevada Residents and United States, 2000 - Most Current Data*.



In 2008, Nevada reached the Healthy People 2010 target to reduce hospitalizations for peptic ulcer disease. Hospitalization rates for both Nevada and the nation decreased over the reported years.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data is from the Nevada Inpatient Hospital Discharge Database (NIHDD). The U.S. data is from the National Hospital Discharge Survey (NHDS).
Note: See appendix for additional information.

Age-Adjusted Rate of Hospitalizations for Peptic Ulcer Disease, Nevada Residents by Gender, 2000 - 2008*.

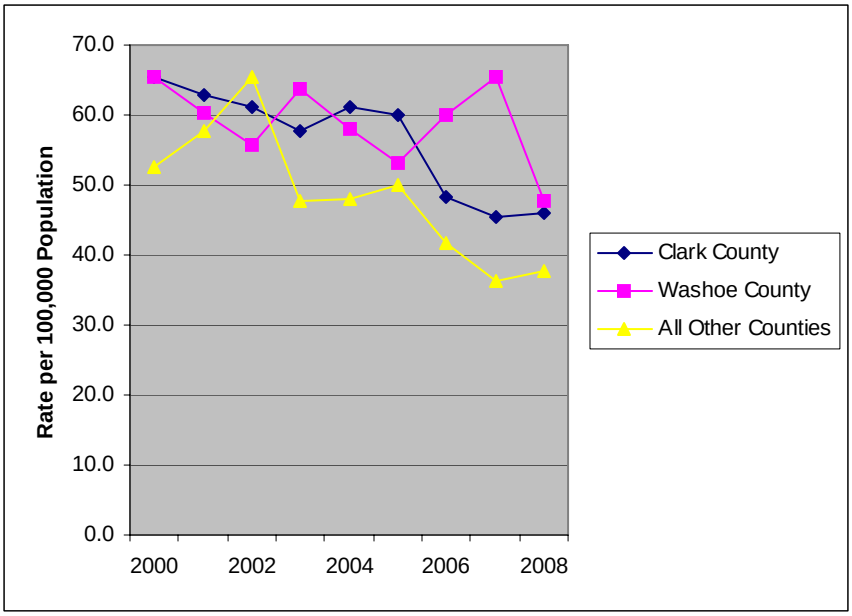


From 2000 to 2008, females had a lower rate of hospitalizations due to peptic ulcer disease compared to males in Nevada.

The rates of hospitalizations for peptic ulcer disease decreased overall across Nevada from 2000 to 2008, with the lowest rates happening in the more rural and frontier counties (All Other Counties).

Stress and diet are no longer believed to cause ulcers. Many researchers believe stress and diet can play a role in exacerbating symptoms and slow healing of pre-existing peptic ulcers.
You have twice the risk of developing a peptic ulcer if you are of African-American or Hispanic background. You also may have an increased risk of developing a peptic ulcer if you have type 'O' blood.[6]

Age-Adjusted Rate of Hospitalizations for Peptic Ulcer Disease, Nevada Residents by County/Region, 2000 - 2008*.



*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data is from the Nevada Inpatient Hospital Discharge Database (NIHDD). No race/ethnicity data available.

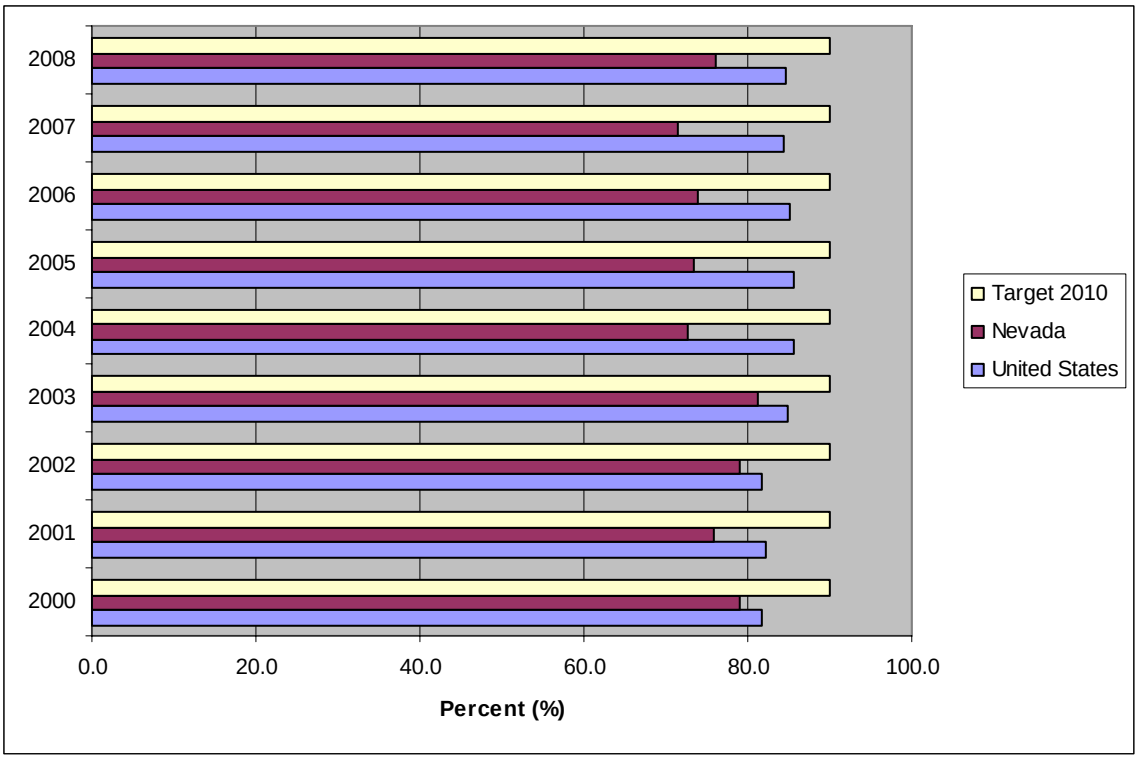
Healthy People 2010 Objective (14-22): Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among children.

Healthy People 2020 Objective IID HP2020-7: Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children.

Healthy People 2020 Objective IID HP2020-7.1: Four doses of Diptheria-Pertussis-Tetanus by 19 to 35 months.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
76.0	84.6	90.0	90.0	Worsening

Proportion of Children Aged 19 to 35 Months who Received Four Doses of Diptheria-Pertussis-Tetanus, Nevada Residents and United States, NIS Data, 2000 - 2008.*



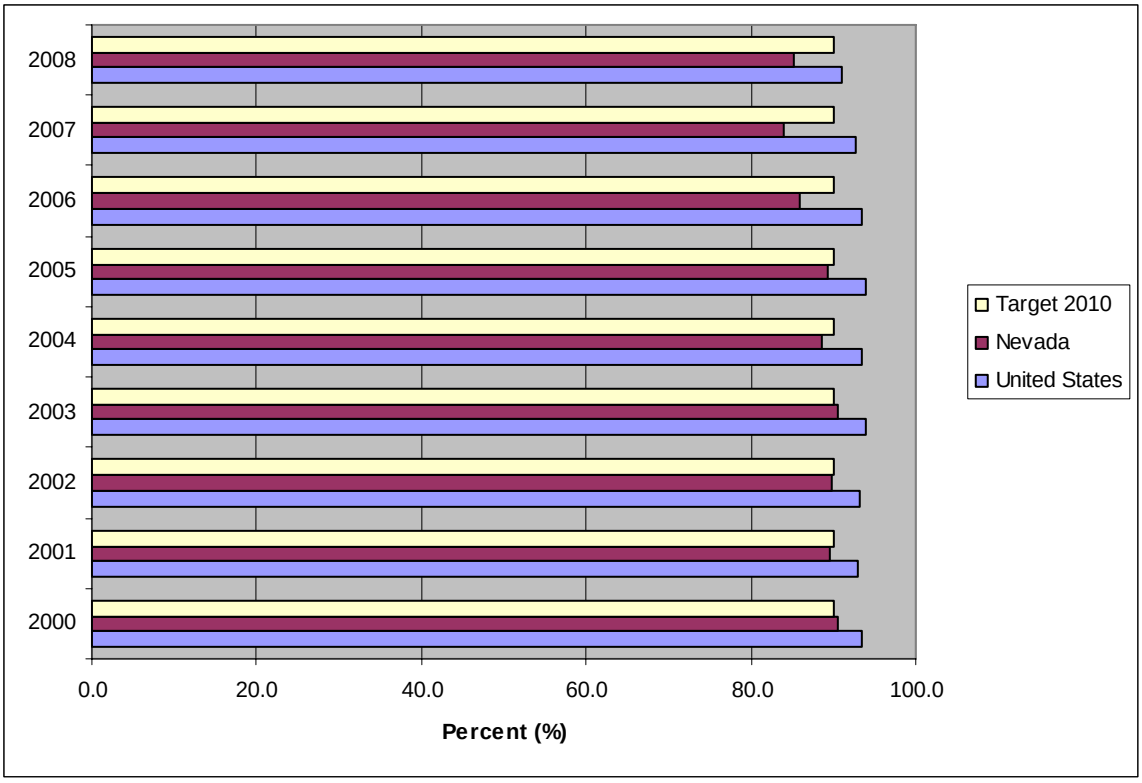
Neither Nevada, nor the United States, reached the Healthy People 2010 target for the percentage of children, aged 19 to 35 months, who received four doses of diphtheria-pertussis-tetanus vaccine from 2000 to 2008. The trend for the nation was steady, with a slight overall increase from 2000 to 2008.

*The Nevada and U.S. data are provided by the Centers for Disease Control and Prevention (CDC), NIS Data Tables.
Note: Additional county, age-group, gender, and race/ethnicity breakdowns are not available.

Healthy People 2020 Objective IID HP2020-7.2: Three doses of Haemophilus Influenza Type B (Hib) vaccine.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
85.2	90.9	90.0	90.0	Worsening

Proportion of Children Aged 19 to 35 Months who Received Three Doses of Haemophilus Influenza Type B (Hib) Vaccine, Nevada Residents and United States, NIS Data, 2000 - 2008.*



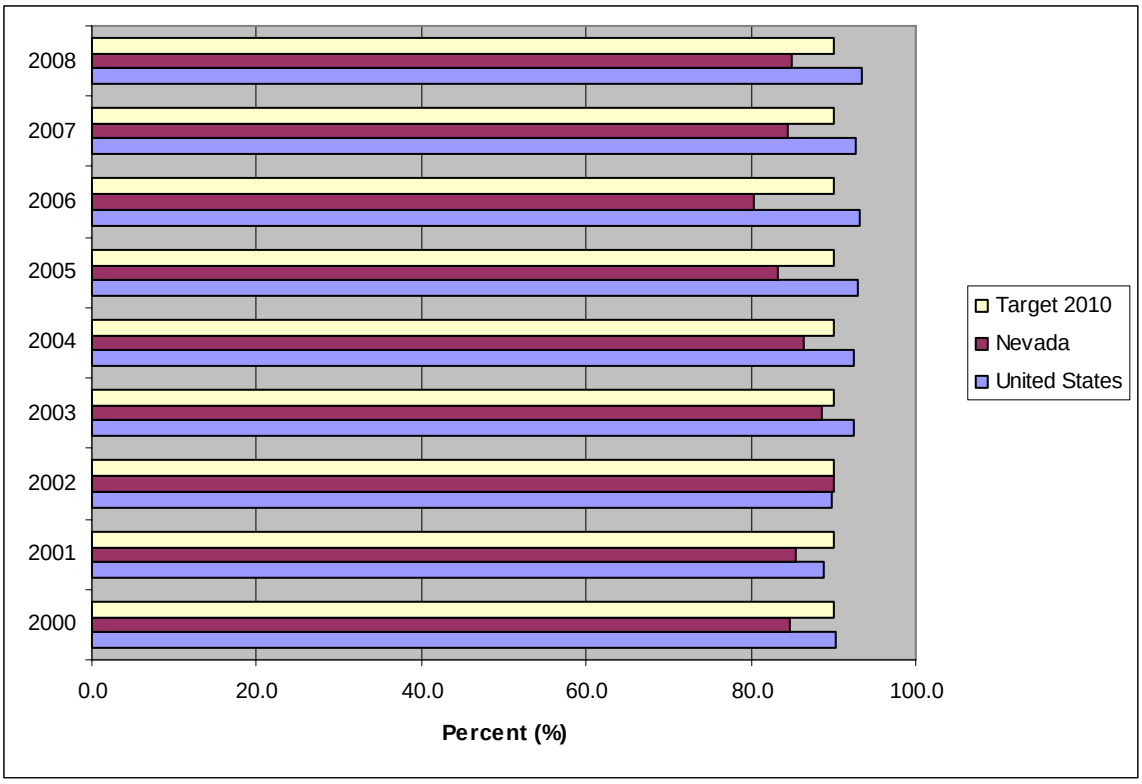
Nevada did not attain the Healthy People 2010 target for the percentage of children, aged 19 to 35 months, who received three doses of haemophilus influenza type B (Hib) vaccine from 2000 to 2008. This proportion, for both the state and the nation, decreased from 2005 to 2008.

*The Nevada and U.S. data are provided by the Centers for Disease Control and Prevention (CDC), NIS Data Tables.
Note: Additional county, age-group, gender, and race/ethnicity breakdowns are not available.

Healthy People 2020 Objective IID HP2020-7.3: Three doses of Hepatitis B vaccine.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
84.9	93.5	90.0	90.0	Fluctuating

Proportion of Children Aged 19 to 35 Months who Received Three Doses of Hepatitis B Vaccine, Nevada Residents and United States, NIS Data, 2000 - 2008.*



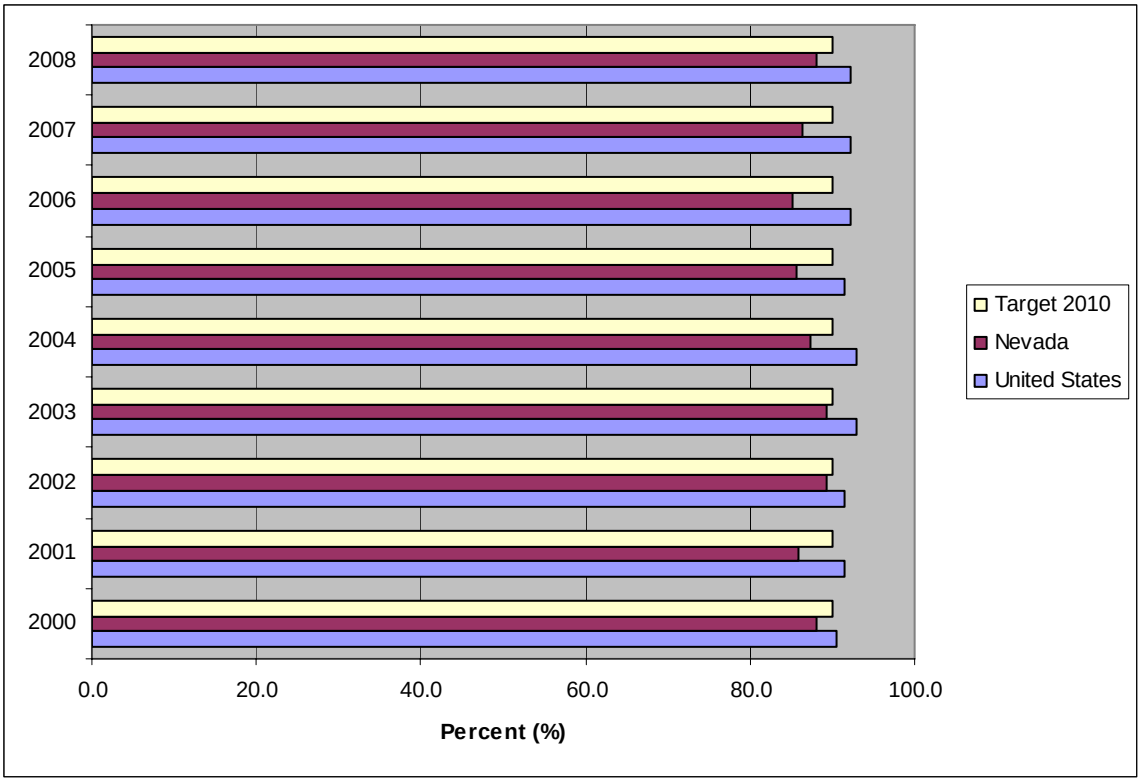
Nevada did not attain the Healthy People 2010 target for the percentage of children, aged 19 to 35 months, who received three doses of hepatitis B vaccine from 2000 to 2008. The proportion on Nevada's children aged 19 to 35 months who received three doses of hepatitis B vaccine increased from 2006 to 2008.

*The Nevada and U.S. data are provided by the Centers for Disease Control and Prevention (CDC), NIS Data Tables.
Note: Additional county, age-group, gender, and race/ethnicity breakdowns are not available.

Healthy People 2020 Objective IID HP2020-7.4: One dose of Measles-Mumps-Rubella (MMR) vaccine.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
88.0	92.1	90.0	90.0	Fluctuating

Proportion of Children Aged 19 to 35 Months who Received One Dose of Measles-Mumps-Rubella (MMR) Vaccine, Nevada Residents and United States, NIS Data, 2000 - 2008.*



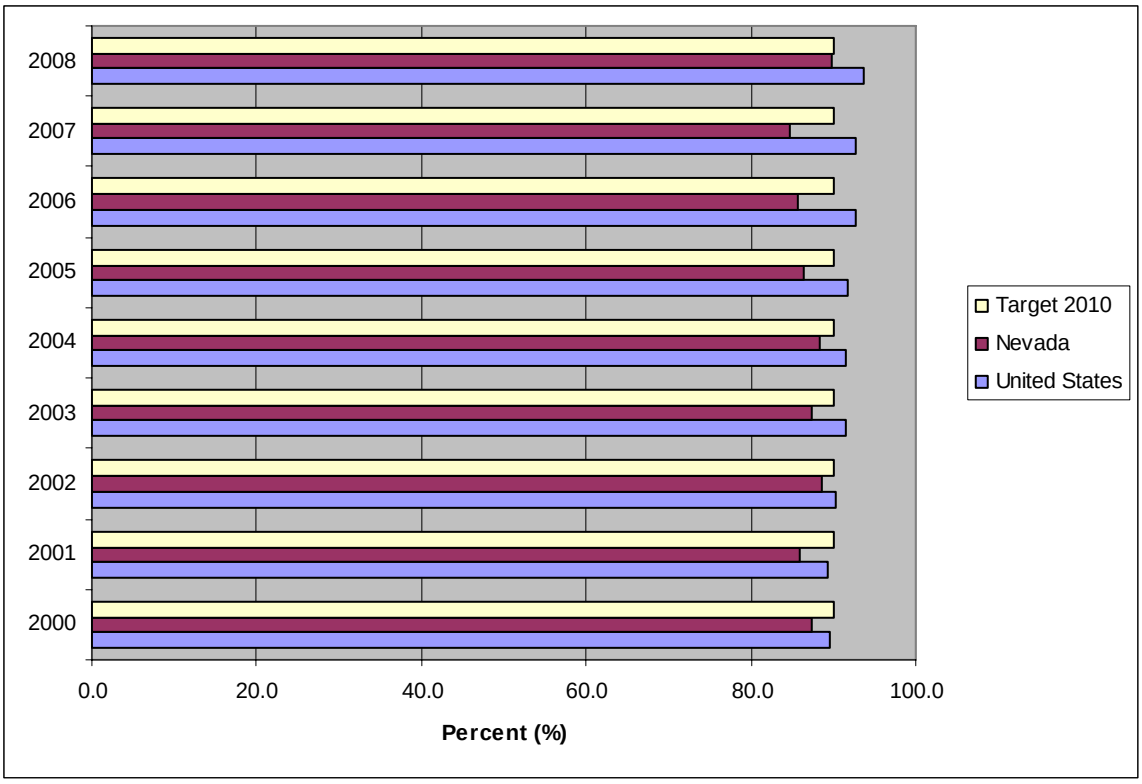
Nevada did not meet the Healthy People 2010 target for the percentage of children, aged 19 to 35 months, who received one dose of measles-mumps-rubella (MMR) vaccine from 2000 to 2008. The percentage of Nevada children, aged 19 to 35 months, who received one dose of measles-mumps-rubella (MMR) vaccine increased from 2006 to 2008.

*The Nevada and U.S. data are provided by the Centers for Disease Control and Prevention (CDC), NIS Data Tables.
Note: Additional county, age-group, gender, and race/ethnicity breakdowns are not available.

Healthy People 2020 Objective IID HP2020-7.5: Three doses of Polio vaccine.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
89.9	93.6	90.0	90.0	fluctuating

Proportion of Children Aged 19 to 35 Months who Received Three Doses of Polio Vaccine, Nevada Residents and United States, NIS Data, 2000 - 2008.*



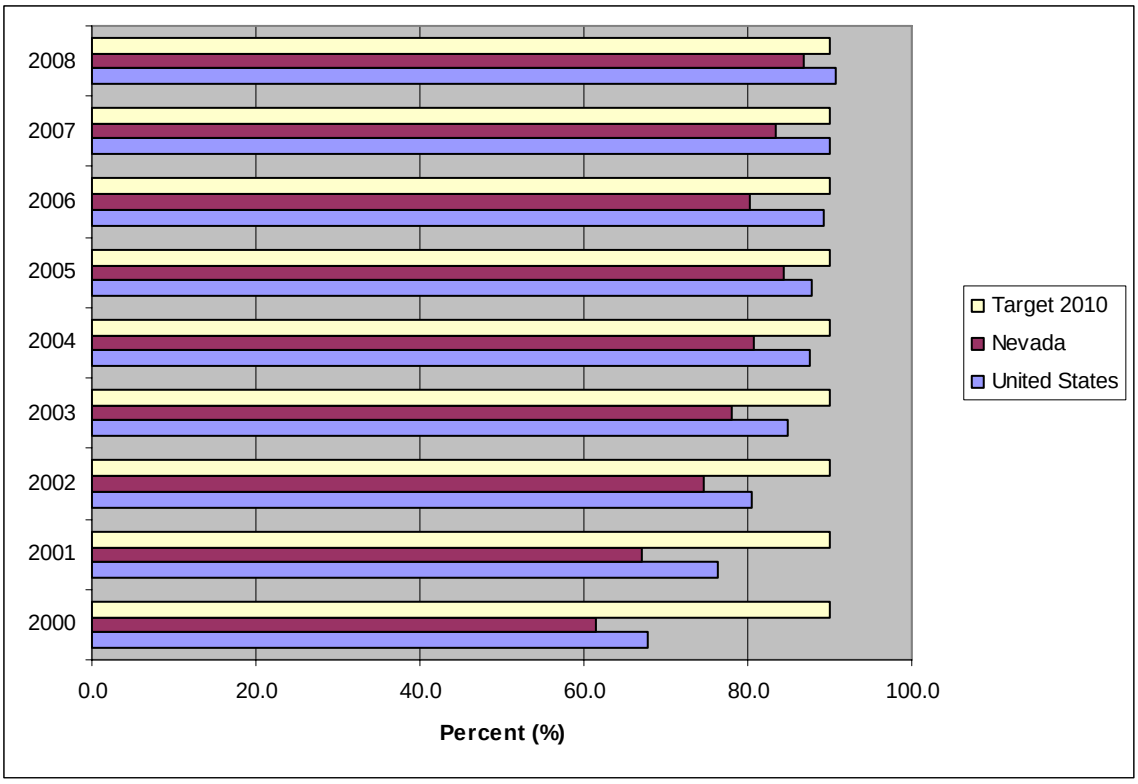
Nevada did not meet the Healthy People 2010 target for the percentage of children, aged 19 to 35 months, who received three doses of polio vaccine from 2000 to 2008. This proportion, in both Nevada and the United States, fluctuated from 2000 to 2008.

*The Nevada and U.S. data are provided by the Centers for Disease Control and Prevention (CDC), NIS Data Tables.
Note: Additional county, age-group, gender, and race/ethnicity breakdowns are not available.

Healthy People 2020 Objective IID HP2020-7.6: One dose of Varicella vaccine

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
86.8	90.7	90.0	90.0	Improving

Proportion of Children Aged 19 to 35 Months who Received One Dose of Varicella Vaccine, Nevada Residents and United States, NIS Data, 2000 - 2008.*



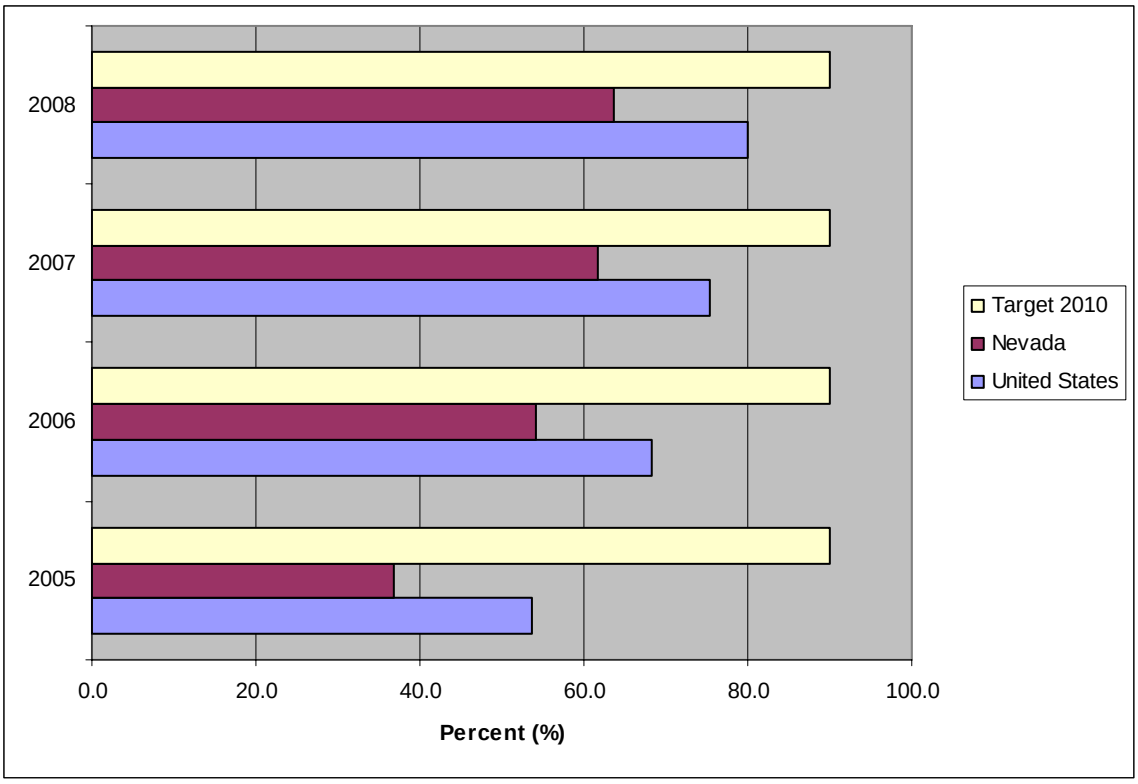
Nevada did not meet the Healthy People 2010 target for the percentage of children, aged 19 to 35 months, who received one dose of varicella vaccine from 2000 to 2008. The trends for both the state and the nation increased from 2000 to 2008.

*The Nevada and U.S. data are provided by the Centers for Disease Control and Prevention (CDC), NIS Data Tables.
Note: Additional county, age-group, gender, and race/ethnicity breakdowns are not available.

Healthy People 2020 Objective IID HP2020-7.7: Four doses of pneumococcal conjugate vaccine

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
63.6	80.1	90.0	90.0	Improving

Proportion of Children Aged 19 to 35 Months who Received Four Doses of Pneumococcal Conjugate Vaccine, Nevada Residents and United States, NIS Data, 2005 - 2008.*



Neither Nevada nor the United States reached the Healthy People 2010 target for the percentage of children, aged 19 to 35 months, who received four doses of pneumococcal conjugate vaccine from 2005 to 2008. The trends for both the state and the nation increased from 2005 to 2008.

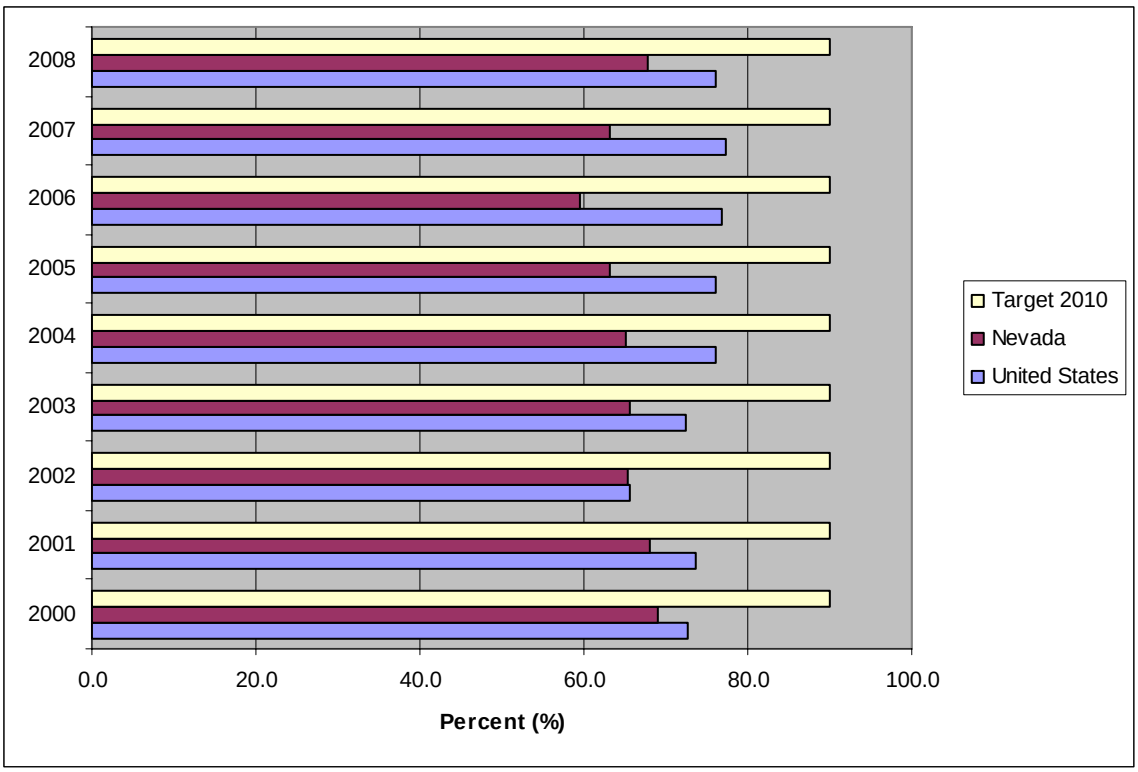
*The Nevada and U.S. data are provided by the Centers for Disease Control and Prevention (CDC), NIS Data Tables.
Note: Additional county, age-group, gender, and race/ethnicity breakdowns are not available.

Healthy People 2010 Objective (14-24): Increase the proportion of children aged 19 to 35 months who receive the recommended vaccines.

Healthy People 2020 Objective IID HP2020-8: Increase the proportion of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and PCV vaccines.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
67.8	76.1	90.0	80.0	Fluctuating

Proportion of Children Aged 19 to 35 Months who Received the Recommended Vaccines, Nevada Residents and United States, NIS Data, 2000 - 2008.*



Neither Nevada nor the United States reached the Healthy People 2010 target for the percentage of children, aged 19 to 35 months, who received the recommended vaccines from 2000 to 2008. The trends for both the state and the nation fluctuated from 2000 to 2008, at 67.8 percent and 76.1 percent respectively in 2008.

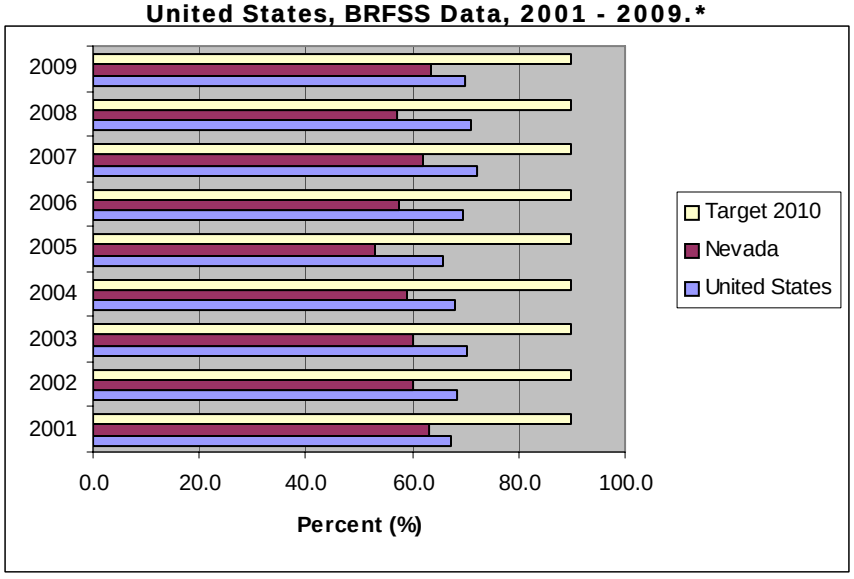
*The Nevada and U.S. data are provided by the Centers for Disease Control and Prevention (CDC), NIS Data Tables.
Note: Additional county, age-group, gender, and race/ethnicity breakdowns are not available.
Note: As of 2002 the varicella vaccine was added to recommended vaccines. Data representing years prior to 2002 do not include this vaccine.

Healthy People 2010 Objective (14-29a.): Increase the proportion of adults, aged 65 years and older, who are vaccinated annually against influenza.

Healthy People 2020 Objective IID HP2020-12.7: Increase the proportion of noninstitutionalized adults, aged 65 years and older, who are vaccinated annually against seasonal influenza.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
63.5	70.1	90.0	90.0	Fluctuating

Proportion of Adults Aged 65 Years and Older Who Are Vaccinated Annually Against Influenza, Nevada Residents and United States, BRFSS Data, 2001 - 2009.*

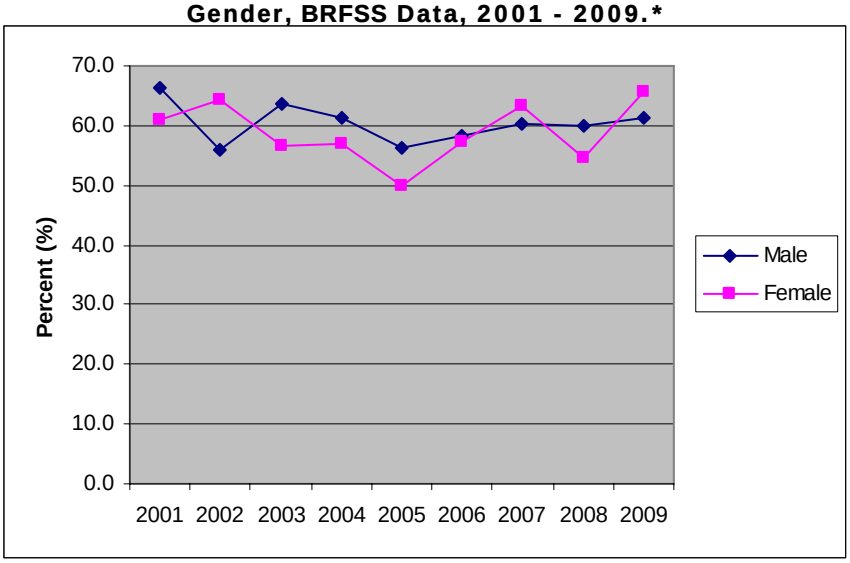


The proportion of adults aged 65 years and older who are vaccinated annually against influenza in the United States fluctuated from 2001 to 2009.

The proportion of Nevada adults aged 65 years and older who are vaccinated annually against influenza, while still consistently lower than the U.S., improved from 2005 to 2009.

From 2001 to 2009, the proportion of both males and female in Nevada who receive annual influenza vaccinations has remained relatively unchanged, hovering above 60.0 percent.

Proportion of Adults Aged 65 Years and Older Who Are Vaccinated Annually Against Influenza, Nevada Residents by Gender, BRFSS Data, 2001 - 2009.*



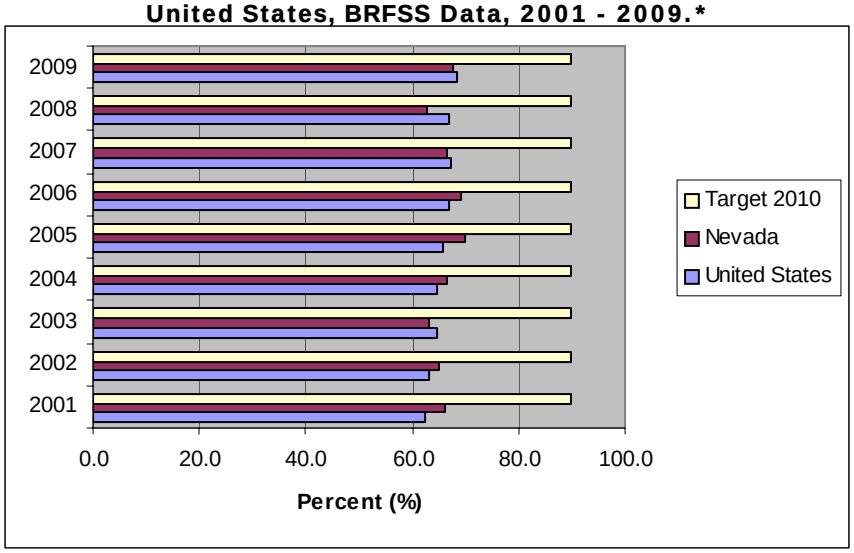
*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Healthy People 2010 Objective (14-29b.): Increase the proportion of adults, aged 65 years and older, who have ever received the pneumococcal vaccine.

Healthy People 2010 Objective IID HP 2020-13.1: Increase the proportion of noninstitutionalized adults, aged 65 years and older, who are vaccinated against pneumococcal disease.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
67.7	68.5	90.0	90.0	Fluctuating

Proportion of Adults Aged 65 Years and Older Who Have Ever Received the Pneumococcal Vaccine, Nevada Residents and United States, BRFSS Data, 2001 - 2009.*

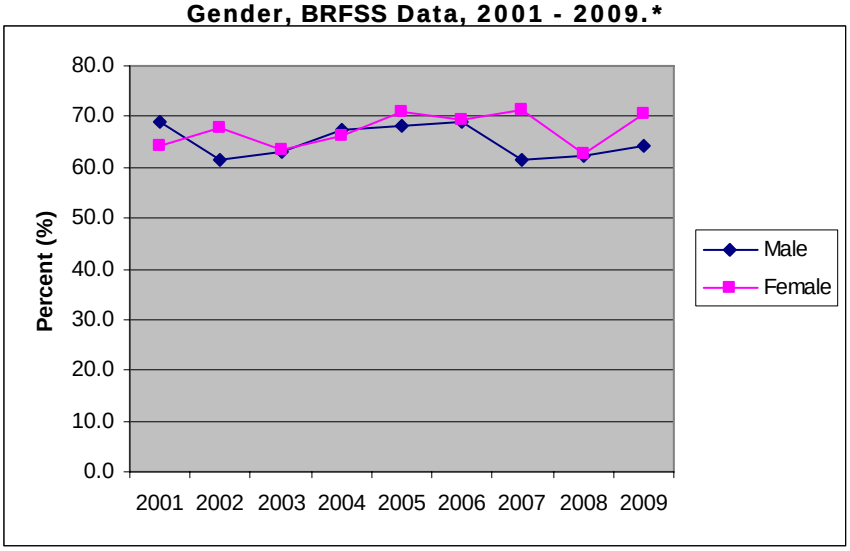


The proportion of Nevada adults aged 65 years and older who have ever received a pneumococcal vaccination was steady from 2001 to 2009. This proportion, among adults aged 65 years and older, nationally increased during the same time period.

Neither region has met the Healthy People 2010 target of 90.0 percent.

Proportion of Adults Aged 65 Years and Older Who Have Ever Received the Pneumococcal Vaccine, Nevada Residents by Gender, BRFSS Data, 2001 - 2009.*

From 2001 to 2009, the proportion of both males and females in Nevada who have ever received a pneumococcal vaccinations remained relatively unchanged hovering around 65.0 percent.



*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Injury and Violence Prevention

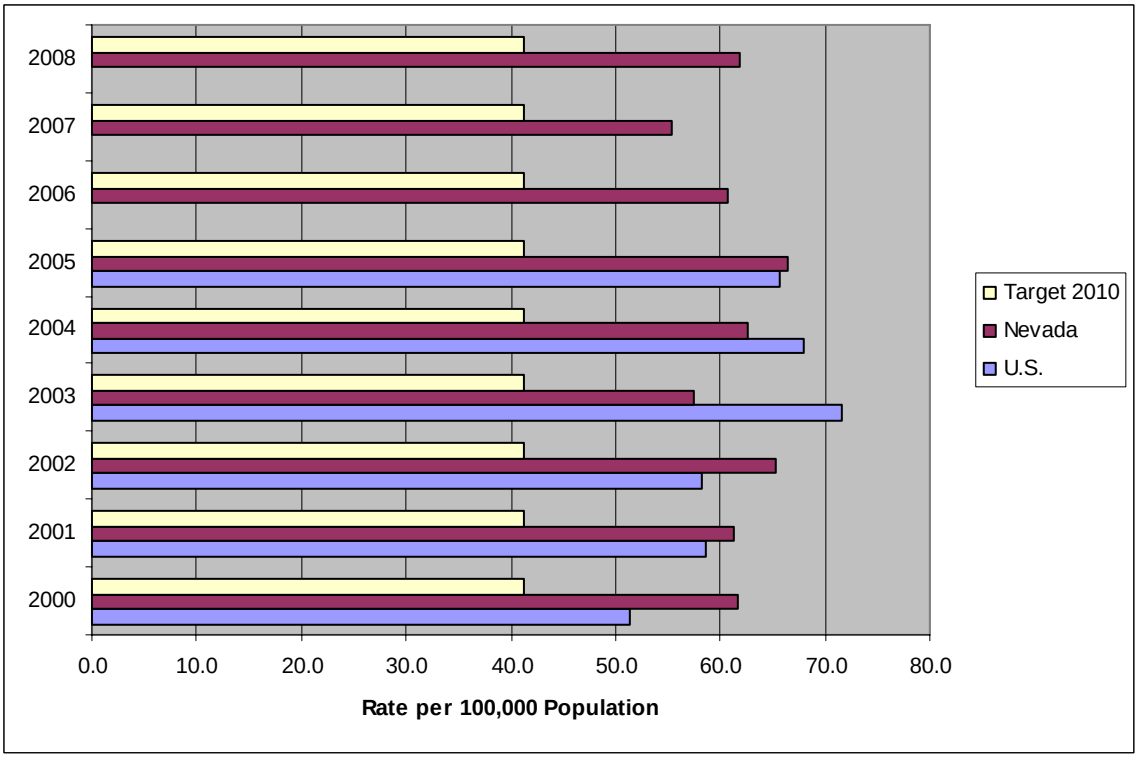
Millions of people each year are affected by injuries either to themselves or to someone they love. Unintentional injuries are the leading cause of death between the ages of 1 and 44 both nationally and in the state of Nevada. Unintentional injuries are a leading cause of disability among Americans, with more than 5 million people in the country reporting chronic, injury-related disabilities. The lives of millions of others have been affected by injuries to themselves or to someone they love.[1]

Healthy People 2010 Objective (15-1): Reduce hospitalizations for non-fatal head injuries.

Healthy People 2020 Objective IVP HP2020-1.2: Reduce hospitalizations for traumatic brain injuries.

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
61.9	65.7	41.2		Fluctuating

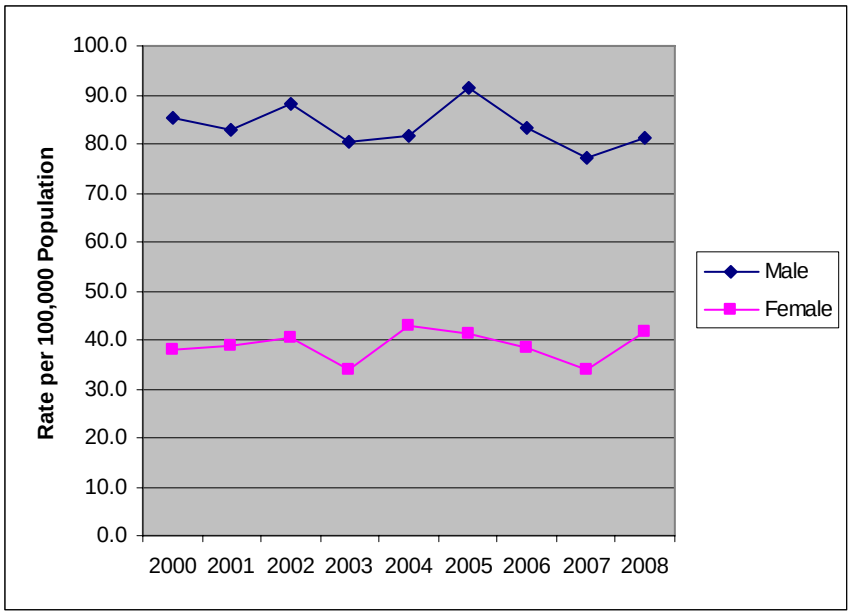
Hospitalization Rate for Non-Fatal Head Injuries, Nevada Residents and United States, 2000 - Most Current Data.*



Neither Nevada and the nation met the Healthy People 2010 target to reduce hospitalizations for non-fatal head injuries from 2000 to 2008.

*The Nevada data are from the Nevada Inpatient Hospital Discharge Database (NIHDD) and the U.S. data are from the National Hospital Discharge Survey (NHDS).
Note: See appendix for additional information.

Hospitalization Rate for Non-Fatal Head Injuries, Nevada Residents by Gender, 2000 - 2008.*

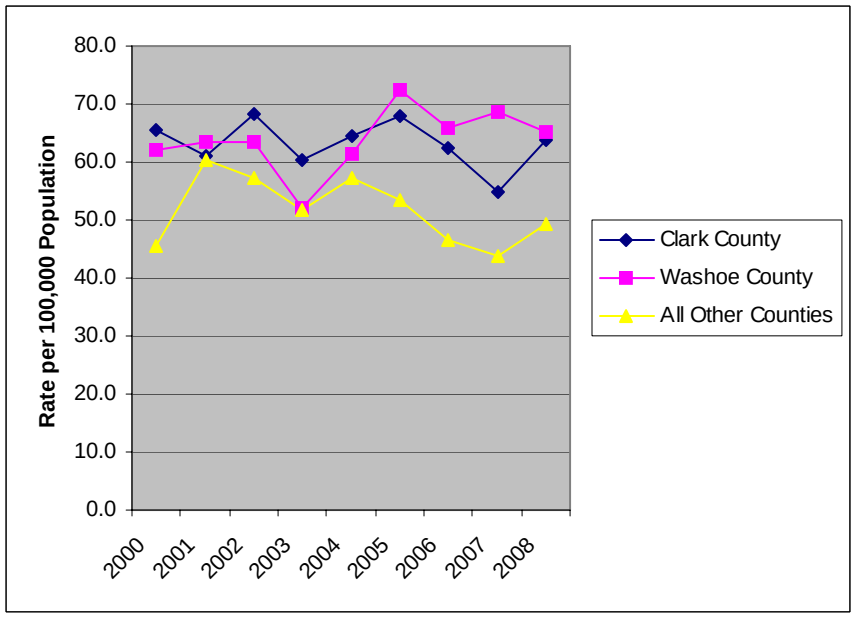


Over the past nine years, males in Nevada consistently have higher rates of hospitalization for non-fatal head traumas than their female counterparts.

Clark and Washoe Counties had the highest hospitalization rates for non-fatal head injuries from 2000 to 2008.
"All Other Counties", which includes Nevada's rural and frontier counties, has consistently had a lower hospitalization rate for non-fatal head injuries.

This follows the population distribution of Nevada since 87.4 percent of the population lives in these two counties, as per the State Demographer's 2009 estimates by county.

Hospitalization Rate for Non-Fatal Head Injuries, Nevada Residents by County/Region, 2000 - 2008.*



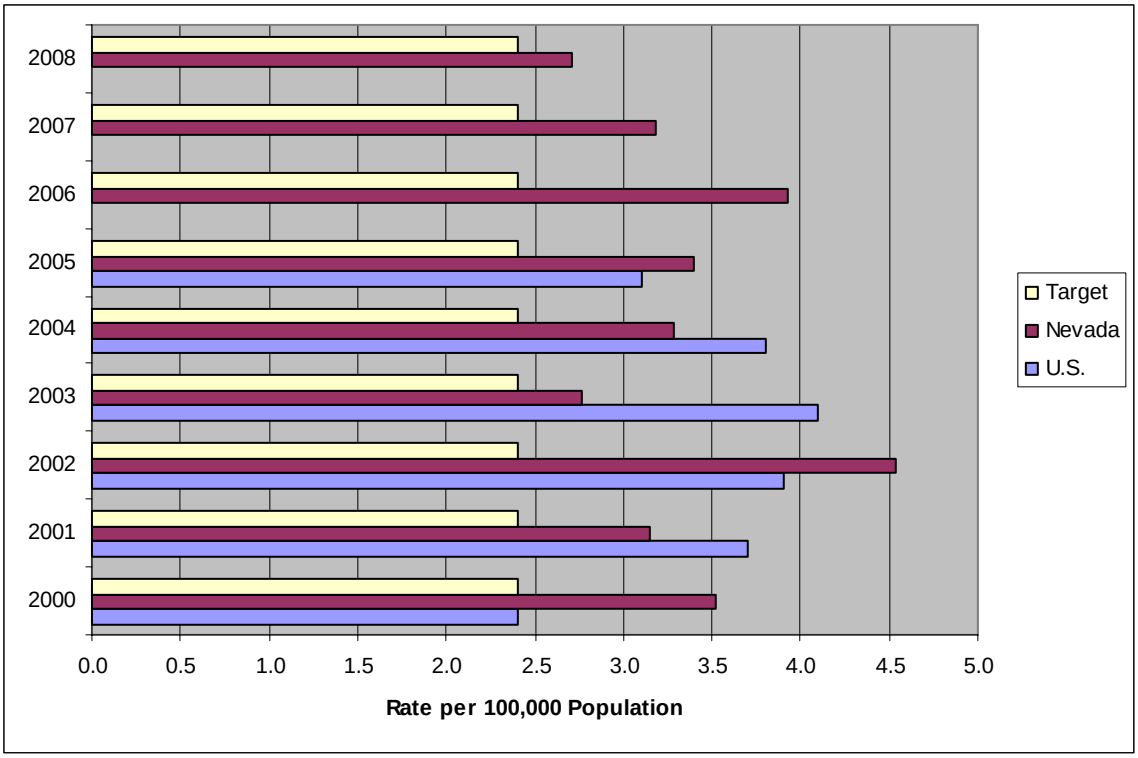
*The Nevada data are from the Nevada Inpatient Hospital Discharge Database (NIHDD).
Note: Race/Ethnicity data is not available.

Healthy People 2010 Objective (15-2): Reduce hospitalizations for nonfatal spinal cord injuries.

Healthy People 2020 Objective IVP HP2020-3.2: Reduce traumatic spinal cord injury morbidity and mortality.

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
2.7	3.1	2.4		Fluctuating

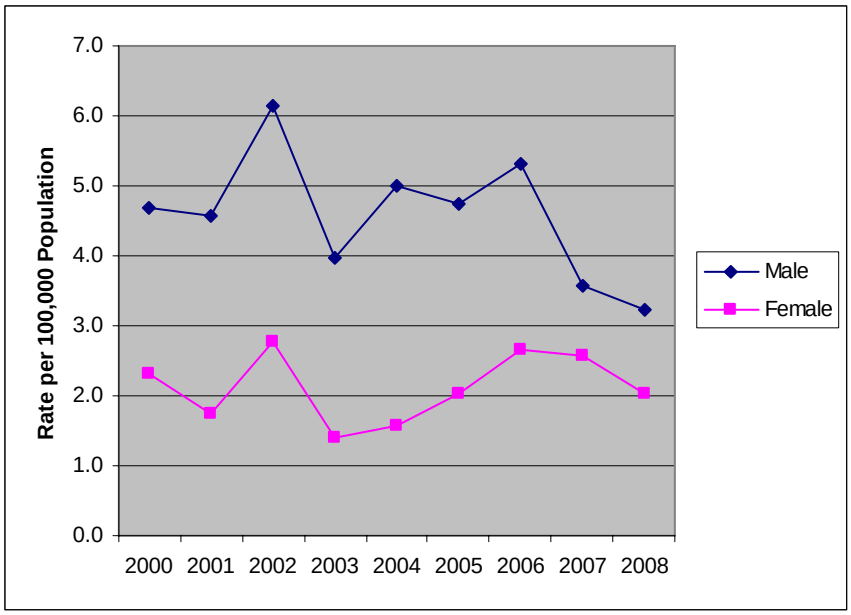
Hospitalization Rate for Non-Fatal Spinal Cord Injuries, Nevada Residents and United States, 2000 - Most Current Data.*



Nevada and the nation have both had difficulty in achieving the Healthy People 2010 target for reducing the hospitalization rate for non-fatal spinal cord injuries. However rates dropped over the last few years and may meet the target by 2010.

*The Nevada data are from the Nevada Inpatient Hospital Discharge Database (NIHDD) and the U.S. data are from the National Hospital Discharge Survey (NHDS).
Note: See appendix for additional information.

Hospitalization Rate for Non-Fatal Spinal Cord Injuries, Nevada Residents by Gender, 2000 - 2008.*



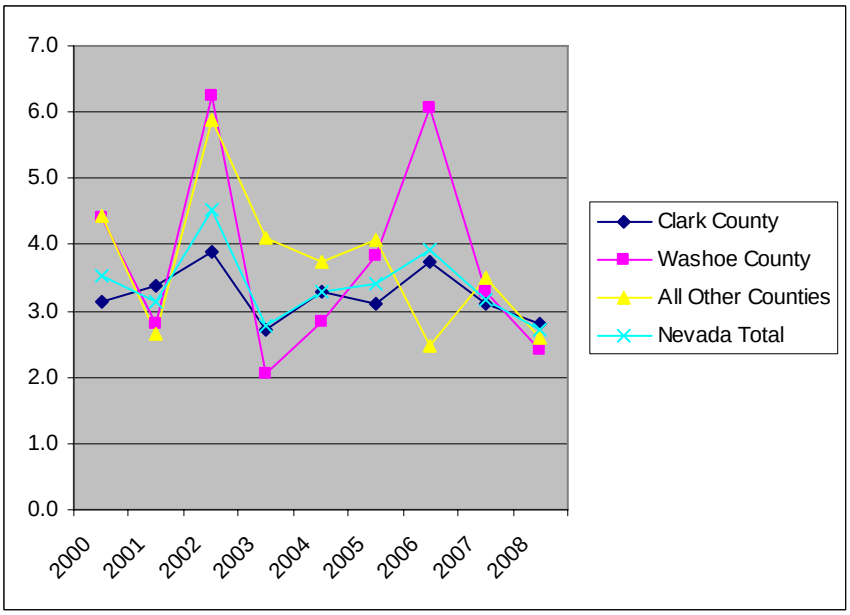
Nevada females had a lower rate of hospitalization for non-fatal spinal cord injuries than Nevada males from 2000 to 2009. The difference in rates for males and females have decreased.

An estimated 50 percent of all spinal cord injuries are the result of a motor vehicle accident, with SUV rollover accidents making up the majority of these.[2]

Other at-risk activities include trampoline accidents, falls, especially in those 45 years of age and older, violence, such as knife and gunshot wounds, and sports injuries, such as diving accidents.[2]

The hospitalization rates for non-fatal spinal cord injuries were similar among all regions in the years 2007 and 2008.

Hospitalization Rate for Non-Fatal Spinal Cord Injuries, Nevada Residents by County/Region, 2000 - 2008.*



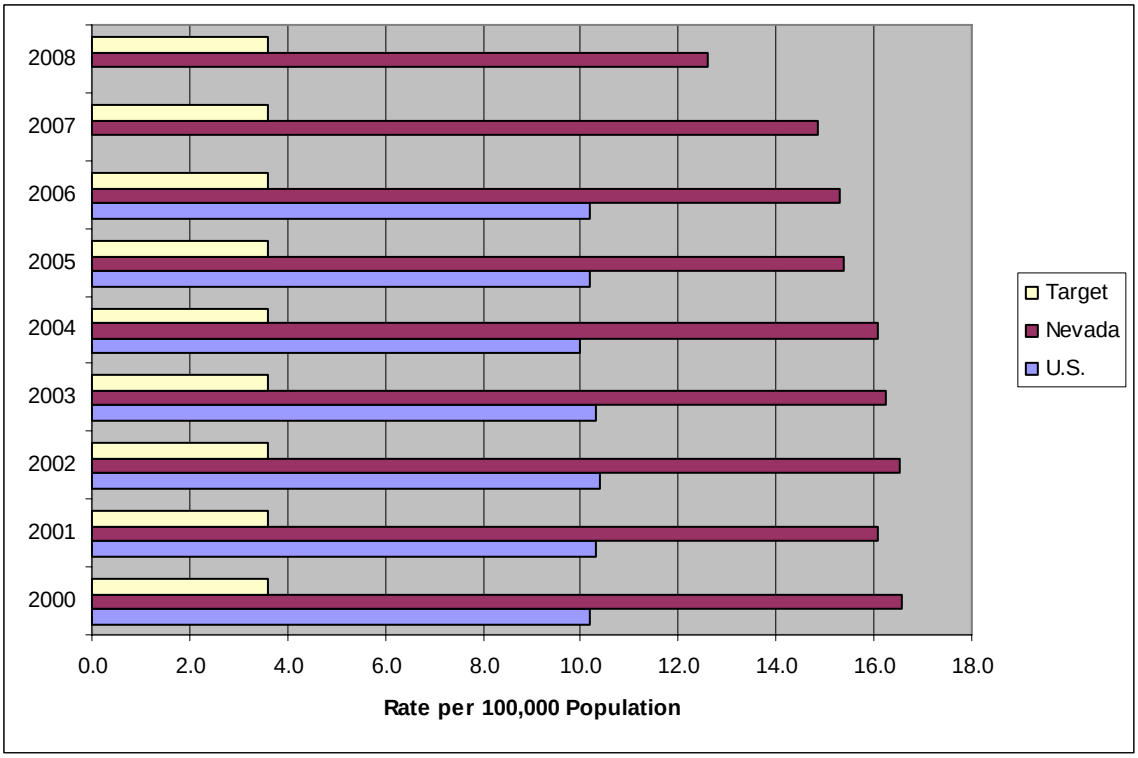
*The Nevada data are from the Nevada Inpatient Hospital Discharge Database (NIHDD).
Note: Race/Ethnicity data are not available.

Healthy People 2010 Objective (15-3): Reduce firearm-related deaths.

Healthy People 2020 Objective IVP HP2020-30: Reduce firearm-related deaths.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
12.6	10.2	3.6		Improving

Age-Adjusted Firearm Related Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*

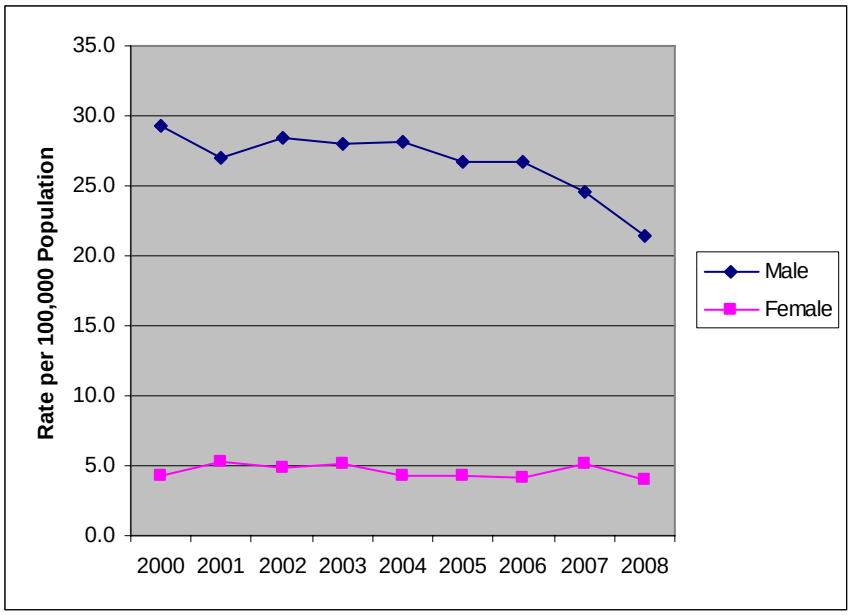


The national and Nevada rates for firearm related deaths were higher than the Healthy People 2010 target from 2000 to 2008. The national rate remained steady during the reported years, while the Nevada rate decreased overall from 2000 to 2008.

In 2009, Pennsylvania State University's Firearm & Injury Center reported that over a twenty-six year period (1980 - 2006), an average of 32,300 Americans died each year from firearm injuries of all reported types.[3] About 30,000 firearm related deaths occur in the United States annually, Nevada had the 7th highest rate of firearm homicides in the nation from 2003—2005.[3]

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Firearm Related Death Rate, Nevada Residents by Gender, 2000 - 2008.*



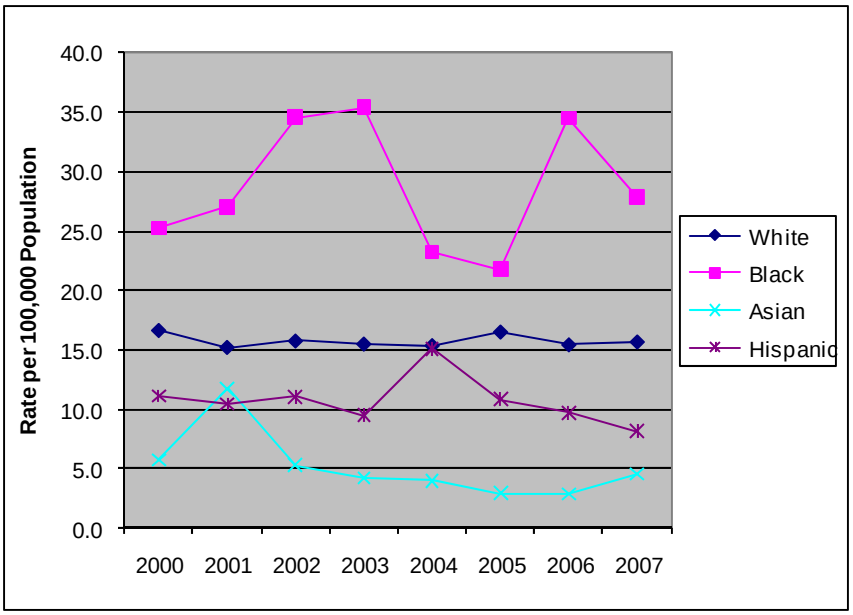
Males had a higher rate of firearm related death rate than females in Nevada from 2000 to 2008. From 2006 to 2008, firearm related deaths among Nevada males have decreased.

In 2004, firearms were used in 59 percent of suicide deaths nationally.[4]

Firearm death rates in the United States vary by state. The five states with the highest firearm death rates are Louisiana, Alaska, Nevada, Mississippi and Alabama. For most states, firearm suicide rates exceed those of firearm homicide.[3]

In Nevada, Blacks had the highest rate of firearm related deaths of all race/ethic groups from 2000 to 2007.

Age-Adjusted Firearm Related Death Rate, Nevada Residents by Race/Ethnicity, 2000 - 2007.*



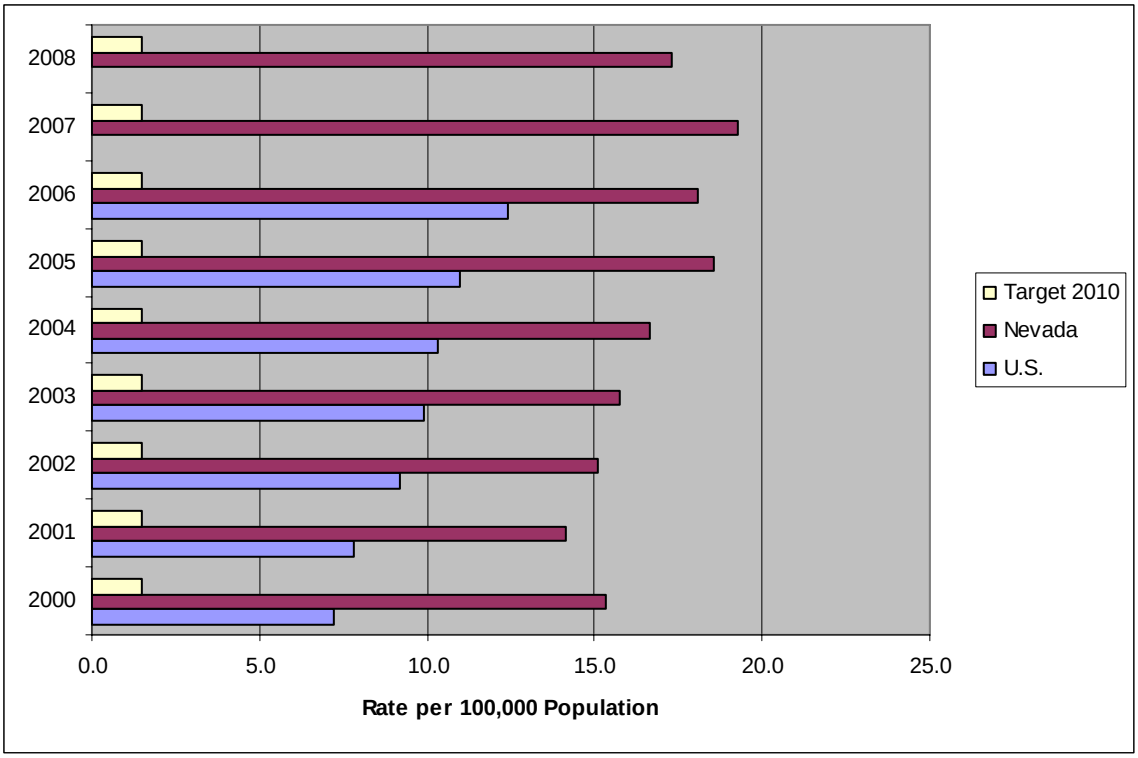
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group due too small counts.

Healthy People 2010 Objective (15-8): Reduce deaths caused by poisonings.

Healthy People 2020 Objective IVP HP2020-9.1: Prevent an increase in the rate of poisoning deaths among all persons.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
17.3	12.4	1.5		Worsening

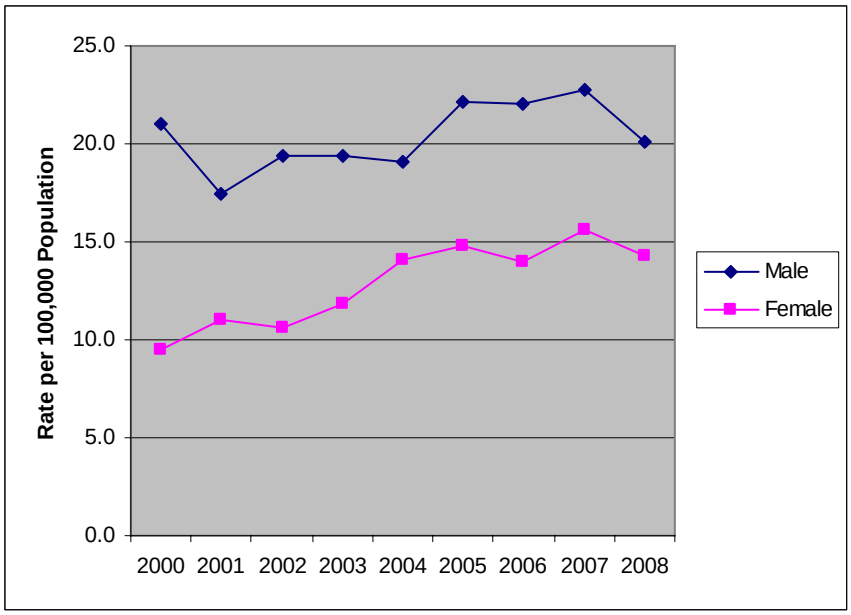
Age-Adjusted Death Rate Caused by Poisoning, Nevada Residents and United States, 2000 - Most Current Data.*



Nevada's death rate caused by intentional and unintentional poisoning has higher than the national rate from 2000 to 2006. Neither the nation nor Nevada met the Healthy People 2010 target for reducing deaths caused by poisonings during the reported years.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

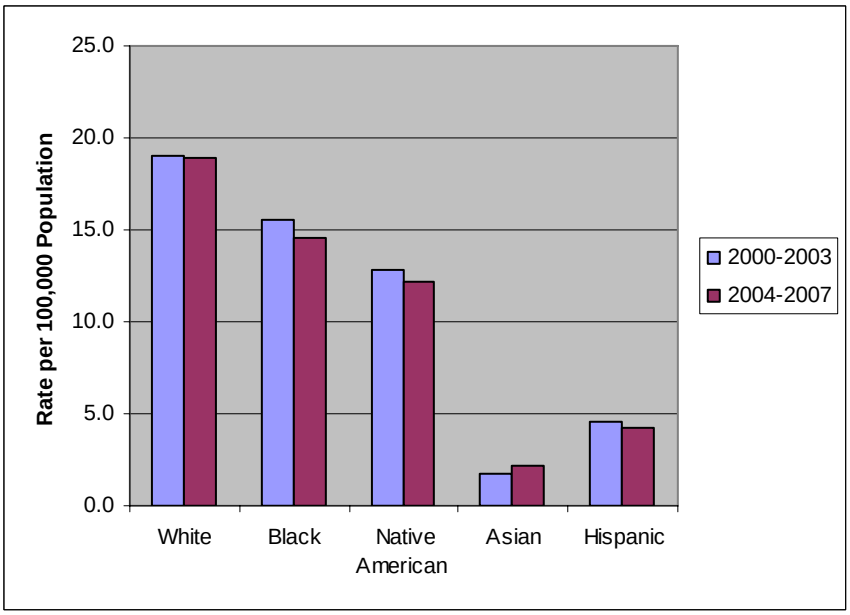
Age-Adjusted Death Rate Caused by Poisoning, Nevada Residents by Gender, 2000 - 2008.*



Males in Nevada had more deaths caused by poisoning than Nevada females over the years 2000 through 2008.

Aggregated Age-Adjusted Death Rate Caused by Poisoning, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2007.*

Whites and Blacks lead all other racial/ethnic groups for deaths caused by poisoning in Nevada, followed by Native Americans, Hispanics, and Asians respectively.



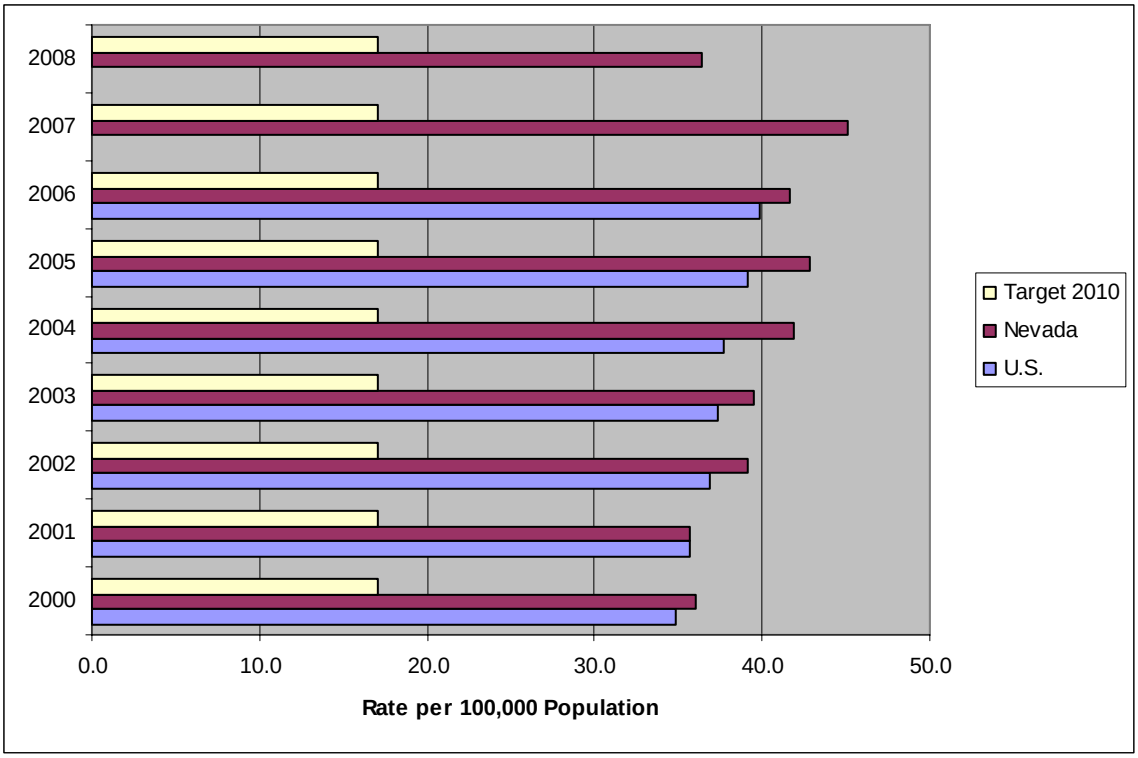
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.

Healthy People 2010 Objective (15-13): Reduce deaths caused by unintentional injuries.

Healthy People 2020 Objective IVP HP2020-11: Reduce unintentional injury deaths.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
36.4	39.8	17.1		Fluctuating

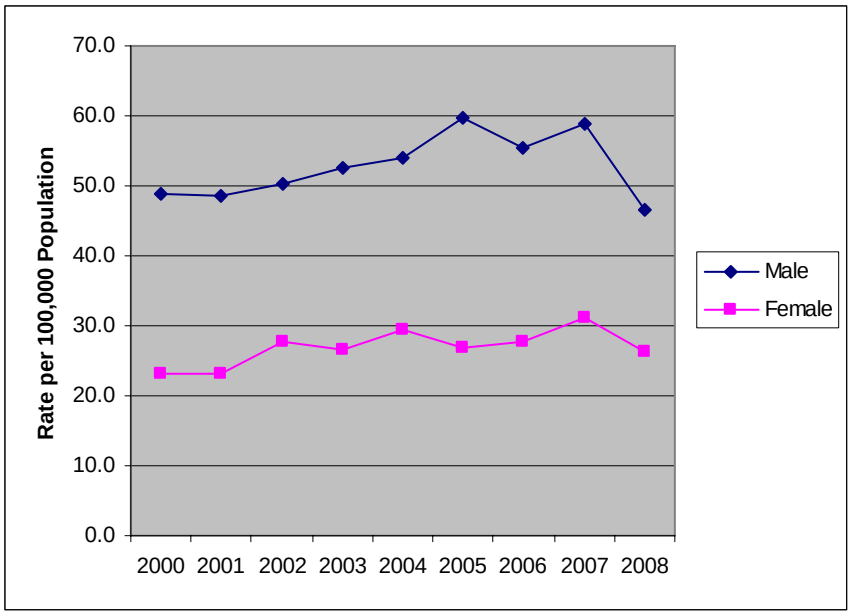
Age-Adjusted Death Rate Caused by Unintentional Injuries, Nevada Residents and United States, 2000 - Most Current Data.*



Both the Nevada and national unintentional injury death rates were higher than the Healthy People 2010 target from 2000 to 2008. Unintentional injuries are the leading cause of death among Nevadans aged 1 to 44 years.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Death Rate Caused by Unintentional Injuries, Nevada Residents by Gender, 2000 - 2008.*

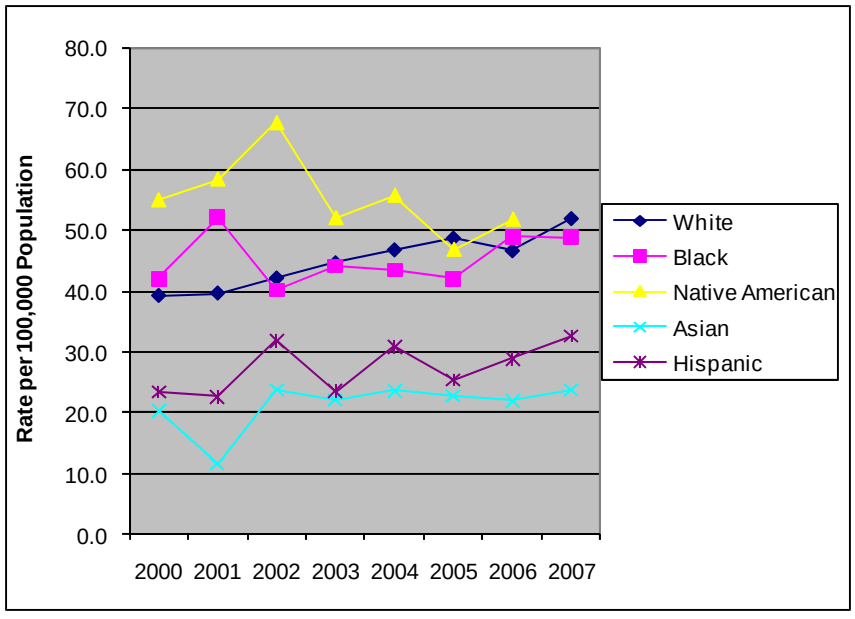


From 2000 to 2008, females had a lower rate of accidental death compared to males in Nevada, whose rate of accidental deaths is nearly double that of females.

Age-Adjusted Death Rate Caused by Unintentional Injuries, Nevada Residents by Race/Ethnicity, 2000 - 2007.*

Native Americans suffered more accidental deaths in Nevada than any other racial group during the years 2000 through 2004. From 2005 to 2007, Whites, Blacks, and Native Americans have had similar unintentional injury death rates.

Asians had the lowest unintentional injury death rate from 2000 to 2008, followed by Hispanics.



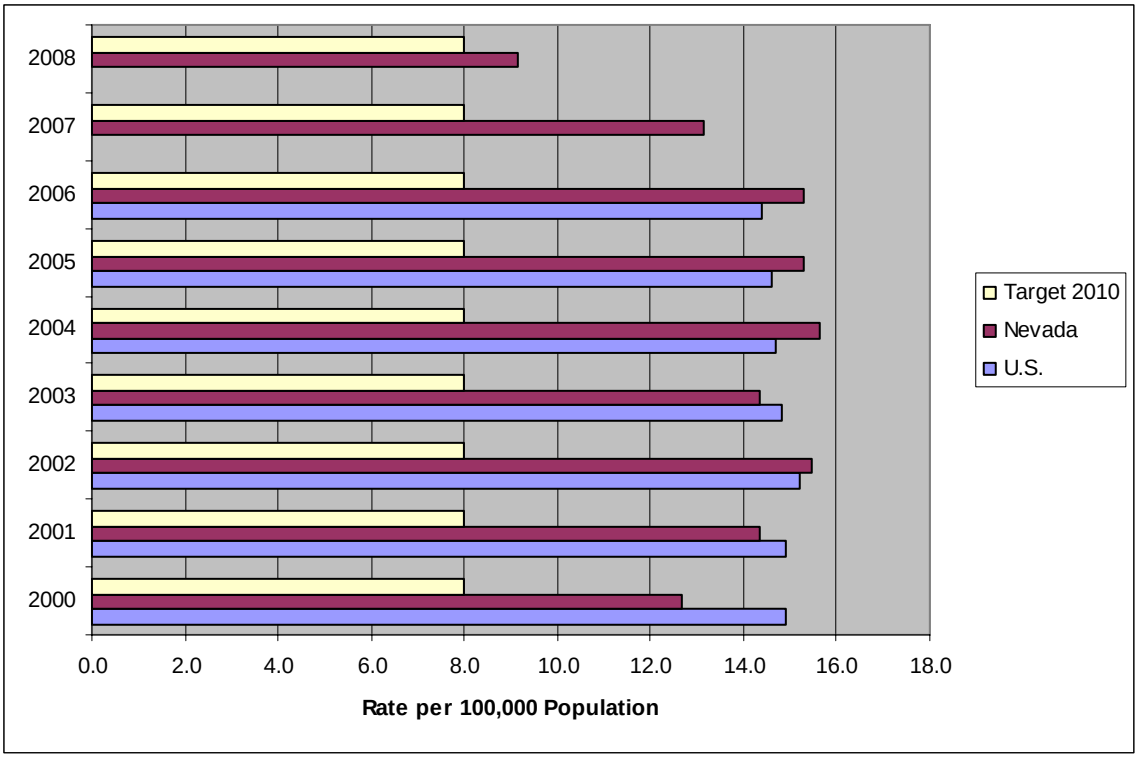
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group for the year 2007 due to small counts.

Healthy People 2010 Objective (15-15a.): Reduce deaths caused by motor vehicle crashes.

Healthy People 2020 Objective IVP HP2020-13.1: Reduce motor vehicle crash-related deaths.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
9.2	14.4	8.0		Improving

Age-Adjusted Death Rate Caused by Motor Vehicle Crashes, Nevada Residents and United States, 2000 - Most Current Data.*

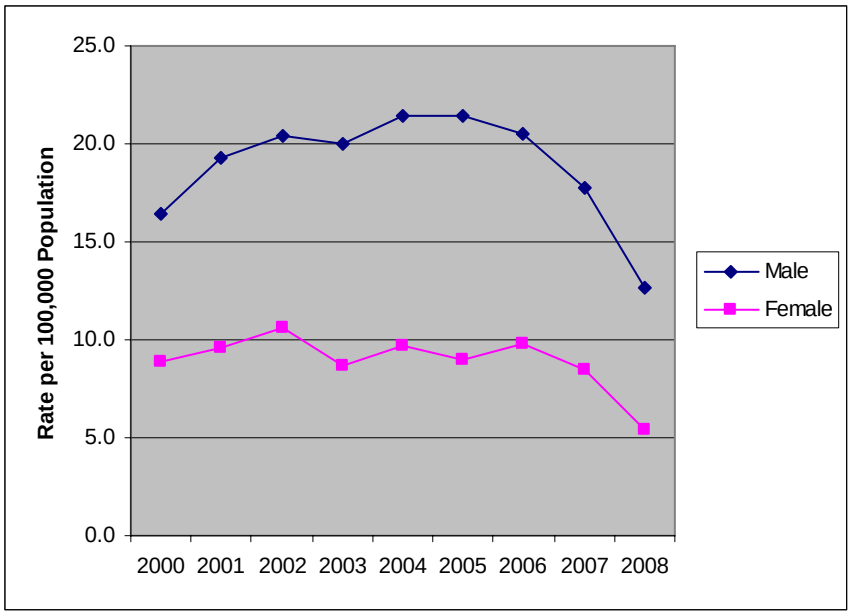


Both the Nevada and the national rates for deaths caused by motor vehicle accidents were higher than the Healthy People 2010 target. However, Nevada rates decreased from 2006 to 2008.

Motor vehicle crashes are the leading cause of death and injury for Nevadans aged 5 to 34 years. In 2006, some 62,225 motor vehicle crashes resulted in 32,669 injuries and 423 deaths. As with many types of injury, motor vehicle crashes disproportionately involve young drivers.[5]

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

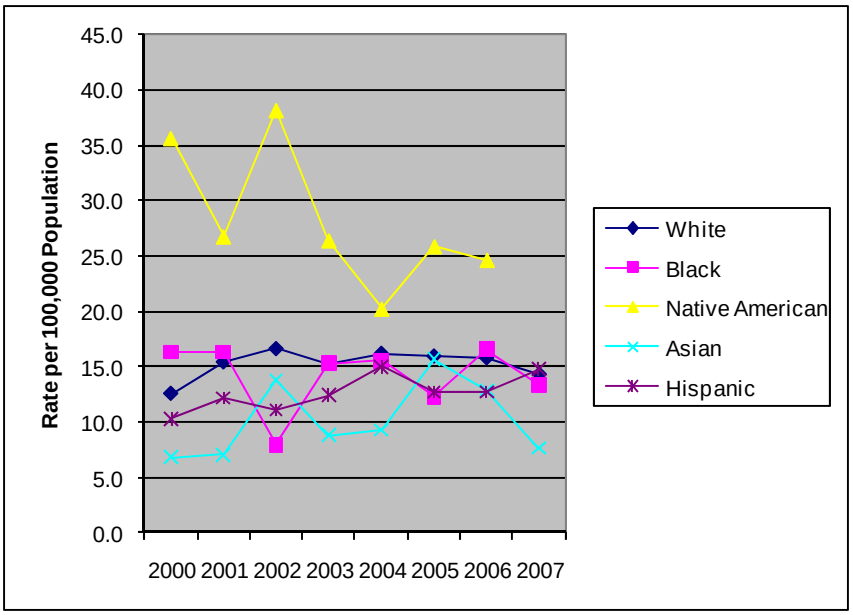
Age-Adjusted Death Rate Caused by Motor Vehicle Crashes, Nevada Residents by Gender, 2000 - 2008.*



Nevada's death rates for motor vehicle crashes among both males and females decreased from 2006 to 2008. Males have a higher rate of deaths due to motor vehicle crashes than females in Nevada.

Age-Adjusted Death Rate Caused by Motor Vehicle Crashes, Nevada Residents by Race/Ethnicity, 2000 - 2007.*

From 2000 to 2003, Native Americans held a higher death rate for motor vehicle accidents than all other races/ethnicities. In 2006 and 2007 Black and White Nevada residents had similar death rates from motor vehicle accidents.



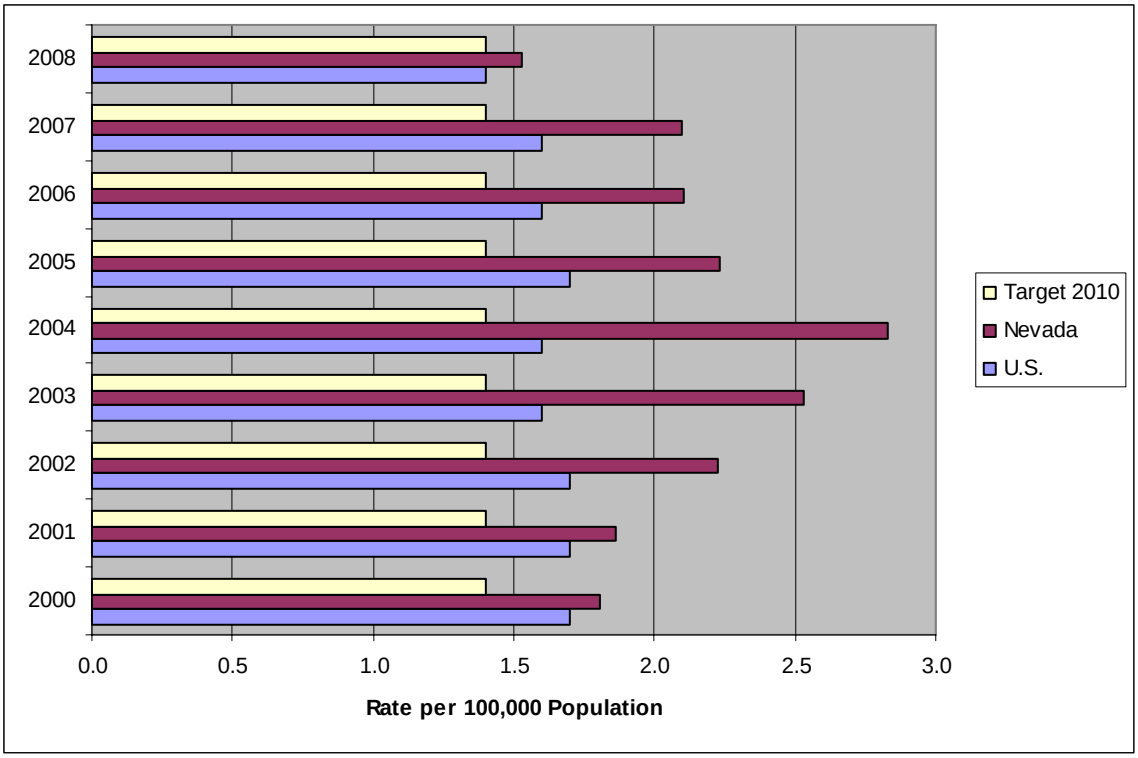
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group for 2007 due to small counts.

Healthy People 2010 Objective (15-16): Reduce pedestrian deaths on public roads.

Healthy People 2020 Objective IVP HP2020-18: Reduce pedestrian deaths on public roads.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
1.5	1.4	1.4		Improving

Age-Adjusted Pedestrian Death Rate on Public Roads, Nevada Residents and United States, 2000 - 2008.*

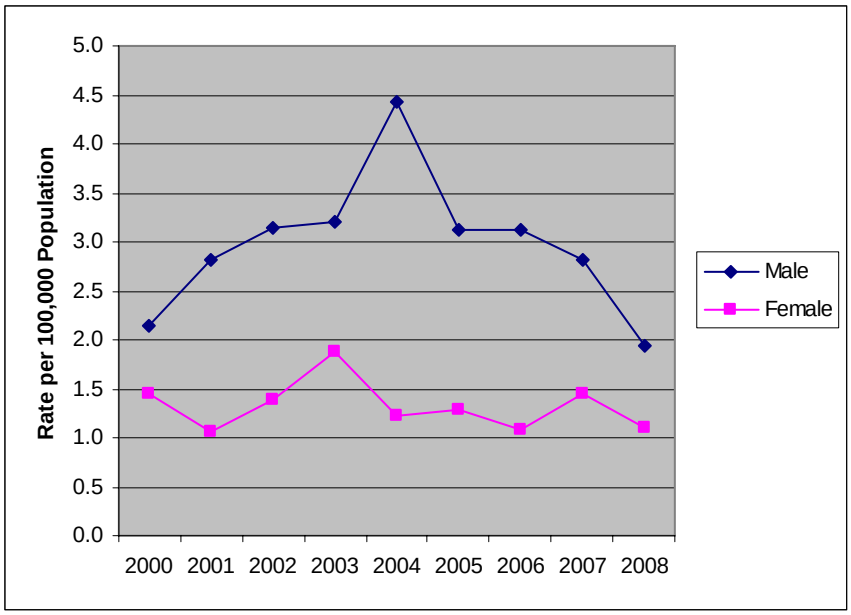


The U.S. and Nevada pedestrian death rates were higher than the Healthy People 2010 target during the years 2000 through 2008. Rates in both regions decreased from 2004 to 2008 and in 2008 the U.S. rate met the Healthy People target.

Pedestrian crashes represent only 0.2 percent of all traffic crashes in Nevada, and they almost always result in a documented injury. These human verses vehicle crashes are disproportionately fatal and account for an average of 6.4 percent of severe injuries and 17.8 percent of all motor vehicle related fatalities in Nevada each year.[5]

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Pedestrian Death Rate on Public Roads, Nevada Residents by Gender, 2000 - 2008.*

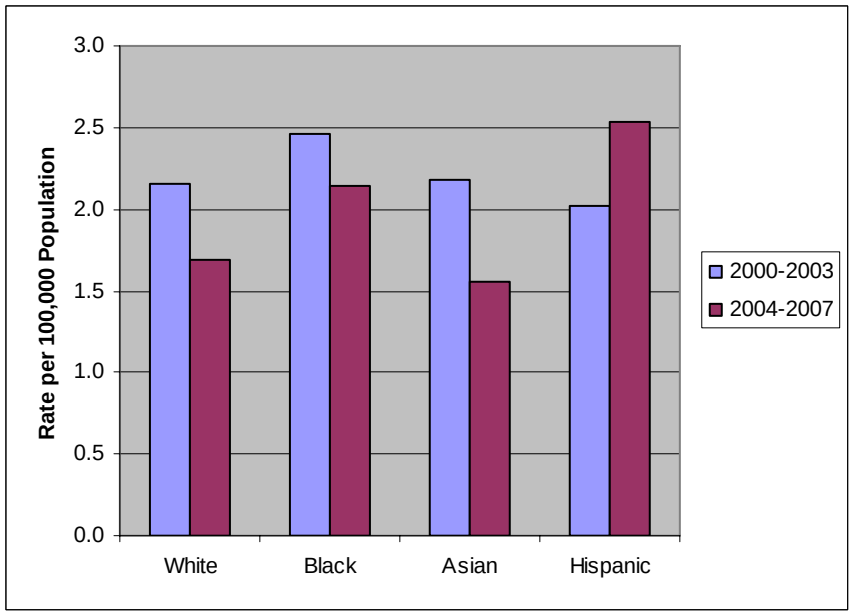


As with many injury related deaths, males had a higher pedestrian death rate than females from 2000 to 2008 in Nevada.

Rates for Nevada females were fairly consistent from 2000 to 2008. However, the pedestrian death rate on public roads for Nevada males was increased from 2000 to 2004 and has decreased from 2004 to 2008.

Aggregated Age-Adjusted Pedestrian Death Rate on Public Roads, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2007.*

The pedestrian death rate on public roads decreased among Nevada's Whites, Blacks, and Asians over the years. However, this rate increased among Nevada's Hispanic population.



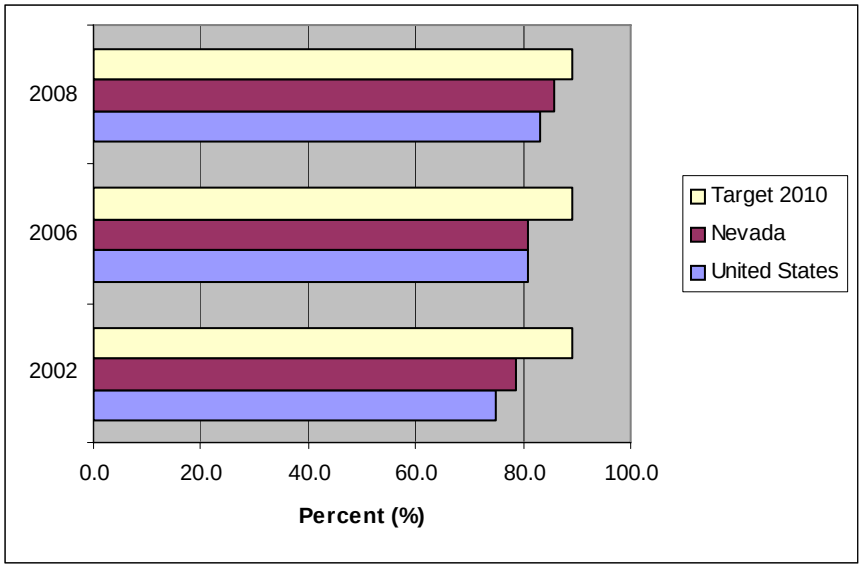
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group due to small counts.

Healthy People 2010 Objective (15-19): Increase the use of safety belts.

Healthy People 2020 Objective IVP HP2020-15: Increase use of safety belts.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
85.8	83.0	89.0		Improving

Percentage of People Who Report Always Using Safety Belts, Nevada Residents and United States, 2002, 2006, 2008.*

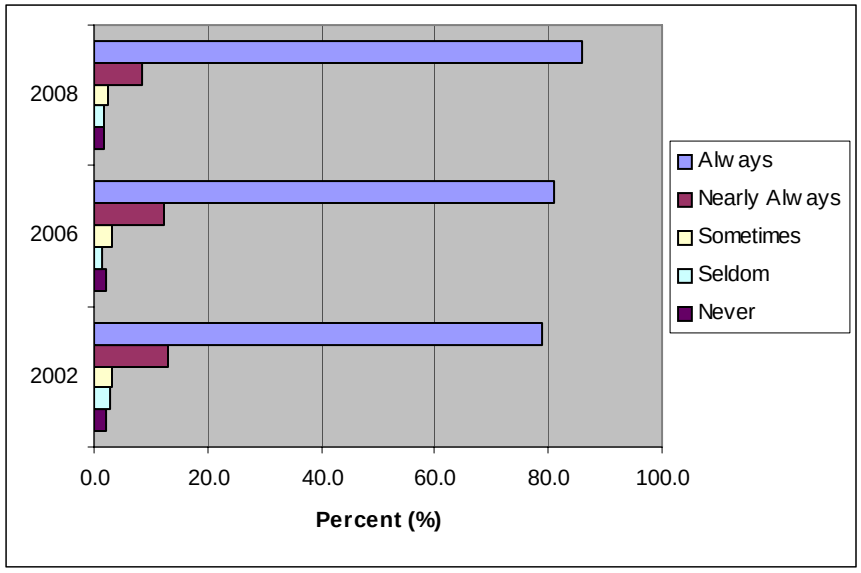


The proportion of adults who report always using a safety belt, in Nevada and the United States, did not meet the Healthy People 2010 target in 2002, 2006, or 2008. The proportion of adults who report always using a safety belt improved in both regions over the reported years, which could be attributed to secondary seatbelt laws.

In Nevada, 37 teen drivers and passengers, ages 16 to 20, were killed during 2007 in motor vehicle crashes, and more than 70 percent (25 teenagers) were not wearing their seat belts at the time of the fatal crash.[6]

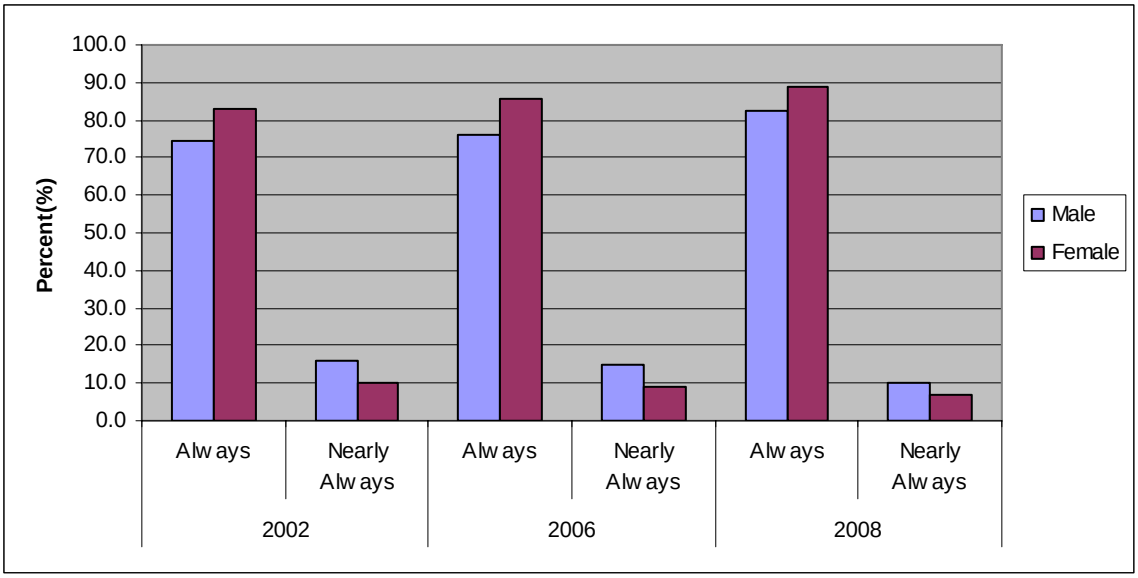
The Nevada Highway Patrol states that more than half of those lives could have been saved with 100 percent seatbelt usage.[6]

Proportion of People Using Safety Belts, Nevada Residents, BRFSS Data, 2002, 2006, 2008.*



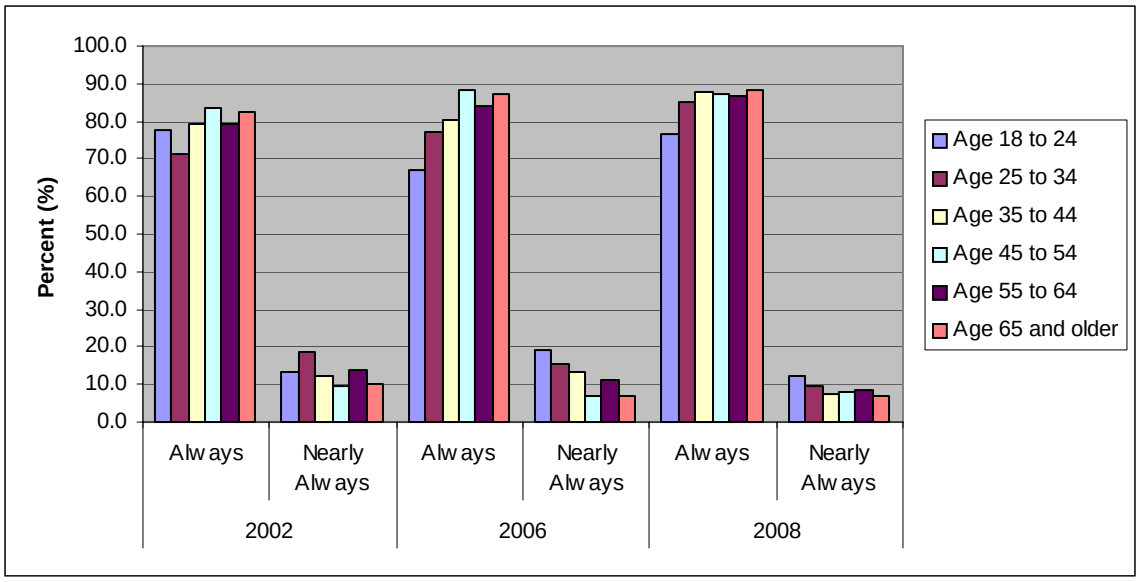
*The Nevada data are from the Behavioral Risk Factor Surveillance Survey (BRFSS). The U.S. data are from the National Occupant Protection Use Survey (NOPUS), DOT, and NHTSA.
Note: Due to the difference is data sources the Nevada data and the U.S. data may not be directly comparable and thus caution must be used when comparing.
Note: For Nevada data, percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of People Using Safety Belts, Nevada Residents by Gender, BRFSS Data, 2002, 2006, 2008.*



The proportion of Nevada females who always wear their seatbelts was higher than the proportion of Nevada males who always wear their seatbelts in 2002, 2006, and 2008

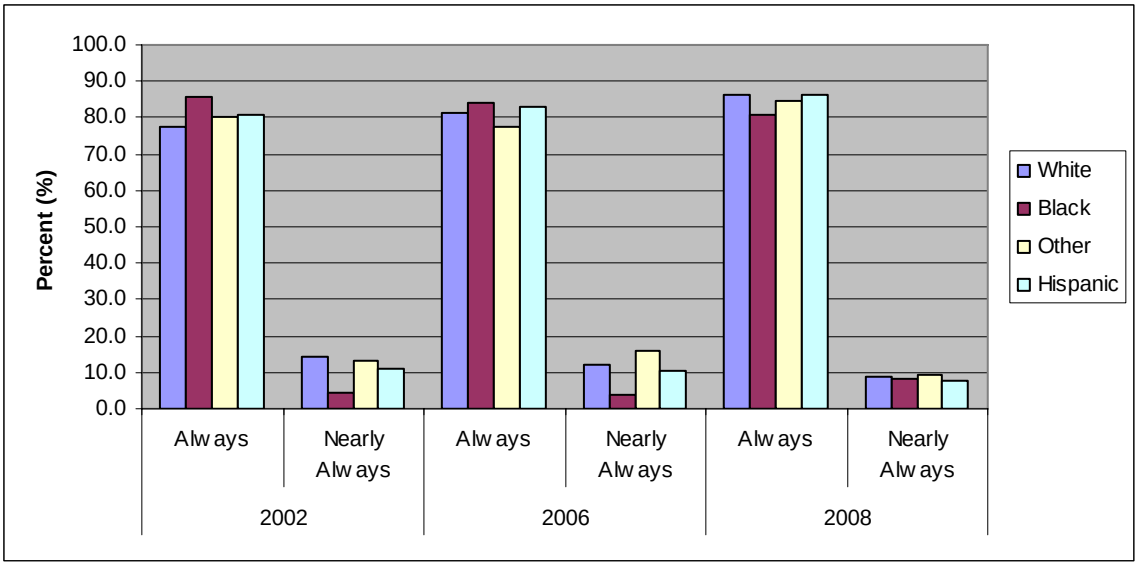
Proportion of People Using Safety Belts, Nevada Residents by Age, BRFSS Data, 2002, 2006, 2008.*



Seatbelt use by Nevada adults aged 18 to 24 years fluctuated in 2002, 2006 and 2008, while use by all other drivers has risen over the reported years 2002-2008. The percentage of people unbuckled who were hurt or killed in vehicle accidents costs the U.S. $18 billion a year.[9]

*These percentages are weighted to survey population characteristics.

Proportion of People Using Safety Belts, Nevada Residents by Race/Ethnicity, BRFSS Data, 2002, 2006, 2008.*



Blacks seatbelt usage appears to have decreased from 2002 to 2008, while all other race/ethnicities are increased.

In one year alone, crash victims who used seatbelts in Nevada would benefit by a health care reduction of more than $503,000. Nevada would also reduce its spending by $1.6 million ($930,000 after reimbursement for Medicaid expenditures).[9]

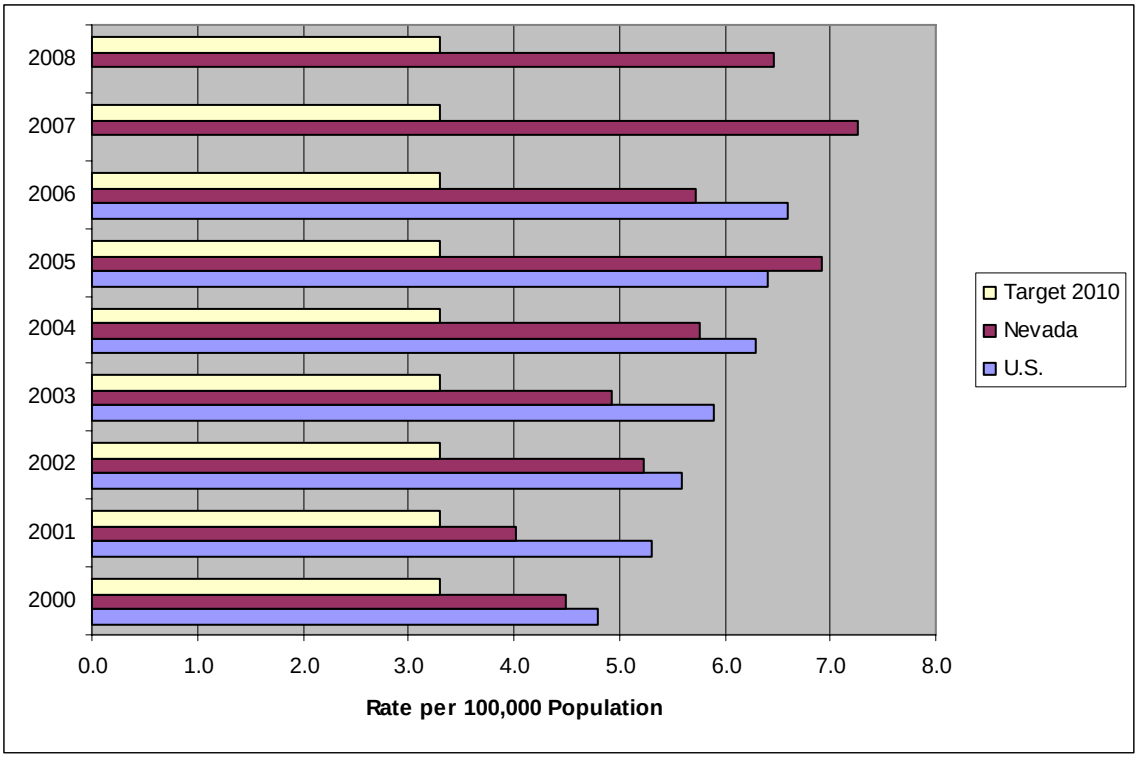
*These percentages are weighted to survey population characteristics. Not all counties were included in the survey results.

Healthy People 2010 Objective (15-27): Reduce deaths from falls.

Healthy People 2020 Objective IVP HP2020–22.1: Reduce fall-related deaths.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
6.5	6.6	3.3		Worsening

Age-Adjusted Death Rate From Falls, Nevada Residents and United States, 2000 - Most Current Data.*



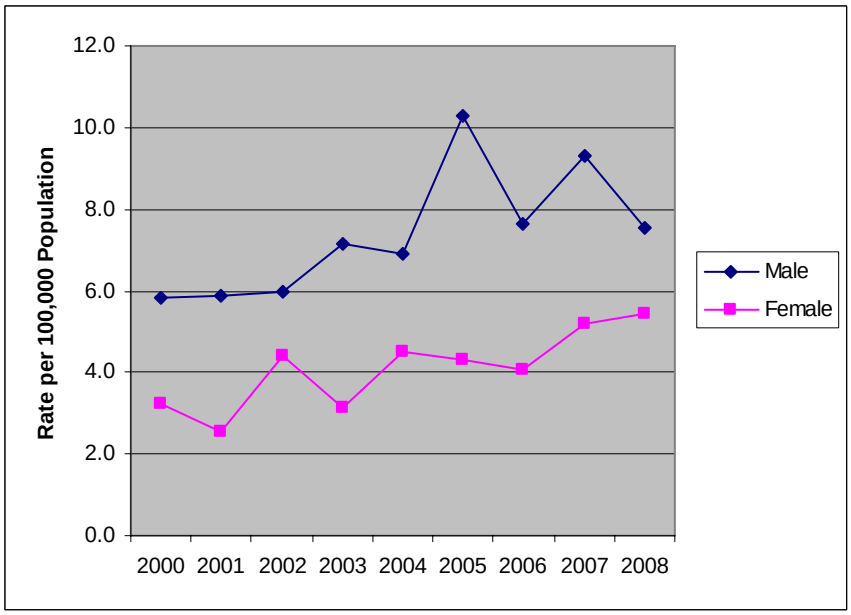
The death rate from falls in Nevada increased from 2000 to 2008, at 6.5 per 100,000 people in 2008.

From 2000 to 2006, Nevada experienced fluctuation in the rate for age-adjusted unintentional fall mortality. The national mortality rate for death from falls also increased from 2000 to 2006.

The Nevada counties with the highest unintentional fall death rates per capita included Esmeralda, Storey, Lincoln, and Carson City.[5]

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

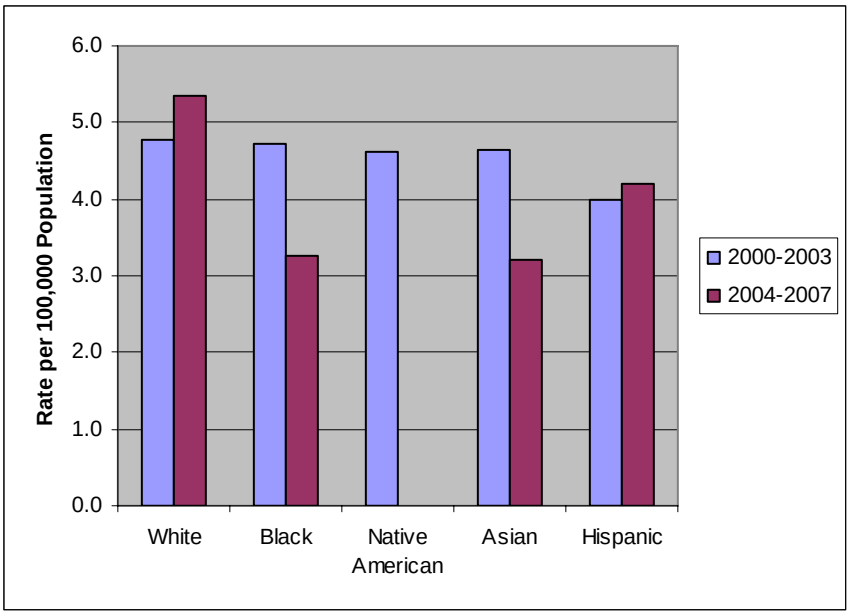
Age-Adjusted Death Rate From Falls, Nevada Residents by Gender, 2000 - 2008.*



Males had a higher death rate from falls than females in Nevada from 2000 to 2008.

Age also is strongly correlated with risk of fall mortality. As age increases so does the rate of deaths due to falls, especially those 60 years and older. The highest rate of fall death occurs among those who are 85 years or older.[7]

Aggregated Age-Adjusted Death Rate From Falls, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2007.*



The highest age-adjusted death rate from falls in Nevada was for those aged 85 and older, at 2,248 per 100,000 population in 2000 to 2003, followed by the 75-84 year age group with an rate of 740 per 100,000 population.[7]

Nevada's death rate from falls increased among White residents in the combined years 2004 through 2007 when compared to 2000 through 2003.

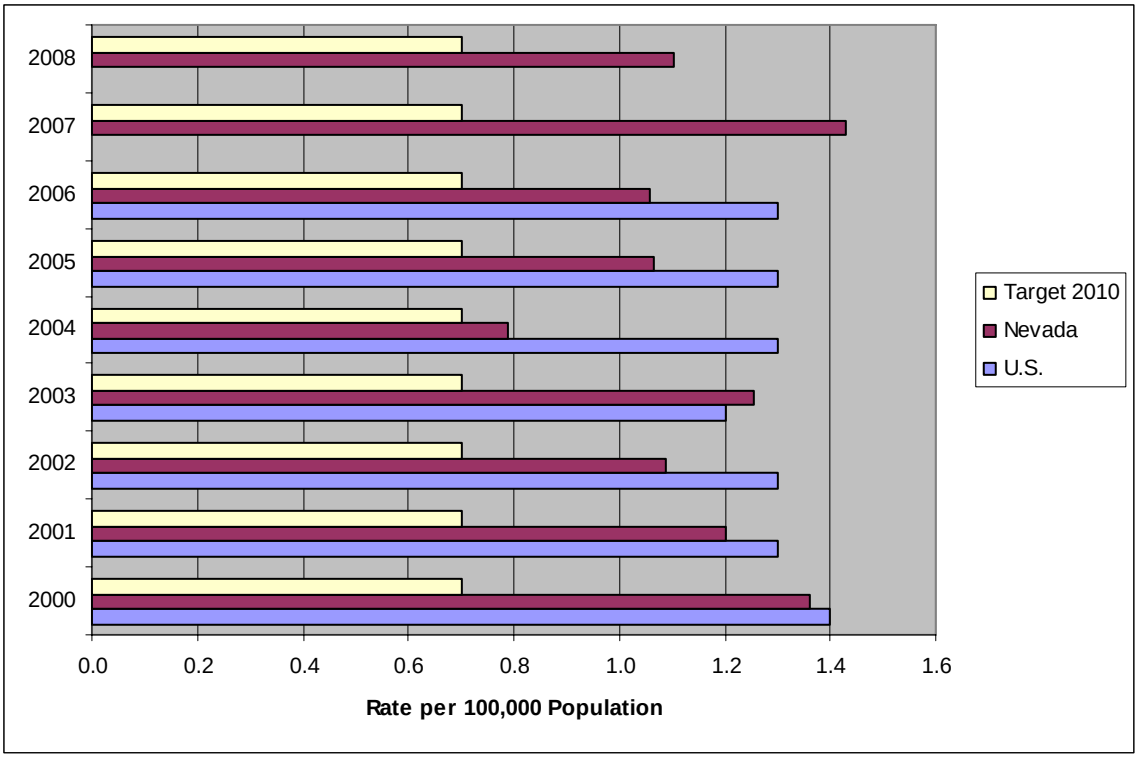
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group for the years 2004-2007 due to small counts.

Healthy People 2010 Objective (15-29): Reduce deaths from drowning.

Healthy People 2020 Objective IVP HP2020-25: Reduce drowning deaths.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
1.1	1.3	0.7		Fluctuating

Age-Adjusted Death Rate From Drowning, Nevada Residents and United States, 2000 - Most Current Data.*



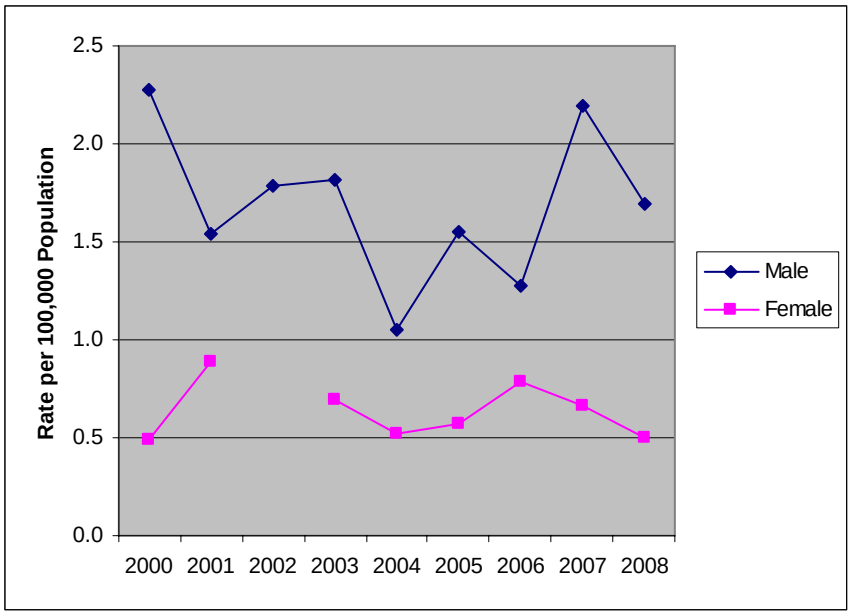
The death rates from drowning in both the U.S. and in Nevada fluctuated from 2000 to 2008. Neither the national, nor the Nevada rates met the Healthy People 2010 target of 0.7 per 100,000 popuation.

In 2005, the CDC reported that, nationally, there were just over 3,500 fatal unintentional drownings. This averages to approximately ten deaths per day. About a quarter of fatal drowning victims are children 0 -14 years of age.

Nearly all who require cardiopulmonary resuscitation (CPR) die or are left with severe brain damage[8]

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Death Rate From Drowning, Nevada Residents by Gender, 2000 - 2008.*

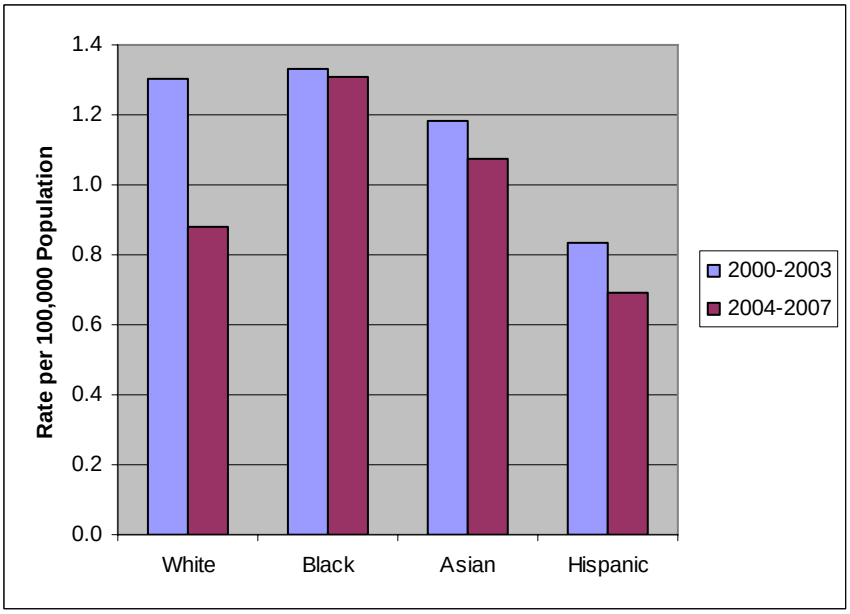


Males lead females in rate of death from drowning which, in 2008, was more than triple that of females.

Children aged 1-4 most often drown in hot tubs, spas, and swimming pools.[8]

Children aged 5-14 most often drown in swimming pools and open water such as rivers, lakes, dams and canals.[8]

Aggregated Age-Adjusted Death Rate From Drowning, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2007.*



Between 2004 and 2007, the fatal unintentional drowning rates for Blacks and Asians were higher than other racial/ethnic groups. Rates for all races/ethnicities have decreased from the combined years 2000 though 2003 to 2004 through 2007.

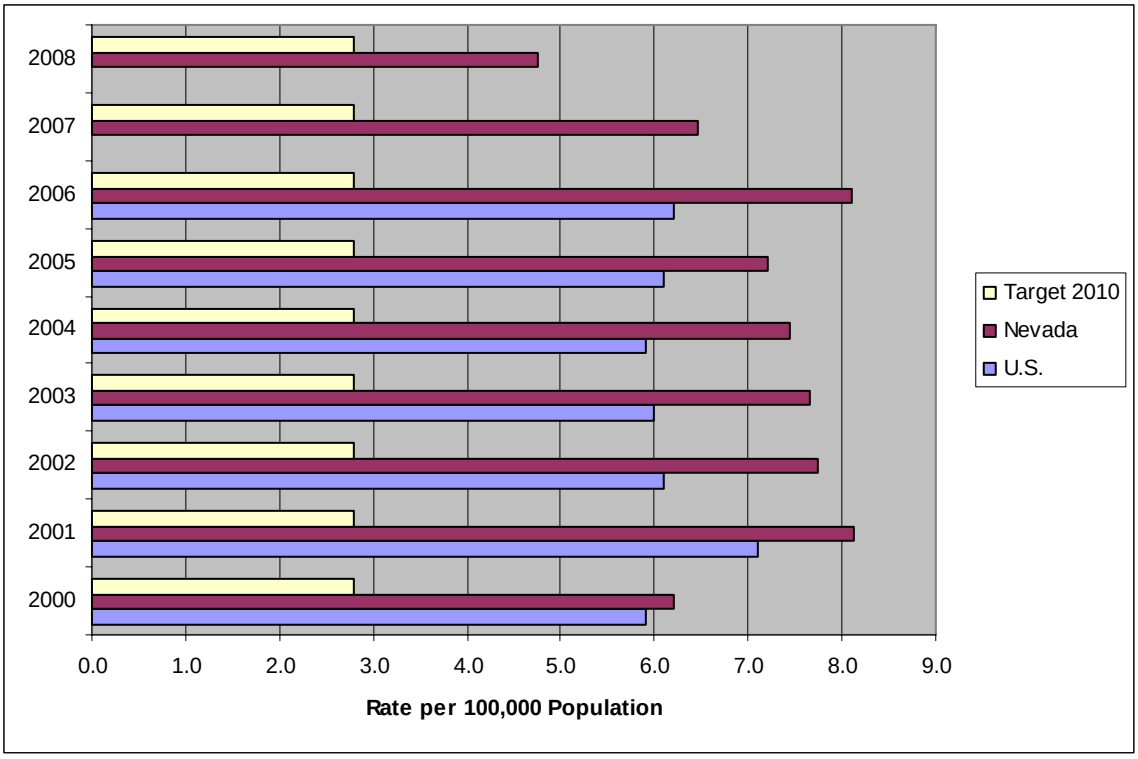
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for female gender for the year 2002 due to small counts.
Note: Data not available for the Native American race/ethnicity group due to small counts.

Healthy People 2010 Objective (15-32): Reduce homicides.

Healthy People 2020 Objective IVP HP2020-29: Reduce homicides.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
4.8	6.2	2.8		Improving

Age-Adjusted Death Rate from Homicides, Nevada Residents and United States, 2000 - Most Current Data.*

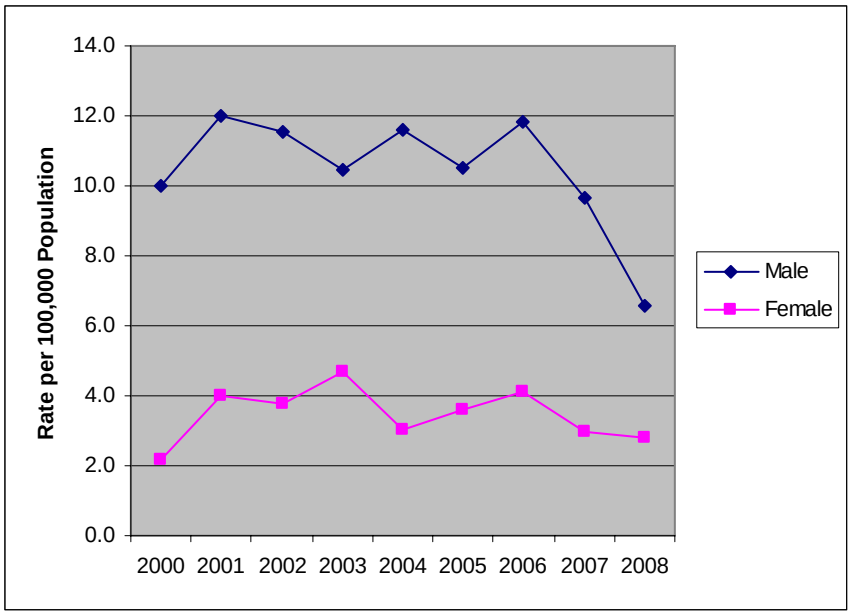


The death rate from homicides in Nevada fluctuated from 2000 to 2008. There was an overall decrease in the homicide death rate from, at 4.8 per 100,000 people in 2008. Comparatively, the national death rate from homicides in 2008 was 6.2 per 100,000 people.

Neither the Nevada nor national rates have met the Healthy People 2010 target of 2.8 per 100,000 people.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Death Rate from Homicides, Nevada Residents by Gender, 2000 - 2008.*

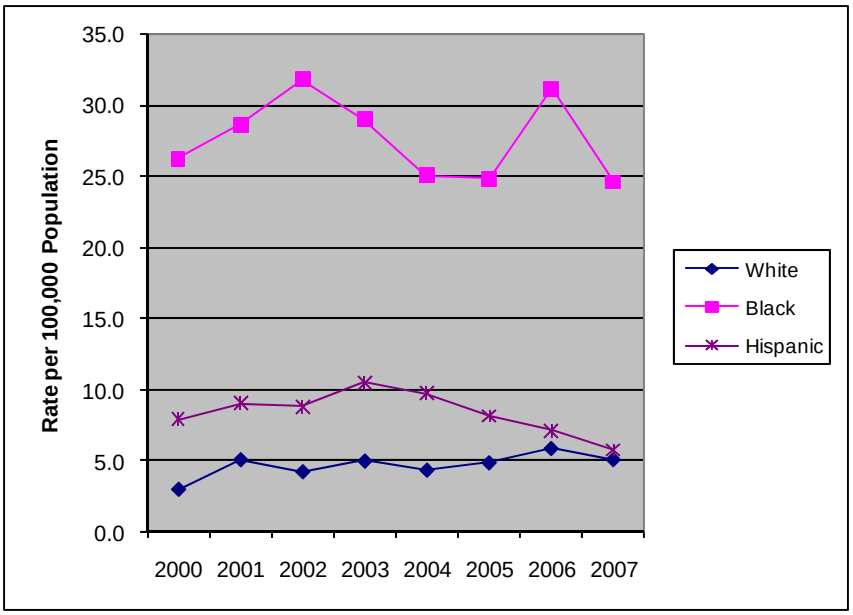


From 2000 to 2008, males were two to five times more likely to be victims of homicide than females in Nevada.

This gap decreased in from 2006 to 2008.

Age-Adjusted Death Rate from Homicides, Nevada Residents by Race/Ethnicity, Aggregated Data 2000 - 2003 and 2004 - 2007.*

In Nevada, Blacks were on average four times more likely to be the victims of homicide than any other racial/ethnic group from 2000 to 2007.



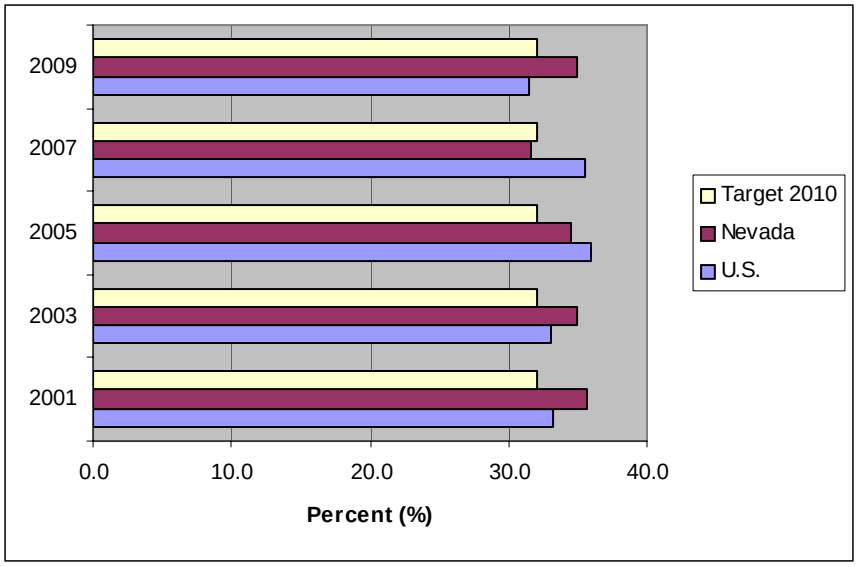
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Asian or Native American race/ethnicity groups due to small counts.

Healthy People 2010 Objective (15-38): Reduce physical fighting among adolescents, grades 9-12.

Healthy People 2020 Objective IVP HP2020-34: Reduce physical fighting among adolescents.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
35.0	32.0	32.0		Fluctuating

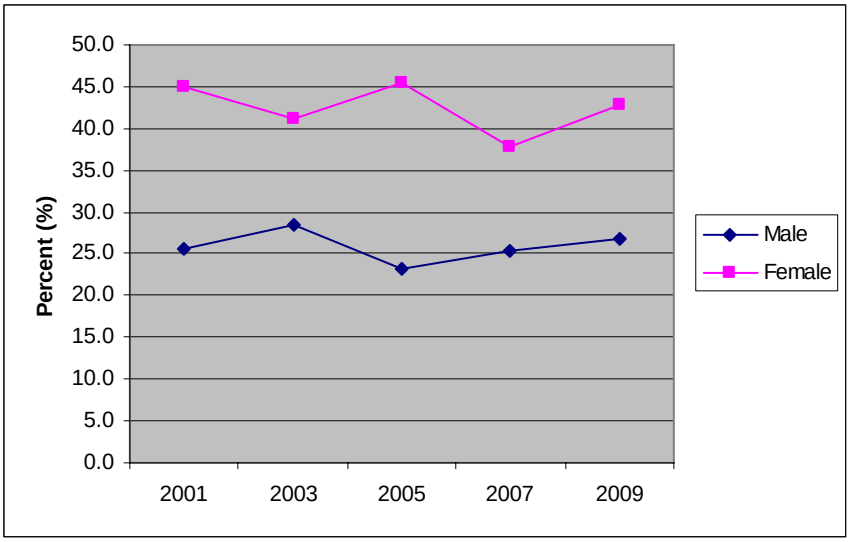
Proportion of Adolescents Who Were In A Physical Fight One or More Times, Grades 9-12, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



From 2001 to 2009, the proportion of Nevada adolescents (9th-12th grade) who were in a physical fight one or more times has been between 30 and 40 percent.

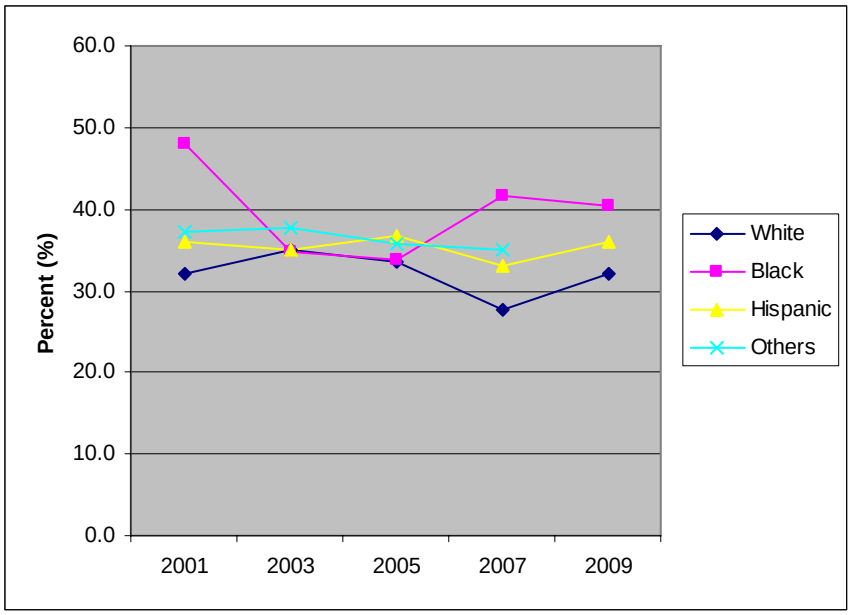
Proportion of Adolescents Who Were In A Physical Fight One or More Times, Grades 9-12, Nevada Residents by Gender, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

In Nevada, nearly twice as many female adolescents reported being in a physical fight than male adolescents from 2001 to 2009.



*Individual county data are not available.
Note: See appendix for additional information.

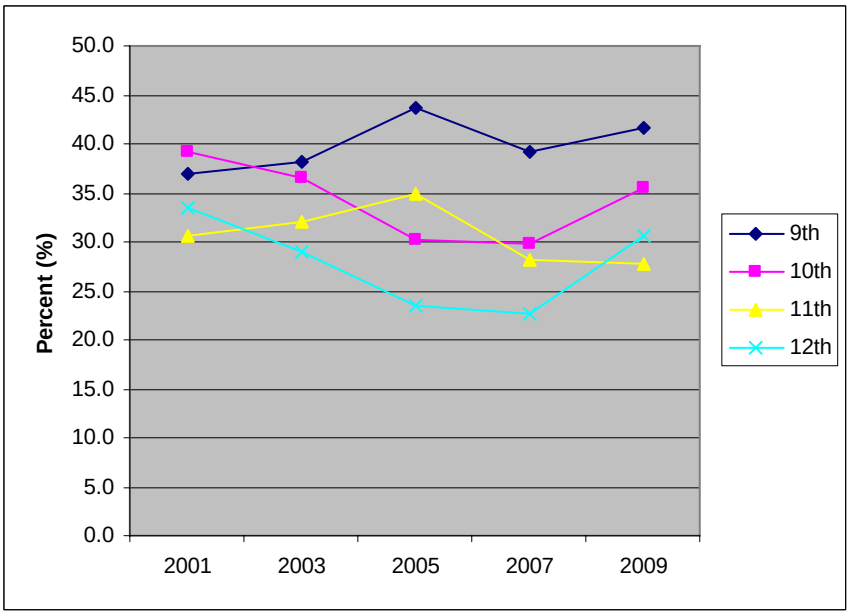
Proportion of Adolescents Who Were In A Physical Fight One or More Times, Grades 9-12, Nevada Residents by Race/ Ethnicity, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



In 2003 and 2005, the proportion of adolescents (grades 9-12) who were involved in physical fighting were similar among all race/ ethnic groups.

In 2007 and 2009, the highest proportion of physical fighting was among Black adolescents in Nevada.

Proportion of Adolescents Who Were In A Physical Fight One or More Times, Grades 9-12, Nevada Residents by Grade, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



In 2009, the highest proportion of physical fights was reported among Nevada 9th (42 percent) and 10th grade students (36 percent).

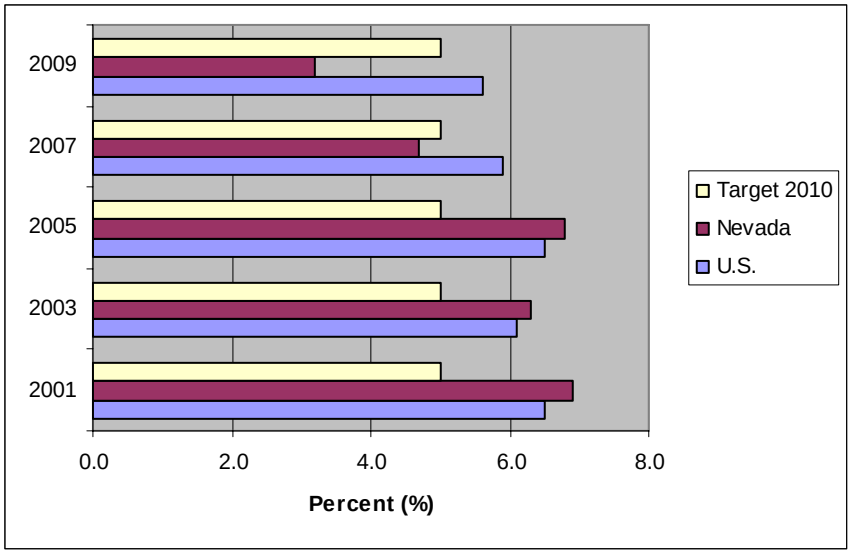
*Individual county data are not available.

Healthy People 2010 Objective (15-39): Reduce weapon carrying by adolescents on school property, grades 9-12.

Healthy People 2020 Objective IVP HP2020-36: Reduce weapon carrying by adolescents on school property.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
3.0	6.0	5.0		Achieved

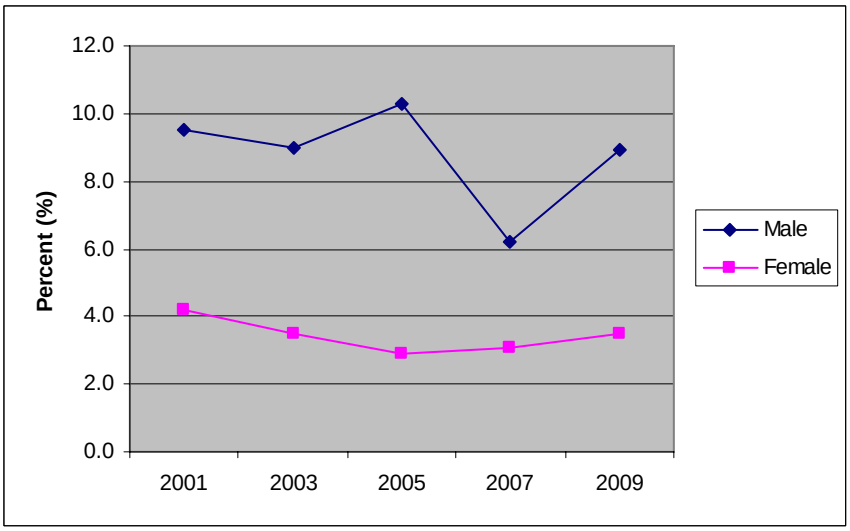
Proportion of Adolescents Who Carried a Weapon On School Property, Grades 9-12, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



In 2007 and 2009, fewer students in Nevada reported carrying a weapon on school property than the national average (YRBSS).[10]

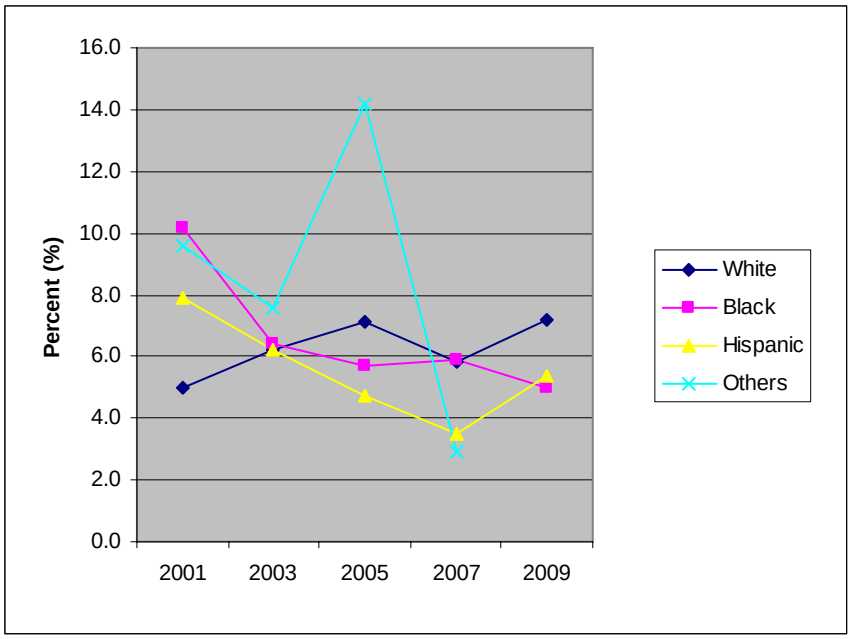
Proportion of Adolescents Who Carried a Weapon On School Property, Grades 9-12, Nevada Residents by Gender, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

From 2001 to 2009, male adolescents were more likely to carry a weapon on school property than female adolescents in Nevada.



*Individual county data are not available.
Note: See appendix for additional information.

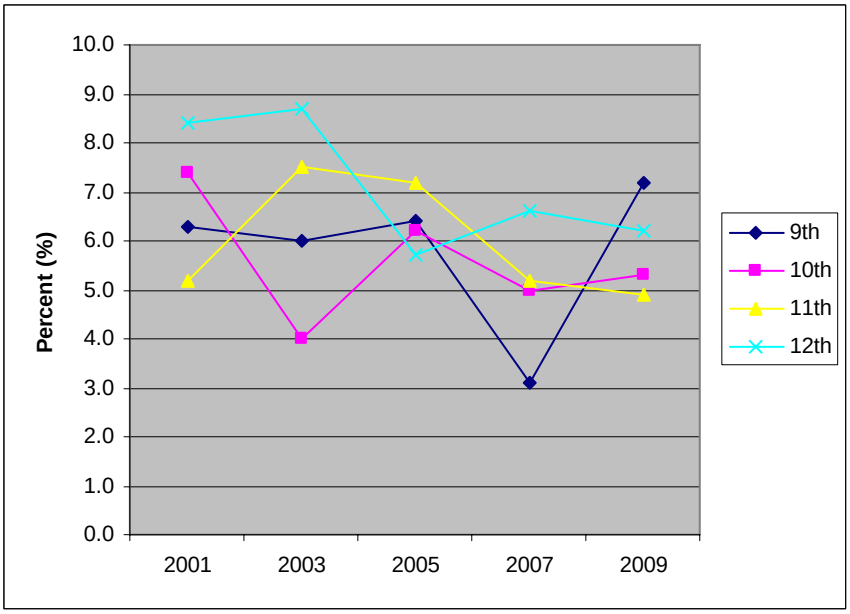
Proportion of Adolescents Who Carried a Weapon On School Property, Grades 9-12, Nevada Residents by Race/Ethnicity, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



In 2009, approximately 7 percent of White adolescents and approximately 5 percent of Black and Hispanic adolescents reported carrying a weapon on school property in Nevada.

Proportion of Adolescents Who Carried a Weapon On School Property, Grades 9-12, Nevada Residents by Grade, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

From 2007 to 2009, there was 4 percent increase in the proportion of 9th grade students who carried a weapon on school property in Nevada.



*Individual county data are not available.

Maternal, Infant, Child Health

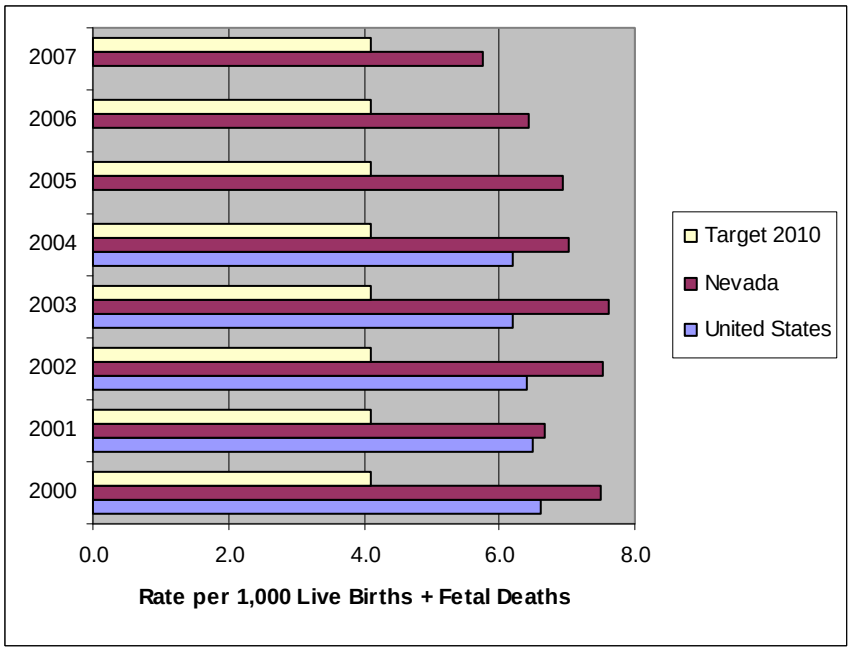
The health of mothers, infants, and children is of critical importance, both as a reflection of the current health status of a large segment of the U.S. population and as a predictor of the health of the next generation. Pregnancy and childbirth have an enormous impact on the physical, mental, emotional, and socioeconomic health of women and their families. Pregnancy-related health consequences are influenced by women's health conditions as well as other factors such as race, ethnicity, age, and income.[1]

Healthy People 2010 Objective (16-1a.): Reduce fetal deaths at 20 or more weeks of gestation.

Healthy People 2020 Objective MICH HP2020-1.1: Reduce fetal deaths at 20 more weeks of gestation.

Most Recent NV Value (2007)	U.S. (2004)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
5.7	6.2	4.1	5.6	Improving

Fetal Deaths at 20 or More Weeks of Gestation, Nevada Residents and United States, 2000 - Most Current Data.*



Nevada had a higher rate of fetal deaths than the United States from 2000 to 2004. However, this rate decreased consistently from 2003 to 2007, at 5.7 percent in 2007.

Neither region reached the Healthy People 2010 target of 4.1 per 1,000 live births in the reported period.

In 2006, the preliminary Infant Mortality rate was 6.7 deaths per 1,000 live births nationally. Fetal deaths, both nationally and in Nevada, are declining.[2]

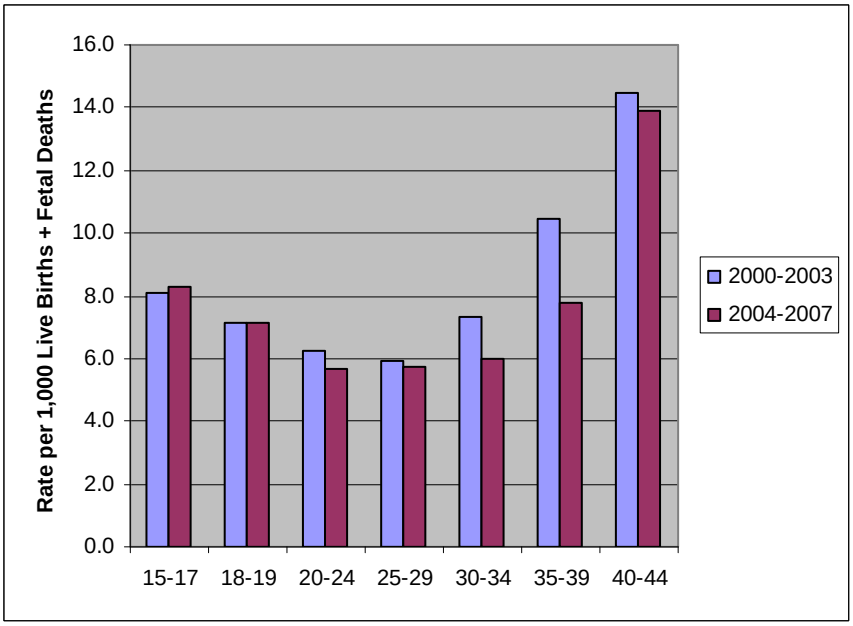
*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2008 Nevada data are not available at this time.
Note: Race/ethnicity data are not available.
Note: See appendix for additional information.

Fetal Deaths at 20 or More Weeks of Gestation, Nevada Residents by County/Region, 2000 - 2007.*

Fetal death refers to the spontaneous intrauterine death of a fetus at any time during pregnancy.[3]

The fetal death rate decreased in Clark and Washoe counties, and fluctuated for all other counties from 2000 to 2007.

Aggregated Fetal Deaths at 20 or More Weeks of Gestation, Nevada Residents by Age of Mother, 2000 - 2003 and 2004 - 2007.*



The 2004 - 2007 aggregated fetal death rate in Nevada was highest for mothers aged 40 to 44 years old, followed by 15 to 17 year olds and 35 to 39 year olds.

In general, the risk for fetal deaths increases with age of mother, after age 29.

For 2001 nationally, 18 percent of infants born very preterm did not survive the first year of life compared with less than 1 percent of infants born moderately preterm.[8]

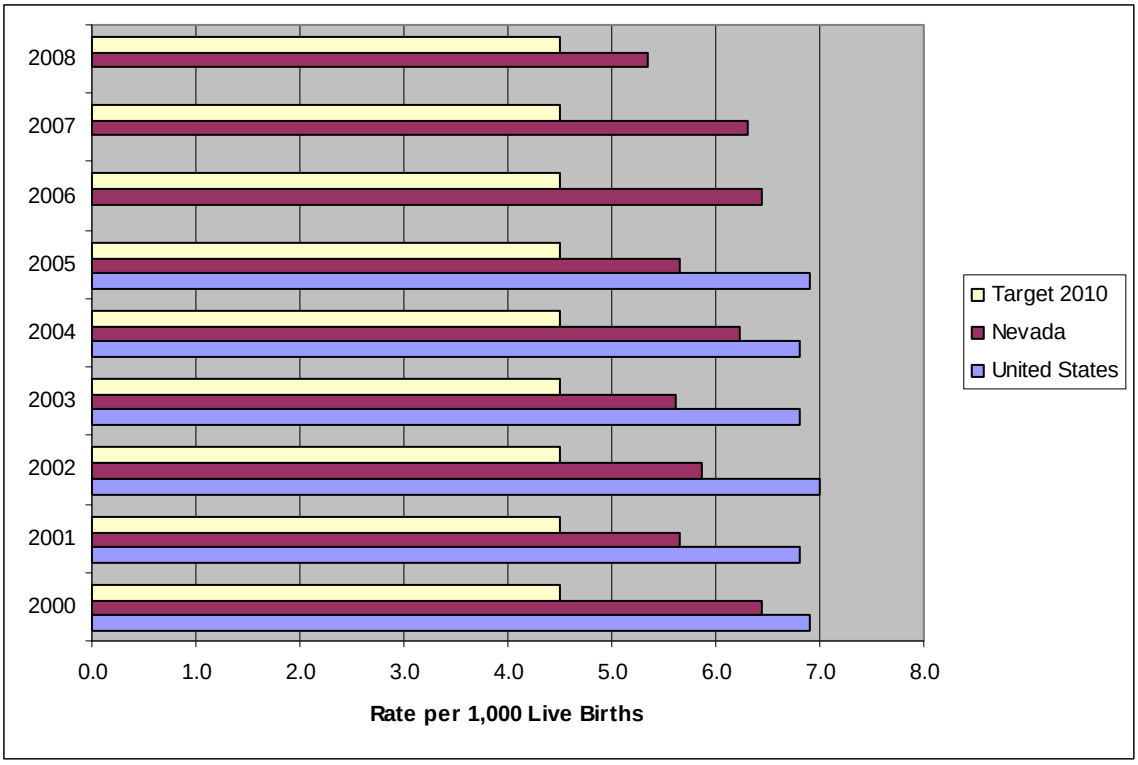
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2008 Nevada data are not available at this time.

Healthy People 2010 Objective (16-1c.): Reduce infant death rate (within 1 year of life).

Healthy People 2020 Objective MICH HP2020-1.3: Reduce infant death rate (within 1 year of life).

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
5.3	6.9	4.5	6.0	Fluctuating

Infant Death Rate (Within 1 Year of Life), Nevada Residents and United States, 2000 - Most Current Data.*

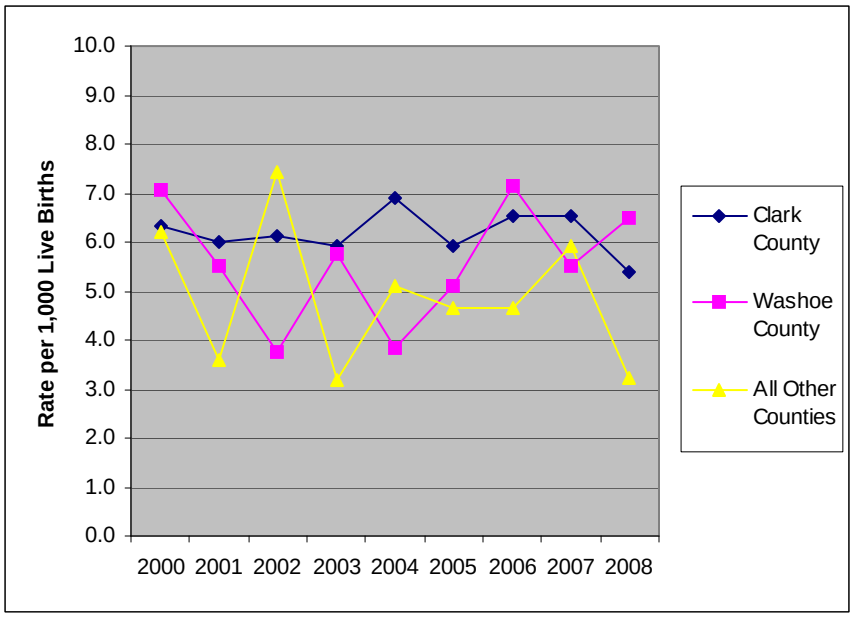


Per the CDC, infant mortality is one of the most important indicators of the health of a nation, as it is associated with a variety of factors such as maternal health, quality and access to medical care, socioeconomic conditions, and public health practices. The U.S. infant mortality rate generally declined throughout the 20th century. In 1900, the U.S. infant mortality rate was approximately 100 infant deaths per 1,000 live births, while in 2000, the rate was 6.89 infant deaths per 1,000 live births. However, the U.S. infant mortality rate did not decline significantly from 2000 to 2005, which has generated concern among researchers and policy makers.[4]

Nevada's infant death rate was lower than that of the U.S. in 2000 through 2005 and decreased overall since 2006, but it was above the Healthy People target of 4.5 per 1,000 live births in 2008.

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Infant Death Rate (within 1 Year of Life), Nevada Residents by County/Region, 2000 - 2008.*

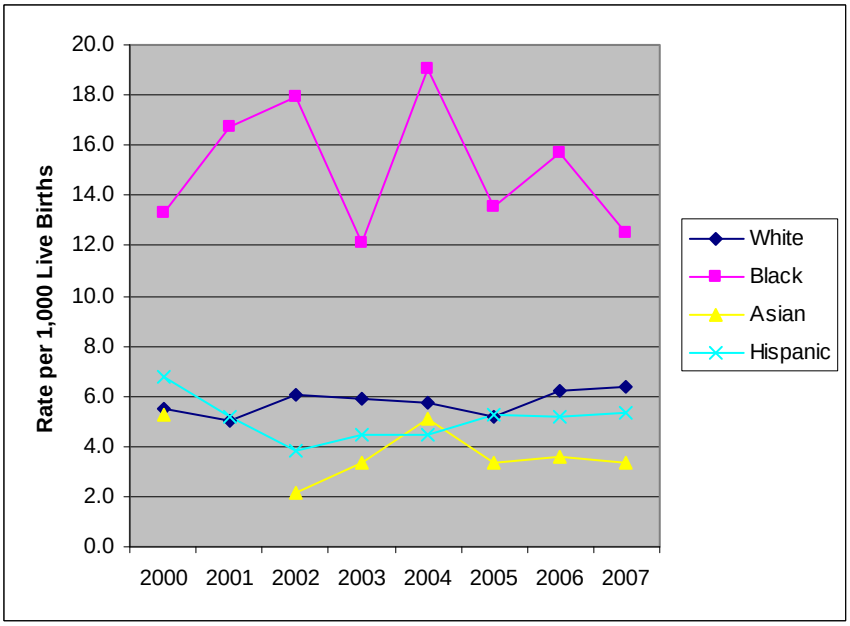


The U.S. infant mortality rate did not decline from 2000 to 2005.[4]

The infant death rate for all Nevada regions fluctuated from 2000 to 2008.

Infant Death Rate (within 1 Year of Life), Nevada Residents by Race/Ethnicity, 2000 - 2007.*

In Nevada, the infant mortality rate for Blacks was more than two times the rate for all other race/ethnic groups from 2000 to 2007.



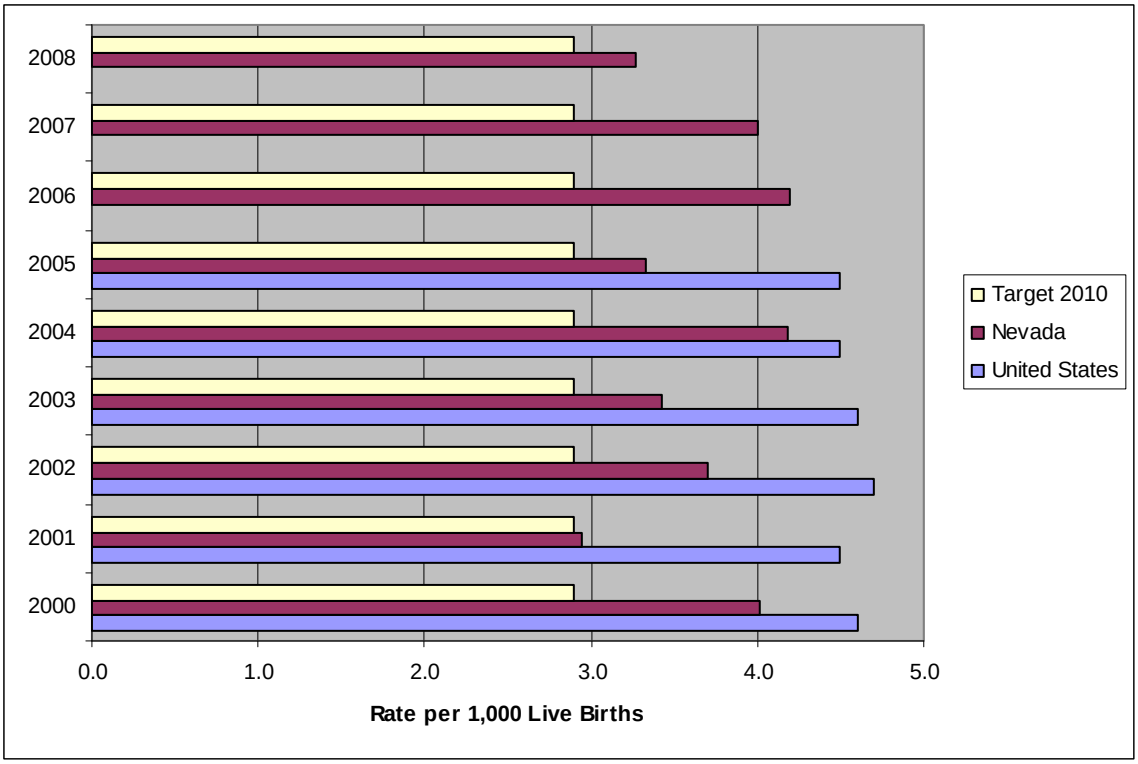
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group for the years 2000-2007 or for the Asian race/ethnicity group for the year 2001 due to small counts.

Healthy People 2010 Objective (16-1d.): Reduce neonatal deaths (within the first 28 days of life).

Healthy People 2020 Objective MICH HP2020-1.4: Reduce neonatal deaths (within the first 28 days of life).

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
3.3	4.5	2.9	4.1	Improving

Neonatal Death Rate (Within the First 28 Days of Life), Nevada Residents and United States, 2000 - Most Current Data.*

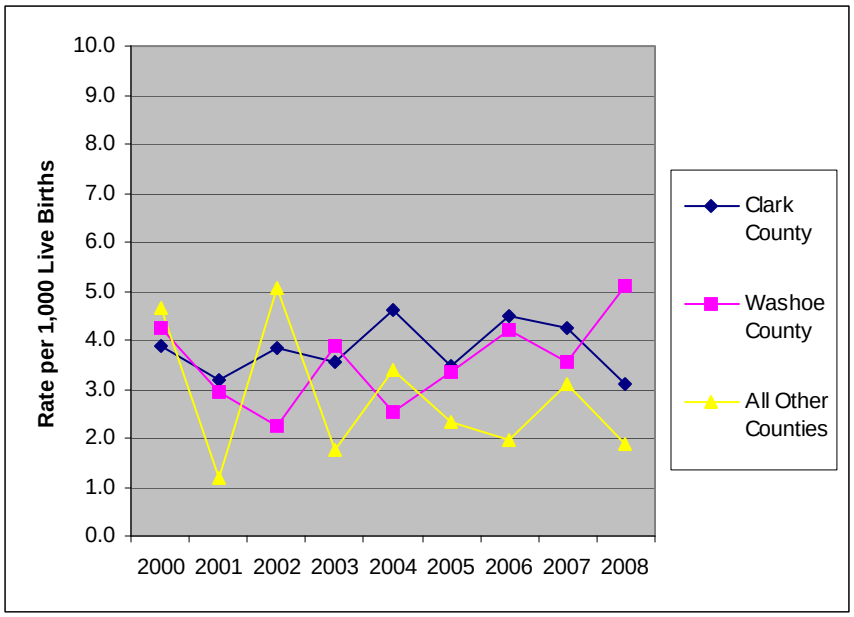


Infant deaths include neonatal deaths, which occur <28 days after birth, and post neonatal deaths, which occur from 28 days to 364 days after birth. Substantial differences were observed in the leading causes of death during the neonatal versus post neonatal periods. Congenital malformations, although ranked first for infant mortality overall, ranks second for both neonates and post neonates. Disorders related to short gestation and low birth weight not elsewhere classified were the leading cause of neonatal death. Sudden Infant Death Syndrome (SIDS) was the leading cause of death during the post neonatal period (CDC).[5]

The neonatal death rate in Nevada was consistently lower than that for the United States from 2000 to 2005. Still, it was higher than the Healthy People 2010 target of 2.9 per 1,000 live births, at 3.3 per 1,000 live births in 2008.

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.

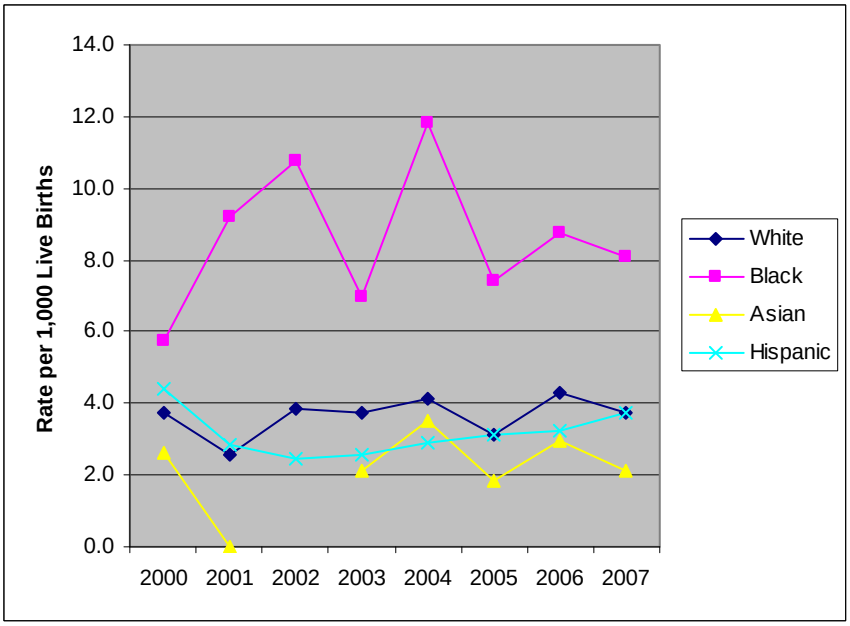
Neonatal Death Rate (within the First 28 Days of Life), Nevada Residents by County/Region, 2000 - 2008.*



There was no consistent increase or decrease in the neonatal death rate in any of Nevada's regions from 2000 to 2008.

Factors that affect the risk of infant mortality for single-born infants include birth weight, Sudden Infant Death Syndrome (SIDS), race, sex, gestation, birth order, maternal age and education, and prenatal care. The most important predictor for infant survival was birth weight, with improved survival associated with increased birth weight.[6]

Neonatal Death Rate (within the First 28 Days of Life), Nevada Residents by Race/Ethnicity, 2000 - 2007.*



From 2000 to 2007, Nevada's Blacks had a higher neonatal death rate than that of any other race/ethnic groups in Nevada.

Black infants had an average of twice the mortality risk of White infants. The higher risk for Blacks was related to higher prevalence of low birth weight and to higher mortality risks in both the neonatal and post-neonatal periods.[6]

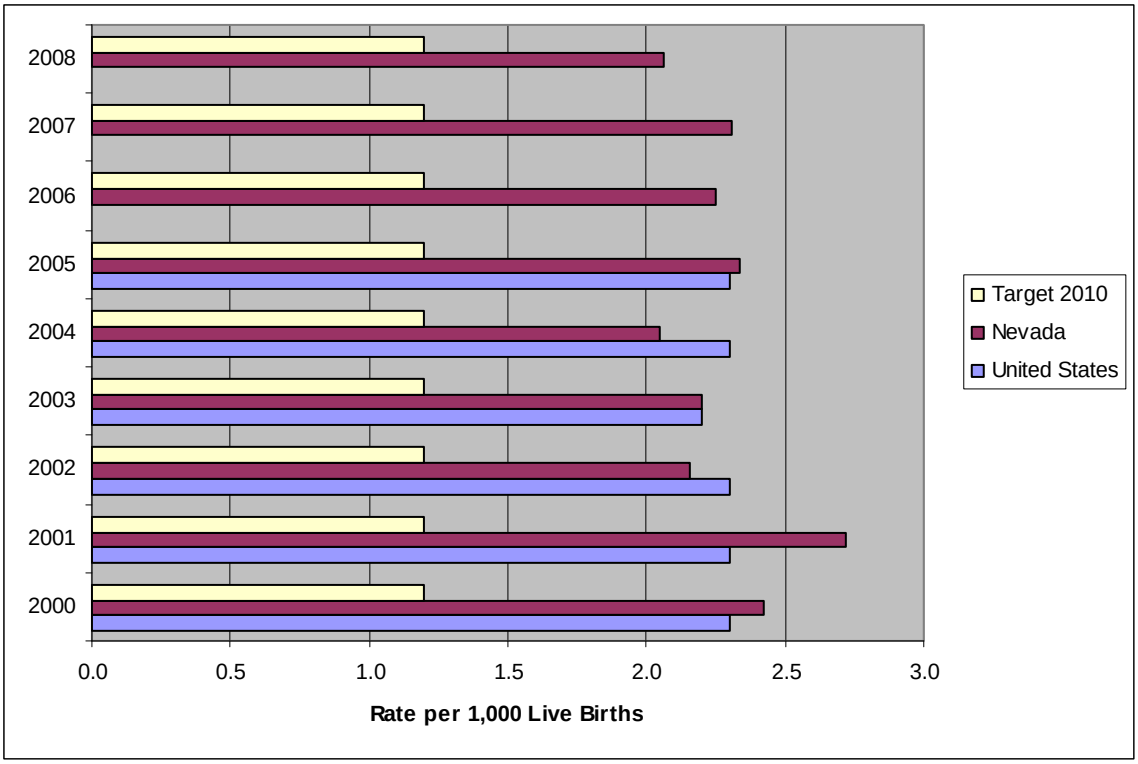
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group for the years 2000-2007 or for the Asian race/ethnicity group for the year 2002 due to small counts.

Healthy People 2010 Objective (16-1e.): Reduce post-neonatal death rate (between 28 days and 1 year).

Healthy People 2020 Objective MICH HP2020-1.5: Reduce post-neonatal deaths (between 28 days and 1 year).

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
2.1	2.3	1.2	2.0	Improving

Postneonatal Death Rate (Between 28 Days and 1 Year of Life), Nevada Residents and United States, 2000 - Most Current Data.*

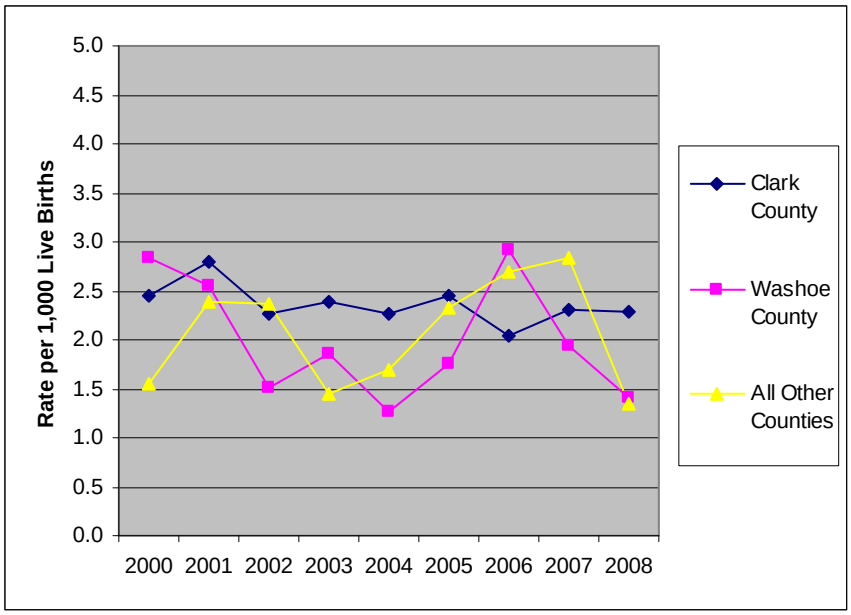


Nevada's post neonatal death rate fluctuated from 2000 to 2008, slightly lower in 2008 than it was in 2000. Still, Nevada did not come close to meeting the Healthy People 2010 goal of 1.2 per 1,000 live births in 2008.

The most important predictor for infant survival is birth weight; survival increases exponentially as birth weight increases to its optimal level. The nearly twofold higher risk of infant mortality among Blacks than among Whites was related to a higher prevalence of low birth weight, higher mortality risks in the neonatal period for infants with birth weights of greater than or equal to 3,000 grams, and to higher mortality during the post neonatal period for all infants, regardless of birth weight.[7]

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Postneonatal Death Rate (between 28 Days and 1 Year), Nevada Residents by County/Region, 2000 - 2008.*

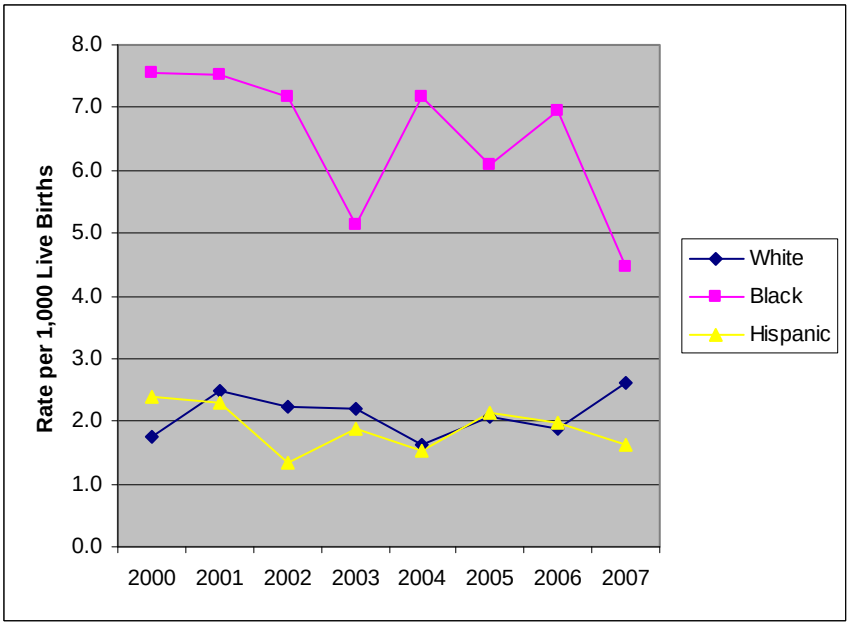


Clark County has had the most consistent postneonatal death rate, which shows a slight decrease from 2000 to 2008.

Postneonatal Death Rate (between 28 Days and 1 Year), Nevada Residents by Race/Ethnicity, 2000 - 2007.*

There was a wide variation in infant mortality rates by race of mother from 2000 to 2007, with the highest rate for infants of Black mothers as high as three times the rates of other mothers in Nevada.

The national infant mortality rate by race for Black women is 2.4 times the rates for White women (CDC).[4]



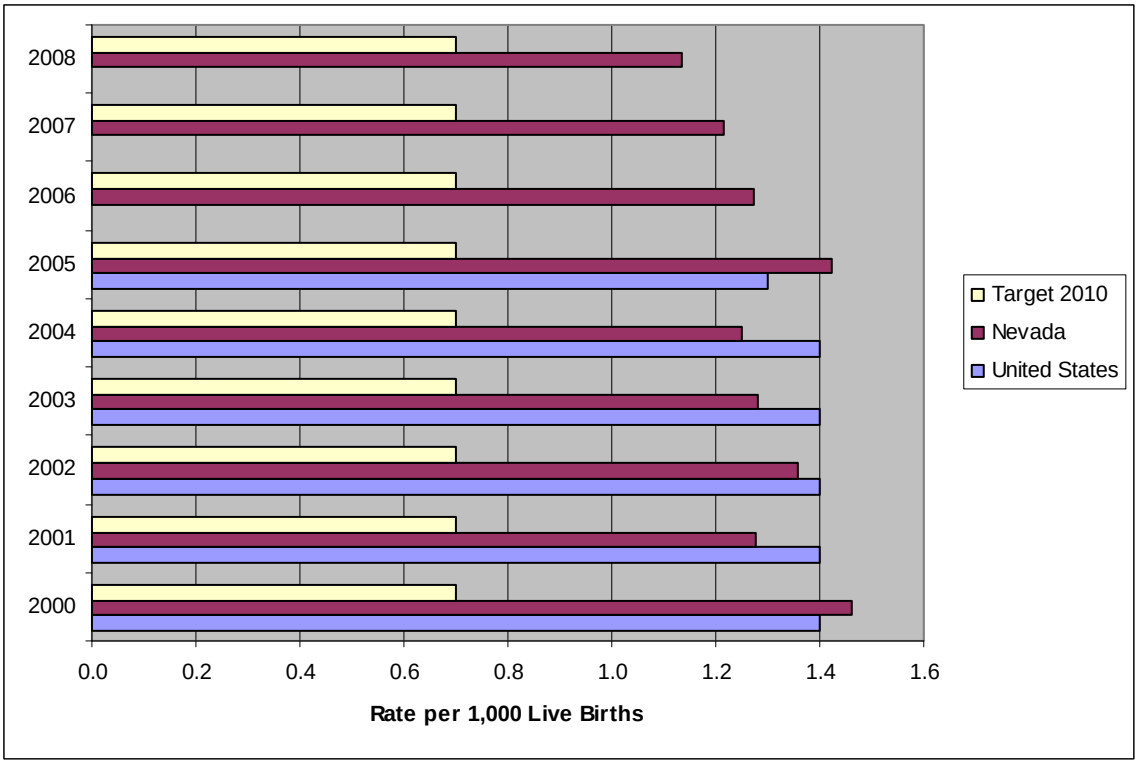
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American or Asian race/ethnicity groups due to small counts.

Healthy People 2010 Objective (16-1f.): Reduce infant deaths due to birth defects.

Healthy People 2020 Objective MICH HP2020-1.6: Reduce infant death rates related to birth defects.

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
1.1	1.3	0.7	1.3	Improving

Infant Death Rate From Birth Defects, Nevada Residents and United States, 2000 - Most Current Data.*



Nevada's infant death rate from birth defects decreased overall from 2000 to 2008, at 1.1 per 1,000 live births in 2008. Still, it was above the Healthy People 2010 goal of 0.7 per 1,000 live births in 2008. Comparatively, the national infant death rate from birth defects was 1.3 per 1,000 live births in 2005.

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Infant Death Rate From Birth Defects, Nevada Residents by Infant Gender, 2000 - 2008.*

From 2002 to 2008, Nevada's infant death rate due to birth defects was higher among female infants than male infants.

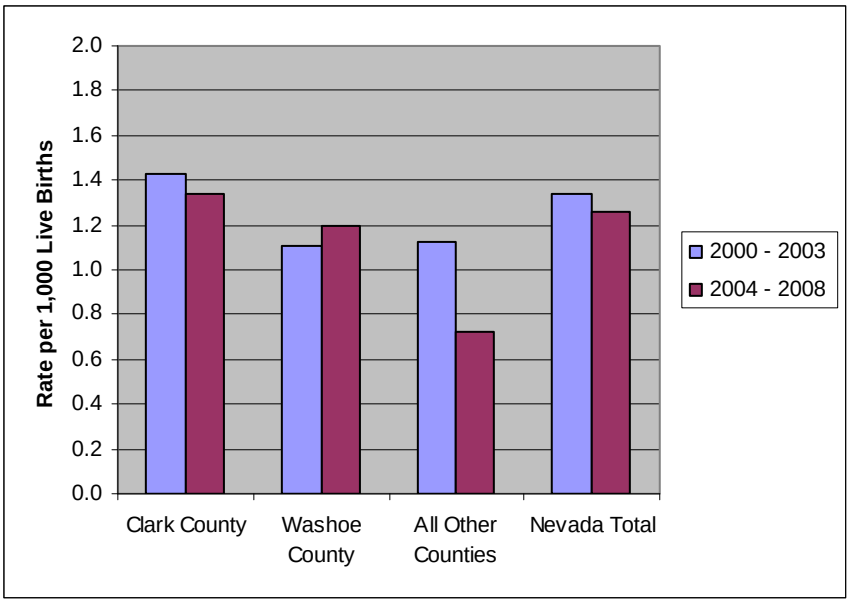
Nevada, in 2006, reported infant mortality for males was .9 per 1,000 live births, while reported infant mortality for females was 1.7 per 1,000 live births.

Nationally, in 2002, the CDC reported the overall infant mortality rate for female infants was 6.3 per 1,000, 17 percent lower than the rate for male infants (7.6).[6]

Washoe county has shown an increase in infant deaths from births defects in 2004 through 2008 pooled data when compared to 2000 through 2003 pooled data. All other regions have shown decreases.

Disorders relating to short gestation and low birth weight were the second leading cause of infant deaths, accounting for 17 percent of all infant deaths, followed by Sudden Infant Death Syndrome (SIDS), accounting for 8 percent of infant deaths.[8]

Aggregated Infant Death Rate From Birth Defects, Nevada Residents by County/Region, 2000 - 2003 and 2004 - 2008.*



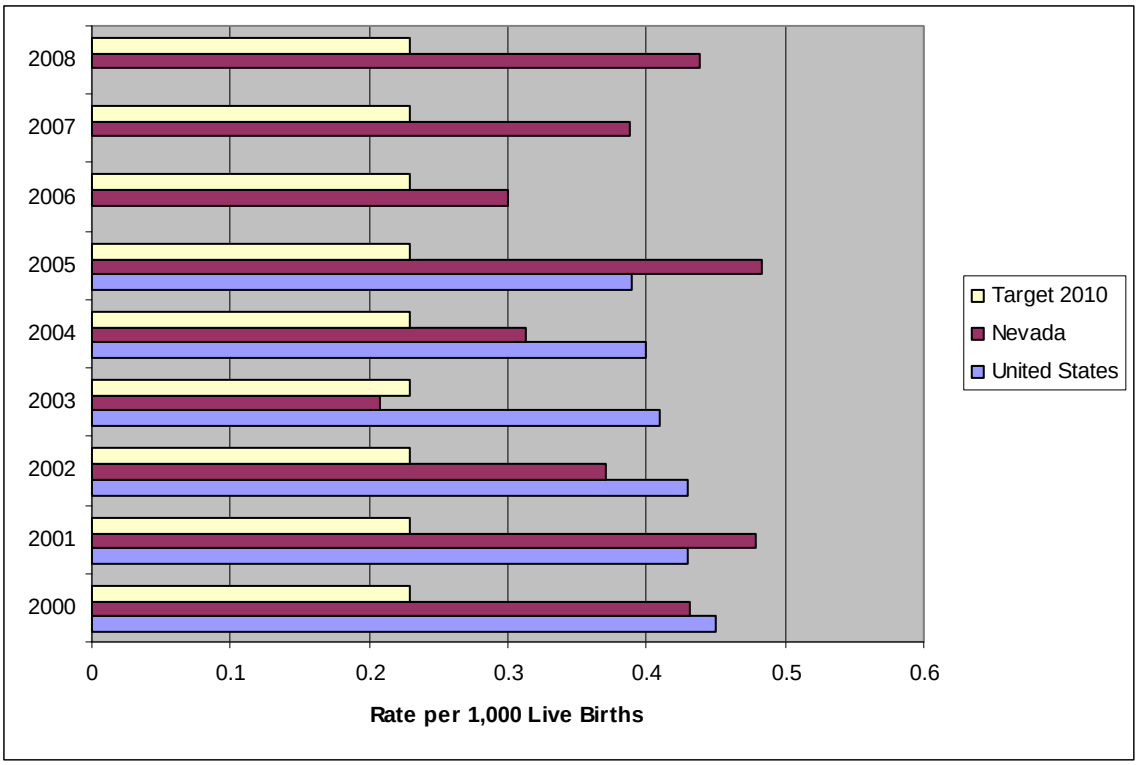
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.

Healthy People 2010 Objective (16-1g.): Reduce infant mortality rate from congenital heart defects.

Healthy People 2020 Objective MICH HP2020-1.7: Reduce infant mortality death rate from congenital heart defects.

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
0.44	0.39	0.23	0.34	Worsening

Infant Death Rate From Congenital Heart Defects, Nevada Residents and United States, 2000 - Most Current Data.*

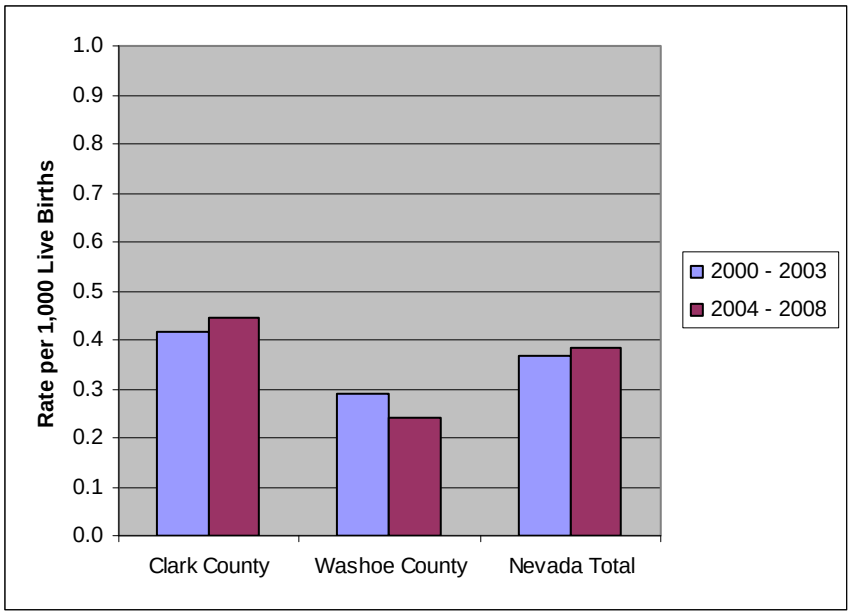


Nevada's infant death rate from congenital heart defects fluctuated from 2000 to 2008. In 2008, this rate was .44 per 1,000 live births, compared to the Healthy People 2010 target of 0.23 per 1,000 live births.

There has been a steady decline in the Infant Death Rate From Congenital Heart Defects in the United States since 2002.[6]

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Aggregated Infant Death Rate From Congenital Heart Defects, Nevada Residents by County/Region, 2000 - 2003 and 2004 - 2008.*

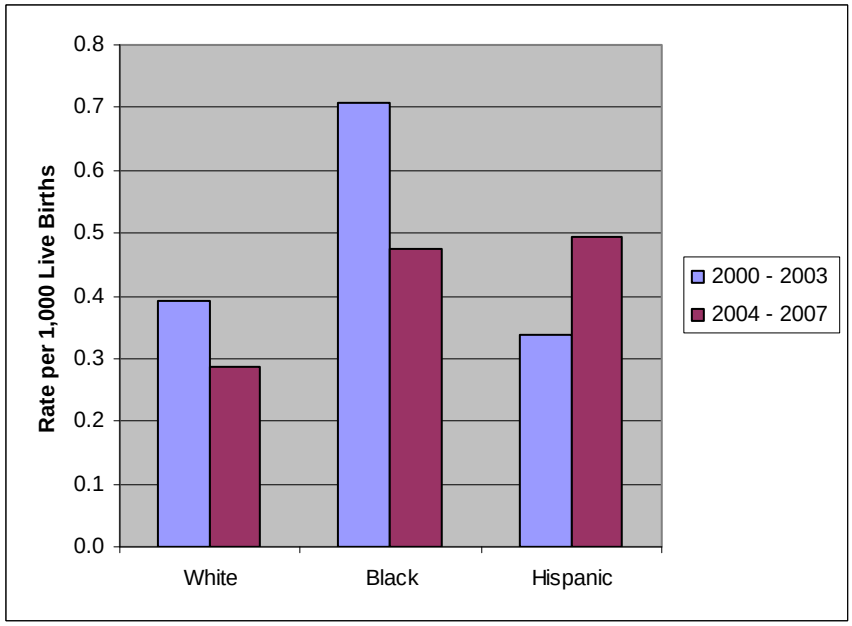


The infant death rate from congenital heart defects was higher in Clark County than in both Washoe County and Nevada in the reported years.

This decade, the infant death rate from congenital heart defects has decreased among Whites and Blacks but has increased in Nevada's Hispanic population.

Congenital malformations was the leading cause of infant death for all groups except for non-Hispanic Black and Puerto Rican mothers, for whom low birth-weight was the leading cause.[9]

Aggregated Infant Death Rate From Congenital Heart Defects, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2007.*



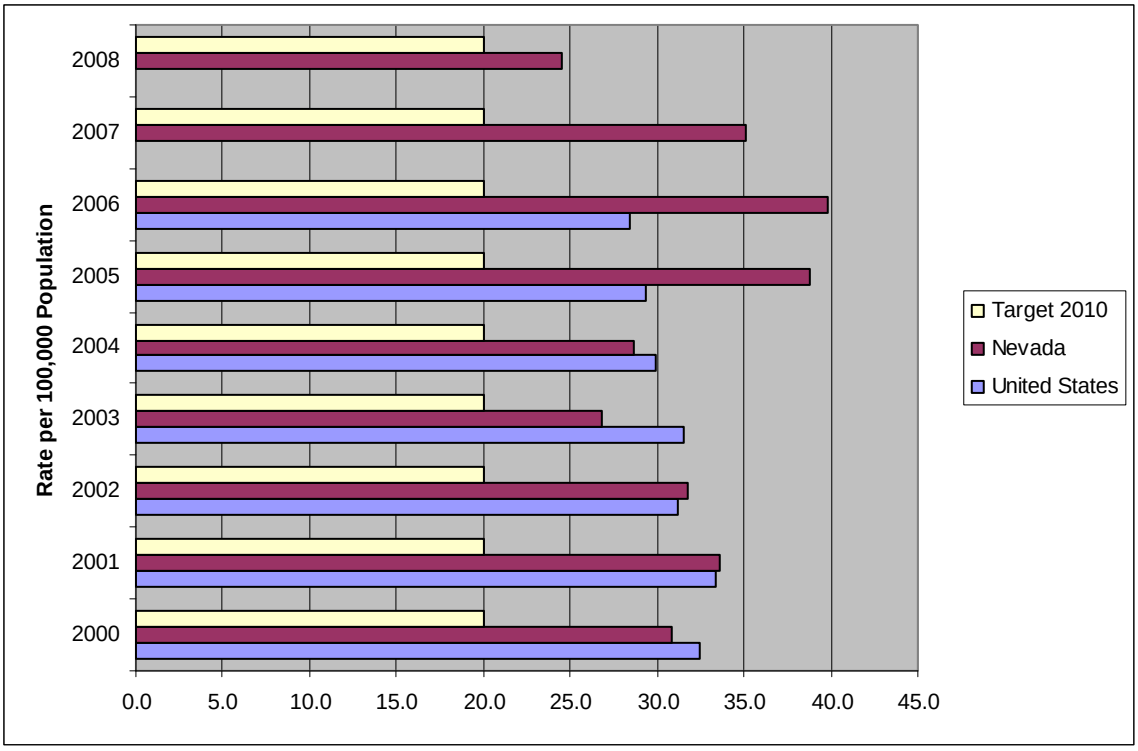
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity or the Asian race/ethnicity groups due to small counts.

Healthy People 2010 Objective (16-2a.): Reduce the rate of child deaths, aged 1 to 4 years.

Healthy People 2020 Objective MICH HP2020-3.1: Reduce the rate of child deaths, aged 1 to 4 years.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
24.5	28.4	20.0	25.7	Improving

Death Rate of Children Aged 1 to 4, Nevada Residents and United States, 2000 - Most Current Data.*

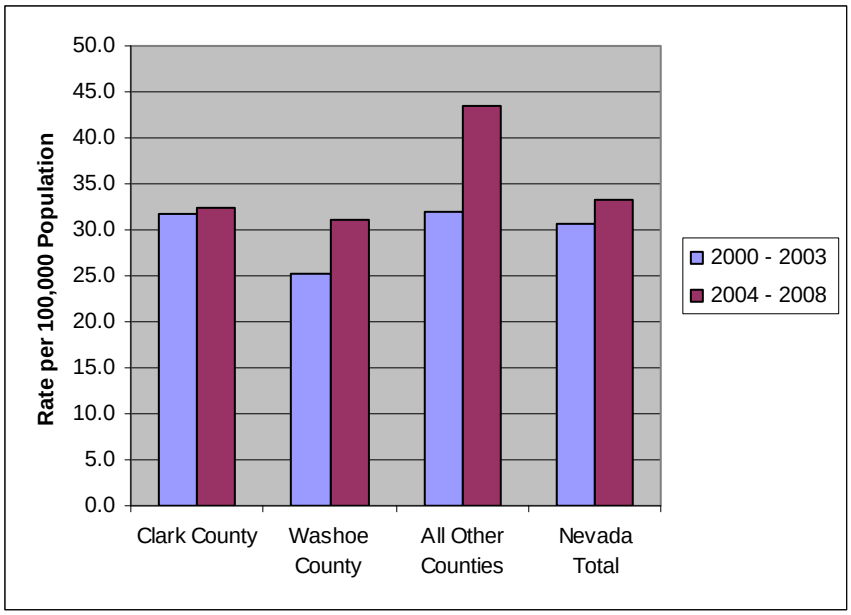


The death rate of Nevada children aged 1 to 4 decreased from 2006 to 2008, at 24.5 per 100,000 people in 2008. Although this rate has not decreased enough to achieve the Healthy People 2010 target, it is considerably lower than in 2006, when it was almost 40 per 100,000 people.

The top three causes of death in children aged 1 to 4 in the United States in order of rank are: accidents; developmental and genetic conditions that were present at birth; and cancer.[10]

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Aggregated Death Rate of Children Aged 1 to 4, Nevada Residents by County/Region, 2000 - 2003 and 2004 - 2008.*



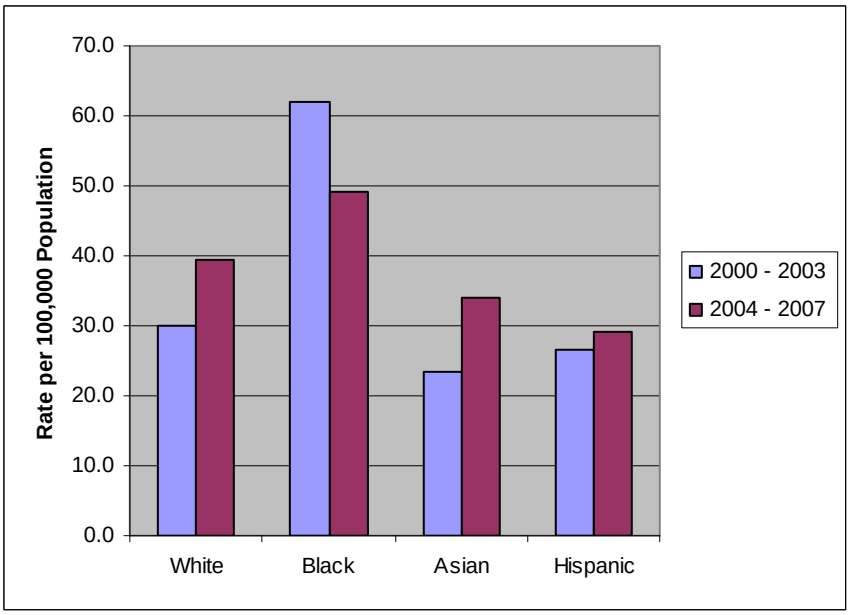
In the more recent years, 2004 through 2008 pooled data, we see a dramatic increase in the death rate of children aged 1 to 4 in Nevada's small, rural, and frontier counties, represented by "All Other Counties".

We also saw a slight increase in the death rate of children aged 1 to 4 in Clark and Washoe Counties during these years.

In 2004 trough 2008 pooled data, the death rate for children aged 1 to 4 decreased in the Black population but increased in all other racial/ethnic subgroups of Nevada.

Automobile accidents account for the largest number of accidental deaths. Make sure that all infants and children use the proper child car seats, booster seats, and seat belts. Other top causes of accidental death are drowning, fire, falls, and poisoning.[10]

Aggregated Death Rate of Children Aged 1 to 4, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2007.*



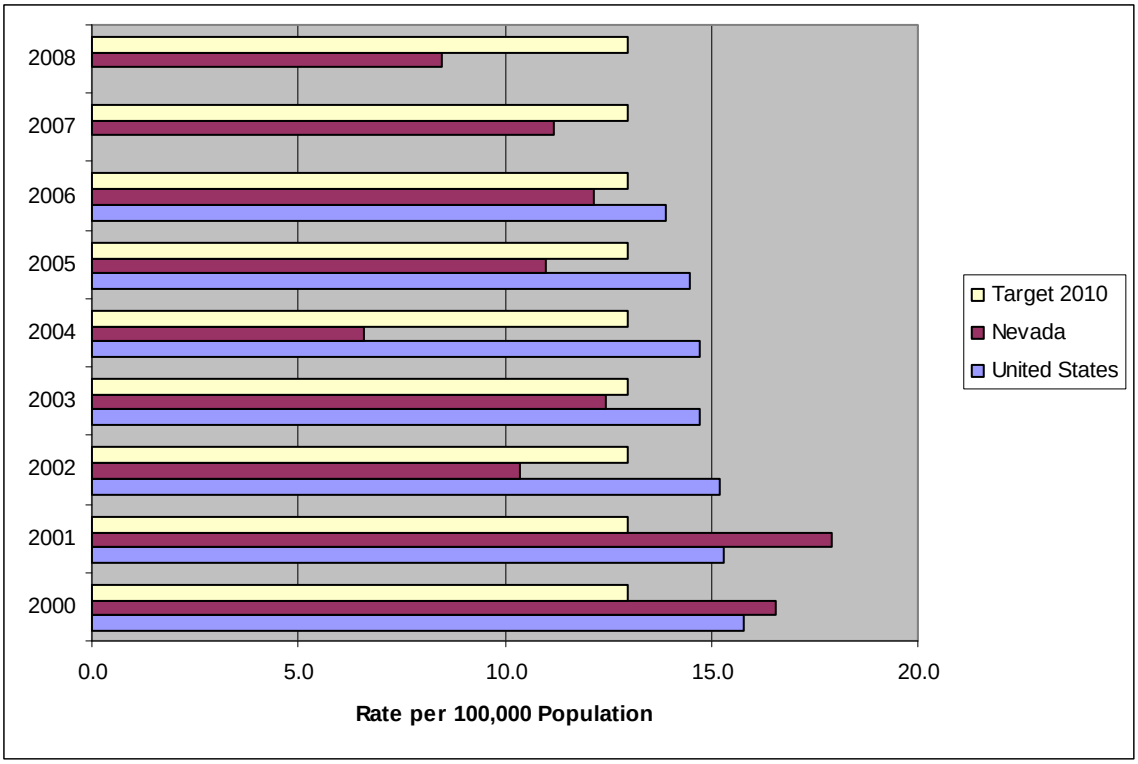
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Date not available for the Native American race/ethnicity group due to small counts.

Healthy People 2010 Objective (16-2b.): Reduce the rate of child deaths, aged 5 to 9 years.

Healthy People 2020 Objective MICH HP2020-3.2: Reduce the rate of child deaths, aged 5 to 9 years.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
8.5	13.9	13	12.3	Surpassed

Death Rate of Children Aged 5 to 9, Nevada Residents and United States, 2000 - Most Current Data.*

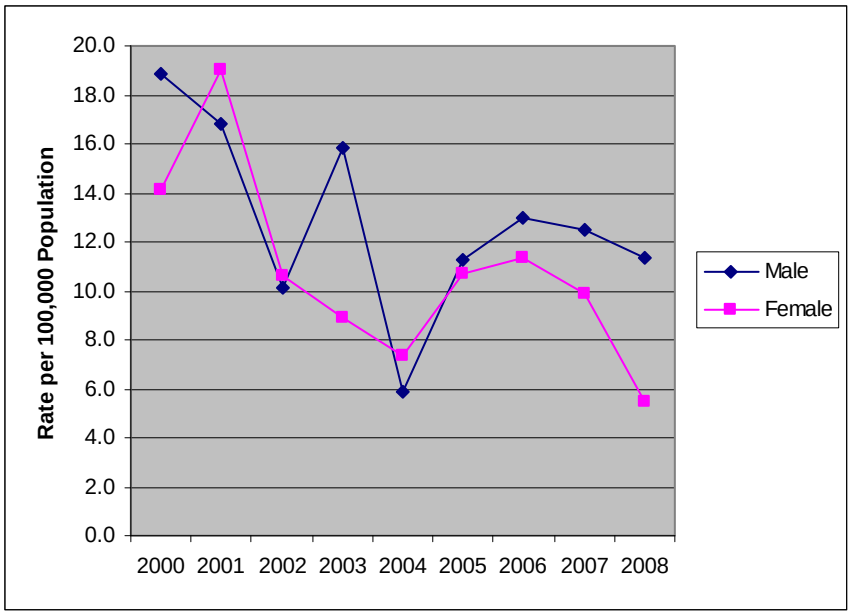


Nevada's death rate for children aged 5 to 9 surpassed the Healthy People 2010 target from 2002 to 2008, at 8.5 per 100,000 people in 2008 compared to the Healthy People 2010 target of 13 per 100,000 people. The national rate had not yet met the Healthy People 2010 target in 2006.

The leading causes of death for children aged 5 to 14 years of age in the United States are, in ranking order: accidents; cancer; and homicide.[10]

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Death Rate of Children Aged 5 to 9, Nevada Residents by Gender, 2000 - 2008.*



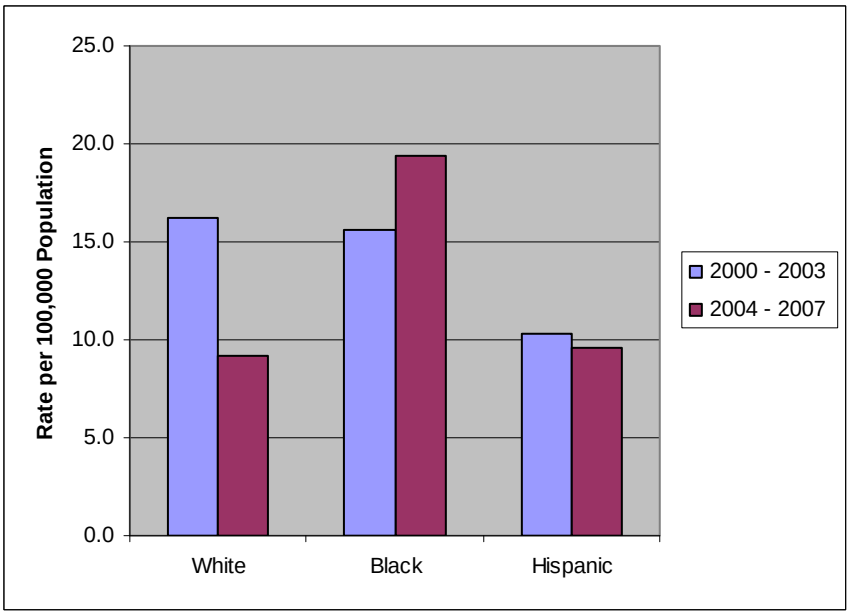
From 2000 to 2007, there was a decrease in the death rate of children aged 5 to 9 among both genders in Nevada. However, in 2008, this rate was higher for males.

Causes of death vary by age. Nationally, unintentional injuries such as car accidents, poisoning from household chemicals or drug overdoses, fires, and drowning are the leading cause of death for children and teenagers.[11]

In 2004 - 2007, the death rate of children, aged 5 to 9 years, had increased among Nevada's Black population and decreased among Nevada's White and Hispanic populations.

Homicide is one of the most disturbing causes of death among children and adolescents. Sociologists feel that the increase of gangs, teenage homicide, teenage suicide, teenage pregnancy, school drop-out, and other problems are a reflection of a rapidly changing society and family structure. Homicide is a complex issue which does not have a simple answer.[10]

Aggregated Death Rate of Children Aged 5 to 9, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2007.*



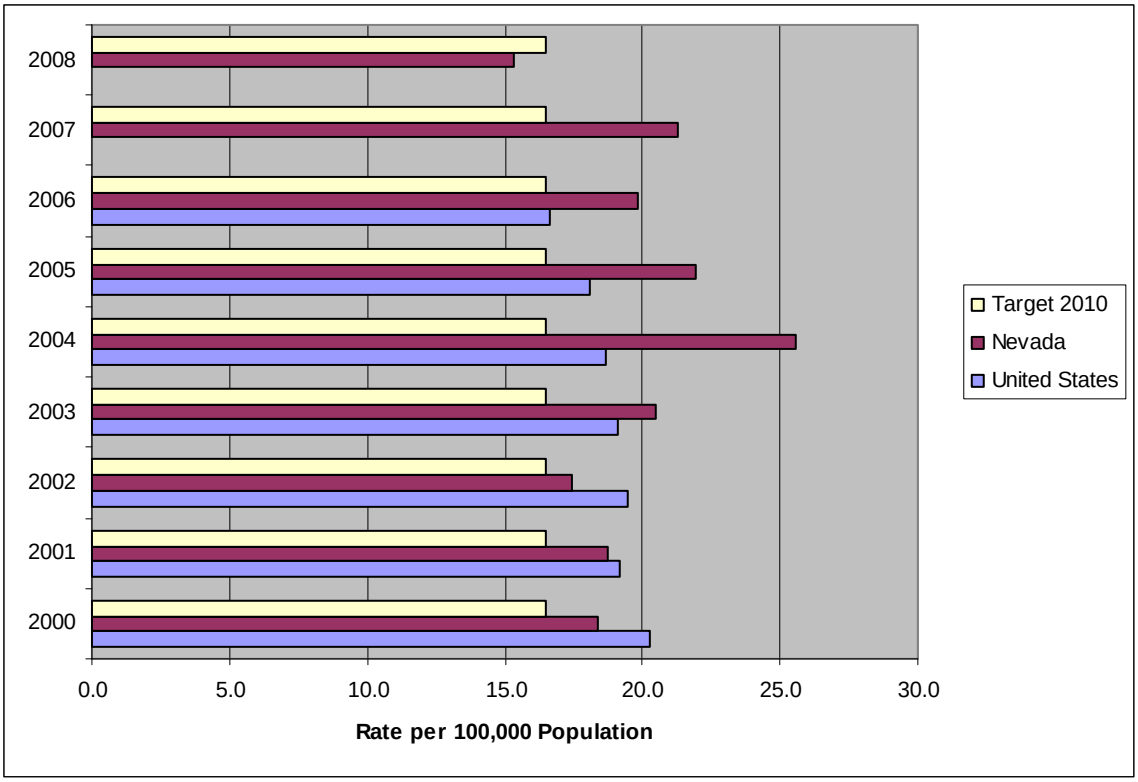
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American and Asian race/ethnicity groups due to small counts.

Healthy People 2010 Objective (16-3a.): Reduce the rate of adolescent deaths, aged 10 to 14 years.

Healthy People 2020 Objective MICH HP2020-4.1: Reduce the rate of adolescent deaths, aged 10 to 14 years.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
15.3	16.6	16.5	15.2	Achieved

Death Rate of Adolescents Aged 10 to 14, Nevada Residents and United States, 2000 - Most Current Data.*

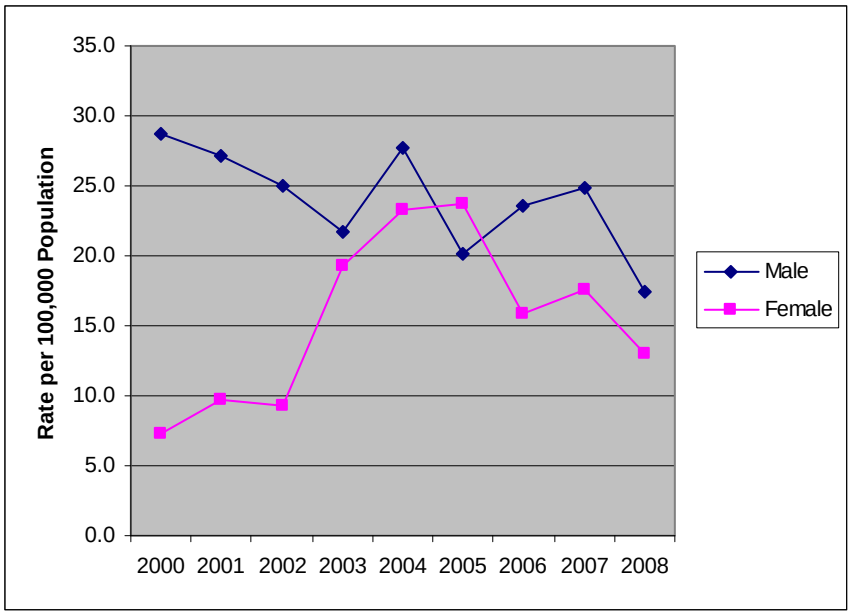


Nevada's death rate among children aged 10 to 14 was higher than the Healthy People 2010 target, of 16.5 per 100,000 people, until 2008. In 2008 Nevada surpassed the Healthy People 2010 target, at 15.3 per 100,000 people.

Causes of death vary by age: in the U.S., unintentional injuries are the leading cause of death for children and teenagers.[12]

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Death Rate of Adolescents Aged 10 to 14, Nevada Residents by Gender, 2000 - 2008.*

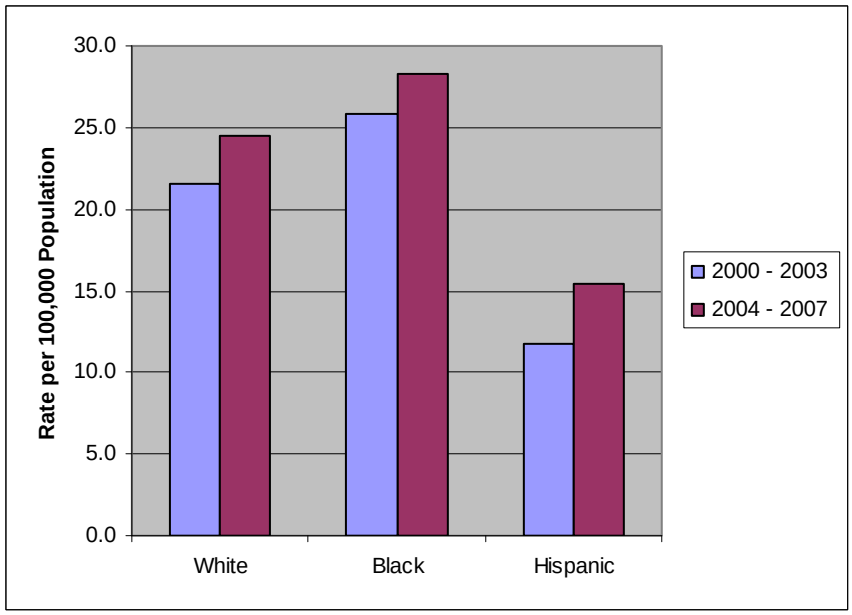


In 2000, males aged 10 to 14 had a much higher death rate than females aged 10 to 14. However, this rate increased for females and decreased for males from 2001 to 2008. Still, males had a higher death rate among adolescents aged 10 to 14 than females aged 10 to 14 in 2008.

Aggregated Death Rate of Adolescents Aged 10 to 14, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2007.*

In all Nevada race/ethnicity groups, the death rate of adolescents aged 10 to 14 increased in the combined years 2004 through 2007.

The substantially higher rates of fatal and non-fatal accidents for boys has been partially attributed to a pattern of poor motor and cognitive regulation, leading to a misjudgment of risk (Kraemer, 2000).[13]



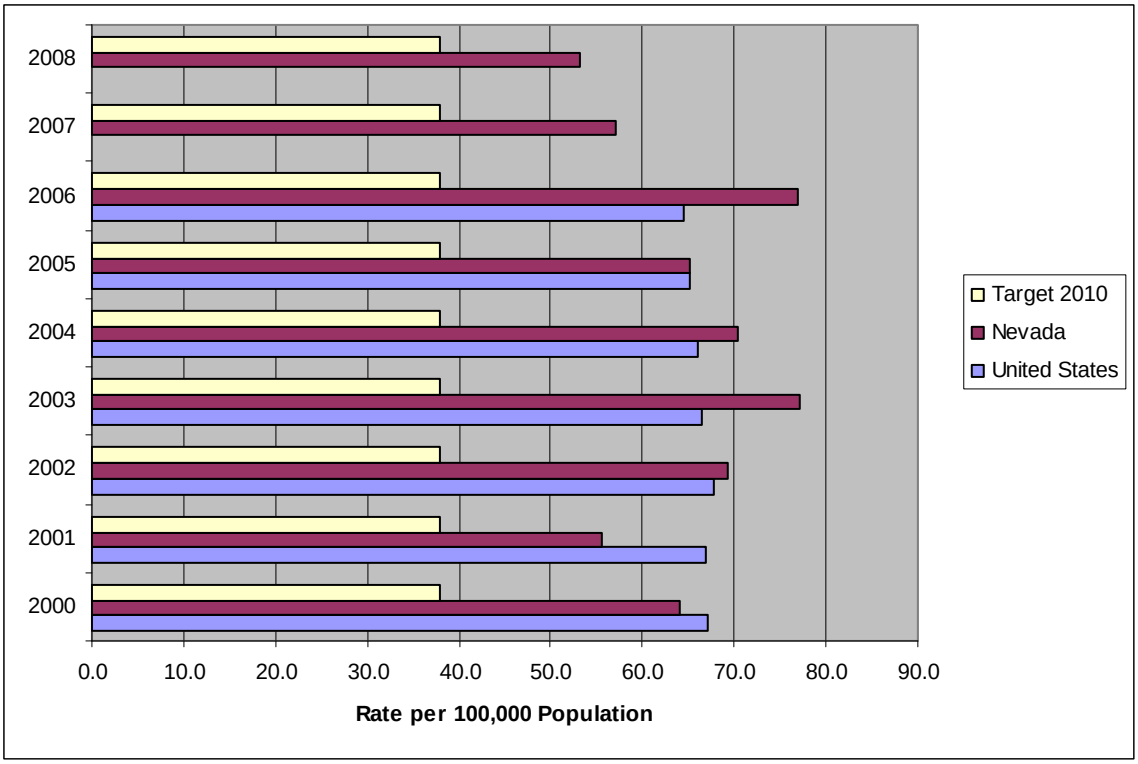
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American and Asian race/ethnicity groups due to small counts.

Healthy People 2010 Objective (16-3b.): Reduce the rate of adolescent deaths, aged 15 to 19 years.

Healthy People 2020 Objective MICH HP2020-4.2: Reduce the rate of adolescent deaths, aged 15 to 19 years.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
53.1	64.4	38.0	55.7	Improving

Death Rate of Adolescents Aged 15 to 19, Nevada Residents and United States, 2000 - Most Current Data.*

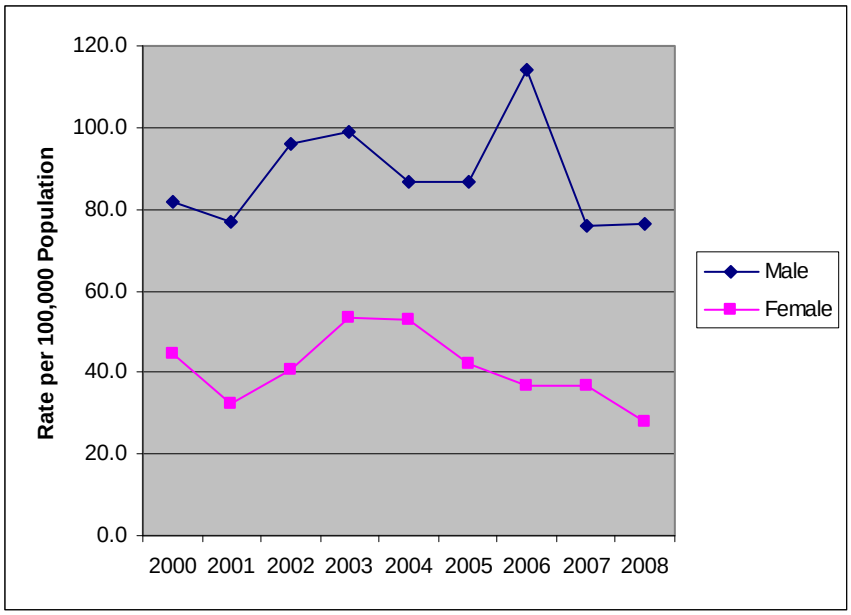


Adolescent death rates among Nevadans aged 15 to 19 years old fluctuated from 2000 to 2008. The Nevada rate decreased but was still higher than the Healthy People 2010 target of 38.0 per 100,000 people in 2008, at 53.1 per 100,000 population.

As the death rates from infection decline, and deaths in childbirth decrease, mortality discrepancies arising from behavioral causes become proportionately much more prominent in adolescents.[13]

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Death Rate of Adolescents Aged 15 to 19, Nevada Residents by Gender, 2000 - 2008.*

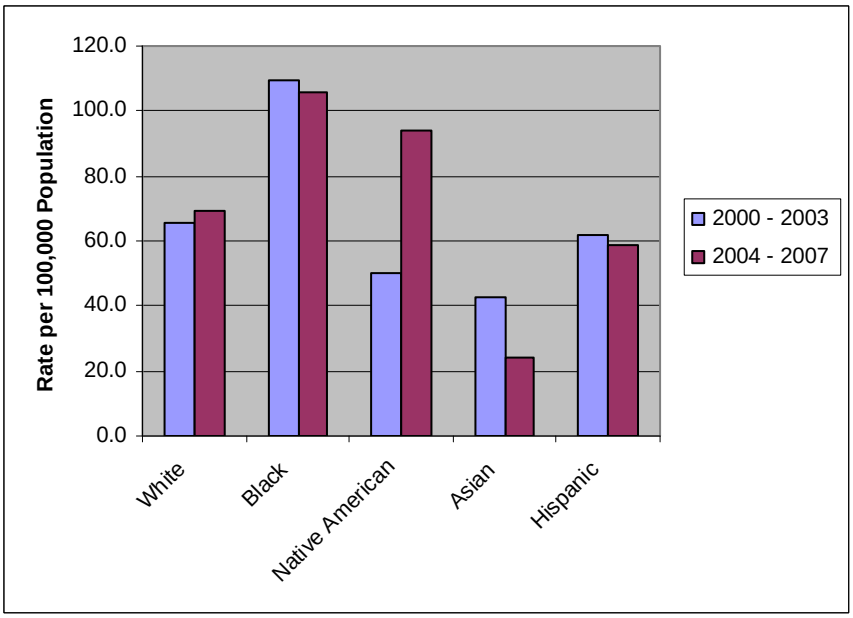


Nevada's death rate for adolescents aged 15 to 19 was much higher among males than females in 2008, and has been since 2000.

The magnitude of the sex difference is perhaps most starkly summarized by the numbers of deaths before age 50; for every 10 premature female deaths, 16 men died prematurely. (Evolutionary Psychology, 2004)[13]

Aggregated Death Rate of Adolescents Aged 15 to 19, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2007.*

This decade, Blacks have consistently had the highest death rate among adolescents aged 15 to 19, and Asians have consistently had the lowest death rate in this age group in Nevada.



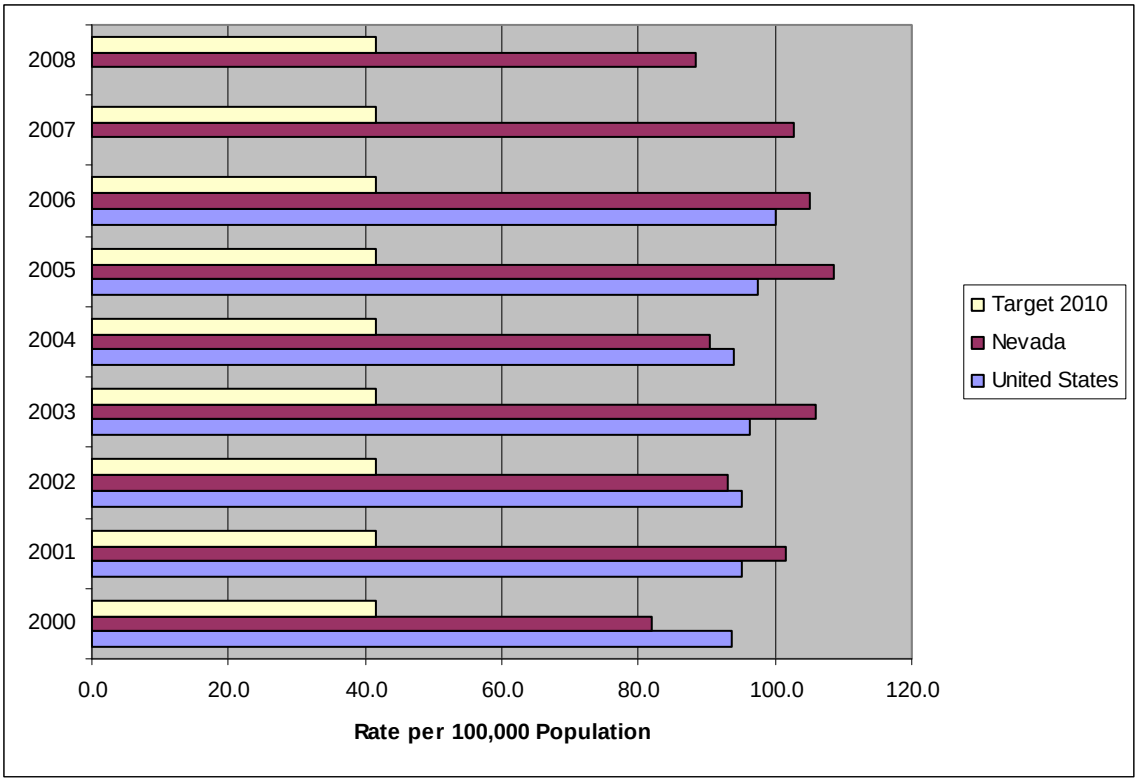
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.

Healthy People 2010 Objective (16-3c.): Reduce the rate of young adult deaths, aged 20 to 24 years.

Healthy People 2020 Objective MICH HP2020-4.3: Reduce the rate of young adult deaths, aged 20 to 24 years.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
88.5	100.2	41.5	88.5	Fluctuating

Death Rate of Young Adults Aged 20 to 24, Nevada Residents and United States, 2000 - Most Current Data.*

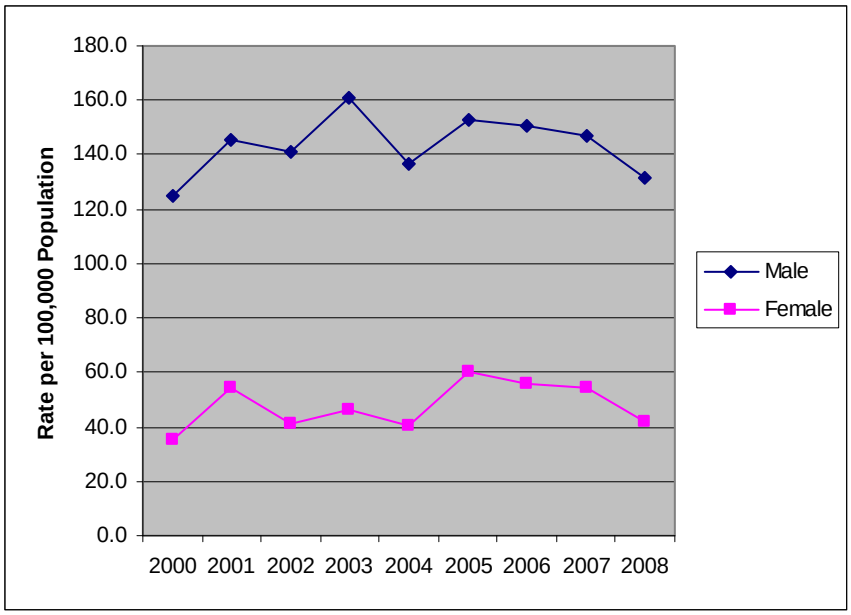


Nevada's death rate among young adults aged 20 to 24 fluctuated from 2000 to 2008. In 2008, this rate was 88.5 per 100,000 people, much higher than the Healthy People 2010 target of 41.5 per 100,000 people.

The national death rate of young adults aged 20 to 24 was also much higher than the Healthy People 2010 target, at 100.2 per 100,000 people in 2006.

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Death Rate of Young Adults Aged 20 to 24, Nevada Residents by Gender, 2000 - 2008.*

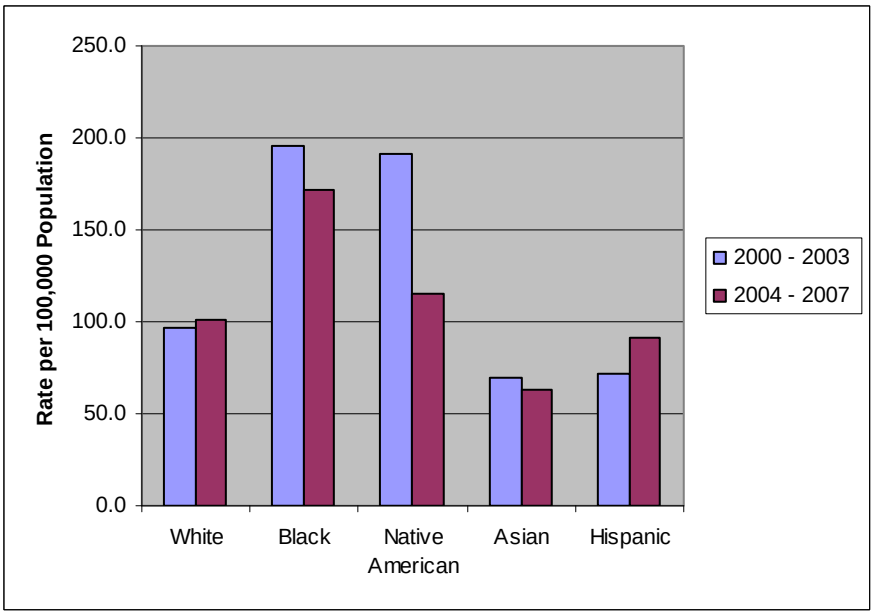


Nevada's death rate for young adults, aged 20 to 24, was much higher among males than females from 2000 to 2008.

There is a substantially higher mortality for men compared to women for different causes and across the life-span in different cultures. Being male is now the single largest demographic risk factor for early mortality in developed countries.[13] (Evolutionary Psychology, 2004)

Aggregated Death Rate of Young Adults Aged 20 to 24, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2007.*

Blacks and Native Americans have consistently had the highest death rate among young adults, aged 20 to 24. Asians have consistently had the lowest death rate in this age group.



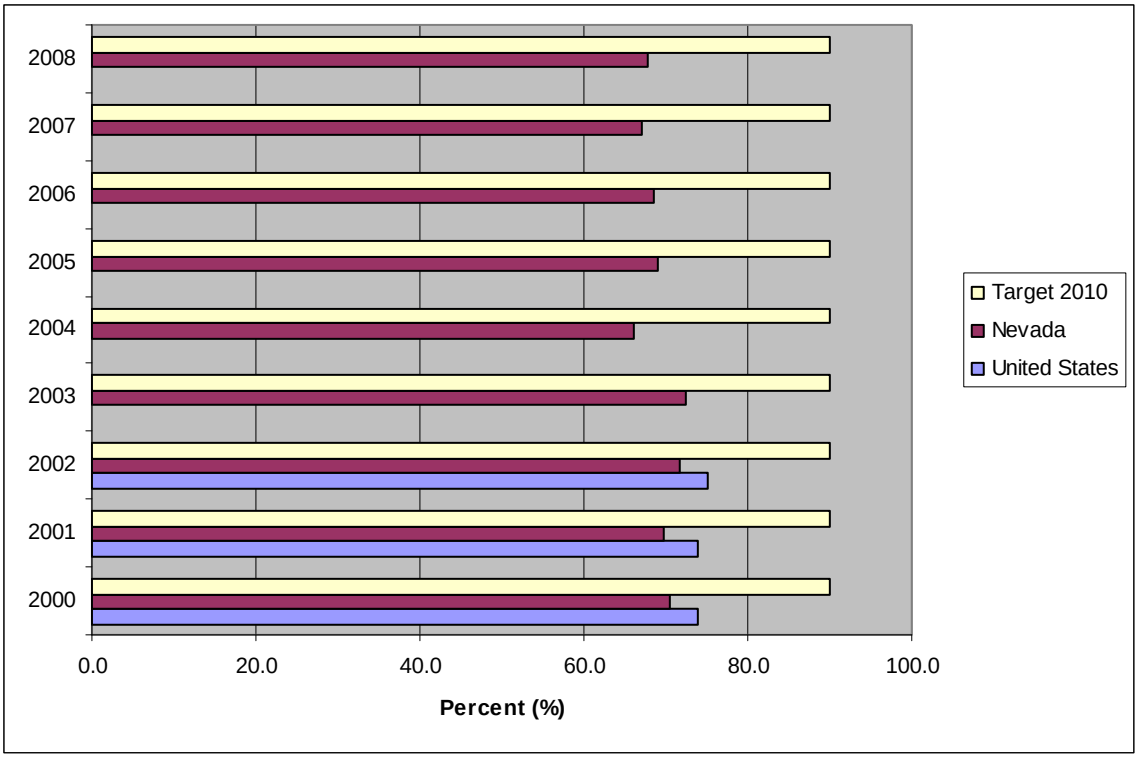
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.

Healthy People 2010 Objective (16-6b.): Increase the proportion of pregnant women receiving early and adequate prenatal care.

Healthy People 2020 Objective MICH HP2020-10: Increase the proportion of women receiving early and adequate prenatal care.

Most Recent NV Value (2008)	U.S. (2002)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
67.8	75.0	90.0	77.6	Worsening

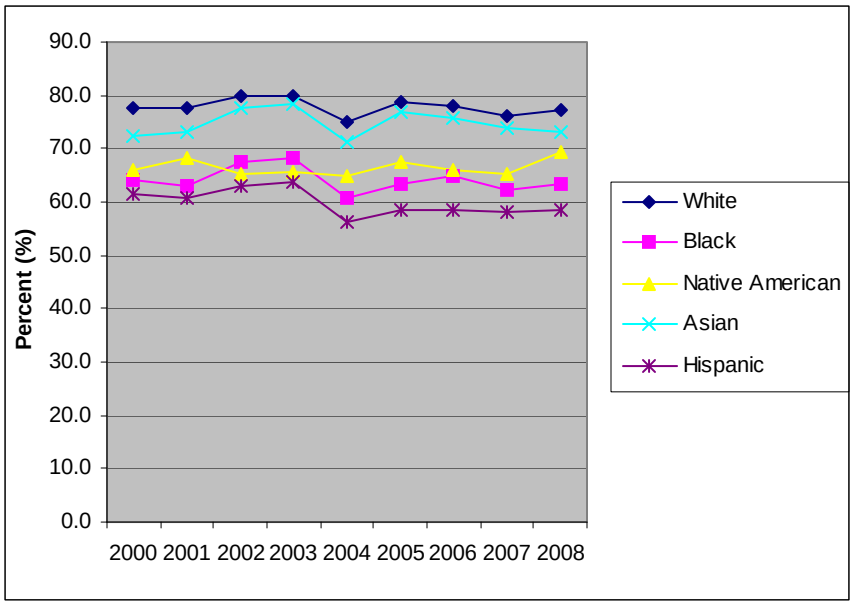
Proportion of Pregnant Women Receiving Early and Adequate Prenatal Care, Nevada Residents and United States, 2000 - Most Current Data.*



The proportion of pregnant Nevada women receiving prenatal care in the 1st trimester of pregnancy slightly decreased from 2000 to 2008, at 67.8 percent in 2008.

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Natality.
Note: 2008 Nevada data are not final and are subject to change.
Note: Used Kotelcheck Index of pre-natal care.
Note: See appendix for additional information.

Proportion of Pregnant Women Receiving Early and Adequate Prenatal Care Beginning in the 1st Trimester of Pregnancy, Nevada Residents by Race/Ethnicity, 2000 - 2008.*

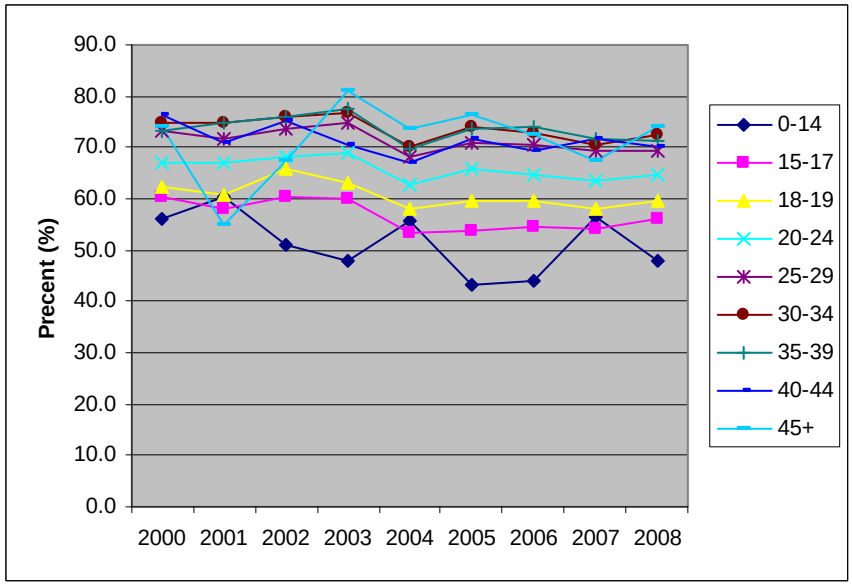


From 2000 to 2008, a higher percentage of Whites obtained early and adequate prenatal care than any other race/ethnicity groups in Nevada. Hispanics had the lowest proportion of pregnant women who obtained early ad adequate prenatal care.

Proportion of Pregnant Women Receiving Early and Adequate Prenatal Care Beginning in the 1st Trimester of Pregnancy, Nevada Residents by Age of Mother, 2000 - 2008.*

The highest proportion of pregnant women receiving early and adequate prenatal care were reported in the age ranges above the age of 30 years and older.

The lowest proportion were reported under the age of 17 years.



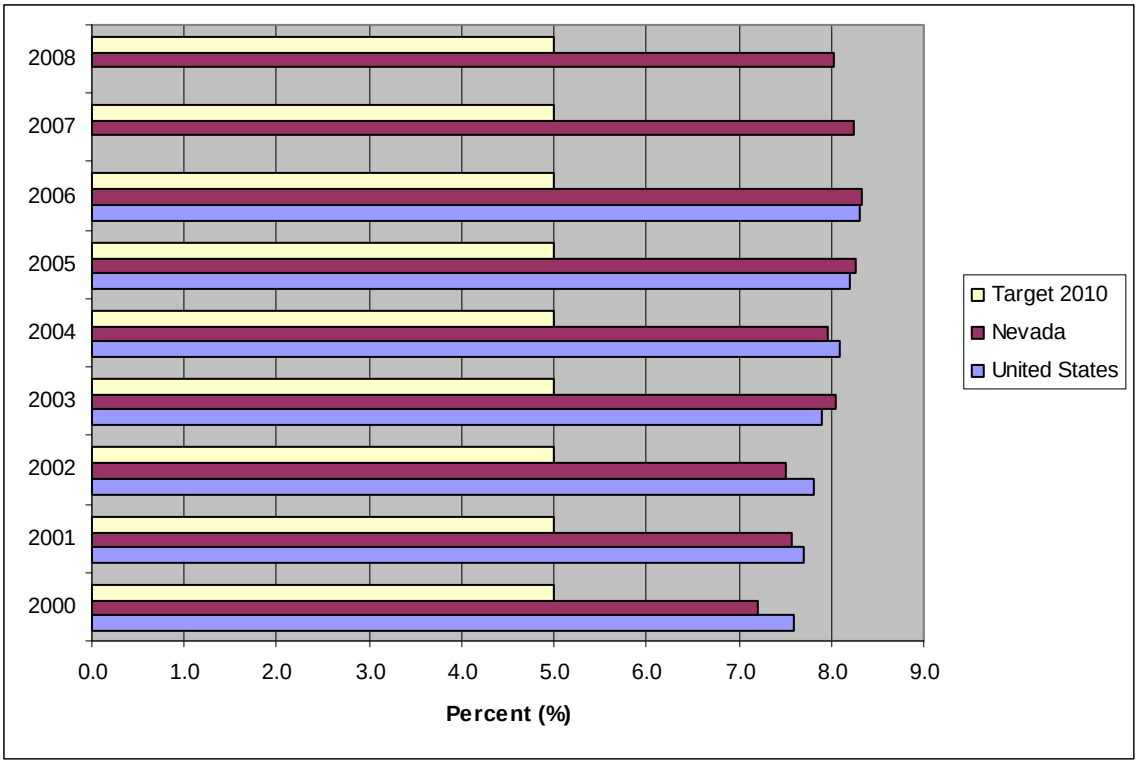
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2008 Nevada data are not final and are subject to change.
Note: Used Kotelcheck Index of pre-natal care.

Healthy People 2010 Objective (16-10a.): Reduce the proportion of low birth weight infants.

Healthy People 2020 Objective MICH HP2020-8.1: Reduce the proportion of low birth weight infants.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
8.0	8.3	5.0	7.8	Fluctuating

Proportion of Low Birth Weight Infants, Nevada Residents and United States, 2000 - Most Current Data.*

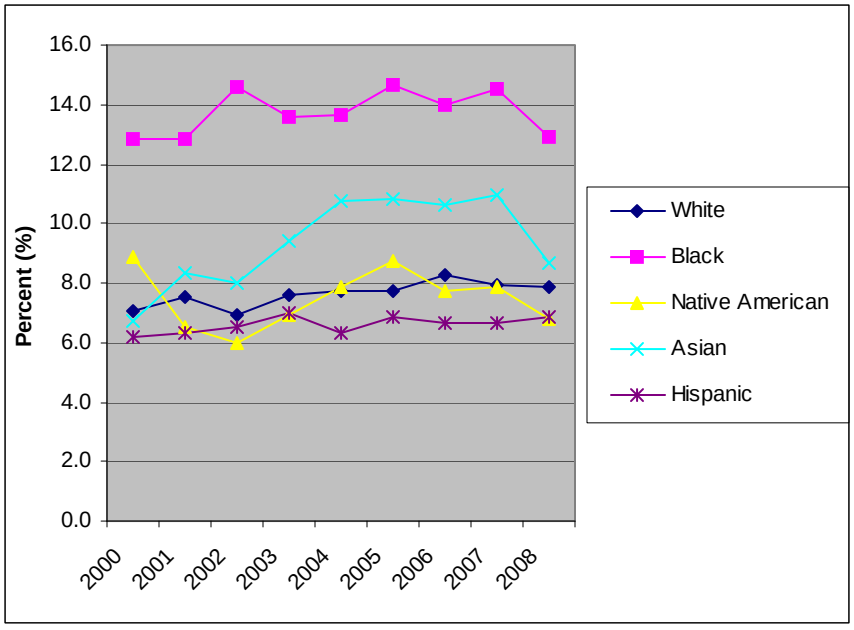


Neither Nevada, nor the United States, had reached the Healthy People 2010 target for proportion of low birth weight infants from 2000 to 2008. There was a no overall increase in the proportion of low birth weight infants in Nevada from 2000 to 2008, at 8.0 percent in 2008.

In Nevada, the proportion of low birth weight (LBW) infants continues to fluctuate, climbing to 8.3 percent in 2006, the highest level in four decades. The percentage of infants born at less than 2,500 grams has risen 19 percent since 1990. All of the increase for 2005–2006 was among moderately LBW (1,500–2,499 grams) infants. LBW rates rose slightly for Hispanic infants, but were unchanged for non-Hispanic White and non-Hispanic Black infants. The LBW rate for infants born in single deliveries also increased in 2006; singleton LBW has risen 10 percent since 1990.[2]

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Natality.
Note: 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Proportion of Low Birth Weight Infants, Nevada Residents by Race/Ethnicity, 2000 - 2008.*

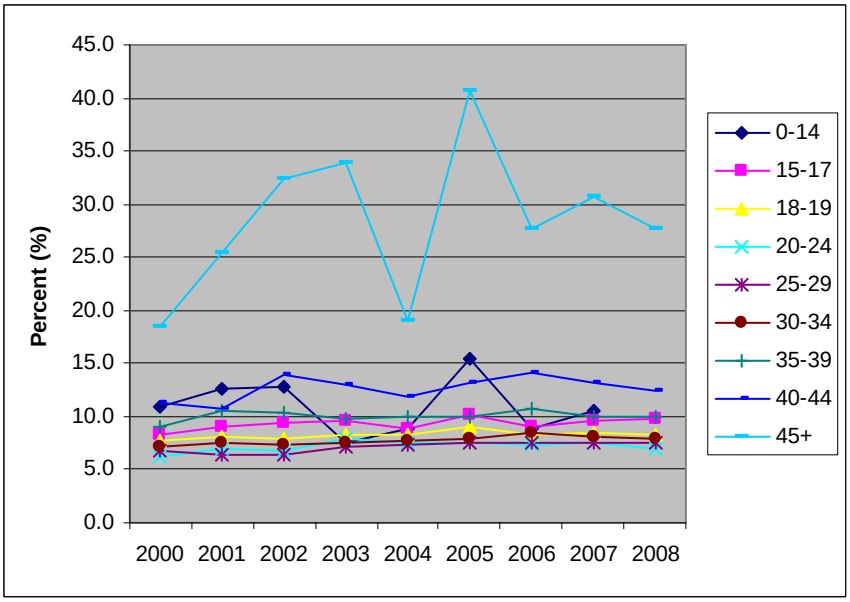


The proportions of low birth weight infants was highest among Blacks, followed by Asians in Nevada during the years 2000 - 2008.

Proportion of Low Birth Weight Infants, Nevada Residents by Age of Mother, 2000 - 2008.*

The highest proportion of low birth weight infants born during the years 2000 to 2008, were reported in mothers aged 45 years and older.

The lowest proportion of low birth weight infants were born to mothers aged 18 to 29 years of age.



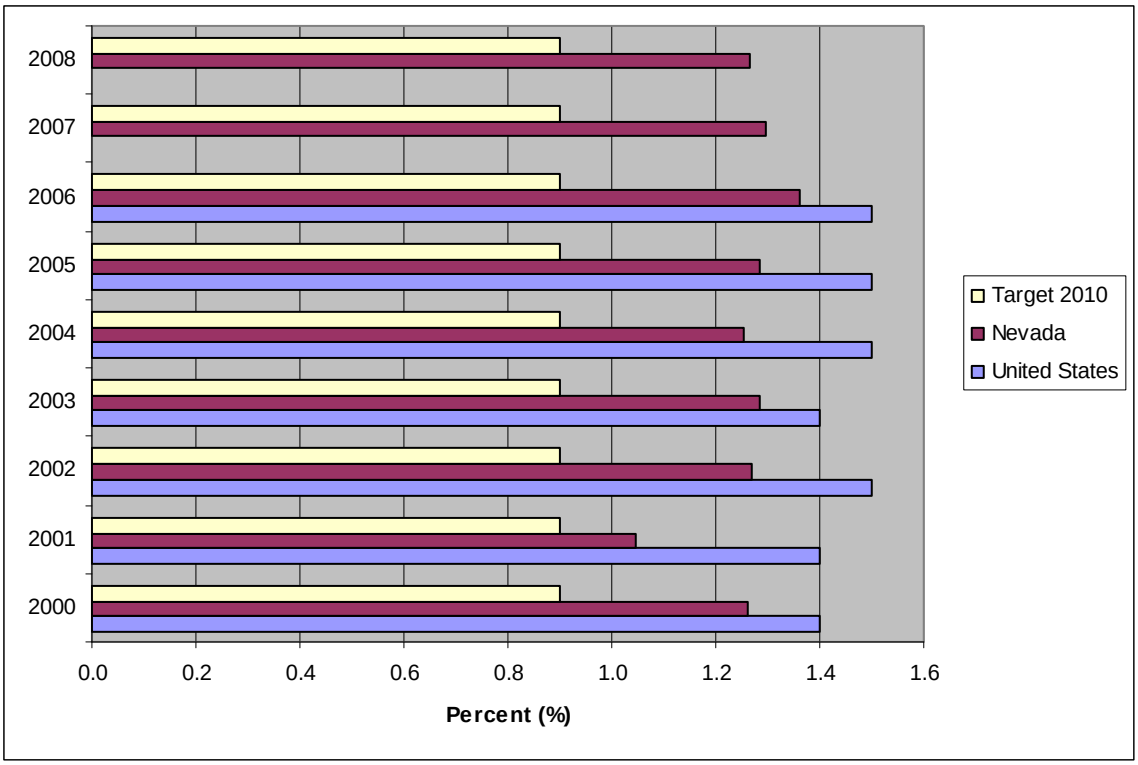
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2008 Nevada data are not final and are subject to change.

Healthy People 2010 Objective (16-10b.): Reduce the proportion of very low birth weight infants.

Healthy People 2020 Objective MICH HP2020-8.2: Reduce the proportion of very low birth weight infants.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
1.3	1.5	0.9	1.4	Fluctuating

Proportion of Very Low Birth Weight Infants, Nevada Residents and United States, 2000 - Most Current Data.*

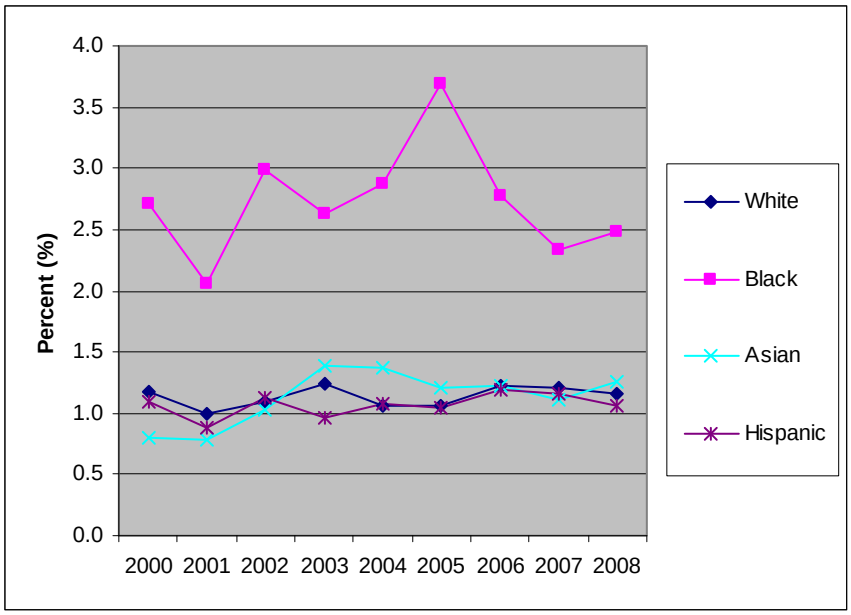


The proportion of very low birth weight infants in Nevada fluctuated from 2000 to 2008, at 1.3 percent in 2008. Neither Nevada, nor the nation, reached the Healthy People 2010 target, of 0.9 percent, for the proportion of very low birth weight infants in the reported years.

Nationally, in 2005, over one-third (35 percent) of fetal deaths at 20 weeks of gestation or more weighed less than 500 grams at delivery, and one-half weighed less than 750 grams. Fetal mortality rates were highest for less than 500-gram fetuses and decreased rapidly with increasing birth weight. Fetal mortality rates were lowest at 3,000–3,999 grams, and then increased slightly for heavier fetuses (CDC).[14]

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Natality.
Note: 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Proportion of Very Low Birth Weight Infants, Nevada Residents by Race, 2000 - 2008.*



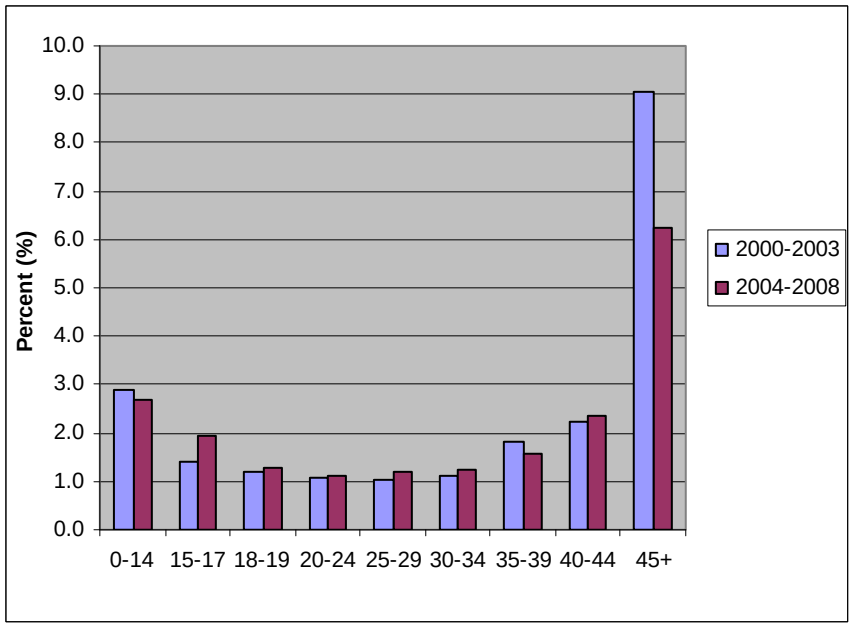
In Nevada, Blacks had a higher proportion of low birth weight infants than all other racial/ethnic groups in 2000 through 2008.

The proportion of very low birth weight infants among Whites, Asians, and Hispanics were similar from 2000 to 2008.

The highest proportion of very low birth weight infants were born to mothers in the youngest and oldest age groups. The highest proportion of very low birth weight infants was among mothers aged 45 years and older, followed by those aged 14 years and younger.

There was a slight increase in the proportion of very low birth weight infants born to mothers in almost all age groups, with the exception of mothers aged 0 to 14, 35 to 39, and 45 years and older.

Aggregated Proportion of Very Low Birth Weight Infants, Nevada Residents by Age Group, 2000 - 2003 and 2004 - 2008.*



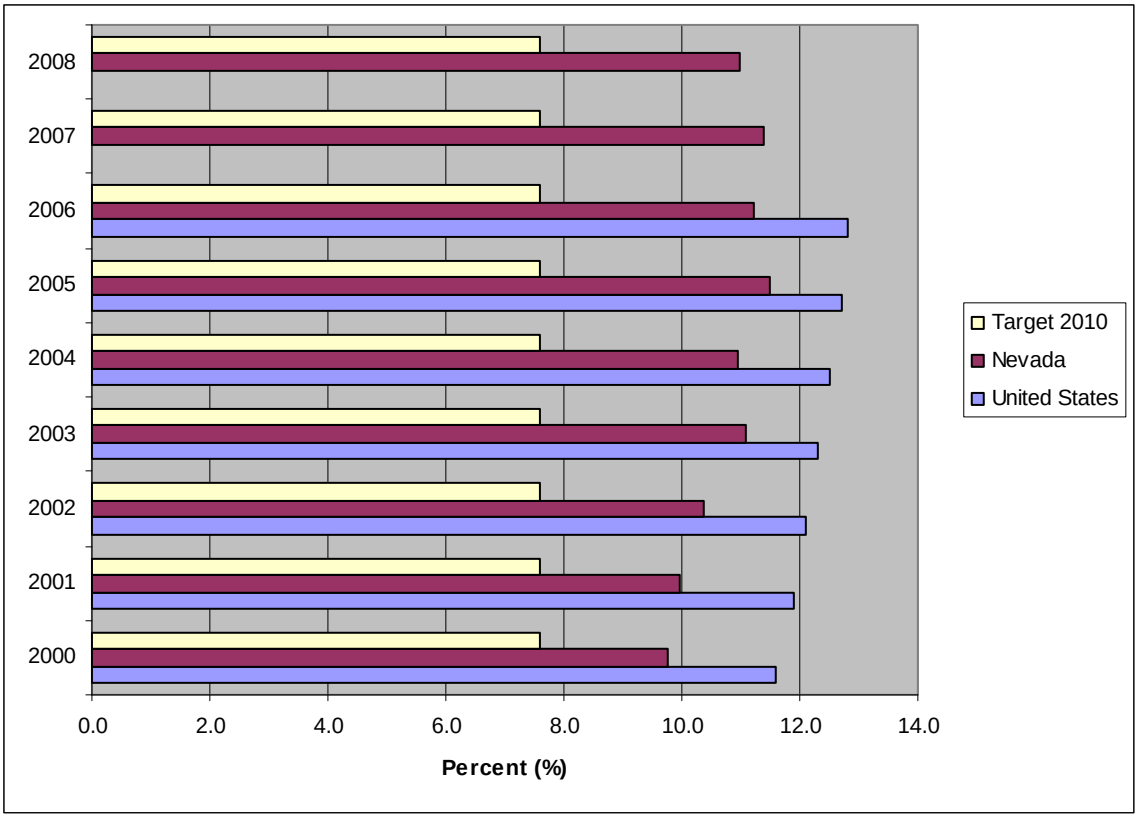
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group due to small counts.

Healthy People 2010 Objective (16-11a.): Reduce total preterm birth.

Healthy People 2020 Objective MICH HP2020-9.1: Reduce total preterm births.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
11.0	12.8	7.6	11.4	Fluctuating

Proportion of Pre Term Births, Infants Born Prior to 37 Completed Weeks of Gestation, Nevada Residents and United States, 2000 - Most Current Data.*

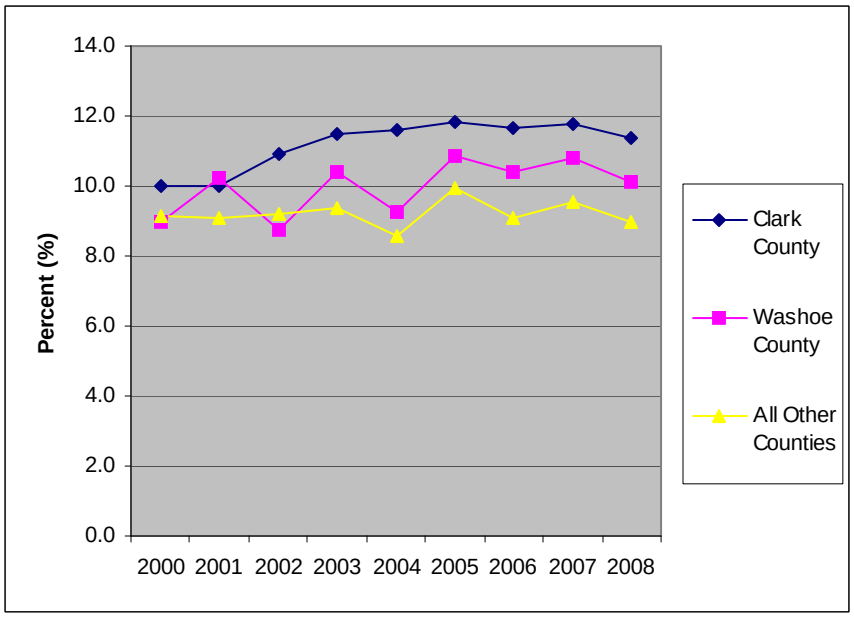


The proportion of pre term births in Nevada fluctuated from 2000 to 2008. Neither Nevada, nor the nation, met the Healthy People 2010 target for the proportion of pre term births from 2000 to 2008.

Nationally, the pre term birth rate has been rising since 2000 and was 12.8 percent of all births in 2006. The percentage of infants delivered at less than 37 completed weeks of gestation has climbed 20 percent since 1990. Most of this rise is attributable to the increase in late preterm births (34–36 weeks), up 25 percent since 1990.[2]

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Natality.
Note: 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Proportion of Pre Term Births, Infants Born Prior to 37 Completed Weeks of Gestation, Nevada Residents by County/ Region, 2000 - 2008.*



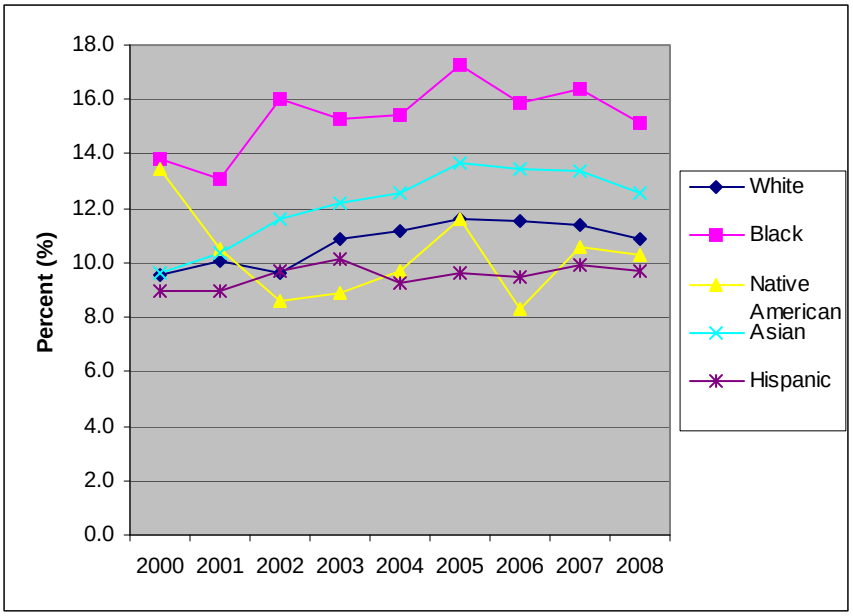
It is very important that data on birth outcomes, especially levels of low birth weight (LBW) and preterm birth, be continuously monitored, because these variables are important predictors of infant mortality and morbidity.[15]

Clark County had the highest rate of pre term births in the state from 2002 to 2008, followed by Washoe County.

Proportion of Pre Term Births, Infants Born Prior to 37 Completed Weeks of Gestation, Nevada Residents by Race/ Ethnicity, 2000 - 2008.*

From the years 2000 to 2008, Nevada preterm birth rates rose slightly for Hispanic, Black, Asian, and White infants.

Nevada's Black population had the highest proportion of pre term births consistently from 2000 to 2008.



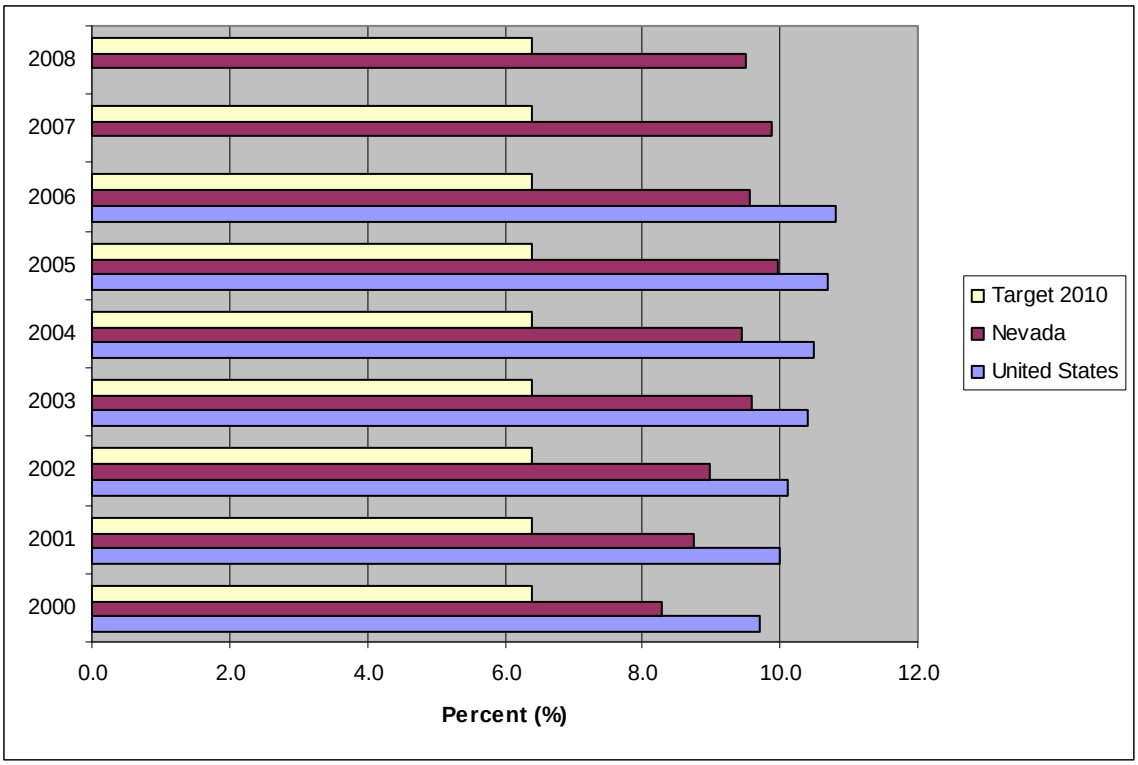
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2008 Nevada data are not final and are subject to change.

Healthy People 2010 Objective (16-11b.): Reduce the proportion of live births at 32 to 36 weeks of gestation.

Healthy People 2020 Objective MICH HP2020-9.2: Reduce the proportion of live births at 34 to 36 weeks of gestation.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
9.5	10.8	6.4	8.1	Worsening

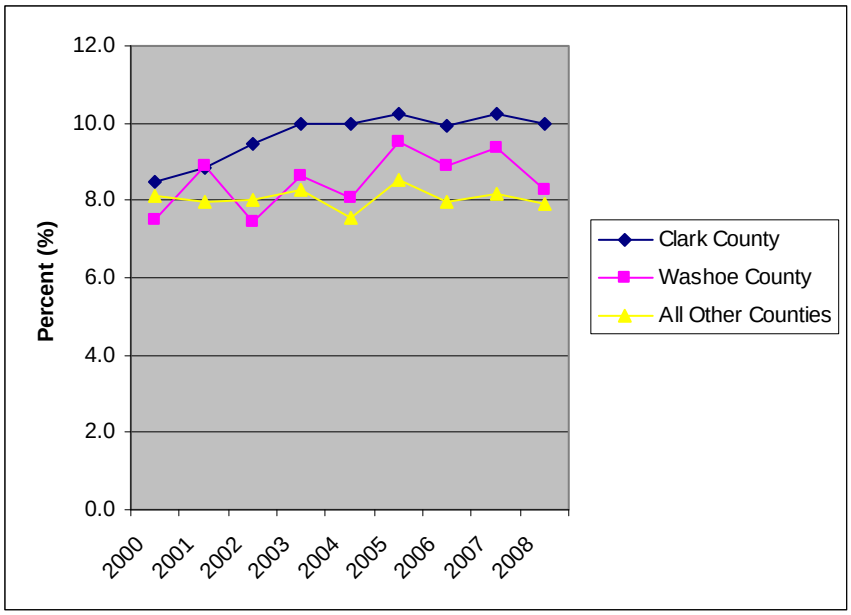
Proportion of Live Births at 32 to 36 Completed Weeks of Gestation, Nevada Residents and United States, 2000 - Most Current Data.*



Neither Nevada, nor the nation, met the Healthy People 2010 target for the proportion of live births at 32 to 36 weeks of gestation from 2000 to 2008. In Nevada, the proportion of live births at 32 to 36 weeks of gestation increased from 2000 to 2008, at 9.5 percent in 2008.

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Natality.
Note: 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

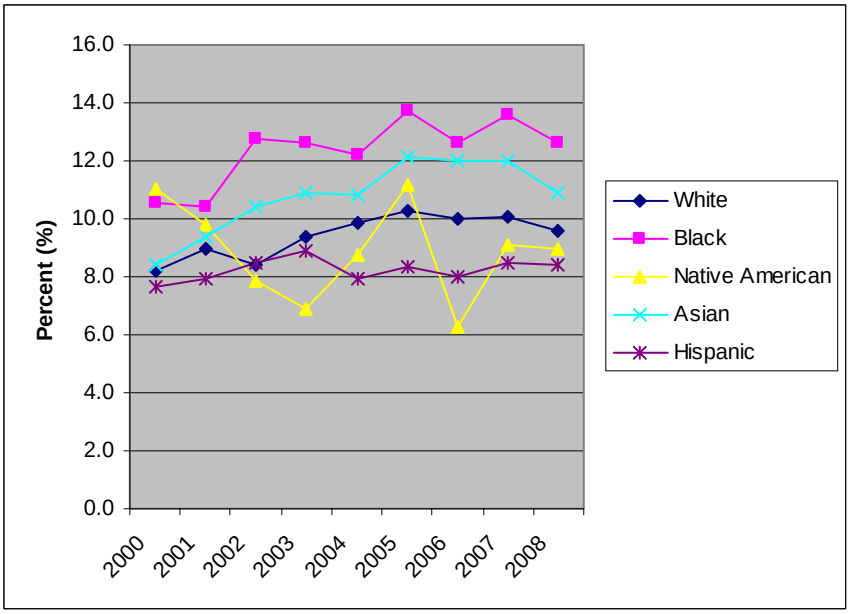
Proportion of Live Births at 32 to 36 Completed Weeks of Gestation, Nevada Residents by County/Region, 2000 - 2008.*



The proportion of live births at 32 to 36 weeks gestation increased overall in Clark County from 2000 to 2008. The proportion of live births at 32 to 36 weeks gestation in "All Other Counties," which includes Nevada's rural and frontier counties as well as Carson County, remained steady from 2000 to 2008.

Proportion of Live Births at 32 to 36 Completed Weeks of Gestation, Nevada Residents by Race/Ethnicity, 2000 - 2008.*

The proportion of live births at 32 to 36 weeks of gestation has increased among Black, Asian, and White Nevada residents from 2000 to 2008.



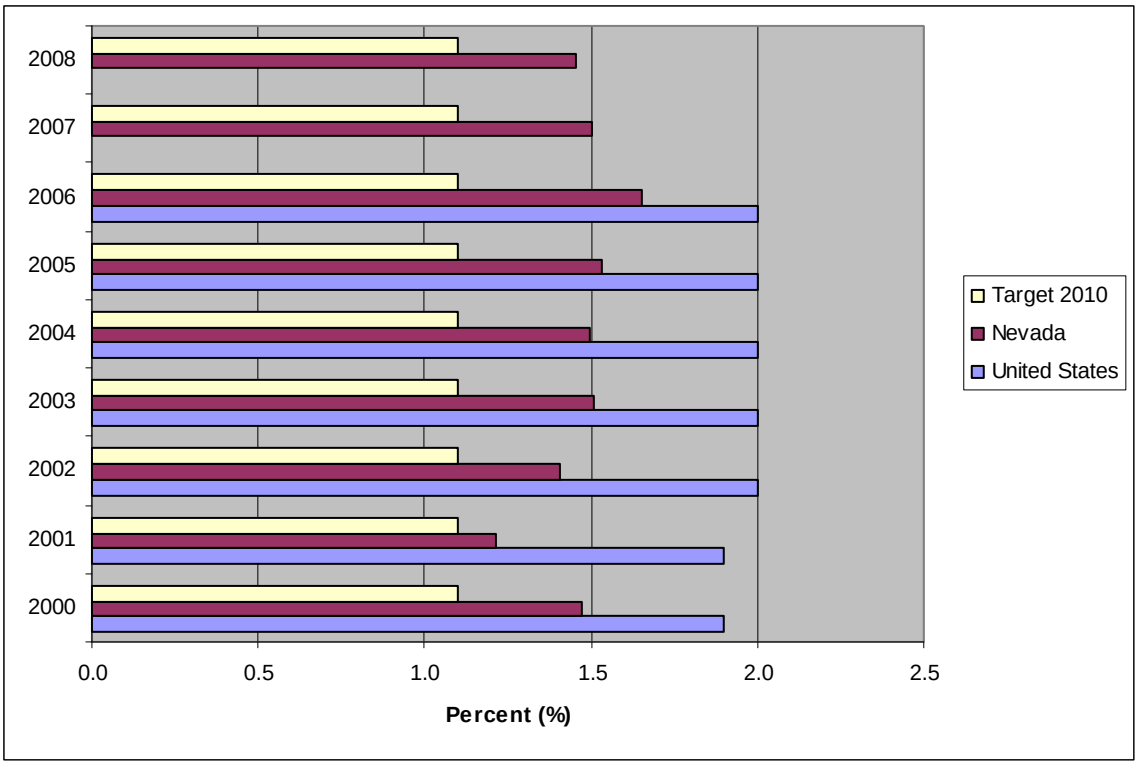
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2008 Nevada data are not final and are subject to change.

Healthy People 2010 Objective (16-11c.): Reduce the proportion of live births at less than 32 completed weeks of gestation.

Healthy People 2020 Objective MICH HP2020-9.4: Reduce the proportion of very preterm or live births at less than 32 weeks of gestation.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
1.5	2.0	1.1	1.8	Fluctuating

Proportion of Live Births at Less Than 32 Completed Weeks of Gestation, Nevada Residents and United States, 2000 - Most Current Data.*

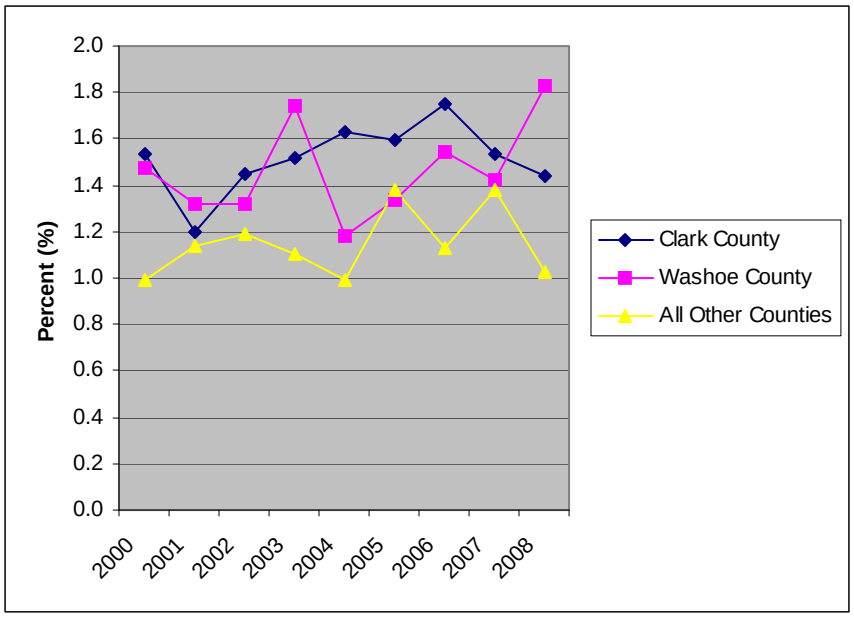


From 2001 to 2006 the proportion of infants born at less than 32 weeks gestation increased in Nevada. Then, in 2007 and 2008 the proportion of live births at less than 32 weeks of gestation decreased in Nevada, still above the Healthy People 201 target, at 1.5 percent in 2008.

This proportion was lower in Nevada than in the nation from 2000 to 2006. Neither region met the Healthy People target of 1.1 percent.

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Natality.
Note: 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Proportion of Live Births at Less Than 32 Completed Weeks of Gestation, Nevada Residents by County/Region, 2000 - 2008.*



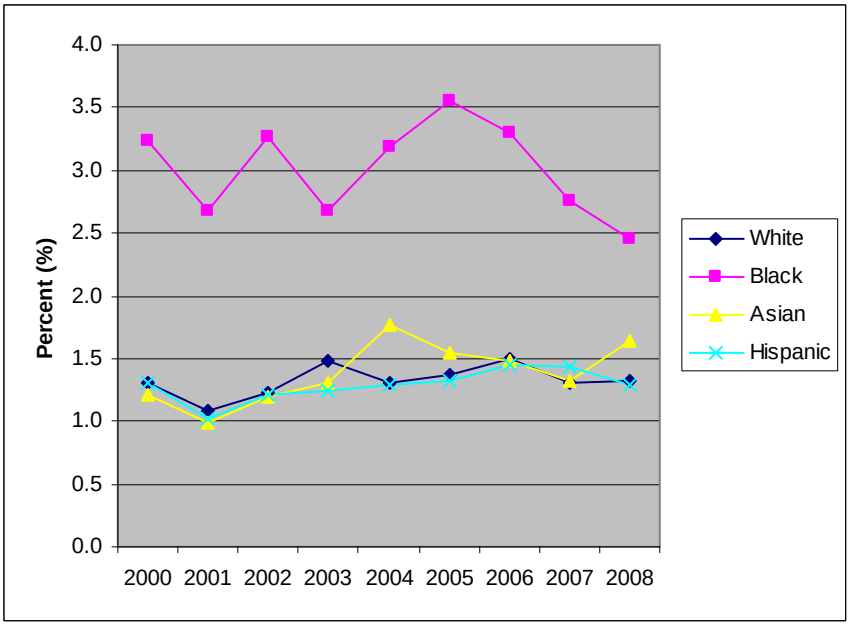
In the United States, more than one-third of all infant deaths are estimated to be pre-term-related.[9]

Rates of live births at less than 32 weeks gestation fluctuated between 2000 and 2008 in all Nevada regions.

In Nevada, Blacks were at the greatest risk of a live birth at less than 32 weeks of gestation. The proportion of live births at less than 32 weeks gestation decreased in Nevada's Black population from 2005 to 2008.

The risk of adverse outcome declines as gestational age increases; however, even infants born late preterm, the bulk of preterm births, are at heightened risk of early death compared with those born later in the pregnancy. There is growing evidence that late preterm infants suffer long-term ill effects.[16]

Proportion of Live Births at Less Than 32 Completed Weeks of Gestation, Nevada Residents by Race/Ethnicity, 2000 - 2008.*



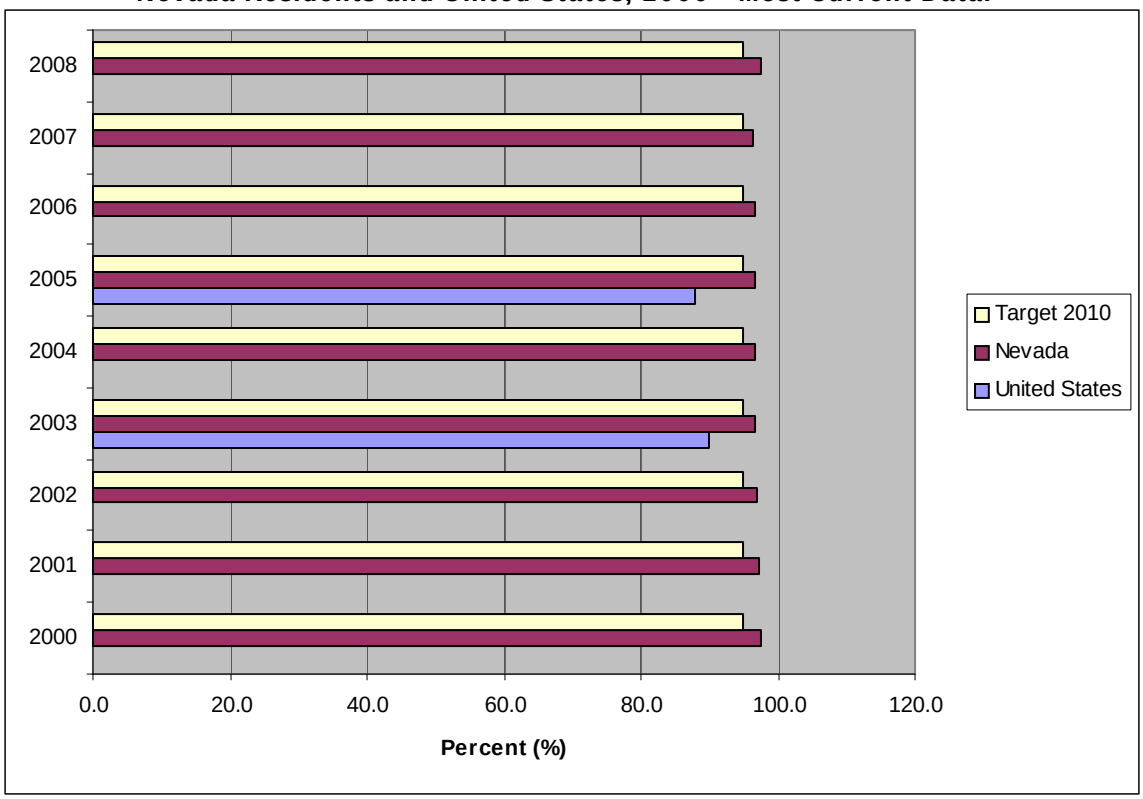
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group due to small counts.

Healthy People 2010 Objective (16-17a.): Increase the proportion of pregnant women abstaining from alcohol.

Healthy People 2020 Objective MICH HP2020-11.1: Increase abstinence from alcohol among pregnant women.

Most Recent NV Value (2008)	U.S. (2005)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
97.4	88.0	95.0	98.3	Surpassed

Proportion of Pregnant Women, Aged 15 to 44 Years, Abstaining from Alcohol, Nevada Residents and United States, 2000 - Most Current Data.*

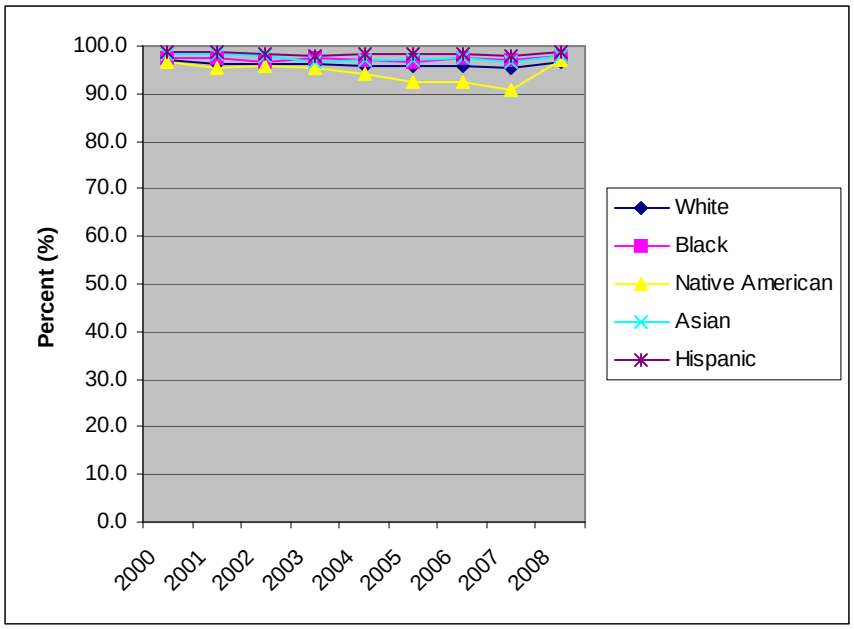


Moderate to heavy alcohol use by women during pregnancy has been associated with many severe adverse effects in their children, including fetal alcohol syndrome (FAS), with facial dysmorphology, growth retardation, and central nervous system deficits and other neurodevelopmental effects. Early prenatal alcohol exposure can occur unintentionally (i.e., before a woman knows she is pregnant); women who drink at high levels before pregnancy are at increased risk for drinking during pregnancy.[17]

Nevada consistently surpassed the Healthy People 2010 target for the percentage of pregnant women abstaining from alcohol from 2000 to 2008.

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Survey on Drug Use and Health (NSDUH), SAMHSA. U.S. data is only available from this source on the CDC Wonder, Data 2010, website for the years 2003 and 2005.
Note: 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Proportion of Pregnant Women, Aged 15 to 44 Years, Abstaining from Alcohol, Nevada Residents by Race/Ethnicity, 2000 -



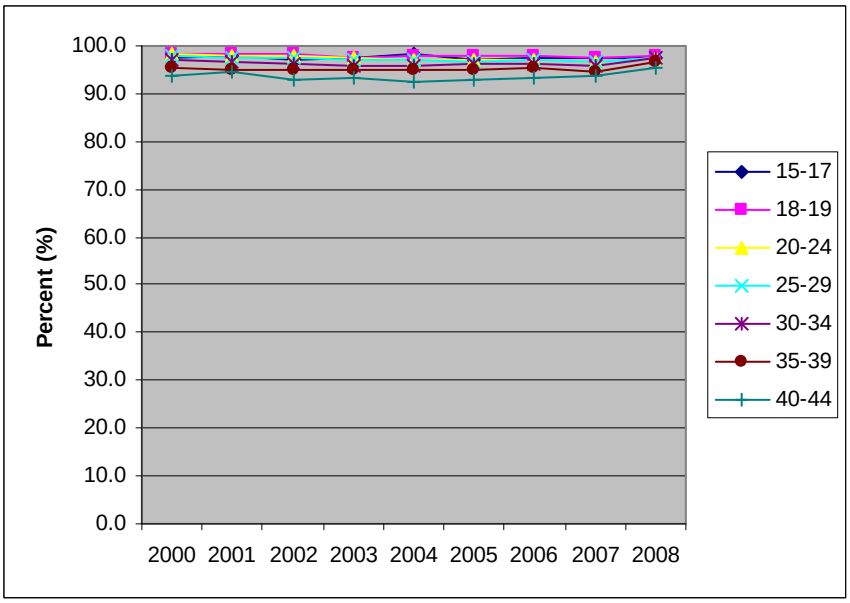
Nevada's Native Americans had the lowest proportion of pregnant women abstaining from alcohol from 2000 to 2008. Rates were steady for all race/ethnicity groups between 2000 and 2008.

Proportion of Pregnant Women, Aged 15 to 44 Years, Abstaining from Alcohol, Nevada Residents by Age of Mother, 2000 - 2008.*

The proportion of pregnant women abstaining from alcohol in Nevada was steady for all age groups this decade.

The highest percentage of women abstaining from alcohol were women in the 18-19 year old age range.

The lowest percentage being found in the age groups 35 years and older.



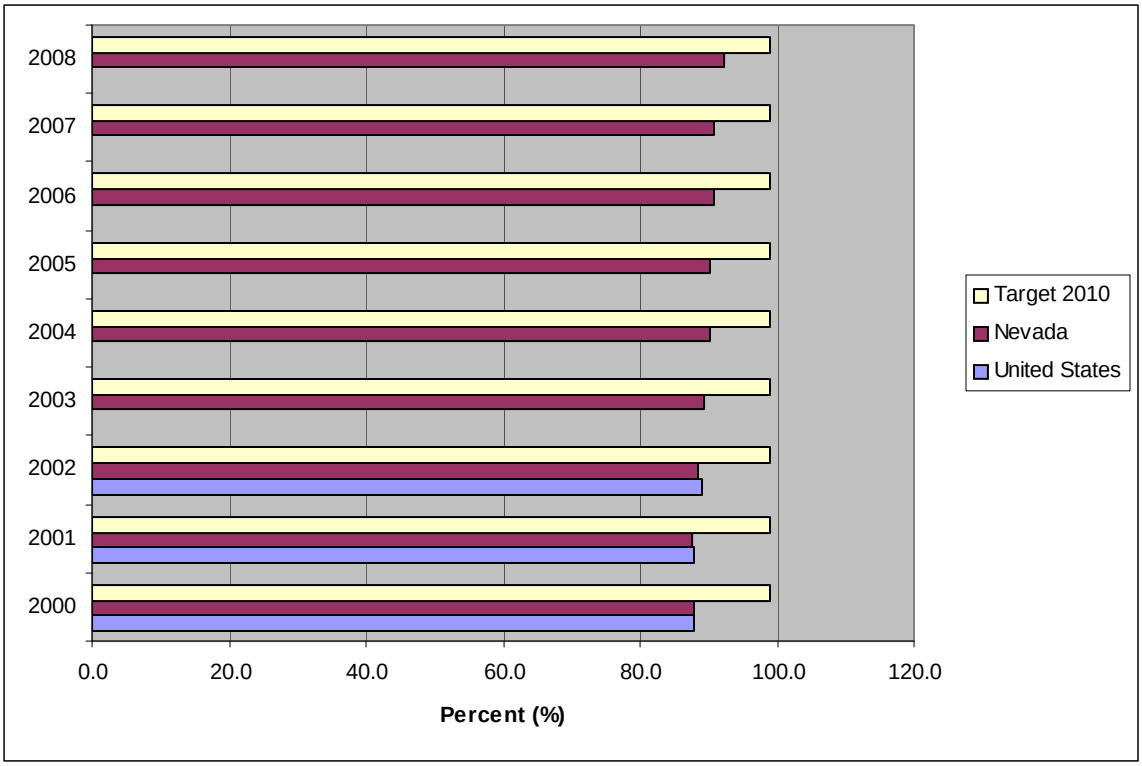
*The Nevada data are from Nevada Vital Statistics Records.
Note: 2008 Nevada data are not final and are subject to change.

Healthy People 2010 Objective (16-17c.): Increase the proportion of pregnant women abstaining from cigarette smoking.

Healthy People 2020 Objective MICH HP2020-11.3: Increase abstinence from cigarettes among pregnant women.

Most Recent NV Value (2008)	U.S. (2002)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
92.4	89.0	99.0	98.6	Improving

Proportion of Pregnant Women Abstaining from Tobacco, Nevada Residents and United States, 2000 - Most Current Data.*

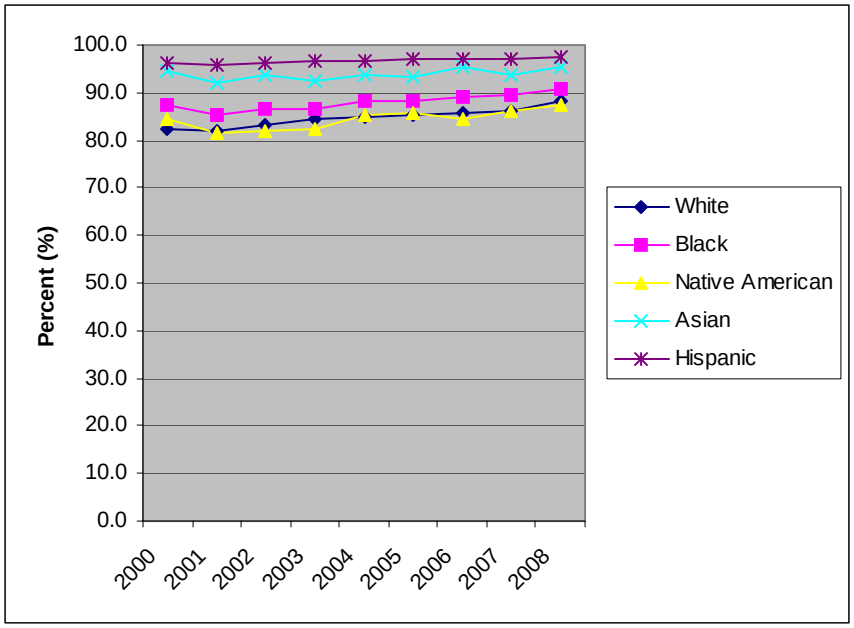


If the mother reported smoking in any of the three trimesters of pregnancy, she was recorded as a smoker.

The proportion of pregnant women abstaining from tobacco increased for both the state and the nation in the reported period. Neither Nevada, nor the U.S., have reached the Healthy People 2010 target.

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Natality.
Note: 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Proportion of Pregnant Women Abstaining from Tobacco, Nevada Residents by Race/Ethnicity, 2000 - 2008.*



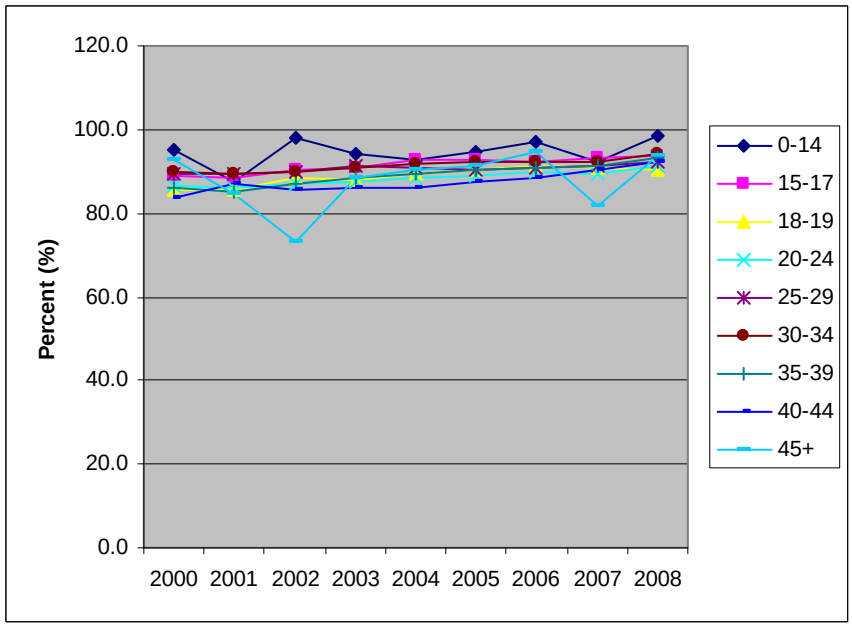
The proportion of pregnant women abstaining from tobacco increased for all race/ethnicity groups from 2000 to 2008.

Hispanics consistently had the highest proportion of pregnant women abstaining from tobacco, while Whites and Native Americans had the lowest.

Proportion of Pregnant Women Abstaining from Tobacco, Nevada Residents by Age of Mother, 2000 - 2008.*

The rate of pregnant women abstaining from tobacco increased slightly for all age groups from 2000 to 2008.

Pregnant women aged 14 years and younger had the highest proportion of pregnant women abstaining from tobacco, while pregnant women aged 40 to 44 had the lowest proportion of pregnant women abstaining from tobacco.



*The Nevada data are from Nevada Vital Statistics Records.
Note: 2008 Nevada data are not final and are subject to change.

Mental Health and Mental Disorders

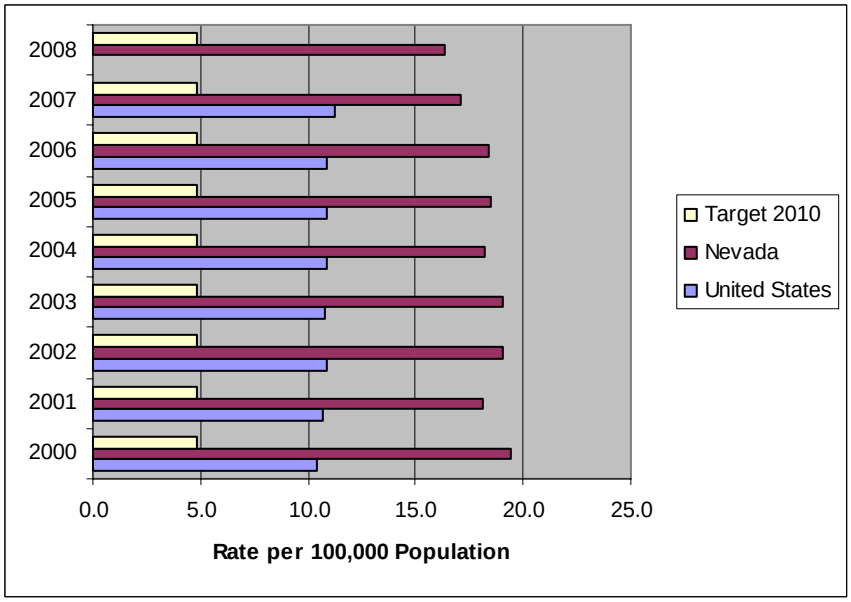
Mental illness and disorders occur across the lifespan, affecting persons of all racial and ethnic groups, both genders, and all educational and socioeconomic groups. Suicide represents one of the leading causes of preventable death and is most often a consequence of a mental disorder. For the past ten years, Nevada has consistently ranked high for suicide deaths. In 2004, suicide was the 7th leading cause of death in Nevada at 2.4 percent of total Nevada deaths, and in the U.S., suicide was ranked as the 11th leading cause of death at 1.3. percent of total U.S. deaths.[1]

Healthy People 2010 Objective (18-1.): Reduce the suicide rate.

Healthy People 2020 Objective MHMD HP2020-1: Reduce the suicide rate.

Most Recent NV Value (2008)	U.S. (2007)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
16.3	11.3	4.8	10.2	Improving

Age-Adjusted Suicide Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*

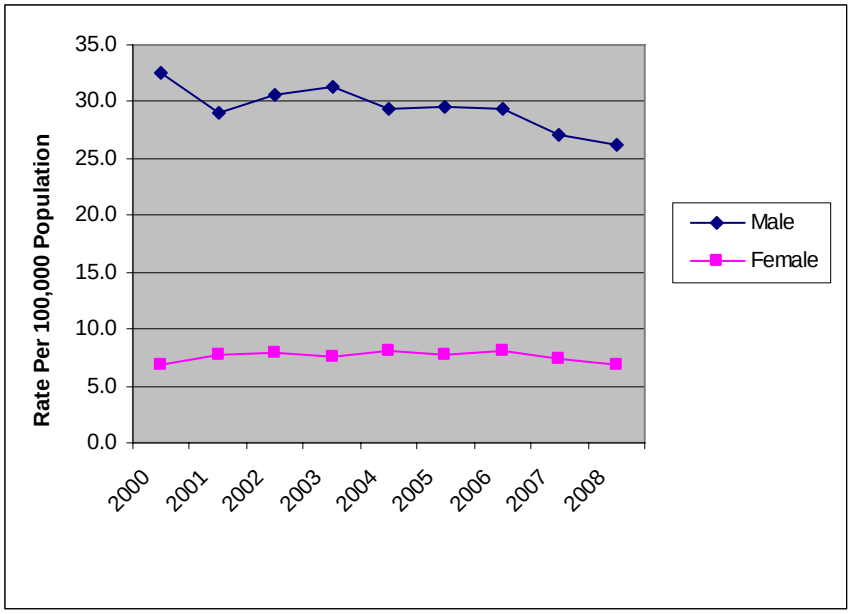


In 2006, the suicide death rate in Nevada was 18.4 per 100,000 population, compared to the national average of 10.9 per 100,000 population.

From 2006 to 2008, the suicide death rate decreased, but is still 3 times higher than the Healthy People 2010 target.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data is from Nevada Vital Statistics Records (NVSR), and the U.S. data is from the National Vital Statistics System (NVSS)– Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

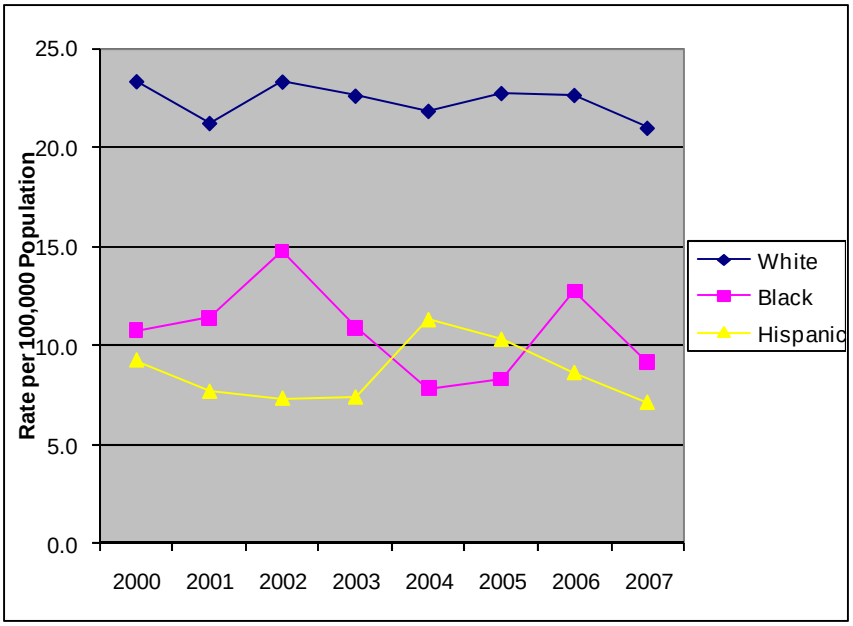
Age-Adjusted Suicide Death Rate, Nevada Residents by Gender, 2000 - 2008.*



Suicide deaths were consistently higher among Nevada males than Nevada females from 2000 to 2008. In 2008, the suicide death rate was nearly 3 times higher among males than females.

Age-Adjusted Suicide Death Rate, Nevada Residents by Race/ Ethnicity, 2000 - 2007.*

Among all race/ ethnicity groups, Whites consistently had the highest suicide death rate in Nevada from 2000 to 2007.



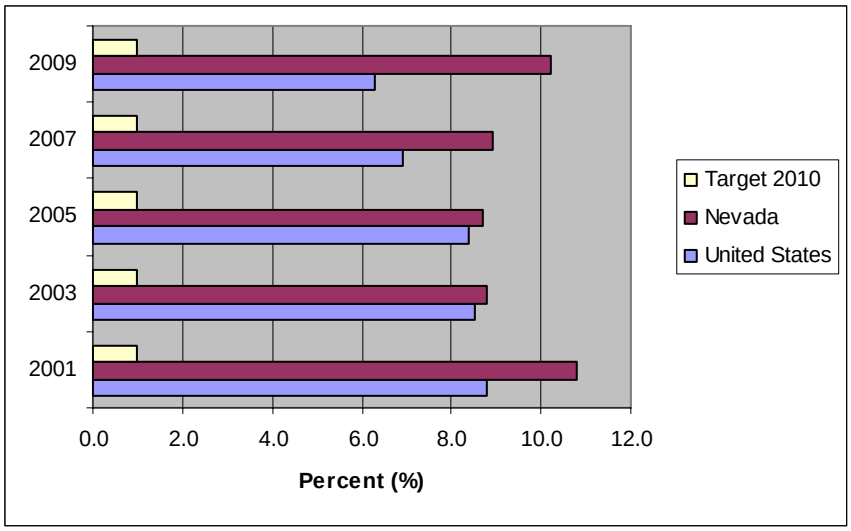
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data is from Nevada Vital Statistics Records (NVSR).
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American or Asian race/ethnicity groups due to small counts. See appendix for age group, county and additional race/ethnicity breakdowns.

Healthy People 2010 Objective (18-2): Reduce the proportion of adolescents, grades 9-12, reporting suicide attempts.

Healthy People 2020 Objective MHMD HP2020-2: Reduce the rate of suicide attempts by adolescents.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
10.2	6.3	1.0	1.7	Fluctuating

Proportion of Adolescents, Grades 9-12, Reporting Suicide Attempts in the Past 12 Months, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



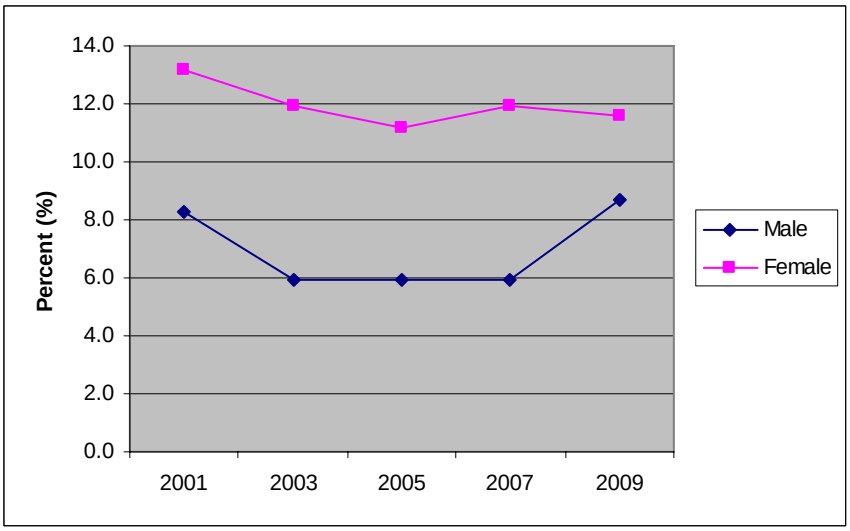
From 2001 to 2009, reported suicide attempts among Nevada adolescents (Grades 9-12) have been higher than that of adolescents in the United States.

Neither region met the Healthy People 2010 target of 1.0 percent.

From 2001 to 2009, suicide attempts were higher among Nevada female adolescents than Nevada male adolescents.

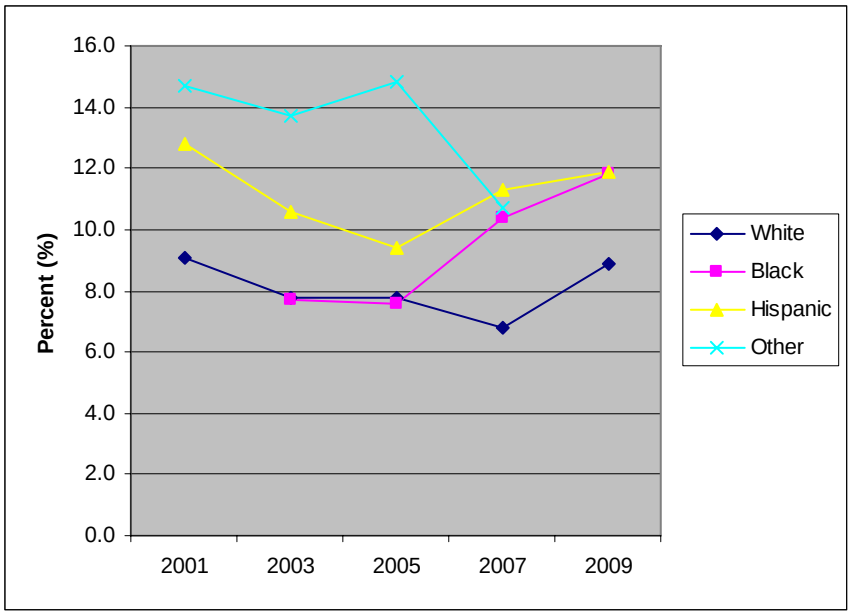
The proportion of Nevada male adolescents (grades 9-12) who reported suicide attempts has increased in Nevada since the year 2007, but had not increased significantly since 2001. The proportion of Nevada female adolescents (grades 9-12) who reported suicide attempts has decreased slightly since 2001.

Proportion of Adolescents, Grades 9-12, Reporting Suicide Attempts in the Past 12 Months, Nevada Residents by Gender, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



*Individual county data are not available.

Proportion of Adolescents, Grades 9-12, Reporting Suicide Attempts in the Past 12 Months, Nevada Residents by Race/ Ethnicity, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



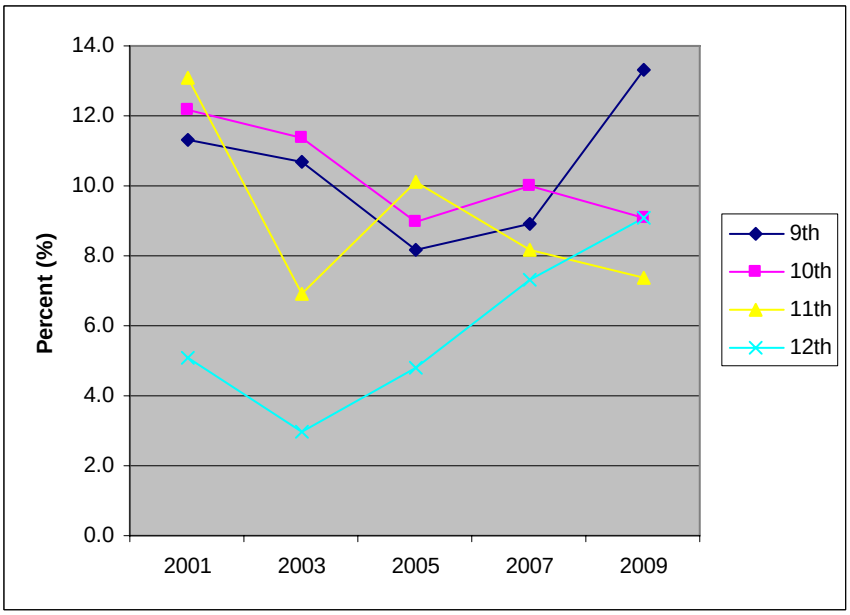
In 2009, approximately 12 percent of Black and Hispanic adolescents reported a suicide attempt in the past 12 months.

The rate for all race/ ethnic groups increased from 2007 to 2009.

Proportion of Adolescents, Grades 9-12, Reporting Suicide Attempts in the Past 12 Months, Nevada Residents by Grade, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

In 2009, approximately 13 percent of 9th grade students reported a suicide attempt in the past 12 months, representing the highest proportion of suicide attempts among high school students.

The proportion of 12th graders attempting suicide increased from 2003 to 2009.



*Individual county data are not available.
Note: Data was not available for the Black race/ethnicity group for the year 2001, and Other race/ethnicity group for the year 2009 due to <100 respondents for those subgroups.

Nutrition and Weight Status

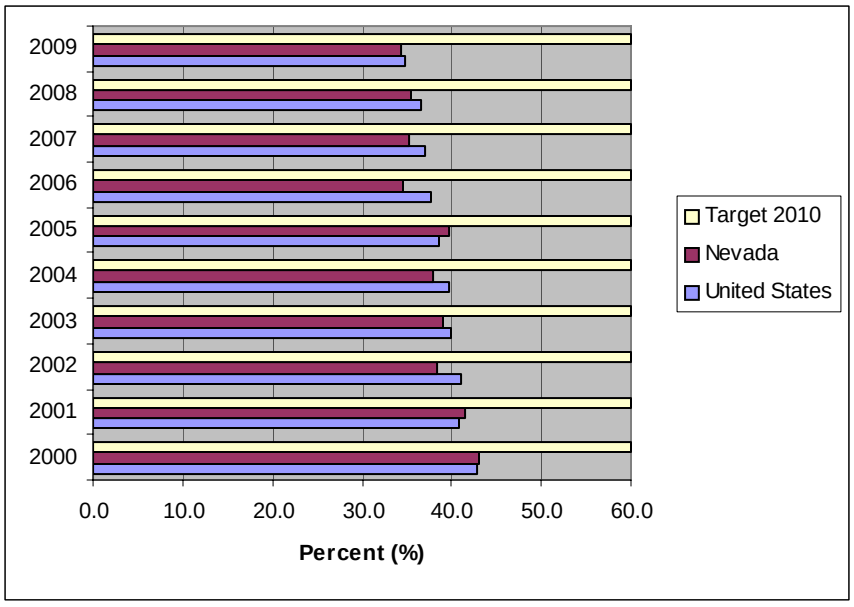
Approximately two thirds of U.S. adults and one fifth of U.S. children are either obese or overweight. During 1980–2004, obesity prevalence among U.S. adults doubled. Recent data indicates an estimated 33 percent of U.S. adults are overweight, 34 percent are obese, including nearly 6 percent who are extremely obese. The prevalence of being overweight among children and adolescents increased substantially during 1999–2004. Approximately 17 percent of U.S. children and adolescents are overweight. Being either obese or overweight increases the risk for many chronic diseases, including heart disease, type 2 diabetes, certain cancers, and stroke.[1]

Healthy People 2010 Objective (19-1): Increase the proportion of adults who are at a healthy weight.

Healthy People 2010 Objective NWS HP2020-8: Increase the proportion of adults who are at a healthy weight.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
34.0	34.7	60.0	33.9	Worsening

Proportion of Adults Who Are At a Healthy Weight, Nevada Residents and United States, BRFSS Data, 2000 - 2009.*

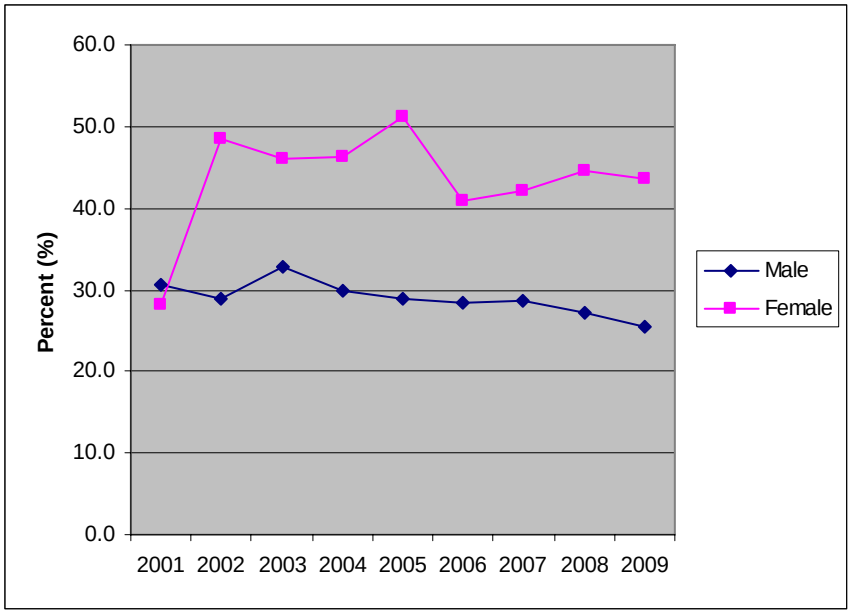


The percentage of Nevada adults who are at a healthy weight (BMI of 18.5 or greater but less than 25.0) paralleled national trends and decreased from 2000 to 2009. These percentages in both the state and the nation were below the Healthy People 2010 Target of 60 percent, at 34.0 percent and 34.7 percent respectively in 2009.

In 2006, estimated costs associated with obesity were $130 billion annually for the U.S. and $337 million for Nevada.[2]

*These percentages are weighted to survey population characteristics.
Note: Body weight estimates from self-reported heights and weights tend to be lower than those from measured height and weight.
Note: See appendix for additional information.

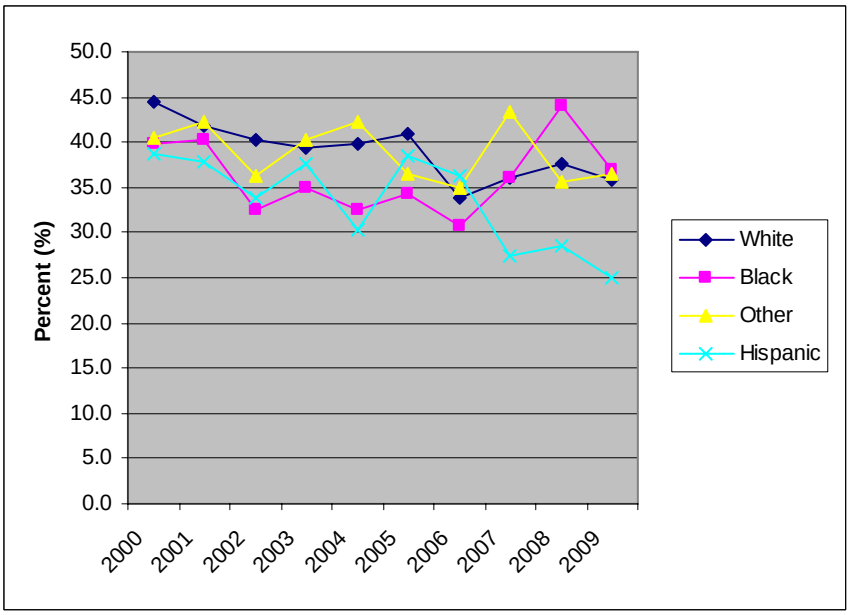
Proportion of Adults Who Are At a Healthy Weight, Nevada Residents by Gender, BRFSS Data, 2000 - 2009.*



From 2001 to 2009, a higher percentage of Nevada females had been at a healthy weight (BMI of 18.5 or greater but less than 25.0) than Nevada males.

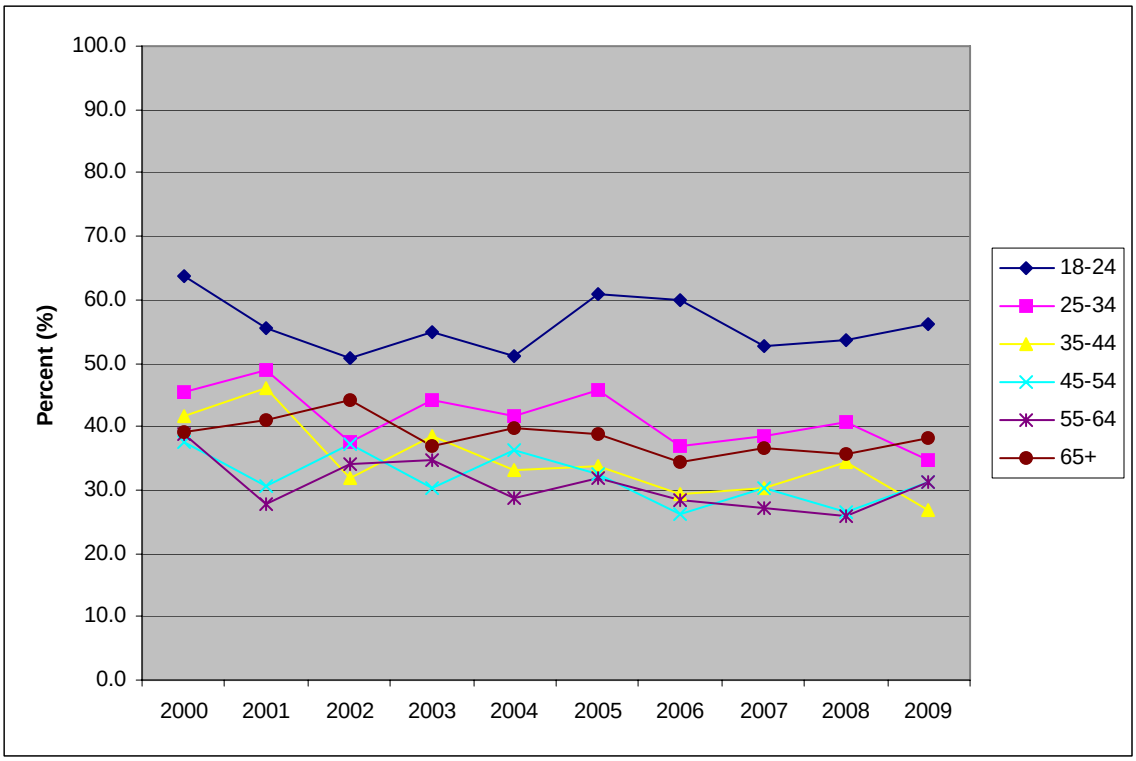
Proportion of Adults Who Are At a Healthy Weight, Nevada Residents by Race/Ethnicity, BRFSS Data, 2000 - 2009.*

Although the percentage of Nevada adults at a healthy weight (BMI of 18.5 or greater but less than 25.0) decreased overall for all racial/ethnic groups from 2000 to 2009, this decrease was greatest among the Hispanic population, from 38.6 percent in 2000 to 25.0 percent in 2009.



*These percentages are weighted to survey population characteristics.
Note: Body weight estimates from self-reported heights and weights tend to be lower than those from measured height and weight.

Proportion of Adults Who Are At a Healthy Weight, Nevada Residents by Age, BRFSS Data, 2000 - 2009.*



Nevada adults aged 18 to 24 had the highest proportion of people who are at a healthy weight from 2000 to 2009, followed by adults aged 25 to 34.

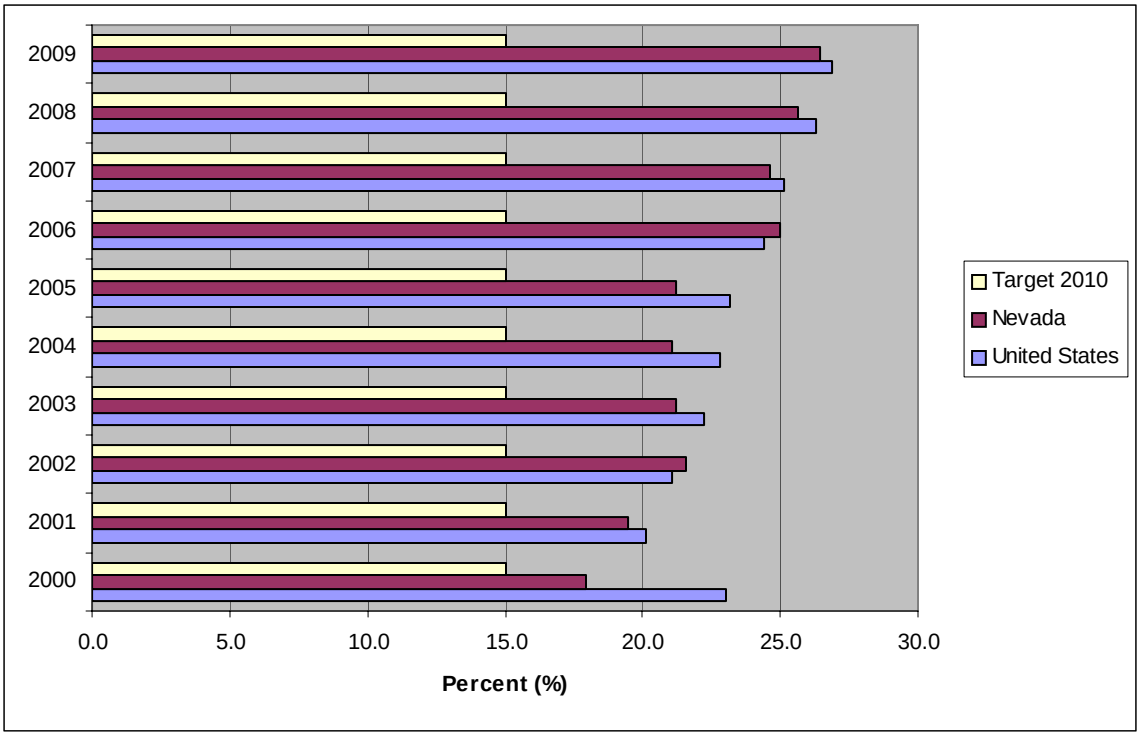
*These percentages are weighted to survey population characteristics.
Note: Body weight estimates from self-reported heights and weights tend to be lower than those from measured height and weight.

Healthy People 2010 Objective (19-2): Reduce the proportion of adults who are obese.

Healthy People 2020 Objective NWS HP2020-9: Reduce the proportion of adults who are obese.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
26.5	26.9	15.0	30.6	Worsening

Proportion of Adults Who Are Obese, Nevada Residents and United States, BRFSS Data, 2000 - 2009.*

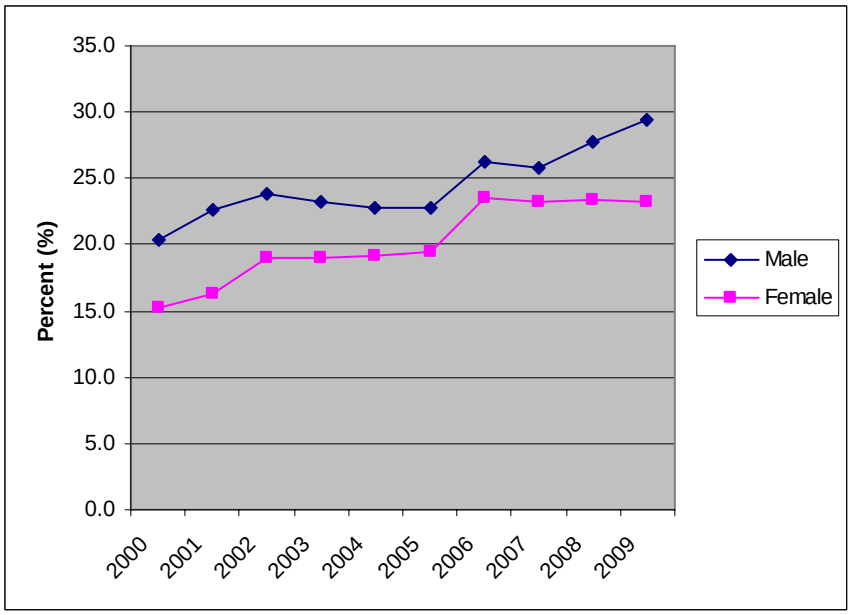


Obesity is having a BMI over 30.0.

The increasing proportion of obese adults in Nevada roughly paralleled U.S. trends from 2001 to 2009. Obesity in Nevada and within the U.S. exceeds the Healthy People 2010 target of 15 percent, at 26.5 percent and 26.9 percent respectively in 2009.

*These percentages are weighted to survey population characteristics.
Note: Body weight estimates from self-reported heights and weights tend to be lower than those from measured height and weight.
Note: See appendix for additional information.

Proportion of Adults Who Are Obese, Nevada Residents by Gender, BRFSS Data, 2000 - 2009.*



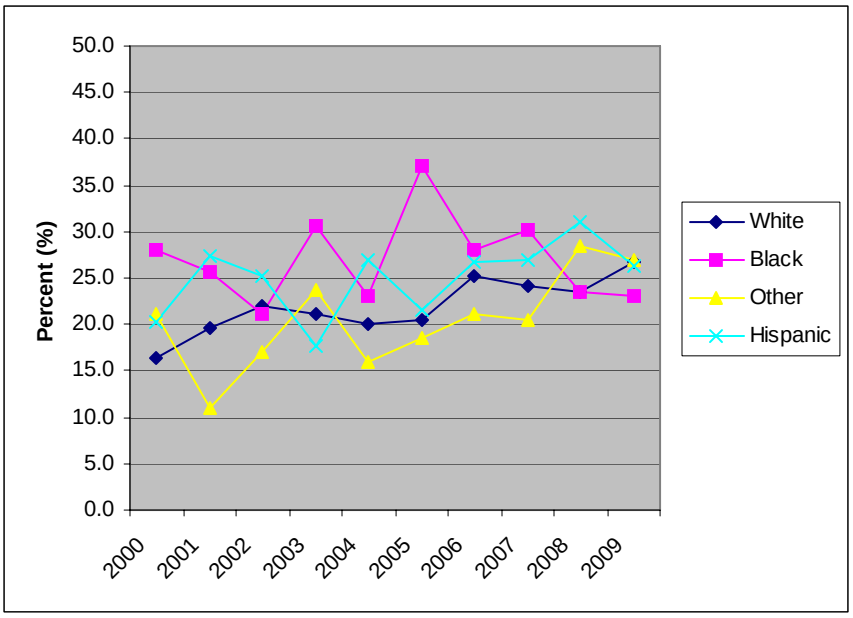
From 2000 to 2009, obesity (BMI greater than or equal to 30.0) was increasing in Nevada and nationally. Nevada males consistently had a higher proportion of obese adults than Nevada females.

Nationwide, substantial increases in the prevalence of overweight and obesity have been seen in all populations regardless of gender, age, race, ethnicity, educational level, socioeconomic status or geographic location.[2]

Nationally, Blacks are the most likely to be overweight or obese (65.8 percent), followed closely by American Indian/ Alaska Native (AI/AN) (62.0 percent), Hispanics (58.0 percent), and Whites (55.0 percent). Asians or Pacific Islanders were least likely to be overweight or obese (36.0 percent).[1]

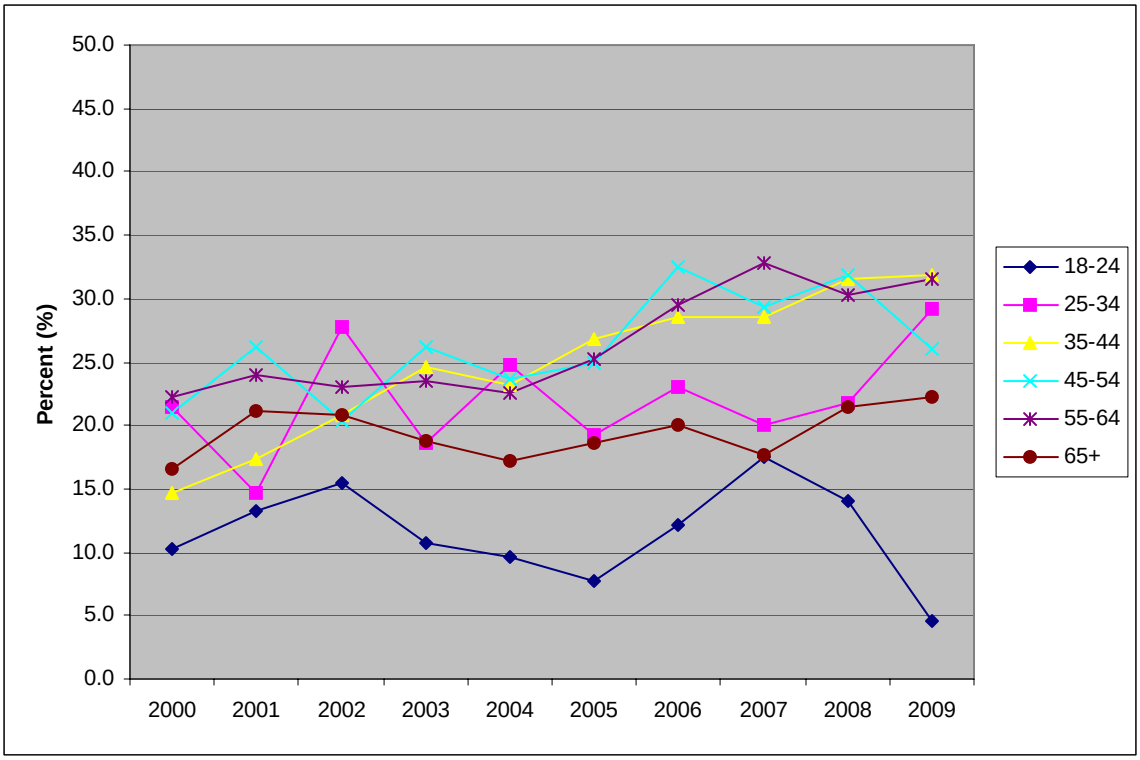
As with the national trend, the trend for obesity (BMI greater than or equal to 30.0) among racial/ethnic groups in Nevada increased overall.

Proportion of Adults Who Are Obese, Nevada Residents by Race/Ethnicity, BRFSS Data, 2000 - 2009.*



*These percentages are weighted to survey population characteristics.
Note: Body weight estimates from self-reported heights and weights tend to be lower than those from measured height and weight.

Proportion of Adults Who Are Obese, Nevada Residents by Age, BRFSS Data, 2000 - 2009.*



Nevada adults aged 18 to 24 years old consistently had the lowest proportion of people who are obese from 2000 to 2009.

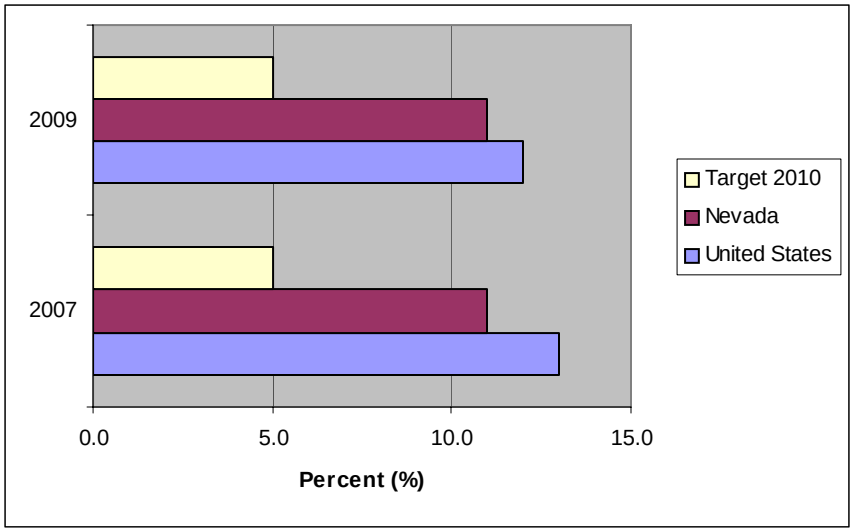
*These percentages are weighted to survey population characteristics.
Note: Body weight estimates from self-reported heights and weights tend to be lower than those from measured height and weight.

Healthy People 2010 Objective (19-3b.): Reduce the proportion of adolescents, aged 12-19 years, who are overweight or obese.

Healthy People 2020 Objective NWS HP2020-10.3: Reduce the proportion of adolescents, aged 12-19 years, who are overweight or obese.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
11.0	12.0	5.0	16.1	None

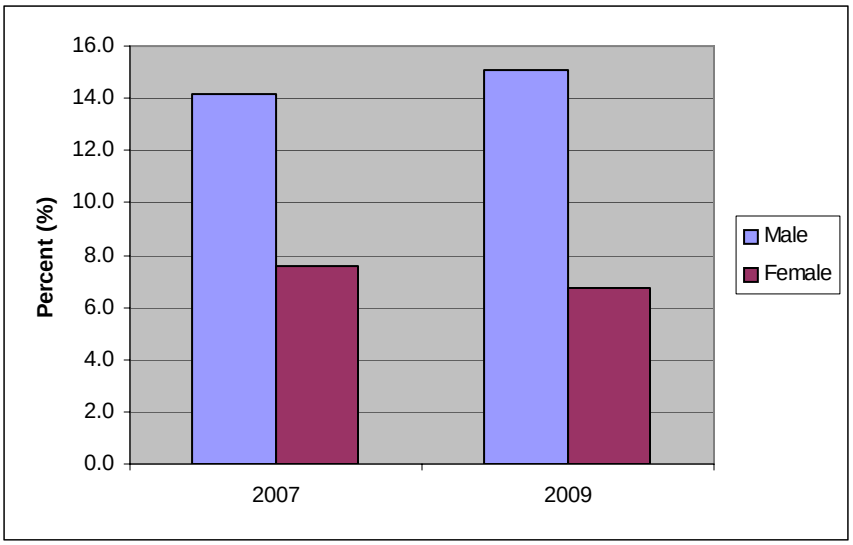
Proportion of Adolescents, Grades 9-12, Who Are Obese Nevada Residents and United States, YRBSS Data, 2007 and 2009.*



In 2007 and 2009, over 10 percent of Nevada adolescents, grades 9-12, were obese. This is double the Healthy People 2010 target of 5 percent.

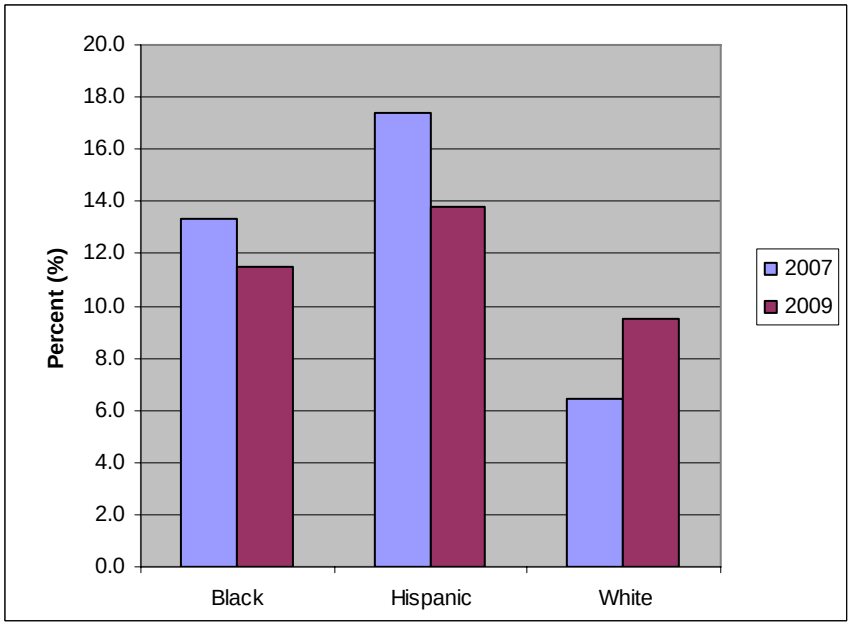
Proportion of Adolescents, Grades 9-12, Who Are Obese, Nevada Residents By Gender, YRBSS Data, 2007 and 2009.*

Male adolescents were two times more likely to be obese than female adolescents in Nevada in 2007 and 2009.



*Individual county data are not available.
Note: Here obese is defined as students who were >= 95th percentile for Body Mass Index (BMI), by age and sex, based on reference data.

Proportion of Adolescents, Grades 9-12, Who Are Obese, Nevada Residents by Race/Ethnicity, YRBSS Data, 2007 and 2009.*

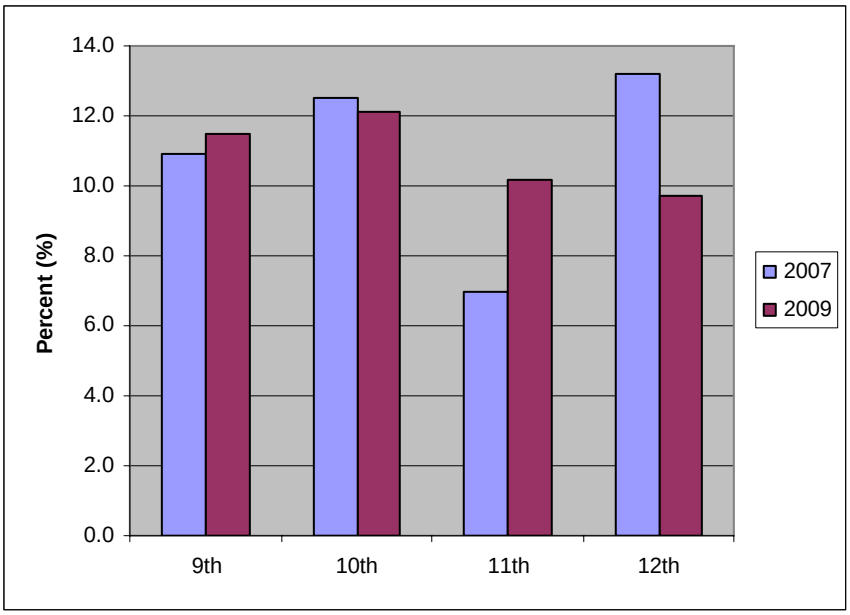


In 2007 and 2009, obesity was least prevalent among Asian students and highest among Hispanic students.

From 2007 to 2009 the proportion of Black and Hispanic adolescents, grade 9 through 12m who were obese decreased, while this proportion among White adolescents increased.

Proportion of Adolescents, Grades 9-12, Who Are Obese, Nevada Residents by Grade, YRBSS Data, 2007 and 2009.*

From 2007 to 2009 obesity decreased among 12th graders, but increased among 11th graders and remained fairly consistent among 9th and 10th graders in Nevada.



*Individual county data are not available.
Note: Here obese is defined as students who were >= 95th percentile for Body Mass Index (BMI), by age and sex, based on reference data.
Note: Data not available for the Asian, Native American, or Multiple Race race/ethnicity groups due to <100 respondents for those subgroups.

Occupational Safety and Health

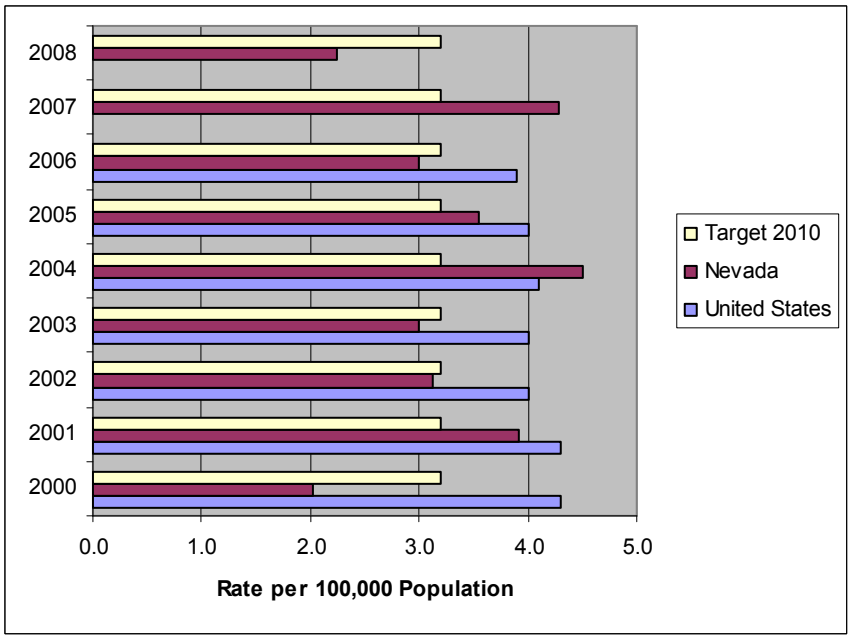
Workplace injuries and illnesses are significant in the United States. Work-related injuries and illnesses include any injuries or illnesses incurred by persons engaged in work-related activities while on or off the worksite. This includes injuries and illnesses that occur during apprenticeships and vocational training, while working in family businesses, and even while volunteering as firefighters or emergency medical service providers.[1]

Healthy People 2010 Objective (20-1a.): Reduce work-related death rate, aged 16 years and older.

Healthy People 2020 Objective OSH HP20020-1.1: Reduce deaths from work-related injuries.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
2.2	3.9	3.2	3.6	Surpassed

Age-Adjusted Work-Related Injury Death Rate, Aged 16 Years and Older, Nevada Residents and United States, 2000 - Most Current Data.*

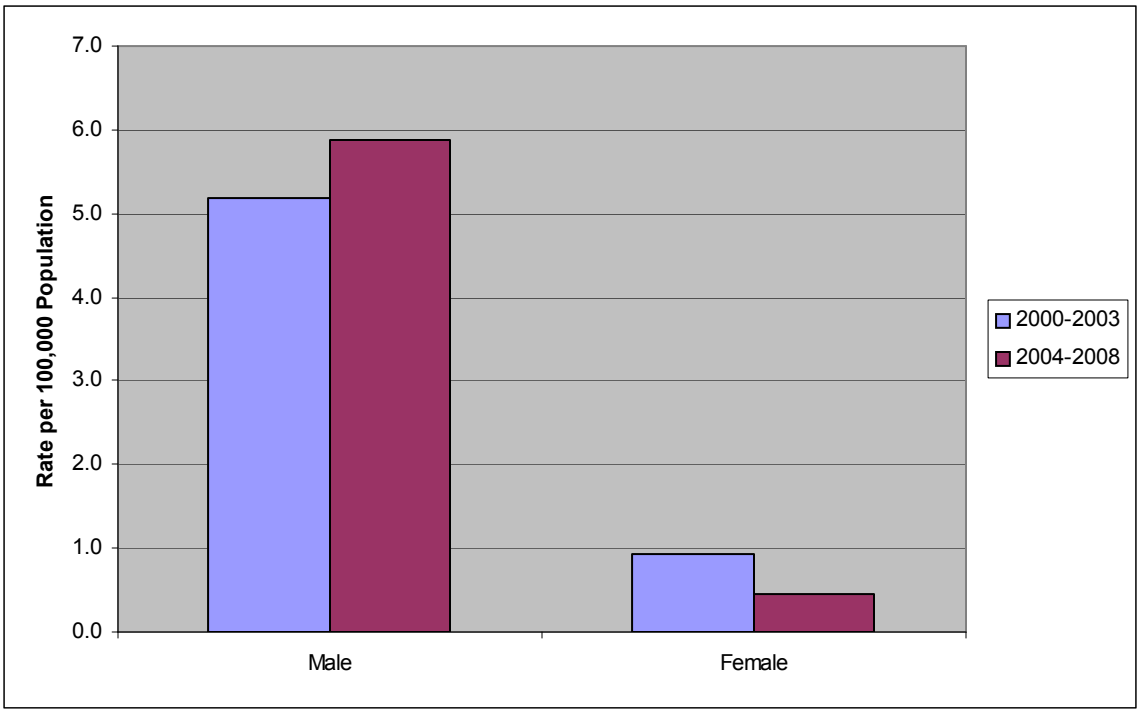


The age-adjusted work-related injury death rate in Nevada achieved or surpassed the Healthy People target of 3.2 in 2000, 2002, 2003, 2006, and 2008.

From 2003 until 2008, there were 324 occupational injury related deaths in Nevada.[2]

*The Nevada data is from Nevada Vital Statistics Records. The U.S. data is from the United States Department of Labor, Bureau of Labor Statistics, Census of Fatal Occupational Injuries.
Note: The Nevada data and U.S. data are from different sources and may not be comparable.
Note: Caution must be used in comparing 2000 and 2001 data to 2002 through 2008 data due to a change in wording from 'workforce' to 'civilian workforce' in 2002.

Aggregated Age-Adjusted Work-Related Injury Death Rate, Aged 16 Years and Older, Nevada Residents by Gender, 2000 - 2003 and 2004 - 2008.*



In Nevada, occupational fatalities primarily involve males. Males are 5.5 times more likely to sustain a fatal occupational injury than females. Adults aged 35 – 54 have the highest per capita rates of fatal occupational injury. Adults aged 20 – 24 years old also have high rates of fatal occupational injury. White non-Hispanics, American Indian and Alaskan Native, and African Americans all have similar rates of occupational injury fatality per capita. Hispanics have occupational injury fatality rates which are approximately 30 percent greater than White non-Hispanics.[2]

Higher rates of health adverse behaviors such as smoking, drinking, and working in hazardous occupations contribute to excess male mortality (Hazzard, 1986).[3] According to the International Labor Organization (ILO), work kills more people than wars – approximately 6,000 a day. Almost 270 million accidents are recorded each year, of which 350,000 are fatal. The ILO estimates that more than 2 million people die from work-related causes every year: approximately 750,000 women and 1,500,000 men, reflecting the fact that men often do more dangerous work than women. ILO experts also point out that the statistics in any case underestimate the real situation, given the lack of information and reporting in many countries. Of these occupational deaths, almost 350,000 occur during work accidents while the rest are due to work-related illnesses. More than 400,000 deaths are caused by exposure to chemicals. Such exposure is also responsible for 35 million of the 160 million cases of work-related diseases recorded worldwide. Sadly, an estimated 22,000 children of school age die at work every year.[4]

*The Nevada data is from Nevada Vital Statistics Records.
Note: Additional county, race/ethnicity, and gender breakdown are not available.

Oral Health

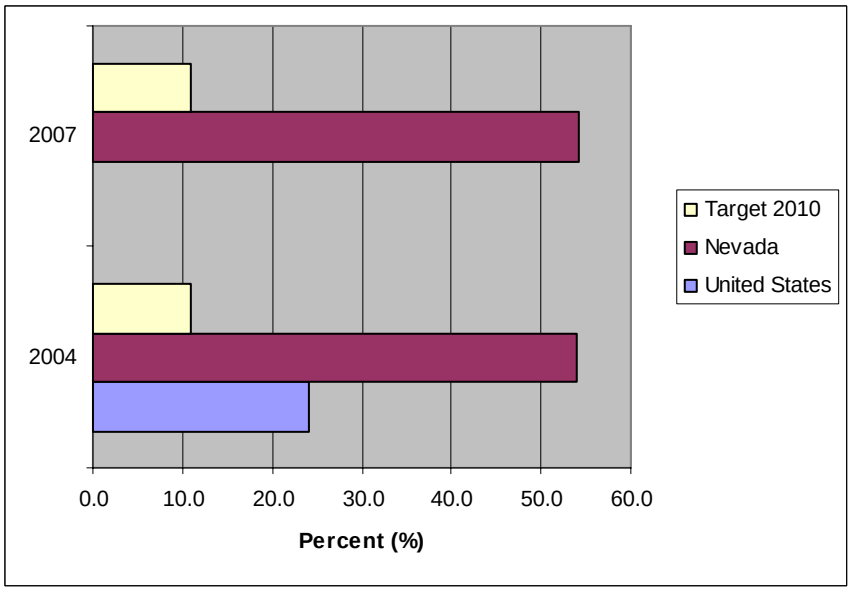
Poor oral health and untreated oral diseases and conditions can have a significant impact on quality of life. Millions of people in the United States experience dental caries, periodontal diseases, and cleft lip and cleft palate. These can result in needless pain and suffering; difficulty in speaking, chewing, and swallowing; increased costs of care; loss of self-esteem; and decreased economic productivity through lost work and school days. Many people in the United States do not receive essential dental services, however through increased access to appropriate and timely care, individuals can enjoy improved oral health.[1]

Healthy People 2010 Objective (21-1a.): Reduce the proportion of young children with dental caries experience in primary teeth.

Healthy People 2020 Objective OH HP2020-1.1: Reduce the proportion of young children with dental caries experience in their primary teeth (aged 3 to 5 years).

Most Recent NV Value (2007)	U.S. (2004)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
54.3 (3-5 yrs)	24.0 (2-4 yrs)	11.0	30.0	Worsening

Proportion of Children With Dental Caries Experience in Primary and Permanent Teeth, Nevada Residents (Aged 3 to 5 Years) and United States (Aged 2 to 4 years), 2004 and 2007.*



In 2007, the Nevada State Health Division conducted an oral health screening of children enrolled in Head Start. The screening found 54 percent of children enrolled in Head Start have experienced dental decay as demonstrated by the presence of a filling or an untreated cavity. 32 percent of the Head Start children had untreated dental decay, 24 percent had early childhood caries and 3 percent were in need of urgent oral health care.[2]

The proportion of children aged 3 to 5 years with dental caries in their primary and permanent teeth in Nevada was over 4 times higher than the target set by Healthy People 2010.

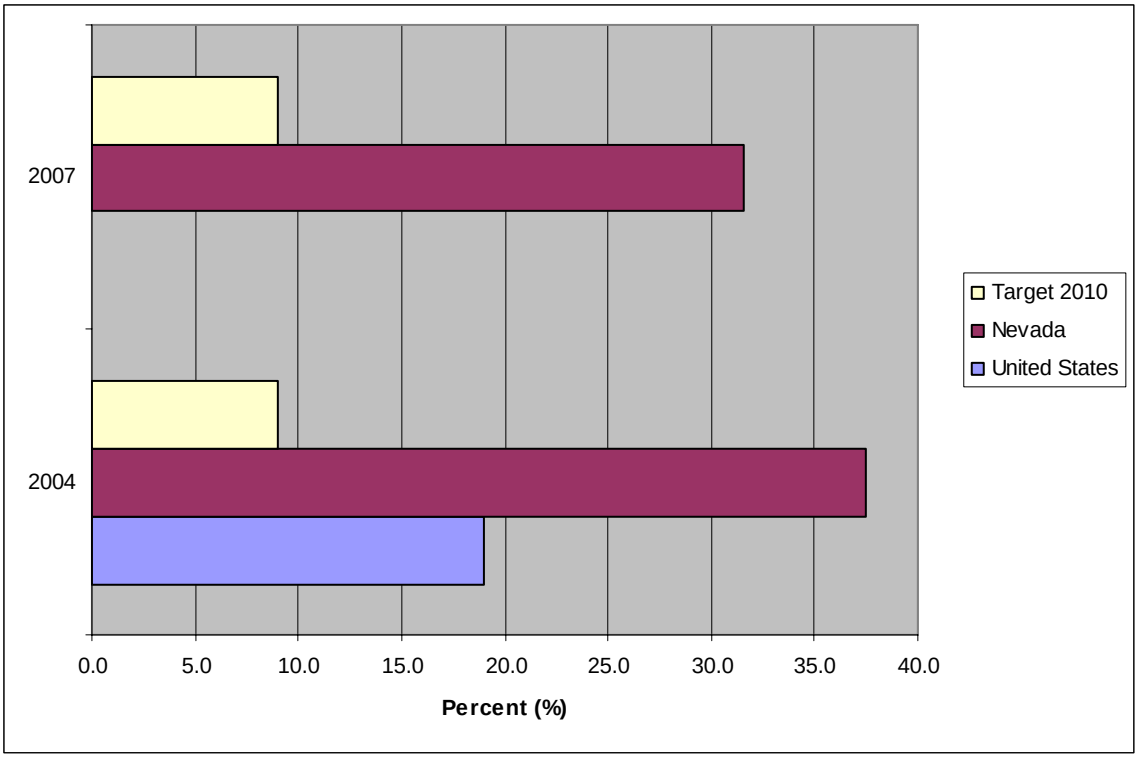
*The Nevada data are from the Head Start Oral Health Survey, Bureau of Child, Family and Community Wellness, Nevada State Health Division (NSHD). The U.S. data are from the National Health and Nutritional Examination Survey (NHANES)
Note: These results are not weighted.
Note: Not comparable to U.S. data because the national rate uses an age grouping of 2-4 years old and Nevada uses 3-5 years old.
Note: See appendix for additional information.

Healthy People 2010 Objective (21-2a.): Reduce the proportion of young children with untreated dental decay.

Healthy People 2020 Objective OH HP2020-2.1: Reduce the proportion of young children with untreated dental decay in primary and permanent teeth (aged 3 to 5 years).

Most Recent NV Value (Year)	U.S. (2004)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
31.6 (3-5 yrs)	19.0 (2-4 yrs)	9.0	21.4	Improving

Proportion of Children Aged 2 to 5 Years With Untreated Dental Decay in Primary and Permanent Teeth, Nevada Residents, 2004 and 2007.*



The proportion of children aged 3 to 5 years with untreated dental decay in their primary and permanent teeth in Nevada was much higher than the goal set by Healthy People 2010. This proportion was lower in 2007 than in 2004.

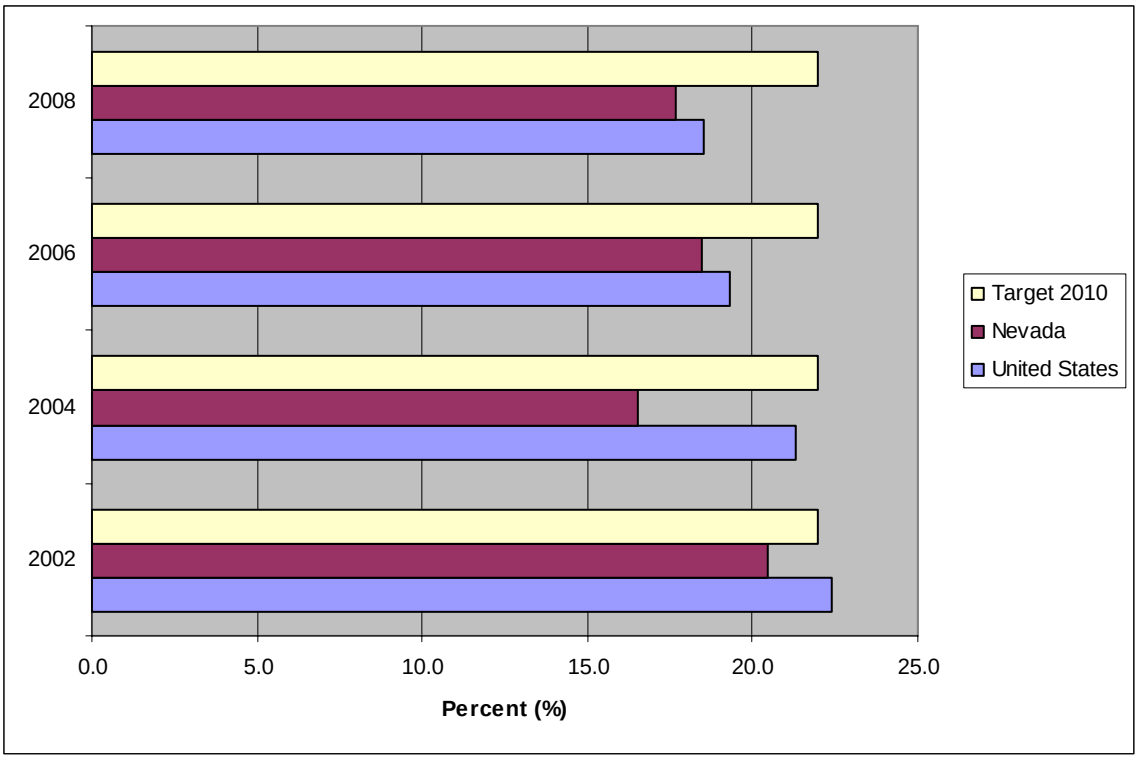
*The Nevada data are from the Head Start Oral Health Survey, Bureau of Child, Family and Community Wellness, Nevada State Health Division (NSHD). The U.S. data are from the National Health and Nutritional Examination Survey (NHANES).
Note: These results are not weighted.
Note: Not comparable to U.S. data because the national rate uses an age grouping of 2-4 years old and Nevada uses 3-5 years old.
Note: See appendix for additional information.

Healthy People 2010 Objective (21-4.): Reduce the proportion of older adults, aged 65 years and older, reporting having all their natural teeth extracted.

Healthy People 2020 Objective OH HP2020-4.2: Reduce the proportion of older adults who have lost all their natural teeth (aged 65 to 74 years).

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
17.7	18.5	22.0	21.6	Surpassed

Proportion of Older Adults Aged 65 Years and Older Reporting Having All of Their Natural Teeth Extracted, Nevada Residents and United States, BRFSS Data, 2002, 2004, 2006, 2008.*

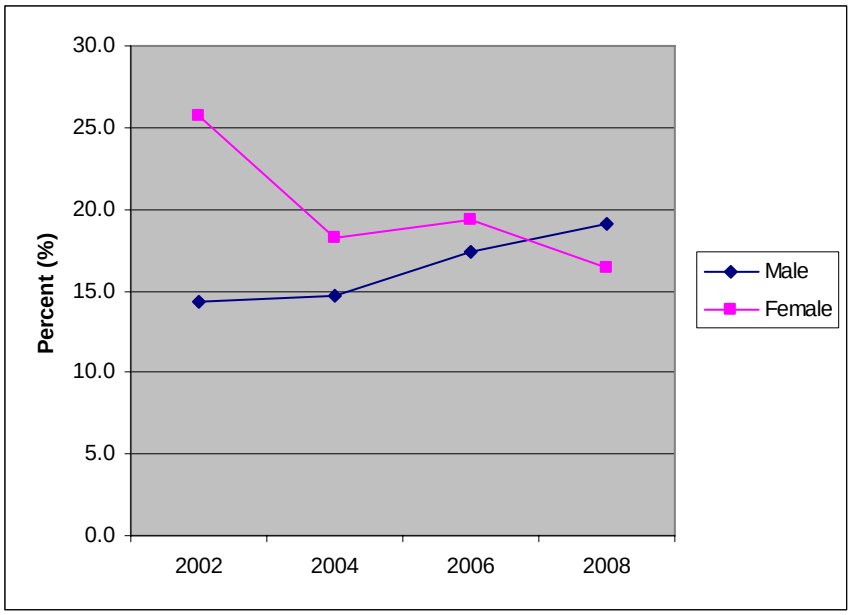


Nevada has achieved and surpassed the Healthy People 2010 target to reduce the proportion of older adults, 65 years and older, who have had all of their natural teeth extracted, with 17.7 percent of adults 65 years and older reporting all of their natural teeth extracted in 2008.

Oral health data for adults is gathered through the Behavioral Risk Factor Surveillance Survey (BRFSS). This is an annual statewide telephone survey that asks residents ages 18 and over a group of health questions to estimate the level of health being maintained. The 2006 BRFSS found 33.8 percent of adults surveyed have not been to the dentist or a dental clinic in the last year. For 33.6 percent of adults it has been more than one year since they had their teeth cleaned by a dentist or dental hygienist and 46.7 percent of adults have lost permanent teeth due to tooth decay or gum disease.[2]

*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

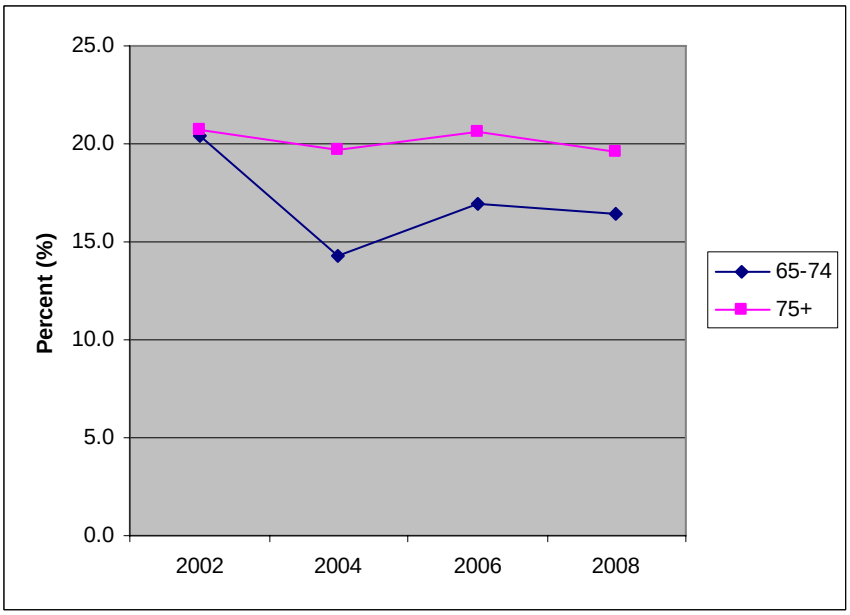
Proportion of Older Adults Aged 65 Years and Older Reporting Having All of Their Natural Teeth Extracted, Nevada Residents by Gender, BRFSS Data, 2002, 2004, 2006, 2008.*



Up until 2006 there had been more females than males who reported having had all of their natural teeth extracted.

In general, the proportion of females, aged 65 years and older, who have had all of their natural teeth extracted decreased from 2002 to 2008, while the proportion of males, aged 65 years and older, who have had all of their natural teeth extracted has increased.

Proportion of Older Adults Aged 65 Years and Older Reporting Having All of Their Natural Teeth Extracted, Nevada Residents by Age, BRFSS Data, 2002, 2004, 2006, 2008.*



In 2002 through 2008, more adults age 75 and above had all their teeth extracted, than adults age 65 to 74.

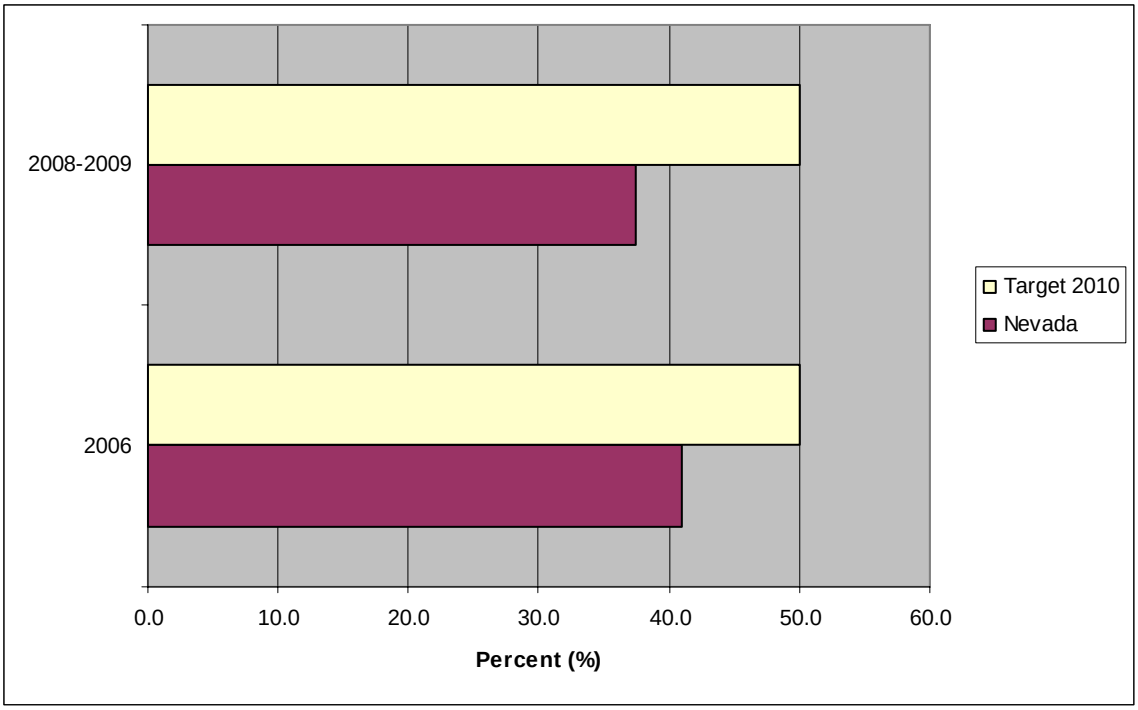
*These percentages are weighted to survey population characteristics.

Healthy People 2010 Objective (21-8a.): Increase the proportion of children aged 8 years, who have received dental sealants on their molar teeth.

Healthy People 2020 Objective OH HP2020-12.2: Increase the proportion of children who have received dental sealants on their molar teeth (aged 6 to 9 years).

Most Recent NV Value (2008-2009)	U.S. (2004)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
37.5	32.0	50.0	28.1	Worsening

Proportion of Third Graders Who Have Received Dental Sealants on Their Molar Teeth, Nevada Residents, 2006 and 2008-2009.*

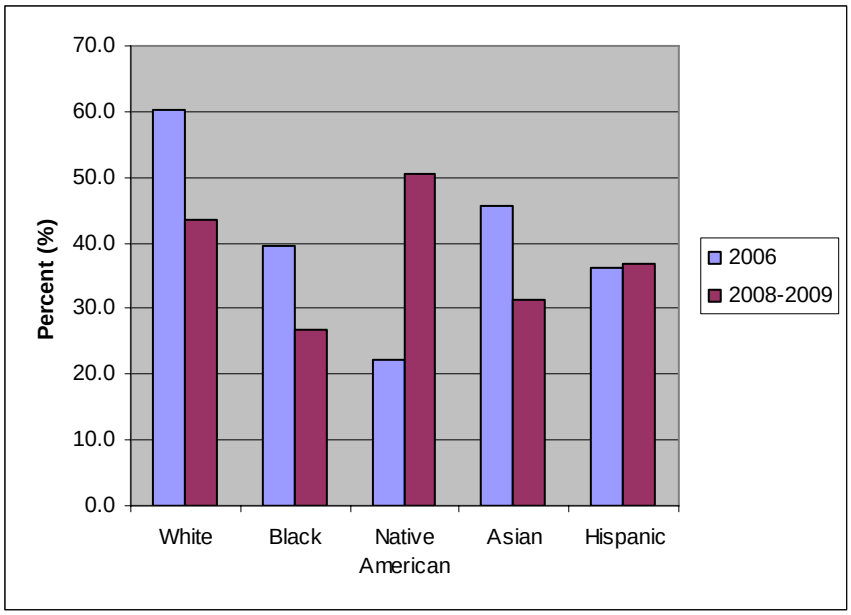


The proportion of Nevada third grade students who received dental sealants on their molar teeth in 2008-2009 was lower than the Healthy People 2010 target for children aged 6 to 9 years and decreased from 2006.

Sealants are a plastic material placed on the pits and fissures of the chewing surfaces of teeth where up to 90 percent of decay occurs in school children. Sealants prevent tooth decay by providing a physical barrier between the teeth and decay-causing bacteria. According to *Oral Health in America: A Report of the Surgeon General*, dental sealants have been shown to reduce decay by over 70 percent.[2]

*The Nevada data are from the Oral Health Survey, Bureau of Child, Family and Community Wellness, Nevada State Health Division (NSHD). Note: These results are not weighted.
Note: See appendix for additional information.

Proportion of Third Graders Who Have Received Dental Sealants on Their Molar Teeth, Nevada Residents by Race/ Ethnicity, 2006 and 2008 - 2009.*



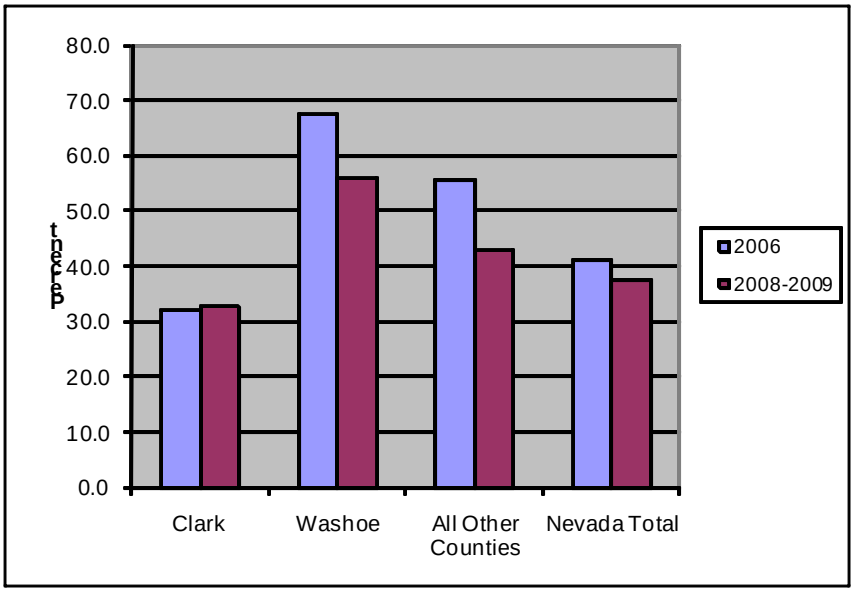
School based dental sealant programs frequently target second graders in schools where more than 50 percent of the children enrolled are eligible for the Federal Free and Reduced Meal Program. These schools are also referred to as "high risk" schools.[2]

The proportion of third graders receiving dental sealants on their molar teeth increased among children in Hispanic and Native American populations in Nevada, but decreased for all other racial/ethnic subgroups from 2006 to 2008-2009.

Advantages of fluoride varnish are: it does not require special dental equipment; it does not require a professional dental cleaning prior to application; it is easy to apply; it dries immediately upon contact with saliva; it is safe and well tolerated by infants, young children, and individuals with special needs; it is inexpensive; it requires minimal training to apply.

Carson City, Clark, Douglas, Elko, Esmeralda, Humboldt, Nye, Washoe, and White Pine counties in Nevada have community-based fluoride varnish programs in progress.[2]

Proportion of Third Graders Who Have Received Dental Sealants on Their Molar Teeth, Nevada Residents by County/ Region, 2006 and 2008 - 2009.*



Clark County had the lowest proportion of third graders who have received dental sealants on their molar teeth. Clark County also had the highest population and has fluoridated water from public watering systems.

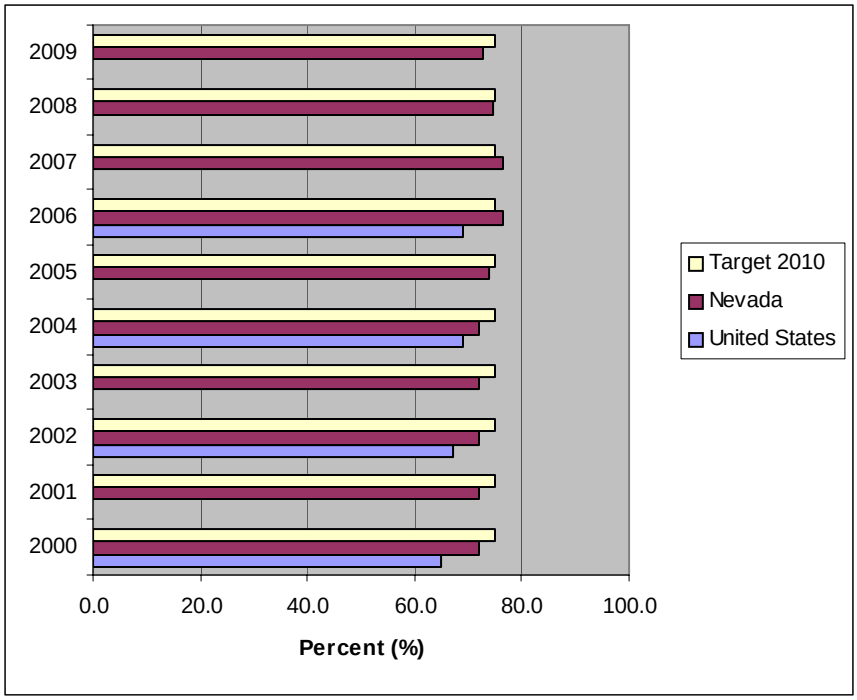
*The Nevada data are from the Oral Health Survey, Bureau of Child, Family and Community Wellness, Nevada State Health Division (NSHD). Note: These results are not weighted.

Healthy People 2010 Objective (21-9): Proportion of the population served by community water systems with fluoridated water.

Healthy People 2020 Objective OH HP2020-13: Increase the proportion of the U.S. population served by community water systems with optimally fluoridated water.

Most Recent NV Value (2009)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
72.8	69.0	75.0	79.6	Fluctuating

Proportion of Population Served by Community Water Systems with Fluoridated Water, Nevada Residents and United States, 2000 - Most Current Data.*



The proportion of the Nevada population which is served by community water systems with fluoridated water is greater than that proportion of the U.S. In 2007, Nevada had surpassed the Healthy People 2010 target, but has since decreased.

Fluoridation is mandated by law in Nevada, but only for counties with populations of 400,000 and over.

Fluoride added to community drinking water at a concentration of 0.7 to 1.2 parts per million has repeatedly been shown to be a safe, inexpensive and extremely effective method of preventing tooth decay. In fact, for every dollar spent on community water fluoridation, up to $42 is saved in treatment costs for tooth decay.[2]

There are 85 community water systems in Nevada serving a population of over 500 persons each. Of the 85 water systems serving over 500 persons, four serve over 100,000 persons.[2]

Three of these are located in Clark County and one is located in Washoe County. The three largest water systems in Clark County are optimally fluoridated. Approximately 75 percent of Nevada's residents are served by these two water systems.[2]

*The Nevada data are from the Water Fluoridation Reporting System. U.S. data are from the Centers for Disease Control and Prevention (CDC), Fluoridation Census.
Note: Nevada and U.S. data are from different sources and thus may not be comparable.
Note: Clark County is the only county in Nevada which has fluoridated water from public watering systems.
Note: Individual county data are not available.

Physical Activity and Fitness

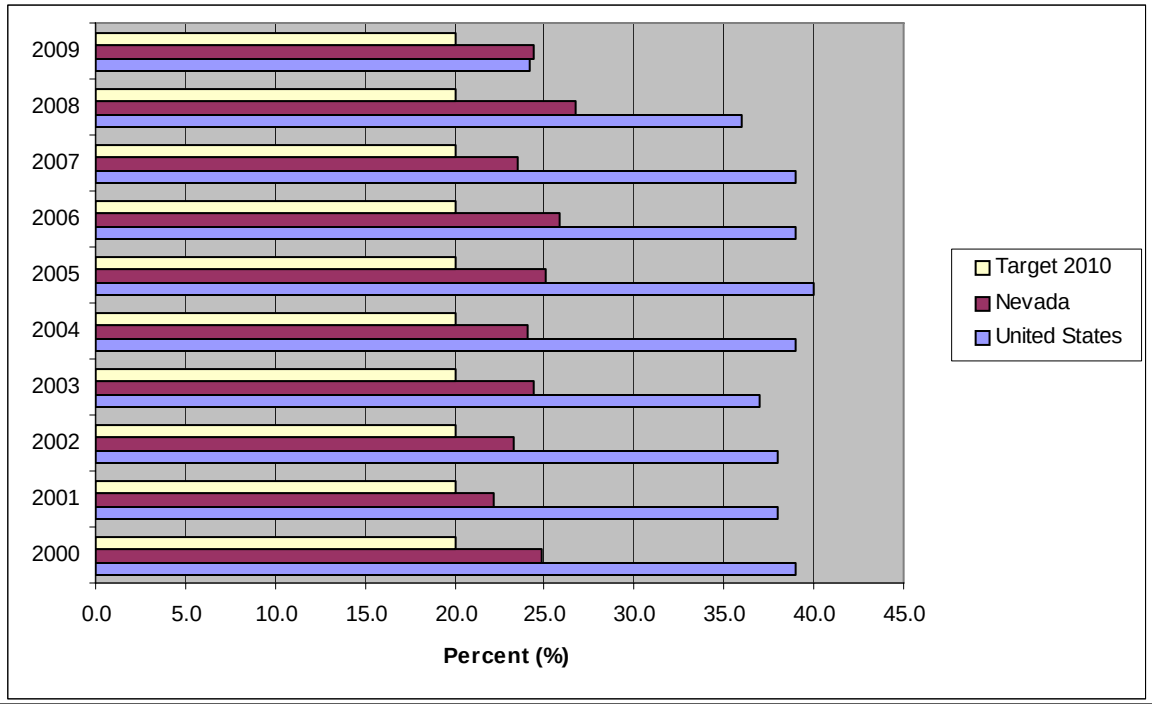
Regular physical activity substantially reduces the risk of dying from coronary heart disease, the nation's leading cause of death for all adults, and decreases the risk of stroke, colon cancer, diabetes and high blood pressure. Physical activity does not need to be strenuous to provide benefit. Moderate intensity physical activity is a vital component of a healthy lifestyle for people of all ages and abilities.[1]

Healthy People 2010 Objective (22-1.): Reduce the proportion of adults who engage in no leisure-time physical activity.

Healthy People 2020 Objective PA HP2020-1: Reduce the proportion of adults who engage in no leisure-time physical activity.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
24.4	24.2	20.0	32.6	Fluctuating

Proportion of Adults Who Engage in No Leisure Time Physical Activity, Nevada Residents and United States, BRFSS Data, 2000 - 2009.*

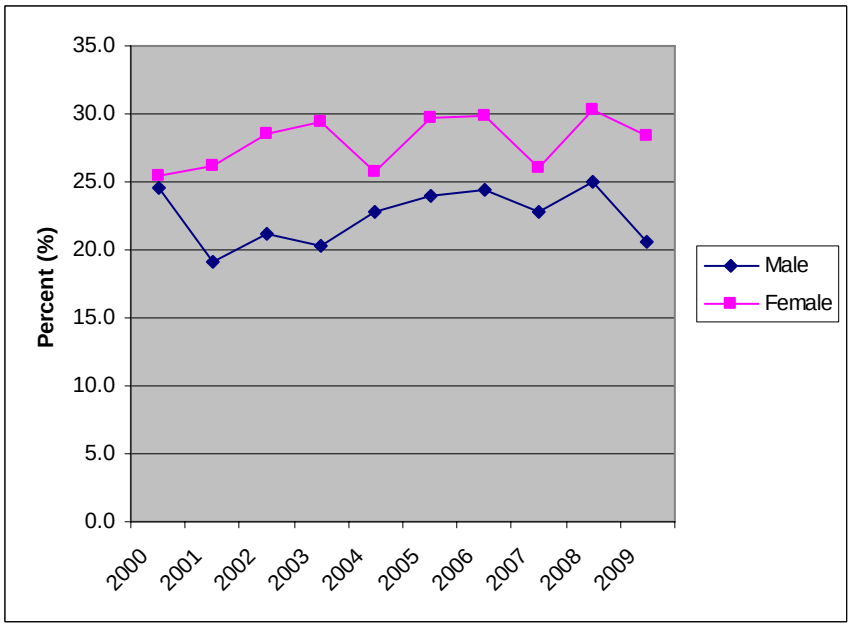


The percentage of Nevada adults who participate in no leisure time physical activity was lower than that of the U.S., but higher than the Healthy People 2010 target of 20.0 percent from 2000 to 2007. In 2009 the national proportion of adults who participate in no leisure time physical activity decreased below that of Nevada but did not meet the Healthy People target.

Define Leisure Time Physical Activity: Adults that report doing physical activity or exercise during the past 30 days other than their regular job.

*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

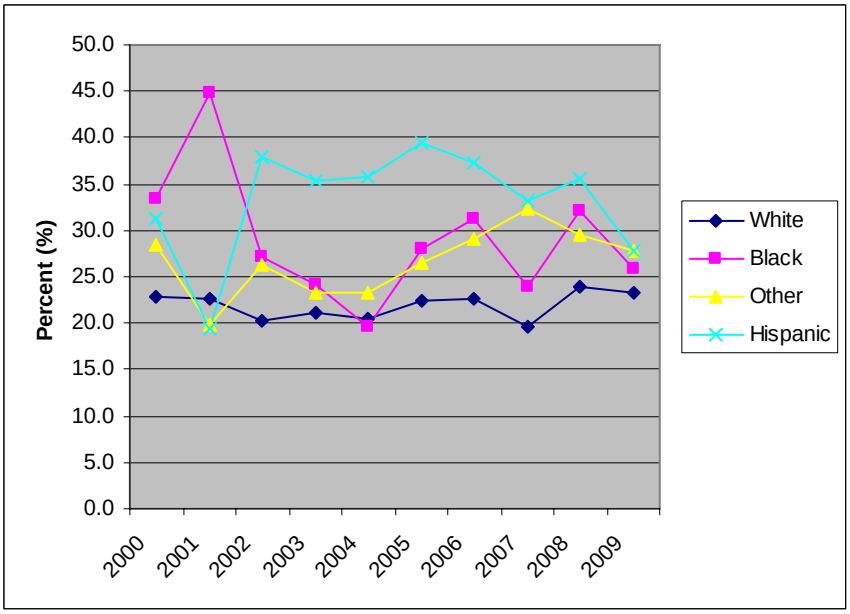
Proportion of Adults Who Engage in No Leisure Time Physical Activity, Nevada Residents by Gender, BRFSS Data, 2000-2009.*



From 2000 to 2009, the proportion of Nevada females who engage in no leisure time physical activity has been higher than the proportion of Nevada males who engage in no leisure time physical activity.

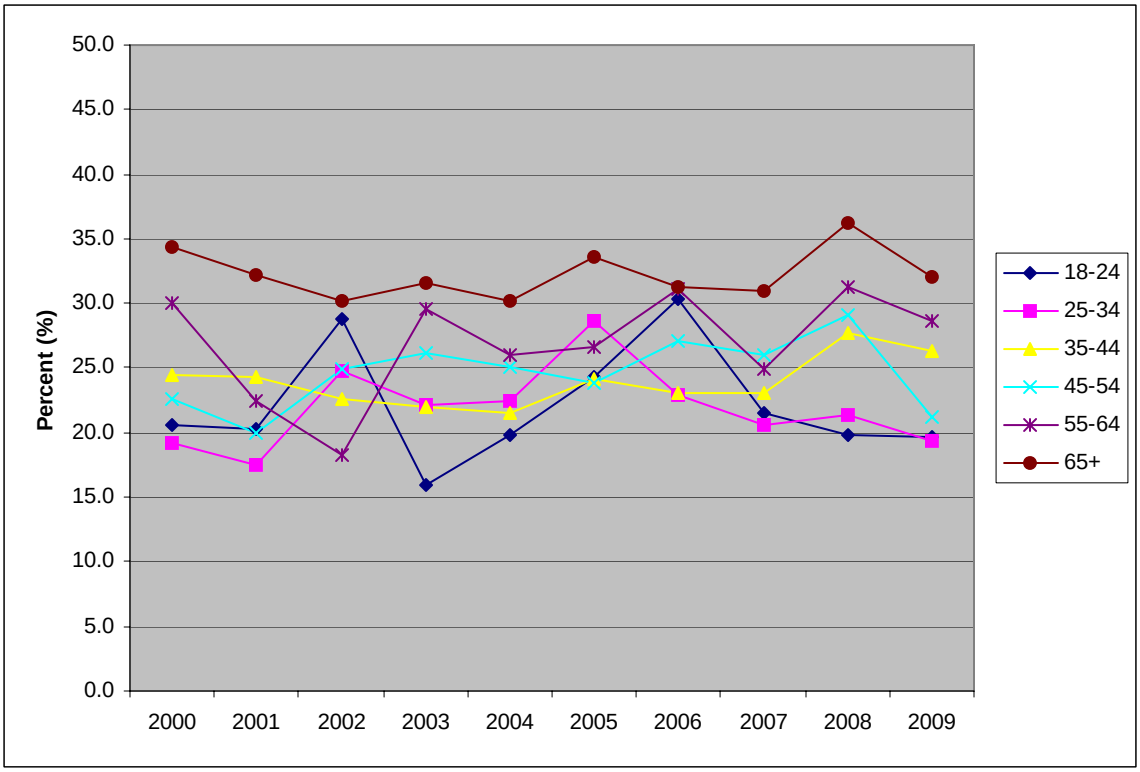
Proportion of Adults Who Engage in No Leisure Time Physical Activity, Nevada Residents by Race/Ethnicity, BRFSS Data, 2000-2009.*

Although historically the proportion for Nevadan's not engaging in leisure time physical activity were highest in Hispanics and lowest in the White population, non-activity among Nevada's racial/ethnic groups converged in 2009 and fall within the range of 23.2 percent to 27.7 percent.



*These percentages are weighted to survey population characteristics.

Proportion of Adults Who Engage in No Leisure Time Physical Activity, Nevada Residents by Age, BRFSS Data, 2000-2009.*



In general, older age groups engage less in leisure time physical activity than younger age groups. From 2000 to 2009, Nevada adults 65 years of age and older had the highest proportion who don't engage in leisure time physical activity.

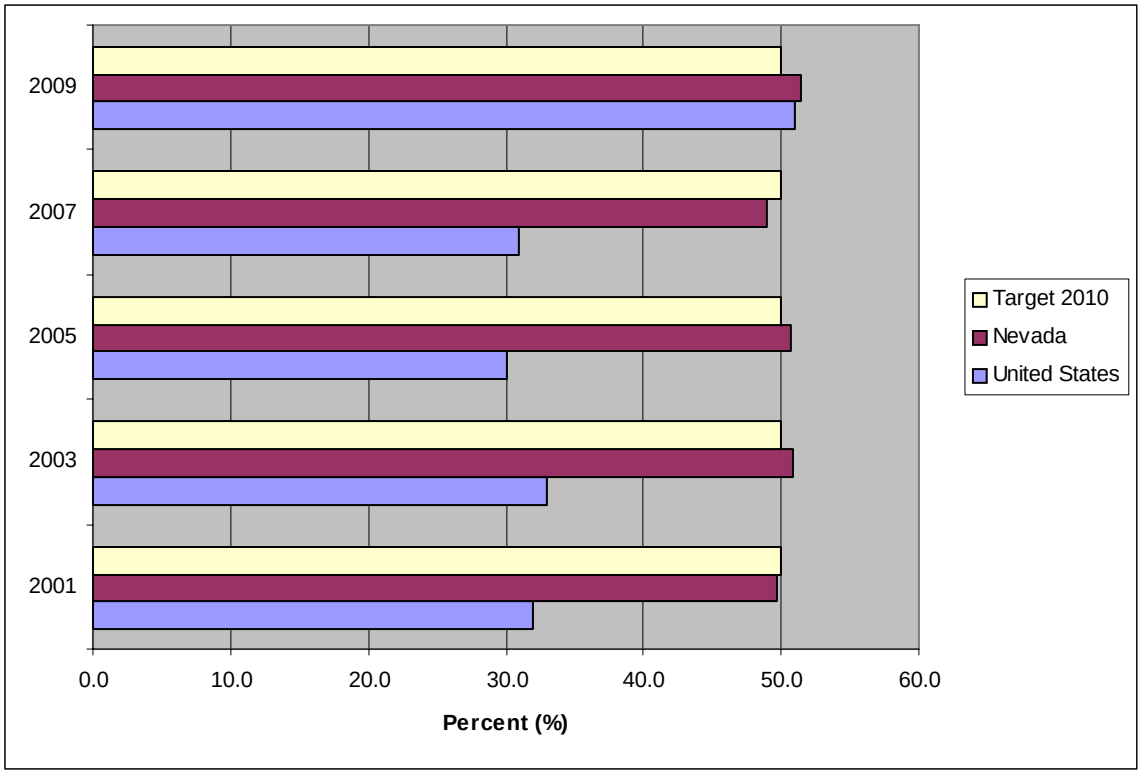
*These percentages are weighted to survey population characteristics.

Healthy People 2010 Objective (22-2.): Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.

Healthy People 2020 Objective PA HP2020-2.1: Increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes/week or 75 minutes/week of vigorous intensity or an equivalent combination.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
51.4	51.0	50.0	47.9	Surpassed

Proportion of Adults Reporting Regular Moderate Physical Activity For At Least 30 Minutes per Day, 5 or More Days per Week, or Vigorous Physical Activity For At Least 20 Minutes per Day, 3 or More Days per Week, Nevada Residents and United States, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*

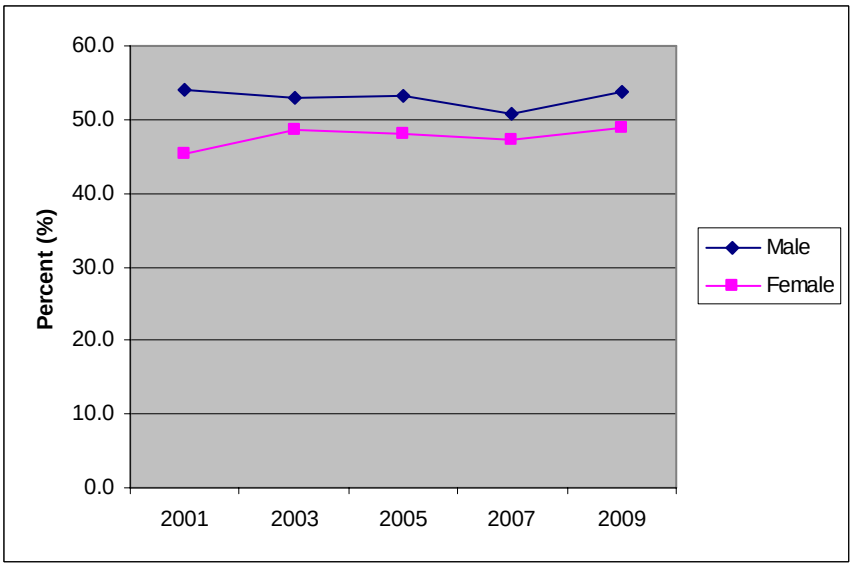


Nevada surpassed both the U.S. and the Healthy People 2010 target for the proportion of adults who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes per week or of vigorous intensity for at least 75 minutes per week from 2001 to 2009.

From 2000 to 2009, approximately half of all adults in Nevada engaged in aerobic physical activity of moderate intensity for at least 75 to 150 minutes on a weekly basis. This is 20 percent higher than the national average of approximately 31 percent from 2001 to 2007.

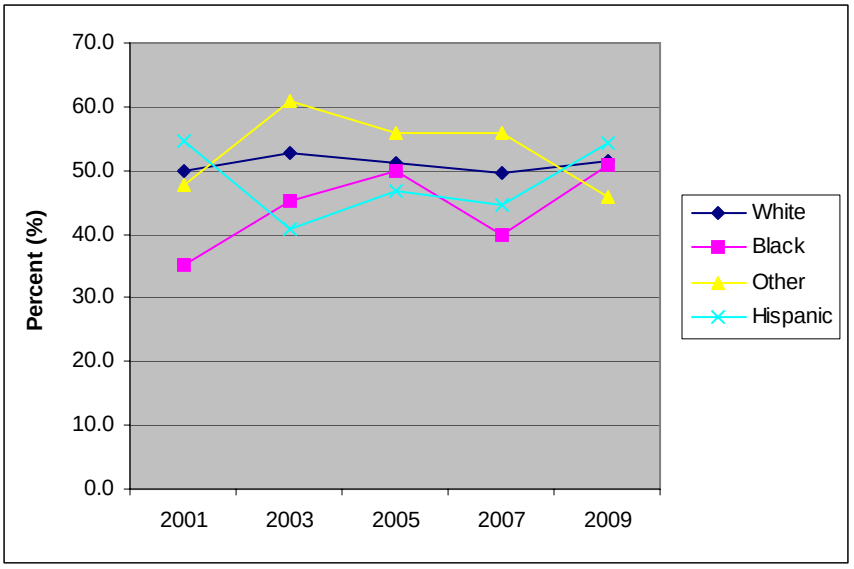
*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of Adults Reporting Regular Moderate Physical Activity For At Least 30 Minutes per Day, 5 or More Days per Week, or Vigorous Physical Activity For At Least 20 Minutes per Day, 3 or More Days per Week, Nevada Residents by Gender, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



From 2001 to 2009, there was a higher proportion of Nevada males reporting regular physical activity than Nevada females.

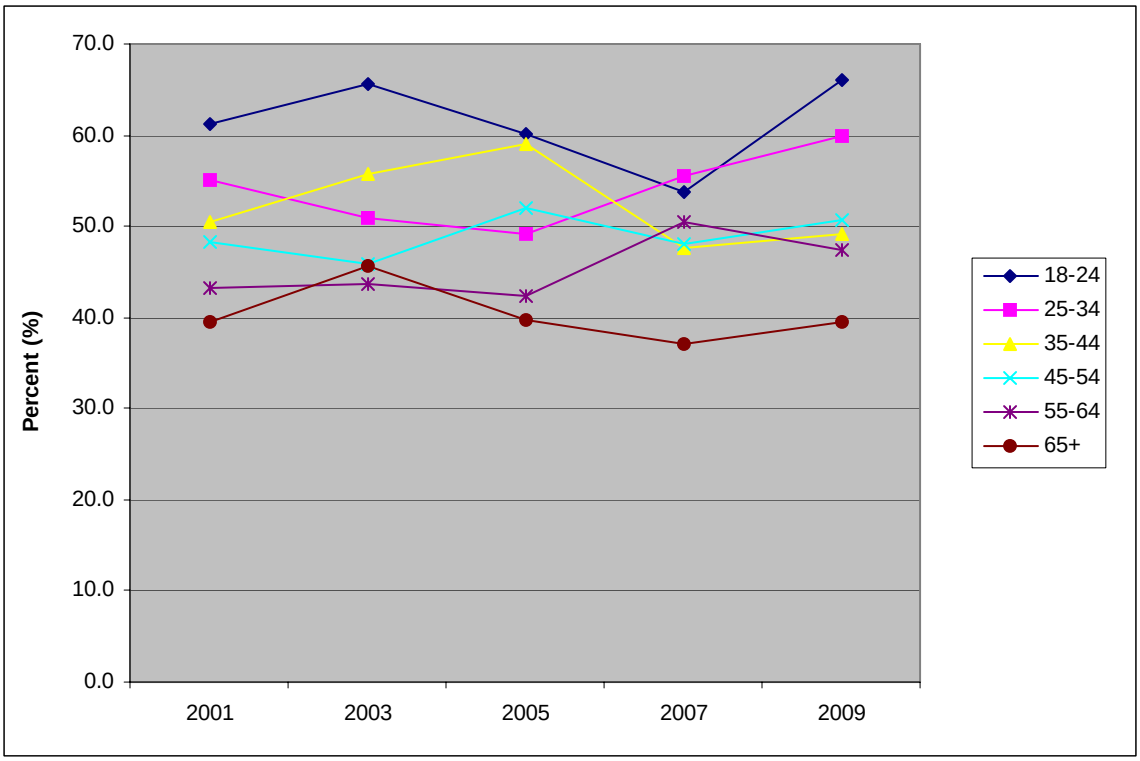
Proportion of Adults Reporting Regular Moderate Physical Activity For At Least 30 Minutes per Day, 5 or More Days per Week, or Vigorous Physical Activity For At Least 20 Minutes per Day, 3 or More Days per Week, Nevada Residents by Race/Ethnicity, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



The percent of White Nevada adults participating in moderate and vigorous aerobic physical activity was constant over the past decade (around 50 percent) while other racial/ethnic groups fluctuated. All race/ethnicity groups were near the 50 percent level in 2009 (45.7 percent - 54.4 percent).

*These percentages are weighted to survey population characteristics.

Proportion of Adults Reporting Regular Moderate Physical Activity For At Least 30 Minutes per Day, 5 or More Days per Week, or Vigorous Physical Activity For At Least 20 Minutes per Day, 3 or More Days per Week, Nevada Residents by Age, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



Moderate and vigorous exercise is more common among younger age groups, with 18 – 24 year olds generally being the most active and individuals 65 years of age or older generally being the least active in 2001 through 2009.

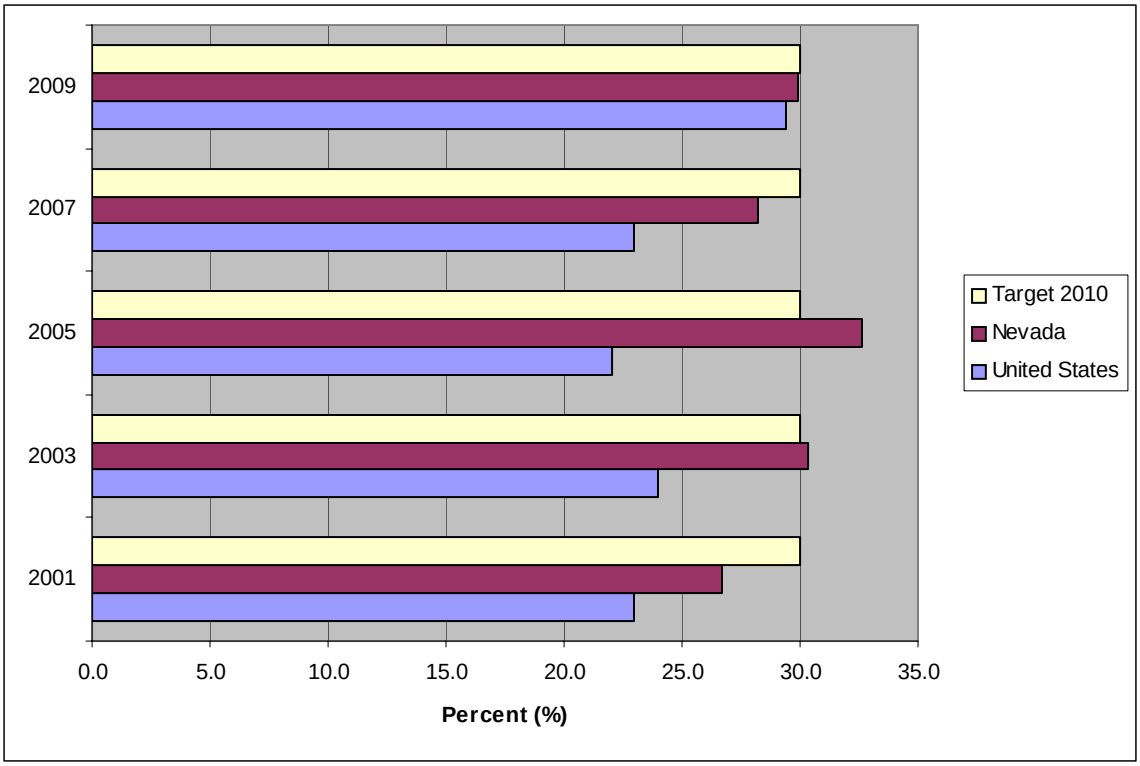
*These percentages are weighted to survey population characteristics.

Healthy People 2010 Objective (22-3.): Increase the proportion of adults who engage in vigorous physical activity promoting the development and maintenance of cardio-respiratory fitness for 20 or more minutes per day 3 or more days per week.

Healthy People 2020 Objective PA HP2020-2.2: Increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity for more than 300 minutes/week or more than 150 minutes/week of vigorous intensity or an equivalent combination.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
29.9	29.4	30.0	31.3	Achieved

Proportion of Adults Who Engage in Vigorous Physical Activity Promoting the Development and Maintenance of Cardio-Respiratory Fitness for 20 or More Minutes per Day 3 or More Days per Week, Nevada Residents and United States, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*

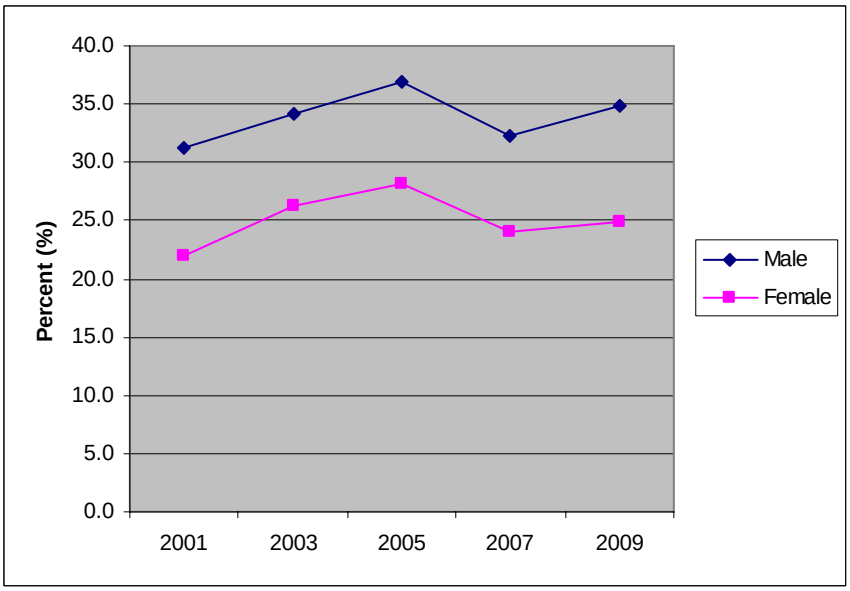


The percentage of Nevada adults who engage in vigorous physical activity for 20 minutes or more for 3 or more days per week has been consistently higher than national values from 2001 to 2009.

Communities can contribute to promoting physical activity by creating safe walking and bicycle paths, supporting farmer's markets, and promoting physical activities.[3]

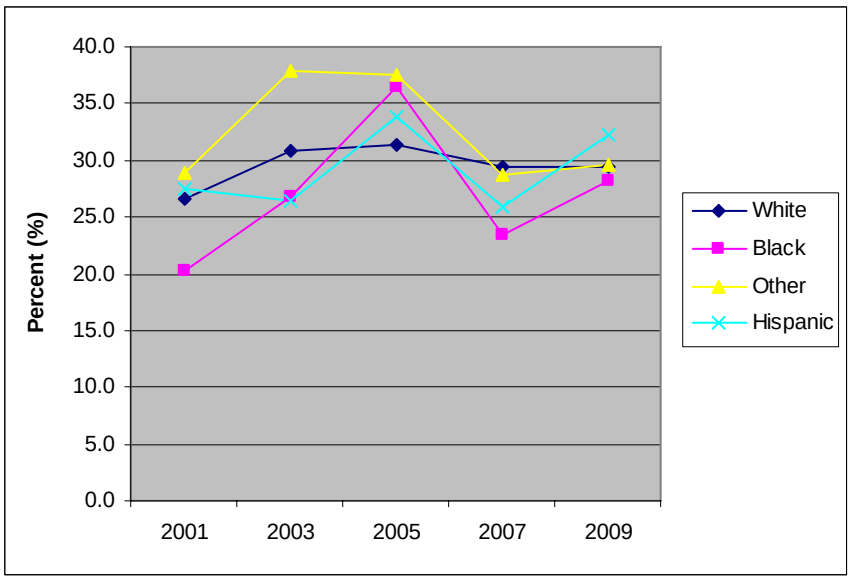
*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of Adults Who Engage in Vigorous Physical Activity Promoting the Development and Maintenance of Cardio-Respiratory Fitness for 20 or More Minutes per Day 3 or More Days per Week, Nevada Residents by Gender, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



The proportion of Nevada males who engage in vigorous physical activity for 20 or more minutes per day on 3 or more days per week was higher than that of Nevada females from 2001 to 2009.

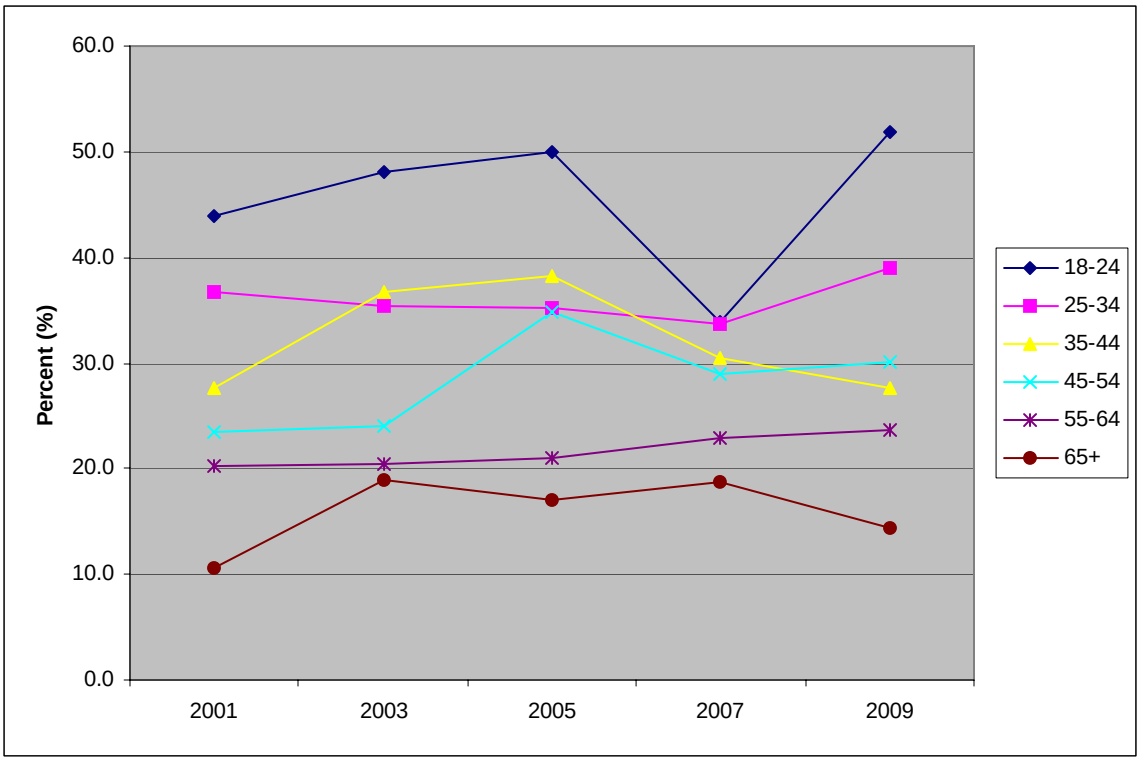
Proportion of Adults Who Engage in Vigorous Physical Activity Promoting the Development and Maintenance of Cardio-Respiratory Fitness for 20 or More Minutes per Day 3 or More Days per Week, Nevada Residents by Race/Ethnicity, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



From 2000 to 2009, Nevada's White population participating in vigorous physical activity for 20 minutes per day for 3 or more days per week was fairly consistent from 2001 to 2009, at about 30 percent, other racial/ethnic groups fluctuated from 2001 to 2009.

*These percentages are weighted to survey population characteristics.

Proportion of Adults Who Engage in Vigorous Physical Activity Promoting the Development and Maintenance of Cardio-Respiratory Fitness for 20 or More Minutes per Day 3 or More Days per Week, Nevada Residents by Age, BRFSS Data, 2001, 2003, 2005, 2007, 2009.*



In general from 2001 to 2009, younger Nevadans participated in vigorous physical activity for 20 minutes per day for 3 or more days per week more frequently than older populations.

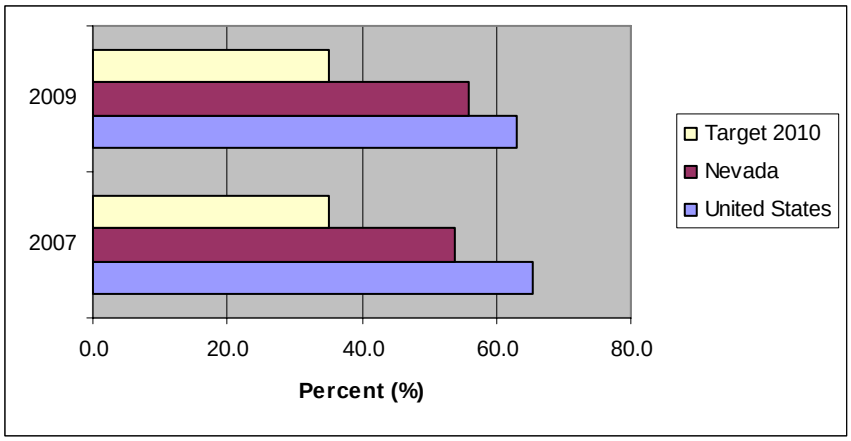
*These percentages are weighted to survey population characteristics.

Healthy People 2010 Objective (22-6.): Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes per day, 5 or more days per week.

Healthy People 2020 Objective PA HP2020-3.3: Increase the proportion of adolescents that meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
55.9	63.0	35.0	TBD	Surpassed

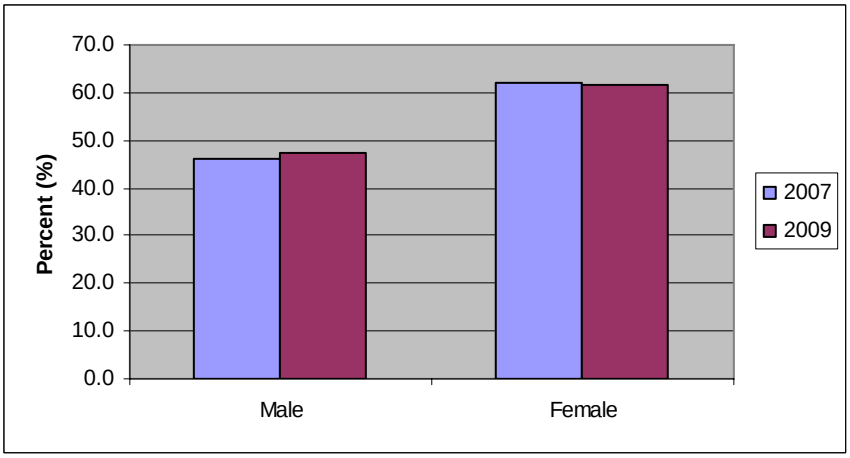
Proportion of Adolescents Who Are Physically Active For At Least 60 Minutes Per Day on Less Than 5 Days per Week
(Doing Any Kind of Physical Activity That Increased Their Heart Rate and Made Them Breath Hard Some Time During The 7 Days Before the Survey)
Nevada Residents and United States, YRBSS Data, 2007 and 2009.*



The proportion of adolescents in Nevada who are physically active for at least 60 minutes per day on less than 5 days per weeks was less than that of the U.S. Both Nevada and the United States surpassed the Health People 2010 target in 2007 or 2009.

Proportion of Adolescents Who Are Physically Active For At Least 60 Minutes Per Day on Less Than 5 Days per Week
(Doing Any Kind of Physical Activity That Increased Their Heart Rate and Made Them Breath Hard Some Time During The 7 Days Before the Survey)
Nevada Residents by Gender, YRBSS Data, 2007 and 2009.*

The proportion of male adolescents in Nevada who are physically active for at least 60 minutes per day on less than 5 days per week was lower than for Nevada female adolescents in 2007 and 2009.

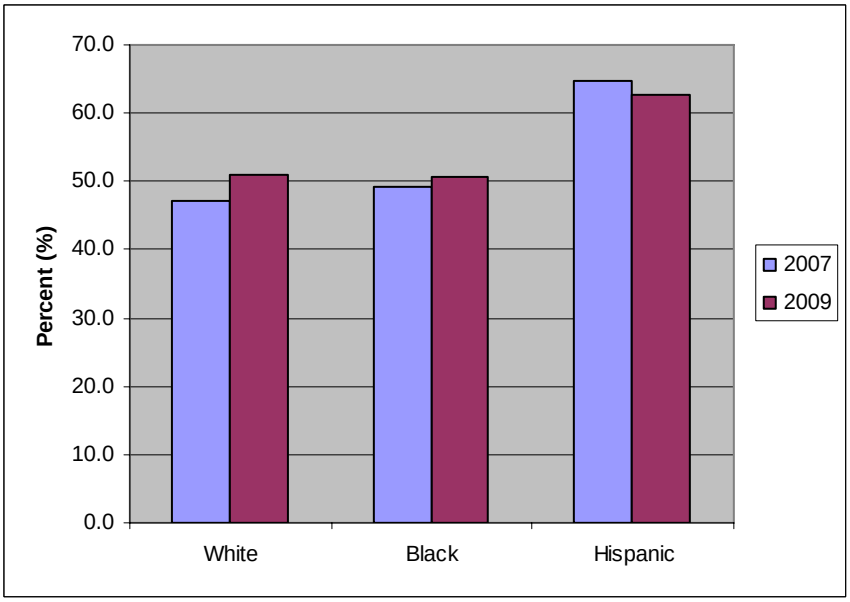


*Individual county data are not available.
Note: Here we represent the proportion of adolescents who are physically active for at least 60 minutes per day on less than 5 days per week rather than the original objective: proportion of adolescents who engage in moderate physical activity for at least 30 minutes per day, 5 or more days per week.

Proportion of Adolescents Who Are Physically Active For At Least 60 Minutes Per Day on Less Than 5 Days per Week

(Doing Any Kind of Physical Activity That Increased Their Heart Rate and Made Them Breath Hard Some Time During The 7 Days Before the Survey)

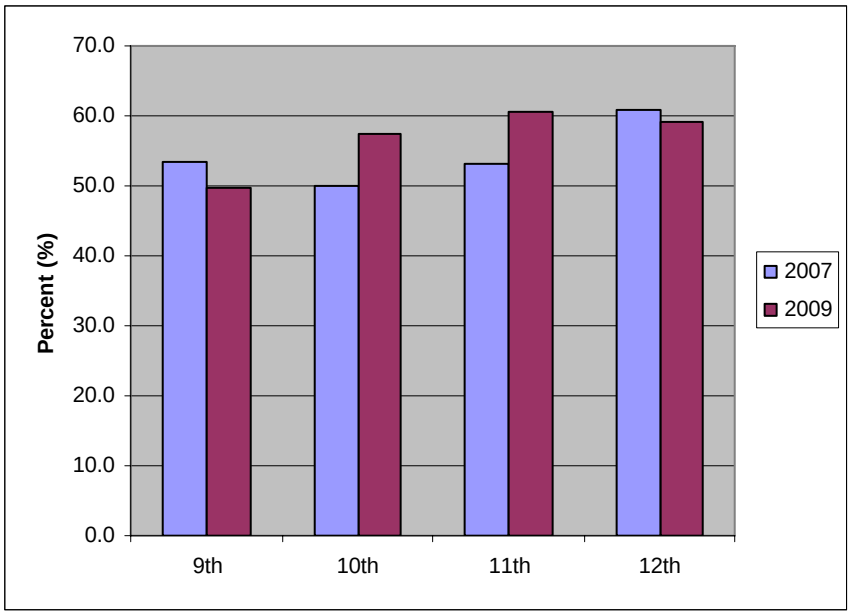
Nevada Residents by Race/Ethnicity, YRBSS Data, 2007 and 2009.*



Proportion of Adolescents Who Are Physically Active For At Least 60 Minutes Per Day on Less Than 5 Days per Week

(Doing Any Kind of Physical Activity That Increased Their Heart Rate and Made Them Breath Hard Some Time During The 7 Days Before the Survey)

Nevada Residents by Grade, YRBSS Data, 2007 and 2009.*



*Individual county data are not available.

Note: Here we represent the proportion of adolescents who are physically active for at least 60 minutes per day on less than 5 days per week rather than the original objective: proportion of adolescents who engage in moderate physical activity for at least 30 minutes per day, 5 or more days per week.

Note: Data not available for Native American, Asian, or Multiple Races race/ethnicity groups due to <100 respondents for those subgroups.

Respiratory Diseases

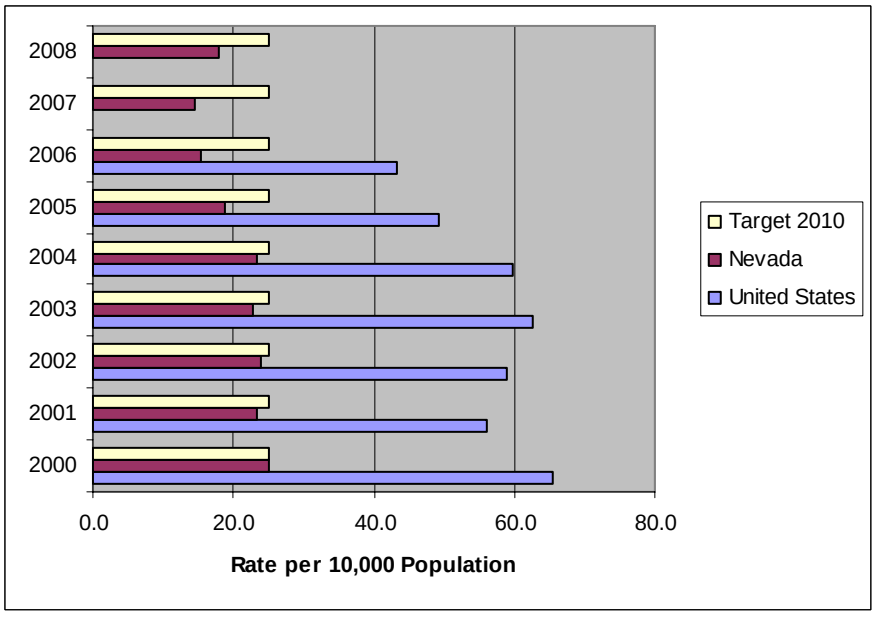
Chronic respiratory diseases are chronic diseases of the airways and other structures of the lung. Some of the most common are asthma, Chronic Obstructive Pulmonary Disease (COPD), respiratory allergies, occupational lung diseases and pulmonary hypertension. The most important risk factors for preventable chronic respiratory diseases include, tobacco smoking, indoor and outdoor air pollution, allergens, and occupational risks and vulnerability.[1]

Healthy People 2010 Objective (24-2a.): Reduce hospitalizations for asthma in children under age 5 years.

Healthy People 2020 Objective RD HP2020-2.1: Reduce hospitalizations for asthma in children under age 5 years.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
18.0	43.3	25.0	18.1	Surpassed

Hospitalization Rate for Asthma in Children Under Age 5 Years, Nevada Residents and United States, 2000 - Most Current Data.*

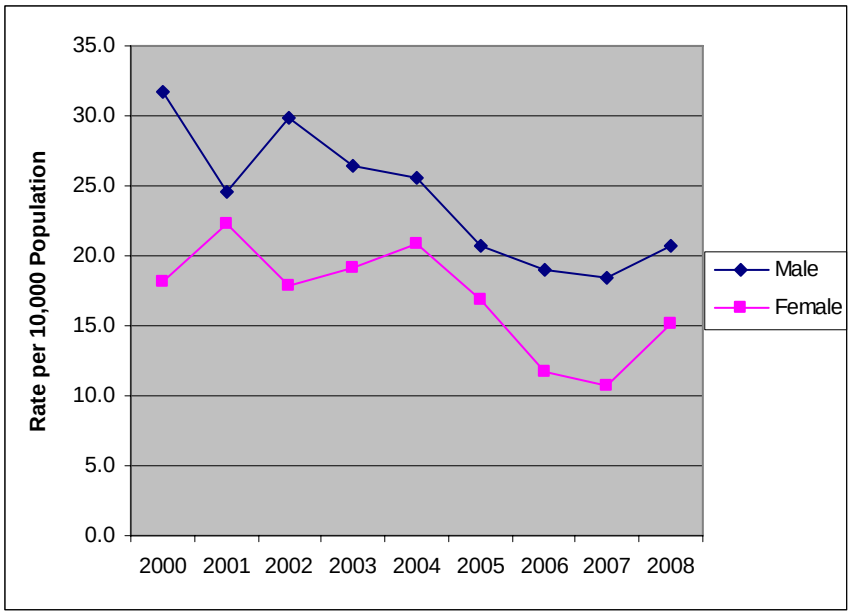


The rate of asthma hospitalizations for children under the age of 5 in Nevada was below the Healthy People 2010 target from 2000 to 2008 and below the national rate from 2000 to 2006.

In the U.S., in 2006, the CDC reports 9.4 percent of children suffer from asthma.[2]

*The Nevada data are from Nevada Inpatient Hospital Discharge Database (NIHDD). The U.S. data are from the National Hospital Discharge Survey (NHDS).
Note: See appendix for additional information.

Hospitalization Rate for Asthma in Children Under Age 5 Years, Nevada Residents by Gender, 2000 - 2008.*

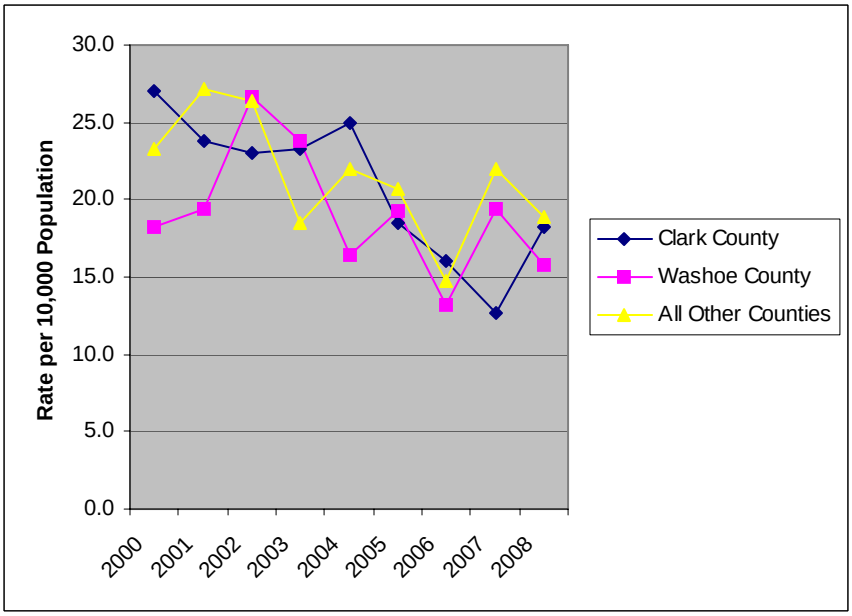


Hospitalization rates for asthma in Nevada's children, aged 5 years and younger, decreased from 2000 to 2008 in both genders. Nevada males however, consistently had a higher hospitalization rate from asthma in this age group.

Among children under 5 years of age, more boys than girls are hospitalized for asthma, but the reverse is true for adults. According to a recent report published in the journal *Chest*, researchers found that the discrepancy was due to overall prevalence of asthma within child vs. adult populations.[3]

Hospitalization Rate for Asthma in Children Under Age 5 Years, Nevada Residents by County/Region, 2000 - 2008.*

The rate of hospitalizations for asthma in children aged 5 years and younger decreased overall in all Nevada regions from 2000 to 2009.



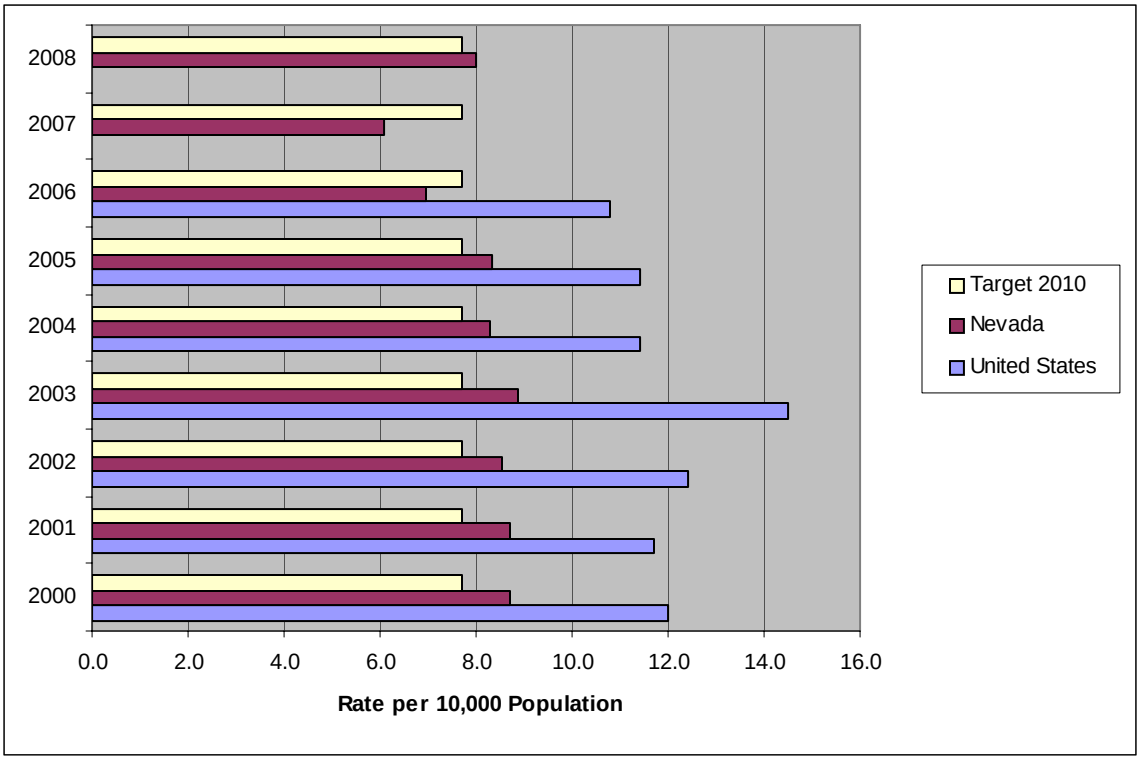
*The Nevada data are from Nevada Inpatient Hospital Discharge Database (NIHDD).

Healthy People 2010 Objective (24-2b.): Reduce hospitalizations for asthma in children and adults, aged 5 to 64 years.

Healthy People 2020 Objective RD HP2020-2.2: Reduce hospitalizations for asthma in children and adults, aged 5 to 64 years.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
8.0	10.8	7.7	8.6	Fluctuating

Hospitalization Rate for Asthma in Children and Adults Aged 5 to 64 Years, Nevada Residents and United States, 2000 - Most Current Data.*

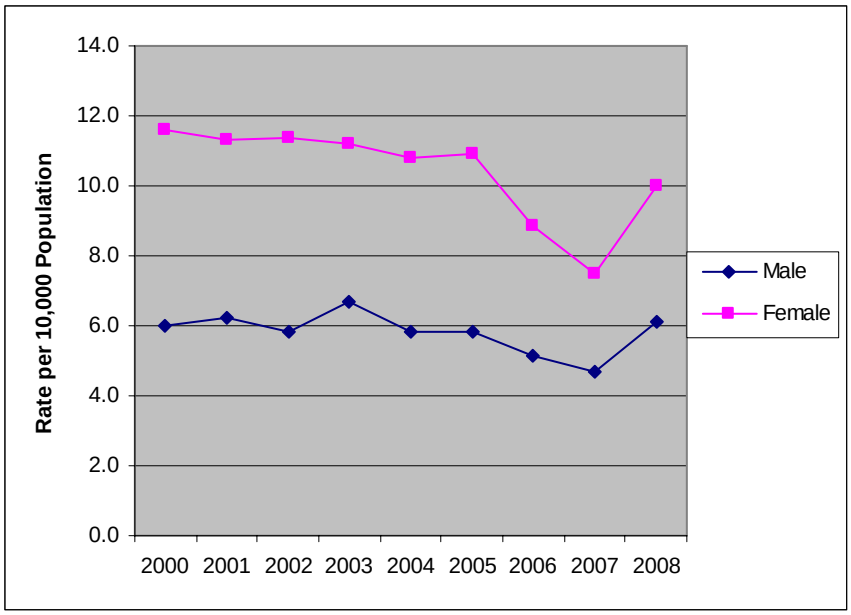


The hospitalization rate for asthma in children and adults aged 5 to 64 years old in Nevada was fairly consistent from 2000 to 2009, only decreasing slightly from 2000 to 2007 and increasing again in 2008.

Obesity is a risk factor for asthma in women. Adult women with a higher body mass index (BMI) have a higher incidence of asthma than other women. The effect of obesity on asthma does not appear to be as important for men.[4]

*The Nevada data are from Nevada Inpatient Hospital Discharge Database (NIHDD). The U.S. data are from the National Hospital Discharge Survey (NHDS).
Note: See appendix for additional information.

Hospitalization Rate for Asthma in Children and Adults Aged 5 to 64 Years, Nevada Residents by Gender, 2000 - 2008.*



Asthma is more common in women than men after late childhood. Young boys have a higher rate of asthma than young girls.[4]

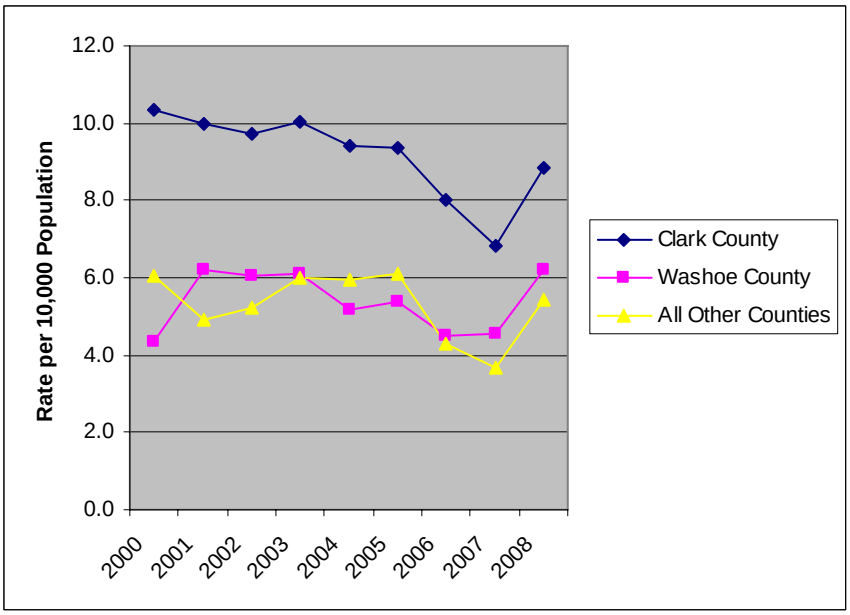
Some time around adolescence, the balance shifts over to girls and stays there. By middle age, women with asthma outnumber men almost 2 to 1.[4]

When considering all Nevada children and adults aged 5 to 64, women had higher hospitalization rates from asthma in 2000 through 2008.

There was a slight overall decrease this decade in the hospitalization rate for asthma in those aged 5 to 64 years in Clark County. However, the hospitalization rates in Washoe and All Other Counties have been fluctuating over the past nine years. All three regions showed increases from 2007 to 2008.

Asthma attack triggers include: secondhand smoke, dust mites, mold, pests (cockroaches & rodents), pets, chemical irritants, and air pollution.[4]

Hospitalization Rate for Asthma in Children and Adults Aged 5 to 64 Years, Nevada Residents by County/Region, 2000 - 2008.*



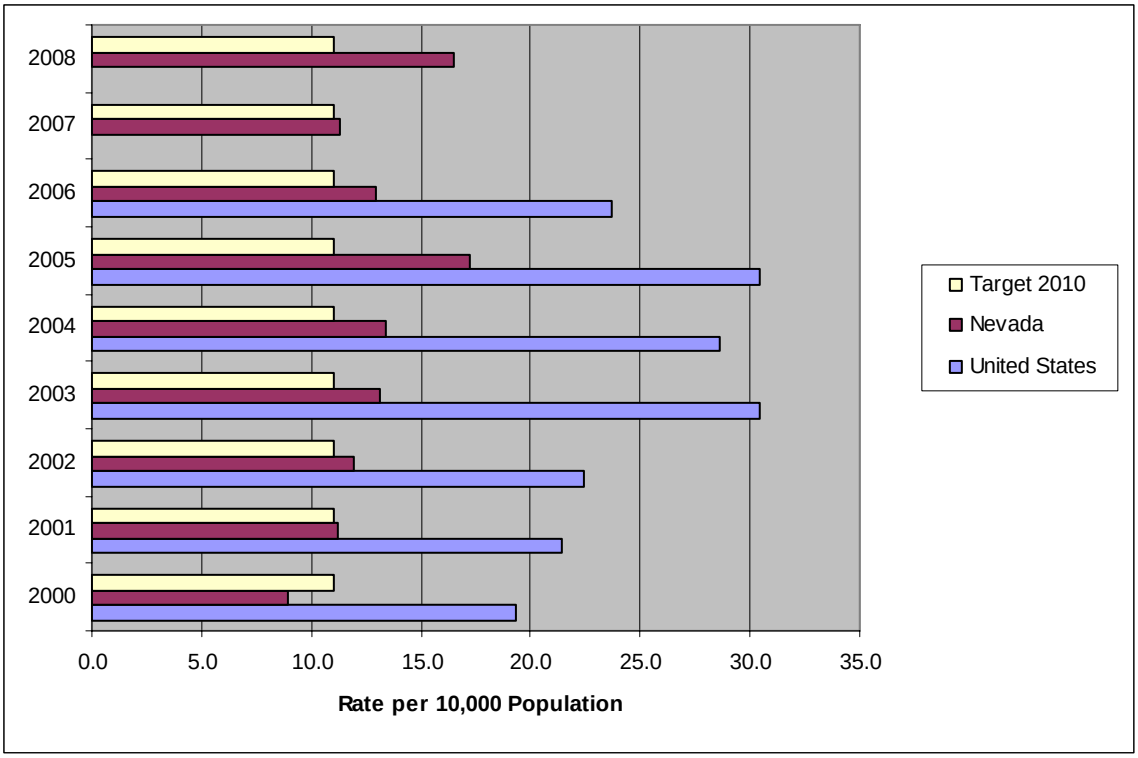
*The Nevada data are from Nevada Inpatient Hospital Discharge Database.
Note: Race/ethnicity data not available.

Healthy People 2010 Objective (24-2c.): Reduce hospitalizations for asthma in adults, aged 65 years and older.

Healthy People 2020 Objective RD HP2020-2.3: Reduce hospitalizations for asthma in adults, aged 65 years and older.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
16.5	23.7	11.0	20.3	Fluctuating

Hospitalization Rate for Asthma in Adults Aged 65 Years and Older, Nevada Residents and United States, 2000 - Most Current Data.*

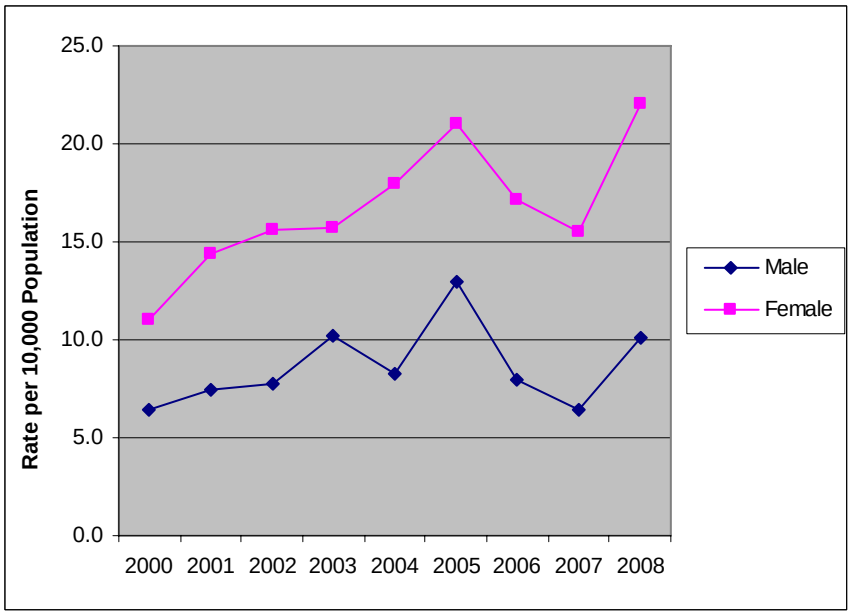


Hospitalization rates for Nevada adults aged 65 years and older increased in 2008 to the highest they have been since 2005, at 16.5 per 10,000 people.

Asthma is a disease that causes the airways of the lungs to tighten. It is a chronic condition that is common among children. Asthma attacks occur when your lungs aren't getting enough air to breathe.[4]

*The Nevada data are from Nevada Inpatient Hospital Discharge Database (NIHDD). The U.S. data are from the National Hospital Discharge Survey (NHDS).
Note: See appendix for additional information.

Hospitalization Rate for Asthma in Adults Aged 65 Years and Older, Nevada Residents by Gender, 2000 - 2008.*



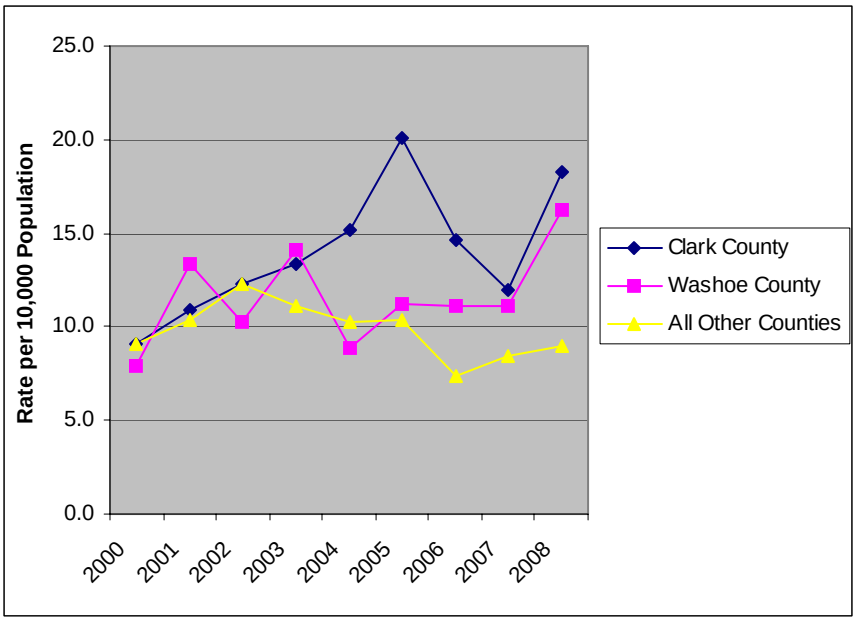
Nevada females aged 65 years and older had higher asthma hospitalization rates than Nevada males in this age group from 2000 to 2008.

Per the Nevada Behavioral Risk Factor Surveillance System (NV BRFSS) data from 1995-2007 observe that the trend for asthma rates in Nevada and the nation are the same; both remain steady.[5]

Asthma hospitalization rates for Nevada adults aged 65 years and older, fluctuated from 2000 to 2008, with an overall increase for Clark and Washoe counties.

Asthma cannot be cured. However, by eliminating asthma triggers inside of the home the number of asthma attacks may be reduced. It is important to work with your doctor to manage your asthma. Consider a diagnostic test to determine what your specific asthma triggers are.[4]

Hospitalization Rate for Asthma in Adults Aged 65 Years and Older, Nevada Residents by County/Region, 2000 - 2008.*



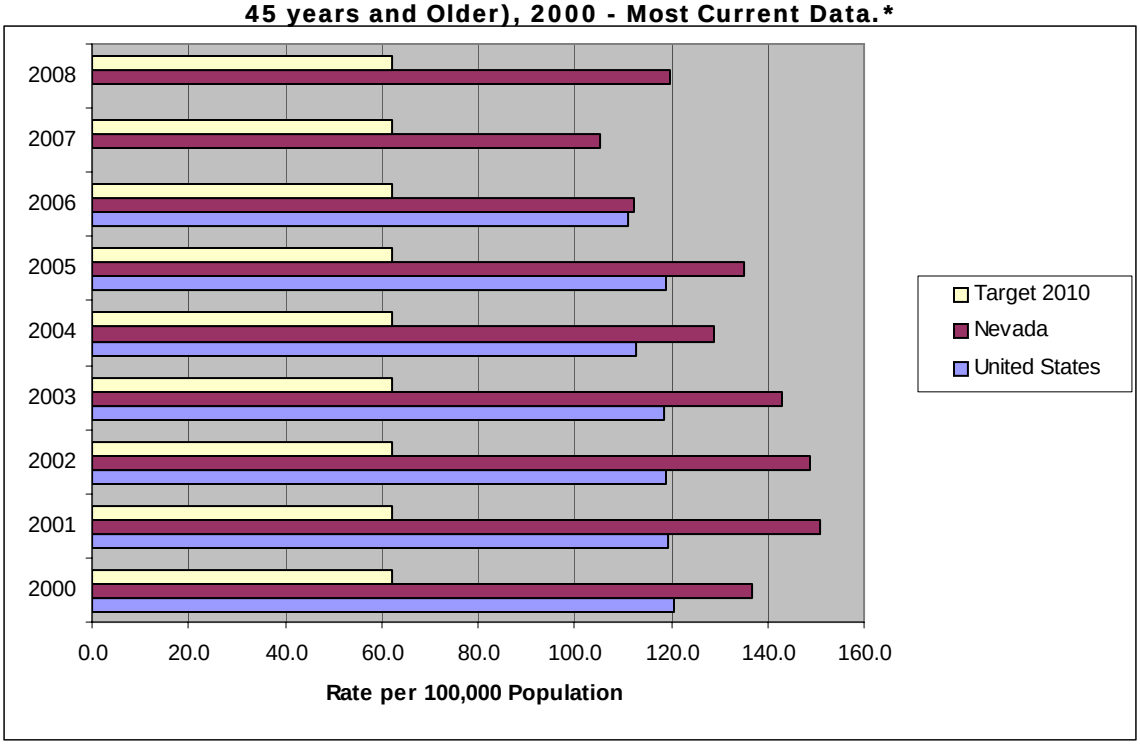
*The Nevada data are from Nevada Inpatient Hospital Discharge Database.
Note: Race/ethnicity data not available.

Healthy People 2010 Objective (24-10.): Reduce deaths from Chronic Obstructive Pulmonary Disease among adults, aged 45 years and older.

Healthy People 2020 Objective RD HP2020-10: Reduce deaths from Chronic Obstructive Pulmonary Disease among adults.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
119.6	112.1	62.3	98.5	Fluctuating

Chronic Obstructive Pulmonary Disease Deaths, Nevada Residents (Crude Rate, Adults Age 45 years and Older) and United States (Age Adjusted Rate, Adults Age 45 years and Older), 2000 - Most Current Data.*

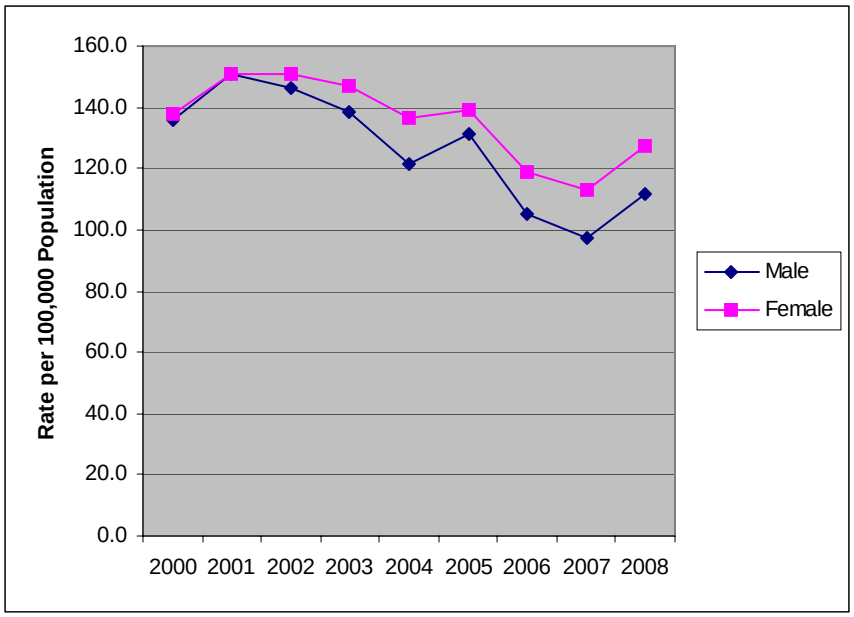


The crude mortality rate for adults 45 years of age or older, from Chronic Obstructive Pulmonary Disease (COPD) in Nevada fluctuated from 2000 to 2008, never meeting the Healthy People 2010 target of 62.3 per 100,000 people.

In 2005, approximately one in 20 deaths in the United States had COPD as the underlying cause. Smoking is estimated to be responsible for at least 75 percent of COPD deaths. Excess health care expenditures are estimated at nearly $6,000 annually for every COPD patient in the United States. For each year during 2000-2005, COPD mortality rates were higher among Whites than among Blacks or persons of all other races. In 2005, states with COPD death rates in the highest quartile were as follows: Idaho, Indiana, Kansas, Kentucky, Maine, Montana, Nevada, Ohio, and Oklahoma.[2]

*The Nevada data are from Nevada Vital Statistics Records. The U.S. data are from the National Vital Statistics System - Mortality.
Note: Nevada rates are crude rates and U.S. rates are age-adjusted to the 2000 U.S. standard population using the age groups under 45-54, 55-64, 65-74, 75-84, and 85 years and over. Thus, data may not be directly comparable. Use caution when comparing Nevada and U.S. rates.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Crude Rate, Chronic Obstructive Pulmonary Disease Death Rate Among Adults Aged 45 Years and Older, Nevada Residents by Gender, 2000 - 2007.*

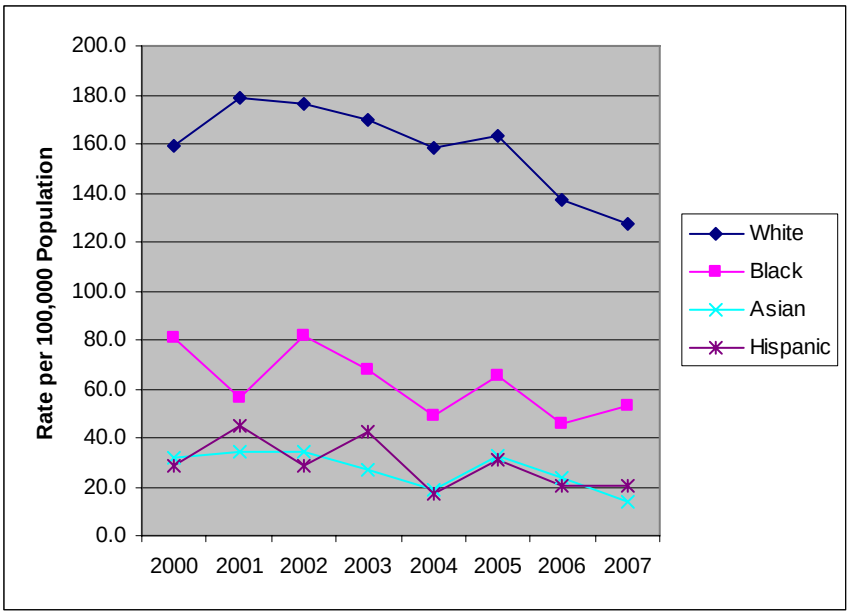


From 2000 to 2008, females had a higher mortality rate of Chronic Obstructive Pulmonary Disease than males in Nevada.

There was a decrease in the number of deaths from this disease over the years 2001 through 2007 in both genders.

Crude Rate, Chronic Obstructive Pulmonary Disease Death Rate Among Adults Aged 45 Years and Older, Nevada Residents by Race/Ethnicity, 2000 - 2007.*

Whites had a higher mortality rate for Chronic Obstructive Pulmonary Disease than any other racial group in Nevada from 2000 to 2007.



*The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American race/ethnicity group due to small counts.

Sexually Transmitted Diseases

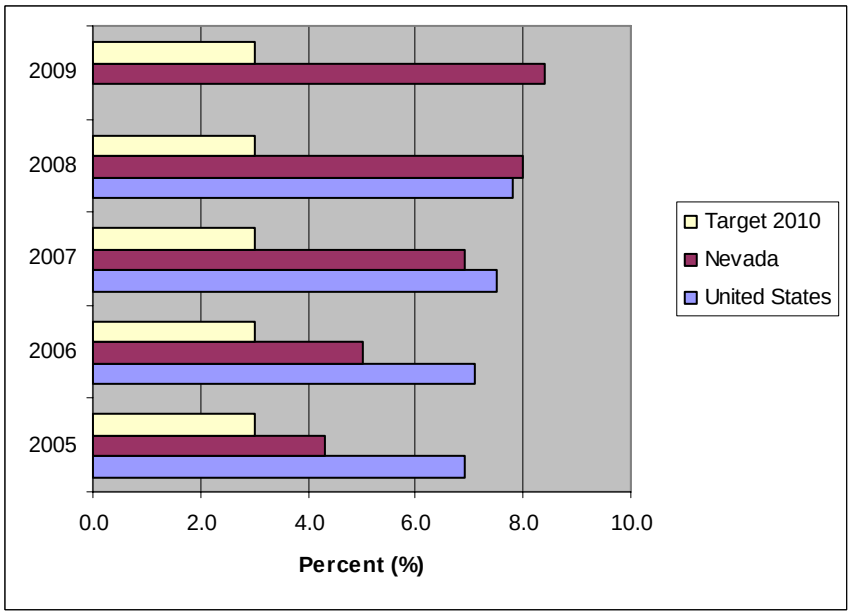
Sexually transmitted diseases (STDs) are common in the United States, with an estimated 19 million new cases of STDs reported each year. Almost 4 million of the new cases of STDs each year occur in adolescents. Women generally suffer more serious STD complications than men, including pelvic inflammatory disease, ectopic pregnancy, infertility, chronic pelvic pain, and cervical cancer from the human papilloma virus. STDs disproportionately affect minorities, with African Americans and Hispanics have higher rates of STDs than Whites.[1]

Healthy People 2010 Objective (25-1a.): Reduce the proportion of females with Chlamydia trachomatis infections, aged 15-24 years, attending family planning clinics.

Healthy People 2020 Objective STD HP2020-1.1: Reduce the proportion of females with Chlamydia trachomatis infections, aged 15-24 years, attending family planning clinics.

Most Recent NV Value (2009)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
8.4	7.8	3.0	6.7	Worsening

Proportion of Females Aged 15 to 24 Years with Chlamydia Trachomatis Infections Attending Family Planning Clinics, Nevada Residents and United States, 2005 - Most Current Data.*



The Healthy People 2010 target for the proportion of females aged 15 to 24 with Chlamydia attending family planning clinics is 3.0 percent. Neither Nevada, nor the nation, has met this target from 2005 to 2009.

In Nevada, the proportion of females 15-24 with Chlamydia attending family planning clinics almost doubled from 2005 to 2009 (4.3 vs. 8.4).

This increase is primarily due to an increase in targeted screening and implementation screening programs targeted to high risk females.

*Nevada and U.S. data are provided by the Centers for Disease Control and Prevention (CDC) Infertility Prevention Program (IPP).
Note: This proportion is a positivity rate and represents the rate of positive cases identified not the rate of infection.

Proportion of Females Aged 15 to 24 Years with Chlamydia Trachomatis Infections Attending Family Planning Clinics, Nevada Residents by Race/Ethnicity, 2002 - 2009.*

Blacks had a higher proportion of females affected by Chlamydia compared other racial/ethnic groups from 2002 to 2009. The proportion of Black females aged 15 to 24 with Chlamydia and attending family planning clinics increased from 2003 to 2009. The proportion of Chlamydia among Black females, aged 15 to 24, was more than double that of Whites and Hispanics from 2002 to 2009. The proportions for Hispanic and White females, aged 15 to 24 years, were steadily increasing from 2004 to 2009. The proportions for Asian females, aged 15 to 24 years, was relativity consistent from 2003 to 2007 with an increase in 2008, and a decrease in 2009, which could be a result of sampling.

Chlamydia is a disease caused by the bacteria Chlamydia trachomatis. Chlamydia infection is the most common sexually transmitted disease in the United States. Infected mothers can pass the disease on to their children via their unwashed hands. Sexually active individuals and individuals with multiple partners are at highest risk. As many as 1 in 4 men with Chlamydia have no symptoms. In men, Chlamydia may produce symptoms similar to gonorrhea. Symptoms may include: burning sensation during urination, discharge from the penis or rectum, testicular tenderness or pain, and rectal discharge or pain. Only about 30 percent of women with Chlamydia have symptoms. Symptoms that may occur in women include: burning sensation during urination, painful sexual intercourse, rectal pain or discharge, symptoms of PID, salpingitis, liver inflammation similar to hepatitis, and vaginal discharge.[1]

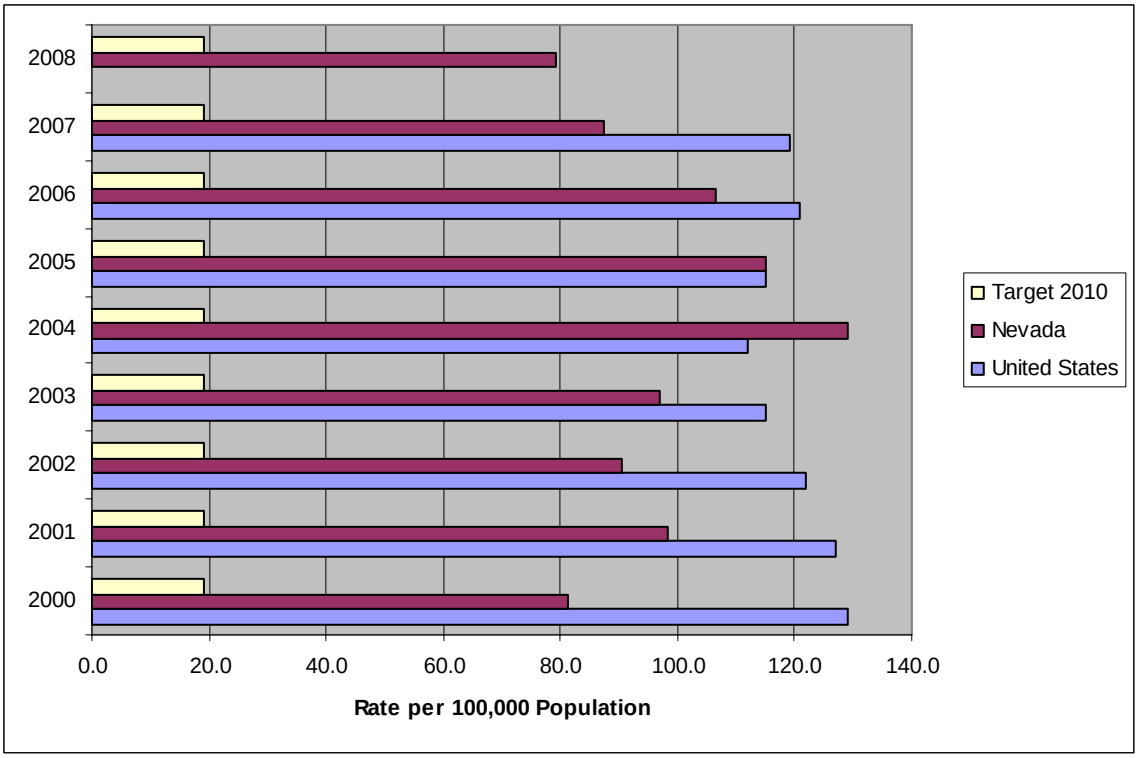
*Nevada data are provided by the Centers for Disease Control and Prevention (CDC) Infertility Prevention Program (IPP).
Note: This proportion is a positivity rate and represents the rate of positive cases identified not the rate of infection.
Note: Data not available for the Native American race/ethnicity group due to small counts.

Healthy People 2010 Objective (25-2a.): Reduce gonorrhea rates.

Healthy People 2020 Objective STD HP2020-6: Reduce gonorrhea rates.

Most Recent NV Value (2008)	U.S. (2007)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
79.2	119.0	19.0	257 (females) 198 (males)	Fluctuating

Rate of Gonorrhea, Nevada Residents and United States, 2000 - Most Current Data.*



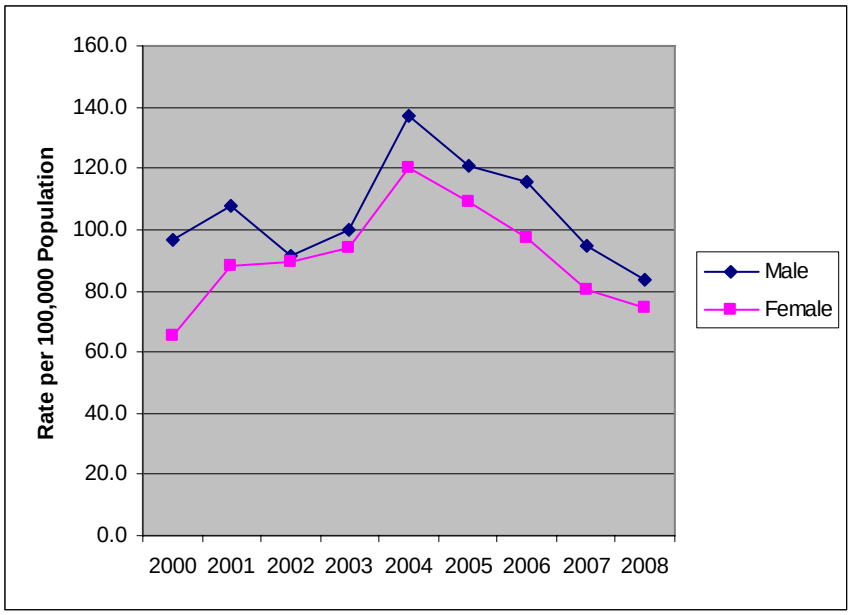
Gonorrhea rates in Nevada decreased from 2004 to 2008, at a low of 79.2 per 100,000 people in 2008. The national rates for gonorrhea fluctuated from 2000 to 2007. Nevada's rates of gonorrhea were below the national average for most years in the reporting period, with the exceptions of 2004 and in 2005.

In the United States, the highest reported rates of gonorrhea infection are among sexually active teenagers, young adults, and African Americans.[1]

Gonorrhea is a sexually transmitted disease (STD). Gonorrhea is caused by *Neisseria gonorrhoeae*, a bacterium that can grow and multiply easily in the warm, moist areas of the reproductive tract, including the cervix (opening to the womb), uterus (womb), and fallopian tubes (egg canals) in women, and in the urethra (urine canal) in women and men. The bacterium can also grow in the mouth, throat, eyes, and anus.[1]

*Nevada data are provided by the STD-MIS database and U.S. data are provided by the STD Surveillance System (STDSS), Centers for Disease Control and Prevention (CDC), NCHHSTP.
Note: See appendix for additional information.

Rate of Gonorrhea, Nevada Residents by Gender, 2000 - 2008.*



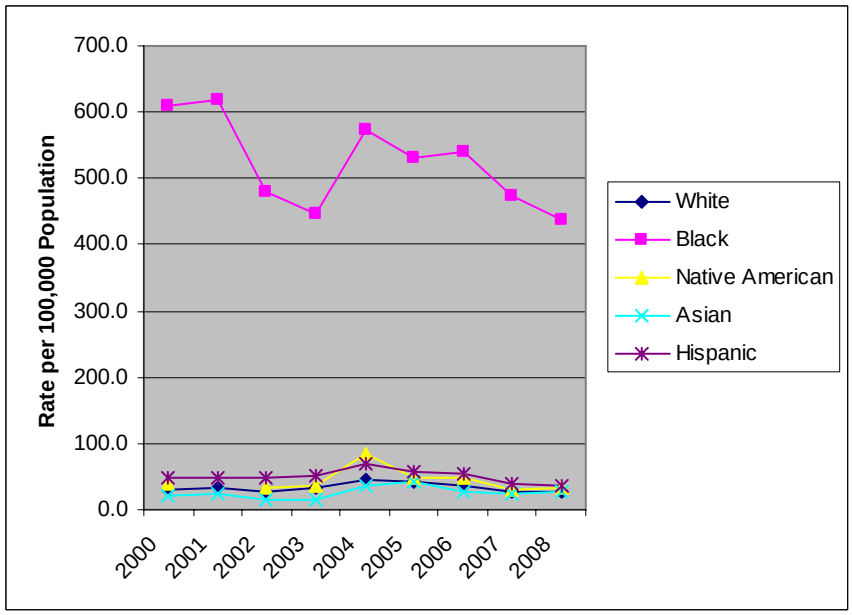
Males had a higher rate of gonorrhea than females in Nevada from 2000 to 2008. In 2008 the rate of gonorrhea among males was 83.6 per 100,000 people and the rate among females was 74.8 per 100,000 people. gonorrhea rates decreased for both males and females from 2004 to 2008.

CDC estimates that more than 700,000 persons in the U.S. contract new gonorrheal infections each year. Only about half of these infections are reported to the CDC.[2]

Throughout the decade, Blacks had significantly higher rates of gonorrhea than all other racial or ethnic groups in Nevada.

Although the rate among Blacks has decreased overall from 2000 to 2008, the rate of gonorrhea among Blacks in 2008 was still 438.2 per 100,000 people; 17.05 times that of Whites (25.7) and 12.13 times that of Hispanics (36.1).

Rate of Gonorrhea, Nevada Residents by Race/Ethnicity, 2000 - 2008.*



After several years of stable gonorrhea rates, the national gonorrhea rate increased for the second consecutive year in 2006, with the rate of reported gonorrheal infections at 120.9 per 100,000 persons (CDC).[3]

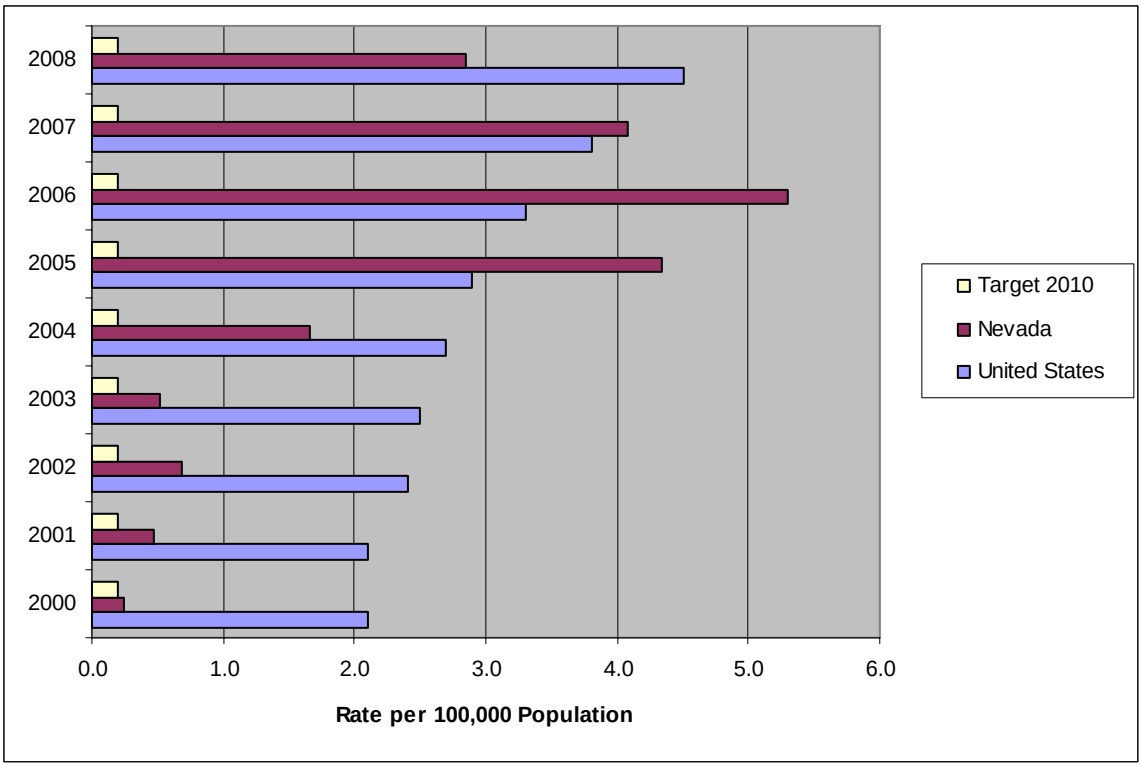
*Nevada data are provided by the STD-MIS database.
Note: Data not available for the Native American race/ethnicity group for the year 2001 due to small counts.

Healthy People 2010 Objective (25-3.): Eliminate sustained domestic transmission of primary and secondary syphilis.

Healthy People 2020 Objective STD HP2020-7: Reduce sustained domestic transmission of primary and secondary syphilis.

Most Recent NV Value (2008)	U.S. (2008)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
2.8	4.5	0.2	1.4 (females) 6.8 (males)	Worsening

Rate of Primary and Secondary Syphilis, Nevada Residents and United States, 2000 - 2008.*

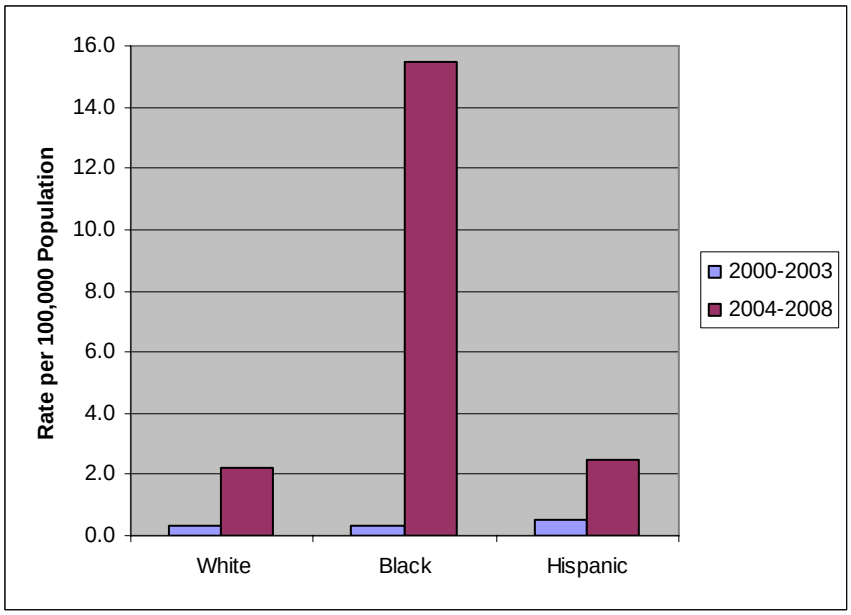


From 2000 to 2006 the rates for primary and secondary syphilis infections increased in both the United States and in Nevada.

In 2004, Nevada began experiencing a primary and secondary syphilis outbreak, with the peak of the outbreak in 2006 with a rate of 5.3 per 100,000. Rates of primary and secondary syphilis began to decline in 2007 and 2008. In 2008 ,the rate of primary and secondary syphilis in Nevada was below the national average at 2.8 cases per 100,000 compared to the national rate of 4.5 cases per 100,000.

*Nevada data are provided by the STD-MIS database and U.S. data are provided by the Centers for Disease Control and Prevention (CDC).
Note: See appendix for additional information.

Aggregated Rate of Primary and Secondary Syphilis, Nevada Residents by Race/Ethnicity, 2000 - 2003 and 2004 - 2008.*



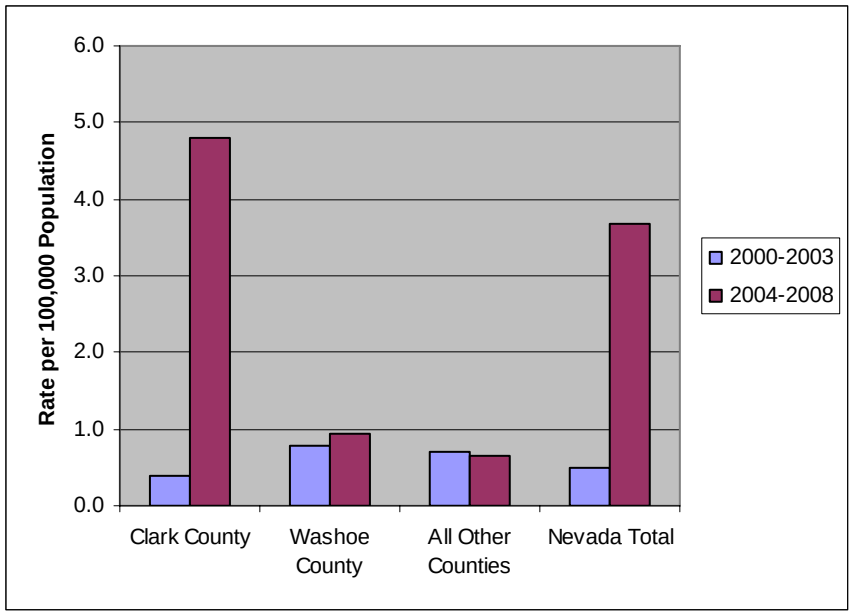
Blacks had the highest prevalence of primary and secondary syphilis in Nevada in the combined years 2004 through 2008.

In the United States, the incidence of primary and secondary syphilis was highest in women 20 to 24 years of age and in men 35 to 39 years of age.[3] In 2006, 64 percent of the nationally reported primary and secondary syphilis cases were among men who have sex with men (MSM).[3]

In 2004 through 2008, Clark County had the highest increase in the rate of primary and secondary syphilis in Nevada.[4]

Syphilis is passed from person to person through direct contact with a syphilis sore. Transmission occurs during vaginal, anal, or oral sex. Pregnant women can pass it to the babies they are carrying. syphilis cannot be spread through contact with toilet seats, doorknobs, swimming pools, hot tubs, bathtubs, shared clothing, or eating utensils.[3]

Aggregated Rate of Primary and Secondary Syphilis, Nevada Residents by County/Region, 2000 - 2003 and 2004 - 2008.*



*Nevada data are provided by the STD-MIS database.
Note: Data not available for the Native American and Asian race/ethnicity groups due to small counts.

Substance Abuse

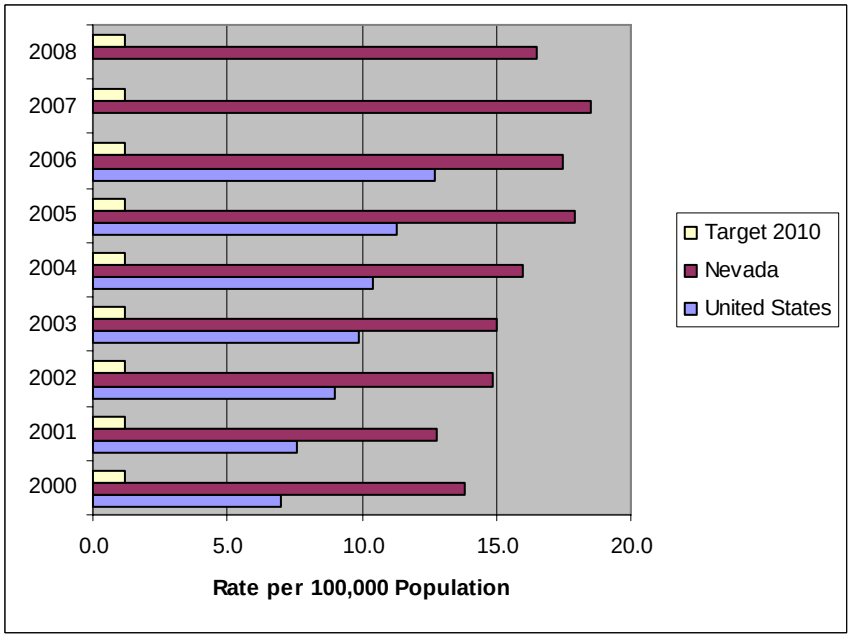
Alcohol and illicit drug use are associated with many of this country's most serious problems, including child and spousal abuse; sexually transmitted diseases, including HIV infection; teen pregnancy; school failure; escalation of health care costs; low worker productivity; and homelessness. Alcohol and illicit drug use can also result in substantial disruptions in family, work, and personal life. Alcohol abuse is associated with motor vehicle crashes, homicides, suicides, and drowning — all leading causes of death among youth. Long-term heavy drinking can lead to heart disease, cancer, alcohol-related liver disease, and pancreatitis. Alcohol use during pregnancy is known to cause fetal alcohol syndrome, a leading cause of preventable mental retardation.[1]

Healthy People 2010 Objective (26-3): Reduce drug induced deaths.

Healthy People 2020 Objective SA HP2020-12: Reduce drug induced deaths.

Most Recent NV Value (2008)	U.S. (2006)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
16.5	12.7	1.2	11.3	Worsening

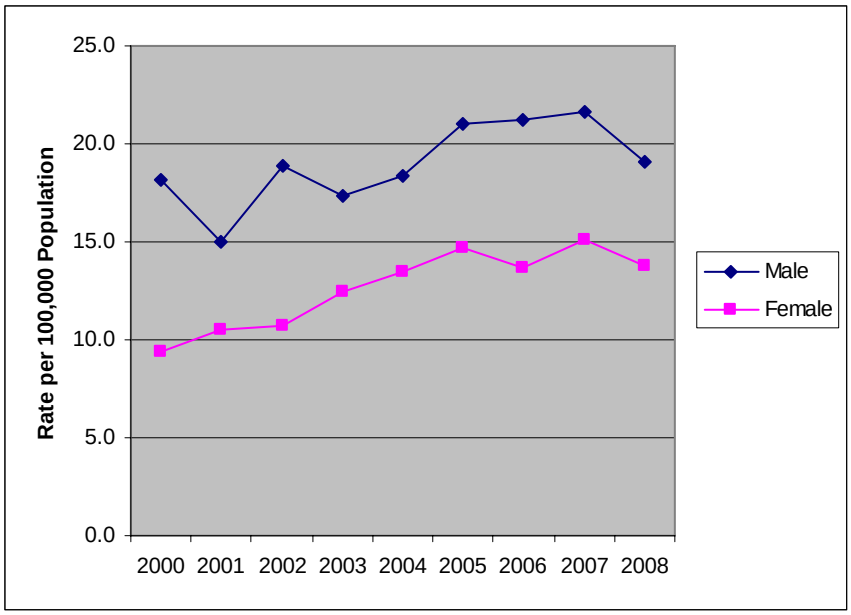
Age-Adjusted Drug Induced Death Rate, Nevada Residents and United States, 2000 - Most Current Data.*



From 2000 to 2008, Nevada exceeded the United States in the number of drug induced deaths.
Neither region met the Healthy People 2010 target of 1.2 per 100,000 people in the reported years.

*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records, and the U.S. data are from the National Vital Statistics System– Mortality.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: See appendix for additional information.

Age-Adjusted Drug Induced Death Rate, Nevada Residents by Gender, 2000 - 2008.*

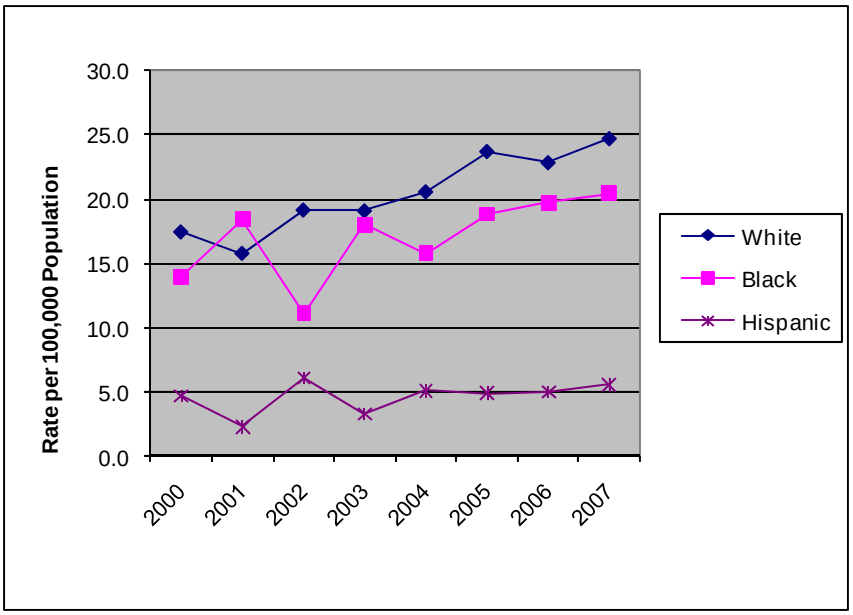


In Nevada, males consistently had a higher rate of drug induced deaths than females from 2000 to 2008.

Age-Adjusted Drug Induced Death Rate, Nevada Residents by Race/Ethnicity, Nevada 2000 - 2007.*

In Nevada, the drug induced death rate was highest among Whites from 2004 to 2007.

Hispanics had a much lower rate of drug induced deaths than Whites or Blacks from 2000 to 2007.



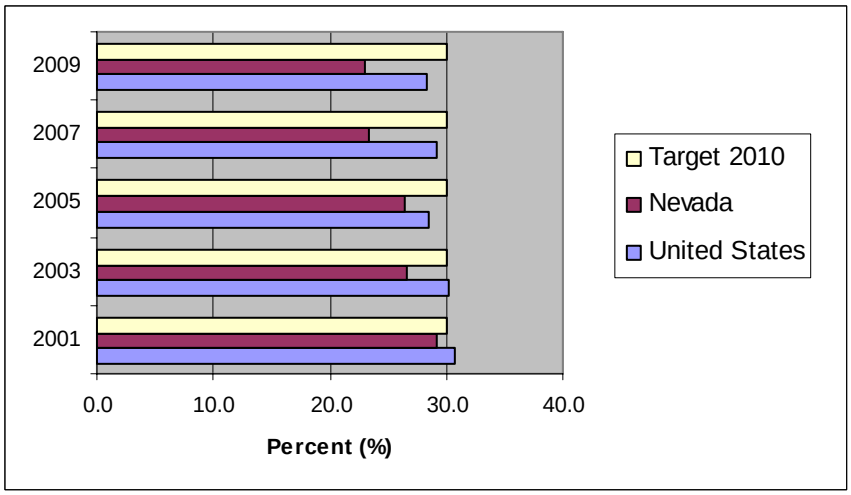
*These rates are age-adjusted to the 2000 U.S. standard population. The Nevada data are from Nevada Vital Statistics Records.
Note: 2007 and 2008 Nevada data are not final and are subject to change.
Note: Data not available for the Native American and Asian race/ethnicity groups due to small counts.

Healthy People 2010 Objective (26-6): Reduce the proportion of adolescents who report they rode, during the previous 30 days with a driver who had been drinking alcohol.

Healthy People 2020 Objective SA HP2020-1: Reduce the proportion of adolescents who report they rode, during the previous 30 days, with a driver who had been drinking alcohol.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
23.0	28.3	30.0	25.5	Surpassed

Proportion of Adolescents, Grades 9-12, Who Report They Rode During the Previous 30 Days, With a Driver Who had Been Drinking Alcohol, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

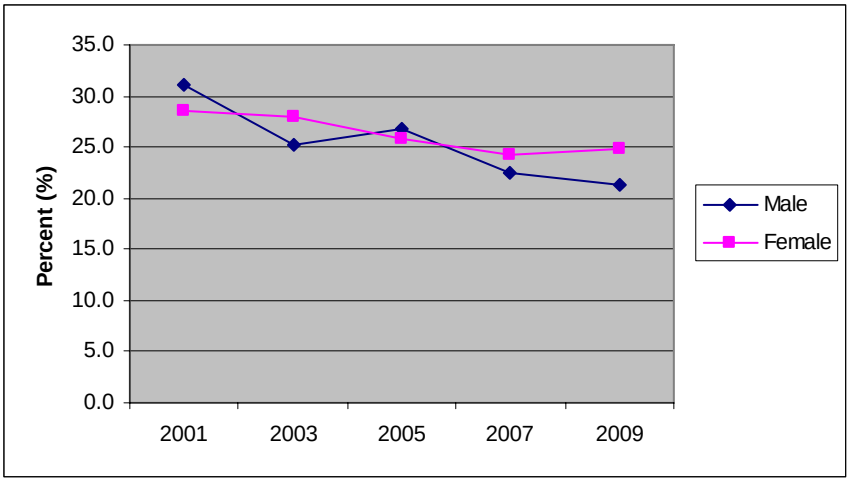


While Nevada consistently reached the Healthy People 2010 Target since 2001, in 2009, over 20 percent of Nevada adolescents, grades 9-12, reported riding in a car with a driver who had been drinking alcohol.

According to the Youth Risk Behavior Surveillance System (YRBSS), female adolescents were more likely to report riding in a car with a driver that had been drinking alcohol, than male adolescents in 2007 and 2009.[2]

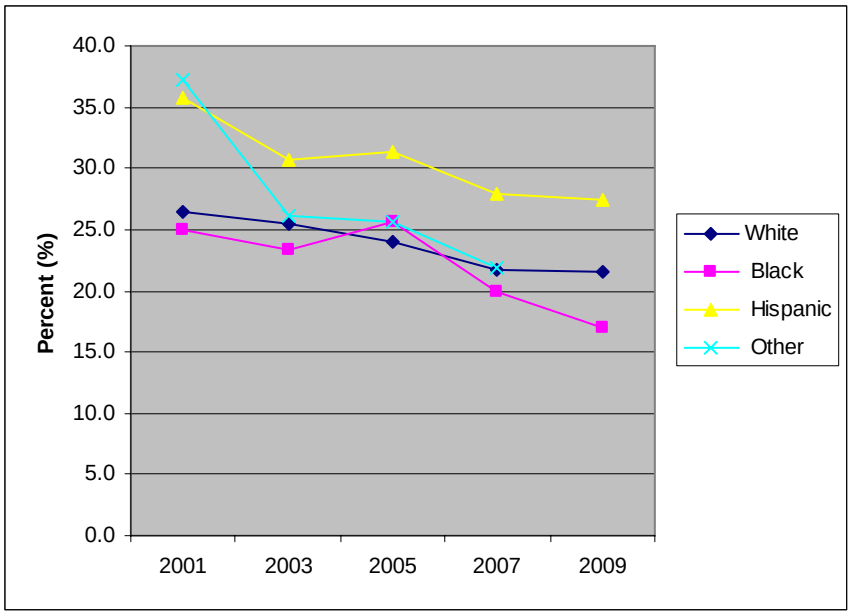
This proportion decreased among both genders from 2001 to 2009.

Proportion of Adolescents, Grades 9-12, Who Report They Rode During the Previous 30 Days, With a Driver Who had Been Drinking Alcohol, Nevada Residents by Gender, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



*Individual county data not available.

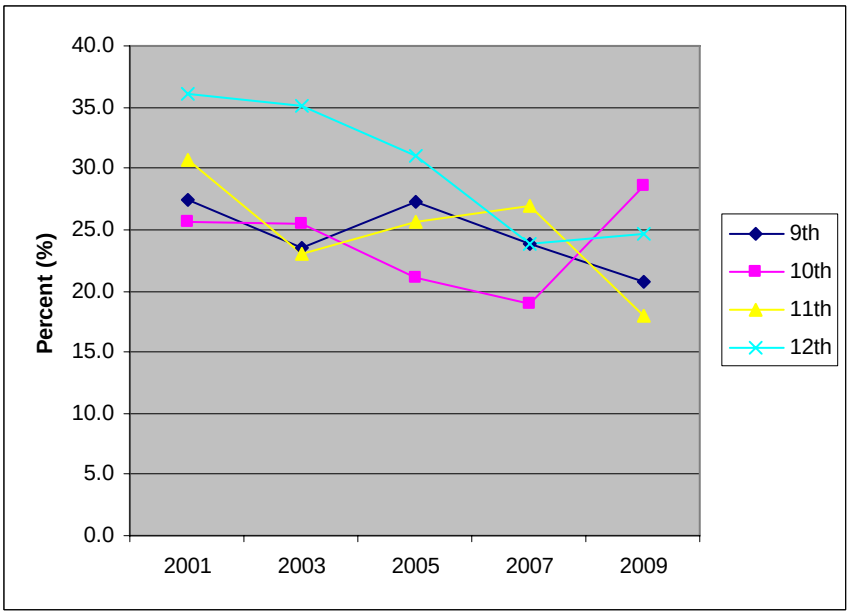
Proportion of Adolescents, Grades 9-12, Who Report They Rode During the Previous 30 Days, with a Driver Who had Been Drinking Alcohol, Nevada Residents by Race/Ethnicity, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



From 2001 to 2009, Nevada saw an overall decrease in the proportion of adolescents who reported they rode in a car with a driver who had been drinking alcohol, for all race/ethnicity groups.

Proportion of Adolescents, Grades 9-12, Who Report They Rode During the Previous 30 Days, with a Driver Who had Been Drinking Alcohol, Nevada Residents by Grade, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

According to the Youth Risk Behavior Surveillance System (YRBSS), the proportion of 10th grade students who reported that they rode in a car with a driver who had been drinking, increased 10 percent (19 percent to 29 percent) from 2007 to 2009, while overall decreases were seen among all other grades from 2001 to 2009.[2]



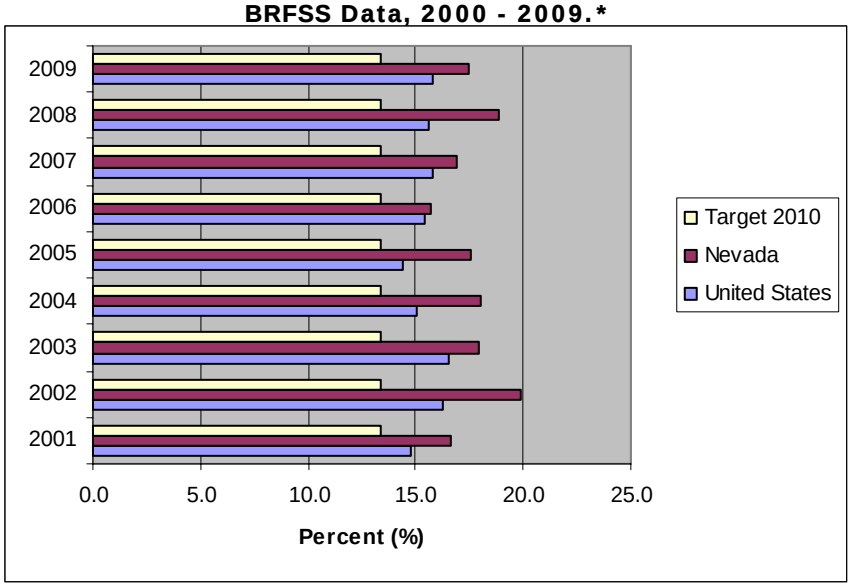
*Individual county data are not available.

Healthy People 2010 Objective (26-11c.): Reduce the proportion of adults, aged 18 years and older, engaging in binge drinking of alcohol.

Healthy People 2020 Objective SA HP2020-14.3: Reduce the proportion of adults, aged 18 years and older, engaging in binge drinking of alcohol.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
17.5	15.8	13.4	24.3	Fluctuating

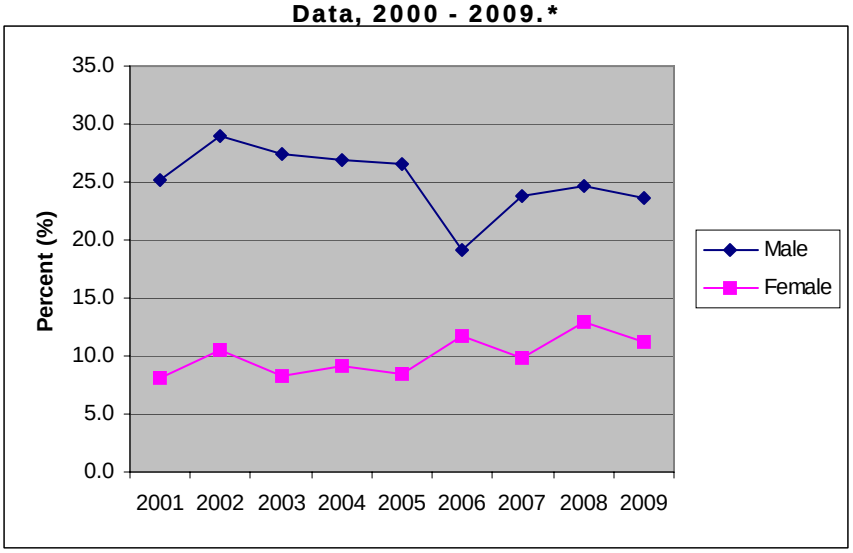
Proportion of Adults Aged 18 Years and Older Engaging in Binge Drinking Alcohol, Nevada Residents and United States, BRFSS Data, 2000 - 2009.*



Nationally the proportion of adults who engage in binge drinking of alcohol remained steady from 2007 to 2009. This proportion, among Nevada adults, was consistently higher than the United States from 2000 to 2009. The Healthy People 2010 target has not been met by either region.

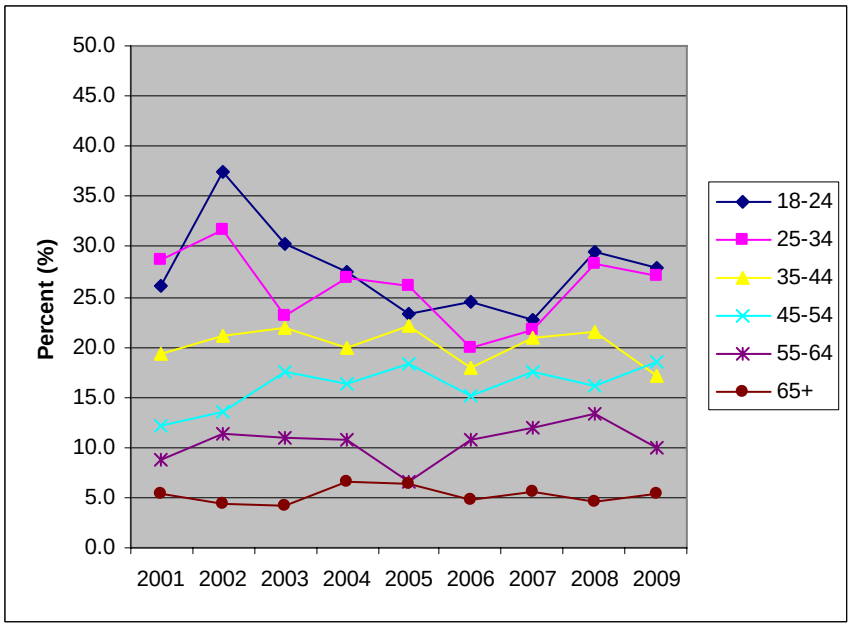
Proportion of Adults Aged 18 Years and Older Engaging in Binge Drinking Alcohol, Nevada Residents by Gender, BRFSS Data, 2000 - 2009.*

The proportion of Nevada adult males, aged 18 and older, who engage in binge drinking alcohol was higher than the proportion of Nevada adult females, aged 18 and older, who engage in binge drinking alcohol from 2001 to 2009.



*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of Adults Aged 18 Years and Older Engaging in Binge Drinking Alcohol, Nevada Residents by Age, BRFSS Data, 2000 - 2009.*

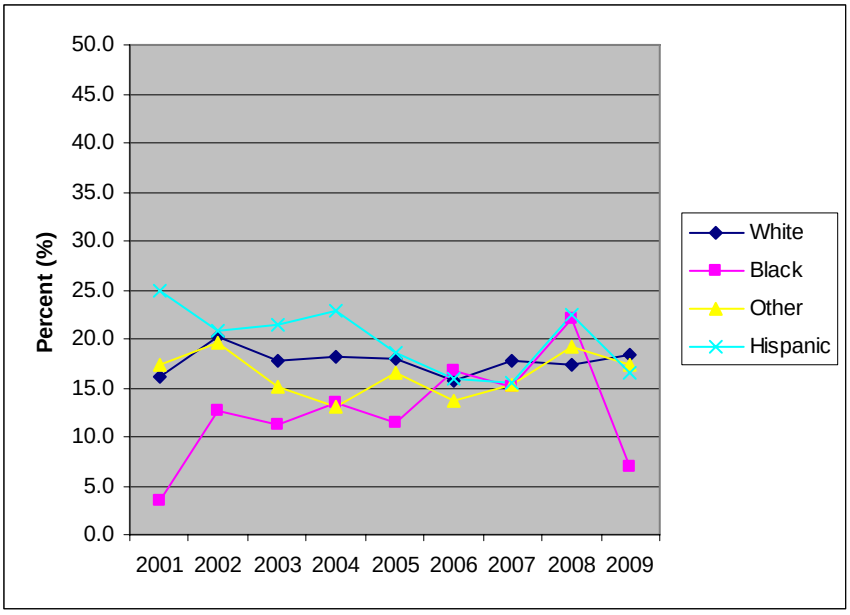


Nevada residents who are 65 years and older had the lowest proportion of people engaging in binge drinking from 2001 to 2009.

The age groups 18 to 24 years old and 25 to 34 years old have consistently had the highest proportion of Nevada residents who engage in binge drinking.

In 2008, there were 107 Nevadans killed in Alcohol-Impaired Driving Accidents. Of these fatalities, 11 were under the age of 21.[3]

Proportion of Adults Aged 18 Years and Older Engaging in Binge Drinking Alcohol, Nevada Residents by Race/Ethnicity, BRFSS Data, 2000 - 2009.*



In 2009, 18.5 percent of White Nevada residents, 6.9 percent of Black Nevada residents, 16.6 percent of Hispanic Nevada residents, and 17.3 percent of Nevada residents reporting 'Other' for race/ethnicity engaged in binge drinking of alcohol.

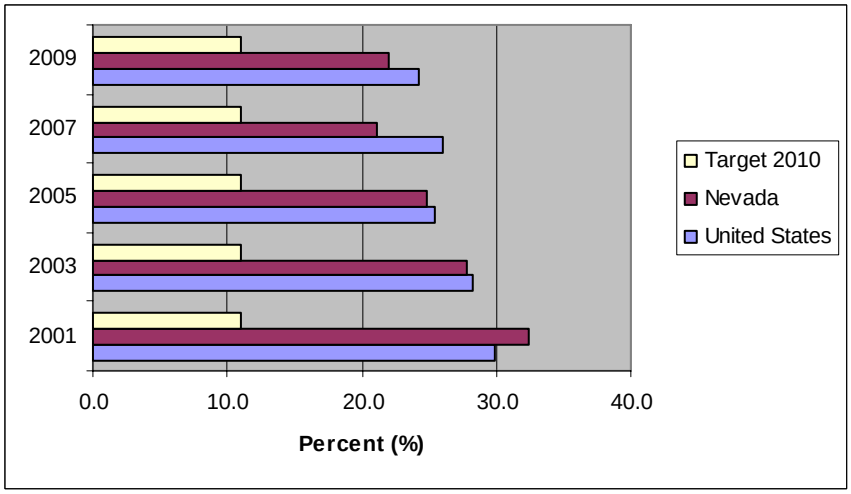
*These percentages are weighted to survey population characteristics.

Healthy People 2010 Objective (26-11d.): Reduce the proportion of adolescents, aged 12 to 17 years, engaging in binge drinking of alcohol.

Healthy People 2020 Objective SA HP2020-14.4: Reduce the proportion of adults and adolescents engaging in binge drinking of alcohol beverages during the past month: adolescents aged 12 to 17 years.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
22.0	24.2	3.1	8.5	Improving

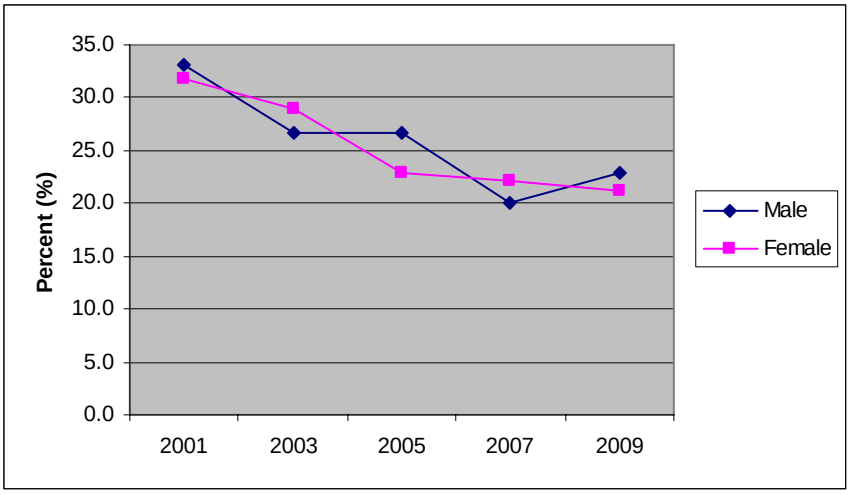
Proportion of Adolescents, Grades 9-12, Who Reported Having Five or More Drinks of Alcohol in a Row Within a Couple Hours, in the Past 30 Days, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



From 2001 to 2009, Nevada experienced a 10 percent decrease (32 percent to 22 percent) in the proportion of adolescents who engage in binge drinking.

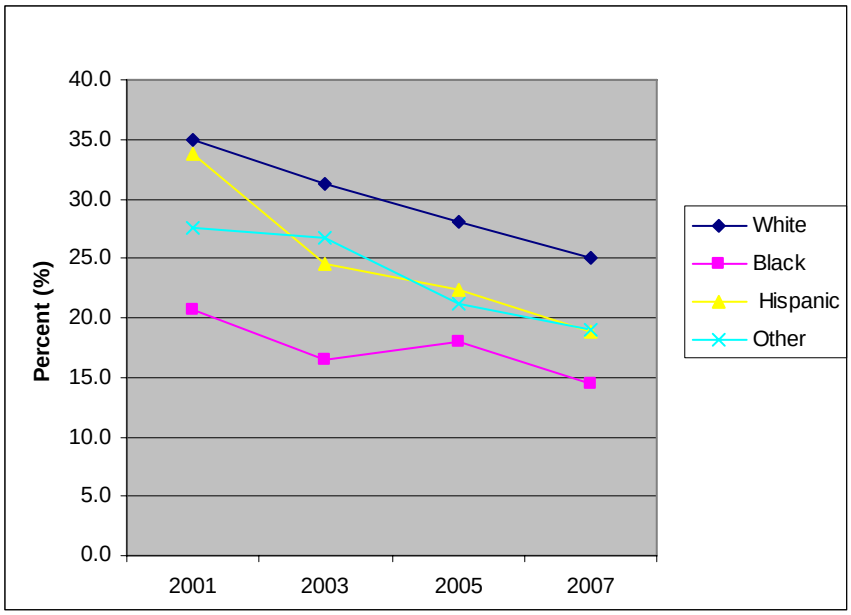
Proportion of Adolescents, Grades 9-12, Who Reported Having Five or More Drinks of Alcohol in a Row Within a Couple Hours, in the Past 30 Days, Nevada Residents by Gender, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

According to the Youth Risk Behavior Surveillance System (YRBSS), binge drinking decreased among both male and female adolescents in Nevada from 2001 to 2009.[2]



*Individual county data are not available.

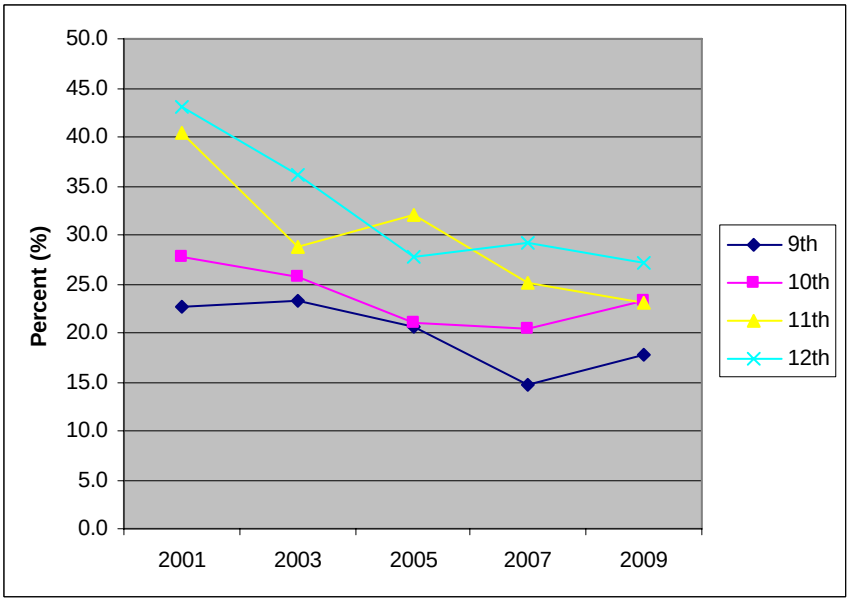
Proportion of Adolescents, Grades 9-12, Who Reported Having Five or More Drinks of Alcohol in a Row Within a Couple Hours in the Past 30 Days, Nevada Residents by Race/Ethnicity, YRBSS Data, 2001, 2003, 2005, 2007.*



Overall, binge drinking decreased among adolescents in Nevada for all race/ethnicity groups from 2001 to 2007.

Proportion of Adolescents, Grades 9-12, Who Reported Having Five or More Drinks of Alcohol in a Row Within a Couple Hours in the Past 30 Days, Nevada Residents by Grade, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

According to the Youth Risk Behavior Surveillance System (YRBSS), in 2009, binge drinking was most prevalent among adolescents in the 12th grade.[2]



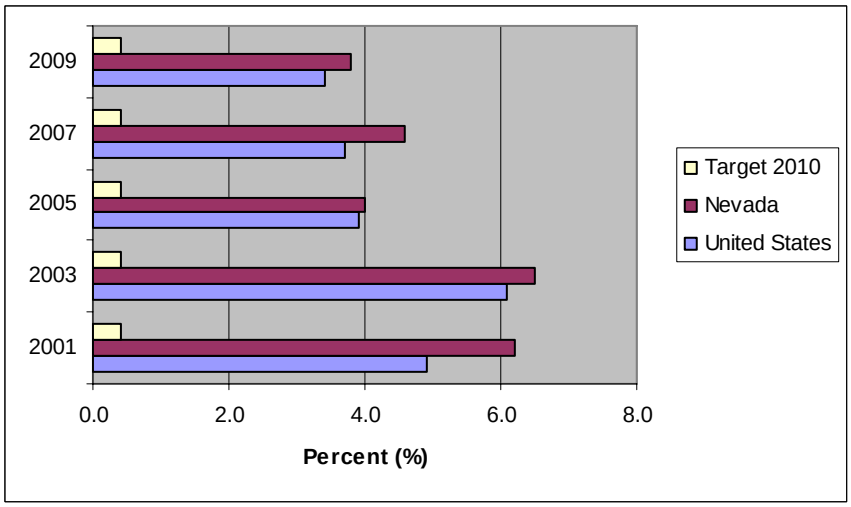
*Individual county data are not available.

Healthy People 2010 Objective (26-14b.): Reduce steroid use among adolescents, in the 10th grade.

Healthy People 2020 Objective SA HP2020-18.2: Reduce steroid use among adolescents, in the 10th grade.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
3.8	3.4	0.4	N/A	Improving

Proportion of Adolescents in the 10th Grade, Reporting Steroid Use, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

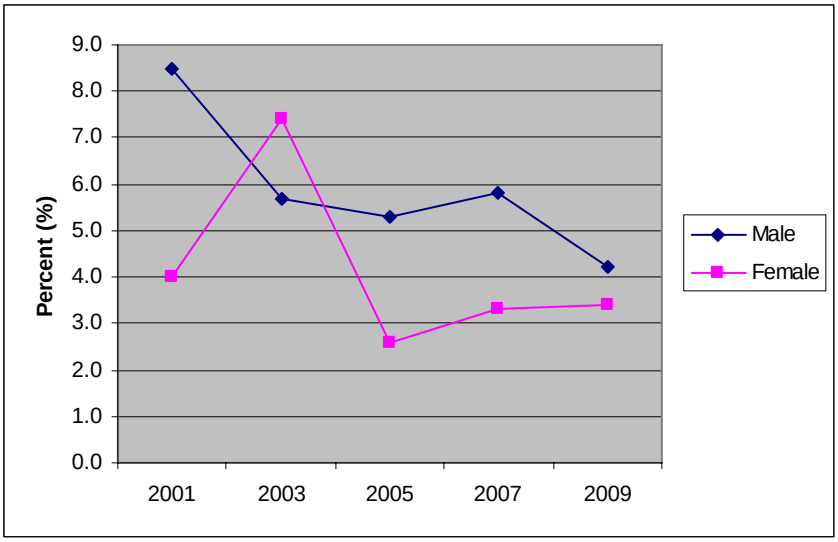


According to the Youth Risk Behavior Surveillance System (YRBS), Nevada 10th graders report more steroid use compared to 10th grade students in the United States.[2] Neither region met the Healthy People 2010 target anytime from 2002 to 2009.

Steroid use for 10th graders overall declined from 2003 to 2009.

Proportion of Adolescents in the 10th Grade, Reporting Steroid Use, Nevada Residents by Gender, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

From 2001 to 2009, Nevada experienced a decrease in the proportion of male adolescents in the 10th grade who report steroid use.



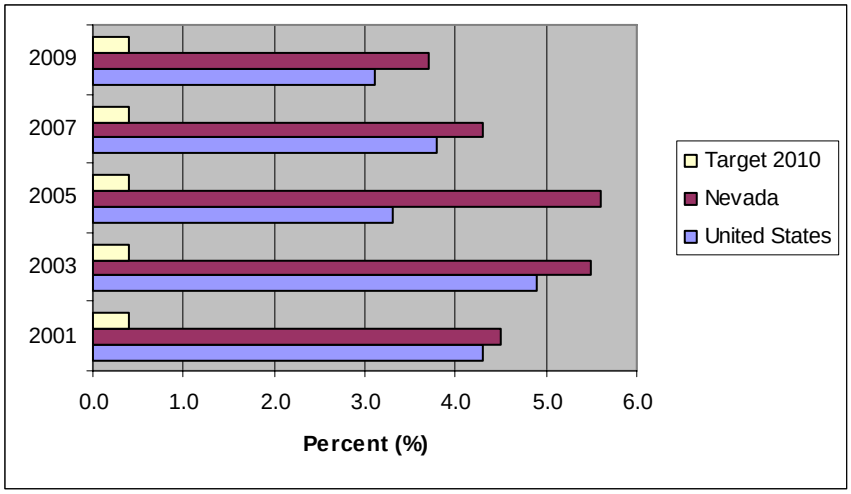
*Individual county data are not available.

Healthy People 2010 Objective (26-14c.): Reduce steroid use among adolescents in the 12th grade.

Healthy People 2020 Objective SA HP2020-18.3: Reduce steroid use among adolescents in the 12th grade.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
3.7	3.1	0.4	N/A	Improving

Proportion of Adolescents in the 12th Grade, Reporting Steroid Use, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



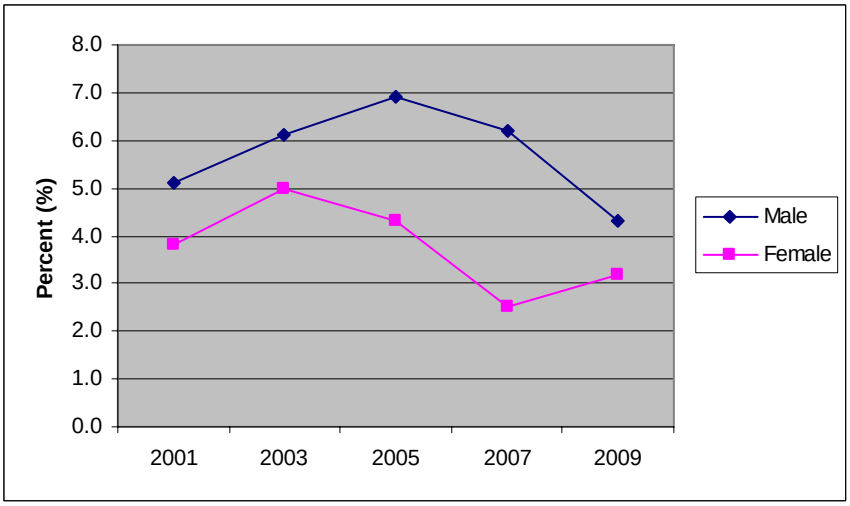
According to the Youth Risk Behavior Surveillance System (YRBSS), Nevada 12th graders report more steroid use than 12th grade students in the United States.[2]

In Nevada, the use of steroids by 12th graders declined from 2005 to 2009.

While male 12th graders had a decrease in steroid use from 2005 to 2009, steroid use among female 12th graders has slightly increased since 2007.

From 2001 to 2009 there was a higher proportion of male 12th graders who reported using steroids than female 12th graders.

Proportion of Adolescents in the 12th Grade, Reporting Steroid Use, Nevada Residents by Gender, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



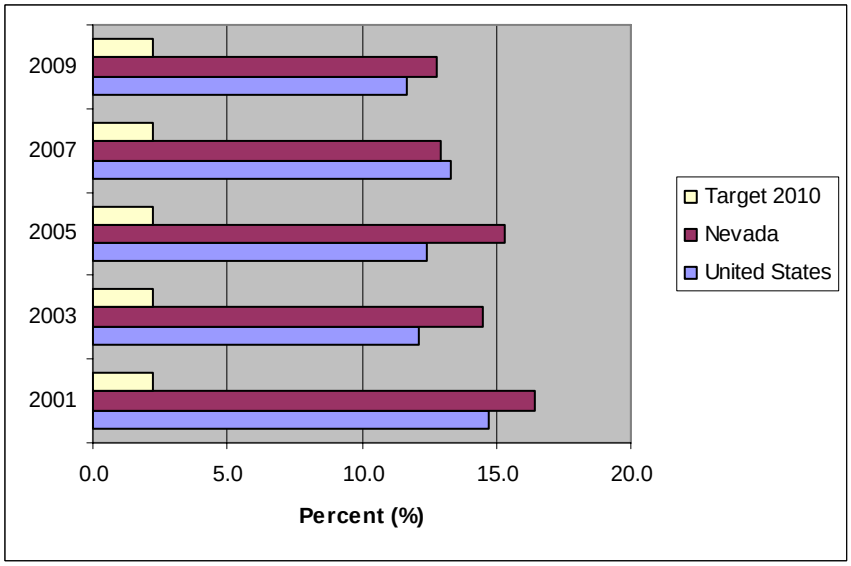
*Individual county data are not available.

Healthy People 2010 Objective (26-15): Reduce the proportion of adolescents who use inhalants.

Healthy People 2020 Objective SA HP2020-21: Reduce the proportion of adolescents who use inhalants.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
13.0	12.0	2.2	N/A	Improving

Proportion of Adolescents, Grades 9-12, Who Reported Using Inhalants During Their Lifetime, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

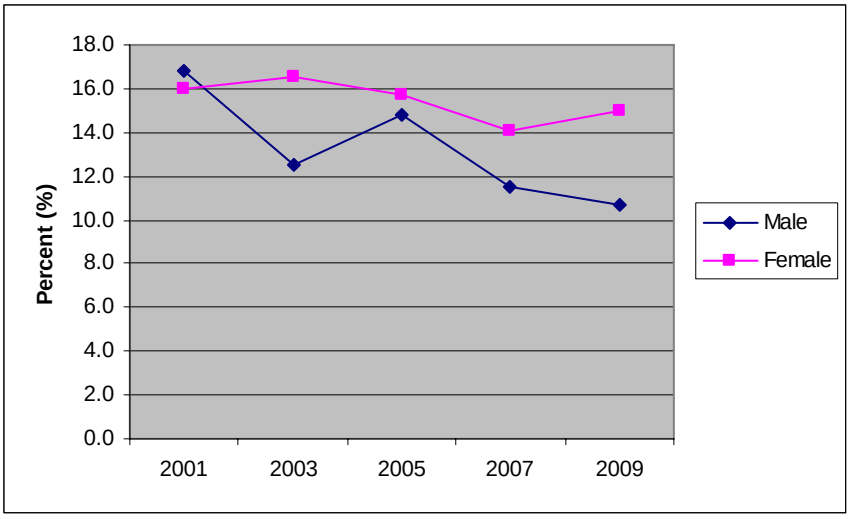


From 2001 to 2009, Nevada had a slight decrease in the percentage of adolescents reporting ever using inhalants.

According to the Youth Risk Behavior Surveillance System (YRBSS), inhalant use was more common among female adolescents in Nevada from 2003 to 2009.[2]

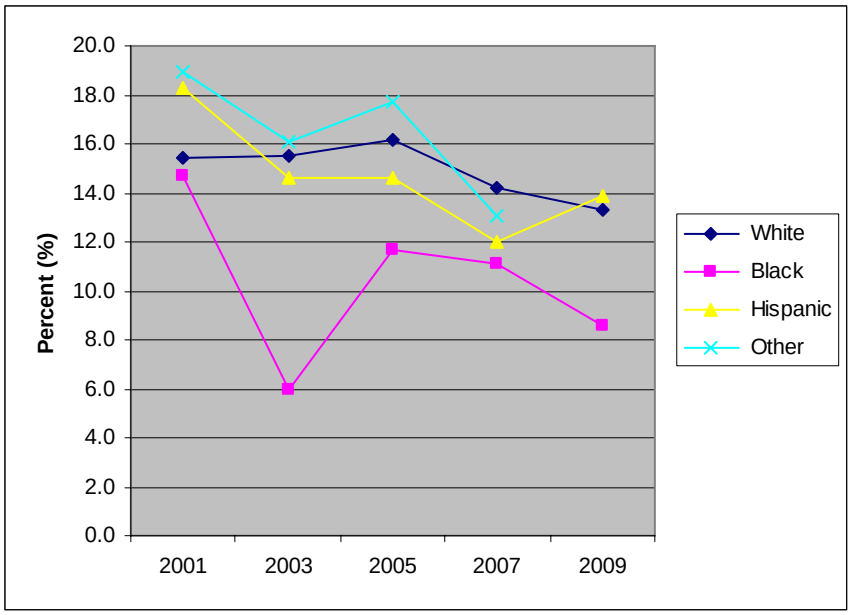
The proportion of male adolescents, in grades 9 through 12, who report ever using inhalants decreased from 2001 to 2009.[2]

Proportion of Adolescents, Grades 9-12, Who Reported Using Inhalants During Their Lifetime, Nevada Residents by Gender, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



*Individual county data are not available.

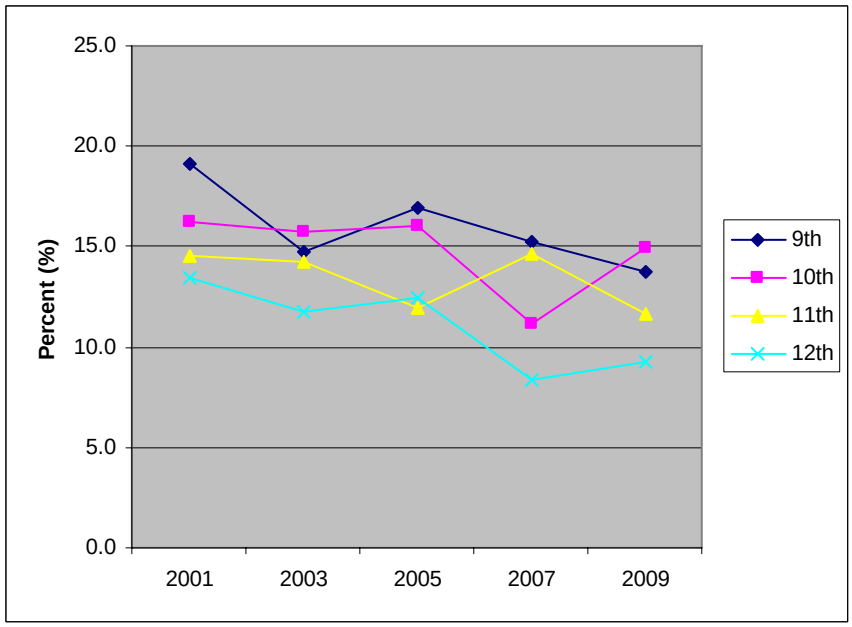
Proportion of Adolescents, Grades 9-12, Who Reported Using Inhalants During Their Lifetime, Nevada Residents by Race/ Ethnicity, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



In 2001, 15 percent of Black adolescents reported using inhalants, which decreased to 9 percent, in 2009. In general, the proportion of adolescents who have ever used inhalants was lowest among the Black population from 2001 to 2009.

Overall, inhalant use has decreased in all racial/ethnic groups since 2001. The rate for Hispanics increased from 2007 to 2009, after years of decline.

Proportion of Adolescents, Grades 9-12, Who Reported Using Inhalants During Their Lifetime, Nevada Residents by Grade, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



According to the Youth Risk Behavior Surveillance System (YRBSS), in 2009, 15 percent of 10th grade Nevada students reported ever using inhalants. Overall, inhalant use decreased among high school students from 2001 to 2009.[2]

*Individual county data are not available.

Tobacco Use

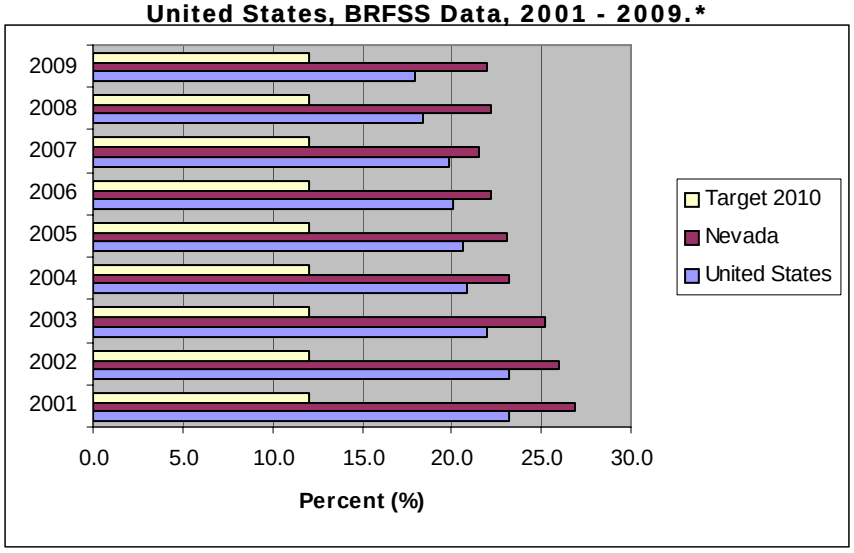
Cigarette smoking is the single most preventable cause of disease and death in the United States, accounting for approximately 443,000 deaths per year, or one in five deaths annually. Smoking is a major risk factor for heart disease, stroke, lung cancer, and chronic lung diseases; all leading causes of death in the U.S. According to the Centers for Disease Control and Prevention (CDC), 22.2 percent of Nevada adults reported smoking in 2008, compared to 18.3 percent nationwide.[1]

Healthy People 2010 Objective (27-1a.): Reduce cigarette smoking by adults.

Healthy People 2020 Objective TU HP2020-1.1: Reduce tobacco use by adults – cigarette smoking.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
22.0	17.9	12.0	12.0	Improving

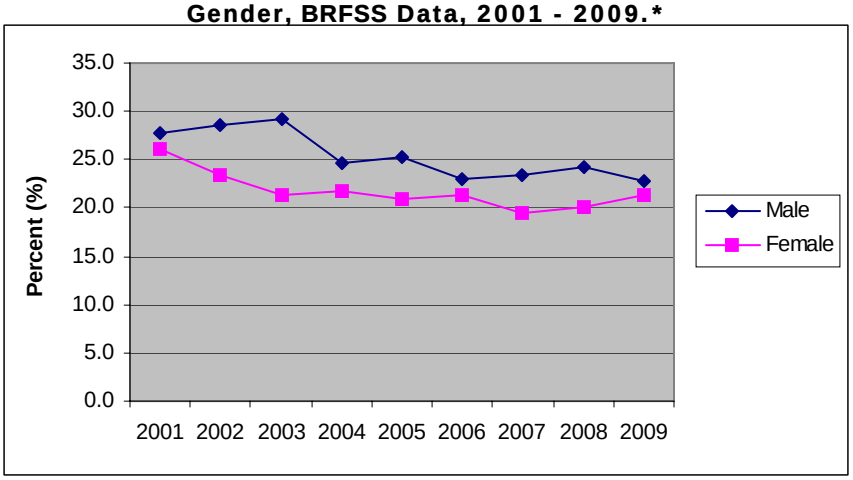
Proportion of Cigarette Smoking Adults, Nevada Residents and United States, BRFSS Data, 2001 - 2009.*



It is estimated that 22.0 percent of Nevada adults smoked in 2009. Although this value is slightly higher than the U.S. proportion of 17.9 percent, smoking in Nevada declined from 2001 to 2009, when 26.9 percent of Nevada adults were smokers. Neither the state, nor the U.S., met the Healthy People 2010 target of 12.0 percent from 2001 to 2009.

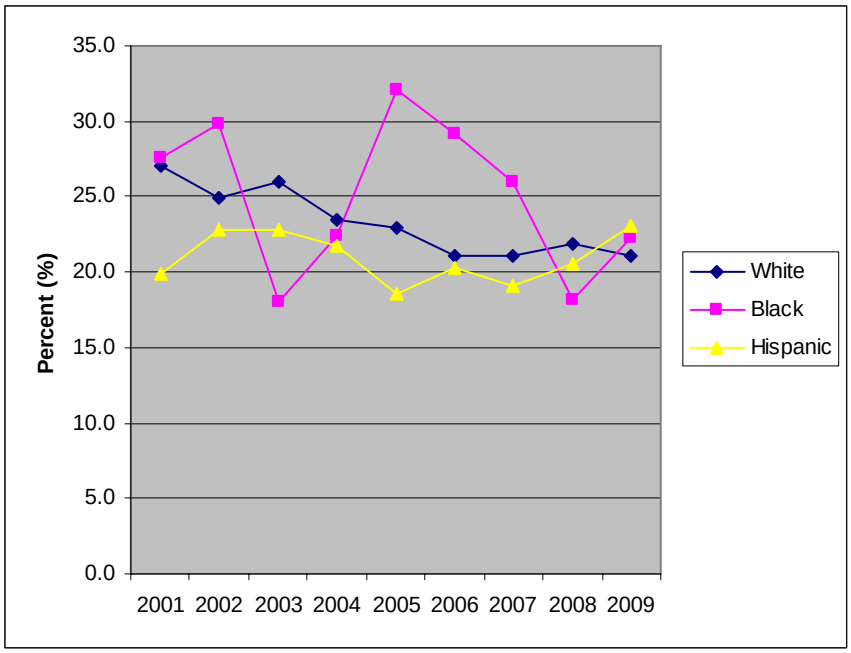
Proportion of Cigarette Smoking Adults, Nevada Residents by Gender, BRFSS Data, 2001 - 2009.*

Tobacco use was higher among Nevada males than Nevada females from 2001 to 2009. Among both genders, however, the percentage of cigarette smoking adults de-creased from 2001 to 2009.



*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of Cigarette Smoking Adults, Nevada Residents by Race/Ethnicity, BRFSS Data, 2001 - 2009.*

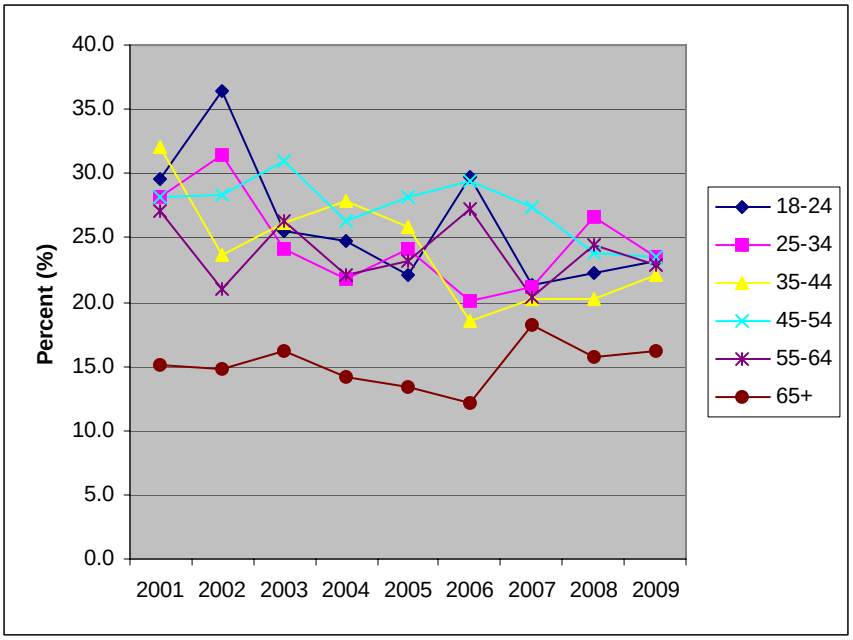


In 2009, Whites, Blacks, and Hispanics, all had fairly close proportions of people who smoked, at 21.1, 22.3, and 23.0 percent respectively.

There was an overall decrease in the proportion of White Nevada residents who smoke, decreasing from a high of 27.1 percent in 2001.

Proportion of Cigarette Smoking Adults, Nevada Residents by Age, BRFSS Data, 2001 - 2009.*

Nevada residents aged 65 years and older had the lowest proportion of cigarette smoking adults from 2001 to 2009, when compared to other age groups.



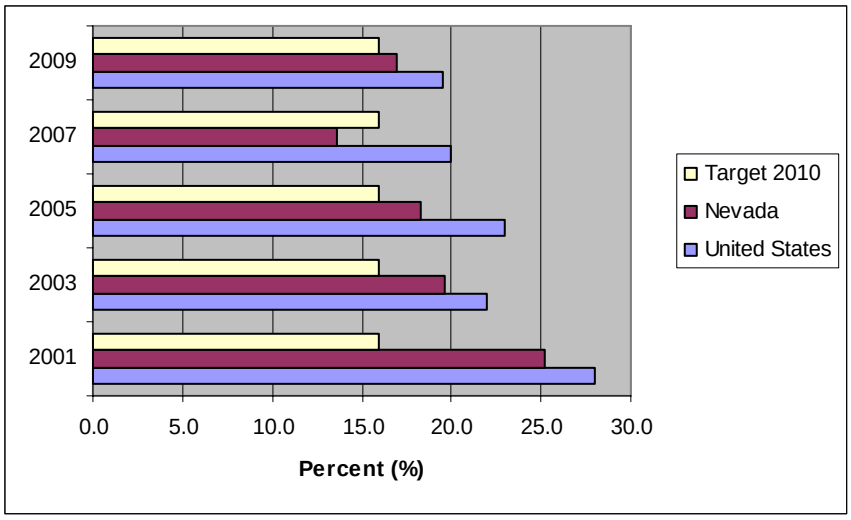
*These percentages are weighted to survey population characteristics.
Note: Data not available for the Other race/ethnicity group due to small counts.

Healthy People 2010 Objective (27-2b.): Reduce the proportion of adolescents, grades 9-12, reporting cigarette use in the past month.

Healthy People 2020 Objective TU HP2020-2.2: Reduce tobacco use (cigarettes) by adolescents in the past month.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
17.0	19.5	16.0	16.0	Fluctuating

Proportion of Adolescents, Grades 9-12, Reporting Cigarette Use in the Past Month, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

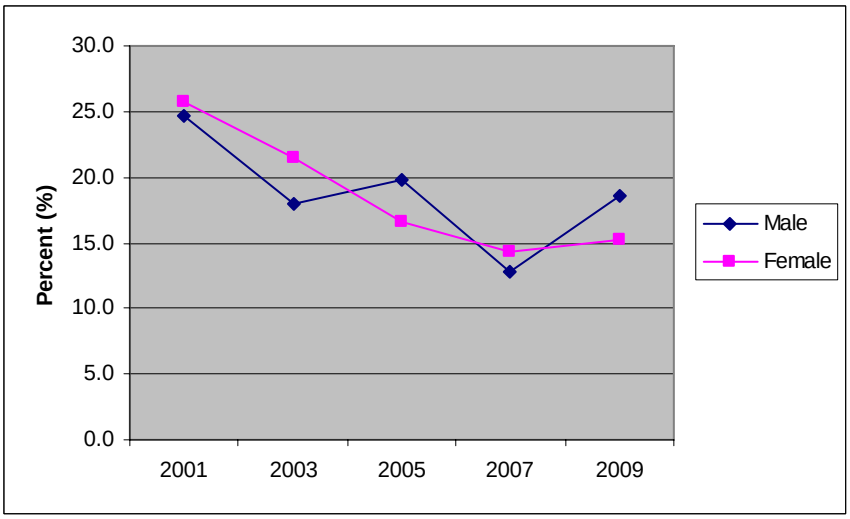


From 2001 to 2007, Nevada saw a decrease in the proportion of adolescents reporting cigarette use, however, in 2009, Nevada saw an increase in the proportion of adolescents reporting cigarette use in the past month.

According to the Youth Risk Behavior Surveillance System (YRBSS), female adolescents were less likely to report using cigarettes in the past month than males in 2009.[2]

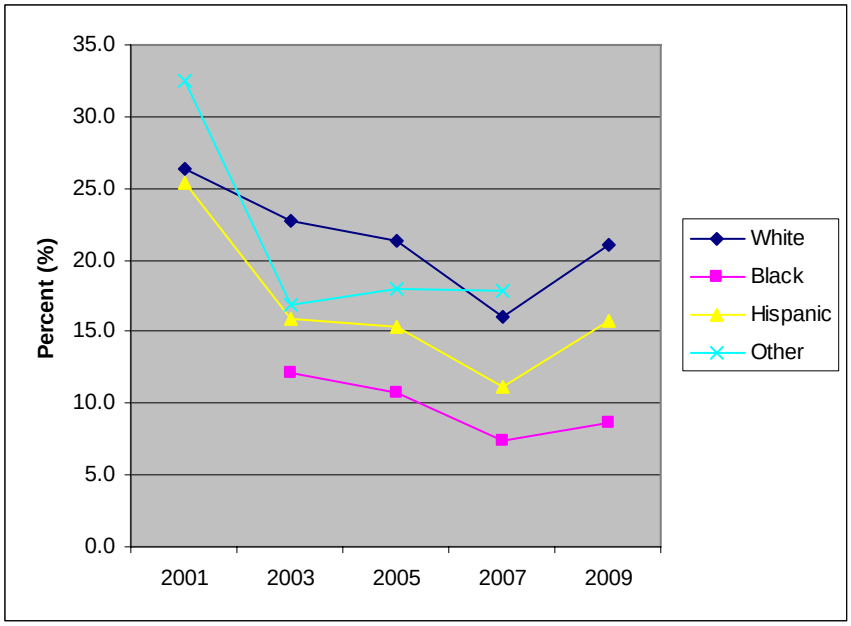
The proportion of adolescents, grades 9 through 12, who report cigarette use in the past month has decreased overall for both genders from 2001 to 2009.

Proportion of Adolescents, Grades 9-12, Reporting Cigarette Use in the Past Month, Nevada Residents by Gender, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*



*Individual county data are not available.

Proportion of Adolescents, Grades 9-12, Reporting Cigarette Use in the Past Month, Nevada Residents by Race/Ethnicity, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

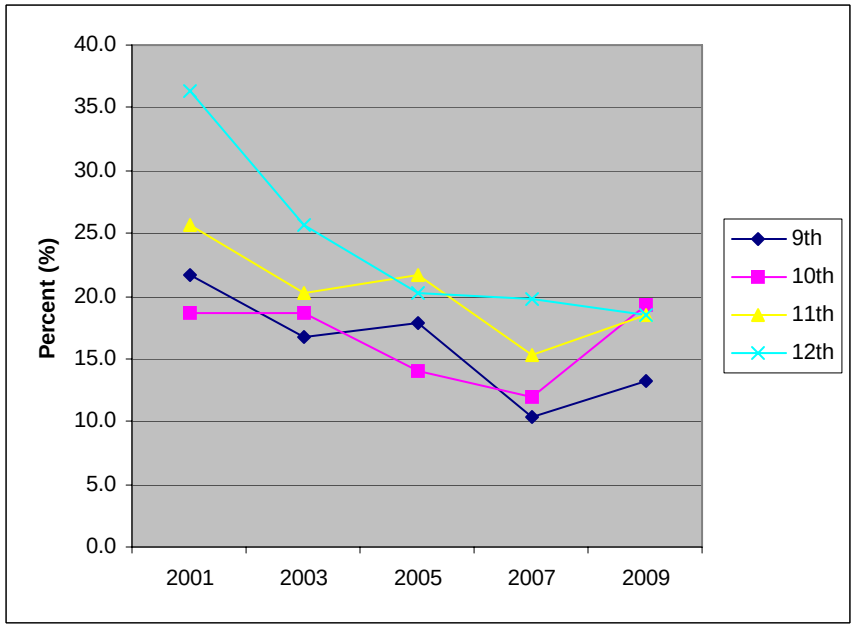


In 2001, over 25 percent of White and Hispanic adolescents reported using cigarettes in the past month, which decreased by 5 percent for Whites and nearly 10 percent for Hispanics, by 2009.[2]

Proportion of Adolescents, Grades 9-12, Reporting Cigarette Use in the Past Month, Nevada Residents by Grade, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

According to the Youth Risk Behavior Surveillance System (YRBSS), adolescents in the 12th grade reported cigarette use more often than students in grades 9 through 11 in 2001, 2003, and 2007.[2]

In 2009 the proportion of adolescents reporting cigarette use in 10th, 11th, and 12th grades were similar.



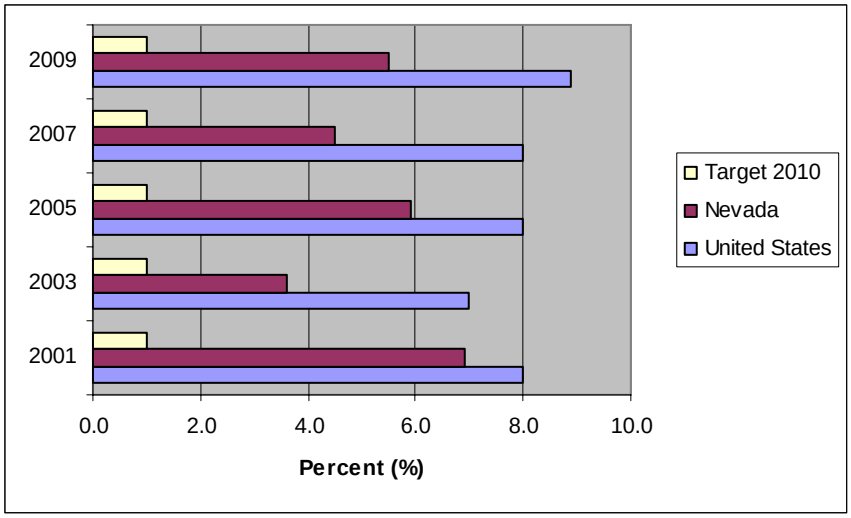
*Individual county data are not available.
Note: Data not available for the Black race/ethnicity group for the year 2001 or for the Other race/ethnicity group for 2009 due to <100 respondents.

Healthy People 2010 Objective (27-2c.): Reduce the proportion of adolescents, grades 9-12, reporting spit tobacco use in the past month.

Healthy People 2020 Objective TU HP2020-2.3: Reduce tobacco use (smokeless tobacco products) by adolescents in the past month.

Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
6.0	9.0	1.0	6.9	Fluctuating

Proportion of Adolescents, Grades 9-12, Reporting Smokeless Tobacco Use in the Past Month, Nevada Residents and United States, YRBSS Data, 2001, 2003, 2005, 2007, 2009.*

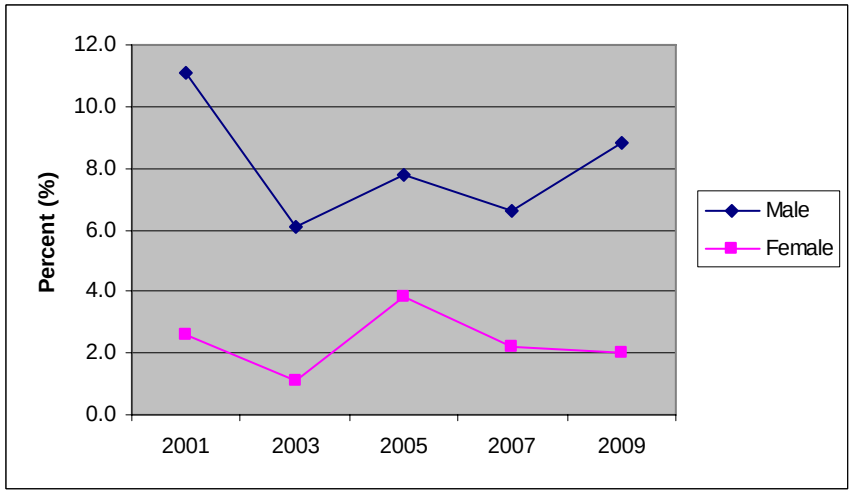


From 2001 to 2009, Nevada reported less smokeless tobacco use among adolescents compared to the United States.

Neither region met the Healthy People 210 target of 1.0 percent from 2001 to 2009, at 6.0 percent and 9.0 percent respectively in 2009.

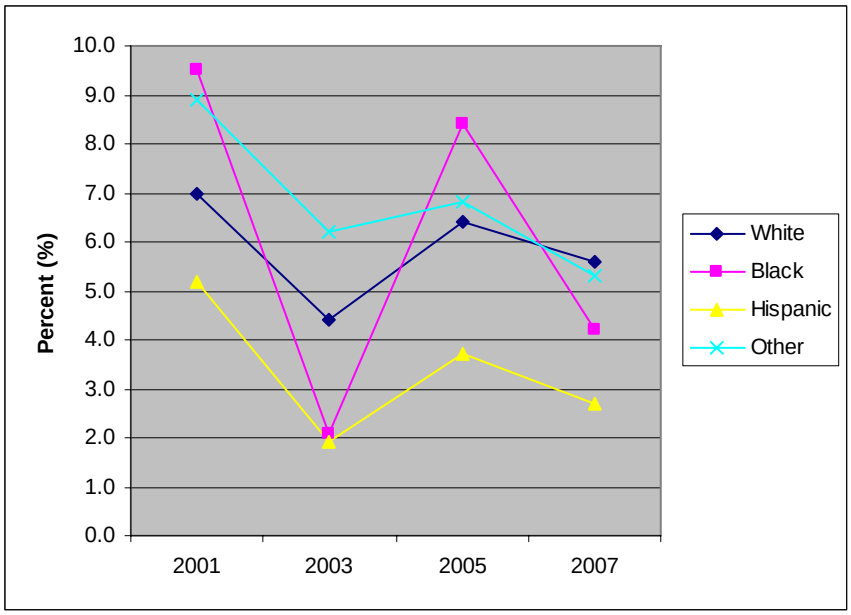
Proportion of Adolescents, Grades 9-12, Reporting Smokeless Tobacco Use in the Past Month, Nevada Residents by Gender, YBRSS Data, 2001, 2003, 2005, 2007, 2009.*

According to the Youth Risk Behavior Surveillance System (YRBSS), from 2001 to 2009, male adolescents were more likely to use smokeless tobacco than female adolescents.[2]



*Individual county data are not available.

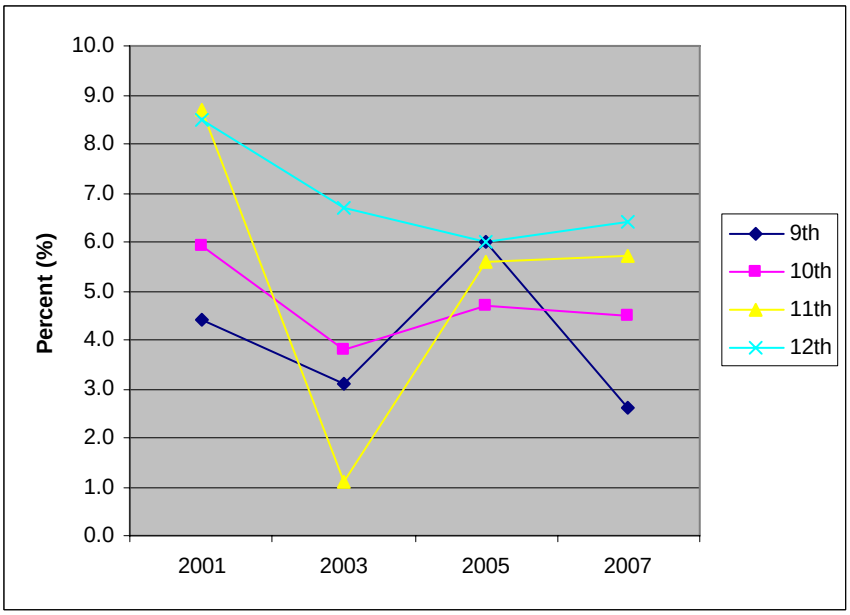
Proportion of Adolescents, Grades 9-12, Reporting Smokeless Tobacco Use in the Past Month, Nevada Residents by Race/ Ethnicity, YRBSS Data, 2001, 2003, 2005, 2007.*



In 2005, there was an increase in smokeless tobacco use among Nevada adolescents for all race/ethnicity groups, followed by a decrease among all race/ethnicities in 2007.

Proportion of Adolescents, Grades 9-12, Reporting Smokeless Tobacco Use in the Past Month, Nevada Residents by Grade, YRBSS Data, 2001, 2003, 2005, 2007.*

According to the Youth Risk Behavior Surveillance System (YRBSS), adolescents in the 12th grade reported smokeless tobacco use more often than students in grades 9 through 11 in 2007.[2]



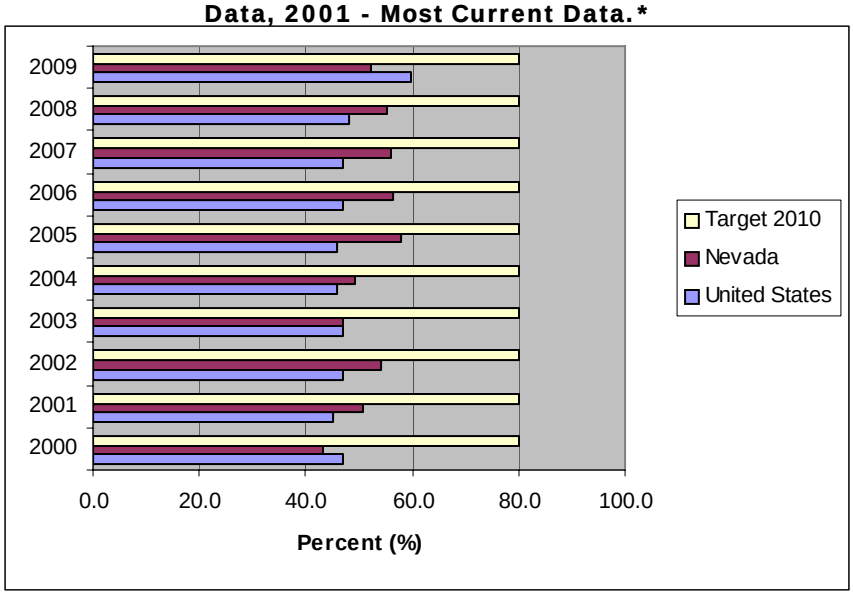
*Individual county data are not available.

Healthy People 2010 Objective (27-5.): Increase smoking cessation attempts by adult smokers.

Healthy People 2020 Objective TU HP2020-4.1: Increase smoking cessation attempts by adult smokers.

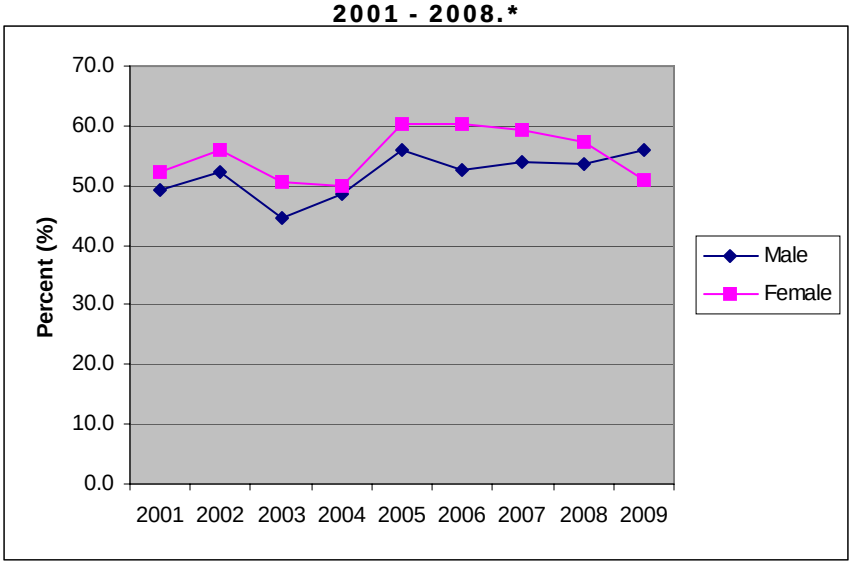
Most Recent NV Value (2009)	U.S. (2009)	HP 2010 Target	HP 2020 Target	Progress Towards Targets
53.5	59.7	80.0	80.0	Fluctuating

Proportion of Adults Reporting Smoking Cessation Attempts in the Past Year, Nevada Residents and United States, BRFSS Data, 2001 - Most Current Data.*



The proportion of Nevada adults who have reported cessation attempts was consistently higher than that of the U.S., but much lower than the Healthy People 2010 target of 80 percent from 2000 to 2009. In 2009, this proportion declined; 53.5 percent of Nevada adult smokers reported cessation attempts in the past year, compared to the national value of 59.7 percent.

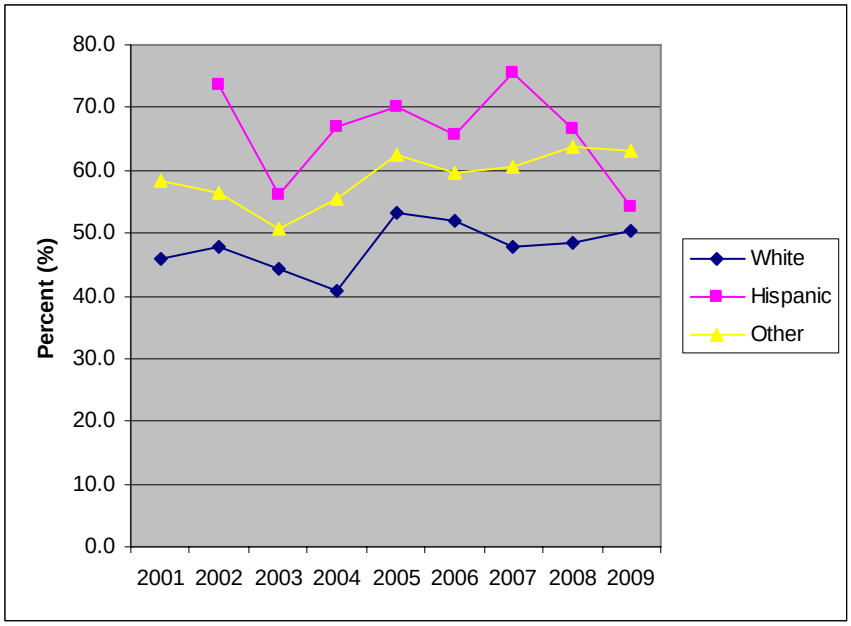
Proportion of Adults Reporting Smoking Cessation Attempts in the Past Year, Nevada Residents by Gender, BRFSS Data, 2001 - 2008.*



From 2001 to 2008, it was reported that a higher proportion of females had made cessation attempts within the past year than males. In 2009, however, more males reported cessation attempts than females.

*These percentages are weighted to survey population characteristics.
Note: See appendix for additional information.

Proportion of Nevada Adults Reporting Smoking Cessation Attempts in the Past Year, Nevada Residents by Race/ Ethnicity, BRFSS Data, 2001 - 2009.*



Whites had the lowest proportion of adults who made smoking cessation attempts among current smokers in the past year than any other race/ ethnicity group from 2001 to 2009.

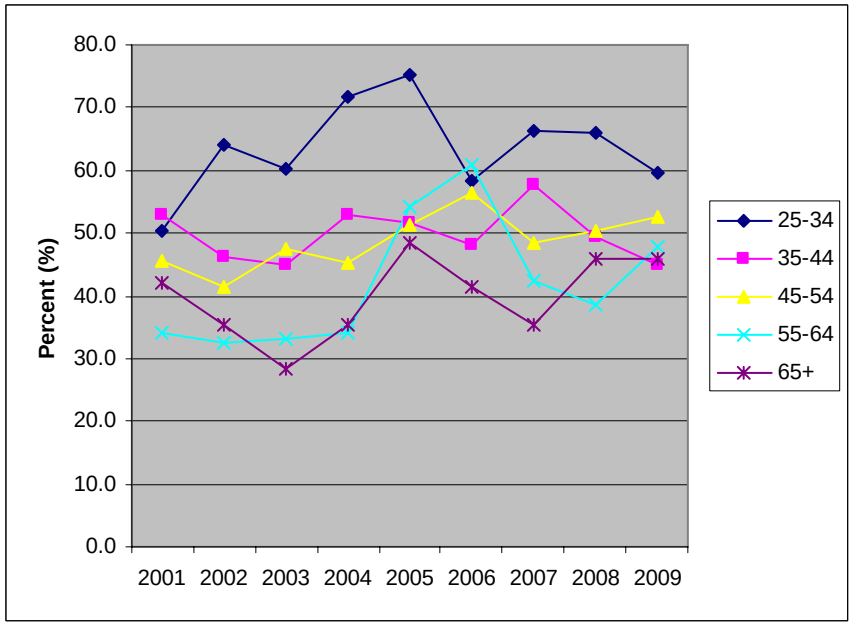
Smokers have twice the risk of fatal heart disease, ten times the risk of lung cancer, and several times the risk of cancers of the mouth, throat, esophagus, pancreas, kidney, bladder, and cervix.[4]

Smokers have four times higher risk for fractures of the hip, wrist, and vertebrae and two-fold increased risk for developing cataracts.[4]

There was no consistent increase or decrease in the percentage of Nevada adults who were current smokers reporting cessation attempts from 2001 to 2009, regardless of age group.[5]

In general, 25 to 34 year old had the highest proportion of smokers reporting cessation attempts in the past year.

Proportion of Nevada Adults Reporting Smoking Cessation Attempts in the Past Year, Nevada Residents by Age, BRFSS Data, 2001 - 2009.*



*These percentages are weighted to survey population characteristics.
Note: Data not available for the Black race/ethnicity group due to small counts and is not included in the Other race/ethnicity group.