NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

NEVADA STATE HEALTH ASSESSMENT 2022

Prepared by:

LARSON INSTITUTE
School of Public Health

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EXECUTIVE SUMMARY

Every three to five years, a State Health Assessment (SHA) is conducted to describe the health of our state. The SHA acts as a data-driven resource that describes Nevada's top health challenges as well as its health-related strengths. This report also attempts to illustrate Nevada's health as a state, compared to the rest of the country.

Since the last SHA was published in 2019, the state of Nevada has made improvements in several important measures, including:

- Reduction in teen birth rate
- Reduction in youth alcohol and tobacco use
- Reduction in rates of HIV infection

Nevada has also taken legislative steps to improve health outcomes for its residents. In 2019, the Affordable Housing Tax Credit program was implemented to subsidize impact fees to reduce the cost of constructing affordable housing in order to increase the amount of housing available for low-income individuals. To better understand the causes of maternal mortality and identify intervention opportunities, the Maternal Mortality Review Committee (MMRC) was established in 2019, and received CDC funding to increase capacity in 2021. Nevadans have other reasons to feel pride in their state, such as beautiful landscapes that provide an abundance of opportunities for recreation and access to nature.

However, Nevada has also experienced worsening health outcomes. The state's overall health ranking according to the America's Health Rankings report has fallen from 35th in the nation in 2019 to 42nd in 2022. Health measures like obesity, diabetes, opioid-related deaths, and childhood immunization rates have all worsened. Educational outcomes and the availability of affordable housing have also fallen in recent years. Finally, access to care continues to be a major problem in the state in large part due to a shortage of physicians in almost every part of the state.

It is important to note that in the time since the last SHA, Nevada has suffered the impact of the COVID-19 pandemic. In addition to the health impact of the disease itself, the pandemic has had a major impact on health outcomes in other ways. School closures forced classes online, exacerbating existing economic and behavioral health disparities among students and increasing the rate of chronic absenteeism. Business closures had a major impact on the financial status of many residents as well. While this report attempts to highlight where changes in some measures of health could be due to the COVID-19 pandemic, it is impossible to quantify exactly how much it has contributed to each measure.

In addition to compiling secondary data on a variety of state health indicators, residents of Nevada were asked to provide insight into the needs of their communities. More than 2,100 survey responses and transcripts from 125 listening tour participants were analyzed for this report. The information from this data provided further insight into health needs and disparities seen in the secondary data. Key findings include:

- Nevadans want their basic needs met, including affordable quality housing, healthy foods, healthy environments, convenient and reliable transportation, education, economic instability, and child care.

- Many residents struggle to receive health care when needed due to insurance limitations, difficulty finding providers that are taking patients, and long wait times to see their providers.

- Behavioral health care access is a major concern among Nevada residents, many of whom reported elevated levels of stress and anxiety.

- Some communities experience disproportionately worse health outcomes.

- Nevada residents know the importance of diet and exercise, but report difficulty accessing affordable, healthy food and quality exercise spaces.

SELECT DISPARITY HIGHLIGHTS

MORTALITY
In Nevada, Black/African American residents have the highest rate of years of potential life lost (YPLL). This is due to a combination of health disparities, from higher rates of maternal and infant mortality to an increased likelihood of dying from heart disease, cancer, or stroke. Rural/frontier residents in Nevada and American Indian/Alaska Native residents have higher rates of YPLL due to gun death than other groups. White Nevadan's have the highest rates of YPLL lost due to suicide of any race or ethnicity.

BEHAVIORAL HEALTH
In Nevada, Hispanic/Latino, American Indian/ Alaska Native, and Hawaiian/Pacific Islander students reported higher rates of depressive episodes and suicidal ideation than other groups. Adults in Nevada who identify as Native Hawaiian/ Pacific Islander report higher rates of poor mental health days than other racial and ethnic groups. Adults with disabilities also report significantly higher rates of depression. Adults who are Black/ African American, are less educated, and earn less money are more likely to smoke cigarettes. Native Hawaiian/Pacific Islander youth were more likely to take prescription pain medicine without a prescription or differently than instructed by their doctor, and Black/African American Nevadans are more likely to participate in non-medical drug use.

CHRONIC DISEASE
White Nevadans have a higher incidence of cancer diagnosis, but Black/African American residents are more likely to die from cancer. Low-income and low-education Nevadans are less likely to eat healthy food and exercise, which is reflected in their high rates of obesity, diabetes, and heart disease. Obesity rates are also high among White, Black/African American,and Hispanic residents. White and Black/African American residents have the highest rates of lung cancer diagnosis in the state. Nevadans with disabilities are also significantly more likely to have chronic health problems like diabetes or heart disease than residents without a disability.

ECONOMICS
Nevadans who earn less and attained lower levels of education are more likely to earn less, or earn lower incomes. LGBTQ residents report higher rates of food scarcity, more unemployment, higher uninsured rates, and lower income. Every race and ethnicity in Nevada experiences higher rates of poverty than white Nevadans, and rural/ frontier communities have lower income per capita than urban communities.

EDUCATION
In Nevada, students that are American Indian/ Alaskan Native, Black/African American, Pacific Islander, and enrolled in individualized education programs (IEP), or are on free or reduced lunches are disproportionately affected by chronic absenteeism. Black/African American students graduate from high school at lower rates than other races and ethnicities, and the American Indian/Alaska Native and Hispanic/Latino communities attain a lower level of education on average.

INTRODUCTION AND FRAMEWORK

In 2022, the Division of Public and Behavioral Health (DPBH) of Nevada's Department of Health and Human Services (DHHS) contracted with the Larson Institute within the School of Public Health at the University of Nevada, Reno (UNR), to complete a state health assessment (SHA).

The process, conducted in collaboration with many community partners and organizations, sought to better understand Nevada's most pressing health challenges. It involved collecting and analyzing key primary and secondary data from state and national sources, used data from local community health assessments, and included an extensive statewide survey and listening tour to hear directly from Nevadans.

The 2022 SHA also built on a state health assessment conducted in 2019, which found some of the state's most significant health challenges to be behavioral health, access to health care, and poverty. Based on these findings this SHA intentionally delved more deeply into these issues. Primary data collection focused on environmental and social stressors, access to care, and available social resources.

The 2022 Nevada State Health Assessment provides an overview of the overall health and wellbeing of Nevadans. It will help guide DPBH's works, as well as inform the work of various community organizations and stakeholders. This assessment lays a strong foundation for the state health improvement plan, which will help guide state and community efforts to address the issues outlined in this report.

KEY FINDINGS

HOW HEALTHY IS NEVADA?

The 2022 America's Health Rankings annual report ranked Nevada 42nd in the nation on a variety of health indicators. Indicators that Nevada was strong in include a low prevalence of excessive drinking, low occupational fatality rate, and low residential segregation. Challenges included a high prevalence of non-medical drug use, high rates of economic hardship, and poor access to care, with an especially low rate of individuals having a primary care provider. The state also saw a 34% increase in adults experiencing frequent mental distress between 2018 and 2021, and a 13% increase in the number of households below the poverty line between 2017 and 2021.

Many of these challenges are reflected in the priority areas identified in various regional health assessments (Table 1).

Table 1. Regional Health Priorities by County/Region

	Clark County	Washoe County	Quad Counties	Northern Nevada Counties	Southern Nevada Counties
1	Access to Care	Mental Health	Access to Care	Substance Use	Mental Health
2	Mental Health	Physical Activity/ Nutrition; Weight Management	Mental Health	Mental Health	Heart Disease
3	Substance Use	Chronic Disease Screenings	Nutrition	Chronic Diseases	Aging Populations

WHAT IS MOST IMPORTANT TO NEVADA RESIDENTS?

In an effort to assess the health status and opinions of Nevada residents, a community survey was conducted. Survey participants were asked if they were ever diagnosed by a healthcare professional for a variety of chronic illnesses. Overweight/obesity was the most commonly reported health problem, along with depression or anxiety.

In addition to the survey, a listening tour gathered information on the needs and priorities of communities throughout the state. Common themes of discussion were access to care, lack of affordable housing and support for low-income households, and behavioral health.

Community survey participants were asked which types of healthcare providers they needed to see in the past 12 months but could not. The greatest unmet medical needs respondents reported were to see a primary care doctor, dentist, or orthodontist.

Survey participants indicated their main barrier to accessing healthcare was the inability to make a timely appointment (43.1%), followed by finding an in-network provider (31.3%), and insurance coverage for needed services.

WHAT CONTRIBUTES TO HEALTH DISPARITIES IN NEVADA?

In Nevada, as well as every state in the nation, systems of oppression, such as racism and classism, impact access to resources and opportunities that influence the population's health. While Nevada is growing increasingly diverse, this diversity is not always reflected by the people in positions of authority and decision-making in the state. This lack of representation ensures the dominant culture continues to be the primary focus of important decisions being made, further contributing to health disparities. Increasing diversity in these positions helps highlight the needs of historically underrepresented communities in the state, increasing equity.

WHAT ASSETS DOES NEVADA HAVE TO IMPROVE HEALTH?

The individuals who participated in our community survey and listening tour were diverse, but common themes emerged. People in Nevada share an abundance of state pride and a strong sense of togetherness. Nevadans recognize how fortunate they are to live in a state with widespread access to nature and a variety of recreational opportunities. Also mentioned was a sense of community, whether from their neighborhood, school, or faith-based organizations. With these foundational strengths, Nevada is in good position to address the needs of the people and have lasting positive impacts on the residents' health outcomes.

NEVADA STATE HEALTH ASSESSMENT

DEVELOPMENT PROCESS

A state health assessment, also referred to as a community health assessment, is a systematic examination of certain indicators of health for a given state, local, or territorial community to identify and analyze its key health needs, issues, and assets. The purpose of this SHA is to develop a better understanding of the health status of Nevadans by assessing their health needs, determining the types of services they use, and identifying the barriers they face when accessing health care and related community resources.

PROJECT STEERING COMMITTEE

To guide the project, the UNR team responsible for the assessment formed a Steering Committee to provide perspectives and expertise to oversee and guide the assessments. More than 30 individuals representing a wide variety of state and local governmental entities and community-based organizations served on the Steering Committee based on their areas of interest and expertise. Steering Committee members contributed two to four hours each month from April 2022 through July 2022. Appendix A provides more information regarding Steering Committee Representation.

METHODS

This SHA utilized two complementary methods of data collection, implemented at the same time. The Community Survey and the Listening Tours are described in detail below.

THE COMMUNITY SURVEY

The first data collection instrument developed for this project was a one-time self-administered survey. The foundation of this tool was the survey instrument utilized by Washoe County Health District (WCHD) for its Community Health Assessment (CHA), which was conducted just prior to the state community health assessment.

The goal of using similar questions is to align data collected by WCHD and the state. The Steering Committee provided guidance as to which questions should be removed and added to fit the specific needs of the state health assessment. The survey instrument was available in two languages, English (Appendix B) and Spanish.

The survey was developed with Qualtrics, a web-based survey that meets requirements for accessibility for third-party screen readers. All questions met accessibility requirements. The survey was made available online on May 6, 2022 and remained active for 6-weeks, closing on June 17, 2022. This survey was made publicly available utilizing Facebook Ads and was also provided in print at two locations: Sierra Nevada Health Center in Carson City and West Flamingo Senior Center in Las Vegas. Individuals who completed the survey, were entered into a raffle to win a $50 electronic gift card. In order to participate in the survey, participants had to currently reside in Nevada and be 18 years of age or older.

At the closure of the online survey, there were 3,738 survey entries. The raw data was downloaded from Qualtrics and some responses were eliminated using the criteria outlined here:

1. Progress at 59% or less: 486 entries removed
2. Duration less than 100 seconds: 24 entries removed
3. IP Address with more than 10 entries, 122 entries removed
4. Duplicates (based on First and Last Names) were removed, unusual names and email addresses: 919 entries removed

After the data cleaning process, 2,187 survey entries were used for analysis. Basic frequencies were run using SPSS to determine the prevalence of the indicator. Subgroup analysis was completed using a chi-squared test to see if there were any significant differences in the prevalence of indicators. For full details on methods and findings from the community survey, please see Appendix C.

1. What is a Community Health Assessment? cdc.gov. Updated July 24, 2018. Access July 26, 2022. https://www.cdc.gov/publichealthgateway/cha/plan.html

TABLE 2. COMMUNITY SURVEY PARTICIPATION AND NEVADA POPULATION DEMOGRAPHICS

	POPULATION (2021)	RESPONSES	PARTICIPATION RATE PER 10,000 POPULATION
COUNTY			
Clark County	2,292,476	1,223	5.3
Washoe County	493,392	477	9.7
Quad Counties (Carson City, Douglas, Lyon, Storey)	173,909	247	14.2
Rural and frontier counties	184,214	192	10.4
Missing zip code		48	
TOTAL	3,147,991	2,187	
SEX AT BIRTH			
Male		22%	
Female		78%	
AGE			
65+	225,702	121	5.4
45-64	384,754	829	21.5
22-44	430,418	1060	24.6
18-24	130,734	167	12.8
Total	3,147,991	2,187	
RACE/ETHNICITY			
Asian	147	6.7%	8.7%
Black/African American	225	10.3%	10.3%
Hispanic/Latinx or Spanish Origin of any race	368	16.8%	29.2%
White/Caucasian	1,172	52.6%	48.2%
Native people	133	6.0%	2.5%
Multiple	124	5.7%	4.6%

LISTENING TOURS

The second data collection tool developed for this assessment was a Listening Tour script. This script was also based on the focus group script utilized by WCHD for its 2022 CHA. The Steering Committee provided feedback and comments on the script. Listening Tours utilized the World Café Conversation Model designed to facilitate sharing among group participants. This model is flexible in its ability to accommodate groups that vary in size. Groups and locations for listening tours were identified by Steering Committee members. Some listening tour locations were identified through pre-existing community relationships among assessment team members. Listening Tour sessions were held throughout Nevada and aimed to include historically marginalized groups.

In total, the assessment team hosted 13 listening tours. These sessions were hosted from May 10 to June 17, 2022. Most sessions were hosted in-person and a couple were held virtually. Most were conducted in English, and two tours were held in Spanish. Group sizes varied; the smallest included two participants and the largest included 20 individuals. The majority of the listening tours were hosted in Las Vegas, two were held virtually, and one was held in Churchill County. All were either voice or video recorded and transcribed by the assessment team.

All personally identifiable information was removed from the final transcripts, which were then uploaded into NVivo, a qualitative data analysis software. An inductive approach was utilized to review and analyze these data. This method was identified as a way to limit researcher bias to allow themes from these data to emerge. The analysis team spilt the transcripts and identified high level themes that emerged from the transcripts. A code book was developed. The major themes included access to healthcare, housing, transportation, behavioral health, community needs, and assets. For full details of the Listening Tour findings, please see Appendix D.

CONSIDERATIONS AND LIMITATIONS

This report was compiled for the purpose of providing a snapshot into the health of Nevada. The goal of the report is to be as comprehensive as possible in reporting indicators for the measurement of Nevada's health status. However, this report should be used as a foundation on which to build. Assessing the community's health is dependent on understanding a multitude of variables which by nature are ever shifting.

Certain secondary sources used in this report have not been updated in recent years. This can be attributed to the ongoing COVID-19 pandemic, which has interfered with data collection activities, as well as high turnover within the public health workforce.

Furthermore, the state does not collect data on certain indicators, such as statewide contraceptive use rates. Future statewide surveys should consider the value in collecting data covering a wider variety of indicators.

The report is limited in representation from Native American/Tribal members. During the recruitment phase, an individual who works closely with tribes in Northern Nevada recommended that future assessments should allow for longer timelines for successful recruitment among Native American/Tribal groups. In their experience, tribal communities respond better to boots on the ground recruitment. Future assessment teams may benefit from recruiting in tribal communities utilizing traditional methods of participant recruitment.

Listening tour groups share certain demographic and socioeconomic similarities that limit the conclusions that can be drawn from their responses. However, these groups were selected because they provide insight into the needs of historically medically underserved communities.

Finally, the methods utilized for primary data collection inherently have certain biases. Recruitment for the Community Survey was based off of convenience sampling; participants were not randomly selected to participate in it. However, the sample size was large and some demographic characteristics of the sample matched Nevada state demographics. For these reasons, results from the survey can be generalizable for the purposes of this report to but should not be considered a statistically reliable population sample.

PUBLIC HEALTH ASSESSMENT

PUBLIC HEALTH GOVERNANCE IN NEVADA

Nevada is one of two states with a "largely decentralized" public health system. This means local public health agencies provide services to the vast majority of residents, and the state public health agency provides public health services where local public health agencies do not exist. In contrast, most states have fully decentralized public health systems, where all public health services are provided by local public health agencies.

Three local health districts serve much of Nevada's population:

- Southern Nevada Health District (SNHD) provides public health services in Clark County;
- Washoe County Health District (WCHD) serves Washoe County residents; and
- The newly established Central Nevada Health District (CNHD) will provide public health services in Churchill, Mineral, Pershing, and Eureka Counties, once it is fully operational.

Carson City Health and Human Services (CCHS) provides public health services to Carson City and, though it is not a health district, certain services to Douglas County, Lyon County, and Storey County residents through interlocal agreements. In addition, DPBH provides public health services in rural and frontier counties not served by a local public health agency.

Chapter 439 of the Nevada Revised Statutes outlines statutory requirements for public health governance and administration in the state, requiring each county to have a county health officer and county board of health or, where a health district exists, a district health officer and district board of health.

To improve access to public health services, Nevada has continued to move toward regionalization and the development of more local health districts, which is demonstrated through the establishment of the Central Nevada Health District.

PUBLIC HEALTH INFRASTRUCTURE CHALLENGES

Nevada has historically struggled to provide adequate public health services statewide. Much of this is due to a lack of funding, with Nevada being ranked last in the nation in funding devoted to public health prior to the COVID-19 pandemic. According to the Trust Fund for America's Health, Nevada, along with Wisconsin, fell last among states with the lowest annual per capita investment in public health at $72 per person, well below the $116 per person average nationwide.[1]

Public health funding in Nevada is provided almost entirely from federal grants, which results in underfunding and a lack of consistency in funding of various projects. This highlights the need for ongoing, non-categorical, flexible general funding to not only continue existing programs, but to allow funding to be shifted as needed to respond to new public health threats that arise and to address gaps that are identified through needs assessments.

In addition to funding challenges, Nevada's public health programs have struggled to maintain adequate staffing levels. This reflects a national trend. The 2021 Public Health Workforce Interests and Needs Survey found that nearly one-third (32%) of the public health workforce is considering leaving their organization this year. This is partially due to the lack of funding mentioned above, but also due to burnout, a lack of advancement opportunities, and the impact of COVID-19. Turnover is costly, and state and local public health authorities are working with Schools of Public Health at the University of Nevada, Reno and the University of Nevada, Las Vegas to expand public health workforce capacity in the state.

1. https://www.americashealthrankings.org/explore/annual/measure/PH_funding/state/ALL

FOUNDATIONAL PUBLIC HEALTH

In an effort to ensure every community in Nevada has the public health services it needs; state and local public health agencies are considering new tools to evaluate Foundational Public Health Services (FPHS). The FPHS framework, developed by the Public Health National Center for Innovations, is used to "explain the vital role of governmental public health in a thriving community; identify capacity and resource gaps; determine the cost for assuring foundational activities; and justify funding needs," while still allowing for the flexibility to address additional needs that are specific to a given region. The framework is based on five foundational areas and eight foundational capacities that all governmental public health entity should provide.[1] Washoe County Health District is working on an FPHS assessment and other state and local health authorities are exploring how best to conduct similar evaluations to determine where gaps exist, and identify the necessary resources to provide the most basic public health services to all Nevadans.

1. hLps://phnci.org/transforma5on/fphs

NEVADA'S POPULATION

Understanding the demography of Nevada provides a means to better understand and address health challenges experienced by different population groups. The U.S. Census estimates that Nevada is home to nearly 3.2 million people as of July 2022.

The Governor's Office of Economic Development states that Nevada is experiencing a population growth rate of 1% annually, significantly higher than the national average of 0.12%[1]. Clark County and Washoe County, along with their neighbors Nye County and Lyon County, respectively, have seen the bulk of the state's growth, with the rural and frontier counties experiencing less growth or a steady decline.

AGE, RACE, AND ETHNICITY

The proportion of older adults in Nevada continues to grow. According to U.S Census estimates, 16.5% of Nevada's residents are 65 years of age or older in 2021, up from 13.4% in 2016. The Aging and Disability Services Division, DHHS, expects Nevada will continue to experience growth in this population at higher rates than the national average through 2030.[2]

Among Nevada residents, 73% identify as white only, 30% identify as Hispanic or Latino, 11% identify as Black or African American, 10% identify as Asian American or Pacific Islander, and 2% identify as American Indian or Alaska Native (Table 3). Nevada has a larger Hispanic/Latino population than the national average, and a higher proportion of residents who are foreign-born. Nevada's population continues to become more diverse, with the Hispanic/Latino population experiencing the most growth between 2010 to 2021.

TABLE 3. RACE/ETHNICITY IN NEVADA AND U.S., 2020

Race/Ethnicity in Nevada and U.S., 2020

Race/Ethnicity	Nevada	U.S.
American Indian/ Alaska Native	1.7%	1.3%
Asian	9.1%	6.1%
Black/African American	10.6%	13.6%
Native Hawaiian/ Pacific Islander	0.9%	0.3%
White	72.8%	75.8%
Hispanic/Latino	29.9%	18.9%

Source: US Census Bureau

TABLE 4. SEXUAL ORIENTATION AND GENDER IDENTITY OF HIGH SCHOOL STUDENTS, NEVADA AND U.S., 2021

Sexual Orientation and Gender Identity of High School Students

	NATIONAL SURVEY		NEVADA HIGH SCHOOL STUDENTS	
DEMOGRAPHICS	MALE	FEMALE	MALE	FEMALE
Heterosexual (straight)	91.2%	77.6%	83.3%	55.7%
Gay or Lesbian	2.1%	2.9%	5.6%	5.2%
Bisexual	3.4%	13.9%	6.5%	24.6%
Not Sure	3.2%	5.6%	N/A	N/A
Some other identity	N/A	N/A	2.2%	6.8%
Questioning	N/A	N/A	2.4%	7.7%

Data Source: Youth Risk Behavior Surveillance System, 2019 and Nevada High School YRBS State Report, 2021.

SEXUAL ORIENTATION AND GENDER IDENTITY

Based on a 2019 report from the Gallup and the Williams Institute, 5.5% of Nevadans identify as lesbian, gay, bisexual, or transgender, the third highest rate in the nation. More than half (56%) of respondents who identified as part of the LGBTQ community were between the ages of 17 and 34, and 58% identified as white[1].

According to the 2021 Youth Risk Behavior Survey, 31.1% of high school students identify as something other than heterosexual. In addition, 5.6% of students identify as gay or lesbian, 15.7% identify as bisexual, 4.7% identify as some other orientation, and 5.1% question their orientation. According to the same survey, 4% of high school students identify as transgender and 2.9% of students question their sexual orientation or gender identity. This represents a 2% increase in students who identify as transgender from 2019.

1.Nevada Governor's Office of Economic Development https://goed.nv.gov/in-case-you-missed-it-state-policyreports-ranks-nevadas-economy-first-in-the-nation/#:~:text=Nevada's%20annual%20population%20growth%20is,national%20average%20of%200.12%20percent

2.Center for Healthy Aging ADSD https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/About/Reports2/Elders%20Count%202021%20-%20FINAL%201.28.2021.pdf

Figure 1. Disability status and types among adults 18 years of age and older, Nevada

Source: CDC, BRFSS

Living with a disability can significantly affect a person's mental and physical health outcomes.[2] This is due to a combination of factors, from stigma to a lack of access to facilities and conditions that promote health and well-being. According to a 2020 report from the federal Centers for Disease Control and Prevention (CDC)[3] , 28.4% of adults in Nevada report living with a disability. Furthermore, a U.S. Census estimate found that 4% of Nevada youth live with a disability, with the majority having cognitive or mobility disabilities.

1.LGBT Demographic Data Interactive. (January 2019). Los Angeles, CA: The Williams Institute, UCLA School of Law.
2.United States Census Bureau, 2021.
https://data.census.gov/table?t=Income+and+Poverty&g=0400000US32&d=ACS+1-Year+Estimates+Selected+Population+Profiles&tid=ACSSPP1Y2021.S0201
3.CDC Disability and Health Promotion
4.CDC Adolescent and School Health https://www.cdc.gov/healthyyouth/data/yrbs/2019_tables/students_by_sexual_identity.htm

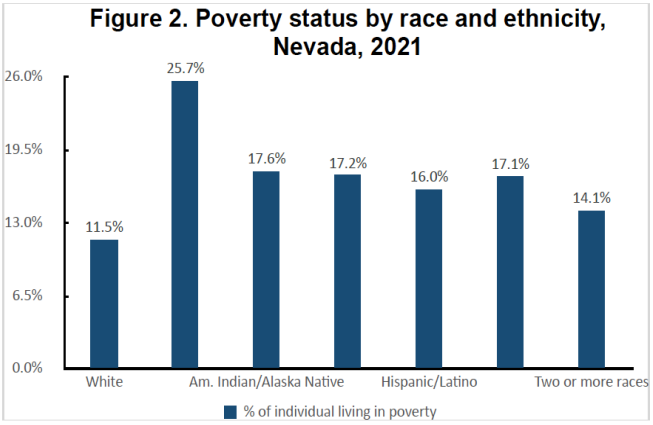
SOCIAL DETERMINANTS OF HEALTH

While many Nevadans may not be familiar with the concept of social determinants of health (SDOH), comments made during the Listening Tours demonstrate that residents understand their importance. Respondents highlighted the need for affordable housing, good education, healthy food, and access to health care services as critical to their health. Factors like these have a major impact on the health, well-being, and quality of life of a population and contribute to disparities and inequities in health outcomes. In Nevada, rapid population growth, the COVID-19 pandemic, and existing societal and structural factors have exacerbated these disparities in the state. Despite these challenges, communities and organizations in the state are working towards improving these issues. Listening tour participants reported a strong sense of togetherness and community that provide a buffer against negative health influences.

A listening tour participant when asked what is most important for overall health: "Cost of living, access to affordable housing, access to healthy foods."

ECONOMICS AND INCOME INEQUALITY

Economic status is strongly correlated with health outcomes. People with lower socioeconomic status experience higher rates of early death and more risk factors that contribute to chronic disease. In 2021, 19% of children and 13% of adults in Nevada were living at or below the federal poverty level, higher than the national average for both categories. Though only 10.6% of Nevadans identify as Black/African American, this population experiences poverty at twice the rate of white Nevadans, and at a higher rate than the Black/African American community in the United States as a whole. While Hispanic/Latino residents experience higher rates of poverty than their white counterparts, their rate of poverty is slightly lower than the national average (Figure 2).[1]

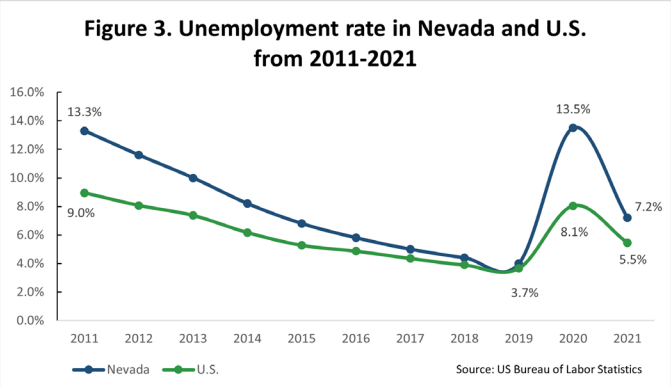


EMPLOYMENT AND WAGES

Nevada was one of the hardest hit states during the COVID-19 pandemic due to the closure of the many entertainment and hospitality venues that fuel its economy. According to Bureau of Labor Statistics, the number of employed leisure and hospitality workers in Las Vegas alone dropped from more than 290,000 in March 2020, to 127,000 in May 2020. Nevada unemployment peaked at 28.5% in April 2020, double the national rate of 14.7% for the same month (Figure 3).[1]

Employment is one of the primary ways of reducing poverty. While Nevada has made significant progress in recovering from the impact of the pandemic, as of December 2022, it still has the highest unemployment rate in the nation, at 5.2%. In addition, LGBT Nevadans report higher rates of unemployment (9%) than non-LGBT residents (5%).

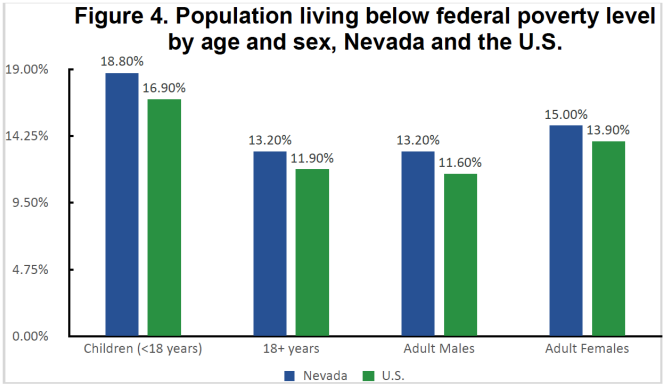
It is important to note that employment rates do not paint a complete picture. Fair wages, paid sick leave, and a feeling of satisfaction with one's work are all important factors to consider. In spite of 82% of Nevada residents who responded to our survey indicating that they were actively earning a wage from a job or commission, 40% of respondents reported being concerned that their household would run out of food before their next paycheck.[2] Additionally, many respondents reported difficulty paying for housing, credit cards, and transportation.



Source: US Bereau of Labor Statistics

POVERTY

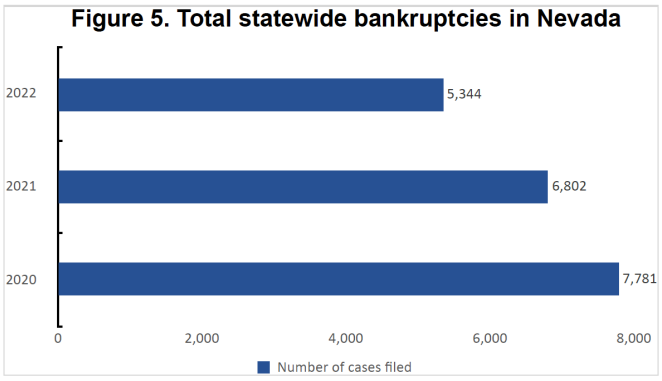
In Nevada, 14.1% of the population lives in poverty, the 40th highest rate in the nation. 18.8% of residents under 18 years old and 20.5% under the age of 5 are living under the poverty line. (Figure 4).[1]



Source: US Census Bureau

BANKRUPTCIES

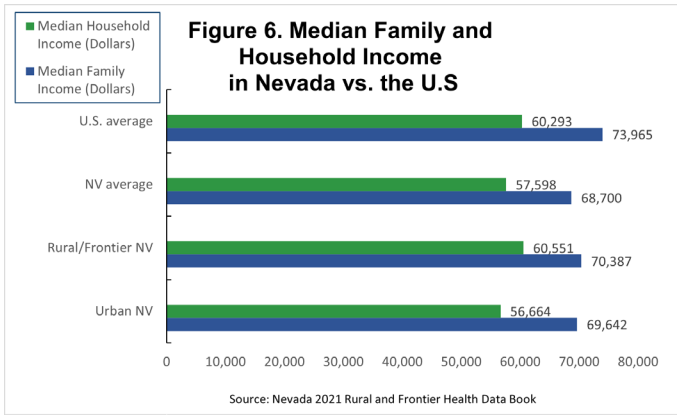
According to the US Bankruptcy Court District of Nevada, annual bankruptcy case filings decreased by 39% from 2020 to 2022, with 86% of those filings coming from Clark County (Figure 5).[2]



Source: US Bankruptcy Couty, 2020-2022

ECONOMIC DISPARITIES

While per capita income has increased for rural and frontier communities in Nevada over the past decade, the average per capita personal income for all rural and frontier counties is below both the urban average and the national average. In spite of this, rural and frontier counties in Nevada experience lower rates of income inequality than urban counties.[3] Rural and frontier communities also experience less poverty and have lower rates of Supplemental Nutrition Assistance Program (SNAP) participation than urban communities. For more in-depth analysis of rural economics, see the 2021 NV Rural and Frontier Health Data Book 10th ed.



Racial and ethnic disparities exist in Nevada as well. 25.8% of Black/African American Nevadans are living in poverty. This is higher than both the national average (21.7%) for this population, and higher than the rate of poverty for white Nevadans (11.1%).[3]

1. US Census Bereau: https://data.census.gov/table?q=nevada+children+in+poverty
2.United States Bankruptcy Court
https://www.nvb.uscourts.gov/about-thecourt/bankruptcy-statistics/case-filingsannual/
3.2021 Rural and Frontier Health Data Report

> “There’s too many kids in the class, too many disturbances, they’re not getting the attention that they need from the teacher, so you can’t put 50 kids in a classroom and expect them to learn.”

EDUCATION

Educational status is associated with both income and health. Individuals with higher levels of education tend to live longer, healthier lives. Furthermore, health and economic-related issues are major causes of student absenteeism and an inability to complete early education.

EARLY CHILDHOOD EDUCATION

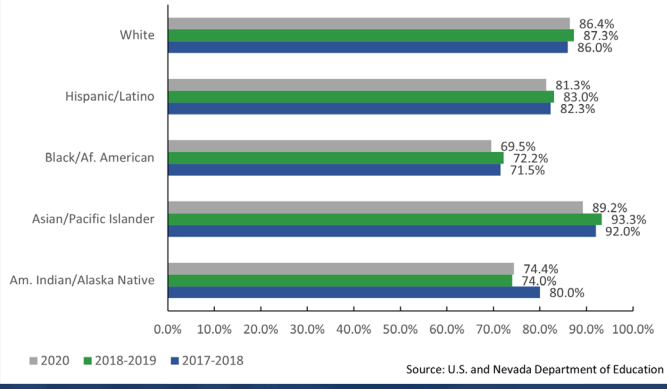
Early education is critical in setting children on a path for long-term success, and investment in developmental programs for the earliest years of life produce the greatest returns. Studies have found that investments in early childhood programs produce economic returns of up to $9 per $1 spent.[1] These programs have the capability to protect against the effects of toxic stress by providing a stable, supportive environment to promote emotional, social, and cognitive development. In addition to the economic impact, these programs benefit the community by reducing crime and reliance on other public support programs.

While Nevada has increased spending on preschool programs, a report for the 2019-2020 school year ranked Nevada 40th in the nation for access to state-funded preschool programs.[2] Child care costs approximately 20% of median family income in the state, well above the 7% considered affordable by the Department of Health and Human Services.[3] The high cost of childcare leaves many families that do not meet income requirements to access state funded programs without childcare services.

GRADUATION RATES AND ABSENTEEISM

The state of Nevada has struggled with poor education outcomes, ranking 40th in the nation in 2022.[4] While increased funding has resulted in an improvement, there is still more work to be done. Nevada’s four-year high school graduation rate has fallen steadily, from 84.1% in the 2019-2020 school year to 81.3% in the 2021-2022 school year. It can be inferred that this decrease is due at least in part to the impact of the COVID-19 pandemic.[t] In the 2021-2022 school year, Mineral County had the lowest four-year graduation rate at 65.71% and Eureka County had the highest graduation rate at 100%.[6] Graduation rates were highest for Asian/Pacific Islander students in Nevada.

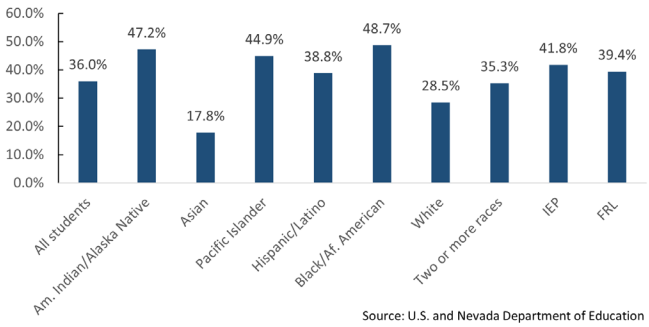
Figure 7. High school graduation rate by race and ethnicity, Nevada



Chronic absenteeism is defined as missing 10% or more of the total number of days enrolled during the school year for any reason. It can prevent children from reaching early learning milestones and make it far less likely that a student will complete high school. The chronic absenteeism rate during the 2020-2021 school year in Nevada was 36%, up from 18.8% in the 2018-2019 school year. This increase reflects the impact of the COVID-19 pandemic forcing school closures and online learning. In Nevada, American Indian/Alaskan Native, Black/African American, and Pacific Islander students, as well as those enrolled in an individualized education plan (IEP), and student who receive free or reduced lunches, are disproportionately affected by chronic absenteeism (Figure 8).[7]

1.Harvard Center Early Childhood Program Effectiveness https://harvardcenter.wpenginepowered.com/wp-content/uploads/2015/05/inbrief-programs-update-1.pdf
2.Nevada YB 2020 https://nieer.org/wp-content/uploads/2021/04/Nevada_YB2020.pdf
3.Economic Policy Institute https://www.epi.org/child-care-costs-in-the-united-states/#/NV
4.America's Health Rankings https://www.americashealthrankings.org/explore/annual/measure/education/state/NV
5.Nevada Department of Education http://nevadareportcard.nv.gov/DI/nv/2022
6.Solis J. Nevada falls short in Early Childhood Education, report finds. Nevada Current. https://www.nevadacurrent.com/2021/04/26/nevada-falls-short-in-early-childhood-education-report-finds/. Published April 28, 2021.
7.Nevada Department of Education http://nevadareportcard.nv.gov/DI/nv/2022

Figure 8. Chronic absenteeism rates by race/ethnicity and educational assistance, Nevada, 2020-2021

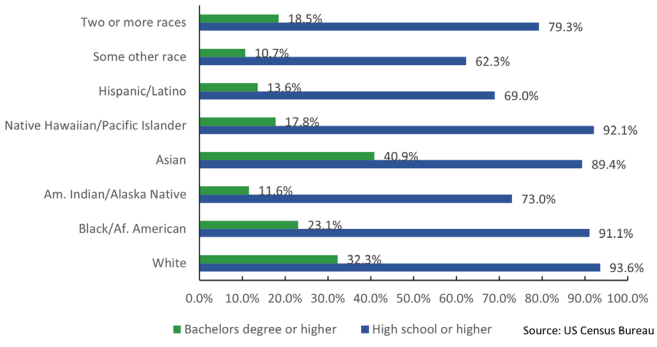


EDUCATIONAL ATTAINMENT

In 2021, 27% of Nevada residents over the age of 25 had only attained a high school or equivalent degree, and 27.6% of residents had attained a bachelor's degree or higher. In addition, 7% of Nevada residents over the age of 25 had no high school degree or equivalent, and 6% had less than a 9th grade education. Hispanic/Latino and American Indian/Alaskan Native residents were disproportionately less likely to attain a high school degree or higher (Figure 9). Nevada residents in poverty were also significantly less likely to graduate from high school, with only 15% over the age of 25 having graduated high school or an equivalent degree program.[1] In the survey conducted for this State Health Assessment, 12% of respondents reported only having graduated high school, and 28% had attended college but did not graduate.

1. US Census Bureau

Figure 9. Educational attainment by race and ethnicity, Nevada, 2021



FOOD INSECURITY

According to the U.S. Department of agriculture, 10.4% of American households experienced hunger in 2021. Food insecurity has a significant impact on health, and adults who are food insecure are at an increased risk for various health conditions, such as diabetes, obesity, heart disease, and mental health disorders. Children who are foodinsecure are more likely to have poor health, behavior problems, poorer developmental outcomes, and struggle in school.

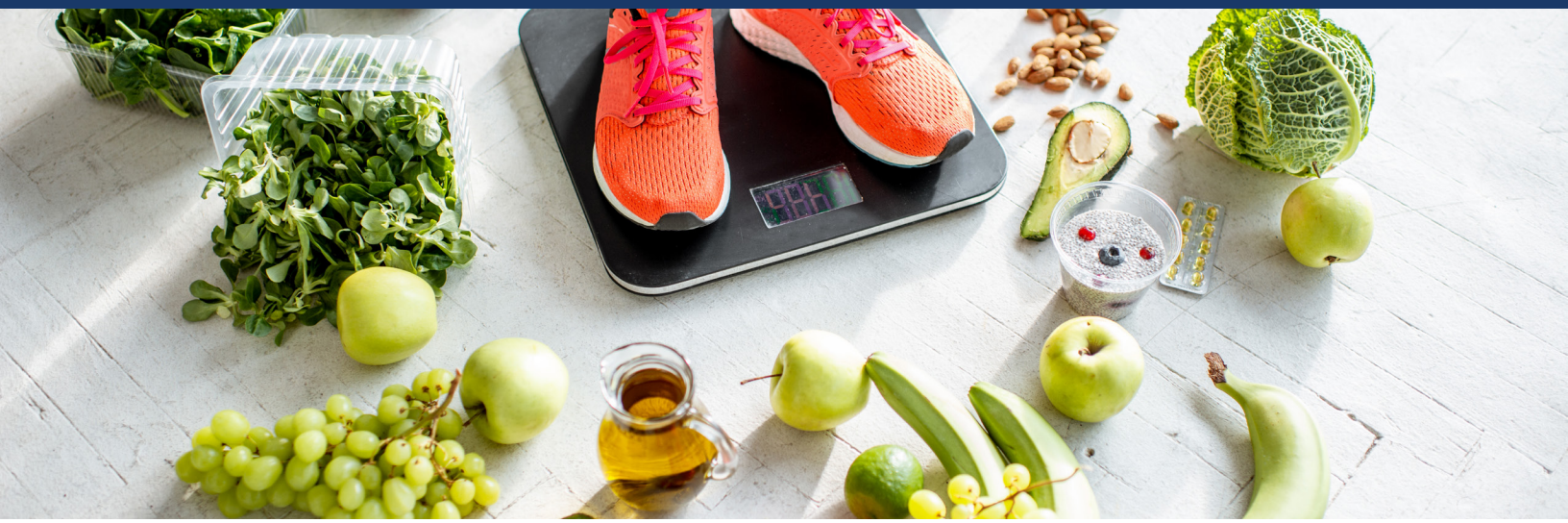
Food and nutritional support programs play a key role in addressing food insecurity for low-income individuals and families. An estimated 1.2 million households relied on the Supplemental Nutrition Assistance Program (SNAP) in 2021.[1] During the COVID-19 pandemic, the Division of Welfare and Supportive Services, DHHS, provided additional emergency allotments to SNAP beneficiaries; however, because the federal public health emergency declaration ended in December 2022, these supplemental benefits end as of March 14, 2023. This reduction in funding is estimated to impact 450,000 households in Nevada that benefitted from the emergency SNAP benefits.[2]

1. United States Census Bureau https://data.census.gov/table?q=food+insecurity+nevada&g=0400000US32&tid=ACSST1Y2021.S2201

2.DHHS https://dhhs.nv.gov/Reports/Press_Releases/2023/450,000_Nevadans_Will_See_Reduction_in_Food_Assistance/

FOOD INSECURITY

In Nevada, food insecurity has been steadily declining, from 12.7% of individuals who were food insecure in 2016 to 11% in 2020, just below the national average of 11.8% (Figure 10).[1] However, this rate is projected to rise. In the first half of 2020, SNAP applications increased 26% for Asian and 23% for Native Hawaiian/Pacific Islander residents.[2] Additionally, child food insecurity is projected to increase to 23%. This reversal on progress is in large part due to the COVID-19 pandemic resulting in higher unemployment, less access to resources, and difficulties caused by social distancing requirements.



This increase is reflected by the proportion of Community Survey participants (41.3%) who indicated they are "sometimes or often times" worried about running out of food before getting money to buy more. A total of 35.4% of participants "sometimes or often times" found that the food they bought did not last long enough and they did not have money to buy more. In addition, 30.6% of participants were "somewhat or extremely unconfident" in finding food assistance resources in their community.

According to a 2019 report, LGBT Nevadans are more likely to be food insecure than non-LGBT residents.[3] The University of Nevada, Reno reports that 28% of undergraduate students reported experiencing food insecurity in 2022, a 3% increase from 2020.[4]

FREE AND REDUCED LUNCHES

In 2021, a total of 283,759 students in Nevada qualified for free or reduced lunch based on household income. This represents 68.4% of the total student population in the state.[1] A smaller percentage of students in rural and frontier counties qualify for free and reduced lunches than students in urban counties (Figure 11). However, due to the COVID-19 pandemic, all children in Nevada are eligible to receive free school meals for the 2022 – 2023 school year as needed.[2]

Figure 10. Percentage of the total population in Nevada who were food insecure, 2016-2020

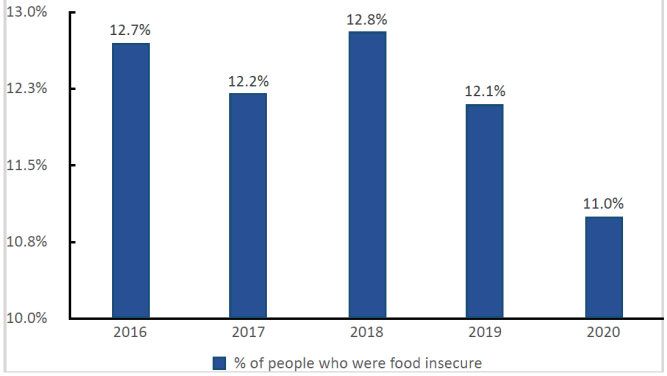
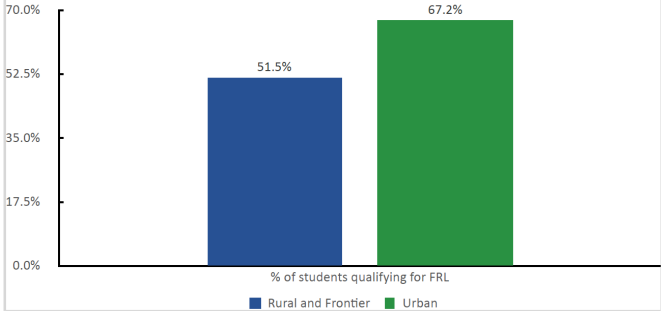


Figure 11. Urban vs. Rural/Frontier students qualifying for Free Reduced School Lunch (FRL) in Nevada, 2020



Source: Nevada Department of Agriculture

FOOD INSECURITY

1.Feeding America https://map.feedingamerica.org/county/2020/overall/nevada

2.Divison of Public and Behavioral Health - Nevada

3.LGBT Demographic Data Interactive. (January 2019). Los Angeles, CA: The Williams Institute, UCLA School of Law. https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=32#density

4.Nevada Today https://www.unr.edu/nevada-today/news/2022/pack-provisions-giving-tuesday

FREE AND REDUCED LUNCHES

1. https://agri.nv.gov/uploadedFiles/agri.nv.gov/Content/Resources/Data_and_Reports/Food_and_Nutrition/School_Nutrition/21-22%20FRL%20Report%20-%20Alpha%20Sorted%20FRL%20Report_FINAL.pdf

2. https://agri.nv.gov/News/2022/Students_in_Nevada_won%E2%80%99t_worry_about_school_meals_next_year/

HOUSING

In recent years, Nevada has seen continued population growth, with a 2.4% increase in population between 2020 and 2022.[1] This growth has come with increased demand for affordable housing, and the supply has struggled to keep up. Housing is considered affordable when no more than one-third of a household's income goes to rent or mortgage. In Nevada, more than half of households were dedicating 30% or more of their income to rent in 2021.[2] Nevada residents with disabilities and seniors are disproportionately affected by the housing shortage and make up 19% and 26% of extremely low-income households, respectively.

State efforts to address the problem include 2019 legislation that created the Nevada Affordable Housing Tax Credit program, subsidized impact fees to reduce the cost of construction of affordable housing, and improved data collection on housing needs.[3] While these efforts reflect acknowledgement that the lack of affordable housing is a serious issue, more work needs to be done.

1.United States Census Bureau https://www.census.gov/quickfacts/fact/table/NV/POP010210

2. https://data.census.gov/table?q=rent+burden+nevada&g=040XX00US32&tid=ACSDP1Y2021.DP04

3.Nevada Homeless Alliance https://nevadahomelessalliance.org/wp-content/uploads/2019/08/HHH-Housing.pdf

4.NLIHC https://nlihc.org/sites/default/files/SHP_NV.pdf

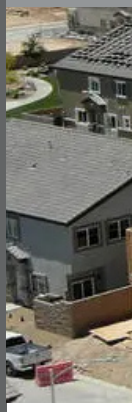
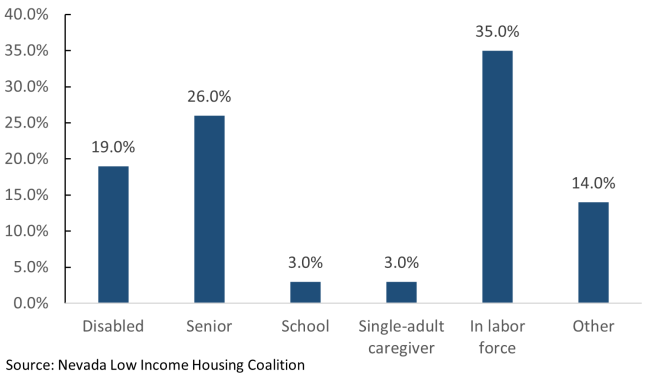


Figure 12. Extremely low-income renter households, Nevada, 2021



Source: Nevada Low Income Housing Coalition

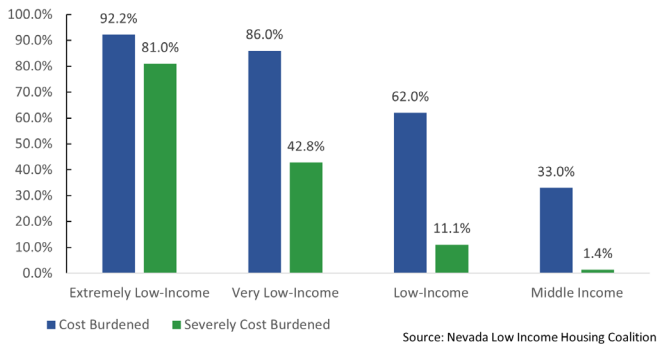
RENT BURDEN

Households spending more than 30% of their income on rent are considered cost burdened, and households spending more than half of their income are severely cost burdened. Low-income renters are disproportionately affected by the lack of affordable housing, leading them to sacrifice other necessities like healthy food and healthcare to pay rent. 92% of extremely low income and 86% of very low-income renters are considered cost burdened (Figure 13).[1]

AFFORDABLE HOUSING

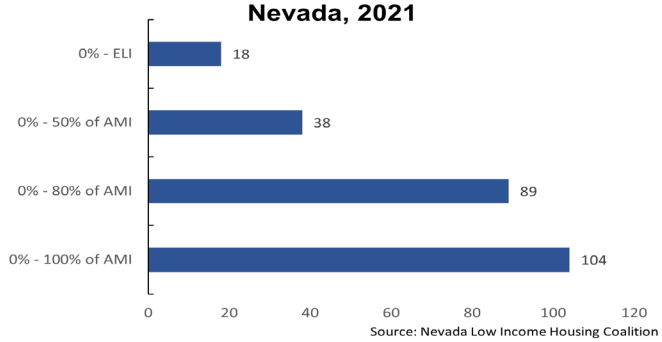
According to a 2022 report from the National Low-Income Housing Coalition, Nevada suffers from a shortage of nearly 80,000 homes that are affordable and available for extremely low-income individuals.[3] Based on area median income (AMI), in 2020, only 38 affordable and available homes were available per 100 households earning 50% or less of AMI in Nevada.[4] Because Black/African American Nevadans are more likely to live in poverty, the lack of affordable housing affects this population disproportionately (Figure 14).

Figure 13. Housing cost burden by income group, Nevada



Source: Nevada Low Income Housing Coalition

Figure 14. Affordable and available homes per 100 renter households, Nevada, 2021



Source: Nevada Low Income Housing Coalition

HOMELESSNESS

State and national homeless data is limited. However, a February 2021 point-in-time count of Nevada's homeless population calculated a total of 7,090 homeless individuals statewide, more than half of which were unsheltered.[1] This is an increase from the 6,900 homeless counted in 2020.[2]

1. https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulationsreports/?filter_Year=2021&filter_Scope=CoC&filter_State=NV&filter_CoC=&program=CoC&group=PopSub

2. https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-ofhomelessness/

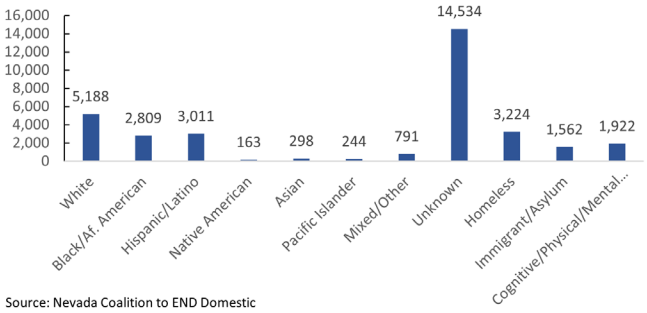
SAFETY & VIOLENCE

Nevada experiences slightly higher rates of most categories of crime than the national average, with aggravated assault, robbery, and rape being the most common violent crime. In spite of a 1.8% increase in 2022, violent crime has been trending downward since 2016.[1] This is reflected in the responses to the Community Survey, in which 84% of respondents indicated they felt "somewhat or very" safe in their neighborhoods.

INTIMATE PARTNER VIOLENCE

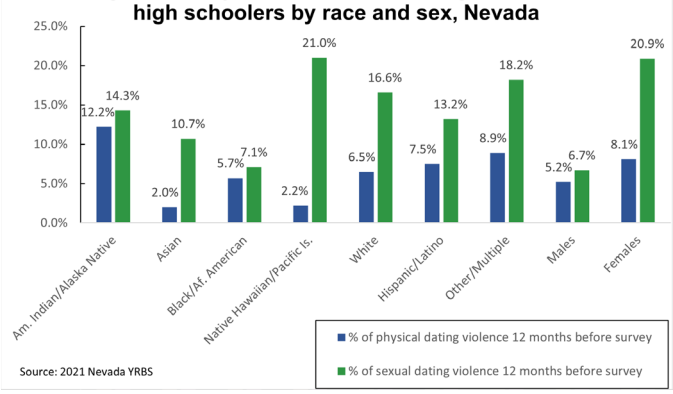
Intimate partner violence (IPV) is abuse or aggression that occurs in a romantic relationship. It includes physical violence, sexual violence, stalking, and psychological aggression from current and former spouses and dating partners. IPV is a serious public health problem that can impact lifelong health and wellbeing of individuals, families, and communities. In 2021, the Nevada Coalition to End Domestic and Sexual Violence documented 26,966 reported cases of IPV in the state.[2] Populations disproportionately affected by IPV in Nevada include Black/African American and Hispanic/Latino residents, as well as residents who are homeless, immigrants/asylum-seekers, and individuals with cognitive, physical, or mental disabilities (Figure 15).

Figure 15. Intimate Partner Violence (IPV) reports by race/ethnicity and special populations, Nevada, 2021



Source: Nevada Coalition to END Domestic and Sexual Violence

Figure 16. Physical and sexual dating violence in high schoolers by race and sex, Nevada



Source: 2021 Nevada YRBS

TEENS AND CHILDREN

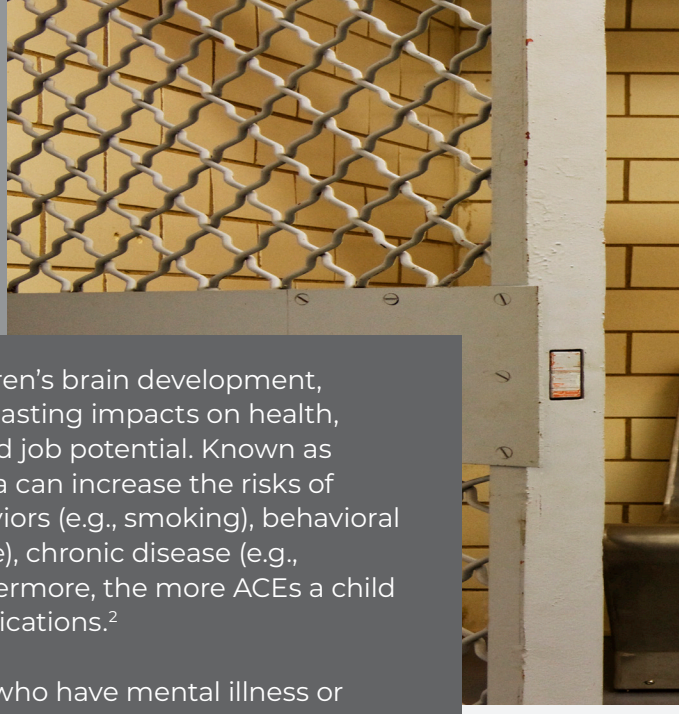
Data from the 2021 Youth Risk Behavior Survey (YRBS) show that 6.8% of high school students reported being physically harmed (i.e., hit, slammed into something, or injured with an object) by an intimate partner in the last 12 months. American Indian/Alaska Native students reported twice the prevalence of this violence compared to their white counterparts. The same report found that 14% of high school students experienced sexual violence from a partner that included unwanted kissing, touching, or intercourse.

The prevalence of sexual violence was three times higher for females compared to males. The prevalence of sexual violence was fairly constant across the age groups, with 14- to 17-year-olds reporting experiences of sexual violence at prevalence between 13-16%.

1. YRBS

1. https://nevadacrimestats.nv.gov/tops/report/violent-crimes/nevada/2022
2. https://www.ncedsv.org/wp-content/uploads/2022/03/Final-2021-CY-DV.pdf

TRAUMA & TOXIC STRESS



Early traumatic experiences can negatively affect children's brain development, immune systems, and stress-response system, having lasting impacts on health, well-being, and life opportunities such as education and job potential. Known as adverse childhood experiences (ACEs), this early trauma can increase the risks of injury, sexually transmitted infections, health risk behaviors (e.g., smoking), behavioral health issues (e.g., depression, suicide, substance abuse), chronic disease (e.g., diabetes, cancer, heart disease), and early death.[1] Furthermore, the more ACEs a child has, the more likely they are to experience these complications.[2]

According to the 2021 Nevada YRBS, living with adults who have mental illness or substance abuse problems were the most frequently reported ACEs among middle and high school students (Figures 17 and 18).

Figure 17. Prevalence of lifetime adverce childhood experiences (ACEs) among high school students, Nevada, 2021

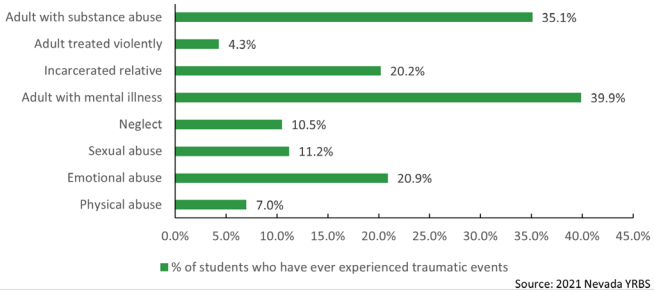
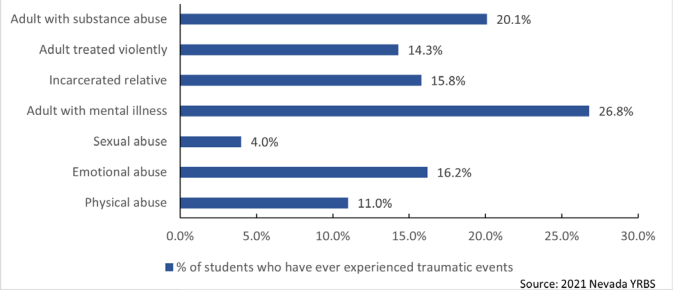


Figure 18. Prevalence of lifetime adverce childhood experiences (ACEs) among high school students, Nevada, 2021



DISPARITIES RELATED TO TRAUMA

Female high school students in Nevada reported a higher prevalence of physical and sexual abuse from a parent or adult compared to male students. White (40.3%) and American Indian/Alaska Native (47.3%) high school students reported the highest prevalence of living with someone that was having a problem with alcohol or drug use, and American Indian/Alaska Native (28.9%), Native Hawaiian/Pacific Islander (26.2%), and Black/African American (26.8%) students reported the highest prevalence of having a parent/guardian incarcerated. Most of these trends are mirrored in middle school respondents as well.[1]

1. CDC
2. https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/

INCARCERATION

Nevada's incarceration rate in 2021 was 713 persons incarcerated per 100,000 people (including prisons, jails, immigration detention, and juvenile justice facilities), higher than the national average of 664 per 100,000.[2] While the vast majority of inmates come from Nevada's most populous regions, Washoe County and Clark County, White Pine County and Nye County have the highest imprisonment rates at 365 per 100,000 population. In addition, certain American Indian and Alaska Native communities have especially high rates of incarceration, with the South Fork Reservation, Ely Reservation, Carson Colony, and Battle Mountain Reservation reporting imprisonment rates in 2020 that were more than four times the state average (Figure 18).[3]

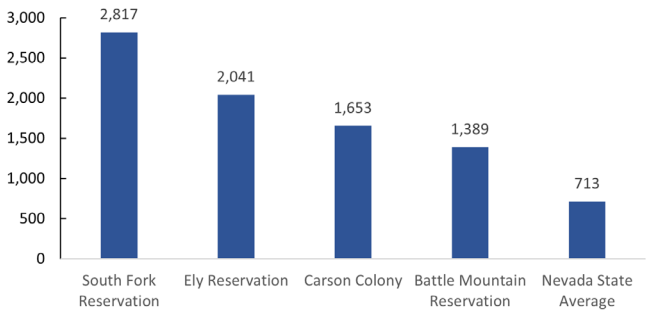
1. https://www.americashealthrankings.org/explore/annual/measure/ACEs_8/state/NV
2. https://www.prisonpolicy.org/global/2021.html
3. Source: Nevada Department of Corrections https://www.prisonpolicy.org/blog/2022/08/09/nvorigin/

In Nevada, a person is more likely to be imprisoned if they are male, a person of color, and living in poverty. Education also affects the imprisonment rate, with individuals earning no more than a high school diploma (or equivalent degree) making up almost 94% of the state prison population (Figure 19).[1]

Incarceration of a parent/caregiver is an ACE, and among women in Nevada's prisons, more than 78 percent are mothers, which has a significant impact on many children in the state.[1]

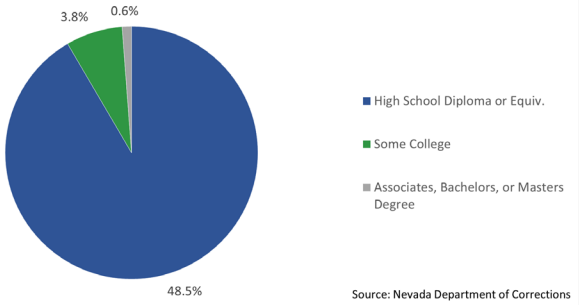
1. https://doc.nv.gov/uploadedFiles/docnvgov/content/About/Statistics/Quarterly_Reports_by_Fiscal_Year/SS.FY20.pdf

Figure 19. Imprisonment Rate for American Indian and Alaskan Native per 100,000, Nevada, 2020



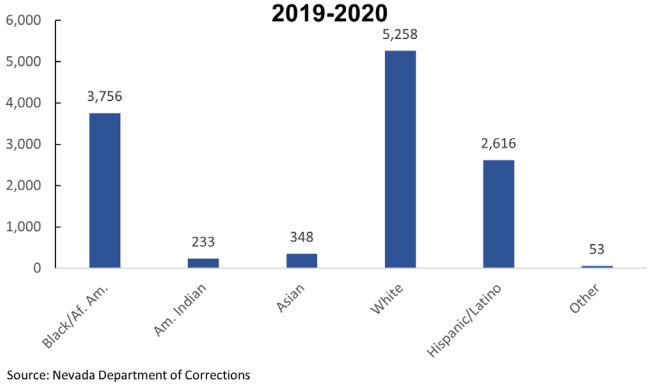
Source: Prison Policy Initiative

Figure 20. Percent of inmates based on educational attainment, Nevada, 2019-2020



Source: Nevada Department of Corrections

Figure 21. Inmates in Nevada based on race, 2019-2020



Source: Nevada Department of Corrections


Frida
Kate O'Hara - 2019

LANGUAGE

Nevada is one of the most diverse states in the nation, with only 49.6% of the state identifying as White alone according to the U.S. Census Bureau. This is reflected in the languages spoken in the state. Spanish, Tagalog, and Chinese are the most commonly spoken languages after English. For some households that are not proficient in English, this can lead to linguistic isolation.

In 2019, 2.2% of U.S. born residents and 48.6% of foreign-born Nevada residents lived in houses where no one over the age of 5 spoke English very well. These linguistically isolated households may be less likely to seek health or social services, and less likely to receive important health information provided to them.

FAMILY & SOCIAL SUPPORT

SINGLE PARENT HOMES

Single-parent households put both adults and children at higher risk for adverse health effects such as emotional and behavioral problems as well as increased risk of morbidity and mortality. Children in these homes are more likely to smoke, abuse alcohol and other substances, and develop depression. Similarly, the single parents also suffer from higher rates of health issues.[1] In Nevada, 27.8% of households in Nevada had children with a single parent in 2020.[2]

SOCIAL AND EMOTIONAL SUPPORT

Social cohesion refers to the strength of relationships and the sense of solidarity among members of a community. These relationships are important for both physical health and mental and emotional well-being. This health impact occurs through access to social capital, which refers to shared group resources, which are accessible through social networks. These networks are able to provide everything from access to work, to emotional support, to physical support, such as a ride to and from a doctor's appointment.

According to the results from the Community Survey, 18.5% of respondents do not know any first names of their neighbors, suggesting that some neighborhoods may lack social cohesion.[3]

RESIDENTIAL SEGREGATION

Residential segregation is a significant contributor to health disparities. Black/African American and Hispanic/Latino residents who live in highly segregated neighborhoods have lower housing quality, higher concentrations of poverty, and less access to high quality work and education.[1]

According to the 2022 America's Health Rankings, Nevada ranks highly in this category due to its low residential segregation. The report found that Nevada had a Black/White Dissimilarity Index of 53, giving Nevada the 5th lowest residential segregation in the nation. While this report did not include the national average, neighboring states Arizona and California had residential segregation scores of 55 and 63, respectively.[2]

SOCIAL AND EMOTIONAL SUPPORT

1. Annie E. Casey Foundation https://www.aecf.org/blog/child-well-being-in-single-parent-families#:~:text=Potential%20Emotional%20and%20Behavioral%20Impact,peers%20raised%20by%20married%20parents
2. American Community Survey https://data.census.gov/table?t=Families+and+Living+Arrangements:Marital+Status+and+Marital+History&g=0400000US32&tid=A CSDP1Y2021.DP02
3. https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/ supportiveneighborhood/state/NV?edition-year=2019

RESIDENTIAL SEGREGATION

1. https://www.rwjf.org/en/insights/blog/2016/03/whats-the-connection-between-residentialsegregation-andhealth.html#:~:text=Segregated%20Opportunities,to%20good%20jobs%20and%20education.
2. https://assets.americashealthrankings.org/app/uploads/allstatesummaries-ahr22.pdf

ENVIRONMENTAL HEALTH

Environmental health examines the impact that the natural and built environment have on health outcomes. From pollutants to drinking water to public transportation, the environment has a major impact on the health of Nevada's residents. In the Community Survey, more than 50% of respondents ranked environmental health as one of the most important issues in the state. This heightened awareness of the importance of environmental health is due in large part to the impacts of climate change seen in the state, with wildfire smoke and water shortages being a regular topic of coverage in local and national news.

NATURAL ENVIRONMENT

Air quality and water security are frequently cited concerns among Nevada residents. With climate change increasing the number and size of wildfires in and out of the state, it is common for Nevadans in some regions to stay indoors during the summers to minimize their exposure to harmful levels of smoke. Water security is also a cause for concern, with water reservoirs and the rivers that supply them hitting historically low levels. This has impacted not only residents in urban regions, but also the rural farmers and ranchers that rely on water for their livelihood.

AIR QUALITY

In spite of a rapidly growing population, Nevada's air quality has been remained fairly steady, and has even seen some seasonal improvement in the winter months due to wood-burning regulations. However, the impact of wildfires in Nevada and California have created significant spikes in short-term air pollution in some regions.

On average, Nevada has the fourth worst air quality in the nation. The state's average PM 2.5 density—a measure of air quality—in 2019 to –2021, was 9.6 micrograms per cubic centimeter, higher than the national average of 7.8 micrograms per cubic centimeter. The state's air quality issues are driven, in part, by the increased frequency and size of wildfires in both Nevada and neighboring California, which cause spikes in air pollution. Northern Nevada, in particular, suffers from smoke blowing into the region during fire season. This is reflected in the American Lung Association's 2022 State of the Air report, which ranked Reno, Carson City, and Fernley together as having the 12th worst short-term particle pollution in the nation and the 21st worth ozone levels. Las Vegas, while less impacted by the spikes in wildfire, still ranks 11th worst for ozone levels.[2] According to an air quality index (AQI) report from the EPA, Las Vegas had only 104 days in 2022 in which the air quality was considered "good," whereas Carson City and Reno had 225 and 229, respectively.[3]

Air pollution affects the health of Nevada residents, including long-term ramifications such as cancer, heart disease, and respiratory disease. In addition, short-term exposure to increased pollution in wildfire smoke can trigger respiratory issues in children and the elderly. More recently, wildfire smoke is suspected to have contributed to deaths due to COVID-19 during the pandemic.[4]

1. https://www.americashealthrankings.org/explore/annual/measure/air/state/NV
2. https://www.lung.org/research/sota/city-rankings/most-polluted-cities
3.U.S. EPA Air Data https://www.epa.gov/outdoor-air-quality-data
4. https://www.hsph.harvard.edu/news/press-releases/wildfire-smoke-may-have-contributed-tothousands-of-extra-covid-19-cases-and-deaths-in-western-u-s-in-2020/

WATER SECURITY

Nevada is the driest state in the nation, receiving a statewide annual average of 10.2 inches of precipitation annually. The majority of the state's residents are concentrated in the Las Vegas and Reno-Sparks metro areas, which receive almost all of their water from nearby Lake Meade and Lake Tahoe, respectively. Due to climate change, nearly all of the state has experienced a drought since 2020.[1]

Since 2000, the Colorado River, which supplies water to southern Nevada, has experienced reduced water levels due to a combination of increasing temperatures and decreasing precipitation levels, in addition to increasing demand for water among the cities and agricultural communities that rely on it. This has resulted Lake Mead—the nation's largest water reservoir and the water supply for southern Nevada, Arizona, southern California, and northern

Mexico—dropping to as low as 34% capacity in 2021.[2]

Recently, metropolitan areas in the state have enacted aggressive water conservation and have been successful in reducing the strain on dwindling water supplies, especially in southern Nevada. Grass removal, reduction in golf course water budget, strict watering regulations, and efficient water recycling has allowed southern Nevada to remain below its annual allocation of water from the Colorado river in spite of a rapidly growing population. This successful approach has been modeled in other regions of the country looking to reduce their water usage.

1. https://www.drought.gov/states/nevada#:~:text=Drought%20in%20Nevada%20from%202000%E2%80%93Present&text=Since%202000%2C%20the%20longest%20duration,affected%2040.63%25%20of%20Nevada%20land.
2. https://statesummaries.ncics.org/chapter/nv/#:~:text=Nevada%20is%20the%20Nation's%20driest,peaks%20of%20the%20Sierra%20Nevada.

NATURAL AND HUMAN CAUSED HAZARDS

In the state of Nevada, the top natural and human-caused disasters identified by the Joint Information Center are earthquakes, floods, wildfires, pandemics, active shooters, cyber-attacks, droughts, and accidental chemical releases. Nevada is the fourth most seismically active state in the country due to the significant number of fault lines in the state. Flash floods and wildfires also pose a threat to the state and its residents. Most of the natural hazards that pose a threat to state are being exacerbated by climate change. A report created as part of the Nevada Climate Initiative projects with high confidence that heat waves, droughts, floods, and wildfires will all increase with frequency and intensity due primarily to rising global temperatures.

BUILT ENVIRONMENT

The built environment was a topic that was mentioned in the Community Survey and during listening tours. Residents highlighted transportation, access to healthy food, safe spaces to exercise, play, and relax as areas of improvement for the state.

WATER PURITY

Access to safe drinking water is essential for all communities. Large community water systems serving the majority of the state generally have maintained safe water drinking standards. A majority (87.5%) of water systems in Nevada were in compliance with drinking water standards in 2021, and 0.1% were in violation, below the national average of 0.8%.[1] However, more than 300,000 of the state's residents rely on smaller, non-community water systems that tend to be more susceptible to contamination.

In Nevada, private wells are the primary source of drinking water for 182,000 residents, and a recent study found that 22% of private wells sampled had arsenic levels exceeding safe levels, in some cases 80 times higher.[2] Elevated levels of uranium, lead, cadmium, and iron were also found. Long-term exposure to elevated levels of arsenic in drinking water has been shown to increase risk of a variety of health problems, including cancer and diabetes.

Nevada's indigenous population is disproportionately affected by contaminated drinking water. Water facilities serving Native American households and communities have been found to be in violation of the Safe Water Drinking Act many times; the most common violations are the presence of volatile organic compounds (VOCs), coliform bacteria, and inorganic chemicals.[3]

1. https://ndep.nv.gov/uploads/documents/2021_Annual_Compliance_Report.pdf
2. https://www.dri.edu/elevated-levels-of-arsenic-and-other-metals-found-in-nevada-private-wells/#:~:text=Elevated%20Levels%20of%20Arsenic%20and%20Other%20Metals%20Found%20in%20Nevada's%20Private%20Wells,-October%2026%2C%202022&text=Above%3A%20Researchers%2
3. https://www.dri.edu/growing-numbers-of-native-american-households-in-nevada-face-plumbingpoverty-water-quality-problems/

FLUORIDATION

Fluoridation of water has proven to be an effective and affordable way to protect communities from tooth decay, so much so that it was named one of the 10 greatest public health achievements of the 20th century. According to the CDC, communities that fluoridate their water reduce cavities in children and adults by about 25% and community savings range from $1.10 to $135 for every dollar invested.[1] In Nevada, 75% of the population is served fluoridated drinking water—just above the national average of 73%—which gives the state a ranking of 27 in the nation.[2]

1. CDC
2. https://assets.americashealthrankings.org/app/uploads/allstatesummaries-ahr22.pdf

TRANSPORTATION

Convenient, affordable transportation is critical to health — whether to and from work, school, grocery stores, and health care providers. However, transportation is a challenge throughout Nevada, and transportation options are especially limited in rural and frontier areas of the state. Lack of transportation disproportionately affects the health of older adults, individuals with disabilities, and children or youth with special health care needs.

TRANSPORT TIME

Commute times have been slowly increasing in Nevada; Washoe County and Clark County experienced 4% and 5% increases in average commute time between 2011 and 2021, respectively.[1] Statewide, the average commute in 2022 was 27 minutes; 32.4% of workers had commute times of 30 minutes or longer.[2,3]

. https://fred.stlouisfed.org/series/B080ACS032003
2. https://www.healthysouthernnevada.org/demographicdata/index/view?id=2802&localeTypeId=1
3. https://data.census.gov/table?q=nevada+commute

PUBLIC TRANSPORTATION

In 2021, 70% of Nevada's workers age 16 and older drove to work alone, slightly higher than the national rate of 68%.[1] Only 2% of workers took public transit to work in the same year, down from 5% in 2016. Some of this reduction in use is due to the shift to remote work during the COVID-19 pandemic, with an estimated 41.1% of the state's workforce working from their place of residence.[2] However, the Nevada Department of Transportation (NDOT) identified issues with accessibility to public transportation and a lack of rapid bus services to employment centers as unmet needs in Nevada's most populous counties. In addition, NDOT highlights a lack of options for seniors who cannot drive and limited access to shopping areas, groceries, and pharmacies. When looking at rural and frontier counties, access to public transit services become even more limited due to reliance on local public organizations and nonprofits.

ACTIVE TRANSPORTATION

Active transportation is a means of getting around that involves human energy, mostly through walking and biking. An ability to utilize active transportation has an overall benefit on individual health by increasing physical activity, and also improves community health by reducing noise and air pollution and motor vehicle accidents. In 2021, 1.5% of workers in Nevada walked or biked to work, down from 5% in 2016.[2]

As mentioned previously, this is likely due, in part, to a shift toward remote work during the pandemic, but limited access to active transport options also plays a role. In recent years, transit authorities have worked to make biking and walking in populous areas safer and more accessible through the development and expansion of bike lanes, bike share programs, and improved pedestrian walkways. In 2017, NDOT also adopted the Complete Streets Policy which aims to make streets more accessible to alternative means of transportation.

1. https://assets.americashealthrankings.org/app/uploads/allstatesummaries-ahr22.pdf
2. https://data.census.gov/table?q=public+transportation&g=0400000US32


Paris
planet hollywood
Aria
BEST RESORTS. BEST REWARDS.
zuma
BELLAGIO
Picasso
AWARD-WINNING DINING DESTINATION
PARK M
30

ACCESS TO HEALTHY FOODS

Food is necessary for survival, and access to healthy, affordable food options plays a major role in the health outcomes in a community. Related concerns are highlighted elsewhere in this report: Food security (Social Determinants of Health) and foodborne-illness (Communicable Disease Control). Environmental influences such as climate change also affect healthy food access. Food deserts are defined as regions wherein the population is low income and has limited access to healthy food options like grocery stores with fresh produce. While recent statewide data on the number of food deserts is not available, a 2019 survey by the USDA as part of the Food Access Research Atlas identified 49 of the state's 687 census tracts as food deserts. Because the COVID-19 pandemic exacerbated food insecurity, the Nevada Department of Agriculture invested in local organizations working to address food insecurity throughout the state.

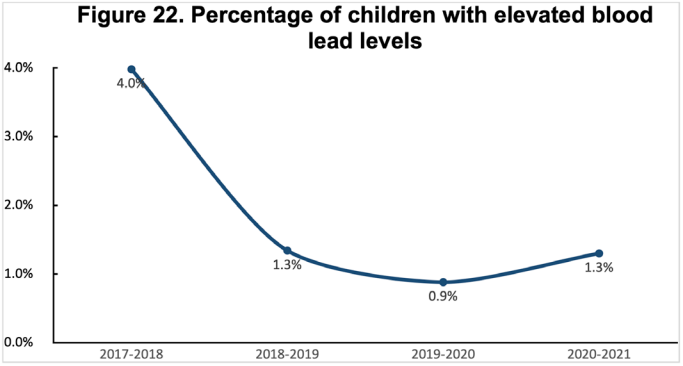
HEALTHY & SAFE HOUSING

Like the lack of affordable housing, Nevada also struggles to meet demand for safe housing. Safe housing reduces exposure to contaminants like lead and radon, reduces fire risk, and ensures proper heating and cooling systems. From 2015 to 2019,18.5% of Nevada households did not have complete kitchen facilities, lacked plumbing facilities, were overcrowded, or had occupants who were severely cost-burdened. This is higher than the national average of 17% and makes Nevada the 44th worst state for this indicator.[1] Native American residents are disproportionately affected; between 1990 and 2019, 0.67% of Native American households in Nevada lacked complete indoor plumbing, compared to the national average of 0.4%.[2]

LEAD EXPOSURE

Chronic, elevated lead exposure is toxic to people of all ages and children face the highest risk. In early childhood, lead poisoning has marked effects on brain development causing lower IQ, issues with learning and behavior, and hearing and speech problems. Children living in older, low-income housing are more likely to be exposed to elevated levels of lead. In Nevada, 5.2% of houses are considered high risk for lead exposure, the lowest rate in the nation, and the number of children testing above the CDC's recommended level has been decreasing, from 351 to 83 between 2018 and 2021.[1,3] However, Nevada has one of the lowest rates of lead testing in the nation, meaning cases of elevated lead blood levels in children likely are being missed.[4]

1. https://www.americashealthrankings.org/explore/annual/measure/severe_housing_problems/state/NV
2. https://www.dri.edu/growing-numbers-of-native-american-households-in-nevada-face-plumbingpoverty-water-quality-problems/
3. https://nvclppp.org/childhood-lead-poisoning-across-nevada/
4. https://nvclppp.org/wp-content/uploads/2021/07/NvCLPPP-Housing-FactSheet_02012021.pdf



Source: Nevada Childhood Lead Poisoning Prevention Program

RADON EXPOSURE

Radon is a colorless, odorless gas released from the soil. Typically, the gas spreads harmlessly into the air, but it can become trapped in buildings where it can increase risk of developing lung cancer. Twelve of Nevada's 17 counties have high radon potential, most of which are rural and frontier counties.[1] While testing can be done with a relatively inexpensive home test kit, radon mitigation is expensive, making it unaffordable for many low-income households.

1. https://naes.agnt.unr.edu/PMS/Pubs/2022-2708.pdf

ACCESS TO NATURE

Spending time in nature improves a variety of health outcomes, such as reducing anxiety, depression, and cardiovascular disease, and improving concentration in children.[1] More than 80% of all land in Nevada is public, second only to Alaska. This means that Nevada's residents simply need to venture a few miles outside of city limits to hike, mountain bike, ride ATVs, camp, fish, and more. Nevada is also home to two national parks and thirteen state parks. Despite this abundance, access is not equal. Low-income individuals with limited or no transportation in populous areas often must rely on parks and local green spaces to access nature, which vary in quality and size.

1. https://www.apa.org/monitor/2020/04/nurtured-nature

ACCESS TO RECREATIONAL FACILITIES

Access to recreational facilities and spaces encourages communities to be physically active and has a positive effect on overall health. In Nevada, 90% of the population has access to recreational facilities, above the national average of 80%. However, the condition, accessibility, and capacity of recreational facilities vary depending on location; facilities in low-income neighborhoods often are poorer quality.[1]

1. https://www.countyhealthrankings.org/reports/state-reports/2022-nevada-state-report

OCCUPATIONAL HEALTH

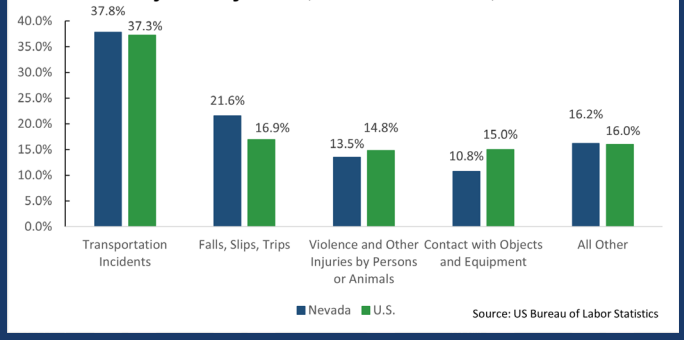
Tracking workplace illness, injuries, and fatalities is important for ensuring a safe work environment and protection for workers. Nevada is rated highly for occupational safety, ranking 10th in the nation for occupational fatalities with 3.6 fatal occupational injuries per 100,000 workers between 2018 and 2020. In 2020 there were 37 fatal occupational injuries, primarily due to transportation incidents (38%) and falls, slips, or trips (22%), down from 39 fatalities the year before. Industries with the highest percentage of fatalities are construction (24%) and transportation and warehousing (27%) (Figure 23). A total of 65% of workers who experienced fatal occupational injuries in 2020 were white and 22% were Hispanic/Latino.[1]

In 2021, the rate of non-fatal occupational injuries and illnesses was 3.3 per 100 full-time employees, slightly higher than the national rate of 2.7. Industries with the highest rates of days away from work were construction, manufacturing, transportation, and local government. All three of these industries had higher rates of days missed than the previous year.[2]

Nevada mandates sick leave for businesses with more than 50 employees. This is significant because small businesses make up the vast majority of private enterprises in the state. Sick leave encourages workers to take time to seek proper treatment when ill or injured, improving their health outcomes. Furthermore, in Nevada, 24.3% of businesses with 50 or fewer employees provide health insurance to employees, which places the state 46th in the nation.[3]

1. https://www.bls.gov/regions/west/news-release/fatalworkinjuries_nevada.htm
2. https://www.bls.gov/regions/west/news-release/workplaceinjuriesandillnesses_nevada.htm#:~:text=Private%20industry%20employers%20reported%2029%2C800,of%20Labor%20Statistics%20reported%20today.
3. https://www.kff.org/other/state-indicator/firms-offering-coverage-by-size/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Figure 23. Percent of total fatal occupational injuries by event, Nevada and U.S., 2020



PREVENTION & HEALTH PROMOTION

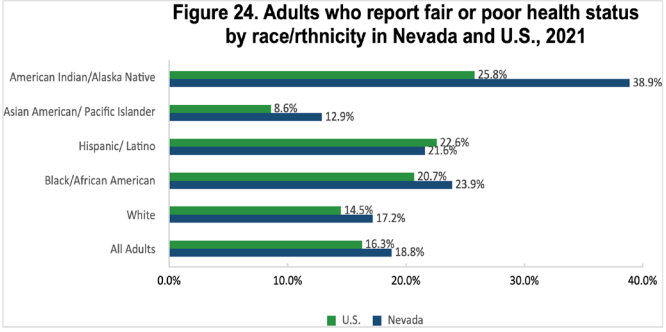
Nevadans recognize that preventing health conditions is more effective than treating a chronic disease. Participants in the Listening Tour as well as Community Survey respondents highlighted behavioral health (both mental health and substance use), healthy food, physical activity, and health education as points of concern. They also mentioned a need for health promotion efforts that promote holistic well-being.

"Also, I'd like to emphasize the mind body spirit--it's an integrated health. Health as prevention. You know you're not just talking about the body, you're talking about the mind and the spirit is part of it, spirituality as well, and that builds a community of people who are healthy mind body and spirit."

OVERALL HEALTH

Self-reported health is an important indicator of population health. In Nevada, 81% of Nevadans reported being in good, very good, or excellent health in 2021.[1] Nevadan's who are Black/African American, Hispanic/Latino, or American Indian/ Alaska Native were more likely to report fair or poor health than other races/ethnicities (Figure 24).

1. https://www.kff.org/other/state-indicator/adult-self-reported-health-status/?activeTab=graph&currentTimeframe=0&startTimeframe=8&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D,%22states%22:%7B%22nevada%22:%7B%7D%7D%7D&sortModel=%7B%22colI



Source: Kaiser Family Foundation

MATERNAL, CHILD, AND ADOLESCENT HEALTH

U.S. Department of Health and Human Services defines maternal and child health as the wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of women, children, and families. A variety of factors can affect maternal and child health, including sociodemographic and behavioral risk factors, racial and ethnic disparities, and the mental and physical health of the parents and caregivers.[1] According to the 2022 Kids Count Data Book produced by the Annie E. Casey Foundation, Nevada ranks 47th in the nation for overall child well-being.[2]

1. Healthy People 2020: https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health
2. https://www.aecf.org/interactive/databook?l=32

MATERNAL MORTALITY

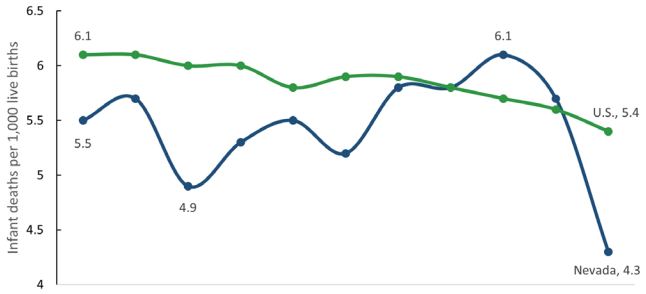
Maternal mortality, or pregnancy related death, is the death of a woman while pregnant or within one year of the end of pregnancy from any cause related to or aggravated by the pregnancy. Between 2018 and 2022, Nevada had a maternal mortality rate of 19.2 deaths per 100,000 live births compared to the national average of 20.4. Black/African American mothers experience maternal mortality at significantly higher rates than White and Hispanic/ Latino mothers. Additionally, Black/African American mothers had the highest rates of severe pregnancy-related health complications in the state.[1] To better

assess causes of maternal mortality, the state Legislature established the Maternal Mortality Review Committee (MMRC) in 2019. In 2021, the CDC provided funding to expand the capacity of the MMRC.
1.https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/MMRC%20MM%20and%20SMM%20LCB%20Report%20December%2028%202022%20FINAL.pdf

INFANT AND CHILD MORTALITY

Infant mortality is defined as death occurring in the first year of life and is an important reflection of social and political conditions, health care delivery, and medical outcomes in a geographic area. According to the CDC, the top causes of infant death are birth defects, preterm birth and low birth rate, sudden infant death syndrome (SIDS), injuries, and maternal pregnancy complications. In 2020, Nevada's infant mortality rate was 4.3 deaths per 1,000 live births, below the national rate of 5.4 (Figure 25). This rate has been decreasing steadily since 2018, but racial and

Figure 25. Infant mortality rate, NV and U.S.



Source: March of Dimes

ethnic disparities remain. In Nevada, Black/African American infants are nearly twice as likely to die as White and Hispanic/Latino infants.[1]
1.https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR_MCH/state/NV

Child mortality is defined as death before the age of 5 years of age. In Nevada, the child mortality rate was 23.2 deaths per 100,000 children between 2018 and 2020.2 This is down from the child mortality rate of 27.8 between 2012 and 2014. As with infant mortality, child mortality disproportionately impacts Black/African American children.
2. https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/child_mortality_a/state/NV

INFANT BREASTFEEDING

Breast milk provides a variety of health benefits for infant growth, immunity, and development. Nevada has a breastfeeding initiation rate of 80%, but only 22.3%[1] of Nevada's infants are exclusively breastfed for 6 months. This is lower than the national rate of 24.9% and places Nevada 40th in the nation.[2]
1.Nevada Breastfeeding Report, 2023
2.https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/breastfed/state/NV

LOW BIRTH WEIGHT

Low birthweight (LBW) refers to a baby that weighs less than 5 pounds, 8 ounces at birth. It is commonly caused by preterm birth and fetal growth restrictions. While LBW infants can be healthy, they are at increased risk for health problems in infancy as well as later in life.[1]
1. https://www.marchofdimes.org/find-support/topics/birth/low-birthweight

Nevada is ranked 40th in the nation for rate of low weight births; 9% of babies were LBW in 2020. Black/African American and Asian mothers are more likely to have LBW babies in Nevada than other races and ethnicities, as are mothers over40 years of age. The rate of LBW births in Nevada has been increasing slowly and is up 1.8% from 1990.[1] This is likely due to a rise in pre-existing maternal health conditions like diabetes and hypertension, as well as a lack of adequate prenatal care in certain communities.
1.https://www.americashealthrankings.org/explore/annual/measure/birthweight/state/NV

ABORTION RATE

In 2020, Nevada had an abortion rate of 17.9 abortions per 1,000 women aged 15 to –44, higher than the national average of 14.4. However, the abortion rate in Nevada has been declining since 1991, when it peaked at 48.5 abortions per 1,000 women.[1]
1. https://data.guttmacher.org/states/trend?state=NV+US&topics=65&dataset=data

WOMEN RECEIVING PRENATAL CARE

Prenatal care refers to health care delivered during pregnancy; it typically includes screening and treatment for medical conditions and identification and interventions for behavioral risk factors associated with poor birth outcomes (e.g., smoking, drinking). Adequate prenatal care is vital for ensuring positive health outcomes for both the mother and the baby.

Nevada ranks 27th in the nation for adequate prenatal care. In 2021, 7.6% of live births in Nevada were to women who received late prenatal care or no care at all, and 78.3% were to women who received early prenatal care.[1] While access to adequate prenatal care has improved over the years, there is still room for improvement. American Indian/Alaska Native women are least likely to receive early prenatal care.
1. https://www.marchofdimes.org/peristats/data?reg=99&top=5&stop=23&lev=1&slev=4&obj=1&sreg=32

SEXUAL HEALTH

Ensuring that young people are properly informed to make thoughtful choices about their sexual health is important to their overall wellbeing.

In Nevada, schools are required to establish a human sexuality course, but the course is opt-in and is not required for graduation, which means there is no way to ensure all students receive sex education. The state has no standard regarding medically accurate sex education, but instruction on HIV/AIDS must be factual. Furthermore, there is no requirement that schools educate students on sexual orientation and gender identity or on consent.[1] In spite of this, 60.1% of Nevada schools have elected to provide instruction on diversity of sexual orientation and gender identities, and 74.6% provide instruction on how to communicate sexual consent between partners. While these numbers have room for improvement, both rates are significantly higher than the national averages.[2]

1.https://siecus.org/state_profile/nevada-fy21-state-profile/
2.https://www.cdc.gov/healthyyouth/data/profiles/pdf/2020/CDC-Profiles-2020.pdf

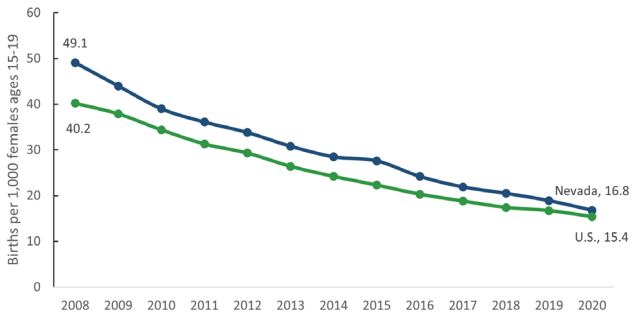
TEEN PREGNANCY AND BIRTH RATE

According to the Centers for Disease Control and Prevention, the teen birth rate is the number of births per 1,000 females aged 15 to 19 years. Teen birth rates in Nevada have declined steadily, down 77% from the peak in 1991.[1] This is likely due in part to a decrease in early sexual activity in Nevada's high school students, with only 14.7% of 2021 Youth Risk Behavior Survey respondents reporting sexual activity within 3 months of the survey, compared to 19.4% in 2019.

Nevada's teen birth rate in 2020 was 16.8, which is higher than the overall teen birth rate in the United States, which has historically been the case (Figure 26). Nationwide, Nevada ranks 30th for teen birth rate.[2]

1.https://powertodecide.org/what-we-do/information/national-state-data/nevada
2.https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/TeenBirth_MCH/state/NV

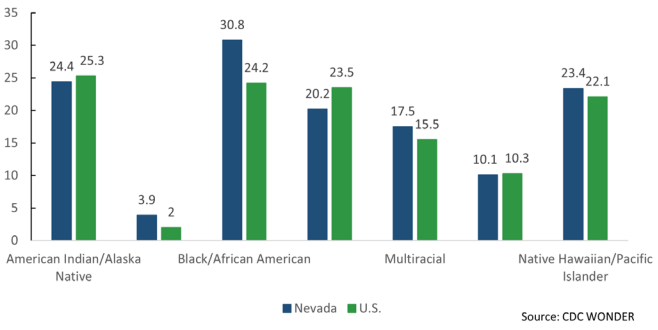
Figure 26. Teen birth rate, Nevada and U.S.



Source: CDC WONDER

A variety of factors impact teen birth rates, including education and income levels. In Nevada, Black/African American teenagers are more likely to give birth than any other racial/ethnic group, and at rates that are higher than the national average (Figure 27).

Figure 27. Teen birth rate by race/ethnicity, Nevada and U.S.



Source: CDC WONDER

NUTRITION
& PHYSICAL ACTIVITY

Nevadans recognize the importance of diet and exercise for overall wellbeing. A total of 78% of Community Survey respondents indicated exercise is fairly or extremely important, and they identified improving green space infrastructure and decreasing the cost of gym membership as priorities in this area. Similarly, respondents identified healthy eating as important, but 36% felt that healthy foods were too expensive.

"I know that specifically in this area that we live in...there's no real grocery store."

"Well, also right now they're talking about gyms and all that and you see most people can't afford a gym and there's no free gyms. Of course, they're all paid."

PHYSICAL ACTIVITY

The Department of Health and Human Services (DHHS) recommends that adults do at least 150 minutes of moderate-intensity activity each week for substantial health benefits. In 2019, 20% of adults engaged in this recommended amount of exercise.[1] Children and adolescents (ages 6 through 17) are recommended to engage in at least one hour of moderate-to-vigorous physical activity daily. However, only 15.3% of high school students and 23.9% of middle school students meet this guideline.[2]

1.https://www.americashealthrankings.org/explore/annual/measure/exercise/state/NV
2. 2021 YRBS

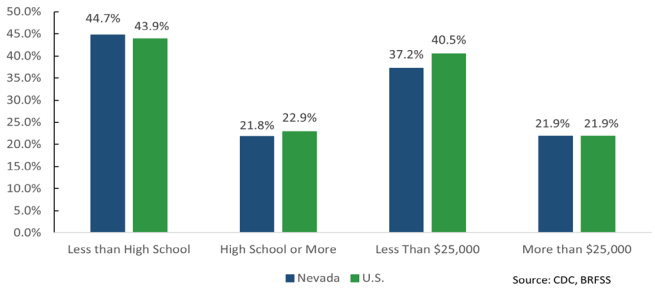
While 90% of Nevadans have adequate access to locations for physical activity, as mentioned previously, the quality and capacity of these locations vary, and accessibility measures do not account for costs that may be prohibitive in certain low-income areas.[1] Furthermore, access varies widely by county; certain regions in Nevada report only 5% of residents have access to exercise opportunities. Physical activity/inactivity is also affected by socioeconomic factors. Individuals who have not completed high school or who earn less than $25,000 per year are far more likely to be inactive than more educated and wealthier residents (Figure 28).[2]

1.https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/health-behaviors/diet-and-exercise/access-to-exercise-opportunities?keywords=&f%5B0%5-type%3Astates&f%5B1%5D=type%3Acounties&year=2022&state=32&tab=
2.https://www.americashealthrankings.org/explore/annual/measure/Sedentary/state/NV

NUTRITION

While most Nevadans have access to exercise opportunities, access to healthy foods was a point of concern for community survey respondents. As discussed previously (Access to Healthy Foods),

Figure 28. Inactivity rates in adults, Nevada and U.S., 2021



residents in many regions of the state lack access to stores that sell healthy food. Statewide, only 5.7% of adults report consuming two or more fruits and three or more vegetables daily, placing Nevada the 43rd in the nation for fruit and vegetable consumption. Fruit and vegetable consumption is impacted by education and income; less educated and lower-income Nevadans eat fewer fruits and vegetables.[1]

1.https://www.americashealthrankings.org/explore/annual/measure/fvcombo/state/NV

SODA CONSUMPTION

Sugary drinks are the single largest source of calories in children's diets and provide nearly half of children's added sugar intake. Consuming sugar-sweetened beverages can increase risk of tooth decay and preventable health issues such as obesity.[1] In Nevada, only 5.5% of high school students report drinking soda two or more times a day, one of the lowest rates in the nation.[2]

1. https://stateofchildhoodobesity.org/sugary-drinks-harm-kids-health/
2. https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/soda_consumption/state/ALL

BEHAVIORAL HEALTH & SUBSTANCE ABUSE

Behavioral health refers to mental health as well as substance use and addiction, and it is a priority concern among Community Survey respondents and Listening Tour participants. According to the 2021 Pain in the Nation report, Nevada ranks 19th in the nation for deaths related to alcohol, drugs, and suicide.[1]

MENTAL HEALTH

The 2021 State of Mental Health in America report ranks Nevada 50th in the nation for overall mental health based on 15 measures. The state also ranks 40th in the nation for adult mental health, 51st for youth mental health, and 46th in the nation for prevalence of mental illness.[1] According to the report, Nevada's low rankings stem primarily from high rates in the following categories:

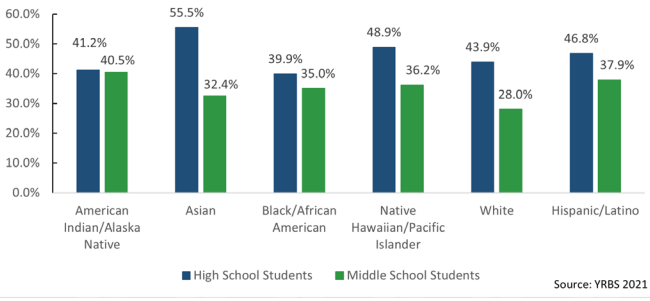
- Youth with at least one major depressive episode (MDE)
- Youth with substance use disorder
- Youth with MDE who did not receive any mental health treatment
- Youth with severe MDE who received inconsistent treatment
- Individualized Education Program (IEP) students identified with emotional disturbances
- Adults with mental illness who did not receive treatment
- Adults with mental illness who are unable to receive treatment

Surveys of Nevadans found that adult Nevadans who are Native Hawaiian/Pacific Islander have the highest frequency of poor mental health days statewide. Gay/Lesbian and bisexual residents in Nevada report significantly higher rates of depressive disorder and suicidal thoughts than heterosexual residents.[2] Nevadans with a disability experience depression at nearly four times the rate of residents without a disability.[3]

Data from the 2021 Youth Risk Behavior Survey (YRBS) also reflect the state's struggles to address youth mental illness. 46.1% of high school students and 34.6% of middle school students reported feeling sad or hopeless almost every day for two weeks in a row. Rates of depressive episodes was highest among American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Hispanic/Latino students (Figure 29). While Nevada does require that schools provide instruction on suicide prevention and the identification of available mental health resources, it is clear that school-based mental health programs have room for improvement.

1. https://mhanational.org/issues/2022/ranking-states
2. Department of Health and Human Services
3. CDC

Figure 29. Percentage of high school and middle school students experiencing depressive episodes by race/ethnicity, Nevada, 2021



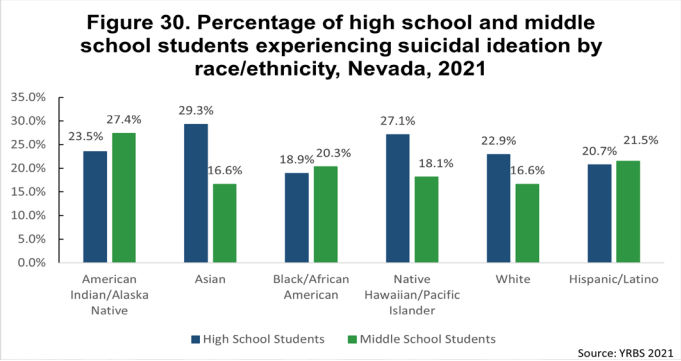
SUICIDE

Nevada has the 39th highest suicide rate in the nation at 19.4 deaths per 100,000. This rate is higher than the national average and has remained mostly unchanged since 2009. Males are more than four times as likely to commit suicide, and adults over the age of 85 die by suicide at almost twice the rate of any other age group. Suicide deaths are also disproportionately high among white Nevadans.[1] While many states experience higher rates of suicide in rural and frontier regions than in urban settings, the opposite is true in Nevada.

Teen suicide in Nevada is also higher than the national average with a rate of 15.1 deaths per 100,000 adolescents ages 15-19. As with the overall rate, male adolescents are significantly more likely to die by suicide than females.[2] According to the 2021 Youth Risk Behavior Survey, more than 20% of high school and middle school students have seriously

contemplated suicide. 12.3% of high school students and 7.7% of middle school students attempted suicide with female students doing so at higher rates than their male counterparts. Asian high school students and American Indian/Alaska Native high school students had the highest prevalence of suicidal ideation (Figure 30).

1. https://www.americashealthrankings.org/explore/annual/measure/Suicide/state/NV
2. https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/teen_suicide/state/NV



TOBACCO, ALCOHOL & DRUG USE

Each year in Nevada, approximately 4,100 deaths[1] are attributable to smoking-related diseases, and if the current smoking rate continues, it will cause the premature death of 5.6 million children alive today.[2] Second-hand smoke also plays a major factor in premature death in Nevada, with strip clubs and casinos still allowing indoor smoking.

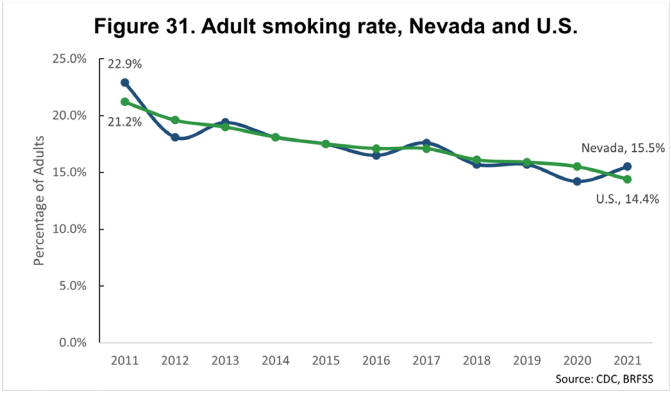
Smoking rates in Nevada have been declining over the years. In 2021, 14.5% of adults reported being current smokers and having smoked at least 100 cigarettes in their lifetime (Figure 31). Data suggests adults who are Black/African American, are less educated, and earn less money are more likely to smoke cigarettes[3] (Figure 32). Nevadans with a disability are also more likely to smoke cigarettes than residents without disabilities.[4] Youth smoking is also declining. According to the 2021 YRBS survey, 7.2% of high school students report having ever smoked a cigarette, compared to 32% in 2015. The prevalence of ever having used electronic vapor products have also decreased from 51% in 2015 to 36.7% in 2021.[5]

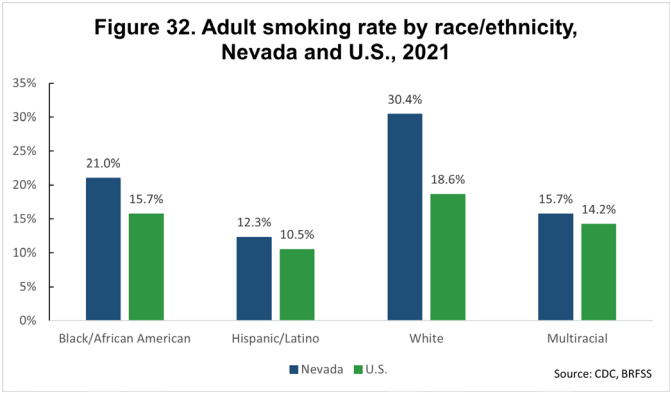
1. CDC
2. DPBH
3. https://www.americashealthrankings.org/explore/annual/measure/smoking/state/NV
4. CDC
5. https://guinncenter.org/wp-content/uploads/2022/05/Guinn-Center-NV95-Youth-Outcomes-2022.pdf

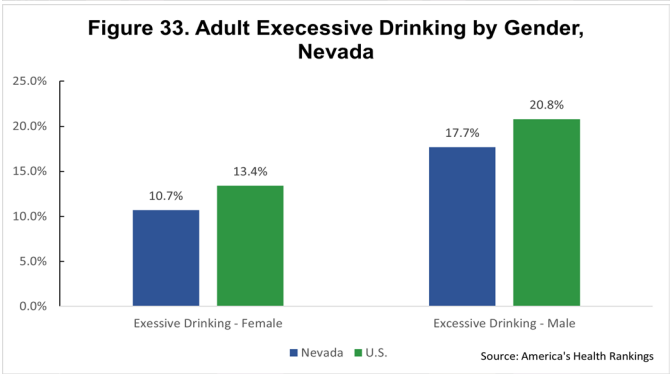
ALCOHOL USE

Nevada ranks 45th in the nation with 9.32% of the population experiencing a substance use disorder (5.71% alcohol use and 2.97% illicit drug use).[1] Alcohol use can increase a person's risk of developing serious health problems such as brain and liver damage, cancer, heart disease, and death. Nevada has some of the highest per capita alcohol consumption in the nation, and 14.2% of adults report excessive drinking, below the national average of 17.3%.[2] In 2019, 546 Nevadan's died due to alcohol, a rate of 15.1 per 100,000.[3] In 2020, 24% of motor vehicle deaths involved someone who was impaired by alcohol.

1. https://casatondemand.org/2022/05/19/the-state-of-mental-health-in-nevada/#:~:text=Within%20the%202022%20Mental%20Health,is%20approximately%2050%20million%20Americans.
2. https://www.americashealthrankings.org/explore/annual/measure/ExcessDrink/state/NV
3. Pain in the Nation

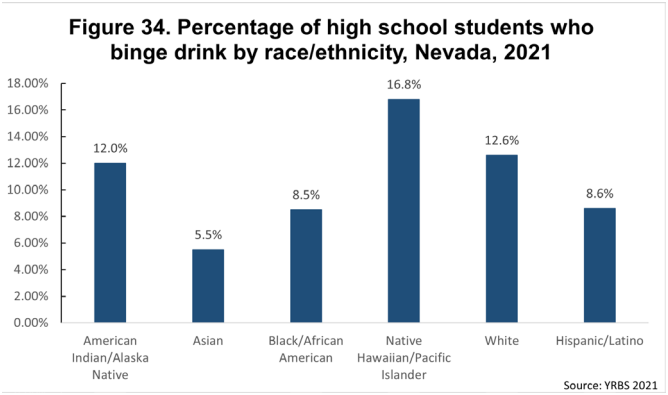






The 2021 Youth Risk Behavior Survey and 2022 Youth Outcomes in Nevada report provides insight into youth alcohol consumption in the state:

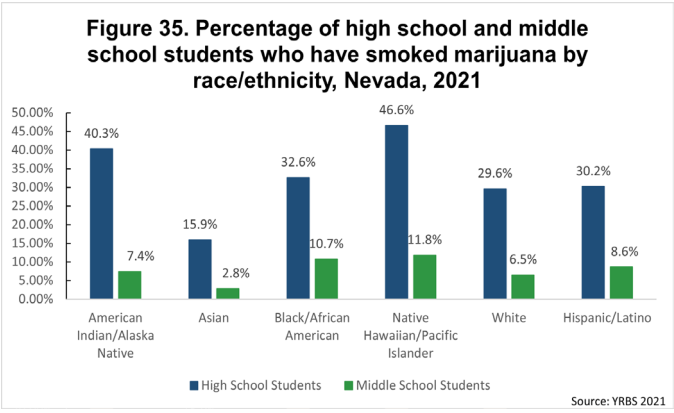
- 11.6% of 11th graders and 14.3% of 12th graders reported binge drinking at least once in the past month (Figure 33).
- American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and White high school students are more likely to binge drink (Figure 34)
- 5.1% of high school students and middle school students reported having at least one drink of alcohol on 20 or more days in the past month



MARIJUANA USE

In 2022, Nevada had the highest prevalence marijuana use, with 45% of adults reporting use of prescription or recreational marijuana in the past 12 months.[1] According to the 2021 YRBS survey, 30.2% of high school students and 7.9% of middle school students had used marijuana in the past year (Figure 35).

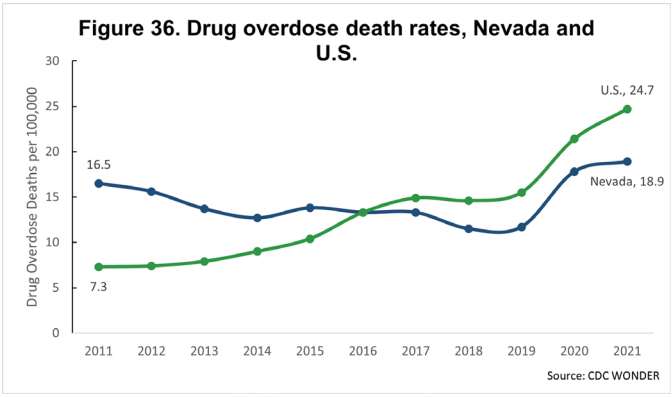
1.https://www.americashealthrankings.org/explore/annual/measure/drug_use/population/drug_use_cannabis/state/NV

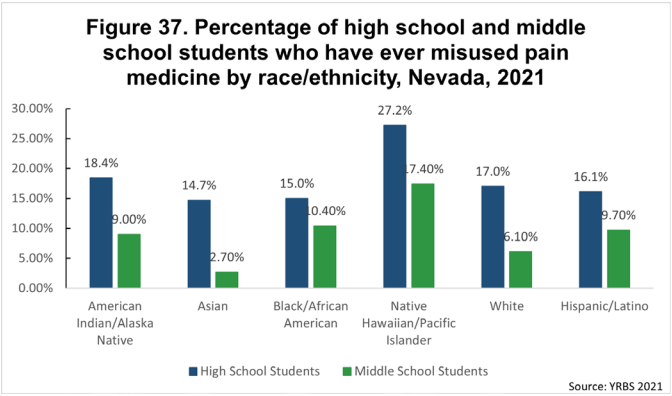


PRESCRIPTION AND ILLICIT DRUG USE

The abuse of prescribed and illicit drugs in Nevada has been devastating in recent years. Over prescription of pain relievers has driven a spike in use of opioids, including prescribed drugs and illicit drugs such as heroin since 1999. In 2022, 23% of adults reported using illicit drugs (excluding marijuana) or non-medical prescription drug use. Only West Virginia and the District of Colombia have higher rates of drug use. Overdose deaths caused by opioids have been climbing and reached a peak rate of 18.9 deaths per 100,000 population (Figure 36). Black/African American Nevadans are more likely to experience non-medical drug use than other races and ethnicities.[1]

1.https://www.americashealthrankings.org/explore/annual/measure/drug_use/state/NV





The 2021 YRBS Survey measured prescription and illicit drug use among high school and middle school students and found the following:

- 16.4% of high school students and 8.4% of middle school students took prescription pain medicine without a prescription or differently than instructed by their doctor
- Native Hawaiian/Pacific Islander youth were more likely to take prescription pain medicine without a prescription or differently than instructed by their doctor than other races/ethnicities (Figure 37)
- Female students were more likely than male students to misuse prescription pain medicine
- 3.8% of high school students reported using cocaine in their lifetime, and 5.2% reported using ecstasy in their lifetime

A 2022 DHHS report on youth substance use indicates that cocaine and methamphetamine use has decreased since 2015.[1]

1.https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/27827#:~:text=Drug%2Drelated%20admissions%20for%20Nevada,and%20cocaine%2C%20in%20that%20order.&text=youth%20in%20Nevada,.have%20declined%20over%20that%20period.

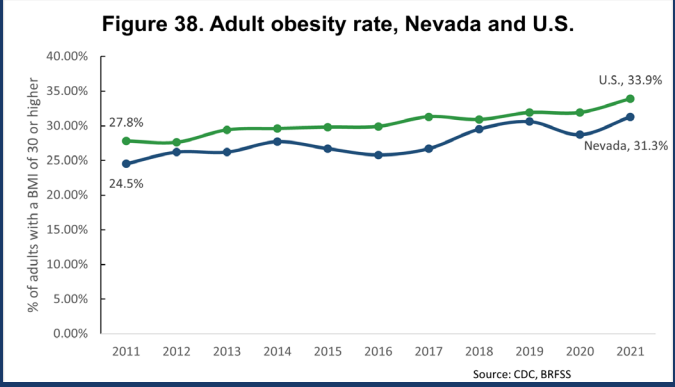
CHRONIC DISEASES & CONDITIONS

Many Nevadans suffer from a variety of chronic diseases, including cancers, cardiovascular disease, respiratory diseases, and diabetes.

OBESITY

Obesity is linked to heart disease, stroke, type 2 diabetes, and some types of cancer. In children, obesity causes greater risk of a variety of health conditions including type 2 diabetes, asthma, joint problems, and high blood pressure. Obesity rates in Nevadan adults have been rising for three decades, from 12.5% in 1990 to 31.3% in 2021 (Figure 38). In Nevada, obesity rates are highest among White, Black/African American, and Hispanic residents. Individuals who are less educated and earn less money are also more likely to be obese in Nevada.[1]

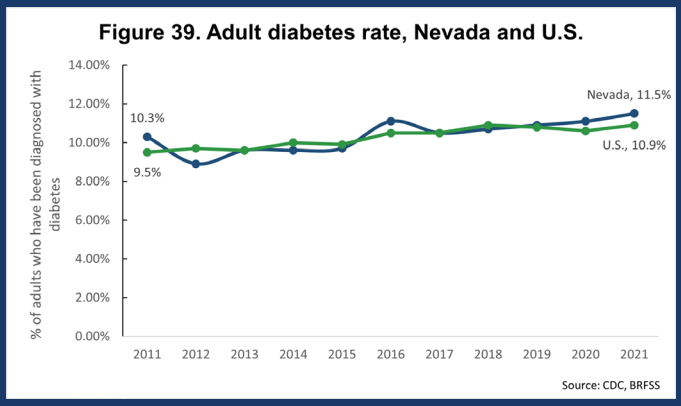
1.https://www.leg.state.nv.us/Division/Research/Documents/RTTL_NRS439.521_2022.pdf



DIABETES

Diabetes is a chronic condition that occurs when blood levels of glucose (sugar) are abnormal. Without proper management, the disease can cause heart attack, stroke, blindness, kidney damage, and limb amputation. As with obesity, diabetes has risen over the years, from 4.8% of adults having been told that they have diabetes in 1995 to 11.5% in 2021 (Figure 39). The prevalence of diabetes in Nevada is highest among residents who earn low incomes, are less educated, and are over the age of 45.[1]

1. https://www.americashealthrankings.org/explore/annual/measure/diabetes/state/NV

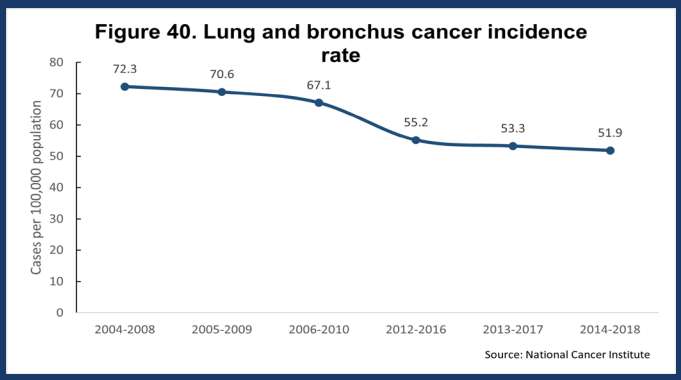


CANCER

According to the CDC, cancer is the second leading cause of death in Nevada. Lung cancer is responsible for the deaths of more Nevadans than any other type, with a 2016-2020 mortality rate of 34.9 deaths per 100,000 population.[1] Nevada has the worst lung cancer screening rate in the nation, with only 1% of individuals who are considered high-risk being screened. In spite of this, lung cancer rates have been decreasing since 2004 (Figure 40).[2] White and Black/African American residents have the highest rates of lung cancer diagnosis in the state.

1.https://statecancerprofiles.cancer.gov/deathrates/index.php?stateFIPS=32&areatype=county&cancer=047&year=0&race=00&sex=0&age=001&type=death&graph=1&sortVariableName=rate&sortOrder=desc

2.https://www.lung.org/research/state-of-lung-cancer/states/nevada#:~:text=The%20rate%20of%20new%20lung,it%20in%20the%20average%20tier.



CARDIOVASCULAR DISEASE AND STROKE

Heart disease is the leading cause of death in Nevada. According to the CDC, Nevada had a heart disease mortality of 201.3 deaths per 100,000 individuals, the 9th highest rate in the nation.[1] In 2021, 7.9% of Nevadans reported ever being told by a health professional that they had some form of heart disease (angina or coronary heart disease; a heart attack or myocardial infarction; or a stroke). This prevalence is comparable to the 7.7% of Nevadans being diagnosed with heart disease in 2015. Nevadans who are Black/African American or earn less than $25,000 per year have higher rates of cardiovascular disease.[2]

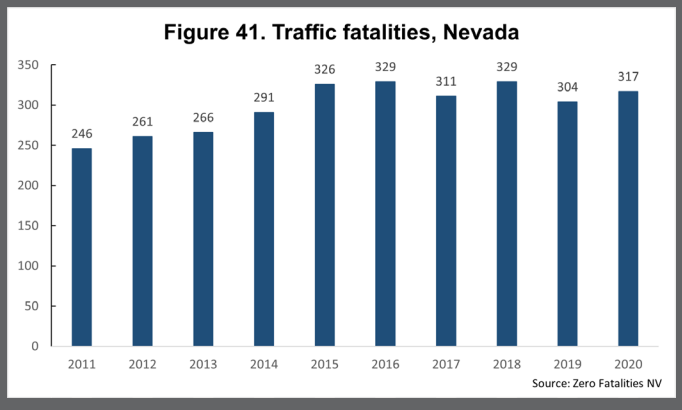
1. CDC

2. https://www.americashealthrankings.org/explore/annual/measure/CVD/state/NV

MOTOR VEHICLE ACCIDENTS

Deaths caused by motor vehicle crashes have been increased since 2013. Between 2016 and 2020 there were 1,489 fatal crashes in Nevada, with 71% of them taking place in urban regions. Of those fatalities, 813 were drivers or passengers, 383 were pedestrians, 259 were motorcyclists, and 34 were bicyclists.[1] According to Nevada's Zero Fatalities initiative, 43% of those accidents involved an impaired driver who had a blood alcohol content (BAC) of 0.08% or greater or tested positive for drugs in their system. A US Department of Transportation Port shows that between 2016 and 2020, an average of 91.5% of Nevada's drivers wore seatbelts, and over the same period there were 345 fatalities in which a passenger or driver were unrestrained.[2] According to numerous national studies, American Indian/Alaskan Native individuals the highest rate of traffic-related deaths.[3]

1.https://ndot.maps.arcgis.com/apps/webappviewer/index.html?id=00d23dc547eb4382bef9beabe07eaefd
2.https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/813307
3.https://www.ghsa.org/sites/default/files/2021-06/An%20Analysis%20of%20Traffic%20Fatalities%20by%20Race%20and%20Ethnicity.pdf



FIREARMS

Firearm related injury and death is a complex public health issue due to the unique social and cultural views of guns in the United States. In Nevada, the rate of gun deaths increased 24% from 2011 to 2020. According to the CDC, 547 Nevadans died in 2020 due to firearm injury deaths, a rate of 17 deaths per 100,000 population. Suicide accounts for 68% of deaths in Nevada, followed by homicides (28%), shootings by police (3%), and unintentional injuries (1%).[1]

1. https://everystat.org/#Nevada

Figure 42. Gun deaths by type, Nevada

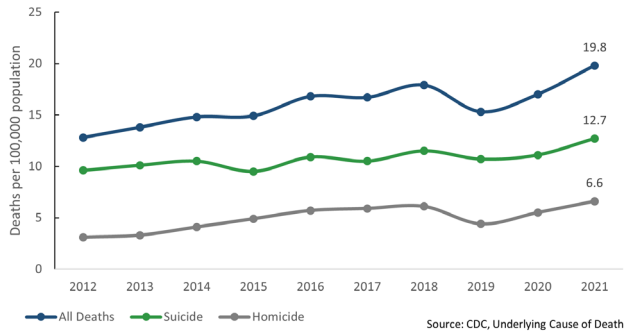
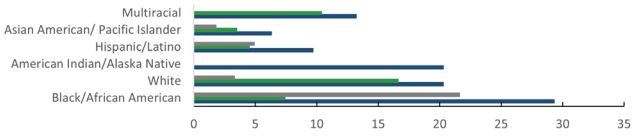


Figure 43. Gun deaths by race/ethnicity, Nevada, 2021



	Black/African American	White	American Indian/Alaska Native	Hispanic/Latino	Asian American/ Pacific Islander	Multiracial
Homicide	21.6	3.3	0	4.9	1.8	0
Suicide	7.4	16.6	0	4.5	3.5	10.4
All Deaths	29.3	20.3	20.3	9.7	6.3	13.2

Source: CDC, Underlying Cause of Death

Deaths per 100,000 population

While Clark County and Washoe County account for the bulk of gun deaths, the rate of gun deaths in Humboldt County, Elko County, and Nye County are nearly double the rate of the more populous counties. Furthermore, while 64% of people killed by guns in Nevada are White, Black/African American, and American Indian/Alaska Native residents die at higher rates. White residents of Nevada are 2.3 times more likely to die by gun suicide than black residents, but Black/African American Nevadans are 6 times more likely to die by gun homicide than their white counterparts (Figure 43).

OLDER ADULTS

Nevada's population of older adults continues to grow—with a 46% increase in the age of residents who are 65 and older between 2011 and 2019—a trend that is expected to continue through 2030. As of 2020, 16.5% of Nevada's residents are 65 or older, and 14.3% of them live alone.[1] Adequate resources required for older adults to live alone, include transportation, community-based exercise and social opportunities, food and medicine delivery, and access to health care. As this report has covered, access to these required resources varies greatly by factors such as socioeconomic status or geographic location.

According to the 2022 America's Health Rankings, 36.9% of adults in Nevada who are 65 or older report being in very good or excellent health, the 45th lowest prevalence in the nation.[2] This is reflected in comments made by senior community members who highlighted a lack of financial assistance for medication, a lack of housing assistance for seniors and veterans, and more social opportunities for seniors.

Among older adults, falls are the leading cause of injury-related death, as well as the top cause of nonfatal injuries and hospital admissions for trauma. Falls have been increasing in Nevada; 23.8% of individuals 65 and older reporting falling in 2020, compared to 16.6% in 2010 (Figure 44).[3] In 2021, 325 seniors died due to a fall, a rate of 77.3 deaths per 100,000 population aged 65 and older.[4]

1.https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/27078
2.Americas Health Rankings https://www.americashealthrankings.org/explore/senior/measure/health_status_sr/state/NV
3.Americas Health Rankings https://www.americashealthrankings.org/explore/senior/measure/falls_sr/state/NV
4.CDC

Figure 44. Percentage of adults aged 65+ who fell, Nevada and U.S.

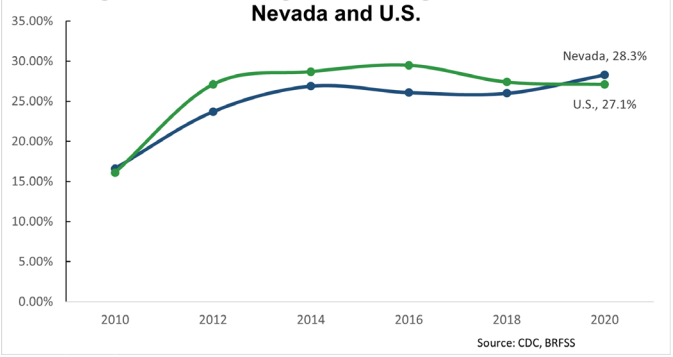


Figure 45. Premature Death, Nevada and U.S.

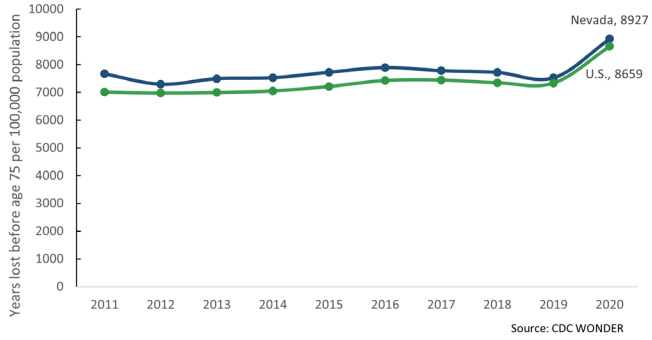
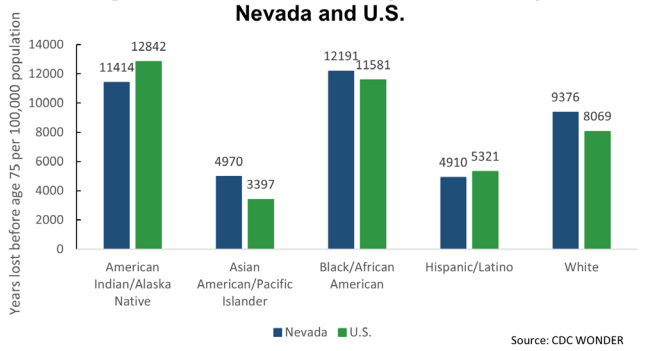


Figure 46. Premature death by race/ethnicity, Nevada and U.S.



CAUSES OF DEATH

The average life expectancy for Nevadans is 78.0 years old, compared to 78.8 years old for the entire United States. Nevada ranked 33rd in life expectancy in 2019. The five primary causes of death in Nevada in 2020 were heart disease, cancer, COVID-19, unintentional injuries, and stroke.[1] In Nevada, Black/African American residents are more likely to die of heart disease, cancer, and stroke than other races or ethnicities.[2] Black/African American and Hispanic/Latino Nevadans were more likely to die due to COVID-19 than other races or ethnicities.

One measure of the burden of early death is to calculate the number of years between a person's age at death and the standard age at death (e.g., 75 years old). This measurement is called years of potential life lost (YPLL). Nevada has seen a decline in YPLL since the 1990's, but between 2019 to 2020 it dramatically rebounded, primarily due to deaths from COVID-19[3] (Figure 45). In Nevada, American Indian/Alaska Native and Black residents had the highest rates of years of potential life lost in 2020 (Figure 46).

1.https://www.nevadatomorrow.org/indicators/index/view?indicatorId=12873&localeId=31
2. DHHS
3.Americas Health Rankings https://www.americashealthrankings.org/explore/annual/measure/YPLL/state/NV

ACCESS TO CARE

The Office of Disease Prevention and Health Promotion defines access to healthcare as the timely use of personal health services to achieve the best health outcomes. There are three primary factors that contribute to a person's ability to access healthcare in Nevada: health insurance coverage, healthcare workforce and availability of services, and the ability to get to health services that are near to and within a timely matter[1]. Healthcare access was a commonly expressed need among community members who participated in our survey, with more than two thirds of respondents highlighting it as a priority issue for the state.

1. Nevada Rural and Frontier Health Data Book—Tenth Edition

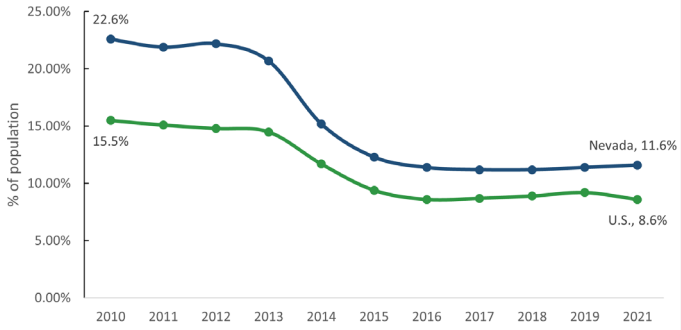
"I think honestly, access or easy access to health care because we ... can only exercise and eat well, like so much... Access to health care, or even just affordable health care, is something that makes the whole community healthy."

HEALTH INSURANCE

Following the implementation of the Affordable Care Act (ACA) in 2010[1], rates of insurance coverage in Nevada have improved. In 2020, 11.6% of Nevadan's were uninsured, compared to 22.6% in 2010[1] (Figure 47). This is significant because a lack of health insurance coverage often results in poor health outcomes. It is worth mentioning that health insurance coverage is just one part of access to care.

"It's like a standoff between the doctors and the insurance companies. And we're the victims of it because the doctor can only sit and talk to you for seven minutes. With an HMO plan, seven minutes, I can't tell you everything in seven minutes."

Figure 47. Uninsured rate, Nevada and U.S.



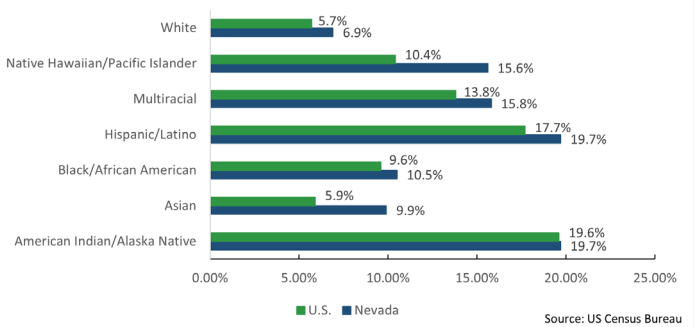
Source: US Census Bureau

Insurance type may limit where a patient can receive care, the type of care, and out of pocket expenditures.

In Nevada, uninsured rates are highest among the Hispanic/Latino and American Indian/Alaska Native populations (Figure 48).

1.Americas Health Rankings https://www.americashealthrankings.org/explore/annual/measure/HealthInsurance/state/NV

Figure 48. Uninsured rate by race/ethnicity, Nevada and U.S.



Source: US Census Bureau

HEALTH CARE PROVIDERS

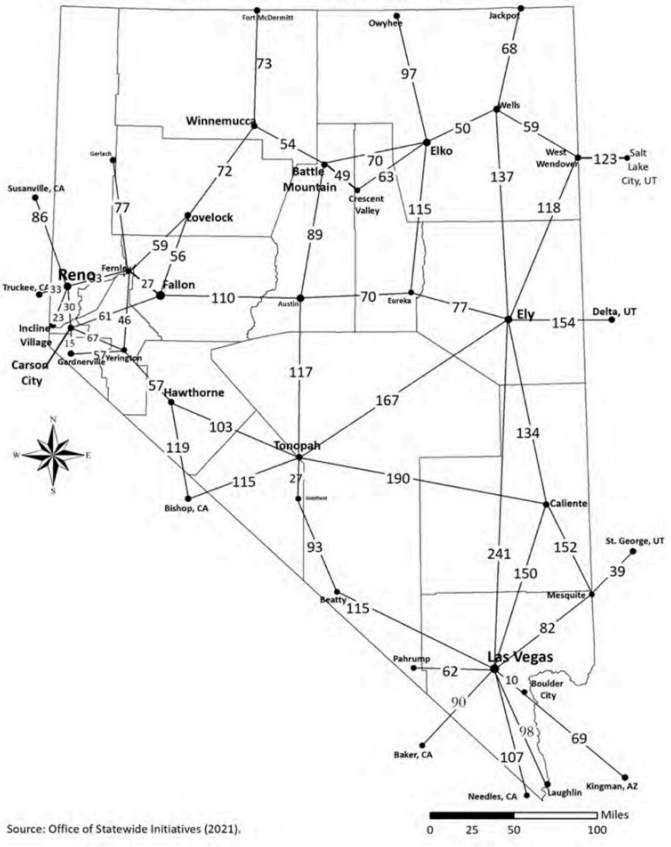
Many participants in the community survey and listening tours expressed difficulty accessing needed care. Insufficient access to care results in worse health outcomes and is a major contributor to health disparities. Nevada ranks 45th in the nation for active physicians per 100,000 population, 49th for primary care physicians, and 49th for general surgeons.[1] In 2021, an estimated 67.3% of Nevada state's population resided in a federally- designated primary medical care Health Professional Shortage Area (HPSA). The HPSA designation is determined by the Health Resources and Services Administration (HRSA) as a shortage of providers for an entire group of people within a defined geographic area.

While these shortages are statewide, geographic disparities exist within Nevada's more populous regions. In Clark County, shortages are especially prominent in North Las Vegas where residents are more likely to be low-income. The same is true in Washoe County for low-income areas in Reno.[2]

Nevada's unique geography and population distribution also makes access to care difficult for the state's rural residents. The average distance between acute care hospitals in rural Nevada and the next level of care or tertiary care hospital is 109 miles and the average distance to the nearest hospital is 56 miles (Figure 49). This journey can become extremely dangerous during the winter when many of these regions experience snowfall.

"...in this being a rural community, it is very difficult to get and maintain health care. Usually if you need to see a specialist you have to go to Reno or Carson City that's just the given. I know I remember when my husband and I first moved here there was a young doctor he had recently graduated and he had to put it in his five years or whatever it is but as soon as he was done, he was out. We can't retain and keep people."

FIGURE 49. AVERAGE DRIVING DISTANCE TO RURAL AND FRONTIER HOSPITALS



ACCESS TO BEHAVIORAL HEALTH CARE

A lack of access to care plays a major role in Nevada's poor behavioral health outcomes. Nevada has 249.8 mental health providers per 100,000 population, less than the national average.[1] In Nevada, 16 out of 17 counties are designated as a Mental Health HPSA, accounting for 3 million Nevadans or 94.5% of the state's population.[2]

Children with mental health problems do not have access to adequate and appropriate treatment options. A 2022 Department of Justice investigation found that the state of Nevada violated Title II of the Americans with Disabilities Act (ADA) for failing to provide appropriate services to children with behavioral health disabilities. The report details that Nevada has relied on "segregated, institutional settings, like hospitals and residential treatment facilities" rather than community-based services to provide care to children with behavioral health disabilities. It also states that 27% of children admitted to residential treatment facilities between August and October of 2019 stayed in those facilities for over 12 months. This combination of lack of access to proper treatment and improper institutionalization of children with behavioral health is detrimental to the state, as it denies its youngest residents the care they need to live healthy, productive lives.

1.Nevada Health Workforce Research Center

2.HRSA https://data.hrsa.gov/tools/shortage-area/hpsa-find

ACCESS TO ORAL HEALTH CARE

Oral health is also important for ensuring positive health outcomes in the community. Most of the state is also designated as a Dental HPSA. The majority of the state's population, 71.2%, reside in a Dental HPSA.[1,2] Four counties, Esmeralda, Eureka, Storey and Pershing counties had zero Licensed Dentists in 2020. In 2022, Nevada had 54.4 dental care providers per 100,000 residents, below the national average of 60.6.

1.Nevada Health Workforce Research Center
2.2021 Nevada Rural and Frontier Health Data Book

CULTURAL COMPETENCY IN HEALTHCARE

Culturally competent care refers to the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients. Ensuring a culturally competent healthcare system in Nevada can play a large role in reducing disparities in health outcomes. As of 2019, the State of Nevada requires that all licensed health facilities provide cultural competency training annually, and at the time of hire, for all staff.

HEALTH LITERACY

Health literacy refers to the ability to understand basic health information in order to make appropriate health decisions. Low levels of health literacy have been linked to medication noncompliance, higher rates of hospitalization, and lower use of preventive services. Studies have found that 88% of adults living in the US do not have adequate health literacy to navigate the healthcare system and promote their wellbeing.[1] Populations who have lower health literacy are older, don't speak English as their primary language, are less educated, low-income, and come from medically underserved populations. For this reason, addressing health literacy in Nevada would have a wide impact on disparities in health outcomes.

1.Milken Institute https://milkeninstitute.org/sites/default/files/202205/Health_Literacy_United_States_Final_Report.pdf

PREVENTIVE SERVICES

Clinical preventive services include services such as annual exams, cancer screenings, immunizations, and other services that allow health issues to be prevented or to be caught early enough to prevent more significant health impacts.

WELL-WOMAN CARE AND REPRODUCTIVE HEALTH

Between 2019-2022 in Nevada, just over half (56.1%) of women aged 18-44 had a dedicated health care provider, the lowest rate in the nation. In the same time period, 64.5% of adult women reported having a preventive medical visit in the past year, again putting Nevada at 50th in the nation.[1] This is significant, because access to high-quality well-woman care:

- Decreases the likelihood of unintentional pregnancies
- Decreases the likelihood of complications during pregnancy
- Provides a variety of screenings, preventive services, and assistance with chronic conditions

The likelihood of a woman in Nevada receiving this care is correlated with their level of education and income. Black/African American women were most likely to receive annual well-woman care, whereas Hispanic/Latina women were less likely.

1.CDC: Behavioral Risk Factor Surveillance System

ACCESS TO CONTRACEPTION

When used correctly, contraceptives are highly effective at preventing unwanted pregnancy. In Nevada, nearly 180,000 women living at or below the poverty level face barriers to accessing contraception. In 2021, the state passed a law aiming to address this disparity by allowing pharmacists to prescribe oral contraceptives without a prescription. While recent statewide data is not available, in 2017, 67.9% of women in Nevada at risk of pregnancy reported using contraceptives.[1]

1.Power to Decide https://powertodecide.org/about-usnewsroom/nearly-180000-women-nevada-livecontraceptive-deserts

CHILD AND ADOLESCENT HEALTH

Early access to healthcare for children allows for the detection of developmental disorders and chronic health issues, which is critical to lifelong health. The percentage of children with developmental disabilities has been increasing over time. By increasing access to early developmental screenings, delays can be detected early to ensure better health outcomes for those children.

Health behaviors established in adolescence often persist through life, and many chronic diseases first emerge at this time. This makes access to proper screening and care during adolescence a unique opportunity to provide lasting health benefits. For this reason, access to comprehensive well-care for adolescents per American Academy of Pediatric guidelines is a vital form of preventive care in all communities.

Despite its known importance, access to comprehensive well-care is not equal. In Nevada, only 67.4% of children aged 0-17 received one or more well-child visits between 2020 and 2021, the lowest rate in the nation. Well-child visits are higher (83.3%) for children aged 0-2 than for children age 3-17 (64.3%), which is suggest a drop off in immunizations and the risk of missed detection of developmental disabilities that may not be recognized until after the age of three. All rates of well-child visits declined slightly from the previous year as a result of the COVID-19 pandemic.[1]

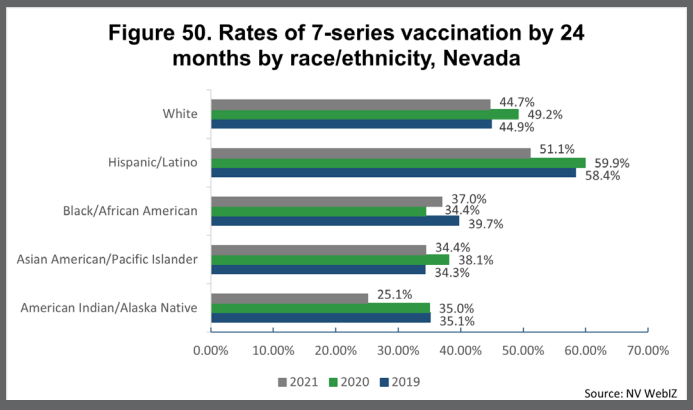
IMMUNIZATIONS

Vaccines are one of the greatest public health interventions in the 20th century and have saved countless lives. Despite this, Nevada has high rates of vaccine hesitancy, lack of access to care, and other barriers that contribute to insufficient rates of vaccination.

Between 2018-2020, 67.5% of children received all recommended doses of the 7-series vaccines by age 24 months, the 42nd lowest rate in the nation.[2] Rates of vaccination fell even further in 2021 to 59.3%, possible due to COVID-19 pandemic and difficulties in accessing care.

Significant disparities exist in vaccination rate in Nevada. In 2021, only 25.1% of American Indian/Alaska Native, 34.4% of Asian/Pacific Islander, and 37% of Black/African American children completed their 7-series vaccination by the age of 24 months (Figure 49). While rates of HPV vaccination in 13–17-year-olds in Nevada have improved over the years, there is still inequity, with Asian/Pacific Islander (22.8%) and White (25.4%) adolescents being less likely to have received the vaccine than other races and ethnicities (Figure 50).[3]

1.National Survey of Children's Health https://www.americashealthrankings.org/explore/health-of-womenand-children/measure/wellchild_visit_0to17/state/NV
2.CDC, National Immunization Survey https://www.americashealthrankings.org/explore/health-ofwomen-and-children/measure/immunize_c/state/NV
3.DHHS https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Boards/BOH/Meetings/2022/Childhood%20Vaccine%20Rates%20in%20NV%20-%20Kristy%20Zigenis.pdf



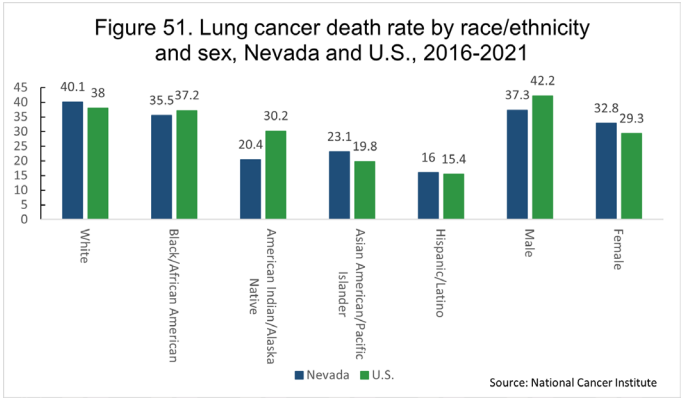
HEALTH SCREENINGS

Cancer is the second leading cause of death in Nevada, and lung cancer has the highest mortality rate (34.9 deaths per 100,000 cases). Between 2016-2020, the rate of deaths from lung and bronchus cancer has fallen nearly 6%.[1] While this may suggest higher screening rates and earlier detection, as mentioned earlier, Nevada is last in the nation for rates of screening of individuals who are high-risk for developing lung cancer.[2] In Nevada, White men are more likely to die of lung cancer than other races or ethnicities and sexes (Figure 51).

According to the American Cancer Society, approximately 2,600 women are diagnosed with breast cancer in Nevada every year, and approximately 440 die from the disease. In an effort to reduce the rates of over-diagnosis and false positives, mammogram recommendations were changed to suggest that women aged 50-74 receive a mammogram every two years.[3] In 2020, 65% of women in Nevada over the age of 45 were considered

up to date on their mammograms.[2] Each year, approximately 150 women in Nevada are diagnosed with cervical cancer, and approximately 50 die from the disease. Cervical cancer mortality is preventable when women have access to vaccination and appropriate screenings. It is currently recommended that women aged 21 to 65 receive a pap screening every three years. In Nevada, 81% of women aged 21-65 were up to date on their pap screening in 2020. While an effective HPV vaccine does exist, only 50.5% of adolescents in Nevada had received the vaccine in 2020.[2]

1. American Lung Association: https://www.lung.org/research/state-of-lung-cancer/states/nevada
2. https://cancerstatisticscenter.cancer.org/#!/state/Nevada
3. US Preventive Services Task Force (USPSTF): https://uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancerscreening#:~:text=Recommendation%20Summary&text=The%20USPSTF%20recommends%20biennial%20screening,aged%2050%20to%2074%20years.&text=The%20decision%20to%20start%20screening,should%20be%20an%20individual%20one.

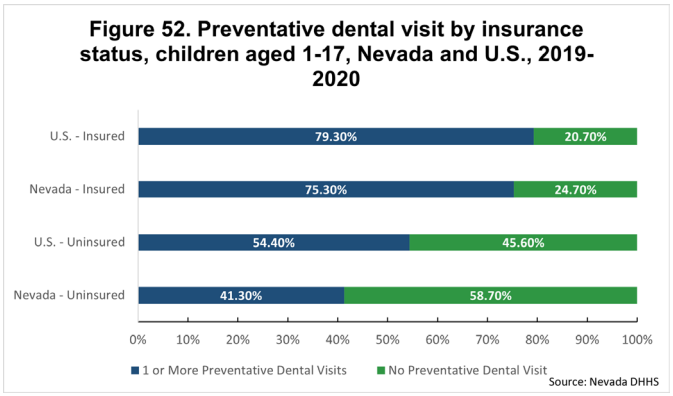


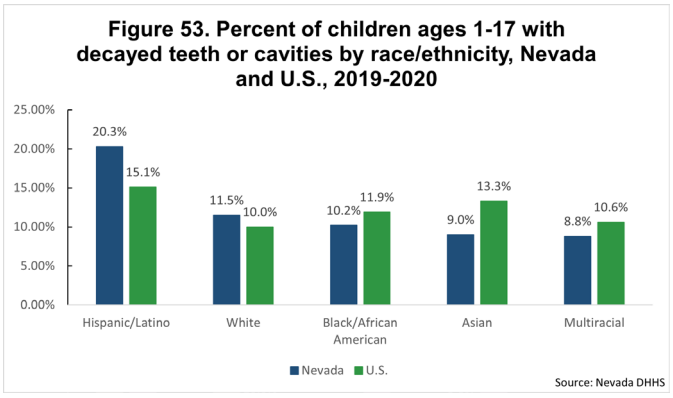
ORAL HEALTH

Oral health is an often-overlooked component of wellbeing. Although tooth decay is preventable, it is one of the most common chronic diseases affecting children and adolescents in the U.S. In Nevada, 64% of third graders have experienced tooth decay, and 29% of them go without treatment. Untreated tooth decay can have serious consequences and negatively impact a child's development, nutrition, and overall health. Between 2020-2021, 71.6% of children aged 1-17 and 60% of adults reported visiting a dentist or dental clinic in the past year.[1]

This low rate of dental care is due in part to a lack of access, with 71.1% of residents residing in a dental health professional shortage area. In rural and frontier Nevada, this rate rises to 88.1%. Nevadans who are uninsured are far less likely to receive preventive dental care (Figure 52). Between 2019 and 2020, 45.6% of uninsured residents did not receive any preventive dental care compared to 24.7% of insured residents. Hispanic adolescents in Nevada are more likely than other races to have tooth decay or cavities (Figure 53).

1. https://oralhealthnevada.com/





COMMUNICABLE DISEASE CONTROL

Communicable (infectious) disease control is the prevention, detection, and response to transmissible diseases. These diseases are illnesses caused by viruses or bacteria that people spread to one another through contact with contaminated surfaces, bodily fluids, insect bites, or through the air.

FOODBORNE AND WATERBORNE INFECTIONS

Most foodborne illnesses present as gastrointestinal symptoms that resolve on their own. However, some individuals suffer long-term health impacts, like kidney failure, brain and nerve damage, or death.

E. COLI

Escherichia Coli O157 (E. coli) is the form of E. coli most often responsible for causing foodborne illness. It typically causes diarrhea, often with blood, as well as severe
stomach cramps and vomiting. In some individuals the symptoms are far more severe, with 5-10% of cases resulting in hemolytic uremic syndrome (HUS), a type of kidney failure. Most individuals with HUS recover within a few weeks, but some suffer permanent kidney damage or death. Between 2010 and 2020 there have been 13 E. coli outbreaks in Nevada.[1]

NOROVIRUS

Norovirus refers to a group of viruses that cause gastrointestinal illness and is the leading cause of foodborne illness outbreaks in the U.S. It is highly contagious, and infection usually occurs after eating food, drinking liquid that has been contaminated, or by touching a contaminated surface and then ingesting the contaminants. Symptoms usually include nausea, vomiting, diarrhea, stomach cramps, muscle aches, fever, chills, and fatigue. Between 2010 to 2020, Nevada has had 309 norovirus outbreaks.

HEALTHCARE-ASSOCIATED INFECTIONS

Healthcare-associated infections (HAIs) are those that affect people while they are receiving health care. They are especially dangerous, because these individuals often have other health conditions that put them at higher risk of life-threatening complications when they become infected. At the very least, these infections are likely to require additional treatment, extending time in the healthcare facility, and requiring the use of more antibiotics, all of which increases the cost to the patient and the healthcare system.

C. DIFFICIL (CDI)

Clostridium difficile (C. diff) is a toxin-producing bacterium that causes diarrhea and inflammation of the colon that can be life-threatening. C. diff infection (CDI) is the leading cause of healthcare-associated infections and while infection rates have been steady or decreasing in recent years, it is still very common. Since 2010, there have been 14 reported C. diff outbreaks in Nevada.[1]

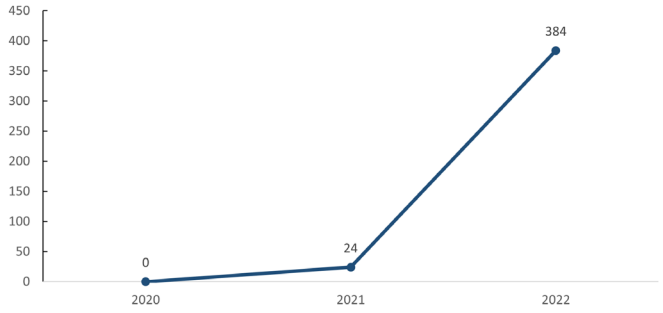
1. CDC National Outbreak Reporting System

C. AURIS

Candida auris (C. auris) is a fungus that spreads rapidly through healthcare facilities and can cause severe infections in patients. It is especially concerning because of it's multidrug-resistant nature, making it difficult to treat. The first known case of C. auris in the U.S. was reported in 2016, and in 2021 case rates began climbing rapidly. C. auris was first found in Nevada in 2020, but there were no clinical cases, meaning that there were no cases diagnosed because of disease treatment in a clinical setting. By 2021, there were 24 clinical cases, and in 2022 there were 384 cases of C. auris reported, more than any other state (Figure 54).[1]

1. https://www.cdc.gov/fungal/candida-auris/tracking-c-auris.html

Figure 54. Clinical cases of *C. auris*, Nevada



BACTERIAL MENINGITIS

Bacterial meningitis is an infection that causes infection of the meninges, a layer of tissue covering the brain and spinal cord. Different bacteria can cause meningitis via different methods of transmission. Common symptoms include nausea, vomiting,

increased sensitivity to light, and confusion. With quick treatment symptoms typically resolve without lasting damage, but some individuals will have lasting neurological issues or may die. As of 2022, Nevada requires all 12th grade students to receive the meningococcal vaccine regardless of whether they received the vaccine when they were younger.

HEPATITIS C.

Hepatitis C virus (HCV) infection is the most common chronic blood-borne infection in the United States. It is usually transmitted through repeated exposures to blood, like sharing needles for injection drug use. Most acute HCV infections become chronic with the potential to cause chronic liver disease. Because there is no vaccine for HCV, limiting behaviors that increase infection risk is the best approach to addressing the disease.[1]

1.https://www.washoecounty.gov/health/programs-and-services/ephp/statistics-surveillance-reports/hepatitis-csurveillance.php#:~:text=Hepatitis%20C%20virus%20(HCV)%20has,to%20their%20local%20health%20jurisdiction.

HIV AND OTHER SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (STIs) are common in Nevada and infection rates have been increasing. Due to the COVID-19 pandemic, many staff who had been working on STI prevention efforts were reassigned to COVID-19 work, severely hindering STI programs. In 2020, Nevada had the 9th highest STI infection rate in the nation. Individuals with STIs are more likely to acquire and transmit HIV infections. Furthermore, STIs can lead to reproductive health complications like infertility and ectopic pregnancy. Promotion of safe sexual behaviors and regular screening are the best tools to address these public health problems.

CHLAMYDIA

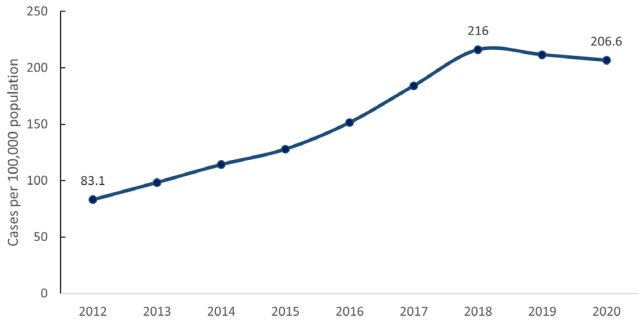
Chlamydia is a bacterial STI and is the most common STI in Nevada. Infection rates have climbed from 357.9 cases per 100,000 in 2010 to 481.3 in 2020.[1] Women in Nevada are more likely to have chlamydia than men. If left untreated, infections in women can cause pelvic inflammatory disease (PID), infertility, and ectopic pregnancies. Black Nevadans are more than twice as likely to contract chlamydia than any other racial or ethnic group. Chlamydia is contracted through vagina, anal, or oral sex with someone who already has the disease. Condom use is the best way for sexually active individuals to avoid contracting the disease.

GONORRHEA

Gonorrhea infection rates have been increasing in Nevada in recent years. Gonorrhea is caused by a bacterial infection that is spread through oral, vaginal, or anal intercourse with someone who has the disease. Left untreated, it can result in severe inflammation of the reproductive tract in women, resulting in PID, infertility, and ectopic pregnancy. Men with gonorrhea are asymptomatic, but in rare cases it can also result in infertility. Furthermore, gonorrhea increases the likelihood of acquiring HIV. Gonorrhea diagnoses have been increasing since 2012 (Figure 55). While any sexually active person can be infected, gonorrhea rates are highest in sexually active teenagers, young adults, and Black/African American individuals.

1. https://www.americashealthrankings.org/explore/annual/measure/chlamydia/state/NV
2. https://www.cdc.gov/std/gonorrhea/stdfact-gonorrheadetailed.htm#:~:text=What%20is%2gonorrhea%3F,urethra%20in%20women%20and%20men.

Figure 55. Gonorrhea Incidence Rate, Nevada

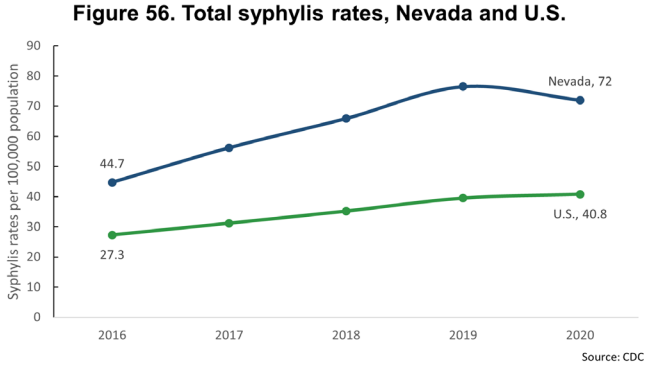


Source: NCHHSTP

SYPHILIS

In 2020, Nevada tied with Mississippi for the nation's highest rate of primary and secondary syphilis in the nation with a rate of 24.9 cases per 100,000 population.1 Total syphilis rates were 72 cases per 100,000 population in 2020 (Figure 56). Syphilis is a bacterial infection spread through direct contact during vaginal, anal, or oral intercourse with sores caused by the disease. Men who have sex with men (MSM), individuals who have HIV, and people taking pre-exposure prophylaxis (PrEP) for HIV are at the highest risk of acquiring syphilis. Condom use is the best way to reduce the risk of getting syphilis. Increasing regular screenings is the best public health response to address the rapid rates of infection.

Figure 56. Total syphylis rates, Nevada and U.S.



Source: CDC

Nevada was also the fourth highest rate of congenital syphilis cases in 2020, with a rate of 131.2 cases per 100,000 live births.[1] Congenital syphilis occurs when a mother with syphilis passes the infection along to her baby, and it can cause miscarriage, stillbirth, premature birth, serious health problems, or death. Early and adequate prenatal care, timely prenatal screenings, and adequate maternal treatment for syphilis are the best options to reduce the impact of this disease.

1. https://www.cdc.gov/std/statistics/2020/tables/2020-STD-Surveillance-State-Ranking-Tables.pdf

HPV

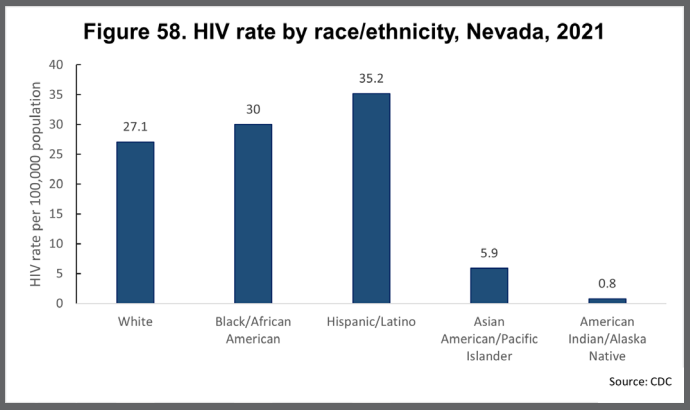
Human Papillomavirus (HPV) is a common sexually transmitted infection. In women it is the primary cause of cervical cancer, and the primary cause of throat cancer in men. Current recommendations are that adolescents receive the HPV vaccine as a part of routine immunizations at age 11 or 12, and that the vaccine can still be administered up to the age of 26. Individuals older than 26 are only advised to receive the vaccine if instructed by their doctor. In 2021, Nevada ranked 40th in the nation for HPV vaccination rates with 56.5% of adolescents between 13-17 having received all recommended doses of the HPV vaccine.[1]

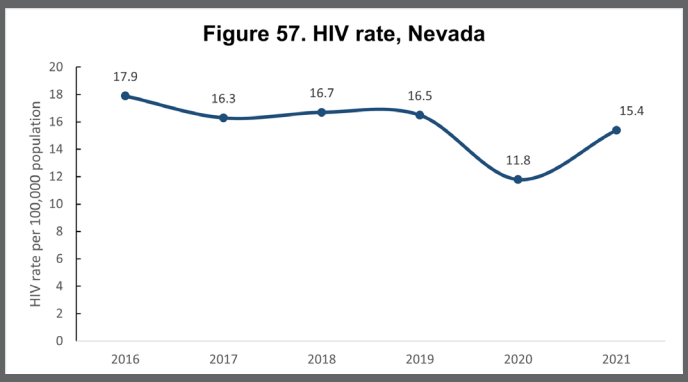
HIV

HIV is a chronic and potentially fatal disease that disproportionately affects sexual, racial, and ethnic minority groups. Nevada's HIV diagnosis rate has been declining, but there was a 26% increase between 2020 and 2021 (Figure 57). In Nevada, there were 494 new HIV diagnoses in 2021, 87% of which were males.

Just over half (52.2%) of HIV transmission in males is from male-to-male sexual contact, whereas most of known transmission in females was from injection drug use. White, Hispanic/Latino, and Black/African American men made up most new cases (Figure 58). Routine testing for HIV to allow for early detection is the best way to limit the spread of the disease and ensure infected individuals receive timely treatment. In 2020, only 38.9% of Nevadans reported ever having been tested for HIV, and nearly 18% of cases were diagnosed late in their infection.

1. https://www.americashealthrankings.org/explore/annual/measure/Immunize_HPV/state/NV
2. https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/HIV-OPHIE/Docs/Nevada%202021%20HIV%20Fast%20Facts%20Updated.pdf





CONDOM USE

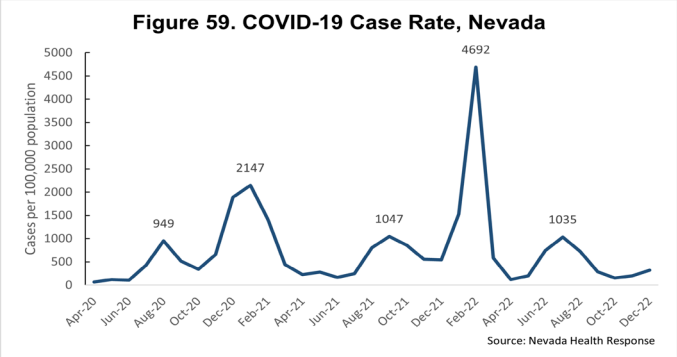
Nevada does not collect data on statewide condom or contraceptive use. However, data collected from the 2021 YRBS shows that 49% of high school students reported using a condom during their last sexual intercourse. Condom use was lowest among Black/African American students (20%) and highest among Asian students (81.2%).

RESPIRATORY INFECTIONS

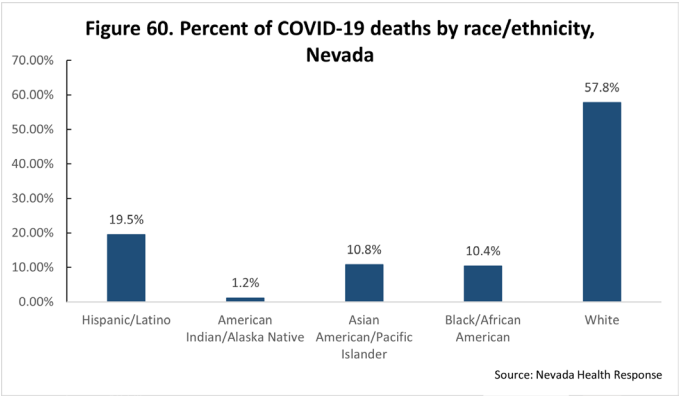
The COVID-19 pandemic has been the dominant source of respiratory illness in the state since early 2020, but recent waves of influenza and Respiratory Syncytial Virus (RSV) have tested the capacity of the state's healthcare faciliities.

COVID-19

Nevada's first reported case of SARS-CoV-2 (COVID-19) was on March 5, 2020, in Las Vegas. By March 12 a state of emergency had been declared, and by March 16 the state reported its first death. Since then, Nevada has experienced over 800,000 cases and nearly 12,000 deaths due to complications from COVID-19 infections.[1]

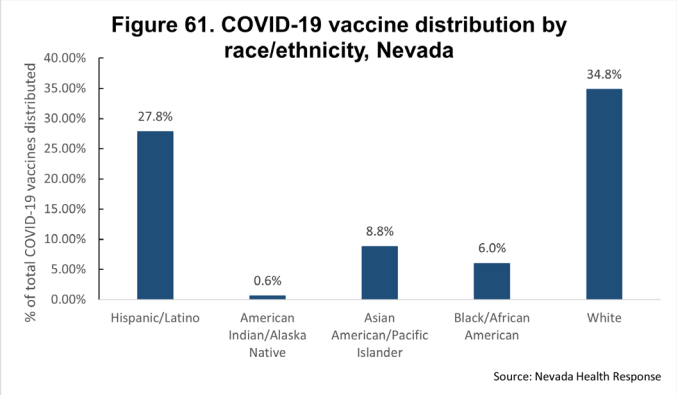


Most heavily impacted by the pandemic has been residents over 70 years old, men, and white Nevadans (Figure 60). While the majority of cases were in the state's most populous regions, rural Pershing County and Mineral County had the highest case rates in the state.



The first doses of the COVID-19 vaccines arrived in Nevada on December 14, 2021, and after a few months it was available to anyone 18 years of age or older. Since then, the vaccine has been made available to everyone 6 months and older. To date, more than 5 million doses of the COVID-19 vaccine have been administered; 65.49% of residents have initiated vaccination and 55.91% are fully vaccinated. White and Hispanic/Latino Nevadans have the highest rates of vaccination, and American Indian/Alaska Native residents have the lowest rates of vaccination. In spite of controversy and misinformation surrounding vaccines, more than 60% of Community Survey respondents indicated a belief that the COVID-19 vaccines were fairly or extremely effective at reducing the impact of COVID-19 (Figure 61).

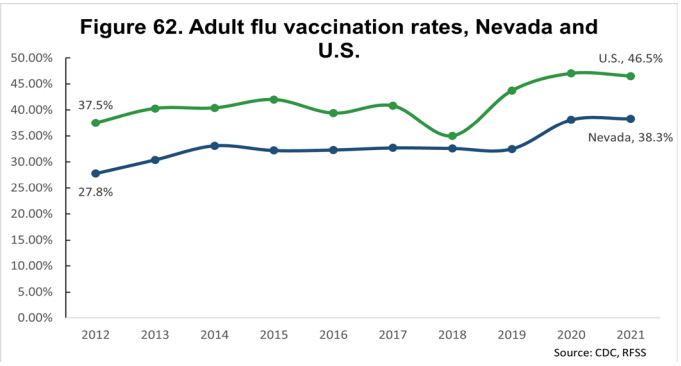
1. https://nvhealthresponse.nv.gov/



FLU

During the COVID-19 pandemic, influenza infection rates in Nevada dropped substantially—largely due to social distancing, mask wearing, increased hand washing, and other COVID-19 mitigation measures. However, toward the end of 2022, the country was hit by an especially harsh flu season. By December, cases in Nevada spiked, with nearly 2,500 patients visiting emergency rooms and 73 being admitted per week, the highest rate since the start of the pandemic.[1] Historically, Nevada has had some of the lowest flu vaccination rates in the nation, ranking 46th in the country in 2022 with a vaccination rate of 38.3% (Figure 61). Black/African American and Hispanic/Latino Nevadans are less likely to receive annual flu shots than other races or ethnicities.[2]

1. https://app.powerbigov.us/view?r=eyJrIjoiMjNkMWQ5N2EtMmRjMS00ODNlLTk2NjQtOW-



FmYzJjOWU4MzYyIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9
2.CDC: BRFSS

RESPIRATORY SYNCYTIAL VIRUS (RSV)

At the same time flu cases were surging in 2022, the country was hit by a wave of respiratory syncytial virus (RSV) cases. This wave peaked in the middle of November with 909 cases being reported each week.[1] The combined spread of influenza, RSV, and COVID-19 put a significant strain on hospitals and pediatric units were at or near capacity for much of the fall and into the winter.

1. https://app.powerbigov.us/view?r=eyJrIjoiMjNkMWQ5N2EtMmRjMS00ODNlLTk2NjQtOW-FmYzJjOU4MzYyIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

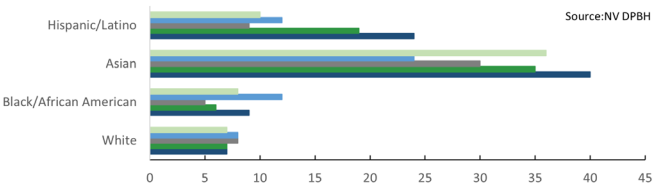
TUBERCULOSIS

Mycobacterium tuberculosis (TB) affects nearly one quarter of the world's population. The majority of cases occur in South-East Asia, Africa, and the Western Pacific regions.[2] It is the leading cause of death by infectious disease. Fortunately, TB is not common in Nevada.

TB incidence in Nevada is higher in residents who are over the age of 45, are Asian, and were born outside of the US (Figures 63 and 64).

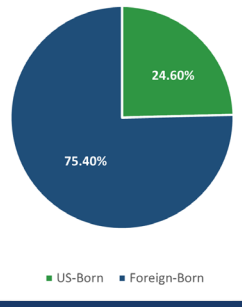
2. https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2022/tb-disease-burden/2-1-tb-incidence

Figure 63. TB Cases per year by race/ethnicity



	White	Black/African American	Asian	Hispanic/Latino
2021	7	8	36	10
2020	8	12	24	12
2019	8	5	30	9
2018	7	6	35	19
2017	7	9	40	24

Figure 64. Percentage of TB cases by origin of patient, Nevada, 2021



US-Born Foreign-Born

Source: NV DPBH

VACCINE PREVENTABLE DISEASES

Vaccination has dramatically reduced infectious disease rates in the U.S. However, vaccine hesitancy and disparities in access to vaccination prevent optimal vaccine rates from being reached, enabling the occurrence of outbreaks of preventable diseases. Between 2017 and 2022, very few cases of measles, mumps, rubella, pertussis were reported in Nevada.[1] However, given recent increases in vaccine hesitancy delays in care, including infant and child vaccinations as a result of the COVID-19 pandemic, higher rates of such vaccine-preventable diseases are occurring.

1. https://www.washoecounty.gov/health/files/ephp/communicable-diseases/annual-

CONCLUSION

When assessing the health of the state, it is clear that Nevada has many strengths but also faces significant challenges to improving health outcomes for everyone. This report represents an important step in identifying needs within the state. The SHA is unique in that it compiles the most important indicators for the entire state into a single report. In this way it lays the groundwork for prioritizing efforts to improve the health of people in Nevada.

The task of meeting the health needs of Nevadans is not limited to public health agencies or healthcare systems alone; rather, it requires the efforts of these partners, combined with social service, transportation, planning, education, criminal justice, environmental, and economic development agencies, as well as private business leaders, non-profit organizations, academic institutions, legislators, tribal officials, and the public. Only through an evidence-based approach that works across sectors and takes the needs of the community into consideration can we truly address the social determinants of health and increase health equity.

NEXT STEPS

Following the SHA, Nevada will develop a State Health Improvement Plan (SHIP) to address key health issues identified through the assessment process. The SHIP will build on the data-driven SHA to develop goals and objectives to improve community health and equity throughout the state. A steering committee, comprised of stakeholders from a variety of sectors, will identify priorities of focus, and SHIP subcommittees will develop action plans to make progress on each priority. The SHIP will provide guidance to DPBH, community partners, and other stakeholders for improving the health of Nevadans over the next five years—and an opportunity for state and local agencies and community partners to align their own work to improve the health of all Nevadans.

APPENDIX A:
STEERING COMMITTEE REPRESENTATION

RACE/ETHNICITY		
White/Caucasian	18	58%
Hispanic/Latino or Spanish Origin of any race	4	12.9%
Black/African American	2	6.6%
Asian	5	16.1%
Native Hawaiian or Other Pacific Islander	1	3.2%
2 or more	1	3.2%
TOTAL	**31**	**100.0%**

INCOME		
< 40 K	3	9.7%
40-60 K	4	12.9%
60-100 K	13	41.9%
100 K +	11	35.5%
TOTAL	**31**	**100.0%**

AGE		
18-24	2	6.5%
25-34	10	32.3%
35-44	8	25.8%
45-54	6	19.4%
55-64	2	6.5%
65+	3	9.7%
TOTAL	**31**	**100.0%**

EDUCATION		
Some college, no formal degree	1	3.2%
Graduated college - Associate's degree	1	3.2%
Graduated college - Bachelor's degree	6	19.4%
Master's degree or professional program (physical therapy, nursing, etc.)	18	58.1%
PhD, medical degree, law degree, or higher	5	16.1%
TOTAL	**31**	**100.0%**

AREA OF REPRESENTATION		
Behavioral health & public policy	1	3.2%
Deaf and Hard of Hearing or Speech Impaired Advocacy	1	3.2%
Economics	1	3.2%
Environmental Engineering	1	3.2%
Government/Public Policy	2	6.5%
Health	2	6.5%
Health Communications	1	3.2%
Medicine	1	3.2%
Nursing	2	6.5%
Physician	1	3.2%
Public Health	15	48.4%
Social Services	2	6.5%
Social Sciences	1	3.2%
TOTAL	**31**	**100.0%**

APPENDIX B:
SURVEY INSTRUMENT

(ENGLISH)

The State of Nevada is conducting a Community Health Assessment. Feedback from Nevada Residents is key for this assessment. The written health needs assessment contains data from many topics; however, this survey aims to fill in the gaps on areas where there is minimal data available and will help identify health priorities for Nevada. This is a confidential survey. You must currently be living in Nevada and be at least 18 years of age. The survey should take approximately 15 minutes to complete.

AT THE END OF THE SURVEY, YOU CAN ENTER YOUR CONTACT INFORMATION AND YOU WILL BE ENTERED INTO A RAFFLE TO WIN 1 OF 50, $50 GIFT CARDS.

Do you currently live in Nevada?
● **YES** ● **NO**

Are you currently 18 years of age, or older?
● **YES** ● **NO**

In the last week, how many times did you participate in deliberate exercise, (such as - jogging, walking, golf, weight-lifting, fitness classes) that lasted for at least 30-minutes or more?

NUMBER OF DAYS _____

How safe do you feel exercising in your neighborhood?
- O Extremely safe
- O Fairly safe
- O Somewhat safe
- O Not safe at all

How important is getting enough exercise to you?
- O Extremely important
- O Fairly important
- O Somewhat important
- O Not important at all

Which of the following is the largest barrier to you being more physically active?
- O Too expensive
- O Too busy/does not fit into my schedule
- O Too tired
- O Bad weather
- O Not enough safe places to exercise
- O I don't like to exercise
- O Not enough support/lack friends/family to keep me motivated
- O Physically unable to exercise
- O No barriers, I exercise enough
- O Other (please specify):

_____

Which of the following would help you increase your physical activity levels? Select all that apply.
- O More or improved park facilities
- O More or improved bike/running trails
- O Improved sidewalks
- O Having an exercise facility where I work
- O Free sport team leagues
- O Less expensive gym memberships
- O More or improved recreation facilities (indoor/outdoor)
- O Having support of friends/family to keep me
- O motivated
- O Walking or exercise groups

ADA Accessible Facilities

Other (please specify):

_____

Where do you currently go most often to be physically active?

- ○ Outdoors (i.e., hiking, biking, running trails)
- ○ Public recreation or community center
- ○ Membership facility (i.e., private gym/pool/ yoga studio)
- ○ Home
- ○ Work
- ○ School or playground
- ○ I do not exercise
- ○ Other (please specify):

_____

NUTRITION & HUNGER

The following questions help identify barriers to eating healthy foods in Nevada.

In the previous 7 days, how many days did you eat a fresh cooked meal in your home? A fresh cooked meal is a meal prepared by you or someone in your home from raw ingredients.

- ○ No days in the past week
- ○ 1-2 days in the past week
- ○ 3-4 days in the past week
- ○ 5-6 days in the past week
- ○ All 7 days in the past week

Where do you, or members of your household, go for groceries most often?

- ○ Large retail stores (Walmart, Target)
- ○ Wholesale club (Costco, Sam's Club)
- ○ Grocery stores (Albertsons, Save-Mart, WinCo,
- ○ Raley's Smiths, Grocery Outlet, Whole Foods)
- ○ Convenience Store
- ○ Dollar Store
- ○ Food Pantry
- ○ Other (please specify):

_____

Which of the following is the largest barrier to eating more foods that you consider healthy?

- ○ Healthy foods are too expensive
- ○ Healthy foods do not taste good
- ○ Healthy foods spoil too quickly
- ○ Limited access to healthy foods
- ○ Do not know how to prepare healthy foods
- ○ Healthy foods take too much time to prepare
- ○ Do not know how to identify healthy foods
- ○ Nothing, I already eat enough healthy foods
- ○ Other (please specify):

_____

FOOD SECURITY

These statements help identify hunger among families in our community.
Identify how often the following situations are true for your household.

Within the past 12 months, we worried whether our food would run out before we got money to buy more.

- ○ Often true
- ○ Sometimes true
- ○ Never true

Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.

- ○ Often true
- ○ Sometimes true
- ○ Never true

If you ran out of food, how confident do you feel about finding food assistance resources in your community?

- ○ Extremely confident
- ○ Somewhat confident
- ○ Somewhat unconfident
- ○ Extremely unconfident

PERCEIVED STRESS

The following questions ask you about your feelings and thoughts during the last month.

In each case, please indicate how often you felt or thought a certain way in the last month.

In the last month, how often have you felt that you were unable to control important things in your life?

0 - NEVER **1 - ALMOST NEVER** **2 - SOMETIMES** **3 - FAIRLY OFTEN** **4 - VERY OFTEN**

In the last month, how often have you felt confident about your ability to handle your personal problems?

0 - NEVER **1 - ALMOST NEVER** **2 - SOMETIMES** **3 - FAIRLY OFTEN** **4 - VERY OFTEN**

In the last month, how often have you felt that things were going your way?

0 - NEVER **1 - ALMOST NEVER** **2 - SOMETIMES** **3 - FAIRLY OFTEN** **4 - VERY OFTEN**

In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

0 - NEVER **1 - ALMOST NEVER** **2 - SOMETIMES** **3 - FAIRLY OFTEN** **4 - VERY OFTEN**

NEIGHBORHOOD SAFETY:
How many first names do you know of your neighbors?

- ○ 0
- ○ 1-2
- ○ 3-4
- ○ 5-6
- ○ 7-8
- ○ 9+

How safe do you feel your neighborhood is from crime?

- ○ Very safe
- ○ Somewhat safe
- ○ Somewhat unsafe
- ○ Very unsafe

ACCESS TO HEALTHCARE

The following questions help identify the types of healthcare providers residents rely on most and the barriers residents face when they need to access them.

In the past 12 months, which, if any, of the following types of healthcare providers have you needed to see, but couldn't? Select all that apply.

- ○ Primary Care, General Practitioner, or Family Doctor
- ○ Pediatrician
- ○ Advanced Practitioner of Nursing (APN) or Physician's Assistant (PA)
- ○ Obstetrician or Gynecologist (OB/GYN)
- ○ Certified Nurse Midwife/Midwife
- ○ Eye doctor, Optometrist, or Ophthalmologist
- ○ Ear Nose and Throat Doctor (ENT)
- ○ Physical Therapist
- ○ Occupational Therapist
- ○ Dentist or Orthodontist
- ○ Urologist
- ○ Psychiatrist, Psychologist, or Counselor
- ○ Specialist such as: Allergist, Cardiologist, Dermatologist, Immunology, Infectious Disease, Neurologist, Oncology, Rheumatologist
- ○ None, I was able to see all healthcare providers necessary
- ○ I did not need to see any healthcare providers in the past 12 months
- ○ Other type of provider (please specify): _____

What are the main barriers you face when accessing healthcare in Nevada? Select all that apply.

- ○ Finding providers who accept my insurance Insurance doe not cover what I need
- ○ Finding providers who are accepting new patients
- ○ Could not get an appointment soon enough/ long wait list to be seen
- ○ Finding a provider close to where I work/live
- ○ Lack of child care when I need to see a provider
- ○ Lack of transportation
- ○ Hours the clinics are open
- ○ Not able to take leave from work without pay
- ○ I do not have health insurance
- ○ Did not know where to go
- ○ Language or cultural barrier
- ○ ADA Compliant Transportation
- ○ ADA Compliant Building Access
- ○ No barriers to accessing healthcare in Nevada
- ○ Other type of provider (please specify): _____

PUBLIC ASSISTANCE & FINANCIAL CHALLENGES

The following questions are related to public assistance, social services, and financial challenges.

In the past 12 months, have you, or someone in your household, had a hard time paying for any of the following? Select all that apply.

- ○ Housing (mortgage or rent)
- ○ Utilities (heat/air conditioning, power, water, trash/waste, or sewer)
- ○ Phone (cell or landline)
- ○ Credit card payments
- ○ Educational Loans
- ○ Medical debt
- ○ Child care
- ○ Transportation (car payment, gas, insurance, public transportation, etc.)
- ○ Have not had a hard time paying for any of the above services in the past 12 months
- ○ Other (please specify):

_____

In the past 12 months, have you, or anyone in your household, received cash income from any source listed below? Select all that apply.

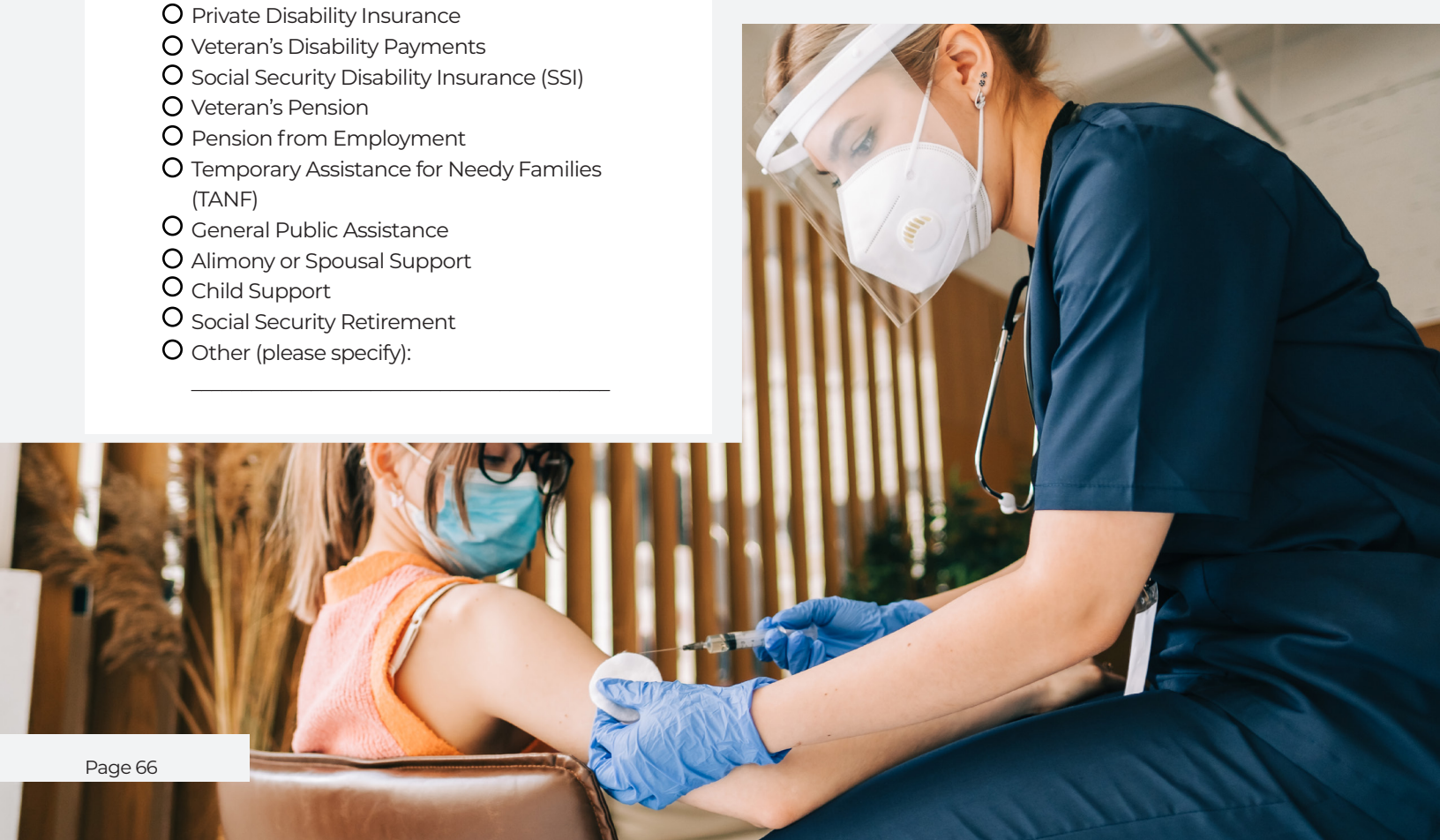
- ○ Earnings (Job or Commission)
- ○ Unemployment Insurance Benefits (UI)
- ○ Worker's Compensation
- ○ Private Disability Insurance
- ○ Veteran's Disability Payments
- ○ Social Security Disability Insurance (SSI)
- ○ Veteran's Pension
- ○ Pension from Employment
- ○ Temporary Assistance for Needy Families (TANF)
- ○ General Public Assistance
- ○ Alimony or Spousal Support
- ○ Child Support
- ○ Social Security Retirement
- ○ Other (please specify):

_____

In the past 12 months, have you, or anyone in your household, received non-cash benefits from any source listed below? Select all that apply.

- ○ Food Stamps or Benefit Card
- ○ WIC (Supplemental Nutrition for Women, Infants, and Children)
- ○ Section 8 Public Housing or Rental Assistance
- ○ Veterans Administration (VA) Medical Services
- ○ SCHIP (State Children's Health Insurance Program)
- ○ Federal Housing Voucher
- ○ Medicaid (Health Insurance)
- ○ Medicare (Health Insurance)
- ○ TANF Child Care Services
- ○ TANF Transportation Services
- ○ Other TANF Funded Services
- ○ P-EBT (Children)
- ○ None
- ○ Other (please specify):

_____



RANKING OF HEALTH PRIORITIES

Choose THREE of the following health-related issues that you believe are the most important.

- ○ Access to health services (i.e., more primary care doctors, affordable health insurance)
- ○ Mental health (i.e., depression, anxiety, suicide)
- ○ Built environment & infrastructure (i.e., bikes, trails, parks, public transporation)
- ○ Environmental health (i.e., clean water and air, food safety
- ○ Preventative health behaviors (i.e., physical activity, healthy eating, immunizations)
- ○ Maternal and child health (i.e., sex education, pre-term birth, family planning)
- ○ Social determinants of health (i.e., K-12 education system, poverty, affordable housing)
- ○ Substance misuse/abuse (i.e., alcohol or prescription drug use/abuse, drug rehabilitation services)
- ○ Violence (i.e., Intimate Partner, Violence, violence in the home, gun related injuries/death)

CHRONIC ILLNESS

Have you ever been diagnosed by a healthcare professional with any of the following health conditions?

	YES	NO	UNSURE	PREFER NOT TO ANSWER
ASTHMA				
AUTOIMMUNE DISEASE				
CANCER				
DEPRESSION OR ANXIETY				
DEVELOPMENTAL DISORDER				
DIABETES (NOT DURING PREGNANCY)				
HEART DIESASE/ANGINA				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
OSTEOPOROSIS				
OVERWEIGHT/OBESITY				

COVID-19 QUESTIONS

In your opinion, how effective is wearing a mask in reducing the transmission of the virus that causes COVID-19?

- ○ Extremely effective
- ○ Fairly effective
- ○ Somewhat effective
- ○ Not effective at all

In your opinion, how important is it to you to receive boosters after receiving the initial COVID-19 vaccinations?

- ○ Extremely important
- ○ Fairly important
- ○ Somewhat important
- ○ Not important at all

What is your assigned sex at birth?

- ○ Male
- ○ Female
- ○ Other (please specify):

_____

What is your sexual identity/sexual orientation?

- ○ Straight (heterosexual)
- ○ Gay
- ○ Lesbian
- ○ Asexual
- ○ Pansexual
- ○ Queer
- ○ Questioning or unsure
- ○ Additional category/identity not listed. Please specify:

_____

How many people adults and children, live in the home you live in (including yourself)?

- ○ Number of adults (18 years or older):

_____

- ○ Number of children (ages 0-17):

_____

What was your total income in 2021, before taxes?

- ○ Less than $20,000
- ○ $20,000 - $39,999
- ○ $40,000 - $59,999
- ○ $60,000 - $79,999
- ○ $80,000 - $99,999
- ○ $100,000 - $119,999
- ○ Over $120,000

What is your gender identity?

- ○ Male
- ○ Female
- ○ Trans Male/Trans Man
- ○ Trans Female/Trans Woman
- ○ Gender nonconforming/non-binary
- ○ Prefer not to answer
- ○ Other:

_____

What year were you born?

_____

Which race/ethnicity do you identify as?
Select all that apply.

- ○ Hispanic/Latinx or Spanish Origin of any race
- ○ Asian
- ○ Black/African American
- ○ Native American or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White/Caucasian
- ○ 2 or more
- ○ Other (please specify):

_____

How many people do you support on your annual income?

_____

What best describes your current employment status?

- ○ Employed full time
- ○ Employed part-time
- ○ Out of work for less than 1 year
- ○ Out of work for more than one year

If you are currently out of work, please select why:

- ○ I am a student
- ○ I am retired
- ○ I am living with a disability
- ○ I am unable to work
- ○ I am a stay at home parent
- ○ I am unable to find childcare/childcare if unaffordable
- ○ I am unable to find work in area of expertise.
- ○ What is your area of expertise? _____
- ○ Other (please specify):

_____

What type of health insurance coverage do you currently have? If you have more than one type of health insurance, please select your primary insurance.

- ○ None/uninsured
- ○ Medicare
- ○ Medicaid
- ○ Private insurance provided through employer
- ○ Veterans/Military'
- ○ Indian Health Service
- ○ Nevada Health Link/Purchased
- ○ Other (please specify):

_____

What is the highest grade or level of school you have completed?

- ○ Less than high school, did not graduate high school
- ○ Graduated high school or a GED equivalent
- ○ Some college, no formal degree
- ○ Graduated college - Associate's degree
- ○ Graduated college - Bachelor's degree
- ○ Master's degree or professional program (physical therapy, nursing, etc.)
- ○ PhD, medical degree, law degree, or higher
- ○ Trade or vocational school

What zip code do you primarily live in?

_____

Is there anything else you would like to tell us about community concerns, health problems or services in the community?

_____

_____

_____

_____

_____

_____

THANK YOU FOR YOUR TIME & RESPONSES

If you would like to be entered for a chance to win a $50 gift card, please provide your contact information below. Your personal information is not linked to the responses you provided.

Name:

_____

Email:

_____

Phone:

_____

If you are participating on behalf of a business or organization, please indicate the agencies name below:

- ○ None
- ○ Southern Nevada Health District
- ○ Washoe County Health District
- ○ Nevada Division of Public and Behavorial Health
- ○ Nonprofit/Community Agency (please specify)
- ○ _____ Federally Qualified Health Center (please specify)
- ○ _____ Hospital/Healthcare Organization (please specify)
- ○ _____ Other (please specify)

_____

_____

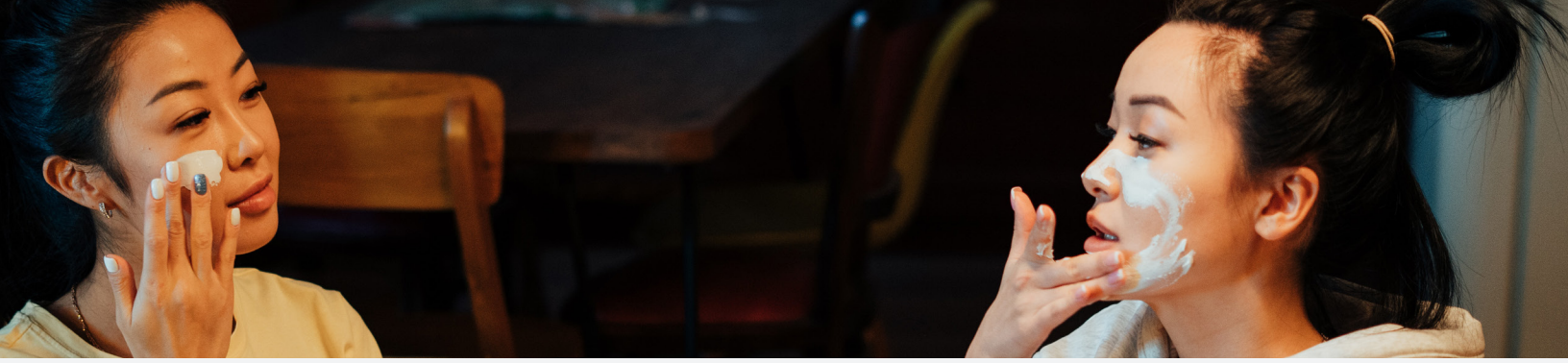
_____

APPENDIX C: COMMUNITY SURVEY FINDINGS

DEMOGRAPHICS

Table 1. Sociodemographic characteristics of community survey participants.

CHARACTERISTICS	VARIABLE	NO.	PERCENT
AGE	18 - 24	167	7.6%
	25 - 44	1,060	48.5%
	45 - 64	829	37.9%
	65 +	121	5.5%
PRIMARY RACE OR ETHNICITY	ASIAN	147	6.7%
	BLACK/AFRICAN AMERICAN	225	10.3%
	HISPANIC/LATINO OR SPANISH ORIGIN OF ANY RACE	368	16.8%
	NATIVE AMERICAN OR ALASKA NATIVE	82	3.7%
	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	51	2.3%
	WHITE/CAUCASIAN	1,172	52.6%
	2 OR MORE	124	5.7%
EDUCATIONAL ATTAINMENT	LESS THAN HIGH SCHOOL, DIDN'T GRADUATE HIGH SCHOOL	11	.5%
	GRADUATED HIGH SCHOOL OR A GED EQUIVALENT	258	11.8%
	SOME COLLEGE, NO FORMAL DEGREE	601	27.5%
	GRADUATED COLLEGE - ASSOCIATE'S DEGREE / TRADE OR VOCATIONAL SCHOOL	286	13%
	GRADUATED COLLEGE - BACHELOR'S DEGREE	611	27.9%
	MASTER'S DEGREE OR PROFESSIONAL PROGRAM (PHYSICAL THERAPY, NURSING, ETC.)	310	14.2%
	PHD, MEDICAL DEGREE, LAW DEGREE, OR HIGHER	62	2.8%
ANNUAL INCOME	< 40 K	483	22.1%
	40 K - 60 K	551	25.2%
	60 K - 100 K	640	29.3%
	100 K +	474	21.7%
	MISSING	39	1.8%
EMPLOYMENT	EMPLOYED FULL TIME	1,923	87.9%
	EMPLOYED PART-TIME	126	5.8%
	OUT OF WORK FOR LESS THAN 1 YEAR	31	1.4%
	OUT OF WORK FOR MORE THAN ONE YEAR	68	3.1%
PRIMARY HEALTH INSURANCE TYPE	INDIAN HEALTH SERVICE	12	.5%
	MEDICAID	136	6.2%
	MEDICARE	192	8.8%
	NEVADA HEALTH LINK/PURCHASED	49	2.2%
	NONE/UNINSURED	54	2.5%
	PRIVATE INSURANCE PROVIDED THROUGH EMPLOYER	1,601	73.2%
	VETERANS/MILITARY	35	1.6%
	OTHER	60	2.7%



PHYSICAL ACTIVITY

Table 2. Some characteristics of physical activity (Community Survey for SHA, Nevada, 2022)

QUESTION	VARIABLE	NO.	PERCENT
Q1. DAYS PARTICIPATED IN PHYSICAL ACTIVITY OR EXERCISE	0 DAYS	479	21.9%
	1 DAY	285	13%
	2 DAYS	435	19.9%
	3 DAYS	423	19.3%
	4 DAYS	228	10.4%
	5+ DAYS	337	15.4%
Q2. FEELING SAFE IN NEIGHBORHOOD WHILE EXERCISING	EXTREMELY SAFE	645	29.5%
	FAIRLY SAFE	969	44.3%
	SOMEWHAT SAFE	453	20.7%
	NOT SAFE AT ALL	120	5.5%
Q3. THE IMPORTANCE OF GETTING ENOUGH EXERCISE	EXTREMELY IMPORTANT	807	36.9%
	FAIRLY IMPORTANT	890	40.7%
	SOMEWHAT IMPORTANT	440	20.1%
	NOT IMPORTANT AT ALL	50	2.3%
Q6. PLACES PARTICIPANTS GO FOR PHYSICAL ACTIVITY	OUTDOORS (I.E., HIKING, BIKING, RUNNING TRAILS)	686	31.4%
	HOME	609	27.8%
	MEMBERSHIP FACILITY (I.E., PRIVATE GYM/POOL/YOGA STUDIO)	472	21.6%
	I DO NOT EXERCISE	152	7%
	PUBLIC RECREATION OR COMMUNITY CENTER	109	4.9%
	WORK	105	4.8%
	SCHOOL OR PLAYGROUND	19	.9%
	NEIGHBORHOOD	26	1.2%
	WALKING FOR SHOPPING PURPOSE (TO THE MARKET, WALKING IN THE MALL, STORE, ETC.)	6	.2%
	OTHER	9	.4%

PHYSICAL ACTIVITY

Table 3. The barriers in front of physical activity (Community Survey for SHA, Nevada, 2022)

QUESTION	VARIABLE	NO.	PERCENT
Q4. THE LARGEST BARRIERS TO BEING PHYSICALLY ACTIVE	TOO BUSY/DOES NOT FIT INTO MY SCHEDULE	716	32.8%
	TOO TIRED	457	20.9%
	BAD WEATHER/WEATHER ISSUES	146	6.7%
	NOT ENOUGH SUPPORT/LACK FRIENDS/FAMILY TO KEEP ME MOTIVATED	130	5.9%
	DOES NOT LIKE TO EXERCISE	126	5.8%
	SAFETY ISSUE OF PLACES TO EXERCISE	124	5.7%
	TOO EXPENSIVE	100	4.6%
	PHYSICALLY UNABLE TO EXERCISE/ANY MEDICAL CONDITION	96	4.4%
	LACK OF MOTIVATION	14	.6%
	OTHER	55	2.5%
	NO BARRIERS, I EXERCISE ENOUGH	223	10.2%
Q5. THINGS THAT WOULD INCREASE PHYSICAL ACTIVITY LEVELS	HAVING AN EXERCISE FACILITY WHERE I WORK	795	36.%
	LESS EXPENSIVE GYM MEMBERSHIPS	686	31.4%
	MORE OR IMPROVED BIKE/RUNNING TRAILS	551	25.2%
	HAVING SUPPORT OF FRIENDS/FAMILY TO KEEP ME MOTIVATED	510	23.3%
	MORE OR IMPROVED PARK FACILITIES	494	22.6%
	MORE OR IMPROVED RECREATION FACILITIES (INDOOR/ OUTDOOR)	434	19.8%
	IMPROVED SIDEWALKS	416	19%
	WALKING OR EXERCISE GROUPS	381	17.4%
	FREE SPORT TEAM LEAGUES	220	10.1%
	ADA ACCESSIBLE FACILITIES	61	2.8%

PHYSICAL ACTIVITY

Table 4. Relationship between days of physical activity and select social demographics (Community survey for SHA, Nevada, 2022)

VARIABLE		0 DAYS		1-2 DAYS PER WEEK		≥3 DAYS PER WEEK	
		NO.	PERCENT	NO.	PERCENT	NO.	PERCENT
AGE GROUPS ‡	18-24	24	14.4%	53	31.7%	90	53.9%
	25-44	203	19.2%	356	33.6%	501	47.3%
	45-64	215	25.9%	274	33.1%	340	41%
	65 +	35	28.9%	33	32.9%	53	45.2%
GENDER ‡	MALE	66	14%	154	32.6%	252	53.4%
	FEMALE	402	24.2%	551	33.1%	711	42.7%
	OTHER	10	21.7%	13	28.3%	23	50%
RACE †	HISPANIC/LATINO	73	19.8%	139	37.8%	156	42.4%
	ASIAN	33	22.4%	46	31.3%	68	46.3%
	BLACK/AFRICAN AMERICAN	49	21.8%	84	37.3%	92	40.9%
	WHITE/CAUCASIAN	262	22.4%	362	30.9%	548	46.8%
	OTHER / MULTIPLE	59	23%	79	30.7%	119	46.3%
SEXUAL IDENTITY †	HETEROSEXUAL	403	21.7%	605	32.5%	853	45.8%
	SEXUAL MINORITY	75	23.4%	113	35.2%	133	41.4%
EDUCATION † †	HIGH SCHOOL OR BELOW	66	24.5%	95	35.3%	108	40.1%
	SOME COLLEGE ETC.	216	24.4%	293	33%	378	42.6%
	BACHELOR'S DEGREE	118	19.3%	198	32.4%	295	48.3%
	GRADUATE'S DEGREE AND +	71	19.1%	117	31.5%	184	49.5%
INCOME †	> 40 K	108	22.4%	159	32.9%	216	44.7%
	40 K - 60 K	125	22.7%	185	33.6%	241	43.7%
	60 K - 100 K	148	23.1%	223	34.8%	269	42%
	100 K +	90	19%	140	29.5%	244	51.5%
RESIDENCY †	URBAN	406	22.1%	595	32.4%	835	45.5%
	RURAL	65	21.5%	108	35.6%	130	42.9%
TOTAL		477	21.9%	716	32.9%	984	45.2%

†NS † †p<0.05 ‡ p<0.001

PHYSICAL ACTIVITY

Table 5. Relationships between the perceived ability to safely exercise in one's neighborhood and select social demographics (Community survey for SHA, Nevada, 2022)

VARIABLE		EXTREMELY SAFE OR FAIRLY SAFE		SOMEWHAT SAFE OR NOT SAFE AT ALL	
		NO.	PERCENT	NO.	PERCENT
AGE GROUPS ‡	18-24	125	74.9%	42	25.1%
	25-44	756	71.3%	304	28.7%
	45-64	633	76.4%	196	23.6%
	65 +	94	77.7%	27	22.3%
GENDER ‡	MALE	376	79.7%	96	20.3%
	FEMALE	1,207	72.5%	457	27.5%
	OTHER	28	60.9%	18	39.1%
RACE †	HISPANIC/LATINO	231	62.8%	137	37.2% Ý
	ASIAN	108	73.5%	39	26.5%
	BLACK/AFRICAN AMERICAN	166	73.8%	59	26.2%
	WHITE/CAUCASIAN	917	78.2%	255	21.8%
	OTHER / MULTIPLE	181	70.4%	76	29.6%
SEXUAL IDENTITY †	HETEROSEXUAL	1,402	75.3%	459	24.7%
	SEXUAL MINORITY	209	65.1%	112	34.9% Ý
EDUCATION † †	HIGH SCHOOL OR BELOW	187	69.5%	82	30.5%
	SOME COLLEGE ETC.	622	70.1%	265	29.9%
	BACHELOR'S DEGREE	469	76.8%	142	23.2%
	GRADUATE'S DEGREE AND +	301	80.9%	71	19.1%
INCOME †	> 40 K	312	64.6%	171	35.4%
	40 K - 60 K	379	68.8%	172	31.2%
	60 K - 100 K	489	76.4%	151	23.6%
	100 K +	407	85.9%	67	14.1%
RESIDENCY †	URBAN	1,329	72.4%	507	27.6% Ý
	RURAL	250	82.5%	53	17.5%
TOTAL		1,608	73.9%	569	26.1%

†NS † †p<0.05 ‡ p<0.001

PHYSICAL ACTIVITY

Table 6. Relationships between the perceived importance of exercise and select social demographics (Community survey for SHA, Nevada, 2022)

VARIABLE		EXTREMELY OR FAIRLY IMPORTANT		SOMEWHAT OR NOT IMPORTANT AT ALL	
		NO.	PERCENT	NO.	PERCENT
AGE GROUPS ‡	18-24	124	74.%	43	25.7%
	25-44	811	76.5%	249	23.5%
	45-64	655	79%	174	21%
	65 +	100	82.6%	21	17.4%
GENDER ‡	MALE	381	80.7%	91	19.3%
	FEMALE	1,280	76.9%	384	23.1%
	OTHER	33	71.7%	13	28.3%
RACE †	HISPANIC/LATINO	275	74.7%	93	25.3%
	ASIAN	126	85.7%	21	14.3%
	BLACK/AFRICAN AMERICAN	186	82.7%	39	17.3%
	WHITE/CAUCASIAN	896	76.5%	276	23.5%
	OTHER / MULTIPLE	202	78.6%	55	21.4%
SEXUAL IDENTITY †	HETEROSEXUAL	1,454	78.1%	407	21.9%
	SEXUAL MINORITY	240	74.8%	81	25.2%
EDUCATION † †	HIGH SCHOOL OR BELOW	199	74%	70	26%
	SOME COLLEGE ETC.	670	75.5%	217	24.5%
	BACHELOR'S DEGREE	482	78.9%	217	24.5%
	GRADUATE'S DEGREE AND +	312	83.9%	60	16.1%
INCOME †	> 40 K	382	79.1%	101	20.9%
	40 K - 60 K	406	73.7%	145	26.3%
	60 K - 100 K	488	76.3%	152	23.8%
	100 K +	394	83.1%	80	16.9%
RESIDENCY †	URBAN	1,426	77.7%	410	22.3%
	RURAL	237	78.2%	66	21.8%
TOTAL		1,694	77.6%	488	22.4%

†NS **† †p<0.05** **‡ p<0.001**

NEIGHBORHOOD SAFETY

Table 7. Neighborhood safety (Community Survey for SHA, Nevada, 2022)

QUESTION	VARIABLE	NO.	PERCENT
Q13. HOW MANY FIRST NAMES DO YOU KNOW OF YOUR NEIGHBORS?	0	405	18.5%
	1-2	724	33.1%
	3-4	521	23.8%
	5-6	274	12.5%
	7-8	102	4.7%
	9+	161	7.4%
Q14. HOW SAFE DO YOU FEEL YOUR NEIGHBORHOOD IS FROM CRIME?	VERY SAFE	617	28.2%
	SOMEWHAT SAFE	1,229	56.2%
	SOMEWHAT UNSAFE	969	12.3%
	VERY UNSAFE	71	3.2%

NUTRITION AND FOOD SECURITY

Table 8. Nutrition and Hunger (Community Survey for SHA, Nevada, 2022)

QUESTION	VARIABLE	NO.	PERCENT
Q7. IN THE PREVIOUS 7 DAYS, HOW MANY TIMES WERE FRESH COOKED MEALS EATEN?	1-2 DAYS IN THE PAST WEEK	425	19.4%
	3-4 DAYS IN THE PAST WEEK	780	35.7%
	5-6 DAYS IN THE PAST WEEK	579	26.5%
	ALL 7 DAYS IN THE PAST WEEK	283	12.9%
	NO DAYS IN THE PAST WEEK	120	5.5%
Q8. LARGEST BARRIERS TO CONSUMING HEALTHY FOODS	HEALTHY FOODS ARE TOO EXPENSIVE	795	36.4%
	NOTHING. I ALREADY EAT ENOUGH HEALTHY FOODS	485	22.2%
	HEALTHY FOODS TAKE TOO MUCH TIME TO PREPARE	324	14.8%
	HEALTHY FOODS SPOIL TOO QUICKLY	209	9.6%
Q9. WHERE PARTICIPANTS GO MOST OFTEN FOR GROCERIES	GROCERY STORES (SAVEMART, WINCO, RALEY'S SMITHS, ETC.)	1,289	58.9%
	WHOLESALE CLUB (COSTCO, SAM'S CLUB)	322	14.7%
	LARGE RETAIL STORES (WALMART, TARGET, ETC.)	474	21.7%
	CONVENIENCE STORE	37	1.7%
	DOLLAR STORE	11	.5%

FOOD SECURITY

Table 9. Food security (Community Survey for SHA, Nevada, 2022)

QUESTION	VARIABLE	NO.	PERCENT
Q10. WITHIN THE PAST 12 MONTHS, WORRIED WHETHER OUR FOOD WOULD RUN OUT BEFORE WE GOT MONEY TO BUY MORE	NEVER TRUE	1,284	58.7%
	OFTEN TRUE	251	11.5%
	SOMETIMES TRUE	652	29.8%
Q11. WITHIN THE PAST 12 MONTHS, HOW TRUE WAS THE FOLLOWING STATEMENT: THE FOOD WE BOUGHT JUST DIDN'T LAST AND WE DIDN'T HAVE MONEY TO BUY MORE	NEVER TRUE	1,413	64.6%
	OFTEN TRUE	202	9.2%
	SOMETIMES TRUE	572	26.2%
Q12. HOW CONFIDENT DID PARTICIPANTS FEEL ABOUT FINDING FOOD ASSISTANCE RESOURCES IN THEIR COMMUNITY	EXTREMELY CONFIDENT	520	23.8%
	SOMEWHAT CONFIDENT	998	45.6%
	SOMEWHAT UNCONFIDENT	441	20.2%
	EXTREMELY UNCONFIDENT	228	10.4%

PUBLIC ASSISTANCE & FINANCIAL CHALLENGES

Table 10. Public assistance (Community Survey for SHA, Nevada, 2022)

QUESTION	VARIABLE	NO.	PERCENT
Q17. IN THE PAST 12 MONTHS, HAVE YOU, OR SOMEONE IN YOUR HOUSEHOLD, HAD A HARD TIME PAYING FOR ANY OF THE FOLLOWING? SELECT ALL THAT APPLY	HOUSING (MORTGAGE OR RENT)	585	26.7%
	TRANSPORTATION (CAR PAYMENT, GAS, INSURANCE, PUBLIC TRANSPORATION, ETC.)	472	21.6%
	UTILITIES (HEAT/ AIR CONDITIONING, POWER, WATER, TRASH/WASTE, OR SEWER)	449	20.5%
Q18. IN THE PAST 12 MONTHS, HAVE YOU, OR ANYONE IN YOUR HOUSEHOLD, RECEIVED NON-CASH BENEFITS FROM ANY SOURCE LISTED BELOW? (PUBLIC BENEFITS)	NONE	1,485	67.9%
	FOOD STAMPS OR BENEFIT CARD	263	12%
	MEDICAID (HEALTH INSURANCE)	251	11.5%
	P-EBT (CHILDREN)	180	8.2%
	MEDICARE (HEALTH INSURANCE)	120	5.5%
	SECTION 8 PUBLIC HOUSING OR RENTAL ASSISTANCE	76	3.5%
	VETERANS ADMINISTRATION (VA) MEDICAL SERVICES	61	2.8%
	WIC (SUPPLEMENTAL NUTRITION FOR WOMEN, INFANTS, AND CHILDREN)	62	2.8%
	SCHIP (STATE CHILDREN'S HEALTH INSURANCE PROGRAM)	33	1.5%
	FEDERAL HOUSING VOUCHER	29	1.3%
	TANF CHILD CARE SERVICES	21	1%
	TANF TRANSPORTATION SERVICES	9	.4%
	OTHER TANF FUNDED SERVICES	8	.4%
Q19. IN THE PAST 12 MONTHS, HAVE YOU, OR ANYONE IN YOUR HOUSEHOLD, RECEIVE CASH INCOME FROM ANY SOURCE LISTED BELOW?	UNEMPLOYMENT INSURANCE BENEFITS (UI)	122	11.2%
	SOCIAL SECURITY RETIREMENT	151	13.8%
	WORKER'S COMPENSATION	100	9.1%
	PENSION FROM EMPLOYMENT	133	12.2%
	CHILD SUPPORT	96	8.8%
	VETERAN'S DISABILITY PAYMENTS	75	6.9%
	SOCIAL SECURITY DISABILITY INSURANCE (SSDI)	79	7.2%
	SUPPLEMENTAL SOCIAL SECURITY (SSI)	71	6.5%
	VETERAN'S PENSION	45	4.1%
	PRIVATE DISABILITY INSURANCE	30	2.7%
	GENERAL PUBLIC ASSISTANCE	26	2.4%
	TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)	22	2%
	ALIMONY OR SPOUSAL SUPPORT	12	1.1%

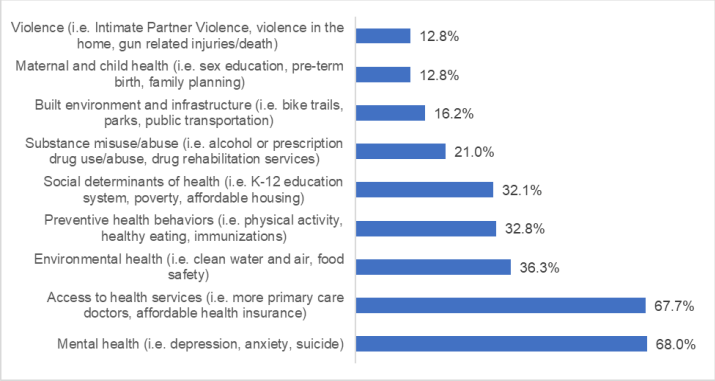
ACCESS TO HEALTH CARE

Table 11. Unmet need and barriers to access to healthcare in the past 12 months (Community Survey for SHA, Nevada, 2022)

QUESTION	VARIABLE	NO.	PERCENT
Q15. IN THE PAST 12 MONTHS, WHICH, IF ANY, OF THE FOLLOWING TYPES OF HEALTHCARE PROVIDERS HAVE YOU NEEDED TO SEE, BUT COULDN'T? (UNMET HEALTHCARE NEED)	NONE, I WAS ABLE TO SEE ALL HEALTHCARE PROVIDERS NECESSARY	765	35%
	PRIMARY CARE, GENERAL PRACTITIONER, OR FAMILY DOCTOR	712	32.6%
	DENTIST OR ORTHODONTIST	465	21.3%
	EYE DOCTOR, OPTOMETRIST, OR OPHTHALMOLOGIST	392	17.9%
	SPECIALIST	313	14.3%
	OBSTETRICIAN OR GYNECOLOGIST (OB/GYN)	297	13.6%
	PSYCHIATRIST, PSYCHOLOGIST, OR COUNSELOR	254	11.6%
	EAR NOSE AND THROAT DOCTOR (ENT)	135	6.2%
	PHYSICAL THERAPIST	135	6.2%
	ADV. PRACT. OF NURSING (APN) OR PHYSICIAN'S ASS. (PA)	134	6.1%
	I DID NOT NEED TO SEE ANY HEALTHCARE PROVIDERS	136	6.2%
	PEDIATRICIAN	110	5%
	OCCUPATIONAL THERAPIST	67	3.1%
	UROLOGIST	41	1.9%
	CERTIFIED NURSE MIDWIFE/MIDWIFE	31	1.4%
	OTHER TYPE OF PROVIDER	56	2.6%
Q16. WHAT ARE THE MAIN BARRIERS YOU FACE WHEN ACCESSING HEALTHCARE IN NEVADA?	NO BARRIERS TO ACCESSING HEALTHCARE IN NEVADA	327	15%
	COULD NOT GET AN APPOINTMENT SOON ENOUGH/LONG WAIT LIST TO BE SEEN	942	43.1%
	FINDING PROVIDERS WHO ACCEPT MY INSURANCE	684	31.3%
	INSURANCE DOES NOT COVER WHAT I NEED	565	25.8%
	FINDING PROVIDERS WHO ARE ACCEPTING NEW PATIENTS	508	23.2%
	HOURS THE CLINICS ARE OPEN	396	18.1%
	FINDING A PROVIDER CLOSE TO WHERE I WORK OR LIVE	369	16.9%
	NOT ABLE TO TAKE LEAVE FROM WORK WITHOUT PAY	187	8.6%
	DID NOT KNOW WHERE TO GO	93	4.3%
	LACK OF CHILDCARE WHEN I NEED TO SEE A PROVIDER	86	3.9%
	I DO NOT HAVE HEALTH INSURANCE	52	2.4%
	LANGUAGE OR CULTURAL BARRIER	21	1%
	ADA COMPLIANT TRANSPORTATION	13	.6%
	ADA COMPLIANT BUILDING ACCESS	10	.5%
	OTHER	140	6.4%

RANKING OF HEALTH PRIORITIES

Figure 2. Health-related issues reported by the participants (Community Survey for SHA, Nevada, 2022)



RANKING OF HEALTH PRIORITIES

Table 12. Health-related issues by demographics (Community Survey for SHA, Nevada, 2022)

VARIABLE		ACCESS TO HEALTH SERVICES		ENVIRONMENTAL HEALTH		MENTAL HEALTH		SUBSTANCE MISUSE/ ABUSE	
		NO.	PERCENT	NO.	PERCENT	NO.	PERCENT	NO	PERCENT
AGE GROUPS ‡	18-24	97	58.1%	67	40.1%	111	66.5%	28	16.8%
	25-44	668	63%	406	38.3%	739	69.7% †	179	16.9%
	45-64	612	73.8% † †	259	31.2%	572	69% †	224	27% † †
	65 +	95	78.5% † †	56	46.3% † †	59	48.8%	29	24% † †
GENDER ‡	MALE	275	58.3%	197	41.7% † †	292	61.9%	88	18.6%
	FEMALE	1,176	70.7% † †	572	34.4%	1,159	69.7% †	368	22.1% †
	OTHER	25	54.3%	21	45.7% † †	34	73.9% †	4	8.7%
RACE †	HISPANIC/LATINO	277	75.3% † †	197	41.7%	292	61.9%	88	18.6%
	ASIAN	113	76.9% † †	63	42.9%	85	57.8%	20	13.6%
	BLACK/AFRICAN AMERICAN	149	66.2%	90	40%	163	72.4%	26	11.6%
	WHITE/CAUCASIAN	752	64.2%	403	34.4%	807	68.9%	279	23.8% † †
	OTHER / MULTIPLE	178	69.3%	94	36.6%	162	63%	54	21%
SEXUAL IDENTITY †	HETEROSEXUAL	1,277	68.6%	664	35.7%	1,257	67.5%	396	21.3%
	SEXUAL MINORITY	199	62%	126	39.3%	228	71%	64	19.9%
EDUCATION † †	HIGH SCHOOL OR BELOW	181	67.3%	81	30.1%	200	74.3% †	63	23.4%
	SOME COLLEGE ETC.	633	71.4%	321	36.2%	624	70.3% †	205	23.1%
	BACHELOR'S DEGREE	402	65.8%	244	39.9% †	403	66%	113	18.5%
	GRADUATE'S DEGREE AND +	229	61.6%	130	34.9%	229	61.6%	73	19.6%
INCOME †	> 40 K	329	68.1%	177	36.6%	346	71.6% †	97	20.1%
	40 K - 60 K	411	74.6%	187	33.9%	390	70.8% †	105	19.1%
	60 K - 100 K	397	62%	249	38.9%	416	65%	135	21.1%
	100 K +	315	66.5%	165	34.8%	311	65.6%	118	24.9%
RESIDENCY †	URBAN	1,246	67.9%	675	36.8%	1,251	68.1%	380	20.7%
	RURAL	199	65.7%	101	33.3%	205	67.7%	74	24.4%
TOTAL									

†p<0.05 † † p<0.001 ‡

HEALTH STATUS

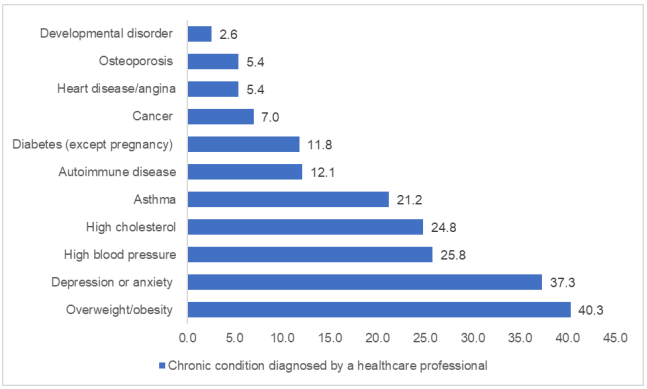
CHRONIC DISEASES

Table 13. Chronic condition diagnosed by a healthcare professional (Community Survey for SHA, Nevada, 2022)

HEALTH CONDITIONS	NO.	PERCENT
OVERWEIGHT/OBESITY	881	40.3%
DEPRESSION OR ANXIETY	815	37.3%
HIGH BLOOD PRESSURE	565	25.8%
HIGH CHOLESTEROL	543	24.8%
ASTHMA	464	21.2%
AUTOIMMUNE DISEASE	264	12.1%
DIABETES (EXCEPT PREGNANCY)	257	11.8%
CANCER	152	7%
HEART DISEASE/ANGINA	118	5.4%
OSTEOPOROSIS	118	5.4%
DEVELOPMENTAL DISORDER	56	2.6%

CHRONIC CONDITIONS

Figure 3. Chronic condition diagnosed by a healthcare professional (Community Survey for SHA, Nevada, 2022)



COVID-19

Table 14. COVID-19 (Community Survey for SHA, Nevada, 2022)

QUESTION	VARIABLE	NO.	PERCENT
Q22. IN YOUR OPINION, HOW EFFECTIVE IS WEARING A MASK IN REDUCING THE TRANSMISSION OF THE VIRUS THAT CAUSES COVID-19?	EXTREMELY EFFECTIVE	670	30.6%
	FAIRLY EFFECTIVE	697	31.9%
	SOMEWHAT EFFECTIVE	480	21.9%
	NOT EFFECTIVE AT ALL	340	15.5%
Q23. IN YOUR OPINION, HOW EFFECTIVE ARE THE COVID-19 VACCINATIONS AT REDUCING TRANSMISSION OF THE VIRUS?	EXTREMELY EFFECTIVE	721	33%
	FAIRLY EFFECTIVE	664	30.4%
	SOMEWHAT EFFECTIVE	447	20.4%
	NOT EFFECTIVE AT ALL	355	16.2%
Q24. IN YOUR OPINION, HOW IMPORTANT IS IT TO YOU TO RECEIVE BOOSTERS AFTER RECEIVING THE INITIAL COVID-19 VACCINATIONS?	EXTREMELY EFFECTIVE	852	39%
	FAIRLY EFFECTIVE	472	21.6%
	SOMEWHAT EFFECTIVE	329	15%
	NOT EFFECTIVE AT ALL	534	24.4%

PERCEIVED STRESS

Table 15. Perceived stress scores by demographics (Community Survey for SHA, Nevada, 2022)

VARIABLE		NO.	MEAN ± STD. DEV.	SIG.
AGE GROUPS	18-24	167	7.53 ± 2.65	P<0.001
	25-44	1,060	7.16 ± 2.90	
	45-64	829	6.37 ± 3.10	
	65 +	121	6.02 ± 2.85	
GENDER	MALE	472	6.81 ± 2.81	NS
	FEMALE	1,664	6.81 ± 3.01	
	OTHER	46	7.43 ± 3.60	
RACE	HISPANIC/LATINO	368	6.60 ± 2.98	NS
	ASIAN	147	6.44 ± 2.88	
	BLACK/AFRICAN AMERICAN	225	6.84 ± 2.88	
	WHITE/CAUCASIAN	1,172	6.94 ± 3.04	
	OTHER / MULTIPLE	257	6.78 ± 2.83	
SEXUAL IDENTITY	HETEROSEXUAL	1,861	6.74 ± 2.97	P<0.005
	SEXUAL MINORITY	321	7.31 ± 3.01	
EDUCATION	HIGH SCHOOL OR BELOW	269	6.83 ± 2.96	P<0.001
	SOME COLLEGE ETC.	887	7.07 ± 2.96	
	BACHELOR'S DEGREE	661	6.75 ± 2.96	
	GRADUATE'S DEGREE AND +	372	6.35 ± 3.03	
INCOME	> 40 K	483	7.60 ± 2.79	P<0.001
	40 K - 60 K	551	7.10 ± 3.00	
	60 K - 100 K	640	6.58 ± 2.91	
	100 K +	474	6.02 ± 3.00	
RESIDENCY	URBAN	1,836	8.77 ± 2.01	NS
	RURAL	303	8.69 ± 2.06	

APPENDIX D

LISTENING TOUR LOCATIONS, SCRIPT & COMMON THEMES

Listening tour locations, language and group sizes.

DATE	LOCATION	LANGUAGE	NUMBER OF PARTICIPANTS
5/10/22	RECONCILIATION APOSTOLIC MINISTRIES	ENGLISH	14
5/19/22	STUDENT GROUP (VIRTUAL)	ENGLISH	6
6/2/22	WILLIAM N. PENNINGTON LIFE CENTER	ENGLISH	10
6/7/22	LATIN CHAMBER OF COMMERCE	SPANISH	10
6/8/22	WEST FLAMINGO SENIOR CENTER	ENGLISH	13
6/8/22	UNITED WAY OF SOUTHERN NEVADA	ENGLISH	2
6/8/22	COMMUNITY COLLABORATIVE FOUNDATION	ENGLISH	3
6/9/22	ALL AMERICAN REPAIRS	SPANISH	9
6/9/22	WIN COURT - LAS VEGAS SPECIALTY COURT	ENGLISH	8
6/9/22	THE LOVEWELL CENTER	ENGLISH	20
6/9/22	COMMUNITY COUNSELING CENTER	ENGLISH	10
6/17/22	TRBIAL COMMUNITY MEMBERS (VIRTUAL)	ENGLISH	2
		TOTAL PARTICIPANTS	125

LISTENING TOUR SCRIPT - FOCUS GROUP INTRODUCTION

Thank you for participating in a Nevada State Health Needs Assessment focus group. My name is (Insert your name), I am going to lead our conversation today by asking the group questions.

We have ninety-minutes to capture your thoughts and feelings about the health of our community. This information will help to determine what community assets exist and will also help identify the most pressing needs of our community.

It is important that you speak one at a time as this focus group will be (voice) recorded. This will also ensure we can have the important details when we review and analyze the information that is collected today for the final report. Everything you share with us will remain confidential, real names will not be used in the transcripts or the report. The audio files and transcripts are kept confidential and only a limited number of persons will have access to them. At the end of the focus group, I will provide you with my contact information if you have comments, questions, or concerns afterwards. I will be asking you a few questions about different quality of life and community health related topics. If you need the question repeated at any time, just ask. Although this is designed to be conversational, it is important that only one of you speak at a time so we can hear one another clearly. If you are not comfortable answering a question or need to think about your response, you can say “pass” or “come back to me.”

Most importantly, this is a safe space, and everyone’s input is respected and valued. We want everyone to have an opportunity to provide feedback. Please be respectful of one another’s responses, there are no right or wrong answers.

QUESTIONS

1. Let's take a moment to introduce ourselves. Please state your name or an alias and share what you consider to be the most positive aspect of your community.
    a. I will start. My name is _____ and one of the most positive aspects of my community is _____.
    b. Who would like to go next?
        i. What do you like best?
2. General Community Questions
    a. What actions do you do each day, or try to do, to make sure you have a good quality of life?
        i. Can you think about a time in your life where you felt your healthiest physically?
        ii. Can you think about a time in your life where you felt your healthiest and mentally?
        iii. What were some things that contributed to that feeling?
    b. In your opinion, what criteria or conditions make an entire community healthy?
        i. What must exist in the community to make sure more people have a good quality of life?
            1. What makes a community healthy?
            2. What makes a community unhealthy?
            3. Are there any elements you believe to be necessary to make a community healthy?
    c. What do you believe are the top two or three most important issues that should be addressed to improve the quality of life in our community?
        i. Economic stability
        ii. Neighborhood environment
        iii. Physical environment
        iv. Education
        v. Food access and quality
        vi. Safety
        vii.Opportunities to engage with your community
        viii. Access to health care and services
        ix. Mental health services
        x. Substance abuse treatment
    d. Have you had any specific challenges in accessing health care services?
        i. Mental health
        ii. Substance abuse
3. Family & Friends Questions
    a. What do you and your family and/or friends do to maintain and improve their own quality of life?
        i. What are some experiences that you or your family or friends rely on to improve quality of life?
        ii. What are some programs/services that you or your family or friends rely on to improve quality of life?
4. Group Closing Question
    a. Thinking about all of the topics and issues discussed, is there anything else you believe is important that was not mentioned?
        i. Is there anything that you'd really like to emphasize and come back to?

CODEBOOK

ACCESS
- Healthcare
- Social Services

HOUSING
- Those who are homeless
- Those with substance abuse disorders
- Young adults with intellectual disabilities
- Veterans
- Vulnerable women & children

TRANSPORTATION
- Public transportation
- Transportation specifically to reach health services
- Transportation for the elderly
- Transportation for those with intellectual disabilities

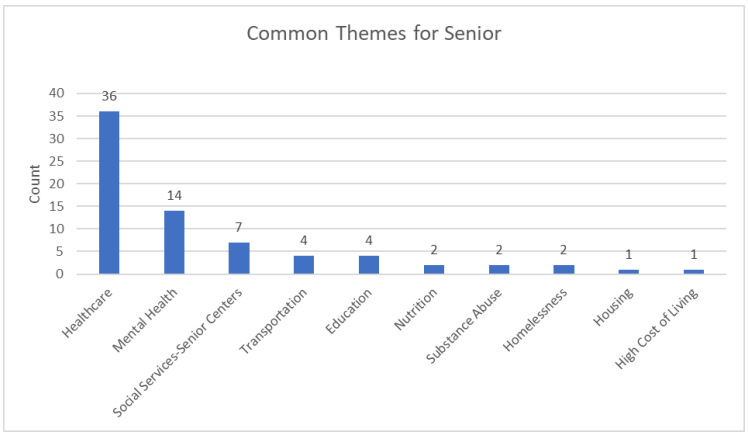
BEHAVIORAL HEALTH
- Substance abuse
  - Availability/access to internet
  - Substance abuse in the homeless community
  - Youth substance abuse
- Mental health
  - Stress relieving activities
  - Connection to others
  - Environment
  - Nutrition

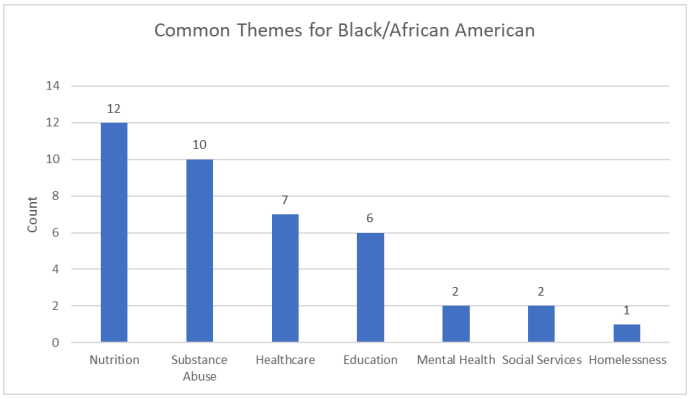
COMMUNITY NEEDS
- High cost of living
- Education
  - Lack of funding
  - Dissastisfied with school district
- Nutrition
  - Lack of affordable, healthy food
- Food insecurity
- Food deserts
- Need more food banks/pantries

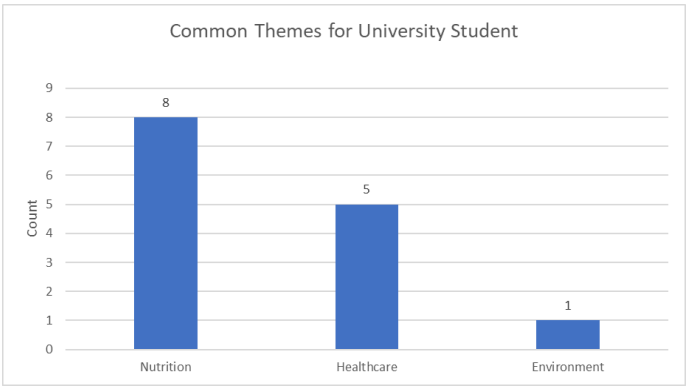
SOCIAL SERVICES
- Community centers
- Senior centers
- Police
- Programs for homelessness
- Programs for those with substance abuse disorders
- Programs for veterans
- Programs for the elderly
- Programs for women and children

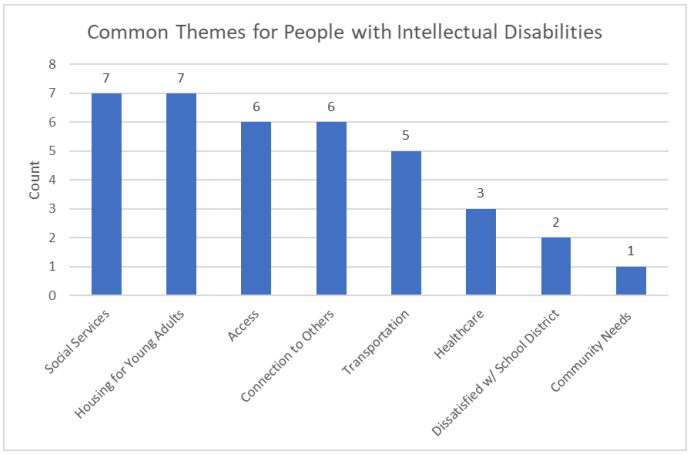
ASSETS

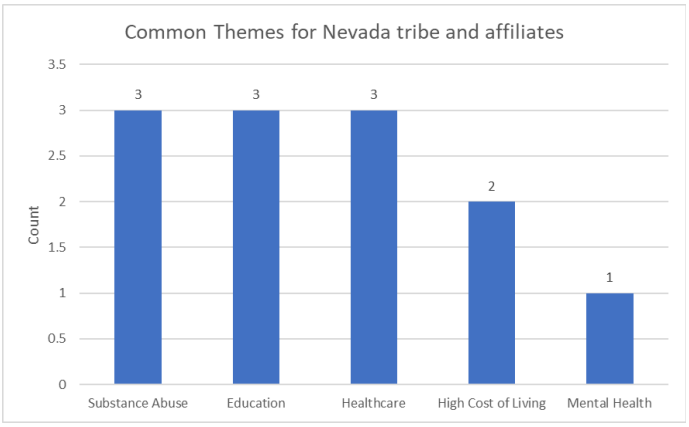
COMMON THEMES FROM LISTENING TOUR GROUPS

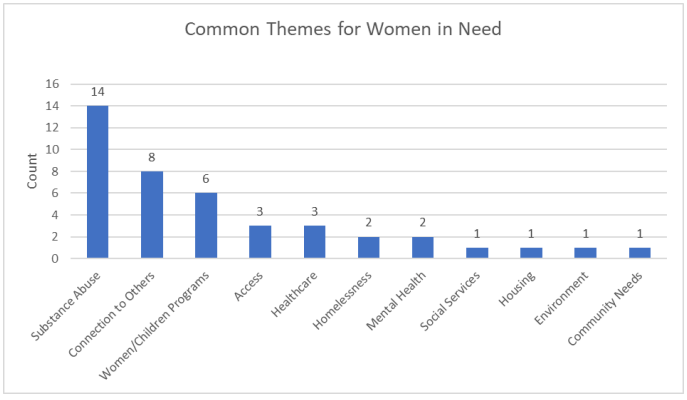


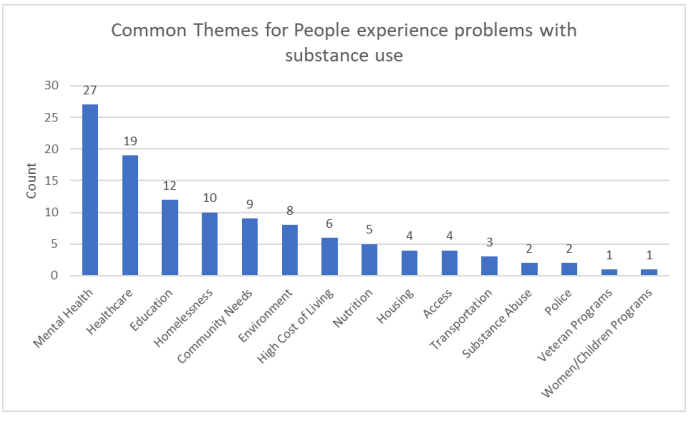

Common Themes for Black/African American
Count
Nutrition
Substance Abuse
Healthcare
Education
Mental Health
Social Services
Homelessness
12
10
7
6
2
2
1

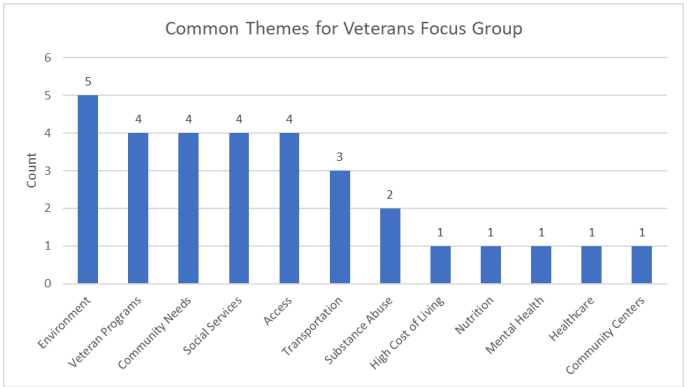

Common Themes for University Student
Count
Nutrition
Healthcare
Environment
8
5
1

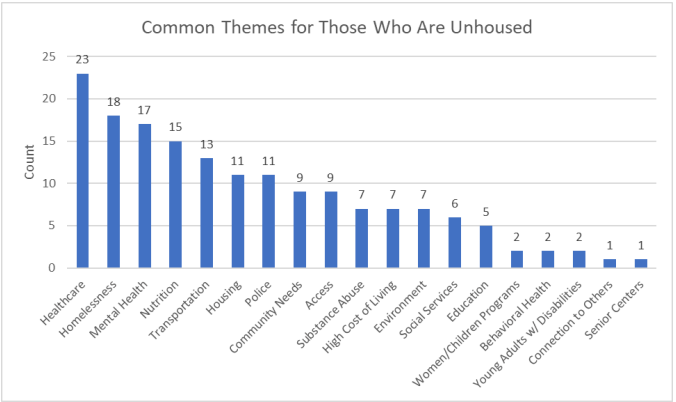

Common Themes for People with Intellectual Disabilities
Count
Social Services
Housing for Young Adults
Access
Connection to Others
Transportation
Healthcare
Dissatisfied w/ School District
Community Needs
7
7
6
6
5
3
2
1


Common Themes for Nevada tribe and affiliates
Count
Substance Abuse
Education
Healthcare
High Cost of Living
Mental Health
3
3
3
2
1


Common Themes for Women in Need
Count
Substance Abuse
Connection to Others
Women/Children Programs
Access
Healthcare
Homelessness
Mental Health
Social Services
Housing
Environment
Community Needs
14
8
6
3
3
2
2
1
1
1
1


Common Themes for People experience problems with substance use
Count
Mental Health
Healthcare
Education
Homelessness
Community Needs
Environment
High Cost of Living
Nutrition
Housing
Access
Transportation
Substance Abuse
Police
Veteran Programs
Women/Children Programs
27
19
12
10
9
8
6
5
4
4
3
2
2
1
1


Common Themes for Veterans Focus Group
Count
Environment
Veteran Programs
Community Needs
Social Services
Access
Transportation
Substance Abuse
High Cost of Living
Nutrition
Mental Health
Healthcare
Community Centers
5
4
4
4
4
3
2
1
1
1
1
1


Common Themes for Those Who Are Unhoused
Count
Healthcare
Homelessness
Mental Health
Nutrition
Transportation
Housing
Police
Community Needs
Access
Substance Abuse
High Cost of Living
Environment
Social Services
Education
Women/Children Programs
Behavioral Health
Young Adults w/ Disabilities
Connection to Others
Senior Centers
23
18
17
15
13
11
11
9
9
7
7
7
6
5
2
2
2
1
1