Chronic Disease Prevention and Health Promotion

STRATEGIC PLAN 2023-2027

NEVADA Wellness

FOREWORD

To our Valued Partners in Public Health and our fellow Nevadans-

Six in ten Americans live with at least one chronic disease. More Nevadans die each year from chronic disease than from all other causes of death combined. The financial impact of chronic disease is alarming, as nearly 90% of annual health care expenditures are for people with chronic and mental health conditions. However, financial impact is only part of the issue. The negative physical, psychological, and emotional impacts on Nevada's citizens heightens the problem to a near state of emergency. People from many racial groups, ethnicities, and people from the Lesbian Gay Bisexual Transgender Queer or Questioning+ (LBGTQ+) community, experience additional health inequities and disparate burdens of disease that injure the community as a whole.

Each year, nearly 900,000 Americans die prematurely from the five leading causes of death – yet 20% to 40% of the deaths from each cause could be prevented, according to the Centers for Disease Control and Prevention. Despite these statistics, the majority of public health efforts to address chronic disease remain focused on secondary and tertiary prevention efforts and are specific to disease type. This is despite evidence that primary prevention efforts will have the greatest impact in reducing the overall burden of disease. This attention on primary prevention has long been recognized by public health professionals and is reflected throughout this plan. The conversation must change from how to treat disease to how to support comprehensive wellness.

Throughout the development of this strategic plan, many public health professionals working in the field of chronic disease across the state volunteered their expertise, experience, and leadership to provide meaningful insight regarding the needs of the community and needs of public health partners in order to decrease the burden of chronic disease in Nevada. The Chronic Disease Prevention and Health Promotion (CDPHP) Section is grateful to these partners for providing insight and recommendations to improve our work, and intends to honor that insight by focusing efforts around the goals outlined in this plan. Through robust and meaningful partnership, the professionals at Chronic Disease Prevention and Health Promotion are dedicated to implementing meaningful prevention programs for all Nevadans. This plan is in full alignment with the CDPHP mission: **to maximize the health of Nevadans by improving policy, systems, and environment that influence quality of life.**

LRHelzer

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CDPHP would also like to recognize and acknowledge the incredible work done every day by partners throughout the state. Throughout implementation of this plan, CDPHP will make every effort to ensure no duplication of efforts, but instead will leverage and build upon the good work conducted.

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- **Aging and Disability Services Division**-Jeff Duncan & Katrina Fowler
- **Churchill Community Coalition***-Tammie Shemenski
- **Department of Health and Human Services Analytics/Data Team**-Evelina Eytchison & Jennifer Thompson
- **Elko County Health Board**-Ashley Gurr & Jessica Segovia
- **Frontier Communities Coalition***-Wendy Nelsen
- **Healthy Communities Coalition***-Wendy Madson
- **High Sierra Area Health Education Center**-Natasha Nyquist-Smith
- **Indian Health Services**-Patricia Taylor
- **Nevada Cancer Coalition**-Cari Herington
- **Nevada Chapter of the American Academy of Pediatrics, Obesity Prevention Chair**-Steven Shane
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- **Churchill Community Coalition***-Tammie Shemenski
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- **Nevada Department of Veterans Services**-Amy Garland
- **Nevada Division of Insurance**-Mark Garratt & Jeremey Gladstone
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- **Supplemental Nutrition Assistance Program–Education**-Tonya Wolf & Stephanie Cook
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- **University of Nevada, Reno Sanford Center for Aging**-Peter Reed
- **Washoe County Health District**-Kevin Dick
- **University of Nevada, Reno Sanford Center for Aging**-Peter Reed
- **Washoe County Health District**-Kevin Dick

**Indicates that this organization is a part of the Nevada Statewide Coalition Partnership*

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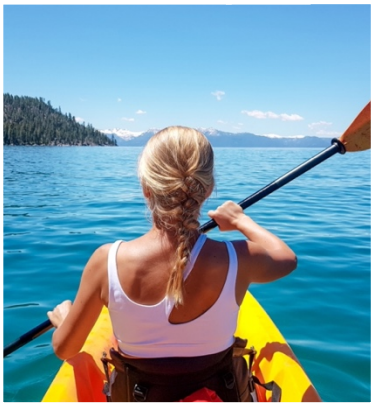
Part 1

Purpose & Use of the Plan

This section captures the purpose of this strategic plan as well as the plan for its implementation.



Purpose

The purpose of the Chronic Disease Prevention and Health Promotion (CDPHP) Strategic Plan is to define specific and reasonable goals to reduce the burden of chronic disease in Nevada over the next five years. These goals will serve as a call to action for all chronic disease partners and decision-makers throughout Nevada. The plan will guide the work of CDPHP within the Nevada Division of Public and Behavioral Health (DPBH) and was built with partner input and in awareness of existing statewide efforts. This plan has a broader chronic disease lens and is not intended to replace the disease-specific strategic plans that are already in place and underway, nor will this plan supersede current work, but will instead leverage and build upon existing efforts.

Audience

This plan will guide the work of the CDPHP in collaboration with its partners, providing guidance as they make decisions about funding, programs, priorities, and needs. It is a guide for collaboration and coordinating efforts for all agencies, nonprofits, governments, and communities working on chronic disease reduction.

Strategic Plan Methodology

CDPHP began the process of developing a five-year strategic plan in November 2021.

The Blueprint Collaborative and OnStrategy were secured to facilitate the strategic planning process. The planning process was divided into three phases:

- **Phase 1** – Needs Assessment
- **Phase 2** – Strategic Plan Development
- **Phase 3** – Communication

Phase 1: Needs Assessment

The Needs Assessment Phase consisted of two parts: (1) Perspectives from the CDPHP leadership and (2) an External Partner Needs Assessment.

(1) Perspectives were secured from the CDPHP leadership via one-on-one interviews to gather themes and key ideas to inform the External Partners' assessment and to inform the broader planning process for the state's chronic disease strategic plan.

(2) The Blueprint Collaborative and OnStrategy conducted individual interviews with 40 partners across 29 organizations and one group interview with the Nevada Statewide Coalition Partnership, which included 11 partners across nine organizations. Additional organizations and partners were invited to participate but were unable to participate or did not respond.

The full list of questions from CDPHP Leadership interviews and External Partner interviews can be found in the Needs Assessment Report, which is captured in its entirety in Appendix C.

The **objectives** of the interviews were to:

- Understand **emerging trends and major shifts/changes** over the past several years and how those are projected to impact the future.
- Identify the **primary needs (partners & residents) statewide related to prevention, education, and reducing chronic disease.**
- Understand **where state work can have the biggest impact** in context of where our partners are focusing and how the state can best engage.
- Clarify **the major challenges or barriers** to "flattening the curve."
- Provide a deep dive to understand **challenges and possible solutions to health equity.**
- Determine how to best support **and work more closely and share information** with partners.
- Solicit suggestions for **tangible steps** that can be taken over the next five years that can reduce the burden of chronic disease in our state.

Phase 2: Strategic Plan Development

A Working Group, which consisted of CDPHP Leadership and Staff, was formed to develop the CDPHP strategic plan draft via several strategic planning workshops to define key plan elements such as vision, priorities, guiding principles, strategic goals, objectives, initiatives, and performance measures. For strategic plan development there were four key questions for consideration:

(1) Where are we now? (current state)

(2) Where do we want to be? (desired future state)

(3) How will we get there? (implementing the plan)

(4) How will we monitor progress? (evaluating plan progress)

Two virtual meetings were held to align on the plan purpose, guiding principles, and plan vision. Discussions took place regarding the current state (per the Needs Assessment results and review of current chronic disease data) as well as desires for CDPHP's impact on chronic disease in the future. Following, two full-day workshops were held to fully flesh out plan elements. Implementation plans were crafted post-workshop and are reflected in Part Four of this document.

The plan draft was shared with key partners, both internal and external to the organization for further input prior to approval and implementation.

Phase 3: Communication

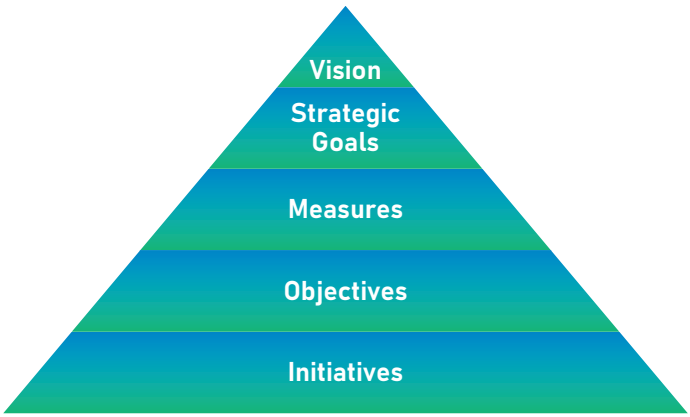
Following the approval of the strategic plan, CDPHP will shift from plan development to plan implementation. The final, approved plan will be shared with all partners, as this work entails implementation efforts by both CDPHP and its partners. The plan will be shared with additional partners and stakeholders over the life of the plan as the opportunity arises and where appropriate.

Timeframe

The timeframe of the Strategic Plan spans five years from 2023-2027.

How the Plan is Organized

The 2023-2027 Chronic Disease Prevention and Health Promotion (CDPHP) strategic plan structure is captured in Figure 1. Strategic plan development began with the establishment of a clear vision for the next five years. The vision, information captured in the Needs Assessment, and review of current chronic disease data for the State of Nevada led to development of five strategic goals. These goals will be accomplished via the defined initiatives (i.e.-projects, programs, activities) for each goal. Performance measures are defined for each goal, enabling progress against the plan to be quantified and monitored. Action plans have been crafted for each initiative to include: a brief description, anticipated results, initiative champion, the role of CDPHP as well as CDPHP partner role for the initiative, and a tentative timeline for completion.



Using the Plan

CDPHP will use this plan as a guide to create annual work plans that will provide the "how" to this plan's "what" as well as connect this plan to disease-specific plans. CDPHP will work with funded partners to focus resources on pursuing these strategies throughout the state. CDPHP's role is to equip funded and non-funded partners (which includes tribes, towns, cities, counties, and coalitions) with the strategies, data, guidance, and support that they need to make the best decisions about sustainable solutions for their communities. CDPHP will create and provide the necessary tools; partners will prioritize their "community's" health challenges and determine when and how to take action.

Principles Guiding Implementation & Use of the Plan

CDPHP grounded its 2023-2027 chronic disease strategic planning process in several guiding principles:

- The plan will be **executed by CDPHP** with the **help of partners** where appropriate.
- Goals were developed to be SMART - specific, measurable, achievable, realistic, and time-bound.
- Performance measures are either "**quantifiable or verifiable.**"
- Performance against this plan will be **evaluated regularly**, as this plan was designed to be **measurable**.

Implementation with Our Partners

The effective prevention and management of chronic conditions is strongly influenced by the contributions made by a wide range of partners, funded and non-funded. All partners have shared responsibility for health outcomes according to their role and capacity within the health care system. Greater cooperation between partners can lead to more successful individual and system outcomes.

Part 2

Opportunities & Challenges

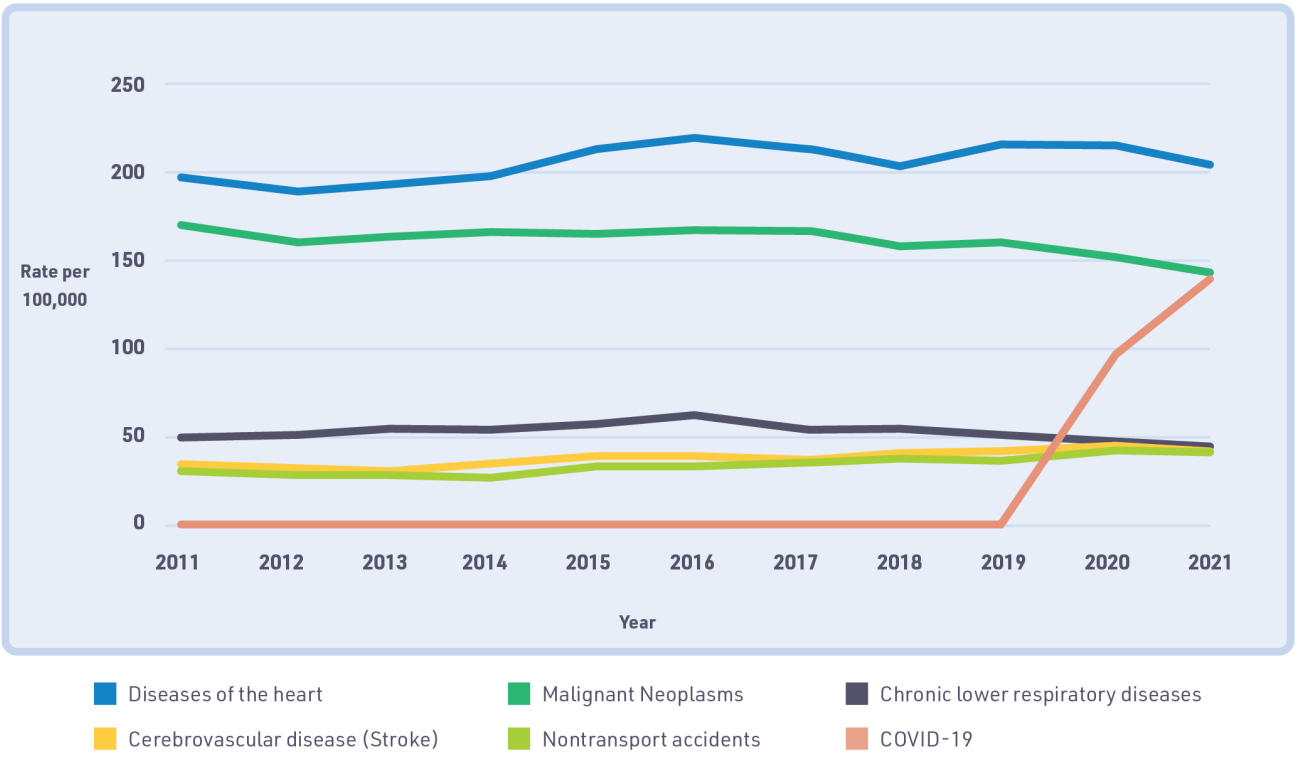
This section highlights the current state of chronic disease, setting the context for the Strategic Plan.

Burden of Chronic Disease in Nevada

Chronic disease is defined as "a health condition or disease which presents for a period of three months or more or is persistent, indefinite or incurable" (per NRS 439.517). Chronic disease impacts individuals, families, and our state, carrying a high financial burden for its prevention and management.

From 2011-2019, four out of the top five leading causes of death in Nevada have been due to chronic diseases (heart disease, cancer-malignant neoplasms, chronic lower respiratory diseases, and stroke). It is only in 2020 and 2021, with the entrance of the COVID-19 pandemic, that this trend was disrupted. That said, of the top six causes of death in our state, these original four chronic diseases are still prevalent. [Fig 2.]

Figure 2. Leading Causes of Death in Nevada, 2011-2021



Source: NV HHS Office of Analytics Vital Records

Figures 3 & 4 shed light on the financial burden of chronic disease in the state. In 2021, net payments by Medicaid to providers for cardiovascular disease (stroke + other cardiovascular diseases) total over $168M; for cancer, payments exceed $96M. Though Medicaid recipients represent only 20% of the Nevada population, this data gives perspective on the burden chronic disease has, not only on individuals, but the state as well. As one can see, the magnitude of managing chronic disease in Nevada is significant. Any impact we can make contributing to the reduction of chronic disease will not only decrease the financial burden on the state, but also improve the lives of Nevadans and their families.

Figure 3. 2021 Nevada Medicaid Net Payments by Chronic Condition

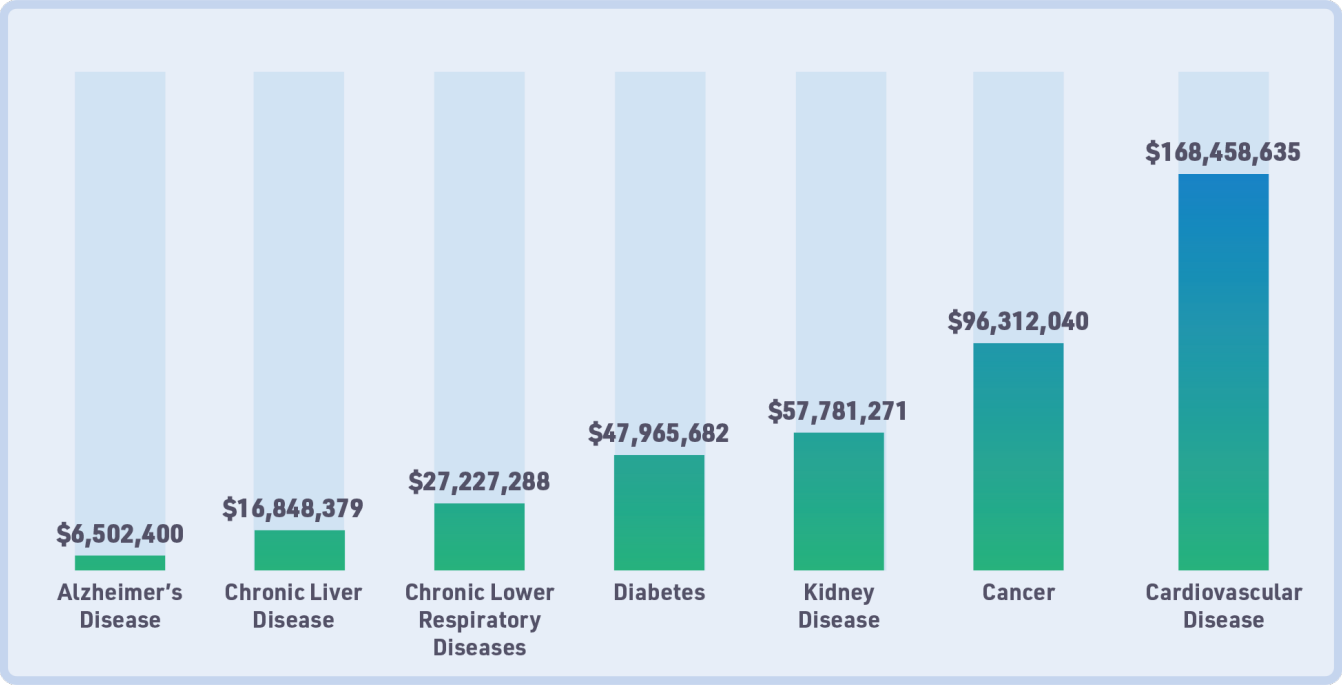
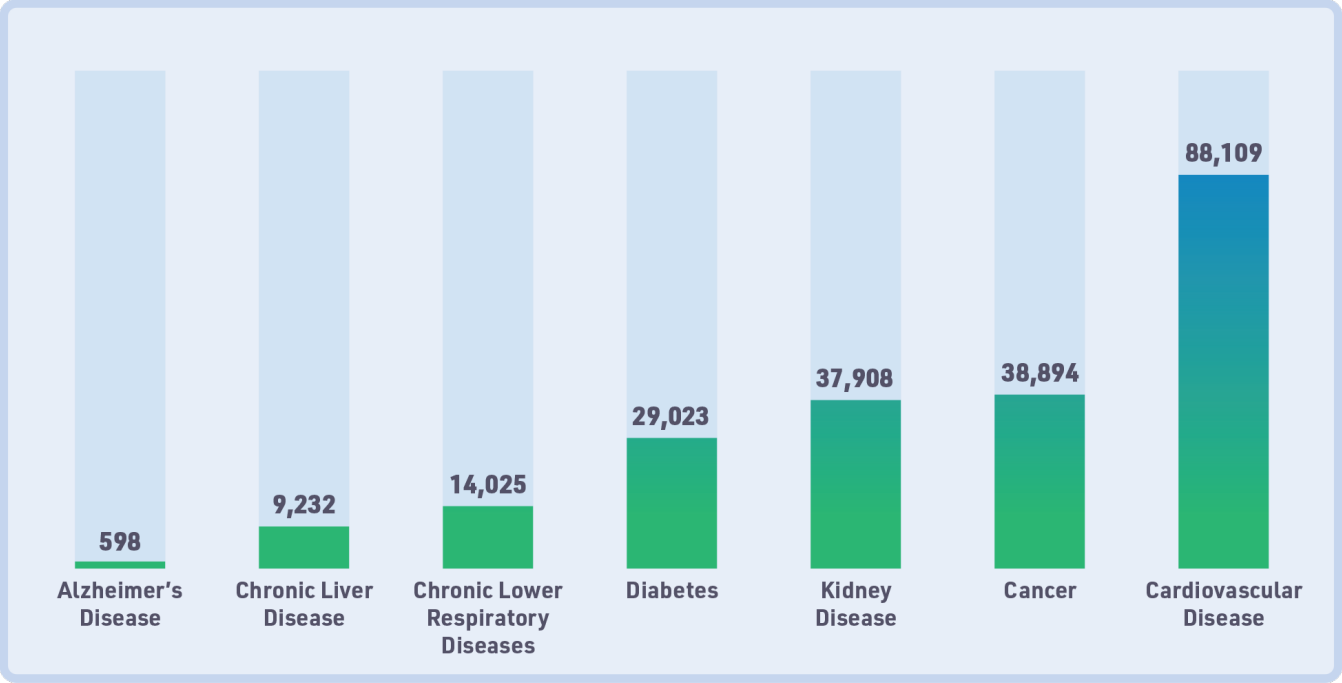


Figure 4. Number of Patient Services by Nevada Medicaid in 2021 by Chronic Condition



Source: Nevada Medicaid Data Warehouse Dimension Data Model (DMM) and Decision Support System (DSS)

Risk Factors for Chronic Disease

There are many factors that contribute to chronic disease which makes preventing and managing chronic disease complex. There are some factors that cannot be controlled by the individual – such factors as age, race, and genetics. There are other risk factors that are considered modifiable.

Top risk factors for chronic disease include:

- Tobacco Use
- Alcohol Use
- Being obese & Overweight
- Unhealthy Diet
- Physical Inactivity

Fortunately, each of these risk factors are modifiable, though greatly impacted by social determinants of health. The Centers for Disease Control and Prevention (CDC) defines social determinants of health as the "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes."

These social determinants of health lead to health inequities across populations. According to the CDC, "health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment."

2019 data from the Nevada Behavioral Risk Factor Surveillance System (BRFSS) captures the disparities of chronic disease risk factors across various ethnic groups and counties within the state. See Figures 5-8, which indicate the disparity in risk factors of specific racial/ethnic groups and geography for adults within our state. Similarly, Figures 9-12 capture the variation in mortality rates of top chronic diseases across specific races/ethnicities for all Nevadans. Finally, Figures 13-18 capture the disparities of chronic disease risk factors for youth per the Nevada Risk Behavior Survey (YRBS). With this data, Chronic Disease Prevention and Health Promotion (CDPHP) and CDPHP partners can target strategies and programs targeting reduction in the root causes of top chronic diseases in our state.

Figure 5. Adults Who Reported Cardiovascular Disease Risk Factors – Prevalence by Race/Ethnicity, NV, 2019

Race/Ethnicity	High BP	Overweight or Obese	No Physical Activity
White-non-Hispanic	34.8%	66.1%	23.5%
Black-non-Hispanic	25.3%	71.6%	21.4%
AI/AN-non-Hispanic	¥	¥	¥
API-non-Hispanic	32.5%	54.5%	29.3%
Hispanic	29.8%	73.1%	30.9%

Source: Nevada Behavioral Risk Factor Surveillance System (BRFSS).

¥: Prevalence estimate suppressed when the unweighted sample size for the denominator was <50

Figure 6. Adults Who Reported Being Overweight or Obese – Prevalence by Race/Ethnicity, and by Region, 2015-2019, Aggregated

Race/Ethnicity	Clark County	Washoe County	Balance of State
White-non-Hispanic	64.1%	61.5%	66.8%
Black-non-Hispanic	72.5%	64.7%	¥
AI/AN-non-Hispanic	67.3%	66.2%	73.2%
API-non-Hispanic	47.8%	33.7%	¥
Hispanic	73.9%	72.0%	73.5%

Source: Nevada Behavioral Risk Factor Surveillance System (BRFSS).

Multiple years were combined due to low respondent counts.

¥: Prevalence estimate suppressed when the unweighted sample size for the denominator was <50

Figure 7. Adults Who Reported No Physical Activity in the Last 30 Days – Prevalence by Race/Ethnicity, and by Region, 2015-2019, Aggregated

Race/Ethnicity	Clark County	Washoe County	Balance of State
White-non-Hispanic	23.4%	19.2%	24.6%
Black-non-Hispanic	28.4%	26.5%v	¥
AI/AN-non-Hispanic	17.0%	26.5%	26.8%
API-non-Hispanic	25.9%	16.1%	¥
Hispanic	32.4%	27.1%	26.9%

Source: Nevada Behavioral Risk Factor Surveillance System (BRFSS).

Multiple years were combined due to low respondent counts.

¥: Prevalence estimate suppressed when the unweighted sample size for the denominator was <50

Figure 8. Current Smokers, Nevada Adults – Prevalence by Race/Ethnicity, and by Region, 2015-2019, Aggregated

Race/Ethnicity	Clark County	Washoe County	Balance of State
White-non-Hispanic	17.3%	16.4%	21.4%
Black-non-Hispanic	20.8%	13.1%	¥
AI/AN-non-Hispanic	17.6%	28.4%	29.2%
API-non-Hispanic	14.8%	5.8%	¥
Hispanic	11.7%	14.4%	14.3%

Source: Nevada Behavioral Risk Factor Surveillance System (BRFSS).

Multiple years were combined due to low respondent counts.

¥: Prevalence estimate suppressed when the unweighted sample size for the denominator was <50

Figure 9. Heart Disease Mortality – Counts and Age-Adjusted Death Rates by Race/Ethnicity and Year, NV, 2015-2019

Year	White		Black		AI/AN		API		Hispanic	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
2019	5,104	223.1	711	311.4	50	139.6	410	143.3	507	134.2
2018	4,788	213.7	647	294.7	59	159.9	376	144.4	471	128.1
2017	4,810	219.4	592	291.6	42	118.2	383	154.3	397	117.0
2016	4,805	224.1	599	303.1	52	161.6	342	144.6	444	131.3
2015	4,561	216.4	553	285.3	42	121.0	294	134.2	453	142.2

Source: Nevada Electronic Death Registry System

Rates per 100,000

Figure 10. All Cancer Incidence and Mortality, Age-Adjusted Rates, Nevada and the United States, 2013-2017

Race/Ethnicity	Nevada Incidence	US Incidence	Nevada Mortality	US Mortality
White-non-Hispanic	410.4	442.0	167.2	159.0
Black-non-Hispanic	359.9	440.6	168.0	182.0
AI/AN-non-Hispanic	261.2	284.4	90.9	106.0
API-non-Hispanic	263.6	28.2	160.0	99.0
Hispanic	293.4	337.7	99.8	112.0
All Race/Ethnicity Groups	397.2	439.8	161.1	158.0

Source: NV Incidence: Nevada Central Cancer Registry. NV Mortality: Nevada Electronic Death Registry System. US Incidence and Mortality: CDC United States Cancer Statistics: 1999-2017 Incidence and Mortality Web-based Report

Rates per 100,000

Figure 11. Chronic Lower Respiratory Disease Mortality – Counts and Age-Adjusted Death Rates by Race/Ethnicity and Region, Nevada, 2015 – 2019

Race/Ethnicity	Clark County		Washoe County		Balance of State	
	Count	Rate	Count	Rate	Count	Rate
White-non-Hispanic	1446	61.3	75	33.0	15	38.2
Black-non-Hispanic	1437	62.7	82	40.5	10	33.5
AI/AN-non-Hispanic	1409	62.2	79	38.1	11	35.6
API-non-Hispanic	1548	70.6	72	35.5	11	36.7
Hispanic	1413	66.0	62	37.3	6	20.7

Source: Nevada Electronic Death Registry System

Rates per 100,000

Figure 12. Stroke Mortality – Counts and Age-Adjusted Death Rates by Race/Ethnicity and Year, Nevada, 2015 – 2019

Year	White		Black		AI/AN		API		Hispanic	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
2019	900	39.9	145	65.5	14	40.0	103	37.7	113	30.6
2018	819	37.2	127	64.0	10	34.4	114	44.7	102	26.2
2017	750	34.4	134	70.2	7	23.0	104	42.0	105	30.7
2016	726	34.5	102	53.5	7	19.9	109	48.6	105	32.8
2015	742	36.2	81	46.3	6	19.7	88	39.3	118	39.1

Source: Nevada Electronic Death Registry System

Rates per 100,000

Figure 13. Percentage of High School Students Who Did Not Eat Fruit or Drink 100% Fruit Juices During the Seven (7) Days Before the Survey

Race/Ethnicity	Value
AI/AN non-Hispanic	17.7%
Asian non-Hispanic	8.1%
Black non-Hispanic	13.2%
Hispanic	7.1%
NH/PI non-Hispanic	3.7%
Other/Multiple	6.9%
White-non-Hispanic	7.4%
Total	7.9%

Source: Nevada Risk Behavior Survey (YRBS), 2019

Figure 14. Percentage of High School Students Who Did Not Eat Vegetables During the Seven (7) Days Before the Survey

Race/Ethnicity	Value
AI/AN non-Hispanic	20.8%
Asian non-Hispanic	11.1%
Black non-Hispanic	21.7%
Hispanic	13.8%
NH/PI non-Hispanic	10.3%
Other/Multiple	9.3%
White-non-Hispanic	9.1%
Total	12.7%

Source: Nevada Risk Behavior Survey (YRBS), 2019

Figure 15. Percentage of High School Students Who Did Not Drink Soda or Pop During the Seven (7) Days Before the Survey

Race/Ethnicity	Value
AI/AN non-Hispanic	24.4%
Asian non-Hispanic	47.5%
Black non-Hispanic	29.9%
Hispanic	32.1%
NH/PI non-Hispanic	33.6%
Other/Multiple	37.6%
White-non-Hispanic	32.6%
Total	33.3%

Source: Nevada Risk Behavior Survey (YRBS), 2019

Figure 16. Percentage of High School Students Who Did Not Participate in At Least Sixty (60) Minutes of Physical Activity on Any Day During the Seven (7) Days Before the Survey

Race/Ethnicity	Value
AI/AN non-Hispanic	20.4%
Asian non-Hispanic	20.5%
Black non-Hispanic	18.8%
Hispanic	18.8%
NH/PI non-Hispanic	23.9%
Other/Multiple	12.0%
White-non-Hispanic	13.5%
Total	16.9%

Source: Nevada Risk Behavior Survey (YRBS), 2019

Figure 17. Percentage of High School Students Who Smoked Cigarettes During the Thirty (30) Days Before the Survey

Race/Ethnicity	Value
AI/AN non-Hispanic	13.0%
Asian non-Hispanic	1.4%
Black non-Hispanic	2.5%
Hispanic	3.6%
NH/PI non-Hispanic	7.3%
Other/Multiple	3.0%
White-non-Hispanic	4.1%
Total	3.6%

Source: Nevada Risk Behavior Survey (YRBS), 2019

Figure 18. Percentage of High School Students Who Used Electronic Vapor Products During the Thirty (30) Days Before the Survey

Race/Ethnicity	Value
AI/AN non-Hispanic	33.7%
Asian non-Hispanic	15.0%
Black non-Hispanic	19.9%
Hispanic	21.3%
NH/PI non-Hispanic	24.6%
Other/Multiple	23.9%
White-non-Hispanic	25.8%
Total	22.5%

Source: Nevada Risk Behavior Survey (YRBS), 2019

Key Needs Assessment Findings

The full Needs Assessment Report is found in Appendix C. The key findings from the assessment guided the development of this plan and are summarized below. The Needs Assessment process brought to light both community needs as well as the needs of our partners.

Key categories of findings include:

(1) Emerging Trends & Major Shifts

(2) Primary Needs for Reducing Chronic Disease

(3) Where the State can have the Biggest Impact

(4) Challenges to Health Equity

(5) Opportunities to Work Better with Partners

Emerging Trends & Major Shifts

There were a handful of emerging trends and shifts in the management of chronic disease that were noted by CDPHP partners. Some shifts have already begun while others provide recommendations for a shift in approach moving forward. Trends included shifting focus from direct service to a Policy, Systems, and Environments approach, using social determinants of health to inform community needs, and shifting to community-led programming and partnerships. In addition, partners noted there have been many positive changes made in recent years in response to the COVID-19 pandemic. The recommendation is for organizations and agencies to take "inventory" of changes made due to the pandemic that should continue and be made permanent as we move back to normal operations.

Primary Needs to Reducing Chronic Disease

There were consistent themes in discussions of community needs regarding chronic disease reduction in Nevada. Themes for community needs included: economic access to health care services, physical access to services, health equity concerns, as well as the need to focus on prevention and improve health literacy. In addition, the need to address root causes of chronic disease reverberated, with the following common causes referenced: mental and behavioral health, substance abuse, tobacco use, and nutrition security and obesity. Also mentioned were needs specific to the rural and tribal communities.

Where the State can have the Biggest Impact

Though there were many areas of need shared by the partners, there were three areas that rose to the top of the needs assessment interviews where the greatest impact might be realized. Most partners expressed the need for sustainable and flexible funding, as many partners rely on federal dollars and grants that have very specific spending requirements. Many partners also expressed concern regarding the provider shortage within our state, with suggestions to use creative solutions to incentivize medical professionals to practice in Nevada. Finally, several partners expressed the desire for a statewide coalition for chronic disease. There are many organizations doing great work in the area of chronic disease prevention and there was a strong appetite among partners to collaborate with each other, their community partners, and state agencies.

Challenges to Health Equity

Several themes arose from the needs assessment regarding health inequity. Some of the challenges noted include the need for improved cultural competency and diversity of doctors and pharmacists, inclusive messaging, engagement with the community for developing solutions to health equity, and improved communication of the services available to people experiencing homelessness.

Opportunities to Work Better with Partners

Partners also expressed several areas of need specific to maximizing their ability to make an impact on chronic disease prevention and reduction. Most needs were tied to funding, such as the need for programmatic funding specific to their areas of focus for sustained efforts, the desire to start grant funding conversations as early as feasible, as well as the desire to collaboratively develop approaches with the state and then submit collaborative requests for federal funding. There were also many requests for more timely reimbursement. In addition to the funding-related needs, multiple partners expressed the desire for access to current, localized data as well as interpretation of the data to help them better focus programming and approaches.

Part 3

Strategic Framework

This section sets out our Vision, 5 Strategic Goals and Aspirational Outcomes.

Our Vision

Wellness achieved for all Nevadans through integration of primary prevention, health equity, useful data, evidence-based policy, and strong partnerships.

Strategic Goals

Our vision is supported by five Strategic Goals:

1. EXPAND PREVENTION

Expand evidence-based primary prevention efforts to reduce chronic diseases across the lifespan. Primary Prevention efforts should focus on the improvement of modifiable risk factors to prevent disease from occurring and should integrate mental health well-being.

2. REDUCE HEALTH INEQUITIES

Support efforts to improve health equity.

3. GENERATE DATA FOR ACTION

Generate timely data and information for action.

4. SUPPORT POLICIES

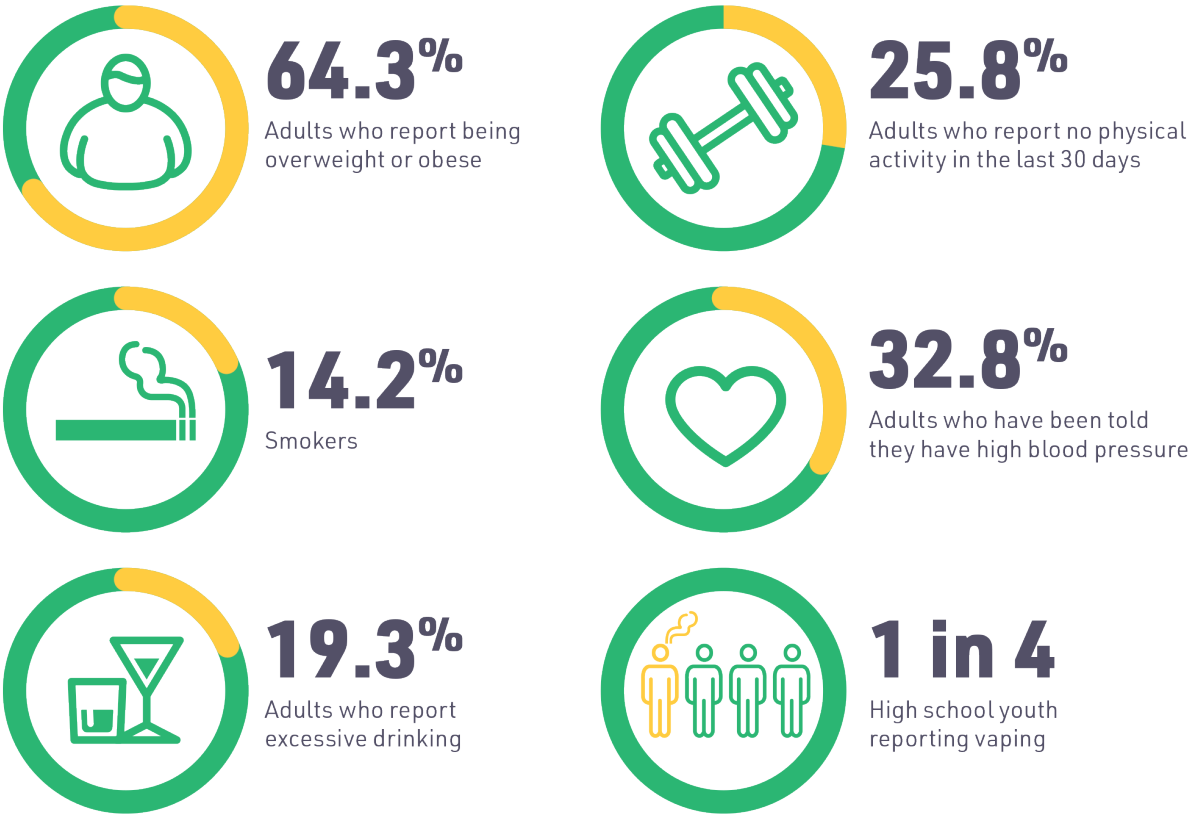
Support policies that promote wellness.

5. STRENGTHEN PARTNERSHIPS

Strengthen partnerships and the capacity of our partners.

Overall Outcomes

Measurable impacts of our efforts are focused on achieving a reduction in the following community indicators. Trends demonstrated here have been evident over the past ten years.



***Note: 1 of every 4 high school youths are vaping; that's more than 91,000 high schoolers (24.2%); Source: 2021 National Youth Tobacco Survey, CDC*

Goal 1

Expand Prevention

Expand prevention efforts to reduce chronic disease across the lifespan.

What Success Will Look Like:

1. 100% Chronic Disease Prevention and Health Promotion programs and funded partners are implementing at least one primary prevention activity.

Our Why:

Enhancing individuals' optimal mental and physical health and reducing chronic disease risk factors have the potential to prevent the onset of chronic diseases.

Background & Rationale

According to the Centers for Disease Control and Prevention, prevention activities are typically categorized by the following three definitions: (source: https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf)

1. Primary Prevention

Intervening before health effects occur, through measures such as vaccinations, altering risky behaviors (poor eating habits, tobacco use), and banning substances known to be associated with a disease or health condition.

2. Secondary Prevention

Screening to identify diseases in the earliest stages, before the onset of signs and symptoms, through measures such as mammography and regular blood pressure testing.

3. Tertiary Prevention

Managing disease post-diagnosis to slow or stop disease progression through measures such as chemotherapy, rehabilitation, and screening for complications.

Today, most of Centers for Disease Control and Prevention (CDPHP) and CDPHP partner's funding and efforts are focused on secondary and tertiary prevention. To best influence the reduction of chronic disease across the lifespan (from conception to death), the recommendation is to shift our focus to primary prevention strategies to reduce the risk factors that may predispose community members to chronic disease. It's important to note that primary prevention includes a focus on mental health. Though partners shared that workforce capacity is an issue overall in our state, multiple partners expressed the need for increased mental health providers for all ages (youth and adults) in both rural and urban communities. Additional key prevention areas referenced by our partners are substance abuse, tobacco use, nutrition security, and obesity, as well as youth-specific needs. Youth-specific needs include: mental and behavioral health resources, expansion of intervention and community-based programs, support services for children with parents in the jail diversion program, and chronic disease prevention.

Goal 1 – Objectives (What) & Initiatives (How)

What We Are Doing (Objectives)	Where Are We Today? (2022)	The Impact We Are Seeking… (2027)	How We Will Do It (Initiatives)
Objective #1 Increase integration of primary prevention activities in CDPHP programs.	Focus is on secondary and tertiary prevention.	100% of CDPHP programs and funded partners are doing at least one primary prevention activity.	**1. Define primary prevention.** Each CDPHP unit/program contributes to and drafts a shared definition for evidence-based primary prevention as it relates to their subject area.
			2. Implement evidence-based primary prevention in all CDPHP units' initiatives Each CDPHP unit/program becomes skilled at implementing their own evidence-based primary prevention initiatives.
			3. Implement evidenced-based primary prevention in all CDPHP programs' initiatives. Each CDPHP unit/program implements an evidence-based primary prevention initiative in all work plans and scope of works documents.
Objective #2 Improve use of Nevada Wellness brand and implement evidence-based primary prevention terminology within CDPHP programs.	Identity and terminology used is "Chronic Disease Prevention," which is clinical, stigmatizing, and limiting.	CDPHP brand and identity are aligned with wellness and prevention efforts, increasing our population reach with more partners at the table.	**1. Change use of terminology from Chronic Disease Prevention to Nevada Wellness.** This initiative may entail: Re-naming of the CDPHP section to better represent prevention and wellness efforts. Reworking CDPHP and partner scopes of work to include primary prevention. Ensuring wellness language is used in all documents.
			2. Maximize Nevada Wellness Brand. Includes changes to logo, websites, promotional materials, etc. Each CDPHP unit/program participates, contributes, and agrees on a logo, websites, promotional materials, etc.
			3. Identify Nevada Wellness current and/or future partners. CDPHP will create a directory of partners detailing primary prevention work and support integration of primary prevention interventions to avoid siloed initiatives and increase the likelihood that partners make adequate contribution for Nevada Wellness success.
Objective #3 Build a dedicated, culturally competent "Wellness" unit to drive integration	A Wellness Unit does not exist.	A dedicated, comprehensive wellness program exists, is staffed to provide capacity and integration to deliver lifespan approach. There's a budget, partners, scopes of work, etc.	**1. Define primary prevention.** Each CDPHP unit/program contributes to and drafts a shared definition for evidence-based primary prevention as it relates to their subject area.
			2. Evaluate CDPHP programs' evolution. CDPHP will review programs to identify focus areas and opportunities for integration.
			3. Review outstanding local & national primary prevention wellness programs. CDPHP will review successful local and national primary prevention programs to bring inspiration/ideas for innovative successful initiatives.

Goal 1 – Performance Measures

Measures	Data Source	Data Owner	2021 Actual	2023 Target	2027 Target
Percent of CDPHP units/programs that have implemented at least one primarily prevention initiative	CDPHP Evaluation and Data	CDPHP Section	Establish baseline	50	100
Percent of CDPHP funded partners that have implemented at least one primarily prevention initiative	CDPHP Evaluation and Data	CDPHP Section	Establish baseline	50	100
Percent of CDPHP programs that have utilized wellness promotion language in all new SOWs/work plans	CDPHP Evaluation and Data	CDPHP Section	Establish baseline	50	100
Dollars obtained to specifically secure dedicated wellness program resource(s)	CDPHP Fiscal	CDPHP Section	Establish baseline	$3.5 Million	$3.5 Million
Number of dedicated positions (people) in place that are dedicated to the wellness program	CDPHP Section	CDPHP Section	1 FTE	2 FTE	3.5 FTE

Goal 2

Reduce Health Inequities

Support efforts to improve health equity.

What Success Will Look Like:

1. Increased representation in program efforts with equity woven into all Centers for Disease Control and Prevention program and partner goals and objectives.
2. Chronic disease reduced across all populations.
3. Programs represent populations served.

Our Why:

Wellness should be inclusive.

Background & Rationale

According to the Centers for Disease Control and Prevention, "health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment." (Source: CDC.gov https://www.cdc.gov/chronicdisease/healthequity/index.htm)

Our goal is to reduce disparities for Nevada residents across all populations, demographics, and geography. Through discussions with partners, we learned that some of the challenges that contribute to health inequities in our state include:

- Differences in challenges related to geographical region, as well as additional challenges experienced by those living in rural and frontier communities.
- Lack of cultural competency and diversity of health care providers.
- Public health messaging may not be clear to the individuals who need to hear it most. Health literacy can be improved in all populations and public health experts should be conscious of appropriate messaging.
- Healthcare-related messaging is often not inclusive, leading to certain populations feeling excluded.
- Poor communication channels to people experiencing homelessness to inform them of available health care services.
- Limited effectiveness of top-down solutions to health equity.

Goal 2 Objectives (What) & Initiatives (How)

What We Are Doing (Objectives)	Where Are We Today? (2022)	The Impact We Are Seeking… (2027)	How We Will Do It (Initiatives)
Objective #1 Increase CDPHP staff competency of health equity and cultural competency/ sensitivity.	A Health Equity Unit exists, but there is no defined training for the organization. Cultural competency/ sensitivity needs improvement.	More staff diversity within Wellness Promotion program. Defined policies and training available that encourage more equity and cultural competency/ sensitivity.	**1. Identify and implement trainings.** Identify a cultural competency training and develop an evaluation tool to evaluate training appropriateness.
			2. Develop process for training implementation and evaluation. Develop and execute a process for rolling out training to CDPHP staff. Ensure that 100% of CDPHP staff have completed training and that a requirement is in place for new hires to complete training as well.
			3. Improve training content and effectiveness. Identify training improvements needed and revision of training to increase self-efficacy based on results of initiative 1.
Objective #2 Increase competency of health equity and cultural competency/ sensitivity of funded partners.	Cultural competency/ sensitivity needs improvement (currently overall moderate). Partners seek employees who have lived experience.	Higher number of partners with high cultural competency/ sensitivity. Community-led programming.	**1. Offer CDPHP cultural competency training to funded partners to support community-led programming.** Communication and roll-out of cultural competency/sensitivity training to all CDPHP funded partners.
			2. Develop process for training implementation and evaluation. Identification of tools needed to support training and evaluation to ensure appropriate fit.
			3. Identify partnerships with new organizations with ties to more disparate communities. Collaborate with funded partners to conduct community-led activities (such as forums, townhalls, panels, etc.) to educate on cultural concerns. Create new partnerships to address chronic disease directly with communities currently the most disparate in population and collaborate on the implementation of community-led activities.
Objective #3 Increase inclusivity and accessibility of all products by CDPHP and partners.	Language Access Plan is currently in development.	Processes established. All materials/ collateral are aligned using the Language Access Plan. Language Access plan fully executed.	**1. Implement Language Access Plan to increase accessibility and inclusivity of all resources produced by CDPHP.** Complete the development and implementation of the Language Access Plan.
			2. Continue to support the Community Health Worker program. Support efforts to increase the number of new partnerships that CDPHP has made with community-based organizations as well as the number of Community Health Workers (CHWs) employed by CDPHP partners.
			3. Continue to support Sexual Orientation and Gender Identity (SOGI) data collection, including the development of SOGI data collection training. Implement methods for SOGI data collection with most current language and trends and ensure CDPHP databases are collecting SOGI indicators where appropriate.
			4. Ensure inclusive and equitable language in all materials and trainings developed by CDPHP. Update CDPHP materials to reflect the principles outlined in the Health Equity Style Guide published by the CDC.

Goal 2 – Performance Measures

Measures	Data Source	Data Owner	2021 Actual	2023 Target	2027 Target
Percent of CDPHP staff who have completed health equity and cultural competency training	CDPHP Evaluation and Data	CDPHP Section	Establish baseline	35	100
Percent of CDPHP funded partners who have completed health equity and cultural competency training	CDPHP Evaluation and Data / Program	CDPHP Section	Establish baseline	25	95
Percent of CDPHP partners who have implemented cultural competency training within their own organizations	CDPHP Evaluation and Data / Program	CDPHP Section	Establish baseline	15	75
Number of partnerships that CDPHP has made with community-based organizations	CDPHP Evaluation and Data / Program	CDPHP Section	36	40	44
Percent of CDPHP collateral aligned to the Language Access Plan	CDPHP Evaluation and Data / Program	CDPHP Section	Zero (0) (Language Access Plan under development)	50	100
Number of Community Health Workers (CHWs) employed by CDPHP partners	CDPHP Evaluation and Data / Program	CDPHP Section	Establish baseline		
Percent of partners who have implemented Sexual Orientation and Gender Identity (SOGI) data training and practices within their organization	CDPHP Evaluation and Data / Program	CDPHP Section	Establish baseline	25	90
Percent of CDPHP materials that include inclusive and equitable language as outlined by the Health Equity Style Guide	CDPHP Evaluation and Data / Program	CDPHP Section	Establish baseline	25	90

Goal 3

Generate Data for Action

Generate timely data and information for action.

What Success Will Look Like:

1. A fully functional, comprehensive Chronic Disease Prevention and Health Promotion (CDPHP) database exists, serving as a chronic disease data source for CDPHP and its partners.
2. Chronic Disease Prevention and Health Promotion and its partners have the capacity to secure the data that shows community need when writing grants and planning programs.

Our Why:

When we provide more timely data to partners as well as explanation of how the data can inform their programs and goals, CDPHP and its partners can get in front of disease instead of chasing the data. We can be part of prevention rather than reaction to disease realized.

Background & Rationale

Conversation with Chronic Disease Prevention and Health Promotion partners highlighted several partner needs around data and information sharing in the area of chronic disease. Needs included:

- Current, county-specific data to better inform programming.
- A better explanation of the data provided. How can they use the information for planning and service delivery so they can better meet community needs?
- Data sharing across programs/partners in the chronic disease space.
- Clarity on how to request data.
- Guidance on transitioning from direct service delivery to evidence-based programming.

Currently, there is a strong culture around data within Chronic Disease Prevention and Health Promotion (CDPHP) and many staff have data at the forefront of their work. In addition, there is a great deal of quantitative and qualitative data available within CDPHP, which simply needs to be consolidated and organized. Data is captured on spreadsheets by varying owners. There is currently a data dashboard in progress to consolidate this data, but there is only a 0.1 FTE available to complete it. (This data dashboard houses outputs/outcomes from programs and population-specific data. It also includes Nevada Health and Human Services Office of Analytics data.) Fortunately, there is department funding for one contract position to see the data dashboard development to completion. Completion, maintenance, and continuous improvement of a data dashboard and increasing staff capacity through training to support data capacity and analysis should go far with assisting our partners.

Goal 3 Objectives (What) & Initiatives (How)

What We Are Doing (Objectives)	Where Are We Today? (2022)	The Impact We Are Seeking… (2027)	How We Will Do It (Initiatives)
Objective #1 Increase CDPHP capacity to provide timely data & information publicly. (partners & general public)	We have passionate/capable people within CDPHP. We have lots of data on spreadsheets. Dashboard currently only pulls data from the NV HHS Office of Analytics.	Consolidated data source (dashboard) with staff dedicated to data.	**1. Complete and launch data dashboard.** Completion of the data dashboard includes upload of all CDPHP program data and ensuring the tool is user friendly and can be utilized by CDPHP staff, partners, and the public. Initial effort will prioritize quantitative data, but once launched, opportunities to incorporate qualitative data will be identified.
			2. Develop and deliver ongoing training. Create training for both the data evaluation team and for users. The data evaluation team will be instructed on how to upload new data and analyze data on the dashboard. Users of the data dashboard will be trained on how to search for and utilize the data.
			3. Promote the availability of the dashboard and training video and support their ongoing use by partners. Ensure that CDPHP staff and partners understand how they can access the dashboard and utilize it to their best capabilities.
Objective #2 Improve CDPHP capacity to utilize data internally. (database for CDPHP internal data)	Lots of data on Excel spreadsheets. We have passionate/capable people within CDPHP.	Functional database with up-to-date available data. Dedicated staff person. We are proactive vs reactive when it comes to data.	**1. Create a database and train CDPHP staff on how to use database.** Establish database and train CDPHP staff on how to use it.
			2. Hire epidemiologist to help us understand/translate the data coming out of the database to CDPHP staff and provide targeted technical assistance to partners. Secure a CDC Epidemiologist Assignee or other contract Epidemiologist.

Goal 3 – Performance Measures

Measures	Data Source	Data Owner	2021 Actual	2023 Target	2027 Target
Percent of programs with up-to-date data uploaded into the dashboard	CDPHP Evaluation and Data / Programs	CDPHP Section	N/A	60	100
Number of trainings developed	CDPHP Evaluation and Data / Programs	CDPHP Section	N/A	2	4
Percent of CDPHP staff who have completed training on use of the data dashboard	CDPHP Evaluation and Data / Programs	CDPHP Section	N/A	20	80
Percent of CDPHP partners who have completed the training on use of the data dashboard	CDPHP Evaluation and Data / Programs	CDPHP Section	N/A	10	75
Data dashboard utilization	CDPHP Evaluation and Data / Programs	CDPHP Section	N/A	Establish metrics	Percentage increase over baseline TBD
Percent of CDPHP staff who have been trained on the use of the CDPHP database	CDPHP Evaluation and Data / Programs	CDPHP Section	N/A	20	80

Goal 4

Support Policies

Support policies that promote wellness.

What Success Will Look Like:

1. A wellness policy toolkit for Chronic Disease Prevention and Health Promotion (CDPHP) to use with partners and policy makers. This toolkit informs how CDPHP will conduct policy work to include policy/grassroots efforts and large-scale statewide policy efforts.
2. Identification of evidence-based policies to adopt or adapt for Nevada.
3. Consistent statewide wellness policies and more support for wellness policies, establishing a framework to pursue "health in all policies" approach.

Our Why:

Policy is the most sustainable way to create population-based change.

Background & Rationale

Today, the chronic disease policies in our state are very piecemeal and disjointed, consisting of various individual program-based policies rather than wellness promotion policies. In order to maximize impact, Chronic Disease Prevention and Health Promotion (CDPHP) sees the need to conduct a comprehensive analysis of current policies, then streamline and align them with a wellness promotion focus.

Chronic Disease Prevention and Health Promotion (CDPHP) staff and partners are at varying degrees of capability with regard to implementing and communicating policy and understanding how to work with Medicaid and other programs. In addition, among our partners, there is misinformation regarding CDPHP's role in policy work. Partner expectations are higher than reality. To address these challenges, there is value in CDPHP developing standardized tools to support the Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease and partner capacity to reach out to decision makers.

Goal 4 Objectives (What) & Initiatives (How)

What We Are Doing (Objectives)	Where Are We Today? (2022)	The Impact We Are Seeking… (2027)	How We Will Do It (Initiatives)
Objective #1 Maximize impact of evidence-based wellness policies.	Current policies are siloed and not utilized to the fullest. We have poorly written policies that are difficult to implement. We have staff to conduct effective policy, but not systematic.	Completed toolkit that systematically identifies approaches to implementing and communicating policy.	**1. Conduct analysis of current statewide wellness policies.** Analysis includes research of what other states are doing regarding evidence-based polices that we may want to mimic or adapt. **2. Develop toolkit.** Develop a toolkit that details roles, strategies for conducting policy work at multiple levels, tools and templates to support policy work, and assists partners in improving capacity to leverage advocacy. **3. Improve capacity to leverage partners to conduct policy, systems, and environmental change work.** • This initiative includes: • Partner education on how to better leverage PSE. • Mobilization of CWCD's ability to conduct PSE work. • Continued technical assistance to partners in conducting PSE work.

Goal 4 – Performance Measures

Measures	Data Source	Data Owner	2021 Actual	2023 Target	2027 Target
Number of states whose wellness policies have been analyzed	CDPHP Section	CDPHP Section	N/A	TBD	TBD
Number of policy toolkits developed	CDPHP Section	CDPHP Section	N/A	1	1
Percent of CDPHP partners who indicate that the policy toolkit is being referenced and used as they conduct their policy work	Partner survey	CDPHP Section	N/A	25	70
Percent of CDPHP partners who report an increased confidence in their ability to conduct PSE work	Partner survey	CDPHP Section	N/A	25	70
Number of states whose wellness policies have been analyzed	CDPHP Section	CDPHP Section	N/A	TBD	TBD
Number of policy toolkits developed	CDPHP Section	CDPHP Section	N/A	1	1

Goal 5

Strengthen Partnership

Strengthen partnerships and the capacity of our partners.

What Success Will Look Like:

1. A connected group of partners working together proactively.
2. Chronic Disease Prevention and Health Promotion and its partners are focused on primary prevention through Policy, Systems, and Environments with a data-driven health equity focus.
3. Chronic Disease Prevention and Health Promotion partners are addressing wellness promotion and are aligned with evolving needs of the community.
4. There is a defined process in place to increase partner engagement and outcomes, leading to innovative, effective, and responsive partnerships.

Our Why:

To improve outcomes, we need good working/trusting relationships with our partners. We can't do it by ourselves.

Background & Rationale

There are currently many organizations and agencies within our state that are doing great work in chronic disease prevention and wellness promotion. Over recent years, we've had increased conversations and collaboration among Chronic Disease Prevention and Health Promotion (CDPHP) and partners, with more discussions with Medicaid and conversations around health inequity. That said, more collaboration is needed. There are silos that divide our partners in the northern vs. southern part of the state and in general, many CDPHP partners are unaware of the great work other chronic disease-focused organizations are doing. There is a strong desire among CDPHP partners to have more consistent and deliberate coordination and collaboration among agencies working on chronic disease so that they/we can make greater collective impact. While the desire to improve coordination is evident, the preferred mechanism for this to occur is not obvious.

In addition to geographic silos, partners expressed the need for greater coordination between clinical services/health care and public health. There is a need for health care professionals to communicate with community-based agencies to bridge the disconnects among medical care, community care, and public health.

Finally, most partners expressed the need for more sustainable and flexible funding. There is misunderstanding of Chronic Disease Prevention and Health Promotion's role and the limited assistance this organization can provide in this area, representing a need to improve understanding roles and collaboration.

Goal 5 Objectives (What) & Initiatives (How)

What We Are Doing (Objectives)	Where Are We Today? (2022)	The Impact We Are Seeking… (2027)	How We Will Do It (Initiatives)
Objective #1 Establish a Nevada Wellness Coalition to strengthen partnerships.	Formal mechanism to improve coordination does not exist. Technical assistance is provided on an individual program basis.	Identify mechanism to improve collaboration. Established regular and sustainable means to improve collaboration. Combine state agencies, state-funded partners and non-profit orgs working in wellness. Improved wellness promotion.	**1. Survey partners re. coalition re. needs/preferred format.** Conduct survey and present results to the CWCD Advisory Board to identify partner needs and preferences regarding a statewide coalition.
			2. Convene partners annually. Establish a format for an annual convening of partners and implement. Annual meeting should include health equity training and CEUs should be offered.
			3. Create a plan for the establishment of an independent coalition. Produce and implement a plan for the development of an independent coalition.
Objective #2 Increase tools and systems of technical assistance to support communication & understanding.	We have a system for routine technical assistance (TA). We have points of contact and subject matter experts to support TA.	There is a tool for consistent messaging.	**1. Create subgrant "Welcome Package."** Develop an easy-to-follow subgrant toolkit for subgrant recipients to use.
			2. Offer Technical Assistance between Quarterly TA calls. Ensure subgrantees are notified of technical assistance opportunities between regularly scheduled calls.

Goal 5 – Performance Measures

Measures	Data Source	Data Owner	2021 Actual	2023 Target	2027 Target
Number of convenings per year of wellness promotion partners	CDPHP Programs	CDPHP Section	N/A	1	1
Percent of subgrant recipients who report that the subgrant process toolkit is helpful and easy-to-use	Partner survey	CDPHP Section	N/A	5	45
Partner satisfaction regarding the grant process	Partner survey	CDPHP Section	N/A	50	75

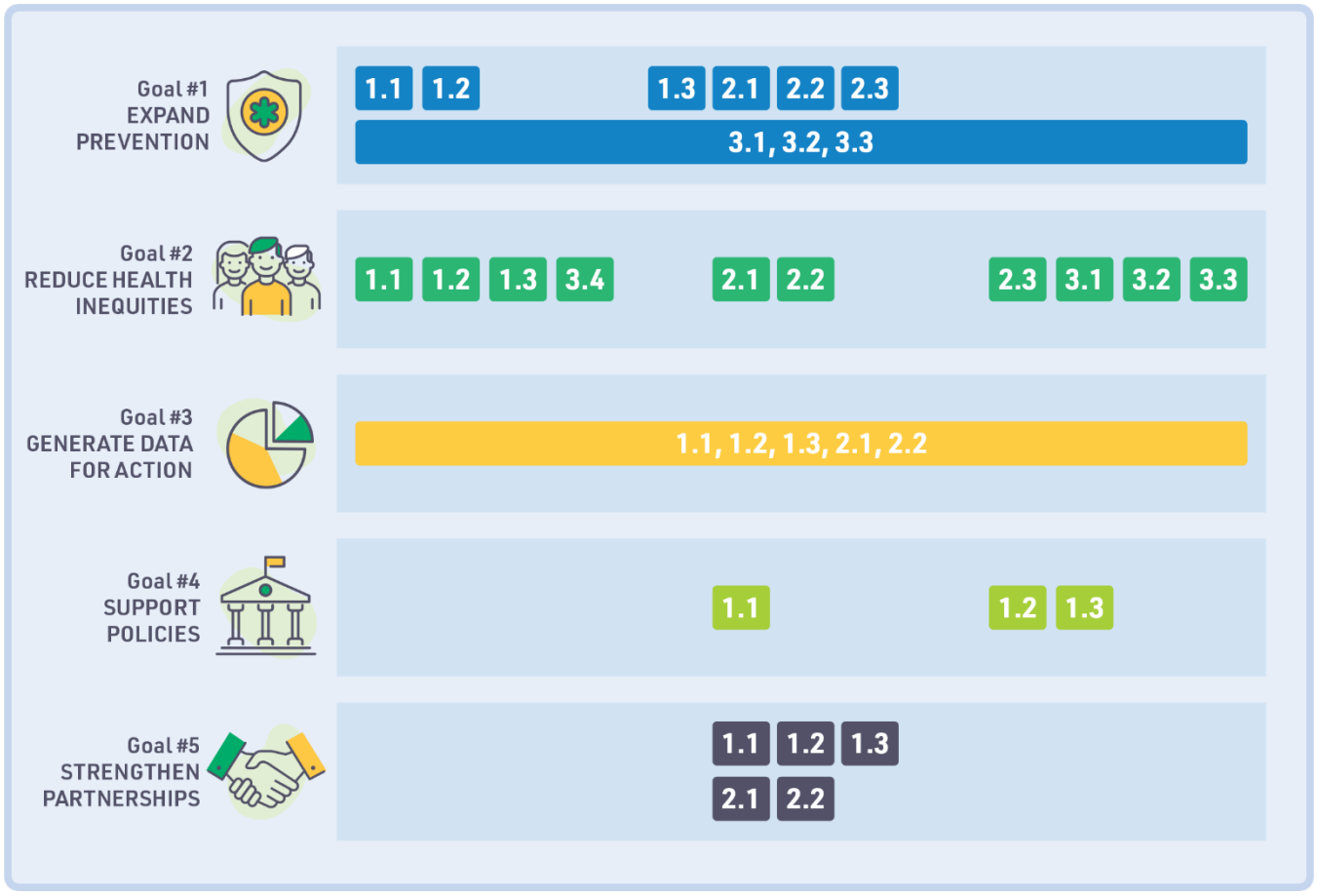
NEVADA Wellness

Part 4

Implementation & Action Plans

Timeline for Initiative Implementation

For each goal, action plans have been developed that capture a brief initiative description, desired initiative results, initiative champion, the role of CDPHP for the initiative, as well as the partner's role. Finally, an estimated timeline for the work is captured. Timing for initiatives is prioritized by now, next, and later with "now" defined as years 1-2, "next" is approximately years 3-4, while "later" is approximately years 4-5 for implementation.



GOAL #1 – ACTION PLANS

Objective 1: Increase integration of primary prevention activities in CDPHP programs. (Champion: Wellness & Prevention Coordinator)

Impact: By the end of 2027, 100% of CDPHP programs and funded partners are doing at least one primary prevention activity.

INITIATIVE #1: Define primary prevention.

Description: Each CDPHP unit/program contributes to and drafts a shared definition for evidence-based primary prevention as it relates to their subject area.

Results: A shared definition for evidence-based primary prevention.

CDPHP Role: CDPHP will review literature and develop an operational definition of primary prevention.	Partner Role: N/A
Timing (Now, Next, Later): Now	

INITIATIVE #2: Implement evidence-based primary prevention in all CDPHP units' initiatives.

Description: Each CDPHP unit/program becomes skilled at implementing their own evidence-based primary prevention initiatives.

Results: All CDPHP units/programs (1) assess, (2) obtain, and (3) applies their knowledge of evidence-based primary prevention initiatives.

CDPHP Role: CDPHP will build training on evidence-based initiatives and public health programming into the CDPHP required training. Programs will assess and apply evidence-based interventions to program work plans.	**Partner Role:** N/A
Timing (Now, Next, Later): Now	

INITIATIVE #3: Implement evidence-based primary prevention in all CDPHP programs' initiatives.

Description: Each CDPHP unit/program implements an evidence-based primary prevention initiative in all work plans and scope of work documents.

Results: At least one evidence-based primary prevention activity is implemented in 100% of CDPHP program work plans.

CDPHP Role: CDPHP will provide technical assistance to partners in researching/ identifying and selecting appropriate evidence-based primary prevention activities in all partner scopes of work.	**Partner Role:** Partners will assist in implementing evidence-based primary prevention initiatives through the subgrant scope of work process appropriate to their work and communities.
Timing (Now, Next, Later): Next	

Objective 2: Improve use of NV Wellness brand and implement evidence-based primary prevention terminology within CDPHP programs. (Champion: Wellness & Prevention Coordinator)

Impact: By the end of 2027, CDPHP brand and identity are aligned with wellness and prevention efforts, increasing our population reach with more partners at the table.

INITIATIVE #1: Change use of terminology from Chronic Disease Prevention to Nevada Wellness.

Description: This initiative may entail:

- Re-naming the CDPHP section to better represent prevention and wellness efforts.
- Reworking CDPHP and partner scopes of work to include primary prevention.
- Ensuring wellness language is used in all documents.
- Restatement of the CDPHP Mission Statement.
- Establishing a timeline and kickoff with all sections.

Results: CDPHP shifts from striving to reduce the burden of chronic disease to reducing the risk factors for a disease. Additionally, Nevada residents understand messages about risk factors for disease onset and/or progression.

CDPHP Role: CDPHP will assess section name and branding compared to the CDPHP mission statement and will recommend a name change to leadership. CDPHP leadership will establish a timeline, staff training, and a kickoff to initiate new criteria. CDPHP programs will prioritize inclusion of wellness language in all materials.	**Partner Role:** Partners will provide feedback to CDPHP on branding efforts and will utilize required branding materials as stipulated in the subgrants.
Timing (Now, Next, Later): Now	

INITIATIVE #2: Maximize Nevada Wellness Brand.

Description: Includes changes to logo, websites, promotional materials, etc. Each CDPHP unit/program participates, contributes, and agrees on a logo, websites, promotional materials, etc.

Results: Each CDPHP unit/program maximizes their use of the Nevada Wellness brand.

CDPHP Role: CDPHP staff will identify and correct changes to CDPHP program websites and materials to represent new wellness language standards and reflect the CDPHP Mission Statement.	**Partner Role:** Partners will support the NV Wellness brand as stipulated in subgrants.
Timing (Now, Next, Later): Now	

INITIATIVE #3: Identify Nevada Wellness current and/or future partners.

Description: CDPHP will create a directory of partners detailing primary prevention work and support integration of primary prevention interventions to avoid siloed initiatives, and increase the likelihood that partners make adequate contribution for Nevada Wellness success.

Results: A CDPHP partner directory is completed and shared with partners for their use.

CDPHP Role: CDPHP will create a partner directory to increase coordination of wellness efforts and will identify new partners to support wellness work.	**Partner Role:** Partners will support collaboration and integration efforts.
Timing (Now, Next, Later): Next	

Objective 3: Build a dedicated, culturally competent "Wellness" unit to drive integration. (Champion: Wellness & Prevention Coordinator)

Impact: By the end of 2027, a dedicated, comprehensive wellness program exists, is staffed to provide capacity and integration to deliver lifespan approach. There's a budget, partners, scopes of work, etc.

INITIATIVE #1: Secure sustainable funding & staff.

Description: CDPHP will leverage existing infrastructure to identify and develop opportunities to allocate dedicated funding to evidence-based wellness efforts.

Results: Dedicated funds and qualified staff are secured.

CDPHP Role: CDPHP will leverage existing resources to maximize primary prevention efforts, including through partner work.	**Partner Role**: CDPHP partners will advocate for dedicated wellness funding to support a comprehensive wellness program.
Timing (Now, Next, Later): Now to Later	

INITIATIVE #2: Evaluate CDPHP programs' evolution.

Description: Review CDPHP programs to identify focus areas and opportunities for integration.

Results: The evolution of all CDPHP programs (how they evolved through the years) are reviewed, analyzed, and presented.

CDPHP Role: CDPHP will review and evaluate program progress toward primary prevention integration.	**Partner Role**: Partners will provide feedback and data through the quarterly report process to support evaluation.
Timing (Now, Next, Later): Now to Later	

INITIATIVE #3: Review outstanding local & national primary prevention wellness programs.

Description: Review successful local and national primary prevention programs to bring inspiration/ideas for innovative successful initiatives.

Results: Information from selected primary prevention top-performing wellness programs is reviewed, analyzed, and presented.

CDPHP Role: CDPHP staff will research evidence-based efforts nationally and in other states to inform wellness prevention program development.	**Partner Role**: Implementation Support
Timing (Now, Next, Later): Now to Later	

Goal #2 – Action Plans

Objective 1: Increase CDPHP staff competency of health equity and cultural competency/sensitivity. (Champion: Health Equity Unit Manager)	
Impact: By the end of 2027, more staff diversity exists within the Wellness Promotion program. Defined policies and training are available that encourage more equity and cultural competency/sensitivity.	
INITIATIVE #1: Identify and implement trainings.	
Description: Identify a cultural competency/sensitivity training and develop an evaluation tool to evaluate training appropriateness.	
Results: Training has been identified and a process to evaluate has been developed.	
CDPHP Role: CDPHP will identify and develop training curriculum using STAR results and STRETCH framework.	**Partner Role**: N/A
Timing (Now, Next, Later): Now	
INITIATIVE #2: Develop process for training implementation and evaluation.	
Description: Develop and execute a process for rolling out training to CDPHP staff. Ensure that 100% of CDPHP staff have completed training and that a requirement is in place for new hires to complete training as well.	
Results: Cultural competency training has gone live on training platform and 100% of CDPHP staff have received first training and is required for new hires.	
CDPHP Role: CDPHP will disseminate training and track completion among staff.	**Partner Role:** N/A
Timing (Now, Next, Later): Now	
INITIATIVE #3: Improve training content and effectiveness through Initiative #1 results.	
Description: Identify training improvements needed and revise training to increase self-efficacy based on results of Initiative #1.	
Results: Opportunities for improvement have been identified and addressed.	
CDPHP Role: CDPHP will disseminate training and track training completion among staff. CDPHP will engage partners.	**Partner Role:** Partners will provide ongoing feedback on the training curriculum.
Timing (Now, Next, Later): Now	

Objective 2: Increase competency of health equity and cultural competency/sensitivity of funded partners. (Champion: CDPHP Section Manager)

Impact: By the end of 2027, a higher number of CDPHP staff and partners have high cultural competency/sensitivity. In addition, more community-led programming takes place.

INITIATIVE #1: Offer CDPHP cultural competency training to funded partners to support community-led programming.

Description: Communication and roll-out of cultural competency training to all CDPHP funded partners. Funded partners will submit their certificate of completion and report in their quarterly report.

Results: CDPHP partners can operationalize health equity.

CDPHP Role: CDPHP will disseminate training to all funded partners and collect certificate of completion.	**Partner Role**: Partners will implement cultural competency training within their organization and send certificates of completion.
Timing (Now, Next, Later): Next	

INITIATIVE #2: Develop process for training implementation and evaluation.

Description: Identify tools needed to support training and evaluation to ensure appropriate fit.

Results: A process is in place for training implementation and evaluation.

CDPHP Role: CDPHP will develop and disseminate resources to funded partners when needed.	**Partner Role:** Partners will request resources from CDPHP and disseminate among staff.
Timing (Now, Next, Later): Next	

INITIATIVE #3: Identify partnerships with new organizations with ties to more disparate communities. Additionally, collaborate with funded partners to conduct community-led activities (such as forums, townhalls, panels, etc.) to educate on cultural concerns.

Description: Create new partnerships to address chronic disease directly with communities currently the most disparate in population and collaborate on the implementation of community-led activities.

Results: An increase in the number and type of community-led activities have been completed.

CDPHP Role: CDPHP will initiate activities with partner collaboration to engage community members.	**Partner Role:** Partners will plan and conduct community-led activities and report areas of focus to CDPHP.
Timing (Now, Next, Later): Later	

Objective 3: Increase inclusivity and accessibility of all products by CDPHP and partners. (Champion: Health Equity Unit Manager)	
Impact: By the end of 2027, all CDPHP and partner materials/collateral are aligned using the Language Access Plan.	
INITIATIVE #1: Implement Language Access Plan. Increase accessibility and inclusivity of all resources produced by CDPHP.	
Description: Complete the development and implementation of the Language Access Plan.	
Results: The Language Access Plan is routinely implemented to ensure appropriate access of services to all Nevada populations.	
CDPHP Role: CDPHP actively implement the DPBH Language Access Plan.	**Partner Role**: Partners will provide feedback and engage community input.
Timing (Now, Next, Later): Later	
INITIATIVE #2: Continue to support the Community Health Worker program.	
Description: Support efforts to increase the number of new partnerships that CDPHP has made with community-based organizations (CBOs) as well as the number of Community Health Workers (CHWs) employed by CDPHP partners.	
Results: An increase in the number of new partnerships with CBOs and the number of new CHWs hired.	
CDPHP Role: CDPHP will conduct outreach to new partners and support funding efforts for CHWs.	**Partner Role:** Partners will develop strategies to increase CHW model integration within communities.
Timing (Now, Next, Later): Later	
INITIATIVE #3: Continue to support Sexual Orientation and Gender Identity (SOGI) data collection, including the development of SOGI data collection training.	
Description: Implement methods for SOGI data collection with most current language and trends and ensure CDPHP databases are collecting SOGI indicators where appropriate.	
Results: CDPHP is collecting SOGI data and making program improvements to better address needs and disparities within this population.	
CDPHP Role: CDPHP will update data collection tools/ databases.	**Partner Role:** Partners will provide feedback and implement SOGI Data training and practices for quality improvement within their organization.
Timing (Now, Next, Later): Later	
INITIATIVE #4: Ensure inclusive and equitable language in all materials and trainings developed by CDPHP.	
Description: Update CDPHP materials to reflect the principles outlined in the Health Equity Style Guide published by the CDC.	
Results: All CDPHP materials have been updated to reflect the principles outlined in the Health Equity Style Guide published by the CDC or any of its successors. CDPHP will continue to uphold the principles of the Health Equity Style Guide and will incorporate Health Equity into the Nevada Wellness brand.	
CDPHP Role: CDPHP will update materials and trainings to reflect the CDC Health Equity Style Guide and will incorporate Health Equity into the Nevada Wellness brand.	**Partner Role:** Partners will provide requested feedback regarding inclusivity of materials and branding.
Timing (Now, Next, Later): Now	

Goal #3 – Action Plans

Objective 1: Increase CDPHP capacity to provide timely data & info publicly. (Champion: Quality Improvement Manager)	
Impact: By the end of 2027, a consolidated data source (dashboard) is completed with staff dedicated to data.	
INITIATIVE #1: Complete and launch data dashboard.	
Description: Completion of the data dashboard includes upload of all CDPHP program data and ensuring the tool is user-friendly and can be utilized by CDPHP staff, partners, and the public. Initial effort will prioritize quantitative data, but once launched, opportunities to incorporate qualitative data will be identified.	
Results: The data dashboard is in place to provide timely data to CDPHP, partners, and the general public.	
CDPHP Role: CDPHP staff will develop a dashboard, input data, and clean data for use.	**Partner Role**: Provide feedback regarding database use. Support CDPHP capacity to collect and showcase data.
Timing (Now, Next, Later): Now → Later	
INITIATIVE #2: Develop and deliver on-going training.	
Description: Create training for both the data evaluation team and for users. The data evaluation team will be instructed on how to upload new data and analyze data on the dashboard. Users of the data dashboard will be trained on how to search for and utilize the data.	
Results: The data evaluation team is fully trained on how to upload new data and analyze data on the dashboard. A training video will instruct users of the data dashboard how to search for the data.	
CDPHP Role: CDPHP staff will attend training to use the completed dashboard. CDPHP staff will also develop a training video to share with staff, partners, and the public. CDPHP evaluation team will provide technical assistance when requested by partners.	**Partner Role:** Partners will utilize the training tools developed by CDPHP as needed.
Timing (Now, Next, Later): Now to Later	
INITIATIVE #3: Promote the availability of the dashboard and training video and encourage their use by partners.	
Description: Ensure that CDPHP staff and partners can understand how they access the dashboard and utilize it to their best capabilities.	
Results: CDPHP staff and partners have access to the CDPHP data dashboard and utilize data to inform program development and improvement.	
CDPHP Role: CDPHP will notify partners about the dashboard. The website link will be sent to the CDPHP listserv and will be posted on the CDPHP website for the general public. The training video will also be available on the website.	**Partner Role:** Partners will utilize the training video and will share the dashboard link and training video link with their respective staff members. Partners will provide feedback and support CDPHP capacity to host the database. Partners will utilize data to inform program development and improvement.
Timing (Now, Next, Later): Now to Later	

Objective 2: Improve CDPHP capacity to utilize data internally. (Champion: Quality Improvement Manager)	
Impact: By the end of 2027, a functional database with up-to-date available data will exist with a dedicated staff person to support. We are proactive vs reactive when it comes to data.	
INITIATIVE #1: Create a database and train CDPHP staff on how to use database.	
Description: Establish database and train CDPHP staff on how to use it.	
Results: Dedicated resources are available to support the database development and maintenance including standardized training.	
CDPHP Role: CDPHP Data and Evaluation staff will organize the data currently housed in various Excel worksheets. Program staff will be trained by the Data and Evaluation team to utilize the data.	**Partner Role**: N/A
Timing (Now, Next, Later): Now to Later	
INITIATIVE #2: Hire epidemiologist to help us understand/translate the data coming out of the database to CDPHP staff and provide targeted technical assistance to partners.	
Description: Secure a CDC Epidemiologist Assignee or other contract Epidemiologist.	
Results: CDPHP has a CDC Epidemiologist Assignee or other contract Epidemiologist in place to provide more targeted technical assistance to partners in the interpretation and use of data.	
CDPHP Role: The data and evaluation unit will house, train, and supervise the contract epidemiologist.	**Partner Role:** Partners will benefit from the expertise of an epidemiologist.
Timing (Now, Next, Later): Now to Later	

Goal #4 – Action Plans

Objective 1: Maximize impact of evidence-based wellness policies. (Champion: CDPHP Section Manager) in collaboration with Bureau leadership

Impact: By the end of 2027, CDPHP and its partners have a completed toolkit that systematically identifies approaches to implementing and communicating policy.

INITIATIVE #1: Conduct analysis of current statewide wellness policies.

Description: Analysis includes research of what other states are doing regarding evidence-based polices that we may want to mimic or adapt.

Results: CDPHP has produced an analysis of state policies pertaining to wellness and prevention of chronic disease.

CDPHP Role: CDPHP Staff will conduct a policy analysis and identify gaps and opportunity in policy.	**Partner Role**: Partners will inform analysis and will support future policy development.
Timing (Now, Next, Later): Next	

INITIATIVE #2: Develop toolkit.

Description: Develop a toolkit, which details roles, strategies for conducting policy work at multiple levels, tools and templates to support policy work, and assists partners in improving capacity to leverage advocacy.

Results: CDPHP and partners have increased confidence in their ability to conduct PSE work.

CDPHP Role: CDPHP will develop a policy toolkit to identify strategies to address policy gaps identified in the policy analysis.	**Partner Role:** Partners will support PSE efforts.
Timing (Now, Next, Later): Later	

INITIATIVE #3: Improve capacity to leverage partners to conduct policy, systems, and environmental change work.

Description: This initiative includes:

- Partner education on how to better leverage PSE.
- Mobilization of CWCD's ability to conduct PSE work.
- Continued technical assistance to partners in conducting PSE work.

Results: CDPHP partners report an increased confidence in ability to conduct PSE work.

CDPHP Role: Identify partners, educate partners, provide PSE resources and technical assistance, and evaluate partner confidence.	**Partner Role:** Conduct PSE work, inform CDPHP regarding opportunities to improve PSE capacity.
Timing (Now, Next, Later): Later	

Goal #5 – Action Plans

Objective 1: Establish a NV Wellness Coalition to strengthen partnerships. (Champion: CDPHP Section Manager) in collaboration with Bureau leadership

Impact: By the end of 2027, a regular and sustainable means to improve collaboration will be established. This coalition will be a combination of state agencies, state-funded partners, and non-profit organizations working in wellness.

INITIATIVE #1: Survey partners re. coalition regarding needs and preferred format.

Description: Conduct survey and present results to the CWCD Advisory Board to identify partner needs and preferences regarding a statewide coalition.

Results: A survey has been conducted and results presented to CWCD for actionable recommendations.

CDPHP Role: CDPHP will survey partners to identify how a coalition might look now, what the dream coalition is, and what resources are needed.	**Partner Role:** Participate in survey, support CDPHP capacity to initiate a chronic disease coalition.
Timing (Now, Next, Later): Next	

INITIATIVE #2: Convene partners annually.

Description: Establish a format for an annual convening of partners and implement. Annual meeting should include health equity training and CEUs should be offered.

Results: Wellness promotion and chronic disease prevention partners convene at least once per year and will contribute to development of an independent coalition.

CDPHP Role: CDPHP will convene partners at least annually as an informal coalition to share efforts and inform planning efforts.	**Partner Role:** Participate in meetings, provide feedback, and share information. Support CDPHP efforts to initiate a chronic disease coalition.
Timing (Now, Next, Later): Next	

INITIATIVE #3: Create a plan for the establishment of an independent coalition.

Description: Produce and implement a plan for the development of an independent coalition.

Results: Establishment of an independent coalition focused on wellness promotion.

CDPHP Role: Create plan.	**Partner Role:** Inform and support plan.
Timing (Now, Next, Later): Next	

Objective 2: Increase tools and systems of technical assistance to support communication & understanding. (Champion: Quality Improvement Manager)	
Impact: By the end of 2027, a tool is in place for consistent messaging to subgrant recipients.	
INITIATIVE #1: Create subgrant "Welcome Package."	
Description: Develop an easy-to-follow subgrant toolkit for subgrant recipients to use.	
Results: Subgrant recipients report that the subgrant process toolkit is helpful and easy-to-use.	
CDPHP Role: Develop easy to follow PDFs and PowerPoint presentations for the subgrant process.	**Partner Role:** Use the developed tools, provide feedback for material improvement.
Timing (Now, Next, Later): Next	
INITIATIVE #2: Offer Technical Assistance (TA) between Quarterly TA calls.	
Description: Ensure subgrantees are notified of technical assistance opportunities between regularly scheduled calls.	
Results: Improved partner satisfaction regarding the grant process.	
CDPHP Role: Each program coordinator will notify the subgrantees of available technical assistance when needed.	**Partner Role:** Partners will reach out to CDPHP staff when they need additional technical assistance.
Timing (Now, Next, Later): Next	

Governance and Reporting

The model CDPHP is using to implement this strategic plan is structured to both directly cascade to staff work plans and collaborative strategic initiative action plans with partners. To accomplish both of those purposes, the guidelines are below:

People – Roles/Responsibilities: The strategic plan is intended to engage the entire organization, as much as is practical, with the specific roles to manage implementation:

- **Strategy Leader (Process Owner):** Lily Helzer, CDPHP Section Manager – responsible for leading the implementation process.
- **Objective Champions**: responsible for leading the execution of initiatives with the direction from and in collaboration with partners or committees, as appropriate.

Reporting on Performance – Cadence of Accountability: Managing the implementation of a strategic plan is a management process that is ideally integrated with the existing processes and meeting structures.

- **Objective Champions** will govern and manage performance 1) Leading regular committee meetings where the basis of the meeting is progress against initiatives, and 2) Report on performance annually.
- **The Strategy Leader** (Lily Helzer, CDPHP Section Manager) will provide key highlights by goal at each Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease Meeting. Updates will be reported within the Nevada Wellness Coalition once it is stood up.

Planning Calendar

Activity	Lead	Timeframe
Strategic Plan Approved by DPBH	Strategy Leader	September 2022
CWCD Meeting - Key Highlights by Goal	Strategy Leader	Q1 2023
CWCD Meeting - Key Highlights by Goal	Strategy Leader	Q2 2023
CWCD Meeting - Key Highlights by Goal	Strategy Leader	Q3 2023
CWCD Meeting - End of Year Review	Strategy Leader	Q4 2023

Appendices

Appendix A – Methodology

Appendix B – CDPHP Leadership Insights

Appendix C - Plans Received from Partners

Appendix D – Needs Assessment Report

Appendix E - Additional Insights

Appendix A – Methodology

APPENDIX A – GLOSSARY OF TERMS

- **Chronic disease:** a health condition or disease which presents for a period of 3 months or more or is persistent, indefinite or incurable.
- **Social determinants of health (SDOH):** conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes.
- **Health inequities:** the unfair and avoidable differences in health status seen within and between countries
- **Primary prevention:** intervening before health effects occur, through measures such as vaccinations, altering risky behaviors (poor eating habits, tobacco use), and banning substances known to be associated with a disease or health condition
- **Secondary prevention:** screening to identify diseases in the earliest stages, before the onset of signs and symptoms, through measures such as mammography and regular blood pressure testing
- **Tertiary prevention:** managing disease post diagnosis to slow or stop disease progression through measures such as chemotherapy, rehabilitation, and screening for complications

Part 1 – Perspectives from CDPHP (CDPHP Manager Interviews)

To inform the external partner assessment phase of the State of Nevada's Chronic Disease strategic planning process, OnStrategy conducted one-on-one interviews with the CDPHP leadership between December 14 and December 21, 2021. The **objectives** of the interviews were to:

Ask the program managers what they would like to know from partners--what is not part of their regular conversations?

Query how much COVID has changed <focus | delivery | services | other> and /or how much partners anticipate the past 2 years' changes will be permanent, problematic, or might be opportunities for wider state impact on chronic disease. etc.? Lessons learned from COVID because the health impacts from COVID will be 10 to 50 years, e.g., causing more diabetes.

Interviewees were:

Lily Helzer - Section Manager

Sarah Rogers - Office of Food Security & Wellness Unit

Dr. Allen Pai - Evaluation Unit

Amanda Santos - Clinical & Community Engagement Unit

Godwin Nwando - Health Equity Unit

Michelle Harden - Population, Health & Wellness Unit

Kellie Decker - Community Wellness Unit

Everyone was asked the following set of open-ended **questions**:

What are the commonly heard issues and concerns from partners?

What do we not know that we would like to learn from partners?

Do you have theories or "inklings" of issues, opportunities to reduce the burden of chronic disease in Nevada that we'd like to validate with partners?

How has COVID changed partners' delivery of services, impact, etc. Do you see COVID-related issues as well as COVID-spurred opportunities (e.g., more telehealth)?

What do partners want the state to do or what gaps are they hoping the state will fill?

In 5 years, what does chronic disease look like in Nevada?

To get there, what do you recommend HHS focuses on (i.e., what does it need to do, create, shift in the next five years?

And what do your external partners need to do, participate in, etc.?

From the leadership's responses, the following themes and key ideas were gathered to inform either the external partner's assessment or the broader planning process and strategic direction for the state's chronic disease strategic plan.

Part 2 – External Needs Assessment (Partner Interviews)

Based on the insights from the CDPHP Leadership Interviews, a list of questions was developed to serve as a guide for the interviews with External Partners. The Blueprint Collaborative and OnStrategy conducted individual interviews with 40 partners across 29 organizations and one group interview with the Nevada Statewide Coalition Partnership, which included 11 partners across 9 organizations. Additional organizations and partners were invited to participate but did not respond. Interviews were conducted between February 15 and March 25, 2022.

The **objectives** of the interviews were to:

- Understand **emerging trends and major shifts**/changes over the past several years and how those are projected to impact the future
- Identify the **primary needs (partners & residents) statewide related to prevention, education, and reducing chronic disease**.
- Understand **where state work can have the biggest impact** in context of where our partners are focusing and how the state can best engage.
- Clarify the **major challenges or barriers** to "flattening the curve".
- Deep dive to understand **challenges and possible solutions to health equity.**
- How to best support and work **more closely and share information** with partners.
- Solicit suggestions for **tangible steps** that can be taken over the next five years that can reduce the burden of chronic disease in our state.

Interviewees were:

Access to Healthcare Network-Trevor Rice & Erla Orozco	**Nevada Public Health Association (NPHA)**-John Packham
Aging and Disability Services Division-Jeff Duncan & Katrina Fowler	**Nevada Statewide Coalition Partnership**-Linda Lang
Community Health Alliance-Steven Shane	**Churchill Community Coalition***-Tammie Shemenski
DHHS Analytics/Data Team-Evelina Eytchison & Jennifer Thompson	**Frontier Communities Coalition***-Wendy Nelsen
Elko County Health Board-Ashley Gurr & Jessica Segovia	**Healthy Communities Coalition***-Wendy Madson
High Sierra AHEC-Natasha Nyquist-Smith	**Nye Communities Coalition***-Sofia Allison & Stacy Smith
Indian Health Services-Patricia Taylor	**PACE Coalition***-Laura Oslund
Medicaid-Briza Virgen & Kaelyne Day	**PACT Coalition***-Jamie Ross
Nevada Cancer Coalition-Cari Herington	**Partnership Carson City***-Samantha Szoyka & Hannah McDonald
Nevada Chronic Care Collaborative-Tom McCoy	**Partnership Douglas County***-Daria Winslow
Nevada Community Health Network (CHW) Association-Jay Kolbet, Clausell & Jenny Claypool	**Office of Rural Health**-Gerald Ackerman
Nevada Dementia Coalition-Jennifer Carson	**Public Employees Benefits Program (PEBP)**-Laura Rich
Nevada Department of Agriculture-Homa Annoshepoor & Patricia Hoppe	**Quality Technical Assistance Center (QTAC) at Dignity Health St. Rose Dominica Hospitals**-Victoria Alejandre
Nevada Department of Veterans Services-Amy Garland	**Southern Nevada Health District (Clark County)**-Michael D. Johnson
Nevada Division of Insurance-Mark Garratt & Jeremey Gladstone	**Supplemental Nutrition Assistance Program–Education**-Tonya Wolf & Stephanie Cook

Nevada Early Childhood Obesity Steering Committee-Marty Elquist	**UNLV, The Nevada Institute for Children's Research and Policy (NICRP)**-Amanda Haboush
Nevada Indian Commission-Marla McDade Williams	**UNLV School of Public Health**-Manoj Sharma & Asma Awan
Nevada Office of Minority Health and Equity-Tina Dortch & April Cruda	**UNR Sanford Center for Aging**-Peter Reed
Nevada Primary Care Office (PCO)-Tarryn Emmerich-Choi	**Washoe County Health District**-Kevin Dick

**Indicates that this organization is a part of the Nevada Statewide Coalition Partnership.*

Each person was asked the following set of **open-ended questions**:

Populations You Serve - Challenges & Concerns

Who are the primary populations you serve?

What are the top 2-3 challenges that the populations you serve have? How are you working to address these challenges?

What media, tools, methods are you using to communicate educational messages and with the populations you serve--and what's working?

Partner Challenges and Concerns

As a health care agency, what are your biggest challenges in achieving your mission (or delivering your services?) How can the state help resolve this challenge?

What is your greatest unfunded need?

What priorities do you recommend for policy changes? Are there policy changes that would alleviate any specific challenges or concerns?

Learning From Our Partners

An objective of this strategic plan is to 'Understand where state work can have the biggest impact, in context of where our partners are focusing and how the state can best engage'. With that said, can you please share a brief overview of your top areas of focus over the next 3-5 years?

If you have a documented 1-, 3-, or 5-year plan which captures your goals, focus, and planned programs could you please share that with us?

How much of your effort and funding is spent on education/prevention vs chronic disease management? (proactive vs. reactive)

How the State (and Specifically the Chronic Disease Section) and Partners Can Work Better Together

In what way is the state currently supporting and engaging with you that you want to be sure continues?

In what ways can the state better support you that it is not currently doing?

How can we get better at getting more partners to share information with each other and with the state?

COVID Impacts

How has COVID changed your focus, delivery of services, and/or the types of services you offer? (impact on the partner)

Equity

We understand that there are issues with health inequity across the state. How would you describe the biggest challenges around inequity?

What are some possible solutions to health inequity in Nevada?

The Bottom Line

Can you describe a few key tangible steps that can be taken over the next five years that can reduce the burden of chronic disease in our state?

SPECIFIC QUESTIONS:

RURAL COMMUNITIES: What are the key challenges of the community you serve and what do you suggest to meet these communities' needs?

TRIBAL PARTNERS: What are the key challenges of the community you serve and what do you suggest to meet these communities' needs?

NEVADA STATEWIDE COALITION PARTNERSHIP & ISSUE-SPECIFIC PARTNERS: What would you say are the major challenges or barriers to "flattening the curve" regarding your specific chronic disease?

NEVADA STATEWIDE COALITION PARTNERSHIP & HEALTH DEPARTMENTS: What type of data are you interested in and what levels of stratification would you like to see for this data?

Appendix B – CDPHP Leadership Insights

SWOT

Strengths

CDPHP:

CDPHP relationships with partners are our biggest strengths to build on.
Those who CDPHP has the strongest partnerships with have been the most effective with regard to PSE.
Our ability to work within policy (both statewide legislature and our partner's implementation of local policy) is a strength!
CDPHP has a great internal team that is very collaborative.
CDPHP invests in interns.
CDPHP develops flexible work plans to support lasting systems change (work plans are written to allow flexibility; broad plans).

Partners:

- Many of the CDPHP partners are experienced in their respective programs.
- Partners collaborate well!
- Partners have the ability to lobby.
- Partners have the ability to establish trust with the community and are well-respected across the state.

Community:

- We have a diverse community throughout the state.

Weaknesses

CDPHP:

- Our programs are siloed.
- CDPHP does not always reach out to new partners.
- State needs to do a better job at explaining the funding limitations.
- There is not enough funding to go around so some partners are "suspicious". Need improvements in transparency.
- CDPHP has challenges with establishing trust with partners and community.
- Having a part-time legislature makes things challenging. Sometimes there are competing needs.

Partners:

- Some partners have challenges with regard to expending funds. Some don't spend any money; others use in a way not intended.
- Community Health Worker (CHW) program could use improvement (relating to the partners).
- Spend down is challenging due to local spending policy is a big issue in Tobacco Control. (funding restrictions)
- Partners are not reporting barriers that they are experiencing.

Community:

Community attendance/participation in existing programs is limited. (e.g.-cancellations, no shows)
Limited provider diversity within the health care community (and limited providers overall).
Communities are not aware of limitations of funding.
Stigma/cultural literacy around certain chronic conditions

Opportunities

CDPHP:

- Flexibility for programs to shift plans
- Build back trust between the state and our partners

- Seeking new and innovative partners
- The Division is revisiting accreditation
- Inclusiveness with community-led approaches
- Learn from the past to make the future better (learning from COVID response…positives and negatives)
- Academic team- learning new and best practices- opportunity to share (CDPHP and partners)
- Giving the community and partners a voice and spot at the table with regard to strategy
- Private industry and the military have more interest in the wellness of the community
- Due to the pandemic, there is interest in building more resilient communities that can better respond to public health crises

Partners:

- We have enthusiastic partners (and a very enthusiastic CDPHP team)

Community:

- None

Threats

CDPHP:

- Mistrust and misinformation
- Misunderstanding of what public health is. There is a difference between individual health and public health.
- A lot of public health work goes on in the background and outcomes aren't seen for some time.
- There are only a limited # of resources. Public health is often competing with other priorities. (e.g.- funds now going to Ukraine support)

Partners:

Mistrust of information coming from the State and the feds

Community:

- The news (media hype!) also plays into misinformation and mistrust
- Social media is a large source of misinformation and can be a double-edged sword

Insights Informing the Strategic Plan

Vision & Expectations 5 Years from Now

The 5-year future was described as follows, with an overall expectation to continue the current successes for the next 5 or so years (and beyond). Numbers in parenthesis indicate the number of mentions by different people.

Flatten the curve and start to move towards a downward trend.

More of an emphasis on primary, preventive care: reaching younger people before they contract a disease. (2)

Because funding we are getting right now is not sustainable, we are leveraging policy and infrastructure.

More community health workers are needed who look like the communities they serve.

Sustainable funding for existing mandates before we add more unfunded mandates.

Continuity of care.

Programs integration across HHS/partners; we are serving the same populations and partners so let's be more coordinated.

More equity; create policies with equity in mind.

Strategic Issues

The following topics were raised that could be some of the strategic issues the plan should address:

How will we link the strategic plan to program plans to realize results? In past, we haven't done this.

What are the reasons for lack of or insufficient integration and can we resolve the reasons we don't do it well enough? (2)

While equity is a global issue, Nevada's equity challenges are unique; how can we address them?

Insights Informing the External Partners Assessment

Equity

While equity is widely understood to be a serious issue related to chronic disease and disease prevention, there may be more good intentions than good programs or effective practices because how to achieve equity is still something we think most partners are learning to do.

Want to understand partners' level of understanding, efforts, etc.

Social determinants: will we get to the point where we're providing alternatives that aren't delivered by health providers (e.g., stress relievers). Or are partners already doing this?

Partners' Concerns

Lack of funding is not perceived to be the primary concern of most partners.

Staffing: skilled people to fulfill the grants! (4)

Stable, consistent funding – it's difficult to make an impact that requires long-term effort when funds are short-term.

How to integrate and assist most at-risk and under-served communities; it's difficult to insert outsiders.

It is challenging to keep people engaged in long-term programs.

Can the state be more transparent about where funding goes?

Social determinants of disease: not just what are the 'top' determinants, but what can be done (and who is doing these things) to address social determinants?

If shift to virtual is permanent, it's important to consider that the communities partners serve may have limited digital/technology access.

Grant funding requiring misaligned budget items affect partners' ability to make an impact. Can HHS make the technical side of grants easier or can we provide them easier-to-access support?

What We Want to Learn from Partners

Rural frontier and native communities: what do partners know and what do they suggest to meet the needs of these communities?

What media, tools, methods are partners using to communicate educational messages with the populations they serve--and what's working?

How can we get better at getting more partners to share information?

We hear a lot of general statements about the state from partners (e.g., "there are disconnects with the state"). Can partners provide specifics to define these general statements?

Theories To Validate

Lack of understanding what Medicaid will cover, so not prescribing helpful preventions, etc.

Ideally, dealing with multiple diseases in one appointment: is this too daunting for partners?

Our messaging tends to be too wrapped up in policy, not resonating with the people we want to affect. "Government speak" is not getting the right messages across.

Covid's Impact

Positive: telehealth; online education; using technology to remind people of appointments, screenings; funding to support health equity efforts (spotlight also raised awareness); more CHWs in rural areas; data collection improved; creative/resourceful outreach (e.g., diabetes screenings at beauty salons).

Negative: people moving less and shopping less so not consuming enough fresh food—credible theories out there that the stress and medical impacts of COVID might double chronic disease, long-term; exacerbating chronic diseases; less in-person and face-to-face with patients.

What Partners Want from the State

Funded mandates. More mandates without funding aren't serving anyone. (2)

Data - either more from the state or help from the state to collect it.

Longer-term funding especially for programs that require adding staff or that require long-term, consistent programming.

Do more to guide partners to apply (we may feel as policy people, we don't have latitude to encourage partners to apply, but is this true?). (2)

They don't get enough clear or definitive guidance from the state or the Feds.

Partners would like HHS to better understand what they do, deliver and their impact.

Appendix C – Plans Received from Partners

Organization	Document	File Name
Washoe County Health District	Chronic Disease and Injury Prevention Program Fiscal Year 2021-2022	CDIP Strategic Goals and Outcomes 2021. Final
UNR Sanford Center for Aging	Sanford Center for Aging Plan (JULY 1, 2019 – JUNE 30, 2020)	FY'20 Strategic Plan - Sanford Center
UNR Sanford Center for Aging	Nevada COVID-19 Aging Network (NV CAN) Rapid Response Plan	Nevada COVID-19 Aging Network - Example Resources for States
UNR School of Medicine	2020-2022 UNR Med Strategic Plan	2020-2022 Strategic Plan FINAL
Partnership Douglas County	Douglas County's Community Prevention Plan (2019)	Partnership Douglas County CCPP
Partnership Carson City	Partnership Carson City Comprehensive Community Prevention Plan (2019)	Partnership Carson City CCPP
Join Together Northern Nevada	Join Together Northern Nevada Comprehensive Community Prevention Plan for Washoe County (2020-2022)	Join Together Northern Nevada CCPP
Churchill Community Coalition	Churchill Community Coalition Comprehensive Community Prevention Plan (2020-2023)	Churchill Community Coalition CCPP
Healthy Communities Coalition	Healthy Communities Coalition Comprehensive Community Prevention Plan (2019-2021)	CCPP 2019 2021
PACE Coalition	PACE Coalition Comprehensive Community Prevention Plan (2020-2023)	PACE CCPP 2020
Nevada Early Childhood Obesity Steering Committee	Nevada Early Childhood Obesity Prevention State Plan (2021-2026)	Nevada State Plan 2021-2026 Final _11.08.21
Nevada Early Childhood Obesity Steering Committee	EARLY CHILDHOOD AGENCY GOALS: A GRAPHIC REPRESENTATION OF ALIGNED SERVICES IN NEVADA	Crosswalk Graphic Draft_12.30.19
High Sierra AHEC	High Sierra AHEC One-Year WORK PLAN	HS-AHEC Action-Work Plan with Evaluation Measures UPDATE DR 07.27.21
Medicaid	Medicaid Administration (Approved May 11, 2015)	Medicaid State Plan
Supplemental Nutrition Assistance Program - Education	Nevada Supplemental Nutrition Assistance Program Education (SNAP-Ed) State Plan (FFY2021-2022)	Nevada SNAP-Ed STATE PLAN FFY21-22_Amendment#1
Nevada Aging and Disability Services Division	NEVADA STATE PLAN FOR AGING (2021 – 2024)	NV_State_Plan_or_Aging-2021-2024-FINAL_06.01.2021
UNLV, The Nevada Institute for Children's Research and Policy (NICRP)	NICRP's review of goals pulled from various state plans	Nevada Strategic Plans to Compare
UNLV, The Nevada Institute for Children's Research and Policy (NICRP)	NICRP's compiled list of state plans	Nevada Strategic Plan Alignment_9.2.19

APPENDIX D – NEEDS ASSESSMENT

Nevada DHHS Chronic Disease Needs Assessment Report

Spring 2022

Executive Summary

Introduction

The Chronic Disease Prevention and Health Promotion Section within the Nevada Division of Public and Behavioral Health began the process of developing a five-year strategic plan in November 2021. The purpose of the Chronic Disease Prevention and Health Promotion (CDPHP) Strategic Plan is to develop specific and reasonable goals to **reduce the burden of chronic disease in Nevada over the next five years**. These goals will serve as a call to action for all chronic disease partners, stakeholders, and decision-makers throughout the Plan's longevity.

The plan is intended to complement existing plans and unify efforts to address the burden of chronic disease in Nevada as a whole. To that end, while this plan is intended to guide the work of CDPHP, it will be built with partner input and an awareness of existing and ongoing statewide efforts.

The Blueprint Collaborative and OnStrategy were secured to facilitate the strategic planning process. The planning process is divided into three phases:

Phase 1 – Needs Assessment (Nov 2021 – Apr 2022)
Phase 2 – Strategic Plan Development (May – mid-Aug 2022)
Phase 3 – Communication (mid-Aug – early-Sept 2022)

The Needs Assessment Phase consisted of two parts: (1) Perspectives from the CDPHP leadership and (2) an External Partner Needs Assessment.

(1) Perspectives were secured from the CDPHP leadership via one-on-one interviews to gather themes and key ideas to inform the external partners' assessment and to inform the broader planning process for the state's chronic disease strategic plan.

(2) The Blueprint Collaborative and OnStrategy conducted individual interviews with 40 partners across 29 organizations and one group interview with the Nevada Statewide Coalition Partnership, which included 11 partners across 9 organizations.

Key Insights from CDPHP Leadership

Insights from CDPHP leadership, which should inform the strategic plan, include the following:

Vision & Expectations 5 Years from Now

The 5-year future was described as follows, with an overall expectation to continue the current successes for the next 5 or so years (and beyond).

Flatten the curve and start to move towards a downward trend.

More of an emphasis on primary, preventive care: reaching younger people before they contract a disease.

Because funding we are getting right now is not sustainable, we are leveraging policy and infrastructure.

More community health workers who look like the communities they serve are needed.

Sustainable funding for existing mandates before we add more unfunded mandates.

Continuity of care.

Programs integration across HHS/partners; we are serving the same populations and partners so let's be more coordinated.

More equity; create policies with equity in mind.

Strategic Issues

The following topics were raised that could be some of the strategic issues the plan should address:

How will we link the strategic plan to program plans to realize results? In past, we haven't done this.

What are the reasons for lack of or insufficient integration and can we resolve the reasons why we don't do it well enough?

While equity is a global issue, Nevada's equity challenges are unique; how can we address them?

Key Insights from Partners

From the partner responses, the following are the key challenges and proposed solutions, organized by theme. This detailed report provides additional context for each theme.

Changes to Approach	
• Shifting focus from direct service to PSE (Policy, Systems, and Environments) • Make positive changes made for COVID permanent • Use social determinants of health to inform needs	• Shift to community-led programming and partnerships • Workforce pipeline program for health care providers

Community Needs	
• Economic access to services • Physical access to services • Focus on prevention	• Reaching all populations (Health Equity) • Addressing root causes of chronic disease • Serving rural populations

Partner Needs	
• Funding • Workforce capacity • Working with the State	• Collaborating across the state • Information/data sharing

Insights

Changes to Approach (Global Shifts)

Shifting Focus from Direct Service to PSE (Policy, Systems, and Environments)

Multiple partners shared that they are shifting their focus from direct service programming to policy, systems, and environmental change approaches to impact the systems that create the structures in which communities work, live and play. This approach could be considered more broadly by the state and other external partners as an approach to reduce the burden of chronic disease in our state. An advantage of an effective PSE change strategy is sustainable impact. These strategies are often complex, as they attempt to drive change at multiple levels.

Make Positive Changes Made for COVID Permanent

COVID-19 has had a major impact on our state, country, and the world. Though there have been many negative impacts, there were also some positive changes that took place in response to the pandemic. Organizations should consider taking "inventory" of changes made due to the pandemic that should continue as we move back to "normal" operations. Examples of some "positive" responses to COVID shared by partners were:

Federally Qualified Health Centers (FQHCs) opened up requirements and removed barriers for telehealth services. Many services are now more accessible.

Partners have had a larger reach. People are attending classes virtually that they couldn't attend in person due to transportation needs.

There's more buy-in re: wellness/mindfulness programming.

Use Social Determinants of Health to Inform Needs

Multiple partners shared that the pandemic drew out social determinants of health, which the Centers for Disease Control and Prevention (CDC) defines as "the conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes." Given that social determinants of health contribute to wide health disparities and inequities, the state can consider using social determinants of health to inform the needs of communities and where/how support can be provided. Specific comments from partners include:

- "Funding should be provided for social determinants of health. Today these needs are generally funded by nonprofits and donations, and this leads to gaps in service. Food insecurity and housing support could be pulled into Medicaid."
- "COVID-19 has drawn out some social determinants. When people have other issues going on it's hard for them to commit to a yearlong…prevention programs. There are…. challenges with commitment when folks have issues with housing, financial issues, etc."

"Our zip code matters more than our genes that affect our health"

– Kevin Dick, Washoe County District Health Officer

Shift to Community-Led Programming and Partnerships

Partners shared a possible solution to health inequity is engaging in community building and community work. One partner noted that "You have to work with people in the community to understand their needs and challenges so that you develop

programs that meet their needs. It's ineffective to just drop into a community with a pre-determined solution. Unfortunately, there has been no funding for relationship-building – only programs." We need more partnerships and community-based initiatives (e.g.- with churches and barbershops) with local groups and organizations. Another partner suggested that solutions to health equity begin with "face-to-face conversations with the community asking "What do you need? "and learning what the participant needs as opposed to the state and partners deciding. We can then inquire "What is that community willing to support and continue if we create it. Will it continue and be sustained?""

"For reducing the burden of those experiencing [chronic] disease – build more community-based health education and management programs. This should be in concert with the medical provider solutions. An integrated support system. The intersection of public health and health care at the community level."

- Peter Reed, UNR Sanford Center for Aging

Workforce Pipeline Program for Health Care Providers

Partners shared that minority communities would like to go to providers from their culture that look like them and therefore we need to support a more diverse workforce. Though Nevada is a diverse state, our provider community does not reflect that diversity. One partner suggested that a pipeline program be funded and developed to encourage youth in underserved communities to get into the field of health care, allowing us to create the next generation of health care providers to serve the underserved communities.

Community Needs

Partners were asked about the specific needs of the communities they serve. The community needs that resonated from multiple interviews are captured below.

Economic Access to Services

Limited access to appropriate and ongoing health care.
Even with insurance and Medicare, it's still hard for some to afford medical care. Many in the community have challenges like food insecurity, housing instability, and transportation issues. These challenges compound and impact an individual's ability to pay for ongoing medical care.

Income eligibility requirements restrict populations served.
There are community members whose income is above the threshold for assistance, yet they cannot afford medical care.

Proposed Solutions:
Adjust income eligibility for services (policy).
Allow for a transition period so all benefits are not lost at once (policy).

> *"Income threshold/requirements eliminate our ability to serve some populations, yet they are the ones suffering"*
> - a Coalition Partner from the Nevada Statewide Coalition Partnership

Physical Access to Services

Lack of transportation to clinical, specialist, and community services.
Transportation challenges were mentioned repeatedly by various partners. The need for additional transportation support was expressed in both the urban and rural communities, though this issue was mentioned more often in rural communities due to the limited number of providers in their community. Homebound patients (elderly, special needs/disabled, etc.) in rural communities are particularly vulnerable. Creative solutions may be needed to resolve this challenge.

Proposed Solutions:
Provide transportation to health care providers in both urban and rural communities.
Keep waivers in place that made teledelivery of clinical or educational services possible.
Resource the Medicaid Transportation Network (MTN) for use in Elko.

> *"There's a lack of providers in Northeastern Nevada. There are openings and we just can't get staff, which delays care. If we have to refer to Reno or Salt Lake City, or even Idaho, then there's no transportation to get them there."*
> - Patricia Taylor, Elko Indian Health Services
>
> *"[Our] program has to use the same bucket of money for screening services and Uber rides. Would be great if there was a separate bucket of funds for transportation."*
> - Erla Orozco, Women's Health Connection

Focus on Prevention

Limited insurance coverage for wellness and prevention activities.
The current legislature consistently does not support wellness programs. Previous legislative bodies have incentivized wellness programs in the past (e.g.- Health Savings Account contributions and reduced premiums), which are beneficial for encouraging prevention.

Proposed Solutions:
Increase funding for primary prevention programs to build prevention capacity.
More policy focusing on prevention and early detection (policy).
Educate people about preventative services. Help them understand what they have access to and what may be free.
Allow treatment for undocumented breast cancer patients (policy).
Support wellness and prevention for Affordable Care Act insurance (policy).
Ensure people can get screening, money for diagnostic testing (policy).
Promote prevention education. There are modifiable risk behaviors for chronic diseases such as diabetes, cardiovascular disease, and high blood pressure.

"We need state leadership and legislature to offer incentives to get healthier."

– Laura Rich, Public Employees' Benefit Program (PEBP)

Reaching All Populations (Health Equity)

Need improved cultural competency and diversity of doctors and pharmacists.
In order to improve health equity, the cultural competency and diversity of medical professionals is needed. It would be ideal to have a diverse set of providers in our state that mirror the population. For some communities there are trust issues with the medical community (e.g.–common in the African American and immigrant communities); in other communities, there are language barriers (e.g.–Spanish-speaking populations).

Messaging is often not inclusive.
Organizations need to consider a "diversity" lens as they are communicating to their target audience. Are people not getting screened because the (chronic disease preventative education) messaging doesn't speak to them? For example, a breast cancer self-check card may inadvertently exclude people of color, as their skin tone is not represented.

Limited effectiveness of top-down solutions to health equity.
Health equity can be improved by engaging in community building and community work so that solutions are not top-down. "You have to work with people in the community to understand their needs and challenges so that you develop programs that meet their needs."

Poor communication channels to inform the homeless community of available services
There are services available to the homeless population, but the challenge is reaching them to inform them of these services.

Proposed Solutions:
Provide cultural competency training for providers.
Create a diverse pipeline for the medical professional community.
Provide current data so that Community Health Workers (CHW) can provide more targeted assistance in the community.
Ensure outreach reflects the target communities (e.g.- photos need to look like the community).
Engage the community in identifying needs rather than coming in with solutions.

"We need to do community-based initiatives so communities can help can solve their own challenges (e.g. churches, barber shops). How can we work with the local groups and agencies and provide more resources?"

– Gerald Ackerman, Office of Rural Health

Addressing Root Causes of Chronic Disease

There were several challenges and proposed solutions specific to addressing the root causes of chronic disease. Challenges are organized by category below. Note that supporting data has been requested from the Office of Analytics to align with the qualitative statements shared from partners below.

MENTAL & BEHAVIORAL HEALTH

Lack of comprehensive behavioral health prevention and promotion resources. More counselors are needed.
Though partners shared that workforce capacity is an issue overall, multiple partners mentioned the need for increased mental health providers for all ages (youth and adults) in both rural and urban communities.

Proposed Solutions:
Provide more mental health resources.
Higher level of funding to pay and keep social workers and mental/behavioral health clinics in our state.

SUBSTANCE ABUSE

Increase in mental health and substance abuse issues.
Partners observed an increase in mental health issues for both youth and adults during the pandemic. Partners also noted the perception of harm has been lowered for marijuana specifically and shared that parents contribute to the issue.

Ease of availability of drugs and alcohol.
As a result of this, partners recommended several policy changes to restrict access to drugs and alcohol, particularly to youth.

Proposed Solutions:
Revisit cannabis laws. They tend to get watered down each legislative session (i.e.-advertising regulations, lounges, number of dispensaries, etc.).
Alcohol and tobacco retailer compliance (policy).
CBD compliance – no laws regarding the minimum age to purchase CBD (policy).

TOBACCO

Tobacco continues to be a large contributor to chronic disease in our state.
Cited by interviewees as one of the highest contributors to cancer and cancer deaths. And while funded through state taxes and a master settlement, tobacco cessation and use prevention messaging seems to have become diluted across Nevada.

Proposed Solutions:
Remove exemptions from the Clean Indoor Air Policy (policy).
Pricing strategies for tobacco and sugar-sweetened beverages (policy).
Double down on tobacco control and prevention (policy).

NUTRITION SECURITY & OBESITY

Consistency is needed across health district policies. Currently, policy often prevents delivering healthy food to children.
Each health district has its own policies. Some policies are so restrictive that childcare centers are limited in ability to provide health food. For example, some centers are trying to create community gardens but cannot cut or wash the food in the center.

Nutrition security is a socioeconomic issue.
This particularly impacts those below the poverty level. Diets are not what they should be and this manifests in illnesses not evident as much in higher economic levels.

Obesity rates are particularly high in tribal communities.

According to the U.S. Department of Health and Human Services' Office of Minority Health, American Indian and Alaska Native adults are **1.6 times more likely to be obese than Caucasians**. In addition, almost 33 percent of all American Indians and Alaskan Natives are obese.

Proposed Solutions:
State-specific policy around food handling in childcare centers and education environments (policy).
Support universal meals in schools (policy).
Develop a statewide obesity prevention and treatment program for adults and children (policy).
Train the community on how to make healthy meals with available resources.
Develop a food and veggie prescription program.
Change the low-income distribution system.

YOUTH-SPECIFIC

Lack of support for mental health and behavioral services for youth. Need to expand intervention and community-based programs.
Partners noted that both prevention and intervention services are needed for youth. It should not be either/or when it comes to funding.

Children whose parents are incarcerated or in a jail diversion program are not being served.
We are serving parents who participate in our jail diversion program, but a big gap is service to their children.

More focus is needed on chronic disease prevention.
As with adults, a focus is needed on prevention in an effort to get ahead of the need for chronic disease management.

Proposed Solutions:
Provide funding for intervention services...period. Grants cover prevention and treatment but the greatest need for our youth is intervention services.
Provide access to minors for behavioral health services (policy).
Provide funds to serve children whose parents are incarcerated or in a jail diversion program.
More prevention CHWs to be in the schools to provide services to get ahead of the problems.
Include education on chronic disease at the high school level (policy).
Require physical activity in schools (policy).

> *"Youth mental health and substance misuse.... cannot be separated as they are interrelated and must be addressed as one."*
> - Linda Lang, Nevada Statewide Coalition Partnership

Serving Rural Populations

Lack of infrastructure and capacity to serve rural communities.
There are no public health departments in the rural counties and this is desperately needed for prevention and screenings. The regional health centers have been reduced to providing primary care, and not public health duties. Even the existing State Health Department needs to increase their capacity to support rural areas.

Lack of preventative care because there are no health districts in the rural communities.
Residents in many rural counties do not have access to health screenings and preventative care (immunizations, early diabetes, substance abuse prevention, early cancer screenings, STD screening and treatment, etc.).

Communication and reach to rural communities are difficult and costly.
While COVID-19 resources helped support outreach, communications and outreach in rural communities presents a challenge across Nevada.

More funding is needed to support the rural communities.
The return on investment (ROI) looks more expensive when serving residents in rural areas. There are unique strategies and resource considerations when effectively serving those living in frontier and rural communities.

Lack of qualified mental health providers in rural areas.
Health care workforce needs are exacerbated in rural areas. This is particularly seen in the need for rural mental health providers.

Mining communities (Elko) have a unique set of health needs.
Nevada is known for mining everything from gold and silver to sand, gravel and crushed stone. Mining is among the most hazardous occupations (workplace injury/accidents as well as environmental health hazards).

Proposed Solutions:
Provide reliable internet.
Provide transportation to health care providers.
Increase allowable funding for remote services.
Better access to telehealth. Expand Project ECHO.
Increase capacity for the State Health Department to support rural areas.
More funding for programs to support all community members in rural areas (not just lower socioeconomic).
Hybrid solutions for training and education.
Change the criteria for funding for rural areas. Providing services in rural counties will appear to have lower ROI (e.g. – a van costs the same regardless of whether 8 or 20 people use it).

A recommendation for policy change is "investment in development of public health infrastructure in rural areas"

– Gerald Ackerman, Office of Rural Health

External Partner Needs

Partners were asked about the challenges they have in achieving their mission or delivering their services. The partner needs that resonated most from our interviews are captured below.

Funding

Sustainable, reliable, and proportional funding from the State to health districts.
Though the health districts serve the majority of the population, the funding provided is not proportional to the population served.

Sustainable funding for all partners, especially after COVID funding stops.
A significant majority of interviewees report reliance on federal funding (CDC and others) rather than funding from the State of Nevada. Partners expressed a desire for funding that they can rely on for infrastructure. Funding is needed especially for rural providers.

Need flexibility in the use of resources and funding for chronic disease.
Most funds are CDC grants, which are restrictive. Partners shared there are many chronic diseases that are important but are not funded. In addition, more funding is desired for prevention activities.

Agencies will need to expand their portfolio of services to meet the demand of the aging population.
Population aging is a major drive of what partner needs are going to be in the future. Funding will need to align with this.

Proposed Solutions:
State to provide funding for base-level work to sustain the organization.
State to provide funds that are more flexible than federal funds and include provision for diseases or services that the feds don't fund (e.g. lung cancer screening, colorectal screening).
Ensure health districts are funded proportionally to the population they serve.
Provide state funds for education so that health departments don't have to rely on federal dollars to do the education and prevention work.
Create and communicate a plan for post-COVID funding.
Fund chronic disease partners through the ACRN funding (opioid settlement dollars) and/or marijuana tax dollars.
DHHS to advocate for funding from the Governor's budget and matching dollars for grants.
Create a grant funding process for pilot programs that, if successful, could be rolled out to the state.

> *"The CDC grants money for particular chronic issues, grants or direct funding, and it doesn't cover all of the chronic diseases."* Examples of diseases referenced were arthritis and Alzheimer's.
> - Tom McCoy, Nevada Chronic Care Collaborative

Workforce Capacity

Provider shortage.
Health care provider shortage was mentioned by many partners. The needs include not only primary care providers and specialists, but also medical assistants, front office staff, and care navigators to help with social services (community health workers). The shortage of mental and behavioral health professionals was mentioned more than once.

Greater coordination is needed between clinical services and public health.
Interviewees identified a gap between clinical services and public health delivery overall. This includes mental and behavioral health.

Proposed Solutions:

Look at ways to get health care providers to the rural communities. Consider loan repayment programs, medical school scholarships, or other incentives to those committed to rural communities.
Reciprocity – Can out-of-state licensure qualifications be recognized? This is often a barrier for new health care workers coming into our state.
Open accessibility/gateway for positions. Increase incentives to grow workforces across the health care sector. Utilize social work interns, Community Health Worker programs for students, etc.
Increase funding for Community Health Workers so that they can help streamline some of these needs identified (reaching our senior population, warm hand-off to community services, and bilingual outreach).
Provide support for case managers. We have Community Health Workers and social workers, but we're missing the middle piece.
Provide more mental health resources.
Enhance telemedicine. This will allow telehealth providers (local or national) to pick up the slack where providers don't exist.
Expand the scope of what existing RNs are licensed to do.

"Workforce. That's what is keeping everyone up at night. That runs the gamut from clinical to non-clinical/administrative folks as well. My mantra recently is the health care sector has not been immune to the issues (great retirement) of the rest of the economy. These are trends we were seeing pre-pandemic: aging workforce, chronic disease, and we are served by aging workforce. The pandemic is accelerating these trends. Particularly in nursing."
- Dr. John Packham, Office of Statewide Initiatives, UNR School of Medicine

Working with the State

Siloed state systems.
Our collective impact on chronic disease would go further if we worked together. The state government is very siloed. We have different agencies with similar goals/common purpose but serving different populations. Currently it is difficult to navigate.

State decisions are not being informed by the field.
To combat the sense of state policy being top-down driven, this strategic planning process is a great opportunity to gather and utilize input from practitioners and providers from across the state.

Partners often have to deal with different key personnel in certain roles due to high turnover at the state.
Frustrations emerge with frequent turnover in state division personnel. Providers and practitioners often experience a shift in reporting requirements, policies when key contact persons change at the state level.

Micromanagement by the state for grants.
Better relationships between state personnel and grant recipients is needed to foster solid outcomes.

Timeframes around scopes of work with grants and budgets.
Grant-writing (nor grant writers) is not an approved use of grant funds. Yet it is a way of life for service providers who seem to always be in a state of emergency over funding, funding cycles, funding requirements and limitations. Also, budget reporting and grant submissions are on varying timetables.

Organizations have to report to various regulators based on the funding they receive. Oftentimes different regulators have different regulations.
See above.

Slow reimbursement process.

Organizations must meet fiscal commitments (operating expenses – personnel, facilities, etc.) and rely on reimbursement to do so. Partners shared the reimbursement process is often slow and the rules seem to change. Other partners shared the desire for additional services to be reimbursable, such as navigation services for example.

Proposed Solutions:
Work together with partners to develop approaches to chronic disease and feed that to the feds.
Reduce state workforce turnover so we can have continuity of work. Consider allowing for flexibility with work structure for state employees.
Provide training on policy/procedures to avoid misunderstanding.
Start the conversation earlier regarding grant and budget timelines.
Regulatory reconciliation – Crosswalk the regulations from various state and federal agencies to help the providers out (policy).
Provide timely reimbursements or provide operating expenses while waiting on the very slow reimbursement process.
Streamline the reimbursement process.
Ensure reimbursement rates from Medicaid are equitable and fair.
Consider reimbursement for cancer data collection (both staff and infrastructure) as well as to providers who offer navigation services.

"Re-prioritize our state dollars. So much of that is political. What does it really take to address chronic disease…should look at it from an innovation or funding standpoint. As Nevada grows, please keep up with the census and fund accordingly."
– Trevor Rice & Erla Orozco, Access to Healthcare

Collaborating Across the State

Need consistent and deliberate coordination and collaboration between agencies working on chronic disease.
There are lots of organizations doing great work but there is poor communication about it. Would be great if we could work collaboratively together.

Need greater coordination between clinical services/health care and public health.
Health care professionals need to be communicating with community-based agencies to bridge the disconnect between medical care, community care, and public health. There needs to be more alignment. More alignment of health district policies around the preparation of healthy food in childcare establishments is desired. Currently, policies vary from district to district. In one district you can't pour milk into a glass or cut fruit in a commercial kitchen. [When] trying to grow a community garden, you can grow it, but can wash it or eat it in the childcare center.

Proposed Solutions:
State should establish a statewide coalition for chronic disease.
Convene a quarterly meeting (and other opportunities for open communication) with all state entities who work on chronic disease so they can share what they are working on. Collaboration should recognize the overlap in chronic disease, substance misuse, and mental health.
Explore collaborations using alternative methods/paraprofessional model of information dissemination (CHW/Promotora model).
Strengthen funding to existing prevention coalitions throughout the state that are working directly with partners, community members, and organizations to decrease health disparities and provide access to needed resources. Coalitions are very effective with both policy changes and programming.
Unify health district policies across the state.

"[The state can have the greatest impact by leading] collaborations with community partners and state agencies so we aren't duplicating work. [For example, we] just completed a statewide childhood obesity plan and aligned our plan with the Early

Childhood Advisory Plan. Both plans are looking at same types of information and issues. That way there's more movement on these issues."

– Amanda Haboush, Nevada Institute for Children's Research & Policy

Information/Data Sharing

Need current county-specific data.
Vital data is not readily available at the service delivery level. Programs and service providers need to be able to target services to those most in need using current data (ex. # children, birth weight, how many under age 5 in Lander County TODAY – not 2 years ago).

Need a better explanation of the data. What does it mean?
Partners requested training on how to interpret the data made available to them. They would like to better understand what the data means and how to apply that information to planning and service delivery to help improve the quality of their services and their ability to meet community needs.

Would like more data sharing across the programs/partners in the chronic disease space.
Resources can be maximized when providers share best practices, lessons learned, and services provided. With an understanding of programming across the county/region/state, program redundancies and gaps can be addressed so the entire population of Nevada is better served.

Need an easier process to request data from the state.
Programs and grant recipients are confused by the data request process, and therefore less likely to use data.

BRFSS data is decreasing every year.
There is concern that if BRFSS data continues to decrease, the data will not be as useful or valuable.

Concentration on evidence-based programming makes it about the criteria rather than service delivery/outcomes.
Programs struggle with the transition from direct service delivery to evidence-based programming.

Proposed Solutions:
State to help with providing more data, proactively sharing the data, and responding to data requests.
Provide access to current population data so that partners can better target service delivery.
Advise how partners can get in touch with the "data folks".
Implement an IT infrastructure to help work with the multiple platforms and ensure data security.
The state should develop robust data collection methods to guide evidence-based care.
DHHS to promote public workshops/documents and send them to all partners
State to provide a repository of various disease-specific action plans.
Create a shared listserv to share public documents, reports, etc.

"[The state can better support our work] by providing an integrated data system. We have to enter information into different systems. Need to improve data system integration…It's hampering every early childhood partner, system, program. We can't say we need additional funding if we can't show outcomes, and we can't show outcomes unless data is integrated."

– Marty Elquist, Nevada Early Childhood Obesity Steering Committee

Appendix E – Additional Insights

Health Literacy

It's difficult to navigate the health care system. Some people go to the ER instead of a primary care doctor or specialist because they simply do not understand their Medicaid coverage.

Proposed Solutions:
Treat the whole person through community-based case managers.

Misc.

Promote diversification of clinical trials and representative enrollment into clinical trials

Funding for Arts, Music, and Other Such Things that Bring Us Joy

One partner suggested that funding and support be provided for art, music, and things that bring us joy. These things contribute to health in our communities and are not affordable to those in lower socioeconomic areas.

Tribal-Specific Challenges

There was limited and conflicting information provided by partners representing the tribal community. Patricia Taylor of Elko Indian Health Services noted that they provide better services than the "non-native" residents of Elko County receive. Many of the challenges she noted were more rural in nature – lack of county health department, lack of providers in the area, and transportation challenges in getting patients to medical care.

Very different feedback on tribal-specific challenges was provided by Marla McDade Williams, Deputy Director, Nevada Department of Health and Human Services. Multiple challenges were noted along with several proposed solutions.

No tribal public health infrastructure at all.

Lack of funding for tribal communities.
Help them be successful in learning and building capacity in public health.

Need better community engagement in tribal community--helping them build resources in a non-judgmental way.
Tribal communities have never worked in the system to even be able to speak about public health.

Proposed Solutions:
Need infrastructure & capacity.
Improve insurance systems & access to providers (primary care network limited for primary/specialty services).
Provide grant-writing assistance.
Have tribal liaisons roles given to members that understand these communities.
Provide education in ways that the tribe understands and create clear links to public health.

There needs to be "recognition that funding needs to go to these communities and we must help them be successful in learning and building capacity for public health."

- Marla McDade Williams, DHHS

Explore Holistic Approaches

Crosswalk clinical and wellness responses for chronic disease (e.g. – tree therapy). It's not always a medicinal solution. One partner shared that they experienced more buy-in regarding wellness/mindfulness programming in response to COVID. Perhaps more holistic approaches should be explored for chronic disease prevention.

"We've taught [wellness/mindfulness programming] for 6 years, but due to COVID, now there is more desire to provide tools for free".
- A partner from the Nevada Statewide Coalition Partnership