



# Dignity Health - St. Rose Dominican Siena, San Martín & Rose de Lima Community Health Assessment

May 2016



**Dignity Health™**  
St. Rose Dominican





# Clark County Coordinated Community Health Assessment Overview

*This community health assessment report is a coordinated effort that the Southern Nevada Health District conducted in partnership with American Heart Association, Boulder City Hospital, Catholic Charities, Center for Progressive Policy and Progress, Clark County School District, Clark County Social Services, Dignity Health St. Rose Dominican Hospital, Federal Reserve Bank of San Francisco, Las Vegas Chamber of Commerce, March of Dimes, Nevada Hand, United Way of Southern Nevada, University Medical Center, University of Nevada – Las Vegas, University of Nevada - Reno*



# Executive Summary

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## **Community Health Assessment (CHA) Background**

The Patient Protection and Affordable Care Act (ACA) added new requirements which nonprofit hospitals must satisfy in order to maintain their tax-exempt status under section 501(c)(3) of the Internal Revenue Code. One such requirement added by ACA, Section 501(r) of the Code, requires nonprofit hospitals to conduct a Community Health Assessment (CHA) and adopt an implementation strategy to meet the identified significant needs of the community at least once every three years.

St. Rose Dominican Hospital (St. Rose or SRDH) is dedicated to enhancing the health of the communities it serves. The findings from this Community Health Assessment (CHA) report will serve as a foundation for understanding the health needs found in the community and will inform the implementation strategies selected. With regard to the CHA, the ACA specifically requires nonprofit hospitals to: (1) collect and take into account input from public health experts as well as community leaders and representatives of high need populations—this includes minority groups, low-income individuals, medically underserved populations, and those with chronic conditions; (2) identify and prioritize community health needs; (3) document a separate CHA for each individual hospital; (4) and make the CHA report widely available to the public. In addition, each nonprofit hospital must adopt an Implementation Strategy that describes how the hospital will address the identified significant community health needs.

Beginning in early 2015, St. Rose, in partnership with the Clark County Community Health Assessment (CHA) collaborative partners and the Southern Nevada Health District (SNHD) conducted an assessment of the health needs of residents of Clark County.

## **Purpose Statement**

The purpose of this CHA is to identify and prioritize significant health needs of the community served by St. Rose. The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

## **Community Definition**

The geographic area for this CHA is Clark County, the common community for all partners participating in the CHA collaborative. All counties within Nevada had a tremendous population growth within the last decade. However, the majority of the population by percent remains within Clark County. Clark County comprises only 7% (8,091 square miles) of Nevada's land mass (110,567 square miles) but contains 72% of the state's total population. Because of Clark County's large contribution to the state population, caution should be exercised when comparing the county to the state.



Clark County's poverty level has increased from 10.9% (2005-2009) to 15.7%. The poverty level increased even more for children under the age of 18 from 15.2% to 23.0% during the same time period. The overall poverty level is highest in the Black/African American community, followed by Native Hawaiian/Pacific Islanders.

## **Community Need Index**

Dignity Health has developed the nation's first standardized Community Need Index (CNI) in partnership with Truven Health Analytics. The CNI identifies the severity of health disparity for every zip code in the United States based on specific barriers to healthcare access. The CNI considers multiple factors that are known to limit health care access such as income, language, educational, insurance and housing barriers. The ability to pinpoint neighborhoods with significant barriers to health care access is an important new advancement for public health advocates and care providers. According to the CNI illustrated below, the primary service area has a mean CNI score of **3.7** and includes both moderate and high-risk areas with significant socio-economic barriers. Zip code areas with the highest risks include 89101, 89102, 89104, 89106, 89108, 89109, 89110, 89115 and 89169.

## **Assessment Process and Methods**

The ACA requirements are mirrored in the Public Health Accreditation Board's (PHAB) standard mandating that health departments participate in or conduct a community health assessment every three to five years. Federally funded community health centers must also ensure their target communities are of high need. The similar requirements from IRS, PHAB, and the federally funded health center requirements put forth by the United States Department of Health and Human Services provide an opportunity to catalyze stronger collaboration and better shared measurement systems among hospitals, health centers, and health departments. Additionally, limited resources for comprehensive health assessments and the move toward new population health models have created the need for an organized, collaborative, public-private approach for conducting assessments. As a result, the American Heart Association, Boulder City Hospital, Catholic Charities, Center for Progressive Policy and Progress, Clark County School District, Clark County Social Services, Dignity Health-St. Rose Dominican Hospitals, Federal Reserve Bank of San Francisco, Las Vegas Chamber of Commerce, March of Dimes, Nevada Hand, United Way, University Medical Center, University of Nevada-Las Vegas and University of Nevada-Reno joined forces with Southern Nevada Health District to identify the communities' strengths and greatest needs in a coordinated community health assessment.

The process of conducting this assessment began with a review of approximately 100 indicators to measure health outcomes and associated health factors of Clark County residents. The indicators included demographic data, social and economic factors, health behaviors, physical environment, health care, and health outcomes. Health needs were identified through the combined analysis of secondary data and community input. Based on the review of the secondary data, a consultant team developed a primary data collection guide used in focus groups which were made up of representatives of minority and underserved populations who identified community concerns and assets. Surveys were collected from key informants to help determine community needs and priorities. Additionally, meetings were held with stakeholders from the community to assist with the analysis and interpretation of data findings. No written comments were received on the most recent previous CHA and Implementation Strategy. There are no known information gaps that limit the ability of this CHA to assess the community's health needs. The assembled data, information, and analyses provide a comprehensive identification and description of significant community health needs.

## Summary of Prioritization Process and Criteria

To be considered a significant health need, a health outcome or a health factor had to meet two criteria. First, existing data had to demonstrate that the primary service area had a health outcome or factor rate worse than the average Clark County rate, demonstrate a worsening trend when compared to Clark County data in recent years, or indicate an apparent health disparity. Second, the health outcome or factor had to be mentioned in a substantial way in at least two primary data collection sources which were focus groups, surveys, or stakeholder meetings.

The process for prioritization included engagement with both Clark County stakeholders and community partners. The first step of the process was a comprehensive presentation by SNHD that included an overview of the CHA findings and key emerging health needs. The second step in the process involved review and prioritization of the key emerging health needs outlined in the SNHD presentation.

As participants discussed each health need, consideration was given to the following criteria: the size of the problem, disparity and equity, known effective interventions, resource feasibility and sustainability, and community salience. Through consensus, participants made final recommendations to the Southern Nevada Health District for priority health needs.

## Summary of Significant Prioritized Needs

The following statements summarize each of the areas of priority for St. Rose, and are based on data and information gathered through the CHA.

A steering committee comprised of community stakeholders reviewed the CHA data to identify and understand specific health concerns within our community and proposed the following seven health priorities for Clark County:

1. Chronic disease: Top death/disability causes
2. Maternal-child health: Prematurity, low birth weight, teen birth
3. Infectious disease: Pneumonia & influenza
4. Injury: Suicide & drug poisoning
5. Access to care
6. Policy and funding related to public health
7. Quality and continuity of care

These seven proposed priorities were presented at a series of public meetings. The goal was to gather community input and feedback in order to refine and finalize the priorities. The community agreed on the following three significant health need priorities:

1. **Access to Healthcare**- Goals: Healthcare Access and Navigation, Healthcare Resources, Health Insurance
2. **Policy and Funding**- Goals: Funding Allocation Transparency, Increase Key Stakeholder Awareness of Financial Landscape of Public Health Funding in Southern Nevada, Increase Advocacy for Health in All Policies
3. **Chronic Disease**- Goals: Reduce Tobacco use, Reduce Obesity

## **Resources Potentially Available**

Resources potentially available to address identified needs include services and programs available through hospitals, government agencies, and community based-organizations. Resources include access to over 15 hospitals for emergency and acute care services, over eight Federally Qualified Health Centers (FQHC), over three food banks, three homeless shelters, school-based health clinics, churches, transportation services, health enrollment navigators, free or low cost medical and dental care, and prevention-based community education.

The Community Health Improvement Plan group (CHIP) is a collaborative effort between SNHD and a diverse array of public and private organizations addressing healthy eating, active living, linkages to care, tobacco-free living and other community health issues. With more than 176 members representing over 70 partner organizations, this is a valuable resource to help St. Rose connect to other community based organizations that are targeting many of the same health priorities.

## **Report Adoption, Availability and Comments**

This CHA report was adopted by the St. Rose community board in May 2016.

This report is widely available to the public on the hospital's web site, and a paper copy is available for inspection upon request at St. Rose Dominican Community Outreach Department.

Written comments on this report can be submitted to the St. Rose Dominican Community Outreach Department or by e-mail to [CHA-StRose@DignityHealth.org](mailto:CHA-StRose@DignityHealth.org).

# Organizational Commitment

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## Community Needs Assessment (CHA) Background

Rooted in Dignity Health's mission, vision and values, St. Rose is dedicated to delivering community benefit with the engagement of its management team, Community Board and Community Health Advisory Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource.

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services,
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

St. Rose is committed to meeting the health needs of the community by ensuring implementation of successful programs that meet the specific needs of the people it serves. Success is achieved through assessment of community needs, involvement of key hospital leaders, and implementation of community benefit activities. Organizational and community commitment includes:

**Executive Leadership Team:** The St. Rose Executive Leadership Team is responsible for reviewing the Community Benefit Report and Plan prior to presentation and approval by the Community Board. The Executive Leadership Team's contribution to the community benefit plan includes reviewing alignment of the Community Benefit Plan with the CHA, the hospital's overall strategic plan, and budgeting for resources.

**Community Health Advisory Committee:** The Community Health Advisory Committee (CHAC), chaired by an Adrian Dominican Sister and the Vice President of Mission, assists the community board in meeting its obligations by reviewing community needs identified in CHA, recommending health priorities, recommending implementation strategies, presenting the hospital's annual Community Benefit Report and Plan, presenting the hospital's CHA Implementation Strategy, and monitoring progress.

**Community Board:** The Community Board is responsible for oversight and adoption of the CHA and, Implementation Strategy, approval of the Community Benefit Report and Plan, and program monitoring. Throughout the fiscal year the community board receives reports on community benefit programs. The chair of the Community Health Advisory Committee reports to the board regarding strategies, programs, and outcomes.

**Community Benefit Department:** The Community Outreach Department, under the Chief Strategy Officer, is accountable for planning, implementing, evaluating, reporting, and ultimately for the success of designated programs. The Community Outreach Department is directly responsible for the CHA and Implementation Strategy, Community Benefit Report and Plan, Dignity Health Community Grants committee, program implementation, evaluation, and monitoring, community collaboration, and reporting of community benefit activities. Key staff positions include: Director of Community Outreach, Henderson Manager of Community Outreach, WIC Manager, Helping Hands Supervisor, Lead Lactation Consultant, Health Educators and Program Coordinators.



St. Rose Dominican's community benefit program includes financial assistance provided to those who are unable to pay the cost of their care, unreimbursed costs of Medicaid, subsidized health services that meet a community need, and community health improvement services. Our community benefit also includes monetary grants we provide to not-for-profit organizations that are working together to improve health on significant needs identified in our Community Health Needs Assessment.

## Impact of Actions Taken Since the Preceding CHA

The significant health needs identified in the 2013 CHA report were:

1. Diabetes Management
2. Adults & Children without Health Insurance
3. Heart Disease & Stroke
4. Breast Cancer Screening
5. Childhood Asthma

Below is an overview of key actions taken and impacts in addressing these priorities in 2015. For more detailed outcomes since the 2013 CHA, please see the Community Benefit 2015 Report and 2016 Plan at [strosehospitals.org](http://strosehospitals.org) or request it and the 2014 Community Benefit Report from [CHA-StRose@dignityhealth.org](mailto:CHA-StRose@dignityhealth.org).

### Diabetes Management

- **CDC NDPP:** Initiated CDC's National Diabetes Prevention Program. Started 4 programs - total of 98 lbs weight loss. Trained 7 Lifestyle Coaches (2 RNs, 3 RDs and 2 RD Master Trainers).
- **American Diabetes Association Program:** 366 Individual and group education participants. Each participant reported back on at least 3 goals and achieved by 80% or greater. Goals include: healthy eating, being active, taking medication, monitoring, problem solving, reducing risks, and healthy coping. 176 support group attendees.
- **Stanford Diabetes Self Management Program (DSMP):** Reached 171 DSMP participants by providing 11 workshops in English and 3 in Spanish. Obtained AADE accreditation for Stanford Plus program. St. Rose was named the Nevada State Quality and Technical Assistance Center (QTAC) and received State grant totaling \$114,828 for diabetes management and prevention. Among participants completing the program, hospital utilization decreased 94.5%, ER visits decreased 96%, and unscheduled physician visits decreased 25%. Average self-rated health score improved from 2.94 pre-program to 2.79 post-program (5 point scale 1=excellent, 5=poor). Reported 15% overall improvement in 6 aspects of self-management.
- **Prevention:** Reached 200 participants at DiBEATes Day in correlation with National Diabetes month; 78 participants - pre diabetes lectures; 60 participants- ADA diabetes awareness health fair, 500 monthly glucose and HbA1c Screenings.

### Adults & Children without health Insurance

Trained and licensed 5 staff as Exchange Enrollment Facilitators to enable them to enroll clients in Medicaid, Nevada Check-up, Nevada Health Link and health plans for the undocumented. In addition, received grant from the Silver State Health Insurance Exchange to enroll the uninsured. Staff attended 83 events and enrolled 358 clients in the following plans:

- Qualified Health Plan: 124
- Medicaid: 199
- Nevada Check-up: 15
- Undocumented Health Plan: 20

### Heart Disease & Stroke

- **Prevention Program Attendance:** Fitness: 16,945, Cardiac Nutrition Class: 63, DASH: 4, Cholesterol Control: 23, Weight Management Club: 358, Cooking Demos: 80, Blood Pressure Screenings: 155, Lipid Panel Screenings: 295, PVD Screenings: 26, Hypnosis for Smoking Cessation: 28, Meditation/Relaxation: 376, Heartsaver CPR: 52
- **CHAMP:** Total Patients: 102; 100% on ACEI 89.8% on Beta Blocker. Zero 30-day Readmits
- **Stroke:** Stroke Sharegiver Visits: 1641 Stroke Club & Aphasia Lunch Bunch: 528

### Breast Cancer Screening 2015

- Clinical Breast Exams: 130
- Diagnostic Mammograms: 222
- Screening Mammograms: 275
- Ultrasounds: 294
- Biopsies: 44
- Surgical Consultations: 46
- Cancer Diagnosis: 4 & Surgical Treatment: 1

### Childhood Asthma

Partnered with and funded the Bower School-Based Health Center and American Lung Association to provide comprehensive services to at-risk children with asthma. This included the Asthma Management Program lead by a Nurse Practitioner at the Bower School-Based Health Center and Open Airways for Schools education for elementary school children.



# *Southern Nevada*

## Community Health Assessment

— May 2016 —







The Southern Nevada Health District led this Community Health Assessment. Xerox Community Health Solutions provided assistance with report preparation.



Community  
Health Solutions



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# Executive Summary

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## Introduction

The Southern Nevada Health District (SNHD) worked collaboratively with multiple community organizations and individuals to conduct a Community Health Assessment (CHA). A CHA is integral in not only identifying a community's health-related needs and strengths, but also in identifying the resources available to adequately address and improve health outcomes.

As health is strongly affected by our ability to make healthy choices, SNHD and its community partners assessed, along with health status, the community behaviors and conditions that influence and affect health status and decisions. This CHA examines the health status of Clark County and how it compares to other counties, the state, and national indicators. The CHA is intended to provide the necessary information to help the community decide where to commit resources to make the greatest possible impact on the population's health status.

## Method

Mobilizing Action through Planning and Partnership (MAPP) is a formal assessment process selected by the CHA Steering Committee for completing the elements of this report. It consists of four assessments that gather primary and secondary, qualitative and quantitative data. These four assessments are the: Community Health Status Assessment (CHSA), Community Themes and Strengths Assessment (CTSA), Local Public Health System Assessment (LPHSA), and Forces of Change Assessment (FOCA).

## Community Health Status Assessment

The CHSA collects, assesses, and reports on core indicators about the health of our residents and factors important to our community's health status to enable identification of health issues and to provide relevant recommendations.

## Demographics

In 2015, Nevada's population was estimated at approximately 2.8 million. This represents a 5.1% population increase since 2010. Clark County, Nevada's most populous county, accounts for 73% of Nevada's total population.<sup>15</sup> The diversity of Clark County's population, like its core population, is also increasing. Much of this is attributed to growth within the under-18 age group – most significantly seen within the Hispanic community.<sup>9</sup>

Clark County's poverty rate has increased from 10.9% (2005-2009) to 15.7% (2010-2014). Poverty levels have increased even more for children under the age of 18 from 15.2% to 23.0% during the same time period. The overall poverty level is highest in the Black/African American community, followed by Native Hawaiian/Other Pacific Islanders.<sup>3</sup>

The influence of education on health status is well recognized. Data from 2010-2014 show slightly lower levels of education among Clark County residents than the nation as a whole. Furthermore, education is unevenly distributed within the county with 26.8% of Whites having at

least a bachelor's degree compared to 8.6% of Hispanics.<sup>15</sup> Geographic distribution shows bachelor's degree attainments are highest in the census-designated places of Summerlin South, Enterprise, and Henderson.<sup>13</sup>

Prior to 2007, Clark County's unemployment rate was comparable to the U.S. national statistics. During the recession, the rates rose well above the U.S. average, peaking at 14% in 2010. In 2014, Clark County unemployment rates remain above the U.S. average by approximately 2%.<sup>6</sup>

### *Access to Healthcare*

In Clark County, 2014 data demonstrated that only 78.6% of adults and 90.3% of children had health insurance.<sup>3</sup> The designated medically underserved areas are along the northern and central urban area and in the rural areas. On the positive side, Clark County had primary care provider rates comparable to national levels, and has seen a decrease in the rate of preventable hospital stays.<sup>3</sup>

As Clark County's public health authority, SNHD plays a key role in providing services, mentoring students and educating youth and the community regarding healthy choices. Despite this pivotal role, Nevada ranked 50<sup>th</sup> and 51<sup>st</sup> in the nation for Health Resources and Services Administration (HRSA) grants and state investment in public health spending, respectively.<sup>14</sup>

### *Self-Assessed Physical and Mental Health*

Feeling healthy is associated with both physical and mental wellbeing; studies have shown that people who self-assess poor physical and mental health have poorer health outcomes. In 2012, Clark County residents reported feeling less well than U.S. residents overall, with rates of self-assessed poor health higher.<sup>4</sup>

### *Chronic Disease*

Chronic disease is a long-lasting illness or condition that can be controlled but not cured. Between 2004 and 2014, chronic diseases ranked consistently among the top 10 causes of death in Clark County, the highest incidence of which occurred in the 89106 and 89101 zip codes.<sup>12</sup>

Clark County compared favorably to the nation on obesity and physical activity indicators. This may be due in part to an increase in grant funding to address physical activity and healthy eating.<sup>12</sup> However, tailored interventions are still needed to address high rates of obesity in adolescents and non-Hispanic Blacks.<sup>3</sup> Continued investment in programming will be critical to continued progress.

Clark County heart disease mortality rates compare favorably to other U.S. counties. Among racial groups, non-Hispanic Blacks have the highest heart disease mortality rates (232.5/100,000 population), followed by non-Hispanic Whites (222.7/100,000) in 2014.<sup>12</sup>

Cancer mortality rates in Clark County decreased from 191.8 to 165.6 deaths per 100,000 population between 2004 and 2014. This compares favorably to other U.S. counties, and is close to meeting the Healthy People 2020 (HP 2020) target of 161.4 deaths per 100,000 persons. Non-Hispanic White residents had higher cancer mortality rates than other groups in recent years.<sup>12</sup>

Mortality rates from chronic lower respiratory diseases have been relatively stable between 2004-2014. While non-Hispanic Whites tended to have the highest mortality rates due to chronic lower respiratory diseases, rates in non-Hispanic Blacks increased substantially from 2011 to 2014.<sup>12</sup>

Mortality rates from cerebrovascular diseases have generally decreased. However, in 2014, 3.9% of Clark County Medicare beneficiaries were treated for stroke.<sup>3</sup> This is higher than the U.S. county median rate of 3.3%, with higher incidence rates noted among non-Hispanic Black and Asian/Pacific Islander residents.<sup>3,12</sup>

Diabetes mortality rates were relatively stable over the past decade in Clark County, with non-Hispanic Black residents at higher risk.<sup>12</sup> Among Clark County Medicare beneficiaries, hospitalization rates due to long-term complications of diabetes were higher than national comparisons, indicating opportunities for improved diabetes management.<sup>3</sup>

In 2014, 18.8% of Clark County Medicare beneficiaries were treated for chronic kidney disease, which is high compared to other U.S. counties. As with many other chronic diseases, non-Hispanic Black residents experienced much higher mortality risks than other populations.<sup>3</sup>

### *Infectious Diseases*

In 2014, there were 25.8 deaths per 100,000 persons due to influenza and pneumonia in Clark County, compared with a national rate of 15.1 per 100,000.<sup>12</sup>

Clark County has a high rate of tuberculosis (TB) (3.7/100,000 persons) compared to the U.S. rate (3.0/100,000 persons).<sup>27</sup> Clark County has experienced a substantial increase in pediatric (children < 5 years) TB cases. The U.S. data does not reflect a similar increase in this population. One potential explanation is the close contact between these children and individuals who were previously housed in a corrections facility and unknowingly developed active TB.<sup>12</sup> The most important risk factor for tuberculosis is being born in a high risk country or being a U.S.-born child of parents from a high risk country of origin.<sup>28</sup>

Rates of sexually transmitted diseases (STDs) have been increasing throughout the nation and in Clark County. In Clark County, the incidence of syphilis has risen much more quickly than the rest of the nation.<sup>11</sup> Rates of condom use are low among teenagers, indicating a potential need for improved education in this area.<sup>3</sup>

Although Clark County represents only 73% of Nevada's total population, it has 89% of all new HIV diagnoses in the state (383 cases in 2014). The highest risk factors include for males, male-to-male sexual contact (78%) and, for females, heterosexual contact with no documented risk factors or HIV infections of their partner(s) (54%).<sup>12</sup>

Hepatitis A rates have dropped dramatically since 2000, placing Clark County in the lowest ten states in the U.S. Acute hepatitis B rates have declined from 2.94 in 2000 to 0.87 per 100,000 in 2014.<sup>12</sup> The highest rates are in residents aged 25-39. Except for a spike due to an outbreak at an endoscopy clinic, the incidence of acute new hepatitis C in Clark County has remained relatively low and steady at 0.1/100,000 population.<sup>12</sup>



## *Injuries*

Unintentional injury death rates have been higher for males than females. While both have declined from 2004-2014, the male rate decreased by 17% and the female rate by 8.8%. Rates among non-Hispanic White and Black residents were about twice as high as among other racial/ethnic groups.<sup>12</sup>

Unintentional injuries, a leading cause of death in those under the age of 25, fall into several categories. Among the younger children, suffocation resulted in the most infant (<1 year) injury deaths, while drowning was the most common injury mechanism for those aged 1-4 years. Motor vehicle crashes were the leading cause of injury deaths among those age 5-19 years, while poisoning among those aged 20-24 years.<sup>12</sup>

## *Environmental Health*

Clark County falls short of meeting national benchmarks on four of five indicators of environmental health. These include air pollution, driving alone to work, long commutes, and severe housing problems.<sup>7</sup>

## *Mental and Behavioral Health*

Suicide mortality is considerably higher in Clark County than in the nation.<sup>7</sup> In 2014, the suicide death rate was 17.6 deaths per 100,000 population in the county, compared with 13 per 100,000 for U.S. overall. For non-Hispanic Whites, the rate was more than twice as high as for other racial/ethnic groups.<sup>12</sup>

Due to the implementation of multiple tobacco cessation programs, tobacco use has dropped dramatically. However, the current smoking prevalence for adults (17.1%) is still above the national HP 2020 target of 12%.<sup>5</sup>

About 13.3% of Clark County adults reported recent binge drinking in 2013, comparing favorably to the state rate of 15.2%. Among high school students, those identifying as Hispanic had the highest rate of binge drinking at 20.8%.<sup>3</sup>

Drug-induced deaths from drug poisonings and those attributed to drug dependence or addiction nearly doubled over the past decade. Drug overdose is now the leading cause of injury mortality. Rates for Clark County were approximately 70% higher than the nation in 2010-2011. Close to two-thirds of drug overdoses involved opioid analgesics. Adults aged 45-54 had higher overdose fatality rates involving opioid analgesics than other age groups, with non-Hispanic Whites representing the majority of opioid analgesics overdoses. Nevada also had a higher-than-the-nation prescribing pattern for opioid analgesics.<sup>32,33</sup>

## *Maternal and Child Health*

Slight declines in neonatal and post-neonatal deaths have been observed in Clark County in recent years.

In 2013, 36% of infant deaths in the U.S. were due to preterm-related complications.<sup>34</sup> During this year, 10.4% of all births in Clark County were preterm. The rate was higher for Black mothers (13.2%).<sup>36</sup> The proportion of low birth weight births in Clark County was 8.0% in 2013. This approaches the national HP 2020 target of 7.8%. However, there were significant

disparities between racial/ethnic groups; 12.3% of low birth weight infants were born to Black mothers.<sup>36</sup> In 2013, 70.3% of all mothers began receiving prenatal care in the first trimester. The proportion was highest among White mothers (81.3%) and lowest among Hispanic (61.3%) and Black (62.3%) mothers, suggesting the need for tailored interventions for Hispanic and Black mothers.<sup>12</sup>

Drinking alcohol during pregnancy can cause multiple complications. In 2014, 99.5% of Clark County's expectant mothers reported abstinence from alcohol. In the same year, self-reported abstinence from cigarette smoking during pregnancy reached 96.1%, short of the HP 2020 target of 98.6%.<sup>41</sup>

Teens giving birth can result in negative health, social, and economic consequences. In Clark County, the teen birth rate was 32.1 live births per 1,000 females aged 15-19 in 2011-2013, higher than the statewide rate of 31.5/1,000.<sup>3</sup>

## Community Themes and Strengths Assessment

The CTSA defines how quality of life is perceived by community members. It identifies what is important to our community and what assets we have that can be used to improve community health.

Methodology included two large group meetings, additional focus groups, and interviews. There was an additional quality of life questionnaire sent to community members. This expansive inclusion allowed a broad spectrum of participation and increased input. Themes and the quality of their strength (good, fair, poor) as well as their perceived importance to the community were extracted.

Participants identified a large number of assets inclusive of the community history, future plans, local community organizations, the public and private sectors, the community environment, and numerous volunteer organizations. Areas of weakness that dominated much of the discussion included the need for improvements in education, health care, the economy, and built environment. The main theme revolved around the perception that although the community has many assets, there is a strong need to improve the surrounding public infrastructure to support and advance identified assets.

## Local Public Health System Assessment

The LPHSA explored competencies, capacities, and future directions of our local public health and health care delivery systems. The assessment, using the National Public Health Performance Standards Program (NPHPSP) local survey and analysis instrument, focused on the Ten Essential Public Health Services. Surveys were sent to a broad scope of individuals and agencies and then were forwarded to additional participants. Additional targeted assessments with specific survey questions and invitees were completed. Survey results indicated the greatest perceived local public health system needs were for improvement in monitoring health status, mobilizing partnerships, assuring a competent workforce, and researching innovative solutions. None of the 10 essential services ranked in the top 25%. Enforcing laws and regulations that protect health and ensure safety ranked the highest. Two interesting themes were revealed. First,

multiple participants noted the need to increase coordination and communication among agencies. Second, there was a general lack of participants self-identifying as part of the local public health system. Addressing the former issue may assist in resolving the latter issue.

## Forces of Change Assessment

The FOCA assists the community in discovering what forces may influence and change the community's health and quality of life and the local health system. The survey, initially completed in 2012, was reviewed in 2015 with no new findings. The survey was based on the National Association of County and City Health Officials (NACCHO) guidelines and input from the CHA steering committee. Efforts were made to identify and invite a minimum of two agencies from each sector of the local public health system. There was a good response with 52 participants. Based on the findings from both the 2012 and 2015 surveys, it was determined that Clark County should pay special attention to the following forces and their associated opportunities and threats:

- Impact of political changes:
  - Affordable Care Act
  - Funding allocations
- Composition and quality of the healthcare system
- Environmental changes:
  - Climate change
  - Water scarcity
- Socioeconomic forces:
  - Unemployment
  - Education

Findings from the CHA are used to guide the development of a Community Health Improvement Plan (CHIP). The CHIP will direct and guide the development of SNHD's and other community partners' activities through the next three to five years.

# Acknowledgements

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Special thanks to the members of the Clark County Community Health Assessment Steering Committee, who represented the following organizations:

- American Heart Association
- Boulder City Hospital
- Catholic Charities
- Center for Progressive Policy and Progress
- Clark County School District
- Clark County Social Services
- Dignity Health – St. Rose Dominican Siena, San Martin, and Rose de Lima campuses
- Federal Reserve Bank of San Francisco
- Las Vegas Chamber of Commerce
- March of Dimes
- Nevada Hand
- Southern Nevada Health District
- United Way
- University Medical Center
- University of Nevada — Las Vegas
- University of Nevada — Reno

Additional appreciation goes to all community organizations, members and partners who participated in assessment activities. Their participation ensured a representative, community-driven approach to health improvement. Together, participants represented the following community sectors:

- Community Core (e.g. citizens, community-based organizations, faith institutions, tribal organizations)
- Physical Environment (e.g. transit, parks and recreation, city planning)
- Health and Social Services (e.g. community health centers, mental health providers, drug treatment centers)
- Schools (e.g. local school district, colleges and universities)
- Safety (e.g. emergency services, law enforcement)
- Community Assistance (e.g. advocacy groups, non-governmental organizations)
- Government and Politics (e.g. elected officials, civic groups, neighborhood associations, military)
- Communications (e.g. radio stations, TV stations, local magazines)
- Private Industry (e.g. local employers)

# 1 Introduction

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*Vision: Healthy people in a healthy Southern Nevada*

The World Health Organization defined health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”<sup>1</sup> To improve the health of our community we need to understand how various factors — such as where and how we live, work, play, and learn; perceptions we have; and the decisions we make — influence health. We need to identify the health issues of an area and their larger context and then develop an ongoing plan to address key steps in the greater health planning process.

To measurably improve the health of the residents of Clark County, SNHD, in collaboration with the University of Nevada, Las Vegas and the Nevada Public Health Foundation, engaged in a comprehensive community health planning process. The National Association of County and City Health Officials (NACCHO), the Nevada Public Health Foundation, and SNHD funded this effort.

There are two main components of the community health planning process:

- A. A community health assessment (CHA), presented in this report, that identifies the health-related needs and strengths of Southern Nevada, and
- B. A community health improvement plan (CHIP), presented in a separate report, that identifies major health priorities, overarching goals, and specific strategies to be implemented in a coordinated plan throughout Clark County.

This report is available at <http://www.healthysouthernnevada.org/>.

## 1.1 Purpose

The findings of this CHA report will help guide future services, programs, and policies for multiple agencies in Clark County, inform the development of the Southern Nevada CHIP, and assist Clark County hospitals in their efforts to meet IRS 990 requirements under the Affordable Care Act. Furthermore, the CHA and CHIP are prerequisites for Public Health Department Accreditation by the Public Health Accreditation Board (PHAB), which recognizes health departments dedicated to the advancement of quality and performance.

The Clark County CHA was conducted to fulfill several objectives:

- To use primary, secondary, quantitative, and qualitative data from a variety of sources to examine and compare the current health status of Clark County to state and national indicators.
- To describe the demographics of Clark County residents.
- To explore the current health priorities of Clark County residents within the

socioeconomic context of their communities and to identify and describe health disparities.

- To examine the forces of change and other factors contributing to health challenges, including social determinants of health, policies, risky behaviors, environmental factors, etc.
- To identify community strengths, resources, and gaps in services which inform and guide funding and programming priorities for Clark County.

The CHA provides data and information to ascertain the priority issues, gaps, and assets. It assists in the development of the Community Health Improvement Plan (CHIP). As an ongoing process the CHA/CHIP further establishes accountability by ensuring measurable health improvement based on the performance measures identified in the CHIP. This process looks to engage multiple organizations working together and sharing resources to contribute to community health improvement.

Clark County encompasses numerous rural towns and urban areas with Las Vegas being the largest urban area. Clark County covers approximately 8,000 square miles. A deliberate effort was made to include data and perspectives of community members from across Clark County. Because this assessment only captures a moment in time, programs and policies discussed here will undoubtedly evolve after publication. Further examination of initiatives and resources are presented in the accompanying CHIP report and future updates to both the CHA and CHIP can help track progress over time. These updates are available at <http://www.healthysouthernnevada.org/>.

## 1.2 CHA Steering Committee

In order to develop a shared vision for the community and help sustain lasting change, SNHD engaged agencies, organizations, and residents of Clark County to form the CHA Steering Committee. This committee oversaw the development of the CHA and MAPP processes and engaged multiple community members in each of the four MAPP assessments.

## 1.3 MAPP Process

This CHA considers health by an expansive definition as encompassing lifestyle behaviors, access to and quality of clinical care, social and economic factors, and the physical environment. SNHD selected Mobilizing for Action through Planning and Partnership (MAPP)<sup>2</sup> as the framework to guide this CHA. MAPP is a participatory and collaborative community-driven strategic planning process, developed by NACCHO, to help communities improve public health.

The six phases of the MAPP process are:

- **Organize for Success & Partnership Development;**
- **Visioning;**
- **Four MAPP Assessments;**
- Identify Strategic Issues;



- Formulate Goals and Strategies; and
- Action Cycle: Plan, Implement, Evaluate.

This CHA report encapsulated the first three phases, bolded above, and is structured around the four MAPP assessments. The CHIP provides detailed information on the remaining three MAPP phases.



Source: <http://archived.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/marcomm.cfm>

### 1.3.1 Community Health Status Assessment

This component utilized social, economic, demographic, and health data from primary and secondary sources to assess the health of the community. This step provided an understanding of Clark County and its residents and helped to identify areas of concern in community health and quality of life. It determined:

- How healthy are our residents?
- What does the health status of our community look like?

### 1.3.2 Community Themes and Strengths Assessment

This assessment provided primary qualitative data on what Clark County residents perceive as important health and community issues and which local assets are available to address these health and community issues. Qualitative information was collected through two community-wide meetings, focus groups, individual interviews, and a Quality of Life questionnaire. This

assessment answers:

- What is important to our community?
- How is quality of life perceived in our community?
- What assets do we have that can be used to improve community health?

### *1.3.3 Local Public Health System Assessment*

The human, informational, financial, and organizational resources that impact public health were evaluated in this step. A community survey and a stakeholder meeting were used to collect primary quantitative and qualitative data, which were then submitted to the National Public Health Performance Standards Program (NPHSP) for analysis. This assessment determined:

- What are the components, activities, competencies, and capacities of our local public health system?
- How are the Essential Services being provided to our community?

### *1.3.4 Forces of Change Assessment*

This assessment identified such forces as legislative, technological, and environmental changes that may affect Clark County and its public health system. Through focus groups and key informant interviews, community partners identified the major forces they perceived as impacting the local public health system and, in turn, the health and quality of life of Clark County residents. This component identified:

- What is occurring or might occur that affects the health of our community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

## 2 Community Health Status Assessment

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### 2.1 Purpose

The Community Health Status Assessment (CHSA) identifies health and quality of life issues that are areas for improvement in Clark County. The CHSA seeks to answer the questions:

- How healthy are our residents?
- What does the health status of our community look like?

### 2.2 Methods

Quantitative social, economic, and health data for Nevada and Clark County came from a variety of primary and secondary data sources at the local, county, state, and national levels.

The Healthy Southern Nevada community dashboard provides over 190 continually updated primary and secondary data indicators of health and quality of life in Clark County from over 24 data sources at <http://www.healthysouthernnevada.org/>. Data obtained through this platform are indicated throughout the report with an endnote reference to this source.<sup>3</sup>

In addition, a number of other secondary data sources were used. Similarly, these sources of health data are marked with endnote references throughout the report. Tables, charts, and figures are labeled directly with data sources. Additional referenced reports are also cited in endnotes.

- Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC)<sup>4</sup>
- Behavioral Risk Factor Surveillance System (BRFSS), Nevada Division of Public and Behavioral Health<sup>5</sup>
- Bureau of Labor Statistics<sup>6</sup>
- County Health Rankings & Roadmaps<sup>7</sup>
- Kaiser Family Foundation State Health Facts<sup>8</sup>
- National Vital Statistics System<sup>9</sup>
- Nevada Youth Risk Behavior Survey<sup>10</sup>
- Sexually Transmitted Disease Surveillance, CDC<sup>11</sup>
- Southern Nevada Health District<sup>12</sup>
- Southern Nevada Health District: Socioeconomic Characteristics of Communities<sup>13</sup>
- Trust for America's Health: Key Health Facts about Nevada<sup>14</sup>
- U.S. Census Bureau: American Community Survey<sup>15</sup>
- Youth Risk Behavior Surveillance System (YRBSS), CDC<sup>16</sup>

## 2.3 Demographics

All counties within Nevada had tremendous population growth within the last decade. However, the majority of the population remains within Clark County. Clark County comprises only 7% (8,091 square miles) of Nevada's land mass (110,567 square miles) but contains 72% of the state's total population. Because of Clark County's large contribution to the state population, caution should be exercised when comparing the county to the state.

### 2.3.1 Race/Ethnicity, Gender, and Age

The diversity of Clark County's population, like its core population, is also increasing. The largest racial group, White (including Hispanic/Latino ethnicity), makes up 62.5% of the population, followed by the populations identifying as Black or African American (11.1%), and as Asian (9.3%). In addition, 30.3% of Clark County residents identify as Hispanic or Latino, a higher percentage than seen across Nevada and much higher than the rest of the U.S.<sup>15</sup>

**Table 2-1: Population Demographics, 2014**

<b>Demographics</b>	<b>Clark County</b>	<b>Nevada</b>	<b>U.S.</b>
Total Population	2,069,681	2,839,099	318,857,056
<b>Race</b>			
White	62.5%	68.0%	73.4%
Black or African American	11.1%	8.6%	12.7%
American Indian and Alaska Native	0.5%	1.1%	0.8%
Asian	9.3%	7.8%	5.2%
Native Hawaiian and Other Pacific Islander	0.7%	0.7%	0.2%
Other race	11.1%	9.5%	4.7%
Two or more races	4.8%	4.4%	3.0%
<b>Ethnicity</b>			
Hispanic or Latino	30.3%	27.8%	17.3%
<b>Gender</b>			
Female	49.9%	49.7%	50.8%
Male	50.1%	50.3%	49.2%
<b>Age</b>			
<5	6.4%	6.2%	6.2%
5-17	17.4%	17.1%	16.9%
18-24	9.0%	9.1%	9.9%
25-44	29.0%	27.9%	26.3%
45-64	25.1%	25.6%	26.2%
65-74	8.3%	8.8%	8.3%
75+	5.0%	5.3%	6.2%

Source: American Community Survey, 2014<sup>15</sup>

Two-thirds of Clark County residents spoke only English at home as of 2014. Among the remaining third, the majority of residents spoke Spanish or Spanish Creole at home.<sup>15</sup>

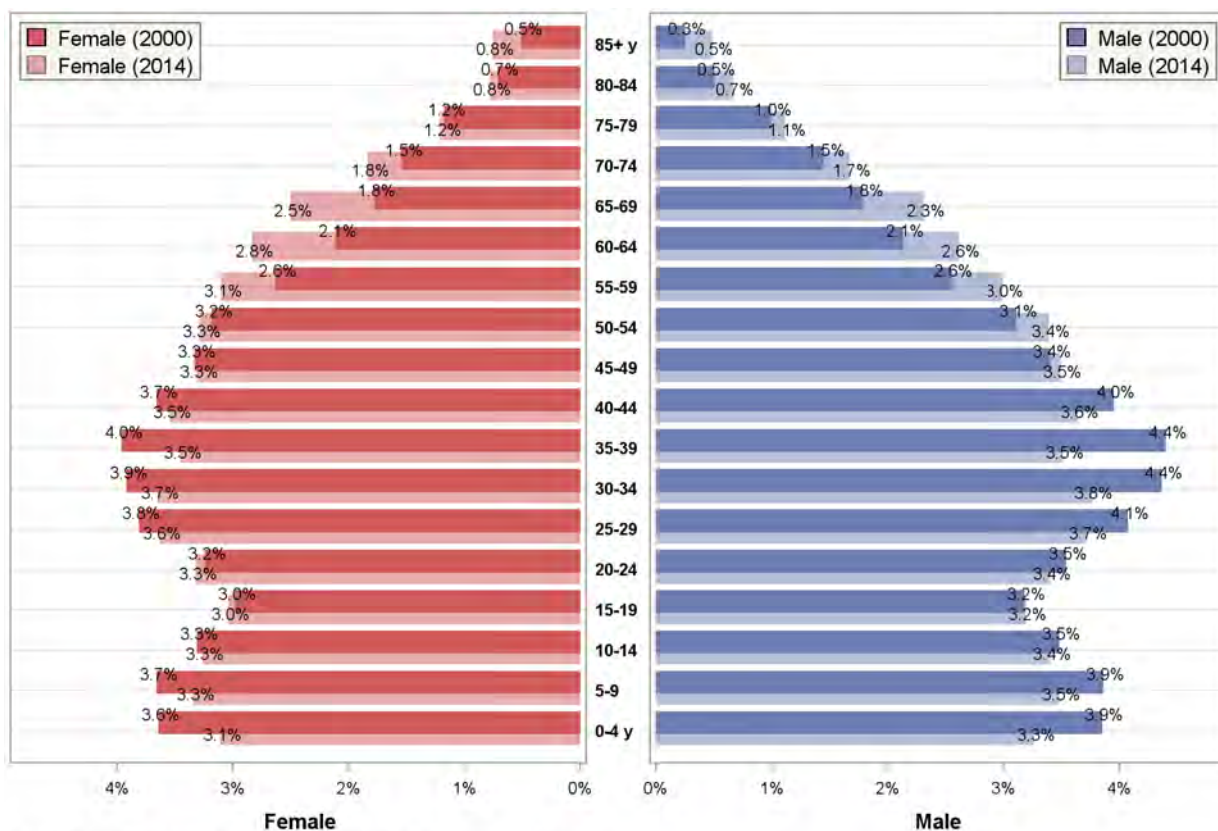
**Table 2-2: Language Spoken at Home among Population 5 years and Over, 2010-2014**

Language Spoken at Home	% of the Population 5 years and Over
Speak only English	66.3%
Speak a language other than English	33.7%
Spanish or Spanish Creole	23.1%
Other Indo-European languages	2.7%
Asian and Pacific Island languages	6.9%
Other languages	1.1%

Source: American Community Survey, 2010-2014<sup>15</sup>

Compared with the U.S. overall, Clark County's population is less influenced by the numbers of Baby Boomers (persons born between 1946 and 1964).<sup>9</sup> However, the changing age makeup between 2000 and 2014 (Figure 2-1) reveals a growing aging population. In Figure 2-1 below, residents aged 36-54 were considered Baby Boomers in the year 2000. By 2014, Baby Boomers were those aged 50-68.

**Figure 2-1: Population by Gender and Age, Clark County, Nevada, 2000 and 2014**



Source: National Vital Statics System, Centers for Disease Control and Prevention<sup>9</sup>

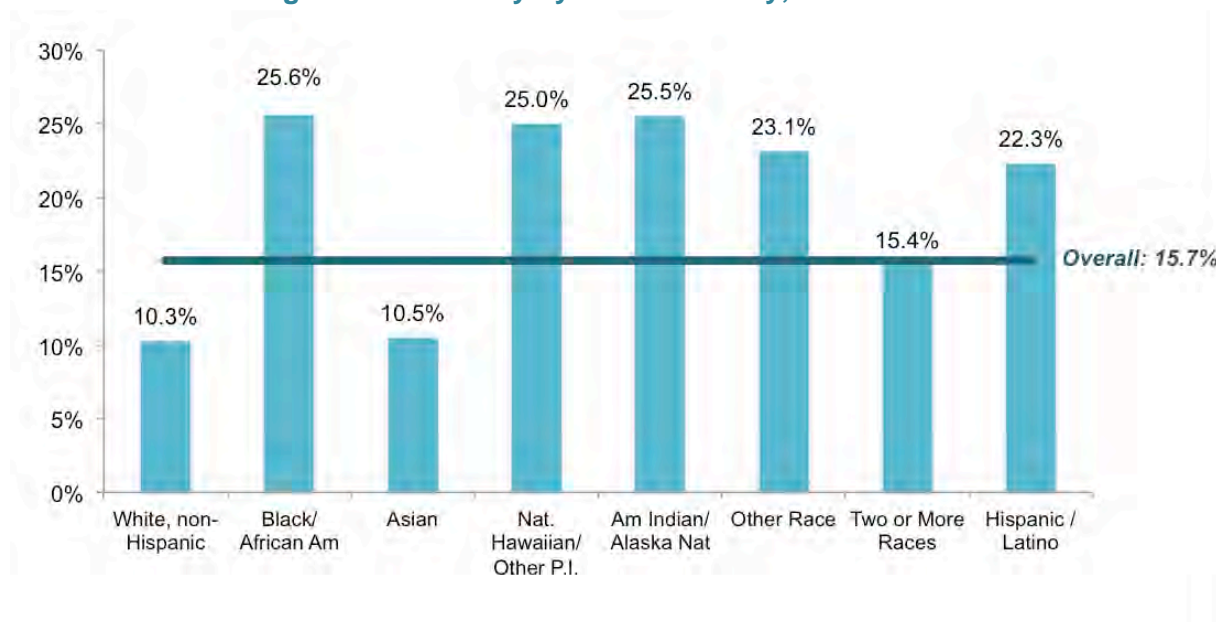
### 2.3.2 Socioeconomic Factors

A community's health is affected by multiple determinants of health, including social and economic factors, physical environment, health behaviors, and — to a lesser extent — clinical care. Each of these determinants contributes a certain amount to the overall health of the population. It is the context of people's lives that has the greatest influence on their health and health outcomes. The choices people make matter, but these choices are influenced by socioeconomic factors. At times even with the best intentions, it may be unlikely that individuals are able to directly control health outcomes as they are limited by their social and economic factors. These factors include income, education, and employment, among others.

#### Income and Poverty

Because studies have shown that low socioeconomic status has been associated with poorer health, a population's financial demographics are an important factor in assessing the overall health of a community. Data from the American Community Survey indicate that the financial status of Clark County residents has steadily declined in recent years.<sup>15</sup> In 2005-2009, 10.9% of Clark County residents of all ages were living below the poverty level. The 2010-2014 data show this has increased to 15.7%. Poverty rates were much higher among the Black/African American, Native Hawaiian/Other Pacific Islander, American Indian/Alaska, Native Hispanic/Latino, and Other Race populations.<sup>3</sup>

**Figure 2–2: Poverty by Race/Ethnicity, 2010-2014**



Source: Healthy Southern Nevada Community Dashboard<sup>3</sup>

The poverty rate among children under 18 years of age also rose, from 15.2% in 2005-2009 to 23.0% in 2010-2014.<sup>3</sup>

Based on data from the 2009-2014 American Community Survey, the median per capita and household income for Clark County is comparable to Nevada and slightly lower than the national average.



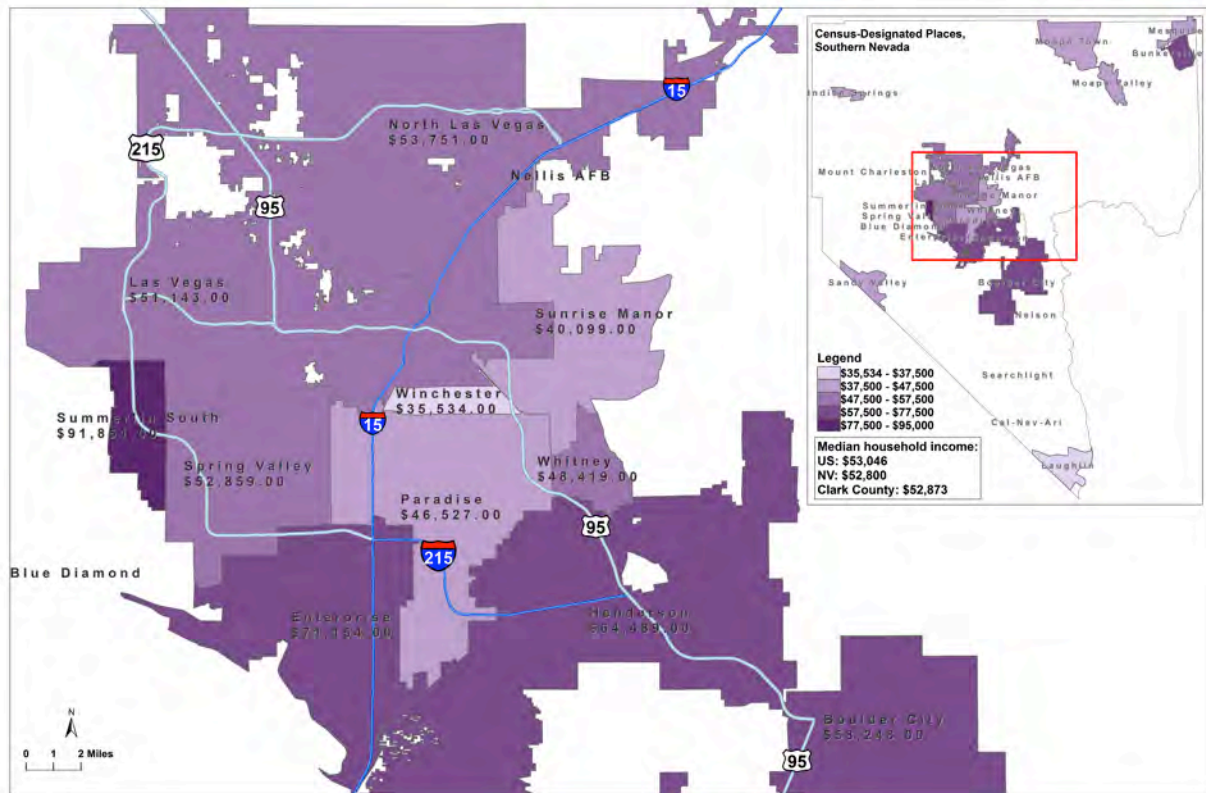
**Table 2-3: Per Capita and Median Household Income, 2010-2014**

	Clark County	Nevada	U.S.
<b>Per capita income</b>	\$26,040	\$26,515	\$28,555
<b>Median household income</b>	\$52,070	\$52,205	\$53,482

Source: American Community Survey, 2010-2014<sup>15</sup>

However, it is important to note that income levels are unevenly distributed throughout the county, as seen in the map below, which provides a visual representation of median household income in 2009-2013. Some rural portions of the county are not represented on the map due to low population counts.<sup>13</sup>

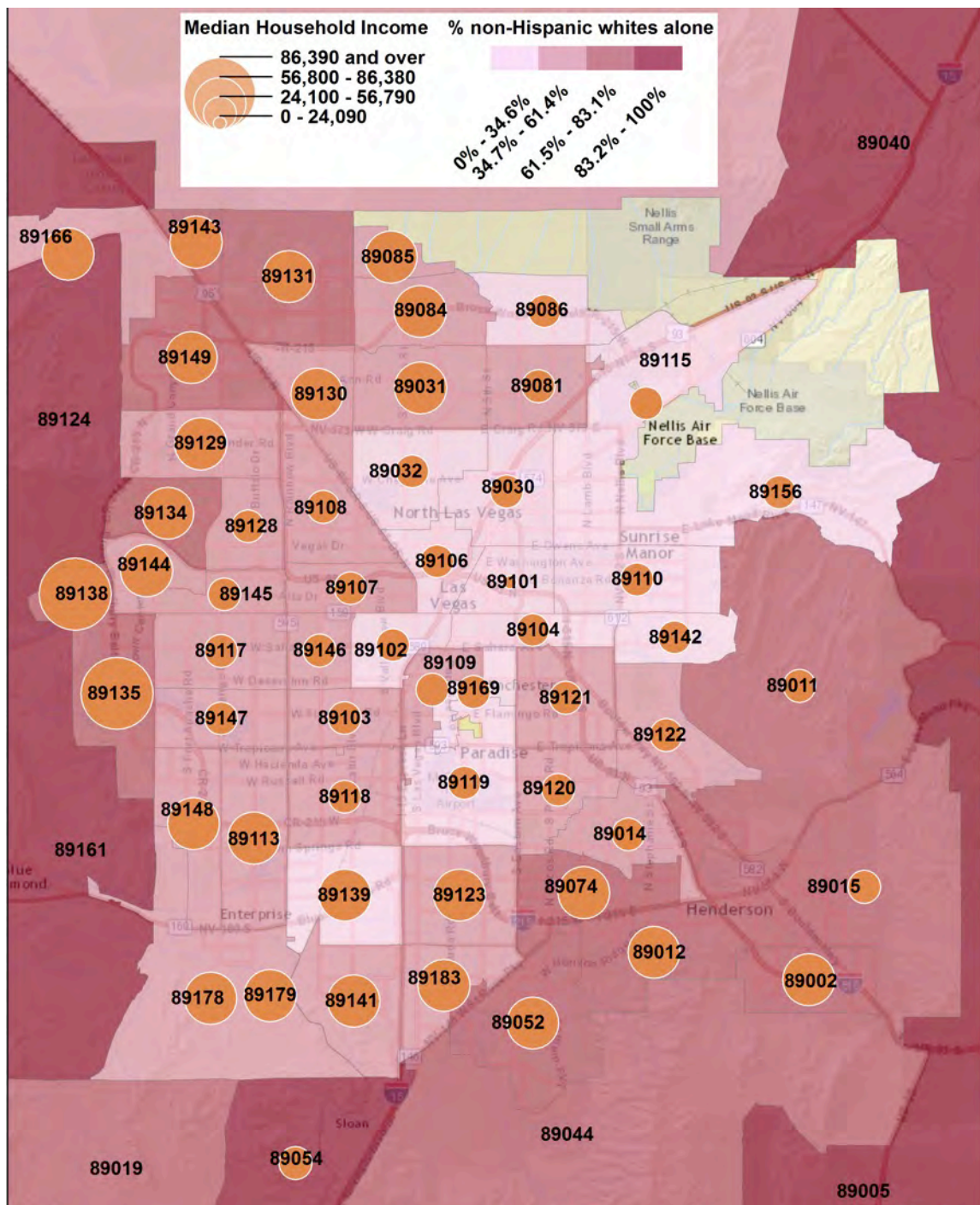
**Figure 2-3: Median Household Income by Census-Designated Places, 2009-2013**



Source: Southern Nevada Health District — Socioeconomic Characteristics of Communities<sup>13</sup>

Data show that since the 2007 recession, income inequalities have increased for racial minorities, especially Hispanic and African-American groups.<sup>17</sup> This income inequality holds true throughout Clark County, Nevada and the U.S, with correlations between lower income areas and higher concentrations of Hispanic and African American residents.<sup>18</sup> The figures below overlay median household income with race/ethnic distribution for the metro areas of Clark County.

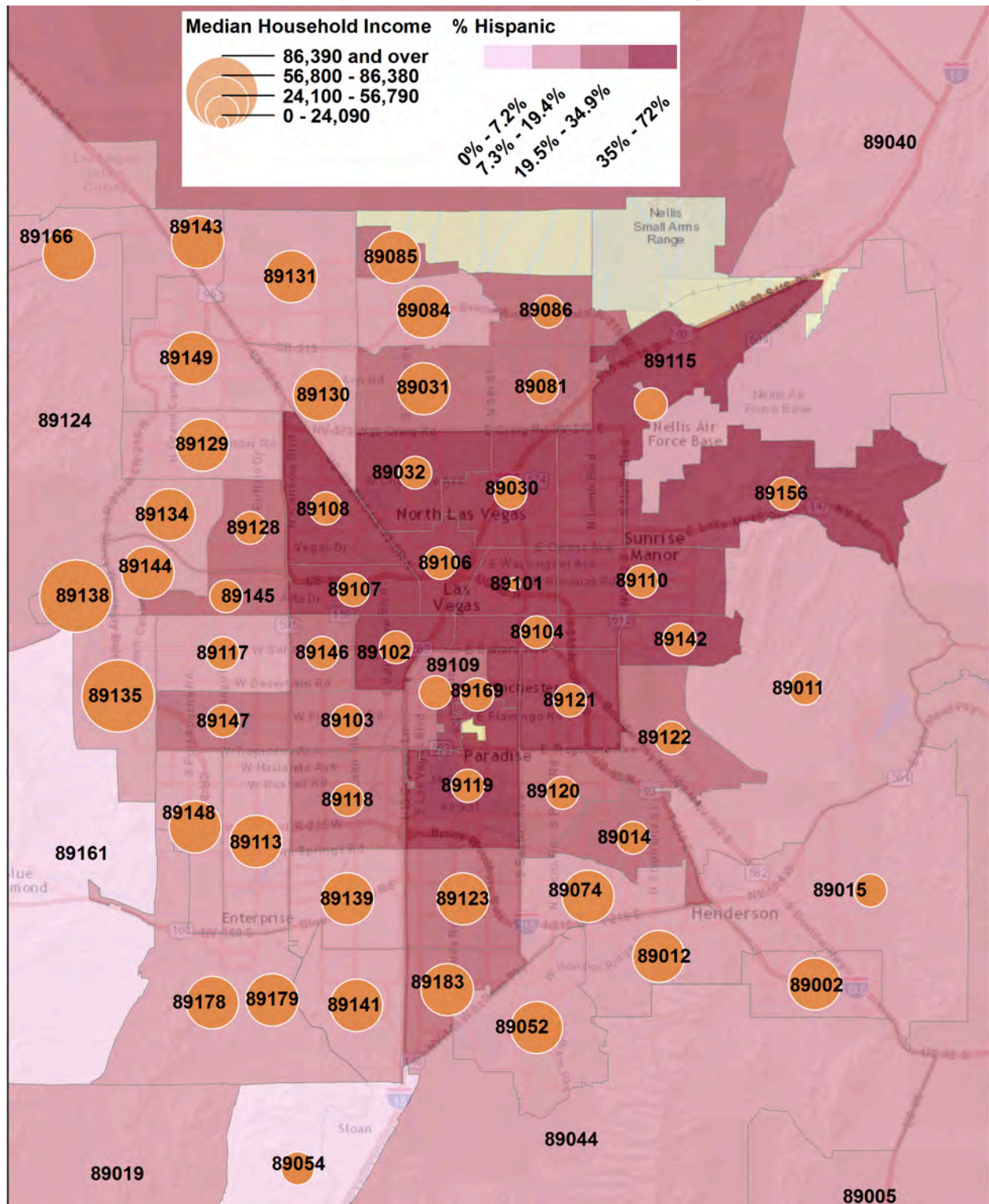
**Figure 2–4: Median Household Income by Residential Zip Codes with Percent Non-Hispanic Whites Alone Overlay, Southern Nevada Metro Enlargement, 2014**



Source: ESRI and American Community Survey<sup>15, 19</sup>

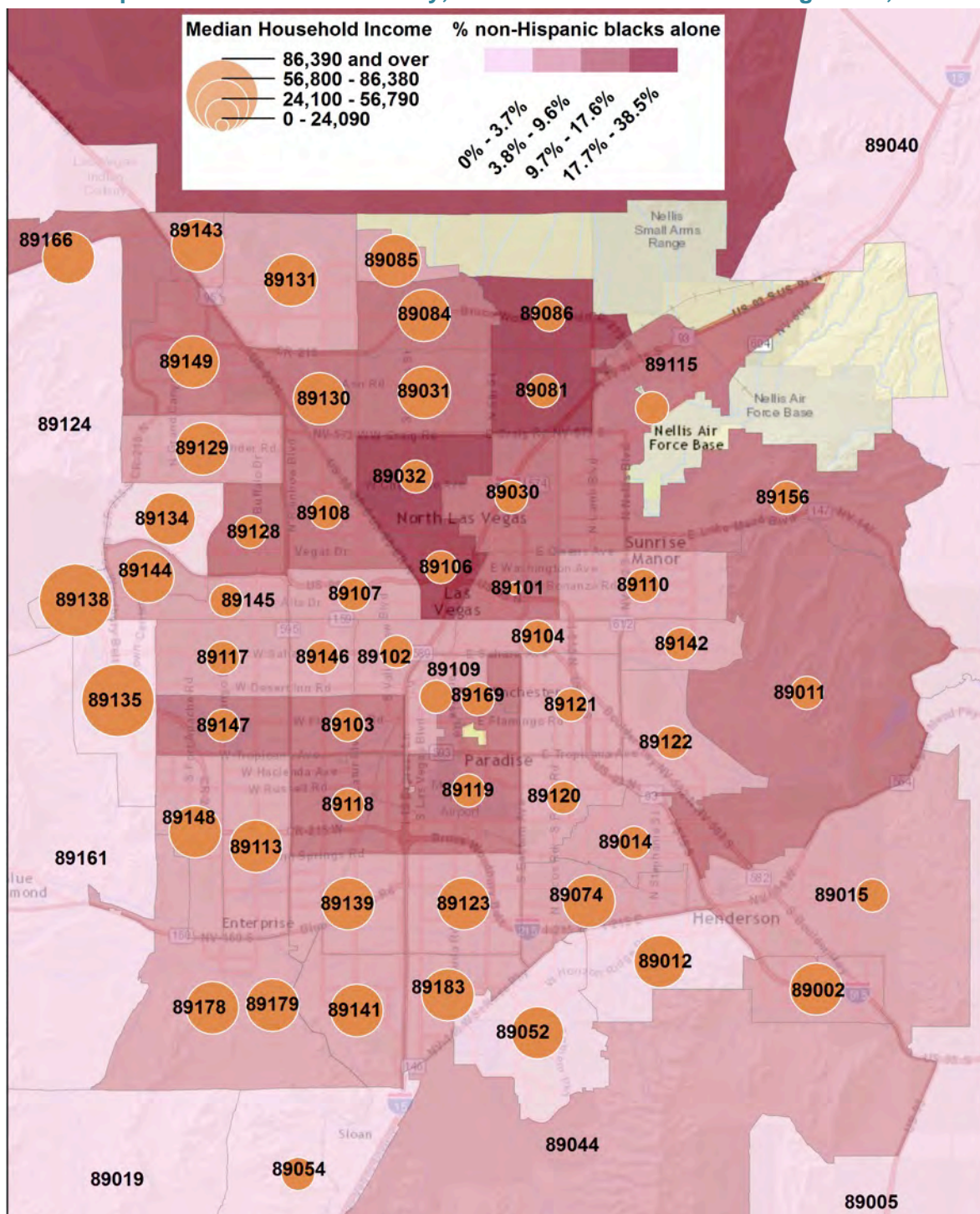


**Figure 2-5: Median Household Income by Residential Zip Codes with Percent Hispanics Overlay, Southern Nevada Metro Enlargement, 2014**



Source: ESRI and American Community Survey<sup>15, 19</sup>

**Figure 2–6: Median Household Income by Residential Zip Codes with Percent Non-Hispanic Blacks Alone Overlay, Southern Nevada Metro Enlargement, 2014**



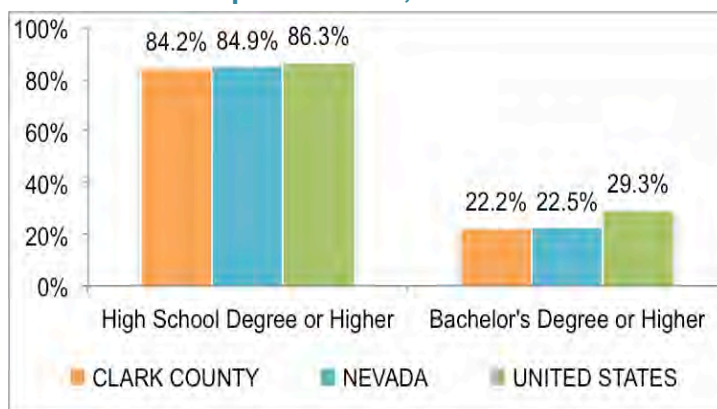
Source: ESRI and American Community Survey<sup>15, 19</sup>



## Educational Attainment

Poor educational attainment can have a substantial impact on health status. As of 2014, Clark County residents had slightly lower education levels than the national average. Furthermore, rates of college graduation vary substantially across race/ethnic groups. While 36.6% of Asian and 26.8% of White residents received at least a bachelor's degree, only 8.6% of Hispanic/Latino residents received a bachelor's degree or higher.<sup>15</sup>

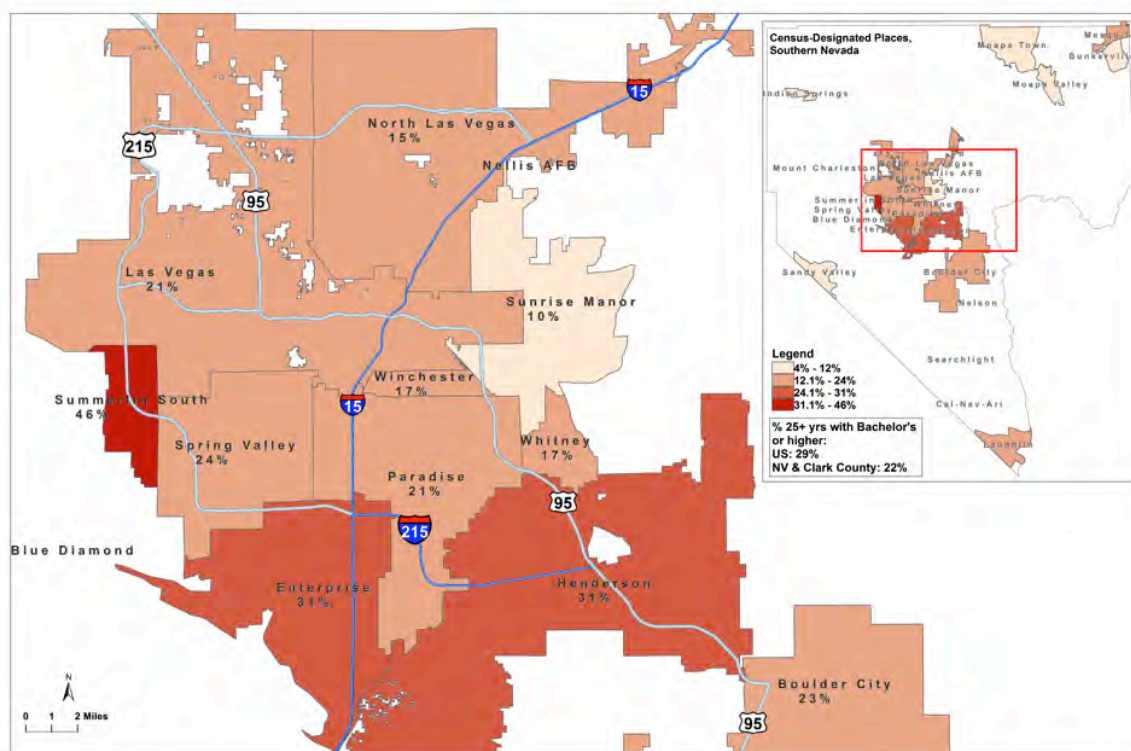
**Figure 2-7: Educational Attainment among Population 25+, 2010-2014**



Source: American Community Survey, 2010-2014<sup>15</sup>

The distribution of educational attainment is geographically uneven across Clark County. As seen in Figure 2-8, Summerlin South, Enterprise, and Henderson have much higher percentages of residents with at least a bachelor's degree.

**Figure 2-8: Percent Population 25 Years and Older with Bachelor's Degree or Higher by Census-Designated Places, 2009-2013**

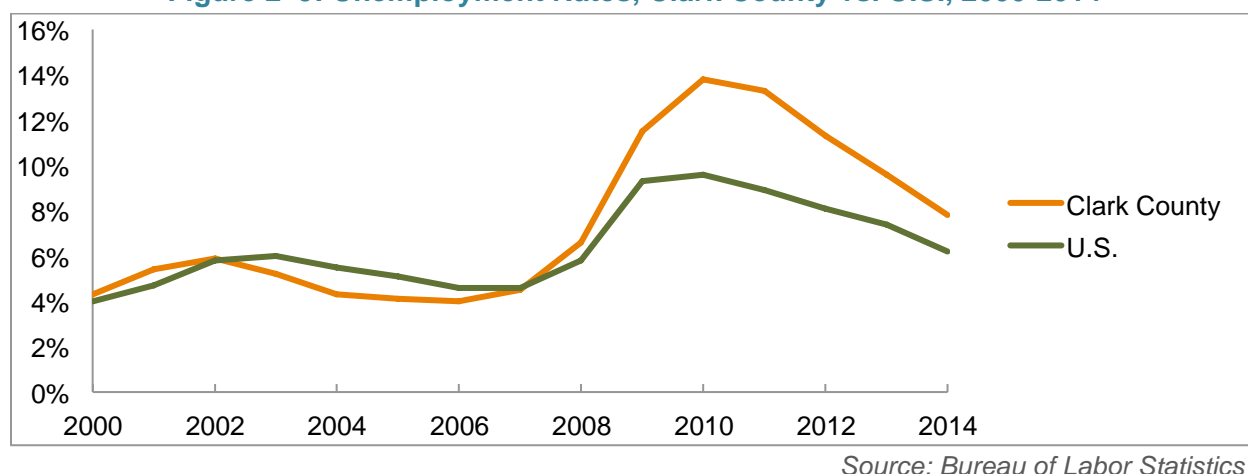


Source: Southern Nevada Health District — Socioeconomic Characteristics of Communities<sup>13</sup>

## Employment

Prior to 2007, Clark County's unemployment rate fluctuated between 4% and 6% and was similar to the U.S. unemployment rate. However, unemployment rose faster since 2008 in the county, reaching 14% in 2010, compared with a national rate of 10% in the same year. As of the end of 2014, Clark County unemployment rates were still above the national average by approximately 2%.<sup>6</sup>

**Figure 2–9: Unemployment Rates, Clark County vs. U.S., 2000-2014**



## 2.4 Access to Healthcare

Access to comprehensive, quality health care services is important for increasing health equity and health-related quality of life. This topic focuses on the critical areas of healthcare professional shortages, including medically underserved areas, insurance coverage, and the public health department.

### 2.4.1 Healthcare Professional Shortages and Insurance Coverage

Access to affordable, quality health care is important to physical, social, and mental health. Neighborhoods with low rates of residents with health insurance coverage often have fewer primary care providers, specialty care providers, dentists, mental health workers, hospital beds, and emergency resources than areas with higher rates of residents with health insurance coverage. Even the insured have more difficulty getting care in these areas.<sup>20</sup>

Health insurance helps individuals and families access needed primary care, specialists, and emergency care, but does not ensure access on its own. It is also necessary for providers to offer affordable care, be available to treat patients, and be located in relatively close proximity to patients. Nevada ranks poorly in many of these measures when compared to other states.

In Clark County in 2014, only 78.6% of adults and 90.3% of children had any type of health insurance, falling short of the Healthy People 2020 target of 100%, and ranking Clark County in the bottom quartile of all U.S. counties. Insurance coverage was especially low among the Hispanic/Latino populations.<sup>3</sup>

**Table 2-4: Access to Care Rankings, Nevada**

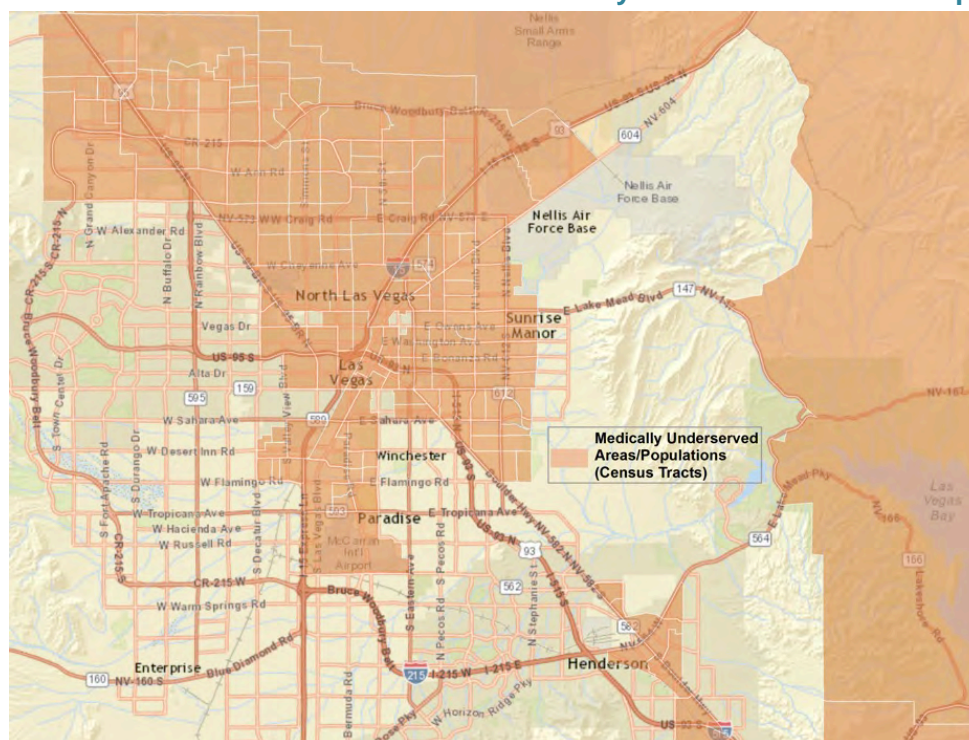
Measure	Value	Ranking	Year(s)
Number of licensed primary-care physicians	NV: 2758	35 <sup>th</sup> /51 (50 states + DC)	2016
Number of physicians in any medical specialty	NV: 2779	36 <sup>th</sup> /51 (50 states + DC)	2016
Proportion of residents who were uninsured	NV: 13% U.S.: 10%	45 <sup>th</sup> /51 (50 states + DC)	2014
Proportion of residents reporting inability to see a doctor due to cost	NV: 17.2% U.S.: 14.3%	42 <sup>nd</sup> /51 (50 states + DC)	2014
Number of hospital beds per 1,000 persons	NV: 2.0 U.S.: 2.5	NV 45 <sup>th</sup> /51 (50 states + DC)	2014
Per capita mental health services expenditures	NV: 89.4 U.S.: 119.6	(No data for FL and NM for ranking)	FY2013

Source: Kaiser Family Foundation<sup>8</sup>

Medically underserved areas have been identified in the central and north urban and in outlying census tracts. Figure 2–10 highlights the medically underserved census tracts of the Southern Nevada metro area.

However, the county compares favorably on some other indicators of healthcare access. As of 2013, there were 55 providers per 100,000 Clark County residents, above the U.S. county median value of 50 providers/100,000 persons. The rate of preventable hospital stays also declined every year from 2009-2013 to 45 per 1,000 Medicare enrollees in the county. This is a measure of how accessible primary care services are in some areas.<sup>3</sup>

**Figure 2–10: Southern Nevada Census Tracts of Medically Underserved Areas/Populations, 2015**



Source: ESRI and HRSA<sup>19, 21</sup>



### 2.4.2 Public Health Department

[SNHD](#) protects the health of Clark County residents by providing community health services such as disease prevention, health promotion, environmental health regulations and inspections, and provision of public health nursing services.

For example, SNHD hosts an annual immunization event for National Infant Immunization Week, primarily targeting babies and infants younger than 2 years old. The event also includes a health fair with vendors who provide health-related services — such as dental/vision screenings and demonstrations of healthier choices — to low-income Clark County residents. The annual Coaches Health Challenge is another sponsored event, which encourages elementary school youth to eat fruits and vegetables and engage in daily physical activity over the course of the program. Participating students track their fruit and vegetable consumption and their physical activity to earn points for their classrooms. In 2015, more than 11,490 CCSD students signed up to participate in the program. The students represented 352 classrooms in 78 local elementary schools.

Despite the crucial role of health departments in ensuring public health, funding is often scarce, as described in a 2012 Institute of Medicine report.<sup>22</sup> Among the 50 U.S. States and the District of Columbia, in FY 2013-2014, Nevada ranked 50<sup>th</sup> in the nation for Health Resources and Services Administration (HRSA) grants to states (\$14.06 per capita), 51<sup>st</sup> in the nation for state investment in public health spending (\$3.59 per capita), and 30<sup>th</sup> in the nation in CDC funding per capita (\$19.76), indicating an acute need for additional financial resources for public health work in Clark County and across all of Nevada.<sup>14</sup>

## 2.5 Self-Assessed Physical and Mental Health

Feeling healthy is associated with both physical and mental well-being. In 2012, Clark County respondents reported a slightly better general health status than was reported by all Nevada respondents, but not as well as all U.S. respondents. Male respondents reported better health than female respondents. Additionally, the data showed wide variations by race/ethnicity. Hispanic residents reported a poorer overall general health status than non-Hispanic White or non-Hispanic Black residents. Non-Hispanic Black residents had the highest proportion (24.1%) of respondents reporting only fair or poor health.

**Table 2-5: Self-Reported Health Status, 2012**

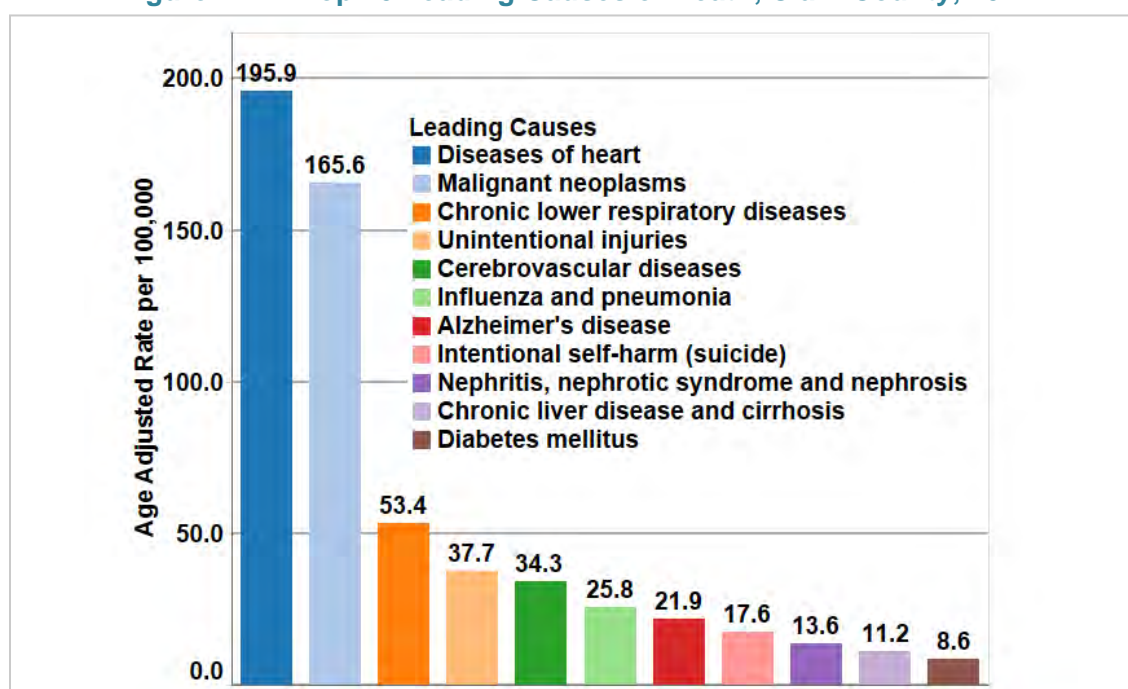
Self-reported Health Status	U.S.	Nevada	Clark County	Male	Female	White	Black	Hispanic
Excellent	19.1%	17.4%	16.7%	18.0%	15.3%	17.7%	16.5%	12.2%
Very good	31.6%	30.8%	30.4%	32.0%	28.8%	35.5%	31.3%	20.8%
Good	31.1%	32.8%	33.1%	32.6%	33.6%	28.9%	27.6%	43.9%
Fair	13.1%	13.2%	13.3%	12.5%	14.1%	12.2%	20.0%	15.2%
Poor	4.9%	5.7%	6.3%	4.8%	7.9%	5.4%	4.1%	7.7%

Source: BRFSS<sup>4</sup>

## 2.6 Chronic Diseases

A chronic disease is a long-lasting illness or condition that can be controlled but not cured. Common examples include heart disease, cancer, chronic lower respiratory disease, stroke, kidney disease, and diabetes. These are among the costliest and most preventable of all health problems. As described by the Centers for Disease Control and Prevention (CDC), chronic disease is the leading cause of death and disability in the United States, accounting for 70% of all deaths (1.7 million) each year.<sup>23</sup> In 2011, at least one million of Nevada's 2.7 million residents were identified as living with at least one chronic disease.<sup>24</sup> In Clark County, chronic diseases were leading contributors to mortality, with heart disease and cancer consistently ranking at the top.

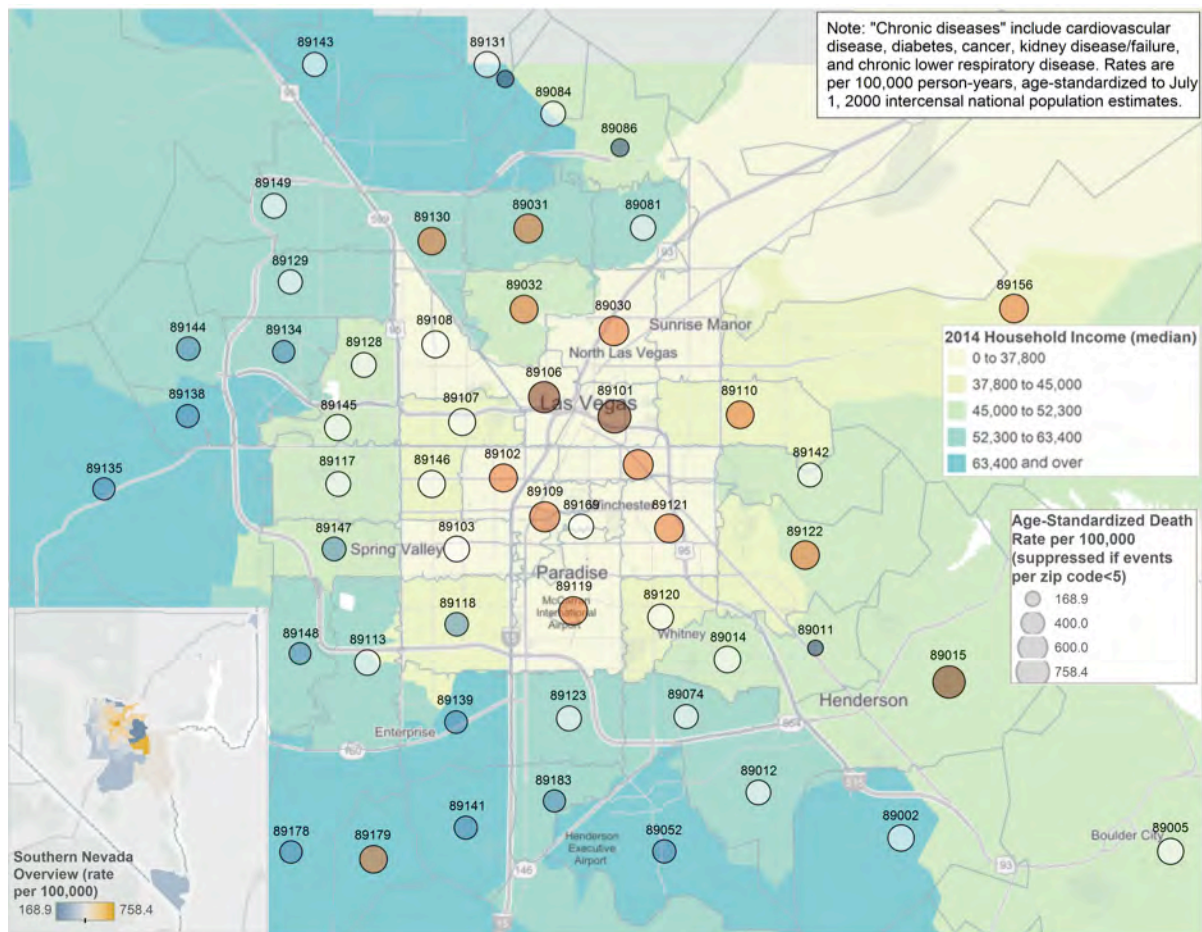
**Figure 2–11: Top 10 Leading Causes of Death, Clark County, 2014**



Source: CDC WONDER<sup>26</sup>

Most chronic diseases can be prevented or controlled through a combination of behavioral changes, early detection, and adequate and appropriate monitoring and treatment. Major behavioral risk factors of chronic disease include lack of exercise or physical activity, poor nutrition, tobacco use, and excessive alcohol consumption.

**Figure 2-12: Age-Adjusted Chronic Disease Mortality, Average 2010-2012**



Source: Southern Nevada Health District <sup>12</sup>

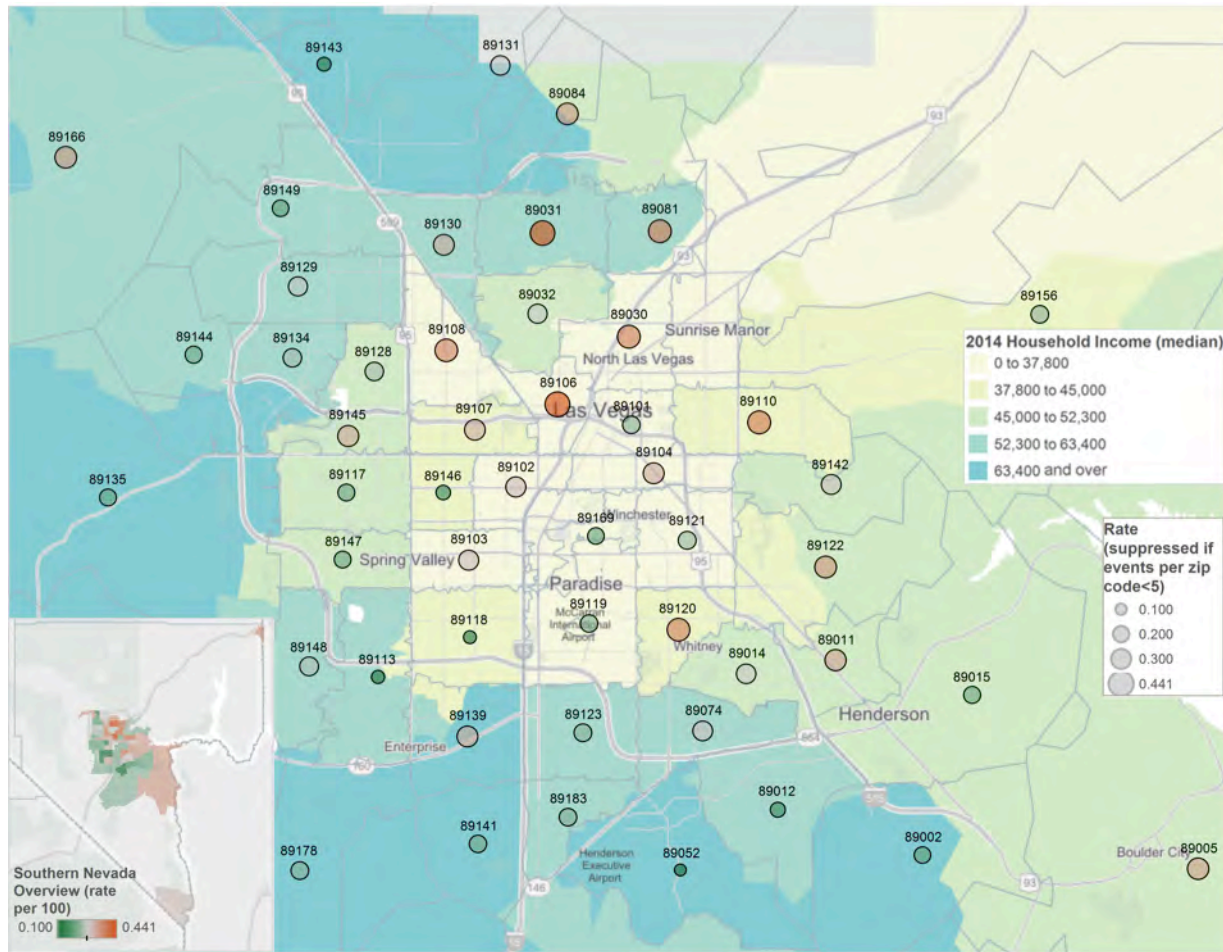
### 2.6.1 Exercise, Nutrition, and Weight

Unhealthy diets and lack of exercise are among the most important yet modifiable behavioral risk factors. They contribute to rising obesity rates and increase the risk for a number of health conditions like cardiovascular disease, type-2 diabetes, cancer, hypertension, stroke, and liver disease. <sup>25</sup>

Compared to national data, Clark County is generally doing well on indicators for obesity and physical activity. In 2012, 25.8% of Clark County adults were obese,\* compared to the median U.S. obesity rate of 31.2%. During the same period, 21.7% of Clark County adults did not participate in any leisure-time physical activity; this also compared favorably to national averages (median: 27.6% across U.S. counties). <sup>3</sup> Since 2010, over \$5 million in grant funding has been allocated towards increasing physical activity and healthy eating in multiple sectors in the community, which has likely contributed to these positive comparisons with the rest of the nation. <sup>12</sup> However, the fact that one-fifth of all adults in Clark County did not participate in any leisure-time physical activity indicates additional progress is needed. <sup>25</sup> Sustained investment in evidence-based strategies is critical to continued success in addressing obesity.

\* Obesity is defined as having a body mass index  $\geq 30$ .

**Figure 2–13: Adult Obesity Prevalence, Average 2011-2013**



Source: Southern Nevada Health District<sup>12</sup>

As of 2013, 12.1% of adolescents in Clark County were obese,<sup>†</sup> with large disparities by race/ethnicity. While only 7.9% of non-Hispanic White adolescents were obese, 17.4% of non-Hispanic Black adolescents and 14.5% of Hispanic adolescents were affected, suggesting tailored interventions are necessary.<sup>3</sup>

Data indicate Clark County needs to expand access to fresh and nutritious foods. As of 2013, 15.0% of residents had experienced food insecurity at some point in the year; among children, the proportion was even higher at 25.3%. Additionally, Clark County residents have limited access to Supplemental Nutrition Assistance Program (SNAP) certified stores, recreation and fitness facilities, and farmers' markets. Unfortunately, Clark County residents also have a high ratio of fast food restaurants per capita.<sup>3</sup>

<sup>†</sup> Obesity for this demographic is defined as being in the top 5<sup>th</sup> percentile for BMI by age and sex.

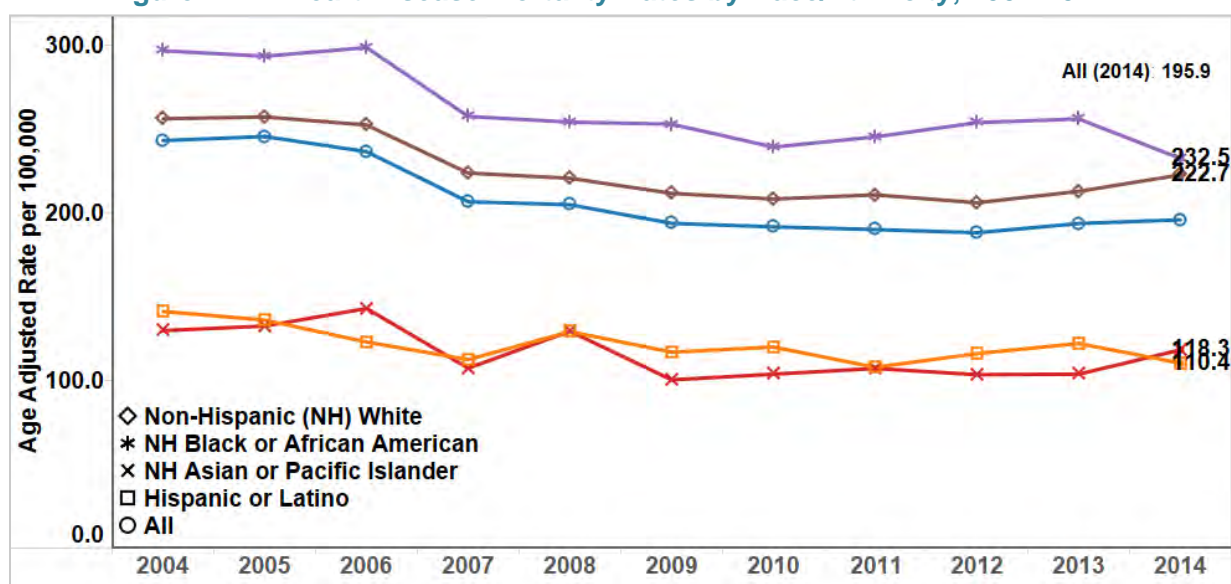


### 2.6.2 Heart Disease

During 2004-2014, the overall heart disease mortality rate dropped from 243.2 to 195.9 deaths per 100,000 persons, which compared well with other U.S. counties.<sup>26</sup> This could be attributed to the drop in smoking prevalence among adults in Clark County. Heart disease mortality rates were almost twice as high in men as in women, at 258.7 per 100,000 male residents in 2014, compared with 140.4 per 100,000 females. Among racial/ethnic groups, heart disease mortality rates were highest among Non-Hispanic Blacks, followed by non-Hispanic Whites.<sup>12</sup>

Elevated levels of blood lipids (hyperlipidemia) are a documented risk factor for heart disease. Among Clark County's Medicare population, 44.2% were treated for hyperlipidemia in 2014, which is somewhat high compared to the rest of the U.S.<sup>3</sup>

**Figure 2-14: Heart Disease Mortality Rates by Race/Ethnicity, 2004-2014**



Source: CDC WONDER<sup>26</sup>

### 2.6.3 Cancer

During 2004-2014, cancer mortality rates in Clark County decreased from 191.8 to 165.6 deaths per 100,000 persons.<sup>26</sup> The decrease in smoking prevalence among adults is believed to have contributed to this decrease in cancer mortality. However, cancer mortality rates are above the Healthy People 2020 target of 161.4 deaths per 100,000 persons, with non-Hispanic White residents at higher risk in recent years.<sup>12</sup>

Colorectal cancer screening rates are lower in Clark County than the rest of Nevada. In 2013, 59.2% of Clark County adults ages 50 and over reported ever receiving a sigmoidoscopy or colonoscopy, compared to 60.7% in Nevada. As of 2013, Hispanic residents of Clark County were much less likely than other race/ethnic groups to be screened for colorectal cancer (39.8%).<sup>3</sup>

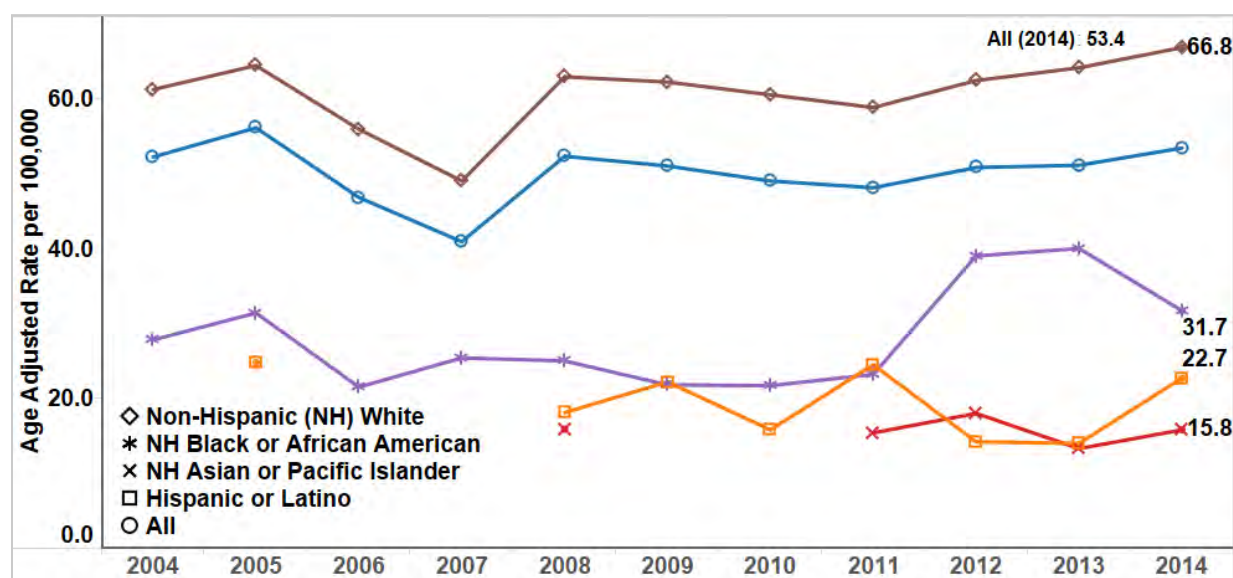
In 2012, cervical cancer screening rates for women ages 18 and over who had a Pap test in the past three years were lower in Clark County (71.8%) than Nevada (72.6%).

By contrast, Clark County mammography rates among women ages 50 and older were higher than the State. While overall mammography rates in Clark County compare favorably to Nevada overall, screening rates were low among women identifying as Asian/Pacific Islander and as Other Race. In addition, the screening rates among female Medicare beneficiaries ages 67-69 in the county (54.4%) was much lower than the median of all U.S. counties (61.4%) in 2012.

#### 2.6.4 Chronic Lower Respiratory Diseases

Chronic lower respiratory diseases, including chronic obstructive pulmonary disease (COPD), impede lung function. COPD is a condition that most commonly includes emphysema and chronic bronchitis. Cigarette smoking is the main – but not the only – cause of COPD. Between 2004 and 2013, the mortality rates from chronic lower respiratory diseases have been relatively stable at around 50 deaths per 100,000 persons. Non-Hispanic Whites have consistently experienced the highest mortality rates from chronic lower respiratory diseases. However, between 2011 and 2014, mortality rates among non-Hispanic Black residents increased substantially from 23.2 to 31.7 deaths per 100,000 persons.<sup>26</sup>

**Figure 2–15: Chronic Lower Respiratory Disease Mortality Rates by Race/Ethnicity\*, 2004-2014**



\*Data suppressed if less than 10 deaths occurred.

Source: CDC WONDER<sup>26</sup>

#### 2.6.5 Cerebrovascular Diseases

Overall, mortality rates from cerebrovascular diseases decreased about 35% from 2004 to 2014 in Clark County. While the cerebrovascular disease death rate declined for all race/ethnic groups over the decade, mortality rates have tended to be highest among non-Hispanic Black residents, at 49.2 deaths per 100,000 persons in 2014.<sup>26</sup>

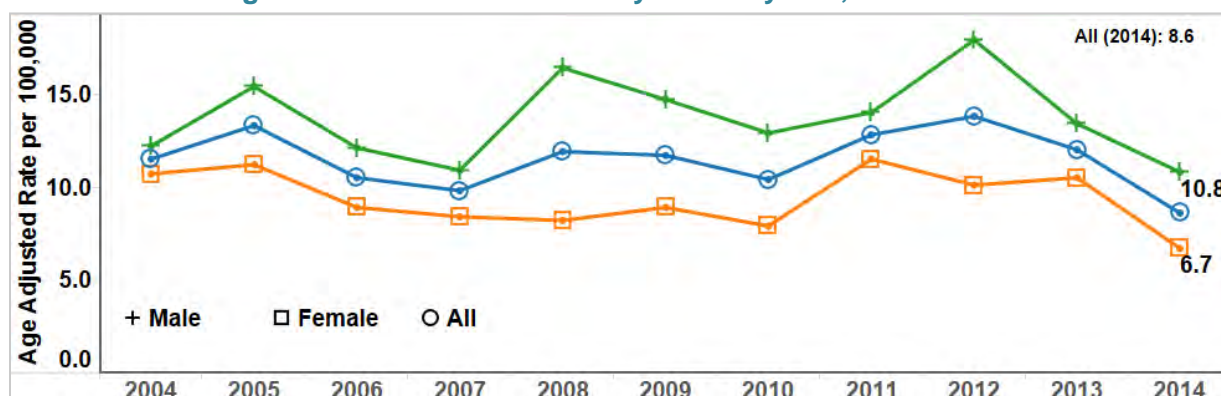
However, the incidence of stroke among Clark County's Medicare population compared unfavorably nationally in 2014. That year, 3.9% of Clark County Medicare beneficiaries were treated for stroke, compared with the median rate of 3.3% among U.S. counties.<sup>3</sup>



### 2.6.6 Diabetes

Mortality rates due to diabetes decreased from 11.5 to 8.6 per 100,000 county residents between 2004 and 2014. (45) Males had consistently higher mortality from diabetes than females, at 10.8 versus 6.7 per 100,000 in 2014. Rates were substantially higher among non-Hispanic Black residents than other racial/ethnic groups.<sup>26</sup>

**Figure 2–16: Diabetes Mortality Rates by Sex, 2004-2014**



Source: CDC WONDER<sup>26</sup>

**Table 2-6: Age-Adjusted Death Rate due to Diabetes per 100,000 Population, 2013 vs. 2014**

Race/Ethnic Group	Diabetes mortality rate, 2013	Diabetes mortality rate, 2014
Total	12.0	8.6
Non-Hispanic (NH) White	12.8	8.9
NH Black	14.8	14.9
NH American Indian	*	*
NH Asian Pacific Islander	*	*
Hispanic	12.2	8.1

\*Data suppressed if less than 10 deaths occurred

Source: CDC WONDER<sup>26</sup>

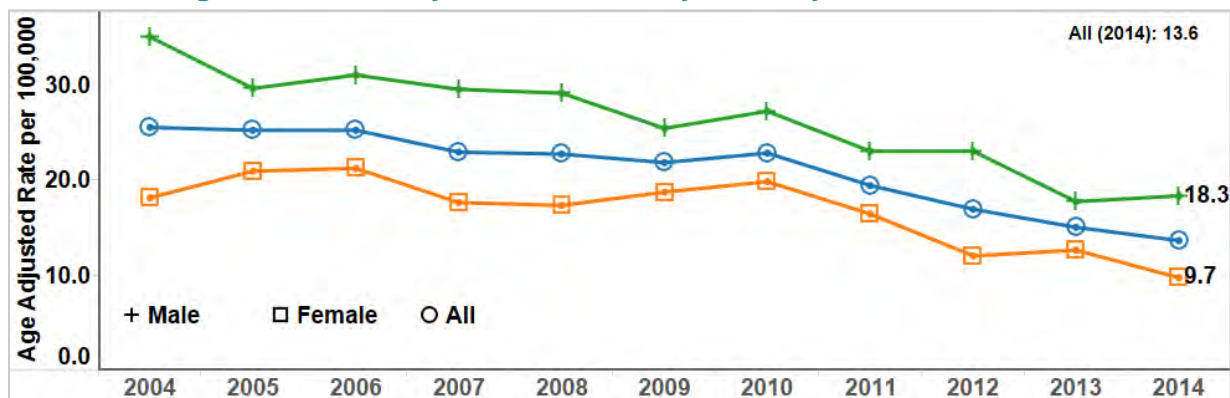
Rates of diabetic screening and prevalence among Clark County Medicare beneficiaries, along with hospitalization rates due to long-term complications of diabetes, indicate opportunities for improved management of diabetes for Clark County residents.<sup>3</sup>

In the U.S., the total estimated cost of diagnosed diabetes was \$245 billion in 2012, including \$176 billion in direct medical costs and \$69 billion in decreased productivity. Decreased productivity includes costs associated with people being absent from work, being less productive while at work, or not being able to work at all because of diabetes.<sup>27</sup>

### 2.6.7 Kidney Disease

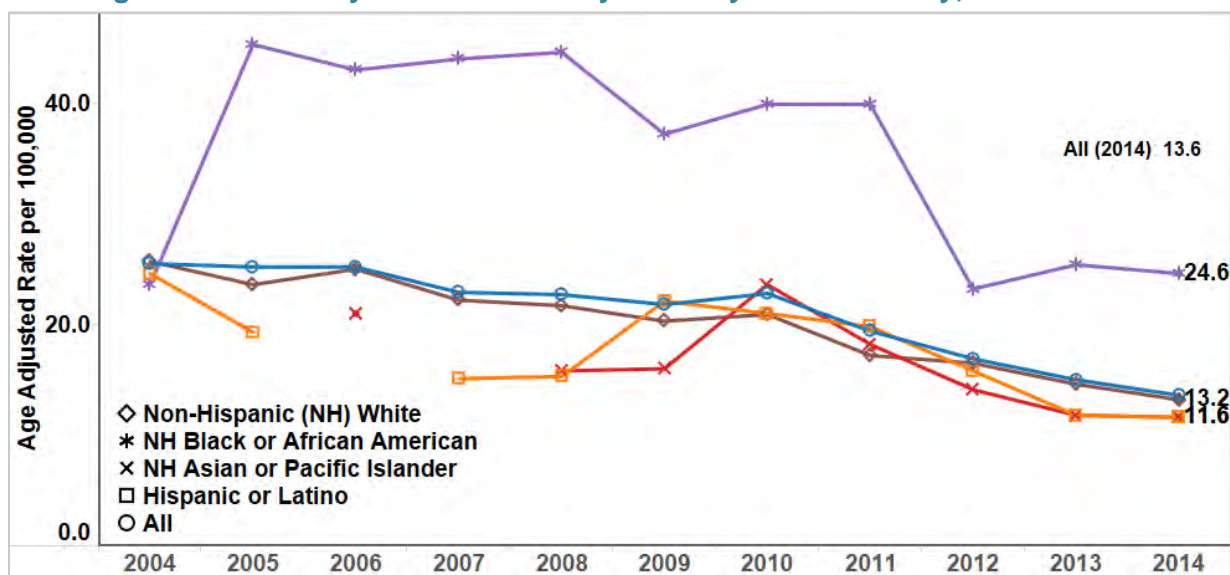
In 2014, 18.8% of Clark County Medicare beneficiaries were treated for chronic kidney disease, placing it in the top quartile of all U.S. counties. Between 2004 and 2014, the mortality rate from kidney disease — including nephritis, nephrotic syndrome, and nephrosis— declined. However, higher rates were seen in the county than in the nation.<sup>26</sup> Further, mortality rates were about 50% higher in males as in females, and substantially higher among non-Hispanic Blacks than other racial/ethnic groups.<sup>26</sup>

**Figure 2–17: Kidney Disease Mortality Rates by Sex, 2004-2014**



Source: CDC WONDER<sup>26</sup>

**Figure 2–18: Kidney Disease Mortality Rates by Race/Ethnicity, 2004-2014\***



\*Data suppressed if less than 10 deaths occurred.

Source: CDC WONDER<sup>26</sup>

## 2.7 Infectious Diseases

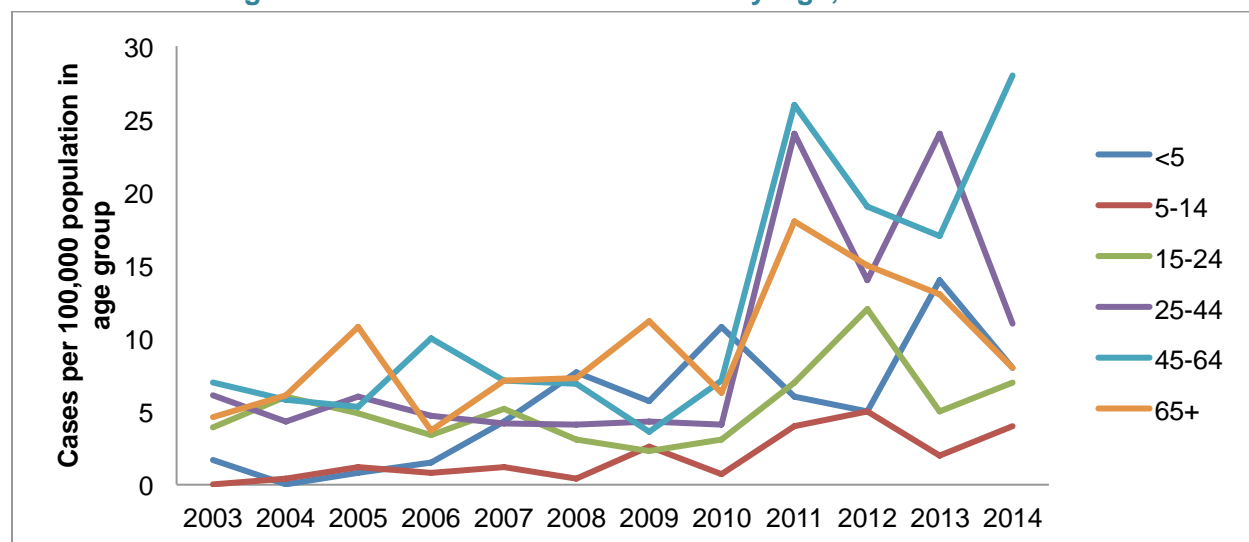
### 2.7.1 Influenza and Pneumonia

In otherwise healthy individuals, influenza is relatively uncomplicated with the infection generally resolving in one week. However, pneumonia (viral, bacterial or a combination) is frequently a complication of influenza. Influenza and pneumonia vaccinations are especially recommended for persons most at risk, including the very young, the elderly, those with chronic diseases and the immunocompromised.<sup>3</sup> In 2014, there were 25.8 deaths per 100,000 residents due to influenza and pneumonia in Clark County.<sup>26</sup>

### 2.7.2 Tuberculosis

In 2013, the average rate of tuberculosis incidence in the U.S. was 3.0 cases/100,000 persons. Nevada had the 9<sup>th</sup> highest rate among the 50 states (3.3 cases/100,000 persons), and the rate in Clark County was even higher at 3.7/100,000 persons.<sup>28</sup> Rates of disease for male and female patients have both remained relatively constant. While incidence rates remained relatively stable across most age groups, a substantial increase in cases was observed in the under-5 age group from 2010-2014, a trend not reflected at the U.S. level. One potential explanation is the close contact between individuals who were previously housed in a corrections facility and unknowingly developed active TB.<sup>12</sup>

**Figure 2–19: Tuberculosis Incidence by Age, 2003-2014**



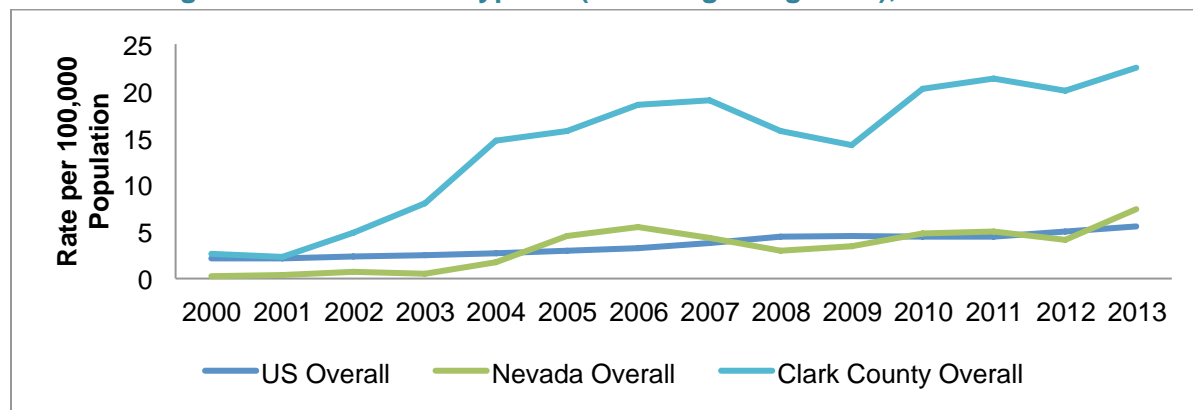
Source: Southern Nevada Health District<sup>12</sup>

In Clark County, as in the U.S., the most important risk factor, by far, is having been born in a country with a high burden of TB disease or a U.S. born child born to parents from a high risk country of origin, even though many TB patients and families have lived in the U.S. for many years prior to diagnosis of tuberculosis.<sup>29</sup>

### 2.7.3 Sexually Transmitted Diseases (STD)

As in the rest of the U.S., incidence rates of sexually transmitted diseases (STDs) have been increasing in recent years. Nevada ranked 24<sup>th</sup> among the 50 states in rates of newly diagnosed gonorrhea infections and 25<sup>th</sup> for newly diagnosed chlamydia infections in 2013.<sup>11</sup> While these rates are comparable to national averages, the incidence rate of syphilis in Clark County has been rising much more quickly, a trend that is largely driven by new cases among male residents.

**Figure 2–20: Rates of Syphilis (Including Congenital), 2000-2013**



Source: Southern Nevada Health District<sup>12</sup>

Among teens, condom use remains an early intervention focus area, as only 56.4% reported using a condom during their last sexual intercourse in 2013.<sup>3</sup>

### 2.7.4 HIV/AIDS

The first HIV infection in Nevada was diagnosed in Clark County in 1982. Since then, the number of persons living with HIV/AIDS has steadily increased while the number of new HIV infections, new AIDS diagnoses, and deaths among People Living with HIV/AIDS (PLWHA) has decreased. Fewer people are becoming infected, and people are living longer once they do become infected due to advances in HIV medication.

#### New HIV Diagnoses

New HIV diagnoses include persons newly diagnosed with HIV infection (both living and deceased) and exclude persons who were diagnosed in another state but who currently live in Clark County. This category also includes persons who were newly diagnosed with HIV and AIDS in the same year.<sup>‡</sup> Between 2008 and 2014, the annual rate of new HIV infections in Clark County has ranged between 16 and 20 persons per 100,000. There were 383 new HIV diagnoses in Clark County in 2014, representing 89% of all new HIV diagnoses in the state, while Clark County represents only 73% of Nevada's population.<sup>12</sup>

Males were much more likely to be newly diagnosed with HIV. In 2014, the rate of new HIV infections among men was 32.6 per 100,000, compared to 4.9 per 100,000 for females. Male-to-

<sup>‡</sup> A recent diagnosis may not reflect a new infection; an individual may be diagnosed with HIV many years after he/she was first infected.

male sexual contact was the highest risk category for males (78%). For females, the highest risk category was heterosexual contact with no documented risk factors/HIV infections of their partner(s) and persons who report no risks, most likely because they could not be interviewed (54%), followed by heterosexual contact with an HIV-infected person, an injection drug user, or a person who has received blood products (38%). Racial differences are also observed. While Blacks made up only 11% of the county population, this group represented 27% of the new HIV cases in 2014. Additionally, Black females had the highest proportion of new HIV diagnoses among females of all races in 2014 (24%).<sup>12</sup>

### *People Living with HIV/AIDS (PLWHA)*

The rate of persons living with HIV (not AIDS) has steadily increased from 344.8 per 100,000 in 2008 to 413.1 per 100,000 in 2014. The rate of persons living with AIDS has also been increasing from 176.6 per 100,000 in 2008 to 212.3 per 100,000 in 2014. There were 8,429 PLWHA in Clark County in 2014; this is 86% of PLWHA in Nevada. Of these, 4,098 were HIV-infected (not AIDS), while 4,331 had an AIDS diagnosis. In 2014, the rate of PLWHA who were Black males was 2.2 times that of White males and 2.7 times that of Hispanic males. Racial disparities among females are even more pronounced; the rate of PLWHA who were Black female was 7.1 times that of the White female rate and 8.9 times that of the Hispanic female rate. The rate of Hispanic males and females are nearly the same as that of White males and females. There were 98 deaths in 2014 among PLWHA in Clark County, an age-adjusted rate of 5.1 per 100,000 persons.<sup>12</sup>

### *2.7.5 Hepatitis*

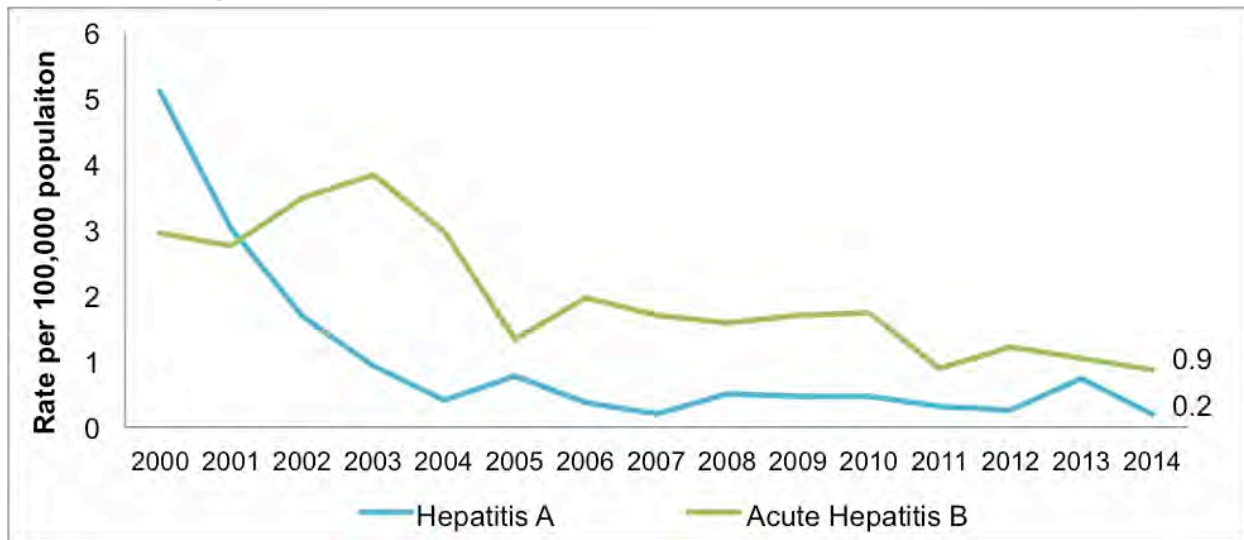
While most people fully recover from hepatitis A infections, the disease can cause severe liver damage or death. Through the mid-1990s, Clark County had among the highest incidence rates of hepatitis A infection in the U.S. Accordingly, the Advisory Committee for Immunization Practices recommended the administration of the hepatitis A vaccine routinely to children in Clark County, which resulted in a dramatic decline in incidence from 2000 to 2014. Local public health experts believe the targeting of food handlers in hepatitis A vaccination efforts was critical for Nevada's drop from the top 10 states for hepatitis A incidence to the lowest 10 states for incidence.<sup>12</sup>

Hepatitis B incidence rate per 100,000 persons also declined in Clark County over the time period 2000-2014, from 2.94 to 0.87. Reduction in hepatitis B rates was most likely due to the routine vaccination of children implemented in 1991 and the prenatal hepatitis B program, implemented in 2005 to reduce vertical transmission that required a birth dose of hepatitis B vaccine for all infants. Residents aged 25-39 have consistently had the highest rates of newly diagnosed hepatitis B infection.<sup>12</sup>

Incidence of acute new hepatitis C cases in Clark County has remained relatively low and steady during the past decade, ending at 0.1 cases per 100,000 persons in 2014. The only spike was observed in 2007-2008, when incidence increased to 0.5 cases per 100,000 persons. This was traced back to an outbreak at an endoscopy clinic.<sup>12</sup>



**Figure 2–21: Incidence of Hepatitis A and Hepatitis B, 2000-2014**



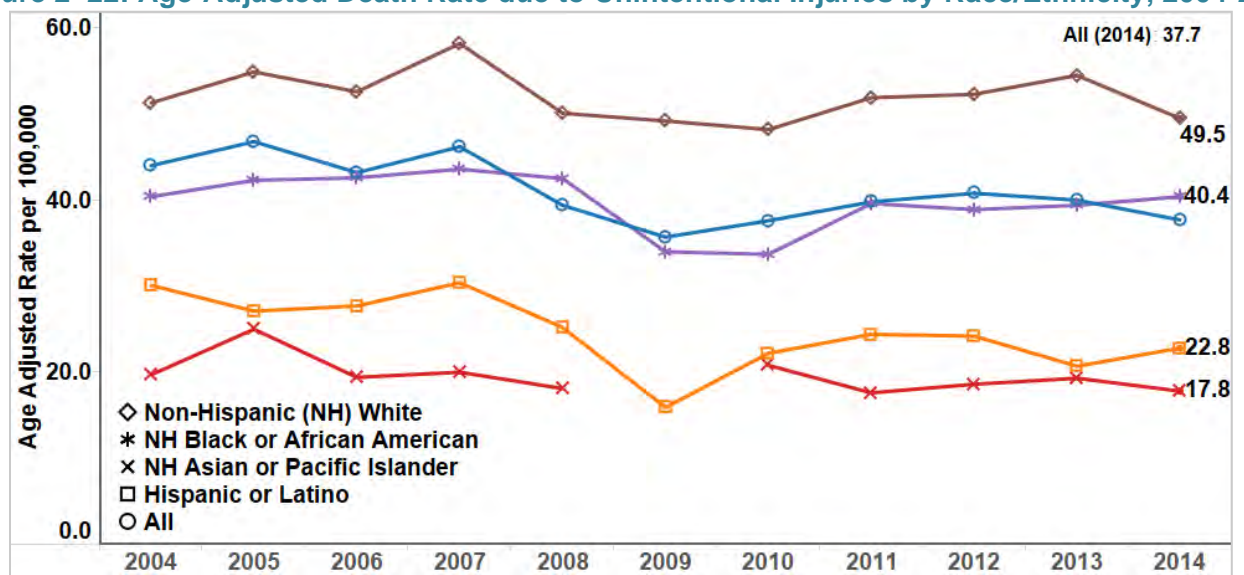
Source: Southern Nevada Health District<sup>12</sup>

## 2.8 Injuries

### 2.8.1 Unintentional Injuries

Between 2004 and 2014, unintentional injury mortality rates declined from 44.0 to 37.7 deaths per 100,000 persons.<sup>26</sup> In 2014, the male death rate was nearly double the female death rate. However, over the past decade, the male death rate declined much more dramatically than the female rate. While unintentional injury mortality declined for most race/ethnicities over the past decade, rates among non-Hispanic White and Black residents were about twice as high as among other racial/ethnic groups.<sup>26</sup>

**Figure 2–22: Age-Adjusted Death Rate due to Unintentional Injuries by Race/Ethnicity, 2004-2014**

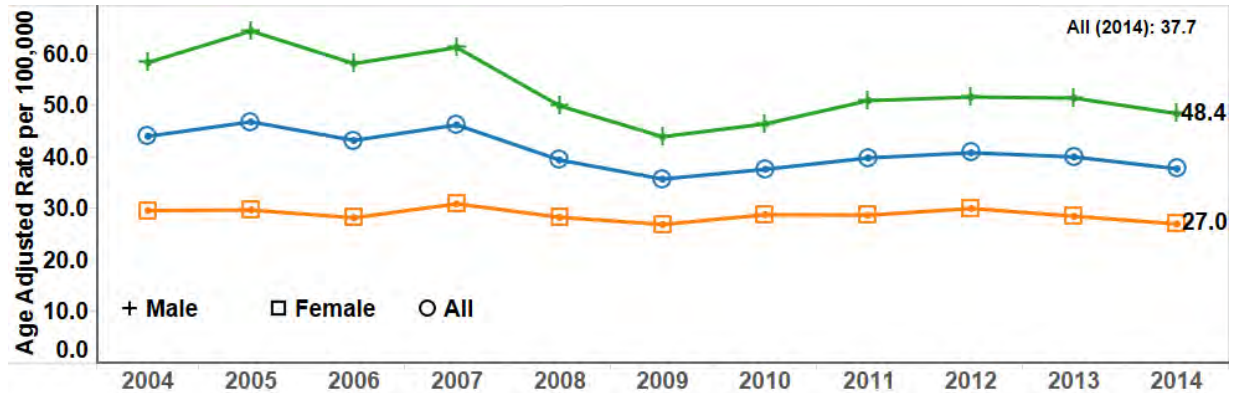


\*Data suppressed if less than 10 deaths occurred.

Source: CDC WONDER<sup>26</sup>



Figure 2-23: Age-Adjusted Death Rate due to Unintentional Injuries by Sex, 2004-2014



\*Data suppressed if less than 10 deaths occurred.

Source: CDC WONDER<sup>26</sup>

Lack of seatbelt use is a highly risky behavior that can lead to motor vehicle injuries and mortality. In 2013, 4.7% of high school students reported rarely or never using seatbelts.<sup>3</sup>

### 2.8.2 Childhood Injuries

Unintentional injuries are a leading cause of deaths among children and youth less than 25 years old in Clark County. In Table 2-7, injury-related fatalities are bolded in red.

Table 2-7: Counts of Death by Leading Causes and Select Age Group, 2005-2014  
Aggregated

Rank	<1	1-4	5-9	10-14	15-19	20-24
1	Congenital Anomalies 368	<b>Unintentional Injuries</b> <b>112</b>	<b>Unintentional Injuries</b> <b>35</b>	<b>Unintentional Injuries</b> <b>57</b>	<b>Unintentional Injuries</b> <b>305</b>	<b>Unintentional Injuries</b> <b>526</b>
2	Short Gestation/Low Birth Weight 146	Congenital Anomalies 34	Malignant Neoplasms 22	<b>Suicide</b> <b>22</b>	<b>Homicide</b> <b>141</b>	<b>Suicide</b> <b>198</b>
3	<b>Unintentional Injuries</b> <b>127</b>	<b>Homicide</b> <b>32</b>	Respiratory Diseases 21	Malignant Neoplasms 22	<b>Suicide</b> <b>100</b>	<b>Homicide</b> <b>189</b>
4	Maternal Complications 97	Malignant Neoplasms 22	Nervous System Diseases 11	<b>Homicide</b> <b>17</b>	Malignant Neoplasms 43	Cardiovascular Disease 84
5	Infections 71	Respiratory Diseases 18	Congenital Anomalies 10	Nervous System Diseases 15	Cardiovascular Disease 27	Malignant Neoplasms 55

Source: Southern Nevada Health District<sup>12</sup>

Among the younger children, suffocation resulted in the most infant (<1 year) injury deaths, while drowning was the most common injury mechanism for those aged 1-4 years. Motor vehicle crashes are the leading cause of injury deaths among those aged 5-19 years, while poisoning among those aged 20-24 years.

**Table 2-8: Counts of Injury-Related Deaths by Mechanism/Intent and Select Age Group, 2005-2014 Aggregated**

Rank	<1	1-4	5-9	10-14	15-19	20-24
1	Suffocation (excl. homicide) 109	Drowning (excl. homicide) 54	Motor Vehicle Trauma 19	Motor Vehicle Trauma 33	Motor Vehicle Trauma 168	Poisoning (excl. suicide/homicide) 239
2	Homicide 28	Homicide 32	Homicide ****	Suicide 22	Homicide 141	Motor Vehicle Trauma 228
3	Motor Vehicle Trauma ****	Motor Vehicle Trauma 20	Drowning (excl. homicide) ****	Homicide 17	Suicide 100	Suicide 198
4	Drowning (excl. homicide) ****	Fire/Flame (excl. homicide) ****	Fire/Flame (excl. homicide)† ****	Unintentional Fall† ****	Poisoning (excl. suicide/homicide) 90	Homicide 189
5	Poisoning (excl. suicide/homicide)† ****	Suffocation (excl. homicide)† ****	Suffocation (excl. homicide)† ****	Poisoning (excl. suicide/homicide)† ****	Drowning (excl. homicide) 16	Firearm (excl. suicide/homicide) 15
6	Unintentional Fall ****	Unintentional Fall† ****	Firearm (excl. suicide/homicide)† ****	Drowning (excl. homicide) ****	Firearm (excl. suicide/homicide) 10	Unintentional Fall 13

\*\*\*\*Cell values are less than 10 are suppressed

.† Counts tied

Source: Southern Nevada Health District<sup>12</sup>

## 2.9 Environmental Health

Clark County falls short of meeting national benchmarks on four out of five indicators for environmental health. Of these, severe housing problems are an area of particular concern.

**Table 2-9: Clark County Ranking on Environmental Health Indicators**

Physical Environment	Clark County	Nevada	National Benchmark (90 <sup>th</sup> percentile)
Air pollution - particulate matter	12.0	12.5	9.5
Drinking water violations	0%	1%	0%
Severe housing problems	23%	22%	9%
Driving alone to work	79%	78%	71%
Long commute - driving alone	31%	29%	15%

Source: County Health Rankings<sup>7</sup>

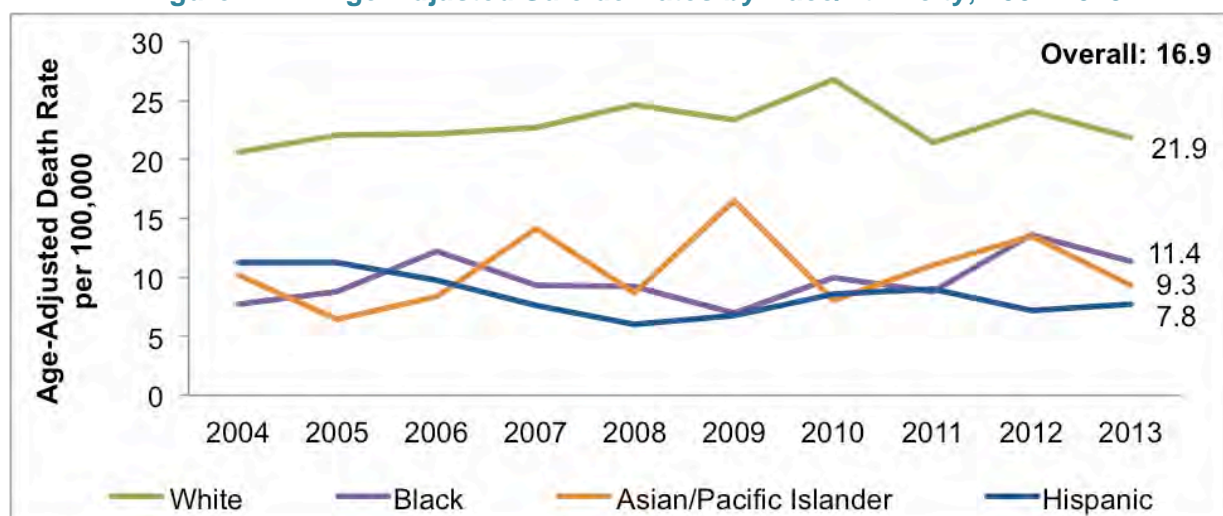
Indoor air quality is an important public health issue in Clark County due to the large number of public facilities that allow smoking. The Nevada Clean Indoor Air Act was passed in 2006 to protect children and adults from second hand smoke in most public and indoor places of employment. During the 2011 legislative session, lawmakers passed Assembly Bill 571 revising the act. This resulted in stand-alone bars, taverns, and saloons in which patrons under 21 years of age are prohibited from entering, were able to allow smoking. This results in the passive exposure to smoke for both patrons and staff of these establishments.<sup>30</sup>

## 2.10 Mental and Behavioral Health

### 2.10.1 Suicide

In 2014, the suicide death rate was 17.6 deaths per 100,000 population in Clark County, compared with 13 per 100,000 for U.S. Male residents had more than three times the suicide morality rate as female residents in the same year, and rates were more than twice as high in non-Hispanic Whites as in other racial/ethnic groups.<sup>12</sup>

**Figure 2–24: Age-Adjusted Suicide Rates by Race/Ethnicity, 2004-2013**



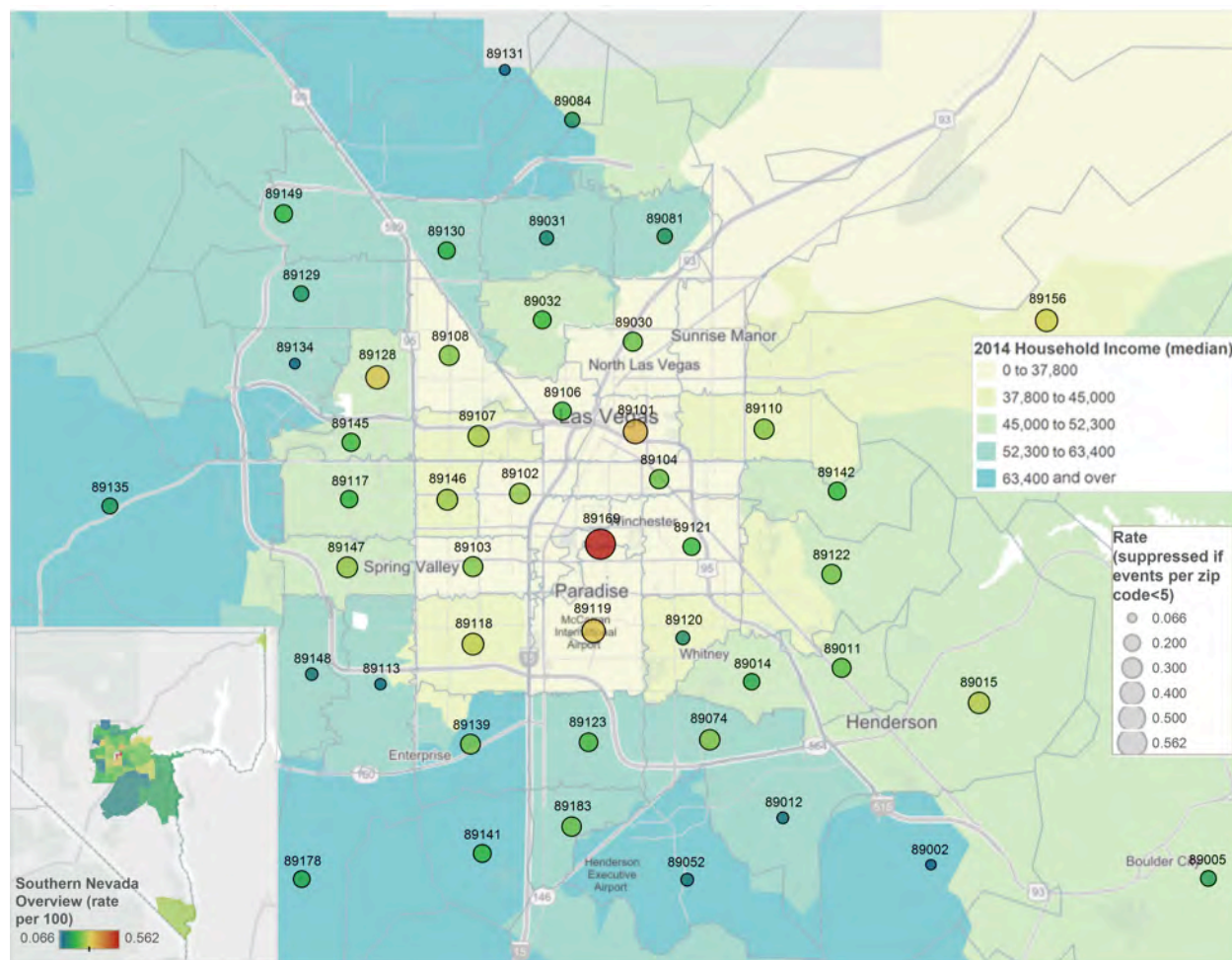
\*Data suppressed if less than 10 deaths occurred.

Source: Southern Nevada Health District<sup>12</sup>

### 2.10.2 Tobacco Use

Cigarette smoking is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions, as well as low birth weight and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for tobacco cessation programs or the effectiveness of existing programs.<sup>7</sup>

**Figure 2–25: Adult Smoking Prevalence, Average 2011-2013**



Source: Southern Nevada Health District<sup>12</sup>

Over the past decade, SNHD's nationally recognized Tobacco Control Program (TCP) has implemented evidence-based, comprehensive programming utilizing the Centers for Disease Control and Prevention's Best Practices. In the 2012 Clark County Community Health Status Assessment,<sup>31</sup> the TCP programs and policy efforts were shown to have contributed to a decrease in youth smoking prevalence from 30.7% in 1999 to 13.7% in 2007,<sup>16</sup> and adult smoking prevalence from 26.6% in 2002 to 21.6% in 2007.<sup>5</sup> Continued efforts have resulted in sustained decreases in smoking prevalence among youth to 5.9% in 2015 and among adults to 17.1% in 2014.<sup>5, 10</sup> Despite the sharp decrease, current smoking rates still fall short of the national Healthy People 2020 target of 12.0%.<sup>3</sup>

### 2.10.3 Alcohol Use

A number of adverse health outcomes are associated with excessive alcohol consumption. These include, but are not limited to, alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, fetal alcohol syndrome, motor-vehicle crash and other injuries, and interpersonal violence.<sup>32</sup>

In 2013, 13.3% of Clark County adults reported recent binge drinking, which is less than the state average of 15.2%. Binge drinking was more prevalent among males (17.9%) than females (8.5%). In 2013, 15.0% of high school students reported recent binge drinking. Students identifying as Hispanic had the highest rates of recent binge drinking at 20.8%.<sup>3</sup>

### 2.10.4 Prescription Drug Abuse

The misuse and abuse of psychotropic pharmaceuticals and illicit drugs pose a serious public health challenge in Clark County. The number of drug-induced deaths, including both drug poisonings and those attributed to drug dependence or addiction, nearly doubled over the past decade.<sup>33</sup> Since 2005-2006, drug overdose has become the leading injury cause of death in Clark County. In comparing Clark County to the nation as a whole, drug overdose rates were about 70% higher for Clark County residents in 2010-2011. The vast majority of drug overdoses were unintentional. Close to two-thirds of drug overdoses involved opioid analgesics. Residents aged 45-54 had higher overdose rates involving opioid analgesics than other age groups. Non-Hispanic Whites had the highest death rate (21.2 deaths per 100,000 in 2010-2012) from opioid analgesic poisonings, followed by American Indians/Alaska Natives, and then non-Hispanic Blacks. Between 2010 and 2012, males far exceeded females in illicit drug-related overdoses, at a rate of 7.8 per 100,000. This is more than twice the rate of 3.6 per 100,000 in females.

The markedly high drug overdose rates in Clark County when compared with the rest of the country are reflective of the higher-than-the-nation prescribing pattern for opioid analgesics in the state of Nevada. Evaluating and modifying prescribing patterns are therefore critical to reversing the fatal drug poisoning epidemic in Clark County.<sup>34</sup>

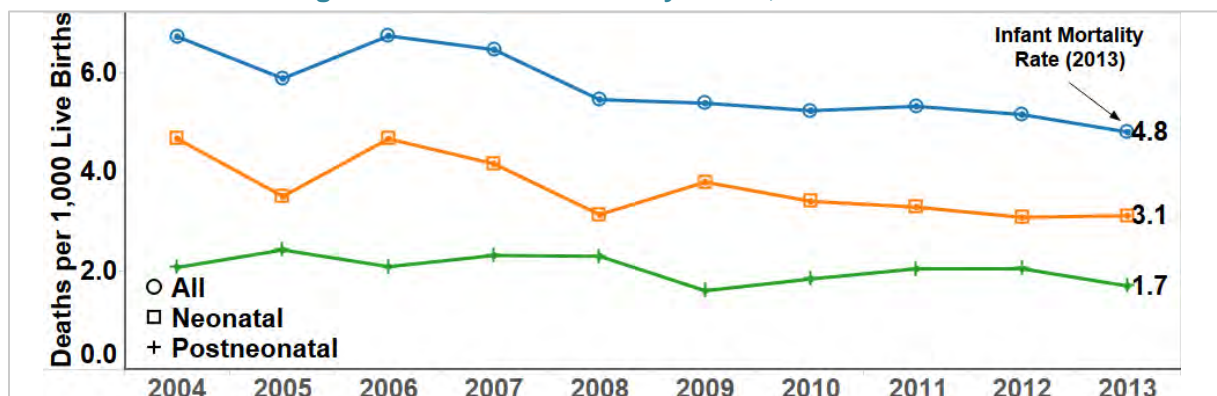
## 2.11 Maternal and Child Health

### 2.11.1 Neonatal and Infant Deaths

Infant (<1 year old) mortality in the U.S. is likely associated with congenital malformations, short gestation, maternal complications during pregnancy, gaps in maternal/infant care, and other post-natal risk factors such as injuries and infections. In Clark County, slight declines in neonatal (<28 days of life) and postneonatal (28 days to one year of age) mortality have been observed over the past decade.<sup>35</sup>



Figure 2–26: Infant Mortality Rates, 2004-2013



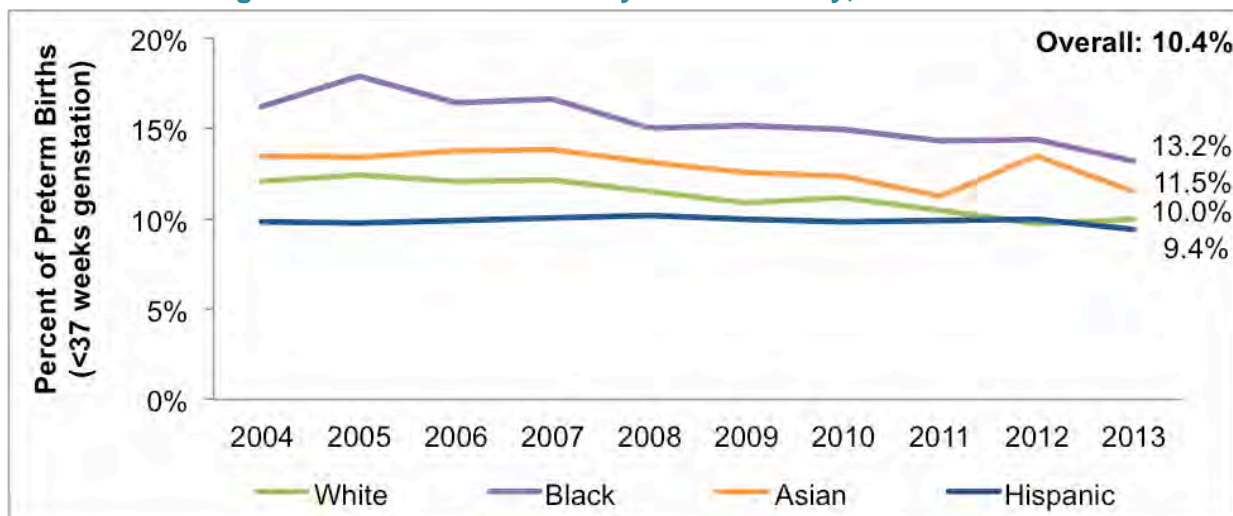
Source: CDC Division of Vital Statistics <sup>35</sup>

### 2.11.2 Preterm Births

Preterm births, those occurring at least 3 weeks before the babies' due dates, can result in negative health outcomes and long-term complications, such as impaired cognitive skills, vision or hearing loss, cerebral palsy, and chronic health issues. In 2013, 36% of infant deaths in the U.S. were due to preterm-related causes of death. <sup>36</sup>

In Clark County, despite declines in preterm birth, Black mothers are still much likelier to experience preterm births than any other racial/ethnic group. In 2013, 10.4% of all births in the county were preterm, but the figure rose to 13.2% of births for Black mothers. <sup>37</sup>

Figure 2–27: Preterm Births by Race/Ethnicity, 2004-2013



Source: Southern Nevada Health District <sup>12</sup>



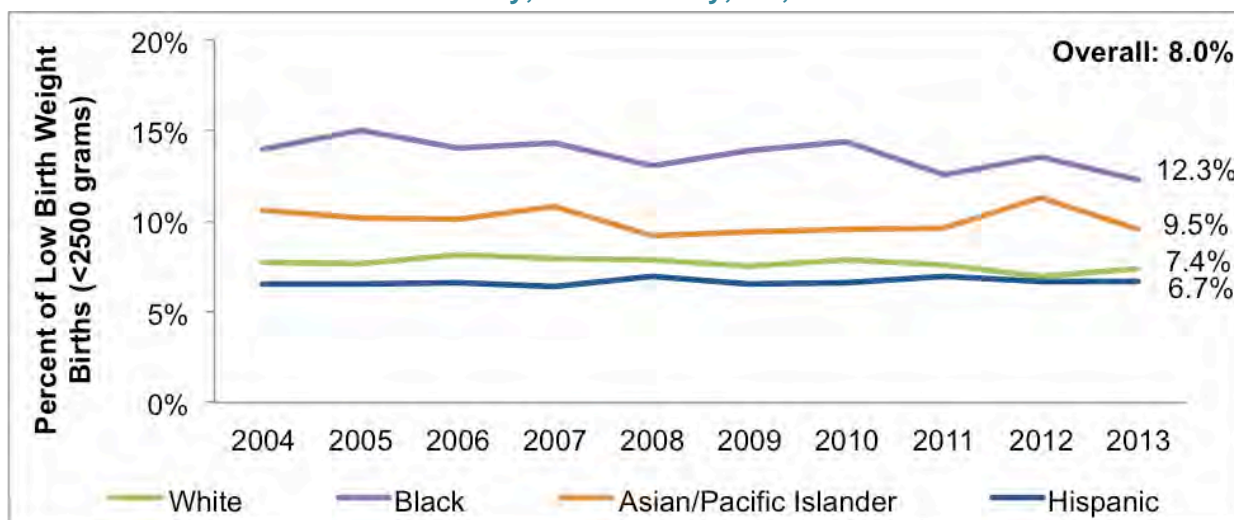
### 2.11.3 Low Birth Weight

Low birth weight (LBW) is defined as a live-born infant weighing less than 2500 grams (5.5 lbs.). It is the biggest factor affecting neonatal and post-neonatal mortality, giving the newborn 40 times the risk of dying during the first four weeks of life compared with a full-term infant. Other consequences of LBW include neurodevelopmental handicaps and lower respiratory tract illnesses.<sup>38</sup>

Many maternal health risk factors can affect birth weight, including the mother's health behaviors, access to health care, social and economic environment, and environmental risks. Modifiable maternal health behaviors, including weight gain, smoking, and alcohol and substance use, have been found to account for more than 10% of the variation in birth weight. Maternal smoking alone accounts for 7% of variation in birth weight.<sup>39</sup> Maternal nutrition, smoking, and excessive alcohol intake have also been found to result in LBW.<sup>40</sup>

The Healthy People 2020 objective for low birth weight is 7.8%. While Clark County as a whole is not far from meeting the target (8.0% in 2013), significant disparities exist among racial/ethnic groups. Low birth weight impacts only 6.7% of births to Hispanic mothers, but 12.3% of births to Black mothers.<sup>37</sup>

**Figure 2–28: Percent of Low Birth Weight (<2,500 g) Infants by Mother's Race/Ethnicity, Clark County, NV, 2004-2013**



Source: Southern Nevada Health District<sup>12</sup>

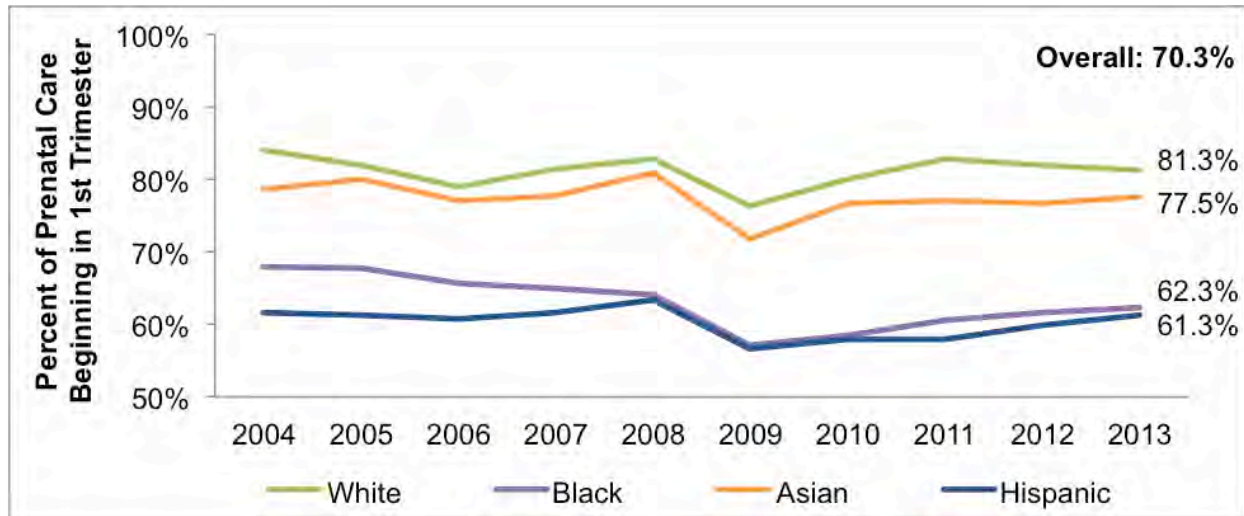
### 2.11.4 Prenatal Care

Early and adequate prenatal care allows for identification and treatment to correct health problems or health-compromising behaviors that can negatively affect the fetus during early gestation. In turn, prenatal care can reduce the risk of poor outcomes like preterm birth, low birth weight, and infant death.

As with other maternal child health indicators, racial/ethnic disparities persist in early prenatal care utilization. In 2013, 70.3% of all Clark County mothers began receiving prenatal care in the first trimester. The proportion was highest among White mothers (81.3%) and lowest among

Hispanic (61.3%) and Black (62.3%) mothers, suggesting the need for tailored interventions for these groups.<sup>12</sup>

**Figure 2–29: Percent of Prenatal Care Beginning in 1st Trimester by Mother's Race/Ethnicity, Clark County, NV, 2004-2013**



Source: Southern Nevada Health District<sup>12</sup>

### 2.11.5 Substance Abstinence during Pregnancy

When a pregnant woman drinks alcohol, the alcohol in the mother's blood passes through the placenta to the baby. Drinking alcohol during pregnancy can cause miscarriage, stillbirth, and a range of lifelong disorders, known as fetal alcohol spectrum disorders (FASDs). The Healthy People 2020 target for abstinence from alcohol among pregnant women is 98.3%. Preliminary 2014 data indicate that 99.5% of expectant mothers in Clark County abstained from alcohol during pregnancy, meeting the Healthy People 2020 target.<sup>12</sup>

Risks associated with smoking during pregnancy include low birth weight, premature birth, certain birth defects (cleft lip or cleft palate), and infant death. Even secondhand smoke puts a woman and her unborn baby at risk. The proportion of Clark County women abstaining from cigarette smoking during pregnancy increased from 95.5% in 2010 to 96.1% in 2014, but failed to reach the Healthy People 2020 target of 98.6%.<sup>41</sup>

### 2.11.6 Teen Pregnancy and Births

Negative health, social, and economic consequences are related to teen pregnancy and births.<sup>42, 43</sup> Children of teenage parents are at greater risk for long-term consequences like lower school achievement, increased health problems, incarceration during adolescence, becoming parents themselves as teenagers, and unemployment as young adults.<sup>44</sup> Reduction in teen birth rate is one of CDC's top six "winnable battles."<sup>45</sup>

Teen mothers and their babies face increased risks to their health when compared with mothers over the age of 20. Pregnancy complications may include premature labor, anemia, and high blood pressure. These risks are even greater for teens under 15 years old.<sup>46</sup> Only 38% of

teenagers who have children before age 18 go on to graduate from high school.<sup>47</sup> Without a solid educational foundation, young women are more likely to have difficulty finding well-paying jobs.

In 2011-2013, the teen birth rate in Nevada was 31.5 births per 1,000 females age 15-19 years. Clark County exceeded this average with a birth rate of 32.1 per 1,000.<sup>3</sup>

## 2.12 Discussion

This CHSA aims to determine the health status of the Southern Nevada community overall and of different resident groups. Behavioral factors, built environment, socioeconomic determinants, resource distribution, and policies all shape community health, as demonstrated in the preceding sections.

Clark County falls within the bottom 25% of US counties for health insurance coverage. Hispanic/Latino residents are especially impacted by this indicator of access to care. While several areas are identified as having insufficient primary and dental care services (in portions of Las Vegas and around the outlying rural portions of the county), access to mental health care is recognized as a challenge across the county.

Among race/ethnic groups, non-Hispanic Black residents are more likely to self-report poor or fair general health. Chronic diseases – especially heart disease and cancer – continue to be a major cause of mortality and morbidity in Southern Nevada. Non-Hispanic Blacks experience the highest rates of mortality due to heart disease, despite high rates of cholesterol screening; mortality rates due to cancer and diabetes are also highest among this race/ethnic group. Cancer screening rates are low for women of Asian/Pacific Islander descent and Other non-Hispanic Race (for breast cancer), and among Hispanic residents (for colorectal cancer).

Chronic disease risk can be modified through diet and exercise, and Clark County as a whole compares favorably to national indicators of obesity and physical activity. However, large racial/ethnic disparities exist: obesity rates are much higher among non-Hispanic Black and Hispanic adolescents than non-Hispanic white adolescents. Children are especially impacted by food insecurity, and the county overall has many fast food restaurants per capita but relatively few SNAP certified stores, recreation and fitness facilities, and farmers markets.

Death rates from unintentional injuries are nearly twice as high among White and non-Hispanic Black residents than other race/ethnic groups. Unintentional injuries are also the leading cause of death among children, adolescents, and young adults ages 1-24 years.

Environmental concerns in Clark County include air pollution and a high proportion (nearly one in four) of houses with severe problems, such as overcrowding, high costs of housing, and lack of kitchen or plumbing facilities. Indoor air pollution is a particular concern in the county due to the many casinos and bars that still permit smoking.

SNHD implemented an evidence-based intervention to decrease smoking prevalence among youth and adults, which led to decreases in smoking rates over the past decade. However, more progress is needed, as Southern Nevada still fails to meet national and local smoking targets. Another risky health behavior, binge drinking, is associated more strongly with male residents than female residents; among youth, students identifying as Hispanic reported the

highest rates of binge drinking. Prescription drug abuse is another major concern in the region, especially among residents ages 45-54, and among non-Hispanic White residents.

As with many chronic diseases, indicators of maternal and child health illustrate poorer outcomes among Black residents. Preterm births, low birth weight, and low prenatal care utilization all disproportionately affect this group. Use of prenatal care services is also very low among Hispanic mothers. The proportion of pregnant women abstaining from smoking during pregnancy is high, but fails to meet national Healthy People 2020 targets.

## 2.13 Conclusions

As in many parts of the U.S., chronic diseases are a major health burden in Clark County. Measures to prevent the onset of chronic diseases, particularly through lifestyle changes such as increasing exercise and modifying diet, could drastically improve health and wellbeing of Clark County residents.

Encouraging screenings, vaccinations, and the modification of risky behaviors (such as increasing seatbelt and condom use) could decrease the rates of infectious disease and injury. Access to mental and behavioral health services is extremely limited in Clark County, which is one driver of poor outcomes in this area. Health disparities are seen throughout the health assessment areas. Policy and funding decisions impact the quality and accessibility of healthcare resources.<sup>35</sup>

In light of these findings, Southern Nevada has chosen to address the following priority areas in the region's 2015-2020 CHIP:

### **Access to Care**

**Vision:** To increase equitable access to healthcare services in a manner that ensures citizens receive appropriate, affordable, high-quality, and compassionate care.

#### **Goal Areas:**

1. Healthcare Access and Navigation: Develop a sustainable system to provide assistance with healthcare navigation to the citizens of Southern Nevada that identifies the right service, for the right person, at the right time.
2. Healthcare Workforce Resources and Transportation: Develop a sustainable system to provide healthcare resources to the citizens of Southern Nevada that overcomes barriers to quantity, type and specialty, and geographic access to them.
3. Health Insurance: Provide health insurance coverage opportunities to the people of Southern Nevada to meet the Healthy People National Coverage goal of 100% by 2020.

### **Chronic Disease**

**Vision:** To achieve a healthier population in Southern Nevada by reducing risks and behaviors that contribute to chronic disease.

#### **Goal Areas:**

1. Obesity: Promote and enhance interventions to reduce obesity in Southern Nevada by increasing physical activity and promoting healthy diets.

2. Tobacco Usage: Enhance interventions to reduce disease burden and lowered quality of life associated with tobacco use and secondhand smoke exposure in Southern Nevada

### **Policy and Funding**

***Vision:*** To improve transparency in public health funding for key stakeholders and the public, thus ensuring a knowledgeable public and key stakeholders in the decision-making process.

#### ***Goal Areas:***

1. Policy: Educate the community and stakeholders about the influence of public health on the success of Southern Nevada and use health data and a Health in All Policies (HiAP) approach to formulate policy and drive decision-making.
2. Funding: Establish and promote awareness of Southern Nevada's public health funding landscape using education and transparent data resources to increase data-driven health policy and funding decision making.

Please see the CHIP report for detailed implementation plans that include performance measures, action plans, and evidence base summaries for each of these three priority areas.



## 3 Community Themes and Strengths Assessment

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### 3.1 Purpose

The Community Themes and Strengths Assessment (CTSA) phase of the MAPP process is intended to provide a deep understanding of health and community issues that residents feel are important, and to identify the local assets available to address those issues, by answering the questions:

- What is important to our community?
- How is quality of life perceived in our community?
- What assets do we have that can be used to improve community health?

The Lincy Institute supported a partnership between the University of Nevada Las Vegas (UNLV) School of Nursing and SNHD to complete this CTSA phase.

### 3.2 Methods

Two large group meetings were held at the UNLV Student Union on April 12 and April 13, 2011. In total, 350 people representing a cross-section of the community and a variety of community organizations and agencies were invited to attend.

A facilitator guided participants to identify themes of importance to the community, assess the community's performance on each theme, evaluate quality of life in Clark County, and identify community assets. At the conclusion of the large group meetings, sectors not represented were identified and focus groups or individual interviews were arranged to fill in gaps. UNLV Institutional Review Board (IRB) approval was obtained for conducting the interviews and focus groups.

There were a total of 62 attendees at the large group meetings. Please see Appendix A for sectors represented at the CTSA group meetings. Twelve additional participants were included in the focus groups and interviews for data collection.

### 3.3 Results

#### 3.3.1 Important Community Issues

The following tables present the community's assessment of issues important to Clark County, and evaluated how well Clark County is performing on the themes, as indicated by **Good**, **Okay**, **Poor**.

The following tables summarize themes that emerged in both group meetings, as well as in the focus groups and interviews.

Theme	Status	Community meeting participants identified the following key characteristics of a healthy community under this theme:	Identified in:
Built environment	Poor	<ul style="list-style-type: none"> <li>• Safe</li> <li>• Multimodal urban planning</li> <li>• Mix of housing</li> <li>• Knowing &amp; interacting with your neighbors</li> </ul> <p><u>As illustrated by:</u></p> <ul style="list-style-type: none"> <li>• Access to parks and trails; healthy and sustainable food; public transit systems; and nature</li> </ul>	<ul style="list-style-type: none"> <li>• Both community meetings</li> <li>• Follow-up focus groups and interviews</li> </ul>
Diversified economy	Poor	<ul style="list-style-type: none"> <li>• Diverse and sustainable economy</li> <li>• Fair taxes that stay in the state</li> </ul> <p><u>As illustrated by:</u></p> <ul style="list-style-type: none"> <li>• Living wages</li> <li>• Low unemployment and poverty rates</li> <li>• Opportunities for growth and improvement</li> </ul>	<ul style="list-style-type: none"> <li>• Both community meetings</li> <li>• Follow-up focus groups and interviews</li> </ul>
Education (access, commitment, quality)	Poor	<ul style="list-style-type: none"> <li>• Affordable</li> <li>• Available</li> <li>• Equitable</li> <li>• Instruction that spans the lifetime and engages students, legal guardians, and the community</li> </ul> <p><u>As illustrated by:</u></p> <ul style="list-style-type: none"> <li>• Appropriate class size</li> <li>• Qualified teachers</li> <li>• Increased literacy rates, graduation rates, and number of post graduates</li> <li>• Variety of opportunities and resources for education, lifelong learning, and career guidance</li> </ul>	<ul style="list-style-type: none"> <li>• Both community meetings</li> <li>• Follow-up focus groups and interviews</li> </ul>
Healthcare (access, quality, continuity)	Poor	<ul style="list-style-type: none"> <li>• Quality</li> <li>• Affordable</li> </ul> <p><u>As illustrated by:</u></p> <ul style="list-style-type: none"> <li>• Adequate supply of primary care providers</li> <li>• Affordable health insurance, primary care, specialty care, and mental health services</li> <li>• Comprehensive prevention and wellness</li> <li>• Academic medical centers for training</li> <li>• Patient safety/transparency</li> <li>• Accountability in healthcare industry</li> </ul>	<ul style="list-style-type: none"> <li>• Both community meetings</li> <li>• Follow-up focus groups and interviews</li> </ul>

Community engagement	Okay	<ul style="list-style-type: none"> <li>Organized collaboration of active dedicated volunteers</li> <li>Engaged public</li> </ul> <p><u>As illustrated by:</u></p> <ul style="list-style-type: none"> <li>Meeting community needs</li> <li>Adequate volunteer resources, recruitment and training</li> <li>Increased sense of community and grassroots movements</li> <li>Parental engagement in education</li> <li>Public/private partnerships</li> <li>Public dialogue</li> </ul>	<ul style="list-style-type: none"> <li>Both community meetings</li> <li>Follow-up focus groups and interviews</li> </ul>
Public safety	Okay	<ul style="list-style-type: none"> <li>Police and fire protection awareness, education, and communication</li> <li>Environment protected from lawlessness through good relationships among neighborhood residents and public service personnel</li> </ul> <p><u>As illustrated by:</u></p> <ul style="list-style-type: none"> <li>Freedom from fear</li> <li>Public readiness</li> </ul>	<ul style="list-style-type: none"> <li>Both community meetings</li> <li>Follow-up focus groups and interviews</li> </ul>

The following themes emerged in one group meeting, as well as in focus groups/interviews.

Theme	Status	Community meeting participants identified the following key characteristics of a healthy community under this theme:	Identified in:
Family support	Poor	<ul style="list-style-type: none"> <li>Access and availability of service and resources to fully participate in community activities</li> <li>Availability and access to wrap-around services for families (inclusive of elderly, disabled)</li> </ul> <p><u>As illustrated by:</u></p> <ul style="list-style-type: none"> <li>Youth programming</li> <li>Equal access</li> <li>Business sponsorship (public-private partnerships, internships for students or adopt-a-school)</li> <li>Funding by the state and county for youth services, family support health, etc.</li> </ul>	<ul style="list-style-type: none"> <li>One of two community meetings</li> <li>Follow-up focus groups and interviews</li> </ul>
Social services	Poor	<ul style="list-style-type: none"> <li>Variety of comprehensive social services for all ages backed with adequate funding</li> </ul> <p><u>As illustrated by:</u></p> <ul style="list-style-type: none"> <li>Programs and services (inpatient and outpatient) for mental health, addiction, youth and families,</li> </ul>	<ul style="list-style-type: none"> <li>One of two community meetings</li> <li>Follow-up focus groups and interviews</li> </ul>

		and seniors	
Cultural opportunities	Okay	<ul style="list-style-type: none"> <li>• Successful identification and promotion of opportunities</li> </ul> <u>As illustrated by:</u> <ul style="list-style-type: none"> <li>• Increased participation community-wide</li> </ul>	<ul style="list-style-type: none"> <li>• One of two community meetings</li> <li>• Follow-up focus groups and interviews</li> </ul>
Good government	Okay	<ul style="list-style-type: none"> <li>• Honest government</li> <li>• Wise spending of tax dollars</li> <li>• Integration of resources</li> </ul> <u>As illustrated by:</u> <ul style="list-style-type: none"> <li>• Effective communication</li> <li>• Transparency of government operations</li> <li>• Sustainable tax resources</li> </ul>	<ul style="list-style-type: none"> <li>• One of two community meetings</li> <li>• Follow-up focus groups and interviews</li> </ul>
Recreation	Okay	<ul style="list-style-type: none"> <li>• Availability of parks and recreational facilities and programs for all ages</li> </ul> <u>As illustrated by:</u> <ul style="list-style-type: none"> <li>• Parks</li> <li>• Farmers' markets</li> <li>• Community activity programs</li> </ul>	<ul style="list-style-type: none"> <li>• One of two community meetings</li> <li>• Follow-up focus groups and interviews</li> </ul>

Finally, the focus groups and interview participants identified Clark County as performing poorly on the following themes. Participants of these data collection methods did not complete the group exercise to identify characteristics of important community themes.

Theme	Status	Identified in:
Mental health services	Poor	<ul style="list-style-type: none"> <li>• Follow-up focus groups and interviews</li> </ul>
Provision of public services at an adequate level	Poor	
Synergy between education and economy	Poor	
Healthy public policies	Poor	
Partnership/communication among organizations	Poor	
Leadership (as distinct from government)	Poor	
Beauty in natural environment	Poor	

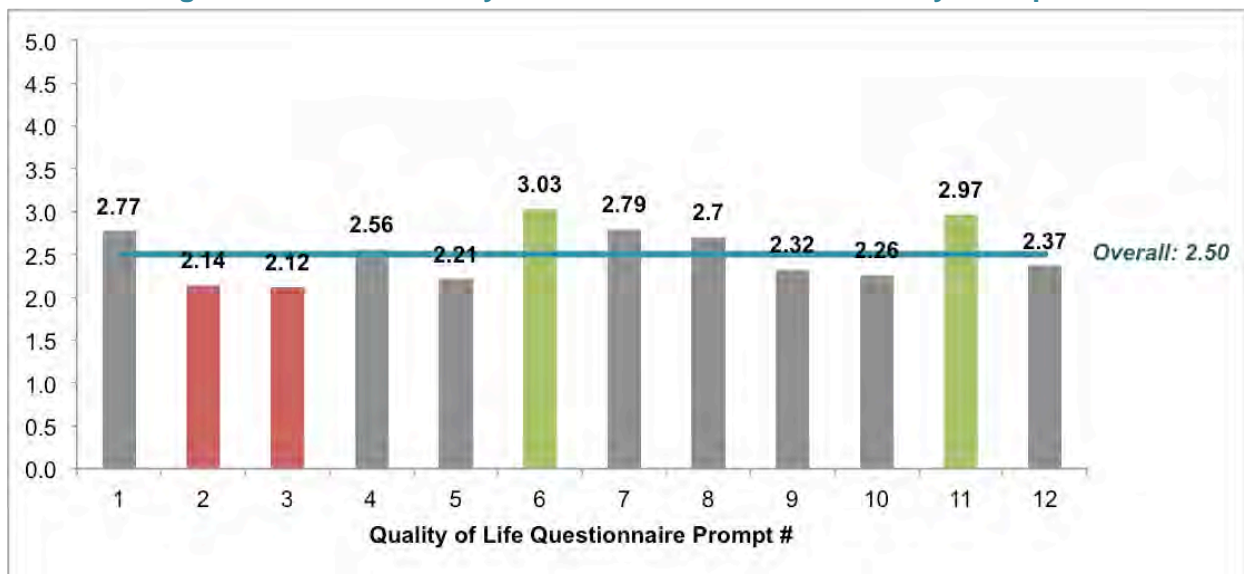
### 3.3.2 Quality of Life

Results from a 12-question quality of life survey indicate that respondents ( $n=57$ ), on average, rated Clark County as a 2.5 on a scale of 1 – 5 (worst to best) for achieving the benchmarks of a healthy community. The Cronbach's alpha coefficient for internal reliability was 0.85, indicating adequate reliability. The questions were:

1. Are you satisfied with the quality of life in our community?
2. Are you satisfied with the health care system in the community?
3. Is this community a good place to raise children?

4. Is this community a good place to grow old?
5. Is there economic opportunity in the community?
6. Is the community a safe place to live?
7. Are their networks of support for individuals and families?
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?
9. Do all residents perceive that they – individually and collectively – can make the community a better place to live?
10. Are community assets broad-based and multi-sectoral?
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?
12. Is there an active sense of civic responsibility and engagement and of civic pride in shared accomplishments?

**Figure 3–1: Mean Quality of Life Questionnaire Scores by Prompt**



Respondents indicated dissatisfaction with the health care system and rated Clark County poorly as a place to raise children. The community's relative strengths were identified as safety and the increasing levels of mutual trust and respect shown in collaborative efforts to achieve community goals.

### 3.3.3 Community Assets

Participants were able to identify long lists of assets in all of the categories reviewed during the meetings: History, Future Plans, Informal Sector, Public Sector, Private Sector, Voluntary Sector, and Environmental. Recurrent themes were good weather, demographic diversity, wealthy individuals, access to politicians, name recognition for Las Vegas, Regional Transportation Commission (RTC), casinos, faith community, Three Square food bank, Opportunity Village, Southern Nevada Health District, Hoover Dam, Nellis Air Force Base, and celebrities. Several participants identified the schools as assets because they are widely



distributed and could be used to build social capital in neighborhoods. A focus group of school nurses identified themselves as public sector assets. The longest list of all was in the Voluntary Sector. Participants concluded that high rates of volunteerism among residents resulted from a need to fill gaps in social and public health services provided by state and local governments.

Below is an overview of the assets identified during the meetings:

History (Prompt: Contributions of history — what makes you proud?)		
<ul style="list-style-type: none"> <li>Affordable living</li> <li>Highest rate of gold Leadership in Energy and Environmental Design (LEED) certified buildings</li> <li>Celebration of diversity (culture, ethnic, race)</li> </ul>	<ul style="list-style-type: none"> <li>Historic West Side</li> <li>Mining</li> <li>Growth (economic, technical)</li> <li>National parks</li> <li>Preservation of cultures</li> </ul>	<ul style="list-style-type: none"> <li>Pioneers, settlers</li> <li>Building Hoover Dam/Lake Mead</li> <li>Bridge across Colorado River</li> <li>Innovators in water conservation</li> </ul>
Future Plans		
<ul style="list-style-type: none"> <li>New City Hall</li> <li>Cleveland Clinic Brain Institute</li> <li>Smith Center for the Arts</li> <li>High speed rail union village</li> <li>Refurbish America</li> </ul>	<ul style="list-style-type: none"> <li>I-215 West Beltway bike trail</li> <li>Clean energy jobs</li> <li>Veterans Administration hospital</li> <li>RUVO brain insurance</li> <li>Private university expansion</li> <li>Crime free corridor downtown partnership</li> </ul>	<ul style="list-style-type: none"> <li>Parks' promotion of healthy lifestyle</li> <li>University of Nevada Las Vegas North expansion</li> <li>Additional federally qualified health centers</li> <li>Tivoli village</li> </ul>
Informal Sector (Prompt: Local resident skills, passion, experiences)		
<ul style="list-style-type: none"> <li>Support groups</li> <li>Community gardens</li> <li>Professional organizations</li> <li>Community events/festivals</li> </ul>	<ul style="list-style-type: none"> <li>Retirement communities/retirees</li> <li>Cultural history</li> <li>Animal rescue groups</li> <li>Artists</li> </ul>	<ul style="list-style-type: none"> <li>Master gardeners</li> <li>Church volunteers/All volunteers</li> <li>Stroke caregivers</li> <li>Park ambassadors</li> </ul>
Public Sector		
<ul style="list-style-type: none"> <li>Clark County School District Community centers</li> <li>City/Clark County social services</li> <li>Nevada Department of Health and Human Services Family Resource Centers</li> <li>Fire departments</li> <li>Police departments</li> <li>Hospital/ Mental health (University Medical Center Children's hospital of Nevada)</li> </ul>	<ul style="list-style-type: none"> <li>University Medical Center-Community health Nurse</li> <li>Regional Transportation Commission of Southern Nevada, RTC SN</li> <li>Las Vegas Metropolitan Police Department, LVMPD</li> <li>Clark County Library District</li> <li>University of Nevada</li> <li>Las Vegas College of Southern Nevada</li> <li>City of Las Vegas Parks and Recreation; Clark County Parks and Recreation</li> </ul>	<ul style="list-style-type: none"> <li>Congressional offices</li> <li>Continuum of Care for the homeless</li> <li>Family Promise</li> <li>Senior development- Senior Centers</li> <li>School-Based Health Centers</li> <li>Nellis Air Force Base</li> <li>Southern Nevada Regional Planning Coalition</li> <li>Head Start</li> <li>Nevada 2-1-1</li> <li>Southern Nevada Health District</li> </ul>
Private Sector		
<ul style="list-style-type: none"> <li>Insurance (life and health)</li> <li>Community leadership</li> <li>Nonprofit board membership</li> <li>Local publications</li> <li>TV and radio station PSAs</li> </ul>	<ul style="list-style-type: none"> <li>Restaurants (Celebrity Chefs)</li> <li>Health clubs</li> <li>Foundations</li> <li>Corporations</li> <li>Hospitals</li> </ul>	<ul style="list-style-type: none"> <li>Unions</li> <li>Zappos</li> <li>Starbucks</li> <li>Walmart/Target/Albertsons/Smiths</li> </ul>

<ul style="list-style-type: none"> <li>Youth sport leagues</li> </ul>	<ul style="list-style-type: none"> <li>Philanthropy and matching funds</li> </ul>	<ul style="list-style-type: none"> <li>(donations/partnerships)</li> <li>Newspaper (RJ, Citylife, Sun, Promotion, Vegas)</li> </ul>
<b>Voluntary Sector</b>		
<ul style="list-style-type: none"> <li>Food banks</li> <li>Vietnam Veterans of America in Las Vegas</li> <li>Corporate volunteers</li> <li>Medical Reserve Corps</li> <li>YMCA</li> <li>United Way of Southern Nevada Volunteer Center</li> <li>Safe Nest</li> <li>Opportunity Village Race activities/ Rugby tour</li> <li>Disabled American Veterans-DAV</li> <li>Student volunteers</li> <li>The Gay and Lesbian Center of Southern Nevada</li> <li>United Way of Southern Nevada</li> <li>Nevada Homeless Alliance</li> </ul>	<ul style="list-style-type: none"> <li>American Association of Retired Persons</li> <li>Habitat for Humanity</li> <li>Catholic Charities of Southern Nevada</li> <li>Nature Conservancy</li> <li>Conventions</li> <li>Special Olympics Nevada</li> <li>Alliance of Nevada Nonprofits</li> <li>Goodwill of Southern Nevada</li> <li>The Salvation Army of Southern Nevada</li> <li>Opportunity Village</li> <li>Support groups (American Heart Association, American Cancer Society, Alzheimer's Association, etc.)</li> <li>HELP of Southern Nevada</li> </ul>	<ul style="list-style-type: none"> <li>Girl scouts/ Boy scouts</li> <li>AmeriCorps VISTA</li> <li>American Red Cross of Southern Nevada</li> <li>After school all stars</li> <li>Deseret Industries</li> <li>Baby's Bounty</li> <li>Meals on Wheels</li> <li>Huntridge Teen Clinic</li> <li>March of Dimes</li> <li>Leid Animal Shelter</li> <li>Aid for AIDS of Nevada-AFAN</li> <li>Helping Kids Clinic</li> <li>Nevada Health Centers' Mammovan</li> <li>Clark County Safe Kids</li> <li>United Way of Southern NV (UWSN)</li> <li>Court-appointed special advocates (CASA)</li> </ul>
<b>Environmental</b>		
<ul style="list-style-type: none"> <li>Mineral resources</li> <li>Local parks and state parks</li> <li>Lake Mead, Colorado River</li> <li>Mild winters</li> <li>Sunshine and wind for energy Recycling programs</li> <li>Water conservation</li> <li>Town Square (outdoor community gathering settings)</li> </ul>	<ul style="list-style-type: none"> <li>Wetlands park</li> <li>Springs Preserve</li> <li>Mount Charleston</li> <li>Desert Research Institute</li> <li>Red Rock</li> <li>Henderson Bird Preserve</li> <li>Bonnie Springs</li> </ul>	<ul style="list-style-type: none"> <li>Open space</li> <li>Sustainability initiatives</li> <li>Hoover Dam</li> <li>Mt. Charleston</li> <li>Hunting/fishing/skiing/hiking/camping/climbing/kayaking/biking</li> <li>Gilcrease Farm</li> </ul>

Participants were also invited to mark local assets on a map. At the end of the two days, the map was covered with pushpins that identified parks and other recreational venues, schools, hospitals, the airport, tourist attractions, and Nellis Air Force Base.

### 3.4 Discussion

This CTSA aims to identify what is important to the Southern Nevada community, how quality of life is perceived, and what assets are available to improve community health.

During the community meetings organized to discuss important community issues, residents tended to focus more on the community issues on which Clark County was performing poorly. All three participant groups (attendees of both community meetings and focus group/individual interview participants) agreed that the following issues were both of great importance and that the Southern Nevada community could improve in these areas:

- Built environment
- Diversified economy
- Education (access, commitment, quality)
- Healthcare (access, quality, continuity)

All three participant groups also agreed that community engagement and public safety are important issues in the community, but that Clark County's performance in these areas is fair.

Regarding quality of life, respondents voiced dissatisfaction with the healthcare system and the suitability of Southern Nevada as a place to raise children. Perceptions of public safety and of mutual trust and respect among community partners were more positive.

Participants in the CTSA process compiled a long list of community assets across seven categories: History, Future Plans, Informal Sector, Public Sector, Private Sector, Voluntary Sector, and Environmental. The numerous assets and resources presented above can be mobilized and employed to address health issues in Southern Nevada.

### 3.5 Conclusions

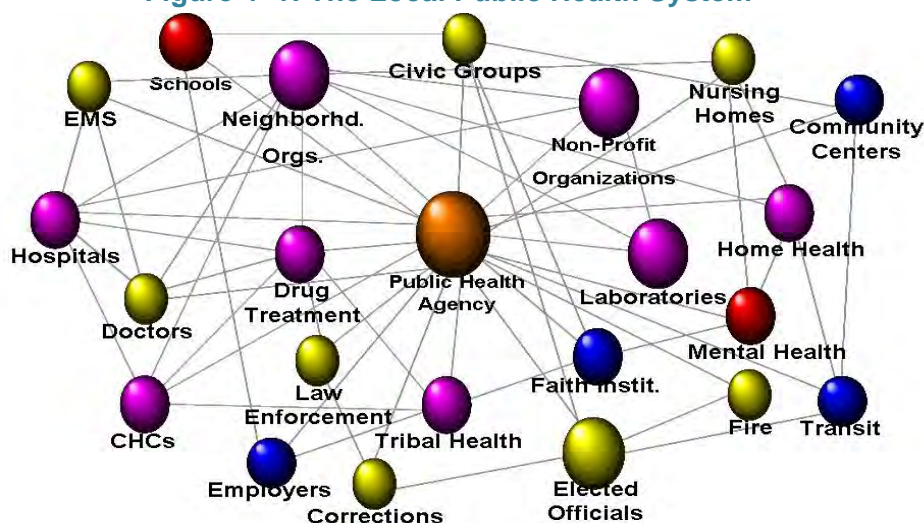
The core group members participating in the CTSA were engaged and wanted to stay involved in the process. In general, however, participants concluded that Clark County falls short in many of the requirements the community agrees are important for a healthy community and desirable quality of life. The need for improvements in education, health care, the economy, and built environment dominated much of the discussion. One person interviewed identified wise government leadership as key to achieving improvements in these areas. This process facilitated the development of the Clark County Vision Statement document, attached in Appendix B.

## 4 Local Public Health System Assessment

### 4.1 Purpose

It takes more than healthcare providers and public health agencies to address the social, economic, environmental and individual factors that influence health. The local public health system comprises agencies, organizations, individuals and businesses that must work together to create conditions for improved health in a community, as illustrated in Figure 4–1.

**Figure 4–1: The Local Public Health System**



The purpose of the Local Public Health System Assessment (LPHSA) is to identify local public health and community assets, gaps, and resources to address the gaps, as related to the Ten Essential Public Health Services. This assessment answers the questions:

- What are the components, activities, competencies, and capacities of our local public health system?
- How are the Essential Services being provided to our community?

### 4.2 Methods

This Clark County LPHSA used the National Public Health Performance Standards Program (NPHPSP) local survey instrument and analysis, developed collaboratively by seven national public health organizations. The assessment focused on standards that are based on the Ten Essential Public Health Services by which local public health system performance can be determined.

The NPHPSP local instrument is divided into separate surveys for each of the Ten Essential Services (ESs). For each of the ESs, the NPHPSP has established two to four model standards that describe the key aspects of an optimally performing public health system. Each model standard is followed by assessment questions. These questions served to refine and assist the responder in assessing measures of performance. Responses to these questions indicated how

well the model standard – which portrayed the highest level of performance or “gold standard” – is being met. Respondents were able to on a scale of: No Activity (0%), Minimal Activity (>0%-25%), Moderate Activity (>25%-50%), Significant Activity (>50%-75%) and Optimal Activity (>75%-100%). These scores were then averaged for results.

The Clark County LPHSA Task Force decided to conduct the assessment using two approaches, one broad and one targeted.

#### 4.2.1 Broad Assessment Approach

Each survey was posted using Survey Monkey and the Task Force invited specific individuals/agencies to complete either one or two surveys that most closely fit with their area of expertise or responsibility. Initially, 761 email invitations were sent. To extend the reach of the surveys, the snowball sampling approach was utilized, which requested invited individuals to forward the survey invitation to other individuals knowledgeable about the particular ES. The surveys were anonymous by default to increase participation, but allowed respondents to self-identify if they were interested in further assisting with the assessment process. All participants were asked to identify which segment of the LPHS they represented; e.g., healthcare provider, nursing home, etc. The survey opened on January 9, 2012, and closed on January 31, 2012.

#### 4.2.2 Targeted Assessment Approach

As preliminary analysis of the survey data showed very low response rates to a small subset of the LPHS's Model Standards, the Task Force planned a half-day retreat in February 2012 to further assess these gaps. Individuals who indicated interest through the survey, all original survey invitees, and select SNHD personnel were invited to participate. The facilitator who had assisted with the CTSA also attended and guided participants to a consensus on a subset of Model Standards, for ESs 3, 4, and 9. These results were then used in place of the online survey results due to the very limited responses from the initial data collection.

The results for all model standards were submitted to the NPHPSP for analysis. The full report is available in Appendix C.

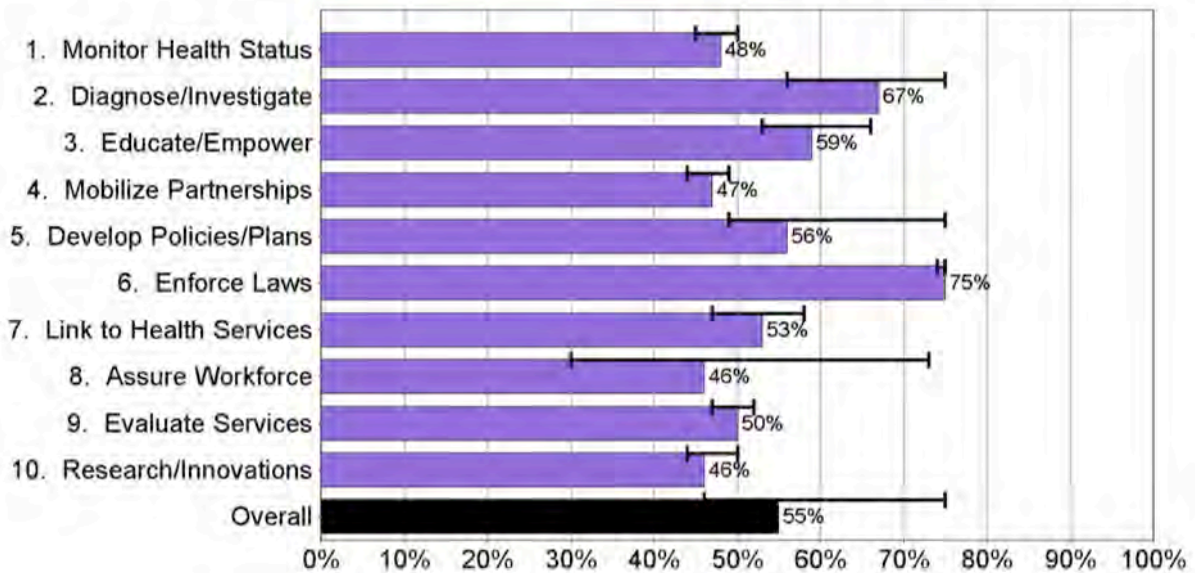
### 4.3 Results

Figure 4–2 presents the performance scores for the Ten Essential Public Health Services (with score ranges), which were calculated using the survey results and qualitative data collected during the Task Force retreat. While no areas overall were ranked as No or Minimal Activity (0%-25%), neither were any areas ranked as Optimal Activity (75%-100%). All areas were ranked as Moderate (25%-50%) or Significant Activity (50%-75%). The essential service “assuring a competent workforce” had the greatest variability in scores. The highest-scoring ES by far was ES 6 (Enforce Laws), at 75%. Performance of ESs 1, 4, 8, and 10 all scored between 46 and 48%, indicating opportunities for improvement in the following services:

- 1: Monitor health status
- 4: Mobilize partnerships
- 8: Assure workforce
- 10: Research/Innovations



**Figure 4–2: Performance Scores for the 10 Essential Public Health Services**

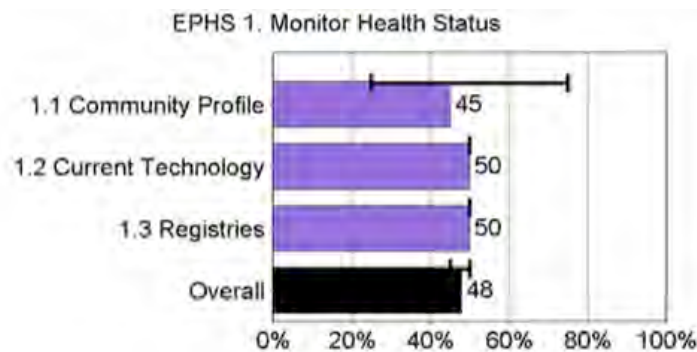


The highest- and lowest-scoring ESs were examined in closer detail below. Discussions of the performance of other ESs are presented in Appendix C.

#### 4.3.1 ES 1: Monitor Health Status to Identify Community Health Problems (Poor Performance)

##### Key Questions:

- Does our local public health system conduct community-wide health assessments to create a community health profile on a regular basis?
- Do we use technology to interpret and communicate the assessment data?
- Is there collaboration in our local public health system to use population health registries?

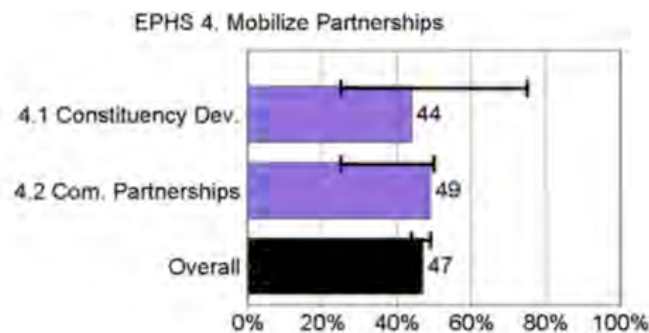


**Findings:** The population-based Community Health Profile had the largest variability in responses, from Minimal to Significant Activity.

#### 4.3.2 ES 4: Mobilize Community Partnerships to Identify and Solve Health Problems (Poor Performance)

##### Key Questions:

- Is there a process in place to develop collaborative relationships between current and potential constituents in the local public health system?
- Is there a broad-based community partnership to assure a comprehensive approach to improving health?

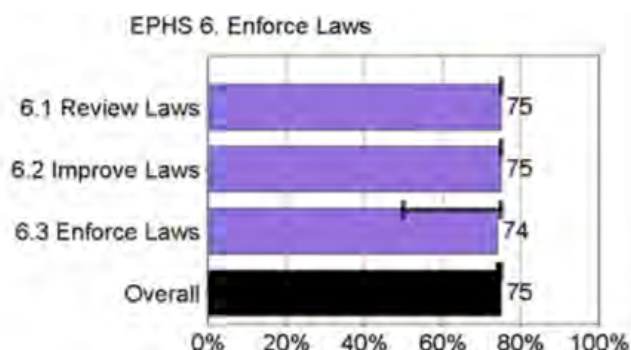


Findings: While online survey responses indicated Moderate to Significant activity under this ES, retreat attendees suggested activity to foster collaboration is actually Minimal. Lack of communication, duplication of efforts, and scarcity of resources were commonly identified as barriers to collaboration.

#### 4.3.3 ES 6: Enforce Laws and Regulations that Protect Health and Ensure Safety (Strong Performance)

##### Key Questions:

- Are health and safety laws, regulations and ordinances reviewed, and are they revised or improved to align with best practices?
- Are there appropriate enforcement activities in our local public health system to assure compliance with health and safety laws and regulations?

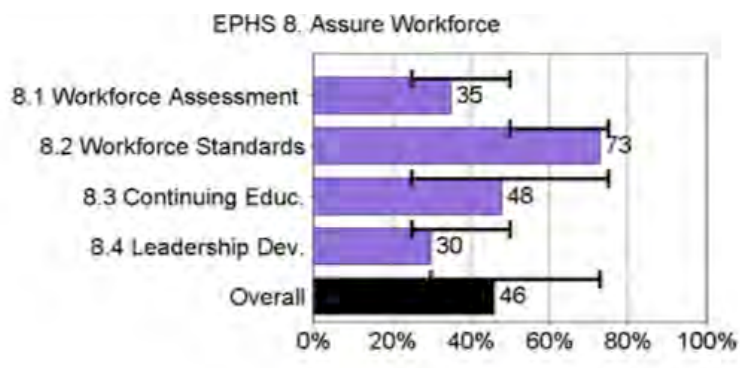


Findings: This was the highest-ranked ES, although it did not reach Optimal Activity. There was little variability among responses or between SNHD employees and non-employees.

#### 4.3.4 ES 8: Assure a Competent Public and Personal Health Care Workforce (Poor Performance)

##### Key Questions:

- Is an assessment of workers within in the local public health system conducted, are gaps addressed, and are assessment results distributed?
- Does the local public health system develop and maintain standards for its workforce?
- Do life-long continuing education opportunities exist for the public health workforce?
- Are there leadership development opportunities in the local public health system?

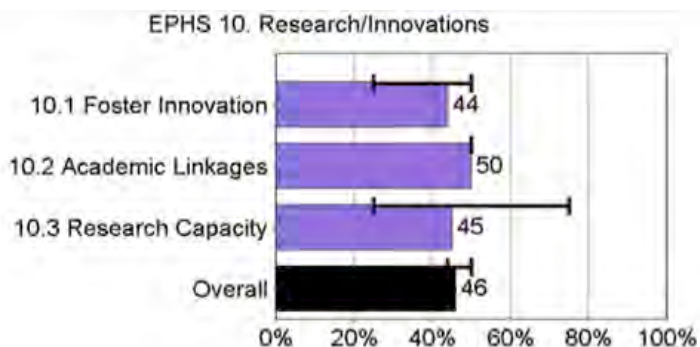


Findings: This ES tied for lowest-ranked with ES 10. There was great variability among responses. Leadership development was ranked the lowest.

#### 4.3.5 ES 10: Research for New Insights and Innovative Solutions to Health Problems (Poor Performance)

##### Key Questions:

- Do organizations within the local public health system foster innovation to strengthen public health practice?
- Are there linkages with institutions of higher learning and research within the public health system?
- Is there capacity in our community to initiate or participate in public health research?



Findings: This survey ES had the fewest responses and was tied for lowest rank with ES 8. Because of the small sample size and great variability in responses to Research Capacity findings are inconclusive.

## 4.4 Discussion

This LPHSA aims to identify the components, activities, competencies, and capacities of the Southern Nevada public health system, and to assess how the Ten Essential Public Health Services are being provided to the community.

Participants in the LPHSA process identified gaps in four of the ten ESs:

ES 1: Monitor Health Status to Identify Community Health Problems: Recorded responses showed agreement that the local public health system's utilization of current technology and registries is operating at 50% effectiveness. However, participants' evaluation of Community Health Profile utilization varied much more widely. Responses ranged from Minimal to Significant Activity, suggesting a closer investigation of how different audiences use the profile may be insightful.

ES 4: Mobilize Community Partnerships to Identify and Solve Health Problems: Substantial efforts need to be made to foster collaboration, improve communication, and reduce duplication of efforts in order to effectively develop and mobilize partnerships.

ES8: Assure a Competent Public and Personal Health Care Workforce: The local public health system was judged to be performing particularly poorly in workforce assessment and leadership development. Development and maintenance of workforce standards were evaluated to be a relative strength. Responses were mixed on the availability and accessibility of lifelong continuing education opportunities for the public health workforce.

ES10: Research for New Insights and Innovative Solutions to Health Problems: Within this area, the linkages between the local public health system and institutions of higher learning and research were judged to be fair. The capacity of public health organizations to foster innovation was assessed to be less promising. The perceived capacity of the community to initiate or participate in public health research was widely variable; additional investigation of this diversity of responses is needed.

Southern Nevada scored the highest in ES 6: Enforce Laws and Regulations that Protect Health and Ensure Safety. Respondents felt that Southern Nevada was relatively strong in three aspects of this service: 1) reviewing health and safety laws, 2) revising and improving such laws, and 3) enforcing compliance with health and safety laws and regulations.

The local public health system is an important resource for improving health and quality of life in Clark County. Identification of gaps in the system is just the first step to strengthening this important asset.

## 4.5 Conclusions

The LPHS fails to function at Optimal Activity for any of the Ten Essential Public Health Services. However, enforcement of laws was judged to come the closest out of the 10 services. The services with the most concerning scores were: monitoring health status, mobilizing partnerships, assuring a competent workforce, and research/innovations. Of particular note was the need for increased coordination and communication among agencies. As the essential service "assuring a competent workforce" had the greatest variability in scores, it was

recommended that this essential service be further investigated. Research for new insights and innovations had the fewest responses and further investigations were also recommended for this ES.

In addition, there was a general lack of knowledge among the community that they were part of the LPHS, an issue that emerged during the retreat. Many responses in the surveys were No Knowledge, indicating a need to educate all members of the LPHS of their roles.



## 5 Forces of Change Assessment

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### 5.1 Purpose

In 2012, SNHD partnered with the UNLV School of Nursing to conduct a Forces of Change Assessment (FOCA). The FOCA is a qualitative assessment designed to help communities answer the following questions:

- What is occurring or might occur that affects the health of our community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

Focus groups and key informant interviews with community partners were conducted to collect information about the community's ideas about the major forces that were acting on the local public health system and impacting the health and quality of life of Clark County residents.

FOCA participants in 2012 identified the following forces:

1. Access to Care (Affordable Care Act)
2. Economics (high unemployment)
3. Education (inadequate funding)
4. Healthcare (healthcare provider shortage, quality of care)
5. Government (people want services but are unwilling to pay)
6. Climate Change (drought and air pollution)

In 2015, a follow-up FOCA was conducted to verify whether these forces were still relevant and to determine if any new forces impacting health in Clark County should be acknowledged.

### 5.2 Methods

The SNHD MAPP Committee developed the 2015 Forces of Change Assessment survey based on NACCHO guidelines, the 2012 FOCA, and input from the CHA Steering Committee. The online survey was designed to collect primary qualitative data on the forces that are influencing the health or quality of life of Clark County residents and impacting the local public health system.

To collect input from a broad spectrum of the local public health system, MAPP Committee members constructed a list of key informants by identifying at least two agencies or organizations from each sector of the LPHS (see Figure 4–1 for an illustration of these sectors). Efforts were made to ensure that all sectors were represented, with a minimum of 25 participants (with the goal of at least one participant per sector) completing the survey.

The following LPHS sectors were invited to participate in the FOCA data collection:

- |                                |             |                             |
|--------------------------------|-------------|-----------------------------|
| • Community Based Organization | • Employers | • Law Enforcement           |
| • Chamber of Commerce          | • EMS       | • Mental Health             |
| • Community Health             | • Faith     | • Neighborhood Associations |
|                                | • Financial | • Non-Governmental          |
|                                | • Fire      |                             |

- |                           |                        |                        |
|---------------------------|------------------------|------------------------|
| Centers                   | • Healthcare Providers | Organizations          |
| • City and Urban Planners | • Higher Education     | • Nursing Homes        |
| • Civic Groups            | • Home Health          | • Parks and Recreation |
| • Corrections             | • Homeless Shelter     | • Public Health        |
| • Dentists                | • Hospitals            | • Schools              |
| • Drug Treatment          | • Laboratories         | • Social Services      |
| • Elected Officials       |                        | • Transit              |
|                           |                        | • Tribal Health        |

## 5.3 Results

Fifty-two participants responded to the survey. Of the respondents, 36 respondents self-identified as belonging in at least one of the listed sectors; 16 respondents skipped this question. Participants represented at least 21 different sectors of the local public health system.

The majority of respondents (77%) felt that the forces that were identified in the 2012 survey were still relevant in 2015. No discrete new forces were identified; however, qualitative data helped further define the forces that are currently impacting the health and quality of life of the population and the ability of the local public health system to operate. The figure below presents the overall forces identified for 2015, followed by a table of the assessment results grouped by type of force and summaries of the opportunities and threats created by each force.

Opportunities and threats identified by multiple respondents are marked with an asterisk.

**Table 5-1: 2015 Forces of Change and Associated Opportunities and Threats**



Economics		
Forces	Opportunities	Threats
<b>Employment Trends</b>	<ul style="list-style-type: none"> <li>Declining unemployment rates*</li> <li>Increased hiring (new businesses)</li> <li>School of Medicine bringing new jobs</li> <li>Jobs with benefits</li> <li>Population growth with improving economic picture</li> </ul>	<ul style="list-style-type: none"> <li>Low wages*</li> <li>High unemployment (declining but still high)</li> <li>Decreased access to insurance</li> <li>Poverty</li> </ul>

Political		
Forces	Opportunities	Threats
<b>Affordable Care Act</b>	<ul style="list-style-type: none"> <li>Highlight public health needs*</li> <li>Reduced burden on SNHD</li> <li>Access to physician care</li> </ul>	<ul style="list-style-type: none"> <li>Poor implementation and utilization; misuse</li> <li>Supreme Court Decision may reduce ACA's impact</li> </ul>
<b>Funding</b>	<ul style="list-style-type: none"> <li>Education- New legislation proposals*</li> <li>Governor Sandoval's new Education Plan</li> <li>Technical Education, STEM</li> </ul>	<ul style="list-style-type: none"> <li>Historically poor education</li> <li>Lack of community support for education</li> <li>Limited spending for public health</li> </ul>

Environmental		
Forces	Opportunities	Threats
<b>Built Environment</b>	<ul style="list-style-type: none"> <li>Better planning and collaboration</li> </ul>	<ul style="list-style-type: none"> <li>Transportation*</li> <li>Inadequate planning</li> <li>Uncontrolled growth</li> </ul>
<b>Climate Change</b>	<i>No opportunities were identified</i>	<i>No threats were identified</i>
<b>Water Resources</b>	<i>No opportunities were identified</i>	<ul style="list-style-type: none"> <li>Water shortage</li> <li>Unaffordable utilities</li> <li>Population growth</li> </ul>

Healthcare		
FORCES	OPPORTUNITIES	THREATS
<b>Access to Care</b>	<ul style="list-style-type: none"> <li>Access to providers*</li> <li>Outreach around options to close gap in access</li> <li>Community-based paramedicine</li> <li>Martin Luther King Clinic</li> <li>Free and reduced cost services</li> </ul>	<ul style="list-style-type: none"> <li>Cost of transportation*</li> <li>Economics</li> <li>Travel</li> <li>Undocumented persons receiving health care put more demands on the system</li> <li>Mental Health</li> <li>Clinics not accepting NV Medicaid</li> </ul>
<b>Provider Shortage and Service Gaps</b>	<ul style="list-style-type: none"> <li>Proposed schools of medicine*</li> </ul>	<ul style="list-style-type: none"> <li>Decreased availability and increased wait times*</li> <li>Lack of mental health care providers and training*</li> <li>Decreased access to providers</li> <li>Lack of specialists and qualified physicians</li> <li>Physician care</li> <li>Lack of funding leading to lack of knowledgeable educators and scientists</li> </ul>

<b>Utilization</b>	<ul style="list-style-type: none"> <li>• Creating outpatient services for mental health</li> </ul>	<ul style="list-style-type: none"> <li>• Immigrants who are undocumented are unable to access system*</li> <li>• Emergency room overcrowding</li> <li>• Poor reimbursement</li> </ul>
<b>Quality of Care</b>	<i>No opportunities were identified</i>	<i>No threats were identified</i>
<b>Poor Coordination of Care and of the LPHS</b>	<ul style="list-style-type: none"> <li>• Increased collaboration with others</li> <li>• Electronic Health Records</li> <li>• Health Information Exchange</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of knowledge of services</li> <li>• Difficulty navigating system (healthcare and social service)</li> </ul>

## 5.4 Discussion

This FOCA aims to identify the forces affecting the health of Southern Nevadans and the local public health system, and which threats or opportunities are generated by such changes. The majority of participants believed that the forces identified in the previous FOCA (conducted in 2012) were still quite relevant in the present: access to care, economics, education, healthcare, government, and climate change. These issues fall under the larger groupings of economic, political, environmental, and healthcare-related forces of change. While aspects of these forces contribute to Southern Nevada's health challenges in certain regards, all forces also provide openings for health improvements.

Under **economic** forces, the declining unemployment rate was emphasized as a strength. However, low wages temper some of the beneficial trend. In the **political** realm, the Affordable Care Act was regarded as imperfectly implemented, but helpful for highlighting public health needs. Conflicting accounts were recorded regarding the opportunities and threats presented by funding decisions, especially around education in Southern Nevada. The number of **environmental** threats identified far outnumbered identified opportunities. Transportation was mentioned multiple times, and the stress of population growth on the built environment and water resources was also highlighted.

Participants discussed **healthcare** forces in the greatest detail. Within this realm, residents' access to providers was touted as an opportunity, as were initiatives to strengthen community-based and reduced-cost care. Development of outpatient mental health services, another highlighted strength, would help to address the needs identified in the CHSA. A number of barriers still remain across the healthcare spectrum, however: the cost of both healthcare itself and the transportation required to access care were identified as substantial threats. The availability of primary care and specialist providers are a concern, as are the complexities of navigating the healthcare system, low reimbursement rates, and an overstressed healthcare system.

## 5.5 Conclusions

External forces of change are important to acknowledge, as they may assist or impede the success of community improvement efforts. Based on the 2015 FOCA, Clark County should pay special attention to the following forces and their associated opportunities and threats:

- Impact of political changes:
  - Affordable Care Act
  - Funding allocations
- Composition and quality of the healthcare system
- Environmental changes:
  - Climate change
  - Water scarcity
- Socioeconomic forces:
  - Unemployment
  - Education



## 6 Resources

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- 1 World Health Organization. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946. World Health Organization; signed on 22 July 1946 by the representatives of 61 States.
- 2 National Association of City and County Health Officials. More information on MAPP can be found at. [Internet]. Available from: <http://www.naccho.org/topics/infrastructure/mapp/index.cfm>.
- 3 Healthy Communities Institute. Healthy Southern Nevada Community Dashboard. [Internet]. [cited 2016 February 15]. Available from: <http://www.healthysouthernnevada.org/modules.php?op=modload&name=NS-Indicator&file=index>.
- 4 Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. [Internet]. Available from: <http://www.cdc.gov/brfss>.
- 5 Nevada Division of Public and Behavioral Health. Behavioral Risk Factor Surveillance System. [Internet]. Available from: [http://dphh.nv.gov/Programs/BRFSS/Behavioral\\_Risk\\_Factor\\_Surveillance\\_System\\_\(FRFS\\_S\)\\_-\\_Home/](http://dphh.nv.gov/Programs/BRFSS/Behavioral_Risk_Factor_Surveillance_System_(FRFS_S)_-_Home/).
- 6 Bureau of Labor Statistics. Create Customized Tables: Local Area Unemployment Statistics. [Internet]. Available from: <http://data.bls.gov/cgi-bin/dsrv?la>.
- 7 County Health Rankings. Rankings Data. [Internet]. Available from: <http://www.countyhealthrankings.org/rankings/data>.
- 8 Kaiser Family Foundation. State Health Facts: Nevada. [Internet]. Available from: <http://kff.org/statedata/?state=NV>.
- 9 National Vital Statistics System, Centers for Disease Control and Prevention. U.S. Census Populations With Bridged Race Categories. [Internet]. Available from: <http://wonder.cdc.gov/bridged-race-population.html>.
- 10 Division of Health Sciences, University of Nevada, Reno. Nevada Youth Risk Behavior Survey. [Internet]. Available from: <http://dhs.unr.edu/chs/research/yrbs>.
- 11 Centers for Disease Control and Prevention. 2013 Sexually Transmitted Diseases Surveillance. [Internet]. Available from: <http://www.cdc.gov/std/stats13/default.htm>.
- 12 Southern Nevada Health District. [Internet]. Available from: <http://southernnevadahealthdistrict.org>.
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# *Southern Nevada*

## Community Health Assessment Appendix





## *Appendix A: Sectors Represented at CTSA Group Meetings*

**Agency types that attended the Community Themes and Strengths Assessment (CTSA) workshops (using Community as Partner Framework, based on NACCHO's Local Public Health System Diagram)**

*Updated February 22, 2016*

<b>Community Core</b>	
<i>Community based Organizations, Faith Institutes, Tribal, private citizens</i>	
Hispanic Organizations	Religious Organizations
African- American organizations	Private Citizens
<b>Physical Environment</b>	
<i>Transit, Parks and Recreation, City Planners</i>	
School Safe Routes	Community Transit
Regional Transportation	Outdoor Advocacy Group
Community Focused Nonprofit	Environmental Research
<b>Health and Social Services</b>	
<i>Mental Health, Drug Treatment, Social Services, Laboratory, Dentists, Home Health, Nursing Homes, Community Health Centers</i>	
Student Health Center	Grief Counseling
Social Services	Teen Health Center
Community Health center	Mental Health Centers
Local government Hospital	Nonprofit Hospital
For Profit Hospital	Healthcare Workforce Advocacy Group
Health Oversight Agency	Rehabilitation Centers
Nonprofit Health Referral Agency	Nursing Homes
Primary Care Providers	
<b>Schools</b>	
<i>Grade Schools, Secondary Education</i>	
Local school district	Universities and colleges
<b>Safety: public protection</b>	
<i>Fire, Emergency Medical services, Law Enforcement, Corrections</i>	
Local Emergency Services	Local Fire and Rescue Departments
Local Police Departments	
<b>Community Assistance</b>	
<i>Advocacy groups, nongovernmental organizations, Non Governmental Organizations</i>	
Children's Advocacy	Chronic Disease Group
Children's Research	Health Choices Groups
Health Disparities Advocacy	Homeless Services
Community Advocacy Groups	
<b>Government and Politics</b>	
<i>Elected officials, Health District, Civic Groups, Neighborhood associations,</i>	
City Officials	State Officials

State Health Oversight Agencies	Military base
Government Social Services	County officials
Federal Officials	Public Health Agency
<b>Communications</b>	
<i>All types of media</i>	
Television stations	Local Magazines
Radio stations	
<b>Private Industry</b>	
<i>Employers, for profit agencies</i>	
Employers	

## *Appendix B: Clark County Vision Statement*



### **A Vision for an Engaged, Educated, and Healthy Community**

A healthy community is one whose residents are knowledgeable and involved in improving quality of life through informed leadership and healthy public policy. Residents in a healthy community have access to resources and services they need, such as high quality health care, an effective public education system, and a safe and supportive environment.

### **Southern Nevada Community Values**

#### **Community engagement**

- A community in which all segments of the population are involved, as illustrated by volunteerism, engagement in education, public/private partnerships, increased social capital, and participation in public dialogue.
- A community supported by visionary leadership, both public and private.

#### **Education**

- A community that values education as illustrated by allocation of needed resources, high school graduation rates that equal or exceed national norms, and lifelong learning opportunities.
- A community where an educated workforce attracts diversified businesses and contributes to a strong, sustainable economy.

#### **Health**

- A community where high quality mental and physical health care is accessible to all residents, including the indigent and underserved.
- A community that recognizes the interaction of policies, systems, and the environment on health and supports public policies that promote health and prevent disease.

#### **Environment**

- A community where residents feel safe, have access to life-sustaining resources such as clean air and water, and reside in nurturing surroundings that meets their needs for self-respect, interaction with others, recreation, and connection with nature.
- A community that values and respects the contributions of many cultures to quality of life.
- A community that supports changes to the built environment that promote healthy, active lifestyles.

*This project was supported by funding from The Lincy Institute Fellowship, UNLV.*



## *Appendix C: Clark County Local Public Health System Assessment*

2012

# Local Public Health System Assessment



Southern Nevada Health District  
Las Vegas, Nevada

### **Acknowledgements**

Thank you to everyone who worked so hard to make this process a success. We couldn't have gathered this valuable data without you, and we hope to continue to have your support and participation as we work towards improving health outcomes in Southern Nevada!

Consultant and report author, Dr. Nancy Menzel

The Southern Nevada Health District grant team/task force, Patricia Rowley, Jim Osti, Eddie Larsen, David Wheeler, and Emily Brown

Southern Nevada Health District Chief Health Officer, Dr. Lawrence Sands

Technology of Participation facilitator, Marilyn Oyler

Three Square Food Bank chefs and staff

And most importantly, all our community partners who make up the local public health system

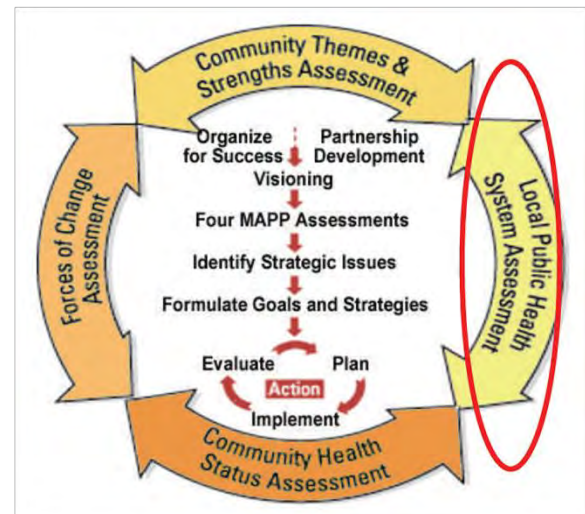
NACCHO for funding

## Introduction

In 1998, the Institute of Medicine defined public health as “what we as a society do collectively to assure the conditions in which people can be healthy.” Improving health is a shared responsibility of health care providers and public health officials, as well as a variety of organizations and individuals who contribute to the well-being of our community. No single entity can make a community healthy. So much more can be accomplished by working together with a common vision to improve health.

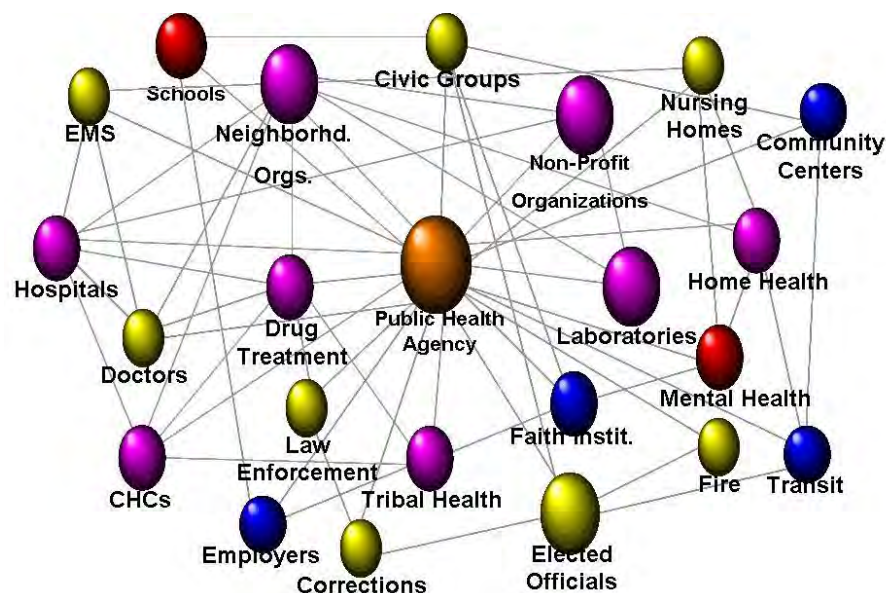
From	To
Operational planning	Strategic planning
Focus on the agency	Focus on community & entire public health system
Needs assessment	Emphasis on assets and resources
Medically oriented model	Broad definition of health
Agency knows all	Everyone knows something

The Southern Nevada Health District (SNHD) has provided a framework for bringing together the individuals, groups and organizations that make up our local public health system, and guides our community to identify and take action on priority health issues. The approach used by SNHD is a paradigm shift from operational to strategic thinking, from a needs- based to an asset-based emphasis, and from an agency focus to a broad community focus — a new way of doing business.



SNHD uses the *Mobilizing for Action through Planning and Partnerships* (MAPP) model for community health planning, developed through a cooperative agreement between the National Association of County & City Health Officials (NACCHO) and the Centers for Disease Control & Prevention (above).

**The Local Public Health System** It takes more than healthcare providers and public health agencies to address the social, economic, environmental and individual factors which influence health. The local public health system is comprised of agencies, organizations, individuals and businesses that must work together to create conditions for improved health in a community (below).



## The Local Public Health System Assessment

The *Local Public Health System Assessment* (LPHSA) is one of four MAPP assessments that inform the development of a strategic community health improvement plan. The purpose of the assessment is to identify the activities and capacities of our local public health system and identify areas for strengthening the system's ability to respond to day-to-day public health issues and to public health emergencies. The LPHSA uses the National Public Health Performance Standards Program (NPHPSP) local instrument, developed collaboratively by seven national public health organizations. The assessment focuses on standards that are based on the Ten Essential Public Health Services by which local public health system performance can be determined.

### The Ten Essential Public Health Services

1. **Monitor** health status to identify community health problems.
2. **Diagnose and investigate** health problems and health hazards in the community.
3. **Inform, educate**, and empower people about health issues.
4. **Mobilize** community partnerships to identify and solve health problems
5. **Develop policies and plans** that support individual and community health efforts.
6. **Enforce** laws and regulations that protect health and ensure safety.
7. **Link** people to needed personal health care services and assure the provision of health care when otherwise unavailable.
8. **Assure** a competent public health and personal health care workforce.
9. **Evaluate** the effectiveness, accessibility, and quality of personal and population-based health services.
10. **Research** for new insights and innovative solutions to health problems.

From the Centers for Disease Control and Prevention's website  
<http://www.cdc.gov/nphpsp/essentialServices.html>

## Background

The Southern Nevada Health District (SNHD) was awarded an Accreditation Readiness for Large Metropolitan Jurisdictions support grant from NACCHO, which was used partially to complete three of the four MAPP assessments. (The Community Themes and Strengths Assessment had previously been completed.) It assembled a task force to complete the LPHSA within the time required by the grant. The Task Force reviewed the NPHPSP Tool Kit to determine the best method for this jurisdiction, which has a population of approximately 2 million people.

## Methods: Assessment Process

The LPHSA Task Force decided to conduct the assessment using two approaches, one broad and one targeted. The NPHPSP Local Instrument (a valid and reliable tool) is divided into separate surveys for each of the Ten Essential Services. For each of the Essential Services, the NPHPSP has established two to four model standards that describe the key aspects of an optimally performing public health system. Each model standard is followed by assessment questions that serve as measures of performance. Responses to these questions should indicate how well the model standard – which portrays the highest level of performance or “gold standard” – is being met.

The broad approach involved putting each survey online using SurveyMonkey, then inviting specific individuals/agencies to complete one or two surveys that most closely fit with their area of expertise or responsibility. For example, many model standards for Essential Service 6, concern public health laws and their enforcement, so members of the Southern Nevada Board of Health, the Board's attorney, and elected officials were invited to complete this survey. The Task Force met to determine which agencies and individuals should receive an e-mailed invitation to complete one or more specific surveys. To extend our reach, we used snowball sampling, requesting that individuals receiving the

invitation forward it to others in the LPHS who were knowledgeable about the particular Essential Service. The survey was anonymous, with a space to self-identify if the individual was interested in assisting with the assessment process in more depth. Before participants could proceed with responding to the surveys, they were required to identify which segment of the LPHS they represented; e.g., health care provider, nursing home.

The responder was asked to answer each question with one of the following standard choices: No, Minimal, Moderate, Significant, Optimal. Because these surveys were being sent to individuals who might have knowledge of only some of the model standards, we added an additional category of No Knowledge to try to avert blanks or selection of a random response.

There were 761 e-mail invitations sent on January 9, 2012, with a reminder e-mail sent three weeks later. The surveys were closed on January 31, 2012, with all data downloaded from SurveyMonkey for data analysis using IBM SPSS Statistics Version 19. Responses were coded from 1 to 5, with 1 representing No and 5 representing Optimal. "No Knowledge" responses were coded as "99" and identified as "missing" to exclude them from calculations of means, medians, and modes. Descriptive statistics, including means and medians, were calculated. Further, *t*-tests for independent samples were completed to identify differences between responses from SNHD employees compared to non-employees. For model standards that had large standard deviations, we used the median instead of the mean.

Concurrent with deploying the surveys, the Task Force planned a half day retreat to assess in person a small subset of the LPHS's Model Standards, based on the preliminary analysis of the survey data. We selected questions which met any of the following conditions: wide variability in responses, significant differences between responses from SNHD employees compared with non-employees, or a relatively low number of responses from non-SNHD organizations. The Task Force invited to this retreat those individuals who had self-identified as interested on the survey, all of the original survey invitees, and selected SNHD administrators and managers. For this event, the Task Force employed a facilitator who had assisted with the Community Themes and Strengths Assessment. The facilitator uses a technique called the Technology of Participation to achieve consensus from the large group. This method allowed participants to use the Discussion Toolboxes in the tool, which was not possible for the online survey. When we had achieved consensus on this subset of Model Standards for Essential Services 3, 4, and 9, we used those results in place of the online survey results. We held the retreat on February 16, 2012.

The results for all model standards (rounded up or down as appropriate to select one of the categorical answers) were submitted to the NPHPSP for analysis. Its full report is in the Appendix. This summary report includes highlights from the full report.

## Results

There were 440 surveys returned. Responses by Essential Services are below.

Essential Service	Responses
1	64
2	42
3	97
4	97
5	64
6	18
7	82
8	30
9	18
10	7



Survey respondents are categorized by agency below.

	Survey 1	Survey 2	Survey 3	Survey 4	Survey 5	Survey 6	Survey 7	Survey 8	Survey 9	Survey 10
Civic Organization				1						
Community resident			1	1	1	2		1		
Educational institution	1		9	5	4	1	1	2		4
Elected official			1	2	1					
Environmental or environmental-health agency				5	1	3				
Faith institution			1				1	1		
Health care provider	2	1	1	5	4		8	1	3	
Health clinic	1	1	3		1	1	2	2	1	1
Health insurer	1	1	1				1		1	
Hospital	1	2	7	5	3	1	18	2	6	
Labor union health benefits provider			1							
Local business and/or employer	2		1	1						
Local government agency	8	5	9	5	15	4	6	3	1	
Mental health care provider	1	1		1	1		2			
Neighborhood organization			1	1						
Non-profit organization/public advocacy group	2	1	5		1		4	1	1	
Nursing home			1		1					
Other community organization										
Public safety and emergency response organization				6	1		1			
Professional organization							1			
Social service provider										
Southern Nevada Board of Health					3		1			
Southern Nevada Health District	42	30	49	55	26	5	32	17	2	2
Transportation provider										
Other	3		6	4	1	1	4		3	
State Government	1						1			
State Health Division	1									
Federal Public Health Agency			1	1	1	1	1		1	
ASC										
Medical Reserve Corp			1	2						
Pharmaceutical			1							
State Health Agency	1						1			
<b>Totals:</b>	64	42	97	97	64	18	82	30	18	7

There were 84 attendees at the half day retreat. Seventy percent of the attendees were non-SNHD employees. They represented a cross-section of the LPHS, including health care providers; hospitals; public safety and emergency response; clergy; city, county, and state government; college and universities; charities; social services; insurers; advocacy organizations; public utilities (water); and the media.

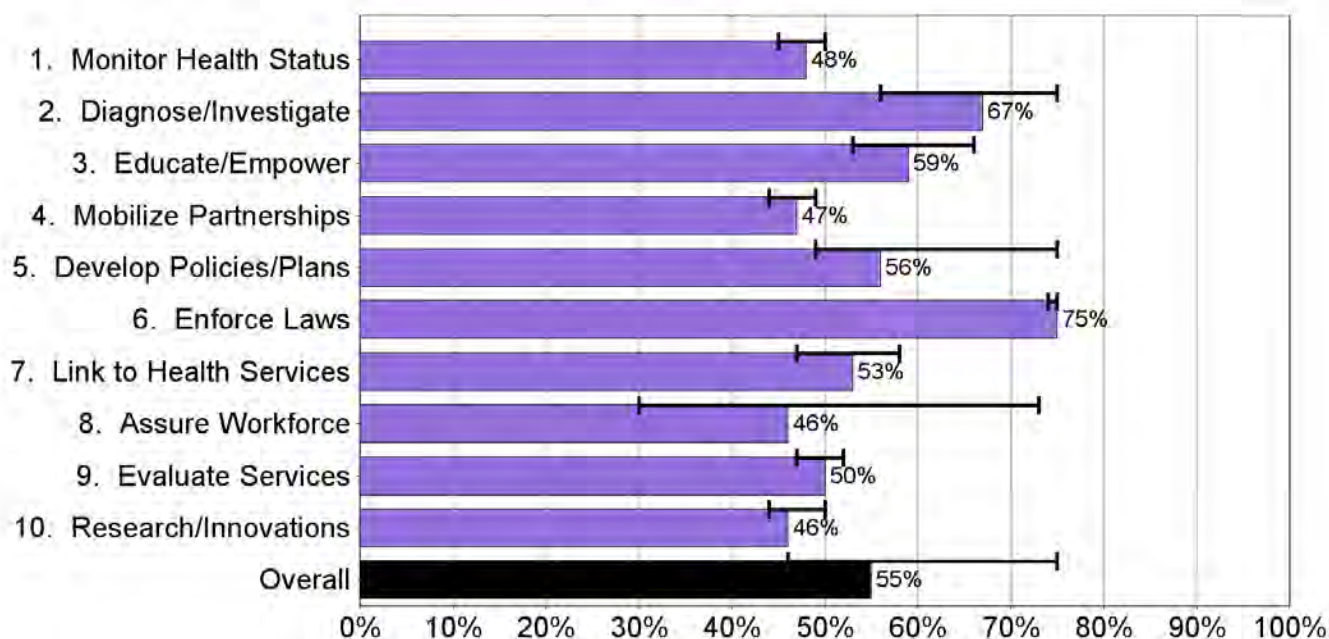
Charts on the following pages depict summary scores for a series of questions. Findings for each section highlight scores related to the key questions represented by the summary chart. The meaning of each category is identified below.

NO ACTIVITY	0% or absolutely no activity.
MINIMAL ACTIVITY	Greater than zero, but no more than 25% of the activity described within the question is met.
MODERATE ACTIVITY	Greater than 25%, but no more than 50% of the activity described within the question is met.
SIGNIFICANT ACTIVITY	Greater than 50%, but no more than 75% of the activity described within the question is met.
OPTIMAL ACTIVITY	Greater than 75% of the activity described within the question is met.

Using the responses to all of the assessment questions, a scoring process generates scores for each first-tier or "stem" question, model standard, Essential Service, and one overall score. Comments from the retreat are included for the summaries on Essentials Services 3, 4, and 9.

## Executive Summary

How well did participants feel the system performed within the ten Essential Public Health Services (EPHS)? Summary of EPHS performance scores and overall score (with range)

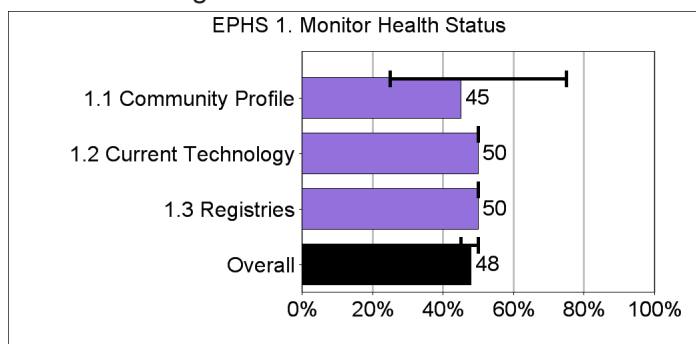


## Summary Findings

- While no areas overall were ranked as No or Minimal Activity, none was ranked as Optimal Activity.
- Assuring a Competent Workforce had the greatest variability in scores and should be investigated further.
- By rank order, the lowest performance scores (Moderate) were for Essential Services 1, 4, 8, 9, and 10.
- The highest scoring Essential Service was 6. Enforce Laws (Significant).

## 1. Monitor Health Status to Identify Community Health Problems

**Key Questions:** Does our local public health system conduct community-wide health assessments to create a community health profile on a regular basis? Do we use technology to interpret and communicate the assessment data? Is there collaboration in our local public health system to use population health registries?

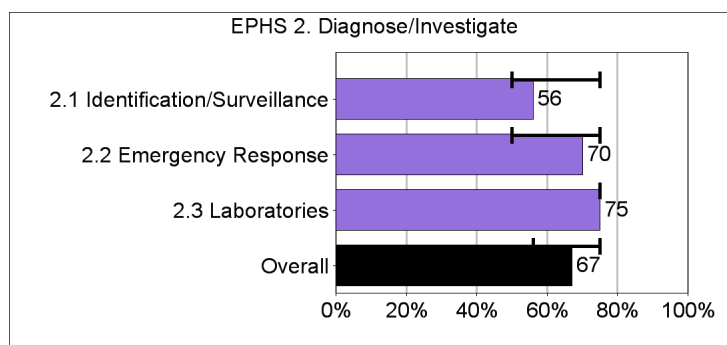


### Summary Findings

- The population-based Community Health Profile had the largest variability in responses, from Minimal to Significant Activity.

## 2. Diagnose and Investigate Health Problems and Health Hazards in the Community

**Key Questions:** Does our local public health system conduct surveillance to identify health threats? How well do we investigate and respond to public health threats and emergencies? Is there access to laboratory support for investigation of health threats?

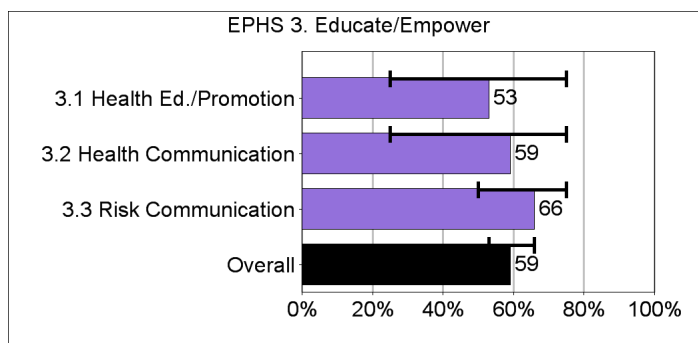


### Summary Findings

- There was little variability between categories with an overall score of Moderate.

### 3. Inform, Educate, and Empower Individuals and Communities about Health Issues

**Key Questions:** Does the local public health system collaborate to create and deliver health education and promotion activities? Do we use health communication plans to inform and influence individual and community decisions about health? Are there risk communication processes in our local public health system to inform and mobilize the community in times of crisis?



#### Summary Findings

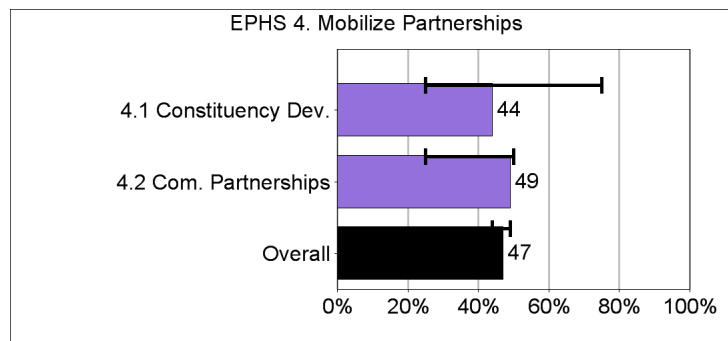
- There was great variability in this model standard, primarily because sections of this Essential Service were assessed during the retreat. While survey takers in general rated these model standards as having Moderate Activity, the consensus retreat rated sections 3.1.1 and 3.2.1 as Minimal Activity. Some of the comments below from the small group exercise reflect participants' view that the LPHS is the SNHD. During the consensus phase, we were able to broaden participants' views of the components of the LPHS.

#### Comments:

- "Limited communication between LPHS and primary care physicians except for emergency preparedness."
- "There is a lack of local/state data available to support policy change."
- "Need a holistic approach to maximize resources/alignment of activities & priorities."
- "LPHS and health care systems need better communication."
- "Communication among organizations in general is limited."
- "Information is provided through website but unclear how effectively. Effectiveness relates to which audience. Need to communicate better to policy makers & public stakeholders than to public."
- "Have educational tools available for general public, but not doing well at communicating how to find these materials."
- "Governor has a strategic plan, but who had input?"
- "All on the side streets; no one on the main road."
- "Much communication but needs to be coordinated in the system."
- "Need to be able to articulate value of public health that translates into support for health in all policies (land use, medical, education, etc.)"

## 4. Mobilize Community Partnerships to Identify and Solve Health Problems

**Key Questions:** Is there a process in place to develop collaborative relationships between current and potential constituents in the local public health system? Is there a broad-based community partnership to assure a comprehensive approach to improving health?



### Summary Findings

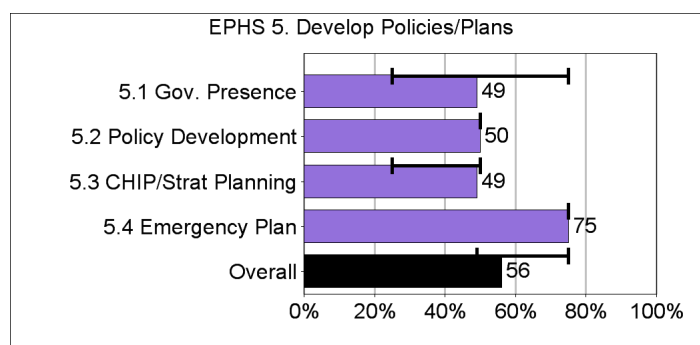
- Sections 4.1.2, 4.1.4, and 4.2.1 were ranked as Minimal Activity by the retreat attendees, whereas responses to the online survey ranged from Moderate to Significant Activity.

#### Comments:

- “Much good stuff is happening but not systematically. Who is responsible for coordinating/fostering system?”
- “Partners do share. Fire/emergency works well. Sometimes a partner can’t help because it doesn’t have resources.”
- “Collaboration within refugee communities good; other programs not so much.”
- “Overall is minimal because until we are in partnerships driven by needs, the likelihood of partnerships forming is minimal.”
- “What can we do to make things better?”
- “No horizontal communication. No overall planning or coordination, leading to duplication of services. Some efforts are present, but much still occurs in a silo. Need method to maintain/update resources.”
- “Territoriality. Groups tend to focus on their particular interest, not necessarily what is in community’s interest in terms of Essential PH Services.”
- “There are gaps in communications between organizations. No over-arching communication.”
- “Unless mandated or required by law, this (responsibilities) does not seem to occur.”
- “Smaller agencies can have difficulty releasing staff to participate in “partnerships.”
- “Lack of clear communication about community’s health – lack of data. Responsibility -- SNHD.”
- “Need to identify barriers to effective communication. Need method to maintain/update resources.”
- “Depoliticize Nevada Department of Health.”

## 5. Develop Policies and Plans that Support Individual and Community Health Efforts

**Key Questions:** Is there a local governmental public health presence in our community? Does the local public health system review and develop policies to protect and promote health? Does the local public health system have a strategic planning process for community health improvement? Is there community-level planning for responding to public health emergencies?

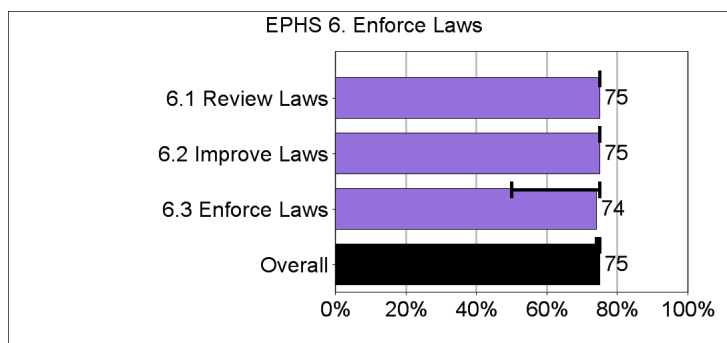


### Summary Findings

- There were significant differences in responses between SNHD employees and non-employees on these standards, with SNHD employees averaging Significant for 5.1, compared to Moderate for non-Employees.

## 6. Enforce Laws and Regulations that Protect Health and Ensure Safety

**Key Questions:** Are health and safety laws, regulations and ordinances reviewed, and are they revised or improved to align with best practices? Are there appropriate enforcement activities in our local public health system to assure compliance with health and safety laws and regulations?



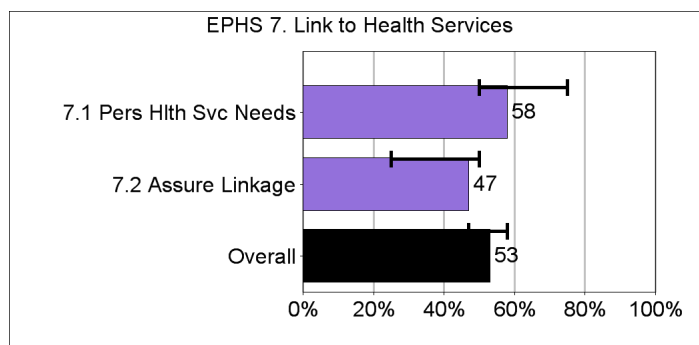
### Summary Findings

- This was the highest ranked Essential Service, although it did not quite reach Optimal Activity.
- There was little variability among responses or between SNHD employees and non-employees.



## 7. Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable

**Key Questions:** Does the local public health system identify personal health service needs of at-risk populations? Do we assure the linkage of people to personal health services?

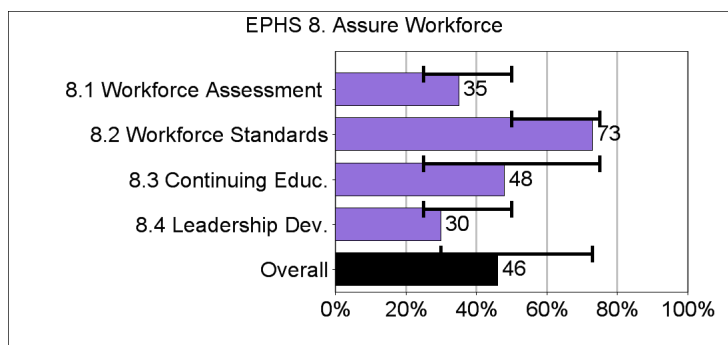


### Summary Findings

- There was little variation in responses to this question and no significant differences between responses from SNHD employees and non-employees.

## 8. Assure a Competent Public and Personal Health Care Workforce

**Key Questions:** Is an assessment of workers within in the local public health system conducted, are gaps addressed, and are assessment results distributed? Does the local public health system develop and maintain standards for its workforce? Do life-long continuing education opportunities exist for the public health workforce? Are there leadership development opportunities in the local public health system?

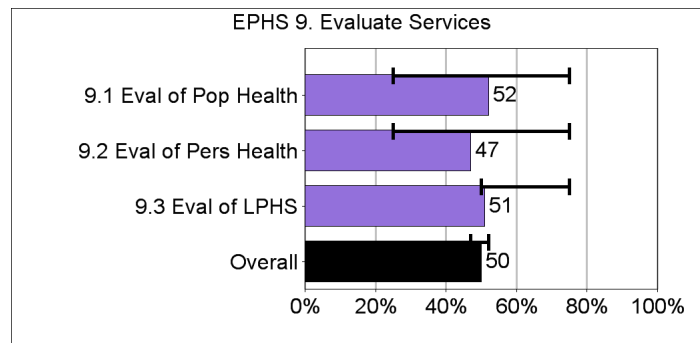


### Summary Findings

- This model standard was ranked the lowest, tied with #10.
- There was great variability among responses.
- There were double the number of responses from SNHD employees ( $n=16$ ) than for non-employees.
- Leadership development was ranked the lowest.

## 9. Evaluate Effectiveness, Accessibility and Quality of Personal and Population-based Health Services

**Key Questions:** Have population-based health services been evaluated in our community? Have personal health services been evaluated in our community? Has the performance of the overall local public health system been evaluated?



### Summary Findings

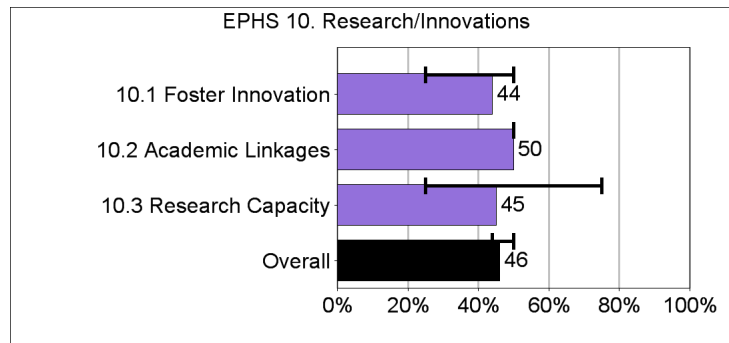
- Subsections 9.1.1, 9.1.2, 9.1.4, 9.2.1, 9.2.3, and 9.2.5 were consensus standards at the retreat, which contributed to the variability shown.
- All were rated as Minimal Activity, except for 9.1.4 and 9.2.3, which were Moderate Activity.
- The wide variability between consensus and survey findings indicates the need for further examination of the LPHS performance.

#### Comments:

- “Nevadans have the worst access to health care services.”
- “There has been no global assessment of the local health system. There are a lot of assessments done by various organizations, but there is no clear report that summarizes the results a venue where to get the results.”
- “On a personal basis, health services are effective and accessible on a moderate level. On a population basis, health services are on a very minimal basis.”
- “Need money in the system and partnerships.”
- “There are attempts to collect surveys, but only certain groups are being targeted. No funding for ongoing research.”
- “The system is overwhelmed – shortage, but there’s no resources to improve even if they want to.”

## 10. Research for New Insights and Innovative Solutions to Health Problems

**Key Questions:** Do organizations within the local public health system foster innovation to strengthen public health practice? Are there linkages with institutions of higher learning and research within the public health system? Is there capacity in our community to initiate or participate in public health research?



### Summary Findings

- This survey had the fewest responses ( $n=6$ ) and was tied for lowest rank.
- Further investigation into performance is recommended because of the small sample size and great variability in responses to Research Capacity.

### Limitations

In addition to the data limitations noted in Appendix A, there are several other limitations. The assessment used a convenience sample that may or may not have been representative of the LPHS. The sample size was small relative to the size of the area's population. There was no system in place to prevent a respondent from taking a survey multiple times. We were unable to obtain face to face consensus or comments on all essential services. In general, participants at the consensus meeting ranked the LPHS lower than online survey takers, which may indicate that the scores for many Essential Services would have been lower had they been included.

### Conclusions and Recommendations

The LPHS is not functioning at Optimum Activity. There was a general lack of knowledge among the community that they were part of the LPHS, which emerged during the retreat. Also, many responses in the surveys were No Knowledge, indicating a need to educate all members of the LPHS of their roles.

Conducting focus groups to identify themes for Essential Services 8, 9, and 10 would assist in prioritizing areas for action, one of the steps recommended in developing a performance improvement plan. Both 8 and 10 were tied for lowest rank. Additional data collection would also help in understanding variability in answers between SNHD staff and community members.

For Essential Service 4, Mobilize Partnerships, the consensus retreat ranked some sections of this area as Minimal Activity, indicating a need for improvement not reflected in the summary scores. Of particular note was the need for increased coordination and communication among agencies, which are functioning in silos, according to the comments.

Overall this assessment process of the local public health system of Southern Nevada highlighted a need for increased education, communication, and collaboration. Along with the recommendation for additional assessments in key Essential Services areas, a local public health steering committee could be created. At the retreat there was strong interest in and commitment to the local public health system and an expressed desire for increased communication and collaboration between SNHD and the community, as well as among community members. Steering committee creation could capitalize on this desire and could utilize the energy and broad strengths of local public health system members in identifying and working towards strategic issues for community health improvement.