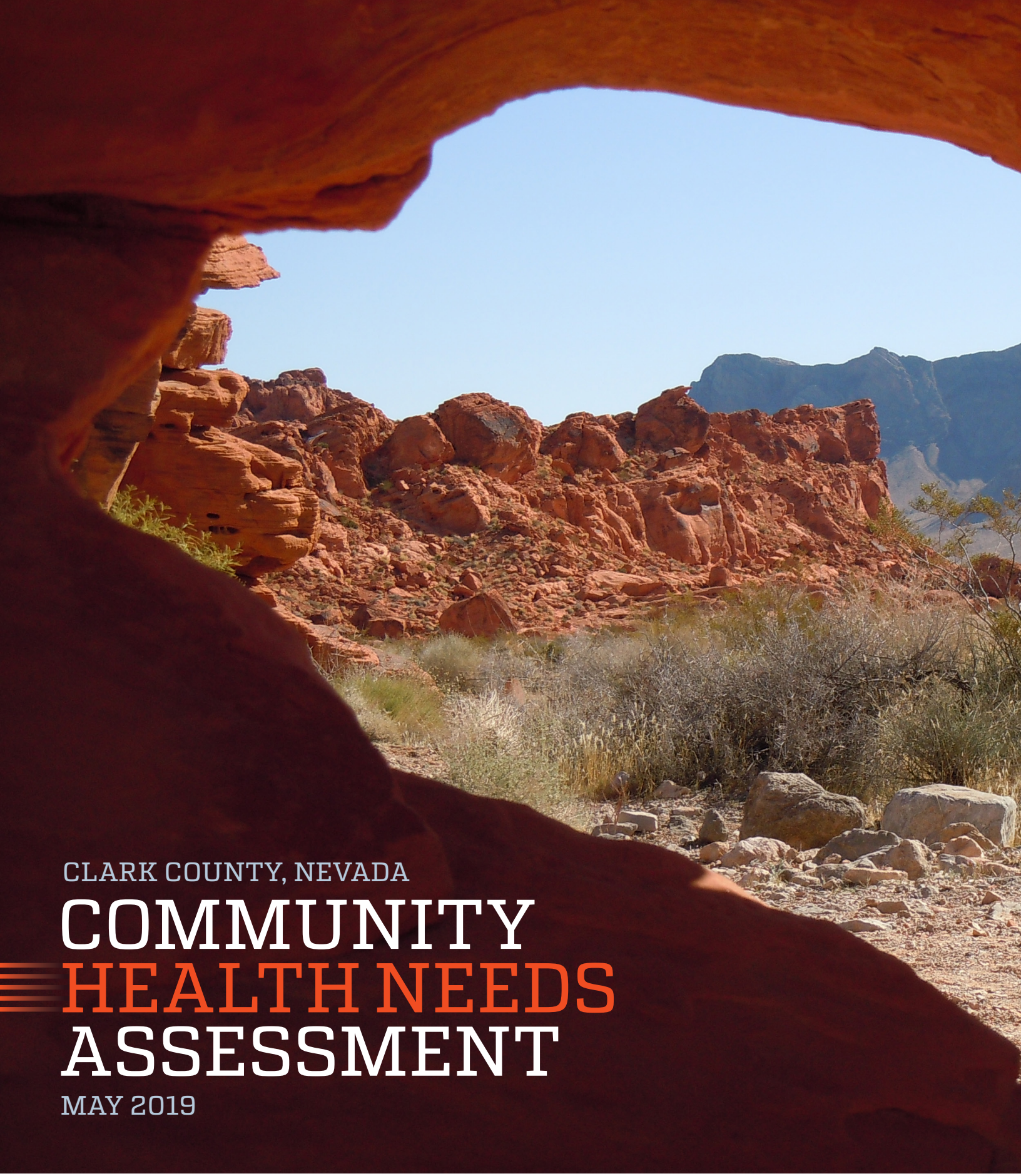

CLARK COUNTY, NEVADA

COMMUNITY HEALTH NEEDS ASSESSMENT

MAY 2019

Dignity Health. St. Rose Dominican

SNHD Southern Nevada Health District

The 2019 Southern Nevada Community Health Needs Assessment was sponsored in full by Dignity Health – St. Rose Dominican Hospitals and the Southern Nevada Health District in collaboration with the Nevada Institute for Children's Research and Policy.

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by Dignity Health – St. Rose Dominican Hospitals. The priorities identified in this report help to guide the hospitals' community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health.

COMMUNITY DEFINITION

Clark County is the most populous county in Nevada, accounting for nearly three-quarters of the state's residents. All ZIP codes that encompass Clark County, Nevada, were analyzed to represent the community benefit service area for Dignity Health – St. Rose Dominican Hospitals. Within this CHNA, special attention has been given to populations that are medically underserved, low-income, or minority groups living in the community, such as older adults, parents of young children, individuals experiencing homelessness, LGBTQ+ individuals, and individuals who primarily speak Spanish in the home.

ASSESSMENT PROCESS AND METHODS

An extensive assessment process utilizing quantitative and qualitative analyses was undertaken to determine community health needs. Quantitative social, economic, and health data for Clark County, Nevada, came from a variety of secondary data sources at the local, state, and national levels. Primary data sources included a randomized telephone survey of Clark County residents and five focus group interviews of vulnerable populations in the community service area.

IDENTIFICATION OF SIGNIFICANT COMMUNITY HEALTH NEEDS

Epidemiologists and subject-matter experts in a broad array of existing and emerging health issues at the Southern Nevada Health District, conducted a broad-sweeping data analysis to identify areas of concern for health-related topics across Clark County. For consideration in their analysis, they looked at size, scale, and severity of the problem and disparity and equity across multiple vulnerable groups. This analysis gave rise to a list of health priority areas, which included: sexual health, maternal/child health, injury, environmental health, mental health, healthcare infrastructure, and healthcare access. From this list of priority areas, a questionnaire was developed and administered during the telephone survey to query what extent community members shared concern for these health topics. Concurrently, focus groups were convened for contextualized feedback regarding general questions aligned with the epidemiologic analysis and community telephone survey. Priority areas receiving at least 65% of agreement from respondents as very/moderately concerned were included as community needs.

LIST OF PRIORITIZED NEEDS

- **Access to care** (health insurance coverage, service navigation, linguistic and cultural sensitivity)
- **Motor vehicle and pedestrian safety** (distracted driving, impaired driving, bicyclist and pedestrian safety)
- **Violence prevention** (gun violence, child abuse, domestic violence, suicide)
- **Substance use** (alcohol use, maternal substance use, opioid overdoses)
- **Mental health** (lack of providers, stigma)

COMMUNITY ASSET ANALYSIS

A community asset analysis was conducted to determine resources available to address the identified significant community needs.

REPORT ADOPTION AND AVAILABILITY

This CHNA report was adopted by the Dignity Health – St. Rose Dominican community board in May 2019. This report is widely available to the public on the organization's web site, and a paper copy is available for inspection upon request at The Dignity Health – St. Rose Dominican Community Health Center. Written comments on this report can be submitted to Dignity Health – St. Rose Dominican, Community Health, 2651 Paseo Verde Pkwy, Ste 180, Henderson, NV 89074 or by email to holly.lyman@dignityhealth.org.

This CHNA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least every three years.

ASSESSMENT PURPOSE AND ORGANIZATIONAL COMMITMENT

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by Dignity Health – St. Rose Dominican Hospitals. 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 CHNA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least every three years.

Dignity Health and our Sponsoring Congregations 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.
- Partnering with others in the community to improve the quality of life.

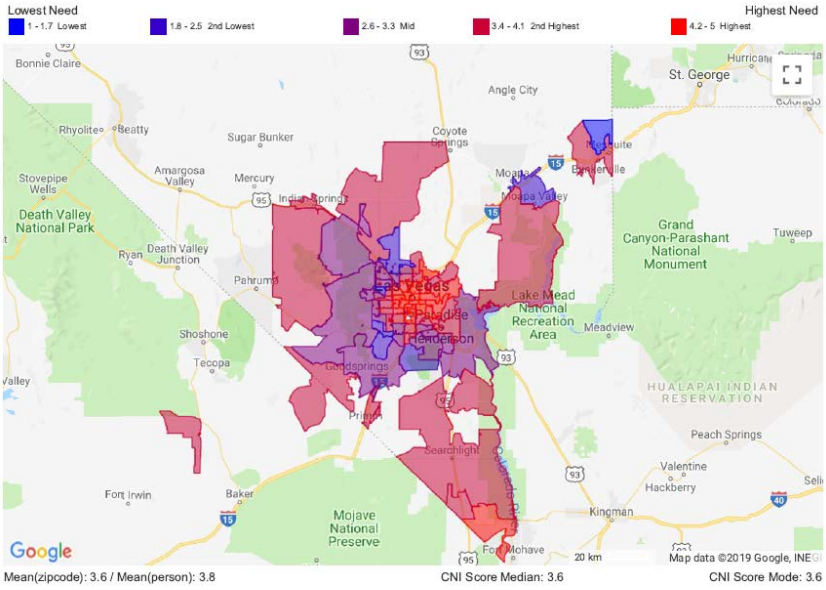
COMMUNITY DEFINITION

COMMUNITY SERVICE AREA

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health. The CNI analyzes data at the ZIP code level on five factors known to contribute or be barriers to healthcare access: income, culture/language, education, housing status, and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each ZIP code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.

All ZIP codes that encompass Clark County, Nevada, were analyzed to represent the community benefit service area (CBSA) for Dignity Health – St. Rose Dominican Hospitals. The average CNI score for this area is 3.6 (ZIP code) and 3.8 (person), with a median of 3.6. The CNI scores range from a low of 1.4 (89034) to a high of 5 (89030, 89101, 89104, 89106, 89115). Figure 1 provides further detail for the geographical distribution of CNI scores[1].

Figure 1 Map of Community Need Index Scores, Clark County, NV 2018



Within this CHNA, special attention has been given to vulnerable groups, populations that are medically underserved, low-income, or minority individuals living in the community. This report specifically assessed older adults, parents of young children, individuals experiencing homelessness, LGBTQ+ individuals, and individuals who primarily speak Spanish in the home.

COMMUNITY OVERVIEW

Dignity Health – St. Rose Dominican Hospitals provide health services throughout Clark County. Clark County is the most populous county in Nevada, accounting for nearly three-quarters of the state's residents. Compared with the state of Nevada and the United States, Clark County has a

[1] Further analysis of the CNI is available upon request

larger proportion of young to middle-age adults 25-49 years old. With respect to race/ethnicity, Non-Hispanic white individuals no longer account for most of the population. Additionally, Hispanic and Asian residents have larger shares of the population in Clark County than in Nevada or the United States. As a result, a higher percentage of Clark County residents speak languages other than English at home when compared with statewide and national estimates. Financially, the median household income in Clark County is about 1% lower than the Nevada median and 5% lower than the United States. Clark County also has a lower percentage of population 25 years and older who have college or higher degrees. Table 1 describes more details of the population characteristics.

Table 1 Population Characteristics, Clark County, Nevada, and the United States, 2017

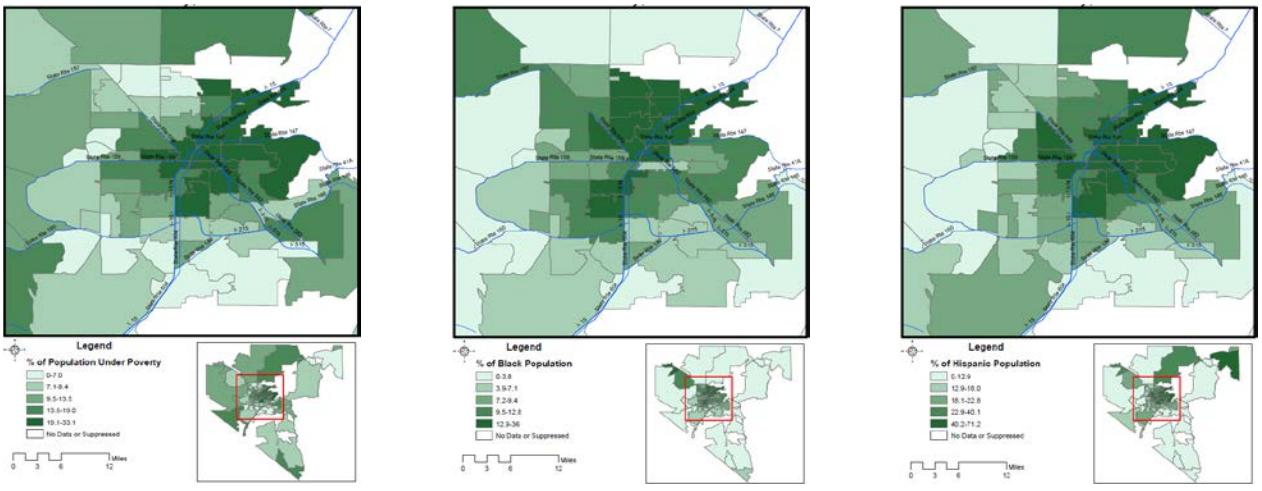
	Clark County		Nevada		United States	
Total Population	2,112,436		2,887,725		321,004,407	
Gender						
Male	1,056,002	49.99%	1,450,091	50.22%	158,018,753	49.23%
Female	1,056,434	50.01%	1,437,634	49.78%	162,985,654	50.77%
Age						
Under 5 years	136,038	6.44%	181,207	6.28%	19,853,515	6.18%
5 to 9 years	142,411	6.74%	190,112	6.58%	20,445,122	6.37%
10 to 14 years	138,641	6.56%	186,824	6.47%	20,713,111	6.45%
15 to 19 years	130,109	6.16%	176,996	6.13%	21,219,050	6.61%
20 to 24 years	136,367	6.46%	184,563	6.39%	22,501,965	7.01%
25 to 29 years	157,665	7.46%	211,829	7.34%	22,406,918	6.98%
30 to 34 years	156,586	7.41%	206,696	7.16%	21,637,255	6.74%
35 to 39 years	147,189	6.97%	193,280	6.69%	20,389,409	6.35%
40 to 44 years	148,917	7.05%	194,427	6.73%	20,267,010	6.31%
45 to 49 years	145,008	6.86%	194,361	6.73%	20,961,596	6.53%
50 to 54 years	139,375	6.60%	193,375	6.70%	22,129,547	6.89%
55 to 59 years	128,512	6.08%	184,727	6.40%	21,523,460	6.71%
60 to 64 years	116,289	5.50%	168,998	5.85%	19,224,060	5.99%
65 to 69 years	103,618	4.91%	150,864	5.22%	15,926,903	4.96%
70 to 74 years	77,194	3.65%	112,082	3.88%	11,576,486	3.61%
75 to 79 years	50,510	2.39%	72,840	2.52%	8,215,566	2.56%
80 to 84 years	31,513	1.49%	45,248	1.57%	5,871,911	1.83%
85 years and over	26,494	1.25%	39,296	1.36%	6,141,523	1.91%
Median Age	36.9		37.7		37.8	
Race/Ethnicity						
Not Hispanic or Latino	1,464,225	69.31%	2,073,420	71.80%	264,493,836	82.40%
White alone	931,891	44.11%	1,457,272	50.46%	197,277,789	61.46%
Black or African American alone	228,127	10.80%	242,682	8.40%	39,445,495	12.29%
American Indian and Alaska Native alone	8,380	0.40%	24,402	0.85%	2,098,763	0.65%
Asian alone	200,206	9.48%	228,268	7.90%	16,989,540	5.29%

Native Hawaiian and Other Pacific Islander alone	14,221	0.67%	17,510	0.61%	515,522	0.16%
Some other race alone	5,263	0.25%	6,429	0.22%	715,432	0.22%
Two or more races	76,137	3.60%	96,857	3.35%	7,451,295	2.32%
Hispanic or Latino	648,211	30.69%	814,305	28.20%	56,510,571	17.60%
Speak a language other than English at home	681,362	34.50%	824,689	30.50%	64,221,193	21.30%
Median Household Income	$ 54,882		$ 55,434		$ 57,652	
Education Attainment (population 25 years and over)						
Less than 9th grade	90,260	6.30%	116,412	5.90%	11,759,554	5.40%
9th to 12th grade, no diploma	120,134	8.40%	162,406	8.30%	15,677,560	7.20%
High school graduate (includes equivalency)	411,807	28.80%	556,851	28.30%	59,093,612	27.30%
Some college, no degree	361,598	25.30%	506,805	25.80%	44,935,834	20.80%
Associate degree	112,318	7.90%	159,428	8.10%	17,917,481	8.30%
Bachelor's degree	222,051	15.50%	306,611	15.60%	41,377,068	19.10%
Graduate or professional degree	110,702	7.70%	159,510	8.10%	25,510,535	11.80%

Data source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Below, Figure 2 depicts the percent of population that falls below the federal poverty level, non-Hispanic black residents and Hispanic residents by ZIP code. As the three maps illustrate, the ZIP codes with the highest percentage of the population living under poverty coincide with those having the highest percentage of non-Hispanic black or Hispanic residents.

Figure 2 Percent of Population under Poverty (left), Percent of Non-Hispanic Black Population (middle), and Percent of Hispanic Population (right), by ZIP Code, Clark County, NV 2013-2017



Data source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

POPULATIONS OF SPECIAL FOCUS

In order to better understand how all members of the Southern Nevada community navigate through the healthcare system, Nevada Institute for Children's Research and Policy (NICRP) and Southern Nevada Health District (SNHD) conducted focus groups of populations that are medically underserved, low-income, or minority groups living in the community. These populations determined recruitment for focus group participants with the goal of contextualizing feedback from other data collection methods. For the purposes of this report, these groups included: those experiencing homelessness, members of the LGBTQ+ community, parents, older adults aged 55 and older, and residents who primarily speak Spanish. Members of these groups may experience specific challenges in accessing health care and their unique experiences should be considered when making recommendations to improve the overall health of the community. Research evidence has accumulated over the past several decades pointing to the powerful role of social factors, such as income, wealth, and education, as the fundamental causes of a wide range of health outcomes (Braveman & Gottlieb, 2014). As social determinants of health were a critical part of this assessment, recruitment efforts for these focus groups were also concentrated in low income neighborhoods and from organizations that serve low-income and racial/ethnic minority populations.

ASSESSMENT PROCESS AND METHODS

Quantitative social, economic, and health data for Clark County, Nevada, came from a variety of primary and secondary data sources at the local, state, and national levels. Primary data sources included a telephone survey of Clark County residents and focus groups of priority populations, both described below. Several secondary data sources were used, and these 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.

COMMUNITY HEALTH STATUS ASSESSMENT

The community health status assessment collected, assessed, and reported on core indicators about the health of Clark County residents and factors important to the community's health status. Multiple health indicators, including public health morbidity and mortality statistics, were selected from a variety of population-based surveys and data sources available to SNHD Epidemiology staff, including U.S. Census estimates, the Behavioral Risk Factor Surveillance System (BRFSS), CDC WONDER mortality database, Nevada Vital Records, National Center for Health Statistics, and others. Specific analytic methods utilized include frequency data for top issues, multi-year trends, data comparisons to statewide and national rates, and a breakdown analysis for key variables (age, sex, race/ethnicity, ZIP code) where relevant.

TELEPHONE SURVEY

SURVEY DEVELOPMENT

The 2019 Community Health Needs Survey (hereby referred to as the telephone survey) was created collaboratively by NICRP and SNHD. An analysis of several community health surveys from counties in other states was reviewed to obtain information on common questions asked. These questions were then tailored for Southern Nevada. The final survey consisted of 17 items which assessed community health needs in three areas: personal health behaviors (7 items), experiences accessing healthcare (7 items), and opinions about community health (3 items). Additionally, 11 demographic questions were asked. Once survey questions were finalized, the survey was translated into Spanish[2]. The full telephone survey report and a copy of the survey are available upon request.

PROCEDURES

The Cannon Survey Center (CSC) at the University of Nevada, Las Vegas (UNLV) was hired to administer this 15-minute survey to Clark County residents. The telephone survey was conducted between February 2, 2019, and March 14, 2019, and yielded 378 completions and 7 partial completions. Telephone numbers were dialed by interviewers manually, thus giving the CSC the legal capacity to contact cell phones. All participants were offered the chance to be entered in a drawing to win a $50 visa gift card. For those who opted into the drawing, a name, telephone number, and e-mail address were collected to be able to notify the winning participant. Two winners were randomly selected and contacted to deliver their gift cards[2].

[2] The full telephone survey report, additional procedure details, and a copy of the survey are available upon request.

ANALYSIS & WEIGHTING

Following the completion of data collection by CSC, data were exported to SPSS. IBM SPSS software version 24 was used to analyze data for this report. This project was submitted to the UNLV Social Behavioral Institution Review Board for approval. It was determined that this project was exempt from IRB review and not considered human subjects research. Sample weights were calculated to adjust for unequal probabilities of selection and non-response bias resulting from differential response rates across a variety of demographic groups.

FOCUS GROUPS

QUESTION DEVELOPMENT

NICRP staff conducted an extensive literature review of group methodology and data collection. The guiding questions for the focus groups were also aligned with the CHNA telephone survey, simultaneously conducted by the CSC at UNLV. The final discussion guide included 11 questions regarding general health activities, access to healthcare, quality of care, satisfaction with healthcare, and recommendations for improvement. There were additional group-specific questions used to capture information about health needs unique to these priority populations[3].

RECRUITMENT

Print and online advertisements were created to recruit focus group participants. Advertisements indicated the time, location, and purpose of the focus group, and stated that a free meal would be provided for participating. Over 50 locations were contacted to ask for assistance with recruiting focus group participants. For participation, each individual was offered a free meal, and it was provided during the focus group[3]. Focus group host locations were recruited through email and phone calls to local community organizations that worked closely with members of each priority population. Targeted locations included community centers, churches, cultural groups, clubs, non-profit organizations, government offices, and UNLV student organizations.

PROCEDURES

A total of seven focus group discussions were held between February 28 and March 21, 2019, with 70 total individuals. At least two members of the research team were present during each focus group. Upon arrival, participants were asked to complete a brief demographic form, and were informed that the group discussion would be audio-recorded to help staff ensure that all data were captured accurately. All groups consented to audio recording, except the group of older adults (aged 55+). Discussions typically lasted anywhere from 1 to 1 ½ hours and had an average of 10 participants, with 70 participants total across all five populations[3].

ANALYSIS

Focus groups were audio-recorded and transcribed (except for the senior focus group, at their request) to accurately report participants' thoughts and ideas as presented during the group discussion. These transcriptions were combined with notes from group facilitators about participants' responses during the discussion to provide a comprehensive picture of how each

[3] A copy of the discussion guide used for each of the five populations, a copy of recruitment materials, additional procedure details, and the full focus group report are available upon request.

population described the health needs of their community. In addition to individual analysis, focus group responses were compared across populations to determine common strengths and needs across groups.

COMMUNITY ASSET ANALYSIS

A community asset analysis was conducted to determine resources available in Clark County to address the identified significant community needs. An existing statewide framework was modified for agencies that fit the community service area, and agencies were assessed for strengths in the areas of greatest need. The results of this analysis were aligned with the identified community needs and are described in further detail below.

LIMITATIONS

Community Health Status Assessment: While secondary data analysis can save time and provide many advantages to telling the story of a population, there are limitations that exist in these analyses. First, indicator measurement may change over time, making historical comparisons difficult across a population. Additionally, the available data are not collected to address this specific report, and thus may not be fully reflective of the goals or processes outlined. Finally, the limited sample size for minority groups stratified across multiple indicators can create difficulty to understanding health challenges for different types of people within a population.

Telephone Survey: This survey uses self-report data in which underreporting and over-reporting of behaviors cannot be determined. Next, despite efforts to collect a representative sample of the community, this survey had a higher representation of individuals who were Non-Hispanic white, had a higher level of education, and were slightly older than the standard characteristics of Clark County. Even though gender and race/ethnicity weights were used, this should still be taken into consideration when interpreting results. In addition, when examining results based on gender and race/ethnicity, although weighted to represent Clark County, the margin of error for each group is considerably higher given the number of respondents in each group is smaller. Therefore, caution should be used when making decisions about these data based on gender, and race and ethnicity.

Focus Groups: Participants who chose to attend the focus groups held for this study may potentially be more interested in health-related topics than the general public. In group settings, participants may choose not to contribute as much feedback or engage in the conversation in comparison to a setting where they were asked questions in confidence, and researchers have less control over the conversations in the room and the data produced by them (Gibbs, 1997).

Research looking at the effectiveness of focus group data collection found that conclusions can be drawn from targeted populations that participated in focus groups but cannot be generalized to the entire population (Bradley, Jorgensen & Robert, 2014). For example, systematic reviews have examined differences between subgroups of the LGBTQ+ community when it comes to health challenges and insurance coverage. This literature review showed that individuals who identify as one of these subgroups all have unique health disparities and should be assessed separately (Kates, et al., 2018).

Future studies could overcome these limitations by hosting a larger number of focus groups, narrowing the scope of recruitment for priority populations, and/or including a follow-up component in which individuals are contacted after the focus group to provide additional feedback or context about the experiences shared during group discussion.

COLLABORATING ORGANIZATIONS

Dignity Health – St. Rose Dominican Hospitals collaborated with SNHD, the local health authority for Clark County, Nevada. This collaboration between local public health agencies and hospital systems has the potential to continue progress towards population health improvement, better coordination of care, and cost savings. Multiple health systems were queried in the design and development of survey instruments and data collection.

CONTRACTED CONSULTANTS

The full telephone survey and focus group reports were prepared by NICRP through a contract with the Nevada Division of Public and Behavioral Health, Rape Prevention Education Program. NICRP is a not-for-profit, non-partisan organization whose primary goal is to advance the well-being of children in Nevada. As a research center in the School of Public Health at UNLV, NICRP is dedicated to conducting academic and community-based research that helps guide the development of policies, practices, and programs which serve to enhance the health and well-being of children and their families. CSC at UNLV was hired to administer the survey to Clark County residents.

COMMUNITY HEALTH STATUS ASSESSMENT

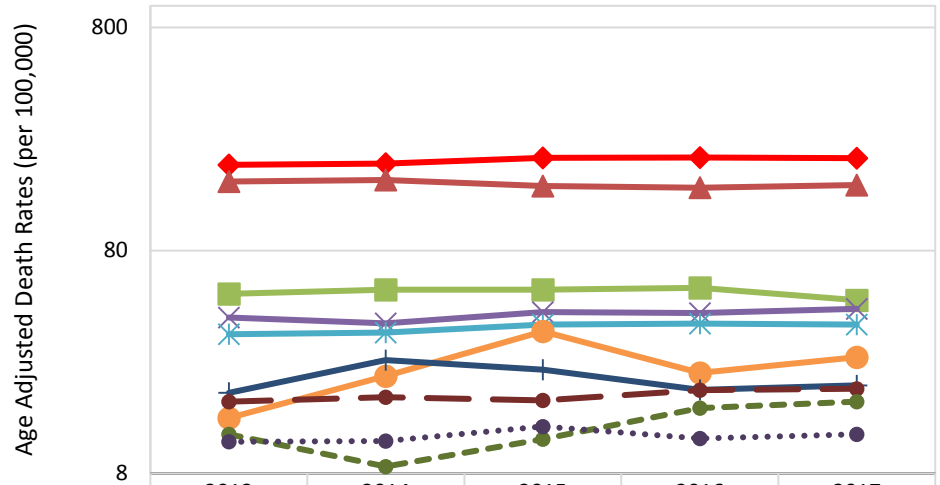
HEALTH STATUS OVERVIEW

The Community Health Status Assessment identifies health and quality of life issues that are areas for improvement in Clark County. Quantitative social, economic, and health data came from a variety of secondary data sources at the local, county, state, and national levels. This assessment seeks to answer questions such as how healthy Clark County residents are and how Clark County compares to the state and the nation.

LEADING CAUSES OF DEATHS

Heart disease, cancer, chronic lower respiratory disease, unintentional injury, stroke, Alzheimer's disease, influenza and pneumonia, suicide, diabetes, and chronic liver disease and cirrhosis caused most of the deaths among Clark County residents from 2013 to 2017. During this five-year period, the most notable increases were deaths due to Alzheimer's disease (up 87%), diabetes (up 40%), and suicide (up 14%) (Figure 3).

Figure 3 Age-Adjusted Death Rates by Diseases and Year, Clark County, NV 2013-2017



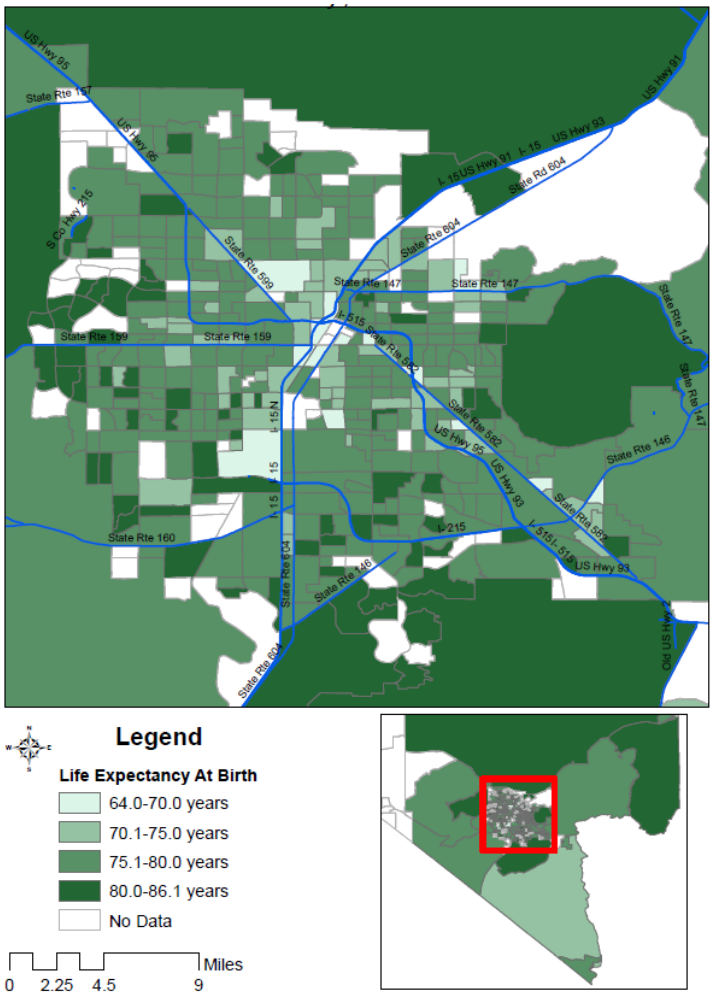
	2013	2014	2015	2016	2017
Heart Disease	193.7	195.9	207.9	208.9	207.5
Cancer	163.3	165.6	155.8	152.9	157.2
Chronic Lower Respiratory Disease	51.1	53.4	53.3	54.4	47.9
Unintentional Injury	40	37.7	42.4	41.9	43.8
Stroke	33.7	34.3	37.2	37.6	37.2
Alzheimer's Disease	14.2	21.9	34.7	22.6	26.6
Influenza and Pneumonia	18.4	25.8	23.4	19	19.9
Suicide	16.8	17.6	17	18.9	19.2
Diabetes	12	8.6	11.4	15.7	16.8
Chronic Liver Disease and Cirrhosis	11.1	11.2	13	11.5	12

Data source: CDC WONDER Online Database, Underlying Cause of Death

LIFE EXPECTANCIES

Life expectancy is a good measure of a population's longevity and general health. At the local level, life expectancy reflects neighborhood safety, quality of healthcare, physical environment, and physical and mental health of residents. Figure 4 shows Clark County residents' life expectancy at birth by census tract. Life expectancy varies widely across the county, ranging from 64 to 86.1 years.

Figure 4 Life Expectancy at Birth by Census Tract, Clark County, NV 2010-2015



Data source: National Center for Health Statistics. US Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates File for Nevada, 2010-2015

SELF-ASSESSED PHYSICAL AND MENTAL HEALTH

Feeling healthy is associated with both physical and mental well-being. In 2017, compared to both Nevada and the US, a slightly higher percentage of Clark County residents reported fair or poor general health status (Table 2). A slightly lower percentage of Clark County residents reported their mental health was not good in 14 or more days during the past 30 days (Table 2).

Table 2 Self-reported General and Mental Health, Clark County, Nevada, and the United States, 2017

	Clark County % (95% CI)	Nevada % (95% CI)	United States % (95% CI)
Self-reported general health fair or poor	20.38 (17.84, 22.91)	20.33 (18.40, 22.26)	18.65 (18.40, 18.90)
Self-reported mental health not good in 14 or more days during the past 30 days	11.16 (9.05, 13.28)	11.70 (10.08, 13.32)	12.42 (12.21, 12.63)

Data source: BRFSS 2017

ACCESS TO CARE

Access to affordable, quality healthcare is important to physical, social, and mental health. In 2017, 22% of Clark County adults 18-64 years old did not have healthcare coverage. This number is significantly higher than the national average at 15%. Similarly, Clark County lags behind the US in vaccinations, preventive screenings, routine checkups, and access to healthcare providers (Table 3).

Table 3 Access to Care Indicators, Clark County, Nevada, and the United States, 2016-2017

	Clark County % (95% CI)	Nevada % (95% CI)	United States % (95% CI)
Had flu vaccine within past 12 months	30.69 (27.75, 33.62)	32.75 (30.50, 35.00)	40.05 (39.73, 40.37)
Ever had a pneumonia shot	32.20 (29.09, 35.30)	34.58 (32.19, 36.98)	38.29 (37.95, 38.62)
Received one or more of the recommended colorectal cancer screening tests	61.54 (57.03, 66.04)	62.16 (58.89, 65.42)	67.60 (67.18, 68.03)
Received a Pap test within the past 3 years	74.34 (70.74, 77.93)	72.57 (69.83, 75.31)	75.44 (75.09, 75.78)
Had a routine checkup within past year	68.68 (65.67, 71.70)	67.94 (65.64, 70.24)	70.68 (70.38, 70.98)
Visited a dentist, dental hygienist or dental clinic within the past year	59.74 (56.92, 62.57)	60.40 (58.24, 62.55)	65.74 (65.46, 66.02)
Do not have health care coverage (adults 18-64 years old)	21.55 (18.39, 24.70)	19.42 (17.01, 21.84)	14.73 (14.44, 15.02)
Do not have a personal health care provider	36.20 (33.07, 39.33)	33.75 (31.37, 36.14)	22.45 (22.17, 22.73)
Needed to see a doctor but could not because of cost during the past 12 months	17.25 (14.76, 19.75)	16.77 (14.88, 18.67)	13.49 (13.26, 13.73)

Data source: BRFSS 2016-2017 (most recent year of data available)

CHRONIC DISEASES

Chronic diseases are long-lasting illnesses or conditions that can be controlled but not cured. Heart disease, cancer, chronic lower respiratory disease, stroke, diabetes, and Alzheimer's disease all fall under this category. In Clark County, chronic diseases were leading contributors to mortality, with heart disease, cancer, and chronic lower respiratory disease consistently ranking at the top (Figure 3).

MORTALITY AND MORBIDITY

The following graphs (Figure 5-Figure 10) show differences of age-adjusted death rates due to chronic diseases by sex and by race/ethnicity. For many of these diseases, certain race/ethnicity groups had much higher death rates than other groups. For example, non-Hispanic black residents had heart disease death rates twice as high as Asian or Hispanic residents (Figure 5), while the death rate due to chronic lower respiratory disease among non-Hispanic white residents was more than double that of any other race/ethnicity group (Figure 7).

Figure 5 Age-Adjusted Death Rates Due to Heart Disease by Sex and Race/Ethnicity, Clark County, NV 2013-2017

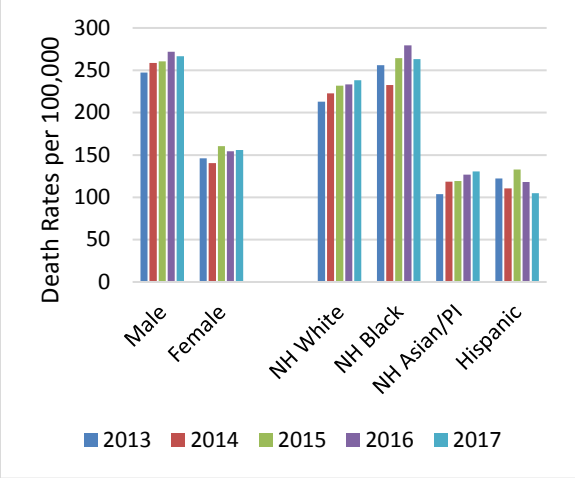


Figure 6 Age-Adjusted Death Rates Due to Cancer by Sex and Race/Ethnicity, Clark County, NV 2013-2017

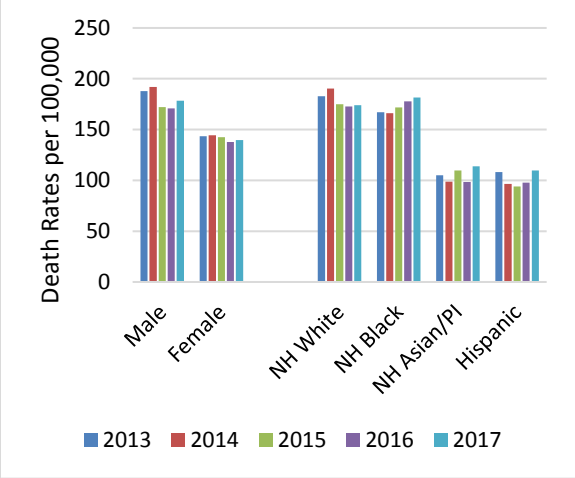


Figure 7 Age-Adjusted Death Rates Due to Chronic Lower Respiratory Disease by Sex and Race/Ethnicity, Clark County, NV 2013-2017

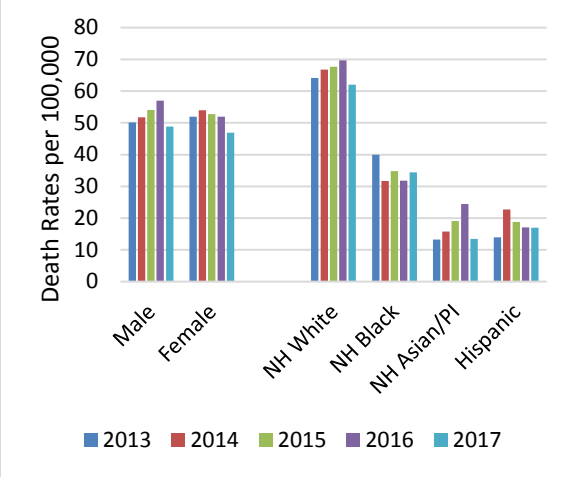


Figure 8 Age-Adjusted Death Rates Due to Stroke by Sex and Race/Ethnicity, Clark County, NV 2013-2017

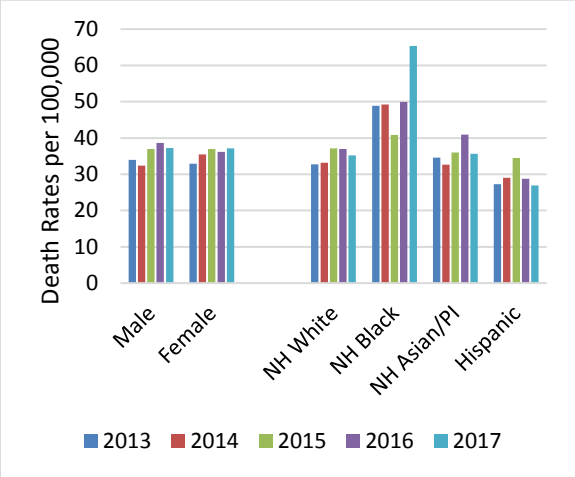


Figure 9 Age-Adjusted Death Rates Due to Alzheimer's Disease by Sex and Race/Ethnicity, Clark County, NV 2013-2017

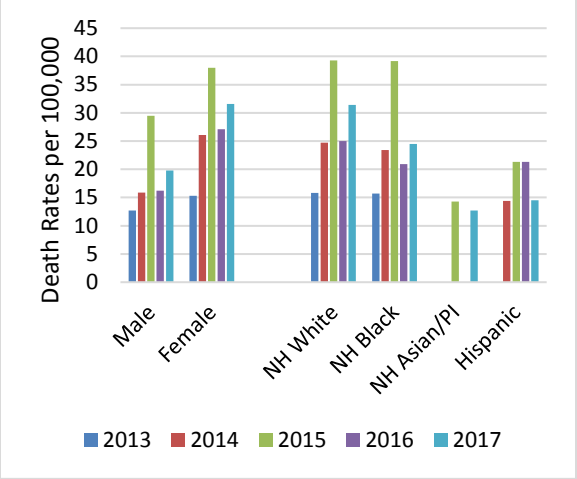
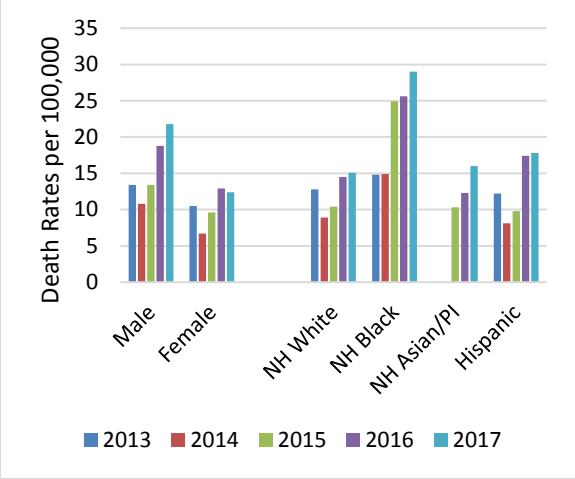


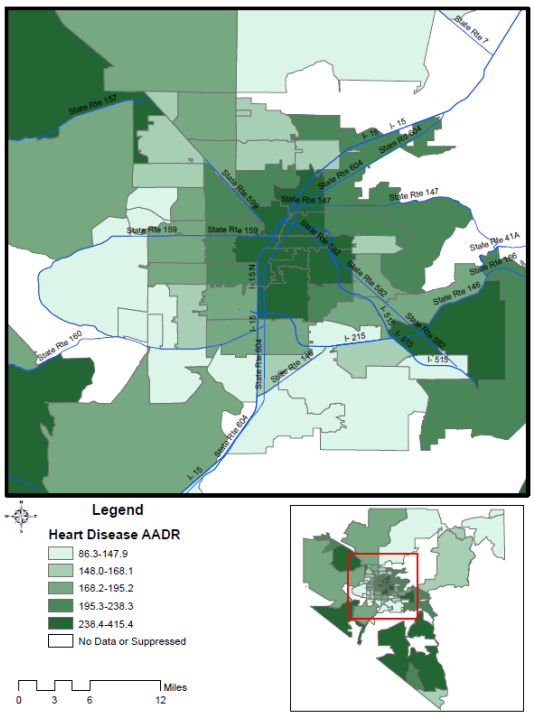
Figure 10 Age-Adjusted Death Rates Due to Diabetes by Sex and Race/Ethnicity, Clark County, NV 2013-2017

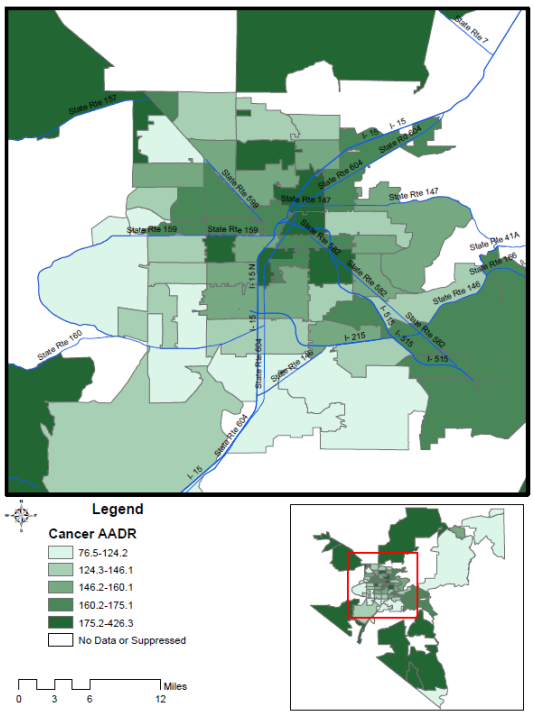


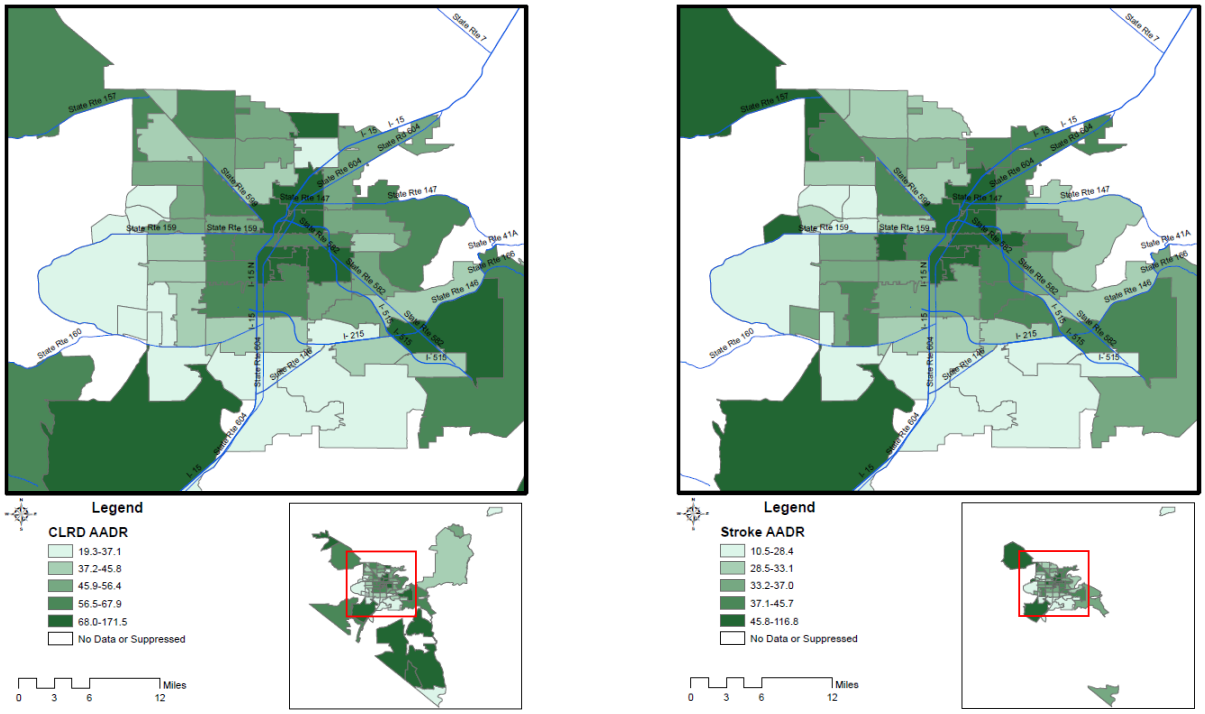
Data source: CDC WONDER Online Database, Underlying Cause of Death

The following maps (Figure 11-Figure 12) illustrate the geographic differences of death and emergency department (ED) visit rates due to selected chronic diseases and conditions. Many of these maps showed a similar pattern: Higher death and ED visit rates are frequently observed in socio-economically disadvantaged areas of Clark County.

Figure 11 Age-Adjusted Death Rates (per 100,000) Due to Heart Disease (first row left), Cancer (first row right), Chronic Lower Respiratory Disease (second row left), and Stroke (second row right), by ZIP Code, Clark County, NV 2013-2017

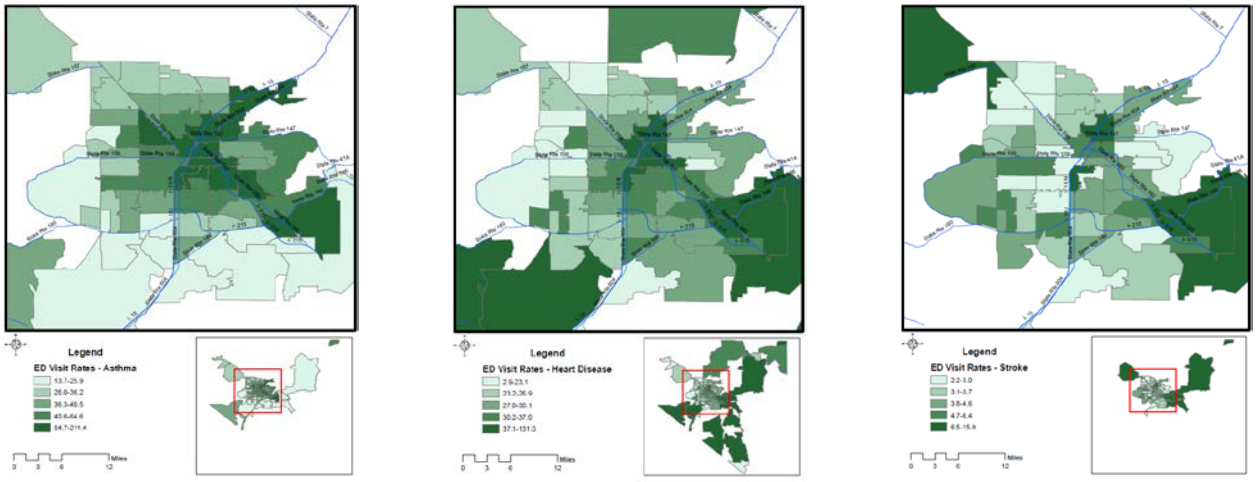






Data Source: Nevada Vital Records Death Certificate Data

Figure 12 Age-Adjusted ED Visit Rates (per 10,000) Due to Asthma (left), Heart Disease (middle), and Stroke (right), by ZIP Code, Clark County, NV 2013-2017



Data Source: Nevada Hospital Discharge Data

Table 4 compares the prevalence of chronic diseases and conditions among Clark County residents with statewide and national prevalence estimates. Clark County had significantly lower prevalence of residents with arthritis and residents who are overweight. Other differences were not statistically significant.

Table 4 Prevalence of Chronic Diseases/Conditions, Clark County, Nevada, and the United States, 2017

	Clark County % (95% CI)	Nevada % (95% CI)	United States % (95% CI)
Ever had depressive disorder	14.16 (11.99, 16.33)	15.61 (13.93, 17.29)	19.12 (18.87, 19.36)
Ever had a heart attack	4.73 (3.44, 6.01)	4.82 (3.85, 5.80)	4.26 (4.15, 4.38)
Have coronary heart disease	4.37 (3.11, 5.63)	4.27 (3.32, 5.23)	4.05 (3.94, 4.16)
Ever had a stroke	2.79 (1.86, 3.72)	3.04 (2.33, 3.76)	3.19 (3.09, 3.30)
Have high blood pressure	32.53 (29.65, 35.41)	32.65 (30.46, 34.84)	32.54 (32.25, 32.83)
Have chronic obstructive pulmonary disease	6.79 (5.35, 8.24)	7.03 (5.92, 8.13)	6.54 (6.40, 6.68)
Have arthritis	18.52 (16.24, 20.80)	20.30 (18.54, 22.05)	24.54 (24.28, 24.79)
Have diabetes	10.78 (8.98, 12.58)	10.43 (9.07, 11.80)	10.89 (10.70, 11.08)
Ever had cancer (excluding skin cancer)	6.18 (4.88, 7.49)	6.54 (5.54, 7.54)	6.79 (6.65, 6.93)
Have kidney disease (excluding kidney stones, bladder infection, or incontinence)	4.45 (3.24, 5.67)	4.15 (3.23, 5.06)	3.16 (3.05, 3.27)
Obese	26.94 (23.96, 29.92)	26.67 (24.42, 28.93)	30.10 (29.80, 30.41)
Overweight	39.16 (35.91, 42.41)	39.00 (36.54, 41.46)	35.30 (34.98, 35.62)

Data source: BRFSS, 2017

HEALTH BEHAVIOR

Table 5 Health Behavior Indicators, Clark County, Nevada, and the United States, 2017

	Clark County % (95% CI)	Nevada % (95% CI)	United States % (95% CI)
No physical activity within past 30 days	29.72 (26.65, 32.79)	28.02 (25.70, 30.35)	26.90 (26.61, 27.20)
Current smoker	17.78 (15.18, 20.38)	17.59 (15.61, 19.56)	16.33 (16.08, 16.57)
Current e-cigarette user	4.89 (3.31, 6.48)	5.44 (4.22, 6.67)	4.39 (4.25, 4.53)
Binge drinker	17.32 (14.63, 20.02)	17.91 (15.86, 19.96)	16.96 (16.70, 17.21)
Heavy drinker	5.33 (3.86, 6.79)	6.21 (5.07, 7.34)	6.19 (6.03, 6.35)
Do not always wear seat belt	8.57 (6.60, 10.55)	9.46 (7.95, 10.98)	11.44 (11.23, 11.64)

Data source: BRFSS 2017

Table 5 compares certain health behaviors among Clark County residents with those among Nevada and the United States. There was a significantly lower percentage of Clark County

residents who did not always wear a seat belt compared with national estimates. Other differences were not statistically significant.

INJURY AND VIOLENCE

LEADING CAUSES OF INJURY MORTALITY AND MORBIDITY

Differences in age-adjusted death rates due to unintentional injury, suicide, and homicide by sex and by race/ethnicity are examined below (Figure 13-Figure 15). In general, males were much more likely to die from injuries than females. Non-Hispanic white residents had much higher death rates due to suicide than all other race/ethnicity groups (Figure 14), while non-Hispanic black residents had the highest homicide death rates compared with any other race/ethnicity groups (Figure 15).

Figure 13 Age-Adjusted Death Rates Due to Unintentional Injury by Sex and Race/Ethnicity, Clark County, NV 2013-2017

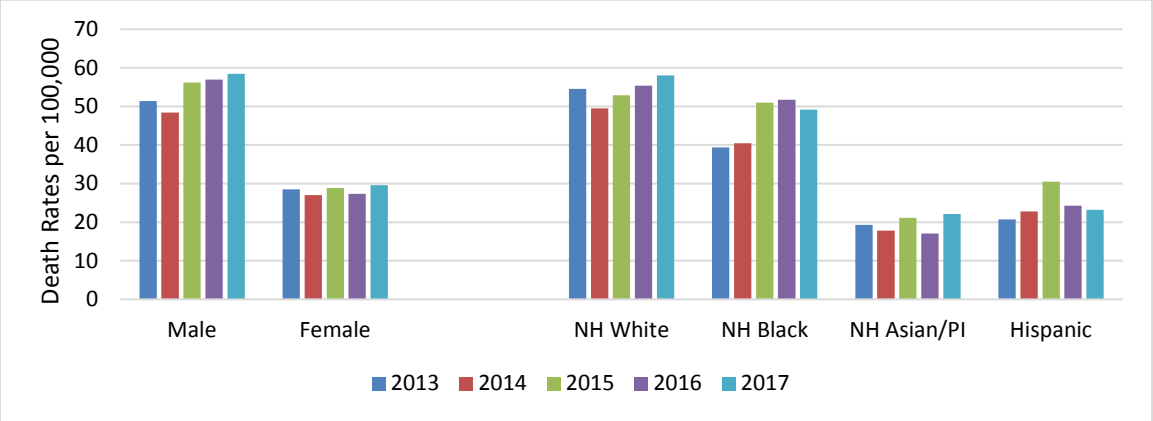


Figure 14 Age-Adjusted Death Rates Due to Suicide by Sex and Race/Ethnicity, Clark County, NV 2013-2017

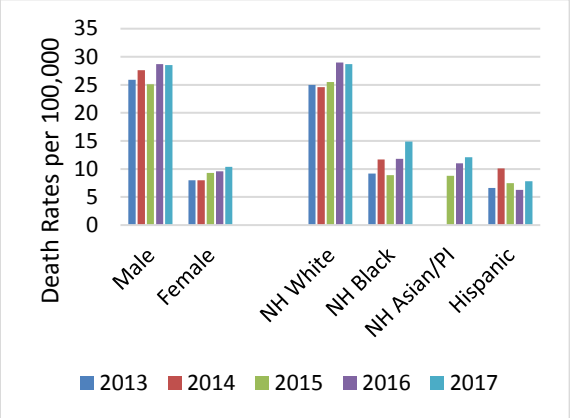
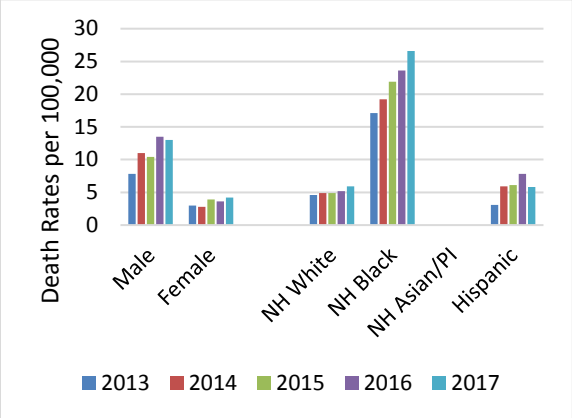


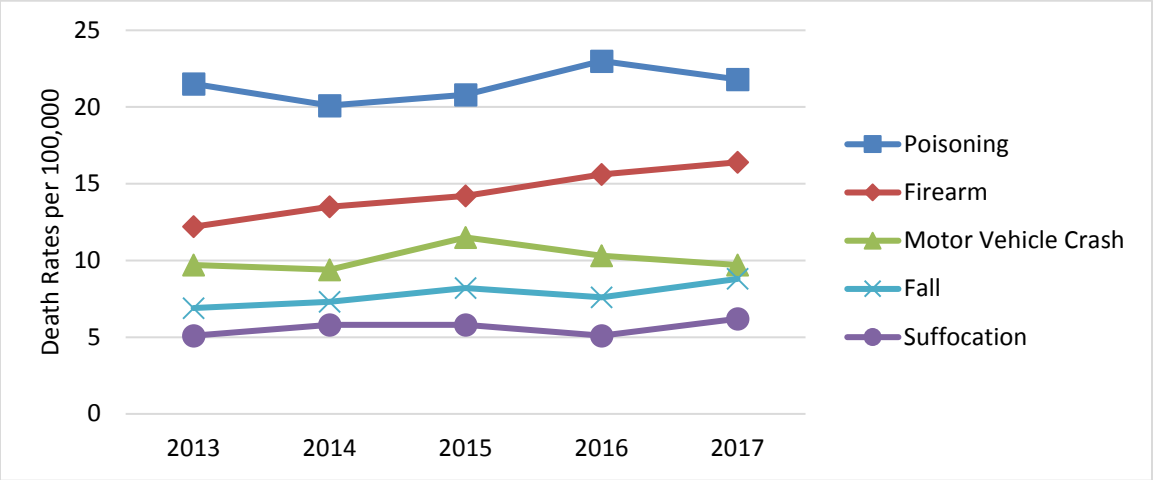
Figure 15 Age-Adjusted Death Rates Due to Homicide by Sex and Race/Ethnicity, Clark County, NV 2013-2017



Data source: CDC WONDER Online Database, Underlying Cause of Death

When injury mechanisms were examined, poisonings had surpassed both firearm injuries and motor vehicle crashes, becoming the leading mechanism of injury deaths (Figure 16). Poisoning includes drug overdose, which is the leading driver of the poisoning mortalities and morbidities in Clark County.

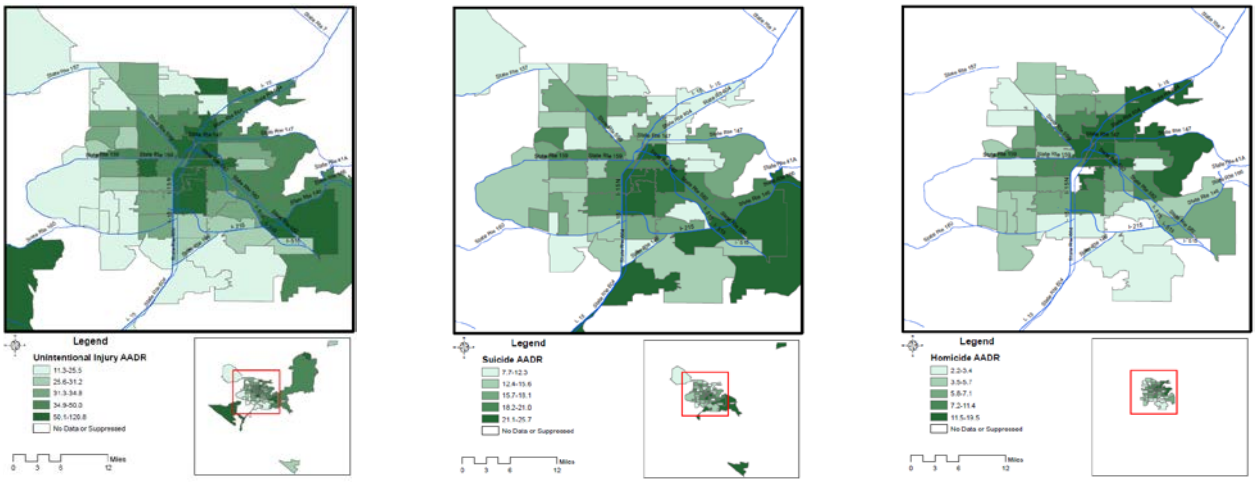
Figure 16 Age-Adjusted Injury Death Rates by Injury Mechanism, Clark County, NV 2013-2017



Data source: CDC WONDER Online Database, Underlying Cause of Death

The three maps below (Figure 17) illustrate geographic differences of death rates due to unintentional and intentional (include suicide and homicide) injuries.

Figure 17 Age-Adjusted Death Rates (per 100,000) Due to Unintentional Injury (left), Suicide (middle), and Homicide (right), by ZIP Code, Clark County, NV 2013-2017



Data Source: Nevada Vital Records Death Certificate Data

OPIOID OVERDOSE

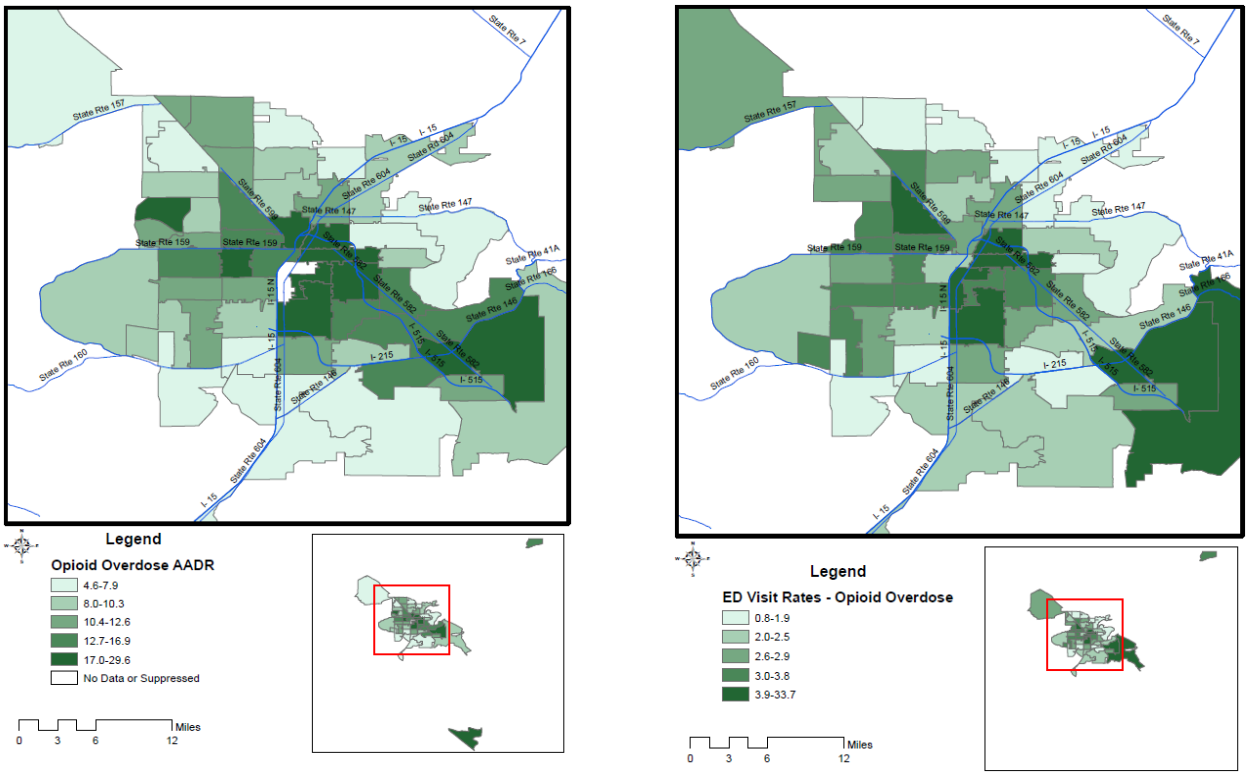
The misuse and overuse of opioid analgesic agents and illicit drugs pose a serious public health challenge. Overdose deaths in Clark County, largely driven by prescription opioids, such as

oxycodone, hydrocodone, codeine, and morphine, reached an age-adjusted rate of 20.3 per 100,000 in 2017 (up from an age-adjusted rate of 20 in 2010). Since 2007, more residents of Clark County have died from opioid overdoses than from motor vehicle crashes. In comparing these findings to national results, the age-adjusted drug overdose death rate was 31.4% higher for Clark County residents from 2010 to 2017.

The majority of drug overdose deaths were unintentional. Nearly two-thirds of drug overdoses involved opioid analgesics. Residents aged 45-54 had higher overdose death rates involving opioid analgesics than other age groups. From 2010-2017, non-Hispanic white residents had the highest age-adjusted death rate (16.8 per 100,000) from opioid analgesic poisonings, followed by black/African American, American Indians/Alaska Native, and Asian or Pacific Islander residents. While the prescription opioid overdose death rate among Clark County residents reached its highest peak in 2011 and has since been steadily decreasing, prescription drugs still account for the highest proportion of opioid-related deaths. As a result, modifying prescribing patterns remains critical to reversing the fatal drug poisoning epidemic in Clark County. Figure 18 illustrates the ZIP codes with the highest rates of opioid overdose deaths and ED visits.

The markedly high drug overdose death rates in Clark County are also reflective of the increase in psychostimulants with abuse potential. Psychostimulants with abuse potential include methamphetamine, amphetamine, MDMA, methylphenidates, and ephedrine. From 2010 to 2017, psychostimulant deaths increased 262.5% among Clark County residents and male deaths far exceeded female deaths by 120.5%.

Figure 18 Age-Adjusted Death Rates (per 100,000) (left) and ED Visit Rates (per 10,000 population) (right) Due to Opioid Overdose by ZIP Code, Clark County, NV 2013-2017



Data Source: Nevada Vital Records Death Certificate Data, Nevada Hospital Discharge Data

INFECTIOUS DISEASES

INFLUENZA

In Clark County, influenza viruses are most common during the fall and winter months. Influenza activity often begins to increase in October and November. Most of the time flu activity peaks between December and February and can last as late as May.

LABORATORY SURVEILLANCE

The Southern Nevada Public Health Laboratory (SNPHL), commercial laboratories, and healthcare providers report cases who test positive for influenza by Rapid Influenza Diagnostic Tests (RIDTs) and confirmative laboratory tests such as Reverse-Transcriptase Polymerase Chain Reaction (RT-PCR). In addition, positive results of influenza virus and influenza A virus subtype are also reported. The most common virus type identified during the 2017-2018 influenza season was Influenza A (69%); however, influenza B viruses have been reported more frequently since the middle of February 2018, claiming 28.7% of tests. Table 6 represents testing data, including the type and subtypes identified in the 2017-2018 season.

Table 6 Positive Influenza Types, Clark County, NV 2017- 2018 Season

Influenza Type		Test Type		Total	Percentage
	Subtype	RIDT	Non-RIDT		
Influenza A	A (Seasonal H3)		37	37	0.3%
	A (H1N1 pdm09)		7	7	0.1 %
	A (not subtyped)	7,255	310	7,565	68.6 %
Influenza B		2,992	169	3,161	28.7 %
Undifferentiated influenza A/B		247	4	251	2.3 %
Total				11,021	100%

Data source: SNHD Influenza Surveillance

INFLUENZA HOSPITALIZATIONS

During the 2017-2018 season, 980 hospitalizations and 62 deaths attributed to influenza were reported, including three pediatric deaths (aged 0-17 years) (Table 7).

Table 7 Influenza Hospitalizations and Deaths, Clark County, NV 2017 – 2018 Season

Age Group	# of Deaths (%)	# of Hospitalizations (%)
0-4	1 (1.6%)	48 (4.9%)
05-17	2 (3.2%)	30 (3.1%)
18-24	1 (1.6%)	29 (2.9%)
25-49	2 (3.2%)	118 (12%)
50-64	14 (22.6%)	184 (18.8%)
65+	42 (67.7%)	571 (58.3%)
Total Confirmed Cases*	62 (100%)	980 (100%)

*Confirmed Cases: Cases with evidence of a positive influenza test by reverse-transcriptase polymerase chain reaction (RT-PCR), viral culture, immunofluorescent antibody staining (direct [DFA] or indirect [IFA]), immunohistochemical (IHC) antigen staining, rapid influenza diagnostic tests (RIDTs) with hospitalizations for 24 hours or longer, or RIDTs with death.
Data source: SNHD Influenza Surveillance

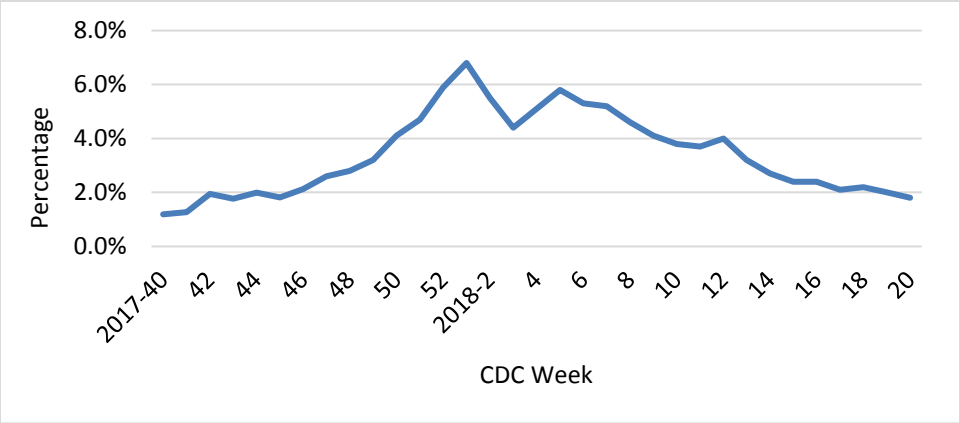
Influenza type A was the predominant virus identified in individuals hospitalized for influenza (83.4%). Of those hospitalized for influenza with documented immunization status (n=228), 91%

received the seasonal influenza vaccine. The highest percentage of hospitalization and death was among adults aged ≥ 65 years (Table 7).

SYNDROMIC SURVEILLANCE

SNHD utilizes Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) to conduct syndromic surveillance in Clark County, NV. ED visits in 16 local hospitals for influenza-like illness (ILI) during the 2017-2018 season were captured by ESSENCE (Figure 19).

Figure 19 Weekly Percentage of Emergency Room Visits for Influenza-Like Illness, Clark County, NV 2017- 2018 Season



Data source: SNHD ESSENCE

MORTALITY

Figure 20 Age-Adjusted Death Rates Due to Influenza and Pneumonia by Sex and Race/Ethnicity, Clark County, NV 2013-2017

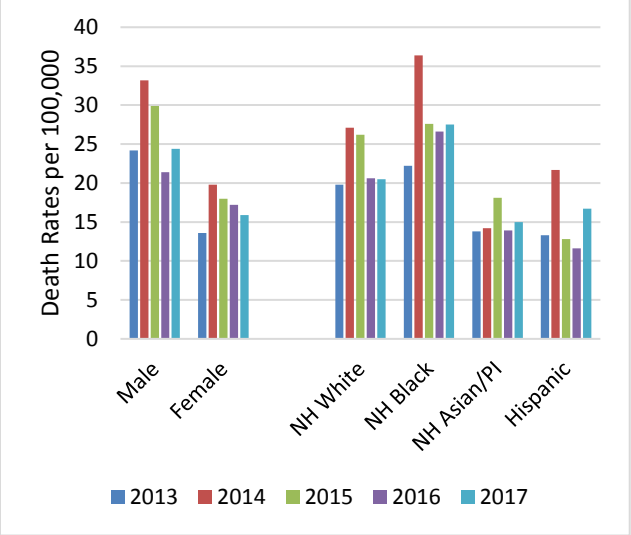
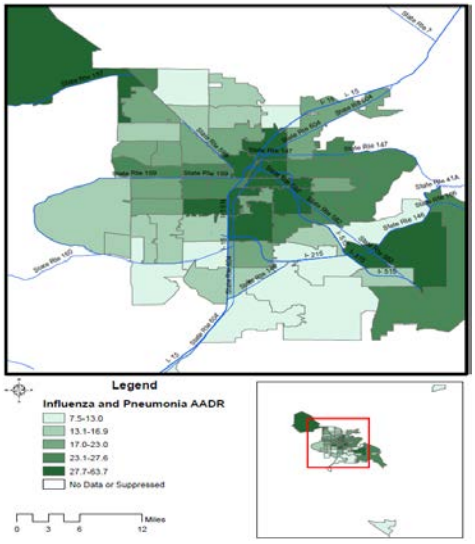


Figure 21 Age-Adjusted Death Rates (per 100,000) Due to Influenza and Pneumonia by ZIP Code, Clark County, NV 2013-2017



Data Source: CDC WONDER Online Database, Underlying Cause of Death; Nevada Vital Records Death Certificate Data

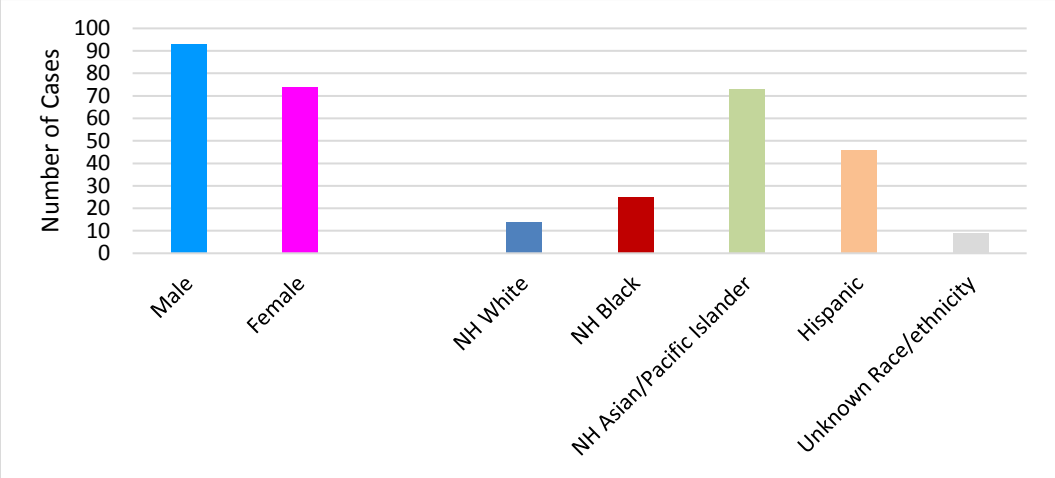
In otherwise healthy individuals, influenza is relatively uncomplicated with the infection generally resolving in one week. When complications do arise, pneumonia is a top complication of influenza. Influenza and pneumonia vaccinations are especially recommended for persons most at risk, including young children, older adults, those with chronic diseases, and immunocompromised individuals. Males and non-Hispanic black residents in Clark County had higher death rates due to influenza and pneumonia (Figure 20). Figure 21 shows geographic variations of influenza and pneumonia mortalities.

TUBERCULOSIS

In 2017, the average rate of tuberculosis (TB) incidence in the US was 2.8 per 100,000 population (CDC, 2017b). Nevada had the 15th highest rate of TB incidence among the 50 states (2.7 per 100,000 population); the rate in Clark County (2.8 per 100,000 population) was comparable to the national average. From 2016-2018, males in Clark County had higher TB incidence than females, and Asian/Pacific Islander and Hispanic residents had a higher number of TB cases then non-Hispanic white and non-Hispanic black residents (Figure 22).

In Clark County, as in the United States, the majority (over 70%) of active TB cases occur among non-US-born persons; the most important risk factor for TB is being born in a country with a high burden of tuberculosis. Additional risk factors for TB include diabetes (36% of Clark County cases in 2017, 20% of cases nationwide), HIV coinfection (8% of Clark County cases in 2017, 6% of cases nationwide), and experiencing homelessness in the past year (3% of Clark County cases in 2017, 5% of cases nationwide).

Figure 22 Number of TB Cases by Gender and Race/Ethnicity, Clark County, NV 2016-2018

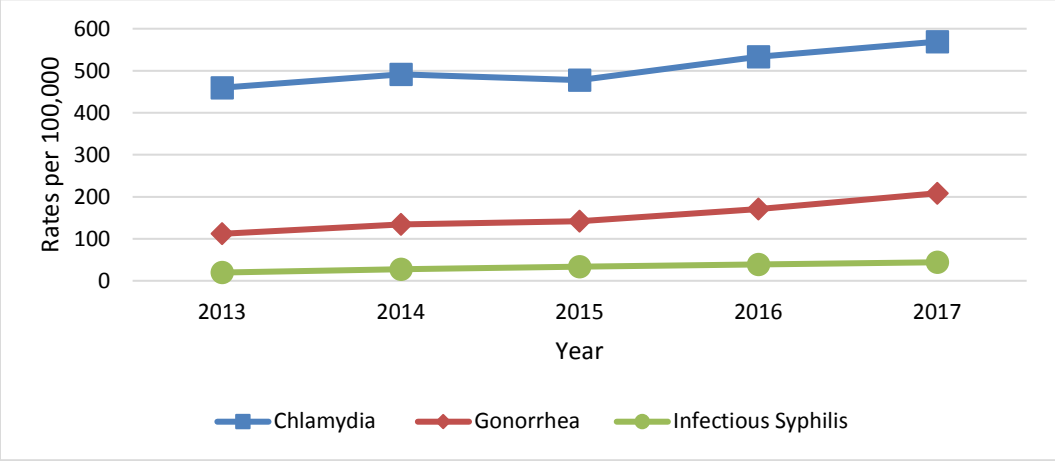


Data source: SNHD TB Surveillance

SEXUALLY TRANSMITTED INFECTIONS

As in the rest of the United States, incidence rates of sexually transmitted infections have been increasing in recent years. From 2013-2014, incidence rates of infectious syphilis more than doubled (124% increase), gonorrhea rates rose 86%, and chlamydia rates increased 24% (Figure 23).

Figure 23 Sexually Transmitted Infection Incidence Rates, Clark County, NV 2013-2017

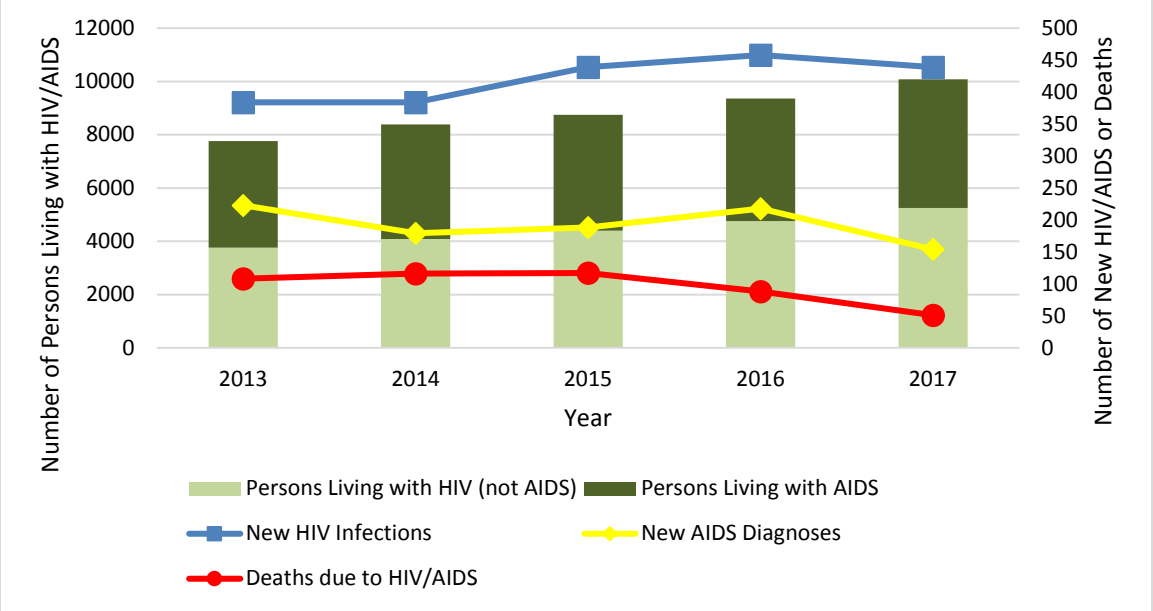


Data source: SNHD STD Surveillance

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 been steadily increasing. The number of persons living with HIV/AIDS (PLWHA) had steadily increased from 7,757 in 2013 to 10,079 in 2017. There were 5,253 persons living with HIV and 4,826 persons living with AIDS in Clark County in 2017 (Figure 24).

Figure 24 Persons Living with HIV/AIDS, New HIV Infections, New AIDS Diagnoses, and Deaths in Clark County, NV 2013-2017



Data source: SNHD HIV/AIDS Surveillance

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. Between 2013 and 2017, the annual number of new HIV infections in Clark County had increased about 20%. Deaths due to HIV/AIDS had decreased (Figure 24).

HEPATITIS

HEPATITIS A

While most people fully recover from Hepatitis A infections, the disease can cause severe liver damage or death. Incidence of Hepatitis A in Clark County declined dramatically in 2000s and early 2010s, aligned with efforts in routine Hepatitis A vaccinations administered to children and targeted vaccination among food handlers. However, Hepatitis A cases have been increasing in Clark County in recent years. There were 39 confirmed acute Hepatitis A cases reported in 2018 compared to 13 cases reported in 2017 and 12 cases reported in 2016. Of the total cases reported in 2018, 54% were among persons who use or inject drugs, compared to 38% who were not using drugs and 8 percent unknown. Additionally, 18% of the total cases reported in 2018 were individuals experiencing homelessness.

HEPATITIS B AND C

Hepatitis B is a serious disease caused by a virus that attacks the liver. Hepatitis B is transmitted when blood, semen, or another body fluid from a person infected with the Hepatitis B virus enters the body of someone who is not infected. This can happen through sexual contact; sharing needles, syringes, or other drug-injection equipment; or from mother to baby at birth. Chronic Hepatitis B can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. The best way to prevent Hepatitis B is through vaccination.

Hepatitis C is a blood-borne virus. Today, most people become infected with the Hepatitis C virus by sharing needles or other equipment to inject drugs. There is no vaccine for Hepatitis C; the best way to prevent Hepatitis C is by avoiding behaviors that can spread the disease, especially injection drug use.

Since 2014, new infections of Hepatitis B and C have been increasing locally and nationally, particularly among young people. A common risk factor for this rise has been an increase in injection drug use among this population. Additionally, geographic areas experiencing the highest burden of opioid use are also experiencing higher rates of Hepatitis B and C.

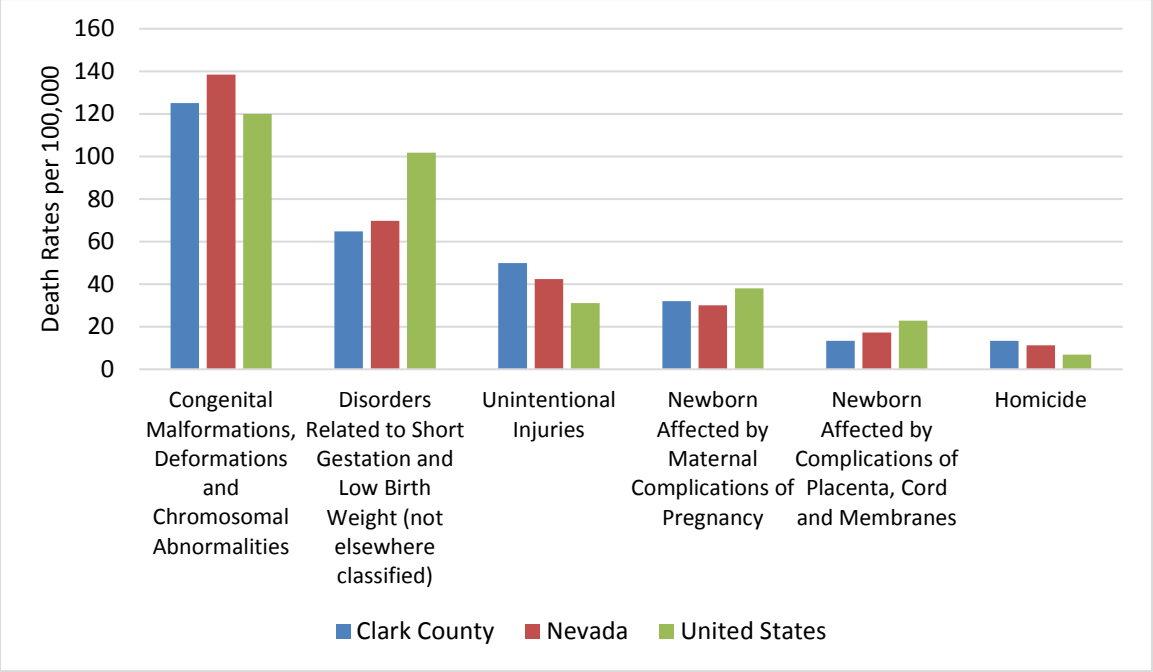
MATERNAL AND CHILD HEALTH

The well-being of pregnant women and children influences the health of the next generation and can predict future public health challenges for families, communities, and the health care system.

INFANT MORTALITY

In Clark County, the leading causes of infant (<1 year old) deaths were birth defects, preterm and low birth weight, unintentional injury, maternal complications of pregnancy, homicide, and complications of placenta, cord, and membranes. When compared to Nevada and the United States, Clark County had higher infant death rates due to unintentional injury and homicide (Figure 25).

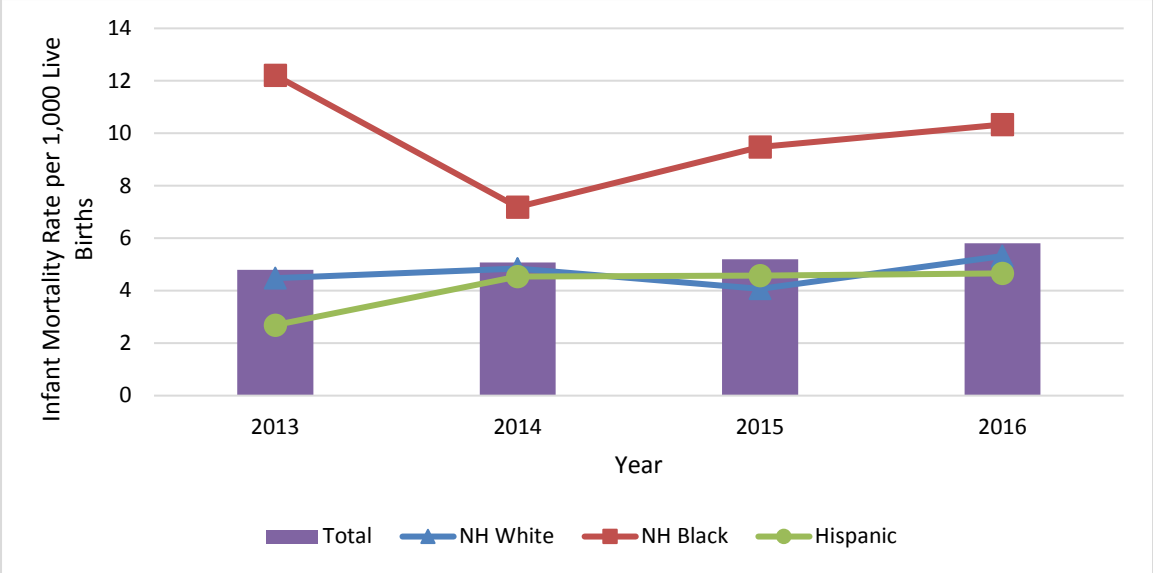
Figure 25 Leading Causes of Infant Deaths, Clark County, Nevada, and the United States, 2013-2017



Data source: CDC WONDER Online Database, Underlying Cause of Death

Since 2013, the infant mortality rate in Clark County has been increasing. Infants born to mothers who are non-Hispanic black had the highest infant mortality rate (9.76 per 1,000 live births during 2013-2016) compared to non-Hispanic white or Hispanic mothers (4.67 and 4.13 per 1,000 live births, respectively, during 2013-2016) (Figure 26).

Figure 26 Infant Mortality Rate by Mother's Race/Ethnicity, Clark County, NV 2013-2016



Data Source: CDC WONDER Online Database, Linked Birth/Infant Death Records

PRETERM BIRTHS

Preterm births, those occurring at least 3 weeks before the due date, can result in negative health outcomes and long-term complications, such as impaired cognitive skills, vision and/or hearing loss, cerebral palsy, and chronic health issues. In Clark County, the overall proportion of preterm births has been increasing since 2013. Non-Hispanic black/African American mothers are still much more likely to experience preterm births than other racial/ethnic groups (Figure 27).

LOW BIRTH WEIGHT

Low birth weight (LBW) is defined as a live-born infant weighing less than 2500 grams (5.5 lbs). According to the Centers for Disease Control and Prevention (CDC), low birth weight infants may be more at risk for many health problems compared to infants of normal weight (CDC, 2016). Risk factors that may increase a pregnant woman's chances of having a low birth weight baby in her lifetime include: smoking, drinking alcohol, lack of weight gain, being younger than 15 years or older than 35 years, and exposure to air pollution or environmental contaminants. Additionally, socioeconomic factors, such as low income, low educational level, stress, domestic violence/abuse or being unmarried may also increase risk. The overall proportion of low birth weight babies in Clark County has been increasing since 2013 (8.1%), reaching 9.5% in 2017. Disparities exist among racial/ethnic groups: Low birth weight impacted only about 8% of births to Hispanic mothers in 2017, but over 15% of births to non-Hispanic black mothers in the same year were low birth weight (Figure 28).

Figure 27 Preterm Births by Mother's Race/Ethnicity, Clark County, NV 2013-2017

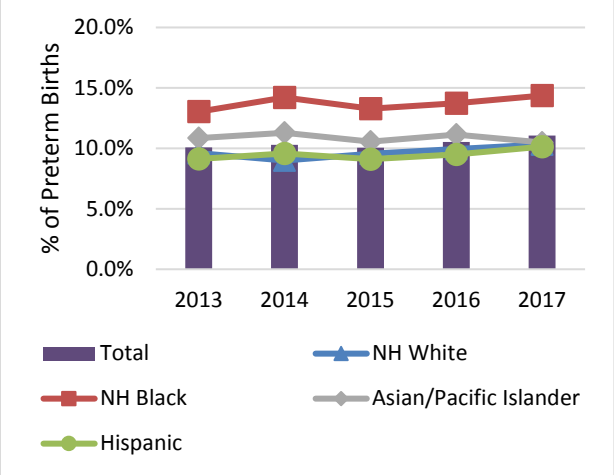
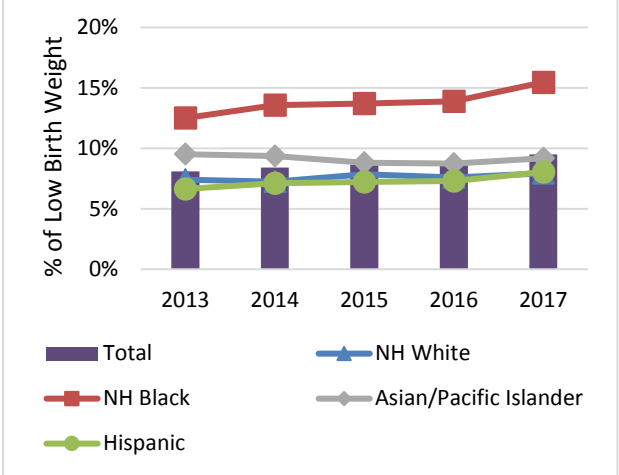


Figure 28 Infants with Low Birth Weight by Mother's Race/Ethnicity, Clark County, NV 2013-2017



Data Source: Nevada Vital Records Birth Certificate Data

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%. Data from 2017

indicate that 99% of expectant mothers in Clark County abstained from alcohol during pregnancy, meeting the Healthy People 2020 target (Nevada Vital Records Birth Certificate Data, 2017).

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 who abstained from cigarette smoking during pregnancy increased from 93.8% in 2013 to 96.0% in 2017 (CDC, 2019), but failed to reach the Healthy People 2020 target of 98.6%.

TEEN PREGNANCY AND BIRTHS

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. In 2017, the teen birth rate in Clark County was 21.0 births per 1,000 females aged 15-19 years (Nevada Vital Records Birth Certificate Data, 2017), which is higher than the national rate of 18.8 (CDC, 2017a).

CHILDHOOD INJURY

Unintentional injury was the leading cause of deaths among children and youths 1-24 years old. Suicide followed unintentional injury as the 2nd leading cause of deaths among 10-24 years old. Homicide was the 3rd leading cause of deaths among 15-24 years old (Table 8).

Table 8 Number of Deaths by Leading Causes and Age Group (<25 years old), Clark County, NV 2013-2017

Rank	<1	1-4	5-9	10-14	15-19	20-24
1	Congenital Abnormalities (160)	Unintentional Injury (46)	Unintentional Injury (18)	Unintentional Injury (20)	Unintentional Injury (105)	Unintentional Injury (227)
2	Preterm / Low Birth Weight (84)	Homicide (16)	Cancer (14)	Suicide (15)	Suicide (67)	Suicide (116)
3	Unintentional Injury (65)	Influenza and Pneumonia (10)	Homicide (7)	Cancer (14)	Homicide (54)	Homicide (97)
4	Maternal Complications (41)	Heart Disease (6)	Chronic Lower Respiratory Disease ****	Homicide (9)	Cancer (18)	Heart Disease (38)
5	Homicide (18)	Cancer (5)	Influenza and Pneumonia ****	Heart Disease (7)	Heart Disease (8)	Cancer (29)

**** Cell values less than 5 are suppressed
Data Source: Nevada Vital Records Death Certificate Data

Among younger children, unintentional suffocation resulted in the most infant (<1 year old) injury deaths, and unintentional drowning was the most common injury mechanism for those aged 1-4 years. Motor vehicle crash was the leading mechanism of injury deaths among 5-9 year olds. Firearm (mostly suicide or homicide) has surpassed motor vehicle crash and became the

leading mechanism of injury deaths among youths and young adults aged 10-24 years (Table 9).

Table 9 Number of Injury-Related Deaths by Mechanism/Intent and Age Group (<25 years old), Clark County, NV 2013-2017

Rank	<1	1-4	5-9	10-14	15-19	20-24
1	Suffocation (excl. homicide) (58)	Drowning (excl. homicide) (23)	Motor Vehicle Crash (7)	Firearm (15)	Firearm (90)	Firearm (154)
2	Homicide (18)	Homicide (16)	Homicide (7)	Motor Vehicle Crash (11)	Motor Vehicle Crash (63)	Motor Vehicle Crash (111)
3	Motor Vehicle Crash ****	Motor Vehicle Crash (12)	Drowning (5)	Drowning ****	Drug Overdose (29)	Drug Overdose (107)
4	Drowning (excl. homicide) ****	Suffocation (excl. homicide) (6)	Fire/Flame (excl. suicide / homicide) ****	Suffocation ****	Suffocation (24)	Suffocation (29)
5	Natural / environment ****	Drug Overdose (excl. homicide) ****	Firearm (excl. homicide) ****	Fall ****	Drowning (7)	Fall (12)

**** Cell values less than 5 are suppressed
Data Source: Nevada Vital Records Death Certificate Data

CHILDHOOD LEAD POISONING

Today, childhood lead poisoning is considered the most preventable environmental disease among young children. With less lead in the environment, lead poisonings have decreased and become less severe, but lead poisoning still occurs. In the United States, the major source of lead exposure among children is lead-based paint and lead-contaminated dust found in older buildings. Children under the age of 6 years are at risk for lead poisoning because they tend to put their hands or other objects into their mouths. Children can be exposed to lead by eating lead-based paint chips, chewing on objects painted with lead-based paint, or swallowing house dust or soil that contains lead.

No safe level of lead exposure has been identified. The CDC and Nevada Childhood Lead Poisoning Prevention Program (NvCLPPP) recommends that Medicaid eligible children should be screened when the child reaches 12 and 24 months of age or at least once before the child reaches 6 years of age.

NvCLPPP in partnership with the Nevada Division of Public and Behavioral Health and SNHD reported a 3% screening rate for children less than 6 years of age in the State of Nevada between October 1, 2016, and September 30, 2018. Nevada has one of the lowest screening rates across the United States.

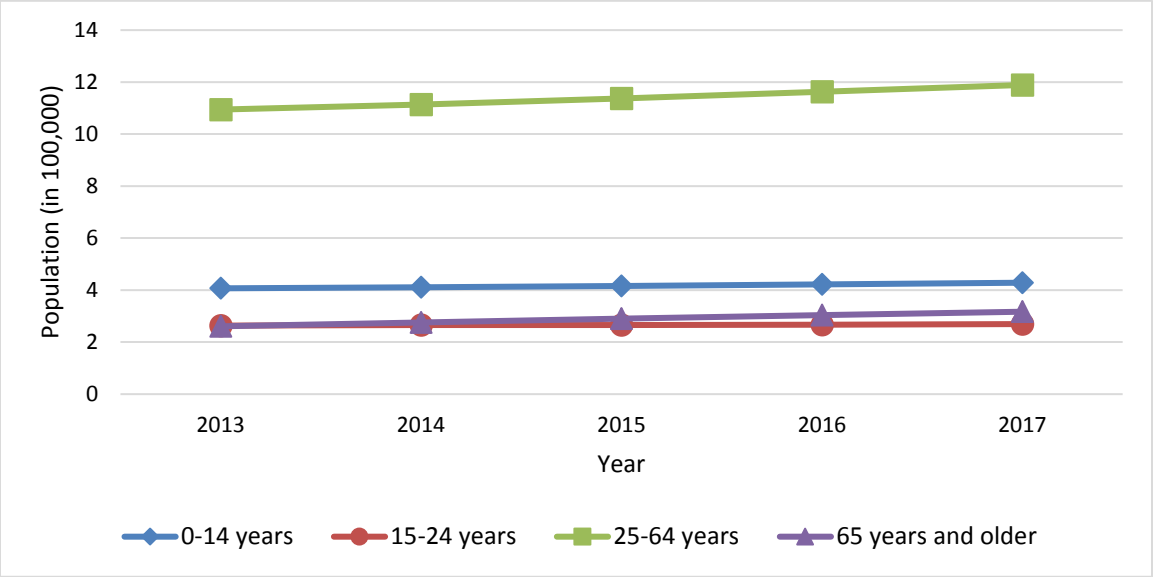
To improve performance in screening rates, healthcare providers and health plans should provide blood lead screening and diagnostics services for children enrolled in Medicaid as

suggested by CDC and NvCLPPP, as well as reporting blood lead results to SNHD as required by the Nevada Administrative Code.

AGING

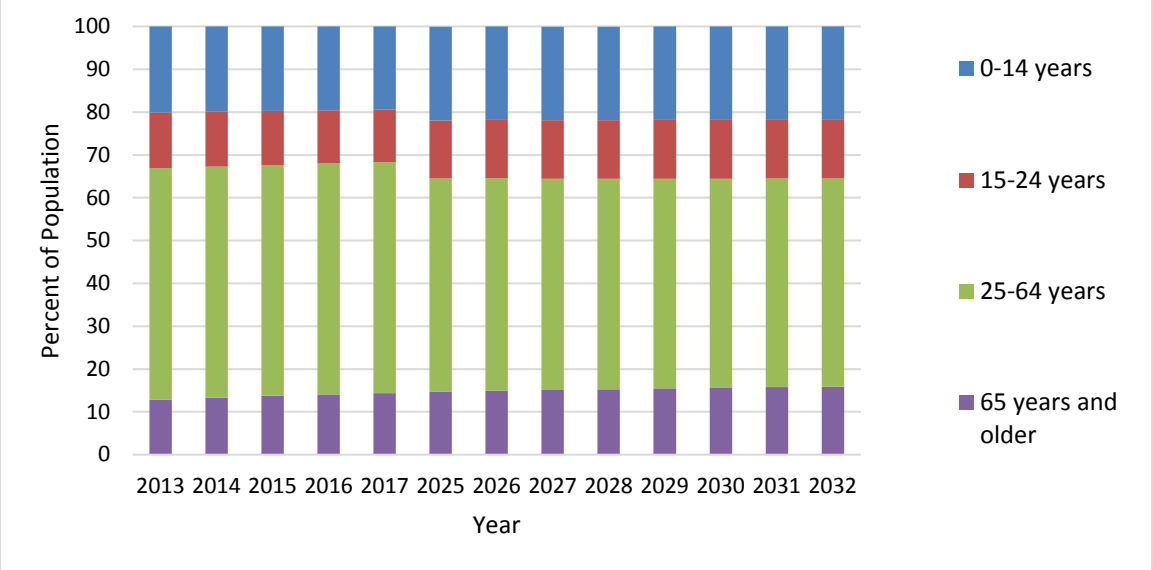
The aging of baby boomers (those born between 1946 and 1964) and the increased longevity of older adults is influencing the demographic landscape of Clark County.

Figure 29 Population Estimate, Clark County, NV 2013-2017



Data source: National Center for Health Statistics (NCHS) bridged-race population estimates, 2017

Figure 30 Percent of Population by Age Group, Clark County, NV 2013-2032



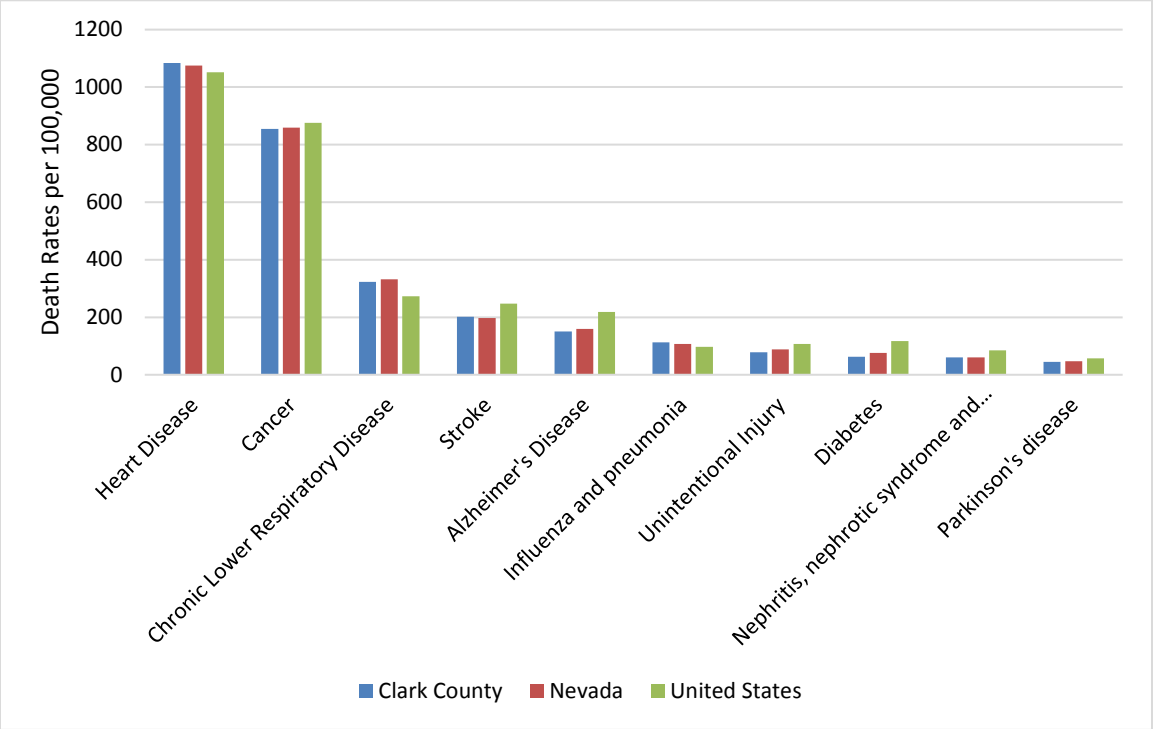
Data source: National Center for Health Statistics (NCHS) bridged-race population estimates, 2017; Nevada State Demographer population projection, vintage 2015

From 2013 to 2017, the population of adults 65 years and older increased 23%, the largest increase among all age groups (Figure 29). This is also the only age group that has been and is projected to be increasing its proportion among the total population (Figure 30). Like any other aging community, Clark County will be confronted with challenges, as well as opportunities, to meet the unique and diverse needs of this age group.

LEADING CAUSES OF MORTALITY IN THE AGING POPULATION

From 2013 to 2017, the top 10 leading causes of death among Clark County residents 65 years and older were: heart disease; cancer; chronic lower respiratory disease; stroke; Alzheimer's disease; influenza and pneumonia; unintentional injury; diabetes; nephritis, nephrotic syndrome and nephrosis; and Parkinson's disease. Comparing death rates with the state of Nevada and the United States, Clark County has similar death rates to Nevada, but higher than the national death rate for heart disease, chronic lower respiratory disease, and influenza and pneumonia (Figure 31).

Figure 31 Leading Causes of Deaths among Adults 65 Years and Older, Clark County, Nevada, and the United States, 2013-2017



Data source: CDC WONDER Online Database, Underlying Cause of Death

HEALTH STATUS, HEALTH BEHAVIOR, AND ACCESS TO CARE IN AGING POPULATION

For many of the health indicators found in Table 10, Clark County adults 65 years and older lagged behind their national peers, although the differences were not statistically significant. The only indicators that were statistically significant were the percentage of adults 65 years and older who were current smokers, and percentage of those who ever had the Shingles vaccine.

Table 10 Health Status, Health Behavior, and Access to Care Indicators among Adults 65 Years and Older, Clark County, Nevada, and the United States

	Clark County % (95% CI)	Nevada % (95% CI)	United States % (95% CI)
Health Status			
Self-reported general health fair or poor	27.24 (21.99, 32.50)	25.74 (21.96, 29.51)	25.72 (25.19, 26.25)
Self-reported mental health not good in 14 or more days during the past 30 days	8.77 (5.06, 12.48)	8.77 (6.11, 11.44)	7.90 (7.56, 8.24)
Ever had depressive disorder	14.67 (10.36, 18.99)	14.86 (11.76, 17.96)	16.05 (15.57, 16.53)
Ever had a heart attack	12.16 (8.45, 15.87)	12.23 (9.53, 14.93)	10.96 (10.60, 11.32)
Have coronary heart disease	12.45 (8.55, 16.35)	11.73 (8.93, 14.53)	11.28 (10.92, 11.65)
Ever had a stroke	8.06 (4.92, 11.21)	8.07 (5.79, 10.35)	7.58 (7.27, 7.88)
Have high blood pressure	61.84 (56.34, 67.34)	60.75 (56.77, 64.72)	60.82 (60.23, 61.40)
Have chronic obstructive pulmonary disease	14.56 (10.46, 18.67)	14.59 (11.64, 17.53)	12.67 (12.30, 13.05)
Have arthritis	42.53 (36.84, 48.21)	44.31 (40.20, 48.41)	50.29 (49.69, 50.89)
Have diabetes	24.76 (19.84, 29.69)	21.92 (18.40, 25.44)	22.87 (22.36, 23.39)
Ever had cancer (excluding skin cancer)	18.13 (13.77, 22.50)	18.14 (14.99, 21.30)	17.89 (17.45, 18.33)
Have kidney disease (excluding kidney stones, bladder infection, or incontinence)	10.59 (6.97, 14.22)	9.15 (6.59, 11.71)	6.79 (6.46, 7.11)
Obese	24.82 (19.77, 29.88)	25.08 (21.43, 28.72)	28.53 (27.98, 29.08)
Overweight	40.93 (35.08, 46.77)	40.20 (36.00, 44.40)	38.73 (38.14, 39.32)
Cognitive decline within past 12 months	17.04 (10.37, 23.72)	16.66 (12.23, 21.10)	11.60 (11.15, 12.05)
Health Behavior			
No physical activity within past 30 days	35.43 (29.75, 41.12)	33.62 (29.56, 37.69)	32.46 (31.88, 33.03)
Current smoker	16.49 (11.88, 21.09)	15.26 (11.99, 18.54)	8.87 (8.55, 9.19)
Current e-cigarette user	2.83 (0.98, 4.67)	2.77 (1.43, 4.10)	0.96 (0.86, 1.05)
Binge drinker	6.56 (3.64, 9.49)	6.48 (4.38, 8.59)	5.12 (4.85, 5.38)
Heavy drinker	2.75 (1.10, 4.39)	4.11 (2.80, 5.41)	4.29 (4.05, 4.53)
Do not always wear seat belt	4.69 (2.10, 7.29)	6.09 (4.16, 8.02)	8.43 (8.10, 8.76)
Preventive Care			
Had flu vaccine within past 12 months	57.94 (52.09, 63.78)	57.59 (53.38, 61.79)	60.18 (59.57, 60.79)

Ever had a pneumonia shot	68.24 (62.65, 73.83)	70.73 (66.73, 74.73)	74.21 (73.66, 74.76)
Ever had the shingles vaccine	37.61 (31.90, 43.32)	39.95 (35.81, 44.09)	44.05 (43.44, 44.66)
Had a routine checkup within past year	88.29 (84.78, 91.80)	86.53 (83.94, 89.13)	88.24 (87.83, 88.65)
Visited a dentist, dental hygienist or dental clinic within the past year	63.49 (58.03, 68.96)	63.69 (59.73, 67.65)	66.72 (66.22, 67.23)
Access to Healthcare			
Needed to see a doctor but could not because of cost during the past 12 months	6.36 (3.47, 9.25)	6.18 (4.11, 8.25)	5.14 (4.86, 5.42)

Data source: BRFSS 2015-2017 (most recent year of data available)

DISCUSSION

The Community Health Status Assessment 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.

Chronic diseases – especially heart disease and cancer – continue to be a major cause of mortality and morbidity in Southern Nevada. 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 still exist.

Death rates from unintentional injuries continue to be nearly twice as high among non-Hispanic 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.

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.

TELEPHONE SURVEY RESULTS

The following sections provide an overview of the demographic characteristics of survey respondents as well as key findings for each category of questions asked in the 2019 Southern Nevada Community Health Survey. The survey included questions about personal health behaviors and perceptions, experiences accessing healthcare, and perceptions of the health needs in the community.

KEY FINDINGS – TELEPHONE SURVEY

1. Challenges in Accessing Healthcare: Having insurance or a primary care provider does not always equal "access"

A primary focus of the survey was to understand how people in Clark County access healthcare, and what barriers they encounter. Barriers to care include the overall cost of care, lack of insurance, and the lack of available medical providers in Southern Nevada which increases wait times both in the office waiting to see a provider as well as ability to schedule an appointment. Although most survey respondents have insurance and a regular source of medical care, they are still reporting that cost and accessibility of medical providers are a barrier. Only 10% of respondents indicated they had no insurance, and this percentage was higher for Hispanic/Latino respondents (26%). In addition, for those that attempted to access healthcare in the past year, nearly 12% of respondents reported that they felt "hassled, made to feel inferior, or discriminated against" when trying to access healthcare. Finally, results from the survey indicate that nearly a quarter (22%) of respondents had delayed or gone without care in the past year primarily due to the high cost of care.

2. Community Safety: Perceptions of safety and social support are critical for a healthy community

Another key finding was perception of safety in the community. Almost a third of respondents disagreed with the statement that the community was a safe place to live (28%) and this proportion was slightly higher in respondents who identified as black/African American or Multi-Racial. Additionally, 30% of respondents disagreed with the statement that neighbors are trusted and look out for one another, and 23.1% disagreed that there are support networks for individuals and families during times of need. When asked to discuss their three most important factors for a healthy community, comments from respondents indicated their desire for more neighborhood/community connections and social support, as well as better partnerships with law enforcement to increase community safety.

Respondents were additionally asked about their concern for several specific items that impact community safety. Most respondents reported that they were very concerned about distracted driving (72%). Other issues that were of concern to most respondents included gun violence (59% very concerned), child abuse (58% very concerned), and domestic violence (58% very concerned). It is also important to note that the percent of those that were very concerned about these safety issues was even higher in some minority populations.

Taken together, these findings support the addition and expansion of health efforts related to community safety, injury and violence prevention, and show that members of the community see these as critical elements in supporting overall health.

SURVEY DEMOGRAPHICS

Illustrated below are the demographic characteristics for the number of respondents who completed the survey, as well as the weighted percentages which represent the demographics of all Clark County residents (Table 11).

Table 11 Summary of 2019 Southern Nevada Community Health Survey Demographics

Response Categories	N	Percent	Weighted Percent
Age			
18-24	35	9.6%	10.6%
25-34	44	11.9%	11.5%
35-44	72	19.5%	20.3%
45-54	51	13.8%	14.4%
55-64	54	14.6%	13.9%
65+	109	29.5%	29.3%
Gender			
Male	160	43.4%	49.7%
Female	209	56.6%	50.3%
Highest Level of Education			
Less than 9th grade	6	1.6%	2.3%
9th - 12th grade, no diploma	15	4.1%	4.6%
High school diploma/GED	82	22.2%	23.2%
Some college, no degree	99	26.8%	24.8%
Associate degree	47	12.7%	12.9%
Bachelor's degree	74	20.1%	10.6%
Graduate/professional degree	46	12.5%	12.5%
Race/Ethnicity			
Hispanic or Latino	55	14.9%	22.9%
White, non-Hispanic	183	49.6%	54.6%
Alaska Native/American Indian	4	1.1%	0.6%
Asian	35	9.5%	9.0%
Black/African American, non-Hispanic	67	18.2%	9.3%
Native Hawaiian/Pacific Islander	4	1.1%	0.6%
Multi-racial	21	5.7%	3.0%
Prefer Language Other Than English			
Yes	82	22.2%	27.3%
No	285	77.2%	72.2%
Sexual Orientation			
Heterosexual	347	94.0%	95.3%
LGBTQ+	14	3.7%	2.5%
Refused	13	3.5%	3.1%
Current Student Status			
Yes, full-time	27	7.3%	7.3%
Yes, part-time	15	4.1%	3.8%
No	327	88.6%	88.9%
Current Employment Status			
Employed full-time	153	41.5%	43.5%
Employed part-time	50	13.6%	14.1%
Not employed, looking for work	30	8.1%	7.0%
Not employed, not looking for work	132	35.8%	34.0%
Refused	4	1.1%	1.4%

Living Arrangement			
Own	210	56.9%	58.1%
Rent	146	39.6%	38.7%
Live with family	8	2.2%	1.5%
Other arrangement	2	0.5%	0.5%
Refused	3	0.8%	1.2%
Type of Housing			
House	266	72.1%	73.2%
Duplex or two-unit building	21	5.7%	5.7%
Building/apartment with 3+ units	69	18.7%	17.8%
Mobile/manufactured home	5	1.4%	1.1%
Senior housing/assisted living	4	1.1%	1.0%
Temporary housing	3	0.8%	0.7%
Refused	1	0.3%	0.5%
Number of Adults in Household			
1	79	21.5%	19.4%
2-3	253	68.9%	71.0%
4-5	30	8.2%	8.5%
6-7	5	1.4%	1.0%
Number of Children in Household			
0	23	62.8%	63.0%
1-2	111	30.2%	29.6%
3-4	21	5.7%	6.0%
5-6	5	1.4%	1.4%

PERSONAL HEALTH BEHAVIORS AND PERCEPTIONS

Respondents were asked to identify the biggest barrier to health in Southern Nevada, as well as three important factors that contribute to a healthy community.

Biggest Barrier to Health: Survey responses identified a broad spectrum of barriers. The top barriers identified as critical needs include: access to healthcare services, overall affordability of living in Las Vegas, affordable insurance, and knowledge of services. The largest barrier reported, accessibility to healthcare services, encompassed several areas of concerns which include the availability and quality of medical professionals, experiences with medical staff, and long wait times to see a doctor. The second largest concern was affordability, cost, and poverty. This is categorized as the overall ability to live in Las Vegas which would encompass general expenses such as housing, food, transportation, and healthcare. The third barrier to community health, related to accessing care, was the affordability of health insurance. The final barrier that emerged from this question was a lack of knowledge about available local services.

Factors for a Healthy Community: When respondents were asked to identify factors that contribute to a healthy community, the answers varied widely. However, four main themes emerged (listed in order of importance): community safety, access to healthcare, community support and connectedness, and knowledge and access to resources.

EXPERIENCES ACCESSING HEALTHCARE

Health Impacts on Daily Activities: Several questions in the survey were included to assess respondents' personal experiences when accessing healthcare. Overall, 23% of individuals

reported having a disability, handicap, or disease that impacted their daily abilities; this finding was consistent across gender and racial/ethnic groups.

Delayed Treatment or Medication: Respondents were asked if they had delayed or gone without needed healthcare in the past year. Overall, 22% of respondents indicated they had delayed or gone without care in the past year. This proportion was even higher among black/African American respondents (29%). Among those that indicated they went without needed care, the biggest barrier reported for all respondents was that the care was too expensive (47%). A large proportion of Hispanic respondents indicated that lack of insurance was a problem (41%). Additionally, 11% of respondents reported having to delay or go without prescription medication in the past year.

Received Non-Emergency Care Out of State: Due to limited access to healthcare providers, some residents of Nevada travel out of state to find a provider. Respondents were asked if, in the past year, they had sought standard treatment out of state. Only 5% of individuals completing the survey reported that they received non-emergency care out of state, which was consistent across gender and race/ethnicity categories. When asked to elaborate on the type of treatment received, examples included psychological counseling, eye surgery, glasses, hip replacement, drug rehabilitation, cancer treatment, and dental services.

Experiences of Harassment when Accessing Care: To gain better understanding of experiences Southern Nevadans face when accessing care, respondents were asked whether they had faced harassment or discrimination when seeking medical treatment. Overall, 12% of all respondents indicated that they have felt "hassled, made to feel inferior, or discriminated against" when trying to access healthcare. Respondents reported that their perceived reasons for this treatment were primarily insurance type (37%) and age (26%).

Service Utilization and Barriers to Access: Respondents were asked about healthcare services that were needed but not received. Overall, most respondents (83.5% or greater) reported that they did not need specific services, and if they did, they were able to access these services. There were only two services that more than 5% of respondents needed but did not use: low-cost dental services/oral health (12.2%) and general financial assistance (9.2%)[4].

PERCEPTIONS OF HEALTH NEEDS IN THE COMMUNITY

Respondents were asked several questions regarding their perceptions of community support for the health of residents. Nearly 29% of respondents indicated they feel the community does a very good job of supporting a healthy lifestyle, while approximately 48% indicated the community does a somewhat good job.

Survey participants responded to several statements on a scale from "major problem" to "no problem" regarding their perception of environmental issues. The top issues seen as major problems included secondhand smoke exposure (39%), pollution from vehicles (35%), and unused/uneaten household food ending up in landfills (35%).

DISCUSSION

The Southern Nevada Community Health Needs Assessment Survey was collected from 369 Southern Nevada residents to better understand personal health behaviors, experiences accessing healthcare, and perceptions of the health needs in the community. The key findings

[4] Further details on service utilization and barriers, and a full copy of the telephone survey are available upon request.

from this survey can be used to inform decisions regarding program implementation and resource development, and to provide guidance on decisions related to funding and/or local policies related to public health and healthcare. The recurring theme throughout the survey responses was that accessing health services in the community is challenging.

FOCUS GROUP RESULTS

The following provides an overview of participant demographics and a breakdown of question responses provided during the focus groups. The sections differentiate between the common themes found among all groups and the responses that were unique to each priority population[5].

KEY FINDINGS – FOCUS GROUP

Though each priority population has its own unique needs and set of circumstances that impact day-to-day experiences, there are many similar aspects of community health that influence each group's ability to maintain a healthy lifestyle. The following key findings outline the resources, services, information, and formative experiences that have the most impact on that goal.

1. Availability is not the same as accessibility

Participants across all groups acknowledged that services and programs exist in the community, but without access to reliable transportation, financial assistance, accommodations for those with disabilities, or information presented in one's preferred language, it is very difficult to utilize those services. A common example provided was the challenge of seeing multiple providers when they are physically located on opposite sides of the city. Many focus group members suggested the need for healthcare clinics that housed primary care physicians as well as specialists, mental health providers, dentists, and social services in one location as a solution to this barrier to care. One important aspect of accessibility is ensuring that people who need these resources know that the resources are available to them. Members of all groups trust what they hear by word of mouth from peers within the same community or from staff of organizations that work with their population.

2. One training doesn't make someone an expert

For participants in socially marginalized groups, such as those experiencing homelessness or those who identify as LGBTQ+, a widely mentioned challenge was finding healthcare providers that are willing to provide care for them and who fully understand the type of care needed. Many participants suggested that providers and staff should take cultural competency trainings to learn how to treat people "like human beings" and to learn more about how healthcare looks different for different types of people. Some also mentioned that those who complete these trainings may identify themselves or their practice as "LGBT Friendly," but then still are discriminatory when individuals go to them to receive care. Additionally, those who provide language interpretation services may have difficulty explaining complex medical terminology and concepts to patients, making communication between doctors and patients frustrating and apt to misinterpretation.

3. Mental health is on everyone's mind

At various points during all focus groups, participants raised concerns about the lack of mental health care for people of all ages, lifestyles, living situations, language preferences, and identities. Members of each group suggested the need for more mental health providers, as well as in-patient facilities and crisis hotlines. Additional concerns were raised about the stigma that persists around mental diagnoses and how that stigma can follow a person throughout their lifespan, preventing them from being able to take advantage of certain opportunities. Support groups, where people can share experiences and resources with each other about effective

[5] The full focus group report is available upon request.

health programs and services that are affordable and available in the community, were also mentioned as a means of providing community backing for mental and emotional health.

FOCUS GROUP DEMOGRAPHICS

Focus group participants were asked to complete a five-question demographic form at the start of each focus group. Demographic questions included participant's age, gender, race/ethnicity, level of education, and how they heard about the focus group. The demographics for each target population are presented in Table 12. Of the 70 total participants, most participants were female (59%), between the ages of 41 and 70 (54%) and did not receive a college degree (63%). Additionally, most focus group participants identified as Hispanic, Latino, or Spanish (39%), or as white/Non-Hispanic (30%).

Table 12 Focus Group Demographics

	ALL (N=70)		HOMELESS (n=16)		LGBTQ+ (n=14)		PARENTS (n=21)		SENIORS (n=8)		SPANISH (n=11)	
	N	%	N	%	N	%	N	%	N	%	N	%
GENDER												
Male	25	35.7%	10	62.5%	7	50%	0	0%	7	87.5%	1	9.1%
Female	41	58.6%	6	37.5%	4	28.6%	20	95.2%	1	12.5%	10	90.9%
Other	3	4.3%	0	0%	3	21.4%	0	0%	0	0%	0	0%
Prefer not to answer	1	1.4%	0	0%	0	0%	1	4.8%	0	0%	0	0%
AGE												
18-20 years	1	1.4%	0	0%	1	7.1%	0	0%	0	0%	0	0%
21-30 years	16	22.9%	2	12.5%	2	14.3%	7	33.3%	0	0%	5	45.5%
31-40 years	10	14.3%	1	6.3%	2	14.3%	5	23.8%	0	0%	2	18.2%
41-50 years	15	21.4%	2	12.5%	5	35.7%	6	28.6%	0	0%	2	18.2%
51-60 years	10	14.3%	4	25%	2	14.3%	0	0%	2	25.0%	2	18.2%
61-70 years	11	15.7%	4	25%	1	7.1%	1	4.8%	5	62.5%	0	0%
71-80 years	3	4.3%	2	12.5%	0	0%	0	0%	1	12.5%	0	0%
Over 80 years	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Prefer not to answer	4	5.7%	1	6.3%	1	7.1%	2	9.5%	0	0%	0	0%
RACE												
White, non-Hispanic	21	30.0%	9	56.3%	6	42.9%	2	9.5%	4	50.0%	0	0%
Hispanic or Latino	27	38.6%	2	12.5%	0	0%	13	61.9%	2	25.0%	10	90.9%
Asian	5	7.1%	0	0%	1	7.1%	3	14.3%	0	0%	1	9.1%
Black/African American, non-Hispanic	13	18.6%	4	25%	4	28.6%	3	14.3%	2	25.0%	0	0%
Native Hawaiian/Pacific Islander	1	1.4%	1	6.3%	0	0%	0	0%	0	0%	0	0%
Other	2	2.9%	0	0%	2	14.3%	0	0%	0	0%	0	0%
Prefer not to answer	1	1.4%	0	0%	1	7.1%	0	0%	0	0%	0	0%
EDUCATION LEVEL												
Less than 9th grade	4	5.7%	1	6.3%	0	0%	2	9.5%	0	0%	1	9.1%
9th to 12th grade, no diploma	12	17.1%	6	37.5%	2	14.3%	2	9.5%	1	12.5%	1	9.1%

High school diploma or GED	16	22.9%	4	25%	4	28.6%	3	14.3%	2	25.0%	3	27.3%
Some college, no degree	12	17.1%	1	6.3%	3	21.4%	4	19%	4	50.0%	0	0%
Associate degree	6	8.6%	3	18.8%	1	7.1%	1	4.8%	0	0%	1	9.1%
Bachelor's degree	9	12.9%	0	0%	1	7.1%	6	28.6%	0	0%	2	18.2%
Graduate/ professional degree	9	12.9%	1	6.3%	3	21.4%	2	9.5%	0	0%	3	27.3%
Prefer not to answer	2	2.9%	0	0%	0	0%	1	4.8%	1	12.5%	0	0%
REFERRAL SOURCE												
Email	11	15.7%	1	6.3%	3	21.4%	3	14.3%	0	0%	4	36.4%
Facebook	1	1.4%	0	0%	1	7.1%	0	0%	0	0%	0	0%
Phone call	7	10.0%	0	0%	0	0%	0	0%	1	12.5%	6	54.5%
Hosting location	27	38.6%	5	31.3%	5	35.7%	12	57.1%	5	62.5%	0	0%
Word of mouth	11	15.7	5	31.3%	2	14.3%	2	9.5%	2	25.0%	0	0%
Other	12	17.1%	5	31.3%	2	14.3%	4	19.0%	0	0%	1	9.1%
Prefer not to answer	1	1.4%	0	0%	1	7.1%	0	0%	0	0%	0	0%

FINDINGS BY QUESTION FORMAT

Members of all priority populations were asked the same eleven questions (plus relevant prompts to elicit more detailed feedback) in order to compare differences in general attitudes and opinions regarding community health.

ALL PARTICIPANTS

Health Information and Access: All participant groups were asked where they seek information about health resources and services, and the benefits and drawbacks of those information sources. Participants in all groups mentioned they trust people they know for information and recommendations about programs and services. All groups, except for those experiencing homelessness, reported that they turn to the Internet for information, since it is quick to use and always available. However, they recognize that there is a lot of misinformation spread online, and that it is often difficult to parse out fact from fiction.

When asked about challenges experienced when trying to access care, participants in all groups mentioned limited access to doctors, limited availability of appointments and services, and cost as major barriers to getting themselves or their children needed care in a timely fashion.

Lastly, members of all groups felt that there were not adequate options in the community available to meet their healthcare needs. High costs were reported by many groups as a challenge to obtaining the healthcare needed, with seniors and native Spanish-speakers citing the high cost of medications and parents citing the cost of programs and activities for children. Both LGBTQ+ and homeless community members reported a lack of healthcare personnel who understood and were sensitive to their situations.

Quality of Care: In the second set of questions for all groups, participants were asked about the care they received, whether discrimination – either personal or systemic – played a role in the quality of care received, and if they are satisfied with the care that they or their children currently receive.

Discrimination: Parents and seniors both reported not having experiences of harassment or discrimination when seeking healthcare. However, members of the other three populations did provide stories of their experiences of discrimination within the healthcare system. For those experiencing homelessness, stories of being made to feel "less than human" or "invisible" were shared by those who were refused care or who were not allowed to accompany homeless friends who were receiving treatment even when they knew important medical history about the patient. Members of the LGBTQ+ community discussed many instances in which they went to healthcare professionals for care or treatment and ended up having to educate that provider about their unique health needs. Additionally, they shared stories of having to advocate for themselves with hospitals and insurance companies to get approval and coverage for the care that is appropriate for their gender identity. Some members of the Spanish-speaking discussion group were students in dental school and described their experiences with patients who treated them differently than other dentists/dental students because they were Hispanic. This was exemplified by one female student having to consistently explain that, *"No, I'm studying to be a dentist – a doctor – not an assistant or hygienist."*

Satisfaction with medical care: When asked about their current levels of satisfaction with the medical care received, some members of the parent discussion group expressed general satisfaction; however, other participants in the parent discussion group and members of all other groups reported varying levels of dissatisfaction with current medical care. Difficulty navigating health insurance was a common theme among many groups. Participants reported that confusion about what is covered, as well as differences between insurance companies and the plans they offer, make it difficult for people to choose the insurance provider and plan that fits their needs best.

Overall Community Health: The final set of questions concentrated on overall community health and support of a healthy lifestyle. When asked about the biggest health issue their community faces, a wide variety of responses were provided by the different groups. Mental health was brought up by three of the five groups, with seniors specifying the lack of mental health facilities as a major concern. Various aspects of low-quality healthcare were mentioned by both parents and those experiencing homelessness, including distrust of doctors, misdiagnoses, and overprescribing of medications. Participants also provided suggestions for what barriers are currently in place that prevent these health issues from being resolved, including financial challenges, misinformation, and difficulty navigating health insurance.

Since members of these populations had described difficulties getting the care they needed, it was important to determine if those with even more limitations within these groups were able to access essential services. All groups were asked whether they believed there was enough support in the community for those with mental/behavioral health needs and for those living with a disability. In all groups, the answer was a resounding "No." While some participants acknowledged the existence of services for people living with these specific types of healthcare needs, they also described the challenges associated with long wait times, transportation and affordability of services.

POPULATION-SPECIFIC QUESTIONS

THOSE EXPERIENCING HOMELESSNESS

In 2018, the annual estimate for the number of people experiencing homelessness in Southern Nevada was 16,641 individuals (Bitfocus, 2018). The health problems of those experiencing homelessness are multifaceted, often resulting in an early occurrence of mortality. During the

2018 Clark County homeless point-in-time count, 44.7% of homeless individuals reported experiencing some type of mental illness, of which 75.7% said that mental illness prevents them from obtaining work or housing (Bitfocus, 2018).

Health Experiences: All participants expressed the need for more accessible hygiene resources, such as clean, functioning toilets and showers. While they greatly appreciate the mobile shower services currently available in the community, they note that the 20-minute time limit to undress, shower, and re-dress, does not provide enough time to thoroughly clean themselves. Participants also described their reliance on paramedics for most of their medical care, obtained only during some kind of emergency situation, and participants described being denied transportation to the hospital on various occasions.

Suggestions for Improvement: Overall, those experiencing homelessness in Southern Nevada are very grateful for the services that currently exist and expressed their deep appreciation for being able to participate in a discussion about community services that allowed their voices to be heard. Financial assistance, security, and community collaboration were thoroughly discussed by the group as ways in which those experiencing homelessness could be supported on a path towards health. Many also discussed the limited availability of services, or how certain programs would reach out to members of their community to assist them with signing up for services but not actually provide what is needed for them to improve their lives.

LGBTQ+

Nevada has the third highest percentage (5.5%) of LGBTQ+ individuals in the nation (LGBT Demographic Data Interactive, 2019). LGBTQ+ individuals have many of the same health concerns as the general population, but they experience certain health challenges at higher rates, such as gaps in the delivery system and varying patterns of health coverage (Kates, et al., 2018). Previous needs assessments have shown that members of the LGBTQ+ community did not know how to find mental healthcare providers that were LGBTQ+ competent; trying to locate providers of whom they were comfortable asking for help was a major barrier (Morten, Farmer-Smith, Smith, Vega & Kadish, 2012).

Health Experiences: All participants in this group described a difficult time finding LGBTQ+ friendly and knowledgeable providers. Many, especially older, participants reported having to educate their healthcare providers about LGBTQ+ health and spend time explaining why certain screenings or procedures are unnecessary (e.g., pregnancy tests for a monogamous lesbian female) or extremely important (i.e. on-time hormone therapy medication). Stigma and fear play a significant role in preventing members of the LGBTQ+ community from seeking and obtaining the healthcare they need, especially in trusting providers and their staff to maintain the confidentiality of their sexual orientation or non-binary gender identity. One member of the group provided a personal example in which his doctor added that he was a “transsexual” to a prescription, which needed to be read and printed by the filling pharmacist.

Suggestions for Improvement: Many focus group participants expressed concern with the difficulty they have looking for LGBTQ+ friendly resources and services. The group suggested a referral network, or LGBTQ+ comprehensive resource guide that has been vetted by peers that have utilized the services. Overall, group participants recognized that it is difficult for generations of stigma to be overturned quickly. However, one member did provide a well-applauded suggestion for any program working with the LGBTQ+ community: include us in the planning process from the very beginning, specifically saying, “*Nothing about us without us!*”

OLDER ADULTS (AGED 55+)

Promoting health and well-being becomes a priority for aging well. Older members of the community often have a harder time living independently and getting what they need due to lack of mobility and the onset of chronic illness. Previous focus groups have found that staying independent, maintaining physical health, and staying active were all connected to aging well (Halaweh, Dahlin-Ivanoff, Svantesson & Willén, 2018). A 2017 survey found that nearly 1 in 4 adults aged 75 or older living in Clark County reported difficulties with being able to live independently (American Community Survey, 2017).

Health Experiences: Participants in this discussion group generally described their access to healthcare services as limited. Transportation and finances were most often talked about as the most important factors for whether a person would be able to obtain the services they needed. Also, financial limitations were described, as insurance did or did not cover. Many participants relied on Social Security and/or disability income and could not afford expensive fee-for-service procedures. When talking about healthcare, dental and mental health were the two types of care that all participants agreed were most lacking in the community for seniors.

Suggestions for Improvement: Many seniors noted the need for improving public transportation to bring seniors in the community closer together and to help them access more services. Since most take public buses frequently, this was also mentioned as a potentially effective way for disseminating information to them about upcoming events, new programs, and educational opportunities. Participants also expressed the need for a central repository of information specific to seniors that would be easy to access. Since most are not yet comfortable with using the Internet, a senior citizen hotline was suggested as a possible way to provide information, like Nevada 2-1-1. Lastly, group members described the need for community advocates to help seniors navigate situations in places like police stations and crisis centers, where someone might go if they were a victim of elder abuse or robbery.

NATIVE SPANISH SPEAKERS

Overcoming language barriers in the healthcare system is essential to providing patients with the best care they can receive. The Spanish language has become a dominant dialect in the United States. In 2010, according the U.S. Census, the number of Limited English Proficient (LEP) U.S. residents accounted for 25.2 million or 9% of the U.S. population over the age of 5 (Pandya et al., 2010). In Clark County, approximately 1 in 5 people (21%) is a native Spanish speaker (Data USA, 2014), making it essential to provide health information, services, and care in Spanish.

Health Experiences: Members of the focus group described a lack of health information (print and digital) available in Spanish and a shortage of bilingual healthcare providers and office staff. Also, participants expressed preference for seeing a Spanish-speaking healthcare provider, noting that even though some places may have good services, if the patient cannot understand the doctor (and vice versa) the health issue does not get better. Many people also described being turned away from providers' offices because their staff did not speak Spanish.

Suggestions for Improvement: While most participants were aware of available translation services for healthcare, many described their experiences using those services or trying to use those services as less than adequate. One common problem is the complexity of medical terminology and how terms do not always translate accurately into Spanish, causing confusion and misunderstanding for the patient. Additionally, many parents resort to using their children to interpret for them when getting healthcare services, since they do not always feel comfortable

asking for a professional interpreter. Some suggestions for improvement from focus group participants include hosting more local neighborhood meetings at parks or people's homes in order to get information about available services to members of the community and providing more guidance about how to access services, especially for families living on a limited income.

PARENTS

Parents play a critical role in assuring that their children get needed care, and parents have unique challenges in their own healthcare. Access to care promotes and improves children's health. A review of literature found that low-income children often cycle between having insurance and being uninsured (Leininger & Levy, 2015). In 2016, Clark County ranked in the bottom 25% of all counties in the United States for the rate of children with access to health insurance. Specifically, ethnic disparities in insurance coverage can be seen among Hispanic/Latino children in Clark County, whose access to health insurance is more than 3% lower than the national average (Healthy Southern Nevada, 2017).

Health Experiences: When asked about the availability of specialists in Southern Nevada, members of both groups explained their challenges in finding adequate specialists to meet the health needs of themselves or their children. Everyone in the focus groups expressed a need for more high-quality specialist physicians in the community who accept various types of insurance, as well as a need for physicians who can be easily reached via public transportation, and who do not have long waiting times to make an appointment. One of the biggest barriers mentioned by parents in both groups was the issue of difficulty in finding affordable, reliable childcare. Also, many parents expressed a lack of knowledge about what services are available in the community for children and families and how to go about finding that information.

Suggestions for Improvement: Parents discussed the need for more affordable options for nutrition and physical activity. Many participants expressed their concern about the cost of healthy foods, and how it is disproportionately higher than foods that are not as nutritious; they suggested that fresh fruits and vegetables be made more accessible outside of grocery stores, such as at local farmer's markets and neighborhood stores. Participants also talked about the need for affordable activities for children, especially those that take place indoors during the summer, ensuring kids stay active during the hottest part of the year. Further, participants discussed the need for additional community support for parents, such as child-friendly support groups and meetings, where they can provide emotional support to each other, learn parenting skills, and obtain important information about child development.

DISCUSSION

Participants in all focus groups greatly appreciated the opportunity to contribute their experiences, opinions, and recommendations regarding health in Southern Nevada, and made it a point to mention that they would be willing to do it again. Much of the feedback described an "adequate" community health environment that could be improved by increasing the number of available healthcare providers, ensuring the cultural competency of providers and staff, providing comprehensive repositories of information specific to unique populations that are easy to access, and working to change the overall culture of the area to prioritize health equity and empathy for everyone.

DESCRIPTION OF SIGNIFICANT COMMUNITY HEALTH NEEDS

METHODOLOGY

Epidemiologists, subject-matter data experts at the Southern Nevada Health District, conducted a broad-sweeping data analysis to identify existing and emerging areas of concern for health-related topics across Clark County. For consideration in their analysis, they looked at size, scale, and severity of the problem, and disparity and equity across multiple vulnerable groups. This analysis gave rise to a list of health areas which included: sexual health, maternal/child health, injury, environmental health, mental health, healthcare infrastructure, and access.

From this list, a questionnaire was developed and administered during the telephone survey to query what extent community members shared concern for these areas of health. Any topic area receiving at least 65% of agreement from respondents as very/moderately concerned were included as community needs. Additionally, focus groups were convened for contextualized feedback to the findings and responses aligned with the epidemiologic analysis and community telephone survey. The list of needs below is not ranked in order of importance.

PRIORITIZED LIST OF NEEDS IDENTIFIED THROUGH CHNA

- **Access to care** (health insurance coverage, service navigation, linguistic and cultural sensitivity)
- **Motor vehicle and pedestrian safety** (distracted driving, impaired driving, bicyclist and pedestrian safety)
- **Violence prevention** (gun violence, child abuse, domestic violence, suicide)
- **Substance use** (alcohol use, maternal substance use, opioid overdoses)
- **Mental health** (lack of providers, stigma)

ACCESS TO CARE

Residents of Southern Nevada continue to face challenges with access to care. These challenges center around health insurance, navigation of healthcare services, and cultural sensitivity for medical providers.

Health insurance: Twenty-two percent of Clark County adults aged 18-64 do not have health insurance coverage in 2017 (American Community Survey, 2017) compared to 15% of adults nationwide. The telephone survey revealed that respondents were concerned about health insurance coverage (74% reported very/moderately concerned); health insurance coverage was of particular concern to black/African American individuals (91%) compared to other groups. In the focus group reports, older adults specifically identified lack of coverage for dental care as a barrier to accessing care.

Service navigation: The focus group findings revealed logistical barriers to service navigation as well as fully understanding available services. Participants stated that while there was general awareness of services and programs that exist throughout the community, without access to reliable transportation, financial assistance, accommodations for those with disabilities, and information presented in one's preferred language, it may be very difficult to utilize those services. A common example provided was the challenge of seeing multiple providers when they are physically located on opposite sides of the city. Many focus group members suggested the need for healthcare clinics that housed primary care physicians as well as specialists, mental health providers, dentists, and social services in one location as a solution.

Linguistic & cultural sensitivity: Finally, one of the barriers to care was sensitivity training for vulnerable populations, specifically individuals experiencing homelessness and the LGBTQ+ community. The focus group results highlighted the importance for regular, ongoing, required cultural humility training for these populations. For participants in these socially marginalized groups, a widely mentioned challenge was finding a healthcare provider that was willing to provide care for them or who fully understand the type of care they needed. Many participants suggested that providers learn more about how healthcare may look different for different types of people and provide opportunities for feedback to reduce discrimination when individuals go to them to receive care. Additionally, those who provide language interpretation services may have difficulty explaining complex medical terminology and concepts to patients, making communication between doctors and patients frustrating and apt to misinterpretation.

MOTOR VEHICLE AND PEDESTRIAN SAFETY

Safety in motor vehicles was identified as a community concern with a focus on distracted driving, impaired driving, and bicyclist and pedestrian safety. In 2015-2017, the age-adjusted death rate due to motor vehicle traffic collisions was 10.5 deaths per 100,000 residents (National Vital Statistics System, 2017). Further, over 17% of Clark County high school students report riding in a car or other vehicle driven by someone who had been drinking alcohol (Nevada YRBS, 2017).

Distracted or impaired driving: From 2013-2017, nearly 30% of Clark County's motor vehicle crash deaths had alcohol involvement (County Health Rankings, 2013-2017). Although this figure has trended down over the past several years, it is still higher than national estimates. This finding is supported as a top community health concern from the telephone survey; when asked directly about their concern for impaired driving, regardless of gender or race, 89% of respondents were very/moderately concerned about distracted or impaired driving.

Bicyclist and pedestrian safety: The highest percentage of traffic fatalities for those admitted to a Nevada trauma center between 2005-2015 were from pedestrian crashes (8%), followed by motorcycle crashes (4%) and motor vehicle crashes (3%) (Center for Traffic Safety Research, 2017). Approximately 30% of pedestrian crash patients brought to a Nevada trauma center were crossing the street improperly. They spent more days in the hospital and accrued significantly higher median hospital costs compared to pedestrians who were injured while crossing properly ($113,475 vs. $52,727). When asked directly about bicyclist and pedestrian safety, over 67% of respondents to the telephone survey were very/moderately concerned about it in the community.

VIOLENCE PREVENTION

Concerns around violence were expressed in the telephone survey, with top concerns identified as gun violence, child abuse, domestic violence, and suicide. The total violent crime rate is 757 crimes per 100,000 residents – higher than both statewide and nationwide estimates (County Health Rankings, 2014-2016). Each topic area is described below in further detail to illuminate need.

Gun violence: Non-Hispanic black men were more likely to die by homicide than any other sex or race in 2017 (National Vital Statistics System, 2017). The telephone survey revealed nearly 80% of respondents were very/moderately concerned about gun violence, with black/African American individuals more likely to be very concerned (94%) compared to other groups.

Child abuse: Abuse and neglect can occur in families where there is a great deal of stress. In 2016, Nevada had 13 child fatalities at a rate of 1.92 deaths for every 100,000 children (*Child Maltreatment Report*, 2016). In 2018, over 2,200 children were removed from the home in Clark County (Nevada DCFS Data Book, 2018). During the telephone survey, over 78% of respondents were either very/moderately concerned about child abuse.

Domestic violence: In 2017, the Nevada Coalition to End Domestic Violence and Sexual Assault identified 18 incidents in which someone lost his/her/their lives due to domestic violence, the majority of these (83%) occurring in Clark County (NCEDSV, 2018). Over 78% of respondents to the telephone survey were very/moderately concerned about domestic violence.

Suicide: White, non-Hispanic men were more likely to die by suicide than any other sex or race in 2017 (National Vital Statistics System, 2017). During the telephone survey, 73% of respondents were either very or moderately concerned about suicide, and black/African American participants reported higher levels of concern (88%) when compared with other groups.

SUBSTANCE USE

Alcohol use: Drinking alcohol has immediate physiological effects on all tissues of the body, including those in the brain. Alcohol abuse is also associated with a variety of other negative outcomes, including employment problems, legal difficulties, financial loss, family disputes, and other interpersonal issues. In Clark County there were 8.5 hospitalizations per 100,000 residents due to alcohol use in 2013-2015 (Nevada Division of Health Care Financing and Policy, 2013-2015). This rate was highest among residents aged 45 – 64 years. Additionally, 17% of Clark County adults reported excessive drinking, characterized as heavy drinking in the 30 days prior to the survey or binge drinking on at least one occasion during that period (County Health Rankings, 2016). This is a significant increase over the previous measurement period (15.8% in 2015). Participants in the telephone survey reflected these concerns; 67% of respondents were very/moderately concerned about alcohol abuse in Clark County.

Maternal substance use: 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%. Data from 2017 indicate that 99% of expectant mothers in Clark County abstained from alcohol during pregnancy[6], meeting the Healthy People 2020 target.

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 who abstained from cigarette smoking during pregnancy increased from 94% in 2013 to 96% in 2017 but failed to reach the Healthy People 2020 target of 98.6%.

When examining results from the telephone survey, participants who identified as multi-racial (91%), black/African American (88%), and Asian (85%) were more likely to be concerned about mother's substance use during pregnancy compared to the other groups.

[6] Data Source: Nevada Vital Records Birth Certificate Data

Opioid overdose: The misuse and overuse of opioid analgesic agents and illicit drugs pose a serious public health challenge in Clark County. Overdose deaths, now largely driven by prescription opioids (e.g., oxycodone, hydrocodone, codeine, morphine) reached an age-adjusted rate of 20.3 per 100,000 in 2017, up from an age-adjusted rate of 20 in 2010. Since 2007, more residents of Clark County have died from opioid overdoses than from motor vehicle crashes. In comparing Clark County to the nation, the age-adjusted drug overdose death rate was 31.4% higher for Clark County residents from 2010 to 2017.

This area of concern was additionally reflected in responses in the telephone survey, where 74% of respondents were very/moderately concerned about opioid overdoses. This concern was especially reflected for black/African American individuals, who reported a higher level of concern (88%) compared with other groups.

MENTAL HEALTH

Concerns around mental health were expressed in all three areas of data analysis. These concerns included both a lack of mental health providers, facilities, and services, as well as stigma.

Lack of Mental Health Providers, Facilities, and Services: The mental health provider rate in Clark County is 185 providers per 100,000 residents (County Health Rankings, 2018). While this is an increase over the 2017 rate (174) it is still much less than the statewide (197) or national (229) rates. The concern about lack of mental health facilities was reflected in the telephone survey, where 75% of respondents indicated they were very/moderately concerned. Specifically, multi-racial individuals were more likely to be concerned about the lack of facilities when compared to the other groups. Mental health was additionally an emphasis during the focus groups; participants raised concerns about the lack of mental health services for people of all ages, lifestyles, living situations, language preferences, and identities. Focus group participants suggested the need for more mental health providers, as well as in-patient facilities and crisis hotlines.

Stigma: While stigma might be challenging to measure on a community level, this was an area discussed during the focus groups. Participants raised concerns about the stigma that persists around mental diagnoses, and how that stigma can follow a person throughout their lifespan and prevent them from being able to take advantage of certain opportunities.

Support groups were also mentioned as a means of providing community support for mental and emotional health, wherein people can share experiences and information with each other about effective health programs and services that are affordable and available in the community.

COMMUNITY ASSET ANALYSIS

A community asset analysis was conducted to determine resources available to address the identified significant community needs. An existing statewide report was utilized as an outline and was modified to exclusively consider agencies that fit the community benefit area. Then, a broad Internet search was conducted to identify additional agencies not included in prior analyses, and strategic documents were gathered for each agency to examine goals, objectives, priorities, and type of service delivered within Clark County. The results of this analysis were aligned with the community needs and are included in Table 13. These findings are by no means an exhaustive list of services in Clark County, Nevada, instead, these results represent agency types that have specifically prioritized the identified needs in goals, objectives, or public strategic planning documents.

Table 13 Community Asset Analysis Results, 2019

Need Identified	Agency Type
Access to care	Hospital systems Local health departments University systems Local coalitions Healthcare quality institutions Federally Qualified Health Centers Government Local non-profits that provide healthcare services Insurance companies
Motor vehicle and pedestrian safety	Law enforcement agencies – local and statewide Local health departments Local municipalities Private companies University systems Schools of medicine Hospital trauma centers Coalition groups Statewide agencies
Violence prevention	Local non-profit agencies that address violence prevention Local and statewide coalitions Law enforcement agencies
Substance use	Treatment agencies Recovery community organizations Medical providers Prevention coalitions Harm reduction services Insurance companies Hospital systems Local health departments University systems Local municipalities Law enforcement agencies
Mental health	Local non-profits that provide healthcare services Recovery community organizations Local chapters of national awareness organizations Statewide agencies Medical providers & Hospital systems Prevention coalitions Treatment agencies

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