

2026–2031 Southern Nevada

COMMUNITY HEALTH IMPROVEMENT PLAN

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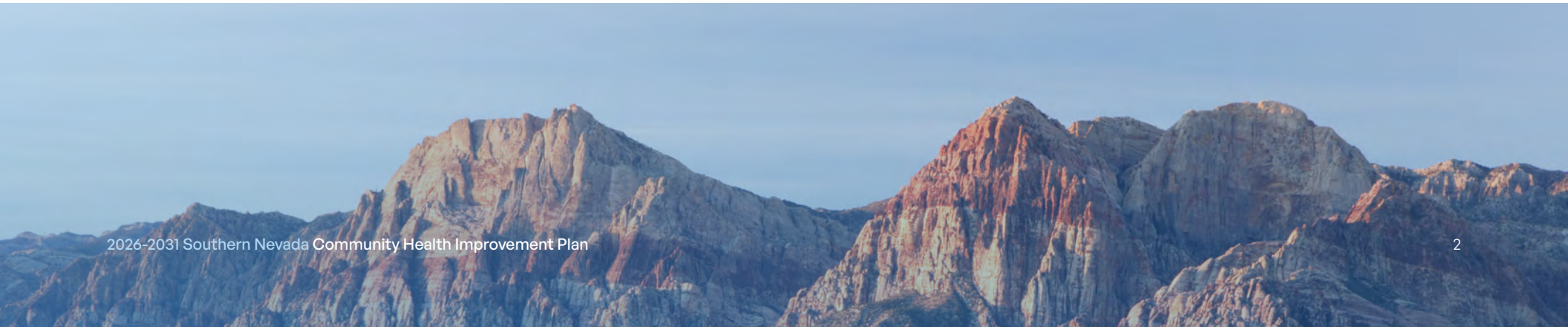

Letter to the Community

We are pleased to present the 2026-2031 Southern Nevada Community Health Improvement Plan (CHIP). Developed through a comprehensive, community-wide strategic planning process, this plan aligns efforts across sectors to achieve the largest impact on the health of our community. Most importantly, it serves as a shared blueprint for action that guides individuals, organizations, and systems as we work together to improve community health.

Creating and maintaining a healthy and safe Southern Nevada is a collective undertaking that will require a continued commitment to serve and support each other. This CHIP represents a path toward measurable improvements for the health of Southern Nevada's community. The process of developing this plan has strengthened partnerships that will continue to support and sustain these efforts. To improve the community's health, it is the shared responsibility of all agencies. With these long-term goals in place, our CHIP is the community's commitment to actively pursue opportunities to work together to improve the health of the Southern Nevada community.

Over the past two years, a diverse group of partners representing multiple sectors have collaborated to conduct assessments, and construct plans to target our most critical public health challenges. Through these efforts, the following strategic issues have been identified as priorities essential to advancing our shared vision of healthy Southern Nevada:

- Ensuring equitable access to high-quality healthcare and essential human services for all community residents
- Promoting health by increasing healthy behaviors that prevent and reduce the burden of chronic disease
- Strengthening public health outcomes through informed policymaking and sustained, appropriate funding of the local public health system
- Preventing and reducing substance use disorders through education, early intervention, treatment access, and community-based support systems

Over the past several months, health department staff, subject matter experts, and community partners have worked collaboratively on developing actionable goals, objectives, and strategies for making tangible progress in these areas over the next five years

I extend my sincere gratitude and appreciation to the many organizations and individuals whose expertise and commitment shaped this plan and are putting it into action. I look forward to our journey as we work together to expand the opportunities for a healthier life for all Southern Nevada residents.



Sincerely,

Cassius Lockett, PhD, MS
District Health Officer
Southern Nevada Health District

Executive Summary

In 2025, the Southern Nevada Health District (SNHD) published the Community Health Assessment (CHA), a comprehensive and systematic review of health status indicators used to identify the most pressing health challenges, available assets, and emerging opportunities to improve health outcomes across Southern Nevada. The CHA process was completed through collaboration with a wide network of community partners, including local hospitals, nonprofit organizations, universities, and other key stakeholders committed to advancing community health.

The CHA was guided by the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 model, a nationally recognized community-driven framework for public health planning. Findings from the CHA were analyzed using multiple MAPP assessments, including the Community Partner Assessment, Community Context Assessment, and Community Status Assessment. These assessments provided a holistic understanding of health outcomes, community conditions, and system capacity across the region. The full CHA reports and supporting documents are available on the Healthy Southern Nevada website at www.healthysouthernnevada.org/tiles/index/display?id=356966798698245621

Through the 2025 CHA process, subject matter experts representing academic institutions, community-based organizations, local health departments, and agencies across the region worked collaboratively to interpret findings and prioritize areas for action. This collective work resulted in the identification of four priority areas that represent the most significant opportunities to improve health outcomes and strengthen systems of care in Southern Nevada:

- Access to Care
- Chronic Disease
- Public Health Funding
- Substance Use[1]

These priority areas form the foundation of the 2026–2031 Southern Nevada Community Health Improvement Plan (CHIP). The CHIP serves as a strategic roadmap for coordinated community action and is designed to translate CHA findings into meaningful, measurable, and sustainable improvement efforts. It outlines shared goals, objectives, and strategies that can be implemented by partners across sectors, including public health agencies, healthcare systems, education institutions, community-based organizations, and local government entities.

The CHIP is essential for aligning community resources, strengthening cross-sector collaboration, and ensuring accountability for progress. It is intended to guide organizational strategic plans and initiatives across Southern Nevada, allowing stakeholders to track progress, celebrate collective achievements, and adapt strategies over time as community needs evolve, and new challenges emerge.



[1] The SNHD Health Executive Council (HEC) unanimously recommended adding Substance Use as a new and distinct priority area in response to rising community needs, stakeholder feedback, and emerging public health data. This recommendation was reviewed with community partners for approval and integration into the CHIP.

The 2026–2031 CHIP includes priority-specific goals and objectives aimed at improving community health outcomes. Within the Access to Care priority area, strategies focus on improving reliable transportation infrastructure, strengthening healthcare provider support, and expanding the distribution of community resource information. The Chronic Disease priority area includes targeted efforts to reduce the impact of cardiovascular disease and diabetes while improving communication and collaboration among partners.

The Public Health Funding priority area emphasizes strengthening public health resources and advancing long-term funding sustainability to support prevention and health promotion efforts. Finally, the Substance Use priority area outlines actions to expand evidence-based prevention programs, reduce overdose deaths, increase access to substance use treatment, and strengthen the intersection of mental health and substance use disorder services.

This CHIP report includes a structured overview of the community health planning process, a profile of Clark County, and an explanation of the MAPP 2.0 framework used to guide priority selection and strategy development. It also highlights the CHIP's mission, vision, and values, which reflect a shared commitment to equity, collaboration, prevention, innovation, and long-term sustainability.

As we move forward, CHIP implementation will require sustained engagement, continuous communication, and shared accountability among partners. The final section of the CHIP outlines the process for ongoing tracking, review, and revision to ensure strategies remain responsive, effective, and aligned with community needs. Through continued collaboration and commitment, the 2026–2031 CHIP provides Southern Nevada with a unified plan to advance health equity, improve health outcomes, and build healthier communities for all.



Acknowledgements

The Southern Nevada Community Health Improvement Plan (CHIP) was developed through the dedication and collaboration of numerous agencies, service providers, and community partners committed to improving health outcomes across the region. Through a coordinated workgroup process, participants identified priority health issues, assessed gaps in existing programs and policies, reviewed evidence-based practices, and developed strategies aimed at advancing health equity and strengthening community systems. The Southern Nevada Health District extends sincere appreciation to all members of the CHIP Steering Committee for their time, expertise, and leadership. We would like to recognize these individuals and thank them for their dedication to this process.

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Contributing Organizations

Alzheimer's Association
Anthem Nevada Medicaid
City of Henderson
Comagine
Daybreak Consulting
Dignity Health
Foundation for Recovery
Helping Hand of Vegas Valley
Intermountain Health
NAMI Southern Nevada
Nevada Homeless Alliance
Nevada Office of Minority Health and Equity
PACT Coalition
Partida Corona Medical Center
Renaissance Behavioral Health
Regional Transportation Commission of Southern Nevada
Select Health
Southern Nevada Health District
Southern Nevada Health Consortium
The Center
Three Square
University of Nevada, Las Vegas
University of Nevada, Reno Extension
YMCA of Southern Nevada

Special Thanks to the Following Individuals and Entities for Their Support and Leadership in the CHIP

Dr. Cassius Lockett
Dr. Anilkumar Mangla
Victoria Burris
Southern Nevada District Board of Health
Southern Nevada Health District Public Health Advisory Board

Priority Areas

Priority Area 1:
Access to Care

Access to care remains a critical priority in Southern Nevada, as many residents experience barriers to receiving timely and affordable healthcare. Challenges such as transportation limitations, provider shortages, long wait times, and lack of awareness of available services disproportionately affect underserved populations. This priority area focuses on improving healthcare access through stronger transportation infrastructure, increased medical provider support, and expanded community resource outreach.

Priority Area 2:
Chronic Disease

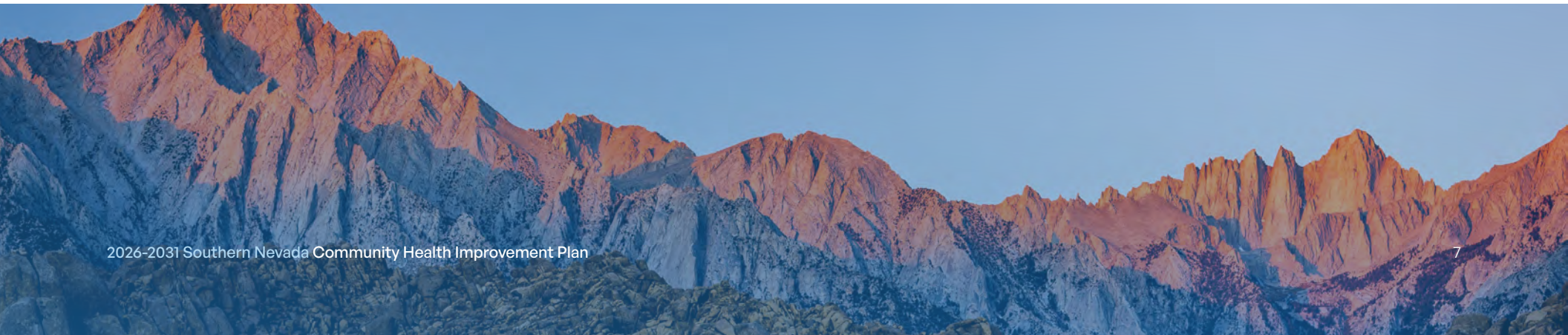
Chronic diseases such as cardiovascular disease and diabetes continue to be leading contributors to illness and premature death in Southern Nevada. These conditions are influenced by preventable risk factors and social determinants of health, including access to nutritious food, education, and healthcare. This priority area emphasizes prevention, early detection, and improved coordination to reduce chronic disease burden and health disparities.

Priority Area 3:
Public Health Funding

Sustainable public health funding is essential to maintaining core services, supporting prevention programs, and strengthening the region's ability to respond to health challenges. Limited or unstable funding can restrict long-term planning and reduce community impact. This priority area focuses on strengthening public health resources and advancing funding strategies that are stable, transparent, and aligned with community needs.

Priority Area 4:
Substance Use

Substance use continues to impact health and safety across Southern Nevada, contributing to overdose deaths, long-term health consequences, and strain on community systems. Substance use is closely linked to mental health, infectious disease risk, and social conditions such as housing and economic instability. This priority area prioritizes evidence-based prevention, expanded treatment access, overdose reduction strategies, and recovery-oriented support systems.



Community Profile

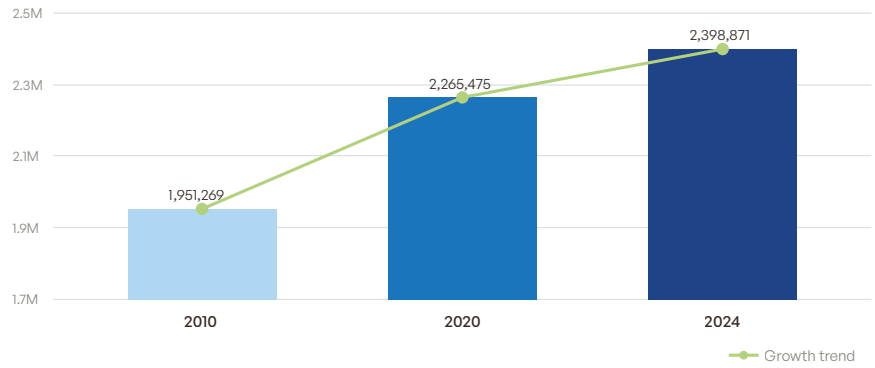
Total Population

There has been steady population growth in Clark County, Nevada over the past decade and into the mid-2020s.

The data highlights that Clark County remains one of the fastest growing and most populated regions in Nevada. This upward trend suggests increasing demand for infrastructure, housing, transportation, education, and public services as the county continues expanding.

Resident Total Population by Year: 2010, 2020, and 2024

2010 population	2024 population	Total growth
1.95M	2.40M	+23.5%

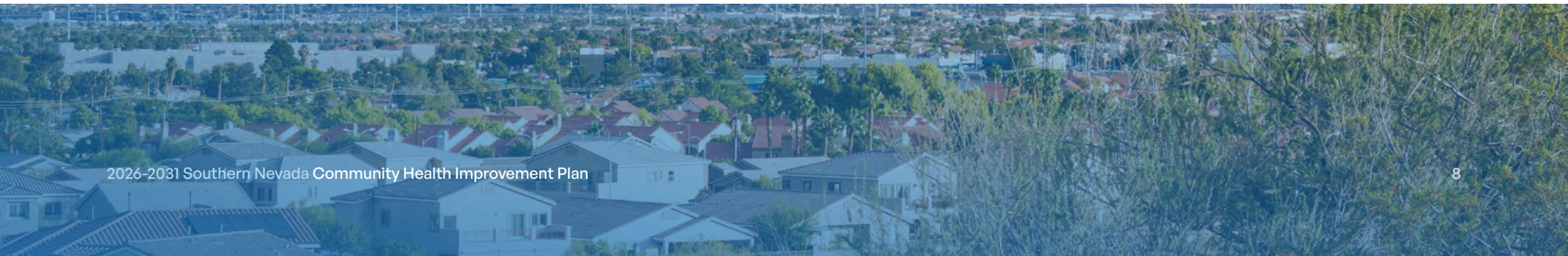


Note. Figure created by the Southern Nevada Health District.
Data source: U.S. Census Bureau QuickFacts: Boulder City, Henderson, Mesquite, North Las Vegas, Las Vegas, and Clark County, Nevada. July 1, 2023.

Population breakdown by race/ethnicity

	UNITED STATES	NEVADA	CLARK COUNTY
American Indian/Alaska Native	1.3%	1.7%	1.3%
Asian	6.4%	9.7%	11.6%
Black/ African American	13.7%	11.0%	14.0%
Hispanic/ Latino	19.5%	29.9%	32.1%
Multiracial	3.1%	5.2%	5.6%
Native Hawaiian/Pacific Islander	0.3%	0.9%	1.0%
White, Non-Hispanic	58.4%	45.4%	38.6%

Note. Figure created by the Southern Nevada Health District.
Data source: U.S. Census Bureau QuickFacts: United States; Nevada; Clark County, Nevada. July 1, 2024.



Median Age

Clark County, 2019-2023



38.3
Clark County

38.9
Nevada

39.7
United States

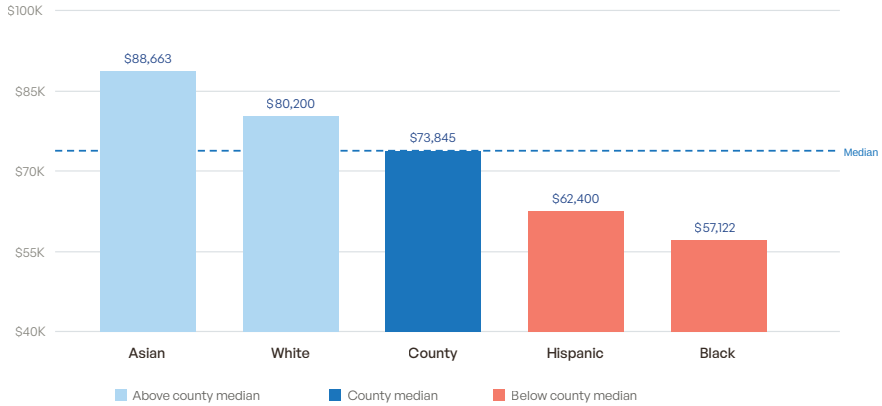
Average Years

Note. Figure created by the Southern Nevada Health District.
Data source: U.S. Census Bureau QuickFacts: United States; Nevada; Clark County, Nevada. July 1, 2024.

Median Household Income

2023 estimates · County median rose 28.2% from 2018

CLARK COUNTY MEDIAN (2023)	GROWTH SINCE 2018	INCOME GAP (BLACK vs. ASIAN)
$73,845	+28.2%	-36%



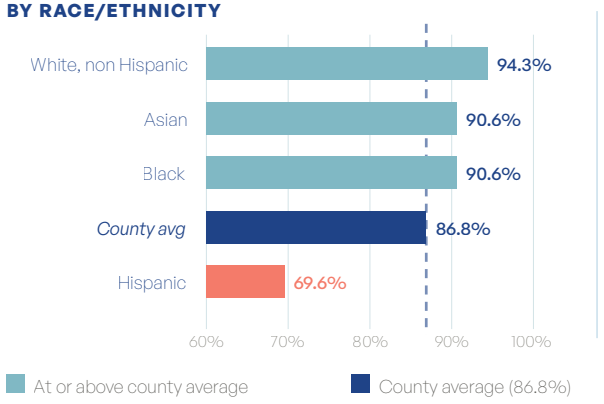
Note. Figure created by the Southern Nevada Health District.
Data source: U.S. Census Bureau QuickFacts: United States; Nevada; Clark County, Nevada. July 1, 2024.

Educational Attainment

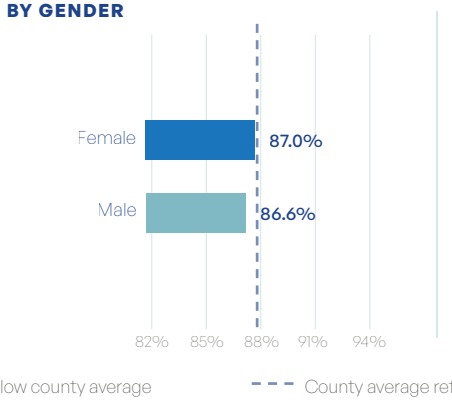
Population ages 25+ with at least High School Diploma, Clark County, 2023

COUNTY AVERAGE (2023)	CHANGE SINCE 2018	LARGEST RACIAL GAP
86.8%	+1.1%	White vs. Hispanic: -26%

BY RACE/ETHNICITY



BY GENDER



At or above county average | County average (86.8%) | Below county average | County average reference line

Note. Figure created by the Southern Nevada Health District.
Data source: U.S. Census Bureau. 2019–2023 American Community Survey 5-Year Estimates.

What is the CHIP?

The purpose of the CHIP is to serve as a community-driven blueprint informed by data from the Community Health Assessment (CHA). It outlines shared goals, strategies, and actions to improve population health, reduce health inequities, and coordinate efforts across community partners. The four priority areas were selected through a large, community-wide prioritization meeting and provide direction for the work moving forward.

Southern Nevada Health District (SNHD) serves as the primary coordinator of the planning process by convening partners and facilitating collaboration; however, it is not the sole lead for implementing each initiative, though it may serve as the lead in areas where appropriate.

Mission, Vision, and Values Statement

Each priority workgroup developed its own mission, vision, and values statements to reflect the unique focus of its area. Together, these individual statements were integrated into the overall mission, vision, and values below, which represent the shared commitment and guiding principles of the CHIP Steering Committee.

Mission

To improve health and quality of life in Southern Nevada by strengthening access to quality healthcare, reducing the burden of chronic disease, addressing substance use through prevention and recovery support, and advancing sustainable public health funding through community collaboration.

Vision

A healthier, safer, and more resilient Southern Nevada where all people have equitable access to care, prevention resources, and supportive services that empower individuals and communities to thrive.

Values

Southern Nevada's Community Health Improvement Plan is guided by:

EQUITY
Ensuring fair access to care and resources for all populations

COLLABORATION
Building strong partnerships to drive shared solutions

COMPASSION
Supporting individuals with dignity, respect, and understanding

PREVENTION
Prioritizing early intervention, education, and wellness

SUSTAINABILITY
Strengthening long-term public health funding and systems

INNOVATION
Using evidence-based and creative approaches to improve outcomes

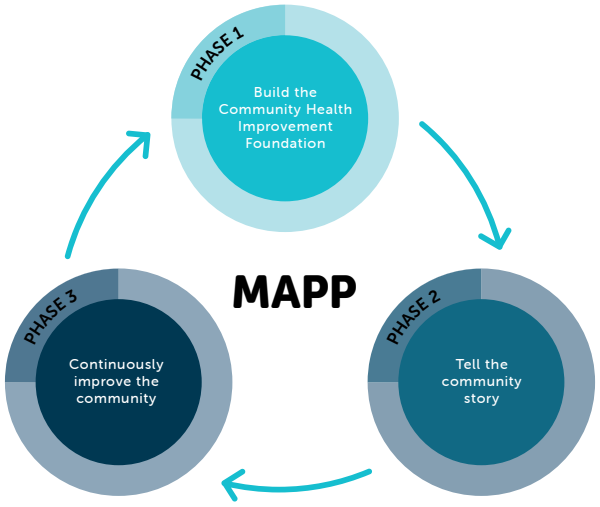
ACCOUNTABILITY
Promoting transparency and data-driven decision-making

RECOVERY SUPPORT
Recognizing recovery as possible and supporting lifelong well-being

MAPP 2.0 Framework

The Southern Nevada Health District (SNHD) used the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework to guide the community-wide health assessment and support health equity efforts. MAPP 2.0 brings together traditional and non-traditional stakeholders to identify priority health issues, align resources, and develop sustainable strategies to improve community health outcomes.

The process includes three key phases: (1) building the Community Health Improvement (CHI) foundation through stakeholder engagement and shared vision development; (2) telling the community story by collecting and analyzing qualitative and quantitative data; and (3) continuously improving the community through strategic partnerships and ongoing quality improvement. SNHD conducted three core assessments: the Community Partner Assessment, the Community Status Assessment, and the Community Context Assessment, which together provided a comprehensive understanding of community strengths, needs, and health inequities.



www.naccho.org/resource-hub-articles/mapp-2-0

SNHD is currently in Phase 3, which focuses on taking action to advance health equity by addressing social determinants of health through transformational and sustainable strategies. This phase emphasizes building and strengthening strategic partnerships through the use of partner profiles and power analyses to ensure stakeholders are well-positioned to address inequities tied to each CHIP goal. Phase 3 also incorporates continuous quality improvement and rapid-cycle evaluation methods to support ongoing, data-driven implementation, allowing partners to refine existing strategies and pilot innovative approaches that build evidence for effective health equity solutions.



Overview of Priority Selection and Selected Priorities

On April 30, 2025, SNHD facilitated a community health indicator prioritization meeting. During this event, more than 195 community members reviewed high level Community Health Assessment (CHA) findings (i.e., Community Partner Assessment, Community Context Assessment, and Community Status Assessment) presented by local subject matter experts. The key areas of opportunity identified include Social Determinants of Health, Access to Care, Mental Health, Chronic Disease, Public Health Funding, Environmental Factors, Substance Use, and Infectious Disease.

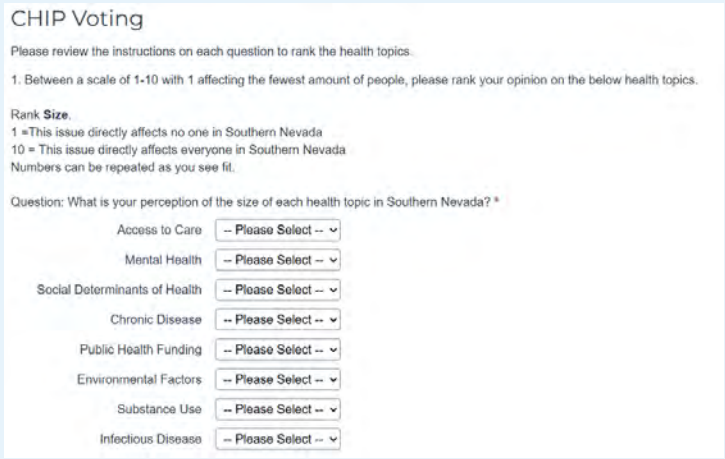
These priority areas were selected based on the following criteria: inclusion in at least two of the three assessments conducted;

- the number of individuals affected; the personal and societal costs;
- the impact on length and quality of life; the feasibility of effective intervention;
- and how Clark County compares to national averages, established benchmarks, and target goals.

Upon completion of presentations and a brief question and answer period, attendees were invited to rank these identified health issues across magnitude, severity, and effectiveness of interventions.

A total of 155 respondents completed the survey. The Hanlon Method for prioritizing health problems was applied to determine the top three priorities for inclusion in the forthcoming 2026-2031 Community Health Improvement Plan (CHIP).

CHIP Voting Questionnaire



CHIP Voting

Please review the instructions on each question to rank the health topics.

1. Between a scale of 1-10 with 1 affecting the fewest amount of people, please rank your opinion on the below health topics.

Rank **Size**.
1 =This issue directly affects no one in Southern Nevada
10 = This issue directly affects everyone in Southern Nevada
Numbers can be repeated as you see fit.

Question: What is your perception of the size of each health topic in Southern Nevada? *

Access to Care	-- Please Select --
Mental Health	-- Please Select --
Social Determinants of Health	-- Please Select --
Chronic Disease	-- Please Select --
Public Health Funding	-- Please Select --
Environmental Factors	-- Please Select --
Substance Use	-- Please Select --
Infectious Disease	-- Please Select --

CHA findings from the Community Partner Assessment, Community Context Assessment, and Community Status Assessments identified persistent and interconnected challenges impacting health outcomes across Southern Nevada.

Data and stakeholder feedback highlighted ongoing barriers to Access to Care, rising burden and inequities related to Chronic Disease, and concerns about limited capacity and sustainability due to gaps in Public Health Funding. In addition, increasing community need and emerging trends reinforced Substance Use as a growing issue affecting individuals, families, and neighborhoods.

In response to these findings, the CHIP priority areas, goals, and objectives were developed to align community-driven strategies with documented needs, strengthen cross-sector collaboration, and improve health outcomes over time.



ACCESS TO CARE

Access to care refers to the ability of individuals to obtain the health services they need—when they need them—without barriers. This includes having affordable, timely, and culturally appropriate medical, mental health, and preventive services available in one's community. Access to care is essential for preventing disease, managing chronic conditions, and improving overall health outcomes. Without timely and affordable care, people are more likely to experience worsened health, avoidable hospitalizations, and increased health disparities, especially in underserved populations.



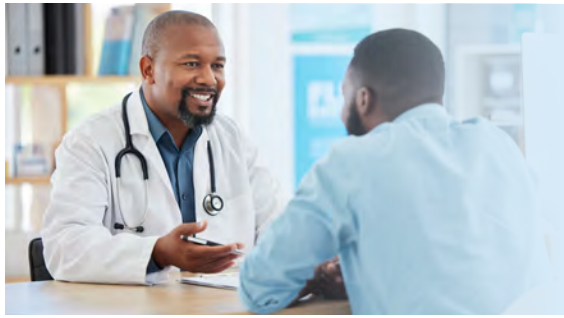
CHRONIC DISEASE

Chronic diseases are long-term health conditions that typically progress slowly and persist over time, often for the rest of a person's life. Common examples include heart disease, diabetes, and cancer—many of which are influenced by lifestyle factors like diet, physical activity, and tobacco use. Chronic diseases are a leading cause of death, and prioritizing them allows for prevention, early detection, and management. Focusing on chronic disease can improve health outcomes and extend life expectancy across populations.



PUBLIC HEALTH FUNDING

Public health funding is the financial support provided by governments, organizations, or institutions to protect and improve the health of communities. It supports different programs and services such as disease prevention, health education, emergency, preparedness, and access to care—which aim to reduce health risks and improve population well-being. Adequate funding supports essential services, preparedness and response, and health equity efforts targeting underserved and at-risk populations. Investing in public health infrastructure strengthens community health and resilience.



SUBSTANCE USE

Substance use refers to the use of drugs or alcohol, whether occasional, regular, or problematic. While some use may be moderate, misuse can lead to serious health issues, including addiction, mental health challenges, and overdose. Substance use is an important community health issue because it affects not only individuals, but also families, public safety, and local resources. Addressing it through prevention, treatment, and support helps create a healthier, safer, and more resilient community.



Priority Area 1:

Access to Care

Promoting health equity through access and utilization of care is important as everyone has the right to be healthy. Health should not depend on ZIP code, economic status, or an individual's heritage, religion, or sexual orientation.

Having access to care helps address disparities and is a critical step in creating a more equitable health system that improves the physical, social, and mental health for everyone in the community.

Goals & Objectives

Goal 1
Improve Access to Reliable Transportation Infrastructure

Objective 1.1: Mobility-Dependent Populations
By December 2031, decrease transportation wait-list times for lower-income residents, individuals with disabilities, and refugees in high-need ZIP codes by expanding enrollment in transportation assistance programs and improving coordination.

Objective 1.2: Public Transportation–Dependent Populations
By December 2031, increase capacity and access in transportation programs (RTC vouchers, Dignity Health referrals) among older adult residents and public transit–reliant populations through tracking utilization, addressing policy barriers, and including senior and mobility-impaired voices.

Objective 1.3: Households With Limited or No Vehicles
By December 2031, expand transportation outreach for households without vehicles, limited mobility independence, those relying on accessible transportation, and zero-vehicle households, by increasing successful service linkages through refugee organization partnerships and multilingual outreach.

Goal 2
Strengthen Healthcare Provider Support During Credentialing

Objective 2.1: Reduce Credentialing Delays
By December 2031, reduce provider credentialing processing time from 90+ days to 30 days by collaborating with Medicaid, Managed Care Organizations (MCOs), and Health Care Finance to streamline workflows and revise policies.

Objective 2.2: Support Underserved Patient Access
By December 2031, increase the number of credentialed providers serving underserved patients through assistance with applications and removal of administrative barriers.

Goal 3
Increase Knowledge and Diversify Community Resource Information Distribution

Objective 3.1: Expand Community Resource Engagement
By December 2031, Access to Care CHIP Workgroup organization representatives will attend at least 25 events per year to promote resource access and track referrals.

Objective 3.2: Diversify Outreach Methods and Improve Community Insight
By December 2031, introduce at least five new outreach strategies (translated materials, digital tools, social media, text systems, pop-up booths) to increase resource access.

Goal 1: Improve Access to Reliable Transportation Infrastructure

Objective 1.1

Mobility-Dependent Populations
By December 2031, decrease transportation wait-list times for lower-income residents, individuals with disabilities, and refugees in high-need ZIP codes by expanding enrollment in transportation assistance programs and improving coordination.

Process Indicators

- Decreased wait times
- Patient satisfaction with transportation services and enrollment processes
- Number of data-sharing agreements established or updated between transportation providers, social services, and healthcare partners
- Frequency of cross-agency coordination meetings focused on transportation access (e.g., quarterly)

Implementation Strategies or Activities

- Collect existing data for current usage from service providers
- Review and streamline procedures to enroll in programs
- Identify barriers to access
- When possible, have a community health worker (CHW) or other community service helper support individuals through the application process

Related Assessment Data

Community Status Assessment:

- Top Barriers to Accessing Care
  - Inadequate coverage, 18.7%
  - No health insurance, 18.3%

Organization(s)/Partners Responsible

- Paratransit/Regional Transportation Commission of Southern Nevada (RTC)
- Dignity Health
- Intermountain Health
- Access to Care Workgroup

Policy Recommendation

Establish and/or support a coordinated transportation assistance policy that expands eligibility and improves enrollment access for mobility-dependent populations in high-need ZIP codes.

Goal 1: Improve Access to Reliable Transportation Infrastructure

Objective 1.2

Public Transportation–Dependent Populations
By December 2031, increase capacity and access in transportation programs (RTC vouchers, Dignity Health referrals) among older adult residents and public transit–reliant populations through tracking utilization, addressing policy barriers, and including senior and mobility-impaired voices.

Process Indicators

- Number of older adult and transit-dependent residents receiving transportation assistance in RTC vouchers, Catholic Charities programs, and Dignity Health referrals
- Number of outreach events or informational sessions targeted at older adult communities
- Number of referrals made and successfully completed through healthcare and community partners

Implementation Strategies or Activities

- Collect/identify data for current enrollment numbers in community transportation programs
- Market community transportation services already in place
- Streamline referral procedures to assist quicker access to services
- Review policy and identify barriers
- Conduct virtual Town Hall and focus group for those populations with transportation insecurity

Organization(s)/Partners Responsible

- Paratransit/RTC
- Dignity Health
- Intermountain Health
- Access to Care Workgroup



Goal 1: Improve Access to Reliable Transportation Infrastructure

Objective 1.3

Households With Limited or No Vehicles
By December 2031, expand transportation outreach for households without vehicles, limited mobility independence, those relying on accessible transportation, and zero-vehicle households, by increasing successful service linkages through refugee organization partnerships and multilingual outreach.

Process Indicators

- Increase in enrollments in community transportation programs
- How many interactions with social media and marketing
- Quantity of multilingual outreach materials developed and distributed (by language and format)
- Number of transportation navigation or enrollment sessions conducted for zero-vehicle households

Implementation Strategies or Activities

- Collect/identify current data – non-vehicle household data
- Conduct additional outreach to identified populations
- Social media campaign to assist with outreach efforts
- Identify different languages for Multilingual Outreach toolkit

Organization(s)/Partners Responsible

- Paratransit/RTC
- Dignity Health
- Intermountain Health
- Access to Care Workgroup



Goal 2: Strengthen Healthcare Provider Support During Credentialing

Objective 2.1

Reduce Credentialing Delays

By December 2031, reduce provider credentialing processing time from 90+ days to 30 days by collaborating with Medicaid, Managed Care Organizations (MCOs), and Health Care Finance to streamline workflows and revise policies.

Process Indicators

- Number of credentialing steps identified for streamlining or elimination
- Number of policy revisions drafted or implemented to reduce processing delays

Implementation Strategies or Activities

- Standardize Credentialing Requirements Across MCOs
- Align documentation requirements
- Create a Shared Credentialing Checklist and Toolkit
- Develop a standardized checklist for providers that outlines all required documentation, common errors, and submission steps to reduce incomplete applications
- Implement an Expedited Credentialing Track
- Use Pre-Enrollment or Provisional Credentialing Policies
- Encourage use of centralized credentialing platforms and electronic verification systems to reduce manual processing and repeated primary source verification

Related Assessment Data

Community Partner Assessment:

- Main area listed by community partners on how they would like to grow their capacity:
  - Better access to health, both with providers and community partners
  - Having the ability to get reimbursed for services
  - Address social determinants to health

Community Status Assessment:

- Clark County had a lower percentage of adults with health insurance coverage (84.3%) than Nevada (85.4%) and the United States (89.0%)

Organization(s)/Partners Responsible

- Access to Care Workgroup

Policy Recommendation

Advocate for simplified provider enrollment policies such as fewer duplicative forms, reduced re-verification frequency, and clearer submission processes.

Goal 2: Strengthen Healthcare Provider Support During Credentialing

Objective 2.2

Support Underserved Patient Access
By December 2031, increase the number of credentialed providers serving underserved patients through assistance with applications and removal of administrative barriers.

Process Indicators

- Number of staff trained on credentialing communication protocols
- Availability of public-facing credentialing timelines and FAQs

Implementation Strategies or Activities

- Provide Technical Assistance for Credentialing Applications
- Offer direct support to providers—especially small practices, Federally Qualified Health Centers (FQHCs), and behavioral health agencies—with completing credentialing paperwork, renewals, and revalidations
- Utilize “Credentialing Navigator” Support Model
- Develop dedicated staff or a shared navigator program that helps providers track application status, respond to requests, and prevent missed deadlines
- Offer Training Workshops for New Providers and Clinics
- Host training sessions explaining Medicaid enrollment, MCO credentialing steps, and common barriers that delay approval
- Track Provider Growth in Underserved Areas

Organization(s)/Partners Responsible

- Access to Care Workgroup



Goal 3: Increase Knowledge and Diversify Community Resource Information Distribution

Objective 3.1

Expand Community Resource Engagement
By December 2031, Access to Care CHIP Workgroup organization representatives will attend at least 25 events per year to promote resource access and track referrals.

Process Indicators

- Increase in community event/ marketing outreach numbers
- Increase in referral numbers from events
- Number of event types represented (health fairs, school events, faith-based gatherings, cultural festivals)
- Frequency of post-event debriefs or data reviews to assess outreach effectiveness

Implementation Strategies or Activities

- Identify events in the community for target populations individuals with limited mobility independence, those relying on accessible transportation, and zero-vehicle households.
- Attend events – provide information on transportation resources
- Track number of referrals that turn into receiving services

Related Assessment Data

Community Context Assessment:

- Community needs and recommendations across all groups
  - More resources on various specialists and healthcare providers
  - Availability of services for resources

Organization(s)/Partners Responsible

- Access to Care Workgroup



Goal 3: Increase Knowledge and Diversify Community Resource Information Distribution

Objective 3.2

Diversify Outreach Methods and Improve Community Insight
By December 2031, introduce at least five new outreach strategies (translated materials, digital tools, social media, text systems, pop-up booths) to increase resource access.

Process Indicators

- Tracking of new implementation strategies
- Tracking of distribution of materials and where they are going
- Number of community engagement activities conducted per year (town halls, focus groups, listening sessions)
- Number of participants engaged, disaggregated by priority populations when possible

Implementation Strategies or Activities

- Identify current strategies of transportation agencies for outreach
- Develop new outreach strategies to reach target populations
- Implement outreach strategy
- Evaluate how effective the strategy was
- Conduct at least one community engagement activity per year (town halls, focus groups, listening sessions) to guide improvements in resource distribution.

Organization(s)/Partners Responsible

- Access to Care Workgroup

Policy Recommendation

Support a community engagement and outreach policy that formalizes resource distribution expectations across partners.



Assets/Resources Available

- Health Equity Program
- FQHC Programs (Clinics, Behavioral Health, Ryan White, etc.)
- Linkage to Action
- Pathways Care Coordination Agency
- Helping Hands Transportation and Food Delivery
- Engelstad Foundation RED Rose
- Senior Peer Counseling
- Medicare Assistance Program,
  Nevada Health Link Insurance, Patient Financial Assistance
- Annual Back to School Fair

Make mental health services accessible to all individuals
– regardless of race, class, or gender –
while working to eliminate the stigma often associated with seeking care





Priority Area 2:

Chronic Disease

The Chronic Disease workgroup focused on a multi-generational strategy to reduce the burden of cardiovascular disease and diabetes through targeted prevention, management, and system-wide collaboration. Recognizing that health outcomes are deeply tied to demographic and geographic factors, this plan prioritizes African American and Hispanic residents aged 35 and older for cardiovascular prevention, while ensuring seniors 65 and older have the robust support needed for disease management. Furthermore, the initiative scales evidence-based diabetes interventions for adults in Clark County's most underserved areas. Central to these efforts is a commitment to strengthening the local public health infrastructure by fostering seamless communication and resource sharing among the organizations dedicated to serving those living with chronic conditions.

Goals & Objectives

Goal 1

Decrease the prevalence of cardiovascular disease among African Americans/Hispanic 35+ (prevention) and Older Adults 65+ (management)

Objective 1.1: Increase Referrals
By Spring 2027, increase referrals to organizations providing Chronic Disease Self-Management Education (CDSME).

Objective 1.2: Promote Get Healthy Clark County resource guide
By June 30, 2027, increase the utilization of the Office of Chronic Disease Prevention and Health Promotion's (OCDPHP) Health and Wellness resource guide among African American and Hispanic adults 35+ and older adults 65+ by promoting the guide at a minimum of 10 community-based locations annually.

Goal 2

Decrease the prevalence of diabetes among adults 18+, African American, Hispanics, living in underserved areas in Clark County.

Objective 2.1: Diabetes prevention & management enrollment
By December 31, 2031, increase enrollment of priority-population residents into diabetes prevention and diabetes self-management programs (e.g., Diabetes Prevention Program (DPP), (Diabetes Self-Management Education (DSME), Prediabetes 101 classes, Mind, Exercise, Nutrition, Do-It! (MEND), Build Healthy Families) by 20%, using a baseline established by June 30, 2027, through program review.

Objective 2.2: Provider-driven referrals & culturally responsive navigation
By December 31, 2028, increase provider-initiated referrals to diabetes programs for the priority population by implementing referral workflows with Primary Care Physicians (PCP), CHWs, and community partners (including Intermountain, UNLV School of Medicine, and SNHD), and providing culturally responsive navigation support.

Objective 2.3: Referrals to DPP/DSME & related programs
By December 31, 2031, increase annual referrals of African American and Hispanic adults 35+ and older adults 65+ to evidence-based cardiovascular and diabetes prevention/management programs (including DPP, DSME, Pathways Programs, and Comagine Compass-tracked programs) by at least 25%, based on a baseline established through audits completed by June 30, 2027.

Goals & Objectives

Goal 3

Strengthen communication and collaboration among organizations that serve residents experiencing chronic diseases (especially cardiovascular disease and diabetes).

Objective 3.1: Cross-promotion of listservs
By December 31, 2027, establish a shared cross-promotion system among at least 10 chronic disease service organizations by linking and promoting one another's listservs.

Objective 3.2: Vendor & community event promotion
By June 30, 2027, establish a collaborative vendor-sharing and event-promotion system to ensure that at least 30 diabetes and cardiovascular disease service providers receive timely notifications about community events (including the Diabetes & Heart Disease Block Party), vendor opportunities, and free/low-cost community classes such as "With Every Heartbeat There's Life."

Objective 3.3: Community of Practice
By September 30, 2026, establish a Chronic Disease Community of Practice that convenes quarterly, with a baseline of membership and collaboration indicators established by March 2027, to strengthen coordination among providers and increase shared resources and best practices.

Goal 4

Reduce preventable risk factors and address social determinants of health, including, but not limited to access to nutritious food, increased physical activity, reduce obesity, and tobacco-free lifestyles in Clark County.

Objective 4.1: Strengthen Healthy Living Policies and Environments
By December 2027, review and recommend at least one policy change, environmental systems, and/or activities that support healthy eating, active living, and tobacco-free lifestyles in Clark County.



Goal 1:

Decrease the prevalence of cardiovascular disease among African Americans/Hispanic 35+ (prevention) and Older Adults 65+ (management)

Objective 1.1

Increase Referrals

By Spring 2027, increase referrals to organizations providing Chronic Disease Self-Management Education (CDSME).

Process Indicators

- Number of referrals generated to CDSME programs by source (SNHD, Dignity Health, community partners)
- Number of participants referred to Self-Measured Blood Pressure Monitoring (SMBP) programs (YMCA, Dignity Health faith-based partnerships)
- Number of staff, CHWs, or volunteers trained on CDSME referral processes

Implementation Strategies or Activities

- The Heart of the Community Block Party
- Clark County Diabetes Group (CCDG) Newsletter
- Chronic Disease Self-Management Education Programs (CDSME)
- Three Square walk-up distribution at SNHD Main Public Health Center
- Develop baseline number of referrals
- Assess number of referrals annually

Related Assessment Data

Community Status Assessment:

- In Clark County in 2023, Non-Hispanic Black/African American adults had the highest percentage of hypertension (41.1%), 47.8% higher than the group with the lowest prevalence, Hispanic adults (any race, 27.8%)

Organization(s)/Partners Responsible

- Southern Nevada Health District
- Dignity Health
- Three Square
- Chronic Disease Workgroup

Policy Recommendation

Advocate for expansion of state grant cycles specific to cardiovascular health opportunities.

Goal 1:

Decrease the prevalence of cardiovascular disease among African Americans/Hispanic 35+ (prevention) and Older Adults 65+ (management)

Objective 1.2

Promote Get Healthy Clark County resource guide

By June 30, 2027, increase the utilization of the Office of Chronic Disease Prevention and Health Promotion's (OCDPHP) Health and Wellness resource guide among African American and Hispanic adults 35+ and older adults 65+ by promoting the guide at a minimum of 10 community-based locations annually.

Process Indicators

- Number of resource guides distributed or accessed (print and digital)
- Number of languages available for the resource guide and supplemental materials
- Number of QR codes, links, or digital access points deployed at community sites

Implementation Strategies or Activities

- Develop culturally tailored messages and Spanish-language outreach
- Collaborate with Barber Shop Outreach Project (BSHOP)/(Beauty Shop Outreach Project (BeSHOP) programs to reach patrons in priority groups
- Share culturally tailored messages with organizations to promote use of the messages.
- Collaborate with churches and senior centers (among other community-based locations) to reach priority populations"

Organization(s)/Partners Responsible

- Southern Nevada Health District
- Dignity Health
- Chronic Disease Workgroup



Goal 2: Decrease the prevalence of diabetes among adults 18+, African American, Hispanics, living in underserved areas in Clark County.

Objective 2.1

Diabetes prevention & management enrollment
By December 31, 2031, increase enrollment of priority-population residents into diabetes prevention and diabetes self-management programs (e.g., Diabetes Prevention Program (DPP), (Diabetes Self-Management Education (DSME), Prediabetes 101 classes, Mind, Exercise, Nutrition, Do-It! (MEND), Build Healthy Families) by 20%, using a baseline established by June 30, 2027, through program review.

Process Indicators

- Number of diabetes-related programs reviewed and included in baseline audit (DPP, DSME, Prediabetes 101, MEND, Build Healthy Families)
- Completion of baseline enrollment audit by June 30, 2027
- Number of Spanish-language or culturally tailored diabetes programs offered
- Number of completions

Implementation Strategies or Activities

- Raise awareness of DPP and DSMES programs and classes by sharing diabetes programs flyers at community events/activities
- Share Comagine's CHW Training flyer with CCDG and others
- CHWs can share DPP/DSMES programs available (Compass)
- Establish baseline enrollment numbers across programs
- Track enrollment numbers annually across programs
- Review and revise, as needed, the cultural appropriateness of materials for non U.S.-born residents
- Identify and collaborate with trusted organizations in ZIP 89101 to promote DPP and DSME programs
- Promote Intermountain Health Prediabetes 101 Classes

Related Assessment Data

Community Status Assessment:

- Diabetes was ranked #4 top concern selected by 19.2% of respondents

Community Status Assessment:

- Diabetes is the sixth leading cause of death in Clark County. The mortality rate represents the number of deaths per 100,000 population for both type 1 and type 2 diabetes. In 2023, the age-adjusted diabetes mortality rate in Clark County was 23.6 per 100,000, an increase from 2019 (22.8 per 100,000).

Organization(s)/Partners Responsible

- Southern Nevada Health District
- Dignity Health
- Comagine
- Chronic Disease Workgroup
- Intermountain Health

Policy Recommendation

Support in adopting a formal Health in All Policies (HiAP) resolution at the county and city levels(e.g., City of Las Vegas, Henderson, North Las Vegas).

Goal 2:

Decrease the prevalence of diabetes among adults 18+, African American, Hispanics, living in underserved areas in Clark County.

Objective 2.2

Provider-driven referrals & culturally responsive navigation

By December 31, 2028, increase provider-initiated referrals to diabetes programs for the priority population by implementing referral workflows with Primary Care Physicians (PCP), CHWs, and community partners (including Intermountain, UNLV School of Medicine, and SNHD), and providing culturally responsive navigation support.

Organization(s)/Partners Responsible

- Southern Nevada Health District
- Dignity Health
- Chronic Disease Workgroup

Process Indicators

- Number of PCPs, clinics, and healthcare systems engaged (Intermountain, UNLV Medical School, SNHD)
- Number of providers trained in referral processes and eligibility criteria
- Number of CHWs or navigators trained to support culturally responsive enrollment
- Number of provider-initiated referrals to diabetes programs

Implementation Strategies or Activities

- Establish baseline number of provider referrals to diabetes programs and number of providers/systems offering culturally responsive navigation support
- Track annually the number of provider referrals to diabetes programs and number of providers/systems offering culturally responsive navigation support
- Develop gold standard referral workflow
- Collaborate with PCPs, CHWs, and community partners to implement the gold standard referral workflow
- Promote access to healthcare and initiate direct referrals with Nevada Health Centers (NVHC) and SNHD's Southern Nevada Community Health Center (SNCHC); process referrals for Barbershop Health Outreach Project (BSHOP/BeSHOP) clients and community outreach events



Goal 2:

Decrease the prevalence of diabetes among adults 18+, African American, Hispanics, living in underserved areas in Clark County.

Objective 2.3

Referrals to DPP/DSME & related programs

By December 31, 2031, increase annual referrals of African American and Hispanic adults 35+ and older adults 65+ to evidence-based cardiovascular and diabetes prevention/management programs (including DPP, DSME, Pathways Programs, and Comagine Compass-tracked programs) by at least 25%, based on a baseline established through audits completed by June 30, 2027.

Process Indicators

- Number of programs included in referral tracking systems (Pathways, Comagine Compass)
- Number of community-based referral sources (barber shops, faith-based organizations, senior centers)
- Number of referral community partners trained on submission and tracking tools

Implementation Strategies or Activities

- Develop baseline number of referrals
- Assess number of referrals annually
- Ensure Spanish language-referrals and recruitment materials are available, develop as needed
- Collaborate with community organizations and leaders to increase trust and reduce barriers

Organization(s)/Partners Responsible

- Southern Nevada Health District
- Dignity Health
- Chronic Disease Workgroup



Goal 3:

Strengthen communication and collaboration among organizations that serve residents experiencing chronic diseases (especially cardiovascular disease and diabetes).

Objective 3.1

Cross-promotion of listservs

By December 31, 2027, establish a shared cross-promotion system among at least 10 chronic disease service organizations by linking and promoting one another's listservs.

Process Indicators

- Number of chronic disease organizations participating in listserv cross-promotion
- Frequency of cross-promotional communications (newsletters, email blasts)
- Number of subscribers reached through shared promotions

Implementation Strategies or Activities

- Develop comprehensive list of chronic disease service providers
- Conduct outreach to link up and collaborate with chronic disease service providers
- Track listservs that are connected/ cross-promoted
- Connect with the Nevada Division of Public and Behavioral Health (DPBH) Learning Collaborative

Related Assessment Data

Community Context Assessment:

- Members of the American Indian/ Alaskan Native population brought up the most unique concerns. They spoke about the generational trauma and stigma they deal with when accessing services, and the prevalence of chronic illness in their community such as diabetes and high blood pressure. (7, p.17)

Organization(s)/Partners Responsible

- Southern Nevada Health District
- Dignity Health

Policy Recommendation

Boost collaborative outreach between partners and advocate for shared resources such as an inter-agency data-sharing agreement.

Goal 3:

Strengthen communication and collaboration among organizations that serve residents experiencing chronic diseases (especially cardiovascular disease and diabetes).

Objective 3.2

Vendor & community event promotion

By June 30, 2027, establish a collaborative vendor-sharing and event-promotion system to ensure that at least 30 diabetes and cardiovascular disease service providers receive timely notifications about community events (including the Diabetes & Heart Disease Block Party), vendor opportunities, and free/low-cost community classes such as “With Every Heartbeat There’s Life.”

Organization(s)/Partners Responsible

- Southern Nevada Health District
- Dignity Health

Process Indicators

- Number of community events promoted (including Diabetes & Heart Disease Block Party)
- Number of vendor opportunities shared annually
- Number of collaborative planning meetings for shared events

Implementation Strategies or Activities

- Develop vendor-sharing and event-promotion system
- Expand outreach to organizations serving low-income, immigrant, and older adult communities
- Review existing agencies that host annual events, refine as needed, and format for event materials to ensure accessibility



Goal 3:

Strengthen communication and collaboration among organizations that serve residents experiencing chronic diseases (especially cardiovascular disease and diabetes).

Objective 3.3

Community of Practice

By September 30, 2026, establish a Chronic Disease Community of Practice that convenes quarterly, with a baseline of membership and collaboration indicators established by March 2027, to strengthen coordination among providers and increase shared resources and best practices.

Process Indicators

- Number of quarterly meetings held
- Number of shared tools, resources, or best practices developed
- Number of joint initiatives or events emerging from the Community of Practice (CoP) and attendance rates
- Number of feedback surveys conducted to assess CoP effectiveness

Implementation Strategies or Activities

- Develop baseline membership list of chronic disease service providers (leverage list developed in 3.1)
- Host quarterly convenings of chronic disease service providers to foster collaboration and networking and elevate smaller grassroots organizations
- Establish collaboration indicators and shared group purpose

Organization(s)/Partners Responsible

- Southern Nevada Health District
- Dignity Health



Goal 4:

Reduce preventable risk factors and address social determinants of health, including, but not limited to access to nutritious food, increased physical activity, reduce obesity, and tobacco-free lifestyles in Clark County.

Objective 4.1

Strengthen Healthy Living Policies and Environments
By December 2027, review and recommend at least one policy change, environmental systems, and/or activities that support healthy eating, active living, and tobacco-free lifestyles in Clark County.

Process Indicators

- Number of policies reviewed related to:
  - Healthy beverages
  - Healthy vending
  - ParkRx/physical activity promotion
- Number of organizations assessed for existing vending and beverage standards
- Number of ParkRx partnerships explored or initiated

Implementation Strategies or Activities

- Complete a comprehensive review of current state laws and existing policies related to:
  - Nutrition standards (including healthy beverage policies in public facilities and workplaces)
  - Healthy vending guidelines in government buildings, schools, and community settings
  - Built environment and physical activity (including ParkRx (Park Prescription programs) partnerships with healthcare providers and parks systems)
- Propose at least one policy, system, or activity recommendation
- Partner with healthcare systems and parks departments to explore integration of ParkRx programs into clinical workflows.

Organization(s)/Partners Responsible

- SNHD Public Health Advisory Board
- SNHD Office of Chronic Disease Prevention & Promotion
- CHIP Chronic Disease Workgroup



Assets/Resources Available

Clinical and Diagnostic Support

- Clinical laboratory testing for disease markers, screening, and health monitoring
- Laboratory service consultation, including guidance on test availability and lower-cost testing options

Chronic Disease Prevention & Health Promotion Programs

- Office of Chronic Disease Prevention and Health Promotion programming and coordination
- Healthy Heart / Cardiovascular Health Programs, including:
  - Workshops and community education
  - Hypertension and cholesterol management support
  - Nutrition education and cooking demonstrations
  - Diabetes Prevention and Management Programs, including:
    - Diabetes Self-Management Education (in-person and virtual)
    - CDC-recognized National Diabetes Prevention Program (NDPP)
    - Lifestyle support focused on healthy eating, physical activity, weight management, and A1c improvement
    - Intermountain Health Prediabetes 101 Class

Nutrition and Food Access Initiatives

- Fruits and Vegetables Prescription Program, providing produce support/ delivery for underserved populations
- Community-based nutrition education and cooking demonstrations

Care Coordination and Patient Support Services

- Chronic disease care management (diabetes, heart failure), including patient education via phone and printed materials
- Community health education classes addressing:
  - Diabetes and hypertension
  - Smoking cessation
  - Advanced care planning
  - Caregiver education and support

Access to Care and Community Outreach

- Annual Back-to-School Fair, connecting families with health services and resources
- Community Health Workers and Social Workers providing support with social determinants of health (SDOH), including:
  - Food access
  - Transportation
  - Housing support
  - Resource navigation and care coordination

> "When I think about health, I think of being my own advocate,"
>
> - Community Context Assessment Focus Group Participant





Priority Area 3:

Public Health Funding

Sustainable public health funding serves as the essential foundation for any successful improvement plan. By securing consistent and transparent funding, communities can move beyond reactive measures to address systemic barriers, such as transportation insecurity and limited access to preventative screenings.

Ultimately, prioritizing public health resources is not merely an administrative necessity; it is a strategic commitment to equity, ensuring that every resident has the foundational support required to lead a healthy, productive, and resilient life.

Goals & Objectives

Goal 1

Increase, maintain, or optimize existing public health resources to support the ongoing implementation, monitoring, and community engagement efforts of the CHIP.

Objective 1.1: Analyze Funding Landscape
By December 2031, collaborate with community partners to conduct a comprehensive landscape and market analysis to identify existing funding streams, funding gaps, or emerging opportunities across Access to Care, Chronic Disease and Substance Use.

Objective 1.2: Build Funding Toolkit
By December 2031, develop, publish, and annually update a Funding Resource Toolkit that consolidates grant-writing resources, state match opportunities, and funding opportunities relevant to Access to Care, Chronic Disease, and Substance Use.

Objective 1.3: Match Partners for Funding
By December 2031, design and implement a matchmaking system that identifies partner capabilities, aligns complementary strengths across organizations, and facilitates teaming for funding opportunities in Access to Care, Chronic Disease, and Substance Use.

Goal 2

Maintain or increase sustainable public health funding to support and strengthen public health capacity and social determinants of health in Southern Nevada.

Objective 2.1: Maintain Public Health Funding
By December 2031, maintain state per-capita public health funding and pursue increases to strengthen public health capacity in Southern Nevada.



Goal 1:

Increase, maintain, or optimize existing public health resources to support the ongoing implementation, monitoring, and community engagement efforts of the CHIP.

Objective 1.1

Analyze Funding Landscape

By December 2031, collaborate with community partners to conduct a comprehensive landscape and market analysis to identify existing funding streams, funding gaps, or emerging opportunities across Access to Care, Chronic Disease and Substance Use.

Process Indicators

- Number of community partners engaged through planning meetings or working sessions to inform the funding landscape and market analysis
- Completion of a comprehensive funding inventory that catalogs funding sources across federal, state, local and philanthropic levels for Access to Care, Chronic Disease, and Substance Use
- Number of funding gaps and emerging funding opportunities identified, documented and tracked by focus area
- Completion of a final funding landscape analysis report with recommendations for CHIP partners

Implementation Strategies or Activities

- Develop template/survey to identify sector specific opportunities, assess current access challenges and identify gaps per CHIP domain
- Distribute template/survey to community partners
- Organize template/survey findings
- Distribute Findings Report

Policy Recommendation

Establish “Innovation & Ingenuity” Funding Margins

- Incorporate a mandatory unrestricted “innovation margin” (e.g., 5–10%) into all public health grant awards. This portion of funding would remain exempt from rigid federal or state line-item restrictions to allow for programmatic agility and cross-sector collaboration.

Related Assessment Data

Community Partner Assessment:

- Areas ranked by community partners on how they would like to grow their capacity and capabilities:
  - #4 Funding and Workforce Development – More space, staff, and funding to increase needed services to the community
- Community Partner Feedback Quote: “There is not enough funding to provide community services”

Organization(s)/Partners Responsible

- Workgroup Members
- MCOs, providers, CHWs
- State offices (e.g., The Governor’s Office of Federal Assistance (OFA))
- CHIP Steering Committee

Goal 1:

Increase, maintain, or optimize existing public health resources to support the ongoing implementation, monitoring, and community engagement efforts of the CHIP.

Objective 1.2

Build Funding Toolkit

By December 2031, develop, publish, and annually update a Funding Resource Toolkit that consolidates grant-writing resources, state match opportunities, and funding opportunities relevant to Access to Care, Chronic Disease, and Substance Use.

Process Indicators

- Number of existing funding toolkits and resources collected from partners to inform toolkit development
- Completion of a funding resource toolkit framework and outline
- Publication of the funding resource toolkit
- Number of training sessions or partner orientations conducted to introduce the toolkit

Implementation Strategies or Activities

- Identify funding resources to include in toolkit
- Compile resources identified into toolkit
- Provide draft toolkit to community partners for edits/additions
- Publish toolkit and send out to partners through an instructional rollout (email, webinar)
- Review toolkit for updates

Organization(s)/Partners Responsible

- Workgroup Members
- Managed Care Organizations (MCOs) and providers
- CHWs
- State offices (e.g., The Governor's Office of Federal Assistance (OFA))
- CHIP Steering Committee

Policy Recommendation

- Establish "Innovation & Ingenuity" Funding Margins
  - Incorporate a mandatory unrestricted "innovation margin" (e.g., 5–10%) into all public health grant awards.
  - This portion of funding would remain exempt from rigid federal or state line-item restrictions to allow for programmatic agility and cross-sector collaboration.

Goal 1:

Increase, maintain, or optimize existing public health resources to support the ongoing implementation, monitoring, and community engagement efforts of the CHIP.

Objective 1.3

Match Partners for Funding

By December 2031, design and implement a matchmaking system that identifies partner capabilities, aligns complementary strengths across organizations, and facilitates teaming for funding opportunities in Access to Care, Chronic Disease, and Substance Use.

Process Indicators

- Development of a partner capability assessment tool (expertise, populations served, grant experience)
- Number of cross-sector partnerships formed (e.g., healthcare, community-based organizations, government)
- Number of matchmaking connections facilitated between organizations
- Number of funding opportunities pursued collaboratively through the matchmaking system

Implementation Strategies or Activities

- Develop survey for community partners to see if there is interest in collaboration for funding and how they want to collaborate
- Distribute survey
- Compile survey results based on alignment to missions
- Share survey results with groups/ organizations that completed survey

Organization(s)/Partners Responsible

- Workgroup Members
- Manage Care Organizations (MCOs) and providers
- CHWs
- State offices (e.g., OFA)
- CHIP Steering Committee



Goal 2:

Maintain or increase sustainable public health funding to support and strengthen public health capacity and social determinants of health in Southern Nevada.

Objective 2.1

Maintain Public Health Funding

By December 2031, maintain state per-capita public health funding and pursue increases to strengthen public health capacity in Southern Nevada.

Process Indicators

- Number of advocacy or education materials developed highlighting public health capacity and social determinants of health needs
- Number of testimonies, presentations, or formal comments provided during budget or legislative processes
- Number of public health funding proposals or budget requests submitted

Implementation Strategies or Activities

- Engage key state legislators and officials to advocate for sustained or increased public health funding
- Prepare briefs demonstrating public health impact, outcomes and local funding needs
- Identify and pursue federal funding opportunities that supplement state per-capita funding and expand public health capacity

Related Assessment Data

Community Status Assessment:

- Threat: Challenges with funding and sustainability – losing funds is a threat as it could eliminate needed community programs. Some organizations may have to narrow a focus which can make it hard to diversify funds as well as have the capacity to serve multiple populations.

Organization(s)/Partners Responsible

- SNHD Leadership and Government Affairs
- Workgroup Partners

Policy Recommendation

Publicize and advocate for continued funding from Public Health Infrastructure Grant (PHIG) or the state for evaluation of the CHIP during its lifetime as well as resources to collaborate with community partners and SNHD staff to realize the impact predicted by the working groups.

Assets/Resources Available

- Funding opportunities and grant applications
- Clinical laboratory testing and support
- Low-cost testing guidance and consultation
- Care management services

"Public health funding is an investment in the health, safety and future of our community. Sustained resources allow public health agencies and community partners to move beyond short-term responses and implement evidence-based interventions that improve health outcomes, reduce preventable illness and disparities, and expand access to essential services across Southern Nevada."

- Dr. Cassius Lockett, District Health Officer, Southern Nevada Health District





Priority Area 4:

Substance Use

The CHIP Substance Use workgroup established a comprehensive framework to safeguard our residents through proactive prevention, life-saving harm reduction, and expanded clinical care. This initiative prioritizes the entire lifespan of our community, from implementing evidence-based prevention in K–12 schools and higher education to enhancing the capacity of our treatment systems. By dismantling systemic barriers to care, such as Medicaid prior authorizations and geographic service gaps, and by fostering an integrated approach to co-occurring mental health disorders, we aim to build a resilient recovery ecosystem. Through strategic legislative advocacy, trauma-informed training for first responders, and widespread public education, this plan serves as a roadmap to reduce overdose fatalities and ensure that every Clark County resident has equitable access to the resources necessary for long-term health and stability.

Goals & Objectives

Goal 1

Expand and improve access to evidence-based prevention programs for K-12 Schools and College Students who live in Clark County

Objective 1.1: Expand School Prevention Programs
By December 2031, conduct a countywide community landscape analysis of prevention programming in Clark County K–12 schools and use findings to expand evidence-based programs to at least 10 more schools.

Objective 1.2: Train Providers on Early Identification & Referral
By December 2031, implement training for at least 200 teachers, counselors, and primary care providers on risk factors for substance use/mental health concerns and on referral pathways, resulting in an increase in early referrals to school or community services.

Objective 1.3: Increase College Prevention Services
By December 2031, increase access to substance use prevention programming for Clark County college students by adding or enhancing prevention services at a minimum of two higher-education campuses.

Goal 2

Reduce Clark County overdose deaths through prevention and education

Objective 2.1: Expand Naloxone Access
By December 2031, expand naloxone availability to at least 50 easy-to-access community locations (e.g., libraries, rec centers, cultural centers, nonprofits, etc.)

Objective 2.2: Educate Community on Overdose Response
December 2031, engage 5,000 residents and educate 1,000 staff at community sites on overdose response, naloxone use, or stigma reduction in identified high-risk ZIP codes.

Objective 2.3: Review and Recommend Policy Changes
Complete a review of current state laws, propose at least one policy recommendation by 2027.



Goals & Objectives

Goal 3

Improve access to substance use treatment and care for people who live in Clark County

Objective 3.1: Expand Treatment Capacity
By December 2031, increase Clark County's detox and treatment capacity, including stimulant use disorder treatment at carceral settings, community settings, and medical/hospital settings.

Objective 3.2: Increase Routine Health Screening in Treatment
By December 2031, ensure that 75% of substance use treatment programs routinely offer or refer for Human Immunodeficiency Virus (HIV)/ Hepatitis C virus (HCV)/ Sexually transmitted infections (STIs) testing.

Objective 3.3: Improve Access to MOUD Services
By December 2031, eliminate Medicaid prior authorization for buprenorphine and increase the number of pharmacies and clinics offering MOUD, supported by a public directory of dispensing locations.

Objective 3.4: Expand Onsite MOUD Access in Clinics
By December 2031, increase the number of infectious disease treatment programs and medical clinics that provide onsite MOUD dispensing least 50%.

Goal 4

Address mental health and substance use disorder intersections for people of Clark County

Objective 4.1: Increase 988 Awareness
By December 2031, increase awareness for people who live in Clark County to know when and how to use 988 through a countywide, multilingual awareness campaign, a peer-to-peer text campaign, and/or a targeted narrow-cast campaign in high-need community locations.

Objective 4.2: Expand Trauma-Informed Training
By December 2031, increase awareness of existing trauma-informed and co-occurring disorder response training and support access to the training for at least 500 Clark County first responders, including law enforcement, Emergency Medical Technicians (EMTs), fire personnel, healthcare workers, and Community Health Workers (CHWs).

Objective 4.3: Improve Policies for Integrated Behavioral Health Access
By August 2026, support at least two system-level policies or reimbursement changes (e.g., increased Medicaid reimbursement for mental health providers, simplified billing for co-located care, provider-type expansion) that improve access to integrated mental health and substance use services.



Goal 1:

Expand and improve access to evidence-based prevention programs for K-12 Schools and College Students who live in Clark County

Objective 1.1

Expand School Prevention Programs
By December 2031, conduct a countywide community landscape analysis of prevention programming in Clark County K–12 schools and use findings to expand evidence-based programs to at least 10 more schools.

Process Indicators

- Number of prevention programs identified from statewide and county partners
- Number of meetings with CCSD Office of Safe and Drug Free Schools and other partners to review findings
- Number of funding or resource alignment proposals developed to support program expansion

Implementation Strategies or Activities

- Review/request the list of currently approved evidence-based programs from the statewide prevention curriculum evaluation group and other policy solutions (e.g., Children's Advocacy Alliance (CAA) Kids Count)
- Identify current schools' program implementation
- Use that data to expand to additional schools or increase funding to existing programs (e.g., Clark County School District (CCSD) Office of Safe and Drug Free Schools) to expand to additional schools/supports, as funding is available

Related Assessment Data

Community Status Assessment:

- In 2023, Black, non-Hispanic and White, non-Hispanic individuals experienced the highest overdose death rate within the county (46.5 and 34.8 per 100,000 population respectively). (10)
- Additionally, the drug overdose death rate in Clark County has risen markedly, increasing from 17.5 per 100,000 population in 2019 to 28.1 per 100,000 in 2023, while Nevada's rate increased from 15.5 to 29.1, surpassing Clark County in 2023. The United States had the highest rates, with an increase from 21.6 to 31.3 per 100,000 population, peaking in 2021 and 2022 before slightly decreasing in 2023. (2)

Organization(s)/Partners Responsible

- Substance Use Workgroup
- Clark County School District

Goal 1:

Expand and improve access to evidence-based prevention programs for K-12 Schools and College Students who live in Clark County

Objective 1.2

Train Providers on Early Identification & Referral

By December 2031, implement training for at least 200 teachers, counselors, and primary care providers on risk factors for substance use/mental health concerns and on referral pathways, resulting in an increase in early referrals to school or community services.

Process Indicators

- Assessment of existing trainings identified addressing youth substance use and mental health risk factors for the target audiences
- Development or adaptation of a standardized training and referral pathway
- Number of systems created to keep referral pathways current (e.g., digital guide, app, update schedule)

Implementation Strategies or Activities

- Identify if training exists for this topic, if no training exists, procure an evidence-based training that has been effective in other communities and adapt it
- Identify who would (develop and) facilitate the training
- Create a list of training recipients, schedule, and implement the training

Organization(s)/Partners Responsible

- UNLV Medical Students
- Clark County School District
- Clark County Medical Society
- Substance Use Workgroup



Goal 1:

Expand and improve access to evidence-based prevention programs for K-12 Schools and College Students who live in Clark County

Objective 1.3

Increase College Prevention Services

By December 2031, increase access to substance use prevention programming for Clark County college students by adding or enhancing prevention services at a minimum of two higher-education campuses.

Process Indicators

- Number of collaborations established with collegiate organizations (e.g., UNLV Recovery, Mobilize Recovery, Youth College & Career Readiness (YCCR))
- Number of campus-based prevention activities launched or enhanced
- Documentation of campus-specific prevention capacity assessments

Implementation Strategies or Activities

- Review 2025 legislation on naloxone training and education and make sure NSHE campuses have support for implementation
- Promotion of CredibleMind among college campuses starting with college campus staff and students

Organization(s)/Partners Responsible

- Substance Use Workgroup
- Supportive collegiate work groups



Goal 2: Reduce Clark County overdose deaths through prevention and education

Objective 2.1

Expand Naloxone Access
By December 2031, expand naloxone availability to at least 50 easy-to-access community locations (e.g., libraries, rec centers, cultural centers, nonprofits, etc.)

Process Indicators

- Development of a countywide inventory of naloxone distribution sites to identify the number of low- or no-barrier naloxone sites identified
- Number of new naloxone distribution sites onboarded

Implementation Strategies or Activities

- List of what programs have naloxone distribution limitations and rationale
- List of current low barrier sites for naloxone access (low/no barrier)
- List of locations that might be interested in low/no barrier naloxone access
- Create outreach plan to locations for training and engagement

Related Assessment Data

Community Status Assessment:

- From 2019 to 2023, the opioid overdose mortality rate among Clark County residents nearly doubled, rising from 9.9 to 19.5 per 100,000. Mirroring increases in Nevada (8.8 to 19.6 per 100,000 population) and the United States (15.5 to 24.0 per 100,000 population) during the same period. (10)

Organization(s)/Partners Responsible

- Substance Use Workgroup

Policy Recommendation

Review the current Nevada overdose-related laws and advocate for Substance Use related goals and objectives.

Goal 2: Reduce Clark County overdose deaths through prevention and education

Objective 2.2

Educate Community on Overdose Response
December 2031, engage 5,000 residents and educate 1,000 staff at community sites on overdose response, naloxone use, or stigma reduction in identified high-risk ZIP codes.

Organization(s)/Partners Responsible

- Substance Use Workgroup

Process Indicators

- Development of ZIP code–specific outreach plan
- Number of community outreach encounters documented (in-person, canvassing, digital)

Implementation Strategies or Activities

- Identify the ZIP codes considered "high risk"
- Within each ZIP code, create a list of businesses, first responders, resources, programs, etc. that could benefit from this information
- Create an outreach plan to these entities and offer assistance and support long term with communities

Objective 2.3

Review and Recommend Policy Changes
Complete a review of current state laws, propose at least one policy recommendation by 2027.

Organization(s)/Partners Responsible

- Substance Use Workgroup

Process Indicators

- Completion of a review of current Nevada overdose-related laws
- Selection of priority policy recommendation(s)

Implementation Strategies or Activities

- Review current state laws as part of local coalition efforts (e.g., Southern Nevada Opioid Advisory Committee (SNOAC)) to understand current gaps in policy for overdose prevention, including the Nevada Public Health Association Policy Committee and Attorney General's Substance Use Response Working Group (SURG) meeting
- Identify one or more relevant to overdose prevention and elevate for Clark County

Goal 3: Improve access to substance use treatment and care for people who live in Clark County

Objective 3.1

Expand Treatment Capacity
By December 2031, increase Clark County's detox and treatment capacity, including stimulant use disorder treatment at carceral settings, community settings, and medical/hospital settings.

Process Indicators

- Identification of treatment gaps for stimulant use disorder
- Assessment of PRSS readiness in emergency departments and hospitals

Implementation Strategies or Activities

- Identify the most recent landscape analysis of available treatment resources in Clark County (e.g., OpenBeds/HasBeds, recent Clark County analysis, etc.) including prescriber data for who has credentialing in Nevada (Clark County)
- Review the National Commission on Correctional Health Care (NCCHC) evaluation of correctional facilities and accreditation for carceral settings and look at gaps of what is currently being offered, identify if discharge planning is an available indicator
- Engage with partners at the Las Vegas Recovery Hospital and how they can support/receive patients
- Understand readiness Peer Recovery Support Specialist (PRSS) for linkage to treatment on-site at emergency rooms and/or Medications for Opioid Use Disorder/Medication-Assisted Treatment (MOUD/MAT) when they have received someone for an overdose

Related Assessment Data

Community Context Assessment:

- To learn more about larger concerns within their communities, all six focus groups were asked to share the main issues that cause them concern. Homelessness, substance use, and affordable housing emerged as the most common concern from multiple groups.
- Individuals with disabilities and 89101 residents discussed substance use as a major issue, especially marijuana and other drug use in public spaces.

Organization(s)/Partners Responsible

- Substance Use Workgroup

Policy Recommendation

Advocate for and support expansion of the programs assessed for MOUD linkage or dispensing.

Goal 3: Improve access to substance use treatment and care for people who live in Clark County

Objective 3.2

Expand Treatment Capacity
By December 2031, ensure that 75% of substance use treatment programs routinely offer or refer for HIV/HCV/STI testing.

Organization(s)/Partners Responsible

- Substance Use Workgroup
- The Center
- Trac-B Wellness

Process Indicators

- Documentation of referral processes where testing is not onsite
- Tracking system established for testing availability and referrals

Implementation Strategies or Activities

- Identify which treatment agencies are providing testing in-house (HIV vs. HCV/STI testing) including what processes they have in place for referral
- Outreach to the ones that are not offering this testing and encourage adoption

Objective 3.3

Increase Routine Health Screening in Treatment
By December 2031, eliminate Medicaid prior authorization for buprenorphine and increase the number of pharmacies and clinics offering MOUD, supported by a public directory of dispensing locations.

Organization(s)/Partners Responsible

- Substance Use Workgroup

Process Indicators

- Completion of a pharmacy and clinic MOUD survey
- Development of a public MOUD pharmacy directory

Implementation Strategies or Activities

- Work with policy committee on steps for Medicaid prior authorization elimination
- Survey pharmacies and clinics offering MOUD to determine gaps
- Create a public directory of locations for MOUD access

Goal 3: Improve access to substance use treatment and care for people who live in Clark County

Objective 3.4

Expand Onsite MOUD Access in Clinics
By December 2031, increase the number of infectious disease treatment programs and medical clinics that provide onsite MOUD dispensing least 50%.

Organization(s)/Partners Responsible

- Substance Use Workgroup

Process Indicators

- Number of programs assessed for MOUD linkage or dispensing
- Number of cross-training or coordination meetings held

Implementation Strategies or Activities

- Identify which infectious disease/testing programs offer screening (SBIRT) and linkage for MOUD/substance use treatment
- Educate on benefits of on-site dispensation



Goal 4: Address mental health and substance use disorder intersections for people of Clark County

Objective 4.1

Increase 988 Awareness
By December 2031, increase awareness for people who live in Clark County to know when and how to use 988 through a countywide, multilingual awareness campaign, a peer-to-peer text campaign, and/or a targeted narrow-cast campaign in high-need community locations.

Process Indicators

- Development or support the development of a countywide 988 marketing plan

Implementation Strategies or Activities

- Create a marketing plan utilizing SNHD CHIP Committee to identify resource placement
- Order or acquire resources
- Place them at identified locations

Related Assessment Data

Community Status Assessment:

- In 2023 the suicide rate in Clark County (10) was 16.0 per 100,000 compared to 13.3 per 100,000 in Nevada* and 14.1 per 100,000 in the United States. (1)

Community Context Assessment:

- American Indian/Alaskan Native, ZIP 89101, Individuals with Disabilities, and Rural Residents all agreed: “We need more mental health services, it is very limited and lacking.”

Organization(s)/Partners Responsible

- Substance Use Workgroup

Goal 4: Address mental health and substance use disorder intersections for people of Clark County

Objective 4.2

Expand Trauma-Informed Training
By December 2031, increase awareness of existing trauma-informed and co-occurring disorder response training and support access to the training for at least 500 Clark County first responders, including law enforcement, EMTs, fire personnel, healthcare workers, and CHW's.

Organization(s)/Partners Responsible

- Substance Use Workgroup
  - NAMI Southern Nevada, UNLV, PACT, SNHD

Process Indicators

- Inventory of existing first responder trainings (Crisis Response and Intervention Training (CRIT))
- Number of first responders registered

Implementation Strategies or Activities

- Identify barriers to current training access
- Remove barriers and offer training broadly to identified audiences

Objective 4.3

Improve Policies for Integrated Behavioral Health Access
By August 2026, support at least two system-level policies or reimbursement changes (e.g., increased Medicaid reimbursement for mental health providers, simplified billing for co-located care, provider-type expansion) that improve access to integrated mental health and substance use services.

Organization(s)/Partners Responsible

- Substance Use Workgroup

Process Indicators

- Number of policy proposals advanced (e.g., PRSS reimbursement)
- Tracking of policy progress milestones

Implementation Strategies or Activities

- Collaborate with CHIP Policy Committee to identify action steps

Assets/Resources Available

Prevention & Education

- **School-Based Programming:** Evidence-based primary prevention reaching ~40 schools, featuring curricula such as Too Good For Drugs, Catch My Breath, and Rainbow Days
- **Family & Life Skills Support:** Funding for parenting programs, positive action initiatives, and essential life skills training
- **"Don't Risk It All" Campaign:** A fentanyl awareness and community engagement program. Includes "train-the-trainer" sessions for student leaders and extensive outreach at high schools and college campuses
- **Henderson Fentanyl Awareness Summit:** An annual professional forum (est. 2023) convening over 200 national, state, and regional leaders to coordinate community updates and strategy
- **CredibleMind:** A digital resource platform dedicated to mental health, wellbeing, and self-care tools (Clark County Thrive)
- **Workforce Development:** Educational programs designed to strengthen the behavioral health workforce and provide vocational support for those in recovery

Overdose Prevention & Crisis Response

- **Overdose Prevention Product Distribution:** Critical overdose prevention through naloxone distribution and community-wide rescue training
- **Community Drug Checking:** Anonymous substance and paraphernalia testing services to monitor local drug supply trends and increase user safety
- **Linkage to Action and EmpowerLink (ODTA Programs):** Integrated overdose prevention services with direct paths to supportive care
- **City of Henderson Crisis Response Team (CRT):** A multidisciplinary team of clinicians and peer specialists providing real-time behavioral health crisis intervention and post-overdose follow-up

> "There is a lack of representation for mental health."
>
> - Community Context Assessment Focus Group Participant

Treatment, Recovery & Clinical Services

- **Linkage to Care (Overdose Data to Action (ODTA) and other programs):** Specialized navigators who bridge the gap between identified needs and professional treatment for priority populations
- **Peer-Based Recovery Support:** Comprehensive sustainment services including individual/group coaching, benefit navigation, and transportation assistance
- **Ambulatory Fellowship Training:** Serving as the primary clinical training site for the Southern Hills Addiction Medicine Fellowship
- **Medication-Assisted Treatment (MAT) Outreach:** Targeted medical outreach to the unhoused community, providing MAT and treatment for co-occurring comorbidities
- **Recovery Housing:** Dedicated residential environments that support long-term sobriety and stability
- **Comprehensive Addiction Services:** Direct clinical treatment and ambulatory services for community members

Next Steps: Implementation and Progress Tracking

The strategies outlined in this Community Health Improvement Plan serve as a roadmap to strengthen and advance public health in Southern Nevada. Development of the CHIP was guided by an extensive community engagement process, which brought together stakeholders across sectors to identify the most pressing health concerns and recommend strategies that build upon and fill gaps in existing health improvement efforts.

Implementation will begin with a structured review of the strategies included in the final CHIP report. Partner organizations have been identified throughout the CHIP to support coordination and collaborative action. To launch implementation, a community-wide meeting will be held during the first year of the CHIP to engage stakeholders, strengthen partnerships, and promote broad participation.

Following implementation launch, progress monitoring will occur on a quarterly basis. Automated quarterly emails and scheduled meetings will be sent to identified partners, providing a direct link to healthysouthernnevada.org where workgroup updates will be posted and partners may submit feedback or progress updates.

To support continued engagement, community partners will also be invited to share organizational updates, upcoming events, and success stories related to CHIP activities. Information submitted by partners will be used to update the CHIP action matrices and track implementation progress. Results and updates will be shared with the community through the Healthy Connect newsletter, distributed approximately one month after quarterly data collection, and posted on healthysouthernnevada.org. This ongoing communication and reporting structure will support transparency, accountability, and long-term sustainability of CHIP goals.



Organizations interested in participating in CHIP implementation activities are encouraged to contact HealthyConnect@snhd.org



Glossary of Terms Used in Action Plans

Priority
Underlying challenges that need to be addressed to achieve our vision

Goal
Answers the question "What do we want to achieve by addressing this priority?"

Strategy
Answers the question, "How do we want to achieve our goal? What action is needed?"

Objectives
Measure the amount or quality of activities related to the strategy. Objectives were formatted using the SMARTIES framework (Specific, Measurable, Achievable, Realistic, Time-bound, Inclusive, and Equitable).

CHA
Community Health Assessment

CHIP
Community Health Improvement Plan

CCA
Community Context Assessment

CPA
Community Partners Assessment

CSA
Community Status Assessment

CHW
Community Health Worker

MAPP
Mobilizing for Action through Planning and Partnerships

MOUD/MAT
Medications for opioid use disorder/ Medication-Assisted Treatment

MCO's
Managed Care Organizations

CDCG
Clark County Diabetes Group

CDSME
Chronic Disease Self-Management Education Programs

DPP
Diabetes Prevention Program

DSME
Diabetes Self-Management Education

CoP
Community of Practice

CAA
Children's Advocacy Alliance

YCRR
Youth College & Career Readiness

PRSS
Peer Recovery Support Specialist

CRIT
Crisis Response and Intervention Training

ODTA
Overdose Data to Action

General References and Resources

[1] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2019–2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2019–2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed February 4, 2025. wonder.cdc.gov/mcd-icd10-expanded.html

[2] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2019–2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2019–2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. ICD-10 codes: X40–X44, X60–X64, X85, Y10–Y15. Accessed February 4, 2025. wonder.cdc.gov/mcd-icd10-expanded.html

[3] Healthy Southern Nevada. Community Health Assessment and Improvement Resources. www.healthysouthernnevada.org/

[4] Nevada Department of Health and Human Services. Behavioral Risk Factor Surveillance System (BRFSS) Nevada Data File for 2023. Carson City, NV: Nevada Department of Health and Human Services. www.cdc.gov/brfss/annual_data/annual_2023.html

[5] Southern Nevada Health District. 2025 Community Health Assessment Full Report. www.healthysouthernnevada.org/content/sites/snhd/2025_CHA/CHA_Full_Report-Binder1_FINAL.pdf

[6] Southern Nevada Health District. 2024 Clark County Community Voice Report (Community Context Assessment). www.healthysouthernnevada.org/content/sites/snhd/2025_CHA/Final_Reports/Focus_Group_Report_Final.pdf

[7] Southern Nevada Health District. 2024 Clark County Youth Photo Voice Project (Community Context Assessment). www.healthysouthernnevada.org/content/sites/snhd/2025_CHA/Final_Reports/Youth_Photovoice_Final.pdf

[8] Southern Nevada Health District. 2024 Southern Nevada Community Partner Assessment. https://www.healthysouthernnevada.org/content/sites/snhd/2025_CHA/Final_Reports/CPA_Report_2024_2024.02.04_Final.pdf

[9] Southern Nevada Health District. 2025 Community Status Assessment Survey. www.healthysouthernnevada.org/content/sites/snhd/2025_CHA/Final_Reports/CSA_Survey_Report-2025.05.05.pdf

[10] Southern Nevada Health District. Nevada Electronic Death Record System (EDRS), Clark County and Nevada Residents, 2019–2023. Rates per 100,000 population calculated using population projections from the Nevada State Demographer vintage 2023 data, age adjusted to the 2000 U.S. Standard Population.

[11] U.S. Census Bureau. 2019–2023 American Community Survey 5-Year Estimates. data.census.gov/

[12] U.S. Census Bureau. QuickFacts: Boulder City, Henderson, Mesquite, North Las Vegas, Las Vegas, and Clark County, Nevada. July 1, 2023. www.census.gov/quickfacts

[13] U.S. Census Bureau. QuickFacts: United States; Nevada; Clark County, Nevada. July 1, 2024. www.census.gov/quickfacts