ALL IN GOOD HEALTH.

SILVER STATE HEALTH IMPROVEMENT PLAN 2023 – 2028

Division of Public Health and Behavioral Health

Published February 2024

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

TABLE OF CONTENTS

A MESSAGE FROM THE ADMINISTRATOR

It is with great pleasure that we present the 2023-2028 Silver State Health Improvement Plan (SSHIP). This is Nevada's first statewide public health improvement plan, and the result of the dedication and engagement of countless partners who provided time and expertise to develop timely, actionable goals and objectives to improve the health of Nevadans. To all who contributed—thank you!

The field of public health works to protect, promote, and improve the health and safety of communities, and the job of the Division of Public and Behavioral Health (DPBH) within the state's Department of Health and Human Services (DHHS) is to ensure all of the people of Nevada—no matter their circumstances—can live the safest, longest, healthiest, and happiest lives possible. The SARS-CoV-2 (COVID-19) pandemic significantly affected this work, and brought more attention and awareness to the field of public health than ever before. It also highlighted cracks in the public health system, as well as structural inequities that resulted in certain populations bearing a disproportionate burden of both the disease and associated challenges accessing education, food, health care, and housing.

With the pandemic's lessons front-of-mind, DPBH led the SSHIP planning process, identifying four key health priorities to focus on through 2028. Many of these priorities align with local community health improvement plans, and all emphasize opportunities to improve health equity.

TOP PRIORITIES

The conditions in which people live influence their health more than genetic factors or access to health care services. While this plan could have focused on any number of these **social determinants of health**, it addresses four key issues: food security, health literacy, air quality/ climate change, and supportive housing.

Access to health care, another social determinant of health, has long been a challenge in Nevada, and a severe and ongoing shortage of nearly every type of health care professional affects individuals' ability to obtain necessary primary, oral, and behavioral health care. This plan highlights new efforts and momentum to address these intractable issues.

Mental health and substance use are also key priorities statewide, and the subject of much attention. The SSHIP aims to elevate and highlight ongoing work in these areas across the state. For example, various state agencies are working to address a 2022 investigation by the United States Department of Justice (DOJ) that found Nevada is overly reliant on institutions to care for children with behavioral health needs. In addition, numerous state and local partners are working to transform the state's behavioral health crisis response system, and a variety of initiatives are underway to increase availability of substance use prevention, harm reduction, treatment, and recovery services. Investing in each component of the state's behavioral health system is

essential to providing appropriate, high quality services, and this plan underscores the importance of adequate funding throughout the system.

Finally, with the height of the COVID-19 pandemic behind us, the SSHIP evaluates opportunities to **transform Nevada's governmental public health system** to ensure it is robust enough not only to keep Nevada communities healthy on a daily basis, but also to respond to future public health crises.

A RESOURCE FOR ALL NEVADANS

This plan provides a roadmap for DPBH and community partners—including state and local agencies, community-based organizations, private businesses, nonprofit organizations, health care systems, academic institutions, and other stakeholders—to work together to improve the health of all in the Silver State. It is a living document designed to be adaptable to changing circumstances, opportunities, and challenges, and will be revised as necessary through 2028.

The SSHIP is a resource for all Nevadans—one that can be used as guidance for prioritizing existing activities or setting new priorities, allocating resources, and implementing programs and policies. It also serves as a foundation from which to facilitate collaboration and take collective action because when we align efforts and work together, we can accomplish more and do more to make everyone's lives healthier, happier, longer, and safer.

ALL IN GOOD HEALTH.

– Cody Phinney

Cody Phinney
MPH, Administrator, DPBH

NEVADA'S 2023 – 2028 PRIORITIES TO IMPROVE HEALTH

SOCIAL DETERMINANTS OF HEALTH

ACCESS TO HEALTH CARE

MENTAL HEALTH AND SUBSTANCE USE

PUBLIC HEALTH INFRASTRUCTURE

THE PLANNING PROCESS

The 2023-2028 SSHIP was developed through a collaborative, community-driven strategic planning process for improving health, loosely based on the Mobilizing for Action through Planning and Partnerships (MAPP) framework. This framework informed both the 2022 State Health Assessment (SHA), and the SSHIP planning process.

The SSHIP's community-based Steering Committee was established in August 2022, to provide guidance and direction for the plan. It was comprised of a diverse group of agencies and organizations serving diverse populations, and identified four priorities based on robust data and extensive community feedback. The Steering Committee's initial list of priorities was developed following a review of SHA data, the results of key informant interviews in Nevada's rural counties, a forces of change assessment, and health needs identified in local community health assessments and community health improvement plans.

In November 2022, the Steering Committee solicited community feedback about key priorities through a statewide survey that asked respondents to select their top two priorities (out of eight possible options) based on six criteria: severity, equity, upstream impact, existing momentum, opportunity, and capacity to address them. The priorities identified through the community survey largely reflected those from the SHA and local health assessments, including access to care, mental health, social determinants of health, and substance use. The Steering Committee combined mental health and substance use into one priority and, having just emerged from the worst of the COVID-19 pandemic, added a priority related to improving public health infrastructure statewide.

In January 2023, one subcommittee was formed for each priority. Subcommittees were comprised of representatives of public health, health care, social services, academia, education, housing, transportation, workforce development, and state and local government, among others. Over the course of two to four meetings, each subcommittee reviewed data, identified areas of focus within their specific priority, and developed goals and objectives for each area of focus. Each subcommittee used a unique process or criteria to do this. For example, the Subcommittee on Public Health Infrastructure chose to align its goals and objectives with the Bipartisan Policy Center's *Public Health Forward: Modernizing the U.S. Public Health System*, which provides a framework to guide strategic investments and decision-making to develop a modernized public health system. The Mental Health and Substance Use Subcommittee acknowledged the number of existing initiatives on the topic, and narrowed its focus to issues that had a statewide impact, required major systems change, involved state resources, and were conducted in partnership with others. The Social Determinants of Health Subcommittee reviewed SHA data and focused on areas of higher need, momentum, and/or capacity. The Access to Care Subcommittee relied heavily on existing expertise and ongoing work through statewide workgroups, the legislative process, and subject matter experts. All draft goals and objectives were reviewed and revised in consultation with subject matter experts during the summer of 2023.

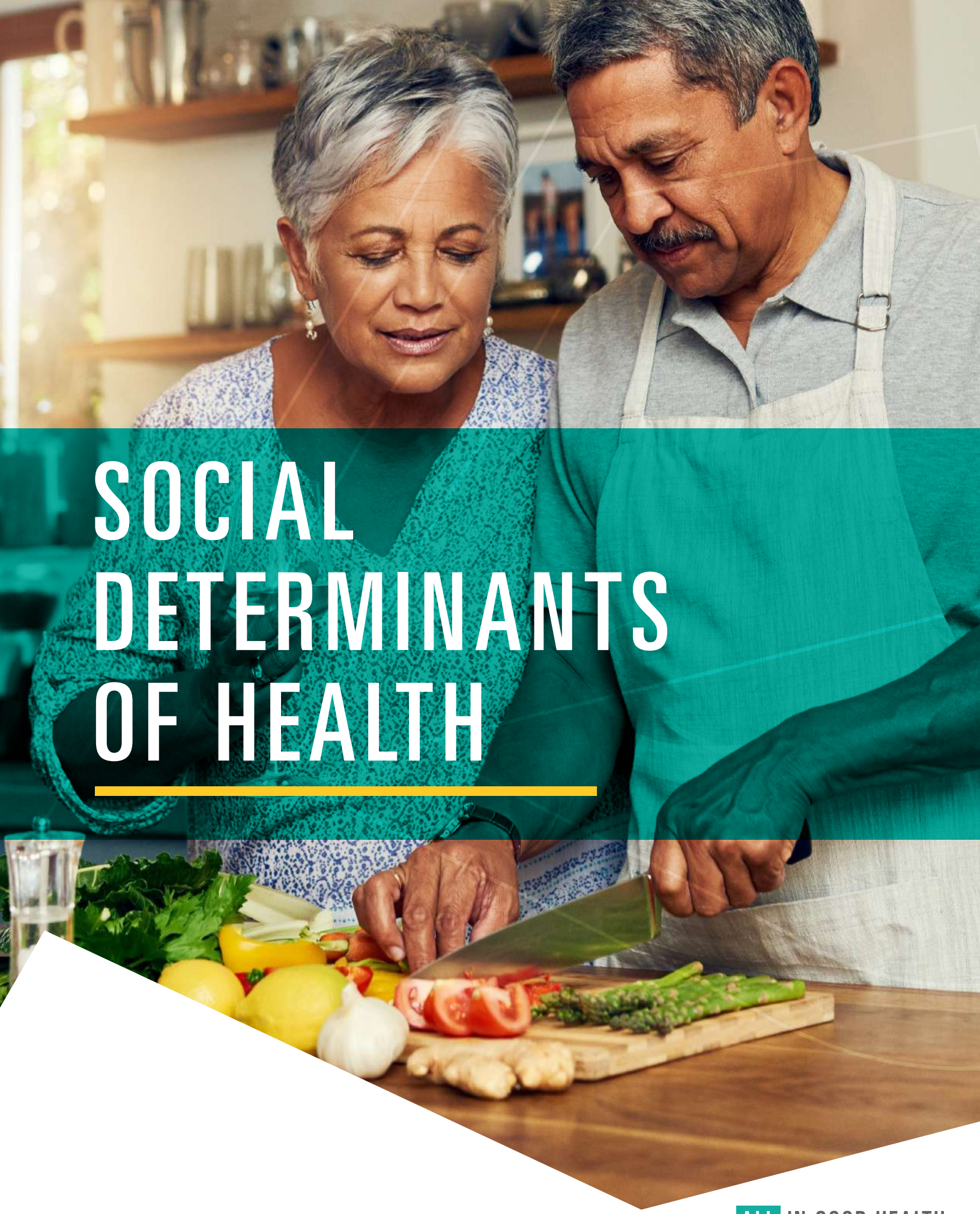
While this plan was published in January 2024, SSHIP implementation began on July 1, 2023. During this period, goals and objectives were actively advanced while the plan was finalized.

FIGURE A: SILVER STATE HEALTH IMPROVEMENT PLANNING PROCESS AND TIMELINE

FIGURE B: SILVER STATE HEALTH IMPROVEMENT PLAN ALIGNMENT WITH LOCAL COMMUNITY HEALTH IMPROVEMENT PLANS

	STATE PRIORITIES										
	ACCESS TO HEALTH CARE			MENTAL HEALTH AND SUBSTANCE USE			SOCIAL DETERMINANTS OF HEALTH				PUBLIC HEALTH INFRASTRUCTURE
RELATED LOCAL PRIORITIES	ACCESS/ HEALTH EQUITY	HEALTH CARE WORK-FORCE	BEHAVIORAL HEALTH WORK-FORCE	CHILDREN'S BEHAVIORAL HEALTH	CRISIS RESPONSE	SUBSTANCE USE DISORDER	FOOD SECURITY	HEALTH LITERACY	AIR QUALITY/ CLIMATE CHANGE	HOUSING / SUPPORTIVE HOUSING	FUNDING, PUBLIC UNDERSTAND-ING/ AWARENESS
SOUTHERN NEVADA HEALTH DISTRICT	X	X (new facilities in medical deserts)	X				X (transportation)	X			X (funding, public understanding/ awareness)
NORTHERN NEVADA PUBLIC HEALTH	X	X	X	X	X		X (access to healthy food)			X (affordable rental housing)	

*Carson City Health and Human Services had not published a recent CHIP at the time of publication.



SOCIAL DETERMINANTS OF HEALTH

INTRODUCTION

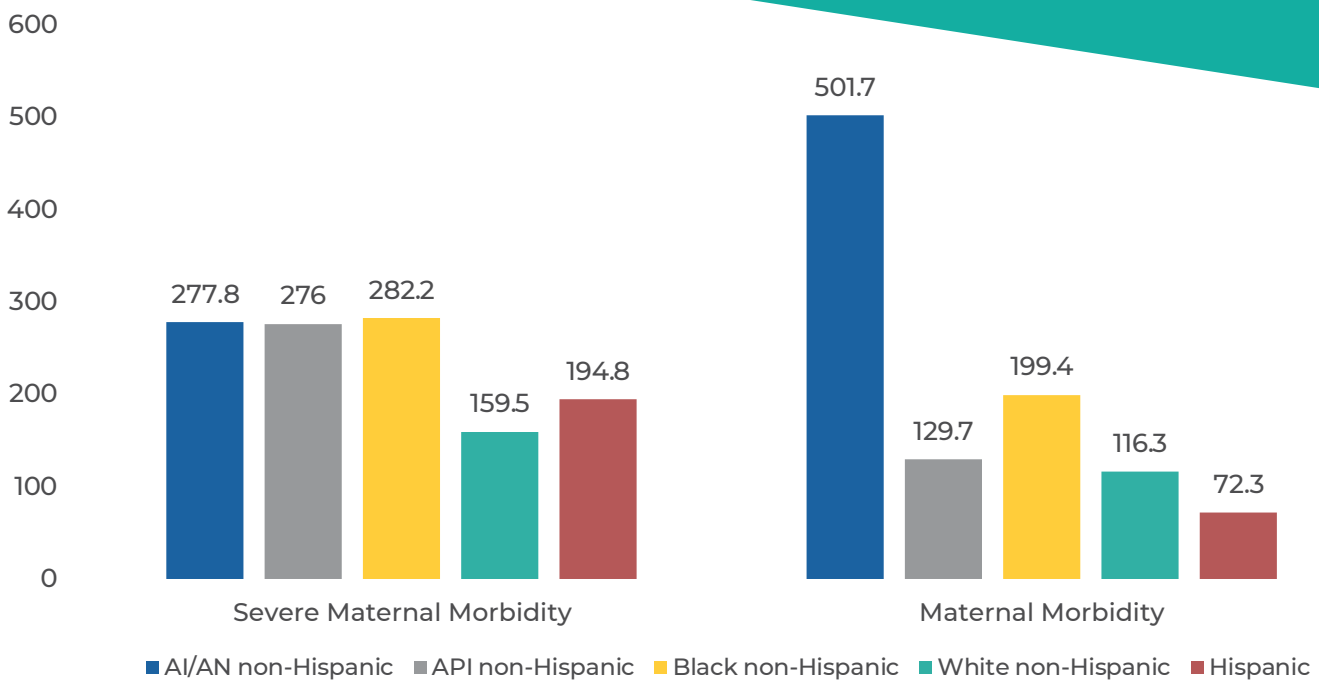
While the health care system traditionally has been viewed as a key driver of health, health behaviors and health outcomes are interconnected to determinants outside of the health care system. In fact, 80 percent of a person's health is determined by social, economic, and environmental factors, and addressing these factors can influence health as much or more than clinical interventions. These "social determinants of health" are the conditions in the environments in which people are born, grow, live, learn, work, play, worship, and age, and affect both health and quality of life. They include factors such as access to quality health care and education, employment and economic stability, neighborhood and physical environment, social support networks, and socioeconomic status. Inequities in social determinants of health lead to disparities in health and health outcomes across populations.[1] For example, poverty is associated with higher risk of chronic disease, mental illness, mortality, and shorter life expectancy,[2] and where a person lives can affect life expectancy by 20 to 30 years, even if only a few miles apart.[3]

Addressing social determinants of health can significantly influence health, but focusing only on these issues overlooks longstanding systems of structural inequities—such as the distribution of resources; differences in the quality of and access to care; and specific opportunities, exposures, and stressors—that affect the health of people and communities. In fact, if certain social determinants of health are addressed without addressing these larger structural inequities, it risks improving the health of some, worsening the health of others, and exacerbating health disparities.[1] Poverty, discrimination—against people of color, women, immigrants, people with disabilities, and LGBTQ+ individuals, among others—and structural racism, in particular, have resulted in longstanding health inequities, which were further exacerbated by the COVID-19 pandemic.

Systems of structural inequities and social determinants of health result in disparities in numerous health conditions and outcomes in Nevada.[4] For example, significant disparities exist in maternal mortality and severe maternal morbidity—unexpected outcomes of labor and delivery that result in major consequences to health. Severe maternal morbidity rates for non-Hispanic American Indian/Alaska Native (AI/AN), Black, and Asian or Pacific Islander (API) individuals in Nevada are more than 1.7 times higher than that of White, non-Hispanic individuals. Disparities are also evident in pregnancy-associated death ratios, defined as deaths of a person while pregnant or within one year of the end of pregnancy. Rates for AI/AN individuals are two and a half times that of Black, non-Hispanic residents, who have the second highest ratio, and nearly seven times that of Hispanic residents.[5] Various factors contribute to these disparities, including, but not limited to, access to and quality of primary care and behavioral health services, health insurance, transportation access, underlying chronic conditions, structural racism, and implicit bias.[6] Similar disparities reflecting long-standing inequities are evident in numerous health conditions and outcomes, further underscoring the need to address social determinants of health to improve health, health equity, overall wellbeing, and quality of life in Nevada.[7]

1. *The "Cliff of Good Health" analogy coined by Dr. Camara Jones explains this concept in more detail.*

FIGURE 1: PREGNANCY ASSOCIATED DEATH (MATERNAL MORTALITY) AND SEVERE MATERNAL MORBIDITY RATIOS, NEVADA, 2020-2021



Source: *Maternal Mortality and Severe Maternal Morbidity Nevada, 2020-2021, Office of Analytics, DHHS, December 2022*

While numerous social determinants of health were discussed and considered in the 2022 State Health Assessment and throughout the state health improvement planning processes, this plan focuses on four key areas, including:

- ☑ Food insecurity;
- ☑ Health literacy;
- ☑ Air quality and climate change; and
- ☑ Housing.

In addition, the Access to Health Care section of the SSHIP is dedicated to issues related to access to health care, another social determinant of health.

FOOD INSECURITY

Food insecurity occurs when households are uncertain they will be able to acquire adequate food to meet the needs of household members due to lack of resources for food.[8] It can be temporary or long-term, but over prolonged periods of time, food insecurity is associated with poor health outcomes and quality of life including chronic disease, mental health issues, and obesity.[9] A variety of factors can influence a household's ability to obtain necessary food—from neighborhood conditions and physical access to food or transportation, to poverty, unemployment, lack of affordable housing or access to health care, systemic racism, and racial discrimination.[10] The ability to obtain healthy food is also important because poor eating habits and insufficient physical activity lead to illness, disability, and chronic diseases that can result in premature death. Reducing food security can help reduce the likelihood of chronic disease, which are among the leading causes of death statewide.

In Nevada, those who are more likely to experience food insecurity include seniors; individuals who are uninsured or undocumented, living in food deserts, experiencing unstable housing or housing insecurity; individuals living in tribal communities; and those who lack access to behavioral health services. The state's geography and population distribution limit access to nutritious foods and present challenges for rural outreach.

Like many other social determinants of health, the COVID-19 pandemic exacerbated food insecurity in Nevada. According to *Feeding America*, which collects state-level information on food insecurity and hunger, the food insecurity rate in Nevada increased between 2019 and 2021, to 13 percent, compared to 10.4 percent nationwide.[11] In addition, while food insecurity can be harmful at any age, lack of access to adequate food can be particularly harmful to children and older adults. Children who are food insecure are more likely to experience developmental impairments in language and motor skills, have social and behavioral problems, and repeat a grade in elementary school.[12] Food insecurity is also a challenge for older Nevadans. The Office of Food Security (OFS), within the Division of Public and Behavioral Health (DPBH) of the state's Department of Health and Human Services (DHHS), estimates nearly 100,000 individuals 60 years of age and older in Nevada will need nutrition or emergency food services by 2025. Older individuals are more likely to live on low, fixed incomes; lack reliable social support and transportation; experience poorer health overall; and have functional limitations that affect their ability to obtain and prepare food. Food insecurity in older adults is strongly associated with diabetes, heart disease, lung disease, stroke, and poor health; it also affects their ability to age in place.[13]

REDUCING FOOD INSECURITY IN NEVADA

The Division of Public and Behavioral Health is involved in various initiatives to reduce food insecurity. For example, the Office of Food Security (OFS) works to reduce hunger, promote public health, and improve health services for children, senior citizens, and people with disabilities, among others, through the Fund for a Healthy Nevada. The OFS also provides administrative support to the Council on Food Security, which works to develop, coordinate, and implement a robust food system in Nevada. The Council was initially established through an executive order in 2014, and codified in *Nevada Revised Statutes (NRS)* 232.496 through Senate Bill 178 during

FOOD INSECURITY

the 2019 Legislative Session. It reviews legislation and policy at the federal, state, and local levels and provides feedback to improve the food policy infrastructure. The Council previously helped redirect edible food that would have been diverted to landfills to communities that needed it, and currently is reviewing the relationship between food waste and climate change, hunger, and economic insecurity.

In addition, the OFS published the 2023 Food Security Strategic Plan, a systemic plan to promote food security efforts statewide. The plan revolves around five themes: leading system change to improve food security through collaboration, information sharing, and policy development; growing local food sources; feeding populations at higher risk of food insecurity; reaching people experiencing food insecurity with nutrition-dense, affordable, and culturally appropriate foods; and building the state's food security ecosystem by increasing capacity and education. It is implementing the plan in collaboration with numerous partners and community-based organizations, such as food banks, food pantries, and a prescription pantry. In Fiscal Year 2023 alone, the resulting collaborations served more than 609,600 individuals and distributed more than 1.67 million pounds of food.

Following the COVID-19 pandemic, DPBH also participated in a program to promote equitable and sustainable food and nutrition security. The State Partnerships Improving Nutrition and Equity (SPINE), program aims to address the economic and social conditions that limit food and nutrition security by evaluating policy, systems, and environmental change, with a focus on health equity. Knowing that early childhood education programs are uniquely positioned to improve breastfeeding, nutrition, and physical activities early in life, DPBH developed a training video for Nevadabreastfeeds.org to support breastfeeding in early childhood education centers; sponsored lactation training certification for six Nevadans, with a focus on Spanish speakers, rural/frontier populations, and African American communities; and expanded the hot meal program and mobile access through Catholic Charities of Northern Nevada.

Finally, traditional food and nutritional support programs play a key role in addressing food insecurity for Nevadans. The federal Supplemental Nutrition Assistance Program (SNAP) provided nutrition benefits to more than 252,400 low-income individuals and families—nearly 1 in 10 Nevadans—to purchase food in 2023,[14] and the program expanded during the COVID-19 public health emergency, providing more than $1 billion in supplemental emergency benefits. In addition, the Nevada Department of Agriculture provides free- and reduced cost meals to children through the National School Lunch Program, School Breakfast Program, and Summer Food Service Program. During the 2022-2023 school year free meals were available to all school children statewide.

FOOD INSECURITY

WHAT CAN WE DO?

The following goal and objectives align with objectives outlined in the 2023 Food Security Strategic Plan.

GOAL 1:

Reduce food insecurity and improve the overall food security ecosystem in Nevada to help eliminate the hunger gap

OBJECTIVES:

1.1: Improve collaboration, communication, coordination, and information-sharing among food ecosystem partners

1.2: Partner with local farmers, food vendors, tribal communities, and other community organizations to support initiatives aimed at increasing mobile access to healthy foods throughout the State of Nevada, and specifically in underserved and remote areas

1.3: Support new strategic partnerships and increase awareness among the food security ecosystem regarding service providers and funding opportunities that can assist with distributing food to people, particularly individuals at increased/ higher risk for food insecurity

1.4: Increase participation in state/federal nutrition programs by individuals experiencing food insecurity and/or who are higher risk for food insecurity

ADDITIONAL PLANS, EFFORTS, AND ALIGNMENT

- Nevada Food Security Strategic Plan (2023), Office of Food Security, DPBH, DHHS
- This area of focus aligns with objectives of Health People 2030 to reduce household food insecurity and hunger.

HEALTH LITERACY

According to Healthy People 2030, health literacy is not simply the result of an individual's ability to find and use health-related information, but also how organizations within the health care system influence (simplify or complicate) this process. Health literacy is critical to improving health and wellness, and involves two key components:

- ***Personal health literacy***—the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others; and
- ***Organizational health literacy***—the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.[15]

On the individual level, health literacy is important because at some point in life, everyone needs to find, understand, and use information about health care services or other services that relate to social determinants of health. It is also important to have a foundational understanding of health, wellness, and the factors that influence health and wellness. Personal health literacy is associated with a range of factors, including age, educational attainment, health insurance coverage, languages spoken prior to beginning school, poverty, racial/ethnic minority status, and self-reported health.[16] People with low health literacy are more likely to visit the emergency department, have more hospital stays, are less likely to follow treatment plans, and have higher mortality rates.[17]

On the organizational level, health care and related organizations serve diverse groups of people with diverse knowledge and life experiences, and need to be able to meet the needs of diverse populations equitably. Poor organizational health literacy affects the quality of health care and health outcomes. For example, individuals living in areas served by organizations with limited health literacy are more likely to experience miscommunication and face challenges accessing services.[18]

Improving both types of health literacy can help reduce health disparities. Increasing personal health literacy disproportionately benefits communities that have been marginalized, and enhancing organizational health literacy can better met the needs of all people by ensuring information is available and used by individuals with varying levels of health literacy.[19] Improving health literacy is also critical to building the trust needed to advance health equity. Trust is essential for people to be willing to engage with systems, care, and behaviors that promote health—regardless of whether the setting is clinical, a public health agency, or a community setting.[20] In addition, health literacy is closely associated with health equity—the attainment of the highest level of health for all—and it will only be achieved when all Nevadans have the opportunity to be as healthy as possible.

HEALTH LITERACY

IMPROVING HEALTH LITERACY AND HEALTH EQUITY IN NEVADA

Language access is critical to health literacy, and when accurate, culturally inclusive messaging is not available to help people make decisions about their health, the result is poor interactions with health care providers, decreased access to health screenings, inaccurate diagnoses, and inadequate treatment of chronic diseases. In 2021, the Nevada Legislature took a step toward improving language access when it passed Senate Bill 318, which requires DPBH and local health districts to take reasonable measures to ensure people with limited English proficiency have meaningful and timely access to services to reduce the spread of COVID-19. The bill also requires each executive branch agency to develop and revise a language access plan. These plans must include information regarding services available to individuals with limited English proficiency and recommendations for improving access to the agency's programs and services for those with limited English proficiency via trained interpreters and translation services, among other things.

The Nevada Office of Minority Health and Equity (NOMHE), within DHHS, also has a significant role in improving health literacy and health equity in the state. The Office works to avoid and reverse health-related disparities among the most vulnerable, high-risk populations in Nevada, with a vision of achieving optimal levels of health and wellness for all minority groups and marginalized communities across the state. Established by the Nevada State Legislature in 2005, lack of resources limited NOMHE's ability to make progress on these issues. However, recent grants expanded its impact, including a variety of resources to improve personal and organizational health literacy in Nevada.

These include the Nevada Health Equity Action Plan (HEAP), which "aims to help government institutions, agencies, and organizations across the state integrate health equity considerations into their work, by providing a framework to examine and challenge practices that perpetuate health inequities." The HEAP includes recommendations that can be used with various populations, as well as strategies for improving health equity in data collection, community engagement and partnership, emergency preparedness, language access, organizational capacity, and policy change and advocacy.

In addition, NOMHE developed the Amplify Equity Toolkit, which highlights best practices, case studies, trainings, modules, and other culturally responsible content, including resources specifically related to improving cultural literacy. The Office also conducted a Core Values Assessment across all divisions of DHHS to "evaluate the processes that prevent equitable provision of services to marginalized communities and identify areas for improvement." The assessment evaluated nine domains, including health literacy and language services, and DHHS used the results to identify priorities and pursue policy changes and operational improvements that focus on health equity.

HEALTH LITERACY

WHAT CAN WE DO?

GOAL 2:

Increase health literacy in Nevada by improving communication access for priority populations to reduce language and other literacy-related barriers

OBJECTIVES:

2.1: Assess and reduce health literacy disparities within marginalized communities and communities of need in Nevada by supporting health equity-related initiatives

ADDITIONAL PLANS, EFFORTS, AND ALIGNMENT

- Nevada Office of Minority Health and Equity, DHHS
  - 2023 Minority Health Report
  - Nevada Health Equity Action Plan, Nevada Office of Minority Health and Equity, DHHS
- Language Access Plan 2022-2023, DPBH, DHHS
- Health Equity in the Workplace, a Toolkit for Advancing Equity at the Organizational Level, Larson Institute for Health Impact and Equity, School of Public Health, University of Nevada, Reno, 2022
- This area of focus aligns with the objectives of Healthy People 2030 to increase the health literacy of the population.

AIR QUALITY AND CLIMATE CHANGE

Air pollution is caused by the release of hazardous substances from both human and natural sources, and major pollutants—carbon monoxide (CO), nitrogen dioxide (NO2), particulate matter (PM), ozone (O3), and sulfur dioxide (SO2)—and are bad for health.[21]

The primary sources of human-caused air pollution are vehicle emissions, fuel oils and natural gas to heat homes, by-products of manufacturing and power generation—including coal-fueled power plants, and fumes from chemical production. Naturally occurring air pollution comes from dust, pollen, wildfire smoke, methane and other gases emitted from decomposing organic material, and volcanic ash and gases. ,[22, 23] While the transportation sector, industry, and power plants are the largest sources of air pollutants in the U.S., air pollution from wildfire smoke, in particular, is becoming increasingly common. [24, 25]

Research shows air pollution can increase the risk of a variety of chronic diseases, including cardiovascular and respiratory disease, cancer, diabetes, obesity, and reproductive, neurological, and immune system disorders. It also contributes to worse health outcomes for individuals living with certain conditions and can increase the likelihood of death, though the effect depends on the length of exposure, concentration, type of pollution, and health status.[26]

Certain populations are more likely to experience the harmful effects of air pollution. These include children, pregnant women, older adults, and those with heart or lung disease. People who live in low-income neighborhoods and communities are also more susceptible to air pollution, as they are more likely to be close to major roads or industrial sources of pollution, experience poor nutrition, and have underlying health conditions.[27]

AIR QUALITY REGULATIONS

The United States Environmental Protection Agency (EPA) regulates air pollution nationwide to improve air quality and mitigate negative consequences on both health and the environment. It monitors six of the most common outdoor air pollutants under the federal Clean Air Act—CO, NO2, PM, O3, SO2, and lead—using health-based air concentration standards known as the National Ambient Air Quality Standards (NAAQS). These standards are reviewed and potentially revised periodically, and states are required to adopt plans to achieve and maintain air quality that meets them.[28]

In Nevada, Chapter 445B of *Nevada Revised Statutes* outlines requirements for controlling air pollution, including requiring the district board of health, county board of health, or board of county commissioners in certain counties to establish and administer an air pollution control program. Currently, this is the responsibility of Clark County's Division of Air Quality; Northern Nevada Public Health (formerly Washoe County Health District) in Washoe County; and, in the rest of the state, the Division of Environmental Protection (NDEP) within the Department of Conservation and Natural

AIR QUALITY AND CLIMATE CHANGE

Each region faces unique air quality challenges, though air pollution from transportation and ozone are common issues in urban Nevada. Wildfire smoke impacts all regions of Nevada, though monitoring for associated pollutants is most prevalent in urban areas. For example, Clark County is heavily affected by regional wildfire smoke, as well as transportation pollution—including pollution that comes from California, Mexico, and Southeast Asia. Dust has also been an issue in southern Nevada, and has resulted in the establishment of robust programs to address it. Wildfire smoke also is an issue of concern in northern Nevada, as the region's geography results in air stagnation in certain weather conditions.

Ozone is also a challenge in urban areas of the state. Often called smog when at ground level, ozone is created by emissions from cars, industrial boilers, power plants, refineries, and other sources that react chemically with sunlight.[29] Ozone is the only pollutant for which any region of the state is not in attainment with federal standards. In Clark County, the Las Vegas Valley is designated as in "moderate nonattainment" for ozone. This is a concern in Washoe County as well, where levels of ozone currently exceed the standard, but the region remains in attainment.

While Nevada meets most national air quality standards, it ranks 47th nationwide for average exposure to particulate matter of 2.5 microns or less (PM2.5)—one of the highest levels and likely due to wildfire smoke—according to America's Health Rankings.[30] While this is just one measure of air pollution, and different from the one adopted by EPA to assess air quality, the American Lung Association also gives nearly all counties for which data is available failing grades for the number of high ozone days and particle matter pollution.[31]

CLIMATE CHANGE

Many of the causes of air pollution also emit greenhouse gases, which contribute to climate change—and Nevada's climate is changing. Temperatures increased by about two degrees over the last century, and eight of the state's 10 warmest years on record occurred between 2000 and 2020, according to the EPA.[32] Already the driest state in the nation, higher temperatures in Nevada result in more extreme droughts, less snow and more rain, and larger, more severe wildfires, with serious consequences for the health of communities.

While the specific impact of climate change is and will be different across Nevada communities, economies, and ecosystems, it will continue to affect the lives of those in the Silver State in the form of threats to public health, agriculture, tourism, the environment, and water resources.[33] Public health consequences range from higher risk of illness, hospitalization, and death due to extreme heat; to respiratory illness and death caused by increased dust and wildfire smoke; and higher risk of flood and reduced water quality.[34] Climate change disproportionately affects the health of children, the elderly, the unhoused, individuals with pre-existing conditions, communities of color, and those with low-income. These consequences are amplified in urban areas, where paved surfaces store heat and can create heat islands.[35] Compounding these problems is the fact that most vulnerable populations and under-resourced communities experience more difficulty in preparing for, adapting to, and recovering from the effects of emergencies and health issues accelerated by climate change.

AIR QUALITY AND CLIMATE CHANGE

Wildfire smoke, in particular, was cited as a frequent concern during 2022 State Health Needs Assessment, and climate change increases the risk of wildfire, smoke production, and air pollution.[36] Smoke can irritate eye and respiratory tract function; exacerbate asthma and heart failure; and lead to premature death. Children, pregnant women, and older adults are especially vulnerable to smoke exposure.[37, 38]

In 2020, Nevada launched the Nevada Climate Initiative, which built on recent activities to address climate change and outlined various goals for reducing greenhouse gas emissions, laying the groundwork for climate adaptation and resilience, and establishing a structure for continued and ongoing climate action across the state.

ENVIRONMENTAL JUSTICE

Air pollution and climate change exacerbate a variety of health risks for marginalized communities, which are disproportionately at risk of exposure to air pollution, extreme heat, and other health hazards. While not unique to Nevada, the disproportionate concentration of environmental health risks to these populations is based in historical discriminatory policies and practices that continue to effect health today, making environmental justice a public health issue.

During the 2023 Legislative Session, the Nevada Legislature considered, but did not pass, at least three bills related to environmental justice. Assembly Joint Resolution 3 proposed amending the Nevada Constitution to guarantee each person the "right to a clean and healthy environment, including pure water, clean air, healthy ecosystems, and a stable climate;" mandating the state conserve, protect, and maintain certain environmental resources regardless of race, ethnicity, gender, geography, or wealth; and prohibiting the state from causing unreasonable degradation, diminution, or depletion of the environment. Assembly Bill 312 would have established the Environmental Justice Advisory Council to advise the legislature, governor, NDEP, or other state agencies on environmental justice; and Assembly Bill 71 would have directed NDEP to conduct an interim study on environmental justice, including communities that face the largest environmental burdens and how to address them.

WHAT CAN WE DO?

Reducing emissions is one of the most effective ways to reduce air pollution, address climate change, and improve the associated effects on the health of communities.[39] Clark County, Northern Nevada Public Health, and NDEP all have specific programs in place to monitor and improve air quality. Educating and informing the public about air quality, extreme heat, and how to stay safe is also critical. In addition, these air quality authorities work to support policies—whether legislation, codes, or ordinances—that help reduce urban heat islands and motor vehicle emissions. This could include, for example, increasing tree canopy coverage; developing and enforcing statewide codes and requirements for green buildings; requiring electric vehicle (EV) charging-ready infrastructure to be installed during construction; and emphasizing renewable energy systems, Smart Trips programs, and active transportation.

AIR QUALITY AND CLIMATE CHANGE

Some of this work falls to state and local air pollution control programs, and some falls to public health authorities. Public health authorities participate in emergency preparedness efforts, coordinate public messaging, and review best practices for mitigation efforts. As one public health preparedness manager put it, "Poor air quality is linked to other threats such as extreme heat, drought, and climate change so we cannot focus our efforts solely on planning or responding to a single threat or hazard. Best approaches require collaboration, communication, and coordination to mitigating negative health outcomes."

GOAL 3:

Reduce exposure to harmful air emissions and climate pollution, and improve ambient air quality and health equity throughout Nevada

OBJECTIVES:

3.1: Increase Nevada's resilience to climate pollution and other pollutants

3.2: Reduce emissions of harmful pollutants

3.3: Improve communication about and accessibility of air quality information

ADDITIONAL PLANS, EFFORTS, AND ALIGNMENT

- All-In Clark County, Clark County's Initiative to Address Climate Change and Resilience
- Nevada Statewide Greenhouse Gas Emissions Inventory and Projections, 1990-2042, NDEP, 2022
- Nevada's State Climate Strategy (developed in 2020)
- 2013-22 Washoe County, Nevada Air Quality Trends Report, Air Quality Management Division, Northern Nevada Public Health, June 22, 2023
- Keep it Clean Programs, Air Quality Management Division, Northern Nevada Public Health
- This area of focus aligns with the objectives of Healthy People 2030 to reduce the number of days people are exposed to unhealthy air.

HOUSING

Housing is an essential social determinant of health, and research shows lack of safe, stable housing is detrimental to physical and mental health.[40] Individuals who experience housing instability—such as frequent moves, falling behind on rent, or couch surfing—are more likely to have poor health than their peers who have stable housing. Housing instability often detracts from regular medical attention, medication compliance, access to treatment, and recuperation, decreasing the effectiveness of health care and leading to more severe conditions and costly treatment. In addition, it can lead to significant stress, mental health problems, obesity, and diabetes. For youth, housing instability is associated with higher risk of depression, early drug use, and teen pregnancy. Lack of stable housing can result in disruptions to other key social determinants of health, such as education, employment, social networks, and social service benefits, further exacerbating health conditions.

Similarly, individuals who experience homelessness generally experience worse health outcomes and higher mortality rates than the rest of the population.[41] They have higher rates of asthma, diabetes, hypertension, and infectious disease, and these and other chronic conditions are exacerbated by poor living conditions and lack of access to health care.[42] Homelessness is also closely associated with mental health and substance use; individuals with behavioral health conditions are more susceptible to homelessness and lack of housing exacerbates mental health and substance use disorders. People experiencing homelessness are disproportionately affected by the ongoing opioid epidemic; they face higher risk of drug-related harms, including hepatitis C, HIV/AIDS, soft tissue infections, and fatal overdose. In addition, average life expectancy of those experiencing homelessness is around 50 years of age—20 to 30 years younger than their housed counterparts.[43] Certain populations in Nevada experience homelessness at disproportionate rates and are at greater risk of poor outcomes, including individuals with serious mental illness or substance use disorder, survivors of domestic violence, and veterans.[44]

SUPPORTIVE HOUSING

Research clearly demonstrates that access to stable housing can improve health and mental health, and reduce health care costs. Supportive housing, in particular, is associated with better health outcomes, including reduced use of emergency departments and lower health care spending. This type of housing generally involves a combination of affordable, permanent housing and assertive, supportive services that vulnerable individuals and families use as a platform for health, recovery and personal growth. Supportive housing typically serves those without housing who experience multiple co-occurring or complex medical, mental health, and/or substance use issues—without requiring them to meet specific requirements.[45]

HOUSING

The Nevada Interagency Council on Homelessness to Housing defines supportive housing as subsidized housing that:

1. Prioritizes people who can benefit from comprehensive support services to retain tenancy; and
2. Utilizes admission practices designed to lower barriers to entry than would be typical for other subsidized or unsubsidized rental housing, especially related to rental history, criminal history, and source of income.

The Interagency Council further describes supportive housing as housing paired with voluntary, tenant-centered support services designed to help individuals living with a disabling behavioral or physical health condition who experienced homelessness or unnecessary institutionalization, or who were at imminent risk of homelessness prior to moving into housing, to retain their housing. Supportive housing services use a "Whole Person Care Coordination" model, assuring access and engagement with health and other needed social services in the community. Specifically, they provide supports to help achieve successful tenancy, improve health, and connect tenants with community-based services, health care, treatment, and/or employment services.[46] Finally, supportive housing is subject to all of the rights and responsibilities defined in Chapter 118A, "Landlord and Tenant: Dwellings," of *Nevada Revised Statutes*.

Supportive Housing...

- Is affordable (less than 30% of tenant income), providing a lease or sublease identical to non-supportive housing, that does not limit the length of tenancy and engages members in supportive services.
- Has demonstrated effectiveness at keeping tenants housed, improving physical and mental health, increasing income and employment, ensuring satisfaction with services and housing, and fostering social and community connections.
- Provides services such as whole person care coordination and housing navigation and sustaining services. Depending upon the population served and financing, services may also include medical treatment, behavioral health treatment, peer support and life skills training.
- Has been shown to achieve short-term health care cost savings, reduce utilization of emergency health services, and decrease psychiatric inpatient events and behavioral health hospitalizations.
- Uses the "Housing First" approach to connect individuals and families experiencing homelessness to permanent housing. The approach reduces barriers to entry and preconditions such as sobriety, treatment or service participation requirements.

Source: Standards for Quality Supportive Housing Guide, CSH, 2022

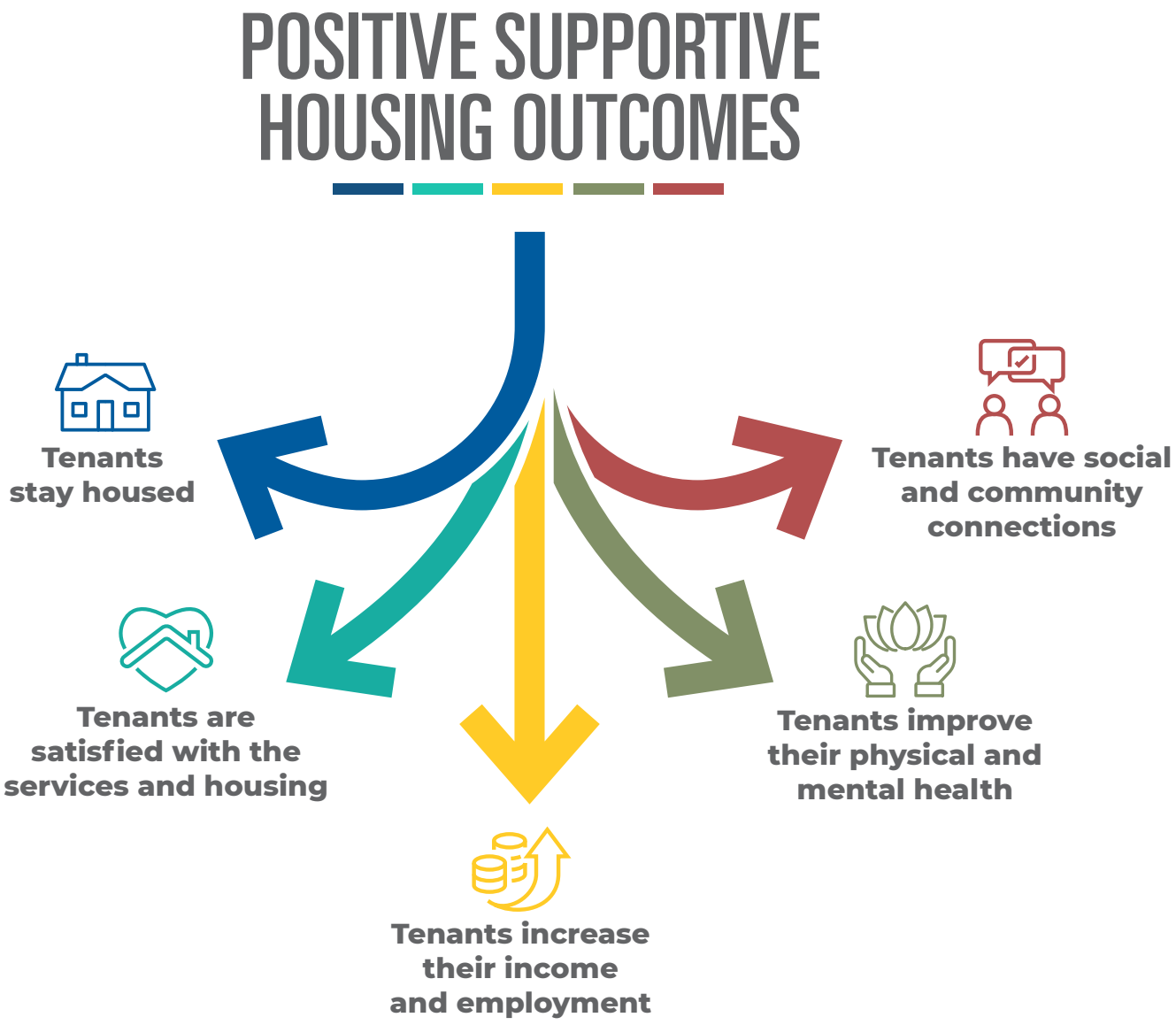
HOUSING

Access to supportive housing helps individuals with multiple chronic or complex health needs, those in recovery, and individuals re-entering the community from the justice system to thrive and be productive members of their communities. Individuals with multiple, chronic health needs often find navigating the complex, fragmented health care system overwhelming, making wraparound supportive services an essential component of linking health care, human services, and housing.[47] Stable housing also is important to long-term recovery, reducing the risk of relapse by enabling individuals to fully engage in treatment without the stress of not having a home. In addition, it can also help stop the cycle of drug use and involvement with the justice system.[48]

However, in Nevada, the inability to access housing is an often-cited barrier to both recovery and reentry, as housing options are limited by background checks and long waits for housing that does not require background checks. In addition, many housing options are time-limited and result in recidivism and cycling between homelessness, justice systems, and institutional care. Mental health care and related services provided in supportive housing are particularly important for lesbian, gay, and bisexual youth experiencing homelessness, who report higher rates of depression, posttraumatic stress disorder (PTSD), self-harm, suicidal ideation, or suicide attempts than their straight, cisgender peers who experience homelessness.[49]

The need for supportive housing in Nevada is identified in numerous regional and state assessments, reports, and strategic plans. For example, nearly all of the state's five regional behavioral health policy boards mention housing, lack of affordable housing, or lack of supportive housing as areas of critical need for individuals with behavioral health challenges. The Northern Regional Behavioral Health Policy Board found that "there is no supportive housing aligned with best practice for residents with mental health issues" in its entire region, which encompasses Carson City and Churchill, Douglas, Lyon, and Storey Counties.[50] In 2019, Corporation for Supportive Housing (CSH) estimated that Nevada needed 6,924 units of supportive housing, including 1,587 for those impacted by the justice system, 824 for aging populations and 799 for individuals with behavioral health needs.[51] The significant need for supportive housing is also acknowledged in various statewide reports and strategic plans related to opioids and substance use. These are listed at the end of this section.

CORE OUTCOMES FOR TENANTS IN SUPPORTIVE HOUSING



Source: Standards for Quality Supportive Housing Guide, CSH, 2022

EFFORTS TO IMPROVE SUPPORTIVE HOUSING IN NEVADA

At the state level, the Nevada Legislature, Nevada Medicaid, the Nevada Interagency Advisory Council on Homelessness to Housing, and the Housing Division within the state's Department of Business and Industry are taking steps to increase the capacity and improve the quality of supportive housing.

Medicaid

in 2019, the Nevada Legislature passed Senate Bill 425, requiring the director of DHHS to include in the State Plan for Medicaid an option to provide certain additional home and community-based services, including tenancy support services to help Medicaid recipients obtain and remain in adequate housing.

Following passage of SB 425, the Division of Health Care Financing and Policy (DHCFP/Medicaid), DHHS, began efforts to pursue a 1915i State Plan Amendment to help develop stable revenue to fund tenancy supports for Medicaid recipients experiencing homelessness. Ultimately, the Division chose not to pursue this option and instead began pursuing a 1915(b)(3) Medicaid State Plan Amendment that would give Medicaid managed care organizations the flexibility to use Medicaid dollars to pay for tenancy support services. This strategy, known as "in lieu of service," will enable managed care plans to offer medically appropriate, cost-effective services as alternatives to other, more costly covered services. To qualify for these services, Medicaid managed care recipients must experience or be at risk of experiencing homelessness and have at least one qualifying condition or meet other qualifying criteria. The "in lieu of service" applies only to Medicaid recipients served by a managed care organization, which are the vast majority of Medicaid recipients. The DHCFP is continuing to work to identify an appropriate way to reimburse tenancy support services for recipients covered under Medicaid Fee-for-Service. Additional information about these efforts is available in this presentation and Nevada Medicaid Managed Care: A Proposal for Housing Supports as In Lieu of Services.

Nevada Interagency Advisory Council on Homelessness to Housing

In 2019, the Legislature passed Assembly Bill 174, codifying the Nevada Interagency Advisory Council on Homelessness to Housing (ICH) in state statute, and continuing the work of the Governor's Interagency Council on Homelessness, which was first established through an executive order in 2013, by then-Governor Brian Sandoval. The Advisory Council is responsible for collaborating with state and local agencies to respond to homelessness, increasing awareness of issues related to homelessness, and promoting cooperation among federal, state, and local agencies to address homelessness. Members include a representative of the Governor's Office, DHHS, Department of Corrections, Housing Division, Department of Veterans Services, as well as local sheriffs, state legislators, district judges, and individuals with lived experience. Bringing this diverse group together provides an opportunity for the state to take an integrated approach to addressing homelessness through interagency cooperation.

HOUSING

In 2022, the ICH updated its strategic plan to address homelessness based on guidance and recommendations from the group's Technical Assistance Committee. The strategic plan outlines the ICH's mission, values, guiding principles, and eight strategic issues for which it identifies specific goals. Goals related to supportive housing recommend developing infrastructure for a work group on supportive housing, providing resources and other support to expand the availability of supportive housing in Nevada, and supporting housing policies that prioritize funding for permanent supportive housing. The Technical Assistance Committee is developing an action plan to make progress toward these and other goals.

Housing Division and the Supportive Housing Development Fund

In 2023, the Nevada Legislature passed Assembly Bill 310, establishing the Supportive Housing Development Fund and appropriating $32.2 million to it from the State General Fund to:

- Develop supportive housing by funding supportive services connected with affordable housing units for those experiencing homelessness or at extreme risk of homelessness—that is, those with less than 30 percent of area median income;
- Build capacity of nonprofits to deliver high quality supportive services through intensive case management; and
- Measure the outcomes to provide data regarding the cost effectiveness of supportive housing compared to emergency crisis services.

The money may not be used for construction costs.

The Nevada Housing Division, within the state's Department of Business and Industry, is responsible for implementing AB 310. As of late 2023, the Division had convened an internal working group and met with advocates to understand the intent of the bill; began drafting required regulations and working on establishing the fund to receive the appropriated general funds; and it is planning to hire two full-time equivalents (FTEs) in early 2024 to oversee the program and ensure grantees adhere to program requirements. In the near future, the Division will schedule a workshop to solicit feedback on the draft regulations, revise them, and submit them for official drafting. In addition, it will consult with the Interagency Advisory Council on Homelessness to Housing regarding potential funding awards, with a goal of making funding opportunities available late winter or early spring 2024.

HOUSING

WHAT CAN WE DO?

GOAL 4:

Increase the availability of supportive housing in Nevada through greater cross-sector, interagency collaboration, and the development of supportive housing units

OBJECTIVES:

4.1: Establish the infrastructure for a work group on supportive housing to create accountability to guide state policy on permanent housing solutions to address homelessness and housing insecurity for people with complex needs comprised of housing providers, advocates, people with lived experience, and specialized subpopulation experts. Define service models and potential for service financing including Medicaid financing

4.2: Support implementation of Assembly Bill 310, the Supportive Housing Development Fund, and leverage evaluation data to help inform longer-term service funding investments with sources like Medicaid

4.3: Support provider capacity-building efforts by assisting community-based organizations and supportive housing projects with determining their total cost of care

4.4: Work with the Division of Health Care Financing and Policy to expand Medicaid's SDOH strategy within its managed care program, including strengthening screening for homelessness and housing instability of their members as part of the state's in lieu of coverage program for housing supports and services. Ensure that regular reporting of this data is part of the managed care organization reporting to the state and reported to the Interagency Council on Homelessness to Housing.

ADDITIONAL PLANS, EFFORTS, AND ALIGNMENT

- Nevada Medicaid Managed Care: A Proposal for Housing Supports as In Lieu of Services, November 29, 2022
- Nevada Interagency Advisory Council on Homelessness to Housing Strategic Plan, October 2022
- Housing and Health Partners Can Work Together to Close the Housing Affordability Gap, January 17, 2020, Center on Budget and Policy Priorities, Peggy Bailey
- Behavioral Health Community Integration Strategic Plan: Nevada's 2023 update to the Strategic Plan for Behavioral Health Community Integration, DPBH, DHHS
- Substance Use Disorder and Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report, DHCFP, DHHS, December 2020
- Regional Behavioral Health Policy Boards annual reports and recommendations

WHAT CAN WE MEASURE?

The indicators below will be monitored by DPBH to evaluate progress toward the goals outlined in this section through July 2028. Specific metrics, as well as baseline and target data, will be available as an addendum to this document.

- Decrease in household food insecurity
- Increase the number of clients served by food security service providers
- Increase the percent of population eligible for SNAP who participate
- Annual health literacy accountability report[2]
- Reduce the number of designated Hydrographic Areas that do not meet EPA health standards air pollutants under the Clean Air Act
- Increase in the number of zero and/or low emissions light and medium-duty vehicles registered in Nevada
- Funding distributed through the Supportive Housing Development Fund (AB 310, 2023)

[2] Assessing health literacy can help target support and resources to the communities that need it most, measuring aggregate personal and organizational health literacy across the state is challenging and has various limitations. For these reasons, progress toward this goal will be documented through an annual report that documents the progress toward improving health literacy throughout the state.

Endnotes

1. *American Academy of Family Physicians. (2019). Advancing Health Equity by Addressing the Social Determinants of Health in Family Medicine (Position Paper). Retrieved from https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine-position-paper.html*
2. *Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). Poverty. Retrieved from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty#*
3. *Graham, G. N. (2016). Why Your ZIP Code Matters More Than Your Genetic Code: Promoting Healthy Outcomes from Mother to Child. Breastfeed Med, 11, 396-397. doi:10.1089/bfm.2016.0113*
4. *Office of Analytics. Department of Health and Human Services (DHHS). (April 2023). Minority Health Report 2023. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Minority%20Health%20Report%202023(1).pdf*
5. *Office of Analytics. DHHS. Maternal Mortality and Severe Maternal Morbidity Nevada, 2020-2021. Carson City, Nevada. December 2022. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/MMRC%20MM%20and%20SMM%20LCB%20Report%20December%2028%202022%20FINAL.pdf*
6. *Centers for Disease Control and Prevention. (April 3, 2023). Working Together to Reduce Black Maternal Mortality. Retrieved from https://www.cdc.gov/healthequity/features/maternal-mortality/index.html#:~:text=States%20and%20communities%20can%3A&text=Identify%20and%20address%20social%20factors,and%20racial%20and%20economic%20inequality*
7. *Parolina, Z., & Leeb, E. K. (2022). The Role of Poverty and Racial Discrimination in Exacerbating the Health Consequences of COVID-19. Lancet Reg Health Am, 7, 100178. doi:10.1016/j.lana.2021.100178*
8. *Coleman-Jensen, A., Rabbitt, M. P., Gregory, C. A., & Singh, A. (2022). Household Food Security in the United States in 2021. U.S. Department of Agriculture, Economic Research Service. Retrieved from https://www.ers.usda.gov/webdocs/publications/104656/err-309_summary.pdf?v=3323.9*
9. *Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). Food Insecurity. Retrieved from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity#*
10. *Feeding America. (n.d.). Hunger and food insecurity. Retrieved from https://www.feedingamerica.org/hunger-in-america/food-insecurity*
11. *Feeding America. (n.d.). Food Insecurity among Overall (all ages) Population in Nevada. Retrieved from https://map.feedingamerica.org/county/2021/overall/nevada*
12. *Nevada DHHS (2023). Nevada Food Security Strategic Plan 2023. Retrieved from https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/FINAL_FSSP.pdf*
13. *Ibid.*
14. *Nevada DHHS. (n.d.) Division of Welfare and Supportive Services (DWSS) Programs - Supplemental Nutrition Assistance Program (SNAP). Retrieved from https://app.powerbigov.us/view?r=eyJrIjoiYmUzYTczNjEtOTljNS00MjkxLWJiYTMtMmQ1Mzk2ZGIyZTQyIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9*
15. *Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.) Health Literacy. Retrieved from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/health-literacy*
16. *Ibid.*
17. *Centers for Disease Control and Prevention, Office of Readiness and Response (n.d.) Infographic: Health Literacy. Retrieved from https://www.cdc.gov/orr/infographics/healthliteracy.htm*
18. *Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.) Health Literacy. Retrieved from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/health-literacy*
19. *Ibid.*
20. *Centers for Disease Control and Prevention (n.d.). What is Health Literacy? Retrieved from https://www.cdc.gov/healthliteracy/learn/index.html*
21. *Li, Dingsheng, (September 13, 2023). Sustainability for all: considerations for the electrification of transportation; UNR School of Public Health; Presentation at Nevada Public Health Association Conference 2023.*
22. *National Institute of Environmental Health Services (n.d.). Air Pollution and Your Health. Retrieved from https://www.niehs.nih.gov/health/topics/agents/air-pollution/index.cfm*
23. *Pfleger, E., Adrian, C., Lutz, R., & Drexler, H. (2023). Science communication on the public health risks of Air Pollution: A computational scoping review from 1958 to 2022. Archives of Public Health. BioMed Central. https://archpublichealth.biomedcentral.com/articles/10.1186/s13690-023-01031-4*
24. *Li, Dingsheng, (September 13, 2023). Sustainability for all: considerations for the electrification of transportation; UNR School of Public Health; Presentation at Nevada Public Health Association Conference 2023.*
25. *Burke, Marshall, et. al., The contribution of wildfire to PM2.5 trends in the USA. Nature. Doi:10.1038/s41586-023-06522-6*
26. *National Institute of Environmental Health Sciences. (n.d.). Air pollution and your health. Retrieved from https://www.niehs.nih.gov/health/topics/agents/air-pollution/index.cfm*
27. *U.S. Environmental Protection Agency. (n.d.) Research on Health Effects from Air Pollution. Retrieved from https://www.epa.gov/air-research/research-health-effects-air-pollution*
28. *U.S. Environmental Protection Agency. (n.d.) Clean Air Act requirements and history. Retrieved from https://www.epa.gov/clean-air-act-overview/clean-air-act-requirements-and-history*
29. *Division of Air Quality, Clark County (n.d.). Criteria Pollutants. Retrieved from https://www.clarkcountynv.gov/government/departments/environment_and_sustainability/division_of_air_quality/planning/criteria_pollutants.php*
30. *United Health Foundation. (n.d.). Air pollution in the United States. America's Health Rankings. Retrieved from https://www.americashealthrankings.org/explore/measures/air*
31. *American Lung Association (2023). State of the Air Report Card: Nevada. Retrieved from https://www.lung.org/research/sota/city-rankings/states/nevada*
32. *U.S. Environmental Protection Agency (2016). What Climate Change Means for Nevada. Retrieved from https://19january2017snapshot.epa.gov/sites/production/files/2016-09/documents/climate-change-nv.pdf*

33. *University of Nevada, Reno, College of Agriculture, Biotechnology and Natural Resources (n.d.). Climate Change Impacts in Nevada. Retrieved from https://extension.unr.edu/publication.aspx?PubID=3957*
34. *Ibid.*
35. *Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (n.d.) Environmental Conditions. Retrieved from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/environmental-conditions*
36. *United State Environmental Protection Agency (n.d.) Research on Health Effects from Air Pollution. Retrieved from https://www.epa.gov/air-research/research-health-effects-air-pollution*
37. *Ibid.*
38. *University of Nevada, Reno, College of Agriculture, Biotechnology and Natural Resources (n.d.). Climate Change Impacts in Nevada.*
39. *World Health Organization (n.d.). Air Pollution. Retrieved from https://www.who.int/health-topics/air-pollution#tab=tab_1*
40. *Taylor, Lauren A. (2018). Housing and Health: An Overview of the Literature, Health Affairs. Retrieved from https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/*
41. *National Health Care for the Homeless Council. (2019). Homelessness and Health: What's the Connection, Fact Sheet https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf*
42. *Nevada DHHS, Nevada Interagency Advisory Council on Homelessness to Housing Strategic Plan. (October 2022). Retrieved from https://dwss.nv.gov/uploadedFiles/dwssnvgov/content/Energy/NV%20ICHH%202022%20Strategic%20Plan.pdf*
43. *National Coalition for the Homeless, 2018*
44. *Nevada DHHS, Nevada Interagency Advisory Council on Homelessness to Housing Strategic Plan. (October 2022).*
45. *CSH. (2022). Standards for Quality Supportive Housing Guide. Retrieved from https://www.csh.org/wp-content/uploads/2022/11/Standards-for-Quality-Supportive-Housing-Guidebook-final-2022.pdf*
46. *Nevada DHHS, Nevada Interagency Advisory Council on Homelessness to Housing Strategic Plan. (October 2022).*
47. *Ibid.*
48. *DHCFP, DHHS (2020). Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report.*
49. *Nevada DHHS, Nevada Interagency Advisory Council on Homelessness to Housing Strategic Plan. (October 2022).*
50. *2022 Northern Regional Behavioral Health Policy Board Annual Report (2022). Retrieved from https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Boards/CBH/Meetings/2023/2022%20NRBHPB%20report%204.1.2023%20FINAL.pdf*
51. *Data from CSH provided via personal email communication on November 27, 2023.*

ACCESS TO HEALTH CARE

INTRODUCTION

Access to health care generally refers to the timely use of personal health services to achieve the best possible health outcomes, and was cited frequently during the 2022 State Health Assessment.[53,54] Key factors that influence an individual's ability to access quality care include health insurance coverage, health care workforce shortages, time and distance from and transportation to health care services, and whether services are provided in a culturally and linguistically-appropriate manner.[55] These factors can either facilitate or impede access to care and influence the risk of both health disparities and poor health outcomes.

Health insurance, for example, helps reduce the cost of health care for individuals and families, and lack of insurance or insufficient insurance coverage can lead individuals to forgo necessary care, with negative consequences for their health. In Nevada, the number of residents without health insurance declined by more than half since the passage of the federal Patient Protection and Affordable Care Act—from nearly 23 percent in 2010 to 11 percent in 2021. Despite this progress, Nevada still ranks among the states with the highest rates of uninsured residents.[56] In addition, having health insurance does not guarantee access to care, especially for the 20 percent of Nevadans who have Medicaid, the state-federal public health insurance program.

The number and geographic distribution of health care professionals also affects an individual's ability to receive care, and though the supply of health professionals in Nevada increased in recent years, persistent, widespread shortages remain across nearly every type of health care provider in many regions of the state. In fact, 70 percent of the state's population lives in an area designated by the federal government as having a shortage of primary care health professionals, 66 percent live in a dental health professional shortage area, and 87 percent live in a mental health professional shortage area.[57] These shortages can result in longer wait times and delayed care, and are more acute in rural and frontier areas.

Transportation is key to accessing necessary services, and transportation challenges are often worse in rural Nevada, where the nearest provider may be hundreds of miles away. Limited time off from work and travel costs also pose challenges to accessing care. These barriers lead not only to poorer health outcomes, but also to health disparities.

Finally, stigma, bias, and lack of culturally- and linguistically-appropriate services influence the quality of the patient-provider interaction, as well as patients' willingness to seek care or return for future care. Improving the cultural competence of health care providers and systems helps enhance both the quality of care and health outcomes and reduces health disparities.

This Plan focuses on three key areas to increase access to high-quality health care. These align with various objectives of Healthy People 2030, and include:

- ☑ Increasing access to oral health care services;
- ☑ Growing and diversifying the behavioral health workforce to improve access to mental health and substance use services;
- ☑ Increasing the number of health care providers and diversity of the health care workforce to better reflect and meet the needs of the communities they serve.

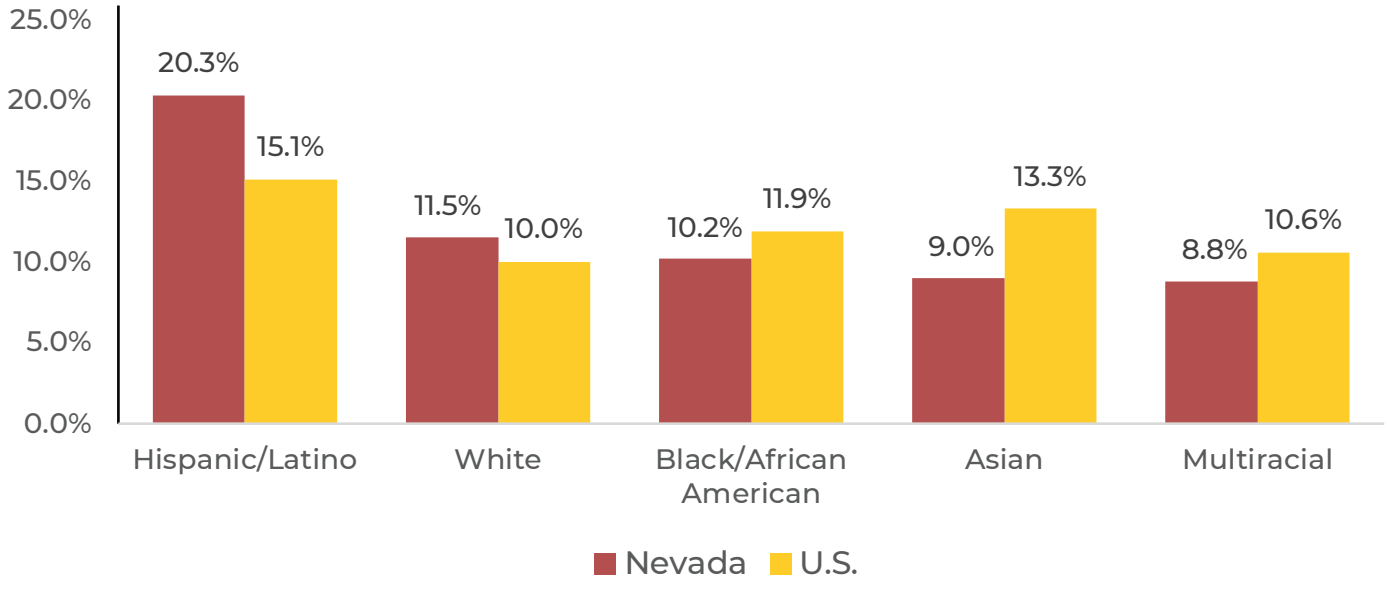
ORAL HEALTH

Access to oral health care influences a variety of health outcomes yet is often overlooked. Oral diseases can cause not only pain and disability, but are also linked to diabetes, heart disease, and stroke. In children they can affect development, nutrition, and overall health. If left untreated, early childhood caries—tooth decay in children less than 6 years of age—destroys tooth structure and can result in pain, infection, loss of chewing function, and early loss of teeth. This is particularly important as tooth decay is the most common chronic disease in both adults and children.[58]

Yet despite the fact that these conditions are largely preventable, many do not receive the care they need. In 2020, only 40 percent of Nevadans reported visiting a dentist or dental clinic in the past year—up from 35 percent in 2018.[59] Rates are slightly higher for children; in 2019, 66 percent of middle school students and 71 percent of high school students reported visiting a dentist in the past year.

In addition, significant disparities exist in oral health across various groups, including underserved and historically marginalized populations, Hispanic families and children, individuals with disabilities, pregnant people, and seniors. For example, in Nevada rates of tooth decay and cavities are disproportionately higher among children who are Hispanic/Latino, from households that speak a language other than English, and from low-income households. In addition, rates are higher in Nevada than the U.S. overall, demonstrating the need for culturally competent dental outreach and awareness programs in multiple languages.

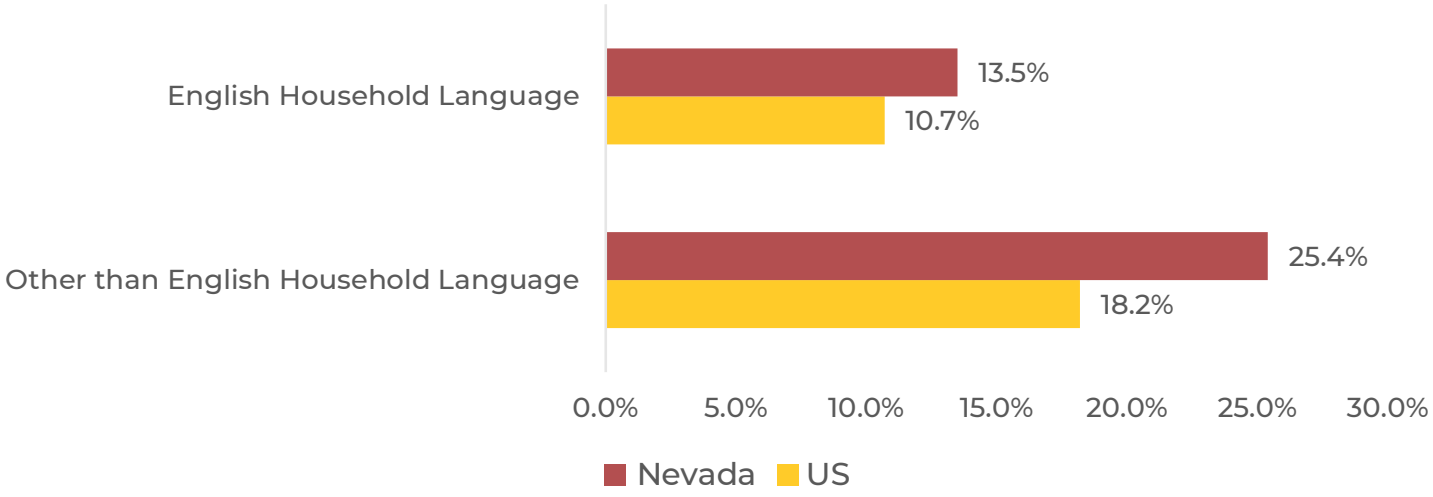
FIGURE 2: PERCENT OF CHILDREN AGES 1-17 WITH DECAYED TEETH OR CAVITIES, BY RACE/ETHNICITY, NEVADA AND U.S., 2019-2020



Source: Oral Health Is Health, 2022-2032 Nevada Oral Health State Plan, Oral Health Program, DHHS, July 2022

ORAL HEALTH

FIGURE 3: PERCENT OF CHILDREN AGES 1-17 WHO HAVE DECAYED TEETH OR CAVITIES IN THE PAST YEAR, BY HOUSEHOLD LANGUAGE, NEVADA AND U.S., 2019-2020



Source: Oral Health Is Health, 2022-2032 Nevada Oral Health State Plan, Oral Health Program, DHHS, July 2022

ORAL HEALTH

Oral health workforce shortages, distribution of oral health providers, and lack of dental insurance coverage all contribute to challenges accessing care. And while approximately 66 percent of all residents live in dental health professional shortage areas, the issue is even worse in rural Nevada, where 88 percent of residents live in areas without enough dental providers.[60] The high cost of dental care and lack of insurance coverage also affect access; those with health insurance are much more likely to access dental care. In 2019-2020, for example, 75 percent of children who were insured received a preventive dental visit, compared to 41 percent of children who were uninsured.[61] Yet it can be challenging to obtain dental care, even for those who have insurance, because not all oral health providers accept Medicaid, further exacerbating access care.

To improve access to oral health care, DPBH is working to build the capacity of the Nevada Oral Health Program, expand the workforce pipeline, and improve access to oral health care, especially in rural Nevada.

IMPROVING ORAL HEALTH IN NEVADA

The Nevada Oral Health Program within DPBH was established in the early 2000s, and aims to protect, promote, and improve the oral health of Nevadans. The Office is staffed by the State Dental Health Officer within the Division of Health Care Financing and Policy (Medicaid), DHHS, and a part-time State Public Health Dental Hygienist.

For the past decade, limited funding constrained the Office's work; however, in 2022, it published the first oral health state plan in 10 years—representing "a reset and a significant investment in Nevada's oral health." The Office is also conducting much-delayed screening of children's oral health, supporting school-based sealant program, working with partners to expand dental benefits to Medicaid recipients with intellectual disabilities/developmental disabilities, and supporting various oral health workforce development initiatives.

- **2022-2032 Nevada Oral Health State Plan.** The 2022-2032 Nevada Oral Health State Plan aims to:
  - Increase understanding that oral health is health;
  - Provide a roadmap to improve oral health across the state by reducing the burden of oral disease with a focus on health disparities and underserved populations; and
  - Identify objectives and strategies for advancing oral health priorities at the state and local level.

  The Plan addresses various priorities, including improving state oral health infrastructure and implementing an oral health surveillance plan. Progress toward implementation will be monitored against an implementation and evaluation plan, as well as regular reports to the Advisory Committee on the State Program of Oral Health.

- **Conducting children's oral health screening.** The Nevada Oral Health Program, in partnership with others, is screening third graders throughout the state for tooth decay, sealants, and urgency of oral health needs. National best practices indicate this data should be collected every 5 years; however, in Nevada, it has not been conducted since 2008. The project is expected to be completed in early 2024, and a report with findings will be available in the spring of 2024. The resulting data will help guide targeted prevention efforts.

ORAL HEALTH

- **Supporting school-based sealant programs.** Dental sealants are an effective means of preventing tooth decay by covering or "sealing" the grooves and crevices found on the top of molar teeth where most tooth decay begins. By covering these pits and fissures, dental sealants are able to prevent tooth decay by as much as 80 percent over a two-year period. However, as a result of the COVID-19 pandemic, many school-based sealant programs closed. Funding from the American Rescue Plan Act (ARPA) is being used to support new and existing school-based sealant programs.

- **Expanding dental benefits to ID/DD waiver recipients.** ARPA funding also is supporting temporary expanded dental benefits for Medicaid recipients who are 21 year of age and older and covered under the Home and Community-Based Services Waiver for Individuals with Intellectual and Development Disabilities (ID/DD Waiver). The program, Every Smile Matters Nevada, is led by DHCFP, the Oral Health Program, and the Aging and Disability Services Division, DHHS. It expands covered dental services from emergency extractions, pain management, and in certain cases, dentures/partial dentures to include services such as routine cleanings, deep cleanings, fluoride treatment to prevent cavities, fillings, crowns, root canals, and bite guards.

- **Providing oral health workforce development opportunities.** The Office of Oral Health received a grant from the federal Health Resources and Services Administration (HRSA) to provide dental assisting curriculum to high school students in rural Nevada to increase workforce capacity and introduce students to the dental profession; train school nurses on oral health screenings; educate dental health professionals interested in public health about expanding services in dental health professional shortage area. It is also conducting continuing education events for oral health providers in the state.

- **Expanding access to oral health care.** The HRSA grant also is helping support a new dental clinic in Tonopah, as well as a statewide oral health needs assessment.

Due to anticipated budget changes after the 2023-2025 Biennium, securing grant funding like the HRSA grant will be key to continuing the Office's efforts to improve the oral health of Nevadans.

In addition, during the 2023 Legislative Session, the Legislature approved Senate Bill 44, transferring the Oral Health Program, state dental health officer, and state public health dental hygienist under the director of DHHS.

ORAL HEALTH

WHAT CAN WE DO?

GOAL 1:

Increase access to oral health care services in Nevada

OBJECTIVES:

1.1: Improve prevention efforts to reduce prevalence of early childhood caries (ECC) and provide timely care for children with ECC

1.2: Develop systems to provide oral health surveillance for the State of Nevada through the Oral Health Program within the Department of Health and Human Services

1.3: Increase access to oral health care in rural Nevada by expanding clinics and patient access points

1.4: Build the infrastructure capacity of the Nevada Oral Health Program to improve oral health statewide

ADDITIONAL PLANS, EFFORTS, AND ALIGNMENT

- Oral Health is Health: 2022-2032 Nevada Oral Health State Plan, Oral Health Program, Division of Public and Behavioral Health, DHHS
- This area of focus aligns with Healthy People 2030 objectives related to oral health.

BEHAVIORAL HEALTH WORKFORCE

Access to behavioral health services—those that treat mental health and substance use disorders—is critical to ensuring individuals receive the support necessary to address their illnesses. Yet Nevada struggles to provide sufficient behavioral health care to residents. In 2020, 508,000 Nevadans met the criteria for any mental illness, and 332,000 received mental health services. In addition, 371,000 Nevadans had a substance use disorder, and 355,000 needed substance use disorder treatment in a specialty facility but did not receive it.[62] According to Mental Health America, the Silver State ranks 39th in the nation for access to mental health care, 40th for adult mental health, 51st for youth mental health, and 51st overall, based on a comparison of various measures related to the prevalence of mental illness and access to care.[63]

Lack of access to behavioral health care is particularly acute for children in Nevada. A 2022 investigation by the Civil Rights Division of the United States Department of Justice found insufficient access to essential community-based services, and an inadequate network of behavioral health providers, among other things. This issue is discussed in more detail in the Mental Health and Substance Use section regarding children's behavioral health.

Nevada's severe and ongoing shortage of the behavioral health professionals is a key factor influencing access to behavioral health services; and despite the fact that the number of these professionals increased in recent years, 87 percent of the state's population—more than 2.84 million people—live in mental health professional shortage areas, including all residents of rural and frontier Nevada. One impact of the provider shortage, according to the DOJ report is months- or years-long waits for assessments and services. For children, in particular, this "results in a crisis-driven system with missed opportunities to intervene when children present as needing help, sometimes resulting in emergency room admissions or hospitalizations."[64]

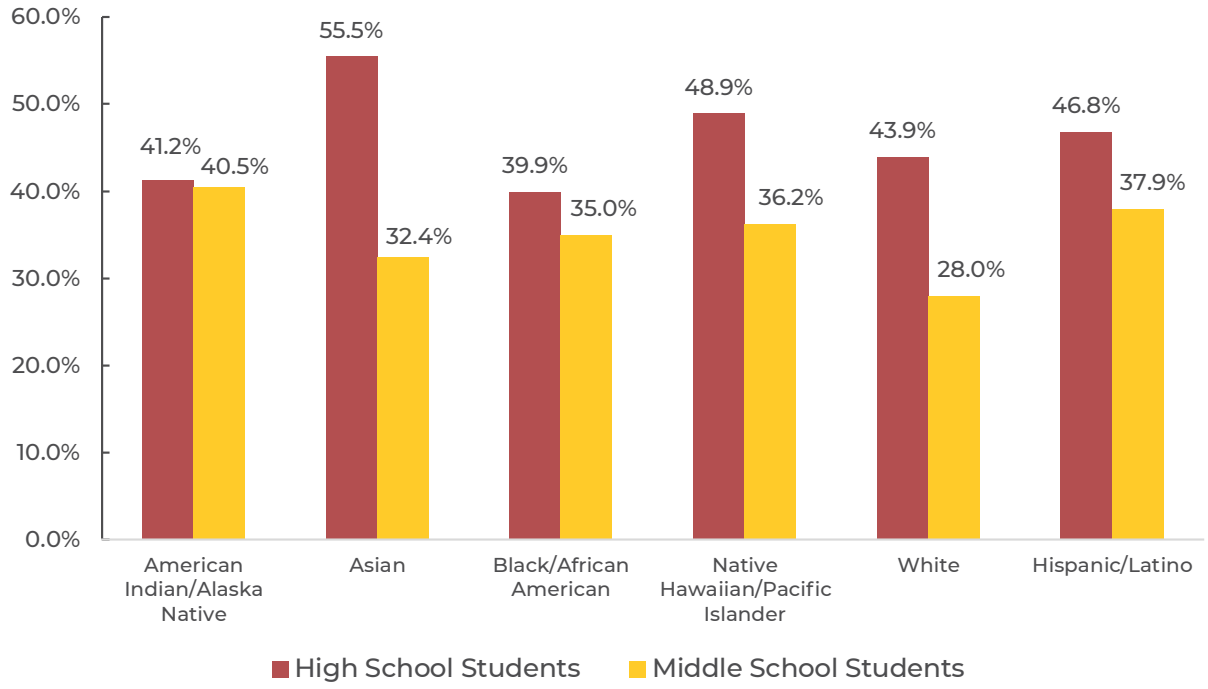
The COVID-19 pandemic compounded Nevada's shortage of behavioral health providers, as demand for behavioral health services increased and behavioral health professionals faced increased workload, higher rates of burnout, and decreased job satisfaction, among other challenges.[65] Nevada needs thousands of additional behavioral health providers just to meet national averages of provider-to-population ratios—and in many areas, the national average is well below a community's actual need. For example, to meet the national average, the state needs an additional 112 marriage and family therapists; 424 mental health and substance use social workers; 193 psychiatrists; 324 psychiatric aides; and 1,714 substance abuse, behavioral disorder and mental health counselors.[66]

Behavioral health provider shortages also affect access to care in schools and, now more than ever, young people need access to these services. In 2021, the U.S. Surgeon General issued an advisory titled *Protecting Youth Mental Health*, calling attention to this urgent public health issue. Prior to the COVID-19 pandemic, mental health challenges were among the leading causes of death and disability among youth, and in recent years, state and national surveys have shown significant increases in mental health symptoms in young people.[67]

BEHAVIORAL HEALTH WORKFORCE

In Nevada, the proportion of high school students who reported persistent feelings of sadness or hopelessness, purposely hurting themselves, considering suicide, planning suicide, or attempting suicide increased between 2017 and 2021. Significant disparities highlight the need for culturally competent services and a diverse workforce. Yet, despite this growing demand for care, Nevada schools currently need twice as many counselors, 3.7 times as many school psychologists, and 35 times as many school social workers to meet national provider-to-population averages.[68]

FIGURE 4: PERCENTAGE OF HIGH SCHOOL AND MIDDLE SCHOOL STUDENTS EXPERIENCING DEPRESSIVE EPISODES, BY RACE/ETHNICITY, NEVADA, 2021



Source: 2021 Nevada Youth Risk Behavior Survey Reports, DPBH and University of Nevada, Reno

Behavioral health workforce shortages result from challenges at various points along education, training, and career pipelines. Opportunities to engage with and introduce young people to behavioral health career opportunities begin as early as K-12, and continue with opportunities to recruit them into the field, educate and train behavioral health professionals, and implement initiatives to retain and support them once they join the workforce. Specific challenges in Nevada include limited capacity in higher education programs, limited internship and practicum opportunities, onerous licensing requirements, and low Medicaid reimbursement rates.[69]

BEHAVIORAL HEALTH WORKFORCE

IMPROVING THE BEHAVIORAL HEALTH WORKFORCE IN NEVADA

Numerous initiatives are underway to increase and retain behavioral health professionals throughout the state, including enhancing the workforce pipeline, offering incentives like loan repayment to practice in underserved areas, helping schools and school districts provide mental health services at school, enabling remote services via telehealth, facilitating paths to professional licensure, expanding use of paraprofessionals such as community health workers and peer recovery support specialists, and upskilling the current workforce, among others.

- **Improving the behavioral health workforce pipeline.** In 2023, the Nevada State Legislature passed Assembly Bill 37 authorizing the establishment of a behavioral health workforce development center to increase the number of high-quality behavioral health providers licensed in the state. The Behavioral Health Education, Retention, and Expansion Network of Nevada (BeHERE NV) will work to develop a robust pipeline for behavioral health providers, incorporate and expand existing successful programs, develop new programs, and reduce barriers to licensure.

  In addition, the Nevada Health Care Workforce and Pipeline Development Workgroup created a Behavioral Health Workforce Pipeline Development Plan, which identifies a vision for the behavioral health workforce in Nevada, as well as specific goals, objectives, and strategies to work toward it. This statewide initiative aimed to improve, grow, and diversify Nevada's public health, behavioral health, and primary care workforces. It brought together more than 40 leaders throughout the state representing public health, behavioral health, primary care, traditional workforce development, K-12 and higher education, minority health and equity, and community-based organizations to break down the silos in which workforce development has traditionally occurred, identify solutions, and develop and implement these strategic plans.

- **Expanding loan repayment options**. The 2023 Legislature also passed Assembly Bill 45, which creates the Student Loan Repayment for Providers of Health Care in Underserved Communities Program to repay student loans of qualified health care providers who commit to practicing for at least 5 years in certain underserved communities. Among the eligible behavioral health providers are clinical professional counselors, psychologists, various social workers, and clinical social workers. This program builds on the state's existing loan repayment program, the Nevada Health Service Corps (NHSC), which was established by the Legislature in 1989. The NHSC has provided loan repayment to 204 health care providers, including marriage and family therapists, clinical psychologists, and licensed clinical social workers.

BEHAVIORAL HEALTH WORKFORCE

- **Increasing access and workforce development opportunities for behavioral health providers in schools.** The Nevada Department of Education, in collaboration with various community partners and coalitions, is working with schools and school districts to enhance school health systems. Schools have had the opportunity to apply for grants to support a mental health provider to provide virtual or in-person services to students at school. In order to make these services sustainable, NDE and Nevada Medicaid are supporting school districts interested in developing a Medicaid billing system. This health equity strategy will create an additional source of revenue to provide greater health support in schools. In addition, NDE is offering frequent training for behavioral health providers in schools in collaboration with Nevada Positive Behaviors Interventions and Supports (PBIS) team at the University of Nevada, Reno.

- **Extending telehealth requirements.** Senate Bill 119 of the 2023 Legislative Session extended certain telehealth requirements in Nevada. Specifically, it mandates most health insurers cover telehealth services in the same amount as services provided in person, if the services are: (1) delivered at certain originating sites in rural areas, by federally qualified health centers, or rural health clinics—excluding audio-only services; or (2) for counseling or treatment related to a mental health disorder, including audio-only telehealth. The bill also requires these services to be covered in the same amount as services provided in-person.

- **Joining interstate behavioral health licensure compacts.** Interstate licensure compacts are legal agreements among multiple states that enable a certain type of health care professionals to practice in the others' jurisdiction if they meet compact requirements. Compacts reduce barriers to practicing in multiple states by eliminating the need to seek a separate license in each state. Currently, Nevada is a member of the Interstate Psychology Interjurisdictional Compact. Other behavioral health licensure compacts include the Counseling Interstate Licensure Compact and the Social Work Licensure Compact.

- **Enhancing cultural competency.** In 2019 and 2021, the Nevada Legislature passed Senate Bill 470 and Assembly Bill 327, respectively, requiring certain medical facilities, facilities for the dependent, and certain types of health care providers to conduct or complete cultural competency training to better understand patients who have different cultural backgrounds, in an effort to improve their care.

- **Increasing navigation and support through the use of community health workers and peers, such as peer recovery support specialists.** The number of community health workers in Nevada increased in recent years, and behavioral health providers are increasingly integrating these and other paraprofessionals, such as peer recovery support specialists, into their practices to expand assistance with navigating health care systems, better engage patients, and improve health outcomes. For example, family peer support specialists, such as those working with Nevada PEP, help families navigate the barriers and complexities of accessing behavioral health services for their children.[70]

BEHAVIORAL HEALTH WORKFORCE

- **Providing training and professional development.** Project ECHO Nevada is a form of telehealth that maximizes scarce specialty resources by connecting university-based faculty specialists and subject matter experts with health care professionals for case consultation and continuing education. It supports health care providers in rural and underserved areas, reduces professional isolation and fear among new providers by creating a collaborative learning environment, and creates a network of regional and national partners to recruit subject matter experts that may not exist in Nevada.

  In addition, the Center for the Application of Substance Abuse Technologies within the University of Nevada, Reno, School of Public Health provides a variety of training, continuing education, and professional development opportunities for behavioral health professionals.

BEHAVIORAL HEALTH WORKFORCE

WHAT CAN WE DO?

GOAL 2:

Grow and diversify the behavioral health workforce in Nevada to improve access to mental health and substance use services

OBJECTIVES:

2.1: Establish the Behavioral Health Workforce Development Center of Nevada to create a robust pipeline for behavioral health professionals that builds on existing successful programs, establishes new programs and training opportunities, and enhances connections through the educational system and professional licensing

2.2: Improve behavioral health professional recruitment and retention by increasing the number of professionals who receive financial incentives, such as loan repayment, to practice in Nevada

2.3: Increase the number of clinical internships available for behavioral health profession students to meet internship experience requirements for licensure

2.4: Increase use and integration of community health workers (CHWs) and peer recovery support specialists in clinical behavioral health settings and schools in Nevada

2.5: Increase the number of opportunities to improve behavioral health professionals' wellness, address mental health needs, and reduce burnout

2.6: Increase the number of school-based mental health professionals to improve mental health provider-to-student ratios

2.7: Maximize the use of telehealth to increase the number of behavioral health professionals providing services in Nevada, especially in rural and underserved areas

ADDITIONAL PLANS, EFFORTS, AND ALIGNMENT

- Behavioral Health Workforce Pipeline Development Plan, Nevada Health Care Workforce and Pipeline Development Workgroup
- Substance Use Disorder and Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report, Division of Health Care Financing and Policy (DHCFP), DHHS, December 2020
- Nevada's Sustainability Plan to Support Expansion of SUD and OUD Treatment and Recovery Provider Capacity, DHCFP, DHHS, June 2021
- Washoe County Health District (now Northern Nevada Public Health) 2022-2025 Community Health Improvement Plan
- This area of focus aligns with Healthy People 2030 objectives related to mental health and mental disorders.

HEALTH CARE WORKFORCE

Nevada also has a critical and ongoing shortage of primary care providers. Though not as severe as the behavioral health workforce shortage, 70 percent of the state population lives in areas without enough primary care providers. Like other health care workforce shortages, these are more acute in rural and frontier regions of the state, were 81 percent of the population lives in primary care health professional shortage areas. To meet national provider-to-patient averages, Nevada needs an additional 255 family medicine physicians, 626 nurse practitioners, and 3,162 registered nurses, among many others.[71]

Various factors contribute to health care workforce shortages, including a growing and aging population; increased demand for care; the inability to educate, train, and retain sufficient health care providers in Nevada; and provider burnout. For example, one challenge to training and retaining physicians is the limited number of graduate medical education (GME) opportunities in the state. Studies show that physicians are more likely to stay in the state in which they complete this training.[72] However, Nevada does not have enough GME opportunities for all Nevada-trained physicians, and is a net exporter of physicians. Only 40 percent of physicians who are trained in Nevada but complete GME elsewhere return to the Silver State, compared to 55 percent who obtain GME in-state and choose to stay here—or compared to the 77 percent of physicians who obtain undergraduate medical education and GME in Nevada who choose to practice in the state.[73] Significant challenges exist to increasing the number of nurses as well, such as shortages of faculty, clinical instructors, and preceptors in nursing programs. Faculty and instructors' salaries are lower than those of nurses employed by hospitals and in other settings, making the latter more attractive. These and other issues contribute to the persistence of such widespread shortages.

While primary care workforce shortages have existed for years, they were exacerbated by the COVID-19 pandemic, which affected both the mental and physical health of health care providers, and led to increased burnout, exhaustion, and trauma. In fact, in a 2023 Harvard Medical School study nearly half of health care providers reported experiencing burnout, and nearly one-third reported an intent to leave their position within a year.[74]

Finally, the current health care workforce does not reflect the communities it serves. More than 30 percent of the state population identifies as Hispanic/Latino, and 11 percent as Black/African American, yet only 5 percent of health care providers are Hispanic/Latino or Black/African American.[75,76] Such lack of representation and diversity in the health care workforce is a barrier to care for underserved communities. It underscores the importance of recruiting from and providing education about health care careers in underrepresented communities, and enhancing cultural competency among health care providers.

HEALTH CARE WORKFORCE

IMPROVING THE HEALTH CARE WORKFORCE IN NEVADA

Many of the initiatives to increase the behavioral health workforce also aim to expand the primary care workforce. A few examples of these efforts are below.

- **Improving the health care workforce pipeline.** The Nevada Health Care Workforce and Pipeline Development Workgroup created a Primary Care Workforce Pipeline Development Plan, which identifies a vision for the primary care workforce in Nevada, as well as specific goals, objectives, and strategies to work toward it. Among these are efforts to increase early exposure to professional opportunities in primary care, and increase primary care workforce training and teaching capacity.

- **Expanding loan repayment options.** Various primary care providers are also eligible for the Student Loan Repayment for Providers of Health Care in Underserved Communities Program created by Assembly Bill 45 (2023), including physicians, physician assistants, licensed nurses, emergency medical technicians, pharmacists, midwives, and doulas, among others. In addition, the Nevada Health Service Corps has provided loan repayment to 204 health care providers, and continues providing it to physicians, physician assistants, nurse practitioners, registered nurses, pharmacists, and nurse midwives.

- **Extending telehealth requirements.** Telehealth requirements extended through Senate Bill 119 (2023) mandate most health insurers cover telehealth services in the same amount as services provided in person, if the services are: (1) delivered at certain originating sites in rural areas, by federally qualified health centers, or rural health clinics—excluding audio-only services. The bill also requires these services to be covered in the same amount as services provided in person.

- **Enhancing cultural competency.** In 2019 and 2021, the Nevada Legislature passed Senate Bill 470 and Assembly Bill 327, respectively, requiring certain medical facilities, facilities for the dependent, and certain types of health care providers to conduct or complete cultural competency training to better understand patients who have different cultural backgrounds, in an effort to improve their care.

- **Addressing health care provider wellbeing.** Initiatives and organizations are increasingly focusing on physician wellbeing to combat burnout, suicide, and improve wellbeing to improve job satisfaction and retention. For example, the Nevada Physician Wellness Coalition provides tools and resources to support the wellbeing of physicians and medical students, and their families.

- **Providing training and professional development.** Project ECHO Nevada also serves the primary care workforce in Nevada, maximizing scarce specialty resources by connecting university-based faculty specialists and subject matter experts with health care professionals for case consultation and continuing education. It supports health care providers in rural and underserved areas, reduces professional isolation and fear among new providers by creating a collaborative learning environment, and creates a network of regional and national partners to recruit subject matter experts that may not exist in Nevada.

HEALTH CARE WORKFORCE

WHAT CAN WE DO?

GOAL 3:

Increase the number and diversity of health care providers in Nevada to better reflect the communities they serve and improve access to care

OBJECTIVES:

3.1: Enhance and diversify the health care career pipeline by increasing the number of young people who are aware of and receive information about health profession career options at an early age, with a focus on underrepresented communities and those in rural and frontier Nevada

3.2: Improve health care provider recruitment to Nevada through increasing the number of professionals who receive financial incentives, loan repayment, and graduate medical education opportunities

3.3: Maximize the efficiency and effectiveness of Nevada's current health care workforce by increasing integration of community health workers (CHWs), who increase minorities' access to care and serve as liaisons between health care providers and the communities they serve

3.4: Increase the number of opportunities to improve health care professionals' wellbeing, address mental health needs, and reduce burnout

3.5: Improve cultural competence within the health care workforce to improve provider-patient communication, reduce health disparities, and improve health outcomes

ADDITIONAL PLANS, EFFORTS, AND ALIGNMENT

- Primary Care Workforce Pipeline Development Plan, Nevada Health Care Workforce and Pipeline Development Workgroup
- Washoe County Health District (now Northern Nevada Public Health) 2022-2025 Community Health Improvement Plan

WHAT CAN WE MEASURE?

The indicators below will be monitored by DPBH to evaluate progress toward the goals outlined in this section through July 2028. Specific metrics, as well as baseline and target data, will be available as an addendum to this document.

- Increase the percent of Nevadans who visited the dentist or dental clinic within the past year for any reason
- Increase the number of Medicaid recipients between 0 and 5 years of age who had a dental exam in the past year
- Increase the number of Medicaid recipients under 21 years of age who had a dental encounter during the year
- Increase the number of middle and high school students who visited a dentist during the preceding 12 months
- Decrease the number and percentage of state population living in a mental health professional shortage area
- Increase the number of behavioral health professionals working in K-12 schools
- Increase the number of school districts collecting data regarding student referrals and access to school- and community-based behavioral health providers
- Increase the number of behavioral health professionals who receive loan repayment from a state loan repayment program
- Reduce the number and percentage of state population living in a primary care health professional shortage area
- Increase the number of graduate medical education (GME) opportunities in Nevada

Endnotes

53 Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.) Access to Health Care Services. Retrieved from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services#:~:text=The%20National%20Academies%20of%20Sciences,to%20needed%20health%20care%20services%2C

54 Dupin Z, Dunning S, Cladianos A. (2022). Nevada State Health Assessment 2022. DPBH.

55 Griswold T, Packham J, Warner J, Etchegoyhen L. (2021) Nevada Rural and Frontier Health Data Book - Tenth Edition. Nevada Health Workforce Research Center, UNR School of Medicine.

56 KFF. Health Insurance Coverage of the Total Population, State Health Facts,; accessed August 2023. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Uninsured%22,%22sort%22:%22desc%22%7D

57 Packham, John, et. al. (May 2023). Health Workforce in Nevada: A Chartbook. Nevada Health Workforce Research Center, UNR School of Medicine.

58 National Institute of Dental and Craniofacial Research, NIH. (n.d.) Dental Caries (Tooth Decay). Retrieved from https://www.nidcr.nih.gov/research/data-statistics/dental-caries#:~:text=Dental%20caries%20(tooth%20decay)%20remains,remain%20among%20some%20population%20groups

59 Centers for Disease Control and Prevention (n.d.) BRFSS Prevalence and Trends Data, Nevada – Dental Visit.

60 Packham, John, et. al. (May 2023). Health Workforce in Nevada: A Chartbook. Nevada Health Workforce Research Center, UNR School of Medicine.

61 Oral Health Program, DHHS. (2022). Nevada Oral Health State Plan.

62 Woodard, S. (July 21, 2022) Improving Access to Behavioral Health Care in Nevada. Presentation to the Nevada Legislature. DPBH, DHHS. Retrieved from https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/27967

63 Reinert, M, Fritze, D. & Nguyen, T. (October 2021). The State of Mental Health in America 2022. Mental Health America. Retrieved from https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf

64 Civil Rights Division, United States Department of Justice. (October 2022). Investigation of Nevada's Use of Institutions to Serve Children with Behavioral Health Disabilities. Retrieved from https://www.justice.gov/d9/press-releases/attachments/2022/10/04/2022.10.04_report_of_nevada_investigation_0.pdf

65 Crocker, K. M., Gnatt, I., Haywood, D., Butterfield, I., Bhat, R., Lalitha, A. R., Jenkins, Z. M., & Castle, D. J. (2023). The impact of COVID-19 on the mental health workforce: A rapid review. International Journal of Mental Health Nursing, 32, 420–445. https://doi.org/10.1111/inm.13097

66 Packham, John, et. al. (May 2023). Health Workforce in Nevada: A Chartbook. Nevada Health Workforce Research Center, UNR School of Medicine.

67 Office of the Surgeon General, U.S. Department of Health and Human Services. Protecting Youth Mental Health: The U.S. Surgeon General's Advisory. (2021) Retrieved from https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

68 Hopeful Futures Campaign. (February 2022). America's School Mental Health Report Card. Retrieved from https://hopefulfutures.us/wp-content/uploads/2022/02/Final_Master_021522.pdf

69 DPBH, DHHS. (2023) Behavioral Health Community Integration Strategic Plan: Nevada's 2023 update to the Strategic Plan for Behavioral Health Community Integration. Retrieved from https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Boards/RBHPB/Meetings/2018/Nevada_Behavioral_Health_Community_Integration_Plan_010123.pdf

70 Nevada Rural Children's Mental Health Consortium. (2022). Service Priorities Report 2022. Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Meetings/RCMHC_Service_Priorities_Report%20_2022_FINAL_ADA.pdf

71 Packham, John, et. al. (May 2023). Health Workforce in Nevada: A Chartbook. Nevada Health Workforce Research Center, UNR School of Medicine.

72 Association of American Medical Colleges. (2022). Report on Residents 2022. Retrieved from https://www.aamc.org/data-reports/students-residents/data/report-residents/2022/executive-summary

73 Packham, John, et. al. (May 2023). Health Workforce in Nevada: A Chartbook. Nevada Health Workforce Research Center, UNR School of Medicine.

74 Rotenstein, L. S., Brown, R., Sinsky, C., & Linzer, M. (2023). The Association of Work Overload with Burnout and Intent to Leave the Job Across the Healthcare Workforce During COVID-19. Journal of General Internal Medicine, 38. https://doi.org/10.1007/s11606-023-07557-8

75 U.S. Census Bureau. (2022). Nevada Quickfacts. Retrieved from https://www.census.gov/quickfacts/fact/table/NV/PST045222

76 Packham, John, et. al. (May 2023). Health Workforce in Nevada: A Chartbook. Nevada Health Workforce Research Center, UNR School of Medicine.

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

MENTAL HEALTH AND SUBSTANCE USE

INTRODUCTION

Two of the top issues identified in the 2022 State Health Assessment were mental health and substance use. Collectively referred to as behavioral health, these are key issues in Nevada and nationwide. Behavioral health and physical health are closely related. Good mental health and psychological wellbeing can reduce the risk of certain physical health conditions, such as heart attacks and stroke, while poor mental health can lead to poor physical health and harmful behaviors. Physical wellbeing also affects mental health, and individuals with physical health challenges are at higher risk of developing mental health conditions.

MENTAL HEALTH

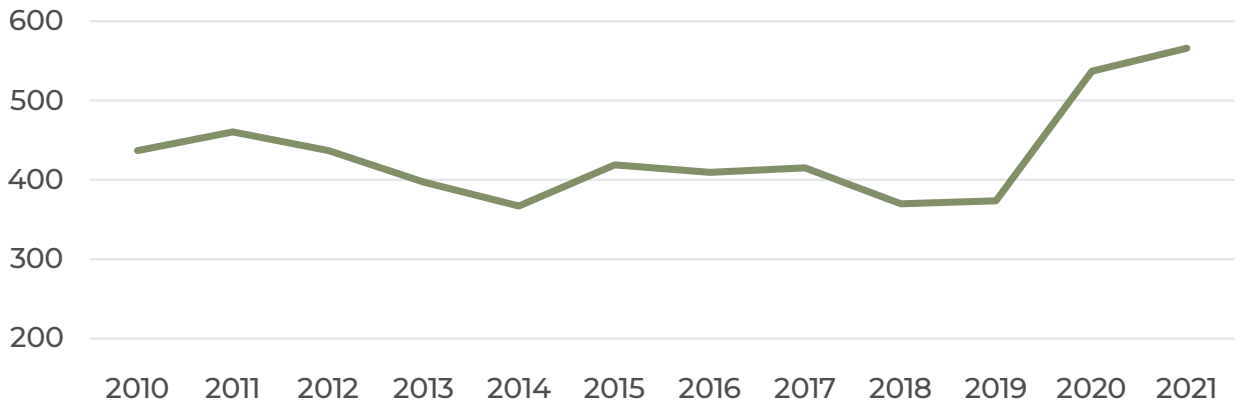
In the United States, one in five adults and one in five youth experience mental illness each year, and one in 20 adults experience serious mental illness resulting in serious functional impairment that substantially interferes with major life activities. Nearly half of all people in the U.S. will be diagnosed with a mental health disorder during their lifetime, and according to Mental Health America, Nevada ranks 51st in the nation when compared to other states on 15 measures related to the prevalence of mental illness and access to insurance and treatment.[77]

SUBSTANCE USE AND THE OPIOID EPIDEMIC

Many steps have been taken to address substance use in Nevada in recent years, but the COVID-19 pandemic exacerbated the challenges they aimed to address. Between 2019 and 2020, unintentional drug overdose deaths increased 55 percent—from 510 to 788. This included a 120 percent increase among Hispanic individuals, 227 percent increase in deaths attributed to fentanyl, and 76 percent increase in deaths related to opioids.[78] The total number of overdose deaths remained largely the same in 2021, at 786. Sixty four percent of these deaths involved an opioid, 62 percent involved a stimulant, and 27 percent involved both.[79] Trends continued in the first half of 2022, with 424 drug overdose deaths.[80]

Opioid deaths represent a large portion of all overdose deaths, and Nevadans continue to experience the effects of substance use. The opioid epidemic in particular has led to high rates of opioid-related overdoses and deaths, increasing rates of fatal overdoses among pregnant and postpartum people, higher rates of neonatal abstinence syndrome, and significant family involvement with the justice and child welfare systems.[81]

FIGURE 5: OPIOID-RELATED OVERDOSE DEATHS, 2010 - 2021



Source: Monitoring Substance Use in Nevada: Trends – Substance Related Overdose Deaths, Office of Analytics, DHHS

INTRODUCTION

CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

It is important to note that the co-occurrence of mental health disorders and substance use disorders are common. Individuals with mental illness are more likely than those without mental illness to experience a substance use disorder.[82] Among those who died of unintentional drug overdose in 2020, half had a mental health disorder. In addition, individuals with mental health and/or substance use disorders are at higher risk for suicide—and suicide rates are increasing.[83]

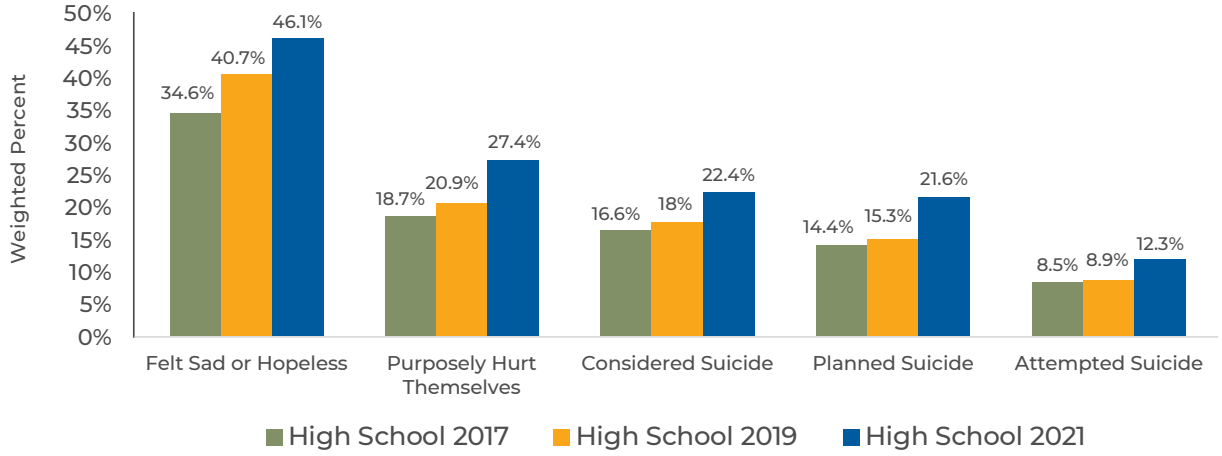
SUICIDE

Nearly two Nevadans died by suicide every day in 2021, despite the fact that suicide is often preventable. According to the federal Centers for Disease Control and Prevention, for every suicide death, there are 4 hospitalizations for suicide attempts, 8 emergency department visits related to suicide, 27 self-reported suicide attempts, and 275 people who seriously consider suicide.[84]

In Nevada, between 2011 and 2021, suicide deaths rates increased by more than 15 percent, and the portion of adults who reported that they considered attempting suicide increased from 3.7 percent in 2020, to 4.5 percent in 2021.[85] Similarly, the percent of middle and high school students who self-reported feeling sad or hopeless, and the percent of high school students who self-reported purposely hurting themselves, considering suicide, planning suicide, or attempting suicide are at their highest rates since 2017. In fact, in 2020, suicide was the leading cause of death for young people between 10 and 17 years of age, and the second leading cause of death for those between 18 and 24 years of age. In addition, suicide rates in rural and frontier Nevada are nearly double the rates of urban areas.[86]

While behavioral health disorders occur in people of all ages and groups, certain populations are disproportionately affected. Specific disparities are discussed in the following sections.

FIGURE 6: MENTAL HEALTH BEHAVIORS, NEVADA HIGH SCHOOL STUDENTS, 2017, 2019, AND 2021



Source: 2022 Epidemiologic Profile: Nevada, Office of Analytics, DHHS, December 2022

INTRODUCTION

Recent Efforts to Improve Suicide Prevention

Much is being done to address and prevent suicide statewide. At the state level, the Nevada Office of Suicide Prevention (NOSP) works to reduce the rates of suicide and suicidal acts. It collaborates with numerous partners to develop, implement, and evaluate strategies to pursue the goals and objectives of the National Strategy for Suicide Prevention.

The state's Suicide Prevention Strategic Plan aims to catalyze collaborative action, improve understanding, and increase wellness in communities across Nevada through enhanced collaboration and identification of best practices. Strong partnerships are the foundation for some of the Office's most successful initiatives, including the Signs of Suicide middle/high school suicide awareness curriculum and screening programs, Suicide Prevention 101, Suicide Alertness for Everyone (also known as SafeTalk), Youth and Adult Mental Health First Aid, and Applied Suicide Intervention Skills Trainings.

In addition, in 2021, the Nevada Legislature passed Assembly Bill 181 (NRS 441A.150), requiring certain health care providers who know of or provide services to a person who has attempted suicide or is suspected of having attempted suicide to report this information to the state's chief medical officer—similar to how drug overdoses are reported. This mandate should improve available data on suicide and suicide attempts.

INTRODUCTION

PROBLEM GAMBLING

Problem gambling is associated with numerous harms to the individual as well as the people and communities around them. These range from negative effects on emotional and physical health to risks of housing crises and homelessness, domestic violence, debt, and family breakdown.[87] Problem gambling also has the highest rate of suicide of any addictive disorder—one in five individuals who experience problem gambling attempt suicide. In 2023, a survey by the UNLV International Gaming Institute found 13 percent of respondents were at high risk for problem gambling, suggesting thousands of Nevadans may be at risk of gambling-related harm.[88] This is important not only for those who experience problem gambling, but also for those around them; one problem gambler affects at least six other people, including their spouse, children, extended family members, friends, and the broader community.[89] Certain groups are more vulnerable to harmful gambling than others. These include young people, certain minority groups, military personnel and veterans, unhoused individuals, and individuals with mental health and substance use issues. For all of these reasons, problem gambling is increasingly described as a public health issue that extends beyond the individual to influence interpersonal relationships, communities, and society as a whole.[90]

Recent Efforts to Address Problem Gambling

In 2005, Nevada established the Advisory Committee on Problem Gambling and the Revolving Account to Support Programs for the Prevention and Treatment of Problem Gambling in the state general fund to support problem gambling prevention, treatment, and recovery programs. Currently, an annual $2 million appropriation funds several programs, including outpatient and residential specialty treatment, that serve approximately 400 individuals each year. To increase the number of people served, in 2022, the Division of Public and Behavioral Health (DPBH) of Nevada's Department of Health and Human Services (DHHS) created the Problem Gambling Integration Project. The Project aims to increase the capacity of programs certified by DPBH's Substance Abuse Prevention and Treatment Agency (SAPTA) to address gambling and problem gambling. As part of this process, the Agency created the SAPTA Certification Problem Gambling Endorsement, as well as a toolkit and process for agencies to obtain the endorsement. Five pilot SAPTA-certified organizations were enrolled and began increasing their capacity to address problem gambling in order to prevent high-risk individuals from developing a gambling disorder and to identify and address gambling-related problems among individuals who are being treated for other addictions or mental health issues. In addition, in 2023, the Nevada Legislature appropriated an additional $500,000 to increase awareness about problem gambling statewide. More information about these and other efforts to address problem gambling in Nevada is available in the DHHS Problem Gambling Services FY 2024-FY2027 Strategic Plan.

FACTORS THAT INFLUENCE BEHAVIORAL HEALTH

Behavioral health is influenced by a variety of factors, such as adverse childhood experiences; social determinants of health; access to behavioral health services; availability of health promotion, prevention and early intervention services; and loneliness and isolation.

Certain social determinants of health, including supportive housing, are addressed in the "Social Determinants of Health" section of this Plan, and access to behavioral health care in Nevada is discussed in more detail in the "Access to Care" section.

INTRODUCTION

Research shows early identification, diagnosis, and treatment of mental health and substance use conditions can help improve recovery and reduce suffering for both individuals and their families,[91] and while not discussed in detail in this Plan, DPBH funds a variety of programs to identify and address early serious mental illness (ESMI), including first-episode psychosis (FEP), through the federal Community Mental Health Services Block Grant (MHBG).[C]

In addition, the 2023 Surgeon General's Advisory regarding the epidemic of loneliness and isolation discusses in detail the link between loneliness, isolation, and mental health challenges.

The COVID-19 pandemic also affected behavioral health in Nevada—increasing demand for services, while reducing supply through behavioral health professional burnout and other workforce challenges. The pandemic contributed to the increase in demand for services by exacerbating many of the factors that influence behavioral health, which resulted in higher rates of anxiety and depression, increases in overdose deaths, and higher rates of suicide. Overall, the pandemic placed additional strain on an already-stressed behavioral health system in Nevada, and it intensified barriers to obtaining necessary care.

LOOKING FORWARD

Numerous individuals, agencies, and organizations across various sectors are working to strengthen Nevada's behavioral health systems and services—at the local, regional, and state level—with funding from various sources. The behavioral health-related goals and objectives outlined in this Plan are based on and align with this work, and reflect findings and recommendations from existing assessments, reports, and strategic plans.

The SSHIP focuses on behavioral health issues that have a statewide impact or the potential to be expanded statewide, involve major systems change, require state resources, and are being addressed through the collaboration of various partners.

Specifically, the SSHIP highlights and builds on efforts in four crucial areas:

- ☑ Children's behavioral health;
- ☑ The crisis response system;
- ☑ Substance use prevention, harm reduction, treatment, and recovery; and
- ☑ Investment in all components of the behavioral health system.

[C] A portion of the MHBG is dedicated specifically to ESMI, and used to enhance community outreach and referral networks to identify and engage this population and affirm diversity, equity, and inclusiveness in access to services; provide education and technical assistance to the behavioral health professionals who work with these populations; and enhance data collection, analysis, and reporting to improve the quality of services for those with ESMI. In 2022, ESMI-dedicated funding supported the NAVIGATE Early Treatment Program of Coordinated Specialty Care for First Episode of Psychosis, which targets individuals experiencing an initial episode of non-affective psychosis such as schizophrenia spectrum and other psychotic disorders, in three clinics throughout the state. The NAVIGATE program currently is available in clinics located in the three most populous Behavioral Health regions (Northern, Southern, and Washoe), which cover approximately 95 percent of Nevada residents. As of September 2023, more than 110 individuals had been served statewide. In addition, supplemental MHGB COVID funds were used to expand a variety of existing ESMI programs throughout the state.

CHILDREN'S BEHAVIORAL HEALTH

Mental health affects young people's ability to succeed in school, at work, and throughout life—and it is critical to their wellbeing. Prior to the COVID-19 pandemic, behavioral health challenges were among the leading causes of disability and poor life outcomes for youth, and in recent years, state and national surveys have shown significant increases in mental health symptoms.[92] In 2021, the U.S. Surgeon General issued an advisory titled *Protecting Youth Mental Health*, calling the impact of the pandemic on youth mental health "devastating," even though the youth mental health crisis is "treatable, and often preventable." These sentiments are echoed in recent reports from Nevada's state and regional Children's Mental Health Consortia.

Many mental health challenges appear early in life, and research shows that prevention and early intervention are critical to the wellbeing of children and their families. However, two-thirds of youth who need mental health treatment do not have access to it, and studies show the delay between onset of symptoms and treatment is often years.[93] Early intervention yields positive returns on investment around improved health, as well as education, criminal justice, and social welfare. In contrast, delaying mental health care results in long-term negative effects for both children and their families, such as school drop-out, unemployment, involvement with the juvenile or criminal justice systems, and even loss of life.[94,95]

However, receiving early intervention requires access to behavioral health care services—another significant challenge in Nevada. Prior to the COVID-19 pandemic children with mental health care needs struggled to receive the support they needed in a timely manner, and these struggles only grew as a result of the pandemic. While many children struggle to find appropriate services, it is particularly difficult for children with high levels of need, those with intellectual and/or developmental disabilities (IDD) and mental health needs, and for children in rural Nevada.[96]

CHALLENGES PROVIDING CHILDREN'S BEHAVIORAL HEALTH SERVICES IN NEVADA

Nevada faces various challenges providing sufficient and appropriate behavioral health services to young people. A 2022 investigation by the U.S. Department of Justice's Civil Rights Division found the state does not:

- Maintain an adequate behavioral health provider network[d];
- Ensure the availability of key community-based behavioral health services;
- Connect children with services that may prevent institutional placement; or
- Connect children who are in institutional settings with community-based services so they can return to and successfully remain in the community.

[d] Concerns related to Nevada's behavioral health provider workforce are addressed in the Access to Care section of the SSHIP

CHILDREN'S BEHAVIORAL HEALTH

According to the investigation's report, instead of providing community-based services such as crisis services, intensive in-home services, intensive care coordination, respite care, therapeutic foster care, and other family-based supports, "Nevada relies on segregated, institutional settings, like hospitals and residential treatment facilities to serve children with behavioral health disabilities."[97] Insufficient access to community-based services leads to various negative consequences for children and their families. When people cannot access needed services in settings like clinics, doctor's offices, and their homes or schools, issues often escalate, and families seek care in hospitals and emergency departments, which serve as gateways to more restrictive and institutionalized care.[98] As a result, children experience "frequent and lengthy" stays in such settings—despite the fact that institutional placements often are avoidable if children are provided appropriate community-based services.

The state's Children's Mental Health Consortia note that the number of days youth are waiting in hospital emergency departments for transitions to safe and appropriate care is increasing due to lack of providers, mental health crisis stabilization beds, and inpatient treatment. In addition, in 2022, 124 children were placed in residential treatment facilities outside of Nevada—from California, Oregon, and Utah to Texas, Oklahoma, Missouri, Arkansas, Tennessee, Mississippi, and Pennsylvania—and 115 placements were for more than 15 days.[99]

The DOJ report underscores the importance of community-based services for children, families, and the state budget. Children served in the community "show a decrease in clinical symptoms, an increase in behavioral and emotional strengths, improved school outcomes, reduced suicide attempts, and decreased contacts with law enforcement," while residential treatment for children is "associated with higher rates of physical and sexual abuse, impaired social and interpersonal development, delayed cognitive, intellectual and language development, higher rates of developmental deficits, emotional attachment disorders, and even poor health and stunted physical growth." In addition, community-based services cost one-quarter that of residential treatment, and transitioning to these services would result in annual savings of $40,000 per child.

Lack of access to early and appropriate services and supports also increase youths' risk for involvement with the child welfare and juvenile justice systems, resulting in increased institutionalization. The DOJ report notes that in certain circumstances, parents surrender their rights to try to obtain better care and resources for their children because they cannot access other services. Between 65 percent and 70 percent of children and adolescents arrested each year have a mental health disorder, and children with behavioral health challenges often end up in a juvenile justice setting because they are not able to access necessary services elsewhere.[100] While youth are ideally served in the least restrictive setting appropriate to their needs, it is difficult to divert youth with behavioral health conditions from residential or institutional placement due to the severe lack of community-based care in Nevada.

Transitions from institutional settings back to the community, and between child-and adult-serving systems, also present challenges in Nevada. Insufficient community-based services can make discharge planning difficult and result in recidivism or longer stays in institutional settings. In addition, youth and adults with behavioral health needs are served by different systems in Nevada, and challenges exist in coordinating transitions between the two.

CHILDREN'S BEHAVIORAL HEALTH

EFFORTS TO IMPROVE CHILDREN'S BEHAVIORAL HEALTH IN NEVADA

Numerous agencies, organizations, and individuals are working to address these challenges and improve Nevada's behavioral health system and services for children. A few such initiatives include the state's efforts to respond to and address the DOJ findings, expand the Children's System of Care, emphasize social-emotional learning in schools, integrate behavioral health systems and services in schools, establish a state Children's Behavioral Health Authority, and invest in children's behavioral health. This work is informed and guided by numerous behavioral health assessments, strategic plans, and reports that evaluate the issue in more detail and make recommendations for improving it. These documents are linked at the end of this section for reference.

- **Responding to the DOJ Investigation / Enhancing Community-Based Services for Children.** Nevada's Department of Health and Human Services is taking various steps to build, strengthen, and coordinate its community-based services in response to the DOJ findings. Many of the key elements of an effective community-based service system already exist in Nevada's Medicaid State Plan, and the report notes the state could "modify its system by expanding the availability of these services, supporting and managing its provider network to increase quality and access, assessing children and diverting them to community-based services before they enter institutions, and, for children already in institutions, engaging them in discharge planning to quickly and successfully return home."

- **Building and Expanding a Children's System of Care.** A System of Care is a coordinated network of community-based services and supports that emphasizes partnership with youth and families to address their specific behavioral health needs in culturally and linguistically appropriate ways. Systems of Care also help reduce gaps between distinct systems, such as behavioral health, child welfare, education, and juvenile justice. The Division of Child and Family Services (DCFS) within the Department of Health and Human Services (DHHS) has made progress on Nevada's System of Care with assistance from recent funding; it also is developing program standards and a governance structure for the System, and working on issues related to oversight, accountability, technical assistance, and training for providers serving children and youth.[101]

- **Integrating Social and Emotional Learning in K-12 schools.** The Nevada Department of Education (NDE) emphasizes integrating social and emotional learning as part of school culture as an essential component of how "schools, communities, and families value and support the social, emotional, and academic development" of their children. Social and emotional learning contributes to health, wellbeing, and safety in schools, and it can cultivate the protective factors that help promote mental health.[102]

CHILDREN'S BEHAVIORAL HEALTH

- **Integrating Behavioral Health Care in School-Based Settings.** Schools are critical access points for youth to receive health care services, and a large portion of visits to school nurses relate to behavioral health. Research shows that providing mental health services in schools has various advantages, including improving clinical outcomes, enhancing family engagement, and reducing stigma. The Nevada Department of Education and DHHS are partnering to enhance integration of behavioral health care in schools, including the development of a School-Based Behavioral Health Toolkit to help schools and districts establish necessary systems to maximize integration of children with behavioral health issues. Currently, at least nine school districts have contracts with Nevada Medicaid to bill for health services. Districts are using the Multi-Tiered Systems of Support (MTSS) framework that provides supports such as prevention services and universal screening to all students, as well as more targeted and intensive services to students who need them.[103]

- **Establishing of a Children's Behavioral Health Authority.** The DHHS established a Children's Mental Health Authority to coordinate efforts across state agencies and with other entities that serve children and youth, from private providers to county juvenile justice services, to enhance children's behavioral health services and supports.

- **Investing in the Children's Behavioral Health System.** Investment is critical to improving children's behavioral health services, and following the COVID-19 pandemic, Nevada allocated a record investment of American Rescue Plan Act (ARPA) funds to mental health services. The investment went to school-based mental health providers; support for schools to be able to bill Medicaid; Nevada's Children's System of Care; wraparound case coordination and intensive case management; increases in services for children with complex behavioral health and developmental disabilities; expansion of mobile crisis response teams, family support, and direct services; and workforce support, among other things.[104]

CHILDREN'S BEHAVIORAL HEALTH

WHAT CAN WE DO?

GOAL 1:

Increase access to children's behavioral health services, including school-based behavioral health services, in Nevada to ensure children are served in the most integrated settings appropriate to their needs

OBJECTIVES:

1.1: Expand availability and use of home- and community-based behavioral health services across settings and the continuum of care (for example, mobile services, high fidelity wraparound services, school-based health services, and in-home therapy)

1.2: Develop, support, and maintain a high quality, well-trained, and adequate network of behavioral health providers to improve quality of and access to care (see Access to Care Goal 2)

1.3: Reduce and prevent unnecessary institutional placements by assessing and diverting children to home- and community-based services when appropriate

1.4: Increase the number of children engaged in discharge planning and connected with home and community-based services prior to exiting institutional settings (such as residential behavioral health or juvenile justice settings), so they can return to and remain in the community successfully

1.5: Develop new Medicaid benefits for children's behavioral health services

1.6: Increase access to specialized behavioral health services for children with intellectual and/or developmental disabilities (IDD) and mental health needs

1.7: Increase the use of pediatric and/or school-based universal screenings across settings (such as services covered under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment [EPSDT] benefit)

ADDITIONAL PLANS, EFFORTS, AND ALIGNMENT

- Behavioral Health Community Integration Strategic Plan: Nevada's 2023 update to the Strategic Plan for Behavioral Health Community Integration, DPBH, DHHS
- Children's Mental/Behavioral Health Consortia
  - Nevada Children's Behavioral Health Consortium
  - Clark County Children's Mental Health Consortium
  - Rural Nevada Children's Mental Health Consortium
  - Washoe County Children's Mental Health Consortium
- Investigation of Nevada's Use of Institutions to Serve Children with Behavioral Health Disabilities, Civil Rights Division, United States Department of Justice, October 4, 2022
- Nevada School Climate/Social Emotional Learning Survey, NDE
- Nevada System of Care Expansion Grant 2019-2023: Strategic Plan
- Statewide Plan for the Improvement of Pupils, NDE
- Regional Behavioral Health Policy Boards annual reports and recommendations
- The goals to address this area of focus align with Healthy People 2030 objectives related to increasing the proportion of children with mental health problems who get treatment, appropriate treatment for certain conditions, and preventive mental health care in school.

CRISIS RESPONSE SYSTEM

"SOMEONE TO TALK TO, SOMEONE TO RESPOND, A SAFE PLACE TO BE"

Crisis services are an integral part of a behavioral health system. They are the first line of services for individuals experiencing a mental health or substance use crisis and critical to connecting people with appropriate care.[105] Lack of access to timely and appropriate services too often results in arrest and charges, emergency department stays, unnecessary decompensation, increased trauma and stigma, and suicide.[106]

A strong crisis response system is essential to effectively addressing behavioral health crises, reducing suicides, and providing a pathway to recovery and wellbeing.[107] A strong crisis system also provides appropriate services and supports for youth and families, as their developmental, social, and clinical needs differ from those of adults.[108] The essential elements of such a system are services that provide individuals in crisis and their families someone to talk to, someone to respond, and a safe place to be. Across the nation, and in Nevada, significant work is occurring to transform the behavioral health crisis response system to ensure these services are available.

CRISIS CALL CENTER—SOMEONE TO TALK TO

A new, three-digit crisis line for behavioral health became operational in Nevada and across the nation on July 16, 2022. The "988" Suicide and Crisis Lifeline was created by the United States Congress to re-direct non-medical suicide or mental health related calls from the 911 system, which is used for fire, police, and medical emergencies.[109]

The 988 lifeline builds on the nation's existing network of locally operated and funded crisis call centers and provides access to trained crisis counselors for individuals experiencing behavioral health crisis—whether thoughts of suicide, mental health or substance use crises, emotional distress, or other related challenges—or their families. It is available 24 hours per day, 7 days per week via phone, text, or online chat at 988lifeline.org.

The goal of 988 is to link those who call, text, or chat with community-based providers who de-escalate the crisis and connect the individual with local services, dispatch mobile crisis response teams, schedule follow-up appointments with local providers, or refer to crisis stabilization centers.

Redirecting behavioral health crisis away from 911, and to 988 and the behavioral health crisis response system, should improve the appropriateness of the response, the services individuals receive, and also alleviate the burden on traditional emergency responders who are not trained in responding to behavioral health crises. However, its effect depends on the availability of other core services, including mobile crisis response and crisis stabilization centers.

Currently, DPBH contracts with a single provider to operate the state's 988 call center and provide call, text, and chat response to individuals who access 988. Plans are in place to enhance 988 call center services to meet national standards including continued call, text, and chat functionality; the ability to dispatch mobile crisis teams; a bed registry with real-time placement for those in need of acute services; and collaboration with other elements of the crisis response system.

CRISIS RESPONSE SYSTEM

MOBILE CRISIS RESPONSE TEAMS—SOMEONE TO RESPOND

Mobile crisis response teams provide in-person, community-based services to those experiencing a behavioral health crisis with the goal of diverting them from emergency departments and the justice system. Teams ideally are comprised of mental health professionals and paraprofessionals, such as peers with lived experience, who respond to individuals wherever they are and connect them with appropriate services. Typically, mobile crisis response teams are activated by crisis lifelines, health care providers, or first responders. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), to maximize effectiveness, mobile crisis services should match the needs of the region they serve and be available 24 hours per day, 7 days per week, 365 days per year.[110]

In addition, it is important that children in behavioral health crisis are served by mobile crisis response teams that meet their specific needs, which differ from those of adults. Responders should be trained to work with children and families in crisis, and services should reflect national standards and best practices, including establishing protocols for schools to work with mobile crisis response in a way that respects the role of the family and engages juvenile justice partners to support diversion from the juvenile justice system.[111]

Various mobile crisis response teams exist in Nevada, though their approach and composition vary. While progress has been made, the capacity of these teams does not sufficiently meet the need. The majority are not available 24 hours per day, 7 days per week, and they do not exist in all areas of the state. Current mobile crisis response capacity often results in long response time to crisis calls, and leaves many to seek care in hospital emergency departments or call law enforcement to address behavioral health crises. Moving forward, Nevada is working to implement designated mobile crisis teams (DMCT) in more densely populated areas of the state; these teams will be required to operate 24 hours per day, 7 days per week, 365 days per year.

CRISIS STABILIZATION CENTERS—A SAFE PLACE TO BE

Crisis receiving and stabilization centers are similar to hospital emergency departments in that they offer “no wrong-door access” to mental health and substance use services. They accept walk-ins, and drop offs from emergency responders. They accept patients 24 hours per day, 7 days per week, and serve individuals of varying ages (as allowed by the facility’s license) and conditions, regardless of acuity. Centers offer triage, assessment, and short-term behavioral health services in comfortable, non-hospital environments. They are designed to prevent and improve behavioral health crisis and/or reduce the acute symptoms of mental illness for individuals who do not need inpatient services.[112] Most patients are deemed stable and safe for discharge and connected to community-based resources—such as Medicaid enrollment, case management, primary care, outpatient therapy, housing, and similar services—in less than 24 hours.[113] Efforts are underway to increase crisis stabilization capacity in Nevada, and DPBH is working with local hospitals to ensure appropriate stabilization services are available.

CRISIS RESPONSE SYSTEM

EFFORTS TO IMPROVE THE BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM

In Nevada, state and local entities are working to develop a comprehensive crisis response system to better meet the needs of children, youth, adults, and families experiencing behavioral health crisis. These efforts build and expand on existing state, regional, and local programs with the goal of providing appropriate and timely behavioral health services in alignment with best practices—ensuring a person in crisis has someone to talk to, someone to respond, and a safe place to be—and ultimately reducing the number of deaths by suicide.

Initial set-up and ongoing sustainability of the 988 lifeline and crisis response system are supported through federal and state funding. Sustainable state funding, established in *Nevada Revised Statutes* (NRS) 433.702 – 708, is provided through a cell phone surcharge to support ongoing investment and management of both the 988 system and related crisis response infrastructure.

State-Level Efforts

At the state level, the Division of Public and Behavioral Health (DPBH), DHHS, developed a vision and mission for the state's Crisis Response System, and is working to establish various components of the system.

> **Vision:** The Crisis Response System and 988 will serve as the foundation of Nevada's behavioral health safety net. We will reduce behavioral health crises, strive to attain zero suicides in our state, and provide a pathway to recovery and well-being.
>
> **Mission:** Everyone in Nevada will have immediate access to effective and culturally informed behavioral health services, crisis services, and suicide prevention through 988 and the Crisis Response System.[114]

In the spring of 2023, DPBH issued a request for information (RFI) for vendors to respond with creative solutions for a crisis response system that meets the behavioral health crisis needs of adults, children, youth, and families in alignment with national best practices for behavioral health crisis care established by SAMHSA. The RFI included consideration for implementation and operation of the 988 lifeline, the Nevada Behavioral Health Crisis Care Hub—software that integrates the call center and connects services, designated mobile crisis teams, and other core services.

The DPBH plans to release the related request for proposals (RFP) in early 2024. The Division is working with local and regional governments, as well as community partners, to build out the crisis response system. Following the release of the RFP, DPBH will engage with communities to ensure appropriate behavioral health crisis services are available statewide.

CRISIS RESPONSE SYSTEM

In addition, DPBH and the Division of Health Care Financing and Policy (DHCFP), DHHS, are taking steps to develop sustainable funding for crisis response services, including submitting a Medicaid State Plan Amendment to establish a rate structure to support crisis response services in Nevada.

Local and Regional Efforts

As DHHS develops statewide infrastructure to support the crisis response system, local and regional governments are taking steps to build components of the crisis response system as well. For example, Washoe County formed a coalition of local governments, law enforcement, hospitals, managed care organizations, behavioral health providers, and other key stakeholders in 2021. The coalition developed a detailed plan, published in 2022, to implement the crisis response system locally. Since then, it has been working toward implementation of key elements in the plan including development of memorandums of understanding (MOUs) among providers, development of a training plan for staff, an approach to address frequent utilizers, as well as specific strategies to meet the needs of youth and families. In addition, the partners have supported Renown Health's efforts to develop a crisis stabilization center for the region.

CHILDREN'S BEHAVIORAL HEALTH

WHAT CAN WE DO?

GOAL 2:

Increase the number of individuals and families who access appropriate care when experiencing a behavioral health crisis by fully implementing Nevada's statewide crisis response system in alignment with national best practices

OBJECTIVES:

2.1: Enhance 988 call center operations to meet national best practice standards (i.e. related to the ability to dispatch, bed registry, case management, data management system), and improve response times for those who access 988

2.2: Increase the number of people whose behavioral health crisis receives a timely response and connection to services through designated mobile crisis teams

2.3: Increase the number of crisis stabilization centers in Nevada that provide individuals experiencing behavioral health crisis somewhere to go

ADDITIONAL PLANS, EFFORTS, AND ALIGNMENT

- National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit, Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services
- National Guidelines for Child and Youth Behavioral Health Crisis Care, SAMHSA
- A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth, National Association of State Mental Health Program Directors, September 2022
- Behavioral Health Community Integration Strategic Plan: Nevada's 2023 update to the Strategic Plan for Behavioral Health Community Integration, DPBH, DHHS
- Regional Behavioral Health Policy Boards annual reports and recommendations

SUBSTANCE USE PREVENTION, HARM REDUCTION, TREATMENT, AND RECOVERY

Nationally, more than 20 million people have a substance use disorder, and most do not receive the treatment they need.[115] Substance use disorders—whether related to illicit drugs, prescription drugs, or alcohol—are linked to various health problems and can lead to overdose and death. Substance use prevention, harm reduction, treatment, and recovery services are essential to addressing these issues. Prevention activities aim to educate and support individuals and communities to prevent use and misuse of drugs and the development of substance use disorders. Harm reduction strategies employ evidence-based interventions and a public health approach to engage, equip, and empower people who use drugs with the tools, information, and resources to keep them as safe and healthy as possible.[116] Treatment and recovery services help individuals stop using drugs, improve their health and wellness, and strive to reach their full potential, and implementing these interventions and services help people with substance use disorders get treatment and reduce related health problems and deaths.

However, the state faces various challenges to providing these services, and individuals face numerous barriers to accessing them. Among these are Nevada's shortage of behavioral health providers; lack of transitional, clinical, and supportive services, especially for those reentering the community after involvement with the justice system; long wait lists and poor coordination among programs; lack of housing and supportive housing; lack of transportation options and employment opportunities; food insecurity; and financial difficulties accessing service. For more in-depth discussion of these and other challenges, please see the resources linked throughout the following section.

EFFORTS TO IMPROVE SUBSTANCE USE PREVENTION, HARM REDUCTION, TREATMENT, AND RECOVERY

Numerous entities are working to address substance use prevention, harm reduction, treatment and recovery in Nevada. These efforts are occurring at the state, regional, and local levels in the public, private, and non-profit sectors, and through governmental agencies, boards, community-based organizations, coalitions, private entities, and individuals. Rather than duplicating this work or creating new initiatives, the SSHIP highlights and aligns with existing statewide efforts. While the section below includes only a small sample of the most recent statewide initiatives, all efforts to address substance use are essential and make a difference in the lives of Nevadans.

Statewide Substance Use Response Working Group and the Advisory Committee for a Resilient Nevada

In 2021, the Nevada Legislature passed two key bills to help guide state efforts and funding for substance use prevention, harm reduction, treatment, and recovery. The first, Assembly Bill 374, created the Statewide Substance Use Response Working Group (SURG) within the Office of the Attorney General. The bill requires the SURGE to "comprehensively review various aspects of substance misuse and substance use disorders and programs and activities to combat substance misuse and substance use disorders" in the state. The SURG is studying, evaluating, and making recommendations regarding Nevada's substance use prevention, treatment, recovery, and response efforts, as well as the use of state and local money to address substance use disorders—including opioid settlement monies—based on an annual report produced by DHHS.

SUBSTANCE USE PREVENTION, HARM REDUCTION, TREATMENT, AND RECOVERY

The second piece of legislation, Senate Bill 390, created the Fund for a Resilient Nevada to hold the proceeds of opioid-related litigation, required DHHS to develop an opioid statewide needs assessment and plan, and established the Advisory Committee for a Resilient Nevada (ACRN) to identify and prioritize recommendations from the needs assessment and statewide plan to allocate money from the Fund. Money deposited in the Fund can be used for statewide projects and grants to address the impacts of opioid use disorder and other substance use disorders.[117]

In addition, SB 390 required regional, local, and tribal governmental entities that would like to apply for grants from the Fund to conduct a needs assessment related to opioid and substance use and develop a plan for the expenditure of the money. Many entities are conducting or have conducted these assessments. The Nevada Association of Counties (NACO) is supporting this work in counties statewide by providing coordination and assistance in developing county opioid needs assessments; and providing resource navigation, guidance on national models and interventions, and coordination with state data analysts and support services. A list of completed county assessments is available on NACO's website.

In 2022, the SURG and ACRN developed the Cross-Sector Task Force to Address Overdose to determine necessary action to reduce the risk of overdose in Nevada communities; prepare responses for state and local jurisdictions in the event that an increase in overdoses occurs; and provide technical assistance, guidance and resources to rapidly implement best practices to reduce risk for overdoses, and enhance capacity to respond to events and recover should such overdose events occur.[118]

While the duties and responsibilities of each of these entities is similar, the ACRN is focused on opiate policy and funding, the SURG has a larger scope that includes studying all substances and making related policy and funding recommendations, and the Cross-Sector Task Force is intended to bring the two groups together to focus on shorter-term goals and leverage existing programs. Plans and reports produced by and for the SURG and ACRN are linked below.

- Annual Report of the Statewide Substance Use Response Working Group ("SURG") 2021, Office of the Attorney General
- Annual Report of the Statewide Substance Use Response Working Group (SURG) 2022, Office of the Attorney General
- Nevada Opioid Needs Assessment and State Plan 2022, DHHS
- Biennial Report of the Advisory Committee for a Resilient Nevada (ACRN) 2022, DHHS
- Annual Report from the Department of Health and Human Services: Fund for a Resilient Nevada, DHHS, December 2022

SUBSTANCE USE PREVENTION, HARM REDUCTION, TREATMENT, AND RECOVERY

One Nevada Agreement on Allocation of Opioid Recoveries
In August 2021, the Nevada Attorney General finalized an intrastate allocation agreement with all of the state's counties and litigating cities that provides a mechanism for allocating opioid-related settlement funds in the state. Known as the One Nevada Agreement on Allocation of Opioid Recoveries, the agreement provides a framework for distributing opioid settlements between the state and local governments in a fair and equitable manner.[119] Any allocation of the state's share of the funds must be deposited in the Fund for a Resilient Nevada.

State Substance Abuse Prevention Plan
Nevada's Substance Abuse Prevention Plan is a strategic plan to guide state efforts to plan, fund, and coordinate statewide substance abuse service delivery in alignment with state and federal regulations. The Prevention Plan provides a path for administering funding and coordinating substance use disorder services in order to implement evidence-based prevention programs, policies, and practices to prevent substance use. It aims to "promote healthy behaviors and reduce the impact of substance use and co-occurring disorders for Nevada's residents and communities" and achieve a vision of "Nevadans [who] are healthy and resilient and able to fully participate in their communities." Two versions of the plan are linked below.

- Two-Year Substance Abuse Prevention Plan: Substance Abuse Prevention and Treatment Block Grant, State of Nevada 2021-2023, DPBH, DHHS
- Five-Year Substance Abuse Prevention Plan: State of Nevada 2018-2023, DPBH, DHHS

SUPPORT Act Grant to Increase Substance Use Disorder Provider Capacity
The Nevada Division of Health Care Financing and Policy (DHCFP), DHHS, was one of 15 states awarded a federal Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act Planning Grant in 2019. The $1.68 million grant aimed to increase the capacity of Medicaid providers to deliver SUD treatment and recovery services through ongoing needs assessments, recruitment and training, and improved reimbursement for these services.

In 2021, Nevada was one of five states to receive a SUPPORT Act Post-Planning grant to develop an integrated care system for the treatment of SUD and OUD available to all residents, regardless of geographic location. The grant targets adolescents and young adults between the ages of 12 and 21, as well as prenatal, pregnant, and postpartum women and their infants to address neonatal abstinence syndrome. Grant activities aim to increase use of and billing options for Screening, Brief Intervention, and Referral to Treatment (SBIRT); enhance provider qualifications and willingness to provide SUD, OUD, and recovery services; increase SUD provider capacity through education, collaboration, and training; and develop medication assisted treatment (MAT) policy for Medicaid recipients.[120] Numerous assessments, strategic plans, and sustainability plans were developed to support these efforts, including those listed below.

SUBSTANCE USE PREVENTION, HARM REDUCTION, TREATMENT, AND RECOVERY

- Substance Use Disorder and Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report, DHCFP, DHHS, December 2020
- Nevada Substance Use Disorder Data Book, October 2019 – March 2021, DHCFP, DHHS
- Nevada Substance Use Disorder and Opioid Use Disorder Treatment and Recovery Services Provider Capacity Expansion Strategic Plan, DHCFP, DHHS, June 2021
- Nevada's Sustainability Plan to Support Expansion of SUD and OUD Treatment and Recovery Provider Capacity, DHCFP, DHHS, June 2021

Nevada State Targeted Response to the Opioid Crisis and State Opioid Response Grants
In 2017 and 2018, DPBH received $10.2 million in federal funding through the State Targeted Response to the Opioid Crisis (STR) grant, and from 2018 through 2023 it received an additional $65.48 million in State Opioid Response (SOR) grants. The SOR grant supports various statewide initiatives, including but not limited to:

- Medications for opioid use disorder and service-linkage efforts for individuals who are incarcerated;
- Development and delivery of opioid use disorder (OUD) and stimulant use disorder trainings for primary care and behavioral health practitioners;
- Residential treatment and transitional housing services for individuals who have an OUD or stimulant use disorder,
- Harm reduction trainings for community stakeholders;
- Opioid and stimulant-specific peer recovery support efforts;
- Hospital-based stimulant chronic psychosis treatment;
- Intensive outpatient services for individuals with an OUD or stimulant use disorder;
- Harm reduction supply purchasing and material distribution;
- Support for pregnant and post-partum mothers who use or have used opioids or stimulants; and
- Overall continuation of support for community efforts to prevent opioid and stimulant overdose and poisoning.

For more information regarding the most recent initiatives funded by the SOR grant, please visit the Nevada State Opioid Response website. This website also provides information and resources related to harm reduction, treatment and recovery, and training/education, among other issues. Key resources related to these grants are listed below.

- Nevada State Opioid Response – An STR/SOR Project
- Nevada Initiative Brief: Addressing Opioid Misuse and Disorders: The Impact of State Targeted Response and State Opioid Response Grants, National Association of State Alcohol and Drug Abuse Directors, 2021
- Nevada State Opioid Response Needs Assessment
- State Unintentional Drug Overdose Reporting System

SUBSTANCE USE PREVENTION, HARM REDUCTION, TREATMENT, AND RECOVERY

Overdose Data to Action

The Overdose Data to Action (OD2A) program collects high quality, comprehensive, and timelier data on opioid prescribing and mortality, which can be used to inform the state's substance use prevention and intervention efforts. Program goals include: 1) improving decision making, resource allocation, and informed intervention strategies based on improved quality and dissemination of fatal and non-fatal substance abuse and opioid use data; 2) enhancing the state's Prescription Drug Monitoring Program (PDMP), which supports evidence-based prescribing and data sharing to inform prevention and intervention strategies; 3) increasing the number of individuals referred for substance use, opioid use, or supportive services by streamlining the referral process; and 4) increasing awareness about opioid use, poly drug risk, and OUD stigma, treatment, and recovery.

Opioid Antagonist Medication Saturation Plan

In Fiscal Year (FY) 2022, 420 fatal overdoses occurred in which a bystander was present in Nevada. To reduce these deaths, DPBH recognizes the importance of increasing access to and use of opioid antagonists, medications that block the effects of opioids and help treat opioid overdose and opioid use disorder. The Division's Opioid Antagonist Medication Saturation Plan establishes a targeted distribution and communication strategy to increase the number of opioid antagonist kits, such as naloxone, at witnessed overdoses from nearly 28,000 in FY 2022, to 50,000 in FY 2024. The Plan aims to increase targeted distribution of opioid antagonists in overdose hotspots; enhance communication among and partnerships with organizations that work with populations that have experienced significant increases in opioid-related overdoses; and leverage existing partnerships to support the expansion of distribution efforts. As the opioid epidemic continues to evolve rapidly, the Plan is fluid and will be updated based on emerging threats and trends.

SUBSTANCE USE PREVENTION, HARM REDUCTION, TREATMENT, AND RECOVERY

WHAT CAN WE DO?

GOAL 3:

Increase the number of individuals receiving appropriate services throughout the continuum of care by increasing and improving prevention, harm reduction, treatment and recovery services in Nevada

OBJECTIVES:

3.1: Increase public awareness and education about substance use disorders, their effects, and available prevention, treatment, and recovery services to promote understanding of substance use disorders, reduce stigma, and increase knowledge about available resources and support

3.2: Improve access to high-quality, evidence-based treatment options and make them affordable and equitable for all individuals in need

3.3: Strengthen and elevate early intervention strategies to identify and address substance use issues promptly—before they evolve into more severe challenges—including through the creation of a robust drug surveillance program.

3.4: Support recovery-oriented systems of care, including access to harm reduction services, to assist individuals in recovery and facilitate their reintegration into society

3.5: Foster collaboration among various stakeholders, including government agencies, healthcare providers, school districts, community organizations, and law enforcement, to create a unified approach to addressing substance use issues

ADDITIONAL PLANS, EFFORTS, AND ALIGNMENT

- Behavioral Health Data Portal, Office of Analytics, DHHS
- Nevada Opioid Needs Assessment and State Plan 2022, DHHS
- Regional Behavioral Health Policy Boards annual reports and recommendations
- The goals to address this area of focus align with Healthy People 2030 objectives related to reducing misuse of drugs and alcohol.

INVESTING IN THE BEHAVIORAL HEALTH SYSTEM

Developing strong behavioral health systems requires sustained and comprehensive investment. Investment is a critical component to successfully implementing the systemic changes necessary to address all of the behavioral health issues in this plan—workforce development; children's behavioral health services; the crisis response system; and substance use prevention, harm reduction, treatment, and recovery services.

Currently, a variety of state, local, and other funding streams support initiatives to improve the behavioral health system in Nevada. Many, like those mentioned in the sections above, focus on specific issues. Others, such as the **Community Mental Health Services Block Grant (MHBG)**, provide critical funding that supports a wide range of behavioral health services and infrastructure. For example, the MHBG covers direct services for serious mental health conditions across the lifespan, mental health services for individuals who do not have health insurance, critical community infrastructure, and efforts to improve the state's mental health workforce. The MHBG also dedicates a portion of funds to addressing early serious mental illness, including first-episode psychosis, as well as to the crisis response system. In addition, it supports efforts of the state's five Regional Behavioral Health Policy Boards to address mental health needs and critical service gaps for adults with serious mental illness and children with serious emotional disturbance. This grant and others are vital to the state's behavioral health system and have led to progress in recent years, but new investments are needed to enhance the system to meet the needs of Nevadans.

Such investments should not redistribute existing money, but rather identify and leverage new opportunities and funding sources, from better using Medicaid and federal funding, to ensuring funding and incentives are aligned with desired outcomes, and beyond. A comprehensive list of recent efforts to increase funding and sustainability for behavioral health, remaining gaps, and strategies to address them, is provided in the 2023 Behavioral Health Community Integration Plan.

INVESTING IN THE BEHAVIORAL HEALTH SYSTEM

WHAT CAN WE DO?

GOAL 4:

Increase investment in the behavioral health system in Nevada—including federal, state, local, and private funding for mental health and substance use treatment and services to adequately support all components of the system

OBJECTIVES:

4.1: Increase overall State General Fund investment in Medicaid, and use these additional dollars to raise reimbursement rates for behavioral health services

4.2: Increase investment in (non-medical) wraparound services to assist those experiencing mental health challenges and substance use disorders

4.3: Increase financial incentives to attract and retain behavioral health professionals in Nevada (see Access to Care Goal 2)

4.4: Increase private sector and philanthropic investment and financial support of robust behavioral health services to help all Nevadans receive appropriate care (e.g. hospital investment in behavioral health clinics)

4.5: Pursue / encourage implementation of strategies to increase sustainable funding and reimbursement in Nevada's behavioral health system, as outlined in the Behavioral Health Community Integration Strategic Plan: Nevada's 2023 update to the Strategic Plan for Behavioral Health Community Integration

ADDITIONAL PLANS, EFFORTS, AND ALIGNMENT

Nearly all of the assessments, plans, and reports listed in the Mental Health and Substance Use section of this Plan identify investment as a requirement to improve behavioral health in Nevada.

- Behavioral Health Community Integration Strategic Plan: Nevada's 2023 update to the Strategic Plan for Behavioral Health Community Integration, DPBH, DHHS
- Regional Behavioral Health Policy Boards annual reports and recommendations

WHAT CAN WE MEASURE?

The indicators below will be monitored by DPBH to evaluate progress toward the goals outlined in this section through July 2028. Specific metrics, as well as baseline and target data, will be available as an addendum to this document.

- Decrease the number of children and youth at out-of-state residential treatment center facilities
- Decrease the total number of youth placements in residential treatment centers that are longer than 15 days
- Increase the number of school districts that collect and report data regarding student referrals and access to school- and community-based behavioral health providers
- Decrease the number of deaths by suicide
- Decrease the number of suicide attempts
- Decrease the portion of Medicaid super utilizers with behavioral health challenges who seek care in hospital emergency departments
- Improve specific 988 performance metrics
- Decrease unintentional drug deaths statewide
- Increase percent of Medicaid budget dedicated to behavioral health services
- Increase the number of school districts billing Medicaid for behavioral health services

Endnotes

77 Reinert, M, Fritze, D. & Nguyen, T. (October 2021). The State of Mental Health in America 2022. Mental Health America. Retrieved from https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf

78 Nevada Overdose Data to Action. (n.d.). Nevada State Unintentional Drug Overdose Reporting System, Report of Deaths 2019 to 2020 – Statewide. Retrieved from https://nvopioidresponse.org/wp-content/uploads/2019/05/sudors_report_2019_2020.pdf

79 Nevada Overdose Data to Action. (n.d.) Nevada State Unintentional Drug Overdose Reporting System, Report of Deaths January to December 2021 – Statewide. Retrieved from https://nvopioidresponse.org/wp-content/uploads/2022/10/SUDORS-Report-2021-All-Statewide.pdf

80 Nevada Overdose Data to Action. (n.d.) Nevada State Unintentional Drug Overdose Reporting System, Report of Deaths January to June 2022 – Statewide.
Retrieved from https://nvopioidresponse.org/wp-content/uploads/2023/04/SUDORS_Report_2022_P1_Statewide_Final_ADA.pdf

81 Nevada Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS). (2022). Nevada Opioid Needs Assessment and Statewide Plan 2022. Mercer. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/Advisory_Committees/ACRN/Updated_NV%20Opioid%20Needs%20Assessment%20and%20Statewide%20Plan%202022_FINAL_R%20KH%20121222(1)(4).pdf

82 Nevada Overdose Data to Action. (n.d.). Nevada State Unintentional Drug Overdose Reporting System, Report of Deaths 2019 to 2020 – Statewide.

83 Substance Abuse and Mental Health Services Administration. (2016). Substance Use and Suicide: A Nexus Requiring a Public Health Approach. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4935.pdf

84 Centers for Disease Control and Prevention. (n.d.). Suicide Data and Statistics. Retrieved from https://www.cdc.gov/suicide/suicide-data-statistics.html

85 Office of Analytics, DPBH, DHHS. (January 2023). Behavioral Health Wellness and Prevention 2022 Epidemiologic Profile: Nevada. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Bureau%20of%20Behavioral%20Health%20Wellness%20and%20Prevention,%20Epidemiologic%20Profile%20for%20Nevada,%202020.pdf

86 Ibid.

87 Marionneau, V., & Nikkinen, J. (2022). Gambling-related suicides and suicidality: A review of qualitative evidence. Frontiers in psychiatry.

88 Dassopoulos, A. & Chandler, R. (2023). A Snapshot of Gambling Behaviors, Attitudes, and Problem Gambling in Nevada: Findings from Surveillance Surveys. Prepared for the Nevada Department of Health and Human Services.

89 Goodwin, B. C., Browne, M., Rockloff, M., & Rose, J. (2017). A typical problem gambler affects six others. International Gambling Studies, 17(2), 276-289.

90 Latvala, T., Lintonen, T., & Konu, A. (2019). Public health effects of gambling–debate on a conceptual model. BMC public health, 19, 1-16.

91 Mental Health America. (2016-2021). Position Statement 41: Early Identification of Mental Health Issues in Young People. Retrieved from https://mhanational.org/issues/position-statement-41-early-identification-mental-health-issues-young-people

92 Office of the Surgeon General, U.S. Department of Health and Human Services. Protecting Youth Mental Health: The U.S. Surgeon General's Advisory. (2021) Retrieved from https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

93 Murthy, V. H. (2022). The Mental Health of Minority and Marginalized Young People: An Opportunity for Action. Public Health Reports 2022, 137(4) 613–616. https://journals.sagepub.com/doi/10.1177/00333549221102390

94 Mental Health America (n.d.) Children's Mental Health. Retrieved from https://www.mhanational.org/issues/childrens-mental-health#:~:text=Mental%20Health%20America%20(MHA)%20supports,Access%20to%20Services.

95 Skokauskas, N., Lavelle, T. A., Munir, K., Sampaio, F., Nystrand, C., McCrone, P., et al. (2018, April). The cost of child and adolescent mental health services. The Lancet Psychiatry. https://doi.org/10.1016/S2215-0366(18)30089-0

96 Nevada Rural Children's Mental Health Consortium. (2022). Service Priorities Report 2022. Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Meetings/RCMHC_Service_Priorities_Report%20_2022_FINAL_ADA.pdf

97 Civil Rights Division, United States Department of Justice. (October 2022). Investigation of Nevada's Use of Institutions to Serve Children with Behavioral Health Disabilities. Retrieved from https://www.justice.gov/d9/press-releases/attachments/2022/10/04/2022.10.04_report_of_nevada_investigation_0.pdf

98 DPBH, DHHS. (2023) Behavioral Health Community Integration Strategic Plan: Nevada's 2023 update to the Strategic Plan for Behavioral Health Community Integration.

99 Office of Analytics, DHHS. (n.d.) Children and Youth at Out-of-State Residential Treatment Center (RTC) Facilities

100 DPBH, DHHS. (2023) Behavioral Health Community Integration Strategic Plan: Nevada's 2023 update to the Strategic Plan for Behavioral Health Community Integration.

101 Ibid.

102 CASEL. (n.d.) What does the Research Say? Hundreds of independent studies confirm: SEL benefits students. Retrieved from https://casel.org/fundamentals-of-sel/what-does-the-research-say/

103 DPBH, DHHS. (2023) Behavioral Health Community Integration Strategic Plan: Nevada's 2023 update to the Strategic Plan for Behavioral Health Community Integration.

104 Clark County Children's Mental Health Consortium. (2023). 2023 Status Report. Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Meetings/CCCMHC%202023%20Status%20Report_1.31.23_ADA(2).pdf

105 Woodard, S. (August 2, 2022) Sequential Intercept Model: Intersection Between Criminal Justice and Behavioral Health. Presentation by DPBH, DHHS. Retrieved from https://sentencing.nv.gov/uploadedFiles/sentencingnvgov/content/Coordinating_Council/Meetings_and_Agendas/2022/8.3.22%20NLJRCC%20Mtg.%20Agenda%20Item%205%20Programs%20and%20Treatment%20Presentation%20-%20Final.pdf

106 DPBH, DHHS (n.d.). Towards a Comprehensive Crisis Response System in Nevada. Retrieved from https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalSAPTA/Nevada%20Crisis%20Systems%20White%20Paper%20Final%203-31.pdf

107 Woodard, S. (August 2, 2022) Sequential Intercept Model: Intersection Between Criminal Justice and Behavioral Health. Presentation by DPBH, DHHS.

108 Schober, M., Harburger, D.S., Sulzbach, D., Zabel, M. (2022). A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth. Technical Assistance Collaborative Paper No. 4. National Association of State Mental Health Program Directors. Retrieved from https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/nasmhpd-a-safe-place-to-be.pdf

109 Woodard, S. (August 2, 2022) Sequential Intercept Model: Intersection Between Criminal Justice and Behavioral Health. Presentation by DPBH, DHHS.

110 SAMHSA, U.S. Department of Health and Human Services. (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. Retrieved from https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

111 Ibid.

112 Ibid.

113 DPBH, DHHS. (n.d.) Crisis Response System. Retrieved from https://dpbh.nv.gov/Programs/CRS/CrisisResponseSystemHome/

114 Woodard, S. (August 2, 2022) Sequential Intercept Model: Intersection Between Criminal Justice and Behavioral Health. Presentation by DPBH, DHHS.

115 Lipari, R. N., & Van Horn, S. L. (2017). Trends in Substance Use Disorders Among Adults Aged 18 or Older. The CBHSQ Report. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/28792721

116 SAMHSA, U.S. Department of Health and Human Services. (n.d.) Harm Reduction. Retrieved from https://www.samhsa.gov/find-help/harm-reduction

117 DPBH, DHHS. (2022). Nevada Opioid Needs Assessment and Statewide Plan 2022. Mercer.

118 Joint Meeting of Advisory Committee for a Resilient Nevada (ACRN) and Substance Use Response Working Group (SURG). (Dec. 13, 2022). Cross-Sector Task Force to Address Overdose. Retrieved from https://ag.nv.gov/uploadedFiles/agnvgov/Content/About/Administration/12122022_Cross%20Sector%20Task%20Force%2012.13.22.pdf

119 Nevada Office of the Attorney General. (n.d.) Press Release: Attorney General Ford, Nevada Leaders Announce One Nevada Agreement for the Fair Allocation of Opioid Settlement Funds. Retrieved from https://ag.nv.gov/News/PR/2021/Attorney_General_Ford,_Nevada_Leaders_Announce_One_Nevada_Agreement_for_the_Fair_Allocation_of_Opioid_Settlement_Funds/

120 DHCFP, DHHS. (December 2020). Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report, Updated Version 3. Retrieved from https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/NV_SUPPORT_Act%20IAR_Final_CMS%20Disclaimer.pdf

PUBLIC HEALTH INFRASTRUCTURE:
TRANSFORMING NEVADA'S GOVERNMENTAL PUBLIC HEALTH SYSTEM

INTRODUCTION

The COVID-19 pandemic exposed the importance of robust public health systems and infrastructure, as well as the consequences of decades of chronic underfunding, workforce shortages, and outdated data and information technology systems. Nevada's capacity to respond to public health challenges was limited prior to the pandemic and exacerbated during the crisis. The pandemic also highlighted and intensified population-level health inequities in access to and quality of care, as well as disparities in health outcomes that have existed for years. It exposed various challenges and opportunities that must be addressed to mitigate the health and economic consequences of this crisis, and to ensure Nevada's governmental public health system is prepared both to continue promoting the health of residents and visitors, and to respond successfully to future public health emergencies.

WHAT DOES THE FIELD OF PUBLIC HEALTH DO?

The field of public health works to protect, promote, and improve the health and safety of communities. It addresses a wide range of factors that affect the health of entire populations—preventing disease and injury, planning and preparing for emergencies, promoting safe and healthy environments and lifestyles, and implementing policies. In contrast to clinical health care, which focuses on treating individuals who are sick, public health professionals work to prevent entire communities from getting sick or injured in the first place. This is often referred to an "upstream" approach to making people healthier.

In fact, health may be determined less by access to and use of health care than the combined impact of the environment and conditions in which people live, learn, work, and play. These are the areas the field of public health works to influence—from ensuring safe drinking water and clean air, to designing safe and healthy built environments and neighborhoods, setting safety standards to protect workers, tracking disease outbreaks and vaccinating communities to avoid the spread of disease, advocating for policies that keep people safe, and beyond.

However, public health efforts are often invisible, occurring behind the scenes to keep entire communities healthy. When public health systems are successful and prevention works as intended, they are largely unnoticed.

The field's focus on prevention also poses challenges to financial investment in public health, because it is difficult to document the impact of crises averted. Often, it is only when public health systems and activities break down and crises ensue that they garner attention and funding.

WHY ARE PUBLIC HEALTH EFFORTS IMPORTANT?

Public health services and programs provide the foundation for healthy people and communities—collectively extending life expectancy, reducing health care costs, and contributing to economic productivity. In fact, public health advances are responsible for 25 of the 30 years of increase in life expectancy during the 20th century.[121] Preventing disease and chronic conditions can also reduce the cost of health care. A 2017 systematic review found public health interventions to be "highly cost-saving" with a median return on investment of 14:1.[122] These findings may have significant implications in Nevada, where Medicaid—the state-federal health insurance program—accounts for approximately 30 percent all state expenditures.[123] Studies also show that healthier people are more productive workers and contribute to a stronger economy.[124]

INTRODUCTION

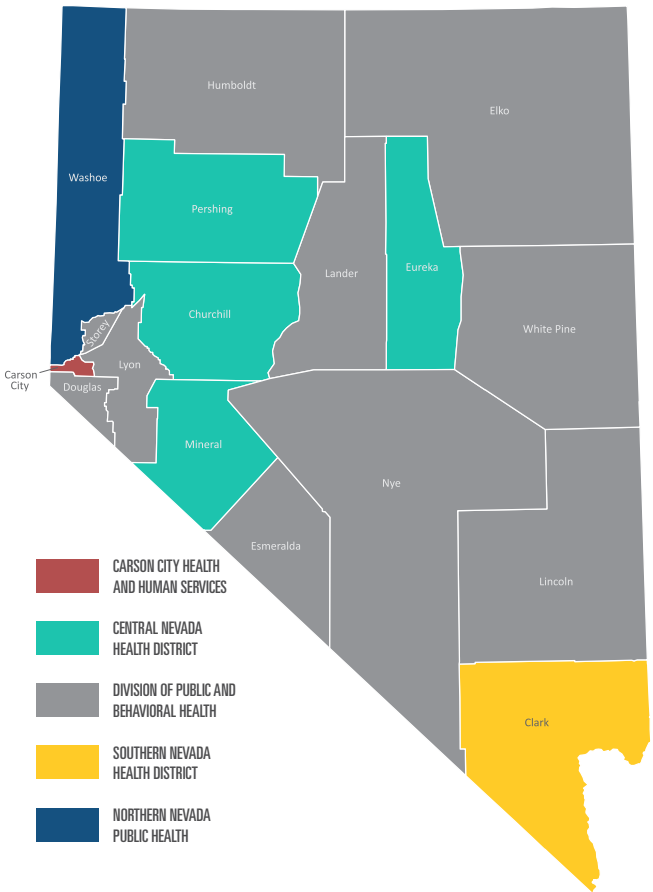
NEVADA'S PUBLIC HEALTH SYSTEM

In Nevada, Chapter 439 of *Nevada Revised Statutes* outlines statutory requirements for public health governance and administration. As of July 2023, four local public health authorities provide public health services in seven counties, to the vast majority of the state's population. The Division of Public and Behavioral Health (DPBH) within the Department of Health and Human Services (DHHS) provides services in the remaining counties.

Local public health authorities include three health districts: Southern Nevada Health District, Northern Nevada Public Health (formerly Washoe County Health District), and as of July 1, 2023, the newly established Central Nevada Health District. Carson City Health and Human Services provides public health services in Carson City and, though it is not a health district, certain services to Douglas, Lyon, and Storey Counties through interlocal agreements.

In addition, all counties are statutorily required to have either a county health officer and county board of health or, where a health district exists, a district health officer and district board of health.

FIGURE 7: PUBLIC HEALTH AUTHORITY JURISDICTION IN NEVADA



INTRODUCTION

LOOKING FORWARD

Because robust public health systems are foundational to maintaining and improving the health of Nevadans and the visitors on which the state's economy depends, this plan addresses four key opportunities:

- ☑ Increasing flexible, sustainable funding for the public health system;
- ☑ Improving public health workforce recruitment and retention;
- ☑ Strengthening and modernizing data and information technology; and
- ☑ Improving the quality of the public health system and its engagement with Nevada communities.

The goals and objectives in this section largely align with the Bipartisan Policy Center's Public Health Forward: Modernizing the U.S. Public Health System, which provides a framework to guide strategic investments and decision-making to develop a modernized public health system in the 21st century. Progress in these areas will help transform Nevada's public health infrastructure to meet current health needs, improve health equity, and prepare for future public health emergencies.

FUNDING CHALLENGES

A robust public health system requires adequate and sustainable funding to support the provision of core public health services with flexibility to address new and emerging public health issues and threats, and to sustain programming when federal or other external grants end. However, Nevada's public health system has been underfunded for decades. Prior to the COVID-19 pandemic, Nevada spent $72 per person on public health—the least of any state, except Wisconsin, with which it tied. Most funding was, and continues to be, provided through short term grants obligated for specific purposes—such as chronic disease prevention or maternal and child health. Lack of long-term investment makes it difficult to develop and maintain long-term programs and services, and lack of flexible funding impedes crisis response efforts when new issues arise.

Typically, public health emergencies—such as H1N1, COVID-19, Ebola, Mpox, SARS, or Zika—are followed by a wave of funding to address immediate short-term needs, rather than sustained investment in the systems and infrastructure necessary to prevent them. When crisis funding recedes, it leaves in its wake the same infrastructure challenges that existed previously. This pattern is evident in the response to various public health crises in the 21st century, and most recently with the COVID-19 pandemic. This pattern of funding can create significant challenges for recruitment and retention of trained public health professionals, as funding and trained staff are lost once an emergency ends. Each emergency and funding opportunity provide a temporary infusion of support, but often require retraining new staff.

Lack of resources not only affected the public health system's response to the COVID-19 pandemic, but also influenced its ability to prepare for future emergencies. Failure to adequately invest in the infrastructure necessary to support the entire system—specifically, the workforce, data, and technology on which the field so heavily relies—affects its ability to provide core services like communicable disease control, chronic disease and injury prevention, emergency preparedness and response, and maternal and child health promotion, among others.

In 2023, the Nevada State Legislature passed Senate Bill 118, appropriating $15 million to DPBH to distribute to local public health authorities and counties for local priorities that are not currently funded. While this represents one-time funding for FY 2024-2025, the bill requires funding not committed for expenditure by June 30, 2025, to be carried forward to the FY 2025-2026, for the same purpose. In addition, though the bill does not provide ongoing funding, or any funding for DPBH for statewide efforts and infrastructure, it represents the state's first non-categorical, flexible investment in Nevada's public health system. It is the first step to strengthening the public health system statewide; and it will help improve each local health authority's ability to respond to ongoing health threats, address unexpected public health emergencies, and continue creating the conditions in which all people can achieve their best health and wellbeing.

The Centers for Disease Control and Prevention (CDC) also provided states and large cities with grant funds to provide more flexible support to address specific infrastructure and data modernization efforts. This is a five-year project with the hope of future funding to meet the longer-term needs of states and cities.

FUNDING CHALLENGES

WHAT CAN WE DO?

GOAL 1:

Invest in the public health system, with funding levels that are appropriate, flexible, and sustainable to better meet current challenges and ongoing needs

OBJECTIVES:

1.1: Increase flexible, non-categorical State General Funds and local government funding provided to state and local public health authorities and counties

1.2: Develop an estimate of the cost to fill the gaps in Foundational Public Health Services (FPHS), based on the FPHS assessments conducted in Goal 4

1.3: Increase the capacity of Nevada's public health system to apply for public health funding to improve the health of communities, address health disparities, and promote health equity by creating one or more positions dedicated to identifying and applying for funding

1.4: Increase new sources/types of federal, philanthropic, and alternative funding for public health to state and local public health authorities and counties, and schools of public health at the University of Nevada, Reno (UNR) and University of Nevada, Las Vegas (UNLV)

WORKFORCE CHALLENGES

Lack of investment in the public health system also affects the public health workforce, which continues to experience challenges with recruitment, retention, and long-term vacancies in hard-to-fill positions. These positions include not only staff trained in public health, but also the many staff who support agency operations through human resources, fiscal and grant management, information technology, and administrative support. Workforce challenges were exacerbated by the COVID-19 pandemic. In 2021, a nationwide survey of state and local public health agencies found 32 percent of the public health workforce was considering leaving their organization in the next year.[125] A similar survey of DPBH employees in 2022, found 24 percent planned to leave the Division with one year, and 18 percent planned to retire within 5 years.

Failure to adequately fund state governmental public health agencies continues to limit the number of available positions, as well as competitive salaries, which are often significantly lower than similar roles in the private sector and at the county level. The top reason DPBH staff cited for planning to leave was pay; only one-third of employees indicated they were somewhat to very satisfied with their pay, meaning nearly two-thirds were not. In Nevada, state-level positions tend to pay less than similar roles at the county level, and vacancy rates are generally higher at DPBH than local public health authorities.

Work overload/burnout and lack of opportunities for advancement were other top reasons staff cited for leaving DPBH. Turnover and the process of recruiting and training staff not only is costly, but also results in lost institutional knowledge, lower productivity, and operational challenges to serving residents.

In addition, only a small portion of the public health workforce has formal public health training. Nationwide this figure is around 14 percent, and though statewide data is not available in Nevada, trends appear similar.[126] This means additional time and resources are necessary to ensure public health professionals have appropriate education and training, and points to the importance of strong relationships and collaboration between public health agencies and institutions of higher education.

WORKFORCE CHALLENGES

WHAT CAN WE DO?

GOAL 2:

Improve recruitment and retention of a diverse and inclusive governmental public health workforce

OBJECTIVES:

2.1: Improve ongoing data collection to identify strengths and needs of the public health workforce statewide by conducting annual workforce development assessments

2.2: Improve access to free, high-quality public health training that meets identified needs of state and local public health professionals in Nevada to improve retention and career advancement

2.3: Elevate and support implementation of the Public Health Workforce Pipeline Development Plan created by the Nevada Health Care Workforce and Pipeline Development Workgroup to strengthen and diversify public health workforce pipelines; expand internships, fellowships, loan-repayment, and other career on-ramp programs; and improve hiring and promotion policies/procedures to ensure diversity and high-quality public health services

2.4: Advance health equity by assessing organizational culture within state and local public health authorities and making organizational changes to improve cultural awareness/competence, create an inclusive workplace, and improve staff retention and the quality of services

2.5: Establish new or enhance implementation of existing academic health departments between academic institutions, state and local health authorities, and technical training programs to build a cross-disciplinary workforce and provide students with experiential opportunities in public health

ADDITIONAL PLANS, EFFORTS, AND ALIGNMENT

- Public Health Workforce Pipeline Development Plan, Nevada Health Care Workforce and Pipeline Development Workgroup

DATA AND INFORMATION TECHNOLOGY MODERNIZATION

Public health systems rely on timely and accurate data to identify issues that affect the health of the community, improve health outcomes, and promote health equity. Outdated, siloed data and information technology (IT) systems hinder efficient data collection, analysis, and sharing. During the COVID-19 pandemic, for example, it was not uncommon for public health data to be shared via fax machine—a manual, labor-intensive, and inefficient process compared to sharing the same data through modern technology. Such systems need to be updated and modernized to use the public health workforce more efficiently, detect new and emerging public health threats more effectively, identify groups that may be at risk more quickly, and respond appropriately using data-informed decisions. Data and IT modernization includes ensuring system interoperability; enhancing bi-directional data sharing across federal, state, and local governmental public health systems, laboratories, and health care systems; improving data security; and standardizing data collection. Modernizing public health data and IT systems will enable public health agencies to analyze and share data with policymakers and the public in a timelier manner but requires both monetary investment and workforce development.

In Nevada, DPBH is working to improve these systems with federal funding from the CDC's Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) Program and the Public Health Infrastructure Grant (PHIG). In 2022, for example, the ELC enabled DPBH to launch EpiTrax, a nearly-statewide disease surveillance system. The Division continues to improve the system by integrating electronic case reporting data from providers and implementing Message Mapping Guides for specific conditions to better align with the CDC. The ELC also is supporting updates to the state's vital records system to enable interoperability with the National Center for Health Statistics, which will improve data accuracy and efficiency.

In addition, through the PHIG, DPBH is evaluating its current capacity, gaps, and opportunities to modernize public health data infrastructure and operations, and to develop and implement plans to modernize data infrastructure and streamline business processes. These efforts include supporting data interoperability to ensure better quality and completeness across systems; reducing manual processes in data collection and reporting activities through automation; using new tools to improve, standardize, and modernize data processing and analytics; and consolidating data and workflows from legacy systems. The Division also is expanding the use of PowerBI to develop internal and external dashboards for various purposes, including quality improvement; enhancing the skills of its workforce; and providing data-related assistance and services for local and Tribal partners.

DATA AND INFORMATION TECHNOLOGY MODERNIZATION

WHAT CAN WE DO?

GOAL 3:

Improve recruitment and retention of a diverse and inclusive governmental public health workforce

OBJECTIVES:

3.1: Modernize and invest in efficient, interoperable data collection and IT systems to improve and enhance the collection, analysis, accuracy, and timeliness of public health data statewide to address health inequities in communities

3.2: Increase data available to the community by developing user-friendly data dashboards and other systems to display real-time data

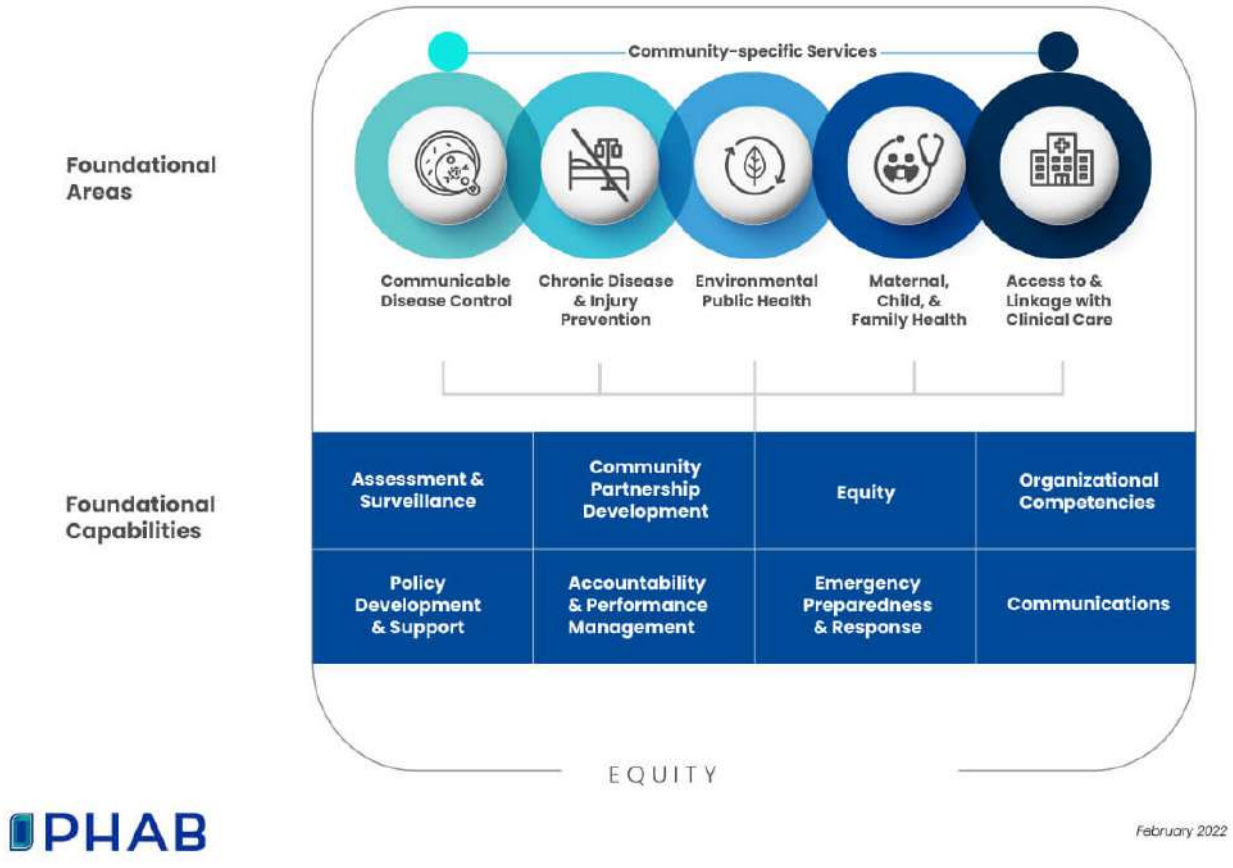
3.3: Explore and identify opportunities to improve data sharing and interoperability between state and local public health authorities and health care entities to reduce health disparities and inequities

QUALITY, GOVERNANCE, AND COMMUNITY ENGAGEMENT

DELIVERING QUALITY PUBLIC HEALTH SERVICES

In Nevada and across the nation, efforts are underway to ensure a minimum set of quality public health services and programs are available in all communities. These Foundational Public Health Services (FPHS) are the unique responsibility of governmental public health systems and include preventing the spread of communicable disease; preventing chronic disease and injury; ensuring air, food, and water quality; improving maternal, child, and family health; and improving access to clinical health care services. To provide these services 24 hours per day, seven days per week, public health departments must have infrastructure that enables the provision of eight foundational capabilities, as shown in the diagram below. In addition, state and local health authorities provide essential community-specific services, which are alluded to in the line above the "Foundational Areas" in this diagram.

FIGURE 8: FOUNDATIONAL PUBLIC HEALTH SERVICES



QUALITY, GOVERNANCE, AND COMMUNITY ENGAGEMENT

Northern Nevada Public Health (formerly Washoe County Health District) evaluated its FPHS and determined that in order to provide these core services, it would need more than 32 additional full-time equivalents (FTEs). This does not include the additional FTEs necessary to provide essential community-specific services.

Other state and local public health authorities in Nevada are planning to conduct similar FPHS assessments to better understand gaps in available services and staffing, and to estimate the cost of ensuring these services are available to everyone in the state.

In order to demonstrate that the services provided are high quality and meet the needs of the community, government public health agencies are increasingly pursuing national accreditation through the Public Health Accreditation Board. Accreditation offers an opportunity to assess an agency's strengths and areas of opportunity, promotes public trust, and shows a commitment to quality and performance improvement. In Nevada, Carson City Health and Human Services, Northern Nevada Public Health, and Southern Nevada Health District are accredited, and DPBH is pursuing accreditation.

REGIONALIZING PUBLIC HEALTH GOVERNANCE AND ADMINISTRATION

Also key to providing the most efficient and effective public health services is ensuring they are delivered in a way that best meets the needs of the communities served. Prior to and through the COVID-19 pandemic, DPBH provided public health services to most rural counties in Nevada, but in July 2023, the state's first rural regional health district was established by the City of Fallon and Churchill, Mineral, Eureka, and Pershing Counties. Central Nevada Health District (CNHD) was developed based on the "belief that local communities knew, understood, and could provide services for their populations better than the state could . . . that through combining the resources and efforts of multiple rural communities, they could increase the efficiency and effectiveness of their services," and that this approach would improve public health outcomes.[127]

Other rural counties are evaluating the best way to improve the efficiency of and access to public health services as well. The Nevada Association of Counties (NACO) and Nevada Economic Assessment Project (NEAP), within the College of Agriculture, Biotechnology and Natural Resource's Extension at UNR, are conducting a county-by-county FPHS assessment to establish a baseline understanding of where and how public health services are delivered across rural and frontier Nevada. The study will collect ratings on the perceived level of expertise, capacity, and implementation of these services in each rural and frontier county, with a goal of providing counties with actionable data about their local and regional assets, as well as gaps, to improve strategic planning, collaboration, and investment in public health infrastructure.

QUALITY, GOVERNANCE, AND COMMUNITY ENGAGEMENT

PARTNERSHIPS AND COMMUNITY ENGAGEMENT

The success of public health efforts also depends on public trust and community engagement. In the spring of 2020, as the COVID-19 pandemic began, polls showed the vast majority of respondents supported public health officials, but by early 2021, only 40 percent of respondents indicated they trusted their state and local health departments.[128,129] Factors influencing this decline include misinformation, politicization, and mixed communication regarding the COVID-19 pandemic, and resulted in serious consequences. Lack of trust undermined the effectiveness of the public health system, and ultimately the health and safety of communities.

In order to rebuild trust, the field of public health is working to enhance community engagement through clear, consistent, and compelling communication about what public health is and why it is important. This requires building relationships with new partners and sectors (for example, education, health care, housing, law enforcement, transportation), the media, residents, and community-based organizations—and especially those who serve communities that disproportionately experience health inequities. It also involves strengthening partnerships to advocate for public health, including public-private partnerships, partnerships with community-based organizations that address social determinants of health, and policymakers who can significantly influence the health of communities and health equity through population-level policies.

In Nevada, various stakeholders are working to rebuild trust in the public health system through enhancing understanding, developing relationships, increasing engagement, and strengthening partnerships.

QUALITY, GOVERNANCE, AND COMMUNITY ENGAGEMENT

WHAT CAN WE DO?

GOAL 4:

Improve and strengthen governance and quality of Nevada's public health system—ensuring a minimum set of public health services for all—and improve partnerships and community engagement to communicate the value and availability of these services in all Nevada communities

OBJECTIVES:

4.1: Assess FPHS provided by each local health authority and by DPBH in rural and frontier counties that do not have public health authorities; identify gaps and the number of FTEs necessary to address them

4.2: Increase the number of state and local health authorities that are accredited or reaccredited by the Public Health Accreditation Board (PHAB) or pursuing PHAB's Pathways Recognition Program

4.3: Continue progress toward enhancing public health services in the 11 rural counties that do not have health districts, including opportunities to regionalize, create efficiencies, and/or share resources

4.4: Strengthen partnerships with and understanding of the role and value of public health authorities among the public, policymakers, other sectors (e.g. education, health care, housing, law enforcement, transportation) and stakeholders (e.g. business, community-based organizations, faith-based organizations) by clearly delineating shared goals, respective responsibilities, and building sustainable and equitable collaborations

WHAT CAN WE MEASURE?

The indicators below will be monitored by DPBH to evaluate progress toward the goals outlined in this section, through July 2028. Specific metrics, as well as baseline and target data, will be available as an addendum to this document.

- Increase or maintain flexible, non-categorical State General Fund dollars allocated to state and local health authorities
- Increase local flexible funding for public health
- Increase per capita funding for public health in Nevada
- Decrease staff vacancy rates and improve retention at state and local public health authorities
- Publish a comprehensive report regarding current capacity, gaps, and opportunities to modernize public health data infrastructure and operations
- Develop an implementation plan to modernize public health data infrastructure
- Increase the number of PowerBI or other dashboards with public health data that are available to partners and the public
- Increase the number of local health authorities and rural counties that have completed an FPHS assessment
- Increase the number of state and local health authorities in Nevada that are accredited by the Public Health Accreditation Board
- Increase the number of local or regional health districts in Nevada

Endnotes

121 Centers for Disease Control and Prevention. (1999). Ten Great Public Health Achievements – United States, 1900-1999. Morbidity and Mortality Weekly Report, 48(12), 241-264. Retrieved from https://www.cdc.gov/mmwr/pdf/wk/mm4812.pdf

122 Masters, R., Anwar, E., Collins, B., Cookson, R., & Capewell, S. (2017). Return on investment of public health interventions: a systematic review. Journal of Epidemiology and Community Health, 71(8), 827-834. https://jech.bmj.com/content/jech/71/8/827.full.pdf

123 Weeks, S. (2023). FY 2024-25 Budget Presentation. Division of Health Care Financing and Policy, DHHS. Retrieved from https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/DHCFP%20Budget%20Presentation%202023_Revised2(1).pdf

124 Harvard University. (2012). Public Health and the U.S. Economy. Chan School of Public Health. Retrieved from https://www.hsph.harvard.edu/news/magazine/public-health-economy-election/

125 De Beaumont Foundation. (2021). 2021 Findings, Public Health Workforce Interests and Needs Survey (PH WINS). Retrieved from https://debeaumont.org/phwins/2021-findings/

126 National Network of Public Health Institutes. (2021). Challenges and Opportunities for Strengthening the US Public Health Infrastructure. Retrieved from https://nnphi.org/wp-content/uploads/2021/06/NNPHI-E2A-Kresge-Report-Web.pdf

127 Central Nevada Health District. (2023). History of CNHD. Retrieved from https://www.centralnevadahd.org/history-of-cnhd/

128 Pew Research Center (2020). Worries About Coronavirus Surge, as Most Americans Expect a Recession – or Worse. Retrieved from https://www.pewresearch.org/politics/2020/03/26/worries-about-coronavirus-surge-as-most-americans-expect-a-recession-or-worse/#:~:text=Nearly%20two%2Dthirds%20of%20Americans,health%20of%20the%20U.S.%20population

129 Simmons-Duffin. S. (2021). Poll Finds Public Health Has a Trust Problem. National Public Radio. Retrieved from https://www.npr.org/2021/05/13/996331692/poll-finds-public-health-has-a-trust-problem

NEXT STEPS: IMPLEMENTATION

NEXT STEPS:

IMPLEMENTATION

Implementation of the 2023-2028 Silver State Health Improvement Plan will be led by DPBH's Office of Public Health Infrastructure and Improvement (OPHII) in cooperation with DPBH programs, other Divisions of DHHS, local health authorities, and partner organizations.

However, this Plan is a resource for all Nevadans, and organizations throughout the state are encouraged to align their work with its priorities, goals, and objectives—identifying and implementing the best strategies to contribute to this collective effort.

Next steps for implementation include developing action plans and a final list of indicators, monitoring progress and tracking results, and reviewing and revising the plan.

Developing Action Plans and a Final List of Indicators

- Identify and collaborate with DPBH staff and partners to develop and implement action plans to make progress toward each objective. Action plans will include SMART objectives, strategies and action steps; outline timelines and target results; and identify existing assets and/or resources needed for implementation. Compile action plans into a comprehensive SSHIP Implementation Plan.
- Develop a final list of indicators to track progress, including baseline and target data, based on initial lists of indicators outlined in "What Can We Measure" sections of the SSHIP.

Monitoring Progress and Track Results

- Develop an accountability and monitoring system within DPBH's Performance Management System to track progress, key indicators, and performance measures.
- Track progress of each individual action plan by engaging stakeholders every 6 to 12 months to review activity and revise strategies and action steps, as necessary.
- Monitor and report overall progress on key indicators through DPBH's Performance Management System.

Reviewing and Revising the Plan

- Review SSHIP implementation progress annually and produce an annual report.
- Review and revise the SSHIP every five years, or more frequently as needed.

Implementation of the SSHIP will require coordination among DPBH; local health authorities; other entities within Nevada's public health system; and various state, local, public, private, and community-based partners. Many of the priorities and focus areas identified in the Plan are complicated, ongoing issues that will not be solved in five years. However, the goal of this plan is to make progress toward improving the conditions that influence the health of Nevada residents and visitors, as well as their overall health.

ACKNOWLEDGMENTS

ACKNOWLEDGMENTS

The 2023-2028 Silver State Health Improvement Plan was developed collaboratively with input from diverse partners and stakeholders across the state. On behalf of DPBH leadership, we would like to express our sincerest gratitude to all who contributed to this plan—for their time, thoughtfulness, expertise, and partnership in making the lives of Nevada residents and visitors healthier, happier, longer, and safer.

Special thanks to the team at the Center for Public Health Excellence within the School of Public Health at the University of Nevada, Reno **(Megan Comlossy, Micki Golden, Rachel Kiser, Tamara Telles,** and **Zach Dupin)**, who led this collaborative process and prepared the Plan with funding and support from the Division of Public and Behavioral Health.

The DPBH Executive Team and the Office of Public Health Infrastructure and Improvement

- **Cody Phinney**, MPH, Administrator, DPBH
- **Julia Peek**, MHA, CPM, Deputy Administrator, Community Health Services
- **Kyle Devine**, MSW, Deputy Administrator, Regulatory and Planning Services
- **Erin Williams**, Deputy Administrator, Administrative Services
- Vacant, Deputy Administrator, Clinical Services
- **Ihsan Azzam**, PhD, MD, Chief Medical Officer
- **Melissa Peek-Bullock**, MPH, State Epidemiologist
- **Mitch DeValliere**, Agency Manager, Office of Public Health Infrastructure and Improvement

ACKNOWLEDGMENTS

SHIP STEERING COMMITTEE

Taylor Allison, Nevada Association of Counties (NACO)

Cecia Alvarado, Somos Votantes Nevada

Allison Cladianos, School of Public Health, University of Nevada Reno (UNR)

April Cruda, Nevada Office of Minority Health and Equity (NOMHE), DHHS

Nilay Etiler, Health Equity and Impact, UNR School of Public Health

Karina Fox, NOMHE

Jeanne Freeman, Carson City Health and Human Services (CCHHS)

Allison Genco, Office of Governor Joe Lombardo

Teri Gilbert-Eisenga, Washoe Tribal Health James Weston, Regional Transportation Commission of Washoe County

Nia Girma, Housing Division, Department of Business and Industry

Joan Hall, Nevada Rural Hospital Partners

Lily Helzer, Chronic Disease Prevention and Health Promotion, DPBH

Carmen Hua, Southern Nevada Health District (SNHD)

Geraldine Inciso, Division of Welfare and Supportive Services (DWSS), DHHS

Joseph Iser, Nevada Public Health Institute (NPHI)

Maddy Larson, Graduate Student, School of Public Health, UNR

Jose Melendrez, Nevada Minority Health and Equity Coalition and School of Public Health, University of Nevada Las Vegas (UNLV)

Julia Peek, Community Health Services, DPBH

Julia Ratti, Northern Nevada Public Health (NNPH)

Tatum Sutliff, Keep Truckee Meadows Beautiful

Christina Thomas, Veterans Advocacy Council Community Development Corporation

André Wade, Silver State Equality

James Weston, Regional Transportation Commission (RTC) of Washoe County

ACKNOWLEDGMENTS

ACCESS TO CARE SUBCOMMITTEE

Stephanie Africa, DPBH

Keith Benson, State Dental Health Officer, Division of Health Care Financing and Policy (DHCFP), DHHS

Colleen Camenisch, Nevada Physician Wellness Coalition

Katie Charleson, Silver State Health Insurance Exchange

Trista Goldstein, Office State Epidemiology (OSE), DPBH

Jannette Gomez, Nevada Oral Health Program, DPBH

Gregory Gray, City of Las Vegas

Tonya Hernandez, Division of Child and Family Services (DCFS), DHHS

Carmen Hua, SNHD

Geraldine Inciso, DWSS, DHHS

Joseph Iser, NPHI

Jeffrey Klein, Nevada Senior Services

Nancy Kuhles, Nevada Speech Language Hearing Association Coalition

Rhonda Lawrence, DCFS, DHHS

Melissa Mowry, Inter-Tribal Council of Nevada

Tracy Palmer, Bureau of Behavioral Health Wellness and Prevention, DPBH

Andy Pasternak, Nevada State Medical Association

Katharyn Reece, CCHHS

Salena Savarda, OSE, DPBH

Breana Taylor, Nevada State Association of School Nurses

Shara Theisen, Nevada Department of Transportation (NDOT)

Lacey Tisler, NDOT

Courtney Welch, Rural Clinics, DPBH

James Weston, RTC Washoe County

ACKNOWLEDGMENTS

MENTAL HEALTH AND SUBSTANCE USE SUBCOMMITTEE

Stephanie Africa, DPBH

Misty Vaughan Allen, Suicide and Prevention, DPBH

Shannon Bennett, Bureau of Behavioral Health Wellness and Prevention, DPBH

Michele Berry, Center for the Application of Substance Abuse Technologies (CASAT)

Parvaneh Carter, NevadaWorks

Katie Charleson, Silver State Health Insurance Exchange

Kristen Clements-Nolle, School of Public Health, UNR

Ruth Condray, DPBH

Stephanie Cook, Bureau of Behavioral Health Wellness and Prevention, DPBH

Rebecca Cruz-Nanez, SNHD

Sarah Dearborn, DHCFP, DHHS

Vanessa Diaz, Fund for a Resilient Nevada, DHHS

Eric Eakin, Chronic Disease Prevention and Health Promotion, DPBH

Shannon Ernst, Churchill County Social Services

Jeanne Freeman, CCHHS

Cameron Ginn, OSE, DPBH

Trista Goldstein, OSE, DPBH

Jannette Gomez, Nevada Oral Health Program, DPBH

Andrea Gregg, High Sierra AHEC

Joan Hall, Nevada Rural Hospital Partners

Tonya Hernandez, DCFS

Sara Hunt, UNLV Mental and Behavioral Health Coalition

Amy Hyne-Sutherland, NACO

Terry L. Kerns, Nevada Office of the Attorney General

Nancy Kuhles, Nevada Speech Language Hearing Association Coalition

Heide Laird, SNHD

Maddy Larson, Graduate Student, School of Public Health, UNR

Lisa Lee

Cindy Lepe

Wendy Madson, Healthy Communities Coalition

Alexandra Neal, NOMHE, DHHS

Mary Jane Ostrander, CCHHS

ACKNOWLEDGMENTS

MENTAL HEALTH AND SUBSTANCE USE SUBCOMMITTEE

Tracy Palmer, Bureau of Behavioral Health Wellness and Prevention, DPBH

Cody Phinney, Administrator, DPBH

Cindy Pitlock, Administrator, DCFS

Ann Polakowski, Children's Mental Health, DCFS

Natalie Powell, CASAT

Katarina Pulver, SNHD

Yanyan Qiu, Tobacco Control Program, DPBH

Julia Ratti, NNPH

Kim Riggs, DWSS, DHHS

Azucena Ledezma Rubio, CCHHS

Michelle Sandoval, Rural Clinics, DPBH

Salena Savarda, OSE, DPBH

Erik Schoen, Community Chest, Inc.

Patricia Segura, Wellness and Prevention Program, DPBH

Denise Stokich, OSE, DPBH

Dana Walburn, Nevada Department of Education

Stacie Weeks, Administrator, DHCFP

Courtney Welch, Rural Clinics, DPBH

Daria Winslow, Partnership Douglas County

Stephanie Woodard, DHHS

Dawn Yohey, DPBH

ACKNOWLEDGMENTS

PUBLIC HEALTH INFRASTRUCTURE SUBCOMMITTEE

Stephanie Africa, DPBH

April Cruda, NOMHE

Eric Eakin, Program, DPBH

Jeanne Freeman, CCHHS

Allison Genco, Office of Governor Joe Lombardo

Joe Ginty, SNHD

Jannette Gomez, Nevada Oral Health Program, DPBH

Andrea Gregg, High Sierra AHEC

Valerie Cauhape Haskin, Rural Regional Behavioral Health Policy Board

Amy Hyne-Sutherland, NACO

Joseph Iser, NPHI

Nancy Kuhles, Nevada Speech Language Hearing Association Coalition

Natalie Mazzullo, Healthy Aging Initiative, UNR, Extension

Tracy Palmer, Bureau of Behavioral Health Wellness and Prevention, DPBH

Mona Lisa Paulo, The Gay and Lesbian Center of Southern Nevada

Julia Peek, Community Health Services, DPBH

Yanyan Qiu, Tobacco Control Program, DPBH

Kim Riggs, DWSS

Andrea Rivers, Office of Public Health Infrastructure and Improvement, DPBH

Sarah Rogers, Child, Family and Community Wellness, DPBH

Azucena Ledezma Rubio, CCHHS

Patricia Segura, Wellness and Prevention Program, DPBH

Lacey Tisler, NDOT

ACKNOWLEDGMENTS

SOCIAL DETERMINANTS OF HEALTH SUBCOMMITTEE

Itzayana Montoya Adame, NNPH

Sarah Adler, Silver State Government Relations

Stephanie Africa, DPBH

Katie Charleson, Silver State Health Insurance Exchange

April Cruda, NOMHE

Nilay Etiler, Larson Institute, UNR

Allison Genco, Office of Governor Joe Lombardo

Jannette Gomez, Nevada Oral Health Program, DPBH

Andrea Gregg, High Sierra AHEC

Valerie Cauhape Haskin, Rural Regional Behavioral Health Policy Board

Amy Hyne-Sutherland, NACO

Geraldine Inciso, DWSS

Nancy Kuhles, Nevada Speech Language Hearing Association Coalition

Mary Jane Ostrander, CCHHS

Tracy Palmer, Bureau of Behavioral Health Wellness and Prevention, DPBH

Mona Lisa Paulo, The Gay and Lesbian Center of Southern Nevada

Katie Peacock-Dutt, Sierra Nevada Health Care System-Reno VA Medical Center

Yanyan Qiu, Tobacco Control Program, DPBH

Kim Riggs, DWSS

Sarah Rogers, Child, Family and Community Wellness, DPBH

Azucena Ledezma Rubio, CCHHS

Salena Savarda, OSE, DPBH

Carolyn Schut, United Healthcare

Jeremy Smith, Truckee Meadows Regional Planning Agency

Denise Stokich, OSE, DPBH

Lacey Tisler, NDOT

Tamera Travis, SNHD

CONTACT US

For questions or to get involved, contact DPBH's Office of Public Health Infrastructure and Improvement: DPBHPHHI@health.nv.gov

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH