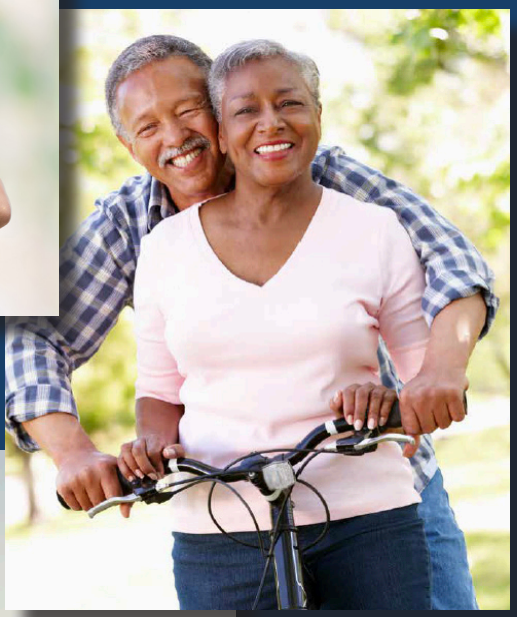

Nevada Department of Health and Human Services

Needs Assessment

April 2022

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Introduction: Purpose and Need

Every biennium, the Nevada Department of Health, and Human Services (DHHS) conducts a statewide needs assessment utilizing qualitative and quantitative data for an evidence-based approach to inform future funding priority areas for consideration of by the Grants Management Advisory Committee (GMAC) (See Appendix A for more details about the GMAC).

The Nevada Department of Health and Human services is comprised of separate divisions that work cooperatively to provide health and social services, programs and supports to individuals who are at risk of poor health and wellness outcomes, who are underserved and those who have been historically marginalized and disproportionately impacted by poverty and barriers to care, including those in rural and frontier communities.

This needs assessment aims to identify priority needs across Nevada, as well as within regions, communities, through an equity lens, with a focus on special/underserved populations to provide data to the DHHS and GMAC as they identify funding investment decisions across a wide range of funding streams to meet the gaps and needs across the State.

To accomplish the mandates set in statute of determining the needs of local communities and setting priorities for funding programs, this report incorporates secondary data, primary data from recent Washoe County Community Health Needs Assessment and the Southern Nevada Health Assessment Report, and preceding needs assessments in addition to other supporting reports and documentation to highlight needs and gaps in infrastructure and services across Nevada's diverse communities, with a focus on underserved populations, access to services, and the incredible diversity of regions between our most urban centers and rural and frontier communities.

Secondary data sources include the Behavioral Risk Factor Surveillance System (BRFSS), Youth Behavior Risk Surveillance System (YRBSS), County Health Rankings, Nevada State Demographer, U.S. Census Bureau, U.S. Housing and Urban Development (HUD), and the Centers for Disease Control (CDC). A list of sources for readers can be found in the Data Sources section with links to the available reports.

As presented in this Needs Assessment, the priority needs areas based on the Current Landscape data as well as rankings and input from recent qualitative report findings from the studies cited in the Community Voices section include:

- Behavioral/Mental Health and/or Substance Use and Abuse
- Access to Health Care
- Housing

Methods and Approach

A formal needs assessment for this project was conducted using an applied Mixed Methods model to integrate qualitative and quantitative data to identify the most pressing needs across Nevada and provide recommendations for the consideration of the Nevada DHHS and the GMAC. Ultimately, the goal of this applied Mixed Methods approach is to integrate different data points, data types, and relevant information into a single report for the DHHS to have readily accessible data to inform decisions around funding investments.

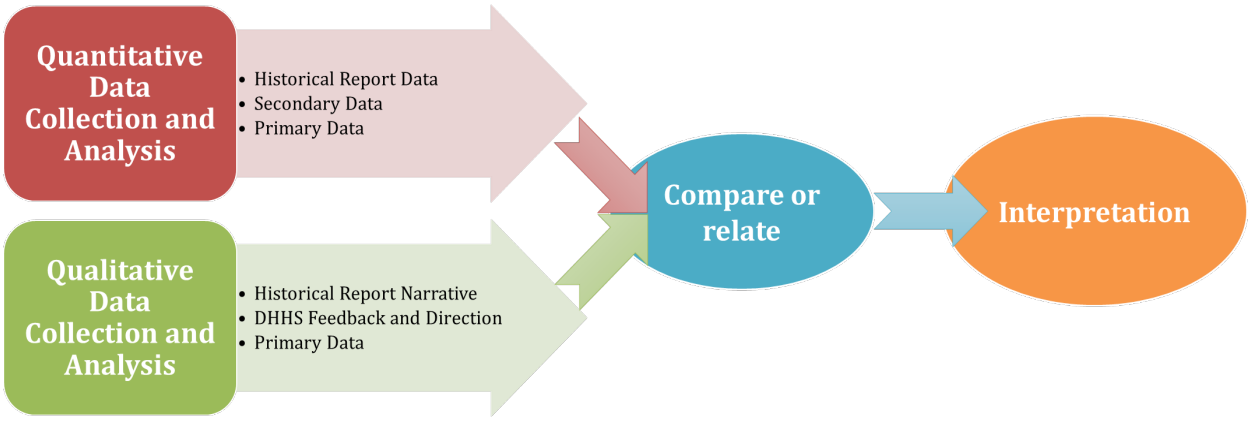
Methods research relies on defining a worldview under which a theoretical lens is defined, a methodological approach is selected and implemented through the collection and analysis of data (Figure 1). The applied Mixed Methods model proposed for this project does not rely on a theoretical lens, but instead focus on the assessment of needs and identification of gaps, which is then analyzed using a Mixed Methods model.[1] Finally, the data collected is a combination of both primary and secondary data related to the purpose for the project.

FIGURE 1. MIXED METHODS MODEL

It is important to note that the Mixed Methods literature offers not only the model for this needs assessment, but also for longer term annual or biennium assessments. Specifically, the model below was selected as it offers the opportunity to select both quantitative and qualitative data for inclusion for a more holistic discussion of the interpretation of results. Considering the vast number of reports with narrative developed precedingly as well as quantitative data collected and reported by secondary resources and primary data that includes both quantitative and qualitative data, the Convergent Parallel Design[2] was the best model-fit for the current project (Figure 2).

[1] Creswell, J. and Plano Clark, V. (2011). *Designing and Conducting Mixed Methods Research (*2nd edition). SAGE Publications. pp 39
[2] Ibid pp. 69

FIGURE 2. DHHS NEEDS ASSESSMENT CONVERGENT PARALLEL DESIGN



The collection of the data and preceding reports was conducted simultaneously during the project period preceding the development of this report and conducting of analysis. A statewide survey was not part of the scope of this project, as recent needs assessments in Clark and Washoe are available and have robust responses from the community, supporting the inclusion of their findings in this report. Collectively, these available data sources improve the ability of DHHS and the GMAC to determine funding investments and programming decision making and design activities.

Data Limitations, Challenges and Technical Notes

There are several data limitations related to the available secondary data from high-quality sources, such as the YRBSS and BRFSS, that have not yet been updated with new data because of delays in survey implementation during the COVID-19 Pandemic. For many of the topics analyzed, there are gaps in the data or delays in the publication of the data due to the pandemic. As new data are available in the coming year, the trend data presented in this needs assessment should be reassessed and updated to maintain assessments of current trends and changes in relative baselines. Traditionally, the updated survey data from the YRBSS and BRFSS would have been available as part of this project; however, considering the COVID-19 Pandemic and associated delays, the data presented throughout has time-based (recency) limitations.

Additionally, there are several areas of focus that present with data limitation at the state level, including health and wellness outcome data for former foster youth, youth who have transitioned out of the juvenile justice system, LGBTQIA+ populations and Nevada's Tribal communities, child welfare system, as well as for children and youth involved in the juvenile justice system. Where limitations were encountered, researchers added national data and national statistics to describe needs and special characteristics of these populations.

Historical Perspective

One of the main goals of this needs assessment is to integrate previous needs assessment findings and observations into the current assessment to show trends as well as to consider the impact of historical investments as DHHS assesses funding requests in the current year and in coming years.

Although the population in Nevada is evolving faster than other states as Nevada is one of the most transient states in the nation, and Clark County remains one of the most transient counties nationally,[3] identified needs from a statewide perspective did not change much between the 2018 and 2020 DHHS needs assessments. Also, the COVID-19 pandemic has magnified many of the existing needs, such as those identified in access to health care and mental/behavioral health services, due to the stress on those systems from the pandemic and increasing mental/behavioral health needs as well as healthcare challenges facing our population.

As will be discussed in more detail, the most significant needs across the past two needs assessments included some combination of health and mental health (to include behavioral health), health care (access to), and housing.[4, 5] The 2019 Nevada State Health Needs Assessment Executive Summary (2019) identified three main priorities based on an overarching question - *What are the most significant health issues impacting the health of Nevada communities?* The data was collected using secondary data, key stakeholder data, and an online community survey (p. 7).[6] The results indicated the greatest health impact was from:

- Behavioral/Mental Health and/or Substance Use and Abuse (33%)
- Access to Health Care (28%)
- Housing and Poverty (15%)[7]

A summary of subcategories incorporated as part of identified need areas from the 2019 Nevada State Health Needs Assessment are summarized in Table 1 below with notation to the number of indicators available for tracking and reporting.[8] These indicators will be revisited in the Current Landscape section as applicable to current needs as identified during the primary data collection as part of this 2022 Need Assessment. However, this data was collected before the onset of the COVID-19 pandemic, which became the most substantial risk to community health, employment, and financial security, during the height of the pandemic, but also has on-going direct and indirect impacts on each of these three main priorities identified, many of those impacts which will not be fully realized for years to come (long COVID-19, mental health and substance abuse increases, education outcomes, etc.).

[3] US Census Bureau, 2000; 2010; 2020
[4] Nevada Department of Health and Human Services. 2018, *2018 Statewide Community Needs Assessment*
[5] Nevada Department of Health and Human Services. (2019) *Nevada State Health Needs Assessment.*
[6] Nevada Department of Health and Human Services. (2019) *Nevada State Health Needs Assessment Executive Summary.*, pp. 7
[7] Ibid pp. 6-7
[8] Ibid pp. 5

TABLE 1. HEALTH CARE INDICATOR DATA BY CATEGORY, WITH SUBCATEGORIES AND TOTAL NUMBER FOR EACH

Category	Subcategories	Total # of Indicators
Access to Healthcare	Access to primary care (9); access to mental health care (3); access to dental care (7); access to insurance/health care affordability (7)	26
Behavioral Health	Mental health (8); suicide (4); substance use (24)	36
Health Behaviors Preventative Care	Immunizations (5); nutrition (2); physical activity and sedentary behaviors (3); preventative health screenings (7); sexual health (2)	19
Health Outcomes	Chronic Disease (9); cancer (13); communicable disease (13); weight status (6); mortality (22); crime/MVA/ pedestrian deaths (3); perceived health status (2)	68
Maternal & Child Health	Abortion (1); prenatal care (10: pre-term births (1); birth rate (3); low birth weight (1); breastfeeding (1); infant mortality (2); child mortality (1)	10
Individuals with Disabilities	All populations (11); children (12)	23
Social Determinants of Health	Adult adverse childhood experiences (ACEs) (11); high school student ACEs (6); education (16); employment (3); food insecurity/hunger (5); income (5); poverty (8); air/water quality (2); crime/violent related behaviors (7); quality of housing (2); motor vehicle related (5)	70

There are county and community-based differences in needs, risks, and resources identified in the 2019 Nevada State Health Needs Assessment (Table 2). [9]

TABLE 2. TOP THREE PRIORITIES FOR COUNTIES AND NEVADA BASED ON THE 2019 STATE HEALTH NEEDS ASSESSMENT

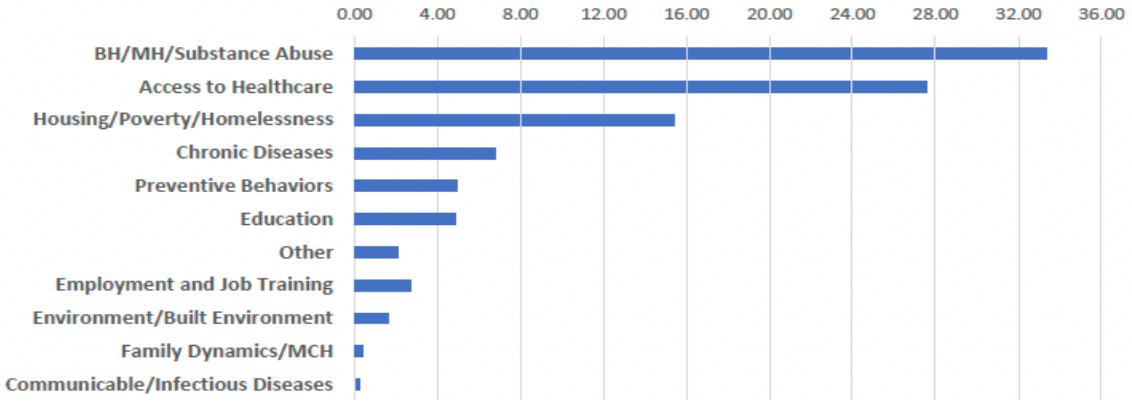
County	Priority 1	Priority 2	Priority 3
Carson City	Behavioral health	Chronic & communicable diseases	Income, poverty & housing
Churchill	Behavioral health	Income, poverty & housing	Access to health care
Clark	Access to health care	Behavioral health	Housing & poverty
Douglas	Behavioral health	Access to health care	Chronic diseases
Elko	Access to health care	Behavioral health	Health behaviors & preventive care
Esmeralda	Access to health care	Maternal and Child Health	Income & poverty
Eureka	Access to health care	Behavioral health	No third priority
Humboldt	Behavioral health	Access to health care	Health behaviors & preventive care
Lander	Behavioral health	Health behaviors & preventive care (tie); Maternal & child health (tie)	Access to health care
Lincoln	Employment & job training	Access to health care	Health behaviors & preventive care
Lyon	Behavioral health	Access to health care	Employment & poverty
Mineral	Behavioral health	Chronic diseases	Employment & poverty
Nye	Access to health care	Employment, income, poverty, housing	Chronic diseases
Pershing	Access to health care	Employment & poverty	Behavioral health
Storey	Behavioral health	Access to health care	No third priority
Washoe	Behavioral health	Housing	Chronic & communicable diseases
White Pine	Access to health care	Education	Behavioral health
Nevada	**Behavioral health**	**Access to health care**	**Poverty**

[9] Nevada Department of Health and Human Services. (2019) *Nevada State Health Needs Assessment Executive Summary*

Qualitative Input from Local Needs Assessments

A survey was conducted as part of the 2019 Nevada State Health Needs Assessment that provides insight into the priorities identified by 2,676 respondents. Graph 1 below shows that Behavioral/Mental Health/Substance Abuse was the most frequent need chosen by respondents, with 33% citing this as a need, Access to Health Care was the second most chosen health priority at 18% of respondents, and the remaining categories all fell under 15% of survey responses.[10]

GRAPH 1. MOST SIGNIFICANT HEALTH ISSUE, BY % OF RESPONDENTS (N=2676)



The Southern Nevada Community Health Assessment Report 2020/2021 included both primary (gathered through surveys and focus groups) with and secondary data published the following priorities:[11]

1. Chronic Disease: Chronic diseases are long-lasting illnesses that persists over a long period of time and require ongoing medical attention, limited activities of daily living, or both. Between 2016-2018, chronic diseases ranked consistently among the top ten causes of death in Clark County. Social determinants of health, such as safe housing; job opportunities; discrimination and violence; language and literacy skills have an impact on the prevalence of chronic diseases in the community. Having appropriate resources to decrease chronic disease in the community is important as it will promote programs and interventions.
2. Access to Care: Promoting health equity within access to care is important as everyone has the right to be healthy. Health should not depend on the ZIP code, economic status, or color of skin of an individual. Having the access to care helps address disparities while it is the first step in creating a more equitable health system that improve the physical, social, and mental health for everyone in the community.

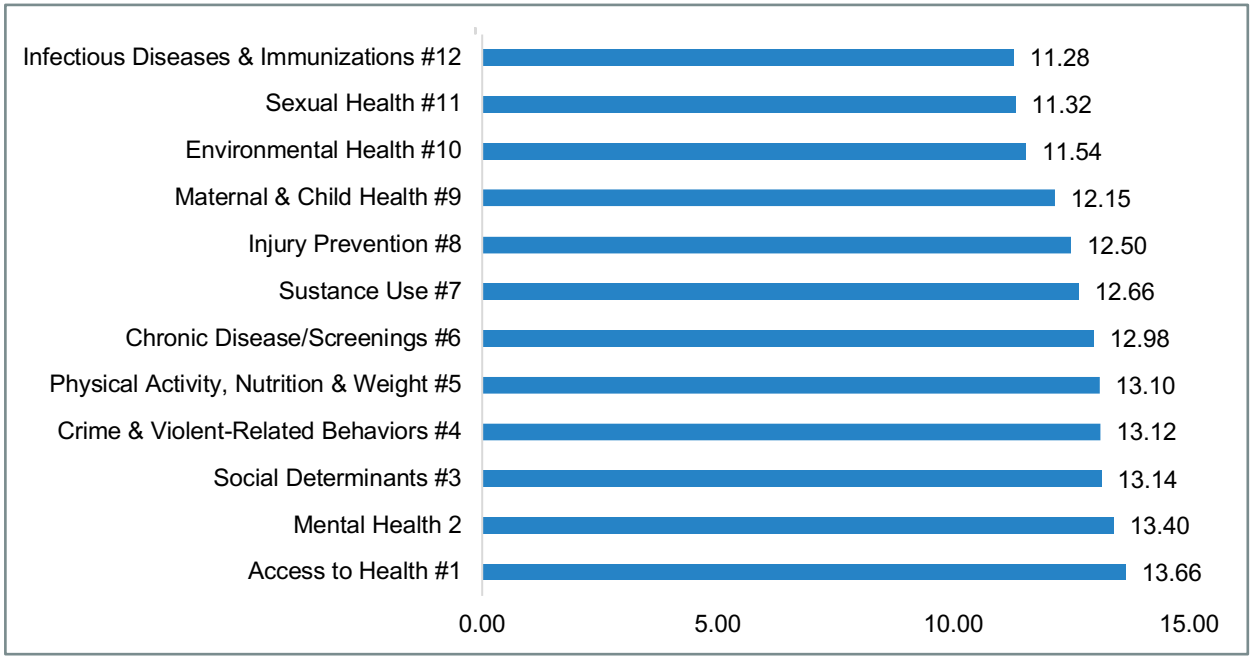
[10] Nevada Department of Health and Human Services. (2019) *Nevada State Health Needs Assessment*

[11] Southern Nevada Health District (SNHD). (2022). Southern Nevada Community Health Assessment Report. Retrieved from https://www.healthysouthernnevada.org/content/sites/snhd/reports/2022Update_SNHD_CHA.pdf pp 14

3. Transportation: Having transportation to and from health care services can improve health as well as health equity which can reduce air pollution and increase physical activity. Reliable access to transportation can help increase employment rates, access to healthy foods, access to health care providers and facilities, and access to parks and recreation for a healthy lifestyle. The assessment identified the high cost of transportation, accessibility to transportation and an insufficient utilization of transportation funding as areas to address.
4. Funding: Having the appropriate public health funding will aid in grants that help reduce issues of Southern Nevada and aid in promoting programs and initiatives. With improvement to transparency with public health funding for key stakeholders and the public, it provides knowledge for individuals in the decision-making process. A high unemployment rate, high health care and transportation costs, limited public health funding, and lack of education funding have been identified as funding focus areas.

The consistency in ranked needs over time, and across regions of the state can be seen in the 2018-2020 Washoe County Health Needs Assessment which published the following health rankings based on both qualitative and quantitative data, with access to health ranked #1, mental health #2, and social determinants of health #3 as seen in Graph 2 below. The Washoe County Needs Assessment included survey responses from 1,438 respondents, and includes additional primary data from 80 participants in Community Workshops.

GRAPH 2. OVERALL HEALTH TOPIC SCORE & RANK



The priorities noted above echo the data in the sections below, and the needs identified when assessing the quantitative data for Nevada. The 2019 Nevada State Health Needs Assessment did not provide data on Pregnant Women and Justice Involved Youth, and we have added those population in this report to help the GMAC and DHHS make funding and prioritization decision based on that data.

Current Landscape/Baseline Data

The previous two sections have identified the historical landscape and the results of the 2019 Needs Assessment. In this section, the current landscape in Nevada will be defined, summarized, and gaps will be identified. Throughout this section focus will be paid to available secondary data resources as well as primary data that was collected recently in other reports and analyses that describe the need in priority areas for targeted funding that will address those needs. The goal of the Current Landscape section is to provide baseline data that can be used to measure the impact of program interventions against.

There are unique population and demographic considerations in Nevada which can determine or impact needs and priorities, including density of need in urban areas as well as high population numbers, versus lower access and lack of infrastructure and resources (intensity of need) in less populated rural and frontier areas. Additionally, we will focus on diversity, equity, and inclusion elements of need of historically marginalized special populations, including Aging Adults/Seniors; Black, Indigenous, People of Color (BIPOC); Children Welfare Involved Children, Youth, and Transition Aged Youth (TAY); Individuals Dealing with Mental Illness and Substance Use Disorders; Individuals Experiencing Homelessness; Individuals with Disabilities/A Disability; Justice System Involved Adults; Justice System Involved Children, Youth and Transition Aged Youth (TAY); Maternal Child Health; Regional Considerations (Rural and Frontier Communities); Sexual and Gender Minority Populations; and Veterans.

Nevada Demographic Profile

Nevada is a unique state with both highly urban metropolitan, rural and frontier communities that are home to a diverse population. Population dispersion across Nevada creates unique regional and community-based needs that are often difficult to address with limited-service providers and resources in rural and frontier communities and less than adequate funding in urban and metropolitan areas. There are 17 counties and equivalents in Nevada; 16 counties governed by their own board of commissioners, and Carson City, which is an independent city that is counted as a county equivalent and is the state capital. The 17 counties in Nevada cover a land mass of 100,567 square miles. Nevada is the 7th largest state in terms of land mass[12], and the 32nd largest state in the country by population size. Given the state's large geographical size and the dispersion of the population across the large rural and frontier areas of the state, there are only eight states in the country that are less densely population in terms of population per square mile.[13]

Nevada communities range from the large urban areas found in Clark (Las Vegas metro area) and Washoe Counties (Reno/Sparks metro area and the adjacent municipality of Carson City) and three Nevada Counties, including Douglas, Lyon and Storey are considered rural. The remaining eleven counties are considered frontier (Churchill, Elko, Esmerelda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing, and White Pine Counties).

[12] World Population Review. (2022). Nevada population 2022. Retrieved from https://worldpopulationreview.com/states/nevada-population
[13] Ibid

TABLE 3. POPULATION DENSITY IN NEVADA BY COUNTY, 2021

Region/County	Population			Geography	
	2021	% of State Population	Population per Square Mile	Area in Square Miles	% of State Land Mass
Rural and Frontier					
Churchill County	26,780	0.8	5.3	4,929	4.5
Douglas County	50,169	1.6	70.3	710	0.6
Elko County	53,589	1.7	3.2	17,179	15.6
Esmeralda County	955	0.0	0.3	3,588	3.3
Eureka County	1,763	0.1	0.5	4,176	3.8
Humboldt County	16,519	0.5	1.8	9,648	8.8
Lander County	5,957	0.2	1.1	5,494	5.0
Lincoln County	4,530	0.1	0.5	10,634	9.7
Lyon County	56,582	1.8	29.6	1,944	1.8
Mineral County	4,508	0.1	1.2	3,756	3.4
Nye County	47,028	1.5	2.7	18,147	16.5
Pershing County	4,723	0.1	0.9	6,037	5.5
Storey County	4,578	0.1	17.4	263	0.2
White Pine County	9,547	0.3	1.1	8,876	8.1
Regional Subtotal	**287,228**	**9.1**	**3.1**	**95,431**	**86.9**
Urban					
Carson City	54,941	1.7	396.8	143	0.1
Clark County	2,358,347	74.3	295.9	7,910	7.2
Washoe County	472,810	14.9	76.8	6,342	5.8
Regional Subtotal	**2,886,098**	**90.9**	**200.4**	**14,395**	**13.1**
Nevada – Total	**3,173,326**	**100.0**	**28.9**	**109,826**	**100.0**

Source: 2021 Rural Health Data Book 10th Ed, p. 17

In Nevada, there are 28.9 people per square mile with population density ranging from 0.3 persons per square mile in Esmeralda County to 396.8 persons per square mile in Carson City (Table 3).[14] While 9.1% of the state's population resides in rural and frontier areas, these counties cover 86.9% of the state's land mass or 95,431 square miles. The state's 3 urban counties – Carson City, Clark County, and Washoe County – has 90.9% of the population, with 2.4 million residents or 74.3% of the state's population residing in Clark County alone. Esmeralda County has less than 1,000 residents. Beyond Clark County, only Washoe County in Northern Nevada accounted for more than 2% of the state's population at nearly 15%.

TABLE 4. POPULATION PROJECTIONS IN NEVADA, BY COUNTY, 2021 TO 2031

Region/County	Population			Change 2021 2031	
	2021	2026	2031	Number	%
Rural and Frontier					
Churchill County	26,780	26,885	27,411	631	2.4
Douglas County	50,169	50,488	50,675	506	1.0
Elko County	53,589	54,389	54,126	537	1.0
Esmeralda County	955	922	861	-94	-9.8
Eureka County	1,763	2,059	2,207	444	25.5
Humboldt County	16,519	16,779	16,603	84	0.5

[14] Griswold, T., Packham, J., Warner, J., Etchegoyhen, L. (2021). Nevada Rural and Frontier Health Data Book - 10th Edition. Retrieved from https://cms2files.revize.com/elkocountynevada/boards/Health/2021/DATA%20BOOK%202021%20Final%203-4-21.pdf pp. 17

Lander County	5,957	5,774	5,493	-464	-7.8
Lincoln County	4,530	4,408	4,348	-182	-4.0
Lyon County	56,582	63,512	66,229	9,647	17.0
Mineral County	4,508	5,513	4,603	95	2.1
Nye County	47,028	48,808	50,566	3,358	7.5
Pershing County	4,723	4,792	4,797	74	1.6
Storey County	4,578	5,228	5,882	1,304	28.5
White Pine County	9,547	9,407	9,056	-491	-5.1
Regional Subtotal	**287,228**	**297,964**	**302,857**	**15,629**	**5.4**
Urban					
Carson City	54,941	55,039	55,294	353	0.6
Clark County	2,358,347	2,483,268	2,564,507	206,160	8.7
Washoe County	472,810	524,466	546,466	73,656	15.6
Regional Subtotal	**2,886,098**	**3,062,773**	**3,166,267**	**280,169**	**9.7**
Nevada – Total	**3,173,326**	**3,360,737**	**3,469,124**	**295,798**	**9.3**

Source: 2021 Rural Health Data Book 10th Ed, p. 16

Nevada has been growing rapidly, and that growth is expected to continue. Over the next decade, the population in Nevada is projected to grow 9.3% from 3,173,326 in 2021 to 3,469,124 in 2031 (Table 4).[15] The population of urban Nevada is projected to grow by 9.7% or 280,169. The population of rural and frontier Nevada is projected to grow by 5.4% or 15,629.

Demographics by Race and Ethnicity

Beyond the dispersion of population presented in Table 4 above, the Nevada population is also more diverse than comparative national data, with higher percentages of Hispanic and non-white residents (Table 5) [16]. Considering many federal grant funds are made available to remediate and address racial disparities in states across the nation, Nevada should be competitive for numerous funding award opportunities based on population data. However, there are nuances to the statewide data, which is heavily reliant on Clark County from an average's perspective as Clark County accounts for nearly 73% of the state's population and is one of the most racially diverse counties in the state.

This impact is visible when comparing a regional model of Clark County, Washoe County, and Balance of State that includes all other counties as shown in Table 4. Additional statewide population diversity data on a county-by-county basis is presented in Table 6.[17]

Table 5. Nevada Race and Ethnicity Demographics Compared to U.S. Population

Geographic Area Name	Hispanic or Latino	White	Black or African American	American Indian and Alaskan Native	Asian	Native Hawaiian and Other Pacific Islander	Two or more races
Nevada	29.2%	48.2%	10.3%	1.7%	8.7%	0.8%	4.6%
U.S.	18.5%	60.1%	13.4%	1.3%	5.9%	0.2%	2.8%

[15] Griswold, T., Packham, J., Warner, J., Etchegoyhen, L. (2021). Nevada Rural and Frontier Health Data Book - 10th Edition. Retrieved from https://cms2files.revize.com/elkocountynevada/boards/Health/2021/DATA%20BOOK%202021%20Final%203-4-21.pdf pp. 16

[16] U.S. Census Bureau. (2021). Quick facts: Nevada. Retrieved from https://www.census.gov/quickfacts/fact/table/NV/PST045221

[17] Ibid

TABLE 6. NEVADA RACE AND ETHNICITY DEMOGRAPHICS BY COUNTY

Region/ County	Hispanic or Latino	White	Black or African American	American Indian and Alaskan Native	Asian	Native Hawaiian and Other Pacific Islander	Two or more races
Clark	31.6%	41.7%	13.1%	1.2%	10.4%	0.9%	4.9%
Washoe	25.0%	62.3%	2.8%	2.2%	5.8%	0.7%	3.9%
Lyon	18.1%	73.8%	1.4%	3.4%	1.6%	0.3%	3.9%
Carson City	24.1%	67.0%	2.1%	2.3%	2.7%	0.1%	2.6%
Elko	24.7%	66.5%	1.3%	6.4%	1.2%	0.3%	2.6%
Nye	15.3%	75.1%	3.7%	1.9%	1.9%	0.6%	3.4%
Douglas	13.2%	80.2%	1.0%	2.2%	1.9%	0.2%	3.1%
Churchill	14.5%	72.5%	2.5%	5.5%	3.0%	0.4%	4.5%
Humboldt	27.5%	64.7%	1.1%	4.9%	0.9%	0.3%	3.0%
White Pine	16.7%	71.0%	5.1%	5.1%	1.1%	0.2%	2.9%
Pershing	24.8%	62.4%	4.6%	4.7%	1.4%	0.4%	3.3%
Lander	23.2%	69.1%	1.0%	5.9%	1.2%	#	2.9%
Lincoln	7.8%	84.5%	3.3%	1.9%	0.7%	0.4%	2.5%
Storey	8.0%	83.6%	1.7%	1.9%	2.4%	0.5%	2.5%
Mineral	13.2%	60.9%	4.8%	18.2%	3.4%	0.2%	4.8%
Eureka	13.2%	80.3%	1.2%	3.2%	1.0%	0.1%	2.6%
Esmeralda	19.2%	66.3%	3.4%	7.1%	0.6%	0.1%	3.9%

#Value greater than zero but less than half unit of measure shown

In general, urban areas of Nevada are more racially and ethnically diverse than rural and frontier regions. Hispanic residents are a growing segment of the population in all 17 counties in Nevada – the percent of the population of Hispanic origin in rural and frontier counties ranges from 8.0% in Storey County to 27.5% in Humboldt County. The Hispanic population in urban counties ranges from 24.1% in Carson City to 31.6% in Clark County.

The Nevada Demographer data shown in Table 7 below show that the fastest projected population growth categories include Hispanic Origin or Any Race at +11.2%, American Indian/Alaskan Native at +9.3%, Asian Pacific Islander at +9.2%, and Black/African American at +8.4% projected increase. [18]

TABLE 7. ANNUAL POPULATION GROWTH BY RACE/ETHNICITY, NEVADA, 2020 TO 2025

Race/Ethnicity	Population		Change 2020 to 2035 (%)
	2020	2025	
White	1,561,977	1,566,048	+0.26%
Black/African American	280,737	304,402	+8.4%
American Indian/Alaskan Native	35,686	36,748	+9.7%
Asian/Pacific Islander	311,509	339,725	+9.2%
Hispanic Origin of Any Race	948,715	1,055,192	+11.2%

[18] Lawton, M. F. (2021). Nevada county population projections 2021-2040. Retrieved from https://tax.nv.gov/uploadedFiles/taxnvgov/Content/TaxLibrary/Nevada%20County%20Population%20Projections%202021%20to%202040.pdf

Current Landscape

This report is focused on some of the broad topical areas on which the GMAC focuses. The previous two sections have identified the historical landscape and the results of the 2019 Needs Assessment. In this section, the current landscape in Nevada will be defined and summarized. Throughout this section, focus will be paid to available secondary data resources as well as primary data that was collected recently in other reports and analyses that describe the need in priority areas for targeted funding that will address those needs.

To help with priorities, we have also looked at the data through the lens of a social determinants of health (SDOH), *"the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."* [19] Healthy People 2030 developed a framework that includes the five domains of SDOH: Education Access and Quality; Economic Stability; Health Care Access and Quality; Neighborhood and Built Environment; and Social and Community Context. This report will focus on Education; Economic Stability; Health Care Access and Outcomes.

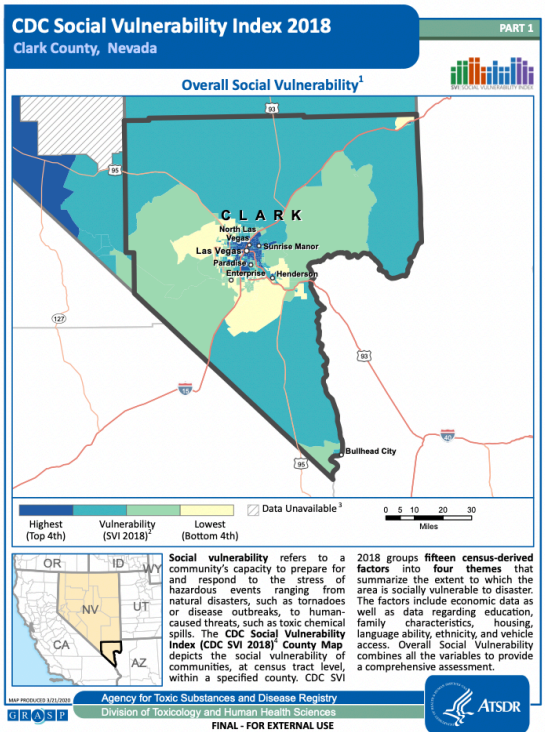
As noted above, there are unique population and demographic considerations in Nevada which can determine or impact needs and priorities, including density of need in urban areas as well as high population numbers, versus lower access and lack of infrastructure and resources (intensity of need) in less populated rural and frontier areas. Additionally, we will focus on diversity, equity, and inclusion elements of need of historically marginalized special populations.

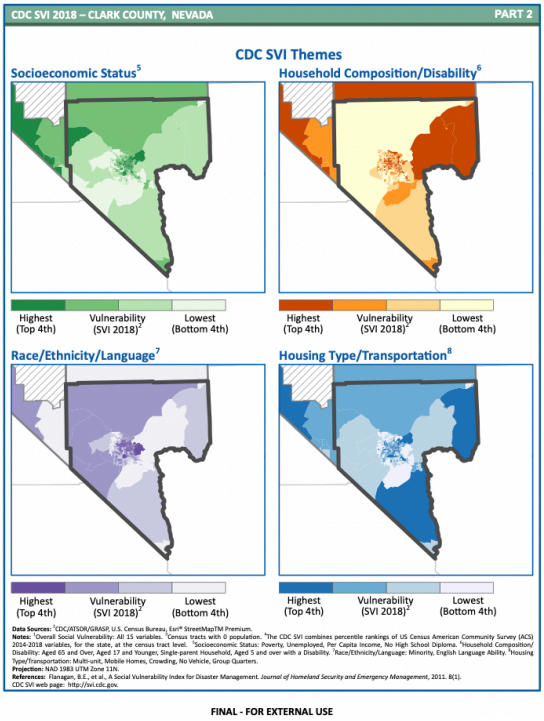
CDC Social Vulnerability Index (SVI) density maps by county provide visual insight on where the most vulnerable and "in need" areas are located. Example maps of Clark County and Washoe County are included below in Figure 3.[20] Several factors define social vulnerability, including poverty, lack of access to transportation, and crowded housing may weaken a community's ability to prevent human suffering and financial loss in a disaster.

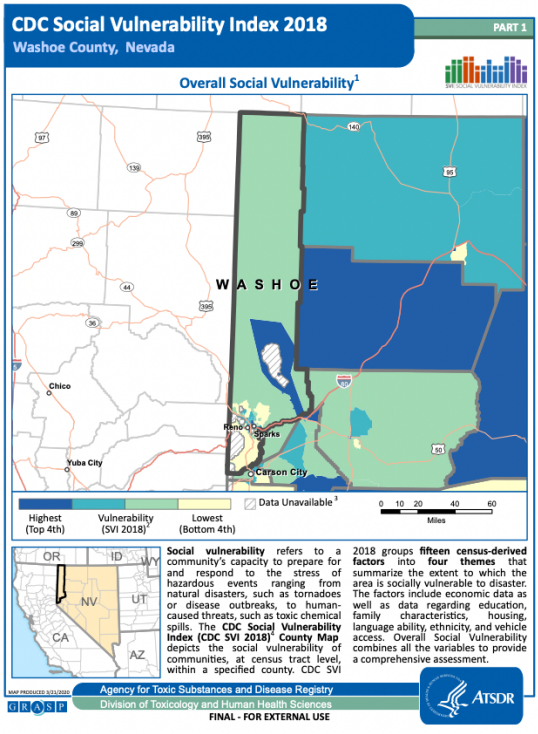
[19] Healthy People 2030. U.S. Department of Health and Human Services. Social Determinants of Health. Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

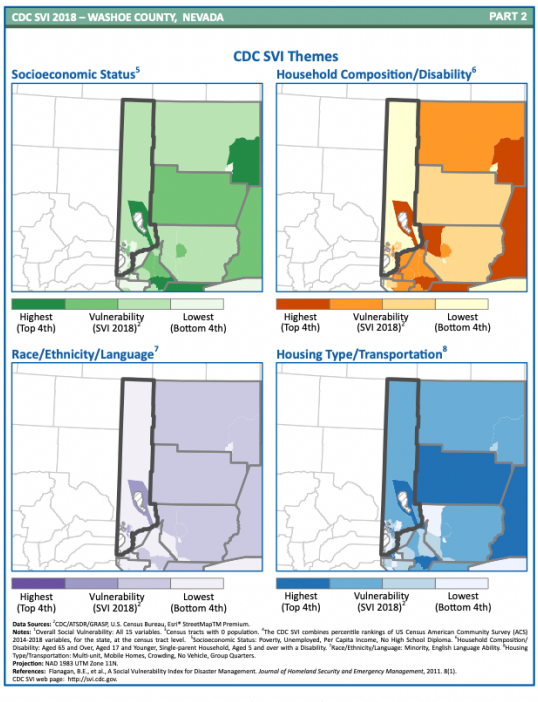
[20] Agency for Toxic Substances and Disease Registry. CDC/ATSDR SVI Fact Sheet. Retrieved from https://www.atsdr.cdc.gov/placeandhealth/svi/fact_sheet/fact_sheet.html

FIGURE 3. SVI MAPS, CLARK AND WASHOE COUNTY



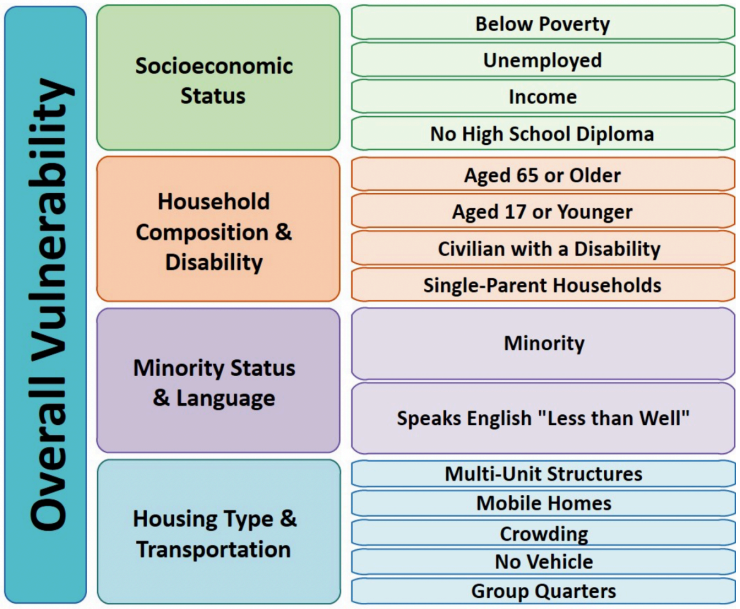






The SVI uses U.S. Census data to determine the social vulnerability of every census tract. The variables used are illustrated in Figure 4 below:

FIGURE 4. SOCIAL VULNERABILITY VARIABLES, AMERICAN COMMUNITY SURVEY (ACS), 2014-2018 (5-YEAR) DATA



An overall SVI score indicates the level of vulnerability of a location. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability). Table 8 below shows the 2018 SVI (most recent data available) for each Nevada county from the CDC.

TABLE 8. 2018 OVERALL SVI SCORE BY COUNTY

County	Score	Indication
Carson City	0.9443	Indicates a **high level** of vulnerability
Pershing County	0.9038	Indicates a **high level** of vulnerability
Mineral County	0.8815	Indicates a **high level** of vulnerability
Lander County	0.8261	Indicates a **high level** of vulnerability
Clark County	0.7404	Indicates a **moderate to high level** of vulnerability
Nye County	0.7309	Indicates a **moderate to high level** of vulnerability
Esmeralda County	0.6395	Indicates a **moderate to high level** of vulnerability
Churchill County	0.6048	Indicates a **moderate to high level** of vulnerability
Humboldt County	0.5869	Indicates a **moderate to high level** of vulnerability
Lyon County	0.5783	Indicates a **moderate to high level** of vulnerability
Washoe County	0.5271	Indicates a **moderate to high level** of vulnerability
Elko County	0.5178	Indicates a **moderate to high level** of vulnerability
Lincoln County	0.4213	Indicates a **low to moderate level** of vulnerability
White Pine County	0.3742	Indicates a **low to moderate level** of vulnerability
Douglas County	0.1793	Indicates a **low** level of vulnerability
Storey County	0.0717	Indicates a **low** level of vulnerability
Eureka County	0.0675	Indicates a **low** level of vulnerability

COVID-19

The COVID-19 pandemic has resulted in systemic impacts and burdens on the healthcare and social service systems, due to job loss, high rates of hospital admissions, and pressure on systems of care. It is unknown at this time what the total burden of the pandemic will be on loss of life, health outcomes and mental and behavioral health impacts. Additionally, impacts on wealth aggregation, job retention and advancement and poverty are all indicators researchers will be watching in years to come.

In Nevada, the COVID-19 pandemic caused a reported 705,614 documented infections has caused the deaths of 10,031 Nevadan residents as of March 21, 2022, with a case fatality rate of 1.4% (Table 9). [21]

TABLE 9. CUMULATIVE COVID-19 CASES AND DEATHS, NEVADA, AS OF MARCH 21, 2022

Measure	Number/ Percent
Number of COVID-19 Cases	705,614
Deaths from COVID-19	10,031
COVID-19 Fatality Rate	1.4%

The total percent of the population that has been vaccinated as of March 21, 2022, in Nevada is 53.29%. Table 10 shows COVID-19 vaccination rates by county, with Carson City reporting the highest rate at 62.02%, followed by Washoe County at 61.15% and Douglas County at 52.59%.[22] The counties reported the lowest rates of vaccination include Storey County at 24.61% and Esmerelda County at 34.19%

TABLE 10. COVID-19 VACCINATION RATE, BY COUNTY, AS OF MARCH 21, 2022

County/Region	%
Carson City	62.02%
Churchill County	45.02%
Clark County	52.59%
Douglas County	54.48%
Elko County	36.54%
Esmeralda County	34.19%
Eureka County	29.50%
Humboldt County	42.27%
Lander County	36.28%
Lincoln County	36.43%
Lyon County	50.12%
Mineral County	50.54%
Nye County	41.87%
Pershing County	35.94%
Storey County	24.61%
Washoe County	61.15%
White Pine County	43.86%

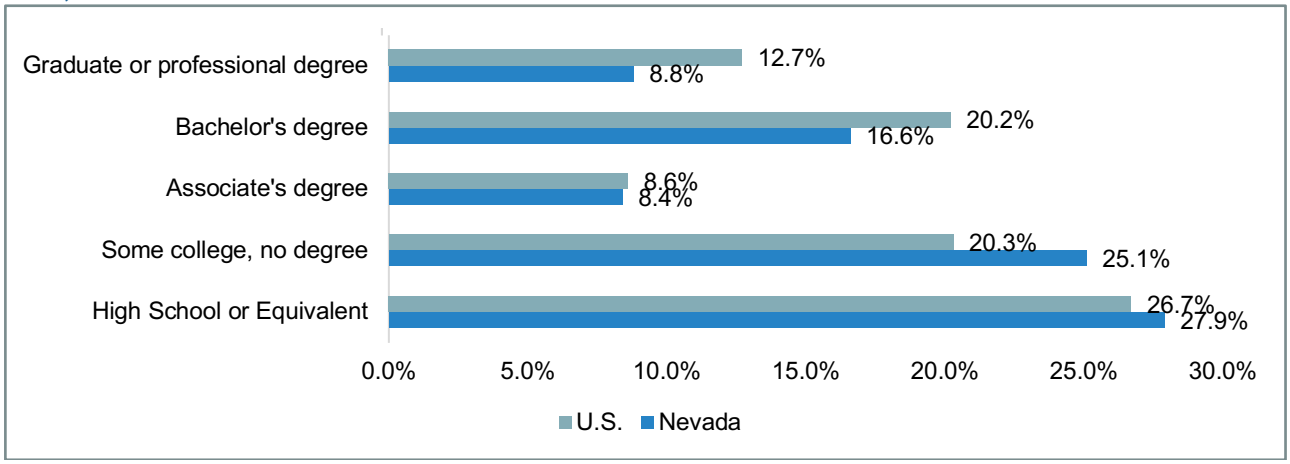
[21] Nevada Health Response. (2021). Coronavirus (COVID-19) in Nevada. Retrieved from https://nvhealthresponse.nv.gov
[22] Ibid

Social Determinants of Health

Education

Individuals with higher educational attainment are more likely to experience individual success leading to positive economic, social, and health outcomes for families and communities.[23] Education is also an essential requirement for the disruption of the cycle of poverty and inequities in health. Given the link between educational attainment and economic status, schools play a critical role in preparing students for success. Graph 3 shows the educational attainment of Nevadans over age 25 as compared to national averages.[24] Nevada has fewer individuals who have a graduate degree at 8.8% versus 12.7% nationally, fewer individuals with Bachelor's degrees at 16.6% versus the national 20.2%.

GRAPH 3. EDUCATION ATTAINMENT (POPULATION 25 YEARS AND OLDER), NEVADA AND U.S, 2020



Early Childhood Education

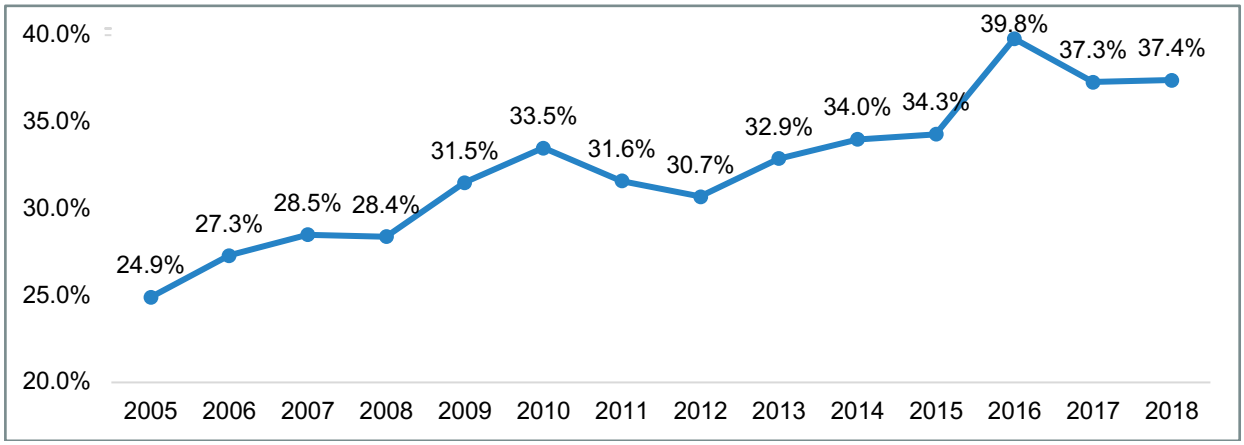
Data shows that early childhood education, and enrollment in preschool programs predicts more positive educational attainment outcomes and health outcomes for children. For example, children who attend early childhood education programs have improved graduation rates and scores on standardized exams, and reduced rates of special education services usage, teen births, and crime. Investment in early childhood education produces high returns on investment, and America's Health Rankings estimates that for every $1 spent on early childhood education there is a $4.19 return in benefits derived mainly from increased lifetime earnings.[25]

The Annie E. Casey Foundation KidsCount database states that in Nevada, 62% of children aged 3-4 are not enrolled in school as of 2021, (up from 68% in the 2009-2011 count), compared to 52% nationally.[26] Changes in the percentage of children enrolled in early childhood education

[23] Healthy People 2030. U.S. Department of Health and Human Services. Social Determinants of Health. Education Access and Quality. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/education-access-and-quality
[24] 2020 American Community Survey 5-Year Estimates. Retrieved from https://data.census.gov/cedsci/profile?g=0400000US32
[25] United Health Foundation. America's Health Rankings. Early Childhood Education in Nevada. Retrieved from https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/Early_Education/state/NV
[26] The Annie E. Casey Foundation. (2021). 45 Nevada: Overall Rank. Retrieved from https://assets.aecf.org/m/databook/2021KCDB-profile-NV.pdf

are seen in Graph 4, which shows increases in enrollment since 2005 as an overall trend, with a few reductions in rates after 2010 and 2016 peaks, rising again through 2018.

GRAPH 4. CHANGE IS EARLY CHILDHOOD EDUCATION ENROLLMENT



Nevada spends less on early childhood education than 40 other states in the country, spending an average of $65.79 per child, well below the national average of $955.22. Additionally, Nevada ranks 48th in preschool enrollment, with only 36.7% of 3- and 4-year-olds attending early childhood education programs, and only 12% of those enrolled are in state preschool, special education or Head Start programs.[27] Table 11 shows the number of Pre-K students enrolled in each county during the 2021-2022 school year. [28]

TABLE 11. PRE-K STUDENTS IN NEVADA, BY COUNTY, 2021-22 SCHOOL YEAR

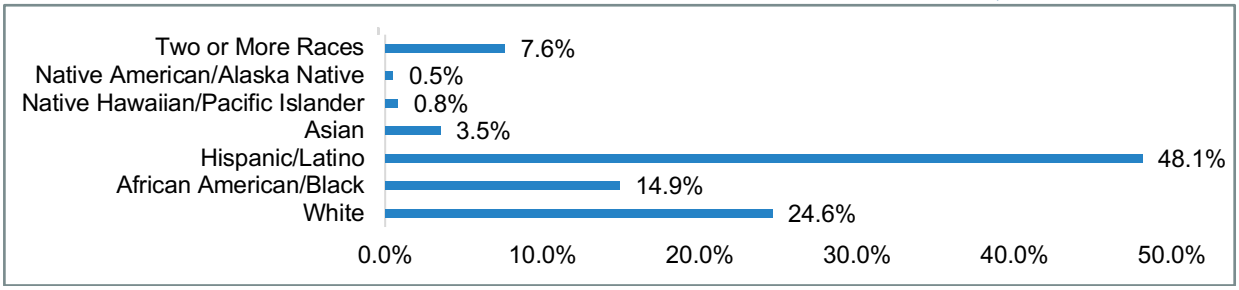
County/Region	#
Carson City	164
Churchill County	120
Clark County	8,501
Douglas County	114
Elko County	227
Esmeralda County	7
Eureka County	12
Humboldt County	112
Lander County	53
Lincoln County	94
Lyon County	85
Mineral County	41
Nye County	209
Pershing County	25
Storey County	166
Washoe County	846
White Pine County	51
Nevada – Total	10,827

[27] Children's Advocacy Alliance Nevada (CAAANV). (2019). 2019 Children's Legislative Briefing Book. Retrieved from https://www.caanv.org/wp-content/uploads/2019/01/Final-LBB-2019_UPDATED-12.5.18.pdf

[28] School Year Counts. Retrieved from 2021-2022schoolyearcounts1021.xlsx (live.com)

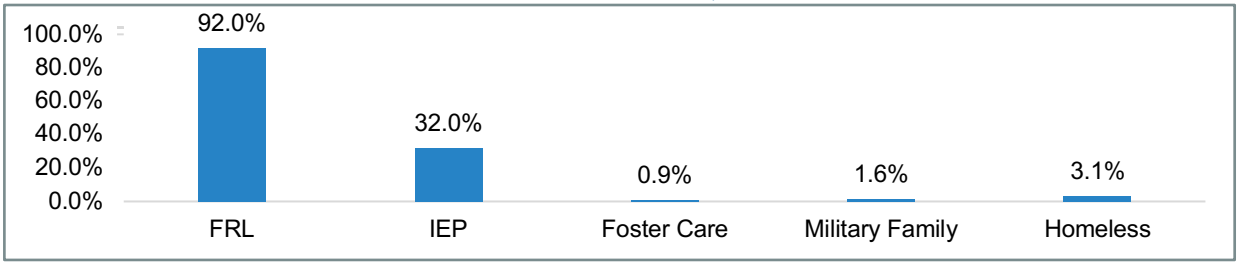
A total of 10,827 Pre-K students were enrolled for the 2021-22 school year in Nevada. Of those, 0.5% were American Indian/Alaskan Native, 3.5% Asian, 14.95 Black/African American, 48.1% Hispanic/Latino, 0.8% Native Hawaiian/Pacific Islander, 7.6% Two or More Races, and 24.6% were White (Graph 5 below).

GRAPH 5. NEVADA PRE-K SCHOOL ENROLLMENT BY RACE/ETHNICITY, 2022



Of the 10,827 Pre-K students, 92.0% qualified to receive free or reduced lunch (FRL); 32.0% were on an Individualized Education Plan (IEP); 0.9% were in foster care; 1.6% were in military families; and 3.1% were considered homeless (Graph 6).[29]

GRAPH 6. NEVADA PRE-K SPECIAL POPULATIONS, 2022



Economic and Financial Stability

Economic and financial stability correlates to several health and mental health outcomes, as well as impacts educational attainment, employment outcomes and housing stability.[30] Work done by the Robert Wood Johnson Foundation on social determinants of health has found that where a person is born, down to the zip code level, impacts their lifelong health outcomes.[31] This data significantly impacts how DHHS assesses needs in specific communities and where funding is prioritized.

To afford basic amenities such as housing, health care and healthy food, it is important to have a consistent, reliable source of income. Research demonstrates that income and employment are strongly associated with health behaviors and outcomes and a reduced risk of living in poverty.[32] However, there are vulnerable populations that may have trouble finding and

[29] School Year Counts. Retrieved from 2021-2022schoolyearcounts1021.xlsx (live.com)
[30] Healthy People 2030. U.S. Department of Health and Human Services. Social Determinants of Health. Economic Stability. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability
[31] Robert Wood Johnson Foundation. (2022). Social Determinants of Health. Retrieved from https://www.rwjf.org/en/our-focus-areas/topics/social-determinants-of-health.html
[32] American Academy of Family Physicians (AAFP). (2019). Poverty and Health - The Family Medicine Perspective (Position Paper). Retrieved from https://www.aafp.org/about/policies/all/poverty-health.html

keeping a job, including people with disabilities, those with chronic conditions, and those with low educational attainment. Access to safe and affordable childcare also impacts ability to work and is a need that has only increased after COVID-19 due to the number of childcare centers that closed in the state and around the county. There are also many individuals who have a steady job but do not earn enough to afford the basic amenities needed to stay healthy.

In comparison with other states, Nevada ranks among the lowest in the nation in many categories related to economic stability as tracked by Prosperity Now's Scorecard program that assesses both outcomes and policymaking in a variety of substantive policy and programmatic areas.

From the perspective of Financial Assets and Income, Nevada ranks among the lowest performing states in terms of:

- Underbanked households at 25.1% compared to 18.7% national average (51st),
- Borrowers over 75% credit card limit at 30% compared to 25.4% national average (45th),
- Consumers with Prime Credit at 47% compared to 53% national average (43rd),
- Bankruptcy Rate at 3.2 compared to 2.3 national average (43rd), and
- Severely Delinquent Borrowers at 18.1% compared to 14.8% national average (42nd).[33]

Comparatively, there are only three indicators in which Nevada ranked among the highest performing states nationally:

- Fell behind on bills 7.9% compared to 13.2% national average (2nd),
- Low financial well-being at 14% compared to 18% nationally (4th), and
- Income volatility 16.1% compared to 20.1% national average (5th).[34]

Below, data is provided on employment, unemployment, and poverty rates, and food insecurity and hunger.

Employment/Unemployment

Multiple aspects of employment—including job security, the work environment, financial compensation, and job demands—may affect health.[35] In order to be able to afford basic amenities such as food, shelter, and utilities, it is important to have a consistent and reliable source of income. The disparity between wealthy and low-income families is evident, as those who are low-income are at an increased risk of chronic illness, behavioral health problems, higher mortality and shorter life expectancy.[36] Furthermore, adults who are poor are considered the most vulnerable to the effects of poverty and experience higher rates of disability and mortality.[37]

[33] Prosperity Now. (February 2021). State Outcome & Policy Report. Retrieved from www.scorecard.prosperitynow.org
[34] Ibid
[35] Healthy People 2030. U.S. Department of Health and Human Services. Social Determinants of Health. Employment. Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/employment
[36] American Academy of Family Physicians (AAFP). (2019). Poverty and Health - The Family Medicine Perspective (Position Paper). Retrieved from https://www.aafp.org/about/policies/all/poverty-health.html
[37] Healthy People 2020. U.S. Department of Health and Human Services. Social Determinants of Health. Poverty. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/poverty

Graph 7 shows rising employment rates from 2016 to 2019 for both Nevada and the nation, then a precipitous drop in Nevada between 2019 and 2020 with a leveling off at the same time nationally. [38]

GRAPH 7. EMPLOYMENT RATES IN NEVADA AND U.S. 2020

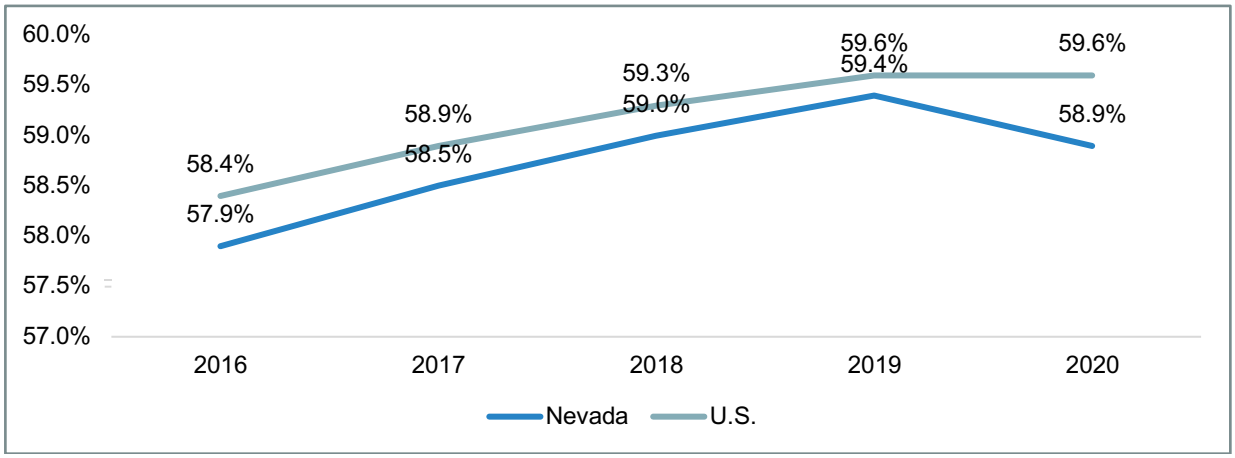
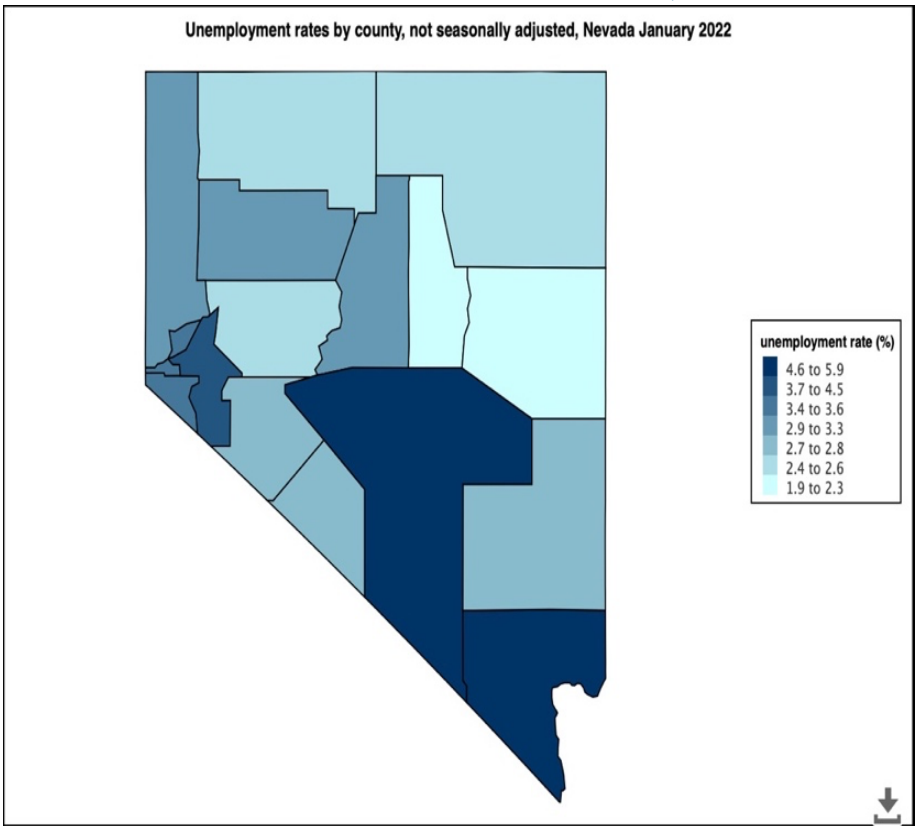


Figure 5 shows levels of unemployment by percentage across Nevada's counties, with Clark and Nye County showing the highest rates of unemployment as of January 2022. [39]

FIGURE 5. UNEMPLOYMENT RATES BY COUNTY, JANUARY 2022



[38] 2020 ACS 5-Year Estimates Data Profiles
[39] U.S. Bureau of Labor Statistics. (2022). Unemployment statistics map. Retrieved from https://data.bls.gov/lausmap/showMap.jsp

Unemployment rates by county as of January 2022 are listed in Table 12.[40] The highest rates of unemployment are seen in Clark County at 5.9%, Nye County 4.6% and Lyon County at 4.1%. The remaining counties all reported rates below 3.6%.

TABLE 12. UNEMPLOYMENT RATES BY COUNTY, NOT SEASONALLY ADJUSTED, JANUARY 2022

County/Region	February 2022 Unemployment Rate
Carson City	3.2
Churchill County	2.4
Clark County	5.3
Douglas County	3.2
Elko County	2.6
Esmeralda County	2.5
Eureka County	1.8
Humboldt County	2.3
Lander County	2.9
Lincoln County	2.4
Lyon County	3.8
Mineral County	2.7
Nye County	4.4
Pershing County	2.9
Storey County	3.3
Washoe County	2.8
White Pine County	2.4
Nevada	4.7
U.S.	4.1

Income and Poverty

Income and poverty impact all aspects of life, including access to safe and stable housing, quality healthcare, education and supports, transportation options and levels of stress. The median household income and per capita income by county in 2020 are shown in Table 13.[41] The highest median household income counties were Elko, Lander and Douglas counties, and the highest per capita income (past 12 months) counties were Douglas, Storey and Washoe Counties. The counties with the highest number of individuals in poverty during 2020 were Mineral County (15.4%), Esmerelda County (14.4%), and Nye County (14.2%). Nevada had a total of 12.5% of persons in poverty versus the United States total of 11.4%.

TABLE 13. MEDIAN HOUSEHOLD INCOME AND PER CAPITA INCOME, BY COUNTY, IN 2020 DOLLARS

County/Region	Median Household Income	Per Capita Income Past 12 Months	Persons in Poverty
Carson City	$58,305	$32,819	12.5%
Churchill County	$56,335	$28,659	10.3%
Clark County	$61,048	$31,651	13.2%
Douglas County	$71,415	$41,921	8.0%

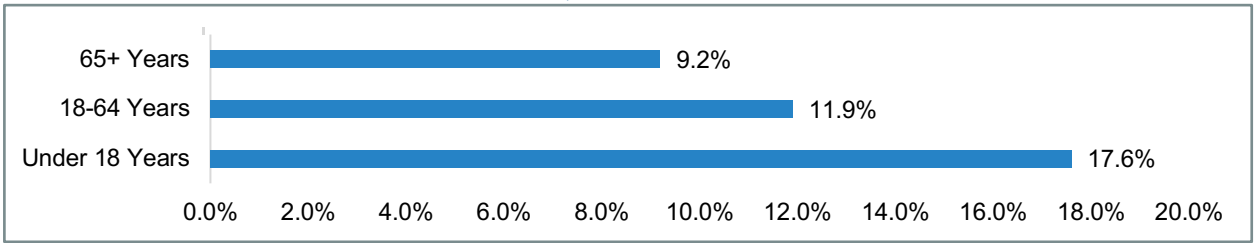
[40] Nevada Department of Employment, Training and Rehabilitation. Sub-State Press Release. March 29,2022. Retrieved from https://nevadaworkforce.com/_docs/Labor-Market-Overview/Current_Sub-State_Release.pdf

[41] U.S. Census Bureau. Quick Facts. Retrieved from https://www.census.gov/quickfacts/

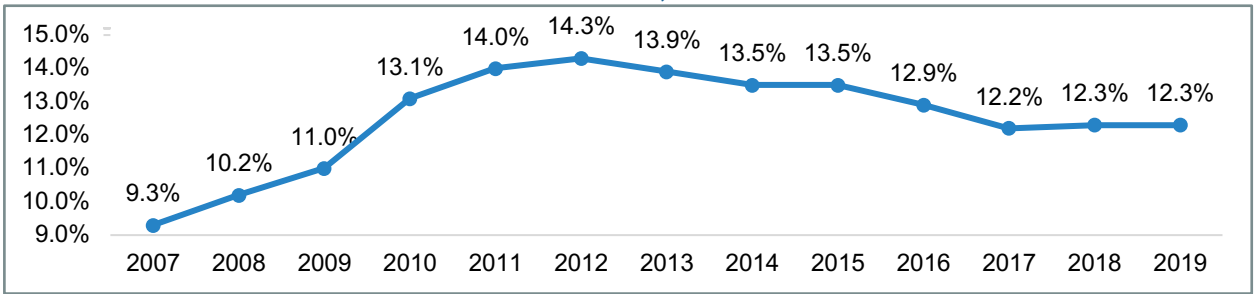
Elko County	$79,375	$34,601	11.2%
Esmeralda County	$31,845	$23,192	14.4%
Eureka County	$67,478	$30,516	10.3%
Humboldt County	$66,213	$33,258	9.8%
Lander County	$73,797	$34,911	9.4%
Lincoln County	$56,537	$26,805	13.2%
Lyon County	$58,814	$29,865	10.1%
Mineral County	$31,500	$21,746	15.4%
Nye County	$47,308	$26,622	14.2%
Pershing County	$57,074	$21,765	10.1%
Storey County	$64,000	$39,758	7.8%
Washoe County	$68,272	$37,689	10.2%
White Pine County	$57,353	$27,322	12.3%
Nevada	$62,043	$32,629	12.5%
United States	$64,994	$35,384	11.4%

Graph 8 shows poverty percentages in Nevada by age.[42] In 2020 9.2% of seniors, aged 65 and older lived in poverty, of those aged 18-64 years 11.9% lived in. poverty, and for children under the age of 18, 17.6% lived in poverty. Graph 9 shows the change in come poverty rate in Nevada, which was 12.3% in 2019.

GRAPH 8. POVERTY BY AGE IN NEVADA, 2020



GRAPH 9. CHANGE IN INCOME POVERTY RATE, NEVADA



Rising inflation has the potential to further poverty rates and challenges experienced by poor and low-income individuals. The Brookings Institution states that rising inflation, as seen in Graph 10 below, negatively impacts low- and middle-income families in a disproportionate way, leavening families with less purchasing power as prices rise.[43,44]

[42] U.S. Census Bureau. Retrieved from https://data.census.gov/

[43] Statista. Projected Annual Inflation Rate in the United States. Retrieved from https://www.statista.com/statistics/244983/projected-inflation-rate-in-the-united-states/

[44] Gill, I., & Nagle, P. (2022). Inflation could wreak vengeance on the world's poor. Retrieved from https://www.brookings.edu/blog/future-development/2022/03/18/inflation-could-wreak-vengeance-on-the-worlds-poor/

GRAPH 10. ANNUAL INFLATION RATE IN THE U.S. FROM 2014-2022

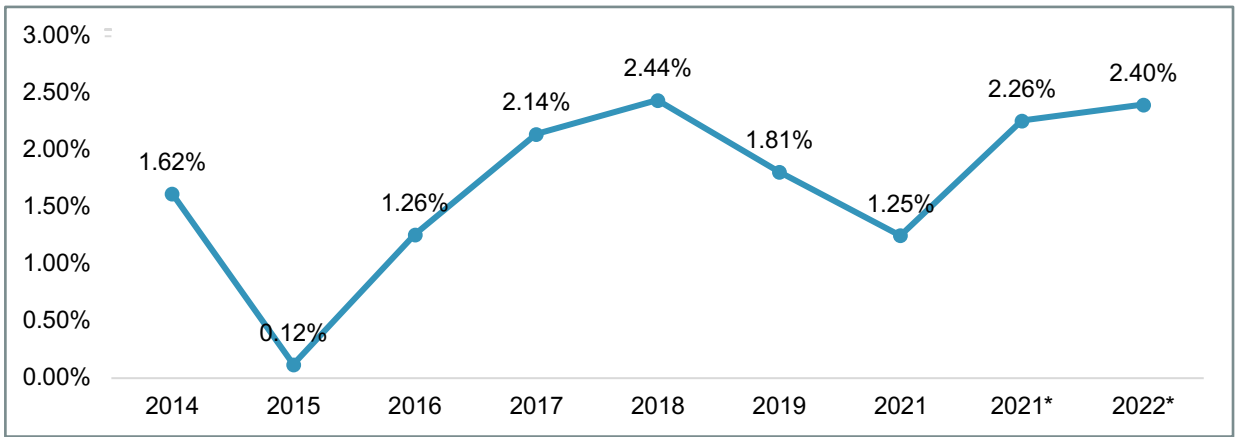


Table 14 below shows that of Nevada's 678,509 school age children, 126,710 youth, or 18.6% of students participate in FRS Program. The counties with the highest percentage of students utilizing FRS include Esmerelda County at 95.75%, Churchill County at 89.21% and Nye County at 88.34%.

TABLE 14. NEVADA COUNTY RANKINGS

County Ranking Highest Population at or below FPL	County	Percentage of Population at or below FPL	Percent of Free and Reduced (FRS) Students	Number of Students on FRS
1	Mineral	20.3%	39.20%	254
2	Nye	17.3%	88.34%	4,882
3	Pershing	15.0%	55.05%	377
4	Carson	14.7%	45.89%	3,527
5	Clark	14.6%	75.46%	226,972
6	Churchill	13.8%	89.21%	3,016
7	Lyon	13.7%	42.23%	3,517
8	Washoe	13.3%	45.41%	29,808
9	Lander	13.2%	30.86%	316
10	White Pine	13%	51.87%	615
11	Lincoln	12.1%	39.94%	369
12	Elko	11.5%	35.20%	3,492
13	Eureka	10%	Unavailable	Unavailable
14	Douglas	9.8%	27.94%	1,479
15	Humboldt	9.1%	47.35%	1,584
16	Storey	7.7%	Unavailable	Unavailable
17	Esmeralda	6.8%	95.74%	82

Housing

Data from the Community Health Rankings database show the percentage of households that spend 50% or more of their household income on housing and the percentages by county in Nevada (Table 15).[45]

[45] County Health Rankings and Roadmaps. (2021). Nevada: Severe housing cost burden. Retrieved from https://www.countyhealthrankings.org/app/nevada/2021/measure/factors/154/data

TABLE 15. PERCENTAGE OF SEVERE HOUSING COST BURDEN BY COUNTY, NEVADA

County/Region	# Households with Severe Cost Burden	County Value
Carson City	2,994	13%
Churchill County	1,089	11%
Clark County	125,285	16%
Douglas County	2,672	13%
Elko County	1,103	6%
Esmeralda County	8	2%
Eureka County	26	4%
Humboldt County	495	8%
Lander County	210	10%
Lincoln County	167	9%
Lyon County	2,269	11%
Mineral County	218	12%
Nye County	2,343	13%
Pershing County	131	7%
Storey County	98	6%
Washoe County	24,126	14%
White Pine County	205	6%

Housing affordability impacts health, wellness, and homeless outcome for Nevadans. In terms of homelessness, the most recent homelessness data does not reflect the true impact of the COVID-19 pandemic and the resulting loss of income, housing, and disruption of housing for all populations. Between 2018-2019 Nevada's rate of home ownership increased from 57.8% to 58.2% respectively.[46] Nevada rents, like those across much of the country, have risen even during the pandemic, putting further strain on individuals and families.

According to a study from Secuity.org, Nevada has the 9th highest rate of homelessness in America with a rate of 227.5 homeless individuals per 100,000 population.[47] Reno has the 24th highest rate of homelessness in the country and Las Vegas has 28th highest. Nevada's homeless rate of 227.5 per 100,000 residents is above the national average of 175.8.

Food Insecurity and Hunger

Food insecurity is defined by the United States Department of Agriculture (USDA) as "households that are uncertain they will have, or be able to acquire, enough food to meet the needs of household members due to insufficient resources for food".[48] Food insecurity and hunger decreases quality of life and is associated with adverse health outcomes and impacts chronic disease as well, with a particular impact on children and seniors.

According to a 2021 Report by Feeding America, 373,370 people were facing hunger across the state, 122,450 of them children. They estimate that 1 in 8 Nevadans is food insecure and faces

[46] Nevada Department of Business & Industry Housing Division. (2021). NRS 278.235 – Annual Housing Progress Report. Retrieved from https://housing.nv.gov/uploadedFiles/housingnewnvgov/Content/Programs/HDB/AHPR%20%202020%20draft%20version%2020210209.pdf page 7

[47] Security. org. (2021). State of homelessness in 2021: Statistics, Analysis, & Trends. Retrieved from https://www.security.org/resources/homeless-statistics/

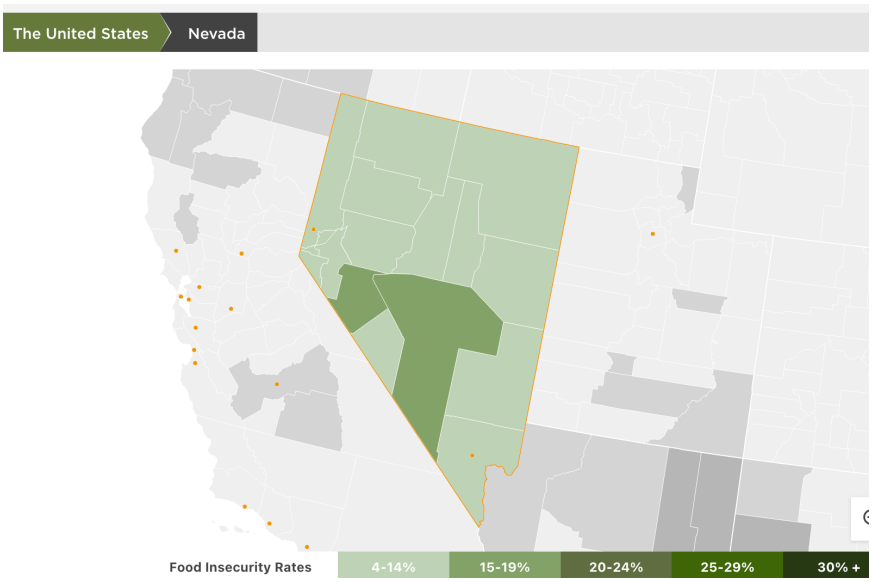
[48] Nevada Department of Health and Human Services. Nevada Council on Food Security. 2021 Annual Report. Retrieved from https://www.leg.state.nv.us/Division/Research/Documents/RTTL_NRS232.4968_2022.pdf

hunger, and 1 in 6 Nevada children face hunger. Additionally, 35.5% of households across the state that are receiving SNAP benefits have children living in them.[49]

A Feeding America reports shows that Nevada ranked as eight in the nation when measuring states with the highest projected overall food insecurity rates in 2021. Nevada's food insecurity rate was 15.2% among the general population. When looking at child food insecurity, Feeding America ranks Nevada as fifth in the country in projected child food insecurity rates for 2021 at 23% of children being food insecure.[50]

Figure 6 shows rates of food insecurity by county across Nevada.[51] Mineral and Nye counties show the highest rates of food insecurity with 15-19% of the population being food insecure.

FIGURE 6. FOOD INSECURITY BY COUNTY, NEVADA



Health Care Access/Health Care

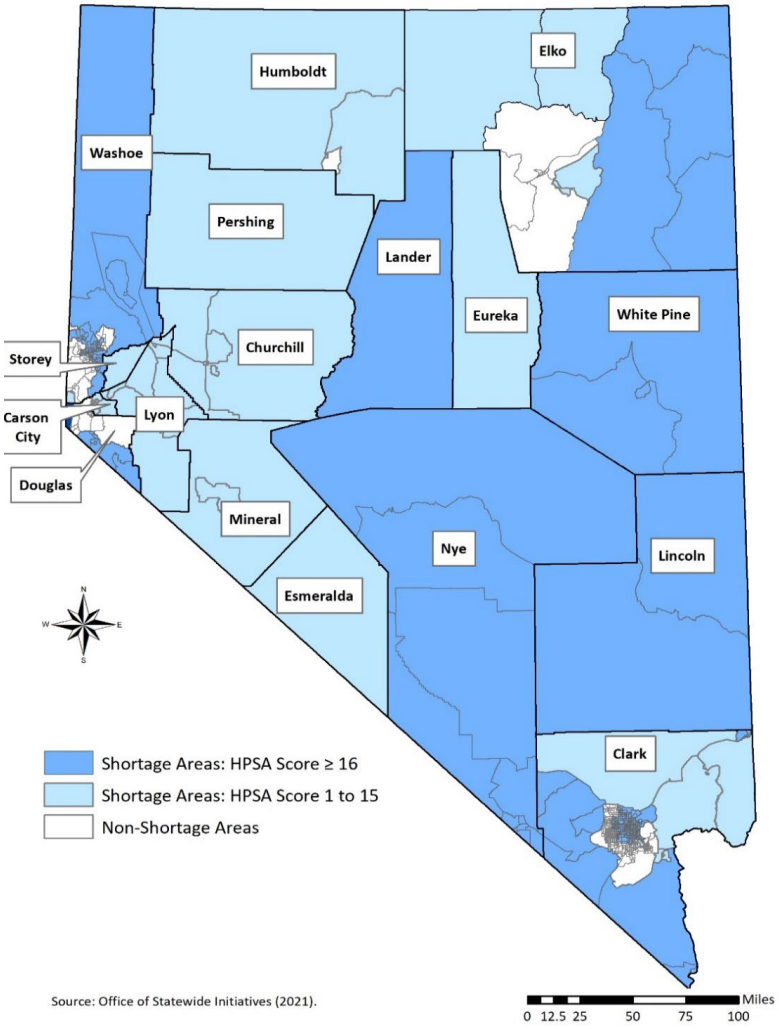
Access to health care helps a person to live a healthy life and prevents more costly medical conditions from developing. Yet gaps in access to affordable care can limit opportunities for health and well-being for some Nevadans. Nevada has a higher percentage of individuals experiencing hardships or limitations in terms of health care access in comparison to national data. These outcome variables further substantiate the need for effective funding allocations to provide community support programs and resources targeted to meet these needs on a statewide basis. In terms of health care, Nevada again ranks among the lowest performing states compared to national averages.

Nevada has faced consistent and historical challenges recruiting and retaining an adequate number of physicians and medical providers that has only been exacerbated by the COVID-19

[49] Feeding America. (2022). Hunger in Nevada. Retrieved from https://www.feedingamerica.org/hunger-in-america/nevada
[50] Feeding America. (2022). Hunger deprives our kids of more than just food. Retrieved from https://www.feedingamerica.org/hunger-in-america/child-hunger-facts
[51] Feeding America. (2021). Food insecurity in Nevada. Retrieved from https://map.feedingamerica.org/county/2019/overall/nevada

pandemic. The *Physician Workforce in Nevada: 2021* report details the lack of providers across the state across a variety of specialties and across Health Professional Shortage Areas (HPSA). The report states that Nevada ranks 48th in the U.S. in primary care physicians with 73.5 per 100,000 population, compared to 94.7 per 100,000 population for the U.S. Only 29.8% of these physicians are women, which ranks Nevada 44th in the country, compared to the U.S. at 36.1%; and 32.2% of Nevada's active physicians are aged 60 and older, speaking to the need for increased recruitment and education of new Nevada physicians to serve communities as these physicians retire. Figure 7 shows the primary medical care HPSAs in Nevada.[52]

FIGURE 7. PRIMARY MEDICAL CARE HEALTH SHORTAGE AREAS (HPSAS) IN NEVADA



[52] Packham, J., Griswold, T., Terpstra, J., Warner, J. (2022) Physician Workforce in Nevada: A Chartbook. Retrieved from https://med.unr.edu/statewide/reports-and-publications pp. 23

Rapidly growing populations in the state have put pressure on medical systems, particularly in specialty areas such as anesthesiology, dermatology, and gastroenterology. Additionally, the shortage in physicians who specialize in psychiatry, mental health, and substance abuse treatment, which have been identified in this report and the previous Needs Assessment as gaps in service, are represented in Table 16 comparing Nevada, Nevada regions and counties, and national averages.[53]

TABLE 16. POPULATION RESIDING IN HPSAS IN NEVADA 2021

Region/ County	Population Residing in HPSAs						Population
	Primary Medical HPSA		Dental HPSA		Mental HPSA		
	Number	% of Population	Number	% of Population	Number	% of Population	
Rural and Frontier							
Churchill County	26,780	100.0	26,780	100.0	26,780	100.0	26,780
Douglas County	33,319	66.4	37,441	74.6	50,169	100.0	50,169
Elko County	21,100	39.4	35,539	66.3	53,589	100.0	53,589
Esmeralda County	955	100.0	955	100.0	955	100.0	955
Eureka County	1,763	100.0	1,763	100.0	1,763	100.0	1,763
Humboldt County	12,986	78.6	12,986	78.6	16,519	100.0	16,519
Lander County	5,957	100.0	5,957	100.0	5,957	100.0	5,957
Lincoln County	4,530	100.0	4,530	100.0	4,530	100.0	4,530
Lyon County	56,582	100.0	56,582	100.0	56,582	100.0	56,582
Mineral County	4,508	100.0	4,508	100.0	4,508	100.0	4,508
Nye County	47,028	100.0	47,028	100.0	47,028	100.0	47,028
Pershing County	4,723	100.0	4,723	100.0	4,723	100.0	4,723
Storey County	4,578	100.0	4,578	100.0	4,578	100.0	4,578
White Pine County	9,547	100.0	9,547	100.0	9,547	100.0	9,547
Regional Subtotal	234,356	81.6	252,917	88.1	287,228	100.0	287,228
Urban							
Carson City	51,049	92.9	51,049	92.9	54,941	100.0	54,941
Clark County	1,514,394	64.2	1,479,376	62.7	2,358,347	100.0	2,358,347
Washoe County	335,222	70.9	472,810	100.0	297,118	62.8	472,810
Regional Subtotal	1,900,665	65.9	2,003,235	69.4	2,710,406	93.9	2,886,09
Nevada	**2,135,021**	**67.3**	**2,256,152**	**71.1**	**2,997,634**	**94.5**	**3,173,326**

As can be seen in Table 16:

- 67.3% of Nevada's population resides in a primary care HPSA.
- In urban areas, 64.2% of Clark County residents, and 73.2% of Washoe County and Carson City residents resides in a primary care HPSA.
- 11 of 14 rural and frontier counties are single-county primary care HPSAs.

Data provided below address health insurance, health outcomes, health factors, prevention and screening trends in Nevada.

[53] Packham, J., Griswold, T., Terpstra, J., Warner, J. (2022) Physician Workforce in Nevada: A Chartbook. Retrieved from https://med.unr.edu/statewide/reports-and-publications pp 22

Health Insurance

Health insurance facilitates access to care and is associated with lower death rates, better health outcomes, and improved productivity.[54] Insurance coverage rates by type and population in Nevada is shown in Table 17. [55]

TABLE 17. HEALTH INSURANCE COVERAGE, NEVADA 2020

Population	Uninsured	Employer Insured	Medicaid	Medicare	Military	Non Group	Other Public
Total Population	10.2%	47.8%	19.1%	15.4%	2.9%	4.5%	
Coverage of Non-Elderly (0-64 years) with incomes below 100% FPL	19.8%	18.4%	52.2%			N/A	6.0%
Coverage of Non-Elderly (0-64 years) with incomes below 200% FPL	15.3%	25.6%	47.0%			5.0%	7.0%
Adults 19-64 Living in Poverty (under 100% FPL)	22.7%	17.6%	48.2%			N/A	N/A
Low-Income Adults 19-64 (under 200% FPL)	20.5%	26.3%	39.0%			6.0%	8.2%

Given the rate of being uninsured and its significant implications for healthcare access, it is important to note several facts about the uninsured:

- Not having insurance disproportionately impacts individuals with low to moderate income;
- Not having insurance disproportionately impacts people of color;
- Not having insurance forces individuals to forgo needed healthcare.

In addition to lack of insurance creating a barrier to accessing health insurance, transportation is also a barrier, as is lack of broadband and internet access. In Nevada, 14.3% of people do not have an internet subscription.[56] In many rural and frontier counties, having broadband and access to telehealth can mean the difference between receiving healthcare and not receiving healthcare.

The Nevada Division of Public and Behavioral Health states that Nevada is identified as the least healthy state when considering the amount of public health funding available relative to other states. This includes a combination of state dollars dedicated to public health and federal dollars from the Centers for Disease Control and Prevention (CDC) and HRSA. Public health is supported across the state with $46 per person in Nevada, significantly lower than the U.S. average of $87 per person.[57] This funding deficit has implications for public health outcomes

[54] American Hospital Association (AHA). (2022). Report: The Importance of Health Coverage. Retrieved from https://www.aha.org/guidesreports/report-importance-health-coverage

[55] Kaiser Family Foundation (KFF). (2021). Health Insurance Coverage of the Total Population (CPS). Retrieved from https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22nevada%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[56] 2020 ACS 5-Year Estimates. Retrieved from https://data.census.gov/cedsci/profile?g=0400000US32

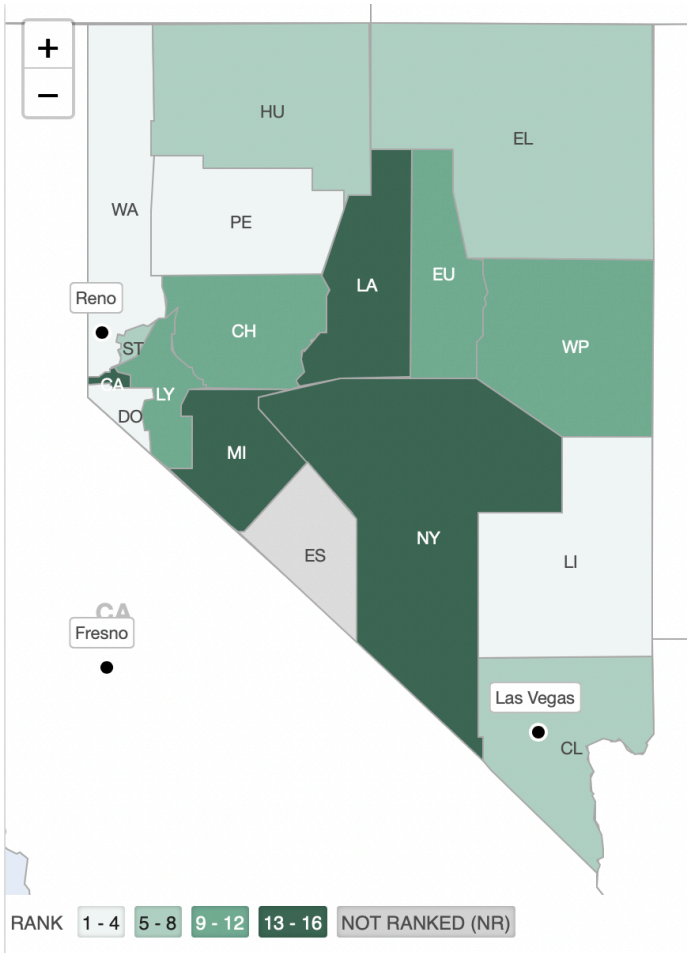
[57] Nevada Division of Public and Behavioral Health. (2020). 2020: Nevada's Maternal and Child Health Needs Assessment. Retrieved from https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/MIECHV/dta/Publications/Needs%20Assessment%20Final.pdf

across the state and is a gap that must be corrected to “move the needle” on some of the priority needs identified throughout this report.

The County Health Ranking Report ranks Nevada counties by **Health Outcomes** and **Health Factors** as seen in Figures 8 and 9.[58] The overall rankings in Health Outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The ranks are based on two types of measures: how long people live and how healthy people feel while alive and includes measures for premature death, poor or fair health, poor physical health days, poor mental health days, and low birthweight.

Figure 8 shows the **Health Outcomes** ranks for Nevada Counties in 2021. The following counties were ranked the highest (1-4): Lincoln County (LI) ranked 1; Douglas County (DO) ranked 2; Pershing County (PE) ranked 3; and Washoe County (WA) ranked 4. The following counties were ranked the lowest for Health Outcomes: Carson City (CA) ranked 13; Lander County (LA) ranked 14; Nye County (NY) ranked 15; and Mineral (MI) ranked 16.[59]

FIGURE 8. NEVADA 2021 HEALTH OUTCOMES



[58] County Health Rankings and Roadmaps. (2021). Nevada. Retrieved from https://www.countyhealthrankings.org/app/nevada/2021/overview
[59] County Health Rankings. Nevada. Overall Rank. Retrieved from https://www.countyhealthrankings.org/app/nevada/2021/rankings/outcomes/overall

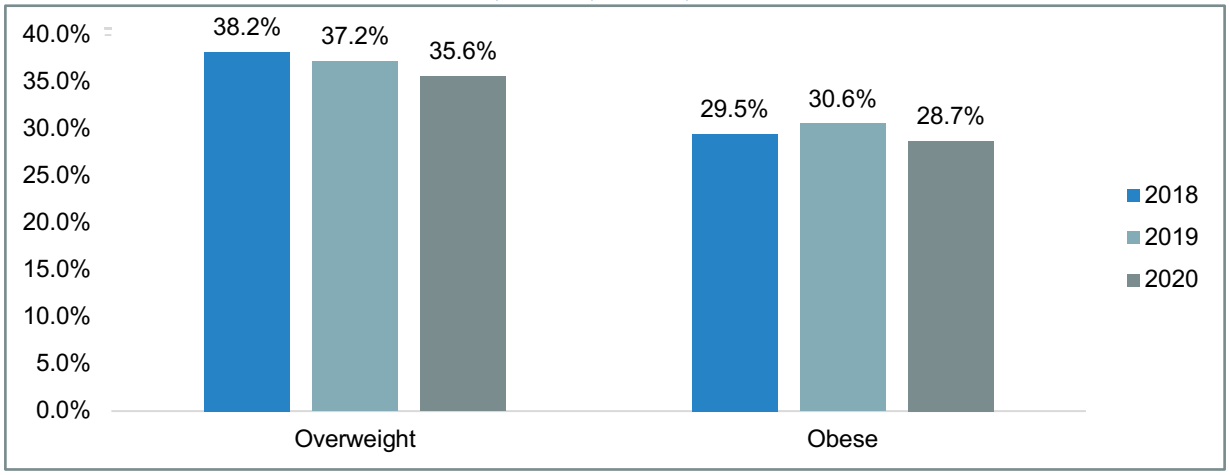
Poor health outcomes include other measures including chronic diseases such as heart disease, hypertension, diabetes, arthritis, and obesity. The prevalence of chronic disease in Nevada compared to the U.S. overall is shows in Table 18. [60]

TABLE 18. CHRONIC DISEASE PREVALENCE, NEVADA AND U.S., 2020 BRFSS DATA

Chronic Conditions Prevalence	Nevada	U.S.
Arthritis	24.9%	24.5%
Currently Have Asthma	9.5%	9.6%
Angina/Coronary Heart Disease	4.3%	4.0%
Heart Attack	5.0%	4.3%
Stroke	3.2%	2.8%
COPD	7.2%	6.2%
Skin Cancer	6.8%	6.4%
Cancer (Other than Skin Cancer)	6.1%	6.8%
Diabetes	11.1%	10.6%
Kidney Disease	3.5%	2.9%

Nevada has a higher prevalence of Heart Attack, COPD, and Diabetes compared to the U.S. In addition to the chronic conditions, BRFSS data show 35.6% of Nevada adults 18 years and older were considered overweight and 28.7% were considered obese (Graph 11). [61] Obesity increases the risk for chronic disease and other health conditions, including psychosocial issues, sleep apnea and breathing problems, and body pain. Obese adults demonstrate a greater risk for a multitude of comorbidities, including heart disease, chronic lower respiratory disease, diabetes mellites, and hypertension, all of which are associated with leading causes of death in Nevada.

GRAPH 11. OBESITY PREVALENCE, 2018, 2019, 2020



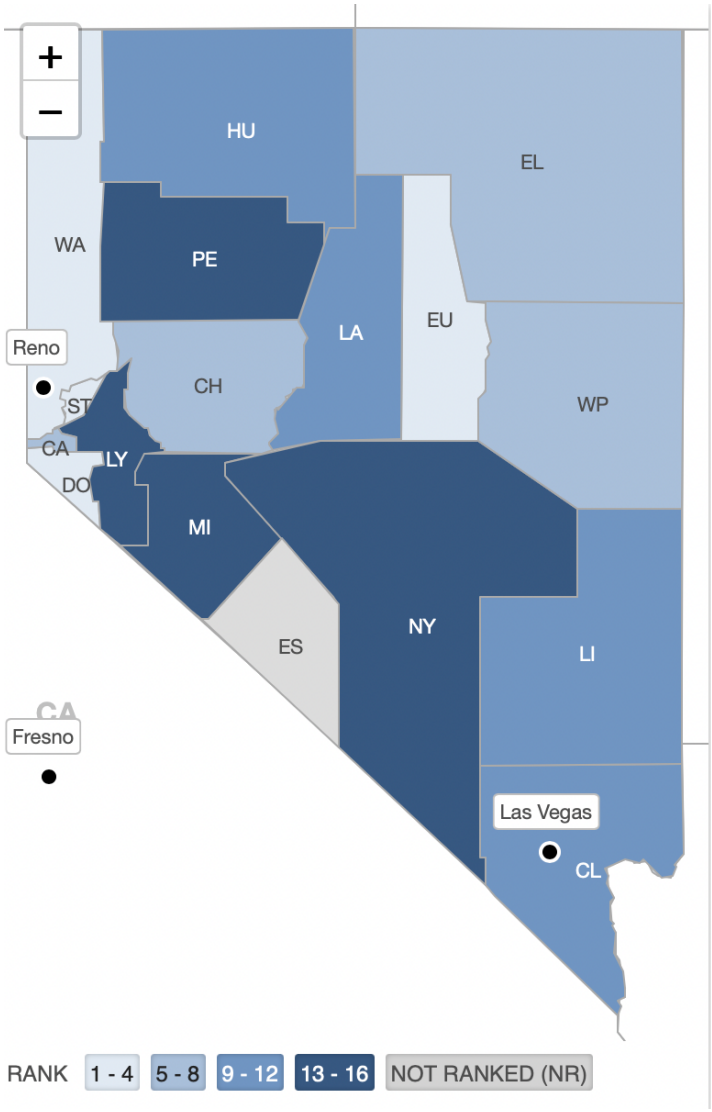
Poor nutrition and inactivity contribute to obesity risk. 2019 BRFSS data show that 43.4% of Nevada adults surveyed consumed fruit less than one time per day and 25.2% consumed vegetables less than one time per day. BRFSS data also show 80% Nevada adults surveyed did not participate in enough aerobic and muscle strengthening exercises to meet guidelines.

[60] Center for Disease Control and Prevention (CDC). (2017). 2020 BRFSS Prevalence & Trends data. Retrieved from https://www.cdc.gov/brfss/brfssprevalence/
[61] Ibid

The overall rankings in **Health Factors** represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.

Figure 9 shows the **Health Factors** ranks for Nevada Counties in 2021. The following counties were ranked the highest (1-4): Douglas County (DO) ranked 1; Washoe County (WA) ranked 2; Eureka County (EU) ranked 3; and Storey County (ST) ranked 4. The following counties were ranked the lowest for Health Factors: Lyon County (LY) ranked 13; Pershing County (PE) ranked 14; Mineral County (MI) ranked 15; and Nye County (NY) ranked 16.[62]

FIGURE 9. NEVADA 2021 HEALTH FACTORS



[62] County Health Rankings. Nevada. Overall Rank. Retrieved from https://www.countyhealthrankings.org/app/nevada/2021/rankings/factors/overall

Nevada has a higher prevalence of Teen Births, Injury Deaths, and Violent Crime compared to the U.S (Table 19). [63] Furthermore, the ratio of primary care physicians and dentists to patients shows the shortages of health care professionals previously mentioned.

TABLE 19. 2021 HEALTH FACTORS, DISAGGREGATED DATA, NEVADA AND U.S

Measure	NV	US
Health Factors		
Health Behaviors		
Adult Smoking	16%	17%
Adult Obesity	27%	30%
Physical Inactivity	23%	23%
Excessive Drinking	18%	19%
Teen Births	25	21
Clinical Care		
Primary Care Physicians Ratio	1,710:1	1,320:1
Dentists Ratio	1,590:1	1,400:1
Preventable Hospital Stays	4,245	4,236
Mammography Screening	34%	42%
Flu Vaccinations*	38%	48%
Social & Economic Factors		
Children in Poverty	18%	17%
Injury Deaths	78	72
Violent Crime	657	386
Physical Environment		
Driving Along to Work	78%	76%

In addition to the health factors above, there are other preventable factors related to behavior and decision making that may increase the likelihood of developing health issues and chronic disease, including substance use. BRFSS data[64] (Table 20), shows:

- 14.2% of Nevada's adult population were current smokers.
- 5.4% of Nevada's population were current e-cigarette users.
- 17.2% of Nevada's population were binge drinkers.
- 7.3% of Nevada's population were heavy drinkers.

TABLE 20. ADULT PREVALENCE SOCIAL BEHAVIORS THAT EFFECT HEALTH

Social Behaviors	Nevada	U.S.
Current Smoker+	14.2%	15.5%
Current E-Cigarette Users*	5.4%	4.6%
Binge Drinkers+	17.2%	15.7%
Heavy Drinkers	7.3%	6.7%

+2020 Data; *2017 Data (most recent available)

[63] County Health Rankings & Roadmaps. (2021). Nevada. 2021 State Level Data and Ranks. Retrieved from https://www.countyhealthrankings.org/sites/default/files/media/document/CHR2021_NV.pdf

[64] Nevada Department of Health and Human Services. Nevada Behavioral Risk Factor Surveillance System (BRFSS) Annual Report 2019. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/BRFSS%20Annual%20Report%202019.pdf

YRBSS data for high school students shows the following social behaviors that effect health (Table 21) [65]:

- 3.6% of Nevada's high school students smoked cigarettes one or more time during past 30 days.
- 15.0% of Nevada's high school students used electronic vapor products one or more time during past 30 days.
- 26.1% of Nevada's high school students drank alcohol one or more times during past 30 days
- 13.3% of Nevada's high school students engaged in binge drinking.
- 19.8% of Nevada's high school students used marijuana during 30 days.
- 18.6% of Nevada's high school students took prescription pain medicine without a doctor's prescription.

TABLE 21. YOUTH PREVALENCE SOCIAL BEHAVIORS THAT EFFECT HEALTH, 2019

Social Behaviors	Nevada	U.S.
High School		
Smoked Cigarettes one or more times during past 30 days	3.6%	6.0%
Used Electronic Vapor Products one or more times during past 30 days	15.0%	13.2%
Drank Alcohol one or more times during past 30 days	26.1%	29.2%
Binge Drinking	13.3%	13.7%
Used Marijuana during 30 days before survey	19.8%	21.7%
Ever Took Prescription Pain Medicine without a Doctor's Prescription	18.6%	14.3%

Preventive Care and Healthy Behaviors

Preventive care helps the early detection or prevention of serious diseases and medical problems before they can become major and is intended to help individuals stay as healthy as possible. Preventive care includes annual check-ups, immunizations, and flu shots, as well as certain tests and screenings, like mammogram, colonoscopy, blood pressure, diabetes, cholesterol. It also includes counseling on smoking cessation, weight loss, eating healthy, treating depression, and reducing alcohol use. In addition to preventative care, healthy behaviors including eating well and being physically active, can not only lead to improved health and extend longevity but also reduce the risk of chronic disease.

Table 22 shows adult preventive care and health behaviors for Nevada and the U.S. [66] Nevada adults had lower rates of cholesterol check, colonoscopy, mammogram, Pap tests and PSA tests, and dental visits compared to the U.S. In addition, Nevada adults had lower rates of immunizations, physical activity, and lower rates of consuming fruits and vegetables

[65] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS) 2019 Data. Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/results.htm
[66] Centers for Disease Control and Prevention. BRFSS Prevalence & Trends Data. Retrieved from https://www.cdc.gov/brfss/brfssprevalence/index.html

TABLE 22. ADULT PREVENTIVE CARE AND HEALTH BEHAVIORS, NEVADA AND U.S.

	Nevada	U.S.
Health Screenings		
Cholesterol Check within Last 5 Years+	85.7%	86.6%
Blood Stool Test*	13.7%	9.3%
Colonoscopy^	55.3%	64.3%
Mammogram*	69.6%	71.5%
Pap Test*	76.0%	77.7%
PSA Test*	29.5%	31.8%
Dental Visit*	60.8%	66.7%
Immunizations		
Flu Shot* age 65 and over	61.8%	67.9%
Pneumonia Vaccine* age 65 and over	70.6%	72.2%
Nutrition		
Fruit Consumption+ Less than one time/day	43.4%	39.3%
Fruit Consumption+ One or more times/day	56.6%	60.7%
Vegetable Consumption+ Less than one time/day	25.2%	20.3%
Vegetable Consumption+ One or more times/day	74.8%	79.7%
Physical Activity		
Physical Activity Index+ – participated in enough Aerobic and Muscle Strengthening exercises to meet guidelines	20.0%	23.2%

BRFFSS Data ^2018, +2019, *2020

For youth, Nevada had lower rates of child immunizations (Table 23). [67, 68, 69, 70]

TABLE 23. YOUTH PREVENTIVE CARE AND HEALTH BEHAVIORS, NEVADA AND U.S

	Nevada	U.S.
Immunizations		
Children 19-35 months appropriately vaccinated*	79.0%	90.0%
Children 6 months to 17 years vaccinated for influenza (2020-21 Flu Season)*	45.0%	58.6%
Teen Influenza Vaccination Coverage (13-17 Years)**	38.2%	-
Teen HPV Vaccinations (13-17 Years)	50.1%	
Nutrition* **		
Middle School Students who did not eat Breakfast on all 7 days	52.2%	N/A
Middle School Students who were not physically active at least 60 minutes on all 7 days	70.2%	N/A
High School Students who did not eat Breakfast on all 7 days	70.4%	66.9%
High School Students who Drank Soda/Pop in 7 days	67.5%	68.3%
Physical Activity* **		
High School Students who were not physically active at least 60 minutes on all 7 days	78.3%	76.8%

Sources: *CDC; **Nevada Tomorrow; ***YRBSS Data

Mental and Behavioral Health

Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, the ability to relate to others, and daily functioning. Mental illnesses are medical conditions that

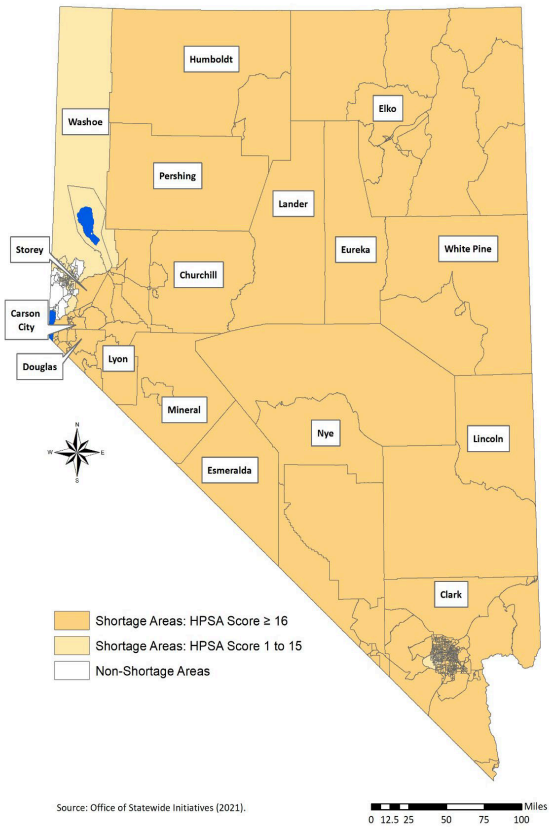
[67] Nevada Tomorrow. Community Dashboard. Retrieved from https://www.nevadatomorrow.org/indicators
[68] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/results.htm
[69] Centers for Disease Control and Prevention. General Population Vaccination Coverage. Retrieved from https://www.cdc.gov/flu/fluvaxview/coverage-2021estimates.htm;
[70] Centers for Disease Control and Prevention. Vaccination Coverage among Children Aged 19-35 Months – United States 2017.. Retrieved from https://www.cdc.gov/mmwr/volumes/67/wr/mm6740a4.htm

often result in a diminished capacity for coping with the ordinary demands of life. Having an adequate number of mental health providers helps to reduce the risk of chronic diseases that are related to anxiety, stress, and even substance abuse. However, Nevada faces significant challenges bringing providers to the state and retaining them in a variety of specialties and subspecialities, with significant challenge faced in terms of mental health.

Nevada has a substantial shortage of mental health professionals and ranks 51st in the country overall for higher prevalence of mental illness and lower rates of access to care.[71] For prevalence of mental illness, Nevada ranks 46; for access to care, Nevada ranks 39; and for mental health workforce availability, Nevada ranks 34 with a ratio of 460:1, impacting access to care and negatively impacting mental health disease course and outcomes.[72]

Figure 10 shows the mental health HPSAs in Nevada.[73] In addition, 94.5% of Nevada's population resides in a mental health HPSA; 16 or 17 counties are single-county mental health HPSAs; and 100.0% of the state's rural and frontier residents live in a mental health HPSA (Table 14 on Page 29).

FIGURE 10. MENTAL HEALTH PROFESSIONAL SHORTAGE AREAS (HPSAS) IN NEVADA



[71] Mental Health America. 2020 Ranking of the States. Retrieved from https://mhanational.org/issues/2022/ranking-states#overall-ranking
[72] Ibid
[73] Packham, J., Griswold, T., Terpstra, J., Warner, J. (2022) Physician Workforce in Nevada: A Chartbook. Retrieved from https://med.unr.edu/statewide/reports-and-publications pp.26

In Nevada (Table 24): [74]

- 11.5% of adults with mental illness remain uninsured.
- 58.0% of individuals experiencing mental illness are going untreated.
- More than quarter (29.3%) of all adults with a mental illness reported they were not able to receive the treatment needed.
- 65.2% of youth with major depression do not receive any mental health treatment.
- Only 18.7% of youth with severe depression received some consistent treatment (defined as 7-25+ visits in a year).
- Children lacking mental health coverage was 7.1%.

TABLE 24. ACCESS TO CARE DATA, NEVADA RANK AND % OF POPULATION, 2022

Health Indicators	Rank	% of Population
Adults with Any Mental Illness (AMI) who are uninsured	30	11.5%
Adults with AMI who did not receive treatment	41	58.0%
Adults with AMI reporting unmet need	45	29.3%
Youth with Major Depressive Episode (MDE) who did not receive mental health services	40	65.2%
Youth with severe MDE who received some consistent treatment	45	18.7%
Children with Private Insurance that Did Not Cover Mental or Emotional Problems	24	7.1%

BRFSS and YRBSS data (Table 25) for mental and emotional health in Nevada show:[75,76]

- 15.6% of Nevada's population had ever been told by a health professional that they had a depressive disorder.
- 13.8% of Nevada's population reported 14-30 days of poor physical or mental health.
- 11.7% of Nevada's population reported 14-30 bad mental health days, in the last 30 days before the survey.
- 42.5% of Nevada's high school students felt sad or hopeless.
- 18.4% of Nevada's high school students seriously considered attempting suicide.

TABLE 25. MENTAL AND EMOTIONAL HEALTH, NEVADA, 2019

Health Indicators	NV	US
Adults		
Ever told you have a depressive disorder	15.6%	19.1%
Poor physical or mental health during past 30 days	13.8%	16.0%
14+ bad mental health days	11.7%	12.4%
Seriously considered attempting suicide	3.2%	-
High School Students		
Felt sad or hopeless	42.5%	36.7%
Seriously considered attempting suicide	18.4%	18.8%

[74] Mental Health America. 2020 Ranking of the States. Retrieved from https://mhanational.org/issues/2022/mental-health-america-access-care-data#six

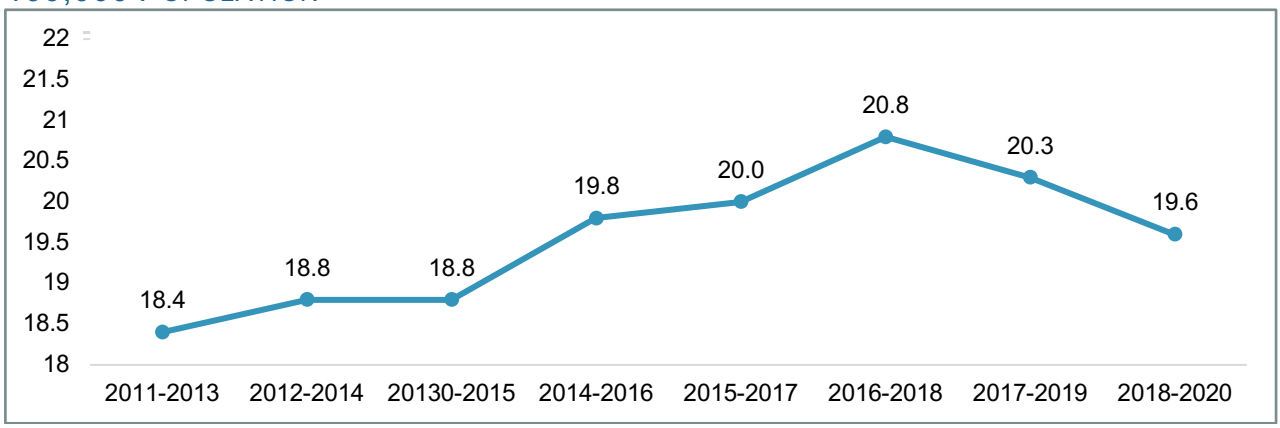
[75] Nevada Department of Health and Human Services. Nevada Behavioral Risk Factor Surveillance System (BRFSS) Annual Report 2019. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/BRFSS%20Annual%20Report%202019.pdf

[76] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/results.htm

The COVID-19 pandemic has had significant impacts on individuals with mental illness and substance abuse disorder, with increases seen over the pandemic in depression, suicide, anxiety, and substance use and mental health problems.[77] Emerging research on COVID-19 shows that the coronavirus pandemic has increased psychological distress both in the general population and among high-risk groups. Behaviors such as physical distancing, as well as their social and economic impacts, are worsening mental health consequences. Research on the psychological impact of mass trauma (e.g., natural disasters, flu outbreaks) suggests that the pandemic might particularly harm the mental health of marginalized populations who have less access to socioeconomic resources and supportive social networks.[78]

Nevada has the 11th highest rate of suicide in the nation, and it is the 8th leading cause of death for Nevadans.[79] Statewide, the age adjusted suicide rate rose through until 2018, as seen in Graph 12 below, then dropped from 2018-2020.[80] The COVID-19 pandemic greatly impacted individuals with mental illness and substance abuse disorders, and while this is the latest statewide data available, the impact of the pandemic on mental health cannot be understated, nationally as well as in Nevada.

Graph 12. Age Adjusted Death Rate due to Suicide in Nevada, Deaths per 100,000 Population



Mental health in Nevada will be explored more in **Individuals Dealing with Mental Illness and Substance Use Disorders** section.

[77] Shim, R.S., and Starks, S.M. (2021). COVID-19, Structural Racism, and Mental Health Inequities: Policy Implications for an Emerging Syndemic. Retrieved from https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000725?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed

[78] American Psychological Association (APA). (2020). How COVID-19 impacts people with disabilities. Retrieved from https://www.apa.org/topics/covid-19/research-disabilities

[79] Nevada Hospital Association. Address the Mental Health Services Crisis. Retrieved from https://nvha.net/advocacy-initiatives/mental-health/

[80] Nevada Tomorrow. (2022). Age-Adjusted Death Rate due to Suicide. Retrieved from https://www.nevadatomorrow.org/?module=indicators&controller=index&action=view&comparisonId=&indicatorId=120&localeId=31&localeChartIdxs=1%7C2%7C3

Populations and Issues of Focus

To understand the needs across geography, populations, populations, and special populations that have been historically marginalized and underserved, this report calls out disparities faced by these populations. The populations highlighted in this report include:

- Aging Adults/Seniors
- Black, Indigenous, People of Color (BIPOC) see if they use commas
- Children Welfare Involved Children, Youth, and Transition Aged Youth (TAY)
- Individuals Dealing with Mental Illness and Substance Use Disorders
- Individuals Experiencing Homelessness
- Individuals with Disabilities/A Disability
- Justice System Involved Adults
- Justice System Involved Children, Youth and Transition Aged Youth (TAY)
- Maternal Child Health
- Regional Considerations (Rural and Frontier Communities)
- Sexual and Gender Minority Populations
- Veterans

Aging Adults/Seniors

Currently, senior citizens, or those ages 65 and older, represent 15.3% of the Nevada population. The growth of this population is expected to continue and is projected to increase 24.6% from 484,103 in 2021 to 603,356 in 2031. The growth rate in the population aged 65 and over in urban counties (26.2%) is projected to be higher than rural and frontier counties (14.0%). Table 26 shows the population of individuals aged 65 and older and the expected change in population between 2021 and 2031.[81]

TABLE 26. POPULATION AGED 65 AND OLDER IN NEVADA, BY COUNTY, 2021 TO 2031

Region/County	Population		Change 2021 2031	
	2021	2031	Number	%
Rural and Frontier				
Churchill County	4,367	4,949	582	13.3
Douglas County	14,450	15,700	1,250	8.6
Elko County	7,897	9,980	2,083	26.4
Esmeralda County	261	227	-34	-13.0
Eureka County	373	421	48	12.8
Humboldt County	2,517	3,181	664	26.4
Lander County	1,009	1,079	70	6.9
Lincoln County	1,075	1,109	34	3.1
Lyon County	12,104	13,903	1,799	14.9
Mineral County	998	925	-73	-7.3
Nye County	13,726	15,485	1,759	12.8
Pershing County	1,054	1,007	-47	-4.4

[81] Griswold, T., Packham, J., Warner, J., Etchegoyhen, L. (2021). Nevada Rural and Frontier Health Data Book - 10th Edition. Retrieved from https://cms2files.revize.com/elkocountynevada/boards/Health/2021/DATA%20BOOK%202021%20Final%203-4-21.pdf

Storey County	1,395	1.915	520	37.3
White Pine County	2.153	2.346	193	9.0
Regional Subtotal	**63,379**	**72,226**	**8,847**	**14.0**
Urban				
Carson City	13,080	13,130	50	0.4
Clark County	329,565	420,797	91,232	27.7
Washoe County	78,079	97,204	19,125	24.5
Regional Subtotal	**420,724**	**531,131**	**110,407**	**26.2**
Nevada – Total	**484,103**	**603,356**	**119,253**	**24.6**

Source: 2021 Rural Health Data Book 10th Ed, p. 25

The Nevada State Plan for Aging published in 2021 states that the migration of seniors to Nevada is continuing, and the rates of migration in the age group of ages 55-64 is higher in rural Nevada, and this has resulted in increased service demand in already stressed areas that lack the needed services and infrastructure to meet the demands of an aging population. Issues that face all individuals and families, such as the lack of affordable housing across the state can be particularly challenging for older adults, many of whom rely on social security benefits to live.[82]

Education

Most adults, age 55 or older have limited higher education backgrounds, with rural areas being the lowest). Northern seniors are more likely to have a bachelor's degree or higher than southern and rural counterparts.[83]

Economic and Financial Stability

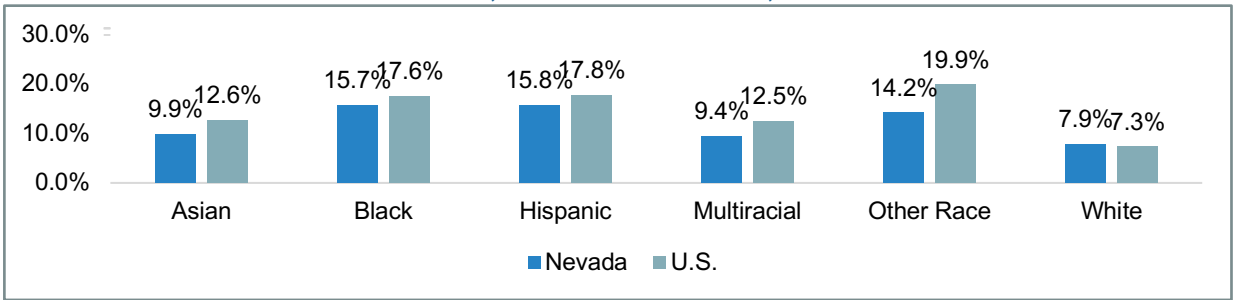
The median household income for householders aged 65 years and over is $49,276, which is 3.8% higher than the median for the U.S. at $47,484.[84] A major source of income for most of the elderly is Social Security. In 2020, the average Social Security payment for Nevadans was $1,493 per month, just under the average for the U.S. at $1,503 per month.[85] Nevada does not have a personal income tax, and therefore, Social Security Benefits are untaxed in the state, allowing retirees to retain more of their benefits.

Nearly a quarter (26%) of Nevadans aged 65-74 and 7% over age 74 continue to participate in the labor force. More than six out of ten people aged 65-85 who remain in the labor force indicate that they are working into retirement purely for financial reasons.[86]

[82] The Nevada Aging and Disability Services Provision. (2020). Nevada State Plan for Aging. Retrieved from https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/About/Reports/StatePlans/NV_State_Plan_or_Aging-2021-2024-FINAL_06.01.2021.pdf
[83] Aging and Disability Services Provision. (2021). Elders Count Nevada. Retrieved from https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/About/Reports2/Elders%20Count%202021%20-%20FINAL%201.28.2021.pdf
[84] U.S. Census Bureau. (2016-2020). Median household income in the past 12 months (In 2020 inflation-adjusted dollars) by age of householder. Retrieved from https://censusreporter.org/data/table/?table=B19049&geo_ids=04000US32,04000US32,01000US
[85] Whiteman, D. (2019). Here's every state's average social security check for 2020. Retrieved from https://www.yahoo.com/video/heres-every-states-average-social-132355610.html
[86] Aging and Disability Services Provision. (2021). Elders Count Nevada. Retrieved from https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/About/Reports2/Elders%20Count%202021%20-%20FINAL%201.28.2021.pdf

As of 2019, 9.5% adults ages 65 and older lived below the poverty level. [87] The percentage of older adults in poverty is higher among Hispanic and Black populations (15.8% and 15.7%, respectively) than White populations (7.9%) (see Graph 24). [88]

GRAPH 13. POVERTY – AGES 65+, NEVADA AND U.S., 2019



Among older adults, poverty is linked to poor health outcomes, including an increased risk of chronic disease, disabilities, homelessness, physical and cognitive decline, and mortality. In addition, they face significant challenges in meeting their daily needs including food, housing, and medical care, which may increase the demand for public services, such as long-term services and supports and healthcare.

Healthcare Access

Nationally, the largest age group enrolled in Medicare is the 65-74 group, comprising 48% of the Medicare enrollees. According to the Administration for Community Living (ACL), there are 472,585 Medicare eligible individuals in Nevada, and constitute approximately 15% of Nevada's population. State data from the BRFSS (Table 27) shows that the vast majority of seniors in Nevada have healthcare coverage and are seeking the care they need.

TABLE 27. HEALTH CARE ACCESS/COVERAGE, NEVADA SENIORS 65+, 2020[89]

Health Indicators	2019 Rate %	2020 Rate %
Healthcare Cost		
Did not see doctor in past 12 months because of cost	4.7%	4.6%
Healthcare Coverage		
Any health care coverage	97.1%	97.3%
Last Checkup		
Within the Past Year	89.5%	88.1%
Withing the Past 2 Years	4.9%	9.1%
Personal Care Provider		
One Person as Personal Doctor/Health Care Provider	82.6%	81.6%

State BRFSS data (Table 28) [90] also shows an increase in chronic health indicators, including arthritis; asthma; angina, coronary heart disease or myocardial infarction; diabetes; kidney

[87] America's Health Rankings. (2022). Senior report: Poverty- Ages 65+. Retrieved from https://www.americashealthrankings.org/explore/senior/measure/poverty_sr/state/NV
[88] Ibid
[89] Center for Disease Control and Prevention (CDC). BRFSS prevalence & trends data. Retrieved from https://www.cdc.gov/brfss/brfssprevalence/
[90] Ibid

disease; and cancer. The CDC lists the leading causes of death in Nevada as (1) heart disease; (2) cancer; and (3) chronic lower respiratory disease.

TABLE 28. HEALTH INDICATORS AMONG SENIORS 65+, 2020

Health Indicators	2019 Rate %	2020 Rate %
Arthritis	46.1%	49.8%
Currently Have Asthma	9.3%	11.4%
Angina or Coronary Heart Disease	9.7%	12.6%
Heart Attack	13.1%	10.9%
Stroke	8.5%	8.2%
Coronary Heart Disease or Myocardial Infarction	14.5%	20.0%
Chronic Obstructive Pulmonary Disease (COPD)	16.4%	16.4%
Diabetes	21.7%	23.9%
Kidney Disease	8.1%	9.8%
Any Types of Cancer	15.5%	19.5%
Skin Cancer	17.3%	20.3%
Vision Impairment	17.3%	17.3%
Obese	28.6%	28.9%
Overweight	37.4%	38.2%
Fair or Poor Health Status	24.0%	25.5%
14 Days When Physical Health Not Good	19.3%	18.0%
Visited Dentist in Past Year	63.3%*	64.4%

*2018

Risk factors for seniors include declines in physical health, substance use or abuse, and prevalence of chronic disease, including overweight and obesity, and the increase in the risk of falling. Therefore, as people age, they use more health care resources. In addition, the population of seniors in Nevada was high hard during the pandemic, as adults aged 60 and over are more vulnerable to COVID-19 associated mortality. While the total cases for this age group was relatively love, 8.7% for ages 60-69 and 7.0% for ages 70+, the death rate was the highest of all groups with 21.6% of deaths between the ages of 60-69 and 57.9% of deaths ages 70+. Vaccination rates for ages 60-69 as 14.6% and for 70+ was 14.3%.[91]

Mental and Behavioral Health

Mental health access is already limited in Nevada due to the number of Health Professional Shortage Areas (HPSAs) detailed previously, and aging adults/senior citizens often face additional challenges accessing care, including inability to pay co-pays, transporting challenges and ageism that sometimes causes their medical concerns to be written off as simply part of the aging process. It is important to look at senior healthcare and senior healthcare access as issues that require specific strategies that address barriers unique to seniors.

The CDC estimates that 20% of individuals over the age of 55 are dealing with some kind of mental health concern, including anxiety, depression, severe cognitive impairments and mood disorders.[92] Depression in particular can lead to health impairments and the loss of social

[91] Nevada Health Response. (2021). Coronavirus (COVID-19) in Nevada. Retrieved from https://nvhealthresponse.nv.gov
[92] Centers for Disease Control and Prevention (CDC). (2008). The State of Mental Health and Aging in America. Retrieved from https://www.cdc.gov/aging/pdf/mental_health.pdf

connectivity and engagement. The CDC states that depression is a treatable but often under-recognized condition in this population. In 2020, 16.9% of older adults, age 65 and older report depression, an increase from 11.9% in 2019 (see Table 29). [93]

TABLE 29. MENTAL HEALTH/SUBSTANCE USE RATES AMONG THE ELDERLY

Mental Health/Substance Use	2019 Rate %	2020 Rate %
Depression	11.9%	16.9%
Alcohol Consumption/Heavy Drinking	5.2%	5.9%
Tobacco Use/Current Smoker	10.0%	13.4%

Isolation and loneliness lead to higher rates of depression, and Nevada ranks 25th in the nation for risk of social isolation in older adults ages 65 and older.[94] This population accesses mental health treatment at a lower rate and have fewer mental health treatments compared to younger age groups. [95] Nevada also has the highest suicide rate among people aged 65 and older.[96]

In addition, Nevadans have been diagnosed with Alzheimer's/dementia. The Alzheimer's Association states that 49,000 people in Nevada aged 65 and older are currently living with Alzheimer's, and of those aged 45 and older 14.9% already have subjective cognitive decline. The burden of Alzheimer's is demonstrated by the 48,000 family caregivers that care for their loved ones with the disease, providing 79 million hours of unpaid care totaling an estimated 1.3 billion in value.[97] The growing numbers of seniors who have Alzheimer's and dementia is a challenge not only for the senior who has the disorder but for their spouses, family, and caregivers and social service and health care is projected to rise.

Black, Indigenous, People of Color (BIPOC)

BIPOC is an acronym that stands for ***Black, Indigenous,*** and ***People of Color*** and is meant to emphasize the unique hardships, discrimination, and prejudice faced by Black and Indigenous people. It refers to:

- **Black** refers to dark-skinned peoples of Africa, Oceania, and Australia or their descendants without regard for the lightness or darkness of skin tone, and who were enslaved by white people.
- **Indigenous** refers to ethnic groups native to the Americas, and who were killed en masse by white people.
- **People of Color** is an umbrella term for non-white people, especially as they face racism and discrimination in a white dominant culture.

[93] Centers for Disease Control and Prevention (CDC). BRFSS Prevalence & Trends Data. Retrieved from https://www.cdc.gov/brfss/data_tools.htm
[94] Aging and Disability Services Provision. (2021). Elders Count Nevada. Retrieved from https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/About/Reports2/Elders%20Count%202021%20-%20FINAL%201.28.2021.pdf
[95] Ibid
[96] America's Health Rankings. (2021). Suicide - ages 65+. Retrieved from https://www.americashealthrankings.org/explore/senior/measure/Suicide_sr/state/NV
[97] Alzheimer's Association. (2022). Nevada. Retrieved from https://www.alz.org/professionals/public-health/state-overview/nevada

As part of DHHS, the Nevada Office of Minority Health works collaboratively with all divisions to improve the quality of health care services for members of minority groups, increase access to health care services, to seek and provide education, and to address, treat and prevent diseases and conditions that are prevalent among minority and underserved populations. The Office of Analytics completed the Minority Health Report which highlighted existing health disparities by socio-economic, race and ethnicity in Nevada. Continued engagement also demonstrated how the COVID-19 pandemic magnified the challenges caused by racial and economic disparities through all major stages of health care. The impact of COVID-19 further exacerbated the challenges of access to healthcare for certain populations including Black, Indigenous, and Latinx people, immigrants, low wage earners, and those in rural and frontier communities across lower socio-economic and marginalized communities. A common thread for accessing care was poverty.

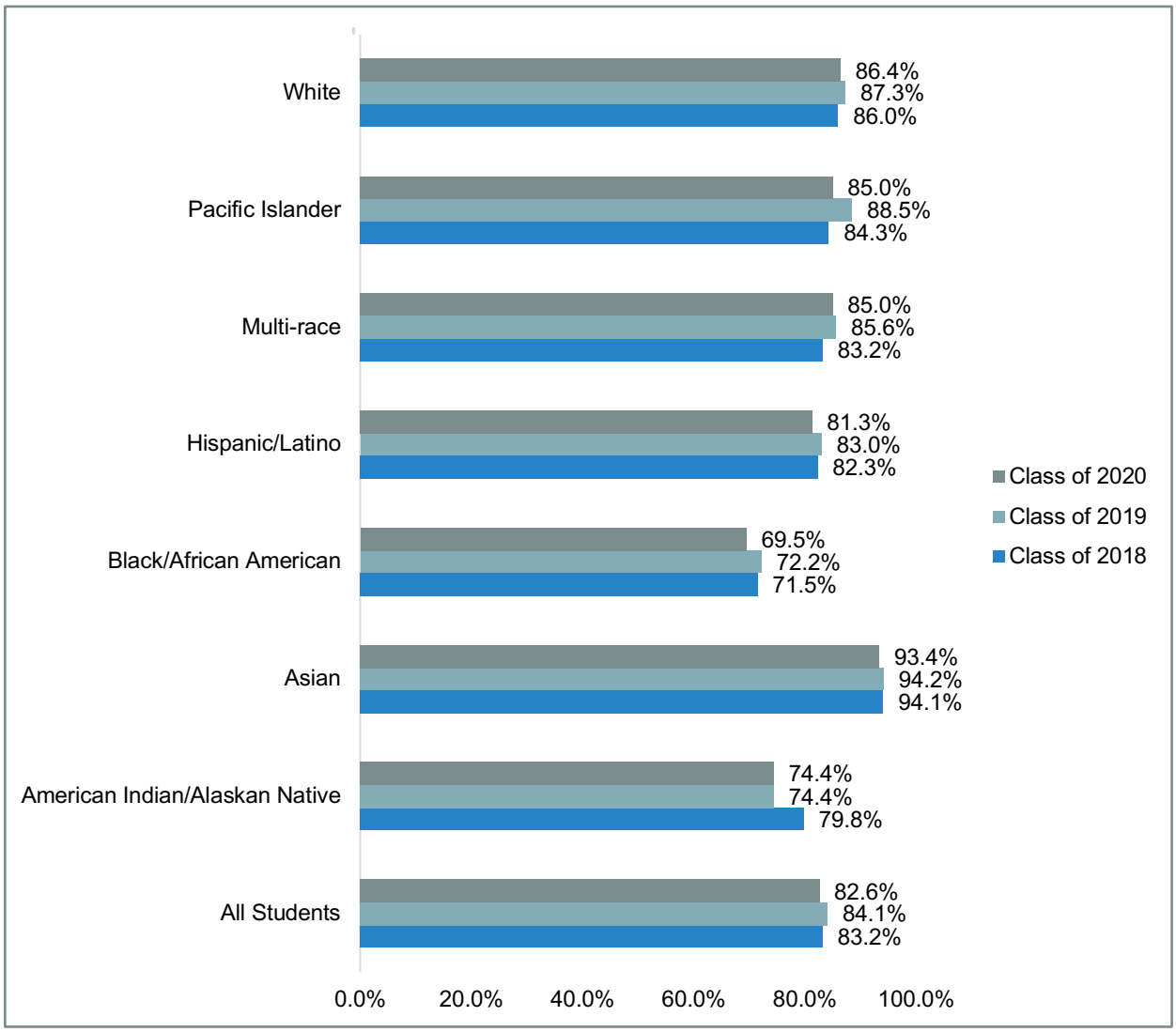
Data across a variety of issue areas including health, home ownership, financial stability, education, exposure to crime, pollution, and employment consistently show disparities across minority groups. To target funding and programmatic strategies to improve health and wellness outcomes across the state, it is necessary to focus on historically marginalized and chronically underserved minority populations, and we have highlighted data and issues that impact different groups throughout this report.

Education

The opportunity gap remains significant across different student populations in Nevada. As can be seen in Graph 27, graduation rates vary substantially by race and ethnicity. In 2020, the graduation rate for all students was 82.6%, compared to 69.5% of Black/African American students, 74.4% for American Indian/Alaskan Native students, and 81.3% for Hispanic/Latino students. In addition:

- The graduation rate for students who identify as American Indian/Alaskan Native decreased 5.4 percentage points from 2018 to 74.4% in 2019 and remaining the same for 2020.
- The graduation rate for students who identify as Asian increased 0.1 percentage points from 2018 to 2019 then decreased 0.8 percentage points from 2019 to 93.4% in 2020.
- The graduation rate for students who identify as Black/African American increased 0.7 percentage points from 2018 to 72.2% in 2019 then decreased 2.7 percentage points from 2019 to 69.5% in 2020.
- The graduation rate for students who identify as Hispanic/Latino increased 0.7 percentage points from 2018 to 2019 then decreased 0.7 percentage point from 2019 to 69.5% in 2020.
- The graduation rate for students who identify with Multi-race increased 2.4 percentage points from 2018 to 2019 then decreased 0.6 percentage points in 2019 to 85.0% in 2020.
- The graduation rate for students who identify as Pacific Islanders increased 4.2 percentage points then decreased 0.6 percentage points from 2019 to 85.0% in 2020.
- The graduation rate for students who identify as White increased 1.3 from 2018 to 2019 then decreased 0.9 percentage points from 2019 to 86.4% in 2020.

GRAPH 14. NEVADA GRADUATION TRENDS BY RACE/ETHNICITY [98]



Increasing Nevada's overall high school graduation rate and closing these gaps for minority populations is vital to the future of our young people and our state's economy.

Economic and Financial Stability

From the perspective of financial assets and income, which is tied heavily to access to services and resources as well as stability, improved health outcomes, and other trackable outcomes, Nevadans of racial/ethnic backgrounds have higher rates of Income Poverty, Liquid Asset Poverty, and instances of zero net worth. Additionally, racial/ethnic populations are more likely to be unbanked, underbanked, have less in savings, higher rates of income volatility, and higher likelihood of falling behind on bills as shown in Table 30. [99]

[98] Nevada High School Class of 2020: Four-Year Adjusted Cohort Graduation Rates. Retrieved from https://doe.nv.gov/uploadedFiles/ndedoenvgov/content/Boards_Commissions_Councils/State_Board_of_Education/2020/December/ACGRGraduationRates.pdf

[99] Prosperity Now Scorecard. Nevada. Retrieved from https://scorecard.prosperitynow.org/reports

TABLE 30. FINANCIAL ASSETS AND INCOME BY RACE/ETHNICITY IN NEVADA

Outcome Measure	Overall	White	People of Color	Black	American Indian	Asian	Pacific Islander/ Native Hawaiian	Latino
Income Poverty Rate	12.9%	10.0%	17.8%	24.5%	28.8%	7.4%	10.6%	18.4%
Liquid Asset Poverty Rate	47.6%	35.6%	59.0%	51.1%	-	69.3%	-	61.9%
Asset Poverty Rate	22.1%	-	-	-	-	-	-	-
Net Worth	$96,530	-	-	-	-	-	-	-
Households with Zero Net Worth	12.8%	15.9%	10.0%	18.1%	-	-	-	7.1%
Saved for Emergencies	58.9%	60.7%	56.6%	-	-	-	-	-
Underbanked Households	25.1%	18.0%	34.3%	-	-	-	-	-
Income Volatility	16.1%	14.5%	18.2%	-	-	-	-	-
Households with Savings Accounts	72.0%	75.0%	68.2%	-	-	-	-	-
Fell Behind on Bills	7.9%	5.3%	11.3%	-	-	-	-	-

Adapted from Prosperity Now Scorecard for Nevada, 2021

Table 31 below shows the disparities in unemployment among different racial/ethnic groups, with the highest unemployment among Black/African American residents, followed by American Indian/Alaskan Native. [100]

TABLE 31. UNEMPLOYMENT RATES BY RACE/ETHNICITY, NEVADA AND U.S., 2020

Region	Overall	White	Black	Hispanic	AIAN	Asian	Pacific Islander/ Native Hawaiian	Some Other Race	Two or More Races
Nevada	6.6%	5.8%	11.2%	6.5%	10.6%	4.8%	7.2%	6.1%	9.7%
U.S.	5.4%	4.4%	9.2%	6.2%	9.7%	4.3%	6.8%	6.4%	7.8%

Health and Access to Health Care

From a Health and Access to Healthcare perspective, data indicates further disparities across racial and ethnicity categories with white, non-Hispanic Nevadans with lower rates of being uninsured, forgoing doctor visits due to costs, and poor or fair health status. Where available, specific populations of minorities generally have worse outcomes compared to white, non-Hispanics. Without the regional dispersion, there is already sufficient data to suggest disparities will exist in rural and frontier communities where higher percentages of Tribal Communities are commonly found based on population dynamics and available data. Two of these variables are correlated with income, uninsured rate, and forgoing doctor visit due to cost, which would be expected to occur in impoverished rural communities regardless of race and ethnicity.

Table 32 shows Nevada rates of non-elderly who are uninsured that forego doctor visits due to cost and report poor or fair health status by race and ethnicity. [101] Hispanic individuals make up the highest uninsured category at 21.7% compared to the overall Nevada uninsured rate of 13.5%, as well as make up the highest percentage who reported foregoing a doctor visit due to cost at 17.0%. Black Nevadans report foregoing a doctor visit due to cost at the highest percentage rate of 13.2%.

[100] U.S. Census Bureau. Retrieved from https://data.census.gov/cedsci/table?q=unemployment%20rates&g=0100000US_0400000US32&tid=ACSST5Y2020.S2301

[101] Kaiser Family Foundation (KFF). (2020). State health facts: Build a Custom State Report. Retrieved from https://www.kff.org/statedata/custom/

TABLE 32. NONELDERLY UNINSURED, FORGOING DOCTOR VISITS, SELF-REPORTED HEALTH STATUS, NV 2020

Outcome Measure	Overall	White	Black	Hispanic / Latino	AIAN	Asian/Nat. Hawaiian/ Pac. Islander	Multiple Races
Uninsured Rates	13.5%	9.3%	8.6%	21.7%	11.3%	11.4%	8.7%
Forgoing Doctor Visit Due to Cost	10.3%	7.8%	13.2%	17.0%	-	-	-
Poor or Fair Health	17.9%	16.9%	23.1%	20.7%	-	-	19.4%

Rates of disease, mortality, and chronic disease are often higher among historically marginalized racial and ethnic groups (see Table 33 and Graph 28 below) [102, 103]. The rates of premature death are highest among the AIAN and Black populations, life expectancy is lower among the AIAN and Black populations, and infant child mortality is highest among these populations. Research shows show that poverty, low education, inadequate social support, and racial segregation contribute to premature death.[104]

TABLE 33. 2021 HEALTH OUTCOMES, DISAGGREGATED STATE-LEVEL RACIAL/ETHNIC DATA

Measure	Overall	AIAN	Asian	Black	Hispanic	White
Health Outcomes						
Premature Death*	7,100	10,200	4,600	11,400	4,600	8,000
Life Expectancy	78.7	78.1	85.3	74.7	86.1	77.3
Premature age-adjusted mortality	360	460	210	530	220	410
Child Mortality	50	70	50	100	40	40
Infant Mortality	6	7	5	11	5	5
Low Birthweight*	9%	7%	10%	14%	7%	8%

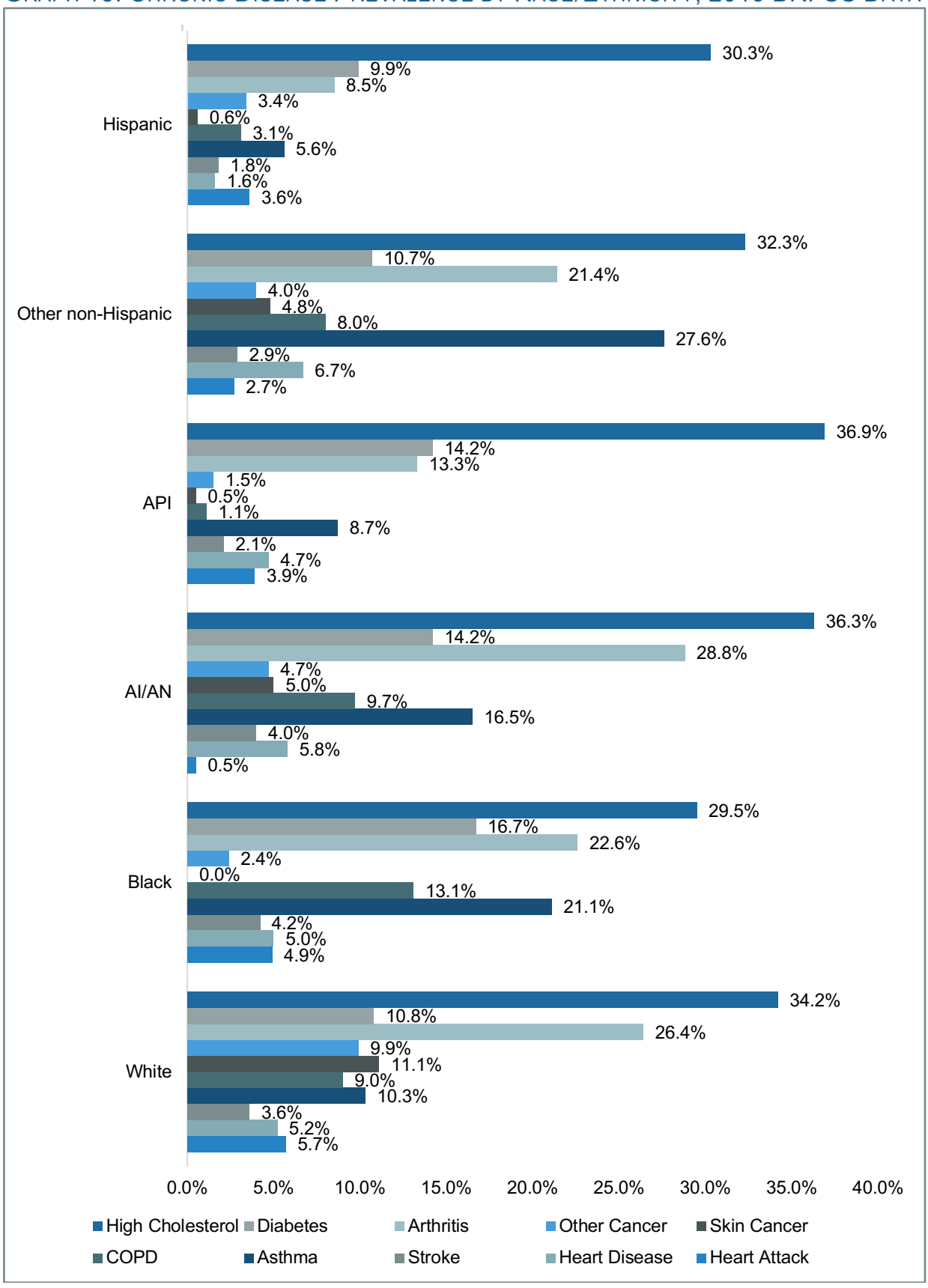
*Ranked measure

[102] County Health Rankings and Roadmaps. (2021). 2021 State Level Data and Ranks. Nevada. Retrieved from https://www.countyhealthrankings.org/app/nevada/2021/overview

[103] Nevada Department of Health and Human Services. Nevada Behavioral Risk Factor Surveillance System (BRFSS) Annual Report 2019. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/BRFSS%20Annual%20Report%202019.pdf

[104] Galea, S., Tracy, M., Hoggatt, K. J., DiMaggio, C., & Karpati, A. (2011). Estimated deaths attributable to social factors in the United States. Retrieved from https://ajph.aphapublications.org/doi/10.2105/AJPH.2010.300086

GRAPH 15. CHRONIC DISEASE PREVALENCE BY RACE/ETHNICITY, 2019 BRFSS DATA



As can be seen in Graph 28 above: [105]

- The prevalence of heart attacks was significantly higher among White populations (5.7%) and Hispanic populations (3.6%) than among American Indian/Alaskan Native populations (0.5%).
- The prevalence of heart disease was significantly higher among White populations (5.2%) than among Hispanic populations (1.6%).
- The prevalence of stroke was higher among Black (4.2%) and American Indian/Alaskan Native populations (4.0%) than Asian/Pacific Islander populations (2.1%).
- The prevalence of asthma was significantly higher among Black populations (21.1%) than among White populations (10.3%) and Hispanic populations (5.6%).
- The prevalence of COPD was significantly higher among White populations (9.0%) and Black populations (13.1%) than among Asian/Pacific Islander populations (1.1%) and Hispanic populations (3.1%).
- The prevalence of skin cancer was significantly higher among White populations (11.0%) than among Asian/Pacific Islander populations (0.5%).
- The prevalence of cancer was significantly higher among White populations (9.9%) than among Black populations (2.4%) and Asian/Pacific Islander populations (1.5%).
- The prevalence of arthritis was significantly higher among White populations (26.4%) than among Asian/Pacific Islander populations (13.3%) and Hispanic populations (8.5%).
- The prevalence of diabetes was higher among Black populations (16.7%) than among White populations (10.8%) and Hispanic populations (9.9%).
- The prevalence of high cholesterol was higher among American Indian/Alaskan Native populations (36.3%), Asian/Pacific Islander populations (36.9%), and White populations (34.2%) than for Black populations (29.5%).

In addition, BRFSS data show higher rates of overweight/obese Nevadans among Hispanics (31.3%), non-Hispanic Blacks (30.5%), non-Hispanic Whites (30.4%).[106]

Figure 11 below shows key findings from the Minority Health Report 2021:[107]

[105] Nevada Department of Health and Human Services. Nevada Behavioral Risk Factor Surveillance System (BRFSS) Annual Report 2019. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/BRFSS%20Annual%20Report%202019.pdf
[106] Ibid
[107] Nevada Department of Health and Human Services. (2021). Minority Health Report 2021. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Minority%20Health%20Report%202021(2).pdf

FIGURE 11. KEY FINDINGS FROM THE MINORITY HEALTH REPORT, 2021

- In 2019, Hispanic populations had significantly lower death rates, at 134.2 per 100,000 population, than Black-non- Hispanic populations (311.4 per 100,000) and White-non-Hispanic populations (223.1 per 100,000).
- In 2019, Black-non-Hispanic populations had the highest mortality rates of heart disease, at 311.4 per 100,000 population, when compared across all other race/ethnicity groups in 2019.
- From 2008 to 2017, the number of cancer cases among Asian/Pacific Islander-non-Hispanic populations increased by 83.3% in cancer burden for all cancer types in Nevada Asian/Pacific Islander-non-Hispanic populations show a 160.5% increase in female breast cancer burden, 72.7% increase in colorectal cancer burden, and 91.8% increase in prostate cancer.
- In 2019, death rates from CLRD were highest among White-non-Hispanic populations, at 61.3 per 100,000 population, compared to all other races/ethnicity groups.
- Black- non-Hispanic populations experienced a significant increase in diabetes death rates from 26.3 per 100,000 population in 2015 to 46.0 per 100,000 population in 2019.
- Black-non-Hispanic populations had significantly higher death rates from homicide for each year from 2015 to 2019 than any other race/ethnicity group.
- Black-non-Hispanic populations had significantly higher rates of reported cases of HIV infection than every other race/ethnicity group for each year from 2015 to 2019.
- In 2019, Black-non-Hispanic populations had significantly higher infant mortality rates, at 11.5 deaths per 1,000 live births, than White-non-Hispanic (3.4 per 1,000 live births) and Hispanic (5.4 per 1,000 live births) populations.
- In 2019, White-non-Hispanic populations (28.0 per 100,000) and Black-non-Hispanic populations (20.1 per 100,000) had significantly higher rates of enteric disease than Asian/Pacific Islander-non-Hispanic populations (11.6 per 100,000).

Table 34 shows the various health factors and disparities by race/ethnicity.

TABLE 34. 2021 HEALTH FACTORS, DISAGGREGATED STATE-LEVEL RACIAL/ETHNIC DATA[108]

Measure	Overall	AIAN	Asian	Black	Hispanic	White
Health Factors						
Health Behaviors						
Drug Overdose Deaths	22	27	7	25	8	32
Motor Vehicle Crash Deaths	11	22	7	13	8	13

[108] County Health Rankings & Roadmaps. (2021). Nevada. 2021 State Level Data and Ranks. Retrieved from https://www.countyhealthrankings.org/sites/default/files/media/document/CHR2021_NV.pdf

Teen Births*	25	34	8	39	31	16
Clinical Care						
Preventable Hospital Stays*	4,245	5,321	3,538	7,925	4,187	3,938
Mammography Screening*	34%	27%	29%	29%	25%	36%
Flu Vaccinations*	38%	34%	37%	24%	29%	41%
Social & Economic Factors						
Reading Scores	2.9	n/a	3.3	2.5	2.7	3.3
Math Scores	2.8	n/a	3.3	2.3	2.6	3.1
Children in Poverty	18%	34%	10%	33%	23%	10%
Median Household Income	$63,300	$44,300	$69,000	$41,000	$52,000	$66,400
Injury Deaths*	78	105	39	85	37	106
Homicides	6	7	3	21	6	5
Suicides	20	19	11	12	8	29
Firearm Fatalities	17	20	8	24	9	21
Physical Environment						
Driving Along to Work*	78%	71%	76%	74%	77%	80%

*Ranked measure

COVID-19 vaccination rates are lower for racial/ethnic groups (Table 35). [109]

TABLE 35. TOTAL POPULATION THAT HAS RECEIVED A COVID-19 VACCINE, BY RACE/ETHNICITY, NEVADA, AS OF MARCH 21, 2022

Race/Ethnicity	%
White	36.4%
Black	6.1%
Hispanic	27.5%
Asian/Pacific Islander	9.2%
American Indian/Alaskan Native	0.6%
Other Race	20.2%

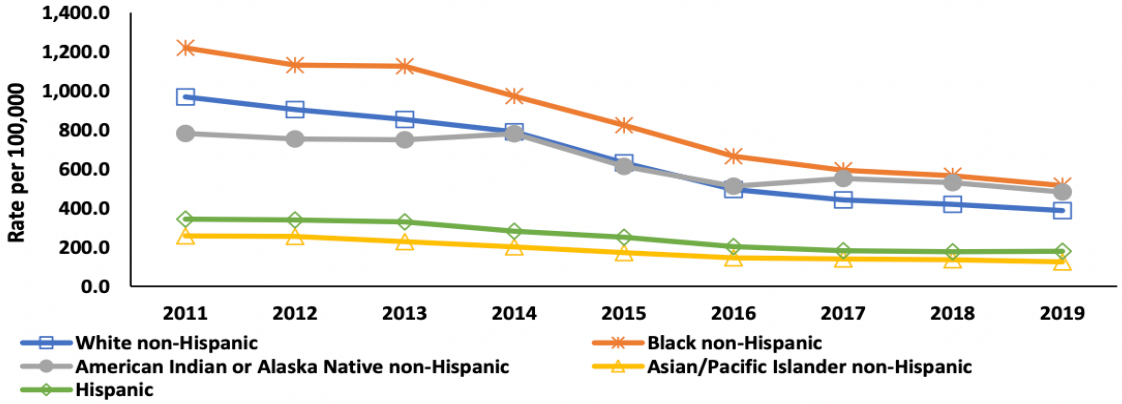
Mental and Behavioral Health

Graph 29 shows state-funded mental health clinic utilization by race and ethnicity between 2011-2019. [110] Usage of state funded mental health clinics was lower for Hispanic and Asian populations. Additionally, the Mental Health Association notes that nationwide youth of depression, particularly American Indian, multiracial, and Black youth were more likely, when they did access mental healthcare, to access non-specialty care in education settings. The data shows declines in utilization among all races and ethnicities over this timeframe, except for the increase in AIAN utilization which increased in 2016.

[109] Nevada Health Response. (2021). Coronavirus (COVID-19) in Nevada. Retrieved from https://nvhealthresponse.nv.gov

[110] Nevada Department of Health and Human Services. (2021). Nevada Behavioral Health EPI Profile. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/2020%20Epidemiologic%20Profile%20(Final).pdf page 21, Figure 18

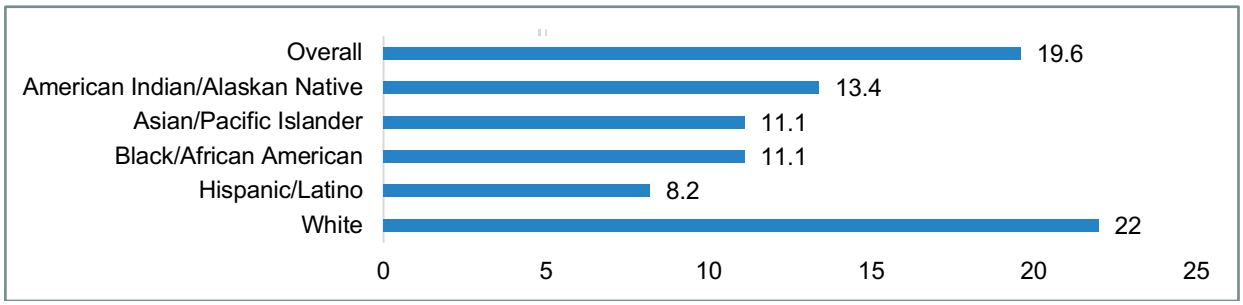
GRAPH 16. STATE-FUNDED MENTAL HEALTH CLINIC UTILIZATION* BY RACE/ETHNICITY CRUDE RATES, 2011-2019



Source: State Funded Mental Health: Avatar.
Race "Unknown" not included in analysis.
**A client is counted only once per year. Clients may be counted more than once across years.*

Looking at statewide suicide death rates through a race/ethnicity lens, the data shows that while the number of deaths per 100,000 people rates are highest for White individuals, American Indian/Alaskan Native rates are higher based on percentage of overall population versus percentage of suicide death rates, as are those for Black/African American and Asian/Pacific Islander populations. [111]

GRAPH 17. AGE-ADJUSTED DEATH RATE DUE TO SUICIDE BY RACE/ETHNICITY IN NEVADA



Indigenous People (American Indian/Alaskan Native)

Nevada's Indian Territory is home to the Great Basin Tribes: Washoe, Northern Paiute, Southern Paiute and Western Shoshone. In Nevada, there are 20 federally recognized tribes, comprised of 27 separate reservations, bands, colonies and community councils. Ninety-seven percent of Nevada's Tribal Nations are rural. The tribal land base in Nevada amounts to over 1.16 million acres. American Indians have dual citizenship; they hold US citizenship as well as Tribal citizenship. And, all American Indians residing in the state of Nevada, whether on or off the reservation, are citizens of the State of Nevada."[112]

[111] Nevada Tomorrow. Age-Adjusted Death Rate Due to Suicide. Retrieved from https://www.nevadatomorrow.org/?module=indicators&controller=index&action=view&comparisonId=&indicatorId=120&localeId=31&localeChartIdxs=1%7C2%7C3

[112] Nevada Indian Commission. (2019). Nevada's Great Basin Tribes. Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/80th2019/ExhibitDocument/OpenExhibitDocument?exhibitId=36430&fileDownloadName=Nevadas%20Great%20Basin%20Tribes_Nevada%20Indian%20Commission.pdf

As a general principle, an American Indian is a person who is a descendant of recognized native groups and an enrolled member of a federally recognized tribe or village. While there exists no universally accepted rule for establishing a person's identity as an American Indian, the criterion for tribal membership differs from one tribe to the next. As sovereign governments, each tribe determines its own eligibility and membership standards and criteria. To determine a particular tribe's membership eligibility, one must contact that tribe directly. For its own purposes, the Bureau of the Census counts anyone as an Indian who declares to be such. By recent counts, there are currently more than two million American Indians, including Native Alaskans and Native Hawaiians.

The physical locations of Indian reservations and colonies across Nevada are shown in Figure 12 below.[113]

FIGURE 12. MAP OF NEVADA INDIAN RESERVATIONS & COLONIES

[113] Indian Reservations & Colonies of Nevada. Retrieved from https://nevadaindianterritory.com/wp-content/uploads/2014/09/ITmap.jpg

On Nevada reservations, a larger portion of the American Indian/Alaskan Native (AIAN) population is under 18, when compared to the White population, at 32.3% of the AIAN and 21.2% of the White population[114]. The median age for an individual living on the reservation in Nevada is 32.3 compared to the average age of 40.4 statewide. The AIAN population of is expected to increase 2.5% between 2022 and 2032. Currently, there are 35,921 AIAN individuals living in the state of Nevada (Table 36 below). [115]

TABLE 36. POPULATION GROWTH RATES, NEVADA, 2022 TO 2032

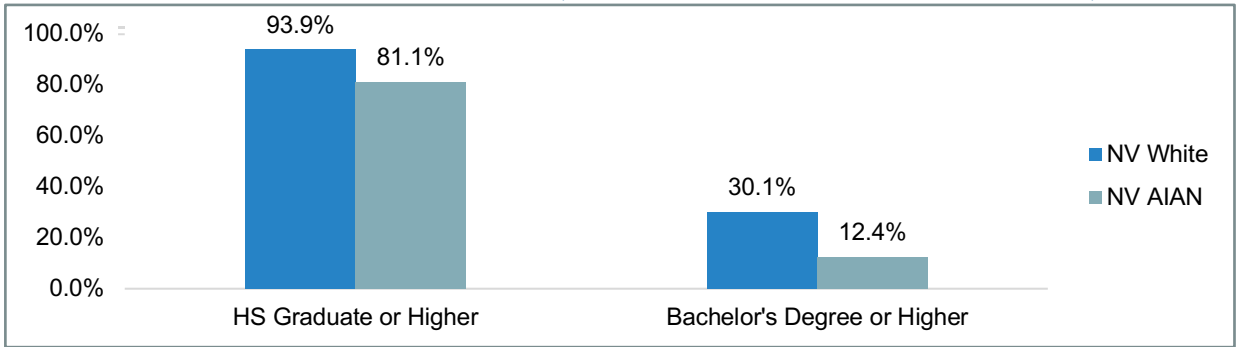
Race/Ethnicity	Population		Change 2022 to 2032 (%)
	2022	2032	
American Indian, Eskimo, Aleut Not of Hispanic Origin	35,921	36,819	+2.5%

Education

AI/AN students make up 1% of U.S. public school students. In 2007, the Education Committee of the National Caucus of Native American State Legislators (NCNASL) reported, "The state of education in our nation's K-12 schools for Native students is distressing," that Native American students performed two to three grade levels below their white peers in reading and math, and they were two times more likely to drop out of school than their white peers. [116]

As can be seen by data from the Nevada Department of Education, this disturbing trend has not changed since this study. The graduation rate for students who identify as AIAN decreased 5.4 percentage points from 2018 to 74.4% in 2019 and remaining the same for 2020 (Graph 27 Page 47).[117] Moreover, the AIAN student population has a lower educational attainment for high school at 81.1% compared to White population at 93.9%; and for Bachelor's Degree or Higher, at 30.1% compared to 12.4% (Graph 31).

GRAPH 18. EDUCATIONAL ATTAINMENT, NV WHITE COMPARED TO NV AIAN, 2020[118]



[114] National Congress of American Indians. Western Area Regional Profile: Arizona, Nevada, Utah. Retrieved from https://www.ncai.org/policy-research-center/research-data/prc-publications/Western_Area_Profile.pdf page 2

[115] Lawton, M. F. (2021). Nevada County Age, Sex, Race and Hispanic Origin Estimates and Projections from 2000 to 2040. Retrieved from https://tax.nv.gov/uploadedFiles/taxnvgov/Content/TaxLibrary/2021_ASRHO_Estimates_and_Projections.pdf

[116] National Caucus of Native American State Legislators. (2008). Striving to achieve: Helping Native American Students Succeed. Retrieved from https://www.ncsl.org/Portals/1/documents/statetribe/strivingtoachieve.pdf

[117] Nevada Department of Education. (2021) Nevada's 2021 Graduation Rate Remains Above 80 Percent Five Years in a Row. Retrieved from https://doe.nv.gov/News__Media/Press_Releases/2021/Nevada_s_2021_Graduation_Rate_Remains_Above_80_Percent_Five_Years_in_a_Row/

[118] 2020 ACS 5-Year Estimates

In addition, Native American students at four-year NSHE institutions had the lowest graduation rate of any other demographic in 2018 and 2019, at 25% and 22%, respectively.[119] The low graduation rates are compounded by other factors, such as higher-than-average poverty and unemployment rates across Native reservations.

Economic and Financial Stability

One major factor behind the high poverty rates and low wealth of American Indians is their low rate of employment. As shown in Table 31 above, the unemployment rate for this population in Nevada is higher than the national average, at 10.6% and 9.7%, respectively. In addition, the median income in the past 12 months (in 2020 inflation-adjusted dollars) for AIAN populations in Nevada was $44,985 compared to $45,877 all AIAN populations in the U.S.[120] These numbers are much lower than the median income for Nevada overall at $62,043 and the U.S. at $64,944 (see Table 13). The poverty rate for Nevada AIAN populations is 23.6% compared to AIAN populations in the U.S. at 24.1%.[121] The poverty rate of Nevada at 12.5% and the U.S. at 11.4%.

Health Care and Health Care Access

As reported previously:

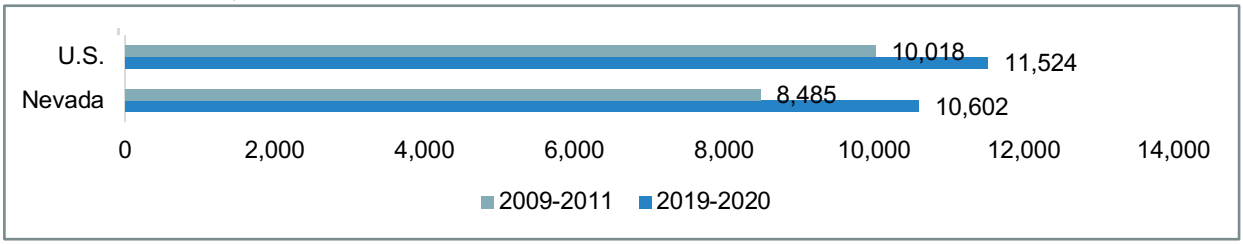
- The vaccination rate for COVID-19 was 0.6%, the lowest in the state (Table 35).
- The prevalence of stroke was higher among Black (4.2%) and American Indian/Alaskan Native populations (4.0%) than Asian/Pacific Islander populations (2.1%) (Graph 28).
- The prevalence of high cholesterol was higher among American Indian/Alaskan Native populations (36.3%), Asian/Pacific Islander populations (36.9%), and White populations (34.2%) than for Black populations (29.5%) (Graph 28).

In addition, American Indian and Tribal Members have shorter life expectancies when compared to other races and have much higher rates of suicide. The life expectancy rate for an American Indian is 5.5 years shorter than compared to all other U.S. races. This data includes higher death rates from chronic illness such as diabetes, cirrhosis, and suicide.[122] The suicide rate of an American Indian youth is 2.5 times the rate of the rest of the county and is the highest youth suicide rate when looking at all other races and ethnicities.[123]. These data demonstrate a critical need to invest in this at-risk population, and the need for targeted, culturally competent services that can support individuals and families to improve health and wellness outcomes.

Graph 32 below shows the annual rates of premature death for the AIAN population in Nevada and the U.S. during two time frames, 2009-2011 and 2019-2020, showing increases in both the Nevada totals as well as national totals during the 2019-2020 timeframe. [124]

[119] Nevada System of Higher Education. (2021). NSHE institutions graduation rate. Retrieved from https://ir.nevada.edu/dashboard.php?d=graduation_rates
[120] American Community Survey, 2020: ACS 5-Year Estimates, Table S1903.
[121] American Community Survey, 2020: ACS 5-Year Estimates, Table S1701.
[122] National Congress of American Indians. (2021-2022). Demographics. Retrieved from https://www.ncai.org/about-tribes/demographics
[123] Ibid
[124] America's Health Rankings. (2021). Annual report. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/YPLL/population/YPLL-AIAN/state/NV

GRAPH 19. PREMATURE DEATH - AMERICAN INDIAN/ ALASKAN NATIVE, NEVADA, UNITED STATES, 2009-2011 VS. 2019-2020



The top five causes of death in 2017 (latest data available) among American Indian populations differed slightly from that of the overall population, with diabetes mellitus ranked fourth highest, which did not fall into the top five among Nevada's population overall (Table 37). [125]

TABLE 37. TOP 5 CAUSES OF DEATH AMONG NATIVE AMERICAN POPULATIONS COMPARED TO TOTAL POPULATION, NEVADA, 2017

Rank	American Indian/Alaskan Native	Total Population
1	Diseases of the Heart	Diseases of the Heart
2	Malignant Neoplasms	Malignant Neoplasms
3	Accidents (unintentional injuries)	Chronic Lower Respiratory Diseases
4	Diabetes Mellitus	Accidents (unintentional injuries)
5	Chronic Lower Respiratory Diseases	Cerebrovascular diseases

Mental and Behavioral Health

The AIAN populations in Nevada continue to suffer from historical trauma, forced assimilation and a history of discrimination and lack of opportunity. Accordingly, 19% of AIAN adults nationally have experienced mental illness in the last year, according to the National Alliance on Mental Illness. They also note that suicide rates for AIAN youth are double the rate of White youth.[126] A number of factors make these challenges even more significant, including a historical mistrust of government resources, lack of insurance and geographic isolation. AIAN suicide rates are the highest in the nation.

Substance use disorders are also prevalent in AIAN populations, supported by data from the 2018 National Survey on Drug Use and Health (NSDUH) included below:[127]

- 10% of Native Americans have a substance use disorder.
- 4% of Native Americans have an illicit drug use disorder.
- 7.1% of Native Americans have an alcohol use disorder.
- Nearly 25% of Native Americans report binge drinking in the past month.
- Native Americans are more likely to report drug abuse in the past month (17.4%) or year (28.5%) than any other ethnic group.

[125] Centers for Disease Control and Prevention (CDC). (n.d.). Underlying cause of death, 1999-2020. Retrieved from http://wonder.cdc.gov/ucd-icd10.html
[126] National Alliance on Mental Illness (MAMI). (2022). Indigenous. Retrieved from https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Indigenous
[127] Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). 2018 NSDUH detailed tables. Retrieved from https://www.samhsa.gov/data/report/2018-nsduh-detailed-tables

Child Welfare Involved Children, Youth and Transition-Aged Youth (TAY)

Nevada's child protective/welfare system ostensibly functions as three regional services areas: the Rural Region operates as a state supervised and state Division of Child and Family Services (DCFS), a division within the Department of Health and Human Services, administered delivery system, and the Northern and Southern Regions operate as state supervised – county administered by the Washoe County Human Services Agency (WCHSA) and Clark County Department of Family Services (CCDFS) child welfare delivery systems.

Child Welfare includes direct child protective services, foster care, adoption and independent living services, foster care licensing in 15 rural Nevada counties, statewide oversight for child welfare (including the two urban county child welfare agencies), and oversight of the Interstate Compact for the Placement of Children. Community based child welfare agencies contracted by the counties provide a continuum of services. The foundation for case planning is the assessment and comprehensive case management services that support the child, the parents, and the caregivers. The continuum includes emergency shelter care, foster family care (including relative placements), group home care, therapeutic foster care, respite care, residential treatment care both in and out-of-state, and independent living services. Additional support services include in-home counseling (family preservation/intensive family services), early childhood services, and other outpatient services. These agencies are funded by DCFS to provide the continuum of care.

The first stage of the child protective services (CPS) process is intake. It is one of the most important decision-making points in the child protection system as is the point at which reports of suspected child abuse and neglect are received. Information gathered by caseworkers is used to make decisions regarding safety and the type of CPS response required. The first part of the CPS process is a referral from an outside source and the Child Welfare Agency's response. Referrals are dispositioned by Intake workers, and upon dispositioning, the referral becomes a report. Dispositions can be one of the following: (1) **Information Only,** where there is insufficient information about the family or maltreatment of the child, or there are no allegations of child abuse/neglect; (2) **Differential Response**, when a report is made and there are no allegations of maltreatment, and/or the allegations do not rise to the level of an investigation, but the family could benefit from community service; or (3) **Investigation** if the agency determines that the information constitutes an allegation according to policy; when the investigation is complete, and a determination of *Substantiated* or *Unsubstantiated* is made.

In SFY 2021, there were a total of 34,363 referrals received to CPS, an increase of 1.9% from 2020. Of the total, 53% were Information Only; 1% was Differential Response; and 46% were Investigation. Figure 13 shows CPS referrals received by disposition each year statewide, in Clark County, Washoe County and in the rural counties across the state.[128]

[128] Nevada Division of Child and Family Services. (2022). Data Book as of January 31, 2022. Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/Data/DCFS_Data_Book_ADA_for_January_2022.pdf.

FIGURE 13. CPS REFERRALS RECEIVED BY DISPOSITION BY YEAR

Statewide – Count of CPS Referrals Received by Disposition by Year

State Fiscal Year	Information Only	Differential Response	Investigation	Total
2018	21,443	992	15,515	37,950
2019	21,429	755	15,429	37,613
2020	18,866	549	14,278	33,693
2021	18,149	497	15,717	34,363
2022 YTD	12,741	275	9,143	22,159

Clark County - Count of CPS Referrals Received by Disposition by Year

State Fiscal Year	Information Only	Differential Response	Investigation	Total
2018	15,184	322	12,679	28,185
2019	15,416	136	12,648	28,200
2020	13,497	214	11,639	25,350
2021	11,813	292	13,067	25,172
2022 YTD	8,035	192	7,846	16,073

Washoe County - Count of CPS Reports by Disposition by Year

State Fiscal Year	Information Only	Differential Response	Investigation	Total
2018	3,456	210	1,955	5,621
2019	3,188	125	1,873	5,186
2020	2,768	159	1,769	4,696
2021	3,648	205	1,788	5,641
2022 YTD	2,990	83	922	3,995

Rural Region - Count of CPS Reports by Disposition by Year

State Fiscal Year	Information Only	Differential Response	Investigation	Total
2018	2,803	460	881	4,144
2019	2,825	494	908	4,227
2020	2,601	176*	870	3,647
2021	2,688	0*	862	3,550
2022 YTD	1,716	0*	375	2,091

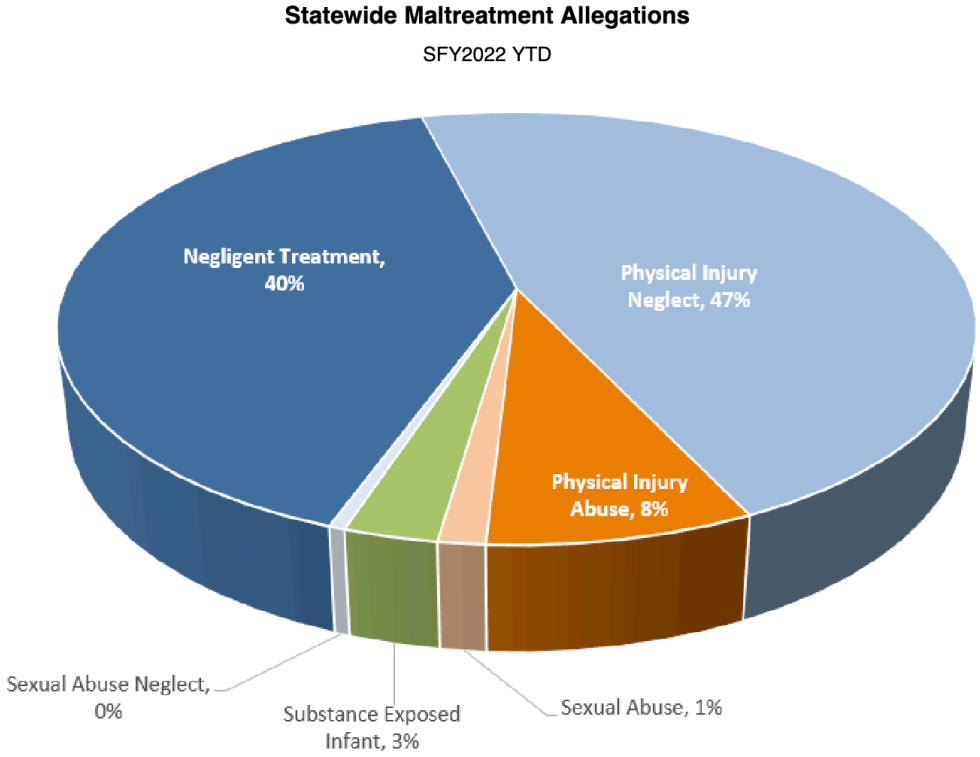
*Note: As of 1/1/2020 DCFS Rural Region no longer dispositions screened-in reports to Differential Response; therefore, counts in this category were lower in SFY2020 and down to zero in subsequent years.

The referral to CPS is the first step to ensure the safety and permanency of children who have been reported as being allegedly abused or neglected. The primary focus of CPS is to ensure that children are protected from harm or risk of harm and to make it safe for the child to live with the parent or caretaker. CPS agencies respond to reports of abuse or neglect of children under the age of 18. Abuse or neglect complaints are defined in statute and include mental injury, physical injury, sexual abuse and exploitation, negligent treatment or maltreatment, and excessive corporal punishment. CPS investigative workers assess the safety of children,

protective capacity of caregivers, and the family functioning, and they identify strengths and risks in the home.

In SFY2022, of the statewide maltreatment allegations reported, 47% were physical injury neglect; 40% were negligent treatment, 8% were physical injury abuse, 3% were substance exposed infants, 1% was sexual abuse (Figure 14). [129]

FIGURE 14. YTD STATEWIDE MALTREATMENT ALLEGATIONS SFY2020



Percent of maltreatment allegations are based on screened-in reports, regardless of finding. There have been no allegations of mental injury abuse or mental injury neglect during this fiscal year (SFY2022).

Source: UNITY database – CFS727 report

Education

Children and youth involved in the child welfare system face numerous barriers, including moving schools frequently, having learning and emotional challenges, and trauma that make learning harder. In Nevada, the graduation rate in 2019 for youth in the foster care system was 44.2% and 50% in 2020. This is far below the general student population graduate rates of 84.1% in 2019 and 82.6% in 2020.[130] Nationally, data shows that former foster youth graduate college at the rate of only 3%.[131]

[129] Nevada Division of Child and Family Services. (2022). Data Book as of January 31, 2022. Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/Data/DCFS_Data_Book_ADA_for_January_2022.pdf
[130] Nevada System of Higher Education (NSHE). (2021). NSHE Foster Youth Fee Waiver Program: A Status Report. Retrieved from https://nshe.nevada.edu/wp-content/uploads/Academic-Affairs/2021%20NSHE%20Foster%20Youth%20Fee%20Waiver%20Report%20-%20FINAL%20(Accessible).pdf
[131] National Foster Youth Institute. Higher Education for Foster Youth. Retrieved from https://nfyi.org/issues/higher-education/

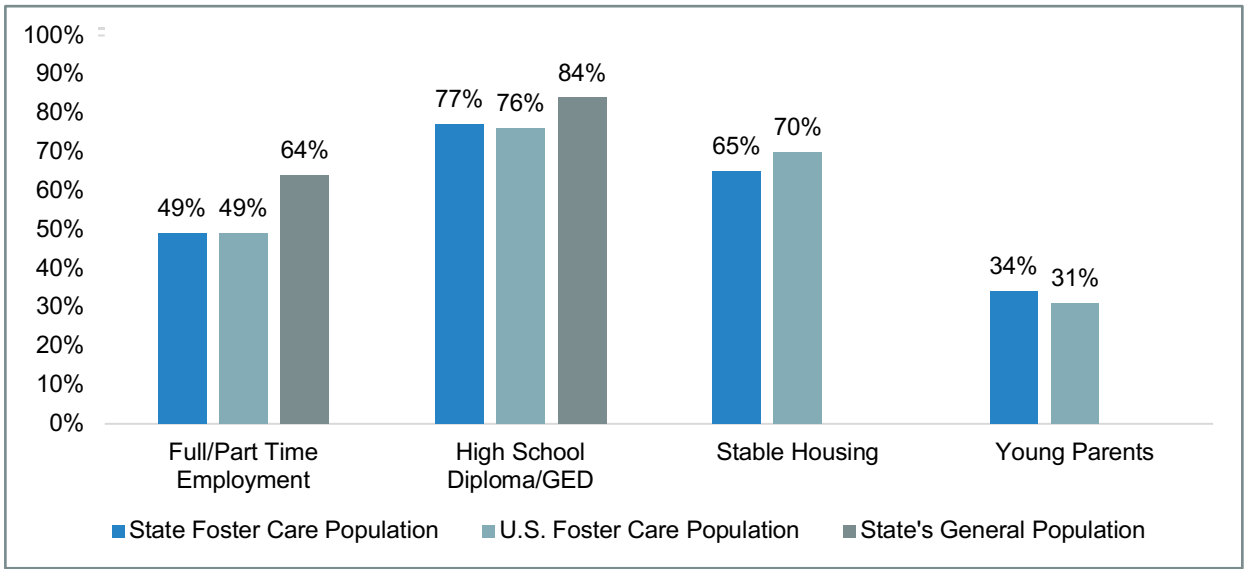
Economic and Financial Stability

According to the National Foster Youth Institute, nationally, outcomes for children and youth who leave foster care are poor for many transition age youth. Statistics that describe the challenges facing foster youth as they transition from care include:[132]

- An average of 1 out of every 4 youth in foster care will become homeless within 4 years of aging out of foster care
- Approximately 25% of former foster youth experience homelessness within 4 years of being emancipated from the foster care system.
- 550,000 youths experience homelessness

It is challenging to find current data for Nevada on outcomes of foster youth after they transition out of care. The Fostering Annie E. Casey Foundation 2018 Nevada Summary, while older, provides data on the outcomes of youth as seen in Graph 19.[133] As research shows, young adults who experience foster care have worse outcomes than their peers in the general population across of variety of spectrums, from education to housing to early parenthood.

Graph 20. Young Adult Outcomes by Age 21



Health Care and Health Care Access

According to the National Foster Youth Institute:[134]

- Approximately 33% of youth who have been emancipated from foster care have no health insurance.
- Roughly 50% of emancipated foster youth have chronic health conditions, including visual and auditory impairments, malnutrition, asthma, and dental decay.

[132] National Foster Youth Institute. Housing & Homelessness. Retrieved from https://nfyi.org/issues/homelessness/
[133] Annie E. Casey Foundation (AECF). (2018). 2018 Nevada profile: Transition Age Youth in Foster Care. Retrieved from https://assets.aecf.org/m/blogimg/nevada-fosteringyouthtransitions-2018.pdf
[134] National Foster Youth Institute. Health & Wellness. Retrieved from https://nfyi.org/issues/health/

Mental and Behavioral Health

Children and youth in foster care, and those who transition out of care, face mental and behavioral health challenges, due to adverse childhood experiences in childhood, resulting in their removal from their family. Data across the country demonstrate that:[135]

- Children in foster care and emancipated youth experience PTSD at a rate that is double that of war veterans.
- Foster Youth tend to experience higher rates of mental health issues, unemployment, homelessness, Post-Traumatic Stress Disorder (PTSD), and lower educational attainment.

Individuals Dealing with Mental Illness and Substance Use Disorders

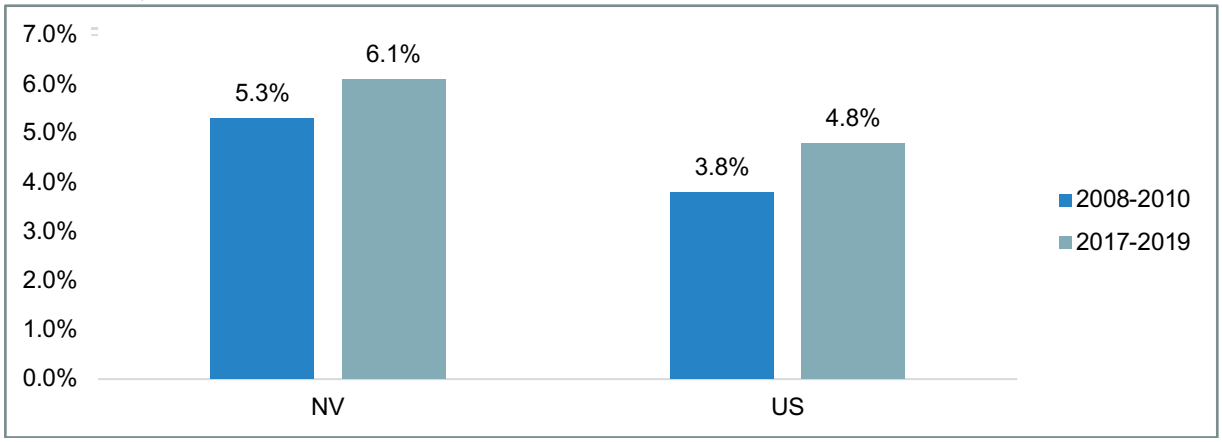
In the United States, 1 in 5 adults experienced mental illness in 2020, according to the National Alliance of Mental Illness (NAMI), and 5.6% of adults experiences serious mental illness (SMI). SMIs include: Major Depression, Schizophrenia, Bipolar Disorder, Obsessive Compulsive Disorder (OCD), Panic Disorder, Post Traumatic Stress Disorder (PTSD), and Borderline Personality Disorder. The annual prevalence of mental health illness and disorders by demographics in the U.S. is:[136]

- Non-Hispanic Asian: 13.9%
- Non-Hispanic white: 22.6%
- Non-Hispanic black or African-American: 17.3%
- Non-Hispanic American Indian/Alaskan Native: 18.7%
- Non-Hispanic mixed/multiracial: 35.8%
- Non-Hispanic Native Hawaiian or Other Pacific Islander: 16.6%
- Hispanic or Latino: 18.4%
- Lesbian, Gay or Bisexual: 47.4%

Lesbian, Gay, or Bisexual individuals experienced high rates of mental health illness at 47.4% of the population, followed by Non-Hispanic mixed/multiracial individuals at 35.8%. Graph 40 below shows the changes in the past year SMI among adults aged 18 or older in Nevada. The annual average percentage with SMI did not significantly change between 2008-2010 and 2017-2019. During 2017-2019, the annual average prevalence of past-year SMI in Nevada was 6.1%, compared the national average of 4.8%.[137]

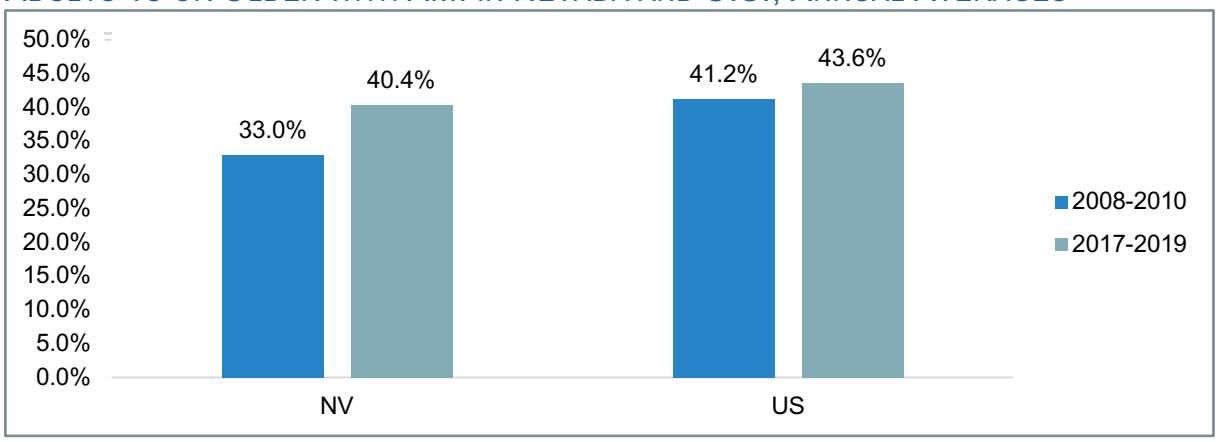
[135] National Foster Youth Institute. Health & Wellness. Retrieved from https://nfyi.org/issues/health/
[136] National Alliance on Mental Illness (NAMI). (2022). Mental Health by the Numbers. Retrieved from https://www.nami.org/mhstats
[137] Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). Behavioral health barometer. Retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt32845/Nevada-BH-Barometer_Volume6.pdf

Graph 21. Changes in the Past Year SMI among Adults 18 or Older in Nevada and U.S., Annual Averages



Graph 41 below shows the changes in the past year mental health service use among adults aged 18 or older with Any Mental Illness (AMI) in Nevada and the U.S. The annual average percentage with AMI who received mental health services did not significantly change between 2008-2010 and 2017-2019. During 2017-2019, the annual average prevalence of past-year mental health service among those with AMI in Nevada was 40.4%, compared the national average of 43.6%.[138]

Graph 22. Changes in the Past Year Mental Health Service Use among Adults 18 or Older with AMI in Nevada and U.S., Annual Averages



Suicide

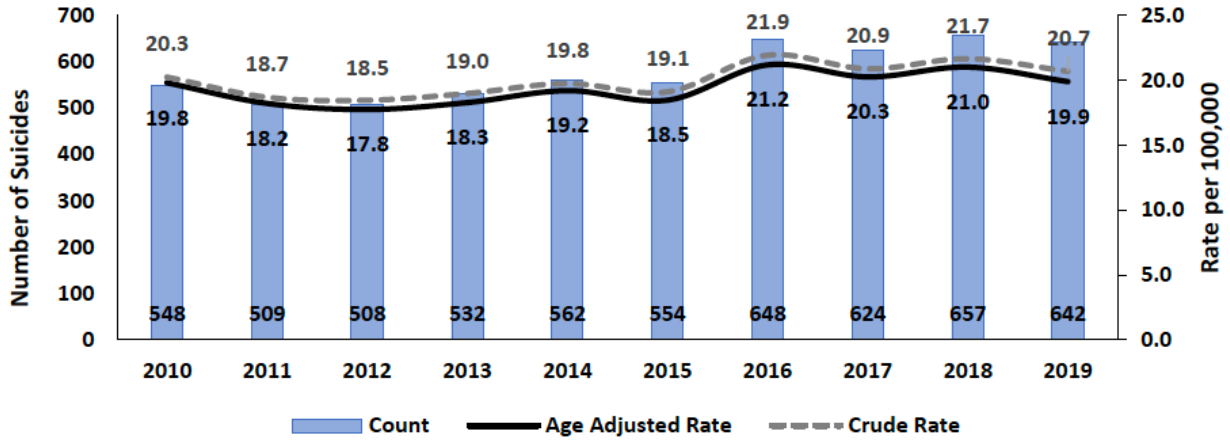
In 2019 the rate was 20.7 per 100,000 population, with rates being the highest among those in the 25-34 age group.[139] The most common cause of suicide is mental illness as risk factors for suicide include depression, bipolar disorder, and personality disorders. Graph 42 shows the suicide rate for Nevada residents from 2010-2019. [140]

[138] Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). Behavioral health barometer. Retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt32845/Nevada-BH-Barometer_Volume6.pdf

[139] Nevada Department of Health and Human Services. (2021). Nevada Behavioral Health EPI Profile. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/2020%20Epidemiologic%20Profile%20(Final).pdf pp. 24

[140] Ibid pp. 24

GRAPH 23. NUMBER OF SUICIDES AND RATES, NEVADA, 2010-2019



Source: Nevada Electronic Death Registry System.

During the 2020 fiscal year (July 1, 2019 -June 30, 2020), Nevada 211, the phone number that helps Nevadans connect with services they need, received 504 calls relating to suicide, which included referrals to suicide survivors support groups; prevention hotlines; in-person intervention; and mobile response teams.[141] The most common method for attempted suicide was substance or drugs (1,798 encounters in 2019) followed by cutting (296 encounters in 2019).

Populations with disproportionately high suicide rates include:[142]

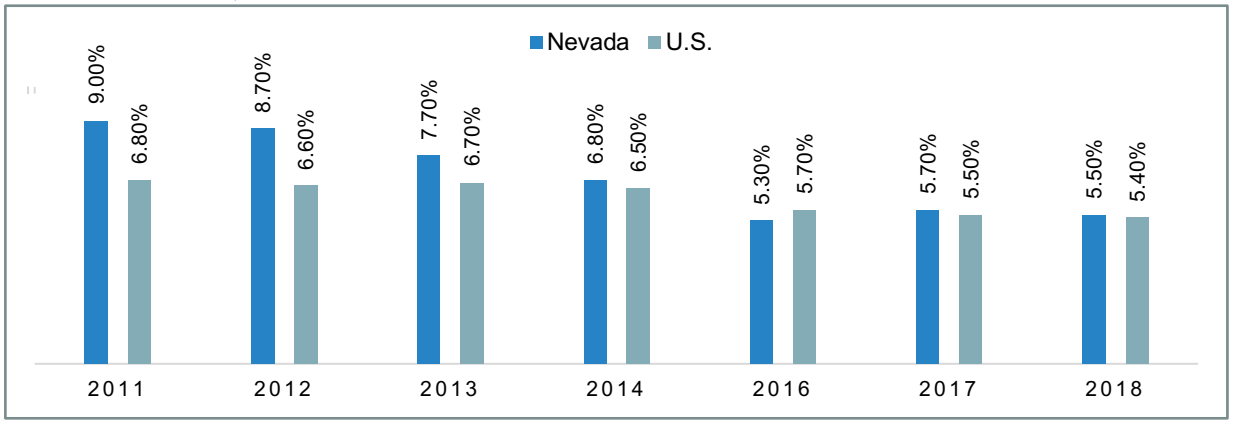
- Men have a suicide rate higher than women.
- American Indian/Alaskan Native population experiences the highest suicide in the nation, followed by the non-Hispanic white population.
- Veterans compared with non-veteran adults.
- Those living in rural areas compared with those living in urban areas.
- LGBTQ youth and adults compared with heterosexual adults and youth.

Substance Use Disorders

Graph 43 shows the rate of alcohol use disorder in the past year for Nevadans aged 12 and older compared to United States rates, where Nevada is seen as consistently higher between 2011 and 2013, then becoming closer to national rates by 2018. [143]

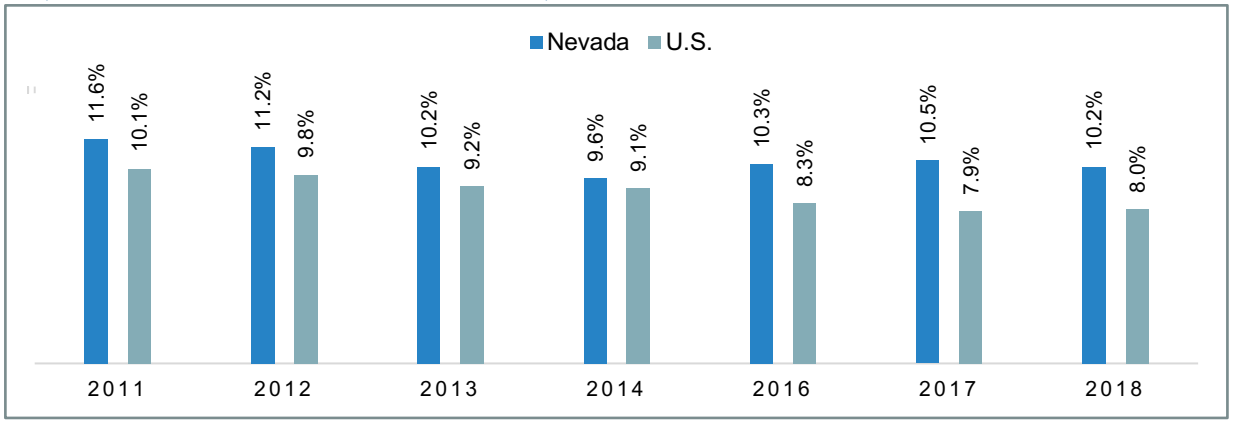
[141] Nevada Department of Health and Human Services. (2021). Nevada Behavioral Health EPI Profile. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/2020%20Epidemiologic%20Profile%20(Final).pdf pp. 24
[142] America's Health Rankings. (2021). Suicide in Nevada: 2021 annual report. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Suicide/state/NV
[143] Nevada Department of Health and Human Services. (2021). Nevada Behavioral Health EPI Profile. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/2020%20Epidemiologic%20Profile%20(Final).pdf pp 27

Graph 24. Alcohol Use Disorder in Past Year Aged 12 and Above, Nevada and United States, 2011-2018



Graph 44 shows rates of illicit drug use among adolescents, aged 12-17, in the past month in Nevada compared to the United States.[144] Nevada has consistently been higher since 2011, and in 2018 the Nevada rate was 10.2% versus 8.0% for the United States.

Graph 25. Illicit Drug Use Among Adolescents in the Past Month, Aged 12-17, Nevada and the United States, 2011-2018



The National Alliance on Mental Illness states as of February 2022, that 1 in 15 adults in the United States experience both a mental health illness and a substance use disorder and 1 in 6 youth experienced a major depressive episode and saw a 31% increase in mental health related emergency room visits in 2020.[145]

Nevada has a substantial shortage of mental health professionals and ranks 51st in the country overall for higher prevalence of mental illness and lower rates of access to care.[146] For prevalence of mental illness, Nevada ranks 45; for access to care, Nevada ranks 49; and for mental health workforce availability, Nevada ranks 33 with a ratio of 510:1.[147]

[144] Nevada Department of Health and Human Services. (2021). Nevada Behavioral Health EPI Profile. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/2020%20Epidemiologic%20Profile%20(Final).pdf pp 27
[145] National Alliance on Mental Illness (NAMI). (2022). Mental health by the Numbers. Retrieved from https://www.nami.org/mhstats
[146] Mental Health America (MHA). (2020). 2020 Ranking the States. Retrieved from https://www.mhanational.org/issues/2020/ranking-states
[147] Ibid

TABLE 38. ACCESS TO CARE DATA, NEVADA RANK AND % OF POPULATION, 2020

Health Indicators	Rank	% of Population
Adults with Any Mental Illness (AMI) who are uninsured	34	10.9%
Adults with AMI who did not receive treatment	47	63.9%
Adults with AMI reporting unmet need	49	28.6%
Youth with Major Depressive Episode (MDE) who did not receive mental health services	36	61.4%
Youth with severe MDE who received some consistent treatment	46	18.0%
Children with Private Insurance that Did Not Cover Mental or Emotional Problems	49	16%

As can be seen in Table 38:

- 10.9% of adults with mental illness remain uninsured.
- 63.9% of individuals experiencing mental illness are going untreated.
- More than quarter (28.6%) of all adults with a mental illness reported they were not able to receive the treatment needed.
- 61.4% of youth with major depression do not receive any mental health treatment.
- Only 18.0% of youth with severe depression received some consistent treatment (defined as 7-25+ visits in a year).
- Children lacking mental health coverage was 16%.

In addition, COVID-19 has had significant impacts on individuals with mental illness and substance abuse disorder, with increases seen over the pandemic in depression, suicide, anxiety, and substance use and mental health problems.[148] Emerging research on COVID-19 shows that the coronavirus pandemic has increased psychological distress both in the general population and among high-risk groups. Behaviors such as physical distancing, as well as their social and economic impacts, are worsening mental health consequences. Research on the psychological impact of mass trauma (e.g., natural disasters, flu outbreaks) suggests that the pandemic might particularly harm the mental health of marginalized populations who have less access to socioeconomic resources and supportive social networks.[149]

Education

- High school students with significant symptoms of depression are more than twice as likely to drop out compared to their peers
- Students aged 6-17 with mental, emotional or behavioral concerns are 3x more likely to repeat a grade.[150]

Economic and Financial Stability

- The rate of unemployment is higher among U.S. adults who have mental illness (6.4%) compared to those who do not (5.1%)

[148] Shim, R.S., and Starks, S.M. (2021). COVID-19, Structural Racism, and Mental Health Inequities: Policy Implications for an Emerging Syndemic. Retrieved from https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000725?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed

[149] American Psychological Association (APA). (2020). How COVID-19 impacts people with disabilities. Retrieved from https://www.apa.org/topics/covid-19/research-disabilities

[150] National Alliance on Mental Illness (NAMI). (2022). Mental health by the Numbers. Retrieved from https://www.nami.org/mhstats

Individuals Experiencing Homelessness

Housing affordability has been an increasing problem in Nevada, where pressures on housing, rental rates and affordable housing shortages are discussed. Nevada has the greatest shortage of affordable housing for Extremely Low Income (ELI) households in the nation.[151] Lack of affordable housing leads to increased risk of individuals and families becoming homeless.

Across Nevada, homelessness has been a consistent challenge, as it is across much of the country. As of January 2022, Nevada had an estimated 7,090 individuals experiencing homelessness across the state. Of the total number of individuals counted in the Point in Time Count, 159 were family households and 924 were Veterans. The Department of Housing and Urban Development's HUD 2021 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations shows the total individuals sheltered was 2,529 and individuals in transitional housing was 764. The breakdown by category is listed below in Table 39. [152] There were 570 unaccompanied young adults (aged 18-24). Additionally, the count of those experiencing chronic homelessness was 1,369 individuals.[153] HUD data below breaks out the homeless population in Nevada by race, with the White population making up the highest percentage by number.

TABLE 39. HUD 2021 CONTINUUM OF CARE HOMELESS ASSISTANCE PROGRAMS HOMELESS POPULATIONS AND SUBPOPULATIONS, NEVADA

Population	Sheltered	
	Emergency Shelter	Transitional Housing*
Household Type		
Households with Children	2,116	619
Households with at Least One Adult/One Child	127	44
Households with Only Children	3	6
Gender		
Female	843	126
Male	1,668	549
Transgender	14	3
Gender Non-Conforming	4	3
Ethnicity		
Hispanic/Latino	403	126
Non-Hispanic/Non-Latino	2,126	638
Race		
Black/African American	878	245
White	1,441	431
Asian	63	20
American Indian/Alaskan Native	45	22
Native Hawaiian/Other Pacific Islander	35	12
Multiple Races	67	34

[151] Nevada Homeless Alliance. Homelessness in Nevada. Retrieved from https://nevadahomelessalliance.org/wp-content/uploads/2019/08/HHH-Housing.pdf

[152] U.S. Department of Housing and Urban Development. (2021). HUD 2021 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations. Retrieved from https://files.hudexchange.info/reports/published/CoC_PopSub_State_NV_2021.pdf

[153] United States Interagency Council on Homelessness. Nevada homelessness statistics. Retrieved from https://www.usich.gov/homelessness-statistics/nv/

Education

Research shows that only 64% of homeless students graduate from high school, compared to 78% for low-income students and 84% for all students. If a student is homeless, they are 87% more likely to drop out of school than peers who are stably housed.[154] The number of homeless children/youth enrolled in public school in SY 2019-2020 was 18,231 (Graph 33).[155]

Graph 26. HUD 2021 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations, Nevada

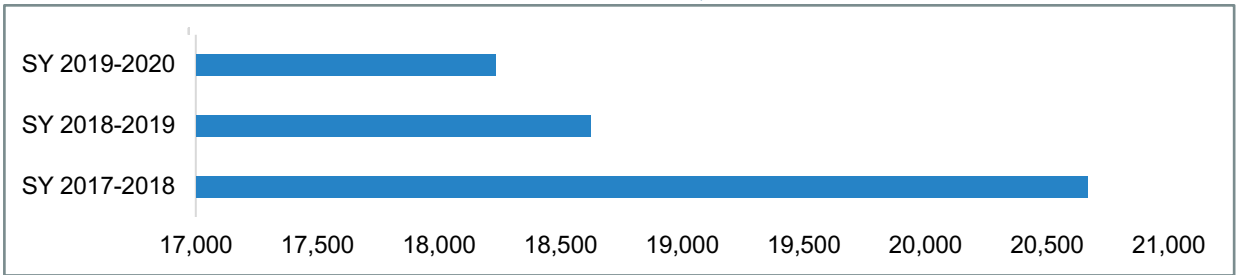


Table 40 below shows the number of homeless children/youth enrolled in Nevada public schools. Homeless students may be counted in more than one subgroup. [156]

Table 40. HUD 2021 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations, Nevada

Group Type	SY 2017 2018	SY 2018 2019	SY 2019 2020
Migratory Children/Youth	15	8	9
Unaccompanied Homeless Youth	1,316	1,050	874
Children with Disabilities (IDEA)	3,250	3,032	2,949
Limited English Proficient (LEP) Students	2,426	2,018	1,894

Economic and Financial Stability

Evidence shows that most people who experience homelessness did not become homeless because of a mental health or substance use disorder but because they could not afford housing.[157] Without stable housing, it is extremely difficult to achieve and maintain mental stability, sobriety, or employment and boost economic and financial stability for individuals. HUD[158], the Substance Abuse and Mental Health Administration (SAMHSA), [159] and the U.S. Interagency Council on Homelessness (USICH),[160] among others, endorse a housing-first approach to address homelessness among people with substance use and mental health needs.

[154] National School Boards Association. (2021). Homeless Students in Public Schools Across America: Down but Not Out. Retrieved from https://www.nsba.org/Perspectives/2021/homeless-students
[155] National Center for Homeless Education. Retrieved from https://profiles.nche.seiservices.com/StateProfile.aspx?StateID=39
[156] National Center for Homeless Education. Nevada. Retrieved from https://profiles.nche.seiservices.com/StateProfile.aspx?StateID=39
[157] Joint Center for Housing Studies of Harvard University. The State of the Nation's Housing 2020. Retrieved from https://www.jchs.harvard.edu/sites/default/files/reports/files/Harvard_JCHS_The_State_of_the_Nations_Housing_2020_Report_Revised_120720.pdf
[158] U.S. Department of Housing and Urban Development (HUD). (2007). The Applicability of Housing First Models to Homeless Persons with Serios Mental Illness. Retrieved from https://www.huduser.gov/portal/publications/hsgfirst.pdf
[159] Substance Abuse and Mental Health Administration (SAMHSA). Homelessness Programs and Resources. Retrieved from https://www.samhsa.gov/homelessness-programs-resources
[160] U.S. Interagency Council on Homelessness (USICH). (2018). Deploy Housing First Systemwide. Retrieved from https://www.usich.gov/solutions/housing/housing-first/

Healthcare Access/Health/Mental and Behavioral Health

Numerous health conditions among people who are homeless are frequently a complex mix of serious physical, mental health, substance use, and social problems. Poor health, high stress, unhealthy and dangerous environments, and an inability to control food intake often result in frequent visits to emergency rooms and hospitalizations. People who are homeless have higher rates of illness and die on average 12 years sooner than the general U.S. population. Simply being without a home is a dangerous health condition.

Living on the street or in crowded homeless shelters is extremely stressful and made worse by being exposed to communicable disease, such as tuberculosis, respiratory illnesses, flu, hepatitis; violence; malnutrition; and harmful weather exposure. Chronic health conditions such as high blood pressure, diabetes, and asthma become worse because there is no safe place to store medications properly. Maintaining a healthy diet is difficult in soup kitchens and shelters as the meals are usually high in salt, sugars, and starch (making for cheap, filling meals but lacking nutritional content). Behavioral health issues such as depression, alcoholism, or other substance use disorders can develop and/or are made worse in such difficult situations, especially if there is no solution in sight. Injuries that result from violence or accidents do not heal properly because bathing, keeping bandages clean, and getting proper rest and recuperation isn't possible on the street or in shelters. Minor issues such as cuts or common colds easily develop into larger problems such as infections or pneumonia.[161]

Contributors to adverse health outcomes among the individuals experiencing homeless nationally include: [162]

- Limited availability of affordable housing;
- Unsafe living conditions (exposure to violence and poor environmental conditions) prior to and during bouts of homelessness;
- Personal, provider, and systematic barriers to health care;
- Social isolation with limited to no social support and social inclusion in the community;
- Influence of social networks that engage in risky behaviors and a disconnect from positive home-based networks; and
- Increased likelihood of involvement with the justice system.

Individuals with Disabilities/A Disability

The American Disabilities Association (ADA) defines an individual with a disability as a person "who has a physical or mental impairment that substantially limits one or more major life activity. This includes people who have a record of such an impairment, even if they do not currently have a disability". The CDC identifies six disability types see in Figure 15.[163]

[161] National Health Care for the Homeless Council. (2019). Homelessness & Health: What's the connection. Retrieved from https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf

[162] National Health Care for the Homeless Council. (2016). Social Determinants of Health: Predictors of Health among People without Homes. Retrieved from http://councilbackup.flywheelsites.com/wp-content/uploads/2011/09/fact-sheet_2016_social-determinants-of-health1.pdf

[163] Centers for Disease Control. Disability Impacts Us All. Retrieved from https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html

FIGURE 15. DISABILITY TYPES

Mobility: Serious difficulty walking or climbing stairs.
Cognition: Serious difficulty concentrating, remembering, or making decisions.
Independent living: Serious difficulty doing errands alone, such as visiting a doctor's office.
Hearing: Deafness or serious difficulty hearing.
Vision: Blind or serious difficulty seeing, even when wearing glasses.
Self-care: Difficulty dressing or bathing.

A 2021 report from the Guinn Center stated that there are an estimated 374,515 individuals with disabilities in Nevada, 264,895 of whom are aged 0-64, and an estimated 189,546 individuals ages 18-64 with a disability.[164] About 74,151 have a cognitive or intellectual disability and 11% or 8,157 of those likely have a severe or profound disability.[165]

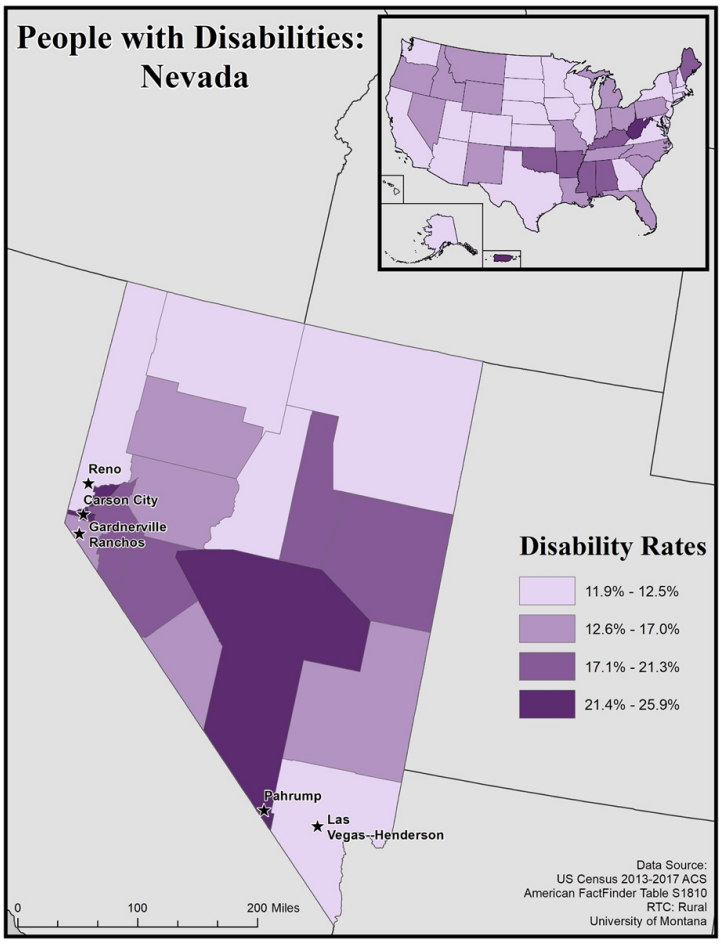
When looking at disability rates, it is important to note that rural areas across the country and the state have higher rates of individuals with disabilities that urban areas per capita. According to the CDC, when compared with adults living in large urban communities, adults living in rural or frontier counties were:

- 9% more likely to report having any disability;
- 24% more likely to report having three or more disabilities; and
- More likely to report specific disability types (ranging from 7% more likely to report a cognitive disability to 35% more likely to report a hearing disability).[166]

The CDC also states that individuals with disabilities may face a wide array of challenges due to their geographical location, including but not limited to, lower socioeconomic position, transportation problems, access to education and vocational rehabilitation services, access to health care and accessible communities.[167] This demonstrates the need to reach into, and tailor strategies to, rural communities and invest in service infrastructure that meets the needs of children and adults with disabilities in those communities, as well as their caregivers. Figure 16 shows the rates of disability across the counties in Nevada.[168]

[164] Guinn Center. (2021). Integrated employment opportunities for individuals with disabilities in Nevada: An assessment. Retrieved from https://guinncenter.org/wp-content/uploads/2022/01/Guinn-Center-Integrated-Employment-2021.pdf page 12
[165] Guinn Center. (2021). Nevada is failing people with disabilities who want to work. Retrieved from https://guinncenter.org/despite-an-emphasis-on-workforce-nevada-is-failing-people-with-disabilities-who-want-to-work/
[166] Centers for Disease Control. Prevalence of Disability & Disability Types. Retrieved from https://www.cdc.gov/ncbddd/disabilityandhealth/features/disability-prevalence-rural-urban.html
[167] Ibid
[168] RTC:Rural. Nevada State Profile. Retrieved from https://rtc.ruralinstitute.umt.edu/old-rtc-wp-site-27may2021/www/?page_id=7319

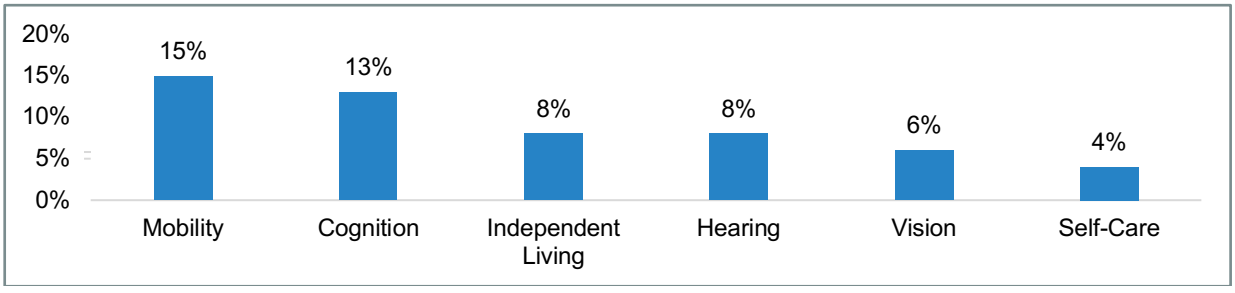
FIGURE 16. DISABILITY RATES ACROSS NEVADA COUNTIES



1

Graph 13 below shows the percentage of Nevada adults living with a functional disability type, with rates ranging from 15% mobility, 13% cognition, 8% independent living, 8% hearing, 6% vision and 4% self-care.

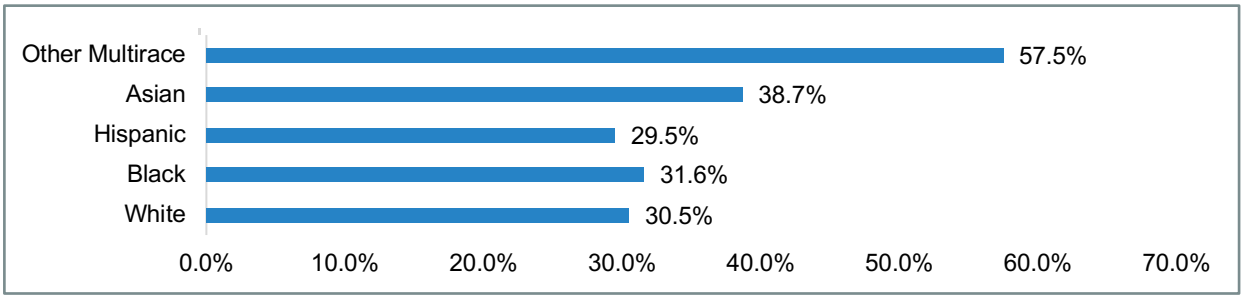
GRAPH 27. PERCENTAGE OF ADULTS IN NEVADA WITH SELECT FUNCTIONAL DISABILITY TYPES[169]



[169] Centers for Disease Control and Prevention (CDC). (2021). Disability & health U.S. state profile data for Nevada (adults 18+ years of age). Retrieved from https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/nevada.html

Graph 14 below shows the percentage of persons with disabilities across racial/ethnic backgrounds in Nevada.

GRAPH 28. PERCENTAGE OF PERSONS WITH ANY DISABILITY IN NEVADA BY RACE/ETHNICITY[170]

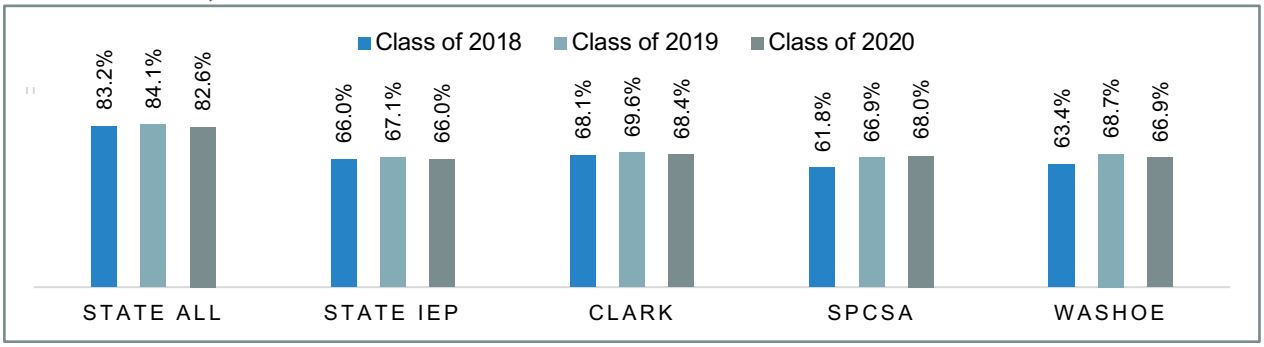


Education

Each public school child who receives special education and related services has an Individualized Education Program (IEP), which creates an opportunity for teachers, parents, school administrators, related services personnel, and students (when appropriate) to work together to improve educational results for children with disabilities. The IEP is the cornerstone of a quality education for each child with a disability and are mandated by federal Individuals with Disabilities Education Act (IDEA) law.

Individuals with disabilities graduate on time, with regular diplomas, at a much lower rate than their peers. The graduation rate for students with disabilities in Nevada in 2020 was 66.0% compared to 82.6% of the total population of students (see Graph 15). The graduation rate from 2020-2021 for students with disabilities decreased 1.51 percentage points to 64.53 percent, according to the Nevada Department of Education.[171]

GRAPH 29. STUDENTS WITH INDIVIDUALIZED EDUCATION PLANS (IEPS) GRADUATION RATE TRENDS, 2018-2020[172]



[170] Centers for Disease Control and Prevention (CDC). (2019). Disability and Health Data System (DHDS). Retrieved from https://dhds.cdc.gov/LP?CategoryId=DISEST&IndicatorId=RACEIND&ShowFootnotes=true&View=Map&yearId=YR4&stratCatId1=DISSTAT&stratId1=DISABL&stratCatId2=&stratId2=&responseId=RACE01&dataValueTypeId=AGEADJPREV&MapClassifierId=quantile&MapClassifierCount=5

[171] The graduation rate for students with disabilities decreased 1.51 percentage points to 64.53 percent.

[172] Nevada Department of Education. (2020). Nevada high school class of 2020: Four-year adjusted cohort graduation rates. Retrieved from https://doe.nv.gov/uploadedFiles/ndedoenvgov/content/Boards_Commissions_Councils/State_Board_of_Education/2020/December/ACGRGraduationRates.pdf page 34

Between the ages of 18-22, young adults with disabilities and their families exchange the security of the school environment for a complex system of adult service programs. Any student accessing special education services who has not earned a standard diploma may receive educational services until their 22nd birthday.

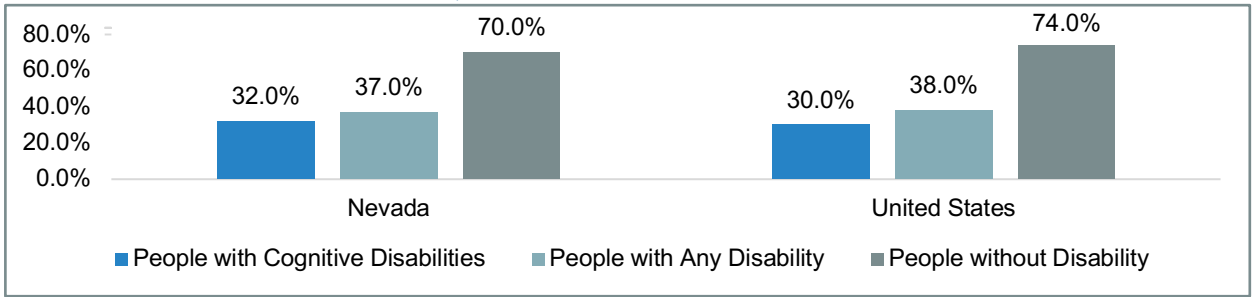
Economic Stability

Individuals with cognitive or intellectual disabilities, face a wide range of financial stability challenges that individuals without disabilities do not. For example, in Nevada, people with a disability are employed at much lower rates than those without a disability (32.0% vs. 70.0%), earn less than those without a disability ($31,800 vs. $63,500), and are twice as likely to live in poverty (23.1% vs. 10.4%). Additionally, while eligible for disability benefits, those benefits often are not enough for most individuals to live independently, or even to support the costs of living in a group home or assisted living facility. Individuals with intellectual disabilities are employed at even lower rates.

The Guinn Center recently published a report showing that Nevada spends less to support residents with Intellectual/Development Disabilities (I/DD), totaling $34.6 million in 2018. This is significantly lower when compared to similar states by population, such as Connecticut ($237.5 million), Kansas ($109 million), Nebraska ($104.6 million), New Mexico ($78.0 million), Mississippi (%60.2 million), Iowa ($58.2 million) and Utah (53.8 million).[173] This lack of spending impacts outcomes for persons with disabilities around employment, training, and supportive services.

Adding to these challenges is the fact that people with a disabilities have a co-occurring health impairment, mental health disorder or chronic illness, and the cost of therapy, physician and specialist visits, medication and hospital charges are often very expensive and not always covered by insurance or benefits.[174] These factors increase the likelihood of an individual experiencing poverty and the health impacts that are associated with poverty. Graph 16 shows the dramatic difference in employment rates for individuals without any disability in Nevada (70.0%) compared to the rate of individuals with cognitive disabilities (32.0%).[175] Nevada rate disparities closely mirror national rate disparities.

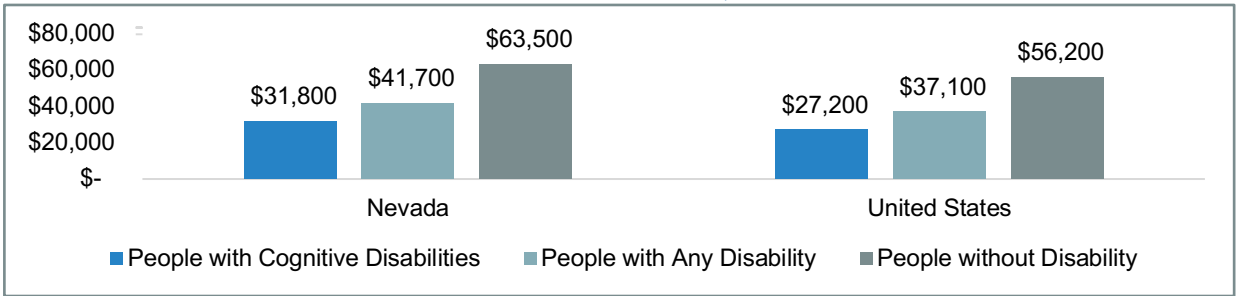
GRAPH 30. EMPLOYMENT RATE, 2020



[173] Guinn Center. (2021). Integrated employment opportunities for individuals with disabilities in Nevada: An assessment. Retrieved from https://guinncenter.org/wp-content/uploads/2022/01/Guinn-Center-Integrated-Employment-2021.pdf
[174] National Alliance on Mental Illness (NAMI). (2022). People with disabilities. Retrieved from https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/People-with-Disabilities
[175] University of Massachusetts. (2021). Build a Chart. Retrieved from https://www.statedata.info/data

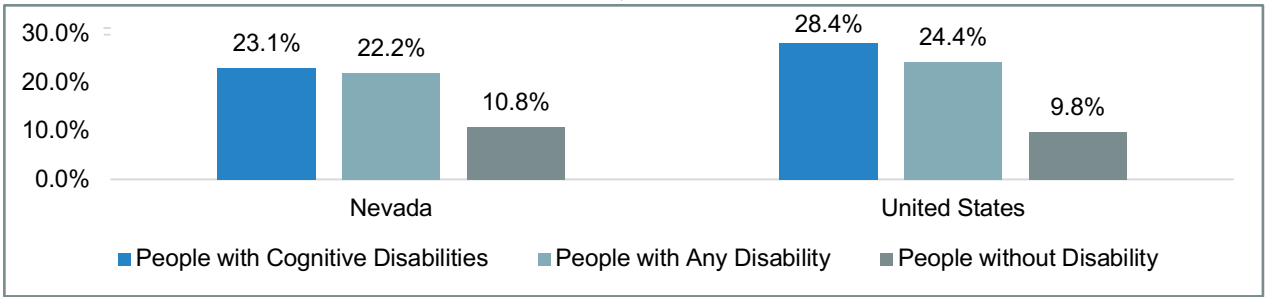
Graph 17 shows the annual mean earnings from work for individuals without a disability, with any disability, and for those with cognitive disabilities. [176] The data shows a decrease in earnings from $63,500 for someone without a disability to 41,700 for those with any disability, and a further decrease to $31,800 for an individual with a cognitive disability.

GRAPH 31. ANNUAL MEAN EARNINGS FROM WORK, 2020



Individuals in Nevada with cognitive disabilities make up the highest percentage living below poverty at 23.1% closely followed by individuals with any disability at 22.2%. Individuals in Nevada without a disability are shown at 10.8%, a large decrease when compared to both groups with disabilities. Nationally, similar trends are seen. Graph 18 shows the percentage below poverty for individuals without a disability, with any disability and for those with a cognitive disability. [177]

GRAPH 32. PERCENTAGE BELOW POVERTY, 2020



Health Care Access

People with disabilities face health inequities and many challenges to achieving optimal health and accessing quality health care. People with disability encounter a range of barriers when they attempt to access health care including: attitudinal barriers, physical barriers, communication barriers, and financial barriers. According to the National Council on Disabilities, the health care system in the United States is complex, highly fragmented, and sometimes overly restrictive in terms of program eligibility, leaving some people with disabilities with no health care coverage and others with cost-sharing obligations and limits on benefits that prevent them from obtaining health-preserving prescription medications, medical equipment, specialty care, dental and vision care, long-term care, and care coordination.[178]

[176] University of Massachusetts. (2021). Build a Chart. Retrieved from https://www.statedata.info/data
[177] Ibid
[178] National Council on Disability. The Current State of Health Care for People with Disabilities. Retrieved from https://www.ncd.gov/publications/2009/Sept302009#Health%20Coverage%20and%20Benefits

Health Outcomes

In Nevada, adults with disabilities experience a number of health disparities and are more likely to be obese, smoke, have diabetes and heart disease (Table 41). [179] Additionally, adults with a disability are more likely to have had depression (24.9%) compared to typical peers (11.7%). Disability healthcare costs in Nevada are about $6B per year ($14,225 per person with a disability), or up to 34% of the state's healthcare spending. [180]

TABLE 41. HEALTH DISPARITIES, AMONG ADULTS 18+ WITH AND WITHOUT A DISABILITY

Health Risks/Behaviors	Disability %	No Disability %
Binge Drinking in Past 30 Days	19.7%	17.8%
Obese	36.3%	27.8%
Smoke	27.6%	11.3%
Chronic Conditions	**Disability %**	**No Disability %**
Ever Had Arthritis	35.1%	13.6%
Currently Have Asthma	14.1%	7.7%
Ever Had Cancer	7.1%	4.6%
Ever Had COPD	14.6%	3.8%
Ever Had Diabetes	15.4%	7.0%
Ever Had a Stroke	5.4%	1.4%
General Health Conditions	**Disability %**	**No Disability %**
Fair or Poor Self-Rated Health	40.4%	10.6%
Ever Had Heart Disease	10.9%	4.1%
Ever Had High Blood Pressure	40.9%	26.1%
Ever Had High Cholesterol	37.0%	28.0%
Mental & Emotional Health	**Disability %**	**No Disability %**
Ever Had Depression	24.9%	11.7%
Mentally Unhealthy Days in Past 30 Days (1-13 days)	26.4%	23.7%
Barriers & Costs of Health Care	**Disability %**	**No Disability %**
Could Not See a Doctor Due to Cost in Past 12 Months	26.3%	12.4%
Have Health Care Coverage	82.3%	82.6%
Prevention & Screenings	**Disability %**	**No Disability %**
Visited a Dentist in the Past Year	52.4%	69.8%
Routine Check-up in Past Year	74.2%	70.6%

Caregiving and support of individuals with disabilities across the lifespan impacts the health and wellness of the individual with disabilities. A shortage of caregivers is expected to be an area of increasing shortage based on a Guinn Center report that stated that Nevada currently has an estimated 13,000 personal care aides who provide support for activities of daily living, such as cooking, dressing, grooming, bathing, transportation, and shopping. The report estimates that by 2026 Nevada will have to add an additional 5,300 caregivers to the state's exiting workforce to be able to keep up with growing demand, and by 2040, 10,000 additional caregivers will be needed, and demand is expected to outstrip capacity.[181]

[179] Centers for Disease Control and Prevention (CDC). (2021). Disability & Health U.S. State Profile Data for Nevada (Adults 18+ Years of Age). Retrieved from https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/nevada.html

[180] Ibid

[181] Guinn Center. (2020). Helping hands: An assessment of the personal care aide workforce in Nevada. Retrieved from https://guinncenter.org/wp-content/uploads/2020/09/Guinn-Center-Helping-Hands-PCAs-Nevada.pdf

Mental and Behavioral Health

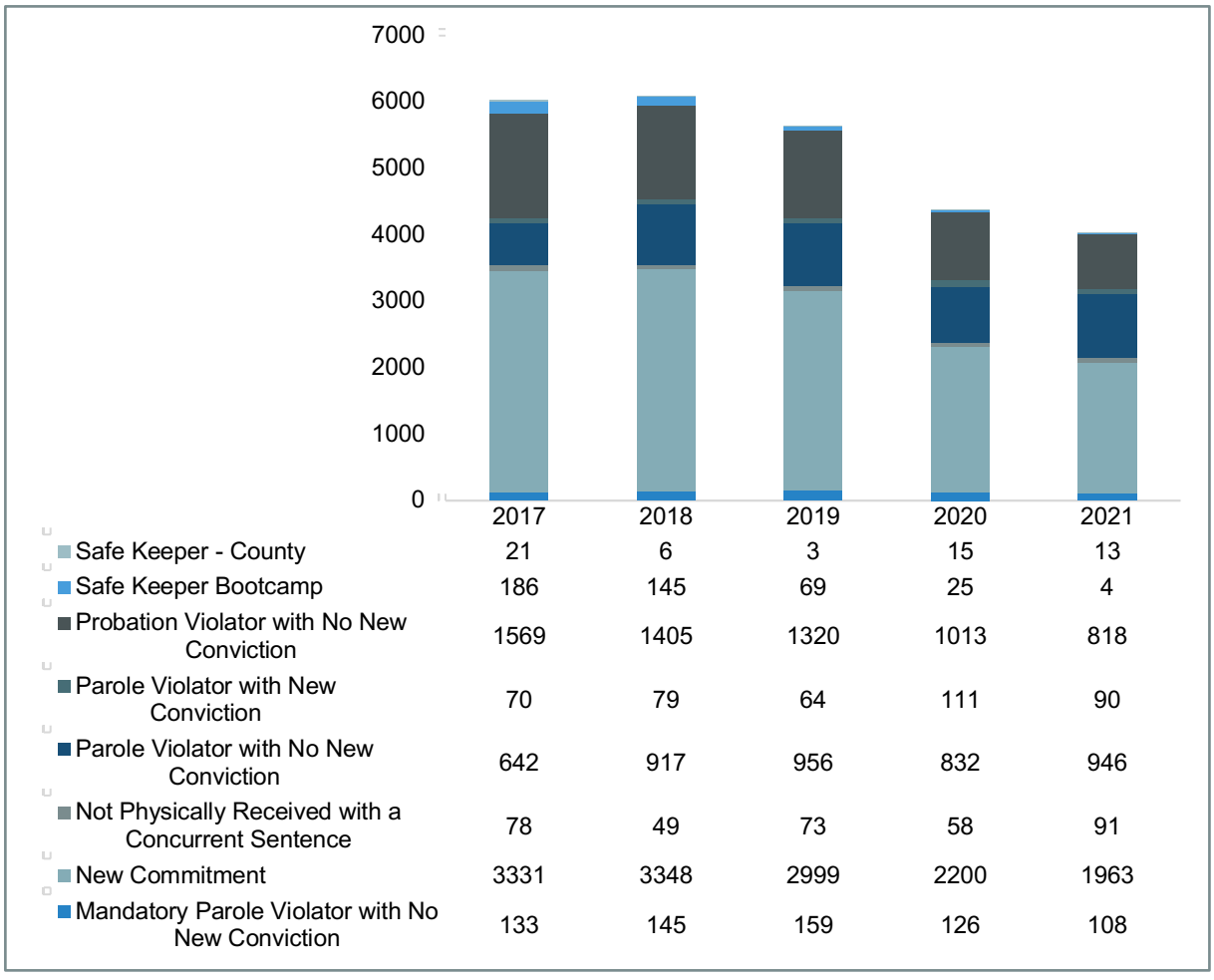
Adults with disabilities report experiencing frequent mental distress at almost 5 times the rate of those without disabilities.[182] An estimated 17.4 million (32.9%) adults with disabilities experienced frequent mental distress in 2018, defined as 14 or more reported mentally unhealthy days in the past 30 days. As can be seen in Table 41 above, approximately 1 in 4 individuals with disabilities in Nevada ever had depression and had 1-13 mentally unhealthy days in the past 30 days. Furthermore, The COVID-19 pandemic exacerbated these challenges, as many individuals with disabilities suffered worsened mental health from increased isolation, disruption of services, routines and social engagements, and greater challenges accessing healthcare and services.

[182] Centers for Disease Control and Prevention (CDC). (2020). The Mental Health of People with Disabilities. Retrieved from https://www.cdc.gov/ncbddd/disabilityandhealth/features/mental-health-for-all.html

Justice System Involved Adults

National Institute of Corrections (NIC) data highlights that the prisoner incarceration rate in Nevada (413 per 100,000 residents) was approximately 13.1% higher than the national average (359 per 100,000 residents).[183,184] Since 2009, Nevada's prison population has grown by seven percent, and the state's female prison population has grown at four times the pace of the overall prison population.[185] The Nevada prison population is projected to grow by 8.6% by 2028. [186] The notable increase in prison population has left Nevada's prisons overcrowded. Growing prison costs have burdened taxpayers while gaps remain in treatment and interventions that reduce recidivism, increase public safety, and address critical behavioral health challenges.[187]

GRAPH 33. NUMBER OF NDOC ADMISSIONS PER YEAR [188]



	2017	2018	2019	2020	2021
Safe Keeper - County	21	6	3	15	13
Safe Keeper Bootcamp	186	145	69	25	4
Probation Violator with No New Conviction	1569	1405	1320	1013	818
Parole Violator with New Conviction	70	79	64	111	90
Parole Violator with No New Conviction	642	917	956	832	946
Not Physically Received with a Concurrent Sentence	78	49	73	58	91
New Commitment	3331	3348	2999	2200	1963
Mandatory Parole Violator with No New Conviction	133	145	159	126	108

[183] National Institute of Corrections. Nevada 2019. Retrieved from https://nicic.gov/state-statistics/2019/nevada-2019
[184] National Institute of Corrections. 2019 National Averages. Retrieved from https://nicic.gov/state-statistics/2019
[185] Nevada Advisory Commission on the Administration of Justice – Justice Reinvestment Initiative. (2019). Final Report. Retrieved from https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/13671
[186] Ibid
[187] Ibid
[188] Sentencing Policy. State of Nevada. Retrieved from https://app.powerbigov.us/view?r=eyJrIjoiMmRkMmNiOTEtNDBlNy00ZjIwLTk3OTQtYzQ5YTA0YzcxZGZmIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

As shown in Table 42 below, 92.05% of the justice involved adult population is male; 50.58% are White; and 31.62% are Black/African American. [189]

TABLE 42. JUSTICE INVOLVED ADULTS, NEVADA

Justice Involved Adults Population	#	%
Gender		
Male	9,567	92.05%
Female	826	7.95%
Total	10,393	100.00%
Ethnicity		
American Indian/Alaskan Native	890	8.58%
Asian	224	2.16%
Black/African American	3,282	31.62%
Pacific Islander/Native Hawaiian	133	1.28%
White	5,250	50.58%
Other/Unknown	614	5.92%

Former inmates face substantial challenges when returning to the community after a period of incarceration. High recidivism and re-offense rates are due to many factors including lacking education, having little or no prior work history, lacking in vocational skills, having a history of substance abuse, having the stigma of being an "ex-con" creating barriers to employment and securing housing, and being more likely to be a person of color who will experience increased barriers and be more likely to suffer from mental illness. [190]

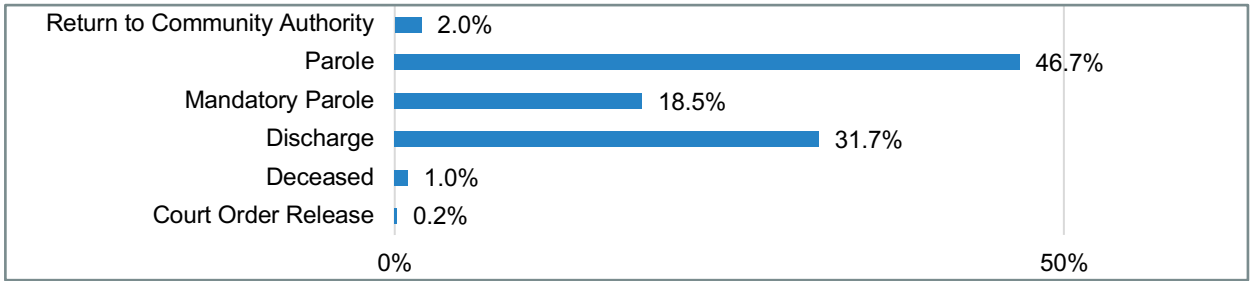
The Nevada Department of Corrections defines recidivism as "the proportion of offenders who return at least once to a correctional facility within NDOC within 36 months of parole or discharge."[191] The latest data released shows that Nevada has a 28% recidivism rate. While this is lower than the national rate of 52%, this data does not take into consideration that many are re-arrested in other jurisdictions (i.e. California and Arizona). However, Nevada as with the nation, does not have one standardized definition of recidivism and that different justice systems within the state define and measure recidivism rates differently.

Recidivism rates are measured when an individual, within 3 years of initial arrest/citation, adjudication, commitment, or placement into an out of home facility, placement under probation or parole supervision or when convicted as an adult is re-arrested, re-adjudicated, re-committed, in violation of supervision, or convicted by an adult court.[192]

[189] Nevada Department of Corrections. StatFacts Monthly. As of December 31, 2021. Retrieved from https://doc.nv.gov/uploadedFiles/docnvgov/content/About/Statistics/Monthly_Reports_by_Year/StatFacts_12302021.pdf
[190] UNLV Center for Crime and Justice Policy. Retrieved from https://www.jrsa.org/pubs/sac-digest/vol-24/nv-PrisonerReentry.pdf
[191] Nevada Department of Corrections. General Questions. What does recidivism mean? Retrieved from https://doc.nv.gov/Programs/FAQ/FAQ/
[192] Nevada Division of Child & Family Services. Juvenile Justice Data and Performance Measurement Committee. Retrieved from https://dcfs.nv.gov/Programs/JJ_OC/Juvenile_Justice_Data_and_Performance_Measure_Committee/

Graph 21 shows the releases by status with the majority being released to parole (46.7%) or discharged (31.7%).[193]

GRAPH 34. NDOC RELEASES BY STATUS



Education

According to the Nevada Department of Corrections, an estimated 58% of inmates in the correctional system have completed high school, compared to the state graduation rate of 81.3% in 2021.[194] Additionally, 78% at a minimum enter correctional facilities with minimal job training.[195] These statistics demonstrate the need for early intervention for youth struggling in school, as well as the need for vocational programs that serve those with limited education as well as other socioeconomic, mental and behavioral health barriers, and substance abuse barriers. Educational and vocational training programs are provided in Nevada's correctional facilities to support successful reentry into communities.

Economic and Financial Stability

People with justice involvement often face many barriers to employment. Those who do gain employment often find it life-changing, and employment often helps to reduce their risk of returning, along with reestablishing social relationships, providing child support, finding stable housing, and accessing other programs (e.g., educational programming, substance abuse, counseling, etc.).

National outcomes for individuals who were formerly incarcerated include the following Prison Policy Initiative statistics:[196]

- Unemployment rate: 27%
- Percent of individuals without a high school diploma, GED, or college degree: 25%
- Rate of homelessness or housing insecurity: 5,700 per 100,000

[193] Sentencing Policy. State of Nevada. Retrieved from https://app.powerbigov.us/view?r=eyJrIjoiMmRkMmNiOTEtNDBlNy00ZjIwLTk3OTQtYzQ5YTA0YzcxZGZmIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

[194] Nevada Department of Education. (2021) Nevada's 2021 Graduation Rate Remains Above 80 Percent Five Years in a Row. Retrieved from https://doe.nv.gov/News__Media/Press_Releases/2021/Nevada_s_2021_Graduation_Rate_Remains_Above_80_Percent_Five_Years_in_a_Row/

[195] The State of Nevada Department of Corrections (DOC). (2021). Education Services. Retrieved from https://doc.nv.gov/Inmates/Education_Services/Home/

[196] Couloute, L. (2018). Nowhere to go: Homelessness among formerly incarcerated people. Retrieved from https://www.prisonpolicy.org/reports/housing.html

Healthcare and Mental and Behavioral Health

For the many inmates who reenter communities after being incarcerated, access to health care and addressing existing health issues is critical. HIV infection rates are high within incarcerated populations nationally, with an estimated 1.3% of inmates having an infection. Substance abuse issues compound existing health issues, and unaddressed mental and behavioral health disorders create additional barriers to successful reentry and employment.[197] When transitioning out of incarceration, barriers to health care include lack of access to insurance, and lack of access to providers who take Medicaid can compound health issues and leave conditions unmet.[198] Statistics that highlight these needs from the federal Office of Minority Health include:[199]

- Approximately half of individuals in prison or jail report having had a chronic condition and almost 20 percent report having had an infectious disease.
- More than half of individuals in prison or jail report having a mental health condition, and about half (53 percent of all state prisoners and 45 percent of all federal prisoners) meet the American Psychiatric Association's Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) criteria for drug dependence. These rates are significantly higher than the general population.
- After release, there is often even less care in the community. Yet the research is clear: continuity of care is essential if we want to see health and safety benefits.
- Whether it be for substance use disorders, mental illness, infectious or chronic conditions, continuity of care must be a priority, particularly in the first days and weeks after release when the risk of relapse, reoffending, and even death, is most acute. Overdose from opioids, for example, was the leading cause of death for former prisoners, with highest risk present in the first week of release.

According to the Prison Policy Initiative, the following statistics describe the prevalence of illness in U.S. state and federal prisons: [200]

- 37% of people in state and federal prisons have been diagnosed with a mental illness.
- 44% are in locally-run jails.
- 1 in 4 experience "serious psychological distress" in jail.
- 66% of people in federal persons reported not receiving any mental health care while incarcerated.
- 27% of police shootings in 2015 involved a mental health crisis.
- 27% of people jailed 3 or more times within a year report having a moderate or serious mental illness.
- Post-traumatic stress, anxiety, impaired decision-making and more are lasting effects of incarceration.

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[197] Pulitzer, Z., Box, M., Hansen, L. *et al.* Patient, medical and legal perspectives on reentry: the need for a low-barrier, collaborative, patient-centered approach. *Health Justice* **9,** 37 (2021). Retrieved from https://doi.org/10.1186/s40352-021-00161-7

[198] U.S. Department of Health and Human Services. Office of Minority Health. Reentry Resources. Retrieved from https://www.minorityhealth.hhs.gov/omh/content.aspx?ID=10326

[199] Ibid

[200] Prison Policy Initiative. Mental health. Retrieved from https://www.prisonpolicy.org/research/mental_health/

In Nevada, the number of people admitted to prison with an identified mental health need has increased 35% over the last decade and the number of women entering prison with a mental health need has grown by 47%. [201] Women in Nevada's prisons are much more likely to suffer from mental illness than men who are incarcerated. Over half of the women who entered prison in 2017 had a mental health issue compared to 25 percent of male admissions. Nevada has only one NDOC prison that houses women, the Florence McClure Women's Correctional Center, which is currently operating well beyond the capacity it was built to house, and most significantly, the facility does not have a mental health unit on-site. [202]

Justice System Involved Children, Youth and Transition-Aged Youth (TAY)

Youth become involved with the juvenile justice system because they are accused of committing a delinquent or criminal act, or for status offenses, such as truancy, underage drinking, or running away from home. A very large number of youth with emotional, behavioral, mental health and/or substance abuse issues become involved in the juvenile justice system. Nevada's formal juvenile justice system is established for the most part by Chapter 62 of the Nevada Revised Statutes (N.R.S.). Section 62A.030 of the N.R.S defines a youth as "a person who is less than 18 years of age, a person who is less than 21 years of age and subject to the jurisdiction of the juvenile court for an unlawful act that was committed before the person reached 18 years of age, and a person who is otherwise subject to the jurisdiction of the juvenile court as a juvenile sex offender".[203]

Nevada's Juvenile Justice System is bifurcated. Counties are responsible for the courts, juvenile probation, and juvenile detention services, while the State is responsible for youth parole and youth correctional facilities. Counties operate independently from one another and from the State.[204] Table 43 below shows decreased numbers of referrals from 2019 (18,609 to 9,755), as well as decreased numbers of arrests (8,314 to 4,320) and also decreased juveniles in secure county detention from 4,340 to 2,534 over the same period. [205]

TABLE 43. STATEWIDE JUVENILE JUSTICE DATA – FFY 2019, 2020, 2021

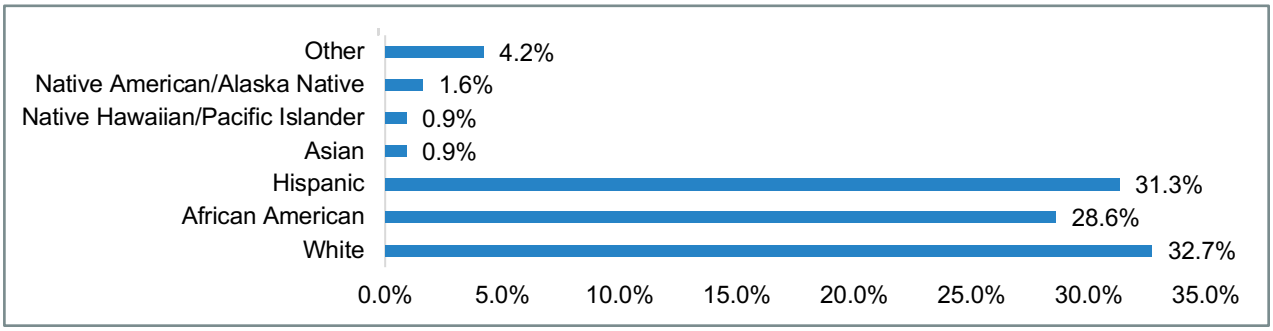
Item	2019	2020	2021
Youth Population (ages 0-17)	688,997	701,884	697,580
Juvenile Services Referrals	18,609	13,514	9,755
Juvenile Diversions	10,177	10,491	2,848
Juvenile Arrests	8,314	6,189	4,320

[201] Nevada Advisory Commission on the Administration of Justice – Justice Reinvestment Initiative. (2019). Final Report. Retrieved from https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/13671
[202] Nevada Advisory Commission on the Administration of Justice – Justice Reinvestment Initiative. (2019). Final Report. Retrieved from https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/13671
[203] Nevada Department of Health and Human Services Division of Child and Family Services. (2021). Overview of Nevada's Juvenile Justice System. Retrieved from https://dcfs.nv.gov/Programs/JJS/Overview/
[204] Nevada Division of Child and Family Services. (2020). Nevada Juvenile Justice and Delinquency Prevention Plan. Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/JJS/ThreeYearPlanEffective2021through2023.pdf
[205] Nevada Division of Child and Family Services. (2022). Data Book as of January 31, 2022. Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/Data/DCFS_Data_Book_ADA_for_January_2022.pdf pp.39

Juveniles in Secure Detention (County)	4,340	3,497	2,534
Juveniles Certified as Adults	65	38	61
Juveniles in Secure Correctional Care	245	233	174

In 2020, of the 13,514 juvenile services referrals in Nevada shown in Table 43 above, 32.7% were White, 28.6% were African American, 31.3% were Hispanic, 0.9% were Asian; 0.9% were Native Hawaiian/Pacific Islander; 1.6% were Native American/Alaskan Native; and 4.2% were Other (Graph 22).[206]

GRAPH 35. JUVENILE JUSTICE REFERRALS POINTS IN TIME BREAKDOWN BY RACE/ETHNICITY FOR FFY2020



Nationally, data shows that youth of color are not only over represented in the juvenile justice system but that these youth are also treated differently by the system than White youth, with higher rates of detention and commitment.[207]

In Nevada, secure detention occurs towards the beginning of system involvement for youth who are not diverted from the system. DCFS monitors seven juvenile detention centers statewide, which are county operated. Youth ages 12-20 who have been committed to DCFS by the juvenile court and placed within one of three youth correctional facilities or in some cases, mental health services/program placement while being supervised by the Nevada Youth Parole Bureau. The three correctional facilities include: Caliente Youth Center, Nevada Youth Training Center and Summit View Youth Center.[208] Table 44 shows the count of individuals at these facilities as of April 13 and 20, 2022. [209] Youth typically stay an average of six to nine months.

TABLE 44. JUVENILE JUSTICE FACILITY POPULATION POINT IN TIME COUNTS

JJ Facility	Count as of 4/20/22	Count as of 4/13/22
Caliente Youth Center – Females	20	18
Caliente Youth Center – Males	19	19
Nevada Youth Training Center – Males	37	36
Summit View Youth Center – Males	36	40
Total JJ Facility Population	**112**	**112**

[206] Nevada Division of Child and Family Services. (2020). State of Nevada: Juvenile Justice Data Page. Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/JJS/2020_Juvenile_Justice_Data_Page.pdf
[207] Youth.gov. (2018). Youth Involved with the Juvenile Justice System. Retrieved from https://youth.gov/youth-topics/juvenile-justice/youth-involved-juvenile-justice-system#_ftn
[208] Nevada Division of Child and Family Services. (2022). Data Book as of January 31, 2022. Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/Data/DCFS_Data_Book_ADA_for_January_2022.pdf
[209] Nevada Division of Child and Family Services. DCFS Data. Retrieved from https://dcfs.nv.gov/layouts/Page_Style_1.aspx?id=252955

All youth released from a juvenile correctional facility are placed on parole with the Nevada Youth Parole Bureau (NYPB). The NYPB provides community-based supervision and case management services for youth 12 to 20 years of age, including providing supports in the areas of education, independent living skills, employment, counseling, and substance use treatment. While the primary focus of the juvenile justice system is on adolescents, a significant number fall into the 16-25-year-old developmental period known as Transitional Aged Youth (TAY). The majority of youth in the juvenile justice system are also involved with the child welfare system as a result of family discord and disruption. In addition to child welfare, these TAY may interact with special education services, mental health services, vocational rehabilitation, and housing authority just to name a few.

Recidivism

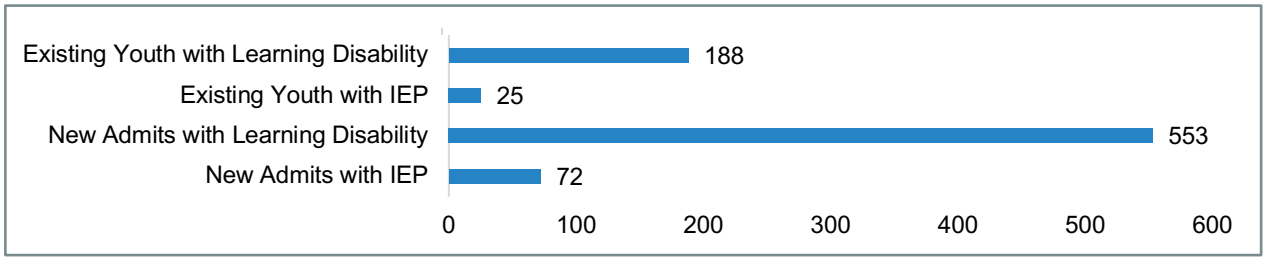
Recidivism is relatively high for youth under age 21. The factors that contribute to rearrest include the presence of substance use disorder and quality of services and positive experiences in institutions. Academic measures while incarcerated are predictive of chances of recidivism. In Nevada, recidivism rates for FFY2020 include:[210]

- Juvenile re-arrest (12-month lookback): 11.39%
- Juvenile re-adjudication (12-month lookback): 6.29%
- State Facility Revocation: 26.32%

Education

Ending the school to prison pipeline is critical, and keeping children in school, intervening early, and supporting youth is essential, especially for those struggling academically or socially. Nationally, at least one in three youth incarcerated have a documented disability.[211] Youth with an Individualized Education Plan (IEP) or 504 Plan are entitled to services through age 21. In 2020, across state facilities, there were 553 youth incarcerated who had an IEP and 188 had a learning disability. Addressing and intervening early in the K-12 system is necessary to stop youth who are struggling with behavioral, leaning and intellectual disabilities from becoming involved in the criminal justice system. Graph 23 shows the number of youth in Nevada correctional facilities who had an IEP in place or a documented learning disability.

GRAPH 36. IEP AND LEARNING DISABILITIES FOR STATE FACILITIES 2020[212]



[210] Nevada Division of Child and Family Services. (2020). State of Nevada: Juvenile Justice Data Page. Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/JJS/2020_Juvenile_Justice_Data_Page.pdf
[211] Children's Defense Fund. (2021). The State of America's Children 2020 - Youth Justice. Retrieved from https://www.childrensdefense.org/policy/resources/soac-2020-youth-justice/
[212] Nevada Division of Child and Family Services. (2020). State of Nevada: Juvenile Justice Data Page. Retrieved from https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/JJS/2020_Juvenile_Justice_Data_Page.pdf

According to national data accessed from Youth.Gov, the following educational outcomes are found for youth involved in the juvenile justice system:[213]

- Nearly half of all students who enter residential juvenile justice facilities have an academic achievement level that is below the grade equivalent for their age. [17]
- Youth in the juvenile justice system are identified as eligible for special education services at three to seven times the rate of youth outside the system. [18]
- Many incarcerated youth are marginally literate or illiterate and have already experienced school failure. [19]

Many youth who are incarcerated have a history of truancy and grade retention (repeating a grade due to failing the previous year). A study of more than 400 incarcerated ninth-graders found that, in the year prior to incarceration, these students had attended school barely half the time and were failing most of their courses. [20]Youth with high truancy who later get funneled into the juvenile justice system are also more likely to have received special education services than their peers who had strong school attendance. [21]

Exclusionary discipline practices such as expulsion or suspension significantly increase a student's likelihood of becoming involved in the juvenile justice system rather than mitigating delinquent behaviors. Alternative disciplinary measures that do not remove at-risk students from the school setting prove more beneficial for youth. [22]

Economic and Financial Stability

Youth who have been incarcerated face a number of barriers to economic stability after re-entering society, including the following effects of their adjudication:[214]

- Low levels of education or substandard education
- Limited vocational skills or training
- Difficulty finding housing
- Potentially disqualification for public housing support
- Difficulty getting a license for certain professions
- Potential Ineligibility to enlist in the military
- A driver's license that has been suspended for certain crimes

Healthcare

The Lancet, a medical journal, states in a recent article, "growing evidence suggests that adolescents who have been in detention die at a rate that is five to 41 times higher than that of their age-matched and sex-matched peers, most often from drug overdose, suicide, injury, or violence".[215] This data describes the poor outcomes for many youth involved in the justice

[213] Youth.gov. (2018). Youth Involved with the Juvenile Justice System. Retrieved from https://youth.gov/youth-topics/juvenile-justice/youth-involved-juvenile-justice-system#_ftn

[214] Juvenile Justice Information Exchange. (2022). Key Issues: Re-entry. Retrieved from https://jjie.org/hub/reentry/key-issues/

[215] Borschmann, R., Janca, E., Carter, A., Willoughby, et al. (2020). The health of adolescents in detention: A global scoping review. The Lancet Public Health, 5(2). doi:10.1016/s2468-2667(19)30217-8. Retrieved from https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(19)30217-8/fulltext

system. Health conditions that many justice involved youth are diagnosed with include mental health disorders, substance use disorders, neurodevelopmental disabilities, self-harm, cognitive dysfunction, infectious disease, and non-communicable diseases like asthma, sexually transmitted diseases.[216] [217]

Mental and Behavioral Health

The National Council of State Legislatures report, Mental Health Needs of Juvenile Offenders, states that between 65-70% of the population of youth in the juvenile justice system nationally has a diagnosable mental health disorder. According to their analysis, one in four of these youth have a mental illness that is severe enough to impair their day-to-day functioning and create barriers to becoming and independent and successful adult.[218] Additionally, it is estimated that 80% of youth involved in the juvenile justice system have a substance use disorder.[219] Additionally, many justice system involved youth have a history of trauma and the mental, behavioral and emotional consequences of that trauma.[220]

Rates of mental and behavioral health disorders for youth involved in the justice system are much higher than the rates of these disorders for their peers, including the following prevalence rates found in justice involved youth nationally:[221]

- Substance use disorder (76%)
- High anxiety (33%)
- Attention Deficit Hyperactivity Disorder (14%)
- Depression (12%)
- Posttraumatic stress disorder (12%)
- Mania (7%)

It should also be noted that the majority of youth in the data described above were diagnosed with one or more co-occurring disorders.

[216] Borschmann, R., Janca, E., Carter, A., Willoughby, et al. (2020). The health of adolescents in detention: A global scoping review. The Lancet Public Health, 5(2). doi:10.1016/s2468-2667(19)30217-8. Retrieved from https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(19)30217-8/fulltext

[217] Boch, S., Sezgin, E., Ruch, D. *et al.* Unjust: the health records of youth with personal/family justice involvement in a large pediatric health system. *Health Justice* **9,** 20 (2021). Retrieved from https://doi.org/10.1186/s40352-021-00147-5

[218] National Conference of State Legislatures. (n.d.). Mental Health Needs of Juvenile Offenders. Retrieved from https://www.ncsl.org/documents/cj/jjguidebook-mental.pdf page 2

[219] Kraut, M. E. (2020). Juvenile Crime and Substance Abuse. Retrieved from https://childsafety.losangelescriminallawyer.pro/juvenile-crime-and-substance-abuse.html

[220] Youth.gov. (2018). Youth Involved with the Juvenile Justice System. Retrieved from https://youth.gov/youth-topics/juvenile-justice/youth-involved-juvenile-justice-system#_ftn

[221] Ibid

Maternal Child Health

Maternal and child health refer to the health of women during pregnancy, childbirth and postpartum. Improving the well-being of mothers, infants, and children is an important public health goal that determines the health of the next generation.

Table 45 lists the indicators for maternal and child health from the 2019 Nevada State Health Needs Assessment. [222]

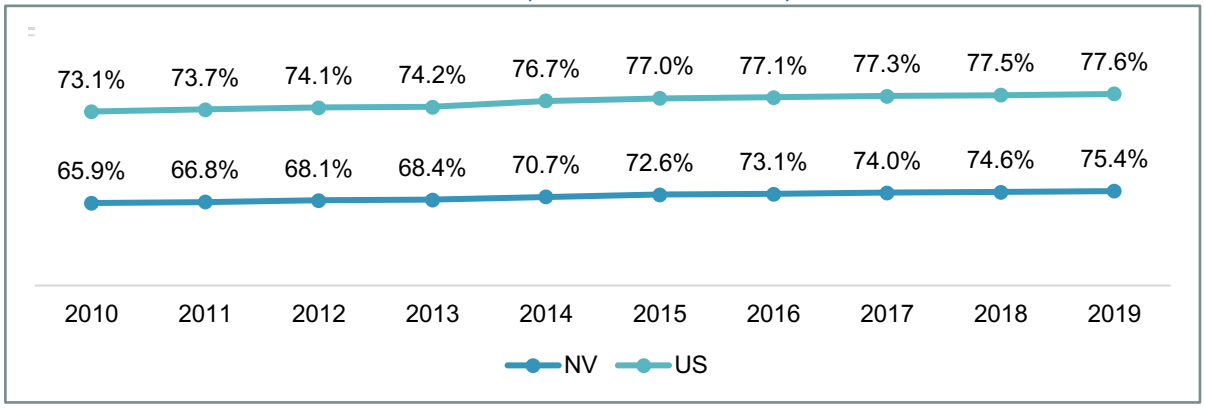
TABLE 45. INDICATORS FOR MATERNAL AND CHILD HEALTH, NEVADA

Indicator	2017	2018
Abortion Among Women 15-44 Years – Rate per 1,000	11.3	11.9
Percent of Women who Received Prenatal Care in First Trimester	68.7%	71.6%
Live Births Among Teens 15-17 – Rate per 1,000	8.2	7.6
Live Births Among Teens 15-19 – Rate per 1,000	19.4	18.0
Live Births Among Teens 20-44 – Rate per 1,000	65.8	64.8
Percent of Infants Born Pre-term*	10.6%	10.0%
Percent of Infants Born Low Birth Weight	9.1%	8.6%
Percent of Infants 0-2 Years Enrolled in Women Infants Children (WIC) Programming Ever Breastfed	54.3%	60.6%
Infant Mortality Rate per 1,000 Live Births Among Infants <1 Year	5.5	5.4
Rate of Death (per 100,000) Among Children 1-18 Years	21.1	20.1

*Less than 37 completed weeks of gestation

The percentage of women who receive prenatal care in the beginning in the first trimester are shown in Graph 46. The percentage of Nevada women who receive prenatal care is consistently less than the national percentage. Furthermore, 76.8% of women who participate in the WIC program did not receive prenatal care in the beginning in the first trimester. [223]

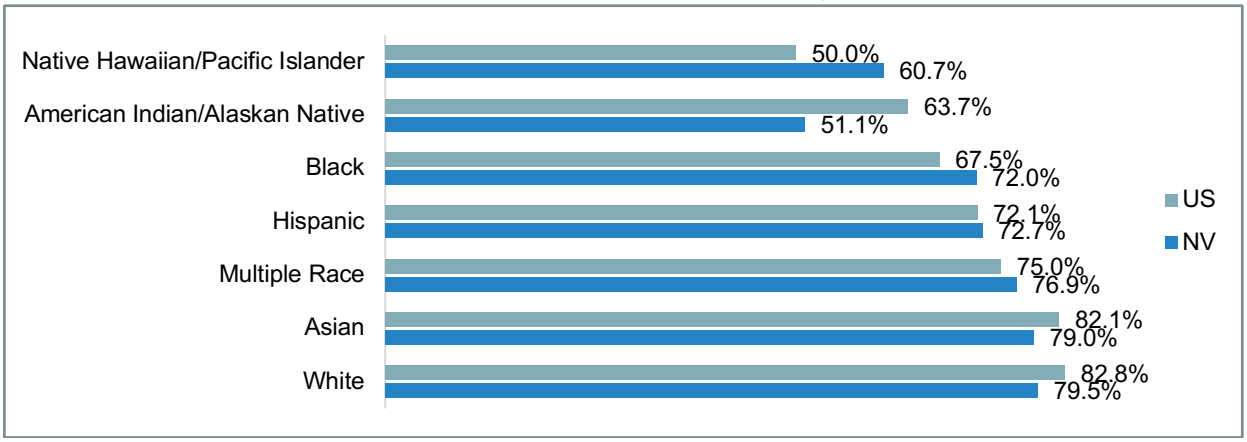
GRAPH 37. PERCENT OF PREGNANT WOMEN WHO RECEIVE PRENATAL CARE BEGINNING IN THE FIRST TRIMESTER, NEVADA AND US, 2019[224]



The data below shows the disparities among race/ethnicity for Nevada women who receive prenatal care (Graph 47).

[222] 2019 Nevada State Health Needs Assessment
[223] Title V MCH Data Dashboard. Retrieved from https://dpbh.nv.gov/Programs/TitleV/MCAH-Data-and-Publications/
[224] Ibid

Graph 38. Percent of Pregnant Women Who Receive Prenatal Care Beginning in the First Trimester by Race/Ethnicity, 2019[225]



The number of Supplemental Nutrition Assistance Program (SNAP) caseloads for children and pregnant women in Nevada are shown in Table 46. Of the total SNAP cases, 77.2% are children 0-18 and 1.3% are pregnant women. For dual SNAP/Medicaid enrollment, 67.2% are children 0-18 and 1.2% are pregnant women.

Table 46. SNAP Caseloads of Children and Children/Pregnant Women

Count of Active SNAP Cases	Count of Children 0 18 SNAP	Count of Children 0 18 SNAP/Medicaid	Pregnant Women Active SNAP Cases	Pregnant Women SNAP, Receiving Medicaid
218,265	168,612	146,774	2,858	2,721

Healthcare Access

According to the PRAMS (Pregnancy Risk Assessment Monitoring System), a joint research project between the Nevada Division of Public and Behavioral Health and the Centers for Disease Control and Prevention (CDC), during the month before a woman got pregnant, 41.8% had health insurance from their job/husband or partner's job; 6.2% had private health insurance from parents; 6.9% had private health insurance from the Nevada Health Insurance Marketplace or HealthCare.gov; 32.6% were on Medicaid; 11.0% had Nevada Check Up; 3.7% had TRICARE or other military health care; 0.8% had Indian Health Service (IHS) or tribal coverage; 5.1% had other health insurance; and 16.8% did not have any health insurance; 11.6% did not go for prenatal care. [226]

In 2019, Nevada ranked 45th in the nation for percentage of children without health insurance at 8%, as an estimated 58,000 Nevada children lacked health coverage in 2019. This estimate increased 16% from 50,000 in 2016. Nevada ranks 51st in the percentage of children with a medical home and 48th in patient provider ratios at 65 per 100,000. [227]

[225] Title V MCH Data Dashboard. Retrieved from https://dpbh.nv.gov/Programs/TitleV/MCAH-Data-and-Publications/
[226] University of Nevada, Reno. School of Community Health Sciences. Nevada Pregnancy Risk Assessment Monitoring System (PRAMS): Birth Year 2017-2019. Retrieved from https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/TitleV/Nevada%20PRAMS%20Report%20Birth%20Year%202017-2019(2).pdf
[227] Children's Advocacy Alliance Nevada (CAANV). (2020). 2020 Nevada Children's Report Card. Retrieved from https://www.caanv.org/wp-content/uploads/2020/11/CAA-070-2020-Childrens-Report-Card-Single-Pages-v3.pdf

Health Outcomes

In Nevada, there are hundreds of babies born with serious health problems each year. The purpose of the PRAMS is to find out why some babies are born healthy and others are not. Data from the PRAMS: Birth Year 2017-2019 are listed below in Table 47.

TABLE 47. PRAMS DATA

Question	No %	Yes %
3 months before you got pregnant with your new baby:		
Did you have diabetes	97.8%	2.2%
Did you have high blood pressure/hypertension	97.0%	3.0%
Did you have depression	87.8%	12.2%
Did you have asthma	90.9%	9.1%
Did you have heart problems	97.2%	2.8%
Did you have health care visits	44.9%	55.1%
Health care visit – regular checkup at family doctor's office	51.7%	48.3%
Health care visit – regular checkup at OB/GYN's office	39.4%	60.6%
Health care visit – visit for depression/anxiety	88.8%	11.2%
Health care visit – teeth cleaned by dentist/dental hygienist	41.3%	58.7%
During health care visits in last 12 months, did health care worker		
Tell you to take vitamin with folic acid	76.1%	23.9%
Talk about maintaining a healthy weight	66.5%	33.5%
Talk about maintaining any medical conditions such as diabetes or high blood pressure	86.1%	13.9%
Talk to you about how to improve health before pregnancy	74.7%	25.3%
Ask if you were smoking cigarettes	31.4%	68.6%
Ask if someone was hurting you emotionally or physically	59.2%	40.8%
Ask if you were feeling down/depressed	56.9%	43.1%

According to the 2020 Nevada Children's Report Card, Nevada received an overall grade of D for the Health Category. This category included rankings on the following: [228]

- **Access to Healthcare (F):** Nevada ranked 45th in the nation for the percentage of children without health insurance at 8%; 51st in the percentage of children with a medical home; and 48th in patient provider ratios at 65 per 100,000.
- **Prenatal/Infant Health (D):** Nevada ranks 30th for infant mortality rates at 6.1 per 1,000; 33rd on the percentage of low birth weight babies at 8.7%; and 44th in women receiving late or no prenatal care at 9%.
- **Immunizations (C-):** Nevada ranked 20th in the nation for children aged 19 to 35 months receiving recommended doses of DTaP, polio, MMR, Hib, hepatitis B, and PCV vaccines, with a percentage of 71.3%; and 34th in the nation for adolescents who completed all 3 doses of the HPV at 66%.
- **Childhood Obesity (C-**): Nevada ranked 29th in the nation for the percentage of students who are overweight at 17% and 21st for those who are obese at 13.1%. Inactivity increased from 53.6% in 2017 to 60.8% in 2019; and 7.3% of youth reported not consistently eating fruit compared to the U.S. at 6.3%.

[228] Children's Advocacy Alliance Nevada (CAANV). (2020). 2020 Nevada Children's Report Card. Retrieved from https://www.caanv.org/wp-content/uploads/2020/11/CAA-070-2020-Childrens-Report-Card-Single-Pages-v3.pdf

- **Dental Health (F-):** In Nevada, 6.9% of children have fair to poor teeth; 27.7% receive no preventive dental care.

In Nevada, 11.7% children ages 2-4 participating in WIC (state rank 47 out of 51) and 16% children ages 10-17 (state rank 21 of 51) were obese.[229] Youth Risk Behavior Surveillance System (YRBSS) 2017 (the latest data available) show that 70.2% of middle school students were not physically active at least 60 minutes per day on all 7 days; and 52.2% did not eat breakfast on all 7 days. YRBSS 2019 data for high school students show that 78.3% were not physically active at least 60 minutes per day on all 7 days; and 70.4% did not eat breakfast on all 7 days.

Mental and Behavioral Health

Women in the state mental health system in Nevada have an increased:[230]

- Rate of giving birth
- Proportion of younger women giving birth
- Proportion who were never married
- Tobacco use
- Proportion on Medicaid
- Late start of prenatal care
- Rate of adverse birth outcomes

Data from the 2020 Epidemiologic Profile include the following information on substance use, tobacco use, and neonatal abstinence syndrome (NAS).

Substance Use

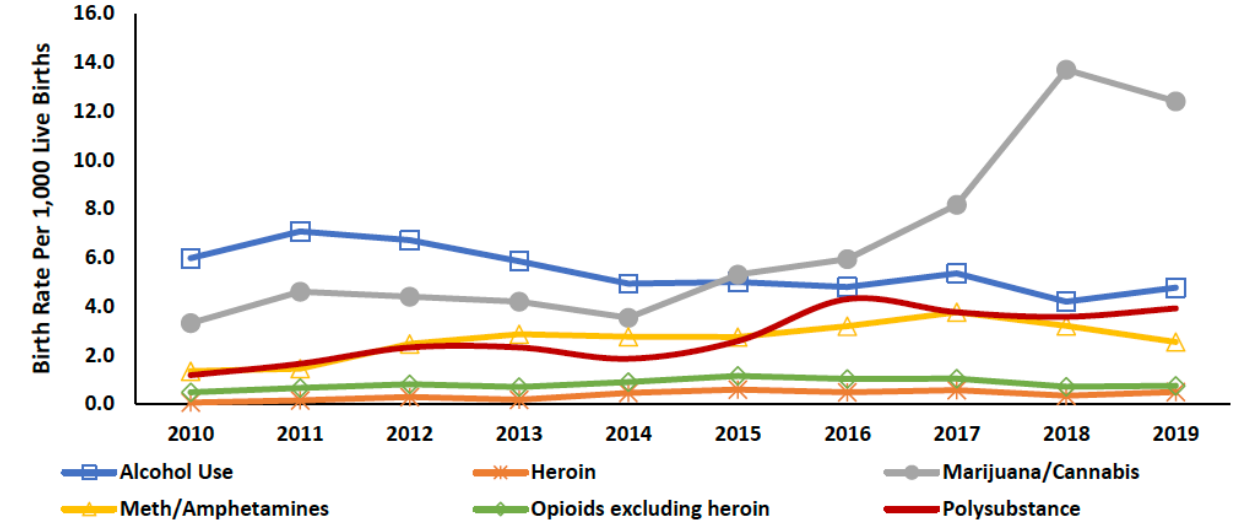
According to the Nevada Behavioral Health EPI Profile, between 2010-2019, there were an average 35,352 live births per year to Nevada residents. The self-reported pre-natal substance use rates in 2019 included: 167 birth certificates indicated alcohol use, 434 birth certificates indicated marijuana use, 89 indicated meth/amphetamine use, 26 indicated opiate use, and 17 indicated heroin use during pregnancy. Between 2010-2019, the highest rate was with marijuana use in 2018, at 13.7 per 1,000 live births. Since 2015, the marijuana use rate has surpassed the alcohol use rate, which was 4.8 per 1,000 births in 2019. In 2019, a rate of 2.5 per 1,000 live births was reported for meth/amphetamines, which is lower than the previous year at 3.2 per 1,000 live births. Polysubstance use (more than one substance) has increased from 2.6 per 1,000 live births in 2015 to 3.9 per 1,000 live births in 2019. [231]

[229] Robert Wood Johnson Foundation. (2020). The State of Childhood Obesity - Helping all Children Grow Up Healthy. Retrieved from https://stateofchildhoodobesity.org/states/nv/

[230] Green, T., and White, L. Mental Illness in Nevada: Screening, Intervention and Intercepts to Avoid System Failure. Retrieved from https://dpbh.nv.gov/uploadedFiles/03%202014-01-29_DPBHmentalIllnessInNV.pdf

[231] Nevada Department of Health and Human Services. (2021). Nevada Behavioral Health EPI Profile. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/2020%20Epidemiologic%20Profile%20(Final).pdf pp 53

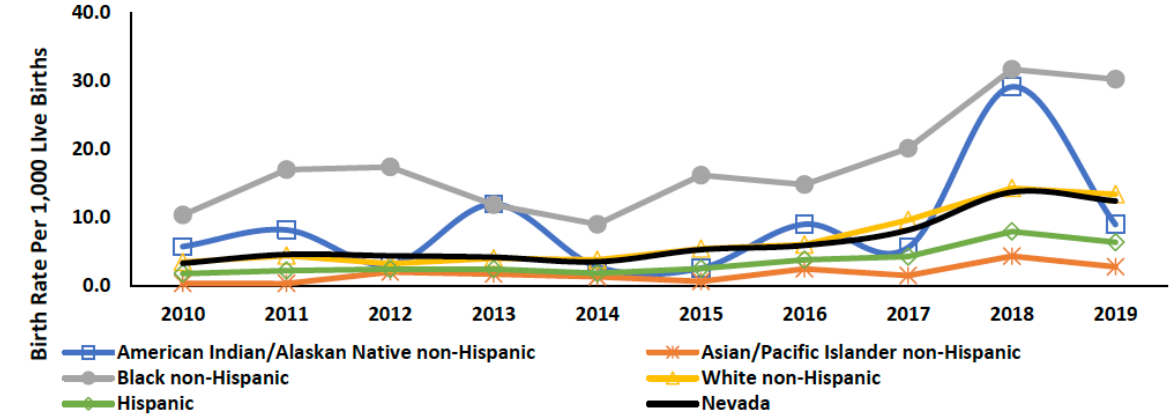
Graph 39. Prenatal Substance Use Birth Rates (Self-Reported) for Select Substances, Nevada, 200-2019



Source: Nevada Electronic Birth Registry System.

Marijuana/cannabis use among pregnant females was significant in the 20-24 age group, at 24.7 per 1,000 live births (age specific). There is a significant increase in marijuana /cannabis use for the PACT/CARE coalition county region from 2017 to 2019, at 8.2 to 12.4 women using marijuana/cannabis per 1,000 live births. Black non-Hispanic mothers self-reported marijuana use was significantly higher than Nevada at 30.2 per 1,000 live births. [232]

Graph 40. Prenatal Marijuana Use by Race/Ethnicity (Self-Reported) for Select Substances, Nevada, 2010-2019



Source: Nevada Electronic Birth Registry System.

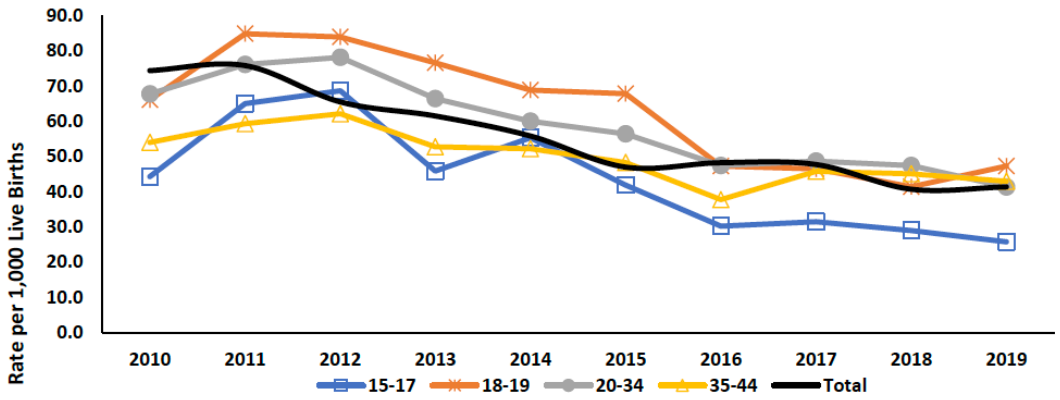
Black non-Hispanic mothers self-reported marijuana use was significantly higher than Nevada at 30.2 per 1,000 live births. [233]

[232] Nevada Department of Health and Human Services. (2021). Nevada Behavioral Health EPI Profile. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/2020%20Epidemiologic%20Profile%20(Final).pdf pp 54

[233] Nevada Department of Health and Human Services. (2021). Nevada Behavioral Health EPI Profile. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/2020%20Epidemiologic%20Profile%20(Final).pdf pp 54

Woman over 45 were not included in the Graph 50 below but did have a significant decrease in tobacco use during pregnancy from 2010-2015 (244.8 to 189.4 per 1,000 live birth respectively). In 2019, the tobacco use during pregnancy was 86.5 per 1,000 live births for woman over 45. Tobacco use during pregnancy has decrease for all mothers ages since 2016. In 2019, there were 17 pregnant women (out of a total of 1,464 women) surveyed in BRFSS. When pregnant women were surveyed for BRFSS, they had significantly higher use for tobacco smoking, at 21.4%, from non-pregnant women 13.7%.[234]

GRAPH 41. PRENATAL TOBACCO USE BY MOTHER'S AGE (SELF-REPORTED) FOR SELECT SUBSTANCES, NEVADA, 2010-2019

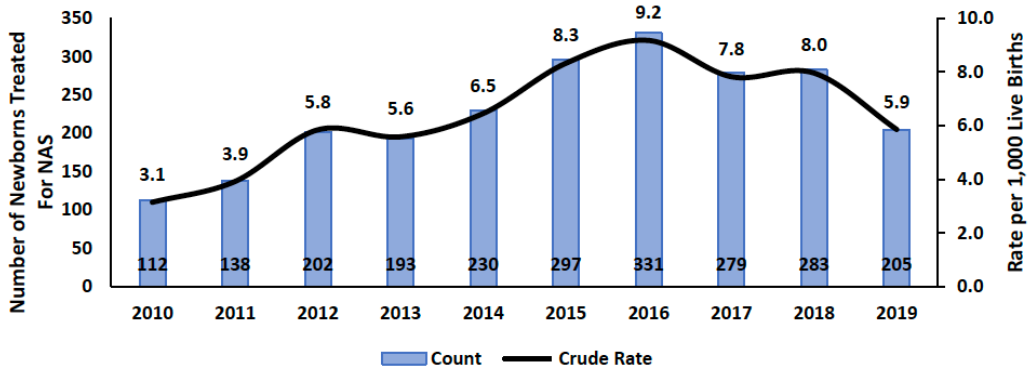


Source: Nevada Electronic Birth Registry System.

Neonatal Abstinence Syndrome (NAS)

Neonatal abstinence syndrome (NAS) is a group of issues that occur in a newborn who was exposed to addictive, illegal, or prescription drugs while in the mother's womb. Withdrawal or abstinence symptoms develop shortly after birth. [235]

GRAPH 42. NEONATAL ABSTINENCE SYNDROME, NEVADA, 2010-2019

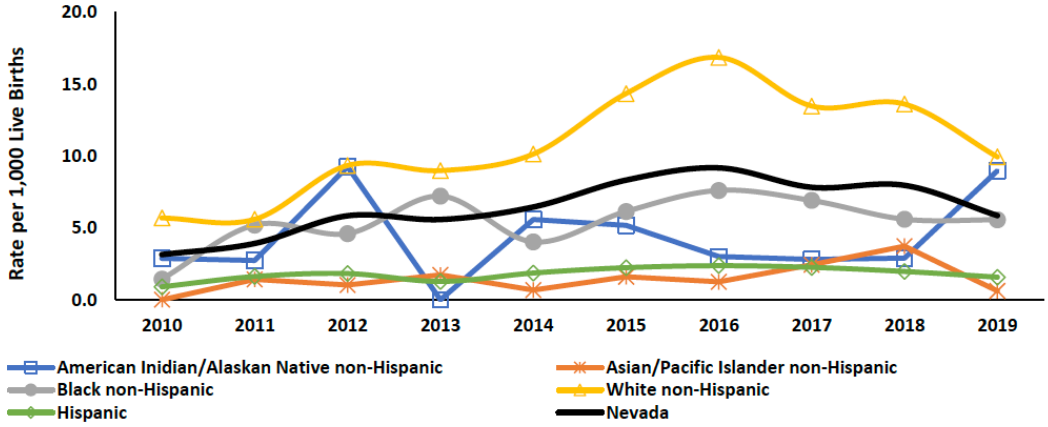


Source: Hospital Inpatient Department Billing and Nevada Electronic Birth Registry System.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

[234] Nevada Department of Health and Human Services. (2021). Nevada Behavioral Health EPI Profile. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/2020%20Epidemiologic%20Profile%20(Final).pdf pp 54
[235] Ibid pp 55

Inpatient admissions for NAS doubled since 2011, from 112 newborns admitted to 205 newborns admitted in 2019 but has significantly decreased from 2018. White non-Hispanic have significantly higher NAS rate compare all other races. The average length of stay for newborns with NAS in 2019 was 19 days. [236]

GRAPH 43. NEONATAL ABSTINENCE SYNDROME BY RACE/ETHNICITY, NEVADA, 2010-2019



Source: Hospital Inpatient Department Billing and Nevada Electronic Birth Registry System.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Adverse Childhood Events (ACEs)

ACEs are potentially traumatic events that occur in childhood (0-17 years). The CDC uses ACEs to help determine different health and well-being outcomes. ACEs studies assess associations between childhood adverse events and later-life health and well-being. ACEs include: Verbal abuse, Physical abuse, Sexual abuse, and Family dysfunction (e.g., an incarcerated, mentally ill, or substance-abusing family member; domestic violence; or absence of a parent because of divorce or separation).

Table 48 shows the prevalence of ACEs in Nevada Middle School students.[237] The data show that approximately 1 in 4 middle school students have experienced at least one type of ACE; and approximately 1 in 6 reported experiencing 3 or more ACEs.

TABLE 48. PREVALENCE OF INDIVIDUAL ACE QUESTIONS, MIDDLE SCHOOL STUDENTS, NEVADA YRBS 2019

Question	No %	Yes %
Ever physically forced to have sex	95.4%	4.6%
Every been hit, beaten, kicked or physically hurt in any way by an adult	86.9%	13.1%
Sometimes, mostly, or always have been sworn at, insulted by, or put down by an adult	65.7%	34.3%
Ever seen adults in their home slap, hit, kick, punch, or beat each other up	83.8%	16.2%
Ever lived with someone who was depressed, mentally ill, or suicidal	77.8%	22.2%
ACE Score	**#**	**%**

[236] Nevada Department of Health and Human Services. (2021). Nevada Behavioral Health EPI Profile. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/2020%20Epidemiologic%20Profile%20(Final).pdf pp 55

[237] 2019 Nevada Middle School YRBS: ACE Special Report. Retrieved from https://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/ClinicalSAPTA/Meetings/5a%20-%202019%20Middle%20School%20YRBS%20ACEs%20Special%20Report%20FINAL.pdf

0	2,345	44.4%
1	1,258	24.8%
2	813	15.9%
3+	889	15.0%

Exposure to ACEs is associated with increased risk of mental health disorders up to decades after their occurrence. Utilization of psychotropic medications is shown to increase with number of ACEs. However, early recognition of ACEs with early intervention may assist in preventing behavioral health issues throughout the life span.

Table 49 shows the prevalence of ACEs in Nevada High School students.[238] The data show that approximately 1 in 4 high school students have experienced at least one type of ACE; and approximately 1 in 5 reported experiencing 3 or more ACEs.

TABLE 49. PREVALENCE OF INDIVIDUAL ACE QUESTIONS, HIGH SCHOOL STUDENTS NEVADA YRBS 2017

Question	No %	Yes %
Ever physically forced to have sex	93.5%	6.5%
Every been hit, beaten, kicked or physically hurt in any way by an adult	82.5%	17.5%
Sometimes, mostly, or always have been sworn at, insulted by, or put down by an adult	66.8%	33.2%
Ever seen adults in their home slap, hit, kick, punch, or beat each other up	83.6%	16.4%
Ever lived with someone who was depressed, mentally ill, or suicidal	69.9%	30.1%
Ever lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs.	68.1%	31.9%
ACE Score	**#**	**%**
0	2,345	37.8%
1	1,258	24.2%
2	813	17.1%
3+	889	20.9%

Regional Considerations (Rural and Frontier Communities)

Education

According to the Nevada Rural and Frontier Health Data Book:[239]

- In 2020, the average high school graduation rate in Nevada was 84.1% – the graduation rate ranged from66.9% in White Pine County to 94.5% in Pershing County.
- The percent of population aged 25 and over with a bachelor's degree was lower in rural and frontier areas of the state (17.8%) when compared to urban areas (25.0%), and the percent of population with a master's degree or higher was lower in rural areas (6.1%) versus urban areas (8.6%).

[238] 2017 Nevada High School YRBS: ACE Special Report. Retrieved from https://scholarworks.unr.edu/bitstream/handle/11714/5003/2017%20Nevada%20High%20School%20YRBS%20-%20ACEs%20Report_acc.pdf?sequence=1&isAllowed=y

[239] Griswold, T., Packham, J., Warner, J., Etchegoyhen, L. (2021). Nevada Rural and Frontier Health Data Book. Retrieved from https://cms2files.revize.com/elkocountynevada/boards/Health/2021/DATA%20BOOK%202021%20Final%203-4-21.pdf

- In 2020, the average public expenditure on education in Nevada was $9,352 per pupil – among rural counties per pupil spending ranged from $10,041 in White Pine County to $30,386 in Eureka County.

Economic and Financial Stability

According to the Nevada Rural and Frontier Health Data Book:[240]

- The average per capita income for all rural and frontier counties ($47,990) was below the urban average of $54,879, and below the U.S. average of $56,490.
- Over the past decade, per capita personal income in rural and frontier counties increased from $41,239 to $47,990.
- Rural populations have higher levels of income from transfer payments from the government (20.8% of total income) than urban populations (16.3%).
- Rural and frontier counties had transfer payments from the following sources: Social Security and other retirement (38.3%); Medicare and other medical benefits (48.9%); income maintenance benefits (9.8%); and unemployment and other benefits (1.9%).
- In 2019, there were 119,574 children in poverty in Nevada (17.6% of children aged 17 and under) – there were 9,820 children in poverty in rural and frontier counties (16.8%).
- In 2020, 298,981 students or 63.2% of the total student population qualified for the Free and Reduced Lunch Program in Nevada, including 21,205 students or 51.5% of the total student population in rural and frontier counties.

Table 50 below shows data for poverty by age and county across Nevada, providing a regional picture of the issue. While Clark County, the largest county in Nevada by population, has the highest total number of individuals living in poverty, Mineral County (20.3%) and Nye County (17.3%), have the highest percentages of individuals living in poverty. [241]

Table 50. Summary of Poverty by Age (Percent at or Below Poverty Threshold)

County	Under 5 Years	5 17 Years	18 64 Years	65 Years and Over	Total Share of State %	Total Below Poverty Threshold	Total Population	% of Population Below Poverty
Carson City	877	1,649	4,282	890	1.9%	7,698	52,245	14.7%
Churchill County	107	738	1,895	505	0.8%	3,245	23,519	13.8%
Clark County	31,653	72,356	175,584	24,856	75.1%	304,449	2,085,154	14.6%
Douglas County	348	785	2,878	636	1.2%	4,647	47,298	9.8%
Elko County	909	1,435	3,078	509	1.5%	5,931	51,609	11.5%
Esmeralda County	0	18	26	31	0.02%	75	1,097	6.8%
Eureka County	0	0	46	127	0.04%	173	1,723	10.0%
Humboldt County	201	250	927	157	0.4%	1,535	16,853	9.1%
Lander County	197	163	311	98	0.2%	769	5,845	13.2%
Lincoln County	44	199	300	25	0.1%	568	4,696	12.1%

[240] Griswold, T., Packham, J., Warner, J., Etchegoyhen, L. (2021). Nevada Rural and Frontier Health Data Book. Retrieved from https://cms2files.revize.com/elkocountynevada/boards/Health/2021/DATA%20BOOK%202021%20Final%203-4-21.pdf

[241] Buffington, A., Webber, K., & Lindsay, A. (2022). University of Nevada Reno extension statewide SNAP-Ed needs assessment, 2020-2021. Retrieved from https://naes.agnt.unr.edu/PMS/Pubs/2021-3976.pdf page 9

Lyon County	545	1,533	4,303	747	1.8%	7,148	52,030	13.7%
Mineral County	93	283	412	106	0.2%	894	4,399	20.3%
Nye County	422	1,527	4,157	1,282	1.8%	7,388	42,757	17.3%
Pershing County	71	183	309	146	0.2%	709	4,714	15.0%
Storey County	19	57	197	27	0.1%	300	3,877	7.7%
Washoe County	5,059	11,495	36,941	5,147	14.5%	58,642	440,168	13.3%
White Pine County	89	343	549	111	0.3%	1,092	8,381	13.0%
Nevada	40,634	93,034	236,195	35,400	8.7%	405,263	2,846,365	14.2%
U.S.	4,390,252	10,320,233	26,622,668	4,317,192	9.5%	45,650,345	313,048,563	14.6%

Affordable housing across the state is a chronic and growing issue, and this issue is the most critical for Very Low-Income Individuals.[242] The Nevada Rural Continuum of Care provides the following information on the rural counties across Nevada covered by the Rural Nevada CoC (RNCoC). [243]

FIGURE 17. LOCATIONS OF COUNTIES IN NEVADA'S RNCOC

List of Counties in Nevada's CoC

- Carson City
- Churchill County
- Douglas County
- Elko County
- Esmeralda County
- Eureka County
- Humboldt County
- Lander County
- Lincoln County
- Lyon County
- Mineral County
- Nye County
- Pershing County
- Storey County
- White Pine County

Locations of Counties in Nevada's RNCoC

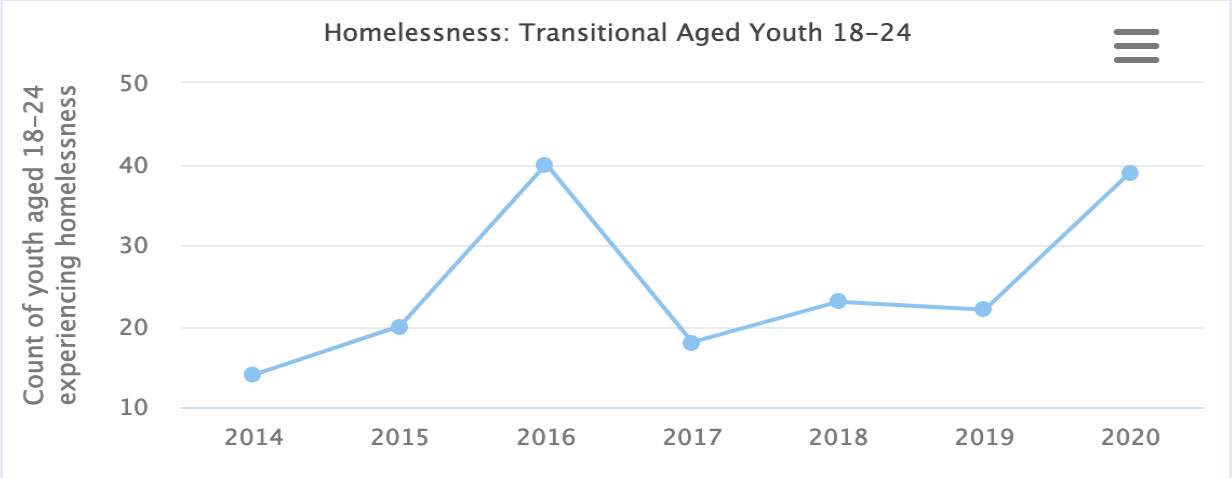
Trends in rural homelessness can be seen below in Graph 34, which shows trends in homelessness Point in Time Counts from 2022-2021, and Graph 35, which shows trends in Transition Aged Youth between 2014-2018.

[242] Nevada Department of Business & Industry Housing Division. NRS 278.235 Annual Housing Progress Report. Retrieved from https://housing.nv.gov/uploadedFiles/housingnewnvgov/Content/Programs/HDB/AHPR%20%202020%20draft%20version%2020210209.pdf

[243] Rural Nevada Continuum of Care. 2021 Point-In-Time Count. Retrieved from https://legistarweb-production.s3.amazonaws.com/uploads/attachment/pdf/1025858/-Rural_Nevada_Continuum_of_Care_Point-in-Time_Count_Report.pdf

Graph 44. Homeless Point in Time Count

Graph 45. Homeless Transitional Aged Youth 18-24

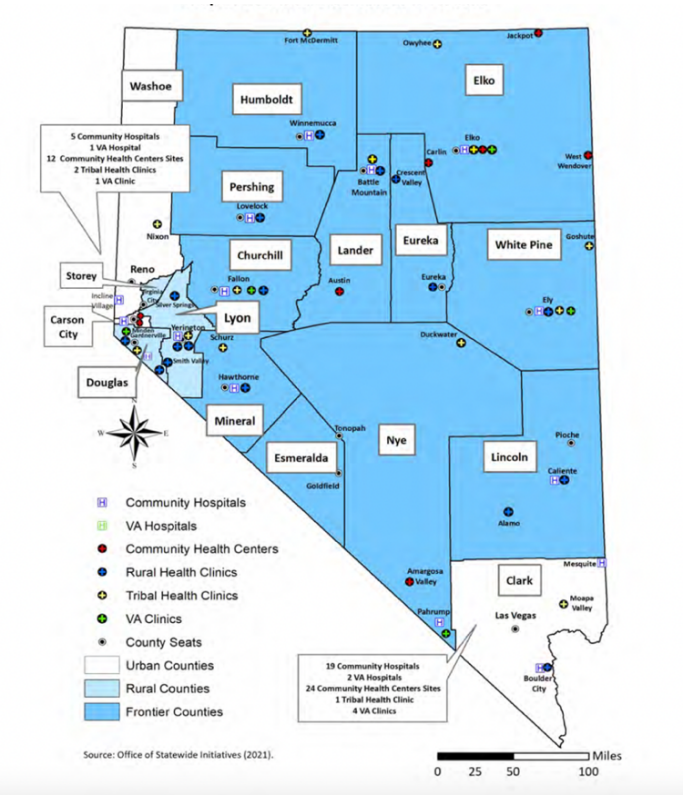


Healthcare Access

Figure 18 below shows the healthcare resources in Nevada and their locations. [244] The majority of healthcare institutions and resources, including hospitals, are located in urban Washoe and Clark counties, with large portions of the state lacking healthcare infrastructure and access to services. Access to services is a critical challenges in many parts of rural and frontier Nevada, compounded by transportation issues, lack of broadband and stigma in small communities for some diseases and disorders.

[244] Griswold, T., Packham, J., Warner, J., Etchegoyhen, L. (2021). Nevada Rural and Frontier Health Data Book. Retrieved from https://cms2files.revize.com/elkocountynevada/boards/Health/2021/DATA%20BOOK%202021%20Final%203-4-21.pdf

FIGURE 18. HEALTHCARE RESOURCES IN NEVADA



Health/Mental and Behavioral Health

The Minority Health Report 2021[245] highlights the following key findings:

- Families experiencing poverty in rural and frontier communities are less likely to be connected to benefits, such as food stamps/SNAP, with the greatest disparity existing in Mineral, Nye, and White Pine counties.
- Self-reported tobacco use among mothers during pregnancy decreased since 2010; however, the rate among mothers in rural communities increased to an eight-year high.
- White-non-Hispanic populations in the Balance of State (35.6%) had a significantly lower prevalence of ever getting tested for HIV than White-non-Hispanic populations in Clark County (40.7%) and Washoe County (40.8%).
- Hispanic populations in the Balance of State had significantly higher death rates from motor vehicle accidents, at 23.3 per 100,000 population, than Hispanic populations in Clark County (5.9 per 100,000) and Washoe County (5.4 per 100,000).
- From 2015-2019, Hispanic populations in Clark County (2.1%) and Washoe County (0.9%) had significantly lower prevalence of heart disease than White-non-Hispanic populations in Clark County (5.7%) and Washoe County (3.6%).
- The 2015-2019 combined prevalence of stroke among American Indian/Alaskan Native-non-Hispanic populations was significantly higher in the Balance of State (9.0%) than in Clark County (1.3%).

[245] Nevada Department of Health and Human Services. (2021). Minority Health Report 2021. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Minority%20Health%20Report%202021(2).pdf

- White-non-Hispanic populations in Washoe County had significantly lower prevalence of being overweight or obese (61.5%) than White-non-Hispanic populations in the Balance of State (66.8%).
- White-non-Hispanic populations in Washoe County had significantly lower prevalence of physical inactivity within the last 30 days (19.2%) than White-non-Hispanic populations in Clark County (23.4%) and the Balance of State (24.6%)
- White-non-Hispanic populations in Washoe County had significantly higher accidental death rates from falls, at 19.5 per 100,000 population, than White-non-Hispanic populations in Clark County (8.4 per 100,000) and the Balance of State (7.5 per 100,000)
- Hispanic populations in the Balance of State had significantly higher death rates from motor vehicle accidents, at 23.3 per 100,000 population, than Hispanic populations in Clark County (5.9 per 100,000) and Washoe County (5.4 per 100,000)
- Death rates from Chronic Lower Respiratory Disease (CLRD) were significantly higher among Black non-Hispanic populations in Clark County (33.7 per 100,000) than Black non-Hispanic populations in Washoe County (7.7 per 100,000)
- White-non-Hispanic populations in Clark County (10.9%) and White-non-Hispanic populations in the Balance of State (12.1%) both had a significantly higher prevalence of adults who had ever been told by a health professional they have diabetes than White-non-Hispanic populations in Washoe County (8.3%)
- White-non-Hispanic populations in Clark County had a significantly lower prevalence of receiving the flu shot (35.5%) than White-non-Hispanic populations in Washoe County (41.6%).
- White-non-Hispanic male populations in Clark County (13.2 per 100,000) had significantly higher rates of reported cases of HIV infection than White-non-Hispanic in Washoe County (6.2 per 100,000) and the Balance of Sate (3.1 per 100,000).
- White-non-Hispanic populations in the Balance of State (35.6%) had a significantly lower prevalence of ever getting tested for HIV than White-non-Hispanic populations in Clark County (40.7%) and Washoe County (40.8%).
- In 2019, Black-non-Hispanic populations in Washoe County had significantly higher rates of chlamydia infection, at 2,163.6 per 100,000 population, than Black-non-Hispanic populations in Clark County (934.1 per 100,000) and the Balance of State (651.7 per 100,000).
- White-non-Hispanic populations in Washoe County had significantly higher birth rates, at 9.5 per 1,000 population, than White-non-Hispanic populations in Clark County (8.1 per 1,000) and the Balance of State (9.3 per 1,000) population.
- White-non-Hispanic populations in the Balance of State had significantly higher teen birth rates, at 15.6 per 1,000 women ages 15-19, than White-non-Hispanic women in Clark County (8.0 per 1,000 women) and Washoe County (10.2 per 1,000 women).
- In 2019, Asian/Pacific Islander–non-Hispanic adult populations in Clark County reported a significantly greater prevalence (15.5%) of difficulty concentrating, remembering, or making decisions because of a physical, mental or emotional condition than Asian/Pacific Islander–non-Hispanic adult populations in Washoe County (3.7%).

Sexual and Gender Populations

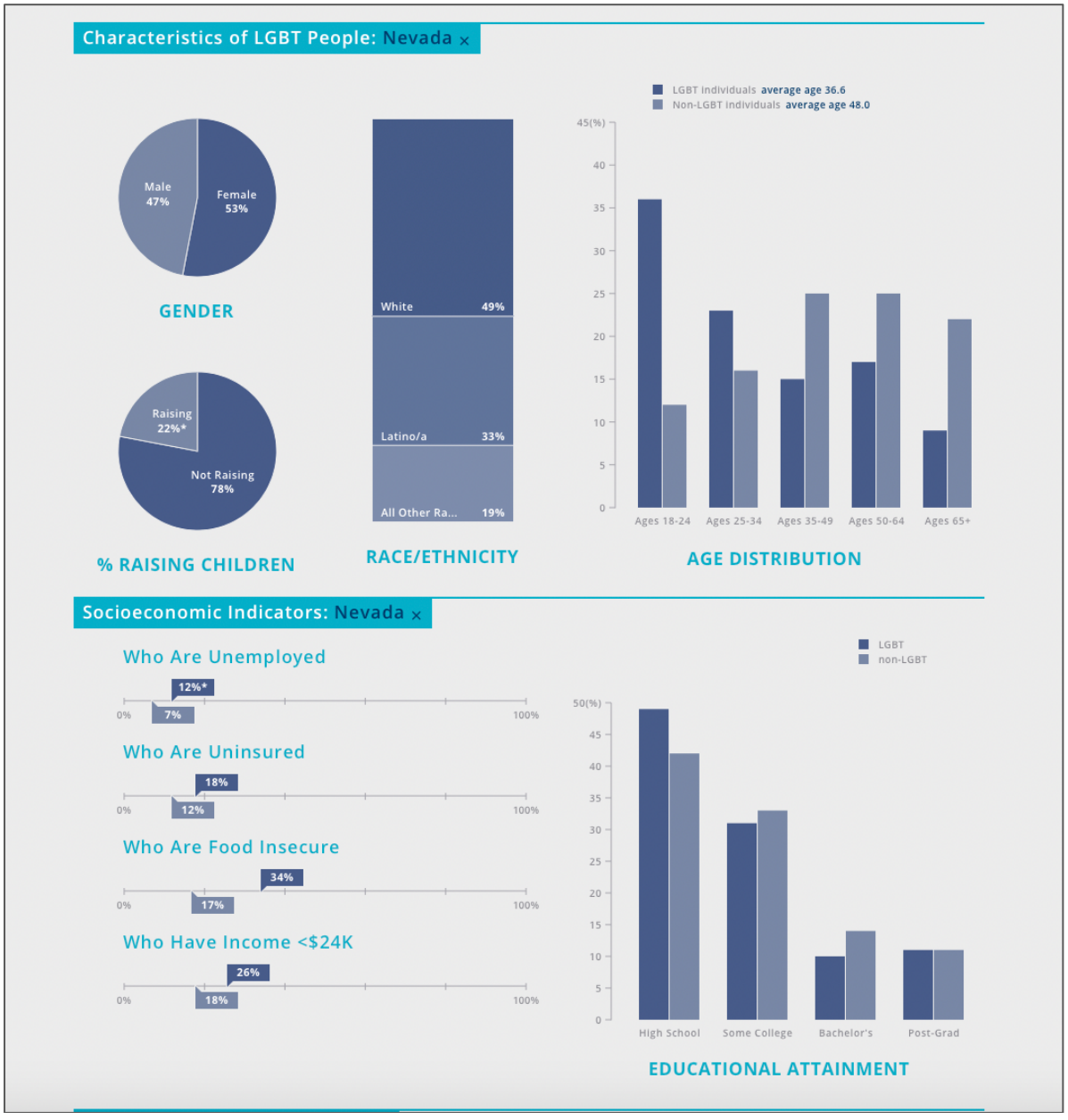
Sexual and gender minority populations include a diverse group of individuals. Definitions and terminology of sexual and gender minorities is continuously changing and evolving, For the purposes of this report, we will use the following CDC definitions and categories under this section.[246] The graphic below provides definitions for some of the commonly used terms researchers use when providing data and insight on sexual and gender minority populations. In this report, we have used the term LGBTQIA+ except for when we cite data from another source that uses a different term, like LGBT, where we have then chosen to keep their term consistent with the data sources as present that data with their terms.

- **Bisexual:** A person who is attracted to both people of their own gender and other genders.
- **Cisgender:** Individuals whose current gender identity is the same as the sex they were assigned at birth.
- **Gay:** A person who is attracted primarily to members of the same gender. Gay is most frequently used to describe men who are attracted primarily to other men, although it can be used for men and women.
- **Gender:** The cultural roles, behaviors, activities, and attributes expected of people based on their sex.
- **Gender Expression:** How an individual chooses to present their gender to others through physical appearance and behaviors, such as style of hair or dress, voice, or movement.
- **Gender Identity:** An individual's sense of their self as man, woman, transgender, or something else.
- **Gender Minority:** Individuals whose gender identity (man, women, other) or expression (masculine, feminine, other) is different from their sex (male, female) assigned at birth.
- **Gender Nonbinary:** Individuals who do not identify their gender as man or woman. Other terms to describe this identity include genderqueer, agender, bigender, gender creative, etc.
- **Gender Nonconforming:** The state of one's physical appearance or behaviors not aligning with societal expectations of their gender (a feminine boy, a masculine girl, etc.).
- **Heterosexual or Straight:** A man who is primarily attracted to women or a woman who is primarily attracted to men.
- **Lesbian:** A woman who is primarily attracted to other women.
- **LGBTQ:** Acronym that refers to the lesbian, gay, bisexual, transgender, and queer/questioning community.
- **Queer:** An umbrella term sometimes used to refer to the entire LGBT community.
- **Questioning:** For some, the process of exploring and discovering one's own sexual orientation, gender identity, or gender expression.
- **Sex:** An individual's biological status as male, female, or something else. Sex is assigned at birth and associated with physical attributes, such as anatomy and chromosomes.
- **Sexual Minority:** Individuals who identify as gay, lesbian, or bisexual, or who are attracted to or have sexual contact with people of the same gender.
- **Sexual Orientation:** Refers to a person's sexual and emotional attraction to another person and the behavior and/or social affiliation that may result from this attraction (lesbian, gay, bisexual, etc.)
- **SGM:** Acronym for sexual and gender minorities.
- **SGMY**: Acronym for sexual and gender minority youth.
- **SMY:** Acronym for sexual minority youth.
- **Transgender:** Individuals whose current gender identity differs from the sex they were assigned at birth.

[246] The Centers for Disease Control. Adolescent and School Health. Terminology. Retrieved rom https://www.cdc.gov/healthyyouth/terminology/sexual-and-gender-identity-terms.htm

According to the Williams Institute,[247] the percentage of the population in Nevada that identifies as LGBT is 5.5%, ranking third in the nation. The characteristics of the LGBT community living in Nevada is depicted in Figure 19 below, which shows that 53% are Female, 47% are Male; 49% are White, 33% are Hispanic, and 19% are Other Races; 22% are raising children; and the average age is 36.6. Socioeconomic indicators include: 26% have an income <$24K; 12% are unemployed; 18% are uninsured; 34% are food insecure; 49% have a high school diploma; 31% have some college; 10% have a Bachelor's degree; and 11% have a post-graduate degree. [248]

FIGURE 19. CHARACTERISTICS OF LGBT PEOPLE IN NEVADA



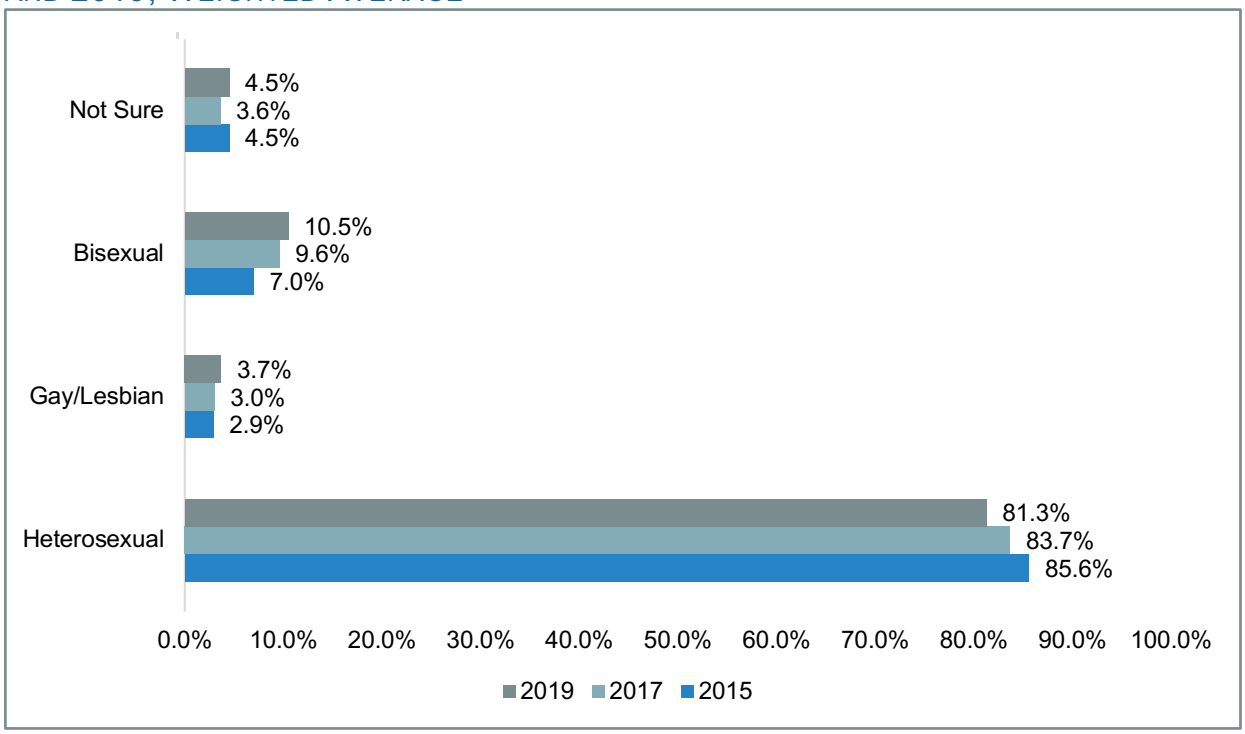
[247]UCLA School of Law. Williams Institute. Retrieved from https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=32#economic

[248] Ibid

Education

The percentage of Nevada high school students that identify as other than heterosexual has increased slightly between 2015, 2017 and 2019. In Nevada high schools, 3.7% of students identify as gay or lesbian, 10.5% identify as bisexual; and 4.5% are not sure of their sexual orientation (Graph 36). [249]

GRAPH 46. SEXUAL ORIENTATION, NEVADA HIGH SCHOOL POPULATION, 2015, 2017, AND 2019, WEIGHTED AVERAGE



Economic and Financial Stability

Data on sexual and gender minorities is lacking in Nevada, therefore, we have included national information here on health impacts on this population. According to the Human Rights Campaign, LGBTQ people are more likely to live in poverty and work in industries that are more impacted by the pandemic, including retail, food service, hospitals and K-12 and post-secondary education.[250]

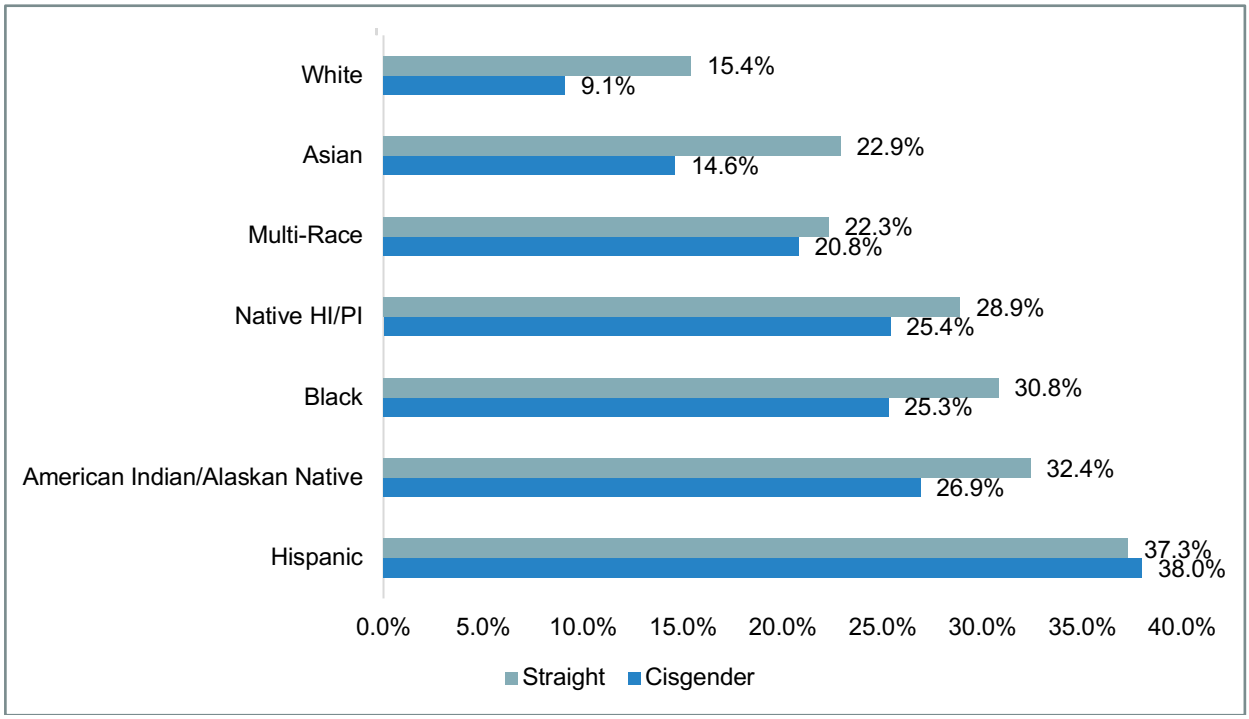
Graph 37 below compares rates of poverty across LGBT and cisgender straight people by race and ethnicity. Poverty rates across all racial and ethnic groups are higher for the LGBT category when compared to cisgender straight groups. [251]

[249]Nevada Department of Health and Human Services. (2021). Nevada Behavioral Health EPI Profile. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/2020%20Epidemiologic%20Profile%20(Final).pdf, pp 56

[250] Human Rights Campaign Foundation. (n.d.). The Lives and Livelihoods of Many in the LGBTQ Community are at risk Amidst the COVID-19 Crisis. Retrieved from https://assets2.hrc.org/files/assets/resources/COVID19-IssueBrief-032020-FINAL.pdf?_ga=2.151720255.749950535.1588281573-2110006584.1588281573

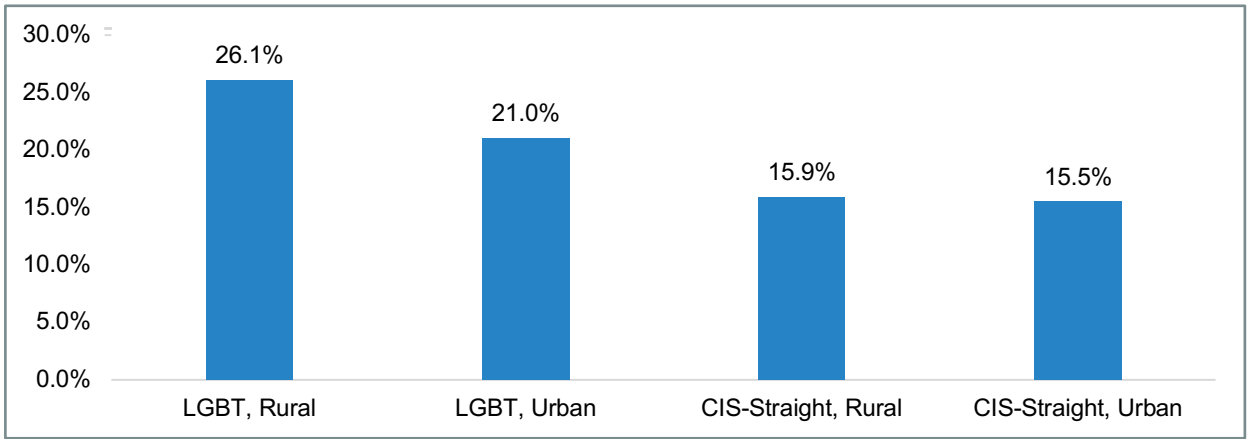
[251] Badgett, M.V., Choi, S.K., Wilson, B.D.M. LGBT Poverty in the United States. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019.pdf pp13

Graph 47. Poverty Rates Comparing LGBT and Cisgender Straight People by Race/Ethnicity



Graph 38 below shows how poverty rates are higher for LGBT individuals living in both rural and urban settings when compared to cisgender straight individuals, respectively. It is of interest to note the difference in poverty rates for LGBT individuals in rural communities compared to cisgender straight individuals in rural settings, 26.1% versus 15.9% respectively. [252] Stigma, isolation, and lack of support systems more readily found in urban settings have been discussed as possible factors for this discrepancy.

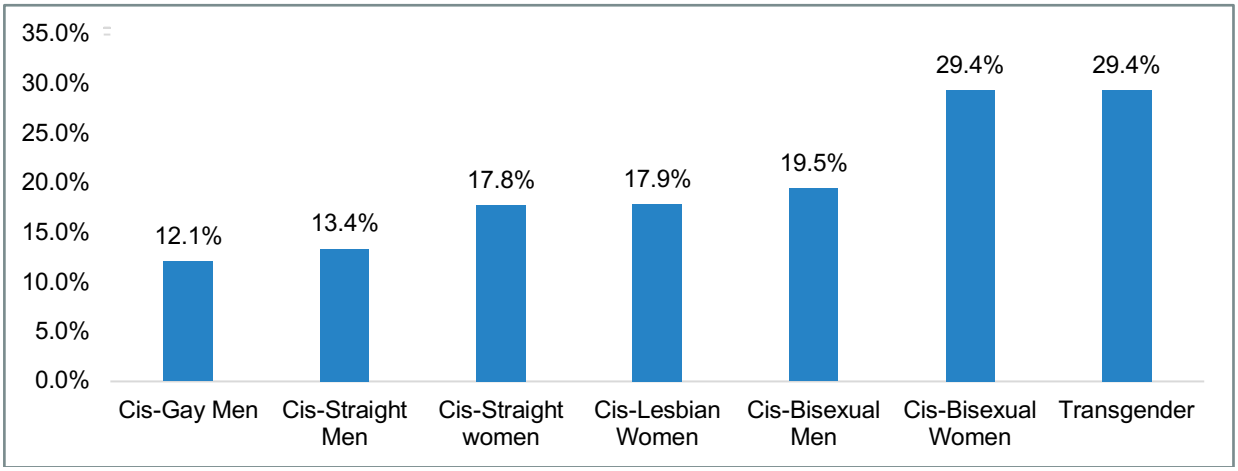
Graph 48. Poverty Rates Comparing LGBT and Cisgender Straight People by Rural and Urban Residence



[252] Badgett, M.V., Choi, S.K., Wilson, B.D.M. LGBT Poverty in the United States. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019.pdf pp 9

The Williams Institute published a report on LGBT Poverty in the United States using data from the Behavioral Risk Factor Surveillance System (BRFSS) Survey showing poverty rates across the United States by sexual orientation and gender identity. High rates of poverty are found among cis Bisexual woman and transgender individuals, both at 29.4%. See Graph 39 below.[253]

GRAPH 49. POVERTY RATES BY SEXUAL ORIENTATION AND GENDER IDENTITY



Healthcare Access

Health disparities continue to (LGBTQIA+) communities continue to face health disparities and challenges/barriers to care, including the stigma associated with sexual and gender minorities that these individuals have to face in daily life and in accessing healthcare. This fear of discriminations causes many to avoid or delay care, and the lack of culturally competent and trained providers further impacts this issue.

Health Outcomes

According to Healthy People 2020:[254]

- Lesbians are less likely to get preventive services for cancer.
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.
- Lesbians and bisexual females are more likely to be overweight or obese.
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than heterosexual or LGB individuals.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.

[253] Badgett, M.V., Choi, S.K., Wilson, B.D.M. LGBT Poverty in the United States. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019.pdf page 8

[254] Healthy People 2020. Lesbian, Gay, Bisexual, and Transgender Health. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

Mental and Behavioral Health

Suicide rates, specifically for Nevadans who are LGBTQ, are not available. In Nevada, as well as nationally, sexual orientation is not included in death certificates. However, suicide is the second leading cause of death among young people ages 10 to 24.1. LGBTQ youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGBTQ peers who reported no or low levels of family rejection. In addition, in a national study, 40% of transgender adults reported having made a suicide attempt; 92% of these individuals reported having attempted suicide before the age of 25.3.

Data from the 2019 Nevada YRBS Sexual and Gender Minority Special Report[255] shows higher rates of mental health behaviors (Table 51), higher rates of negative emotional health outcomes (Table 52), and higher rates of adverse childhood experiences (ACEs) for Nevada high schools students that identify as a sexual or gender minority.

Table 51. Mental Health Behaviors, LGBT and non-LGBT Nevada Adults, 2018

Behavior	Non LGBT	LGBT
Ever Seriously Considered Attempting Suicide During Past 12 Months	3.0%	10.7%
General Health Poor or Fair	20.2%	19.1%
Depressive Disorder Diagnosis	14.3%	34.7%
Ten or More Days of Poor Mental Health	14.9%	29.7%

Table 52. Emotional Health, Nevada High School Students, By Sexual and Gender Identity, 2019

Behavior	Heterosexual	LGB & Not Sure	Cisgender	Transgender & Not Sure
Felt Sad/Hopeless almost every day two/more weeks in a row	35.4%	63.4%	39.9%	60.9%
Seriously considered attempting suicide during past 12 mo.	13.2%	38.9%	17.4%	33.5%
Never/Rarely got the kind of help needed when they felt sad, empty, hopeless, angry or anxious	53.8%	64.4%	55.8%	65.8%
Ten or More Days of Poor Mental Health	14.9%	29.7%	29.7%	29.7%

Table 53. Adverse Childhood Experiences (ACEs), Nevada High School Students, By Sexual and Gender Identity, 2019

ACEs	Heterosexual	LGB & Not Sure	Cisgender	Transgender & Not Sure
Ever been hit, beaten, kicked, or physically hurt by an adult	15.5%	32.5%	18.0%	33.4%
Physically forced to have sex	4.2%	14.6%	5.5%	18.1%
Ever been sworn at, insulted by, or put down by adult in home	31.8%	46.9%	34.2%	46.5%
Ever seen or heard adults in their home slap, hit, kick, punch, or beat each other up	15.5%	30.5%	17.7%	32.7%
Ever lived with someone who was depressed, mentally ill, or suicidal	30.4%	46.0%	33.2%	41.5%
Ever lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs	28.6%	37.9%	30.3%	37.7%

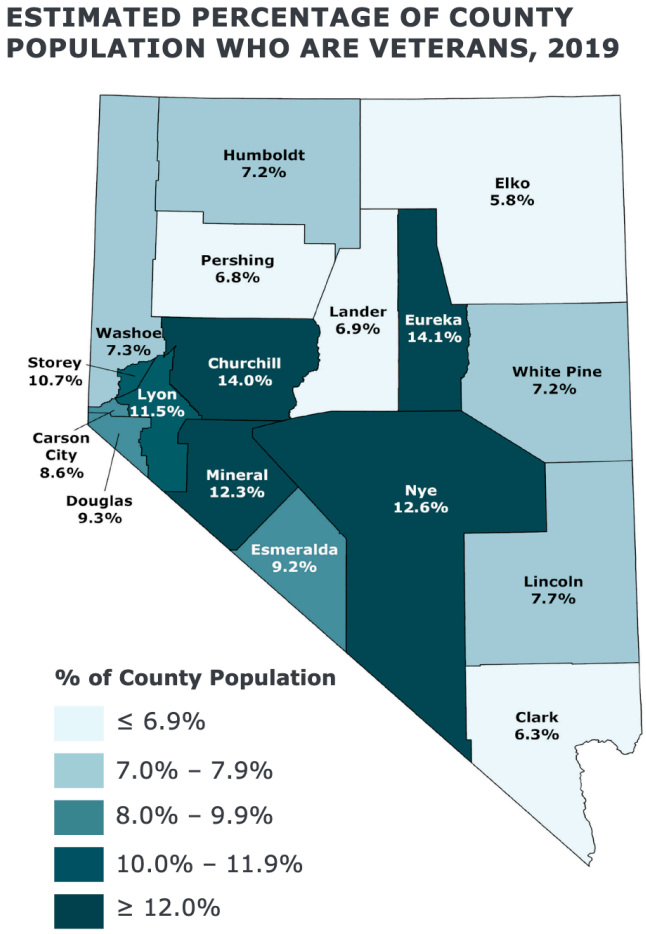
[255] 2019 Nevada YRBS Sexual and Gender Minority Special Report. Retrieved from https://scholarworks.unr.edu/bitstream/handle/11714/7536/2019%20YRBS%20Sexual%20and%20Gender%20Minority%20Special%20Report%20FINAL.pdf?sequence=3&isAllowed=y

Veterans

Nevada has a relatively large number of veterans who call Nevada home. According to the Nevada Department of Veteran Services, Nevada had 242,380 veterans, 10.4% of the population versus 6.6% nationally. Like the rest of the U.S., in Nevada the majority of veterans are male (88.6%) and nearly half (49.0%) are age 65 or over.[256] Nevada veterans by county are shown in Figure 20 below. [257]

In addition to the many health conditions faced by veterans, they also face social needs such as homelessness, unemployment, poverty, and disability. In Nevada, 3.9% (924) veterans are homeless,[258] 5% are unemployed, 8% live in poverty, and 29% of the state's veterans have a disability.[259]

FIGURE 20. NEVADA VETERAN BY COUNTY



[256] Nevada Department of Veterans Services. (2020). State Fiscal Year 2020 Annual Report. Retrieved from https://veterans.nv.gov/wp-content/uploads/2021/03/NDVS-Annual-Report-2020_FINAL-1.pdf

[257] Nevada Legislature. Veterans in Nevada: An Overview. Retrieved from https://www.leg.state.nv.us/Division/Research/Content/items/veterans-in-nevada-an-overview

[258] United States Interagency Council on Homelessness. Nevada homelessness statistics. Retrieved from https://www.usich.gov/homelessness-statistics/nv/

[259] Nevada Department of Veterans Services. (2020). State Fiscal Year 2020 Annual Report. Retrieved from https://veterans.nv.gov/wp-content/uploads/2021/03/NDVS-Annual-Report-2020_FINAL-1.pdf

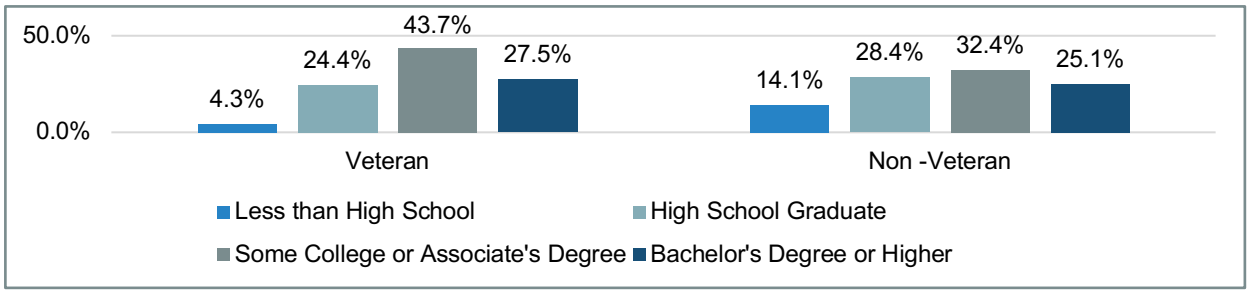
Education

Based on the responses of more than 30,000 veterans, from a total sample size of more than 340,000 respondents:

- Veterans disproportionately hold certificates or certifications. Among adults without degrees, veterans are far more likely than nonveterans to have a certificate or certification (57% versus 35% for nonveterans).
- Certificates and certifications boost employability and earnings for veterans without degrees. Veterans with certificates and certifications but no degree are more likely to be working (73% versus 64%) and earn more (an average bump of $10,000 in median income) compared to those without any credential.
- Veterans without degrees see less need for additional education than non-veterans without degrees. Just 37% of veterans without degrees feel they need more education to advance in their careers, compared to 47% among their non-veteran peers.

The educational attainment of veterans versus non-veterans in Nevada shows that veterans have a higher educational attainment for some college or Associate's degrees and Bachelor's degree or higher. [260]

GRAPH 50. EDUCATIONAL ATTAINMENT FOR THE CIVILIAN POPULATION 25 YEARS AND OVER IN NEVADA



Economic and Financial Stability

U.S. Census Bureau data shows that Nevada 8.5% of Nevada veterans 18 to 64 years old and 6.6% of Nevada veterans 65 and over live in poverty; the median household income for Nevada veterans is $43,372; and 26.8% of Nevada veterans have a service-connected disability (56,969 veterans).

Healthcare Access

According to the Nevada Department of Veterans Services, 280,000 Nevada veterans are enrolled in VA Benefits and Health programs, and a significant number of veterans and spouses are not. It's estimated that more than half of Nevada's veterans are not connected to the VA and receiving care through community-based providers and may not even be identified as a veteran. They may be missing out on compensation, support services and working with incomplete or incorrect information about their eligibility.[261]

[260] ACS 5-Year Estimates 2020
[261] Nevada Department of Veterans Services. Health Providers. Retrieved from https://veterans.nv.gov/health-providers/

Health Outcomes

Veterans face unique health conditions, including musculoskeletal injuries, pain, mental illness, post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), environmental and toxic exposures, and military sexual trauma (MST).[262] The four leading causes of death are the same for both veteran and non-veterans, which are heart disease, malignant neoplasms or cancers, chronic lower respiratory disease, and cerebrovascular disease (stroke) (Table 54). [263]

TABLE 54. PRIMARY CAUSES OF DEATH BY VETERAN STATUS, NEVADA, 2016-2020 COMBINED

Primary Cause of Death	Veteran	Non Veteran
Diseases of the Heart	30%	24%
Malignant Neoplasms	22%	21%
Chronic Lower Respiratory Diseases	7%	6%
Stroke	4%	5%
Non-Transport Accidents	3%	5%
Diabetes Mellitus	3%	3%
Alzheimer's Disease	3%	3%
COVID-19	2%	3%
Suicide	2%	2%
Influenza and Pneumonia	2%	2%
All Other Causes	23%	26%

Mental and Behavioral Health

As can be seen in Table 54 above, suicide ranks as the ninth primary cause of death among both veteran and non-veteran populations at 2% of the total deaths of each group. [264]

As more women serve on the front lines, they, too, are experiencing combat trauma, which creates a new challenge – understanding how the toll of combat affects the female psyche. While men and women experience similar symptoms of trauma, such as numbing, hyperarousal, re-experiencing, and avoidance), some are more common for women. Women also experience a higher risk of sexual assault and exposure to sexual harassment (MST) during military service. An estimated 1 in 4 female veterans and 1 in 100 male veterans in the VA health care system report experiencing MST.[265] The symptoms associated with MST can include PTSD and other psychological health issues such as depression, mood disorders, and substance use disorders; difficulty with relationships and social functions; physical health problems such as chronic pain, and trouble staying focused; other medical and mental health conditions such as obesity or weight loss, chronic pulmonary disease, bipolar disorders, and eating disorders. [266]

[262] South-Paul, J.E., Lewis, E.L. (2021). Health of Veterans-Strengths and Challenges. The Journal of the American Board of Family Medicine March 2021, 34 (2) 257-263; DOI: https://doi.org/10.3122/jabfm.2021.02.210031

[263] Nevada Department of Health and Human Services. (2021). Special Surveillance Report Veteran Suicide. Retrieved from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Veteran%20Suicide%20Report%20November%202021.pdf

[264] Ibid

[265] DAV.org. Military Sexual Trauma. Retrieved from https://www.dav.org/veterans/resources/military-sexual-trauma-mst/

[266] Ibid

Ranking of Needs

Ranking of needs for this assessment was conducted through an Applied Mixed Methods methodological approach described in previous section. From a data perspective, this Needs Assessment did not incorporate new national data from the YRBS and BRFSS as those surveys were delayed in implementation and administration because of the COVID-19 Pandemic.

Without updated data to continue to monitor trend data related to previously identified needs and ranked needs from the two previous DHHS needs assessments, recent health needs assessment from Clark County and Washoe County, the state's two largest population centers, were utilized, and the authors relied on extensive collection of secondary data and information sources which are discussed in detail throughout previous sections of this needs assessment.

While statewide needs are often inclusive of data and considerations from all community types across the state, they are often driven by population density as seen with Clark County, which accounts for roughly 75% of the statewide population followed by Washoe County at approximately 15% of the population with the remaining 10% of Nevadans living in the other 15 counties many of which have less than 5,000 residents.

As presented in this Needs Assessment, the priority needs areas based on the Current Landscape data as well as rankings and input from recent qualitative report findings from the studies cited in the Community Voices section include:

- Behavioral/Mental Health and/or Substance Use and Abuse
- Access to Health Care
- Housing

Appendices

Appendix A - About the Grants Management Advisory Committee (GMAC)

The GMAC was created under Nevada Revised Statute (NRS 232.383[267]) and consists of fifteen (15) members appointed by the Director of the Department of Health and Human Services (DHHS) who represent specific populations/issue areas (detailed in the NRS language below). Funding decisions made by the GMAC are based on the Committee's charter from the State of Nevada.

The NRS informs how the GMAC functions, as well as what requests for funding are allowable and how those requests should be made to ensure funding is directed to programs that can provide a return on investment for the grant. It is notable that the statute highlights the importance of avoiding duplication in funding, and the need to determine and understand the data driven needs of local communities to set funding priorities. The Grant Management Unit (GMU) works as support to GMAC to work with agencies under the DHHS to ensure no supplanting of funds.

The specific duties and required are outlined in statute for the GMAC and for each member of GMAC to consider:

- Review requests for monetary grant awards to agencies that provide services to persons.
- Submit recommendations concerning each funding request to the Director, through the GMU.
- Adopt policies setting forth criteria for determining funding recommendations.
- Monitor monetary grant awards.
- Assist Department staff in determining the needs of local communities and in setting priorities for funding programs administered by the Department.
- Consider funding strategies for the Department, including, without limitation, seeking ways to avoid unnecessary duplication of the services for which awards of money to agencies of the State or its political subdivisions and nonprofit community organizations or educational institutions are granted, and make recommendations concerning funding strategies to the Director.
- Consider funding strategies for the Department and make recommendations concerning funding strategies to the Director.

As noted below, NRS 232.383 prescribes the makeup of the GMAC and the representation required on the Committee by members representing specific communities or community interests.[268]

[267] Chapter 232 – State Departments. NRS 232.383. Retrieved from https://www.leg.state.nv.us/nrs/nrs-232.html#NRS232Sec383
[268] Ibid

NRS 232.383: Creation; composition; prohibition on grants to entity employing member; terms of members; salary; expenses; quorum; members holding public office or employed by governmental entity; Chair; meetings; rules.

1. The Grants Management Advisory Committee is hereby created within the Department.
2. The Advisory Committee consists of the following 15 members appointed by the Director:
    a. A superintendent of a county school district or the superintendent's designee;
    b. A director of a local agency which provides services for abused or neglected children, or the director's designee;
    c. A member who possesses knowledge, skill, and experience in the provision of services to children;
    d. A representative of a department of juvenile justice services;
    e. A member who possesses knowledge, skill, and experience in the provision of services to senior citizens;
    f. Two members who possess knowledge, skill and experience in finance or in business generally;
    g. A representative of the Nevada Association of Counties;
    h. A member who possesses knowledge, skill and experience in building partnerships between the public sector and the private sector;
    i. Two members of the public who possess knowledge of or experience in the provision of services to persons or families who are disadvantaged or at risk;
    j. A member who possesses knowledge, skill and experience in the provision of services to persons with disabilities;
    k. A member who possesses knowledge, skill and experience in the provision of services relating to the cessation of the use of tobacco;
    l. A member who possesses knowledge, skill and experience in the provision of health services to children; and
    m. A representative who is a member of the Nevada Commission on Aging, created by NRS 427A.032, who must not be a Legislator.

Appendix B - Informational Data Resources

2019 Nevada State Health Needs Assessment

https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/NV_SHNA_FINAL.pdf

This report contains information regarding a wide variety of factors that influence health outcomes in individuals across all counties in Nevada. Specific data pertaining to social services contained within this report included adoption services, case management, congregate meals, counseling services, day care, education and training services, employment services, family planning services, foster care, health related and home health services, home based services, home-delivered meals, housing services, independent transitional living services, information and referral, legal services, pregnancy and parenting, prevention and intervention, protective services, recreation services, residential treatment, services for individuals with disabilities, services for youth at-risk, substance abuse services and transportation. Data regarding public health was also obtained, and included information regarding behavioral health, health behaviors and preventive care, maternal and child health, individuals with disabilities and social determinants of health (SDOH). The purpose of this assessment is to serve as a basis for future initiatives to improve public health outcomes in Nevada.

2020 Health Rankings Report - Nevada

https://www.countyhealthrankings.org/sites/default/files/media/document/CHR2020_NV.pdf

The Count Health Rankings Report, supported by the Robert Wood Johnson Foundation, displays data regarding various health outcomes for 15 counties in Nevada. Examples of specific health outcomes portrayed in the County Health Rankings include high school graduation rates, access to healthy foods, rates of smoking, children in poverty, and teen births.

American Community Survey (ACS)

https://www.census.gov/programs-surveys/acs

An ongoing survey conducted by the United States Census Bureau that collections information via mail, telephone, and in-person visits to collect data about jobs and occupations, educational attainment, veterans, whether people own or rent their home, and other topics. Unknown race/ethnicity populations were excluded from analyses.

America's Health Rankings

https://www.americashealthrankings.org

America's Health Rankings is a longstanding platform that builds on United Health Foundation's work to help draw attention to the cornerstones of public health and better understand the health of various populations. The platform provides an analysis of national health on a state-by-state basis by evaluating a historical and comprehensive set of health, environmental and socioeconomic data to determine national health benchmarks and state rankings. The platform analyzes more than 340 measures of behaviors, social and economic factors, physical environment and clinical care data. Data is based on public-use data sets, such as the U.S. Census and the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS).

Behavioral Risk Factor Surveillance System (BRFSS)

https://www.cdc.gov/brfss/index.html

BRFSS is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and healthcare access primarily related to chronic disease and injury. More than 350,000 adults are interviewed each year throughout the U.S., making the BRFSS the largest telephone health survey in the world. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors and prevalence of chronic disease. The survey consists of a set of federally grant funded core questions and the states may include and pay for their own questions in the survey. While the survey's focus is chronic disease, topics covered by the survey include car safety, obesity, and exercise among many others. The BRFSS uses a weighting system to estimate the prevalence of various chronic health indicators each year.

Centers for Disease Control and Prevention Social Vulnerability Index (SVI)

https://www.atsdr.cdc.gov/placeandhealth/svi/index.html

ATSDR's Geospatial Research, Analysis & Services Program (GRASP) created Centers for Disease Control and Prevention Social Vulnerability Index (CDC SVI or simply SVI, hereafter) to help public health officials and emergency response planners identify and map the communities that will most likely need support before, during, and after a hazardous event [8].

County Health Rankings

https://www.countyhealthrankings.org

The County Health Rankings & Roadmaps (CHR&R) program provides data, evidence, guidance, and examples to build awareness of the multiple factors that influence health and support community leaders working to improve health and increase health equity. The Rankings are unique in their ability to measure the health of nearly every county in all 50 states, and are complemented by guidance, tools, and resources designed to accelerate community learning and action. CHR&R is known for effectively translating and communicating complex data and evidence-based policy into accessible models, reports, and products that deepen the understanding of what makes communities healthy and inspires and supports improvement efforts.

Nevada Rural and Frontier Data Book – Tenth Edition

https://med.unr.edu/statewide/reports-and-publications/nevada-rural-and-frontier-health-data-book

The *Nevada Rural and Frontier Health Data Book – Tenth Edition* is a publication from the Nevada Health Workforce Research Center in the Office of Statewide Initiatives at the University of Nevada, Reno School of Medicine. This publication contains a wide range of up-to-date county-level information on the economy, social environment, population health, health workforce, and the health care delivery system.

Nevada State Demographer Office

https://tax.nv.gov/Publications/Population_Statistics_and_Reports/

The Nevada State Demographer Office is funded by the Nevada Department of Taxation and is part of the Nevada Small Business Development Center. The Demographer's Office is

responsible for conducting annual population estimates for the state of Nevada, each county, and other demographic groups. This report utilized population estimates for years 2017 – 2019, provided by the State Demographer in 2019. Unknown race/ethnicity populations were excluded from analyses.

Nevada Tomorrow

https://www.nevadatomorrow.org

Nevada Tomorrow provides a free, dynamic, easy to use, one-stop digital resource for access to community quality of life data. You will find up-to-date demographic, education, environmental, economic, health, social determinant and equity data that highlights trends, challenges and opportunities in our Nevada communities; hundreds of maps, tables and figures and promising practices.

Southern Nevada Health Assessment Report

https://www.healthysouthernnevada.org/content/sites/snhd/reports/2022Update_SNHD_CHA.pdf

This report displays various community health needs in Nevada. The purpose of this resource is to identify specific populations that may be at risk for experiencing poor health outcomes. Findings from this report helped identify the 2021 health priorities for southern Nevada, which include chronic disease, access to care, transportation, and funding. These results function as the basis of the *Community Health Improvement Plan (CHIP) from 2021-2025.*

Washoe County Community Health Needs Assessment

https://www.washoecounty.gov/health/files/data-publications-reports/2018-2020%20CHNA_FINAL.pdf

The *Washoe County Community Health Needs Assessment* serves as a platform to collect health outcomes data for several distinct purposes. This document functions as a resource for organizations working to improve social and health outcomes in Nevada, and also informed the development of two actions plans which included the *Community Health Improvement Plan*, and the *Renown Health's Community Benefit Plan.* This source displays both primary and secondary data which consists of a wide variety of specific health topics. Primary data was collected from the population of interest via public forums, focus groups, surveys, interviews and/or panel discussions. Secondary health data was obtained through trusted online survey measures including the Youth Risk Behavioral Survey (YRBS), the Behavioral Risk Factor Surveillance Survey (BRFSS), and the American Community Survey (ACS) data.

Youth Risk Behavior Surveillance System (YRBSS)

https://www.cdc.gov/healthyyouth/data/yrbs/index.htm

The YRBSS monitors priority health-risk behaviors as well as the prevalence of certain risk factors to chronic disease. Nevada's YRBSS includes a national school-based survey designed by the Centers for Disease Control and Prevention to collect data for the purposes of tracking progress toward meeting school health and health promotion program goals, support modification of school health curricula, support new legislation, and/or seek funding and other support for new initiatives.

About the Authors

Strategic Progress, LLC is a Nevada-based company specializing in public policy research and data analytics, federal grant development and strategic positioning of large-scale initiatives. This report was written for the Nevada Department of Health and Human Services, in collaboration with their leadership team.

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