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Healthcare Access and Health Outcomes in Southern Nevada

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Abstract

In a publication from the Robert Wood Johnson Foundation, it was recognized that a person's zip code was a more important predictor of health than their genetic code. Where we live influences not only our access to health care, but other health indicators as well. Clark County has a low primary care physician to population ratio compared to other counties in Nevada and in the US. Clark County also has highest rates of uninsured in the Mountain West and among the highest in the nation.

Southern Nevada fared worse than other Mountain West Metropolitan areas in health indicators and preventative care. Compared to other Mountain West Metropolitan areas of Albuquerque, NM; Boise, IA; Colorado Springs, CO; Denver, CO; Ogden, UT; Phoenix, AZ; Provo-Orem, UT; Salt Lake City, UT and Tucson, AZ, the region had the highest rate of diabetes and people reporting fair or poor health. Clark county residents had a higher rate of smoking compared to the US median. Residents were less likely to exercise and had higher rates of heavy alcohol consumption compared to other Mountain West communities. Residents reported the lowest utilization of mammography, colonoscopy, flu vaccinations (adults 65+) and pneumonia vaccinations (adults 65+) in the Mountain West.

The Black population had a higher mortality rate than other race/ethnicities in Clark County. In 2009, Clark County ranked 1st in Nevada for violent crime rates and second for property crime rates.

Introduction

Where people live has strong implications for their health. Place Matters. In building a

sustainable and health community, the focus must shift from an individualistic, medical view of health to a view that considers health within the context of the social environment and policy perspective (Wolff, 2003). This is not to say that individuals should be taken out of their own health equation as personal behavior and choice does influence health. Rather, a person's health and that of the community are products of the social environment and the choices that the individual makes as members of the community (Norris, Lampe, 1994). To address health issues in a meaningful way, consideration must be given to the relationship between health/wellness and the key components of the environment in which people live, work and play. Access to healthcare and health education are two of those key components (RWJF, 2009).

The purpose of this manuscript was to provide data regarding access to healthcare/health insurance and health indicators for Clark County, Nevada. Data on such existing conditions was then used by members of the Southern Nevada Strong team to set goals and priorities for future development of the region. The overall goal of the Southern Nevada Strong project was to develop the *Southern Nevada Regional Plan for Sustainable Development* (SNvRPSD); a single, integrated and consolidated plan that will promote and guide sustainable regional development in Southern Nevada over the next 20 years.

Methods

Regional, state, and national data sources were utilized for data collection. Data sources for the healthcare access and health outcomes included: Nevada Office of Rural Health – Nevada Rural and Frontier Health Data 2011 and 2012, Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (CDC, BRFSS) 2005 and 2010 data, County Health Rankings 2012 data, CDC's Youth Risk Behavior Surveillance System (CDC, YRBSS) 2009, U.S. Census Bureau Small Area Health Insurance Estimates 2009 data, U.S. Census, American Community Survey (ACS) 3-Year Estimate 2008-2010, U.S. Census, ACS 5 Year Estimate 2006-2010, U.S. Census Bureau Small Area Income and Poverty Estimates 2010 data, National Vital Statistics Report 2012 data and data from

Nevada State Health Division. Throughout, the Mountain West Metropolitan Areas of Albuquerque, NM; Boise, IA; Colorado Springs, CO; Denver, CO; Ogden, UT; Phoenix, AZ; Provo-Orem, UT; Salt Lake City, UT and Tucson, AZ were used for comparisons. Because Clark County and Southern Nevada are the same geographic area, they are used interchangeably throughout the manuscript. Because Clark County, Las Vegas Metropolitan Area and Southern Nevada are the same geographic area, they are used interchangeably throughout the manuscript and are referred to as 'the region'.

Results

1.1 HEALTHCARE ACCESS

Southern Nevada has a low physician to population ratio compared to other counties in Nevada and in the US. Clark County has a primary care physician to population ratio of 1:1,244 while the national benchmark for this ratio is 1:631 (County Health Rankings, 2012). Clark County has 77 licensed MD's and DO's per 100,000 population compared to 114 in Carson City and 91 in Washoe County.

In addition to having a low physician to population ratio, Clark County also has a high number of preventable hospital stays. Preventable hospital stays are measured by the hospital discharge rate for diagnoses that should have been handled in

an ambulatory setting and are calculated as a rate per 1,000 Medicare enrollees. Clark County had 61 preventable hospital stays per year while the national benchmark is 49 per year. The measure represents the population's "tendency to overuse the hospital as a main source of care" (County Health Rankings, 2012). When primary care is unavailable or inaccessible, people tend to use hospitals' emergency rooms as a source of care. This may be the case in Southern Nevada as primary care physicians have double the population to care for compared to national benchmarks.

Medically underserved areas for primary care and dentistry have been identified in the central corridor of the city and in outlying census tract (Figure 1 & Figure 2). Medically Underserved Areas or MUA are "geographic areas (contiguous county areas or smaller) that reach a certain score or lower on the Index of Medical Underservice (IMU), which is a summary of weighted values for four characteristics of these areas: 1) the ratio of primary medical care physicians per 1,000 population, 2) infant mortality rate, 3) percentage of the population with incomes below the poverty level, and 4) percentage of the population age 65 or over" (Department of Health and Human Services, 2008). In 2008, there were approximately 1,435 whole county MUAs and 1,090 counties with sub-county MUA or MUP designations in the US (Department of Health and Human Services, 2008).

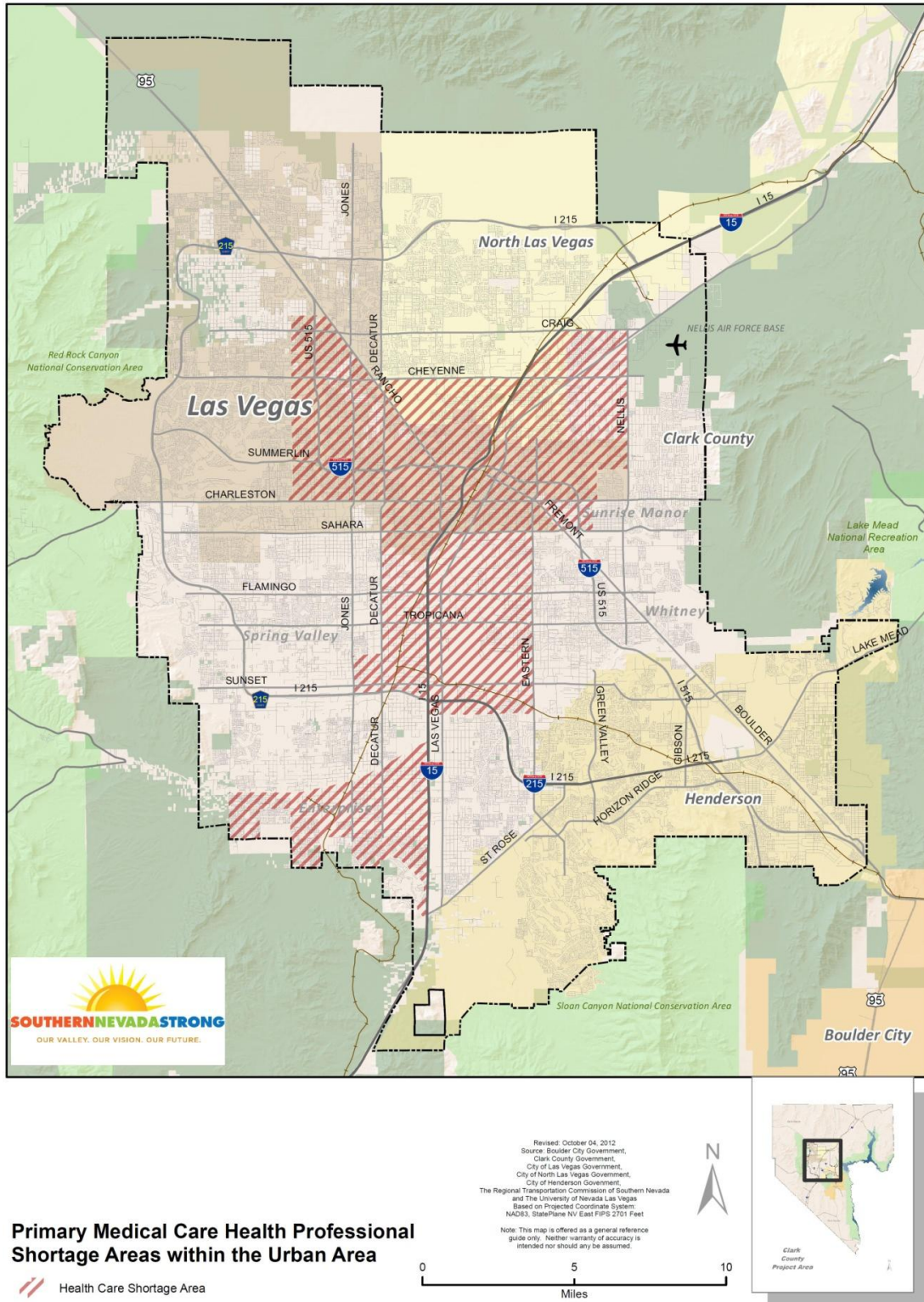


Figure 1: Primary Medical Care Shortage Areas (Nevada Office of Rural Health, 2012)

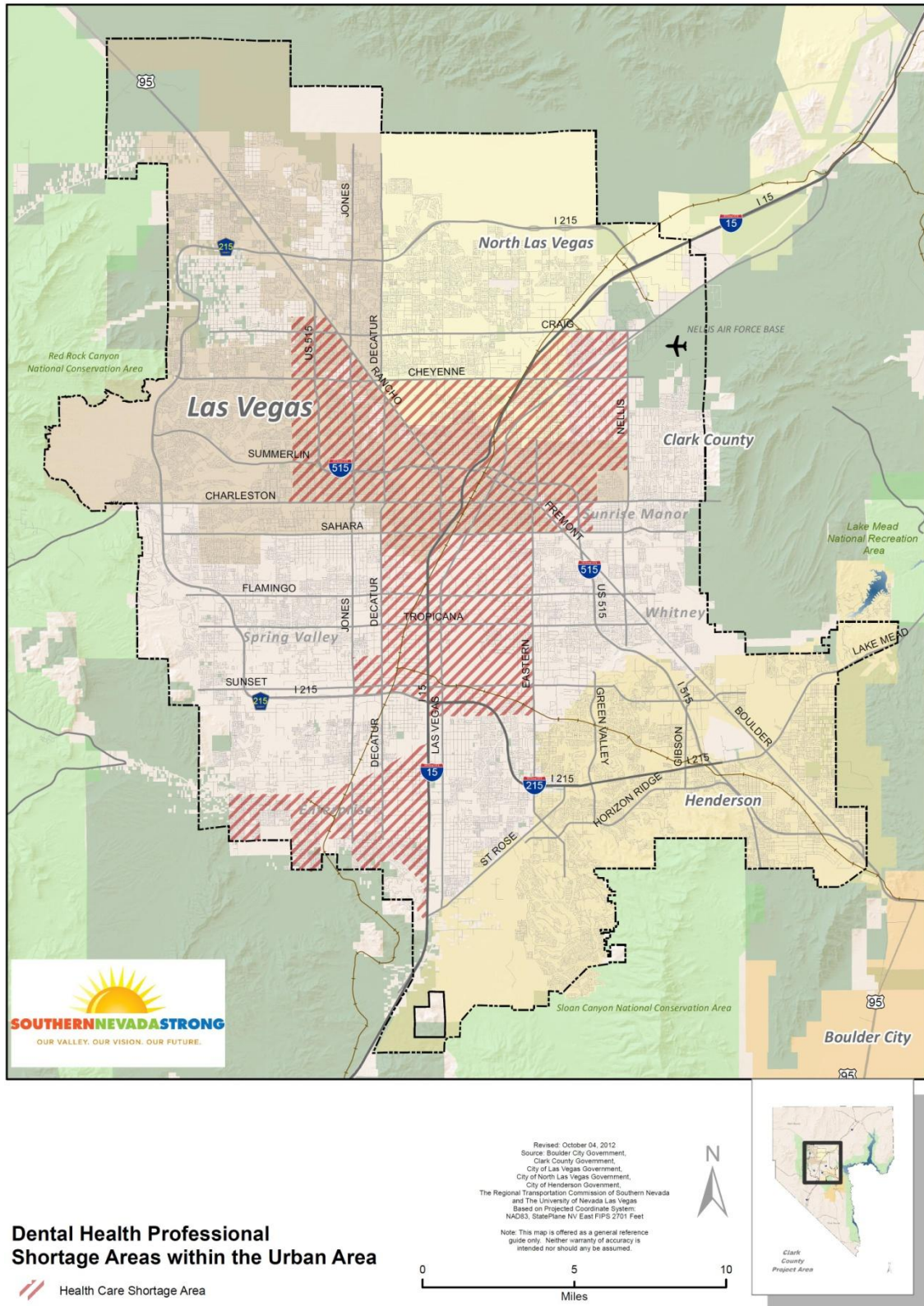


Figure 2: Dental Health Professional Shortage Areas (Nevada Office of Rural Health, 2012)

Many residents reported that they failed to seek medical care due to concerns about cost. According to the Centers for Disease Control, 18 percent of Clark County residents reported that they did not see a doctor when they needed to in the past 12 months due to cost. This percentage has increased since 2005 and remains higher than the national percentage. A

slightly higher proportion of Clark County residents had their routine medical exam in 2010 compared to 2005 (58.8 percent and 61.4 percent, respectively); however this proportion is lower than the US proportion (67.4 percent in 2010) (Table 1) (CDC, BRFSS SMART data 2010 and 2005).

Table 1:

Access to Healthcare, Clark County and US, 2005-2010 (Centers for Disease Control and Prevention, BRFSS, SMART 2005 & 2010)

	2005		2010	
	Clark County %	US %	Clark County %	US %
A time in the past 12 months when they needed to see a doctor but could not because of cost	13.3	13.5	18.0	14.6
Routine Check-up in the past 12 months	58.8	66.3	61.4	67.4
Visited a dentist, dental hygienist or dental clinic within the past year	64.8	67.4	68.3	69.5

The region's adults have lower rates of health insurance coverage than those in the Mountain West and the nation as a whole. According to the US Census Bureau, in 2009, 24.9 percent of Southern Nevada's residents under age 65 had no health insurance, while 18.1 percent under age 19 had no insurance. These are some of the highest rates in the nation and the highest rates compared to other

metropolitan areas in the Mountain West (Table 2). The US average for uninsured in 2009 was 17 percent for people under 65. Nevada's rate for uninsured is double California's rate. By comparison: Massachusetts has the lowest rates: 4.5 percent of people under 65, and only 2.4 percent of those under 18 (NPR, 2009).

Table 2:

Comparison of Percent Uninsured Between Mountain West Cities, 2010 (U.S. Census Bureau Small Area Health Insurance Estimates, 2009; *U.S. Census, ACS 3-Year Estimate, 2008-2010)

City, State (MSA)	Uninsured < 65 years	Uninsured < 19 years
Albuquerque, NM (MSA)	19.8%	10.6%
Denver, CO (MSA)	21.6%	12.9%
Las Vegas, NV (MSA)	24.9%	18.1%
Phoenix (MSA)	20.2%	12.8%
Salt Lake City, UT (MSA)	17%	11.4%
US Average*	15.1%	8.6%

Enrollment in Nevada state healthcare programs has increased since 2002. There was a 70.1 percent increase in Medicaid enrollment and a 23.8 percent increase in Nevada Check-ups in Clark County since 2002. Clark County and Nevada both saw increases

in the percentage of Medicaid and Nevada Check-up enrollments in 2010 compared to 2002. The percent change was more dramatic in Clark County with 23.8 percent change in Nevada Check-ups compared to 8.6 percent increase in Nevada (Table 3).

Table 3:

Enrollment in Nevada Medicaid and Nevada Check-up (Nevada Office of Rural Health, 2011)

	Clark County	Nevada
Medicaid Enrollment - % of population, 2010	12.7%	12.3%
% change in Medicaid enrollment 2002 to 2010	70.1%	63.1%
Nevada Check-up - % of population, 2010	4.6%	4.8%
% change in Nevada Check-up enrollment '02 to '10	23.8%	8.6%

Middle-income households are more likely to be uninsured than lower-income households. The percentage of uninsured between 19 and 65 years of age escalates with an increase in the family income (or a higher percentage of the federal poverty level). In 2009, 21.9 percent of Southern Nevada’s residents under the age of 65 and 16.9 percent under the age of 19 in households earning \$88,200/year or less for a family of four (400 percent of the federal poverty level) were uninsured. In comparison, 9.5 percent of residents under the age of 65 were uninsured. Almost seven percent of children under the age of 19 in households earning \$30,429/year or less for a family of four (138 percent above federal poverty

level) were uninsured. With each incremental increase in income, the percent of uninsured is higher (Table 4). Nevada Medicaid and Nevada Check-up are programs which provide health insurance for many low-income families. In Southern Nevada and in the nation, there has been an increase in the number of ‘working uninsured’. Working uninsured consists of people who do not qualify for government assistance because their income exceeds the standards; however, they 1) cannot afford the premiums of their employer sponsored plan or 2) their employer does not offer health insurance and they cannot afford an individual plan (Henry J. Kaiser Family Foundation, 2013).

Table 4:

Uninsured by Percent Federal Poverty Level in Clark County (U.S. Census Bureau Small Area Health Insurance Estimates, 2009)

Clark County Uninsured	% Uninsured < 65 years	% Uninsured < 19 years
All residents without health insurance coverage	24.9%	18.1%
Family of 4 at or below \$30,429 annual income (138% of federal poverty level*)	9.5%	7.9%
Family of 4 at or below \$44,100 annual income (200% of federal poverty level*)	14.1%	11.7%
Family of 4 at or below \$55,125 annual income (250% of federal poverty level*)	16.9%	13.9%
Family of 4 at or below \$88,200 (400% of federal poverty level*)	21.9%	16.9%

*2009 federal poverty level: one person = \$10,830, two person family = \$14,570, family of three = \$18,310, family of four: \$22,050

The Patient Protection and Affordable Care Act (PPACA) will extend Medicaid coverage to adults under the age of 65 with incomes equal to or less than 133 percent of the federal poverty level. Projection for Nevada by the Kaiser Commission show that the PPACA could decrease the number of uninsured adults living at 133 percent of the federal poverty level or lower by 47 to 72.7 percent in 2019 based on the model utilized. Medicaid enrollment is projected to increase by 61.7 to 88.6 percent in 2019 compared to the baseline in 2009 based different projection models. State spending on Medicaid would increase by 2.9 to 5.2 percent while federal spending would increase by 49.8 to 59.3 percent, again, based on the Kaiser’s projection model (Kaiser Commission, 2010).

1.2 HEALTHY PEOPLE

Compared to Mountain West Counties and the US, Clark County’s rates of poverty are average. Research has established a link between income and health (Marmott, 2006). People who live in poverty have a greater risk of unhealthy behaviors and chronic diseases (Marmott, 2006). In 2010, 15 percent of Clark County residents were living in poverty. However, 22.2 percent of families with children under the age of 18 were living in poverty (Table 5). This impacts a family’s ability to provide healthy food, safe shelter and access to pediatric health care for children, which could ultimately increase the risk of health problems and risky health behaviors in adulthood (Marmott, 2006).

Table 5:

Comparison of Population Living in Poverty Between Mountain West Cities, 2010 (U.S. Census Bureau Small Area Income and Poverty Estimates, 2010).

City, State (County)	All Ages	Under 18 living in family in poverty	5-17 living in family in poverty	Median Household Income
Albuquerque, NM (Bernalillo)	16.4%	23.9%	22.5%	\$47,405
Denver, CO (Denver)	21.3%	30.8%	27.3%	\$45,415
Las Vegas, NV (Clark)	15%	22.2%	20.1%	\$51,427
Phoenix (Maricopa)	16.6%	23.5%	21.5%	\$50,424
Salt Lake City, UT (Salt Lake)	13.7%	17.8%	16.3%	\$56,664
US Average	15.3%	21.6%	19.8%	\$50,046

Compared to other Mountain West Metropolitan areas, Clark County had the highest rates of diabetes and people reporting fair or poor health. In the region, 9 percent of people reported being diagnosed with diabetes and 17.4 percent of the residents rated their general health as fair or poor; these rates were the highest in the Mountain West. Rates of diabetes increased from 7.2 percent in 2005 to 9 percent in

2010. Compared to other Mountain West Metropolitan Areas, Southern Nevada had similar rates of asthma and people reporting disabilities; however, rates of asthma did increase in 2010 compared to 2005. The region had the second highest rate of coronary artery disease (CAD). However, this rate was lower than the US average (CDC, BRFSS, SMART 2010, 2005).

Table 6:

Comparison of Chronic Disease and Conditions Between Mountain West Cities, 2010 (Centers for Disease Control and Prevention, BRFSS SMART data 2010, *2005)

City, State (MSA) 2010	Diabetes	Asthma	CAD	Fair or Poor Health	People with Disability
Denver, CO (MSA)	5.4%	9.9%	2.8%	9.8%	18.9%
Las Vegas, NV (MSA)	9%	9.3%	3.9%	17.4%	19.8%
Phoenix (MSA)	7.1%	9.6%	3.6%	13.1%	18.3%
Salt Lake City, UT (MSA)	6.6%	10.1%	2.8%	12.3%	19.4%
US Average	8.7%	9.1%	4.1%	14.7%	21.2%
Las Vegas, NV (MSA), 2005*	7.2%	6.8%	4.4%**	17%	19%

Southern Nevada’s adult residents have higher chronic disease risk factors than other Mountain West regions. Southern Nevada residents were less likely

to exercise compared to other Mountain West communities and had high rates of heavy alcohol consumption, tied for first with Denver although, for

both of these behaviors, the rates improved in the region since 2005 (CDC BRFSS, SMART 2010, 2005). In 2009, 22.1 percent of Southern Nevada residents were smokers compared to the US median of 17.3 percent (CDC, BRFSS, 2011). Nevada's rate

for smoking is the highest of any Western state, and among the top 8 highest rates of any state (Centers for Disease Control, 2011). Nevada's \$0.80 per pack cigarette tax ranks 34th among US states (CDC, 2011).

Table 7:

Comparison of Chronic Disease Risk Factors Between Mountain West Cities, 2010 (Centers for Disease Control and Prevention, BRFSS SMART data 2010, 2005, *2009)

City, State (MSA), 2010	Heavy Drinker	Current Smoker	Overweight	Obese	Exercise	5 Servings Fruit/Veg*
Denver, CO (MSA)	5.1%	14.6%	37.4%	19.6%	83.8%	24.3%
Las Vegas, NV (MSA)	5.1%	22.1%	37.3%	23.1%	76.3%	23.9%
Phoenix (MSA)	4.5%	14.8%	41.1%	22.8%	81.5%	23.6%
Salt Lake City, UT (MSA)	4%	10.8%	34.6%	23.6%	81.7%	23.2%
US Average	5.0%	17.3%	36.2%	27.5%	76.1%	23.4%
Las Vegas, NV (MSA) 2005	6.5%	23.5%	37.1%	21%	71.3%	

Southern Nevada's youth have higher rates of risky behaviors than other Mountain West regions. *Youth Risk Behavior Survey* is conducted annually by the Centers for Disease control and prevention. The survey includes national and Clark County data monitoring six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and young adults enrolled in grades 9 – 12 at the time of the survey including: tobacco use, alcohol and other drug use, sexual risk behaviors, unhealthy dietary behavior and physical inactivity. Results from the 2009 survey appear in Table 8. In Clark County, 15.4% of youth reported smoking at least one day in the past 30 days compared to 19.5 percent of national youth. Among students who currently smoke, 8.9 percent of Clark County children smoke 10 or more cigarettes per day compared to 7.8 percent of students in the nation. 4.2 percent of the region's students report using chewing tobacco, snuff or dip compared to 8.9 percent of students in the nation. Fewer Clark County students reported drinking at least one alcoholic drink within the last 30 days (36.7 percent) compared to the

national students (41.8 percent). Almost forty-eight percent (47.8) of the region's students reported that they have had sex and 37 percent reported that they did not use a condom during their last sexual intercourse, neither of which were significantly different than national students. Fewer Clark County students reported being physically active for 60 minutes, 5 days per week (57.6 percent) compared to National averages (63 percent). More students reported eating 5 or more servings of fruit and vegetables (82.5 percent) compared to national students (77.7 percent). Twelve percent of all students were considered to be obese however 12.9 percent in Clark County of the region's students were considered to be overweight, whereas 15.8 percent of national students were considered to be overweight. More high school students in Clark County had been offered, sold or given illegal drugs at school (38.8 percent) or have ever used methamphetamines (5.9 percent) compared to the nation (22.7 percent and 4.1 percent, respectively); however, Clark County students were not significantly more likely to use marijuana, cocaine or inhalants. The region's

students were more likely to have seriously considered (18.2 percent) or attempted (10.0 percent) suicide than students in the nation (13.8 percent and 6.3 percent, respectively). Clark County is greatly impacted by suicide when considering both adolescents and adults. Because of the high number of suicides, several suicide prevention efforts have been established by the Office of Suicide Prevention. These include: Early Identification, Intervention and Prevention of Suicide; a Suicide Prevention Hotline which had 28,051 calls in 2009 and 29,370 calls in

2010; Suicide Prevention Awareness, Education and Training through which over 900 Nevadans have been trained in the Applied Suicide Intervention Skills Training (ASIST) and over 8,000 have been trained in NV Gatekeeper Training Awareness, Prevention and Postvention programs; and an Increase in number of local or regional groups that collaborate with the Office of Suicide Prevention to implement the state plan (Office of Suicide Prevention, 2011).

Table 8:

Risky Health Behaviors of High School Students, Clark County and the Nation (CDC, Youth Risk Behavior Surveillance System, 2009)

	Clark County	National
Smoking at least 1 day in past 30	15.4	19.5
Currently smoke 10 or more per day	8.9	7.8
Chew tobacco	4.2	8.9
Currently use marijuana	20.5	20.8
Ever used cocaine	7.7	6.4
Ever used inhalants	12.4	11.7
Ever used methamphetamines	5.9	4.1
Offered, sold, given illegal drugs at school	38.8	22.7
Overweight	12.9	15.8
Obese	12.3	12.0
1 alcoholic drink in past 30 days	36.7	41.8
Ever had sex	47.8	46.0
Did not use condom during last intercourse	37	38.9
Physically active 60 minutes, 5 days/week	57.6	63
Eating 5 or more fruit & vegetables	82.5	77.7
Seriously considered suicide	18.2	13.8
Attempted suicide	10.0	6.3

Southern Nevada residents reported the lowest utilization of mammography, colonoscopy, flu vaccinations (65+) and pneumonia vaccinations (65+) in the Mountain West and the second lowest

utilization of Papanicolaou (Pap) test. Compared to 2005, Southern Nevada residents' utilization of colonoscopy, flu vaccination (65+) and pneumonia vaccination (65+) were higher in 2009 (Table 9).

Table 9:

Comparison of Preventative Care Utilization Between Mountain West Cities, 2010 (Centers for Disease Control and Prevention, BRFSS SMART data 2010)

City, State (County)	Pap test 18+ Past 3 yrs	Mammogram 50+ Past 2 yrs	PSA 40+ Past 2 yrs	Colono- scopy 50+ Ever	Flu 65+ Past yr	Pneumonia 65+ Ever
Albuquerque, NM (MSA)	83.6	79.4	54.6	65.7	74	72.8
Boise, ID (ADA)	77.1	71.7	50.5	62.2	61.6	70.2
Colorado Springs, CO (MSA)	77.5	77.7	46.8	65.3	69.5	72.3
Denver, CO (MSA)	81.3	73.6	50.5	67.5	76.4	75.7
Las Vegas, NV (MSA)	79	69.9	51.6	60.5	59.4	64
Ogden, UT (MSA)	76.4	74	53.2	72.6	71.4	65.2
Phoenix (MSA)	83.3	78.6	51.8	64.4	68.8	73.7
Provo-Orem, UT (MSA)	63.3	73.3	48.4	68.9	64.4	68
Salt Lake City, UT (MSA)	78.8	72.2	49.9	71.5	70.2	73.6
Tucson, AZ (MSA)	84.9	79.6	56.2	71.1	69.1	75.3
U.S. average	81.3	77.9	53.2	65.2	67.5	68.8
Las Vegas, NV (MSA) 2005	82.9	74.1	53	55	54.1	69.5

Heart disease and cancer are the leading causes of death in Southern Nevada. The ten leading causes of death in Southern Nevada and in the Nation are listed in Table 10. The top 3 causes of death in Clark County and the Nation were the same in 2008 (heart disease, malignant neoplasm, and chronic lower

respiratory disease). Clark County residents were more likely to die from lung cancer, pedestrian deaths, prostate and breast cancers (Nevada State Office of Rural Health, 2011, CDC, National Vital Statistics, 2009).

Table 10:

Top 10 Leading Causes of Death in Clark County and the Nation, 2008 (Nevada State Office of Rural Health, 2011, CDC, National Vital Statistics, 2009)

	Clark County	Nation
1	Heart Disease	Heart Disease
2	Malignant Neoplasm	Malignant Neoplasm
3	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease
4	Lung Cancer	Stroke
5	Stroke	Accident (unintentional injury)
6	Pedestrian Deaths	Alzheimer's disease
7	Prostate Cancer	Diabetes
8	Breast Cancer	Flu and pneumonia
9	Kidney Disease	Kidney Disease
10	Flu and Pneumonia	Intentional self-harm (suicide)

Age adjusted mortality rate is lower in Clark County than Nevada as a whole (782.2 per 100,000 compared to 808.1 per 100,000) in 2008. The black population had a higher age adjusted mortality rate than other race/ethnicities in Clark County, Nevada and the

Nation (Table 11) (Nevada State Health Division 2008, CDC, 2008). In 2009, Nevada had a higher mortality rate than any other Mountain West State (Table 12) (CDC, National Vital Statistics, 2009).

Table 11:

Comparison of Mortality Rates for Clark County, Nevada and the Nation by Race/Ethnicity, 2008 (Nevada State Office of Rural Health, 2011; CDC, National Vital Statistics, 2009)

Rate per 100,000 people			
	Clark County	Nevada	Nation
White	783.9	818.4	751.2
Black	1032.8	1034.7	942.6
Native American	493.8	650.3	625.3
Asian	701.2	690.7	409.7
Hispanic	723.2	684.5	530.7
Total	782.2	808.1	760.3

Table 12:

Comparison of Age Adjusted Mortality Rates Between Mountain West States, 2009 (CDC, National Vital Statistics, 2009)

Location	Age Adjusted Mortality Rate per 100,000 People
Nevada	789.6
Utah	699.0
Colorado	677.8
New Mexico	748.0
Arizona	688.9
Idaho	744.9
US	740.0

In 2009, Clark County ranked 1st of Nevada Counties for violent crimes (786.1 /100,000) and second for property crimes (3,059.2 /100,000 population) (Nevada State Office of Rural Health, 2011). Clark County remains above the national violent crime rate in 2009 which was 429.4 / 100,000 and parity with that national property crime rate was 3,036 / 100,000 (US Department of Justice, 2009)

Discussion

Compared to other Mountain West cities and the Nation, Southern Nevadans have poorer access to healthcare and health indicators. A high percentage of residents lack health insurance and access to primary care physicians. It is hoped that expansion of Medicaid coverage through the Patient Protection and Affordable Care Act will reduce the number of people without health insurance in Southern Nevada. Additionally, providing incentive for primary care physicians to locate in the region, specifically in MUA, could improve access to primary care physicians and lower the physician to population ratio. Improved transportation to medical care facilities could also make medical care more accessible. Expanded access to health insurance and health care could increase the number of Southern Nevadans who receive preventative services on a regular basis.

Southern Nevadans are less likely to be physically active and more likely to have chronic diseases and risk factors attributed to physical inactivity such as coronary artery disease, obesity and

diabetes. Efforts to promote neighborhoods that encourage healthy behaviors could improve the quality of life and reduce chronic diseases in Southern Nevada. These include improved walkability and an increase parks and recreation facilities in underserved areas, and improved access to healthy food.

As part of Southern Nevada Strong Sustainable Communities Planning Grant project, six task groups made up of subject matter experts were formed. Subject matter experts came from the public, non-profit and private sectors from across the valley. The task groups included: Healthy Communities, Economic Development and Education, Transportation, Housing, the Environment and Public Engagement and Equity. The Healthy Communities group used the above information as well as their experience and expertise to identify goals to be included in the *Southern Nevada Regional Plan for Sustainable Development (SNvRPSD)*. The SNvRPSD will be a single, integrated and consolidated plan that will promote and guide sustainable regional development in Southern Nevada over the next 20 years. Goals and strategies formulated to address access to health care and health outcomes in Southern Nevada included:

Goal 1. Improve access to healthcare and community services.

Objective 1.1. Improve transportation access to healthcare.

- Strategy 1.1.1. Encourage the development of primary care offices, healthcare and health-related facilities, especially in mixed-use areas and locations that are well-served by transit.
- Strategy 1.1.2. Improve transportation access to affordable, high-quality preventive care and treatment services.
- Strategy 1.1.3. Work with service providers to locate new health and social services facilities in locations that are underserved.
- Strategy 1.1.4. Encourage the co-location of healthcare and behavioral health services to increase access to care. Support the development of a one-stop shop or resource center for all types of social services, including an employment opportunity center.

Goal 2. Improve access to affordable and healthy food options.

- Strategy 2.1.1. Identify public land, co-location opportunities, or private land to increase the development of urban agriculture, community gardens, and farmer's markets.
- Strategy 2.1.2. Promote healthy food options in areas with especially high fast food densities, such as low income communities.
- Strategy 2.1.3. Support land use incentives (e.g. building upgrades or expansions) for healthy food outlets and those that incorporate locally sourced foods.
- Strategy 2.1.4. Support the furtherance of *Food Security in Nevada, Nevada's Plan for*

Action, to reduce food insecurity in Southern Nevada.

Strategy 2.1.5. Increase the outlets where Supplemental Nutritional Program (SNAP) benefits are available.

Strategy 2.1.6. Support local municipalities processes of increasing access to healthy foods through grocery stores and farmers markets (example of local food access policy: Las Vegas Food Access Policy Guide)

Goal 3. Promote neighborhoods that encourage healthy behaviors.

Objective 3.1. Support the creation of multi-modal transportation systems that support active living and healthy lifestyles

- Strategy 3.1.1. Promote mixed-use, walkable neighborhoods and parks and recreation facilities in areas that are underserved.
- Strategy 3.1.2. Improve safety, access and visibility for pedestrians and cyclists (See Transportation Component).
- Strategy 3.1.3. Using the preferred alternative, highlight opportunities to concentrate development in existing communities to make more cohesive, connected neighborhoods.
- Strategy 3.1.4. Encourage the development of design standards or land use policies that require the retrofitting of low-income or at-risk communities to include the basic attributes (sidewalks, lighting, street trees) for a walkable community.
- Strategy 3.1.5. To reduce pedestrian/vehicular conflicts along corridors in close proximity to schools, goods and services, identify and implement traffic calming measures or new design techniques for roadways, sidewalks, bike paths, and intersections.

Strategy 3.1.6. Incorporate Safe Routes to School concepts within comprehensive plans or development codes.

Strategy 3.1.7. Promote adoption of RTC Complete Streets design manual standards.

Objective 3.2. Increase awareness of public health issues at the neighborhood scale.

Strategy 3.2.1. Align land use planning practices to promote positive health outcomes in such as vibrant and livable neighborhoods, a diverse mix of uses, healthy and nutritious food access, reduced air pollution, physical activity, complete streets, and more local jobs.

These goals and strategies will be included in the Regional Plan which is the final deliverable to HUD for the planning grant. The next step after completing the planning grant will be to apply for the HUD Sustainable Community Implementation Grant to implement the goal and strategies outlined above. Only entities that received the planning grant can apply for the implementation grant and the awarded amounts are projected to be fifty to one-hundred million dollars

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References

Centers for Disease Control and Prevention.(2010). BRFSS. SMART, Albuquerque 2010. Retrieved August 19th, 2012 from

- <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=2&yr2=2010&VarRepost=Y&cat=XX#XX>
- Centers for Disease Control and Prevention.(2010). BRFSS. SMART, Boise 2010. Retrieved August 19th, 2012 from <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=10&yr2=2010&VarRepost=Y&cat=XX#XX>
- Centers for Disease Control and Prevention.(2010). BRFSS. SMART, Colorado Springs 2010. Retrieved August 19th, 2012 from <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=128&yr2=2010&VarRepost=Y&cat=XX#XX>
- Centers for Disease Control and Prevention.(2010). BRFSS. SMART, Denver 2010. Retrieved August 19th, 2012 from <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=24&yr2=2010&VarRepost=Y&cat=XX#XX>
- Centers for Disease Control and Prevention.(2005). BRFSS. SMART, Las Vegas 2005. Retrieved August 19th, 2012 from <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=46&yr2=2005&VarRepost=&cat=XX#XX>
- Centers for Disease Control and Prevention.(2010). BRFSS. SMART, Las Vegas 2010. Retrieved August 19th, 2012 from <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=46&yr2=2010&VarRepost=Y&cat=XX#XX>
- Centers for Disease Control and Prevention.(2010). BRFSS. SMART, Ogden 2010. Retrieved August 19th, 2012 from <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=63&yr2=2010&VarRepost=Y&cat=XX#XX>
- Centers for Disease Control and Prevention.(2010). BRFSS. SMART, Phoenix 2010. Retrieved August 19th, 2012 from <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=68&yr2=2010&VarRepost=Y&cat=XX#XX>
- Centers for Disease Control and Prevention.(2010). BRFSS. SMART, Provo 2010. Retrieved August 19th, 2012 from <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=140&yr2=2010&VarRepost=Y&cat=XX#XX>
- Centers for Disease Control and Prevention.(2010). BRFSS. SMART, Salt Lake City 2010. Retrieved August 19th, 2012 from <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=78&yr2=2010&VarRepost=Y&cat=XX#XX>
- Centers for Disease Control and Prevention.(2010). BRFSS. SMART, Tucson City 2010. Retrieved August 19th, 2012 from <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=88&yr2=2010&VarRepost=Y&cat=XX#XX>
- Centers for Disease Control and Prevention.(2005). BRFSS. SMART, US 2005. Retrieved August 19th, 2012 from <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=All&yr2=2005&VarRepost=Y&cat=XX#XX>
- Centers for Disease Control and Prevention.(2010). BRFSS. SMART, US 2010. Retrieved August 19th, 2012 from <http://apps.nccd.cdc.gov/BRFSS-SMART/SelQuestion.asp?MMSA=All&yr2=2010&VarRepost=Y&cat=XX#XX>
- Centers for Disease Control and Prevention (2009). National Vital Statistics. Retrieved August 19th, 2012 from <http://www.cdc.gov/nchs/deaths.htm>
- Centers for Disease Control and Prevention (2011). Smoking and Tobacco. Retrieved August 19th, 2012 from http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2010/states/nevada/index.htm
- Centers for Disease Control and Prevention. Youth Risk Behavior Survey 2009. Retrieved August 19th, 2012 from <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5905a1.htm>

- County Health Rankings (2012). Clark County, Nevada. Available at:
<http://www.countyhealthrankings.org/#app/nevada/2012/clark/county/1/overall>
- Department of Conservation and Natural Resources. (2012). The Big Bend in the Colorado State Park. Retrieved November 1, 2012 from
<http://parks.nv.gov/parks/big-bend-of-the-colorado-state-recreation-area/>
- Department of Health and Human Services. (2008). Designation of Medically Underserved Populations and Health Professional Shortage Areas. Retrieved October 11, 2012 from
http://www.acponline.org/acp_policy/letters/medically_underserved_populations_2008.pdf
- Henry J. Kaiser Family Foundation.(2013). The Uninsured: A Primer - Key Facts about Health Insurance on the Eve of Coverage Expansions. Retrieved February 4, 2014 from <http://kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-on-the-eve-of-coverage-expansions/>
- Kaiser Commission on Medicaid and the Uninsured. Medicaid Coverage and Spending in Health Reform. Retrieved December 3rd, 2012 from
<http://www.kff.org/medicaid/index.cfm>
- Marmot, M. G., & Wilkinson, R. G. (2006). *Social determinants of health* Oxford University Press, USA.
- Norris, T & Lampe, D. (1994). Healthy Communities, Healthy People: A Challenge of Coordination and Compassion. *National Civic Review*. 83(3). 280-289.
- National Public Radio. (2009). The Uninsured: Rates by State and Congressional District. Retrieved October 16, 2012 from
<http://www.npr.org/templates/story/story.php?storyId=113042669>
- Nevada State Office of Rural Health. Nevada Rural and Frontier Health Data Book, 2011 edition. (2011). Retrieved August 19th, 2012 from
<http://www.medicine.nevada.edu/CEHSO/databk11/NevadaRuralFrontierDataBook2011.pdf>
- Office of Suicide Prevention (2011). Suicide in Nevada Fact Sheet 2011. Retrieved March 3, 2014 from
<http://dhhs.nv.gov/Suicide/DOCS/Factsheet2011Final.pdf>
- Robert Woods Johnson Foundation. (2009). Commission on Building a Healthier American. Retrieved August 19th, 2012 from
<http://www.commissiononhealth.org>.
- US Census, American Community Survey 3-year Estimate – 2008-2010. Retrieved June 20th 2012 from
<http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>
- US Census, American Community Survey 5-year Estimate – 2006-2010. Retrieved June 20th 2012 from
<http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>
- U.S. Census Bureau Small Area Health Insurance Estimates (2009). Retrieved August 19th, 2012 from
<http://www.census.gov/did/www/sahie/index.html>
- U.S. Census Bureau Small Area Income and Poverty Estimates (2010). Retrieved August 19th, 2012 from <http://www.census.gov/cgi-bin/saie/saie.cgi>
- U.S. Census Bureau. (2012). 2010 Census urban area facts. Retrieved September 4, 2012 from
<http://www.census.gov/geo/www/ua/uafacts.html>
- US Department of Justice. Crime in the United States (2009). Retrieved August 19th, 2012 from
http://www2.fbi.gov/ucr/cius2009/offenses/property_crime/index.html

Wolff, T. (2003). The Healthy Communities
Movement: A Time for Transformation.
National Civic Review. 92(2). 95-111.