Nevada Office of Minority Health and Equity (NOMHE)
Update on Nevada's Health Disparities, 2020
Prepared for Nevada State Legislature, July 2020

Health: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Health Disparities: preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

Health Equity: the realization by all people of the highest attainable level of health.

NOMHE's mission is: 1) to improve the quality of health care services for members of minority groups; 2) to increase access to health care services for members of minority groups; and 3) to disseminate information to, and to educate the public on, matters concerning health care issues of members of minority groups.

NOMHE promotes embedding health equity as a guiding priority in systems to combat health disparities. NOMHE supports improved data collection and use of statistical findings in conjunction with input from community alliances, policy makers and programmatic service providers to address health disparities.

The following information has been compiled to present an overview of health disparities facing Nevada with comparisons to national indicators and including their impact on the distribution of the state's COVID-19 cases.

Where Does Nevada Rank?

The United Health Foundation publishes the America's Health Rankings Annual Report (https://bit.ly/2VQZmbR). The Foundation conducts a state by state assessment of health based on behaviors, community and environment, policy, clinical care and outcomes. The report ranked Nevada 35th in the nation in 2019. The state's noted strengths are low prevalence of obesity, high HPV immunization coverage among adolescents and low percentage of children in poverty. Its challenges are high violent crime rate, low rate of primary care physicians, and high cardiovascular death rate.

Nationally, the occurrence of diabetes was found to be at its highest levels in the Foundation's reporting history. Chronic diseases, such as diabetes, often create a potentially fatal co-morbidity dynamic, especially within minority populations.

Where Nevada's Minority Populations Rank

According to the *2019 Nevada Minority Health Report*, Nevada's population in 2017 was comprised of a white majority, with the rest of the population comprising: 29.0% Hispanic, 9.4% Asian/Pacific Islander (API), 8.7% Black, and 1.2% American Indian/Alaska Native (AI/AN). In 2017, chronic diseases represented six of the top ten leading causes of death in Nevada. Because of their pervasive nature, chronic disease, particularly within vulnerable populations, can exacerbate disparities. Nevada's Behavioral Risk Factor Surveillance System (BRFSS) 2017 Report (https://bit.ly/2YZQJ0w) allows its user to monitor and assess the prevalence of chronic disease. The examination of chronic conditions by different demographic characteristics helps identify potential disparities in health-related behaviors.

While the United Health Foundation's identification of higher national rates of diabetes to the disease's prevalence in Nevada (10.9% compared to 9.1%, respectively), the BRFSS found the prevalence of diabetes was highest among Black non-Hispanic persons at 16.7%.

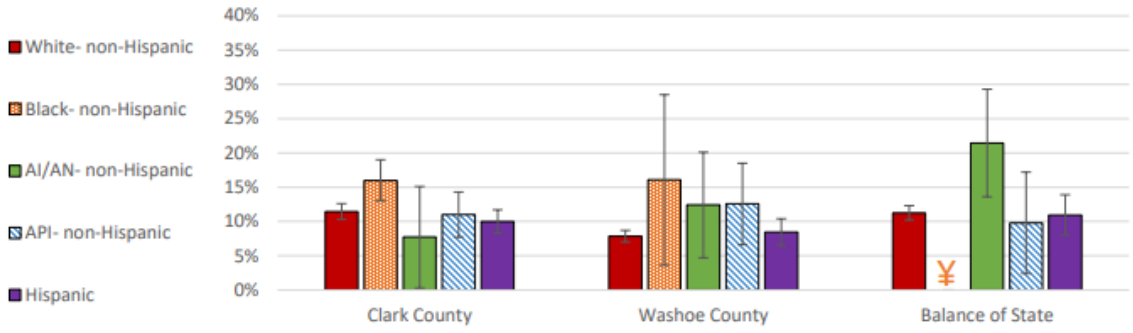
This prevalence was demonstrated in the **2019 Nevada Minority Health Report** (https://bit.ly/3iIO43o). The following graph shows the disease's occurrence across all categories of race.

Figure 46. Adults Who Have Been Told They Have Diabetes – Prevalence by Race/Ethnicity, Nevada, 2017

Race /Ethnicity:	White (non-Hispanic)	Black (non-Hispanic)	AI/AN (non-Hispanic)	API (non-Hispanic)	Hispanic
Percent (95% C.I.)	10.8% (9.1-12.5)	16.7% (10.9-22.5)	14.2% (3.8-24.6)	14.2% (6.5-21.9)	9.9% (6.9-12.9)

Source: Nevada Behavioral Risk Factor Surveillance System (BRFSS).
Note: Graph scaled to 30% to display difference between groups.

Figure 47. Adults Who Have Been Told They Have Diabetes – Prevalence by Race/Ethnicity and Region, 2013-2017, Aggregated



Race/Ethnicity:	Clark County	Washoe County	Balance of State
White-non-Hispanic	11.4% (10.3-12.6)	7.8% (7.0-8.7)	11.3% (10.2-12.3)
Black-non-Hispanic	16.0% (13.0-19.0)	16.1% (3.6-28.5)	¥
AI/AN-non-Hispanic	7.7% (0.3-15.1)	12.4% (3.6-28.5)	21.5% (13.6-29.3)
API-non-Hispanic	11.0% (7.7-14.3)	12.6% (6.6-18.5)	9.8% (2.4-17.2)
Hispanic	10.0% (8.3-11.7)	8.5% (6.5-10.4)	10.9% (8.0-13.9)

Source: Nevada Behavioral Risk Factor Surveillance System (BRFSS). Multiple years were combined in order to achieve at least 50 respondents.
¥: Prevalence estimate suppressed when the unweighted sample size for the denominator was <50.
Note: Graph scaled to 40% to display difference between groups.

Additional Disparities Among Categories of Chronic Disease Highlighted by the 2017 BRFSS Report

- the prevalence of high cholesterol was highest among Asian/Pacific Islander non-Hispanic persons at 36.9%
- the prevalence of arthritis was highest among American Indian/Alaska Native non-Hispanic person at 28.8%
- the prevalence of Chronic Obstructive Pulmonary Disorder (COPD) was highest among Black non-Hispanic persons at 13.1%

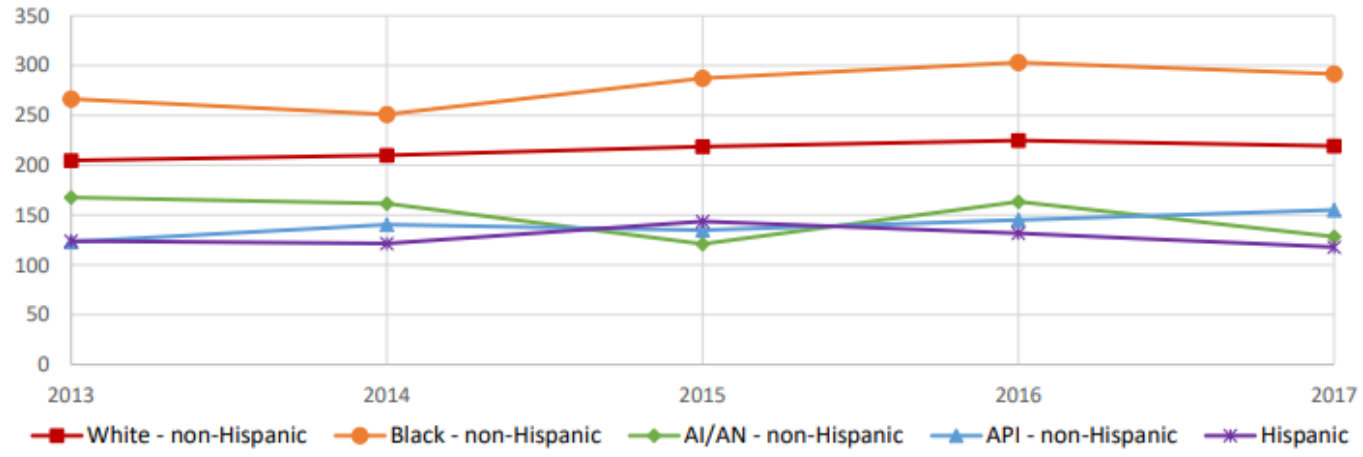
Additional Disparities Among Categories of Mental Health Highlighted by the 2017 BRFSS Report

- the prevalence of poor mental health was highest among Black non-Hispanic persons at 18.3%
- the prevalence of depression was highest among AI/AN non-Hispanic persons at 22.2%

Additional Key Findings Highlighted by the 2019 Minority Health Report

- In 2017, Black non-Hispanic populations had the highest mortality rates of heart disease, at 291.7 per 100,000 population, when compared across all other race/ethnicity groups

Figure 12. Heart Disease Mortality – Counts and Age-Adjusted Death Rates by Race/Ethnicity and Year, 2013 – 2017



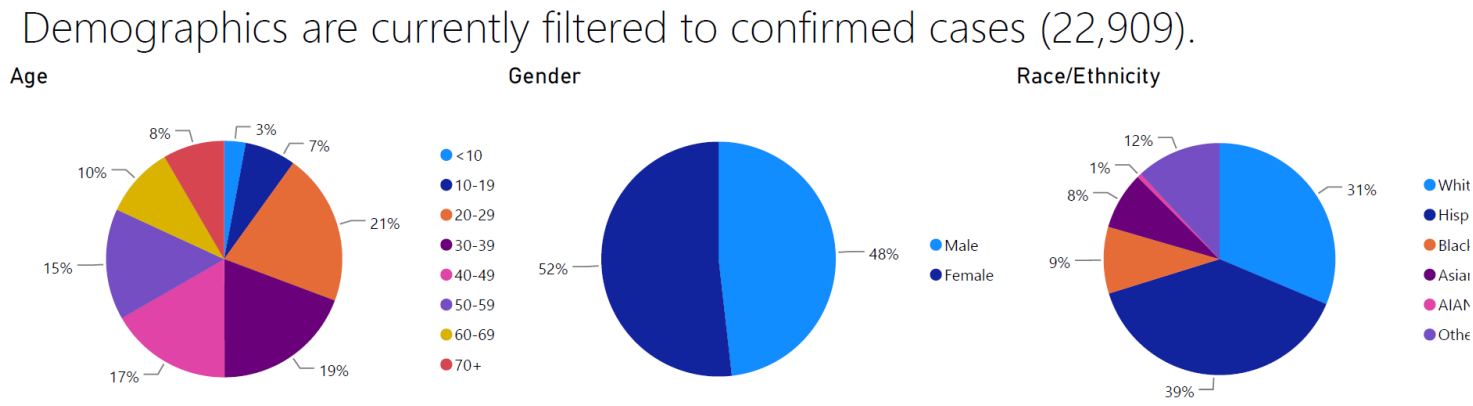
Year:	White (non-Hispanic) Count	White (non-Hispanic) Rate (CI)	Black (non-Hispanic) Count	Black (non-Hispanic) Rate (CI)	AI/AN (non-Hispanic) Count	AI/AN (non-Hispanic) Rate (CI)	API (non-Hispanic) Count	API (non-Hispanic) Rate (CI)	Hispanic Count	Hispanic Rate (CI)
2017	4,814	219.4 (213.2-225.6)	590	291.7 (268.1-315.2)	44	128.2 (90.3-166.1)	384	155.2 (139.6-170.7)	400	117.9 (106.4-129.5)
2016	4,827	224.8 (218.5-231.2)	599	303.1 (278.8-327.3)	53	163.6 (119.5-207.6)	344	145.0 (129.7-160.4)	448	131.6 (119.4-143.8)
2015	4,608	218.7 (212.4-225.0)	557	287.4 (263.5-311.2)	42	121.0 (84.4-157.6)	296	134.8 (119.4-150.1)	459	143.6 (130.5-156.8)
2014	4,419	210.0 (203.8-216.2)	464	251.1 (228.2-273.9)	40	161.6 (111.5-211.6)	264	140.6 (123.6-157.5)	372	121.4 (109.0-133.7)
2013	4,192	204.8 (198.6-211.0)	467	266.4 (242.3-290.6)	43	167.7 (117.6-217.8)	226	123.1 (107.1-139.2)	354	124.0 (111.0-136.9)

Source: Nevada Electronic Death Registry System.

- Black non-Hispanic populations had a higher prevalence of Chronic Lower Respiratory Disease (CLRD) (21.1%) during the year 2017 than White non-Hispanic populations (10.3%) and Hispanic populations (5.6%)
- In 2017, Black non-Hispanic populations had significantly higher infant mortality rates, at 10.4 deaths per 1,000 live births, than White non-Hispanic (4.5 per 1,000 live births) and Hispanic (5.4 per 1,000 live births) populations
- Black non-Hispanic populations had significantly higher rates of reported cases of HIV infection than every other race/ethnicity group for each year from 2013 to 2017
- From 2005 to 2014, the number of cancer cases among Asian/Pacific Islander non-Hispanic populations nearly doubled with a 96.1% increase in cancer burden for all cancer types in Nevada.

COVID-19 and Health Disparities

Health outcomes continue to be influenced by manageable determinants (i.e. Social Determinants of Health/SDoH). In order to reverse disparities, these determinants must be better defined. For example, today, SDoH are understood to include the negative, systemic impacts of racism. Most notably, the nation is facing the unequal burden of disparities in relation to the disproportionate severity of COVID-19 on minorities. In Nevada, public health officials are taking steps to recognize and address inequality as a co-morbidity as much as any other chronic disease. One such action being the development of a COVID-19 Dashboard (https://bit.ly/2NZO5li) capable of producing racially stratified data and reports. **Of the 22,909 COVID-19 cases Nevada reported on July 6, 2020, 57% of cases that include demographic information, represent a person identifying with an ethnic/racially diverse population**.



Increased co-morbidities, inadequate housing, and higher likelihood of frontline employment are examples of disparities understood to increase the viral transmissibility and disease severity disproportionately experience by ethnic/racially diverse populations.