Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Cody Phinney, MPH
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

The Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease (CWCD)

Meeting Agenda

July 25, 2024

1:00 P.M. To Adjournment

Microsoft Teams meeting

Join on your computer, mobile app or room device
Click here to join the meeting
Meeting ID: 238 633 817 008
Passcode: AH796Q
Download Teams | Join on the web
Or call in (audio only)
+1 775-321-6111,,505313096# United States, Reno
Phone Conference ID: 505 313 096#
Find a local number | Reset PIN
Thank you for planning to attend this Teams meeting.
Learn More | Meeting options

Note: Agenda items may be taken out of order, combined for consideration, or removed from the agenda at the chairperson's discretion.

1. Call to Order and roll call:

Members: Dr. Ihsan Azzam, Andrew Snyder, Dr. Krista Schonrock, Dr. Georgia Dounis, Laura Valley, Dr. Steve Shane, Cari Herington, Kagan Griffin, Maria Azzarelli, Dr. Amber Donnelli
Legislative members: Senator Dina Neal, Assemblyman Dr. David Orentlicher

2. Public Comment:

Public comment may be presented in-person, by computer, phone, or written comment. No action may be taken upon a matter raised under public comment unless the matter itself has been specifically included on an agenda as an action item. To provide public comment telephonically, dial 775-321-6111. When prompted to provide the Meeting ID, enter 505313096#. Due to time considerations, each individual offering public comment will be limited to not more than five (5) minutes. A person making comment will be asked to begin by stating their name for the record and to spell their last name. A person may also have comments added to the minutes of the meeting by submitting them in writing either in addition to testifying or in lieu of testifying. Written comments may be submitted electronically before, during, or after the meeting by emailing Michelle Harden at mharden@health.nv.gov. You may also mail written documents to the Division of Public and Behavioral Health, 4150 Technology Way, 3rd. Floor, Carson City, NV 89706.

3. For Possible Action:

Discussion and possible action to elect new CWCD chair – Sarah Rogers, Interim Chair

4. For Possible Action:

Approval of April 25, 2024, meeting minutes- Sarah Rogers, Interim Chair (or newly voted chair)

5. For Possible Action:

Request for Information for vacant council seats and possible recommendation to the Administrator for appointment, per NRS 439.518- Sarah Rogers, Interim Chair (or newly voted chair)

- Representative of organization committed to the prevention and treatment of chronic disease
- One representative who is a member of a racial or ethnic minority group appointed from a list of persons submitted to the Administrator by the Advisory Committee of the Office of Minority Health within the Office for Consumer Health Assistance of the Department
- One representative of private employers in this State who has experience in matters relating to employment and human resources

6. Informational:

National Kidney Foundation Presentation- Nina Sherpa-Pine and Amy Hewitt, Nation Kidney Foundation

7. For Possible Action:

Discussion and possible action to approve kidney disease resources and location of resources- Sarah Rogers, Interim Chair (or newly voted chair)

8. For Possible Action:

Discussion regarding Wellness at Work Website updates and possible action to approve recommendations- Janet Osalvo, Nevada Public Health Foundation

9. Informational:

Present partner Chronic Disease Prevention and Health Promotion Program Reports – Sarah Rogers, Interim Chair (or newly voted chair)

- Maria Azzarelli, EMHA, CHES®, Manager, CDPHP, Southern Nevada Health District
- Kellie Goatley - Seals MPH, Public Health Supervisor, Washoe County Health District
- Nicki Aaker, RN, Director, Carson City Health, and Human Services
- Brooke Conway Kleven, PT, DPT, PhD, Nevada Institute for Children's Research and Policy (NICRP), University of Nevada, Las Vegas

10. Informational:

Present Chronic Disease Prevention and Health Promotion (CDPHP) Section Update and Program Reports- Michelle Harden, Quality Improvement Manager, Chronic Disease Prevention and Health Promotion Section

11. Public Comment:

Sarah Rogers, Interim Chair (or newly voted chair)

12. Adjournment:

Sarah Rogers, Interim Chair (or newly voted chair)

Note: Unless a specific time is noted, items on the agenda may be taken in any order and any agenda items not covered at this meeting may be placed on the agenda for the next scheduled meeting.

This body will provide at least two (2) public comment periods in compliance with the minimum requirements of the Open Meeting Law prior to adjournment. No action may be taken on a matter raised under public comment unless the item has been specifically included on the agenda as an item upon which action may be taken. The Chair retains discretion to only provide for the Open Meeting Law's minimum public comment and not call for additional item-specific public comment when it is deemed necessary by the chair to the orderly conduct of the meeting.

Please be advised that at the discretion of the Chair, public comments may be limited to five (5) minutes.

Members of the public who are living with a disability and require accommodations or assistance at the meeting are requested to notify the Commission Secretary in writing at: Division of Public and Behavioral Health, 4150 Technology Way, 3rd Floor, Carson City, NV 89706, or by calling Michelle Harden at 775-389-9181 no later than three (3) working days prior to the meeting date.

Supporting material for this meeting can be obtained at: Division of Public and Behavioral Health, 4150 Technology Way, Suite 210, Carson City, NV 89706, or by calling Michelle Harden at 775-389-9181 or via email at mharden@health.nv.gov.

NOTICES OF PUBLIC MEETINGS HAVE BEEN POSTED AT THE FOLLOWING LOCATIONS:

This notice and agenda have been posted on or before 9 AM on the third working day before the meeting at the following locations:
Bureau of Child, Family, and Community Wellness – 4150 Technology Way, 1st Floor, Carson City

The agenda may be viewed electronically at the following websites:
Division of Public and Behavioral Health website: https://dpbh.nv.gov/CWCD2024
Nevada Public Notice Website: https://notice.nv.gov/

Agenda Item #4

Kidney Disease Advisory Committee Minutes

[DRAFT] Minutes

April 30, 2024

1:00 P.M.

The Kidney Disease Advisory Committee held a public meeting on April 30, 2024 beginning at approximately 1:04 P.M.

Sub-committee Members Present
Elizabeth Britton, Fresenius Medical Care
Katrina Russell, RN, CNN Nephrology Nurse Consultant
Dr. Krista Schonrock, MD, Select Health
Rayleen D. Earney, M Ed., CHES, Southern Nevada Health District

Board Members not Present
Dr. Lary Lehrner, MD, Nephrologist
Justin Iorri, Justins Kidney Foundation

Division of Public and Behavioral Health Staff Present
Sarah Rogers, Nutrition Unit Deputy Chief, Department of Public and Behavioral Health (DPBH)
Paige Musser, Chronic Disease and Health Promotion (CDPHP)
Amber Hise, RD, Section Manager, CDPHP
Michelle Harden, Quality Improvement Manager, Division of Public and Behavioral Health, CDPHP

1. Call to Order and roll call

   Sarah Rogers confirmed the start of the meeting and the commencement of recording.

   Paige Musser provided reminders to mute phones and introduced the protocol for speaking and signing in.

Elizabeth Britton notified the subcommittee that she is taking over for Rocco Graciano stating that he is no longer in Nevada. She has been asked to be his replacement.

2. Public Comment

   Ms. Rogers read the public comment script.

   Ms. Rogers asked for public comment.

   Katrina Russell requested a copy of the agenda which Ms. Rogers provided in the chat.

   No other public comment was heard.

3. Informational: Discussion regarding possible appointment of new chair to the Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease (CWCD)

   Ms. Rogers explained the need for appointing a new chair as Chris Syverson's term has expired. The decision was deferred to the July meeting by CWCD council members.

4. For Possible Action: Discussion and possible action to make recommendations to CWCD regarding the Council's role in increasing education concerning and awareness of kidney disease

   Rayleen Earney shared insights on educational resources from ADA and Comagine (formerly Health Insight), emphasizing the importance of chronic kidney disease guidelines.

   Dr. Katrina Russell mentioned a presentation by the National Kidney Foundation, suggesting it as a potential resource for the group.

   Ms. Rogers proposed gathering these resources for review and potential approval at the next meeting.

   Dr. Krista Schonrock moved to approve for it to be on the next agenda item.

   Ms. Earney seconded the motion.

5. Informational: Presentation: Stopping the Cascade: Preventing Chronic Kidney Disease by Preventing or Managing Type 2 Diabetes

Amber Hise presented on strategies to manage type 2 diabetes as a preventative measure against chronic kidney disease. She discussed funding, statistics, preventative strategies, and outlined the stages and resources available through the diabetes prevention and control program.

6. For Possible Action: Discussion and possible action to establish meeting dates for the remainder of 2024

   Discussion on future meeting dates led by Ms. Rogers. Dates proposed:

   - July 11th and October 10th at 1:30 PM.

   These dates were agreed upon following a motion by Ms. Earney and a second by Dr. Schonrock.

7. Public Comment

   Ms. Rogers provided another opportunity for public comment.

   Michelle Harden was introduced as the new Quality Improvement Manager. No further comments were made.

8. Adjournment

   Ms. Rogers called for a motion to adjourn.

   Dr. Schonrock moved to adjourn.

   Ms. Earney seconded the motion.

   Which passed unanimously.

Meeting adjourned at 1:35 pm

Agenda Item #5

Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Cody Phinney, MPH
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

DATE: JUNE 18, 2024

RE: THE ADVISORY COUNCIL ON THE STATE PROGRAM FOR WELLNESS AND THE PREVENTION OF CHRONIC DISEASE SEEKING A MEMBER

DURING THE 73RD SESSION OF THE NEVADA LEGISLATURE THE ADVISORY COUNCIL ON THE STATE PROGRAM FOR WELLNESS AND THE PREVENTION OF CHRONIC DISEASE (CWCD) (NEVADA REVISED STATUTES [NRS] 439.514 THROUGH 439.525, INCLUSIVE) WAS ESTABLISHED. THE COUNCILS PURPOSE IS TO RAISE PUBLIC AWARENESS RELATING TO WELLNESS AND CHRONIC DISEASES AND TO EDUCATE THE RESIDENTS OF THIS STATE ABOUT: WELLNESS, INCLUDING BUT NOT LIMITED TO BEHAVIORAL HEALTH, PROPER NUTRITION, MAINTAINING ORAL HEALTH, INCREASING PHYSICAL FITNESS, PREVENTING OBESITY AND TOBACCO USE; AND PREVENTION OF CHRONIC DISEASE INCLUDING BUT NOT LIMITED TO ASTHMA, CANCER, DIABETES, CARDIOVASCULAR, DISEASE AND ORAL DISEASE.

APPOINTMENTS ARE MADE BASED ON THE REPRESENTATION AS OUTLINED IN NRS 439.518.

"One representative of private employers in this State who has experience in matters relating to employment and human resources.

One representative of an organization committed to the prevention and treatment of chronic diseases."

CWCD IS SEEKING A NEW MEMBERS. IF YOU ARE INTERESTED IN BEING CONSIDERED FOR POSSIBLE APPOINTMENT, PLEASE SUBMIT A LETTER OF INTEREST AND A RESUME BY FRIDAY, JULY 5, 2024, TO MICHELLE HARDEN, PHONE 775-389-9181, EMAIL: MHARDEN@HEALTH.NV.GOV OR AMBER HISE, PHONE 775-461-6749, EMAIL: AHISE@HEALTH.NV.GOV OR TO MAILING ADDRESS: 4150 TECHNOLOGY WAY SUITE 210 CARSON CITY, NEVADA 89706, ATTN: MICHELLE HARDEN. MATERIALS SUBMITTED WILL BE FORWARDED TO THE COUNCIL FOR CONSIDERATION AT THE PRECEDING COUNCIL MEETING.

Agenda Item #6

National Kidney Foundation Serving California, Nevada, Oregon, and Washington

NATIONAL KIDNEY FOUNDATION®

National Kidney Foundation Overview

National Kidney Foundation

WHO WE ARE

With a national office in NY and 36 local offices across the U.S., the National Kidney Foundation is a non-profit organization dedicated to the awareness, prevention, and treatment of kidney disease.

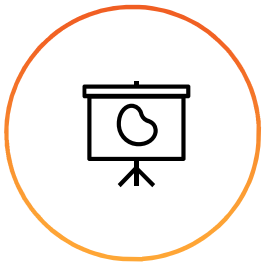
MISSION STATEMENT

The National Kidney Foundation is revolutionizing the fight to save lives by eliminating preventable kidney disease, accelerating innovation for the dignity of the patient experience, and dismantling structural inequities in kidney care, dialysis, and transplantation.

NATIONAL KIDNEY FOUNDATION®

What we do

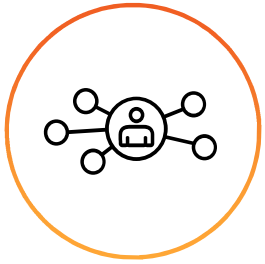
Patient education and resources



Clinical education and resources

Community programs

Advocacy



Public awareness

Population health and health equity

Clinical quality improvement and systems change

Clinical research support

NATIONAL KIDNEY FOUNDATION®

FREE Printable Flyers

PATIENT EDUCATION

- About CKD
- CKD Risk Factors
- Diseases and Conditions
- Nutrition
- Superfoods
- Living with Kidney Disease and Kidney Failure
- Kidney Failure Treatment (ESKD)
- Kidney Disease Treatment

Most are available in English & Spanish and many are available in up to 12 different languages!

Do you have questions about kidney disease, living donation or transplant?

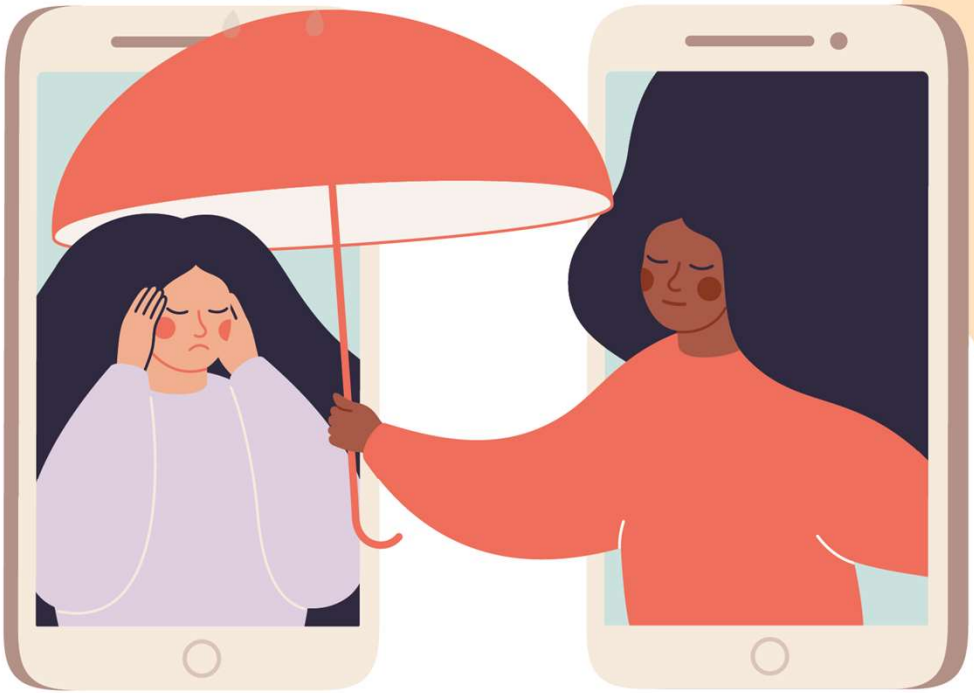
We can help!

855.653.2273
nkfcares@kidney.org

Hablamos Español

NKF *Cares*®
National Kidney Foundation

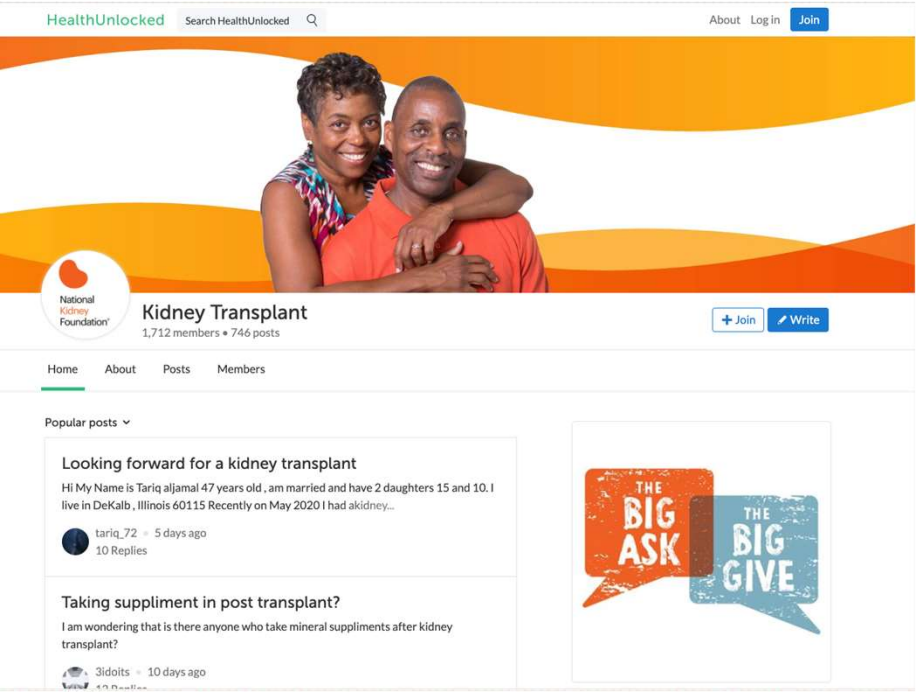
NKFpeers



Coping with kidney disease?
We're here for you.

Talk on the phone with someone who's been there.

855.653.7337
nkfpeers@kidney.org



NATIONAL KIDNEY FOUNDATION®

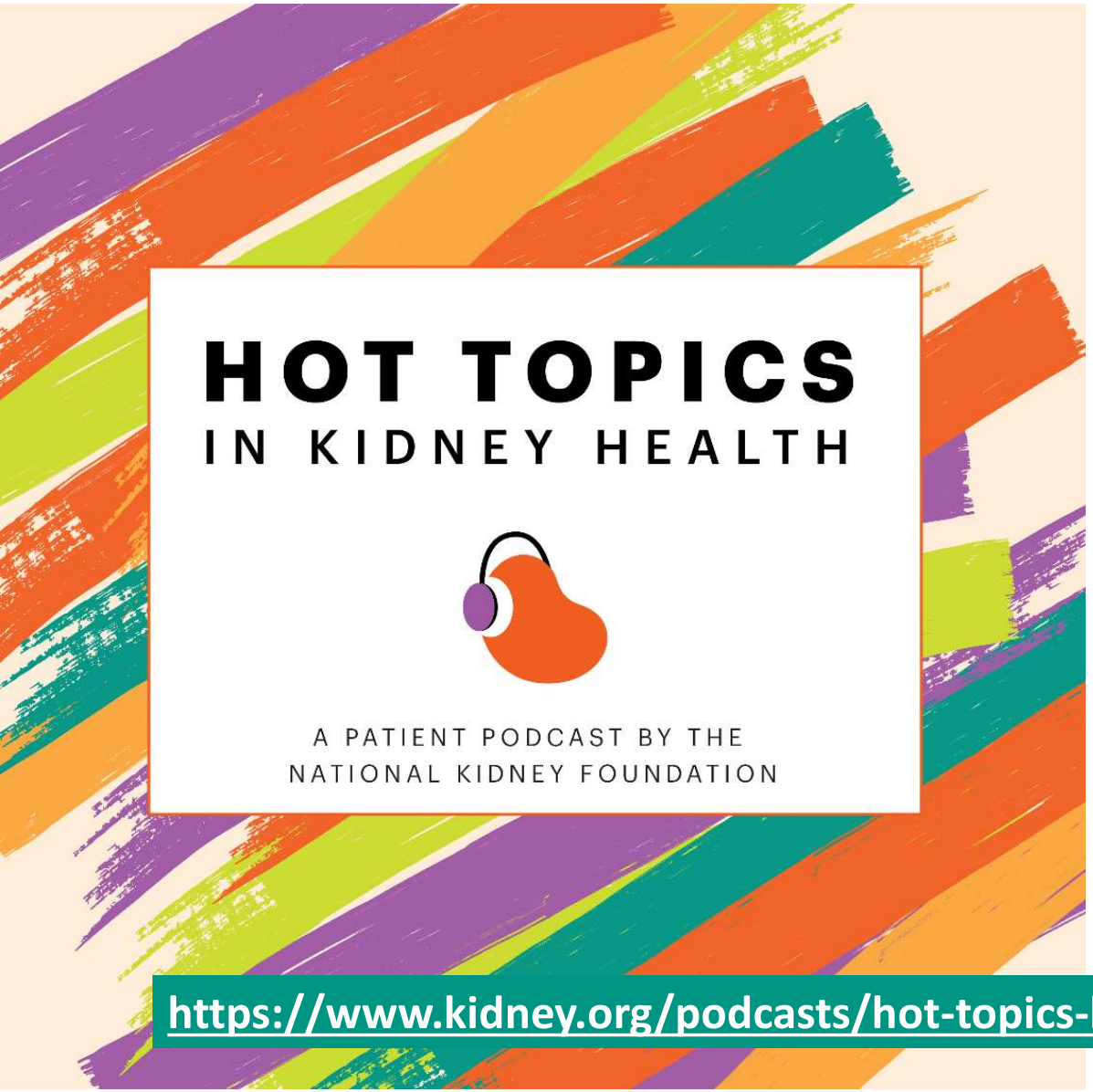
KIDNEY.ORG/ONLINE-COMMUNITIES

Online Communities

Connect with kidney patients and living donors through NKF's online communities.

Ask questions and get answers and support in an online platform monitored by NKF

Remain anonymous



A podcast for patients and care partners on the latest in kidney health. Download today from wherever you listen to podcasts.

https://www.kidney.org/podcasts/hot-topics-kidney-health

kidney learning center

Get “kidney smart” and learn more about kidney transplant and living donation! NKF’s Kidney Learning Center provides accessible, self-paced education through engaging videos delivered by patients and living donors.

PROGRAM TOPICS INCLUDE:

- First Steps to Transplant
- Finding a Living Donor
- Becoming a Living Donor
- After Transplant

SIGN UP AT

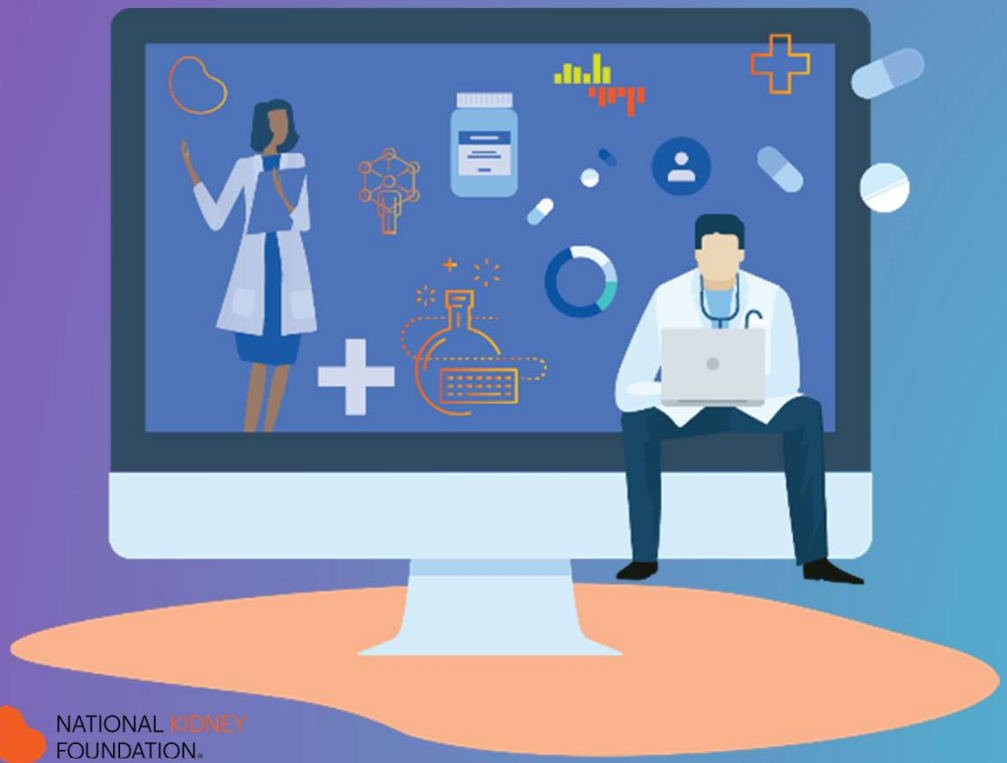
LearningCenter.kidney.org

English and Spanish closed captioning are available.

NATIONAL KIDNEY FOUNDATION®

PERC

PROFESSIONAL EDUCATION RESOURCE CENTER



NATIONAL KIDNEY FOUNDATION®

Courses are Free for NKF Members!

JOIN TODAY!

CME/CE COURSES FOR:

- Physicians
- Pharmacists
- Advanced Practitioners
- Nurses
- Dialysis Technicians
- Social Workers
- Dietitians
- Transplant Professionals

Patient Solutions

for Health Professionals

As you support those living with kidney disease, remember that NKF offers a suite of patient education and peer support programs in English and Spanish.

Explore the programs to see what is available to supplement the clinical care your practice or organization already provides.

kidney.org/professionals/patient-solutions-health-professionals

JOIN or
RENEW
TODAY!

National
Kidney
Foundation®

PROFESSIONAL MEMBERSHIP

Experience the advantages of NKF membership. Join today and make NKF your professional home.

- E-tools
- Clinician support materials
- Free CME and CE activities

kidney.org/membership

Legislative Wins & Priorities

- Securing the US Organ Procurement & Transplant Network Act
- Removing race from KDRI
- 32 States with Living Donor Protection Acts
- The Improving Access to Home Dialysis Act
- Funding for early detection, research and innovation

VOICES FOR KIDNEY HEALTH®

National Kidney Foundation

https://voices.kidney.org/

National Kidney Foundation serving California, Nevada, Oregon, and Washington (CNOW)

CNOW Programs

- **Patient and community education programs**
  - The Big Ask: The Big Give
  - Patient education series
  - CKD nutrition series
  - Drive for Dialysis
- **Medical professional education programs**
  - Nephrology Journal Clubs
  - Renal Roundtables
  - Dialysis Team Transplant Education
  - Medical Symposium
- **Health equity initiatives**
  - Bay Area Ending Disparities in CKD Stakeholder Summit
- **Signature events**
  - Kidney Walks
  - Authors Luncheon

Monthly Lunch & Learn Sessions for Dialysis Professionals

Navigating Transplant: A Guide to Empowering Your Patients

Session 7 – July 24 @12PM PT:

Getting to Transplant: Insights from Patients, Providers, and Living Donors

Register here:

https://nkfcnow.org/PatientProviderLDpanel

NATIONAL KIDNEY FOUNDATION®

NS0

FY24 ANNUAL REGIONAL IMPACT

BY THE NUMBERS

490+ National & International Attendees
at the hybrid 35th Annual Authors Luncheon

2,800+ Connections Made
at 21 Health Fairs, Screenings & Community Education Events

495 Virtual Attendees
at Patient & Community Education Webinars

260+ Professional Attendees
at the 55th Annual Bay Area Medical Symposium

300+ Professional Attendees
at 8 Journal Clubs & Renal Roundtables

59 Learning in Action Work Group Members & 77 Attendees
at Ending Disparities Leadership Summit

40 in-person Attendees
at Finding a Living Donor Programs

1,200+ Learners
at 3 Virtual Dialysis Team Transplant Education Sessions

1,300+ Participants Assembled
1,500 Kits at 4 Drive for Dialysis Events

1,250 Local Walkers
at the Northern California Kidney Walk & Southern California Kidney Walk

NATIONAL KIDNEY FOUNDATION®
serving
California, Nevada, Oregon, & Washington

Slide 18

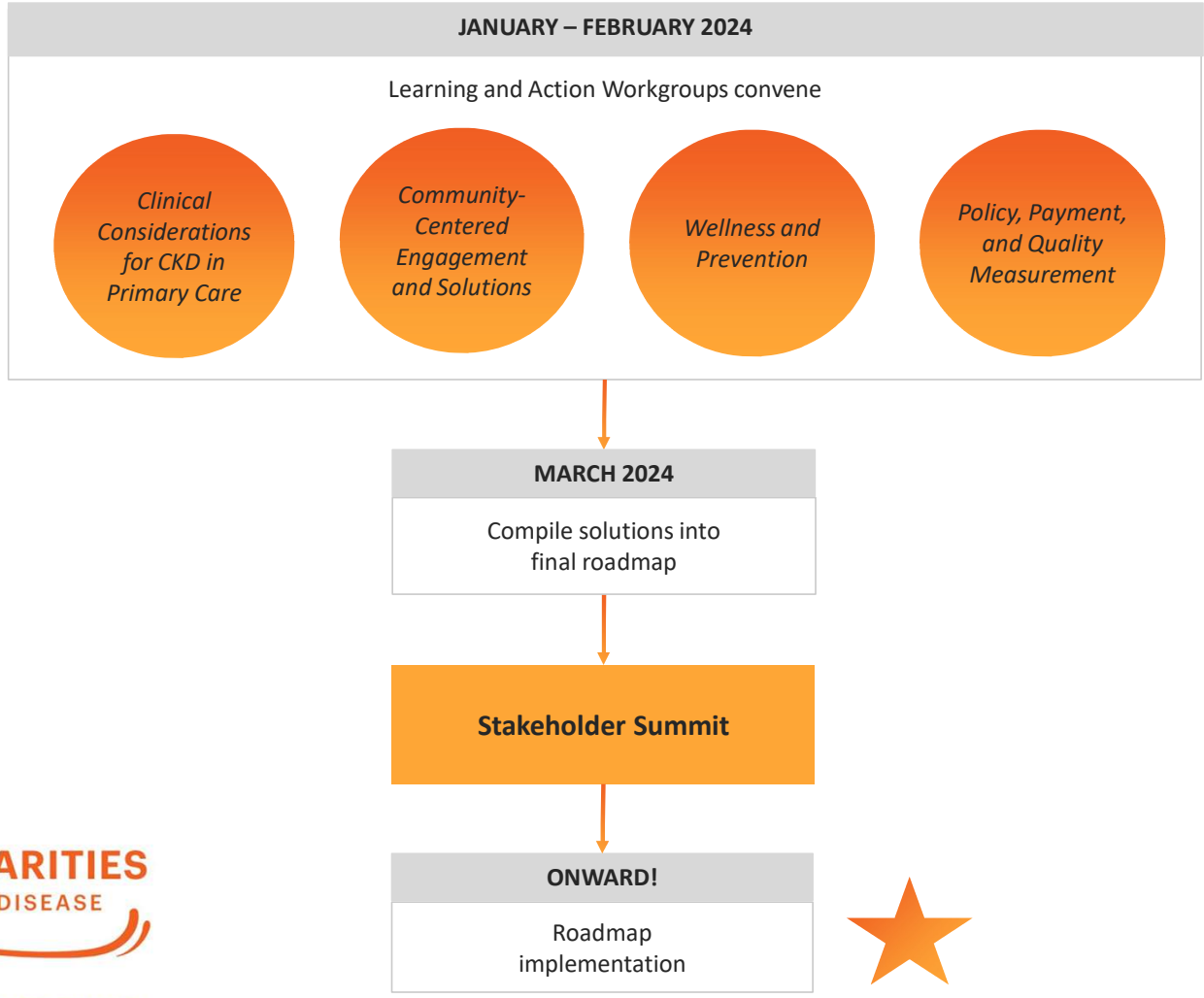
NS0 Not sure if we want to add this?
Nina Sherpa-Pine, 2024-07-11T18:43:37.799

Population Health: CKDintercept Program

- Aim is to improve CKD testing, early diagnosis, and management in primary care to prevent or delay end stage renal disease (ESRD) and reduce risk of cardiovascular disease (CVD) morbidity and mortality.

- We work with primary care practices, health systems, laboratories, public and private insurers, public health departments, and other stakeholders.

- We collaborate with local stakeholders to:
  - Facilitate quality improvement initiatives
  - Provide clinical tools and resources to optimize workflows and improve the delivery of care
  - Equip organizations with community engagement resources, and tools to facilitate access to services.



ENDING DISPARITIES
IN CHRONIC KIDNEY DISEASE
MARCH 2024
BAY AREA STAKEHOLDER SUMMIT

Barriers to CKD early detection and care delivery in primary care

- Lack of Systemic Focus on Preventive Health and Wellness
- Lack of Person-Centered Education and Awareness
- Structural Barriers that Disproportionately Impact Underserved Communities
- Competing Priorities in Clinical Quality Improvement
- Primary Care Capacity

NATIONAL KIDNEY FOUNDATION®

Stakeholder Summit Outcomes

59 LAWG members, representing 43 organizations

77 live attendees, 115 registered (67% show-rate)

13 recommendations developed, with 123 commitments to advance them

"Changing the current payment model, with an incremental increase in payment, will be more cost-effective than the much larger costs of taking care of patients who need a kidney transplant or who are on hemodialysis."

- Policy, Payment, and Quality Measurement Workgroup Participant

"Sometimes discrimination is perceived as a synonym to invisibility. Having representation and awareness in health education materials can be sign of inclusivity."

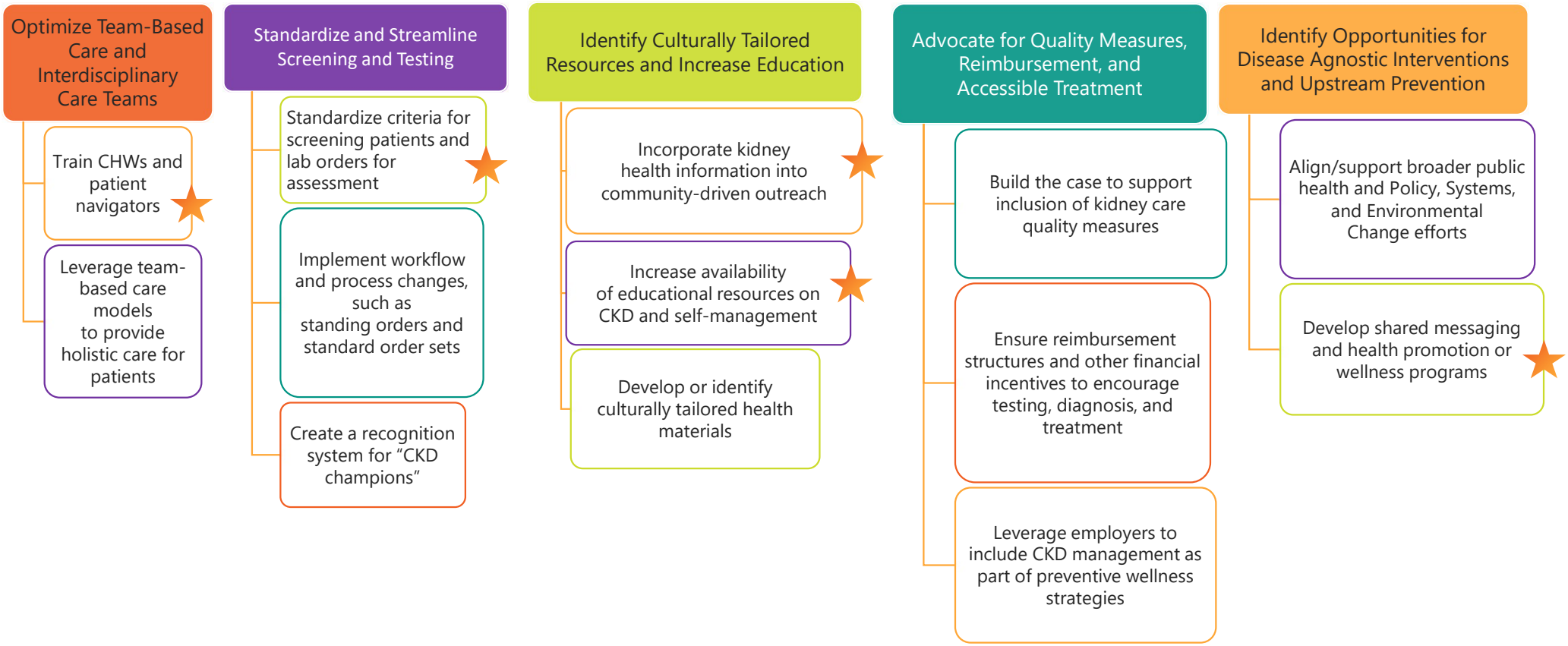
- Community-Centered Engagement and Solutions Workgroup Participant

"In Public Health, we must design our societies and our cultures to be health promoting, where the healthy choice is the easy choice."

- Wellness and Prevention Workgroup Participant

NATIONAL KIDNEY FOUNDATION®

Bay Area Ending Disparities in CKD Roadmap



NATIONAL KIDNEY FOUNDATION®

Questions?

Contact us

Amy Hewitt, Executive Director
amy.hewitt@kidney.org

Programs: Professional and Patient
Patty McCormac, RN, PHN, Senior Director, Programs
patty.mcCormac@kidney.org

Programs: Health Equity
Nina Sherpa-Pine, MSc, CHES (she/her/hers/),
Director, Community Impact and Health Partnerships
nina.sherpapine@kidney.org

NATIONAL KIDNEY FOUNDATION®

Thank you!

Agenda Item #7

Chronic Kidney Disease: "The Silent Killer"

What is chronic kidney disease?

Chronic kidney disease (CKD) is a gradual loss of kidney function that damages your kidneys and decreases their ability to filter wastes and excess fluid that can lead to kidney failure. An estimated 37 million people (twice the population of New York) live with chronic kidney disease.

It is known as "the silent killer" because there are usually no symptoms until the late stages of the disease when dialysis or a kidney transplant may be needed.

Those that are over 60 years old and have diabetes or have high blood pressure are at the highest risk for chronic kidney disease.

Facts About CKD

- **1 in 10** adults know they have kidney disease.
- **1 in 3** people are at risk for developing kidney disease.
- CKD is often not diagnosed. Two simple tests ordered by your doctor can check your kidney health.

Estimated Glomerular Filtration Rate (eGFR) Test	Urine Albumin-Creatinine Ratio (uACR) Test
A blood test to see how well your kidneys are filtering blood.	A urine test to see if your kidneys are leaking protein (albumin)

These Factors Increase Your Risk

- Family history of CKD
- Obesity and smoking
- Race and ethnicity
- Over age 60 with diabetes or hypertension:
  - **1 in 3 adults with diabetes** have CKD
  - **1 in 5** adults **with hypertension** have CKD

If you have chronic kidney disease, you can prevent it from advancing by getting diagnosed early. Talk to your doctor about getting screened!

If you do not have a doctor, contact your local health department to find testing services:

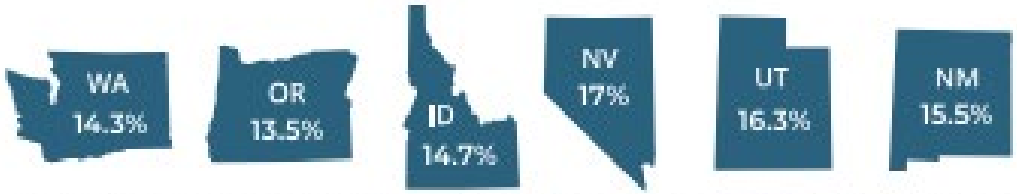
Idaho Nevada New Mexico Oregon Utah Washington

This material was prepared by Comagine Health, a Medicare Quality Innovation Network-Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW-GEN-22-QIN-118

Quality Improvement Organizations | Comagine Health

Chronic Kidney Disease (CKD) impacts Medicare beneficiaries everywhere.

Nearly 15% of Medicare beneficiaries in Comagine Health's six-state service area have CKD. Due to underdiagnosis, the actual number is likely even higher.



Nevadans have the highest CKD rates in our service area
The average prevalence of CKD among traditional fee-for-service Medicare beneficiaries in our six-state region is 14.9%. Nevada tops the list at 17%.

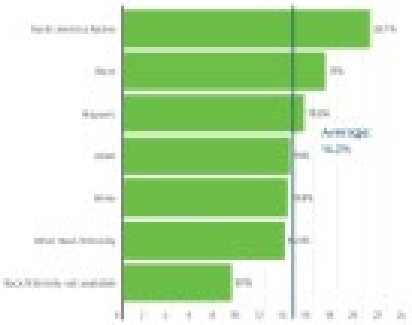
CKD rates are highest in Native American and Black populations
CKD prevalence in our six-state region is highest among Native American (20.7%) and Black (17%) Medicare beneficiaries.A

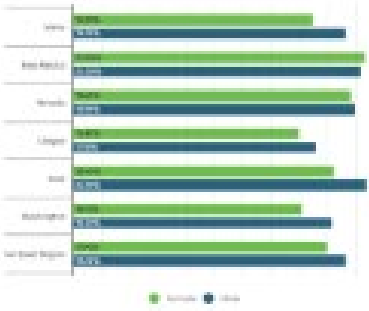
CKD is more prevalent among men
Men have a higher prevalence of CKD than women within our six-state region.

CKD Rates Across Demographics

Across the Comagine Health six-state region, **Native American** and **Black** populations have the highest CKD prevalence.

For more detailed data visualization on this topic, see the **community report data dashboard** above.





Men have a higher prevalence of CKD in our six-state region than **women**, with with rates of 19.2% and 17.9% respectively.A

Why We Care

CKD is a gradual loss of kidney function that damages your kidneys and decreases their ability to filter wastes and excess fluid that can lead to kidney failure. An estimated 37 million people (twice the population of New York) live with CKD.

It is known as "the silent killer" because there are usually no symptoms until the late stages of the disease when dialysis or a kidney transplant may be needed. Patients over 60 years old with diabetes and/or high blood pressure are at the highest risk for CKD.

80 million
Americans are at risk for Chronic Kidney Disease (CKD) in the U.S.[1]

37 million
Americans have CKD and aren't aware of it.[1]

Nearly 40%
of those with stage 4 CKD aren't aware they have it.[2]

9 in 10
adults with CKD don't know they have it, causing late-stage diagnosis and one in four patients to "crash" into dialysis.[3]

What You Can Do

One of the most effective actions health care professionals can take to prevent kidney disease and lowering the rates of CKD across our region is CKD screening and management planning.

A plan for proper CKD screening and management in the primary care setting for patients with diabetes and hypertension is the best way to catch CKD early and slow its progression.

Two key markers for CKD are urine **albumin creatinine ratio (uACR)** and **estimated glomerular filtration rate (eGFR)**. uACR is the most reliable screening test and should be performed at least annually to diagnose and monitor kidney damage in patients with diabetes.[4]

Most laboratories now offer a combined test to measure uACR and eGFR. By consolidating these blood and urine tests into a single lab order, ordering is easier and providers can interpret results more efficiently. This makes it easier for providers to determine if a patient has CKD and, if they do, how far the disease has progressed.

This combined test is called **The Kidney Profile**. It was developed through a Laboratory Engagement Initiative (LEI) partnership between the National Kidney Foundation (NKF), Labcorp and Quest Diagnostics. Contact your nearest Labcorp or Quest Diagnostics laboratory for more information. Many smaller or community laboratories have now recreated this same blood and urine combined test with their own ordering name.

[1] Centers for Disease Control and Prevention. Chronic Kidney Disease in the United States, 2019. US Department of Health and Human Services; 2019.
[2] United States Renal Data System. 2020 Annual Data Report. https://adr.usrds.org/2020/chronic-kidney-disease/1-ckd-in-the-general-population
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Chronic Kidney Disease

HEAT MAP

GFR Stages					Albuminuria Categories		
					A1	**A2**	**A3**
					Normal to mildly increased	Moderately increased	Severely increased
					<30 mg/g	30-299 mg/g	≥300 mg/g
	CKD Stage 1	**G1**	Normal or high	≥90	**(1)** N18.1	**Monitor (1)** N18.1	**Refer (2)** N18.1
	CKD Stage 2	**G2**	Mildly decreased	60-90	**(1)** N18.2	**Monitor (1)** N18.2	**Refer (2)** N18.2
	CKD Stage 3a	**G3a**	Mildly to moderately decreased	45-59	**Monitor (1)** N18.31	**Monitor (2)** N18.31	**Refer (3)** N18.31
	CKS Stage 3b	**G3b**	Moderately to severely decreased	30-44	**Monitor (2)** N18.32	**Monitor (3)** N18.32	**Refer (3)** N18.32
	CKD Stage 4	**G4**	Severely decreased	15-29	**Refer (3)** N18.4	**Refer (3)** N18.4	**Refer (4+)** N18.4
	CKD Stage 5	**G5**	Kidney failure	<15	**Refer (4+)** N18.5	**Refer (4+)** N18.5	**Refer (4+)** N18.5

*** Monitoring Recommendations:** Annual frequency of blood/urine testing for each colored box is indicated with a number between 1-4+ in parentheses.

Risk of Disease Progression

- **Low or no risk** (Note: two specimens demonstrating proteinuria are required to diagnose CKD in patients with eGFR >60)
- **Moderately increased risk**
- **High risk**
- **Very high risk**
- **Extremely high risk**

Refer

- eGFR <30 (G4/G5) or uACR >300 (A3)
- >25% decrease in eGFR (AKI or progressive CKD may be difficult to distinguish)
- Sustained decline in eGFR >5 mL/min/1.73m2/year
- Hereditary or unknown cause of CKD
- Other situations when nephrology referral is appropriate are in this National Kidney Foundation management flowchart.

Scan here to view NKF management flowchart.

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How to Manage CKD

Conditions of ↑ CKD Risk

Diabetes
Hypertension
Cardiovascular Disease
Age >60 years
Obesity
Family History of CKD
AKI History

Yes

Screen for CKD

- "Spot" urine for albumin-to creatine ratio (uACR) to detect albuminuria
- Serum creatinine to estimate glomerular filtration rate (eGFR)

Is either of the following present for 3 months or more?

- eGFR <60 ml/min/1.73 m2
- uACR >30 mg/g

No → Periodically repeat evaluation

Yes

Classify CKD stage

Assign GFR Category

45 – 59 = G3a
30 – 44 = G3b
15 – 29 = G4
<15 = G5

Identify and treat specific cause of CKD *

Assign Albuminuria Category

<30 = A1 (normal or mildly ↑)
30-299 = A2 (moderately ↑)
>/= 300 = A3 (severely ↑)

Patient Safety

eGFR <60
- Consider eGFR in drug dosing
- Reduce risk of AKI volume depletion

eGFR 45 to <60
- Avoid prolonged NSAIDs
- Hold metformin for iodinated contrast imaging procedures

eGFR 30 to <45
- Avoid prolonged NSAIDs
- Use metformin with close monitoring at 50% dose
- Adjust DOAC dose based on FDA prescribing guides
- Consider avoid PICC lines to preserve future veinous access; consider nephrology consult or use single or double lumen central catheters instead
- Consider iodinated contrast-induced AKI prevention in high-risk circumstances
  - Avoid iodinated contrast or minimize dose
  - Consider isotonic saline infusion before, during, and after procedure
  - Hold metformin at time of or before procedure
  - Consider withhold other nonessential potentially nephrotoxic agents

eGFR <30
- Annual comprehensive medication review for dosing and other safety concerns
- Avoid any NSAIDs, bisphosphonates, and metformin
- Continue SGLT-2i until dialysis (if tolerated); Refer to FDA prescribing guides for guidance on initiating SGLT-2i in G4 CKD
- Avoid PICC lines; use single and double lumen central catheters instead
- Monitor PT/INR closely if on warfarin (increased bleed risk)
- Adjust DOAC dose or avoid depending on FDA prescribing guides
- Iodinated contrast-induced AKI prevention recommended
  - Avoid iodinated contrast or minimize dose
  - Consider isotonic saline infusion before, during and after procedure
  - Withhold nonessential potentially nephrotoxic agents
- Gadolinium contrast = risk of nephrogenic systemic fibrosis; consult radiology & nephrology, macrocyclic agent preferred and minimize dose

CKD Progression + Complications (for patients not on dialysis)

BP Goals
- No DM:
  - SBP <120 (when tolerated) using standardized office BP measurment
  - SBP <130 reasonable, especially if no access to standardized BP measurement
- With DM:
  - SBP <130 using standardized office BP measurement
- Balance risk for AKI and polypharmacy, especially if very low kidney function
- Consider less intensive therapy if limited life expectancy or symptomatic postural hypotension

BP Treatment
- ACE-I or ARB 1st line if DM or uACR >30 (A2/A3), titrated to highest tolerated/approved dose
- Thiazide, CCB, or ACE-I/ARB 1st line if uACR < 30 (A1)
- Avoid any combination of ACE-I, ARB, and DRI therapy
- Diuretic usually required
- Dietary sodium <2000 mg/day

DM Goals:
- Individualized A1C goal ranging from <6.5% to < 8%, depending on:
  - CKD severity, macrovascular complications, comorbidities, life expectancy, hypoglycemia awareness, resources for hypoglycemia management, and propensity for hypoglycemia
- CGM time in range (TIR) > 70% (either 70-180 mg/dL or patient-specific range)

T2DM Treatment
- Prioritize SGLT-2i, metformin, and/or GLP-1 RA

Vaccination for influenza, pneumococcus, and full COVID-19 series

CKD Complications Screening
- Acidosis – Bicarbonate goal: 22-26; treat <22 with oral bicarbonate supplements and promote base-producing diet
- Anemia – CKD G3a+; Evaluate if Hb <13 g/dL (men) or <12 g/dL (women). Treat iron deficiency first. Consider ESA to treat Hb <10 g/dL if favorable risk/benefit (Target 9-11.5 g/dL) or refer to nephrology.
- CKD-MBD – CKD G3a+; evaluate calcium, phosphate, 25-OH vitamin D, and iPTH. Supplement vitamin D deficiency. Refer to nephrology if hyper phosphatemia or significant iPTH elevation. Consider BMD testing if results will impact treatment decisions.

Nephrology Referral
- eGFR <30 (G4/G5) or uACR >300 (A3)
- >25% decrease in eGFR (AKI or progressive CKD may be difficult to distinguish)
- Sustained decline in eGFR >5 mL/min/1.73m2/year
- 2^0 hyperparathyroidism
- CKD and HTN refractory to treatment with >4 antihypertensive agents
- Persistent hyperkalemia / metabolic acidosis
- Recurrent or extensive kidney stones
- Persistent unexplained hematuria
- Hereditary or unknown cause of CKD

CKD and CVD (for patients not on dialysis)

CKD = ↑CVD risk

Consider statin therapy
- All >/= 50 years
- 18-49 years at high CVD risk (history of ASCVD, DM, 10-yr ASCVD risk >10%)
- Additional lipid-lowering treatment may be warranted for higher risk individuals

Consider SGLT-2i (independent of T2DM) if eGFR within FDA prescribing guidelines, especially if uACR > 30 (A2+)

Consider NS-MRA after max tolerated ACE-I/ARB if:
- T2DM, uACR > 30 (A2+), eGFR >25, AND K <5

Low-dose aspirin for secondary ASCVD prevention unless bleeding risk outweighs benefits

* **Cause of CKD** is classified based on presence or absence of systemic disease and the location within the kidney of observed or presumed pathologic-anotomic findings.

How to Evaluate for Chronic Kidney Disease

Know the criteria for CKD

- Abnormalities of kidney structure or function, present for >3 months, with implications for health
- Either of the following must be present for >3 months:
  - Markers of kidney damage (one or more)
  - eGFR <60 ml/min/1.73 m^2

Screen for CKD with two simple tests.

- "Spot" urine for albumin-to-creatinine ratio (uACR) to detect albuminuria
- Serum creatinine to estimate glomerular filtration rate (eGFR)

What if CKD is detected?

- Classify CKD based on cause, GFR category, and albuminuria category
- Implement a clinical action plan based on patient's CKD classification (See flip side)
  - Consider co-management with a nephrologist if the clinical action plan cannot be carried out
  - Refer to a nephrologist when eGFR <30 mL/min/1.73 m^2 or uACR >300 mg/g
- Learn more at **kidney.org/professionals**

Why should you classify CKD?

- To have a more precise picture of each patient's condition
- To guide decisions for testing and treatment
- To evaluate patient's risk of progression and complications
- Because neither the category of GFR nor the category of albuminuria alone can fully capture prognosis of CKD

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How do you classify CKD?

- Identify cause of CKD*
- Assign GFR category
- Assign albuminuria category

*Cause of CKD is classified based on presence or absence of systemic disease and the location within the kidney of observed or presumed pathologic-anotomic findings.

GFR categories in CKD

Category	GFR (ml/min/1.73 m^2)	Terms
G1 †	≥90	Normal or high
G2 †	60-89	Mildly decreased*
G3a	45-59	Mildly to moderately decreased
G3b	30-44	Moderately to severely decreased
G4	15-29	Severely decreased
G5	<15	Kidney failure

*Relative to young adult level.
† In the absence of evidence of kidney damage, neither GFR category G1 nor G2 fulfill the criteria for CKD.

Albuminuria categories in CKD

Category	uACR (mg/g)	Terms
A1	<30	Normal to mildly increased
A2	30–299	Moderately increased*
A3	≥300	Severely increased†

*Relative to young adult level.
†Including nephrotic syndrome (uACR >2220 mg/g)
uACR >30 for >3 months indicates CKD.

Abbreviations

25-OH Vitamin D, 25-hydroxy vitamin D; **A Stage**, albuminuria category; **ACE-I**, angiotensin-converting-enzyme inhibitor; **AKI**, acute kidney injury; **ARB**, angiotensin receptor blocker; **ASCVD**, atherosclerotic cardiovascular disease; **BMD**, bone mineral density; **BP**, blood pressure; **CCB**, calcium-channel blocker; **CKD**, chronic kidney disease; **CGM**, continuous glucose monitoring; **CKD-MBD**, chronic kidney disease mineral and bone disorder; **COVID-19**, coronavirus disease 2019; **CVD**, cardiovascular disease; **DM**, diabetes mellitus; **DOAC**, direct-acting oral anticoagulant; **DRI**, direct renin inhibitor; **eGFR**, estimated glomerular filtration rate; **ESA**, erythropoietin-stimulating agent; **FDA**, Food & Drug Administration; **G Stage**, GFR category; **GLP-1 RA,** glucagon-like peptide 1 receptor agonist; **Hb**, hemoglobin; **HTN**, hypertension; **iPTH**, intact-parathyroid hormone; **NS-MRA**, non-steroidal mineralocorticoid receptor antagonist; **NSAIDs**, nonsteroidal anti-inflammatory drugs; **PICC**, peripherally inserted central catheter; **PT/INR**, prothrombin time/international normalized ratio; **SBP**, systolic blood pressure; **SGLT-2i**, sodium-glucose cotransporter-2 inhibitor; **T2DM**, type 2 diabetes mellitus; **uACR**, urine albumin-to-creatinine ratio.

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Preparing for Emergencies:

A Guide for People on Dialysis

Centers for Medicare & Medicaid Services

March 2023

Version	Date	Notes
1.0	2016	Original document developed
2.0	5/8/17	Reviewed by subject matter experts and updated as needed
2.1	6/26/17	Corrected error for Network 16 geographic area listing
2.2	3/2/23	Updated broken links and corrected Network contact information

Table of Contents

Preparation and Background

Emergency preparedness for the dialysis community is essential for ensuring the continuity of patient care. Each of the various topics covered within this booklet has been thoroughly discussed and vetted, keeping in mind the essential needs of the kidney community during an emergency or disaster.

In addition, the content and material within this booklet have been created through a highly organized and collaborative approach that focuses on emergency preparedness. Subject matter expertise was essential to the development of this critical document and was provided by representatives from the End Stage Renal Disease (ESRD) Networks, dialysis organizations, national renal-related organizations, clinicians with renal-specific focus, renal dietitians, and the Kidney Community Emergency Response (KCER) Program.

The time, effort, and dedication from all who assisted in the development of this booklet are reflective of the strong commitment to both emergency preparedness and people on dialysis within the ESRD community.

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Introduction

It is important for people on dialysis to plan ahead for emergencies and disasters in order to stay safe.

Emergencies and disasters often happen without warning, so it is important to prepare before they happen. When you are on dialysis, disasters can make it hard for you to get your treatment because of changes to water, power, sanitation, or transportation.

This booklet provides information that will help you prepare for an emergency, including:

- Helpful tips to make sure that you are prepared
- What to include in your **Emergency Go-Kit**
- What grocery items to have ready for your **3-Day Emergency Diet**
- What to do when you cannot leave your home
- What to do when you must leave your home
- What to do when your dialysis facility is closed

What to Do to Get Ready for an Emergency or Disaster

□ I have made my **Emergency Go-Kit** (page 8).

□ I have read and understand my dialysis facility's disaster plan.

□ My dialysis team has taught me how to unhook from the machine in an emergency.

□ I have made alternative arrangements for my treatment before an emergency happens (page 6).

□ I have filled out and added important contact information to my **Personal Information Form** (page 10).

□ I have completed my **Medical Supplies Checklist** (page 9).

□ I have added my **Personal Information Form** and **Medical Supplies Checklist** to my **Emergency Go-Kit**.

□ I keep my **Personal Information Form** and **Medical Supplies Checklist** current and update it if necessary whenever something changes.

□ I have made sure that I have enough food in the house for a **3-Day Emergency Diet** (page 16).

□ I will listen to my local news to learn about the emergency or disaster. I make sure cell phones are always charged and ready to use.

□ I have two options for places to stay, near and far, if I must leave my home. I have added this information to my **Personal Information Form**.

□ I make and share my emergency plan with household members and my dialysis facility.

□ I have plans in place for my pets (if applicable).

□ I have arranged back-up transportation to the dialysis facility and added it to my **Personal Information Form**.

□ I have contacted my local or city Emergency Management Office to find out about services to help prepare for and manage an emergency.

□ I have made sure that my car has enough gas in it (if applicable).

Make Alternative Arrangements for Your Treatment Before an Emergency

If you get hemodialysis at a dialysis facility:

□ Make sure your dialysis facility has your current street address and phone number(s) in case they need to contact you.

□ Make arrangements for back-up transportation to your dialysis facility.

□ Ask your dialysis facility about other dialysis facilities near you that can treat you if your dialysis facility closes.

If you perform home hemodialysis:

□ Contact your water and power companies to register for special priority to restore your lost services. Keep their phone numbers up-to-date on your Personal Information Form.

□ Keep a flashlight and batteries near your dialysis machine.

□ Contact your local dialysis facility about back-up treatment locations both near to and far from your home.

If you use Continuous Ambulatory Peritoneal Dialysis (CAPD):

□ Keep the battery charged at all times if you use an ultraviolet device. (Note: The charge should last for three days.)

□ As directed by your dialysis team, keep a five-to seven-day supply of peritoneal dialysis supplies at home. Check expiration dates and replace as needed, or every six months.

If you use Continuous Cycling Peritoneal Dialysis (CCPD):

□ Learn and practice manual CAPD, so if you lose power, you can switch from CCPD to manual CAPD.

□ As directed by your dialysis team, keep a five-to seven-day supply of CCPD (and CAPD if you have learned to do manual CAPD) supplies available.

□ Check the expiration dates and replace as needed.

□ Contact your water and power companies ahead of time to register for special priority to restore lost services. Keep their phone numbers up-to-date on your Personal Information Form.

“Get-Ready” Emergency Go-Kit Checklist

- Get your **Go-Kit** ready before an emergency or disaster happens.
- You may put these items in more than one bag or container.
- Make sure you know where your **Go-Kit** is stored.
- Check items every six months to ensure your medications have not expired, that your food is still fresh, and that batteries are working.

3-Day Emergency Diet Plan and Shopping List items

□ Bottled or distilled water

□ Small radio with batteries or a hand crank

□ Flashlights and batteries

□ First-aid kit

□ Hand sanitizer

□ Plain, unscented household chlorine bleach (**How to Disinfect Water**, page 27)

□ Cell phone and charger

□ Measuring cups, teaspoons, and tablespoons

□ Manual can opener

□ Cash

□ Walking shoes and a change of clothes

□ Food and water for your pets (if you have pets)

□ Personal Information Form and Medical Supplies Checklist

“Get-Ready” Medical Supplies Checklist

- Add these items to your **Emergency Go-Kit**.
- Check your medications to ensure they have not expired.

□ Five-to seven-day supply of all prescription medicines. Check the expiration dates of all of your medications each month. Use and replace the ones that are due to expire.

□ Five-day supply of antibiotics if you are on peritoneal dialysis and it is recommended by your doctor.

□ Add these to your medical supplies if you have diabetes: Glucose meter, one spare battery and testing fluid.

□ Five-to seven-day supply of blood sugar test strips and lancets.

□ Five-to seven-day supply of syringes and insulin if you use insulin. (Keep insulin cool but do not freeze it. It is best kept in the refrigerator, but it can be kept at room temperature for up to a month.)

□ Glucose (glucose tablets, Glucagon, oral glucose gel) in case your sugar level drops.

Personal Information Form

To be ready for an emergency, complete the **Personal Information Form** with a list of people and organizations you will need to reach. Family, household members, caregivers, and friends will want to know where you are. They may even be able to help you safely leave your home, if you need to. Include on your list your nephrologist (kidney doctor) and your dialysis facility. You will need to let them know if you can't get your treatments. You can get this form from your dialysis facility or ESRD Network.

You can also get a **Wallet Card** from your dialysis facility or ESRD Network (page 38) to record your important medical information. You may carry this card in your wallet.

Personal Information Form directions:

Please fill out the form, beginning on the next page, with your personal information. Write in pencil to make it easy to change. Put your **Personal Information Form** in your **Emergency Go-Kit**.

Have copies of your identification and medical information available:

- Driver's license, ID card, and/or US permanent resident card
- Social Security card
- Passport
- Healthcare insurance card
- Treatment orders
- Legal documents (e.g., advance directive, do not resuscitate [DNR] order, or medical power of attorney information)

Personal Information Form

In all emergencies, call 9-1-1.

Non-emergency phone #: _____

My Dialysis Facility: _____

Phone Number: _____

Emergency Hotline: _____

Back-Up Facility Near Home: _____

Phone Number: _____

Back-Up Facility Far from Home: _____

Phone Number: _____

Kidney Doctor (Nephrologist): _____

Phone Number: _____

Primary Care Doctor: _____

Phone Number: _____

My Pharmacy: _____

Phone Number: _____

Transportation Company: _____

Phone Number: _____

Transportation (family/friend): _____

Phone Number: _____

My ESRD Network: _____

Phone Number: _____

Family Members, Caregivers, and/or Friends

Name/Relation: _____

Phone Number: _____

Name/Relation: _____

Phone Number: _____

Name/Relation: _____

Phone Number: _____

Name/Relation: _____

Phone Number: _____

Medical Information Form

Health Insurance Provider: _____

Policy Number: _____

Phone Number: _____

Medication and Dosages:

_____
_____
_____
_____
_____
_____

Allergies:

_____
_____
_____
_____
_____
_____

Treatment Type:

□ Hemodialysis

□ Home Hemodialysis

□ CAPD

□ CCPD

Local Emergency Information

Local Hospital: _____

Phone Number: _____

Local Fire Department: _____

Phone Number: _____

Local Police: _____

Phone Number: _____

Electric Company: _____

Phone Number: _____

Utility Company: _____

Phone Number: _____

Water Company: _____

Phone Number: _____

Medical ID Jewelry

If you are injured or unable to communicate, medical staff will need to know quickly that you are on dialysis and other important facts about your health. One way to alert people to your health needs is to wear a medical ID on a bracelet or necklace. These medical IDs show an internationally recognized symbol to alert responders of medical conditions. They can be specified to list any medical information that may need to be relayed in the event of an emergency. It also provides a phone number that medical staff can call to get more detailed medical information about you. The ID also comes with a medical information card, which has important information about your health. It is important to carry this medical information card with you at all times.

Wearing a medical ID at all times helps ensure that you get the care you need, and that you don't get care that could be harmful to someone with your medical condition.

Note: A necklace might be missed if it gets tangled in your clothes. A bracelet is easy to see, but don't wear one on the same side as your dialysis access. It could block blood flow if it is pulled up the arm.

To get a Medical ID: Ask your nurse or social worker for information about medical IDs.

Sources of medical IDs include:

National Kidney Foundation

- 1-855-NKF-CARES (1-855-653-2273)
- www.kidney.org

MedicAlert Foundation

- 1-800-ID-ALERT (1-800-432-5378)
- www.medicalert.org

American Medical ID

- 1-800-363-5985
- www.americanmedical-id.com

Medical Tags

- 1-888-679-4292
- https://medicaltags.com/

Your Local Pharmacy

3-Day Emergency Diet Plan

Hemodialysis takes some of the water and wastes out of your blood. Wastes and water build up between treatments. When you get three or more treatments a week, this build-up should not cause a problem. When you can't get a treatment, the extra water and wastes in your body can cause problems. When you can't get your treatments, you will need to follow a special, strict diet to limit buildup of water, protein wastes, and potassium.

The **3-Day Emergency Diet Plan** will help you follow an emergency diet. This diet does not take the place of dialysis, but you can reduce the waste that builds up in your blood if you follow the plan and change what you eat. **This may save your life**. Review the plan with your facility dietitian to see if you need to make changes based on your own personal needs. Ask questions before an emergency. If you are on peritoneal dialysis and can't do your treatments, this diet may apply to you, too.

In an emergency or disaster situation, you should do everything you can to get your regular dialysis treatments. If you miss one or more treatments, follow the **3-Day Emergency Diet Plan** until you can get treatment. You should always try to get dialysis within three days of your last treatment.

The best way to get ready for an emergency is to plan before one happens. Collect the foods on the **3-Day Emergency Diet Shopping List**. Keep them someplace close in your home so you can get your emergency food easily. The list allows for six days of food and water so the 3-Day Emergency Diet can be repeated a second time if needed.

In an emergency situation, eat fresh foods first, while you have them. If you have diabetes, avoid the sweets in this plan. But do have some high sugar foods like hard candies on hand in case your sugar is low.

Pediatric Dialysis Diet Plan

Talk to your doctor and dietitian about what to feed infants, children, and teens who are on dialysis. Children's food will need to be adjusted for their age and weight.

3-Day Emergency Diet Shopping List

This shopping list is for six days of food and water for the kidney patient, so the **3-Day Emergency Diet** can be repeated a second time if needed.

Review this list with your dietitian to tailor it for your needs and local availability.

Drinks

What to Buy	How Much to Buy
Distilled or bottled water	1 to 2 gallons
Dry milk or evaporated milk	3 packages of dry milk or 4 cans of evaporated milk (8 oz. each)
Cranberry, apple, or grape juice	6 cans or boxes (4 oz. each)

Food

What to Buy	How Much to Buy
Cold cereal No bran, granola, or cereal with dried fruit or nuts.	6 single-serving boxes, or 1 box
Fruit or "fruit cups" with pears, peaches, mandarin oranges, mixed fruit, applesauce, or pineapple packed in water or juice. No heavy syrup, raisins, or dried fruit.	12 cans or individual cups (4 oz. each) *Be sure to drain liquid from fruit or count toward daily fluids.
Low sodium vegetables, such as asparagus, carrots, green beans, peas, corn, yellow squash, or wax beans.	6 cans (8 oz. each) *Be sure to drain liquid from vegetables or count toward daily fluids.
No dried beans such as pinto, navy, black, ranch style, or kidney beans. No potatoes or tomatoes.	—
Low sodium or no-salt-added tuna, crab, chicken, salmon, or turkey	6 cans (3 or 4 oz. each)
Unsalted peanut butter or almond butter	1 jar

Mayonnaise	3 small jars (or 8 to 12 single-serve foil-wrapped packs and discard once opened)
Jelly (sugar-free if you have diabetes)	1 small jar
Vanilla wafers, graham crackers, or plain unsalted crackers	1 box
Sugar-free candy, such as sourballs, hard candy, jelly beans, or mints	1 package
Sugar-free chewing gum	1 jumbo pack

Foods That Will Spoil

What to Buy	How Much to Buy
Dry milk	3 packages
White bread *Keep frozen, so always available when needed.	1 loaf

Note: Use before expiration date and replace with fresh items. Discard after expiration date.

Options to Season Your Food

What to Buy	How Much to Buy
Olive oil or vegetable oil	1 small bottle
Balsamic or flavored vinegar	1 small bottle
Salt-free seasonings, spices, and dried herbs such as cinnamon, dill, oregano, rosemary, garlic powder, and onion powder	—

Sweets

What to Buy	How Much to Buy
Sourball candy, hard candy, jelly beans, or mints	1 package
Honey	1 small jar
White sugar	1 small box granulated or packets
Marshmallows (optional)	—

Note: If you have diabetes, avoid the sweets in this plan; but keep some high-sugar foods (hard candy) on hand in case your sugar is low. Speak to your dietitian.

Do not include these foods in your 3-day emergency diet:

- Sports drinks and drinks with phosphates
- Powdered drink mixes other than powdered milk
- Foods high in potassium such as:
    - Dried beans (e.g., pinto, navy, black, ranch style, or kidney beans)
    - Potatoes
    - Tomatoes
    - Sports drinks (e.g., Gatorade)

3-Day Emergency Diet

If there is an emergency and you think you may have to miss your dialysis treatment, start the **3-Day Emergency Diet** right away. It won't harm you to start it sooner than you need to.

Tips

- Use fresh foods first, if you have them.
- Once you open a can or a frozen item, throw out the opened item if you can't keep it cold or **use it within four hours**.
- After losing power, it is safe to use food in the freezer as long as there are ice crystals in the food.
- You can freeze bread for three months in a sealed bag.
- Speak to your dietitian if you are on a gluten-free diet.
- You may want to have a mix of sugar candy and unsweetened candy.
- If you have diabetes, avoid the sweets in this diet plan. Check your blood sugar to see if you need a snack. Have some high-sugar content foods like hard candies in case you go "low" with too little sugar in your body.
- If you have diabetes, speak to your dietitian for snack ideas.
- Water is the best choice to drink.
- No sports drinks or beverages that contain phosphate.

Restrict fluid intake

A fluid plan will help you avoid trouble with breathing and swelling. Speak to your healthcare team about how much fluid you can have. Try taking medications with applesauce to reduce fluid intake.

- Remember that all fruits and vegetables contain water.

Tips to help reduce your thirst

- Suck on hard candy
- Chew gum
- Limit salt intake
- Have a mix of sugared candy and unsweetened candy
- Rinse your mouth out with mouthwash

Day One (example)

Drink no more than 4 oz. of water each time you take your medicine, and remember to count this toward your daily fluid allowance.

Breakfast

Cereal and fruit:

- ½ cup milk or mix ¼ cup evaporated milk with ¼ cup distilled water, from sealed containers
- 1 serving of cereal (No bran. No granola. No cereal with dried fruits and nuts.)
- 1 tbsp. sugar (optional)
- ¼ cup (2 oz.) fruit from a can or jar, drained

Morning Snack (optional)

- 5 vanilla wafers or 1½ squares graham crackers
- 2 tbsp. peanut butter
- 10 hard candies or sourballs (People with diabetes should have sugar-free candies.)

Lunch

- Peanut or almond butter and jelly sandwich: 2 slices of white bread
- 2 tbsp. unsalted peanut butter or almond butter 2 tbsp. jelly or sugar-free jelly
- ½ cup canned or jarred fruit, drained
- ½ cup (4 oz.) water (or beverage from shopping list)

Afternoon Snack (optional)

For people who do not have diabetes:

- 5 vanilla wafers or 1½ squares graham crackers
- 2 tbsp. peanut butter
- ½ cup applesauce

For people who have diabetes:

- ½ cup applesauce

Dinner

Chicken sandwich:

- 2 slices of white bread
- ½ can (2 oz.) chicken with 2 tbsp. mayonnaise
- ½ cup canned vegetables, drained
- ½ cup cranberry juice

Evening Snack (optional)

For people who do not have diabetes:

- 10 jelly beans
- 5 vanilla wafers or 1½ squares graham crackers

For people who have diabetes:

- 1 slice of bread
- 1 oz. (2 tbsp.) of protein (peanut butter, almond butter, chicken, or tuna)

Note: Once you open a can or a frozen item, throw out the opened item if you can't keep it cold or use it within four hours.

Day Two (example)

Drink no more than 4 oz. of water each time you take your medicine, and remember to count this toward your daily fluid allowance.

Breakfast

Cereal and fruit:

- ½ cup milk or mix ¼ cup evaporated milk with ¼ cup distilled water, from sealed containers
- 1 serving of cereal (No bran. No granola. No cereal with dried fruits and nuts.)
- 1 tbsp. sugar (optional)
- ¼ cup (2 oz.) fruit from a can or jar, drained

Morning Snack (optional)

- ½ cup applesauce
- 10 jelly beans (People with diabetes should have sugar-free jelly beans.)

Lunch

Chicken sandwich:

- 2 slices of white bread
- ¼ can (1 oz.) chicken with 1 tbsp. mayonnaise
- ½ cup canned or jarred fruit, drained
- ½ cup (4 oz.) water

Afternoon Snack (optional)

- 10 mints (People with diabetes should have sugar-free mints.)
- ½ cup applesauce

Dinner

Tuna sandwich:

- 2 slices of white bread
- ½ can (2 oz.) tuna with 1 to 2 tbsp. mayonnaise/oil
- ½ cup canned vegetables, drained
- ½ cup cranberry juice

Evening Snack (optional)

For people who do not have diabetes:

- 5 vanilla wafers or 1½ squares graham crackers
- 10 hard candies

For people who have diabetes:

- 1 slice of bread
- 1 oz. (2 tbsp.) of protein (peanut butter, almond butter, chicken, or tuna)

Note: Once you open a can or a frozen item, throw out the opened item if you can't keep it cold or use it within four hours.

Day Three (example)

Drink no more than 4 oz. of water each time you take your medicine, and remember to count this toward your daily fluid allowance.

Breakfast

Cereal and fruit:

- ½ cup milk or mix ¼ cup evaporated milk with ¼ cup distilled water, from sealed containers
- 1 serving of cereal (No bran. No granola. No cereal with dried fruits and nuts.)
- 1 tbsp. sugar, optional
- ¼ cup (2 oz.) canned or jarred fruit, drained

Morning Snack (optional)

- 5 vanilla wafers or 1½ squares graham crackers
- 10 hard candies (People with diabetes should have sugar-free candies.)

Lunch

- Peanut or almond butter and jelly sandwich: 2 slices of white bread
- 2 tbsp. unsalted peanut or almond butter 2 tbsp. jelly or sugar-free jelly
- ½ cup canned or jarred fruit, drained
- ½ cup (4 oz.) juice

Afternoon Snack (optional)

- ½ cup applesauce
- 10 jelly beans (People with diabetes should have sugar-free jelly beans.)

Dinner

Salmon sandwich:

- 2 slices of white bread
- ½ can (2 oz.) salmon with 1 to 2 tbsp. mayonnaise/oil
- ½ cup canned vegetables, drained
- ½ cup water

Evening Snack (optional)

For people who do not have diabetes:

- 5 vanilla wafers or 1½ squares graham crackers

For people who have diabetes:

- 1 slice of bread
- 1 oz. (2 tbsp.) of protein (peanut butter, almond butter, chicken, or tuna)

Note: Once you open a can or a frozen item, throw out the opened item if you can't keep it cold or use it within four hours.

How to Disinfect Water

Keep distilled or bottled water on hand to drink. If you run out of stored water, you may disinfect water to drink, to brush your teeth, or for other uses. **It is <u>not</u> safe to use this water for dialysis.**

When using bleach to disinfect water, use **<u>plain</u>** household chlorine bleach that contains 8.25% of sodium hypochlorite. Do not use bleach that has other active ingredients. For example, do not use scented bleach. **Do not guess when measuring bleach.**

To disinfect water with unscented household liquid chlorine bleach:

- Filter the water through a clean cloth, paper towel, or coffee filter or allow it to settle.
- Put the clear water in a clean container.
- Use liquid chlorine bleach that has been stored at room temperature for less than a year. The label must say that it contains 8.25% of sodium hypochlorite. Use the table below as a guide to decide how much bleach to add to the water.
- Double the amount of bleach if the water is cloudy, colored, or very cold.

Disinfecting Water with Unscented Liquid Chlorine Bleach

Volume of Water	Amount of Household Bleach to Add
2 gallons	1/8 teaspoon
4 gallons	1/4 teaspoon
8 gallons	1/2 teaspoon

Stir water and bleach mixture and let stand for 30 minutes. The disinfected water should have a slight chlorine odor. If it doesn't, repeat the dosage and let stand for another 15 minutes before use.

Notes:

- If the chlorine taste is too strong, pour the water from one clean container to another and let it stand for a few hours before use.
- Make sure to keep this disinfected water in clean containers, sealed tightly.
- Listen for "Boil Water Advisories" from community officials.
- Do not drink water from a swimming pool or spa. Chemicals used to treat the water could harm you.
- Never mix bleach with ammonia or other cleaners.
- Open windows and doors to get fresh air when you use bleach.

When Your Dialysis Facility Is Closed

If an emergency or disaster happens near you, be ready with a back-up plan to get the care you need. Your dialysis facility may close because:

- There is no power or water.
- There is damage to the building.
- The facility is in an area that is under evacuation orders.
- The weather stops facility staff from getting there safely.

What to do when your dialysis facility closes:

- Call your dialysis care team or your facility's emergency phone number to learn where and when to get treatment.
- If you cannot call your dialysis care team or your facility's emergency phone number, call your back-up facility listed on your **Personal Information Form** (page 10).
- Tell your family and household members where you will be receiving treatment.
- Start your **3-Day Emergency Diet** (page 16).
- Start **limiting the fluids** you drink (page 20).
- If you drive to get treatment, have directions to get to your back-up facility and practice the route before an emergency. Check road safety too if possible, including if roads are impacted by flooding, downed power lines, etc.
- Make plans for a ride to your back-up dialysis facility. This could be a car service, bus, train, taxi, or a family member, household member, caregiver, or friend.
- Listen to your local news to learn about the emergency or disaster.

When You Cannot Leave Your Home

You may need to stay home to be safe in an emergency or disaster. Officials and/or local news reports will tell you when you should stay home. Staying at home in an emergency or disaster is known as "sheltering in place."

What to do when you cannot leave your home:

- Lock and seal windows and doors.
- Consider the specific emergency and select the safest room in your home. (ex: high winds—rooms with fewest windows)
- Keep your prescription medicines handy.
- Keep a cell phone and charger, home phone, battery-operated radio or computer with you.
- Call family, household members, caregivers, friends, and your dialysis facility to let them know where you are.
- Start your **3-Day Emergency Diet** (page 16).
- Start **limiting the fluids** you drink (page 20).
- Listen to your local news to learn about the emergency or disaster.
- Have your **Emergency Go-Kit** (page 8) ready in case public officials tell you to leave.

When You Must Leave Your Home

To stay safe in some emergencies, you may have to leave your home. You will be safest if you know your back-up treatment options before an emergency requires you to leave. You may need to leave your home if it becomes unsafe or if you receive a required evacuation order. An order will likely come from officials within your community to ensure your protection and safety.

It is very important that you follow any evacuation orders issued by emergency officials. If you chose not to follow evacuation orders, you may have difficulty accessing treatment for an extended period of time.

What to do when you must leave your home:

- Take your **Emergency Go-Kit** with you - **Emergency Go-Kit Checklist** (page 8).
- Take your prescription medicines with you. The **Medical Supplies Checklist** (page 9) tells you how much medicine to bring.
- Take your **Personal Information Form** (page 10) with you.
- Tell family members, household members, caregivers, friends, and your dialysis facility where you plan to go.
- If your dialysis facility is closed, call your facility's emergency number to find out where you should go for treatment.
- If you cannot contact your dialysis facility, your back-up facility is listed on your **Personal Information Form.**
- Start your **3-Day Emergency Diet** (page 16).
- Start **limiting the fluids** you drink (page 20).
- If you must go to a shelter, tell the person in charge that you need dialysis.
- Listen to your local news to learn about the emergency or disaster.

How to Get Off of a Dialysis Machine in an Emergency

Your dialysis facility staff will show you what to do if you are on a dialysis machine during an emergency. You will practice this at least once a year at your facility. The instructions should include where your emergency pack is kept and how to disconnect yourself from the dialysis machine. An emergency pack usually contains tape, clamps, and other medical items and should be kept within your reach while you are on the dialysis machine, if possible.

If you are on a dialysis machine in an emergency, stay calm. Wait for the facility staff to tell you what to do.

These steps are **only** for emergencies in which you must leave the facility:

- Keep your access needles **in** until you get to a safe place.
- **Never** cut your access needle lines. **Never** cut the line between the clamp and your access—you will bleed to death.
- If you have a **catheter**, your staff should help you before you disconnect.
- Do not try to unhook yourself.

Care of Your Access in an Emergency

Once you are off of your machine, wait for someone in charge to tell you where to go. This could be a dialysis facility staff member or a paramedic, police officer, or fire fighter. Do not stop to pull out your needles until you have been checked by staff, or you are sure that you are out of danger.

Be careful! Do not let someone who does not know you touch or inject something into your access. Healthcare workers who are not familiar with dialysis may not know what a fistula, graft, or catheter is, and could harm you.

To Learn More

Medicare

- 1-800-MEDICARE (1-800-633-4227)
- TTY: 1-877-486-2048
- Medicare Website: www.medicare.gov

Dialysis facilities

- Find & Compare Providers: https://www.medicare.gov/care-compare/
- Call your ESRD Network (page 35) to learn about:
    - Dialysis
    - Kidney transplants
    - Where to find dialysis facilities and transplant centers
    - How to get help from other agencies
    - What you can do when problems at your facility are not solved by talking to the staff at the facility

Your ESRD Network works to ensure that you are getting the best care, and communicates with facilities to keep staff aware of key issues about dialysis and transplants.

In addition, you can call your State Survey Agency. The State Survey Agency makes sure that dialysis facilities meet Medicare standards. Call 1-800-MEDICARE (1-800-633-4227) if you have problems with your facility that you cannot solve by talking to the facility staff.

Note: The phone numbers listed in this booklet were correct at the time of printing. Phone numbers can change. Utilize the resources below to get the most up-to-date phone numbers for dialysis facilities, ESRD Networks, and State Survey Agencies:

- 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048)
- Medicare Website: www.medicare.gov
- Map of ESRD Networks

For More Information on Making an Emergency Plan

This booklet highlights the most important items specifically needed for a dialysis patient. You can make personal emergency plans that are specific for your situation and include more details.

The following websites for the Kidney Community Emergency Response (KCER) Program, Ready.gov, and the American Red Cross can help you plan in depth for an emergency.

Kidney Community Emergency Response (KCER) Program

Access resources for patients, providers, and other stakeholders that are geared toward preparing the dialysis community for emergencies and disasters.

- English:
    - www.kcercoalition.com
- Español:
    - www.kcercoalition.com/en/en-espanol

Ready.gov

It is a good idea to have an emergency plan in place before an emergency or disaster happens. This website is a good resource to help you make your plan.

- English:
    - www.ready.gov
- Español:
    - www.ready.gov/es

American Red Cross

This website can help you connect with family and household members in an emergency. Be sure they know where to look!

- English:
    - www.redcross.org/safeandwell
    - www.redcross.org
- Español:
    - https://www.redcross.org/cruz-roja/obtener-ayuda/contactar-y-ubicar-a-los-seres-queridos.html
    - www.redcross.org/cruz-roja

ESRD Network Contact Information

Network Number, Name, Coverage Area, and Contact Information
Network 1 (CT, ME, MA, NH, RI, VT) IPRO: ESRD Network of New England Toll-free Patient Line: (866) 286-ESRD (866-286-3773) Phone: (203) 387-9332 Website: www.esrd.ipro.org
Network 2 (NY) IPRO: ESRD Network of New York Toll-free Patient Line: (866) 238-ESRD (866-238-3773) Phone: (516) 209-5578 Website: www.esrd.ipro.org
Network 3 (NJ, PR, VI) Quality Insights Renal Network 3 Toll-free Patient Line: (888) 877-8400 Phone: (609) 490-0310 Website: www.qirn3.org
Network 4 (DE, PA) Quality Insights Renal Network 4 Toll-free Patient Line: (800) 548-9205 Phone: (610) 265-2418 Website: www.qirn4.org
Network 5 (DC, MD, VA, WV) Quality Insights Renal Network 5 Toll-free Patient Line: (866) 651-6272 Phone: (804) 320-0004 Website: www.qirn5.org

Network 6 (GA, NC, SC) IPRO: ESRD Network of the South Atlantic Toll-free Patient Line: (800) 524-7139 Phone: (919) 463-4500 Website: www.esrd.ipro.org
Network 7 (FL) HSAG: The Florida ESRD Network Toll-free Patient Line: (800) 826-ESRD (800-826-3773) Phone: (813) 383-1530 Website: www.hsag.com/esrdnetwork7
Network 8 (AL, MS, TN) Alliant Health Solutions Network 8 Toll-free Patient Line: (877) 936-9260 Phone: (601) 936-9260 Website: https://quality.allianthealth.org
Network 9 (IN, KY, OH) IPRO: ESRD Network of the Ohio River Valley Toll-free Patient Line: (844) 819-3010 Phone: (216) 593-0001 Website: www.esrd.ipro.org
Network 10 (IL) Qsource ESRD Network 10 Toll-free Patient Line: (800) 456-6919 Phone: (317) 257-8265 Website: https://esrd.qsource.org
Network 11 (MI, MN, ND, SD, WI) Midwest Kidney Network Toll-free Patient Line: (800) 973-ESRD (800-973-3773) Phone: (651) 644-9877 Website: www.midwestkidneynetwork.org

Network 12 (IA, KS, MO, NE) Qsource ESRD Network 12 Toll-free Patient Line: (800) 444-9965 Phone: (816) 880-9990 Website: https://esrd.qsource.org
Network 13 (AR, LA, OK) HSAG: ESRD Network 13 Toll-free Patient Line: (800) 472-8664 Phone: (405) 942-6000 Website: www.hsag.com/esrdnetwork13
Network 14 (TX) Alliant Health Solutions Network 14 Toll-free Patient Line: (877) 886-4435 Phone: (972) 503-3215 Website: https://quality.allianthealth.org
Network 15 (AZ, CO, NV, NM, UT, WY) HSAG: ESRD Network 15 Toll-free Patient Line: (800) 783-8818 Phone: (303) 831-8818 Website: www.hsag.com/esrdnetwork15
Network 16 (AK, ID, MT, OR, WA) Comagine Health ESRD Network 16 Toll-free Patient Line: (800) 262-1514 Phone: (206) 923-0714 Website: www.nwrn.org
Network 17 (AS, GU, HI, MP, N. CA) HSAG: ESRD Network 17 Toll-free Patient Line: (800) 232-ESRD (800-232-3773) Phone: (415) 897-2400 Website: www.hsag.com/esrdnetwork17

Network 18 (S. CA)
HSAG: ESRD Network 18
Toll-free Patient Line: (800) 637-4767
Phone: (888) 268-1539
Website: www.hsag.com/esrdnetwork18

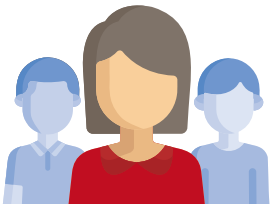
Professional version

American Heart Association.

American Diabetes Association.
Connected for Life.

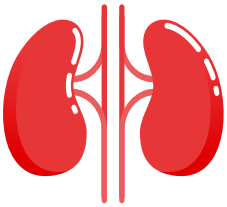
Learn more about diabetic kidney disease

Know Diabetes by Heart™



Approximately 1 in 3 American adults with diabetes has CKD.

CVD risk is high in people with CKD.



Kidney disease is ranked in the top leading causes of death in the United States.

Every 24 hours, 170 people with diabetes begin treatment for kidney failure.

Screening for Diabetes-Related Kidney Disease

Who?

- ✓ Everyone with type 2 diabetes
- ✓ Everyone with type 1 diabetes for ≥ 5 years

How?

UACR and eGFR

When?

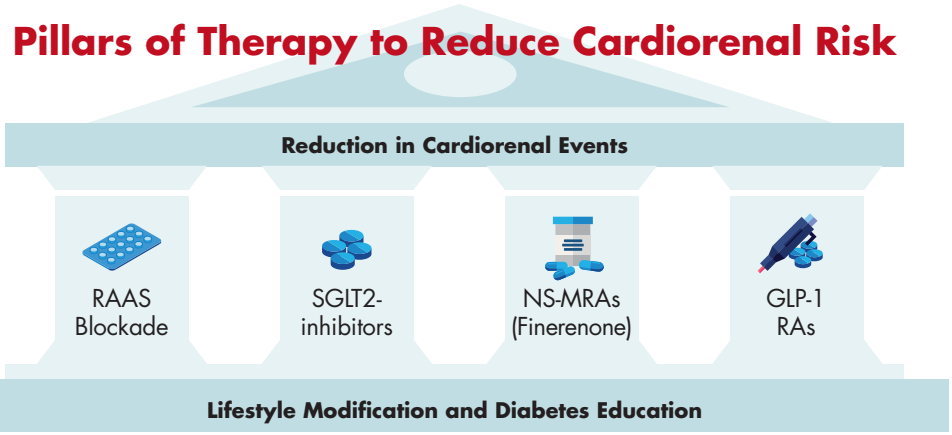
Annually

Management of Diabetes-Related Kidney Disease

Why Manage?

- Decreases risk of CKD progression
- Cardiovascular risk reduction

Pillars of Therapy to Reduce Cardiorenal Risk



CKD = Chronic kidney disease
CVD = Cardiovascular disease
UACR = Urinary albumin to creatinine ratio
eGFR = Estimated glomerular filtration rate

RAAS Blockade = Renin–angiotensin–aldosterone system blockade
SGLT2-inhibitors = Sodium-glucose cotransporter 2 inhibitor
NS-MRAs = Nonsteroidal mineralocorticoid receptor antagonists
GLP-1 RAs = Glucagon-like peptide 1 agonists

Learn more at **KnowDiabetesbyHeart.org**

This infographic is based on recommendations from the ADA's *Standards of Care in Diabetes—2024*

Agenda Item #9

Chronic Disease Prevention and Health Promotion Section Report
Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease
April- June 2024

Southern Nevada Health District (SNHD): Office of Chronic Disease Prevention & Health Promotion (OCDPHP) Report

Staff: Amanda Brown, a Health Educator in our office transferred to the Office of Public Health Preparedness. Her duties including media liaison have been transferred to Lily Davalos in our office who oversees our social media and websites. We will recruit for Amanda's position in October/November.

Section News: No updates.

Programming

Chronic Disease Prevention Program (CDPP)

Physical Activity:
CDPP provides support to the CCSD Safe Routes to School Program (SRTS) to expand SRTS participation and increase the number of schools participating in the Achievement Level Program (ALP). This school year, with our support, the following outcomes were noted:

- The number of schools that received Achievement Level Recognition status increased by nearly 40% from 28 to 40. This includes 8 schools that reached Platinum Level (highest level), also an increase from last school year.
- Over 400 schools received SRTS support for programs and activities including bike rodeos, presentations, Walk and Roll and Nevada Moves Day programs, educational presentations for parents, safety equipment (signage, No U-Turn banners, yellow safety vests), and Positive Presence campaigns.
- SRTS partnered with the City of Las Vegas to conduct 11 walk audits at local schools and 32 school observations and then worked with those schools to develop school action plans to increase safety.

The 2024 Move Your Way (MYW) Initiative kicked off in May. Move Your Way promotional and educational materials are distributed at community events and sponsored pool parties that provide free admission for families during the summer to promote physical activity. To date, the CDPP team and partners have participated in 8 events reaching over 1,850 people. In addition, CDPP and partners are also conducting targeted outreach to the Hispanic community to promote MYW at culturally specific events. To date, the team has attended 3 culturally targeted events reaching over 1,100 people with culturally and linguistically appropriate educational materials and resources to promote physical activity. The Move Your Way initiative will run through Labor Day.

Nutrition:
The spring 2024 Pop-Up Stands kicked off in April. Two Pop-Up stands occurred monthly through June at the RTC's Bonneville Transit Center. Pop-Up Stands sell regionally grown fresh produce at discounted prices and accept SNAP/EBT and Double Up Food Bucks coupons. They are open to all, but intended to serve our neighbors who have financial or transportation

barriers to accessing fresh fruits and vegetables. In total, markets sold over 1,500 pounds of produce, with over 20% of transactions being SNAP transactions. In addition, over $200 worth of Double Up Food Bucks coupons were distributed. The Pop-Up stands will resume in September.

The CDPP worked with 2 places of faith serving the Hispanic community this quarter to provide Faithful Families Classes in Spanish. Iglesia ECHO and Ven y Ve Church each hosted 8 Faithful Families classes during April. Faithful Families is an evidence-based curriculum that provides education on healthy nutrition and physical activity appropriate for faith-based settings. Classes were taught by CDPP staff and promotoras. 32 people attended at least one class.

CDPP along with 100 Black Men, sponsored the May online kids cooking class. The class featured a heart-healthy recipe and in commemoration of Stroke Awareness Month, educational materials promoting heart health were provided along with ingredients. 60 people participated in the May class

CDPP staff updated the Healthy Fellowship Guide. The Healthy Fellowship Guide is a guide for faith-based organizations to support implementation of healthy eating and physical activity policies, programs, and practices. The updated guide is on our Get Healthy and Viva Saludable websites.

Heart and Stroke:
The CDPP's Barbershop Health Outreach Program (BSHOP) hosted 'Shop Talk: Cut to the Chase' at Masterpiece Barber School on June 27 and 'Salon Talk: A Healthy You is a Beautiful You' at The Beauty Spot on June 1. Both events are geared towards the African American community.

- Shop Talk was an interactive event featuring experts addressing topics specific to men's health including heart disease, mental health, and prostate health. Over 50 men attended Shop Talk. 12 men received a BP screening/referral, and 13 men received a referral for mental health services. The event was featured in a new story on Channel 3.
- Over 30 women attended Salon Talk, which also featured expert panelists addressing topics such as heart disease, mental health, and stress management. 17 women received a BP screening/referral at Salon Talk. The salon owner is also planning a follow up activity addressing stress management and physical activity through yoga.

CDPP sponsored a free, Self-Monitoring Blood Pressure Program (SMBPP) community class at the Durango YMCA. The class began in March with 25 participants and ended in June. The class was offered in English and Spanish. 21 people completed the course (84%). Of those that completed the course, 62% were able to lower their BP from elevated, stage 2, or stage 1 to the normal range and 10% were able to lower their BP but not to the normal range yet.

Diabetes:
This quarter, CDPP staff facilitated 8 Diabetes Self-Management & Education (DSMES) classes. All the classes were offered in-person. Four classes were provided in Spanish and 4 were provided in English. Three classes were offered at SNHD and 5 were offered at off-site locations

including CenterWell, YMCA, and the Arthur Sartini Senior Housing Complex. In total, 90 people attended at least 1 class.

CDPP sponsored a free, evidence-based Diabetes Prevention Program (DPP) class for the community. The DPP class was facilitated by our partner, AAA Healthcare Institute and held at Nevada Partners. The class began in fall 2023 and wrapped up in June (maintenance is ongoing). In total, 14 participants registered for the class and 11 completed the course. Of those that completed the course, 73% reduced their weight and increased their physical activity. 36% of completers reduced their A1c to within goal range (5.1% - 6.7%) and significantly reduced their risk of developing type 2 diabetes. CDPP is sponsoring another community DPP class which began at the end of June.

Obesity:
With support from our state subgrant, CDPP designed a postcard with information about the 5210 initiative and promoting the Nevada HEAL website for healthcare providers. The postcard was sent to 75 pediatricians in Southern Nevada and 750 members of the Clark County Medical Society. Additional materials were distributed at a CCMS event in June.

CDPP ran a 5210-campaign promoting 5210 guidelines to the general community. The digital campaign ran in English and Spanish and included online banner ads and paid social media ads.

Community Outreach/Engagement:
Not including events already listed above, our CHWs participated in 5 community events this quarter reaching over 500 people. Culturally and linguistically appropriate educational materials and resources to prevent and self-manage chronic were distributed.

Tobacco Control Program (TCP)

TPP staff participated in 15 events at local high schools to promote vape-free lifestyles. A total of 107 youth-focused counter-marketing events have occurred in schools and the community during the project period.

TPP staff began recruiting high school sports teams to partner with during the 2024-2025 school year. Teams shared vaping prevention messages on their social media pages, in addition to social media pages of individual athletes from each team. This year's initiatives resulted in 135 youth-led counter marketing initiatives conducted in communities, schools and online.

The SNHD TCP's African American initiative titled Because We Matter, partnered with 12 local churches for No Menthol May. Approximately 85% of African American adults who smoke use menthol cigarettes. Staff provided educational materials, including social media ads, videos, handouts, branded promotional items, and the Nevada Tobacco Quitline cessation information to participating churches to raise community awareness about population-specific tobacco issues, flavoring in tobacco products, the risks of menthol tobacco products, tobacco marketing,

and the harm to African Americans. Staff engaged the community, distributed educational and promotional materials, and presented on No Menthol May topics during outreach activities.

Because We Matter sponsored and partnered with Clark County Parks and Recreation for the 34th annual Jazz in the Park series, running from May 11th to June 8th. This smoke-free community event, primarily attended by African Americans in Clark County, consisted of five event dates. Staff provided educational materials on tobacco-related topics, including vaping, flavoring, and menthol, and promoted the Nevada Tobacco Quitline to attendees at all five events. The total attendance for all five events in the series was over 11,000.

The TCP's Hispanic/Latinx initiative, Por Mi Por Ti Por Nosotros, Viva Saludable partnered with the Mexican Patriotic Committee's annual Cinco de Mayo event; CCSD's Mariachi competition, and Latinas in Power (LIP) painting event to promote tobacco-free lifestyles and cessation resources. Nearly 4,000 individuals attended the events. TPP staff also updated a youth prevention video, tailoring it for Latinx youth. The video discusses the dangers of vaping and offers cessation resources. The video will be shown during an upcoming Latino Youth Leadership Conference.

The SNHD Tobacco Control Program's Native Hawaiian/ Pacific Islander initiative, Island eNVy, partnered with the fourth Annual May Day event in Las Vegas on May 5th. This family friendly event was smoke and vape-free with over 450 in attendance.

The TCP is collaborating with statewide partners to conduct tobacco purchase assessments in tobacco retail settings. These assessments assess a retailer's adherence to Nevada's tobacco laws including ID verification. Additionally, tobacco retailers will be given a Tobacco Retailer toolkit to educate them on how to be a Responsible Retailer. The surveys began on April 1st. By the end of May, 600 assessments were completed at stores in Southern Nevada.

TPP staff actively participate in Attracting Addiction, a statewide initiative to share information on the dangers of flavored tobacco. Attracting Addiction recently launched a new campaign, "It's Why Kids Try," to highlight the tobacco industry's predatory marketing of flavored products to appeal to youth.

Electronic referrals from University Medical Center (UMC) and Southern Nevada Health District were made to the Nevada Tobacco Quitline. Patients who use tobacco were electronically referred via the electronic health record system. UMC is the highest source of electronic referrals to the Quitline in the State of Nevada, averaging over 900 a month. Over 27,000 UMC patients have been electronically referred to the Quitline to date.

TCP staff continued communication with the Nevada State University Policy and Sustainability committee members, professors, Nevada State Student Association, and the Office of Culture, Planning, and Policy to provide technical assistance on tobacco-free policy. The policy is expected to be adopted in December 2024. Staff continued discussions with the CSN Faculty Senate's Environmental Strategies committee and staff tabled at CSN's West Charleston campus

to educate students, faculty, and staff about the benefits of a tobacco-free policy. A media campaign consisting of web banners and social ads promoting the benefits of a tobacco-free campus also ran during this time.

July 2024

Northern Nevada Public Health (NNPH) - formally Washoe County Health District
Chronic Disease and Injury Prevention (CDIP) Program Report
Summary of activities April 2024 – July 2024

Staffing

The NNPH CDIP program has six full-time staff and a program manager. The team has several intermittent hourly (IH) staff who help complete grant deliverables for the program. In addition to the programmatic team members, two employees dedicate time to support the CDIP program, a Community Health Worker and an Office Specialist. In May, the team welcomed Stephanie Purnell as a Public Service Intern who will be assisting with tasks associated with the Northern Nevada Food Council.

Section News

- Chad Kingsley became the new District Health Officer at NNPH on May 13, 2024.
- In May, the CDIP team conducted strategic planning to take a close look at program activities and determine priorities, activities and direction of the program for FY25-27. The strategic map is included at the end of this report.
- In July, the CDIP team began reviving youth vaping prevention efforts with funding allocated to NNPH from the Public Health Fund.

Programming

The Chronic Disease and Injury Prevention Program (CDIP) focuses on the modifiable risk factors of tobacco use and exposure, lack of physical activity, and poor nutrition, as well as injury prevention (intentional and unintentional) and responsible cannabis use, including eliminating secondhand cannabis smoke exposure. These modifiable risk factors impact the leading causes of death in Washoe County, and by moving the needle on these risk factors, the CDIP Program aims to reduce illness and premature deaths in Washoe County and improve quality of life of those that live, work, and visit our community. Key approaches include efforts concentrating on policy, systems, and environmental change.

Tobacco Prevention and Control highlights

- An Extra Mile Award (EMA) was presented to the Reno Brewery District for their age-restricted bars with voluntary indoor smoke free policies. The Extra Mile Award honors businesses that have gone above and beyond the requirements of the Nevada Clean Air Act. Located on East Fourth Street, near downtown Reno, the Brewery District includes Reno's largest locally owned breweries and distilleries and is known for their handcrafted beers. Smoke-free environments are in demand now more than ever and many local businesses, like those in the Brewery District say being smoke-free better meets the needs of their customers and the community-at-large.
- Staff provided outreach to two tobacco retailers, talking to them about storefront reorganization in preparation for activities next fiscal year to reduce point-of-sale tobacco marketing. Convenience stores often sell tobacco products and when they do, they often have large amounts of window/storefront space dedicated to advertising tobacco products. The CDIP program has had success working to provide alternative window/storefront messaging options to store owners, and the program plans to continue efforts in the next fiscal year.

July 2024

- Two earned media Spanish language interviews were conducted on smoke free workplaces (Telemundo and KUNR). The coverage was based on the study, led by University of Nevada, Reno Associate Professor Eric Crosbie, that showed second-hand smoke in indoor casino areas is up to 18 times more harmful than outdoor levels. The study also showed that all indoor casino locations, including "family-friendly" locations designated as non-smoking such as arcades and restaurants, measured unsafe levels of second-hand smoke. Approximately 35,000 viewers were reached.
- Staff worked with Bethel AME Church in Sparks to host two No Menthol Sunday educational events on May 17th and May 19th. These events reached approximately 50 community members with information on menthol flavoring in tobacco products and other tobacco industry tactics employed to target and addict the African American population. Additionally, the church reached 1,000 community members with this messaging through the distribution of flyers at businesses, multifamily housing properties, schools, etc., located near the church.
- Staff recruited and provided TA to one new multifamily housing property, Dick Scott Manor, which opened with a SF/VF policy in place. This property consists of 12 units, primarily serving low-income veterans.

Physical Activity and Nutrition highlights

- In April, staff launched Power Up Kids in 11 elementary school classrooms at Peavine, Elmcrest, Loder and Juniper. Staff are provided weekly nutrition education and physical activity programming from until the end of the school year. In May, staff attended Lena Juniper's family picnic day for kindergarten classrooms. Part of the Power Up Kids Program is to engage families and students in healthy eating and active living. Staff provided interactive games, educational materials, a planting activity, and fruits and vegetables for students and families to enjoy and try.
- Staff organized the Biketopia event on April 28th in partnership with Reno Public Market and Truckee Meadows Bicycle Alliance. The event kicked off Bike Month which is celebrated during the month of May. Fifteen community organizations participated to share information and resources for residents to safely take part in Bike Month, the event attracted about 100 attendees.
- Staff are creating family engagement resources to continue Healthy Eating and Active Living messaging during summer break for families and students. Resources include tips for creating healthy and affordable recipes, free and affordable community events families can attend, and activity sheets for families to engage in physical activity together.
- Staff coordinated three senior fitness workshop events on June 7th, 10th and 21st at the Reno and Sparks Senior Center in collaboration with the Sanford Center for Aging. The free workshop engaged seniors to participate in chair yoga, balancing, stretching and strengthening exercises to promote an active lifestyle and to help prevent falls among seniors.
- The Healthy Corner Store (HCS) Program launched a video campaign on Facebook in English and Spanish from June 3rd through June 28th with three videos including :30 :15, and :10 second segments. The videos highlight the HCS program, aiming to increase community awareness about the initiative and gain interest from stores to participate.

July 2024

Cannabis and Opioid/Substance Prevention highlights

- Staff helped coordinate, promote, and staff the bi-annual Washoe County Rx Drug Take Back event on April 27th. This included helping expand an additional site, community-based, online, and local media promotion, and managing one collection site.
- Staff collaborated to research, prepare, and apply for the new 2024 Washoe Opioid Abatement and Recovery Fund competitive grant opportunity. The application includes evidence-based strategies to help reduce opioid-related substance use disorder and overdoses in Washoe County. The team expects to hear about the outcome of the application in August.

Injury Prevention highlights

- Staff presented to 30 attendees at the Vision Zero Truckee Meadows Task Force meeting. Staff shared findings from the Get Active Washoe Survey and the Walking Audit conducted last summer, focusing on physical activity engagement and the built environment. Sharing the report allowed for open discussion on current projects regarding safe, active transportation and the role CDIP could have within these projects.
- Staff helped coordinate and deliver a 16-hour Applied Suicide Intervention Skills Training (ASIST) on June 20th and June 21st. Twenty-four local participants from a variety of fields, including social workers, administrators, mental health professionals and law enforcement completed the training to become certified in identifying and assisting to keep a person with thoughts of suicide safe. This training increases community capacity to reduce suicide attempts and deaths.

Chronic Disease Prevention and Health Promotion Section Report
Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease

July 2024

CHRONIC DISEASE & INJURY PREVENTION PROGRAM STRATEGIC MAP 2025-2027

MISSION

To advance the Health District's mission to improve and protect our community's quality of life and increase equitable opportunities for better health in the areas of Chronic Disease and Injury Prevention.

VISION

A healthy community designed with equitable access, education, and resources to maximize quality of life.

VALUES

Prioritize policy, systems, and environmental changes for community health.

Decrease Cannabis

- Increase community awareness on the health impacts of cannabis use and secondhand smoke exposure, through messaging on responsible cannabis use among adults who use and prevention education for youth
- Compile local data on cannabis use and exposure, including a community needs assessment to inform programmatic activities
- Develop a two-year workplan to guide CDIP in addressing the topic area of cannabis use and exposure

Injury Prevention

- Reduce the rate of unintentional slips and falls injury among seniors
- Collaborate with local agencies to reduce the rates of injury
- Lead coordination of Suicide Prevention activities to reduce gun violence-related injury and deaths

Healthy Eating Active Living

- Create opportunities to make the healthy choice the easy choice through access, education and collaboration.
- Increase access to healthy foods and beverages where availability is limited
- Promote and offer resources to communicate healthy behaviors for healthy eating and active living
- Identify and support policies that improve the nutrition environment and increases physical activity opportunities

Youth Vaping prevention, Tobacco Control

- Eliminate exposure to secondhand tobacco smoke in Washoe County
- Promote quitting tobacco or vaping among adults and youth
- Prevent initiation of tobacco and/or vaping use among youth and young adults

STRATEGIES

CREATE environments that support healthy behaviors

EDUCATE using evidence-based information

COLLABORATE for greater impact

ADVOCATE for policy and systems change

NORTHERN NEVADA Public Health
www.GetHealthyWashoe.org

Carson City Health and Human Services Report
1st Quarter 2024 (1/1/2024 - 3/31/2024)

Chronic Disease Prevention and Health Promotion (CDPHP) Division

Adolescent Health Education Program

Program funded through:

1. The Title V Sexual Risk Avoidance Education (SRAE) Program
2. The Personal Responsibility Education Program (PREP)

Making Proud Choices, Comprehensive Sexual Education

Provides both abstinence and contraceptive use by using evidence-based, medically accurate safe sex education to youth ages 13-19 years old, with priority enrollment given to youth who are disproportionately impacted. The goal is to prevent teen pregnancy and exposure to sexually transmitted infections (STIs), including HIV/AIDS. In addition to evidence-based curricula, this program will address the adult preparatory topics: Healthy relationships, positive adolescent development and healthy life skills.

- Statistics –
  - Total participants enrolled: 304
  - Total participants completing 75% of the curriculum (a requirement for completion of the program): 269
- CCHHS Adolescent Health staff conducted classes at the following locations:
  - Carson High School
  - Western Nevada Regional Youth Center (WNRYC)
  - Carson City Juvenile Services - Probation

Promoting Health Among Teens, Abstinence Only

Provides evidence-based, medically accurate abstinence education to youth ages 10-19 years of age with priority enrollment given to youth who are disproportionately impacted. The overall goal is to prevent teen pregnancy and exposure to sexually transmitted infections (STIs), including HIV/AIDS. Additionally, it teaches young people sexual risk avoidance, personal responsibility, self-regulation, goal setting, and healthy decision making. This program promotes the prevention of youth risky behaviors without normalizing teen sexual activity and emphasizes focusing on a positive future.

- Statistics –
  - Total participants enrolled: 190
  - Total participants completing 75% of the curriculum (a requirement for completion of the program): 121
- CCHHS Adolescent Health staff conducted classes at the following location:
  - Eagle Valley Middle School
  - Fritsch Elementary

Ryan White- Part B Program (Outreach Services: Retention-in-Care)

Program funded through:

Office of HIV/Ryan White: Ryan White HIV/AIDS Program – Part B

Program's purpose is to:

- Identify people who do not know their HIV status so are not in care.
- Linkage or re-engagement of People Living with HIV (PLWH) into medical care and the HRSA Ryan White HIV/AIDS (RWHAP) services.

The program works with individuals with a last known address within one of the 15 rural and frontier counties. Clark and Washoe counties are excluded.

Statistics: 48 services were provided to 39 clients.

Tobacco Control and Prevention Program

Program funded through:

1. Centers for Disease Prevention and Control's ("CDC") Tobacco Control and Prevention
2. Nevada Clinical Services formerly the Funds for Healthy Nevada
3. Health Disparities Grant through the Nevada Cancer Coalition

- Tobacco Control and Prevention Program staff continue to be members of the Nevada Tobacco Control and Smoke-free Coalition ("NTCSC") formally known as Nevada Tobacco Prevention Coalition. Leadership positions staff currently hold on the NTCSC includes Secretary and Communication Chair. Staff represent CCHHS as a health authority.
- Staff continue to assist in the development of educational materials for statewide partners to use on priority policies related to the Nevada Clean Indoor Air Act, Tobacco Prevention and Control Funding, Restricting Flavored Tobacco Products, and Addressing Youth Access via Tobacco Retailers.
- Working with Northern Nevada Public Health to build a student athlete initiative to

promote vape-free lifestyles to student athletes by providing quitting resources and facts through the Nevada Interscholastic Activities Association (NIAA).

Prevention Health and Health Services

Program funded through:

Preventive Health and Health Services (PHHS) Block Grant

- The program works on educating individuals who are overweight or obese. Program available to individuals whose BMI is higher than 25 and are interested in receiving more information on healthier lifestyles within CCHHS's Family Planning Clinic.
- Staff are continually looking for evidence-based programs to refer patients too.

Outreach

Staff participated in eight (8) community outreach events.

- CCMES Health Fair - 4/18/24
- Walk us Home/ Pinwheels for Prevention- Resource Fair – 4/27/24
- Empire Elementary STEM Fiesta Night – 5/3/24
- Mental Health Walk and Resource Fair – 5/11/24
- Carson High School Northern Region championship game - 5/10/24
- Carson High School Northern Region championship game - 5/17/24
- Kids to Park Day - 5/18/24
- Nv Outdoor Experience – 6/22/24

Budget

- General Funds – None
- Grants – 100%

Nevada Institute for Children's Research and Policy

Report Summary

Project Period: April – June 2024

In partnership with the Nevada Early Childhood Obesity Prevention (NECOP) Workgroup members, NICRP will implement NECOP State Plan activities to help improve weight status among children zero (0) to eight (8) years of age.

The 2021-2026 state plan is divided into seven (7) overarching goals:

(1) Early Care and Education Facilities

(2) Awareness and Education for parents

(3) Awareness and Education for providers and community partners

(4) Establish Data Collection Systems

(5) Increase knowledge of best practice and current research in Early Childhood Obesity prevention strategies

(6) Increase number of Caring for our Children (CFOC) and Physical Activity and Nutrition (PAN) standards being met in Nevada, and

(7) Increase sustainable funding to support Nevada Early Childhood Obesity Prevention efforts

These goals are inclusive of 39 total objectives, further broken down into a total of 56 activities to be completed over the five-year state plan. Workgroup members and organizations provide quarterly updates on progress toward each of these activities.

Systems and Data Collection

NICRP worked with the NECOP members to develop an internal system for collecting and analyzing quarterly progress of all 7 goals among partnering members and organizations. The following progress has been reported since the last report on March 31, 2024:

During this project time period, NICRP convened one (1) meeting on June 18, 2024 with the Early Childhood Obesity Prevention Workgroup to track and evaluate the implementation of The Nevada State Early Childhood Obesity Plan. The workgroup continues with the goals and activities, specifically focusing on reviewing Latisha Brown and the childcare licensing team's recommendations regarding our proposed revisions to the Nevada Early Child Care Regulations and the Nevada Registry Wellness Training rubric discussed in detail below. NICRP plans to continue discussing with the workgroup ways to increase awareness through the implementation of Year 3 objectives and activities. The next workgroup meeting for Quarter 4 of the 2024 fiscal year will be held both in-person (in Las Vegas) and virtually on September 17, 2024.

The NECOP workgroup also assisted with the Nevada Early Childhood Advisory Council on their Data Dashboard, providing updated data and indicators to use on their Health tab.

Reports

Achieving a State of Healthy Weight (ASHW) is a national report inclusive of 47 high-impact obesity prevention standards (HIOPS, or 'standards') in child care licensing regulations that promote infant feeding practices, healthy nutrition and mealtime practices, opportunities for active play, and decreasing the frequency of screentime. The NECOP workgroup reviewed Nevada's current national standings based on the 2022 ASHW Report and developed proposed amendments to 23 of the 32 Nevada Administrative Codes (NAC) on the ASHW standards which Nevada is currently not meeting. A survey was then sent out to licensed childcare facilities in the state to gain an understanding of potential barriers associated with these proposed changes. Among the provider responses, a high percentage reported approving of regulatory changes given the following recommendations are taken into consideration:

1. Rephrase any verbiage utilizing the term "primary care provider" to specify healthcare provider and/or childcare provider.
2. Specify quantities and/or duration of any amendment which requires an adjusted volume or time component.
3. Among all amendments, be mindful of developmental delay and children/caregivers with adaptive needs.

The survey was then distributed to families in the state of Nevada to gain insight on implications and barriers for children and their families. The parent/caregiver survey was disseminated between August – September 2023, with a total of 132 completed responses during this time. Of the 19 total revisions provided in the survey for parents, 6 had the majority in approval of the changes. Of the remaining 13 revisions, the greatest concern among parents was a lack of assistance/support/ knowledge, followed by a lack of potential funding for facilities.

The full report is now finalized and was reviewed by the workgroup at the 2024 Q1 quarterly meeting. Several members of NECOP workgroup met with Latisha Brown from Nevada childcare licensing on March 29, 2024, to discuss the report and proposed revisions to the corresponding Nevada regulations. On June 13, 2024, Latisha and her team were instrumental in providing their comments on the Nevada Early Child Care Regulations. These comments were sent to the workgroup to review prior to the June (2024 Q3) meeting. NICPR will compile the licensing team's comments comprehensively prior to the Q4 workgroup meeting. Once completed, the workgroup will discuss and determine the next steps, including addressing the state licensing board and/or awaiting the 2025 legislative session.

Policy

Per NAC 432A.323, all licensed childcare providers are required to complete two or more hours of training in wellness including childhood obesity, nutrition, and moderate or vigorous physical activity within 90 days of employment and each year thereafter. The Nevada Registry worked with the EC Obesity Prevention workgroup to develop content guidelines for wellness courses, which was finalized during Q1 of 2023. The document outlines the content guidelines, course objectives and trainer qualification requirements for the required training. During Q2-Q4 of 2023, the Nevada Registry continued to partner with the workgroup to develop a review process of all current statewide trainings, along with a checklist for all new training applications. All new sessions submitted until the checklist is

finalized will continue to be approved but will need to meet updated criteria by January 1, 2024. After that point, online courses that do not meet the requirements will be removed from the calendar. Two (2) UNR Extension interns have assisted with the development of a scoring sheet for this evaluation system during the last project year. During the March quarterly meeting, an update was provided that a program manager at UNR Extension had committed their time to assist with this project. However, at the June quarterly meeting, it was reported that no progress had been made on the training rubric since the previous meeting. The project, previously overseen by temporary staff, has since come to a halt.

Education

Project year-to-date, the workgroup has developed and disseminated two (2) educational materials to partners and community collaborators, including an infographic of Nevada childhood obesity data and a toolkit for the National Child and Adult Care Food Program (CACFP) Week in March. Three (3) additional reports are in progress and planned for dissemination during Q4 of the 2024 project year, including an Obesity Prevention Policy Brief for Pediatricians, a breastfeeding awareness toolkit, and a childhood obesity prevention toolkit. All finalized reports are available on the workgroup's webpage: Nevada Early Childhood Obesity Prevention Workgroup - NICRP (unlv.edu)

Agenda Item #10

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

CDPHP Section Updates

July 25th, 2024

This update highlights the various funding sources supporting chronic disease prevention initiatives, including federal grants from the CDC and state-specific funds like the Fund for a Healthy Nevada. It details program achievements, ongoing challenges, and plans, offering the Council a clear picture of the current landscape of wellness and chronic disease prevention in Nevada.

Office of Food Security and Wellness (OFS)

Council on Food Security (CFS)

The Office of Food Security (OFS) provides administrative support to the CFS. The July 2024 agenda and 2024 Annual Report draft are being routed for management approval. Efforts are currently focused on the State Health Improvement Plan (SHIP) and the 2023 Food Strategic Plan. Currently, OFS is running a workgroup to hold a 2025 Food Security Conference in the Northern Region. The OFS also oversees the Food for People, Not Landfills (FFPNL) subcommittee created by CFS. The following steps are to reach out to agencies to establish representatives and then begin the meetings. These activities are pending staff capacity. The Program should be at full capacity by the end of July to begin working on this project.

Funds for a Healthy Nevada (FHN)

The OFS mainly manages two million annually from the tobacco settlement money (NRS 439:620-630) recovered by the State of Nevada called the Funds for a Healthy Nevada (FHN). FHN is a two-year grant cycle with 11 grantees for SFY24-SFY25 (Food Banks, Food Pantries, and a RX Pantry). The FHN funds support initiatives and programming to reduce hunger throughout Nevada communities, promote public health, and improve health services for children, senior citizens, and persons with disabilities. The Program is working on Scope of Work (SOW) amendments for SFY25. The FHN Survey will be released in July 2024, and the FHN report will be updated following the survey analysis.

Wellness Prevention Program (WPP)

OFS also manages the WPP that oversees obesity prevention, Supplemental Nutrition Assistance Program Education (SNAP-ED) funds, the State Partnerships Improving Nutrition and Equity (SPINE) and participates in the

National Association of Chronic Disease Directors (NACDD) opportunities with the Public Health AmeriCorps (PHA) and the Public Health Associate Program (PHAP).

SPINE:

All planned deliverables for the current period have been completed. We continue to make progress on the FFPNL Program and are exploring ways to enhance its implementation and reach. The Program is open to discussing any potential areas of collaboration or shared interests with CWCD regarding this Program.

SNAP-ED

SNAP-Ed Update:

CACFP GIS Mapping: Transitioning map hosting to UNR
Collaborating with UNR, SEI, and NDA on FFY24 deliverables
This move ensures the long-term sustainability and accessibility of the mapping tool

5210 Program

The Program received website maintenance funds from the Preventive Health and Health Services (PHHS) Block Grant Program, and the coordinator supports activities related to the PHHS grant. The PHHS grant allows the State to address our unique public health needs and challenges with innovative and community-driven methods. See more information by clicking on the Centers for Disease Control (CDC) and clicking NV PHHS to review the current executed grant. SOWs for NNPH and WCHSA Health Districts with budgets have been established. Currently, program staff are working on amendments to clean up repetitive information. Website maintenance is occurring with KPS3.

Obesity Prevention:

2023 Obesity Report was complete, please reach out if anyone is interested in it. The state legislature will post to their website as well.

Population Health & Wellness Unit

Tobacco Control Program

The Tobacco Control Program (TCP) aims to reduce chronic disease morbidity, mortality, and disability related to commercial tobacco use dependence and

secondhand smoke exposure in Nevada. Some of the recent activities of TCP are listed below:

The tobacco control program has worked with its partners to finalize the scope of work for Year 5, CDC Tobacco grant. Currently, the Year 5 subawards are processed in ROCS.

Three representatives from the CDC came for a two-and-a-half-day site visit to Carson City in April 2024. This visit is a requirement of the CDC Tobacco Grant.

The Tobacco Data dashboard summarizing the tobacco cessation data is currently under construction.

The Synar Strategic Plan is completed and ready to be published on the Bureau of Behavioral Health Wellness and Prevention website.

Nevada Tobacco Control Plan 2024-2029 is under review with the Public Information Officer. Once approved, it will be posted on the state tobacco control program website.

We are wrapping up year 1 of Fund for Healthy Nevada (FHN) Tobacco activities. Year 2 will begin on July 1.

Working on updates to the state tobacco control program website

The Nevada Tobacco Control Program is preparing for site visits of the FHN partners this fall.

Building our Largest Dementia (BOLD) program

BOLD aims to create a statewide dementia infrastructure by strengthening existing local community health capacity to empower healthcare providers and community leaders through education on Alzheimer's and related dementia (ADRD) awareness, risk reduction, early detection, and leveraging resources across multiple sectors to improve equitable access to support people living with, caring for, and treating people living with ADRD. Some of the recent activities of the BOLD Program are given below:

Nevada's Division of Public and Behavioral Health (DPBH) currently houses the Building Our Largest Dementia (BOLD) infrastructure for Alzheimer's Act Program through the Chronic Disease Prevention and Health Promotion (CDPHP) section under the Alzheimer's Disease and Related Dementia (ADRD) program. CDPHP has been granted a 5-year BOLD grant (9/30/2023-9/29/2028,

450,000/year) in 2023. In this new grant cycle, the Nevada BOLD program will partner with the University of Nevada, Reno (UNR) Dementia Engagement, Education, and Research (DEER) program and the Alzheimer's Association in Nevada.

The free, downloadable Dementia Self-Management Guidebook was launched in March on the DEER Program website (https://deerprogram.org/dementia-self-management/) and has since been downloaded by 184 individuals as of May 2024.

The Nevada BOLD Coalition met to discuss the 2024 Alzheimer's Disease facts and figures, focusing on incidence and prevalence within the State. These monthly meetings provide a platform for state representatives and coalitions to collaborate in in-person and virtually. The agenda includes events planning, resource sharing, and strategies to enhance the quality of life for individuals affected by dementia and their caregivers throughout Nevada.

The 8-week Dementia Self-Management Program pilot, offered by the UNR DEER program, was completed, showing a 16.9% improvement in self-efficacy from the pre- to post-implementation survey.

Dementia Friendly Nevada (DFNV) Public Service Announcements for positive dementia messaging are now available on the DFNV website and distributed to all partner organizations.

Residents of Carson City showed an interest in launching a Dementia Friendly Carson City Community Group. The Dementia Friendly Carson City Community Group Co-Facilitator training was conducted on March 14, 2024. Two individuals attended and have begun planning the next steps of launching the Community Group, including recruiting members, planning a kickoff event, and conducting a dementia community needs assessment.

Community Wellness Unit

The Community Wellness Unit Manager will be on leave as of July 3, 2024, due to military training and a deployment for a year.

Cardiovascular Health (CVH) Program

The Centers for Disease Control and Prevention (CDC) is on schedule to complete the first year of its five-year National CVH grant, DP-23-0004, which began on June 30, 2023.

The Program is in the third quarter of The Innovative Cardiovascular Health grant, CDC DP-23-0005, which began on September 30, 2023. The Program is currently working on an RFP to implement a mobile application to track heart disease lifestyle change programs with bidirectional social service tracking capability to ideally begin during year 2 of the grant.

The CVH program is undergoing a staffing reduction and is combining its Heart Disease grants evaluation function with Diabetes grants. As a result, the Program is looking to hire an evaluator to oversee the combined evaluation process.

The Nevada Statewide Cardiovascular Health Learning Collaborative (LC) aims to strengthen efforts to expand team-based care outside the clinical environment to increase coordination, communication, and follow-up care among identified communities and populations. The LC completed its 12th session for the Year. For additional information, please get in touch with Troy Lovick atTlovick@health.nv.gov.

Diabetes Prevention and Control Program (DPCP)

The DPCP is approaching the end of Year 1 CDC DP-23-0020: A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes which will commence June 30, 2024. The Program has received Year two funding for the DP23 -0020 grant and is working to complete the technical review.

The following are the Partnerships DPCP has curated for renewal during year 2 of the DP 23 - 0020 grant: (1) the University of Nevada, Reno – Sanford Center for Aging, (2) the Nevada Business Group on Health, and (3) Roseman University of Health Sciences.

The Community Wellness Manager was certified as a Diabetes Prevention Program and a Diabetes Self-Monitoring and Education State Qualified Specialist.

Clinical & Community Engagement Unit

Women's Health Connection (WHC)

Women's Health Connection is a breast and cervical cancer early detection program dedicated to serving low-income, high-risk, uninsured, and underinsured women in Nevada.

The Program aims to lessen the impact of breast and cervical cancer by focusing on education, early screening, diagnostics, care coordination/case management, and enhancing accessibility to treatment.

Women's Health Connection has been federally funded through the Center for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) since 1997

Since its implementation in 1997, Women's Health Connection has provided breast and cervical cancer screening to over 79,615 women.

The Program has diagnosed approximately 1,373 women with breast cancer and 2,100 women with invasive cervical cancers or premalignant cervical lesions.

- In SFY 23, WHC served 6,904 women.
  - 5,410 served for Breast Cancer
  - 4,290 served for Cervical Cancer
- The Focus of WHC is screening.
  - SFY 24 Goal is 7,350 women served.

Comprehensive Cancer Control Program

The State of Nevada's Comprehensive Cancer Control Program works towards bringing together communities and partner organizations who strive to reduce the burden of cancer in Nevada by combining efforts to:

- Reduce cancer risk.
- Find cancers earlier.
- Improve treatments.
- Increase the number of people who survive cancer.
- Advancing health equity to reduce cancer disparities.

This Program is funded through the Centers for Disease Control (CDC) and Prevention National Comprehensive Cancer Control Program, which assists Nevada in supporting the Nevada Cancer Coalition in fighting cancer in our State.

The Comprehensive Cancer Control Program at the Nevada Division of Public and Behavioral Health is funded through the Centers for Disease Control and Prevention (grant CDC-RFA-DP22-2022). The goals of the Comprehensive Cancer Control Program, as outlined by the CDC, align with the Healthy People 2030 goals:

- Reduce the proportion of students in grades 9 through 12 who report sunburn.
- Increase the proportion of cancer survivors who are living five years or longer after diagnosis.
- Increase quality of life for cancer survivors
- Increase the proportion of people who discuss interventions to prevent cancer with their providers.
- Reduce the overall cancer death rate.
- Reduce the female breast cancer death rate.
- Reduce the colorectal cancer death rate.
- Reduce the prostate cancer death rate.

The Comprehensive Cancer Control Program is in year 4 of the current Nevada cancer plan, which can be found on the Nevada Cancer Coalition website. The Program has also started working on the 2026 – 2030 Nevada Cancer plan, which will be presented at the Nevada Cancer Summit in September of 2025.

WISEWOMAN

The Well-Integrated Screening and Evaluation of Women Across the Nation (WISEWOMAN) Program was created to help women understand cardiovascular disease (CVD) risk reduction with a focus on hypertension by providing services to promote lasting heart-healthy lifestyles, including knowledge, skills, and opportunities to improve risk factors to prevent, delay, or control CVD and other chronic diseases.

Authorized by Congress in 1993, the WISEWOMAN Program is funded through the Centers for Disease Control and Prevention (CDC) to extend preventive health services offered to participants enrolled in the National Breast and Cancer Early Detection Program (NBCCEDP), Women's Health Connection (WHC) Program.

WISEWOMAN Eligibility and Services

- Clients 40 – 64 years of age
- Clients with a low income (below or at 250 percent of the Federal Poverty Level)
- Clients who are underinsured or uninsured.

- Clients enrolled in the Women's Health Connection Program
    - The intent and benefit of coupling the WHC and WISEWOMAN programs is to create a stronger link across many clients and services.
- Heart disease and stroke risk factor screenings (blood pressure, cholesterol, Diabetes, body mass index, smoking)
- Health Risk Assessment
- Risk Reduction Counseling
- Healthy Behavior Support Services and Evidence-Based Lifestyle Program
- Follow-up for patients identified with heart disease and stroke risk factors.

Risk Reduction Counseling and Health Behavior Support Services Referral

Clients who are found to be at risk for cardiovascular disease are referred to Risk Reduction Counseling. Risk Reduction Counseling interprets a client's health risk assessment and screening test results for possible health-related recommendations and refers them to a Healthy Behavior Support Service. Healthy Behavior Support Services include Health Coaching to improve and maintain health and Evidence-Based Lifestyle Programs to promote and sustain healthy behaviors.

PHHS Block Grant

The Preventive Health and Health Services (PHHS) Block Grant, administered by the Chronic Disease Prevention and Health Promotion Section of the Bureau of Child Family and Community Wellness, is a critical funding source that supports a wide range of public health initiatives in the State. For Fiscal Years 2023 and 2024, the grant focused on key objectives, including reducing adolescent dating violence, enhancing public health workforce capacity, addressing obesity in children and adults, and decreasing the prevalence of chronic kidney disease. The grant funding supports the Local Health Districts and community partnerships. These objectives are pursued through various activities such as educational programs, tribal and community partnerships, data utilization improvements, and support for advisory committees. Additional activities for the FY25 grant cycle will improve on prior activities and fill gaps in funding for program partners while continuing to build on sustainable and long-term program funding.

The written application for the PHHS Block Grant was due on July 12, 2024. Additionally, there has been a change in grant management. The prior Grant Manager has taken a new position, and Michelle Harden, Quality Improvement Manager for the CDPHP, now manages the grant.

Funding from salary savings has been strategically reallocated across partners through subgrant amendments. This reallocation allows for more efficient use of resources and supports the diverse range of activities outlined in the work plan. These activities include public awareness campaigns, workforce training, school-based interventions, and community health initiatives, all aimed at improving public health outcomes in Nevada.