

NCC-U68 2016 State Primary Care Needs Assessment

Nevada Primary Care Office, Division of Public and Behavioral Health
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INTRODUCTION and BACKGROUND

This Primary Care Needs Assessment identifies communities in Nevada with the greatest unmet health needs as well as health disparities through comparisons across communities and populations. There are many lenses through which health needs can be viewed, and the Primary Care Office (PCO) has a very distinct lens with the health professional shortage area (HPSA) designation process. Incorporating population-to-provider ratios with data for population health, demographics and geographic features within a *rational service area*, the designation process is a reasonable foundation for directing resources toward the greatest unmet health needs.

The PCO is the only *resource* in the state to collect the data necessary to calculate population-to-provider ratios, consistent with requirements under the federal Health Resources Services Administration (HRSA), Shortage Designation Branch (SDB). Partnering programs within the Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS), as well as other state and community-based partners, are essential *resources* for data on population health, demographic and geographic features.

Following a brief section on **Methodology**, this report is generally organized according to these *resources*, with **Nevada Data and Rankings** primarily from the DHHS quarterly report, **Unmet Health Care Needs and Disparities** primarily from the Maternal and Child Health Five Year Needs Assessment, and **Health Professional Shortage Area Designations** reflecting the provider data collection from the PCO, together with our partner resources to establish and maintain the resulting designations for primary, dental and behavioral health care.

The single greatest factor resulting in HPSA designations is the severe shortage of providers that is experienced throughout our state. Health care coverage expansion under the Affordable Care Act has resulted in a 73% increase in our state Medicaid enrollments, creating even more demand for providers. Consequently, primary care workforce development is not only a priority for the PCO, but for all of DHHS. State funding has been approved for two new positions to expand the PCO in the current biennium, with plans to transition our programs into the DHHS Director's Office in the next biennium. The last section of our report, **Primary Care Workforce Development Recommendations and Initiatives**, elaborates this expanded workload that leverages a health professional pipeline mapping project from 2014.

METHODOLOGY

Data Collection

The PCO conducts primary data collection through provider surveys. Online surveys are published biennially in collaboration with the Medical, Osteopathic and Dental licensing boards,

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but the majority of information is collected through phone surveys and direct outreach to health care collectives, clinics and individual providers. Psychiatrists are included under the Medical Board, and we do not collect data on other behavioral health professionals due to insufficient resources. These data are featured in the section on **Health Professional Shortage Area Designations**. This year, the PCO also collected primary data through a survey of all the professional health licensing boards, as referenced in the **Workforce Development** section. In 2014, the PCO Manager coordinated the Behavioral Health Professional Pipeline Mapping Project, which included facilitated discussion groups across multiple professions, with various stakeholders; resulting recommendations are included in the **Workforce Development** section.

All other data in this report are from secondary sources. The DHHS Director's Office compiles Nevada rankings across a broad range of national measures of economic, health and social well-being on a quarterly basis; this resource makes up the majority of the section on **Nevada Data and Rankings**. The Maternal, Child and Adolescent Health program within DPBH conducted a Five-Year Needs Assessment, from which data is taken for much of the section on **Unmet Health Care Needs and Disparities**. Footnotes are provided throughout the report to identify specific data sources, with inclusion of hotlinks to Internet sources in many cases.

Strengths and Limitations

The volume of data and the diverse range of sources included in this report add both breadth and depth to create a robust assessment of primary care need in Nevada. While much of the data speaks for itself in terms of relative health status of different target populations across different measures, it is challenging to summarize the data into a broad statement of need that accurately reflects all these measures.

The tool that is often utilized with policy-makers to broadly communicate need is a HPSA designation map that is created and published by our partners at the State Office of Rural Health. A map is created for each designation category: primary, dental and behavioral health, with each biennial publication of the *Data Book*. The 2015 maps are included in our section on **Health Professional Shortage Area Designations**.

A significant limitation is the provider data collection method. The survey process is labor intensive, unpredictable, and fraught with methodological weaknesses.

- There is no requirement for providers to participate in the survey, so those who do participate may reflect a subset who are more likely to participate in government programs, thereby skewing the overall results toward higher Medicaid participation.
- Survey respondents may be an Office Manager or support staff who don't have actual data that can be provided to answer questions about rates of acceptance for Medicaid, Medicare or sliding-fee-scale.
- Survey respondents are typically asked to estimate the level of acceptance for Medicaid, Medicare or sliding-fee-scale, and typically overestimate that level, again skewing results toward higher Medicaid participation.

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- The HRSA requirement to survey two-thirds of the provider population in order to impute results to the whole target population is arbitrary and does not have any basis in statistical validity. Random sampling with samples as small as 10% in urban areas would produce more accurate results with significantly less investment of time and effort from PCO staff.
- The high volume of manual data entry that is required for this process introduces another opportunity for error that could be greatly reduced with random sampling.

Despite these challenges, the PCO staff make every effort to develop and maintain accurate data, working in collaboration with our partners whenever possible to review data and the resulting HPSA designations.

NEVADA DATA and RANKINGS

Geographic and Demographic Overview

Nevada is a large frontier state of roughly 110,000 square miles with a multitude of mountain ranges, from the Sierra-Nevada rising over 14,000' elevation on our western border, to Wheeler Peak at over 13,000' on the eastern border, with more ranges covering the vast distances between, including nearly 500 miles of Highway 50, *The Loneliest Road in America*. Our population of 2,839,099, is concentrated in the two urban counties of Clark and Washoe, comprising about 89%. Statewide, Nevadans identify predominantly as White, at 76.1%, with 9.1% African American, 8.3% Asian, and 1.6% American Indian or Alaskan Native. Nevadans with Hispanic or Latino origins make up approximately 27.8% of our population, and 4% of the population identify as two or more races.¹

Poverty

Based on federal poverty guidelines, rates for Nevadans were several points below national averages from 2005 to 2009, for both children (15%) and adults (11%). Beginning in 2010, rates increased up to 16% for adults and 23% for children in 2013, in parallel with national averages; then dropped a point each to 15% and 22%, respectively in 2014. Older Nevadans have stayed slightly below the national average with a low of 6% in 2004 to a high of 9% in 2013, dropping to 8% in 2014. Poverty rates for single female-headed households with children have generally increased over the ten-year period, from 32% in 2005 up to 44% in 2009, down to 40% in 2014, while remaining several points below national averages.² However, Nevada's percent of children who live in single parent families has grown steadily in the last decade from 32% in 2005 to 39% in 2014, exceeding the national average by several points.³

¹ United States Census Bureau, <http://quickfacts.census.gov/qfd/states/32000.html>

² U.S. Census, American Community Survey

³ Kids Count

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Nevada households receiving public assistance is slightly below the national average at 131 per 1,000 compared to 139. The maximum income threshold for TANF eligibility is considerably higher than the national average at \$1,546 [per month for a family of 3], while the maximum benefit is below the national average at \$383.⁴ The TANF work participation rate is slightly higher than the national average at 36% with average 26 hours per week. Job retention has increased from 63% to 72% over the last decade, while job entry has decreased from 37% to 15%. Earnings gains have declined in recent years from 44% in FY06 to 24% in FY11, compared to 31% nationally.⁵

Economy and Employment

Nevada's population grew by at least 50% every decade from 1950 through 2000, and experienced the highest growth rate among states through the early 2000s, with a sharp decline in 2009 down to only 1%,⁶ due to the great recession. For the next few years, Nevada experienced the highest rates in the nation for foreclosure with one in every 359 housing units statewide,⁷ as well as the highest rates for unemployment, which peaked at 13.7% in 2010.⁸

Reflecting the recovery of the last few years, in January 2016, Nevada's job growth ranked 3rd in the nation with 60 straight months of year-over-year job gains, with construction and leisure industries leading the way. Unemployment dropped back down to an average 6.8% in 2015, although still above the national average of 5.3%, and Nevada's population gain was the fourth strongest in the U.S.⁹

Tourism and gaming employ nearly 400,000 Nevadans, but these are typically low wage jobs with an average salary of \$31,000. Approximately 57,000 of these employees are members of the Culinary Workers Union, which offers full coverage health benefits with no premiums or deductibles through the Culinary Health Fund.¹⁰

Logistics and manufacturing are also significant industries for Nevada, employing 66,000 and 42,000 Nevadans, respectively, with average yearly wages between \$56,000 and \$54,000. Mining was reported as the fourth top industry in Nevada, accounting for 15,000 jobs where support positions are paid low wages, but miners and administrators earn average salaries of

⁴ Urban institute, Welfare Rules Databook

⁵ U.S. Dept. of Health and Human Services, Administration for Children and Families, Office of Family Assistance

⁶ 10 fastest-growing states, CNN Money,

http://money.cnn.com/galleries/2010/pf/1012/gallery.fastest_growing_states/

⁷ <http://vegasinc.com/business/tourism/2013/sep/11/nevadas-foreclosure-rate-back-highest-us-report-sa/>

⁸ <http://www.nevadaworkforce.com/>

⁹ ibid

¹⁰ <http://www.culinaryunion226.org/>

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90,000. Aerospace was reported as the fifth largest industry with 13,000 Nevada employees and average earnings of \$78,000.¹¹

While tourism and gaming, logistics, manufacturing and aerospace are primarily in the urban and suburban areas of the state, mining is concentrated in rural and frontier Nevada, primarily in the northeast region of the state. Because the price of gold typically goes up when other economic indicators go down, mining activity increased through the recession, expanding populations and housing demands in rural and frontier areas, then contracting as broader economic sectors recovered. Establishing health care networks can be difficult in these areas due to multiple factors: the transient population, the boom and bust cycle of mining, the low density population, the vast distances between population centers, and the libertarian philosophy of regional leadership. When the mines are active, employees have health coverage and access to providers. However, many providers in these communities do not accept Medicaid, leaving a significant portion of the population without local access. Consequently, these Nevadans must sometimes travel to surrounding states for primary or dental care. Behavioral health care is supported to a significant degree through telehealth systems that connect rural and frontier Nevada to providers in urban areas in Washoe and Clark counties.

Statewide, the health care sector has been more stable than other sectors over the past several years, with growing demand for health care services and focused efforts to improve access to care. Nevada Health Care Industry online job postings totaled 29,100 in 2015, up from 20,400 in 2014, and the top industries are general medical/surgical hospitals, offices of other health practitioners, and offices of physicians. The overwhelming majority of these jobs are full-time, at 92%, and the top occupations in demand are registered nurses, followed by medical and health services managers. The top in-demand skills are patient care and acute care, with a majority requiring at least some college.¹²

Child Welfare

While reports of maltreatment have increased over the last decade in Nevada, fatalities have started to decrease, with rates comparable to national averages. Both immediate response times and post-investigation services have improved in recent years and are below the national averages. Length of stay in foster care has improved in the last two years, but the rate of adoptions--35% in 2014-- has fluctuated over the period and is significantly below the national average of 47%.¹³

Seniors

¹¹ <http://www.newsmax.com/FastFeatures/industries-nevada-economy/2015/04/14/id/638269/> NOTE: This article did not include the health care industry among the top five in Nevada, although employment numbers are higher than both mining and aerospace.

¹² Silver State Solutions, Health Care Sector 2015, Nevada Department of Employment, Training and Rehabilitation.

¹³ U.S. Dept. of Health and Human Services, Administration for Children and Families

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Seniors make up 14% of Nevada’s population, with 8% in poverty, slightly below the national average of 10%. Thirty-six percent of seniors have some disability; predominately ambulatory, vision or hearing, followed by mental and self-care. While the disability rates are very close to national averages, the nursing facility residency rate of 122 per 1000 for Nevadans is significantly lower than the national rate of 228 per 1000 in 2013.¹⁴

Disability

Rates for non-institutionalized Nevadans with disabilities were similar to national averages, ranging from 5% for children up to 36% for seniors. The overall number with a disability is slightly below the national rate at 120 per 1,000 in 2014. Developmental services spending was well below the national rate, at \$2,432 per participant compared to \$8,835 in 2013, while the percent of disabled who are working is several points above the national rate, at 42% compared to 35% in 2014.¹⁵

Health

Nevada ranked 47th in 2015 in the overall ranking from the Annie E. Casey Foundation’s 10 infant, children and teen indicators. Several individual measures were similar to national averages, including: low birth weight – 8%, infant mortality rate – 5%, child and teen death rate – 24%.¹⁶ While the teen birth rate has been significantly higher than the national rate for most of the last decade, we have seen gradual improvement, closing some of the gap in 2013 at 30 per 1,000 compared to 27 nationally.¹⁷

Nineteen percent of adults reported poor or fair health in 2013, compared to 17% nationally, although the average number of *poor physical health days* was slightly below the national average at 3.7. Consumption of fruit and vegetables, and physical activity are stable over the period and similar to national averages.¹⁸ In 2015, Nevada dropped a point below the national average, to 17% adult smokers, after many years of exceeding national averages.¹⁹ Rates for binge drinking are similar to national rates at 16%, while illicit drug use is slightly higher at 11%.²⁰ Obesity is slightly lower at 28%, while diabetes (10%), high blood pressure (31%), high cholesterol (39%) and stroke (3%) are all similar to national rates. Cardiac heart disease and heart attack rates have been relatively stable over the last decade similar to national rates, while cardiovascular deaths have steadily declined to 275 per 100,000, and cancer deaths have dropped to slightly below national rates in 2015, to 188 per 100,000.²¹

¹⁴ U.S. Census, American Community Survey

¹⁵ *ibid*

¹⁶ Kids Count

¹⁷ United Health Foundation, America’s Health Rankings

¹⁸ *ibid*

¹⁹ Centers for Disease control and Prevention, Behavioral Risk Factor Surveillance System

²⁰ SAMHSA, Substance Abuse and Mental Health Services

²¹ United Health Foundation, America’s Health Rankings

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Health Care

Early prenatal care has improved for Nevada, from 67% in 2002 to 75% in 2011. Immunization improved to 85% through 2011, but additional vaccine requirements resulted in a drop to 65% in 2012, with a modest improvement to 68% in 2015.²² Nevada ranks last, at 52%, for the number of adults aged 65 and over who have had a flu shot in the past year, but does a little better at 74% for blood cholesterol checks within the last 5 years. Mammograms, pap smears and colorectal cancer screening at the recommended ages are at 67%, 73% and 61% respectively, all several points below the national average.²³

Dental visits have declined over the decade, both statewide and nationally, to 60% and 65%, respectively, in 2015. Nevada has fewer primary care physicians per 100,000 at 86 in 2015, compared to 127 nationally.²⁴ This measure is elaborated below, in the section on Health Professional Shortage Area Designations.

Hospital-related measures show mixed results with: improvement on preventable hospitalizations at 46 per 1,000 Medicare recipients, compared to 58 nationally in 2015; slightly higher rates of death in low mortality diagnosis related groups and infections due to medical care; and at or near the bottom for appropriate timing of antibiotics for surgery patients. The percent with heart failure who received recommended hospital care is just above the national average at 96%, while dramatic improvement has been made for hospital patients with pneumonia who received recommended hospital care at 93%. Hospice patients receiving care consistent with stated end-of-life wishes is slightly below the national average at 93%.²⁵

Mental Health

The average number of poor mental health days per month reported by Nevadans rose slightly to 4.0% through the recession, and declined to 3.4% in 2015, slightly below the national average. Frequent mental distress is reported at a slightly higher rate than nationally. Nevada's per capita mental health spending is significantly below the national average at \$89 compared to \$120, and the state's adult public mental healthcare system has earned failing grades for *health promotion and measurement*, as well as *community integration and social inclusion*, from the National Alliance on Mental Illness.²⁶

²² *ibid*

²³ Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System

²⁴ United Health Foundation, America's Health Rankings

²⁵ U.S. Dept. of Health and Human Services, Agency for Healthcare Research and Quality

²⁶ Grading the States 2009

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Suicide

In 2014, Nevada's suicide rate was above the national average of 13, at 20 per 100,000. Among seniors, the rate is more than twice the national average at 35 per 100,000 compared to 17. Among high school students, the rate is approximately 11% compared to 8% nationally.²⁷

Health Insurance

The number of private sector establishments offering health insurance to employees was at 53% in 2013, down from 63% in 2008, compared to a national average of 50%. Average health insurance premiums were slightly lower than the national average.²⁸ Although Nevada has made significant progress from a high of 23% uninsured in 2010 to 15% in 2014, it is still higher than the 12% rate nationally, for total population.²⁹

While most states saw a significant decrease in rates of uninsured children between 2013 and 2014, Nevada had the highest percentage point drop from 14.4% to 10%. However, there were only three states with uninsured children rates higher than 10% in 2014. Despite expansion under the Affordable Care Act, disparities still exist: poor children in Nevada (below 138% of federal poverty guidelines) had an uninsured rate of 13.2%; the rate for uninsured Hispanic children was 14% compared to 7.2% and 7.3% for white and non-white children, respectively.³⁰

Nevada's Medicaid spending per capita ranked at or near the bottom, among the 50 states, for most of the last decade, rising to 39th in FY14 and 36th in FY15,³¹ reflecting expansion of Medicaid under the Affordable Care Act, going from 20% uninsured in 2013 to 15% uninsured in 2015. In this timeframe, Medicaid enrollment in Nevada has increased by 73 percent – the second highest percentage increase in the US, after Kentucky.³² In actual dollars, Nevada Medicaid and Check Up spent \$1,778,419,393 in state fiscal year 2014, with 60% federal share and 40% state share. Increased expenditures of \$154,816,777 covered 125,989 new enrollees at the end of SFY 2014, who were 100% federally funded.³³

The high point for Medicaid eligibility for pregnant women in Nevada was 185% of the federal poverty level through a Medicaid HIFA (Health Insurance Flexibility and Accountability) waiver program that expired in 2011. Although technically, this rate decreased to 164% of poverty

²⁷ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

²⁸ Kaiser Family Foundation, State Health Facts

²⁹ U.S. Census, American Community Survey

³⁰ <http://www.shadac.org/publications/state-level-trends-childrens-health-insurance-coverage-2016-report>

³¹ National Association of State Budget Officers, State Expenditure Report; U.S. Census, Annual Population Estimates.

³² <https://www.healthinsurance.org/nevada/>, December 3, 2015

³³ Nevada Medicaid Fact Book, 2015

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guidelines in 2015,³⁴ the actual coverage is comparable to pre-ACA levels because categories of income that were previously included are now excluded, e.g., child support.

Nationally, Medicaid expenditures under long-term services and supports have been increasing for home and community-based services, while decreasing for institutional spending. In 2013, home and community-based services spending, nationally, exceeded 50% of the total LTSS spending for the first time. Nevada was slightly below the national average for HCBS spending, at 48.5%.³⁵

UNMET HEALTH CARE NEEDS and DISPARITIES

The Nevada PCO staff work closely with the Maternal, Child and Adolescent Health Program (MCAHP) to support access to care for these key populations. The Nevada MCAHP recently conducted an extensive process for their Five Year Needs Assessment³⁶, in which the PCO participated and continues to benefit. A broad range of stakeholders and consumers were surveyed and invited to participate in focus groups, facilitated in Clark, Elko and Washoe counties, reflecting urban, rural, north and south regions with diverse industries and cultures.

Stakeholders included public and private agencies, both non-profit and for profit. Consumers included women with children who were primarily under- or uninsured, had children with special needs, or utilized government funded social service programs, such as Women, Infants, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). Primary data gained through participation from these stakeholders and consumers were used in combination with secondary data sources to develop priorities for six population domains: 1) Women's/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) Adolescent Health; 5) Children and Youth with Special Health Care Needs; and 6) Cross-Cutting/Life Course.

Significant racial/ethnic disparities for health outcomes in Nevada were explored through a combination of the *life course perspective*, the *MCH Pyramid of Health Services* and the *10 MCH Essential Services*.

Women's/Maternal Health

Under this domain, identified priorities focused on prevention through wellness screening, prenatal care/visits, and access to family planning services. In 2013, 60.1% of women had a preventive medical visit compared to 58.6% in 2009. By race/ethnicity, Black women were far more likely to report having a preventive medical visit in the past year (83.8%) compared to Asian (61.9%) and White (55.4%) in 2014. Ongoing efforts to educate women about expanded

³⁴ Kaiser Family Foundation, State Health Facts

³⁵ Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY2013, Truven Health Analytics

³⁶ Available online at <http://dpbh.staging.nv.gov/Programs/TitleV/dta/Publications/TitleV - Publications/> as part of the Title V Block Grant publication.

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insurance options under the Affordable Care Act continue through the MCAHP and their partners, as well as enrollment assistance through the Silver State Health Insurance Exchange.

The percent of pregnant women who received prenatal care beginning in the first trimester has improved slightly in recent years, from 68% in 2012 to 70% in 2014, moving Nevada closer to the Healthy People 2020 objective of 77.8%. In 2013, uninsured women and those enrolled in Medicaid were the least likely to receive prenatal care beginning in the first trimester, at 55.1% and 55.2%, respectively. Women with private insurance were the most likely to receive prenatal care in the first trimester, at 82.7%, followed by women with other types of public insurance at 77.2%. By race/ethnicity, White women were the most likely to receive prenatal care in the first trimester, at 77.2%, followed by Asian at 76.3%, Hispanic 59.8%, and Black 59.6%.

The Guttmacher Institute reported that 187,410 Nevada women were in need of publicly supported family planning services and supplies in 2013, based on sexually active women aged 13-44 with income below 250% of the federal poverty level. Large portions of these women are young, women of color, low-income or uninsured, as reflected in the table below:

	Below 20	20 and Over		
AGE	36,790	150,620		
	20%	80%		
	White	Hispanic	Black	Other
RACE	65,500	75,000	22,470	24,440
	35%	40%	12%	13%
	Below 100%	100-137%	138-199%	200-249%
INCOME (FPL)	55,770	23,950	43,070	27,830
	37%	16%	29%	18%
	Uninsured	Insured		
COVERAGE	70,880	116,530		
	38%	62%		

Public funding for family planning services and supplies in Nevada come from Medicaid (57%), Title X (37%), Other Federal sources (5%) and state-only sources (1%), through safety-net health centers including state and local health departments, federally qualified health centers, Planned Parenthood affiliates, and hospital-based clinics. Combined, these centers served just 29,650, or 16% of the total population in need. The reported number of teens served was just 4,780, or 13% of the teen population in need. Only two states, Louisiana and Texas, serve a lower percentage of the total population in need, at 14% and 15%, respectively.³⁷

³⁷ Contraceptive Needs and Services, 2013, Guttmacher Institute, July 2015

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Perinatal/Infant Health

Nevada's Infant Mortality Rate (IMR) is below the HP 2020 objective of 6.0 per 1,000 live births reporting at 5.8 in 2009, falling to 5.1 in 2014. However, racial/ethnic disparities persist with high rates for Blacks at 9.6 and for American Indian/Alaskan Natives at 9.4, while Asians have the lowest rate at 3.8, followed by Hispanics at 4.4 and Whites at 5.2. Those participating in the WIC program had a lower overall rate of 4.7, compared to those who did not participate at 5.5.

Rates for sleep related sudden unexpected infant death (SUID) declined by 23% from 93.1 per 100,000 live births in 2009 to 71.4 in 2013. The rate was significantly higher for Blacks at 159.1 compared to Whites at 84.1 and Hispanics at 38.9. Rates were also much higher for moms with less than a high school education compared to those with some college, at 116.1 and 40.1, respectively. Disparate rates were also seen among teenagers at 162 compared to women 30-34 years of age at 89.9. The Healthy Start program was awarded federal funding to focus on reducing racial disparities and improving perinatal outcomes to provide coordinated services to foster continuous access to care for women who are pregnant or of childbearing age.

The rate for initiation of breastfeeding in Nevada was slightly above the national rate, at 80.9% in 2014; for those participating in Nevada's Home Visiting Program, the rate was 92.1%. These rates drop off dramatically at six months, when roughly 19% exclusively breastfeed. Ongoing efforts to support breastfeeding continue with the Nevada Breastfeeding Program and Bring Your Baby to Work program.

Child Health

In 2007, only 18.6% of children, ages 10-71 months received a developmental screening using a parent-completed screening tool. In 2011-2012, the percent increased to 21.9%, with 19.5% of children without special health care needs receiving a developmental screening compared to 48.9% of children with special healthcare needs. Twenty-six percent of both uninsured children and those on Medicaid received a developmental screening compared to 18% of those with private insurance. By race/ethnicity, Black (23.5%) and Hispanic (23.3%) children were more likely to receive a developmental screening compared to White children (20.8%).

Multiple programs housed in the MCAH section conduct outreach and support for screening, immunization, nutrition and physical activity. The Nevada Early Hearing Detection and Intervention ensures screening of all children, and employs an audiologist to provide training on the correct newborn screening methods; this has resulted in improved screening and diagnosis. The Nevada Home Visiting Program conducts periodic screenings for specialty care and makes referrals to both primary and specialty care providers. The Bright Futures initiative promotes increased access to regular well child visits, with distribution of resource kits that increase program awareness, including Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits.

Immunization rates have dropped in the recent past in various populations, possibly attributed to nonmedical vaccine exemptions. The MCAH needs assessment found that parents and

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stakeholders were concerned about myths surrounding vaccines as well as the rising number of children in their communities who were not vaccinated. Parents requested clear information and school-based immunizations. In 2013, the percent of children who received the combined series of vaccines significantly increased to 60.6% from 38.3% in 2009. However, Nevada is still below the national percentage of 70.4%, as well as the HP 2020 objective of 80%. Several initiatives are being carried out by MCAH partners and stakeholders, including Immunize Nevada, which provided 78% more vaccines than last year and conducted community outreach and education.

The prevalence of overweight or obese children increased by 15% to 38.1% in Nevada, from 2012 to 2014. Results from the needs assessment indicated a lack of education and service related to factors that lead to obesity, including adult and child nutrition as well as physical activity. Both parents and stakeholders suggested increasing regulation related to children's food, promoting affordable sports, utilizing activity buses and collaborating with Family Resource Centers. A Statewide Obesity Prevention Taskforce is planned to lead these efforts and the Comprehensive School Physical Activity Program provides training to school staff and other partners.

Adolescent Health

Comprehensive annual check-ups are recommended for adolescents, and health coverage and access were top needs highlighted in the needs assessment. In 2011-12, 67.3% of Nevada's adolescents, ages 12 – 17 had a preventive medical visit in the past year, which is below the HP 2020 goal of 75.6%. Hispanics were much less likely to get a preventive medical visit in the past year, at 62.1% compared to Whites at 72.0% and Blacks at 72.7%. Adolescents born outside the U.S. were least likely to receive a preventive medical visit at 57.8% compared to 73.1% for those born in the U.S. The needs assessment showed that insurance was a barrier to seeking and receiving health services. Those with private insurance received preventive services at a rate of 74.2% compared to Medicaid at 70.1%, both far above the 33.6% rate for adolescents without insurance. Females had a higher rate than males, at 72.5% compared to 61.8%.

The rate for Nevada females aged 13-17 who got at least one dose of the HPV vaccine in 2013 was 53.8% compared to the national average of 57.3%.; Nevada males had a much lower rate at 31.9%. Hispanic adolescents had a significantly higher rate at 71.2% compared to Whites at 46.9% and Blacks at 48.5%. Female adolescents on Medicaid were at 65.6% compared to 61.7% for those with other public insurance, 58.0% for those without insurance, and 49.4% for those with private insurance. Geographically, urban adolescents were much higher than their rural counterparts, at 69.5% and 41.7%, respectively.

Teen pregnancy prevention was one of the priorities underscored in the needs assessment. The Nevada Adolescent Health Program addresses this issue, with supplemental support from the National Governor's Association Collaborative on Improving Birth Outcomes, which promotes Long Acting Reversible Contraceptives (LARC). Nevada's teen birth rate significantly

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declined by 53% from a high of 26.4 per 1,000 in 2007 to a record low of 12.3 in 2013, which is similar to the national teen birth rate. However, disparities persist with Hispanics representing over half of teen births in 2011 at 53%, compared to 26% for Whites, 16% for Blacks, 4% for Asians, and 1% for American Indian or Alaska Natives.

Rates of engagement in physical activity among adolescents was better for Blacks at 29.3%, compared to just 14% overall, in 2011-12.

Children and Youth with Special Health Care Needs

Nevada's children and youth with special health care needs (CYSHCN) composed 14.9% of the overall child and youth population in 2011-12; 23.6% were aged 12-17 and 6.8% were aged 0-5 years. Medicaid covered 16.8%, while 15.2% had private insurance and 10.5% were uninsured. A plurality were of multiple races at 20.6%, followed by White at 17.4%, then Black at 13.1% and Hispanic at 9.0%. Eighteen percent of males have special health care needs compared to 11.7% of females.

The MCAH program is funding the development of Nevada's medical home portal in collaboration with the Department of Pediatrics at University of Utah Health Sciences Center. This portal will support screening and services for CYSHCN and others with a comprehensive, coordinated and integrated state system. The number of children with a medical home in Nevada increased significantly from 37.2% in 2007 to 43.3%. Those age 6-11 were more likely to have a medical home at 63.3%. Across race/ethnicity, children of multiple race were more likely to have a medical home at 61.3% compared to Whites at 57%. and Hispanics at just 25.8%. By insurance status, children with private insurance were more likely to have a medical home than those on Medicaid, at 51.4% and 38.5%, respectively.

Cross-Cutting/Life Course

A life course approach links socioeconomic conditions in one phase of life to health outcomes at a later stage, to address risk factors associated with inequality. Key focus areas include tobacco use among adolescents, pregnant women and women of childbearing age, and insurance coverage for children.

Tobacco use prevention was identified as a top priority for pregnant women and children, through the needs assessment. In 2014, 3.8% of women in Nevada reported smoking in the last three months of pregnancy, a 12% decrease from 2013. Collaboration with the Tobacco Prevention and Cessation Program and Nevada Medicaid includes strategies for pregnant women. Customized Text4Baby messages are also sent to mothers who sign up for the services, and substance use prevention information is distributed to this target population in collaboration with the Substance Abuse Prevention and Treatment Agency (SAPTA).

One of the most prevalent unmet health care needs for women, children and adolescents in Nevada is mental health. In 2011-2012, just 49.3% of children with a mental/behavioral condition received treatment or counseling, far below the HP 2020 objective of 75.0%. White

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children were the most likely to receive treatment or counseling, at 59.3%. In the same timeframe, the suicide rate for teens ages 15 - 19 was 9.6 per 100,000. White teens were more likely than any other race/ethnic group to commit suicide at a rate of 11.7; males were three times more likely than females; and rural/frontier teens were twice as likely as their urban counterparts to commit suicide. These patterns of suicide risk in Nevada are similar to those in the U.S. and most developed nations. Over 8,000 Nevadans have been trained on suicide intervention, including school district superintendents and administrators, following recent legislation to require school training in suicide and bullying prevention. Surveys show reduced stigma and taboo around the subject of suicide. School-based health centers receive Title V funds to provide comprehensive mental/behavioral health services to children, and Nevada 2-1-1 provides additional resources and support for children, youth and families.

Health Access

Health insurance was identified as a major concern for all population domains, as a key barrier to health access, in addition to the limited number of providers accepting Medicaid, the high volume of paperwork required for the application process, and lack of transportation, particularly in Clark County.

Nevada Medicaid is administered by the Division of Health Care Financing and Policy (DHCFP) with contracted managed care organizations for a majority of the population in Clark and Washoe Counties, and fee-for-service in rural and frontier counties. The Children's Health Insurance Program (CHIP) is also managed by the DHCFP and covers children without private insurance or Medicaid coverage. In 2013, 21,356 children were covered, with significant increase to 32,825 in 2014. The overall uninsured rate for Nevada children has dropped from 18.0% in 2009 to 13.9% in 2013, but the HP 2020 objective is to increase coverage to 100%. Children aged 12-17 have the highest uninsured rate at 16%. Native Hawaiian/other Pacific Islander children are most likely to be uninsured at 20.7% compared to multi-race children who are least likely to be uninsured at 7.9%. Children born outside the U.S. were twice as likely as those born in the U.S. to be uninsured.

The Primary Care Office (PCO) is funded to establish and maintain health professional shortage area designations to leverage federal resources for recruitment and retention of health professionals, to help improve access to health care.

HEALTH PROFESSIONAL SHORTAGE AREA DESIGNATIONS

For the PCO, the health professional shortage area (HPSA) designation process is a practical analysis of the primary data collected through our provider surveys, and the secondary data collected from our partners. The HPSA designations reflect the principle indicators, at the county and sub-county levels, that the PCO considers for assessing specific needs to support recruitment of providers:

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- Lack statewide access to preventive and primary care services;
- Experience shortage of primary care, mental health and dental providers;
- Experience key barriers to access to health care (e.g. waiting time, travel time, water fluoridation);
- Demonstrate the highest need for health services, such as levels of poverty, infant mortality, low-birth weights, life expectancy, percent or number unserved and underserved; and
- Have insufficient training for the providers.

The HPSA scoring rubric from the Federal Register weights these indicators as follows, for Primary Care and Dental Care:

Indicator	Weight
Population-to-provider ratio	10
Poverty	5
Low Birth Weight/Infant Mortality	5
Population without fluoridated water	1
Travel Time/Distance	5

Because the population-to-provider ratio is weighted so heavily, collecting, maintaining and analyzing this data is a key function of the PCO. Although health care providers must be licensed in every state, most states do not require providers to submit information about their practices that meets the needs of the designation process, including hours of practice, payer mix, and whether they are accepting new patients. Consequently, extensive personnel resources are leveraged through the PCO to manually survey providers, effectively implementing a continual needs assessment for this principal indicator, based on rational service areas for health care access.

Primary Care Providers

According to the 2015 State Physician Workforce Data Book³⁸, Nevada ranks 49th out of the 50 states for *Active Patient Care Physicians per 100,000 Population*, gaining one rank to 48th for *Active Patient Care Primary Care Physicians*, but falling to 50th for *Active Patient Care General Surgeons*.

The high need for primary care physicians is also reflected in Nevada's health professional shortage area designations, as shown in the following table and map below:

³⁸ Published by the Association of American Medical Colleges, <https://www.aamc.org/data/>

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Nevada Primary Care Provider ¹ Shortages					
Health Professional Shortage Area (HPSA) Name	# of Provider FTEs ² Short	HPSA Provider FTE	HPSA Designation Population	Population to Provider Ratio	HPSA Score
Douglas County - Topaz Area	0.52	0	1827	1827:0	8
Eastern Elko Service Area	1.64	0.5	7491	14982:1	16
Esmeralda County	0.26	0	892	892:0	7
Eureka County	0.49	0	1724	1724:0	12
Incline Village	0.14	2.8	10,278	3671:1	7
Indian Springs	2.2	1	11,204	11204:1	14
Lander County	0.42	1.1	5318	4835:1	13
Lincoln County	0.16	1.1	4406	4005:1	16
Lyon County	9.43	5	50,502	10,100:1	16
Mineral County	0.72	0.6	4630	7,717:1	18
Mountain City/Jarbridge Service Area	0.37	0	1302	1,302:0	12
Northern Clark Service Area	1.99	1	10,450	10,450:1	14
Northern Nye County	0.56	1	5446	5,446:1	14
Northern Washoe County	1.23	0	4292	4,292:0	16
Pershing County	1.35	0	4731	4,731:0	17
Pyramid Lake	0.4	0	1392	1,392:0	9
Storey County	1.14	0	3985	3,985:0	12
Low Income - Carson Valley ³	2.62	3.6	18,648	5,180:1	15
Low Income - Central Las Vegas ³	6.17	0.5	20,019	40,038:1	18
Low Income - East Central Las Vegas ²	19.48	13.2	98,029	7,426:1	16
Low Income – Laughlin ³	0.76	0.2	2885	14,425:1	16

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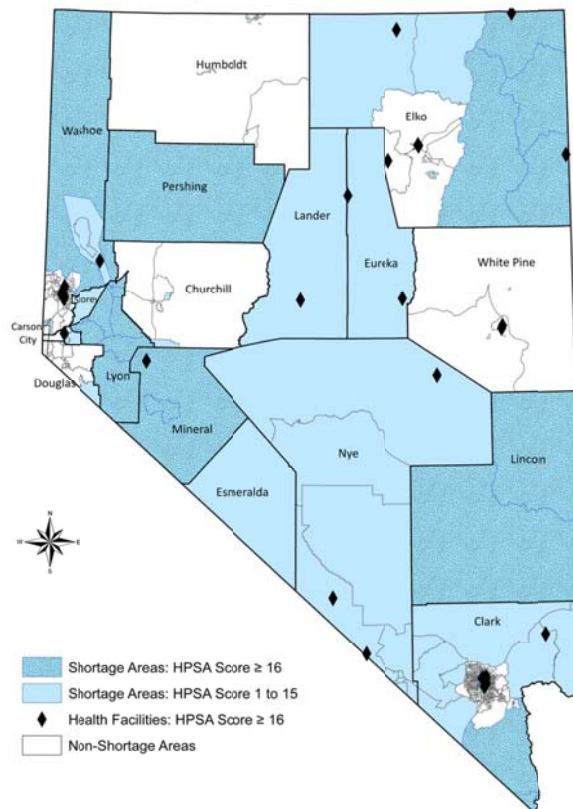
Low Income – Mesquite ³	0.48	0.8	3836	4,795:1	12
Low Income - Reno/Sparks ³	5.71	18	71,131	3,952:1	11
Low Income - South Central Las Vegas ³	0.09	27.5	82,761	3,009:1	10
Low Income - Southern Nye County ³	1.85	3.5	16,048	4,585:1	14
Low Income - West Central Las Vegas ³	15.68	0.1	47,346	473,460:1	13
Total	75.86	81.5			

¹Primary care providers include family medicine, internal medicine, general medicine, OB/GYN, pediatric, and geriatric MDs and DOs

²Full Time Equivalency: 1 FTE = 40 hour workweek of direct outpatient care

³Low income FTE is calculated by adding the percentages of care given to Medicaid and sliding fee scale/charity care patients and multiplying it by the provider's FTE. For Low Income HPSAs, the population considered is those under the 200% poverty threshold.

Map 4.1: Primary Medical Care Health Professional Shortage Areas (HPSAs) in Nevada – 2015



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To summarize the above table and map, Nevada has 26 primary care HPSA designations in 14 out of 17 counties, including eight whole county designations, and eighteen partial county designations, with fourteen HPSA scores at 14 or higher, reflecting the highest level of need for HRSA-funded programs. While most of the score is derived from the population-to-provider ratio, the whole county HPSAs also gain significant points from excessive travel times in rural and frontier areas that may be hundreds of miles from a primary care provider. The partial county designations are typically in more urban areas with high poverty rates and limited access to providers who accept Medicaid, as well as transportation challenges.

Out of the 26 primary care designations, ten received the full 10 points for population-to-provider ratio; seven are in rural or frontier areas and the remaining three are in low-income areas of East, West and Central Las Vegas. Nineteen of the designations received the full 5 points for travel time/distance, twelve of which are in rural/frontier areas.

The three counties that do not have primary care HPSA designations do have designations for rural health clinics (2), tribal health clinics (3) or Indian Health Services facilities (1). For Nevada overall, there are twenty-four Tribal Health Clinics with average HPSA score of 17, three Indian Health Service Facilities with average HPSA score of 18.7, and eight Rural Health Clinics with average HPSA score of 13.

Dental Care Providers

According to the report on *Supply of Dentists in the US: 2001 – 2013*³⁹, Nevada ranked 33rd out of the 50 states and the District of Columbia, for the number of dentists per 100,000 population. This is a significant improvement from 2001, when Nevada ranked 49th!

However, many areas of our state continue to have difficulty accessing dentists, because Medicaid may not be accepted, or dentists who do accept Medicaid may not take new patients.

Nevada Dental Care Provider¹ Shortages					
Health Professional Shortage Area (HPSA) Name	# of Provider FTEs² Short	HPSA Provider FTE	HPSA Designation Population	Population to Provider Ratio	HPSA Score
Eastern Elko/Wendover	1.29	0	6,446	6,446:0	16
Esmeralda County	0.18	0	892	892:0	6
Lander County	0.26	0.8	5,318	6,648:1	12

³⁹ Published by the American Dental Association, 2015, <http://www.ada.org/en/science-research/health-policy-institute/data-center/supply-of-dentists>

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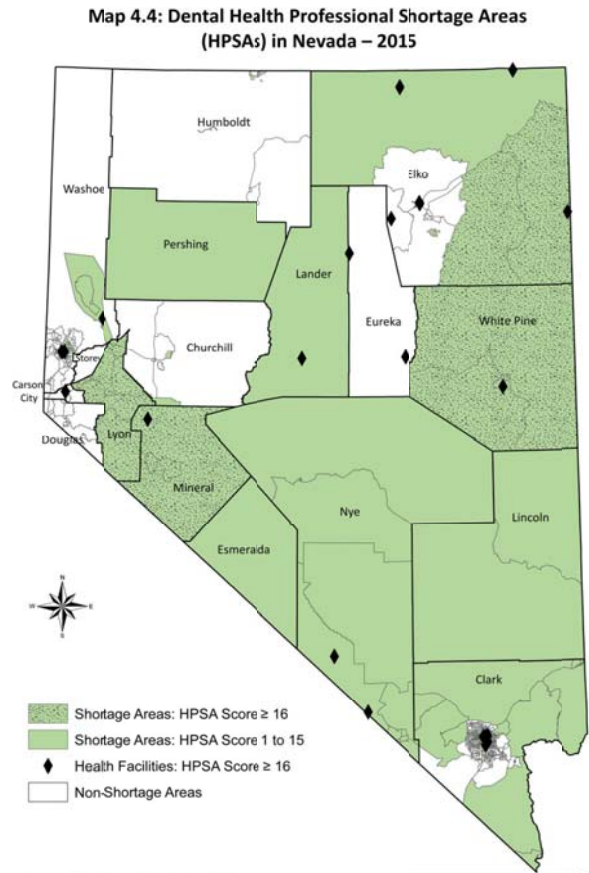
Lincoln County	0.45	0.5	4,727	9,454:1	14
North Clark	0.27	6.8	35,333	5,196:1	10
Northern Elko Service Area	0.47	0	2,347	2,347:0	14
Northern Nye County	0.16	1.2	5,446	4,538:1	8
Pershing County	0.25	0.7	4,731	6,759:1	14
Southern Nye County	2.38	7.1	37,933	5,343:1	14
Low Income - Central Las Vegas ³	0.51	4.5	20,019	4,449:1	9
Low Income - East Central Las Vegas ³	17.71	6.8	98,029	14,416:1	17
Low Income - Lyon County ³	4.08	0	16,323	16,323:0	16
Low Income - Mineral County ³	0.29	0.1	1543	15,430:1	18
Low Income - Reno/Sparks ³	9.45	8.2	70,593	8,609:1	18
Low Income - South Central Las Vegas ³	15.69	5	82,761	16,552:1	16
Low Income - South Clark - Searchlight/Laughlin ³		0	2885	2,885:0	14
Low Income - West Central Las Vegas ³	7.14	4.7	47,346	10,074:1	15
Low Income - White Pine County ³	0.69	0.1	3170	31,700:1	18
Total	61.27	46.5			

¹Dental care providers include primary care dentists (DDS and DMD).

²Full Time Equivalency: 1 FTE = 40 hour workweek of direct patient care

³Low income FTE is calculated by adding the percentages of care given to Medicaid and sliding fee scale/charity care patients and multiplying it by the provider's FTE. For Low Income HPSAs, the population considered is those under the 200% poverty threshold.

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Summarizing the dental table and map, there are 18 designations including 5 whole county (Nye is split north/south because of its size), 3 sub-county and 9 low income. Seven of these designations score the full 10 points for population-to-provider ratio, six of which are in low-income designations, both rural and urban. Fourteen score the full 5 points for travel time/distance.

With regard to poverty level, low-income designations in Reno, South Central Las Vegas, East Central Las Vegas, Central Las Vegas and Southern Nye County received 4 out of 5 possible points.

Another factor for dental care is that most of Nevada does not have fluoridated water. This results in an additional point from the HPSA scoring rubric, for all designations, except Clark County.

Mental Health Providers

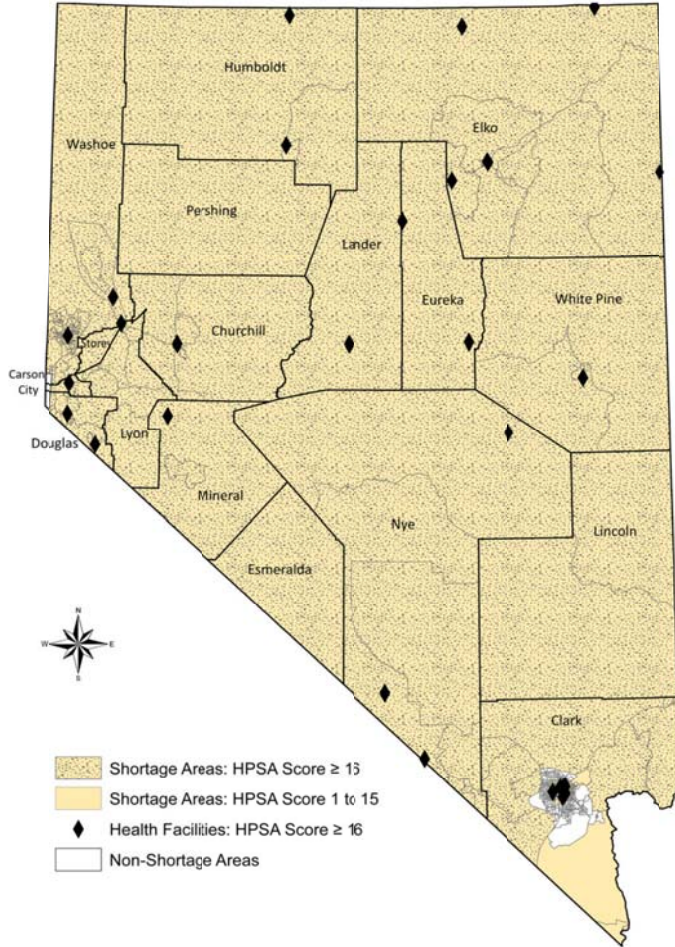
Nevada is ranked at the bottom for the number of psychiatrists, at 5.1 per 100,000, compared to a national average of 8.9.⁴⁰ Our state experiences its most comprehensive and severe

⁴⁰ American Medical Association Master Files

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shortages in the mental and behavioral health category, and nearly the whole state is designated, as reflected in both the map⁴¹ and in the table below.

Map 4.7: Mental Health Professional Shortage Areas (HPSAs) in Nevada – 2015



Nevada Mental Health Provider ¹ Shortages						
Health Professional Shortage Area (HPSA) Name	HPSA Discipline Class	# of Provider FTEs ² Short	HPSA Provider FTE	HPSA Designation Population	Population to Provider Ratio	HPSA Score
Henderson	Mental Health	1.29	0	25,819	25,819:0	11

⁴¹ <http://medicine.nevada.edu/statewide/reports/data-book-2015>

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Las Vegas Mental Health Catchment Area	Mental Health	4.75	26	614,980	23,653:1	17
Laughlin - Southern Clark County	Mental Health	0.28	0	8444	8,444:0	12
Northern Nevada Mental Health Catchment Area	Mental Health	0	35.2	680,837	19,342:1	18
Southern Nevada Rural Catchment Area	Mental Health	2.43	0.3	75,824	75,824:1	18
Total		8.75	61.5			
¹ Mental health providers include outpatient psychiatrists (MD and DO). ² Full Time Equivalency: 1 FTE = 40 hour workweek of direct patient care						

For mental health, scores are particularly high at 18 in the Northern Nevada and Southern Nevada Rural Catchment Areas, with a 17 for the Las Vegas Catchment area. Although the number of designations is small, the catchment areas are large because services are delivered across hundreds of miles utilizing telehealth. In addition to high population-to-provider ratios and long distances, Nevada also has higher rates for elderly populations, substance abuse and alcohol abuse, increasing the need for behavioral health services and providers.

Collectively, these designations play a critical role in helping support health care access throughout Nevada, by leveraging federal resources for loan repayment, scholarship, Physician Visa waiver, and Medicare bonus programs. While we have increased our participation rates in these programs in recent years, Nevada has a long way to go to reach comparable levels with some of our neighboring states. In addition to providing more outreach to potential program participants, we are also taking a hard look at all of the factors internal to Nevada that impact health professional workforce development.

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PRIMARY CARE WORKFORCE DEVELOPMENT RECOMMENDATIONS and INITIATIVES

In 2013, the Nevada Division of Mental Health and Developmental Services was restructured; Developmental Services merged with Aging and Disability Services, and Mental Health merged with Public Health to form what is now the Division of Public and Behavioral Health (DPBH). The PCO Manager was appointed to coordinate a *Behavioral Health Professional Pipeline Mapping Project* in 2014, to review requirements for education and training, licensure and certification, scopes of practice, Medicaid and Medicare reimbursement, State Personnel Classification, and eligibility for loan repayment and scholarship programs.

This project engaged over 50 partners including representatives from the Nevada System of Higher Education, behavioral health state licensing boards, behavioral health professional associations, and multiple health care professionals employed by DPBH. Individual focus groups were created for each licensed behavioral health profession: Psychiatry, Psychology, Advanced Practice Registered Nurses, Psychiatric Nurses, Licensed Clinical Social Workers, Marriage and Family Therapists/Clinical Professional Counselors, and Licensed Alcohol and Drug Counselors. Discussions were facilitated for each group over a two-month period, resulting in dozens of recommendations for improvements to expand the “pipeline” for behavioral health professionals.

Education and Training

Nevada did not have sufficient training programs for psychiatric nurse practitioners in 2014, and many nurses working in behavioral clinical services for DPBH were not able to support medication management. As part of the pipeline project, DPBH collaborated with the Nevada Western Interstate Commission for Higher Education (WICHE) to provide financial support for nurses to enroll in a new psychiatric nurse practitioner program developed at the Orvis School of Nursing, University of Nevada, Reno.

We also partnered with regional WICHE to develop an accredited intern program for Psychologists, with state WICHE funding support for stipends. Four Psychology Interns were accepted into the program in the first year; 50 applications were received for the second year and the interview process is currently underway. The DPBH will be requesting support for six interns per year, for the next biennium, through the 2017 session of the Nevada State Legislature, and hopes to sustain this program in subsequent years. We are in preliminary discussions with Nevada WICHE to use this model to pilot internship and training programs for other health professions, as well.

Other recommendations for Education and Training include the following:

- Develop a certification program in integrated behavioral health, including substance abuse disorders;

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- Develop blended clinical supervision roles to share responsibilities between employers and educational institutions;
- Include training for billing Medicare, Medicaid and private insurance in health professional curriculum;
- Develop reimbursement model to support faculty with clinical revenue;
- Create more graduate medical education (GME) slots for psychiatry students; and
- Create more graduate assistant slots for 1st and 2nd year doctoral psychology students.

Because GME slots have been a concern for many stakeholders across our state, the Governor's Office created a GME Task Force in 2014 and recommended \$10 million in state funding, which was approved by the 2015 Legislature. A Request for Applications was published in February 2016 to support GME slots at public and/or private institutions supporting residency programs for primary and behavioral health doctors of medicine, osteopathy and psychiatry.

Some work has begun with training on Medicaid reimbursement, with partners advocating for other recommendations as resources allow.

Licensure and Certification

Recommendations for licensure and certification include the following:

- Establish online FAQs and provide outreach to training programs;
- Develop transparent process for employers to collaborate on validation of core competencies and clinical expertise;
- Expand scope of telehealth for both practice and supervision;
- Collect minimum data set across all professions;
- Engage national-level professional boards to develop standards consistent with best practices and contemporary research to advance state-level boards to adopt national standards; and
- Consider cross-board collaborative to support online data collection.

A survey of Nevada professional licensing boards in February 2016 found that while all the boards have websites, only about half have FAQs, with a few under construction. Although some boards have online applications for certain types of licenses, a majority of processes are still manual. Consequently, there is limited data collection, less transparency, less standardization and longer processing times. Moving the licensing boards toward online systems will require financial resources and political pressure, through the legislative process.

Significant progress was made through the 2015 Legislative session, including:

- telehealth reimbursement parity for Medicaid and other third-party payers;
- the interstate compact was ratified to provide for reciprocal licensure of physicians (MD or DO) in all other member states of the compact; and

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- new requirements are in place for expedited license by endorsement for all health professional boards.

We hope to build on this progress for the next Legislative session in 2017, through existing partnerships and successful strategies from the last session.

Scope of Practice

Scope of Practice links closely to licensure requirements, but is a distinct area of focus because professional associations can be strong advocates, tapping their membership for trends and best practices as they evolve through actual experience. Recommendations for Scope of Practice include the following:

- Conduct survey on supervision practices, including training and adherence to evidence-based practices;
- Clarify ability to consult on psychotropic medications;
- Require completion of minor in addictions for Alcohol and Other Drugs Counselor interns.

These are examples of specific issues that came up in focus group discussions, within professional classifications. Further research and mapping, including other states' practices, are needed to help develop clearer and better standards. As best practices are established for patient medical homes and team-based care, scopes of practice should be reviewed and updated to include new classifications such as peer support workers, community health workers and paramedicine. Nevada DHHS is working to develop all of these classifications, with legislation passed in 2015 to support the regulatory process.

Medicaid and Medicare Reimbursement

Because the Division of Health Care Financing and Policy (DHCFP) is a sister agency to DPBH, significant progress has been made on many of the recommendations for Medicaid, through amendments to the state plan, including the following:

- Rates for acute hospital inpatient psychiatric services were increased;
- Fiscal analysis was conducted for reimbursement of APRNs in school-based health centers and community health centers;
- Rates were increased for APRNs based on expanded scope of practice from the 2013 Legislative session;
- Policy was drafted to upgrade licensed clinical alcohol and drug counselors to Qualified Mental Health Practitioner status for Medicaid reimbursement;

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- Policy revisions were drafted related to excluding use of interns as clinical supervisors; they must be licensed with at least 2 years of clinical experience.

The PCO Manager provides regular updates to the Medical Care Advisory Council as a means of keeping track of the status of all of the recommendations related to Medicaid.

Because Medicare is wholly administered at the federal level, we do not have the same opportunity to implement changes as is the case with Medicaid. However, we did communicate some of our recommendations as part of a response to a federal *Career Pathways Request for Information* that was a collaborative among the Departments of Education, Health and Human Services, and Labor. Recommendations included the following:

- More Medicare supported GME slots are needed in Nevada to help recruit and retain primary and behavioral health provider residents;
- Medicare reimbursement needs to support all behavioral health professionals, consistent with scopes of practice;
- Expansion of reimbursement for interns would also help expand the pipeline;
- Federal support for data development on health professionals is needed to support existing processes for health professional shortage area designations, and to project workforce supply and demand in the future;
- Streamline process for Supplemental Support Income/Social Security Disability Insurance eligibility and expand authorization for completing disability assessment;
- Consider centralized contracting process with standard rates;
- Expand reimbursement to case management and rehabilitative services; and
- Increase reimbursement for Nurse Practitioners and Certified Nurse Specialists to the level of Primary Care Providers.

State Personnel Classification

State Personnel Classification plays a significant role in the behavioral health professional pipeline in Nevada, because the state provides direct services for behavioral health and community nursing, with nearly 2,000 positions under the Department of Health and Human Services. Recommendations in this area cut across five sectors: Increase Salaries; Supplemental Support; Develop Career Pathways; Develop Marketing Campaign; and Expand Outreach.

Increase Salaries

- Increase salaries for psychiatrists, psychologists and nurses;
- Revise class specification for Clinical Social Workers based on licensure requirement;
 - Upgrade CSW I from grade 35 to 37, CSW II from 37 to 39, and CSW III from 39 to 41;

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- Add CSW IV (43) and CSW V (45) to mirror track for Mental Health Counselor series.

Supplemental Support

- Consider covering travel, relocation, continuing medical education and licensure costs;
- Consider shift differential for inpatient, after hours, or emergency call;
- Consider incentive pay for dual certification;
- Develop promotional steps and annual cost of living adjustment;
- Develop incentives for licensed professionals willing to provide supervision for interns;
- Reinstate 5% pay for bilingual staff and for hard to fill locations, e.g., critical shortage areas; and
- Improve process to request accelerated pay for a new hire.

Develop Career Pathways

- Promote general career path, and develop state-career path for under/graduate social work students, and include specialties, such as child therapy and rural social work; and
- Create state positions for clinical internship to include job duties specific to supervising interns.

Develop Marketing Campaign

- Address stigma with public service announcements from American Psychiatric Association;
- Ask Governor, et al, to do welcome at annual National Psychiatric Association meeting in Las Vegas and talk about steps to improve behavioral health system in Nevada; and
- Do mini-internships for Legislators and others to spend a day with behavioral health professionals.

Expand Outreach

- Add cultural competence to the Knowledge, Skills and Abilities section of the class series for all social service providers;
- Expand definition of Cultural Competence: *The delivery of services responsive to the cultural context of racial and ethnic minority groups, as well as differently abled or oriented groups, including but not limited to their languages, histories, traditions, beliefs and values.*

Loan Repayment and Scholarship Programs

The PCO serves as the state liaison for National Health Service Corps, Nurse CORPS and Nevada Conrad 30/J-1 Physician Visa Waiver programs. We also collaborate with the State Office of

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Rural Health on the state loan repayment program and with the Nevada WICHE for tuition and intern support programs. Because we have a key role in these programs, we were able to identify some specific issues to be addressed, and may have opportunities to advocate for change more directly. Recommendations include the following:

- Currently, alcohol and drug abuse counselors are not eligible for scholarships or loan repayment under the National Health Service Corps, or for reimbursement under Medicare, while the Affordable Care Act advocates for integration of substance abuse treatment with mental health and primary care. Developmental Disability Counselors are also not eligible for these programs. Expanded eligibility should include the full range of behavioral health professionals for scholarship, loan repayment and reimbursement.
- Currently, telehealth is limited to not more than 25% of direct patient care hours per week, for National Health Service Corps loan repayment clinicians. This is a tremendous obstacle for western states with large rural and frontier areas, but also for urban populations with provider shortages. Studies have shown that telehealth is just as effective as face-to-face counseling for behavioral health. It is time for the NHSC to update this policy.
- State resources are needed to promote programs and provide matching funds.

The issues that are specific to the National Health Service Corps have been raised with HRSA Administration, informally; it is not clear what avenues are available to PCOs to make more formal policy recommendations to the HRSA Administration.

With regard to state resources, some funds were added back for state loan repayment matching funds through the Office of Rural Health, and collaboration with NV WICHE resulted in financial support for DPBH Psychology Interns and Psychiatric Nurse education. The expansion of our PCO to do broader health care workforce development is funded with state resources and will support expanded outreach for existing programs, and will also support collection of comparative data, particularly for scopes of practice, licensure and certification requirements. This data will be used to develop a statewide strategic plan to direct our limited resources to the areas with greatest need where we can have the most impact.

CONCLUSIONS

The health care rankings and the unmet health care needs and disparities that are extensively elaborated in this report are addressed through multiple programs within the NV DHHS, as well as other public and private partners and stakeholders. While these needs and disparities are relevant to the work of the PCO, we actually have a very limited toolkit with which to address them. The HPSA designation process attempts to account for the principle indicators of access, provider shortage, geographic and structural barriers, health status, poverty, disparity and

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cultural competence. Through this practical analysis, a relative degree of need is calculated to leverage federal resources for loan repayment and scholarship that serve as the foundation for recruitment and retention efforts through the PCO. Increased funding for these programs under the Affordable Care Act has been helpful in boosting provider participation levels, but the exponential growth in demand far outstrips the incremental growth in funding – *we're going to need a bigger boat!*

The expansion of our PCO, with state funds to do broader workforce development, will continue to engage stakeholders and we will continue to conduct research to help identify areas for improvement, including policies as well as procedures. Essentially, our aim is to create better systems for provider recruitment and retention, in concert with environmental changes that are taking place under health care reform, including patient-centered medical homes and accountable care organizations that promote team-based care. By engaging the full-range of provider types and supporting practice at the top of scope, we believe we can make a stronger contribution to the provider side of the equation. Expanding workforce training opportunities with our education partners to support patient health literacy at all levels can enhance patient understanding, compliance and trust. In turn, this can help address health disparities where rates of chronic illness and high cost health care are most prevalent.

While we do not anticipate that our efforts will fully address the growing need for health care professionals, we believe that the proactive steps we are taking will lead to significant improvements. We appreciate the support of our federal partners in this worthwhile endeavor.