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Department of Health and Human Services

Patient Protection Commission

(NRS 439.908)

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Governor
State of Nevada

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PATIENT PROTECTION COMMISSION (PPC)

Commissioners

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Marilyn Kirkpatrick, Vice Chair
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Dr. Andria Peterson
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Dr. Bayo Curry-Winchell and Wendy Simons
Two members who are persons with expertise and experience in advocating on behalf of patients.

Bethany Sexton
One member who represents the private nonprofit health insurer with the highest percentage of insureds in this State who are adversely impacted by social determinants of health.

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Jalyn Behunin
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Walter Davis
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I. Introduction

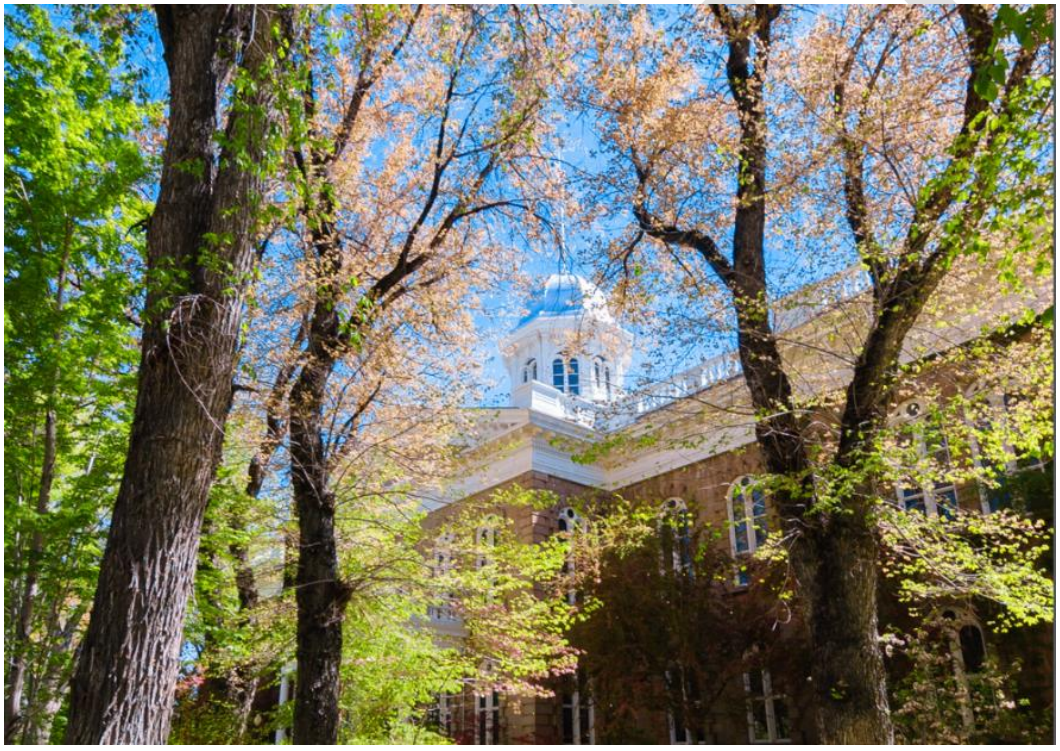
The Nevada Patient Protection Commission (PPC) is a public body located within the Nevada Department of Health and Human Services (DHHS). The PPC is comprised of 12 voting members and 4 nonvoting members appointed by the Governor with representation from across the health care spectrum, including advocates, providers, and industry professionals who are dedicated to improving health care in Nevada. Nevada Revised Statutes (NRS) 439.902-918 provides the PPC with statutory authority to systematically review issues related to the health care needs of residents of Nevada and the quality, accessibility, and affordability of health care in the State. This report is being submitted in accordance with NRS 439.918.2.(a), which requires the PPC to submit a semi-annual report describing the meetings and activities of the Commission during the immediately preceding six months. The report must include, without limitation, a description of any issues identified as negatively impacting the quality, accessibility or affordability of health care in this State and any recommendations for legislation, regulations or other changes to policy or budgets to address those issues.

As directed by Governor Joe Lombardo's Executive Order 2024-002, the Commission has focused their attention on reviewing available data and national best practices to provide recommendations within this report aimed at addressing the state's health care workforce shortage, to allow all Nevadans access to quality health care. The longstanding shortage of health care providers statewide has direct negative implications on health care access, quality and affordability for Nevada residents. Each recommendation included in this report aims to address the statewide health care workforce challenges and provide an opportunity to address the health care needs of Nevadans. This report is meant to reflect the Commission's activities over the past six months and includes several recommendations for the Governor and the Nevada Legislature to consider as the State approaches the upcoming 83rd (2025) Legislative Session and beyond.

II. Executive Order 2024-002

On April 11, 2024, Governor Joe Lombardo signed Executive Order 2024-002, directing the PPC to make recommendations aimed at addressing the state's health care workforce shortage and improving patient access to quality health care, statewide. The Executive Order directs the PPC to review available data and national best practices to provide recommendations for the following:

- Attracting and retaining talent to address health-care workforce challenges in urban and rural communities;
- Improving access to primary care and public health services;
- Removing unnecessary state administrative hurdles to recruiting and retaining health-care workers;
- Identifying sustainable funding strategies for strengthening the state's health-care workforce, which includes supporting competitive Medicaid reimbursements;
- Ensuring recommended strategies for increasing provider reimbursement are based on payment methodologies that incentivize and reward for better quality and value for the taxpayer dollar; and
- Identifying strategies for evaluating new and existing state investments in efforts to improve the capacity and size of the state's health-care workforce.



(Photo of Nevada State Capitol Building, https://www.canva.com/)

Over the past six months, the Commission held five public meetings and reviewed available health care workforce data and national best practices through various presentations from external parties and other means. For more information about these meetings and materials, please go to: https://ppc.nv.gov/. Additionally, the Commission issued a public solicitation to seek health care workforce policy recommendations. Nearly 50 recommendations were submitted through the solicitation from various organizations and individuals throughout the state. Among these recommendations, a handful of themes were present with a large number focusing on increasing insurance reimbursement rates, expanding

education and training programs, improving access to care, implementing interstate licensure compacts and reciprocity, and reducing administrative barriers for providers. The Commission used the solicitation responses and other information received through public comment, Commission meeting presentations, and available data and national best practices to guide their work over the past six months. The legislative measures and formal recommendations included in this report are meant to address the health care workforce shortage in Nevada.

III. Bill Draft Requests

Pursuant to NRS 218D.213, the Commission may submit up to three bill draft requests (BDRs) to the Nevada Legislature on or before September 1st preceding each regular session. In alignment with the Commission's efforts to address Governor Lombardo's Executive Order, the Commission developed three BDRs for consideration during the 83rd (2025) Legislative Session that are intended to address the health care workforce needs of the State. Each proposed legislative measure was developed based upon recommendations received by the public and stakeholders, input from subject matter experts and available national and state data. It should also be noted that each BDR is anticipated to have a fiscal impact. Any potential fiscal impacts will be determined during the course of the legislative process in 2025.

A. Senate Bill 40: Medicaid Health Care Workforce Account (BDR 38-451)

The Commission's first legislative measure, Senate Bill 40 (BDR 38-451), seeks to improve the capacity and size of the state's health care workforce, while increasing access to care for Medicaid recipients.[1] The legislative measure would establish a Medicaid Health Care Workforce Account and would authorize the Division of Health Care Financing and Policy (DHCFP) within the Department of Health and Human Services (DHHS) to administer the account. The account would provide sustainable funding to support and expand Graduate Medical Education (GME) programs, fellowship programs, apprenticeship programs and loan repayment programs. Funding allocated to the account will be matched with federal Medicaid funds, which will provide a higher return on any state investment for provider workforce initiatives.

Graduate Medical Education (GME) refers to the formal residency and fellowship training and education medical students receive upon graduation from medical school. According to the Association of American Medical Colleges (AAMC), 57.1% of physicians in the United States continue practicing in the state where they completed their residency, and Nevada aligns closely at 57.2%.[2] Of the physicians practicing in Nevada, 70.9% are in Clark County, 22.4% in Washoe County, 2.9% in Carson City, and 3.8% in the remainder of the state. In 2023, the rate of licensed physicians per 100K population in Nevada was lower than the national rate at 328.8 compared to 449.2 per 100K population and all counties except Carson City and Washoe County were below the national rate.[3] Investing in providers and programs that enhance GME will encourage current residents entering the medical field to stay in the state to complete their training as well as attract new talent from other states to practice in Nevada.

Currently, Nevada has existing GME residency programs for family medicine, internal medicine, pediatrics, anesthesiology, psychiatry and behavioral sciences, emergency medicine, general surgery, obstetrics and gynecology, orthopedic surgery,

[1] Nevada State Legislature. (2024, November 15). SB 40 (BDR 38-451). Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bill/11814/Overview

[2] Boyle, P. (2021, December 1). *America's medical residents, by the numbers*. Retrieved from AAMC: https://www.aamc.org/news/america-s-medical-residents-numbers-0

[3] Packham, J., Griswold, T., Mwalili, N., Brown, A., & Etchegoyhen, L. (2023, October). *Physician Workforce in Nevada: A Chartbook*. Retrieved from https://www.nvhealthforce.org/wp-content/uploads/2024/03/23-Physician-Workforce-in-Nevada-a-Chartbook.pdf#:~:text=John%20Packham,%20PhD.%20Tabor%20Griswold,%20PhD

plastic surgery, otolaryngology, and neurology.[4] Each year roughly half of the students among these programs graduated from a Nevada medical school. This is likely due to the limited residency programs available in the state which forces students to move elsewhere for additional training.[5] Expanding access to these existing GME programs will provide more opportunity for Nevada students to learn and practice in the state upon graduation.

Along with retaining talent in Nevada, GME programs can be utilized to provide medical services to rural and underserved areas by sending residents to meet with patients who typically have limited access to care. This supplies an opportunity for residents to be exposed to a variety of medical conditions while providing services to individuals and communities that otherwise may not have a chance to receive them. However, Nevada historically has had difficulty not only getting these programs stood up but also ensuring that they are financially stable as well. As an example, in October 2018, the University of Nevada, Reno, School of Medicine and Nevada Health Centers partnered to open a rural residency program for family medicine in Elko, Nevada. The program was successful in providing services to patients and education to residents for nearly five years until it ended in the summer of 2023. Although there were a variety of reasons the program didn't survive, unsustainable funding was a key factor. GME programs come with many costs for the host provider, which includes hiring a program director and physicians to supervise the residents, among other operating costs.[6] In fact, the cost per resident per year is roughly $209,000 and growing and many facilities struggle to maintain sufficient long-term funding.[7]

The Commission discussed the need to establish sustainable funding opportunities to support and expand existing GME programs that are not reliant on state or federal grants, which are short-term in nature. After presentations and discussion with subject matter experts, on August 16th, the Commission voted to use one of their BDRs to create the Medicaid Health Care Workforce Account to leverage Medicaid federal funds to support the expansion of GME programs through increased reimbursement for training sites that will improve the capacity and size of the state's health care workforce and increase access to care. This proposed change would give Nevada Medicaid the ability to expand its partnership efforts with local universities, teaching hospitals and other teaching entities to support GME programs by providing the necessary funding through increased reimbursement for services provided at these facilities in support of the staffing and infrastructure already in place, while leveraging federal Medicaid matching dollars. As the state's Medicaid program, DHCFP can leverage, on average, $6 additional dollars in federal funds under Title XIX of the Social Security Act for every $4 state dollars spent on these efforts. This will ensure a higher return on investment for the state taxpayer's dollar.

According to a return-on-investment study conducted in Indiana, by 2026, for every $1.00 invested into GME programs, the return is estimated to be $12.56. This total is up 48% from $8.46 in 2022.[8] This return on investment is seen by the state through many avenues, including but not limited to, direct impact due to the program, indirect impact such as related

[4] *Medical Residency in Nevada*. (2024). Retrieved from Residency Programs List: https://www.residencyprogramslist.com/in-nevada#:~:text=Search%20residency%20programs%20by%20criteria%20to

[5] Do, K., Do, J., Kawana, E., & Zhang, R. (2023, July 11). *Nevada's Healthcare Crisis: A Severe Shortage of Physicians and Residency Positions*. Retrieved from National Library of Medicine: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10414134/#:~:text=As%20of%20now%2C%20there%20are%20around%20404%20residency,and%20UNLV%20medical%20students%2C%20respectively%20%5B%206%20%5D

[6] Mercer. (2024, July 19). *Graduate Medical Education in Nevada*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/6.0_Final%20ADA%207-19-24%20NV%20GME%20PPC.pdf

[7] American Academy of Family Physicians. (2023, October). *Graduate Medical Education Financing Policy*. Retrieved from https://www.aafp.org/about/policies/all/graduate-medical-education-financing.html#:~:text=According%20to%20a%202018%20study%2C%20the%20median%20cost,2022-2023%2C%20given%20inflation%2C%20has%20been%20updated%20to%20%24209%2C000.

[8] Tripp Umbach. (2022, October 25). *The Economic Impact of Graduate Medical Education Expansion in Indiana*. Retrieved from https://www.in.gov/che/files/FINAL_Economic-Impact-of-Graduate-Medical-Education-in-Indiana.pdf

purchases, and induced impacts such as household spending. As the number of GME positions in a state increase, the demand for goods and services and spending in the community increases and drives the economy overall. For every dollar Nevada invests in expanding GME programs in the state, Nevadans will be positively impacted, regardless of their interaction with the health care system.

B. Senate Bill 29: Increase Medicaid Rates and Establish Accountable Care Payment Models (BDR 38-450)

The Commission's second legislative measure, Senate Bill 29 (BDR 38-450), focuses on increasing provider reimbursements that incentivize and reward providers that deliver higher quality care and bring greater value to the taxpayer dollar.[9] The Commission received feedback through public solicitation, meeting presentations and public comment that Nevada Medicaid reimbursement rates are too low for many provider types and services. Nevada Medicaid is a taxpayer-funded health insurance program that serves 1 in 4 Nevadans and covers 1 in 2 births in Nevada. Low reimbursement rates can discourage providers from accepting Medicaid recipients and in turn decrease access to care for those individuals. To address these issues, the Commission voted to submit a legislative measure (BDR 38-450) that would request Nevada Medicaid to increase its reimbursement rates by 5% for services provided by a physician or advanced practice registered nurse (APRN) to eligible recipients. The BDR requests that Nevada Medicaid also add a 3% bonus payment for services provided to Nevadans in rural communities by a physician or an APRN and a separate 3% bonus payment for these providers who participate in value-based payment models.

Additionally, the BDR requests that Nevada Medicaid seek federal authority to establish accountable care payment models, also known as value-based payment (VBP) models, that rewards providers for delivering high quality and coordinated care in a manner that drives greater efficiencies and improved health outcomes. Unlike traditional fee-for-service (FFS) where providers are paid a certain amount for each service that is delivered, under an ACO, payments are dependent on the outcome of the care and the quality of the services provided, all with a goal to focus on improving health care while reducing costs. The Centers for Medicare and Medicaid Services (CMS) Innovation Center previously awarded several grants to states to implement these new types of payment models, which focus on paying providers for quality of services rather than quantity of services. These models have proven successful by states who have implemented the changes and experienced significant cost savings that can be better allocated to areas in need.

Depending on the model selected, providers can opt in to a shared risk program, where if the quality of services exceeds the benchmark, they receive a portion of the savings. If quality does not meet the benchmark, then the provider owes money to cover the additional costs. One of the goals of these models is to drive the provider focus on removing a lot of the barriers for patients and unnecessary cost drivers by reducing inefficiencies in the system such as reducing the number of duplicate tests, increasing preventive tests and screenings, and increasing wellness visits rather than emergency room visits for routine care.

Colorado, Maine, Minnesota, Oregon, and Vermont were among the first states to implement an ACO model and saw significant savings in the initial years. Colorado saved $77 million in the first four years, Vermont saved $14.6 million in the first year, and emergency department visits decreased by 23% in Oregon.[10] Minnesota's accountable care model, Integrated Health Partnerships (IHP), saved $14.8 million in year one with a reduction in emergency room visits by 7% and

[9] Nevada State Legislature. (2024, November 13). *SB29 (BDR 38-450).* Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bill/11796/Overview

[10] Houston, R., & McGinnis, T. (2016, February). *Program Design Considerations for Medicaid Accountable Care Organizations*. Retrieved from https://www.chcs.org/media/Program-Design-Considerations-for-Medicaid-Accountable-Care-Organizations.pdf

hospital stays by 14%.[11] Today this savings is closer to $401 million in health care spending. These trends are expected to continue over time with increased savings seen each year as states have higher participation in the program.
This initiative, if passed by the legislature, would provide Nevada Medicaid with the necessary authority and resources to establish the infrastructure needed to implement and operate an ACO model for providers and hospitals. Currently, the use of value-based payment models in Nevada is minimal compared to other states. By aligning with national best practices through an ACO model, Nevada Medicaid can better contain health care costs while improving health outcomes in the state.

Lastly, the BDR requests Nevada Medicaid to issue a biennial survey to enrolled providers requesting recommendations on how to improve the provider's billing experience and increasing provider participation in Nevada Medicaid.

C. Senate Bill 34: Interstate Licensure Compacts (BDR 54-449)

The Commission's third legislative measure, Senate Bill 34 (BDR 54-449), requires Nevada to enact multiple interstate licensure compacts.[12] The purpose of this BDR is to address the ongoing challenges with building an adequate health care workforce to care for residents by removing any unnecessary licensing barriers for recruiting and retaining health care providers. One of these barriers is the lengthy administrative process for obtaining a license to practice in the state. According to public feedback received through written and oral comments made to the Commission, in some instances, it can take applicants months to complete the process - from time the application is submitted to time the license is issued.

Unnecessary delays for processing a state license to practice in Nevada can lead to frustration for potential providers and result in providers choosing to practice elsewhere – in states where the process is less burdensome and more timely. Interstate licensure compacts have been established for several occupations to address these types of barriers and support the portability of provider licensure across state lines. Through licensure compacts, states establish uniform standards to lower barriers to multi-state practice while preserving a state's practice act and initial licensure process. Licensure compacts also enhance public protection through a data system that allows member states to efficiently communicate licensure data, including disciplinary actions against licenses. Enacting licensure portability policies such as licensure compacts support recruitment of health care professionals and reduce administrative burdens associated with licensure for qualified health care professionals. A state might desire portability policies to:

- Support gainful employment of military personnel who move frequently;
- Expedite the deployment of healthcare professionals in the instance of a public health emergency;
- Create an accessible regulatory environment that support health professions recruitment; and
- Enhance access to health care services[13]

Currently, Nevada is a member of interstate licensure compacts for the following professions: emergency medical services, massage therapists, physicians, teachers, and psychologists. These compacts have proven to be beneficial to Nevadans by not only expediting the process for licensed professionals, but also attracting new talent to the state. As of July 2024, the number of physician medical licenses issued in Nevada had increased 63% from the previous year and the Nevada State Board of Medical Examiners attributes this in part to the Interstate Medical Licensure Compact along

[11] Minnesota Department of Health and Department of Human Services. (2015, August). *Integrated Health Partnerships*. Retrieved from https://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_196131.pdf

[12] Nevada State Legislature. (2024, November 15). *SB34 (BDR 54-449).* Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bill/11805/Overview

[13] National Governors Association. (n.d.). *Common State Policy Solutions to Support Health Professions Portability*. Retrieved from https://www.nga.org/wp-content/uploads/2022/10/State-Policy-Options-to-Support-Portability.pdf

with improvements to internal processes.[14] The Board also stated that approximately 50% of new medical licenses are issued through the Interstate Medical Licensure Compact.[15]

The following table summarizes the compacts Nevada is not currently participating in (excluding the social work and the counseling compacts). The table also includes the number of states who have passed legislation to join the compact.

Compact	States/Territories in Compact	Provider Type
Advanced Practice Registered Nurse (APRN) Compact	4 states	Nurse Practitioners (NPs)
Audiology and Speech Language Pathology Interstate Compact	33 states	Audiologists
		Speech Language Pathologists
Dentist and Dental Hygienist Compact	9 states	Dentists
		Dental Hygienists
Dietitian Licensure Compact	3 states	Dietitians and Nutritionists
Interstate Compact for School Psychologists	2 states	School Psychologists
Nurse Licensure Compact	40 states and 2 territories	Registered Nurses (RNs)
Occupational Therapy Licensure Compact	31 states	Occupational Therapists
Physical Therapy Licensure Compact	38 states and 1 territory	Physical Therapists
PA Licensure Compact	13 states	Physician Assistants

Source: National Center for Interstate Compacts[16]

During the August 16th meeting, the Commission voted to use a BDR to require Nevada to join the five interstate licensure compacts outlined in the table below. These compacts include the:

- Audiology and Speech Language Pathology Interstate Compact
- Nurse Licensure Compact
- Occupational Therapy Licensure Compact
- Physical Therapy Licensure Compact
- Physician Assistant (PA) Compact

Compact	Provider Type	National Rate (per 100,000 Residents)	Nevada Rate (per 100,000 Residents)	Nevada Ranking
Audiology and Speech Language Pathology Interstate Compact	Audiologists	4.2	2.5	49
	Speech Language Pathologists	59.3	30.2	50
Nurse Licensure Compact	Registered Nurses (RNs)	948.1	810.5	45

[14] Mueller, T. (2024, August 20). *Nevada Medical License Counts Surge*. Retrieved from The Nevada Independent: https://thenevadaindependent.com/field-notes/tabitha-mueller/nevada-medical-license-counts-surge

[15] Nevada State Board of Medical Examiners. (2024, March 11). *Presentation Before the Joint Interim Standing Committee on Health and Human Services*. Retrieved from https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/29897

[16] National Center for Interstate Compacts. (2024). Compact Database. Retrieved from https://compacts.csg.org/

Occupational Therapy Licensure Compact	Occupational Therapists	43.2	38.2	35
Physical Therapy Licensure Compact	Physical Therapists	71.9	58.9	46
PA Licensure Compact	Physician Assistants	37.7	27.9	36

Sources: U.S. Bureau of Labor Statistics,[17] American Speech-Language-Hearing Association,[18] Kaiser Family Foundation,[19] Population estimates are from the US Census[20]

Currently, Nevada ranks well below the national average in all the health care provider types listed above. The threshold number of states required to activate a licensure compact is usually between seven and ten states. Once the threshold is reached, a commission is formed to govern the compact and ensure coordination between the participating states. All five compacts being proposed have met the state threshold and are considered activated. The PA Compact is the newest compact included in the recommended list and is not currently operational. There is a seven-state threshold to activate the PA compact, which was met in May 2024. Currently 13 states including Delaware, Utah, Washington, Wisconsin, West Virginia, Nebraska, Virginia, Oklahoma, Ohio, Maine, Colorado, Tennessee, and Minnesota have enacted the PA Compact model legislation. Those states are working through creating the inter-state commission and setting up the compact to be fully operational, which is expected to take 18-24 months. The Occupational Therapy Compact and the Audiology and Speech Language Pathology Compact are also not currently operational but are establishing the necessary systems and will begin issuing compact privileges in 2025.

By joining these interstate licensure compacts, Nevada could support increased mobility for essential health care providers and expedite the process for licensure. This would allow providers the opportunity to establish themselves as a practitioner in the state with greater ease and expediency.

IV. Recommendations to Address Nevada's Health Care Workforce Shortage

Along with the proposed solutions identified in the Commission's BDRs, the following recommendations reflect opportunities for the State to address the chronic health care workforce shortage and increase access to quality health care. Any potential fiscal impacts will be determined by the legislative process if they are addressed in future legislation.

A. Health Care Cross-Government Collaboration & Prioritization of Workforce Initiatives

The following recommendations by the Commission center on the need to support greater collaboration across state agencies, localities, and private entities with respect to the funding of health care workforce initiatives. Such efforts are critical to reducing unnecessary duplication of activities and maximizing the use of limited resources.

[17] U.S. Bureau of Labor Statistics. (2023, May). Occupational Employment and Wage Statistics (OEWS) Tables. Retrieved from https://www.bls.gov/oes/tables.htm

[18] American Speech-Language-Hearing Association (ASHA). (2024, August). Annual Workforce Data: 2023 ASHA-Certified Audiologist- and Speech-Language Pathologist-to-Population Ratios. Retrieved from https://www.asha.org/siteassets/surveys/audiologist-and-slp-to-population-ratios-report.pdf

[19] Kaiser Family Foundation (KFF). (2024, September). State Health Facts: Total Number of Physician Assistants. Retrieved from https://www.kff.org/other/state-indicator/total-number-of-physician-assistants/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[20] United States Census Bureau. (2021, April 27). 2020 Census: Percent Change in Resident Population for the 50 States, the District of Columbia, and Puerto Rico: 2010 to 2020. Retrieved from https://www.census.gov/library/visualizations/2021/dec/2020-percent-change-map.html

1. Recommendation: Health care workforce initiatives should be coordinated across state and local governments and assessed for their effectiveness to ensure the strategic deployment of limited state resources. This includes:

- ***Establishing or designating an agency or taskforce to lead statewide health care workforce efforts, conduct statewide assessments of health care workforce gaps, and convene state leaders and other health care industry stakeholders to develop and implement a health care workforce strategic plan.***
- ***Assessing existing State programs and whether they are effective in enhancing the state's health care workforce.***
- ***Ensuring state investments in workforce initiatives have a high return on investment for the state.***

To meet the health care needs of Nevadans, the state should coordinate across agencies and with localities when deploying limited state resources in support of the expansion of initiatives to develop the state's health care workforce. Currently, the state lacks a coordinated statewide strategy for addressing workforce challenges; instead, these initiatives appear, for the most part, to be developed and conducted in a fragmented manner with limited agency and government collaboration.

In response to this challenge, other states have tasked certain committees or state entities with the responsibility of assessing the workforce needs and developing a strategic plan for the deployment of state resources for these initiatives. For example, the Virginia Health Care Workforce Development Authority (VHWDA) was established by the legislature to identify and address health care workforce issues in Virginia.[21] The VHDWA used an assessment to conduct a statewide study of the health care needs and workforce gaps.[22] The final report from this study identified available funding streams, including state, federal and private funding, for enhancing the state's health care workforce, along with existing state regulatory barriers for providers seeking to enter the state's health care workforce. Using this information, the VHDWA created a strategic plan for addressing the workforce with statewide goals, objectives with measurable outcomes. This plan also included a matrix, detailing the roles and responsibilities of agency partners and other parties. Virginia uses this plan as the basis for funding and operationalizing its workforce initiatives.

Like Virginia, Vermont has also taken steps to improve coordination amongst state entities with respect to workforce development initiatives. This included requiring a state agency to consult with an advisory group to develop and maintain a health care workforce strategic plan for the state.[23] This plan identified issues and provided recommendations for solutions.[24] These recommendations identified the entities responsible for future implementation and coordination of these efforts in support of enhancing the workforce, reducing duplication of efforts, and maximizing limited resources.

Nevada could benefit from a similar approach to its workforce initiatives in health care. This includes identifying a state entity or body responsible for ensuring statewide collaboration regarding the use of resources for workforce initiatives and conducting a comprehensive, statewide assessment of the current gaps in the state's health care workforce by provider type and service array. Using this assessment, Nevada could develop a statewide strategic plan for addressing

[21] Virginia Health Workforce Development Authority (n.d.). *Purpose*. Retrieved from https://www.vhwda.org/about/purpose

[22] Virginia Health Workforce Development Authority (2023, January). *Initiatives: Health Workforce Study*. Retrieved from https://www.vhwda.org/initiatives/health-workforce-study

[23] Vermont Legislature (2020). *AB155 An act relating to increasing the supply of nurses and primary care providers in Vermont*. Retrieved from https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT155/ACT155%20As%20Enacted.pdf

[24] Vermont Legislature (2021, October 15). *Health Care Workforce Development Strategic Plan*. Retrieved from https://legislature.vermont.gov/Documents/2022/WorkGroups/House%20Health%20Care/Health%20Care%20Workforce/W~Ena%20Backus~Vermont%20Health%20Care%20Workforce%20Development%20Strategic%20Plan%2011-11-2021%20Revised~1-6-2022.pdf

these gaps similar to Virginia and Vermont. Additionally, the PPC found that statewide workforce development efforts should be assessed regularly as to their effectiveness in recruiting and retaining providers to serve Nevadans. This includes studying the return on investment for the state with respect to these initiatives currently funded by state programs.

2. ***Recommendation: The state should establish and fund one state webpage to serve as the state's single resource for health care employers, employees, stakeholders, providers and students on health care workforce resources and workforce development initiatives, like the Nevada Health Force website at the Division of Public and Behavioral Health.***

During the Commission's review of Nevada's current efforts, it became clear that the state has multiple initiatives and aimed at improving the health care workforce pipeline and increasing provider recruitment and retention. Unfortunately, as stated earlier, the state lacks one designated party or entity that is responsible for consolidating this information, monitoring the effectiveness of existing programs, and ensuring that these efforts are coordinated in a strategic manner.

To improve transparency, the State should establish a comprehensive public resource about these efforts. A recent successful state example is the website developed by the Division of Public and Behavioral Health (DPBH).[25] The website provides information on health care career opportunities, provides educational and training resources, and connects people to partners. During a Commission meeting in September, DPBH shared plans for future website enhancements, including content expansions and information on career pathways related to public health, behavioral health and primary care careers. DPBH stated the website will also eventually include a user self-assessment, where a user can review career position requirements and determine what may be needed to qualify for certain positions. The assessment tool will also include the average salary of various positions, and the training and education required.

The Commission discussed the need for Nevada to provide sustainable funding for the Nevada Health Force website, which is a great example of state agency innovation and provides future opportunities to serve as a resource for statewide health care career workforce resources and information.

3. ***Recommendation: Developing the health care workforce should not be sole responsibility of state agencies that interact with the state's health care system; other agencies that are designed to promote the development of the labor workforce should also prioritize the enhancement of the state's health care workforce. This includes:***

- ***The Office of Workforce Innovation (OWINN) and the Governor's Workforce Development Board (GWDB) prioritizing these efforts through available funding, including federal funding reserved for statewide workforce investment activities from the Workforce Innovation and Opportunity Act (WIOA), on health care workforce training, education initiatives and apprenticeships to increase health care provider supply.***

Some states have aligned health care workforce policy activities with broader state workforce development activities. According to the National Governor's Association, states play an important role in workforce development activities, including directing federal pass-through funding to support these activities and developing a state workforce plan.[26] In Nevada, the Governor's Workforce Development Board (GWDB) is viewed as the primary leader of workforce policy in the State through the examination of the statewide workforce development system, creating the Workforce Innovation and

[25] Nevada Division of Public and Behavioral Health (n.d.). *Building Nevada's Health Workforce*. Retrieved from https://www.nvhealthforce.org/

[26] National Governors Association. (n.d.). *State Health Workforce Toolkit: Data and Planning*. Retrieved from https://www.nga.org/state-health-workforce-toolkit/data-and-planning/#dataPolicy

Opportunity Act (WIOA) State Plan, and recommending policy improvements of the workforce development system to the Office and the Office of Workforce Innovation (OWINN).[27]

The Commission recognizes that, while the state's workforce needs are diverse, the GWDB and OWINN have an opportunity to prioritize workforce development for the health care industry. By including the health care industry needs in the WIOA State Plan, Nevada could receive sustainable federal funding to strengthen and improve the capacity of the state's health care workforce.

B. Establish Pathways from Education to Health Care Workforce

The Commission identified the state's education system as another area where the state may find additional opportunities to increase the number of health care providers in the state. This includes the following recommendations:

1. ***Recommendation: The state should explore ways to increase youth exposure to health care careers early in high school and incentivize youth to complete health-related courses prior to college or professional training school, including requiring the Nevada System of Higher Education (NSHE) to offer credits tied to such courses or certifications before high school graduation.***

Existing health care education and training programs must be enhanced to meet the needs of both students and the community. Health care workforce development efforts should expose students to career opportunities as early as elementary school and include opportunities for high school students to take courses focused on health care. Additionally, certain certification programs should be offered to high school students who may be inclined to enter the workforce upon graduation. For example, legislation recently passed in the State of Hawaii established a High School Health Care Workforce Certificate Program.[28] This program is intended to allow public high school students the opportunity to receive certification to fill entry-level health care positions that pay a living wage and offer opportunities for advancement. Hawaii lawmakers recognized that over a thousand entry-level health care positions could be filled by certified high school students upon their graduation.

The Commission recognizes the need for Nevada to create more opportunities for high school students to receive exposure to health care careers. By exposing more students to health care career opportunities and offering education and training during high school, the State will be able to recruit and retain the next generation and fill more entry-level positions. Additionally, the Commission recommends the Nevada System of Higher Education (NSHE) medical schools, nursing schools or other health care related programs offer potential college credit for students who have completed health related courses or certifications during high school. By offering college credit to high school students who show interest in health-related courses, more students will qualify for entry-level health care occupations and may be inclined to pursue additional higher education in health-related programs, which in turn promotes upward mobility of workers.

2. ***Recommendation: The OWINN should ensure collaboration with the Department of Health and Human Services (DHHS), Nevada Area Health Education Centers (AHECs) and representatives of the health care industry during implementation of AB 428 (2023) to ensure health care career pathways are developed to interest a person to enter or advance in health occupations in high need areas.***

[27] Office of Workforce Innovation (OWINN). (n.d.). *Governor's Workforce Development Board (GWDB)*. Retrieved from https://gowinn.nv.gov/boards-commissions/gwdb/

[28] Hawai'i State Legislature. (2024, June 28). *HB1827 HD2 SD1 CD1*. Retrieved from https://www.capitol.hawaii.gov/session/measure_indiv.aspx?billtype=HB&billnumber=1827&year=2024

During the 2023 Legislative Session, Nevada passed Assembly Bill (AB) 428 which mandates the creation of career pathways that engage students from kindergarten through post-secondary education and/or certification programs, aimed at fostering economic growth and workforce diversification. A recent Request for Proposals (RFP) was distributed by the OWINN, asking applicants to create a structured career pathway demonstration program tasked with targeting students as early as kindergarten and continuing through high school and on to employment.[29] According to OWINN, the pathway will enable students to acquire the skills, certifications and experiences necessary for sustainable careers that address the long-term needs of their communities and the state of Nevada in teaching, healthcare, and clean energy and manufacturing.

The Commission received presentations from various agencies such as the Nevada Area Education Centers (AHEC) and DPBH—both of which are actively involved in establishing career pathways for the health care industry. The Commission recognized the need for OWINN to collaborate with the DHHS, AHEC and other representatives of the health care industry during implementation of AB 428 (2023). This will reduce duplication of efforts and align statewide efforts to establish health care career pathways to interest a person to enter or advance in health occupations in high need areas.

3. Recommendation: State funding in support of Nevada AHECs should be increased to enhance health care workforce development pipeline efforts statewide.

Nationally, AHECs are organizations dedicated to enhancing quality health care, particularly primary and preventive care, by improving the supply and distribution of health care professionals through strategic partnerships with academic programs, communities and professional organizations. Congress established the AHEC program in 1971 to strengthen and diversify the healthcare workforce in rural and medically underserved communities. In Nevada, there are three regional AHECs – High Sierra, Desert Meadows, and Frontier. High Sierra AHEC serves Washoe, Carson City, Churchill, Douglas, Lyon and Storey County. Desert Meadows AHEC serves Clark, Nye and Esmeralda County. Frontier AHEC serves Elko, Eureka, Humboldt, Lander and Mineral County. In September, the Commission received a presentation regarding Nevada AHEC workforce development activities and information regarding each regional AHEC's programs and existing operating budget.

Nevada AHEC programs focus on recruiting, training, and retaining health care professionals, especially in underserved and rural areas. Starting as early as 5th grade, they offer early career exploration, continuing education, technical assistance, and student programs to enhance practice opportunities for health care providers. Additionally, AHECs build strong relationships with community organizations, academic institutions, and employers. These partnerships address local healthcare needs, ensure educational programs are relevant and impactful, and improve the coordination of efforts across the state. As an example, High Sierra AHEC coordinated the efforts of the Nevada Health Care Workforce Pipeline and Development Workgroup and led the Primary Care Workgroup Subcommittee.

According to the AHEC presentation to the Commission, during fiscal year 2023-2024, the three Nevada AHECs received a combined total of $432,750 federal HRSA funds and $51,000 state general funds.[30] Two of the three AHECs (Frontier and Desert Meadows) currently operate with less than two full-time employees (FTE). In contrast, High Sierra AHEC operates with 9 FTE and 3 interns. With additional staff and resources, High Sierra AHEC is better prepared to actively seek additional federal and state grant funding opportunities to expand their program operations. High Sierra AHEC is also the

[29] Office of Workforce Innovation (OWINN). (2024, October 31). *AB428 Career Pathways Demonstration Program (CPDP)*. Retrieved from https://gowinn.nv.gov/wp-content/uploads/2024/11/AB428-NV-CPDP-.pdf

[30] Nevada Patient Protection Commission. (n.d.). *Nevada Area Health Education Centers (AHEC)*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%209.20.24%20Patient%20Protection%20Commission.pdf

only Nevada AHEC that is not hosted and operates as a 501(c)3 nonprofit organization. AHECs have proven to be successful partners in Nevada and other states in collaborating and implementing health care workforce development planning and pipeline initiatives. Other states have invested in their AHECs to sustain and expand health careers promotional programming. In 2023, Kentucky allocated state funding to expand existing programs that included a statewide nursing pipeline for high school and college students; enhancement of school-based presentations and longitudinal programs, including expansion into middle schools; and development of new pre-med prep programs.[31]

To support Nevada AHECs to perform the duties assigned to them in NRS 396.907 and increase the number of primary care providers, the PPC recommends Nevada increase the amount of state funding provided to each regional AHEC.[32] Additional funding will allow Nevada AHECs to enhance school-based (K-12) presentations, longitudinal pathway programs, provide educational programs to health care professional students, provide continuing education to practicing health care professionals, strengthen the workforce development pipeline, and enhance community health initiatives. Without an increase in state funding, Nevada AHECs will have limited ability to inspire the next generation to enter the health care workforce. By providing more state funding to each regional AHEC, Nevada will be able to improve health care workforce pipeline efforts and "grow our own" skilled and compassionate future health care providers.

C. Enhance Provider Recruitment and Retention

The Commission made additional recommendations as outlined below that focus on expanding resources and programs in the areas of provider recruitment and retention to ensure that upfront investments in education and training results in the retainment of providers to serve Nevadans, with acute attention to Nevada's hard to serve communities in frontier or rural regions of the state.

1. ***Recommendation: The state should focus a portion of its development of workforce initiatives on establishing incentives for recruiting health care occupations in areas, where providers are in significant undersupply or in historically underserved rural and frontier areas of the state communities.***

Nevada should continue to develop workforce incentives focused on recruiting occupations in undersupply and target rural or underserved communities to improve access to care. Offering financial incentives to providers who decide to live and work in rural or underserved communities, through stipends, loan repayment options and higher reimbursement rates have proven effective and could be enhanced with additional funding.

Loan repayment has been a successful tool used to recruit and retain more health care providers in Nevada. The Nevada Health Service Corps (NHSC) loan repayment program is administered by the Nevada State Office of Rural Health in the Office of Statewide Initiatives based at the University of Nevada, Reno School of Medicine and was established by the Nevada State Legislature in 1989.[33] The purpose of the program is to encourage health practitioners to practice in areas of Nevada in which a shortage of that type of practitioner exists. A practitioner may enter into the NHSC by engaging in full-time clinical practice in an assigned medically underserved community in exchange for loan repayment funds. According to Dr. John Packham, Associate Dean of the Office of Statewide Initiatives, since the inception of the state and

[31] Northeast AHEC. (2024, June 11). *Kentucky AHEC Program Receives $5 Million in State Funding*. Retrieved from https://www.neahec.org/news/kentucky-ahec-program-receives-5-million-in-state-funding

[32] Nevada State Legislature. (n.d.). *NRS 396.907 Area Health Education Center Program; Establishment; duties; use of gifts and other money.* Retrieved from https://www.leg.state.nv.us/nrs/nrs-396.html#NRS396Sec907

[33] University of Nevada, Reno School of Medicine. (n.d.). *Nevada State Office of Rural Health: Office of Statewide Initiatives*. Retrieved from https://med.unr.edu/statewide/programs/nevada-state-office-of-rural-health/nevada-health-service-corps

federally funded program in 1989, 70 physicians have been supported through loan repayment in Nevada. Currently 45 physicians are actively practicing and 44 of them remain in Nevada.

During the Commission's meeting in October, the Nevada State Treasurer's Office provided a presentation regarding the implementation of the Student Loan Repayment Program for Providers of Health Care in Underserved Communities, which was established by AB 45 from the 2023 Legislative Session.[34] The program is anticipated to launch in January 2025 and will likely build upon the success of the Nevada Health Service Corps program. The Program will receive $2.5 million each fiscal year as an automatic statutory trigger from the Abandoned Property Trust Account. Eligible providers such as physicians, physician assistants, licensed nurses, optometrists, psychologists, and social workers, etc., who are successfully approved for this program can receive up to $120,000 in exchange for practicing in an underserved community in Nevada. Funds will be disbursed to approved applicants over a 5-year period.

The Commission agreed Nevada should continue to focus additional new funding for workforce incentives towards recruiting occupations in undersupply and target rural or underserved communities to improve access to care.

2. ***Recommendation: The state should expand loan repayment options and consider creating housing assistance programs for new providers who agree to practice in rural and underserved areas of the State.***

In addition to expanding loan repayment options for health care providers with an emphasis on underserved areas of the state, the Commission agreed the State should consider creating a housing assistance program for providers who may be relocating or working for extended periods of time in rural areas underserved areas. Housing assistance programs have been successful in other states in retaining and recruiting health care providers. For instance, St. Luke's Wood River in Idaho partnered with local community organizations to develop a 12-unit single family home project for their employees. Bozeman Health in Montana invested in securing 100 units in future workforce housing in partnership with capital groups, ensuring affordable rental options for their staff. Additionally, the Cleveland Clinic offers forgivable loans of $20,000 for down payment and closing costs, which are completely forgiven if the employee remains with the clinic and occupies the home.[35] The Nevada Housing Division has a similar program for teachers called "Home Is Possible for Teachers", which provides down payment assistance to help recruit and retain educators in the state.[36]

3. ***Recommendation: Develop public-private partnerships to fund health care workforce initiatives, leveraging resources from both sectors to maximize impact.***

The Commission recognizes that investments in the state's health-care workforce must be sustainable to ensure the most efficient use of limited taxpayer dollars. The Commission discussed the need to expand federal, state, public, and private funding investments into Graduate Medical Education (GME) residency and fellowship programs and other workforce initiatives. For example, SB 369 (2023) failed to pass, but would have established tax credits for certain businesses who donate money to assist in establishing graduate medical education residency or fellowship programs. As mentioned

[34] Nevada Patient Protection Commission. (2024, October 18). *Student Loan Repayment Program for Providers of Health Care in Underserved Communities' Program*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%20Healthcare%20provider%20loan%20repayment%2010.18.24_AB45_Updated.pdf

[35] American Hospital Association. (2022, June). *Workforce Solutions: Recruitment and Retention Strategies in the Wake of the COVID 19 Pandemic*. Retrieved from https://www.aha.org/guidesreports/2022-06-29-workforce-solutions-recruitment-and-retention-strategies-wake-covid-19

[36] Nevada Housing Division. (n.d.). *Home is Possible for Teachers*. Retrieved from https://www.homeispossiblenv.org/home-possible-teachers

earlier, the Medicaid Health Care Workforce Fund proposed by SB 40 (BDR 38-451) will assist the State in leveraging more federal funding to match any state investments allocated to the account. Nevada can benefit from developing future opportunities for government and non-governmental organizations to invest in health care workforce initiatives.

Pursuant to NRS 422.175 to 422.205, the Nevada Department of Health and Human Services (DHHS) Division of Health Care Financing and Policy (DHCFP) must establish an advisory committee to provide advisory recommendations to DHCFP and Medicaid managed care organizations (MCOs) regarding the investment of profits by MCOs in the communities they serve. Specifically, this advisory committee must be established in any county where the population is 700,000 or more. Currently, only Clark County satisfies this requirement. The State's current contract with MCOs includes a requirement that each MCO must reinvest at least 3 percent of its pretax profits in the community being served by the MCO. Annually, MCOs are required to submit a written plan to DHCFP detailing the anticipated community reinvestment activities. During the 82nd legislative session, the Division received state approval in its budget to finance the expansion of the Medicaid Managed Care Program to all counties in the State pursuant to NRS 422.273. The statewide expansion will begin on January 1, 2026, with the implementation of the next Managed Care Contract Period, resulting in about a 10 percent increase in Medicaid recipients served by the State's Medicaid Managed Care Program.[37] With the expansion of statewide managed care, MCOs will be serving all Nevada Counties. The DHCFP has an opportunity to include language in the State's contract with MCOs requesting a percentage of their profits be reinvested to support the recruitment and retainment of health care providers. This will ensure each Nevada County receives a sustainable allotment of Medicaid reinvestment dollars. By reinvesting in the health care workforce, more patients, including Medicaid recipients will have greater access to care.

4. Recommendation: The state should explore ways to reduce or defer the amount of interest students owe on medical education loans.

According to the American Medical Association (AMA), reducing medical student indebtedness may contribute to a reduction in the shortage of physicians.[38] The AMA also stated that the enormous debt load medical students face is further compounded during low paying residency and fellowship training. Even if graduates qualify to have their payments suspended during training, their loans continue to accrue interest, which increases their overall debt. Identifying ways to reduce or cap the amount of interest borrowers must pay will incentivize more students to pursue medical education. The high cost and interest rates on educations loans is often a barrier to attracting and retaining providers, especially for students from rural or underserved communities. Legislation has been introduced by Congress at the federal level HR 4122 (2021-2022) that if implemented would have allowed borrowers to qualify for interest-free deferment on their student loans while serving in medical or dental internships or residency programs.[39]

The PPC discussed the need for Nevada to identify ways to incentivize providers to practice in Nevada through loan interest reduction or deferment. By reducing or deferring medical education loan debt issued to health care providers, Nevada can incentivize more providers to practice and complete their graduate medical education in the State.

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[37] Nevada Division of Health Care Financing and Policy. (n.d.). *Statewide Managed Care Program*. Retrieved from https://dhcfp.nv.gov/Providers/Statewide_Managed_Care/

[38] James L. Madara, M. (2021, July 1). *AMA: American Medical Association Support for HR 4122, "Residential Education Deferred Interest (REDI) Act"*. Retrieved from https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-7-1-Letter-to-Babin-and-Houlahan-re-Resident-Education-Deferred-Interest-Act-(Final).pdf

[39] 117th House of Representatives. (2021, July 24). *H.R. 4122 - REDI Act*. Retrieved from https://www.congress.gov/bill/117th-congress/house-bill/4122?q=%7B%22search%22%3A%22hr+4122%22%7D&s=3&r=1

D. Nursing Workforce

According to a report developed by the UNR Nevada Health Care Workforce Research Center, Nevada needs an additional 3,162 registered nurses (RNs), 3,284 licensed practical nurses (LPNs), 5,055 certified nursing assistants (CNAs), 626 nurse practitioners (NPs/APRNs) and 307 certified registered nurse anesthetists (CRNAs) to meet national population-provider averages.[40] The COVID-19 pandemic has exacerbated a national shortage of registered nurses, making it critical that policymakers invest in all segments of the nursing workforce, from education and training to retention. Therefore, in addition to the BDR recommendation to authorize the state to participate in the interstate nurse licensure compact, the PPC made the following recommendations to address this shortage:

1. Recommendation: The state should fund and support a Nevada Nurse Workforce Center to serve as a hub to advance nursing education, practice, leadership, workforce development, and policy.

According to the National Forum of State Nursing Workforce Centers, State Nursing Workforce Centers serve as hubs that support nursing workforce research, nursing education, practice, leadership, and workforce development at the state and local levels focused on the utilization of evidence.[41] Services of nursing workforce centers typically include: conducting localized research; publishing reports related to supply, demand, and educational capacity of the nursing workforce; and implementing other activities to improve the nursing workforce in their states. They utilize data-driven insights and expert consultation at community, regional, and state levels to foster meaningful discussions about the real challenges facing the nursing workforce and practical solutions to address them.

A December 2022 report from UNR's Nevada Health Workforce Research Center laid out several ways to alleviate the nursing shortage, one of which included a proposal to establish a statewide Nevada Nurse Workforce Center.[42] A Nevada Nurse Workforce Center would address the nursing shortage by studying the unique characteristics of the nursing workforce in Nevada; developing strategies to increase the number of new nurses in the state; recruiting nurses to the profession; implementing strategies to retain nurses in the workforce; and advocating for changes in policy to improve the stability of the nursing workforce in Nevada.

Other states who have enacted legislation to establish a statewide Nursing Workforce Center including: Washington, Florida, Hawaii, Illinois, Tennessee, and Texas.[43] Nevada recently passed legislation through AB 37 (2023),

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[40] Nevada Health Force. (2023, May). *Health Workforce in Nevada: A Chartbook*. Retrieved from https://www.nvhealthforce.org/wp-content/uploads/2024/03/Health-Workforce-in-Nevada-a-Chartbook.pdf

[41] National Forum of State Nursing Workforce Centers. (n.d.). *National Nursing Workforce Center Act*. Retrieved from https://nursingworkforcecenters.org/national-nursing-workforce-center-bill/

[42] Nevada State Legislature. (2022, December). *Addressing Nevada's Nursing Workforce Shortages: A Call to Action*. Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/82nd2023/ExhibitDocument/OpenExhibitDocument?exhibitId=69305&fileDownloadName=SB375_NevadaNursingCalltoActionDEC2022_PreparedbyJohnPackhamUNR.pdf

[43] Washington State Legislature. (2005). *RCW 18.79.202 License fee surcharge - Use of Proceeds - Nursing resource center account – Report to the legislature - Review - Rules*. Retrieved from https://app.leg.wa.gov/rcw/default.aspx?cite=18.79.202; The Florida Senate. (2021). *464.0195 Florida Center for Nursing; goals*. Retrieved from https://www.flsenate.gov/laws/statutes/2021/464.0195;
State of Hawaii. (2003). *H.B. 422 UH; Nursing; Center for Nursing, Center for Nursing Special Fund, and Center for Nursing Fee; Established*. Retrieved from https://www.capitol.hawaii.gov/sessions/session2003/bills/HB422_cd1_.htm;
Illinois General Assembly. (2023, July 28). *Public Act 103-0285*. Retrieved from https://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=103-0285&GA=103 ;

which established a Behavioral Health Workforce Development Center within the Nevada System of Higher Education (NSHE).[44] Establishing a similar Center devoted to nursing would allow the state to address the nursing shortage at the state and local level by conducting localized research, publishing reports related to supply, demand, and educational capacity of the nursing workforce, and then developing and implementing strategies to improve the nursing workforce in Nevada.

The Commission received several letters of support regarding this proposal from the Nevada Action Coalition, UNLV School of Nursing, UNR Orvis School of Nursing, UNR School of Medicine and Nevada Rural Hospital Partners.[45]

2. Recommendation: The state should provide additional funding to the DPBH and DHHS to continue the Nurse Apprenticeship Program over the 2026-2027 biennium.

In February 2022, the Nevada Legislature's Interim Finance Committee (IFC) approved federal American Rescue Plan Act (ARPA) funding to support existing Nurse Apprentice Programs (NAP) and to encourage the creation of new programs in Nevada hospitals and skilled nursing facilities. This funding aims to address the existing nursing workforce shortage and support Nevada health care facilities experiencing sever staffing shortages. The Nevada State Board of Nursing adopted regulation LCB File No. R018-22AP in 2022 to allow apprentice nurses to work in all medical facilities licensed pursuant to NRS 449.[46] This expanded the types of facilities which can employ apprentice nurses. A nurse apprentice is an employee of an agency who is currently enrolled in a pre-licensure registered nurse (RN) or licensed practical nurse (LPN) nursing program. Under supervision of registered nurses, nurse apprentices work at a health care facility providing nursing care following the Nevada State Board of Nursing approved skills list.[47] The Nevada Nurse Apprentice Program has proven to be a successful tool for Nevada health care facilities to produce graduate nurses with clinical experience and retain licensed nurses, thus increasing the nursing workforce in Nevada.

Since March 2022, the Nevada Rural Hospital Partners (NRHP) has executed the grant program on behalf of the Nevada Division of Public and Behavioral Health (DPBH). NRHP has worked closely with all eligible facilities, nursing schools and

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Tennessee General Assembly Fiscal Review Committee. (2022, February 9). *Fiscal Note HB 2148 - SB 2401*. Retrieved from https://www.capitol.tn.gov/Bills/112/Fiscal/HB2148.pdf
State of Texas. (2007, September 1). *Sec 105.002 Establishment of Center*. Retrieved from https://statutes.capitol.texas.gov/Docs/HS/htm/HS.105.htm#105.002

[44] Nevada State Legislature. (2023). *AB37*. Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/82nd2023/Bill/9566/Text

[45] Nevada Action Coalition. (2024, August 15). *Nevada Nurse Workforce Center Sustainability Request*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%20Nevada%20Workforce%20Center%20Sustainability%20Request.pdf;
University of Nevada, Reno Orvis School of Nursing. (2024, October 15). *Support the Establishment of Sustainable Nevada Nursing Workforce Center (NNWC)*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%20-%20OSN%20LOS%20-%20Nevada%20Nursing%20Workforce%20Center.pdf ;
University of Nevada, Reno School of Medicine Office of Statewide Initiatives. (2024, October 16). *Support for the Nevada Nursing Workforce Center (NNWC)*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%2024%20Support%20Letter%20-%20NNWC%20to%20NV%20PPC%2010-17-24.pdf;
Nevada Rural Hospital Partners. (2024, October 17). *Support for Nevada Nurse Workforce Center (NNWC)*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%20NRHP%20PPC%20LOS%2010-17-24.pdf

[46] Nevada State Legislature. (2022, June 13). *Approved Regulation of the State Board of Nursing*. Retrieved from https://www.leg.state.nv.us/Register/2022Register/R018-22AP.pdf

[47] Nevada State Board of Nursing. (2023, February 1). *Nurse Apprentice Skills List*. Retrieved from https://nevadanursingboard.org/wp-content/uploads/2023/03/NSBN-Apprentice-Nurse-Skills-List-updated-02012023.pdf

nursing students to increase awareness and utilization of the Nevada Nurse Apprentice Program Grant opportunity.[48] Through the grant opportunity, health facilities receive funding to pay for nurse apprentice salaries. The funding is also used to pay a stipend to supervising RNs and to offer graduating nurses a retention payment if they agree to work for the facility for a number of years. Nursing students also receive travel reimbursement if they travel 50 miles or more (one way) to work as nurse apprentices. This has incentivized nursing students to seek apprenticeship experience and work in rural and underserved areas. According to the NAP ARPA Grant state fiscal year (SFY) report for 2023 and 2024, a total of 242 nurses (58 in SFY23 and 184 in SFY24) have been retained since March 2022. Additionally, the number of programs statewide has increased and the number of nursing students working as nurse apprentices has tripled since the program's inception with 250-300 nursing students working in Nevada health care facilities each month. On July 16th, the IFC approved additional ARPA funding to extend the NAP ARPA Grant through the current SFY25, which ends June 30, 2025. The Nevada Nurse Apprenticeship Program has proven to be a successful and innovative 'earn while you learn' model for Nevada to recruit and retain nursing students and address the nursing shortage.

The Commission recommends the State appropriate additional funding during the next Legislative Session to ensure the Nevada Nurse Apprentice Program continues through the 2026-2027 biennium.

E. Increase Access to Care for Medicaid Recipients

The Medicaid program provides health care coverage to one in four Nevadans; many of the workforce challenges for health care have disproportionately affected this population given its size and the historical challenges with provider participation in Nevada. Therefore, the Commission recommended the following:

1. ***Recommendation: Nevada Medicaid should be authorized and funded by the legislature to pilot a virtual "Hospital at Home" program to increase access to care in rural and frontier areas. This includes:***

- ***Ensuring the development of the pilot program will not negatively impact existing medical services and workforce supply in rural and underserved communities; and***
- ***Prior to launching the Nevada pilot program, engaging with the Commission to solicit feedback on proposed pilot program models.***

Nevadans living in rural areas of the state face unique challenges in finding an available health-care provider and require creative solutions for addressing these challenges. In September, the Commission received a presentation regarding an innovative care model that other states have implemented to increase access to care and treat patients within their own home.[49] Federally, the Centers for Medicare and Medicaid Services (CMS) has authorized innovative care models such as the Emergency Department in Home (EDiH) and Hospital at Home (HaH) to provide in-home care for patients who qualify and would normally receive services in an emergency department or inpatient setting. Hospital at Home models seek to increase access to emergency, outpatient and inpatient care options in rural areas; support the emergency medical services (EMS) system by reducing avoidable emergency department transports; decrease hospital overcrowding in urban settings; and better allocate available health care workforce resources.

[48] Nevada Rural Hospital Partners Foundation. (n.d.). *Nevada Nurse Apprentice Program*. Retrieved from https://nap.nrhp.org/

[49] Tripp | Hollander Advisors. (2024, September 20). *Hospital At Home and Other Virtual-Forward Innovations: Improving Patient Access to Care and Workforce Retention*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/ADA%20Nevada%20Patient%20Protection%20Commission_EDiH-HaH_9.20.24.pdf

These models rely on a combination of in-person clinicians (EMS/paramedics) with remote physicians and nurses, to provide emergency level, in-patient and primary care for patients who can safely be treated at home in rural areas. Rather than removing patients from their own communities to access care, eligible patients would be able to opt-in to receiving necessary care at home.

To increase access to care for rural and frontier communities, the Commission recommends Nevada Medicaid secure necessary funding and authority to establish a pilot program based on Hospital at Home care models. The Commission had robust discussion regarding the development of the pilot program and emphasized the importance of ensuring the pilot program remains safe, affordable and does not negatively impact existing medical services and workforce supply in rural and underserved communities. The pilot will allow an innovative opportunity for Nevada to share key learnings about safety, quality, and cost to inform future health care regulatory and payment policy.

2. ***Recommendation: Nevada Medicaid should review prior authorization (PA) data and requirements to simplify and streamline the process for health care providers as applicable. Recommend Nevada Medicaid establish a data dashboard to support the transparency and review of PA data. Following the establishment of such a data dashboard, Nevada Medicaid should review which PAs should and can be removed without undue risk of increasing fraud, waste and abuse. In addition, Nevada Medicaid should report to the Legislature each biennium regarding the Division's findings related to PA data and activities made to reduce provider administrative burden.***

The PA process in Nevada Medicaid is a payment review mechanism conducted by physicians and other clinicians on behalf of the state or health carrier that is designed to ensure certain services are medically necessary, appropriate, and meet program requirements before they are deemed reimbursable. Medicaid policies outline which services require a PA. Requests from providers are submitted electronically to Medicaid (state or health carrier), including all necessary documentation, and are reviewed by a physician or other appropriate clinician to determine whether the definition of medical necessity and service requirements have been met. Once approved, an authorization number is issued for claims, and denied requests can be appealed through established procedures. While this process helps protect the state from payment fraud and inappropriate, unauthorized payments to providers, it can be time-consuming and administratively burdensome for providers.

In June, the Commission issued a solicitation, asking providers of health care to provide feedback on how to improve the Nevada Medicaid billing experience and increase provider utilization to increase access to care for Medicaid recipients. Although most providers responded noting that low Medicaid reimbursement rates were often the cause for low provider utilization, another common response included the recommendation to reduce prior authorization challenges. During a PPC meeting in July, the Nevada State Medical Association (NSMA), the State's oldest and largest physician advocacy organization, shared that PA reform is the single most requested administrative fix according to their members.[50] NSMA claims the Medicaid PA authorization process can be cumbersome, complex and distinct variations exist amount Medicaid Fee-for-service (FFS) and the four Medicaid Managed Care Organizations (MCOs).

The PPC recommends that Nevada Medicaid review and streamline the PA process to address inefficiencies and unnecessary barriers to care. Specifically, it suggests identifying and removing PAs for services that are routinely approved and pose minimal risk of fraud, waste, and abuse. These requirements often add unnecessary administrative burdens for

[50] Nevada State Medical Association. (2024, July 2024). *Nevada Medicaid: Physician Perspectives*. Retrieved from https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2024/5.1_Final%20ADA%20NSMA%20and%20NV%20Medicaid-%20PPC%20Presentation%2007192024-%20Final(1).pdf

providers while delaying timely access to care for patients. By simplifying and reducing the scope of PAs, Nevada Medicaid can improve efficiency, enhance patient outcomes, and lower provider workloads, all while maintaining program integrity and oversight.

F. Increase Access to Primary Care

The Governor's Executive Order 2024-002 requests the PPC provide recommendations for increasing access to primary care and public health services. The Commission explored this issue and made the following recommendation:

1. ***Recommendation: Prioritize health care workforce investments on those that will support the expansion of primary care providers.***

According to 2023 data provided by the UNR Nevada Health Workforce Research Center, Nevada ranks 48th in the U.S. for primary care physicians per 100,000 people.[51] Approximately half of the osteopathic physicians (565) are licensed in primary care specialties (45.3%), as compared to only 1,943 of allopathic physicians (26.0%) in primary care specialties. An estimated 2,282,125 Nevadans or 69.7% of the state's population reside in a federally designated primary care health care provider shortage area (HPSA). Additionally, 12 of 17 counties in Nevada are single-county primary care HPSAs including 11 of 14 rural and frontier counties. Increasing the number of primary care providers will increase access to more affordable preventative health care services for Nevada patients. Current research has shown that there is a higher probability of a healthy community when there are more primary care physicians available for the general population.

An increase in the number of primary care physicians has also been shown to lower the frequency of patients presenting to the emergency department or hospital, which helps reduce health care costs while improving long-term health outcomes.[52] Training programs should be expanded to grow and retain more primary care providers such as physicians, advanced practice registered nurses and physician assistants. Consumers often perceive overall access to care based on the availability and affordability of primary care services. For patients in Nevada, many may wait up to or even longer than one month to see their primary care physicians. For specialty care, the wait time may even be extended, and this is assuming that the specialty exists in the state.

While this recommendation seeks to prioritize investments into primary care, the Commission acknowledges there is a need to increase access to health care generally, which includes primary care, public health and behavioral health services. The State of Nevada has made significant investments to improve public health and behavioral health services in recent years. Examples include the passing of SB 118 (2023), which allocated millions of dollars toward public health infrastructure and service improvement.[53] Additionally, Nevada recently announced that over $200 million in Medicaid funds will be invested in children's community behavioral health services over the next three years with the use of a portion of the state's hospital provider tax revenue.

[51] Nevada Health Force. (2023, October). *Physician Workforce in Nevada: A Chartbook*. Retrieved from https://www.nvhealthforce.org/wp-content/uploads/2024/03/23-Physician-Workforce-in-Nevada-a-Chartbook.pdf

[52] Kenny Do, J. D. (2023, July 11). *Nevada's Healthcare Crisis: A Severe Shortage of Physicians and Residency Positions*. Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC10414134/#REF4

[53] Nevada State Legislature. (2023, February 8). *SB118*. Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/82nd2023/Bill/9765/Overview

The Commission supports any state investment directed at improving health care access, quality and affordability, and recommends future investments in programs aim at increasing primary care services statewide, especially for rural and underserved communities.[54]

G. Direct Care Workforce

Another topic the Commission discussed as needed increased attention by lawmakers is the direct care workforce that serve seniors and people with disabilities in Nevada.

1. Recommendation: Support direct care workers by strengthening career pipelines, expanding training and educational opportunities throughout the state, and increasing wages and benefits for the existing workforce.

According to the U.S. Bureau of Labor Statistics, direct care workers are categorized as Certified Nursing Assistants, Home Health Aides, and Personal Care Aides. Direct care workers assist older adults and people with disabilities with essential daily tasks and activities across a range of long-term care settings.[55] Direct care workers provide essential services in a variety of settings, including home and community-based settings, residential care settings and nursing facilities. Nevada is considered to have one of the fastest growing populations. This population is becoming older and more diverse as well, with 1 in 6 Nevadans aged 65 and older.[56]

With the increase in the size of the state's aging population and the lack of a sufficient number of health care providers in the state to care for this population, Nevada should begin to address these gaps now to mitigate the negative effects of the workforce gaps on this population especially as the size of this population is not expected to decrease any time soon. This includes strengthening recruitment and retention efforts to increase the state's direct care workforce. Nevada ranks 50th out of 51 states including D.C. in terms of the number of direct care workers per 100,000 residents, indicating a significant shortage.[57] Recruitment and retention efforts are often difficult, when direct care workers in Nevada face low wages, which can lead to financial instability and high turnover rates.

Nevada currently has a $16 an hour minimum wage for Home Care Workers and a proposal has been discussed to further increase the minimum wage to $20/hour.[58] Increasing wages and benefits for direct care workers will help reduce turnover, improve worker satisfaction and reduce reliance on public assistance, such as Medicaid and SNAP. According to the Nevada Health Care Career Manual, employers often train home health aides and personal care aides on the job and only require a high school diploma to start.[59] These careers offer an opportunity for upward mobility into other health care professions. These positions offer high school graduates and others without prior health care experience an entry point into the health care workforce pipeline. By increasing wages, offering essential benefits, and

[54] Nevada Governor Joe Lombardo. (2024, March 21). *Governor Lombardo Announces Plans for Behavioral Health Care Services for Nevada Children*. Retrieved from https://gov.nv.gov/Newsroom/PRs/2024/2024-03-22_behavioral_health_care/

[55] PHI. (2021, September 7). *Direct Care Workers in the United States*. Retrieved from https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2/

[56] Davidson, M. S. (2019, June 19). *Nevada growing older, more diverse, Census data shows*. Retrieved from https://www.reviewjournal.com/local/local-nevada/nevada-growing-older-more-diverse-census-data-shows-1691182/

[57] PHI. (n.d.). *Direct Care Workforce State Index State Profile*. Retrieved from https://www.phinational.org/state/nevada/

[58] Alvarez, C. (2024, May 31). *Nevada homecare workers call on officials for higher pay, better working conditions*. Retrieved from https://www.knpr.org/news-88-9-knpr/2024-05-31/nevada-homecare-workers-call-on-state-lawmakers-for-higher-pay-better-working-conditions

[59] Nevada Health Force. (2024-2025). *Health Care Careers in Nevada*. Retrieved from https://www.nvhealthforce.org/wp-content/uploads/2024/03/2024-2025_HCCM_Interactive-Careers-Manual-1.pdf

expanding training and educational opportunities provided to this workforce, the State will be able to ensure older and vulnerable Nevadans have access to the assistance they need for daily tasks.

H. Physician Retention and Wellness

Burnout and fatigue among providers have historically been a challenge when trying to retain a health care workforce. These issues were compounded by the COVID-19 pandemic, leading to what many referred to as "The Great Resignation."[60] High demand and stressful working conditions during the pandemic combined with staffing shortages caused many health care professionals to leave the industry.

1. ***Recommendation: To aid in workforce retention and provider wellness, the state should establish a Physician Wellness Program in Nevada to allow physicians to access a confidential wellness program. This program should:***

- ***Be offered as a grant opportunity by DHHS to an eligible 501 (c)(3) nonprofit that primarily represents physicians to administer the Program statewide; and***
- ***Support physicians through evidence-based wellbeing initiatives with a statewide physician and physician family resource line, online wellness resources and training.***

Nevada ranks well below the national average, at 48th for active physicians per 100,000 population. In addition, Nevada had the fifth highest population increase between 2010 and 2020 according to initial results of the 2020 Census.[61] According to data provided by the Nevada Health Workforce Research Center, 2 million Nevadans, nearly 70% of the state's population, reside in a federally designated primary care health provider shortage area (HPSA). Additionally, 2.8 million Nevadans, nearly 88% of the state's population, reside in a federally designated mental health provider shortage area. Every County in Nevada has a physician shortage of varying degrees, and 11 of 14 rural and frontier areas of Nevada are single-county primary care HPSAs.

With such a severe shortage of physicians in Nevada, the Commission recognizes the importance of retaining the existing physician workforce to ensure access to care, patient safety and quality outcomes. To address these barriers and support the retention of employees, the Commission recommends that the state invest in programs that create a supportive environment for providers including incentives to practice and remain in the state of Nevada. This includes investing in a statewide Physician Wellness Program operated by an independent 501(c)(3) nonprofit and that the legislature provide DHHS with funding for this program that can be provided as a grant funding opportunity.

The Commission also recommends that the organization selected to operate such a program be independent from (without affiliation with) any health system, health facility, or health care regulatory body. The selected organization should also not be mandated by certain state reporting requirements regarding any patient specific data. Otherwise, providers may be hesitant to use available resources due to potential implications to their licensure. Similar health care professional well-being grant programs have been developed through legislation in Arizona and Minnesota.[62, 63]

[60] *The Great Resignation in Healthcare & What To Do About It*. (2022). Retrieved from Mend: https://mend.com/resource/great-resignation-in-healthcare-what-to-do-about-it/#burnout

[61] United States Census Bureau. (2021, April 27). *2020 Census: Percent Change in Resident Population for the 50 States, the District of Columbia, and Puerto Rico: 2010 to 2020*. Retrieved from https://www.census.gov/library/visualizations/2021/dec/2020-percent-change-map.html

[62] Arizona State Legislature. (2022). *HB 2429*. Retrieved from https://www.azleg.gov/legtext/55leg/2r/bills/hb2429s.pdf

[63] Minnesota Legislature. (2023-2024). *SF 3531*. Retrieved from https://www.revisor.mn.gov/bills/text.php?number=SF3531&version=latest&session_year=2024&session_number=0

2. ***Recommendation: State licensure boards, hospitals, health systems and the Nevada Division of Insurance should remove intrusive mental health questions from physician and other health care provider licensure and credentialing applications.***

Currently in Nevada, certain entities, including Division of Insurance, state licensure boards, and health systems, require physicians and other health care practitioners to answer questions about their mental health history and current treatment information when filling out applications for credentialing and/or licensure. Overly invasive questions in licensing and credentialing applications have been found to prevent health workers from seeking support and increasing the risk of suicide.[64] Such questioning tends to be unnecessarily broad or stigmatizing. Examples include asking about past mental health disorders and treatment, neither of which has any bearing on a health worker's ability to provide care and runs afoul of the protections of the Americans with Disabilities Act. For example, one study found that 4 in 10 physicians report not seeking help for burnout or depression because of concern that their employer or state medical board would be notified.[65,]

More than 40 professional medical organizations, including the American Academy of Family Physicians and the American Psychiatric Association, signed a joint statement in 2020 calling for changes in disclosure rules about mental health.[66] California recently passed legislation aimed at prohibiting licensure boards from requiring applicants to disclose specific information that does not impair the applicants ability to provide safe patient care.[67] As of September 2024, 34 licensure boards and 375 hospitals have verified their licensing or credentialing applications are free of intrusive mental health questions.[68]

Destigmatizing mental health care for physicians and other providers can create an environment that encourages voluntary self-disclosure and help-seeking behavior. Rather than requiring a provider to disclose past mental health challenges or current mental health conditions, providers could be asked to simply disclose any health condition that would affect the provider's ability to practice medicine in a competent, safe and ethical manner. Therefore, the Commission recommends Nevada join other states in recognizing the importance of removing intrusive mental questions from licensure and credentialing applications, to remove any barriers that prevent health care providers from seeking care when necessary.

I. Occupational Licensure

In response to the COVID-19 pandemic, the State of Nevada temporarily waived certain licensure requirements to bolster the health care workforce and combat the public health emergency. Emergency Directive 011 allowed health care

[64] Dr. Lorna Breen Heroes' Foundation. (n.d.). *Remove Barriers to Mental Health Care for Health Workers*. Retrieved from https://drlornabreen.org/removebarriers/

[65] Leslie Kane, M. (2023). *US Physician Burnout and Depression Report*. Retrieved from https://www.medscape.com/slideshow/2023-lifestyle-burnout-6016058?reg=1; Jerry L Halverson, M. (2024, May 21). *Depression*. Retrieved from https://emedicine.medscape.com/article/286759-overview?form=fpf

[66] Joint Commission. (n.d.). *Joint Statement Supporting Clinician Health in the Post-COVID Pandemic Era*. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/covid19/joint-statement-supporting-clinician-health.pdf

[67] Digital Democracy. (2023-2024). *AB 2164: Physicians and surgeons: licensure requirements: disclosure*. Retrieved from https://digitaldemocracy.calmatters.org/bills/ca_202320240ab2164

[68] Dr. Lorna Breen Heroes' Foundation. (2024, September 1). *Record Number of Licensure Boards and Hospitals Take Action to Prevent Suicide for the Healthcare Workforce*. Retrieved from https://drlornabreen.org/record-number-of-licensure-boards-and-hospitals-take-action-to-prevent-suicide-for-the-healthcare-workforce/

professionals who held a valid license in good standing in another state to practice in Nevada during the declared emergency.[69] The waivers and exemptions did not apply to providers with licenses that had been revoked or surrendered as a result of disciplinary proceedings. At a national level, the Centers for Medicare and Medicaid Services (CMS) temporarily waived these requirements that out-of-state Medicare practitioners be licensed in the state where they are providing services.[70] CMS also released guidance stating that state Medicaid agencies could use Section 1135 waiver authority to permit providers located out of state to provide care to another state's Medicaid enrollee impacted by the COVID-19 emergency. These changes were particularly helpful in enabling providers to meet increasing demand for services throughout the pandemic.

While the public health emergency has officially ended, the need for Nevada to reduce barriers and increase flexibility to maintain the capacity of providers has not. In order to tackle the ongoing challenges with building an adequate health care workforce to care for residents, Nevada must remove any unnecessary barriers for recruiting and retaining health care providers. In addition to enacting interstate licensure compacts, the Commission discussed several recommendations for Nevada to expedite and streamline the occupational licensure process for providers of health care.

1. ***Recommendation: Each health care occupational licensing board should offer temporary or provisional licenses for providers already licensed in another state during the time they are fulfilling the requirements needed to qualify for endorsement in this state, or while awaiting verification of documentation supporting such an endorsement, including obtaining background checks.***

This recommendation seeks to establish administrative uniformity among all state health care occupational licensing boards and expedite the licensure process for health care professionals. In Nevada, the duration of time varies from the time of application submission to when a license is issued. Much of this variation depends on the Board's internal processes and whether they issue a provisional or temporary license while background checks or other verifications are pending. For example, the Nevada State Board of Nursing issues a temporary license to all applicants who meet certain criteria while background checks and other documentation are being processed. This process ensures that nurses applying for a Nevada license can begin practicing in the state within a few days, instead of a few weeks or even months.

Other occupational licensing boards who do not currently offer a temporary or provisional license delay issuance of licenses until a background check or other application review has been completed. In Nevada, all occupational licensing boards rely on the Nevada Department of Public Safety to conduct applicant background checks – a process that can often take several weeks or several months depending on various circumstances.

The Commission recommends each occupational licensing board issue temporary or provisional licenses based on an affidavit from the applicant that the information provided on the application is true and that the verifying documentation has been requested.

2. ***Recommendation: Each health care occupational licensing board, including the Board of Medical Examiners and Board of Osteopathic Medicine, should provide licensure reciprocity for out-of-state licensed health care providers seeking the same licensure in this state.***

[69] Nevada Governor Joe Lombardo. (2020, March 12). *Declaration of Emergency Directive 011*. Retrieved from https://gov.nv.gov/layouts/full_page.aspx?id=302852

[70] CMS. (2022, October 13). *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*. Retrieved from https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

Licensure reciprocity enables a health professional with a license or certification from another state to become licensed or certified in a new state without going through the initial license application process. Endorsement is essentially a "stamp of approval" that validates the process of initial licensure that was completed by an external state's licensing authority, but still requires the individual to become licensed within the state in order to practice within the state. Without active endorsement policies, health care professionals licensed in an external state have to undergo the process of initial licensure, which generally includes submitting transcripts, validating completion of all training requirements (including educational programs, examinations, and experience if applicable). Typically, certain activities such as background checks and finger printing are still required.

In 2012, Nevada Governor Brian Sandoval issued Executive Order 2012-11 providing licensure reciprocity for military spouses seeking licensure in this state.[71] The Executive Order requested each occupational licensing board facilitate endorsement of a current license from another state as long as the requirements for licensure were equivalent to the Nevada requirements; and required each board to issue a provisional or temporary license to expedite application procedures for a military spouse. In 2015, the Nevada Legislature passed AB 89, which authorized certain providers of health care and professionals to obtain an expedited license by endorsement to practice their respective professions in this State if the provider: (1) holds a valid and unrestricted license to practice in the District of Columbia or another state or territory of the United States; (2) is an active member or veteran of, the spouse of an active member or veteran of, or the surviving spouse of a veteran of, the Armed Forces of the United States; and (3) meets certain other requirements.[72]

The Commission recommends Nevada consider expanding the current licensure reciprocity laws and expedited application processes currently offered to active military, veterans and military spouses to all health care providers applying for Nevada licensure. This process could be expanded more broadly to streamline the licensure process and avoid unnecessary delays that prevent or delay health care professionals from practicing in Nevada.

3. ***Recommendation: The state should establish a single state authority over all health care occupational licensing boards to ensure uniform standards to reduce the unnecessary duplication in requirements that lead to unintended administrative barriers and delays to entering the workforce.***

Nevada's occupational licensing boards operate independently from the legislative and executive branch of state government. As a result, each individual board has established their own methods of operating, which in turn leads to variation and inconsistencies among the various occupational licensing boards. In 2023, the Nevada Legislature adopted SB 481, now codified as NRS 232.8415, which establishes the Nevada Office of Boards and Commissions and Councils Standards within the Department of Business and Industry. The new office has purview over 37 professional and occupational licensing boards and is required to establish centralized administration, uniform standards, uphold transparency and consumer protection, and ensure efficacy and efficiency. It is currently unclear how the office intends to hold licensing boards accountable to certain metrics or establish uniform standards.

At the direction of the Governor, the Department of Business and Industry has undertaken a process to develop a framework for reform and modernization of Nevada's boards and commissions.[73] The Commission recommends the office

[71] State of Nevada Executive Department. (2012, May). *Executive Order 2012-11*. Retrieved from https://medboard.nv.gov/uploadedFiles/medboardnvgov/content/Forms/EO_2012-11.pdf

[72] Nevada State Legislature. (2015). *AB89*. Retrieved from https://www.leg.state.nv.us/Session/78th2015/Bills/AB/AB89_EN.pdf

[73] Boards and Commissions. (n.d.). *Reforming Nevada's Boards and Commissions*. Retrieved from https://business.nv.gov/Boards_and_Commissions/Boards_and_Commissions/

use their authority to ensure all health care occupational licensing boards operate uniformly and be held accountable for certain metrics. An example of how the State could create uniformity among the various licensing boards would be to establish a universal application for all health care professionals to submit their applications through a single online portal. This would streamline the licensure process for healthcare professionals and create a "one-stop shop" for licensure application submission.

In addition to establishing a uniform application process, the Commission recommends each occupation licensing board be held accountable for certain metrics, such as regularly reporting the length of time from application to licensure. By increasing transparency of licensure issuance delays, the State can direct necessary resources to resolve any barriers that may prevent or delay the issuance of licenses to health care professionals.

4. ***Recommendation: The state should align occupational licensure training requirements and facility training requirements to remove duplication or unnecessary requirements.***

This recommendation seeks to remove any redundant requirements from the provider onboarding process and align facility training and licensure or CME requirements. The Commission received information through a public solicitation stating that facilities may have training requirements that are duplicative of occupational licensing training requirements. By recognizing similar training courses and aligning facility and licensing board training requirements, the health care provider onboarding process will be streamlined, and providers can spend less time taking unnecessary training and have more time for patient care.

J. Increase Health Workforce Diversity

Recommendation: Identify ways to recruit and retain a more diverse health care workforce.

Diversity in the health care workforce is critical as it improves communication, decision-making, and adherence to care plans among patients when there is commonality between patients and their providers.[74] The Fitzhugh Mullan Institute for Health Workforce Equity maintains a Health Workforce Diversity Tracker that displays a labor force Diversity Index that can be used to evaluate diversity for the selected state, profession, and race.[75] A Diversity Index less than 1 indicates underrepresentation for the selected race in that profession.

As shown in the table below, in Nevada, among physicians, Hispanics have the lowest index at 0.2620 while all other races have a Diversity Index greater than 1. Similarly, among physician assistants and registered nurses, Black and Hispanic Nevadans have indices lower than 1 whereas Asian and White Nevadans have indices greater than 1. On the other hand, Hispanics have an index greater than 1 among medical assistants and all other races have indices less than 1.

[74] Rosenkranz, K., Arora, T., Termuhlen, P., Stain, S., Misra, S., Dent, D., & Nfonsam, V. (2021, July). *Diversity, Equity and Inclusion in Medicine: Why It Matters and How do We Achieve It?* . Retrieved from Journal of Surgical Education: https://gme.dartmouth-hitchcock.org/sites/default/files/2021-10/diversity-equity-inclusion-in-medicine.pdf#:~:text=Commonality%20between%20patients%20and%20their%20providers%20results%20in,all%20benefit%20from%20diversity%20in%20the%20healthcare%20workplace

[75] Fitzhugh Mullan Institute for Health Workforce Equity. (2023). Health Workforce Diversity Tracker. Retrieved from https://www.gwhwi.org/diversitytracker.html

Race	Physician	Physician Assistant	Registered Nurse	Medical Assistant
Asian	2.905	1.840	3.553	0.682
Black	1.188	0.078	0.681	0.832
Hispanic	0.262	0.551	0.310	1.785
White	1.166	1.388	1.093	0.706

The PPC discussed how lack of diversity in the Nevada's existing health care workforce and in Nevada's medical schools may deter prospective medical graduates from completing their graduate medical education (GME) in Nevada. Results from a recent JAMA study suggest that additional efforts are needed to increase the representation of Black, Hispanic, and Native American people in the health care profession and measuring and reporting on representation of these groups in the health care workforce and educational pipeline may encourage these efforts.[76]

Several states including Indiana, Minnesota and Virginia have created interactive dashboards to monitor trends in diversity of the health care workforce.[77]These states collect demographic information from health care professionals during their licensure renewal process. In 2021, Nevada passed similar legislation that is now codified in NRS 439A.116, which requires the Nevada Department of Health and Human Services (DHHS) to establish a database that collects information such as the race and ethnicity of the applicant, the primary language spoken, the geographic location and setting where the provider practices.[78]

As of writing this report, DHHS is still in the process of establishing the database and is working with the Health Care Workforce Working Group to establish a process of collecting the provider information from each health care occupational licensing board. Once the database is operational, the Health Care Workforce Working Group established by NRS 439A.121 will be able to analyze information and provide recommendations on how to attract more persons and increase diversity among various types of providers. According to a publication from the American Public Health Association, numerous studies have demonstrated that the quality of health care in the United States varies according to patients' race and ethnicity.[79] By diversifying the health care workforce, the patient-physician relationship will have less racial differences and in turn can reduce racial disparities in the patient care provided to Nevadans.

Commission Collaboration

NRS 439.918.1, paragraphs (a) and (b) requires the Commission to attempt to identify and facilitate collaboration between existing state governmental entities that study or address issues related to the quality, accessibility, and affordability of health care in this State. The Commission is willing to collaborate with any public, private or state governmental entity that studies or addresses issues related to the quality, accessibility, and affordability of health care in this State; and looks

[76] Edward Salsberg, M., Chelsea Richwine, P., Sara Westergaard, M. M., & al, e. (2021, March 31). *Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce*. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777977?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=033121#google_vignette

[77] Bowen Portal. (n.d.). *Indiana Physician Workforce Dashboards*. Retrieved from https://bowenportal.org/indiana-physician-workforce/;
Minnesota Department of Health. (2024). *Minnesota's Licensed Health Care Workforce Data*. Retrieved from https://www.health.state.mn.us/data/workforce/hcwdash/index.html?url_var=sexraceethnicity#NaN;
Virginia Department of Health Professionals. (n.d.). *Virginia Healthcare Workforce: Gender and Racial/Ethnic Diversity*. Retrieved From https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/Dashboards/GenderandRacialEthnicDiversity/

[78] Nevada State Legislature. (n.d.). *NRS 439A.116*. Retrieved from https://www.leg.state.nv.us/nrs/nrs-439a.html#NRS439ASec116

[79] Somnath Saha, M. M., Jose J. Arbelaez, M. M., & Lisa A. Cooper MD, M. (2003, May). *Patient-Physician Relationships and Racial Disparities in the Quality of Healthcare*. Retrieved from https://ajph.aphapublications.org/doi/full/10.2105/AJPH.93.10.1713

forward to continuing this practice through open communication with the Commission and offering direct collaboration from the Executive Director. During the reporting period, the Executive Director met with various health care and workforce development stakeholders, governmental entities and institutions of higher education to build relationships and collaborate on statewide efforts related to the scope of the Commission. Additionally, the Executive Director was appointed to serve on various committees which relate to the scope of the Commission:

Nevada Division of Insurance Commissioner's Life & Health Advisory Subcommittee
Per NRS 629.095, the Commissioner of Insurance is required to develop a standardized form for use by insurers and other entities to obtain information related to the credentials of certain providers of health care. The Subcommittee discussed the need to revise the current NDOI-901 Universal Credentialing Form, which had not been updated since 2016. The Subcommittee discussed the need to remove intrusive and stigmatizing mental health questions, identify opportunities to shorten the form and develop a shorter form for provider re-credentialing. Following feedback from the Subcommittee, the Division is currently revising the form and implemented an addendum form to allow providers to re-certify by simply attesting there had been no changes since the last credentialing form submission. The Executive Director is grateful for the opportunity to collaborate with the Division of Insurance and the Subcommittee to reduce the administrative burden for insurers and health care providers by streamlining the universal credentialing form and re-credentialing process.

Health Care Workforce Working Group
The Health Care Workforce Working Group (HCWWG) was established by SB379 (2021) and is codified in NRS 439A.111-122. The HCWWG is responsible for making recommendations to the Director of the Department of Health and Human Services (DHHS) concerning the information collected from applicants for the renewal of a license, certificate, or registration as a provider of health care. The PPC Executive Director was appointed to the board by the DHHS Director in July 2024 and will serve a two-year term. The HCWWG held its first meeting on October 17th and is discussing how to establish a health care provider database as required per NRS 439A.116.

Reduce Duplication of Efforts

The Commission is committed to coordinating with any state governmental entity to reduce any duplication of efforts among and between those entities and the Commission. Commission staff monitor public meeting notices and attend meetings that relate to health care access, quality and affordability. Additionally, Commission staff monitor available data, reports and other publications relating to the scope of the Commission. The Executive Director will continue to identify opportunities for the Commission to reduce duplication and coordinate with partners statewide.

Next Steps

The Commission is scheduled to meet on January 17, 2025, and is expected to receive information from the Nevada Division of Insurance related to the Health Insurance Market in Nevada. In addition to reviewing information related to health care access, quality and affordability, the Commission will continue reviewing available data and national best practices related to addressing the health care workforce shortage in the State. The Executive Director will be supporting the Commission during the upcoming 83rd Legislative Session. In addition to monitoring their own bills, the Commission will be monitoring legislation introduced that pertains to the scope of the Commission.

Enclosures:

1. PPC Meeting Minutes (June – December 2024)
2. Solicitation of Health Care Workforce Recommendations (June 2024)
3. Solicitation of Health Care Provider Recommendations Relating to Nevada Medicaid (June 2024)