EXECUTIVE SUMMARY

A. Project Background

The Nevada Legislature passed Assembly Bill (AB) 513 during its 2001 session to appropriate $800,000 to the Department of Human Resources (DHR or the Department). This report presents one of four strategic plans mandated by the legislation. It was requested to develop initiatives that would ensure the availability and accessibility of health care services in rural Nevada. In September 2001, the Department convened the Rural Health Care Task Force (Task Force) to oversee the development of a rural health care strategic plan. As one of its first tasks, the Task Force engaged LECG, LLC (LECG) to assist in the development of the plan. With offices in 10 U.S. cities and six other countries, LECG has expertise in health system planning, finance, and delivery. It subcontracted with Mercer Government Human Services Consulting and McDonell Consulting to complete this initiative.

At least 20 years ago, the rural health care system in the United States was generally competitive. The capital infrastructure, including more than 1,000 hospitals built with Hill-Burton funds, was well regarded. Financing and policy schemes did not (either directly or indirectly) discriminate against the small rural provider. Primary care, embodied by the general practitioner, was the centerpiece of an individual's relationship with the health care system.

Contrast this position with the developments that have driven the health care industry's evolution over the last twenty years. Today's health care environment has many features that place the rural health care system at a distinct disadvantage. Some of the important features driving this divergence include:

- Technological advances
- Modality and acuity shifts

EXHIBIT C Legislative Committee on Health Care Document consists of 22 pages.

☒ Entire document provided.

☐ Due to size limitations, pages _____ provided.
A copy of the complete document is available through the Research Library (775/684-6827 or e-mail library@lcb.state.nv.us).

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- Information transparency
- Rural health care revenue
- Consumer expectations

Within Nevada, residents of rural communities are frequently required to travel significant distances to obtain needed physical health, behavioral health, substance abuse, and dental services. As of January 2002, all of Nevada's 15 rural counties (either wholly or in part) were federally designated as primary health care professional shortage areas. For behavioral health care, the professional shortage area designation was given to 14 counties. For dental services, 10 entire and two partial counties were designated as professional shortage areas.

This report contains the following:

- A fact-finding section that includes results of the public input process, an analysis of insurance and other patient based payments that finance the majority of rural health care in Nevada, and a related analysis of financial flows in rural Nevada.
- A review of other States' initiatives that addresses the issues Nevada is facing, including manpower development, finance, and delivery issues.
- An analysis of health care resources and needs in rural Nevada today and over the next decade.
- Both statewide and county specific recommendations based on the policy statement and principles contained herein.

B. Policy Statement

Members of the Task Force and the consulting team thought it was vitally important to convey to the readers of this report how strongly we think about the need to provide quality health care services to rural Nevadans. After much discussion, we agreed that the following policy statement conveys the needed commitment to rural health care that we urge the Governor, Legislature, and State health policy makers to adopt:

Rural residents, like their urban counterparts, have a fundamental right to high quality and affordable health care. Access to health care services should be reasonably available to the great majority of rural residents. The vast geographic distances and low population density that characterize rural Nevada make sustaining an economically viable health care delivery system impossible without the commitment of public resources at local and State levels. Poor health in rural areas is costly, in both human and financial terms. That cost is borne by all Nevadans, just as investment in improving rural health care ultimately benefits all Nevadans. These factors, combined with an understanding of the unique importance of health care to the rural community, support the need for funding/payment structures and public policy decisions that consistently support the delivery of rural health care services.

C. Project Summary

1. Fact Finding

Fact finding on rural health care issues in Nevada was accomplished in numerous ways. It began with the public input process. Public input was solicited through individual or group stakeholder interviews (including Task Force members), rural community stakeholder meetings, public forums, and distribution of a consumer survey. Secondly, an inventory of current health care resources in rural Nevada was conducted. Finally, a study of insurance and cash payer financing was completed to understand who pays for what kind of health care services in rural Nevada today.

a. Public Input

From December 19, 2001 through July 24, 2002, we interviewed a total of 32 health care stakeholders regarding the current state of rural health care in Nevada, and their thoughts on how the system might be improved. We also felt that input by Nevada rural health care professionals and residents were of vital importance to the success of

this initiative. For that reason, stakeholder meetings and public forums were conducted in Battle Mountain, Caliente, Carson City, Elko, Ely, Eureka, Fallon, Hawthorne, Lovelock, Minden, Pahrump, Tonopah, Virginia City, Winnemucca, and Yerington. To obtain the input of Native American health care professionals, we met with tribal representatives at the Reno/Sparks Indian Colony. We also attended a meeting of the Committee on Emergency Medical Services to solicit the opinions of the Committee members on rural health care issues.

The consulting team also developed a survey for distribution to interested consumers. The survey was not intended to be statistically valid. Its purpose was to solicit the opinions of individuals who attended the public forums or could not be interviewed regarding health care issues. Through July 2002, 253 surveys have been returned and analyzed.

b. Health Care Financing and Insurance Coverage in Nevada – The Base Case

The base case economic model describes the dynamics of health insurance coverage, health expenditures and revenues, and employment factors in rural/frontier Nevada. Creating a model to describe current access to health care coverage establishes the benchmark for people covered, the source of their coverage, and the costs of their care.

c. Health Services Inventory

The consultants and Task Force compiled an inventory of health care facilities, their service offerings, and the number of health care professionals that are currently available in each rural/frontier county of Nevada. We then analyzed access to these facilities and personnel in relationship to Nevada's population. Finally, we used this information to develop the gap analysis and strategic plan.

Throughout this project, the Task Force and consulting team had difficulty obtaining reliable health care data. As a result, a recommendation has been added to the strategic plan to develop an integrated data collection and outcome measurement system.

2. Other States' Initiatives

The Task Force looked to other states' experiences for ways to address common rural health care problems: health professional shortages, infrastructure development, and financing issues. It should be noted that Nevada has already implemented a number of the more innovative programs and initiatives described in Chapter III.

3. Analysis

a. Gap Analysis

The gap analysis identified projected gaps in availability and accessibility of appropriate health care services in rural/frontier Nevada. LECG analyzed gaps along three parameters: primary care workforce, health services and economic sustainability, and coverage. For each parameter, we compared the current status to the proposed standard; this allowed us to identify gaps in the rural health care system.

b. Financial Analysis

In rural/frontier Nevada, the estimated returns of increased health care expenditures are high because of the skilled nature of health related jobs that would be created. The overall economic impact of the health care sector on employment and income in rural Nevada (excluding Carson City) is 4,673 jobs and more than $145 million annually.

4. Developing the Strategic Plan

In addition to the fact finding process described previously, the Task Force heard presentations from a number of State agencies and health care organizations, including the Office of Rural Health, the Nevada Indian Commission, the Department's Division of Mental Health and Developmental Services and Bureau of Alcohol and Drug Abuse, and the Carson City Mental Health Coalition. The Task Force spent several working sessions developing the policy statement and principles included in this report. They focused Task Force discussions and development of the strategic plan.

D. The Rural Health Care Environment in Nevada

Geography and population density are probably the two most important characteristics of rural Nevada that must be considered to understand the difficulties inherent in providing health care services. The geography of rural Nevada is a significant barrier to efficient provision of care. Stakeholders and community members reported traveling hundreds of miles to receive care. Air and ambulance transport can provide life saving access for emergency services; however, both are subject to weather and other delays, including equipment availability, on a regular basis.

The population density of rural Nevada averages 2.96 people per square mile. To understand this level of population density, Carson City had a population density of 366.8 persons per square mile in 2000. [1]

The access standard for primary care services set by the Task Force was one hour travel time for 90 percent of the rural/frontier population. LECG reviewed how the current primary care facility locations satisfied this standard. Results of the analysis show that a one hour drive time covers 78 percent of the rural/frontier population, 12

[1] The rural/frontier population density, excluding Carson City County, is 2.4 persons per square mile.

percent less than the Task Force's standard. If tribal health clinics were to provide access to all rural residents, coverage would increase to 89 percent of the population. There are several communities that are completely unserved, including Warm Springs, North Fork, and Round Mountain.

The behavioral health care analysis indicates that a one hour drive time covers 81 percent of the rural/frontier population, nine percent less than the standard set by the Task Force. However, because of critical staffing shortfalls, the existence of clinics does not ensure that services can be provided on a regular basis.

To access secondary services, LECG looked at the standard set by the Task Force; this standard is 45 minutes driving time for 90 percent of the rural/frontier population. Since ambulances can provide some secondary care services (at least on an intermediate basis while transporting a patient to a facility), we added locations in which ambulance services are available 24 hours a day. Results of our analysis show that from existing hospitals, a 45 minute drive time covers 61 percent of the rural/frontier population, 29 percent shy of the Task Force's standard.

The analysis shows that two-thirds of the rural/frontier population has access to a tertiary center within three hours driving time, while only one-third of the rural/frontier population has access to a tertiary center within one hour driving time. That is 24 and 57 percent less than the Task Force's acceptable standards for a planned event and an emergency, respectively. However, these figures increased to 100 and 83 percent, if one assumes air transport is available.

From 1990 to 1999, Nevada's population grew by 50.6 percent. This represents the fastest rate of growth of any state during the same time period and five times the population growth rate for the entire nation. Population growth has not been limited to the State's urban counties. Indeed, 11 of the State's 15 rural and frontier counties

posted double digit percentage increases in population during the past decade; these counties are projected to grow at a faster rate (28.6 percent) than urban Nevada.

In addition to rapid population growth, population aging is a significant demographic influence on health and health care services. The State Demographer projects that the number of Nevadans age 65 years and older will increase by approximately 78 percent over the next 10 years.

The proportion of children is expected to decrease from 26 percent of total population in 2000 to 21 percent in 2015. Adults age 65 years and older are expected to increase from 11 percent in 2000 to 16 percent in 2015 without factoring in the rate of senior citizen migration.

LECG estimates that the proportion of persons insured through government and private-sector employer-based insurance in rural/frontier Nevada will decrease from 54 percent of total rural/frontier population in 2000 to 51 percent in 2015. Nearly 26 percent of children and 23 percent of adults under 65 years of age in rural Nevada were uninsured in 2000. The percentage of uninsured in rural Nevada was estimated at 21.4 percent in 2000. Total uninsured is forecast to increase in absolute terms but remain constant between 20 and 21 percent of the total rural/frontier population from 2000 to 2015.

The following data provides a description of the insurance and payment situation in rural/frontier Nevada in 2000. See Appendix H, Table 2 and Figure 3.

- 22 percent of rural/frontier Nevadans receive health insurance from government-sponsored insurance (i.e., Medicaid, Medicare, and Military/Veteran); 36 percent of insurance-based health care expenditures can be attributed to the same group of Nevadans.
- 54 percent of rural/frontier Nevadans receive health insurance from employer-based insurance (including government employees); 51 percent of insurance-based health care expenditures can be attributed to this group.

- Eight percent of rural/frontier Nevadans receive health insurance from other private insurance; six percent of insurance-based health care expenditures can be attributed to the same group.
- 21 percent of rural/frontier Nevadans have no health insurance, and represent seven percent of the documented health care expenditures.

In most rural communities, to talk about health care delivery, one must talk about hospitals. Hospitals are the cornerstone of health care delivery in rural Nevada. There are 14 hospitals in rural Nevada. All but two are non-profit. In rural locales, there are approximately 258 acute care beds and approximately the same number of long term care beds. Seven rural hospitals provide long term care services to address community needs. These facilities' financial viability rests heavily on their LTC components.

Where hospitals are not available, rural health clinics provide access to primary care services. There is a network of clinic providers across the state. However, there are glaring exceptions to clinic coverage. Some communities have no primary care provider, or limit the individuals (such as Medicaid recipients) that they will treat.

EMS are inadequate in most rural communities. Although capital equipment is generally available, it is old and unreliable. Neighboring counties often do not have the same telecommunications systems and have difficulty communicating with each other. Even within a community, the hospital, providers, and EMS personnel are often unable to communicate among themselves because of county topography or aging radio and telephone equipment.

Access to specialty services is marginal for rural Nevadans. This is particularly true for obstetric and pediatric services. Although the recent malpractice insurance crisis may have exacerbated these issues, it is clear that workforce development is probably the single most pressing long-term need for rural health care delivery in Nevada. In addition to the specialist types listed above, behavioral health, substance abuse, and dental providers should be added to the list of critically needed practitioners in rural communities.

Availability of health care professionals does not equate to people actually receiving services. Anecdotal evidence suggests that although facilities and personnel are available in some communities, rural/frontier residents are not always able to access these providers. The most glaring example of this is the lack of acceptance of Medicaid patients by dental providers.

To the extent that resources are available, American Indians and Alaska Natives served by IHS receive preventive, primary medical care (hospital and ambulatory), community health, substance abuse, and rehabilitation services. However, in Nevada there has consistently been inadequate resources and funding for tribal facilities. The Nevada facilities must compete with Arizona and Utah for limited federal funding. Currently, about $500 in IHS funding is allocated annually for each Native American in Nevada. Other than individuals who qualify for Medicaid, no State funds provide health care services for Native Americans in Nevada. All funding comes from the federal government and the tribes.

All of the issues (e.g., manpower shortages, poor transportation, limited technology, and little preventive care) described in this report also affect Native Americans in Nevada. The health status of Native Americans in Nevada is worse than the average Nevadan. Problems that have been identified include:

- Poor nutrition, coupled with unsafe water supplies and inadequate waste disposal facilities, have resulted in a greater incidence of illness among Native Americans.
- Other major health concerns include maternal and child health needs, otitis media, and problems associated with aging. Heart disease, alcoholism, mental illness, diabetes, and accidents are also serious problems for Native Americans.
- Many reservations and Indian communities are located in isolated areas where impassable roads and populations spread out over miles create challenges to providing quality health care.

E. Rural Health Care Issues in Nevada

During its deliberations, the Task Force identified many critical issues. The following summarizes the most urgent.

1. Access to Care

The number one issue in rural health care in Nevada is lack of access to needed medical care. This issue was confirmed by the stakeholders, community residents, the inventory of services, the base case findings, the gap and financial analyses, and survey results. The issue has many aspects, including workforce, transportation, finance, demographics, and geography.

Access problems affect the under and uninsured, individuals on Medicaid, women (including pregnant women), adolescents, Veterans, and adults not yet eligible for Medicare. Individuals with limited income are often not able to purchase health insurance. If Nevada residents are employed, coverage for their dependents is frequently unaffordable.

As one might expect, the issues and recommendations concerning access varied from community to community (see the Community Profiles for county-specific suggestions). However, there were common suggestions across communities:

- To attract health care professionals to rural communities, housing, malpractice insurance, and other benefits should be provided.
- Mobile vans are needed in areas that do not have health care providers.
- Hospitals need modern equipment to provide basic diagnostic care (x-rays, CT scans, ultrasounds, blood work, etc.).
- All Nevada residents should be able to access care at any Nevada facility (including Native Americans, Medicaid and Medicare recipients, and Veterans).
- Nevada needs additional J1 Visa physician slots; the application process needs to be streamlined.

- There should be a one-stop gateway to care; primary care and behavioral health care must be integrated, and case coordinators must be available to help patients navigate the system.
- State agency administration in rural communities should be consolidated into a single location to allow the sharing of administrative resources.

2. Insurance and Other Coverage Issues

The uninsured rates in Nevada and rural Nevada are among the highest in the nation. Currently, when one excludes senior citizens, nearly one in four rural Nevadans is without health insurance.

While premiums have been rising across the State and nation this past year, reported premium increases in rural Nevada are at crisis levels. Stakeholders, community residents, and local government leaders reported health insurance premiums ranging from $400 to over $900 per month; increases up to 40 percent were noted. In several counties, the number of county employees who elect to purchase family coverage has fallen to less than 5 percent of the workforce. One county reported that only 2 percent of its workforce has elected family coverage.

Insuring more individuals in rural/frontier Nevada will lead to, among other things:

- Greater economic activity in the health sector (which will in turn affect the entire economy)
- Increased money in the economy, particularly if both private and public sector programs are used to maximize Federal funding
- Greater worker retention for employers, which may enable them to reap the benefits of investments in human capital for longer periods of time
- Lower health care premium costs across the population
- Overall improvement in average health status of workers and greater worker productivity

3. Hospitals

Hospitals are the core health care facility in most rural communities. Each of the facilities is needed to reach 61 percent of rural residents within the Task Force's access standard of 45 minutes driving time. With the addition of proposed hospitals in Gardnerville, Pahrump, Overton, Mesquite, and Wendover, this percentage is increased to 65 percent. Including ambulance services raises coverage to 80 percent.

The financial condition of most of Nevada's rural hospitals is often tenuous. One event can, and often does, make the difference between positive and negative financial outcomes. Examples include the loss of one physician, the departure of one major employer from the community, or a State budget shortfall that unexpectedly reduces payment sources.

4. Long Term Care

The supply of nursing home beds in non-metropolitan areas is nearly 43 percent higher than in metropolitan areas. Rates of institutionalization are higher among rural seniors compared with their urban counterparts. Whether due to the lack of alternatives, such as home based care, or the availability of beds driving greater institutionalization, nursing facility payments are the largest part of most states' (including Nevada's) Medicaid budgets and growing rapidly.

With a large and growing proportion of the elderly in rural communities, stakeholders expressed concern about the capacity and financing of inpatient long-term care and its facilities. Rural communities will not likely be able to obtain the resources required to support both inpatient needs and programs that foster independent living. Staffing inadequacies also affect the availability of home and community based services.

5. EMS

In rural settings, EMS rely heavily on volunteers. Simply recruiting and maintaining sufficient numbers of trained people challenges communities. In addition, funding communication, transportation, and clinical equipment burdens local budgets, especially in times of economic downturn. One result is a patchwork of radio and telephone equipment, which at best limits communication between emergency medical systems across jurisdictional lines and, at worst, fails altogether. While far from optimal under any circumstances, the inadequacy of the rural emergency provider network (EMS, law enforcement, and hospitals) to communicate is of special concern in the face of biohazards or terrorism.

There are many key issues that must be addressed to develop EMS effectiveness. Below are the most pressing needs for improving the effectiveness of Nevada's EMS system:

- **Recruitment and retention –** The Nevada EMS and the local communities report major problems in trying to attract people to serve in a (largely) volunteer service. Indeed, some communities have transport equipment that goes unused because the workforce is not available.
- **Clinical quality –** The pace of clinical advancement seems to accelerate every year and physicians routinely report their inability to keep current with the latest treatments and protocols. However, the flip side of this "knowledge gap" is that esoteric treatments, once appropriate only for the academic medical center environment, continually filter down as this knowledge becomes more widely disseminated and accepted. Rural communities and their EMS personnel are often overlooked in their potential ability to treat complex clinical conditions.
- **EMS communication system integration –** Significant problems were reported in the currently disparate communications systems being used by ground and air EMS systems and their supporting hospitals.
- **Regulatory relief –** EMS is subject to significant federal, State, and (sometimes) local regulations. Often times these regulations no longer reflect the true clinical realities, particularly within the limits of the rural communities.

6. Behavioral Health

Behavioral health manpower is also addressed in the workforce section, below. Publicly available data is misleading with respect to behavioral health practitioners in rural Nevada. Every community reported a shortage of staff. Licensure data indicates otherwise, but does not account for non-practicing professionals, or those who are licensed in one locale but practice in another.

The Division of Mental Health and Developmental Services has serious staffing shortages in rural communities. At any one time, the Division has 10 – 15 vacancies. Over the last two years, DMHDS managers have interviewed well over 100 people for positions within the Division.

Not only is local access limited, but transportation to urban services for those in acute need is problematic for hospitals, local law enforcement, and EMS. Financing of behavioral health and substance abuse services was also listed as a significant difficulty.

7. Workforce

As stated previously, the most significant health care issue that was identified by the stakeholder interviewees was poor health care access because of insufficient numbers of health care professionals. This included physicians (primary and specialty care), nurses, dentists, psychiatrists, behavioral health and substance abuse professionals, pharmacists, certified nurse's aides, laboratory and radiology technicians, and medical coders and billers. Suggestions to address this issue included:

- Develop incentives to practice in rural areas
- Award Millennium Scholarship funds to individuals pursuing health care professions
- Implement licensing requirements that support providers' placement in rural communities

- Support the rural practice environment (on-call arrangements, on-going training, telemedicine, loan forgiveness, scope of practice expansions, etc.)
- Ensure realistic rural reimbursement for public programs, such as Medicaid, Nevada Check-Up, and disproportionate share
- Develop mobile dental and medical capabilities

Information provided by the Office of Rural Health shows that there are currently 193 residents training in Nevada; 130 are in Las Vegas and 63 are in Reno. It is estimated that 50 percent will remain in the State to practice after their training is completed, although most will likely work in Clark or Washoe Counties.

According to the federal Health Resources and Services Administration, there are 786 nurses for every 100,000 citizens in the United States. In Nevada, there are 520. This ranking is the lowest in the nation. The average nurse vacancy rate in Nevada hospitals is 14 percent, although some hospitals have a vacancy rate as high as 30 percent. A crisis is considered to be 9 percent. Nevada also has the lowest proportion of pharmacists to citizens in the nation.

Several of the interviewees were critical of the Nevada state boards that license physicians, dentists, and nurses. Licensing requirements are too stringent and a lack of reciprocity with other states hinders the State's ability to attract physicians to Nevada.

The gap analysis for physical health physicians, dentists, and behavioral health practitioners shows severe shortages today and into the future. This result is at odds with the State's licensure data. However, when the State licensure data is reconciled with surveys conducted by LECG, the Office of Rural Health, and other State agency information, the picture is clear. Anecdotal and stakeholder input was almost always consistent with the survey and State agency data.

8. Public Health

Services provided by the Bureau of Community Health's community health nurses were cited repeatedly as one of the significant successes in rural health care delivery in Nevada. The nurses are respected members of the health care community in rural counties.

Public health services should be strengthened and integrated into the overall health care delivery system. It was suggested that DHR work with interested counties to develop local health departments. Additionally, expansion of the scope of practice of community health nurses should also be considered.

9. Telemedicine

Currently, there are telemedicine projects in various stages of development in at least 40 states (including Nevada). The most prevalent uses have been in health professional education and training, continuing education, and fixed image transmission, such as teleradiology. The technical capacity to apply telemedicine in direct service delivery is evolving, particularly in home health care, behavioral health, and specialty consultation.

A telemedicine network developed by the Northeast Nevada Area Health Education Center, with support from the Nevada Legislature, the University of Nevada School of Medicine, Nevada Rural Hospital Partners, and various federal programs links Nevada rural communities. Utilization is growing but administrative and payment issues are ongoing difficulties. Additional efforts are needed. Reportedly, there are ongoing concerns regarding access to the Internet, as well as training and liability issues surrounding the appropriate use of telemedicine in rural Nevada.

10. Transportation

Transportation for emergency, non-emergent, and chronic care services was raised in every community as a significant barrier to care. This service gap most critically affects Veterans, senior citizens, and the needy.

Behavioral health and substance abuse transports are an ongoing crisis in most rural communities. Statute and regulation require that law enforcement personnel transport individuals in crisis; in some instances, medical personnel are also required. Because admission at State behavioral health and detox facilities is not mandatory in all cases, the transport personnel can be tied up for many hours waiting for the patient to be admitted, or even refused. This is a significant expense for county law enforcement, as well as the behavioral and physical health providers.

11. State Health Care Responsibilities

Interviewees reported that there is little State financial support for health care in rural communities. After funding is distributed to Las Vegas and Reno, only 5 to 10 percent remains for rural counties. Several individuals stated that health care cannot exist on its own in rural areas; federal, State, county, and patient support is vital.

Other interviewees said that the State must determine the extent of its health care responsibilities. The Legislature should guarantee a level of service to its residents, and if they wish, the counties can enhance this level. Areas that the interviewees thought that the State should help fund include:

- EMS infrastructure, equipment, and communication capabilities
- Development/expansion of rural health centers for delivery of physical and behavioral health care services and substance abuse prevention/treatment
- Service coordination infrastructure to ensure comprehensive access to care (no-wrong-door)
- Health care transportation systems

- A regional behavioral health center in Elko
- A low cost loan fund to support capital needs for health care facilities

12. Preventive Health

Another area of importance to the individuals we interviewed was the development of preventive health initiatives. As the statistics included in Appendix G indicate, the health of Nevada's citizens requires significant interventions/improvement. Suggestions included:

- Developing/enhancing programs for smoking cessation, suicide prevention, and preventing school drop-outs, teen pregnancies, and drug/alcohol abuse
- Expanding the community health infrastructure to increase care options for rural residents
- Designing an effective statewide public health campaign to address the need for good nutrition and fitness

13. Data – Availability, Accuracy, and Accessibility

As indicated throughout the report, the availability of and confidence in data is an ongoing concern. There is no agency with a mandate and funding to collect rural health data. The limited data that is available is often misleading, inaccurate, or dated. The Task Force recommends that the Legislature fund the Office of Rural Health and charge it with the responsibility of collecting, consolidating, and coordinating rural health data. This data would be used for planning and funding purposes.

F. Recommended Goals, Strategies, and Action Steps for Nevada Rural Health Care

The Rural Health Care Task Force strategic plan begins with a statement of principles developed by the Task Force to help guide the planning process. The principles include elements of the Task Force's policy statement, social contract considerations, and the rationale for supporting specific recommendations. Statewide

goals, strategies, and action steps are included; county-specific suggestions are also presented at the end of each community profile.

1. Statewide Goals and Strategies

The strategic plan goals are intended to represent statewide issues presented in four general categories: planning and coordination, service delivery, sustainable financing, and infrastructure development.

a. Planning and Coordination Goal

- Create an ongoing mechanism for planning and coordination of rural health care

b. Service Delivery Goals

- Enhance rural physical health primary care model
- Create long term viability in behavioral health, substance abuse, and support services
- Improve service access and response capabilities
- Invest in public and preventive health for long term benefits

c. Sustainable Financing Goals

- Improve insurance coverage for uninsured and underinsured Nevadans
- Develop adequate capital funding
- Develop adequate operational funding

d. Infrastructure Development Goals

- Ensure long term viability of rural health care facilities
- Expand capacity to provide health care services within rural communities
- Support maximum use of technology in rural communities

2. County Specific Issues

Although each of the 15 communities that we visited was very different and had its own health care issues and needs, there were some common issues. These issues are described extensively in the report's last chapter, but include:

- Accessibility to needed health care services, including primary care, specialty care, behavioral health and substance abuse services, dental care, long term care, and social services (including transportation)
- Lack of sufficient number and mix of health care professionals
- Increasing number of uninsured individuals in rural communities
- Lack of chronic and preventive care services
- Need for county or regional health departments

G. Conclusion

This report highlights the substantial health care issues and needs that exist in rural Nevada. Consideration of the action steps contained in the strategic plan is the first, and most critical, activity. Numerous decisions are yet to be made. We strongly recommend that the Governor and the Legislature implement a quasi-governmental board for rural health planning and coordination. This board can then consider the numerous activities contained in the strategic plan and suggest funding priorities based on available resources.

Another key factor to the success of rural health initiatives is the development of an integrated data collection and outcome measurement system. Unless the Governor, the Legislature, and State policy makers have access to complete, correct, and current health care data, rural health care initiatives will only be stopgap solutions.

As stated in the Task Force's policy statement, rural residents, like their urban counterparts, have a fundamental right to high quality and affordable health care. Implementation of the Rural Health Care Task Force's strategic plan will assure that

rural health care is available, of high quality, and affordable. We urge the Governor, Nevada legislators, and State policy makers to give it serious consideration.