



Nevada's Health Workforce Needs Assessment for 2026

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Joseph Lombardo
Governor
State of Nevada

Stacie Weeks, JD, MPH
Director
Nevada Health Authority

Acknowledgements

Prepared by:

Director's Office
Nevada Health Authority
State of Nevada

Thank you to the following for providing data, leadership, and technical support for this report

Madison Lopey, MS

Chief Biostatistician
Office of Analytics
Nevada Health Authority

Dylan Malmlov, MPH

Executive Director
Patient Protection Commission
Nevada Health Authority

Jonathan Chastain, DO

Clinical Informaticist
Medicaid-Academic Partnership
University of Nevada, Reno School of Medicine

Stephanie Purnell, MPH

Policy Analyst
Patient Protection Commission
Nevada Health Authority

Malinda Southard, DC, CPM

Deputy Director
Community Engagement and Workforce Development
Nevada Health Authority

Allison Genco Herzik

Chief of Staff
Nevada Health Authority

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Executive Summary

Purpose and Scope

Senate Bill 5 (36th Special Session) directed the Nevada Health Authority to conduct a statewide health care workforce needs assessment to identify workforce shortages to inform the Statewide Health Care Access and Recruitment Program (SHARP) grant award recommendations. This assessment examines workforce supply, geographic distribution, Medicaid participation, and service utilization patterns across Nevada's health care workforce.

Overview

Nevada's health care workforce shortage is both substantial and broad. The state's physician workforce is three-quarters of the national average, resulting in a shortfall of 2,441 physicians. Comparable deficits appear across nursing, allied health, and most acutely, behavioral health professions.

These shortages reflect long-term structural challenges driven by rapid population growth, an aging population, and an aging provider workforce that is not being replaced at the pace required to meet demand. They also limit timely access to preventive, behavioral, maternal, and specialty care, underscoring the need for targeted investments that strengthen both the pipeline and distribution of providers across the state.

Key Findings

Shortages span nearly every profession. Physicians, nurses, and most allied health fields fall below national supply levels, and no major profession has fully closed the gap to national average. Nevada would need about 2,441 additional physicians to reach the national rate.

Behavioral health is the most severe shortage in the state. Nevada has substantially fewer psychiatrists and counselors per resident than the nation, and fewer than each of its neighboring states. For substance use and mental health counselors, Nevada (approximately 69 per 100,000 residents) trails Arizona, New Mexico, Utah, and Colorado; Colorado's supply is more than three times that of Nevada. Child and adolescent psychiatrists are among the most severely understaffed of any field. These shortages coincide with the state's poor mental health rankings.

Maternal, infant, and child health represents a critical gap with measurable consequences. Pediatrics is one of the most undersupplied physician fields in the state, at about 60% of the national rate, and obstetrics-gynecology also falls below national levels. These gaps align with the state's outcomes, including some of the lowest rates in the country for children receiving a routine visit in the past year and persistently low levels of early and adequate prenatal care.

Primary care shortages have downstream health and cost effects. Primary care serves as the entry point to the health care system; limited access is associated with delayed care, less effective chronic disease management, and avoidable emergency department use. Gaps in primary care physicians represent 40% of the total number of physicians to reach national rates, where an additional 971 primary care physicians are needed to close the gap.

Specialty and chronic disease care are undersupplied. Most major specialties, such as cardiology, oncology, gastroenterology, endocrinology, and surgical specialties operate well below national levels, indicating limited statewide capacity for diagnosing and managing complex and chronic conditions. These are of concern as complex and chronic disease rates continue to increase and as Nevada's population grows and ages.

Nursing and Allied Health gaps strain the system. Registered nurses, nursing assistants, therapists, pharmacists, and other allied health professionals fall below national supply levels, reducing capacity across hospitals, behavioral health, long-term care, and community-based services, the backbone functions that keep the system operating.

The workforce is more concentrated in hospital-based care rather than preventive care. Among physicians, the best-supplied specialties are procedural and acute-care fields; pain medicine and anesthesiology exceed national levels. The deepest shortages occur in fields that provide ongoing, community-based, and behavioral care, including psychiatry, child and adolescent psychiatry, primary care, and pediatrics.

The shortage is geographically uneven, and statewide averages obscure local conditions. Provider supply is concentrated in Washoe and Clark County, leaving rural and frontier communities with the largest gaps and many areas federally designated as Health Professional Shortage Areas.

Implications for Grant Funding

This report identifies areas of need, and the professions, specialties, and locations where the evidence indicates the most serious shortages. These will guide the prioritization of SHARP grant funds.

By statute, SHARP funds are directed toward urban shortage areas and the shared capacity that serves the entire state. On the other hand, rural and frontier needs are addressed through the separate Rural Health Transformation Program, a federal grant program that began in December 2025, and is expected to continue through at least September of 2031. The intention is for the two funding streams to complement rather than duplicate each other. The report presents this as a regional strategy, where some services, like primary care, should be available in every community, while other care, such as complex cancer care, are most effective when concentrated at regional or central hubs.

Recommendations

- **Expand Health Education and Training**
 - Expand health professions education programs, including Graduate Medical Education (GME), rural and community-based training, and faculty capacity.
 - Strengthen career pathways and stackable credentials in fields like nursing, allied health, and behavioral health.
 - Build K-12 and post-secondary partnerships to grow the in-state workforce and improve job placement.
- **Increase Recruitment, Retention, and Practice Flexibility**
 - Increase financial incentives: loan repayment, scholarships, service-obligation programs.
 - Streamline licensure, credentialing and administrative processes to reduce barriers to practice.
 - Increase evidence-based scope of practice and licensure portability.
- **Practice Team and Community-Based Care Models**
 - Expand team-based and community-based care models including behavioral health integration into routine care.
 - Scale telehealth, remote patient monitoring, mobile health, eConsult, and other care-extending models.
- **Develop and Support Sustainable Payment Models and Encourage Medicaid Participation**
 - Advance payment models that support team-based, community-responsive service delivery.
 - Align incentives to encourage primary care, prevention, and integrated behavioral health.
- **Workforce Data, Planning, and Infrastructure**
 - Build on and leverage cross-agency and statewide efforts to strengthen long-term workforce forecasting, evaluation, and coordinated statewide planning.

Conclusion

Nevada faces significant workforce challenges, however, initiatives such as the Statewide Health Care Access and Recruitment Program strengthening urban access and regional hubs, the Rural Health Transformation Program expanding rural and frontier capacity, and GME programs working to train and retain providers, the state has an opportunity to build a more resilient, sustainable, and equitable health care system that keeps care closer to home and improves health outcomes across Nevada.

Introduction

Legislative Mandate

The Nevada Legislature passed Senate Bill (SB) 5 during the 36th Special Session (2025), appropriating \$60 million to the newly created Statewide Health care Access and Recruitment Program (SHARP) account administered by the Nevada Health Authority (NVHA).¹ The bill requires the NVHA to conduct a comprehensive biennial health care needs assessment on or before July 1 of each even-numbered year, with findings transmitted to the Governor and the Joint Interim Standing Committee on Health and Human Services to inform SHARP grant award recommendations to the Interim Finance Committee.

The assessment mandated by SB 5 must include: (1) a quantitative analysis of health care workforce supply by profession specialty and geographic area; (2) a comparison of provider supply against benchmarks established by the Health Resources and Services Administration (HRSA) or other nationally recognized organizations; (3) identification of critical shortages in essential professions, specialties, and clinical services; and (4) identification of unmet needs in specific health technologies and therapies. The report must include a summary of findings, a prioritized list of funding recommendations, and recommendations for legislation and regulatory changes.

In addition, SB 5 directs SHARP funds toward urban shortage areas, as the program is prohibited from duplicating investments made through the Rural Health Transformation Program (RHTP). As a result, the analyses in this report serve to inform SHARP, RHTP, Graduate Medical Education (GME), and other efforts focused on strengthening the health care workforce across the state.

Background and Context

Nevada's health workforce challenges are well-documented and longstanding. Three intersecting factors define the current landscape: rapid and sustained population growth, chronic undersupply of providers across nearly every specialty and profession, and geographic maldistribution of the existing workforce.

Population Growth and Changing Demographics

Nevada has been among the fastest growing states in the nation for decades. Between 2000 and 2024, the state's population grew from approximately 2.0 million to more than 3.3 million, a 63% increase, at an annual growth rate exceeding the national average.² The Nevada State Demographer's 20-year projection model anticipates continued growth through 2044, with Clark and Washoe counties absorbing the large majority of new residents.³ Alongside this growth, Nevada's population is aging: the median age increased from 35 years in 2000 to 39 years in 2024, and the share of residents aged 65 and older is projected to expand substantially over the next two decades. Older populations consume health care services at significantly higher rates than younger cohorts, and the burden of chronic conditions including cardiovascular disease, diabetes, cancer, and behavioral health disorder are rising accordingly.

Provider Supply: Persistent and Growing Gaps

Despite meaningful growth in the licensed health care workforce over the past decade, Nevada's provider-to-population ratios remain well below national averages across virtually every profession and specialty. According to the Nevada Health Workforce Research Center's *Physician Workforce in Nevada – 2025*, Nevada has 219.8 actively practicing physicians per 100,000 population, compared to a national average of 297.1.⁴ In 35 of 37 specialty areas tracked by the American Medical Association (AMA), Nevada's per-capita physician rates fall below the national average, with the most acute deficits in pediatrics (411 additional physicians needed), family medicine (251), medical oncology (126), neurology (90), and psychiatry (105).⁴

The shortage extends well beyond the physician workforce. Prior assessments estimate the state would need an additional 4,865 registered nurses and 5,092 nursing assistants to match national per-capita rates.⁵ Behavioral health workforce gaps are especially severe: nearly 91% of Nevada’s population resides in a federally designated Health Professional Shortage Area (HPSA) for mental health care, and every county carries some level of mental health shortage designation.⁴ These deficits translate directly into access barriers. About 30% of Nevada residents reported not seeing a doctor for a routine check-up in the past year, with the most common barriers to care being providers not accepting new patients and inability to schedule timely appointments.^{6,7}

Geographic Maldistribution

Nevada’s workforce shortage is compounded by geographic concentration. Of the 7,183 actively practicing physicians in Nevada, 69% are in Clark County and 22% are in Washoe County.⁴ Carson City and the state’s 14 rural and frontier counties together account for fewer than 6% of the physician workforce. All 17 Nevada counties carry at least a partial primary care HPSA designation, and 12 of the state’s 14 rural and frontier counties are single-county primary care HPSAs. Rural residents face not only provider shortages, but structural barriers including geographic distance, limited transportation, fewer telehealth-capable facilities, and higher rates of poverty and social vulnerability.

An Aging Physician Workforce and Pipeline Constraints

Nevada faces additional near-term pressure from workforce aging. The average age of a practicing physician in the state is 54.8 years, and 43.6% of active physicians are over 55.⁴ In several critical shortage specialties, the aging dynamic is more acute: 74.5% of cardiologists, 69.6% of urologists, and 65.5% of ophthalmologists are over 55. Graduate Medical Education (GME) expansion has meaningfully accelerated Nevada’s physician pipeline, with GME graduates growing from 49 in 2004 to 272 in 2024.⁸ Research consistently shows that physicians are far more likely to practice in the state where they complete residency, making sustained GME investment among the higher-leverage long-term workforce strategies.⁹ Nevertheless, current pipeline growth does not yet compensate for projected retirement attrition or growing demand driven by population growth and demographic aging.

Literature Review

National Workforce Projections

There is strong evidence for impending physician shortages across the country. The Association of American Medical Colleges’ (AAMC) most recent *Complexities of Physician Supply and Demand: Projections from 2021 to 2036 (2024)* report projects a national shortfall between 12,500 and 86,000 physicians by 2036 under the most likely scenarios, including between 20,200 and 40,400 primary care physicians and 10,100 to 19,900 surgical specialists, with most specialties in the “Other” category, including psychiatry, also projected to be in shortage.¹⁰ HRSA’s own Health Workforce Simulation Model projects a shortage of 87,150 full-time equivalent (FTE) primary care physicians alone by 2037.¹¹ The primary drivers are an aging population, with the US population aged 65 and older projected to grow 34.1% between 2021 and 2036, a physician workforce itself approaching retirement at scale, rising chronic disease burden, and a federally capped GME pipeline that has not kept pace with demand.¹⁰ These national trends are not just predictive for Nevada, but reflect current conditions.

Primary Care and Usual Sources of Care

A large body of evidence links primary care access to better population health outcomes, lower total health system costs, and reduced disparities.¹² Patients with a usual source of primary care are more likely to receive recommended preventive services, have better managed chronic conditions, experience fewer preventable hospitalizations, and incur lower per-capita health care costs.¹³ Primary care also functions as the entry point to specialty care; gaps in access can create downstream demand pressure on specialists and emergency departments. Nevada’s low rate, 27%, of usual

source of care may be associated with rates of preventable ED utilization, poorer chronic disease management, and worse outcomes across several key health indicators.

Behavioral Health Integration and Workforce Needs

Nevada's behavioral health workforce crisis has received increasing policy attention, and the need is well-supported in the literature.^{14,15} Untreated mental health and substance use disorders drive significant health care costs, reduce workforce productivity, and contribute to adverse social outcomes.¹⁶ Integrated behavioral health models, where mental health and substance use services collaborate closely with primary care, have demonstrated effectiveness in improving access, reducing stigma, and reducing total costs of care particularly in Medicaid populations.¹⁷ Nevada's near-universal mental health HPSA designation signals that behavioral health workforce development must be a central priority in any comprehensive needs assessment.

Rural and Frontier Health Access

Rural and frontier populations in Nevada face the compounding factors of workforce shortages, geographic isolation, lower population density, and higher social vulnerability. Research consistently finds that rural populations experience greater chronic disease burden, higher rates of behavioral health conditions, poorer maternal and infant health outcomes, and earlier mortality than urban populations.¹⁸ Evidence-based supply-side strategies in rural settings include rural training tracks in medical education, loan repayment, service-obligation programs, telehealth expansion, community health worker integration, and critical access hospital support.¹⁹

Research Questions

This assessment addresses five primary research questions:

1. What is the current supply of health care providers in Nevada by profession, specialty, and geographic area, and how does that supply compare to national benchmarks?
2. Where are shortages most critical and which professions, specialties, and geographic areas have the greatest gap between current supply and population need?
3. What does the utilization of health care services by Nevada Medicaid beneficiaries reveal about unmet need and effective access across service categories and geographic areas?
4. What are the implications of these findings for NVHA grant investment prioritization and complementary policy and regulatory action?
5. What are the limitations of the current assessment, and what data infrastructure and methodology investments are needed to support more comprehensive future cycles?

Methods

This assessment was conducted to evaluate the supply, distribution, and utilization of Nevada's health care workforce and identify areas of need. Consistent with the requirements of SB 5 (36th special session), the assessment examined workforce supply across health professions, specialties, and geographic areas; compared provider availability against regional and national benchmarks; identified critical workforce shortages; and evaluated access to care among Nevada Medicaid members. A multi-source analytic approach was used to combine workforce, population, Medicaid, and shortage designation data to provide a comprehensive view of the Nevada health care workforce and service delivery landscape.

Data Sources

Health care workforce supply estimates were obtained from the U.S. Bureau of Labor Statistics *Occupational Employment and Wage Statistics* (May 2025), and the University of Nevada, Reno School of Medicine, *Nevada Instant Atlas* (2024). Physician workforce data by specialty were obtained from the American Medical Association *Physician Professional Data* (2024), accessed through the Association of Medical Colleges (AAMC) *U.S. Physician Workforce Data Dashboard* (2026). Population estimates used to calculate provider-to-population ratios were obtained from the U.S. Census Bureau, *Population Estimates* (2024).

Medicaid provider participation and service utilization were evaluated using Nevada Medicaid enrollment and claims data from the Nevada Office of Analytics (OOA) (2025). Health Professional Shortage Area (HPSA) designations were obtained from the Nevada Health Workforce Research Center's *Physician Workforce in Nevada – 2025*, constructed from the U.S. Health Resources and Services Administration (HRSA) HPSA data.

Measures

Workforce supply was assessed using provider counts and provider-to-population ratios (providers per 100,000 population). Measures were calculated for Nevada overall and compared with neighboring states (Arizona, Colorado, New Mexico, and Utah), and national benchmarks where available. Comparison states were selected because they share geographic proximity with Nevada, face many of the same regional workforce recruitment and retention challenges, and provide relevant comparisons for population growth, rural service delivery, and health care market conditions in the Mountain West region.

For selected professions and physician specialties, workforce needs were evaluated by comparing Nevada's provider-to-population ratios to national averages. The estimated workforce gap was calculated as the additional number of providers needed for Nevada to achieve the national provider-to-population ratio.

Geographic distribution of the workforce was assessed using county-level provider counts and provider-to-population ratios. Maps were developed to identify regional variation in workforce availability and potential areas of shortage.

Medicaid analyses focused on active providers serving Medicaid members, Medicaid provider-to-enrollee ratios, telehealth utilization, and patterns of care delivery. Analyses examined where Medicaid members received services, including services delivered within their region, elsewhere in Nevada, or outside the state. For this analysis, regions are based on the Behavioral Health Regions and stratified by Clark, Washoe, Rural, Northern, Southern, and Out of State. Northern includes Carson City, Churchill, Douglas, Lyon, and Storey Counties; Rural includes Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties; and Southern includes Esmeralda, Lincoln, Mineral, and Nye Counties. A map of the regions is available in the appendix.

Analytic Approach

The assessment was conducted in three phases.

First, statewide workforce supply and distribution were evaluated across selected health professions and physician specialties. Workforce counts, provider-to-population ratios, county-level maps, and comparisons with regional and national benchmarks were used to identify professions and specialties with potential shortages.

Second, findings from the statewide workforce analysis were used to identify priority areas for further review. A particular focus was placed on primary care, maternal health, pediatrics, behavioral health, and selected medical specialties due to their importance in addressing Nevada's current and projected health care needs. These areas were also selected because they are commonly associated with documented workforce shortages, play a critical role in preventive and ongoing care, and have significant implications for access to services for Nevadans.

Third, Medicaid claims and enrollment data were used to assess provider participation and service access among Medicaid members. These analyses evaluated the active Medicaid workforce, geographic access to care, telehealth utilization, and patient travel patterns. Comparing broader workforce estimates with providers actively serving Medicaid members provided additional insight into the effective supply of care available to Nevada residents. Because workforce supply estimates and Medicaid participation measures are derived from different sources and don't capture the whole population, they are not directly comparable; together, however, they help distinguish between the total workforce present in the state and the proportion of that workforce that is actively accessible to Medicaid beneficiaries.

Findings from the workforce supply, geographic distribution, Medicaid participation, and HPSA designations were synthesized to identify critical workforce shortages, geographic disparities, and areas for targeted policy and workforce investment.

Overview of Statewide Workforce

Nevada's current health care workforce profile reveals a consistent pattern of undersupply across nearly all major provider types, with particularly acute shortages in primary care, behavioral health, and high-complexity specialty care. Table 1 uses employment data from the U.S. Bureau of Labor Statistics Occupation Employment and Wage Statistics (OEWS) survey, which captures actively employed workers and enables direct comparison against neighboring states and national averages. Table 2 uses unpublished licensure data from multiple Nevada licensing boards, aggregated through the Nevada Instant Atlas, which provides the most complete county-level counts of licensed providers available in the state. Figure 1 maps licensed provider density per 100,000 population by county across the professions captured in Table 2. Table 3 uses data from the American Medical Association (AMA), Physician Professional Data accessed through the American Association of Medical Colleges (AAMC), which captures active provider counts as classified by major professional activity (MPA) and compares across neighboring states and national averages. Figure 2 uses licensure data from the Nevada State Board of Medical Examiners and Nevada State Board of Osteopathic Medicine accessed through the Nevada Instant Atlas.

Health Care Workforce

Across nearly every profession category, Nevada's employed provider ratios fall below the national average and most peer state averages. Location quotients (LQ) below 1.0 indicate lower provider concentration relative to the US average. The pattern is not limited to one profession or sector; it's consistent across physician, nursing, behavioral health, and allied health professions, suggesting a broad structural workforce shortage, rather than isolated gaps. For example, Nevada's physician workforce (LQ 0.75) would require about 2,441 additional physicians to reach the national provider-to-population ratio. Similar deficits are observed among licensed practical nurses (LPNs) (LQ 0.53), certified nursing assistants (CNAs) (LQ 0.65), and registered nurses (RNs) (LQ 0.88), indicating challenges across the clinical workforce pipeline.

While shortages are widespread, the scale and implications of those shortages vary across the system. Nevada generally performs better in professions tied closely to acute and hospital-based care. Respiratory therapists (RTs) and Paramedics are at or near the national average. In contrast, the state's largest workforce deficits are concentrated in professions that support community-based, preventive, longitudinal, and behavioral health care. This pattern suggests Nevada may be comparatively stronger in responding to acute health care needs than in delivering the preventive, behavioral, and chronic care services necessary to improve long-term population health outcomes and control costs.

Behavioral health workforce shortages are particularly acute. Psychiatrists (LQ 0.62), substance use and mental health counselors (LQ 0.53), and health care social workers (LQ 0.60) all fall well below national averages. Nevada has among the highest prevalence of mental health and substance use issues and lowest relative access to insurance and mental

health care.¹⁵ The shortage of counselors and therapists is concerning because these providers form the foundation of community-based and outpatient mental health care delivery, the first point of contact for most individuals seeking behavioral health care.

A similar pattern emerges in primary care, where shortages are concentrated among providers serving as the foundation of preventive care, chronic disease management, and care coordination. As with behavioral health, these challenges have implications that extend beyond access, affecting the ability of the health system to identify health needs early, manage chronic conditions, and connect patients to timely specialty and supportive services and control costs.

There is a notable exception to the pattern of shortages. Nevada's nurse practitioner (NP) workforce is at parity with the national average (LQ 1.00). This parity may reflect the effect of Nevada's full practice authority law, enacted in 2013 which removed physician supervision requirements.²⁰ A policy linked in the literature to improved provider supply in primary care and rural settings.²¹

Another pattern is the consistent shortage of rehabilitation and supportive care professions. Physical therapists (LQ 0.70), occupational therapists (LQ 0.75), speech-language pathologists (LQ 0.68), pharmacists (LQ 0.74), and dietitians and nutritionists (LQ 0.74) all fall below national averages. Although these shortages may not create the same immediate access concerns as primary care or behavioral health, they affect recovery, chronic disease management, aging populations, and successful transitions of care across settings.

Nevada vs. Peer States

Table 1 compares Nevada against four neighboring states, Arizona, New Mexico, Utah, and Colorado, selected for geographic proximity, demographic comparability, and similar Medicaid policy contexts. The comparison is instructive in several ways. For physicians overall, Nevada (228 per 100,000) performs similarly to New Mexico (263) and Arizona (264), and Utah (227), suggesting that Nevada's physician shortage is not entirely out of step with the broader Mountain West region. However, Colorado (317 per 100,000), which has made sustained investments in GME expansion and provider recruitment, significantly outperforms Nevada.²² Apart from Colorado, Nevada and its peer states fall below the national average of 304 physicians per 100,000 population, indicating that the Mountain West is a physician-underserved region relative to the rest of the country.

Nevada's behavioral health workforce disadvantage is more pronounced in regional comparisons. For substance use, behavioral health, and mental health counselors, Nevada (68.8 per 100,000) falls far below Arizona (118.7), New Mexico (97.3), Utah (134.7), and Colorado (228.3). Among clinical and counseling psychologists, Nevada (15.7) would need approximately 181 additional providers to meet the national average. These professionals represent the front door to mental and behavioral health care, representing a gap that is reflected in the state's poor mental health performance. Mental Health America's 2025 state rankings, which combine measures of mental illness prevalence and access to care, ranked Nevada last (51st) among not only its peer states Arizona (50), New Mexico (43), Utah (31), and Colorado (41), but all states and the District of Columbia. Notably, the indicators contributing most to this ranking, youth experiencing major depressive episodes (22.63% versus 18.82% nationally), adults with substance use disorders (22.45% versus 18.05% nationally), and youth who did not receive preventive care in the last year (37.90% versus 28.60% nationally), align with the behavioral health workforce specialties where Nevada faces its steepest shortages.¹⁵

Table 1. Nevada Health Care Workforce Employment

Profession	Active Providers	Ratio per 100,000 Population						Location Quotient (LQ)	Gap to National Average
		NV	AZ	NM	UT	CO	US		
Physicians/Physician's Assistant									
Physicians	7438	228.6	265.2	263.0	227.1	315.7	303.6	0.75	2441
Primary Care Physicians	3285	100.8	107.2	122.9	88.2	133.1	130.6	0.77	971
Physician's Assistant (PA)	1190	36.6	46.8	30.1	47.7	53.1	45.7	0.80	298
Nursing									
Nurse Practitioners (NP)	2940	90.4	99.8	87.9	81.6	69.0	90.4	1.00	1
Registered Nurses (RN)	27570	847.4	852.7	823.3	735.9	910.2	965.3	0.88	3836
Licensed Practical Nurses (LPN)	3210	98.7	68.8	87.0	48.2	84.0	186.0	0.53	2842
Certified Nurse Assistants (CNA)	8670	266.5	229.6	216.3	352.6	348.7	408.4	0.65	4616
Mental and Behavioral Health									
Psychiatry	241	7.4	9.6	11.3	6.9	10.9	12.0	0.62	149
Clinical and Counseling Psychologists	510	15.7	15.1	10.3	28.5	32.4	21.2	0.74	181
Health Care Social Workers	1070	32.9	37.5	34.3	55.1	67.6	54.7	0.60	709
SUD, BH, Mental Health Counselors	2240	68.8	118.7	97.3	134.7	228.3	129.5	0.53	1974
Child, Family, and School Social Workers	3730	114.6	102.8	134.0	52.2	130.9	112.6	1.02	0
Mental and Behavioral Health Social Workers	1140	35.0	47.8	29.2	48.0	33.1	37.0	0.95	65
Allied Health									
Physical Therapists (PT)	1670	51.3	60.1	63.5	66.5	90.7	73.1	0.70	709
Occupational Therapists (OT)	1090	33.5	31.6	40.4	27.7	62.5	44.8	0.75	367
Speech-Language Pathologists (SLP)	1170	36.0	37.5	48.9	41.4	71.1	52.6	0.68	541
Respiratory Therapists	1420	43.6	40.6	28.2	29.1	34.6	40.1	1.09	0
Dietitians and Nutritionists	540	16.6	16.9	18.3	31.1	-	22.5	0.74	193
Pharmacists	2330	71.6	101.8	83.2	89.1	85.7	96.7	0.74	817
Optometrists	360	11.1	12.7	6.6	11.7	16.4	12.3	0.90	41
Podiatrists	40	1.2	3.3	2.8	2.6	2.3	2.8	0.44	51
Paramedics	910	28.0	24.1	40.0	28.3	39.2	29.3	0.96	42
Dental									
Dentists, General	1040	32.0	38.8	31.0	21.1	38.9	33.4	0.96	46
Dental Hygienists	2040	62.7	66.7	65.8	112.5	74.6	64.4	0.97	56

Source. U.S. Bureau of Labor Statistics. (2024). Occupational Employment and Wage Statistics (OEWS) Profiles; Association of American Medical Colleges. (2024). U.S. Physician Workforce Data Dashboard; Primary Care Physicians include: Family Medicine/General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology; US Census Bureau (2024), population estimates

Geographic Concentration and Maldistribution

Table 2 and figure 1 shifts from the statewide employment snapshot to the geographic distribution of select licensed providers. These data show where the workforce is concentrated and where persistent shortages may limit access. Patterns are strongly shaped by the state's unique geography. Nevada's population is concentrated in two urban counties, Washoe and Clark (88.7%), yet 86.9% of the state's land area is rural or frontier.

Rural and Frontier Shortages

Rural and frontier counties, defined as all counties excluding Clark, Washoe, and Carson City, show the most severe deficits across nearly every profession category. Allopathic physicians are licensed at 69 per 100,000 in rural and frontier areas, less than a quarter of Washoe County (287) and well below Clark County (181). Primary care physicians in rural and frontier areas are at 60 per 100,000, that accounts for one or two providers in many individual counties.

Behavioral health in rural and frontier Nevada is extremely low, and functionally absent. Psychiatrists are licensed at 1 per 100,000 in rural and frontier areas, more than three times below the threshold for the federal HRSA threshold of a Mental Health Professional Shortage Area Designation (approximately 30,000:1). Further, psychologists are licensed at 4 per 100,000, clinical professional counselors at 17, and alcohol, drug, and gambling counselors at 12. For most individual rural and frontier counties these translate to very few licensed providers serving a geographically dispersed population.

Addressing rural and frontier workforce shortages is a priority that this assessment documents and supports. However, the Statewide Health Access and Recruitment Program (SHARP) grant, which this assessment informs, is constrained from duplicating investments made through the Rural Health Transformation Program (RHTP). SHARP investments are therefore focused on urban shortage areas, where RHTP does not operate. The rural and frontier data presented here are intended to serve as a reference for the RHTP, Graduate Medical Education (GME), and other initiatives aimed at improving the rural and frontier health workforce.

Urban Shortages: Clark, Washoe, and Carson City

Clark County, home to about 73% of Nevada's population, shows a consistent pattern of below-statewide average provider ratios across most professions despite holding the largest absolute provider counts in the state. Allopathic physicians are licensed at 181 per 100,000, below both the statewide rate of 189 and Washoe County's 287, and primary care physicians at 60 per 100,000 tied with the rural and frontier average and the lowest among the three urban regions. The disconnect between Clark County's share of providers in count and per-capita ratios reflects the scale of the population it serves; each additional gap in per capita supply in Clark County translates to thousands of residents with limited access.

This gap is most acute for behavioral health, where psychiatrists are licensed at 9 per 100,000, just above the rural and frontier rate of 1, but still well below Washoe County (16). Psychologists are licensed at 13 per 100,000, less than half of Washoe County's 33. Alcohol, drug, and gambling counselors are licensed at 6 per 100,000 in Clark County, the lowest of any urban region. Clinical professional counselors (30) are at or near statewide averages, but licensed social workers (45) fall well short of Washoe County's ratio.

Washoe County consistently shows the strongest provider ratios in the state across most profession categories, with allopathic physicians at 287 per 100,000, primary care physicians at 92, APRNs at 128. Although Washoe County often exceeds statewide averages in provider ratios, it has fewer providers than Clark County in absolute terms, and lags behind national benchmarks and state peers in provider counts and health outcomes.

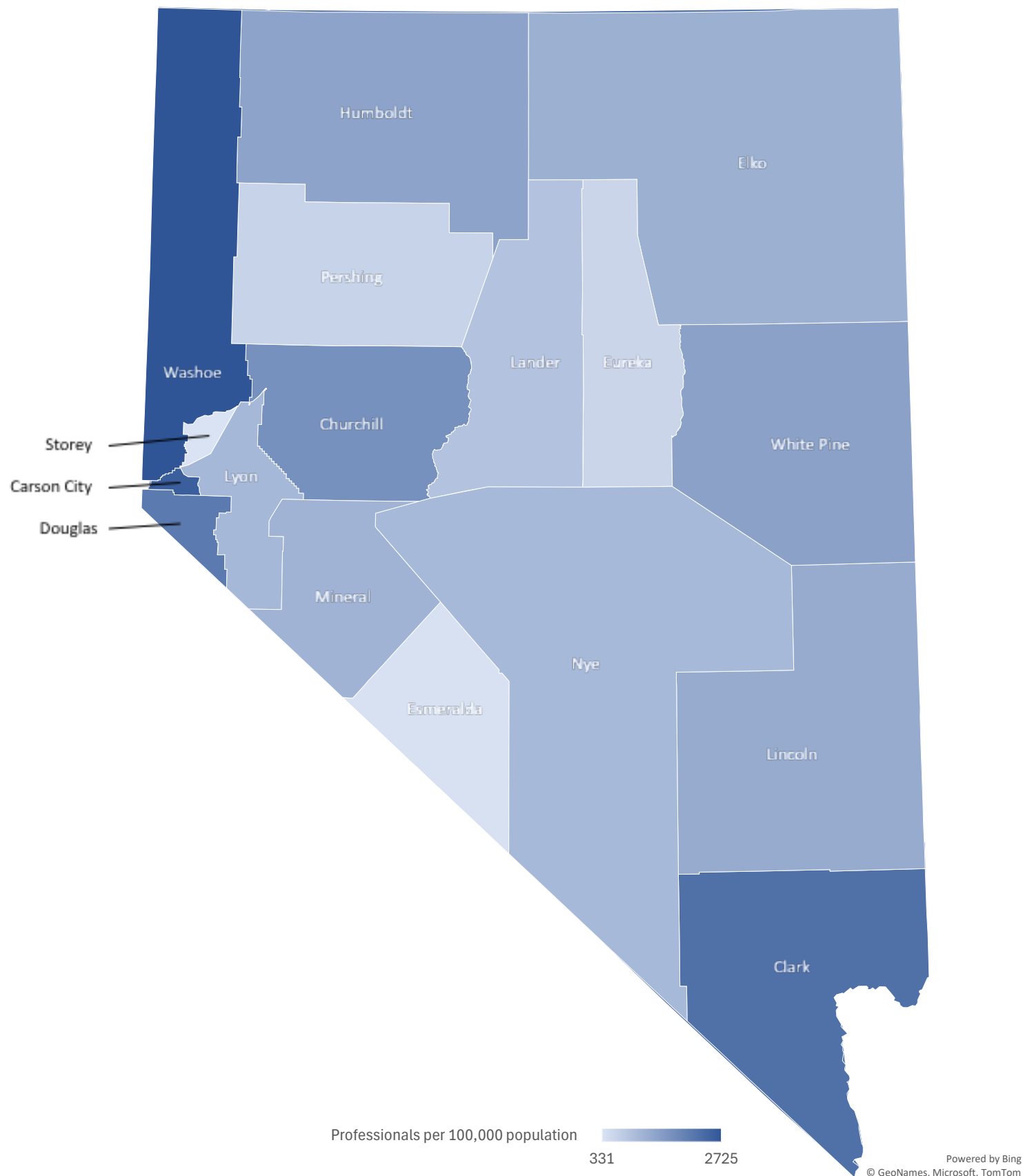
In Carson City, physician ratios are high relative to the rest of the state, with allopathic MDs at 326 per 100,000, and primary care physicians at 111, likely reflecting the concentration of state government employees relative to a small population base. This data should be interpreted cautiously, however, as the departure or overestimate of FTE hours would substantially shift per-capita ratios.

Table 2. Nevada Licensed Health Care Workforce in Nevada by Region

Profession	Nevada		Clark County		Washoe County		Carson City		Rural and Frontier	
	Licensed Providers	Ratio per 100,000	Licensed Providers	Ratio per 100,000	Licensed Providers	Ratio per 100,000	Licensed Providers	Ratio per 100,000	Licensed Providers	Ratio per 100,000
Allopathic Physicians (MDs)	6229	189	4334	181	1482	287	194	326	219	69
Osteopathic Physicians (DOs)	1337	41	1057	44	190	37	7	12	62	20
Primary Care Physicians	2169	66	1435	60	478	92	66	111	190	60
Physician Assistants	1266	38	832	35	301	58	48	81	85	27
Advanced Practitioners of Nursing	3507	107	2631	110	661	128	60	101	155	49
Registered Nurses	33875	1030	25268	1054	6123	1184	578	972	1906	603
Licensed Practical Nurses	3638	111	2940	123	406	78	42	71	250	79
Certified Registered Nurse Anesthetists	158	5	114	5	15	3	8	13	21	7
Alcohol, Drug and Gambling Counselors	234	7	134	6	49	9	13	22	38	12
Clinical Professional Counselors	953	29	731	30	148	29	20	34	54	17
Licensed Clinical Social Workers	1619	49	1069	45	388	75	56	94	106	34
Marriage and Family Therapists	1471	45	986	41	383	74	31	52	71	22
Psychiatrists (MDs & DOs) *	303	9	212	9	83	16	5	8	3	1
Psychologists	508	15	302	13	173	33	20	34	13	4
Chiropractors	704	21	495	21	145	28	19	32	45	14
Clinical/Medical Lab Technologists	1308	40	1076	45	158	31	16	27	58	18
Clinical Medical Lab Technicians	242	7	197	8	31	6	3	5	11	3
Occupational Therapists	1081	33	839	35	176	34	16	27	50	16
Opticians	0	0	0	0	0	0	0	0	0	0
Optometrists	514	16	353	15	110	21	19	32	32	10
Paramedics	2478	75	1878	78	401	78	22	37	177	56
Pharmacists	2642	80	1995	83	460	89	49	82	138	44
Physical Therapists	1159	35	833	35	209	40	38	64	79	25
Podiatrists	132	4	102	4	20	4	2	3	8	3
Respiratory Therapists	1327	40	1118	47	153	30	13	22	43	14
Speech-Language Pathologists	1088	33	657	27	350	68	26	44	55	17
Social Workers	894	27	459	19	299	58	51	86	85	27
Dentists	2102	64	1575	66	368	71	53	89	106	34
Dental Hygienists	1290	39	784	33	334	65	45	76	127	40

Source. Nevada Instant Atlas (2024) utilizing unpublished licensure data from multiple licensing boards. *Data from 2022.

Figure 1. Nevada Licensed Health Care Professionals per 100,000 Population by County, 2024, Selected Professions



Source. Nevada Instant Atlas, counts reflect selected professions listed in Table 2 (2024).

Physician Workforce

Table 3 provides a more granular view of the physician workforce, disaggregating Nevada's supply across specialties and comparing each against Arizona, New Mexico, Utah, Colorado, and the national average. Nevada's statewide physician location quotient of 0.75 against the national average implies a gap of approximately 2,441 physicians to reach per-capita parity. However, there is considerable variation across specialties. The specialties with the largest gaps from the national average are internal medicine (316 additional physicians needed), pediatrics (318), family medicine and general practice (253), psychiatry (150), and pathology (101), followed by cardiovascular disease (87), obstetrics and gynecology (85), hematology and oncology (112), pulmonary disease (68), and gastroenterology (68). These ten specialties collectively account for the majority of the physician workforce gap, which spans the full range of services from primary and preventive care, child health, maternal health, behavioral health, and management of chronic and complex disease.

The relative shortage is most pronounced in the specialties where LQ indicates the deepest structural undersupply. Hematology and oncology (LQ 0.47) rank among the lowest LQ, meaning Nevada has less than half the national per-capita supply of these providers. These figures are clinically significant, as Nevadans with cancer diagnoses and limited in-state access to specialized oncology care are faced with referrals to out-of-state providers, long waits, or long-distance travel as their only alternatives. Allergy and immunology (LQ 0.38) and vascular disease (LQ 0.43) are the two lowest LQs in the table, compounding concerns about access to complex specialty care for Nevada's growing and aging population.

Among primary care and preventative medicine specialties, Nevada is particularly weak in regional comparisons. Nevada's per-capita ratios for pediatrics, family medicine and general practice, preventive medicine, and child and adolescent psychiatry are lower than all four neighboring states. Across the full table, Nevada's per-capita ratio ranks last among the comparison states in 19 specialty areas. The breadth of this low-ranking spans primary care, behavioral health, surgical subspecialties and diagnostic specialties, reinforcing the key takeaway that the physician workforce shortage is structural and broad, rather than isolated.

Child and adolescent psychiatry (LQ 0.48) have just 53 active practitioners in the state, or a ratio of 1.6 per 100,000. Nevada has less than half the national per-capita supply for this provider type already in critical shortage nationally. The downstream effects are measurable, as children with untreated psychiatric conditions experience higher rates of emergency department utilization, school disruption and adverse long-term health outcomes, and their families frequently encounter multi-month wait times or travel to another state entirely for care.²³⁻²⁵ Nevada ranks below all peer states in this specialty.

The pattern across cardiovascular disease (LQ 0.60), pulmonary disease (LQ 0.67), and gastroenterology (LQ 0.59) illustrates a second layer of concern: the chronic disease management workforce is undersupplied relative to an aging Nevada population carrying an increasing burden of cardiovascular disease, diabetes, chronic obstructive pulmonary disease (COPD), and obesity related conditions. As the share of Nevadans aged 65 and older grows over the next two decades, this gap will intensify without investment in specialty physician recruitment and GME pipeline expansion.

Figure 2 maps licensed physician density by county across Nevada. The map reinforces what the statewide and regional data show: physician supply is heavily concentrated in Clark and Washoe counties with rural and frontier counties operating at a fraction of the per-capita levels needed to meet access thresholds. Within the urban counties, Washoe county's physician density (323 per 100,000) is 43% larger than Clark County (225) relative to population density.

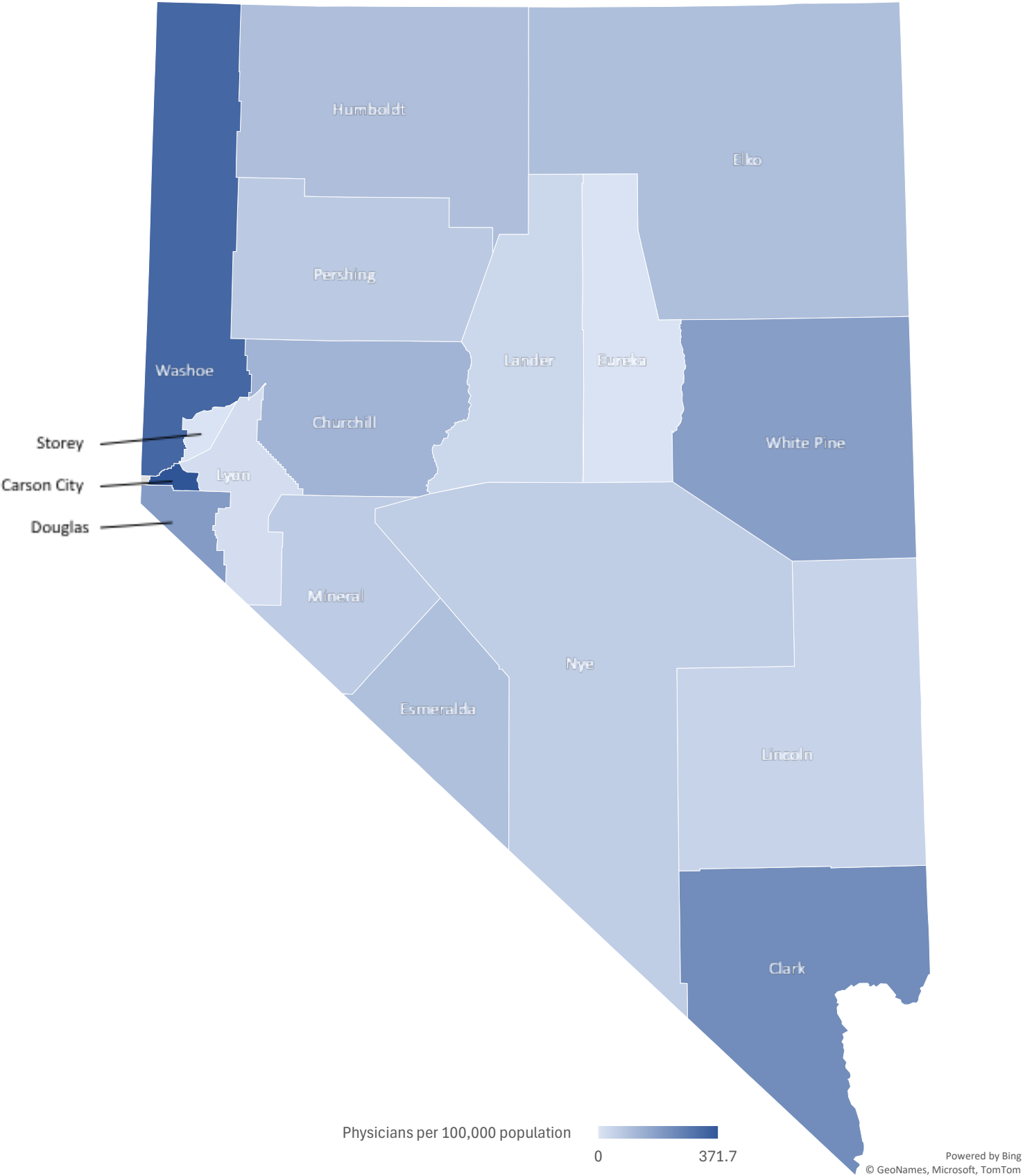
The data above identify critical shortage areas in primary and preventative care, behavioral and mental health, maternal and child health, and chronic disease management. The data supports focused attention towards the specialties where the combination of LQ, absolute gap, population health impact, and cross-state underperformance is most pronounced, a set that includes family medicine, pediatrics, psychiatry, internal medicine and the oncologic and cardiovascular specialties most tied to Nevada's chronic disease burden.

Table 3. Active Physician Workforce in Nevada by Specialty

Specialty	Active Providers	Ratio per 100,000 Population						Location Quotient (LQ)	Gap to National Average
		NV	AZ	NM	UT	CO	US		
Total	7438	228.6	265.2	263	227.1	315.7	303.6	0.75	2441
Family Medicine/General Practice	952	29.3	30.6	46.6	30.1	47.6	37.1	0.79	253
Pediatrics	469	14.3	18.9	20.2	20.1	23.1	24.0	0.60	318
Pediatric Cardiology	20	0.6	0.7	0.0	1.0	1.1	1.0	0.60	13
Obstetrics and Gynecology	339	10.4	10.4	11.2	9.1	14.1	13.0	0.80	85
Psychiatry	241	7.4	9.6	11.3	6.9	10.9	12.0	0.62	150
Child and Adolescent Psychiatry	53	1.6	2.2	3.8	2.1	3.5	3.3	0.48	56
Allergy and Immunology	18	0.6	1.1	0.8	0.9	2.2	1.6	0.38	30
Internal Medicine	1525	46.8	47.3	44.9	28.9	48.3	56.5	0.83	316
Neurology	106	3.3	4.9	3.4	4.1	4.4	5.2	0.63	61
Pulmonary Disease	140	4.3	5.9	5.1	4.3	6.7	6.4	0.67	68
Emergency Medicine	484	14.9	15.1	18.1	14.1	20.8	15.5	0.96	19
Anesthesiology	450	13.8	14.9	7.9	13.9	16.4	12.8	1.08	-33
Preventive Medicine	41	1.3	1.5	2.7	1.6	3.4	1.9	0.68	19
Radiology	273	8.4	11.3	8.2	8.8	11.1	11.1	0.76	88
Radiation Oncology	35	1.1	1.8	1.1	1.3	1.5	1.7	0.65	19
Pain Medicine and Pain Management	94	2.9	2.4	2.0	2.3	1.6	2.2	1.32	-23
Dermatology	64	2.0	3.6	2.2	3.9	4.3	4.0	0.50	64
Physical Medicine and Rehabilitation	93	2.9	2.3	2.7	3.4	3.4	3.0	0.97	3
Cardiovascular Disease	132	4.1	5.6	4.4	3.2	4.8	6.8	0.60	87
Gastroenterology	97	3.0	4.3	3.9	3.3	4.4	5.1	0.59	68
Pathology	107	3.3	6.0	7.4	5.1	5.9	6.4	0.52	101
General Surgery	240	7.3	8.3	9.7	6.3	9.7	8.9	0.82	53
Ophthalmology	129	4.0	4.6	4.0	5.3	5.5	5.9	0.68	61
Orthopedic Surgery	183	5.7	6.1	6.2	6.5	8.8	6.8	0.84	35
Urology	62	1.9	2.9	2.5	2.6	3.1	3.2	0.59	42
Otolaryngology	53	1.6	2.5	2.2	3.1	3.3	3.0	0.53	46
Plastic Surgery	60	1.8	2.6	1.2	2.2	2.1	2.3	0.78	17
Neurological Surgery	29	0.9	1.9	1.3	1.7	2.1	1.9	0.47	32
Thoracic Surgery	30	0.9	1.2	1.3	1.1	1.3	1.4	0.64	17
Vascular Disease	18	0.6	1.1	0.9	0.7	1.0	1.4	0.43	24
Hematology and Oncology	99	3.1	5.2	4.7	4.6	5.8	6.6	0.47	112

Source. AMA Physician Professional Data (2024) accessed via the AAMC U.S. Physician Workforce Data Dashboard (2026); US Census Bureau (2024), population estimates. Note. Full profession-level data are available in the appendix; some categories were combined for reporting

Figure 2. Nevada Licensed Physician Workforce per 100,000 Population by County, 2024



Source. Nevada Instant Atlas, physician licensure data from the Nevada State Board of Medical Examiners and Nevada State Board of Osteopathic Medicine (2024).

Critical Shortage Areas

Workforce shortages were identified across much of Nevada's health care system. However, not all shortages have the same implications for access, health outcomes, and health system performance. To identify critical shortage areas for further analysis, workforce supply findings were considered alongside the supply of workforce deficits, the role each profession plays in the health care system, Nevada's performance on independent measures of access and outcomes, and possible future demand. Based on these criteria, primary care, maternal and child health, behavioral health, and selected physician specialties emerged as significant workforce challenges.

Primary Care

Primary care represents the foundation of the health care system and serves as the primary entry point for prevention, chronic disease management, care coordination, and referral to specialty care. Nevada has 100.8 primary care physicians per 100,000 population compared to 130.6 nationally (LQ 0.77), representing an estimated gap of 971 physicians accounting for about 40% of the total estimated physician workforce gap.

The importance of this shortage extends beyond supply alone. A large body of research has demonstrated that greater access to primary care is associated with improved health outcomes, lower mortality, and reduced health care costs.²⁶ Nevada's workforce challenges align with broader indicators of health system performance. The state ranks near the bottom nationally on measures of access and affordability, prevention and treatment, and access to usual source of care.²⁷ Workforce shortages may contribute to delays in preventive services, increased reliance on emergency departments and acute care, and poorer management of chronic disease.

Maternal, Infant, and Child Health

Maternal, infant, and child health emerged as a primary focus area due to the shortage across multiple workforce categories and Nevada's poor performance on key maternal and child health indicators. Obstetrics and gynecology remain below national benchmarks (LQ 0.80), while pediatrics represents one of Nevada's largest physician specialty shortages (LQ 0.60), with an estimated gap of 318 pediatricians, and 13% of the total estimated physician workforce gap. Child and adolescent psychiatry also remain substantially below national averages (LQ 0.48).

These workforce deficits coincide with persistent challenges in maternal and child health access and outcomes. Nevada ranks near the bottom nationally on measures on women's health care access, affordability, prevention, and quality.²⁸ National survey data also indicate that Nevada trails most states on measures of pediatric preventive access to care.²⁷ Given the importance of early intervention, preventive care, and care coordination in this population, workforce shortages may have long-term implications for population health.

Behavioral Health

Behavioral health shortages are among the most severe identified in this assessment. Nevada has 7.4 psychiatrists per 100,000 population compared to 12.0 nationally (LQ 0.62), while child and adolescent psychiatry (LQ 0.48), health care social workers (LQ 0.60), and substance use and mental health counselors (LQ 0.53) also remain well below national benchmarks. Nevada would need an estimated 149 additional psychiatrists, 709 health care social workers, and 1,974 counselors to reach national levels.

These shortages are particularly significant because behavioral health providers frequently serve as the first point of contact for individuals seeking mental health or substance use treatment. Research has linked behavioral health workforce shortages to reduced access to care, longer wait times, increased emergency department utilization, and poorer outcomes.²⁹ Nevada consistently ranks among the lowest performing states nationally on measures of mental health access and behavioral health system performance, suggesting that workforce constraints may be contributing to broader access challenges.²⁷

Specialty Care

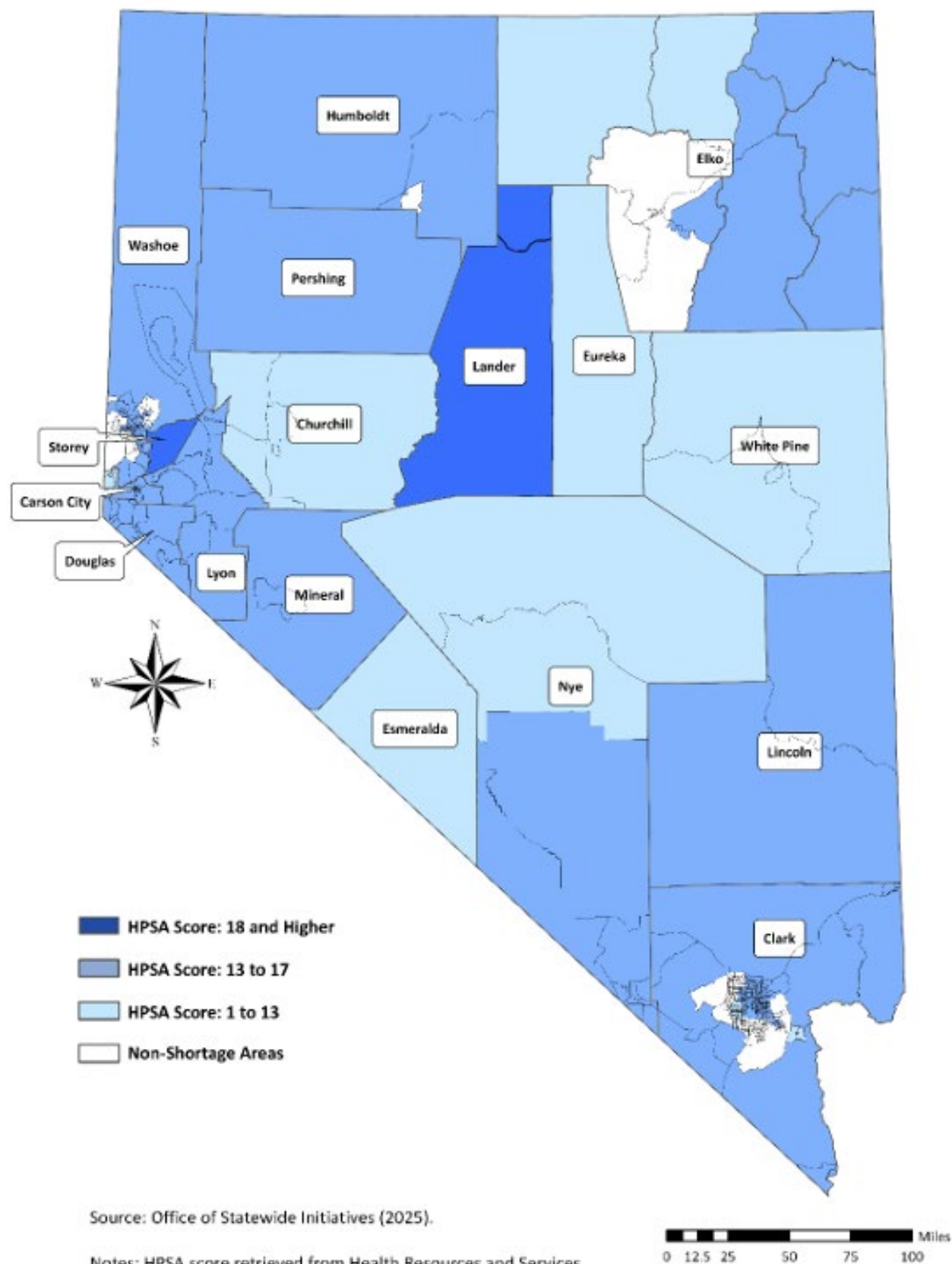
Beyond primary care and behavioral health, physician workforce data suggest significant shortages in several specialties that support management of chronic disease, complex medical conditions, and an aging population. Internal medicine, cardiovascular disease, gastroenterology, pulmonary medicine, neurology, physical medicine and rehabilitation, obstetrics and gynecology, and oncology all remain well below national benchmarks.

Although shortages vary by specialty, the overall pattern suggests limited subspecialty capacity relative to current and future demand. These specialties play an important role in managing cardiovascular disease, cancer, neurological disorders, chronic respiratory conditions, and other high-burden conditions that account for a significant share of morbidity, mortality, and health care spending. Specialty shortages may contribute to longer wait times, delayed diagnoses, and increased travel for care, particularly for residents of rural and frontier communities.

Health Professional Shortage Areas

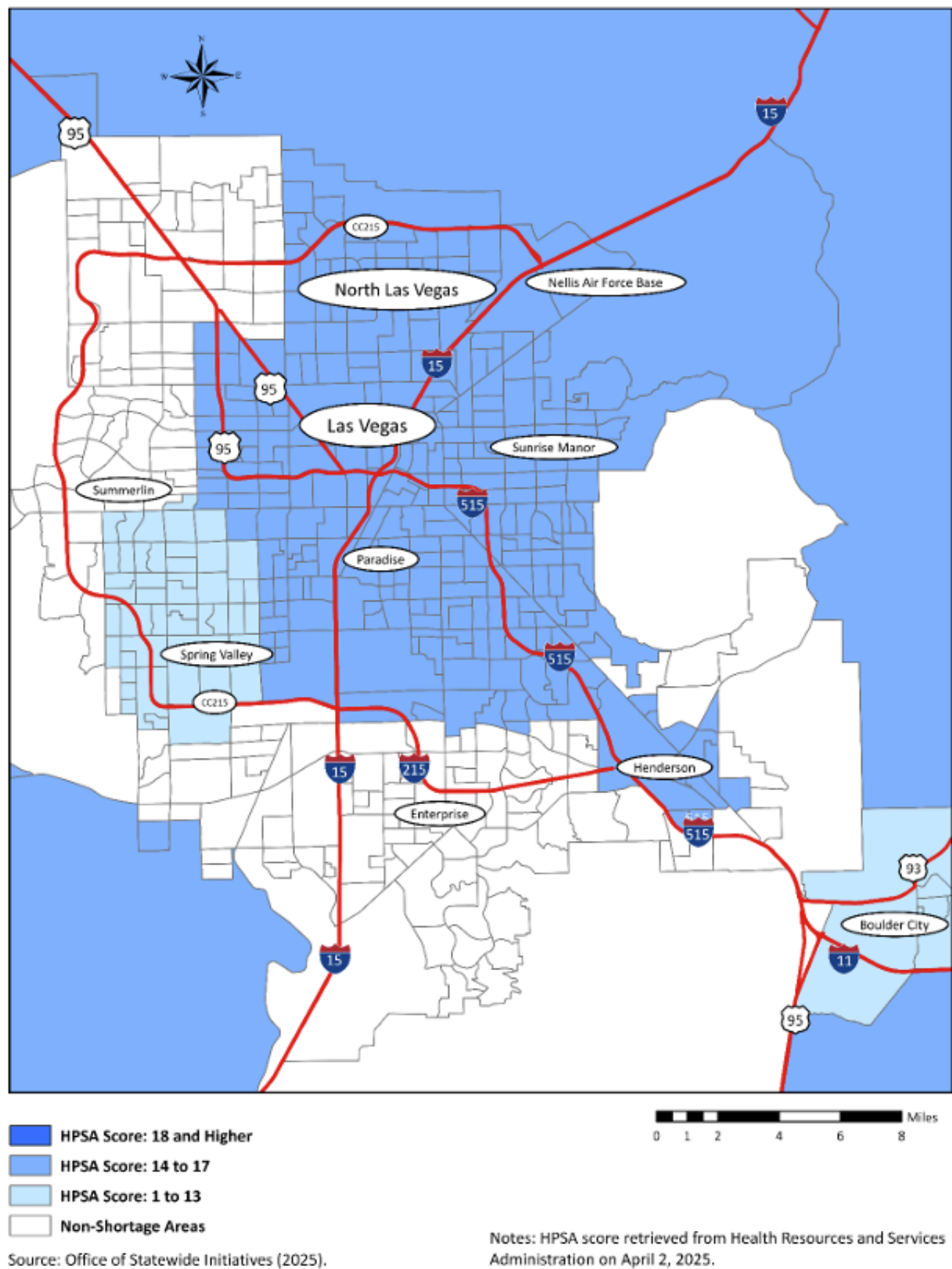
Federal Health Professional Shortage Area (HPSA) designations reinforce and extend these findings. All 17 Nevada counties carry at least a partial primary care HPSA designation, and most rural and frontier counties meet federal thresholds for severe primary care undersupply. Mental health shortages are even more widespread: nearly the entire state is designated a Mental Health HPSA, with 15 of 17 counties designated as full county shortage areas, and 91.7% of Nevadans residing in a Mental Health HPSA. These designations underscore the structural nature of Nevada's access challenges and indicate that workforce gaps are not isolated to specific communities or professions. Instead, they reflect a statewide pattern of insufficient primary and behavioral health capacity that has direct implications for prevention, chronic disease management, and timely access to care.

Figure 3. Primary Care Health Professional Shortage Areas (HPSAs) in Nevada



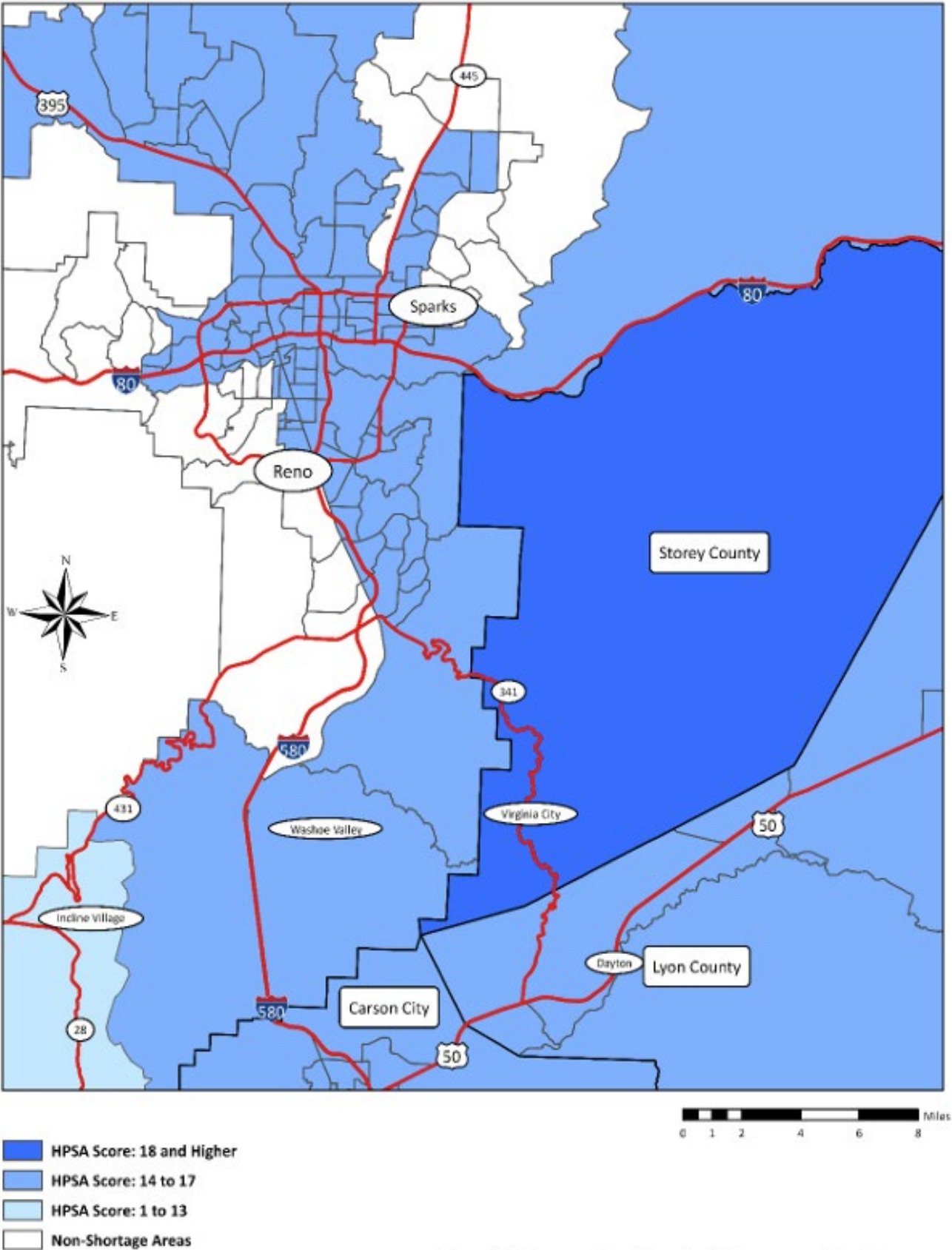
Source. Office of Statewide Initiatives, *Physician Workforce in Nevada – 2025*, (2025).

Figure 4. Primary Care Professional Shortage Areas (HPSAs) in Southern Nevada



Source. Office of Statewide Initiatives, *Physician Workforce in Nevada – 2025*, (2025).

Figure 5. Primary Care Health Professional Shortage Areas (HPSAs) in Northern Nevada



Source: Office of Statewide Initiatives (2025).

Notes: HPSA score retrieved from Health Resources and Services Administration on April 2, 2025.

Source. Office of Statewide Initiatives, *Physician Workforce in Nevada – 2025*, (2025).

Figure 6. Mental Health Professional Shortage Areas (HPSAs) in Nevada

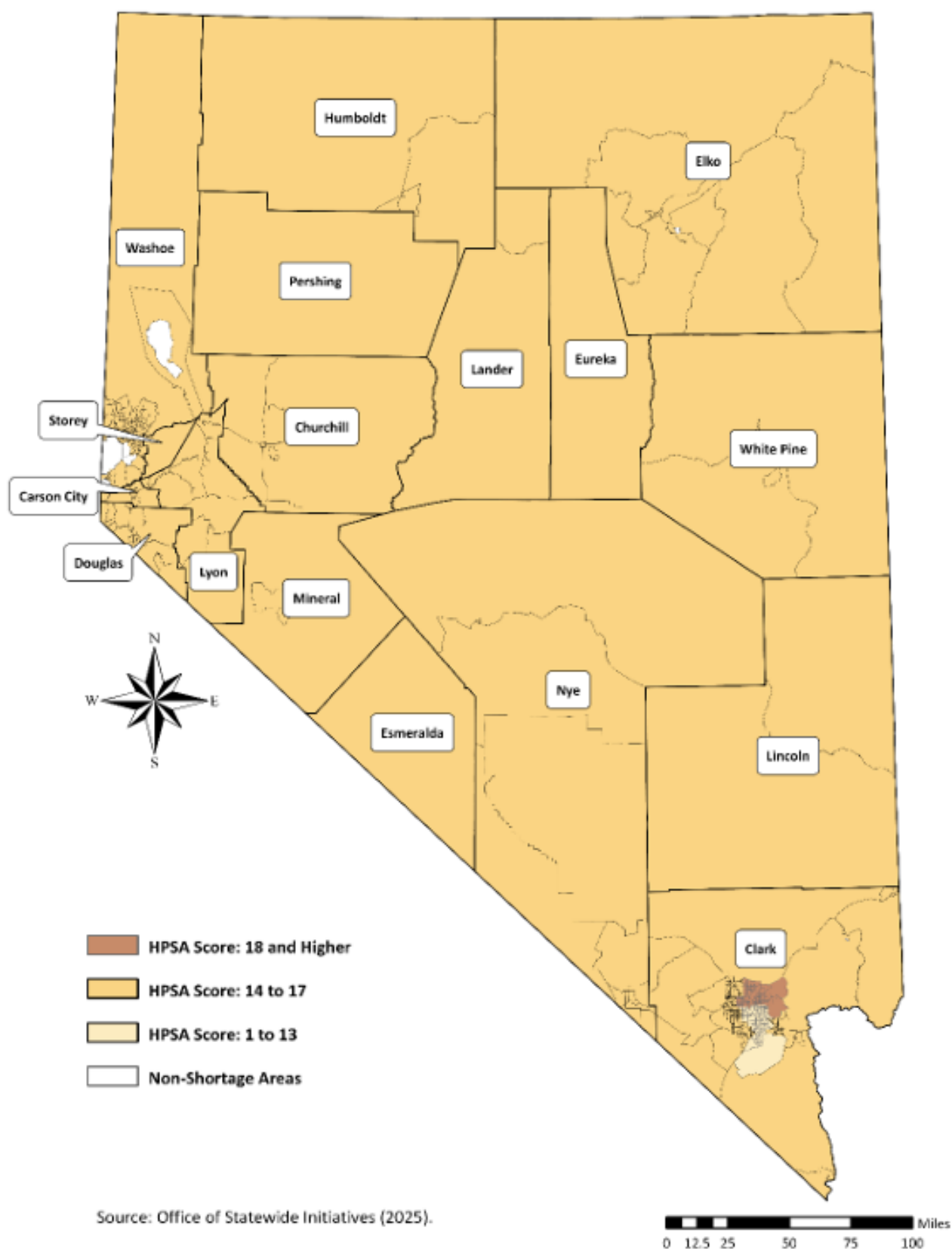
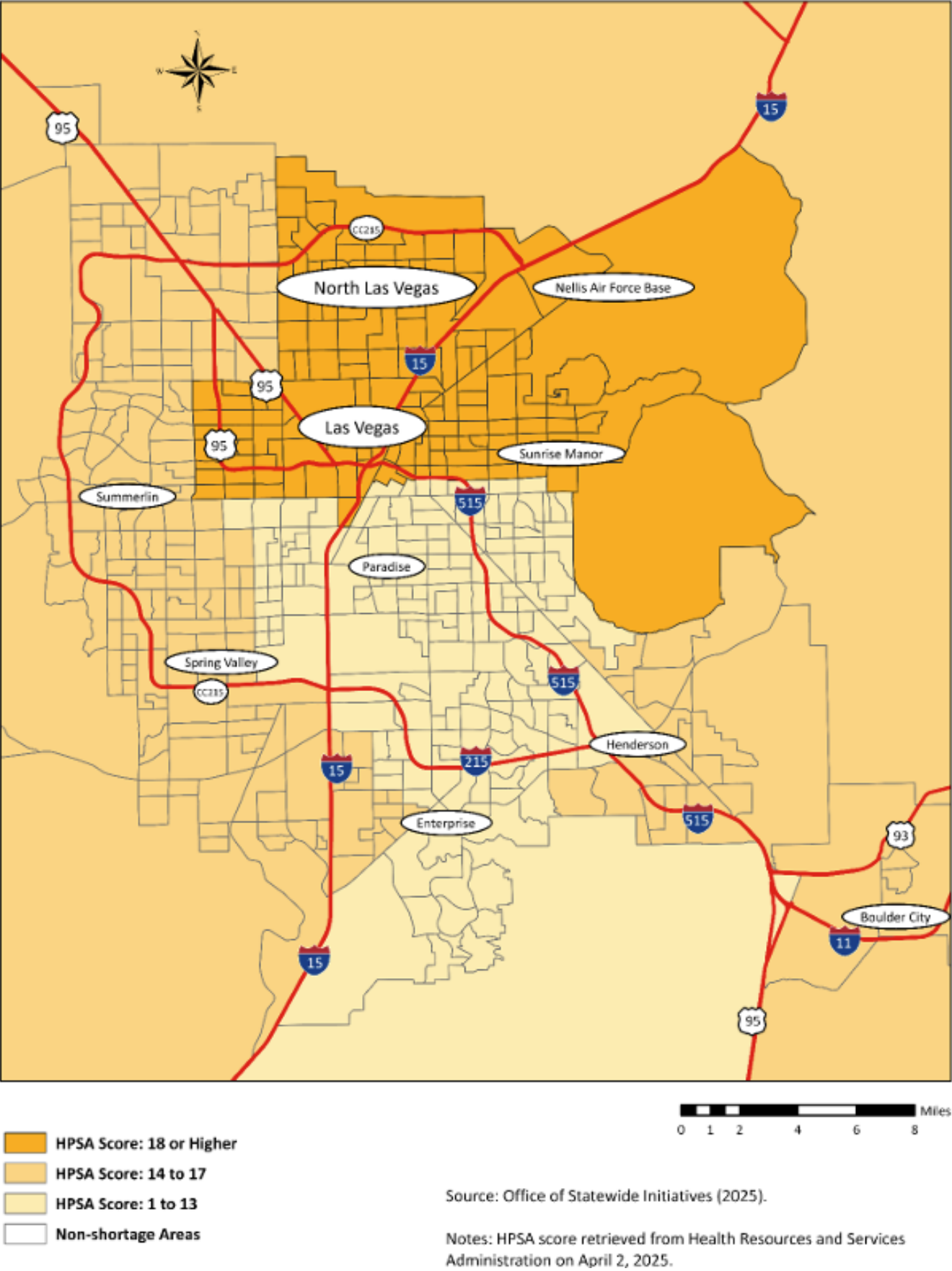
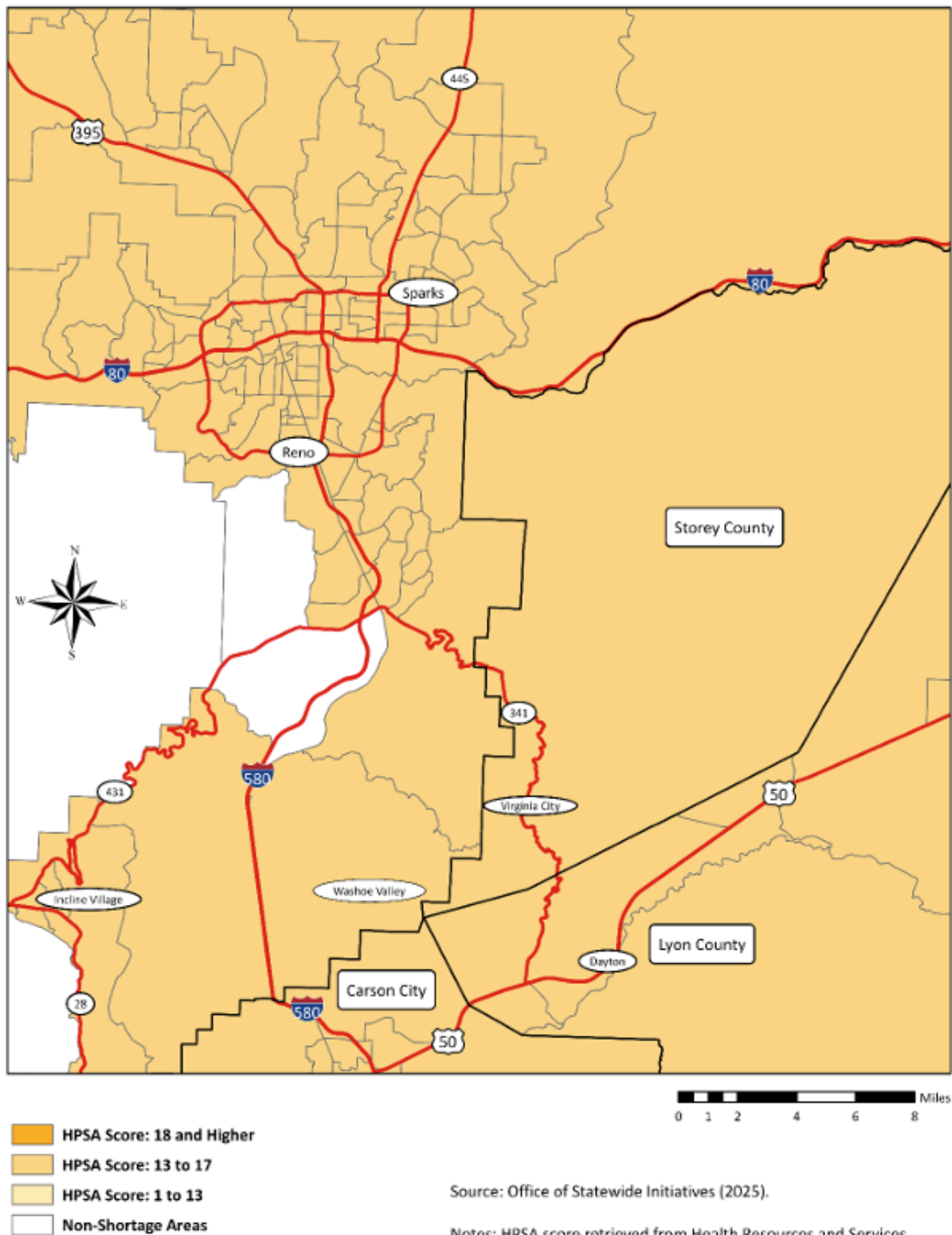


Figure 7. Mental Health Professional Shortage Areas (HPSAs) in Southern Nevada



Source. Office of Statewide Initiatives, *Physician Workforce in Nevada – 2025*, (2025).

Figure 8. Mental Health Professional Shortage Areas (HPSAs) in Northern Nevada



Source. Office of Statewide Initiatives, *Physician Workforce in Nevada – 2025*, (2025).

Primary Care

While the prior tables and maps describe Nevada’s provider supply relative to national and regional benchmarks, the Medicaid claims-based analysis narrows the focus to providers with observed Medicaid service activity. These counts should not be interpreted as the total number of practicing clinicians in the state, but rather as an indicator of the provider capacity demonstrably available to Medicaid beneficiaries.

Active Medicaid provider counts in critical shortage areas presented in Table 4 are substantial when viewed alongside statewide active provider counts from Table 3. However, these figures should not be treated as directly comparable estimates because they are derived from different data sources and operational definitions. Table 3 describes the statewide physician workforce, whereas Medicaid claims data identifies providers with at least one observed Medicaid claim and uses the Medicaid population as the denominator. Accordingly, this comparison is best understood as contextual. It indicates that claims-observed Medicaid participation appears broad enough to warrant deeper analysis of geography, service volume, and effective access.

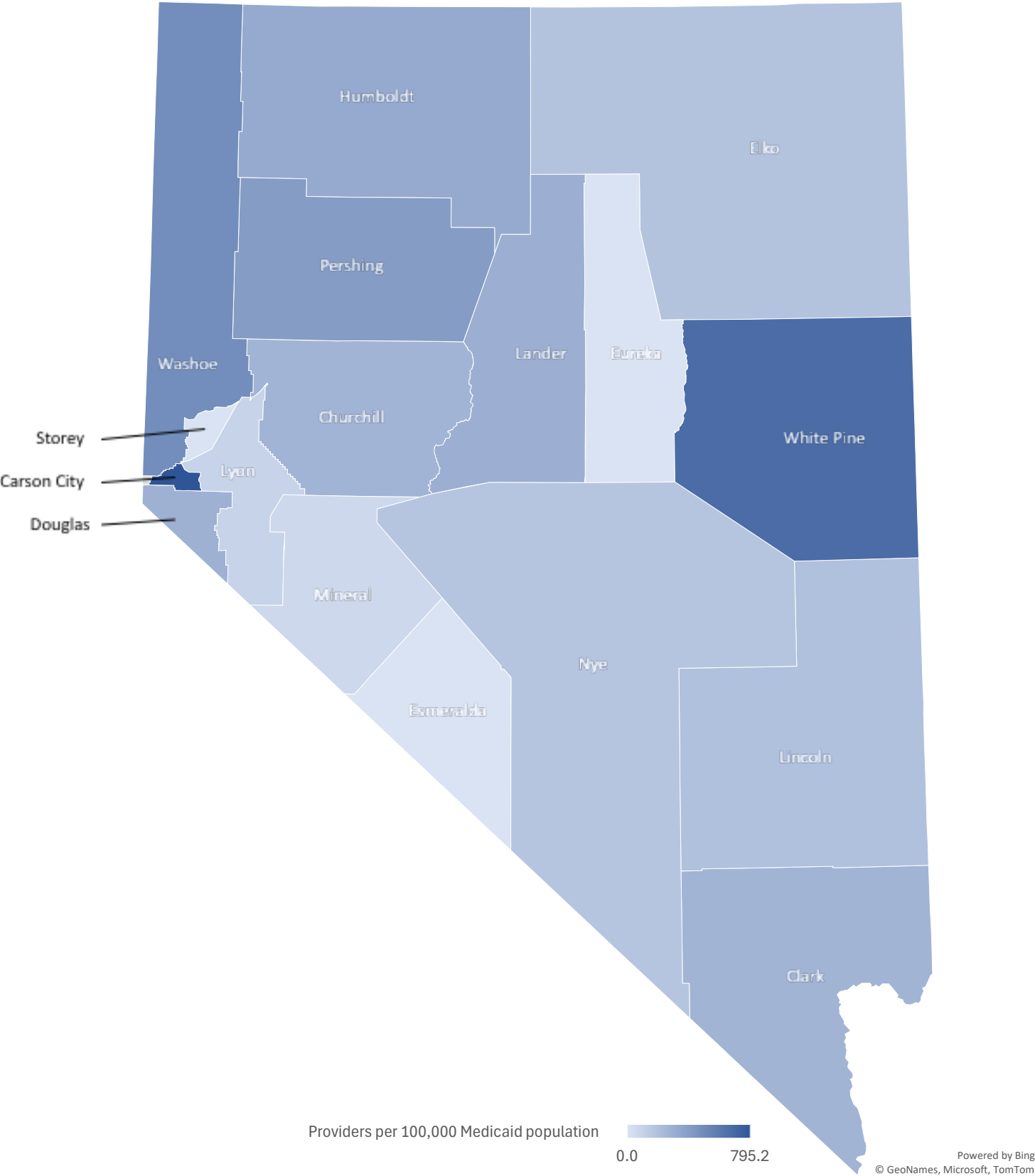
Table 4. *Active Medicaid Primary Care Providers, 2025*

Profession	Active Medicaid Providers	Number per 100,000 Medicaid Population
Family Medicine	910	95.1
General Practice	30	3.1
Internal Medicine	1,148	119.9
Pediatrics	398	108.0
Obstetrics/Gynecology	306	77.0
Geriatric Medicine	7	9.6

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025). Medicaid population is defined as the unique number of members enrolled in Medicaid during the selected timeframe. Family medicine, general practice, and internal medicine utilize the total population and pediatrics is limited to under 18 years old, obstetrics/gynecology is females over 10 years old, and geriatric medicine is individuals over 64 years old.

Additional analyses demonstrate significant geographic disparities, particularly within Clark County, where the largest absolute number of primary care providers and Medicaid beneficiaries reside. Despite this, Clark County has relatively low provider-to-population ratios compared to urban counterparts. Significant variation in access to Medicaid primary care providers exists across counties, consistent with earlier findings.

Figure 9. Medicaid Primary Care Providers per 100,000 Medicaid Population by County, 2025



Source. Nevada Office of Analytics, Medicaid claims data (2025).

Table 5. Location of Primary Care Services Received by Medicaid Recipients, 2025

Provider County	Member County				
	Clark	Washoe	Rural	Southern	Northern
Clark	327,070 (97.7%)	2,626 (6.3%)	604 (9.9%)	4,427 (59.5%)	974 (6.0%)
Washoe	1,082 (0.3%)	37,862 (90.2%)	701 (11.5%)	254 (3.4%)	6,211 (38.6%)
Rural	249 (0.1%)	43 (0.1%)	3,542 (58.2%)	18 (0.2%)	92 (0.6%)
Southern	1,411 (0.4%)	6 (0.0%)	35 (0.6%)	2,421 (32.5%)	17 (0.1%)
Northern	2,133 (0.6%)	936 (2.2%)	213 (3.5%)	158 (2.1%)	8,327 (51.7%)
Out of State	2,703 (0.8%)	521 (1.2%)	995 (16.3%)	163 (2.2%)	489 (3.0%)

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025).

Table 6. Medicaid Primary Care Telehealth Service Utilization, 2025

Region/County	Received Telehealth Services			
	# of Claims	% of Total Claims	# of Patients	% of Total Patients
Clark County	27,057	1%	15,774	4%
Washoe County	2,942	1%	1,301	3%
Rural	114	0%	70	1%
Southern	435	1%	280	4%
Northern	440	0%	195	1%

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025).

Patterns of service utilization suggest that access to primary care is concentrated around regional hubs. While most Medicaid members receive services within their home region, residents of rural and northern counties frequently rely on providers in Washoe county, and some obtain services outside Nevada altogether. These patterns indicate that local provider participation may be limited in many rural and frontier communities.

Evaluating the location of services by both provider and member county further highlights out-of-region travel. In rural areas, nearly 42% of members received services outside of the region, and about 16% received services outside the state. In the southern region, most members received services in Clark County (59%). Similarly, many members from the northern region traveled to Washoe county (39%). Members in the southern and northern areas had relatively low out-of-state service use at 2% and 3% respectively. By comparison only about 2% of Clark County members and 10% of Washoe County members received care outside the region. While out-of-state travel remains relatively low across regions, this likely reflects the nature of primary care utilization rather than adequate access, instead of seeking care across state lines, many may delay or forgo care, or substitute toward urgent care or emergency settings.

Telehealth utilization further suggests that access is concentrated to these regional hubs. Despite persistent workforce shortages and long travel distances, only a small proportion of primary care services were delivered through telehealth across all regions. Some common telehealth-appropriate primary care services include chronic disease follow-up, medication management, and evaluation of low-acuity acute conditions. During the reporting period, about 1% of primary claims were provided via telehealth, and only 1-4% of Medicaid members receiving primary care services used telehealth.

Maternal Health

Table 7 shows the active Medicaid maternal health workforce and large variation across maternal health provider types; to add some context, Medicaid covers approximately 1 in 2 births in the state.³⁰ While Obstetrics/Gynecology has the largest number of Medicaid-participating providers (77 per 100,000 Medicaid enrollees), the availability of higher-risk and specialty maternity care is far more limited. Maternal -fetal medicine has only 26 participating providers statewide (6.5 per 100,000), and perinatal medicine is nearly absent with just two providers. Nurse midwives and neonatologists appear somewhat more available at 14.3 and 15.1 per 100,000, respectively. The relatively high number of neonatologists may reflect the relative prevalence of neonatal intensive care units in southern Nevada. Overall, these figures underscore that Nevada’s maternal health system relies on a small pool of specialists, and the workforce available to Medicaid members, particularly for high-risk pregnancies, is thin.

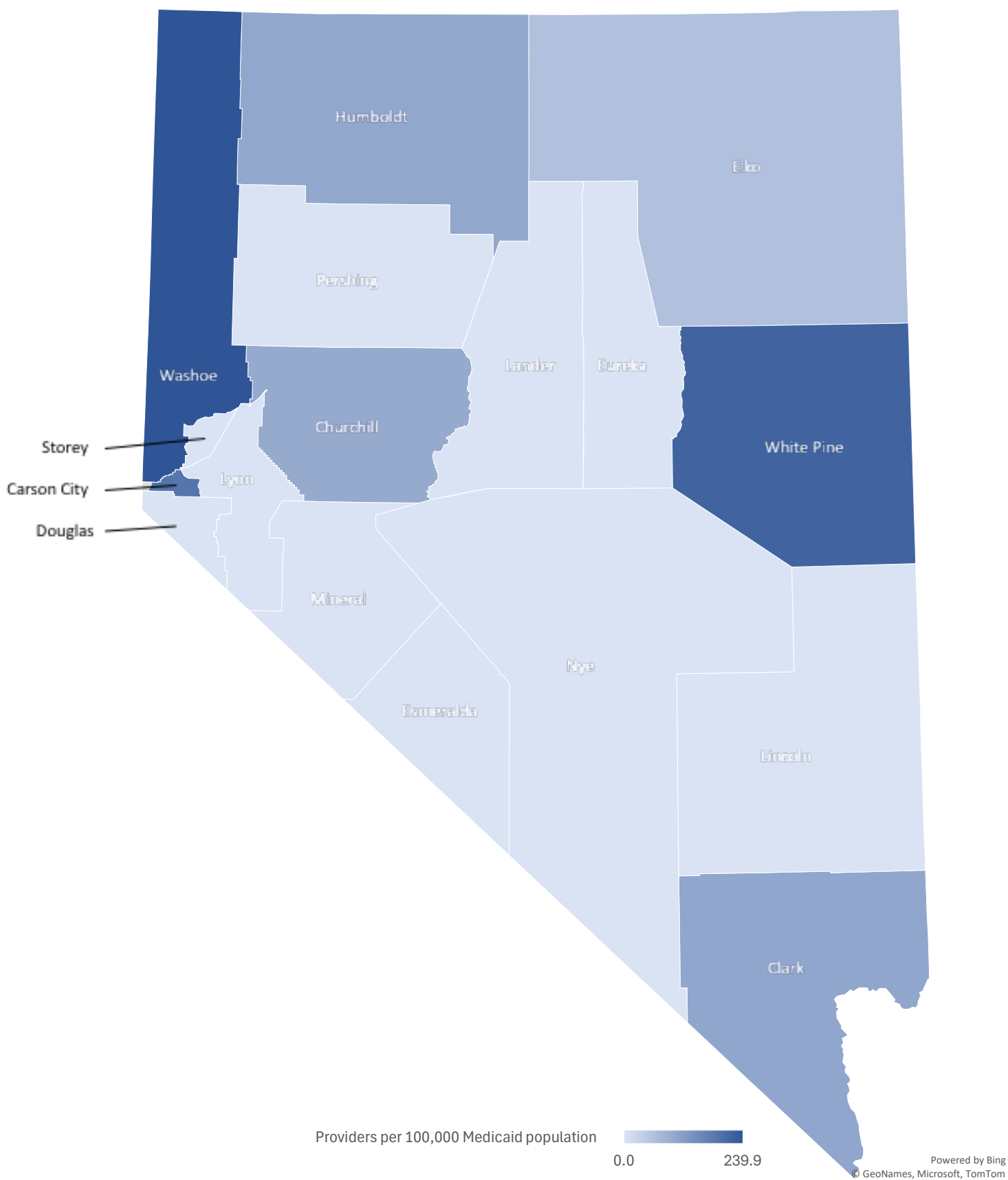
Table 7. Active Medicaid Maternal Health Providers, 2025

Profession	Active Medicaid Providers	Number per 100,000 Medicaid Population
Obstetrics/Gynecology	306	77.0
Maternal Fetal Medicine	26	6.5
Neonatology	60	15.1
Perinatal Medicine	2	0.5
Nurse Midwife	57	14.3

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025). Medicaid population is defined as the unique number of females over 10 years old enrolled in Medicaid during the selected timeframe.

Figure 10 reveals the maldistribution of providers present in the state. Maternal health providers are most highly concentrated in Washoe and White Pine counties and Carson City, followed by Clark, Churchill, Humboldt, and to a lesser degree Elko. The remaining counties in the state demonstrate lower ratios of maternal health providers consistent with the overall finding of provider workforce shortages being experienced most acutely in rural Nevada. There is an interesting pattern across shortage area maps, counties including Elko and White Pine have relatively high provider availability for certain services, but effectively none for others, suggesting that rural communities have selective service capacity that may be based on local hospital infrastructure, provider mix, and patient volume. As a result, patients may be able to obtain certain services locally, while needing to travel for other services.

Figure 10. Medicaid Maternal Health Providers by County, 2025



Source: Nevada Office of Analytics, Medicaid claims data (2025).

Table 8. Location of Maternal Health Services Received by Medicaid, 2025

Provider County	Member County				
	Clark	Washoe	Rural	Southern	Northern
Clark	53,030 (98.6%)	312 (4.9%)	37 (4.3%)	974 (91.8%)	132 (6.0%)
Washoe	409 (0.8%)	5,829 (91.5%)	155 (18.0%)	40 (3.8%)	992 (44.9%)
Rural	0 (0.0%)	0 (0.0%)	342 (39.7%)	3 (0.3%)	0 (0.0%)
Southern	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Northern	6 (0.0%)	28 (0.4%)	20 (2.3%)	20 (1.9%)	852 (38.6%)
Out of State	317 (0.6%)	199 (3.1%)	307 (35.7%)	24 (2.3%)	233 (10.5%)

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025). Member Counts, excluding pharmacy and glasses/contacts/etc. claims

Table 9. Medicaid Maternal Health Telehealth Service Utilization, 2025

Region/County	Received Telehealth Services			
	# of Claims	% of Total Claims	# of Patients	% of Total Patients
Clark County	2,586	1%	1,670	3%
Washoe County	209	1%	147	2%
Rural	10	0%	8	1%
Southern	63	1%	39	3%
Northern	32	0%	23	1%

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025).

Tables 8 and 9 demonstrate notable patterns where Medicaid members actually receive maternity services. More than one-third of rural residents received maternal health services out of state, the highest out-of-state utilization rate among all critical shortage specialties, while only 41 percent of maternal services for rural residents occurred locally. In the Southern region, access was effectively nonexistent, no members received maternal care in their own community, and 92% traveled to Clark County for services.

A similar, but less acute dynamic is observed in the Northern region, where 40% of members received maternal health services locally, while 43% received care in Washoe County, and 11% accessed services out-of-state. Telehealth, which could provide supplemental support in low-capacity regions, remains minimally used across all maternal health services areas, even in counties requiring long-distance travel.

Pediatrics

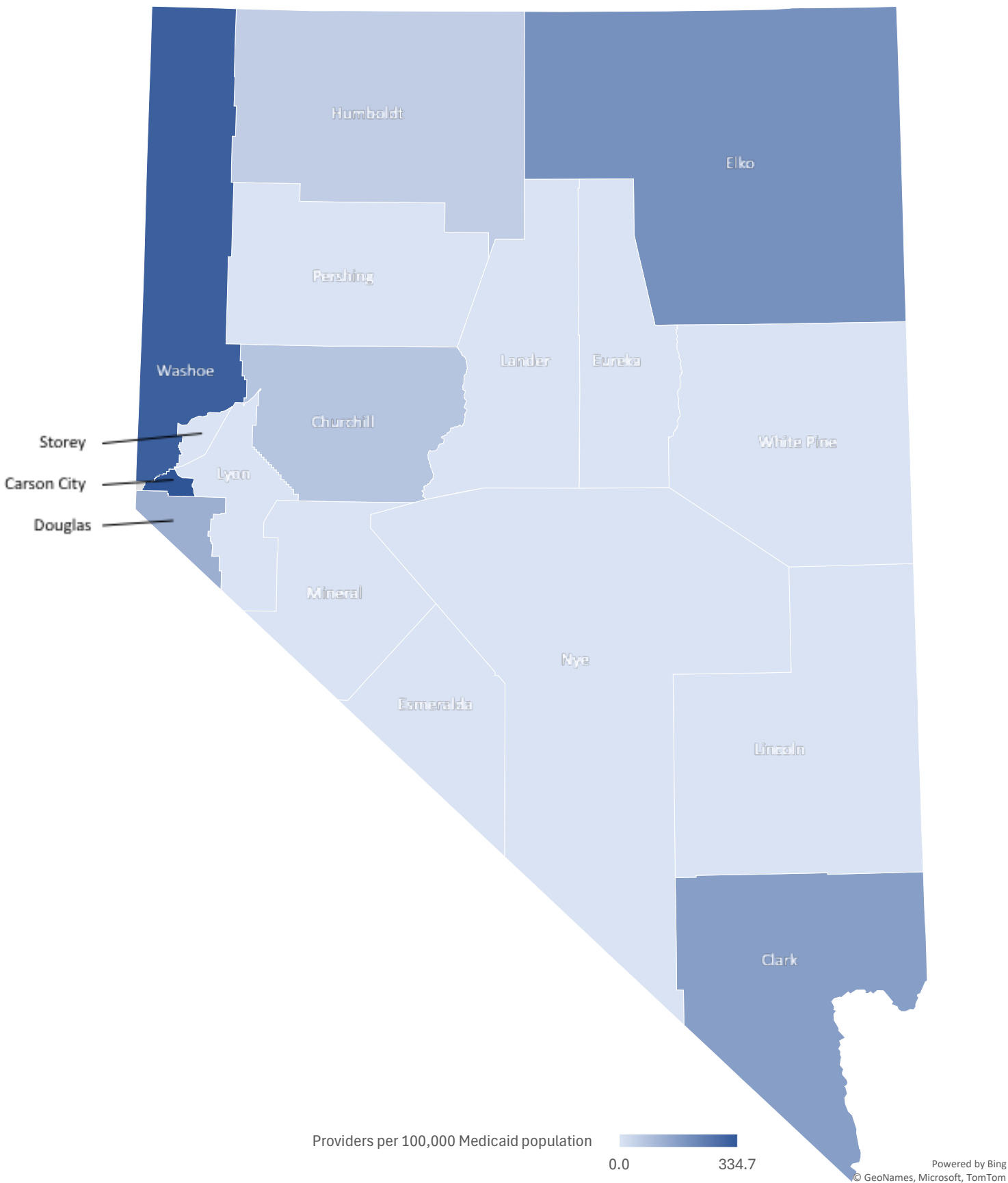
Pediatric provider participation in Nevada Medicaid appears relatively strong when compared with other shortage areas. Nevada Medicaid covers a substantial portion of the state's child population, and in 2025, members had access to 398 pediatricians (108.0 per 100,000), 151 pediatric dentists (41.0), and 79 pediatric specialists (21.4) (Table 10). Although Nevada maintains a modest general pediatric workforce, the supply of pediatric subspecialists, who care for medically complex conditions is limited, indicating a system reliant on a small number of high-demand providers.

Table 10. Active Pediatric Medicaid Providers, 2025

Profession	Active Medicaid Providers	Number per 100,000 Medicaid Population
Pediatrics	398	108.0
Pediatric Dentistry	151	41.0
Pediatric Specialty	79	21.4

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025). Medicaid population is defined as the unique number of youth under 18 years old enrolled in Medicaid during the selected timeframe.

Figure 11. Medicaid Pediatric Providers by County, 2025



Source. Nevada Office of Analytics, Medicaid claims data (2025).

A similar maldistribution is observed when looking at the number of pediatricians per 100,000 Medicaid population. Washoe County and Carson City again exhibit the highest concentration of providers followed by Elko and Clark counties. The central region of the state shows a significantly lower concentration of pediatricians compared to the rest of the state.

Table 11. *Location of Pediatric Services Received by Medicaid, 2025*

Provider County	Member County				
	Clark	Washoe	Rural	Southern	Northern
Clark	178,854 (99.3%)	2,981 (12.2%)	1,114 (26.6%)	2,224 (90.0%)	1,513 (14.4%)
Washoe	189 (0.1%)	20,222 (82.9%)	534 (12.8%)	112 (4.5%)	3,041 (28.9%)
Rural	1 (0.0%)	2 (0.0%)	1,818 (43.4%)	4 (0.2%)	3 (0.0%)
Southern	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Northern	7 (0.0%)	1,064 (4.4%)	36 (0.9%)	33 (1.3%)	5,836 (55.5%)
Out of State	1,141 (0.6%)	129 (0.5%)	684 (16.3%)	99 (4.0%)	124 (1.2%)

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025). Member Counts, excluding pharmacy and glasses/contacts/etc. claims.

Table 12. *Medicaid Pediatric Telehealth Service Utilization, 2025*

Region/County	Received Telehealth Services			
	# of Claims	% of Total Claims	# of Patients	% of Total Patients
Clark County	6,504	1%	4,899	3%
Washoe County	134	0%	108	0%
Rural	7	0%	6	0%
Southern	65	1%	47	2%
Northern	103	0%	68	1%

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025).

Patterns of care utilization are consistent with previous provider types, with the majority of services concentrated within Clark and Washoe Counties (Table 11). Most Medicaid children receive services and care in their communities; however there are some notable trends. Children in northern regions receive care in Washoe, and children in the southern region overwhelmingly receive services in Clark County (90%). Rural residents rely on services provided outside their communities. In addition, a substantial portion of pediatric care is delivered out-of-state, particularly for those in rural areas.

Telehealth utilization for pediatric services remains limited across all regions of the state (Table 12). Between 0-3% of pediatric Medicaid members received telehealth services, accounting for about 0-1% of total pediatric claims. Interestingly, Clark County reported the highest utilization, with rural and frontier regions with very minimal use, despite limited local access and long-travel distances.

Behavioral Health

Behavioral health represents one of Nevada’s most significant challenges. As discussed in the critical shortage identification, Nevada ranks among the lowest states nationally in behavioral health workforce supply and access to care. Within Medicaid, psychiatrists remain in short supply at 24.8 per 100,000 and the availability of clinical psychologists is similarly limited at 13.6 per 100,000. While clinical social workers and marriage and family therapists are more numerous, their supply still demonstrates gaps relative to population need.

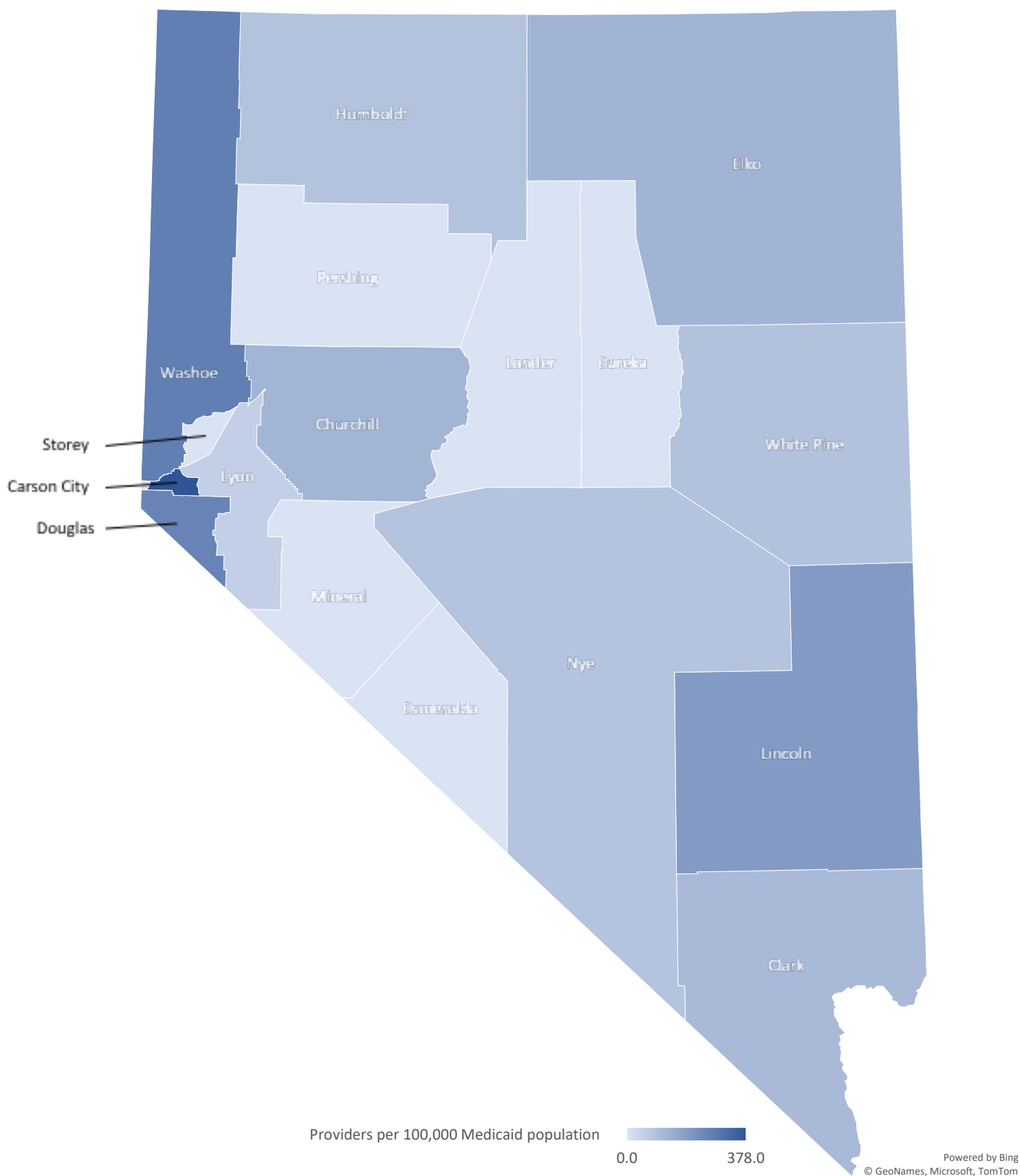
Table 13. *Active Medicaid Behavioral Health Providers, 2025*

Profession	Active Medicaid Providers	Number per 100,000 Medicaid Population
Psychiatrists	237	24.8
Clinical Psychologists	130	13.6
Clinical Social Workers	565	59.0
Marriage and Family Therapists	319	33.3

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025). Medicaid population is defined as the total unique number of individuals enrolled in Medicaid during the selected timeframe.

The distribution of Medicaid behavioral health providers demonstrates substantial variation (Figure 12). Provider concentrations are highest in Clark County, Washoe County, and portions of northeastern Nevada, while much of central and several rural counties demonstrate substantially lower provider density. This pattern mirrors the statewide workforce findings and suggests that access challenges are driven not only by overall provider shortages, but also by the concentration of providers within a limited number of population centers. For many rural and frontier residents, obtaining behavioral health services requires significant travel.

Figure 12. Medicaid Behavioral Health Providers by County, 2025



Source: Nevada Office of Analytics, Medicaid claims data (2025).

Table 14. Location of Behavioral Health Services Received by Medicaid, 2025

Provider County	Member County				
	Clark	Washoe	Rural	Southern	Northern
Clark	51,068 (94.3%)	2,152 (22.1%)	376 (35.2%)	1,643 (70.5%)	874 (20.5%)
Washoe	2,095 (3.9%)	7,091 (72.9%)	182 (17.0%)	51 (2.2%)	1,340 (31.5%)
Rural	128 (0.2%)	11 (0.1%)	271 (25.4%)	9 (0.4%)	23 (0.5%)
Southern	106 (0.2%)	1 (0.0%)	24 (2.2%)	593 (25.4%)	16 (0.4%)
Northern	295 (0.5%)	376 (3.9%)	176 (16.5%)	33 (1.4%)	1,978 (46.5%)
Out of State	484 (0.9%)	100 (1.0%)	39 (3.7%)	2 (0.1%)	25 (0.6%)

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025). Member Counts, excluding pharmacy and glasses/contacts/etc. claims

Table 15. Medicaid Behavioral Health Telehealth Service Utilization, 2025

Region/County	Received Telehealth Services			
	# of Claims	% of Total Claims	# of Patients	% of Total Patients
Clark County	81,382	11%	15,026	28%
Washoe County	10,576	10%	2,264	25%
Rural	1,007	11%	265	26%
Southern	1,623	6%	334	15%
Northern	4,679	10%	1,046	26%

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025).

The Medicaid observation of middling concentration of behavioral health providers in Clark County is consistent with the acute gap observed in broader workforce data described earlier in this report. However, despite the gaps, members in Clark County are generally not traveling, with 94% of them receiving behavioral health services in Clark County. This suggests an already strained local provider network that is seeing an influx of thousands of members from other regions.

Telehealth services for behavioral health providers are significantly higher than for the other critical shortage areas. This is consistent with national trends and the well-established history of telehealth utilization among behavioral health specialties. Whereas the Southern region had a relatively higher utilization of telehealth services for maternal health, it demonstrates a lower utilization rate than the other regions for behavioral health services. This may be balanced by the relatively high concentration of behavioral health providers observed in southern rural counties as 25% of members from the Southern region are able to receive care in this region, second only to primary care at 33% and the majority of the rest receiving services in Clark County. Overall, these rates still suggest that significant travel is required for individuals in the Southern region to receive services. Likewise, 25% of members in the Rural region received behavioral health services in their region but showed a greater dispersion across the state with 35% of members receiving services in Clark County, 17% in Washoe County, 16% in the Northern region, 4% out of state, and 2% in the Southern region.

Medical Specialties

Medical specialties represent a broad group of providers responsible for managing many of the chronic and complex conditions that contribute most significantly to morbidity, mortality, and health care spending. Table 16 presents the active Medicaid medical specialists' workforce across five specialty groupings. Surgical specialists comprise the largest group (701; 73.2 per 100,000), followed by cardiovascular (205; 21.4), gastroenterology (113, 11.8), oncology (77, 8.0), Endocrinology (43, 4.5). As Nevada's population continues to grow and age, demand for specialty care is expected to increase, particularly for chronic disease, cancer, diabetes, and cardiovascular conditions.

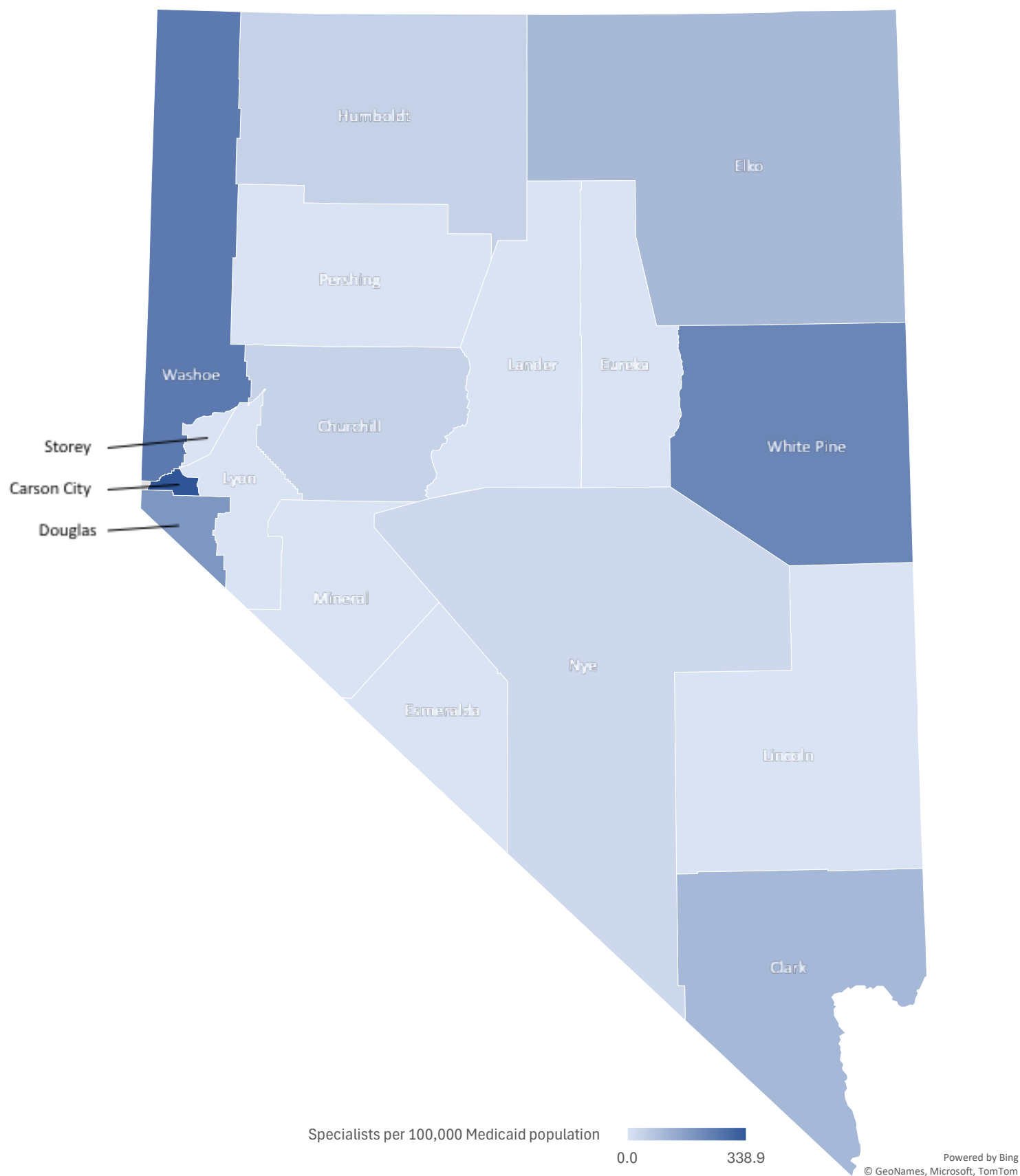
Table 16. *Active Medicaid Medical Specialists, 2025*

Profession	Active Medicaid Providers	Number per 100,000 Medicaid Population
Cardiovascular	205	21.4
Endocrinology	43	4.5
Gastroenterology	113	11.8
Oncology	77	8.0
Surgical	701	73.2

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025). Medicaid population is defined as the total unique number of individuals enrolled in Medicaid during the selected timeframe.

The geographic distribution of Medicaid medical specialists demonstrates a familiar pattern of concentration in Nevada's urban counties (Figure 13). Provider density is highest in Clark County, Washoe County, and Carson City, while much of central Nevada and several rural and frontier counties exhibit substantially lower concentrations of specialists. Compared with primary care and behavioral health, specialty services are often more centralized due to equipment, staffing, and infrastructure requirements. However, this concentration may create significant access barriers for rural residents who require ongoing specialty care, frequent follow-up visits, or complex treatment regimens.

Figure 13. Medicaid Medical Specialists by County



Source. Nevada Office of Analytics, Medicaid claims data (2025).

Table 18. Location of Medical Specialist Services Received by Medicaid Members

Provider County	Member County				
	Clark	Washoe	Rural	Southern	Northern
Clark	117,033 (98.7%)	289 (1.6%)	139 (4.6%)	2,982 (75.2%)	279 (2.9%)
Washoe	251 (0.2%)	16,081 (90.8%)	1,115 (36.7%)	236 (6.0%)	4,625 (47.5%)
Rural	234 (0.2%)	18 (0.1%)	825 (27.2%)	15 (0.4%)	12 (0.1%)
Southern	116 (0.1%)	2 (0.0%)	0 (0.0%)	504 (12.7%)	0 (0.0%)
Northern	97 (0.1%)	875 (4.9%)	61 (2.0%)	129 (3.3%)	4,329 (44.4%)
Out of State	790 (0.7%)	446 (2.5%)	898 (29.6%)	98 (2.5%)	501 (5.1%)

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025). Member Counts, excluding pharmacy and glasses/contacts/etc. claims

Table 17. Medicaid Medical Specialties Telehealth Service Utilization

Region/County	Received Telehealth Services			
	# of Claims	% of Total Claims	# of Patients	% of Total Patients
Clark County	3,076	0%	2,049	2%
Washoe County	226	0%	192	1%
Rural	59	1%	39	2%
Southern	148	1%	109	3%
Northern	196	0%	146	2%

Source. Nevada Office of Analytics, *Medicaid Claims Data*. (2025).

Patterns of care utilization are consistent with earlier findings and suggest reliance on major urban centers (Table 18). Significant numbers of Medicaid members in the Rural, Southern, and Northern region are traveling outside of their region for critical shortage provider care. The Southern region appears to be the most heavily impacted, often traveling to Clark County to receive care while individuals from the Rural region appear to travel more broadly. These findings are consistent with the overall licensed physician workforce findings discussed earlier in the report and reinforce the evidence of significant gaps in providers, maldistribution, and strain on access hubs.

Telehealth utilization among medical specialists remains limited relative to behavioral health services (Table 17). Across regions, telehealth accounted for about 0-1% of specialist claims and only 1-3% of specialty patients. These findings likely reflect the nature of specialty care, which frequently requires in-person diagnostic testing, imaging procedures, infusions, or physical exams. While telehealth may support consultation, follow-up care, and care coordination, it appears to be playing a more limited role.

Discussion

Statewide Undersupply

Nevada's workforce assessment reveals broad, structural shortages across nearly every major provider category, with the most significant deficits concentrated in primary care, behavioral health, maternal and child health, nursing, allied health professions, and selected medical specialties. These shortages are reflected not only in workforce supply measures, but also in Nevada's performance on national indicators of access, quality, prevention, and health outcomes.^{27,28} Together, the findings suggest that workforce shortages are not isolated profession-specific challenges, but system-level constraints that affect access to care, chronic disease management, care coordination, and population health.

While shortages are widespread, the pattern of those shortages is not uniform. Nevada appears closer to national benchmarks in professions tied to acute, procedural, and hospital-based care including anesthesiology, emergency medicine, pain medicine, and physical medicine and rehabilitation. However, large deficits remain in many specialties and in the professions most central to preventive, longitudinal, behavioral health, maternal and child health, and community-based care. This imbalance reflects a system that is comparatively better equipped to respond to acute needs than to provide preventive, behavioral, and chronic care services necessary to manage disease, reduce unnecessary utilization, and improve long-term outcomes. The consequences of this imbalance may be reflected in broader measures of health care access and utilization. Nevada ranks among the lowest states in the percentage of adults with a usual source of care (79.7%) and in the percentage who report visiting a doctor or health care provider in the past year (78.9%).³¹ A substantial share of adults also reports having no personal health care provider (26.8%).³² Limited access to routine and preventative care may contribute to delayed diagnosis and treatment, greater reliance on emergency departments, and missed opportunities to manage chronic disease and behavioral health conditions. Consistent with this pattern, a large and rising share (19.2%) of Nevadans reported visiting an emergency department in the past year, while the state performs poorly on measures of chronic disease prevalence (26.7%), pre-existing conditions (41.6%), unhealthy days in the past month (9.3), and suicide mortality (20.3 per 100,000).^{31–33} While workforce shortages are not the sole driver of these outcomes, the concentration of deficits suggests they may be an important contributing factor.

Statewide Challenges

While workforce shortages are statewide, it does not present in the same way everywhere, nor should it be addressed in the same way. Clark County consistently falls below state and national benchmarks across several provider types despite having the largest absolute number of clinicians. In urban settings, shortages often lead to delayed care and appear as long wait times, limited appointment availability, bottlenecks for services, and insufficient capacity rather than an absence of service.

In contrast, rural and frontier communities face different constraints. Small populations, long distances, and limited infrastructure make it impractical to sustain many specialty services locally. The findings support a tiered, regionalized approach to workforce planning that aligns services with what can be realistically and sustainably delivered at the local, regional, and centralized levels.

Research on rural health systems increasingly supports hub-and-spoke models of care, where essential services are available locally while higher-acuity and lower-volume services are concentrated in regional referral centers.^{34–36} Similar approaches are widely used in trauma systems, perinatal care, and other specialized services where outcomes improve when expertise and resources are concentrated.^{37,38}

Under this framework, communities should have access to essential services locally, such as primary care, behavioral health, emergency medical services, public health, nursing, care coordination, and basic rehabilitative services. These functions derive much of their value from proximity, continuity, and timely access.

Regional referral centers serving multi-county catchment areas can provide services that are difficult to sustain in every community, such as specialized obstetric care, emergency medicine, diagnostic imaging, specialty clinics, and selected behavioral health and chronic disease services.

Centralized or shared statewide capacity, primarily located in Reno or Las Vegas, can support highly specialized, low-volume services such as oncology, maternal-fetal medicine, pediatric subspecialties, neonatology, neurosurgery, and other complex specialty care. This approach strengthens access while recognizing that not every service can or should be replicated in every community.

Importantly, telehealth, remote patient monitoring, mobile clinics, and other emerging care modalities can help extend specialty expertise across distances, bridging gaps between local and regional access points as appropriate.

Nursing and Allied Health as Cross Cutting Priorities

Nursing and allied health professions represent some of Nevada's largest workforce gaps. Registered nurses, licensed practical nurses, certified nursing assistants, therapists, pharmacists, dietitians, and other allied health professionals support nearly every component of the healthcare system.

In many settings, workforce constraints are driven by shortages of nursing and allied health professionals as by physician shortages. Hospitals cannot expand capacity without nurses. Behavioral health programs depend on counselors, social workers, and care coordinators. Rehabilitation, chronic disease management, maternal health services, and cancer care all rely on multidisciplinary teams.

Implications

Taken together, the findings support several guiding priorities for Nevada's workforce strategy:

- Prioritize workforce investments in areas with the highest gaps and greatest potential population health impact, particularly primary care, behavioral health, maternal and child health, nursing, allied health, and chronic disease specialties.
- Ensure every community has access to essential local services, including primary care, behavioral health, nursing, EMS, and care coordination.
- Expand regional specialty capacity in Washoe County, Clark County, and other regional referral centers serving large catchment areas.
- Strengthen centralized, high-complexity specialty lines that Nevada must maintain at the state level to reduce outward migration of care.
- Grow and retain the nursing and allied health pipeline, which is essential for system stability and for enabling team-based care models.
- Leverage telehealth, specialist consultation, and regional partnerships to extend expertise into underserved communities.
- Continue improving workforce data and planning capacity to support evidence-based investment decisions.

These findings provide a framework for the recommendations that follow and support a workforce strategy that balances local access, regional capacity, and statewide specialty resources to meet Nevada's current and future health care needs.

Limitations

This assessment has several important limitations that should be considered when interpreting findings. First, workforce estimates were derived from multiple data sources that measure different aspects of the workforce supply. Employment data reflects providers actively employed in Nevada but may not capture all practicing providers, particularly in small practices or non-traditional settings. Conversely, licensure data capture all individuals holding an active license but do not distinguish between full-time and part-time practice, active or inactive practice, or providers who maintain a Nevada license while practicing primarily elsewhere. As a result, licensure counts may overestimate the workforce available to provide care.

Second, the assessment primarily relies on headcounts rather than full-time equivalent (FTE) measures. Headcounts do not account for variation in hours worked, clinical effort, administrative responsibilities, telehealth practice, or

retirement transitions. The workforce capacity may differ from the number of licensed or employed providers reported. Future assessments should explore methods to estimate effective workforce capacity where feasible.

Additionally, provider supply does not necessarily equate to provider availability. Workforce counts don't capture appointment availability, wait times, Medicaid participation, panel capacity, geographic accessibility, or other factors that influence whether people can receive timely care. Similarly, provider-to-population ratios can't fully measure differences in patient complexity, disease burden, or service utilization patterns across communities.

Further, Medicaid claims analyses reflect services delivered to Medicaid members and should not be interpreted as representing the entire Nevada health care workforce. Providers who serve predominantly commercial, Medicare, Veterans Affairs (VA), Indian Health Service, or other populations may be underrepresented. However, Medicaid claims provide valuable insight into the workforce actively serving one of Nevada's largest and most vulnerable populations.

Finally, workforce assessments represent a snapshot in time. Health care labor markets are dynamic and influenced by a variety of factors, like population growth, economic conditions, educational pipelines, policy changes, reimbursement, and emerging care delivery models. Workforce needs and shortages may evolve over time and should be monitored through ongoing assessments.

Future Research

This assessment establishes a foundation for a more comprehensive and longitudinal workforce planning infrastructure in Nevada. Future work should align and coordinate ongoing efforts while expanding methods to capture not only provider supply but also workforce capacity, distribution, utilization, and access. These additional measures will support more accurate assessments of community needs and help guide resource allocation.

Future assessments should also aim to inform strategic priorities across workforce development programs, including the Rural Health Transformation Project initiatives, the Statewide Health Care Access and Recruitment Program, Graduate Medical Education, and others, to ensure Nevada is advancing a cohesive and unified statewide workforce strategy.

Several opportunities should be explored further. Future work should integrate population health needs and develop need-based demand modeling so that identified gaps reflect what is needed in the community, rather than rely solely on raw provider counts. Expanded measures of access, such as appointment availability, wait times, provider panel capacity, Medicaid participation, and travel burdens, would further refine understanding of where access challenges are most acute. Full-time equivalent (FTE) data where feasible to capture providers working full-time or part-time or who have an active license but don't actively practice. Continued analysis of workforce aging, retirement risk, education pipelines, recruiting patterns, and workforce retention to help identify emerging shortages before they become critical.

Future assessments may also benefit from expanded analyses of specialty specific workforce needs, including oncology, behavioral health, maternal and child health and other areas identified as strategic priorities. Finally, as telehealth and new care delivery models continue to evolve, additional research is needed to understand how technology, regional referral networks, and team-based care models can most effectively improve access while supporting a sustainable workforce.

Conclusion

Nevada faces significant shortages across the health care workforce spectrum, with the most acute gaps in primary care, behavioral health, maternal and child health, nursing, allied health professions, and several medical specialties. Yet these challenges also create a meaningful opportunity. With dedicated initiatives such as the Statewide Health Care Access and Recruitment Program strengthening urban access and regional hubs, the Rural Health Transformation

Program expanding rural and frontier capacity, and Graduate Medical Education (GME) programs working to train and retain providers, the state has an opportunity to build a more resilient, sustainable, and equitable health care system that keeps care closer to home and improves health outcomes across Nevada.

Recommendations

The recommendations below make up the prioritized list, and reflect the priorities identified as the most important in addressing Nevada's health care workforce needs. These recommendations were prioritized based on their potential to address documented workforce shortages, feasibility of implementation, and alignment with statewide initiatives. They are presented by thematic area for clarity and are not ranked in any particular order.

Education and Training

Career Pathways Programs

Structured and connected education programs and support services that enable students to advance over time to better jobs and high levels of education and training.

- Build grow-your-own pathways, recruiting and training students from rural, underserved, and underrepresented communities who are more likely to practice locally.^{19,39}
- Create stackable credential and career ladders, for instance Iowa's "ladder program" in nursing creating a pathway to becoming a Licensed Practical Nurse (LPN), then advancing to the next level from an LPN to an associate's degree in nursing, then on to becoming a RN.⁴⁰
- Fund K-12 programs to increase health career academic, dual-enrollment, and pre-health exposure.
- Expand apprenticeships and earn-while-you-learn models, such as Washington's apprenticeship program from certified nursing assistants and home care aides to becoming an LPN.⁴⁰
- Strengthen community college and technical training programs to provide students with transferable credits to further their education or gain advanced credentials, such as Good Jobs Hawaii providing free skills training to local residents for professions such as a certified nurse aide, mental health tech, EKG tech certification, etc.⁴⁰
- Develop partnerships across stakeholders to help with job placement and transitions to practice.

Health Professions Education Pathways

Expand the capacity to train the health care workforce across professions and specialties including faculty, preceptors, and training sites.

- Expand enrollment and seats or establish programs in high-need professions such as nursing, physicians assistants, behavioral health, and allied health.
- Leverage the Western Interstate Commission on Higher Education to fund training in professions the state doesn't have or doesn't have enough capacity with return-to-serve obligations.⁴¹
- Develop continuing medical education opportunities for providers for upskilling, for instance developing competencies for primary care providers in underserved areas to provide appropriate behavioral health interventions.⁴²
- Address faculty and preceptor shortages through strategies such as loan repayment, salary support, stipends, or other incentives to grow the supply of instructors.⁴³
- Develop community-based training and rotation sites located at federally-qualified health centers (FQHCs), Rural Health Centers (RHCs), rural hospitals, tribal clinics, and behavioral health settings.^{19,44}

Graduate Medical Education (GME)

Expand funding for physician residency and fellowship training targeted toward shortage areas.

- Increase the number of state-funded residency/fellowship positions, prioritizing specialties and regions where Nevada is most undersupplied.⁴⁵
- Expand rural and community-based training, fund rural training tracks and require rotations through rural areas, and primary care sites.
- Include non-physician professions, extending funding to advanced practice providers, covering residencies, clinical training and rotations through state funded GME.⁴⁶
- Tie funding to desired outcomes, such as in-state practice, or on HPSA or medical underserved areas (MUA), or on programs serving Medicaid and underserved populations.

Recruitment, Retention, and Practice Flexibility

Attract providers to Nevada, support their long-term retention, and modernize regulatory and administrative frameworks to promote practice flexibility, reduce burnout, and sustain a healthy, stable workforce.

- Expand financial incentives such as loan repayment, scholarships, service obligations for high-need specialties and locations.⁴⁷
- Streamline facility and payer credentialing and enrollment.
- Expand evidence-based scope of practice.⁴⁸
- Reduce clinician burden by supporting provider well-being and reducing administrative burdens.⁴⁹
- Expand licensure portability to increase reciprocity, multistate, and telehealth practice.^{50,51}
- Address cost-of-living barriers, for instance, homeownership and housing assistance for health professionals, similar programs have been developed through the Home is Possible for Teachers program.⁵²

Innovative Care Models and Technology

Team and Community-Based Care Models

Expanding evidence-based team and community-based care approaches that expand and extend care capacity, improve coordination.

- Support team-based care models that extend provider reach and improve care coordination.
- Increase the use of Community Health Workers, Peer Specialists, Social Workers, and other community-embedded roles to extend the reach of primary care and behavioral health services, particularly in underserved areas.⁵³
- Integrate behavioral health into primary care and other routine settings to improve access and reduce fragmentation.⁵⁴
- Expand community paramedicine and mobile health programs that enable trained personnel and mobile teams to deliver preventive, urgent, and follow-up care outside traditional facilities.

Technology

Adopt digital tools and technology supported care models to enhance access, reduce administrative burden, and support more efficient clinical workflows.

- Expand telehealth, tele-supervision, and virtual care infrastructure across specialties and regions.
- Increase remote patient monitoring for earlier intervention, chronic disease management for digital monitoring.
- Develop eConsult system that enables providers to get timely specialist input.⁵⁵

- Leverage emerging technologies, including automation and artificial intelligence, in appropriate and evidence-informed ways to reduce administrative burden and streamline clinical workflows.
- Modernize digital workflows and IT systems to improve efficiency and interoperability.

Payment and Participation

Align payment and participation policies to support sustainable practice models and improve access and provider engagement across settings.

- Reduce administrative burden to encourage provider enrollment and retention in Medicaid.
- Support payment models that incentivize primary care, prevention, and integrated behavioral health.
- Invest in value-based and population-based payment approaches that sustain team-based and care-coordination functions.⁵⁶

Data Systems and Workforce Planning

Foundational infrastructure directing statewide healthcare workforce development strategy.

- Support the development of and build a provider workforce data system capturing licensed and actively practicing providers, FTE/clinical hours, specialty, and practice location.
- Link provider participation to claims and outcomes data to determine population need rather than relying on headcounts alone.
- Define health care regions to inform targeted resource allocation based on local, regional, and centralized need.⁵⁷
- Reduce duplication and fragmentation across agencies, boards, universities, and programs.
- Develop a unified statewide health workforce strategy to focus limited state resources, set shared priorities and leverage cross-agency expertise.²²

Certified Areas of Need

Pursuant to Section 9 of SB 5, and based on the findings of this assessment, the Nevada Health Authority determines the most critical shortages in the health care workforce of this state include:

Health Care Professions

Primary Care Providers

Family medicine, internal medicine, pediatrics, geriatrics, nurse practitioners, physician assistants, other primary care providers essential to preventive care, chronic disease management and care coordination.

Behavioral Health Providers

Psychiatrists, child and adolescent psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, and other behavioral health providers necessary to improve timely access to mental health and substance use treatment.

Maternal, Infant, and Child Health Providers

OB/GYNs, mental-fetal medicine, pediatricians, pediatric subspecialists, certified nurse midwives, and other providers essential to improving maternal and child health outcomes.

Medical Specialties

High-need medical specialties including cardiology, oncology, neurology, endocrinology, pulmonology, gastroenterology, and related specialties that improve in-state capacity for managing complex and chronic conditions.

Nursing and Allied Health Professionals

Registered nurses, licensed practical nurses, nursing assistants, therapists, and other allied health workers are essential to system capacity across all care settings.

Geographic Areas

Rural and Frontier Communities

Experience the most significant shortages in essential workforce capacity, particularly in primary care, behavioral health nursing, emergency medical services, and other foundational providers.

Urban Shortages in Health Professional Shortage Areas and Medically Underserved Areas

Demonstrate significant unmet need for primary care, behavioral health, and other essential health care services.

Regional and Centralized Shortages

Require workforce capacity and expertise to provide specialty services supporting surrounding rural and frontier communities, and sustained investment in high-complexity specialties including oncology, pediatric subspecialties, and other professions most effective in regional care models.

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Appendix

Physician Specialty Groupings

Family Medicine/General Practice

Pediatrics

- Pediatrics
- Neonatal-Perinatal Medicine
- Pediatric Critical Care Medicine
- Pediatric Anesthesiology (Anesthesiology)
- Pediatric Emergency Medicine (Pediatrics)
- Internal Medicine/Pediatrics

Pediatric Cardiology

Obstetrics and Gynecology

Psychiatry

Child and Adolescent Psychiatry

Allergy and Immunology

Internal Medicine

- Internal Medicine
- Nephrology
- Infectious Disease
- Rheumatology
- Clinical Cardiac Electrophysiology
- Interventional Cardiology
- Hospice and Palliative Medicine
- Sports Medicine
- Endocrinology, Diabetes, and Metabolism
- Geriatric Medicine

Neurology

- Neurology
- Clinical Neurophysiology

Pulmonary Disease

- Pulmonary Disease
- Critical Care Medicine

Emergency Medicine

Anesthesiology

Preventive Medicine

Radiology

- Radiology and Diagnostic Radiology
- Neuroradiology
- Vascular and Interventional Radiology

Radiation Oncology

Pain Medicine and Pain Management

Dermatology

Physical medicine and Rehabilitation

Cardiovascular Disease

Gastroenterology

Pathology

General Surgery

- General Surgery
- Surgical Critical Care (Surgery)

Ophthalmology

Orthopedic Surgery

- Orthopedic Surgery
- Sports Medicine (Orthopedic Surgery)

Urology

Otolaryngology

Plastic Surgery

Neurological Surgery

Thoracic Surgery

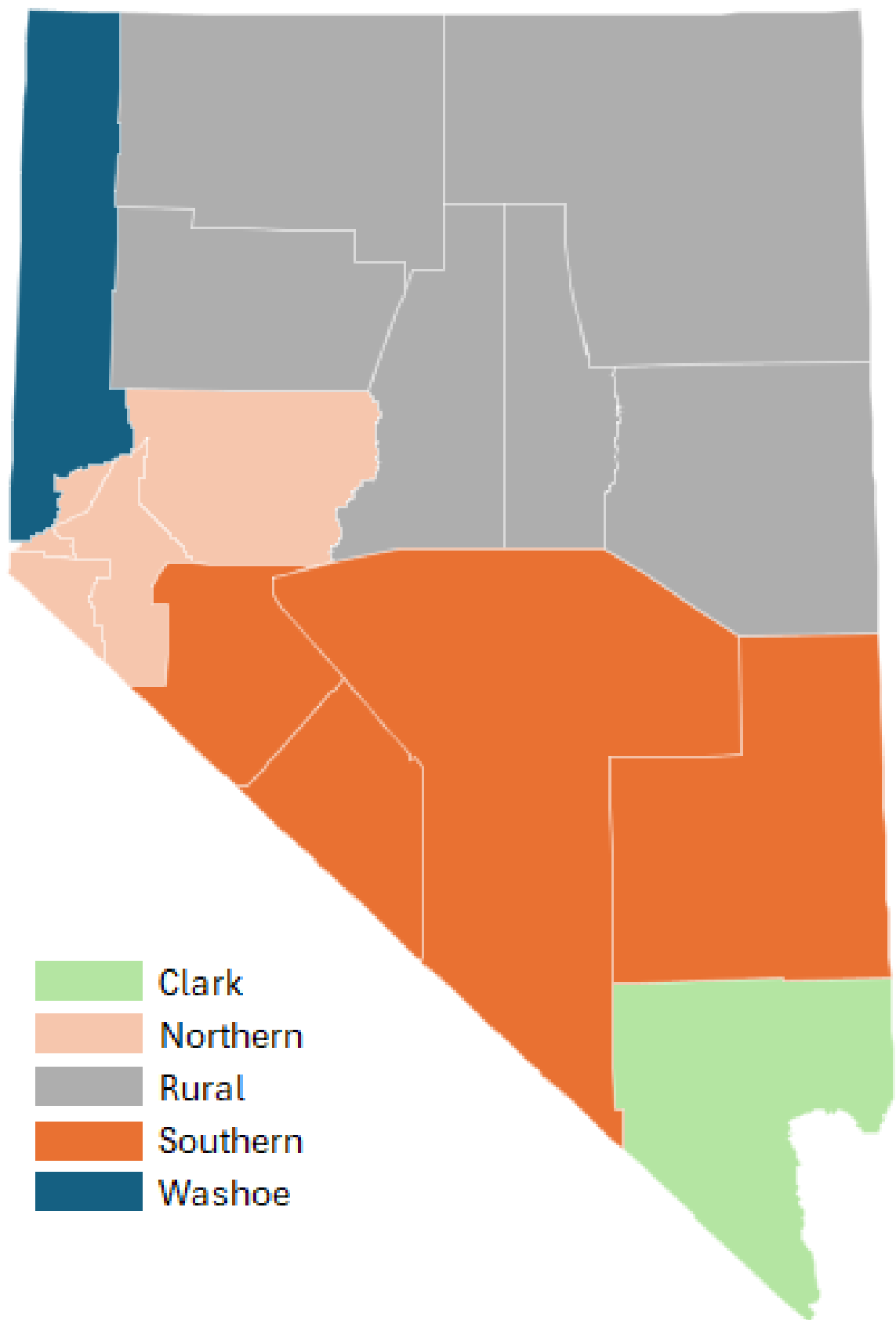
Vascular Disease

Hematology and Oncology

- Hematology and Oncology
- Pediatric Hematology and Oncology

Source: Groupings are based on AAMC groupings from Nicole Mwalili, MPH, Tabor Griswold, PhD, John Packham, PhD, et al. Physician Workforce in Nevada

Figure 14. Study Regions



Source. Nevada Office of Analytics, Behavioral Health Regions, (2026).