

# **Nevada Rural Health Plan**

**Revised Edition**

**April 2008**

**Prepared by the:**

**Nevada Flex Program Advisory Committee  
Nevada Rural Hospital Flexibility Program  
(Nevada Flex Program)**

**Copyright © 2008 Nevada Office of Rural Health**



# **Nevada Rural Health Plan**

**Revised Edition**

**April 2008**

**Prepared by the:**

**Nevada Flex Program Advisory Committee  
Nevada Rural Hospital Flexibility Program  
(Nevada Flex Program)**

**Contact Information:**

**John Packham, PhD  
Director, Nevada Rural Hospital Flexibility Program  
Nevada Office of Rural Health  
Center for Education and Health Services Outreach  
University of Nevada School of Medicine  
411 West Second Street / Mailstop 348  
Reno, Nevada 89503-5308  
Phone: (775) 784-1235 / Fax: (775) 784-1137  
[jpackham@medicine.nevada.edu](mailto:jpackham@medicine.nevada.edu)**

**Copyright © 2008 Nevada Office of Rural Health**



# Nevada Rural Health Plan

Revised Edition

April 2008

## — Table of Contents —

SECTION	Page
TABLE OF CONTENTS .....	i
NEVADA FLEX PROGRAM ADVISORY COMMITTEE .....	iii
ABBREVIATIONS USED IN THE NEVADA RURAL HEALTH PLAN .....	iv
<b>I OVERVIEW .....</b>	<b>1</b>
A. Background .....	1
B. Nevada Rural Hospital Flexibility Program .....	2
<b>II HEALTH AND HEALTH CARE IN RURAL AND FRONTIER NEVADA .....</b>	<b>5</b>
A. Social and Demographic Profile of Rural and Frontier Nevada .....	6
B. Population Health Profile of Rural and Frontier Nevada .....	8
C. Health Care Workforce in Rural and Frontier Nevada .....	8
D. Health Care Resources in Rural and Frontier Nevada .....	11
<b>III HEALTH CARE POLICY AND STRATEGIC PLANNING FOR RURAL AND FRONTIER NEVADA .....</b>	<b>17</b>
A. Major Rural and Frontier Health Care Policy Issues in Nevada .....	17
B. Nevada’s Current Statewide Strategic Plan for Rural Health Care .....	19
C. The Role of the Nevada Flex Program in Strategic Health Care Planning and Development in Nevada .....	23

---

<b>IV</b>	<b>CRITICAL ACCESS HOSPITAL DESIGNATION IN NEVADA .....</b>	<b>26</b>
	<b>A. Description of the Application Process .....</b>	<b>26</b>
	<b>B. State of Nevada Designation Process .....</b>	<b>29</b>
	<b>C. Criteria for Application Review .....</b>	<b>29</b>
	<b>D. Public Understanding of the Process .....</b>	<b>30</b>
	<b>E. Monitoring and Evaluation .....</b>	<b>31</b>
	<b>F. Conclusion – Critical Access Hospital Designation in Nevada .....</b>	<b>31</b>
<b>V</b>	<b>CONCLUSION: THE FUTURE OF HEALTH CARE IN RURAL NEVADA .....</b>	<b>32</b>
<b>VI</b>	<b>APPENDICES .....</b>	<b>33</b>
	<b>APPENDIX 1: Health and Health Care in Rural and Frontier Nevada</b>	
	<b>APPENDIX 2: Information on Critical Access Hospitals, Hospitals Eligible for CAH Designation, and Communities that Plan to Build Acute Care Hospitals in Rural Nevada</b>	
	<b>APPENDIX 3: Preliminary Application for Eligibility Determination for the Nevada Critical Access Hospital Program (2 pages)</b>	

---

# Nevada Flex Program Advisory Committee

## Nevada Rural Hospital Flexibility Program

Gerald Ackerman  
Director, Northeastern Nevada AHEC

Robin Keith  
President, Nevada Rural Hospital Partners

Diane Allen  
Health Facilities Surveyor & Chief Nurse  
Nevada Bureau of Licensure and Certification

Rick Kilburn  
CAH Administrator/CEO  
William Bee Ririe Hospital

Steve Boline  
Regional Chief Financial Officer  
Nevada Rural Hospital Partners

Fergus Laughridge  
EMS Supervisor  
Nevada Bureau of Licensure and Certification

Gerry Conley  
CAH Administrator/CEO  
Carson Valley Medical Center

Tom Maher  
CAH Administrator/CEO  
Boulder City Hospital

Susan Conley  
CAH Administrator/CEO  
Mesa View Regional Hospital

Rich Munger  
CAH Administrator/CEO  
Mt. Grant General Hospital

Susan Davila  
CAH Administrator/CEO  
Desert View Regional Medical Center

John Packham  
Director, Nevada Flex Program  
Nevada Office of Rural Health

Caroline Ford  
Director, Nevada Office of Rural Health

Jim Parrish  
CAH Administrator/CEO  
Humboldt General Hospital

Rosanna Gignac  
EMS Coordinator, Northeastern Nevada AHEC

Shannon Price  
Research Analyst, University of Nevada, Reno

Tabor Griswold  
Health Services Research Analyst  
Nevada Office of Rural Health

Peter Basler  
CAH Administrator/CEO  
Incline Village Community Hospital

Tom Harris  
Professor, University of Nevada, Reno

Matt Rees  
CAH Administrator/CEO  
Pershing General Hospital

Charlie Harrison  
Chief Operating Officer  
Boulder City Hospital

Vickie Wright  
Nurse Executive  
Nevada Hospital Association

Deborah Huber  
Project Coordinator, HealthInsight (Nevada QIO)

## Abbreviations Used in the Nevada Rural Health Plan

- AHEC = Nevada Area Health Education Centers
- AOA = American Osteopathic Association
- BLC = Nevada Bureau of Licensure and Certification
- CAH = Critical Access Hospital
- DHHS = Nevada Department of Health and Human Services
- FLEX/CAH = Medicare Rural Hospital Flexibility Program
- HPSA = Health Professions Shortage Area
- JCAHO = Joint Commission on the Accreditation  
of Healthcare Organizations
- MUA/MUP = Medically Underserved Area/Population
- NCES = Nevada Cooperative Extension Service
- NEMA = Nevada Emergency Medical Association
- NHA = Nevada Hospital Association
- NHSC = Nevada Health Service Corps
- NRHP = Nevada Rural Hospital Partners
- NSHE = Nevada System for Higher Education
- NVRHC = Nevada Rural Health Centers, Inc.
- ORH = Nevada Office of Rural Health
- UNSOM = University of Nevada School of Medicine
- WAN = NRHP's Wide Area Network Project
- WICHE = Western Interstate Commission on Higher Education

# Nevada Rural Health Plan

Revised Edition

April 2008

## I. OVERVIEW

### A. Background

This version of the *Nevada Rural Health Plan* (April 2008) represents an attempt by rural health stakeholders in Nevada to describe the current state of health and health care in rural and frontier regions of Nevada, and formulate a vision for improving the organization and delivery of health care services in rural and frontier Nevada for the first decade of the new century. The development of the *Nevada Rural Health Plan* is consistent with the national Medicare Rural Hospital Flexibility Program's vision of improving access to appropriate health care services of high quality in rural and frontier America via strengthening Critical Access Hospitals (CAHs) and helping them operate as the hub of a collaborative delivery system in those communities where they exist. The plan is also consistent with the goals and objectives of our state's version of the federal Medical Rural Hospital Flexibility Program and national objectives established by the federal Office of Rural Health Policy: the Nevada Rural Hospital Flexibility Program.

The first version of this plan was developed in 1997 in advance of Nevada's initial application for funding from the Medicare Rural Hospital Flexibility Program. The first edition of the plan described Nevada's rural health care system and provided designation guidelines for hospitals considering CAH certification. It was developed by members of the original Nevada CAH Task Force which included representatives from Office of Rural Health, Nevada Rural Hospital Partners (NRHP), Nevada Hospital Association (NHA), and the Nevada Department of Human Services (DHHS). The second revision (April 2002) continued the plan's focus on rural hospitals and primarily incorporated changes in CAH regulations emanating from the Congressional legislation effecting the program in 1999 and 2001. The 2004 version of the plan incorporated regulatory changes to the Medicare Rural Hospital Flexibility Program to date, including those changes published in the August 11, 2004 *Federal Register* (pages 49214-49222).

The 2008 edition of the *Nevada Rural Health Plan* represents a major step by CAHs, public agencies, and rural health care organizations in Nevada – via the Nevada Flex Program Advisory Committee – to develop a more comprehensive and inclusive vision for improving health care services in rural and frontier regions of Nevada. This revision also reflects the shift in focus of the Nevada Flex Program and its partners from the assessment and certification of CAHs in Nevada, to the program's present focus on improving rural hospital performance and enhancing the economic viability of rural hospitals and health care providers in Nevada. This revised version of Nevada's plan incorporates the findings and recommendations of a statewide rural health task force charged by the 71<sup>st</sup> Nevada State Legislature (Assembly Bill 513) with developing a strategic plan for rural health care in Nevada. This current version of the *Nevada Rural Health Plan* thus represents our state's commitment to a comprehensive

vision for improving hospital care and health services across the continuum of care in rural and frontier regions of Nevada.

## **B. Nevada Rural Hospital Flexibility Program**

The Nevada Rural Hospital Flexibility Program or “Nevada Flex Program” was established in 1999. The program is administered by the Nevada Office of Rural Health based at the University of Nevada School of Medicine and supported by funding from the Medicare Rural Hospital Flexibility Program, which was authorized by section 4201 of the Balanced Budget Act of 1997 (BBA). Overseen by the federal Office of Rural Health Policy, the national Flex program administers grants to 45 of 47 states currently eligible for program funding.

The purposes of state programs are to assist eligible hospitals and their communities to ascertain the benefit or feasibility of conversion to cost-based Critical Access Hospital (CAH) status, process through the conversion event, enable those hospitals to develop networks to ensure financial viability and ensure access across the continuum of care, facilitate EMS integration for those hospitals, and support quality and performance improvement in those facilities and communities. The development of the Nevada Flex Program over the past decade has been consistent with the aims and intent of the national program.

Since 2000, the Nevada Flex Program has advanced health and health care in rural and frontier Nevada in a number of important ways. Major accomplishments of the Nevada Flex Program to date include:

- The designation of ten Critical Access Hospitals in Nevada by the Centers for Medicare and Medicaid Services (CMS) (certification date): Battle Mountain General Hospital (February 2001); Boulder City Hospital (September 2005); Carson Valley Medical Center in Gardnerville (April 2004); Desert View Regional Medical Center in Pahrump (December 2006); Humboldt General Hospital in Winnemucca (March 2005); Incline Village Community Hospital (December 2000); Mesa View Regional Hospital in Mesquite (November 2004); Mt. Grant General Hospital in Hawthorne (September 2000); Pershing General Hospital in Lovelock (February 2001); and William Bee Ririe Hospital in Ely (April 2001).
- The provision of a wide-range of technical assistance to fifteen rural and frontier hospitals and their respective communities in Nevada, including on-site survey preparation, revenue cycle enhancement, assistance with financial management, financial feasibility assessments, assistance with hospital benchmarking, review and creation of hospital policies and procedures, development of network agreements and contracts, board education, strategic hospital planning, grant writing, and loan applications.
- Preparatory technical assistance, financial feasibility assessments, and community outreach provided to four hospitals currently evaluating CAH designation (Fallon, Caliente, Tonopah,

and Yerington) and two communities currently planning or building acute care hospitals (Dayton and Fernley).

- Support for rural hospital network development, the expansion of telecommunications capacity, and increased telehealth utilization across rural and frontier Nevada, resulting in improved operational efficiencies in all CAHs and other rural hospitals, as well as improved access to basic ancillary services (e.g., radiology services) and specialty care (e.g., dermatology consults via compressed video) for residents in over 35 rural and frontier communities.
- Improvements in over 70 EMS systems in 35 rural and frontier communities in Nevada. Flex funding and technical assistance has been effectively leveraged with community and state resources and grant funds to expand educational and training opportunities for rural EMS volunteers and instructors, and to increase access to vital pre-hospital services across rural and frontier Nevada.
- Comprehensive community health assessments undertaken in five rural communities: Battle Mountain, Boulder City, Lovelock, Yerington, and Ely. Flex Program staff and subcontractors have also provided detailed health service feasibility assessments in Lovelock (long term care expansion; Rural Health Clinic feasibility assessment and expansion), Battle Mountain (EMS services), Ely (OB and labor and delivery) and Winnemucca (kidney dialysis services, long-term care expansion).
- Improved capacity to undertake rural health care data collection, analysis and dissemination. Data and reports include the publication of the *Nevada Rural and Frontier Health Data Book* (four revisions to date), county-level hospital and health-sector economic impact assessments conducted on an annual basis (all rural and frontier counties), and sub-county and facility-level economic impact analysis conducted as requested.
- The development and implementation of health care quality improvement projects in fifteen rural and frontier hospitals, including facilitation of Nevada rural and frontier hospital participation in the national Hospital Compare initiative. Rural hospital quality improvement projects have been guided by the “Nevada Flex QI Network” that has met on a quarterly basis for the past six years and has served as a model network structure for rural hospital staff.
- Effective leveraging of Flex dollars with the resources and grant funds of the Office of Rural Health and Flex Program partners. For example, the Flex CFO and Flex Director will assume primary responsibility for implementing the Nevada Rural Hospital Benchmarking Initiative, which has been developed with a combination of Flex and SHIP Consortium dollars.
- Improved collaboration among rural health care stakeholders across Nevada, including the greater coordination of legislative, regulatory, and advocacy efforts on rural health issues.

The Nevada Flex Program has also had a major financial impact on those facilities that have been designated as Critical Access Hospitals. Highlights include:

- The combined net operating income and net income, for the initial five non-tribal converted CAHs in Nevada, through the fiscal year ended June 30, 2006, has increased approximately \$9.2 million and \$8.5 million respectively.
- For the FY 2001, the operating margin for the five non-tribal converted CAHs was minus 12.72%. By FY 2006, the operating margin for the same facilities had been reduced to minus 4.54%. During the same period, non-operating revenues, mainly state and county tax subsidies, decreased approximately \$0.7 million due to the boom and bust nature of the rural economic environment in CAH communities.
- The enhanced financial operations have led to the ability of converted CAHs to invest over \$14.0 million in capital improvements, including equipment to improve and expand existing services since 2000. One of Nevada's CAHs (Pershing General Hospital) recently completed a \$2.5 million improvement to their facility, while another (William Bee Ririe Hospital) continues with their \$7.5 million capital improvement project.
- Nevada CAH facilities have experienced an average growth in gross patient revenue of greater than 11% while deductions to revenue have only grown at an average rate of less than 9%.
- New CAH facilities in Gardnerville (2004), Mesquite (2004), and Pahrump (2006) have improved access to hospital services and emergency care for nearly 100,000 rural residents of Nevada that, in some cases, previously required trips of over an hour.
- As CAHs have increased net revenue and cash flow, each has been able to increase or maintain their scope of services, offer competitive wages and recruit professionals in a highly competitive regional labor market, and, thus improve service to communities that face significant economic challenges and geographic access barriers.

In summary, through Flex funding, Nevada has been able to establish an effective, statewide technical and financial assistance center for small rural hospitals that simply did not exist prior to the existence of the Nevada Flex Program. In turn, the Nevada Flex Program's successes have improved the ability of CAHs, CAH-eligible hospitals, and rural communities to meet existing and emerging health care needs.

A key element of the Nevada Flex Program's success has been the productive collaboration of the program's Advisory Committee. The committee includes representatives from the Nevada Office of Rural Health, Nevada Rural Hospital Partners (NRHP), Nevada Hospital Association (NHA), HealthInsight (Nevada's Quality Improvement Organization or QIO), University of Nevada Reno, Nevada Cooperative Extension Service, Nevada Health Division and Bureau of Licensure and Certification, Nevada Medicaid, Nevada EMS Bureau, and Critical Access Hospital Administrators and CEOs.

Since 1999, committee members have met on a quarterly basis to develop and implement FLEX Program activities, and to improve coordination on rural health advocacy, cross-cutting program development, grant writing, and rural hospital and health policy development. In conclusion, the 2008 version of the *Nevada Rural Health Plan* is consistent with the goals and objectives of the Nevada Rural Hospital Flexibility Program and vision of the program's advisory committee.

## II. HEALTH AND HEALTH CARE IN RURAL AND FRONTIER NEVADA

The maps and tables contained in Appendix 1 provide a current, detailed portrait of health and health care in rural and frontier Nevada. Maps 1 through 3 provide a descriptive overview of rural and frontier regions of Nevada, as well as health care resources available to residents of those areas. Map 1 highlights the state's three urban counties (shaded in gray) and the fourteen rural and frontier counties (white or blank). It also indicates the location of Nevada's major towns and cities. According to 2006 population estimates prepared by the Nevada State Demographer's Office, 2,250,328 Nevadans or 89.3% of the state's population reside in the state's three urban counties. Approximately 70% of the state's population resides in Clark County (Las Vegas metropolitan area) alone. In comparison, an estimated 268,541 Nevadans or 10.7% of Nevada's population reside in the state's rural and frontier counties.

The rural and frontier population is spread over 95,431 square miles or about 87% of the state's land mass. While the proportion of the state's population residing in rural areas is expected to decline over the next decade, the absolute number of rural and frontier residents is projected to increase by approximately 51,536 or 18.8% between 2006 and 2016.

Most of Nevada's rural and frontier communities are located in sparsely populated counties that are considerable distances from the state's urban and tertiary care centers. Map 2 underscores the vast distances separating the state's rural communities from urban centers, as well as the considerable distances separating these communities from one another. The average distance between acute care hospitals in rural Nevada and the closest tertiary care hospital is 115 miles and the average distance to the nearest incorporated town is 47 miles. Consequently, the primary health care delivery issue for rural residents and communities in Nevada is how best to overcome the spatial isolation and enormous geographic distances that characterize most of rural and frontier Nevada.

Map 3 provides a current snapshot of the major health care services available to rural and frontier residents of Nevada (this map excludes the offices of individual physicians or other health providers). While most of the state's tertiary care centers and health resources are concentrated in the state's three urban counties, a large number of acute care hospital services, clinics and medical centers, and emergency medical services are scattered across each of the state's fourteen rural and frontier counties. These facilities and services – described in greater detail below and Appendix 1 – provide most of the basic health care received by our state's rural and frontier populations.

### **A. Social and Demographic Profile of Nevada**

Like most western and southern states in the US, Nevada's demographic profile is characterized by rapid population growth, aging, and diversification. Current data on demographic trends in Nevada are detailed in Tables 1 through 4 of Appendix 1. Rural and frontier Nevada is distinguished by small towns separated by vast distances with two highly urbanized areas in the northern and southern parts of the state. As Table 1 indicates, rural and frontier areas of the state comprise 95,431 square miles out of the total 109,826 square miles or about 87% of the land mass area. Nearly a quarter of a million Nevadans or nearly 11% of the state's total population are distributed throughout the fourteen counties comprising rural and frontier Nevada. From 1990 to 2000, Nevada's population grew by 66.6% to 1,998,257. This represents the fastest rate of growth of any state during the same time period and five times the population growth rate for the entire nation. During the past decade, the population of Clark County (Las Vegas metropolitan area) increased by 634,306 or 85.5% and the population of Washoe County increased by 29.7% to 339,486. Population growth has not been limited to the state's urban counties. Indeed, nine of the state's fourteen rural and frontier counties posted double-digit percentage increases in population during the past decade.

According to the Nevada State Demographer's Office, the state's population is projected to increase by approximately 1,010,097 or 40.4% from 2006 to 2016. Table 2 highlights that most of this growth will continue to take place in the Las Vegas metropolitan area. The population of Clark County is projected to increase from an estimated 2.63 million in 2006 to 3.69 million in 2016. While urban counties in Nevada will experience the greatest growth in absolute numbers, the population of rural and frontier Nevada is expected to grow by 18.8% or an additional 51,536 residents during the coming decade.

In addition to rapid population growth, population aging represents a second major demographic influence on health and health care services in Nevada. One of the fastest growing segments of the state's population are those aged 65 and older. At present, this group represents 13% of the population in rural and frontier counties and 11% of the population in the state's three urban counties. Table 3 provides data on projected population expansion among those aged 65 and over, indicating that this segment of the population will grow by nearly 20,000 or 49.8% in rural and frontier counties through 2016.

The changing racial and ethnic composition of the state is another major demographic force affecting health and health care in Nevada. In just the past three years, the state has added over 100,000 residents of Hispanic origin. Table 4 highlights the rapid pace of population growth among Nevadans of Hispanic origin. Again, while most of the state's Hispanic population growth will take place in southern Nevada, the Hispanic population in rural and frontier Nevada will increase by 24% or estimated 8,133 individuals between 2006 and 2016. The state's Native American and Asian populations – though small compared to other racial categories such as white and black groups – are also expected to increase substantially over the course of the coming decade.

Rapid population growth, an aging population, increasing population diversity, and the vast distances separating towns and cities in the state continue to put pressures on both urban and rural health care resources in Nevada. Demographic forces are driving a dramatic increase in the overall demand for health care services in Nevada. In turn, the increased aggregate demand for health services is generating an expansion of health care facilities – from primary care provided in outpatient settings to additional hospital construction – and a commensurate growth of the state's health care workforce. For example, against the backdrop of rural hospital closures across the nation, three rural communities in Nevada will have constructed acute care facilities since 2003 (Gardnerville, Mesquite, and Pahrump) and two additional communities (Fernely and Dayton) are exploring new hospital construction.

Tables 5 and 6 illustrate important economic and labor market differences between rural and urban regions of Nevada. While no region has been immune from the economic dislocation resulting from the 9/11 terrorist attacks and their resulting impact on our state's tourist-dependent economy, rural and frontier regions are nonetheless less diversified and more adversely affected by the economic swings associated with agriculture, ranching, and mining. Table 5 reveals that per capita income in most rural and frontier counties of Nevada is well below national averages, whereas per capita income in urban areas has typically been equal to or greater than the national average.

Likewise, Table 6 indicates that, in a given year, unemployment rates in most rural and frontier counties of the state are higher than their urban counterparts. Swings in unemployment, at least over the past five years, have also been greater in rural and frontier regions than urban areas of Nevada. One consequence of this economic volatility is the increased difficulty in long-range planning for the health care needs of rural and frontier Nevadans. For example, projecting and stabilizing a primary care workforce based on the cyclical nature of Nevada's mining industry is an increasing difficult task in a number of Nevada communities. In general, characteristics of the local population, insurance coverage, and availability of local services wax and wane with the boom and bust cycle of rural and frontier industries in Nevada.

## **B. Population Health Profile of Rural and Frontier Nevada**

In the most general terms, Nevada's population is characterized by poor health status indicators, unhealthy behavior and lifestyles, and persistent access barriers to health care services. As such, the state's urban and rural health care systems – already burdened by a rapidly growing, aging, and diverse population – are burdened with a comparatively unhealthier population. Nevada perennially ranks among the bottom tier of US states along a wide range of health measures, including deaths from heart disease and cancer, as well as motor-vehicle and occupational fatalities.

The state also suffers from high levels of mental illness and behavioral health problems as evidenced by the state's historically high suicide rate. Nevada's poor health profile is closely tied to high prevalence rates for a wide range of "at risk" behaviors such as cigarette smoking and immoderate alcohol consumption – rates that have not appreciably improved over the past decade. Tables 7 and 8 provide the most current information on morbidity and mortality trends in Nevada and variation in rates across the major regions of the state.

The state's comparatively poor health record is aggravated by low rates of routine preventive health services use such as prenatal care, childhood immunization compliance, recommended cancer screening, and lower levels of general health knowledge such as awareness of risk factors for diabetes and other chronic health conditions. In addition, the state's poor population health profile is compounded by high percentages of adults lacking health insurance coverage, access barriers to mental health care, and the geographic maldistribution of primary health care resources. Table 9 reveals consistently high rates of uninsured Nevadans across regions of the state over time. In summary, Nevada is characterized by a poor overall population health profile and abundant unmet health care needs.

Tables 10 and 11 provide additional information on health insurance coverage in Nevada, focusing on public health insurance coverage for the elderly and disabled through the Medicare program and public health insurance coverage for the poor through the federal and state Medicaid program. Both programs represent essential safety net programs for rural and frontier populations in Nevada and a vital source of revenue for hospitals serving those populations.

## **C. Health Care Workforce in Rural and Frontier Nevada**

Like many rural and frontier regions of the nation, rural communities in Nevada struggle to maintain sufficient levels of primary health care practitioners and resources to meet the health needs of the population. Without exception, rural communities lack 24-hour coverage from medical and surgical specialists. There are approximately 40,000 Nevadans in rural and frontier areas who live 30 miles from accessible primary care. More than 30,000 people live in excess of an hour-and-one-half's driving time from regularly available specialists. An additional

estimated 100,000 people live from 2.5 to 5 hours from subspecialty care. On top of these geographic and transportation barriers, rural residents face financial access barriers, as well as difficulties identifying urban subspecialists who take rural Medicare and Medicaid patients. Tables 12 through 17 in Appendix 1 provide data on the health care workforce in rural and frontier areas of Nevada.

### Health Professions Shortage Areas and Medically Underserved Area Designations

Table 12 summarizes the current Health Professions Shortage Areas (HPSAs) designations for rural and frontier counties in Nevada. Ten of Nevada's fourteen rural and frontier counties are designated as full-county Primary Care Health Professional Shortage Areas (HPSA's), thirteen are Mental Health HPSA's, and eleven are Dental HPSA's. In general, Nevada's rural and frontier regions have been characterized by substantial shortages of primary care and basic dental care, as well as significant gaps in the availability of mental health services. With the steady closure of mental health clinics and services over the past decade, patients with suspected psychiatric problems who present themselves at rural emergency rooms can be held for days before receiving a psychiatric evaluation or, minimally, an evaluation from social workers qualified to do such evaluations.

Table 13 provides a detailed account of projected employment in selected health industry sectors in Nevada across the major regions of the state – Las Vegas MSA, Reno-Sparks MSA, and rural and frontier counties – through 2014. This table reveals substantial employment demand across all health sectors and across all regions of the state. In absolute terms, the greatest employment demand is in the urban regions of Las Vegas and Reno. However, projected percentage growth in health care occupations in rural and frontier counties is similar to, if not greater, than urban areas for many health industry sectors. For example, the net number of new job growth through 2014 in rural and frontier hospitals is one-tenth of that in the Las Vegas region – the hospital sector will generate, respectively, 815 and 8,015 new jobs in those regions. Nonetheless, hospital job growth between 2004 and 2014 in rural and frontier Nevada represents a 33% increase during the same time period. Consequently, rural and frontier facilities must compete with the fierce demand for registered nurses and other health care professionals in urban centers in Nevada.

Tables 14 through 16 document the geographic distribution of, respectively, licensed physicians, dentists, and registered nurses in Nevada. In each health profession, the number of providers per capita is lower in rural and frontier regions than urban areas of the state.

Table 17 provides detailed data on the distribution of EMS by level of training and residence. As expected the per capita distribution of EMS personnel is greater in rural as compared to urban regions of the state. Despite comparatively higher employment levels than urban areas of the state, rural and frontier EMS systems struggle to maintain a sufficient EMS workforce given the largely volunteer nature of the rural EMS workforce and the importance rural EMS plays in the continuum of care available in most rural and frontier communities.

## Education and Training Programs Supporting Rural Facilities and Practitioners in Nevada

*Nevada System for Higher Education* – The vast majority of health care education opportunities in Nevada – ranging from associate degree programs to degrees in allopathic medicine and dentistry – are administered on seven of the eight campuses of the Nevada System for Higher Education (NSHE):

- College of Southern Nevada (CSN) – Las Vegas
- Great Basin College (GBC) – Elko
- Nevada State College (NSC) – Henderson
- Truckee Meadows Community College (TMCC) – Reno
- University of Nevada, Reno (UNR)
- University of Nevada, Las Vegas (UNLV)
- Western Nevada College (WNC) – Carson City

Each of these institutions has worked on a collaborative basis with rural health care providers and one another to develop training and professional degree programs – including courses offered via compressed video – addressing health workforce needs in rural areas of the state.

*University of Nevada School of Medicine* – Recruitment and retention services are important programs offered through the University of Nevada School of Medicine (UNSOM) and Nevada Office of Rural Health in partnership with other entities in the state. A major program is the Nevada Health Service Corps (NHSC). NHSC is both a scholarship and loan repayment for primary care physicians, physician assistants, nurse practitioners and certified nurse midwife candidates. This program offers a state, and state/federal portion of loan repayment. Another program is the Health Care Access Program (HCAP) available through the Nevada WICHE (Western Interstate Commission on Higher Education). HCAP is a newly established obligated service program for physician assistants, pharmacists, dentists, physical therapy and occupational therapy students. Lastly, consortium planning and development of recruitment and retention activities are a central component of how all programs are coordinated within the state with various agencies and organizations.

Additional programs offered through the School of Medicine and focused upon recruitment and retention activities include: technical assistance in specific areas such as grant writing, board training, and community development. Extensive work around rural representation for improved telecommunications access and infrastructure support are important work activities of the Nevada Office of Rural Health and the Rural Telecommunications Task Force. Additionally, Continuing Education and Continuing Medical Education for rural health professionals are provided through the School's Area Health Education Centers (AHEC) and the Office of Continuing Medical Education. AHEC established and has maintained a medical information link to all of the facilities and practitioners, now WEB based, that links their research needs to a School of Medicine library resource center. This allows for the most up to date information to be available for both emergency and other daily resource purposes. Finally,

a major undertaking over the past two years has been the development of a broad based, descriptive Nevada Flex Program website. This has been a joint project of the Nevada Rural Hospital Partners and the Nevada Office of Rural Health. The website will provide information on the recruitment and retention of health professionals in Nevada and linkages to nationally-based recruitment and retention programs.

*Nevada Area Health Education Centers* – The Nevada Area Health Education Centers (AHEC) continuing education programs are a major component of the AHEC program. The Nevada AHEC collaborates with the School of Medicine’s Office of Continuing Medical Education to provide continuing medical education throughout Nevada. These continuing education programs are developed as a result of extensive needs assessment conducted using focus groups, surveys, evaluations and an examination of the Healthy People 2000 and 2010 objectives. With a landmass of 109,826 square miles, Nevada has always been a difficult state to provide distance education. Recent advances in technology have provided a mechanism for the AHEC to conduct more continuing education classes with fewer resources. These technology resources have also allowed the AHEC to partner with outside agencies and programs for delivery of specialized training, social programs and other issues that limited resources would not allow in the past. Nevada AHEC also continues to provide traditional delivery classes, conferences, mini-residency programs and other educational offerings.

#### **D. Health Care Resources in Rural and Frontier Nevada**

##### Nevada’s Unique Geography

Like many regions of the US, Nevada struggles to recruit and retain primary care physicians and other health professions to its rural and frontier regions, as well as provide 24/7 emergency and basic inpatient care to rural and frontier communities. These issues are compounded by the dramatic distances that separate rural and frontier communities from one another in Nevada, as well as the distances that separate rural clinics and hospitals from urban teaching and specialty centers. Focusing on hospitals located in rural and frontier counties, Table 18 documents the considerable degree of isolation faced by providers in these locales. On average, the typical rural hospital in Nevada is 47 miles from the nearest incorporated town and almost 115 miles from the nearest source of tertiary care. Incidentally, these facilities are separated from the Nevada Office of Rural Health in Reno by an average of 231 miles, which makes the provision of on-site technical assistance a demanding task for the office.

The problems in delivering health care to rural Nevadans are not unlike other rural and frontier areas of the United States: isolation, employment insurance disruptions associated with agriculture and mining, practitioner shortages, poor health status, and limited local resources to address these problems. In Nevada’s larger rural counties a Critical Access Hospital or small rural hospital serves the county or multi-county region. In smaller rural communities, a clinic – often publicly funded – serves a limited service area. The typical primary care provider – MDs,

as well as nurse practitioners, physicians assistants, and DOs – does more than see patients during the course of the day. Primary care providers are often the medical director for the county emergency services, may serve as instructors, county health officers, and coroners. The case load of the rural primary care practitioner is broad-based and varied. Primary care practitioners can be faced with caring for patients discharged from urban hospitals with no prior knowledge of the patient’s case. Consultations with urban specialists help the rural practitioner feel comfortable and less isolated in carrying this sometimes burdensome caseload. The telecommunication links with urban specialists have the potential to increase the rural practitioner’s job satisfaction by decreasing the feelings of isolation and increasing their potential to facilitate continuity of care in the rural practice setting. In general, Nevada’s rural and frontier hospitals and clinics have made considerable strides in the development and utilization of telemedicine, teleradiology, and electronic patient records. These new technologies have allowed rural and frontier practitioners and consumers in Nevada to overcome many of the primary care barriers associated with the state’s unique geography and the distances between rural facilities and urban tertiary care centers.

### Rural and Frontier Hospitals in Nevada

A complete and current descriptions of Nevada’s rural and frontier hospital facilities are provided in Table 19, including information on hospital ownership, tax status, and service area and population served. Rural hospitals have been an anchor in our isolated communities. Half of Nevada’s rural hospitals are located in the county seat. Historically, all of the state’s rural hospitals were public, not-for-profit facilities, that were built with or improved upon by Hill-Burton funds from the late 1940s to 1970. Many are aging and remodeling or in some cases rebuilding is needed.

Of these fifteen facilities, six receive hospital-district tax support: Battle Mountain General Hospital; Grover C. Dils Medical Center (Caliente); Humboldt General Hospital (Winnemucca); Mount Grant General Hospital (Hawthorne); Pershing General Hospital (Lovelock); and William Bee Ririe Hospital (Ely). One hospital is a non-governmental/nonprofit facility receiving tax support: South Lyon Medical Center (Yerington). Five hospitals are non-governmental/nonprofit facilities receiving no tax support: Boulder City Hospital; Carson Valley Medical Center (Gardneville); Churchill Community Hospital (Fallon); Incline Village Community Hospital; and Nye Regional Medical Center (Tonopah). Three hospitals are private/for-profit entities: Mesa View Regional Hospital (Mesquite), Desert View Regional Medical Center (Pahrump), and Northeastern Nevada Regional Medical Center (Elko).

Table 20 documents the distribution of hospital-based resources in rural and frontier counties of Nevada. Currently, the largest rural and frontier hospital maintains 90 licensed acute care beds and the smallest is 4 beds. The number of acute care beds per population ranges from 0.5 acute care beds per 1,000 population in Douglas County to 2.7 per 1,000 population in White Pine County. At present, Nye County has the largest number of long-term care beds with 154, and three counties are without hospital-based or freestanding long-term care facilities. The

statewide growth of the segment of the population aged 65 and over will only aggravate the shortage of long-term care beds and access to nursing care faced by most rural and frontier communities.

Tables 21 through 25 list utilization and financial performance data for all rural and frontier hospitals for the most recent period (fiscal year ending June 30, 2005). They also highlight important aggregate differences between rural and urban hospitals in Nevada. As these tables suggest, providing low-volume hospital services and health care to remote rural and frontier areas has never been a fiscally viable undertaking.

While rural and frontier hospitals struggle with financial and economic viability, a growing body of research highlights the critical role of the hospital sector and health services as engines of income and employment growth in rural and frontier communities in Nevada. Tables 26 and 27 provide data from the most recent economic impact or “IMPLAN” analyses conducted for Nevada’s fourteen rural and frontier counties. Table 27 reveals that in 2006 the hospital sector employed approximately 1,553 and generates, through what is termed the “multiplier effect,” an additional 663 jobs for a total of 2,213 jobs in our state’s rural and frontier counties. Table 27 demonstrates that the hospital sector in rural and frontier Nevada directly generates \$103.6 million in income for individuals and, through the multiplier effect generates an additional \$20.6 million in income for rural and frontier communities.

#### Rural and Frontier Hospital Network Development in Nevada

In Nevada, the problems experienced by isolated rural hospitals and the state’s vast geography have prompted rural health network development before the trend became commonplace. The Nevada Rural Hospital Partners (NRHP) is the most defined formal rural health network in Nevada. NRHP is a voluntary consortium of fourteen of Nevada’s small, rural and frontier hospitals. Consortium hospitals are community, county, or district not-for-profit facilities. Each member hospital is represented with an equal vote on the NRHP Board of Directors. The group has a long history of cooperative effort as the Rural Council of the Nevada Hospital Association. With funding submitted by ORH to the Robert Wood Johnson Foundation’s (RWJF) “Hospital-Based Rural Health Care Program,” the network was formalized in 1988. NRHP allows a non-voting membership or “foundation membership” option for tribal facilities and for-profit hospitals.

The goals of the RWJF program – to improve the viability of rural hospitals, access to health care by rural residents, and the quality of health services in rural areas – remain central components of NRHP’s mission. NRHP is presently a self-sustaining organization supported by member dues, grants, and contracts. In its short history, NRHP has an outstanding record of accomplishment for its members and for all of rural Nevada, including the development of group purchasing and contracting (e.g., reference laboratory services, workers compensation, group health insurance); educational programs (e.g., board development, billing, and human resource workshops); advocacy and rural health policy development; grant writing and

technical assistance; and program management. NRHP currently manages a self-funded liability insurance risk pool, the Liability Cooperative of Nevada or “LiCON,” and administers a self-funded maintenance repair program, the Technical Equipment and Asset Maintenance of Nevada program or “TEAM.” Along with the Nevada Office of Rural Health, NRHP has played a lead role in the development of the state’s telehealth network.

NRHP plays a pivotal role in the development of rural health networks in Nevada, network-related components of the Nevada Rural Hospital Flexibility Program and the activities of the Nevada Flex Advisory Committee. NRHP and the Nevada Flex Chief Financial Officer (CFO), who is employed by NRHP through CAH funding, administer many of the fiscal elements of the Nevada Rural Hospital Flexibility Program. The Flex CFO provides financial consultation and data support to CAH facilities and to other facilities and practitioners within the CAH service area that are networked. Since 1999, the Nevada Flex Program, NRHP and ORH have collaborated on a daily basis to implement network-related activities and technical assistance for all small rural and frontier hospitals in Nevada.

Perhaps the greatest accomplishment of NRHP has been the improved credibility of member hospitals, both within the state and nationally. While this benefit is not always tangible, it allows hospitals to influence rules, regulations, and laws to improve hospitals' ability to operate. Another significant rural network to emerge in Nevada has been the telehealth network developed by NRHP and the Nevada Office of Rural Health. NRHP has recently begun implementation of its Wide Area Network or “WAN” for rural hospitals which will eventually serve all member hospitals. This telecommunications network: (a) provides e-mail and Internet access for hospital staff; (b) improve the NRHP’s capacity to assist individual facilities with benchmarking and operational technical assistance; and (c) generally, facilitates rural health care networking and information sharing.

The changing face of health care in Nevada has now seen the emergence of corporate health care entities and, in 1998, the first rural acquisition by a for-profit hospital group. Corporate policies for non-profit entities dictate shrinking participation in some programs, but will remain unchanged in others. NRHP, possessing the purchasing and negotiating power of the member facilities, has meant significant cost savings and strength in covering service areas. Future network development for services and telehealth applications will need to accommodate the growth of corporate health care entities, the multiple issues of managed care, and the unique nature of partnerships between academic health centers, hospitals, clinics, and practitioners around access to health care issues.

#### Community Health Centers and Rural Health Clinics in Nevada

Table 28 provides a list of Federally Qualified Health Centers located in rural and frontier Nevada. Nevada Rural Health Centers Inc. (NVRHC) currently operates nine active Federally Qualified Health Centers or primary care clinics in the rural and frontier communities of Amargosa Valley, Austin, Beatty, Carlin, Crescent Valley, Eureka, Gerlach, Jackpot, and

Wendover. NVRHC also operates four primary care clinics in underserved areas of Carson City and Las Vegas. These clinics are staffed by physicians, physician assistants, and/or nurse practitioners who are fully licensed by the State of Nevada and employed by NVRHC. These clinics are based on the full service, family practice model. However, few of the clinics provide 24-hour, seven-day-a-week emergency care. NVRHC is a federally funded Community Health Center Program that has operated clinics in rural and frontier Nevada for two decades. NVRHC operates a centralized pharmacy that provides nine clinics with dispensaries. NVRHC provides care to an estimated 50,000 individuals scattered over the rural and frontier regions of Nevada.

In addition to FQHCs, there are eight certified Rural Health Clinics (RHCs) in the frontier communities of Battle Mountain, Caliente, Ely, Hawthorne, Lovelock, and Yerington (three clinics). In addition to the FQHC and RHCs, there are independent clinics in Pahrump (Nye County) and Mesquite (Clark County). These clinics are small group practices made up of physician employees of hospital-based outpatient centers. In summary, rural community health centers and clinics in Nevada face a variety of similar challenges, including isolation from other practitioners, meeting demands for practice coverage, need to offer a full scope of services with few resources, and competition from other practices in larger cities where patients typically go to shop and purchase other services.

#### Tribal Medical Clinics and Health Centers in Nevada

Table 29 provides a comprehensive list of tribal health centers and medical clinics, which serve a wide number of Native American tribes in every county of the state. The state of Nevada has three service units of the Indian Health Service (IHS): (1) Schurz Service Unit, which encompasses the southern and western area of Nevada; (2) Duck Valley Service Unit, serving northern Elko County; and (3) Elko Service Unit, which encompasses the central and northeastern parts of Nevada. Tribal medical clinics and health centers provide essential primary care to often isolated populations across every rural and frontier county of the state. In the most recent year for which data is available (2003), tribal medical clinics and health centers in Nevada served over 16,400 active users of these facilities.

#### Emergency Medical Services in Rural and Frontier Nevada

Emergency medical services consist of mostly community based volunteer ambulance services that are staffed with EMT-Basic and EMT-Intermediate personnel. The state's urban areas receive advanced life support (ALS) services from a mixture of private and fire-department-based ALS ambulance services. Five rural communities have implemented programs to upgrade their services to the ALS level. Access to emergency medical services is through 911 call centers that are generally operated by county-based multi-community law enforcement dispatch centers. These centers also provide dispatch services to the volunteer ambulance services. The joint law enforcement-fire department dispatch center in Reno, Nevada receives 911 authority for Washoe County. A private contractor provides regional ALS dispatch and services. Two rotor-wing (helicopter) and four fixed-wing air ambulances augment ground

services through out the state. The air ambulances are staffed by registered nurses trained as flight nurses.

Due to geographical considerations and extreme weather conditions response times can be as much as 90 minutes. Rural services have response areas that, in a number of cases, encompass thousands of square miles. They have transport times to regional medical facilities that are as long as 2.5 hours. These distances are crucial for those who are medically and/or traumatically injured. Application of the concept of the “golden hour” is often impossible in the rural and frontier areas. The chances for survival are increased by assuring timely transportation from incident to arrival at an appropriate medical treatment facility (e.g., clinic, urgent care, or regional medical center). In the rural or frontier areas of the state this is often impossible. Even though Nevada has statewide triage criteria in place and three trauma centers, for those incidents occurring outside the immediate urban area rarely can trauma criteria be established or implemented. Due to their limited scope of practice, rural services are able to provide only basic life support and some intermediate-level pre-hospital care. Because of their remoteness from the larger, more populated communities, they lack the educational opportunities to enhance their in-service training programs. They receive little, if any, patient outcome information mostly because definitive care is provided somewhere other than their community.

The Emergency Medical Services office of the Nevada State Health Division establishes and enforces standards for emergency medical care. The State EMS office certifies approximately 4,100 EMS personnel including First Responders and licenses approximately 1,295 volunteer ambulance attendants. The majority of these individuals, approximately 800, are members of rural and frontier volunteer ambulance services that responded to approximately 22,500 calls in 2003. The State EMS office also issues operating permits to approximately 80 ground and air ambulance and provides consultation and technical assistance to the emergency service providers for Nevada’s 14 rural and frontier counties as well as Washoe County. A registry of all Nevada certified personnel is maintained as part of the EMS program activities.

### Telehealth Network

For the past decade, the Nevada Office of Rural Health, University of Nevada, Reno, University of Nevada School of Medicine (UNSOM) and Nevada Rural Hospital Partners have successfully implemented a telehealth project in Nevada. Tables 30 and 31 provide a current list of telehealth sites in hospitals, clinics and multispecialty group practices in, respectively, rural and urban counties of the state. Most of Nevada’s rural and frontier counties have been equipped for the delivery of telehealth and education through T-1 lines and compressed video. Telehealth network partners have developed a sustainable project that continues to provide distance education, continuing education, meetings, Internet access, teleradiology and telemedicine. The project has been funded by the Department of Commerce, National Library of Medicine, Department of Agriculture, Medicare Rural Hospital Flexibility Program, state funds, and private dollars.

The telehealth network has been responsible for training, education, statewide meetings, teleradiology, telemedicine and other activities that have benefitted rural residents, students, patients and health professionals in Nevada. Programs are offered at least weekly and range from the training of Certified Nursing Assistants to trauma rounds for medical staff in rural hospitals. The system has also been utilized for college certificate and degree programs in EMS, nursing, medicine, education, and business. In addition the system has also been used as a mechanism for rural residents to meet in a multi-community setting on similar issues. The Nevada Flex Program and telehealth network partners are currently developing policy and procedures to implement all aspects of consultation, and are negotiating with Medicare and the Nevada Medicaid program for reimbursement for telehealth consultations.

### **III. HEALTH CARE POLICY AND STRATEGIC PLANNING FOR RURAL AND FRONTIER NEVADA**

During its 2001 session, the Nevada State Legislature passed Assembly Bill (AB) 513, which directed the Nevada Department of Human Services (DHHS) to develop a strategic plan that would ensure the availability and accessibility of health care services in rural and frontier Nevada. In September 2001, the DHR convened a “rural health care task force” comprised of major rural health care stakeholders across the state to oversee the development of a rural health care strategic plan. The DHR also engaged a private contractor to oversee the development of the plan. This section describes the major policy issues identified by the task force its final report submitted to the Governor of Nevada, *Strategic Plan for Rural Health Care* (October 2002) and the broad contours of the task force’s strategic plan deemed necessary to ensure the availability and accessibility of health care services in rural and frontier Nevada. The section concludes with a description of the goals of the Nevada Flex Program. The purpose of this discussion is to highlight the consistency of Nevada Flex Program objectives and activities with broader strategic planning efforts currently being developed and implemented in Nevada.

#### **A. Major Rural and Frontier Health Care Policy Issues in Nevada**

In their final report to the Governor of Nevada, the rural health care task force identified the thirteen most urgent health care policy issues facing rural communities and state policy makers. These inter-related issues and problems include:

- (1) Lack of access to necessary medical care in many regions of rural and frontier Nevada.
- (2) High numbers and percentages of uninsured residents across both urban and rural areas of the state.
- (3) Persistent threats to the economic viability of rural and frontier hospitals.

- (4) Growing concerns about the capacity and financing of long term care in rural communities.
- (5) Need to improve the effectiveness of Nevada's rural and frontier emergency medical services (EMS) system.
- (6) Lack of access to behavioral health resources and practitioners in rural Nevada.
- (7) Insufficient numbers of health care professionals in rural and frontier Nevada, including physicians, nurses, dentists, and pharmacists, as well as a number of allied health professions.
- (8) Lack of integration between public health services provided by community health nurses and the overall health care delivery system in many rural communities.
- (9) Resolution of administrative and payment issues limiting the full utilization of the state's telehealth network linking rural hospitals and clinics to urban teaching hubs and specialists.
- (10) Gaps in transportation for emergency, non-emergent, and chronic care services which represents a significant barrier to care in every rural and frontier community.
- (11) Financial support from the State is incommensurate with the level of need in rural and frontier communities.
- (12) Preventive health services in rural communities are underdeveloped in relation to the state's high levels of suicide, substance abuse, and obesity.
- (13) Availability, accuracy, and accessibility of data needed to inform rural health policy is poor and undeveloped.

In summary, the task force's final report listed these thirteen, interrelated statewide issues as the most pressing health care problems and needs facing providers and residents in rural and frontier Nevada.

## **B. Nevada's Current Statewide Strategic Plan for Rural Health Care**

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

Policy statement issued by the Rural Health Care Task Force in *Strategic Plan for Rural Health Care* (October 2001, p.27).

The research and analysis conducted and overseen by the rural health care task force during the early part of this decade resulted in the development of a comprehensive set of statewide goals, strategies, and actions steps for rural health care in Nevada.

The statewide rural health strategic plan is organized in four general categories: (1) planning and coordination; (2) service delivery; (3) sustainable financing; and (4) infrastructure development. The final report also contains a lengthy set of county-level issues and recommendations identified during the course of the task force's work. The following section outlines the statewide goals, strategies, and action steps contained in the Nevada strategic rural health care plan developed by the task force. Each goal contains multiple strategies; in turn, each strategy contains multiple action steps for state policy makers, public agencies, private organizations and associations, educational institutions, hospitals and other health care providers, and other rural health care stakeholders.

The following outline of the state's current strategic plan for rural health care provides a comprehensive, yet succinct summary of health care problems currently facing rural and frontier communities in Nevada, as well as proposed strategies identified by major rural health care stakeholders, providers, and communities for addressing our state's rural health care issues.

### *Planning and Coordination Goal*

#### Goal 1: Create an Ongoing Mechanism for Planning and Coordination of Rural Health Care.

Strategy 1.1: Establish and maintain a quasi-governmental board for rural health planning and coordination.

Strategy 1.2: Facilitate information integration on a statewide basis.

*Service Delivery Goals*

Goal 2: Enhance Rural Physical Health Primary Care Model.

Strategy 2.1: Maintain sufficient primary care workforce base.

Strategy 2.2: Implement existing plan to address nursing shortage.

Strategy 2.3: Improve dental care services and access.

Goal 3: Create Long Term Viability in Behavioral Health, Substance Abuse, and Support Services.

Strategy 3.1: Obtain needed staff.

Strategy 3.2: Develop or enhance appropriate facilities/treatment sites.

Strategy 3.3: Coordinate and integrate service delivery across the continuum of care.

Strategy 3.4: Secure additional funding to provide needed services.

Goal 4: Improve Service Access and Response Capabilities.

Strategy 4.1: Make EMS systems more available, timely, and effective.

Strategy 4.2: Improve ability to treat time sensitive conditions (e.g., esp., heart attacks, strokes, births, and trauma).

Strategy 4.3: Ensure service access and continuity of care for chronic/specialty care patients (e.g., dialysis, chemotherapy).

Goal 5: Invest in Public and Preventive Health for Long Term Benefits.

Strategy 5.1: Maintain/expand preventive health services (e.g., esp., immunizations, smoking cessation; teen pregnancy; suicide prevention; fitness education; oral health; nutrition).

Strategy 5.2: Enhance environmental health program (e.g., mining, water supply).

Strategy 5.3: Develop rural bio-terrorism and related emergency responses.

*Sustainable Finance Goals*

Goal 6: Improve Insurance Coverage for Uninsured and Underinsured Nevadans.

- Strategy 6.1: Increase the number of Nevadans with health insurance.
- Strategy 6.2: Standardize insurance coverage and costs for rural customers.
- Strategy 6.3: Address the cost and coverage issues around medical malpractice insurance.
- Strategy 6.4: Implement regulatory reforms.

Goal 7: Develop Adequate Capital Financing.

- Strategy 7.1: Establish public/private investment/trust fund.
- Strategy 7.2: Develop foundation and philanthropic support.
- Strategy 7.3: Develop public and private partnerships.

Goal 8: Develop Adequate Operational Funding.

- Strategy 8.1: Improve grant procurement capabilities.
- Strategy 8.2: Make needed State tax code revisions.
- Strategy 8.3: Standardize and enhance State support across rural Nevada.
- Strategy 8.4: Enhance county support across rural Nevada.
- Strategy 8.5: Develop private sector capacity and initiatives in rural Nevada.

*Infrastructure Development Goals*

Goal 9: Ensure Long Term Viability of Rural Health Care Facilities.

- Strategy 9.1: Stabilize revenues and investment of facilities.
- Strategy 9.2: Ensure availability of appropriate diagnostic and treatment services.
- Strategy 9.3: Improve quality, service delivery, and customer satisfaction.

Strategy 9.4: Keep current with plant, property, and equipment.

Goal 10: Expand Capacity to Provide Health Care Services within Rural Communities.

Strategy 10.1: Assure reasonable access to diagnostic services.

Strategy 10.2: Continue development of inpatient and outpatient services.

Strategy 10.3: Develop facilities and services for the aged.

Strategy 10.4: Strengthen public health presence in rural communities.

Strategy 10.5: Address tertiary care access issues.

Strategy 10.6: Develop and centralize administrative capabilities when effective.

Strategy 10.7: Enhance and coordinate medical transportation systems.

Goal 11: Support Maximum Use of Technology in Rural Communities.

Strategy 11.1: Support improvement and utilization of communication systems.

Strategy 11.2: Expand telemedicine capabilities.

Strategy 11.3: Enhance public broadband infrastructure.

In summary, these eleven goals and their associated strategies and action steps describe work in progress by rural health care stakeholders across the state. Shortly after the publication of *Strategic Plan for Rural Health Care* the Governor of Nevada appointed a Rural Health Care Accountability Group to oversee and evaluate the implementation of the task force's recommendations. The group has assisted state policymakers with the prioritization of rural health care issues requiring legislation for the 2003, 2005, and 2007 sessions of the Nevada State Legislature, and is developing priorities for the upcoming 2009 session.

### **C. The Role of the Nevada Flex Program in Strategic Health Care Planning and Development in Nevada.**

Since 1999, the Nevada Flex Program has undertaken a wide-range of activities that have improved the delivery of hospital care and health services in rural and frontier Nevada. These programs and activities are consistent with the goals and recommendations embodied in recent statewide strategic planning undertaken by the State of Nevada and overseen by rural health care stakeholders across our state.

An important component of the Nevada Flex Program's success has been the productive collaboration of the program's advisory committee and the coordination of Flex program activities with planning efforts coordinated by the State of Nevada. Committee members have met on a bimonthly basis since 1999 to develop and implement Nevada Flex Program activities, and to improve coordination on rural health advocacy, cross-cutting program development, grant writing, and the larger tasks associated with rural hospital and health policy development. As such, while focused primarily on issues confronting rural and frontier hospitals in Nevada, the Nevada Flex Program and its advisory committee have been actively engaged in strategic health care planning for the past decade.

Moreover, the goals, strategies, and action steps recommended by the State's rural health care task force are consistent with the mission of the Nevada Flex Program and the objectives to be pursued by Flex program staff and partners. The mission of the Nevada Flex Program is to increase access to quality inpatient services, clinic and outpatient services, skilled nursing and long-term care services, and pre-hospital/EMS services for residents of rural and frontier Nevada. The vision of the Nevada Flex Program is to increase access to health care services for all residents of rural and frontier Nevada by improving the economic viability of health care providers and expanding the continuum of health services through the provision of technical assistance and support to rural and frontier hospitals and communities in Nevada.

Over the next five years, the Nevada Flex Program and partners will pursue the program's mission and vision by building on a wide-range of proven and innovative activities supported by Flex grant funding since 1999.

Specifically, Nevada Flex Program staff, subcontractors, and program partners will:

- (1) Support fifteen rural and frontier hospitals in Nevada through the provision of technical assistance**, including development of network agreements and contracts; Medicare survey preparation and on-site mock surveys; creation and development of hospital policies and procedures; assistance with grant writing and loan applications; periodic seminars and workshops on rural hospital reimbursement and compliance issues; and regular updates and information dissemination via the Nevada Flex Program website.

- (2) Advance performance and quality improvement in Nevada’s fifteen rural and frontier hospitals**, including full implementation of the Nevada Rural Hospital Benchmarking Initiative and the associated use of rural-sensitive quality indicators; support for strategic hospital planning; development of Balanced Scorecards and other performance improvement tools; full implementation of the Nevada Rural Hospital Revenue Cycle Initiative; development of customized inpatient, outpatient, and ER patient satisfaction surveys; development of customized employee satisfaction surveys; facilitation of Nevada rural hospital participation in Hospital Compare, CAHPS Hospital Survey, and other national quality improvement efforts; coordination of Flex-supported quality improvement activities with HealthInsight (Nevada QIO); financial and staff support for the Nevada Flex QI Network, a quarterly meeting of all rural hospital quality improvement/risk managers, who oversee the utilization of rural-relevant quality data for quality improvement projects; and oversight of CAH compliance with QA/Credentialing in coordination with Nevada Rural Hospital Partners’ credentialing program.
- (3) Facilitate the improvement and integration of rural and frontier EMS services in Nevada**, including the development and provision of EMT Basic and EMT Intermediate courses to rural EMS providers, EMS Continuing Education courses to rural EMS providers and EMS Medical Directors, and “train-the-trainer” courses to rural EMS instructors by the Nevada Flex EMS Coordinator; financial and staff support for the Annual Nevada Rural EMS Conference; and rural trauma and EMS systems development in conjunction with the Nevada EMS Bureau and local EMS agencies.
- (4) Undertake and support rural health care strategic planning and policy development** through the already-established meeting structure and processes of the Nevada Flex Program Advisory Committee and in coordination with ongoing, Flex-supported benchmarking and performance improvement activities, health services research, program evaluation, and routine data collection efforts.
- (5) Assist CAH-eligible hospitals and rural communities in Nevada assess the feasibility of CAH designation and/or the feasibility of new hospital construction**, including annual feasibility assessments for the four CAH-eligible facilities that meet CAH statutory requirements, assistance with the initial CAH certification survey for facilities electing to pursue CAH designation, and assistance to two rural communities in Nevada without acute care facilities who are exploring new hospital construction.
- (6) Undertake a wide-range of health services research and data collection for rural and frontier hospitals and communities in Nevada**, including annual updates of the county-level and sub-county assessments of the employment and payroll impact of hospitals and the health sector (IMPLAN reports); financial feasibility

assessments for new and expanded service lines for requesting facilities; community health care needs assessments for requesting rural hospitals and communities; biennial updates to the *Nevada Rural and Frontier Health Data Book*; support for Nevada Rural Health Works research and policy analysis; and routine data requests from hospitals, health care providers, and public and private agencies.

- (7) Support rural health care network development in Nevada**, including expansion and routine maintenance of telehealth and other telecommunications capacity in rural facilities; support for increased provider utilization of the telehealth network; advocate for improved reimbursement of telehealth consultations; support for the digital capabilities of the Picture Archiving Communication Systems (PACS); support for the state's principal rural hospital network, Nevada Rural Hospital Partners; and general support for rural health care network development among CAHs and other rural hospitals, Rural Health Clinics (RHCs) and community health centers (FQHCs), rural communities in Nevada, and geographically isolated providers in California on the eastern slope of the Sierra Nevada.
- (8) Evaluate Nevada Flex Program activities and impacts in conjunction with national monitoring team efforts**, including the utilization of evaluation findings for ongoing program performance improvement, rural hospital advocacy efforts, rural health care planning and policy development in Nevada, and utilization of program evaluation data by individual hospitals for internal performance improvement.

In summary, the Nevada Flex Program Advisory Committee believes that the goals and objectives of the Nevada Flex Program are consistent with the recommendations developed in the *Strategic Plan for Rural Health Care* developed by the State of Nevada and rural health care stakeholders in Nevada during the previous decade. Indeed, the full implementation of Nevada Flex Program activities are seen by many rural health care stakeholders and policymakers as integral to the success of the statewide strategic health care plan.

The cornerstone of Nevada Flex Program activity is the development of "in-house" performance measurement and strategic planning capacity in all rural and frontier hospitals. As such, the improved ability of rural and frontier hospitals to undertake long-term, strategic planning is consistent with renewed statewide efforts to develop sustainable financing and support for quality health care services in all regions of rural and frontier Nevada.

#### IV. CRITICAL ACCESS HOSPITAL DESIGNATION IN NEVADA

A key role played by the Nevada Flex Program has been the facilitation of “Critical Access Hospital” or CAH designation for CAH-eligible facilities in Nevada. A complete list of Nevada’s ten Critical Access Hospitals and other CAH-eligible facilities is contained in Appendix 2. Since 1999, the Nevada Flex Program has performed financial impact evaluations for facilities considering CAH designation, undertaken community outreach and board education activities for hospitals pursuing CAH certification, and provided “mock certification surveys” for those facilities that have scheduled CAH/Medicare surveys with the State of Nevada Bureau of Licensure and Certification.

##### A. Description of the Application Process

In accordance with the regulations in 42 Code of Federal Regulation (CFR) 485, Subpart F and provisions set forth in this plan, a hospital or other health facility electing Critical Access Hospital status must meet the following requirements. The hospital or facility:

- (1) Must apply for CAH designation with the Nevada Office of Rural Health (Appendix 3 contains a copy of the preliminary application for CAH eligibility in Nevada).
- (2) Must (a) be located outside any area that is a Metropolitan Statistical Area (MSA), as defined by the Office of Management and Budget, – or – (b) be located outside an urban area as defined by the Census Bureau, – or – (c) if located in a MSA or urban area (“Metropolitan CAH”), be treated as being located in a rural area.

Hospitals located in MSA or urban areas of Nevada are “treated as being located in a rural area” if the hospital (a) is located in a rural census tract of a MSA as determined by the most recent version of the Goldsmith Modification; – or – (b) is located in an area designated as a rural area by any law or regulation of the State within which it is located; – or – (c) is designated as a rural hospital by State law or regulation; – or – (d) would qualify as a rural referral center if the hospital were located in a rural area; – or – (e) would qualify as a sole community hospital if the hospital were located in a rural area.

- (3) Must be located more than a 35 mile drive from any other hospital or CAH; – or – in the case of mountainous terrain or in areas with only secondary roads available, a 15 mile drive from another hospital or CAH.
- (4) Must make available 24 hour emergency care services that the Nevada State Bureau of Licensure and Certification determines are necessary for ensuring access.
- (5) Must have a stated plan for the coverage of Emergency Medical Treatment

and Active Labor Act (EMTALA) regulations upon conversion as a CAH.

- (6) Must have a plan for the delivery of emergency medical services (EMS) for the defined service area of the CAH including air transport. The CAH will additionally participate in the further development of EMS planning for the network of CAHs within Nevada when such planning efforts are initiated by the Nevada Office of Rural Health.
- (7) Agrees to limit inpatient acute care beds to no more than 25 designated beds. If swing-bed approval has been granted, all 25 beds can be used interchangeably for acute care or swing-bed services. CAHs are allowed to establish distinct part rehabilitation and psychiatric units of up to 10 beds each, which will not be included in the revised total 25 CAH bed count.
- (8) Agrees to provide inpatient care for an annual average of 96 hours or less per admission. The average 96-hour stay does not apply to beds in distinct part rehabilitation and psychiatric units.
- (9) Must meet CAH staffing requirements – in particular, a CAH must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present.
- (10) Must be a member of a rural health network and have an agreement with at least one full service hospital in the network for: (a) Patient referral and transfer – this agreement will specify practitioners that are eligible to possess transfer privileges including evidence of practice protocols if they are non-physician practitioners; (b) the development and use of communications systems; (c) the provision of emergency and non-emergency transportation; and (d) the use of DRG (Diagnosis Related Groups) codes for use between the urban and rural facility.
- (11) Agrees to participate in ongoing quality-of-care improvement and community health planning activities, including the Nevada Flex Program Quality Improvement Network, a committee organized by the Nevada Flex Program in partnership with HealthInsight (QIO) and Nevada Rural Hospital Partners (NRHP).
- (12) Must be a full or foundation member of Nevada Rural Hospital Partners (NRHP), the state rural hospital association – any substitution for this condition must be submitted in writing to and approved by the Nevada Flex Advisory Committee.
- (13) Must ensure appropriate mechanisms for credentialing and quality assurance – a process for Nevada CAHs overseen by Nevada Rural Hospital Partners (NRHP) –

with a combination of the following entities: (a) one hospital that is a member of the network; (b) HealthInsight (Nevada's QIO); or (c) an appropriate and qualified entity identified by the Nevada Flex Program Advisory Committee. Any substitution for these conditions must be submitted in writing to and approved by the advisory committee. The *Nevada Rural Health Plan* empowers the advisory committee to identify qualified entities for the purpose of quality assurance and credentialing. The Nevada Flex Program Advisory Committee will identify and approve "qualified entities for the purpose of quality assurance and credentialing" on the basis of their expertise in developing quality-of-care improvement activities, incident/trend reporting, preparing quality-assurance plans, risk management consultation, and/or credentialing for small rural and frontier hospitals.

- (14) Must have a transfer agreement to another full service hospital should the CAH lose their Medicare certification.
- (15) Must have evidence of protocols for all non-physician practitioners credentialed by the CAH that would be applicable to the practice acts in force within Nevada and applicable to medical staff participation in the facility according to staff policies and procedures.
- (16) Agrees to participate in the planning for and application of telecommunications technology including the delivery of telehealth services, administrative connectivity, trauma assessments and other applications such as protocols for the supervision of non-physician practitioners. Any CAH which utilizes telecommunications technology at the time of application must agree to participate in planning efforts for a rural network (if they are members of such) or provide individual facility evidence of protocols, credentialing, and procedures for medical records and patient referrals appropriate to the specific uses of their system.
- (17) Agrees to comply with CMS rules and regulations that apply to the Critical Access Hospital program that are in effect at the time of application and thereafter as long as they are designated as a CAH.
- (18) Agrees to undertake a financial feasibility study and community health care needs assessment. A preliminary financial feasibility study must be completed and accompany the application to the Nevada Office of Rural Health. The community health care needs assessment should include a description of the current services available, identified gaps in services, and proposed services and their impact upon the CAH service area. The community health care needs assessment must evaluate the availability and utilization of health care services including acute care, primary care and

emergency medical services.

- (19) Understand that a hospital license issued by the Bureau of Licensure and Certification is non transferable.

## **B. State of Nevada Designation Process**

The Nevada Office of Rural Health (ORH) – in conjunction with the Nevada Rural Hospital Partners (NRHP), the Nevada Hospital Association (NHA), and the Nevada State Bureau of Licensure and Certification (BLC) – coordinate the following Nevada Flex Program and CAH-related activities, including the:

- Identification of prospective hospital candidates whose average daily census, length of stay, and fiscal situation warrant their potential for conversion to a CAH – Appendix 2 contains a current and complete list of certified Critical Access Hospitals and facilities and communities deemed by the ORH as “CAH-eligible”.
- Provision of public information and education regarding the program and subsequent health planning activities to rural communities in the state. These methods would include both written advertisements as well as program updates at identified meetings and conferences; and would extend to site specific activities to inform and educate communities regarding potential program impacts.
- Provision of technical assistance to health facilities and other interested parties in efforts aimed at network development, community needs assessment and education, financial feasibility and other pertinent health planning. Future federal funding aimed at technical assistance for the purposes of this program would be integrated into these technical assistance efforts.
- Identification and development of network partners that either must be an element of specific program criteria, or would aid in the execution of a rural health system.

## **C. Criteria For Application Review**

Any hospital requesting review as a CAH shall complete the “Preliminary Application for CAH Eligibility Determination” including a financial impact assessment of CAH designation and requested attachments, to the Nevada Office of Rural Health (ORH). This application is contained in Appendix 3. Application review and eligibility determination shall be made within 30 working days and forwarded onward to the Nevada State Bureau of Licensure and Certification (BLC). Application criteria deemed incomplete shall be returned with comments to the applicant for necessary modification and if responded to appropriately, shall be

resubmitted to the ORH and reviewed expeditiously for completeness and forwarded onward to the BLC. Application to the ORH can be delayed upon request by the submitting facility within the thirty day review period.

The application forwarded to the BLC by the ORH shall have the eligibility determination marked upon the face cover and must include all information on the applicant's ability to meet all federal and state criteria for designation as a CAH. Within 30 days of receiving a completed and eligible application, the BLC will contact the prospective CAH to determine the readiness for the CAH survey. BLC assures that no hospital will be surveyed for CAH designation until all federal eligibility criteria and state-specific criteria have been met. If eligibility criteria have been met, the BLC will send documentation to the CMS Region IX Office and the Nevada ORH that verifies that the hospital meets all eligibility requirements and is ready for the CAH survey. The BLC in conjunction with the ORH shall verify to the CMS Region IX Office regarding the applicant's compliance to the program criteria. The CMS regional office will authorize a survey, and the BLC will notify the facility that a survey will take place at some unannounced time in the near future. The survey will verify that the CAH meets the federal facility requirements and CAH Conditions of Participation. Details about the survey process are available in Appendix W of the CMS State Operations Manual and the Nevada Flex Program's "Checklist for the Medicare Critical Access Hospital (CAH) Certification Survey." Copies of both documents can be obtained from the ORH.

CAH accreditation is also available through the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association's (AOA) Healthcare Facilities Accreditation Program. Any facility seeking CAH accreditation from JCAHO or AOA must complete the preliminary application contained in Appendix 3 and notify the ORH in writing of their intent to seek CAH accreditation from either JCAHO or AOA.

#### **D. Public Understanding of the Process**

Public information will be sent to interested and eligible facilities by the Nevada Office of Rural Health (ORH). On-site consultations will be done for community education purposes, as requested by interested facilities, groups or individuals, by the ORH. Documentation of the entire process will be kept on file at the ORH.

## **E. Monitoring and Evaluation**

The Nevada Office of Rural Health (ORH) shall be responsible for the following monitoring activities of CAHs and prospective CAHs in meeting community health needs:

- Ongoing review of the effectiveness of the program, in conjunction with the partner organizations, and make modifications regarding the regulatory or process components;
- Ongoing identification of network issues that represent concerns pertinent to the operation of state policies and programs;
- Ongoing review of reimbursement issues affecting Medicare and Medicaid pertinent to the CAH program; and
- Ongoing review and assessment of a CAH-designated facility's performance in meeting identified health needs (as stated in the community needs assessments).

The Nevada State Bureau of Licensure and Certification (BLC) shall be responsible for the following activities:

- Provide ongoing monitoring of a CAH facility to confirm compliance with state and federal regulations; and
- Provide ongoing comment to the ORH and collaborating entities regarding program operation, suggestions for improvement of community outreach and education, quality assurance and quality improvement, health planning, and other CAH network activities.

The Nevada Office of Rural Health assumes primary responsibility for overseeing and monitoring Nevada Flex Program activities and the CAH designation process in Nevada.

## **F. Conclusion – Critical Access Hospital Designation in Nevada**

CAH designation is a crucial element of continued financial and economic viability for most rural and frontier hospitals in Nevada. Likewise, resources provided to the Nevada Rural Hospital Flexibility Program are a key source of the limited assistance available to vulnerable rural and frontier hospitals and health care providers in Nevada. The Nevada Flex Program Advisory Committee believes that the designation process guidelines embodied in this document, as well as the ongoing assessment and refinement of Nevada Flex Program activities are essential to the program's success and the continuity of our state's federal appropriation, our credibility among rural health care providers and communities in Nevada, and our

advocacy efforts with state policymakers.

## V. CONCLUSION: THE FUTURE OF HEALTH CARE IN RURAL NEVADA

This version of the *Nevada Rural Health Plan* represents an organic, changing vision for improving health care services in rural and frontier regions of Nevada. In order to attain these goals, the Nevada Flex Program and its Advisory Committee are committed to:

- The continued inclusion of a broader range of rural health stakeholders in rural health care planning than is currently represented in the Nevada Flex Advisory Committee and that is reflected in the current version of the state rural health plan;
- The ongoing development and refinement of the *Nevada Rural Health Plan* that addresses the dynamic nature of rural and frontier hospital services and health care in Nevada;
- Greater coordination of Flex program planning with existing community-level, regional, and statewide rural health care planning, including coordination with the Governor's Rural Health Care Accountability Group charged with monitoring the implementation of strategies and action steps contained in the State's *Strategic Plan for Rural Health Care* in Nevada; and
- Ultimately, the development of a comprehensive vision for rural and frontier hospital and health care delivery in Nevada, i.e., the plan must become a *prescriptive*, as opposed to simply, *descriptive* document.

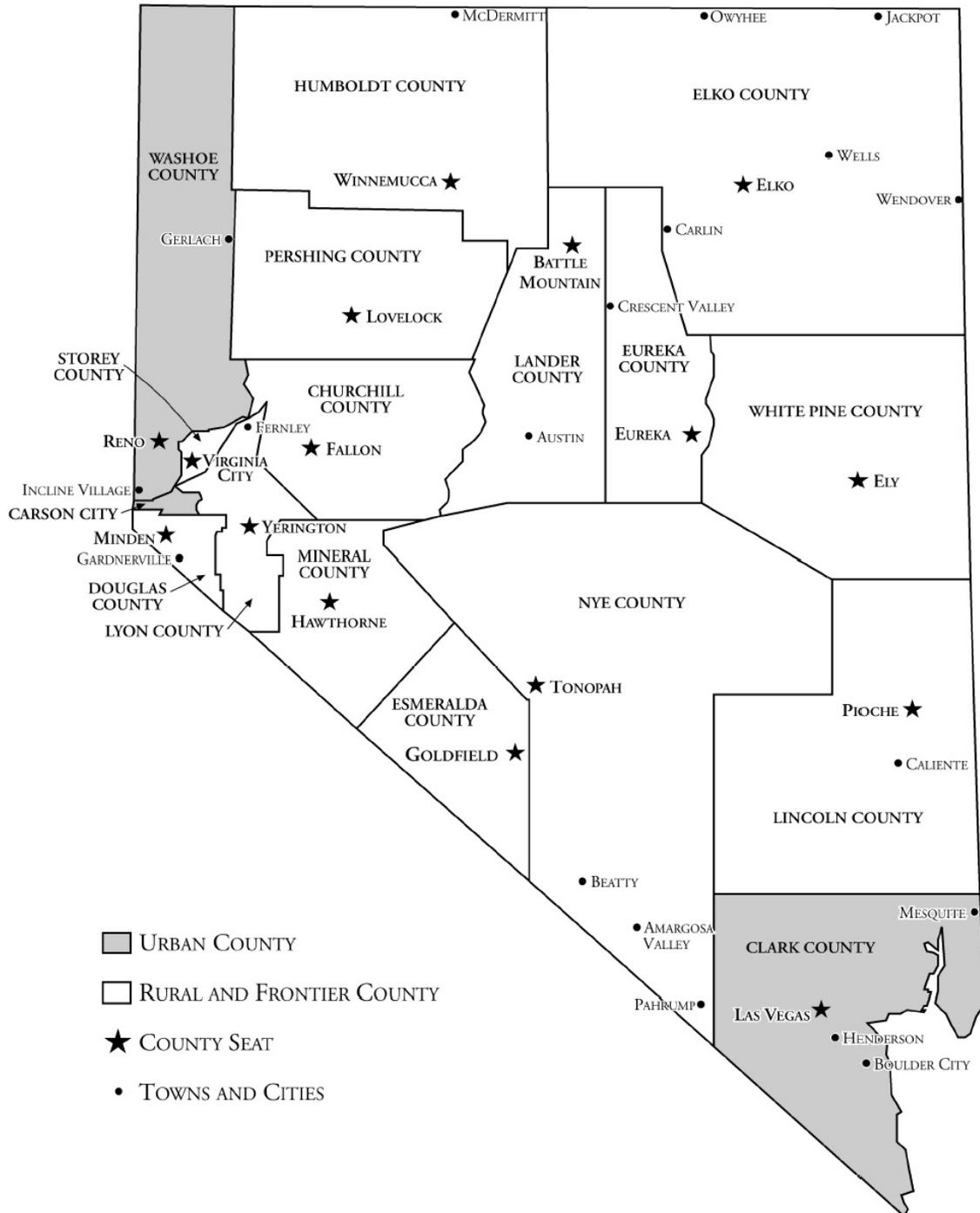
The Nevada Flex Program Advisory Committee believes that the overview of Nevada's rural health care system and the designation process guidelines embodied in this document, as well as the ongoing assessment and refinement of Nevada Flex Program activities are essential to the program's success, the Flex program's credibility among rural health care providers and communities in Nevada, and our advocacy efforts with state policymakers. As such, we will continue to update and revise this plan as our state's rural and frontier health care system continues to change.

**NEVADA RURAL HEALTH PLAN**

**APPENDIX 1: Health and Health Care in  
Rural and Frontier Nevada**

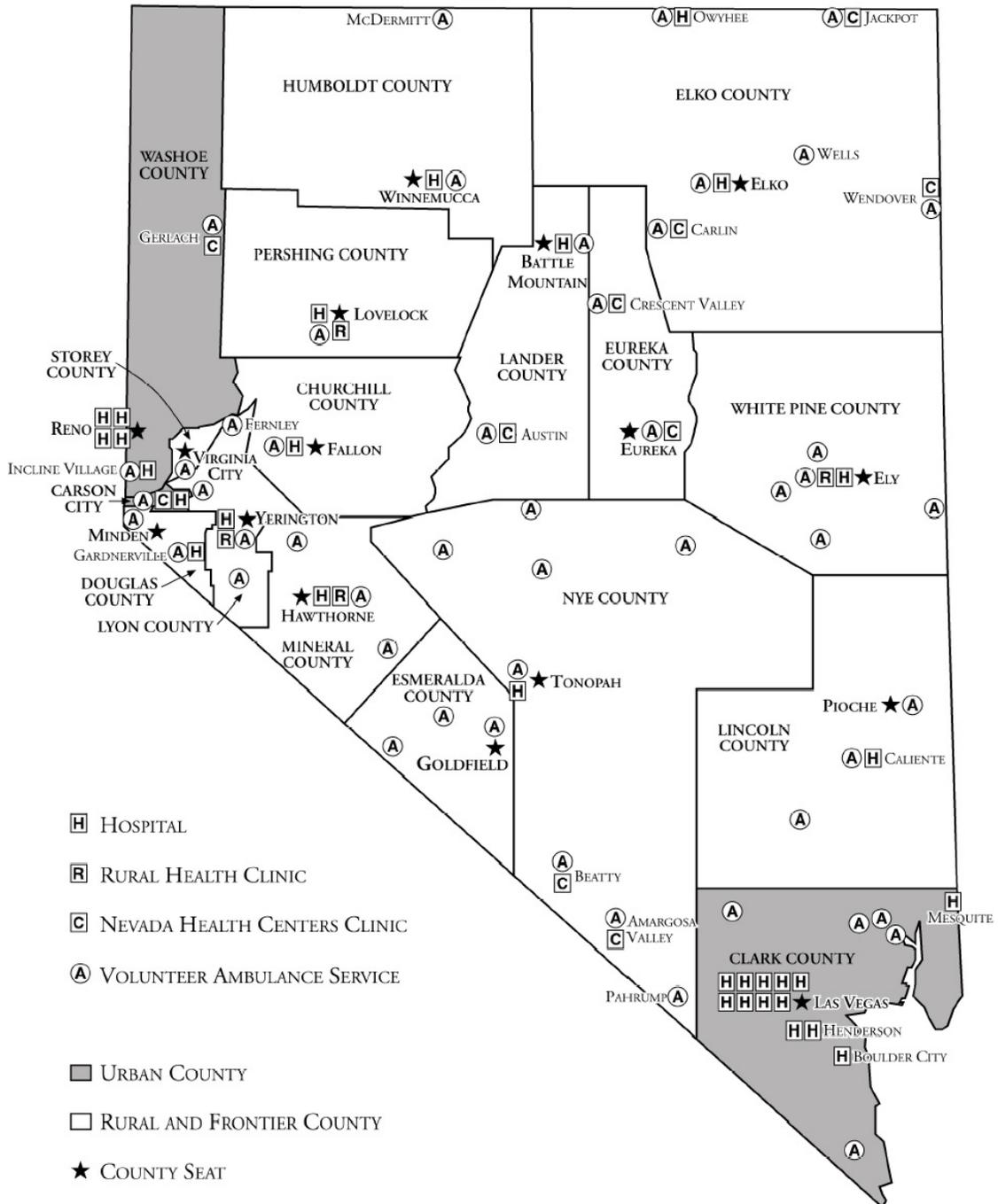


Map 1: Nevada Counties, County Seats, and Towns





Map 3: Hospital and Healthcare Resources in Nevada



**Table 1: Population and Geography in Nevada by County – 2005**

County/Region	Estimated Population 2005		Geography	
	Number	Percent of State Population	Area in Square Miles	Percent of State Land Mass
<b>Rural and Frontier</b>				
Churchill County	26,585	1.1	4,929	4.5
Douglas County	50,108	2.0	710	0.6
Elko County	47,586	1.9	17,179	15.6
Esmeralda County	1,276	0.1	3,588	3.3
Eureka County	1,485	0.1	4,176	3.8
Humboldt County	17,293	0.7	9,648	8.8
Lander County	5,509	0.2	5,494	5.0
Lincoln County	3,886	0.2	10,634	9.7
Lyon County	48,860	1.9	1,994	1.8
Mineral County	4,629	0.2	3,756	3.4
Nye County	41,302	1.6	18,147	16.5
Pershing County	6,736	0.3	6,037	5.5
Storey County	4,012	0.2	263	0.2
White Pine County	9,275	0.4	8,876	8.1
Subtotal	268,541	10.7	95,431	86.9
<b>Urban</b>				
Carson City	57,104	2.3	143	0.1
Clark County	1,796,380	71.3	7,910	7.2
Washoe County	396,844	15.8	6,342	5.8
Subtotal	2,250,328	89.3	14,395	13.1
Nevada – Total	2,518,869	100.0	109,826	100.0

Source: Nevada State Demographer's Office (2006a).

**Table 2: Projected Population in Nevada by County – 2006 to 2016**

County/Region	Estimated Population			Change – 2006 to 2016	
	2006	2011	2016	Number	Percent
<b>Rural and Frontier</b>					
Churchill County	27,037	29,015	31,306	4,270	15.8
Douglas County	50,752	54,415	58,434	7,682	15.1
Elko County	47,137	45,981	43,659	- 3,481	- 7.4
Esmeralda County	1,243	1,131	1,057	- 186	- 14.9
Eureka County	1,505	1,634	1,592	88	5.8
Humboldt County	17,396	17,456	16,748	- 648	- 3.7
Lander County	5,419	5,471	5,537	118	2.2
Lincoln County	4,070	4,897	5,087	1,347	33.1
Lyon County	51,373	63,222	73,749	22,377	43.6
Mineral County	4,619	4,685	4,765	146	3.2
Nye County	43,570	53,908	62,323	18,753	43.0
Pershing County	6,763	6,801	5,325	- 35	- 0.5
Storey County	4,106	4,589	5,069	963	23.4
White Pine County	9,209	9,296	9,352	143	1.6
Subtotal	274,198	302,502	325,734	51,536	18.8
<b>Urban</b>					
Carson City	58,245	64,184	70,071	11,826	20.3
Clark County	1,892,391	2,379,242	2,791,542	899,151	47.5
Washoe County	406,223	455,878	505,614	99,391	24.5
Subtotal	2,356,859	2,899,30	3,367,228	1,010,097	42.9
Nevada – Total	2,631,057	3,201,806	3,692,962	1,061,904	40.4

Source: Nevada State Demographer's Office (2006b).

**Table 3: Projected Population Aged 65 and Over in Nevada by County – 2006 to 2016**

County/Region	Estimated Population 65 and over			Change – 2006 to 2016	
	2006	2011	2016	Number	Percent
<b>Rural and Frontier</b>					
Churchill County	3,165	3,513	4,111	947	29.9
Douglas County	8,586	10,304	12,629	4,043	47.1
Elko County	3,600	4,587	5,722	2,122	58.9
Esmeralda County	210	215	237	27	12.7
Eureka County	187	203	198	11	5.8
Humboldt County	1,734	2,183	2,714	980	56.5
Lander County	531	741	962	431	81.1
Lincoln County	660	884	1,135	475	72.0
Lyon County	7,371	9,361	11,660	4,288	58.2
Mineral County	984	936	945	- 39	- 4.0
Nye County	9,281	12,194	14,737	5,455	58.8
Pershing County	685	756	838	153	22.3
Storey County	683	921	1,163	480	70.2
White Pine County	1,417	1,427	1,523	106	7.5
Subtotal	39,095	48,224	58,572	19,477	49.8
<b>Urban</b>					
Carson City	8,372	9,535	11,294	2,922	34.6
Clark County	205,755	264,019	329,600	123,844	60.2
Washoe County	42,260	49,503	60,635	18,374	43.5
Subtotal	318,830	400,684	495,776	176,946	55.5
Nevada – Total	357,924	448,908	554,347	196,423	54.9

Source: Nevada State Demographer's Office (2006c).

**Table 4: Projected Hispanic Population in Nevada by County – 2006 to 2016**

County/Region	Estimated Hispanic Population			Change – 2006 to 2016	
	2006	2011	2016	Number	Percent
<b>Rural and Frontier</b>					
Churchill County	2,739	3,228	3,810	1,071	39.1
Douglas County	3,999	4,522	5,108	1,109	27.7
Elko County	9,510	8,910	7,881	- 1,629	- 17.1
Esmeralda County	155	155	159	4	2.8
Eureka County	144	156	152	8	5.8
Humboldt County	3,376	3,722	4,110	734	21.7
Lander County	1,157	1,203	1,249	93	8.0
Lincoln County	184	248	301	117	63.6
Lyon County	6,234	8,205	10,129	3,896	62.5
Mineral County	409	458	511	101	24.7
Nye County	3,874	5,075	6,243	2,369	61.2
Pershing County	1,098	1,167	1,207	108	9.9
Storey County	230	293	360	129	56.1
White Pine County	788	802	809	21	2.7
Subtotal	33,896	38,145	42,030	8,133	24.0
<b>Urban</b>					
Carson City	9,978	12,705	15,728	5,751	57.6
Clark County	499,401	695,487	880,574	381,173	76.3
Washoe County	85,659	110,621	137,862	52,202	60.9
Subtotal	595,038	818,812	1,034,164	439,126	73.8
Nevada – Total	628,934	856,957	1,076,193	447,259	71.1

Source: Nevada State Demographer's Office (2006c).

**Table 5: Per Capita Income as a Percent of US Per Capita Income  
in Nevada by County – 2000 to 2004**

County/Region	Per Capita Income as a Percent Of US per Capita Income (Dollars)				
	2000	2001	2002	2003	2004
<b>Rural and Frontier</b>					
Churchill County	84	85	88	94	97
Douglas County	132	133	133	130	129
Elko County	82	81	82	83	86
Esmeralda County	82	85	91	97	102
Eureka County	78	83	77	84	87
Humboldt County	83	77	84	76	78
Lander County	85	81	85	84	85
Lincoln County	62	66	64	66	65
Lyon County	77	77	76	74	73
Mineral County	81	72	76	77	77
Nye County	81	81	79	82	82
Pershing County	57	53	53	53	55
Storey County	95	96	96	92	93
White Pine County	81	83	86	84	92
Average	90	89	90	83	86
<b>Urban</b>					
Carson City	107	105	105	104	109
Clark County	99	97	95	98	100
Washoe County	121	121	119	120	120
Average	104	101	100	108	110
Nevada – Average	102	100	100	101	102

Source: Bureau of Economic Analysis (2006a).

**Table 6: Labor Force and Unemployment in Nevada by County – 2006**

County/Region	Labor Force Estimates – 2006			
	Labor Force	Employed	Unemployed	Unemployment Rate
<b>Rural and Frontier</b>				
Churchill County	12,978	12,393	585	4.5
Douglas County	22,398	21,360	1,038	4.6
Elko County	24,372	23,399	973	4.0
Esmeralda County	459	437	22	4.8
Eureka County	711	679	32	4.6
Humboldt County	7,999	7,667	332	4.2
Lander County	2,871	2,740	130	4.5
Lincoln County	1,530	1,455	75	4.9
Lyon County	21,228	20,061	1,167	5.5
Mineral County	2,120	1,973	147	6.9
Nye County	17,105	16,228	876	5.1
Pershing County	2,455	2,316	139	5.7
Storey County	2,202	2,103	99	4.5
White Pine County	4,354	4,168	167	4.3
Subtotal	122,782	116,979	5,782	5.0
<b>Urban</b>				
Carson City	27,868	26,532	1,336	4.8
Clark County	902,286	866,196	36,090	4.0
Washoe County	215,432	206,803	8,629	4.0
Subtotal	1,145,586	1,099,531	46,055	4.3
Nevada – Total	1,268,368	1,216,510	51,837	4.0

Source: Nevada Department of Employment Training and Rehabilitation (2006).

**Table 7: Behavioral Risk Factor Prevalence Rates in Nevada by Region – 2004**

Behavioral Risk Factor	Behavioral Risk Factor Prevalence Rates – 2004 (Percent of Population Engaging in Health Consequential Behavior)				
	Clark County	Washoe County	Rural and Frontier	Nevada – Total	US
Core Questions					
Alcohol, Binge Drinking, 5+ at a Single Occasion	17.2	21.6	17.9	18.0	15.1
Alcohol, Heavy Drinking, Daily Men 2+, Women 1+	N/P	N/P	N/P	6.9	4.9
Arthritis Burden, Told Have Arthritis	N/P	N/P	N/P	25.1	27.0
Asthma, Currently Has	7.7	6.0	5.9	7.1	8.0
Asthma, Ever Had	N/P	N/P	N/P	12.6	12.6
Blood Cholesterol, Told Was High	38.8	33.0	32.0	36.8	35.6
Diabetes, Ever Had	6.4	6.1	6.9	6.4	7.3
Diabetes, Now Taking Insulin	N/P	N/P	N/P	23.5	7.0
Diabetes, Eyes Affected or Retinopathy	N/P	N/P	N/P	24.2	N/A
Disability, Limited in Any Way	17.0	15.7	15.2	16.5	18.6
Disability, Use Aid Equipment	N/P	N/P	N/P	5.4	6.2
Flu Shot, Age 65+, Not Within the Past 12 Months	44.3	34.0	33.9	41.0	34.3
Fruits and Vegetables, Not Enough	80.9	76.3	78.1	79.6	76.8
Health Status in General (Fair/Poor)	17.3	13.2	22.7	18.1	14.8
Healthy Days	N/P	N/P	N/P	N/P	N/A
Health Care Access	N/P	N/P	N/P	N/P	N/A
HIV/AIDS, No HIV Test	N/P	N/P	N/P	53.5	N/A
HIV/AIDS, Participates in High Risk Behavior	N/P	N/P	N/P	3.4	N/A
HIV/AIDS, at Risk, Never Counseled by Doctor	N/P	N/P	N/P	88.5	N/A
Hypertension, Ever Been Told	24.3	23.9	20.6	23.6	25.5
Overweight or Obese (Body Mass Index >=25.0)	61.9	51.3	60.8	60.0	61.1
Physical Activity, No Leisure Time in Last 30 Days	26.4	15.6	24.0	24.2	23.8

**Table 7: Behavioral Risk Factor Prevalence Rates In Nevada by Region – 2004, Continued**

Behavioral Risk Factor	Behavioral Risk Factor Prevalence Rates – 2004 (Percent of Population Engaging in Health Consequential Behavior)				
	Clark County	Washoe County	Rural and Frontier	Nevada – Total	US
Core Questions, Continued					
Pneumonia Vaccine, Age 65+, Not Ever	33.0	31.7	35.9	33.3	34.1
Smoking, Current Status	24.2	21.5	21.0	21.7	20.9
Smoking, Stopped for Day or More, Trying to Quit	N/P	N/P	N/P	49.3	N/A
Optional Questions					
Blood Stool, Never Had Test (Age 50+)	73.1	77.8	73.4	N/P	73.5
Mammogram No Test in past Two Years (Females)	29.9	29.5	35.5	30.7	25.2
Mammogram & Breast Exam, Never Had (Females)	14.9	12.9	21.5	16.0	N/A
Oral Health, Did Not Visit Dentists in past Year	N/P	N/P	N/P	35.5	29.3
Oral Health, Age 65+, Had 6 or More Teeth Removed	N/P	N/P	N/P	30.6	N/A
Oral Health, No Insurance	N/P	N/P	N/P	38.4	N/A
Pap Smear, No Test in past Three Years (Females)	13.9	15.1	21.1	15.2	14.0
Sigmoidoscopy or Colonoscopy, Never Had	54.5	51.7	55.4	N/P	46.6

Sources: Bureau of Health Planning and Statistics (2006c) and Centers for Disease Control (2006b).

**Table 8: Leading Causes of Death in Nevada by Region of Residence – 2004**

Cause of Death	Age-adjusted Mortality Rate per 100,000 Population – 2004 (Regional Rank and Rate)									
	Clark County		Washoe County		Rural and Frontier Counties		Nevada		United States	
Diseases of the Heart, Total	1	232.0	1	238.5	1	235.9	1	233.8	1	217.5
Malignant Neoplasms, Total	2	182.9	2	185.2	2	200.8	2	186.3	2	184.6
Chronic Lower Respiratory Disease	5	49.5	3	75.4	3	62.0	3	55.5	5	41.8
Trachea, Bronchus and Lung Cancer	3	53.9	4	58.2	4	57.3	4	55.1	3	52.9
Cerebrovascular Diseases (Stroke)	4	51.8	5	57.4	5	49.7	5	52.6	4	50.0
Pedestrian Deaths (Non Transport)	6	25.3	9	18.0	6	29.1	6	24.7	6	36.6
Transport Accidents	13	15.7	14	15.2	7	28.4	13	17.2	12	15.8
Intentional Self-harm (Suicide)	12	16.2	8	19.0	8	27.4	11	18.2	16	10.7
Influenza and Pneumonia	9	21.1	10	17.3	9	23.3	8	20.9	10	20.4
Diabetes Mellitus	15	11.2	13	15.3	10	22.9	14	13.7	7	24.4
Colorectal Cancer	8	21.1	7	20.3	11	19.6	9	20.8	11	17.9
Alzheimer's Disease	11	17.9	15	14.0	12	18.2	12	17.4	8	21.7
Prostate Cancer (Men)	18	8.9	18	11.4	13	18.1	17	10.8	17	9.7
Septicemia	10	19.7	11	16.4	14	16.3	10	18.7	15	11.2
Nephritis, Nephrotic Syndrome, Nephrosis	7	24.3	16	12.5	15	15.7	7	21.1	13	14.3
Chronic Liver Disease and Cirrhosis	16	9.6	12	15.9	16	15.4	16	11.5	18	8.8
Essential Hypertensive Renal	19	5.5	19	9.7	17	9.9	18	7.0	19	7.6
Breast Cancer (Women)	14	14.6	17	12.2	18	9.2	15	13.4	14	13.6
Pneumonitis Due to Solids and Liquids	20	5.5	21	5.5	19	8.3	21	5.9	21	5.6
Atherosclerosis	26	3.3	6	22.7	20	7.2	20	7.1	9	21.0
Benign Neoplasms	23	3.9	23	4.1	21	5.7	24	4.3	23	4.5
Parkinson's	21	4.8	20	8.2	22	4.8	23	5.3	20	6.1
Assault (Homicide)	17	9.1	22	4.2	23	4.2	19	7.8	22	5.6
Lip, Oral Cavity and Pharynx Cancer	25	3.3	24	1.9	24	2.9	22	3.0	24	2.7
Total Mortality Rate		843.2		880.7		916.8		861.1		801.1

Source: Bureau of Health Planning and Statistics (2006c) and Centers for Disease Control and Prevention (2006b).

**Table 9: Health Insurance Coverage in Nevada by County– 2000 to 2004**

County/Region	Uninsured as a Percent of Total Population					
	2000	2001	2002	2003	2004	Five Year Average
Rural and Frontier						
Churchill County	16.5	16.6	14.5	14.5	15.2	15.5
Douglas County	15.9	16.0	14.1	14.1	14.9	15.0
Elko County	19.2	19.2	17.1	17.0	17.8	18.1
Esmeralda County	16.8	16.9	14.9	15.0	15.7	15.9
Eureka County	17.1	16.9	14.8	14.6	15.3	15.7
Humboldt County	19.8	19.8	17.9	18.0	18.7	18.8
Lander County	19.1	19.1	17.0	16.9	17.7	18.0
Lincoln County	16.4	16.3	14.4	14.2	15.0	15.3
Lyon County	16.2	16.2	14.4	14.4	15.2	15.3
Mineral County	16.5	16.6	14.7	14.7	15.4	15.6
Nye County	15.9	15.9	14.0	14.0	14.7	14.9
Pershing County	18.7	18.8	16.9	17.0	14.7	17.2
Storey County	15.2	15.1	13.4	13.2	14.0	14.2
White Pine County	17.1	17.1	15.0	15.1	15.8	16.0
Average	17.2	17.2	15.2	15.2	15.7	16.1
Urban						
Carson City	16.5	16.6	14.6	14.6	15.4	15.5
Clark County	17.9	17.9	15.9	16.0	16.8	16.9
Washoe County	17.5	17.5	15.5	15.5	16.3	16.5
Average	17.3	17.3	15.3	15.4	16.2	16.3
Nevada – Average	17.7	17.8	15.8	17.8	15.8	16.6

Source: Great Basin Primary Care Association (2005).

**Table 10: Medicare Enrollment in Nevada by County – 2000 to 2005**

County/Region	Medicare Enrollment				Change – 2000 to 2005	
	Number – 2000	Percent of Population	Number – 2005	Percent of Population	Number	Percent
<b>Rural and Frontier</b>						
Churchill County	3,167	13.2	3,834	14.4	667	21.1
Douglas County	5,793	14.0	7,847	15.7	2,054	35.5
Elko County	2,999	6.6	4,108	8.6	1,109	37.0
Esmeralda County	145	14.9	189	14.8	44	30.3
Eureka County	232	14.1	254	17.1	22	9.5
Humboldt County	1,501	9.3	1,891	10.9	390	26.0
Lander County	466	8.0	584	10.6	118	25.3
Lincoln County	781	18.8	1,283	33.0	502	64.3
Lyon County	5,641	16.4	8,163	16.7	2,522	44.7
Mineral County	1,118	22.0	1,258	27.2	140	12.5
Nye County	6,862	21.1	9,993	24.2	3,131	45.6
Pershing County	519	7.8	635	9.4	116	22.4
Storey County	165	4.9	187	4.7	22	13.3
White Pine County	1,389	15.1	1,620	17.5	231	16.6
Subtotal	30,778	13.3	41,846	15.6	11,068	36.0
<b>Urban</b>						
Carson City	9,770	18.6	11,239	19.7	1,469	15.0
Clark County	159,007	11.6	204,135	11.4	45,128	28.4
Washoe County	40,054	11.8	51,582	13.0	11,528	28.8
Subtotal	208,831	11.8	266,956	11.9	29,222	27.8
Nevada – Total	239,609	12.0	308,802	12.3	69,193	28.9

Source: Centers for Medicare and Medicaid Services (2006a).

**Table 11: Medicaid Enrollment in Nevada by County – 2002 to 2006**

County/Region	Medicaid Enrollment				Change – 2002 to 2006	
	Number – 2002	Percent of Population	Number – 2006	Percent of Population	Number	Percent
<b>Rural and Frontier</b>						
Churchill County	2,001	8.0	2,237	8.3	236	11.8
Douglas County	1,379	3.1	1,655	3.3	276	20.0
Elko County	2,313	5.0	2,756	5.8	443	19.2
Esmeralda County	69	6.2	46	3.7	- 23	- 33.3
Eureka County	39	2.8	36	2.4	- 3	- 7.7
Humboldt County	968	5.9	1,044	6.0	76	7.9
Lander County	274	5.0	268	4.9	-6	- 2.2
Lincoln County	335	8.7	308	7.6	- 27	- 8.1
Lyon County	2,064	5.3	2,733	5.3	669	32.4
Mineral County	623	13.3	678	14.7	55	8.8
Nye County	3,615	10.3	4,836	11.1	1,221	33.8
Pershing County	333	4.8	402	5.9	69	20.7
Storey County	41	1.1	45	1.1	4	9.8
White Pine County	793	9.0	761	8.3	- 32	- 4.0
Subtotal	14,847	6.1	17,805	6.5	2,258	19.9
<b>Urban</b>						
Carson City	3,960	7.2	4,527	7.8	567	14.
Clark County	101,262	6.5	125,714	6.6	24,452	24.
Washoe County	20,666	5.8	24,676	6.1	4,010	19.
Subtotal	125,888	6.4	154,917	6.6	29,029	23.4
Nevada – Total	140,735	6.4	172,722	6.6	31,987	22.7

Source: Nevada Division of Welfare and Supportive Services (2006).

**Table 12: Single-County Health Professional Shortage Areas (HPSAs) and Underserved Areas (Medical and Dental) in Rural and Frontier Nevada by County – 2006**

County	Medical		Dental		Mental Health
	HPSA	MUA	HPSA	DUA	HPSA
Churchill County	No	No	No	Yes	Yes
Douglas County	No	No	No	No	No
Elko County	No	No	Yes	No	Yes
Esmeralda County	Yes	Yes	Yes	Yes	Yes
Eureka County	Yes	Yes	Yes	Yes	Yes
Humboldt County	Yes	No	No	No	Yes
Lander County	Yes	Yes	Yes	Yes	Yes
Lincoln County	Yes	Yes	Yes	Yes	Yes
Lyon County	Yes	Yes	Yes	Yes	Yes
Mineral County	Yes	No	Yes	Yes	Yes
Nye County	Yes	No	Yes	Yes	Yes
Pershing County	Yes	No	Yes	Yes	Yes
Storey County	Yes	Yes	Yes	Yes	Yes
White Pine County	No	No	Yes	Yes	Yes
Rural and Frontier Total	10	6	11	11	13

Sources: Bureau of Health Professions (2006) and Nevada Office of Rural Health (2006).

**Table 13: Estimated Employment in Selected Health Industry Sectors  
in Nevada by Region – 2004 to 2014**

Health Industry Sector / Region	Estimated Employment		Projected Employment Change – 2004 to 2014	
	2004	2014	Number	Percent
<b>Community Care Facilities for the Elderly</b>				
Las Vegas MSA	1,266	2,139	873	69.0
Reno MSA	437	690	253	57.9
Rural and Frontier Counties	350	481	131	37.4
Nevada – Community Care Facilities for the Elderly	2,053	3,310	1,257	61.2
<b>Home Health Care Services</b>				
Las Vegas MSA	2,290	3,864	1,574	68.7
Reno MSA	788	1,200	412	52.3
Rural and Frontier Counties	318	487	170	53.4
Nevada – Home Health Care Services	3,396	5,552	2,156	63.5
<b>Hospitals</b>				
Las Vegas MSA	16,834	24,849	8,015	47.6
Reno MSA	6,802	8,964	2,161	31.8
Rural and Frontier Counties	2,439	3,253	815	33.4
Nevada – Hospitals	26,075	37,066	10,991	42.2
<b>Medical and Diagnostic Laboratories</b>				
Las Vegas MSA	1,856	2,876	1,020	55.0
Reno MSA	595	851	256	43.0
Rural and Frontier Counties	113	192	79	69.9
Nevada – Medical and Dental Laboratories	2,564	3,919	1,355	52.8
<b>Nursing and Residential Care Facilities</b>				
Las Vegas MSA	6,014	9,564	3,550	59.0
Reno MSA	1,573	2,967	1,160	64.2
Rural and Frontier Counties	1,022	1,354	332	32.5
Nevada – Nursing and Personal Care Facilities	8,989	13,671	4,682	52.1

**Table 13: Estimated Employment in Selected Health Industry Sectors  
in Nevada by Region – 2004 to 2014, cont.**

Health Industry Sector / Region	Estimated Employment		Projected Employment Change – 2004 to 2014	
	2004	2014	Number	Percent
<b>Offices of Dentists</b>				
Las Vegas MSA	4,030	6,507	2,477	61.5
Reno MSA	1,234	1,664	430	34.8
Rural and Frontier Counties	597	847	250	41.9
Nevada – Offices of Dentists	5,861	9,018	3,157	53.9
<b>Offices of Physicians</b>				
Las Vegas MSA	10,216	15,667	5,451	53.4
Reno MSA	3,451	5,091	1,640	47.5
Rural and Frontier Counties	1,232	1,832	600	48.7
Nevada – Offices of Physicians	14,899	22,590	7,691	51.6
<b>Outpatient Care Centers</b>				
Las Vegas MSA	2,032	3,462	1,430	70.4
Reno MSA	792	1,315	523	66.0
Rural and Frontier Counties	230	357	127	55.2
Nevada – Outpatient Care Centers	3,053	5,134	2,081	68.2
<b>Other Health Care Services</b>				
Las Vegas MSA	5,188	11,205	6,017	116.0
Reno MSA	1,476	2,311	836	56.7
Rural and Frontier Counties	166	369	204	122.4
Nevada – Other Ambulatory Health Care Services	6,611	13,977	7,366	111.4
<b>All Health Care Sectors</b>				
Las Vegas MSA	55,791	88,88	33,093	59.3
Reno MSA	19,202	27,605	8,403	43.8
Rural and Frontier Counties	7,737	11,208	3,471	44.9
Nevada – Total	82,729	127,697	44,968	54.4

Source: Nevada Department of Employment, Training, and Rehabilitation (2006).

**Table 14: Licensed Physicians (MD) in Nevada by County – 2002 to 2006**

County/Region	Licensed Physicians (MD)					
	Number		Change		Number per 100,000 Population	
	2002	2006	Number	Percent	2002	2006
<b>Rural and Frontier</b>						
Churchill County	21	27	6	28.6	83.6	99.9
Douglas County	72	79	7	9.7	162.9	155.7
Elko County	48	48	0	0.0	103.1	101.8
Esmeralda County	0	0	0	N/A	N/A	N/A
Eureka County	2	2	0	0.0	144.5	132.9
Humboldt County	6	6	0	0.0	36.8	34.5
Lander County	3	2	- 1	- 33.3	54.1	36.9
Lincoln County	3	1	- 2	- 66.7	77.3	24.6
Lyon County	14	11	- 3	- 21.4	36.1	21.4
Mineral County	6	6	0	0.0	127.8	129.9
Nye County	21	17	- 4	- 19.0	59.9	39.0
Pershing County	2	2	0	0.0	28.8	29.6
Storey County	0	1	1	100.0	100.0	24.4
White Pine County	11	13	2	18.2	124.1	141.2
Subtotal	209	215	6	2.9	86.3	78.4
<b>Urban</b>						
Carson City	137	144	7	5.1	249.8	247.2
Clark County	2,321	2,750	429	18.5	149.8	145.3
Washoe County	879	953	74	8.4	244.6	234.6
Subtotal	3,337	3,847	510	15.3	169.9	163.2
Nevada – Total	3,546	4,062	516	14.6	160.7	154.4

Sources: Nevada State Board of Medical Examiners (2006) and Nevada State Demographer's Office (2006a, 2006b).

**Table 15: Licensed Dentists in Nevada by County – 2004 to 2006**

County/Region	Licensed Dentists					
	Number		Change		Number per 100,000 Population	
	2004	2006	Number	Percent	2004	2006
Rural and Frontier						
Churchill County	4	7	3	75.0	15.2	25.9
Douglas County	24	23	- 1	- 4.2	51.8	45.3
Elko County	17	18	1	5.9	37.5	38.2
Esmeralda County	0	0	N/A	N/A	N/A	N/A
Eureka County	0	0	N/A	N/A	N/A	N/A
Humboldt County	7	7	0	0.0	43.3	40.2
Lander County	1	1	0	0.0	19.6	18.5
Lincoln County	1	1	0	0.0	28.8	24.6
Lyon County	11	8	- 3	- 27.3	25.3	15.6
Mineral County	1	1	0	0.0	22.5	21.6
Nye County	6	5	- 1	- 16.7	15.8	11.5
Pershing County	2	1	- 1	- 50.7	35.8	14.8
Storey County	0	2	2	200.0	N/A	48.7
White Pine County	5	5	0	0.0	66.1	54.3
Subtotal	79	79	0	0.0	31.9	28.8
Urban						
Carson City	25	36	11	44.0	47.3	61.8
Clark County	763	902	139	18.2	45.2	47.7
Washoe County	224	230	6	2.7	59.1	56.6
Subtotal	1,012	1,168	156	15.4	47.8	49.6
Nevada – Total	1,091	1,247	156	14.3	46.1	47.4

Sources: Nevada State Board of Dental Examiners (2006) and Nevada State Demographer's Office (2006a, 2006b).

**Table 16: Licensed Registered Nurses (RN) In Nevada by County – 2002 to 2006**

County/Region	Licensed Registered Nurses					
	Number		Change		Number per 100,000 Population	
	2002	2006	Number	Percent	2002	2006
<b>Rural and Frontier</b>						
Churchill County	132	140	8	6.1	525.6	517.8
Douglas County	262	327	65	24.8	592.6	644.3
Elko County	219	247	28	12.8	470.2	524.0
Esmeralda County	6	4	- 2	- 33.3	533.3	321.8
Eureka County	3	1	- 2	- 66.7	216.8	66.5
Humboldt County	51	52	1	2.0	312.7	298.9
Lander County	15	24	9	60.0	270.4	442.9
Lincoln County	12	13	1	8.3	309.4	319.4
Lyon County	158	206	48	30.4	407.5	401.0
Mineral County	14	16	2	14.3	298.2	346.4
Nye County	101	131	30	29.7	288.3	300.7
Pershing County	13	18	5	38.5	187.4	266.1
Storey County	19	23	4	21.1	522.1	560.1
White Pine County	43	47	4	9.3	485.2	510.4
Subtotal	1,048	1,249	201	19.2	432.9	455.5
<b>Urban</b>						
Carson City	453	480	27	6.0	826.0	824.1
Clark County	8,831	11,054	2,223	25.2	569.9	584.1
Washoe County	2,742	3,284	542	19.8	762.9	808.4
Subtotal	12,026	14,818	2,792	23.2	612.3	628.7
Nevada – Total	13,074	16,067	2,993	22.9	592.7	610.7

Sources: Nevada State Board of Nursing (2006, 2002) and Nevada State Demographer's Office (2006a, 2006b).

**Table 17: Licensed Emergency Medical Technicians (EMT) in Nevada by County – 2006**

County/Region	Licensed Emergency Medical Technicians – 2006					
	First Responder	Basic	Intermediate	Advanced	Nevada – Total	Total Number per 100,000 Population
Rural and Frontier						
Churchill County	7	52	33	9	101	373.6
Douglas County	3	64	39	30	136	268.0
Elko County	102	212	162	7	483	1,024.7
Esmeralda County	10	11	13	0	34	2,735.1
Eureka County	15	9	18	0	42	2,791.6
Humboldt County	225	65	19	4	313	1,799.3
Lander County	71	28	14	1	114	2,103.7
Lincoln County	26	19	30	0	75	1,842.6
Lyon County	26	127	88	26	267	519.7
Mineral County	2	47	17	0	66	1,428.8
Nye County	45	106	85	29	265	608.2
Pershing County	14	19	14	0	47	694.9
Storey County	10	28	24	10	72	1,753.5
White Pine County	81	44	33	0	158	1,715.8
Subtotal	637	831	589	116	2,173	792.5
Urban						
Carson City	27	79	68	37	211	362.3
Clark County	97	1,119	1,492	837	3,545	187.3
Washoe County	142	618	338	149	1,247	307.0
Subtotal	266	1,816	1,898	1,023	5,003	212.3
Nevada – Total	903	2,647	2,487	1,139	7,176	272.7

Sources: Emergency Medical Services, Nevada State Health Division (2006), Emergency Medical Services, Southern Nevada Health District (2006), and Nevada State Demographer's Office (2006b).

**Table 18: The Unique Geography of Hospitals in Rural and Frontier Nevada – 2008**

Hospital	Distance in Miles to –			
	Nearest Incorporated Town	Nearest Hospital	Nearest Tertiary Hospital	Nevada Office of Rural Health Office in Reno
<b>Critical Access Hospitals (CAH)</b>				
Battle Mountain General Hospital	49	54	218	218
Boulder City Hospital	10	10	10	469
Carson Valley Medical Center - Gardnerville	15	15	15	45
Desert View Regional Medical Center – Pahrump	62	62	62	403
Humboldt General Hospital – Winnemucca	54	54	165	165
Incline Village Community Hospital	16	37	37	37
Mesa View Hospital – Mesquite	39	39	39	493
Mt. Grant General Hospital – Hawthorne	57	57	123	133
Pershing General Hospital – Lovelock	56	56	93	93
William Bee Ririe Hospital – Ely	118	118	242	320
CAH Hospitals – Average Distance	47.6	50.2	100.4	237.6
<b>CAH-Eligible Hospitals</b>				
Banner Churchill Community Hospital – Fallon	27	56	61	61
Grover C. Dils Medical Center – Caliente	25	96	149	427
Northeastern Nevada Regional Hospital – Elko	20	70	230	289
Nye Regional Medical Center – Tonopah	93	104	209	236
South Lyon Medical Center – Yerington	57	57	67	79
CAH-Eligible Hospitals – Average Distance	44.4	76.6	143.2	218.4
Overall Average Distance	46.5	59.0	114.7	231.2

Source: Nevada Department of Transportation (2008).

**Table 19: Ownership, Tax Status, and Service Area of Rural and Frontier Hospitals in Nevada – 2008**

Rural and Frontier Hospital – City, County *CAH or Critical Access Hospital	Ownership	Tax Status	Service Area	Service Area Population
Banner Churchill Community Hospital – Fallon, Churchill Co.	Private – Banner Health System	Not-for- profit	Churchill Co., Northern Lyon Co.	50,000
Battle Mountain General Hospital – Battle Mountain, Lander Co.*	Public – Lander County Hospital District	Not-for- profit	Lander Co., Northern Eureka Co.	5,000
Boulder City Hospital – Boulder City, Clark Co.*	Private – Boulder City Hospital, Inc.	Not-for- profit	Boulder City, Henderson, Searchlight	75,000
Carson Valley Medical Center – Gardnerville, Douglas Co.*	Private – Barton Healthcare System and Renown Health	Not-for- profit	Douglas Co., Bordering California Cos.	50,000
Desert View Regional Medical Center – Pahrump, Nye Co.*	Private – Rural Health Management Corp.	For-profit	Pahrump, Southern Nye Co.	35,000
Grover C. Dils Medical Center – Caliente, Lincoln Co.	Public – Lincoln County Hospital District	Not-for- profit	Lincoln Co.	5,000
Humboldt General Hospital – Winnemucca, Humboldt Co.*	Public – Humboldt County Hospital District	Not-for- profit	Humboldt Co.	20,000
Incline Village Community Hospital – Incline Village, Washoe Co.*	Private – Tahoe Forest Hospital District	Not-for- profit	Incline Village, North Lake Tahoe Area	10,000
Mesa View Regional Hospital – Mesquite, Clark Co.*	Private – Community Health Systems	For-profit	Mesquite, Moapa, Western Clark Co.	20,000
Mount Grant General Hospital – Hawthorne, Mineral Co.*	Public – Mineral County Hospital District	Not-for- profit	Mineral Co.	5,000
Northeastern Nevada Regional Hospital – Elko, Elko Co.	Private – Life Point Hospitals	For-profit	Elko Co.	45,000
Nye Regional Medical Center – Tonopah, Nye Co.	Private – Primecare Nevada	Not-for- Profit	Northern Nye Co., Esmeralda Co.	5,000

**Table 19: Ownership, Tax Status, and Service Area of Rural and Frontier Hospitals in Nevada – 2007, Continued**

Rural and Frontier Hospital – City, County *CAH or Critical Access Hospital	Ownership	Tax Status	Service Area	Service Area Population
Pershing General Hospital – Lovelock, Pershing Co.*	Public – Pershing County Hospital District	Not-for- profit	Pershing Co.	7,500
South Lyon Medical Center – Yerington, Lyon Co.	Non-governmental – Receives Lyon County Tax Support	Not-for- profit	Southern Lyon Co.	5,000
William Bee Ririe Hospital – Ely, White Pine Co.*	Public – White Pine County Hospital District	Not-for- profit	White Pine Co., Western Eureka Co.	10,000

Source: Nevada Office of Rural Health (2006) and Nevada Rural Hospital Partners (2006).

**Table 20: Distribution of Health Care Resources in Nevada by County – 2007**

County/Region	Licensed Acute Care Beds – 2007		Licensed Long-term Care Beds – 2007	
	Number	Number per 1000 Population	Number	Number per 1000 Population
<b>Rural and Frontier</b>				
Churchill County	40	1.5	102	3.8
Douglas County	23	0.5	60	1.2
Elko County	90	1.6	112	2.4
Esmeralda County	0	N/A	0	N/A
Eureka County	0	N/A	0	N/A
Humboldt County	22	1.3	30	1.7
Lander County	7	1.3	18	3.3
Lincoln County	4	1.0	16	3.9
Lyon County	14	0.3	49	1.0
Mineral County	11	2.4	24	5.2
Nye County	34	0.8	154	3.5
Pershing County	5	0.7	30	4.4
Storey County	0	N/A	0	N/A
White Pine County	25	2.7	97	10.5
Subtotal	275	1.0	692	2.5
<b>Urban</b>				
Carson City	172	3.0	193	3.3
Clark County	3,371	1.8	3,412	1.8
Washoe County	1,062	2.6	1,097	2.7
Subtotal	4,605	2.0	4,702	2.0
Nevada – Total	4,930	1.9	5,394	2.1

Source: Nevada Office of Rural Health (2006) and Nevada State Demographer's Office (2006b).

**Table 21: Utilization Trends in Rural and Frontier Hospitals in Nevada – 2005**

Hospital *CAH or Critical Access Hospital	Admissions	Inpatient Days	Average Length of Stay (Days)	Average Daily Census	Occupancy Rate
Banner Churchill Community Hosp	1,913	6,213	3.2	17.0	42.6
Battle Mountain General Hospital*	54	169	3.1	0.5	6.6
Boulder City Hospital*	972	4,062	3.6	9.7	48.5
Carson Valley Medical Center*	709	1,961	2.8	5.4	35.8
Grover C. Dils Medical Center	184	515	2.8	1.4	35.3
Humboldt General Hospital*	571	1,684	2.9	4.6	21.0
Incline Village Community Hospital*	40	89	2.2	0.2	6.1
Mesa View Regional Hospital*	827	2,048	2.5	5.6	22.4
Mount Grant General Hospital*	315	978	3.1	2.7	24.4
Northeastern Nevada Regional Hosp	2,287	6,754	3.0	18.5	24.7
Nye Regional Medical Center	387	767	2.0	2.1	21.0
Pershing General Hospital*	162	476	2.9	1.3	18.6
South Lyon Medical Center	393	1,078	2.7	3.0	21.1
William Bee Ririe Hospital*	680	1,704	2.5	4.7	31.1
Rural and Frontier Hospitals	9,536	28,666	3.0	78.4	24.2
Urban Hospitals	229,681	1,103,758	4.8	3,019.5	69.2
Nevada – Total	239,217	1,132,424	4.7	3,102.5	66.2

**Table 21: Utilization Trends in Rural and Frontier Hospitals in Nevada – 2005, Continued**

Hospital  *CAH or Critical Access Hospital	Admissions			Inpatient Days		
	Number	Percent Of Nevada Total	Adjusted Number of Admissions	Number	Percent of Nevada Total	Adjusted Number of Inpatient Days
Banner Churchill Community Hosp	1,913	0.8	4,790	6,213	0.5	15,558
Battle Mountain General Hospital*	54	0.0	1,148	169	0.0	3,591
Boulder City Hospital*	972	0.4	2,426	4,062	0.4	9,835
Carson Valley Medical Center*	709	0.3	4,118	1,961	0.2	11,389
Grover C. Dils Medical Center	184	0.1	871	515	0.0	2,439
Humboldt General Hospital*	571	0.2	2,436	1,684	0.1	6,936
Incline Village Community Hospital*	40	0.0	885	89	0.0	1,970
Mesa View Regional Hospital*	827	0.3	2,058	2,048	0.2	5,096
Mount Grant General Hospital*	315	0.1	1,234	978	0.1	3,900
Northeastern Nevada Regional Hosp	2,287	1.0	4,529	6,754	0.6	13,376
Nye Regional Medical Center	387	0.2	1,008	767	0.2	1,998
Pershing General Hospital*	162	0.1	1,024	476	0.0	3,010
South Lyon Medical Center	393	0.2	2,528	1,078	0.1	6,934
William Bee Ririe Hospital*	680	0.3	3,406	1,704	0.2	8,535
Rural and Frontier Hospitals	9,531	4.0	32,462	28,610	2.5	94,567
Urban Hospitals	230,176	96.0	311,262	1,102,107	97.8	405,950
Nevada – Total	239,217	100.0	343,724	1,132,424	100.0	500,517

Source: Nevada Division of Health Care Financing and Policy (2006b).

**Table 22: Financial Trends in Rural and Frontier Hospitals in Nevada  
– Total Operating Revenue – 2005**

Hospital	Total Operating Revenue – 2005			
	Inpatient	Outpatient	Other	Total Operating Revenue
*CAH or Critical Access Hospital				
Banner Churchill Community Hosp	16,252,589	17,827,063	5,565,633	39,645,285
Battle Mountain General Hospital*	209,767	3,037,732	1,916,294	5,163,793
Boulder City Hospital*	4,238,139	8,198,006	4,442,962	16,879,107
Carson Valley Medical Center*	2,838,094	17,597,447	299,272	20,734,813
Grover C. Dils Medical Center	1,207,600	1,261,012	1,779,993	4,248,605
Humboldt General Hospital*	3,414,659	7,872,218	3,165,447	14,452,324
Incline Village Community Hospital*	374,231	6,094,125	599,833	7,068,189
Mesa View Regional Hospital*	6,899,073	6,941,874	91,366	13,932,313
Mt. Grant General Hospital*	1,133,913	3,055,613	3,078,500	7,268,026
Northeastern Nevada Reg Hospital	18,989,269	18,652,698	2,066,325	39,708,292
Nye Regional Medical Center	3,329,896	2,073,912	874,610	6,278,418
Pershing General Hospital*	1,341,859	4,297,308	2,695,118	8,334,285
South Lyon Medical Center	2,072,708	4,216,461	4,094,111	10,383,280
William Bee Ririe Hospital*	1,958,178	12,485,672	5,856,798	20,300,648
Rural and Frontier Hospitals	64,259,975	113,611,141	36,526,262	214,397,378
Urban Hospitals	1,806,494,960	1,000,869,973	112,091,854	2,919,456,787
Nevada – Total	1,870,754,935	1,114,481,114	148,618,116	3,133,854,165

Source: Nevada Division of Health Care Financing and Policy (2006b).

**Table 23: Financial Trends in Rural and Frontier Hospitals in Nevada  
– Net Operating Revenue – 2005**

Hospital  *CAH or Critical Access Hospital	Net Operating Revenue – 2005		
	Total Operating Revenue	Operating Expenses	Net Operating Revenue
Banner Churchill Community Hospital	39,645,285	38,947,550	697,735
Battle Mountain General Hospital*	5,163,793	6,289,704	(1,125,911)
Boulder City Hospital*	16,879,107	16,581,464	297,643
Carson Valley Medical Center*	20,734,813	18,072,155	2,662,658
Grover C. Dils Medical Center	4,248,605	4,564,937	(316,332)
Humboldt General Hospital*	14,452,324	15,418,158	(965,834)
Incline Village Community Hospital*	7,068,189	6,622,845	445,344
Mesa View Regional Hospital*	13,932,313	17,142,235	(3,209,922)
Mt. Grant General Hospital*	7,268,026	8,026,705	(758,679)
Northeastern Nevada Reg Hospital	39,708,292	27,266,685	12,441,607
Nye Regional Medical Center	6,278,418	9,483,561	(3,205,143)
Pershing General Hospital*	8,334,285	9,147,528	(813,243)
South Lyon Medical Center	10,383,280	10,494,186	(110,906)
William Bee Ririe Hospital*	20,300,648	18,157,991	2,142,657
Rural and Frontier Hospitals	214,397,378	206,215,704	8,181,674
Urban Hospitals	2,919,456,787	2,860,016,352	59,440,435
Nevada – Total	3,133,854,165	3,066,232,056	67,622,109

Source: Nevada Division of Health Care Financing and Policy (2006b).

**Table 24: Financial Trends in Rural and Frontier Hospitals in Nevada  
– Net Income – 2005**

Hospital  *CAH or Critical Access Hospital	Net Income – 2005			
	Net Operating Revenue	Non– Operating Revenue	Non – Operating Expenses	Net Income (Loss)
Banner Churchill Community Hosp	697,735	7,503	0	705,238
Battle Mountain General Hospital*	(1,125,911)	3,340,425	11,300	2,203,214
Boulder City Hospital*	297,643	503,983	34,707	766,919
Carson Valley Medical Center*	2,662,658	131,487	0	2,794,145
Grover C. Dilsmedical Center	(316,332)	521,942	4,449	201,161
Humboldt General Hospital*	(965,834)	2,706,112	0	1,737,278
Incline Village Community Hospital*	445,344	6,584	0	451,928
Mesa View Regional Hospital*	(3,209,922)	0	5,994	(3,215,916)
Mt. Grant General Hospital*	(758,679)	446,808	14,387	(326,258)
Northeastern Nevada Reg Hospital	12,441,607	13,857	6,563,119	5,892,345
Nye Regional Medical Center	(3,205,143)	(2,302)	0	(3,207,445)
Pershing General Hospital*	(813,243)	844,878	0	31,635
South Lyon Medical Center	(110,906)	253,832	0	142,926
William Bee Ririe Hospital*	2,142,657	1,002,181	47,024	3,097,814
Rural and Frontier Hospitals	8,181,674	9,774,290	6,680,980	11,274,984
Urban Hospitals	59,440,435	26,790,258	28,065,341	58,165,352
Nevada – Total	67,622,109	36,564,548	34,746,321	69,440,336

Source: Nevada Division of Health Care Financing and Policy (2006b).

**Table 25: Financial Trends in Rural and Frontier Hospitals in Nevada –  
Net Operating Revenue per Adjusted Admission and Per Adjusted Inpatient Day – 2005**

Hospital  *CAH or Critical Access Hospital	Net Operating Revenue – 2005		
	Net Operating Revenue	Net Operating Revenue per Adjusted Admission	Net Operating Revenue per Adjusted Inpatient Day
Banner Churchill Community Hospital	697,735	146	45
Battle Mountain General Hospital*	(1,125,911)	(981)	(314)
Boulder City Hospital*	297,643	98	27
Carson Valley Medical Center*	2,662,658	647	234
Grover C. Dilsmedical Center	(316,332)	(363)	(130)
Humboldt General Hospital*	(965,834)	(396)	(139)
Incline Village Community Hospital*	445,344	503	226
Mesa View Regional Hospital*	(3,209,922)	(1,560)	(630)
Mt. Grant General Hospital*	(758,679)	(615)	(195)
Northeastern Nevada Reg Hospital	12,441,607	2,747	930
Nye Regional Medical Center	(3,205,143)	(3,179)	(1,604)
Pershing General Hospital*	(813,243)	(794)	(270)
South Lyon Medical Center	(110,906)	(44)	(16)
William Bee Ririe Hospital*	2,142,657	629	251
Rural and Frontier Hospitals	8,181,674	247	85
Urban Hospitals	59,440,435	191	146
Nevada – Total	67,622,109	196	135

Source: Nevada Division of Health Care Financing and Policy (2006b).

**Table 26: Impact of the Hospital Sector on Employment in Nevada by County – 2006**

County	Employment Impact of Hospitals (Number of Jobs)			
	Hospital Employment	Type II Employment Multiplier	Secondary Employment Impact	Total Employment Impact
Rural and Frontier Counties				
Churchill County	342	1.67	229	571
Douglas County	129	1.50	65	194
Elko County	207	1.40	83	290
Esmeralda County	0	—	—	—
Eureka County	0	—	—	—
Humboldt County	110	1.42	46	156
Lander County	73	1.23	17	90
Lincoln County	62	1.25	16	78
Lyon County	192	1.34	65	257
Mineral County	105	1.22	23	128
Nye County	126	1.45	57	183
Pershing County	83	1.26	22	105
Storey County	0	—	—	—
White Pine County	124	1.33	41	165
Subtotal	1,553	1.43	663	2,216
Urban Counties				
Carson City	1,001	1.67	671	1,672
Clark County	13,417	1.74	9,929	23,346
Washoe County	4,646	1.68	3,159	7,805
Subtotal	19,064	1.72	13,759	32,823
Nevada – Total	20,617	1.70	14,421	35,038

Sources: Center for Health Information Analysis (2007) and Minnesota IMPLAN Group (2007).

**Table 27: Impact of Hospitals on Income in Nevada by County – 2006**

County	Income Impact of Hospitals (Dollars)			
	Hospital Payroll	Type II Income Multiplier	Secondary Income Impact	Total Income Impact
Rural and Frontier				
Churchill County	21,457,463	1.34	7,295,537	28,753,000
Douglas County	8,276,292	1.24	1,986,310	10,262,602
Elko County	11,245,536	1.31	3,486,116	14,731,652
Esmeralda County	0	—	—	—
Eureka County	0	—	—	—
Humboldt County	4,486,024	1.31	1,390,667	5,876,691
Lander County	2,844,692	1.18	512,045	3,356,737
Lincoln County	2,432,917	1.17	413,596	2,846,513
Lyon County	7,326,327	1.26	1,904,845	9,231,172
Mineral County	4,095,130	1.17	696,172	4,791,302
Nye County	5,257,276	1.20	1,051,455	6,308,731
Pershing County	4,024,056	1.13	523,127	4,547,183
Storey County	0	—	—	—
White Pine County	11,574,216	1.12	1,388,906	12,963,122
Subtotal	83,019,929	1.25	20,648,777	103,668,706
Urban				
Carson City	57,562,127	1.38	\$21,873,608	79,435,735
Clark County	930,851,516	1.44	409,574,667	1,340,426,183
Washoe County	262,874,668	1.46	120,922,347	383,797,015
Subtotal	1,251,288,311	1.44	552,370,623	1,803,658,934
Nevada – Total	1,334,308,240	1.43	573,019,400	1,907,327,640

Sources: Center for Health Information Analysis (2007) and Minnesota IMPLAN Group (2007).

**Table 28: Federally Qualified Community Health Centers (FQHCs)  
in Rural and Frontier Areas of Nevada – 2008**

Clinic – Location	Estimated Service Area	Estimated Service Area Population – 2007
Amargosa Valley Medical Clinic	Amargosa Valley, Southern Nye Co., Bordering California Counties	1,500
Austin Medical Clinic	Austin, Southern Lander Co.	500
Beatty Medical Clinic	Beatty, Southern Nye Co.	1,500
Carlin Community Health Center	Carlin, Western Elko Co.	2,500
Crescent Valley Medical Clinic	Crescent Valley, Northern Eureka Co.	500
Elko Medical and Dental Clinic	Elko, Central Elko Co.	45,000
Eureka Medical Clinic	Eureka, Eureka Co.	500
Gerlach Medical Clinic	Gerlach, Northern Washoe Co.	500
Jackpot Community Health Center	Jackpot, Northern Elko Co., Southern Idaho Counties	1,500
Wendover Community Health Center	West Wendover, Eastern Elko Co., Wendover Ut	5,000
Total	30,000 Square Miles	59,000

Source: Nevada Health Centers (2006) and Nevada Office of Rural Health (2006).

**Table 29: Tribal Medical Clinics and Health Centers in Nevada  
by Tribe and Service Area – 2008**

Service Unit	Tribe/Colony	Service Area (Percent of County Tribal Population)
Duck Valley Service Unit		
Owyhee Community Health Center	Duck Valley Shoshone-Paiute Tribe	Elko (42) Owyhee, ID (100)
Elko Service Unit		
Southern Bands Health Clinic – Elko	Te-moak Western Shoshone	Elko (56) Eureka (45) Lander (100) Tooele, UT (100)
	Elko Band	
	South Fork Band	
	Wells Band	
	Battle Mountain Band	
Duckwater Health Clinic	Duckwater Shoshone Tribe	Nye (100)
Newe Clinic – Ely	Ely Shoshone	Eureka (61) White Pine (100)
Goshute Health Clinic – Ipabah Ut	Confederated Tribes of the Goshute Reservation	Elko (2%) Juab, UT (100) Tooele, UT (100)
Schurz Service Unit		
Mcdermitt Health Center	Fort Mcdermitt Paiute and Shoshone	Humboldt (67) Malheur, OR (100)
Fallon Tribal Health Center	Lovelock Paiute Fallon Paiute-shoshone Summit Lake Paiute (Winnemucca )	Churchill (100) Lander (100) Lyon (4) Nye (66) Pershing (100) Humboldt (31)
Las Vegas Tribal Health Center	Las Vegas Paiute Fort Mojave	Clark (100 ) Lincoln (100) Nye (16)
Moapa Health Clinic	Moapa Band of Paiute	Clark (23)
Pyramid Lake Health Center	Pyramid Lake Paiute	Lyon (18) Washoe (27)

**Table 29: Tribal Medical Clinics and Health Centers in Nevada  
by Tribe and Service Area– 2008, Continued**

Service Unit	Tribe/Colony	Service Area (Percent of County Tribal Population)
Schurz Service Unit, Continued		
Reno-sparks Health Center	Reno/Sparks Indian Colony	Washoe (73)
Walker River Health Center	Timbisha Shoshone Walker River Paiute Yomba Shoshone	Esmeralda (100) Mineral (100) Nye (18)
Yerington Health Center	Yerington Paiute	Lyon (63)
Washoe Tribal Health Center – Gardnerville	Washoe Tribe of Nevada and California	Carson City (100)
	Carson Colony	Douglas (100)
	Dresslerville Colony	Lyon (14)
	Stewart Community	Alpine, CA (100)
	Woodfords Colony	

Source: Phoenix Area Indian Health Service (2006).

**Table 30: Telehealth Sites in Rural and Frontier Nevada – 2008**

Rural and Frontier Telehealth Site	County	Site Type and Function
Amargosa Valley Medical Clinic	Nye	Clinic Spoke
Austin Medical Clinic	Lander	Clinic Spoke
Banner Churchill Community Hospital	Churchill	Hospital Spoke
Battle Mountain General Hospital	Lander	Hospital Spoke
Boulder City Hospital	Clark	Hospital Spoke
Carlin Clinic	Elko	Clinic Spoke
Carson Valley Medical Center	Douglas	Hospital Spoke
Crescent Valley Clinic	Eureka	Clinic Spoke
Duckwater IHS Clinic	Nye	Clinic Spoke
Eureka Medical Clinic	Eureka	Clinic Spoke
Goshute Indian Health Clinic (2 Sites) – Ibapah	Juab (UT)	Clinic Spoke
Great Basin College (2 Sites)	Elko	Teaching Hub
Grover C. Dils Medical Center – Caliente	Lincoln	Hospital Spoke
Humboldt General Hospital – Winnemucca	Humboldt	Hospital Spoke
Incline Village Community Hospital	Washoe	Hospital Spoke
Mesa View Regional Hospital – Mesquite	Clark	Hospital Spoke
Mt. Grant General Hospital – Hawthorne	Mineral	Hospital Spoke
Northeastern Nevada Regional Hospital – Elko	Elko	Hospital Spoke
Nye Regional Medical Center – Tonopah	Nye	Hospital Spoke
Owyhee Community Health Facility	Elko	Hospital Spoke
Pershing General Hospital – Lovelock	Pershing	Hospital Spoke
South Lyon Medical Center – Yerington (2 Sites)	Lyon	Hospital Spoke
Washoe Tribal Health Center (IHS) – Gardnerville	Douglas	Clinic Spoke
Wendover Clinic	Elko	Clinic Spoke
William Bee Ririe Hospital – Ely (2 Sites)	White Pine	Hospital Spoke
Rural and Frontier Total – 29 Sites		

Source: Nevada Office of Rural Health (2008).

**Table 31: Telehealth Sites in Urban Nevada – 2008**

Urban Telehealth Site	City	Site Type and Function
Carson-Tahoe Hospital	Carson City	Hospital Hub
Carson-Tahoe Urgent Care	Carson City	Clinic Spoke
Nevada Health Centers	Carson City	Clinic Hub
Nevada Rural Hospital Partners	Reno	Teaching Hub
Renown Health Medical Center	Reno	Hospital Hub
Southern Nevada Area Health Education Center (Ahec)	Las Vegas	Teaching Hub
Univ of Nevada School of Medicine (UNSOM) – Deans Office	Reno	Teaching Hub
UNSOM – Deans Office	Las Vegas	Teaching Hub
UNSOM – Family Medicine Center – North	Reno	Teaching Hub
UNSOM – Family Medicine Center – South	Las Vegas	Teaching Hub
UNSOM – Jones Conference Center	Reno	Teaching Hub
UNSOM – Medical Associates North Clinic at the Plaza	Reno	Clinic Hub
UNSOM – Nelson Building	Reno	Teaching Hub
UNSOM – Pennington Medical Education Building (4 Sites)	Reno	Teaching Hub
University Medical Center (UMC) – Patient Care Center (2 Sites)	Las Vegas	Teaching Hub
Urban Total – 19 Sites		

Source: Nevada Office of Rural Health (2008).



**NEVADA RURAL HEALTH PLAN**

**APPENDIX 2: Information on Critical Access Hospitals  
and Hospitals Eligible for Critical Access Hospital  
Designation in Nevada**



The following table provides a profile of the fourteen hospitals in Nevada – ten Critical Access Hospitals and four CAH-eligible hospitals – currently receiving support and technical assistance from the Nevada Flex Program, program partners, and subcontractors (the same hospitals are members of the Nevada SHIP Consortium). This table also includes information on two communities considering new hospital construction and/or designation as CAH facilities. All figures are for the fiscal year ending June 30, 2006. During the proposed budget period, the Nevada Flex Program will continue to work with all these hospitals and communities.

Certified Critical Access Hospitals in Nevada		
Battle Mt General Hospital CEO: Peggy Lindsey 535 South Humboldt Street Battle Mountain NV 89820 775-635-6060	CAH certification: Feb1, 2001 CAH Provider No.: 29-1303 Ownership: Public, Not-for-Profit Primary Care HPSA: Yes Population served: 6,000 SHIP Hospital: Yes	Acute beds: 7 (7 swing) LTC beds: 18 Medicare admits: 66.7 % of tot Net income (loss): \$1,564,968 Ave daily census: 0.4 Ave LOS: 2.8 days
Boulder City Hospital CEO: Tom Maher 901 Adams Boulevard Boulder City NV 89005 702-293-4111	CAH certification: March 1, 2005 CAH Provider No.: 29-1309 Ownership: Private, Not-for-Profit Primary Care HPSA: No Population served: 20,000 SHIP Hospital: Yes	Acute beds: 20 LTC beds: 47 Medicare admits: 49.0 % of tot Net income (loss): \$(496,364) Ave daily census: 9.7 Ave LOS: 3.7 days
Carson Valley Medical Center CEO: Gerry Conley 1107 Highway 395 Gardnerville NV 89410 775-782-1500	CAH certification: April 1, 2004 CAH Provider No.: 29-1306 Ownership: Private, Not-for-Profit Primary Care HPSA: No Population served: 48,000 SHIP Hospital: Yes	Acute beds: 15 LTC beds: 0 Medicare admits: 63.5 % of tot Net income (loss): \$2,599,633 Ave daily census: 5.9 Ave LOS: 3.1 days
Desert View Regional Med Ctr CEO: Susan Davila 360 South Lola Lane Pahrump NV 89408 775-751-7530	CAH certification: Dec 1, 2006 CAH Provider No.: 29-1310 Ownership: For Profit Primary Care HPSA: Yes Population served: 40,000 SHIP Hospital: Yes	Acute beds: 25 LTC beds: 0 Medicare admits: N/A Net income (loss): N/A Ave daily census: N/A Ave LOS: N/A
Humboldt General Hospital CEO: Jim Parrish 118 East Haskell Street Winnemucca NV 89445 775-623-5222	CAH certification: Sept 1, 2005 CAH Provider No.: 29-1308 Ownership: Public, Not-for-Profit Primary Care HPSA: Yes Population served: 16,000 SHIP Hospital: Yes	Acute beds: 22 (2 swing) LTC beds: 30 Medicare admits: 15.2 % of tot Net income (loss): \$2,589,110 Ave daily census: 6.0 Ave LOS: 2.7 days

Certified Critical Access Hospitals in Nevada			
Incline Village Community Hospital Director: Pete Basler 880 Alder Avenue Incline Village NV 89451 775-833-4100	CAH certification: Dec 1, 2000 CAH Provider No.: 29-1301 Ownership: Public, Not-for-Profit Primary Care HPSA: No Population served: 10,000 SHIP Hospital: Yes	Acute beds: 4 LTC beds: 0 Medicare admits: 50.0 % of tot Net income (loss): \$113,986 Ave daily census: 0.2 Ave LOS: 2.7 days	
Mesa View Regional Hospital CEO: Susan Conley 1299 Bertha Howe Avenue Mesquite, Nevada 89027 702-346-7037	CAH certification: Nov 1, 2004 CAH Provider No.: 29-1307 Ownership: For Profit Primary Care HPSA: No Population served: 20,000 SHIP Hospital: Yes	Acute beds: 25 LTC beds: 0 Medicare admits: 46.2 % of tot Net income (loss): \$(2,393,190) Ave daily census: 6.0 Ave LOS: 2.4 days	
Mt. Grant General Hospital CEO: Richard Munger First and A Streets PO Box 1510 Hawthorne NV 89415 775-945-2461	CAH certification: Sept 1, 2000 CAH Provider No.: 29-1300 Ownership: Public, Not-for-Profit Primary Care HPSA: Yes Population served: 5,000 SHIP Hospital: Yes	Acute beds: 11 (7 swing) LTC beds: 24 Medicare admits: 59.3% of tot Net income (loss): \$(189,213) Ave daily census: 3.1 Ave LOS: 3.3 days	
Pershing General Hospital CEO: Matt Rees 855 6 <sup>th</sup> Street / PO Box 661 Lovelock NV 89419 775-273-2621	CAH certification: April 1, 2001 CAH Provider No.: 29-1304 Ownership: Public, Not-for-Profit Primary Care HPSA: Yes Population served: 7,000 SHIP Hospital: Yes	Acute beds: 7 (7 swing) LTC beds: 32 Medicare admits: 53.1% of tot Net income (loss): \$449,998 Ave daily census: 1.0 Ave LOS: 2.8 days	
William Bee Ririe Hospital CEO: Rick Kilburn 1500 Avenue H Ely NV 89301 775-289-3001	CAH certification: April 1, 2001 CAH Provider No.: 29-1302 Ownership: Public, Not-for-Profit Primary Care HPSA: Yes Population served: 12,000 SHIP Hospital: Yes	Acute beds: 15 LTC beds: 0 Medicare admits: 44.9% of tot Net income (loss): \$1,456,630 Ave daily census: 4.8 Ave LOS: 3.0 days	
Hospitals in Nevada that Meet the Statutory Requirements of CAH Designation			
Churchill Community Hospital CEO: Steve Fraker 801 East Williams Avenue Fallon NV 89406 775-423-3151	Ownership: Private, Not-for-Profit Primary Care HPSA: No Population served: 12,000 SHIP Hospital: Yes	Acute beds: 40 LTC beds: 0 Medicare admits: 34.2 % of tot Net income (loss): \$2,597,262 Ave daily census: 18.1 Ave LOS: 3.1 days	

Hospitals in Nevada that Meet the Statutory Requirements of CAH Designation		
Grover C. Dils Medical Center CEO: Jason Bleak Highway 93 North Caliente NV 89008 775-726-3171	Ownership: Public, Not-for-Profit Primary Care HPSA: Yes Population served: 3,000 SHIP Hospital: Yes	Acute beds: 4 (4 swing) LTC beds: 16 Medicare admits: 71.7 % of tot Net income (loss): \$(184,513) Ave daily census: 0.7 Ave LOS: 2.5 days
Nye Regional Medical Center CEO: Karin Scoccia 825 Main Street /PO Box 391 Tonopah NV 89049 775-482-6233	Ownership: Private, Not-for-Profit Primary Care HPSA: Yes Population served: 3,000 SHIP Hospital: Yes	Acute beds: 10 (3 swing) LTC beds: 32 Medicare admits: 38.3% of tot Net income (loss): \$1,671,949 Ave daily census: 1.8 Ave LOS: 2.0 days
South Lyon Medical Center CEO: Joan Hall Surprise and Whitacre Streets PO Box 940 Yerington NV 89447 775-463-2301	Ownership: Private, Not-for-Profit Primary Care HPSA: Yes Population served: 5,000 SHIP Hospital: Yes	Acute beds: 14 (14swing) LTC beds: 49 Medicare admits: 75.1% of tot Net income (loss): \$(281,681) Ave daily census: 2.8 Ave LOS: 2.7 days

Rural Communities in Nevada Planning New Hospital Construction		
Carson Dayton Hospital (proposed) CEO: Ed Epperson 5 Pine Cone Road Dayton NV 89403	Ownership: Private, Not-for-Profit Primary Care HPSA: Yes Population served: 15,000 SHIP Hospital: No, N/A	Projected open date: TBD Acute beds: 5 LTC beds: 0
Renown Regional Medical Center Fernley (proposed) CEO: James Miller US 95A and Fernley Hills Drive Fernley NV 89408 775-982-5529	Ownership: Private, Not-for-Profit Primary Care HPSA: Yes Population served: 15,000 SHIP Hospital: No, N/A	Projected open date: TBD Acute beds: 25 LTC beds: 0



**NEVADA RURAL HEALTH PLAN**

**APPENDIX 3: Preliminary Application for Eligibility  
Determination Critical Access Hospital Program (2 pages)**



## Preliminary Application for CAH Eligibility Determination Nevada Rural Hospital Flexibility Program

Submit completed application and attachments to:

Nevada Office of Rural Health (ORH)  
University of Nevada School of Medicine  
411 West Second Street / Mailstop 348  
Reno, Nevada 89503-5308  
Attn: John Packham

Date Submitted: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Administrator: \_\_\_\_\_

Physical Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Current Number of Acute Beds: \_\_\_\_\_

Current Number of Long Term Care Beds: \_\_\_\_\_

Current Number of Swing Beds: \_\_\_\_\_

Current Medicare/CMS provider type(s)/number:

\_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_

Most recent date Certified by BLC as an acute care facility: \_\_\_\_\_

Copy of Current License Attached:    yes\_\_\_\_\_    no\_\_\_\_\_

Certification as a Hospital Attached:    yes\_\_\_\_\_    no\_\_\_\_\_

Distance to closest hospital facility:    \_\_\_\_\_ miles

Name of closest hospital: \_\_\_\_\_

Proposed Number of CAH Beds: \_\_\_\_\_  
Proposed Number of Swing Beds: \_\_\_\_\_  
Proposed Number of Psychiatric Distinct Part Unit Beds: \_\_\_\_\_  
Proposed Number of Rehabilitation Distinct Part Unit Beds: \_\_\_\_\_

Proposed List of CAH Services: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Most recent analysis of the financial impact of CAH designation attached:  
yes \_\_\_\_\_ no \_\_\_\_\_

Preliminary community based outreach and education regarding CAH conversion performed\*:  
yes \_\_\_\_\_ no \_\_\_\_\_

Description of types of activities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Agreements and Assurances attached: yes \_\_\_\_\_ no \_\_\_\_\_

Letter of intent to seek JCAHO or AOA CAH accreditation attached: yes \_\_\_\_\_

\* Not necessary for preliminary program eligibility determination-optional response. Must be initiated in the community before conversion activities begin.

---

**To be completed by the Nevada Office of Rural Health:**

Date Received by ORH: \_\_\_\_\_

Eligible: \_\_\_\_\_ Ineligible: \_\_\_\_\_ Incomplete: \_\_\_\_\_ Date Forwarded to BLC: \_\_\_\_\_

