Guinn Center For Policy Priorities

Oct 2014 POLICY BRIEF guinncenter.org

Nevada's Mental Health Workforce: Shortages and Opportunities

Executive Summary

Nevada faces critical shortages in its mental health workforce and has been unable to adequately meet mental and behavioral health community needs. Short- and long-term solutions are necessary to address these issues. In the short term, Nevada should focus on removing licensing barriers for mental health professionals who want to move to Nevada, and should explore increasing State mental health employee salaries and providing pay incentives to be more competitive with other states in the Intermountain West and the Veterans Administration (VA). To build a long-term, sustainable mental health workforce, Nevada should create a comprehensive workforce development plan. Specific recommendations include:

1. **Exam Requirements:** Simplify requirements for licensed mental health professionals coming to Nevada. The curriculum covered in State exams can be folded into continuing education requirements. Eliminate provisions that require applicants who have been licensed and practicing for several years to take a new national exam.
2. **Years of Practice Requirements:** Eliminate provisions that require mental health professionals coming to Nevada to have been licensed for a minimum number of years in another state.
3. **Training Requirements:** Accept training requirements of other states in mental health professions that have substantially the same scope of practice and education requirements.
4. **Fingerprinting:** Create uniform procedures for administering fingerprinting and allow provisional or full licenses to be granted before receipt of fingerprint results. Improve DPS review times.
5. **Temporary Licenses:** Require each mental health licensing board to offer a temporary or provisional license to professionals who are licensed in other states and are in good standing so they can begin practicing before they meet all Nevada requirements.
6. **Timelines:** Create a uniform 30-day timeline to consider applications from mental health professionals licensed in other states.
7. **Interstate Compacts:** Consider joining interstate compacts in medicine, nursing, and psychology to improve recruitment from other states, which could facilitate the use of telehealth to help meet needs in underserved areas.
8. **State Employee Compensation:** Consider increasing State employee salaries, benefits and incentives such as loan forgiveness for mental health professionals, particularly psychiatrists and psychologists, to make pay schedules more competitive with other states in the Intermountain West region and the VA, and to reduce reliance on contract workers.
9. **Long-Term Planning:** Direct the Department of Employment Training and Rehabilitation (DETR), with the advice of the Health Care and Medical Services Sector Council, to coordinate workforce development efforts and create a statewide mental health workforce development plan with an emphasis on engagement, training, recruitment, and retention. Require DETR to submit an evaluation of the impact of the plan to the Legislature every two years to ensure that goals are met and that government resources are being used cost-effectively.
10. **Data Collection:** Require mental health licensing boards to collect data about providers, including whether licensees are actively practicing in the State, how many hours they are practicing, and in what locations.

Nevada's Mental Health Workforce: Shortages and Opportunities

Introduction

Improving the mental health system has become a high priority in Nevada and increasing the mental health workforce has emerged as a critical component of this effort. The focus on mental health grew out of several high profile issues. In 2013, the quality of patient care at Rawson-Neal Psychiatric Hospital in Las Vegas came under scrutiny and the hospital lost its accreditation.[1] In January 2014, a drop-in mental health clinic that had recently opened to address overcrowded emergency rooms was forced to close by the Federal Centers for Medicaid and Medicare Services (CMS).[2]

These challenges spurred a critical look at the broader mental health system, which includes State and local agencies, law enforcement, and private providers. In December 2013, the Governor convened the Behavioral Health and Wellness Council, which issued a report with recommendations in May 2014.[3] Due to shortages in the mental health workforce, the Council's report emphasized the need to create a comprehensive workforce development system.[4]

There are several entities working to build this workforce development system. The Health Care and Medical Services Sector Council, an advisory component of the Nevada Workforce Investment Board in DETR, has been working on analyzing workforce supply and demand and has been active in coordinating with the Nevada System of Higher Education (NSHE) to build a workforce pipeline.[5] In addition, the Department of Health and Human Services' (DHHS) Division of Public and Behavior Health has worked collaboratively with licensing boards and NSHE to conduct the Behavioral Health Workforce Pipeline Mapping Project. This effort has examined issues such as: education and training opportunities; licensing; scope of practice; Medicaid and Medicare reimbursement; State personnel issues; and loan repayment/ scholarship opportunities.

Objective

This policy brief discusses the shortage of mental health professionals in Nevada. It also focuses on two key short-term issues identified by the Behavioral Health and Wellness Council that can be addressed by the Nevada Legislature in the 2015 session.

- The need to reduce licensing barriers for mental health professionals who want to move to Nevada; and
- Competitiveness of pay, benefits, and incentives for mental health professionals employed by State agencies.

Developing a sustainable behavior health workforce will necessitate long-term coordination and action by all stakeholders, including State agencies, K-12 education, higher education, and providers. This policy brief concludes by outlining steps Nevada could take to build a comprehensive workforce development plan.

Part I: Current Mental Health Workforce Not Meeting Needs or Demand

A. Significant Shortages in Mental Health Services in Nevada

The shortage of mental health workers in Nevada has resulted in critical unmet needs. Psychiatric patients often end up in emergency rooms for more than a week, resulting in acute overcrowding issues that effectively limit healthcare access for the whole community.[6] Currently, 1.4 million people in Nevada (53 percent) reside in an area designated as a Mental Health Professional Shortage Area (Mental HPSA) by the Federal Health Resources and Services Administration.[7] This includes all rural counties, Washoe County, and geographic areas representing 36 percent of the population in Clark County. These areas have a documented shortage of mental health workers, which includes psychiatrists, clinical psychologists, clinical social workers, and psychiatric nurse specialists.[8] An area can also be designated as a Mental HPSA if there are unusually high needs for mental health services due to factors such as poverty and high incidence of alcohol and substance abuse.

Nevada's Behavioral Health and Wellness Council found that there is a significant shortage of mental health professionals. In its May 2014 report to the Office of the Governor, the Council indicated "there is a shortage of psychiatrists throughout the country, and Nevada is no exception. Over half of the psychiatry positions in State service in Nevada are currently vacant, requiring the State to fill positions with contracted or locum tenens [temporary] psychiatrists."[9]

The University of Nevada School of Medicine has done extensive work to analyze the supply and demand of health workers.[10] As shown in Table 1, demand for certain mental health professions is projected to grow by 9 percent per year from 2010 to 2020, which will exacerbate the existing shortage.[11]

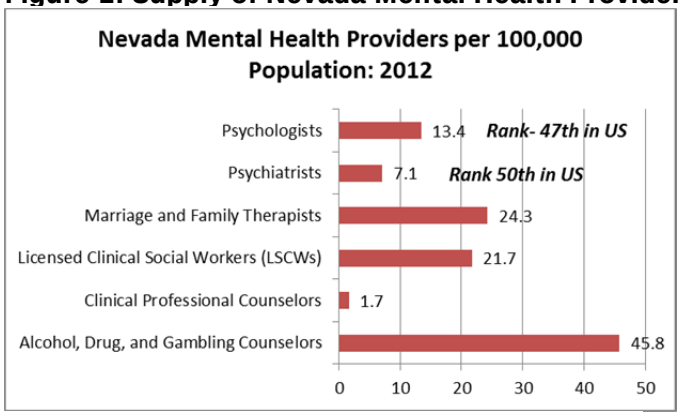
Table 1: Demand for Nevada Mental Health Providers

Profession	2010	2012	2020	Percent Growth 2010 to 2020	Annual Openings 2010 to 2020
Child, Family, and School Social Workers	2,812	2,838	2,940	4.6%	80
Clinical, Counseling, and School Psychologists	655	671	731	11.6%	29
Educational, Vocational, and School Counselors	1,345	1,361	1,420	5.6%	37
Marriage and Family Therapists	100	104	125	25.0%	4
Medical and Public Health Social Workers	739	767	878	18.8%	32
Mental Health and Substance Abuse Social Workers	397	409	459	15.6%	15
Mental Health Counselors	507	531	624	23.1%	23
Psychiatric Aides	491	495	513	5.1%	8
Substance Abuse and Behavioral Counselors	260	264	284	9.2%	8
Total	**7,306**	**7,440**	**7,974**	**9.1%**	**236**

Source: University of Nevada School of Medicine, Health Workforce in Nevada 2013 Edition (psychiatric nurses not included in data)

Nevada is currently producing an insufficient number of graduates to meet the needs of residents in Mental HPSAs or to meet the demand shown in Table 1. In 2013, seven physicians completed a psychiatry residency program at the University of Nevada School of Medicine, of which five remained in Nevada.[12] In addition, two physicians completed a fellowship in child and adolescent psychiatry and only one remained in the State.[13] The number of Nevada graduates in other mental health fields was also limited. In 2013, there were 18 graduates with a doctorate in psychology, 1,017 graduates with a bachelor's degree or higher in all fields of nursing (of which only a small number will go into psychiatric nursing), 85 graduates with a master's degree in social work, and 44 graduates with a master's degree in counseling.[14] Each year, providers also retire or leave the state, further exacerbating shortages.

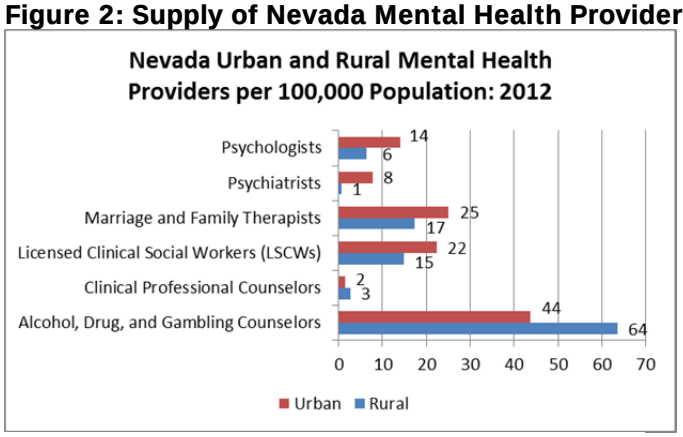
Figure 1: Supply of Nevada Mental Health Providers



Source: University of Nevada School of Medicine, Health Workforce in Nevada 2013 Edition (psychiatric nurses not included in data)

Looking at the current supply of mental health professionals, Nevada ranks 50th in the nation for psychiatrists and 47th in the nation for psychologists (see Figure 1). The national average for psychiatrists was 13 per 100,000 people in 2012 while Nevada had only 7 per 100,000. For psychologists, the national average was 29 per 100,000 while Nevada only had 13 per 100,000.[15] The number of clinical professional counselors in Nevada is also small at 1.7 per 100,000 While the number of professionals per 100,000 is higher for other categories, the existing supply has been insufficient to meet needs.

Figure 2: Supply of Nevada Mental Health Providers: Urban vs Rural Areas



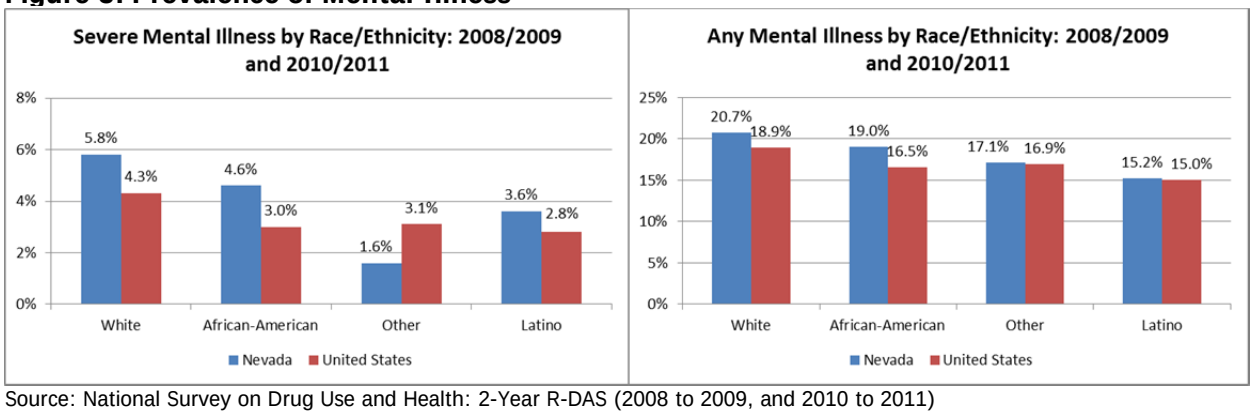
Source: University of Nevada School of Medicine, Health Workforce in Nevada 2013 Edition (psychiatric nurses not included in data)

There are also differences between the availability of mental health providers in rural and urban areas. Figure 2 shows that the shortage of psychiatrists and psychologists is particularly pronounced in rural areas. Conversely, there are substantially more alcohol, drug and gambling counselors per 100,000 in rural areas than in urban areas. This is likely due to existence of several substance abuse providers in rural areas that employ counselors such as Vitality Center in Elko, New Frontier in Fallon, and the Shoshone Paiute Tribe.

B. Mental Illness Affects all Ethnicities

Nevada's population has become increasingly diverse. As of 2013, the population is 52 percent white, 28 percent Latino, 9 percent African-American, and 8 percent Asian.[16] The population needing mental health services is also diverse. Figure 3 reveals the percentage of population within each racial and ethnic category that has experienced Severe Mental Illness[17] and Any Mental Illness[18] in Nevada compared to the United States (U.S.) based on the National Survey on Drug Use and Health. This data shows that the highest incidence of mental illness is among whites and African-Americans in both the U.S. and Nevada. However, this data may under-identify mental illness in the Latino community due to stigma and other cultural barriers. Nevada's mental illness prevalence rates are also higher than the U.S. average for all groups except Other.

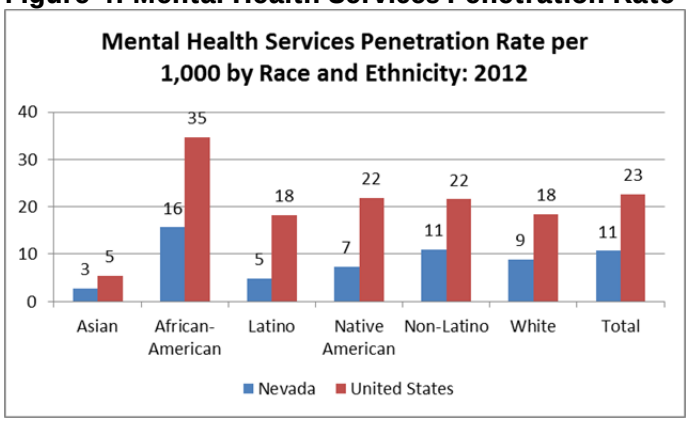
Figure 3: Prevalence of Mental Illness



Source: National Survey on Drug Use and Health: 2-Year R-DAS (2008 to 2009, and 2010 to 2011)

C. Service Penetration Rate is Low, Especially for Latinos and Asians

Figure 4: Mental Health Services Penetration Rate



Source: Substance Abuse and Mental Health Services Administration (SAHMSA), CMHS Uniform Reporting System Output Tables

Another key indicator reflecting how well Nevada's population is being served by mental health services is the service penetration rate, which measures persons served by public mental health services per 1,000 in population. As shown in Figure 4, the service penetration rates in Nevada are far lower than in the U.S. across all races and ethnicities. African-Americans have the highest rate while Latinos and Asians have the lowest rates. Low penetration rates could reflect both the unavailability of services as well as cultural and linguistic barriers to accessing services.

Part II: Reforming Licensing Policies to Remove Barriers

Nevada has seven licensing boards for mental health professions, which issue multiple types of licenses. Several of these boards license all specialties, not just mental health. These boards are authorized by statute in the *Nevada Revised Statutes* (NRS) and have the authority to promulgate regulations through the *Nevada Administrative Code* (NAC). Each board is listed below:

- Board of Medical Examiners
- Board of Osteopathic Medicine
- Board of Psychological Examiners
- Board of Nursing
- Board of Examiners for Social Workers
- Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors
- Board of Examiners for Alcohol, Drug and Gambling Counselors

Given that Nevada is not currently producing enough graduates to fill the demand in the mental health workforce, many people come from other states to practice in Nevada. For example, there were 5,802 nurses who applied for Nevada licenses in fiscal year 2013-14, of which 70 percent were from out-of-

state.[19] In the field of osteopathic medicine, the percentage of applicants from other states is approximately 25 percent.[20]

A. Barriers to Licensing of Mental Health Professionals Moving to Nevada

Currently, mental health professionals licensed in another state must obtain a Nevada license to practice in Nevada. All of the professional boards listed above have procedures for licensing professionals from other states, which are commonly called endorsement procedures. Despite this, potential licensees continue to experience challenges. The Nevada Behavioral Health and Wellness Council recommends that, "State professional boards should consider allowing reciprocity for mental health professionals licensed in other states and willing to move to Nevada. When a professional licensed in another state wants to move to Nevada, long and unnecessary delays in allowing them to practice are self-defeating and pose a serious barrier to recruitment."[21]

As part of this analysis, the Guinn Center interviewed each licensing board and reviewed the applicable statues and regulations. There are several barriers that exist across multiple boards for mental health professionals seeking to move to Nevada: exam and years of experience requirements, fingerprinting policies, training requirements, and the review time period.

1. Exam and Years of Experience Requirements

Exam requirements for licensed providers seeking to work in Nevada vary across licensing boards and can cause delays in filling positions for critically needed services. Table 2 summarizes the requirements for each board. In some cases, boards do not require an exam for applicants who already have a license in another state. In other cases, the boards require additional State tests or require professionals to take a new test if they have not taken the standard test within a specified number of years. Some boards also require applicants from other states to have practiced for a certain number of years.

Table 2: Exam Requirements for Applicants Already Licensed in Other States

Profession	National Exam	State Exam	Oral Exam	Practice Requirement
Physicians	Must have passed exam in last 10 years	Yes		
Osteopathic Physicians	No			Must have been practicing continuously for past 5 years
Psychology	No	Yes		1. Must have been practicing continuously for past 5 years, or 2. Must have been licensed for at least 20 years
Nursing	No			
Social Workers	1. Must have passed exam in last 10 years, or 2. Must have passed an exam in another state and held a license for at least 20 years and practiced social work 50% of the time in the last 10 years.			
Marriage and Family Therapists/ Clinical Professional Counselors	Yes		Yes	
Alcohol, Drug and Gambling Counselors	No		Yes	

The endorsement provisions for each profession are discussed in detail below.

- ***Physicians:*** The requirements for physicians are complex and depend on the license desired. While the Board of Medical Examiners has a provision for endorsement, the Board emphasizes that it is not considered reciprocity and is intended for applicants from other states who do not meet all the regular certification and testing requirements (NRS 630.1605).[22] The Board requires doctors from other states to have taken the required national exam within the last 10 years (NAC 630.080). Applicants must also take a State exam, which is done as a take-home exam (NAC 630.080 1.a.).

  The Board of Medical Examiners offers several other licenses that exempt out-of-state physicians from the examination requirements, including a temporary license in a community without adequate healthcare (NRS 630.261), an authorized facility license to practice as a psychiatrist in mental health centers (NRS 630.262), and a locum tenens license for temporary work not to exceed three months (NRS 630.261). These licenses are not well-utilized. As of August 2014, there were only three active authorized facility licenses and two pending approval. There were no active locum tenens licenses at that time.[23] In addition, the Board of Medical Examiners indicates that some insurers have reportedly refused to pay for the services of a psychiatrist on an authorized facility license. Also, temporary licenses that force providers to leave after three months can be counterproductive given the shortage in health professionals.

- ***Osteopathic Physicians:*** Osteopathic physicians who have practiced in other states and have been continuously practicing for the last five years are eligible for a license by endorsement and are not required to take an exam (NRS 633.400). As with medical doctors, osteopathic physicians do not need to take an exam to be eligible for an authorized facility license (NRS 633.417). A temporary license is also available to fill in for another doctor for six months (NRS 633.391).

- ***Psychology:*** For psychologists, a one-year provisional license can be granted without an exam to a person with a license in another state, but a written State test must subsequently be taken in person (NRS 641.90 and NRS 641.170 3.f). In addition, this option is only available to people who have been practicing continuously for five years or have held a license in another state or Canada for 20 years (NAC 641.025 and 641.028). These years of experience requirements create unnecessary barriers for licensed psychologists from outside Nevada who meet all the other qualifications.

- ***Nursing:*** For nurses, a temporary license is issued without an examination if a person has a license in good standing in another state (NRS 632.300). A permanent license is issued once fingerprint results have been received.

- ***Social Workers:*** A social worker who is licensed in another state can receive a license without taking an exam if the other state's licensing requirements are substantially equivalent to Nevada's requirements (NRS 641B.270). However, the applicant needs to have passed the national exam within the last 15 years. Alternatively, an applicant who has passed an exam in another state can be licensed if the applicant has held a license for at least 20 years and has practiced social work 50 percent of the time in the last 10 years (NAC 641B.126).

- ***Marriage and Family Therapists & Clinical Professional Counselors:*** The application process for marriage and family therapists and counselors from other states is quite involved. Applicants who

are licensed in another state can receive an interim permit if they meet all qualifications except for the national examination (NAC 641A.111). Before receiving the interim permit, the applicant must undergo an academic review and an in-person board interview, which can be an expensive disincentive for a person living outside Nevada. Once the permit is received, applicants have one year to pass the national exam before receiving a full license.[24]

- ***Alcohol, Drug and Gambling Counselors:*** Applicants licensed in another state can receive a Nevada license without taking an examination if the other state's licensing requirements are substantially equivalent to Nevada's requirements (NRS 641C.300). All applicants licensed in other states must complete an in-person oral exam (NRS 641C.290).

The Board of Nursing has the most seamless requirements for out-of-state licensed professionals seeking an endorsement here in Nevada and can serve as a model for other licensing boards.

Recommendation: To expedite licensure of mental health professionals coming from other states, Nevada can simplify current exam requirements by requiring only national exams and not State-specific exams. The curriculum covered in State exams can be folded into continuing education requirements. In addition, new exams should not be required for applicants who have not recently taken an exam. Lastly, Nevada can eliminate provisions that require licensed mental health professionals coming to Nevada to have been licensed for a minimum number of years in another state.

2. Training Requirements

Licensing boards also sometimes require endorsement candidates to meet post-graduate training requirements. While some Nevada boards use standards that are widely accepted in other states, other boards have requirements that are specific to Nevada.

The fields of medicine, osteopathic medicine, and psychology all have national training standards that are accepted in Nevada. The Board of Medical Examiners accepts the training of physicians certified in a specialty recognized by the American Board of Medical Specialties (NRS 630.160) and the Board of Osteopathic Medicine accepts training approved by the American Osteopathic Association or the Accreditation Council for Graduate Medical Education (NRS 633.311). In addition, Nevada's Board of Psychological Examiners is one of 42 states that accept the Certificate of Professional Qualification in Psychology, which has specific post-graduate training requirements.[25]

In contrast, training standards for other professions vary from state to state. This is true for social workers, marriage and family therapists, and drug and alcohol counselors. In some cases, it is difficult to match up professional classifications in Nevada with ones in other states because the titles or educational requirements are different.

Social work is one example where training and supervision requirements are different across states. Differences between requirements in Nevada and California have created barriers for social workers seeking to relocate to Nevada. Social workers seeking endorsement in Nevada must currently have 3,000 hours of postgraduate social work supervised by a licensed mental health practitioner (NAC 641.126). In contrast, California requires 3,200 hours. While this exceeds Nevada's requirement, there are different supervision requirements. In California, 1,700 hours must be under a licensed clinic social worker and the remainder can be under a licensed mental health professional.[26] If the supervision of an applicant does not meet Nevada's standards, the postgraduate hours are not accepted. To address this issue, the

Nevada Board of Examiners for Social Workers is developing a regulation to accept the supervision requirements in other states.[27]

Recommendation: A new policy to accept training requirements of other states across all mental health licensing boards would help ensure that applicants from other states do not need to complete additional training hours prior to being licensed in Nevada. However, to ensure that applicants are qualified to provide services in Nevada, the scope of practice and education requirements would need to be substantially similar to Nevada.

3. Fingerprinting Processes

All licensing boards require applicants to go through a criminal background check by submitting fingerprints to the Nevada Department of Public Safety (DPS) and the Federal Bureau of Investigation (FBI). While DPS indicates that this process takes 45 days, the Board of Nursing reports it can take up to four months to receive fingerprint results.[28]

The licensing boards vary in their fingerprinting administration policies. Most of the boards send a fingerprint card to the prospective licensee upon receipt of the application. The Board of Nursing has expedited this process by providing the option of onsite fingerprinting. The Board of Nursing also encourages applicants to use electronic fingerprinting, which can result in faster processing. If nursing applicants choose to use fingerprint cards, the card must be sent to the Board, which is then forwarded to DPS and the FBI for processing. The Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors has streamlined the process by allowing applicants to submit fingerprints directly to DPS and the FBI instead of submitting them to the Board.

Board policies also vary regarding whether fingerprint results must be received prior to issuing a license. Boards currently use three different models. The Board of Medical Examiners and Board of Psychological Examiners issue licenses before the fingerprint results have been received. Any issues are addressed by the boards after the results are received. The Board of Nursing issues a temporary license pending receipt of fingerprints. A permanent license is issued upon receipt of fingerprints. The remaining boards require that fingerprint results be received prior to issuing a license.

While not requiring fingerprint results prior to licensure can expedite the process, some boards have expressed concern that this practice creates an unacceptable risk to public safety. However, the boards with this expedited policy indicate that a very small number of fingerprint results come back with negative information that was not disclosed in the application. Of all the licensing boards, the Board of Nursing has the highest volume of applicants. In 2013-14, the Board of Nursing received 5,802 licensure applications. Of these, 155 applicants (2.7 percent) had background check issues and ultimately 19 applicants (0.3 percent) were found to have submitted a fraudulent application, indicating that they should not have received a temporary license. For the other boards with an expedited fingerprinting process, the Board of Psychological Examiners indicates that it has never had to address an issue after receipt of fingerprints and the Board of Medical Examiners indicates that it cannot disclose information about the results of background checks.

Recommendation: Licensing boards should streamline and standardize fingerprint administration with options such as electronic filing and direct submission of fingerprints. DPS should also review its procedures to improve processing time. Given that very few potential licensees fail to disclose an issue that is later revealed in a background check, a reasonable path forward would be to expedite licensing by not waiting for background checks to be completed, and then address any issues after the background

check is completed. Accordingly, the licensing boards should create uniform procedures for administering fingerprinting and allow provisional or full licenses to be granted before receipt of fingerprint results.

4. Review Time Period

The time it takes to get a license varies significantly across professional boards and most boards do not have a statutory or regulatory time limit by which they have to make a decision. The board with the fastest review time is the Board of Nursing, which indicates that it approves temporary licenses for applicants from other states in an average of 5.7 days for 80 percent of licenses.[29] In contrast, the Board of Medical Examiners indicates that the average licensing time is 60 days.[30] The Board of Osteopathic Medicine indicates that it takes four to six weeks to approve an endorsement application while a regular application takes eight to twelve weeks.[31]

Only two boards have review time periods mentioned in statute. The Board of Psychological Examiners has 120 days to determine whether an applicant is qualified for licensure (NRS 641.170) and the Board of Examiners for Alcohol, Drug and Gambling Counselors has 90 days to reject an application (NAC 641C.215).

There have been recent legislative efforts to place time limits on the endorsement process. Senate Bill 324 from the 2013 Legislative Session would have created timelines in certain circumstances.[32] While this bill did not pass, the Legislative Committee on Health Care requested that this bill be redrafted for the 2015 Session (Bill Draft Request [BDR] 54-62).[33] This bill would create a timeline for endorsements as shown in Table 3. It is important to note that these timelines do not affect all mental health professions and that they do not treat fingerprints uniformly.

Table 3: Timeline for Endorsement Proposed Under SB 324 (2013)/BDR 54-62 (2015)

Profession	Timeline to notify of incomplete application	Timeline to consider endorsement once application is complete
Physicians	15 days	45 days
Osteopathic Doctors	15 days	45 days or 10 days after receipt of fingerprints, whichever is later
Podiatrists	15 days	45 days
Military personnel, veterans, as well as spouses of military personnel/ veterans in any health profession listed in NRS 630 to 641C and NRS 644*	15 days	30 days or 10 days after receipt of fingerprints, whichever is later. Boards also have the ability to grant a provisional license pending approval of a full license.

* The provisions regarding military spouses are an extension of Executive Order 2012-11, which directs every professional licensing board to facilitate endorsement of military spouses licensed in other states, provide a temporary or provisional license while awaiting verification, and expedite applications for military spouses.[34]

Most of the boards, except for medicine and osteopathic medicine, have an option to provide a provisional or temporary license until an applicant from another state meets all requirements. The medical and osteopathic boards instead have options for temporary licenses for people who do not intend to stay in Nevada for an extended period of time (NRS 630.261 and NRS 633.391). The timeline for granting a temporary or provisional license can also vary significantly across boards.

Recommendation: To promote greater efficiency and predictability for licensees, the Legislature should consider establishing a uniform 30-day timeline across all mental health professions for granting licenses by endorsement. These provisions should also include timelines for granting temporary and provisional

licenses. The Legislature should also consider requiring that every board offer a temporary or provisional license so that mental health professionals can begin meeting the needs of the community as soon as possible. To ensure public safety, any evidence of a past investigation or disciplinary process in another state or by a hospital credentialing authority should make the applicant ineligible for a temporary or provisional license.

B. Models of License Reciprocity

The recommendations discussed in the previous section for removing barriers from Nevada's current endorsement practices can be done unilaterally by Nevada and do not require agreement by other states. Another option is to look at how reciprocity agreements between states can be developed to promote license portability. Under reciprocity, professionals are licensed in a single state but can practice in multiple states. Having reciprocity in place in Nevada would simplify recruitment from other states and would facilitate practice of telehealth in remote and underserved areas. There are two options for developing reciprocity agreements: individual states can negotiate with each other, or states can come together at a national level to negotiate interstate compacts.

The first option will likely be considered during the 2015 Session of the Nevada Legislature. A bill draft has been requested by the Legislative Committee on Health Care that would allow Nevada licensing boards that regulate health professions to negotiate reciprocity agreements with other states.[35] Specifically, this proposal would allow certain licensing boards that regulate health professions (NRS 630, 630A, 632-641C, or 644) to enter into a reciprocity agreement with the corresponding regulatory agency in another state if licensing requirements are substantially similar to Nevada.[36] This agreement would allow a provider to practice concurrently in Nevada and other states.

However, based on discussions with the licensing boards for mental health professions in Nevada, it appears unlikely that the State's licensing boards would use this provision. Nevada's licensing boards do not have the resources to negotiate separate agreements with multiple states since they are supported solely by fees and have limited staff. In addition, it would be inefficient for Nevada to try to broker agreements one state at a time.

The alternative to state-by-state negotiation of reciprocity agreements is national-level negotiation of interstate compacts. In recent years, states have begun to come together to develop interstate compacts that allow health provider licenses to be recognized in multiple states. These compacts are typically negotiated by national associations such as the Federation of State Medical Boards and the National Council of State Boards of Nursing, which have more resources to negotiate compacts than individual states. The Council of State Governments has also been active in helping to develop health licensure compacts.[37] Compacts must be adopted by individual state legislatures to be effective.

Nevada does not currently participate in any compacts or agreements for licensure reciprocity. There are three existing compacts and agreements that affect health professionals: the Nurse Licensure Compact, the Advance Practice Registered Nursing Compact, and the Psychology Agreement of Reciprocity. There are also two new compacts: the Interstate Medical Licensure Compact, which is ready to be adopted by states, and the Interjurisdictional Telepsychology Compact for Psychologists, which is under development. Each is discussed below.

1. Nursing Compacts

The most established interstate compact in the health field is the Nurse Licensure Compact, which became effective in 2000.[38] Currently, 24 states are in the compact. A nurse who lives in a compact state

can practice in any participating state, which facilitates practicing in multiple states and in the practice of telehealth. If a nurse permanently relocates to another compact state, the nurse must apply for licensure by endorsement and complete the Declaration of Primary State of Residence for the new home state. States in the compact use Nursys, a national database for verification of nurse licensure, discipline and practice privileges, which is currently used in Nevada. While the Nurse Licensure Compact has been reviewed by the U.S. Department of Health and Human Services, it has not been formally evaluated.[39]

Model legislation must be adopted in Nevada to participate in this existing national compact.[40] There have been three unsuccessful attempts to pass this legislation in Nevada (SB 423 in 2001, SB 93 in 2003, and SB 412 in 2007). Concerns were raised during consideration of the compact about having two sets of standards for nurses. Stakeholders also expressed concerns that not all states participating in the compact require criminal background checks, which is a public safety issue. Similar concerns have also been raised in other states.

There is also an Advance Practice Registered Nursing (APRN) Compact, which has been adopted by three states but has yet to be implemented.[41] Issues are still being addressed such as grandfathering of current APRNs and prescribing authority. New model legislation is being developed by the National Council of State Boards of Nursing and will likely be ready for implementation in the next couple of years.[42] The Nevada Board of Nursing should actively monitor this compact as changes are made to see if it could benefit Nevada.

2. Psychology Agreement of Reciprocity

The Association of State and Provincial Psychology Boards has created an Agreement of Reciprocity which has been implemented by five states and two Canadian provinces. Under the agreement, an individual holding a license in a participating jurisdiction may obtain a license to practice in another participating jurisdiction. To be part of the agreement of reciprocity, a state must demonstrate that its requirements for licensure meet the standards required by other participating jurisdictions. Nevada participated in this agreement until the State eliminated the oral exam for psychologists in 2009 (*Statutes of Nevada* 2009, Chapter 494). In order to participate in this agreement again, Nevada's requirements would need to mirror the other participating states. However, adding on requirements to match other states would not likely help speed the licensure process.

3. Interstate Medical Licensure Compact

The Federation of State Medical Boards has been working on a compact among states to speed the process of issuing licenses for physicians who wish to practice in multiple states.[43] Joining the compact could help Nevada recruit physicians from member states. It would also help facilitate the supply of doctors providing services remotely through telemedicine, which could help reduce costs in areas that have been underserved.[44]

The Federation of State Medical Boards released model legislative language in September 2014, which can be adopted by state legislatures beginning in 2015.[45] The compact provides a streamlined process that allows physicians to become licensed in multiple states without changing a state's existing medical practice act. The compact adopts a simplified, prevailing standard for licensure, which includes nationally recognized education, training and certification standards. It also requires a background check. In addition, the compact affirms that the practice of medicine occurs where the patient is located, and therefore requires the physician to be under the jurisdiction of the state medical board where the patient is located. It also creates a coordinated information system of physicians that have applied for licensure

under the compact for disciplinary purposes. The compact will become effective once it has been adopted by seven states.

4. Interjurisdictional Telepsychology Compact for Psychologists

The Association of State and Provincial Psychology Boards has been developing an interstate compact to facilitate the practice of telepsychology. The proposed compact would allow licensed psychologists to practice telepsychology across jurisdictional lines. While this compact is more limited in scope than the proposed Medical Licensure Compact, it could help Nevada address the shortage of psychologists in the State by providing a mechanism to receive services through technology.

Draft language for the compact has been created and a 90 day comment period ends on November 30, 2014.[46] Once the language is complete, legislation will need to be adopted by seven states for the compact to be effective. This compact does not create a standard for licensure of psychologists. Rather, any licensed psychologist in a compact state would be eligible to obtain an E.Passport Certificate to practice telepsychology. A background check would be required. As with the medical licensure compact, this compact creates a coordinated information system with identifying information, licensure information, and disciplinary information.

5. Limitations of Compacts

The Nevada Legislature should carefully consider the fiscal impact on each licensing board when deciding whether to join an interstate compact. While interstate compacts have the potential to increase the availability of critically needed mental health services in Nevada, they can also increase administrative costs and reduce fee revenue. Licensing boards would have to contribute to the cost of administration of the compact and would have to pay for use of the coordinated information system, which includes licensure information and disciplinary actions. In the case of nursing, Nevada is already using the database system (Nursys) so some of the necessary infrastructure is already in place. Implementation of licensure compacts could also reduce fee revenue since licensees that practice in Nevada but live in another state would not pay licensing fees. Licensing boards could explore raising license fees to offset the increase in administrative costs and the reduction in fee revenue.

A review of licensing fees in states participating in the Nurse Licensure Compact provides insight into whether it would be reasonable for Nevada to increase its fees to cover increased costs and reduced fee revenue. With the exception of Nevada and California, all the other states in the Intermountain West participate in the Nurse Licensure Compact. Nevada's registered nurse application and fingerprinting fee is $151. Fees in Intermountain West states are: $350 in Arizona, $201 in California, $88 in Colorado, $154 in New Mexico, $186 in Texas, and $100 in Utah.[47] Currently, Nevada's fees are significantly lower than the fees collected in Arizona, California, and Texas.

Recommendation: During the 2015 session, the Legislature should consider joining interstate compacts in medicine, nursing, and psychology to improve recruitment from other states, which could facilitate the use of telehealth to help meet needs in underserved areas.

Part III: Competitiveness of Compensation for Nevada Mental Health Professionals

Another key issue affecting the ability to attract mental health professionals to Nevada is the competitiveness of compensation. Nevada faces competition from other states as well as the VA, which has recently increased salaries for mental health professionals. The Nevada Behavioral Health and Wellness Council made several recommendations related to pay:[48]

- Examine the need for an increase in salaries for State-employed psychiatrists and other clinical specialties. These increases could be immediate or staggered over several years.
- Consider recruiting incentives such as signing bonuses or reimbursement of moving expenses for the positions that are most difficult to fill.
- Provide pay incentives for additional board certifications (e.g. child psychiatry).

1. Challenges Faced by State Agencies

While both private and public health providers in Nevada face pay competitiveness issues, the ability to offer a competitive salary has been particularly problematic for the State agencies that provide mental health services: the DHHS and the Department of Corrections. State salary schedules limit the compensation that can be offered to health professionals and these salaries have been effectively reduced by furloughs since 2009. Consequently, these agencies have experienced a large number of vacancies and have resorted to contracting out this work to meet the growing demand for mental health services.

Table 4 shows the number and percentage of vacancies in mental health positions in DHHS and the Department of Corrections and their corresponding salaries. This data reveals that the most critical shortfalls are for Senior Psychiatrists (33.6 positions) and Psychiatric Nurses (43.2 positions). Across all positions, the average vacancy rate is 14 percent. The highest salary ranges are for Licensed Psychologists and Senior Psychiatrists while the lowest salary ranges are for Mental Health Technicians and Psychiatric Caseworkers. Psychiatrists can earn significantly higher salaries working in the VA. Effective November 30, 2014, the salary range for psychiatrists working in the VA will be $98,967 to $260,000.[49]

Table 4: Vacancies in State Mental Health Positions and Salary Ranges

Position	Vacancies: DHHS	Percent Vacant DHHS	Vacancies: Department of Corrections	Percent Vacant Corrections	Low End of Salary Range	High End of Salary Range
Clinical Program Manager	2.0	9%			$54,204	$102,228
Clinical Social Worker	3.5	6%			$45,560	$81,139
Licensed Psychologist	2.0	7%			$67,692	$107,114
Mental Health Counselor	5.0	10%			$45,560	$97,593
Mental Health Technician	9.5	5%			$27,895	$40,110
Psychiatric Caseworker	2.0	3%			$38,523	$61,950
Psychiatric Nurse	40.2	15%	3.0	11%	$49,694	$97,593
Senior Psychiatrist	32.0	76%	1.6	29%	$155,621	$176,902
Substance Abuse Counselor	1.0	22%			$38,523	$67,692

Source: Department of Corrections (2013-14), Department of Health and Human Services (September 2014)

As a result of these vacancies, these two departments have contracted out for services. In 2013-14, the Department of Corrections reports that it expended $544,581 for contract Senior Psychiatrists while DHHS reports that it spent $9.8 million on contract staff in Southern Nevada Adult Mental Health Services, including $5.6 million for psychiatrists and physicians, $1.9 million for psychiatric nurses, and $1.4 million on mental health technicians.[50] In addition, from August 2013 through August 2014, DHHS came to the Interim Finance Committee five times to request either new funds for contract positions or a

transfer of funds from salaries to professional services to hire contract positions (see Table 5). These funds totaled $6.1 million.

Table 5: Department of Health and Human Services Requests to Interim Finance Committee for Transfers and Additional Funds for Contract Mental Health Services

Date	Amount	Agenda Item	Purpose
Aug-13	$1,066,344	Item D	New contract positions for Rawson Neal Psychiatric Hospital: Occupational Therapist, Psychologist, Social Workers, Psychiatrists
Feb-14	$3,606,904	Item E-41	Fill vacancies at Southern Nevada Adult Mental Health Services with contract positions
Apr-14	$205,656	Item D-46	Fill vacant psychiatrist positions at Northern Nevada Adult Mental Health Services
Jun-14	$464,610	Item G-60	Fill vacancies at Southern Nevada Adult Mental Health Services with contract positions
Aug-14	$785,000	Item G-80	Fill vacant psychiatrist and psychologist positions at Lake's Crossing Center with contract positions
TOTAL	**$6,128,514**		

Source: Agendas and Minutes of Nevada Interim Finance Committee

The State pays a premium for contract positions. DHHS reports that contract Senior Psychiatrists are paid $145 to $165 per hour compared to $120 per hour (including benefits) for regular staff.[51] In addition, contract psychiatric nurses are paid $51 to $62 per hour compared to $53 per hour for regular staff.[52] Vacancy savings alone have been insufficient to cover these contract staff costs. In 2013-14, Southern Nevada Adult Mental Health Services had salary savings of $7.6 million in 2013-14, which did not fully cover $9.8 million in contract staff costs. During the current biennium, the State has been able to fund these contract costs using salary savings from vacancies, funds allocated from the Interim Finance Committee contingency account, and additional federal reimbursement resulting from expansion of Medicaid to single adults. Over the long-term, additional funds will likely be needed to sustain the current level of contract staff.

There are also several downsides to employing a large number of contract staff. Many of the contractors employed by DHHS are temporary, decreasing the continuity and quality of care they provide.[53] In addition, a consultant report to DHHS in May 2013 found that excessive use of temporary physicians compromises treatment team coherence and functioning.[54] Contractors may also have limited hours and be less invested in institutional well-being.

Instead of relying on contract labor, the Nevada Legislature could choose to increase the salary levels of mental health professionals, which would require increased State appropriations. This was last done in 2007, when the State increased the salary schedules for certain mental health positions by two ranges to assist in recruitment (*Statutes of Nevada* 2007, Chapter 349). To help understand how much salaries may need to be increased, the next section compares average salaries in Nevada to nearby states and the national average.

2. Nevada Salaries Compared to Intermountain West States

To understand the competitiveness of mental health salaries in Nevada, we reviewed both public and private average salaries from 2007 to 2013 across the Intermountain West, which includes Arizona,

California, Colorado, New Mexico, Texas, and Utah. This analysis finds that salaries in Nevada are the least competitive for psychiatrists and psychologists and the most competitive for nurses and social workers. Table 6 compares the average salary for each profession across the region in 2013.

Table 6: Salaries of Mental Health Professionals in the Intermountain West, 2013

State	Psychiatrists	Psychologists	Registered Nurses	Mental Health & Substance Abuse Social Workers	Mental Health Counselors
Arizona	229,740	58,050	71,430	33,490	43,290
California	191,460	80,450	96,980	50,420	46,970
Colorado	194,560	73,390	68,980	41,290	43,800
Nevada	177,390	65,860	78,800	50,400	46,400
New Mexico	124,000	62,360	64,900	40,910	38,370
Texas	190,040	62,160	67,860	38,150	44,270
Utah	86,260	66,030	60,090	41,650	49,080
United States	182,660	72,710	68,910	44,420	43,700

Source: Bureau of Labor Statistics, Occupational Employment Statistics (OES) Survey

- ***Psychiatrists:*** The competitiveness of salaries for Nevada's psychiatrists has varied over the years. In 2008, Nevada had the highest average pay in the nation at $215,000 (in constant 2013 dollars). Salaries eroded over the next few years. By 2013, Nevada ranked fifth in the region and below the national average with an average salary of $178,000. To be competitive with Arizona, which had the highest average salary in 2013, annual wages would need to rise to $230,000, which is an increase of $52,000 over current levels.

- ***Psychologists:*** Pay for psychologists is also low in Nevada compared to other states in the region. Nevada wages consistently ranked fourth in the region from 2007 to 2013 and real wages have declined since the economic downturn began in 2008. In 2013, the average salary for psychologists in Nevada was $66,000, which falls just slightly below the national average. To be competitive with California, which had the highest wage for psychologists in 2013 at $80,000, the average salary in Nevada would need to increase by $14,000 over current levels.

- ***Nurses:*** The average annual salary for Nevada's nurses has consistently ranked second behind California from 2007 to 2013. The average salary for nurses was not as negatively affected by the economic downturn as other fields. Real wages increased annually from 2007 to 2011 and then declined slightly in 2012 and 2013. In 2013, the average salary for nurses in Nevada was $79,000, which is above the national average.

- ***Social Work:*** In the field of social work, average salaries in Nevada have been very competitive in the region. While there has been a striking decline in real wages for Nevada's social workers following the economic downturn, salaries have consistently ranked first or second from 2007 to 2013. In 2013, the average salary for social workers was $50,000 in both California and Nevada.

- ***Counselors:*** The average annual salary for mental health counselors has also declined following the economic downturn throughout the region. From 2007 to 2012, Nevada had the highest average

annual salary for counselors in the region. In 2013, as salaries began to increase in some states, Nevada's average salary slipped to third at $46,000.

Recommendation: This analysis of mental health professional salaries illustrates that Nevada's average salaries for psychiatrists and psychologists rank low compared to other states. While Nevada's pay is competitive in other mental health fields, there is insufficient evidence to determine if pay is sufficient across states in these fields. The State should consider increasing State employee salaries, benefits and incentives such as loan forgiveness for mental health professionals, particularly psychiatrists and psychologists, to make pay schedules more competitive with other states in the Intermountain West region and the VA, and to reduce reliance on contract workers. Additional appropriations would likely be necessary to accommodate these higher State salaries and maintain current service levels.

Part IV: Long Term Workforce Solutions

Addressing licensing and pay issues are short-term solutions that can help meet immediate critical mental health workforce shortages. However, these efforts simply enhance Nevada's competitiveness relative to other states but do not increase the overall supply of mental health professionals. Over the long term, Nevada needs to focus on growing the workforce pipeline within the State.

To address these long-term issues, Nevada should consolidate current behavioral health workforce development efforts and create a statewide plan. As discussed in this policy brief, there have been several high profile efforts to address mental health workforce issues. The Behavior Health and Wellness Council, the Health Care and Medical Services Sector Council under DETR, and DHHS, have all been working on various aspects of workforce development. In addition, the University of Nevada School of Medicine sponsors the Medical Education Council of Nevada, which is tasked with determining health workforce needs in the State and making recommendations to the School of Medicine and Legislature (NRS 396.908). The Governor also established the Graduate Medical Education Task Force to explore how to increase residency slots.[55]

To streamline efforts, reduce silos, and minimize duplication of efforts, one agency should be tasked with bringing all of these efforts together into a comprehensive plan. Of the existing entities, DETR, which sponsors the Health Care and Medical Services Sector Council, is likely best suited to take on this task because it has been the most active and already has broad participation within the health industry and higher education.

Other states have created plans that can serve as models for Nevada. Some of these plans focus on the general healthcare workforce while others are specific to mental health. California has created a plan specific to the mental healthcare workforce.[56] General healthcare workforce development plans are more common. For example, 16 states and the District of Columbia received a Health Care Workforce Development Grant funded by the Affordable Care Act.[57] In addition, the National Governor's Association is currently working with seven states to build statewide plans for the healthcare workforce.[58]

To help facilitate development of the plan, several states, including Colorado and New Mexico, have passed statutes requiring licensing boards to collect data about providers, including whether licensees are actively practicing in the State, how many hours they are practicing, and in what locations.[59] In New Mexico, this data collection revealed that only 63 percent of licensed psychiatrists are practicing in the State.[60] By providing accurate data of the services being provided, New Mexico has been able to focus its efforts on the areas of most critical need. In Nevada, the University of Nevada School of Medicine has

been working with the Nevada Board of Nursing to begin collecting this data on a voluntary basis. Adoption of a statute would help expand this data collection to other boards and would ensure that consistent data is collected on a statewide basis.

Nevada's behavioral health workforce development plan should emphasize both short- and long-term approaches to fulfill the following goals: engagement, training, recruitment, and retention. It should also include a robust evaluation component.

- ***Engage:*** To increase the number and diversity of students interested in behavioral health careers, the plan will need to develop initiatives to engage students in grades K-12 in health careers. Key components should include educating students about career options, increasing science, technology, engineering, and math (STEM) education efforts, and ensuring that students of all ethnicities have access to higher level science and math courses in high school. Mentorship programs will also be important so that students from diverse backgrounds have role models that help them envision themselves in a health career.

  Nevada can build on existing efforts to educate K-12 students about health careers. For example, the High Sierra Health Education Center and the University of Nevada School of Medicine developed a publication called *Health Careers in Nevada*, which is targeted at middle and high school students who are interested in exploring health careers and educational opportunities in the State.[61] The School of Medicine can partner with school districts to publicize this initiative and develop mentoring opportunities. In addition, Nevada could create a short licensing guide similar to one developed in California that summarizes all the licensing requirements for each healthcare field.[62]

- ***Train:*** The mental health workforce development plan should build on existing efforts to enhance opportunities for training through institutions of higher education and clinical placement programs. The plan should focus on pre-graduate training such as internships, externships, and practica, as well as post-graduate training such as residencies and post-doctorate programs. Given limited public resources, Nevada should explore expanding public-private partnerships, such as those at Renown and Sunrise Hospitals, to increase residency slots and post-graduate internships.

- ***Recruit:*** To bolster recruitment in underserved areas, a statewide plan should focus on innovative strategies such as tying scholarships to a commitment to provide services in underserved Nevada. For example, New Mexico has a BA/MD program that provides a scholarship during a student's undergraduate career in exchange for a commitment to attend medical school and practice in the State.[63] In addition, California has a stipend program for graduate students studying Clinical Psychology, Marriage and Family Therapy, Psychiatric Mental Health Nurse Practice, and Social Work. In exchange for the stipend, students must commit to at least one year of work in the public mental health system after graduation.[64]

  Loan forgiveness programs can be a crucial tool in recruiting recent graduates to underserved areas. The plan should review utilization of existing loan forgiveness programs. It should also expand the State's commitment to loan forgiveness programs for graduates who agree to provide services in underserved areas through the Nevada Health Service Corps.[65] State and/or private funding can be used to pay the federal match for federal programs and/or to expand loan forgiveness programs. For example, Colorado and California have expanded loan forgiveness opportunities. Colorado's efforts have been funded by a combination of public and private resources, including the Colorado Health

Foundation, the Colorado Trust, and the CompreCare Foundation.[66] In California, the State created the Mental Health Loan Assumption Program, which provides up to $10,000 to repay educational loans in exchange for a 12-month service obligation in a hard-to-fill or retain position within the County Public Mental Health System.[67] This effort is funded by Proposition 63, a tax on high-income earners approved by voters in 2004.

- ***Retain:*** To retain employees, research shows that it is important to respond to employee needs, promote a positive work environment, provide fairness and equity, reward effort, and encourage professional development.[68] To this end, the workforce development plan should ensure that salaries are competitive with other states in the Intermountain West region and with the VA. To reward effort and growth, the salary structure can include higher salaries for people who obtain additional specializations and credentials. The plan should also aim to ensure that behavioral health professionals have a good working environment with reasonable caseloads and health benefits. To promote equity and fairness, the focus should be on having permanent staff in lieu of contractors, who are paid more than regular staff. The State can also provide ongoing professional development for mental health providers. For example, California has created the Statewide Technical Assistance Center, more commonly known as Working Well Together (WWT), which provides ongoing professional development and is highly utilized throughout all California counties.[69]

- **Evaluate:** An important component of any workforce development plan is evaluation. This should include a review of how well workforce development programs are being utilized in different regions of Nevada. To determine the impact of workforce development programs, the evaluation should analyze growth in completions of degree programs, residencies, and clinical placement programs. It should also analyze the retention rate of people who complete educational programs in Nevada. Finally, the evaluation should monitor progress in meeting workforce shortages for each profession on a geographic basis. California has evaluated the effectiveness of its mental health workforce development plan and has made changes based on the findings in the evaluation.[70]

Recommendation: The Legislature and Governor should enact a statute that directs DETR, with the advice of the Health Care and Medical Services Sector Council, to create a statewide mental health workforce development plan. The Statute should also require DETR to submit an evaluation to the Legislature every two years. To facilitate creation and monitoring of the plan, the statute should require mental health licensing boards to collect data about providers, including whether licensees are actively practicing in the State, how many hours they are practicing, and in what locations.

Part V: Conclusion and Recommendations

Building up Nevada's mental health workforce is critical to improving the quantity and quality of behavioral health services in the State. Stakeholders have begun to work together to develop strategies to achieve this goal, through groups such as the Behavioral Health and Wellness Council, the Health Care and Medical Services Sector Council, and DHHS. While State departments can make administrative changes, Legislative action is needed during the 2015 session to enable the State to attract more mental health professionals and to create a foundation for long-term workforce growth.

The Guinn Center for Policy Priorities recommends that the State focus on both short- and long-term strategies to attract more mental health professionals to the State. In the short-term, the State can focus on removing barriers to licensing for out-of-state mental health professionals who want to practice in

Nevada and making compensation for State mental health employees more competitive. In the long term, the State should create and implement a comprehensive plan to build a sustainable workforce for the State's future. Specific recommendations are listed below.

1. **Exam Requirements:** Simplify requirements for licensed mental health professionals coming to Nevada. The curriculum covered in State exams can be folded into continuing education requirements. Eliminate provisions that require applicants who have been licensed and practicing for several years to take a new national exam.
2. **Years of Practice Requirements:** Eliminate provisions that require mental health professionals coming to Nevada to have been licensed for a minimum number of years in another state.
3. **Training Requirements:** Accept training requirements of other states in mental health professions that have substantially the same scope of practice and education requirements.
4. **Fingerprinting:** Create uniform procedures for administering fingerprinting and allow provisional or full licenses to be granted before receipt of fingerprint results. Improve DPS review times.
5. **Temporary Licenses:** Require each mental health licensing board to offer a temporary or provisional license to professionals who are licensed in other states and are in good standing so they can begin practicing before they meet all Nevada requirements. Any evidence of a past investigation or disciplinary process in another state or by a hospital credentialing authority would make the applicant ineligible for this provision.
6. **Timelines:** Create a uniform 30-day timeline to consider applications from mental health professionals licensed in other states.
7. **Interstate Compacts:** Consider joining interstate compacts in medicine, nursing, and psychology to improve recruitment from other states, which could facilitate the use of telehealth to help meet needs in underserved areas.
8. **State Employee Compensation:** Consider increasing State employee salaries, benefits and incentives such as loan forgiveness for mental health professionals, particularly psychiatrists and psychologists, to make pay schedules more competitive with other states in the Intermountain West region and the VA, and to reduce reliance on contract workers.
9. **Long-Term Planning:** Direct the Department of Employment Training and Rehabilitation (DETR), with the advice of the Health Care and Medical Services Sector Council, to coordinate workforce development efforts and create a statewide mental health workforce development plan with an emphasis on engagement, training, recruitment, and retention. Require DETR to submit an evaluation of the impact of the plan to the Legislature every two years to ensure that goals are met and that government resources are being used cost-effectively.
10. **Data Collection:** Require mental health licensing boards to collect data about providers, including whether licensees are actively practicing in the State, how many hours they are practicing, and in what locations.

About the Kenny C. Guinn Center for Policy Priorities

The Kenny C. Guinn Center for Policy Priorities is a 501(c)(3) nonprofit, bipartisan, think-do tank focused on independent, fact-based, relevant, and well-reasoned analysis of critical policy issues facing the State of Nevada. The Guinn Center engages policy-makers, experts, and the public with innovative, fact-based research, ideas, and analysis to advance policy solutions, inform the public debate, and expand public engagement. The Guinn Center does not take institutional positions on policy issues.

Contact Information
Kenny C. Guinn Center for Policy Priorities
c/o InNEVation Center
6795 Edmond Street
Suite 300/Box 10
Las Vegas, NV 89118
Phone: (702) 522-2178
Email: info@guinncenter.org
www.guinncenter.org

Contacts
Nancy E. Brune, Ph.D.
Executive Director
nbrune@guinncenter.org, (702) 522-2178

Victoria Carreón
Director of Research & Policy
vcarreon@guinncenter.org, (702) 522-2178

---

[1] Ysenia Amaro. "State will not appeal denial of accreditation to Rawson-Neal." *Las Vegas Review Journal.* (July 25, 2013) http://www.reviewjournal.com/news/nevada-and-west/state-will-not-appeal-denial-accreditation-rawson-neal

[2] Andrew Doughman. "Drop-in mental health clinic at Rawson-Neal to close Friday." *Las Vegas Sun.* (January 23, 2014) http://www.lasvegassun.com/news/2014/jan/23/drop--mental-health-clinic-rawson-neal-close-frida/

[3] Department of Health and Human Services, Nevada Division of Public and Behavioral Health, Behavioral Health and Wellness Council. http://www.health.nv.gov/BHWC.htm

[4] Joel A. Dvoskin, Chair of the Behavioral Health and Wellness Council. Proposed Council Recommendations. (May 2014) http://www.health.nv.gov/BHWC/Reports/2014-05_ReportAndRecommendationsToGovernorSandoval.pdf

[5] Nevada Department of Employment Training and Rehabilitation. Health Care and Medical Services Sector Council. http://detr.state.nv.us/GWIB_SectorCouncils/gwib_HealthSector.htm

[6] Joel A. Dvoskin, Chair of the Behavioral Health and Wellness Council. Proposed Council Recommendations. (May 2014) http://www.health.nv.gov/BHWC/Reports/2014-05_ReportAndRecommendationsToGovernorSandoval.pdf

[7] U.S. Department of Health and Human Services, Health Resources and Services Administration. Find Shortage Areas. Data as of August 29, 2014. http://hpsafind.hrsa.gov/HPSASearch.aspx; U.S. Census, American Community Survey 2012 5 year estimate, table B01003.

[8] U.S. Department of Health and Human Services, Health Resources and Services Administration. *Mental Health HPSA Designation Criteria.* http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsacriteria.html

[9] Joel A. Dvoskin, Chair of the Behavioral Health and Wellness Council. Proposed Council Recommendations. (May 2014) http://www.health.nv.gov/BHWC/Reports/2014-05_ReportAndRecommendationsToGovernorSandoval.pdf

[10] John Packham, Tabor Griswold, & Christopher Marchand. Health Workforce in Nevada: 2013 Edition. (March 2013) http://medicine.nevada.edu/Documents/unsom/statewide/reports/HWIN_2013-FINAL_REPORT-MARCH_2013.pdf

[11] Ibid Table 2.13

[12] John Packham & Trabor Griswold, University of Nevada School of Medicine Health Policy Project. Nevada Residency and Fellowship Training Outcomes-2004 to 2014: Key Findings from the Annual UNSOM Graduate Medical Education Exit Survey (July 2014) http://medicine.nevada.edu/Documents/unsom/statewide/reports/UNSOM_GME_Exit_Survey_2004-2014_-_July_2014.pdf

[13] John Packham, Tabor Griswold, & Christopher Marchand. Health Workforce in Nevada: 2013 Edition. (March 2013) http://medicine.nevada.edu/Documents/unsom/statewide/reports/HWIN_2013-FINAL_REPORT-MARCH_2013.pdf

[14] Integrated Postsecondary Education Data System. http://nces.ed.gov/ipeds/datacenter/

[15] John Packham, Tabor Griswold, & Christopher Marchand. Health Workforce in Nevada: 2013 Edition. (March 2013) http://medicine.nevada.edu/Documents/unsom/statewide/reports/HWIN_2013-FINAL_REPORT-MARCH_2013.pdf Table 3.10

[16] U.S. Census State and County Quick Facts. http://quickfacts.census.gov/qfd/states/32000.html

[17] Severe Mental Illness (SMI) among persons aged 18 or older is defined as having a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association [APA], 1994)

that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities. See: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings. http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm#c-1

[18] Any Mental Illness (AMI) among adults aged 18 or older is defined as currently or at any time in the past 12 months having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association [APA], 1994). See: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings. http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm

[19] Email communications from Chris Sansom, Board of Nursing, September 8 and 12, 2014

[20] Barbara Longo, State Board of Osteopathic Medicine, testimony to Legislative Committee on Health Care (January 8, 2014) http://www.leg.state.nv.us/Interim/77th2013/Minutes/HealthCare//IM-HealthCare-010814-10757.pdf

[21] Joel A. Dvoskin, Chair of the Behavioral Health and Wellness Council. Proposed Council Recommendations. (May 2014) http://www.health.nv.gov/BHWC/Reports/2014-05_ReportAndRecommendationsToGovernorSandoval.pdf

[22] Nevada State Board of Medical Examiners. Application for licensure. http://www.medboard.nv.gov/Forms/Licensing/Physician%20Application.pdf

[23] Phone interview with Lynette Daniels, Nevada Board of Medical Examiners. (August 29, 2014).

[24] Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors. Interim Permit. http://marriage.nv.gov/Services/Interim_Permit/

[25] Association of State and Provincial Psychology Boards. Mobility Program: Certificate of Professional Qualification in Psychology (CPQ) http://c.ymcdn.com/sites/www.asppb.net/resource/resmgr/mobility_/mobility_program_cpq_list.pdf

[26] California Business and Professions Code §4996.23. http://www.bbs.ca.gov/pdf/publications/lawsregs.pdf

[27] Proposed Regulation of the Board of Examiners for Social Workers. LCB File No. R025-14. http://www.leg.state.nv.us/Register/2014Register/R025-14RP1.pdf

[28] Nevada Department of Public Safety, Identification File Request for State of Nevada Records of Criminal History Form. http://www.nvrepository.state.nv.us/Criminal/forms/DPS_006_Form.pdf & State Board of Nursing. Fingerprinting or Renewal FAQs. http://nevadanursingboard.org/wp-content/uploads/2014/04/fingerprintFAQ.pdf

[29] Testimony of Debra Scott. Minutes of Legislative Committee on Health Care (January 8, 2014) http://www.leg.state.nv.us/Interim/77th2013/Minutes/HealthCare//IM-HealthCare-010814-10757.pdf

[30] Board of Medical Examiners. Testimony before the Legislative Committee on Health Care. (January 8, 2014) http://www.leg.state.nv.us/Interim/77th2013/Exhibits/HealthCare/E010814L.pdf

[31] Board of Osteopathic Medicine. Testimony before the Legislative Committee on Health Care: Osteopathic Board Licensing Statistics. (January 8, 2014) http://www.leg.state.nv.us/Interim/77th2013/Exhibits/HealthCare/E010814K.pdf

[32] Senate Bill 324, 2013 Legislative Session. http://www.leg.state.nv.us/Session/77th2013/Bills/SB/SB324_R1.pdf

[33] Bill Draft Request List (2015 Nevada Legislative Session) http://www.leg.state.nv.us/Session/78th2015/BDRList/page.cfm

[34] State of Nevada, Executive Order 2012-11. http://gov.nv.gov/News-and-Media/Executive-Orders/2012/EO_-2012-11---Providing-Reciprocity-for-Military-Spouses-Seeking-Licensure-in-this-State/

[35] BDR 54-62 has been requested for the 2015 Legislative session by the Legislative Committee on Health Care, which is based on Senate Bill 324 from the 2013 Session

[36] Senate Bill 324, 2013 Legislative Session. http://www.leg.state.nv.us/Session/77th2013/Bills/SB/SB324_R1.pdf

[37] Council of State Governments. *Interstate Compacts-Background, History and Modern Use.* *http://knowledgecenter.csg.org/kc/system/files/Webinar2014_InterstateCompacts101_PP.pdf*

[38] National Council of State Boards of Nursing, Nurse Licensure Compact. https://www.ncsbn.org/nlc.htm

[39] U.S. Department of Health and Human Services, Health Resources and Services Administration. *Health Licensing Board Report to Congress.* http://www.hrsa.gov/ruralhealth/about/telehealth/licenserpt10.pdf

[40] National Council of State Boards of Nursing. Nurse Licensure Compact Model Legislation. (1998) https://www.ncsbn.org/2539.htm

[41] National Council of State Boards of Nursing, Advance Practice Registered Nursing Compact Timeline (2012) https://www.ncsbn.org/APRN_Compact_hx_timeline_April_2012_(2).pdf

[42] Nurse Licensure Compact Administrators. Review of 2012-13. https://www.ncsbn.org/12_NLCA_AnnualReport_web.pdf

[43] Federation of State Medical Boards. Interstate Medical Licensure Compact Information Center. http://www.fsmb.org/state-medical-boards/interstate-model-compact/

[44] National Center for Interstate Compacts. Medical Licensure Compact Nears Completion. (September 12, 2014) http://knowledgecenter.csg.org/kc/content/medical-licensure-compact-nears-completion

[45] Federation of State Medical Boards. Model legislation for the Interstate Medical Licensure Compact (September 2014) http://www.fsmb.org/Media/Default/PDF/Advocacy/Interstate%20Medical%20Licensure%20Compact%20(FINAL)%20September%202014.pdf

[46] Association of State and Provincial Psychology Boards. Interjurisdictional Telepsychology Compact. http://www.asppb.net/?page=compact

[47] Nursing License Map http://nursinglicensemap.com/

[48] Joel A. Dvoskin, Chair of the Behavioral Health and Wellness Council. Proposed Council Recommendations. (May 2014) http://www.health.nv.gov/BHWC/Reports/2014-05_ReportAndRecommendationsToGovernorSandoval.pdf

[49] Federal Register. Vol. 79, No 181, p 56125-56126, Pay Table 2 (September 18, 2014) http://www.gpo.gov/fdsys/pkg/FR-2014-09-18/pdf/2014-22187.pdf

[50] Information provided by Department of Corrections and Department of Health and Human Services pursuant to public records requests (September and October 2014)
[51] Richard Whitley, Department of Health and Human Services. Memorandum to Laura Freed, Legislative Counsel Bureau. "Follow up to February 6, 2014, Interim Finance Committee Meeting." (February 19, 2014)
[52] Ibid
[53] Joel A. Dvoskin, Chair of the Behavioral Health and Wellness Council. Proposed Council Recommendations. (May 2014) http://www.health.nv.gov/BHWC/Reports/2014-05_ReportAndRecommendationsToGovernorSandoval.pdf
[54] Kenneth Applebaum & Joel Dvoskin. Consultation Report on Rawson-Neal Psychiatric Hospital. (May 23, 2013) page 15 of 19, Included in Interim Finance Committee meeting packet for August 6, 2013. page 86.
http://www.leg.state.nv.us/interim/77th2013/Committee/Interim/IFC/Other/6-August-2013/8-6-13%20IFC%20Meeting%20Packet.pdf
[55] Nevada Department of Health and Human Services, Graduate Medical Education Task Force.
http://dhhs.nv.gov/About/GMETF/Home/
[56] California Office of Statewide Health Planning and Development, Mental Health Services Act Workforce Education and Training Five-Year Plan: 2014–2019 http://www.oshpd.ca.gov/HWDD/pdfs/WET/WET-Five-Year-Plan-2014-2019-FINAL.pdf
[57] Health Workforce Information System. *State Health Workforce Planning Reports* (February 7, 2013) http://ruralhealth.und.edu/projects/hwic/pdf/state-health-workforce-planning.pdf
[58] National Governor's Association. *States to Focus on Health Care Workforce* (May 12, 2014) http://www.nga.org/cms/home/nga-center-for-best-practices/center-divisions/page-health-division/col2-content/list---health-left/list-health-highlight/content-reference-1@/states-to-focus-on-health-care-w.html
[59] Colorado House Bill 12-1052 (2012) http://www.leg.state.co.us/CLICS/CLICS2012A/csl.nsf/fsbillcont3/D64782352F2BC6B387257981007DDE2A?Open&file=1052_enr.pdf ; and New Mexico House Bill 19 (2012) http://legiscan.com/NM/text/HB19/2012
[60] 2013 Annual Report: New Mexico Health Workforce Committee. (October 1, 2013) page 49 http://www.nmnec.org/uploads/FileLinks/933875ef41ef4474b4e844f09423bbef/2013_Annual_Report_New_Mexico_Health_Workforce_Committee.pdf
[61] High Sierra Area Health Education Center (AHEC) & University of Nevada School of Medicine. *Health Care Careers in Nevada 2014-2015.* (January 2014)
http://medicine.nevada.edu/Documents/unsom/statewide/reports/Health_Care_Careers_in_Nevada_2014-2015.pdf
[62] California State and Consumer Services Agency. California Healthcare Jobs: Working for Tomorrow
http://www.dca.ca.gov/publications/healthcare_jobs.pdf
[63] University of New Mexico School of Medicine. Combined BA/MD Degree Program http://som.unm.edu/bamd/index.html
[64] California Office of Statewide Health Planning and Development. Workforce Education and Training Program. http://www.oshpd.ca.gov/HWDD/wet.html
[65] University of Nevada School of Medicine. Nevada Health Service Corps: Nevada State Office of Rural Health. http://medicine.nevada.edu/statewide/rural-health/health-service
[66] Colorado Department of Public Health and Environment. Colorado Health Service Corps https://www.colorado.gov/cdphe/colorado-health-service-corps; and Colorado Department of Public Health and Environment. "Pound of Cure: To help solve provider shortage problem, program focuses on ways to keep good people." Newslink Volume 32, Number 5, July and August 2013. Pages 4 and 5 https://www.colorado.gov/pacific/sites/default/files/PCO_CHSC_Newslink.pdf
[67] California Health Professions Education Council. Mental Health Loan Assumption Program (MHLAP). http://www.oshpd.ca.gov/HPEF/MHLAP.html
[68] Sunil Ramlall. *Journal of American Academy of Business*. "A Review of Employee Motivational Theories and their Implications for Employee Retention within Organizations." Cambridge; Sep 2004; 5, 1/2, page 58.
[69] Working Well Together Training and Technical Assistance. http://workingwelltogether.org/; and California Office of Statewide Health Planning and Development. *MHSA WET Five-Year Plan: Summarizing County-Reported Mental Health Workforce Needs.* (December 2013) http://www.oshpd.ca.gov/HWDD/pdfs/wet/Summarizing-County-Reported-Mental-Health-Workforce-Needs.pdf
[70] California Office of Statewide Health Planning and Development. *MHSA WET Five-Year Plan: Summarizing County-Reported Mental Health Workforce Needs.* (December 2013) http://www.oshpd.ca.gov/HWDD/pdfs/wet/Summarizing-County-Reported-Mental-Health-Workforce-Needs.pdf