

## Title X Rural Needs Assessment

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### INTRODUCTION

Title X supports critical infrastructure needs that are not reimbursable under Medicaid or commercial insurance, such as staff salaries, individual patient education, community-level outreach, and public education about family planning, women’s health, and sexual health issues. Without Title X, access to high-quality family planning services for low-income Nevada residents would not be possible.

Family Planning Summary (2010)	No.
<b>Title X-Supported Centers</b>	<b>22</b>
<b>Health department clinics</b>	19
<b>Federally qualified health centers</b>	--
<b>Planned Parenthood clinics</b>	2
<b>Hospital outpatient clinics</b>	--
<b>Other independent clinics</b>	1
<b>Clients Served Contraceptive Care</b>	<b>23,890</b>
<b>Health department clinics</b>	16,460
<b>Federally qualified health centers</b>	--
<b>Planned Parenthood clinics</b>	6,720
<b>Hospital outpatient clinics</b>	--
<b>Other independent clinics</b>	710

Title X–supported centers provided contraceptive care to 21,990 women in Nevada in 2012. These centers served 12% of women in the state in need of publicly supported contraceptive services and supplies, compared with 22% served by such centers nationally. Of the total contraceptive clients served by these centers in 2010, 60% had incomes at or below the federal poverty level, compared with 69% nationally. The Title X network served 21,987 women and 1,410 men, for a total of 23,397 residents of Nevada in 2012. These 14 clinics in 10 counties currently provide family planning services in hard to reach rural and frontier counties in Nevada.

In 2012, 185,870 women in Nevada were in need of publicly supported contraceptive services and supplies. Such women are sexually active; aged 13–44; able to become pregnant, postpartum nor trying to become pregnant; and either have a family income below 250% of the federal poverty level or are younger than age 20. Forty-two percent of women in need of publicly supported contraceptive services and supplies are uninsured, compared with 30% nationally. Title X–supported family planning centers play an especially important role in serving the

uninsured, who often cannot afford to pay out-of-pocket at private health care providers. Of the 23,397 patients served, 61% had incomes at or below 100% of the federal poverty level (FPL), meaning they earned \$11,170 a year or less. Eighty-five percent of Title X patients in Nevada earned less than \$27,925 a year (250% of the FPL)

In 2008, 13,020 Nevada residents obtained abortions, a rate of 23.8 per 1,000 women aged 15–44, compared with 19.3 per 1,000 nationally. In 2010, there were 6,020 pregnancies among Nevada teens aged 15–19, a rate of 68 pregnancies per 1,000 teen women, compared with 57 per 1,000 nationally. In 2008, 31,000 Nevada residents had an unintended pregnancy, a rate of 57 per 1,000 women aged 15–44, costing the state and federal governments \$74 million.

In 2010, contraceptive services provided at Title X–supported centers in Nevada helped women younger than age 20 avoid 1,300 unintended pregnancies. In 2012, contraceptive services provided at Title X– supported centers in Nevada helped women avoid 5,400 unintended pregnancies, which would have resulted in 2,700 unplanned births and 1,800. Family planning services at Nevada’s Title X-funded health centers helped prevent 9,100 unintended pregnancies in 2010, which would likely have resulted in 4,500 unintended births and 3,100 abortions. In the absence of these services, the number of unintended pregnancies in Nevada would be 15% higher, and the number of abortions would be 15% higher. The number of teen pregnancies in Nevada would be 17% higher.

By helping women avoid unintended pregnancies and the births that would follow, the services provided at Title X–supported centers in Nevada saved \$13.0 million in public funds in 2010. The average cost of a Medicaid-funded birth is \$12,613. In 2012, births resulting from unintended pregnancies cost Nevada’s taxpayers \$74 million. The Title X program helps alleviate these costs by preventing unintended pregnancy through contraception, counseling, and other services. Title X-funded services produce significant cost savings to the federal and state governments; services provided at Title X–supported sites in Nevada accounted for \$19 million in such savings in 2010 alone.

## DEMOGRAPHICS

### Population

According to the US Census Bureau's most recent 5-year estimates (2008-2012), the total population of the 11 rural counties included in this assessment was 273,630, an increase from 235,726 in 2000. While the growth has not been as dramatic as the 35% Nevada has experienced overall during that time, it still equates to a 16.1% increase. Since 2000, two of the counties experienced population decreases, with Lander County seeing the smallest drop by less than 1% to 5,751, and Mineral County's population decreased by 7% to 4,718. In contrast, Lyon County faced the largest increase over that time period (50.1%) with 17,296 new residents. The other two counties with double-digit percentage growths were Lincoln County and Nye County, at 26.8% and 34.8% respectively.

The populations in these 11 counties range from a low of 4,718 in Mineral County to a high of 55,184 in Carson City. Carson City also has the highest population density at 378/mi<sup>2</sup> followed by Lyon County at a distant 25.7/mi<sup>2</sup>. Lincoln County ranks last with 0.5/mi<sup>2</sup>. Interestingly, Carson City's density ranks higher than Clark County – at 241.6 mi<sup>2</sup> – in spite of the latter having 72% of the state's population.

Population by County

County	2000	2012	2000-2012 % Change	Population Density/mi <sup>2</sup> (2012)
Carson City	52,457	55,184	5.2	378.0
Churchill	23,982	24,779	3.3	4.9
Elko	45,291	49,133	8.5	2.9
Humboldt	16,106	16,511	2.5	1.7
Lander	5,794	5,751	-0.7	1.0
Lincoln	4,165	5,282	26.8	0.5
Lyon	34,501	51,797	50.1	25.7
Mineral	5,071	4,718	-7.0	1.2
Nye	32,485	43,801	34.8	2.4
Pershing	6,693	6,707	0.2	1.1
White Pine	9,181	9,967	8.6	1.1
<b>Total</b>	235,726	273,630	16.1	2.5

Source: 2008-2012 ACS 5-Year Estimates

### Women by County & Age

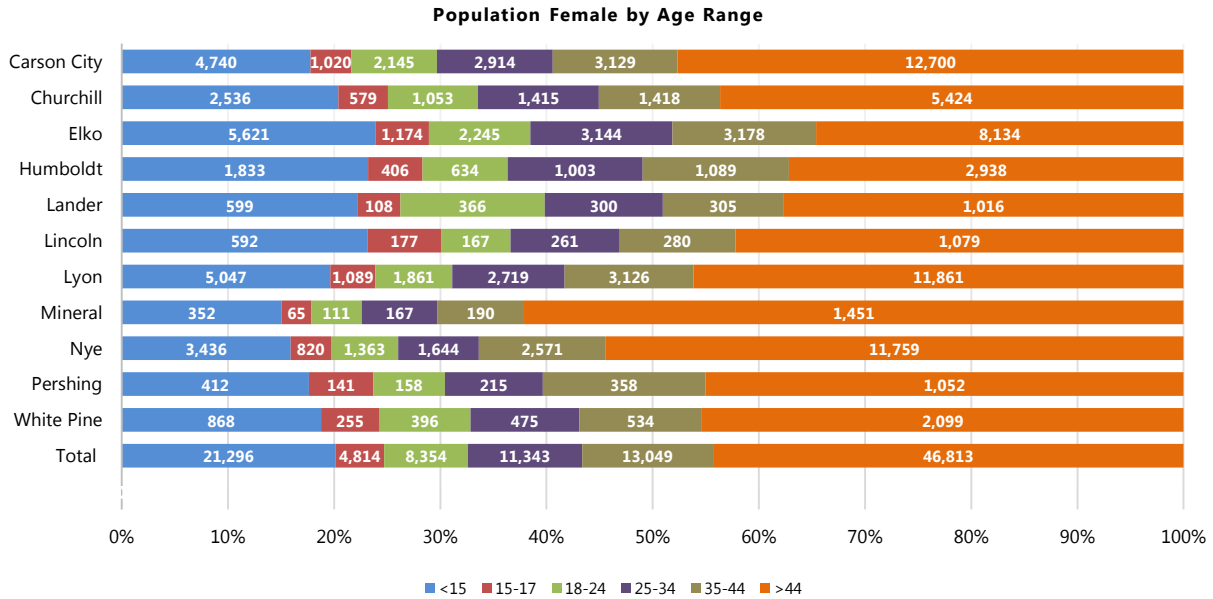
In 10 out of the 11 counties, women make up less than half of the population, and in total comprise only 38.6% of the population. While 3 counties are nearly evenly distributed between males and females – Lyon, Mineral, and Nye – Pershing County has the lowest percent of females at 34.8%.

Population Female by County (2012)

County	Carson City	Churchill	Elko	Humboldt	Lander	Lincoln	Lyon	Mineral	Nye	Pershing	White Pine	Total
%	48.3	50.1	47.8	47.9	46.8	48.4	49.6	49.5	49.3	34.8	46.4	38.6
n	26,648	12,425	23,496	7,903	2,694	2,556	25,703	2,336	21,593	2,336	4,627	105,669

Source: 2008-2012 ACS 5-Year Estimates

The chart below shows the distribution of the female population by age ranges. While the proportion of males and females in Mineral and Nye counties is almost even, their female population also tends to be older compared to the other counties, especially for those aged 44 years and older. In these two counties, the majority of the female population is over 44 years of age at 62.1% and 54.5% respectively. On the other hand, the female populations in Elko, Humboldt, and Lander counties tend to be younger, particularly those under 15 years old, with a larger percentage of women in their prime reproductive years (ages 15-44).



### Women by Race

While rural residents remain overwhelmingly white – in fact, the population of whites increased by 2% in Nevada over the last decade – overall, the population has experienced some shifts in its racial and ethnic composition. In Nevada, the Hispanic and Latino community saw the largest gain from 12.2% in 2000 to 15.7% in 2012. Five of the rural counties have a higher proportion of Hispanic and Latinos than the state average at above 20%. In Lander County, Hispanic and Latinos make up a quarter (24.6%) of the population, significantly more than the low of 5.6% in Lincoln County. Of those that identify as Hispanic or Latino in Lincoln and Pershing counties, only about one-third are women at 37.6% and 33% respectively.

**Percent of Female Population by Race and Ethnicity**

County	% American Indian or Alaska Native	% Asian American	% Black or African American	% Native Hawaiian or Other Pacific Islander	% White	% Some Other Race	% Two or More Races
Carson City	2.5	2.5	0.3	0.2	86.2	6.4	1.9
Churchill	5.6	4.3	1.2	0.2	80.9	4.4	3.3
Elko	5.9	1.1	0.6	0.2	88.7	2.1	1.4
Humboldt	5.6	0.8	0.2	0.1	88.0	3.2	2.1
Lander	5.0	0.7	0.1	0.0	90.2	1.7	2.3
Lincoln	6.0	0.4	0.9	0.1	92.0	0.5	0.1
Lyon	3.3	2.3	0.5	0.3	88.0	2.9	2.7
Mineral	14.9	2.7	0.4	0.1	72.9	2.2	6.8
Nye	1.6	1.7	1.9	0.4	90.4	1.8	2.1

County	% American Indian or Alaska Native	% Asian American	% Black or African American	% Native Hawaiian or Other Pacific Islander	% White	% Some Other Race	% Two or More Races
Pershing	3.3	0.6	0.0	0.0	89.8	2.1	4.2
White Pine	12.1	0.6	0.7	0.2	83.1	1.0	2.3
<b>Total</b>	3.8	1.5	0.7	0.2	89.8	2.0	1.9

Source: 2008-2012 ACS 5-Year Estimates

**Percent of Population Hispanic or Latino**

County	% of Total Female Population	Hispanic or Latino	
		% Total Population	% Female
Carson City	20.8	21.4	47.0
Churchill	11.6	12.3	47.6
Elko	22.7	23.0	47.3
Humboldt	24.4	24.3	48.0
Lander	25.4	24.6	48.4
Lincoln	5.6	7.2	37.6
Lyon	14.7	14.9	48.9
Mineral	9.7	9.4	51.1
Nye	13.3	13.7	47.9
Pershing	21.3	22.5	33.0
White Pine	11.9	13.2	41.8
<b>Total</b>	17.4	17.0	47.0

Source: 2008-2012 ACS 5-Year Estimates

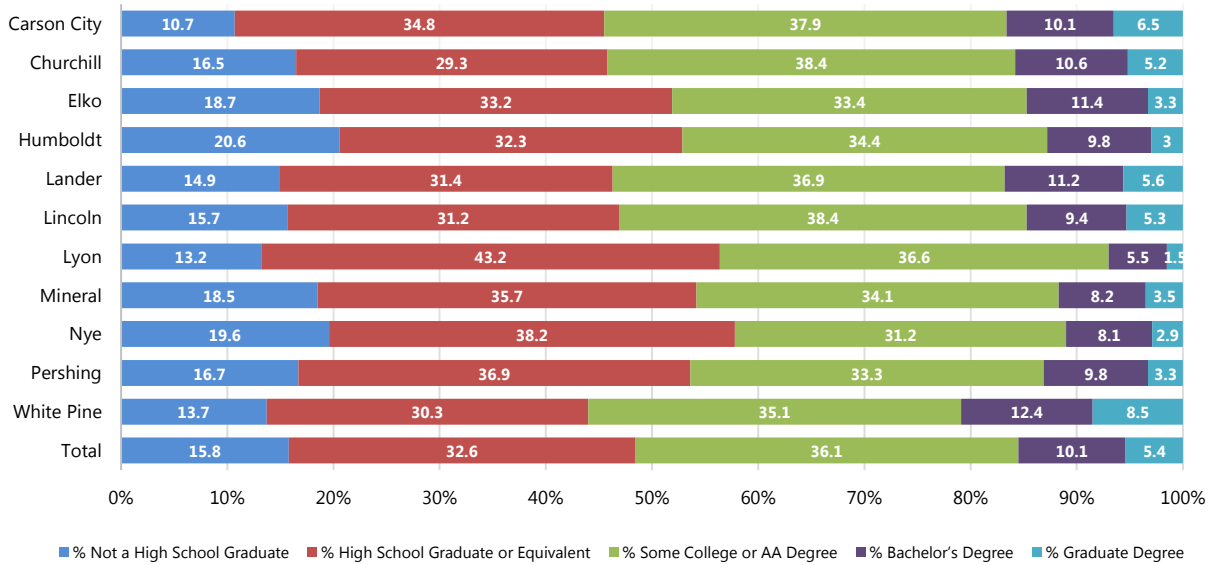
The 2013 CHN Family Planning Annual Report showed 27% of clients seen are Hispanic, compared to the Rural Health Data Book which shows 15.5% Hispanic in rural counties. This discrepancy may come from the many undocumented clients that work in the many seasonal agricultural farms in the rural counties of Nevada.

**Educational Attainment**

The rates of educational attainment and achievement are significantly lower in rural regions compared to both state and national averages. In 2012, Nevada’s rural adults aged 25 years and older were just as likely to graduate from high school (85.5%) compared to their statewide (84.4%) and nationwide (85.7%) counterparts. However, the same population was significantly less likely to earn a Bachelor’s degree or higher, as only 1 in 6 (16.4%) adults aged 25 years and older possessed a college degree versus 28.5% nationally and 22.2% statewide.

In 2012, only populations above 25 years old in Carson City (89.3%), Lyon County (86.8%), and White Pine County (86.3%) attained a GE or high school diploma above the US average. Humboldt and Nye counties had the lowest percentages at 79.4% and 80.4% respectively. The percentage of college graduates in these counties fell well short of the state average, and only White Pine approaches that mark at 20.9%. Compared to all of Nevada’s rural counties, only college graduation rates Carson City (16.6%) and White Pine meet the 16.4% mark.

**Educational Attainment for Population 25 Years and Older by County**

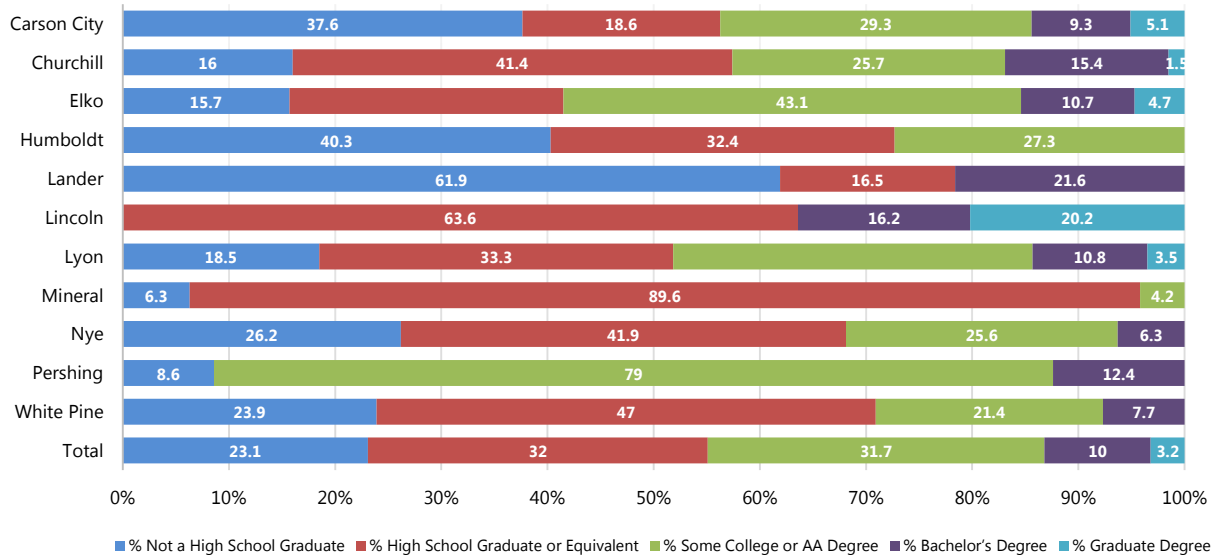


### Education of Women Who Had a Birth in the Past Year

In general, women who had given birth in the 12 months prior have lower levels of educational attainment in all counties. This may be due to factors related to raising a child that serve as a barrier to educational attainment. Lander County has a high of 62% of women with less than a high school diploma, followed by Humboldt (40.3%), and Carson City (37.6%). In Lincoln County, all women who had given birth in the past year have at least a GE or high school diploma. Mineral County is second with nearly 95% of these women possessing at least a GE or high school diploma.

However, these women are more likely to hold a bachelor's degree in 5 counties (Churchill, Lander, Lincoln, Lyon, and Pershing) than the general population in those counties. Interestingly, these women in Lincoln County are nearly 4 times (20.2%) more likely to possess a graduate degree than the general county population (5.3%). These women are also twice as likely to hold a bachelor's degree (16.2%) as the general population (9.4%) in Lincoln County.

### Educational Attainment of Women Who Had a Birth in the Past Year



Source: 2008-2012 ACS 5-Year Estimates

### Marital Status (Population 15 Years and Over)

In the 11 counties, both males and females 15 years and older are less likely to be single compared to their counterparts in the US and NV as a whole. Single persons are more likely to have multiple partners and, therefore, be at increased risk for unplanned pregnancies and sexually transmitted infections.

While 35% of these males in the US and NV are single, only Mineral County has a higher percentage of single males with 38%. Women in these counties are also much less likely to be single compared to the US (28.7%) and NV (27.3%). Four counties have significantly low percentages (<20%) of single women, especially in Nye where only 15% of women are single. Only males (33%) and females (29%) in White Pine are as likely to be single compared to counterparts in the US and NV.

### Marital Status for Population 15 Years and Over by County

County	% Single		% Married		% Separated		% Widowed		% Divorced	
	M	F	M	F	M	F	M	F	M	F
Carson City	30.9	21.6	48.4	46.9	1.9	3.0	2.4	11.0	16.4	17.4
Churchill	28.5	21.3	57.0	52.7	2.1	2.0	1.3	8.2	11.1	15.7
Elko	30.4	20.2	55.0	59.2	0.8	2.7	1.9	5.8	12.0	12.1
Humboldt	27.2	22.0	59.9	58.2	0.6	2.0	2.3	5.9	10.0	11.9
Lander	23.1	20.9	60.6	62.1	1.5	0.5	5.3	4.8	9.5	11.7
Lincoln	28.2	18.2	57.9	61.8	1.1	2.1	4.2	8.4	8.7	9.5
Lyon	29.2	20.5	53.0	51.6	1.0	1.8	3.4	8.6	13.4	17.4
Mineral	37.9	17.1	40.6	41.4	1.7	2.0	6.7	24.6	13.0	14.9
Nye	22.8	15.3	56.2	54.9	2.5	3.4	4.9	10.9	13.5	15.5
Pershing	32.1	18.3	41.4	63.8	1.9	0.5	1.9	8.0	22.6	9.3
White Pine	33.6	29.1	42.2	43.6	2.7	2.5	5.0	8.7	16.4	16.1
Total	28.8	20.1	52.9	53.1	1.6	2.5	3.1	9.0	13.7	15.2

Source: 2008-2012 ACS 5-Year Estimates

## Nativity

The most common places of birth for foreign-born Nevadans include Latin American regions and countries such as Central America (52%), Mexico (44%), and the Caribbean (3.2%); Asian countries such as the Philippines (14%) and China (4%). In the rural counties, Mexico is by far the most common birth place for those born outside of the US – in fact, Mexican immigrants comprise over half of all foreign-born in 7 of the counties, and are the majority of in all counties except for Mineral. Immigrants from the Philippines are the next most common community, followed by a host of Central American nationalities.

In 2012, US Census data indicates that an estimated 7.2% of the US population were not citizens compared to 11.3% of Nevada’s population. These estimates include those lawfully residing, including people with work or student visas. The lower percentages of non-citizens in the 11 rural counties’ suggests that non-naturalized citizens and undocumented immigrants may be more likely to reside in Nevada’s urban counties. According to the most recent Pew Research Center study (2014), Nevada had the highest number of undocumented immigrants in 2012 at 7.6% of its total population compared to 3.6% nationally. The study also estimated that Nevada led the nation with undocumented immigrants constituting up to 10% of its labor force and with nearly one-fifth (18%) of students having at-least one undocumented parent. Although the estimated numbers of those undocumented actually continues to decline from its peak in 2009, the percentage still reflects the challenges facing the state to meet the various complex needs that are indicative of the immigrant experience.

**Nativity by County and Place of Birth**

County	Foreign Born		Foreign Born & Non-Citizen		Most Common Countries of Birth Outside of the US
	n	%	n	%	
<b>Carson City</b>	6,487	11.6	3,913	7.0	Mexico (60%), Nicaragua (4.6%), India (4%), China (3%)
<b>Churchill</b>	1,416	5.9	719	3.0	Mexico (39%), Philippines (28%), India (9%), Canada (6.7%)
<b>Elko</b>	4,819	9.9	3,539	7.3	Mexico (73%), Philippines (4.5%), Peru (3.7%), Canada (3%)
<b>Humboldt</b>	2,246	13.8	1,057	6.5	Mexico (80%), Cuba (3%), Canada (3%)
<b>Lander</b>	552	9.9	315	5.7	Mexico (76%), El Salvador (8%), Canada (5%), Philippines (3.3%)
<b>Lincoln</b>	113	2.2	103	2.0	Mexico (42.5%), Venezuela (36%), Honduras (9.7%), South Africa (9%)
<b>Lyon</b>	3,806	7.5	2,369	4.7	Mexico (41%), Philippines (9%), Nicaragua (8%), Canada (6%)
<b>Mineral</b>	158	3.4	68	1.5	Philippines (26%), Canada (21.5%), Mexico (15%), Korea (15%)
<b>Nye</b>	3,616	8.2	2,253	5.1	Mexico (51%), Philippines (8%), Caribbean (6.7%), Cuba (5%)
<b>Pershing</b>	848	12.0	670	9.5	Mexico (78%), Canada (5%), Guatemala (3.7%)
<b>White Pine</b>	225	2.4	140	1.5	Mexico (56.4%), Korea (10%), Canada (8.4%), Vietnam (7.6%)

Source: 2008-2012 ACS 5-Year Estimates

## Limited English Proficiency

The Bureau of Primary Health Care (BPHC) set a national benchmark for linguistic isolation (households that speak a language other than English) at 10.3%. Using that standard, Pershing County contains populations that are facing significant linguistic isolation, while several others have large populations with Limited English Proficiency (LEP). It is reasonable to suspect that this rate has been influenced by the increase in the Hispanic and Latino population over the last decade; moreover, Spanish is also the language most likely spoken by individuals with LEP followed by Chinese and Tagalog in over half of the 11 counties. Moreover, the most common languages other than English are largely consistent with the most common languages spoken in the countries of origin for those born outside of the US: Spanish and Tagalog.

The presence and impact of migratory and seasonal farm workers in the rural communities must also be considered in these estimates and will require further study. The table shows the estimated proportion of the rural counties' populations speaking a language other than English and the other primary languages.

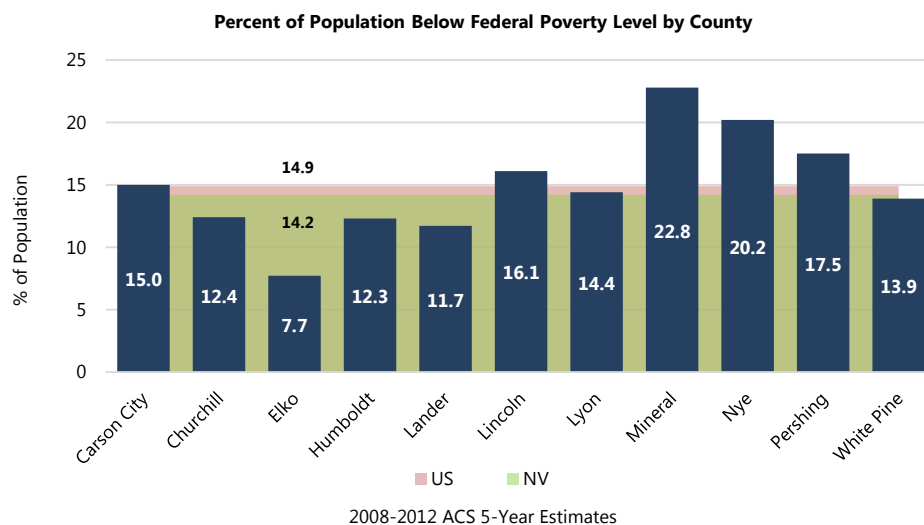
County	n	%	Primary Languages Other Than English
Carson City	4,431	8.5	Spanish, Chinese
Churchill	1,145	5.0	Spanish, Tagalog
Elko	2,772	6.2	Spanish, Tagalog
Humboldt	1,475	9.7	Spanish, Russian
Lander	370	7.0	Spanish
Lincoln	29	0.6	Spanish
Lyon	1,913	3.9	Spanish, Tagalog
Mineral	53	1.2	Spanish, Chinese
Nye	2,211	5.3	Spanish, Chinese
Pershing	713	11.2	Spanish, Thai
White Pine	179	1.9	Spanish, Other Native American
<b>Total</b>	<b>15,291</b>	<b>6.0</b>	<b>Spanish, Tagalog</b>

Source: 2008-2012 ACS 5-Year Estimates

## ECONOMIC INDICATORS

### Population Below Poverty Level

In 2012, the estimated proportion of the population with incomes below the Federal Poverty Level (FPL) was lower in 5 out of the 11 counties than both the national (14.9%) and state (14.2%) averages.



In general, while residents identifying as white account for the large majority of the population in all 11 counties, non-whites are more likely to live in poverty compared. There is some variability, however, where whites in Nye and White Pine counties are more likely to live in poverty than all minority groups except for American Indian or Alaskan Natives (AIAN). AIAN and Black or African Americans (BAA) in 8 out of 11 counties are most likely to live in poverty – the exceptions being Humboldt, Mineral, and White Pine. In those 8 counties, the rate of poverty for those two minority



groups far exceeds both US and Nevada averages, with nearly half (45.1%) of AIANs in Pershing and 100% of BAAs in Lander in poverty. In Elko County, Asian Americans are most likely to live in poverty compared to other groups, and all Native Hawaiian or Pacific Islanders in Mineral County live in poverty.

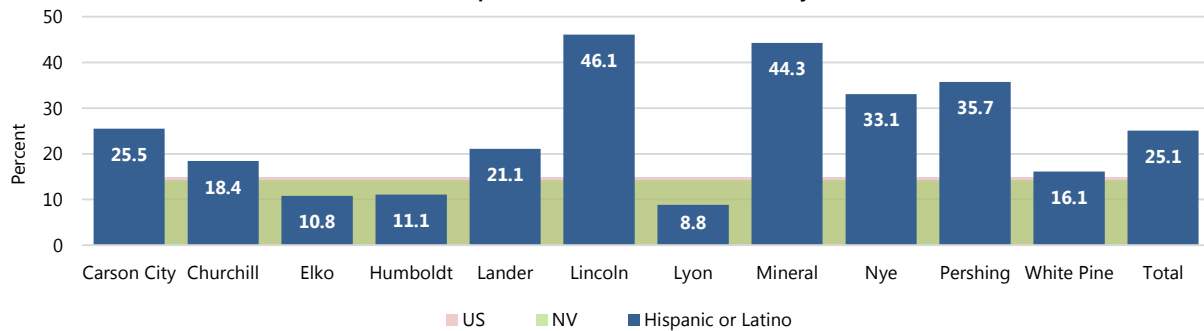
**Population Below Federal Poverty Level by Race and Ethnicity**

County	% Am Indian or Alaska Native	% Asian American	% Black or African Am	% Native Hawaiian or Pac Islander	% White	% Some Other Race	% Two or More Races
Carson City	24.0	4.5	33.0	0.0	14.3	25.1	13.8
Churchill	19.0	3.3	17.9	1.7	11.8	20.8	36.4
Elko	20.3	30.2	28.8	6.9	6.5	7.2	18.9
Humboldt	35.1	8.3	7.7	0.0	11.3	3.2	34
Lander	33.6	0.0	100	0.0	10.8	0.0	17.7
Lincoln	30.8	0.0	0.0	0.0	15.4	0.0	0.0
Lyon	25.7	6.5	27.2	25.6	14.3	6.9	10.4
Mineral	36.1	0.0	35.4	100	21.1	10.5	28.1
Nye	21.7	4.6	32.9	11.9	20.0	29.0	13.8
Pershing	45.1	6.7	0.0	0.0	16.7	13.2	12.5
White Pine	18.7	0.0	8.8	0.0	13.7	0.0	15.5
<b>Total</b>	27.8	11.5	28.4	15.0	16.8	27.6	22.4

Source: 2008-2012 ACS 5-Year Estimates

Those identifying as Hispanic and Latinos fare similarly or worse compared to non-whites in all the counties except for Lyon, where they have the lowest rate of poverty at 8.8%. Nearly half of Hispanics and Latinos in Lincoln (46.1%) and Mineral (44.3%) counties live in poverty, while at least one-fourth do in Carson City (25.5%), Nye (33.1%), and White Pine (35.7%).

**Percent Hispanic or Latino Below Federal Poverty Level**



Source: 2008-2012 ACS 5-Year Estimates

### Poverty by Age and Sex

Generally, females are more likely to live in poverty than males, especially females in their prime reproductive years (ages 15-44). The greatest variability in that trend is for ages 25-34, where other mediating factors may play a role in Carson City, Lander, and Mineral counties.

**Estimated Population Below Federal Poverty Level by Age and Sex**

County	<15		15-17		18-24		25-34		35-44		>44	
	M	F	M	F	M	F	M	F	M	F	M	F
Carson City	2.0%	2.4%	0.0%	0.3%	1.1%	1.3%	1.2%	1.0%	0.8%	0.8%	2.0%	2.0%
Churchill	1.7%	2.4%	0.1%	0.2%	0.9%	1.6%	0.4%	0.7%	0.7%	1.0%	1.9%	1.7%

County	<15		15-17		18-24		25-34		35-44		>44	
	M	F	M	F	M	F	M	F	M	F	M	F
Elko	1.2%	1.3%	0.1%	0.2%	0.4%	0.8%	0.2%	0.7%	0.3%	0.4%	0.7%	1.4%
Humboldt	1.9%	1.9%	0.1%	0.0%	1.4%	0.7%	0.2%	0.8%	0.2%	1.0%	2.4%	1.9%
Lander	2.0%	1.6%	0.2%	0.3%	1.0%	0.7%	1.6%	1.1%	0.5%	0.5%	0.9%	1.4%
Lincoln	2.6%	1.5%	0.7%	0.8%	0.6%	0.0%	0.6%	1.1%	0.3%	0.5%	3.0%	4.2%
Lyon	1.8%	1.4%	0.2%	0.5%	0.7%	1.2%	0.6%	0.9%	0.5%	1.3%	2.0%	3.2%
Mineral	2.2%	1.7%	0.0%	0.2%	1.5%	1.6%	2.4%	1.0%	0.1%	1.5%	5.3%	5.5%
Nye	2.6%	3.1%	0.5%	0.9%	0.9%	1.2%	0.9%	0.9%	1.0%	1.8%	2.9%	3.4%
Pershing	2.6%	3.2%	1.2%	0.7%	0.2%	0.4%	1.2%	1.3%	0.5%	2.4%	1.8%	1.9%
White Pine	1.5%	2.3%	0.3%	0.7%	0.0%	0.6%	0.7%	1.0%	0.1%	1.2%	1.3%	4.1%
<b>Total</b>	1.9%	2.0%	0.2%	0.4%	0.8%	1.1%	0.7%	0.9%	0.6%	1.1%	2.0%	2.5%

Source: 2008-2012 ACS 5-Year Estimates

## Unemployment

In challenging economic times, urban counties are hard hit as they are not recession proof. Rural counties in NV, due to its metal production, are often recession proof and younger populations increase as jobs are more prevalent in rural counties during challenging economic times. However, unemployment rates in the rural counties that are not supported by recession-proof mining are higher compared to the rest of rural NV and the 6.9% statewide rate in November 2014. Increases in mining are expected for the next decade, further increasing the population of people in their prime reproductive age. The challenge comes due to the healthcare infrastructure that is often unable to keep up with the boom of mining in rural counties where healthcare shortages are already evident.

Unemployment Rate by County

County	Carson City	Churchill	Elko	Humboldt	Lander	Lincoln	Lyon	Mineral	Nye	Pershing	White Pine	NV
%	7.1	5.4	4.4	4.8	4.2	8.0	8.9	10.0	8.0	6.5	5.0	6.9

Source: Bureau of Labor Statistics, 2014

## Insurance Status

Since Medicaid expanded in Nevada in 2013, statewide enrollments have climbed by 71.5% to over 573,000 by the end 2014. This translates to over one-fifth (21.2%) of the state's population on Medicaid compared to roughly 10% in 2013. According the Nevada Health and Human Services Department, the percentage of Nevadans that remain uninsured fell to 12% in July 2014 – a dramatic decrease from the second highest rate in the US at 20.7% in 2012.

This increase in insured individuals may create higher demand for health care services including family planning. Critically important is the system's ability to respond to newly insured patients in the region, including capacity, billing and staffing capability, and appropriate outreach programs. Additionally, newly or re-insured individuals may not be aware of the family planning services available in the state, or the benefits of choosing an FQHC for comprehensive health care.

Percent of Population Uninsured and Population Medicaid-CHIP by County

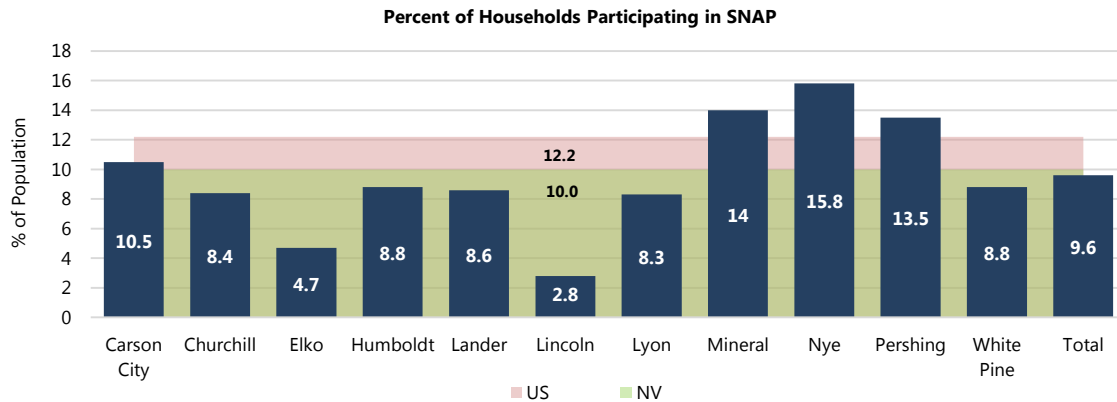
County	Carson City	Churchill	Elko	Humboldt	Lander	Lincoln	Lyon	Mineral	Nye	Pershing	White Pine
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<b>Uninsured*</b>	19.9	17.6	18.9	22.3	16.1	23.8	22.4	21.3	20.5	15.4	16.8
<b>Medicaid-CHIP#</b>	17.9	19.0	11.7	12.9	12.3	12.0	18.2	18.6	23.1	11.7	13.2

Sources: \*UDS Mapper, 2014, #Nevada Division of Health Care Financing and Policy, 2014

### Participating in the Supplemental Nutrition Assistance Program (SNAP)

Except for Lincoln, the counties with higher rates of poverty are also more likely to have populations participating in SNAP. These include Carson City, Mineral, Nye, and Pershing where the percentage of the population participating in SNAP exceeds that of the entire state.



Source: 2008-2012 ACS 5-Year Estimates

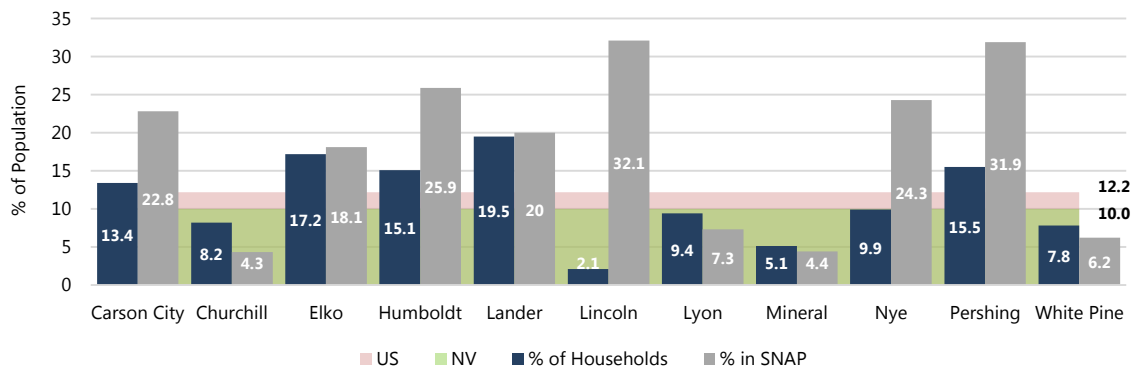
Of households (HH) participating in SNAP, the vast majority identify as white trailed by American Indian or Alaskan Natives. However, racial and ethnic minorities are more likely to participate in SNAP as a proportion of their population. Large disparities are seen in Elko, Humboldt, Lander, Lyon, Mineral, and White Pine, particularly for those identifying as American Indian, Alaskan Native, or Black. This pattern is also seen in those that identify as Hispanic or Latino in 8 of the counties – most dramatically in Humboldt, Lincoln, and Pershing.

### Households Participating in SNAP by Race and Ethnicity

County	% Am Indian or Alaska Native		% Asian American		% Black or African Am		% Native Haw or Pac Islander		% White		% Some Other Race		% Two or More Races	
	HH	SNAP	HH	SNAP	HH	SNAP	HH	SNAP	HH	SNAP	HH	SNAP	HH	SNAP
<b>Carson City</b>	1.8	5.3	2.6	1.4	0.9	1.4	0.1	0.0	80.2	69.6	4.4	4.0	1.3	2.3
<b>Churchill</b>	4.7	5.7	2.0	0.3	1.2	1.0	0.3	0.1	83.5	87.9	2.9	0.0	1.1	0.9
<b>Elko</b>	5.9	14.0	1.3	0.0	0.5	1.0	0.2	0.0	74.8	66.3	1.2	5.8	1.1	0.6
<b>Humboldt</b>	6.1	24.0	0.5	0.0	0.2	0.0	0.1	1.1	78.1	47.5	2.3	0.0	1.2	3.6
<b>Lander</b>	2.6	6.5	0.0	0.0	0.0	0.0	0.0	0.0	77.5	73.5	0.3	0.0	0.4	0.0
<b>Lincoln</b>	5.1	0.0	0.5	0.0	0.6	0.0	0.0	0.0	91.1	67.9	0.7	0.0	0.0	0.0
<b>Lyon</b>	3.1	10.7	0.3	1.4	0.6	3.8	0.2	0.0	85.7	74.9	1.6	0.0	1.5	2.4
<b>Mineral</b>	12.2	21.3	1.3	0.0	1.7	4.1	0.0	0.0	78.4	66.0	2.1	0.0	0.7	4.8
<b>Nye</b>	2.1	3.0	1.4	0.1	2.5	4.1	0.3	0.0	83.1	68.4	1.7	1.5	0.9	0.1
<b>Pershing</b>	2.4	4.3	0.6	0.0	0.3	0.0	0.0	0.0	80.0	63.8	1.7	0.0	3.5	0.0
<b>White Pine</b>	7.6	24.5	0.1	0.0	0.0	0.0	0.0	0.0	82.6	68.3	0.8	0.0	2.3	1.0

Source: 2008-2012 ACS 5-Year Estimates

**Percent of Hispanic or Latino Households Participating in SNAP**



Source: 2008-2012 ACS 5-Year Estimates

### HEALTH BEHAVIORS AND STATUS

As a result of facing numerous barriers to social mobility, economic development, and access to primary care, rural communities experience significant health disparities. Morbidity and mortality rates are noticeably higher in Nevada’s rural counties compared to the rest of the state, including: chronic diseases, prenatal and perinatal health, lack of preventive screenings, mental and behavioral health; respiratory and heart diseases; and cancers among others.

### High School Students’ Sexual Behaviors

According to the 2013 Youth Risk Behavior System, teens in rural Nevada are significantly more likely to have ever had sexual intercourse and to have had more than four sexual partners compared to teens nationally (47% and 15% respectively) and to teens in Nevada’s urban counties. More rural teens also report being sexually active compared to their urban counterparts.

**Teenage Sexual Activity and Experience**

Counties	% Ever had sexual intercourse	% Had Sexual intercourse <13 Years Old	% Had Sexual intercourse with >4 Persons	% Currently Sexually Active	% Got pregnant or gotten someone pregnant
Carson City-Douglas	48.4	3.7	18.1	35.4	4.3
Elko-Eureka-White Pine	55.2	7.5	19.6	38.4	6.6
Churchill-Humboldt-Lander-Pershing	59.4	5.0	19.7	41.4	5.4
Lyon-Mineral-Storey	60.3	6.4	18.1	40.6	4.0
Nye-Lincoln	47.2	5.3	16.2	31.1	6.4
Washoe	47.0	6.5	13.3	29.1	6.1
Clark	40.2	5.7	12.9	26.4	4.5

Source: Nevada, Youth Risk Behavior System, 2013

As expected, there is a correlation between the percent of teen pregnancy, contraception use, substance usage before sex, and exposure to sex education per the YRBS. In general, female teens were very unlikely to use any form of contraception across Nevada – though in the rurals they were more likely to use any compared to urban areas. While roughly 40% of male teens reported not using a condom during their last sexual intercourse, they were more likely to use them in the rural counties versus those in Washoe and Clark. A quarter of the teens in Lincoln, Lyon, Mineral, Nye, and Storey, counties reported no exposure to AIDS/HIV education in school, and teens in many of those counties are

also less likely to use contraception during sexual intercourse. Teens in rural Nevada were as likely as teens nationally (22%) to consume alcohol or drugs before sex

**Teenage Contraception Use and Exposure to HIV/AIDS Education**

Counties	% No condom during last sexual intercourse	% Female no contraception used during last sexual intercourse	% No methods to prevent pregnancy during last sexual intercourse	% Alcohol or drugs before last sexual intercourse	% Taught in school about AIDS/HIV infection
Carson City-Douglas	39.3	90.1	86.4	23.9	93.2
Elko-Eureka-White Pine	44.6	96.4	85.2	22.8	87.8
Churchill-Humboldt-Lander-Pershing	37.4	95.4	88.8	20.3	86.2
Lyon-Mineral-Storey	43.6	96.7	90.2	23.8	76.9
Nye-Lincoln	42.1	--	84.4	18.1	78.5
Washoe	46.8	--	81.3	25.3	84.8
Clark	43.5	97.5	80.5	22.2	80.3

Source: Nevada, Youth Risk Behavior System, 2013

### Birth Rates per 1,000 Population

Place	Age-Adjusted Birth Rates For Teenagers Aged 15-19		
	2000	2013	2000-2013 % Change
Nevada	67.4	36.1	-46.4
US	52.0	31.3	-39.8

Source: National Vital Statistics Report, 2013

In most of the counties, the trend in teen birth rates have mirrored those of the US and Nevada. Since 2000, the rates across NV have decreased by nearly half (46%), a rate more dramatic than the US as a whole (40%). Interestingly, teen birth rates increased from 2012 to 2013 in Lander and Nye counties – by 63.5% and 3.6% respectively – and Lander County had the highest teen birth rates of the 11 counties at 50.2 per 1,000 population. As noted earlier, of females that had given birth within the previous 12 months, Lander County had the highest proportion of those females with less than a high school education (62%).

**Birth Rates per 1,000 Population**

County	All Females (Crude)			Teenage (15-19 Years, Age Adjusted)		
	2012	2013	2012-2013 % Change	2012	2013	2012-2013 % Change
Carson City	10.1	9.8	-11.1	35.1	34.4	-2.0
Churchill	12.6	12.4	-1.6	27.4	16.7	-39.1
Elko	13.3	12.1	-9.0	34.8	33.6	-3.4
Humboldt	15.3	14.5	-5.2	49.3	36.3	-26.4
Lander	15.3	14.0	-8.5	30.7	50.2	63.5
Lincoln	7.8	3.9	-50.0	--	0.0	--
Lyon	9.9	10.8	9.1	34.8	33.8	-2.9
Mineral	11.3	12.0	6.2	33.9	--	--
Nye	8.0	7.6	-5.0	27.4	28.4	3.6
Pershing	9.0	9.0	0.0	40.3	32.7	-18.9
White Pine	11.0	8.3	-24.5	35.3	14.9	-57.8

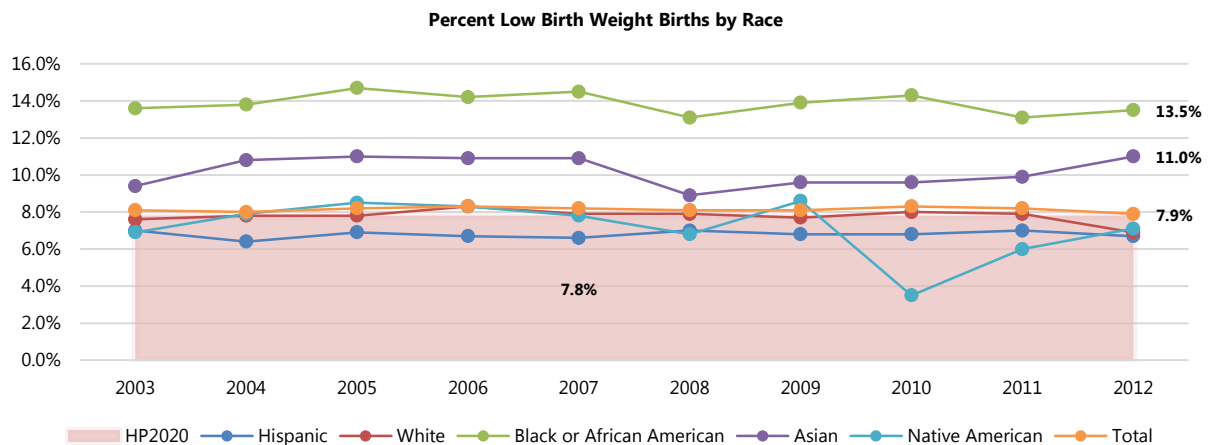
Source: Nevada Office of Public Health Informatics and Epidemiology, 2014

While teen birth rates in most counties has experienced negative growth, they still remain consistently above the birth rates for all females across the board. The higher teen birth rates may also be driving the increases in Lyon and Mineral counties. In some counties, teen birth rates are more than double – even triple as in Lander and Nye – those for all other females in those counties. In relation to rates of poverty in these counties for this age group, the data suggests that young teens are often single parents that may face struggles being able to provide for their infants.

### Low Birth Weight & Infant Mortality Rates

Babies born to mothers who do not receive prenatal care are three times more likely to have a low birth weight (under 2,500 grams) and five times more likely not to survive. Factors most commonly associated with late or no

prenatal care include race/ethnicity, low income status, low education level, perinatal substance abuse, adolescence, language and other barriers such as transportation and lack of insurance. Black or African American mothers in Nevada are consistently almost twice as likely to give birth to a low birth weight baby as white or Hispanic/Latino mothers.



Due to the high rates of births to teens in poverty, the risk of low and very low birth weight babies – and infant mortality – are more likely in these rural counties. The US rate percentage of low birth weight babies remained essentially unchanged from 7.99% in 2012 to 8.02% in 2013. The same stability is seen nationally in the rate percentage of very low birth weight babies from 1.42% to 1.41% over that same time period. In many rural counties these numbers are too small to be reported, and data on low birth weight is not consistently available in most of the rural counties. Where data is available shows that mothers are more at risk for low and very birth weight babies in Churchill, Mineral, and Nye counties.

**Birth Weight and Infant Mortality by County**

County	% Low Birth Weight		% Very Low Birth Weight		Infant Mortality	
	2012	2013	2012	2013	2012	2013
Carson City	28.6	57.0	10.7	14.7	--	--
Churchill	4.72	8.33	--	--	--	--
Elko	5.23	5.01	--	--	--	--
Humboldt	7.89	5.88	2.63	1.96	--	--
Lander	7.37	--	--	--	--	--
Lincoln	--	--	--	--	--	--
Lyon	3.66	6.53	--	2.12	--	15.9
Mineral	15.09	13.21	--	--	--	--
Nye	9.3	8.9	--	--	--	--
Pershing	12.7	--	--	--	--	--
White Pine	6.42	--	--	--	--	--

Source: Nevada Office of Public Health Informatics and Epidemiology, 2014

### Cervical Cancer and Screening

Women’s preventive healthcare in the rural and frontier region is lagging behind the rest of the state. Only 72% of age-appropriate women in the region have regular pap smears, compared to over 78% statewide; 66% for mammograms,

compared to over 67% statewide; and 75% for breast exams, compared to nearly 77% statewide (Rural and Frontier Nevada Community Health Assessment).

According to a UNLV study, an annual average of 116 cases of cervical cancer are newly diagnosed every year in Nevada: 73 in White women, 19 in Hispanics, 11 in Asians, 10 in Blacks, 4 in others. Overall, Black and Hispanic women have the highest rates for cervical cancer in the state, followed by Asians. Whites have the lowest incidence of cervical cancer (Figure 21). However, in comparative terms the Nevada overall incidence rate is high. This is especially so among White women with a standardized incidence rate ratio of 119, (95% CI, 98.9-142.2), compared to the US Whites. Relative to the US average, an average excess of 17 cases (15% of all cases) per year are recorded in Nevada. The lower screening (pap smear) rates in the state may be a contributing factor for this.

The age-adjusted observed survival rate for the SEER-17 population is 70% after 4 years, whereas in Nevada the same rate is 62%. The mortality rate for cervical cancer has decreased in the state from 6.0 per 100,000 in the early 1980s to 2.8 per 100,000 in 2008. In 2006-2008, on average there were 34 deaths by cervical cancer each year in Nevada.

### Sexually Transmitted Infections (STI)

Sexually transmitted infection rates in rural counties are some of the highest in Nevada at 291.3. The positive chlamydia cases are higher in those aged 30 and above compared with the national rate in both genders. STI clinics and family planning clinics account for over 25% of the reported diagnosis of STI in Nevada—emphasizing their importance in the healthcare environment for early detection and treatment. Chlamydia and gonorrhea infection rates are especially high for those aged 15 to 29 years of age. While those rates are not broken out by county or region, it is reasonable to infer that STIs are an important health issue given the higher rates of sexual activity among the younger population per YRBS findings.

**Rates of Sexually Transmitted Infections per 100,000 Population**

STI Rates per 100,000 Population	Chlamydia		Gonorrhea		Primary & Secondary Syphilis		Early Latent Syphilis	
	2013 Rate	'12-'13 % Change	2013 Rate	'12-'13 % Change	2013 Rate	'12-'13 % Change	2013 Rate	'12-'13 % Change
<b>County</b>								
<b>Carson-Douglas-Lyon</b>	264.9	3.80	24.4	--	1.3	3.80	--	--
<b>Other Rural Counties</b>	218.9	-27.3	30.0	--	2.2	-27.3	0.6	--
<b>Nevada</b>	400.2	-0.5	91.8	81.60	7.5	-0.5	8.5	81.60
<b>Age Group</b>								
<b>15-19</b>	1,617.6	-6.2	295.0	125.00	4.9	-6.2	3.3	125.00
<b>20-24</b>	2,105.7	-2.5	360.0	161.10	24.6	-2.5	28.8	161.10
<b>25-29</b>	1,035.5	7.70	237.6	87.00	22.2	7.70	22.7	87.00
<b>30-34</b>	503.8	8.40	165.6	62.50	13.2	8.40	16.2	62.50
<b>35-39</b>	255.2	15.20	90.3	46.70	11.6	15.20	8.4	46.70
<b>40-44</b>	135.5	-4.2	61.4	112.50	9.1	-4.2	14.4	112.50

Source: NV Division of Public & Behavioral Health, STD Prevention & Control Program, 2014

From 2012 to 2013, data shows that the number of new HIV infections in Nevada has increased in nearly all age groups except for those aged 35-44 years. Likewise, overall prevalence of persons with HIV/AIDS has grown in those same age groups – though the prevalence has decreased 6% in the rural counties overall. It is impossible to ascertain whether that negative growth is due to attrition, migration, or other factors. Nevertheless, the state has experienced a rise in transmission through male-to-male sexual contact, and even more when combined with intravenous drug usage.

### HIV/AIDS Incidence and Prevalence

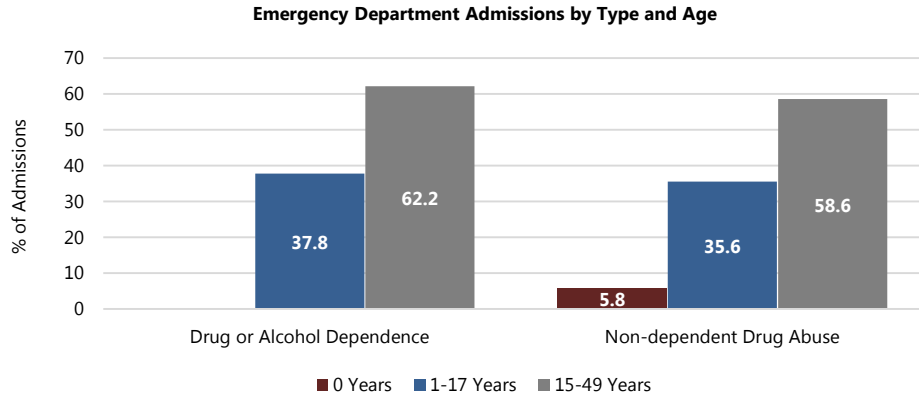
HIV / AIDS	New HIV Infections		All Persons Living with HIV/AIDS	
	n	'12-'13 % Change	n	'12-'13 % Change
<b>County</b>				
<b>All Rural Counties</b>	11	--	412	-6.0
<b>Nevada</b>	437	27.0	9,155	4.0
<b>Age Group</b>				
<b>&lt; 13</b>	2	--	11	0.0
<b>13 to 24</b>	98	32.0	337	9.0
<b>25 to 34</b>	159	43.0	1,388	7.0
<b>35 to 44</b>	76	-14	2,148	-3.0
<b>45 to 54</b>	69	38.0	3,220	2.0
<b>55 to 64</b>	29	71.0	1,541	13.0
<b>Transmission Category</b>				
<b>Males</b>				
<b>Male-to-male sexual contact (MSM)</b>	291	21.0	5,812	5.0
<b>Injection drug use (IDU)</b>	13	--	498	0.0
<b>MSM+IDU</b>	30	88.0	584	7.0
<b>Heterosexual contact</b>	16	--	283	7.0
<b>Perinatal Exposure</b>	0	--	33	0.0
<b>Transfusion/Hemophilia</b>	0	--	7	0.0
<b>No identified risk (NIR)</b>	31	-9.0	472	2.0
<b>Subtotal</b>	381	26.0	7,689	4.0
<b>Females</b>				
<b>IDU</b>	5	--	245	-2.0
<b>Heterosexual contact</b>	32	191.0	890	3.0
<b>Perinatal Exposure</b>	3	--	36	9.0
<b>Transfusion/Hemophilia</b>	0	--	4	0.0
<b>No identified risk (NIR)</b>	16	-41.0	291	6.0
<b>Subtotal</b>	56	33.0	1,466	3.0
<b>Total</b>	437	27.0	9,155	4.0

Source: NV Division of Public & Behavioral Health, HIV/AIDS Surveillance Program, 2014

## SUBSTANCE USE AND ABUSE

Since 1979, Nevada's drug overdose mortality rate has grown by 306%, and the state had the fourth highest death rate in 2010 at 20.7 per 100,000 people. According to the National Survey on Drug Use and Health (NSDUH), 9.4% of Nevadans reported using illicit drugs in the past month compared the national average of 8%, ranking as one of the highest in the US. Besides alcohol, non-medical use and abuse of prescription medications is also widespread across the Silver State for those aged 12 years and older. In 2010-2011, the state had the fourth highest teen usage rate at 7.8% and fifth highest for everyone aged 26 years and older at 4.3%. Nevada youth (ages 17 years or under) accounted for over one-third of emergency department admissions in 2012 as a result of substance use or abuse.





Source: Nevada Office of Public Health Informatics and Epidemiology, 2014

## GEOGRAPHIC BARRIERS

In Nevada, with 14 out of 17 counties being rural and frontier regions, only an estimated 10% of Nevadans are spread out over 87% of the state’s land mass (Griswold et al., 2013). This represents a roughly 15% increase (or 41,688 people) in total population from 2000. Rural county populations range from a high of 49,133 in Elko County to a low of 916 in Esmeralda County. Of the 11 counties included in this assessment, Lyon County has the highest population density at 25.7/mi<sup>2</sup>, and Lincoln comes in last at 0.39/mi<sup>2</sup>. For comparison, the density of New York County – the most populous US county and includes Manhattan – is nearly 10 times that of Lyon County at 26,822/mi<sup>2</sup>. These geographical circumstances present tremendous challenges to accessing the healthcare system. In addition to health professional shortages, residents in these areas face long distances to available providers and transportation limitations (Talbot et al., 2013).

**Geographic Barriers to Primary Care Access**

Indicator	NV	Rural counties
% of population living in Primary Care HPSA	36.0	66.9
% of population living in Dental Care HPSA	35.4	56.5
% of population living in Mental Health HPSA	31.6	100
Average distance to nearest hospital (miles)	-	59.0
Average distance to nearest tertiary/acute care hospital (miles)	-	114.7

Source: Nevada Rural & Frontier Health Data Book 2013

To illustrate the vast expanse of Nevada, Figure 1 shows five states that fit into the rural and frontier regions that CHN serves. Figure 2 highlights the vast distances separating the state’s rural communities from urban centers as well as the considerable distances separating these communities from one another. Most rural and frontier communities in Nevada are in sparsely populated counties and are long distances from tertiary care centers located mostly in urban areas. The average distance between acute care hospitals in rural Nevada and the next level of care or tertiary care hospital is 114.7 miles and the average distance to the nearest incorporated town is 46.5 miles.

Resources are vastly scattered in rural Nevada; for low income families, these distances add to the difficulty of accessing healthcare services. The lack of public transportation systems is another significant barrier to services which would connect one community to another.

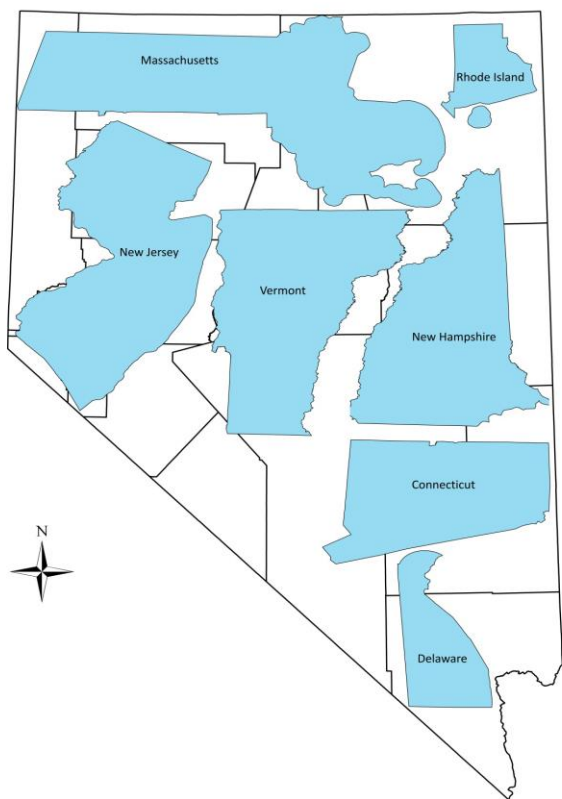


Figure 1: Five northeastern states easily fit within Nevada's borders.

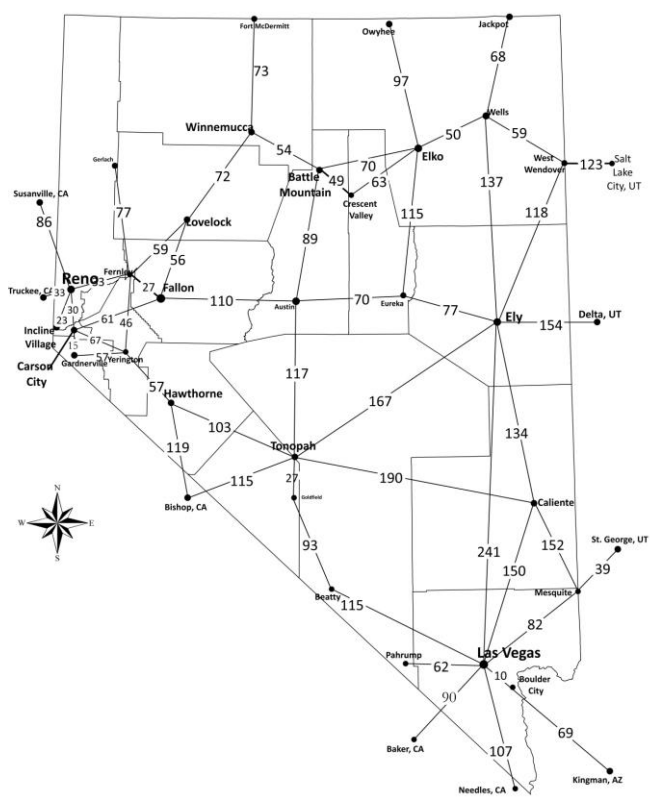


Figure 2: Distance in miles between rural and urban communities.

## PROVIDER SHORTAGES

By any measure, most health professions are in short supply in Nevada and vast areas of the state are medically under-served. Presently, all fourteen rural counties are designated in whole or in part by the federal government as Primary Care Health Professional Shortage Areas (HPSAs); eleven include medically underserved areas, medically underserved populations, and/or Governor Designations. Sixty-seven percent of Nevada's rural population lives in a designated Primary Care HPSA (Griswold et al., 2013).

Nevada ranks 46th among US states in the number of primary care physicians per population. The ratio of PCPs per 100,000 population in Nevada is 37% below the national average, and rural Nevada's ratio is 43% below the national average. Nevada's expansive rural regions, high rates of uninsured residents, and poverty make it harder to attract and retain practitioners (Ku, 2011). Within Nevada, there are disparities in the number of licensed primary care physicians available to urban versus rural and frontier communities. The glaring disparity in supply is evident in rural areas, where the number of providers is a mere 45 per 100,000 residents in rural areas compared to 51 in urban counties (Griswold, Packham, Etchegoyhen, Marchand, & Lee, 2013). When looking at PCPs that are accepting new Medicaid patients in 2012, that number drops 42% to 26.1 providers per 100,000 population. The rural population's lack of access to healthcare is severe, where a waitlist to be seen by a healthcare provider is at least two weeks and is over 100 patients in many locations.

Knowledge of where advanced practice registered nurses (APRN) work has become increasingly important as an estimated 32 million additional people will have health insurance beginning in 2014 (Kaplan et al., 2012). APRNs make up a considerable amount of the workforce in underserved areas (Kaplan et al., 2012). Shortages of primary care and specialty physicians in rural areas are well documented, and APRNs are frequently cited as being the providers likely

to fill these gaps (Doescher, 2009; Kaplan et al., 2012; Rosenblatt, 2006). Despite strides taken by state lawmakers within the decade to double nursing program enrollment and relax practice restriction on APRNs, Nevada continues to rank 51st in the nation with 24.5 nurse practitioners per 100,000 population (Kaiser Family Foundation, 2011; Griswold et al., 2013). At 17.3 per 100,000 population, the number of APRNs per capita in rural Nevada is barely half of the national ratio of 34.

In 2011, Nevada ranked 34th in the U.S. with 23 PAs per 100,000 population compared to the national average of 27. Alaska more than doubled Nevada’s ratio with 75, followed by South Dakota with 65 (Kaiser Family Foundation, 2011). In 2012, Nevada’s PA supply dropped to 18.8, with marked and consistent disparities between rural (15.2) versus urban counties (19.2) (Griswold et al., 2013).

All but two of the rural counties (Esmeralda and Churchill) have either a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) in the county but resources are stretched. In identifying issues of unmet primary care need, HRSA’s BPHC uses FQHC penetration rates to estimate the number of low-income individuals (<200% FPL) being served by a Health Center Program (HCP) grantee; BPHC considers a penetration rate below 25 percent as extreme unmet primary care need. All but three counties demonstrate a shortage of primary care services for low-income populations.

## EXISTING PROVIDERS & SERVICES

### Types of Services

From 2011 to 2013, the number of patients and services provided at some CHN locations has decreased by as much as half – a likely indicator that the rural and frontier provider shortage continues to worsen as opposed to a negative growth in demand for services. This is particularly urgent for the rising rates of gonorrhea and HIV, where the incidence rates outpaced any growth in screening rates. Coupled with the lower rates of exposure to sex education in schools, high rates of teenage sexual activity, and teen birth rates there is a tremendous need to ensure these services are available and accessible to the state’s rural and frontier regions.

**Number of CHN Patients by Service Type**

Service	CY 2011	CY 2012	CY 2013	'11-13 % Change	'12-13 % Change
<b>Cervical PAP test</b>	817	783	429	-47.5	-45.2
<b>Clinical Breast Exam</b>	909	839	396	-56.4	-52.8
<b>STD - Chlamydia</b>	1,198	1,516	1,149	-4.1	-24.2
<b>STD - Gonorrhea</b>	1,274	1,594	1,194	-6.3	-25.1
<b>STD - Syphilis</b>	70	79	51	-27.1	-35.4
<b>HIV</b>	405	208	230	-43.2	10.6
<b>Pregnancy tests</b>	--	506	550	--	8.7
<b>Coverage Type</b>					
<b>Uninsured Clients</b>	1,690	2,119	1,564	-7.5	-26.2
<b>Medicaid Clients</b>	306	394	298	-2.6	-24.4
<b>Insured Clients</b>	300	357	291	-3.0	-18.5
<b>Patients*</b>					
<b>Total</b>	--	12,767	12,301	--	-3.7

\* Not just FP or STD

Source: Exhibit D – Types of Services by Year

## ESTIMATED NEED

In 2010, the Guttmacher Institute (2014) estimates approximately 347,000 Nevadan women aged 13-44 years were in need of contraceptive services and supplies, and 50% (or 173,000) of them were in need of publically funded services and supplies. In contrast in the 11 counties, of the estimated 26,000 women who needed such services, 53% were in need of publically funded services and supplies. Moreover, 24.2% of the women qualified for Medicaid compared to 22% statewide.

The gap in services throughout the 11 counties is quite severe, with four out of five females of prime reproductive age unable to access needed services and supplies. Even with 4 part-time providers throughout Lyon County (Exhibit B), the margin of unserved women remains above 96%. While it seems Lander County was able to address the need for services in 2010, a margin of hundreds to thousands of women remain with unmet contraceptive needs in the other counties.

County	Females 13-44 Years	Females Needing Contraceptive Services Supplies	Female Clients Served at Publically Funded Clinics	Unserved Females Needing Contraceptive Services Supplies	
				n	%
<b>Carson City</b>	9,760	5,670	1,650	4,020	70.9
<b>Churchill</b>	4,850	2,460	450	2,010	81.7
<b>Elko</b>	10,290	5,170	590	4,580	88.6
<b>Humboldt</b>	3,260	1,620	290	1,330	82.1
<b>Lander</b>	1,150	580	680	--	-17.2
<b>Lincoln</b>	880	420	20	400	95.2
<b>Lyon</b>	9,640	4,820	180	4,640	96.3
<b>Mineral</b>	760	390	--	60*	84.6
<b>Nye</b>	6,720	3,300	500	2,800	84.8
<b>Pershing</b>	920	450	150	300	66.7
<b>White Pine</b>	1,540	760	450	310	40.8
<b>Total</b>	49,770	25,640	4,960	20,680	80.7

\*Estimate adapted from projected patients in 2015 (See Exhibit F).  
Source: Guttmacher Institute, 2014

## TARGET AREAS

Virtually all of Nevada's rural and frontier counties are designated as federal shortage areas, and the local health care systems are already overloaded. Though the absolute numbers may be relatively small, there is a high percentage of residents without access to family planning services because of excessive distance between services and a sheer lack of providers. Moreover, finding culturally and linguistically appropriate staff is a perpetual challenge.

While all the counties targeted in this assessment are in need of increased access to family planning services and supplies, some counties may demonstrate a relatively greater and more urgent need based on the battery of key demographic, health, and behavioral indicators. Counties are ranked in descending order where a lower priority rank score indicates a greater relative need. These counties may be considered in terms of priority for establishing and expanding family planning services:

County	Teen Birth Rate per 1,000	% Below Poverty Level	% Females Unserved	% Medicaid	% LEP	Severity Score Total*	Priority Rank*
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<b>Carson City</b>	34.4	15	70.9	17.9	8.5	24	7
<b>Churchill</b>	16.7	12.4	81.7	19.0	5.0	33	10
<b>Elko</b>	33.6	7.7	88.6	11.7	6.2	35	6
<b>Humboldt</b>	36.3	12.3	82.1	12.9	9.7	26	4
<b>Lander</b>	50.2	11.7	-17.2	12.3	7.0	34	9
<b>Lincoln</b>	0.0	16.1	95.2	12.0	0.6	37	8
<b>Lyon</b>	33.8	14.4	96.3	18.2	3.9	24	2
<b>Mineral</b>	33.9	22.8	84.6	18.6	1.2	23	5
<b>Nye</b>	28.4	20.2	84.8	23.1	5.3	21	1
<b>Pershing</b>	32.7	17.5	66.7	11.7	11.2	31	3
<b>White Pine</b>	14.9	13.9	40.8	13.2	1.9	42	11

\*Score based on sum of ranking of severity for key indicators in descending order (1=most severe and 11=least severe).  
#Priority Rank based on severity score total (1=highest priority and 11=lowest priority)