Children's Health

Many things we need can wait. The Child cannot. Now is the time his bones are being formed; his blood is being made; his senses are being developed. To him we cannot say "Tomorrow". His name is "Today". Gabriela Mistral

The Problem

The single most important task of any society is the care and nurturing of its children, and their health and well being is the single most important measure of effectiveness of government policies and the best gauge of our priorities. Nevada is not doing as well as it can on some important national indicators of child health and well being. We rank 21st in percentage of children living in poverty with almost 40% (240,000) of our children at our below 200% of poverty and 11.5 percent (70,000) of our children without health insurance, three points above the national average of 7.5% (U.S. Census Bureau). Every two hours a child in Nevada is abused or neglected, and every 2 days a baby in Nevada dies before her or his first birthday (Children's Defense Fund).

Infants and children develop in predictable ways, so periodic health visits can identify developmental delays caused by poor nutrition, prenatal exposure to drugs or alcohol, birth defects, neglect, or illness. Use of state funds to provide early intervention services to prevent permanent damage from these conditions and deliver educational messages (such as poison control, use of safety belts, and the importance of good nutrition) as part of routine health care are wise investments for our state.

Despite a growing economy the percentage of Nevadans living at 100% of the poverty level increased significantly from 8.0% in 2001-2002 to 9.9% in 2002-2003 (U.S. Census Bureau). Over half of our children (55.1%, about 320,000) have both of their parents working outside the home, and the cost of day care now exceeds $4,800 per year. As families strive to make ends meet, more grandparents are raising their grandchildren and more children are entering the foster care system.

Many children in Nevada lack continuous and regular access to primary health care, and our rapidly growing population, limited health care centers, and large numbers of uninsured children all compound this problem. Nevada has made much progress for Medicaid providers by simplifying regulations and streamlining paperwork. But stringent eligibility criteria, reductions in federal block grants, limited numbers of physicians who provide services to Medicaid, and under-insured or uninsured clients, remain major barriers to care. Managed care options often restrict access to preventive health services with shorter visits and restrictive screening.

The dramatic success of immunization programs worldwide clearly demonstrates why public officials should promote and support a sustained, universal prevention and health maintenance approach for all children. Infections that routinely killed children 50 years ago are now only rarely seen. Nevada has improved its immunization rates from 35% in 1991 to 77.8% today (Nevada State Health Division) and is approaching the Healthy People 2010 immunization goal of 90% with rates for different vaccinations ranging from 70% to 87.5%. Yet, we are still below the national average (Healthy People 2010), ranking 34th in the nation and leaving almost a quarter of our 2-year-olds not fully immunized (Children's Defense Fund). Immunizable diseases are most dangerous for the very young, and every dollar spent on immunization saves $10 later in medical costs.

Current Services

The Nevada Check-Up Program has improved the health care situation for low-income children and families, providing them with health insurance for children to age 19.

Routine immunizations are required for entry into Nevada schools and for children attending licensed child care. Nevada's All Kids Count Project (a computerized registry network) provides families with reminders of their child's next vaccine and allows immunization providers rapid access to complete immunization histories thereby reducing missed opportunities or duplicate immunizations. With federal and state funds, the Nevada immunization program provides free vaccines to public health clinics and private physicians.

Early intervention services are available statewide for children birth to 3 years who have special needs and who qualify under the program guidelines. The state's Head Start and Early Head Start programs, serving over 3,000 children in 50 centers throughout the state, include assessment and assistance with health needs of the children and their families. Nevada's Head Start programs were able to increase students' access to health insurance by 37%, to regular medical care by 149%, and to regular dental care by 183% (Nevada Head Start Association).

Gaps in Services

In January, 2005 27,132 children were enrolled in Nevada Check Up, an increase of about 9% from November 2002, when about 24,950 children were enrolled. However as one of the fastest growing states and with the percent of citizens in poverty, the need for this program will continue to grow. Many children from poor families are unable to find physicians who will accept them as patients either because they can not pay, or, for those on Medicaid or Nevada Check Up, lack of incentives and actual barriers (low reimbursement rates, burden of paperwork, high rate of missed appointments, etc.).

Nevada still has much work to do to meet or exceed The Healthy People 2010 goals of immunization levels of 90%. We need complete information on the status of children not seen in the public health clinics, increase the percent of pediatricians and family practitioners that participate in the free vaccine program, and require that all insurance programs offer well-child coverage or reimburse for immunizations.

Nevada Can Do Better

- Require well-child care and immunizations as benefits under all health insurance packages offered in Nevada.

- Continue efforts to decrease administrative burdens and increase reimbursement rates to primary care physicians who provide low cost health care.

- Provide health insurance for every child to cover the full range of their needs, and expand outreach efforts for Medicaid and Nevada Check Up.

- Provide funding for accessible health and dental care, including mobile clinics and "one stop shopping" support services.

- Support training programs for physicians, dentists, nurse practitioners, nurses, and physician assistants specializing in primary care and pediatrics.

- Support early intervention programs for developmentally delayed children from birth to three.

- Increase staffing for immunization clinics and fund vaccine purchases.

Many more services are needed to help families and children with special needs. In particular, parents need help in navigating the complex maze of services. Most programs require that families be without insurance for 6 months before they are eligible for assistance. For a child with a special health care need, even 1 month without insurance would be too long. Furthermore, even when insurance is available, it often does not cover the full range of the child's needs, leaving families to pay large medical bills out of pocket.

Dental Care

The Problem

Oral health is integral to children's general health. Although preventable, tooth decay is a chronic disease affecting all age groups, it is the most common chronic disease of childhood. The burden of disease is far worse for those who have limited access to prevention and treatment services. In *Oral Health in America 2003* Nevada received an F for both dentist availability and state support for oral health funding (U.S. Department of Health and Human Services).

Dentists: Nevada ranks in the bottom half of the nation for dentists per capita, 1864 residents per dentist in Nevada compared to 1656 residents per dentist nationwide (Nevada State Health Division). As of March 2003, 13 Nevada counties remain federally designated dental health professional shortage areas.

Access to Care: Children who are low income or minority remain significantly underserved in Nevada. Poor children suffer twice as much decay, and are three times as likely to have unmet oral health needs. For every child without medical insurance, there are 2.6 children without dental insurance (Vargas, Isman and Crall, unpublished paper). Only 4% of dental care is publicly funded compared to 32.2% of medical care.
The uninsured, Medicaid coverage, and safety net provider capacity all negatively affect access and contribute to a large underserved population. Survey data indicate that the most common reasons why Nevada's children do not get dental care when they need it are: 1) inability to pay for it; 2) lack of insurance; 3) difficulty in getting an appointment; and 3) dentists not accepting Medicaid/insurance (Nevada State Health Division).

Medicare/Medicaid coverage: Nevada Medicaid providers continue to face low reimbursement rates and cumbersome reimbursement procedures that have often hindered their abilities to care for Medicaid beneficiaries. Of the 1,284 licensed dentists in Nevada in 2003 only 299 (23.3%) were listed as Medicaid providers (Nevada State Health Division Bureau of Family Health Services).

Current Services

Some gains have been made in Nevada in the last few years, particularly in the area of oral health leadership through the state Oral Health Program, the establishment of a dental school in Southern Nevada, and increased dental access through dental credentialing legislation. *Oral Health in America 2003* gave Nevada an A for licensure by credential, oral health infrastructure with coalition building, and its Oral Plan and Sealant Program.

In 2001, the Legislature passed SB 133, which established three additional forms of licensure by credential. As of May 2004, Temporary, Limited, Restricted or Geographically Restricted Nevada licenses had been issued to 245 dentists (State Board of Dental Examiners). About 50% had provided the Nevada State Board of Dental Examiners with a Nevada address. The remainder had out of state addresses.

Community water fluoridation prevents decay and provides a protective benefit to Nevada's children. About 70% of Nevada's total population receives fluoridated water due to the large proportion of citizens who drink water from unfluoridated sources.

The data presented in this article are a synopsis of several papers available at the Nevada State Health Division's website: http://health2k.state.nv.us/oral/ohfactsheets.htm.

Nevada Can Do Better

- Support the reauthorization of SB 133 that has brought in over 200 new dentists to Nevada in the last three years.
- Promote, fund, and support expansion of existing and establishment of new school-based dental sealant programs.
- Support licensure and practice incentives that attract dentists to Nevada and underserved areas.
- Allow volunteer service to apply towards continuing education requirements for dental professionals.
- Increase Medicaid reimpbursement rates.
- Continue funding and supporting successful programs such as Miles for Smiles, and legislative initiatives that increase access to dental care.
- Simplify eligibility and reimbursement processes for Medicaid and Nevada Check Up.
- Support programs to expand insurance coverage (employer based coverage).
- Support efforts for data collection and surveillance to better understand Nevada's access needs.
- Support proven community based prevention strategies (water fluoridation and sealant programs).
- Encourage community health centers to include a dental health component.
- Support mobile/portable dental services where appropriate and feasible

Long-Term Care

The Problem

People are living longer and consequently chronic diseases and conditions are more prevalent. The longer one lives the more likely one will develop a chronic condition. Families used to care for parents and older relatives and friends, but now are often not geographically close. Children move farther from their parents because of work; parents move farther from their children because of the beneficial tax policies or climate conditions of another location, both reasons older people are moving to Nevada. Yet these older newcomers still expect the services that they received in their heavily taxed home states. Life-style choices are catching up with people. Lack of exercise, poor diet, smoking, and obesity are taking their toll, and especially for older people there is no effective way to significantly turn back the clock and give them another chance at good health. Despite health education in schools, these same poor life-style choices are pushing young people into chronic diseases and conditions that will increase their need for long-term care.

Chronically ill people have needs that must be met on a daily basis over extended periods of time. These individuals may never improve and, barring a catastrophic event, most certainly both their health and their functional status will continue to decline adding up to months if not years in which they will need support.

Current Services

Long-term care is not simply medical care provided in a nursing facility. Chronically ill people may live in their own homes or the homes of family members, group homes, assisted living facilities, or nursing facilities, depending on how severe their chronic condition is. The scope of services provided can range from the provision of room and board, to daily attendants, to personal care, medication management and wound care. These services can be provided through on-site staff or independent agencies (home health) depending upon the site of care.

Currently there is no good documentation of the numbers of chronically ill individuals in Nevada. First and foremost, it is necessary to complete a needs assessment throughout the state, to determine the demographics of the chronically ill population, where they currently reside, the severity of their conditions, and what support services are needed to keep them in the safest, yet least restrictive environment possible. In general, most people want to stay in their own homes for as long as possible. Doing what is medically and socially best for the individual usually translates into doing what is economically most beneficial in the long run for the payer, whether that is the individual, the insurance company, or Medicare/Medicaid (the taxpayer).

Gaps in Services

Medicare doesn't help with long-term care, but Medicaid does. Yet not all chronically ill people are eligible for Medicaid. Medicare may help with some home health services, but Medicaid doesn't. People enter expensive long-term care facilities because no one will pay for less expensive services in their homes and they can't afford to pay for the entire amount themselves. Policy changes are needed to give the chronically ill greater access to home health services so that they may stay in the comfort and security of their own home until significant functional, health, or safety issues require a move to a higher level of care.

Duplication of services must be avoided. Government agencies should not engage in turf struggles for oversight of the needs of the chronically ill population. Draconian requirements and convoluted application procedures increase the difficulty of meeting and the cost of providing for their needs.

Caregivers must be considered in this formula as well. Paid caregivers include physicians, nurse practitioners, physician's assistants, nurses, certi-

fied nursing assistants, social workers, therapists, dietitians, pharmacists or personal care assistants. They may serve the chronically ill person in any of the locations mentioned above, but are most likely to work with them in nursing facilities, group homes, and assisted living facilities. What is important is that they are appropriately trained in the care of the chronically ill and elderly. Some people filling these roles may be generically trained in their area of care and they may know the needs and expectations of a healthy young individual who is receiving short-term care, but they have received little if any education on working with the older chronically ill patient.

The family member or friend who is the primary caregiver for a chronically ill person also needs some special attention. Most often these caregivers are women who do not get the respite and help they need to safely and capably provide care. Some of these caregivers take time off from work or even give up employment entirely to care for someone. The financial impact can be overwhelming and demoralizing.

Submitted by the Office of Geriatric Medicine, Chronic Illness and Disability Management, UNSOM.

Nevada Can Do Better

- Provide necessary funding to determine the true needs of the chronically ill and disabled in Nevada.

- Develop policies that facilitate the collaboration between private, state and federal funding sources to adequately meet the needs of this population, including those with behavioral disturbances who are currently being placed out of state.

- Establish requirements for all trained professionals to ensure a minimal competency in the care of this population, with ongoing testing and certification.

- Encourage the development of educational programs and opportunities for the chronically ill, disabled and their family members that supports functional independence for as long as possible.

Mental Health

The Problem

As Nevada's population of people with mental illness continues to increase each year, it is becoming abundantly clear that the current resources cannot meet their needs. Currently, the state carries much of the burden of providing services (outpatient treatment, co-occurring disorder treatment, housing, and homeless outreach). Due to the lack of appropriate private insurance programs, limited or no consumer income, and little relief from local, non-profit agencies, the burden is increasingly transferred to hospital emergency rooms and local jails.

Over the past two years, the following issues have turned from bad to worse:

- **Housing Resources** – Although there are various providers of low-cost housing in Nevada, the options available to mentally ill persons is minimal. Emergency shelter space is limited for men and virtually non-existent for women and children causing these individuals to turn to hospital emergency rooms for immediate assistance.

- **Co-Occurring Disorder Treatment** – Approximately 80% of the mentally ill suffer from a co-occurring drug or alcohol problem. Despite evidence-based practices that have proven that these problems are better treated simultaneously rather than independently, there are very few integrated treatment programs.

- **Transition from Adolescent to Adult Services** – Many children and adolescents are institutionalized in the system for a number of years with inadequate transition planning or training to be successful and independent in the adult world. Add mental illness to the equation, and these new adults are often lost when they turn 18 and are not connected to the services they need. Too often they end up in the adult jail soon after their 18th birthday, and begin their adult experience in the criminal justice system.

Current Services

During the 2003 session a statewide coalition of mental health advocates convinced legislators to increase the adult mental health budget by almost 31% over the biennium. The increases featured expansions of residential support, psychiatric emergency services, service coordination, provider rate increases, an additional PACT team and a mobile crisis team for Southern Nevada, additional medication clinic services and outpatient counseling, and a new inpatient hospital in Las Vegas.

Related mental health programs that received legislative attention in 2003 included the state's first Mental Health Court in Reno, designed to provide treatment and services to mentally ill persons involved in the criminal justice system in lieu of incarceration. Funding was not secured for a Community Triage Center, to provide a crisis alternative to jail for persons experiencing an acute psychotic and/or substance abuse issue. These programs are designed to continue engagement in mental health services in order to increase stability and independence and decrease the risk of recidivism.

Gaps in Services

- Lack of co-occurring disorder treatment programs, including inpatient programs and transitional housing with appropriate supports.
- Outside of hospital ERs and state mental health facilities, there are no triage centers available to provide immediate, urgent services to individuals in need.
- Gap in transitioning mentally ill adolescents to the adult mental health system.
- Gap in treatment and services for children and adolescents in the criminal justice system when incarcerated and transitioning back to community.
- Lack of programs supplementing specialty court programs and the people they serve.

- Lack of programs and facilities to address the needs of mentally ill individuals with such co-occurring medical conditions as dementia, Alzheimer's, and traumatic brain injuries.
- Large gaps in the availability of low-cost, low-income housing.

Desiree's Story

Desiree was 28 years old, and had been diagnosed with schizoaffective disorder, borderline personality disorder, alcohol abuse, and methamphetamine abuse. Her medications were effective in addressing her psychotic and affective disorders. Her case managers and support staff provided daily assistance and support in times of crisis. She had been through various inpatient substance abuse treatment programs. But while she engaged these services on a fairly consistent basis, had a doctor, various case managers and support staff, she did not have the services to truly meet her needs. Desiree was nearing completion of a court program and was anxious about the upcoming graduation and transition into community without court supervision and support.

Desiree did not have access to a comprehensive, inpatient, co-occurring disorder treatment program that could address her mental illness and substance abuse simultaneously. There was no triage center to provide an extended support system during off-hours. And there was no supplemental program to help her move from intense support and supervision to independence.

The prospect of having to cope without any support system overwhelmed her. After a meal out one evening she had a cab driver drop her off at a freeway overpass. Before the driver realized what she was doing she had jumped off the overpass.

Nevada Can Do Better

- Follow the recommendations of the Nevada Commission on the Nevada Mental Health Plan Implementation established by Senate Bill 301.
- Develop Community Triage Centers in Northern and Southern Nevada to provide immediate services and reduce the over-crowding of hospital ERs.
- Develop statewide programs, inpatient and outpatient, to provide treatment and services for individuals with mental illness and a co-occurring medical condition as well as programs for individuals with mental illness and a co-occurring substance abuse condition.
- Increase funding for state mental health housing.
- Develop a comprehensive treatment program for mentally ill children and adolescents in the criminal justice system and juvenile detention facilities that supports psychiatric rehabilitation and transition back into the community.
- Require mental health screenings of juveniles in detention facilities upon intake. Increase funding for juvenile detention facilities to hire qualified mental health personnel.
- Develop a statewide, seamless transition plan from adolescent services to adult services.

Perinatal Care

The Problem

Adequate and accessible perinatal health care (during pregnancy and in the postpartum period) is vital to the well being of both mother and baby. Because early identification of problems or risk factors can lead to better outcomes and lower health care costs, high quality prenatal care is also beneficial and cost-effective for the citizens of Nevada.

Infant and maternal mortality rates are two of the most telling indicators of a nation's ability and commitment to care for the basic needs of its citizens, and they are directly related to access to and quality of prenatal care. Even though the US is the richest country in the world, possessing the most sophisticated medical technology and ranking first in the world for Gross Domestic Product, we rank 23rd in the world in infant mortality and 32nd in maternal mortality (Children's Defense Fund). Nevada ranked 14th among states (rank 1 is the best) in infant mortality in 2004 (6.0 deaths per 1000 live births, National Vital Statistics Report, 2004), but Nevada's African American babies suffer disproportionately with an infant mortality rate of 16.7 (*Healthy People 2010*).

In 2002, Nevada ranked **last** among states in the percentage of babies born to mothers who receive care in their first trimester (75.9% in Nevada vs. 83.7% nationally), and only two states did worse than Nevada in the percentage of women who get late or no prenatal care (7.1% in Nevada vs. 3.6% nationally (National Vital Statistics Report, 2003). Low birth weight (LBW) is related to prenatal care and is a serious risk factor for infant mortality and morbidity and an important measure of the quality of our perinatal health care efforts. Maternal risk factors for LBW have been well documented, and when women are identified early and treated with continuous prenatal care there is a much better chance of a healthy outcome for both mother and baby. In 2002, Nevada ranked 19th among states in percent of LBW babies, and in 2003 our rate of 8.05% (Nevada State Health Division) was slightly above the average for the nation (7.9%, National Vital Statistics Report, 2004) and below the *Healthy People 2010* goal of 5%. The problem of teen pregnancy also needs continued attention because these mothers are much more likely to have a low birth weight baby, get late or no prenatal care, drop out of school, and need assistance from the welfare system. Although Nevada has had a downward trend in the rate of teen pregnancies, in 2002 we ranked 40th in the nation for births to mothers 15-19 years of age (53.9 live births per 1000 women age 15-19 years in Nevada vs. 43 nationally, National Vital Statistics Report).

Current Services

Access to early, quality prenatal care is in a crisis nationwide with medical liability insurance rates for doctors rising 28% in 2004 alone. With some of the highest insurance premiums for Obstetrics-Gynecology doctors in the nation, many doctors can no longer afford to provide obstetric care. Nevada has been named as one of 15 states most at risk by the American College of Obstetrics and Gynecology (News release, 2004) due to the number of obstetrical providers either retiring, leaving the state or dropping obstetrical services. Although Medicaid and Nevada Check-Up have made progress in encouraging pregnant women to seek financial assistance, without health care providers to provide the care, financial assistance is of little benefit.

Nevada state agencies provide a range of services including a toll-free phone number (800-429-2669) to assist pregnant women in finding a health care provider and resources to pay for prenatal care (Health Division); substance abuse treatment resources such as a help line, treatment programs with sliding scale fees, and detoxification programs (Bureau of Alcohol and Drug Abuse); nutritious food and nutrition counseling for pregnant, postpartum, and breastfeeding women (WIC); case management, information

and referral for Medicaid eligible pregnant women (MOMS Program, Medicaid); new baby centers with parenting classes, workshops, resources (Human Resources); and smoking cessation programs (UNR School of Medicine).

Gaps in Services

Nevada still has a long way to go to provide adequate early prenatal care to mothers and much work to do to ensure a health care environment to support physicians providing perinatal services. Other gaps include lack of transportation for doctor visits, lack of child care for other children, and language or literacy barriers. Perinatal substance abuse also needs much more attention as the few programs that exist are fully utilized with long waiting lists.

There are ethical, humanitarian and financial reasons for providing early and continuous prenatal care for every pregnant woman. If a mother delays getting prenatal care until the second trimester, her medical costs will average $9,000 more than if she begins care early. Similarly, the costs of care for an infant whose mother received no care can average $45,000 as compared with only $7,000 for the infant whose mother received earlier, comprehensive care. National studies have shown that every dollar invested in adequate prenatal care can result in a savings of over $3 in later medical costs.

Nevada Can Do Better

- Require inclusion of maternity coverage in all insurance plans.

- Focus increased attention on the particular needs for perinatal care in the African American community.

- Provide incentives and support for doctors to provide obstetric care ensuring prompt and competitive payment to providers of quality prenatal services.

- Support and expand existing successful state programs and resources like the MOMS and WIC programs.

- Continue current Medicaid practices to provide prompt determination of eligibility and payment for back services for pregnant women.

- Maintain state agency web sites with current, accurate, easily accessible information.

- Support access to perinatal genetic services, and support full funding of the birth defects registry to serve the entire state.

- Increase breast-feeding rates and duration to come into compliance with American Academy of Pediatrics recommendations by educating new mothers, health care providers, employers, and the public.

Prescription Drugs

The Problem

National spending on outpatient prescription drugs has risen considerably in recent years. In 2002, overall national spending on prescription drugs increased by 15.3%. Over a third of that increase is attributed to rising drug prices. With the price of brand name drugs most frequently used by seniors increasing at 4.3 times the rate of inflation from January 2003 to January 2004, drug price inflation will again be a major contributor to rising drug spending (Families USA, June 2004). At the same time, the number of U.S. citizens with health insurance covering prescription drugs is declining. The percent of the non-elderly population without health insurance rose from 16.5% in 2001 to 17.3% in 2003, an increase of 2.4 million. This increase is the largest real increase in uninsured since 1987, due in large part to loss of employment-based coverage (Kaiser Family Foundation 2004). The problem is literally an epidemic because many, especially seniors on a fixed income, are forced to risk their health by sharing drugs, skipping doses, or doing without medicine altogether because it is simply too expensive.

A number of factors contribute to increasing drug prices: the increased number of prescriptions (utilization) was responsible for 42% of the overall increase in prescription spending from 1997-2002; changes in the types of drugs used (with newer, higher priced drugs replacing older, less-expensive drugs) accounted for 34% of the increase; manufacturer price increases for existing drugs accounted for 25% of the increase (Kaiser Family Foundation, 2004).

In addition, the prices paid by the uninsured for their prescriptions are about twice as much as the federal government pays for the same drugs under the Federal Supply Schedule. Drug prices charged for the same prescription to uninsured individuals would be $100 compared to $65 for those enrolled in HMO's or Medicaid or $46 charged to the Department of Defense or Veteran Affairs. Uninsured families are charged far more for prescriptions than their insured neighbors, even in the same pharmacy. In the U.S., we pay 30 to 70% more than Canadians and Mexicans pay for identical prescriptions.

Nevada has the fastest growing senior population in the nation. This group is most vulnerable to the problems of high drug costs.

Current Services

Some state agencies, HMOs and other large networks are able to negotiate lower prices for prescription drugs for their clients and members. Individuals without insurance coverage for drugs are powerless in the marketplace.

Nevada's *Senior Rx Program* offers subsidized prescription drug insurance for low-income seniors. The subsidies are provided by the tobacco settlement funds. In 1999, the Legislature specified that up to 30% of those funds could be used for a prescription drug program for senior citizens. Recent changes makes the program accessible to more seniors. As of July 1, 2004, the maximum annual household income for singles increased to $22,434, and to $29,205 for married couples.

In late 2003, Congress passed the Medicare Prescription Drug Improvement and Modernization Act. Discount drug cards became available to seniors in June 2004, and will expand to a full prescription drug benefit plan in 2006. However, these programs will not insulate seniors from drug prices which are increasing at a rate far greater than the rate of inflation. In addition, the new law prohibits the government from negotiating for lower drug prices as done by other federal agencies and private medical plans.

Gaps in Services

Because they have more medical concerns, seniors, representing only 12% of the population nationally, consume one-third of all prescription drugs. More than 10 million children (approximately 15% of all children) in the United States are among the uninsured.

Nevada's *Senior Rx Program and the Medicare Prescription Drug Act* provide prescription

drugs at reduced cost. However, many low-income seniors may find even the discounted cost of drugs too expensive on their limited income, especially when combined with the premium. In the United States the uninsured pay far more for drugs than citizens of other countries pay for the identical prescriptions.

Pending in Congress is Senate Bill 2328, legislation that would legalize the safe importation of prescription drugs from Canada. Many Americans are already buying their drugs from Canada and many states and cities would like to move in that direction. They are hindered by federal law and drug industry policies which claim that importation is not safe. Several states and cities are challenging that policy.

Sylvia's Story

Sylvia is an 85-year-old widow living on a fixed income. When she reached 65 and was eligible for Medicare, she and her husband purchased supplemental insurance but did not take additional coverage for prescription drugs. At the time, they were experiencing few medical problems and determined that the cost of the additional insurance was not warranted. Ten years later, Sylvia's husband was diagnosed with prostate cancer and the cost of his prescription drugs used much of their savings. When her husband passed away, Sylvia was left with depleted funds for living expenses. At age 85, Sylvia finds that she also needs more prescription drugs to treat high blood pressure, arthritis, and depression. With rent to be paid, supplemental insurance fees, and costs of everyday necessities, Sylvia sometimes skips doses of arthritis medication, causing her pain to increase, her mobility and her quality of life to decrease.

Submitted by the Nevada Health Reform Project, the Nevada Nurses Association, and AARP Nevada.

Nevada Can Do Better

- Ensure that the Nevada *Senior Rx Program* supplements the new Medicare Prescription Drug Benefit (Part D) in ways that minimize confusion and hardship for beneficiaries.

- Expand the program to cover persons with disabilities who are not eligible for Medicaid and are without insurance coverage for prescription drugs.

- Review programs other states are using for reducing the cost of prescription drugs.

- Support legislation that permits reimportation of pharmaceutical drugs in order to reduce costs.

Reproductive Health Care

The Problem

Family planning is defined broadly to include contraceptive practice; fertility levels, trends and determinants; adolescent pregnancy; abortion; public policies and legal issues affecting child-bearing; program operation, development and evaluation; information, education and communication activities; sexually transmitted diseases; and reproductive, maternal and child health (Family Planning Perspectives, Alan Guttmacher Institute).

Seventy-five percent of women's health care visits involve reproductive health and span three decades in the average woman's lifetime (AGI). In Nevada nearly 421,000 women are of child-bearing age; twelve percent become pregnant every year. Seven percent of women who never have access to regular birth control have nearly half of all of the unintended pregnancies. In Nevada, 238,580 women are in need of contraceptive services and supplies – nearly half need public supported services. Nine percent of child bearing age women living in poverty; one fourth have neither private health insurance nor Medicaid coverage. Every dollar spent on family planning services saves $3 in Medicaid costs for prenatal and newborn care (*Contraception Counts Nevada*, AGI, 2004).

Emergency contraception (EC) is hormonal post-coital birth control that if taken within 120 hours of unprotected intercourse could reduce pregnancy by 75%. It is most effective when taken within 24 hours of unprotected intercourse. In the U.S. easier access to EC could prevent 1.7 million unintended pregnancies and roughly 800,000 abortions annually (*Emergency Contraception: Steps Being Taken to Improve Access,* AGI, 2002). In Nevada that means possibly preventing 26,000 unplanned pregnancies and nearly 3500 abortions every year. Each year nearly 32,000 rape and incest survivors become pregnant. Yet not all doctors discuss advanced prescriptions for emergency contraception with their patients; not all emergency rooms provide EC to rape survivors and pharmacists can refuse to dispense a prescription between a patient and her doctor. Patients and pharmacists alike often confuse emergency contraception with the abortion pill, mifepristone.

Current Services

Reproductive health care services are offered through private medical providers, hospital and county outpatient clinics, and community-based clinics in Nevada. Only a few providers allow patients to pay for services on a sliding fee scale, which allows low-income patients full access to needed services.

In urban Clark and Washoe counties, the District Health Departments, Community Health Centers, and Planned Parenthood Healthcare Centers all provide a fairly full range of reproductive health care services. Collaborative agreements between these entities ensure that no duplication of services occurs. In the rural communities of Nevada, Tribal Health Centers, Nevada Rural Health Centers and Community Health Nurses provide the care outside of private physicians.

Gaps in Services

Fully one-third of Nevadans remain uninsured, yet many could be covered by Medicaid. Patients should know what their rights are and where they can access reproductive health care. Coverage of contraceptive prescriptions is required for Nevada women with private insurance that includes prescriptions (excluding religious-based providers). But that only affects one third of Nevada women: federal employees, employees in self-funded programs and some retirees subject to the Employee Retirement Income Security Act (ERISA) still face inequity. Women still have challenges accessing screening and treatment of ovarian cancer, breast cancer at an early age and osteoporosis. Not all pharmacies carry emergency contraceptive methods; some pharmacists will refuse to dispense a prescription.

Candace's Story

Candace is an active 23-year-old woman working and attending the University of Nevada, Reno part time. As a part-time student she is not entitled to medical benefits offered by the University system; she is overage for her parents' insurance program and un-insured as a part-time employee. She has put off her annual exam because of cost – increasing her risk of late detection for breast or cervical cancer and screening for STDs (the second health issue for women, behind heart disease, AGI). Birth control pills can range from $17-$70 per monthly cycle, something she can ill afford on her low wages.

Submitted by Planned Parenthoods Mar Monte and Southern Nevada, and Nevada Physicians for Choice.

Nevada Can Do Better

- Assure that reproductive health clinics are designated as essential community providers which are included in managed care networks.

- Study the cost/benefit of providing state family planning funding for low-income women to reduce the demands on social services for unwanted, unplanned pregnancies.

- Expand contraceptive equity to include more Nevada women.

- Assure pharmacies dispense all legal prescriptions or refer patients to another pharmacist or pharmacy that will.

- Investigate collaborative drug therapy agreements in which physicians or nurse practitioners delegate their authority to specified pharmacists to enable patient access to Emergency Contraception during weekend and after hours.

- Make provisions for comprehensive, quality reproductive health care which includes screening and treatment for all Nevada women.

Teen Sexuality

The Problem

While teen pregnancy rates have dropped in the past decade, Nevada continues to place among the top ten states with the highest teen pregnancy rates, teen birth rates and teen abortion rates. In 2000, Nevada ranked first in teen pregnancy; eighth in teen birth rate; and fourth in teen abortion rates (Alan Guttmacher Institute, 2004, www.guttmacher.org).

Although the number of young people who are sexually active has declined, sexual involvement is beginning at earlier ages. Nearly seven percent of children under age 13 have been sexually active; 17% of seventh and eighth graders; more than a third (34.4 %) of ninth graders; and 60.5% of twelfth graders acknowledge sexual activity.

Nearly two thirds of the time young people are using a method of contraception; however, they do not use it regularly or always correctly (SIECUS). Almost all sexually active young women are likely to use a method of contraceptives but not quite half of sexually active young men are willing to use contraceptives.

Teen pregnancy and teen STD's have many consequences, costing American taxpayers $7 billion annually in lost tax revenues, public assistance, child health care, foster care, and involvement with the criminal justice system, creating a pool of uneducated teen moms and a cycle of poverty for teens and their children. The health of children of teen parents is greatly diminished – low birth weights, health and developmental problems and often, abuse and/or neglect (Planned Parenthood Federation of America Fact Sheet, Annie E. Casey Foundation, 1998).

With accurate information about sexuality and sexual behavior, teens make responsible choices, including abstinence. However, federal funds are limited to abstinence-only education.

Among the significant factors associated with delayed onset of sexual activity for both boys and girls are fear of sexually transmitted diseases or pregnancy; close relationships with parents, particularly mothers; higher socioeconomic status; and limited unsupervised hours. Poverty, violence, and lack of parental supervision are among the factors associated with early onset of sexual activity (SIECUS). Young people living or growing up in poor neighborhoods start their sexual activity at an earlier age, report less contraceptive use, and have their first pregnancy at an earlier age.

Current Status

Nevada now has the twelfth highest teen pregnancy rate in the country, down from previous high rankings. Every year about 1 in 4 sexually experienced teens acquires an STD. While Nevada has a statewide policy to teach sexuality education, parents have to opt IN for their students to obtain sex education. Additionally, it is up to individual school districts to determine whether abstinence is covered or stressed and whether or not contraception is covered or stressed. In the last budget crisis Washoe County was willing to cut 90% of its sexuality education program, which would have provided only fourth graders with sex education, and for only four hours.

Gaps in Service

There is evidence that comprehensive sexuality education programs that provide information about both abstinence and contraception can help delay teenaged sexual activity, reduce the number of sexual partners and increase contraceptive use when teens do become sexually active. These findings were underscored in Call to Action to Promote Sexual Health and Responsible Sexual Behavior, issued by former Surgeon General David Satcher in June 2001.

Sexuality education programs in Nevada currently caution young people not to have sex until marriage. The majority of school districts accept federal abstinence-only-until-marriage funding which promotes abstinence as the preferred or the only option for adolescents, in spite of stud-

ies finding that abstinence-only programs are ineffective: they fail to delay the onset of intercourse and oral sex, and often provide medically inaccurate and potentially misleading information.

The most successful programs aimed at reducing teenage pregnancy and addressing the pandemic of STDs are those targeting younger adolescents who are not yet sexually experienced. Additionally, each sexuality program needs to be balanced and realistic, encouraging postponement of sex, but also promoting safe sex practices for the sexually active. Informing teens about sex neither initiates early sexual activity, promotes sexual activity or increases the number of partners, as some claim.

Analysis of the decline in the teenage pregnancy rate 1988 and 1995 found that approximately one quarter of the decline was due to delayed onset of sexual intercourse among teenagers, while three quaarters was due to the increased use of highly effective and long-acting contraceptive methods among sexually experienced teenagers.

Easy and confidential access to family planning services through clinics, school-linked health centers and condom availability programs have been found to help prevent unintended pregnancy and risky sexual behavior. Confidential access to contraceptive services is crucial to preventing teenage pregnancy.

Sexuality educators and reproductive health care providers must involve young men in pregnancy prevention. Researchers have found that lumping sexual activity with substance abuse or violence or suicide and other risk behaviors are confusing messages: sexual activity is only to be postponed; risk behaviors are to be permanently prevented (SIECUS).

Submitted by Planned Parenthoods Mar Monte and Southern Nevada, Physicians for Choice, The Feminist Majority campus pro-choice student organization and American Association of University Women, Nevada (AAUW).

Nevada Can Do Better

- Expand sexuality education requirements to be uniformly medically accurate, age appropriate for K-12, covering abstinence and stressing contraception education.

- Do not allow school districts to accept federal funding linked to abstinence-only-until-marriage programs.

- Provide funding for long-term teenage pregnancy and STD prevention media campaign that addresses the risks of sexual behavior and male responsibility in prevention.

- Provide confidential access to family planning services through clinics, health centers and condom availability programs.

- Continue to provide public funding for family planning to low-income teenagers.