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Nevada's Care Workforce:
Obstacles and Opportunities for Policymakers

A Report Utilizing the Nevada P-20 to Workforce Research (NPWR) Data System

Prepared by

The Lincy Institute

Submitted to the Nevada Office of Workforce Innovation (OWINN)

September 2024

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With special thanks to Brookings Mountain West and The Lincy Institute Student Researchers Annie Vong, Freddy Nie, Madison Dwyer, Isabelle Graham, and Taylor Volk for their assistance, and to inaugural Robert E. Lang Memorial Fellow, Dr. Mallory Constantine, for her valuable input.

"There are only four kinds of people in the world: those who have been caregivers, those who are currently caregivers, those who will be caregivers, and those who will need caregivers."
-Rosalynn Carter

Abstract

The care economy includes "the paid and unpaid labor and services that support caregiving in all its forms."[1] This work includes domestic tasks, caring for family members, including children, the elderly, and those who are ill or have disabilities. Care work is often undervalued, underpaid, and without a fair system of work benefits in place (e.g. contracts, paid leave, workers' rights), and in many cases falls disproportionately on women and communities of color. For our study, we examine the care economy in Nevada by focusing on three areas of care: (1) child care; (2) elder care; and (3) mental and behavioral health care. In all three areas, Nevada is well below its expected share of workforce needed to provide critical care to our residents. Through the Nevada Office of Workforce Innovation's (OWINN) proposal to utilize the Nevada P-20 to Workforce Research Data System (NPWR), The Lincy Institute utilizes state data to assess the current and projected landscape of Nevada's care workforce. Assessing the available NPWR data and providing a review of the current state of play, we offer policy recommendations and actions that can be taken to improve Nevada's care economy now and in the future.

Introduction

In response to the Office of Workforce Innovation's (OWINN), 2024 call for proposals to utilize the Nevada P-20 to Workforce Research Data System (NPWR), The Lincy Institute was awarded funding to evaluate the present and future of care work in Nevada. The project proposal included an analysis of data obtained through NPWR and collateral data collected from educational and governmental institutions and workforce agencies in Nevada and nationally. The study aims to both examine the demographic composition of the state's care workforce and the compensation these workers receive as well as provide policy recommendations to improve educational opportunities and workforce outcomes.

In this policy brief, we expand on the growing national conversation around care work and examine the potential to understand the data behind Nevada's care economy through the NPWR data system. First, we offer a state of play on the national care economy and then do the same for Nevada. Next, we discuss the potential for the NPWR data to help the State of Nevada address its most critical questions related to evaluating the care workforce. We conclude with a discussion of public policy interventions, both to improve the NPWR data system and the state of the care workforce and economy in Nevada.

The National Care Economy

Nevada, like many states, is facing a shortage of trained, qualified workers to care for its children, older adults, and those in need of mental and behavioral health services. We refer collectively to these employees as the care workforce and the sectors in which these employees work as the care economy. The challenges facing the care economy and those that utilize the services of the care workforce are not unique to Nevada. The national landscape is fraught with present and future workforce pipeline and affordability concerns.

Access to affordable, quality child care remains one of the largest burdens for families with young children in the U.S. Nearly 68 percent of U.S. children under the age of six have all available parents participating in the workforce.[2] Child care is not simply important for children's learning and development, but an essential economic support to ensure working-age adults can participate in the labor force. Nevertheless, the average cost of child care in the U.S. falls above the U.S. Department of Health and Human Services' (HSS) recommended threshold of 7 percent of a family's annual income.[3] According to Child Care Aware of America, the national price of child care in 2023 was $11,582, costing 10 percent of a married couple with children's median income, and 32 percent of a single parent with children's median household income to afford the national price.[4]

Access to child care facilities is another challenge that extends beyond simply finding a facility that is near one's home or place of employment. Access includes the type of care provided, the qualifications of the child care providers, and the availability of financial assistance, if any. Assistance in the form of subsidies and discounted rates for certain employees is limited. And as with all aspects of healthcare, states are now facing the reality of expiring federal resources for child care provided through the American Rescue Plan Act (ARPA) and other federal programs and the shortcomings of state budgets to meet increasing pressures to support families.

The child care and early learning workforce is also underpaid and undervalued. While child care is expensive, many child care workers are compensated with low to poverty wages for their critical work.[5] According to data from the National Survey of Early Care and Education in 2019, full-time teachers of infant or toddler classrooms earn less than $11 per hour on average.[6] Bureau of Labor Statistics (BLS) national estimates suggest that the median annual income for child care workers is $30,370. For child care professionals that require child care themselves, it would take between 59 percent to over 100 percent of their annual income to afford center-based care for their own children—a cost that forces many of these vital workers out of the labor force to care for their own children.[7]

Elder care is another growing facet of the care economy and preparing and rewarding an expanding elder care workforce is critical for our communities, states, and nation. Estimates from HSS suggest that someone turning 65 today has almost a 70 percent change of needing some form of long-term elder care.[8] The aging population of the U.S. is the primary driver of an increased demand for care work with the population aged 65 and over growing from 13 percent to 17 percent between 2012 and 2022.[9] As noted in a recent Brookings Institution report, "by the time the last baby boomers turn 65 in 2030, the Census Bureau projects that 73 million older Americans will make up over one-fifth of the U.S. population."[10]

As of 2022, the elder care workforce consisted of approximately 5.2 million workers nationally, including workers in a variety of settings such as nursing homes, hospitals, and personal residences.[11] Between 2022 and 2032, BLS expects the direct care workforce to expand to an additional 865,000 workers. Even then, the U.S. will remain in an elder care workforce deficit, with the economy losing 400,000 workers in nursing and residential care facilities in first two years of the COVID-19 pandemic and remaining roughly 130,000 workers short of pre-pandemic levels.[12] Moreover, there is likely to be shifts within the elder care workforce. A 2018 survey found that 77 percent of Americans aged 50 and older would prefer to remain in their current communities for as long as possible. The preference for in-home care has likely accelerated due to the COVID-19 pandemic.

The significant shortage of workers has resulted in a rapidly increasing price tag for elder care. According to the most recent "Cost of Care Survey" by Genworth, the national median amount paid for assisted living residences in 2021 was $4,500 per month.[13] As of 2021, the average annual price to live in a nursing home in the U.S. was $93,075 ($255 a day) in a semi-private room and $105,850 ($290 a day) in a private room.[14] Those prices are expected to grow significantly by 2030, with the cost of a semi-private room projected to be $125,085 annually and $142,254 for a private room.[15]

Lastly, the mental health workforce continues to face challenges to meet the demand in providing mental and behavioral health care to those in need. Like the crisis found in our nation's child care landscape, the coronavirus pandemic did not create a mental health crisis—it made a dire situation even worse.[16] According to the American Academy of Pediatrics, the "worsening crisis in child and adolescent mental health is inextricably tied to the stress brought on by COVID-19," and "[...] the pandemic has struck at the safety and stability of families. More than 140,000 children in the United States lost a primary and/or secondary caregiver, with youth of color disproportionately impacted."[17]

A recent analysis conducted by the National Conference of State Legislatures highlights the need for more providers in the face of the growing prevalence of mental and behavioral health conditions, including the explosion in substance use disorders stemming from the opioid epidemic, and the existing burdens on the current workforce due to high caseloads that lead to burnout and the bureaucratic barriers to credentialling and reimbursement.[18] The National Center for Health Workforce Analysis within HSS's Health Resources and Services Administration estimates substantial shortages in marriage and family therapists, mental health counselors, psychologists, and psychiatrists through 2036.[19] The analysis also notes that more than half of the U.S. population lives in a Mental Health Professional Shortage Area (HPSA) and that these shortages are particularly acute in rural counties.[20] The result is that while the need for behavioral and mental health services continues to increase, the workforce providing these services has not kept pace. Consequently, in 2022 nearly half of U.S. adults with a mental illness did not receive treatment and those that did had an average wait time of 48 days.[21]

Nevada's Care Economy

Child Care in Nevada

Consistent with national trends, Nevada has a dearth of trained child care professionals who are employed to support working families by caring for their children in licensed child care and preschool facilities. According to the BLS's Occupational Employment and Wage Statistics (OEWS) that are summarized in Table 1,[22] Nevada has 58 percent of its expected share of child care workers (*n*=2,830). The Las Vegas-Henderson-Paradise Metropolitan Statistical Area (MSA), referred to subsequently as the Las Vegas metro, with a higher concentration of children five years of age or younger than the rest of Nevada,[23] employs just 52 percent of its expected share of child care workers (*n*=1,860).

Table 1: Nevada's Child Care Workforce, 2023

Area	Employees	Share of Expected Employment	Mean Hourly Wage	Annual Mean Wage
Nevada	2,830	58%	$14.45	$30.050
Las Vegas-Henderson-Paradise MSA	1,860	52%	$13.93	$28,970
Reno-Sparks MSA	630	75%	$15.49	$33,230

Notes: MSA is the initialism for metropolitan statistical area; share of expected employment is derived from location quotients.
Source: Bureau of Labor Statistics, Occupational Employment and Wage Statistics, 2023.

The Reno-Sparks MSA, referred to subsequently as the Reno metro, with 630 child care workers, fares better with 75 percent of expected employment in this occupation. The Governor's Office of Workforce Innovation, OWINN's predecessor, estimates that nearly three-quarters of Nevada children five years of age or younger do not have access to a licensed child care provider.[24]

Elder Care in Nevada

Consistent with national trends, between 2020 and 2030 Nevada is expected to see an increase of over 230,000 people 65 years of age or older.[25] This increase, coupled with more older adults choosing to "age in place," is increasing the demand for home care workers. Data from the BLS that is summarized in Table 2, report that with 14,530 employees, Nevada employs just 40 percent of its predicted number of home health and personal care aides. In the Las Vegas metro there are 11,810 home health and personal care employees (45 percent of expected employment). The Reno metro, with 1,910 people working as home health and personal care aides, employs just 31 percent of its expected employment in this sector.

Table 2: Nevada's Home Health and Personal Care Workforce, 2023

Area	Employees	Share of Expected Employment	Mean Hourly Wage	Annual Mean Wage
Nevada	14,530	40%	$15.69	$32,630
Las Vegas-Henderson-Paradise MSA	11,810	45%	$14.93	$31.050
Reno-Sparks MSA	1,910	31%	$18.64	$38,760

Notes: MSA is the initialism for metropolitan statistical area; share of expected employment is derived from location quotients.
Source: Bureau of Labor Statistics, Occupational Employment and Wage Statistics, 2023.

Additionally, the cost of elder care in the Mountain West varies geographically and by the type of elder care needed. Table 3 shows that although Nevada fares well among Mountain West states in the annual median cost of in-home care and community and assisted living, the Silver State reported the highest costs for both semi-private nursing home rooms ($122,458) and for private nursing home rooms ($148,738).[26] According to data from the Centers for Medicare & Medicaid Services, Nevada saves about $75,000 annually for every client who receives home-based care rather than being sent to a nursing home.

Table 3: Annual Median Cost of Long-Term Care in the Mountain West, 2023

State	In-Home Care		Community and Assisted Living		Nursing Home Facilities	
	Homemaker Services	Home Health Aide	Adult Day Health Care	Assisted Living Facility	Semi-Private Room	Private Room
Arizona	$75,504	$82,368	$104,000	$66,000	$91,250	$113,150
Colorado	$80,080	$86,944	$23,400	$60,870	$113,698	$125,195
Nevada	$74,360	$68,640	$19,500	$60,000	$122,458	$148,738
New Mexico	$102,960	$68,640	$45,630	$65,400	$105,120	$120,085
Utah	$77,792	$80,080	$12,480	$49,800	$91,250	$121,363

Source: "The Cost of Care Survey." *Genworth,* 2023.

In addition to cost, Nevada also has limited nursing home capacity. Data reported by ProPublica through June 2024 finds that among Mountain West States, Nevada (67) has the fewest number of nursing homes.[27] New Mexico, with more than a million less people than Nevada, has 68 nursing homes, while similarly populated Utah has 98.[28] Inspections of Nevada's 67 nursing homes found: 62 (92.5 percent) with infection-related deficiencies; seven nursing homes demonstrate serious deficiencies; and two nursing homes had payments suspended.[29] In total Nevada's nursing homes accrued $934,000 in penalties through June 2024. The ProPublica analysis also reports that over half of the workers staffing these facilities left their jobs over a 12-month period.[30]

Missing from these and other care workforce data is the invisible care workforce. These care providers are not just adults who opt out of the labor market because of their families' care needs but also children who help to fill these gaps. The 2020 report "Caregiving in the U.S." produced by American Association of Retired Persons and the National Alliance for Caregiving estimates that nationally there are 5.4 million child caregivers providing care to family members.[31]

The wage data presented in Tables 1 and 2 suggest a reason why there are so few people employed as child care providers or home health and personal care employees. Whereas the BLS reports that the mean hourly and annual mean wage for all occupations in Nevada is $28.32 and $58,900 respectively, these care sector jobs pay roughly half as much. The cost of care services also is important to consider. For instance, in Las Vegas the starting hourly rate to hire a child care provider is $18.32 and $20.31 per hour for in-home senior care.[32]

Taken together, these data suggest a grim market reality; low wages may deter people from entering these fields, while the high costs for these services may strain families' budgets to the point where it may be more economically feasible for people to exit the labor market to care for a young child or an elderly parent. These pressures may be particularly acute for the tens of thousands of Nevadans who are employed in low-skill, low-wage occupations. This point can be exemplified by comparing the hourly pay rates for child care providers or home health and personal care aides and the costs of those services. For both occupations, excluding the certification and licensing costs that must be satisfied before being eligible to work, it would cost workers substantially more to access the services that they are providing than they are paid.

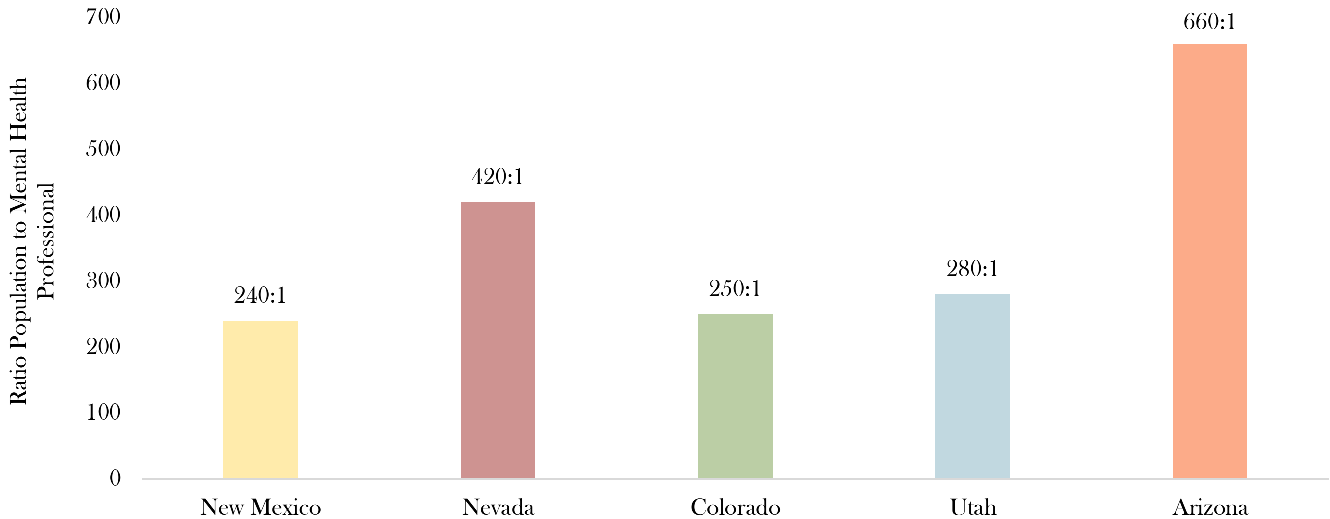
Mental and Behavioral Health Care in Nevada

Another important component of Nevada's care worker landscape is the availability and access to mental health care providers. Nevada persistently ranks at or near the bottom in the country for overall access to mental health services despite the high demand for these services. According to 2023 data from Mental Health America, Nevada ranked 29th nationally for access to mental health care.[33]

Figure 1 details the ratio of population to mental health professional in the Mountain West states in 2023.[34] Arizona with 7.4 million residents, reported the lowest mental health workforce availability, with one mental health professional for every 660 residents. Nevada, with 3.2 million residents reported the second lowest mental health workforce availability among Mountain West states, with one mental health professional for every 420 residents. Colorado, with 5.8 million residents, has one mental health professional for every 250 residents. New Mexico, with a ratio of 240 to 1 has the most per capita mental health care providers.

Data on HPSAs for mental health care indicate that Nevada is missing the greatest number of mental health care practitioners among Mountain West states to eliminate its HPSA designations.[35] According to the Kaiser Family Foundation, HPSA is a designation given to a geographical area, population group, or healthcare facility that has a shortage of health professionals; the population for designated HPSAs includes the population that lives in the geographic area as well as those that are not located in the geographic area but are served by the facilities.[36] As of 2022, Nevada was meeting just 28.6 percent of the state's need for mental health care professionals and would need to add an additional 235 practitioners to remove its HPSA designation.[37]

Figure 1: Mental Health Workforce Ratios in the Mountain West, 2023



Source: "The State of Mental Health in America." *Mental Health America*. 2023.

Further, data from the 2022 Hopeful Futures Campaign report "America's School Mental Health Report Card" show that despite a recommended ratio of 500 to 1, Nevada has just one school psychologist available for every 1,866 students. The availability of school social workers also is lacking, with just one social worker available for every 8,730 students; the recommended ratio of students to school social workers is 250 to 1. In other words, Nevada's school mental health workforce is currently operating with 26.8 percent of the recommended number of school psychologists, and just 2.9 percent of the recommended number of school social workers.[38]

Because many mental health occupations require advanced training, workers in this sector of the care economy tend to be better compensated compared to child care providers or home health and personal care aides. However, even after completing their degrees, many mental health providers such as psychologists or counselors need to complete internships or residencies before being eligible to apply for a license. The dearth of internship and residency opportunities available in Nevada creates a barrier that may cause graduates from Nevada's college and universities with these degrees to pursue careers out of state.

Limitations of the NPWR Data

The data reported above provide a general understanding of the contours of Nevada's care workforce and its deficits. These data do not provide information about these workers' demographics, rates of employment turnover, or credentialling. In hopes of examining these factors, we requested through the NPWR portal Employee Wage Reporting Tables data provided by the Department of Employment, Training, and Rehabilitation (DETR) for the years 2013 through 2023.

The DETR employee wage data are organized such that each line of data represents wages earned each quarter for each job worked. Data for individuals who work multiple jobs in a quarter are reported separately for each job. Thus, an individual who worked two jobs for an entire year has eight lines of data, while an individual who was employed in the same job for the entire year has four lines of data. Collapsing these data by the unique identifier yields annual total wages earned by each employee in the database. In addition to the unique identifiers generated by the NPWR system and variables identifying the reporting year and quarter, the DETR data files contain columns identifying the county in which an individual was employed and six-digit North American Industry Classification System (NAICS) codes that classify the type of business establishment in which an individual is employed.

Merging the 11 annual DETR files accessed through NPWR yields a dataset with 67,067,003 observations of quarterly wage data. Within the merged data file, the corresponding NAICS code are missing for 17.8 percent of the observations. The missing NAICS code data range from less than 1 percent in 2013 to 25 percent in 2022. County identifier data is missing for 56.7 percent of the observations. Nearly 12 percent of observations are missing both NAICS codes and county identifiers

Figures 2 and 3 present total wages and the number of unique employees, respectively, by NAICS code. The observations are categorized into "Health Care and Social Assistance," the NACIS two-digit code most relevant to this analysis, "Missing NAICS Code," and "Other NAICS Codes" based on the NAICS code values in the DETR wage data. It is possible for an individual to have observations with NAICS codes fitting more than one of the categories in Figure 3. This would occur for people who had more than one employer in different sectors in a reporting period. In such cases, the individual would be counted in each of the categories for which there is an observation.

Figure 4 presents the total wages by county, within the observations for NAICS Code 62, "Health Care and Social Assistance." Total wages for observations with missing county data ($37.7 million) are more than the total wages for observations from all Nevada counties combined ($31.6 million).

Figure 2: Wages by NAICS Code

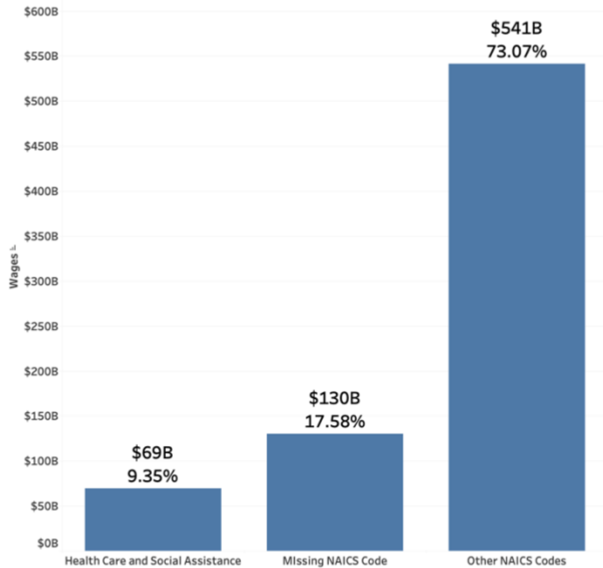


Figure 3: Unique Employees by NAICS Code

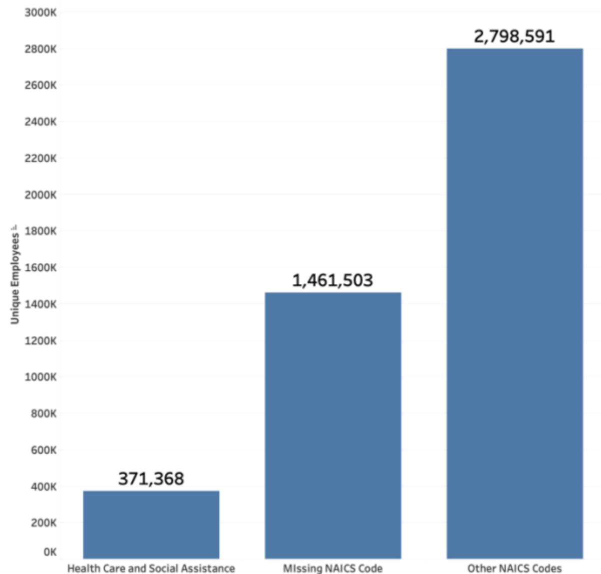
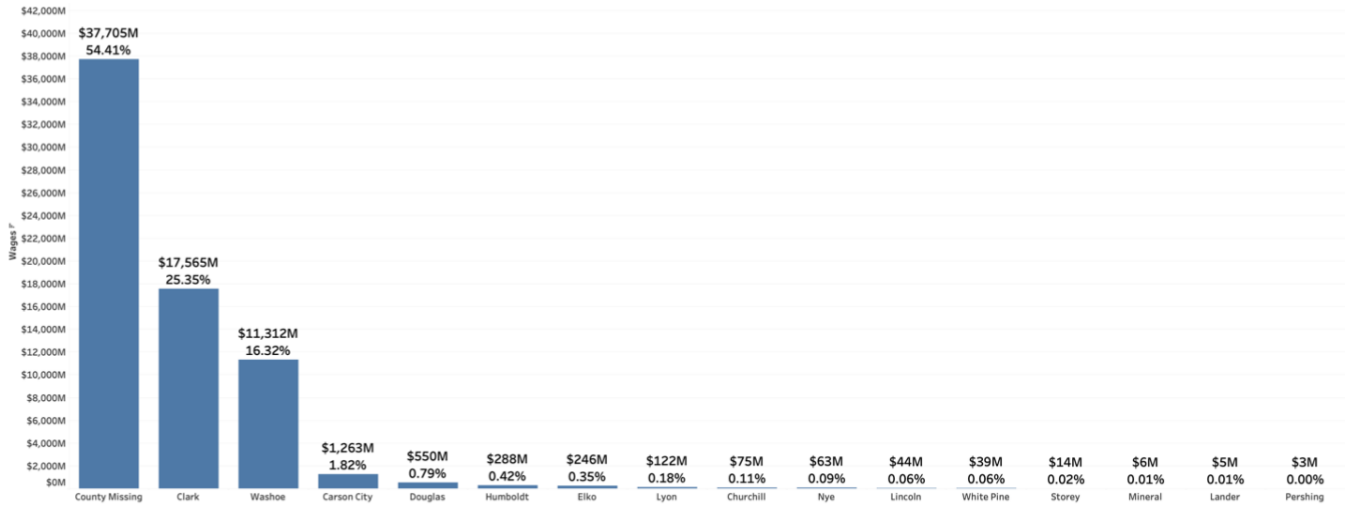
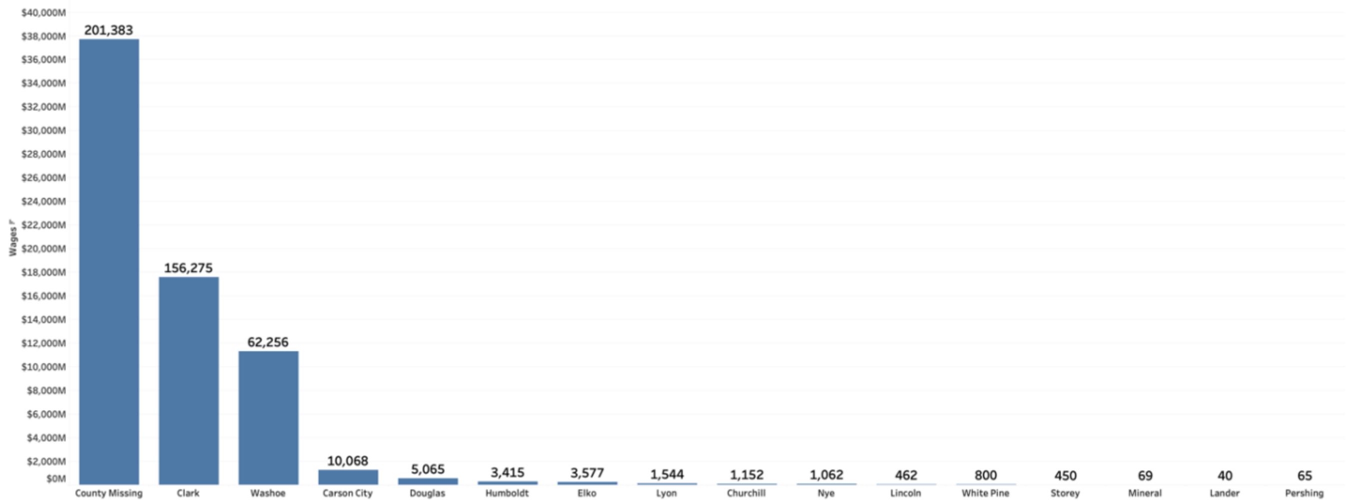


Figure 4: Health Care and Social Assistance Wages by County



Similarly, Figure 5 presents the number of unique employees by county, for NAICS Code 62 "Health Care and Social Assistance." Because the wage data are reported by the job worked, an individual might have observations from multiple jobs across different sectors.

Figure 5: Health Care and Social Assistance Unique Employees by County



For observations with NAICS Code 62 "Health Care and Social Assistance" and when the county data is available, Figures 6 and 7 map the total wages and number of unique employees in each county.

Figure 6: Map Health Care and Social Assistance Wages by County

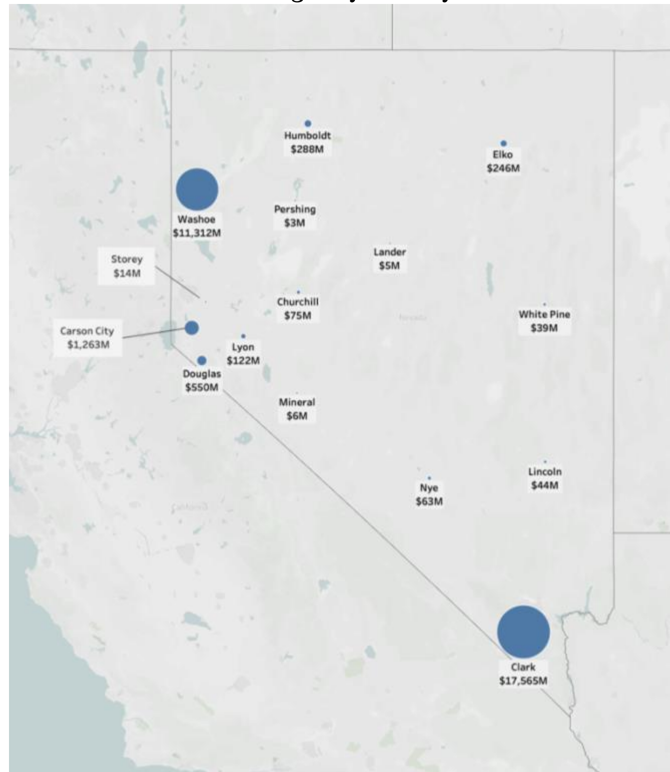
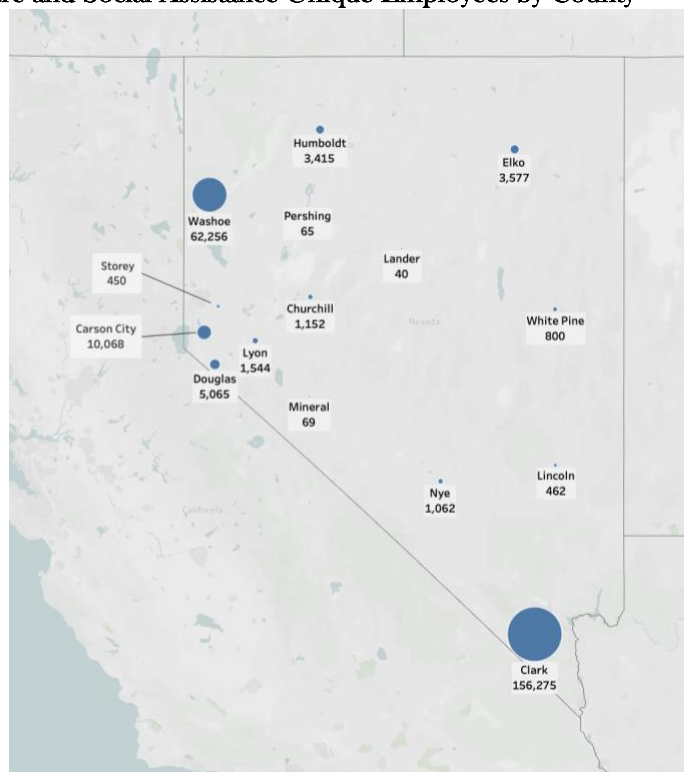


Figure 7: Map of Health Care and Social Assistance Unique Employees by County



The high levels of missing data undermine the data's reliability, and their use is likely to yield biased estimates since it is unknow if the missing data are randomly distributed or concentrated in specific occupations or counties. Sophisticated statistical methods can impute missing data, but these methods require strong assumptions about the causes for the missing data to leverage statistical horsepower to predict missingness using information gleaned from other variables such as demographic characteristics or educational attainment.

The NAICS six-digit codes and their accompanying descriptions provide information about the type of business in which an individual works, but not the job duties an individual performs. Many different jobs exist within a given industry, but the DETR data are unable to differentiate between a person who, for example, provides care from someone, who oversees billing, or works as a custodian. To this end, in the merged data set there are 402,349 observations for "Home Health Care Services" (NAICS 621610). The reported quarterly wages range from $0 to $6,807,690. In total there are 14 observations where reported quarterly wages exceed $1 million and over 45,000 observations where quarterly wages are less than $1,000 (the average quarterly wage for NAICS 621610 is $10,841.05 with a standard deviation of $20,496.54). The variation in the quarterly wage data is indicative of the point that multiple occupations are subsumed under a given NAICS code.

In contrast, the OEWS wage data provided by the BLS use Standard Occupational Classification (SOC) codes (the DETR website reports the OEWS data in a searchable form). The first two digits identify the Major Occupational Group, followed by a four-digit code that classifies an employee into specific occupational categories, such as those presented in Tables 1 and 2. The limitations of the SOC codes are they do not identify the type of business in which a person is employed or the exact wages that a specific individual earns. Ideally, the desirable attributes of the OEWS data (i.e., occupational categories) and the NAICS data (i.e., type of establishment in which an individual works) could be combined with the DETR wage data. This, however, is not feasible since the OEWS and NACIS data are derived from different surveys that utilize different methodologies. Also of concern, neither SOC nor NAICS provide individual or aggregate level data detailing race and ethnicity, gender, length of employment, or credentialling.

Recommendations for Improving NPWR

Consistent with DETR's reporting of the Current Employment Statistics that utilize the NAICS framework, the DETR wage data that are accessible through NPWR can be used to analyze broad changes in employment densities for different sectors over time.

By extension, these data can be used to examine changes in wages between or within sectors by comparing sector average quarterly wages over time. However, analyses of this type are of limited utility because of the significant variation in jobs and wages that are nested within each NAICS sector.

A straightforward way to differentiate the occupations within the NAICS sectors is to incorporate state licensing data into the NPWR portal. Licensing data obtained from the state boards that oversee various sectors of the health workforce and aggregated regionally are reported in the "Health Workforce in Nevada: A Chartbook — 2023 Edition" prepared by the Nevada Health Workforce Research Center. Including these data at the individual level in the NPWR portal would facilitate analyses of licensed employees in Nevada. For instance, merging licensing data with the DETR wage data would allow within sector comparisons of wage variation or employment stability between licensed and unlicensed employees both cross sectionally and over time. Merging these data with NPWR's educational outcome data provided by the Nevada Department of Education (NDE) or the Nevada System of Higher Education (NSHE) would enable analyses of graduates who secure licensing and then enter and remain in the workforce.

Analyses of these types would be useful for understanding the dynamics of the state's labor market and its pipelines particularly given the fact that Nevada has the highest share of licensed employees in the country.[39] At the same time, the sheer number of boards and commissions that oversee parts of Nevada's workforce creates administrative complexity to incorporate these data into NPWR. Fortunately, during the 2023 legislative session Senate Bill 431 created the Office of Nevada Boards, Commissions and Councils Standards within the Department of Business and Industry and put under the office's purview "all professional and occupational licensing boards created by the Legislature" permissible under federal law and the Nevada Constitution. This consolidation, in turn, should alleviate some of the administrative hurdles that need to be addressed to make these data accessible through NPWR.

Nationally, we know that the care workforce, regardless of the sector, skews heavily female.[40] The early child care workforce tends to be more ethically and racially diverse than the population as a whole.[41] Black and Hispanic women compose more than half of all home health care workers.[42] Within the NPWR portal, individual level data for race and ethnicity and gender is contained in the NDE and NSHE data. However, these data are only available for individuals who graduated from a Nevada public or charter high school or who enrolled at an NSHE institution. This limits data coverage given the large share of Nevadans who have migrated to the state either domestically or internationally and the state's low levels of educational attainment.

To this end, merging NDE data obtained through NPWR for the years 2013 through 2023 yields race and ethnicity matches for 281,538 high school graduates. Doing the same for the NSHE data provides race and ethnicity matches for 544,066 enrollees. The DETR data for these years contains 3,308,679 unique individuals. Put differently, if all the individuals with race and ethnic identifying data mined from the NDE and NSHE data are also in the DETR data and there is no overlap between the individuals contained in the NDE and NSHE data, which is highly unlikely given the number of enrollees at NSHE institutions who graduated from Nevada high schools, then this would account for a quarter of all workers between 2013 and 2023.[43]

Unfortunately, there does not appear to be a state agency that collects individual level gender *and* racial and ethnicity data. As part of the driver's license application the Nevada Department of Vehicles collects information on licensees' gender. The quarterly "IVQ Nevada Unemployment Rate Demographics Report" produced by DETR to comply with NRS 232,920 utilizes race and ethnicity data from various iterations of the American Community Survey produced by the U.S. Census Bureau that incorporate 1-year, 3-year, and 5-year samples for Nevada. Given Nevada's high level of racial and ethnic diversity and the wealth gaps between racial and ethnic group, it cannot be overstated that the lack of comprehensive, individual-level data detailing basic demographic characteristics significantly limits the utility of analyzes that can be performed using data accessed through the NPWR portal.

Policy Recommendations

While the NPWR data is unable to facilitate some of the project's goals, our review of policies implemented in other states, analyses of other data, and engagement with policymakers in Nevada provides the basis for the policy recommendations that follow.

Child Care Workforce

Policy interventions to bolster the child care workforce generally focus on compensation and easing regulatory burdens. A third set of policies focusing on increasing child care facilities is outside the scope of this report but as discussed below, is as an active policy area.

The most straightforward path to growing the child care workforce is to increase wages. This, of course, assumes that child care facilities are highly profitable businesses. While the profitability of a center depends upon services provided, hours of operation, number of children enrolled, and ownership (privately owned versus franchise), the margins for these businesses are typically slim.[44] Subsides for child care facilities can make it possible for owners to boost employee compensation, as would making these business eligible for tax abatements to reduce some of their operating costs contingent upon meeting minimum wage thresholds. We recommend that Nevada lawmakers consider these policies during the 2025 legislative session.

Another approach that has gained traction outside of Nevada is providing child care subsidies for staff working in early child care education facilities. Pioneered by Kentucky in 2022, in its first year 3,200 Kentucky parents working in child care participated and 5,600 children benefited from the program.[45] Arizona, Colorado, Indiana, Iowa, Massachusetts, Nebraska, and Rhode Island adopted similar policies, while Arkansas extend their program to include adoptive parents.[46] We propose that Nevada lawmakers should follow these states' examples and implement a similar program in 2025.[47]

The ubiquity of child care challenges has broader economic implications. In 2023, the U.S. Chamber of Commerce Foundation released a series of reports for select states that combine surveys of parents with children under the age of six, summaries of child care subsidies, benefits, and accommodations, and assessments of opportunity costs stemming from child care obligations (e.g., missing work, exiting the workforce, delaying educational goals) to estimate the annual loss in economic productivity due to child care challenges.[48] These losses include foregone tax revenue and costs incurred by employers due to employee absences and turnover. Although Nevada is not included in the reports, the estimated annual economic loss for Arkansas and Utah, states with similar populations, were $865 million and $1.36 billion respectively.[49] For neighboring Arizona, the estimated annual economic loss was $1.77 billion.[50]

In 2021, Canada introduced a policy to reshape its child care market by providing child care for an average of $10 a day (roughly $7.50 in U.S. dollars) through a $30 billion investment.[51] Unsurprisingly, the reduction in costs dramatically increased demand for child care that was not backed by a commensurate investment in expanding the child care workforce. The challenges occurring in Canada demonstrate how a bold policy intervention that boosts the demand side for services can create challenges on the supply side. In some provinces, the need for child care workers led to wage increases,[52] but in general the lack of investment in the country's child care workforce has resulted in long waiting lists.[53]

While it is unlikely that the U.S. or Nevada would fund a policy at the scale of Canada's $10 a day child care, policies that seek to ease the costs for families must also make investments in facilities and the workforce to ensure that the supply is able to meet increased demand. However, state proposals have tended to focus on reducing child care costs either through direct subsidies, tax credits, or variations of the "Tri-Share" model that share child care costs between employers, employees, and state governments.[54] Nevada recently announced the approval of 18 applications to be supported by $30 million in federal funds to expand child care capacity, but these funds cannot be used to support operations or staffing.[55]

The implementation of a recent federal rule that reduces the cost of child care to no more than 7 percent of income for families that receive assistance may indirectly benefit workers. The program is expected to help cover child care costs for about 800,000 low-income families served by 140,000 providers. As part of the rule, providers will be paid based upon enrollments as opposed to attendance. The change will allow providers to stabilize their budgets, which may facilitate wage increases, and help some facilities remain open that have struggled to do so after the expiration of stabilization funding that was provided during the COVID-19 pandemic.

Still, investments in the child care workforce are scant. A recent report from the Bipartisan Policy Center offers a comprehensive inventory of proposals targeted at the state level grouped into four buckets to stabilize the child care workforce and promote quality child care.[56] These include: defining the workforce by codifying occupational definitions, establishing associated competencies, and centralizing workforce data including licensing requirements, existing training programs, and available subsidies; ensuring the provision of quality care through the use of competency-based training for each role in the sector that incentivize career pathways and increased enforcement and oversight of competency requirements; evaluating operating and workforce costs to provide quality child care; and identifying funding sources from state and federal sources to stabilize the workforce and to meet desired outcomes. A first step for Nevada is to create a taskforce within the NDE to focus attention on child care and early childhood education that can provide a platform to develop policies that align with these suggestions.

In the meantime, addressing regulatory and licensing barriers offers an immediate policy intervention to increase the supply of child care workers. The 2023 "Child Care Policy Report" estimates that it costs a child care provider between $100 to $200, plus the time and effort to navigate multiple agencies, to be eligible for employment.

Moreover, the background check and licensing fee is only applicable to a single facility, meaning that a person who works at multiple facilities must duplicate the process for each work site irrespective if the sites are owned by the same entity. The report recommends fee waivers for potential child care workers; per worker, instead of per worker per site, licensing and background check requirements; and the creation of a one-stop hub to access and process the required documents needed to become a licensed child care provider.

Elder Care Workforce

There are parallels between the challenges facing the child care and elder care workforces. Most notably, the care occupations for both require licensing and background checks and tend to be poorly compensated, while neither area of care work requires substantial educational attainment (see Tables 1 and 2). Consequently, it is not uncommon for employees in these fields to qualify for income-based social-service programs such as SNAP or Medicaid. Both sectors also have extensive employment turnover as employees frequently change jobs to secure better working conditions and compensation. For instance, an analysis conducted by the Federal Reserve Bank of Cleveland estimates that between 2010 to 2022 nearly 15 percent of child care workers left their occupation and a third of child care centers had turnover rates of 20 percent or greater.[57] The Home Care Association of American estimates that the turnover rate for home care workers in 2022 was more than 77 percent, a 12 percentage point increase from the prior year.[58]

However, because home based elder care services are often contracted through Medicaid, home care workers in Nevada have been organized through the Service Employees International Union Local 1107. Because of the union's lobbying efforts, in 2023, Senate Bill 511 increased the Medicaid reimbursement rate for these services, resulting in an increase in the minimum wage for these workers from $11 an hour to $16. The union's goal for the 2025 legislative session is a minimum hourly wage rate of $20.[59]

The child care and elder care workforce also differ in terms of their future workforce needs. While Nevada's child population is anticipated to increase as the state continues to grow, these increases are dwarfed by the expected population growth of those 65 years of age or older.[60] Certainly, additional wage increases should help to grow the workforce, but other policy interventions are likely to be needed.

Akin to its child care workforce report, in 2023 the Bipartisan Policy Center issued a policy framework to address what they define as the home health and personal care workforce at the national level.[61] In addition to policies related to compensation that are similar to those already in place in Nevada, the report recommends policies to improve worker retention such as improving worker training programs and developing career lattices to incentivize career progression and growth. Also suggested is including personal care aides as a registered occupation within the U.S. Department of Labor's Registered Apprenticeship programs so that training programs are eligible to access federal funding through the Workforce Innovation and Opportunity Act, more commonly known as WIOA. Other reforms focus on targeted immigration reforms to grow the sector's workforce.

At the state level, several states took advantage of ARPA funding to increase resources available to support home and community-based services to evaluate and strengthen their policies related to the elder care workforce. For instance, building from its existing workforce development programs and collaborations with service providers, Arizona used ARPA funding to augment its workforce infrastructure to create career pathways, improve training, assist providers with workforce planning, recruit new employees, and develop a workforce data and analytics hub.[62] In addition to increasing provider payments, Colorado invested in its direct care workforce data infrastructure, training and curriculum, including career pathways, and developed a resource and job hub.[63]

Nevada policymakers should look to these examples as ways to grow the elder care workforce and improve employee retention. Other policy interventions that should be pursued are reducing the costs for licensing and background checks, creating a centralized job posting platform, and subsidizing continuing education opportunities via tax credits for employers.

Mental and Behavioral Health Workforce

A silver lining of the COVID-19 pandemic was the heightened attention to the need for mental and behavioral health support and the glaring deficits in Nevada's mental health ecosystem. The inadequacies in providing sufficient services to children with behavioral health disabilities were so pronounced that in 2022 the U.S. Department of Justice found Nevada in violation of the American with Disabilities Act due to the state's propensity to institutionalize these children for extended periods of time in lieu of provided coordained community care.[64] In response, policy makers have begun efforts to address these shortcomings

In the 2023 legislative session, Assembly Bill 37 established what would become the Behavioral Health, Education, Retention & Expansion Network of Nevada or BeHERENV. Supported with roughly $2 million in funding for the biennium, BeHERENV builds on 2009 legislation passed in Nebraska to develop a robust pipeline of behavioral health specialists by incorporating and expanding existing programs with new initiatives that coordinate educational systems with professional licensing. The program's goals are to conduct outreach and education to grow the mental health provider pipeline, expand educational training programs at NSHE institutions, and retain providers by offering supervision, licensing support, and technical assistance to help providers navigate the administrative aspects of running a successful practice.

BeHERENV works as a hub-and-spoke model. UNLV and UNR serve as the main hubs that support the regional hubs (the spokes) in each of Nevada's three Behavioral Health Regions outside of Clark and Washoe counties. Each of the regional hubs offers specialty training to strengthen clinical training programs and oversee local recruitment. While program development and implementation are ongoing, the Nebraska model upon which BeHERENV is based saw a 44 percent increase in Nebraska's behavioral health workforce between 2009 and 2023.

In 2012, the UNLV Department of Psychology established the Partnership for Research, Assessment, Counseling, Therapy and Innovative Clinical Education. Better known as UNLV PRACTICE, the initiative serves as a community mental health training clinic that provides in-person and telehealth therapy and psychological assessment. During the subsequent decade, UNLV PRACTICE expanded its research and services, including the establishment of a satellite location in the Las Vegas Medical District, and coordinated specialty care programs including support for early serious mental illness treatment.

In 2023, UNLV PRACTICE received a grant from Intermountain Health to develop a strategic plan to expand its footprint. Out of the strategic planning process, UNLV PRACTICE developed a framework to integrate mental and behavioral health with physical healthcare to unify the fragmented mental and behavioral health landscape into a financially sustainable coordinated and collaborate system that provides integrated community care, supports a robust, cross discipline research agenda, and expands clinical training capacity.

Both BeHERENV and UNLV PRACTICE's strategic plan provide a foundation to grow the mental and behavioral health workforce and expand access to care. However, these initiatives are supported by one-time state funding in the case of BeHERENV or philanthropy in the case of UNLV PRACTICE. For these programs to meet their ambitious goals, the Nevada Legislature must provide permanent state funding.

Investments in growing the mental and behavioral workforce pipeline and implementing a model of integrated care also require that policies are in place to ease licensing hurdles and ensure that providers can sustain their practices. Indeed, even after mental health providers earn their degrees, they must complete several additional steps before they are licensed to provide care.

The example of psychologists demonstrates these challenges. After completion of a doctoral degree from a program that is accredited by the American Psychological Association, a person must complete postdoctoral training totaling 1,750 hours, but Nevada has few of these positions, particularly for child psychologists. The positions that do exist often not provide competitive compensation or benefits compared to neighboring California and Utah. Once the obligations of a postdoctoral positions have been fulfilled, then a person must complete the state licensure exam requirements. Unlike some other states, Nevada requires passage of Parts 1 and 2 of the Examination for Professional Practice in Psychology and the Nevada State Exam. To minimize the attrition of Nevada graduates with degree in mental health related fields, the state needs to invest in post-graduate educational opportunities that are required for licensing. In addition to ensuring that Nevada's licensing requirements are in line with those of neighboring states, the state should implement licensing reciprocity for all mental health professions.

Other policy interventions are needed to ensure that providers can sustain their practices. Currently, many providers only accept cash payments for services due to the difficulties in securing reimbursement from insurance companies due to long payments periods and time-consuming billing processes. Others may struggle to have their practices accepted as part of an insurance panel. Table 3 presents data from the Nevada Department of Insurance's 2023 "Aggregated Provider Denial Report" for mental health related specialties. In total, insurance companies issued 118 provider denial letters for these services out of a total of 1,097. More than half of all denials summarized in Table 3 were for Applied Behavior Analysis Therapy that is used to treat children on the autism spectrum. Per the report, the main reasons for denials were that the specialty was not need within the insurance network (43.1 percent); business decision (22.5 percent); or outside of the service area (14.5 percent).[65]

Other providers will not accept Medicaid patients due to low reimbursement rates. While the recent increase in funding may encourage more providers to accept patients that rely on Medicaid for their mental and behavioral health services, sustaining this funding coupled with more aggressive enforcement of the 2008 Mental Health Parity and Addiction Equity Act's requirement that insurers offer plans that provide coverage for mental health benefits similar to the coverage for physical health services should increase the number of providers that are accepted for paneling and expand access to those in need who are reliant on Medicaid.

Table 3: Insurance Provider Denials for Mental Health Related Specialties, 2023

Specialty	Count
Applied Behavior Analysis Therapy	63
Behavior Analyst	4
Behavioral Health	18
Clinic/Center Mental Health	6
Clinical Psychologist	1
Counselor – Mental Health	7
Counselor – Addiction (Substance Use Disorder)	1
Marriage and Family Therapist	6
Psychiatry and Neurology	5
Psychiatry and Neurology – Child Adolescent Psychiatry	1
Psychiatry and Neurology – Geriatric Psychiatry	1
Psychologist	3
Substance Abuse Rehabilitation Facility	2
Total	**118**

Source: Nevada Department of Insurance 2023 Aggregated Provider Denial Report

Conclusion: Next Steps

Although limitations to the NPWR data system detailed above prohibited us from achieving some of the goals of the project proposal, The Lincy Institute remains committed to improving the NPWR system and to continuing our work examining Nevada's care workforce.

In July 2024, The Lincy Institute commissioned Tripp Umbach, a highly regarded, nationally recognized consulting firm that has a long history of working on healthcare related projects with The Lincy Institute and other organizations in Nevada, to develop an economic impact analysis of Southern Nevada's care economy. The resulting report will develop recommendations to facilitate workforce development for the care economy including strategies to invest resources efficiently to promote education and training and ensure long-term sustainability to support caregivers and those in need of these services. With an expected completion in Fall 2024, the report will be released at a public forum giving Nevada policy makers an opportunity to use data-driven recommendations to propose changes for the care workforce and care economy at the 83rd session of the Nevada Legislature in 2025.

Among those opportunities include the following policy recommendations and legislative actions detailed above:

- Integrate occupational licensing data and comprehensive race and ethnicity and gender data into the NPWR system.
- Evaluate the efficacy of subsidies and tax abatements for child care facilities to reduce operating costs and increase employee compensation.
- Provide child care subsidies for staff working in early child care education facilities.
- Create a child care and early childhood education taskforce within the Nevada Department of Education to develop policies to stabilize the child care workforce and promote quality child care.
- Streamline child care and home health and personal care licensing and background check requirements, including fee waivers, and create one-stop hubs to access and process required documents.
- Increase the minimum wage for home care workers from $16 to $20 per hour.
- Urge Nevada's federal delegation to include home health and personal care aides as a registered occupation within the U.S. Department of Labor's Registered Apprenticeship programs.
- Urge Nevada's federal delegation to support targeted immigration reforms to grow the home health and personal care workforce.
- Subsidize continuing education opportunities for home health and personal care workers via tax credits for employers.
- Provide dedicated state funding to support BeHERENV and UNLV PRACTICE.
- Increase the number of post-graduate educational training positions for mental health related fields that are required for licensing.
- Align Nevada's licensing requirements for mental health related fields with those of neighboring states and implement licensing reciprocity for all mental health professions.
- Sustain increased Medicaid funding for mental health services and enforce the 2008 Mental Health Parity and Addiction Equity Act's mental and behavioral health coverage requirement.

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