

Semi-Annual Report of the Patient Protection Commission

Pursuant to NRS 439.908



Nevada Health Authority – Director’s Office Patient Protection Commission

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I. Patient Protection Commission

Commissioners

Ms. Bethany Sexton, MBA, Chair

One member who represents the private nonprofit health insurer with the highest percentage of insureds in this State who are adversely impacted by social determinants of health.

Dr. Andria Peterson, PharmD, Vice Chair

One member who has expertise and experience in advocating for persons with special health care needs and has education and experience in health care.

Dr. Jonathan Chastain, DO

One member who is an employee or a consultant of the Authority with expertise in health information technology and patient access to medical records.

Dr. Mark Glyman, MD, DDS, FACS

One of two members who are persons with expertise and experience in advocating on behalf of patients.

Dr. Ikram Khan, MD

One member who is a provider of health care who operates a for-profit business to provide health care.

Ms. Marilyn Kirkpatrick

One member who represents a nonprofit public hospital that is located in the county of this State that spends the largest amount of money on hospital care for indigent persons pursuant to chapter 428 of NRS.

Dr. Adam Porath, PharmD, BCACP, BCPS-AQ Cardiology

One member who is a pharmacist at a pharmacy not affiliated with any chain of pharmacies or a person who has expertise and experience in advocating on behalf of patients.

Dr. Travis Walker, MD, MPH, FAAFP

One member who is a physician or registered nurse who practices primarily at a federally qualified health center, as defined in 42 U.S.C. § 1396d(l)(2)(B).

Ex-Officio (Non-voting) Commissioners

Stacie Weeks, JD, MPH, Director, Nevada Health Authority

Theresa Carsten, Executive Officer, Public Employees Benefits Program

Ned Gaines, CIE, AIC, AINS, AIRC, MCM, Insurance Commissioner, Nevada Division of Insurance

Janel Davis, Executive Director, Silver State Health Insurance Exchange

Commission Staff

Dylan Malmlov, MPH, Executive Director

Stephanie Purnell, MPH, Policy Analyst

Alexandra Lopez-Duarte, Executive Assistant

II. Introduction

The Nevada Patient Protection Commission (PPC; Commission) is a public body located within the Nevada Health Authority (NVHA; The Authority). The PPC is comprised of 12 voting members and 4 non-voting members appointed by the Director of the Nevada Health Authority subject to approval by the Governor. Member representation includes those from across the health care spectrum including advocates, providers, and industry professionals who are dedicated to improving health care in Nevada. Nevada Revised Statute [\(NRS\) 439.902-918](#) provides the PPC with statutory authority to systematically review issues related to the health care needs of residents of Nevada and the quality, accessibility, and affordability of health care in the state. This report is being submitted in accordance with NRS 439.918.2.(a), which requires the PPC to submit a semi-annual report describing the meetings and activities of the Commission during the immediately preceding six months. The report must include, without limitation, a description of any issues identified as negatively impacting the quality, accessibility or affordability of health care in this state and any recommendations for legislation, regulations or other changes to policy or budgets to address those issues.

During the reporting period, the commission has focused their attention on reviewing statewide data, reports, research, and stakeholder perspectives to develop a shared understanding of the current landscape of perinatal health in the state to inform evidence-based decision making. The Commission has gathered policy recommendations from the public and is currently reviewing potential policy and legislative opportunities aimed at addressing identified challenges and improving health outcomes, access to care, affordability and system capacity for moms and babies in Nevada. This report is meant to reflect the Commission's activities over the past six months and includes a summary and analysis of the literature on the current maternal and infant health system status in Nevada.

III. Meetings and Activities

Over the past six months, the Commission has held five public meetings focused on understanding Nevada's maternal and infant health system, identifying key challenges, and exploring potential policy solutions. The Commission's work is guided by the 7 steps to effective decision-making, and over the course of the Commission's meetings, they have reviewed statewide data, research, and reports to identify problems; gathered evidence and information; solicited and gathered policy options to review and evaluated those policy options to address the challenges identified through the review process.¹ Meeting materials, presentations, and additional information regarding the Commission's work are available on the [Commission's website](#).

The Commission reviewed a wide range of data, research, reports, and stakeholder perspectives to inform this work. Commissioners heard 11 presentations from experts and organizations representing multiple sectors of Nevada's health care system, including public health professionals, clinicians, workforce and rural health experts, Nevada Health Authority and Medicaid leadership, hospital and health system representatives and national policy organizations.

In addition to presentations and data review, the Commission actively sought public input. Through a public submission process and testimony provided during public meetings, the Commission received 58 unique policy recommendations related to maternal and infant health. These recommendations were reviewed and organized into policy concept and problem summaries to support further discussion and evaluation by the Commission.

Collectively, these meetings, presentations, data review, and policy proposals informed the Commission's understanding of Nevada's perinatal health landscape and helped identify areas for further policy consideration.

IV. Review of Nevada's Perinatal Health System

Purpose

Nevada faces persistent challenges in perinatal health outcomes, access to care, and workforce capacity. Improving outcomes for moms and babies requires a comprehensive, data-driven understanding of the current perinatal health landscape. The purpose of this review is to assess the state of perinatal health care in Nevada by examining available data, existing research, and stakeholder perspectives. This work supports the PPC in developing a shared understanding of Nevada's perinatal landscape to inform evidence-based policy development.

Approach and Methods

To develop a comprehensive understanding of perinatal health care in Nevada, the PPC conducted a multifaceted review to assess perinatal health care access, quality, and system capacity in Nevada, incorporating a literature review and an analysis of Nevada data.

Literature Review

Sources were eligible if they (a) were published within the last five years; (b) were Nevada-specific or directly applicable to the Nevada population and (c) addressed perinatal access, quality, outcomes, behavioral health, or workforce capacity. The population of interest was pregnant and postpartum people and infants in Nevada. Eligible source types include state surveillance and mortality reports, needs assessments, behavioral health and workforce reports, dashboards and national score cards, and peer-reviewed literature. Identified materials were reviewed for key themes related to system gaps and performance.

Analysis of Data

The PPC reviewed and compiled publicly available data describing Nevada's birthing population, drawing primarily on the Nevada Office of Analytics data dashboards and published reports along with other public data sources. These data characterized maternal demographics, clinical risk factors, maternal morbidity and mortality, infant outcomes, and perinatal care utilization, including comparisons between Medicaid-covered and statewide births and stratification by age, race/ethnicity, and geography where available. Publicly reported data, pregnancy risk assessment and monitoring system (PRAMS) and behavioral risk factor surveillance system (BRFSS), CDC wonder natality, and a social and economic vulnerability index derived from the American Community Survey (ACS) data provided additional context on population health and social determinants of health.

Stakeholder Engagement

The PPC engaged authors of state reports and partners across Nevada Medicaid, DPBH, DHS, MCOs, and clinical systems. Presentations and cross-agency discussions provided clarification on report findings, validated themes emerging from the Medicaid analysis, and informed interpretation of statewide perinatal system status.

Results

The available evidence documents maternal and infant mortality and morbidity rates in Nevada that are above national averages on several indicators, persistent disparities by race, geography, and insurance coverage across data sources, and recurring patterns in workforce capacity and distribution, geographic access, payment design, behavioral health integration, and clinical quality infrastructure. National comparisons and scorecards reflect these challenges, where Nevada ranks 39th of 51 on health and reproductive care outcomes, 49th on coverage, access, and affordability, and 51st on health care quality and prevention.² The findings that follow describe the underlying state reports, analyses, literature, and stakeholder findings for Nevada families, providers and the perinatal care system.

The findings are organized around four questions: (1) Who is giving birth in Nevada? (2) What outcomes are moms and babies experiencing? (3) What factors affect access to care? (4) What are the common themes across the literature?

Demographics

In 2024, there were 32,080 births in Nevada, of which 17,145 (53.4%) were financed by Medicaid, highlighting the large role Medicaid plays in supporting maternal and infant health across the state. Medicaid-covered births represented more than half of all births in Nevada, consistent with the broader national and state trends showing Medicaid as a primary payer for maternity care.³

The age distribution of all births in Nevada was most concentrated among people aged 20-34. Among Medicaid-covered births, younger maternal age groups made up a larger share of births compared to Nevada overall. Within the <20-24-year-old cohort, Medicaid financed 78.2% of births. In contrast, births among older maternal age groups, particularly ages 35 and older, represented a smaller portion of Medicaid-covered births than Nevada births overall. This pattern suggests Medicaid disproportionately serves younger birthing populations, who may face greater financial and social barriers to care.

Nevada's birthing population was racially and ethnically diverse. Hispanic or Latino individuals represented the largest share of births statewide (40.0%) and nearly half of Medicaid-covered births (48.4%). Black or African American individuals also represented a disproportionately larger share of Medicaid births (18.6%) compared to Nevada births overall (12.7%). Notably, about 78% of births to Black women in Nevada were financed by Medicaid. Conversely, White individuals represented 25.5% of Medicaid birth compared to 36.7% statewide, while Asian/Pacific Islander individuals accounted for 5.5% of Medicaid births and 9.1% of births statewide. These findings demonstrate that Medicaid plays a particularly important role in financing births among historically underserved populations and populations that continue to experience higher rates of maternal and infant health disparities nationally and within Nevada.

Geographically, most births occurred in Clark County, which accounted for 74.5% of births statewide and 79.1% of Medicaid-covered births. Washoe County represented 15.3% of statewide births but only 12.3% of Medicaid births, while rural and frontier counties accounted for about 1 in 10 births statewide (10.6%) and 8.6% of Medicaid births. Nevada's concentration of births in Clark County is consistent with broader statewide population trends, while rural and frontier regions continue to face unique challenges related to workforce shortages, transportation, and access to maternity services.

Table 1.*Characteristics of Pregnant People in Nevada, 2024*

	Medicaid, n (%)	Nevada, n (%)
Total	17,145 (53.4%)	32,080 (100%)
Age		
<20	1,105 (6.4%)	1,206 (3.8%)
20-24	4,131 (24.1%)	5,487 (17.1%)
25-29	4,970 (29.0%)	9,090 (28.3%)
30-34	4,169 (24.3%)	9,590 (30.0%)
35-39	2,169 (12.7%)	5,356 (16.7%)
40-44	570 (3.3%)	1,271 (4.0%)
45+	31 (0.1%)	80 (0.2%)
Race/Ethnicity		
Hispanic or Latino	8,302 (48.4%)	12,756 (40.0%)
White	4,378 (25.5%)	11,779 (36.7%)
Black or African American	3,184 (18.6%)	4,084 (12.7%)
American Indian/Alaska Native	159 (0.9%)	225 (0.7%)
Asian/Pacific Islander	947 (5.5%)	2,927 (9.1%)
Other	35 (0.2%)	58 (0.1%)
Region		
Clark County	13,567 (79.1%)	23,905 (74.5%)
Washoe County	2,107 (12.3%)	4,903 (15.3%)
Rural and Frontier	1,468 (8.6%)	3,272 (10.2%)

Source: Nevada Office of Analytics, *Maternal and Child Health in Nevada* (2024). [Maternal and Child Health Data Dashboard](#)

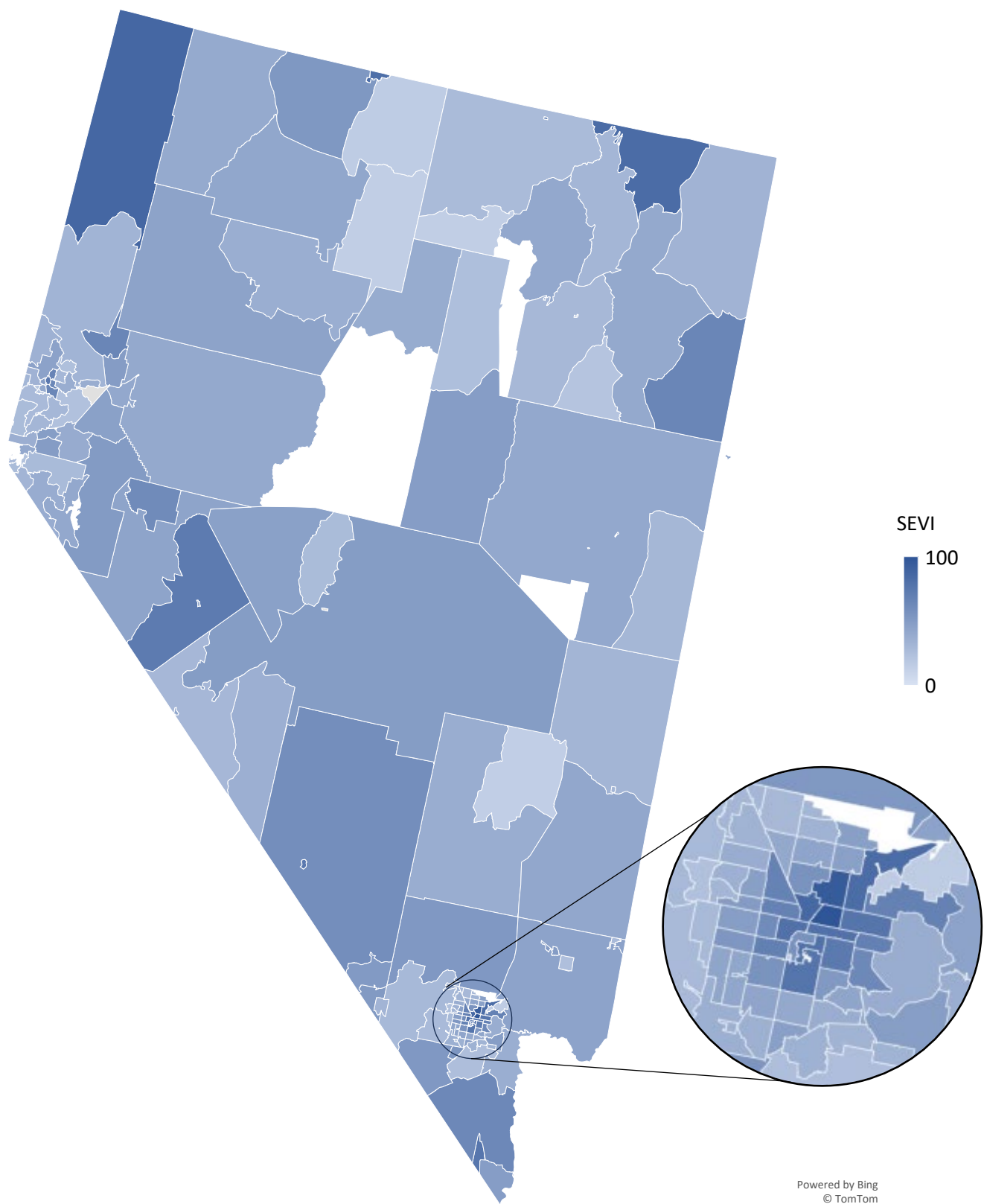
Social and Economic Vulnerability

To help contextualize disparities and describe the broader challenges impacting maternal and infant health across Nevada, this report utilizes the Social and Economic Vulnerability Index (SEVI), a composite measure developed using community-level social and economic indicators. The SEVI is intended to provide context regarding the communities and populations experiencing higher levels of disadvantage and vulnerability across the state.

The SEVI incorporates indicators related to unemployment, income and benefits, poverty, insurance coverage, household composition, transportation access, educational attainment, language proficiency, and broadband access, with a full description of the index provided in the appendix. Together, these indicators help describe the broader social and economic conditions that may influence health care access, utilization and outcomes.

Higher SEVI scores reflect communities experiencing greater levels of social and economic vulnerability. These communities may face increased barriers related to transportation, affordability, provider access, housing stability, employment flexibility, childcare, and access to supportive services and infrastructure. These factors can affect an individual's ability to access and engage with health care services throughout pregnancy and the postpartum period.⁴

Figure 1.
Social and Economic Vulnerability Index (SEVI) by ZIP Code



Note. ZIP code level Social and Economic Vulnerability Index (SEVI) scores derived from the American Community Survey; higher values indicate greater neighborhood level vulnerability.

Outcomes

Maternal Clinical Risk Factors, Morbidity, and Mortality

Maternal clinical risk factors and adverse maternal outcomes remain significant contributors to maternal and infant health challenges in Nevada. Table 2 summarizes selected maternal clinical conditions, delivery characteristics, and severe maternal morbidity (SMM) and mortality among Nevada births in 2024 comparing Medicaid-covered births to statewide rates.

Several chronic and pregnancy-related conditions were common across both the Medicaid and statewide birthing populations. Obesity affected nearly 1 in 3 (33.8%) women among Medicaid covered births compared to Nevada overall (31.8%). Gestational hypertension and gestational diabetes were also prevalent, affecting about 8-9% of pregnancies statewide. These conditions are associated with increased risk of complications during pregnancy and delivery including preeclampsia, cesarean delivery, preterm birth, and longer-term chronic disease risk for both mom and baby. Although less common, severe pregnancy-related complications such as eclampsia occurred at higher rates among Medicaid-covered births (1.3%) compared to Nevada overall (0.9%). Eclampsia is a severe hypertensive complication of pregnancy associated with seizures, maternal morbidity, and mortality.

Cesarean delivery rates were similar between Medicaid-covered births and Nevada overall, with about one-third of births delivered by c-section. While cesarean delivery can be medically necessary and lifesaving, higher rates may also reflect broader trends related to maternal risk factors, clinical practice patterns, and access to prenatal and obstetric care.

Rates of severe maternal morbidity (SMM) and pregnancy-associated death (PAD) further demonstrate the significant challenges facing Nevada. SMM occurred at a higher rate among Medicaid-covered births (220.8 per 100,000 births) compared to Nevada overall (201.5 per 100,000 births). Similarly, pregnancy associated death rates were higher among Medicaid-covered births (99.1 per 100,000 births) compared to statewide rates (81.0 per 100,000 births). These findings are consistent with broader national trends showing higher rates of maternal morbidity and mortality among populations experiencing greater social, economic, and health care access challenges.

Together, these findings highlight the substantial burden of maternal clinical risk factors among Nevada’s birthing population and reinforce the importance of prevention, early identification, chronic disease management, behavioral health integration, timely prenatal care, and coordinated postpartum follow-up in improving maternal health outcomes statewide.

Table 2.
Maternal Clinical Risk Factors, Morbidity and Mortality

Indicator	Medicaid, n (%)	Nevada, n (%)
Gestational Hypertension	1073 (8.0%)	2722 (8.4%)
Gestational Diabetes	1155 (8.5%)	2986 (9.2%)
Obesity	4561 (33.8%)	10309 (31.8%)
Eclampsia	172 (1.3%)	300 (0.9%)
Cesarean-Delivery	4356 (32.2%)	10,639 (32.8%)
Severe Maternal Morbidity (SMM)	220.8	201.5
Pregnancy Associated Death (PAD)	99.1	81

Sources: CDC Wonder, *Nativity* (2024). Nevada Office of Analytics, *Medicaid Claims* (2025).

Infant Outcomes

Infant outcomes provide important insight into the health of pregnant and postpartum individuals, access to timely and appropriate care, and the broader socioeconomic conditions affecting families and communities. Table 3 summarizes selected infant health outcomes among Medicaid births in 2024, comparing Medicaid-covered births to statewide rates and highlighting disparities across racial and ethnic groups.

Preterm birth and low birthweight remain significant challenges in Nevada and were more common among Medicaid covered births than Nevada overall. In 2024, 12.3% of Medicaid-covered births were preterm compared to 10.9% statewide, both are above the national and Healthy People 2030 goal of 10.4% and 9.4% respectively.⁵ Similarly, low birthweight affected 11.0% of Medicaid-covered births compared to 9.7% of births statewide. Both outcomes are associated with increased risk of infant mortality, developmental complications, chronic health conditions, and higher health care utilization during infancy and childhood.

Substantial disparities were observed across racial and ethnic groups. Black infants experienced the highest rates of both preterm birth and low birthweight statewide and within the Medicaid population. Among Medicaid-covered births, babies born to black mothers had a 33% higher likelihood of being preterm relative to the statewide Medicaid rate and had a 50% higher likelihood when compared to the statewide preterm birth rate. Disparities in outcomes were more pronounced among low-birthweight babies, where babies born to black mothers had 68% and 91% higher likelihood of low-birthweight compared to Medicaid births and statewide births respectively.

Infant mortality rates were slightly higher among Medicaid-covered births (5.8 per 1,000 live births) compared to Nevada overall (5.4). Although infant mortality is a relatively rare outcome, it remains one of the most significant indicators of population health and reflects a wide range of contributing factors including maternal health, prenatal care access, birth outcomes, socioeconomic conditions, and healthcare access during infancy. Linked birth and infant death records show higher infant mortality rates among Medicaid-covered births compared to privately insured populations.⁶

Additional infant health indicators further highlight ongoing maternal and infant health challenges in Nevada. Rates of neonatal abstinence syndrome (NAS) remain elevated despite recent declines, reflecting the continued impact of substance use and behavioral health challenges during pregnancy.⁷ Safe sleep adherence and breastfeeding initiation have also declined in recent years, according to Nevada’s Title V health needs assessment. Qualitative findings from families and stakeholders further identified barriers related to breastfeeding support, behavioral health access, stigma, transportation, childcare, and coordination of services during the pregnancy and postpartum period.

These findings demonstrate infant outcomes are closely connected to maternal health, behavioral health, social and economic factors, and access to care throughout pregnancy and infancy. The higher prevalence of adverse outcomes among Medicaid-covered births further underscores the importance of targeted prevention, early intervention, and comprehensive maternal and infant health supports across communities.

Table 3.
Infant Outcomes, 2024

Indicator	Medicaid, n (%)	Nevada, n (%)
Preterm Birth	2114 (12.3%)	3514 (10.9%)
Hispanic	969 (11.7%)	1388 (10.8%)
White	467 (10.7%)	1086 (9.2%)
Black	522 (16.4%)	634 (15.5%)
Other	156 (13.7%)	406 (12.6%)
Low Birthweight	1894 (11.0%)	3114 (9.7%)
Hispanic	738 (8.9%)	1080 (8.4%)
White	420 (9.6%)	936 (7.9%)
Black	589 (18.5%)	698 (17.1%)
Other	147 (12.9%)	400 (12.5%)
Infant Mortality (IMR)	5.8	5.4

Source: Nevada Office of Analytics, *Maternal and Child Health in Nevada* (2024). [Maternal and Child Health Data Dashboard](#)

Descriptive Statistics of Utilization

Table 4 demonstrates lower utilization of perinatal and preventative care services across the state, with lower rates among Medicaid-covered births compared to Nevada, with disparities observed by geographic areas. Early and adequate prenatal care, defined as receiving the recommended number of prenatal visits and beginning care within the first trimester, was received by 64.3% of Medicaid covered births, compared to 71.2% statewide. This is substantially lower than the national rate and Healthy People 2030 goal of 75% and 80.5% respectively.⁸ Utilization was lowest in Washoe County and rural/frontier areas, where fewer than 60% of Medicaid-covered pregnancies received early and adequate prenatal care, compared to 66.6% in Clark County. These findings suggest that access challenges extend beyond clinical coverage alone and may reflect provider shortages, transportation barriers, limited appointment availability, and differences in regional maternity care infrastructure.

The table also shows elevated rates of NICU admission among Medicaid-covered births (12.4%) compared to Nevada overall (10.7%). While NICU admission is influenced by many clinical factors, higher utilization may reflect increased maternal and infant risk burden, differences in practice patterns, and reimbursement incentives may also influence observed rates.

Additional population-level indicators suggest that gaps in care utilization extend beyond prenatal services alone. Nevada PRAMS data indicates that about 84% of women reported attending a postpartum visit, compared to 90.3% nationally, meaning about 1 in 6 did not receive a postpartum follow-up.⁹ BRFSS data similarly shows that only 64.9% of Nevada women ages 18-44 reported having a routine medical check-up in the past year.¹⁰ Together, these findings suggest broader challenges in engagement with preventative and longitudinal services before, during, and after pregnancy.

Importantly, utilization patterns likely reflect the impact of multiple interacting barriers rather than any single factor. The following sections explore several of these challenges, including cost and coverage barriers, administrative complexity, workforce shortages and provider capacity limitations, geographic access challenges, and maternity care deserts.

Table 4.
Perinatal and Preventative Care Utilization

Indicator	Medicaid, n (%)	Nevada, n (%)
Early and Adequate Prenatal Care	11026 (64.3%)	22831 (71.2%)
<i>Geography</i>		
Clark County	9030 (66.6%)	17539 (73.4%)
Washoe County	1135 (53.9%)	3082 (62.9%)
Rural and Frontier	861 (58.7%)	2210 (67.5%)
<i>Race/Ethnicity</i>		
Hispanic	5381 (64.8%)	8846 (69.3%)
White	2840 (64.9%)	8791 (74.6%)
Black	2037 (64.0%)	2682 (65.7%)
Other	768 (67.3%)	2512 (78.3%)
NICU Admission	1678 (12.4%)	3461 (10.7%)

Sources: Nevada Office of Analytics, *Maternal and Child Health in Nevada* (2024). [Maternal and Child Health Data Dashboard](#). CDC Wonder, *Nativity* (2024).

Cost and Coverage Barriers

Financial, insurance, and care navigation challenges may further limit access to preventative, prenatal and postpartum care services across Nevada. In 2022, 14% of Nevada women ages 19-64 lacked health insurance coverage, compared to 10% nationally.² Even among insured populations, gaps in preventative and longitudinal care utilization remain evident. About one in three Nevada women ages 18-44 reported not having someone they think of as a personal healthcare provider, and 20% did not receive a routine check-up within the past two years, both higher than national benchmarks.² These gaps may reduce access to preventive, preconception, and chronic disease management services prior to pregnancy.

Cost-related barriers are also significant. About 26% of Nevada women ages 18-44 reported a time in the past year when they needed a doctor but could not because of cost.² Preventative screening rates further suggest challenges with continuity and engagement in care with declines observed in breast cancer screening utilization between 2020 and 2022.⁷

Stakeholder interviews and statewide assessments additionally identified administrative complexity and coverage navigation challenges as barriers to timely care access. Common themes included confusion regarding Medicaid eligibility and benefits, difficulties obtaining or maintaining coverage, variation in managed care processes and gaps in behavioral health and substance disorder treatment access. Gaps across obstetric, primary care, behavioral health, pediatric, and social service systems was also identified as a barrier to coordinated maternal and infant care, particularly for individuals with complex medical, behavioral health, or social needs.^{7,11}

These findings suggest that access barriers extend beyond provider availability alone and may reflect broader challenges related to affordability, continuity of coverage, care coordination, and health system navigation.

Workforce Supply and Capacity

Nevada faces significant workforce and geographic access challenges that may limit timely access to care particularly in rural and frontier communities. Compared to neighboring states and national averages, Nevada has lower provider-to-population ratios across several key maternal and child health professions, including obstetrics and gynecology where an additional 82 providers are needed to meet national per capita benchmarks, pediatrics (262 additional needed), neonatology (20 additional needed), and family medicine (255 additional needed). The state ranks below the national average in every provider category included in Table 6, with particularly large shortages in pediatric and primary care. Provider supply is also unevenly distributed geographically, with nearly three-quarters of providers concentrated in Clark County.¹²

Table 6.
Workforce Supply

Profession	Active Providers	Ratio per 100,000 Population						Location Quotient (LQ)	Gap to National Average
		NV	AZ	NM	UT	CO	US		
Obstetrics and Gynecology	339	10.4	10.4	11.2	9.1	14.1	13.0	0.80	82
Family Medicine/General Practice	952	29.3	30.6	46.6	30.1	47.6	37.1	0.79	255
Pediatrics	336	10.3	14.4	17.3	14.4	17.1	18.4	0.56	262
Neonatal-Perinatal Medicine	45	1.4	1.2	1.3	1.9	1.8	2.0	0.70	20
Physician Assistant	1190	36.6	46.8	30.1	47.7	53.1	45.7	0.80	298

Source: AMA Physician Professional Data (2024) accessed via the AAMC U.S. Physician Workforce Data Dashboard (2026); US Census Bureau (2024), population estimates. Note. Some categories were combined for reporting.

These shortages contribute to broader maternity care access challenges across the state. Nearly half of Nevada counties (47.1%) are classified as maternity care deserts, compared to 32.6% nationally.¹³ Rural travel burdens are substantial, with nearly 40% of women in rural areas living more than 30 minutes from a birthing hospital, compared to 9.1% in urban areas.¹³ In some counties with highest travel burden, average travel times to the nearest birthing hospital exceed two hours. These geographic barriers may contribute to delays in prenatal care initiation, reduced continuity of care, and increased strain on health systems.

Shortages extend beyond obstetric care alone. Nevada also experiences widespread primary care and behavioral health workforce shortages, including Mental Health Professional Shortage Area (HPSA) designations affecting much of the state population, particularly in rural and frontier communities.¹² Given the importance of integrated behavioral health, chronic disease management, postpartum support in maternal health outcomes, and well-child and women visits, these broader workforce constraints may further impact access to comprehensive perinatal care services.

There are several emerging policy and infrastructure opportunities that could help address workforce and access gaps. Programs such as the Rural Health Transformation Program (RHTP), the Statewide Health Care Access and Recruitment Grant Program (SHARP), and Graduate Medical Education (GME) expansion initiatives may provide opportunities to strengthen provider recruitment, training, retention, and care delivery capacity, particularly in underserved regions and high-need maternal health specialties.¹⁴

Discussion

Cross Cutting Themes

Across the reports, data sources, and stakeholder findings reviewed, several consistent themes emerge. Challenges in maternal and infant health are not isolated to one point in care, one provider type, or population, but reflect overlapping issues related to timely access to care, workforce capacity, behavioral health and substance use, care coordination and system gaps, socioeconomic conditions, quality, and preventative care.

Taken together, the evidence suggests that Nevada's perinatal health challenges are best understood as system-level issues. Many families experience barriers before pregnancy, during prenatal care, at delivery, during the postpartum period, and throughout the infant's first year of life. These barriers are often interconnected; for example, limited provider availability may delay prenatal care, transportation or childcare barriers may make it harder to attend visits, behavioral health needs may go unidentified, and limited data infrastructure may make it difficult to identify gaps, coordinate care, or evaluate whether interventions are improving outcomes.

The reports also point to important opportunities. Nevada has existing programs, clinical providers, public health infrastructure, Medicaid coverage, managed care organizations, community-based partners, and emerging policy efforts that can be aligned to support maternal and infant health. The common theme across the literature is not simply that Nevada needs more services, but services must be easier to access, better coordinated, and more responsive to the needs of families across different regions and socioeconomic conditions.

Access to Care

A consistent theme across the literature is that many Nevada families face challenges accessing timely and appropriate prenatal, postpartum, behavioral health, and preventative care. These barriers are not limited to insurance coverage or region. They include health-related social needs, like transportation challenges, childcare, affordability, care navigation, and awareness of available resources. As a result, access to care varies significantly across the state and is shaped by a variety of factors, such as geography, socioeconomic conditions, and provider availability, among others.

This variation is important in the perinatal period because missed or delayed care can affect maternal health birth outcomes, postpartum recovery, behavioral health needs, and infant health. Rural and frontier communities face long travel distances and fewer local services, while urban communities face capacity constraints, affordability barriers, and fragmented referral pathways. Across the literature, the access challenges are not simply whether services exist, but whether pregnant and postpartum people can connect to the right care at the right time and remain engaged across the full continuum of care.

Workforce Capacity

Workforce capacity is a large driver of Nevada's access challenges. Shortages and uneven geographic distribution of providers limit the ability for families to receive timely prenatal, postpartum, behavioral health, pediatric, and preventive care. Shortages extend beyond OB/GYNs and include the broader perinatal care team such as family medicine providers, pediatricians, nurses, behavioral health providers, substance use treatment providers, care coordinators, community health workers, doulas, and social workers. Rural and frontier communities face the most visible gaps because many areas have few local maternity care options, but urban areas face capacity constraints as well. These limitations can contribute to delayed care, reduced postpartum follow-up and inconsistent access to supportive services across the perinatal continuum.

Care Coordination

Care coordination was a recurring theme across reports, particularly between phases of pregnancy, including prenatal, delivery, postpartum, continuing, and specialist care. The findings point to fragmented referral pathways, inconsistent workflows, and limited cross-provider communication as barriers that can affect both patients and providers. These challenges seem to reflect the difficulty of coordinating care across multiple organizations, programs, payers, and service systems that operate with different processes, data systems, and accountability structures.

These gaps can make it harder for families to understand available resources, complete referrals, access behavioral health or social supports, and remain connected after delivery. This suggests an opportunity to strengthen handoffs, clarify roles, improve communication between clinical and community partners, and build more consistent workflows across the perinatal continuum.

Behavioral Health and Substance Use

Behavioral health emerged as a leading driver of maternal mortality. Mental health conditions, including deaths by suicide and overdose related to substance use disorder are among the leading underlying causes of pregnancy-related death.¹⁵ Recent federal reviews attribute roughly two in five pregnancy-related deaths to mental health conditions and find that many of these deaths are preventable.¹⁵ The literature also notes that perinatal mental health conditions affected about one in five women yet remain among the most underdiagnosed complications of pregnancy.¹⁶ Behavioral health is best understood as a thread running through the other themes rather than a separate domain: identification depends on workforce capacity, sustained treatment depends on coordination across systems, and outcomes are shaped by stigma and by social conditions. In Nevada, reviewed maternal deaths reflect national findings with substance use and overdose appearing as a top contributor.¹⁷

Social Determinants of Health

Socioeconomic factors shape whether pregnant and postpartum people can access, navigate, and remain engaged in care. Across the reviewed reports, barriers such as transportation, housing instability, childcare, employment flexibility, affordability, language access, food insecurity, broadband access, and knowledge of available resources were repeatedly

identified as factors affecting perinatal health.^{7,11,17,18} These challenges can make routine care difficult to complete, particularly for families coordinating prenatal care, behavioral health, pediatric care, social services, and postpartum follow-up. The literature consistently contextualizes perinatal outcomes within broader socioeconomic conditions. Medicaid finances roughly 41% of births nationally and a higher share in rural areas, underscoring the program's central role in maternity care for lower-income populations.³ Nevada exceeds this benchmark, with Medicaid financing more than half of all births and disproportionate share of births among younger, Hispanic, and Black populations.¹⁹

Quality and Preventative Care

The factors described above contribute to Nevada's poor performance on maternal and women's health quality and prevention measures. National scorecards rank Nevada among the worst states for maternal health care quality and prevention, reflecting gaps in timely prenatal care, postpartum follow-up, preventative care, behavioral health screening and access to coordinated services.² These findings suggest that Nevada's challenges are not limited to individual outcomes, but reflect broader system issues that affect whether women and families can receive preventive, timely, and continuous care across the perinatal continuum. Additionally, there are notable quality infrastructure gaps including the absence of a statewide Perinatal Quality Collaborative. Nevada is one of only two states without a PQC, limiting the mechanism through which evidence-based standards are translated into consistent practice.²⁰ Quality and prevention are tightly linked to access, workforce capacity, and coordination. Outcome disparities across groups reflect both variation in clinical practice and the upstream conditions previously described.

Summary of Cross Cutting Themes

Overall, the reviewed reports point to interconnected challenges across the perinatal health system. Access barriers, workforce capacity, gaps in care pathways, behavioral health and substance use needs, social determinants of health, and quality and prevention each affect whether families can receive timely, coordinated and appropriate care. These themes provide a foundation for the Commission's next phase of work, evaluating practical, evidence-based policy concepts to improve perinatal health across Nevada.

V. Commission Collaboration

Throughout this reporting period, the Commission engaged state agency partners, clinical stakeholders, policy experts, and the public to build a shared understanding of Nevada's perinatal health landscape and identify opportunities for improvement. This included collaboration with Maternal Child Health (MCH) Title V, the Nevada Health Authority, Nevada Medicaid, Nevada Hospital Association and Nevada Rural Hospital Partners, Nevada Chapter of American College of Obstetricians and Gynecologists (ACOG), Princeton State Health and Value Strategies (SHVS), and other partners with expertise in maternal and infant health, health care delivery, payment reform, rural access, and system improvement.

The Commission also supported public engagement through open public meetings and opportunities for individuals and organizations to submit written policy recommendations. In addition, the Commission presented its interim perinatal health focus to the Interim Health and Human Services Committee to inform the legislature of the Commission's work. Commission staff also worked with MCH Title V, NVHA, Medicaid, and the Children's Cabinet to facilitate an application through the Center for Maternal and Child Health Medicaid Partnerships (CMMP) state technical assistance cohort (STAC). Nevada was accepted for this opportunity, which will support continued collaboration between Maternal Child Health and Medicaid to strengthen maternal health policy, care delivery, and system improvement efforts.

VI. Next Steps

Over the next six months, the Commission's perinatal health work will move from landscape review and issue identification toward evaluation of policy concepts and development of actionable recommendations. Building on findings summarized in this review, the Commission will assess potential policy options based on their expected impact, feasibility, fiscal considerations, implementation requirements, and alignment with Nevada's broader maternal and infant health needs. This process will help identify concepts for recommendation to the Governor, Legislature, Nevada Health Authority, and Department of Human Services.

The Commission's workplan will include continued stakeholder engagement, review of submitted policy recommendations, discussion of evidence-based and state-tested models, and refinement of concepts that may be advanced through legislation, regulation, Medicaid policy, agency action, programmatic initiatives, or cross-agency collaboration. The goal is to develop a focused set of practical, data-informed recommendations that address the most persistent challenges affecting moms and babies in Nevada.

VII. Conclusion

The Commission's review highlights Nevada's perinatal health challenges as interconnected and system-level in nature. Across the data and literature, recurring issues include access to timely care, workforce capacity, care coordination, behavioral health, social determinants of health, prevention and quality performance. These findings provide a foundation for the development of policies to improve perinatal health outcomes across Nevada.

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Appendix

Social and Economic Vulnerability Index (SEVI)

Index Purpose and Justification

The Social and Economic Vulnerability Index (SEVI) was developed to quantify neighborhood-level disadvantage and to capture the social context in which perinatal care occurs. The index is intended to supplement individual-level clinical and demographic variables by incorporating upstream social and economic conditions that influence access to care, care navigation, and health outcomes.

SEVI is conceptually aligned with established neighborhood vulnerability tools, including the CDC Social Vulnerability Index and the Area Deprivation Index, but was constructed using variables directly available from the American Community Survey (ACS) to reflect conditions most relevant to maternal and infant health in Nevada.

Data Sources and Geographic Unit

SEVI was derived using 2023 inflation-adjusted American Community Survey (ACS) 5-year estimates aggregated at the ZIP code level. Each ZIP code was scored relative to all other Nevada ZIP codes.

Index Construction

Variables were organized into conceptual domains representing employment, income and benefits, insurance coverage, poverty, housing and transportation stability, education and language, workforce participation, and digital access.

Each variable was standardized using a z-score transformation:

$$z = \frac{x - \mu}{\sigma}$$

where x represents the ZIP-code value, μ is the statewide mean, and σ is the statewide standard deviation.

Standardized values were summed across all variables for each ZIP code to create a composite vulnerability score. Composite scores were then rescaled to a 0–100 range, where 0 represents the least vulnerable ZIP codes and 100 represents the most vulnerable ZIP codes in the state.

SEVI Variable Definitions

Employment

- Unemployment rate

Income and Benefits (2023 inflation-adjusted dollars)

- Households with income less than \$10,000
- Households with income \$10,000–\$14,999
- Households with income \$15,000–\$24,999
- Median household income
- Households receiving Food Stamp/SNAP benefits in the past 12 months

Health Insurance Coverage

- Population with public health insurance coverage
- Population with no health insurance coverage

- Civilian noninstitutionalized population under 19 years with no health insurance coverage

Poverty

- Families with income below the federal poverty level
- Families with related children under 5 years of age below the poverty level
- Families with female householder and no spouse present below the poverty level
- Families with female householder and related children under 5 years only below the poverty level
- Families receiving Food Stamp/SNAP benefits in the past 12 months

Housing and Transportation Stability

- Households with no vehicle available

Education and Language

- Population with high school graduate or higher (reverse coded)
- Population who speaks English less than “very well”

Workforce Participation

- Families with all parents in the labor force
- Ratio of workers to dependents ≤ 1.00

Digital Access

- Households with a broadband internet subscription