ADVANCING

PERINATAL BEHAVIORAL HEALTHCARE

IN NEVADA

ROSEMAN UNIVERSITY OF HEALTH SCIENCES

LARSON INSTITUTE School of Public Health

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INTRODUCTION

About

This project examines the intersections between healthcare, behavioral health, child welfare, infant and early childhood systems in Nevada, identifying barriers to care that must be addressed to improve outcomes for perinatal women, their infants, and families.

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The content is solely the responsibility of the authors and does not necessarily reflect the official views of the State of Nevada or the Substance Abuse and Mental Health Services Administration.

It is our sincere intention to accurately reflect the perspectives of all who graciously shared their views and experiences with us as part of this project. All interviews were conducted anonymously, and no quote or statement is attributed to any person or entity to maintain confidentiality of our contributors.

ACKNOWLEDGEMENTS

Authors and Project Sponsors

This document was developed by Stephanie Woodard, Psy.D., Principal Consultant, Sierra Health Strategies and Clinical Associate Professor in the School of Public Health, University of Nevada, Reno, Munachimso "Muna" Emesobum, MBBS, MPH, Graduate Assistant, Sarbyen Sheni, MPH, Research Associate, and Jane Fox, MPH, Director, Larson Institute for Health Impact at the University of Nevada Reno School of Public Health in partnership with project sponsors, Andria Peterson, Pharm.D., Chair, Department of Bioethics, Humanism and Policy, Executive Director of the Roseman Medical Group EMPOWERED Program, School of Medicine, Roseman University of Health Sciences and Farzad Kamyar, M.D., MBA, Psychiatry Clerkship Director College of Medicine, Psychiatrist, Roseman Medical Group EMPOWERED Program, School of Medicine, Roseman University of Health Science.

Contributors

Significant contributions were made to this project by national subject matter experts, representatives from state agencies within the Nevada Department of Human Services, including the Division of Public and Behavioral Health, Aging and Disability Services Division, Division of Child and Family Services, and the Nevada Health Authority, healthcare providers including obstetricians, gynecologists, pediatricians, maternal fetal medicine specialists, psychiatrists, addiction medicine specialists, and behavioral health providers, committee members, professional medical association representatives, hospitals, health systems, payers, and child welfare agencies. This project was also informed by women with lived experiences of perinatal behavioral health issues.

A special thanks to the Department of Human Services, Office of Analytics, Nevada Health Authority, Office of Statewide Initiatives, Division of Public and Behavioral Health, Division of Healthcare Financing and Policy, Nevada Primary Care Association and University of Nevada, Reno, for contributing data to the project.

EXECUTIVE SUMMARY

Maternal and infant mortality rates in Nevada remain a significant concern despite advancements in health care coverage, efforts to expand access to high quality medical care, and emphasis on improving clinical practices for high-risk pregnancies and premature babies. Along with high rates of maternal and infant mortality, mental health and substance use challenges among women in the perinatal period in Nevada continue to rise. The presence of perinatal behavioral health conditions classifies a pregnancy as high risk, and as such, efforts to prevent, screen, and intervene early in pregnancy are paramount to addressing care needs and reducing poor outcomes for both pregnant women and their infants. Integrated, coordinated medical and behavioral health services focused on evidence-based, trauma-informed, and culturally relevant practices designed for pregnant and parenting individuals have been shown to improve maternal and infant health and reduce negative outcomes associated with untreated and undertreated behavioral health issues. Additionally, specialty care centered on caregivers' and infants' needs in the post-partum period can enhance positive outcomes by reducing involvement in child welfare and family justice systems, ameliorating the developmental impacts, and supporting strong starts for infants during critical developmental periods.

In response to perinatal health challenges, states like Nevada have been pursuing policy, financing, and evidence-based practice options to address the escalating rates of poor maternal and infant health outcomes connected to lack of adequate access to prenatal and post-partum care in a fragmented reproductive healthcare system. The advancements Nevada has made to date are necessary for improved perinatal behavioral health outcomes; however, they are not sufficient to support a sustained, statewide coordinated, systems approach.

EXECUTIVE SUMMARY

This project explores the intersections between healthcare, behavioral health, child welfare, and infant and early childhood systems, along with the barriers to care that must be addressed to continue making progress toward improving outcomes for pregnant women, their infants, and families. Barriers such as stigma, provider workforce shortages within behavioral health and healthcare, lack of comprehensive care coordination strategies, inadequate access to prenatal care, and limited access to care within the community all contribute to significant gaps in care that negatively impact perinatal health outcomes.

The scope of this project spanned across multiple systems, including healthcare, behavioral health, social services, child welfare, and developmental pediatric care. Contributors to this report included a broad range of healthcare providers, behavioral health practitioners, state agencies, health systems, payers, child welfare agencies, and women in substance use disorder treatment.

Through key informant interviews and focus groups, contributors offered insights into the barriers and facilitators regarding perinatal behavioral health integration as well as screening and linkage to specialized perinatal behavioral healthcare. They also gave insights into dyad-centered care, infant and early child mental health, the intersections of parenting and social supports, as well as child welfare. In addition, contributors provided perspectives on Nevada's current policies, practices, and funding strategies for perinatal behavioral health and made recommendations to improve outcomes through integrated, coordinated care across multiple systems. Common themes from the interviews and focus groups were analyzed and grouped into themes to reflect current facilitators and barriers for effective implementation of perinatal behavioral health best practices in the states.

EXECUTIVE SUMMARY

Geographic mapping of women's health and specialty behavioral health service availability in Nevada was conducted to better visualize the distribution of resources and burden of unmet need across Nevada's seventeen counties. This work is intended to inform policymakers and guide recommendations for a data-driven approach to addressing community needs across the state.

Recommendations were developed in collaboration with individuals who contributed to this work and include a proposal to use the interconnected systems framework to advance perinatal behavioral health in Nevada. The recommendations are informed by recognition of a range of structural barriers that contribute to the current fragmented systems of care. Despite many efforts by providers, systems, payers, advocates, and policymakers, a coordinated, collaborative approach is needed to reform existing policies and practices to align with best practices for implementation across multiple systems. The recommendations are written with the vision and sincere hope that they can serve as a foundation to continue the efforts of many to bring about the needed changes within multiple systems to enhance care and improve outcomes for pregnant women, their infants, their families, and their communities.

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KEY FINDINGS

Adverse Outomes

Unmet perinatal behavioral health needs in Nevada contribute to adverse outcomes for both mothers and their newborns.

Adverse outcomes include exposure to substances in utero, developmental needs, child welfare involvement, and increased maternal morbidity and mortality related to overdose and suicide.

Prenatal Care

Barriers to providing integrated and coordinated behavioral health screening and treatment include lack of access to adequate prenatal care, challenges with reimbursement for integrated care models, stigma, and difficulties accessing specialty care for behavioral health.

Funding

Several efforts, including the creation of legislative policy and standards of care, and allocation of funding exist to support the expansion of screening for mental health and substance use disorders during the perinatal period to identify pregnant and postpartum women in need of behavioral health care within medical settings

Care Coordination

Specialty care for perinatal behavioral health care is limited and difficult to locate.

Care coordination across systems and payers presents complexities for providers with limited time and resources to support referrals

KEY FINDINGS

Interconnected Systems

Challenges with navigating multiple systems with unclear eligibility requirements, including social services to address food insecurity, housing, transportation, and employment create additional barriers for pregnant and postpartum women and their families seeking care and resources.

Child Welfare

Child welfare systems lack the funding and resources to support prevention of child welfare involvement, family preservation, and family reunification, leading to high rates of child welfare involvement for families impacted by perinatal substance use.

Infant and Early Childhood Services

Infant and early childhood systems, including pediatric healthcare, childcare, and developmental services are fragmented and need a coordinated approach to serving families in need of care across systems

Multistakeholder Coordination

Efforts to address sustainable financing, care quality and outcomes, and alignment of policies and best practices with standards of care must be coordinated across state agencies while local communities coordinate resources and services to support navigation for women and families in need of care.

RECOMMENDATIONS

Recommendations in this report serve as a call to action for state policymakers, providers, healthcare systems, payers and funders, state agencies, and advocates to prioritize maternal and child health, recognizing that healthy starts for newborns and families begin during the critical perinatal period. Improved outcomes and enhanced quality of care can be achieved by integrating perinatal behavioral health into broader systems of care and aligning policy, financing, and practice strategies.

1

Develop a perinatal behavioral health strategic plan across state agencies within the Department of Human Services and the Nevada Health Authority as part of the Children's Behavioral Health Transformation and connected to the Managed Care Quality Strategy

2

Increase access and availability to coordinated specialty perinatal behavioral health services that are evidence-based, culturally responsive, trauma-informed, and focused on dyad centered care across the continuum of care.

3

Increase access to high-quality, comprehensive, integrated perinatal behavioral health care across primary care, reproductive health, hospital, and pediatric settings.

4

Establish regional-level perinatal behavioral health treatment networks to facilitate collaboration, communication, and resource sharing to support continuity of care and navigation to recovery supports.

5

Support families impacted by perinatal behavioral health issues to remain together and support infant and toddler development through connected early childhood systems.

METHODOLOGY

This project employed a mixed-methods approach, including qualitative data collected through key informant interviews and focus groups combined with quantitative analysis of several secondary data sources. To provide context for this report, we conducted a literature review of national and state-level data, research papers, policies, regulations, and guidelines related to perinatal behavioral health. These documents were identified through independent research by the team and recommendations from contributors.

Primary data collection was conducted using qualitative methods, including focus group discussions and key informant interviews with contributors relevant to the topic area, with national and Nevada experience and expertise. We also interviewed individuals with lived/living experience with perinatal behavioral health issues to gain insights from their experiences with the various systems they have encountered.
Interview/focus group guides were developed based on issues identified through a literature review and interviews with subject matter experts.

Key informant interviews and focus groups were facilitated using a semi-structured guide (see Appendix) comprised of questions related to facilitators and barriers related to:

- Implementation of perinatal behavioral health screening and referral to care;
- Social determinants of health (SDoH);
- Perinatal behavioral health care and specialty services;
- Perinatal behavioral health screening in hospital settings and Plans of Safe Care;
- Intersection of child welfare and the judicial system; and
- Developmental pediatric services.

With participants' consent, interview sessions were recorded and transcribed using Microsoft Teams and Otter.ai, and then systematically coded using Taguette.

METHODOLOGY

Through an inductive coding process, the research team analyzed transcripts and deliberated on emerging themes, which have been documented in the qualitative findings section of this report. The findings reflect the experiences of interviewees and highlight existing practices and policies as well as system gaps surrounding perinatal behavioral health in Nevada. To foster openness and ensure anonymity, no direct attributions are made to individual participants, agencies, or organizations.

MAPPING

With ArcGIS and ArcGIS Pro, the research team utilized secondary data from the following sources to develop a geographic mapping of women's health and behavioral health services available in Nevada(see appendix for mapping):

- Women's Set-Aside programs: Division of Public and Behavioral Health (DPBH).
- Home visiting initiatives: DPBH Data Dashboard.
- Federally Qualified Health Centers (FQHCs): Health Resources and Services Administration (HRSA), Uniform Data System (UDS) through Nevada Primary Care Association (NVPCA).
- Certified Community Behavioral Health Clinics (CCBHCs): DPBH Data Dashboard.
- Obstetrics and gynecology (OB/GYN) providers: Office of Statewide Initiatives, University of Nevada, Reno School of Medicine, based on analysis of the HRSA Area Health Resource File.
- Hospitals submitting CARA referrals: Plans of Safe Care forms collected under the Comprehensive Addiction and Recovery Act (CARA) from the Office of Analytics, Department of Human Services (DHS).

To assess the burden of substance use, supplementary datasets were requested from the Office of Analytics, Department of Human Services (DHS), through a formal data request. However, our data request to DHS could not be processed. We recommend that future mapping efforts include:

METHODOLOGY

- Overdose fatalities (county-level).
- Emergency department (ED) visits for non-overdose cases.
- Substance use–related ED visits (county-level).
- Open Child Protective Services (CPS) cases involving parental substance use.

LIMITATIONS

This report provides a snapshot of the current perinatal behavioral health system in Nevada. Due to the short duration of the project, our research was limited to an overview of the system and best practices. Lack of access to state data on county-level overdose fatalities, ED visits for non-overdose cases, substance use, emergency department visits, open CPS cases with parental substance use, and additional Medicaid utilization data also contribute to the limitations of this study. Purposive sampling was based on the availability of the contributors identified, and we acknowledge that the information contained in this report is likely not comprehensive.

To this end, we describe themes from across multiple contributors and consider this work exploratory rather than exhaustive. Additionally, the scope of this project was vast, covering the continuum of care from prevention and early intervention of behavioral health needs in the perinatal period through the post-partum period, including intersections with child welfare and infant and early childhood dyad care. Given the broad range of topics addressed, the study is limited in depth, offering only an initial glimpse into areas more appropriate for further investigation in future research. Future efforts may include additional datasets and insights from other invested contributors to provide a more in-depth examination of the multiple systems that intersect to support perinatal behavioral health and infant and early childhood care in Nevada.

PART 1

PERINATAL BEHAVIORAL HEALTH BEST PRACTICES

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Best practices for the prevention, identification, intervention, treatment and recovery support for behavioral health conditions in pregnant and post-partum women have been well-established in the literature and summarized as standards of care by national associations and federal agencies. While the evidence continues to grow as perinatal behavioral health practices are innovating, there is sufficient support detailing best practices at the clinical and policy levels that can serve as a foundation for an integrated and coordinated system of care. Below is a summary of key practices and policies in perinatal behavioral health.

PERINATAL BEHAVIORAL HEALTH SCREENING

Behavioral health screening (screening for substance use and mental health) has been recommended by several national associations including the American College of Obstetricians and Gynecologists (ACOG, 2019), American Association of Pediatrics (AAP, 2017) and the US Preventive Services Taskforce (USPSTF, 2019) for over a decade because of the adverse events associated with undiagnosed and untreated behavioral health issues during pregnancy and in the post-partum period. The Alliance for Innovation on Maternal Health (AIM) has created patient safety bundles to offer a "structured way to improve processes of care and patient outcomes (AIM, 2025). Patient safety bundles are collections of evidence-informed best practices, developed by multidisciplinary experts, that address clinically specific conditions in pregnant and postpartum women, aiming to improve care and health outcomes. Each AIM patient safety bundle includes details on implementation, resources, data collection measures, packages to support practice change at the health system and provider levels and learning modules to increase provider competencies.
The goal of addressing perinatal behavioral health is so high a priority that AIM currently has two of the eight core patient safety bundles focused on it: Care for Pregnant and Post-partum Women with Substance Use Disorders and Perinatal Mental Health Conditions (AIM, 2021).

PERINATAL BEHAVIORAL HEALTH BEST PRACTICES

Both patient safety bundles recommend that providers use validated screening tools to screen pregnant patients for mental health and substance use issues across care settings. Screenings should be administered with a trauma-informed, inclusive approach with an emphasis on patient strengths. Education for providers, office staff, patients, and patient-support networks can reduce stigma, address provider bias, and support the development of appropriate care pathways to address unique patient needs. The AIM perinatal behavioral health patient safety bundles underscore the importance of including patients in shared decision making, addressing risk, and overdose prevention. Care plans are recommended to include patient-selected natural supports (e.g., family members, friends) and community referral sources to address patients' holistic needs, including social determinants of health. Patient-centered care should be evidence-based and focus on overdose prevention and illness severity in a strength-based, contextually relevant approach responsive to the patient's values and needs (AIM, 2025).

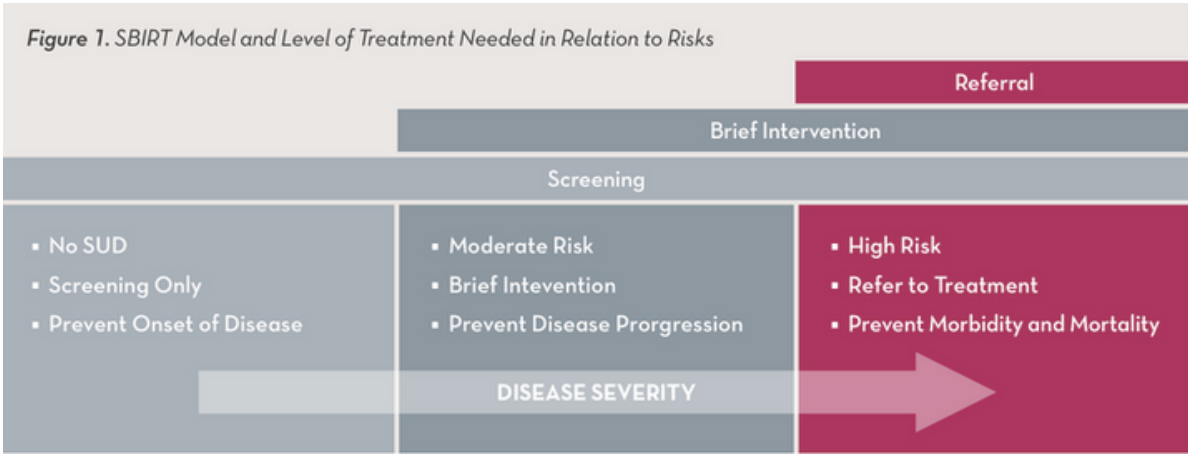


Figure 1: SBIRT MODEL, Source: Association of Maternal and Child Health Programs (AMCHP) Brief, 2020

PERINATAL BEHAVIORAL HEALTH BEST PRACTICES

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a best practice for addressing behavioral health among pregnant and postpartum women to improve maternal and child health outcomes (Association of Maternal & Child Health Programs, 2020). ACOG recommends early and universal screening for substance use and co-occurring mental health conditions as part of prenatal care (ACOG, 2019). Pregnancy presents a unique window of opportunity for behavior change, and routine screening during prenatal appointments serve as a timely avenue to detect and address behavioral health issues(Rockliffe et al., 2022). National reports and research studies indicate that universal screening using tools such as NIDA Quick Screen, PHQ-9, 5Ps, and 4Ps, among others, helps to determine an individual's level of risk for substance/alcohol use and facilitate referrals for specialty care (Association of Maternal & Child Health Programs, 2020; White et al., 2024). Key recommendations include incorporating SBIRT into existing protocols, particularly during the first prenatal visit, as universal screening for substance use remains the first step in identifying risk and connecting patients to the care they need (ACOG, 2017). Early detection enables timely intervention, counseling, and referral to reduce risks for mother and infant. In addition to screening, integrating brief interventions and coordinated referrals to behavioral health resources has been shown to improve awareness of substance use and motivation for behavior change (ACOG, 2017; Association of Maternal & Child Health Programs, 2020; Levy et al., 2016). For pregnant women with substance use disorders, coordinated care among obstetricians, specialty care providers, pediatricians, and community health services to provide medication-assisted treatment, behavioral therapy, care plans, and social support can help to improve their health outcomes and overall well-being.

PERINATAL BEHAVIORAL HEALTH BEST PRACTICES

BEHAVIORAL HEALTH INTEGRATION AND COLLABORATIVE CARE MODELS

Beyond early detection through screening, the research emphasizes the role of integrated and collaborative care models in managing perinatal health. Integrated care is the provision and coordination of holistic interventions for physical and behavioral health conditions, taking into account social determinants of health (National Council for Mental Wellbeing, 2022). This care strategy aims to reduce fragmentation and promote continuity of care throughout the perinatal period. The strategy is grounded in the Comprehensive Healthcare Integration (CHI) framework, which proposes care coordination, quality improvement, and linkages to community health infrastructure as a better approach to improve and sustain interventions (National Council for Mental Wellbeing, 2024). In addition, the AIM perinatal behavioral health patient safety bundles recommend developing workflows to integrate mental health care into obstetric settings, including pharmacotherapy (AIM, 2025). The report also recommends the integration of substance use disorder services into obstetric settings, including access to overdose prevention support and medications for the treatment of opioid use disorder (MOUD). When psychiatric or addiction medicine consultation is needed by obstetric providers to support care for women during the perinatal period, collaborative care models can be used as a bridge between prescribers and behavioral health specialists and the treating provider using a consultation model. Several models can be used for consultation, including the creation of collaborative care relationships to formalize care coordination and clinical consultation between providers or the use of a perinatal access line for case consultation (AIM, 2025; National Council for Mental Wellbeing, 2022; PSI, 2025). Behavioral health integration in pediatric settings is also a best practice, extending access to behavioral health care to women during the post-partum period and providing support for the social and emotional development of infants, toddlers, and children (Foy et al., 2025).

PERINATAL BEHAVIORAL HEALTH BEST PRACTICES

Health plans have leveraged payments for collaborative care models to promote the practice of providers working together to support people throughout the perinatal period in accessing specialty care. Examples include the Collaborative Care (CoMC) Model for the Perinatal Population, which APA endorses with some specific modifications to address the unique needs of this population (APA, 2019).

CARE NAVIGATION AND COORDINATION

Care navigation and case coordination are needed to ensure “warm hand-offs” and closed-loop referrals, connecting patients with community agencies who provide access to needed resources, such as housing, childcare, transportation, and employment/education American Academy of Pediatrics (AIM, 2025; National council for mental well-being, 2023). In addition, when a patient’s care needs exceed the capacity of obstetric or pediatric settings to provide care due to patient severity or complexity, referral to community specialty care is warranted. This requires providers to maintain an updated contact list of referral sources for care coordination. More formal care coordination arrangements may involve patient confidentiality agreements to enable collaborative care between providers and/or provider contracts to establish a reimbursement structure for care provided. Peer support specialists and case managers play critical roles in helping patients connect to community resources and care, and in addressing barriers to accessing care. Managed care organizations (MCOs) and other payers often provide case management and care navigation for high-risk pregnancies to ensure timely access to care and to address social determinants of health (SDoH).

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Social determinants of health refer to the social, behavioral, and systemic factors that encompass the lived environment, behavioral and social norms, and the systems that shape daily life. These factors directly influence access to care throughout the perinatal period, with major impacts on well-being and health

outcomes. For pregnant women with SUDs, barriers such as stigma and fear of involvement with child protective services limit their access to prenatal care (ACOG, 2011; Prince et al., 2023). This is further compounded by the broader social determinants of health including poverty, lack of transportation, unemployment, low income, homelessness, food insecurity, exposure to violence, lack of social support, and discrimination, creating a cycle of disadvantage for this vulnerable population (Girardi et al., 2023). Intimate partner violence is linked with increased risk of perinatal depression and suicidal ideation; housing instability and perceived lower socioeconomic status are associated with a higher risk of postpartum depression; and low social support is associated with antenatal depression, anxiety and self-harm during pregnancy (ACOG, 2023). A wide range of factors contribute to perinatal behavioral health conditions and the coordinated efforts to address perinatal behavioral health must take into context these social conditions that continuously affect prenatal and postpartum persons. By recognizing and integrating social determinants of health as predisposing factors, health systems can employ a comprehensive approach with interventions to address root causes and systemic barriers in prevention, treatment and recovery. Social determinants of health (SDoH) play a critical role in shaping access to health and behavioral health care, including prenatal care, perinatal behavioral health services, specialty services, and pediatric care.

PERINATAL BEHAVIORAL HEALTH TREATMENT

Standards of care for the treatment of perinatal behavioral health issues during pregnancy and the post-partum period have been widely promoted by the American Psychiatric Association, the American Society of Addiction Medicine, the American College of Obstetrics and Gynecology and the American Academy of Pediatrics. These standards of care support the delivery of timely, no-barrier access to comprehensive, evidence-based, trauma-informed, responsive, recovery-oriented, and holistic health and behavioral health services across a continuum of care in a range of settings. The care continuum for perinatal behavioral health includes settings such as integrated primary

care, obstetric and pediatric settings, home-visiting programs, outpatient behavioral health settings in collaboration with medical providers. It also includes high-intensity community-based care such as intensive outpatient treatment and partial hospitalization, residential treatment settings that allow for pregnant and post-partum women to reside with their child, and inpatient care for individuals needing acute care. Treatment for behavioral health conditions may include medications for the treatment of psychiatric or substance use issues, including MOUD, individual and group psychotherapy, peer recovery support, self-help and illness management recovery, psychosocial rehabilitation, basic skills training, and parenting education and support.

The intensity of care should be matched to a patient's needs and address both physical and behavioral health conditions. During the post-partum period, care should be centered on the dyad, ensuring both the parent and the newborn's needs are addressed. Post-partum hospital-based practices, such as Eat, Sleep, Console (ESC), encourage early parental bonding and comfort for infants who are at-risk for or are experiencing withdrawal. Supportive dyad care in the post-partum period, instead of mother/infant separation for the treatment of neonatal abstinence syndrome, has been shown to result in positive outcomes for both the infant and post-partum parent (Gold et al., 2025). Programs providing specialty care for pregnant and post-partum women should be informed by an infant and early childhood mental health (IECMH) paradigm. These programs may be endorsed by national organizations, such as the Association for Infant and Early Childhood Mental Health and Post-Partum Support International, to meet IECMH standards.

Finally, federal regulations for the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) require states to ensure pregnant women are prioritized for treatment services and that such services are broadly advertised to ensure timely access to care (SAMHSA, 2023). Under 45 CFR 96.131, states are required to monitor the capacity of funded treatment programs through a continually updated system, in an effort to match pregnant women with appropriate care as quickly as possible and to ensure

that interim services are provided within 48 hours if appropriate care cannot be located (Code of Federal Regulations, 2025).

CARE COORDINATION FOR HOSPITAL DISCHARGE USING PLANS OF SAFE CARE

Additional best practices for care coordination include the development of comprehensive hospital discharge plans, called Family Care Plans or Plans of Safe Care, for newborns impacted by perinatal substance exposure. Comprehensive hospital discharge plans support continuity of care between the hospital and outpatient medical providers for post-partum follow-up and newborn care with pediatricians. Following the federal passage of the Comprehensive Addiction and Recovery Act (CARA) in 2016, states were required to establish specific criteria for healthcare providers to determine if substance exposure during pregnancy has resulted in 1) Fetal Alcohol Spectrum Disorder (FASD), 2) withdrawal symptoms, or 3) meeting the state's definition of "affected by" prenatal substance use (CADCA, 2016; United States Code, 2012). Family Care Plans/Plans of Safe Care are developed prior to the infant's discharge to ensure their safety and well-being, and include a plan to address the infant's health and the caregiver's substance use treatment needs through referrals to treatment, supportive services, and community resources. Family Care Plans/Plans of Safe Care are also required to result in a notification to the state child welfare agency, without identifying information, as part of a larger public health surveillance strategy (Pregnancy Justice, 2020). States are required to establish systems to collect and report on notifications to the child welfare agency; however, such notifications are intended to be anonymous and are not considered reports to child welfare for abuse or neglect. Common misconceptions about the federal laws regarding Plans of Safe Care have resulted in efforts to clarify the requirements of the Child Abuse Prevention and Treatment Act (CAPTA), which first delineated the requirements for states to develop policies and procedures for medical providers to identify infants who meet the criteria for a Plan of Safe Care. Such clarifications underscore that substance exposure does not, in and of itself,

demonstrate abuse or neglect. Notifications of substance exposure meeting the criteria for a Plan of Safe Care should not be handled as a report to child welfare agencies and should not be treated in the same manner as suspected abuse or neglect. Federally authorized CAPTA funding to states is provided, in part, to support states in creating and designing programs to support infants and their families (Pregnancy Justice, 2020). Model legislation has been developed to support states in implementing a comprehensive approach to addressing perinatal substance use through policies that provide protection for pregnant and postpartum individuals with substance use disorders against legal/criminal penalties for receiving medical care including MOUD and establishes that an infant affected by withdrawal or parental substance use alone is not sufficient reason to report the parent for child abuse or neglect (LAPPA, 2023).

CHILD WELFARE

The child welfare system plays a significant role in perinatal behavioral health as it intersects with the systems of care related to both parents and children. The system is designed to protect children's well-being by ensuring their safety and working towards permanency and stability. Although it is not structured to directly address the needs of postpartum parents, it presents an opportunity for the coordination of care for pregnant and post-partum women experiencing behavioral health issues. However, most families' point of involvement with the child welfare system is due to reports of suspected child neglect or abuse (Child Welfare Information Gateway, 2025). Pregnant and post-partum women with mental health challenges or substance use disorders may face increased scrutiny or risk of custody issues, which may influence their willingness to seek care. These considerations highlight the importance of trauma-informed practices and collaboration between child welfare agencies, healthcare providers, health systems, and behavioral health providers. Child welfare officers can identify parents with behavioral health challenges and make timely referrals for trauma-informed interventions that can support treatment and recovery, divert families away from child welfare involvement,

and bolster natural supports with prevention and family preservation services while ensuring the safety and well-being of infants and young children (Child Welfare Information Gateway, 2016). To strengthen families, it is important to employ family-centered approaches focused on the needs of both children and their mothers/caregivers. By fostering interagency collaboration and supportive, non-punitive approaches to coordinated healthcare, infant and early childhood services and child welfare can more effectively address the complex needs of families, reduce stressors, and promote healthier outcomes for both parents and children.

MEDICAID PERINATAL HEALTH INNOVATIONS

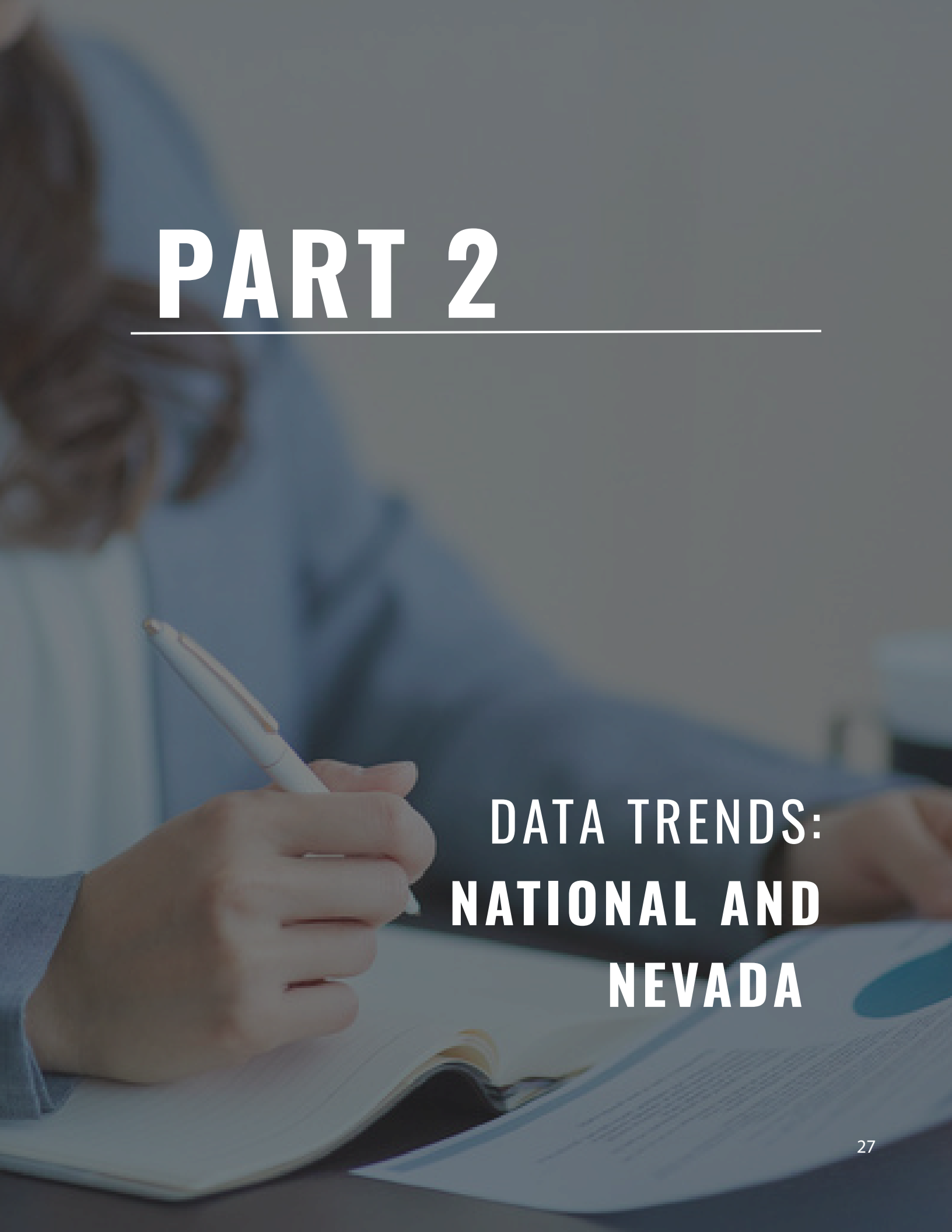
The Centers for Medicare and Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI) have created programs to promote the innovation and implementation of integrated and coordinated care for perinatal behavioral health, including the Maternal Opioid Misuse (MOM) Model (CMS, 2020). The MOM Model supports states in designing programs to reduce fragmentation of care for pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD), including the coordination and integration of health, behavioral health, well-being, and recovery services. CMS has also promoted opportunities for states to innovate and improve health outcomes for individuals with chronic health and behavioral health conditions with initiatives promoting behavioral health integration through the Health Home Model (CMS, 2010) and has specifically targeted the improvement of perinatal health with the Transforming Maternal Health (TMaH) model (CMS, 2025). States have expanded Medicaid eligibility to additional high-need populations, such as pregnant women, and have extended coverage for the post-partum period, recognizing the need for continuity of care. They have also created reimbursement structures to encourage integrated care models, such as collaborative care. State Medicaid authorities have driven quality and outcome initiatives through quality collaboratives to support benefit design and implement measures to monitor quality and outcomes for high-risk, high-cost populations, including high-risk pregnancies (NCSL, 2023).

States have also established value-based payment structures focused on quality and outcome measures and increased data collection and reporting requirements to use national quality and outcome measures that often include timeliness and access to prenatal care, screening for maternal depression and substance use, referrals to appropriate care for a positive screen, and developmental screening in pediatrics including screening for perinatal behavioral health issues and social determinants of health (CMS, 2020). State Medicaid authorities have established health information technology innovations to improve communication between providers and health systems for continuity of care, including requiring the use of electronic health records and health information exchanges, and developing all-payer claims databases to analyze data across payers to evaluate the types, costs, and outcomes of care being delivered across health systems (ACPD, 2025; CMS, 2021).

IMPLEMENTATION OF INTEGRATED PERINATAL BEHAVIORAL HEALTH USING AN INTERCONNECTED SYSTEMS FRAMEWORK

The interconnected systems framework (ISF) for the integration of perinatal behavioral health into primary care settings has been used to guide health system-level planning, design, implementation, and adaptation (Hameed et al., 2024). The framework integrates mental health support into broader systems of care to address the complex needs of pregnant and post-partum women and their families. It shifts from an individualistic, biomedical view to one that emphasizes community, social determinants of health, and the interplay between physical and mental well-being. This approach encourages collaboration among stakeholders, systematic integration of evidence-based interventions, and the creation of a more cohesive, accessible, and equitable system of perinatal care at the community and health system levels. Key elements of the ISF include the use of a systems thinking approach, a focus on integration of care and the connections between systems, a commitment to address social determinants of care as drivers of health, engagement of invested stakeholders at the policy, financing and community levels, prioritizing experiences of individuals with lived/living experience, and using

implementation science to guide the design and implementation of the system. The interconnected systems framework for perinatal mental health advocates for a paradigm shift in how care is delivered, moving towards a more unified, equitable, and community-centered approach supporting the well-being of pregnant and post-partum women and their families by addressing the complex interplay factors influencing their health. By extending the ISF beyond primary health settings to include other systems with touchpoints to perinatal health and behavioral health, the framework can be comprehensive and have a greater impact across the care continuum. It is recommended the ISF include pregnant and parenting women, infants, and families, hospitals and birthing centers, reproductive health providers, Medicaid, child welfare and the family court system, infant and early childhood services, including early intervention and pediatric services, and perinatal behavioral health providers. Together, these systems contribute to the larger perinatal behavioral health system. This inclusive approach is needed to reduce silos contributing to fragmented care, resulting in gaps between systems and to enhance continuity across systems for a more coordinated and comprehensive system design.



PART 2

DATA TRENDS: NATIONAL AND NEVADA

NATIONAL AND NEVADA DATA

PREVALENCE OF PERINATAL MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Perinatal behavioral health conditions, which include mental health conditions and substance use, during pregnancy and postpartum period (up to one year after delivery), are common and yet, often go undetected or undertreated

1 in 5 women are affected by mental health conditions during the perinatal period, including symptoms of depression, anxiety, and sadness affect (WHO, 2022).

Rates of women diagnosed with PPD increased 10% from 2010 to 2021(Policy Center for Maternal Mental Health, 2025).

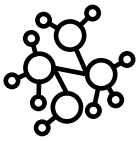
Post-partum depression (PPD), major depression occurring within the postpartum period is estimated to impact 1 in 8 women (CDC, 2024).

Methamphetamine use during pregnancy is an emerging issue. A cohort study of 2008-2019 births in California found that prenatal methamphetamine use occurred in 0.39% of pregnancies and is associated with increased risk of high blood pressure, severe maternal mortality, NICU admission, and infant mortality (Hayer et al., 2024).

NATIONAL AND NEVADA DATA

Approximately **50%** of postpartum depression cases remain undiagnosed, often due to low rates of self-reporting largely attributed to stigma (Zauderer, 2009).

Substance use during pregnancy, including alcohol, opioids, tobacco, and illicit drugs, is a public health concern with significant impacts on both infant and maternal health. Prevalence rates of reported substance use among pregnant women over the past month: 9.4% tobacco or nicotine use, 8.4% alcohol use, 4.9% illicit drug use, 4.4% marijuana, 0.2% opioids, and 0.2% cocaine (NASADAD, 2025)



Polysubstance use during pregnancy is common and often involves alcohol, cannabis, and nicotine (England, 2020; Tran et al., 2023).

Opioid use among pregnant women has increased over the past two decades, contributing to a 5-fold increase in the number of cases of Neonatal Abstinence Syndrome (Policy Center for Maternal Mental Health, 2025).

Cannabis is the most frequently used illegal drug during pregnancy and is common among women of reproductive age (SAMHSA, 2014). Although it remains illegal at the federal level, its legalization across different states has increased its accessibility contributing to its high prevalence rates.

An estimated 34 – 60% of cannabis users continue to use during pregnancy, believing it is relatively safe (ACOG, 2017) or as a means to manage pregnancy-related symptoms (Sood et al., 2022), despite clinical guidance recommending discontinuing use during pregnancy (ACOG, 2025).

PART 2

PERINATAL BEHAVIORAL HEALTH OUTCOMES

Untreated mental health and substance use disorders during pregnancy can lead to negative neonatal outcomes such as preterm birth, low birth weight, and early childhood developmental delays (CDC, 2024; Ragsdale et al., 2024; Shi et al., 2021; Viteri et al., 2015).

Up to 20% of perinatal postpartum maternal deaths are due to suicide, making it one of the top three causes of pregnancy-related death in the U.S. (Campbell et al., 2021; Palladino et al., 2011). Substance use disorders are linked to pregnancy-associated deaths particularly unintentional drug overdoses and suicide (Duggal et al., 2025; Trost et al., 2021).

When left untreated, perinatal depression can increase the risk of suicide, interfere with family relationships, disrupt caregiving, and may also contribute to lasting emotional, behavioral, and developmental issues in the growing infant (Valdes et al., 2023).

Perinatal behavioral health is a critical factor influencing maternal and infant health outcomes.

PERINATAL BEHAVIORAL HEALTH OUTCOMES

The resulting burden of untreated perinatal behavioral health conditions places significant cost implications on the US healthcare system with estimated annual costs of $14 billion (Luca et al., 2020).

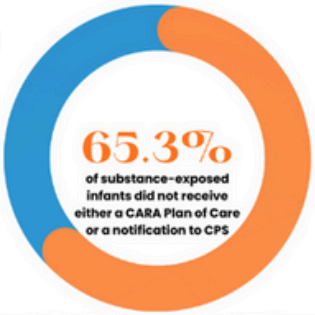
A Mathematica analysis of the economic burden of untreated perinatal mood and anxiety disorders in the U.S. found an average of $32,000 per affected but untreated mother-child dyad and a total estimated cost of $14.2 billion for births in 2017, with over half ($7.5 billion) incurred within the perinatal period (Mathematica, 2019).

PART 2

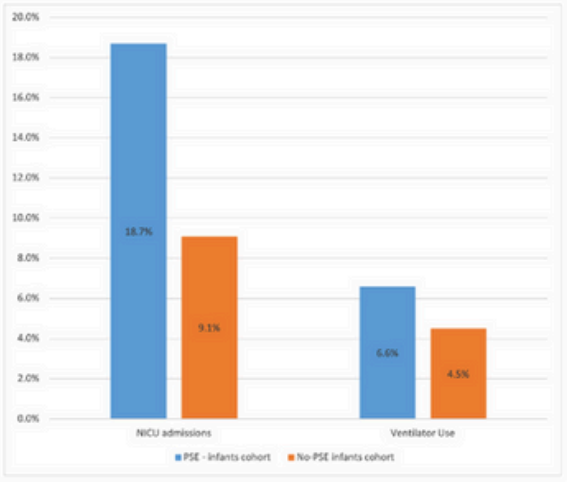
PERINATAL BEHAVIORAL HEALTH OUTCOMES

HEALTH OUTCOMES OF INFANTS WITH GESTATIONAL EXPOSURE TO SUBSTANCES IN NEVADA (2018-2020)

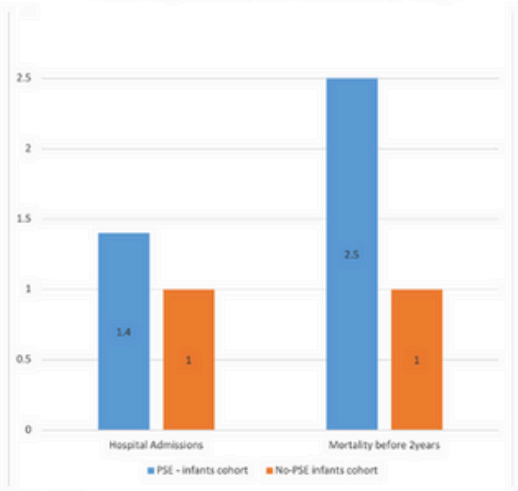
Infants with prenatal exposure(PSE) to substances face significantly higher risks of adverse health outcomes and are **9.2 times more likely** to have a CPS report than non-exposed infants. Yet, more than half leave the hospital without a plan for care if they show no immediate adverse effects at birth.



They are **twice as likely to** require medical interventions at birth; NICU visits (18.7% vs. 9.1%) use of ventilators (6.6% vs. 4.5%)



They are **1.4 times more likely** to be admitted to the hospital and **2.5 times more likely** to die before their second birthday.



Data Source: Office of Analytics, DHS

Mothers with a history of a substance-exposed pregnancy had a

70%

likelihood of substance use recurrence in future pregnancies.

At least

12%

of infants born in Nevada have been gestationally exposed to substances.

PERINATAL BEHAVIORAL HEALTH OUTCOMES

Gestational exposure to maternal substance use in utero contributes to negative health outcomes for mothers and infants.

Mothers who used substances during pregnancy are more frequently separated from their newborns at birth, resulting in increased stressors and trauma. They are also twice as likely to use substances in subsequent pregnancies as mothers who were not separated from their newborns (Reddy et al., 2024).

Child Protective Services (CPS) involvement is listed as one of the top social/emotional stressors among the recorded pregnancy-associated deaths in the Maternal Mortality Review Committee (MMRC) 2022-2023 report (Office of Analytics, 2024b).

Additionally, not all newborns with gestational exposure meet the criteria for a CARA Plan of Care; a substantial number of infants in Nevada's hospitals are discharged with CARA Plans of Care, demonstrating an opportunity for care coordination and support to navigate to necessary resources for maternal and infant care (Figure 3). Nevada hospitals have variable rates of CARA Plans of Safe Care (Figure 4). Data from an initial analysis of CARA Plan of Safe Care hospital data may guide additional exploration of the rates of CARA Plans of Care by hospital and county, noting that CARA Plans are developed by the discharging hospital for the newborn, and data is not currently available to determine the county of residence of the discharged infant. As illustrated in the gestational exposure report (Figure 2) and CARA plan data (Figures 3-4), there are gaps reflecting systemic barriers to care across Nevada's current perinatal health care system, including a lack of prenatal care resulting in maternal substance use going undetected and untreated during pregnancy.

CARA PLANS: DATA TRENDS

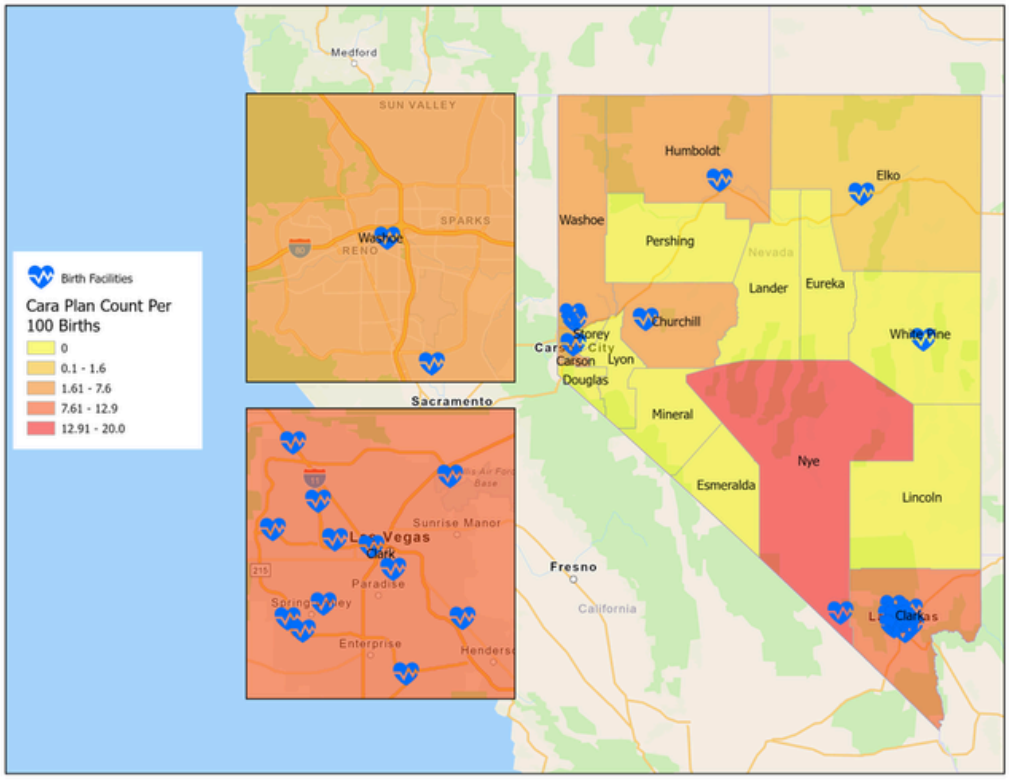


Figure 3: CARA plans per 100 births by facility (2021 - 2024)

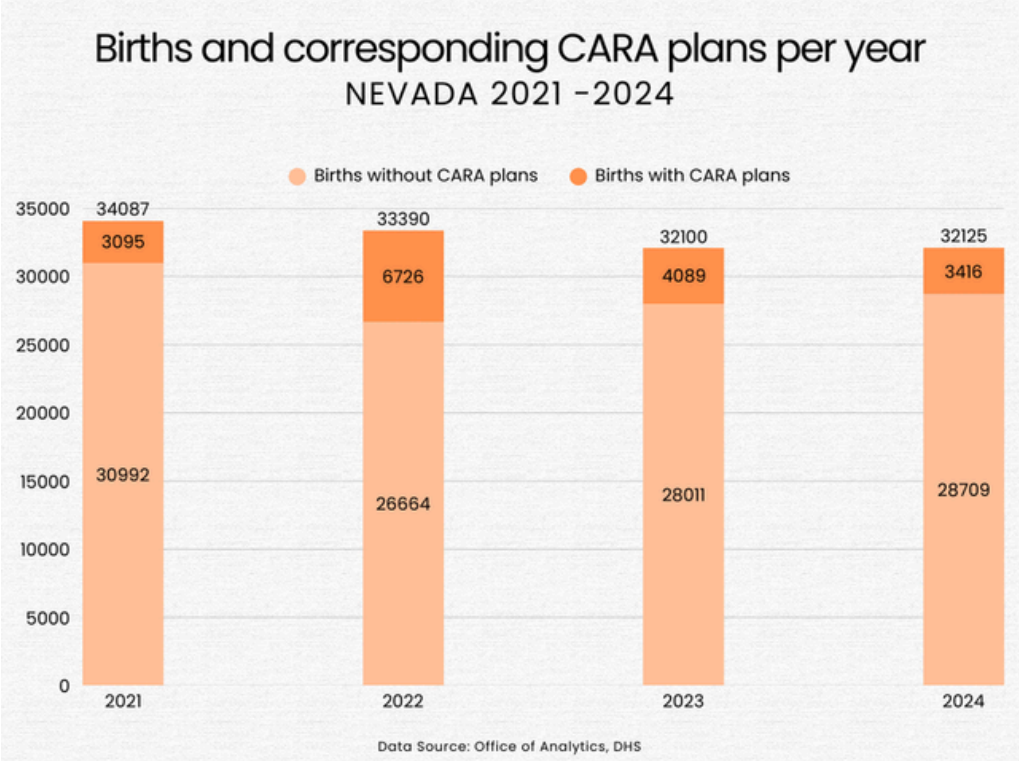


Figure 4: CARA Plan Counts per NV Facilities

NEVADA'S EFFORTS TO ENHANCE SCREENING AND IMPROVE QUALITY OF CARE

PERINATAL BEHAVIORAL HEALTH SCREENING INITIATIVE

Nevada Department of Human Services has promoted universal behavioral health screening using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocols as part of the state's public health effort to address opioid use disorder, with a primary focus on screening pregnant women for substance use disorders. The Perinatal Health Initiative (PHI) was created in 2017 to develop a multistate agency strategic plan, informed by subject matter experts across neonatology, psychiatry, addiction medicine, and maternal fetal medicine, to address the increasing rates of neonatal abstinence syndrome in newborns following gestational exposure to opioids and other substances. The PHI created and disseminated two reference guides to educate providers on SBIRT: Reference Guide for Reproductive Health Complicated by Substance Use-updated 2025 (PHI, 2025) and Reference Guide for Labor and Delivery Complicated by Substance Use-updated 2021 (Kamyar, 2021) and provided funding through the State Opioid Response grant focused on training and technical assistance for providers to support implementation of SBIRT as outlined in the reference guides. Assembly Bill 442 (2021) requires health providers and prescribers receive training on SBIRT (Nevada, 2021). Nevada also addresses maternal health screening through the Division of Healthcare Financing and Policy (DHCFP), which reimburses up to three screenings within the first year postpartum when billed under the newborn's Medicaid number. (Billing code 99420, Description: Health-risk assessment for postpartum depression)(DHCFP, 2017). In Nevada, Medicaid covered approximately 42% of all births (13,206 births) in 2023 (KFF, 2023),.

Despite these collective efforts, uptake in substance use screening at the provider level is still low and it demonstrates a comprehensive approach to address barriers to screening is needed to increase screening rates.

NEVADA'S EFFORTS TO ENHANCE SCREENING AND IMPROVE QUALITY OF CARE

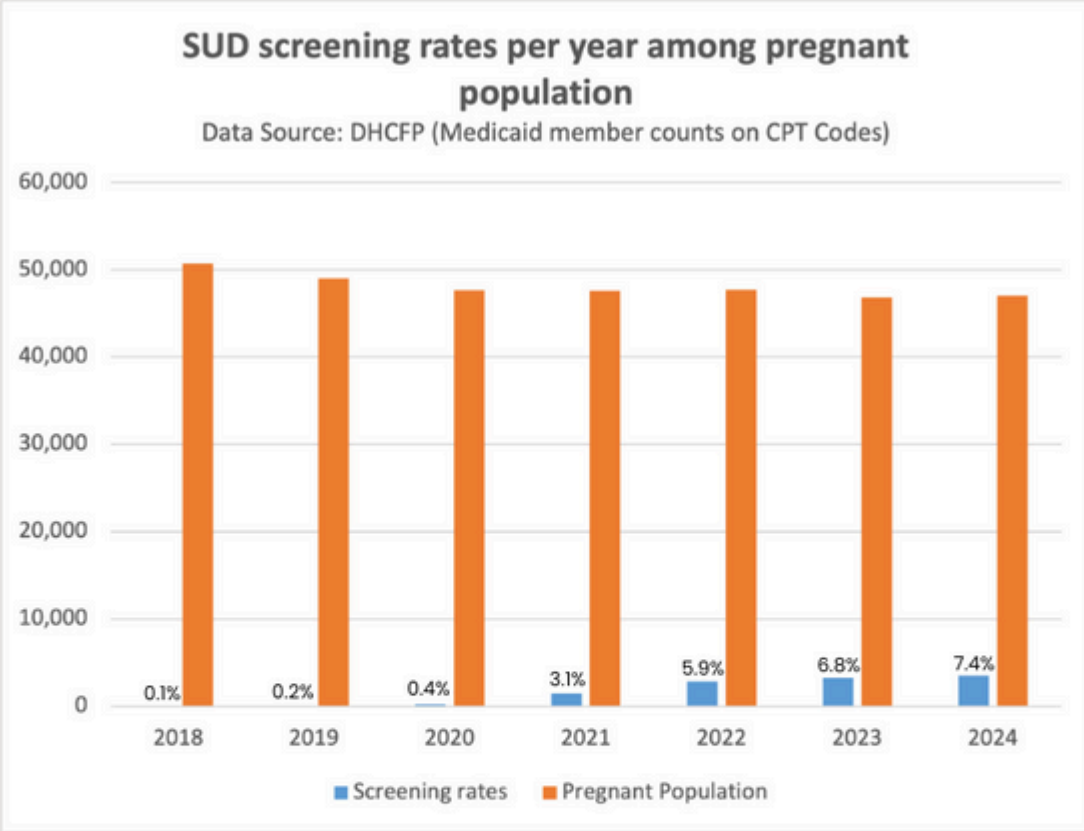


Figure 5: SUD screening rates among pregnant women (2018 -2024). Source: DHCFP

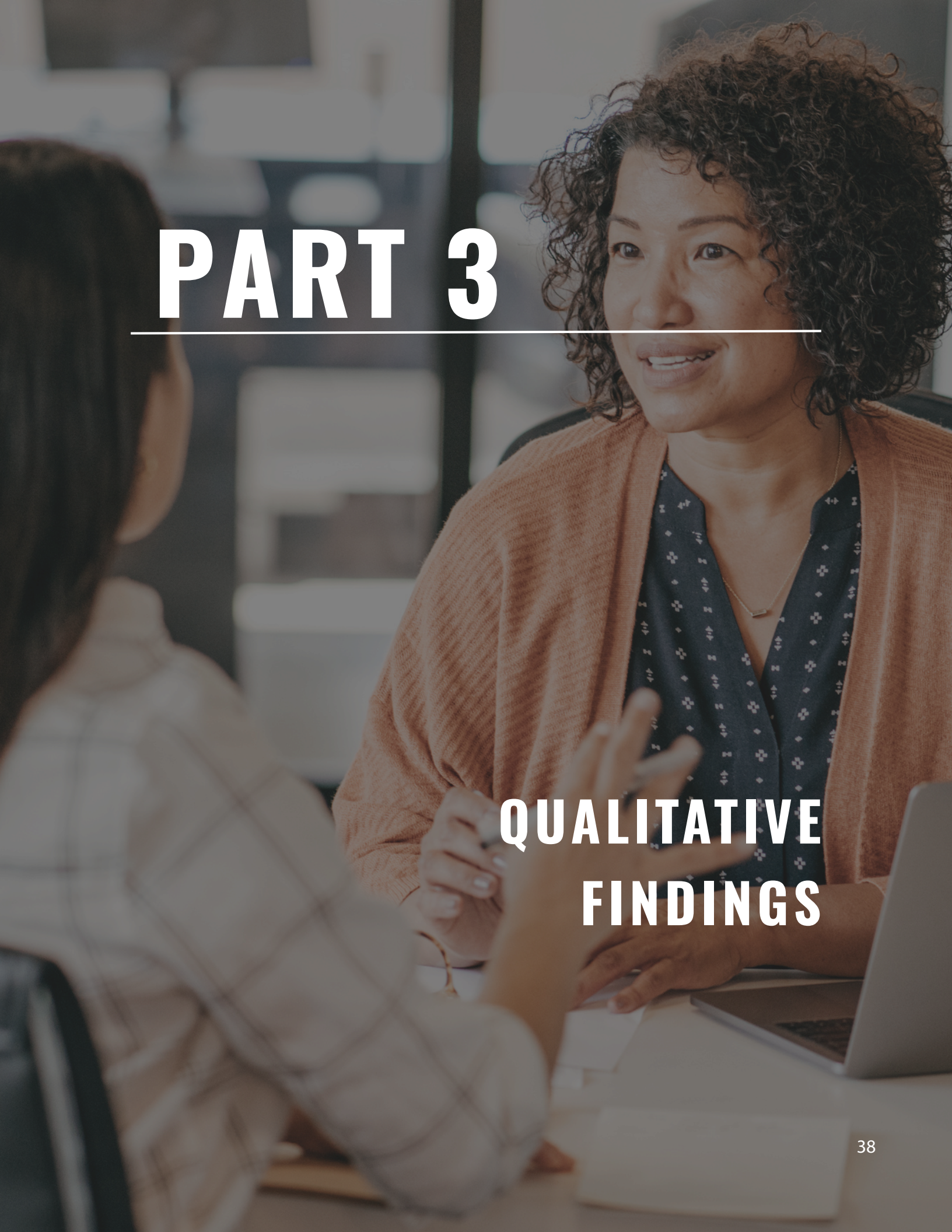
Medicaid data indicates a progressive increase in substance use disorder screening among the pregnant population (0.1% in 2018 to 7.4% in 2024; Figure 5), overall screening rates remain exceptionally low.

NEVADA MEDICAID QUALITY STRATEGY 2025-2027

The Nevada Health Authority recently established “high-risk pregnancy” provisions in all managed care contracts beginning January of 2025 and classify a behavioral health condition as a qualifying condition for enhanced case management. The Nevada Health Authority has also prioritized prenatal care, prevention services, behavioral health, and addressing disparities in the updated 2025-2027 Quality Strategy for managed Medicaid (DHCFP, 2024). The 2025-2027 Quality Strategy includes measures for timeliness of prenatal visits, depression screening and follow-up in the prenatal and post-partum period, initiation and engagement in substance use treatment, 7-and 30-day follow-up after discharge from inpatient or residential care for substance use disorder treatment, and developmental screenings between birth and age 3.

The Quality Strategy also requires MCOs to stratify data for performance measures by race, ethnicity, sex, and geography to determine where disparities exist to implement plans to reduce disparities. Priority conditions in the Quality Strategy include high-risk or high-cost substance use disorders, including opioid use disorders, members with co-morbid (physical and behavioral health) conditions, adults with serious mental illness, and high-risk pregnancy, including members who are pregnant and have an opioid use disorder or history of substance use disorder.

While not all these priority conditions directly relate to perinatal behavioral health conditions, it is likely that most, if not all, members with prenatal or post-partum behavioral health conditions would meet criteria for one or more priority conditions. Nevada Medicaid’s Quality Strategy represents an opportunity to align standards of care, measures, case management requirements, and provider incentives to improve quality of care and outcomes for pregnant and post-partum women with perinatal health and behavioral health needs.



PART 3

QUALITATIVE FINDINGS

QUALITATIVE ANALYSIS OF PERINATAL BEHAVIORAL HEALTH IN NEVADA

To gain insight into the barriers and facilitators to the effective implementation of perinatal behavioral health in Nevada, key informant interviews and focus groups were conducted using a semi-structured interview format. Contributors included a broad range of healthcare providers, behavioral health practitioners, representatives from state agencies, health systems, payers, child welfare agencies, and women in substance use disorder treatment. They offered insights into the barriers and facilitators regarding perinatal behavioral health screening and linkages to specialized perinatal behavioral healthcare. Contributors provided insights into dyad-centered infant and early childhood care and the intersections with parenting and social supports as well as child welfare. They provided perspectives on Nevada's current policies, practices, and funding strategies for perinatal behavioral health, and made recommendations outlining opportunities to improve outcomes through high-quality, sustainable, connected, and coordinated care.

The semi-structured interviews and focus groups included questions across the following domains:

- Implementation of perinatal behavioral health screening and referral to care;
- Social determinants of health (SDoH);
- Perinatal behavioral health care and specialty services;
- Perinatal behavioral health screening in hospital settings and Plans of Safe Care;
- Intersection of child welfare and the family judicial system; and
- Developmental pediatric services, parenting support and post-partum care.

Qualitative data analysis revealed consistent themes across interviews and those themes are summarized below. Special attention was given to responses from individuals with lived/living experience, and these are highlighted when themes emerged that contrasted with those of other respondents, to ensure their insights and experiences were represented in the summaries.

QUALITATIVE ANALYSIS OF PERINATAL BEHAVIORAL HEALTH IN NEVADA

Each domain includes a summary of relevant contextual and background information, along with detailed findings.
It is important to note that while each domain has been defined and evaluated as a distinct construct, the domains are interconnected within and between systems and, therefore, have interdependencies and shared landscape between them. For this reason, we have identified cross-cutting themes spanning across the domains and summarized them as a distinct domain.

PERINATAL BEHAVIORAL HEALTH: SOCIO-ECOLOGICAL MODEL

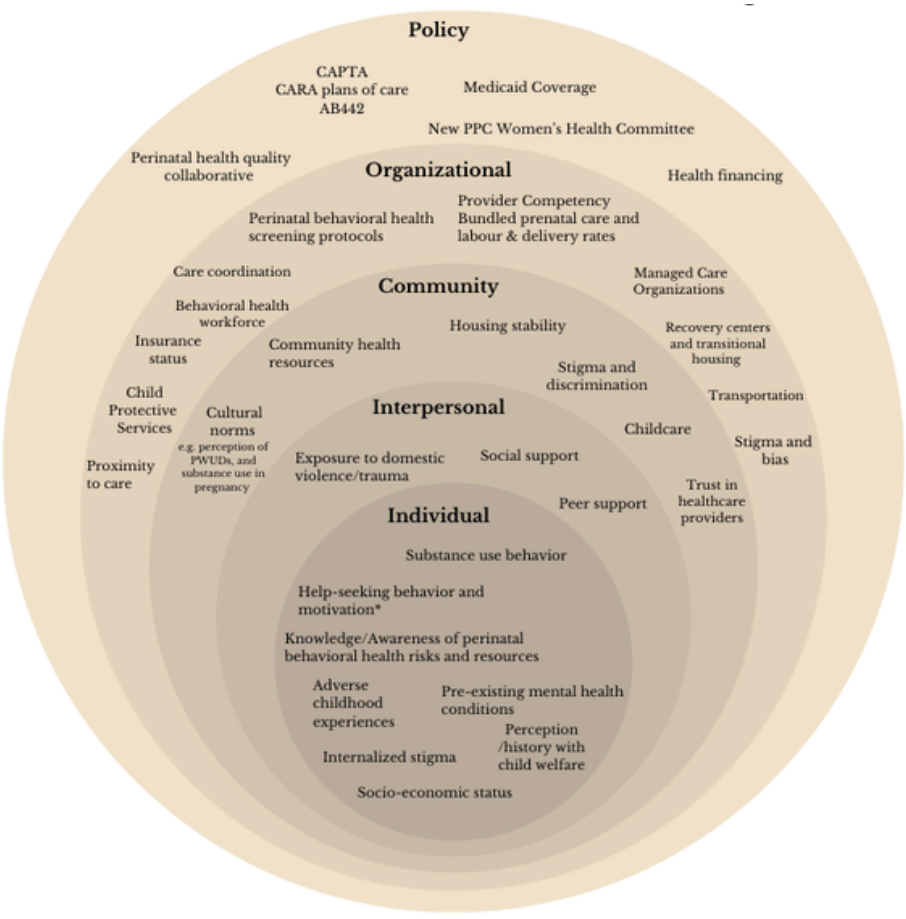


Figure 6: Health outcomes of infants with gestational exposure to substances in Nevada

QUALITATIVE ANALYSIS OF PERINATAL BEHAVIORAL HEALTH IN NEVADA

PERINATAL BEHAVIORAL HEALTH: SOCIO-ECOLOGICAL MODEL

The socioecological model (Figure 6) illustrates our findings by illustrating the interconnectedness of the factors influencing perinatal behavioral health. At the individual level, personal characteristics such as substance use, mental health conditions, perceptions of child welfare, internalized stigma, knowledge of prenatal and postpartum behavioral health risks and resources, adverse childhood experiences and socio-economic status influence outcomes for both mother and infant. The interpersonal level highlights how social networks, and social interactions promote or hinder general well-being and recovery during the perinatal period. At the community level, social determinants of health and cultural norms influence how pregnant and post-partum persons experiencing behavioral health conditions access health services and other community resources. It depicts how the social environment can affect a family's capacity to thrive. The organizational level comprises existing systems that define the current scope and quality of perinatal behavioral health services. Lastly, the policy level includes federal and state legislations and funding mechanisms that determine the policy environment for care coordination.

CROSS-CUTTING THEMES

Themes in this domain include the influence of stigma and bias, quality and outcomes across systems and care settings, siloed systems, aligned standards of care and incentives, accountability and oversight, system integration, use of evidence-based interventions and best practices, capacity building, sustainability, and workforce.

FACILITATORS

Agencies have begun to provide sensitivity and implicit bias training to staff to address stigma and bias within their services delivery system and have seen positive results from such training. Grant funding has supported innovation and capacity building within health and behavioral health systems. Federal funding continues to be allocated to Nevada to support access to care, services, and programs through multiple state agencies. These programs include child welfare services for prevention, reunification, and family preservation, home visiting, behavioral health services, including women's set-aside funding, and early intervention services to support infant developmental milestones. Opioid settlement litigation funding through the Fund for Resilient Nevada has identified perinatal substance use as a priority and has provided funding to support programs that address the needs of this population.

> *"You can't get a new program off the ground without taking a hit to your income. And so federal funding or state funding can really bridge that gap. And we already see that when we invest in these communities, we have great outcomes. So I'm continuing to encourage our legislators to set aside funds for this so that we can have healthier pregnancies and change lives because if you treat someone with addiction and they get pregnant, you're treating two people. So you're changing two lives at once. "*

CROSS-CUTTING THEMES

Nevada Medicaid has been innovative in their efforts to increase care quality and improve outcome for prenatal and post-partum care, including perinatal behavioral health care, through policies for collaborative care, residential substance use treatment, and integrated behavioral health care through CCBHCs and FQHCs. The Nevada State Legislature promoted and passed legislation that serves as a foundation for improving systems, including healthcare, by supporting evidence-based policies that impact prevention, access to care, and workforce development. Evidence-based practices and standards of care across the care and recovery continuum are well-established and promoted by professional associations and national/federal organizations. Policy and payment options, efforts to support quality and outcome measures, and payment reform can leverage existing standards of care and evidence-based practices to guide policy design and implementation. National organizations and associations have supported the dissemination of evidence-based practices through training and technical assistance to states, agencies, and providers. The efforts across Nevada to address perinatal behavioral health through policy and practice across systems have established a foundation on which Nevada can build for continued improvement.

BARRIERS

Stigma and bias were identified as pervasive across community and medical settings. Providers expressed concern about lack of training in behavioral health and noted this lack of training often translates in providers avoiding behavioral health issues within their patients. Health systems and child welfare systems were perceived as having high levels of bias against individuals with perinatal behavioral health issues, with the highest rates of bias and stigma specifically toward individuals with perinatal substance use. Respondents also emphasized perinatal behavioral health issues resulted in more newborn removals by child welfare and greater difficulty in reunification.

CROSS-CUTTING THEMES

> *"I didn't want to say anything because I didn't want her (my baby) to get taken away. I thought about getting an abortion. I thought about what's going to happen, what's going on with my other three kids? It's scary. You don't want to tell somebody you're using drugs because you have a prior CPS case."*

> *"I get to work with a lot of the case workers, and I'm always really sad and disappointed at, like, how they present themselves, like they present themselves very uneducated and rude and like, just again, really, like, I couldn't, I wouldn't be able to handle somebody talking to me. Yeah, I would help her create a text message to ask her caseworker if there's any housing resources. But she didn't want to come off like, like rude or something, so I helped her drop a beautiful text message saying, I'm still working with empowered and my other resources, but I'm just asking, do you know of anything else? And the reply, why are you asking? And why do you need sober living if you're not drinking or using drugs? And like, of course, that person's not going to want to reach out to them."*

Women in care provided examples of being denied care or experiencing suboptimal care when they presented for care in emergency rooms or outpatient healthcare settings. They also noted fear or experience of stigma within medical settings resulted in them actively delaying or avoiding care.

> *"Women also have a lot of stigma about reporting BH symptoms and substance use. For many women, they don't feel comfortable disclosing because of fear of judgement or fear of CPS. It takes a lot of trust to get women to be honest."*

Misalignment with standards of care and reimbursement creates conflicts within health systems, with mounting pressure to provide high volume care with little incentive to meet or exceed a standard of care that is not reflected in payment structures. The inability to establish a Perinatal Quality Collaborative to support the adoption of quality standards and aligned incentives for care is seen as a barrier to progress toward better outcomes across systems. Quality of care is often sacrificed to meet productivity standards which leave providers feeling ethically conflicted and concerned about liability for patient care without sufficient time to address the range of patient needs. Use of evidence-based interventions across care settings was hindered by a lack of training in trauma-informed care practices or by insufficient resources to train and implement evidence-based care. Grant funding has been available to support the expansion or enhancement of services for individuals with substance use disorders; however, concerns were expressed about the oversight and

accountability for how funding is used to expand and maintain access to services. Respondents noted that many grant-funded programs are expected to become sustainable through other funding streams, leading to the dismantling of safety-net programs when funding is no longer available.

> *"And the sustainability piece to me, it's like, how do I say this in a nice way? That word doesn't really mean anything when there is nothing to sustain it. Like I love when people ask me what the sustainability plan is, and I mean all you can really do is shrug your shoulders and say I hope that someone thinks this is important enough to give us maybe 20% of what we asked for within the general fund."*

> *"But yeah, we are going to face a funding cliff. We're trying to do our hardest to substantiate what we're doing, to put together what our budget would be if we were able to be funded. But it's, you know, it's a challenging time"*

Grant funding for capacity-building and program expansion should be distinguished from funding for essential services, which require ongoing grant support. Grant reporting requirements, data collection, and restrictions have led to few programs applying for state and federal funding. Workforce shortage was a priority barrier to address with health and behavioral health workforces being insufficient to meet the needs of Nevada's growing population. A lack of community providers specializing in perinatal behavioral health increases pressure on existing providers to meet patients' needs without adequate training.

In addition, respondents noted a need for continuing education and formal consultation to support the development of competencies in perinatal behavioral health across all disciplines and settings. State and local agencies lack a comprehensive approach to align programs, funding, or policies to support individuals' interfacing with one or more system of care resulting fragmented care, siloed programming, and eligibility criteria that is difficult to navigate.

> *"Having more resources available for moms who need them and more time for providers to screen and work with patients. In other cities, I knew exactly where to refer for care. In Nevada, I feel helpless; no one knows how the system works. Hospitals have no incentive to for good quality, they get a bundled rate regardless. There is no quality control or enforcement, without it, there is no real incentive for providers to screen; if anything, they do not benefit from more work. An example of "hassle-free" is in another state, if a woman screens positive for severe post-partum depression, the medical assistant will notify the front desk, who then makes a referral, and the patient leaves with a scheduled appointment for follow-up with a BH specialist. We need a closed-loop referral to ensure follow-up with treatment and medication. Here, there is no coordination of that kind of care."*

IMPLEMENTATION OF PERINATAL BEHAVIORAL HEALTH SCREENING AND REFERRAL TO CARE

Themes in this domain include perinatal behavioral health screening practices across primary care and obstetrics/gynecology settings, standardized screening tools, the use of biological testing, screening processes, provider competencies, training and technical assistance needs, integration of behavioral health services, collaborative care for psychiatric and addiction medicine consultation, FQHCs and bundled universal obstetric payment, adequate access to prenatal care, use of referrals for warm hand-offs, closed loop referrals, stigma, and provider bias.

FACILITATORS

Pregnancy is viewed as critical period when health behavior change is most likely to occur. Women with lived experience emphasized that pregnancy was a time when they were most likely to accept help for a range of issues they may have been facing including behavioral health, intimate partner violence, housing instability, and overall well-being. They also felt that providers who offered non-judgmental support and took time to establish rapport made them more likely to disclose issues and concerns, including substance use. Implementation of universal behavioral health screening during the first trimester of pregnancy was seen as a standard of care that should be implemented across prenatal care settings and referrals to specialty behavioral health care was seen as a priority resource for women who needed to be connected to care.

BARRIERS

Respondents noted that the lack of access to adequate prenatal care remains a high-priority barrier in Nevada. Providers expressed concerns with the bundled universal rate for prenatal care, labor and delivery, and post-partum care. This is seen as a primary factor restricting access to prenatal care in care settings such as FQHCs and community based reproductive health clinics due to lack of reimbursement for care.

IMPLEMENTATION OF PERINATAL BEHAVIORAL HEALTH SCREENING AND REFERRAL TO CARE

"With this bundled package, it really, it really narrows access to care and it really prevents OBs in family medicine and OB GYNs; it disincentivizes people from practicing because of the reimbursement, the way it is. In a political landscape that this could be changing, if it's unbundled, you can autonomously bill for your own services without limitation."

While many providers see universal screening for behavioral health in obstetric settings as important, they noted several barriers to implementing the practice, such as providers' time constraints and health systems that pressure them to see high patient volumes, reducing time for rapport building, screening, and referrals for care. Due to time pressures, lack of incentives, and insufficient leadership support for implementing screenings, care settings continue to forgo screening or use only biological screening (urine drug screens), resulting in high variability in standards of care across the community and making collaboration difficult. The cost of building screening into their workflows and electronic health records was deemed prohibitive. Perceived lack of access to training and technical assistance to support implementation; respondents were unaware of resources available to support implementation at the provider, clinic, or health systems levels.

"We would love to screen, but we don't want to screen, not because it's not the right thing to do, but because we don't know who to do a warm handoff to, and not just a referral."

"So one of the barriers that we've tapped into quite a bit is there's a lot of apprehension from providers, especially OBs to screen, because they don't know what to do next"

"Providers do not feel they have the time to do the screening. Once you find it, you need to give more time to it and they already do not have enough time."

IMPLEMENTATION OF PERINATAL BEHAVIORAL HEALTH SCREENING AND REFERRAL TO CARE

Integration of behavioral health supports into care settings has also posed a challenge due to the lack of reimbursement for behavioral health and collaborative care, which has prevented moving to an integrated care model. For organizations that have integrated behavioral health into care settings, challenges in billing and receiving reimbursement for collaborative care were noted. Providers articulated that screening protocols needed to be clear, concise and easy to use. Complicated processes, poor internal communication, and a lack of available community referral resources were identified as primary drivers of non-screening. There is variable capacity to participate in value-based contracting at both the provider and payer levels. Providers noted concerns about the requirements to collect and report data without sufficient administrative support, the administrative burden placed on providers, and documentation standards in electronic health records.

> *"That is definitely one of the barriers, the providers say they are doing it. But they're not billing for it. And without that billing, we don't really know if it's happening unless we go into their electronic health record and look for that screening or if they submit supplemental data, which most providers do not submit supplemental data to the to the payers. I review any NICU admissions that the babies that were born to moms with SUD and then I go in through the EMR and look this was this mom screened and I can tell you 9 out of 10 the mom was screened, but we didn't get a claim for that. So as far as we're concerned, that member didn't get screened. So, it's difficult. We don't have accurate and up-to-date data on who is screening and who's not."*

Payers noted that the bundled universal rate made value-based contracting difficult due to lack of transparency in claims coding for procedures, such as screening or care consultations. Respondents also noted women in the community receiving behavioral health services (psychiatry and addiction services) are often discharged from care once they become pregnant, further reducing access to comprehensive care for pregnant women with behavioral health conditions. This coincides with the fact that minimal education on perinatal behavioral health has been provided to health workers caring for pregnant women and training would be needed to enhance competencies.

IMPLEMENTATION OF PERINATAL BEHAVIORAL HEALTH SCREENING AND REFERRAL TO CARE

Additionally, providers expressed interest in receiving training or consultation to provide psychiatric or addiction medicine prescribing, but the lack of consultation services, such as psychiatric access lines, results in providers being apprehensive about providing care. Providers also shared that the high rates of cannabis use in the pregnant population without available evidence-based patient education materials place them in a difficult position when educating patients on the risks of continued use. Respondents with lived/living experience noted the avoidance of prenatal care due to severe substance use and only using the emergency room for medical care. They also mentioned previous negative experiences with providers as reasons for avoiding prenatal care or answering honestly during behavioral health screenings.

SOCIAL DETERMINANTS OF HEALTH AND CARE NAVIGATION

Themes in this domain include assessing social determinants of health, availability and accessibility of childcare, transportation, housing supports, employment, role of peers, care coordination to reduce barriers to accessing care, role of managed care, social supports, and cycles of poverty.

FACILITATORS

Programs that conduct ongoing assessments of patient needs systematically can help remove barriers to care and recovery by developing holistic care plans that address social determinants of health. These programs were viewed as highly effective in addressing the needs of pregnant and post-partum women. Respondents noted that programs offering peer recovery support and/or care navigation that assist with gathering essential documentation and identification, transportation, childcare, housing, healthy nutrition options, social services, employment and educational opportunities were instrumental in removing barriers to access to care and recovery. The Women, Infants, and Children (WIC) program provides a range of screenings when meeting with applicants and enrollees in its programs and serves as a referring agency, connecting pregnant women with substance use issues to local healthcare agencies ranging from community health centers to non-profit organizations. Knowledge of and assistance in applying for public assistance and benefit programs such as nutrition assistance, childcare subsidies, insurance coverage, utility support, and housing programs were seen as program strengths. Transitional housing programs offering housing with psychosocial support and employment pathways for pregnant and post-partum populations help to alleviate some of the burdens of housing insecurity, unemployment, and reduce people returning to poverty and homelessness. Respondents shared that within these settings, they can access childcare, parenting education, and peer support that helps them maintain recovery while learning or regaining critical independent life skills.

SOCIAL DETERMINANTS OF HEALTH AND CARE NAVIGATION

BARRIERS

Some programs supporting pregnant and post-partum women actively assess barriers to care, such as transportation, childcare, and housing; however, these assessments do not occur consistently, and it was unclear to many respondents how this information guides case management or care navigation. While managed care organizations provide case management for pregnant and post-partum clients, many shared this is done telephonically and lacks the intensity needed for behavioral health and healthcare navigation for a complex patient population with significant needs. Lack of viable transportation options, even when coordinated through health providers or health plans, was seen as woefully insufficient.

Public transportation options were identified as a barrier to care when bus transfers may be required, often resulting in several hours spent in transit. Additionally, long wait times for a bus in extreme heat or cold for pregnant women or parents accompanied by young children were seen as untenable and, often, unsafe. Women in care noted that transportation barriers contributed to disengagement from services, even when they viewed those services as essential, because the added burden felt too great to overcome.

"I find transportation to be one of our biggest barriers. We do provide bus passes and ride and or rides through MTM. Also, stigma I think is a big factor, especially in those who are using substances during pregnancy."

"...that's the hardest thing, flipping transportation. And, like, because I have a 15-month-old baby, and then I have a seven-year-old and taking two buses just to get to somewhere, it takes an hour and then an hour to get back. And it's really, really hard."

SOCIAL DETERMINANTS OF HEALTH AND CARE NAVIGATION

"I just think like it'd be helpful if rehabs had, like, like a transportation system, like, where they go and they pick you up and bring you here, because the hardest thing for me to get into treatment was getting there."

"We try to provide holistic support to the entire family when it's needed, especially when there is parental SUD. It is very difficult to get assessments for children and families. The wait lists are very long and an assessment is needed before we can get them care. Treatment in the community is inaccessible; distance and transportation are barriers to care. There is not a sufficient array of services around the population centers in the community. This means people sometimes have to travel for hours by bus just to get to appointments."

Healthcare providers noted that they distributed brochures and resource guides with information on community support services to clients during their medical appointments; however, these referrals were deemed insufficient to connect patients to community resources. There was a recognition that care navigation and expertise in available resources for case management were needed but unavailable within their healthcare settings and systems.

"I had such a hard time with doing the screening, not because I didn't want to deal with the problems, but because I didn't know how to deal with the problems. So we would identify, because before we were even doing screening, you would identify a social determinant of health, right? Okay, I have trouble with transportation, and then I'd be like, Oh, that sucks, and I don't know what to do for you, right? It was such a hard thing to deal with as a provider because I know that's the reason you can't get your care.
It's not because you don't want to, it's because you're physically like, maybe you can't get here, or you're homeless, or you can't get the food you need or whatever, but we had no way of helping, and so it almost makes you want to shy away from asking those questions."

Community resources through non-profit providers and county agencies are difficult to access, with unclear eligibility criteria, and require complicated applications for services and supports. Housing support was identified as inadequate or unsafe for pregnant women, women with newborns or young children.

SOCIAL DETERMINANTS OF HEALTH AND CARE NAVIGATION

Eligibility requirements for programs were also a perceived barrier to moving to self-sufficiency, with housing programs requiring employment as a condition of eligibility, employment opportunities requiring childcare, and childcare subsidies being scarce for parents who were unhoused or unemployed. Women receiving care repeatedly noted they believed there was an intentional lack of resources to support them in securing housing options due to discrimination.

> *"....so for a lot of women who are either CPS involved or court involved or having to test for whatever reason, they are like you can't bring your kids. You can't leave your kid in your car, like, you can't even bring your kid into the building of the testing facility. And that, I think creates, a huge barrier, you know."*

The challenges navigating social services eligibility requirements were connected to feelings of frustration, hopelessness, and having a sense of "being stuck" in systems that perpetuate poverty.

> *"...then I think housing is an issue too. When section eight does open up, who knows how long your wait list is, and then these women have housing insecurity, and it's like, how could get a job? And then you can apply for children's cabinet. Okay, well, how are they gonna get a job, or they don't have childcare?"*

> *"Transportation makes it a little bit harder. if they don't have transportation and they have an opportunity. So there could be a really good job in Summerlin, but it doesn't make sense to take the bus three hours and go back. So I think there are employment opportunities. But again, transportation often is a big barrier. And then also daycare. A couple of the casinos have daycare at their casinos, which have worked great for some of our ladies that were able to get those jobs. But again, like, with employment, you have to, like, sometimes you can't get approved for daycare until you get employment, and sometimes it's really hard to get approved for job seeking. So like, you can't be going to interviews with your baby, And again, a lot of our ladies are doing this all on their own."*

SOCIAL DETERMINANTS OF HEALTH AND CARE NAVIGATION

Women in care also endorsed mistrust with child welfare agencies in supporting them in securing housing options suitable for reunification. They expressed concerns about inaccurate and/or incomplete information on resource availability or eligibility given, and they perceived information regarding resources was withheld if child welfare case workers did not believe the caregiver was making adequate progress toward their goals.

"They said If I came into care, I would get my child back in 2 weeks. It has been 3 weeks, and my child has been placed in foster care. The goal line continues to be moved by the CPS worker."

PERINATAL BEHAVIORAL HEALTH CARE

Themes in this domain include access, availability, and quality of perinatal behavioral health services for pregnant and post-partum women and families, medication assisted treatment and medications for opioid use disorder, treatment availability for stimulant use disorders, complexity of care needs for women with severe mental health and substance use disorder needs, specialty services for post-partum depression, trauma-informed care, community-based outpatient treatment, residential services, withdrawal management services, endorsements for specialty mental health and substance use providers, block grant requirements for waitlist and capacity management, public outreach and education on availability of care, and state laws that address prenatal substance use

FACILITATORS

Perinatal behavioral health has become a priority in Nevada, and the health system has started taking steps to provide support for pregnant and postpartum women with mental health conditions and/or substance use disorders. Participants shared that the availability of recovery centers is a key facilitator, addressing social determinants of health by providing transitional/residential housing, education on parenting, skills acquisition training, reintegration opportunities and peer-support networks where mothers can take turns in assisting each other with childcare during recovery and treatment. They mentioned some, but not all, programs allow mothers to remain in treatment with their babies. This reduces the burden of finding childcare which may cause mothers to forgo treatment and reduces the disruptions caused by separations. Several (transitional housing) programs help mothers access essential resources like transportation to medical appointments and court hearings, as well as connect families to diaper banks and domestic violence support services.

PERINATAL BEHAVIORAL HEALTH CARE

"We have a case manager, and she'll sit with a client and do a needs assessment ranging from like, are you experiencing housing, transportation issues? and help them get set up with things like MTM for transportation. We'll give them Ubers to their pregnancy appointments if they don't have transportation. The case manager can help find resources in the community, like helping them get set up and access other resources like the diaper bank."

Participants also mentioned that residential treatment providers can serve as advocates and liaisons between clients and the child welfare system, as they incorporate coaching and supervision in their models of care. Medicaid coverage for residential treatment for substance use disorders is currently limited to 30 days. While the coverage facilitates access to care during a critical period, there is a need for an extension, as respondents shared that 30 days is not enough time for recovery. More importantly, respondents highlighted that partnerships among community agencies help in resource management and care navigation for families. These developments show momentum toward a better-coordinated system of care for perinatal behavioral health.

BARRIERS

Despite the promising initiatives shared by contributing stakeholders, social and systemic barriers still hinder the quality and sustainability of these interventions. The severity and complexity of behavioral health issues, particularly polysubstance use, among this population complicates treatment and recovery.

"I think most women who come into my office who are using and pregnant, it is not a planned pregnancy. It is a pregnancy that happened while using, and so there is that like stigma already, of like, I'm using, like, what does that mean, especially if you've had previous pregnancies where you were sober and you've had like, different pregnancies at different phases of your recovery. So there's so much internal stigma and what they think that means about themselves as a mom. And then just going out today, where there's so many expectations for what moms are supposed to be like, how they're supposed to present, how they're supposed to be able to handle everything, and then you couple that with the societal stigma of what it means to be a person who is using."

PERINATAL BEHAVIORAL HEALTH CARE

The severity and complexity of needs are further compounded by co-occurring mental health issues, homelessness, and stigma, contributing to difficulties in managing screening, early intervention, and referrals to care. Respondents shared that high rates of meth exposure among pregnant women are particularly challenging given the absence of withdrawal management for meth and the limited capacity of existing withdrawal services for other substances, especially for pregnant women. They also mentioned systemic issues such as poor interagency collaboration, competition among agencies for clients and gaps in communication between providers. These factors strongly contribute to a fragmented system of care. They noted Medicaid is limited in its coverage of specialty perinatal behavioral health services and that managed care organizations may not provide OB care with MOUD services. Nevada also lacks a perinatal quality collaborative to guide innovation and advocate at the state level for payment reforms and better care coordination.

Respondents also emphasized that access to services and the limited capacity of behavioral health providers remain persistent issues. Long waitlists and limited statewide capacity result in referrals being turned away by community providers.

"Nevada needs to expand services beyond just the traditional outpatient providers in the safety net. They are not sufficient, and the quality of care is poor. People wait too long for care, and they become more severe in the process."

"Severe lack of OB ability to provide behavioral health screenings, the provider should only need to make one phone call to hand off the patient. There isn't a lot that providers can do in a compressed 15-minute clinical encounter. OBs need BH in the office with them so they can do a warm hand off."

PERINATAL BEHAVIORAL HEALTH CARE

Respondents mentioned that workforce shortages, including limited specialty psychiatry/addiction treatment providers contribute to this gap. Providers reported staff burnout due to heavy caseloads and limited resources, while some agencies face internal resistance to implementing recent changes or protocols to improve care. Women receiving care also stated they face barriers in accessing medications as a result of pharmacies Women receiving care also stated they face barriers in accessing medications as a result of pharmacies refusing to dispense prescribed medications to manage substance use disorders during pregnancy. This often requires provider intervention and leads to distrust in the care system. Stigma discouraging women with SUD from seeking care remained a recurring theme throughout our interviews. Participants emphasized that the quality of their experiences with providers was a strong determinant of whether and how they accessed care. They reported they experience stigma and bias with providers, which strains provider-client relationship.

Women in care and respondents noted that there is a shortage of beds for pregnant women and women with dependent children. They also noted that when residential programs are available, the length of stay is typically 30 days or less, resulting in women being discharged from care when their Medicaid coverage ends, even when they continue to meet medical necessity.

PERINATAL BEHAVIORAL HEALTH CARE

Respondents emphasized that the shorter lengths of stay were due to the lack of access to block grant funding that previously covered medically necessary lengths of stay between 60-90 days. Discharge from treatment due to the end of coverage for women who still meet criteria for residential care has resulted in greater challenges with maintaining custody or reunification with newborns, higher rates of relapse post-discharge, and women returning to homelessness. Respondents underscored the importance of residential treatment programs adhering to best practices for addiction management in this priority population, including ASAM, which supports lengths of stay for medically necessary care.

The limited funding and strong reliance on grant funding for these residential programs also raises concerns about sustainability. Additionally, only a few programs are structured to accommodate women with children. With limited access to childcare, employment opportunities, and stable housing, pregnant and postpartum women with behavioral health conditions remain trapped in a cycle of poverty that hinders full recovery. Lastly, the absence of endorsement for specialty providers and a lack of health homes tailored to pregnant and postpartum women were mentioned as key barriers to providing comprehensive and coordinated care.

LABOR AND DELIVERY, PLANS OF SAFE CARE

Themes in this domain include the role of hospitals in behavioral health screening, inadequate prenatal care, CARA and Plans of Safe Care for discharge, dyadic care including Eat, Sleep, Console, and utilization of Neonatal Intensive Care Units.

FACILITATORS

In practice, hospitals play a critical role in screening birthing mothers for behavioral health issues that may have implications for the dyad. Implementing universal screening at labor and delivery has increased the identification of maternal behavioral health issues. For women who have been established in behavioral health services prior to labor and delivery, continuity of care is enhanced when outpatient providers directly consult with the birthing center or hospital. Such consultations also strengthen Plans of Safe Care to ensure mothers who have been established in care are encouraged to continue treatment with their providers post-discharge. For mothers who have received MOUD prior to labor and delivery, universal screening and provider consultation also create opportunities for continuity of care, managing infant substance use exposure. The information gathered through screening and/or consultation provides critical guidance for providers to determine next steps in monitoring and managing potential withdrawal. Respondents noted that some facilities have adopted the Eat, Sleep, Console (ESC) dyadic, hospital-based model of care for infants experiencing Newborn Opiate Withdrawal Syndrome (NOWS). ESC shifts the focus from withdrawal symptoms alone and evaluates whether the infant can eat properly, be consoled, or sleep uninterrupted for the required amount of time. This approach prioritizes parental interaction and caregiving as the first line of treatment, supporting both infant and parent, while reducing reliance on pharmacological interventions and longer hospital admissions.

LABOR AND DELIVERY, PLANS OF SAFE CARE

Respondents also noted that extensive training has been conducted to educate birthing hospitals on how to conduct universal screening in accordance with best practices, and that support has been provided to address provider bias and enhance the screening process to better support mothers who disclose behavioral health issues and/or prenatal substance use. Women in care noted they felt supported and less stigmatized when disclosing they were in treatment for behavioral health conditions when there was greater communication between the hospital and their outpatient provider.

> *"Treating moms and babies together. As much as you can treat them together it is beneficial. Not doing it impacts bonding, breast feeding, etc. Rural communities do a good job at this because they do not have a NICU. Post-discharge – if they can go to primary care where they can both be treated, it is more beneficial and interlinked. This does not happen often here."*

BARRIERS

Respondents noted concerns about the feasibility of universal screening without urine drug screening upon admission to labor and delivery, citing concerns about patient disclosure with questionnaires. Several respondents noted concerns about high rates of NICU utilization for monitoring newborns gestationally exposed to substances without sufficient evidence that NICU admission was warranted. This was particularly problematic for providers who believed dyad-focused care, such as Eat, Sleep, Console, was better for both mother and newborn and reduced separation in rural communities without NICUs. Contributing to this, respondents shared NICU admissions for fetal monitoring come at a high cost and create additional barriers to dyadic care. Furthermore, the State Board of Health requires hospitals to develop a CARA Plan of Care for any infant meeting the state-established criteria.

LABOR AND DELIVERY, PLANS OF SAFE CARE

Respondents noted a high degree of variability in CARA Plans of Safe Care between hospitals and between providers. This has resulted in some hospitals reporting high rates of CARA Plans of Care for maternal cannabis use, while others do not create CARA Plans of Care for maternal cannabis use. Providers reported being unable to access CARA Plans of Care following discharge, resulting in poor care continuity, particularly for post-partum follow-up and pediatric appointments. In addition, hospitals often lack timely access to resources for mothers and newborns during discharge planning, including CARA Plans of Care, and there is limited monitoring or navigation support for these plans. While hospitals create CARA Plans of Care based on state criteria and submit these plans to the Division of Public and Behavioral Health (DPBH) for monitoring, in compliance with the regulation but DPBH does not conduct monitoring, resulting in a gap in care. Although consultations are currently underway to modify how plans are monitored, respondents emphasized the need for a more realistic monitoring framework through local organizations and MCOs. They also shared that documenting CARA Plans of Care, along with discharge plans, offers an opportunity to close gaps in care coordination, particularly when it is communicated to continuing care providers, such as pediatricians, developmental specialists, and specialty care providers, for follow-up.

"In most cases, pediatricians don't receive information on in-utero substance exposure from OBs. When they do know, it is because they have eyes on the ground. They can refer to the discharge summary; they do include plans of safe care. They are somewhat helpful in giving a larger picture of what to follow up on. It is better than nothing. It is a good place to start."

LABOR AND DELIVERY, PLANS OF SAFE CARE

Respondents also noted unclear guidance on the difference between notifications to child welfare and reports of abuse and neglect. This lack of clarity has led to providers reporting prenatal substance use at high rates due to liability concerns. Additionally, respondents brought up concerns about the potential removal of newborns from parental custody due to these reports. Women in care reported high rates of trauma resulting from threats of their newborns being removed from their care through child welfare and relapse following newborn removal. Women in care also expressed feeling highly stigmatized and shamed following disclosure of prenatal substance use.

> *"When you instantly take our kids away, it just makes us use more. It really just, like, sends us over the edge, yeah, and then you don't support us, and you don't, like, check in with us, treat us like we're criminals and say that we're never gonna get our kids back."*

DOMAIN VI

INTERSECTION WITH CHILD WELFARE AND FAMILY COURTS

Themes in this domain include Safe Babies Courts, foster care, family preservation and reunification, challenges with navigating the child welfare system and the cycles of poverty, options for dyadic foster care, role of residential treatment providers in supporting safety and reunification, CAPTA reporting.

FACILITATORS

Safe babies courts were described by respondents as a valuable resource because of their dyadic approach and incorporation of parent-child psychotherapy in their interventions. Within this context, resources focus on the welfare of both children and their parents, supported by partnerships and collaborations. Some collaborations are informal, e.g., CARA and NEIS, which provide home visiting and developmental assessments that involve parental participation. CARA also partners with treatment agencies to provide residential treatment for mothers with substance use disorders, ensuring that parents' behavioral health needs are addressed. These partnerships were viewed as instrumental in supporting reunification and family-centered care.

BARRIERS

Despite these facilitators, respondents who were women in substance use disorder treatment expressed mistrust in the welfare and judicial system because of their previous experiences with the system during their childhood or as adults. Some shared that they were afraid of their babies being taken away and felt triggered by any form of involvement with the system. They described a perceived "moving target" with the requirements for reunification with their babies, calling for better transparency in case management.

> *"...like, you have good CPS workers, you have bad CPS workers. I've seen it on both sides, so it scares me, because it's like, I've seen women get their kids taken away, and they're doing everything by the book, being in a program, working their program, and they still get their kids taken. Isn't it scary? You don't know if you're gonna be in that same situation all over again. You just don't know."*

INTERSECTION WITH CHILD WELFARE AND FAMILY COURTS

"And I think that, like, systematic trust as well, A lot of times like these clients come from, like, family backgrounds where there's not a lot of trust in the system. They haven't had great experiences. I have a client that I'm seeing now who's an outpatient and has had some pretty rough experiences with CPS. And so even though she was using methamphetamine through her pregnancy, she was like, I couldn't tell anyone, because they would just take my babies. And that was her worst fear. "

The nature of grant funding for programs raised concerns about long-term sustainability, especially when funding cycles end. Additionally, respondents noted that financing issues further complicate service delivery, as many programs operate a "no client, no pay" model, face difficulties with Medicaid reimbursements, and may serve families who are uninsured.

"If you don't have a client for that hour, you don't get paid for that hour. And so, you know, it just becomes a really tough environment to negotiate in terms of a business."

Lastly, respondents noted the limited availability of PPW residential and transitional living services for mothers and infants, mentioning that some homes restrict access based on whether the woman is pregnant or with an infant.

PEDIATRICS AND DEVELOPMENTAL SERVICES

Themes in this domain include Nevada Early Intervention Services, home visiting, dyadic care, infant and early childhood specialty services, continuity for developmental screening and early intervention, Bright Futures recommendations, continuity of Plans of Safe Care.

FACILITATORS

Respondents identified several facilitators to the linkage of pediatric and developmental services. Child welfare was noted as a key entry point for enrollment in Nevada Early Intervention Services (NEIS). Infants discharged from the NICU with a diagnosis of Neonatal Abstinence Syndrome (NAS) and those entering CPS custody are automatically enrolled in NEIS. Additionally, data from Nevada Center for Excellence in Disabilities (NCED) showed an increase in referrals for FASD assessments, which reflects an increased awareness about services and the potential for better care coordination. Participants also mentioned integrating maternal behavioral health screening into newborn screening to ensure dyadic care is a frontline approach to addressing perinatal health issues. National reports such as the National Association of State Alcohol and Drug Abuse Directors (NASADAD) brief on SBIRT for Pregnant and Postpartum Women from and the Advancing Perinatal Healthcare Integration guidelines also reinforce the importance of dyadic approaches in addressing the needs of both mother and infant. Both reports outline strategies to reduce fragmentation and promote continuity of care throughout the perinatal period.

BARRIERS

Respondents described multiple points of disconnect at critical touchpoints of care, particularly in the communication of CARA plans of care and CPS referrals. They noted that CARA plans of care are not monitored or communicated to continuing providers, such as pediatricians, obstetricians, or managed care organizations, after discharge, leaving major gaps in the continuity of care and in the implementation of care plans. They also identified restrictions following the grant funding for Nevada Early Intervention Services, which limits how babies are screened and enrolled in programs.

PEDIATRICS AND DEVELOPMENTAL SERVICES

"They are auto eligible only if they require treatment for neonatal abstinence syndrome. So if they were treated with morphine, then they get made auto eligible. And it's very unfortunate. I wish all of the kids with substance exposure could be enrolled, but it's just not a possibility."

A common concern raised by many respondents was the need for continuous screening and developmental assessments, particularly for prenatally exposed infants who may not have shown visible symptoms at birth but remain at risk of adverse outcomes in their early childhood. They stressed the need for parental support and a designated development specialist to follow up on care plans, which are often unavailable. Participants also noted that home visiting programs represent another unmet need. Although the HRSA-funded home visiting model provides key benefits, the program's reach is limited by capacity and geographic availability under Title IV-E and the Maternal, Infant, and Early Childhood Home Visiting (MIECHVS) program.

Finally, respondents highlighted limited access to specialty providers and bottlenecks in using child-parent psychotherapy in providing care. Even when such services exist, families are often unaware of them, making care navigation difficult.

CASE STUDIES

MIA, FEMALE, AGE 24

At 29 weeks pregnant, Mia was referred from a medication-assisted treatment program to a recovery and housing center. Mia needed housing, identification, transportation and prenatal care. The center provided her with access to prenatal care and assisted with her application for identification documents. Providing shelter for Mia was challenging at first as she declined emergency shelter due to past trauma and experience with shelters.

Prior to labor and delivery, Mia was referred for case management and admitted to the hospital for observation. Upon delivery, the recovery program advocated for her and her newborn to remain together. The hospital implemented Eat, Sleep, Console (ESC), a non-medication-based approach that supports infant well-being through maternal bonding/nursing. Upon discharge, Mia was transitioned into temporary housing.
Both mom and baby are currently together and doing well.

JANINE, FEMALE, AGE 29

One week after giving birth, Janine was referred to specialty care by a non-profit organization. She had an opioid use disorder and was facing homelessness, living in her car. Janine's son was in the NICU being treated for NAS.

Janine disclosed to her care provider that she had an open CPS case due to her infant being substance exposed to and identified an urgent need for medication assisted treatment for OUD. She was referred to specialty care with a same-day appointment.

Janine did not show up to her appointment and attempts to follow up with her have been unsuccessful.

These two case studies illustrate how different the journey can be for mothers navigating substance use during the perinatal period. While Mia's case demonstrates how effective behavioral health care coordination can support recovery and stability, Janine's case portrays the challenges of engaging in treatment, amid child welfare involvement and ongoing substance use

PART 4

RECOMMENDATIONS

PART 4

RECOMMENDATIONS

Recommendations to advance perinatal healthcare in Nevada serve as a call to action for state policymakers, providers, health care systems, payers and funders, state agencies, and advocates to prioritize maternal and child health, recognizing that healthy starts for newborns and families begin during the critical perinatal period. The structural barriers contributing to the current fragmented systems of care must be addressed through a coordinated, collaborative approach across multiple systems to reform existing policies and practices, align with best practices and implementation incentives, and support families to thrive. Through the development of an interconnected systems approach to perinatal behavioral health care, mental health and substance use disorder services can be integrated into broader systems of care, including early childhood systems, to address the complex needs of pregnant and post-partum women and their families. This framework emphasizes a systems-thinking approach, with a focus on integrating care and the connections among existing systems, while also addressing social determinants of health as drivers of care. The Interconnected Systems Framework provides a structure for collaboration among stakeholders, systematic integration of evidence-based interventions, and the creation of a more cohesive, accessible, and equitable system of perinatal care at the community and health system levels. The Interconnected Systems Framework for perinatal behavioral health calls for a paradigm shift in how care is delivered, moving towards a unified, equitable, and community-centered approach that supports the well-being of pregnant and post-partum women and their families by addressing the complex interplay of factors influencing their health. The recommendations are written with this vision, recognizing that the exploration and consideration of recommendations should be taken holistically as part of a system and comprehensive strategy. It is our sincere hope that these recommendations will serve as a foundation for continuing the efforts of many to bring about the needed changes across multiple systems to enhance care and improve outcomes for pregnant women, their infants, their families, and their communities.

RECOMMENDATION 1

DEVELOP A PERINATAL BEHAVIORAL HEALTH STRATEGIC PLAN ACROSS STATE AGENCIES WITHIN DEPARTMENT OF HUMAN SERVICES AND THE NEVADA HEALTH AUTHORITY AS PART OF THE CHILDREN'S BEHAVIORAL HEALTH TRANSFORMATION AND CONNECTED TO THE MANAGED CARE QUALITY STRATEGY.

1.1: Establish a unified vision and goals for an interconnected system across state agencies, focusing on timely access to high-quality care and support for pregnant and post-partum women, recognizing that prenatal behavioral conditions qualify as high-risk pregnancies and must be prioritized for care. The unified vision and goals should emphasize a focus on supporting healthy families and strong starts in early childhood and target reducing adverse outcomes, including child welfare involvement and maternal mortality by suicide and overdose.

1.2: Map existing programs, funding, authority, and policies across state agencies with touchpoints to systems and services that are part of the continuum for perinatal behavioral health, including programs supporting maternal and child health, home-visiting, child welfare prevention, preservation, and reunification, early intervention and developmental screening, workforce development, and access to behavioral health services.

1.3 Connect perinatal behavioral health initiatives to existing behavioral health and child welfare innovation efforts to align

measures, standards of care, incentives, accountability and oversight, data reporting, public health surveillance, health information exchange, and the selection and implementation of evidence-based practices. Include coordination with advisory committees; county representatives, individuals with lived/living experience, the Patient Protection Commission Women's Subcommittee, Hospital Quality Collaborative, managed care quality oversight meetings, the Maternal Mortality Review Committee, Child Death Review Committees, Fetal and Infant Mortality Review, and maternal child health coalitions.

1.4: Create and implement a strategic plan, with a governance structure to oversee implementation, with a continuous quality improvement plan. Establish legislative priorities to support implementation of the strategic plan, including the allocation of funding to support programs and positions for sustainable action. Prioritize efforts, including direct funding to support system-level implementation of policies within Nevada Medicaid to build community-level capacity; workforce initiatives; training and technical assistance in evidence-based practices; establishing a Perinatal Quality Collaborative; and sustainable funding for coverage of non-Medicaid reimbursable services and supports.

RECOMMENDATION 2

ESTABLISH REGIONAL LEVEL PERINATAL BEHAVIORAL HEALTH TREATMENT NETWORKS TO FACILITATE COLLABORATION, COMMUNICATION, AND RESOURCE SHARING TO SUPPORT CONTINUITY OF CARE AND NAVIGATION TO RECOVERY SUPPORTS.

2.1: Engage healthcare and behavioral health providers, social service agencies, child welfare agencies, hospitals, early intervention programs, health systems and payers across the five behavioral health regions in asset mapping, readiness assessment, planning, and convening using an interconnected framework to establish the foundation of a local perinatal behavioral health treatment network.

2.2: Promote standards of care and evidence-based practices to enhance the quality of care and care coordination (i.e., AIM Perinatal Behavioral Health Patient Safety Bundles).

2.3: Identify opportunities for capacity building through training and technical assistance and connect to existing resources at the regional, state, and national levels.

2.4: Coordinate with state agencies and existing consortia/committees to ensure communication supports existing policies.

Recommendations 3, 4, and 5 include sub-recommendations to be implemented at specific levels across systems and are specific at the provider, health systems, payer, and state/local authority levels.

RECOMMENDATION 3

INCREASE ACCESS TO HIGH-QUALITY, COMPREHENSIVE, INTEGRATED PERINATAL BEHAVIORAL HEALTH CARE ACROSS PRIMARY CARE, REPRODUCTIVE HEALTH, HOSPITAL, AND PEDIATRIC SETTINGS.

3.1 Adopt the AIM Patient Safety Bundles as the standard of care guide for implementation of perinatal mental health and substance use disorders. (All levels)

3.2 Incentivize providers to screen for perinatal behavioral health (mental health and substance use) and connect to follow-up care through alternative payment structures, such as rate enhancements or value-based contracting and the reduction of administrative burden. Design models for payment, incentive alignment, and reimbursement structures to practice change in accordance with best practices using implementation science methodology. (Payers, Health Systems)

3.3 Create pathways to care to allow providers to quickly refer warm-hand-off and closed-loop referrals by establishing care coordination agreements and/or through contract requirements with managed care. This includes streamlining Plans of Safe Care within reproductive health settings and hospitals by ensuring their transmission to managed care organizations to monitor and support care navigation. (Providers, Payers, Health Systems)

RECOMMENDATION 3

INCREASE ACCESS TO HIGH-QUALITY, COMPREHENSIVE, INTEGRATED PERINATAL BEHAVIORAL HEALTH CARE ACROSS PRIMARY CARE, REPRODUCTIVE HEALTH, HOSPITAL, AND PEDIATRIC SETTINGS.

3.4 Establish and sustain a Perinatal Access Line to connect providers with consultation support for psychiatry and addiction medicine. (Payers, State Agencies)

3.5 Promote integrated health and behavioral health care delivery models by aligning policy and reimbursement structures, removing barriers for enrollment and billing behavioral health services in medical settings. This includes ensuring managed care organizations have structures in place to reimburse a range of behavioral health integration models, including Collaborative Care Models. Clarify policy to exclude integrated behavioral health services from the universal bundled rate for pregnancy and post-partum care. Conduct Return on Investment studies to inform policy changes and evaluate effective models. (Payers, State Agencies)

3.6 Evaluate the universal bundled rate for pregnancy and post-partum care, as this policy has been identified as severely restricting access to community-based obstetric care and post-partum follow-up through providers, including FQHCs and Rural Health Clinics. (Payers, State Agencies, Providers, Health Systems)

RECOMMENDATION 3

INCREASE ACCESS TO HIGH-QUALITY, COMPREHENSIVE, INTEGRATED PERINATAL BEHAVIORAL HEALTH CARE ACROSS PRIMARY CARE, REPRODUCTIVE HEALTH, HOSPITAL, AND PEDIATRIC SETTINGS.

3.7 Create a central repository for updated, reliable, high-quality information that providers can use to educate patients on perinatal behavioral health issues (both mental health and substance use) during pregnancy and the post-partum period. This information should include risks of substance use (including cannabis) during pregnancy and breastfeeding, treatment options and tools for shared decision making, resources for self-help, and information on no barrier/low barrier referrals to care and recovery supports. Materials should be broadly distributed with education for providers on the content and how to integrate the information into their care pathways and screening workflows. Review existing state websites, such as Sober Moms, Health Babies and the Women's Substance Use Prevention and Treatment webpages, for consistency and accuracy of information. MothertoBaby and Postpartum Support International have patient education materials that can be referenced. (Health Systems, State Agencies)

RECOMMENDATION 3

INCREASE ACCESS TO HIGH-QUALITY, COMPREHENSIVE, INTEGRATED PERINATAL BEHAVIORAL HEALTH CARE ACROSS PRIMARY CARE, REPRODUCTIVE HEALTH, HOSPITAL, AND PEDIATRIC SETTINGS.

3.8 Enhance workforce competencies in perinatal behavioral health and integrated care delivery by infusing curriculum into pre-service behavioral health specialties and internships, medical and nursing education, residencies, and fellowships. Provide continuing education, training, and technical assistance to providers, hospitals, and health systems, including standards of care, provider bias, and the impact of stigma, as well as relevant, accurate information on state laws, policies, and resources available to support practice implementation. This recommendation includes educating providers on Plans of Safe Care across the care continuum. (Payers, Health Systems, State Agencies)

3.9: Promote hospital-based, dyadic care using Eat, Sleep, Console for the management of newborns with Neonatal Abstinence Syndrome. Evaluate the utilization of Neonatal Intensive Care Unit admissions for medical necessity for newborns for monitoring for withdrawal symptoms. Support improvement of care through quality and outcome measures through the Hospital Quality Collaborative to reduce unnecessary NICU admissions and the increased cost of care. (Payers, Health Systems, State Agencies)

RECOMMENDATION 4

INCREASE ACCESS AND AVAILABILITY TO COORDINATED SPECIALTY PERINATAL BEHAVIORAL HEALTH SERVICES THAT ARE EVIDENCE-BASED, RESPONSIVE, TRAUMA-INFORMED, AND FOCUSED ON DYAD CENTERED CARE ACROSS THE CONTINUUM OF CARE.

4.1: Evaluate the availability and adequacy of specialty mental health and substance use disorder services across health care payer networks, by region, to include inpatient medication induction services, medically managed withdrawal management for pregnant women, residential treatment programs, transitional living options with recovery supports, outpatient treatment, partial hospitalization programs, intensive outpatient treatment, and outpatient behavioral health services. Assess all providers to determine if the care offered to pregnant and post-partum women allows infants and young children to accompany caregivers into care. Direct funding to support the development of an adequate network with an emphasis on sustainable funding through braided funding models. (Payers, State Agencies)

4.2: Establish policies to prohibit state-funded or contracted specialty behavioral health providers, in non-hospital settings, from excluding caregivers with infants from accompanying them to care. (Payers, State Agencies)

RECOMMENDATION 4

INCREASE ACCESS AND AVAILABILITY TO COORDINATED SPECIALTY PERINATAL BEHAVIORAL HEALTH SERVICES THAT ARE EVIDENCE-BASED, RESPONSIVE, TRAUMA-INFORMED, AND FOCUSED ON DYAD CENTERED CARE ACROSS THE CONTINUUM OF CARE.

4.3: Provide adequate, sustainable funding through braided federal and state funding to ensure pregnant and post-partum women have immediate access to medically necessary care for substance use and co-occurring disorders, regardless of limitations of existing Medicaid benefits. Recognize these efforts as critical for supporting care and recovery for high-priority populations, reducing adverse outcomes associated with incomplete episodes of care, and increasing opportunities for reunification and family preservation for families at risk or involved in child welfare. Establish a capacity and waitlist management system to monitor the availability of substance use disorder treatment services in accordance with federal regulations to expedite access to services for all individuals during the perinatal period, regardless of insurance status or payer. Delays in care should be minimized, and efforts should be made to actively reduce unnecessary wait times for admission into care. (State Agencies)

4.4: Enact policies to promote access to opioid partial agonist medications for opioid use disorder (MOUD), including coverage for hospital-based induction, allowance of admission of individuals prescribed MOUD in state-funded and contracted substance use disorder providers and child welfare programs without restrictions.

RECOMMENDATION 4

INCREASE ACCESS AND AVAILABILITY TO COORDINATED SPECIALTY PERINATAL BEHAVIORAL HEALTH SERVICES THAT ARE EVIDENCE-BASED, RESPONSIVE, TRAUMA-INFORMED, AND FOCUSED ON DYAD CENTERED CARE ACROSS THE CONTINUUM OF CARE.

Reduce exposure to opioid agonist medications, unless determined medically necessary for the treatment of OUD in pregnant and postpartum women. Require all contracted pharmacies to fill authorized MOUD prescriptions without delay. Encourage providers who actively treat pregnant women with MOUD to support the development of a Plan of Safe Care prior to delivery. (Providers, Payers, State Agencies)

4.5: Adopt endorsements through the Nevada Association for Infant and Early Childhood Mental Health and the Perinatal Mental Health Certification Program through Postpartum Support International for providers and provider agencies who meet established criteria for providing specialty perinatal behavioral health services. Incentivize endorsements through enhanced reimbursements for providers and provider agencies. Offer stipends for training and applying for endorsements. Recognition of these endorsements will help identify programs with practices and competencies that support caregivers, young children, and families affected by perinatal behavioral health conditions. (Health Systems, Payers, State Agencies)

RECOMMENDATION 4

INCREASE ACCESS AND AVAILABILITY TO COORDINATED SPECIALTY PERINATAL BEHAVIORAL HEALTH SERVICES THAT ARE EVIDENCE-BASED, RESPONSIVE, TRAUMA-INFORMED, AND FOCUSED ON DYAD CENTERED CARE ACROSS THE CONTINUUM OF CARE.

4.6: Enhance workforce competencies through training in evidence-based practices and standards of care for the assessment, treatment, and recovery support to include level of care determinations, comprehensive treatment and family care planning, trauma-informed care, including Child Parent Psychotherapy and Reflective Supervision, and parenting support. (Providers, Health Systems, Payers, State Agencies)

4.7: Develop and adopt reimbursement rates for peer and family recovery support specialists, parenting coaches, community health workers, lactation consultants, and doulas at levels that recognize them as essential care team members in providing comprehensive family-centered care. (Payers, State Agencies)

RECOMMENDATION 5

SUPPORT FAMILIES IMPACTED BY PERINATAL BEHAVIORAL HEALTH ISSUES TO REMAIN TOGETHER AND SUPPORT INFANT AND TODDLER DEVELOPMENT THROUGH EARLY CHILDHOOD SYSTEMS.

5.1: Reevaluate regulations to guide the practice of Plans of Safe Care to divert families away from the child welfare system and direct them toward comprehensive supports for infants and caregivers needing care. Reference CAPTA and CARA to ensure regulations clearly differentiate between notifications and reports to child welfare. Reduce bifurcation in care navigation and case management by connecting individuals with high-risk pregnancies due to perinatal substance use to managed care for high-risk case management prior to labor and delivery, and for continuity for postpartum and pediatric care. (Payers, State Agencies, Providers)

5.2: Establish a rapid review process for the Maternal Mortality Review Committee to ensure data and information are available as a public health surveillance tool to track causes of maternal mortality for actionable prevention solutions. Explore contracting with a public health agency or University to resolve the backlog of MMRC reviews from 2020 to date, ensuring data and information are available to inform recommendations on interventions and the development of quality and outcome initiatives, as described in Recommendations 1 and 2 above.

RECOMMENDATION 5

SUPPORT FAMILIES IMPACTED BY PERINATAL BEHAVIORAL HEALTH ISSUES TO REMAIN TOGETHER AND SUPPORT INFANT AND TODDLER DEVELOPMENT THROUGH EARLY CHILDHOOD SYSTEMS.

5.3: Direct federal, state, and local child welfare prevention and family preservation funding to support families impacted by perinatal behavioral health issues to divert families away from the child welfare system, provide support to reduce the risk of child welfare involvement, and support reunification. (State and Local Child Welfare Agencies)

5.4: Coordinate efforts for programs to address social determinants of health, home visiting, and early childhood services for infants, toddlers, and families to existing initiatives at the state and local levels, including agencies such as Nevada Early Intervention Services, First 5 of Nevada, Children's Cabinet, Children's Advocacy Alliance, County Social Service and Child Welfare Agencies, and Family Resource Centers. (Providers, Payers, State and Local Agencies)

5.5: Secure sustainable funding to expand access to Safe Babies Courts, NEIS, and Home-Visiting. Evaluate these and similar programs when formulating priorities for state agency budgets and the Children's Behavioral Health Transformation efforts, including the Specialty Managed Care Plan. (Payers, State Agencies)

PART 4

CONCLUSION

As Nevada continues to address the concerning maternal and infant mortality rates, perinatal behavioral health issues must be addressed as a critical part of a comprehensive plan to improve access, quality, and outcomes of reproductive health care. Perinatal behavioral health conditions classify a pregnancy as high-risk requiring timely access to high quality care. Through the implementation of best practices for prevention and intervention services through an integrated, coordinated medical and behavioral health care delivery system, women, infants, and families can receive the care they need. In addition, specialty care services centered on caregivers' and infants' needs in the post-partum period must be expanded to improve outcomes, reduce involvement in child welfare and developmental impacts, and support strong starts for infants during critical developmental periods. By using an Interconnected Systems Framework, Nevada can improve outcomes through an integrated, coordinated care across multiple systems and build upon current policies, practices, and funding strategies for perinatal behavioral health.

ACONYMS

APPENDIX

APA - American Psychiatric Association
AAP - American Academy of Pediatrics
ACOG - American College of Obstetrics and Gynecology
AMCHP - Association of Maternal & Child Health Programs
BH – Behavioral Health
CARA - Comprehensive Addiction and Recovery Act
CAPTA - Child Abuse and Prevention Treatment Act
CCBHCs - Certified Community Behavioral Health Clinics
CoCM - Collaborative Care Model
CDC – Centers for Disease Control
CPS - Child Protective Services
CMS - Centers for Medicare and Medicaid Services
DCFS - Division of Child and Family Services
DHCFP – Division of Health Care Financing and Policy
DDHS - Department of Data, Analytics, and Health Statistics
DHS – Department of Human Services
DPBH -Division of Public and Behavioral Health
ED - Emergency department
FQHCs - Federally Qualified Health Centers
HRSA - Health Resources and Services Administration
MAT – Medication-assisted treatment
MOUD – Medication for Opioid Use Disorder
MCOs - Managed care organizations
MIECHVS- Maternal, Infant, and Early Childhood Home Visiting Program
NASADAD - National Association of State Alcohol and Drug Abuse Directors
NDSUH - National Survey on Drug Use and Health
NEIS – Nevada Early Intervention Services

APPENDIX

ACRONYMS

NHA - Nevada Health Authority
NICU – Neonatal Intensive Care Unit
OBs - Obstetricians
OB/GYN – Obstetrics and Gynecology
OUD -Opioid Use Disorder
PBH- Perinatal behavioral health
PHI – Perinatal Health Initiative
PSE – Prenatal Substance Exposure
PSI - Postpartum Support International
PWUD – People who use drugs
SDOH - Social Determinants of Health
SUD - Substance use disorder
UDS - Uniform Data System
UNR – University of Nevada, Reno

APPENDIX

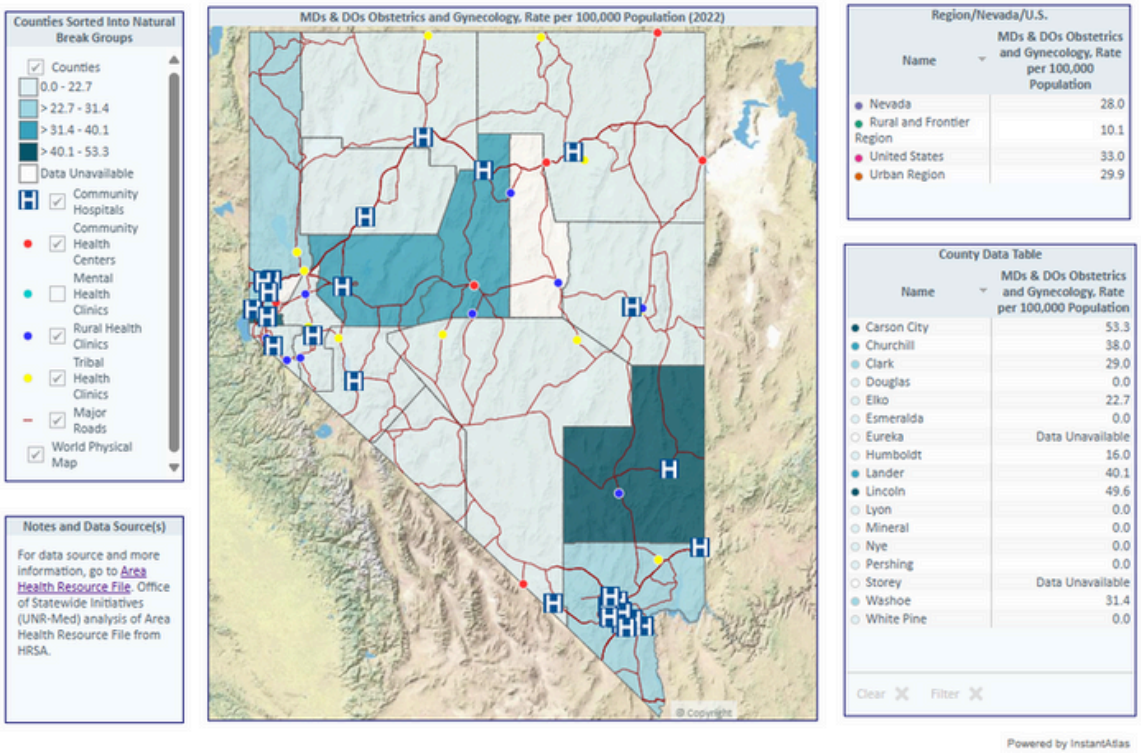
GLOSSARY OF TERMS

Terms	Definition
Comprehensive Addiction and Recovery Act (CARA)	Federal legislation addressing prevention, treatment and recovery services for substance use.
Continuity of care	A patient's ongoing healthcare management by a care team
Care Coordination	The process of organizing patient healthcare across multiple providers
Dyad	Unit of two (Mother and Infant)
Dyadic/Dyad Care	An approach that recognizes and treats a child and their primary caregiver (or caregivers) as a single, interdependent unit rather than as separate individuals.
Maternal Morbidity	Health complications resulting from pregnancy or childbirth
Maternal Mortality	Death of a woman during pregnancy or within one year after the end of pregnancy
Perinatal	The period of pregnancy and through one-year post-partum

GLOSSARY OF TERMS

Terms	Definition
Perinatal behavioral health	Mental health conditions, including substance use disorders, which occur in the perinatal period.
Perinatal Quality Collaborative	State and regional network of stakeholders working to improve quality of care for mothers and babies
Pregnancy Associated Death (PAD)	Death during pregnancy or within one year of the end of pregnancy attributed to any cause.
Pregnancy Related Death (PRD)	Death during pregnancy or within one year of the end of pregnancy from a pregnancy-related complication
Specialty care	Treatment services offered at dedicated addiction clinics often including medication assisted treatment (MAT), counseling and relapse prevention
Warm handoff	In-person hand-over or transfer of a patient from one provider to another
Managed Care Organizations (MCOs)	A health plan using managed care/coordination among providers to offer high quality services at a reduced cost

NEVADA PERINATAL BEHAVIORAL HEALTH SERVICES MAPPING



Map1: MDs & DOs Obstetrics and Gynecology in Nevada
Source: Area Health Resource File. Office of Statewide Initiatives (UNR-MED) analysis of Area Health Resource File from HRSA
Link: https://med2.unr.edu/SI/CountyData/atlas.html

This map and its accompanying data highlight the uneven distribution of obstetrics and gynecology (OB/GYN) physicians (MDs and DOs) across Nevada in 2022, underscoring a pressing health disparity challenge between urban and rural/frontier regions. While Nevada's overall rate of 28.0 providers per 100,000 population falls slightly below the national average of 33.0, this figure disguises the further existing disparity. With only four counties having rates above the US average (Carson, Churchill, Lander & Lincoln). Urban centers, particularly Carson City (53.3), Clark County (29.0), and Washoe County (31.4), concentrate the majority of OB/GYN specialists, ensuring access for metropolitan residents.

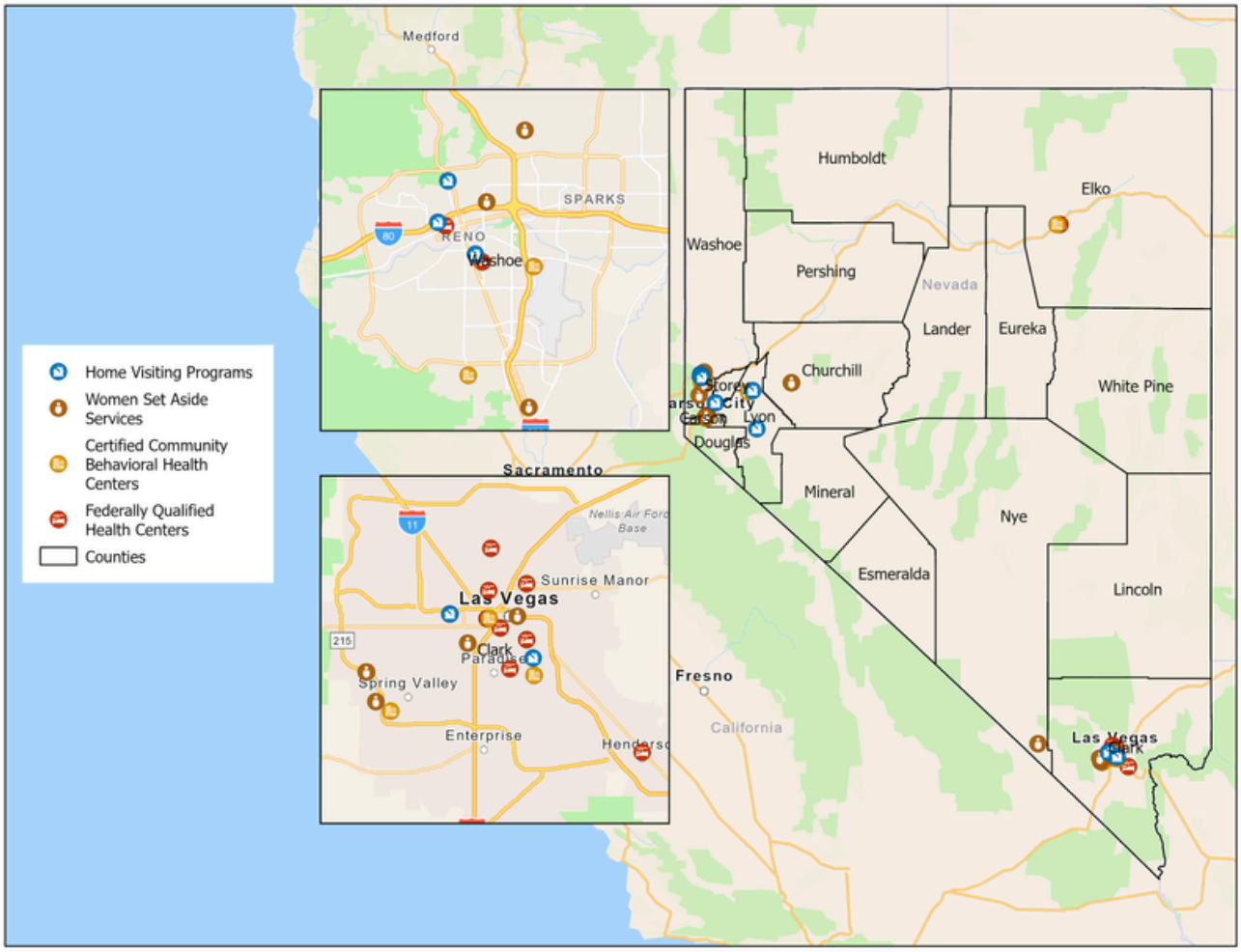
NEVADA PERINATAL BEHAVIORAL HEALTH SERVICES

By contrast, the state's rural and frontier regions average only 10.1 per 100,000, with seven counties (Douglas, Eureka, Lyon, Mineral, Nye, Pershing, and White Pine) reporting no providers. In these areas, residents often face travel for out of town to obtain prenatal, delivery, and gynecological services. A striking outlier is Lincoln County, which shows a rate of 49.6 per 100,000, a figure likely inflated by its very small population and the presence of about two providers. Ultimately, Nevada's provider distribution reflects a significant geographic imbalance, with women's health resources clustered in urban hubs and vast stretches of the state left underserved.

NEVADA'S PERINATAL BEHAVIORAL HEALTH NETWORK: ACCESS AND GEOGRAPHIC GAPS

The geographic mapping of perinatal behavioral health services across Nevada reveals a clear concentration of resources in urban areas, while rural regions have limited or no service availability. These services included Federally Qualified Health Centers (FQHCs), Certified Community Behavioral Health Clinics (CCBHCs), Home Visiting Programs, Women's Set-Aside–funded programs (including treatment centers), and other women-centered initiatives. Table 1 and Map 2 show a notable density of available services in urban counties such as Washoe, Clark, and Carson. In contrast, rural counties—including Douglas, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Pershing, and White Pine—lack dedicated perinatal behavioral health services. Although statewide initiatives such as Sober Moms, Healthy Babies and Doula Co-op aim to bridge these gaps through online and community-based resources, these efforts are inherently limited in reach and accessibility.

NEVADA PERINATAL BEHAVIORAL HEALTH SERVICES



Map 2: Perinatal Behavioral Health Service Providers in Nevada: Federally Qualified Health Centers, Certified Community Behavioral Health Centers, Women Set Aside Programs, Home Visiting Services.
Map Link: Map1: MDs & DOs Obstetrics and Gynecology in Nevada
Source: Area Health Resource File. Office of Statewide Initiatives (UNR-MED) analysis of Area Health Resource File from HRSA
Link: https://med2.unr.edu/SI/CountyData/atlas.html

Source: Health Resources and Services Administration (HRSA), Uniform Data System (UDS) 2025, Division of Public and Behavioral Health (DPBH) Dashboard 2025, Division of Public and Behavioral Health (DPBH) 2025

Federally Qualified Health Centers (FQHC)
Certified Community Behavioral Health Centers (CCBHC)
Women Set Aside Programs (WSAP)
Home Visiting Services (HVS)

TABLE 1: NEVADA PERINATAL BEHAVIORAL HEALTH SERVICES (COUNTY LEVEL)

County	Facility/Program	Category
Carson City	• Sierra Nevada Health Center • Community Counseling Center • Vitality Unlimited and Vitality Integrated Programs	• FQHC • CCBHC & WSAP • CCHBC
Churchill	• New Frontier Treatment Center, Fallon	• CCBHC & WSAP
Clark	• First Person Care Clinic, Las Vegas • FirstMed Health and Wellness Center, Las Vegas • Hope Christian Health Center Corp N Las Vegas • Southern Nevada Health District, Las Vegas • Martin Luther King Family Health, Las Vegas • North Las Vegas Family Health, Las Vegas • Henderson Family Health Center, Las Vegas • Eastern Family Medical & Dental, Las Vegas • Cambridge Family Health Center, Las Vegas	FQHC

TABLE 1: NEVADA PERINATAL BEHAVIORAL HEALTH SERVICES (COUNTY LEVEL)

County	Facility/Program	Category
Clark	• Bridge Counseling Associates, Las Vegas • Serenity Nonprofit, Las Vegas • Unshakable, Inc., Las Vegas • West Care Nevada, Las Vegas • Empowered, Las Vegas • Southern Nevada Health District: Nurse Family Partnership, Las Vegas • Sunrise Children's Foundation: Early Head Start and HIPPY, Las Vegas	• CCBHC • CCBHC • WSAP • WSAP • HVS • HVS
Elko	• Elko Family Medical & Dental Center • Vitality Unlimited | Vitality Integrated Programs	• FQHC • CCBHC
Lyon	• Rural Nevada Counseling (RNC), Silver Springs • Yerington Paiute Tribe: Parents as Teachers • Lyon County Human Services: Parents as Teachers home visiting services	• FQHC • HVS • HVS

TABLE 1: NEVADA PERINATAL BEHAVIORAL HEALTH SERVICES (COUNTY LEVEL)

County	Facility/Program	Category
NYE	• Living Free Health and Fitness, Pahrump	• HVS
Storey	• Community Chest, Inc, Virginia City	• HVS
Washoe	• Community Health Alliance, Reno • Northern Nevada HOPES • Quest Counseling, Reno • Vitality Unlimited | Vitality Integrated Programs, Reno • Step 2, Reno • Washoe County Human Services Agency • The Empowerment Center • University of Nevada, Reno: Early Head Start • The Children's Cabinet	• FQHC • FQHC • CCBHC • CCBHC • WSAP • WSAP • WSAP • HVS • HVS
Women Set Aside Programs (WSAP)		
Statewide	• Sober Moms, Healthy Babies • Empowering Nevada • Maternal Child Health Initiatives and Coalition • Doula Co-op	

Source: Health Resources and Services Administration (HRSA), Uniform Data System (UDS) 2025, Division of Public and Behavioral Health (DPBH) Dashboard 2025 Link: https://arcg.is/X1nWe

TABLE 2: FEDERALLY QUALIFIED HEALTH CENTERS PROVIDING BEHAVIORAL HEALTH SERVICES

This table lists all Federally Qualified Health Centers (FQHCs) indicating whether each facility provides behavioral health services, women's health services, or both.

Federally Qualified Health Centers	Behavioral Health Service	Women's Health Service
Community Health Alliance, Reno	Yes	No
First Person Care Clinic, Las Vegas	Yes	No
FirstMed Health and Wellness Center Las Vegas	Yes	No
Hope Christian Health Center Corp N Las Vegas	Yes	No
Sierra Nevada Health Center, Carson	Yes	No
Northern Nevada HOPES, Reno	Yes	No
Southern Nevada Health District, Las Vegas	Yes	No
Martin Luther King Family Health, Las Vegas	Yes	No

TABLE 2: FEDERALLY QUALIFIED HEALTH CENTERS PROVIDING BEHAVIORAL HEALTH SERVICES

Federally Qualified Health Centers	Behavioral Health Service	Women's Health Service
North Las Vegas Family Health, Las Vegas	Yes	No
Henderson Family Health Center, Las Vegas	Yes	No
Henderson Family Health Center, Las Vegas	Yes	No
Eastern Family Medical & Dental, Las Vegas	Yes	No
Sierra Nevada Health Center, Carson	Yes	No
Cambridge Family Health Center, Las Vegas	Yes	No

Source: Health Resources and Services Administration (HRSA), Uniform Data System (UDS) 2025

TABLE 3: CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS PROVIDING BEHAVIORAL HEALTH SERVICES

This table lists all Certified Community Behavioral Health Centers (CCBHCs) and indicates whether each facility provides behavioral health services, women's health services, or both.

Certified Community Behavioral Health Centers	Behavioral Health Service	Women's Health Service
Community Counseling Center (CCC), Carson	Yes	No
New Frontier Treatment Center, Fallon	Yes	No
Quest Counseling, Reno	Yes	No
Rural Nevada Counseling (RNC), Silver Springs	Yes	No
Vitality Unlimited | Vitality Integrated Programs, Carson, Elko and Reno	Yes	No
Bridge Counseling Associates, Las Vegas	Yes	No
Serenity Nonprofit, Las Vegas	Yes	No

Source: Division of Public and Behavioral Health (DPBH) Dashboard 2025

TABLE 4: HOME VISITING PROGRAMS AND WOMEN SET ASIDE SERVICES

This table lists all Home Visiting Programs, Women Set Aside Services.

Home Visiting Programs	• Southern Nevada Health District: Nurse Family Partnership, Las Vegas • Sunrise Children's Foundation: Early Head Start and HIPPY, Las Vegas • University of Nevada, Reno: Early Head Start, Reno • Yerington Paiute Tribe: Parents as Teachers • Lyon County Human Services: Parents as Teachers home visiting services • The Children's Cabinet - Washoe County • Community Chest, Inc, Virginia City
Women Set Aside Services	• New Frontier, Fallon • Step 2, Reno • Carson City Community Counseling Center • Unshakable, Inc., Las Vegas • Living Free Health and Fitness, Pahrump • West Care Nevada, Las Vegas • Perinatal Exposure Education Program (PEEP)

Source: Division of Public and Behavioral Health (DPBH) Dashboard 2025

TABLE 5: OTHER WOMEN-CENTERED INITIATIVES

Other Women-Centered Initiatives	• Nevada Home Visiting • Sober Moms, Healthy Babies • The Empowerment Center • Maternal Child Health Initiatives • Doula Co-op • Nevada Statewide Maternal Child Health Coalition • The Empowerment Center • Empowered- Roseman University, Las Vegas • Nevada Opioid Center of Excellence-Perinatal Substance Use Disorder Resources

Source: Division of Public and Behavioral Health (DPBH) Dashboard 2025

TABLE 6: CARA PLANS PER 100 BIRTHS PER COUNTY (HOSPITALS LISTED)

This table shows all hospitals included in the GIS mapping by county and CARA plan counts per 100 births.

Hospitals	County	Rate per 100 births
Carson Tahoe Regional Medical Center	Carson City	3.6
Banner Churchill Community Hospital, Fallon	Churchill	7.6
Centennial Hills Hospital Medical Center, Las Vegas	Clark	12.9
Henderson Hospital		
MountainView Hospital, Las Vegas		
Southern Hills Medical Center, Las Vegas		
Spring Valley Hospital Medical Center, Las Vegas		
St. Rose Dominican Siena Campus, Las Vegas		
Summerlin Hospital Medical Center, Las Vegas		

Source: Division of Public and Behavioral Health (DPBH) Dashboard 2025

TABLE 6: CARA PLANS PER 100 BIRTHS PER COUNTY (HOSPITALS LISTED)

Hospitals	County	CARA plan count per 100 births
Sunrise Hospital Medical Center, Las Vegas	Clark	
University Medical Center, Las Vegas		
Mike O'Callaghan Federal Hospital, Las Vegas		
Serenity Birth Center, Las Vegas		
St Rose Dominican Hospital San Martin, Las Vegas		
Northeastern Nevada Regional Health, Elko	Elko	1.6
Humboldt General Hospital	Humbolt	3.4
Desert View Regional Medical Center, Pahrump	Nye	20.0
Northern Nevada Sierra Medical Center, Reno	Washoe	4.3
Renown Regional Medical Center, Reno		

Source: Division of Public and Behavioral Health (DPBH) Dashboard 2025

TABLE 6: CARA PLANS PER 100 BIRTHS PER COUNTY (HOSPITALS LISTED)

Hospitals	County	CARA plan count per 100 births
William B Ririe Hospital, Ely	White pine	0.0
No documented hospitals submitting CARA plans	Esmeralda	0.0
	Eureka	0.0
	Douglas	0.0
	Lander	0.0
	Lincoln	0.0
	Lyon	0.0
	Pershin	0.0
	Storey	0.0

Source: Division of Public and Behavioral Health (DPBH) Dashboard 2025

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