

Maternal Mortality Review Committee Report and Maternal Mortality and Severe Maternal Morbidity Data Preliminary Report Nevada, 2024-2025

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Table of Contents

Acknowledgements	2
Introduction	4
Dedication	4
Recommendations	5
2026 Maternal Mortality Review Committee Recommendations	5
General Recommendations and Priorities of the MMRC	5
2026 Nevada Office of Minority Health and Equity Advisory Committee Recommendations	11
Maternal Mortality and Severe Maternal Morbidity Data Report Nevada, 2024-2025	11
Data and Equity Statement	11
Background	11
Maternal Mortality Data	12
Definitions Associated with Maternal Mortality	12
Pregnancy-Associated Death (PAD)	13
Methodology	13
General Statistics	16
Maternal Demographics	17
Underlying Causes of Pregnancy-Associated Deaths	24
Pregnancy-Related Death (PRD)	28
Methodology	28
General Statistics	28
Maternal Demographics	29
Underlying Causes of Pregnancy-Related Deaths	36
Maternal Deaths	38
Methodology	38
General Statistics	38
Maternal Demographics	39
Severe Maternal Morbidity (SMM) Data	40
Definition	40
Methodology	40
Data Sources	40
Identification of Severe Maternal Morbidity	41

Analysis	42
General Statistics	42
Indicators Associated with SMM	43
Maternal Demographics	45
Data Summary	49
MMRC Support Staff and Other Acknowledgements.....	51
Advisory Committee of the Office of Minority Health and Equity Members.....	51
Maternal Mortality Review Committee Members.....	52
Appendix A: MMRC MMRIA Data.....	53
Appendix B: Recommendation by Expected Impact	58
.....	58
.....	60
Appendix C: SMM Indicators and ICD-10 CM Codes.....	61

Introduction

Per Nevada Revised Statutes (NRS) [442.767](#), a biennial report must be developed and submitted by December 31 of each even-numbered year, in collaboration with the Advisory Committee of the Office of Minority Health and Equity and the Chief Medical Officer. The report must include a description of maternal mortality (MM) and severe maternal morbidity (SMM) incidents reviewed over the preceding 24 months, ensuring confidentiality. It must also summarize identified disparities, outline corrective action plans to reduce maternal mortality and morbidity, and provide recommendations for legislation or policy changes to improve health care delivery in the state. Both the Maternal Mortality Review Committee and the Advisory Committee of the Office of Minority Health and Equity provided recommendations to reduce MM and SMM.

Dedication

It is with deepest sympathy this report is dedicated to the memory of the Nevada women whose lives were lost due to maternal mortality. Each death represents a profound loss to their families, communities, and the state, and the report honors their lives and the legacies they leave behind.

The authors acknowledge the deep impact that these tragedies have on families and loved ones and are committed to using the findings in this report to guide meaningful change. Through a comprehensive review of the data, the aim is to better understand the factors contributing to maternal mortality and severe morbidity in Nevada, with the ultimate goal of preventing future losses.

Staff extend their gratitude to the families and friends who, despite their grief, have shared their stories to help inform this work. Their courage and willingness to contribute are invaluable in collective efforts to improve maternal health and ensure every woman receives the care and support she deserves.

Sincere gratitude is also due to the Maternal Mortality Review Committee for their extensive time and expertise committed to case review and the Advisory Committee of the Office of Minority Health and Equity who reviewed the report for additional recommendations; all generously volunteered their time and expertise.

Recommendations

2026 Maternal Mortality Review Committee Recommendations

The Maternal Mortality Review Committee (MMRC) identified recommendations to improve care in Nevada and to improve the work of the Committee and identified by contributing factors as well as perceived level of impact if implemented (giant through small) and level (system, provider, etc.) at which the recommendation would be implemented, per Centers for Disease Control and Prevention (CDC) best practices. Implementation of these recommendations would decrease preventable MM and severe SMM in Nevada through a range of interventions spanning medical best practices, systems level changes, social services and referral pathways, disparity and bias reduction, and through policy recommendations. Recommendations were generated by MMRC members in relation to a specific MM case review based on the facts available. For data specific to the cases reviewed by the MMRC to date please see the [Appendix A: MMRC Data](#) section of this report.

General Recommendations and Priorities of the MMRC

Maternal Mortality Review Committees (MMRCs) improve maternal health outcomes by leveraging data and best practices with the goal of accelerating improvement efforts for maternal and infant health outcomes. MMRCs review individual cases of maternal mortality to identify causes and systemic factors. Several recommendations of various topics are repeated across cases and expected impact levels. Please see [Appendix B: Recommendations by Expected Impact](#) section for further details. In the majority of states MMRCs share information with Perinatal Quality Collaboratives (PQC) who use this information to guide interventions, enhance clinical practices, and reduce preventable maternal deaths. Nevada is one of two states that do not have an established PQC. The MMRC recommendations strongly support the creation of a statewide PQC to help implement the critical MMRC recommendations detailed in this report.

Mental health and substance use disorder continue to be common contributing factors in MM, as was also seen in prior biennial MMRC reports. Per the deaths reviewed, those experiencing substance use disorder and or mental health issues struggle to access behavioral health treatment. The MMRC strongly encourages strengthening continuity of care and prioritizing pregnant people or people that have given birth within 365 days in access to care. The impact of traumatic experiences and the need to better address them early in the life course also continues to be a key priority highlighted in recommendations in this report and prior MMRC legislative reports. The suggestion that all hospitals in Nevada should enroll in and administer the Alliance for Innovation on Maternal Health (AIM) patient safety bundles is also highlighted. Participation in AIM helps ensure the adhering to national guidelines on standards of care to prevent negative outcomes.

MMRC recommendations are presented grouped by topic, below, and are based on de-identified case review. Recommendations for each topic area listed below are intended for healthcare systems, including hospitals, clinics, health training programs, urgent care, trauma centers, and payors to public services and programs, unless otherwise noted.

Lack of Access/Financial resources

1. The State of Nevada and Nevada Schools of Medicine should expand and strengthen the network of mental health providers, including offering incentives to recruit, educate, and retain mental health professionals.
2. Nevada Legislature should pass legislation allowing Nevada to enter into reciprocity agreements with other states to recognize out-of-state licenses for mental health professionals, particularly those with equivalent standards. This would reduce the time and costs associated with re-licensing and encourage qualified professionals to practice in Nevada.

3. Nevada State Medicaid should ensure access to appropriate mental health placement options that align with everyone's level of care needs.
4. The State and other relevant payers should ensure all residents have access to care which is recommended, including rehabilitation facilities, regardless of patient demographic characteristics.
5. State of Nevada agencies such as Nevada Medicaid should provide funding and appoint case care coordinators or community health workers to assist individuals facing multiple diagnoses related to substance use, mental health, and pregnancy. These case workers should be trained in trauma-informed care and motivational interviewing to support care follow-up and assist individuals in navigating the healthcare system.
6. State of Nevada agencies such as Nevada Medicaid and clinicians should ensure all patients who use substances are educated and informed about the risk of use in line with national practice guidelines and standards of care, including overdose prevention strategies such as test strip and naloxone usage.

Recommendations for Communities

1. State and relevant payers should have processes to connect those who do not qualify for insurance to receive health care and care coordination.

Failure to screen/inadequate assessment of risk

1. State of Nevada agencies such as Nevada Medicaid and clinicians should ensure all patients who use substances are educated and informed about the risk of use in line with national practice guidelines and standards of care, including overdose prevention strategies such as test strip and naloxone usage.
2. Facilities should provide resources and linkages to care with appropriate risk assessments for pregnant individuals without prenatal care that get care in the Emergency Department (ED) visits.

Recommendations for Providers.

1. Orthostatic vital signs should have been done prior to discharge from ED with complaints of dizziness and history of postpartum.

Chronic Disease

1. Clinicians should offer treatment for chronic disease including obesity, diabetes and hypertension.

Recommendations for Providers

1. When a patient presents with recurrent symptoms (symptoms that have not responded to treatment) the treatment cannot remain the same. Since chronic pain is associated with depression, a pain evaluation should be performed.
2. Providers managing chronic conditions should deliver care in accordance with national clinical guidelines and established standards of care.
3. Pain specialists should practice medicine in line with national guidelines, standards of care, and per Assembly Bill (AB) AB474 of the 2017 Legislative Session regulations in Nevada when treating patients.

Clinical Skill/Quality of Care

1. The State of Nevada should develop a perinatal quality collaborative to improve uptake of current standards of care recommendations.
2. Nevada hospitals should align with and become Alliance for Innovation on Maternal Health (AIM) designated facilities to adopt and utilize evidence-based AIM bundles like Perinatal Mental Health Conditions Bundle to guide best practice treatment for perinatal women.
3. An ultrasound should have been done in triage labor and delivery per American College of Obstetricians and Gynecologist (ACOG) guidelines and an appropriate birth spacing interval followed per ACOG standards, including education and prevention of first cesarean section to obstetric providers.

Recommendations for Providers

1. Pain specialists should practice medicine in line with national guidelines, standards of care, and per AB474 of the 2017 Legislative Session in Nevada when treating patients.
2. Mental Health clinicians should practice medicine in line with national guidelines, standards of care, and best practices when treating patients.
3. Providers managing chronic conditions should deliver care in accordance with national clinical guidelines and established standards of care.
4. Healthcare providers should administer the PHQ9 or other mental health evaluation for patients at risk for depression.
5. Clinicians should ensure appropriate specialty evaluation for postpartum patients with postpartum concerns.
6. Clinicians should further evaluate patients who present with symptoms of hypovolemia including prolonged assessment or imaging.
7. Emergency Room (ER) nurses need training on maternal warning signs.

Continuity of Care and Care Coordination

1. State of Nevada agencies and programs such as the Division of Public and Behavioral, Health Care Quality and Compliance (N.B., this is now with Nevada Health Authority), should ensure hospital Emergency Departments provide a standard prenatal care workup to patients who indicate they have not had prenatal care when seeking prenatal care.
2. Facilities should ensure discharge to appropriate mental health placement options that align with each individual's level of care needs.
3. All treatment centers, including prisons, hospitals, and inpatient/outpatient drug/mental health clinics should ensure continuity of care during transitions.
4. Clinical offices should follow up with patients who do not show up for appointments, especially the first visit.
5. Regional support is needed, there should be repeated offers from providers, care teams, and social services at time of interface. The state should support an increase in outreach to people with substance use disorders by peers and professionals at hospitals and jails to increase success rates.
6. ERs should implement an evidence-based protocol for handling positive self-harm screenings, ensuring immediate confirmation of mental health care with patients. An ER counselor should promptly communicate with the patient's mental health provider, sharing relevant records to verify ongoing care and provide an updated assessment of the patient's mental state.
7. State of Nevada agencies such as Nevada Medicaid should provide funding and appoint case care coordinators or community health workers to assist individuals facing multiple diagnoses related to substance use, mental health, and pregnancy. These case workers should be trained in trauma-informed care and motivational interviewing to support care follow-up and assist individuals in navigating the healthcare system.
8. Clinicians should ensure discharge to appropriate mental health placement options that align with each individual's level of care needs.
9. Nevada State Medicaid should establish and collaborate with legal guardians to ensure coordinated and continuous care to appropriate mental health placement options that align with each individual's level of care.
10. Insurers and birthing facilities should increase access to patient navigators to follow up for up to 1 year postpartum for high-risk patients, especially those with a history of chronic diseases.
11. Nevada Department of Health (DHS) should provide a service such as "care everywhere" where outside source information may pull for the patient from other sources which cues continuity of care for diagnoses, for example, if this was in place, the obstetric office may have seen the bipolar disorder diagnosis and could have worked with their patient regarding this.

Recommendations for Providers

1. Clinician who starts a patient on medication and initiates a safety plan needs to ensure follow through.

Mental Health Conditions

1. State agencies such as Medicaid should explore non-traditional ways to engage the health care system including long-term inpatient mental health care visits for persons with severe mental health conditions.
2. State of Nevada agencies and programs such as the Department of Human Services, Division of Public and Behavioral Health, Behavioral Health and Wellness Program and groups such as the Perinatal Health Initiative should assess the system for accessing care for people who use substances in pregnancy and reduce stigma in accessing care given Nevada's data show people who use substances experience delays in accessing care.
3. State of Nevada agencies such as Nevada Medicaid should provide funding and appoint case care coordinators or community health workers to assist individuals facing multiple diagnosis related to substance use, mental health, and pregnancy. These case workers should be trained in trauma-informed care and motivational interviewing to support care follow-up and assist individuals in navigation of the healthcare system.
4. Provide better continuity of care for people with mental health conditions. State agencies such as Medicaid should explore other non-traditional ways to engage the health care system including utilizing home-based nursing care visits and/or telehealth for perinatal patients.

Recommendations for Providers

1. Clinicians should implement ACOG optimizing postpartum care in the postpartum period for patients with a mental health history.

Substance Use Disorder- Alcohol, Illicit/Prescription Drugs

1. Naloxone should be widely available in the community for bystander administration and should be given by first responders to any unresponsive person when etiology is unknown.
2. The state should support an increase in outreach to people with substance use disorders by peers and professionals at hospitals and jails to increase success rates in the program.
3. Nevada state agencies should implement adolescent-specific mental health care to prevent deaths among pregnant adolescents using substances. This includes expanding specialized programs, training providers in trauma-informed care, and ensuring adolescents have access to case coordinators and timely mental health screenings. Strengthening collaboration between healthcare, education, and social services will provide continuous support for adolescents throughout pregnancy and postpartum.
4. State of Nevada agencies such as Nevada Medicaid should provide funding and appoint case care coordinators or community health workers to assist individuals facing multiple diagnoses related to substance use, mental health, and pregnancy. These case workers should be trained in trauma-informed care and motivational interviewing to support care follow-up and assist individuals in navigating the healthcare system.
5. All treatment centers, including prisons, hospitals, and inpatient/outpatient drug/mental health clinics, should ensure continuity of care during transitions.
6. Regional support is needed, including repeated offers from providers, care teams, social services at time of interface. The state should support an increase in outreach to people with substance use disorders by peers and professionals at hospitals and jails to increase success rates in the program.

Recommendations for Providers

1. Clinicians should follow standard of care in treatment of mental health including substance use during the perinatal period.
2. Clinicians should practice in line with national guidelines, standards of care, and per AB474 of the 2017 Legislative Session, when treating patients, particularly with substance use disorder or with controlled substances.

3. Clinicians should follow standard of care in the treatment of mental health and substance use disorders including assessing risk factors, screenings and referrals during the perinatal period including postpartum.
4. Clinicians should universally perform questionnaire screening on all patients for mental health and substance use disorders at minimum at the first prenatal visit, third trimester, at labor and delivery, and postpartum visits.

Recommendations for the Community

1. The State of Nevada should implement more programs for free medication-assisted substance use treatment and ensure providers are available to provide the treatment.

Trauma

1. The Nevada Department of Education should include trauma resiliency in the K-12 curriculum.
2. The Nevada Department of Education should provide staff training in trauma-informed education and resiliency.
3. State of Nevada agencies and programs such as the Nevada Department of Education and Department of Human Services should develop and implement at least two robust evidence-based education-based programs and support to effectively screen for and address Adverse Childhood Experiences (ACEs) in educational settings then provide interventions if screened positive.

Recommendations for the Community

1. State of Nevada agencies and programs such as the Nevada Department of Education and Department of Human Services should develop and implement at least two robust evidence-based education-based programs and support to effectively screen for and address ACEs in educational settings.

Lack of knowledge regarding importance of event, or of treatment, or of follow-up

1. Nevada hospitals should align with and become Alliance for Innovation on Maternal Health (AIM) designated facilities to adopt and utilize evidence-based AIM bundles like Obstetric Hemorrhage Bundle to guide best practice treatment for patients that experience obstetric hemorrhage.
2. In situations of severe hemorrhage, the massive transfusion protocol should be followed.
3. State of Nevada agencies such as Nevada Medicaid and clinicians should ensure all patients who use substances are educated and informed about the risk of use in line with national practice guidelines and standards of care, including overdose prevention strategies such as test strip and naloxone usage.
4. The entire health care system should offer every person with an OUD, medication for opioid use disorder as the standard of care.
5. The entire health care system should ensure continuity of care during transitions. All treatment centers, including prisons, hospitals, and inpatient/outpatient drug/mental health clinics, should ensure continuity of care during transitions.

Recommendations for Providers

1. The entire health care system should treat all co-occurring co-morbidities including mental health before, during and after pregnancy as the standard of care.
2. Mental Health clinicians should practice medicine in line with national guidelines, standards of care, and best practices when treating patients.
3. Provider should have tested for thrombosis preventive screening and activated recognition and prevention of hemorrhage per Alliance for Innovation on Maternal Health (AIM).

Inadequate community outreach/resources

1. DHCFP should encourage all MCOs to utilize and bill in lieu of services (ILOS) in perinatal populations for housing and food insecurity.
2. State of Nevada agencies such as Nevada Medicaid should provide funding and appoint case care coordinators or community health workers to follow patients at high risk consistently.

3. State of Nevada should promote available resources including 211, 988, 1-833-TLC-MAMA, and Family Navigation Network.

Lack of standardized policies/procedures

1. The State of Nevada should develop a perinatal quality collaborative to improve uptake of current standard of care recommendations.
2. The entire health care system should offer buprenorphine as first line standard of treatment to all reproductive aged people who can become pregnant that have an opioid use disorder.

Lack of referral/consultation or delay in care

1. State of Nevada agencies, such as Child Protective Services, should have stronger training and protocols to follow for referral and follow-up for treatment interventions to improve outcomes across the spectrum of needs.
2. State of Nevada agencies such as the Division of Health Care Financing and Policy should audit Medicaid perinatal patient navigators and case managers to ensure quality care coordination, timely referral to needed services, and patient connection to services is occurring.

Recommendations for Providers

1. An ultrasound should have been done in triage labor and delivery per ACOG guidelines and an appropriate birth spacing interval followed per ACOG standards, including education and prevention of first cesarean section to obstetric providers.

Discrimination

1. The entire health care system should not use judgmental, discriminatory, or stigmatizing language when providing care of any capacity for persons with a substance use and or mental health disorder. Instead, positive person first language should be used.
2. Health care systems, including clinicians, should escalate care as appropriate when it appears that a patient's health is declining and not minimizing symptomatology or care based on bias.

Unstable Housing

1. The State of Nevada should invest in low-income housing support at rates that are comparable to poverty levels.
2. Medicaid should encourage all Managed Care Organizations to utilize and bill in lieu of services (ILOS) in perinatal populations for housing and food insecurity.

Lack of family/friend or support system

Recommendations for Providers

1. Clinicians should establish a safety plan with any patient at risk of suicide that would include a family safety plan and emphasizing reduction of access to lethal with her support system.

Violence

1. State should evaluate support for victims of intimate partner violence and reduce gaps in access to services.

Law enforcement

Recommendations for the community

1. State of Nevada agencies such as the Office of Traffic Safety (OTS) should launch updated seatbelt campaigns that emphasize the life-threatening risks and long-term consequences of not wearing a seatbelt. These campaigns should focus on personal safety, real-life stories, and the impact on loved ones to encourage better compliance.

- a. This recommendation resulted in social media development by the OTS that was shared by OTS and DHS.

2026 Nevada Office of Minority Health and Equity Advisory Committee Recommendations

Recommendations from the Nevada Office of Minority Health and Equity Advisory Committee are based on review of the first draft of the Maternal Mortality and Severe Maternal Morbidity 2024-2025 Legislative Report at the August 18, 2026 meeting and November 2026 meeting.

Maternal Mortality and Severe Maternal Morbidity Data Report Nevada, 2024-2025

This report was produced by the Nevada Health Authority Office of Analytics staff on behalf of the Division of Public and Behavioral Health, Department of Human Services.

Data and Equity Statement

Demographic language may differ throughout this report depending on the sources from which data were retrieved. To report the data accurately, variables such as race, ethnicity and sex are described in the report as they were in the source data. Every effort has been made to be inclusive and equitable across every demographic to provide a fair and accurate representation of the people of Nevada. The Department of Human Services recognizes the terms female and woman do not include all birthing people but used descriptors as presented in source data, such as when referring to rates per 100,000 women of reproductive age.

The data in the remainder of this report is sourced from different origins than the MMRC case review data discussed in the MMRC MMRIA section above. Data may be suppressed to protect confidentiality in accordance with best practices, which may affect the reporting of small cell sizes and certain population groups, including American Indian/Alaska Native and Native Hawaiian/Pacific Islander populations where individual identification could be possible.

Background

The Nevada MMRC was established in 2020. The Committee reviews all pregnancy-associated deaths in Nevada (encompassing all deaths of Nevadans while pregnant or within one year of the end of pregnancy, due to any cause) and develops recommendations to prevent future deaths.¹ [Nevada Revised Statutes \(NRS\) 442.767](https://www.leg.state.nv.us/nrs/nrs-442.html#NRS442Sec767) states the Department of Human Services compile and publish a biennial report on or before December 31 of each even-numbered year consisting of data concerning MM and SMM in this Nevada. This report will cover the years 2020 through 2025 and focus on 2024 and 2025 as these are the most recent two years for which data is available.

Maternal Mortality

Maternal mortality is defined as deaths due to complications from pregnancy or childbirth. This report provides insight into demographic characteristics, cause of death, and drug overdose deaths associated with pregnancy-associated deaths from January 2024 to December 2025. This report also provides data on pregnancy-related

¹ Nevada Legislature website. <https://www.leg.state.nv.us/nrs/nrs-442.html#NRS442Sec767>

deaths from Pregnancy Maternal Surveillance System (PMSS) during 2020 through 2024. PMSS is a national surveillance program conducted by the Centers for Disease Control and Prevention (CDC) to understand better the risk factors for and causes of pregnancy-related deaths in the United States. The Nevada Health Authority Office of Analytics annually provides a list of pregnancy-associated deaths to the CDC.² Medically trained epidemiologists at the CDC review and analyze the cases provided, determine which cases meet the CDC's definition of pregnancy-related mortality, and the CDC sends the finalized dataset back to the Office of Analytics. At the time of this report, 2024 data was the latest year available which is included in this report. For more information on PMSS, please visit [CDC PMSS](#).

Severe Maternal Morbidity

Maternal morbidity is a continuum from mild adverse effects to life-threatening events or death. Severe Maternal Morbidity (SMM) refers to conditions and diagnoses which indicate potentially life-threatening maternal complications. SMM includes unexpected outcomes of labor and delivery resulting in significant short- or long-term consequences for health.³ SMM relates to higher risks of adverse pregnancy outcomes like preterm birth and infant death.⁴ SMM is associated with a high rate of preventability. SMM can be considered a near miss for maternal mortality because, without identification and treatment, the conditions would lead to maternal death in some cases. Identifying SMM is important for preventing injuries leading to mortality and highlighting opportunities to avoid repeat injuries. This report highlights Nevada disparity data on SMM across race, ethnicity, geography, insurance status, education, age, as well as prenatal and delivery characteristics such as prenatal care initiation, adequacy of prenatal care, parity, method of delivery, plurality, and chronic disease.

Maternal Mortality Data

As noted previously, MM is defined as deaths due to complications from pregnancy or childbirth. There are three terms or definitions related to MM, and they are described below and shown in Figure 1. Populations are disparately impacted by MM are reflected in the graphs and tables below.

Definitions Associated with Maternal Mortality

Pregnancy-Associated Death (PAD) is the death of a person while pregnant or within one year of the termination of pregnancy, regardless of the cause. Pregnancy-associated death ratio is the number of pregnancy-associated deaths per 100,000 live births.

Pregnancy-Related Death (PRD) is the death of a person during pregnancy or within one year of the end of pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. Pregnancy-related death ratio is the number of pregnancy-related deaths per 100,000 live births.

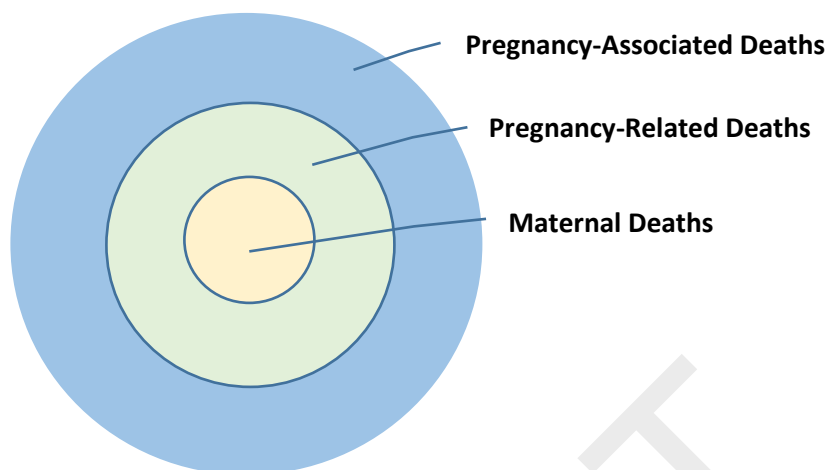
Maternal Death is the death of a person while pregnant or within 42 days of the termination of pregnancy, regardless of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

² [Maternal Mortality Prevention](#)

³ Severe Maternal Morbidity, New York City, 2008-2014. <https://www.cdc.gov/maternal-infant-health/php/severe-maternal-morbidity/index.html>

⁴ Geller SE, Rosenberg D, Cox SM, Brown ML, Simonson L, Driscoll CA, et al. The continuum of maternal morbidity and mortality: factors associated with severity. Am J Obstet Gynecol 2004;191:939-44.

Figure 1: Relationship Among Three Parts of Maternal Mortality – Pregnancy-Associated Deaths, Pregnancy-Related Deaths, and Maternal Deaths



The Maternal Mortality section of this report will explore Pregnancy-Associated Deaths, then Pregnancy-Related Deaths, and finally Maternal Deaths.

Pregnancy-Associated Death (PAD)

Methodology

Data Sources

Web-Enabled Vital Records Registry Systems (WEVRRS)

Statewide births, deaths, and fetal deaths are collected by the Office of Vital Records, in the Division of Public and Behavioral Health. WEVRRS is a software utilized by physicians, registered nurses, midwives, informants or funeral directors, and other individuals to collect and consolidate birth and death-related information.

Hospital Billing Data (Emergency Department Encounter and Hospital Inpatient Admissions)

The hospital billing data provides health billing data for emergency department encounters and inpatient admissions for Nevada's non-federal hospitals. NRS 449.485 mandates all hospitals in Nevada report information as prescribed by the Director of the Department of Human Services. The data are collected using a standard universal billing form. The data includes demographics such as age, gender, race/ethnicity, and uses International Classification of Diseases-9-Clinical Modification (ICD-9-CM) diagnoses codes and International Classification of Diseases-10-Clinical Modification (ICD-10-CM) diagnoses. ICD-10-CM diagnoses codes replaced ICD-9-CM diagnoses codes in the last quarter of 2015. Therefore, data prior to last quarter in 2015 may not be directly comparable to data thereafter. In addition, the data includes billed hospital charges, procedure codes, discharge status, and external cause of injury codes. The billing information is for billed charges and not the actual payment received by the hospital.

State Demographer Data

The Nevada State Demographer provides the Nevada population of women of reproductive age which is used in calculating rates.

Identification of Pregnancy-Associated Deaths

The methodology is based on Reference Guide for Pregnancy-Associated Death Identification which was developed by the Pregnancy-Associated Death Identification Workgroup, consisting of members from state departments of health and the Centers for Disease Control and Prevention (CDC)⁵.

Identifying by Vital and Hospital Discharge Records Linkages

A death data set is created for a given year for all Nevada female residents ages 10-60 years. Two data sets (birth and fetal death records, delivery and postpartum emergency department encounter and hospital inpatient admission records) are created for the same given calendar year and previous calendar year. Death records of people ages 10-60 years are first linked with birth and fetal death records based on mother's social security number (SSN). Death records of people ages 10-60 years that are not linked using SSN are then matched to birth and fetal death records using mother's first name, mother's last name, and mother's date of birth. Non-matched death records are then linked with delivery and postpartum emergency department encounter and hospital inpatient admission records based on mother's SSN, mother's name, and date of birth. SAS software is used for the linkages.

Identifying by Causes of Death Information

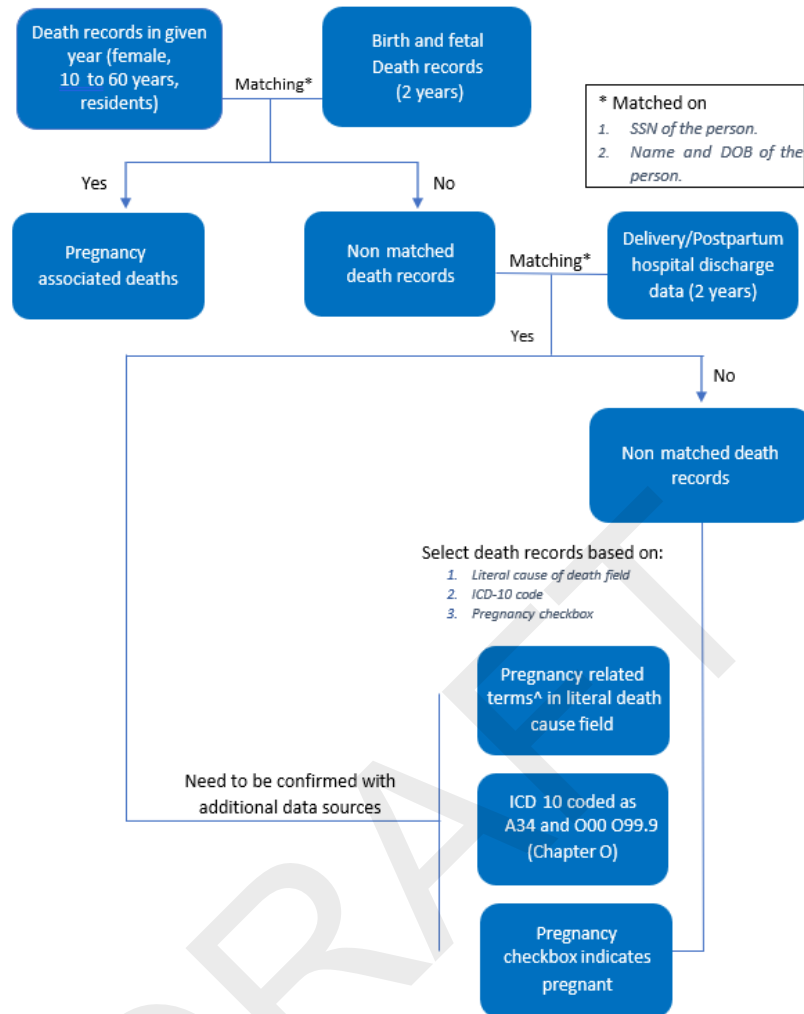
Some pregnancy-associated deaths, such as those occurred early during pregnancy, will not have birth or fetal death records to link. In order to identify pregnancy-associated deaths among those death records, the only records selected are death records of female ages 10-60 where the underlying causes of death were coded in A34 and O00-O99.9 (i.e., ICD-10 codes related to pregnancy) and/or the literal death cause field contains any of the following pregnancy-related terms: amniotic, chorioamnionitis, eclampsia, ectopic, intrauterine fetal demise, peripartum, peripartum cardiomyopathy, placental, postpartum, pregnancy, pregnant, uterine hemorrhage, and uterine rupture. Selected pregnancy-associated deaths should be confirmed with additional data sources to avoid misclassification. Examples of additional confirmatory sources are provided in the section on Additional Data Sources.

Identifying by Pregnancy Checkboxes on the Death Records

Staff also select death records of females ages 10-60 where the pregnancy checkbox on the death record was checked as: pregnant at time of death, not pregnant but pregnant within 42 days of death or not pregnant but pregnant 43 days to one year before death. Selected pregnancy-associated deaths should be confirmed with additional data sources to avoid misclassification. Examples of additional confirmatory sources are provided in the section on Additional Data Sources.

⁵ Centers for Disease Control and Prevention (CDC). "Reference Guide for Pregnancy-Associated Death Identification." <https://www.cdc.gov/maternal-mortality/php/mmrc/reference-guide.html>

Figure 2: Flow Chart of Identifying Pregnancy-Associated Deaths



^ Pregnancy-related terms are amniotic, chorioamnionitis, eclampsia, ectopic, intrauterine fetal demise, peripartum, peripartum cardiomyopathy, placental, postpartum, pregnancy, pregnant, uterine hemorrhage, and uterine rupture.

Additional Data Sources

Additional data sources identified by the Pregnancy-Associated Death Identification Workgroup that can help confirm pregnancy for deaths which do not link to vital records and hospital discharge records, but have pregnancy indicated by causes of death information and/or pregnancy checkbox on the death record.

- Obituaries
- Social Media
- Media and News Reports
- Certifier Confirmation
- Autopsy Reports

Analysis

The analyses in the report are for pregnancy-associated deaths for Nevada residents only. Pregnancy-associated death ratio is the number of pregnancy-associated deaths per 100,000 live births. The calculation for maternal mortality ratio = (Number of resident maternal deaths/Number of resident live births) x 100,000. Pregnancy-related death rate is the number of pregnancy-related deaths per 100,000 women of reproductive age. The calculation for maternal mortality rate = (Number of resident maternal deaths/Number of resident women of reproductive age) x 100,000.

The linkages and analyses were performed by using SAS 9.4.

General Statistics

There were 150 pregnancy-associated deaths (PAD) in Nevada from 2021 to 2025 (sum of counts by year displayed in Figure 3a). There was a total of 55 pregnancy-associated deaths from January 2024 to December 2025.

The highest ratio was in 2021, at 116.4 PAD per 100,000 live births (Figure 3b) and a rate of 6.1 PAD per 100,000 women of reproductive age (Figure 3c).

Figure 3a: Count of Pregnancy-Associated Deaths, Nevada 2021-2025

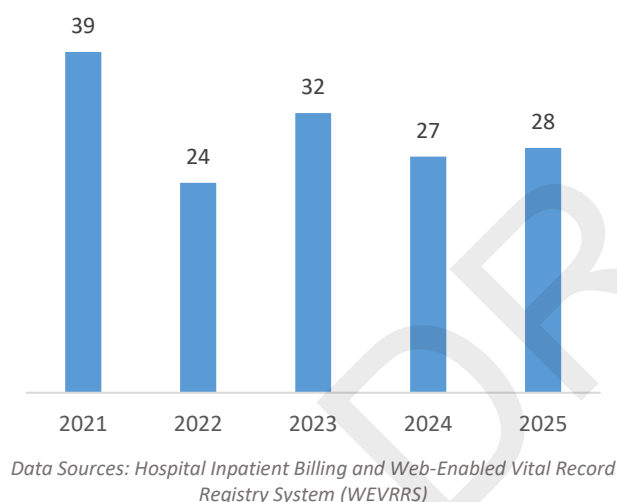


Figure 3b: Pregnancy-Associated Death Ratio per 100,000 Live Births, Nevada 2021-2025

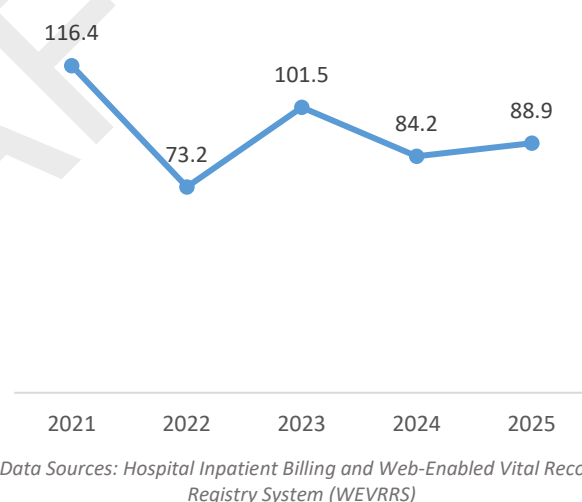
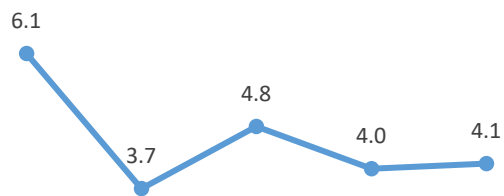


Figure 3c: Pregnancy-Associated Death (PAD) Rate per 100,000 Women of Reproductive Age by Year, Nevada 2021-2025

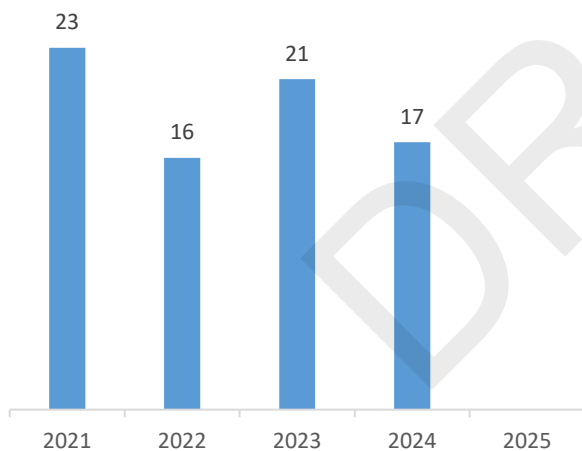


2021 2022 2023 2024 2025

Data Sources: Hospital Inpatient Billing, State Demographer, Web-Enabled Vital Record Registry System (WEVRRS)

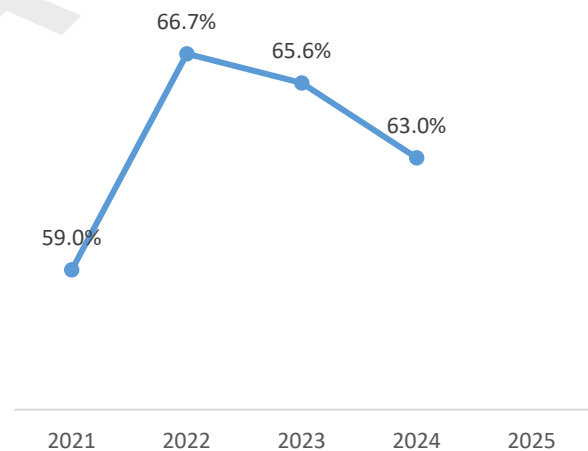
Medicaid is a major payor of Nevada births. From 2021 to 2025, over half of Nevada births had Medicaid as the primary insurance/payor source. The count of PAD cases has varied over the years (Figure 4a), and the percentage of PAD cases associated with Medicaid-covered births in Nevada (Figure 4b).

Figure 4a: Count of Pregnancy-Associated Deaths (PAD) associated with Medicaid-covered births, Nevada 2021-2025



Data Sources: Hospital Inpatient Billing and Web-Enabled Vital Record Registry System (WEVRRS)

Figure 4b: Percent of Pregnancy-Associated Deaths (PAD) associated with Medicaid-covered births, Nevada 2021-2025



Data Sources: Hospital Inpatient Billing and Web-Enabled Vital Record Registry System (WEVRRS)

Maternal Demographics

A total of 55 Nevadans had a pregnancy-associated death from 2024 through 2025. By race and ethnicity, these Nevadans who died were 30.9% White, non-Hispanic, 29.1% Black, non-Hispanic, 30.9% Hispanic, 7.3% Asian/Pacific Islander (API), non-Hispanic, 1.8% were American Indian/Alaska Native (AI/AN), non-Hispanic.

AI/AN, non-Hispanic Nevadans had the highest pregnancy-associated death ratio at 248.8 per 100,000 live births (Figure 5b). Black, non-Hispanic Nevadans had the second highest pregnancy-associated death ratio at 203.6 per

100,000 live births and accounted for 29.1% of the pregnancy-associated deaths (Figure 5a 5b). Hispanic Nevadans had the lowest death ratio at 67.5 per 100,000 live births. Additionally, Black, non-Hispanic Nevadans had the highest death rate at 12.7 per 100,000 women of reproductive age (Figure 5c), nearly 2 times higher than the next highest group (AIAN, non-Hispanics at 6.5 per 100,000 women of reproductive age).

Figure 54a: Percent of Pregnancy-Associated Deaths (PAD) by Maternal Race/Ethnicity, Nevada 2024-2025

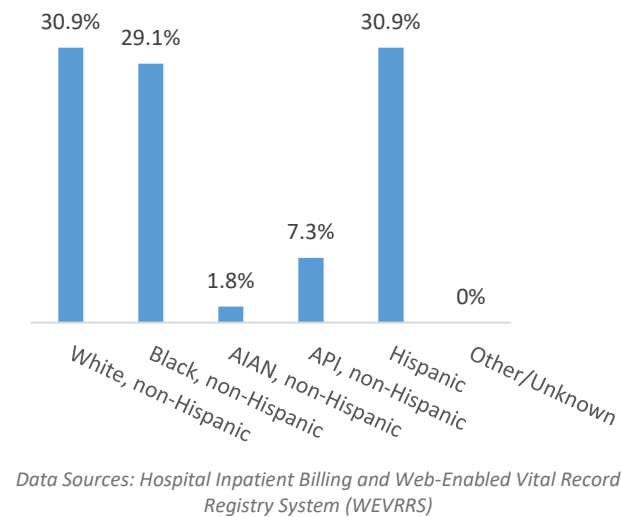


Figure 5b: Pregnancy-Associated Death (PAD) Ratio per 100,000 Live Births by Maternal Race/Ethnicity, Nevada 2024-2025

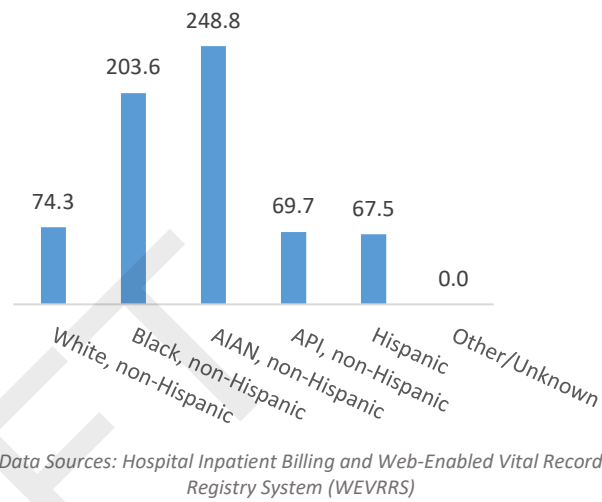
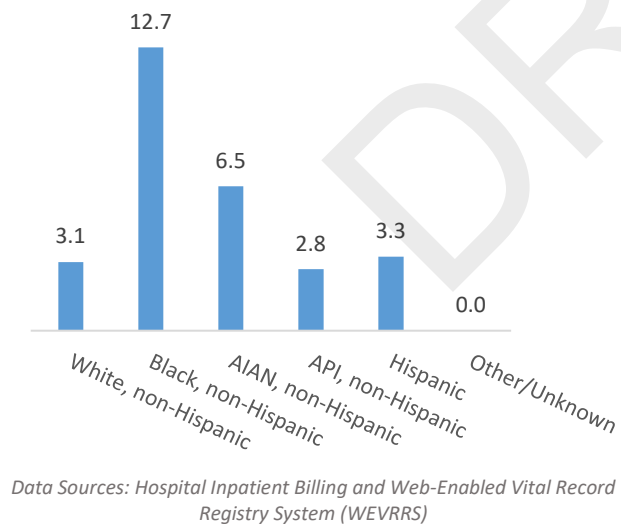


Figure 5c: Pregnancy-Associated Death (PAD) Rate per 100,000 Women of Reproductive Age by Race/Ethnicity, Nevada 2024-2025



Nevadans aged 30-34 accounted for a total of 29.1% of deaths (Figure 6a). Nevadans aged 40-60 had the highest pregnancy-associated death ratio at 143.6 PAD per 100,000 live births, followed by the 20-24 age group at a ratio of 121.3 PAD per 100,000 live births (Figure 6b).

Figure 6a: Percent of Pregnancy-Associated Death (PAD) by Maternal Age Group Nevada 2024-2025

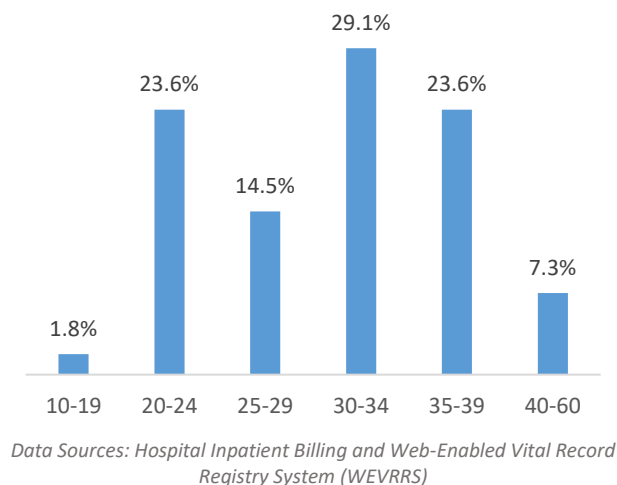


Figure 6b: Pregnancy-Associated Death (PAD) Ratio per 100,000 Live Births by Maternal Age Group, Nevada 2024-2025

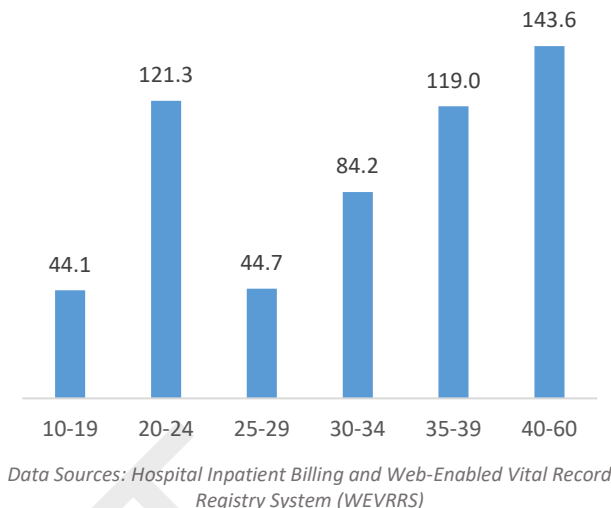


Figure 6c: Pregnancy-Associated Death (PAD) Rate per 100,000 Women of Reproductive Age by Maternal Age Group, Nevada 2024-2025

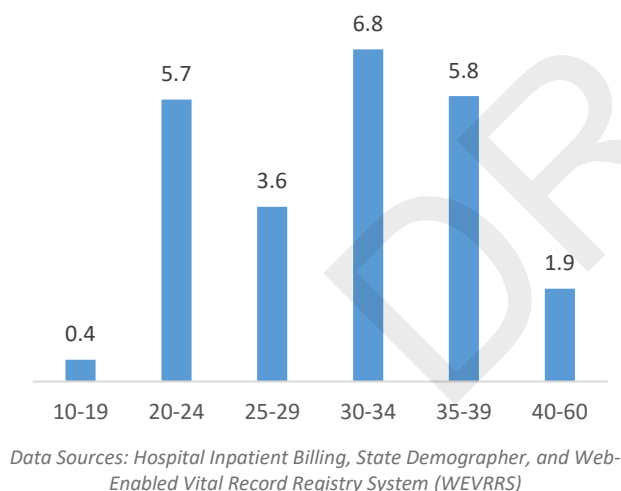
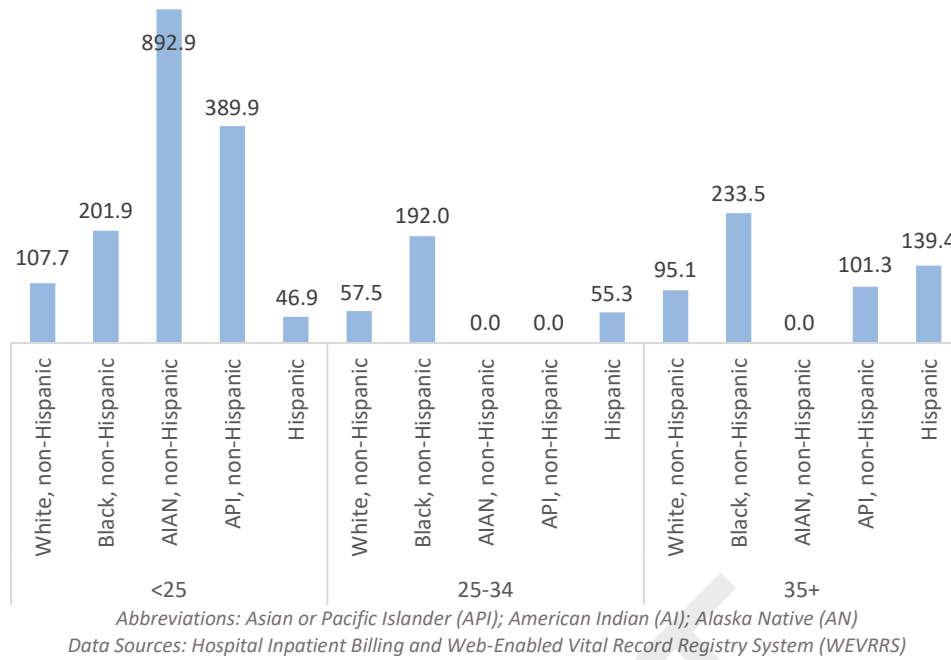


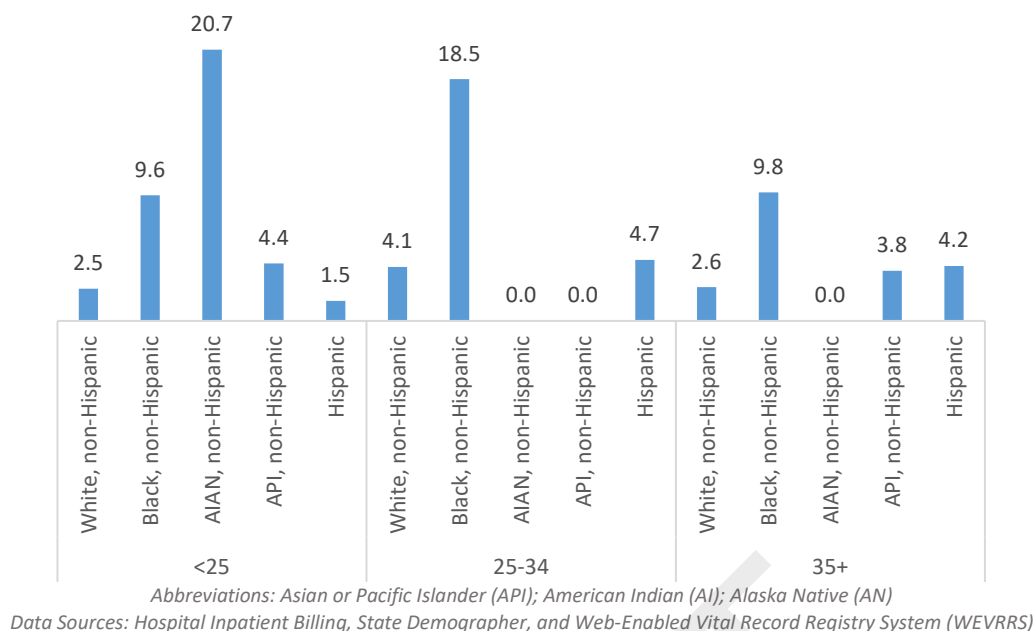
Figure 7 illustrates the pregnancy-associated death ratio for each race and ethnicity within the age groups of <25, 25-34, and 35 and older. For age group <25, American Indian/Alaska Native (AI/AN), non-Hispanic Nevadans had the highest PAD ratio at 892.9 per 100,000 live births, with Asian/Pacific Islander (API) non-Hispanic being the second highest at 389.9 per 100,000 live births. For age group 25-34, Black, non-Hispanic had the highest PAD ratio at 192.0 per 100,000 live births. There were no reported counts for AIAN, non-Hispanic or API, non-Hispanic. For age group 35+, Black, non-Hispanic Nevadans had the highest PAD ratio at 233.5 per 100,000 live births, and there were no reported counts for AIAN non-Hispanic.

Figure 7: Pregnancy-Associated Death (PAD) Ratio per 100,000 Live Births by Maternal Age and Race/Ethnicity, Nevada 2024-2025



American Indian/Alaska Native (AI/AN), non-Hispanic Nevadans within the age group 25-34 had the highest pregnancy-associated death rates at 20.7 per 100,000 women of reproductive age each (Figure 8).

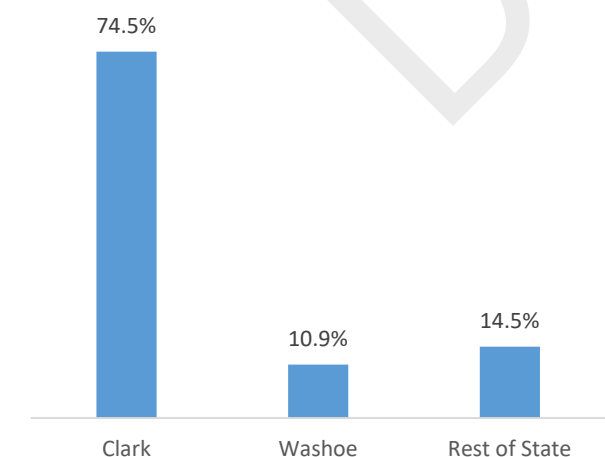
Figure 8: Pregnancy-Associated Death (PAD) Rate per 100,000 Women of Reproductive Age by Maternal Age and Race/Ethnicity, Nevada 2024-2025



Most pregnancy-associated deaths occurred in Clark County (74.5%) (Figure 9a), which is proportional to its live births' percentage of 74.6%. However, the Rest of State category had the highest pregnancy-associated death ratio at 127.3 per 100,000 live births and Washoe County had the lowest ratio at 60.8 per 100,000 live births (Figure 9b). Counties included in the category of Rest of State were Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine.

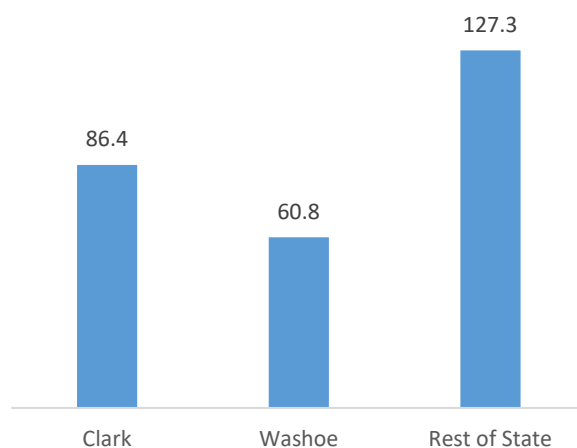
The Rest of State had the highest death rate at 6.0 per 100,000 women of reproductive age, followed by Clark County at 4.1 per 100,000 women of reproductive age (Figure 9c).

Figure 9a: Percent of Pregnancy-Associated Deaths (PAD) by County of Residence, Nevada 2024-2025



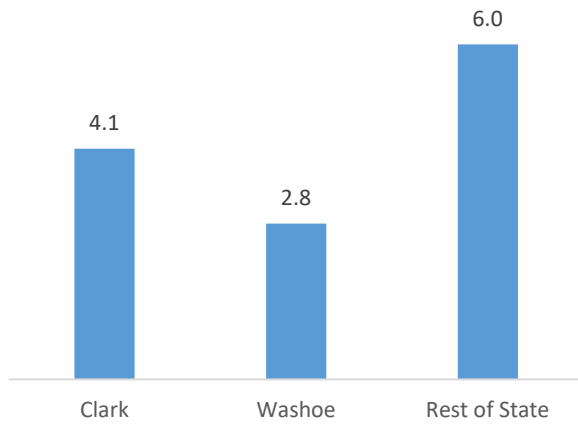
Data Sources: Hospital Inpatient Billing and Web-Enabled Vital Record Registry System (WEVRRS)

Figure 9b: Pregnancy-Associated Death (PAD) Ratio per 100,000 Live Births by County of Residence, Nevada 2024-2025



Data Sources: Hospital Inpatient Billing and Web-Enabled Vital Record Registry System (WEVRRS)

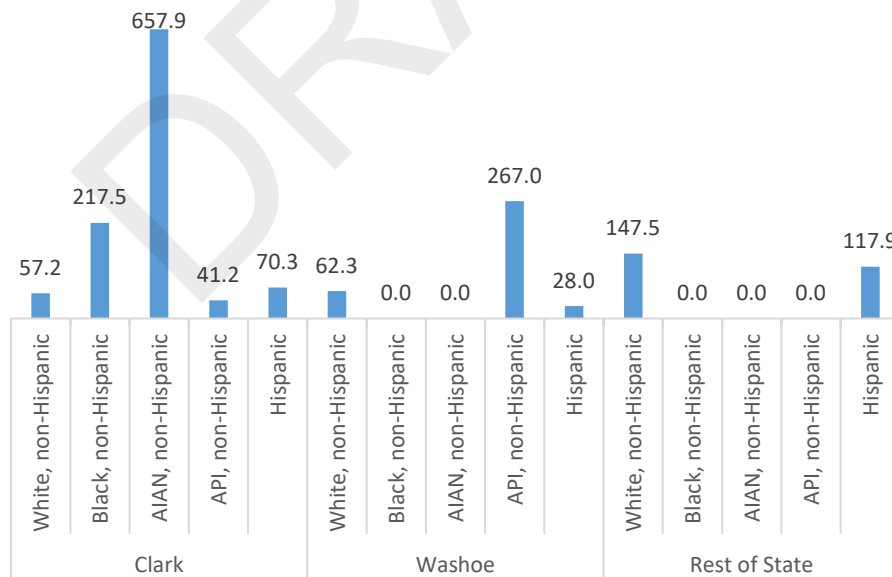
Figure 9c6: Pregnancy-Associated Death (PAD) Rate per 100,000 Women of Reproductive Age by County of Residence, Nevada 2024-2025



Data Sources: Hospital Inpatient Billing, State Demographer, and Web-Enabled Vital Record Registry System (WEVRRS)

The pregnancy-associated death ratio for each race and ethnicity group within Clark County, Washoe County and Rest of State is shown in Figure 10. In Clark County, American Indian/Alaska Native (AI/AN), non-Hispanic Nevadans had the highest PAD ratio at 657.9 per 100,000 live births. In Washoe County, Asian/Pacific Islander (API), non-Hispanic Nevadans had the highest PAD ratio at 267.0 per 100,000 live births. In the Rest of State, White, non-Hispanic Nevadans had the highest PAD ratio at 147.5 per 100,000 live births.

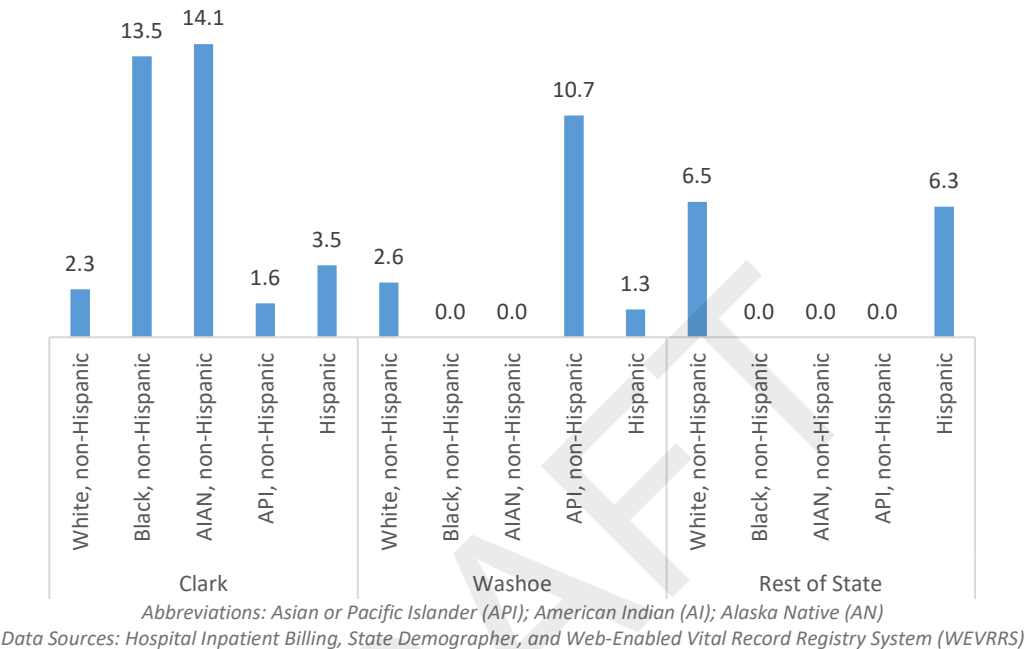
Figure 10: Pregnancy-Associated Death (PAD) Ratio per 100,000 Live Births by County of Residence and Maternal Race/Ethnicity, Nevada 2024-2025



Abbreviations: Asian or Pacific Islander (API); American Indian (AI); Alaska Native (AN)
Data Sources: Hospital Inpatient Billing and Web-Enabled Vital Record Registry System (WEVRRS)

In Clark County, American Indian/Alaska Native (AI/AN), non-Hispanic had the highest PAD Rate of 14.1 per 100,000 women of reproductive age, followed by Black, non-Hispanic at 13.5. In Washoe County, Asian/Pacific Islander (API), non-Hispanic Nevadans had the highest rate of PAD at 10.7 per 100,000 women of reproductive age (Figure 11).

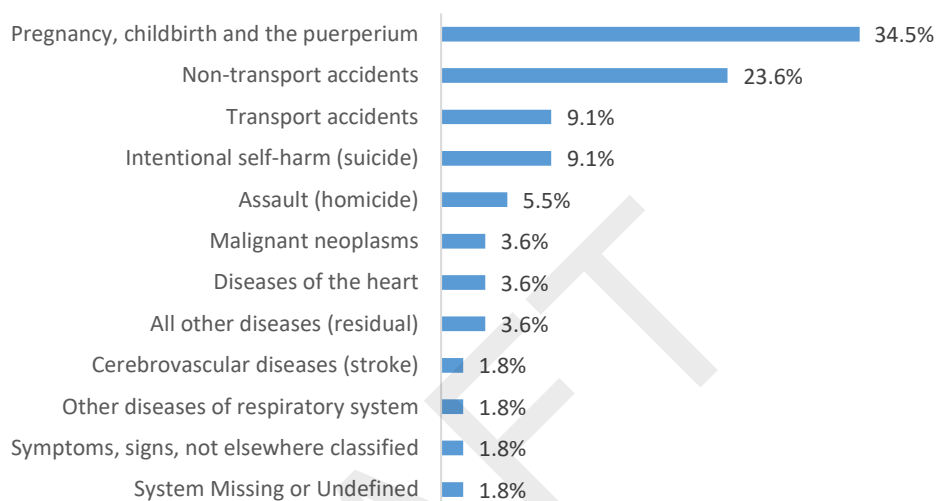
Figure 11: Pregnancy-Associated Death (PAD) Rate per 100,000 Women of Reproductive Age by County of Residence and Maternal Race/Ethnicity, Nevada 2024-2025



Underlying Causes of Pregnancy-Associated Deaths

During the years 2024 through 2025, the most common underlying cause of pregnancy-associated death were *Pregnancy, childbirth, the puerperium and Non-transport accidents* accounting for 34.5% and 23.6% of all pregnancy-associated deaths, respectively. The next most common cause of death was *Transport accidents and Intentional self-harm* both at 9.1% of pregnancy-associated deaths (Figure 12).

Figure 12: Underlying Causes of Death for Pregnancy-Associated Deaths by Percent, Nevada 2024-2025



Data Sources: Hospital Inpatient Billing and Web-Enabled Vital Record Registry System (WEVRRS)

Table 1: Underlying Causes of Death for Pregnancy-Associated Deaths by Race/Ethnicity, Nevada 2024-2025

Causes of Death	White, non-Hispanic		Black, non-Hispanic		AIAN, non-Hispanic		API, non-Hispanic		Hispanic		Other/Unknown		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Pregnancy, childbirth and the puerperium	5	29.4%	5	31.3%	1	100.0%	3	75.0%	5	29.4%	0	0.0%	19	34.5%
Non-transport accidents	4	23.5%	4	25.0%	0	0.0%	0	0.0%	5	29.4%	0	0.0%	13	23.6%
Transport accidents	2	11.8%	2	12.5%	0	0.0%	0	0.0%	1	5.9%	0	0.0%	5	9.1%
Intentional self-harm (suicide)	2	11.8%	1	6.3%	0	0.0%	0	0.0%	2	11.8%	0	0.0%	5	9.1%
Assault (homicide)	1	5.9%	2	12.5%	0	0.0%	0	0.0%	0	0.0%	0	100.0%	3	5.5%
Malignant neoplasms	1	5.9%	0	0.0%	0	0.0%	0	0.0%	1	5.9%	0	0.0%	2	3.6%
Diseases of the heart	1	5.9%	0	0.0%	0	0.0%	0	0.0%	1	5.9%	0	0.0%	2	3.6%
All other diseases (residual)	0	0.0%	2	12.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	3.6%
Cerebrovascular diseases (stroke)	0	0.0%	0	0.0%	0	0.0%	1	25.0%	0	0.0%	0	0.0%	1	1.8%
Other diseases of respiratory system	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	5.9%	0	0.0%	1	1.8%
Symptoms, signs, not elsewhere classified	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	5.9%	0	0.0%	1	1.8%
System Missing or Undefined	1	5.9%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	1.8%
Total	17	100.0%	16	100.0%	1	100.0%	4	100.0%	17	100.0%	0	100.0%	55	100.0%

Abbreviations: Asian or Pacific Islander (API); American Indian/Alaska Native (AIAN).

Data Sources: Hospital Billing Data, Nevada Electronic Birth and Death Registry

Table 2: Underlying Causes of Death for Pregnancy-Associated Deaths by County of Residence, Nevada 2024-2025

Causes of Death	Clark		Washoe		Rest of State		Unknown		Total	
	N	%	N	%	N	%	N	%	N	%
Pregnancy, childbirth and the puerperium	13	31.7%	4	66.7%	2	25.0%	0	0.0%	19	34.5%
Non-transport accidents	9	22.0%	0	0.0%	4	50.0%	0	0.0%	13	23.6%
Transport accidents	5	12.2%	0	0.0%	0	0.0%	0	0.0%	5	9.1%
Intentional self-harm (suicide)	4	9.8%	0	0.0%	1	12.5%	0	0.0%	5	9.1%
Assault (homicide)	3	7.3%	0	0.0%	0	0.0%	0	100.0%	3	5.5%
Malignant neoplasms	2	4.9%	0	0.0%	0	0.0%	0	0.0%	2	3.6%
Diseases of the heart	1	2.4%	1	16.7%	0	0.0%	0	0.0%	2	3.6%
All other diseases (residual)	2	4.9%	0	0.0%	0	0.0%	0	0.0%	2	3.6%
Cerebrovascular diseases (stroke)	0	0.0%	1	16.7%	0	0.0%	0	0.0%	1	1.8%
Other diseases of respiratory system	1	2.4%	0	0.0%	0	0.0%	0	0.0%	1	1.8%
Symptoms, signs, not elsewhere classified	1	2.4%	0	0.0%	0	0.0%	0	0.0%	1	1.8%
System Missing or Undefined	0	0.0%	0	0.0%	1	12.5%	0	0.0%	1	1.8%
Total	41	100.0%	6	100.0%	8	100.0%	0	0.0%	41	100.0%

Data Sources: Hospital Billing Data, Nevada Electronic Birth and Death Registry

Drug Overdose Deaths

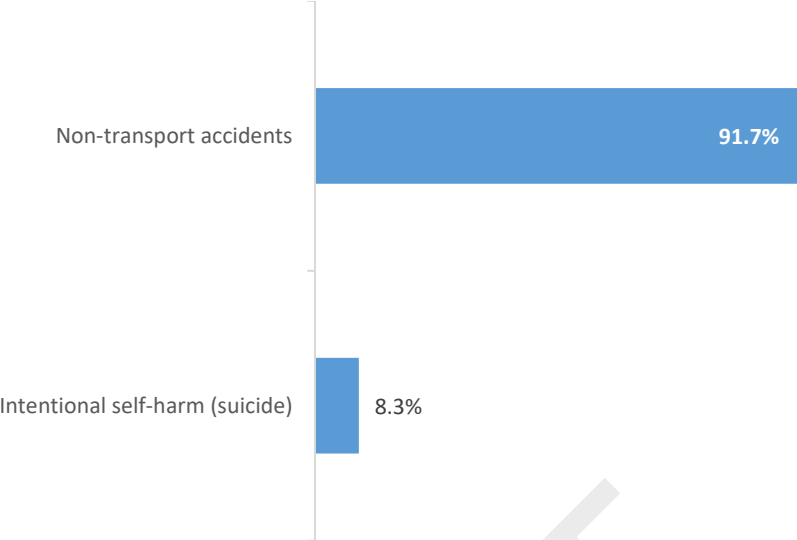
Pregnancy-associated deaths can intersect with substance use-related drug overdoses. The underlying cause of death for pregnancy-associated deaths were described above; however, additional information may be available on the death certificate which can provide more information surrounding the circumstances of death. These conditions are known as non-underlying causes of death or multiple causes of death.⁶

To identify drug overdose-related non-underlying causes of death for Nevadans with confirmed pregnancy-associated deaths, certain ICD-10 codes were looked for on the death records: X40-X44 (unintentional), X60-X64 (suicide), X85 (homicide), and Y10-Y14 (undetermined). These codes are related to the cause of death category of *Injury by drug overdose* (which can refer to an overdose caused by any opioid, heroin, natural and semisynthetic opioids, methadone, or other synthetic opioids (other than methadone)).

Figure 13 displays underlying causes of death for pregnancy-associated deaths that also had an ICD10 code on the death certificate confirming *Injury by drug overdose*. Most drug overdoses identified in pregnancy-associated deaths were associated with the underlying cause of death of *non-transport accidents* (91.7%). Of the drug overdoses associated with pregnancy-associated deaths, 8.3% were coded as intentional overdoses.

⁶ Centers for Disease Control and Prevention (CDC). Health, United States 2020-2021 – Cause of Death. <https://www.cdc.gov/nchs/hus/sources-definitions/cause-of-death.htm>

Figure 13: Percent of Drug Overdoses Associated with Pregnancy-Associated Deaths by Underlying Cause of Death, Nevada 2024-2025



Drug overdose deaths are identified using underlying and contributing ICD-10 cause-of-death codes X40-X44(unintentional), X60-X64(suicide), X85(homicide), and Y10-Y14(undetermined)
Data Sources: Hospital Inpatient Billing and Web-Enabled Vital Record Registry System (WEVRRS)

Pregnancy-Related Death (PRD)

Methodology

Data Sources

Web-Enabled Vital Records Registry Systems (WEVRRS)

Statewide births, deaths, and fetal deaths are collected by the Office of Vital Records, in the Division of Public and Behavioral Health. WEVRRS is a software utilized by physicians, registered nurses, midwives, informants or funeral directors, and other individuals to collect and consolidate birth and death-related information.

State Demographer

The Nevada State Demographer provides the Nevada population of women of reproductive age which is used in calculating rates.

Pregnancy Mortality Surveillance System (PMSS)

The Centers for Disease Control (CDC) manage this system which collects national data regarding pregnancy-related deaths in the United States.

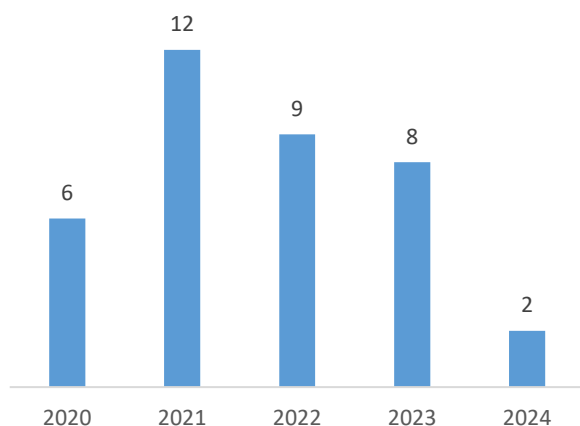
Identification of Pregnancy-Related Deaths

CDC conducts National pregnancy-related mortality surveillance to better understand the risk factors for and causes of pregnancy-related deaths in the United States. The Pregnancy Mortality Surveillance System (PMSS) defines a pregnancy-related death as the death of a woman while pregnant or within 1 year of the end of pregnancy from any cause related to or aggravated by the pregnancy. The Nevada Department Human Services Office of Analytics annually provides a list of pregnancy-associated deaths to the CDC. Medically trained epidemiologists at the CDC review and analyze the cases provided, determine which cases meet the CDC's definition of pregnancy-related mortality, and send a list of cases back to the Office of Analytics.

General Statistics

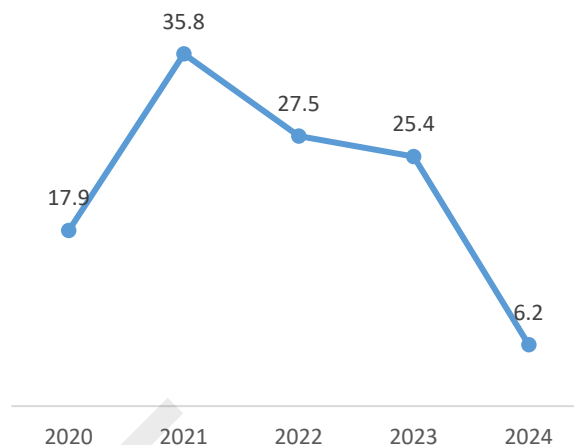
There were 37 pregnancy-related deaths for Nevada residents from 2020 to 2024 according to data from the Pregnancy Mortality Surveillance System (total of years shown in Figure 14a) - the most recent year of data available from PMSS is 2024. The highest ratio occurred in 2021, at 35.8 per 100,000 live births (Figure 14b). The highest pregnancy-related death rate was in 2021 at 1.9 per 100,000 women of reproductive age (Figure 14c). We observe a trend of decrease since 2021 that came to the lowest in 2024 at 2 pregnancy related death counts with a ratio of 6.2 per 100,000 deliveries and rate of 0.3 per 100,000 women of reproductive age.

Figure 14a 7: Count of Pregnancy-Related Deaths (PRD), Nevada 2020-2024



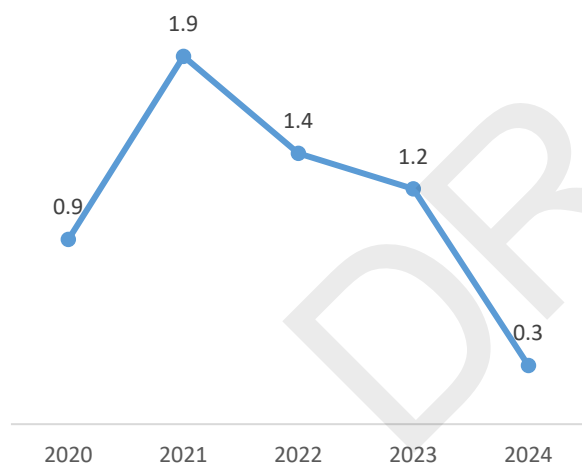
Data Sources: Pregnancy Mortality Surveillance System (PMSS) and Web-Enabled Vital Record Registry System (WEVRRS)

Figure 14b: Pregnancy-Related Death (PRD) Ratio per 100,000 Live Births, Nevada 2020-2024



Data Sources: Pregnancy Mortality Surveillance System (PMSS) and Web-Enabled Vital Record Registry System (WEVRRS)

Figure 14c 8: Pregnancy-Related Death (PRD) Rate per 100,000 Women of Reproductive Age, Nevada 2020-2024

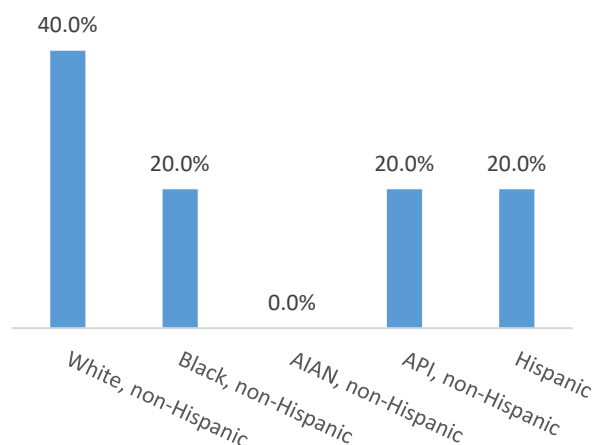


Data Sources: Pregnancy Mortality Surveillance System (PMSS), State Demographer, and Web-Enabled Vital Record Registry System (WEVRRS)

Maternal Demographics

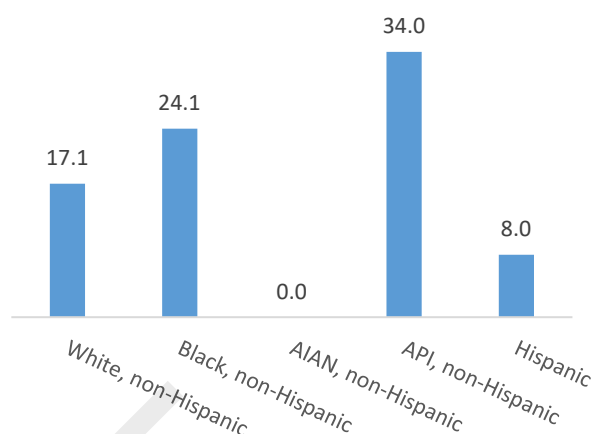
40% of the pregnancy-related deaths occurring between 2023 through 2024 are among White, non-Hispanic women (Figure 15a). API, non-Hispanic Nevadans had the highest pregnancy-related death ratio at 34.0 per 100, 000 live births (Figure 15b). Hispanic Nevadans had the lowest death ratio of those who died at 8.0 per 100,000 live births, accounting for 20.0% of all deaths. AIAN, non-Hispanic Nevadans had no pregnancy-related deaths in the years under review. Black, non-Hispanic Nevadans had the highest death rate at 1.6 per 100,000 women of reproductive age (Figure 15c).

Figure 15a: Percent of Pregnancy-Related Deaths (PRD) by Race/Ethnicity, Nevada 2023-2024



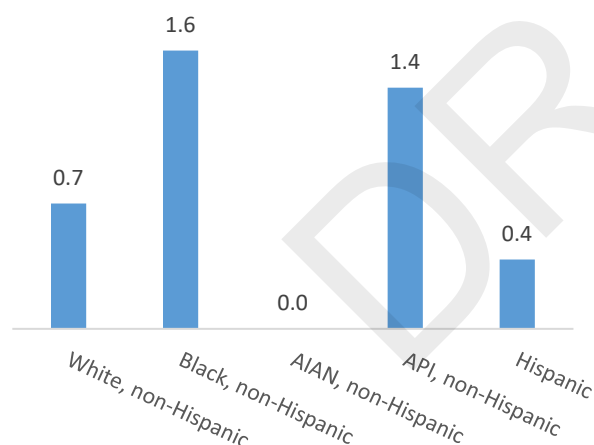
Abbreviations: Asian or Pacific Islander (API); American Indian (AI); Alaska Native (AN). Data Sources: Pregnancy Mortality Surveillance System (PMSS) and Web-Enabled Vital Record Registry System (WEVRRS)

Figure 15b: Pregnancy-Related Death (PRD) Ratio per 100,000 Live Births by Race/Ethnicity, Nevada 2023-2024



Abbreviations: Asian or Pacific Islander (API); American Indian (AI); Alaska Native (AN). Data Sources: Pregnancy Mortality Surveillance System (PMSS) and Web-Enabled Vital Record Registry System (WEVRRS)

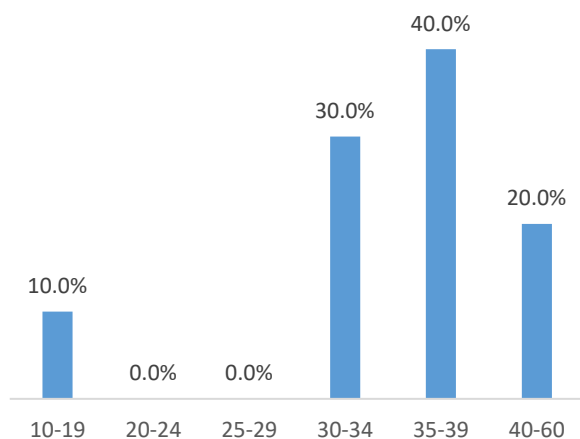
Figure 15c 9: Pregnancy-Related Death (PRD) Rate per 100,000 Women of Reproductive Age and Percent by Race/Ethnicity, Nevada 2023-2024



Abbreviations: Asian or Pacific Islander (API); American Indian (AI); Alaska Native (AN). Data Sources: Pregnancy Mortality Surveillance System (PMSS), State Demographer, and Web-Enabled Vital Record Registry System (WEVRRS)

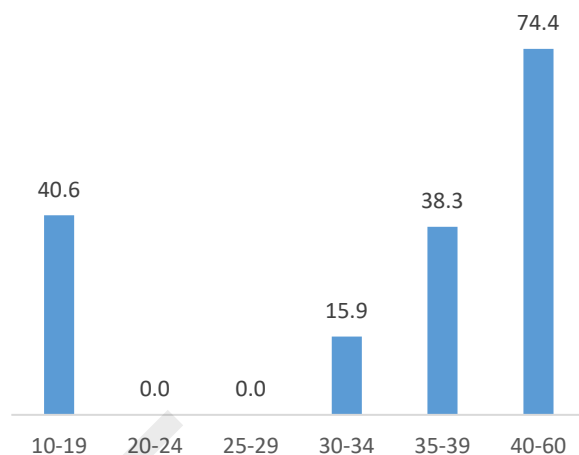
Among the 30 to 39 age group, seventy percent of the deaths occurred in total (Figure 16a). Nevadans aged 40-60 had the highest pregnancy-related death ratio at 74.4 per 100,000 live births, followed by 10-19 age group at a ratio of 40.6 per 100,000 live births (Figure 16b). For the age group 35-39, the highest pregnancy-related death rate was at 1.8 per 100,000 women of reproductive age followed by the age group 30-34 at 1.3 per 100,000 women of reproductive age (Figure 16c).

Figure 16a: Pregnancy-Related Death (PRD) Percent by Maternal Age, Nevada 2023-2024



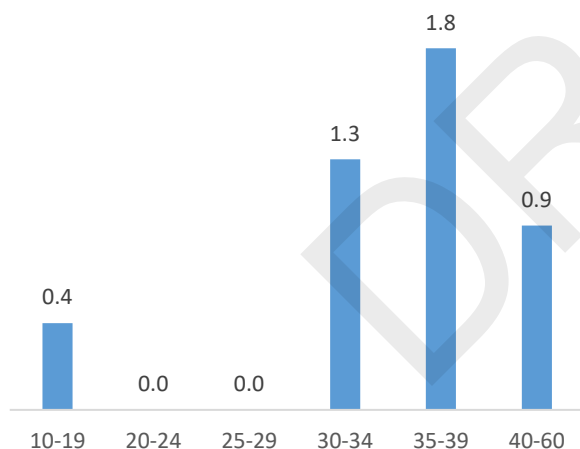
Data Sources: Pregnancy Mortality Surveillance System (PMSS) and Web-Enabled Vital Record Registry System (WEVRRS)

Figure 16b: Pregnancy-Related Death (PRD) Ratio per 100,000 Live Births, Nevada 2023-2024



Data Sources: Pregnancy Mortality Surveillance System (PMSS) and Web-Enabled Vital Record Registry System (WEVRRS)

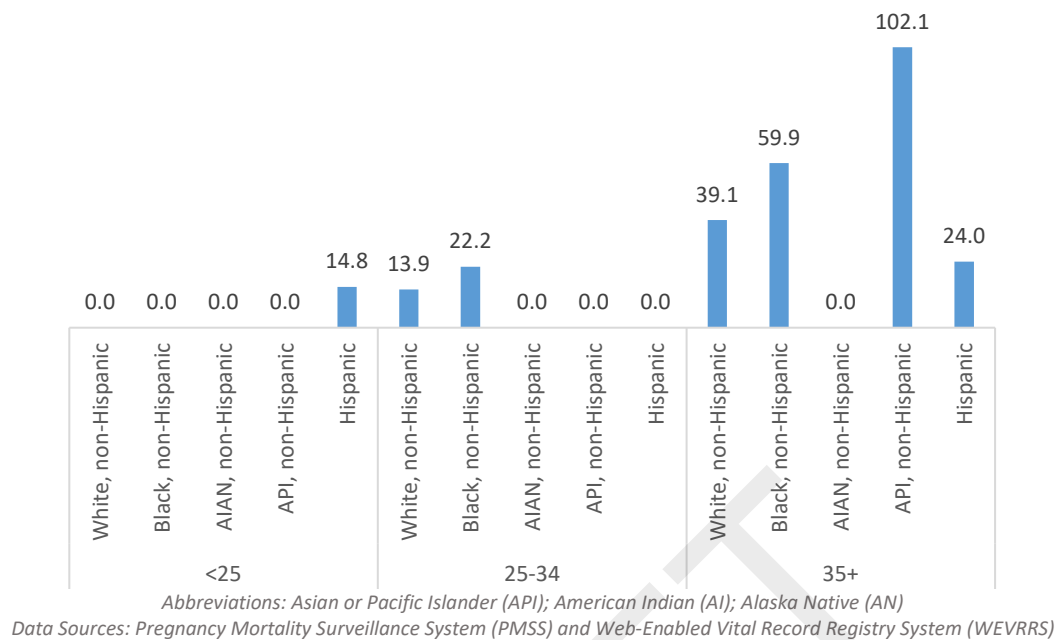
Figure 16c: Pregnancy-Related Death (PRD) Rate per 100,000 Women of Reproductive Age and Percent by Maternal Age, Nevada 2023-2024



Data Sources: Pregnancy Mortality Surveillance System (PMSS), State Demographer, and Web-Enabled Vital Record Registry System (WEVRRS)

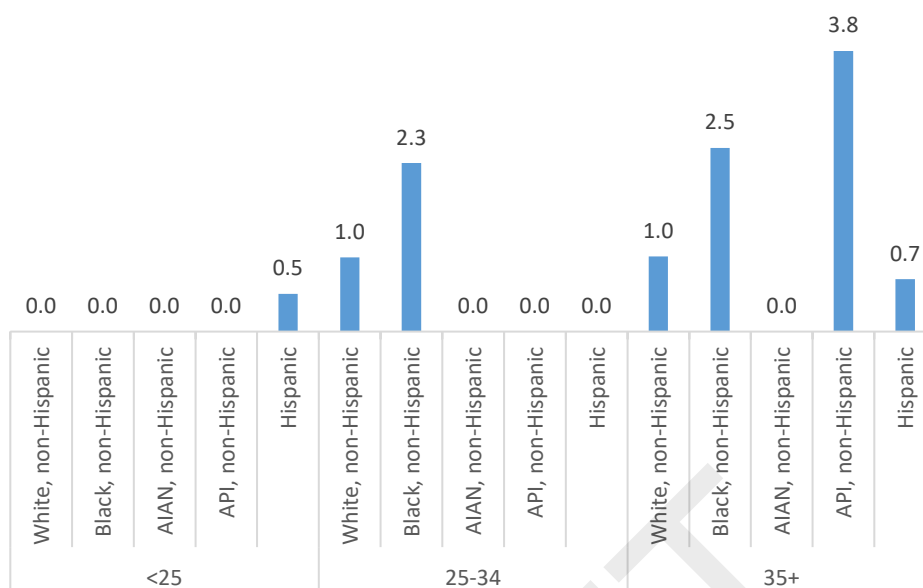
Figure 17 illustrates the pregnancy-related death ratio for each race and ethnicity within age groups of under 25, 25-34, and 35 and older. For ages 35 and above Asian/Pacific Islander (API), non-Hispanic Nevadans had the highest death ratio at 102.1 per 100,000 live births and followed by Black, non-Hispanic Nevadans with death ratio at 59.9 per 100,000 live births. For the 25-34 age group, Black, non-Hispanic Nevadans had the highest death ratio at 22.2 per 100,000 live births.

Figure 17: Pregnancy-Related Death (PRD) Ratio per 100,000 Live Births by Maternal Age and Race/Ethnicity, Nevada 2023-2024



For the age group 35 and above, API, non-Hispanic Nevadans had the highest death rate at 3.8 per 100,000 women of reproductive age (Figure 18).

Figure 18: Pregnancy-Related Death (PRD) Rate per 100,000 Women of Reproductive Age by Maternal Age and Race/Ethnicity, Nevada 2023-2024

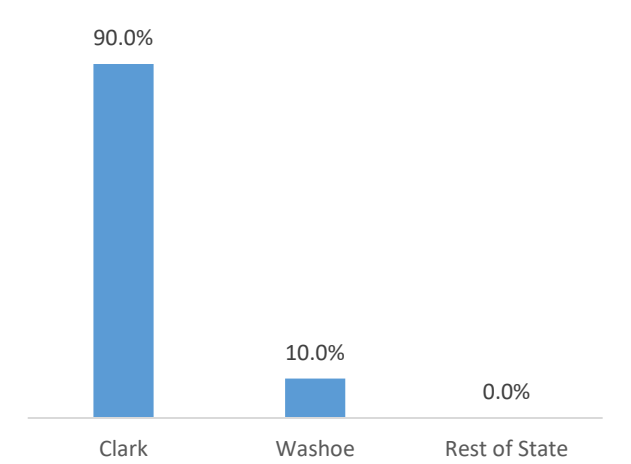


Abbreviations: Asian or Pacific Islander (API); American Indian (AI); Alaska Native (AN)

Data Sources: Pregnancy Mortality Surveillance System (PMSS), State Demographers, and Web-Enabled Vital Record Registry System (WEVRRS)

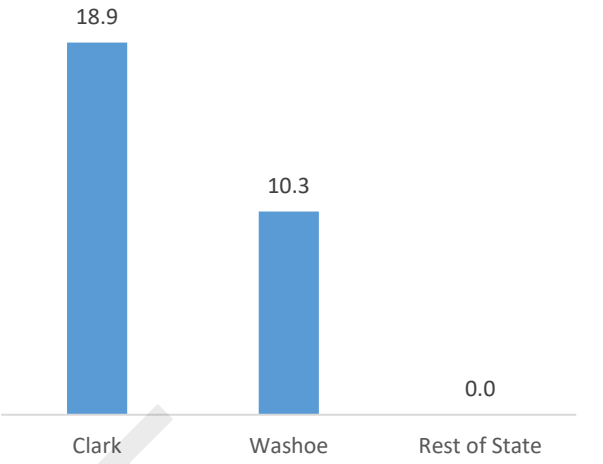
Clark County had the highest pregnancy-related death ratio at 18.9 per 100,000 live births, accounting for 90% of all pregnancy-related deaths, Washoe had 10% of all pregnancy-related deaths, and Rest of State did not have any pregnancy-related death (Figure 19a). The highest pregnancy-related death rate was in Clark County at 0.9 per 100,000 women of reproductive age (Figure 19c).

Figure 19a: Percent of Pregnancy-Related Deaths (PRD) by County of Residence, Nevada 2023-2024



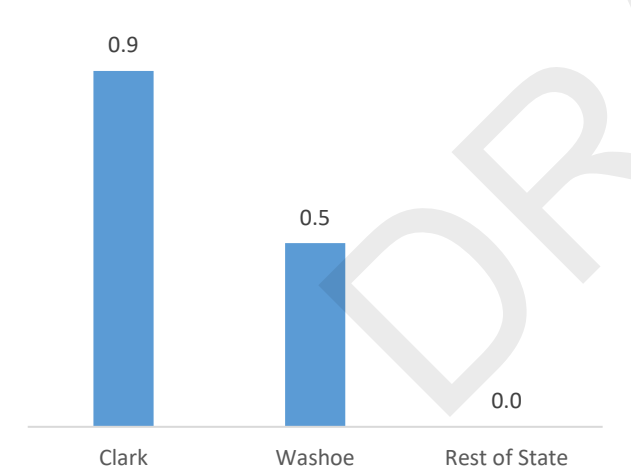
Data Sources: Pregnancy Mortality Surveillance System (PMSS) and Web-Enabled Vital Record Registry System (WEVRRS)

Figure 19b: Pregnancy-Related Death (PRD) Ratio per 100,000 Live Births by County of Residence, Nevada 2023-2024



Data Sources: Pregnancy Mortality Surveillance System (PMSS) and Web-Enabled Vital Record Registry System (WEVRRS)

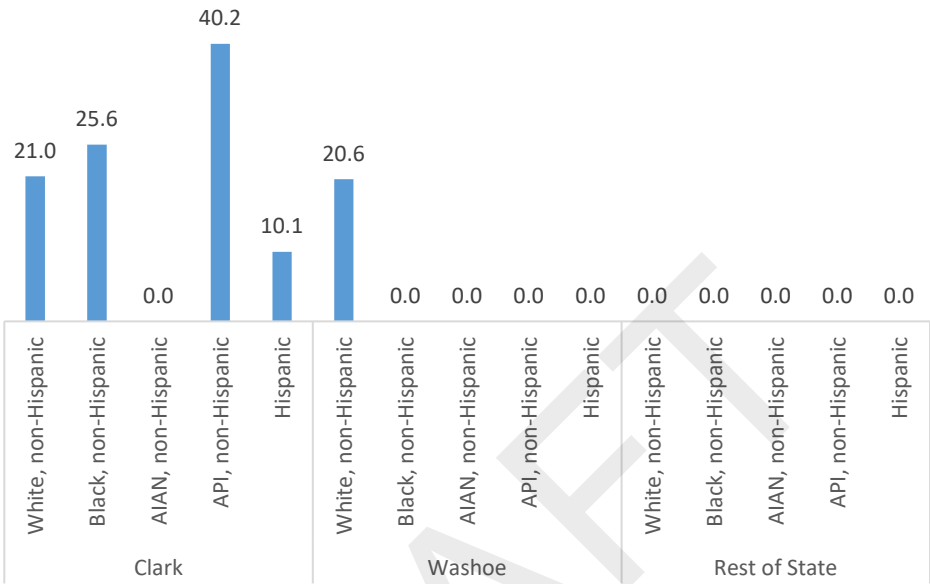
Figure 19c 10: Pregnancy-Related Death (PRD) Rate per 100,000 Women of Reproductive Age by County of Residence, Nevada 2023-2024



Data Sources: Pregnancy Mortality Surveillance System (PMSS), State Demographers, and Web-Enabled Vital Record Registry System (WEVRRS)

Figure 20 illustrates the pregnancy-related death ratio for each race and ethnicity group within Clark County, Washoe County and Rest of State. In Clark County, API, non-Hispanic Nevadans had the highest ratio at 40.2 per 100,000 live births, and Hispanic had the lowest ratio of 10.1 per 100,000 live births. In Washoe County, White, non-Hispanic Nevadans is the only group had pregnancy-related deaths with a ratio of 20.6 per 100,000 live births, and Rest of State did not have any pregnancy-related death.

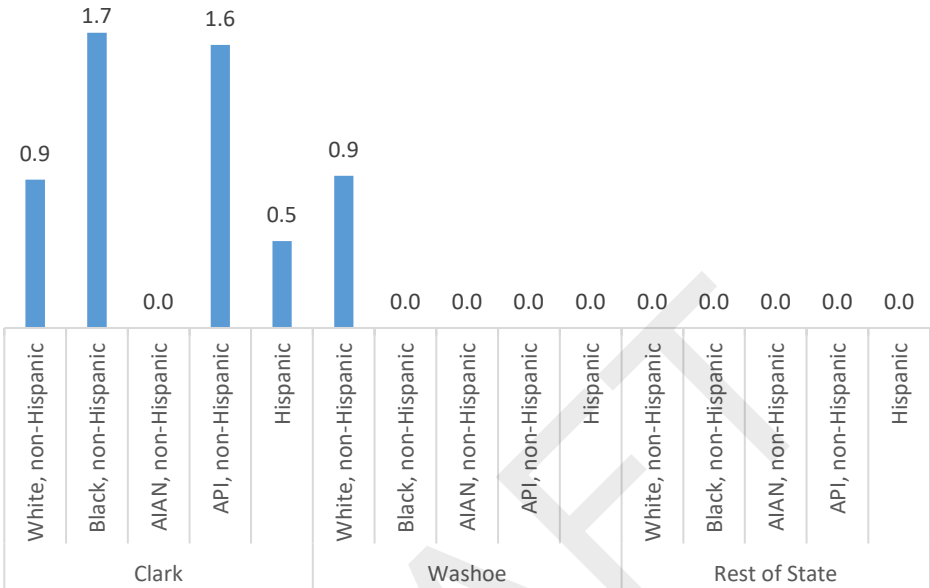
Figure 20 11: Pregnancy-Related Death (PRD) Ratio per 100,000 Live Births by County of Residence and Race/Ethnicity, Nevada 2023-2024



Abbreviations: Asian or Pacific Islander (API); American Indian (AI); Alaska Native (AN)
 Data Sources: Pregnancy Mortality Surveillance System (PMSS) and Web-Enabled Vital Record Registry System (WEVRRS)

In Clark County, Black, non-Hispanic Nevadans had the highest pregnancy-related death rate at 1.7 per 100,000 women of reproductive age, followed closely by Asian/Pacific Islander (API), non-Hispanic Nevadans at 1.6 per 100,000 women of reproductive age. In Washoe County, White, non-Hispanic Nevadans was the only group had Pregnancy-related Death with a rate at 0.9 per 100,000 women of reproductive age (Figure 21).

Figure 21: Pregnancy-Related Death (PRD) Rate per 100,000 Women of Reproductive Age by County of Residence and Race/Ethnicity, Nevada 2023-2024



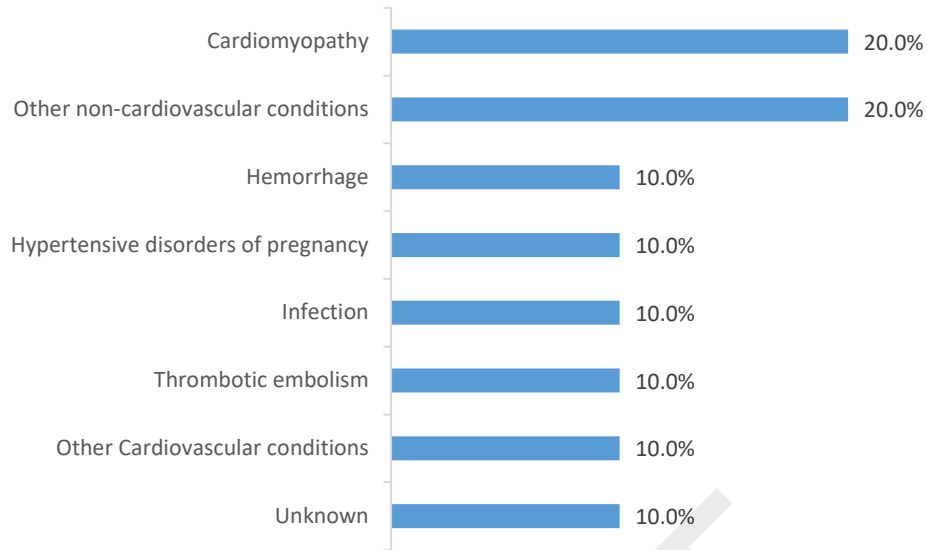
Abbreviations: Asian or Pacific Islander (API); American Indian (AI); Alaska Native (AN)Islander
 Data Sources: Pregnancy Mortality Surveillance System (PMSS), State Demographer, and Web-Enabled Vital Record Registry System (WEVRRS)

Underlying Causes of Pregnancy-Related Deaths

During 2023 and 2024, the most common causes of pregnancy-related death were heart-related conditions which accounted for 30% of all pregnancy related deaths with 20% for *Cardiomyopathy* and 10% for *other Cardiovascular condition*.

The second highest cause is *other non-Cardiovascular conditions* for 20%. *Hemorrhage*, *Hypertensive disorders of pregnancy*, *Infection*, *Thrombotic Embolism*, and *Unknown* each accounted for 10% (Figure 22).

Figure 22: Underlying Causes of Death of Pregnancy-Related Deaths by Percent, Nevada 2023-2024



Data Sources: Pregnancy Mortality Surveillance System (PMSS) and Web-Enabled Vital Record Registry System (WEVRRS)

Table 3: Count of Pregnancy-Related Deaths by Underlying Causes of Death, Nevada 2023-2024

Cause of Death	White, non-Hispanic		Black, non-Hispanic		AIAN, non-Hispanic		API, non-Hispanic		Hispanic		Other/Unknown		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cardiomyopathy	0	0.0%	2	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0%	2	20.0%
Other non-cardiovascular conditions	1	25.0%	0	0.0%	0	0.0%	1	50.0%	0	0.0%	0	0%	2	20.0%
Hemorrhage	1	25.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0%	1	10.0%
Hypertensive disorders of pregnancy	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	50.0%	0	0%	1	10.0%
Infection	1	25.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0%	1	10.0%
Thrombotic embolism	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	50.0%	0	0%	1	10.0%
Other Cardiovascular conditions	1	25.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0%	1	10.0%
Unknown	0	0.0%	0	0.0%	0	0.0%	1	50.0%	0	0.0%	2	0%	1	10.0%
Total	4	100.0%	2	100.0%	0	0%	2	100.0%	2	100.0%	0	0%	10	100.0%

AIAN stands for American Indian Alaska Native, and API is Asian Pacific Islander.

Data Sources: Pregnancy Mortality Surveillance System (PMSS), Nevada Electronic Birth Registry.

Table 4: Count of Pregnancy-Related Deaths by Underlying Causes of Death by County, Nevada 2023-2024

Cause of Death	Clark		Washoe		Rest of State		Total	
	N	%	N	%	N	%	N	%
Cardiomyopathy	2	22.2%	0	0.0%	0	0%	2	20.0%
Other non-cardiovascular conditions	2	22.2%	0	0.0%	0	0%	2	20.0%
Hemorrhage	1	11.1%	0	0.0%	0	0%	1	10.0%
Hypertensive disorders of pregnancy	1	11.1%	0	0.0%	0	0%	1	10.0%
Infection	1	11.1%	0	0.0%	0	0%	1	10.0%
Thrombotic embolism	1	11.1%	0	0.0%	0	0%	1	10.0%
Other Cardiovascular conditions	0	0.0%	1	100.0%	0	0%	1	10.0%
Unknown	1	11.1%	0	0.0%	0	0%	1	10.0%
Total	9	100.0%	1	100.0%	0	0%	10	100.0%

Data Sources: Pregnancy Mortality Surveillance System (PMSS), Nevada Electronic Birth Registry.

Maternal Deaths

Methodology

Data Sources

Data sources used to identify maternal deaths are the same as those used to identify pregnancy-related deaths.

Identification of Maternal Deaths

Methodology to identify maternal deaths is based upon that used to identify pregnancy-related deaths but is restricted to individuals who died while pregnant or within 42 days of the termination of pregnancy, regardless of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes regardless of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

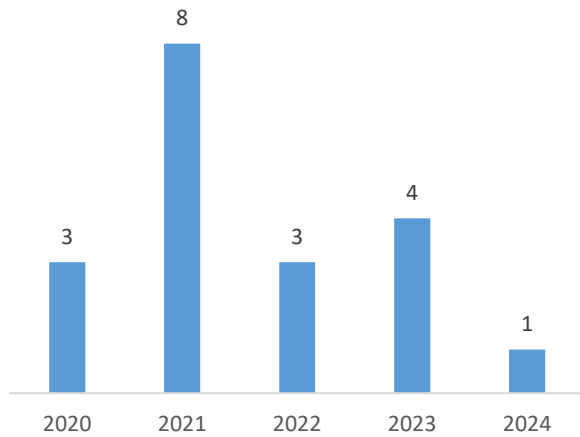
Note: There are missing values for date of delivery or termination of pregnancy from PMSS data. This may result in underestimation, as the duration between termination of pregnancy and death cannot be determined.

General Statistics

There were 19 maternal deaths in Nevada from 2020 to 2024 (sum of counts by year in Figure 23a).

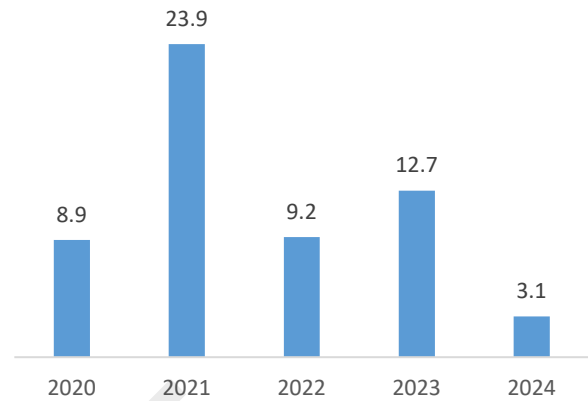
The highest ratios were in 2021 at 23.9 per 100,000 live births (Figure 23b) and a rate of 1.2 per 100,000 women of reproductive age and have been decreasing since then (Figure 23c).

Figure 23a: Count of Maternal Deaths (MD), Nevada 2020-2024



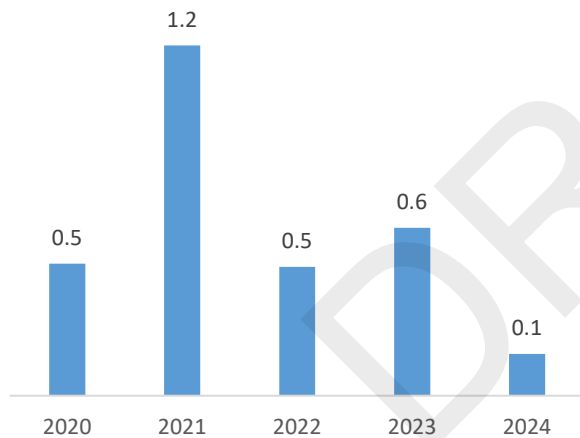
Data Sources: Pregnancy Mortality Surveillance System (PMSS) and Web-Enabled Vital Record Registry System (WEVRRS)

Figure 23b: Maternal Death (MD) Ratio per 100,000 Live Births, Nevada 2020-2024



Data Sources: Pregnancy Mortality Surveillance System (PMSS) and Web-Enabled Vital Record Registry System (WEVRRS)

Figure 23c: Maternal Death (MD) Rate per 100,000 Women of Reproductive Age, Nevada 2020-2024



Data Sources: Pregnancy Mortality Surveillance System (PMSS), State Demographer, and Web-Enabled Vital Record Registry System (WEVRRS)

Maternal Demographics

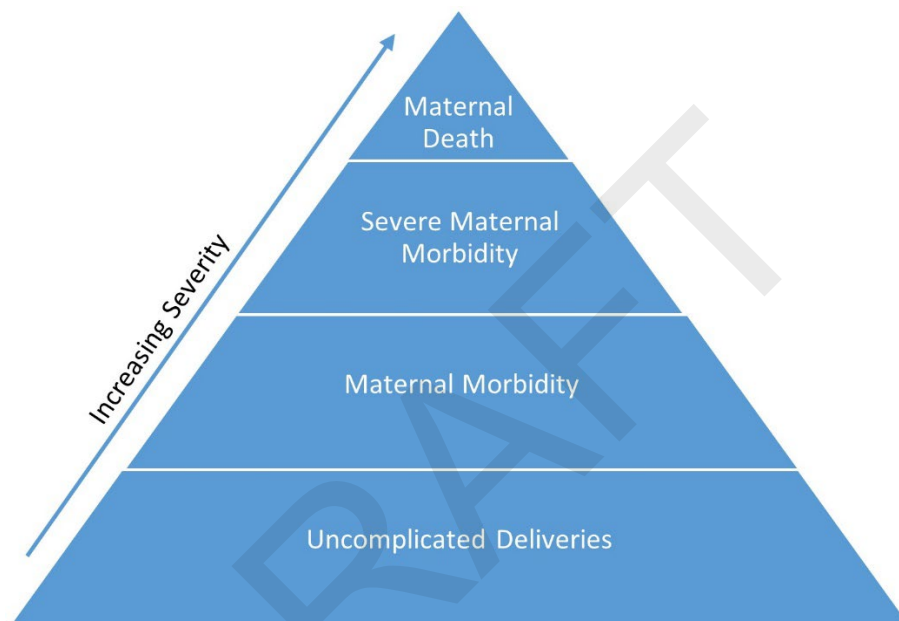
A total of 19 Nevadans had a maternal death during 2020 to 2024. By race and ethnicity, the Nevadans who died were 7 White, non-Hispanic, 4 Black, non-Hispanic, 1 American Indian/Alaska Native non-Hispanic, 3 Asian/Pacific Islander non-Hispanic, and 4 Hispanic. There were 4 Nevadans in the <25 age group, 6 in the 25-34 age group, and 9 in the 35+ age group.

Severe Maternal Morbidity (SMM) Data

Definition

As noted in the Background section of this report, maternal morbidity is a continuum from mild adverse effects to life-threatening events or death.**Error! Bookmark not defined.** Severe Maternal Morbidity (SMM) refers to conditions and diagnoses which indicate potentially life-threatening maternal complications. ⁷SMM includes unexpected outcomes of labor and delivery resulting in significant short- or long-term consequences to health. ⁸ Figure 24 below illustrates the maternal morbidity continuum.

Figure 24: Maternal Morbidity Continuum



Methodology

Data Sources

Nevada Electronic Birth Registry Data

Nevada Department of Human Services, Office of Vital Records used Web-enabled Vital Records Registry System (WEVRRS) to collect information on all live births in Nevada and issue birth certificates. The birth certificate contains demographic information, such as the mother's age, race, education, and pregnancy information, such as parity and prenatal care.

Hospital Inpatient Billing (HIB) Data

The Hospital Inpatient Billing data provides health billing data for patients discharged from Nevada's non-federal hospitals. NRS 449.485 mandates all hospitals in Nevada report information as prescribed by the director of the Department of Human Services. The data are collected using a standard universal billing form. The data are for patients admitted for at least 24 hours as an inpatient but do not include patients discharged from the emergency room. The data consists of demographics such as age, gender, race/ethnicity and uses International Classification

⁷ Severe Maternal Morbidity, <https://www.cdc.gov/maternal-infant-health/pho/severe-maternal-morbidity/index.html>

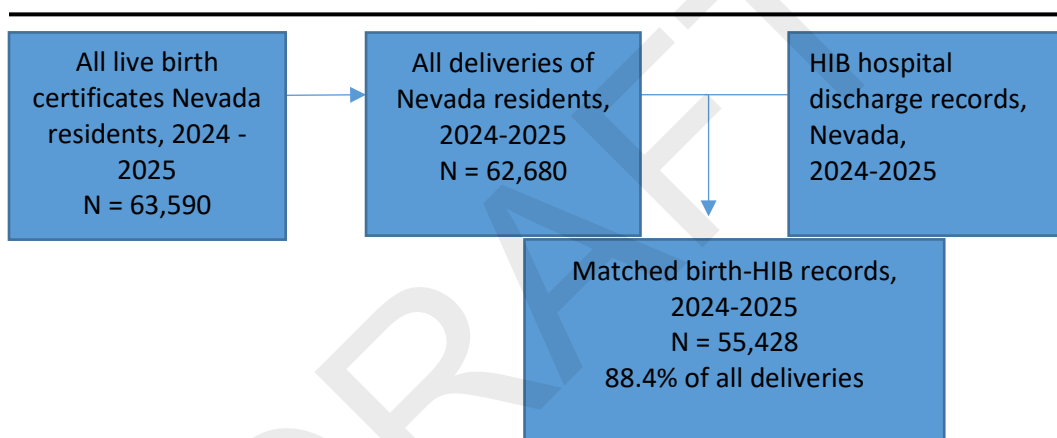
⁸ American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine, Kilpatrick SK, Ecker JL. Severe maternal morbidity: screening and review. Am J Obstet Gynecol. 2016;215(3): 817–822.

of Diseases-10-Clinical 5 Modification (ICD-10-CM) diagnoses (up to 33 diagnoses respectively). In addition, the data includes billed hospital charges, procedure codes, length of hospital stay, discharge status, and external cause of injury codes. The billing data information is for billed charges and not the actual payment received by the hospital.

Identification of Severe Maternal Morbidity

Nevada birth certificates were matched with the mother's delivery hospitalization record from Hospital Inpatient Billing (HIB) data. Multiple births (e.g., twins, triplets) were counted as one delivery (only one birth certificate was matched per hospital discharge record, even with multiple births). The total number of live births to Nevada residents was 63,590 from January 2024 to December 2025. The total number of deliveries was 62,680 comprising all records from singleton births and one record per multiple births. Approximately 88.4% of all deliveries were matched with a hospital discharge record. All analyses are based on matched data (N=55,428). Birth certificates and hospital discharge records were matched with the mother's social security number, name, birth date, medical record number, and the facility of the delivery hospitalization. Non-matched birth certificates may be due to home births, missing social security numbers, misspelled names, etc.

Figure 25: Data Matching Process for Birth Certificates and HIB Records, Nevada 2024-2025



SMM events were identified during delivery hospitalizations using an algorithm developed by researchers at the CDC.⁹ The algorithm originally used ICD-9-CM codes to identify 25 indicators of SMM that represent either serious complications of pregnancy or delivery, such as disseminated intravascular coagulation or eclampsia, or procedures used to manage serious conditions, such as blood transfusion or hysterectomy. We have been following The Alliance for Innovation on Maternal Health (AIM) methods and CDC's guidance to update this algorithm, including the conversion from ICD-9 to ICD-10 as well as SMM indicators and their identification methods. The current CDC guidance (updated May15, 2024) identifies 21 SMM indicators, of which 16 are defined using ICD-10 diagnosis codes and 5 using procedure codes. A complete list of conditions and ICD-10 codes is provided in Appendix A.

To ensure that only the most severe cases of these 21 indicators during delivery hospitalizations were captured, these indicators were classified as SMM only if they additionally met one of the following criteria:

- The mother's length of stay was equal to or greater than the 90th percentile by delivery method.
- The mother was transferred before or after delivery to a different facility.
- The mother died during delivery hospitalization.
- At least one of the five procedure indicators was present.

⁹ Callaghan WM, Creanga AA, Kuklina EV. Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States. *Obstetrics and Gynecology* 2012; 120:1029-36

Analysis

All SMM rates were calculated per 10,000 live deliveries that successfully matched with a HIB record. Chi-square test was used to test the significance of the association between maternal characteristics and SMM. The analyses in this report include blood transfusion in SMM calculation unless otherwise noted. P-values less than 0.05 were deemed statistically significant.

Records with missing data on a variable of interest were not represented in the graph of SMM but are represented in the tables.

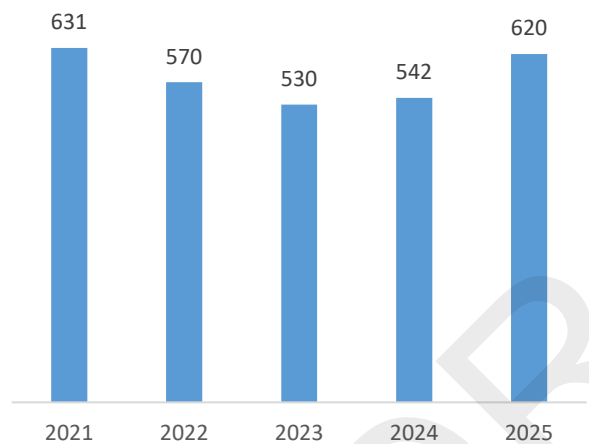
All analyses were conducted using SAS 9.4.

General Statistics

Between January 2024 to December 2025, there were 1,162 identified SMM cases in Nevada.

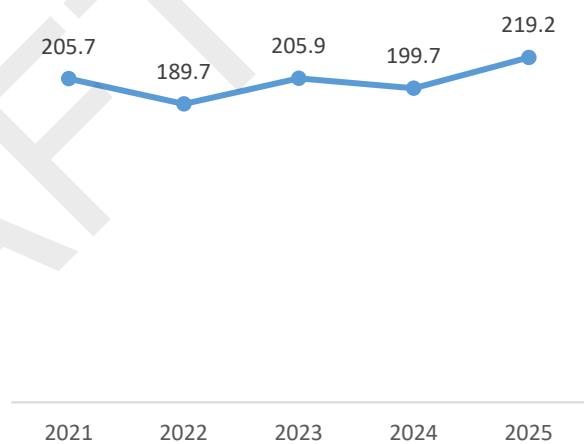
The SMM rate in Nevada is steady during 2021 to 2025 with low fluctuation (Figure 26b).

Figure 26a: Count of Severe Maternal Morbidity (SMM) Cases, Nevada 2021-2025



Data Sources: Hospital Inpatient Billing and Nevada Electronic Birth Registry

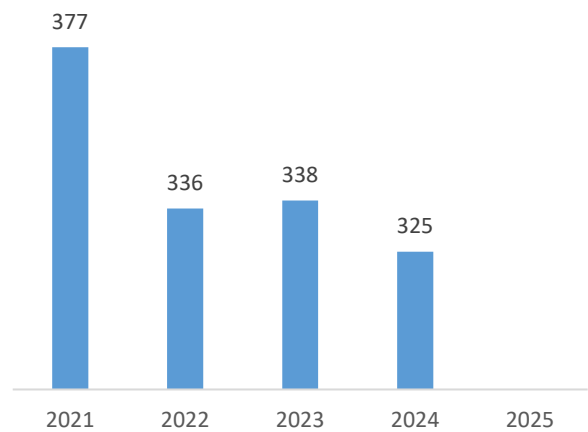
Figure 26b: Severe Maternal Morbidity (SMM) Rate per 10,000 Deliveries, Nevada 2021-2025



Data Sources: Hospital Inpatient Billing and Nevada Electronic Birth Registry

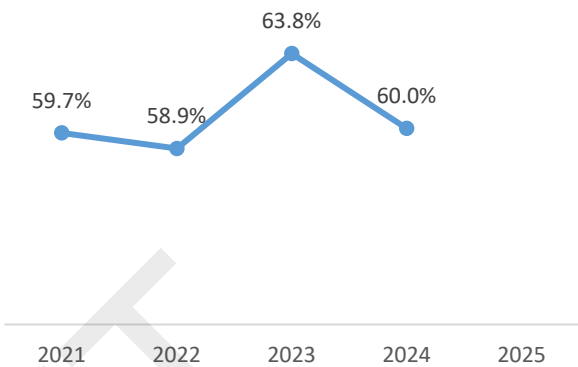
We observe an increase in the percentage of SMM Cases with associated with Medicaid-covered births in Nevada from 58.9% in 2022 to 63.8% in 2023 but it has decreased to 60.0% in 2024 (Figure 27b).

Figure 27a: Count of Severe Maternal Morbidity (SMM) Cases associated with Medicaid-covered Births, Nevada 2021-2025



Data Sources: Hospital Inpatient Billing and Nevada Electronic Birth Registry

Figure 27b: Percent of Severe Maternal Morbidity (SMM) associated with Medicaid-covered Births, Nevada 2021-2025



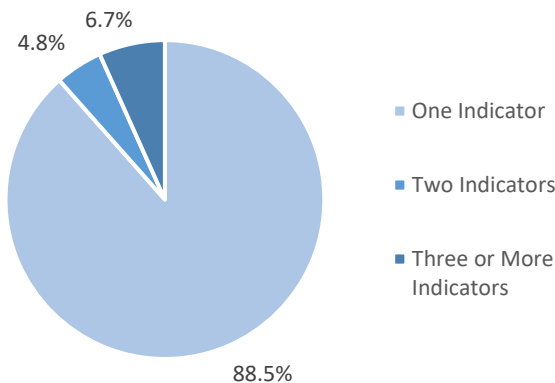
Data Sources: Hospital Inpatient Billing and Nevada Electronic Birth Registry

Indicators Associated with SMM

There are 21 procedure-based or diagnosis-based indicators associated with SMM (list available in Table 5). See Appendix A for a complete list including the ICD or procedure codes used to identify these SMM indicators.

Most deliveries with SMM during 2024 to 2025 were associated with one indicator (88.5%), although 6.7% of deliveries during this time were associated with two indicators, and 4.8% had three or more indicators present (Figure 28).

Figure 28: Distribution of Severe Maternal Morbidity (SMM) Indicators, Nevada 2024–2025



Data Sources: Hospital Inpatient Billing and Nevada Electronic Birth Registry

Table 5 below displays the rates of SMM per 10,000 deliveries during 2024 to 2025 by diagnosis-based and procedure-based indicators. The top five diagnosis-based indicators of SMM during these years were *Acute Respiratory Distress Syndrome* (12.6 per 10,000 deliveries), *Acute Renal Failure* (10.1 per 10,000 deliveries), *Sepsis* (8.5 per 10,000 deliveries), *Disseminated Intravascular Coagulation* (8.3 per 10,000 deliveries), *Shock* (6.9 per 10,000 deliveries), and *Eclampsia* (5.1 per 10,000 deliveries). None of *adult respiratory distress syndrome* cases were confirmed COVID-19 cases in these two years.¹²

Table 5: Rate of Severe Maternal Morbidity (SMM) by Diagnosis-Based and Procedure-Based Indicators per 10,000 Deliveries, Nevada 2024–2025

SMM Indicator	Rate per 10,000 deliveries
Diagnosis-Based Indicators	
Acute Respiratory Distress Syndrome	12.6
Acute Renal Failure	10.1
Sepsis	8.5
Disseminated Intravascular Coagulation	8.3
Shock	6.9
Eclampsia	5.1
Pulmonary Edema / Acute Heart Failure	5.1
Puerperal Cerebrovascular Disorders	1.8
Air and Thrombotic Embolism	1.3
Cardiac Arrest / Ventricular Fibrillation	1.1
Sickle Cell Anemia with Crisis	0.7
Severe Anesthesia Complications	0.4
Amniotic Fluid Embolism	0.2
Procedure-Based Indicators	
Blood transfusion	166.7
Hysterectomy	18.4
Ventilation	6.7
Conversion of cardiac rhythm	1.4
Temporary Tracheostomy	166.7
SMM with Blood Transfusion Rate	209.6

* Around 18.6% of adult respiratory distress syndrome SMM cases were confirmed COVID-19 cases in these two years.

Data Sources: Hospital Inpatient Billing and Nevada Electronic Birth Registry

The top three leading procedure-based indicators of SMM were *Blood transfusion* (166.7 per 10,000 deliveries), *Hysterectomy* (18.4 per 10,000 deliveries), and *Ventilation* (6.7 per 10,000 deliveries).

Blood transfusion is often associated with SMM as shown in national data previously mentioned. The 1,162 SMM cases identified in Nevada during January 2024 through December 2025 included all cases associated with blood transfusions. When excluding cases associated with blood transfusions, the SMM case count dropped to 330 and the rate decreased from 209.6 to 59.5 per 10,000 deliveries (Figure 29b).

Figure 29a: Count of Severe Maternal Morbidity (SMM) Cases by Blood Transfusion Indicator, Nevada 2024-2025

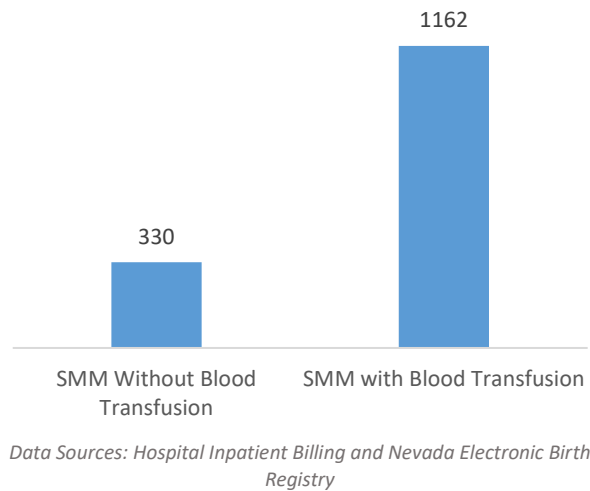
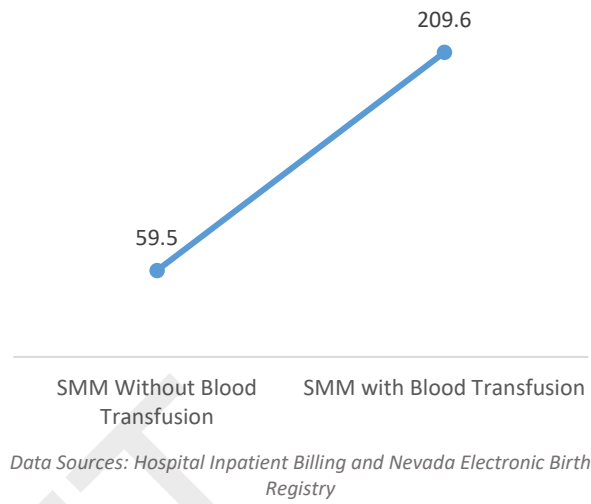


Figure 29b: Severe Maternal Morbidity (SMM) Rate per 10,000 Deliveries by Blood Transfusion Indicator, Nevada 2024-2025



Maternal Demographics

When comparing the race and ethnicity of pregnant Nevadans among the 1,162 SMM cases identified during 2024 to 2025 and excluding the Unknown category, AI/AN, non-Hispanic Nevadans had the highest rate of SMM at 331.3 per 10,000 deliveries (Figure 30b). The second highest group was Black, non-Hispanic Nevadans with an SMM rate of 307.1 per 10,000 deliveries, followed by API, non-Hispanic Nevadans at 227.8 per 10,000 deliveries. Hispanic Nevadans accounted for the highest proportion of SMM cases (40.4%) followed by White, non-Hispanic (26.2%) (Figure 30a). Hispanic and White, non-Hispanic Nevadans had the lowest rates of SMM (205.7 and 106.7 per 10,000 deliveries, respectively) (Figure 30b).

Figure 30a: Percent of Severe Maternal Morbidity (SMM) by Maternal Race/Ethnicity, Nevada 2024–2025

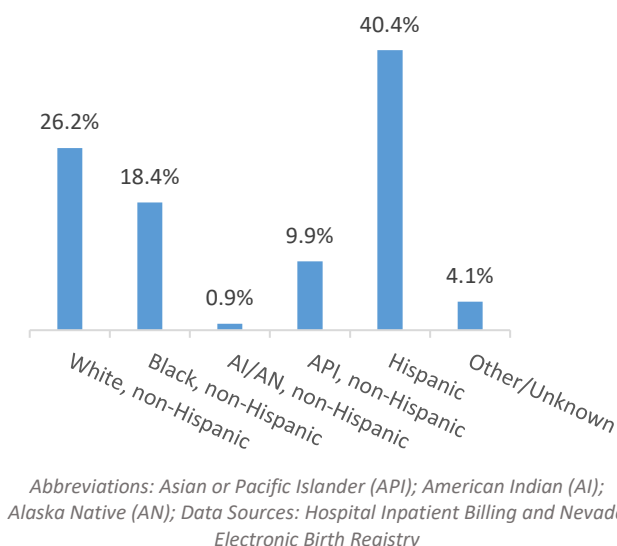
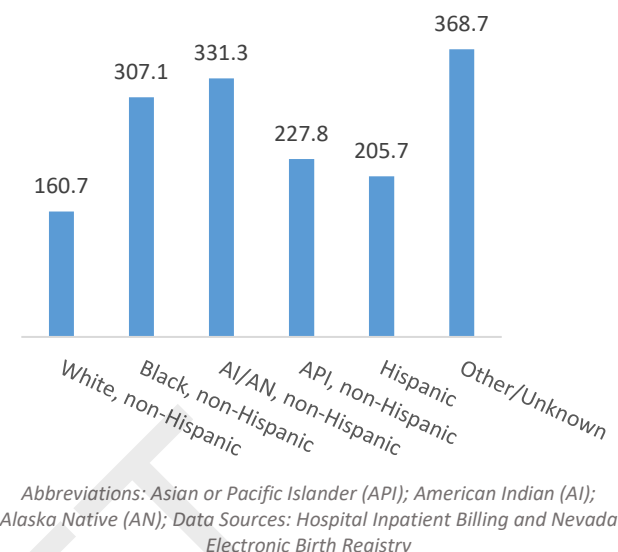


Figure 30b: Severe Maternal Morbidity (SMM) Rate per 10,000 Deliveries by Maternal Race/Ethnicity, Nevada 2024–2025



When stratifying SMM cases by age groups, although the 40 years and older age group only accounted for 7.3% of all SMM cases, they had the highest SMM rate of 353.7 per 10,000 deliveries (Figure 31b). The 25-29 age group accounted for approximately 22.8% of SMM cases and had the lowest rate of SMM (170.5 per 10,000 deliveries).

Figure 31a: Severe Maternal Morbidity (SMM) Percent by Maternal Age, Nevada 2024–2025

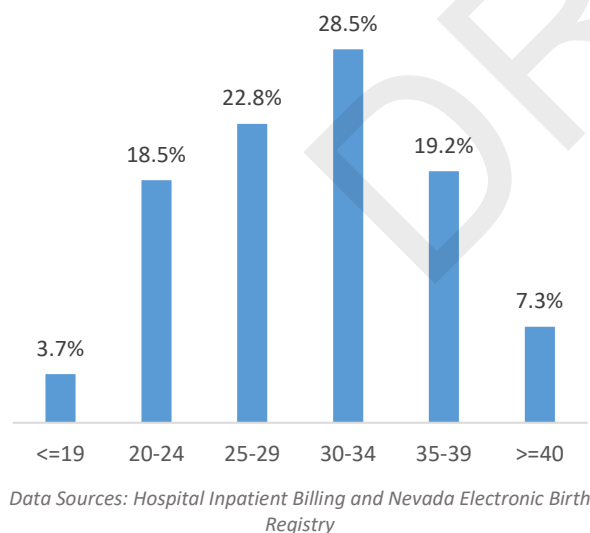


Figure 31b: Severe Maternal Morbidity (SMM) Rate per 10,000 Deliveries by Maternal Age, Nevada 2024–2025

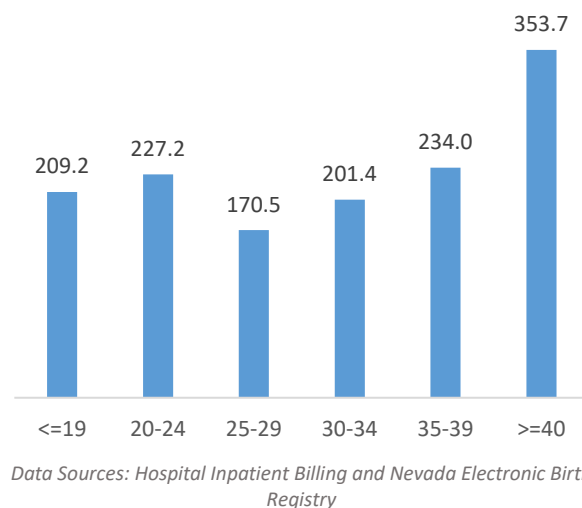


Table 6 shows the comparison of maternal demographic characteristics among SMM cases. When considering the SMM rate, including blood transfusions, the SMM is significantly associated with maternal age ($p < 0.0001$), maternal race and ethnicity ($p < 0.0001$), education ($p = 0.013$), and health insurance status ($p = 0.014$). The maternal demographic characteristics (age, race and ethnicity, and education) are all below the common significance threshold of 0.05 and are statistically significant factors associated with the SMM rate.

Table 6: Severe Maternal Morbidity by Maternal Demographics, Nevada 2024–2025

Maternal Demographics	Count of SMM Cases	Rate per 10,000 Deliveries	Count of All Deliveries	Percent of All Deliveries	Percent of SMM Cases
Maternal Age (Years)					
<=19	43	209.2	2,055	3.7%	3.7%
20-24	215	227.2	9,463	17.1%	18.5%
25-29	265	170.5	15,542	28.0%	22.8%
30-34	331	201.4	16,434	29.6%	28.5%
35-39	223	234.0	9,531	17.2%	19.2%
>=40	85	353.7	2,403	4.3%	7.3%
Race/ Ethnicity					
White, non-Hispanic	305	160.7	18,974	34.2%	26.2%
Black, non-Hispanic	214	307.1	6,969	12.6%	18.4%
AI/AN, non-Hispanic	11	331.3	332	0.6%	0.9%
API, non-Hispanic	115	227.8	5,049	9.1%	9.9%
Hispanic	469	205.7	22,802	41.1%	40.4%
Other/Unknown	48	368.7	1,302	2.3%	4.1%
Education					
Less than High School	162	244.4	6,629	12.0%	13.9%
High School Graduate	394	211.0	18,671	33.7%	33.9%
Some College	246	178.7	13,768	24.8%	21.2%
College Graduate or Higher	268	195.8	13,689	24.7%	23.1%
Unknown	92	344.4	2,671	4.8%	7.9%
Health Insurance Status*					
Medicaid	518	229.1	22,608	40.8%	44.6%
Other Government	30	285.2	1,052	1.9%	2.6%
Private	581	195.8	29,669	53.5%	50.0%
Self-pay	18	151.0	1,192	2.2%	1.5%
Other	14	168.3	832	1.5%	1.2%
Unknown	1	133.3	75	0.1%	0.1%

* Health Insurance status indicates the primary payer for the delivery as recorded on hospital discharge form.

Table 7 shows the maternal prenatal and delivery-related characteristics have p-values below the common significance threshold of 0.05, indicating that they are statistically significant factors associated with the SMM rate. Specifically, prenatal care initiation ($p < 0.0001$), adequacy of prenatal care ($p < 0.0001$), parity ($p = 0.007$), method of delivery ($p < 0.0001$), and plurality ($p < 0.0001$) are all significantly associated with the SMM rate. Chronic disease includes deliveries to pregnant people with chronic hypertension, pre-existing diabetes or chronic heart disease as recorded on birth certificate. When testing each of these three conditions individually, only chronic hypertension shows statistical significance ($p < 0.0001$).

Table 7: Severe Maternal Morbidity by Maternal Prenatal and Delivery-Related Characteristics, Nevada 2022–2023

Maternal Prenatal and Delivery-Related Characteristics	Count of SMM Cases	Rate per 10,000 Deliveries	Count of All Deliveries	Percent of All Deliveries	Percent of SMM Cases
Prenatal Care Initiation					
No Care	48	363.9	1319	2.4%	4.1%
First Trimester	779	188.0	41439	74.8%	67.0%
Second Trimester	180	220.5	8165	14.7%	15.5%
Third Trimester	68	407.7	1668	3.0%	5.9%
Had Care but Unknown Start Date	14	129.6	1080	1.9%	1.2%
Unknown	73	415.5	1757	3.2%	6.3%
Adequacy of Prenatal Care					
Inadequate	168	282.6	5,944	10.7%	14.5%
Intermediate	98	182.3	5,377	9.7%	8.4%
Adequate	282	144.4	19,524	35.2%	24.3%
Adequate Plus	476	235.2	20,241	36.5%	41.0%
Data Missing/Unknown	138	317.8	4,342	7.8%	11.9%
Parity					
0 Previous Live Births	462	221.4	20,863	37.6%	39.8%
1 Previous Live Births	279	177.4	15,726	28.4%	24.0%
2+ Previous Live Births	374	218.6	17,108	30.9%	32.2%
Unknown	47	271.5	1,731	3.1%	4.0%
Method of Delivery*					
Repeat Cesarean	311	347.2	8,957	16.2%	26.8%
Primary Cesarean	410	391.6	10,469	18.9%	35.3%
Vaginal	441	122.5	36,002	65.0%	38.0%
Plurality					
Singleton Birth	1,094	200.4	54,604	98.5%	94.1%
Multiple Birth	68	825.2	824	1.5%	5.9%
Pre-Pregnancy BMI~					
Underweight (<18.5)	38	215.4	1,764	3.2%	3.3%
Normal Weight (18.5- 24.9)	405	203.0	19,955	36.0%	34.9%
Overweight (25.0 - 29.9)	331	214.7	15,417	27.8%	28.5%
Class I (30.0 - 34.9)	184	188.6	9,755	17.6%	15.8%
Class II (35.0 - 39.9)	95	199.0	4,774	8.6%	8.2%
Class III (>=40)	80	246.5	3,246	5.9%	6.9%
Unknown	29	560.9	517	0.9%	2.5%
Chronic Hypertension					
No Chronic Hypertension	1,115	206.0	54,134	97.7%	96.0%
Chronic Hypertension	47	363.2	1,294	2.3%	4.0%

*Method of delivery was identified from hospital discharge data using ICD-10 codes.

~ Pre-pregnancy BMI was calculated using the formula (weight(lb.)/height(in)^2) *703 with mother's weight and height as recorded on birth certificate.

Data Summary

Maternal Mortality

Pregnancy-Associated Death (PAD)

The pregnancy-associated death ratios in the years 2023 and 2024 are stable and have shown slight decrease compared to years of 2021-2023. With 84.2 and 88.9 per 100,000 live births in 2024 and 2025 respectively compared to the high of 116.4 in 2021 and 101.5 in 2023. Pregnancy-associated death rates have also shown similar trend with a rate of 4.0 and 4.1 per 100,000 reproductive aged women in 2024 and 2025 respectively compared to 6.1 in 2021 and 4.8 in 2023. The percentage of PAD cases with Medicaid in Nevada increased in 2022 to 66.7% from 59.0% of 2021, and it has been steady with slight decrease since then. (And will update when 2025 date is finalized.)

In 2024 to 2025, American Indian/Alaska Native (AI/AN), non-Hispanic Nevadans had the highest pregnancy-associated death ratio at 248.8 per 100,000 live births followed by Black, non-Hispanic Nevadans at 203.6 per 100,000 live births. We observe a very big gap between these two race/ethnic groups and the rest three with the third highest ratio at 74.3 for White, non-Hispanic group.

In 2024 to 2025, Nevadans with a maternal age of 30-34 accounted for 29.1% of pregnancy-associated deaths, and the 40-60 age group had the highest pregnancy-associated death ratio at 143.6 per 100,000 live births.

The Rest of State has a much higher Ratio of pregnancy-associated death at 127.3 per 100,000 live births in 2024 to 2025 than the metropolitan areas of Clark and Washoe County (86.4 and 60.8 per 100,000 live births respectively).

The most common underlying cause of death was *Pregnancy, Childbirth and the Puerperium*, accounting for 34.5% of all pregnancy-associated deaths. The second most common cause of death was *Non-transport Accidents* at 23.6% of pregnancy-associated deaths.

Pregnancy-Related Death (PRD)

The pregnancy-related death data is available through 2024; the highest PRD death ratio occurred in 2021 in the past 5-year period, at 35.8 per 100,000 live births, which is a sharp increase from 2020. However, it has been decreasing since then and came to the lowest in 2024 at 6.2 per 100,000 live births.

In 2023 to 2024 Asian/Pacific Islander (API), non-Hispanic Nevadans had the highest pregnancy-related death ratio at 34.0 per 100,000 live births. Black, non-Hispanic Nevadans had the highest death rate at 1.6 per 100,000 women of reproductive age.

In 2023 to 2024 Nevadans aged 40-60 had the highest PRD ratio at 74.4 per 100,000 live births, followed by 10-19 age group at a ratio of 40.6 per 100,000 live births.

During 2023 and 2024, the most common underlying causes of pregnancy-related death were *Cardiomyopathy* and *Other non-cardiovascular conditions* both accounted for 20%. *Hemorrhage, Hypertensive disorders of pregnancy, Infection, Thrombotic embolism, other cardiovascular conditions*, and *Unknown* each accounted for 10%.

Maternal Deaths

There were 19 maternal deaths in Nevada from 2020 to 2024.

The highest ratios were in 2021 at 23.9 per 100,000 live births and a rate of 1.2 per 100,000 women of reproductive age.

By race and ethnicity, the Nevadans who died were 7 White, non-Hispanic, 4 Black, non-Hispanic, 1 American Indian/Alaska Native non-Hispanic, 3 Asian/Pacific Islander non-Hispanic, and 4 Hispanic. There were 4 Nevadans in the <25 age group, 6 in the 25-34 age group, and 9 in the 35+ age group.

Severe Maternal Morbidity

From 2021 to 2025, Nevada's Severe Maternal Morbidity (SMM) rate has been stable but with a slight increase in 2025 at 219.2 per 10,000 deliveries. The percentage of SMM Cases with Medicaid in Nevada has a spike in 2023 at 63.8% but went back down in 2024

(And will update when 2025 date is finalized).

Most deliveries with SMM in 2024 to 2025 were associated with one indicator (88.5%). The top three leading diagnosis-based indicators for SMM were *Acute Respiratory Distress Syndrome* (12.6 per 10,000 deliveries), *Acute Renal Failure* (10.1 per 10,000 deliveries), and *Sepsis* (8.5 per 10,000 deliveries). The leading procedure-based indicator was *Blood transfusion*.

When comparing maternal demographic characteristics, maternal age, race/ethnicity, education, prenatal care initiation, adequacy of prenatal care, parity, method of delivery, plurality, and chronic hypertension are all risk factors for severe maternal morbidity.

Other than the Other/Unknown group, AI/AN, non-Hispanic Nevadans accounted for 0.9% of SMM cases but had the highest SMM rate followed by Black, non-Hispanic Nevadans who accounted for 18.4% of SMM cases (331.3 and 307.1 per 10,000 deliveries, respectively). Nevadans aged 40 years and older had the highest rate of SMM (353.7 per 10,000 deliveries) but accounted for only 7.3% of cases. The 25-29 age group had the lowest rate of SMM (170.5 per 10,000 deliveries) and accounted for 22.8% of cases.

MMRC Support Staff and Other Acknowledgements

The Nevada MMRC functions with support of staff from the DPBH, Maternal, Child and Adolescent Health Section. A special thanks to Robyn Cunnally, Registered Nurse, Joan Stewing, Registered Nurse, Cortnee Scurry, MSW, Colleen Barrett, MPH, and Praseetha Balakrishnan, MS. Office of Analytics MMRC support is crucial and deeply appreciated.

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The families who shared information in informant interviews are deeply appreciated for their generosity in sharing crucial information in the hopes of preventing other families from experiencing a similar, devastating loss. We dedicate this report to the memories of all the individuals lost to maternal mortality and to their loved ones.

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Title V Maternal and Child Health Block Grant: 6-BO4MC54561

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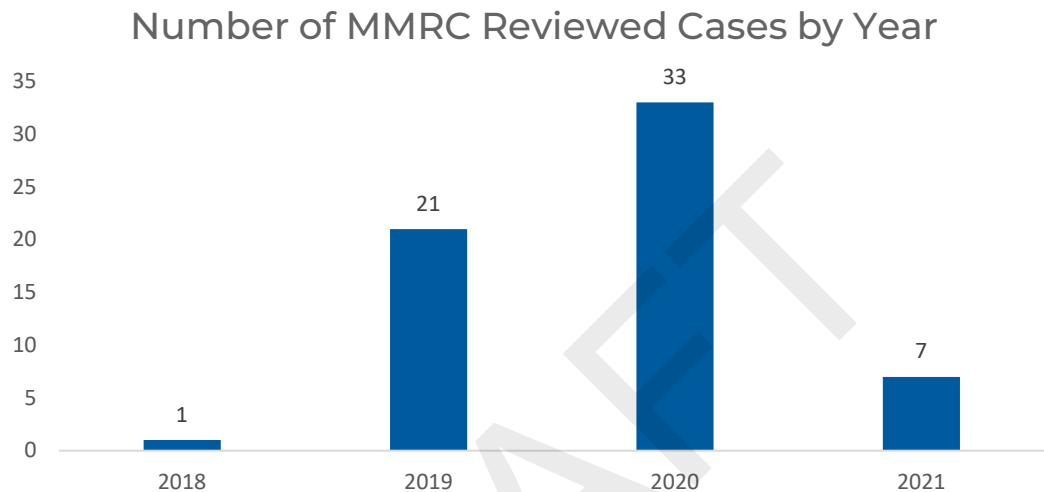
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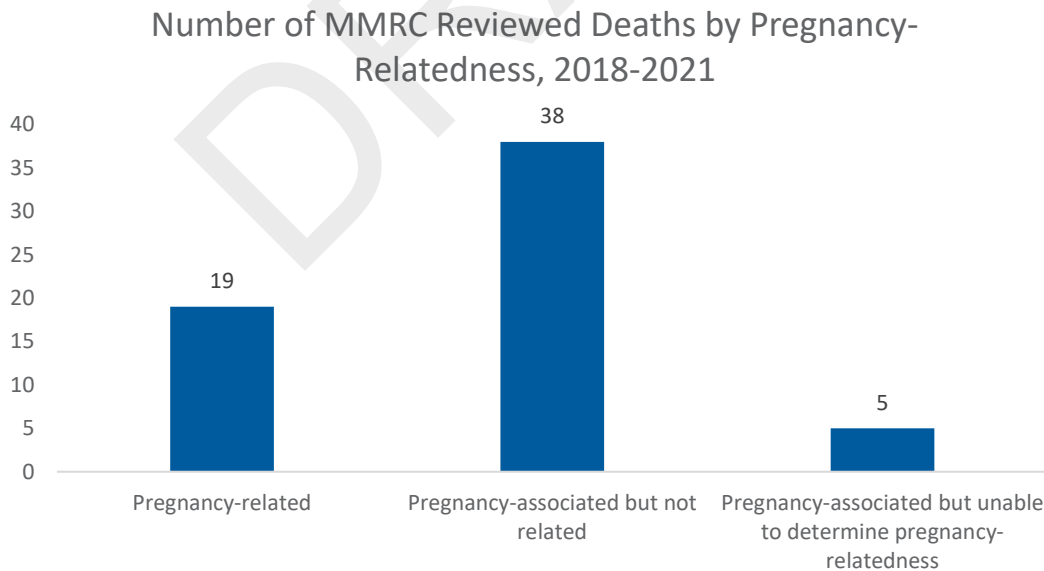
Pamela Adzima, DNP, MHA, RN
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Appendix A: MMRC MMRIA Data

The following aggregate data includes cases reviewed by year of death and finalized by the MMRC from 2018 to 2021 (1 case reviewed in 2018, 21 in 2019, 33 in 2020, and 7 in 2021). Since inception, the MMRC has reviewed a total of 62 deaths to date. The following data charts use N=62 and were pulled from the Maternal Mortality Review Information Application (MMRIA) Data System in an aggregate report to ensure that the cases reviewed are non-identifiable. Due to the small number of deaths reviewed, please interpret the data with caution. All data in Appendix A is sourced from Nevada’s Maternal Mortality Review Information Application (MMRIA). MMRIA is housed and managed by the Centers for Disease Control and Prevention and administered by the Maternal, Child, and Adolescent Health Section.

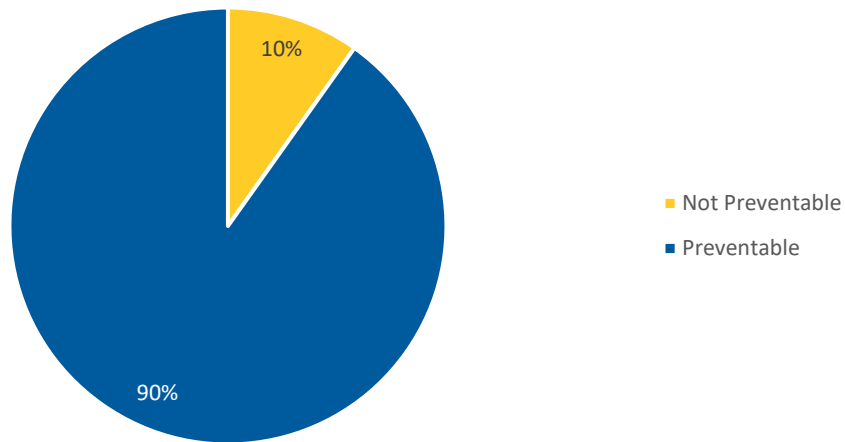


Appendix Figure 1: MMRC Reviewed Cases by Year, CDC MMRIA Data



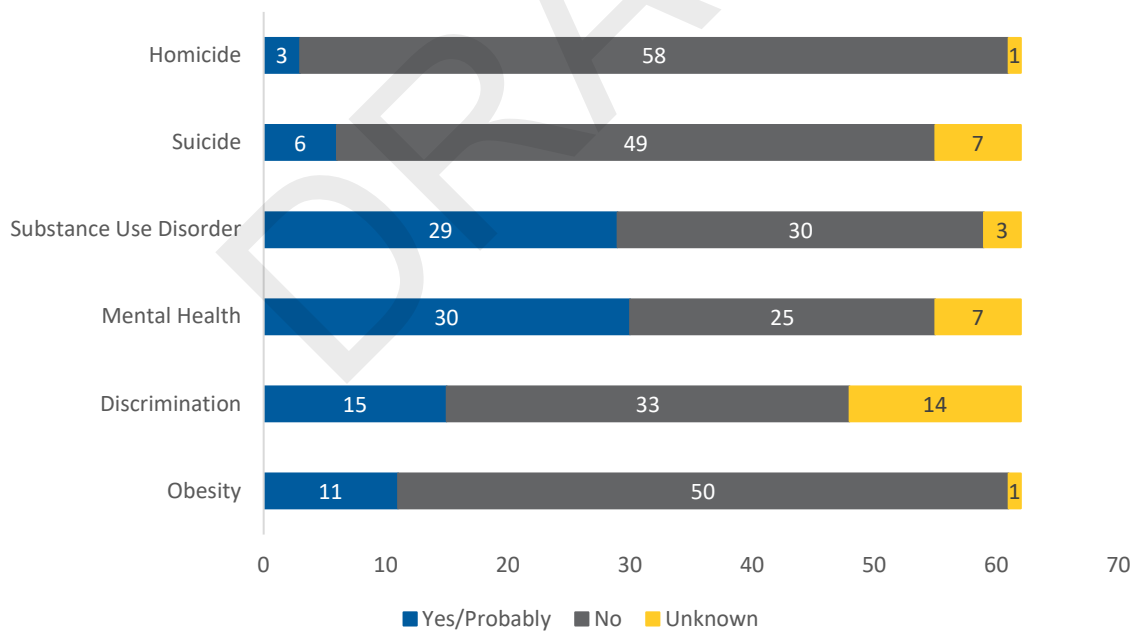
Appendix Figure 2: MMRC Reviewed Cases by Pregnancy Relatedness, CDC MMRIA Data

Preventability of MMRC Review Cases, 2018-2021



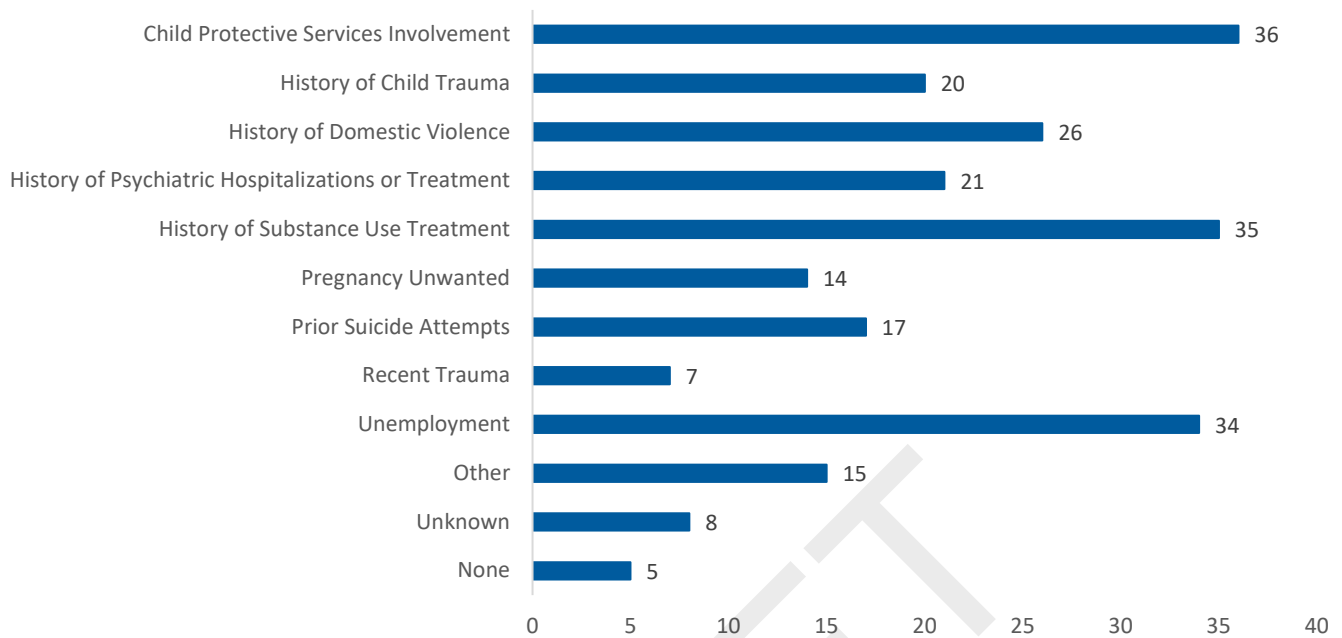
Appendix Figure 3: Percent of Preventability of MMRC Reviewed Cases between 2018-2020, CDC MMRIA Data

Number of MMRC Reviewed Deaths by Committee Determination Contributors to Death, 2018-2021



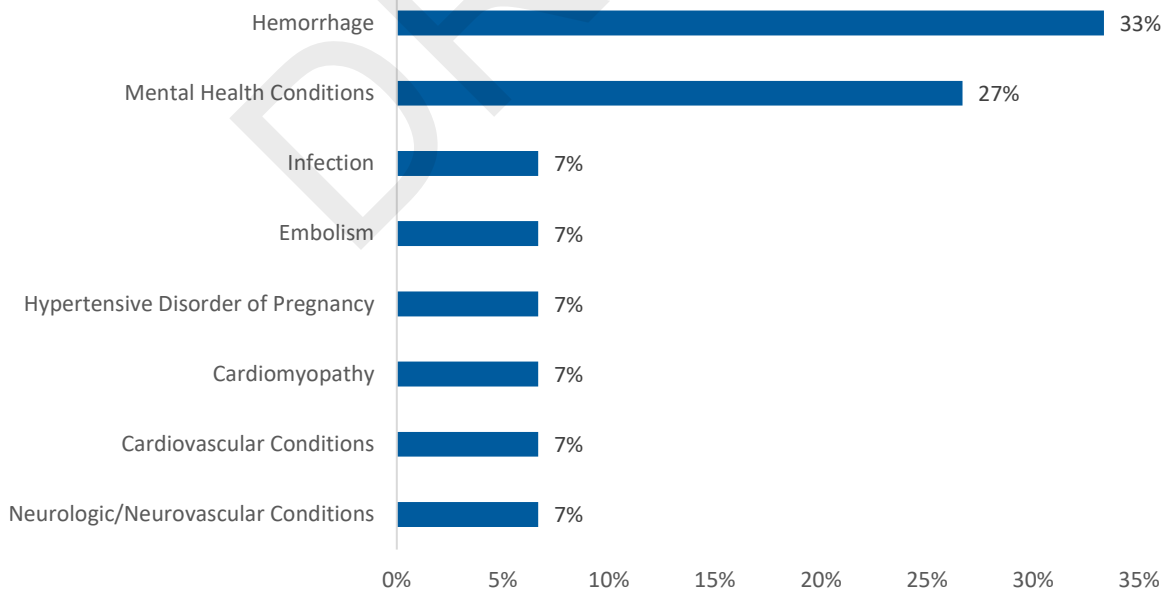
Appendix Figure 4: Number of MMRC Reviewed Cases by Committee Determination Contributors to Death between 2018-2020, CDC MMRIA Data

Number of Cases by Social Emotional Stressor, 2018-2021



Appendix Figure 5: Number of MMRC Reviewed Cases by Social/Emotional Stressor between 2018-2020, CDC MMRIA Data

Primary Causes of Death for MMRC Pregnancy-Related Cases, 2018-2021



Appendix Figure 6: Percent of Primary Causes of Death for MMRC Reviewed Pregnancy-Related Cases 2018-2020, CDC MMRIA Data

MMRC Reviewed Cases , 2018-2021		
Demographics	Number	Percent
Age		
<20	3	5%
20-24	9	15%
25-29	19	31%
30-34	9	15%
35-39	14	23%
40-44	8	13%
Race/Ethnicity		
Non-Hispanic White	27	44%
Non-Hispanic Black	14	23%
Non-Hispanic American Indian or Alaska Native	3	5%
Non-Hispanic Asian/ Pacific Islander	3	5%
Hispanic	15	24%
Marital Status		
Married/Widowed	21	34%
Divorce/Never Married	38	61%
Unknown	3	5%
Insurance		
Medicaid	28	45%
Private	14	23%
Other	20	32%
Education		
High school diploma equivalent or less	50	81%
Completed some college	4	6%
Associate or bachelor's degree	8	13%
Completed advanced degree	0	0%
Region		
Metropolitan (large and small)	52	84%
Micropolitan (mixed urban/rural)	7	11%
Rural	1	2%
Undetermined	1	2%

Appendix Table 1: Demographic characteristics of MMRC reviewed cases between 2018-2021, CDC MMRIA Data

Pregnancy- Associated Death Ratio per 100,00 live births by, Contributing Factors, MMRC Review Cases 2018-2021						
Demographics	Obesity	Discrimination	Mental Health	Substance Use	Suicide	Homicide
Age						
<20	0.0	15.8	31.6	31.6	0.0	0.0
20-24	3.7	11.0	22.0	18.3	7.3	0.0
25-29	7.3	12.2	36.7	34.3	2.4	7.3
30-34	2.7	5.4	13.4	16.1	5.4	0.0
35-39	14.9	14.9	9.9	5.0	5.0	0.0
40-44	64.7	21.6	21.6	43.1	0.0	0.0
Race/Ethnicity						
Non-Hispanic White	3.9	7.7	34.7	30.9	7.7	1.9
Non-Hispanic Black	15.0	29.9	29.9	34.9	0.0	5.0
Non-Hispanic American Indian or Alaska Native	0.0	0.0	156.7	156.7	0.0	0.0
Non-Hispanic Asian/ Pacific Islander	0.0	15.8	7.9	7.9	0.0	0.0
Hispanic	9.8	5.9	1.0	9.8	3.9	2.0

Appendix Table 2: Pregnancy- Associated Death Ratio per 100,000 live births by Contributing Factors of MMRC reviewed cases between 2018-2021, CDC MMRIA Data

Appendix B: Recommendation by Expected Impact

Recommendations for MMRC Reviewed Cases, 2020-2021 by Expected Impact	
Expected Impact	Number of Recommendations
Extra Large	28
Giant	22
Large	21
Medium	31
Small	4

Appendix Table 3: Number of Recommendation from MMRC Review Cases between 2020-2021 by expected impact lever if recommendations were implemented, CDC MMRIA Data

Recommendations Repeated for MMRC Review Cases, 2020-2021			
Repeat Recommendation	Number of Cases	Expected Impact	Contributing Factors
All treatment centers, including prisons, hospitals, and inpatient/outpatient drug/mental health clinics, should ensure continuity of care during transitions.	4	3 Large, 1 Extra Large	Substance use
All treatment centers, including prisons, hospitals, and inpatient/outpatient drug/mental health clinics, should treat all co-occurring co-morbidities including mental health before, during and after pregnancy as the standard of care.	2	2 Extra Large	Co-Occurring mental health and substance use not addressed
An US should have been done in triage L&D per ACOG guidelines and an appropriate birth spacing interval followed per ACOG standards, including education and prevention of first cesarean section to obstetric providers.	2	1 Extra Large, 1 Giant	Clinical skill/Quality of care
Clinicians should follow standard of care in the treatment of mental health and substance use disorders including , assessing risk factors, screenings and referrals during the perinatal period including postpartum.	2	1 Large, 1 Medium	Mental health conditions

Recommendations Repeated for MMRC Review Cases, 2020-2021			
Repeat Recommendation	Number of Cases	Expected Impact	Contributing Factors
Mental Health clinicians should practice medicine in line with national guidelines, standards of care, and best practices when treating patients.	2	2 Extra Large	Mental health conditions
Providers managing chronic conditions should deliver care in accordance with national clinical guidelines and established standards of care.	2	2 Medium	Chronic disease/Quality of Care
State of Nevada agencies and programs such as the Department of Health and Human Services, Division of Public and Behavioral Health, Behavioral Health and Wellness Program and groups such as the Perinatal Health Initiative or Perinatal Quality Collaborative should develop a focused campaign and dedicate funding for reduction of substance/alcohol use in pregnancy.	2	1 Giant, 1 Medium	Substance use
State of Nevada agencies and programs such as the Nevada Department of Education and Department of Health and Human Services should develop and implement at least two robust evidence-based education-based programs and support to effectively screen for and address ACEs in educational settings then provide interventions if screened positive.	2	2 Giant	ACES/Trauma
State of Nevada agencies and programs such as the Nevada Department of Education and Department of Health and Human Services should develop and implement at least two robust evidence-based education-based programs and support to effectively screen for and address ACEs in educational settings.	4	4 Giant	ACES/Trauma

Recommendations Repeated for MMRC Review Cases, 2020-2021			
Repeat Recommendation	Number of Cases	Expected Impact	Contributing Factors
State of Nevada agencies such as Nevada Medicaid should provide funding and appoint case care coordinators or community health workers to assist individuals facing multiple diagnoses related to substance use, mental health, and pregnancy. These case workers should be trained in trauma-informed care and motivational interviewing to support care follow-up and assist individuals in navigating the healthcare system.	4	1 Extra Large, 2 Giant, 1 Medium	Continuity of care/Access to financial resources/ Mental health
State of Nevada agencies such as the Division of Health Care Financing and Policy should audit Medicaid perinatal patient navigators and case managers to ensure quality care coordination, timely referral to needed services, and patient connection to services is occurring.	2	2 Extra Large	Delay of care/Mental health conditions
The obstetric providers should be using universal questionnaire-based screening for mental health and substance use using validated questionnaires for all patients that enter prenatal care.	2	2 Large	Assessment and Screening
The State of Nevada should develop a Perinatal Quality Collaborative to improve uptake of current standard of care recommendations.	3	3 Extra Large	Policy and procedure/Continuity of care

Appendix Table 4: Repeated Recommendations from MMRC Review Cases between 2020-2021 by expected impact lever if recommendations were implemented and contributing factors, CDC MMRIA Data

Appendix C: SMM Indicators and ICD-10 CM Codes

Complete List of SMM Indicators and Associated ICD-10-CM Codes

Classification	Severe Maternal Morbidity Indicator	ICD-10/Procedure Codes
Diagnosis	Acute myocardial infarction	I21.xx, I22.x
	Aneurysm	I71.xx, I79.0
	Acute renal failure	N17.x, O90.4
	Acute respiratory distress syndrome	J80, J95.1, J95.2, J95.3, J95.82x, J96.0x, J96.2x, R09.2, R06.03, R09.2
	Amniotic fluid embolism	O88.112, O88.113, O88.119, O88.12, O88.13
	Cardiac arrest/ventricular fibrillation	I46.x, I49.0x
	Disseminated intravascular coagulation	D65, D68.8, D68.9, O45.002, O45.003, O45.009, O45.012, O45.013, O45.019, O45.022, O45.023, O45.029, O45.092, O45.093, O45.099, O46.002, O46.003, O46.009, O46.012, O46.013, O46.019, O46.022, O46.023, O46.029, O46.092, O46.093, O46.099, O67.0, O72.3
	Eclampsia	O15.x
	Heart failure/arrest during surgery or procedure	I97.120, I97.121, I97.130, I97.131, I97.710, I97.711
	Puerperal cerebrovascular disorders	A81.2, G45.x, G46.x, G93.49, H34.0x, I60.xx, I61.xx, I62.xx, I63.00, I63.01x, I63.1xx, I63.2xx, I63.3xx, I63.4xx, I63.5xx, I63.6, I63.8x, I63.9, I65.xx, I66.xx, I67.xx, I68.xx, O22.50, O22.52, O22.53, I97.810, I97.811, I97.820, I97.821, O87.3
	Pulmonary edema/Acute heart failure	I50.1, I50.20, I50.21, I50.23, I50.30, I50.31, I50.33, I50.40, I50.41, I50.43, I50.810, I50.811, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J81.0
	Severe anesthesia complications	O29.112–O29.119, O29.122–O29.129, O29.192–O29.199, O29.212–O29.219, O29.292–O29.299, O74.0, O74.1, O74.2, O74.3, O89.0x, O89.1, O89.2, T88.2XXA, T88.3XXA
	Sepsis	A32.7, A40.x, A41.x, I76, O85, O86.04, R65.20, R65.21, T81.12XA, T81.44XA
Procedure	Shock	O75.1, R57.x, T78.2XXA, T81.10XA, T81.11XA, T81.19XA, T88.6XXA
	Sickle cell disease with crisis	D57.00, D57.01, D57.02, D57.211, D57.212, D57.219, D57.411, D57.412, D57.419, D57.811, D57.812, D57.819
	Air and thrombotic embolism	I26.x, O88.012–O88.03, O88.212–O88.23, O88.312–O88.33, O88.812–O88.83, T80.0XXA
	Conversion of cardiac rhythm	5A12012, 5A2204Z
	Blood transfusion	30230H0, 30230K0, 30230L0, 30230M0, 30230N0, 30230P0, 30230R0, 30230T0, 30230H1, 30230K1, 30230L1, 30230M1, 30230N1, 30230P1, 30230R1, 30230T1, 30233H0, 30233K0, 30233L0, 30233M0, 30233N0, 30233P0, 30233R0, 30233T0, 30233H1, 30233K1, 30233L1, 30233M1, 30233N1, 30233P1, 30233R1, 30233T1, 30240H0, 30240K0, 30240L0, 30240M0, 30240N0, 30240P0, 30240R0, 30240T0, 30240H1, 30240K1, 30240L1, 30240M1, 30240N1, 30240P1, 30240R1, 30240T1, 30243H0, 30243K0, 30243L0, 30243M0, 30243N0, 30243P0, 30243R0, 30243T0, 30243H1, 30243K1, 30243L1, 30243M1, 30243N1, 30243P1, 30243R1, 30243T1
	Hysterectomy	OUT90ZL, OUT90ZZ, OUT97ZL, OUT97ZZ
Procedure	Temporary tracheostomy	0B110F4, 0B113F4, 0B114F4
	Ventilation	5A1935Z, 5A1945Z, 5A1955Z

*Source: <https://www.cdc.gov/maternal-infant-health/php/severe-maternal-morbidity/icd.html>

Classification	Severe Maternal Morbidity Indicator	ICD-10/Procedure Codes
Diagnosis	Acute myocardial infarction	I21.xx, I22.x
	Aneurysm	I71.xx, I79.0
	Acute renal failure	N17.x, O90.4
	Acute respiratory distress syndrome	J80, J95.1, J95.2, J95.3, J95.82x, J96.0x, J96.2x, R09.2, R06.03, R09.2
	Amniotic fluid embolism	O88.112, O88.113, O88.119, O88.12, O88.13
	Cardiac arrest/ventricular fibrillation	I46.x, I49.0x
	Disseminated intravascular coagulation	D65, D68.8, D68.9, O45.002, O45.003, O45.009, O45.012, O45.013, O45.019, O45.022, O45.023, O45.029, O45.092, O45.093, O45.099, O46.002, O46.003, O46.009, O46.012, O46.013, O46.019, O46.022, O46.023, O46.029, O46.092, O46.093, O46.099, O67.0, O72.3
	Eclampsia	O15.x
	Heart failure/arrest during surgery or procedure	I97.120, I97.121, I97.130, I97.131, I97.710, I97.711
	Puerperal cerebrovascular disorders	A81.2, G45.x, G46.x, G93.49, H34.0x, I60.xx, I61.xx, I62.xx, I63.00, I63.01x, I63.1xx, I63.2xx, I63.3xx, I63.4xx, I63.5xx, I63.6, I63.8x, I63.9, I65.xx, I66.xx, I67.xx, I68.xx, O22.50, O22.52, O22.53, I97.810, I97.811, I97.820, I97.821, O87.3
	Pulmonary edema/Acute heart failure	I50.1, I50.20, I50.21, I50.23, I50.30, I50.31, I50.33, I50.40, I50.41, I50.43, I50.810, I50.811, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J81.0
	Severe anesthesia complications	O29.112–O29.119, O29.122–O29.129, O29.192–O29.199, O29.212–O29.219, O29.292–O29.299, O74.0, O74.1, O74.2, O74.3, O89.0x, O89.1, O89.2, T88.2XXA, T88.3XXA
	Sepsis	A32.7, A40.x, A41.x, I76, O85, O86.04, R65.20, R65.21, T81.12XA, T81.44XA
	Shock	O75.1, R57.x, T78.2XXA, T81.10XA, T81.11XA, T81.19XA, T88.6XXA
	Sickle cell disease with crisis	D57.00, D57.01, D57.02, D57.211, D57.212, D57.219, D57.411, D57.412, D57.419, D57.811, D57.812, D57.819
	Air and thrombotic embolism	I26.x, O88.012–O88.03, O88.212–O88.23, O88.312–O88.33, O88.812–O88.83, T80.0XXA
Procedure	Conversion of cardiac rhythm	5A12012, 5A2204Z
	Blood transfusion	30230H0, 30230K0, 30230L0, 30230M0, 30230N0, 30230P0, 30230R0, 30230T0, 30230H1, 30230K1, 30230L1, 30230M1, 30230N1, 30230P1, 30230R1, 30230T1, 30233H0, 30233K0, 30233L0, 30233M0, 30233N0, 30233P0, 30233R0, 30233T0, 30233H1, 30233K1, 30233L1, 30233M1, 30233N1, 30233P1, 30233R1, 30233T1, 30240H0, 30240K0, 30240L0, 30240M0, 30240N0, 30240P0, 30240R0, 30240T0, 30240H1, 30240K1, 30240L1, 30240M1, 30240N1, 30240P1, 30240R1, 30240T1, 30243H0, 30243K0, 30243L0, 30243M0, 30243N0, 30243P0, 30243R0, 30243T0, 30243H1, 30243K1, 30243L1, 30243M1, 30243N1, 30243P1, 30243R1, 30243T1
	Hysterectomy	0UT90ZL, 0UT90ZZ, 0UT97ZL, 0UT97ZZ
	Temporary tracheostomy	0B110F4, 0B113F4, 0B114F4
	Ventilation	5A1935Z, 5A1945Z, 5A1955Z

*Source: <https://www.cdc.gov/maternal-infant-health/php/severe-maternal-morbidity/icd.html>