COMMONWEALTH of VIRGINIA
Office of the Governor

Janet Vestal Kelly
Secretary of Health and Human Resources

January 16, 2026

MEMORANDUM

TO: The Honorable Glenn Youngkin
Governor of Virginia

The Honorable L. Louise Lucas
Chair, Senate Finance and Appropriations Committee

The Honorable Barbara A. Favola
Chair, Senate Education and Health Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Rodney T. Willett
Chair, House Health and Human Services Committee

FROM: The Honorable Janet V. Kelly, Secretary
Office of Health and Human Resources

SUBJECT: Final Report to the Governor and General Assembly on Executive Order 32 – Maternal Health Data and Quality Measures Task Force

This report is submitted in compliance with Executive Order 32 (2024) that directs:

> *"The Task Force shall report its findings and conclusions to the Governor and the General Assembly by December 1 of each year regarding its activities and shall conclude its work by December 1, 2025. By December 1, 2024, the Secretary of Health and Human Resources shall provide a report to the Governor outlining recommendations including budgetary, legislative, or administrative measures with the goal of improving maternal health, including maternal mental health and substance use and progress towards eliminating health disparities."*

Should you have any questions or need additional information, please contact the Office of the Secretary of Health and Human Resources at (804) 786-7765.

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Task Force on Maternal Health Data & Quality Measures

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EXECUTIVE SUMMARY

The State Health Commissioner presents the 2025 report of the Task Force on Maternal Health Data and Quality Measures.

In 2024, Governor Glenn Youngkin issued Executive Order 32 (provided as Appendix A), which tasked the State Health Commissioner with re-establishing the Maternal Health Data and Quality Measures Task Force (the Task Force). The charge was to evaluate maternal health data collection processes to inform policies in the Commonwealth that improve maternal care, quality, and outcomes. The Task Force was directed to report its findings to the Governor and General Assembly and conclude its work by December 1, 2025. This report summarizes the 2024 and 2025 Task Force meetings and the recommendations from the Task Force. The VCU Center for Public Policy (CPP) within the L. Douglas Wilder School of Government and Public Affairs provided facilitation services and assistance with writing this report.

Prioritized Task Force Recommendations

The Task Force prepared recommendations to address maternal health data collection, data sharing, and data reporting throughout the Commonwealth. The Task Force recommended prioritizing the following recommendations.

1. Expand and invest in workforce development, especially in rural areas.
2. Strengthen access to care: transportation, child care, broadband access for telehealth appointments, and understanding how to complete paperwork (i.e., health literacy).
3. Collect and publish data on fetal and infant health outcomes.
4. Obtain data on the number of prenatal and post-partum patients who have access to primary care providers, and who see their primary care provider.

Recommendations Summary

Additional recommendations and greater detail are provided in the Final Recommendations section of this report.

1: Create a program or use an existing program (e.g., the Emergency Department Care Coordination program) to streamline efforts and ensure continuity of care between hospitals, obstetricians, midwives, and community providers.		
Outcomes	**Implementation**	**Legislation & Budget**
Improved quality of maternal health care.	The Emergency Department Care Coordination (EDCC) program Advisory Council may need to consider expanding the program to emphasize maternal health care data.	May require additional funding for database creation, integration, education, and promotion.

2: Expand and invest in workforce development, especially in rural areas.		
Outcomes	**Implementation**	**Legislation & Budget**
Increased number of practitioners to service maternal health patients across the Commonwealth, especially in rural communities.	Opportunities include: • Medical education loan repayment • Expanding the roles of allied workforce positions (e.g., doulas, community health workers) • Expanding training and residency opportunities in rural communities	Virginia funding opportunities: • Supplemental payment for obstetric-gynecological residencies[1] • Funds for community health workers [2] • Rural Health Transformation funding through VA Rural Vitality[3]

[1] budget.lis.virginia.gov/item/2025/1/HB1600/Enrolled/1/288/#:~:text=b.%20Effective%20July%201,the%20budget%20process.
[2] budget.lis.virginia.gov/item/2025/1/HB1600/Enrolled/1/278/#:~:text=J.%20Out%20of,for%20this%20purpose.
[3] hhr.virginia.gov/initiatives/rural-health/

3: Strengthen access to care: transportation, child care, broadband access for telehealth appointments, and understanding how to complete paperwork (i.e., health literacy).		
Outcomes	**Implementation**	**Legislation & Budget**
Reduced barriers to accessing maternal health care caused by transportation, child care, broadband, and health literacy issues.	Opportunities include: • Mobile health clinics • Home visiting programs • Engaging community health workers	Virginia funding opportunities: • Rural Health Transformation funding through VA Rural Vitality Virginia legislation passed in 2025: • Pregnancy mobile application to promote awareness of maternal health programs (Chapter 696 2025)[4]

[4] lis.virginia.gov/bill-details/20251/HB1929

4: Collect and publish data on fetal and infant health outcomes.		
Outcomes	**Implementation**	**Legislation & Budget**
Increased access to the data necessary to better understand fetal and infant loss and how to prevent them.	Collection and publication of data points not currently available to the public, including: • Manner of infant death • Still births • Substance-Exposed Infants (SEI) • Demographic information on the above data points	Virginia funding opportunities: Funding may be required to establish a process to collect data. Legislation may be necessary to allow the Virginia Neonatal Perinatal Collaborative (VNPC) Fetal Infant Mortality Review (FIMR) program to access medical records to report this information.

5: Obtain data on the number of prenatal and post-partum patients who have access to primary care providers, and who see their primary care provider.		
Outcomes	**Implementation**	**Legislation & Budget**
Better understanding of the primary care needs of maternal health patients in Virginia and how to meet these needs.	Collection and publication of data points not currently available to the public, including: • Patients assigned to a primary care provider (PCP) • Patients seeing PCPs within the postpartum window • Patients seeing PCPs during pregnancy	Implementing the collection, analysis, and publication of this data may require additional funding.

ACKNOWLEDGEMENTS

The Secretary of Health and Human Resources and the State Health Commissioner would like to express our gratitude to the many collaborators who provided invaluable support and insight into this project.

Task Force on Maternal Health Data and Quality Measures Co-Chairs

Dr. Karen Shelton, State Health Commissioner

Dr. Siobhan Dunnavant, OB/GYN Associates

Panelists and Presenters to the Task Force

Dr. Avery Michienzi, Assistant Professor Emergency Medicine/Medical Toxicology, University of Virginia, Blue Ridge Poison Center

Dr. Seema Sarin, Medical Director, Commercial and Specialty Business, Anthem Blue Cross and Blue Shield

Dr. Daphne Bazile, Obstetrician and Gynecologist, Bon Secours

Dr. Jaclyn Nunziato, Obstetrician and Gynecologist, Carilion Clinic

Dr. Richard Lucidi, Obstetrician and Gynecologist, VCU Health

Christina Jennings, Certified Women's Health Nurse Practitioner, Virginia Department of Health, Chickahominy Health District

Kate Hulbert, Certified Nurse Midwife, VCU Health

Ildiko Baugus, Certified Professional Midwife & Licensed Midwife, Meraki Midwives

The Center for Public Policy, Virginia Commonwealth University L. Douglas Wilder School of Government and Public Affairs

Gina Barber, Director of Administration and Senior Consultant

Dr. Brittany Keegan, Director of Research Promotion and Engagement & Assistant Professor

Dr. Jenn Reid, Evaluation Director and Senior Consultant

Sofia Tortolero, Consultant and Facilitator

A full list of Task Force members and representing organizations is included as Appendix B.

INTRODUCTION

The Maternal Health Data and Quality Measures Task Force (the Task Force) was re-established through Executive Order 32 (2024), issued by Governor Glenn Youngkin. The State Health Commissioner was directed to re-establish the Task Force to evaluate maternal health data collection processes to inform policies in the Commonwealth that improve maternal health care quality and outcomes. The full Executive Order is provided as Appendix A.

The Task Force was directed to:

1. Monitor progress and evaluate all data from state-level stakeholders, including third-party payers, and all available electronic claims data to examine quality of care with regard to race, ethnicity, and other demographic and clinical outcomes data;
2. Monitor progress and evaluate data from existing state-level sources mandated for maternal care, including the Healthcare Effectiveness Data and Information Set (HEDIS) measure updates to Prenatal and Postpartum Care and Postpartum Depression;
3. Examine the barriers preventing the collection and reporting of timely maternal health data from all stakeholders, including payers;
4. Examine current maternal health benefit requirements and determine the need for additional benefits to protect women's health;
5. Evaluate the impact of Social Determinants of Health screening on pregnant women and its impact on outcomes data;
6. Analyze available data one year after delivery, including local-health district level data that will assist in better understanding the scope of the issue; and

Develop recommendations, based upon best practices, for standard quality metrics on maternal care. Beginning in May 2025, the VCU Center for Public Policy (CPP) conducted facilitated sessions and administered a survey to the Task Force with the goal of identifying the recommendations prioritized by this Task Force.

TASK FORCE MEETINGS SUMMARY

Over the course of one year, State Health Commissioner Dr. Karen Shelton convened eight Task Force meetings to complete the directives of Executive Order 32. Task Force meeting agendas are summarized below.

October 17, 2024

For the first meeting in October 2024, the Task Force was informed of the directive of Executive Order 32 and provided with the Task Force meeting workplan. Information and data presented to the Task Force during the meeting included:

- Maternal Health Data Sources at the Virginia Department of Health presented by Dr. Karen Shelton and Maternal and Child Health Epidemiology and Evaluation Unit Supervisor Kelly Conatser from the Virginia Department of Health (VDH).

- Virginia Medicaid Maternal Health Update presented by Director Cheryl Roberts and Deputy of Programs and Operations Adrienne Fegans from the Department of Medical Assistance Services (DMAS).

November 8, 2024

During the second meeting in November 2024, the following information and data was presented to the Task Force:

- Virginia Data to Support Maternal Health presented by Kyle Russell, Chief Executive Officer, Virginia Health Information (VHI),
- Virginia Doula and Community Initiatives presented by Kenda Sutton-El, Founder and Executive Director, Birth In Color.
- Presumptive Eligibility for Pregnant Women presented by Sara Cariano, Director of Eligibility, Policy, and Outreach from DMAS.

Task Force members also participated in discussions on the importance of quality maternal health data and a survey of data gaps.

March 19, 2025

During the third meeting in March 2025, the Task Force received updated and new information after the conclusion of the 2025 General Assembly session. Those presentations included:

- 2025 Maternal Health Legislative Update presented by Leah Mills, Chief Deputy Secretary of Health and Human Resources
- Virginia Hospital & Healthcare Association (VHHA) Health Overview presented by Vice President of Data Analytics David Vaamonde and Director of Data Analytics Andre Tolleris from VHHA
- Virginia's Title V Needs Assessment Update presented by State Health Commissioner Dr. Karen Shelton
- Virginia's Medicaid Update presented by DMAS Director Cheryl Roberts

May 9, 2025

During the fourth meeting in May 2025, the Task Force participated in a facilitated activity to determine what information the Task Force had not yet received but wanted to hear. This facilitation was guided by three primary questions:

1. What additional information needs to be shared with the Task Force to move forward and achieve our objectives?
2. What perspectives have not yet been shared?
3. What do you recommend this Task Force do next?

In addition, the Task Force received the following presentations:

- Maternal Mortality Dashboard Update and Review of Maternal Mortality Report presented by State Health Commissioner Dr. Karen Shelton.
- Provider Perspectives presented by Dr. Shannon Walsh from VCU Health and Shannon Pursell from the Virginia Neonatal Perinatal Collaborative.

June 25, 2025

During the fifth meeting in June 2025, the Task Force received presentations on topics they identified in the previous meeting as information they would like to receive. They included:

- Cannabis Use During Pregnancy presented by Dr. Avery Michienzi, Medical Toxicology Faculty, from the University of Virginia
- Cannabis Use During Pregnancy: VDH Data presented by Maternal and Infant Programs Coordinator Lauren Kozlowski and Community Health Improvement Epidemiology Program Manager Kenesha Smith Barber from VDH
- Maternal and Child Healthcare Coverage under Commercial Health Plans presented by Director of Medical Operations Dr. Louis Thompson and Medical Director Dr. Seema Sarin from Anthem Blue Cross and Blue Shield, Virginia

August 22, 2025

Prior to the August meeting, CPP administered a survey to the Task Force members to begin the process of generating recommendations. During the sixth meeting in August 2025, CPP presented the results of the survey to the Task Force (provided as Appendix C). The remainder of the meeting was a panel discussion to share the perspectives of maternal health providers in Virginia.

The panel included:

- Dr. Brittany Keegan, Assistant Professor and Director of Research Development and Engagement, VCU Center for Public Policy (Moderator)
- Dr. Daphne Bazile, Obstetrician and Gynecologist, Bon Secours (Virtual)
- Dr. Jaclyn Nunziato, Obstetrician and Gynecologist, Carilion Clinic (Virtual)
- Dr. Richard Lucidi, Obstetrician and Gynecologist, VCU Health
- Christina Jennings, Certified Women's Health Nurse Practitioner, Virginia Department of Health – Chickahominy Health District
- Kate Hulbert, Certified Nurse Midwife, VCU Health
- Ildiko Baugus, Certified Professional Midwife & Licensed Midwife, Meraki Midwives, LLC

September 24, 2025

During the seventh meeting in September 2025, which was held in South Hill at the VCU Health Community Memorial Hospital, the Task Force identified the draft recommendations that they felt were the highest priority. These were taken from their survey results and the August provider panel responses (provided in Appendix D).

In addition, the Task Force received information on the following topics:

- Rural Health Transformation Update presented by Secretary of Health and Human Resources Janet V. Kelly
- Landscape of Virginia Birth Hospitals and Rural Maternal Health presented by State Health Commissioner Dr. Karen Shelton
- National Academy for State Health Policy Annual Conference Update presented by Maternal and Infant Programs Coordinator Lauren Kozlowski from VDH, Senior Advisor Mariam Siddiqui and Maternal and Women's Health Operations and Program Analyst Maryssa Sadler from DMAS

October 29, 2025

During the eighth meeting held in October 2025, the Task Force participated in a facilitated discussion to further develop their prioritized recommendations (provided as Appendix E). The Task Force provided additional information, context, and details for each recommendation. They discussed:

1. Who is responsible? Who is being asked to take action? (organization, person, etc.)
2. What is the action? What, specifically, are we asking them to do?
3. Who is impacted? Who or what is on the receiving end of this action?
4. Timeline: When does this need to happen?
5. Authority: Is legislation required? If not, who is the decision maker / "owner" of the recommendation?
6. Funding: Does this recommendation require funding? If yes, what potential funding sources exist?
7. Data: What new data needs to be collected (or what available data needs to be published) to adequately address the recommendation and measure success?

The resulting recommendations are provided in the Task Force Recommendations section of this report.

In addition, the Task Force received the following presentation:

- Maternal Health Website Launch presented by State Health Commissioner Dr. Karen Shelton

METHODOLOGY

The Task Force employed a collaborative, data-driven methodology centered on regular meetings featuring expert presentations, survey and data reviews, panels, facilitated discussions, and small-group breakouts. These sessions allowed members to:

- Review dashboards and reports including the Virginia Department of Health's Maternal Mortality Dashboard, showing a 68% reduction in maternal mortality since 2021;
- Identify barriers such as data silos, workforce shortages.
- Discuss emerging themes such as care coordination, postpartum support, integration of doulas/midwives; and
- Develop policy recommendations informed by member and stakeholder input.

Document Review Facilitation

The CPP supported the Task Force in facilitating the development of recommendations to focus on improving the quality and standards of maternal health care, as well as identifying key metrics for accountability and implementation. The CPP facilitated Task Force discussions at four of the eight 2025 meetings (i.e., May, August, September, and October) to guide Task Force members toward recommendations. During these meetings, qualitative data were collected and analyzed, which led to the development of prioritized recommendations. Additionally, a survey was administered to the Task Force members to assist in collecting feedback and the results from this survey were reviewed during meetings.

At the May 2025 meeting, Gina Barber, Director of Administration and Senior Consultant, introduced the CPP team, reviewed Executive Order 32, and summarized the data that had been presented to the Task Force to date. Then, the CPP facilitated a discussion guided by three questions to gather information on what additional knowledge areas were needed to move successfully towards constructing recommendations.

1. What additional information needs to be shared with the Task Force to move forward and achieve our objectives?
2. What perspectives have not yet been shared?
3. What do you recommend this Task Force do next?

The information from these three questions was summarized during the meeting through descriptive content analysis and verified by Task Force members. This activity yielded potential recommendations and additional requests for information on maternal healthcare.

It was determined that a panel of health providers (i.e., OBGYNs, Midwives, Doulas) was needed to provide insight into health provider perspectives, challenges and successes, and necessary resources and support. The Task Force members also considered exploring the intersection between substance abuse and maternal health and its effect on pregnancy outcomes.

At the August 2025 meeting, Dr. Brittany Keegan, Assistant Professor and Director of Research and Outreach at the CPP, moderated a discussion with a panel of maternal health care providers. Additionally, Dr. Keegan presented the survey findings to Task Force members. The findings were determined through a systematic content analysis of open-ended survey responses, which were used to extract key concepts and themes from survey responses.

At the September 2025 meeting, Ms. Barber facilitated a process designed to help Task Force members identify and refine the highest priority recommendations. Members broke into groups and were given the one-pager with survey findings for reference, along with a worksheet that guided them in prioritizing the recommendations. Members were asked to prioritize their choices individually first, then share them with their small group members, and proceed to make a group decision regarding prioritization. Each group was asked to share a summary of their final responses. This discussion enabled the entire Task Force to hear the strengths and concerns associated with the recommendations. Finally, a Mentimeter survey was conducted to highlight common themes and areas of alignment.

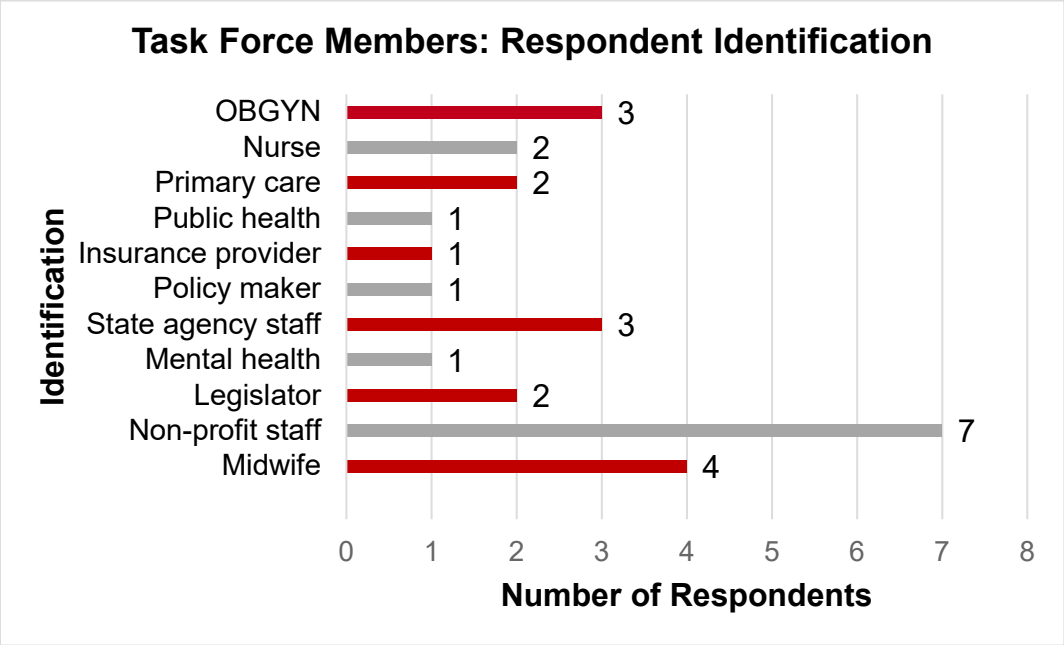
At the October 2025 meeting, Ms. Barber facilitated a breakout session to capture the final components of the prioritized recommendations. In-person and virtual attendees provided commentary and suggestions to refine the prioritized recommendations. Task Force members were also asked to consider any other recommendations that had not been listed. The one-page summary and discussion questions guided the activity.

Surveying Task Force Members

A web-based survey was sent out to all Task Force members two weeks prior to the August 2025 meeting. The initial email invitation to participate was followed by two reminder emails. The purpose of this survey was to collect information from the Task Force to clarify recommendations. The survey ensured that all voices on the Task Force had an equal chance to be heard and considered. In both the invitations and the survey, links were provided to all past Task Force meeting presentations and minutes. Participants were encouraged to read through these materials.

Of the fifty-one Task Force members, twenty-eight responded to the survey, resulting in a response rate of 55%. Each stakeholder group (see Fig. 1 below) was represented in the data. Findings were used by CPP to guide the facilitated discussion at the September 2025 meeting.

Figure 1: Total number of responses from each Task Force stakeholder group



The Task Force members were asked to identify the top three to five opportunities or unmet needs in Virginia related to maternal health care. In addition, the survey asked respondents to specify the policy or programmatic actions they would recommend. Finally, they were asked what data they felt could be utilized or published to improve maternal health (a summary of survey findings can be found in the Recommendations from the Survey section of this report). The survey findings were presented to the Task Force at the September 2025 meeting.

RECOMMENDATION DEVELOPMENT

Initial Recommendations Impressions

Over the course of the first three meetings, the Task Force discussed areas of maternal health care they felt could lead to potential recommendations. These areas included:

- Analysis on addiction and needs of perinatal population
- Standardizing maternal health data across data sources
- Community-level assessment of maternal health care
- Impact of midwives and doulas on maternal health
- Current program expansions or changes needed

Additional details on these areas for discussion are provided in the Final Recommendations section of this report.

During the May 2025 meeting, the Task Force discussed the additional knowledge areas they needed to move successfully towards constructing recommendations. The recommendations and requests for information discussed are outlined below.

Proposed recommendations:

- Focus on health and wellness with youth before pregnancy occurs.
- Explore the connections between the affordability of care and maternal health outcomes.
- Address mental health morbidity and its impact on maternal health.
- Implement granular data collection to better understand local maternal health trends.
- Improve patient education around marijuana use and pregnancy.
- Improve medical education regarding the fact that patients don't always associate marijuana use with smoking.
- Develop education geared towards individual communities.
- Connect data to communities for localized action and intervention.

Additional information requested:

- Which mental health conditions are most associated with maternal morbidity.
- Cannabis impact on pregnancy
- Hospital levels of care related to pregnancy.
- Wellness impact on pregnancy (overall, both psychological and physical).
- Data on the impact of midwives, doulas, and non-hospital births (home and birth centers) on maternal morbidity and mortality.
- Maternal mortality data by doula/midwife presence.
- Insurance coverage in Virginia for both public and private insurance holders (how much and what is covered during and post-pregnancy).
- Maternal leave policies.
- Social Needs of Communities broken down (have Unite Us present to the Task Force) (i.e., access to care, quality of care available, care needs of the community).
- Impact from fears around medical malpractice (no medical malpractice cap).
- Which substances are most frequently involved in overdose cases? Where? Who should education be focused on (and where).
- How many women experience pregnancy-related complications (non-fatal)? (Number of pregnancy ED visits and for what reason).

Recommendations from the Survey

Prior to the August 2025 meeting, Task Force members completed a survey developed by the VCU CPP to further refine their recommendations. The survey received 28 total responses, which resulted in a 55% response rate. The findings were sorted into three primary categories:

- Opportunities and unmet needs
- Policy and program recommendations
- Information dissemination

The opportunities and unmet needs category explored opportunities in promoting maternal health care, as well as unmet maternal health needs, that the Task Force felt were the highest priorities to advance. Six primary recommendations emerged in this category:

- **A1a** - Expanding maternal health support and resources, with a primary focus on maternal health deserts. This included making sure that maternal health care is accessible in all areas of the Commonwealth (e.g., through transportation support or expanding telehealth options), as well as making sure that those living in maternal health deserts know how to access available care.
- **A1b** - Promoting maternal mental health, including ensuring that health care providers are able to identify a mother in need of mental health support, having support workers who can help connect mothers to mental health care, and empowering mothers to advocate for their own mental health needs.
- **A1c** - Addressing substance use, especially cannabis use, during pregnancy. This primarily focused on ensuring that both health care providers and mothers are aware of how substance use during and after pregnancy impacts the baby and mother.
- **A1d** - Building partnerships and collaborations among public and private service providers to ensure continuity of care, resource sharing, and a more streamlined experience for those seeking maternal health care.
- **A1e** - Ensuring financial resources for pregnant women and new mothers, with a focus on connecting these women with existing resources (e.g., WIC) as well as advocating for these resources to be maintained and/or expanded.
- **A1f** - Using all of the above recommendations to provide early access to care as well as fourth-trimester care, ensuring that mothers and babies are supported throughout the pregnancy, birth, and postpartum experience.

The policy and program recommendations questions category asked Task Force members to consider what specific policy or programmatic actions they would recommend to address the aforementioned opportunities and unmet needs. Task Force responses included the following concepts:

- **A2a** - Allocating funding to support maternal health care in rural areas.
- **A2b** - Allocating funding to ensure transportation and childcare for pregnant women in maternal health deserts and other underserved areas.
- **A2c** - Expanding and investing in workforce development; this included increasing the number of maternal health care providers across the Commonwealth as well as providing additional support to current providers.
- **A2d** - Creating a public awareness campaign about the work of midwives, doulas, and how pregnant women can access their care (i.e., sharing information about what midwives and doulas do, how their work is different from OBGYNs, what specific types of care they can provide, how they can be contacted, and prices/payment options for their services).
- **A2e** - Creating a public awareness campaign around cannabis use during pregnancy (i.e., how cannabis use impacts women and babies during and after pregnancy).
- **A2f** - Creating educational resources for maternal health providers about substance use, screening, and connecting mothers using substances with additional support.
- **A2g** - Creating a program (or using an existing program such as the Emergency Department of Care Coordination program) to streamline efforts and ensure continuity of care between hospitals, obstetricians, midwives, and community providers.
- **A2h** - Implementing presumptive Medicaid for pregnant mothers, and advocating for Medicaid to be protected.

Finally, the survey asked Task Force members to consider what information and data would be needed to support these recommendations. First, participants shared ideas as to what information should be included on a centralized maternal health resource website that all Virginians could access and use for their maternal health care needs. They recommended that this website include:

- **A3a** - An up-to-date, searchable list of maternal health providers.
- **A3b** - An up-to-date, searchable list of maternity case management agencies.
- **A3c** - A list of mental health and crisis hotlines.
- **A3d** - A directory of resources that can help fund maternal health care.
- **A3e** - Information on Medicaid (i.e., what it is and who is eligible) and directions on how to sign up.
- **A3f** - Educational resources for pregnancy in general.
- **A3g** - Educational resources on cannabis use during pregnancy and the postpartum period.
- **A3h** - Current guidelines for maternity care.

- **A3i** - Updates on current maternal health policies and legislation, including a summary of the policy or legislation, the full text of the policy or legislation, which policymakers and/or agencies are supporting it, and its status (this information could be found directly on the website, or provided via a link to Virginia's Legislative Information System).
- **A3j** – An interactive database of maternal health statistics in Virginia, disaggregated by race, ethnicity, geography, insurance status, provider type, and outcomes.

Participants also shared their ideas about what data could be better utilized or published to improve mental health in Virginia:

- **A3l** - Longitudinal studies tracking maternal health outcomes.
- **A3m** - Number of hospital and emergency department visits by pregnant women (not including labor).
- **A3n** - In-hospital and out-of-hospital birth rates and outcomes.
- **A3o** - C-section rates (including the number of C-sections and what type of prenatal care the woman received).
- **A3p** - The findings of a statewide community needs assessment.
- **A3q** - Postpartum coverage gaps.
- **A3r** - Maternal mortality and morbidity rates.
- **A3s** - Infant health outcomes.
- **A3t** - Information on successful programs that could be replicated elsewhere.

Suggestions from the August Panel

During the August 2025 Task Force meeting, a panel of maternal health care providers shared ideas for improving maternal health in Virginia. Their responses fell into three categories:

- Services and programs
- Education and awareness
- Data and information

The services and programs category highlighted eight ideas as to how and where maternal health resources could be added or expanded across Virginia. These included:

- **B1a** - Increasing access to maternal health care in rural areas.
- **B1b** - Reducing disparities in access to fertility treatment.
- **B1c** - Extending Medicaid postpartum coverage and creating clear reimbursement structures.

- **B1d** - Strengthening access to care in various ways, including ensuring that pregnant and postpartum mothers can easily access:
  - Transportation.
  - Child care.
  - Broadband for telehealth appointments.
  - Information on how to complete paperwork (i.e., health literacy).
- **B1e** - Investing more funding in supporting maternal mental health.
- **B1f** - Expanding private insurance coverage for doula and midwife care.
- **B1g** - Creating infrastructure for group care models (i.e., centering programs).

Education and awareness suggestions considered what information Virginians need to better access maternal healthcare and advocate for their needs. It also considered ways of providing this education and awareness. Ideas included:

- **B2a** - Providing maternal health navigators to help patients better access and understand different types of care; this included funding to increase the number of navigators as well as ensuring that women know how to access them.
- **B2b** - Providing information on services provided by midwives and doulas, as well as information on how to access these services.
- **B2c** - Raising awareness of pre-conception counseling (i.e., that this type of counseling exists, what information it provides, and how it can be accessed).
- **B2d** - Investing in and/or establishing centering programs that provide screening & education.

Finally, panelists identified a set of data and information priorities that could strengthen how maternal health care is delivered and evaluated in Virginia. The following data needs reflect those priorities.

- **B3a** - Quantifying maternal health needs to support resource requests.
- **B3b** - Obtaining data on the number of women who are receiving prenatal mental health screenings.
- **B3c** - Obtaining data on maternal morbidity and mortality rates, as well as “near misses” that fall outside standard pregnancy-related reporting.
- **B3d** - Obtaining data on fetal health outcomes (it was noted that the Virginia Neonatal Perinatal Collaborative is currently working on this).
- **B3e** - Obtaining data on preventable deaths.
- **B3f** - Collecting patient satisfaction data to evaluate quality of care.

- **B3g** - Obtaining data on the number of patients who have access to primary care providers, and who actually have primary care providers.
- **B3h** - Identifying the number of patients who would benefit from social work services.

Draft Recommendation Prioritization

"The Task Force reviewed the survey results and the summary of ideas proposed by the provider panel at the August meeting. Working in small groups, members then used a worksheet to select up to five high-priority recommendations." After discussion, the Task Force identified the following as the highest priority recommendations for Virginia to address.

- **A1c** - Addressing substance use, especially cannabis use, during pregnancy (1 vote).
- **A2b** - Allocate funding to ensure transportation and childcare for pregnant women in underserved areas (1 vote).
- **A2c** - Expand and invest in workforce development (2 votes).
- **A2g** - Create a program or use an existing program (e.g., the Emergency Department of Care Coordination program) to streamline efforts and ensure continuity of care between hospitals, obstetricians, midwives, and community providers (3 votes).
- **A2h** - Implement presumptive Medicaid for pregnant mothers, and ensure protection of Medicaid (1 vote).
- **A3s** - Collect and publish data on infant health outcomes (1 vote).
- **B1a** - Increase access to care in rural areas (1 vote).
- **B1d** - Strengthen access to care through Transportation, Child care, Broadband access for telehealth appointments, and understanding how to complete paperwork (i.e., health literacy) (2 votes).
- **B2a** - Provide maternity health navigators to help patients better access and understand different types of care (1 vote).
- **B3d** - Obtain data on fetal health outcomes (Virginia Neonatal Perinatal Collaborative is currently working on this) (1 vote).
- **B3g** - Obtain data on the number of patients who have access to primary care providers, and who actually have primary care providers (1 vote).

To condense the above list to the maximum five recommendations the Task Force was able to consider at the final meeting in October 2025, CPP provided the following list of draft

recommendations. These recommendations were reviewed, revised, and finalized during the October meeting.

1. **A2g** - Create a program or use an existing program (e.g., the Emergency Department of Care Coordination program) to streamline efforts and ensure continuity of care between hospitals, obstetricians, midwives, and community providers.
2. **A2c & B1a** - Expand and invest in workforce development, especially in rural areas.
3. **A2b & B1d** - Strengthen access to care: Transportation, child care, broadband access for telehealth appointments, understanding how to complete paperwork (i.e., health literacy).
4. **A3s & B3d** - Collect and publish data on fetal and infant health outcomes.
5. **B3g** - Obtain data on the number of prenatal and post-partum patients who have access to primary care providers, and who see their primary care provider.

FINAL RECOMMENDATIONS

The following recommendations were developed by the Task Force with the purpose of evaluating maternal health data collection processes to inform policies in the Commonwealth that improve maternal health care quality and outcomes.

This section contains three categories of recommendations.

- The Prioritized Recommendations are those that the Task Force indicated were most important to address.
- The second set, labeled Garden Plot, are items the Task Force felt were important to consider for future action.
- The final group consists of Recommendations from Meetings Prior to May 9th, 2025.

All three categories of recommendations should be taken into consideration when deciding on the next steps to advance and improve maternal healthcare in the Commonwealth.

Prioritized Recommendations

The Task Force recommendations resulting from the October 2025 facilitated discussion are as follows. These recommendations are not presented in order of prioritization.

Recommendation 1

Create a program or use an existing program (e.g., the Emergency Department Care Coordination program) to streamline efforts and ensure continuity of care between hospitals, obstetricians, midwives, and community providers.

Question	Responses
Who is responsible for the implementation of this recommendation?	The Virginia Department of Health (VDH), in partnership with the Department of Medical Assistance Services (DMAS), Virginia Health Information (VHI), the Virginia Hospital and Healthcare Association (VHHA), maternal health care providers, hospital systems, acute care facilities, community health centers, Managed Care Organizations (MCOs), Urban Baby Beginnings (UBB), Virginia Neonatal Perinatal Collaborative (VNPC).
What is the action the Task Force is recommending?	Establish a comprehensive outpatient patient-level database that automatically shares electronic medical records (EMR) between providers, including primary care, behavioral health, emergency department, and community providers. Standardize responses to alerts across care teams. Evaluate the current system integration and use case. Community referral guides created by a provider coalition. Research what other states are doing to meet this need. Evaluation of current programs and any new programs to assess effectiveness and impact.
Who would be impacted by implementing this recommendation?	Patients, families, providers, Project LINK programs, hospitals.
When does the Task Force recommend implementing this recommendation?	Within 1 year
Is legislation required to implement this recommendation?	Not necessarily, if implemented through the Emergency Department of Care Coordination.

	Related legislation that passed in 2025: Maternal health; protocols and resources for hospitals and outpatient providers, etc.[5][6]; Childbirth; postpartum process, definitions[7].
What funding might be required to implement this recommendation?	Additional funding may be required for database creation, integration, education, and promotion. The Virginia Opioid Abatement Authority (OAA) Program may be a funding source to consider.
What data is needed to adequately address the recommendation or measure success?	Outpatient and readmission data EMR Access Resources needed to implement the recommendation Create evaluation and implementation plans to measure success
Additional information	The 2017 Virginia General Assembly established the Emergency Department Care Coordination (EDCC) program (§ 32.1-372[8]), and in 2023, the General Assembly changed the EDCC program to the SmartChart Network Program, effective January 2024. Established within VDH, the program provides a single, statewide technology solution that connects all health care providers, insurance carriers, and other organizations with a treatment, payment, or operations relationship with a patient in the Commonwealth to facilitate real-time communication and collaboration and improve the quality of patient care. The program's Advisory Council includes representatives from VDH, DMAS, the Department of Health Professions, VHHA, the Virginia Association of Health Plans, the Medical Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Chapter of the American Academy of Pediatricians, and the Virginia Academy of Family Physicians. The Task Force recommends that this existing program be used.

[5] lis.virginia.gov/bill-details/20251/HB2753
[6] lis.virginia.gov/bill-details/20251/SB1279
[7] lis.virginia.gov/bill-details/20251/SB1384
[8] lis.virginia.gov/bill-details/20251/SB1384

Recommendation 2

Expand and invest in workforce development, especially in rural areas.

Question	Responses
Who is responsible for the implementation of this recommendation?	Virginia Health Workforce Development Authority, in partnership with VDH, community colleges, K-12, Virginia Board of Health, Virginia Department of Health Professions, VNPC, Tobacco Commission Education Grant Program, DBHDS Project LINK, Goodwill Industries
What is the action the Task Force is recommending?	Provide incentives for more providers to practice in rural areas, such as community health graduate medical education loan repayment programs, scholarships, and childcare benefits. Expand the roles of non-traditional or allied workforce members (peers, doulas, community health workers), such as utilizing certified nurse-midwives to address maternity care shortages. Expand training opportunities for obstetrics (OB), nurse midwives, and ultrasound techs in rural areas. Include housing and transportation stipends and program development funds. Expand the Levels of Care Assessment Tool (LOCATe)[9] that surveys birthing hospitals to better understand the healthcare services available to pregnant women and infants in Virginia, to provide data on workforce reach and capacity. Provide digital learning kits (including a tablet and hotspot) to students in workforce programs in partnership with Verizon, AT&T, etc. Offer rural learning hubs and simulation labs in libraries or community colleges to remote students. Invest in multicultural workforce training to build knowledge of and respect for birth traditions in other cultures. Build partnerships with academia to build the pipeline. Increase the number of travel practitioners.

[9] govnpc.org/initiatives/

	Evaluate workforce development needs and develop strategies that address supervision, trauma, burnout, and workforce retention. Partner with Federally Qualified Health Center (FQHCs) with OB practices. Regionalize practices in maternal health deserts for support. Evaluation of current programs and any new programs to assess effectiveness and impact.
Who would be impacted by implementing this recommendation?	Licensed and non-licensed professionals, patients, and community health centers.
When does the Task Force recommend implementing this recommendation?	Within the next 6 months
Is legislation required to implement this recommendation?	Related legislation passed in 2025: Community Health Workers[10]; OBGYN & Psych Graduate Medical Residencies[11]; Health insurance; reimbursement for services rendered by certain practitioners, etc.[12]; Certified nurse midwives, licensed certified midwives, etc.; coverage for nursery services[13]; Certified nurse midwives; licensed certified midwives; independent practice; organized medical staff[14]; Postpartum doula care; DMAS to amend state plan for medical assistance services[15].
What funding might be required to implement this recommendation?	Additional funding may be needed to provide incentives, expand workforce and training offerings, collect data, and offer remote

[10] budget.lis.virginia.gov/item/2025/1/HB1600/Enrolled/1/278/#:~:text=J.%20Out%20of,for%20this%20purpose.
[11] budget.lis.virginia.gov/item/2025/1/HB1600/Enrolled/1/288/#:~:text=b.%20Effective%20July%201,the%20budget%20process.
[12] lis.virginia.gov/bill-details/20251/HB1923
[13] lis.virginia.gov/bill-details/20251/HB1904
[14] lis.virginia.gov/bill-details/20251/HB1635
[15] lis.virginia.gov/bill-details/20251/HB1614

	learning resources. The Rural Health Transformation (RHT) Program may be a federal funding source to consider.
What data is needed to adequately address the recommendation or measure success?	Current residency programs and the length of the rural commitments, and the percentage of those who stay beyond commitments. Staff turnover rates at rural providers. Create evaluation and implementation plans to measure success.

Recommendation 3

Strengthen access to care: Transportation, child care, broadband access for telehealth appointments, and understanding how to complete paperwork (i.e., health literacy).

Question	Responses
Who is responsible for the implementation of this recommendation?	DMAS and the Virginia Department of Social Services (VDSS), in partnership with Broadband Equity, Access, and Deployment (BEAD) program within the Virginia Office of Broadband, Unite Us, and MCOs.
What is the action the Task Force is recommending?	Establish mobile health programs to reduce transportation and broadband barriers. Increase Medicaid transportation providers, especially in rural communities. Partner with rideshare companies, school-based health centers. Pilot child care programs for parents attending medical appointments. Expand the availability of home visit programs. Use Community Health Workers to provide local care and needs navigation. Create a specialized pregnant women's unit to handle application case maintenance and resource support throughout pregnancy and the postpartum period. Improve MCO members understanding of existing local transportation, child care, and broadband providers they can access through their benefits. Evaluation of current programs and any new programs to assess effectiveness and impact.

	Build partnerships with academia to build the pipeline. Increase the number of travel practitioners. Evaluate workforce development needs and develop strategies that address supervision, trauma, burnout, and workforce retention. Partner with FQHCs with OB practices. Regionalize practices in maternal health deserts for support.
Who would be impacted by implementing this recommendation?	Patients with barriers to access transportation, childcare, and broadband. Patients with health literacy needs. Rural patients.
When does the Task Force recommend implementing this recommendation?	Within 1 year
Is legislation required to implement this recommendation?	Related legislation passed in 2025: Maternal Mobile Health Clinic Program Pilot[16]; Pregnancy mobile application; promoting awareness of the government. maternal & infant health programs, etc.[17]; Community Grants for Maternal Mental Health Care Programs[18]; FQHCs[19].
What funding might be required to implement this recommendation?	Funding may be required for a statewide integrated e-referral network that bridges medical and social care providers. Funding may be required for community health workers and service providers. The BEAD Program may be a federal funding source to consider.
What data is needed to adequately address	Data disaggregated by race/ethnicity and geography, other social determinants of health.

[16] budget.lis.virginia.gov/item/2025/1/HB1600/Enrolled/1/277/#:~:text=J.%20Out%20of,of%20the%20program.
[17] lis.virginia.gov/bill-details/20251/HB1929
[18] budget.lis.virginia.gov/item/2025/1/HB1600/Enrolled/1/279/#:~:text=6.%20Of%20this,in%20annual%20revenue.
[19] budget.lis.virginia.gov/item/2025/1/HB1600/Enrolled/1/279/#:~:text=4.%20Out%20of,and%20urban%20settings.

the recommendation or measure success?	Missed appointments due to transportation or child care barriers. Patient satisfaction. Health literacy outcomes. Create evaluation and implementation plans to measure success.
Additional information	Task Force members and maternal health providers agreed that the largest barriers to accessing maternal health care are transportation, child care, broadband, and health literacy. Addressing access to these key resources will improve access to maternal health care around the Commonwealth.

Recommendation 4

Collect and publish data on fetal and infant health outcomes.

Question	Responses
Who is responsible for the implementation of this recommendation?	VDH, in partnership with DMAS, VHI, Office of the Chief Medical Examiner, MCOs, VNPC, and local providers.
What is the action the Task Force is recommending?	Publish data on manner of death, still births, demographics. Publish data on substance use-related outcomes, such as Substance-Exposed Infants (SEI). Publish data on bereavement support. Partner with FQHC and the Virginia Community Health Association. Collect data on fetal/infant health before, during, and after labor.
Is legislation required to implement this recommendation?	Yes, if it is desired to allow VNPC's Fetal Infant Mortality Review (FIMR) program to have access to medical records. Related legislation passed in 2025: Perinatal Health Hub Program Pilot[20] (funding to reduce infant mortality)

[20] budget.lis.virginia.gov/item/2025/1/HB1600/Enrolled/1/277/#:~:text=H.1.%20Out,forward%20and%20reappropriated.

What funding might be required to implement this recommendation?	VNPC's Health Resources and Services Administration (HRSA) grant funding through 2028 may be a funding source to consider.
Additional information	Maternal health providers identified this data gap to the Task Force. While VDH publishes data on infant mortality, low birth weight, and preterm birth, other data needs have been identified. Additionally, some of the requested data may be available through the Centers for Disease Control and Prevention's (CDC) Pregnancy Risk Assessment Monitoring System (PRAMS). VNPC is re-establishing the Virginia Fetal Infant Mortality Review (FIMR) program through a Health Resources and Services Administration (HRSA) Maternal Health Innovation Grant to review cases of fetal and infant death. A central team aims to oversee regional FIMR case review teams in each of Virginia's five health planning regions. These regional teams plan to generate targeted recommendations that community action teams will adapt for implementation.

Recommendation 5

Obtain data on the number of prenatal and post-partum patients who have access to primary care providers, and who see their primary care provider.

Question	Responses
Who is responsible for the implementation of this recommendation?	VDH, in partnership with DMAS, MCOs, providers, insurance, health systems, American College of Obstetricians and Gynecologists (ACOG).
What is the action the Task Force is recommending?	Collect data on postpartum coverage loss after 6-8 weeks for those who are uninsured. A. Medicaid and other claims data • Use enrollment files to identify whether a patient is assigned to a PCP (managed care plans often require assignment). • Use claims to determine if a PCP was seen within a given postpartum window (e.g., 6 weeks, 6 months, or 12 months). • Identify PCPs using national provider identifier (NPI) taxonomy codes (family medicine, internal medicine, general practice, pediatrics, FQHCs). • Key metrics:

	○ Percent of deliveries with a postpartum PCP visit within 60 days ○ Percent of prenatal patients with ≥ 1 PCP encounter during pregnancy ○ Percent of Medicaid members with an assigned PCP but no visit • Best practice: Link birth certificate → Medicaid ID → claims to ensure the analytic denominator truly represents birthing individuals. B. Electronic Health Record (EHR) data / Health Information Exchanges (HIE) • Pull the "PCP on file" or "care team" field in EHRs to assess access. • Use encounter data to measure engagement (completed PCP visits). • Many EHRs (Epic, Cerner) allow you to extract structured data on care-team attribution and visit counts. • Integrate hospital, OB/GYN, and primary care records through HIE — e.g., ConnectVirginia — to track continuity. • Best practice: Require OB practices and hospitals to record a "PCP of record" at intake and at discharge. C. Vital records + administrative data linkage • Use birth certificates as a complete list of deliveries → link to Medicaid, All-Payers Claims Database (APCD), or hospital data. • Once linked, you can calculate: ○ Percent of mothers with a PCP listed in any data source ○ percent who had ≥ 1 PCP visit postpartum Utilize Patient-Reported Surveys • Administrative data misperceives access and non-claim visits (e.g., free clinics). Use: ○ PRAMS includes questions on postpartum visits, insurance, and barriers to care. ○ Health system patient-experience surveys asking:

	▪ "Do you have a primary care provider you can see for your own health?" ▪ "Have you seen this provider since delivery?"
Additional information	Maternal health providers identified this data gap to the Task Force. The Task Force agrees that maternal health is impacted by prenatal health, and overall long-term health is impacted by postpartum health. Primary care providers are critical to ensuring that maternal health patients receive high-quality health care before, during, and after pregnancy. Having a better understanding of how many patients have access to primary care will support the development of further recommendations to support high-quality maternal health care in Virginia.

Additional Recommendations – Garden Plot

What we should be moving toward

• Need for family-centered treatment for families impacted by substance use disorders
• Need continued support for the VPNC Maternal Health Task Force beyond HRSA funding for the data quality component in its strategic plan
• Provide family health care visits for parents and children to receive care in the same appointment
• Suggestion for VDH maternal health website:
  ○ Pregnancy centers are a resource for finding care and services
• Suggested data partners:
  ○ Virginia Cannabis Control Authority
  ○ Families Forward
• Perinatal substance use training for OBGYNs, Doulas, Midwives, Pediatricians, and community health workers
• Virginia State scan of services needed by pregnant women that fall outside of healthcare, which are needed to ensure healthy births and healthy moms. Example of this service is child care for mom.

• **Universal interventions offered to all pregnant and postpartum women:**
  ○ Normalize preventive care
  ○ Reduce stigma (e.g., for mental health)
  ○ Catch issues early before they escalate

What we should be moving toward

• **Address health disparities**
  ○ Risk is sometimes underrecognized in marginalized populations
• **What is needed:**
  ○ Universal screening
  ○ Universal education & guidance
  ○ Universal home or community contact postpartum
  ○ Universal access to support services
  ○ Universal integration of mental and physical care
• **Challenges**:
  ○ Requires resources and workforce (nurses, CHWs, doulas)
  ○ Need data systems to track universal uptake
  ○ Risk of "checklist" culture unless paired with meaningful follow-up
  ○ Must be culturally tailored to avoid one-size-fits-all messaging

More data is needed on perinatal substance use, including: • Prenatal exposure • Child born exposed • Post-natal exposure

Recommendations from Meetings Prior to May 9, 2025

These recommendations originated from the first three Task Force meetings.

An Analysis on Addiction and Needs of Perinatal Population

There is a need to acknowledge substance use and recovery in the perinatal population. To do so, there needs to be an understanding of what those needs and barriers might be for women in accessing help. Therefore, it is recommended that data be collected that allows a clearer understanding (as expressed during the October 17, 2024, and March 9, 2025, meetings).

- Data on substance use and addiction among the perinatal population in Virginia
- Data on the availability and accessibility of addiction treatment providers

- Data to identify gaps and barriers in accessing addiction care and recovery services

Standardizing Maternal Health Data Across Data Sources

Care and service providers need to clearly understand the data they receive from the various sources available in Virginia related to maternal health. Variations exist across data sources, creating differences in reporting across entities. Items need to be standardized so data can be comparable across sources (as expressed during the October 17, 2024, November 8, 2024, and March 9, 2025, meetings).

- Standardized definition of severe maternal mortality (length of time after delivery)
- Standardization of deaths that need to be included in maternal mortality counts
- Standardization in what determines a maternal health desert
    - Collect access to care data
- Standardization in Virginia on what makes an area 'rural' (definitions differ across federal agencies/departments)
- Real-time data needed to guide provider actions
- Standardization of data on infant mortality (what should be included)

A Community-Level Assessment of Maternal Health Care

A statewide community-level assessment is needed to understand the needs of Virginia's maternal population. This would be a survey of pre- and postnatal women, as well as health and service providers, to collect additional data (related to the needs of their patients) (as expressed during the October 17, 2024, and November 8, 2024, meetings).

- Mental and behavioral health needs
- Experiences with pre- and postnatal visits, including both actual use and feelings or attitudes about these visits
- Additional health needs (for example, dental, cardiovascular, and diabetes care)
- Gaps in and barriers to accessing maternal health care
- Fears or concerns about seeking help for addiction and recovery
- Knowledge and awareness of programs available locally and through Virginia state agencies
- Understanding, use, and local availability of midwife and doula services
- Barriers to receiving care from a midwife or doula
- Perceptions, comfort level, and use of birthing centers

The Impact of Midwives and Doulas on Maternal Health

There is a need to more clearly understand the impact of midwifery and doula services, as highlighted in the October 17, 2024, and March 19, 2025 meetings.

- Barriers and challenges experienced by midwives and doulas
- Outcomes of pregnancies involving midwife and doula care, including both prenatal and postnatal periods
- Insurance-related barriers that limit the provision and accessibility of this care

CONCLUSION

This report presents recommendations from the Task Force on Maternal Health Data and Quality Measures for 2024–2025, which it identifies as Virginia's top priorities. Appendix H summarizes Virginia's efforts and initiatives between 2022 and 2025 to improve maternal health in the Commonwealth.

APPENDIX A – EXECUTIVE ORDER 32

EXECUTIVE ORDER THIRTY-TWO (2024)

REESTABLISHING THE TASK FORCE ON MATERNAL HEALTH DATA AND QUALITY MEASURES

By virtue of the authority vested in me as Governor of the Commonwealth, I hereby issue this Executive Order to reestablish the Task Force on Maternal Health Data and Quality Measures.

Importance of the Initiative

Supporting women's health services is key to the well-being of women and families in the Commonwealth. Enhancing quality maternal health care underscores my commitment to supporting the holistic well-being of those who are or may become mothers and their children. The Commonwealth can-and must-effectively address disparities and promote the health and dignity of every mother.

Quality health care for women, prior to pregnancy, prenatal, at birth, and postpartum, is essential. The data shows this care is especially critical in addressing the higher maternal mortality rates for African American, indigenous, and Hispanic women, as well as women in rural and underserved communities. Access to maternal health services supports thriving families by ensuring that pregnant women receive essential prenatal care, including medical screenings, nutritional support, and information and education that improve birth outcomes.

Our ongoing efforts have improved prenatal care, with additional investment and partnerships with maternal health hubs in areas such as Petersburg and have expanded access to doulas and nurse midwives who are specially trained to provide direct support for mothers before, during, and after childbirth.

We have broadened health care coverage and access for expectant mothers and are helping secure mothers' access to financial assistance, as well as increased legal enforcement to hold fathers accountable for meeting their financial responsibilities to their children. Virginia was also recently selected to participate in a National Governors Association's Improving Maternal and Child Health in Rural America Learning Collaborative that will provide insights and best practices to improve maternal health outcomes.

While we have made progress, our work in this area plays a crucial role in reducing maternal and infant mortality rates, which is why further action is necessary to solidify these accomplishments.

Directive

I hereby direct the State Health Commissioner to re-establish the Task Force on Maternal Health Data and Quality Measures (the Task Force) for the purpose of evaluating maternal health data collection processes to inform policies in the Commonwealth that improve maternal care, quality, and outcomes.

The Task Force shall include:

(i) The Director of the Department of Medical Assistance Services or her designee;

(ii) The Director of the Virginia Neonatal Perinatal Collaborative or her designee;

(iii) the Program Manager for the Maternal Mortality Review Team;

(iv) Individuals as designated by the Secretary of Health and Human Resources, who to the extent possible shall be:

a. members of nonprofits related to health information or data;

b. licensed obstetricians or gynecologists practicing in the Commonwealth;

c. individuals who are licensed nurse practitioners or registered nurses who work in the area of maternal health in the Commonwealth;

d. individuals who are certified nurse midwives; individuals who are licensed certified midwives in the Commonwealth;

e. experts in postpartum care and depression in the Commonwealth;

f. individuals who are experts in maternal health data collection processes;

g. representatives from organizations or groups in the Commonwealth that specialize in serving at-risk populations and improving equity and outcomes in maternal health;

h. individuals who are licensed in neonatal and premature infant care and nutrition in the Commonwealth;

i. representatives in maternal health from each of the health care payers; and

j. health care experts who serve underserved and minority populations in the Commonwealth;

k. the Commissioner of the Department of Behavioral Health and Developmental Services and the Commissioner of the Department of Social Services or their designees;

(v) the Secretary of Education or her designee, the Chief Diversity, Opportunity and Inclusion Officer or his designee, the Chair of the Virginia Council on Women, as well as any other stakeholders as may be appropriate appointed by the Governor.

The Task Force shall:

(i) Monitor progress and evaluate all data from state-level stakeholders, including third-party payers, and all available electronic claims data to examine quality of care with regard to race, ethnicity, and other demographic and clinical outcomes data;

(ii) Monitor progress and evaluate data from existing state-level sources mandated for maternal care, including the Healthcare Effectiveness Data and Information Set (HEDIS) measure updates to Prenatal and Postpartum Care and Postpartum Depression;

(iii) Examine the barriers preventing the collection and reporting of timely maternal health data from all stakeholders, including payers;

(iv) Examine current maternal health benefit requirements and determine the need for additional benefits to protect women's health;

(v) Evaluate the impact of Social Determinants of Health screening on pregnant women and its impact on outcomes data;

(vi) Analyze available data one year after delivery, including local-health district level data that will assist in better understanding the scope of the issue; and

(vii) Develop recommendations, based upon best practices, for standard quality metrics on maternal care.

All agencies of the Commonwealth shall assist the Task Force upon request. The Virginia Department of Health and the Virginia Department of Medical Assistance Services shall provide staff assistance to the Task Force. The Task Force shall report its findings and conclusions to the Governor and General Assembly by December 1 of each year regarding its activities and shall conclude its work by December 1, 2025.

Providing Postnatal Support Services

By December 1, 2024, the Secretary of Health and Human Resources shall provide a report to the Governor outlining recommendations including budgetary, legislative, or administrative measures with the goal of improving maternal health, including maternal mental health and substance use and progress towards eliminating health disparities. This report shall include recommendations for:

(i) The identification and provision of services, referrals, and educational initiatives that improve maternal health outcomes and address pregnant, breastfeeding, and postpartum women.

(ii) The provision of resources and dissemination of information pertaining to maternal mental health conditions including postpartum depression and other postpartum and perinatal mental health conditions and substance use issues affecting women including their symptoms, treatment options, and the availability of resources.

Effective Date of the Executive Order

This Executive Order shall be effective upon signing and shall remain in full force and effect unless amended or rescinded by further executive order or directive. Given under my hand and under the Seal of the Commonwealth of Virginia this 26th day of June 2024.

APPENDIX B – TASK FORCE MEMBERS

- **The Honorable Janet V. Kelly**
  Secretary, Office of Health and Human Resources
- **Cheryl Roberts**
  Director, Department of Medical Assistance Services
- **Karen Shelton, MD, Co-Chair**
  State Health Commissioner, Virginia Department of Health
- **The Honorable Lashrecse Aird**
  Senate of Virginia, District 13
- **The Honorable Amanda Batten**
  Virginia House of Delegates, District 71
- **The Honorable Martin Brown**
  Chief Diversity, Opportunity, and Inclusion Officer, Office of the Governor
- **The Honorable Tara Durant**
  Senate of Virginia, District 27
- **Emily Anne Gullickson**
  Chief Deputy Secretary for Secretary of Education; Acting State Superintendent of Public Instruction, Department of Education
- **The Honorable Charniele Herring**
  Virginia House of Delegates, District 4
- **The Honorable Emily Jordan**
  Senate of Virginia, District 17
- **The Honorable Anne Ferrell Tata**
  Virginia House of Delegates, District 99
- **The Honorable Kimberly Taylor**
  Virginia House of Delegate, District 82
- **Tonya Adkins, MD**
  Chief Executive Officer, HealthWorks for Northern Virginia
- **Gabriela Ammatuna**
  Certified Midwife, VA Affiliate – American College of Nurse-Midwives

- **Ildiko Baugus**
  Certified Professional Midwife, Meraki Midwives, LLC
- **Daphne Bazile, MD**
  Obstetrician and Gynecologist, Southside Regional Hospital
- **Julie Bilodeau**
  Chief Executive Officer, Crossover Healthcare Ministry
- **Tanya Callender**
  Director of Women's and Neonatal Services – The Birthplace, Bon Secours Southside Medical Center
- **Nikki Cox**
  Director, Division of Family Services, Virginia Department of Social Services
- **Kelly Cannon**
  Chief Executive Officer, Virginia Hospital and Healthcare Association
- **Heidi Dix**
  Senior Vice President, Virginia Association of Health Plans
- **Siobhan Dunnavant, MD, Co-Chair**
  Obstetrician and Gynecologist, OB/GYN Associates
- **Kurt Elward, MD**
  Family Medicine Physician, Sentara
- **Jenny Fox, MD**
  Neonatal Physician, Virginia Commonwealth University Children's Hospital of Richmond
- **Charles Frazier, MD**
  Family Medicine, Riverside Health System
- **Leah Kipley**
  Assistant Director, National Safe Haven Alliance
- **Glenda Knight**
  Women's Services & Specialty Population Manager, Department of Behavioral Health and Developmental Services
- **Nicole Lawter**
  American College of Obstetricians and Gynecologists

- **Sheila Mathis**
  Certified Nurse Midwife, Veritas Training and Consulting Services
- **Joely Mauck**
  Chair, Virginia Council on Women
- **Jumelie Miller**
  Chief Executive Officer, UnitedHealthcare Community Plan of Virginia
- **Jaclyn Nunziato, MD**
  Obstetrician and Gynecologist, Carilion Clinic
- **Lee Ouyang, MD**
  Obstetrician and Gynecologist, Medical Society of Virginia
- **John Gerald Pierce, MD**
  Executive Director, Liberty University College of Osteopathic Medicine
- **Pamela Harvey Pilch**
  Birth Rights and Midwifery Attorney
- **Shannon Pursell**
  Executive Director, Virginia Neonatal Perinatal Collaborative
- **Mandolin Restivo**
  Executive Director, Postpartum Support Virginia
- **Eric Reynolds**
  Director, Office of the Children's Ombudsman
- **Fidelma Rigby, MD**
  OBGYN, Virginia Commonwealth University Health Medical Center
- **Melanie Rouse**
  Virginia Maternal Mortality Projects Manager, Virginia Department of Health
- **Ann Russell**
  Chief Executive Officer, Blue Ridge Women's Center
- **Kyle Russell**
  Chief Executive Officer, Virginia Health Information
- **George Saade, MD**
  Obstetrician and Gynecologist, Old Dominion University
- **Stephanie Spencer**
  Founder, Urban Baby Beginnings

- **Kenda Sutton-El**
  Founder and Executive Director, Birth in Color RVA
- **Shelia Talbott**
  Associate Dean, Mary Baldwin University
- **Louis (Tom) Thompson, MD**
  Director of Medical Operations, Anthem Blue Cross Blue Shield – Virginia
- **Paula Tomko**
  Chief Executive Officer, Central Virginia Health Services
- **Jennifer Wells, MD**
  Perinatal Psychiatrist, Carilion Clinic
- **Ashley Wiley**
  Women's Health Nurse Practitioner, Randolph-Macon College
- **Verneeta Williams, MD**
  Family Practice Physician, Board of Virginia Academy of Family Physicians

APPENDIX C – SURVEY FINDINGS

Maternal Health Data and Quality Measures Task Force: Survey Findings & Recommendations

A1 - OPPORTUNITIES AND UNMET NEEDS

Which opportunities or unmet needs do you feel are of the highest priority for this Task Force to advance?

- A1a - Expanding support and resources for maternal health deserts
- A1b - Promoting maternal mental health
- A1c - Addressing substance use, especially cannabis use, during pregnancy
- A1d - Building partnerships and collaborations among public and private service providers
- A1e - Ensuring early access to care and 4th trimester care
- A1f - Ensuring financial resources for pregnant women and new mothers

A2- POLICY AND PROGRAM RECOMMENDATIONS

What specific policy or programmatic actions would you recommend to address these opportunities or unmet needs?

- A2a - Allocate funding to support maternal health in rural areas
- A2b - Allocate funding to ensure transportation and childcare for pregnant women in underserved areas
- A2c - Expand and invest in workforce development
- A2d - Create a public awareness campaign about the work of midwives, doulas, and how to access their services
- A2e - Create a public awareness campaign around cannabis use during pregnancy
- A2f - Create educational resources for maternal health providers about substance use and screening
- A2g - Create a program or use an existing program (e.g. the Emergency Department of Care Coordination program) to streamline efforts and ensure continuity of care between hospitals, obstetricians, midwives, and community providers
- A2h - Implement presumptive Medicaid for pregnant mothers, and ensure protection of Medicaid

A3 - INFORMATION DISSEMINATION

WHAT INFORMATION WOULD YOU RECOMMEND ON A CENTRALIZED MATERNAL HEALTH RESOURCE WEBSITE?

- A3a - An up-to-date, searchable list of providers
- A3b - Maternity case management agencies
- A3c - A list of mental health and crisis hotlines
- A3d - A directory of funding resources
- A3e - Information on Medicaid/steps to sign up
- A3f - Educational resources
- A3g - Educational resources on cannabis use
- A3h - Current guidelines for maternity care
- A3i - Updates on policies and legislation
- A3j - Maternal health statistics in Virginia, disaggregated by race, ethnicity, geography, insurance status, provider type, and outcomes

WHAT DATA COULD BE BETTER UTILIZED OR PUBLISHED TO IMPROVE MATERNAL HEALTH IN VIRGINIA?

- A3l - Longitudinal studies tracking maternal health outcomes
- A3m - Hospital / ED visits (not including labor)
- A3n - In-hospital and out-of-hospital birth rates and outcomes
- A3o - C-section rates
- A3p -Findings of a statewide community needs assessment
- A3q - Postpartum coverage gaps
- A3r - Maternal mortality and morbidity rates
- A3s - Infant health outcomes
- A3t - Information on successful programs

METHODOLOGY

Findings were collected via an online survey sent to all Task Force members; the survey was open from July 15 - August 1, 2025. There were a total of 26 responses, including 2 legislators, 7 nonprofit staff members, 4 out-of-hospital providers, 8 in-hospital providers, 4 government agency representatives, and 1 insurance company representative.

APPENDIX D – PANELIST'S RESPONSES

Maternal Health Data and Quality Measures Task Force: August 22 Panelists' Responses

QUESTIONS ASKED OF THE PANELISTS

- What trends are you seeing in maternal health and the quality of maternal health care in your region?
- In your experience, what barriers are preventing your patients from accessing prenatal and postpartum health care?
- What are best practices that improve patient care?

B1 - SERVICES AND PROGRAMS

- B1a - Increase access to care in rural areas
- B1b - Reduce disparities in access to fertility treatment
- B1c - Extend Medicaid postpartum coverage, and create clear reimbursement structures
- B1d - Strengthen access to care
  - Transportation
  - Child care
  - Broadband access for telehealth appointments
  - Understanding how to complete paperwork (i.e. health literacy)
- B1e - Invest in maternal mental health
- B1f - Expand private insurance coverage for doula care
- B1g - Create infrastructure for group care models (i.e. centering programs)

B2 - EDUCATION AND AWARENESS

- B2a - Provide maternity health navigators to help patients better access and understand different types of care
- B2b - Provide information on services provided by midwives and doulas, as well as information on how to access these services
- B2c - Raise awareness of pre-conception counseling
- B2d - Invest/establish in centering programs that provide screening and education

B3 - DATA AND INFORMATION

- B3a - Quantify maternal health needs to support resource requests
- B3b - Obtain data on the number of women who are receiving prenatal mental health screenings
- B3c - Obtain data on maternal morbidity and mortality rates, as well as "near misses" that fall outside standard pregnancy-related reporting
- B3d - Obtain data on fetal health outcomes (Virginia Neonatal Perinatal Collaborative is currently working on this)
- B3e - Obtain data on preventable deaths
- B3f - Collect patient satisfaction data to evaluate quality of care
- B3g -Obtain data on the number of patients who have access to primary care providers, and who actually have primary care providers
- B3h - Identify the number of patients who would benefit from social work services

APPENDIX E – DRAFT RECOMMENDATIONS PRIORITIZATION WORKSHEET

Task Force Prioritization - Results of September 24th Meeting	
1	**A2g** - Create a program or use an existing program (e.g., the Emergency Department of Care Coordination program) to streamline efforts and ensure continuity of care between hospitals, obstetricians, midwives, and community providers.
2	**A2c** & **B1a** - Expand and invest in workforce development, especially in rural areas.
3	**A2b** & **B1d** - Strengthen access to care: Transportation, child care, broadband access for telehealth appointments, understanding how to complete paperwork (i.e., health literacy).
4	**A3s** & **B3d** - Collect and publish data on fetal and infant health outcomes.
5	**B3g** - Obtain data on the number of prenatal and post-partum patients who have access to primary care providers, and who see their primary care provider.

Next Meeting Preparation: Key Considerations

In our next meeting, we will seek to answer the below questions for each prioritized recommendation. Please consider these questions when reviewing the recommendations and come prepared to discuss.

- **Who is responsible?** Who is being asked to take action? (organization, person, etc.)
- **What is the action?** What, specifically, are we asking them to do?
- **Who is impacted?** Who or what is on the receiving end of this action?
- **Timeline:** When does this need to happen?
- **Authority:** Is legislation required? If not, who is the decision maker or "owner" of the recommendation?
- **Funding:** Does this recommendation require funding? If yes, what potential funding sources exist?
- NEW! **Data**: What new data needs to be collected (or what available data needs to be published) to adequately address the recommendation and measure success?

APPENDIX F – DRAFT RECOMMENDATIONS PRIORITIZATION WORKSHEET

EXECUTIVE DIRECTIVE ELEVEN (2024)

SUPPORTING HEALTHIER PREGNANT WOMEN, MOTHERS, AND INFANTS BY REPORTING ACTIONABLE DATA ON MATERNAL MORTALITY

By virtue of the authority vested in me as Governor of the Commonwealth of Virginia, I hereby direct the Virginia Department of Health to enhance the Maternal and Child Health Data Dashboard to include actionable data on pregnancy-associated and pregnancy-related mortality and causes, and to establish a centralized maternal health website to provide families with essential resources in one accessible location.

Importance of the Initiative

To be the best place to live, work, and raise a family, Virginia must focus on supporting healthy babies, and ensuring mothers have the resources they need during pregnancy, during birth, and postpartum.

In 2021, there were 64 pregnancy-associated deaths in Virginia, and while that number represents a decrease from 82 in 2020, every single maternal death is an incredible tragedy. The pregnancy-associated death rate declined from 86.6 per 100,000 live births in 2020 to 66.9 per 100,000 in 2021. Over 80 percent of pregnancy-related deaths in Virginia are medically preventable. The leading causes include cardiac conditions, mental health challenges, and substance use. By leveraging solutions, these newly announced initiatives and investments build on the Administration's continued efforts to ensure Virginia has *Healthy Moms, Healthy Families, and Healthy Communities.*

Our Administration has made improving the health of our mothers and our babies a top priority. Virginia must reduce maternal mortality and promote the health of mothers and babies by leading a unified, statewide effort to eliminate confusion, streamline maternal health initiatives, and maximize the impact of every dollar invested.

Maternal health is a main pillar of our Partnership for Petersburg efforts, as well as across the Commonwealth. In the City of Petersburg, we have worked specifically with providers, from Medicaid managed care organizations to non-profit organizations such as Urban Baby Beginnings, to ensure women and their families are connected to care. Examples include expanded clinic hours, like Saturday OB-GYN hours at Bon Secours Southside Medical Center, and communications campaigns like the "Ask about Aspirin" initiative, which

encourages providers and patients to discuss low-dose aspirin as a preventive measure for preeclampsia, a leading cause of maternal mortality.

Our Unwavering Commitment to this Effort Has Produced Results:

Nearly $500 million is currently spent annually to support maternal health services in the Commonwealth:

- Medicaid pays for one out of every three births in Virginia. In 2024, the Department of Medical Assistance Services (DMAS) spent more than $300 million on medical services for pregnant women including prenatal care and labor and delivery.
- The Virginia Department of Health (VDH) spends $170 million on programs providing all-around support to women before, during, and after childbirth as well as continued infant care. VDH continues to support healthy mothers and babies to develop lifelong healthy habits and combat food insecurity. Local health departments provide home visiting for pregnant women and new mothers through the Maternal Infant, and Early Childhood Home Visiting (MEICHV) Program. The Department of Behavioral Health and Developmental Services (DBHDS) spent $9 million in FY 2024 through Project Link to reduce barriers to accessing services needed by pregnant women impacted by substance use disorders or mental health disorders and Permanent Supportive Housing to provide stable housing for moms with complex behavioral health, medical, and social needs. DBHDS will utilize $4 million of FY 2025 appropriations to expand the Virginia Mental Health Access Program improving access to menta and emotional health services to pregnant and postpartum moms.

Increased Postpartum Visits for Medicaid Members

- Postpartum OB-GYN visits for Medicaid members in Petersburg increased almost 20 percent.
- Increased access to O8-GYN services by introducing quarterly Saturday O8-GYN clinic hours at Bon Secours Southside Medical Center for Medicaid members in Petersburg.
- INOVA Health Center also announced extended hours across the health system to increase access to expecting mothers.
- Medicaid and FAMIS MOMS members now receive guaranteed health coverage for 12 months following pregnancy. This expanded coverage enables new parents to receive critical postpartum care, an important step to improving health outcomes for mothers and babies.

Expanded Access to Doula Services

- As of October 2024, 191 doulas received state certification by VDH and there are 147 Medicaid-enrolled doulas, achieving 259 doula-supported births for Medicaid members and supporting 349 families that received doula services covered by Virginia Medicaid.
- The Department of Medical Assistance Services (DMAS) partnered with Germana Community College, Mary Washington Hospital, Rappahannock Health District, and VDH to create a doula training program. The first cohort reached the full capacity of 12 students and additional interested students are placed on a waitlist for future semesters.

Improved Maternal Health Data and Best Practices

- Issued Executive Order 32 to reestablish the Task Force on Maternal Health Data & Quality Measures to evaluate the quality of care and barriers that prevent the collection and reporting of timely maternal health data.
- Enhanced rural maternal health technical assistance, winning national recognition.

Maternal mortality rates are uneven across Virginia. Rural areas face critical disparities in maternal health outcomes, with limited access to care and maternity deserts that jeopardize the health and safety of mothers and babies. Maternal mortality rates for non-Hispanic Black women in Virginia are more than double those of non-Hispanic White women, underscoring the urgent need for clear data to target action.

Scaling this approach while maintaining our community focus fortifies maternal healthcare systems to empower mothers with the resources, information, and care they need to ensure the best outcomes for themselves and their babies.

To do that, we need to take our collection and publication of actionable data about maternal mortality to the next level. The Virginia Department of Health's initial unverified internal data is showing positive trends and that our comprehensive effort has been making some progress.

What is clear is that we need better data, reported by our state and local health departments and our managed care organizations to better guide our future efforts.

Prior to legislation patroned by former Senator Siobhan Dunnavant, MD, an O8-GYN and expert in maternal health, data was only reported every three years, not annually. This means that today, as we are trying to make decisions, we are using information that is three years old, from 2021. Furthermore, the data collected and publicly reported has been too high level, without enough detail to help health officials at all levels of government take action to support the health of mothers and babies.

On June 26, 2024, I issued Executive Order 32, Reestablishing the Tak Force on Maternal Health Data and Quality Measures, in order to collect and evaluate maternal health

data and better inform policies in the Commonwealth. In addition to analyzing the data to determine the need for additional benefits to protect women's health, the Task Force examines quality of care and the barriers that prevent the collection and reporting of timely maternal health data, especially in underserved communities.

Today's Executive Directive is a key initial recommendation of the Task Force's work. Accelerating and strengthening the collection and publication of data is vital to continue our work to produce results for all of Virginia's mothers and babies.

Directive

Accordingly, pursuant to the power vested in me as the Chief Executive Officer of the Commonwealth, and pursuant to Article V of the Constitution and laws of Virginia, I hereby direct the State Health Commissioner and the Virginia Department of Health, in consultation with the Secretary of Health and Human Resources, to do the following:

I. Improve the Publication of Actionable Data on Maternal Health

a. Ensure the Department of Health's Maternal and Child Health Data Dashboard includes pregnancy-associated and pregnancy-related mortality as well as maternal mortality and cause data, including relevant regional and population demographic information.

b. Collect, analyze, and publicly share robust maternal health data to drive policy decisions, pinpoint disparities, and measure progress.

c. Make regular updates to the VDH website and ensure data remains current, transparent, and actionable for policymakers, healthcare providers, and families.

II. Develop a Comprehensive Maternal Health Resource Website

a. Create a centralized maternal health website to provide mothers with essential resources in one accessible location, including information on public and private agencies providing family resources and other parent resource centers.

b. Centralize existing state resources and consolidate maternal and child health information currently spread across various state agencies, including:

i.VDH programs such as WIC, home visiting, Resource Mothers, and pregnancy-related resources (e.g., breastfeeding and infant health).

ii. Adoption information from the Department of Social Services.

iii.Tax credit information from the Department of Social Services.

iv.Childcare assistance from the Department of Education.

c. Partner with existing platforms to enhance the directory of maternal health resources and ensure comprehensive service referrals for prenatal, pregnancy, and postpartum care.

d. Ensure the website includes a comprehensive list with descriptions of services offered by public arid private agencies, including adoption agencies and faith-based organizations, and other services available to assist a woman throughout her pregnancy, upon childbirth, and while the child is dependent.

Effective Date

This Executive Directive shall be effective upon its signing and shall remain in force and effect unless amended or rescinded by further executive order or directive. Given under my hand and under the Seal of the Commonwealth of Virginia this 17th day of December 2024.

APPENDIX G – TASK FORCE MEETING MINUTES

Maternal Health Data Task Force – Executive Order Thirty-Two

October 17, 2024

1:00 pm – 3:00 pm

Patrick Henry Building, East Reading Room

Draft Minutes – Meeting One

Members Present: Secretary Janet Kelly, VDH Commissioner Dr. Karen Shelton, DMAS Director Cheryl Roberts, Senator Lashrecse Aird, Delegate Anne Ferrell Tata, DSS Commissioner James Williams, Emily Anne Gullickson, Ildiko Baugus, Dr. Daphne Bazile, Julie Bilodeau, Kelly Cannon, Heidi Dix, Dr. Kurt Elward, Dr. Charles Frazier, Pamela Harvey Pilch, Leah Kipley, Glenda Knight, Nicole Lawter, Dr. Sheila Mathis, Shannon Pursell, Fidelma Rigby, Melanie Rouse, Kyle Rusell, Tameeka Smith, Stephanie Spencer, Kenda Sutton-El, Dr. Louis (Tom) Thompson, Paula Tomko

Members Present Virtually: Dr, Kurt Elward, Delegate Anne Ferrell Tata, Dr. Jaclyn Nunziato, Dr. Lee Ouyang, Dr. Jennifer Wells, Octavia Wynn

Health and Human Resources Staff: Leah Mills, HHR: Jona Roka, HHR; Mindy Diaz, HHR; Kelly Conatser, VDH; Dane De Silva, VDH; Dr. Vanessa Walker-Harris, VDH; Cynthia deSA, VDH; Rebecca Edelstein, VDH; Lauren Kozlowski, VDH; Julie Keeney, VDH; Jennifer Macdonald, VDH; Parker Parks, VDH; Allie Atkeson, VDH; Adrienne Fegans, DMAS

Meeting Discussion:

Secretary Kelly opened the meeting and welcomed the Task Force members. She stated that maternal and child health was a priority for Governor Youngkin and acknowledged the continuation of work from the previous Maternal Health Data Task Force. Secretary Kelly then addressed ongoing initiatives at the state level, highlighted data trends in Virginia, and provided suggestions for the Task Force's consideration. Secretary Kelly then introduced Senator Lashrecse Aird.

Senator Aird provided remarks following Secretary Kelly, highlighting the work around maternal mortality that commenced in the Virginia legislature in 2019. Her remarks emphasized the necessity and usefulness of having ongoing conversations about maternal health data.

Dr. Shelton welcomed the Task Force members and asked they briefly introduce themselves and share which agency or organization they represented. After the introductions, she highlighted the charges outlined in Governor Youngkin's Executive Order 32, noting that they

were identical to those for the Maternal Health Data Task Force convened in the past, with an additional focus on postnatal support services. She discussed the Task Force's goal of building interagency collaboration and working with community members to build on previous efforts. Finally, she highlighted the proposed work plan that was distributed to the attendees.

Kelly Conatser, the Maternal and Child Health Epidemiology and Evaluation Unit Supervisor at the Department of Health (VDH), was the first presenter of the day. He presented on available maternal health data resources at VDH, sharing details on maternal health outcomes and various indicators, including maternal mortality and severe maternal morbidity. The presentation covered methods of data collection, their strengths and limitations, and the frequency and years available for each source. He also highlighted the Maternal and Child Health Dashboard and introduced upcoming dashboards focusing on severe maternal morbidity hospitalizations, maternal mortality, and maternal opioid use. Additional topics included the Pregnancy Risk Assessment Monitoring System, data on postpartum depression and anxiety, well-women visits, Title V maternal and child health data, and barriers to maternal health.

Director Roberts and Adrienne Fegans, Deputy of Programs and Operations at the Department of Medical Assistance Services (DMAS), presented on Virginia Medicaid Maternal Health. Director Roberts outlined DMAS's mission and noted that Medicaid covers one of three births in the Commonwealth. She highlighted key maternal health data, including Virginia's position as the third state to expand postpartum Medicaid coverage for 12 months, regardless of income changes, and the fourth state to offer doula benefits. She also discussed the use of HEDIS measures for maternal care and the variety of data sources utilized. Director Roberts outlined member engagement and education strategies such as the enhanced MCO Benefit Comparison Chart and the revised “New Mom” letter. maternal health outcomes.

Additionally, Director Roberts informed the Task Force members about the cardiovascular issues in the maternal population and showed the audience the Ask about Aspirin campaign. A key finding from the work was the effectiveness of the usage of low dose aspirin while pregnant to prevent preeclampsia hypertension, and cardiovascular disease. The Ask About Aspirin, which was unveiled this summer, which highlights the importance of encouraging members to speak with their prenatal care providers about the medication.

Director Roberts then shared the collaboration with the Virginia Hospital and Healthcare Association on maternal health initiatives, which led to the integration of postpartum visits in discharge checklists within electronic medical records. She noted the expansion of Saturday and evening hours for OB/GYNs, highlighting Dr. Bazile as an early adopter and mentioning that Inova has now announced extended hours across their health system.

Adrienne Fegans presented on member engagement and highlights the importance of getting feedback from Medicaid members and the importance of getting the word out to members that programs are available. She also shared DMAS's "new mom" letters for members, which now included an easy-to-read information flyer with charts to help members understand the various maternal benefits that are covered by the different Medicaid Manage Care Organizations.

After the presentations concluded, Dr. Shelton led a discussion among Task Force members focused on the need for real-time data, substance use and recovery in the perinatal population, and barriers faced by various types of midwives. Questions were raised about standardizing the reporting of severe maternal morbidity, and definitions of maternal mortality up to the 42-day period. Another question was raised about what types of death were included in the pregnancy-associated mortality data. The issue of maternity care deserts was raised and whether the Task Force could collect access to care data due to the impact this has caused, particularly in the southwest and Eastern Shore. It was then discussed there was no standard definition of "rural" in that it varied by federal designation/agency. It was noted by a member for the need for representation of all midwifery certifications and scopes of practice on the Task Force to ensure diverse experiences are captured. One of the Task Force members asked for a feedback survey and copy of slides presented in order to obtain community level feedback on what data was needed to make improvements.

Public Comment Period:

- A member of the public in attendance commented that they are wondering why we are still seeing high levels of morbidity if members have access to health benefits? Will the Task Force explore that?
- An addiction specialist in attendance raised the issue of accessibility of addiction-related providers and how we can do a better job of getting our moms who want care and recovery but are afraid to ask for help. How do we easily make it available without giving out the private numbers of our Medication-Assisted Treatment (MAT) providers? How can we address this?

Dr. Shelton concluded the meeting by highlighting the behavioral health resources available through the Right Help, Right Now initiative. She acknowledged the vital work of Postpartum Support Virginia and emphasized VMAP for Moms+, the provider-to-provider consultation line for behavioral health issues, along with the training and coordination set to launch in fall 2024.

Next Steps:

- The Task Force is planned to reconvene on November 8th, 2024.

Maternal Health Data and Quality Measures Task Force Meeting Notes

November 8, 2024

Patrick Henry Building, 9am-11am

Members Present: Secretary Janet Kelly, VDH Commissioner Dr. Karen Shelton (Co-Chair), DMAS Director Cheryl Roberts, DSS Commissioner James Williams, Chief Martin Brown, Dr. Siobhan Dunnavant (Co-Chair), Ildiko Baugus, Heidi Dix, Dr. Kurt Elward, Dr. Charles Frazier, Leah Kipley, Glenda Knight, Nicole Lawter, Shannon Pursell, Fidelma Rigby, Melanie Rouse, Kyle Rusell, Tameeka Smith, Stephanie Spencer, Kenda Sutton-El, Dr. Louis (Tom) Thompson, Paula Tomko, Susan Murphy, George Saade, Verneeta Williams, Kathryn Hanes representing for Pamela Pilch, Mary Brandenburg representing for Kelly Cannon, Alyson Buckner representing Emily Anne Gullickson

Members Present Virtually: Senator Emily Jordan, Sheila Mathis, Gabriela Ammatuna, Dr. John Pierce, Dr. Lee Ouyang, Dr. Jennifer Wells, Joely Mauck, Candance Roney representing Glenda Knight

Health and Human Resources Staff: Leah Mills, HHR; Jona Roka, HHR; Mindy Diaz, HHR; Kelly Conatser, VDH; Dane De Silva, VDH; Dr. Vanessa Walker-Harris, VDH; Cynthia deSA, VDH; Rebecca Edelstein, VDH; Lauren Kozlowski, VDH; Julie Keeney, VDH; Jennifer Macdonald, VDH; Parker Parks, VDH; Allie Atkeson, VDH; Adrienne Fegans, DMAS

Opening Remarks from Secretary Kelly and Member Introductions

- Secretary Kelly announced that Dr. Siobhan Dunnavant would be joining the Task Force as Co-Chair.
- Dr. Shelton reviewed the minutes from the first meeting and gave an overview of the meeting agenda. She then thanked everyone for coming, which was followed by
- introductions.
- Introduction of the members of the Task Force starting with the members in person, followed by the members who joined virtually.

Virginia Data to Support Maternal Health - Kyle Russell, Chief Executive Officer of Virginia Health Information (VHI)

- This presentation started with an introduction of VHI and their collaboration with other organizations.
- VHI oversees the Patient Level Data System (PLD), All Payer Claims Database (APCD), and Emergency Department Care Coordination Program (EDCC/SmartChart).

- Mr. Russell discussed the history of VHI and how the PLD was created.
- Gaps identified included maternal emergency department data (efforts are being made to improve this) something they will be addressing & working for in the 2025 GA Session.
- Mr. Russell described the APCD system, a database with a wide variety of information through claims data. One weakness is that there is no RISA/FEHBP/TRICARE/ uninsured data or dental claims. They are continuing to revise the system to improve it; to do this they would need increased funds to increase the matching rate and reduce the data lag.
- Mr. Russell then discussed the EDCC program, now known as SmartChart. This program has no data lag because it is real time data. This system was created in 2017 and was historically limited to ED care coordination data only. An example was shown highlighting Sentara's positive experience using EDCC data for their maternal workflow.
- Mr. Russell finished the presentation by discussing opportunities for attendees and other stakeholders to get involved and utilize the data from the EDCC program.

Virginia Doula and Community Initiatives - Kenda Sutton-El, Founder and Executive Director of Birth in Color

- Ms. Sutton-El provided a history of Birth in Color, which was launched in 2018 to respond to the rising maternal mortality rate. They are a Virginia based non-profit that focuses on the various intersections of reproductive justice, culturally competent maternal healthcare, and the celebration of people of color. Ms. Sutton-El emphasized the need to shift from victim blaming to supporting moms with needed resources.
- Ms. Sutton-El spoke to the services that Birth in Color provides including childbirth education, lactation clinics, prenatal and postpartum yoga. Ms. Sutton-El defined doulas and described the scope of doula services offered.
- Ms. Sutton-El stated that all Medicaid managed care plans in Virginia cover doula services, which include four prenatal visits, continuous labor and birth support, four postpartum visits, and phone/text support as needed.
- She also explained the steps required to become a doula through Birth in Color and the impact of a strong support system for mothers, especially in the postpartum period.
- Ms. Sutton-El discussed the elements of the doula workforce support which include billing and reimbursement and coordinated care. She shared the necessary components of the doula workforce development plan and next steps for Birth in Color.

The Importance of Quality Maternal Health Data - Dr. Siobhan Dunnavant, OBGYN from HCA VA Physicians

- Dr. Dunnavant spoke about the importance of high-quality maternal health data and how it can be utilized to improve quality of care and outcomes. She emphasized best care practices, following data trends, and tracking of outcomes.

Virginia Medicaid Presumptive Eligibility Overview - Sara Cariano, Director of Eligibility, Policy, and Outreach, Virginia Department of Medical Assistance Services (DMAS)

- Ms. Cariano presented on the current Medicaid application process, and the specific Cover VA unit and call center for pregnant women. She shared the application process for Medicaid and the timeline from application to approval with full coverage.
- Ms. Cariano noted that in Virginia there is Hospital Presumptive Eligibility (HPE), which provides coverage for pregnant women, children under 19, low-income parent/caretakers, and adults under expanded Medicaid. There are 49 hospitals are participating in HPE.
- Ms. Cariano described that Virginia has HPE, which is only for the Medicaid population, but not presumptive eligibility, an expansion of presumptive eligibility processes to other entities.
- Ms. Cariano gave an overview of presumptive eligibility, qualified entities, and current barriers for implementing the policy.
    - Dr. Dunnavant asked who captures presumptive eligibility and there was a follow-up discussion about the application and determination process.
- Ms. Cariano continued to discuss the coverage limitations of presumptive eligibility. Presumptive eligibility provides coverage for ambulatory prenatal care, prescription drugs and visits related to pregnancy. Presumptive eligibility does not cover labor and delivery.
- Ms. Cariano shared a comparison between full benefit Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) vs. Presumptive Eligibility.
- Ms. Cariano ended the presentation by mentioning the operational considerations outside of policy implications. Policy considerations included:
    - Expanding HPE to FAMIS pregnant women and children
    - Enhancing monitoring of pregnancy-related application vs. community-based application
    - Increasing income limit for pregnancy-related coverage
        - Income eligibility for Medicaid for pregnant women is 143% vs 205% for FAMIS
    - Creating specialized pregnant women unit to handle application case maintenance and resource support throughout pregnancy and postpartum period

Survey of the Data Gaps and Task Force Discussion

- Dr. Shelton opened the floor for discussion and provided a survey link for the Task Force to fill out for feedback.
- Dr. Shelton summarized the presentations and the data sources that were discussed and asked the Task Force for any thoughts or ideas coming forward.
    - Stephanie Spencer mentioned that Urban Baby Beginnings (UBB) uses the EDCC platform. UBB identifies individuals going to the hospital multiple times but have no follow up care and asked if this could potentially be monitored on a larger scale. She mentioned that this data would be important for people outside of the hospital systems, such as social workers, to know.
    - Dr. Shelton mentioned that there should be necessary flags for occurrences like "frequent fliers" in EDCC.
- Dr. Dunnavant mentioned how all aspects of maternal health should be connected, especially in the inpatient and outpatient settings.
- Stephanie Spencer described UBB's collaboration with VNPC to connect the dots but wondered how this information should get back to the providers.
- Dr. Saade spoke to the large number diagnoses with bias and how administrative databases could be inaccurate due to these biased codes. They have used natural language processing instead of codes to see if they could increase the accuracy of the diagnosis.
- Shannon Pursell spoke to the importance of data linkages and how All-Payers Claims Database (APCD) and inpatient data is one point in time but discussed opportunities to link data together. She noted data gaps in Maternal Mortality Review Team case reviews included data on the frequency of ED visits and details on care coordination and outcomes.
- Tameeka Smith spoke on focusing on what the data is conveying and how to use these insights in real time to the organizations in those geographical areas. She asked how we intend to use AI to link all of this together.
- Kathryn Haines discussed a recent labor and delivery hospital unit closure and discussed implications to ERs and practices in the area. She highlighted the need of obtaining data during closures to evaluate the impact on emergency rooms ERs and the resulting outcomes.

Review of the Previous Recommendations and Task Force Discussion

- The 22 recommendations from the previous report were discussed.
- Shannon Pursell stated VNPC is working on Recommendation 6, continuing to fund a yearly VNPC report and Recommendation 22, developing a Fetal Infant Mortality Review (FIMR) team.

- Kyle Russell from VHI said that they are working on Recommendation 1, to improve the Virginia APCD by enhancing their patient linkage capabilities. However, he acknowledged that current limitations make these linkages less than ideal. He stated it would be helpful to have an authorization to link with other systems and that linkages should be encouraged while protecting the process.
- The Task Force members then discussed pulling forward additional 2023 report recommendations:
    - There was mention of continuing the work for Recommendation 13, expanding Medicaid facility reimbursement to birthing centers.
    - Stephanie Spencer brought forth Recommendation 16, increase sustained funding for Community Health Workers and recommendation 7, incorporate evidence-based home visiting program into the model of care.
    - Kenda Sutton brought forth recommendation 11, expanding dental care and coverage as well as Recommendation 14, to expand access and utilization of doula services.
    - An online participant emphasized work underway regarding Recommendation 3, ensuring behavioral health access for pregnant and postpartum women, specifically the expansion of VMAP into the perinatal space with VMAP for Moms.

Public Comment

- A representative from Anthem asked about the data on postpartum morbidity and mortality, and if that is where we are seeing some of the adverse outcomes.
- No other comments were offered from the public in person or online.

Next Steps

- Deputy Secretary Leah Mills thanked everyone for being there and said all presentations could be accessed online on the HHR website. Dr. Shelton closed the meeting and stated the next meeting would focus on additional directives from the Executive Order.

Maternal Health Data and Quality Measures Task Force Meeting Notes

March 19, 2025

Patrick Henry Building, 2:00 p.m.–4:15 p.m.

Members Present: Secretary Janet Kelly, VDH Commissioner Dr. Karen Shelton (Co-Chair), DMAS Director Cheryl Roberts, Dr. Siobhan Dunnavant (Co-Chair), Nicole Lawter, Melanie Rouse, Stephanie Spencer, Kenda Sutton-El, Dr. Louis (Tom) Thompson, Paula Tomko, Delegate Amanda Batten, Julie Bilodeau, Kelly Cannon, Nikki Cox, Eric Reynolds, Sheila Talbott, Delegate Kim Taylor, Dr. Daphne Bazil, Shannon Purcell

Members Present Virtually: Gabriela Ammatuna, Ildiko Baugus, Senator Emily Jordan, Leah Kipley, Lee Ouyang, Ashley Wiley

Health and Human Resources Staff: Leah Mills, HHR; Jona Roka, HHR; Mindy Diaz, HHR; Kelly Conatser, VDH; Dane De Silva, VDH; Dr. Vanessa Walker-Harris, VDH; Cynthia deSa, VDH; Rebecca Edelstein, VDH; Lauren Kozlowski, VDH; Julie Keeney, VDH; Jennifer Macdonald, VDH; Parker Parks, VDH; Allie Atkeson, DMAS

Opening Remarks and Member Introductions – Janet Vestal Kelly, Secretary of Health and Human Resources

Secretary Kelly welcomed everyone to the meeting and thanked the Health and Human Resources Team for their tremendous work, as well as Delegates Amanda Batten and Kim Taylor, and Senators Emily Jordan and Tara Durant, during the 2025 General Assembly (GA) session to improve maternal health outcomes. It was a short session this year, but incredibly productive and impactful.

Secretary Kelly provided an overview of Governor Youngkin's Executive Directive Eleven which directs the Virginia Department of Health (VDH) to "enhance the Maternal and Child Health Data Dashboard to include actionable data on pregnancy-associated and pregnancy-related mortality and causes, and to establish a centralized maternal health website to provide families with essential resources in one accessible location." Thanks were given for the work of the Task Force, and other essential partners. The great progress that has been made could not have happened without this work.

VDH Commissioner Dr. Karen Shelton was introduced, and she welcomed the membership and guests, expressing gratitude for their work and dedication. Roundtable introductions were made, including members participating virtually. Commissioner Shelton reviewed the November meeting notes and then gave a brief overview of the meeting agenda.

2025 Maternal Health Legislative Update – Leah Mills, Chief Deputy Secretary of Health and Human Resources

Chief Deputy Secretary Mills thanked everyone for being an active part of this crucial work and gave a maternal health legislative update that covered the 2025 session of the GA. She noted that legislation is currently being considered by Governor Youngkin before the GA reconvenes on April 2. Deputy Mills highlighted that nearly $500 million is spent on maternal health services in the Commonwealth. She also discussed several of the maternal health legislative proposals addressed by the GA during the 2025 GA Session. She also highlighted Executive Directive Eleven, issued by Governor Youngkin, which directed the VDH to enhance the Maternal and Child Health Data Dashboard to include actionable data on pregnancy-associated and pregnancy-associated mortality and causes and establish a centralized maternal health website to provide families with essential resources in one accessible location. Deputy Mills stated that maternal health was a bipartisan topic of interest this year and that more information would be forthcoming after the reconvened session.

Virginia Hospital & Healthcare Association (VHHA) Data Presentation – David Vaamonde, Vice President of Analytics, VHHA and Andre Tolleris, Director of Data Analytics, VHHA

Mr. Vaamonde and Mr. Tolleris presented information on maternal health data and measures, maternal health disparities, barriers to data collection, the role of social determinants of health (SDoH), and severe maternal morbidity (SMM) trends. VHHA gathers, processes, and disseminates patient-level information from its member hospitals, including inpatient data, emergency department statistics, and a limited amount of patient data. Most of the maternal health analyses and resources offered by VHHA are derived from the inpatient database. VHHA leverages the inpatient data to calculate supplementary metrics, including readmission rates, Agency for Healthcare Research and Quality (AHRQ), and geo-spatial analytics. VHHA provides dashboards and analytics to its member organizations via the VHHAAnyltics.com platform. Below is a summary of the data.

Summary of the Data:

- There were 690,425 births between 2017 and 2024, which was an average of 88k births per year with a slight decline in recent years.
- Commercial insurance (53.4%) remains the largest payer of births followed by Medicaid (36.1%).
- The C-section rate for 2023 was 33.05% (aligned with national average), but low-risk C-sections (26.7%) exceeded target (23.6%).
- SMM has increased over time: 1.74% (2017), 3.26% (2021 peak), 2.64% (2024).
- The Medicaid SMM rate (2.85%) slightly exceeds the commercial insurance SMM rate (2.34%).

- Black & Hispanic-Black mothers face the highest SMM rates.
- Chronic conditions, including the following, are present in 40% of deliveries: anemia, obesity, and mental health, which increases risks. Addressing chronic conditions earlier through screening can improve outcomes.
- VHHA, Virginia Health Information, and VDH all have access to inpatient level data, but do not share the same access to data regarding emergency department care, outpatient care, the All Payer's Claim Database, and real-time hospital admissions data.
- Several key challenges limit the collection and accuracy of maternal health data in Virginia:
    - True maternal health mortality rates are hard to measure since a sizeable percentage of deaths occur post-discharge.
    - Virginia does not have a comprehensive outpatient-level database; this makes it hard to measure prenatal and postpartum care outcomes.
    - Data sharing restrictions such as patient privacy and security guardrails can limit data sharing between hospitals, public health agencies, and researchers.
    - Many rural areas in Virginia lack obstetric care facilities, leading to potential under-reporting complications that occur outside traditional healthcare settings.

Virginia's Title V Needs Assessment Update – Dr. Karen Shelton, Commissioner VDH

Dr. Shelton provided the Task Force with an overview of Title V and its defined purpose to, "provide and to assure mothers and children (in particular, those with low income or with limited availability of health services) access to quality maternal and child health services."

Title V was created in the Social Security Act of 1935 and is the oldest state/federal partnership; these funds became a block grant in 1981. The Title V Assessment is a systematic process required every five years by the Health Resources and Services Administration (HRSA). Qualitative and quantitative methodology is used in identifying and prioritizing maternal and child health services needs. The next report is due in July 2025. To date, 500 stakeholder surveys have been completed, 93 key informant interviews completed, and 20 focus groups facilitated with 83 individuals. In April, work will begin to finalize the Measurable State Action Plan ahead of the July submission of the report to HRSA.

Dr. Shelton noted several overarching themes. One of Virginia's strengths, as identified in the focus groups, was the presence of programs and providers who also serve as patient advocates. Barriers included provider shortages, insurance limitations, and care coordination challenges.

Dr. Shelton highlighted the maternal health work and programs carried out by VDH and the local health districts (LDHs). The following maternal health programs and services were discussed:

- BabyCare provides comprehensive case management and wraparound services, behavioral risk screenings, and expanded prenatal services for pregnant women and infants up to age two, to reduce maternal and infant mortality and morbidity. The BabyCare program is available in 13 LDHs. The first report on outcomes of the BabyCare program will be completed by July. 2024 data for the program showed the follwing, reflecting a 10% increase from 2023:
    - 614 mothers served through 4,218 encounters
    - 903 infants served through 7,201 encounters
- Resource Mothers support pregnant and parenting teens through mentorship, education, and case management, to improve health, stability, and navigation of parenthood. Resource Mothers saw increased enrollment and engagement in 2024, with fewer rapid repeat pregnancies. The program is available in 4 LDHs and 1 private hospital. 2024 data for the program showed:
    - 180 teens enrolled
    - 2,117 encounters completed (6% increase from 2023)
    - 1,107 lessons taught (Growing Great Kids and AIM for Teen Moms)
    - 37 repeat pregnancies (subsequent pregnancy within 18 months); 7 less than in 2023
- Home visiting programs are available through the following organizations: VDH, Healthy Families, Healthy Start, Nurse Family Partnership, Parents as Teachers, and Resource Mothers. However, these programs are not offered in every health district. Currently, programs are available in varying degrees and through varying programs in over 60 LHDs. Central Virginia and Western Virginia have large unserved areas.
- District Highlight: The Easten Shore Health Department (HD) provided prenatal care services to 161 patients with a total of 838 visits in 2024.
- District Highlight: The Chesterfield HD provided direct prenatal care services to women in need for a total of 383 patients with a total of 1839 visits in 2024.
- District Highlight: The Chickahominy HD provided direct prenatal care services to 45 women with a total of 222 visits in 2024.

Dr. Shelton discussed VDH's Community Health Worker program and the use of maternal mortality for allocation of resources.

Dr. Shelton noted that two dashboards are in development to improve publication of actionable data on maternal health: the Maternal Mortality Dashboard (includes natural deaths up to 42

days postpartum) and the Pregnancy Associated Mortality Dashboard (includes deaths up to one year post pregnancy, regardless of pregnancy outcome). Dr. Shelton gave the Task Force infographics and examples of the data that can be expected through these dashboards. The emphasis is placed on delivering real-time data to guide efforts and action. A comprehensive maternal health resource website is also being planned.

Virginia Medicaid Update – Cheryl Roberts, Director DMAS

Director Roberts provided the total number of deliveries for FY2023 and FY2024, as well as birth outcome summaries, including rates of prematurity, full-term, and post-term births. She shared information on the timeliness of prenatal care for Medicaid members in the Commonwealth, as well as completion rates for postpartum visits between 7- and 84-days following delivery. There was a slight decrease (1.8%) in births from FY2023 to FY2024 and a slight increase in premature births from FY2022 to FY2024.

Task Force Member Discussion – facilitated by Dr. Shelton and Dr. Dunnavant

- The Task Force discussed the use of a screening tool for SDoH and the importance of it being used in addition to mental health screenings. Concern was voiced regarding the importance of both being conducted and reimbursement for SDoH screening.
- Questions were raised regarding referrals for various services offered throughout the Commonwealth. How are individuals made aware of available resources and can referral sources be assessed for their effectiveness? Is the Unite Us platform still being funded by the Commonwealth, how can partners and/or facilities engage with it as a referral system, and how can data from the platform be tracked.
- An update on the Right Help, Right Now initiative may be helpful to assess how it has impacted the Commonwealth.
- A Task Force member requested clarification on whether perinatal services can be unbundled and billed for separately under Virginia Medicaid. They asked whether Virginia only offers a global payment for perinatal care and how that impacts the ability to track things like the postpartum visits and mental health screenings. It was later clarified that payments could be unbundled.
- The timeliness of Commonwealth data was also discussed, including delays in processing certain metrics and how these delays affect maternal health efforts — particularly in informing reports, guiding work, and supporting funding requests.

Public Comment Period

No comments provided.

Next Steps

The Task Force is scheduled to be reconvened on May 9, 2025, from 10am–noon. Additional meeting details will be provided closer to the meeting date.

Maternal Health Data and Quality Measures Task Force Meeting Notes

May 9, 2025

Patrick Henry Building, 10:00 a.m.- 12:00 p.m.

Members Present: Secretary Janet Kelly, VDH Commissioner Dr. Karen Shelton (Co-Chair), DMAS Director Cheryl Roberts, Kelly Cannon, Lee Ouyang, Hannah Hughson (designee for Education Secretariat/Emily Anne Gullickson), Leah Kipley, Kyle Russell, Stephanie Spencer, Paula Tomko, Nicole Lawter, Shane Ashby (designee for Tameeka Smith), George Saade, Michael Perez (designee for DOI office/Chief Martin Brown), Senator Tara Durant, Delegate Kim Taylor, and Shannon Pursell.

Members Present Virtually: Gabriella Ammatuna, Dr. Daphne Bazile, Melanie Rouse, Ildiko Baugus, Louis (Tom) Thompson, Ann Russell, Verneeta Williams, Sheila Talbott

Health and Human Resources Staff: Leah Mills, HHR; Jona Roka, HHR; Mindy Diaz, HHR; Dane De Silva, VDH; Dr. Vanessa Walker-Harris, VDH; Rebecca Edelstein, VDH; Lauren Kozlowski, VDH; Allie Atkeson, DMAS

Opening Remarks and Member Introductions – Janet Vestal Kelly, Secretary of Health and Human Resources

Secretary Kelly thanked everyone for attending the meeting. She acknowledged Commissioner Karen Shelton, Director Cheryl Roberts, Senator Tara Durant, Delegate Kim Taylor, Dr. Shannon Walsh, and Shannon Pursell. Secretary Kelly also noted that the Governor issued a press release regarding the Virginia Department of Health's (VDH) updated maternal health dashboard, highlighting the significant progress made by the Task Force partners and stakeholders so far. This includes a 49 percent reduction in maternal mortality since 2021.

Maternal Mortality Dashboard Update and Review of Maternal Mortality Report – Dr. Karen Shelton, Commissioner, VDH

Dr. Shelton began with her presentation, noting the introduction of various legislative and budget amendments aimed at supporting maternal health. Dr. Shelton presented data from the updated maternal mortality dashboard, explained how it functions, and its new features. She demonstrated how to navigate through different tabs, such as "Maternal and Child Health Indicators," and how to view the data by locality and region.

Dr. Shelton further explained the definitions of maternal health, emphasizing their importance for accurate data interpretation. Through VDH's Dashboard, maternal mortality rates can be broken down by locality, city, region, and state. Dr. Shelton explained that due to varying population sizes, the impact of maternal deaths can differ significantly between localities. The data can also be broken down by age groups, race and ethnicity, and rural/urban areas. Dr.

Shelton also emphasized the importance of considering both the rates and the actual numbers, as the population size can influence the interpretation of the data. She then reviewed the causes of maternal mortality, sharing statistics that can be accessed on the VDH website.

Additionally, there is a section on pregnancy-associated deaths on the dashboard, which can also be examined by locality. This section is broken into factors such as cause, manner of death, age, and locality/region. Dr. Shelton then presented a review of the maternal mortality data, highlighting key recommendation themes based on the 2024 Maternal Mortality Report. These themes included evidence-based standards of care, maternal levels of care, care coordination, mental health and substance use disorder services, community outreach, public and provider education, and awareness. Overall, the report emphasizes that care should be affordable, accessible, and well-coordinated. Dr. Shelton introduced the Center for Public Policy (CPP) and opened the floor for questions.

Maternal Mortality Reports

Summary of Data:

- Infant mortality in Virginia has decreased to 5.8 per 1,000 births.
- Teen pregnancies have significantly decreased over the last 10 years, now at 15.2 per 1,000 females aged 15 – 19 in 2023.
- Maternal smoking has decreased from 6.1% to 2.6% from 2015 – 2023.
- Accidental overdose accounted for 40% of pregnancy-related deaths in 2023.
- Nearly 40% of cases had at least one community-related contributor.
- 86% of maternal deaths were determined to be preventable.
- Over 73% of cases had at least one provider-related contributor.
- Nearly 53% of all cases had at least one facility-related factor.
- 100% of cases had at least one patient-related factor.

Questions:

- Question: One issue that is coming up is how the data is communicated to the community to help members advocate for themselves. How is the Task Force connected to the community? People want to see how this information applies to them and the data should be communicated in a timely manner.

  - Dr. Shelton's response: This is one of the key goals of the Task Force, to make this data actionable. While timely data is important, it's equally important to ensure that the data is accurate and complete, which is why discrepancies may arise in the reporting.
- Question: How about tracking information for women who don't die but experience close calls?
  - Dr. Shelton's response: VDH does track near maternal morbidity, which is also critical to ensure healthy moms and healthy babies. Eventually, there will be a plan to add this data to the dashboard.
- A Task Force member made a comment regarding HB831 (2024 Session) and how its workgroup is focused on defining near maternal morbidity.
- Question: Where does the data come from and are there any concerns regarding the ability to collect or show data in the Pregnancy Risk Assessment Monitoring System (PRAMS) system?

Facilitated Activity – VCU Center for Public Policy (CPP)

Gina Barber, Director of Administration and Senior Consultant at the Center for Public Policy (CPP), introduced the other CPP members who will be facilitating the Task Force meetings. She outlined the objectives and deliverables for the group. Dr. Jennifer Reid, Evaluation Director at CPP, summarized multiple the various presentations the Task Force has reviewed since October. The conversation started with three questions and participants were asked to share their responses with their colleagues.

Discussion Questions:

1. What additional information needs to be shared with the Task Force to move forward and achieve our objectives?
2. What perspectives have not yet been shared?
3. What do you recommend this Task Force do next?

Task Force Member Discussion:

- One member expressed interest in exploring how mental health impacts maternal mortality and morbidity.
- Members discussed the differences between tobacco smoking and marijuana use. Some patients perceive these substances differently, and it was suggested that further exploration of this issue might be valuable.
- There was a suggestion to gather more data on out-of-hospital births to strengthen collaboration and support the important work of these providers. This data could help improve birth outcomes across the entire state.

(The first three recommendations were focused on maternal health prior to pregnancy.)

- There was an emphasis on shifting the messaging from focusing on women's health during pregnancy to focusing on women's health before pregnancy. Wellness should begin early, and marketing campaigns should target women before they conceive.
- A member mentioned adding this information to high school curricula to reach younger audiences.
- Marijuana overuse syndrome was discussed, particularly the gastrointestinal symptoms it can cause in some patients who use it for nausea. Overuse can lead to complications such as preeclampsia.
- There was a discussion on current treatment efforts for substance abuse and maternal health.
- The intersection of infant mortality and maternal mortality was noted, with a request for clarification on the PRAMS data.
- The group discussed the varying abilities of hospitals to provide adequate care, highlighting the disparities that exist.
- Members discussed how to improve the understanding of C-section and induction rates by hospitals, as well as the impact insurance reimbursement has on maternal health and the coverage of care.
    - There is a need to better understand the overlap of data points and demographic factors in these areas.
- Members suggested having an OB/GYN panel discuss at the next Task Force meeting. The Task Force agreed that a strong representation of OB/GYN perspectives is necessary, especially to hear about both the challenges and successes they face in their work.
- The use of machine learning in data analysis was proposed as a way to improve communication with the community, especially regarding preventative measures. There was a suggestion to explore how records and text communications can be used with artificial intelligence to detect nuanced issues such as suicide ideation and hemorrhage risk.

Provider Perspectives – Dr. Shannon Walsh, Physician at VCU Health, and Shannon Pursell, Executive Director at Virginia Neonatal Perinatal Collaborative (VNPC)

Dr. Walsh introduced herself, explaining her background as an emergency medicine physician and how it links to maternal health. She then introduced Shannon Pursell, Executive Director of the VNPC, who presented on the organization and its work in Virginia hospitals. Ms. Pursell discussed the importance of matching the level of care between different hospitals and providers. She explained the need for advocacy and information sharing, particularly from

women and pregnancy providers, and emphasized the role of data in supporting successful initiatives and identifying areas for improvement.

Pursell shared updates on building a contact list or inventory of all hospitals, emergency departments (EDs), and NICUs to streamline communication. She also discussed the need to break down infant mortality rates by gestational age and maternal age.

Pursell presented opportunities for the state, particularly in improving emergency medical services (EMS) knowledge and resources for rural maternal hospitals. She noted the importance of tracking data for midwives and doulas in hospitals, comparing outcomes for hospitals that employ these providers to those that do not.

Summary of Virginia's Birth and Health Infrastructure:

- Birth hospitals in Virginia: 49 (down from 68, representing a 25% decrease)
- Freestanding birth centers: 21
- NICUs: 17
- Non-birth hospitals: 72
- Freestanding EDs: 26
- Traditional EDs: 82

Closing Remarks

Dr. Shelton thanked the Task Force members and members of the public and informed them that the next meeting would take place on June 25, 2025, from 10:00 a.m. to 12:00 p.m. The location is to be determined.

Maternal Health Data and Quality Measures Task Force Meeting Notes -- Draft

June 25, 2025

Virginia Department of Medical Assistance Services, 10:00 a.m. – 12:15 p.m.

Members Present: VDH Commissioner Dr. Karen Shelton (Co-Chair), DMAS Director Cheryl Roberts, Lee Ouyang, Emily Anne Gullickson, Leah Kipley, Nicole Lawter, Ildiko Baugus, Nikole Cox, Joely Mauck, Eric Reynolds, Melanie Rouse, Delegate Anne Ferell Tata, Louis Thompson, Shannon Pursell, Hannah Coley (designee for Kelly Cannon), and Yulisa Arellano (designee for Julie Bilodeau)

Members Present Virtually: Ann Russell, Ashley Wiley, Delegate Amanda Batten, Dr. Jennifer Wells, Dr. Kurt Elward, Gabriela Ammatuna, Mandolin Restivo, Paula Tomko, Senator Emily Jordan, Stephanie Spencer, Tanya Callender, Michael Perez (designee for Martin Brown) Health and Human Resources Staff: Leah Mills, HHR; Jona Roka, HHR; Mindy Diaz,

HHR; Melanie Cruz, Virginia Management Fellow; Elizabeth Gillanders, HHR Fellow; Cheryl Oppan, HHR Fellow; Brandon Tomlinson, HHR Fellow; Katie Rankin, HHR Intern

Opening Remarks and Member Introductions – Leah Mills, Deputy Secretary of Health and Human Resources

Deputy Secretary Mills welcomed attendees and thanked them for their participation. She acknowledged Commissioner Dr. Karen Shelton, Director Cheryl Roberts, Delegate Anne Ferrell Tata, Delegate Amanda Batten, and Senator Emily Jordan. She extended thanks to Director Roberts for hosting this meeting and highlighted her leadership in launching Cardinal Care. Deputy Secretary Mills also welcomed the 2025 Health and Human Resources Governor's Fellows.

Task Force Welcome – Dr. Karen Shelton, Commissioner, Virginia Department of Health

Commissioner Shelton welcomed Task Force members and noted the previous meeting's discussions focused on tobacco use reduction in Virginia, which led to further conversation around increasing cannabis use.

Presentation – Cannabis Use During Pregnancy – Dr. Avery Michienzi, Medical Toxicology Faculty, University of Virginia

Dr. Avery Michienzi, a toxicologist at the University of Virginia (UVA), presented on the intersection of toxicology and maternal health, focusing on cannabis use during pregnancy. She began by explaining that cannabis use is on the rise, influenced by factors such as decriminalization and increased accessibility, which contributes to the perception that cannabis is safe. Dr. Michienzi emphasized that cannabis, while legal in some forms, still poses potential health risks to pregnant women and their children. She emphasized the complexity of cannabis, highlighting that it contains a variety of cannabinoids—most notably THC and CBD—which can be found in both natural and synthetic forms. These compounds are marketed through a wide range of products and channels, often taking advantage of legal ambiguities and regulatory gaps.

Cannabis is commonly used during pregnancy for anxiety, insomnia, chronic pain, and nausea. A major concern discussed was the gap in education and guidance from health professionals; many patients reported being told not to use cannabis but were not given reasons or alternatives. Dr. Michienzi drew a comparison to other legal substances like tobacco and alcohol, reinforcing that legality does not equate to safety. Dr. Michienzi reported that 70% of women believe cannabis has little to no harm during pregnancy if only used 1-2 times per week.

She also addressed cannabis use while breastfeeding, noting that THC can transfer into breast milk. The presentation emphasized that many pregnant women perceive cannabis as safe due to its natural origin and lack of adequate public health messaging. Dr. Michienzi cited research showing conflicting information online and a desire among pregnant women for more information directly from healthcare providers. The presentation concluded with recommended communication approaches for OB/GYNs and references to public health resources from the Centers for Disease Control and Prevention, American College of Obstetricians and Gynecologists, Substance Abuse Mental Health Services Administration, and the Virginia Cannabis Control Authority.

Data Highlights:

- *Are Health Care Providers Caring for Pregnant and Postpartum Women Ready to Confront the Perinatal Cannabis Use Challenge* - Survey of 75 providers:
    - 46% of providers are aware of short or long-term effects of cannabis during pregnancy67% of providers want more training on perinatal cannabis use and its
    - health impacts
    - 35% of providers are unaware of the impacts that cannabis use has on maternal and perinatal health
- *Recommendations From Cannabis Dispensaries About First Trimester Cannabis Use - Colorado study of 400 phone calls to dispensaries*:
    - 69% of dispensaries recommended cannabis use for morning sickness
    - Only 5% of dispensaries warned of potential fetal harm
    - 81.5% recommended patients talk to a healthcare provider, but only 31.8% made the recommendation without prompting
- Health risks associated with cannabis use during pregnancy include:
    - Reduced placental perfusion and fetal oxygen
    - Increased risk of low birth weight, stillbirth, NICU admission, and preterm birth
    - Long-term child impacts such as attention deficits, memory issues, increased risk for mental health disorders, and academic difficulties
    - Delta-9 THC is lipophilic, meaning it can pass through breast milk and potentially cause apneic spells in infants

Presentation – Cannabis Use During Pregnancy: VDH Data – Lauren Kozlowski, Maternal and Infant Programs Consultant, Virginia Department of Health; Kenesha Smith Barber, Community Health Improvement Epidemiology Program Manager, Virginia Department of Health

Lauren Kozlowski and Kenesha Smith Barber shared the data VDH collects on cannabis use during pregnancy. They reported that the percentage of women reporting marijuana use

increased from 1.8% in the year prior to legalization (2019) to 2.4% in 2023, representing a 33% increase. The highest reported usage by race is among non-Hispanic White women. In 2020, the highest reported postpartum marijuana use by maternal age was among 25- to 34-year-olds.

Presentation – Maternal Health: For Commercial Health Plans – Dr. Louis Thompson, Director of Medical Operations – Commercial East Coast Region, Anthem Blue Cross and Blue Shield, Virginia and Dr. Seema Sarin, Medical Director, Commercial and Specialty Business, Anthem Blue Cross and Blue Shield, Virginia

Dr. Louis Thompson's presentation addressed how commercial plans are working to meet maternal health needs and strategic goals. He reviewed national and Virginia-specific maternal health trends, including data from the March of Dimes. He noted increasing rates of preterm births and maternal morbidity, highlighting that access to care remains a major barrier, particularly due to transportation, provider shortages, and a lack of diversity in healthcare providers.

Dr. Seema Sarin followed by outlining Virginia's current coverage landscape. She explained that approximately one-third of births are covered by Medicaid, with the remainder relying on commercial insurance. She reviewed maternal health benefits currently required and how these apply in Virginia, including prenatal care, midwifery services, home births, and postpartum care. Elevance Health is working to go beyond standard coverage by focusing on social determinants of health, behavioral health integration, and the creation of personalized maternal care plans. Dr. Sarin emphasized that 80% of health outcomes are influenced by factors outside of care, such as socioeconomic status, and that proactive, data-informed care is essential.

Elevance Health's Whole Health Index (WHI), a validated screening tool, helps identify behavioral and social risk factors early. WHI data is used to create dashboards that map maternal health deserts and inform care coordination. The organization also provides access to maternity health advocates and virtual care services such as Pomelo Care. Their approach emphasizes a holistic, upstream model of care that includes early intervention and aims to close racial and ethnic disparities in maternal and child health outcomes.

Presentation Highlights:

- Required commercial plan benefits in Virginia include:
  - Prenatal and postpartum care
  - Licensed nurse midwifery and home birth services
  - Dental, ultrasound, and fetal screening services
  - Tobacco use intervention and counseling

  - Breastfeeding support
- Elevance Health initiatives:
  - There was an 18.8% improvement in preterm birth rates among the Elevance Health Foundation program participants
  - Mapped maternal health data across Virginia using WHI dashboard
  - Partnerships with maternity health advocates and Pomelo virtual care services
  - Reached 475,000 individuals nationwide through awareness efforts, screenings, and other services

Questions and Discussion

- Question: How long do pregnancy benefits last postpartum? Are there differences across plans?
  - Dr. Thompson's response: Medicaid provides up to one year of postpartum coverage. Commercial plans may also offer up to one year, but this can vary by provider and employer.
- Question: Non-medically necessary inductions were not listed as a risk factor for C-sections. Has this been evaluated in the data?
  - Dr. Thompson's response: Early induction is discouraged. A process is currently in development to better evaluate and potentially prohibit non-medically necessary inductions.
- Question: How can we include requirements for the coverage of specific services?
  - Dr. Thompson's response: There is an ongoing conversation about the path to requiring specific services through regulation. Coverage mandates vary and must align with Virginia's legislative and regulatory framework.
- Question: Does coverage of an at-home birth include licensed midwives?
  - Dr. Thompson response: Yes, coverage includes licensed midwives. Postpartum care typically includes reimbursement for up to four standard visits.
- Question: What is the barrier for extending postpartum benefits?
  - Dr. Thompson response: This is often influenced by employers and the type of insurance plans offered. Coverage varies across different sectors, and the General Assembly determines what is required across all plans.
- Task Force member comment: There are instances where Medicaid recipients appear to have better access to resources than those with commercial insurance. This points to an unintentional disparity. Analyzing access points and understanding what mothers are seeking is key.

Facilitated Activity – VCU Center for Public Policy (CPP)

Dr. Brittany Keegan from CPP noted the limited time for discussion and announced that a follow-up survey would be distributed to gather input on the next steps and recommendations.

Closing Remarks

Deputy Secretary Mills informed attendees that the next meeting is scheduled for August 22, 2025, and emphasized the importance of transitioning from information-gathering to actionable recommendations for the final report due in December 2025 to the General Assembly.

Commissioner Shelton echoed this sentiment, highlighting that recurring themes have emerged and that the group should now focus on developing policy recommendations.

Maternal Health Data and Quality Measures Task Force Meeting Notes -- DRAFT

August 22, 2025

Patrick Henry Building, 10:00 AM – 12:00 PM

Members Present: VDH Commissioner Dr. Karen Shelton (Co-Chair), DMAS Director Cheryl Roberts, Senator Tara Durant, Delegate Amanda Batten, Dr. Siobhan Dunnavant (Co-Chair), Nicole Lawter, Ildiko Baugus, George Saade, Eric Reynolds, Jumelie Miller, Leah Kipley, Shannon Pursell, Julie Bilodeau, Kelly Cannon, Niki Cox, Shelia Talbott, Paula Tomko, Hannah Matty (designee for Kyle Russell), and Kathy Haines (designee for Pamela Pilch)

Members Present Virtually: Delegate Anne Ferell Tata, Heidi Dix, Dr. Daphne Bazile, Dr. Jaclyn Nunziato, Dr. Lee Ouyang, Dr. Melanie Rouse, Joely Mauck, Stephanie Spencer, Mandolin Restivo, Dr. Kurt Elward, and Gabriela Ammatuna

Health and Human Resources Staff: Leah Mills, HHR; Mindy Diaz, HHR; Melanie Cruz, Virginia Management Fellow; Cheryl Oppan, HHR

Opening Remarks and Member Introductions: **Leah Mills, Deputy Secretary, Health and Human Resources**

Deputy Secretary Mills welcomed Task Force members and thanked them for their participation. She acknowledged Commissioner Dr. Karen Shelton, Director Cheryl Roberts, and recognized Senator Tara Durant, Delegate Amanda Batten, and Delegate Anne Ferell Tata. She commended VDH and DMAS for their work and efforts throughout the taskforce. Deputy Secretary Mills then introduced Commissioner Shelton to provide opening remarks.

Task Force Welcome: Dr. Karen Shelton, Commissioner, Virginia Department of Health

Commissioner Shelton welcomed Task Force members and noted the previous meeting's focus on cannabis use during pregnancy. She recognized virtual attendees, state legislators,

and Health and Human Resources staff. Commissioner Shelton introduced Dr. Brittany Keegan from the VCU Center for Public Policy (CPP) to review the maternal health survey findings and recommendations as well as lead the provider panel discussion.

Maternal Health Survey Findings and Recommendations: Dr. Brittany Keegan, VCU Center for Public Policy

Dr. Brittany Keegan provided a brief synopsis of each section outlined in the survey. The survey received 26 total responses, and a key takeaway was access to maternal health services in rural areas. Expanding support and resources for maternal health deserts was a top priority for the Task Force as they address upcoming challenges and unmet needs. Promoting maternal mental health and addressing substance use, particularly cannabis use, were also top priorities.

Under policy and program recommendations, financial resources to support maternal health in rural areas and increasing transportation access and childcare options for pregnant women in underserved regions were identified top priorities. Shannon Pursell commented on the survey emphasizing the importance of focusing on data quality measures and not duplicating findings from other maternal health task force meetings. She noted that the title of the survey should be changed to Maternal Health Data and Quality Measures Survey rather than Maternal Health Task Force Survey.

Provider Panel Participants:

Dr. Daphne Bazile, *Obstetrician and Gynecologist, Bon Secours (Virtual)*

Dr. Jaclyn Nunziato, *Obstetrician and Gynecologist, Carilion Clinic (Virtual)*

Dr. Richard Lucidi, *Obstetrician and Gynecologist, VCU Health*

Christina Jennings, *Certified Women's Health Nurse Practitioner, Virginia Department of Health, Chickahominy Health District*

Kate Hulbert, *Certified Nurse Midwife, VCU Health*

Ildiko Baugus, *Certified Professional Midwife & Licensed Midwife, Meraki Midwives*

Provider Panel Questions:

- What trends are you seeing in the data for maternal health care?
    - Dr. Jaclyn Nunziato
        - No significant reimbursement rates for telehealth visits
        - Do not have enough staff to support the current increase or decrease of patients, particularly in Southwest Virginia
        - Lack of care coordination and navigators

  - Dr. Daphne Bazile
    - Facing challenges with people getting their information from social media rather than trusted sources
  - Christina Jennings
    - There is a need for care in Goochland County
  - Ildiko Baugus
    - Patients cannot afford insurance
    - Portsmouth is considered a maternity care desert
- What resources do you need to better support women in underserved areas, especially in maternity health deserts?
  - Ildiko Baugus
    - Being able to get all the resources for each patient including maternal medicine, OB care, etc.
    - More training for paramedics for dealing with postpartum mental health challenges
    - Reimbursement for substance use disorder screening and domestic violence screening
  - Dr. Jaclyn Nunziato
    - Need to invest in care navigation otherwise collecting data alone is insufficient; we need to come up with strategic plans to address on the ground challenges
  - Christina Jennings
    - Patients may have difficulty communicating with medical staff
    - Patients may be unable to communicate their needsWe need to address
    - mental health care and provide resources to address those challenges
  - Dr. Richard Lucidi
    - Pre-conception care is also essential, ensuring women are taking their vitamins, screening for medical issues, etc.
  - Dr. Lee Ouyang
    - Can we quantify how many people need resources so we can bring concrete statistics to legislators?
- What are some things Virginia could do to expand access to care in rural areas and minoritized populations?
  - Christina Jennings
    - Financial resources
  - Kate Hulbert

        - More postpartum visits, only one is provided now but at least two would be beneficial
- What are some of the other reasons patients miss pre-natal or postpartum patients?
    - Kate Hulbert
        - Childcare and transportation are barriers for not coming to appointments
    - Dr. Jaclyn Nunziato
        - Not having broadband service is an issue for telehealth appointments in rural areas
        - Financial infrastructure in localities that don't have service
    - Dr. Lee Ouyang
        - Accessing medical appointments during the work week is challenging
- What types of data would be useful to assist in your practice?
    - Dr. Jaclyn Nunziato
        - I would love to see data on those who have signed sterilization forms
        - Annual visits coded for pre-conception counseling
        - Data does not include other conversations that need to be captured such as former conditions that impact the future health of the patient

Provider Panel Discussion:

- Shannon Pursell
    - We have a maternal morbidity workgroup, so we have an opportunity to look at maternal mortality
    - Reimbursement and financial resources have come up several times and there are multiple funding streams that are in use and accessible
    - Several recommendations that came up in the meeting today were present in 2024; ensure that people are aware of the 2024 recommendations
    - Optimizing postpartum care would be an ideal step for moving forward
- Stephanie Spencer
    - How are the providers on the panel currently utilizing the resources available in the community today? How are current resources in the community being used?
    - Do integrated models include MCO care coordinators, doulas, peer support specialists, doulas, home visiting or maternal health hubs? What are the barriers providers have experienced when it comes to accessing these resources?
- What does the current data show regarding the utilization of current services and programming?
    - Dr. Lee Ouyang

        - We currently do not have an answer to that problem, but it is certainly something to think about
    - Dr. Jaclyn Nunziato
        - It is important to collect data in a more meaningful way; data is wonderful, but it may not account for those near misses/ close calls
        - Outcome data and lack of implementation on the bedside is a struggle. We lack the infrastructure to provide quality care at the bedside
        - The American College of Obstetricians and Gynecologists (ACOG) recommends providers see their patients within two weeks of birth, but this can be difficult because OBGYNs do not have capacity for this
- Delegate Amanda Batten
    - What are the health risks and outcomes for women who have a planned pregnancy versus an unplanned pregnancy?
        - Dr. Jaclyn Nunziato
            - As providers, we need to do a better job of educating our patients about reproductive health planning
- Christina Jennings
    - The passion and energy we all pour into maternity care is impressive, however, there is a cost. Providers work themselves to the point of exhaustion. Providers are affected on a personal level

Closing Remarks:

Dr. Keegan thanked the panelists and members for joining and sharing their thoughts.

Dr. Dunnavant stated that when we seek to translate medical experience into moving the policy needle, we need data. As legislators, we need clear guidance and data. Interconnected care is the golden egg to achieve better outcomes, and we must emphasize regional efforts moving forward. Additionally, access to mental health care is a challenge. People should be referred to mental health resources so we can track how many people are being referred. To conclude, we must translate the language of clinical care in a way that legislators can understand and better meet the needs and challenges of maternal health providers.

Commissioner Shelton thanked the Task Force members for their attendance and participation. She stated the next meeting was on September 24th, 2025, at 10am and would be held at VCU Health Community Memorial Hospital.

Maternal Health Data and Quality Measures Task Force Meeting Notes -- Draft

September 24th, 2025 | 10:00 a.m. – 12:00 p.m.

VCU Health Community Memorial Hospital, Education Conference Room

Members Present: VDH Commissioner Dr. Karen Shelton (Co-Chair), DMAS Director Cheryl Roberts, Julie Bilodeau, Tanya Callender, Kelly Cannon, Jumelie Miller, Shannon Pursell, Ann Russell

Members Present Virtually: Delegate Amanda Batten, Gabriela Ammatuna, Dr. Daphne Bazile, Nikki Cox, Dr. Kurt Elward, Leah Kipley, Nicole Lawter, Sheila Mathis, Joely Mauck, Dr. Lee Ouyang, Eric Reynolds, Kenda Sutton-El, Dr. Louis Thompson, Ashley Wiley, Ildiko Baugus, Stephanie Spencer, Mandolin Restivo, John Mandeville (designee for Paula Tomko)

Health and Human Resources Staff: Leah Mills, HHR; Jona Roka, HHR; Mindy Diaz, HHR; Cheryl Oppan, HHR; Bella Griffin, HHR; Elizabeth Gillanders, HHR; Dane De Silva, VDH; Rebecca Edelstein, VDH; Lauren Kozlowski, VDH; Mariam Siddiqui, DMAS; Karla Callaham, DMAS

Welcome Remarks and Introductions

> ***The Honorable Janet V. Kelly, Secretary of Health and Human Resources Dr. Karen Shelton, Commissioner, Virginia Department of Health (Co-Chair) Sheldon Barr, President, VCU Health Community Memorial Hospital***

The meeting opened with remarks from Janet V. Kelly, Secretary of Health and Human Resources (HHR), who welcomed members and noted that this was the seventh meeting of the Maternal Health Data and Quality Measures Task Force. She emphasized that maternal health has been a top priority for the Governor, who has a personal connection to the issue through his mother's work in the field. She reflected on several accomplishments to date, including:

- Passage of the Safety Bundle legislative package to update maternal care protocols.
- Implementation of safety bundles to standardize protocols across maternal health providers.
- Creation of a rural health transformation program from the U.S. Department Health and Human Services that will be carried by The Office of the Secretary of Health and Human Resources.
- Twelve listening sessions in rural areas focused on challenges with accessing quality healthcare in rural Virginia and potential solutions.

Secretary Kelly then introduced Sheldon Barr, President of VCU Health Community Memorial Hospital. President Barr began by thanking Secretary Kelly and the HHR team and described the myriads of programs and supports her hospital has set up to address both health and social needs. She emphasized that maternal health is not only a medical issue, but the cornerstone of community well-being—when mothers thrive, communities prosper. She stressed that every woman deserves the opportunity to have a safe and healthy childbirth.

Drawing on the 2024 VCU Community Health Needs Assessment, President Barr highlighted several realities her hospital faces: 60% of their patients are Medicaid enrollees, who experience higher rates of maternal morbidity; one-third of patients are victims of domestic violence; and adverse outcomes are far too common for children born in their facility. She reminded the group that “these are our neighbors, friends, and families,” and that many babies are fighting for survival from the very first days of life. She shared a moving story about a baby born at 24 weeks, where the care team’s resuscitation efforts helped the child not only survive but double weight, birth weight—demonstrating that delivering high-risk babies can be done.

VCU Health Community Memorial Hospital delivers approximately 200 babies each year, including 15–20 high-risk cases supported through virtual care. To expand access, they have added a second nurse practitioner and continue to ask how comprehensive care resources best support mothers can. Sister facilities in Richmond provide additional capacity, including 1,300 ultrasounds. President Barr described ongoing training for providers on domestic and intimate partner violence, as well as substance abuse, and highlighted initiatives to improve maternal health and infant outcomes in rural communities.

She emphasized the hospital’s strong community connections, which encompass education, partnerships with nonprofits, and other postpartum initiatives. One innovative program provides new mothers with wristbands identifying them as postpartum patients, helping raise awareness and support in the community.

President Barr also underscored the geographic barriers faced by mothers in rural Virginia. Many in South Hill must travel long distances to receive care since the nearest birthing center is in Danville, which is an hour and a half away. About one in five Medicaid patients never make it to scheduled doctor appointments, raising the question of how providers can build trust and engage patients more effectively. She noted that one of their nurse practitioners is pursuing a Doctor of Medical Technology (DMT) degree, further strengthening their workforce.

In closing, President Barr emphasized that maternal health challenges are not just the hospital’s problem but the community’s problem. She called on local governments, providers, and community leaders to align efforts and find creative ways to improve maternal health outcomes, thanking the Task Force for leading this effort.

Rural Health Transformation Update

The Honorable Janet V. Kelly, Secretary of Health and Human Resources

Secretary Kelly stressed the importance of data as the foundation of the Task Force's work and thanked members for their contributions. She described a new federal rural health initiative that will provide $500 million in non-competitive funds and another $500 million in competitive funds for states. The federal government is seeking what she described as a "major transformation" in rural health. Virginia's application is due November 5, 2025.

Landscape of Virginia Birth Hospitals in Rural Health Update

Dr. Karen Shelton, Commissioner, Virginia Department of Health (Co-Chair)

Dr. Shelton presented an overview of Virginia's birthing hospitals and maternal health access in Virginia. Currently, there are 49 birthing hospitals, while 93 localities lack a birthing hospital. She explained that adverse outcomes are more common in areas where residents must travel more than 30 minutes to receive care, particularly when 20% or more of the population lives under 200% of the poverty line.

Several hospitals have closed obstetric units, especially in rural areas, increasing average driving times from 18 minutes to 38 minutes. Medicaid reimbursement challenges have made it difficult to attract OB/GYN providers, and perinatal workforce shortages persist.

Dr. Shelton noted that maternity care deserts are associated with:

- Higher rates of preterm births.
- Increased C-sections.
- More instances of low birth weight.

She highlighted specific cases, including closures at Lewis Gale Medical Center in 2024, which increased drive times in Halifax County, and limited utilization of obstetric services at Warren Memorial Hospital. Even when hospitals remain open, provider availability may not keep pace.

- Ongoing initiatives include:
- Collaborative Safe Births to improve hospital readiness for emergency deliveries.
- NICU transport team training.
- A Health Resources and Services Administration (HRSA) planning grant to build the Cumberland Plateau Perinatal Network, addressing maternal care across four counties.

Dr. Shelton emphasized that transportation barriers are raised in nearly every rural health listening session and called for ideas from Task Force members.

Facilitated Recommendations Discussion

Gina Barber, Director of Administration and Senior Consultant, VCU Center for Public Policy

Gina Barber, Director of Administration and Senior Consultant at the VCU Center for Public Policy, facilitated an exercise designed to help Task Force members identify and refine priority recommendations. She began by asking members to reflect individually on the most urgent needs in maternal health, after which participants joined small groups for deeper discussion. The small groups included both in-person and virtual participants to ensure all voices were captured.

During group discussion, several themes emerged. Members stressed the need for increased workforce incentives in rural areas to attract and retain skilled providers. Expanding the availability of birthing centers and ensuring Medicaid support for maternal services were also frequently cited. Many members highlighted the importance of continuity of care, ensuring that mothers experience seamless transitions between providers and systems, while still maintaining confidentiality and data integrity.

Another strong theme was the integration of doulas and midwives into care models to improve maternal outcomes and provide culturally responsive support. Members also underscored the necessity of including postpartum care and support as a core component of the Task Force's recommendations, rather than limiting focus to pregnancy and delivery.

Finally, some participants expressed concern that discussions were not sufficiently data-centered, cautioning that recommendations must be grounded in robust evidence. Some members emphasized the importance of aggregating, analyzing, and publishing existing data to inform decision-making, build public trust, and track progress over time

Each group reported back to the full Task Force, and the results were compiled using an online participation tool (MentiMeter) to highlight common themes and areas of alignment.

The following are the identified priorities of the in-person and virtual participants:

- **Addressing substance use during pregnancy**, with particular concern about rising cannabis use and its effects on maternal and infant health.
- **Allocating funding for transportation and childcare** in underserved areas to reduce access barriers for families.
- **Expanding workforce development efforts** to address provider shortages, particularly in rural and underserved regions.
- **Streamlining care coordination** across hospitals, OB/GYNs, midwives, doulas, and community providers to reduce fragmentation.

- **Collecting and publishing infant and fetal health outcomes** to improve transparency and guide evidence-based interventions.
- **Increasing access to care in rural areas**, including the deployment of maternity health navigators and strengthening the role of primary care providers.

National Academy for State Health Policy Annual Conference Update

Lauren Kozlowski, Maternal and Infant Programs Coordinator, Virginia Department of Health Mariam Siddiqui, Senior Advisor, Department of Medical Assistance Services

Lauren Kozlowski (VDH) and Mariam Siddiqui (DMAS) reported on Virginia's participation in the National Academy for State Health Policy (NASHP) Policy. The initiative runs through June 2027 and focuses on the Cumberland Plateau region. Goals include increasing awareness of maternity benefits, strengthening referral pathways, and developing recommendations for addressing care deserts.

Key takeaways from other states include:

- **California**: Framework and roadmap for maternity care transformation.
- **Iowa**: Alliance for Innovation on Maternal Health (AIM) Project and job simulator training.
- **MedStar DC**: "Safe Babies, Safe Moms" five-year initiative, a clinical and community partnership that addresses disparities in maternal and infant care.

Task Force Meeting Concludes and Closing Remarks

Dr. Karen Shelton, Commissioner, Virginia Department of Health (Co-Chair)

Dr. Shelton thanked participants and shared that VDH will soon launch a maternal health website hub. She reminded members that the next Task Force meeting will be held on October 29, 2025, from 10:00am – 12:00pm in Richmond at the Patrick Henry Building.

Maternal Health Data and Quality Measures Task Force Meeting Notes -- Draft

October 29, 2025

Patrick Henry Building, 10:00 a.m.- 12:00 p.m.

Members Present: Leah Mills (Chair), Dr. Karen Shelton (Co-Chair), Delegate Kimberly Taylor, Shannon Pursell, Melanie Rouse, Stephanie Spencer, Kelly Cannon, Eric Reynolds, Martin Brown, Leah Kipley, Glenda Knight, Amy Nelson (designee for Nicole Lewter), Jumelie Miller, Julie Bilodeau, Ann Russell, Tanya Callender, Dr. Louis Thompson, Kenda Sutton-El, Joely Mauck, Michael Perez (designee for Martin Brown),

Members Present Virtually: Tonya Adkins, Amy Hammond, Dr. Daphne Bazile, Craig Patterson (designee for Niki Cox), Dr. Lee Ouyang, Cheryl Roberts.

Health and Human Resources Staff: Jona Roka, HHR, Mindy Diaz, HHR; Cheryk, Oppa., HHR; Dane De Silva, VDH; Dr. Vanessa Walker-Harris, VDH; Rebecca Edelstein, VDH; Lauren Kozlowski,

Opening Remarks and Member Introductions: Leah Mills, Deputy Secretary of Health and Human Resources. Dr. Karen Shelton, Commissioner, Virginia Department of Health (Co-Chair). Sheldon Barr, President, Community Memorial Hospital

Deputy Secretary Mills opened the meeting by thanking everyone for being present and acknowledged that she was attending on behalf of the Secretary. She reminded participants that this was the final meeting of the Maternal Health Task Force and expressed her gratitude for everyone's time, input, and dedication throughout the process. Deputy Mills explained that most of the meeting would focus on a facilitated discussion led by Virginia Commonwealth University, designed to capture final insights and reflections from the group.

Deputy Mills extended special thanks to the Health and Human Resources (HHR) team, including Jona Roka, Mindy Diaz, and Cheryl Oppan, as well as to the Virginia Department of Health (VDH) and the Department of Medical Assistance Services (DMAS) teams for their consistent collaboration and support. She also provided an update on recent actions from Governor Youngkin's office, highlighting the launch of the Virginia Food Emergency Program, which will support approximately 850,000 SNAP recipients. She noted that this program will provide weekly, rather than monthly, benefits, and that the official launch is scheduled for Monday, with plans to continue through November.

Deputy Mills emphasized that the Governor has outlined three key pillars guiding this work: access to care, navigation of services, and the use of data to inform decision-making. She reiterated that data should drive where resources and interventions are directed, especially when addressing maternal health deserts across Virginia. Deputy Mills encouraged members to consider how existing programs can be supplemented rather than replaced. She also shared that all the feedback and discussion from today's session will be incorporated into the task force's final report.

Delegate Taylor was then introduced and recognized for her leadership and engagement on this issue. She expressed that maternal health is deeply personal to her due to her own experiences, and she thanked the task force for its efforts. Delegate Taylor emphasized that the data collected through this process will be critical in shaping future policy decisions. She also noted that, under Executive Order 12, the Commonwealth will be receiving additional funding to support rural health initiatives.

Dr. Shelton followed with her remarks, beginning by thanking everyone for their continued involvement and taking roll call. She expressed appreciation for the recent expansions in SNAP and WIC benefits and highlighted the Rural Health Transformation Program as an important opportunity through the Centers for Medicare & Medicaid Services (CMS). Dr. Shelton explained that this program involves a competitive application process and thanked Director Roberts for her leadership in developing several key initiatives, including Live Well Together, Connected to Care, Homegrown Heroes, and Care IQ. She concluded by emphasizing that strong and healthy communities begin with healthy mothers and healthy babies.

VDH Website: Dr. Karen Shelton, Commissioner, Virginia Department of Health

The directive of the task force continues to focus on bringing maternal health resources together from across Virginia. During the meeting, an update was provided on the launch of a new VDH maternal health website (available at vdh.virginia.gov). Dr. Shelton's presentation included slides highlighting the structure and features of the site. The website organizes information into six main topics, each with separate tabs that provide access to a wide range of resources. These include pregnancy and postpartum resources, resources for families and partners, resources for providers, and resources for community organizations. There is also a “Share Your Thoughts” link where visitors can submit feedback and ideas for improvement.

Dr. Shelton walked through the navigation of the website and demonstrated how to access the different sections. Under the Pregnancy Information tab, users can find a variety of educational materials and tools designed to support access to care. The Doula Resources tab provides both information for individuals seeking doula services and guidance for those interested in becoming certified doulas. The Provider Resources section contains educational materials and best practice information for healthcare professionals. She expressed her appreciation that these resources are now consolidated in one accessible location.

A brief data dashboard update was also shared during the presentation. The Maternal Mortality tab was highlighted, showing a decrease in maternal mortality rates over the past two years. This improvement reflects ongoing efforts and increased awareness around maternal health across the Commonwealth. The Maternal Mortality Review Team (MMRT) was recognized for its role in analyzing these outcomes and identifying contributing factors. The latest data indicate that Virginia reported 45 maternal deaths, with the majority due to natural causes. Although any loss is tragic, the decline in total cases is seen as a positive trend.

However, the data also revealed continuing disparities in outcomes for Black mothers and an increase in maternal mortality among other racial groups. Age remains a significant risk factor, and accidental deaths were reported to be primarily associated with overdoses. Many of the

current numbers have returned to pre-COVID levels, but the group acknowledged that there is still progress to be made. Additionally, severe maternal morbidity has been increasing, emphasizing the need for ongoing monitoring and prevention efforts. A new dashboard is under development to better reflect and categorize these trends, with the guiding principle that "what we measure, we can improve."

Facilitated Recommendations Discussion – VCU Center for Public Policy; Gina Barber, Director of Administration and Senior Consultant

Gina Barber began this portion of the meeting to further develop the recommendations for the final report. The facilitation included a mix of online and in-person participation. Members were asked to respond to a set of guiding questions for each of the five recommendations, writing their ideas on sticky notes and placing them on flip charts corresponding to each topic. This interactive activity allowed participants to collaborate and share diverse perspectives. Groups had about 30 minutes to complete the exercise before reporting out their key points and suggestions to the full group.

- Who is responsible? Who is being asked to take action? (organization, person, etc.)
- What is the action? What, specifically, are we asking them to do?
- Who is impacted? Who or what is on the receiving end of this action?
- Timeline: When does this need to happen?
- Authority: Is legislation required? If not, who is the decision maker or "owner" of the recommendation?
- Funding: Does this recommendation require funding? If yes, what potential funding sources exist?
- Data: What new data needs to be collected (or what available data needs to be published) to adequately address the recommendation and measure success?

<u>Recommendation 1: Create or Strengthen Programs to Ensure Continuity of Care</u>

Responsibility:
All providers who provide maternity care, hospitals and private practices, community health centers, VDH, EDCC Program, provider offices, VHI, VHHA, health systems, DMAS, DHP, MCOs, Urban Baby Beginnings, and the Virginia Neonatal Perinatal Collaborative.

Action:
Create processes that automatically share care data between Virginia providers, similar to the EDCC program. Ensure EDCC is gathering critical information, including the patient's primary care provider. Standardize responses to alerts across all hospitals, EDs, and care teams.

Engage outpatient providers (primary care, behavioral health, community services). Ability for ED to directly refer patients to providers for follow-up care through EMR. Establish a comprehensive outpatient patient-level database to share EMRs between providers. Evaluate current system integration and use cases. Create community referral guides. Research other states' approaches. Evaluate current and new programs to assess effectiveness and impact.

Impact:
Hospitals, providers, patients, families, and Project LINK programs.

Timeline:
Immediately, within a year.

Authority:
Not necessarily legislation; it can be implemented through EDCC.

Funding:
Yes, for database creation, integration, education, and promotion. Virginia Opioid Abatement Authority (OAA) may be a funding source.

Data:
Outpatient and readmission data, EMR access.

Comments / Discussion:
Gina Barber explained the activity for facilitation. Participants suggested creating a program or using an existing program to streamline efforts and ensure continuity of care between hospitals, obstetricians, midwives, and community providers. Emphasis was placed on standardizing alerts, engaging allocation providers, and evaluating program effectiveness. VHI was noted as a potential funding partner.

Recommendation 2: Expand and Invest in the Maternal Health Workforce

Responsibility:
Virginia Department of Health Professions (DHP), Virginia Health Workforce Development Authority, VDH, Community Colleges, Public Schools, Virginia Board of Health, VNPC, Tobacco Commission Education Grant Program, DBHDS Project LINK, Goodwill Industries.

Action:
Create a robust community health GME loan repayment program to attract more providers to community/rural health. Partner FQHCs with hospital OB practices. Expand roles of non-traditional or allied workforce (peers, doulas, community health workers). Provide incentives for providers to practice in rural areas. Expand training for OBs, nurse midwives, and ultrasound techs in rural areas with housing and transportation stipends. Expand the Levels of Care Assessment Tool (LOCATe) to survey birthing hospitals. Provide digital learning kits, rural

learning hubs, and simulation labs. Invest in multicultural workforce training. Evaluate workforce development needs and strategies.

Impact:
Community health centers, licensed and non-licensed professionals, and patients.

Timeline:
Now, to have an impact over the next 2–4 years, within the next 6 months.

Authority:
No legislation required.

Funding:
Additional funding may be needed for incentives, workforce expansion, training, and remote learning resources. The Rural Health Transformation (RHT) Program may be a source.

Data:
Current residency programs, length of rural commitments, percentage who stay beyond commitments, and staff turnover rates.

Comments / Discussion:
Discussion highlighted closing maternity care programs in rural areas and the need for mandatory rural rotations. Participants emphasized using schools of public health and other academic institutions to expand reach. Digital learning kits and simulation labs were suggested to improve rural training.

Recommendation 3: Strengthen Access to Care

Responsibility:
DMAS, VDSS, BEAD Program within the Virginia Office of Broadband, Unite Us, MCOs, FQHCs.

Action:
Train more rural FQHC providers. Establish mobile health programs and partnerships with rideshare companies. Partner with school-based health centers for on-site care. Pilot flexible/drop-in child care programs for parents attending medical appointments. Expand home visit programs. Use CHWs to provide local care and navigation. Create specialized pregnant women's units. Improve MCO members' understanding of transportation, child care, and broadband services.

Impact:
Low-income and uninsured patients, rural residents, patients without reliable transportation or broadband access, and caregivers balancing child care and health needs.

Timeline:
Planning should start immediately; ongoing implementation within one year.

Authority:
No legislation required.

Funding:
State budget appropriations or public-private partnerships may support transportation coordination, community health workers, and service providers. The BEAD Program may be a federal funding source.

Data:
Access metrics (missed appointments due to transportation or child care), participant satisfaction, health literacy outcomes, disaggregated by race, ethnicity, geography, and social determinants of health.

Comments / Discussion:
Stephanie Spencer noted that access to care and access to resources are two distinct actions that should be considered separately. Emphasis on evaluating current resources, identifying gaps, and understanding community capacity needs.

Recommendation 4: Collect and Publish Data on Fetal and Infant Health Outcomes

Responsibility:
VDH, in partnership with DMAS, VHI, Office of the Chief Medical Examiner, MCOs, VNPC, local providers, and FQHCs.

Action:
Partner with FQHCs and the Virginia Community Health Association to collect and publish data on fetal and infant health outcomes, including manner of death, stillbirths, demographics, substance use-related outcomes, and bereavement support. Collect data before, during, and after labor.

Impact:
All maternity patients.

Timeline:
Immediately.

Authority:
No legislation required; collaboration with VCHA is needed. Access to medical records may require additional authorization for VNPC's FIMR program.

Funding:
Funding is required for data collection and publication. VNPC's HRSA grant may be a potential source.

Data:
Stillbirths, fetal loss, infant loss, by locality and demographic; social needs and bereavement support.

Comments / Discussion:
Discussion emphasized evaluating bereavement tools in the community and hospital-based programs. Existing VMPc programs were noted as examples.

Recommendation 5: Track Primary Care Access for Prenatal and Postpartum Patients

Responsibility:
Prenatal care clinicians/offices, health systems, VDH, DMAS, MCOs, private insurance, ACOG.

Action:
Use multiple data sources, including Medicaid claims, enrollment files, EHRs, health information exchanges, and patient-reported surveys (e.g., PRAMS) to track primary care access and postpartum follow-up. Link birth certificate data with Medicaid and claims to evaluate care continuity.

Impact:
Mothers receiving prenatal and postpartum care.

Timeline:
Within a year.

Authority:
Not specified.

Funding:
Yes.

Data:
Primary care access, insurance acceptance, and patient-reported data on barriers and follow-up visits.

Comments / Discussion:
PRAMS funding status in Virginia was discussed; participants noted the need for infrastructure to support PCP access and universal interventions such as home visits, co-visits, and family-

centered education. Data collection should include perinatal substance use and postnatal exposures.

Garden Plot:

Garden Plot

Participants emphasized the importance of a universal intervention model offering services to all pregnant and postpartum women, including universal screening, education, postpartum community contact, and access to support services. Virtual participants highlighted that such a model can normalize preventive care and reduce stigma though it requires sufficient workforce and data systems to track uptake. In-person participants stressed the need for continued HRSA funding for the VNPC beyond 2028, family-centered co-visits, and expanded tracking of prenatal and postnatal substance exposure. Stronger partnerships with organizations like the Virginia Cannabis Control Authority, VDH, DMAS, Families Forward, and VHI were recommended, along with more training for providers on perinatal substance use and enhanced resources on the VDH maternal health website.

Task Force Meeting Concludes and Closing Remarks- Dr. Karen Shelton, Commissioner, Virginia Department of Health (Co-Chair)

In closing, Deputy Mills reminded the group that all of the work and discussion completed throughout the Task Force process will be encompassed in the final report. She emphasized that the recommendations presented during this meeting are meant to build upon the foundation of prior efforts and ongoing initiatives across the Commonwealth. Deputy Mills encouraged members to reflect on how these ideas connect to existing programs and policies and how they can inform the report's broader vision for maternal health improvement in Virginia.

Dr. Shelton reiterated that the work of the Task Force will continue to have an impact beyond the life of the group itself, serving as a guide for future action. He shared his optimism for what lies ahead, reaffirming the ultimate goal of achieving the healthiest babies and healthiest communities throughout Virginia.

As part of the next steps, Leah noted that the final report will include summaries of all presentations, not just the facilitation process. This will ensure that participant comments, concerns, and insights are fully represented. The team will also work to develop and refine recommendations that reflect the collective input gathered from discussions, data, and stakeholder engagement.

APPENDIX H – VIRGINIA'S MATERNAL HEALTH INITIATIVES

Virginia's Maternal Health Initiatives – 2022 to 2025

- **Marked Drop in Maternal Mortality**: Virginia's maternal mortality rates have dropped 68 percent since 2021.
- **Increasing Regional Postpartum Visits:** The Department of Medical Assistance Services (DMAS) increased postpartum OB/GYN visits for Medicaid members in Petersburg by 16 percent.
- **Investments in Doula Services:** Since 2022, 350 births have been supported by a doula, and 158 doulas are enrolled in Medicaid. In 2025, Governor Youngkin signed legislation to increase the number of postpartum doula visits from four to six.
- **Extending Medicaid Postpartum Coverage**: In 2022, Virginia extended postpartum coverage from 60 days to 12 months for Medicaid members. Since 2020, the postpartum visit rate has increased from 63.4 percent to 72.4 percent in 2023.
- **Increased Medicaid Rates for Obstetrics/Gynecology** Services: Governor Youngkin signed the 2022 Appropriations Act, and increased practitioner rates for obstetrics and gynecology services by 15 percent.
- **Implemented *Right Help, Right Now*:** In 2022, Governor Youngkin Announced the *Right Help, Right Now* Behavioral Health Transformation Plan, prioritizing behavioral health access, quality, and outcomes for all Virginians, which has included support for maternal-infant mental health initiatives, including support in the 2024 biennium budget for the expansion of VMAP Moms+, and highlighted supports for pregnant and parenting women with substance use disorders such as Project LINK.
- **Issued Executive Order 32:** Governor Youngkin signed Executive Order 32 re-establishing the Task Force on Maternal Health Data and Quality Measures, which aims to improve data collection, inform policies, and address maternal health disparities.
- **Issued Executive Directive 11:** Governor Youngkin signed Executive Directive 11 to support healthier pregnant women, mothers, and infants by improving and reporting actionable maternal health data. The data will assist policy makers, health care providers, and families.
- **Enhanced and Launched New Virginia Maternal Health Dashboards:** The Virginia Department of Health upgraded and launched two Virginia Department of Health data

dashboards aimed at offering actionable data on maternal mortality and pregnancy-associated deaths. One tracks maternal mortality and the other pregnancy-associated deaths — alongside an upgraded Maternal and Child Health (MCH) Dashboard that breaks down preterm birth, infant mortality, low birthweight and prenatal care data by region, race, and ethnicity. The data are designed to be used as a resource to establish best practices to assist mothers during pregnancy, birth, and postpartum.

- **Launched a Statewide Maternal Health Website**: VDH launched the Maternal Health website pursuant to Executive Directive 11 that provides resources and information for mothers, families, providers and organizations. The website combines maternal health resources from across state agencies and maternal health partners.
- **Increased Payments for Psychiatric and Obstetric-Gynecological Graduate Medical Residencies:** The supplemental payments for all qualifying obstetric-gynecological and psychiatric residencies was raised from $100,000 to $150,000 annually to increase applications and help grow the necessary workforce.
- **Provided $2.5 million to Fund Perinatal Health Hub Pilot Programs:** Funding was provided for increasing the number of perinatal health hubs throughout the Commonwealth. VDH, in collaboration with the Virginia Neonatal Perinatal Collaborative, will provide two-year grant awards for community-based providers (hubs) that will improve perinatal outcomes and reduce maternal and infant mortality in their communities.
- **Increased Access to Obstetric-Gynecological Services:** Introduced quarterly Saturday clinic hours at Bon Secours Southside Regional Hospital for Medicaid members in Petersburg. Since the inception of the project, postpartum visit rates have increased by 16 percent. INOVA Health Center also extended hours across the health system to increase access to expecting mothers.

Medicaid Member Focused Initiatives:

- DMAS created a comparison chart for pregnant and postpartum members that includes information on their enhanced benefits such as groceries, diapers, car seats etc.
- A pregnancy unit was created at DMAS' Cover VA. This unit connects pregnant women with coverage.
- DMAS revamped their social media strategy to reach more potentially eligible members and educate current members about their benefits.

- In August 2024, DMAS launched the "**Ask About Aspirin**" campaign to educate members and providers about low-dose aspirin as an intervention to reduce pre-eclampsia.
- DMAS is working with two MCOs through the CMS and Mathematica quality improvement project to reduce rates of maternal cardiovascular disease.
- DMAS is contracting with a mobile app vendor to provide Medicaid members increased access to information and resources regarding their pregnancy. All MCOs currently offer mobile apps to connect members with nurses, doulas and lactation counselors.
- In 2024 DMAS worked with the VHHA to ensure postpartum visits are a part of the hospital discharge process.

Highlighting Improvements in Petersburg's Maternal Health

- MCOs have contributed more than five million dollars to the Petersburg community, supporting over 1000 events since August 2022.
  - There are currently 35 state-certified, Medicaid approved doulas providing care in the Petersburg area.
  - Since the inception of the project, postpartum visit rates for Medicaid members residing in Petersburg have increased by 16 percent.
  - In November 2023, DMAS collaborated with Dr. Daphne Bazile of Bon Secours Southside to extend the OB/GYN Saturday clinic days. There have been six successful clinics with and over 100 members have been served. This has also enabled Dr. Bazile to hire additional providers.
  - Since the inception of the Partnership for Petersburg in 2022, Postpartum visits in Petersburg increased from 36% during Calendar Year 2022 to 49% in Calendar Year 2024, to 50% in Calendar Year 2024.

Urban Baby Beginnings opened a maternal health hub on April 12, 2023 to provide one-stop access to a range of maternal health services, with support from a **$825,000** grant over three years from the Anthem Blue Cross and Blue Shield