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State of Louisiana

Louisiana Department of Health
Office of Public Health

LOUISIANA COMMISSION ON PERINATAL CARE AND PREVENTION OF INFANT MORTALITY MEETING MINUTES

September 18, 2025
1:00 p.m. - 3:00 p.m.

Location:
Louisiana State Capitol
900 N Third Street
Baton Rouge, LA
Governor's Press Room

Meeting Minutes

I. Call to Order

a. The meeting was called to order at 1:12 PM by the Chair, Dr. Steve Spedale

II. Roll Call – Chair/Presiding Officer

a. Ten members were in attendance in-person, and a quorum was present.
b. Members in attendance included Dr. Scott Barrilleaux, Dr. Joseph Biggio, Dr. Karli Boggs, Representative Stephanie Berault, Ms. Aundria Cannon, Ms. Leslie Lewis, Ms. Erika Moss, Dr. Steve Spedale, Dr. Marshall St. Amant, and Ms. Amy Zapata.
c. Members not in attendance included Senator Regina Barrow, Dr. Courtney Campbell, Ms. Emily Stevens, and Dr. Rodney Wise.
d. Guests in attendance included Dr. Vincent Culotta, Dr. Peter Croughan, and Dr. Gillispie-Bell. Ms. Yoruba Baltrip-Coleman provided administrative support.

III. Perinatal Commission Statute/Charge Review- Louisiana Legislative Resolution RS 40:2018. Subsection F

a. The Chair reviewed the Perinatal Commission charge and operating guidelines found in Louisiana Legislative Resolution RS 40:2018, Subsection F, found attached to the back page of the agenda.

IV. Public Comment

a. The Chair reviewed the Perinatal Commission charge and operating guidelines found in Louisiana Legislative Resolution RS 40:2018, Subsection F, found attached to the back page of the agenda.

V. Approval of Meeting Minutes

a. The meeting minutes from July 17, 2025 were reviewed. Dr. Barrilleaux motioned for the meeting minutes to be approved, and Dr. Spedale seconded the motion. The Perinatal Commission members present approved the meeting minutes from the July 17, 2025 meeting unanimously.

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VI. Louisiana State Board of Medical Examiners (LSBME) Physician Demographics - Dr. Vincent Culotta, MD, Obstetrics & Gynecology

Dr. Culotta reported on the general physician population in Louisiana, with an emphasis on the population of interest to the Perinatal Commission, which includes obstetrics and gynecology (OB-GYN), pediatrics, family medicine, general practitioners and subspecialties in fetal, maternal, and the neonatal-perinatal physicians. The statistics are representative of the population through August 2025, and are based on numbers per 10,000 population using 2020 census in the denominator and based on reported numbers to the Louisiana State Board of Medical Examiners. One likely variable affecting the reporting include some "active" physicians actually being retired from practice but maintaining licensure. Efforts to combat this potential skew include adding a retired physician license class.

There were 22,102 total active licensed physicians practicing as of August 2025 in Louisiana, 17,623 medical doctors, (an increase of +1,132), 979 doctors of osteopathy, (an increase of +52), and 3,500 compact licensed physicians, (an increase of +1,092). There were 13,082 reported primary physician business addresses in Louisiana. Dr. Culotta presented data that broke down where physicians are concentrated by region. The highest percentage of physicians were concentrated in Region 1 (New Orleans) at 36%, Region 2 (Baton Rouge) at 15%. The lowest concentration of physicians were in Regions 3, 5 and 6, at 4%. Consistently across the board there were more physician representation in Regions 1 and 2, and overall there were more physician representation in those same regions when broken down according to medical specialty. Slides will be supplied upon request to members and attendees.

VII. Project M.O.M. – Dr. Peter Croughan, MD, Deputy Secretary for the Louisiana Department of Health (LDH)

Dr. Croughan presented follow up contextual information about the Louisiana State-wide focus on maternal child health prioritized by Project M.O.M., which stands for Maternal Overdose Mortality. As evidenced by the State Health Improvement Plan (SHIP), overdose is the number cause of death in pregnant women. Through Project M.O.M., LDH aims to reduce pregnancy-associated opioid overdose deaths by 80% within three years and protect infants from loss or foster care placement. The mission is to improve care and coordination for pregnant women with substance use disorder through policy, partnership, peer support, and practice transformation. Goals of Project M.O.M. are to, 1) Advance cross-agency collaboration; 2) Improve access to and coordination of prenatal and postpartum care, 3) Reduce stigma and improve access to and treatment for substance use disorder (SUD), and, 4) Increase patient engagement and retention in treatment programs.

Progress made since Project M.O.M. was announce in April 2025 has been significant. In May, a Director was hired, the Project M.O.M. landing page was published and the Journey Map was created. In July over 100 stakeholders were convened from every region across the state and Project M.O.M. was officially launched. Efforts for the remainder of the year will focus on developing the model for Project M.O.M. along with financial incentives to align stakeholders with the Project goals. Three catalyst sites for work began and efforts will continue to add sites before the end of the 2025. Continued collaboration is anticipated through stakeholders in the community, with providers, across hospitals, with community leaders, local government and governing agencies like Department of Child and Family Services (DCFS).

VIII. Medicaid Advisory Committee (MAC) Subcommittee Report Out – Dr. Steven Spedale, MD, FAAP, Infamedics President, Perinatal Commission Chair

Dr. Spedale provided information related to breastfeeding with respect to access to hospital grade breast pump availability, breastfeeding education, and a potential pilot program to

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increase breastfeeding and access to hospital grade breast pumps. Potential areas of impact include identifying and providing access to mothers of preterm infants, who typically do not have effective lactogenesis present compared to mothers of term infants. Prolonged use of a hospital grade breast pumps instead of personal purchase breast pumps or those provided through insurance is more beneficial in establishing milk supply. Identified areas for improvement include WIC's limited supply of hospital grade pumps, pumps supplied through Medicaid are not available until the mother is 32 weeks gestation, and those pumps not being hospital grade and taking longer than a week to obtain. Additionally, prescribing physicians must also document breastfeeding education, which does not reflect a real-world scenario, as the prescribing provider at 32 weeks would usually be an obstetric provider and breastfeeding education normally falls to a lactation consultant (mainly hospital-based) or a pediatric provider.

Efforts for improvement include building capacity to those hospitals that have or are exploring breast pump loaner programs, with some hospitals receiving grants to purchase hospital grade pumps to be loaned to the mother at birth. Other hospitals lease hospital grade pumps to mothers who are not WIC or Medicaid eligible with the agreement that the pump will be returned at the end of use. The workgroup suggested that pilot program with input from LDH and Louisiana Medicaid Managed Care Organizations be organized. Early steps for this pilot program would include: surveying all Level III/IV NICU on the existence of a donor program at their facility; reviewing MCO current breast milk population and type of pump provided to lactating mothers; measuring the impact of more timely availability of hospital grade breast milk pump on breastfeeding rates in the VLBW population; and trending the use of donor milk and potential cost savings associated with an improvement in breastfeeding rates.

IX. LaPQC Initiatives Update and Perinatal Transfer Workgroup Update – Dr. Veronica Gillispie-Bell, Bureau of Family Health (BFH) Medical Director for Louisiana Perinatal Quality Collaborative (LaPQC) and Pregnancy-Associated Mortality Review (PAMR) and Ochsner Health obstetrician-gynecologist

Dr. Gillispie-Bell provided a brief overview of the five LaPQC Initiatives, The Gift, Safe Births Initiative, Community Birth Initiative, Caregiver Perinatal Depression Screening (CPDS) and Obstetric Readiness in Emergency Departments (ORED).

a. The Gift – the Gift is focusing on three subgroups: The Gift 3.0, Optimizing Newborn Care and the Substance Exposed Dyad. The Gift 3.0 is focusing on implementing and sustaining ten steps for optimizing breastfeeding with the goal that by December 2026, all participating birthing facilities will achieve a breastfeeding initiation rate of 80% and a breastfeeding exclusivity rate of 50% across all racial and ethnic groups. The ten steps include: breastfeeding policy, staff education, patient education, assistance with initiation, teaching maintenance, providing only breastmilk, rooming-in, feeding on demand, avoiding artificial nipples, and fostering support groups. Optimizing Newborn Care (ONC) includes a goal to by December 2027, the percentage of infants in the NICU/Special Care Nursery who are receiving breastmilk at discharge from direct breastfeeding, expressed breastmilk, or donor human milk will increase by 10% from baseline across all racial/ethnic groups in participating facilities. The goal for the Substance Exposed Dyad states that by December 2026, 80% of participating facilities will implement evidence-based practices around the care of the substance-exposed newborns by using non-pharmacologic care and family centered care to decrease length of stay by 1-day.

b. **Safe Births Initiative** – Goals for this initiative are by December 31, 2026, decrease the severe maternal morbidity (SMM) among patients experiencing substance use disorders (SUD) by 20% and by December 31, 2026, 85% of patients being discharged from a birth hospitalization have a scheduled postpartum visit prior to discharge. The Postpartum

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Transition involves efforts to universally screen for social determinants of health and referral to resources, educate on Maternal Urgent Warning Signs, schedule postpartum visits for outpatient obstetrical care, ongoing specialist care, and community supports and services. Improving Care for the Substance-Exposed Dyad (ICSED) 2.0 include universally screening for substance use disorder, referring to treatment, providing training for staff and clinicians (anti-stigma, pathology, respectful care), and expanding overdose prevention and naloxone distribution efforts. Care efforts are also aimed at improving discharge care coordination by working with community partners, creating a clinical, technical assistance warm-line staffed by addiction care professionals, and employing one to two perinatal substance use navigators to provide coordinated care an build family-based referral systems between clinics, hospitals, SUD treatment providers and peer support networks.

c. **Community Birth Initiative** – Goals for this initiative state that by December 2025, 90% of Free-Standing Birth Centers (FSBCs) will have policies, protocols and procedures related to readiness, recognition and response to postpartum hemorrhage, and by December 2025, 90% of FSBCs will have policies, protocols and procedures related to readiness, recognition and response to neonatal emergencies. Three objectives from these goals include improving readiness in Free-Standing Birth Centers, improve readiness in hospitals for community birth and to improve collaborative care through multi-disciplinary drill training and education.
d. **Caregiver Perinatal Depression Screening (CPDS)** – Goal of this initiative is by the end of 9 months, participating clinics will implement best practice guidelines for screening by screening 90% of caregivers at the 1mth, 2mth, 4mth, and 6mth well child visit, and develop processes for screening, referral to treatment and warm handoffs and connecting 80% of caregivers who had a moderate to severe range on a validated depression screening tool. This initiative with be co-implemented with The Bureau of Family Health's Pediatric Programs (development screening, care coordination, and medical home), and the Health Resources and Services Administration (HRSA)-funded Provider to Provider Consultation Line (PPCL).
e. **Obstetric Readiness in Emergency Departments (ORED)** – the aim of this initiative is to by By the end of the 9 months, participating clinics will implement best practice guidelines for screening by screening 90% of caregivers at the 1mth, 2mth, 4mth, and 6mth well child visit and develop processes for screening, referral to treatment and warm handoffs and connecting 80% of caregivers who had a moderate to severe range on a validated depression screening tool. Areas of focus include screening for pregnancy and lactation status and implementation of best practices for screening, diagnosing, and treating severe hypertension.
f. **Perinatal Transfer Workgroup** – Purpose of the workgroup is to support the development of maternal and neonatal transfer protocols to ensure safe transitions of care from community birth to hospitals. The workgroups goals are to: improve the whole person safety and efficiency of the transfer process through the establishment of (state) system-wide maternal and neonatal protocols, collect and analyze qualitative and quantitative transfer data for the purpose of quality improvement, and finally, to inform efforts and make recommendations to build greater collaboration between community-based midwives, Emergency Medical Services, and hospital care teams and enhance the patient experience of care when transfers occur. The vision for the Perinatal Transfer Workgroup is to create a protocol that can be adopted through collaboration between midwives and hospitals that identifies conditions for transfer (maternal and newborn), create a template for maternal and newborn documentation for transfer, create a template for what is communication prior to transfer, create expectations for hospitals for respectful, inter-professional collaboration and communication. The Workgroup has developed

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Louisiana Maternal Transfer Form, Louisiana Newborn Transfer Form and the SBAR Form (transfer for community to hospital). The Workgroup is currently working with existing FSBC and OB Hospitalist Group to socialize this concept and prepare for them to test out protocol once created.

X. Public Comment

a. The Chair called for public comments. There were no public comments.

XI. Announcements

a. Perinatal Commission Vacancies – Ms. Baltrip-Coleman reported that two vacancies remain on the Perinatal Commission: one Neonatologist and one Family Practice Physician vacancy. Ms. Baltrip-Coleman submitted a list of seven names, three for the Neonatologist position and four for the Family Practice position, to the Boards Councils and Commissions Strategy and Operations Lead, Jasmine Thomas, for review. Ms. Thomas forwarded the list for escalation to the Governor for nomination. There were three applicants for the Neonatologist vacancy and four applicants for the Family Practitioner vacancy. There has been no status change.

b. The next Perinatal Commission Meeting will be held on January 15, 2026 at Dr. Spedale's office at Woman's Hospital in Baton Rouge.

XII. Adjournment 2:43

a. Dr. Barrilleaux motioned to conclude the meeting, seconded by Dr. St. Amant. The meeting adjourned at 2:443P.M.

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The Commission will undertake all of its responsibilities assigned by Louisiana Legislative Resolution RS 40:2018. Subsection F. outlines the functions of this Commission to: §2018. Commission on Perinatal Care and Prevention of Infant Mortality; maternal and infant mortality studies; confidentiality; prohibited disclosure and discovery

A. There shall be established within the Louisiana Department of Health, a commission which shall be designated the "Commission on Perinatal Care and Prevention of Infant Mortality", composed of sixteen members, as provided in Subsection B of this Section.

1. Research and review all state regulations, guidelines, policies, and procedures that impact perinatal care and, when appropriate, make recommendations to the secretary of the Department of Health and Hospitals.
2. Research and review all state laws that impact perinatal care and, when appropriate, make recommendations to the legislature.
3. Accept grants and other forms of funding to conduct maternal and infant mortality studies
4. Contract, in accordance with the applicable provisions of state law, for the performance of maternal and infant mortality studies

Note: the order of the agenda may not be followed as listed in order to accommodate presenter schedules.

Presenters, members, and guests may submit requests for accessibility and accommodations prior to a scheduled meeting. Please submit a request to PerinatalCommission@la.gov at least 48 hours prior to the meeting with details of the required accommodations.

In lieu of verbal public comment, individuals may submit a prepared statement in accordance with Senate Rule 13.79. Statements should be emailed to PerinatalCommission@la.gov and must be received at least 24 hours prior to the meeting to be included in the record for the meeting.

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