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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

May 21, 2026
1:00 p.m. - 3:00 p.m.

Virtual Meeting Anchor Location:
Woman's Hospital, 3rd Floor, Support Building,
500 Rue de la Vie, Suite 305
Baton Rouge, LA 70817

I. Call to Order

a. The Chair, Dr. Steve Spedale, called the meeting to order at 1:05 PM.

II. Roll Call – Chair/Presiding Officer

a. Nine members attended and a quorum was present.
b. Members in attendance included Dr. Scott Barrilleaux, Dr. Karli Boggs, Representative Stephanie Berault, Ms. Aundria Cannon, Ms. Leslie Lewis, Ms. Erika Moss, Dr. Steven Spedale, Ms. Emily Stevens, Ms. Amy Zapata.
c. Five members not in attendance included Senator Regina Barrow, Dr. Joseph Biggio, Dr. Courtney Campbell, Dr. Rodney Wise, and Dr. St. Amant.
d. Guests in attendance included Ms. Cheri Johnson, Ms. Allison Champagne, Ms. Elizabeth Fontenot, Mr. Matthew Wallace, Ms. Berkley Durbin, Ms. Rebecca Majdoch, Ms. Ashley Coates, Dr. Veronica Gillispie-Bell, and Ms. Driana Pommier.

III. Perinatal Commission Statute/Charge Review- LA.R.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 asked for public comment. There was no public comment.

V. Approval of Meeting Minutes

a. Perinatal Commission members reviewed the meeting minutes from March 19, 2026. Dr. Barrilleaux motioned for the meeting minutes from March 19, 2026, to be approved. Dr. Boggs seconded the motion. The Perinatal Commission members approved the meeting minutes from March 19, 2026, unanimously, as is, with no nays.

VI. Department/State Updates – Surgeon General Griffin Check-in

a. Ms. Driana Pommier attended as Surgeon General Griffin's proxy. There were no updates from the Surgeon General's office.

VII. Perinatal Commission annual chair election and vote

a. The Chair informed the Perinatal Commission members that it was time to nominate and vote for the chair position and called for nominations for the position. Dr. Barrilleaux nominated Dr. Spedale. No other nominations were made. Dr. Barrilleaux motioned for Dr. Spedale to continue as Perinatal Commission Chair for the next year, seconded by Ms. Lewis. Perinatal Commission members voted unanimously, and Dr. Spedale will continue as Perinatal Commission Chair until May 2027.

VIII. 2020 – 2022 Pregnancy-Associated Mortality Review (PAMR) Report Review of Data – Dr. Veronica Gillispie-Bell, Bureau of Family Health (BFH) Medical Director for Louisiana Perinatal Quality Collaborative (LaPQC) and PAMR, and Ochsner Health obstetrician-gynecologist

a. Louisiana began reporting and collecting Maternal Mortality Review data in 2008. Since then, information in two-to-five-year blocks has been collected and reviewed through 2022. The Louisiana Pregnancy Associated Mortality Review (PAMR) Committee reviews all pregnancy-associated deaths, works to understand the drivers of maternal mortality, complications of pregnancy, and disparities, determines interventions at the level of individuals, families, providers, birthing facilities, health systems, and communities that can lead to prevention, and informs initiatives to improve maternal outcomes in Louisiana. The PAMR Committee review process begins with case identification then moves to case selection, abstraction, informant interviews, case narrative development, care review presentation, data entry, data analysis and finally to prioritization and dissemination.
    i. Key decision questions for the Committee include: (1) Was the death pregnancy-related? (2) What was the underlying cause of death? (3) Was the death preventable? (4) What factors contributed to the death? (5) If there was at least some chance that the death could have been prevented, what were the specific and feasible actions that, if implemented or altered, might have changed the course of events?
    ii. Additional tools for review include informant interviews, which amplifies family and loved ones' voices and provides qualitative data to be included in the review of pregnancy-associated deaths.
        1. The Utah Tool assists in determining if a death from accidental overdose or suicide is related to the pregnancy. The Utah Tool is a checklist of standardized criteria to facilitate determination of pregnancy-relatedness for suicide and drug-related deaths. The tool guides abstractors in what information to include in the case narrative. The tool assists committee members in determining whether such deaths could be considered pregnancy-related. Note: If a case meets at least one of the criteria on the checklist, it suggests that the case was related to or aggravated by the pregnancy or its management, meaning the case could be considered pregnancy-related.
        2. Louisiana Bias or Racism and Social Determinants of Health (LABoRS) Tool assists in determining if bias, discrimination, racism, and/or social determinants of health contributed to a death. The tool provides a standardized process to help committee members build consensus around whether bias, discrimination, racism, and/or social determinants of health contributed to a death. The tool supports the broader identification of contributing factors and the development of actionable recommendations that address factors related to social determinants of health, including those related to bias, discrimination, and/or racism. The tool is comprised of four sections: demographics, social determinants of health and social/emotional stress identified

during abstraction, case findings checklist, and a community vital signs dashboard.

a. The Community Vital Signs (CVS) Dashboard was developed by the CDC, in partnership with Emory University, to help Maternal Mortality Review Committees (MMRCs) consider the social and environmental factors that may have impacted a woman's life. The CVS Dashboard also examines data indicators across several domains and compares the decedents community's environmental risks to the rest of Louisiana and to the U.S.

b. **Pregnancy-associated death** is a death that occurs during or within one year of pregnancy, regardless of the cause. Pregnancy-associated death is an umbrella term that includes pregnancy-related deaths, pregnancy-associated but not related, deaths, and pregnancy-associated, but unable to determine relatedness, deaths. **Pregnancy-related death** is a death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by the pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. An example cause of death is eclampsia. **Pregnancy-associated but not related death** is a death during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy. An example cause of death is unintentional motor vehicle collision. **Pregnancy-associated but unable to determine relatedness** is a pregnancy-associated death where the cause of death is unable to be determined as "pregnancy-related" or "pregnancy-associated but not related." An example cause of death is suicide.

c. From 2020-2022, Louisiana had 222 confirmed pregnancy-associated deaths. This represents a pregnancy-associated mortality ratio of 129.8 deaths per 100,000 births. 69% of those deaths were pregnancy-associated, but not related, 23% of those deaths were pregnancy-related, and 8% of the deaths were pregnancy-associated, but unable to determine pregnancy-relatedness. The highest cause of pregnancy-associated deaths was attributed to drug overdose, with 47 pregnancy-associated, but not related deaths, five pregnancy-related deaths, and six pregnancy-associated, but unable to determine pregnancy-relatedness deaths. The second highest cause of pregnancy-associated death was attributed to motor vehicle collisions. 27 deaths were pregnancy-associated but not related and two deaths were pregnancy-associated, but unable to determine pregnancy-relatedness. The third leading cause of pregnancy-associated death was due to homicide, with 25 of those deaths being pregnancy-associated, but not related, one death was pregnancy-related and two deaths were pregnancy-associated, but unable to determine pregnancy-relatedness. Of the leading causes of pregnancy-related deaths, 12 deaths were attributed to COVID-19, nine were due to cardiovascular conditions, and seven from cardiomyopathy. Of the reported pregnancy-related deaths, 18 % occurred during pregnancy, 51% occurred zero to 42 days after pregnancy, and 31% occurred 43 days to one year after pregnancy. 88% of pregnancy-related deaths were preventable. 41% were due to obesity, 22% due to substance use disorder, 20% due to mental health conditions, and 8% due to discrimination. The leading cause of pregnancy-associated, but not related, deaths was due drug overdose, with 24% occurring during pregnancy, 9% occurring 0-42 days after pregnancy and 67% occurring 43 days to one year after pregnancy. 85% of those deaths were determined to be preventable, with 40% attributed to substance use disorder (SUD), 16% due to mental health conditions, 10% to obesity, and 2% attributed to discrimination. The top five psychosocial risk factors that contribute to drug overdose and suicide included history of substance use, pre-existing mental health conditions, unemployment, history of treatment for substance use, and child protective services involvement. Other risk factors included history of domestic violence, recent trauma, unwanted pregnancy, history of childhood trauma and having a prior suicide attempt.

d. Priority areas for prevention aim to (1) Reduce the number of pregnancy-associated deaths from drug overdose and suicide by improving screening for substance use disorders and perinatal mood and anxiety disorders, implementing evidence-based treatments, and expanding access to overdose prevention strategies. (2) Improve screening for and address social determinants of health, including community and social well-being, and design solutions that improve care coordination and access to care, especially in the fourth trimester. (3) Implement strategies and programs to reduce harm by decreasing interpersonal and community-level violence and improving vehicular safety. (4) Implement strategies to ensure patient-centered care for all women who are pregnant and/or giving birth. (5) Improve clinical quality of care by increasing provider knowledge on the leading conditions impacting maternal morbidity and mortality. Intervention points aimed at preventing maternal mortality included policy makers, insurance payers, government and public health agencies, healthcare professionals, healthcare systems, and social and local community organizations.

e. Preventing maternal mortality involves implementing policies that support a strong system of care, increased clinical and systems change, and monitoring maternal outcomes. The Louisiana Pregnancy-Associated Mortality Review (PAMR), the Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS), the Violence and Injury Prevention Program, and the Domestic Abuse Fatality Review (DAFR) monitor maternal outcomes.

f. Efforts currently supporting clinical and systems change include the Louisiana Perinatal Quality Collaborative (LaPQC), the Louisiana Provider-to-Provider Consultation Line (PPCL), Transforming Maternal Health Grant (TMaH), and the Maternal Health Innovation Grant (MHI). Supportive services for families include the Louisiana Maternal, Infant, and Early Childhood Visiting Program and the Reproductive Health Program.

g. Policies that enable strong systems of care:
   i. **Act 122 (2024 Legislative Session)** – Requires all hospitals and birthing centers that provide labor and delivery services, prior to discharge following birth, provide the mother and her family members information about post-birth warning signs, including symptoms, and available resources.
   ii. **Act 77 (2025 Legislative Session)** – Removes exceptions for certain hospitals to meet the requirement of maintaining in-house obstetric anesthesia personnel on a twenty-four basis.
   iii. **Act 437 (2025 Legislative Session)** – Requires healthcare providers issuing routine prenatal care to screen for substance use disorder during the first prenatal visit using a validated verbal screening tool.
   iv. **House Concurrent Resolution 113 (HCR 113) (2024 Legislative Session)** – Creates a task to study the implementation and impact of the Family Connects model of postpartum newborn nurse home visiting in Louisiana and other states. HCR 113 also aims to develop policy and funding recommendations to implement the Family Connects model in this state, to provide for the composition and duties of the task force, and to report findings to the Louisiana Legislature.
   v. **Act 190 (2025 Legislative Session)** – Requires health coverage plans delivered or issued for delivery in Louisiana that provides benefits for maternity services shall include coverage for voluntary home visiting services provided through a home visiting program.

The Louisiana Pregnancy-Associated Mortality Review 2020-2022 Report is available on the Partners for Family Health Louisiana website at 2020-2022-PAMR-Report.

IX. Public Comment

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

X. Pregnancy Risk Assessment Monitoring Systems (PRAMS) Survey Overview – Ms. Rebecca Majdoch, Data to Action Team Lead, Louisiana Department of Health (LDH), Office of Public Health (OPH), Bureau of Family Health (BFH)

a. The Louisianan Pregnancy Risk Assessment Monitoring System (PRAMS) is funded by the Center for Disease Control (CDC) and was developed in 1987 to reduce infant morbidity and mortality. Louisiana joined in 1997 and was first funded in 2000. PRAMS is an ongoing, population-based risk factor surveillance system designed to describe selected maternal behaviors and experiences that occur before and during pregnancy, as well as during a child's early infancy. PRAMS is conducted in phases and is currently in phase nine. PRAMS uses standardized data collection procedures and questionnaires. The Pregnancy Risk Assessment Monitoring System samples women who had a recent live birth. Women are randomly drawn from the birth certificate file. Women from some groups are sampled at a higher rate to ensure enough data is available. Women complete the surveys by mail, web, and telephone using a standard protocol and questionnaire. Participation in the study is entirely voluntary, and every woman selected to complete the survey has the right to refuse without loss of any services.

b. PRAMS Phase Nine questionnaire design consisted of a mail-in 14-page booklet in a two-column format with shading. Question types included (1) core questions that were utilized by all sites and couldn't be changed, (2) site-specific standard questions developed and tested by the CDC and site-developed and tested by states, and (3) supplement questions reflecting emerging issues and priority topics. Selected core question topics in Phase Nine included content of preconception, prenatal, and postpartum provider discussions, unintended pregnancy, contraception, health insurance, Medicaid and Supplemental Nutrition Program for Women, Infants, and Children participation, cigarette smoking and alcohol use, maternal depression and anxiety, physical abuse, breastfeeding, infant sleep environment, income, social drivers of health, and racism and discrimination. Linked birth certificate variables (using the terminology on the birth certificate), such as age of the mother and father, race and ethnicity, education, marital status, infant birthweight, infant gestational age, and parity were also included.

c. The PRAMS questionnaire is mailed to approximately 200 Louisiana women each month (approximately 3.0% of live births in the state). After the birth year ends, the CDC weighs the data and returns it for the Bureau of Family Health to analyze. Information collected by the Louisiana PRAMS is used by health professionals, policymakers, and researchers to develop and modify programs and policies designed to improve the health of mothers and infants. PRAMS provides quantitative and qualitative data on: (a) factors that influence pregnancy outcomes**;** (b) mothers' experience of pregnancy complications; and (c) mothers' experiences and behaviors after the baby is born. Statements from women that can provide insights beyond the numbers, ,can be used to add women's voices and perspectives to the topics. Louisiana has participated in topic-specific supplements. Most recently the non-clinical drivers of health, called social determinants of health for this supplement, as part of the questionnaire for 2022 births.

d. PRAMS has a five-year cooperative agreement with the CDC. The most recent five-year agreement was May 2021-April 2026. The CDC funded a one-year supplement to extend data collection through April 30, 2027 for the 2026 birth year. The program is finalizing 2025 data collection and beginning to collect 2026 data while is still waiting for 2024 weighted data from the CDC.

e. Data products produced, including Louisiana PRAMS data, can be found at Louisiana PRAMS. The 2020-2022 surveillance report is being finalized, and the annual data report through 2022 can be accessed at Louisiana PRAMS Data Report 2022. A new 2023 data dashboard, which includes phase nine data can be found on the 2023 Data Dashboard.

Data requests for the Data to Action Team can be made via the Data Center Requests link.

f. Ms. Majdoch also reported findings from the **2022 PRAMS Social Determinants of Health Supplement**. The goal was to utilize the maternal and infant social determinants of health supplement data from 2022 to evaluate racial disparities in four key areas. Those domains evaluated economic stability, social and community context, health and health care and neighborhood and built environment. The program used descriptive analysis and logistic regression modeling to estimate the difference in outcomes based on the race of those that responded. Economic stability included topics like living situation, living needs not being met, obtaining balanced meals and needing food but being unable to buy it. Community context included topics such as discrimination experience related to race and ethnicity and access to needed support. Health and health care topics included access to needed mental health care services during the postpartum period, reasons for not getting services, understanding of explanations by providers, and postpartum stress. The final domain of neighborhood and built environment examined the lack of reliable transportation. 601 mothers responded and of those, 36% were Black and 65% were non-Black, 52% were insured by Medicaid, 56% were between the ages of 25-34, 51% were married, 19% lived in a rural area, and 62% had a previous live birth. The study found statistical differences in two domains. From domain two, health and health care, Black mothers were two times more likely to feel that they were treated badly or unfairly because of their race/ethnicity. Neighborhood and built environment, domain three, concluded that among those needing mental healthcare, Black individuals had 2.3 times higher odds of not being able to get mental health services. There were no reported statistical differences among the other domains. Reported study limitations included one year of data with a small sample size (601 respondents), overall response rate (weighted, 49.2% response rate), which is below the 50% CDC threshold at 47% in Black respondents vs. 50.4% in Non-Black respondents, the inability to use multiple-year data due to questions varying in yearly questionnaires, and limited statistical power due to small sample size. A copy of the PRAMS report is available upon request.

XI. Legislative Updates – Ms. Ashley Coates, Senior Advisor to the Bureau of Family Health Director

a. Ms. Coates reminded attendees that session began on Monday, March 9, 2026, and that it would adjourn no later than Monday June 1, 2026 at 6:00 PM. She then discussed how a bill becomes a law in Louisiana by successful vote and passage through both the House chamber and the Senate chamber. A bill is introduced in one chamber for a first reading, and after a third reading goes to the floor for a vote and upon final passage, goes to the next chamber for three more readings before a vote on the final passage there. After returning to the originating chamber and passing any amendments, the bill goes to the Governor to either be signed, vetoed, or the Governor can decide to neither sign nor veto the bill.

b. There were eight (8) House bills relevant to the Perinatal Commission and its work, and there were six (6) Senate bills relevant to the work of the Perinatal Commission. Maternal and infant health related instruments originating in the House were HB 222 (Rep. Stephanie Berault); HB 779 (Rep. Aimee Adatto Freeman); HB 1141 Rep. Terry Landry Jr.); HB 1231 (Rep. Stephanie Berault); HR 161 (Rep. Joy Walters); HR 192 (Rep. Annie Spell); HR 284 (Rep. Annie Spell); and 110 (Rep. C. Denise Marcelle). Maternal and infant health related instruments originating in the Senate were SB 30 (Sen. Patrick McMath); SB 32 (Sen. Patrick McMath); SB 66 (Sen. Valarie Hodges); SB 451 (Sen. Caleb Kleinpeter); SB 470 (Sen. Beth Mizell); and SR 114 (Sen. Brach Meyers). A copy of the bill presentation is available upon request. Proposed bills are on the Louisiana State Legislature website.

XII. Other Business

a. There were no Perinatal Commission vacancy updates, and the family practitioner and neonatologist vacancies remain unfilled.

XIII. Announcements

a. The next Perinatal Commission meeting will be July 16, 2026 in Baton Rouge at the State Capitol in the Governor's Press Room.

XIV. Adjournment

a. Ms. Zapata motioned to adjourn the meeting, seconded by Ms. Cannon. The meeting adjourned at 2:46 PM.

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.