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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

July 16, 2026
1:00 p.m. - 3:00 p.m.
Location:
Louisiana State Capitol, Governor's Press Room
900 N Third Street
Baton Rouge, LA. 70804

I. Call to Order – Chair/Presiding Officer

a. The Chair, Dr. Steve Spedale began the meeting at 1:09 PM.

II. Roll Call – Chair/Presiding Officer

a. Three members attended, and a quorum was not present.
b. Members in attendance included Ms. Erika Moss, Dr. Steve Spedale, and Dr. St. Amant.
c. Members not in attendance included Dr. Scott Barrilleaux, Senator Regina Barrow, Dr. Joseph Biggio, Dr. Karli Boggs, Representative Stephanie Berault, Dr. Courtney Campbell, Ms. Aundria Cannon, Ms. Leslie Lewis, Ms. Emily Stevens, Ms. Amy Zapata, and Mr. Rodney Wise
d. Guests in attendance included Ms. Brittany Williams, Ms. Kiley Mayheld, Dr. Victoria Williams, Ms. Shatamia Webb, Ms. Kiersten Gillette-Pierce, Ms. Divine Bailey-Nicholas, Ms. Grace Jackson, Ms. Meshawn Siddiq, Ms. Frankie Robertson, Surgeon General Dr. Evelyn Griffin, Dr. Pete Croughan, Ms. Nanette McCann, Mr. Matthew Wallace, Ms. Rebecca Majdoch, Ms. Berkley Durbin, and Ms. Ayesha Umrigar. Ms. Baltrip-Coleman, Perinatal Special Projects Manager, served as administrative support for the meeting.

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 Revised Statute 40:2018, Subsection F, attached to the back page of the agenda and accessible here at RS 40:2018.

IV. Public Comment

a. The Chair asked for public comment. There was no public comment.

V. Approval of Meeting Minutes

a. The Perinatal Commission members did not approve the meeting minutes from May 21, 2026, because a quorum was not present.

VI. Surgeon General Griffin Check-in

Surgeon General Griffin reminded attendees about the work being done in rural communities, specifically with the Rural Health Transformation Program. She

directed attention to workforce development to increase access to care in those rural areas of the state. One current option beginning to be explored aims to increase and improve training for entry-level health care workers, with the goal of establishing a more robust community-level workforce. Additionally, her office is examining opportunities to entice physicians working in Louisiana to remain here and decrease medical migration to other states.

VII. Data to Action Check-in/Updates – Ms. Rebecca Majdoch, Data to Action Team Lead, Louisiana Department of Health – Bureau of Family Health

a. When Chair Spedale deferred to her or anyone with a data related question, there was none. Ms. Majdoch said that she serves as a data information resource and attended in case data-related questions or needs arose, in which case she would help clarify the specific needs and provide suggestions on where to find the data, or if her Data To Action Team could potentially provide the data.

VIII. Project Maternal Overdose Mortality (M.O.M.) Updates and Implementation – Dr. Pete Croughan, Deputy Secretary

a. Dr. Croughan provided a snapshot of maternal mortality data to reflect pregnancy-associated deaths in Louisiana. Based on the Pregnancy-Associated Mortality Review (PAMR) Report published in April 2026, 2020-2022-PAMR-Final Report, drug overdose was the leading cause of death at 35%, with substance use disorder a contributing factor at 40%. The pregnancy-associated ratio per 100,000 live births, broken down according to Louisiana's nine regions, shows the highest numbers of deaths to be concentrated in Regions 2 (Baton Rouge area), 7 (Shreveport area), 8 (Monroe area) and 6 (Alexandria area) with 187.9, 184.8, 155 and 130.9 respectively. The Project MOM vision is to achieve an 80% reduction in overdose deaths among pregnant and postpartum women in Louisiana within three years.

b. Project MOM aims to support compassionate, person-centered conversations with pregnant women who use illicit drugs, tobacco, or other substances by promoting respectful, nonjudgmental discussions about health and treatment options. Project MOM helps create opportunities for supportive conversations between women and health care providers that builds trust, creates opportunities for supportive conversations, reduces stigma, and connects patients with evidence-based care. Acknowledged barriers to overcome include reducing stigma, bias and patient fear limit disclosure and engagement, inconsistent or absent universal screening practices, fragmented systems across obstetric, emergency departments behavioral health and community care, limited access to medications for opioid use disorder (MOUD), lack navigation and longitudinal postpartum support, and limited access to perinatal support, education, and evidence-based programs – prenatal through postpartum.

c. The Project M.O.M. Framework consists of four coordinated, person-centered, judgment-free components:

- Talk, identify and engage – involves starting the conversation, building trust and opening the door to care. Talking aims to reduce stigma and create safe spaces for disclosure, providing universal, evidence-based verbal screening across maternal care settings, and identify early opportunities for compassionate engagement in care.
- Care and deliver evidence-based treatment – involves providing the right treatment, supporting recovering and saving lives. Efforts are aimed at integrating obstetric substance use disorder (SUD) behavioral health and primary care across the perinatal continuum, provide timely access to MOUD and clinical pathways and offer naloxone distribution and overdose prevention.
- Connect Navigate & Coordinate – involves removing barriers, coordinating care and ensuring that no woman falls through the cracks. Efforts are aimed at the M.O.M. Care Team, a coordinated network of hospital-based and regional navigators, and providing personalized, compassionate support with timely intervention, warm handoffs, and ongoing care coordination.

- Thrive and sustain outcomes – involves providing support today, strengthening tomorrow and helping families thrive. Efforts are aimed at improving maternal and infant health outcomes, sustained recovery and engagement through first year postpartum, resulting in stronger families through stability, support, and family preservation.

d. The implementation strategy incorporates a catalyst site strategy by accelerating implementation of evidence-based maternal SUD care and an integrated care navigation strategy that connects women, providers, hospitals, and community services through the MOM Care Team. These two implementation strategies are aimed at improving maternal and infant outcomes.

e. Advancing Evidence into Practice – Project MOM builds on the foundation established through the Louisiana Perinatal Quality Collaborative (LaPQC) by expanding implementation beyond traditional quality improvement teams to engage multidisciplinary providers, hospital staff, and community partners in advancing integrated systems of care for pregnant and postpartum women with SUD beyond hospital walls. Along with the LaPQC focus on evidence-based best practices, Project M.O.M. supports implementation through Catalyst Sites and providing regional technical assistance. In conjunction with the LaPQC focus on quality improvement resources, Project M.O.M. support provides workflow development, implementation coaching, and multidisciplinary engagement. Project M.O.M supports the LaPQC focus on statewide learning and collaboration by strengthening hospital-community partnerships and advances integrated care beyond the hospital walls.

f. **Project M.O.M. Catalyst Site Strategy** centers on building a statewide model for maternal recovery care. The goal is to create a sustainable statewide system that ensures every mother has timely access to screening, treatment, navigation, and recovery support. Implementation will be launched through a network of catalyst site hospitals and include partnering with hospitals committed to improving care for pregnant and postpartum women at risk for substance use disorder. Activities will be aimed at supporting hospitals with clinical education and provider training, perinatal and regional navigator integration, evidence-based resources, technical assistance, and implementation guidance. Additionally, activities will be focused on developing integrated care resources, workflows, and navigation pathways, collecting data to identify gaps, delays, and opportunities to improve care, developing and test standardization, creating evidence-based workflows that can be replicated statewide, and finally expanding the network in phased cohorts to increase statewide access and impact.

    a. There are 11 catalyst hospitals chosen across seven of the state's nine regions that will provide the foundation for statewide expansion beginning in Fall 2026.

g. **The Catalyst Site Readiness Assessment** used a readiness survey to inform project implementation. 64 multidisciplinary respondents representing 11 Project M.O.M catalyst sites and two prospective hospitals. The findings are guiding implementation priorities and technical assistance opportunities across the state. The top five priorities for Project M.O.M. were identified using results from the survey:

    - 74% reported a lack of timely initiation and coordinated transitions of MOUD across care settings,
    - 54% reported culture shifts that treat SUD in pregnancy as a medical condition with staff and provider training identified as a need,
    - 52% of the surveyed agreed with embedding hospital-based perinatal navigators.
    - 51% reported secure data-sharing systems and care coordination infrastructure,
    - and 45% implemented verbal screening and evidence-based clinical pathways in prenatal clinic settings.

    These results are consistent with a 2023 statewide obstetric provider survey where only 27% of providers reported clear hospital workflows for SUD/OUD screening, referral and treatment.

h. **Integrated Care Navigation Strategy** aims to connect hospitals, providers, and community services through the M.O.M. Care Team, to create a coordinated system of care that ensures pregnant and postpartum women experience seamless transitions between health care and community services. At the center of this approach is the M.O.M. Care Team—a coordinated network of healthcare providers, navigators, and community partners dedicated to supporting each woman throughout her pregnancy and postpartum journey. The strategy includes representation from the behavioral health and recovery team, a clinical care team, and a community support team. This integrated strategy is designed to break down the silos that often delay or prevent timely access to care and treatment. These fragmented systems create significant barriers for pregnant and postpartum women with substance use disorder—particularly those who avoid seeking care because of stigma, fear of judgment, or concerns about losing custody of their infant. By strengthening coordination across healthcare and community partners, the M.O.M. Care Team helps create a more seamless, compassionate, and patient- centered system of care. Women may enter Project M.O.M. through multiple access points, including prenatal care, the emergency department, labor and delivery, inpatient care, behavioral health, substance use treatment, or through community referrals. Regardless of where they enter, hospital-based Perinatal Navigators and Regional Project M.O.M. Navigators work together as the M.O.M. Care Team to provide a personalized, client-centered approach with a consistent point of contact. This team ensures coordinated care across obstetric, primary care, behavioral health, and substance use treatment providers while connecting women with the community resources and supports available within their region or parish.

i. Project M.O.M. Regional Navigator Team – the M.O.M. Care Team brings together hospital and community partners to ensure every pregnant and postpartum woman has the supports she needs, when she needs it, through pregnancy and the first year postpartum. By working together across systems, Project M.O.M. aims to improve access to treatment, reduce gaps in care, and support healthier outcomes for moms and babies.

IX. Mama + Collaborative, Expanding Access to Doula, Birth Worker, and Midwifery Care Throughout Pregnancy and Postpartum presentation– Ms. Frankie Robertson, Dr. Victoria Williams, Ms. Nanette McCann, Ms. Meshawn Siddiq, Ms. Divine Bailey-Nicholas, Ms. Shatamia Webb, Ms. Kiersten T. Gillet-Pierce, and Ms. Grace Jackson.

a. Ms. Robertson of the Amandla Group introduced four objectives associated with the presentation.
    1. Describe complementary roles of obstetrician/gynecologists OB/GYNs, midwives, and doulas
    2. Increase patient awareness of birthing team options
    3. Improve referrals and collaborative practice
    4. Expand postpartum support

b. Together with Birthmark, the Institute of Women & Ethnic Studies and the Amandla Group, The Mama+ Health Policy collaborative is committed to addressing the maternal health emergency and closing maternal health gaps for black birthing people in Louisiana. Louisiana has significant maternal health challenges. Collaborative, patient-centered care can improve experiences and outcomes. Newcomb Institute published a state-wide analysis, finding that maternity care deserts are widespread and may be increasing. 30% of parishes lack maternity care and 47% lack obstetric physicians with rural areas most affected. In addition to access, quality of care, workforce stability, and a policy environment supportive of care will help shape outcomes and improvement.

c. The presentation delineated the roles of practitioners and medical support, how each of the roles are significant in contributing to improving birth outcomes, and how the birthing team can work collaboratively to improve birthing outcomes. Every provider shares the goal of healthy mothers and babies, and safe, appropriate care. See role delineations below.

1. Obstetrician/gynecologist (OB/GYN) – Necessary for high-risk medical management and surgical obstetric care and should always be at the center of patient care, collaborating across the care team.
2. Midwife – Operates at the center of low-risk pregnancies, birth and postpartum care, and practice in hospitals, clinics and birth centers. The certified professional midwife (CPM) works in the home and birth center settings
3. Doula – Provides continuous, non-medical support
4. Nurses, nurse-practitioners, behavioral health specialists – Complete the lower-risk birthing team of support professionals. The Certified nurse midwife (CNM) collaborates across the care team, working in the hospital, clinic and birth center.

- Ms. Gillette-Pierce, a student Midwife, provided a historical overview of midwifery practice in Louisiana. Ms. Webb walked through a day in the life of a midwife and as the operator of Baby Catcher Birth Center.
- Ms. Bailey-Nicholas, of Divine Birth Wisdom, provided insight into working as a home birth midwife, stressing that this is a vital part of Louisiana's maternal health workforce. She stressed that licensed midwives (LM) and certified professional midwives (CPMs) care for healthy women with low-risk pregnancies while working collaboratively within Louisiana's maternal healthcare system to provide prenatal, birth, postpartum and newborn care. The midwife model of care involves building relationships, providing education that leads to informed decision-making, and offering continuous support. A midwife provides consultation, collaboration and transfer support when appropriate. Collaboration helps Louisiana families receive the right care at the right time. Home birth midwives play an important role in maternal health in Louisiana. The use of a midwife can help expand access in rural & underserved communities, support physiologic birth for low-risk pregnancies, strengthen collaborative maternity care, help provide longer prenatal visits and relationship-based care, and can help improve recognition of when a consultation or transfer is needed.
- Ms. Jackson, CPMLM, described a day in the life of a midwife and as operator of Grace Midwifery Collective. Ms. Jackson stressed that clear referral protocols between doula, midwives, and OB/GYNs ensure timely escalation of care. Evidence shows that structured collaborative pathways reduce delays in care and improve patient safety and their experience. Doulas remain consistent even when clinical providers rotate or shift. When doulas identify early warning signs, they direct the patient toward needed emergency care and clinical evaluations. Midwives consult obstetricians for complications requiring medical management. Obstetricians rely on midwives and doulas to maintain continuity and patient-centered communication.
- Dr. Williams, a doula, licensed social worker, maternal child health consultant, and Advocacy Director at Birthmark Doula, described the evidence for doula care that supports positive, research-supported outcomes: Doula involvement is consistently associated with improved maternal and infant health indicators across diverse populations. Doulas help birthing women understand medical information, navigate care options, and make informed decisions throughout pregnancy and labor. Non-clinical, uninterrupted support leads to better communication with providers, reduced anxiety, and stronger patient satisfaction. When continuous doula support is provided, outcomes include reductions in cesarean births, epidural use, and labor augmentation. Dr. Williams stressed that bridging postpartum gaps between hospital discharge and home life, improves continuity of care during the vulnerable first weeks, which is especially impactful for high-risk populations experiencing disparities in postpartum morbidity. Doula support also supports evidence showing higher breastfeeding initiation, longer duration, and greater exclusivity among families. Louisiana legislation

making doula support accessible include Louisiana Act No 270 enacted in 2023, requires health insurance plans that provide maternity benefits to cover maternity support services provided by doulas before, during, and after childbirth. Louisiana Act No 228 enacted in 2025 requires the Louisiana Medicaid program to provide coverage for doula services during pregnancy, labor and birth, and the postpartum period. The act also requires the Louisiana Department of Health to implement the benefit and establishes enrollment and reimbursement requirements for doulas. Dr. Williams also described a day in the life of a mental health professional in conjunction with and as part of an effectively collaborating birthing team. She stressed that coverage doesn't equal access and that providers should be instrumental in helping patients access care.

Optimal service and collaboration involve discussing the role of a birthing team at the first prenatal visit, providing brochures, QR codes for resource management, referral lists, providing website resources and normalizing doula involvement.

- Ms. Siddiq, doula, certified lactation consultant and Health, Education and Research (H.E.R.) Institute representative on the Louisiana Doula Registry Board, provided insight into the day in the life of a lactation professional and how her work intersects with the above-mentioned health professionals that make up the birthing team.

d. Action steps for practices involve creating and strengthening referral pathways, providing waiting room materials that provide resource information and direction, creating collaborative community partnerships, and inviting doulas, midwives, lactation professionals and mental health professionals to prenatal education. The end goal or key takeaway is to create lasting collaborations that improve patient-centered care so that every patient is provided with education about all available support. Additionally, available support should be widely known and shared across the continuum of care and among the health care team.

e. Opportunities for collaboration – Ms. Robertson discussed the Louisiana Birth and Beyond Convening – Breaking Barriers, Advancing Innovation for a Healthier Louisiana, being held August 18-19, 2026, in Alexandria, Louisiana. The focus will be on strengthening partnerships among healthcare, birth workers, policymakers, and communities to improve maternal and infant health outcomes across Louisiana. Everyone was invited to register and attend for free.

X. Public Comment

a. Chair Spedale asked for public comments, and there were no public comments.

XI. Other Business

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

XII. Announcements

a. Next Perinatal Commission Meeting is scheduled on September 17, 2026, in Baton Rouge. The location is TBD, due to ongoing construction at the Louisiana State Capitol Building.

XIII. Adjournment

a. Chair Spedale adjourned the meeting at 2:50 PM.

The Commission will undertake all of its responsibilities assigned by LA.R.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.

The Functions of the Commission shall be to:

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.