Oregon Perinatal Collaborative

2026 Maternity Care Access Convening Report

OREGON PERINATAL COLLABORATIVE

Executive Summary

On May 8th, 2026, the Oregon Perinatal Collaborative and the Oregon Health Authority convened 74 stakeholders from across our state to understand the current crisis in maternity care and the drivers of hospital Labor and Delivery unit closures and to contribute their expertise to possible solutions to improve the health of Oregon families and communities. The convening included nurses, physicians, midwives, doulas, hospital leaders, behavioral health providers, community organizations, policymakers, public health, coordinated care organizations, funders, the Office of Rural Health, and Federally Qualified Health Center representatives. Participants were engaged through presentations, panels, breakout groups, and discussions.

Oregonians are facing increasing challenges in accessing high-quality care during pregnancy, birth, and the postpartum period. These challenges are especially acute in rural, Black, and Native American/Alaska Native communities and around maternal mental health. At least nine Oregon counties are maternity care deserts, more than are currently recognized in the March of Dimes report, whose measures weren't designed for rural western states. Oregon's complex maternity care access issues are driven by:

- Nurse, obstetrician, family medicine, midwife, and behavioral health workforce challenges
- Inadequate payment for increasingly complex and costly perinatal care
- Worsening health of pregnant people
- The lack of a coordinated maternity care system

The maternity care access crisis carries profound short- and long-term costs and population health consequences that require coordinated and collaborative action to keep Oregon families healthy. Support for physical and behavioral health during pregnancy and the first year after birth creates far-reaching benefits across generations including decreased preterm births, increased breastfeeding, lower infant and childhood mortality, reduced adverse childhood events, fewer children in foster care, and reduced rates of addiction and chronic disease. Greater attention to, and investment in maternal health is needed for Oregon to reach population health goals.

Significant work is underway to center maternal health needs and improve access to care, but short and long-term planning for more coordinated statewide work will be needed to gain traction and create system change. The Oregon Health Authority has made critical investments in maternal health in Oregon with Rural Health Transformation Program funding for the Oregon Perinatal Collaborative Perinatal Mobile Simulation Program, a 24/7

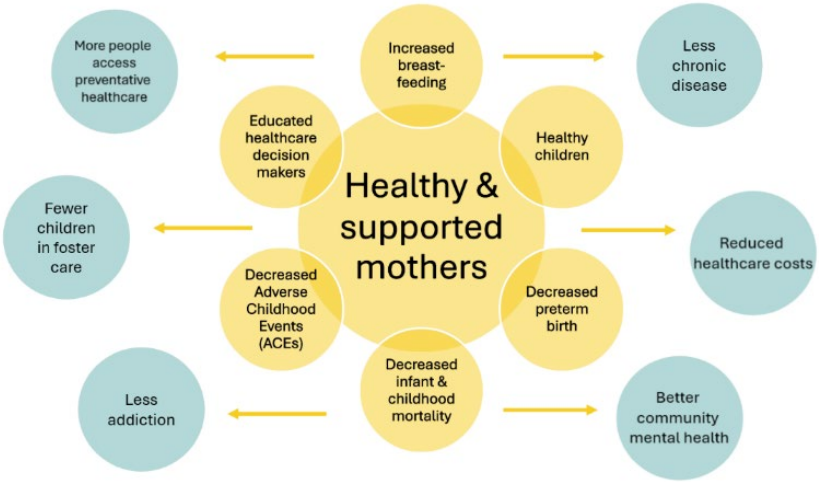
Perinatal Substance Use Disorder Advice Line for providers, expansion of Family Connects home visiting and direct funding for rural hospitals, clinics, and local public health. The Oregon Perinatal Collaborative continues to act on the recommendations of the Maternal Mortality & Morbidity Review Committee through statewide coordinated quality improvement, quality improvement support for small, rural, and critical access hospitals, targeted continuing education for the perinatal workforce, convenings, and policy recommendations to improve maternal and infant health.

There were significant areas of agreement on innovative solutions to the problems we face in maternity care access in Oregon including the following that had the greatest level of interest and agreement:

- Make maternal health a central public health priority to support long-term population health
- Create taskforce on a coordinated maternity care system
- Increase/reform Medicaid payment for perinatal services
- Invest in maternity and behavioral health workforce
- Create Oregon rural obstetric service corps to replace reliance on high-cost locums
- Protect nurse & provider time for quality improvement & education
- Increase access to midwives, family medicine physicians, doulas, & traditional health workers

This report provides a summary of the May 8th Convening, highlighting essential information on the current state and proposed recommendations for change. It includes content from speaker presentations, participant input and key recommendations for policymakers, hospitals, and leaders in maternal health to realize a vision of excellent access to appropriate maternal health care to support population health in Oregon.

Impacts of maternal health on population health



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Background & Acknowledgements

The Oregon Perinatal Collaborative (OPC) looks at all births in our state to understand drivers of maternal and newborn mortality and issues in access to care and respectful care in order to create quality improvement initiatives and other programs to improve care and outcomes for mothers, birthing people, and babies. In our work with nurses, providers, doulas, public health, community organizations, and the 45 hospitals providing birth services in our state, and with the essential information provided by the Maternal Mortality Review Committee, OPC has been able to recognize and begin mapping an emerging maternity care access crisis in Oregon. We identified a need to bring stakeholders together to create a shared understanding of this crisis and begin to build collective capacity to take action to maintain and then improve access to high-quality maternity care for Oregon.

We partnered with the Oregon Health Authority and a stakeholder advisory committee to plan this statewide maternity care access convening and are grateful to everyone who made this convening possible:

Maternity Care Access Convening Planning Committee

- Silke Akerson, MPH, CPM – Oregon Perinatal Collaborative
- Cayenne Buell, MPH – Oregon Perinatal Collaborative
- Laurel Durham, MPH, RN – Oregon Perinatal Collaborative
- Katie Mayward, MSc. – Oregon Health Authority
- Phillip Wetmore – Comagine Health

Maternity Care Access Convening Advisory Committee

- Shane Alderson – Baker County Commissioner
- Sarah Andersen, MPH – Oregon Office of Rural Health
- Amy Down-Maul, MBA, RN – Hospital Association of Oregon
- Geoff Maly, MD – Wallowa Memorial Hospital
- Jen Pierce, BSN, RN – Samaritan North Lincoln Hospital

Maternity Care Deserts Panel

- Melissa Cheyney, PhD, CPM – Oregon State University
- Kestrel Gates – Early Parent Network
- Debbie Morris, CNO – Blue Mountain Hospital
- Lily Wittich, MD – St. Luke's Clinic

Maternity Care Workforce Panel

- Kristine Bell, MBA, RN – Providence Health & Services
- Cathy Emeis, CNM – OHSU School of Nursing
- Dan Grigg – Wallowa Memorial Hospital
- Jen Pierce, BSN, RN – Samaritan North Lincoln Hospital
- Wendy Warren, MD – Cascades East Family Medicine Residency, Sky Lakes Medical Center

Presenters

- Sarah Andersen – Oregon Office of Rural Health
- Kristine Bell, MBA, RN – Providence Health & Services
- Kelly Hansen – Oregon Maternal Mortality & Morbidity Review Committee
- Sejal Hathi, MD – Oregon Health Authority
- Arundhati Headrick, MD, PhD – Oregon Health & Science University
- Roberta Hunte, PhD, MS – Portland State University, Black Futures for Perinatal Health
- LaKota Scott, ND – Northwest Portland Indica Health Board

Funding to support travel for rural partners

Thank you to The Roundhouse Foundation for funding travel for our rural partners.

Participants

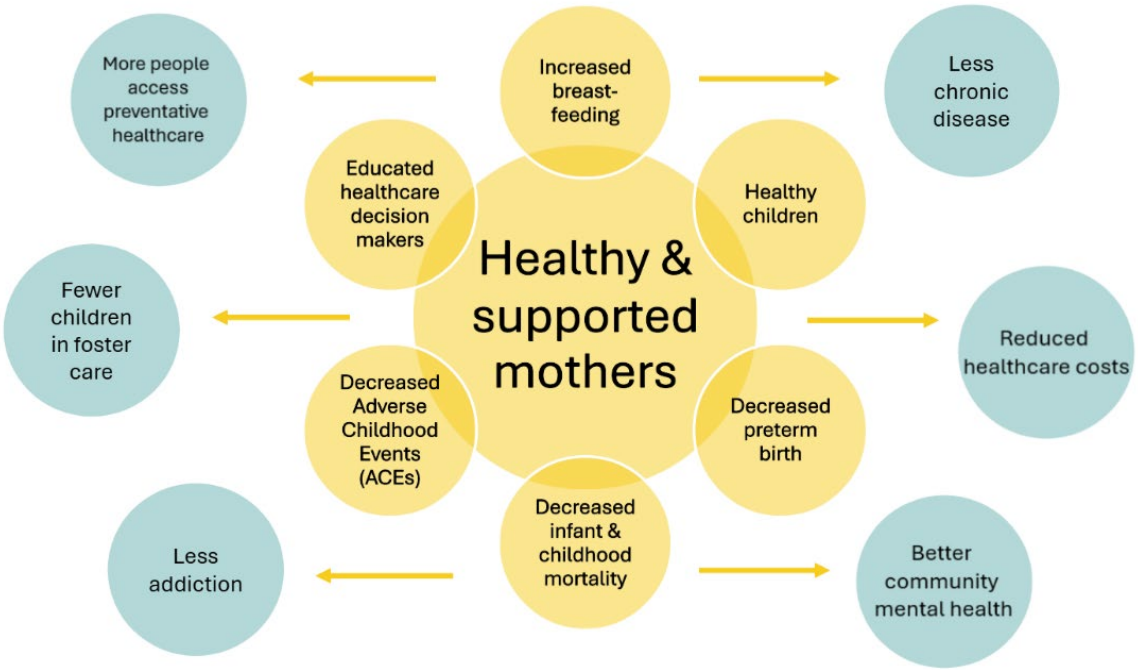
Thank you to all 74 attendees who dedicated a full day to share their expertise.

Context

Why focus on maternal health?

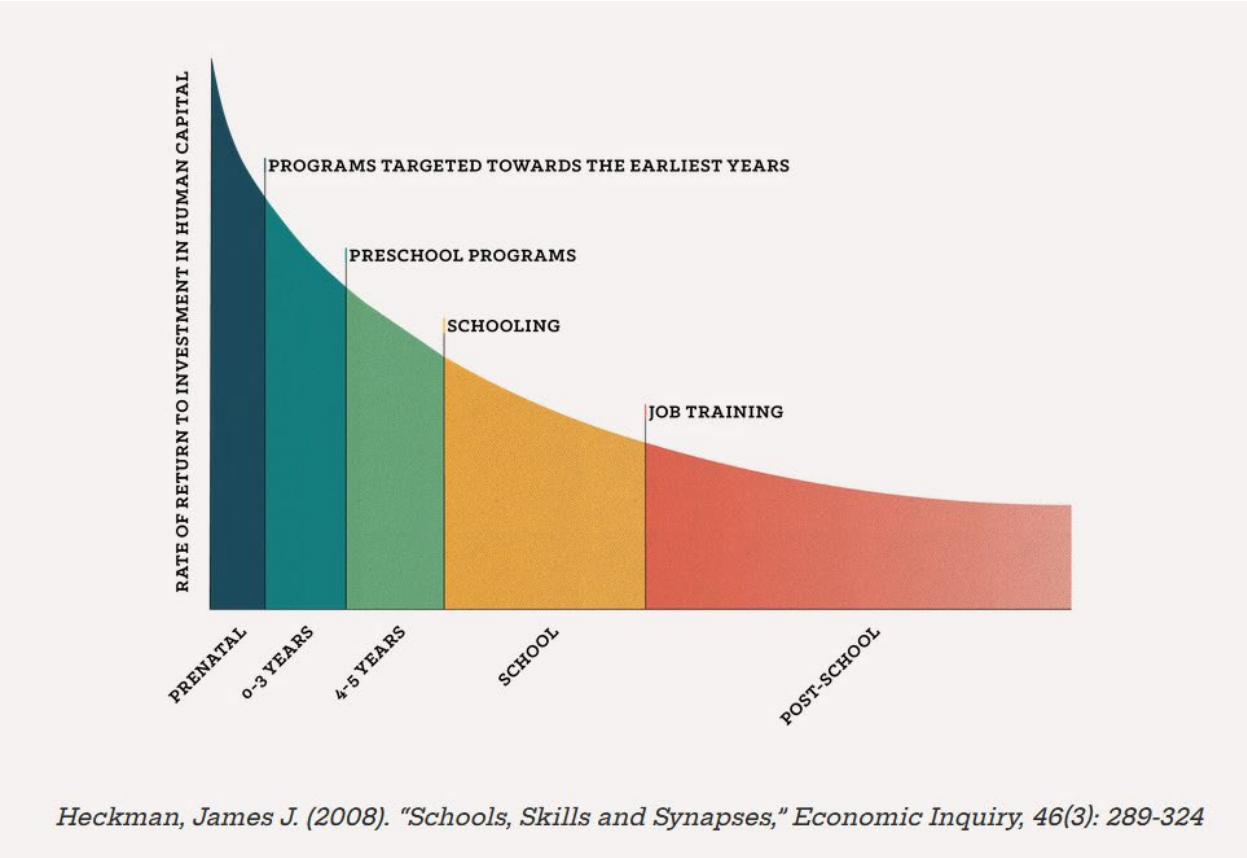
Maternal health is at the center of community and population health. When we have communities, services, and environments that support healthy mothers and birthing people, we see a wide range of health improvements in infants, children, and their families and communities not just in the short term but across generations (Girardi et al., 2023). For example, when pregnant people with substance use disorders receive wraparound, integrated physical and behavioral health care we see not just lower rates of preterm birth and decreased neonatal intensive care unit stays but also fewer children in foster care and a decrease in Adverse Childhood Events, leading to lifelong health benefits (McConnell et al., 2020; Vartanian et al., 2018). Pregnancy, birth, and the first year of life impact every current and future Oregonian because what we experience during this critical developmental period and with our first caregivers can set the stage for health, or disease, in powerful ways.

Impacts of maternal health on population health



We also see in Heckman's curve that prenatal maternal health and the first year of life are the most cost-effective and impactful times to improve population health (Heckman, 2008). The return on public health investment during this sensitive time period is particularly compelling during periods of budget challenges.

Heckman's Curve: Rate of Return to Investment in Human Capital



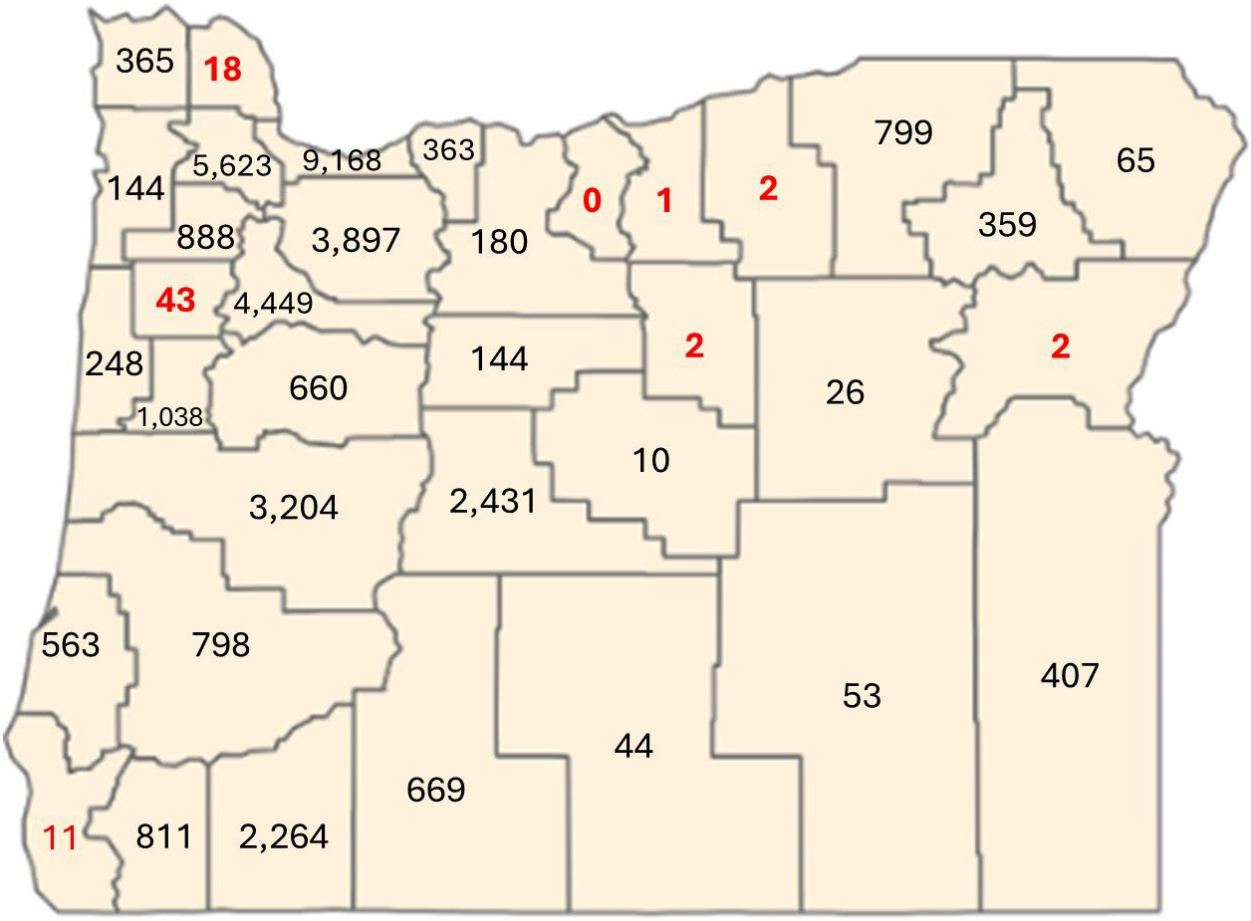
Heckman, James J. (2008). "Schools, Skills and Synapses," Economic Inquiry, 46(3): 289-324

With this framing, it becomes clear that understanding the current state of birth and maternity care in Oregon should be central to taking action to improve population health.

Birth in Oregon

There are approximately 40,000 births per year in Oregon, with wide variation in concentration of where births occur. Some rural and frontier counties record very small numbers of annual births due to low populations, declining birth rates, and because people must travel outside their home county to give birth because a local hospital lacks birthing services or cannot care for the complexity of their pregnancy. While most births are planned for the hospital, approximately 5% of Oregon births are planned community births (home or freestanding birth center).

Oregon Births by County – 2025



Note: Counties in red indicate counties without a birthing hospital.

There are 45 hospitals that provide birth services in Oregon, with annual birth volumes ranging from fewer than 30 to more than 3,300 births per year. These hospitals face many shared challenges in providing high-quality care to Oregon families, but small and rural hospitals face additional challenges.

Map of Oregon Birthing Hospitals – 2025

Maternal Mortality in Oregon

The Oregon Maternal Mortality & Morbidity Review Committee reviews maternal deaths in Oregon, reports on the drivers of maternal mortality, and makes recommendations to improve care and outcomes. According to the 2025 Maternal Mortality & Morbidity Review Committee report, 46% of maternal deaths in Oregon (during pregnancy or in the first year postpartum) were pregnancy-related, meaning that they resulted from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. The largest proportion of pregnancy-related deaths in Oregon occurred in the postpartum period.

Critically, nearly three out of four pregnancy-related deaths in Oregon (72%) were potentially preventable. Mental health conditions and substance use were the leading causes of these deaths in Oregon. Infection, hemorrhage, amniotic fluid embolism, and cardiovascular conditions were the other leading causes. Discrimination, domestic violence, and childhood trauma were also significant contributors.

Maternal Mortality and Morbidity Report findings highlight failures in continuity of care including problems with access to complete records, communication between prenatal, labor and delivery, and postpartum clinicians. Missed opportunities for recognition, screening, and referral to mental health and substance use disorder care were common. Systemic barriers included loss of insurance coverage, inability to miss work, inability to afford care, provider shortages in patients' geographic areas, and lack of public transportation.

Oregon Maternity Care Access

Oregonians face complex challenges in accessing safe and respectful maternity care especially in rural, Black, and Native American/Alaska Native communities and around maternal mental health. Maternity care access challenges in Oregon look different depending on geography, community, and primary language and include the following themes:

- **Rural**
    - Labor & Delivery unit and clinic closures
    - Long travel times, lack of transportation, weather blocking travel
    - Limited local options for people with pregnancy complications or seeking vaginal birth after cesarean section
- **Urban**
    - Long wait times for prenatal care
    - Hospitals closed to new admissions due to staffing and/or bed availability

- **Racial, ethnic, and cultural**
    - Lack of culturally congruent care
    - Implicit bias among health care staff
    - Structural racism
- **Language**
    - Inconsistent access to interpretation services

Rural Access

Rural Oregon communities have higher unmet health care needs in general, and these are compounded for families seeking maternity care. National data show that rural mothers and birthing people experience disproportionately poor outcomes (Harrington et al., 2023; Kozhimannil et al., 2019) and the Oregon Office of Rural Health data shows that rural Oregonians are more likely to have inadequate prenatal care and to have to travel long distances to access care. Rural residents face nearly twice the risk of maternal mortality compared to urban residents, as well as higher rates of severe maternal morbidity, and less behavioral health access. Rural, small, and critical access hospitals providing birth services also face compounding challenges beyond those shared statewide. In 2024 the Oregon Perinatal Collaborative visited all birthing hospitals in Oregon and found the following themes in rural hospitals (Oregon Perinatal Collaborative, 2024):

- Major provider staffing shortage
- Difficulty maintaining emergency obstetric skills at low birth volumes
- Challenges with consultation and transfer
- A strong desire for more connection and support

Maternity Care Deserts

Oregon has more counties with low, or no, maternity care access than are acknowledged in the March of Dimes report on maternity care deserts. The March of Dimes definitions that are used to categorize counties in the US that are maternity care deserts or low maternity care access have significant limitations for rural western states like Oregon and lead to a substantial undercount of affected communities. In the 2024 report, only three Oregon counties (Sherman, Gilliam, and Wheeler) were identified as maternity care deserts, and no Oregon counties were counted as having low access. These results rely heavily on insurance coverage rates and don't measure the actual presence of care, creating misleading results.

Insurance coverage alone cannot compensate for the absence of a birthing hospital in Columbia, Polk, Curry, Coos, Morrow, and Baker counties, or for the obstetric provider shortages affecting the ability to consistently provide maternity services at hospitals across eastern, central, and coastal Oregon. The national provider adequacy metric is

calibrated for more populated states. While 60 obstetric providers may be adequate for 10,000 births annually, 2.3 providers for the 386 births per year in Malheur would not be close to adequate. In actuality, six obstetric providers currently attend births at St. Alphonsus in Ontario to serve that birth volume. For this, and other reasons, Oregon needs to develop its own framework for defining and measuring maternity care adequacy.

Maternal Mental Health

Oregon faces significant gaps in maternal mental health infrastructure. There are too few maternal mental health providers, too few prescribers who feel comfortable treating mental health conditions during pregnancy and postpartum, and no inpatient mother-baby mental health units in the state. Oregon also lacks intensive outpatient or partial hospitalization programs specific to maternal mental health. Maternal mental health screening rates remain low, health plans are not required to develop maternal mental health quality management programs, and there is no coverage for group programs such as group parenting programs.

Rural and coastal communities face compounding challenges, such as higher rates of "deaths of despair" (overdoses, suicide, alcohol-related deaths) and fewer maternal mental health providers.

Oregon does have several promising models for perinatal mental health and substance use treatment, including Project Nurture (Portland Metro), Nurture Oregon (Deschutes, Jackson, Lincoln, and Umatilla counties), the Harm Reduction and BRidges to Care clinic at OHSU, and the Oregon Psychiatric Access Line (OPAL) for medication management consultations for providers (1-855-966-7255).

Black and African American Communities

Black/African American people in Oregon face disparities in the perinatal period and challenges in accessing care, especially respectful, culturally matched care. Black people experience disproportionate rates of maternal mortality and morbidity, preterm birth, low birth weight, and infant mortality even at higher socioeconomic positions due to structural inequalities and racism (Issue Brief: Black Maternal Health, 2020). Widespread and long-term negative experiences with healthcare systems contribute to late entry to prenatal care and high rates of emergency department use during pregnancy and postpartum. Higher rates of Child Protective Service referrals and implicit bias, particularly against Black fathers, can make care feel less safe for Black families. Increased xenophobia and immigration concerns further deter Black immigrants from health care settings.

Barriers to care are systemic and intersecting. Health care is not designed to see or respond to the whole person, and systems do not consistently incorporate partners, family,

and nonhealthcare supports into care. Standardized systems can erase or minimize the broader societal contexts that shape experience, which is especially consequential for Black birthing people who cannot simply set those contexts aside. Programs designed by and for pregnant and parenting Black families, such as those provided through the Healthy Birth Initiative in Multnomah County highlight the positive impact possible.

American Indian and Alaska Native Communities

American Indian and Alaska Native people experience disproportionate rates of maternal and newborn mortality and morbidity and have some of the highest rates of inadequate prenatal care (*Infant Mortality and American Indians/Alaska Natives | Office of Minority Health*, 2026; Manohar et al., 2025).

American Indian and Alaska Native mothers and birthing people in Oregon face a number of barriers to receiving care, including:

- Inadequate access to prenatal care
- Inadequate postpartum care
- Eligibility issues for non-tribal members
- Staffing shortages
- Fear of losing their child
- Separation of family during substance use disorder treatment
- Limited availability of substance use disorder treatment
- Inconsistency in breastfeeding recommendations
- Communication barriers
- Legal system involvement
- Housing instability
- Transportation gaps

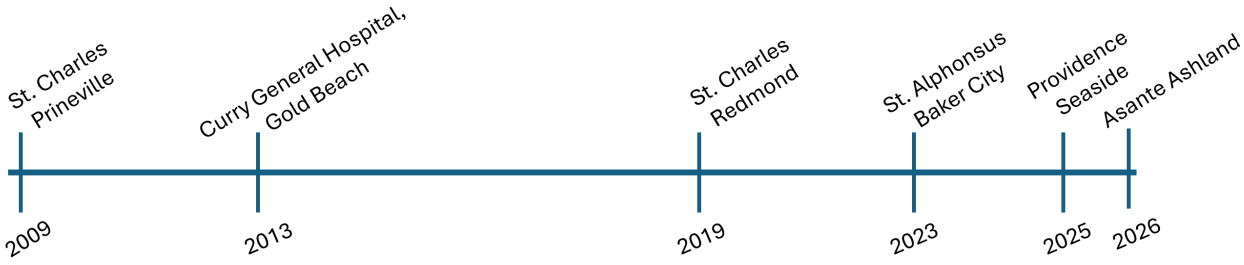
Oregon's nine federally recognized tribes have created innovative ways to bridge these gaps and care for mothers and babies. Programs that provide home visiting, lactation support, care navigation, culturally responsive substance use disorder treatment with transportation, community events, and housing and food provide critical support.

L&D Closures in Oregon: History & Drivers

Recent History of L&D Closures

Oregon has seen an acceleration of hospital Labor & Delivery unit closures with three closures in the past three years and several more proposed. While each closure draws attention to the specific hospital and community involved, these closures illuminate pressures faced by all birthing hospitals in Oregon, particularly small and rural facilities.

Oregon Labor & Delivery Unit Closures



These closures have significant impacts on communities beyond the immediate one of no longer being able to access birth services locally. Families, communities, and hospitals have shared a wide range of impacts including:

- Increased cost of having a baby due to long travel to care and need to stay in another location ahead of the due date
- Decreased access to related services such as lactation, pediatric care, or home visiting
- Decreased hospital revenue from related services like ultrasound
- Decreased use of the local hospital for other services
- Decreased appeal of rural communities for families as services are hollowed out

In 2024, the OPC visited all (then) 47 birthing hospitals in Oregon to build relationships and learn directly from them about their strengths and challenges (Oregon Perinatal Collaborative, 2024). Every hospital was grappling with three universal challenges that contribute to closures:

- Staffing challenges
    - Labor-trained nurses, obstetric providers, in-hospital newborn coverage
- Worsening health of pregnant people
    - Chronic conditions, complex social and behavioral health needs
- Inadequate payment for increasingly complex pregnancy care.

Maternity Care Workforce Issues

In both the 2024 OPC report and this 2026 Maternity Care Access convening, Oregon hospitals have highlighted workforce challenges related to L&D nurses and obstetric providers including obstetricians, midwives and family medicine providers that are complex and include both the recruitment and retention of these team members. While these challenges are present across Oregon, rural areas describe unique and urgent

challenges. Even when successfully recruiting providers and nurses to rural communities, it is not uncommon to have these individuals leave within a short time to practice in higher volume settings, requiring near constant attention to recruitment and retention. Some recruitment considerations are impacted by community level factors (housing costs, schools, available arts/ entertainment, etc.) that are outside the control of hospitals.

Despite significant work to recruit and retain local providers and nurses, there remains a strong dependency on locums tenens in many sites, leading to increased costs as well as fragmented care by clinicians only in the community for short time periods.

Supporting clinical competency and high-quality care in low-volume environments is also challenging. Frequent education and simulations help team members develop and maintain competency in obstetric and newborn emergencies, but many sites do not have team members available or trained in perinatal education or simulation, or the resources/ time to provide this. Nurses in some rural hospitals in Oregon staff multiple units within the hospital, increasing the volume of education and competencies required. Even for routine procedures such as cesarean section, obstetric providers in low volume areas express the need for additional volume to maintain competency. And temporary staff, such as locums tenens, are not actively involved in the quality improvement work that permanent staff are.

Worsening Health of Pregnant People

Clinicians, hospital leaders, and other stakeholders across the state are consistently reporting concerns about the worsening health among pregnant people to OPC and this theme continued in this convening. Reports of increasing chronic conditions such as hypertension, diabetes, mental health conditions, and substance use disorders, as well as increasing unmet basic needs such as food, housing and transportation are widespread. These conditions and needs that require more complex and labor-intensive care exacerbate already existing staffing challenges, increase resources needed and cost of care, and amplify the need for education, quality improvement work and coordinated levels of care.

Economics of Maternity Care

More than half of a hospital's costs (56.1%) are tied to service lines where reimbursements are less than the cost to deliver care, and obstetric services lines fall into this category for most Oregon hospitals (American Hospital Association, 2026). Maternity services are core to a hospital's role in its community, but their losses must be subsidized by other services. Operating at a loss is compounded in counties and hospitals with a lower number of births. 79% of Oregon births occur in counties with more than 1,000 births per year, while the remaining 21% are distributed across counties with fewer than 1,000 births, including

seven hospitals with fewer than 100 births annually. These small hospitals still have to pay the fixed costs of maintaining an L&D unit with a very low amount of revenue making financial sustainability difficult without support. This impact is aggravated by the higher proportion of Medicaid patients in rural counties which further decreases revenue

The two key payments of maternity care are the payment to the hospital and the global payment to the obstetric provider. Of note, there are other payments for pregnancy and postpartum care not captured in this simplified summary (for example, payments for doulas, outpatient lab/ imaging, home visiting, etc.).

Key structural economic challenges for hospitals include:

- Unpredictable birth volume against fixed staffing and call coverage costs
- High overhead costs independent of daily birth volume
- Payment increases have not kept pace with increases in labor expenses, which is the largest expense for most hospitals
- Prolonged labor spanning multiple days not fully recognized in payment
- Interfacility transfers not fully compensated
- Subsidies required for anesthesia services
- Shift of gynecological procedure volume to outpatient and ambulatory surgical centers, reducing cross-subsidy
- Increasing high-cost locum physician use
- High cost of travel nurse contracts when unable to fill posted positions
- New nurse staffing ratio requirements (HB 2697) leading to increased costs to ensure compliance (for example, to create/ hire new role to cover breaks)

It will be important to track the impact of the upcoming change to the historic global obstetric fee payment model paid to obstetric providers for prenatal visits, delivery, and postpartum care for uncomplicated pregnancies. This model does not reflect the complexities of modern obstetric care and in January of 2027, the Centers for Medicare and Medicaid Services will replace 17 current obstetric billing codes with six revised and 12 new codes intended to better reflect team-based care, labor management, antepartum care, and transfers. It is yet to be determined how this will impact obstetric providers and practices and maternity care economics.

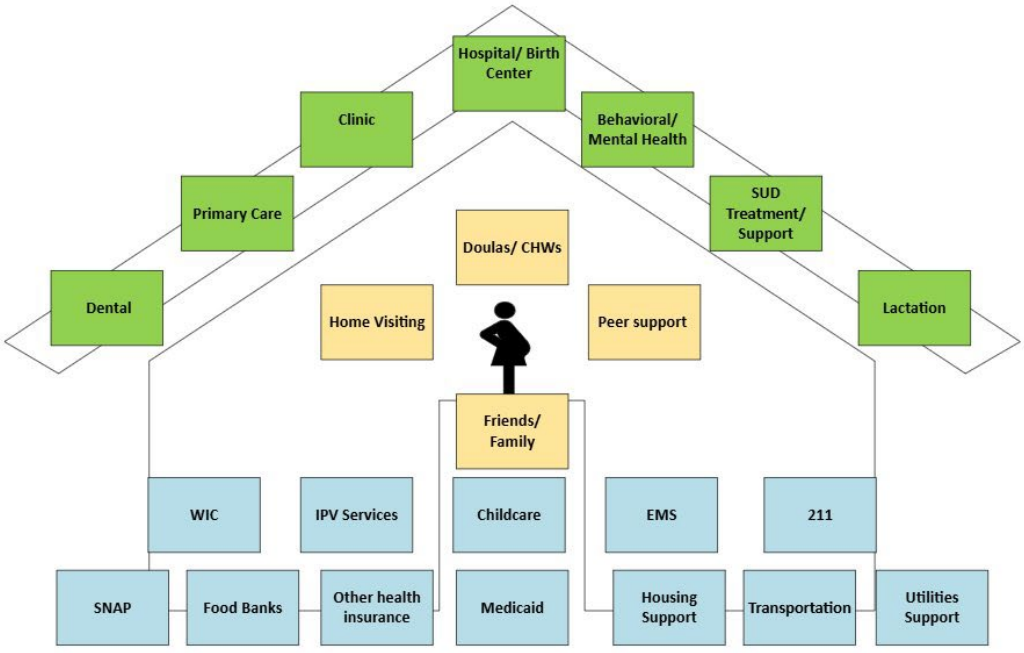
Current Work & Recommendations

There are many ways that Oregon can address the problems in maternity care access that have been shared in this report. This section outlines the current work of the Oregon Health Authority and the Oregon Perinatal Collaborative in this area, then covers a range of previously proposed potential solutions, and finally makes targeted recommendations for action based on the input from participants in the Maternity Care Access Convening.

Maternity Care System Framework

We believe that a framework for understanding our maternity care system is needed for effective and sustainable solutions to improve access to high-quality maternity care in Oregon. A maternity care system framework can help us understand the full range of resources that are needed to provide adequate care at a reasonable distance to support healthy moms and birthing people in Oregon. Not every mother or pregnant person needs all of these resources or types of care, but all of these elements are needed for maternal health, and population health, in Oregon. We can ask, what would it mean to have maternity care adequacy in Oregon? What policies and systems would need to be in place for all pregnant mothers and people in Oregon to have the care that they need while bringing future generations into the world?

The Maternity Care System



Current Oregon Work to Build on

Oregon Health Authority

In addition to ongoing work on home visiting, preconception and pregnancy health, maternal mental health, community-based perinatal services, 2025 investment in maternity services, and review of maternal morbidity and mortality, Oregon Health Authority is providing new critical investments in maternal health access in Oregon through the Rural Health Transformation Program including: critical investments in maternal health access in Oregon through the Rural Health Transformation Program including:

- Direct funding for rural hospitals, clinics, & local public health
- OPC Perinatal Mobile Simulation Program to provide on-site training for rural hospitals
- 24/7 Perinatal substance use disorder Advice Line for providers through OHSU
- Expansion of Family Connects home visiting to 5 additional counties
- Maternity care specific technical assistance to coordinate regional and statewide convenings
- Support for Nurture Oregon expansion through new locations, mobile services, and workforce training
- Development of Family Care Plans through Comagine Health
- Expansion of Center M in 10 new rural communities
- Perinatal health workforce development through Portland New Family Fund to strengthen culturally and linguistically responsive perinatal workforce in rural communities.

Oregon Perinatal Collaborative

OPC takes action on the recommendations of the Oregon Maternal Mortality and Morbidity Review Committee and carries out a range of work to improve care and outcomes for mothers, birthing people, and babies in Oregon including:

- Quality improvement initiatives
- Quarterly critical access hospital maternal and infant health meetings
- Annual hospital visits to birthing hospitals
- Mobile simulation program
- Annual continuing education summit
- Oregon Association of Women's Health, Obstetric and Neonatal Nurses/Oregon Perinatal Collaborative webinar series
- Convenings and policy recommendations to improve maternal and infant health

Proposed Policy Changes

This is a summary of possible policy solutions proposed by local and national maternity care leaders and organizations that are being tracked by OPC and Oregon Health Authority. Maternal health is a non-partisan issue. Many state legislators and members of Congress become advocates once they understand the local impact in their communities. Structural changes at every level are needed to improve maternal health, and there are many opportunities for engagement.

Federal

- Keeping Obstetrics Local Act to prevent L&D unit closures in rural and underserved communities
- Restore and expand Medicaid funding
- Increase Medicaid payment rates for perinatal services
- Establish capacity payments for critical access hospitals and small and rural L&D units
- Maintain funding for perinatal quality collaboratives and maternal health programs within Health Resources and Services Administration and Centers for Disease Control and Prevention

State

- Reform payment for pregnancy, birth, and postpartum care
- Create a maternity care access taskforce
- Create low-volume payment adjustments for L&D services to support maintenance of the obstetric service line
- Invest in perinatal and behavioral health workforce development
- Create and fund an Oregon rural obstetric service corps
- Provide grants to support collaboration between rural hospitals
- Fund simulation programs to maintain obstetric emergency skills
- Remove barriers to licensure for providers and nurses relocating from other states—explore multi-state licensure compact
- Create a nurse staffing ratio exemption or flexibility for low-volume L&D units
- Identify and incentivize methods for coordinated care organizations to invest in continued local labor and delivery services; reevaluate restrictions that may impede such investment
- Provide malpractice insurance supplements to rural providers
- Fund expansion of Nurture perinatal substance use disorder programs

Payment Reform

- Increase Medicaid payment rates for perinatal services, tied to quality and cost-effective care
- Increase and reform payment models for perinatal substance use disorder care

- Create funding or payment models that protect time for quality improvement, education, and team huddles
- Develop Centers for Medicare and Medicaid guidance to support Medicaid access to midwives and doulas
- Require coordinated care organizations to reinvest profits above an identified threshold back into community maternity services

County and Community

- Make maternal health a priority in planning
- Create and support/ integrate local perinatal health taskforces

Hospital

- Create and preserve practice support, quality improvement, and education positions for L&D units and clinics
- Provide protected time for quality improvement and education in perinatal health
- Support opportunities for collaboration between clinics, hospitals, and hospital systems
- Reevaluate how the profit/loss of L&D units is assessed within hospital financial structures
    - *See also:*
      Sustaining Rural Labor & Delivery Programs — Stroudwater Associates

Oregon Maternal Mortality & Morbidity Review Committee Recommendations:

- All payers, including Medicaid, should prioritize coordinated mental health/substance use disorder care for pregnant people
- Systems need to support improved communication between care teams across medical specialties and disciplines
- Care teams need implicit bias training and support
- Continue to strengthen postpartum support systems statewide
- Improve education and support for gun safety, especially in cases with known mental health conditions
- Encourage vaccine uptake in traditionally underserved communities with culturally specific outreach
- Increase access to blood products in delivery settings
- Hospitals should implement robust emergency simulation trainings
- Increase access to autopsies for maternal deaths
- Improve range of and access to social service programs to address upstream social determinants of health, ensuring people entering pregnancy are in a better state of health

Solutions Gathered During Convening

Participants in the Maternity Care Access Convening were asked to share their expertise and make recommendations to improve sustainable access to high-quality maternity care in Oregon. This section provides a high-level summary of those participant recommendations with the most consensus or recurrence organized into the breakout topics where they were gathered. Complete notes on participant discussions and recommendations are included in Appendix A.

While some recommendations will require legislative and policy change and some are focused on specific populations, there are actionable recommendations for all members of the maternity system of care in Oregon, including but not limited to hospital leaders, clinicians, traditional health workers, public health professionals, and community based programs and supports.

Breakout Groups

Maternity Care Adequacy

Participants identified a need for a framework for maternity care adequacy in Oregon that would include the following key elements:

- Sustainable Medicaid payment for perinatal care
- Nurse, physician, midwife, doula, and peer workforce development
- Integrated maternal care system with:
    - Integration/coordination between:
        - Levels of care
        - Physical and behavioral health
        - Pregnancy, birth, and postpartum care
        - Clinics, hospitals, and health systems
    - Smooth consultation, referral, and transfer
    - Strong community-based and family-centered care
    - Support for housing, basic income, and transportation

Maternity Care Payment Increase and Reform

Participants identified a need for major restructuring of the payment system for maternity care and highlighted changes needed to make it sustainable and to support cost-effective, quality care in both the short and long term:

- Increase maternity care reimbursement to cover cost of increasingly complex care
- Create alternative payment model for integrated perinatal substance use disorder care

- Create payment structures that incentivize prevention and best practices to improve outcomes
- Explore a single-payer solution for maternal and child health

Capacity payments & other direct supports to small, rural hospitals

Participants highlighted changes needed for capacity payments and other direct supports to small, rural hospitals to have a sustained impact on their ability to continue providing maternity services.

- When making investments or determining whether these investments are possible, consider that "losing maternity services means losing the future of a community"
- Rural hospitals need to be funded as an essential service
- Capacity payments should be established for low-volume hospitals where L&D services are needed
- Compensation structures must cover fixed costs, training, and on-call availability
- Create an Oregon obstetric service corps to reduce dependence on costly locum tenens physicians

Maternal health workforce development

Participants highlighted changes needed to increase workforce development of nurses, obstetricians, midwives, family medicine physicians, and behavioral health providers in Oregon.

- Increase education and training pathways through:
    - Community colleges and distance learning programs
    - Decreased cost of education, funded clinical placements and loan forgiveness programs
    - Increased available spots in nursing, medical, and midwifery programs and obstetric and family medicine obstetric residencies
- Address areas identified to improve retention
- Train and recruit nurses, providers, and healthcare interpreters of color
- Create funded pathways for traditional health workers to become nurses and providers
- Sustainable reimbursement for all maternity workforce roles

Maternal health quality improvement and safety

Participants highlighted changes needed to support a consistent, sustainable focus on maternal health quality improvement and safety across Oregon hospitals, clinics, Oregon Health Authority, and healthcare payers.

- Quality improvement needs to be considered essential and built into operational budgets

- Create easy to access quality improvement best practices resource
- Provide support/technical assistance for maternal health quality improvement
- Fund Oregon Maternal Data Center participation for all hospitals
- Standardize interoperable electronic health record systems to improve both quality improvement tracking and direct care
- Create reimbursement models that support protected time for quality improvement and education

Maternal health investment for population health

Participants highlighted changes needed to prioritize maternal public health investments to improve population health, reduce chronic disease burden, and decrease costs across government health and social spending over the short- and long-term.

- Make maternal health a public health priority:
    - Focus on social determinants of health including housing, nutrition, basic income, childcare, and transportation.
    - Explore universal income during pregnancy and for one year postpartum.
    - Prioritize perinatal families for housing assistance.
- Invest in social support infrastructure to address isolation
- Invest in sexual and relationship health and substance use education in schools
- Invest in integrated perinatal substance use disorder care
- Increase parental leave to one year
- Strengthen lactation support
- Include perinatal experts and advocates in all policy and planning spaces that affect maternal and child health.
- Expand access to traditional health workers and doulas

Core Recommendation: System of Maternity Care

There is one core recommendation of the Maternity Care Access Convening that incorporates expertise provided before and during the convening: **Take steps to create a coordinated system of maternity care now with long term commitment to the necessary work.**

Key components of the work to create and support a coordinated, sustainable system of care include:

- Identify and outline short and long-term steps
    - Each step should be designed to build on the previous
    - Ensure stakeholders within the system of care are included in each step
    - Ensure definitions of success are developed and consider where immediate impact is possible and where longitudinal measurement is needed.
- Include maternal and newborn levels of care
- Maintain emphasis on continuity and coordination of care for pregnancy through 12 months postpartum
- Ensure system is economically sustainable
    - Payment reform and increases are necessary
- Explore feasibility of creating an Oregon obstetric service corp as an alternative to high-cost locum tenens who are not connected to statewide quality and safety work

Closing: A Note on What's Possible

Healthcare in general, and maternity care in particular, face extreme challenges. And, at the same time, **we know that a better system is possible**. Daily experiences across our state, OPC hospital visits over the past three years, statewide quality improvement initiatives, and convenings like this one demonstrate that there are incredible people working hard to make Oregon a safe, welcoming place to be pregnant, give birth, be born and thrive in healthy communities across Oregon, even as the work is becoming more complex.

This convening shows us that we have experts from all of the diverse fields needed who are interested in helping design a maternity system of care that delivers the care and support needed during pregnancy to promote healthy communities and restore or increase joy in work for the multidisciplinary workforce.

To accomplish this, we need to first believe a better system is possible. With this fundamental belief, we can embrace the complexity and seek short- and long-term

solutions developed in collaboration among all stakeholders that leverage past learning while looking to the future. The work will not be done overnight, but we can start to feel meaningful impacts quickly as we commit to a coordinated, stepwise approach that centers families and the workforce caring for them. We look forward to working together to improve access to high quality care and support for mothers and birthing people in Oregon.

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Appendix A – Participant Discussions & Recommendations

Summary of all Maternity Care Access Convening participant and presenter discussions and recommendations

Maternity Care Adequacy Table Discussions

Convening participants discussed the concept of maternity care adequacy at their tables starting with the question: what systems would need to be in place for all pregnant mothers and people in Oregon to have the care that they need while bringing future generations into the world?

Maternity Care System

- Sustainable Medicaid payment for perinatal care including
    - Perinatal education and support groups
- Create an integrated maternal health system with:
    - Smooth communication/coordination between clinics, hospitals, and health systems
    - Integrated physical and behavioral health team models
    - Interoperability of all electronic health records
    - Centers that provide VBAC access in all parts of the state
    - Coordinated/consistent maternity transport team
    - Program to financially support 3rd trimester relocation for high-risk rural patients
        - Maternity homes model
    - Mobile services where needed
    - Deliberately planned location of tertiary services where they are needed
    - Consistent and effective screening, referral and warm handoff
        - With support from patient navigators
- Sustainable reimbursement for Nurture perinatal substance use disorder programs
- Fund and incentivize prevention in maternal health
    - Strong patient education component
    - Programs to reduce need for neonatal intensive care unit admissions
    - Programs to prevent maternal depression and isolation
- Community-based care
    - Strong system of local community health workers with relationships with/ intentional collaboration with clinics, hospitals, community organizations
    - Community-based midwifery care
- Universal telehealth support for small hospitals during maternal and newborn emergencies
- Increase prenatal visits to 30 minutes and complex visits to 1 hour
- Universal basic income

Workforce-specific

- Train and recruit providers and healthcare interpreters of color
- Supported pathways for traditional health workers to become nurses and providers
- Community college programs for nursing, midwifery, behavioral health
- Sustainable reimbursement for all maternity workforce roles from peers to obstetricians
- Reduce cost of education and access to educational programs for nurses, physicians, midwives
- Reliable loan repayment options for maternal health workforce
- Training in perinatal health for all parts of workforce with emphasis on:
    - Behavioral health
    - Emergency departments

Barriers

- Current system is broken
    - May need to break it and start over
- Cost of living
- Current economic model for healthcare
- Inconsistent access to rapid transfer to higher levels of care
- Level 3 and 4 hospitals closed to admission to transfers
- Competition between hospitals/health systems

Breakout Group Discussions

Convening participants broke into five working groups, each tasked with developing recommendations in a specific domain. Each participant rotated through three different topics based on their interests. What follows is a synthesis of the key highlights and recommendations discussed by each group.

Maternity Care Payment Increase and Reform

This group explored what changes are needed to make maternity care payment sustainable and to support cost-effective, quality care in both the short and long term.

Key highlights:

- Current payment system needs fundamental restructuring, not incremental adjustments.
    - Short-term costs may be unavoidable on the path to long-term improvement and sustainability, but that shouldn't be a reason to shy away from change.
- Medicaid needs to remain reliably funded for any progress
    - Including access for people without citizenship
- While some reimbursement decisions are made at the federal level, there is meaningful room for state-level action.
- Reimbursement commensurate with the full complexity of pregnancy care, including patients with housing instability and substance use disorders is needed.
- Current payment leads to perverse incentives—for instance, higher-risk pregnancies may generate more revenue.
- The RVU model for provider compensation creates different reimbursement rates for the same work depending on provider type.

- Peer support workers cannot bill for transport or more than two hours per day, which limits their ability to effectively do their job and contributes to workforce attrition.
- Community birth settings deserve a funded model, including a home birth facility fee, which is currently unavailable in Oregon.
- There are hospital-specific issues including the cost burden of inductions (which occupy beds and staff time without higher reimbursement) and the need to address antepartum outlier payment.
- Consistency is needed in what coverage can be expected from private payers and to address the significant administrative burden of insurance denials.

Specific recommendations:

- Create a statewide alternative payment model for substance use disorder and mental health care in perinatal settings
- Explore a single-payer solution for maternal and child health
- Prioritize coordinated care organization contracting for specialty care at state rate rather than through piecemeal negotiations
- Prioritize reimbursement for preventive care, including perinatal care as an entry point for identifying chronic disease
- Explore coupling freestanding birth centers with federally qualified health centers
- Explore opt-out rather than opt-in models for doulas, given high acceptance once patients understand the benefit

Capacity payments & other direct supports to small, rural hospitals

This group focused on what is needed for capacity payments and other direct supports to have real impact on small and rural hospitals' ability to continue providing maternity services, as well as what long-term sustainability requires.

Key Highlights:

- “Losing maternity services means losing the future of a community”
- Rural hospitals need to be funded as an essential service
    - The compensation structure must cover fixed costs, training, and incentives for staff to maintain on-call availability.
- The cost of locum tenens physicians and travel nurses is a significant and unsustainable expense.
- Even with improved payment, there are sustainability concerns.
    - Engagement strategies and community investment (i.e., training the existing workforce) must accompany payment reform for it to be successful in a rural setting.
- There is need for clear integration of traditional health workers, doulas, and other community-based providers into care models where this coordination and collaboration benefits the patients and decreases total cost of care.
- Existing models, such as Medicare payments for emergency departments, may offer a template for fixed-fee structures for L&D services.
- It is important to distinguish between on-site and on-call teams for sustainable staffing structure.

Specific recommendations:

- Establish capacity payments for low-volume hospitals.
- Fund rural hospitals as essential services with predictable, baseline revenue.
- Create an Oregon obstetric service corps to reduce dependence on costly locum tenens providers.

Maternal health workforce development

This group explored what short- and long-term changes are needed to increase workforce development of nurses, obstetricians, midwives, family medicine physicians, and behavioral providers in Oregon.

Key highlights and recommendations:

- Education and training pathways:
    - Support online and distance learning programs to reach a larger audience
    - Fund clinical placements and pay preceptors for their teaching time
    - Recruit BIPOC preceptors for BIPOC students
    - Create viable funding and loan forgiveness options for RN, CNM, and MD education
    - Increase available spots in nursing, medical, and midwifery programs and increase obstetric and family medicine obstetric residencies
    - Create Certified Midwife licensure in Oregon to reduce barriers, lower costs, and free up nursing program spots.
    - Expand clinical rotations to rural students
- Early pipeline:
    - Create and fund high school programs introducing students to healthcare careers with specific attention to maternity care workforce.
    - Support healthcare job shadowing for high school students and remove administrative barriers to these programs.
- Retention and working conditions:
    - Move toward 8-hour shifts and more flexible scheduling to improve work/life balance and reduce burnout.
    - Provide on-site childcare and housing support for providers in areas with high-cost or limited housing.
    - Expand opportunities for career advancement for those already in the maternity care workforce.
    - Investigate why providers and nurses are declining jobs so underlying issues can be addressed.
- Expanded workforce roles:
    - Additional roles affecting access include: medical assistants, doulas, traditional health workers, interpreters, and surgical techs.
    - Provide perinatal training for EMS providers.
    - Maximize effective use of telehealth (e.g., TeleBaby programs).
- Collaboration over competition:

    - Develop collaborative recruitment models across hospital systems rather than competing for the same limited pool of providers.
    - Explore a youth mental health corps (e.g., AmeriCorps model).

Maternal health quality improvement and safety

This group discussed what is needed in the short- and long-term to support a consistent, sustainable focus on maternal health quality improvement and safety across Oregon hospitals, clinics, Oregon Health Authority, and healthcare payers.

Key highlights:

- Quality improvement needs to be considered essential and built into operational budgets
- Need consensus on both internal and public-facing quality metrics and consistency in reporting
    - Caution about unintended consequences of poorly designed incentives.
- Need for increased access to data and data training for leaders in maternal child health.
- Emphasize both quantitative and qualitative approaches to measurement.
    - Important to develop robust narratives around quality in perinatal care.
    - "No data without stories, and no stories without data."
- Standardized EHR systems could improve both metrics and direct care.
- To reliably participate in quality improvement work, teams need: reimbursement for time, protected time away from direct care, and streamlined administrative processes (e.g., maintenance of certification Part IV requirements).
- Spread of best practices should be a primary quality improvement strategy.
    - Ideas for this included an online repository, improved awareness of existing resources, and supported adaptation to local settings.
- Reduce burden and coordination across projects and stakeholders to streamline participation.
- Clear, visible statewide standards increase transparency and give site leaders tools to advocate internally for resources.
- At the individual patient level, community health worker and navigation roles are essential for tracking patients and supporting connections across obstetric, pediatric, and behavioral health services.

Specific recommendations:

- Create an online repository of best practices (similar to the Association of Maternal & Child Health Programs).
- Fund Oregon Maternal Data Center participation for all hospitals
    - Include technical assistance support for file development.
- Create communication channels that allow clinical teams to confirm standards for specific maternal/ newborn topics across Oregon.

Investment in maternal health for long-term, system-wide improvement in population health and cost savings

This group explored how Oregon can prioritize maternal public health investments to improve population health, reduce chronic disease burden, and decrease costs across government health and social spending over the short- and long-term.

Key highlights:

- Make maternal health a public health priority:
    - Focus on social determinants of health including housing, nutrition, basic income, childcare, and transportation.
    - Explore universal income during pregnancy and for one year postpartum.
    - Prioritize perinatal families for housing assistance.
- Invest in social support infrastructure, as social isolation and healthcare access solutions overlap
    - Use neighborhood hub and/or community center models to provide space for peer connection, traditional health worker navigation, care coordination, and group support.
    - Provide prenatal home visits and group prenatal and postpartum care (this could also serve as an opportunity to offer place-based solutions).
    - Invest in multigenerational spaces (e.g., daycares and elder care are in the same space)
- Invest in sexual and relationship health and substance use education in schools
    - Emphasize parent education and involvement—support them as educators.
    - Support culturally-specific sexual health education.
- Invest in integrated perinatal substance use disorder care
    - Prioritize family-oriented treatment models.
    - Integrated behavioral and physical health care for perinatal substance use disorder may serve as a potential pilot project for broader healthcare integration.
- Extend and expand postpartum care to one full year, including doula and traditional health worker support for respite care and sleep.
- Increase parental leave, with a goal of one year for all parents through a centralized program.
- Strengthen lactation support
    - Provide Oregon Health Plan coverage for tele-lactation services and lactation education coverage as a benefit separate from general perinatal education.
    - Offer lactation training for the full perinatal workforce.
- Include perinatal experts and advocates in all policy and planning spaces that affect maternal and child health.
- Expand access to traditional health workers and doulas through:
    - Improved payment processes
    - Quality incentive metrics
    - Clear billing guidance

    - Pathway for traditional health workers to train as doulas and be reimbursed at a higher combined rate.

Presenter Recommendations to improve access in Black/African American and Native American/Alaska Native Communities

During their presentations, Dr. Roberta Hunte and Dr. Lakota Scott included some specific recommendations to improve access to maternity care in Black/African American and Native/American/Alaska Native communities.

Specific recommendations:

- Operationalize Prevention
    - Embed postpartum risk, mental health, and continuity into perinatal quality improvement
    - Make continuity and community integration visible for learning
    - Use convening power to reduce fragmentation that drives emergency department reliance
- Establish collaborative team-based approach to perinatal care as well as behavioral health and substance use disorder treatment
- Ensure consistent breastfeeding guidance is provided
- Increase access to doula programs and patient navigation services
- Provide community education on neonatal abstinence syndrome and neonatal opioid withdrawal syndrome

Large Group Discussion on Action

The convening closed with an open discussion on next steps and collective action.

Key highlights:

- Importance of individual and organizational engagement in policy
- Each person in the room holds unique expertise that legislators, colleagues, and community members need to hear.
    - Attendees are subject matter experts who local legislators need to hear from
    - Good policy takes time and staying the course matters.
- Data and storytelling as tools everyone can and should use.
- Each participant is a translator between the clinical and policy worlds and is capable of making the case for maternity care investment to a wide range of audiences
- On workforce sustainability, it was noted that caring for patients requires that clinicians themselves be cared for
    - Work/life balance in the perinatal workforce is not a secondary concern but a precondition for high-quality care.
- Making connections for future work:
    - Diana Smith, clinical lead for OPC statewide perinatal substance use disorder work, requested that anyone interested connect directly with her
    - Kelly Hansen of the Oregon Maternal Mortality & Morbidity Review Committee shared about the need for people to apply to seats as they open

and shared that the Maternal Mortality & Morbidity Review Committee can present findings to organizations on request

- In response to a question about sustainability beyond the Rural Health Transformation Program grant period, Oregon Health Authority confirmed that there will be regional discussions to consider long-term solutions before the end of the grant period.