CALIFORNIA MATERNAL HEALTH INNOVATION

Funded by the Health Resources and Services Administration (HRSA)

California Maternal Health Strategic Plan

For Health Resources and Services Administration (HRSA)
State Maternal Health Innovation (MHI) Program

September 2025

CMQCC California Maternal Quality Care Collaborative

DHCS California Department of Health Care Services

CDPH California Department of Public Health

Office of the California Surgeon General

Table of Contents

Section I. Overview of Maternal Health & Resources 3
a) State-Level Maternal Health Strengths and Existing State and Local Initiatives Aimed at Improving Maternal Health and Wellness in California 3
Introduction 3
Existing Statewide Strengths and Assets in California 4
Existing Community-Based/Community-Led Strengths and Assets 15
HRSA-Funded Projects in California 17
Maternal Health-Related Policy and Legislation 18
b) Community Investment in Maternal Health in California 18
Birthing Care Pathway Medi-Cal Member Engagement 19
Postpartum Interviews 19
c) Challenges and Gaps Identified to Improve Maternal Health and Wellness in California 20
Section II. California Maternal Health Task Force 28
a) Vision and Mission 28
b) Development, Composition, and Progress to Date 28
c) Meeting Frequency and Activities for 2024 - 2028 31
Section III. State Maternal Health Innovation Program Goals & Strategic Plan 36
a) Overview of California Maternal Health Innovation 36
b) California Maternal Health Innovation Goals 39
c) Strategies to Address Maternal Health Needs 39
d) Alignment with Title V Needs Assessment 49
e) California Innovations to Support Maternal Health 50
Appendices 53
Appendix A: HRSA-Funded Grants in California Focused on Maternal Health Since FY 2018 (As of September 2024) 53
Appendix B: Postpartum Interviews Themes and Quotes 57
Appendix C: California MCAH Title V Needs Assessment Summary (2021) 67

Section I. Overview of Maternal Health & Resources

a) State-Level Maternal Health Strengths and Existing State and Local Initiatives Aimed at Improving Maternal Health and Wellness in California

Introduction

California has a decades-long, robust history of prioritizing maternal health. The state led the nation in 1996 by launching the first Perinatal Quality Collaborative (PQC) – California Perinatal Quality Care Collaborative (CPQCC) – and establishing the first Pregnancy-Associated Mortality Review (PAMR) Committee (CA-PAMR committees are now housed under the umbrella of the Pregnancy-Associated Review Committee (CA-PARC)). To address California's rising maternal mortality rates, the California Maternal Quality Care Collaborative (CMQCC) was established in 2006 and has worked across the state to help reduce maternal mortality by 65% from 2006 to 2016.[1] California is working toward a vision of being a state where all mothers and babies are thriving at 12 months by coordinating health care, public health, and community systems to improve severe maternal morbidity and mortality via a collective impact approach.

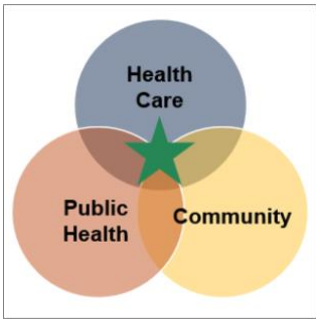
To inform development of the statewide Maternal Health Strategic Plan, maternal health stakeholders identified reports that provided a California-specific, comprehensive assessment of maternal health needs and offered recommendations. CMQCC and its partners drew the recommendations in the Strategic Plan from the following population-level reports:

- **Maternal Mortality** (California Pregnancy Mortality Surveillance System [CA-PMSS] Report 2021: Pregnancy-Related Deaths 2008-2016; CA-PAMR Report 2018: From 2002 to 2007, Maternal Death Reviews);
- **Black Mothers' Birthing Experiences and Outcomes** (Centering Black Mothers in California 2023; The California Black Birth Justice Agenda: Unifying the Vision for Systemic Change 2023);
- **American Indian/Alaska Native Mothers' Birthing Experiences and Outcomes** (California American Indian/Alaska Native Maternal and Infant Health Status Report 2019);
- **Existing Action Plans for Investment in Maternal, Child, and Adolescent Health (MCAH)** (California Title V Action Plan 2024; CalAIM Population Health Management (PHM) Policy Guide 2024); and
- **Maternal Mental Health** (CA-PAMR Report 2019: Pregnancy-Associated Suicide, 2002-2012).

These reports identify maternal and infant health needs and offer concrete, empirical recommendations based on the identified needs. CMQCC brought these recommendations to the California Maternal Health Task Force (MHTF) Steering Committee, who used the recommendations as a foundation for the Strategic Plan.

[1] What We Do, n.d., CMQCC.

California recognizes the importance of bringing together health care, public health, and community systems to meaningfully improve physical health, behavioral health, and health-related social needs for pregnant and postpartum women, their newborns, and their families. Many organizations, from grassroots organizations to State agencies, have worked for decades to effectuate these goals, as described in further detail below.



Existing Statewide Strengths and Assets in California

CMQCC, as the state's PQC together with CPQCC, partners with State agencies to improve health outcomes and experiences for pregnant and postpartum women, and newborns through early childhood; to reduce rates of maternal and infant mortality and morbidity; and to address the needs of patient populations more likely to be impacted by negative health outcomes. One in 10 births in the United States are in California and of those births, 40% are covered by Medi-Cal (California Medicaid).[2] CMQCC's State agency partners for maternal health initiatives – including this Health Resources and Services Administration (HRSA) State Maternal Health Innovation (MHI) Program – comprise:

- **Department of Health Care Services (DHCS)**: Serves as the state Medicaid agency and oversees Medi-Cal and initiatives focused on improving maternal health outcomes for pregnant and postpartum Medi-Cal members, including the Birthing Care Pathway (see more below).
- **California Department of Public Health (CDPH):** Oversees the Title V Block Grant funding supporting many of California's maternal and infant programs, as well as many other initiatives for pregnant and postpartum women and their families (see more below).
- **California Office of the Surgeon General (CA-OSG):** One of only six states with a surgeon general, CA-OSG leads statewide initiatives to improve the public's health, including Strong Start & Beyond, focused on California's birthing population (see more below).

DHCS, CDPH, and CA-OSG all partner with CMQCC to promote synergy across maternal health initiatives in California. Areas of CMQCC's State agency partnerships include: serving as and advising the PQC, contracting with CDPH for the Regional Perinatal Programs of California (RPPC), working together under California's legislative mandate to oversee the CA-PARC (established under CDPH), engaging in the review and reporting of maternal deaths, playing a key role in the CA-OSG's Strong Start & Beyond California Maternal Health Blueprint, and contributing to the development of the DHCS Birthing Care Pathway as workgroup members, interviewees, and subject matter experts.

[2] California Health Care Almanac: Maternity Care in California: Delivering the Data, 2023, California Health Care Foundation (CHCF).

The table below summarizes statewide organizations and their key maternal health-related initiatives that promote and present opportunities for innovation and collaboration to improve maternal health outcomes in California. Collaborating and leveraging the following systems of care and programs to address maternal health outcome challenges is a key strategy of California MHI. A high-level summary is in **Figure 1: California's Maternal Health Assets.** Outlining these initiatives highlights the opportunities for coordination by strategically bringing these organizations together through this project.

Figure 1: California's Maternal Health Assets (2024)

California's Key Maternal Health Initiatives	
Statewide Organization	**Role in Improving Maternal Health**
California Perinatal Quality Collaborative (PQC) *California Perinatal Quality Care Collaborative (CPQCC) and California Maternal Quality Care Collaborative (CMQCC) work side-by-side as California's PQC.*	CPQCC and CMQCC serve as California's PQC. CPQCC aims to improve health outcomes and experiences and reduce rates of mortality and morbidity for newborns through early childhood, and to address the needs of patient and family populations more likely to be impacted by negative health outcomes. CPQCC's programs focus on neonatal intensive care unit (NICU) data collection, data analysis, quality improvement (QI), community engagement and family centered-care, and follow-up care for high-risk infants. CMQCC aims to improve health outcomes and experiences for pregnant and postpartum patient populations, to reduce rates of preventable maternal mortality and morbidity, and to address the needs of patient populations more likely to be impacted by negative health outcomes. CMQCC uses maternal mortality review findings, research, and community engagement to develop QI toolkits, lead statewide hospital QI collaboratives, and provide performance metrics and benchmarking data for member hospitals' QI efforts through its Maternal Data Center. CMQCC is spearheading multiple ongoing initiatives, including: • **Low-Dose Aspirin to Prevent Preeclampsia and Preterm Birth Initiative.** CMQCC, in partnership with March of Dimes, is collaborating with select hospitals and community organizations statewide to promote the use of daily low-dose aspirin for women at risk for preeclampsia. • **Community Birth Partnership Initiative (CBPI).** CBPI aims to improve health outcomes during pregnancy and birth by increasing the quality and whole-person safety of hospital transfer processes when a transfer is needed for a community birth. CBPI also seeks to enhance integration between perinatal care systems that have traditionally worked in isolation from each other in California. • **Reducing Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Delivery Rates by Supporting Vaginal Births.** This Centers for Disease Control and Prevention (CDC)-funded project works to overcome identified clinician-based barriers to reduce NTSV cesarean delivery rates through QI strategies and by applying an implementation science framework.
California Department of Health Care Services (DHCS)	DHCS is California's Medicaid agency. Since Medi-Cal covers more than 40% of all births statewide, DHCS has taken steps to strengthen coverage and care for pregnant and postpartum Medi-Cal members through the following: • Starting in 2019, DHCS pioneered **CalAIM** as a broad transformation of Medi-Cal to create what DHCS describes as, "a more coordinated, person-centered, and equitable health system that works for all Californians." Such initiatives impacting pregnant and postpartum Medi-Cal members and their families include, but are not limited to: ○ The **Bold Goals 50x2025 Initiative** was launched in 2022 when DHCS released the Comprehensive Quality Strategy (CQS). This initiative is a set of five goals to improve clinical and health outcome rates for Medi-Cal members more likely to experience

California's Key Maternal Health Initiatives	
Statewide Organization	**Role in Improving Maternal Health**
	negative outcomes, relative to other members', by 50% by 2025. Two of the five goals are specific to maternal health: reducing negative maternity care outcome rates by 50% for Black and American Indian/Alaska Native women, relative to other members', and improving maternal and adolescent depression screening rates by 50%. In July 2025, DHCS released an updated CQS for public comment that builds on the 2022 CQS by maintaining maternal outcomes and health equity at birth as a key clinical focus area, adding significant programming on maternity care to align with the Birthing Care Pathway, and ensuring the successful achievement of its Bold Goals. ○ In January 2023, DHCS launched the **Population Health Management (PHM) Program** in Medi-Cal managed care to establish a cohesive, statewide approach for ensuring Medi-Cal members have access to a comprehensive set of services based on their needs and preferences across the continuum of care. ▪ PHM includes **Transitional Care Services (TCS)** to ensure Medi-Cal managed care members are supported from discharge planning until they have been successfully connected to all needed services and supports. ▪ PHM includes three types of services and supports across the care continuum: ● **Basic Population Health Management (BPHM):** All members in Medi-Cal managed care receive BPHM. ● **Complex Care Management (CCM):** Medi-Cal managed care members who need extra support to avoid adverse outcomes, but who are not the group more likely to be impacted, receive CCM. ● **Enhanced Care Management (ECM):** Medi-Cal managed care members with complex clinical and non-clinical needs receive ECM through intensive coordination of health and health-related services. One of ECM's Populations of Focus is pregnant and postpartum Medi-Cal members who are more likely to experience negative birth outcomes. ▪ DHCS launched **Medi-Cal Connect** (formerly PHM Service) to help safely and easily connect Medi-Cal managed care members and their health history and data with their providers, delivery systems, state programs, and other relevant entities. The first of five phases of Medi-Cal Connect's rollout launched in July 2024, with the expectation that Medi-Cal is fully available statewide by 2026. ▪ The **Risk Stratification, Segmentation, and Tiering (RSST)** Algorithm is a predictive analytics system that is part of

California's Key Maternal Health Initiatives	
Statewide Organization	**Role in Improving Maternal Health**
	DHCS' PHM Strategy. It aims to identify Medi-Cal members, including pregnant and postpartum members, who are more likely to be impacted by negative outcomes or who may underutilize essential services and who may benefit from additional outreach or care coordination. Each month, the RSST Algorithm assigns each eligible member to a risk tier – low, medium-rising, or high – based on a predicted likelihood of future outcomes. DHCS launched Version 1 of RSST in Medi-Cal Connect in July 2025. Models for birthing populations were trained alongside adult and pediatric models but did not meet performance standards for inclusion in Version 1. These models will be revised, retrained, and incorporated into a future RSST release. ○ **Community Supports**, which launched in January 2022, are statewide services provided by Medi-Cal managed care plans (MCPs) as alternatives ("in lieu of services") to other services covered by Medi-Cal that can help members avoid higher levels of care. Pregnant and postpartum women can receive any Community Support for which they qualify, regardless of whether they are enrolled in ECM (see above). Of the 15 pre-approved Community Supports, the ones that pregnant and postpartum Medi-Cal members are more likely to benefit from include Transitional Rent, Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Medically Supportive Food/Meals/Medically Tailored Meals. ▪ In April 2025, DHCS released two Community Supports Policy Guides (Volume I and Volume II) to MCPs encouraging the plans to engage in maternal health partnerships and collaborations with community providers to meet the health-related social needs of pregnant and postpartum Medi-Cal members. ▪ As of April 2025, DHCS recognizes pregnancy and up to 12 months postpartum as an optional Population of Focus for Transitional Rent. As Transitional Rent is implemented, DHCS will continue coordinating with maternal health partners to refine the benefit's design to meet the specific needs of pregnant and postpartum Medi-Cal members. ● DHCS began developing a comprehensive policy and care model roadmap called the **Birthing Care Pathway** in 2023 to cover the journey of all pregnant and postpartum Medi-Cal members from conception through 12 months postpartum. The Birthing Care Pathway is designed to be a strategic roadmap for State entities, MCPs, counties, providers, social service entities, philanthropy, and other key partners serving pregnant and postpartum Medi-Cal members. The goals of the Birthing Care Pathway are to reduce maternal morbidity and mortality and reduce negative

California's Key Maternal Health Initiatives	
Statewide Organization	**Role in Improving Maternal Health**
	health outcomes for member populations that are more likely to be impacted, such as Black, American Indian/Alaska Native, and Pacific Islander Medi-Cal members. ○ In February 2025, DHCS released the Birthing Care Pathway Report, which summarizes the current state of maternal health in Medi-Cal; outlines DHCS' vision for the Birthing Care Pathway; shares findings from Birthing Care Pathway Medi-Cal member engagement; provides an overview of the partner engagement conducted to date; discusses the policies DHCS is implementing for the Birthing Care Pathway and shares progress to date; and identifies strategic opportunities for further exploration for the Birthing Care Pathway. DHCS is actively implementing or continuing to implement the 42 policy solutions identified in the Birthing Care Pathway Report. ○ The Birthing Care Pathway is a foundational initiative for California and a core strategy featured in and amplified by California MHI. ● In July 2025, DHCS, the Purchaser Business Group on Health (PBGH), CMQCC, CDPH, and CA-OSG jointly released **Enhancing Postpartum Care for California's Birthing Population through "The Postpartum Pathway": A Concept Paper**. In response to increasing negative maternal health outcomes in California – and in recognition that the majority of maternal morbidity and mortality occurs during the postpartum period – these organizations came together between 2022 – 2024 to conceptualize a more coordinated, patient-centered approach to postpartum care. During that time, DHCS convened the Postpartum Sub-Workgroup to further develop a clinical practice-level postpartum care pathway. The Concept Paper memorializes the collaborative work of DHCS, PBGH, CMQCC, CDPH, and CA-OSG. It summarizes key outputs from DHCS' Birthing Care Pathway Postpartum Sub-Workgroup, including actionable recommendations and a proposed clinical model, which together aim to enhance postpartum care for all Californian women. The Postpartum Pathway is aspirational in nature and its recommendations will require testing by stakeholders to determine feasibility and long-term sustainability. ● The **Comprehensive Perinatal Services Program (CPSP)** was first established as a pilot program (the Obstetrical Access Project) in 13 California counties from July 1979 through June 1982 and was expanded statewide in 1987 by the California State Legislature as a Medi-Cal benefit.[3] DHCS and CDPH jointly oversee CPSP which provides a set of services from conception through 60 days postpartum, including obstetrical care plus enhanced services: health education, nutrition, and psychosocial services; trimester assessments; individualized care planning; vitamin/mineral supplements; and case coordination and referrals to

[3] CPSP State Statute: California Welfare & Institutions Code § 14134.5; CPSP State Regulation: Title 22 § 55179 – 51179.9, 51249, 51348 – 51348.2, 51504.

California's Key Maternal Health Initiatives	
Statewide Organization	**Role in Improving Maternal Health**
	other services (e.g., Women, Infants, and Children (WIC), dental care). DHCS is currently reviewing how to best modernize and support CPSP through the Birthing Care Pathway. ● DHCS has been **increasing** **Medi-Cal provider reimbursement rates** to ensure Medi-Cal providers are adequately reimbursed for their services and to promote provider participation in Medi-Cal. In January 2024, the rate was increased to 87.5% of Medicare rates for obstetric service providers and professionals (e.g., OB/GYNs, doulas, midwives) across fee-for-service and MCPs, and DHCS calculated an equivalent rate benchmark and increase for services that do not have a rate established by Medicare. In January 2025, DHCS leveraged hospital-specific state directed payment arrangements to enhance reimbursement for and improve the availability of labor and delivery and hospital-based birthing center services. ● The **American Indian Maternal Support Services (AIMSS)** program is administered by DHCS' Office of Tribal Affairs and provides perinatal case management (e.g., health care, education, emotional support, referrals to community services, follow-up during and after pregnancy) and evidence-based home visitation services to American Indian/Alaska Native pregnant and postpartum women through their infant's first year of life. AIMSS is Title V-funded and currently has four American Indian/Alaska Native programs that receive funds, in Fresno, Humboldt, Placer, and Shasta counties. ● In June 2025, the National Academy for State Health Policy (NASHP), with support from HRSA's Maternal and Child Health Bureau, selected California as one of eight states to participate in the **Advancing State Strategies to Address Maternity Care Deserts Policy Academy**. Over two years, the Academy will support DHCS and CDPH to expand access to quality maternity care, especially in areas that experience significant negative outcomes. DHCS and CDPH will partner with HCAI, CMQCC, and Medi-Cal MCPs to identify, develop, and strengthen policy strategies to address maternity care shortage areas, including factors that impact health care access and workforce development. This work builds on the DHCS policies outlined in the Birthing Care Pathway Report. It also reflects DHCS' priorities to address deficiencies in access and quality of care in maternal health and ensure that all pregnant women, especially women in low-income communities, receive the support they need to safely navigate pregnancy and childbirth.
California Department of Public Health (CDPH)	CDPH's Maternal, Child, and Adolescent Health (MCAH) Division manages California's **Title V Maternal & Child Health (MCH) Block Grant,** which is federally administered by HRSA and provides funding to California to improve the health and well-being of mothers, infants, children and youth, children with special health care needs, and their families. The Title V Block Grant provides the foundation for the state to conduct the mandated five-year population level needs assessment and informs the state and local five-year

California's Key Maternal Health Initiatives	
Statewide Organization	**Role in Improving Maternal Health**
	Action Plans. See Section III for more information on the California MCAH Title V Needs Assessment findings and priorities. In addition to the state-level five-year needs assessment and action plans, CDPH distributes Title V funding to 61 local health jurisdictions to support the **local MCAH programs,** which are responsible for implementing and overseeing many CDPH programs, including but not limited to: ● The **Adolescent Family Life Program** (AFLP), a strengths-based case management program designed to support and empower expectant and parenting girls and youth. AFLP services are provided by county health departments, hospitals, and community-based organizations (CBOs) with case managers meeting with youth to establish a relationship and offer support with accessing services, setting goals, and planning for the future. AFLP is available in 15 California counties for girls and youth up to 21 years of age at the time of enrollment who are pregnant and/or parenting, including partners in pregnancy and parenting. AFLP is funded through federal Title V MCH Block Grant funds and federal Medicaid funds. ● **California Women, Infants, and Children** (WIC) is the state's WIC program since 1972 and provides nutrition education, breastfeeding support, healthy food, and referrals to health care and other community services to eligible pregnant and postpartum women with infants and children up to age five. ● The **California Home Visiting Program** (CHVP), which provides evidence-based home visiting services to eligible pregnant and newly parenting families. ● **Black Infant Health** (BIH), an evidence-informed intervention that uses a group-based approach to facilitate community-building among Black pregnant women. ● The **Perinatal Equity Initiative** (PEI), a community-driven and implemented initiative designed to support Black families, a population more likely to experience infant mortality. PEI complements programs and services offered through BIH and provides meaningful support and resources to Black families in California. ● The **Regional Perinatal Programs of California** (RPPC), a cooperative network of public and private health care professionals, identifies and addresses the special needs of high-risk pregnant women and infants, particularly in areas with significant rates of negative outcomes, and supports birthing hospitals with QI activities and resources. ● The **California Genetic Disease Screening Program** (GDSP), a statewide program that seeks to mitigate genetic and congenital disorders including through screening programs specific to pregnant women and infants. ● The **California Sudden Infant Death Syndrome** (SIDS) program, which strives to reduce the number of SIDS deaths and all forms of sudden unexplained infant death (SUID) in California.

California's Key Maternal Health Initiatives	
Statewide Organization	**Role in Improving Maternal Health**
	CDPH and the University of California San Francisco (UCSF), in collaboration with 14 local community partners and MCAH programs, published **Centering Black Mothers in California** in 2023. This report is informing the development of a CDPH action plan for increasing positive birth outcomes for Black mothers, in partnership with the community. In addition to Centering Black Mothers in California, CDPH published multiple reports used to inform this Strategic Plan, including: ● CA-PMSS Report 2021: Pregnancy-Related Deaths 2008-2016 ● California American Indian/Alaska Native Maternal and Infant Health Status Report 2019 ● California Title V Action Plan 2024 ● CA-PAMR Report 2018: From 2002 to 2007, Maternal Death Reviews ● CA PAMR Report 2019: Pregnancy-Associated Suicide CDPH also maintains two sources of population-specific data that support the work of county, regional, and local entities: ● The **Maternal and Infant Health Assessment** (MIHA) is an annual, statewide-representative survey of people in California who have recently had a live birth. MIHA collects self-reported information about maternal and infant experiences and about maternal attitudes and behaviors before, during, and shortly after pregnancy. ● The MCAH Division publishes online **data dashboards** for California, all designed to serve the data needs of partners and stakeholders. State, county, and/or regional-level data are shown by year and various stratifications or subgroups.
California Office of the Surgeon General (CA-OSG)	CA-OSG is advancing the health and well-being of pregnant and postpartum Californian women through the following initiatives: ● **Strong Start & Beyond**, a movement that leverages California's investments and partnerships to implement transformative solutions to improve the reproductive and maternal health of California's women and girls, and strives to (1) educate and empower women and girls on their reproductive health, including through the launch of a new Preconception Risk Medical Assessment (PReMA), to be conducted in the community, and (2) reduce maternal mortality by building patient trust and empowering patients to become active participants in their health through creative use of social media and other forms of technology and AI. ● The **ACEs Aware** initiative, a first-in-the-nation effort to screen patients for adverse childhood experiences (ACEs) that is now led by the newly created University of California (UC) ACEs Aware Family Resilience Network (UCAAN).

California's Key Maternal Health Initiatives	
Statewide Organization	**Role in Improving Maternal Health**
	● The California Maternal Health Blueprint, published in September 2024, which outlines two critical goals: educating and empowering women about their reproductive health, and reducing maternal mortality rates.
California Department of Social Services (CDSS)	CDSS oversees the following programs that address the health-related social needs of pregnant and postpartum Californian women and their children and families: ● CalFresh, California's Supplemental Nutrition Assistance Program (**SNAP**), or food stamp program. ● Cal-Learn, a required statewide program for pregnant teen girls and teen parents enrolled in the California Work Opportunity and Responsibility to Kids (CalWORKs) – CalWORKs is California's Temporary Aid to Needy Families (**TANF**) program. ● The CalWORKs Home Visiting Program (HVP), administered by county welfare departments to support positive health outcomes for low-income pregnant women and parents, families, and infants and to expand educational, economic, and financial capability opportunities.
California Department of Developmental Services (DDS)	DDS works to ensure Californians with developmental disabilities can make choices and lead independent, productive lives as members of their communities in the least restrictive setting possible. DSS administers or oversees the following programs, among others: ● Early Start, California's early intervention program for infants and toddlers with disabilities and their families. Early Start services are federally mandated, available statewide, and provided in a coordinated, family-centered system. ● Coordination and delivery of services for Californians with developmental disabilities through a statewide network of 21 community-based, nonprofit agencies known as Regional Centers that provide assessments, determine eligibility for services, and offer case management services.
California Department of Health Care Access and Information (HCAI)	HCAI administers numerous initiatives with the goal of increasing the volume and variety of health care providers in areas of unmet need across California, including: ● The California State Loan Repayment Program for primary care physicians, dentists, dental hygienists, physician assistants, nurse practitioners, certified nurse midwives (CNMs), pharmacists, and mental/behavioral health providers working in federally designated Health Professional Shortage Areas (HPSAs). ● The Song-Brown Healthcare Workforce Training Program aims to increase the number of students and residents receiving quality primary care education and training in areas of unmet needed throughout California. ● The California Health Workforce Education and Training Council which is responsible for helping coordinate California's health workforce education and training. ● **Statewide certification requirements for community health workers (CHWs), promotoras, and representatives**.

California's Key Maternal Health Initiatives	
Statewide Organization	**Role in Improving Maternal Health**
California Labor and Workforce Development Agency (LWDA) and California Business, Consumer Services and Housing Agency (BCSH)	The LWDA's Economic Development Department (EDD) provides **short-term wage replacement benefits** to eligible pregnant and postpartum California women who work through two types of claims – (1) **Disability Insurance** and (2) **Paid Family Leave**. While neither Disability Insurance nor Paid Family Leave provides job protection, only monetary benefits, pregnant and postpartum Californian women may also be entitled to **unpaid, job protected leave** through (1) **California Pregnancy Disability Leave** (administered by BCSH); (2) the **California Family Rights Act**; and (3) the **federal Family and Medical Leave Act**. In January 2025, Legal Aid at Work (LAAW) and EDD developed a guide for health care and social services providers on the different types of leave, pay, and accommodations for pregnant and postpartum women workers in California. This guide was disseminated to Tribal and Indian Health Provider (IHP) Representatives in August 2025 and to MCPs in September 2025 to share with their providers and care managers. In 2026, this guide will also be posted on a new CMQCC webpage addressing the leave rights of pregnant and postpartum women in California.
First 5 California	**First 5** is a uniquely California entity founded in 1998, when California voters passed Proposition 10 – which levies a tax on tobacco products – to fund critical services for California parents, families, and children ages zero to five. There is one First 5 county commission in each of the state's 58 counties, with First 5 Association of California distributing funds to communities through local First 5s. The First 5s focus on early learning and care, effective interactions and teaching (e.g., investments in child care and teachers), positive parenting, tobacco and vaping cessation, public outreach, and advocacy and policy.
Philanthropic Partners	There are multiple California-based philanthropic organizations committed to improving maternal health throughout the state, including but not limited to: ● The **California Health Care Foundation (CHCF)** is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need, especially low-income Californians and communities who have traditionally faced significant barriers to care. Through investments in reducing negative health outcomes for those more likely to be impacted, including support for DHCS' Birthing Care Pathway, CHCF specifically aims to improve maternity care and maternal outcomes by, with, and for Black mothers in California. ● The **David and Lucile Packard Foundation** states that the organization "works with people and communities to create enduring solutions for just societies and a healthy, resilient natural world." In 2024, the Foundation launched the Children and Families Initiative (CFI), a ten-year strategy dedicated to improving maternal and infant health outcomes and supporting healthy child development from birth to age three, with a

California's Key Maternal Health Initiatives	
Statewide Organization	**Role in Improving Maternal Health**
	focus on populations more likely to be impacted by negative health outcomes, including Black and American Indian/Alaska Native children and families. The CFI makes focused investments in select communities in California, Louisiana, and Mississippi, along with providing funding at the state level and nationally to support advocacy networks. The CFI is a funder of the DHCS Birthing Care Pathway, among other California initiatives. ● Founded in 2000, **Skyline Foundation** works to improve the full integration of midwifery into the national health care system, with the goal of supporting communities more likely to be impacted by negative outcomes. Skyline Foundation supports CMQCC's Community Birth Partnership Initiative, and the program's activities include engaging community midwives and hospital staff in virtual learning. ● **Merck for Mothers** is a global initiative to help create a world where no mother has to die while giving life. Merck for Mothers is supporting CMQCC in developing postpartum discharge webpages for use by clinicians and patients, which are currently being piloted by five hospital teams across California and will become publicly available in 2026.
Academic Institutions	California is home to the largest higher education system in the United States. It includes three public segments – the **University of California (UC)** system, the **California State University (CSU)** system, and **California Community Colleges** – as well as more than 150 private nonprofit colleges and universities, including Stanford University, where CMQCC and CPQCC are housed. California's academic institutions and affiliated academic health centers have applied for and received maternal health-focused federal grants and pioneered maternal health improvement initiatives at the state and local levels. They continue to serve as innovation hubs and key elements of the pipeline for educating and training the state's maternal health care workforce.

Existing Community-Based/Community-Led Strengths and Assets

Maternity care providers, advocates, and community members across California have launched multiple initiatives to improve the prenatal and postpartum care outcomes and experiences at the county, regional, and local levels. The table below seeks to provide only a sample of county, regional, and local initiatives and projects; this list is not exhaustive or complete. The California MHTF's priority over the next three years is to discover, learn, and connect efforts across the state that improve coordination of systems to advance maternal health.

Community-Based/Community-Led Maternal Health Strengths & Assets		
Initiative	**County**	**Description**
African American Infant and Maternal Mortality Prevention Initiative	Los Angeles (LA) County	A coalition of county agencies, community organizations, providers, funders, and community members working to reduce Black maternal and infant mortality rates and ensure healthy, joyous births for Black families in LA County.

Community-Based/Community-Led Maternal Health Strengths & Assets		
Initiative	**County**	**Description**
Abundant Birth Project	Alameda, Contra Costa, Los Angeles, and Riverside Counties	The first pregnancy guaranteed income supplement program in the United States, this pilot initiative is led by CDPH and the San Francisco Department of Public Health and provides cash supplements to eligible Black and Pacific Islander pregnant women as a strategy to reduce preterm birth and achieve better maternal health outcomes.
BElovedBIRTH Black Centering	Alameda County	A midwifery-led, team-based Alameda Health System model that provides high-quality prenatal and postpartum care to Black women and people who have given birth using a group prenatal care approach.
Black Maternal Health Center of Excellence	Los Angeles County	A maternity care center at Charles Drew University of Medicine and Science, a historically Black graduate institution, that focuses on reducing maternal and infant mortality rates for Black families in LA County and the U.S.
BLACK Wellness & Prosperity Center	Fresno County	A nonprofit organization founded to improve Black maternal and infant health outcomes in California's Central Valley by providing services and connections to Black pregnant and postpartum women.
Black Women for Wellness	Los Angeles and San Joaquin Counties	A nonprofit organization committed to the health and well-being of Black women and girls, including maternal and infant health, through health education, empowerment, and advocacy.
CenteringPregnancy	Statewide	A group prenatal care model offered at 51 clinical sites across California.
Frontline Doulas	Los Angeles County	A nonprofit-sponsored program that provides no-cost doula care to pregnant women and their families who identify as African American.
MAMA's Neighborhood	Los Angeles County	A pregnancy medical home model designed for prenatal patients enrolled with the Los Angeles County Department of Health Services.
MAMA's Perinatal Resources to Optimize Mental Health Interventions and Substance Use Treatment Excellence (PROMISE)	Los Angeles County	A behavioral health program funded by a 2023 HRSA Maternal Mental Health and Substance Use Disorders Award that includes a perinatal consultation line through which perinatal and primary care providers can receive provider-to-provider consultations from reproductive health psychiatrists and physicians with expertise in perinatal substance use.
Maternal Mental Health NOW	Los Angeles County	A nonprofit-sponsored project taking a systems-change approach to improving access for the prevention, screening, and treatment of prenatal and postpartum depression in Los Angeles County.

Community-Based/Community-Led Maternal Health Strengths & Assets		
Initiative	**County**	**Description**
My Sister's House	Sacramento County	A nonprofit organization serving Asian and Pacific Islander women, including pregnant and postpartum women, and children, as well as other women and children more likely to experience negative perinatal health outcomes, who are impacted by domestic violence, sexual assault, and human trafficking by providing a high-quality and responsive safe haven, job training, and community services.
Postpartum Support International California	Statewide	A California chapter of the world's leading nonprofit organization dedicated to helping women and people who have given birth who are suffering from perinatal mood disorders.
Reproductive Health Hotline (ReproHH)	Statewide	A no-cost, confidential, on-demand phone service, staffed and operated by University of California San Francisco (UCSF) clinicians who specialize in sexual and reproductive health, that provides evidence-based clinical information about sexual and reproductive health to U.S.-based health care providers.
Sacramento Maternal Mental Health Collaborative (SMMHC)	Sacramento County	A community-driven effort that acknowledges the need to ensure that every woman in Sacramento receives information on risk, prevention, and treatment of pregnancy and postpartum mood and anxiety disorders. It brings together mothers with lived experience, health care organizations, MCPs, community leaders, advocates, and service providers to identify gaps, create solutions, and ensure that all mothers receive the mental health support they need. Be Mom Aware was founded in 2021 as a SMMHC project to raise awareness of maternal mental health conditions, improve familial health system literacy and empowerment, and collaborate with health care systems and community partners to center high-quality, respectful care.
SisterWeb	San Francisco County	A nonprofit community doula organization that offers no-cost doula care to pregnant Black women with the aim of reducing negative health outcomes.
Welcome Baby	Los Angeles County	A no-cost, voluntary, universally provided hospital- and home-based intervention for pregnant and postpartum women with the goal to maximize the health, safety, and security of the baby and parent-child relationship and facilitate access to support and services.

HRSA-Funded Projects in California

HRSA has awarded grants to other California entities to support MCH-focused initiatives at the state and local levels. Partnership between CA-OSG and California MHI will further connect grantees for

coordination and collaboration to improve maternal health outcomes. For more details on HRSA grants awarded to California since FY 2018, see Appendix A.[4]

Maternal Health-Related Policy and Legislation

The California State Legislature and Governor are also committed to improving maternal and infant health and have enacted a number of laws in recent years that will be leveraged throughout the grant period to drive change. Key legislation includes:

- **Momnibus Bill (SB 65; 2021**): Required State agencies to contract with midwifery training programs, established CA-PARC to review pregnancy-related deaths and severe maternal morbidity (absorbing the former CA-PAMR), required local health departments to establish Fetal and Infant Mortality Review Committees (upon appropriation by the Legislature), required DHCS to establish the Doula Implementation Stakeholder Workgroup, and provided an exception to all pregnant women from needing to participate in welfare-to-work activities in CalWORKs.
- **Proposition 1 (2024):** Revised the state's Mental Health Services Act to support housing and personalized support services (e.g., employment assistance, education) and mental health services (e.g., mobile crisis, outreach services), and approved a $6.4 billion bond to help build more behavioral health facilities and housing facilities, all of which can ultimately help pregnant and postpartum women with behavioral health needs and improve maternal mental health in California.
- **Maternal Mental Health Program (SB 1207; 2022):** Encouraged Medi-Cal MCPs to improve screening, treatment, and referral to maternal mental health services, including doula services, and incentivized training opportunities.
- **Maternal Mental Health Screening (AB 2193; 2018):** Required perinatal providers (including midwives) to screen pregnant and postpartum women for maternal mental health conditions and required Medi-Cal MCPs and health insurers to develop a maternal mental health program.
- **California Dignity in Pregnancy and Childbirth Act (SB 464; 2019):** Required labor and delivery hospitals and birth centers to "implement an evidence-based implicit bias program" for all perinatal care providers, required CDPH to publish pregnancy-related morbidity and mortality rates, required that death certificates include additional information on the pregnancy status of the deceased, and required hospitals to provide all patients with information on their rights to comprehensive, respectful, patient-involved perinatal care.[5]

b) Community Investment in Maternal Health in California

Partnering with women with lived experience, and CBOs that serve pregnant and postpartum women, is critical for the development of the California Maternal Health Strategic Plan. CMQCC, DHCS, CDPH, and CA-OSG are amplifying community voices and investing in the community's identified policy priorities, and this work will continue throughout the Strategic Plan development and implementation.

[4] See Sections II and III for details on the Community Innovation Funds for Systems Change through Enhancement Awards provided to California doula organizations that serve Medi-Cal birthing communities.

[5] California State Legislature. SB 464: California Dignity in Pregnancy and Childbirth Act. Bill Text. 2019–2020. Accessed September 25, 2025. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB464

Birthing Care Pathway Medi-Cal Member Engagement

In Fall 2023, DHCS engaged 30 Medi-Cal members who were either pregnant or up to 24 months postpartum to share their lived birthing experiences while enrolled in Medi-Cal. Medi-Cal members were selected to represent a variety of experiences and especially to represent the lived experience of groups significantly impacted by negative health outcomes. Members participated in one of three activities – interviews, journaling, or a workgroup with other Medi-Cal members – and all were compensated for their participation. Key findings from the Birthing Care Pathway member engagement activities include:

- **Feeling Heard and Respected.** Feeling respected and heard by health care providers is critical to a member's perinatal experience in Medi-Cal. Members often feel that their birth plans and breastfeeding choices are not respected; however, members feel like midwives and doulas listen to their needs and preferences.
- **Disrespectful Health Care.** Some Medi-Cal members experienced disrespect in their health care encounters during pregnancies, births, and the postpartum periods, but felt connected to their health care providers and better supported when they received high-quality, respectful care.
- **Trust Building Opportunities.** Key moments for trust building with Medi-Cal members are often missed, particularly around trauma-informed approaches to intimate partner violence (IPV) screenings, smooth hospital discharge after birth, timely access to high-quality breast pumps, and mindful discussions on behavioral health screening results and referrals to services.
- **Care Coordination.** Medi-Cal members often felt like it was their responsibility to independently navigate and coordinate many aspects of their perinatal care – ranging from coordinating their care across different health care providers to ensuring Medi-Cal coverage for themselves and their newborns.
- **Behavioral Health Services.** Finding mental health providers that accept Medi-Cal, are taking new patients, and have perinatal experience is difficult; Medi-Cal members want more frequent and intensive mental health support.
- **Medi-Cal Benefits.** Medi-Cal members often do not understand what Medi-Cal benefits and public benefits/social services are available to them during pregnancy or the postpartum period (e.g., doula services, ECM, WIC, CalFresh, and transportation services).

Postpartum Interviews

CMQCC conducted interviews with 30 postpartum women in California who had delivered in a hospital within the past two years to learn more about their birthing and postpartum experiences. Below are the themes that emerged from the interviews and exemplary quotes can be found in Appendix B:

- **Autonomy.** Participants shared reports of providers making decisions on behalf of patients without patient involvement, participants feeling disempowered, and providers being dismissive of birthing choices (e.g., delayed cord clamping). There were also positive reports of autonomy when participant requests and needs were heard and centered in their birthing experience or postpartum care, resulting in the participant feeling empowered.
- **Barriers to Medical Recovery.** Participants described challenges with fully recovering due to external factors such as having to return to work, lack of support (e.g., cannot stay in bed for wound recovery), or needing to prioritize care for others. This also includes being ignored by providers and a lack of continuity of care.

- **Patient Experiences, Treatment, and Care.** Participants described medical mistrust that is rooted in past experiences, observations, or generational trauma.
- **Centering Religious/Spiritual/Family Needs.** Participants discussed needs and practices during labor, birth, and the postpartum period related to religion, spirituality, and other needs related to their families. This includes experiences of having such needs met, supported, not supported, or not accommodated, or the participant did not feel safe with asking about whether their needs could be met or asking for accommodations.
- **Community Resources and Connections.** Participants discussed use of community resources and connections to community, utility of community-based resources, and the quality or type of care received from the community resources (e.g., doulas).
- **Knowledge Gaps in Postpartum Care.** Participants described knowledge gaps for addressing their postpartum needs due to a lack of education, resources, and information. Participants reported a lack of prenatal education about the postpartum experience; sources of postpartum education and information, such as from their community, social media, or family; and education from medical staff.
- **Lactation Support.** Participants described experiences with lactation, such as accessing lactation education, trouble/challenges breastfeeding, access and utilization of lactation equipment or necessities (e.g., pumps, nipple shields, or pillows), and access to lactation consultants.
- **Mental Health.** Participants described struggles with getting needed support with mental health and descriptions of their mental, emotional, and behavioral health. Participants reported postpartum depression, anxiety, baby blues, or the range of emotions they needed to manage, process, or experience, as well as the ways in which they navigated getting support or the lack of support available to them from family, insurance, providers, or community.
- **Patient Assessment of Hospital Quality.** Participants described their assessments of hospital quality, such as the measures of hospital quality (e.g., comfort, birth experience, family centeredness) and the degree of quality.
- **Poor Communication Interactions with Clinical Staff.** Participants reported experiences of clinical staff being dismissive of participant questions and concerns about their health or the baby's health or lack of clarity when information is communicated. This also includes the consequences of poor communication such as miscommunication between medical staff, miscommunication with participant about medical information, distrust, diminished provider trust, or rushed decisions.
- **Practicing Self-Care.** Participants reported difficulty with taking care of their own needs, such as self-care, feelings of exhaustion, or difficulty finding time to take care of themselves.
- **Support Infrastructure.** Participants discussed the social and emotional infrastructure to support postpartum women, such as a support network, family support, or unexpected support from work, social services, or their care team.

c) Challenges and Gaps Identified to Improve Maternal Health and Wellness in California

Bringing together the findings from the California-specific reports detailed above, patient reported experiences, data findings, and discussion with the California MHTF Steering Committee, numerous challenges and gaps were identified to improve maternal health in California. To address these challenges and gaps, the strategic approach was organized into five areas that require improvement:

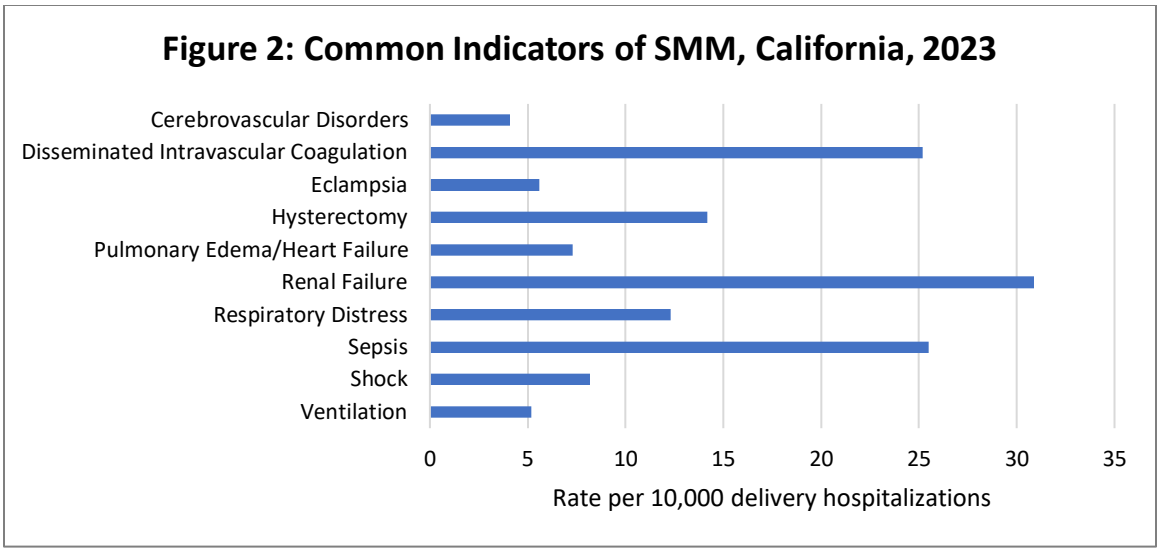
1) Inadequate patient care experiences, lacking high-quality, respectful and trauma-informed care.
2) Lack of access and links to risk-appropriate care.

3) No universal standards in place for risk assessment and appropriate follow-up for medical, behavioral, and social drivers of health.
4) Limited maternal health data access and data transparency.
5) Siloed services, programs, and interventions.

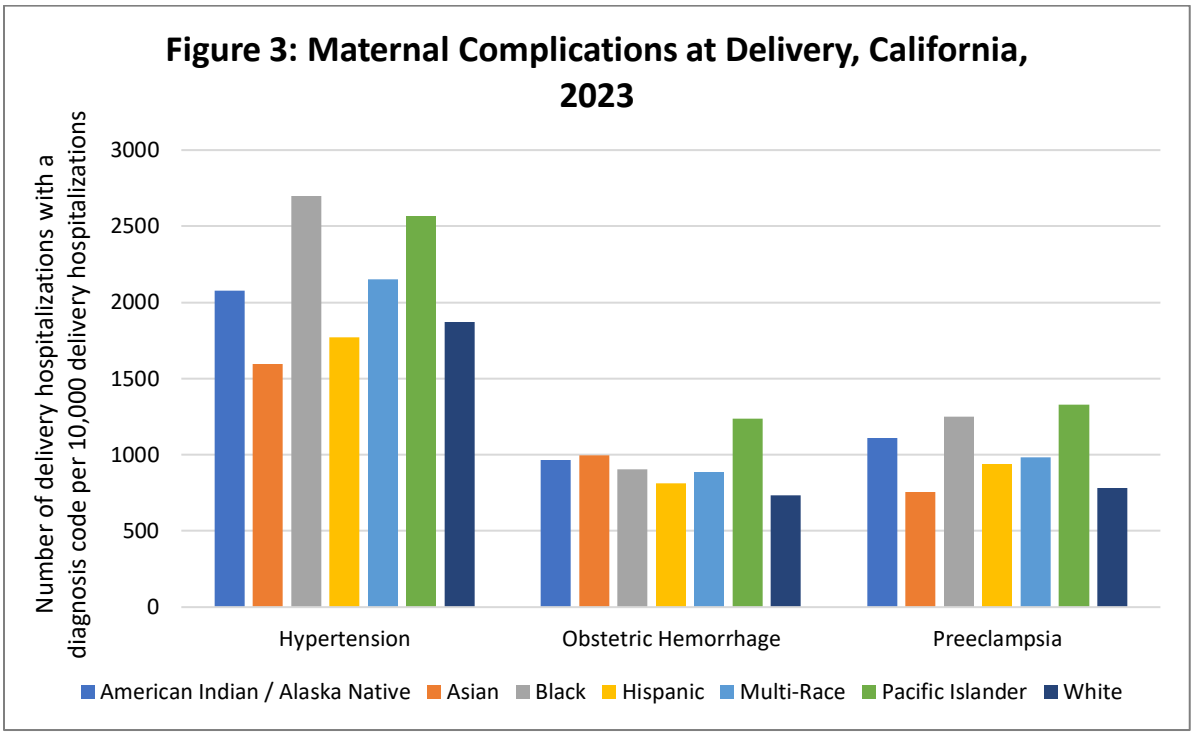
Challenge/Gap #1: Inadequate patient care experiences lacking high-quality, respectful, trauma-informed care. Stark deficiencies exist in maternal and infant outcomes in California. To reduce maternal morbidity and mortality, systems must be held accountable for providing high-quality, respectful, and trauma-informed care for pregnant and postpartum women and infants. There is a need for improving high-quality care as well as collecting and using qualitative and care experience data to inform the improvement of patient experiences.

- **Structural Deficiencies.** CMQCC is committed to working with state and local partners and community members with lived experience to collectively understand and confront structural deficiencies that prohibit patients from receiving optimal care and outcomes.
- **Maternal Morbidity, Delivery Complications, and Mortality.** The top three severe maternal morbidity (SMM) indicators in California in 2023 were renal failure (30.9 instances per 10,000 delivery hospitalizations), sepsis (25.5 instances per 10,000 delivery hospitalizations), and disseminated intravascular coagulation (25.2 instances per 10,000 delivery hospitalizations) (see Figure 2). When considering maternal complications at delivery that can impact maternal and infant health, the top three concerns amongst all pregnant and postpartum Californian women in 2023 were hypertension (1,822.1 instances per 10,000 delivery hospitalizations, preeclampsia (885.6 instances per 10,000 delivery hospitalizations), and obstetric hemorrhage (823.6 instances per 10,000 delivery hospitalizations) (see Figure 3).[6] Pregnancy-related deaths in California in 2020 – 2022 were primarily due to sepsis/infection (33.2%) – including COVID-19 and other infections – followed by hemorrhage (17.7%, and cardiovascular disease (17.2%) (see Figure 4).[7]
- **Fetal and Infant Mortality.** Maternal complications can contribute to fetal and infant mortality. In 2022, California's fetal mortality rate was 5.48 per 1,000 live births statewide.[8] More than 19% of fetal deaths were due to placental, cord, and membrane complication; 12.5% were due to maternal complications; and 10.2% were due to congenital malformation.[9]

[6] Selected Maternal Complications Dashboard, 2025, CDPH.
[7] Pregnancy-Related Mortality Dashboard, 2025, CDPH.
[8] Fetal Mortality Dashboard, 2025, CDPH.
[9] Fetal Mortality Dashboard, 2025, CDPH.

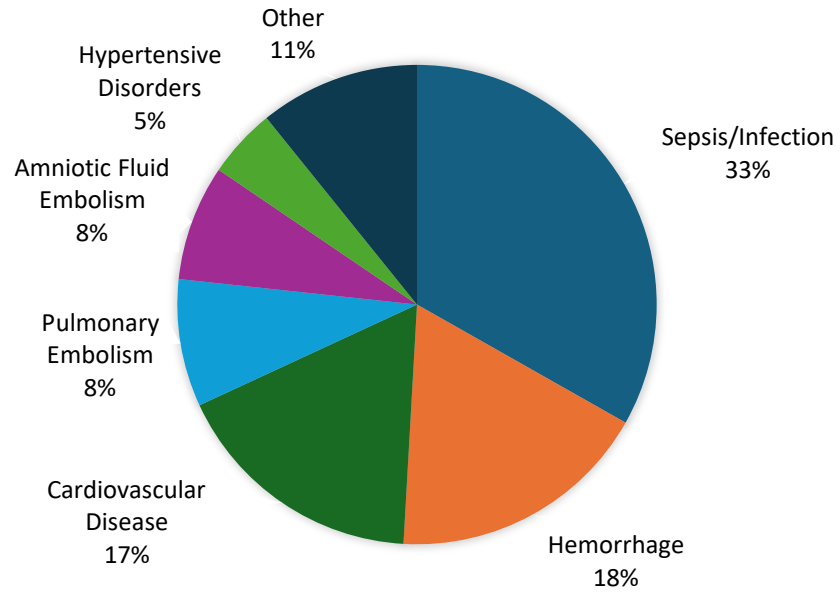


Source: Severe Maternal Morbidity Dashboard



Source: Selected Maternal Complications Dashboard

Figure 4: Pregnancy-Related Deaths by Cause of Death, California, 2020 - 2022



Source: Pregnancy-Related Mortality Dashboard

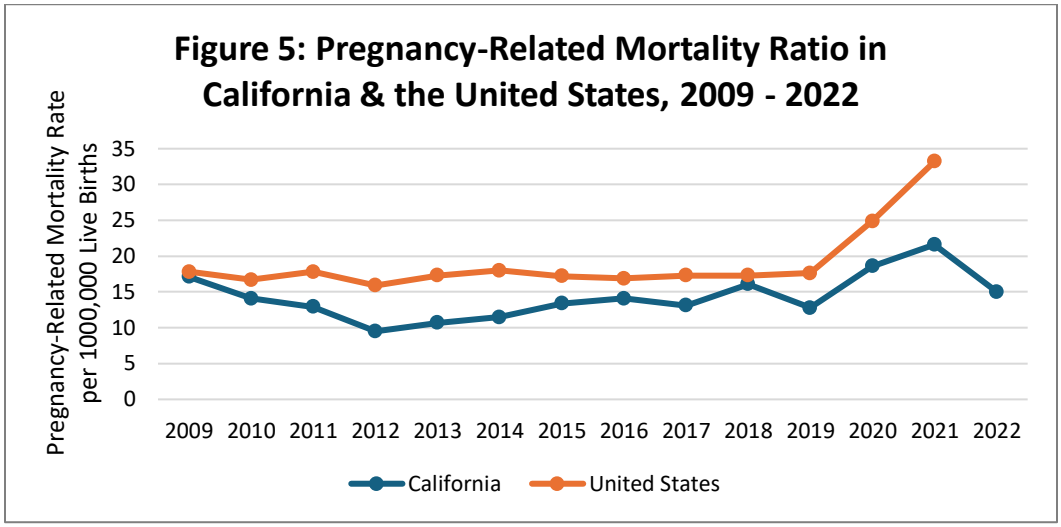
Challenge/Gap #2: Lack of access and links to risk-appropriate care. To reduce maternal morbidity and mortality, pregnant and postpartum women and infants must be provided quality, risk-appropriate access with coordinated transitions of care to the perinatal and postpartum care team and services they desire and need to ensure a healthy and joyous birth outcome. There is a need to improve California's system of integrated perinatal care that promotes access to the right level of care that meets patient needs and preferences, establishes levels of maternal care in California, and addresses the state's maternity care shortage areas.

In California, the maternal morbidity and mortality rates are rising. Pregnancy-related mortality ratio is defined as deaths while pregnant or within one year of the end of pregnancy from causes related to or aggravated by the pregnancy or its management (per 100,000 live births). SMM includes unexpected and potentially life-threatening complications from labor and delivery, such as hemorrhage, infection, and cardiac events, that result in significant short- or long-term consequences (per 10,000 delivery hospitalizations).

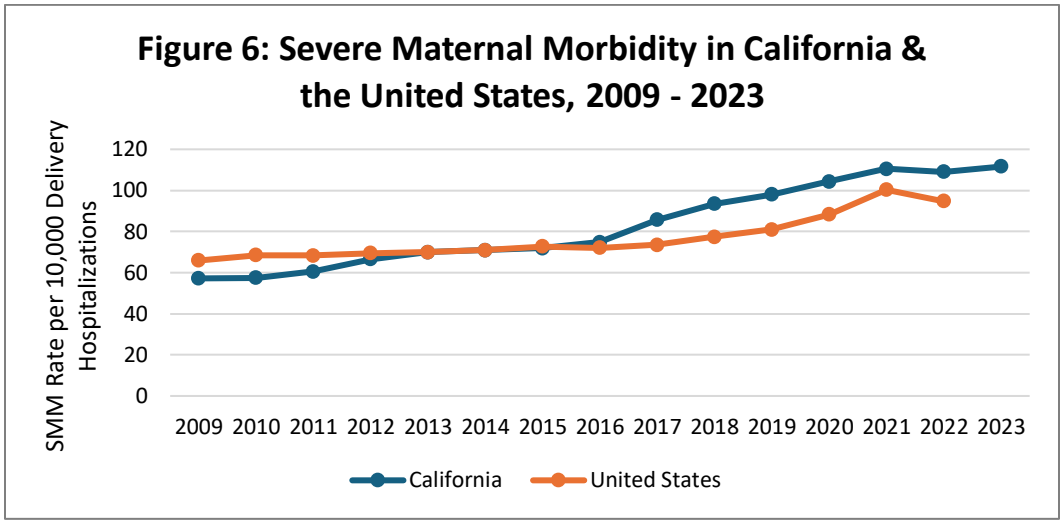
- **Maternal Morbidity and Morbidity Rates.** California has maintained one of the lowest pregnancy-related mortality ratios nationwide until recently, when the ratio rose to 21.6 in 2021, continuing a trend since 2019 and spiking higher in the 2020 – 2021 years of the COVID-19 pandemic before dropping to 15.0 in 2022 (see Figure 5).[10] Similarly, the SMM rate rose to 111.6.5 in 2023.[11] Compared to national data, California's SMM rate has been above the United States' SMM rate since 2017 and in 2020 (see Figure 6).[12] The pregnancy-related mortality ratio in 2023 for Medi-Cal-enrolled women (28.9) was significantly higher than the ratio for women

[10] Pregnancy-Related Mortality Dashboard, 2025, CDPH.
[11] Severe Maternal Morbidity Dashboard, 2025, CDPH.
[12] Severe Maternal Morbidity Dashboard, 2025, CDPH.

with private insurance (9.4).[13] Similarly, women with public insurance face higher SMM rates than their privately insured peers.[14] California's pregnancy-related mortality ratio in 2022 was 15.0, and its SMM rate in 2023 was 111.6.[15]



Source: Pregnancy-Related Mortality Dashboard



Source: Severe Maternal Morbidity Dashboard

In addition to rising maternal morbidity and mortality rates, maternal health care workforce shortages and access to maternal health services challenges have increased:

- **Rising Labor and Delivery Unit Closures.** At least 46 maternity units have closed in California since 2012, four of those closures in the first four months of 2024.[16] Between 2019 and 2020, there was a 21.7% decrease in the number of birthing hospitals in California and about 6.4% of

[13] Pregnancy-Related Mortality Dashboard, 2025, CDPH.
[14] Severe Maternal Morbidity Dashboard, 2025, CDPH.
[15] Severe Maternal Morbidity Dashboard, 2025, CDPH.
[16] California Hospitals Close Maternity Wards, 2023, CalMatters; California hospitals keep closing their labor wards. Can lawmakers do anything about it?, 2023, Dave Cortese, Representing Senate District 15.

pregnant women in California had no birthing hospital within 30 minutes of their residence.[17] That figure increases to 43.0% of pregnant women in the state's rural areas.[18] Pregnant women in counties with the highest travel times (top 20%) had to travel more than 107 miles and approximately 132 minutes, on average.[19]

- **Limited Maternal Behavioral Health Providers.** A November 2023 report from the Policy Center for Maternal Mental Health identified the top ten counties in the United States with the lowest maternal mental health resources by calculating the number of perinatal mental health certified providers and reproductive psychiatrists/prescribers by zip code and birth rates – four counties from California are included in the top ten counties nationwide with low maternal mental health resources (Los Angeles, San Diego, San Bernardino, and Riverside counties).[20] Los Angeles County is the top county nationwide for the highest gap of maternal mental health providers.[21] Furthermore, only 16% of substance use disorder (SUD) treatment facilities in California offering specialized programming for pregnant and postpartum women accepted Medi-Cal in 2018.[22]
- **Lack of Understanding of Available Midwifery Care.** Midwives – certified nurse midwives (CNMs) and licensed midwives (LMs) – are a growing maternal health workforce in California, attending about 14% of births statewide in 2021; however, Californians report that they are unclear if their insurance covers midwifery care (Medi-Cal covers both CNMs and LMs, though there are challenges with enrolling in Medi-Cal and contracting with health plans).[23]
- **Limited Availability and Low Reimbursement for Freestanding Birth Centers (FBCs).** In a 2018 survey, 40% of surveyed postpartum Californian women reported they would be interested in a future birth at a birth center; however, there are only seven state-licensed FBCs in California, and licensure is required for Medi-Cal reimbursement.[24,25] FBC providers, including midwives, face multiple obstacles to providing services through Medi-Cal, including licensure, reimbursement, and administrative challenges.[26] While Medi-Cal MCPs are required to contract with FBCs, the reimbursement rates are low so many FBCs choose not to accept pregnant Medi-Cal members for care.[27]
- **Challenges Accessing Doulas, CHWs, and Lactation Consultants.** Both doulas and CHWs are covered by Medi-Cal and workforces are expanding statewide, but access challenges exist including a lack of awareness of and familiarity with coverage for these professionals, challenges contracting with Medi-Cal MCPs, and unwillingness by some hospital care teams to accept these

[17] Where You Live Matters: Maternity Care Access in California, 2023, March of Dimes.
[18] Where You Live Matters: Maternity Care Access in California, 2023, March of Dimes.
[19] Where You Live Matters: Maternity Care Access in California, 2023, March of Dimes.
[20] U.S. "Maternal Mental Health Dark Zones" – Counties with the Highest Risk and Lowest Resources Revealed, 2023, Policy Center for Maternal Mental Health.
[21] U.S. "Maternal Mental Health Dark Zones" – Counties with the Highest Risk and Lowest Resources Revealed, 2023, Policy Center for Maternal Mental Health.
[22] Substance Use Disorder and Maternal and Infant Health, 2020, Medicaid and CHIP Payment and Access Commission (MACPAC).
[23] California Health Care Almanac: Maternity Care in California: Delivering the Data, 2023, California Health Care Foundation (CHCF); Listening to Mothers in California: A Population-Based Survey of Women's Childbearing Experiences, 2018, National Partnership for Women & Families.
[24] Listening to Mothers in California: A Population-Based Survey of Women's Childbearing Experiences, 2018, National Partnership for Women & Families.
[25] CalHealthFind Database: Alternative Birth Centers, 2021, CDPH.
[26] Access to Maternity Providers: Midwives and Birth Centers, 2023, MACPAC.
[27] Medi-Cal Explained: Maternity Care, 2020, CHCF.

health workers as part of the care team.[28] Similarly, lactation consultants are available in California (and covered in a limited fashion by Medi-Cal) and also experience many of the same financial barriers that doulas and CHWs report.[29]

Challenge/Gap #3: No universal standards in place for risk assessment and appropriate follow-up for medical, behavioral, and social drivers of health. To reduce maternal morbidity and mortality, medical, social, and economic needs must be systematically and universally identified through universal risk assessment and comprehensively met in the community where pregnant and postpartum women and infants live. There is a need to improve chronic disease screening, management and treatment; mental health screening and triage; connections between medical providers and community social services; universal risk assessment and triage during prenatal care; entry to hospital for labor and delivery; hospital postpartum discharge; and postpartum care up to one year.

In addition to the numerous medical needs, pregnant and postpartum women face barriers to achieving optimal mental and emotional health.

- **Challenges with Depression During Pregnancy & Postpartum.** In California, about 15% of pregnant women had prenatal depression between 2020 – 2022 with about 14% of postpartum women reporting postpartum depression in the same time period.[30] Untreated depression during pregnancy can make it challenging for the woman to care for herself and is associated with adverse birth outcomes for newborns, including low birth weight, small for gestational age, and preterm birth.[31] Similarly, untreated postpartum depression is associated with worse maternal and infant outcomes, creating an environment that is not conducive to the personal development of postpartum women or the optimal development of a child.[32]
- **Risk of Suicide During Pregnancy and Postpartum.** A 2019 report by the CA-PARC found that suicide accounts for about 4% of California deaths occurring during pregnancy or within 12 months postpartum.[33] Pregnant and postpartum women with existing mental health conditions and who develop new conditions during the perinatal period (e.g., postpartum depression or psychosis) face a significantly higher risk of suicide than their peers without these conditions. However, maternal suicide is preventable regardless of mental health history.
- **Alcohol Use, Tobacco Use, and Cannabis Use During Pregnancy and Postpartum.** About 7% of pregnant women had alcohol use in the third trimester of pregnancy between 2020 – 2022.[34] Tobacco use during the third trimester in California was 1.7% among pregnant women between 2020 – 2022 and cannabis use at any time during pregnancy over the same time period was 5.2%.[35]

[28] Listening to Mothers in California: A Population-Based Survey of Women's Childbearing Experiences, 2018, National Partnership for Women & Families; Lawmakers Discuss the Future of Community Health Workers in California, 2024, CHCF; Doula Implementation Stakeholder Meeting – January 31, 2024, DHCS; The Experiences of Black Community-Based Doulas as They Mitigate Systems of Racism: A Qualitative Study, 2023, Journal of Midwifery & Women's Health.
[29] Reducing Barriers to Breastfeeding in Disadvantaged Communities, 2024, UCLA Center for Health Policy Research.
[30] Maternal Mental Health Dashboard, 2025, CHCF.
[31] Untreated Depression During Pregnancy and Its Effect on Pregnancy Outcomes: A Systematic Review, 2021, Cureus.
[32] Consequences of Maternal Postpartum Depression: A Systematic Review of Maternal and Infant Outcomes, 2019, Women's Health.
[33] CA-PAMR Report: Pregnancy Associated Suicide, 2002-2012, 2019, CA-PAMR.
[34] Prenatal Substance Use Dashboard, 2025, CDPH.
[35] Prenatal Substance Use Dashboard, 2025, CDPH.

- **SUD During Pregnancy and Postpartum.** Cannabis, amphetamine, and opioid use disorders are the most common SUDs diagnosed during labor and delivery in hospitals in California, with 1.5% of births in 2023 having a SUD at delivery.[36]

Challenge/Gap #4: Limited maternal health data access and data transparency. To reduce maternal morbidity and mortality, California must establish data transparency, interoperability, and accountability standards for data collection, analysis, and use when serving and caring for pregnant and postpartum women. There is a need to improve maternal health data collection, community qualitative data, and general data communication and dissemination. Challenges exist with disparate maternal health data and accessibility, such as:

- **Missing Behavioral Health Data.** California reports pregnancy-related mortality ratios but not the broader pregnancy-associated mortality ratio, which includes "deaths by violence" including suicide, substance use, homicide (including domestic violence), and injury. Due to this lapse, there are limited ways to quantify the scope of the maternal mental health and substance use crisis impacting pregnant and postpartum women and their families.
- **Small Sample Sizes for Populations.** California does not publish data with small sample sizes, resulting in maternal health data that is often not able to be quantified and addressed, given some groups have smaller sample sizes.
- **Non-Shareable Labor and Delivery Hospital Data.** CMQCC's Maternal Data Center contains dozens of hospital clinical quality measures for 200 labor and delivery hospitals in California representing 99% of all births statewide.[37] However, hospital data is not "owned" by CMQCC. Instead, CMQCC is a data steward that supports hospitals in understanding their data in order to drive change. Data accessibility is limited and can only be shared with permission from hospitals.

Challenge/Gap #5: Siloed services, programs, and interventions. To reduce maternal morbidity and mortality, California must establish shared visions and collaboration between medical providers, public health systems, and community to improve perinatal health outcomes. There is a need to establish and convene consistent statewide maternal health meetings and conferences, deepen the impact of the California MHTF, and expand community engagement.

California is fortunate to have many active, committed local organizations that are collaboratively working across their communities and the state to improve maternal health and reduce poor maternal and infant health outcomes. Many of these CBOs are building up doula networks (e.g., BLACK Wellness & Prosperity Center in Fresno County, SisterWeb Doula Network in San Francisco County, Frontline Doulas in Los Angeles County), advocating for high-quality and respectful maternity care, facilitating care that is meaningful to and appropriate for the birthing woman, and addressing maternal health workforce shortages and improving access (e.g., MAMA's PROMISE Program in Los Angeles County). However, silos and a lack of integration across maternal health CBOs persists. These are detailed above in Section I.

[36] Substance Use Disorder at Delivery Dashboard, 2025, CDPH.
[37] As of September 2025.

Section II. California Maternal Health Task Force

a) Vision and Mission

Vision. All mothers and babies in California are thriving at one year postpartum.

Mission. A statewide task force focused on systems integration to better coordinate health care, public health, and community systems to improve maternal health via a collective impact approach.

b) Development, Composition, and Progress to Date

The 12-member California MHTF Steering Committee was seated during the first half of 2024. Prospective Steering Committee members submitted applications and were selected by California MHI leaders involved in the submission of the grant application to ensure an expert committee that broadly represented California's communities was recruited to help guide the work. As of September 2025, the California MHTF Steering Committee is composed of three clinicians (25% of membership) and nine non-clinical health experts (75% of membership). The California MHTF Steering Committee developed the five goals of the California MHTF, established five Subcommittees (one Subcommittee for each goal), and appointed Subcommittee chairs with the expertise and leadership experience needed to achieve each goal. The Subcommittee chairs were charged with developing the strategies, objectives, and activities under each goal.

California MHTF Goals/Subcommittees		
Goal		**Goal Statement**
	Improve Care Experience	Systems are held accountable for providing high-quality, respectful, and trauma-informed care for pregnant and postpartum women and infants.
	Increase Access & Links to Risk Appropriate Care	Pregnant and postpartum women and infants are provided quality, risk appropriate access with smooth transitions in care to the perinatal and postpartum care team and services they desire and need to ensure a healthy and joyous birth outcome.
	Improve Risk Assessment & Follow-Up	Medical, social, and economic needs are systematically and universally identified through universal risk assessment and comprehensively met in the communities where women live.
	Modernize Data Access & Data Transparency	Establish a standard of data transparency, interoperability, and accountability for data collection, analysis, and use for serving and caring for mothers and infants.
	Break Down Silos & Integrate Systems	Organizations and care delivery systems responsible for serving and caring for pregnant and postpartum women are

		coordinated and integrated across systems, public health programs, communities, and health care services.

California MHTF Steering Committee Members

Clinicians[38]

- Cristina Gamboa, MD, OB/GYN and Director, Ambulatory Women's Health Services at Salud Para La Gente
- Jeffrey Gould, MD, MPH, Senior Advisor, CPQCC/CMQCC and Principal Investigator, California MHI
- Brenda Jones, DHSc, LSSGB, CCHC, WHNP, CPPS, RN, Clinical Director of Maternal and Child Services at Kaiser Permanente Medical Center in San Francisco

Community Birth & Maternal Health Professionals and Advocates

- Ajira Darch, Creative; Liberation Strategist; Full Spectrum Community Birth Worker; Executive Director of Roots of Labor Birth Collective; Podcast Co-Host of Doula Stories; Founder of Bay Area Bodymilk Cooperative

Public Health Officials

- Palav Babaria, MD, Chief Quality Officer and Deputy Director of Quality and Population Health Management, DHCS
- Priya Batra, MD, MS, Deputy Director, Health Promotion Bureau, Los Angeles County Department of Public Health
- Curtis Chan, MD, MPH, California Conference of Local Health Officers Co-Chair, Maternal Child & Adolescent Health Committee; Deputy Health Officer, San Mateo County Health
- Diana Ramos, MD, MPH, MBA, FACOG, California Surgeon General
- Karen Ramstrom, DO, MSPH, Branch Chief of Maternal & Infant Health at MCAH Division, CDPH

Public Health Professionals Specializing in Perinatal & Family Health

- Leslie Kowalewski, Executive Director of Maternal, Child and Family Health, CPQCC/CMQCC and Project Director, California MHI
- Mashariki Kudumu, MPH, Founder, Kudumu Partnerships for Equity and Justice
- Antoinette Medina, MPA, Program Coordinator, California Tribal Epidemiology Center

Progress to Date

With the seating of the California MHTF Steering Committee, a Landscape/Needs Assessment was completed to inform the Draft Strategic Plan submitted to HRSA in September 2024. In addition to the Landscape/Needs Assessment findings, recommendations from maternal health experts, public reports, data, and community organizations were compiled to inform recommendations outlined in the Draft Strategic Plan. In Fall 2024, the California MHTF Steering Committee began communicating broadly about the Draft Strategic Plan and conducting community engagement to help shape what would inform this Final Strategic Plan.

[38] In this context, clinicians are health care professionals actively involved in the care of neonates and pregnant/postpartum patients, who also play a role in driving quality improvement.

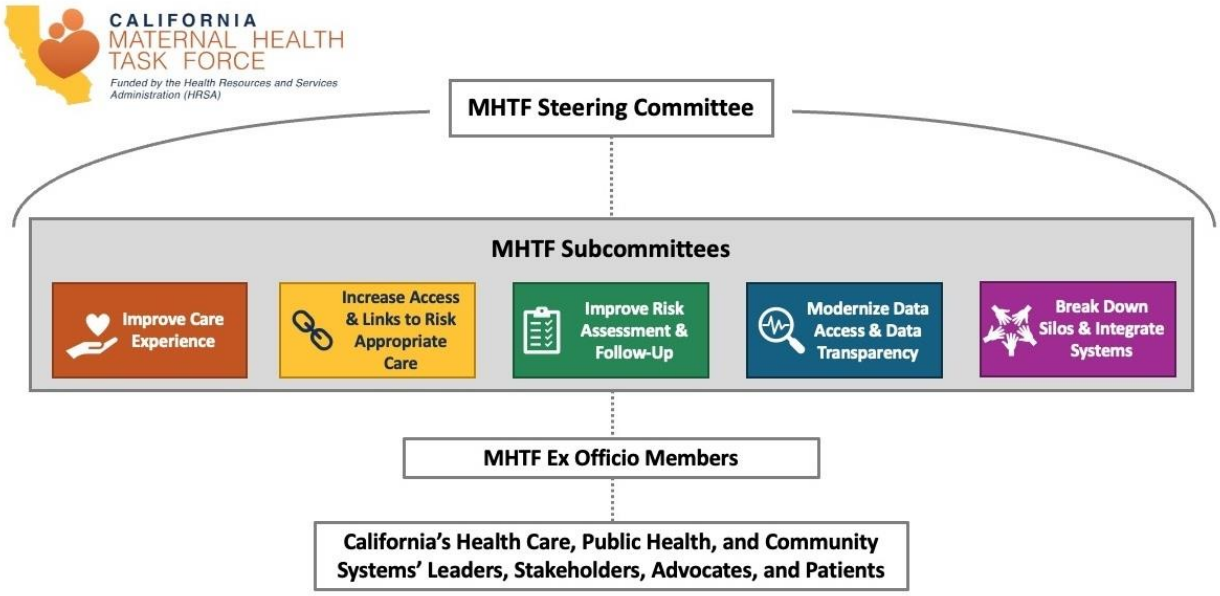
California MHTF Subcommittees

Between April – August 2025, the California MHTF Steering Committee finalized its governance structure and recruited co-chairs and members for the five Subcommittees identified in the Draft Strategic Plan's priorities:

- Improve Care Experience
- Increase Access & Links to Risk Appropriate Care
- Improve Risk Assessment & Follow-Up
- Modernize Data Access & Data Transparency
- Break Down Silos & Integrate Systems

Subcommittees are responsible for identifying the priorities and relevant expertise needed to inform the direction of their work. The Subcommittee membership is based on a framework of Subcommittee members as decision-makers and thought leaders to guide the Strategic Plan. Centering the voices and lived experience of those impacted by this work is essential to ensuring the strategies, objectives, and activities will ensure improved maternal health outcomes. This is different from the partners, stakeholders, policy makers, and change makers who will serve as ex officio members. Ex officio members will provide content expertise, represent partner organizations, and update and report on relevant updates and activities. The selection process for Subcommittee membership ensures representation from several domains in the systems of focus for California MHI (health care (providers, payers, facilities), public health (local and statewide), and community (nonprofits, consumer advocates, birth workers)) and the HRSA objectives for perspectives and expertise to guide and inform decision-making and intervention.

Figure 7: California MHTF Organizational Structure



Community Innovation Funds for System Change

A key component in ensuring the California maternal health community is engaged in the development and implementation of the Strategic Plan is the earmark of $450,000 in the MHI award for one-time Community Innovation Funds for Systems Change. These awards will extend the reach and execution of the MHI award by sharing resources with CBOs serving a variety of birthing populations across the state.

The California MHTF Steering Committee and Subcommittees will lead the identification, selection, and evaluation of implementation proposals that will extend the reach of the grant.

In 2025, the first year of this community investment, the California MHTF partnered with MOMS Orange County to fund Doula Organization Enhancement Awards which will support CBOs, doula hubs, and doula organizations in training, recruiting, supporting doulas, and/or introducing and connecting doulas to public health programs, health care providers, and maternal health CBOs and agencies. The award also aims to improve the capacity of doulas to leverage Medi-Cal's doula benefit by enhancing existing efforts/organizations focused on training doulas to bill and access the benefit.

Birth Services/Hospital Closures

A project team led by California MHI's Principal Investigator, Dr. Jeffrey Gould, has developed engagement strategies and tools and confirmed local organizations to begin conversations on the impact of birth services/hospital closures on their community. These organizations include a family health center serving American Indian/Alaska Native populations in the far northern region of California as well as a coastal agricultural community in the Bay Area. Through initial conversations with leaders in the communities and input from a steering committee member with experience with a threatened closure, the project team aims to improve engagement strategies and tools and develop materials for communities with threatened birth services/hospital closure. There is recognition by the project team that birth services/hospital closures are a public health threat and there is opportunity to align with existing local health jurisdictions around emergency preparedness, health care workforce, and hospital preparedness. The project's biostatistics team provided an analysis to characterize a hospital's role through delivery volume and market share. Maternal and neonatal outcomes at threatened birth services/hospital closure locations were compared with those at other sites not closing during the two years prior to the closure. The biostatistics team evaluated how these outcomes changed before and after the closure to identify insights to help anticipate the potential impacts of a birth services/hospital closure on quality of care and access.

c) Meeting Frequency and Activities for 2024 - 2028

The California MHTF Steering Committee has met monthly since March 2024 via Zoom or in person to facilitate in-depth discussion and decision making to monitor the quality of collaborator engagement across California; develop and advance the Strategic Plan's goals; ensure effective communication and coordination; and provide recruitment support and direction to the Subcommittees.

With the submission of the Draft Strategic Plan in September 2024, the California MHTF Steering Committee and Subcommittees **have completed** the following activities:

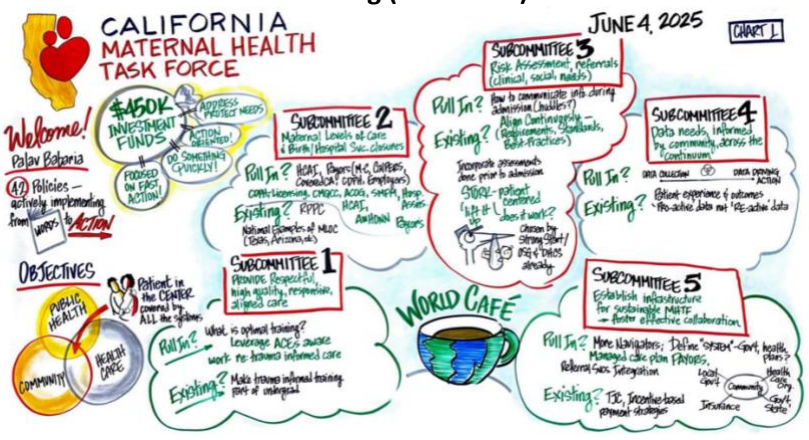
Year 2 (September 2024 – September 2025):

a. Established California MHTF Subcommittees and appointed Subcommittee Co-Chairs by March 2025. Subcommittee members are anticipated to be selected and seated for each subcommittee by Fall 2025.
b. Developed Subcommittee-specific methodology to prioritize recommendations; wrote Specific, Measurable, Achievable, Relevant, Time-Bound, and Representative (SMART-R) objectives; and selected community-informed, evidence-based, innovative strategies and activities to reach identified objectives.
c. Convened a one-day, in-person meeting of the California MHTF Steering Committee and Subcommittees in Sacramento in June 2025 to advance the development of the Subcommittees'

Action Plans and establish collaboration pathways across Subcommittees and with key state and local partners to finalize the Strategic Plan for submission to HRSA in September 2025 (see Figure 8 for an illustration that captures discussions from the meeting).

d. Implemented opportunities for community input and listening sessions to shape the Strategic Plan, including a public webinar with more than 300 attendees and the release of the Strategic Plan Summary for public comment and feedback in June 2025.
e. Developed and implemented a communications and transparency plan for the work of the California MHTF, including the expansion of a California MHTF public-facing website.
f. Developed a process, scoring criteria, and evaluation plan for the California MHTF Community Innovation Funds for Systems Change that will fund local strategies by CBOs. These projects include opportunities that enhance and increase capacity of specific strategies to improve care experience and outcomes for the pregnant and postpartum populations more likely to be impacted by mortality and severe morbidity, but also more likely to benefit from preventive efforts. These strategies will inform sustainable solutions such as policy or systems changes.
g. Developed preliminary community engagement strategies and tools to begin conversations with local system leaders in California counties that have experienced a birth services/hospital closure and/or threatened closure.
h. Distributed the first round of Community Innovation Funds for Systems Change through Enhancement Awards to California doula organizations that serve Medi-Cal birthing communities with high-quality, respectful, trauma-informed care. These awards will support CBOs, doula hubs, and doula organizations in training, recruiting, and/or supporting doulas, and/or with introducing and connecting doulas to public health programs, health care providers, and communities (see more on the California MHI website).
i. Launched the California MHTF website, a key component of broadening public-facing communications on the work of the MHTF and for stakeholders to engage directly with the MHTF with this email address: info@cmqcc.org.
j. Continued work on the hospital-by-hospital impact analysis considering how hospital obstetric unit closures in both rural and densely populated counties are impacting quality of and access to care.

Figure 8: Discussion Mural from California MHTF Steering Committee & Subcommittees In-Person Meeting (June 2025)



The California MHTF Steering Committee and Subcommittees **will complete** the following activities:

Years 3 – 5 (September 2025 – September 2028):

a. Develop a plan, evaluation metrics, and timeline for piloting and scaling up the CA Maternal Health Strategic Plan (CA MHSP) implementation strategies and objectives in one or multiple regions in California. The following is a list of the specific objectives for Subcommittees 1-5.

Subcommittee 1: Improve Care Experience

Strategy 1: Establish a Commitment to Trauma-Informed Care as a Systemwide Expectation Via Staff Training and Integration of Patient Feedback Across Systems

- **Year 3.** By September 30, 2026, Subcommittee 1 will bring together systems in a California Maternity Care Work Group and partner with State agencies and other entities to identify opportunities to improve trauma-informed care training and provider resources.
- **Years 4 & 5.** By September 30, 2028, Subcommittee 1 will expand trauma-informed care training and continuous learning practices statewide for perinatal care providers.

Strategy 2: Close Feeback Loops with Health Care, Public Health, and Community Systems to Establish Consistent Processes and Accountability for Patients' Perinatal Care Experience

- **Year 3.** By September 30, 2026, Subcommittee 1 will identify opportunities to solicit input from perinatal care providers, birth workers, doulas, patients, and community members to promote meaningful, actionable, and systemwide change.
- **Years 4 & 5.** By September 30, 2028, Subcommittee 1 will have initiated input opportunities and received and shared feedback across the health care, public health, and community systems, including patient feedback shared with perinatal care providers and leadership, to identify lessons and best practices to inform systemwide change and create a sustainable feedback loop.

Subcommittee 2: Increase Access and Links to Appropriate Care

Strategy 1: Implement The Joint Commission's Maternal Levels of Care in California

- **Year 3.** By September 30, 2026, Subcommittee 2 will develop an implementation plan to pilot Maternal Levels of Care in select hospitals.
- **Years 4 & 5.** By September 30, 2028, Subcommittee 2 will launch the Maternal Levels of Care implementation pilot and develop an implementation plan for other labor and delivery hospitals.

Subcommittee 3: Improve Risk Assessment and Follow-Up

Strategy 1: Improve Transitions of Care for Pregnant and Postpartum Women Throughout the Perinatal Care Continuum

- **Year 3.** By September 30, 2026, Subcommittee 3 will launch the TCS Implementation Learning Collaborative.
- **Years 4 & 5.** By September 30, 2028, Subcommittee 3 will disseminate lessons learned from the TCS Implementation Learning Collaborative.

Strategy 2: Improve Medical, Social, and Behavioral Risk Assessment and Appropriate Follow-Up During Transitions of Care in the Prenatal, Delivery, and Postpartum Periods

- **Year 3.** By September 30, 2026, Subcommittee 3 will develop the "California Implementation Plan for Universal Screenings & Risk Assessment and Appropriate Follow-Up."
- **Years 4 & 5.** By September 30, 2028, Subcommittee 3 will launch and scale up the "California Implementation Plan for Universal Screenings & Risk Assessment and Appropriate Follow-Up."

Subcommittee 4: Modernize Data Access and Data Transparency

Strategy 1: Support Data Interoperability Across Health Care and Public Health Systems

- **Year 3.** By September 30, 2026, Subcommittee 4 will identify California MHTF data sharing needs and current California-led efforts to improve data interoperability.
- **Years 4 & 5.** By September 30, 2028, Subcommittee 4 will support, inform, promote, and implement California strategies to improve data interoperability.

Strategy 2: Collect and Share Pregnant and Postpartum Women's Reported Birth Experiences

- **Year 3.** By September 30, 2026, Subcommittee 4 will establish a process for standardizing and collecting patient-reported care experience data across California health care, public health, and community systems working to improve maternal health outcomes.
- **Years 4 & 5.** By September 30, 2028, Subcommittee 4 will engage patient experience data owners and implementers to standardize and establish reportable patient experience findings.

Strategy 3: Strengthen California's Existing Data Frameworks and Platforms

- **Year 3.** By September 30, 2026, Subcommittee 4 will inventory and promote maternal health data that is currently, and will continue to be, collected and available to meet health care, public health, and community needs and expectations.
- **Years 4 & 5.** By September 30, 2028, Subcommittee 4 will evaluate Subcommittee goals, strategies, and opportunities to close identified data gaps.

Subcommittee 5: Break Down Silos and Integrate Systems

Strategy 1: Promote Use of a Shared Systems Framework Across California MHTF

- **Year 3.** By September 30, 2026, Subcommittee 5 will identify health systems resources and draft a systems framework.
- **Years 4 & 5.** By September 30, 2028, Subcommittee 5 will have a systems framework and resources and tools available.

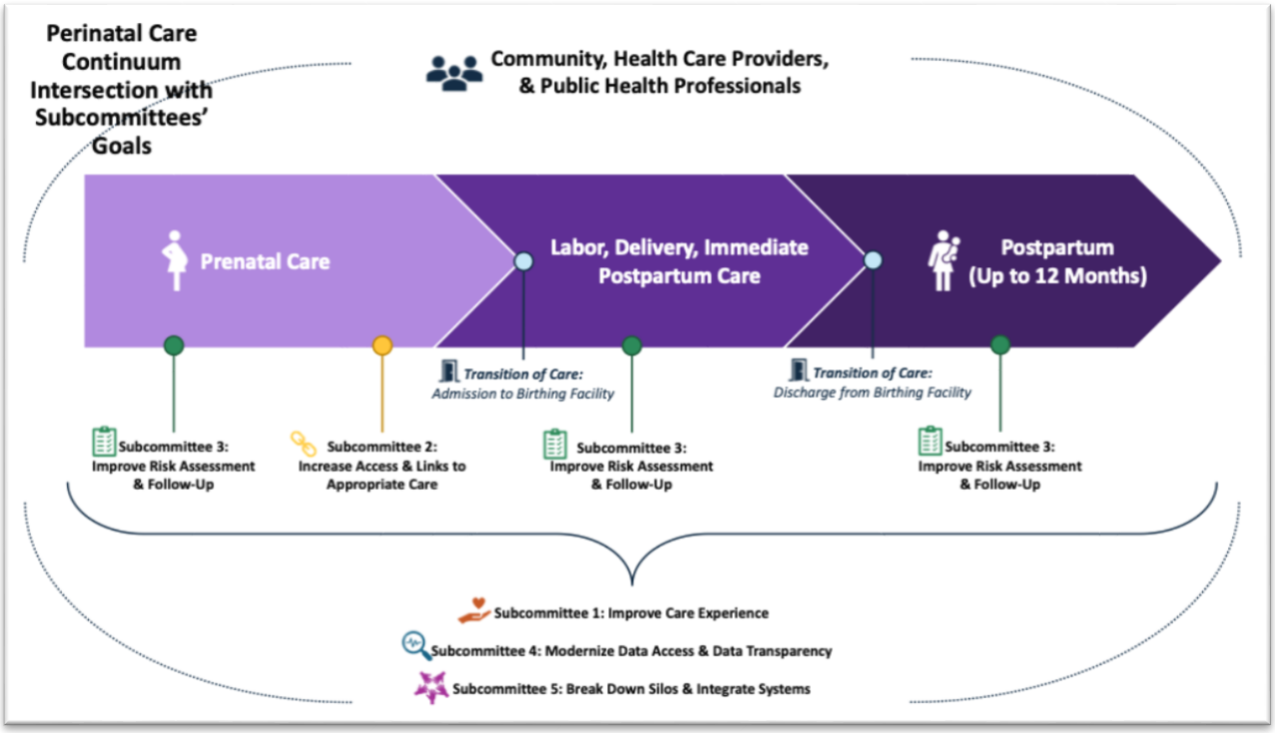
Strategy 2: Institutionalize Maternal Health Prioritization Across Key State Agencies

- **Year 3.** By September 30, 2026, Subcommittee 5 will use the proposed systems framework to identify and fill gaps in Subcommittee 5 representatives and involvement from State agencies and engage these State agency leaders to explore the concept of institutionalizing maternal health prioritization and possible mechanisms for systems change.
- **Years 4 & 5.** By September 30, 2028, Subcommittee 5 will have regularly engaged with leadership at each identified key State agency on maternal health prioritization.

Strategy 3: Identify Opportunities to Share Best Practices to Promote Coordination and Integration of Systems

- **Year 3.** By September 30, 2026, Subcommittee 5 will identify opportunities to share best practices for improving maternal health outcomes, including developing a vision for a 2028 Maternal Health Summit to share California MHTF impact and lessons to date.
- **Years 4 & 5.** By September 30, 2028, Subcommittee 5 will have hosted the 2028 Maternal Health Summit and supported additional sharing of best practices.

b. Socialize and refine the CA MHTF Framework Visual which represents where each of the Subcommittee's strategies will impact quality of care and outcomes along the "Perinatal Care Continuum:"



c. Fund Round 2 (Federal FY 3) Community Innovation Fund for System Change proposals that align with the Landscape/Needs Assessment and Strategic Plan.
d. Conduct initial birth services/hospital closure community impact engagement sessions and refine strategies and tools to scale reach to other California counties. Validate the need and content of Birth Services/Hospital Closure preparedness materials with community stakeholders which have been cited by Subcommittees 1 and 2.
e. Review process and outcome measures from Subcommittee Action Plans to update the Strategic Plan in subsequent years.
f. Promote scale-up of current and emerging innovations that align with the strategic priorities of the Maternal Health Strategic Plan.
g. Evaluate project strategies and memorialize results in reports and on the California MHTF website for public access.

Section III. State Maternal Health Innovation Program Goals & Strategic Plan

a) Overview of California Maternal Health Innovation

California has a wealth of maternal health assets at the forefront of health policy innovation and the commitment of health care leaders for continued investment in the future of maternal health (see Figure 1 in Section I). Leveraging these assets, the California MHTF has outlined its steps to developing the goals, strategies, objectives, and activities included in this Strategic Plan (see Figure 9). To address change across health care, public health, and community systems, the California MHTF has identified the "why, how, and what" of California MHI's work as a guiding star to improve maternal mortality and morbidity rates, and design and implement the California MHI's identified goals (see Figure 10).

Figure 9: Developing the California Maternal Health Strategic Plan's Goals, Strategies, and Proposed Activities

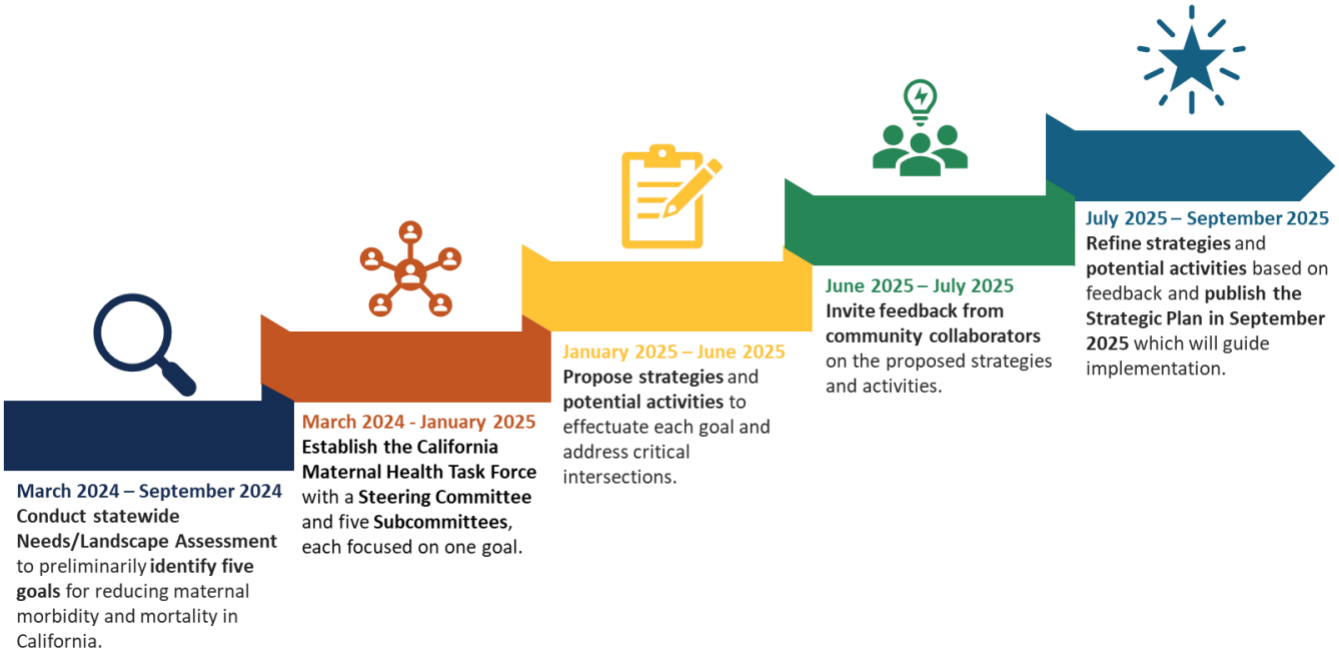
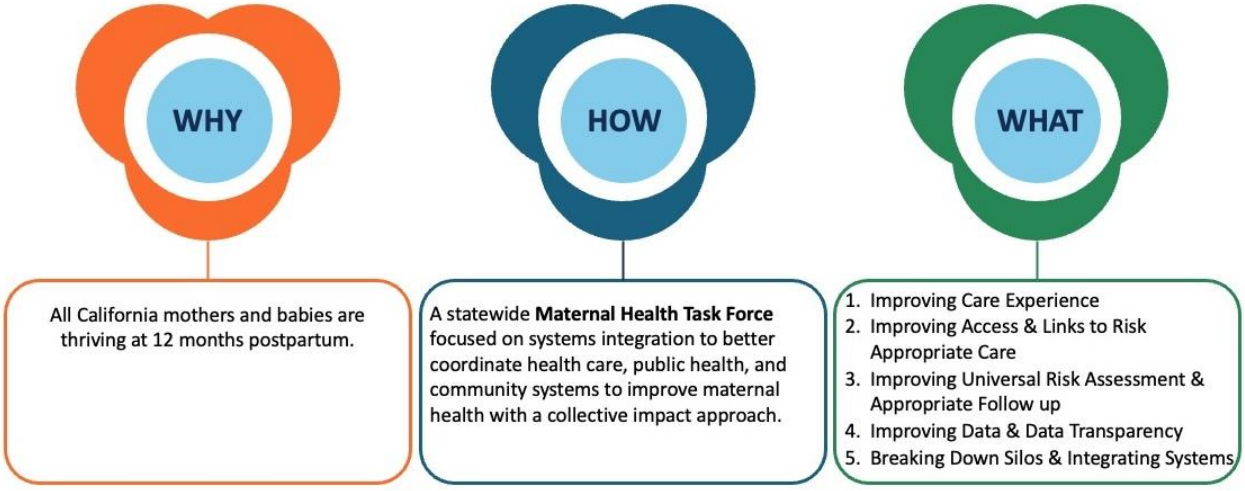


Figure 10: California MHTF's "Why, How, and What" to Improve Maternal Mortality & Morbidity



California's numerous innovative maternal health efforts are siloed with little to no opportunity to assess their true impact due to lack of shared measurement and coordination. The California MHTF conducted a comprehensive statewide review with the **Landscape/Needs Assessment** to identify strengths, commitments, and investments in California's maternal health initiatives. Building off the Landscape/Needs Assessment, the California MHTF then developed the **Draft Strategic Plan** with initial proposed approaches to bring together California's collective efforts to address maternal morbidity and mortality.

In June 2025, the California MHTF convened in Sacramento to review and refine dozens of identified strategies to address maternal mortality and morbidity in California. The California MHTF refined these opportunities and aligned them with the five identified goals of California MHI (see Figure 1 in Section I). Also in June 2025, the California MHI team virtually presented the **California MHTF Launch Event** with more than 300 attendees. The launch event helped explain the intent of California MHI and the current state and proposed vision for maternity systems of care in California. The California MHI team used this launch event to present proposed strategic plan priorities and activities that the California MHTF had refined earlier that month in Sacramento and to solicit **public comment and feedback** from community members and other maternal health collaborators. Participants and public stakeholders were invited to submit feedback on the Draft Strategic Plan with a user-friendly **Strategic Plan Summary.**

In July 2025, nearly 70 respondents provided detailed public comments and feedback on how to strengthen proposed goals, strategies, and activities to ensure all Californian women and babies are thriving at 12 months postpartum. Over a three-week comment period, public health professionals, health care providers, community advocates, community-based and advocacy organizations, and maternal health patients from 29 of California's 58 counties shared their feedback via an online survey response tool. Their responses are captured in **six key cross-cutting themes:**

1. **Listen To and Empower Pregnant and Postpartum Women.** Respondents recommended that the full continuum of maternal health must be considered to ensure more positive maternal and infant outcomes, as well as the need for trauma-informed care and referrals after positive ACEs screenings. Respondents noted that access to IPV, social drivers of health, and perinatal mental

health screenings and follow-up services should be expanded. The need to conduct listening sessions on patients' lived experience and to share findings with providers and health systems was emphasized, as was the need to integrate lactation supports and services throughout California's maternal health landscape.

2. **Implement Risk-Appropriate Care in Outpatient and Community Settings.** Respondents recommended that the strategies should be expanded to address perinatal concerns in outpatient settings – not just inpatient or post-delivery – particularly during both the prenatal and postpartum periods. In this same vein, leveraging universal risk assessments to help inform outpatient care was emphasized, as was ensuring medical, behavioral, and social support during the postpartum period. Respondents also noted the need to expand access to lactation consultants and home visiting programs statewide.
3. **Increase Access to Midwives, Home Births, and FBCs.** Many respondents stressed the need to improve patient access to midwifery care (including CNMs and LMs), home births, and FBCs. They recommended reducing reimbursement and licensure barriers for home births and FBCs and ensuring FBCs are included in The Joint Commission's Maternal Levels of Care designation (included in Subcommittee 2).
4. **Enhance Data & Infrastructure.** Respondents noted the need to publish and regularly review disaggregated and stratified maternal health and birth outcomes data. Feedback included requests to publish total births stratified by facility type and provider type, develop user-friendly maternal health dashboards, leverage existing platforms and databases, and ensure feedback loops and interoperability for referrals across the health care, public health, and community systems.
5. **Develop and Train Perinatal Workforce.** Respondents emphasized the need to invest in small and rural hospitals with labor and delivery units at risk of closing and ensure these communities have access to FBCs and midwives. Training perinatal care teams beyond physicians (e.g., midwives, peer mentors, home visitors, doulas, community health workers) and ensuring physicians understand the valuable role these non-physician professionals play was a key theme. Sharing best practices with perinatal care teams and improving value-based maternity payment models in Medi-Cal were also identified as opportunities for consideration.
6. **Collaborate Across Programs and Stakeholders.** Respondents encouraged California MHI to collaborate and leverage existing maternal health initiatives and programs in California, including many innovations noted in Section I. They also stressed the need to provide clear and regular communications to the public on this work and to include women and people who have given birth and local providers and entities in the design and implementation of California MHI.

b) California Maternal Health Innovation Goals

Leveraging the findings noted above from the Landscape/Needs Assessment, feedback from community and partner engagement, and collaboration with the California MHTF helped to identify five overarching California MHI goals:

1) Improve the care experience;
2) Increase access and links to risk appropriate care;
3) Improve risk assessment and follow-up;
4) Modernize data access and data transparency; and
5) Break down silos and integrate systems.

Focusing on these five goals supports an innovative, collaborative approach to addressing maternal mortality and morbidity in California to ensure sustainable, long-lasting change. Specifically, these goals address the underlying systemic deficiencies contributing to maternal mortality and morbidity by strategically bringing together California's maternal health stakeholders for collective impact. This work and approach lay the foundation for change, ensuring that California MHI efforts continue beyond this grant. By focusing on the root causes of maternal mortality and morbidity, California MHI aims to unify key maternal health partners around a common agenda in California.

c) Strategies to Address Maternal Health Needs

Each goal includes strategies, objectives, and activities for the upcoming years of California MHI. As noted above, the Landscape/Needs Assessment, community and partner engagement findings, and the expertise of the California MHTF helped inform and develop the strategies, objectives, and activities to address negative maternal health and birth outcomes in California. These goals will unify existing and emerging innovations in California in a coordinated effort to improve maternal health.

For the goals noted below, the Subcommittees will develop and regularly report out process and outcome measures. This will be done across the programs' years and through the objectives below, for each goals' strategies.

Goal 1: Improve Care Experience

Goal Statement: Systems are held accountable for providing high-quality, respectful, and trauma-informed care for pregnant and postpartum women and infants.

Objective	Activities
Strategy 1: Establish a Commitment to Trauma-Informed Care as a Systemwide Expectation Via Staff Training and Integration of Patient Feedback Across Systems	
Year 3. By September 30, 2026, Subcommittee 1 will bring together systems in a California Maternity Care Work Group and partner with State agencies and other entities to identify opportunities to improve trauma-informed care training and provider resources.	a. Launch a California Maternity Care Work Group with statewide representation to bring together providers and stakeholders in the health care, public health, and community systems that educate, advocate for, regulate, certify, license, and pay the perinatal care workforce. b. Identify perinatal care trainings on trauma-informed care for perinatal care providers across the continuum of training and education. c. Partner with ACEs Aware to better understand and leverage their statewide training for trauma-informed care and toxic stress. Promote trauma-informed perinatal care risk assessment practices and ensure non-clinical perinatal care professionals – including doulas, community health workers, and TCS coordinators – have the necessary resources to support pregnant and postpartum patients as they are assessed by clinical providers for medical, behavioral, and social risk factors.
Years 4 & 5. By September 30, 2028, Subcommittee 1 will expand trauma-informed care training and continuous learning practices statewide for perinatal care providers.	a. Integrate trauma-informed care as the standard framework for and between providers and patients within all perinatal care trainings (e.g., undergraduate, medical school, residence, fellowship, training programs) and sustained through continuous learning opportunities. b. Regularly convene the California Maternity Care Work Group and share findings and resources with other **Subcommittees,** as appropriate, to support California MHI.
Strategy 2: Close Feeback Loops with Health Care, Public Health, and Community Systems to Establish Consistent Processes and Accountability for Patients' Perinatal Care Experience	
Year 3. By September 30, 2026, Subcommittee 1 will identify opportunities to solicit input from perinatal care providers, birth workers, doulas, patients, and community members to promote	a. Identify how to best engage health care, public health, and community systems and patients in listening sessions and meetings to provide feedback on birthing experiences and care. b. Review select Medi-Cal MCPs' Member Advisory Committees and hospitals' Member Feedback Assessments to identify cross-cutting themes to share back with MCP and hospital leadership.

meaningful, actionable, and systemwide change.	c. Partner with **Subcommittee 4** to identify patient birthing experience surveys to review and select a survey to be piloted in California hospitals, health systems, FBCs, and/or other clinical settings. d. Coordinate public awareness campaigns to amplify pregnant and postpartum women's birthing experiences in California. e. Develop and launch an effort to improve patient understanding of risk assessment and appropriate follow-up, leveraging campaigns such as the CDC Hear Her® campaign.
Years 4 & 5. By September 30, 2028, Subcommittee 1 will have initiated input opportunities and received and shared feedback across the health care, public health, and community systems, including patient feedback shared with perinatal care providers and leadership, to identify lessons and best practices to inform systemwide change and create a sustainable feedback loop.	a. Conduct community listening sessions with pregnant and postpartum women and their families and labor and delivery staff, providers, hospital leadership, and stakeholders. b. Conduct hospital listening sessions to understand what is and is not working with the integration of midwives, doulas, CHWs, promotoras, and community navigators. c. Facilitate meetings on how to improve maternal health and birth outcomes at the local level with perinatal health CBOs and labor and delivery hospitals to develop trust. d. Share themes identified in the Medi-Cal MCPs' Member Advisory Committees and hospitals' Member Feedback Assessments with MCP and hospital leadership to support health care systems' changes and reforms. e. Partner with **Subcommittee 4** to launch a piloted survey in California hospitals, health systems, FBCs, and/or other clinical settings to survey pregnant and postpartum women's birthing experiences.

Goal 2: Increase Access & Links to Risk Appropriate Care

Goal Statement: Pregnant and postpartum women and infants are provided quality, risk appropriate access with smooth transitions in care to the perinatal and postpartum care team and services they desire and need to ensure a healthy and joyous birth outcome.

Objective	Activities
Strategy 1: Implement The Joint Commission's Maternal Levels of Care in California	
Year 3. By September 30, 2026, Subcommittee 2 will develop an implementation plan to pilot Maternal Levels of Care in select hospitals.	a. Summarize strategies used to achieve Maternal Levels of Care in other states to inform priority strategies. b. Convene, in partnership with CA-OSG, labor and delivery hospitals to gather input on strategies to support implementation of Maternal Levels of Care and identify barriers to implementation. c. Launch quarterly meetings with key partners to implement the Maternal Levels of Care (e.g., State agencies, hospitals, FBCs, providers, professional associations). d. Promote Maternal Levels of Care designation with labor and delivery hospitals and FBCs. e. Develop the Maternal Levels of Care implementation plan for a pilot in select hospitals, including how to address barriers to implementation. f. Plan for and garner professional associations' (e.g., American College of Obstetricians and Gynecologists (ACOG), Society for Maternal-Fetal Medicine (SMFM), California Nurse-Midwives Association (CNMA)) support of the obstetric comorbidity index (OB CMI), a complementary tool for Maternal Levels of Care and transport.[39] g. Launch OB CMI pilot.
Years 4 & 5. By September 30, 2028, Subcommittee 2 will launch the Maternal Levels of Care implementation pilot and develop an implementation plan for other labor and delivery hospitals.	a. Launch the Maternal Levels of Care implementation pilot. b. Collect and analyze early implementation data to adjust strategies based on feedback, share early successes, and monitor risks or barriers to implementation. c. Communicate with stakeholders and providers and staff. d. Coordinate and collaborate with the California MHTF birth services/hospital closure project (see page 31 for more details).

[39] OB CMI is a validated tool for determining a pregnant woman's level of risk during pregnancy. DHCS is leveraging OB CMI as part of TCS for assessing risk for pregnant and postpartum women as outlined in the 2025 Birthing Care Pathway Report; CA-OSG also encourages OB CMI implementation in the 2024 California Maternal Health Blueprint. For more information on OB CMI, see a 2019 American Journal of Obstetrics & Gynecology article here.

	e. Partner with **Subcommittee 3**, professional associations, MCPs, hospitals, and outpatient care stakeholders to explore the use of OB CMI, prenatally and at admission, and scale OB CMI across all birthing facilities in California. f. Update and share the Maternal Levels of Care implementation plan for scaling across California.

Goal 3: Improve Risk Assessment & Follow-Up

Goal Statement: Medical, social, and economic needs are systematically and universally identified through universal risk assessment and comprehensively met in the communities where women live.

Objective	Activities
Strategy 1: Improve Transitions of Care for Pregnant & Postpartum Women Throughout the Perinatal Care Continuum	
Year 3. By September 30, 2026, Subcommittee 3 will launch the TCS Implementation Learning Collaborative.	a. Identify California labor and delivery hospitals, health systems, perinatal care providers, and leaders in health care, public health, and community systems to participate in a learning collaborative to support implementation of DHCS' TCS Policy Checklist, which will go live for Medi-Cal MCPs in January 2026. b. Launch the TCS Implementation Learning Collaborative
Years 4 & 5. By September 30, 2028, Subcommittee 3 will disseminate lessons learned from the TCS Implementation Learning Collaborative.	a. Continue the TCS Implementation Learning Collaborative and consider expansion to additional participants. b. Identify best practices and lessons learned and disseminate to other health care, public health, and community systems leaders and stakeholders to leverage when implementing DHCS' TCS for pregnant and postpartum women.
Strategy 2: Improve Medical, Social, and Behavioral Risk Assessment and Appropriate Follow-Up During Transitions of Care in the Prenatal, Delivery, and Postpartum Periods	
Year 3. By September 30, 2026, Subcommittee 3 will develop the "California Implementation Plan for Universal Screenings & Risk Assessment and Appropriate Follow-Up."	a. Describe the current state of universal screenings and risk assessment and appropriate follow up in outpatient and inpatient settings, including the prenatal period, admission for labor and delivery, discharge from a hospital after delivery, and the postpartum period. b. Review and leverage key initiatives (i.e. TCS Policy Checklist) in California related to universal screenings, risk assessment, and appropriate follow-up during the prenatal, delivery, and postpartum periods to identify how to facilitate coordination across community, public health, and outpatient clinics and address gaps or barriers to access. c. Draft the "California Implementation Plan for Universal Screenings & Risk Assessment and Appropriate Follow-Up."

	d. Socialize the "California Implementation Plan for Universal Screenings & Risk Assessment and Appropriate Follow-Up" with select State agencies to secure buy-in and approval. e. Recruit community, public health, and outpatient clinic partners to field test components of the "California Implementation Plan for Universal Screenings & Risk Assessment and Appropriate Follow-Up" plan and their relation to complementary system elements (e.g., hospital discharge and the CMQCC postpartum landing pages, the DHCS TCS Policy Checklist). Findings from field testing the components of the plan will shape the pilot.
Years 4 & 5. By September 30, 2028, Subcommittee 3 will launch and scale up the "California Implementation Plan for Universal Screenings & Risk Assessment and Appropriate Follow-Up."	a. In partnership with DHCS, doulas, CHWs, and system leads across health care, public health, and community, launch the pilot plan for the "California Implementation Plan for Universal Screenings & Risk Assessment and Appropriate Follow-Up" in select counties. b. Revise the "California Implementation Plan for Universal Screenings & Risk Assessment and Appropriate Follow-Up" with quality improvement and evaluation findings. c. Engage with stakeholders to identify collaborators and opportunities to scale up the "California Implementation Plan for Universal Screenings & Risk Assessment and Appropriate Follow-Up" statewide. d. Publish the "California Implementation Plan for Universal Screenings & Risk Assessment and Appropriate Follow-Up" for scale up in California. e. Scale up the "California Implementation Plan for Universal Screenings & Risk Assessment and Appropriate Follow-Up."

Goal 4: Modernize Data Access & Data Transparency

Goal Statement: Establish a standard of data transparency, interoperability, and accountability for data collection, analysis, and use for serving and caring for mothers and infants.

Objective	Activities
Strategy 1: Support Data Interoperability Across Health Care & Public Health Systems	
Year 3. By September 30, 2026, Subcommittee 4 will identify California MHTF data sharing needs and current California-led efforts to improve data interoperability.	a. Identify current policies and mandates around health information exchanges, electronic medical records, Medi-Cal Connect, and "shovel-ready" opportunities to improve data interoperability. b. Outline California MHTF priority data sharing and interoperability needs and a use case to link health care, public health, and community data, outlining the data sources needed. c. Identify legal, privacy, and security barriers to achieve data sharing needs, open-door opportunities for data sharing, and barriers preventing data interoperability. d. Understand how and where data interoperability is currently occurring. e. Explore how medical record data collection tools can be shared to standardize data collection on depression screening, hemorrhage risk assessment, and other select maternal health outcome measures. f. Identify key partners to engage in mitigating barriers to data interoperability. g. Identify opportunities to empower patients with health information and data via phone technology. h. Outline a plan to scale current California interoperability efforts and promote new data sharing opportunities to improve data access, sharing, and interoperability opportunities.
Years 4 & 5. By September 30, 2028, Subcommittee 4 will support, inform, promote, and implement California strategies to improve data interoperability.	a. Outline a public-facing briefing paper that identifies potential opportunities, successful demonstrated working examples, barriers, and strategies needed to scale current data interoperability and data sharing efforts happening in California to improve data access, sharing, and interoperability.
Strategy 2: Collect and Share Pregnant and Postpartum Women's Reported Birth Experiences	
Year 3. By September 30, 2026, Subcommittee 4 will establish a process for standardizing and collecting patient-reported care experience data across	a. Identify currently collected patient care experience, outpatient feedback, and data sources that capture feedback on autonomy, respect, and mistreatment in the health care setting. b. In collaboration with **Subcommittee 1,** select and validate measures to evaluate patient feedback on the health care system.

California health care, public health, and community systems working to improve maternal health outcomes.	c. Identify barriers to obtaining and sharing patient reported data with community and health care system.
Years 4 & 5. By September 30, 2028, Subcommittee 4 will engage patient experience data owners and implementers to standardize and establish reportable patient experience findings.	a. Partner with health care and public health systems to establish, standardize, and implement patient reported experience and outcome survey metrics. b. Pilot additional survey metrics to deepen the understanding of women's prenatal, birth, and postpartum experiences and solicit feedback. c. Report patient reported findings to health care, public health, and community systems.
Strategy 3: Strengthen California's Existing Data Frameworks & Platforms	
Year 3. By September 30, 2026, Subcommittee 4 will inventory and promote maternal health data that is currently, and will continue to be, collected and available to meet health care, public health, and community needs and expectations.	a. Identify existing databases, publicly reported data, national performance data metrics, and sources of maternal health data variables (such as HCAI, DHCS, CDPH MCAH dashboards, Healthy Places Index, ACOG, California Conference of Local Health Officers (CCLHO)). b. Identify and expand disaggregated data identifying what can be made available at the county, hospital, public health, population, and community levels. c. Identify list of local county public health, health care, California MHTF members, policy leaders, funders, and community members to engage in shaping a maternal health dashboard. d. Use the CDPH/MCAH dashboards to identify "hot spots" of poor maternal health outcomes and opportunities to address those outcomes. e. Engage the community to understand what they are working on and the data needed to track and report progress on community defined measures and priorities (e.g., preferred language, high-quality providers, access to care, distance to care). f. Map available data to California MHI and Subcommittee priority areas, and identify gaps, to track outcomes. g. Explore feasibility of collecting and reporting birth data by provider type (e.g., physicians, CNMs, LMs) and facility type (e.g., hospital, FBCs, home). h. Convene a Maternal Health State of the State webinar to promote current data sources and variables already available that can be used to inform action.
Years 4 & 5. By September 30, 2028, Subcommittee 4 will evaluate Subcommittee goals, strategies, and opportunities to close identified data gaps.	a. Leverage available data to evaluate progress on risk assessment and referral programs for pregnant and postpartum women. b. Inventory data gaps and engage data leads across health care, public health, and community systems to identify opportunities to close data gaps.

Goal 5: Break Down Silos & Integrate Systems

Goal Statement: Organizations and care delivery systems responsible for serving and caring for prenatal and postpartum women are coordinated and integrated across systems, public health programs, communities, and health care services.

Objective	Activities
Strategy 1: Promote Use of a Shared Systems Framework Across California MHTF	
Year 3. By September 30, 2026, Subcommittee 5 will identify health systems resources and draft a systems framework.	a. Identify and summarize the problem to solve in a systems approach across health care, public health, and community systems. b. Include county-level partners (e.g., local MCAH directors, First 5s, WIC agencies) in an effort to strengthen county-level partnerships and improve local systems coordination. c. Review existing systems frameworks and operational levers that address maternal health systems – including health care, public health, and community – and identify systems change points to inform selection of a systems framework. d. Identify key elements and principles of existing frameworks, including DHCS' Birthing Care Pathway. e. Draft the systems framework and seek feedback. f. Draft an Interagency Agreement systems resource guide to support the California MHTF's application of the framework.
Years 4 & 5. By September 30, 2028, Subcommittee 5 will have a systems framework and resources and tools available.	a. Improve the systems framework and resources and tools in response to lessons learned while using the framework.
Strategy 2: Institutionalize Maternal Health Prioritization Across Key State Agencies	
Year 3. By September 30, 2026, Subcommittee 5 will use the proposed systems framework to identify and fill gaps in Subcommittee 5 representatives and involvement from State agencies and engage these State agency leaders to explore the concept of institutionalizing	a. Engage State agency leaders identified in the systems framework (e.g., DHCS, CDPH, CA-OSG, HCAI) to identify how to institutionalize maternal health prioritization amongst their agencies' priorities. b. Explore possible and preferred mechanisms to institutionalize maternal health prioritization (e.g., regular meetings of agency leadership, interagency agreements).

maternal health prioritization and possible mechanisms for systems change.	
Years 4 & 5. By September 30, 2028, Subcommittee 5 will have regularly engaged with leadership at each identified key State agency on maternal health prioritization.	a. Identify next steps to implement agreed upon mechanism for institutionalizing maternal health prioritization. b. Work with **Subcommittee 4** to engage State agencies and other collaborators to finalize and operationalize a shared list of maternal health indicators.
Strategy 3: Identify Opportunities to Share Best Practices to Promote Coordination & Integration of Systems	
Year 3. By September 30, 2026, Subcommittee 5 will identify opportunities to share best practices on improving maternal health outcomes, including developing a vision for a 2027 Maternal Health Summit to share California MHTF accomplishments and lessons to date.	a. Draft initial vision for the Maternal Health Summit and solicit a conference planner to support the Maternal Health Summit. b. Identify resources to support training and sharing of best practices on improving maternal health outcomes.
Years 4 & 5. By September 30, 2028, Subcommittee 5 will have hosted the 2027 Maternal Health Summit and supported additional sharing of best practices.	a. Finalize the vision and logistics for the 2027 Maternal Health Summit. b. Convene the Maternal Health Summit. c. Memorialize findings and achievements from the Maternal Health Summit to inform priority areas of work for the upcoming HRSA State MHI Program application in Spring 2028.

d) Alignment with Title V Needs Assessment

California's Title V MCH Services Block Grant, which is federally administered by HRSA, provides funding to California to improve the health and well-being of mothers, infants, children and youth, including children and youth with special health care needs, and their families. The California Title V Program is administered by the MCAH Division of CDPH. MCAH provides Title V funding to 61 local health jurisdictions (LHJs) to support their local MCAH programs.

California submitted the most recent California MCAH Title V Needs Assessment in 2021, which includes findings and priority needs across the five Title V population domains: 1) Women/Maternal; 2) Perinatal/Infant; 3) Child; 4) Adolescent; and 5) Children and Youth with Special Health Care Needs (CYSHCN). Each population domain has a Domain Team of staff with program, evaluation, and epidemiology expertise from across CDPH/MCAH. To develop the California MCAH Title V Needs Assessment, the five Domain Teams conducted extensive outreach and engagement of stakeholders, reviewed program and population data, and analyzed local MCAH needs assessments from the 61 LHJs in California. Appendix C details the 2021 California MCAH Title V Needs Assessment's key findings, priority needs, focus areas, and corresponding performance measures (including National Performance Measures (NPMs) and State Performance Measures (SPMs)).

In September 2024, CDPH published an annual report update to the California MCAH Title V Needs Assessment which highlighted changes in the health status and needs of the state's MCAH population since 2021 including but not limited to an increased pregnancy-related mortality among Black pregnant women; increased Black infant mortality rate; increased concern for emotional and mental health of children, adolescents, and young adults; increased number of children experiencing violence at home, with higher rates of child abuse among CYSCHN; increased rates of IPV, especially in households of CYSCHN; and increased negative impacts on caregiver emotional health. The 2024 update also includes information on changes to the CDPH/MCAH organizational structure and individual program capacity with increased funding to expand BIH, CHVP, maternal mortality and morbidity review committees, and behavioral health services for children, youth, and families via the Children and Youth Behavioral Health Initiative (CYBHI) and CalAIM.

CDPH is currently preparing the 2026 Title V Needs Assessment for submission to HRSA in September 2025. In September 2024, the final local MCAH Needs Assessment's top six priority need areas for the Women/Maternal Domain included:

- Mental health (44 out of 61 local MCAH programs selected this as a top three priority)
- Access to care/health insurance (36)
- Substance use (16)
- Prenatal care (15)
- Housing security/homelessness (13)
- Economic family supports (9)

LHJ MCAH Needs Assessment

CDPH requires each of California's 61 MCAH LHJs to conduct a needs assessment every five years to identify problems and priority areas to inform the **California Title V Needs Assessment.** LHJs conduct data review and community engagement activities to develop the MCAH LHJ Needs Assessment, which they then submit to CDPH about one year prior to the federally-required Title V Needs Assessment's due date. Local MCAH Needs Assessments may be available on county websites.

Findings from the Title V Needs Assessment were utilized to help shape California MHI's goals, strategies, objectives, and activities outlined earlier in Section III.

e) California Innovations to Support Maternal Health

Year 1 was focused on the California MHTF Steering Committee infrastructure build-out to deliver on HRSA State MHI Program deliverables. The following innovative ideas have been outlined to meet the goals of the grant: reductions in maternal mortality and SMM. To achieve the strategic priorities, key innovative strategies were identified. In consultation with health care leaders and one-on-one interviews with California MHTF Steering Committee members, as well as a comprehensive review of existing practices for systems change, the California MHI team identified numerous evidenced-based innovations and strategies for systems change. The California MHTF Steering Committee then discussed and identified the following key innovative approaches to support the work of the strategic priorities.

Innovations		
Innovation	**Purpose**	**What Makes It Innovative**
Community Innovations Funds for Systems Change	A key component in ensuring the California maternal health community is engaged in the development and implementation of the Final Strategic Plan is the earmark of $450,000 from the MHI award for one-time Community Innovation Funds for Systems Change. These awards will extend the reach and execution of the MHI award by sharing resources with CBOs serving a variety of birthing populations across the state. The California MHTF Steering Committee and Subcommittees will lead the identification, selection and evaluation of implementation proposals that will extend the reach of the grant. In 2025, the first year of this community investment, the California MHTF partnered with MOMS Orange County to fund Doula Organization Enhancement Awards which will support CBOs, doula hubs, and doula organizations in training, recruiting, supporting doulas, and/or introducing and connecting doulas to public health programs, health care providers, and maternal health CBOs and agencies. The award also aims to improve the capacity of doulas to leverage Medi-Cal's doula benefit by enhancing existing efforts/organizations focused on training doulas to bill and access the benefit.	This funding seeks to expand the doula workforce in California areas with little to no doula service and/or expand the number of doulas supporting families in different languages with high-quality, respectful, trauma-informed care. While there are multiple existing organizations enabling Medi-Cal doula care, this funding bolsters their work and fills a critical gap in efforts to increase the number of doulas in Medi-Cal birthing communities.

State Leadership Collaboration	To strengthen collaboration among State agencies, local community programs, and public health systems to improve maternal health outcomes in California.	Because California is a large state, State agencies, community, and other public health systems are often not integrated or working together. This grant will unite and focus all maternal health entities on a shared Strategic Plan.
Birth Services/Hospital Closure Project	A project team led by California MHI Principal Investigator, Dr. Jeffrey Gould, has developed engagement strategies and tools and confirmed local organizations to begin conversations on the impact of birth services/hospital closures on their community. These include a family health center serving American Indian/Alaska Native populations in the far northern region of California as well as a coastal agricultural community in the Bay Area. Through initial conversations with leaders in the communities and input from a steering committee member with experience with a threatened closure, the project team aims to improve engagement strategies and tools and develop materials for communities with threatened birth services/hospital closure. There is recognition by the project team that birth services/hospital closures are a public health threat and there is opportunity to align with existing local health jurisdictions around emergency preparedness, health care workforce, and hospital preparedness.	In the last ten years, over 50+ hospital closures or labor and delivery suspensions have occurred in California. However, there have been no efforts to date to understand the impact these closures have had on families and communities. This grant will explore this impact and help identify solutions to the closures.
Infrastructure Innovations		
Innovation	**Purpose**	**What Makes It Innovative**
Systems Level Continuous Quality Improvement and Impact Measurement	To evaluate the performance of and provide data on quality improvement activities being funded by the MHI grant. This can include California MHTF Steering Committee and Subcommittees' ability to plan, execute, and evaluate action plans written to meet objectives.	Continuous QI and impact measurement has not been utilized to date to measure activities at a state level that call for integration of systems such as health care, public health, and community. This approach will measure how well California MHI is bringing systems together and the impact of this work on both systems and population indicators.

Dedicated Communications Resources for California MHI (staff, technology)	To develop strategic and precise communication tools and products, messaging, and methods that inform quality improvement and demonstrate ability to reach the appropriate stakeholders with the right info, at the right time, with the right platform.	Multiple communication efforts are implemented across California each day by multiple entities. Currently, there is no megaphone that unites, aligns, and broadcasts important maternal health messages. Establishing a cohesive communication strategy will help amplify maternal health messaging and reach more audiences across California. The development of a CA MHI website for stakeholders and system leaders to connect and collaborate.
Systems Dynamics (SD) Modeling	To identify precise information about how and which systems influence points of interaction that impact patient care/outcomes. It is the project's hope that use of SD Modeling will result in strategic investments to better integrate systems to improve maternal health outcomes.	SD Modeling has not been used broadly in public health or health care to identify mechanisms to improve integration and coordination of systems of care. SD Modeling provides the ability to identify silos, barriers, and innovate ways to close gaps by studying how systems work.

Appendices

Appendix A: HRSA-Funded Grants in California Focused on Maternal Health Since FY 2018 (As of September 2024)

HRSA Grant	Brief Description	California Entity	Awarded FY	Amount	End Date
Ongoing Grants					
Title V Maternal and Child Health (MCH) Services Block Grant	Address maternal and infant mortality, improve prenatal and postpartum care, deliver community-based care	CDPH	2018 – Current	$17.5M in 2024 and ~$40M other years	N/A States apply for funding each year
Maternal, Infant & Early Childhood Home Visiting (MIECHV) Program	Support home visiting programs *This does not include the $2.8M American Rescue Plan Act of 2021 (ARPA) MIECHV funding CDPH received in 2021*	CDPH	2018 – Current	~$9M - $26M (dependent on the year)	Two years after the awarded FY
State Systems Development Initiative (SSDI)	Improve data integration and support for maternal health	DHCS	2018 – Current	~$43K in 2024 and $100K in prior years	Five years after the awarded FY
MCH Nutrition Training Program	Train maternal and pediatric providers in nutrition care	• University of California, Berkeley (UCB) • University of California, Los Angeles (UCLA)	2018 – Current	$225K per site per year	Five years after the awarded FY
Healthy Start Initiative: Eliminating Disparities in Perinatal	Improve maternal health outcomes and prevent adverse	Counties and CBOs in: • Alameda • Fresno • Los Angeles	2018 – Current	~$750K – 1M per site per year	Five years after the awarded FY

HRSA Grant	Brief Description	California Entity	Awarded FY	Amount	End Date
Health (Healthy Start)	perinatal outcomes	• San Diego			
Maternal and Child Health Measurement Research Network (MCH-RN)	Support research on maternal, prenatal, and children's health (up to age 25)	• UCLA (2018 – 2022) • UCSF (2018 – 2021)	2018 – 2022	$130K – 1.2M per site per year	Three years after the awarded FY
Maternal and Child Health Field-Initiated Research Studies (MCH FIRST) Program	Support research to advance the health of all maternal and child populations	• UCB (2023) • UCSF (2022) • University of California, Davis (2020 – 2021) • University of California, San Diego (2018) • The Rand Corporation (2018)	2023, 2022, 2020 – 2021, 2018	$100 – 300K per site per year	Three years after the awarded FY
Integrated Maternal Health Services (IMHS)	Implement maternity medical homes	Charles R. Drew University of Medicine & Science (Los Angeles)	2023	$1.8M	Five years after the awarded FY
Maternal Health Research Collaborative for Minority-Serving Institutions (MH-RC-MSI) Research Centers (RCs) [The Collaborative]	Develop a multi-institutional research network comprised of minority-serving institutions focused on maternal mortality and morbidity	Loma Linda University (San Bernardino)	2023	~$470K	Five years after the awarded FY
Centers of Excellence in Maternal & Child Health Education Science & Practice	Train graduate and post-grad public health students on maternal and child health best practices	• UCB • UCLA	2022 & 2023	~$350K per site per year	Five years after the awarded FY

HRSA Grant	Brief Description	California Entity	Awarded FY	Amount	End Date
Screening and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD)	Launch perinatal consultation line to support providers with insights from reproductive health psychiatrists and physicians with expertise in perinatal substance use	Los Angeles County	2023	~$750K	Five years after the awarded FY
FY23 Quality Improvement Fund – Maternal Health Awards	Support health centers focused on maternal morbidity and mortality[40]	• Bay Area Community Health (Fremont) • North County Health Project (San Marcos)[41]	2023	$2M per site	One year after the awarded FY
Maternal and Child Health Pipeline Training Program (MCHPTP)	Promote the development of a representative workforce and recruit Black, Hispanic, Asian, Pacific Islander, and American Indian/Alaska Native students to enter MCH public health and related fields (e.g., pediatrics, MCH nutrition, MCH social work, psychology, etc.)	• UCB (2021) • UCLA (2018 – 2020)	2021, 2018 – 2020	~$155K per site per year	Five years after the awarded FY

[40] HRSA's announcement specifically highlighted that the awarded health centers would support Black and American Indian/Alaska Native pregnant and postpartum women.

[41] TrueCare, which manages North County Health Project, is a federally qualified health center (FQHC) network serving San Diego and Riverside Counties with a focus on providing high-quality, comprehensive, and affordable care. TrueCare is a level 3 patient-centered medical home.

HRSA Grant	Brief Description	California Entity	Awarded FY	Amount	End Date
	There is no HRSA webpage for this grant				
Concluded Grants					
Maternal and Child Health Public Health Training Program	*There is no HRSA webpage for this grant*	• UCB • UCLA	2018 – 2021	$154 – 520K per site per year	

Appendix B: Postpartum Interviews Themes and Quotes

Theme	Definition	Quote
Autonomy	Participants shared reports of providers making decisions on behalf of patients without patient involvement, participants feeling disempowered, and providers being dismissive of birthing choices (e.g., delayed cord clamping). There were also positive reports of autonomy when participant requests and needs were heard and centered in their birthing experience or postpartum care resulting in the participant feeling empowered.	● "Just as far as handling my baby, instead of asking me if they can do certain things, they just would come in the room and like, "Oh, I'm going to get the baby for this." And I'm just like, "Well, what is that for?" And when I would ask questions, they would be confused as to why am I asking questions." ● "And I let them know that I didn't want any medication to start labor. I wanted it just to go on its own, to start on its own. And they told me that they would be putting me on Pitocin and things like that, and I told them I didn't want that." ● "That's another reason why I didn't want to have a baby in the hospital. It's a trust thing too. And I felt more comfortable birthing outside of the hospital. I didn't want any of those interventions that they want to always just throw you on really quick. And they don't want to listen--it seems like they don't want to listen to you or wait around to hear what you got to say. It's just like, "No, we're going to do this, and this is what we're going to do. So, hey, even if you had a birth plan, all that's out the window. This is what we're doing." And it seems kind of like your voice is stripped away from you."
Barriers to Medical Recovery	Participants described challenges with fully recovering due to external factors, such as having to return to work, lack of support (e.g., cannot stay in bed for wound recovery), or needing to prioritize care for others. This also includes being ignored and a lack of continuity of care.	● "So kind of the hardest part was just the pain in the stomach and still having to get around and do stuff for all the other kids, cook, drive, dropping them off to school, stuff like that." ● "Working, still having to do all this and still being exhausted and still having to go to work" ● "No, I had to call, and I scheduled it. And the first time I went, they turned me away because the provider didn't

Theme	Definition	Quote
		show up. Yeah. I'm like, "Okay." And transportation is already hard. So I got turned away."
Patient Experiences, Treatment, and Care	Participants described medical mistrust that is rooted in past experiences, observations, or generational trauma.	● "I did encounter a few people that were kind of questioning who the baby's father was just because of how light my baby was born. And my husband is Jamaican, and so he has darker skin. So one of the nurses asked me, "Oh, is your baby's father White?" And I'm like, "No, you saw my baby father. He's Black."" ● "The brushes and the combs that they give you, I mean, for your hair, that does not work on our hair at all. [laughter] It literally does not work. It doesn't do anything." ● "Immediately after birth, they asked me if she wanted to wear the Huggies or the drug-testing diaper. And I was like, "Well, that's kind of a weird thing to ask me. I don't know why you guys would offer that. Is it mandatory?" And she basically told me-- the nurse told me that, yes, I could say no to the drug-testing diapers where they tested the baby's stool for opiates. But basically, the CPS could investigate me for saying no. So it didn't sound very much like I had an option, and I let them do the drug-testing diaper because of that. And then I guess they forgot to put in my charts that I had morphine at the beginning of birth, and they almost made a report to CPS about my baby having opiates in her stool. And I had to clarify for them that they gave me morphine during early labor."
Centering Religious/ Spiritual/Family Needs	Participants discussed needs and practices during labor, birth, and the postpartum period related to religion, spirituality, and other needs related to their families. This includes experiences of having such needs met, supported, not supported, or not	● "Because some religions don't want their baby circumcised. Some religions don't want their baby taking certain medications and immunizations and stuff. And sometimes they just come in and do it."

Theme	Definition	Quote
	accommodated, or the participant did not feel safe with asking about whether their needs could be met or asking for accommodations.	● "It'd be nice to have Native practices more respected in the hospitals, but you can't light sage. And even having a Native person available on call that's willing to come and pray in our way and just make other Native women feel comfortable, that'd be nice too because usually, they always have a Christian or a Catholic on standby." ● "So now that I'm fully transitioned to Islam and I actually practice my religion, I think prayer. Having some type of-- having some type of identification in my chart or something where doctors know and understand that no men, no male nurses, no male doctors. Having a prayer available. Food-wise, I guess it would just be a vegetarian meal, if anything. And then no pork. And honestly, I don't expect the hospital to provide halal meat, so I would just think they would do vegetarian or something. I think that would be pretty much it. Having maybe better gowns, Islamic gowns, that kind of cover more."
Community Resources and Connections	Participants discussed use of community resources and connections to community, utility of community-based resources, and the quality or type of care received from the community resources (e.g., doulas).	● "Because honestly, the group, it was right after, and we jumped right into it. And it's once a week. And that honestly helped my mental just because-- I mean, I have my husband and everything. But when you have that group with other women and they're experiencing similar things and you can talk about it, then it really helps a lot." ● "Just meeting the other women and knowing that I wasn't alone, and I can see and communicate with other people that are going through it and venting out and getting out" ● "I did have a WIC lady, yes. Well, they connected me from the Black Infant Health to that lady"

Theme	Definition	Quote
Knowledge Gaps in Postpartum Care	Participants described knowledge gaps for addressing their postpartum needs due to a lack of education, resources, and information. Participants reported a lack of prenatal education about the postpartum experience; sources of postpartum education and information, such as from their community, social media, or family; and education from medical staff.	● "But nobody told me this the first time, so I did not buy anything during my first pregnancy. And then I felt stupid when I saw-- so after that, I had so many friends who went through deliveries. And their baby registry, every single one of them had those kits. And I was like, "This is great. I'm so happy that they have done their research." I just am not a researcher myself. I just kind of go with the flow. And so, I did not take the time to think about, "After I get home, what does postpartum look like?" And I think a lot of people shared with me what their pregnancy looks like, but nobody talked about postpartum, which was kind of sad. And so I think I was just more prepared the second time around." ● "And then maybe just recommend they attend an hour Zoom where you hear different stories, people's real experience on the postpartum [depression] and what they felt and what triggered it, just so you have a better-- because the pamphlets, I don't think anybody really reads the pamphlets, or if do they kind of-- I'm not going to lie. I think if you do, you kind of scan them, and they're outdated. They're great and all, but I don't think too many people really read them. I think it'll be better for more-- because we're in the day of social media, more social media awareness on it. Just YouTube videos, or even if you're like, "Hey, check out this YouTube video," instead of just, "Here's a pamphlet. You need to discuss anything like that." Just more active information, I guess." ● "I don't think I searched up any postpartum information. I don't remember if I did come across any

Theme	Definition	Quote
		either. But I do have one person that I follow on my Instagram. I just really enjoyed watching how peaceful she was with herself, how she had a routine. She did her yoga with the baby. She had this whole routine and just still took care of herself, still took care of her household, had a lot of information. There was actually another girl who I went to high school with, and we reconnected. And her whole page and livelihood is centered around motherhood. And so I think she did have a couple of things too on after giving birth and pre as well. I don't know if it went too deep into postpartum, but I think those are the ones that I mainly look at or I mainly follow."
Lactation Support	Participants described experiences with lactation, such as accessing lactation education, trouble/challenges breastfeeding, access and utilization of lactation equipment or necessities (e.g., pumps, nipple shields, or pillows), and access to lactation consultants.	● "And they told me from day one when I gave birth that I could speak to a lactation consultant because my daughter was just not latching properly, and my nipples had blood blisters on them. And I didn't get to speak to one until my last five minutes when I was checking out for the second time after the sepsis. That's the only time that I got to speak to a lactation consultant, was on my way out from the visit that I shouldn't have even had to begin with. Also, during this stay, one of the nurses went into my old room and they found the little hospital bracelet that I almost left behind, and they gave it to me, which I was thankful for because I almost left my daughter's little name [bracelet] thing that they make for the babies when they're born." ● "I felt like it was just hard for the fact that I was pumping. And literally, the first thing that was said, is like, "Yeah, breast milk is the best." And I didn't want my daughter to not have breast milk, knowing how beneficial

Theme	Definition	Quote
		it is. So I set out to pump. And when I asked about pumping, it was, "Pumping's hard. That's the hardest thing you can do." Because not only am I washing bottles, I'm washing pump parts every two hours." ● "But I think the lactation consultants were my favorite part of both the deliveries. They were very helpful. They set up appointments right then and there for a few days after and then the follow-up. I think the lactation clinic that is part of the-- so my insurance is of the Insurance Group, so the lactation clinic associated with it is fantastic, and I couldn't recommend that enough to anyone who's delivering in the Insurance Group. That really helped me both the times to be sane and to just manage, have a schedule of pumping and getting the milk supply going."
Mental Health	Participants described struggles with getting needed support with mental health and descriptions of their mental, emotional, and behavioral health. Participants reported postpartum depression, anxiety, baby blues, or the range of emotions they need to manage, process, or experience, as well as the ways in which they navigated getting support or the lack of support available to them from family, insurance, providers, or community.	● "And also, my birthday came up, and I was just really sad because no one cared about me on my birthday. It was just about the baby." ● "They shared with us the different steps for postpartum depression. And sometimes you know that you're experiencing it and sometimes it just creeps up on you and how to deal with it. And it's okay to ask for help and that you're not alone, that other people is actually going through postpartum depression, as well. And to give you different ways of having family help you with after you have the baby and different things like that." ● "I had went through a really dark place and was convincing myself that I didn't deserve to have the baby anymore. And I was just convinced that I had failed him."
Patient Assessment of Hospital Quality	Participants described their assessments of hospital quality,	● "They gave me one hour in a dirty room, and I was also by myself, and

Theme	Definition	Quote
	such as the measures of hospital quality (e.g., comfort, birth experience, family centeredness) and the degree of quality.	this was my first baby. And they basically told me, "If you're not more dilated, then we're sending you home." They also didn't fasten the belts to monitor the contractions tight enough, I don't think, because I noticed that it just didn't feel like it was picking up my contractions accurately because they were painful enough to where I was actually crying." ● "Okay. So you guys don't have any room. The AC is not working. I'm going to leave." So I asked them, "Can I leave?" They brought me a paper. I signed it, and we left. By the time we left, my contractions were really just back to back." ● "And I think as part of postpartum, I would have appreciated foods that were not constipating, because I'm taking all the stuff that is going to help me with a bowel movement, and then I'm eating this food. It's contradictory. I would have liked for them to have a specific meal which is more suitable for postpartum mothers than just regular someone there with a knee surgery, because they don't eat the same. So I felt like that could have helped a little bit. And that was one of the reasons I actually asked my husband to get food from home, because I'm like, "I'm not eating pasta and bread, because I don't want to be constipated."
Poor Communication Interactions with Clinical Staff	Participants reported experiences of clinical staff being dismissive of participant questions and concerns about their health or the baby's health or lack of clarity when information is communicated. This also includes the consequences of poor communication such as miscommunication between	● "And I did not experience very good treatment by the nurses. When I was screaming while I was waiting on the epidural because at that point, I was in a lot of pain, I was already up to like a four and a half. They told me that I couldn't be screaming, and they were making fun of me, a group of nurses, outside of my door."

Theme	Definition	Quote
	medical staff, miscommunication with participant about medical information, distrust, diminished provider trust, or rushed decisions.	● "And I just was noticing a lot of kind of micro aggressive behavior. Again, I'm not sure if they were necessarily aware of it, but it made me feel uncomfortable. And they put those nurses right back in charge of me, in charge of taking care of my daughter. So it was to the point where I don't know if it was also maybe a bit of the lack of sleep that had me paranoid or just the combination of everything that was going on. But I did not ever leave my daughter's side in the hospital. I felt really paranoid about letting the nurses take off with her, even just for me to be able to get sleep. So I was dying of sepsis with about two hours of sleep a day because I was just trying so hard to make sure that my daughter was fed." ● "I was telling him I was going to throw up, and he said, "No, you're not." How do you know what I'm feeling? And then I did throw up, and I had throw-up in my hair the first time I saw my daughter."
Practicing Self-Care	Participants reported difficulty with taking care of their own needs, such as self-care, feelings of exhaustion, or difficulty finding time to take care of themselves.	● "I was hallucinating at one point and sleepwalking. And I had never done that before. But with this last pregnancy, I was hallucinating that my husband was telling me to get stuff. So I'm sleepwalking, going and grabbing things out of the kitchen and out of the medicine cabinet, so. And I'm walking over to him. He's knocked out, and I'm like, "Here." And he's like, "What are you doing?" And I'm like, "Oh, I thought you just woke me up and told me to get this. My bad." [laughter] It was a struggle for sleep." ● "But I think the main thing that stressed me out was I had to still eat and I still had to actually shower. I would have to take another shower even if I showered with my baby

Theme	Definition	Quote
		because I couldn't really wash myself while she was being held. It took both of my hands to hold her or even just one. But I couldn't wash my hair or do things with one hand. So a lot of the time that I would get stressed out shortly after birth was more so because of my own needs rather than her." ● "I still have times where I'm like, "Oh my God, this is too much. It's just too much." And then I think it's like a day-to-day thing dealing with a small child. I don't think you ever mentally go back to who you were prior to having the baby. It completely changes your mentality. It just changes you. So I don't even feel like I'm the same person as I used to be. At this point, I don't care about how I look. I don't care about my appearance or anything like that. Those are things that I would take pride in before I had her. So now it's just literally all about her. Sometimes you can kind of lose yourself in that."
Support Infrastructure	Participants discussed the social and emotional infrastructure to support postpartum women, such as a support network, family support, or unexpected support from work, social services, or their care team.	● "So my delivery, I had a rough experience because I had to go to the hospital alone. I was left at home alone when I was starting labor, and it was on the day before Christmas Eve, and I had to take a taxi alone to the hospital. And then when I got there, I had my big hospital bag. Well, I had a hospital bag for me and then the diaper bag. I don't know why I took so much in hindsight, but I had not progressed fast enough for them to their standards." ● "Well, my mom was a big support with me. So she made me feel a lot better. And she was really pushing like, "Don't let them step on you." She's one of those people, a go getter, "Don't let them step on you. You better be calling every day. Did you call today? Did you do this?" So

Theme	Definition	Quote
		it was really nice to have someone that cared about me at that point." ● "My doula, she helped me with everything during birth. And also, before I had him during my pregnancy, she helped me with experimenting different health options. And she also was there to help me with breastfeeding, with coaching as far as mental health. If I needed some type of advice or advocating for me, she was there to help me out. I was high-risk. So it was a lot of different things that I didn't know. So she was able to help me out. So when I had my doctor's appointments, I was able to go in and know exactly what to tell them. So I was able to make sure that me being an African-American mom, that I was able to get treated like others. So it was a lot of different things that she helped me with."

Appendix C: California MCAH Title V Needs Assessment Summary (2021)

Key Findings	Priority Needs	Focus Areas	Performance Measures
Domain: Women/Maternal			
• **Maternal Mortality.** While California's maternal mortality rate is one of the lowest in the country, the rate for Black women continues to be 2X to 4X above the rates for women from other racial/ethnic groups. • **Maternal Morbidity.** Maternal morbidity rates are increasing across California with Black and American Indian / Alaska Native women, and women with chronic conditions, more likely to be impacted. • **Maternal Mental Health.** With about one in five pregnant and postpartum Californian women reporting symptoms of depression during the perinatal period, there is a need for enhanced maternal mental health support. Black and Hispanic women and people who have given birth are more likely to be impacted by depressive symptoms. • **Perinatal Substance Use Disorder.** Rates of perinatal substance use disorder and neonatal abstinence syndrome (NAS) are increasing in California. Local MCAH programs identified maternal substance use as a top priority for intervention. • **Well-Woman/Postpartum Visits.** Wellness/postpartum visit attendance differs greatly by health insurance status in California, and provider	• Ensure women in California are healthy before, during, and after pregnancy.	• Reduce the impact of chronic conditions related to maternal mortality. • Reduce the impact of chronic conditions related to maternal morbidity. • Improve mental health for all mothers in California. • Ensure optimal health before pregnancy and improve pregnancy planning and birth spacing. • Reduce maternal substance use.	• NPM 1: Percent of women ages 18 – 44 with a preventive medical visit in the past year.

Key Findings	Priority Needs	Focus Areas	Performance Measures
shortages and transportation challenges in rural areas exacerbate access challenges.			
Domain: Perinatal/Infant			
• **Preterm Birth and Infant Mortality.** In California, Black and American Indian/Alaska Native mothers are more likely to experience negative birth outcomes such as preterm birth, and these families are more likely to be impacted by infant mortality. Comprehensive interventions are needed to address negative infant health outcomes statewide. • **Low Birthweight.** Though this indicator is stable in California, Black newborns are more likely to be born at low birthweights. • **Breastfeeding.** Rates of exclusive breastfeeding through three months postpartum have increased in California in recent years, though some patient populations are more likely to have lower rates.	• Ensure all infants are healthy and thrive in their first year of life. • Reduce infant mortality with a focus on children and families more likely to be impacted.	• Improve healthy infant development through breastfeeding and caregiver/infant bonding. • Reduce infant mortality with a focus on children and families more likely to be impacted. • Reduce preterm births.	• NPM 3: Percent of very low birthweight infants born in a hospital with a Level III+ NICU. • SPM: Percent of women who report exclusive breastfeeding at three months. • SPM: Preterm birth rate among infants born to non-Hispanic Black women.
Domain: Child			
• **Developmental & Social-Emotional Screening.** Local MCAH programs in California identified expansion of developmental and social-emotional screening for children under the age of three as a key area of need. • **Resilience & ACEs.** The proportion of California children who are "flourishing" (i.e., receiving all of the support and care needed to reach their full potential) has	• Optimize the healthy development of all children so they can flourish and reach their full potential.	• Expand and support developmental screening. • Raise awareness of ACEs and prevent toxic stress through building resilience. • Support and build partnerships to improve the physical health of all children.	• NPM 6: Percent of children ages 9 – 35 months who received a developmental screening using a parent-completed screening tool in the past year.

Key Findings	Priority Needs	Focus Areas	Performance Measures
substantial room for improvement. Relatedly, ACEs are prevalent among California children, indicating a need for a trauma-informed approach to care and promotion of resilience. • **Physical Health.** California children need access to preventive dental care and an array of population-based interventions to maintain a healthy weight.			
Domain: Adolescent			
• **Mental Health.** Local MCAH programs identified adolescent mental health as one of the highest priority needs given high rates of depression and anxiety disorders, mental health hospitalizations, and suicide among California youth, with certain adolescent populations more likely to be affected. • **Access to Care.** Only 68.3% of California youth ages 12 – 17 are continuously and adequately insured. Barriers to accessing care include transportation; availability of nearby services; concerns over confidentiality, judgment, disrespect; and cost. • **Sexual & Reproductive Health.** Access to comprehensive sexual health education and linkage to sexual and reproductive health services are essential. There is also an urgent need for linkage to youth-friendly supports and services for adolescents experiencing IPV	• Enhance strengths, skills, and supports to promote positive development and ensure youth are healthy and thrive.	• Improve sexual and reproductive health and well-being for all adolescents in California. • Improve awareness of and access to youth-friendly services for all adolescents in California. • Improve social, emotional, and mental health and build resilience among all adolescents in California.	• NPM 10: Percent of adolescents ages 12 – 17 with a preventive medical visit in the past year.

Key Findings	Priority Needs	Focus Areas	Performance Measures
and other forms of sexual violence. • **Physical Activity & Nutrition.** Local MCAH programs should partner with communities to promote physical activity and healthy eating among California youth.			
Domain: CYSHCN			
• **Families are Partners in Care.** Generally, California health care providers excel at engaging families as partners in care for CYSHCN who are enrolled in CCS, though improvements are needed for families not enrolled in CCS. • **Continuous Screening.** California's childhood screening rates lag behind those of other states due to geographical challenges, inadequate reimbursement rates, language differences and other family needs, and information asymmetries on developmental milestones. • **Community-Based Services.** There is a need for better coordination of services and communication within and between systems (e.g., health care, social services, education, public health) that serve families of CYSHCN. • **Adequate Insurance.** There are challenges in helping CYSHCN in California maintain Medi-Cal and CCS coverage due to churn. • **Transition to Adult Care.** It is difficult for CYSHCN ages 12 – 17 to receive services necessary to transition	• Make systems of care easier to navigate for CYSHCN and their families. • Increase engagement and build resilience among CYSHCN and their families.	• Build capacity at the state and local levels to improve systems that serve CYSHCN and their families. • Increase access to coordinated primary and specialty care for CYSHCN. • Empower and support CYSHCN, families, and family-serving organizations to participate in health program planning and implementation.	• NPM 12: Percent of adolescents with and without special health care needs ages 12 – 17 who received services necessary to make transitions to adult health care.

Key Findings	Priority Needs	Focus Areas	Performance Measures
smoothly from pediatric to adult care. • **Medical Home.** With additional support for case management and care coordination, increased availability of specialty providers, and improved reimbursement rates, provider practices in California can become medical homes for CYSHCN and improve health outcomes for this population.			