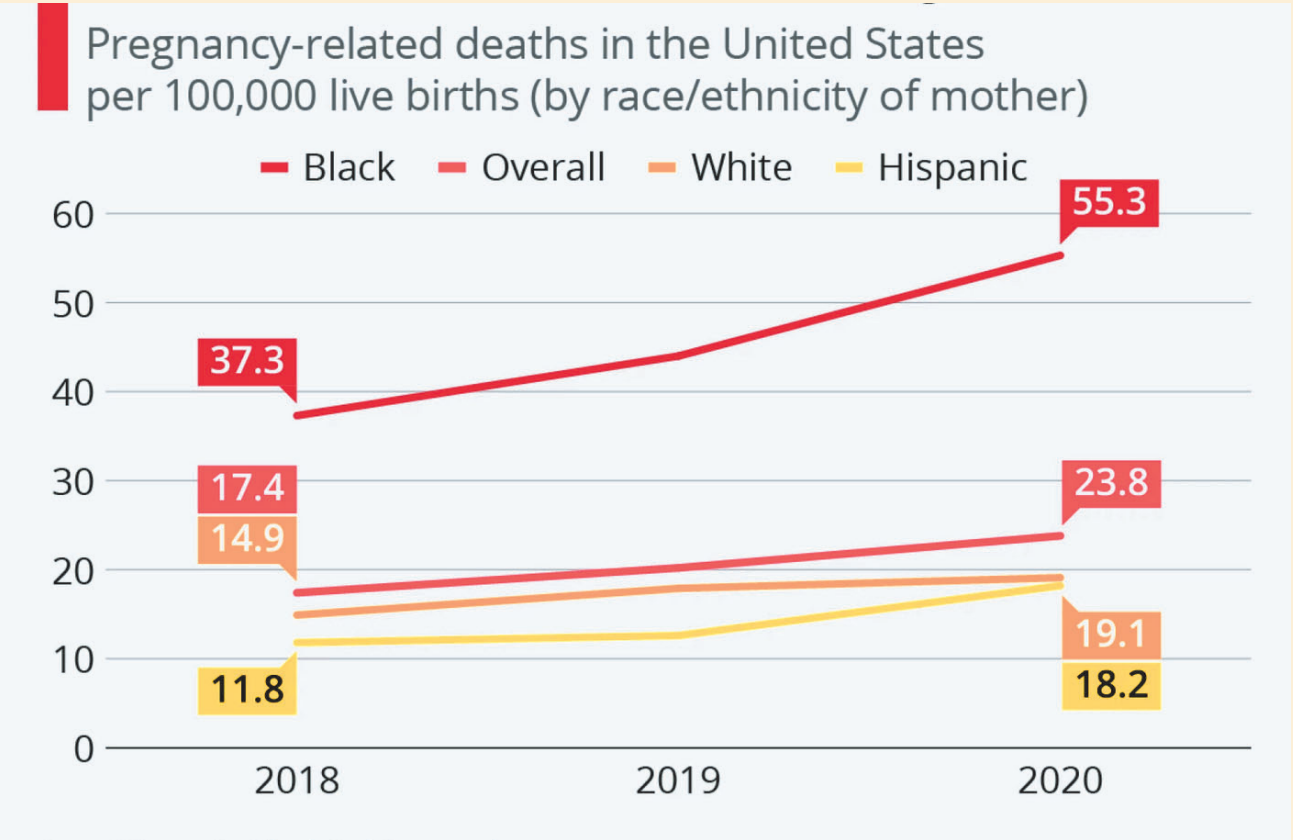
Bridging the Maternal Gap in the Bayou

Team 49

The Uneven Burden of U.S. Maternal Mortality

Figure A: Black women make up 37% of births but 62% of maternal deaths.[1]



[1] Ferrell, J., & Westwood, R. (2024, April 12). New Report Reveals Racial Component of Louisiana's Maternal Mortality Crisis. Red River Radio. https://www.redriverradio.org/news/2024-04-12/new-report-reveals-racial-component-of-louisianas-maternal-mortality-crisis

Welcome to Rural Louisiana's Bayou

Although beautiful, it faces a deadly challenge: quality maternal healthcare.

- Black mothers in LA are 3-4x more likely to die.[1]
- While Black women account for 37% of births…They represent 62% of pregnancy-related deaths.[2]
- Leading causes: cardiovascular conditions, hemorrhage, hypertensive disorders.[3]
- 26.6% of parishes are maternity care deserts.[4]

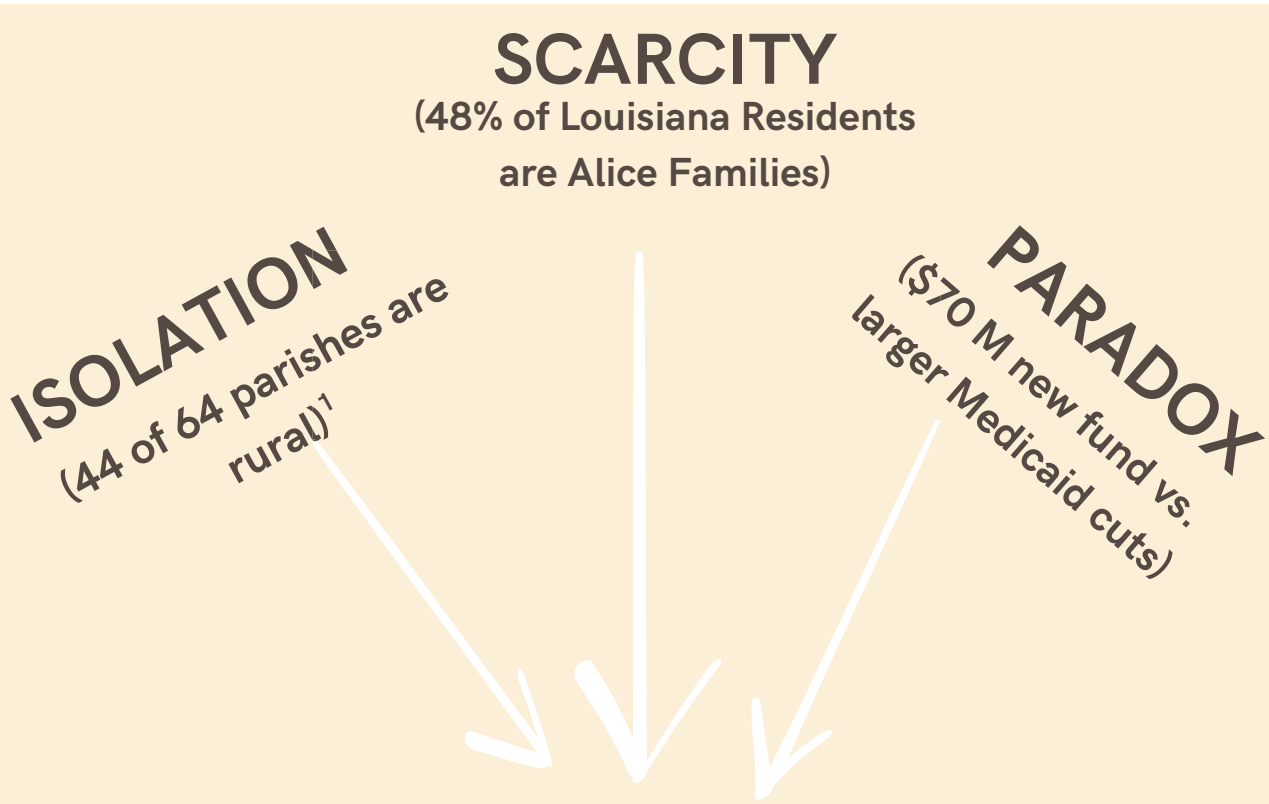
[1]LOUISIANA PREGNANCY- ASSOCIATED MORTALITY REVIEW REPORT. 2017.

[2]Ferrell, Jeff, and Rosemary Westwood. "New Report Reveals Racial Component of Louisiana's Maternal Mortality Crisis." Red River Radio, 12 Apr. 2024, www.redriverradio.org/news/2024-04-12/new-report-reveals-racial-component-of-louisianas-maternal-mortality-crisis. Accessed 24 Oct. 2025.

[3]Outhuse, Andrea, et al. 2024.

[4]"Where You Live Matters: Maternity Care Access in Louisiana." March of Dimes | PeriStats, www.marchofdimes.org/peristats/reports/louisiana/maternity-care-deserts.

Louisiana's rural health system faces a dual challenge:
it is structurally fragile and on the verge of a significant financial shock.



The Challenge

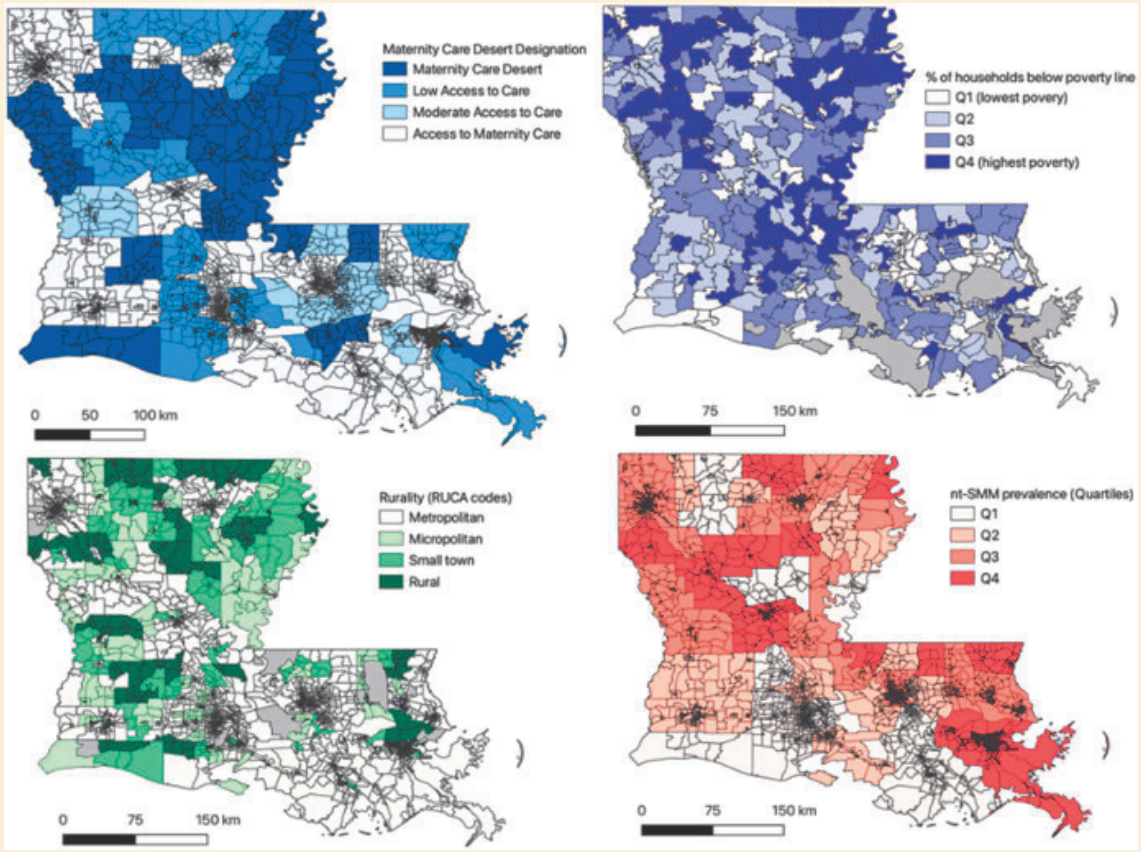
In short, we must use this temporary $70 million to build a new, sustainable system, while simultaneously plugging a leak in the old one.

[1]"Rural Health Transformation Program | Louisiana Department of Health." La.gov, 2025, ldh.la.gov/page/rural-health-transformation-program.

[2] Health Professional Shortage Areas. (n.d.). Well-Ahead Louisiana. https://wellaheadla.com/healthcare-access/health-professional-shortage-areas/

Maternal Health Deserts by Parish

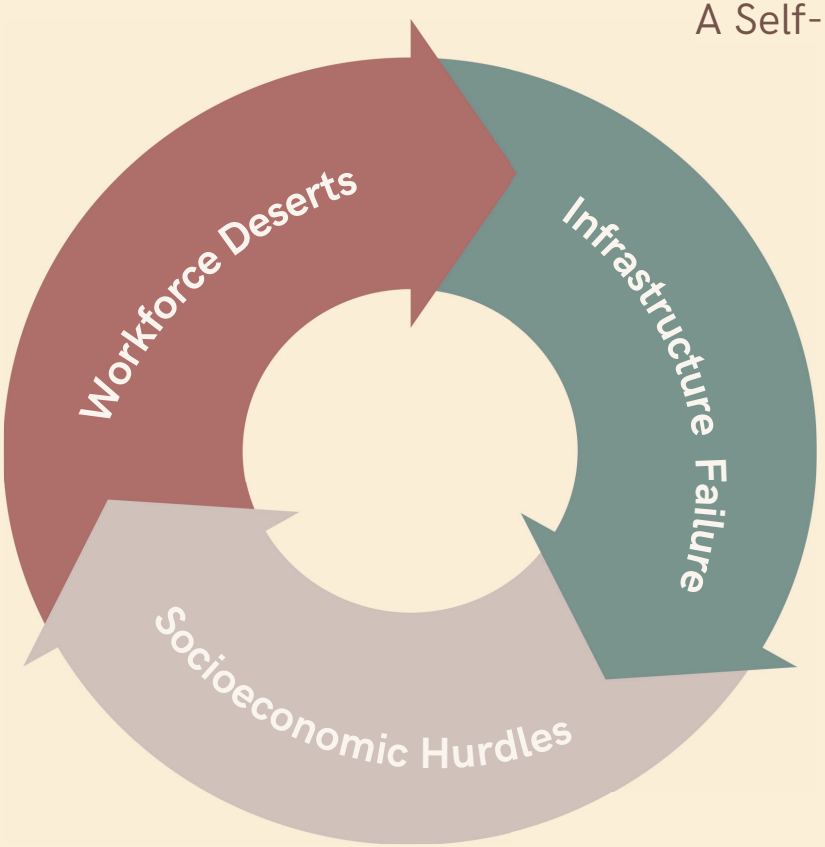
Figure B: 44 of 64 parishes in Louisiana are maternal health deserts [1]



[1]Distribution of maternity care desert designation by county, rurality and poverty by ZIP code, and non-transfusion SMM prevalence by county in Louisiana, 2016–2021. Public Health. https://doi.org/10.1016/j.puhe.2025.105824

Louisiana's Rural Health System

A Self-Perpetuating Cycle of Collapse



1 **Workforce Deserts**

Provider shortages → clinic closures → longer travel times

2 **Infrastructure Failure**

Creates maternity care deserts and force patients to travel unsustainable distances.

3 **Socioeconomic Hurdles**

Poverty and limited transportation keep patients from accessing even the few services that remain.

These issues create a vicious cycle: provider shortages lead to clinic closures, which increase travel burdens, which further discourage providers from working in these areas.

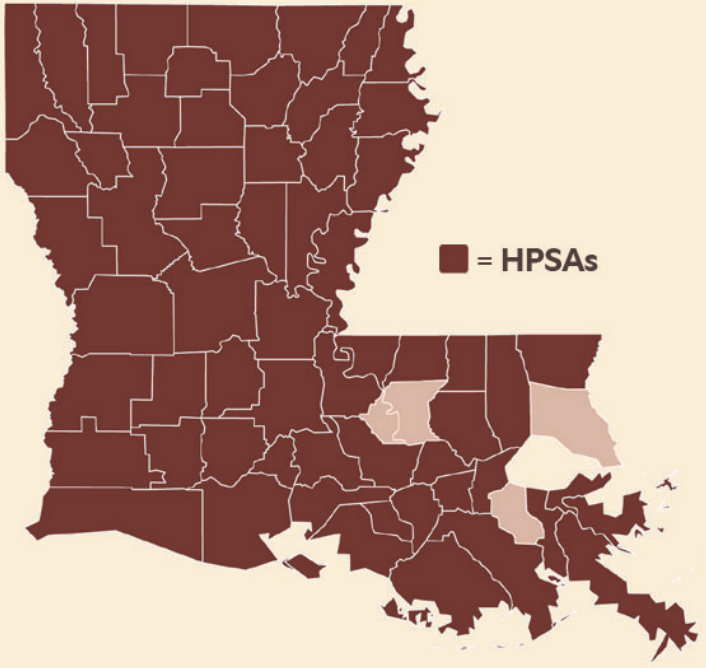
Criteria for Solutions

Effectiveness: Does it directly improve health outcomes?	Directly improves health outcomes. (e.g ↓ Mortality Rates)
Equity: Does it prioritize the most vulnerable?	Prioritizes the most vulnerable. (Closes Black-White Mortality Gap)
Feasibility: Can it be implemented within 5 years with existing systems?	Fast implementation with existing systems. (No new major legislation)
Cost-Efficiency: Does it maximize value and create Medicaid savings?	Maximizes value and creates Medicaid savings. (Demonstrable ROI)
Sustainability: Will it survive beyond the 5-year grant?	Survives beyond initial funding. (Self-sustaining model by Year 6)

WHY RURAL HEALTH MATTERS

ACCESS COLLAPSING

1. Nearly 1 in 3 residents live in Louisiana's rural parishes.[1]
2. 32.8% of Louisiana physicians are nearing retirement age; nearly half of new primary care residents leave the state.[2]



[1]Bruhl, A. (2025, September 15). Louisiana health department seeks feedback to improve rural health care. Louisiana First News. https://www.louisianafirstnews.com/news/louisiana-news/louisiana-rural-health-feedback/

[2]"Louisiana Physician Shortage Facts." Cicero Institute, ciceroinstitute.org/research/louisiana-physician-shortage-facts/.

Why Rural Health Matters

3. Workforce Vacuum:
   - Rural areas have a primary care physician ratio of <1 per 3,500 people, far below the national average.[1]
4. Systemic Strain:
   - 26 hospitals are at risk of closing [2]
   - Longer ER wait times and farther travel distances for emergencies are the direct result.

In Louisiana, your **zip code** too often **<u>determines</u>** your **health outcome**.

[1] Designated Health Professional Shortage Areas Statistics. (2025).

[2] Gamble, M. (2025, June 30). 759 hospitals at risk of closure, state by state. Becker's Hospital Review | Healthcare News & Analysis; Becker's Hospital Review | Healthcare News & Analysis. https://www.beckershospitalreview.com/finance/760-hospitals-at-risk-of-closure-state-by-state/

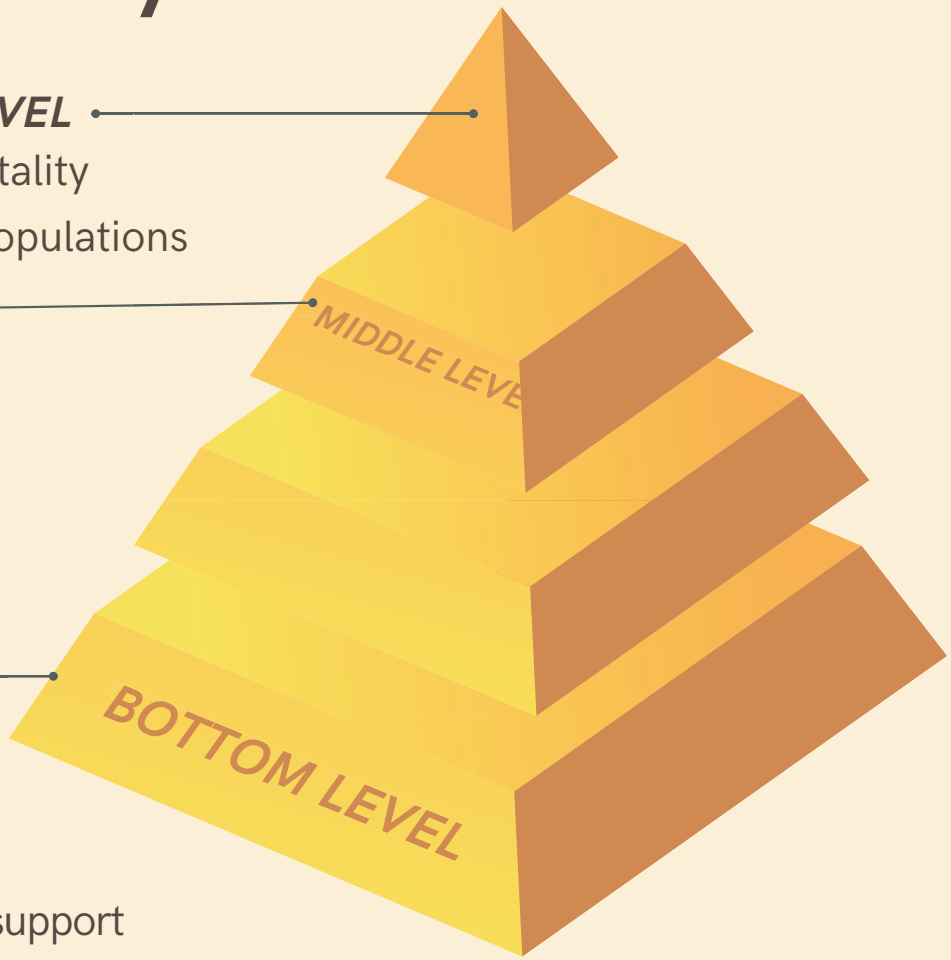
Chosen Track: Care Delivery Innovation

TOP LEVEL

- Focus on reducing maternal and infant mortality
- Deliver care directly to underserved rural populations

- Access & Delivery Innovations
  - Telehealth prenatal consultations
  - Mobile maternity clinics

- Training community health workers for rural outreach
- Mobile units for prenatal and maternal checkups
- Telehealth connections for remote consultations
- Policy funding for doulas and community-based birth support
- Behavioral education campaigns for teens and young adults



Chosen Track

While infrastructure and workforce are critical, they are long-term and costly. **Care Delivery Innovation** is the most urgent and catalytic lever because it:

1. **Solves for Geography Now**: Mobile units and telehealth bridge maternity care deserts today.
2. **Maximizes a Scarce Workforce**: Technology and community health workers extend provider reach.
3. **Creates the Blueprint for the Future:** Pilots build infrastructure, attract talent, and prove sustainability.

Investing in how we deliver care is the **fastest** way to save lives and the necessary first step to guide all future investments in workforce and infrastructure.

Solution Overview

We are creating a targeted, mobile-first system to end maternal care deserts and save lives.

Louisiana Maternal Health Corps: The LMHC is a state-coordinated initiative that deploys integrated teams to bring comprehensive care directly to the highest-risk parishes

LOUISIANA
MATERNAL
HEALTH CORPS

SOLUTION OVERVIEW

The Mobile Fleet: Maternity Pods on the Move

The Community Workforce: Perinatal

The Tech Bridge: Virtual Specialty Hub

COMPONENT 1: THE MOBILE FLEET

MATERNITY PODS ON THE MOVE

1. NEED:
   - Problem: Geographic isolation is a primary driver of poor outcomes.
   - Stats:
     - 25% of LA parishes are maternity care deserts, forcing dangerous long-distance travel for basic care. [2]
     - 12.1% of rural Louisianans travel >30 minutes to a birthing facility. [1]

[1] Gleason, N., Ackerman, S., & Shipman, S. A. (2018). eConsult—Transforming Primary Care or Exacerbating Clinician Burnout? JAMA Internal Medicine, 178(6), 790. https://doi.org/10.1001/jamainternmed.2018.0762

[2] March of Dimes."Maternity Care Deserts Report." March of Dimes, 2024, www.marchofdimes.org/maternity-care-deserts-report.

Component 1: The Mobile Fleet

MATERNITY PODS ON THE MOVE

2. OUR PLAN:

- Deploy 5 state-of-the-art mobile "Maternity Pods" on a scheduled circuit through the 10 highest-need rural parishes.
- Services Onboard: Prenatal exams, ultrasounds, lab work, dental varnish, and behavioral health screenings.
- Each pod is staffed by a NP/PA, medical assistant, and doula.

Component 1: The Mobile Fleet

Maternity Pods on the Move

Mobile health clinics have been shown to reduce low-birth-weight rates by 30% and generate $30 of savings for every $1 invested.[1]

[1]Henny, Chris, et al. "The Business Case for Telemedicine." International Maritime Health, vol. 64, no. 3, 2013, pp. 129–135, pubmed.ncbi.nlm.nih.gov/24072539/.

Component 1: The Mobile Fleet

Maternity Pods on the Move

4. BENEFITS:

- Immediate Access: Brings vital care directly into communities, eliminating the transportation barrier.
- Prevention-Focused: Identifies high-risk pregnancies early for management.
- Cost-Avoidance: Prevents costly emergency transports and NICU stays.[1]

[1]Malone, Nelson C., et al. "Mobile Health Clinics in the United States." International Journal for Equity in Health, vol. 19, no. 1, 20 Mar. 2020, pp. 1–9, equityhealthj.biomedcentral.com/articles/10.1186/s12939-020-1135-7, https://doi.org/10.1186/s12939-020-1135-7.

Component 2: The Community Workforce

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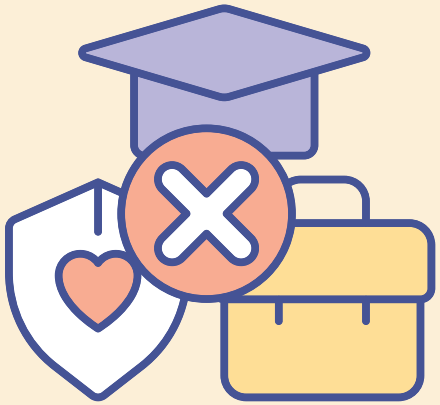
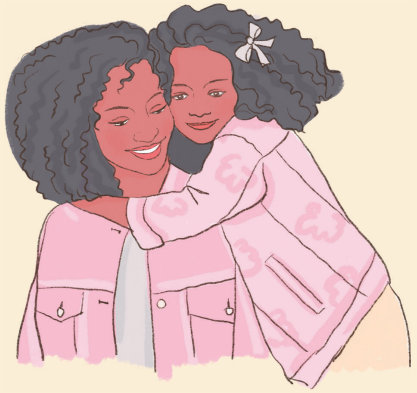




1. NEED:
   - Problem: Clinical care alone is insufficient. Patients face complex social, economic, and informational barriers. There is a deep trust deficit in the healthcare system.
   - "Black mothers account for 62% of pregnancy-related deaths despite being 37% of births."[1]

[1]LOUISIANA PREGNANCY- ASSOCIATED MORTALITY REVIEW REPORT. 2017.

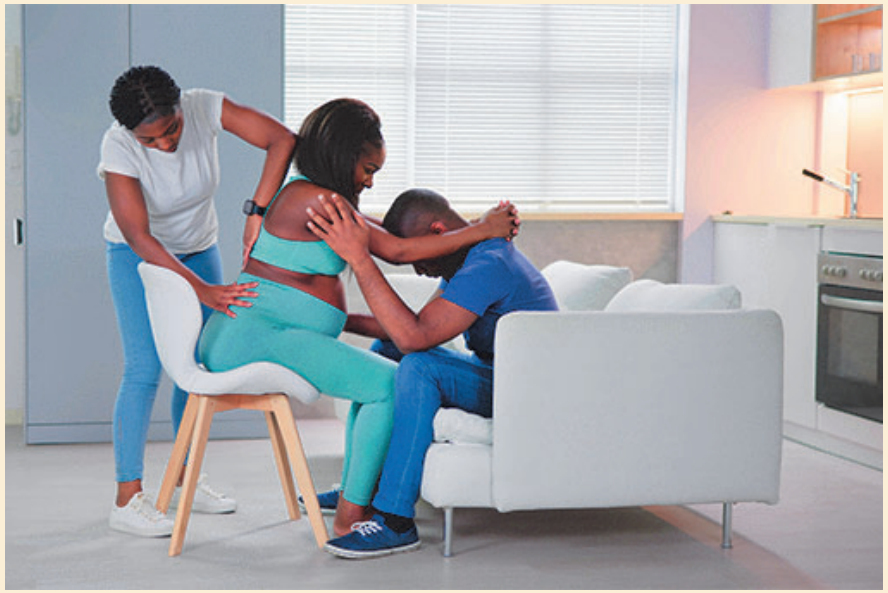
Component 2: The Community Workforce

2. OUR PLAN:
   - Recruit and train 50 local women from rural communities as Perinatal Navigators (CHWs/Doulas).
   - Provide 1:1 support: education, appointment coordination, transportation help, and advocacy.

Grant-funded Navigators → Medicaid-reimbursed & FQHC-based roles by Year 5

Component 2: The Community Workforce

3. EVIDENCE:
   - "Community-based doula support can reduce C-section rates by 40% and improve breastfeeding initiation by 90%."[1]
4. BENEFITS:
   - Builds Trust: Leverages local knowledge and shared experience.
   - Improves Outcomes: Directly linked to better birth outcomes and patient satisfaction.
   - Economic Development: Creates a new, sustainable career pathway within communities.



[1]Gruber, Kenneth J., et al. "Impact of Doulas on Healthy Birth Outcomes." The Journal of Perinatal Education, vol. 22, no. 1, 2013, pp. 49-58, www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/, https://doi.org/10.1891/1058-1243.22.1.49.

Component 3 - The Tech Bridge: "Virtual Specialty Hub"

1. NEED:
    - Problem: A lack of local specialist consultation (e.g., OB/GYN, endocrinologists for gestational diabetes) leads to delayed care and poor management of complications.[1]

[1]CDC. "Diabetes Self-Management in Rural America as a Public Health Issue." Rural Health, 8 July 2024, www.cdc.gov/rural-health/php/public-health-strategy/public-health-considerations-for-diabetes-self-management-education-and-support-in-rural-america.html.

Component 3 - The Tech Bridge: "Virtual Specialty Hub"

2. OUR PLAN:
   - Telehealth terminals in every Maternity Pod and partnering FQHC.
   - Central "Virtual Hub" (e.g., Tulane/LSU) for specialist consults.
   - Remote blood pressure monitors for high-risk pregnancies.

Impact: Seamless care coordination & efficient specialist use

Component 3 - The Tech Bridge: "Virtual Specialty Hub"

3. EVIDENCE:
   - "Telehealth programs for high-risk obstetrics have been shown to double attendance at postpartum visits and significantly improve blood pressure control." [1]
4. BENEFITS:
   - Expert Access: Puts world-class specialist knowledge in every rural parish.
   - Continuity of Care: Ensures seamless coordination between the mobile team and specialists.
   - Efficiency: Maximizes the impact of scarce specialist time.

[1] Zhang, Ran, et al. "Improving Maternal Postpartum Access to Care through Telemedicine (IMPACT): A Multi-Center Randomized Controlled Trial of Postpartum Interventions to Improve Access and Outcomes." Contemporary Clinical Trials, Mar. 2025, p. 107882, https://doi.org/10.1016/j.cct.2025.107882. Accessed 26 Mar. 2025.

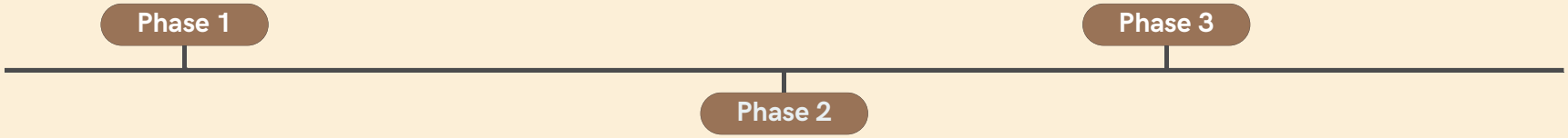
Timeline

Phase 1: Foundation & Pilot (Months 1-12)

- **Key Activities:**
  - Build partnerships and governance
  - Launch 2 mobile maternity pods
  - Establish virtual specialty hub
  - Train first cohort of navigators

Phase 3: Sustainability & Transition (Year 5)

- **Key Activities:**
  - Transition to Medicaid billing
  - Secure state adoption
  - Develop replication playbook



Full-Scale Rollout (Years 2-4)

- **Key Activities:**
  - Phase 2: Full-Scale Rollout (Years 2–4)
  - Expand fleet and workforce
  - Integrate telehealth across 10 parishes
  - Evaluate outcomes and cost savings

Responsible Parties:

Responsible Party	Key Responsibilities
Louisiana Department of Health	Lead Agency & Funder. Oversees the entire program, distributes the Transformation Fund grant, and leads policy development.
Medicaid	Financing Partner. Works with LDH to develop and approve new billing codes for Perinatal Navigator services and pod-based telehealth to ensure sustainability.
Partnering Health Systems (Tulane, LSU, Ochsner)	Clinical & Telehealth Hub. Provides the specialist physicians for the Virtual Hub, helps develop clinical protocols, and donates/leases equipment.
Federally Qualified Health Centers (FQHCs)	Community Anchors. Host pod visits in their parking lots, provide shared electronic health record access, and refer patients to the program.
Local Parish Governments and Community Organizations	Community Liaisons. Help recruit local women as Perinatal Navigators, promote the program, and identify safe locations for pod stops.

The Cost-Benefit Argument

Mobile clinics generate $30 of savings for every $1 invested [1].

Our model applies this proven ROI to maternal health.

[1] Tulane University. (2021, June 16). How Do Mobile Health Clinics Improve Access to Health Care? Publichealth.tulane.edu. https://publichealth.tulane.edu/blog/mobile-health-clinics/

The Budget: Investment & Impact

Category	Investment	Impact / Value Proposition
Mobile Fleet and Operations	**$32.85M**	Brings **10,000+ prenatal visits** directly to mothers in maternity care deserts.[1]
Perinatal Navigator Workforce	**$25.55M**	Provides **1:1 maternal support** and creates **50 local jobs** in high-poverty parishes.[2]
Telehealth Technology & Support	**$10.95M**	Enables **5,000+ specialist consults** without requiring travel.[3]

[1]"Rural Health Transformation Program | Louisiana Department of Health." La.gov, 2025, ldh.la.gov/page/rural-health-transformation-program.

[2]"Rural Health Transformation (RHT) Program | CMS." Cms.gov, 2025, www.cms.gov/priorities/rural-health-transformation-rht-program/overview.

[3]"What to Know about a Chance at $50 Billion in Rural Health Funding." American Medical Association, 15 Oct. 2025, www.ama-assn.org/public-health/population-health/what-know-about-chance-50-billion-rural-health-funding.

The Budget: Investment & Impact

Category	Investment	Impact / Value Proposition
Program Administration & Evaluation	**$3.65M**	Ensures transparency, accountability, and scalability
Total Cost	**$69.35M**	Delivers care to 10,000+ mothers, creates 50 rural jobs, and saves lives + Medicaid dollars
Total Projected Savings (5 Years)	**$70-$85M**	A self-sustaining maternal health system that pays for itself by Year 4 and saves lives for decades

ROI Predictions

Projected Return on Investment: >$3 Saved for Every $1 Invested

Driver of Savings	Evidence Base	Estimated Impact (5 Years)
Reduced NICU Stays & Complications	Each preterm/NICU birth costs ≈ $72 K [4]. Mobile prenatal care can cut preterm births by 15-30%. [1]	≈ $35 M saved from fewer NICU days and high-risk deliveries.
Fewer Emergency Transports & Readmissions	Mobile health clinics save $36 for every $1 spent. [2]	≈ $20 M saved through prevented ER visits and transport costs.
Improved Chronic Condition Management	The use of telehealth saves $147 and $186 per visit for patients. [3]	≈ $6 M saved from lower readmissions and emergency follow-ups.

[1] Cristian Meghea, Raffo, J. E., X, Y., Wang, M., Luo, Z., Peggy Vander Meulen, Lloyd, C., & Lee Anne Roman. (2023). Community Health Worker Home Visiting, Birth Outcomes, Maternal Care, and Disparities Among Birthing Individuals With Medicaid Insurance. JAMA Pediatrics, 177(9), 939-939. https://doi.org/10.1001/jamapediatrics.2023.2310

[2] Oriol, N. E., Cote, P. J., Vavasis, A. P., Bennet, J., Delorenzo, D., Blanc, P., & Kohane, I. (2009). Calculating the return on investment of mobile healthcare. BMC medicine, 7, 27. https://doi.org/10.1186/1741-7015-7-27

[3] Patel, K. B., Turner, K., Alishahi Tabriz, A., Gonzalez, B. D., Oswald, L. B., Nguyen, O. T., Hong, Y.-R., Jim, H. S. L., Nichols, A. C., Wang, X., Robinson, E., Naso, C., & Spiess, P. E. (2023). Estimated indirect cost savings of using telehealth among nonelderly patients with cancer. JAMA Network Open, 6(1). https://doi.org/10.1001/jamanetworkopen.2022.50211

[4] Valencia, Z., Sen, A., & Martin, K. (2023, July 25). NICU admissions and spending increased slightly from 2017-2021. Health Care Cost Institute. https://healthcostinstitute.org/hcci-originals-dropdown/all-hcci-reports/nicu-use-and-spending-1

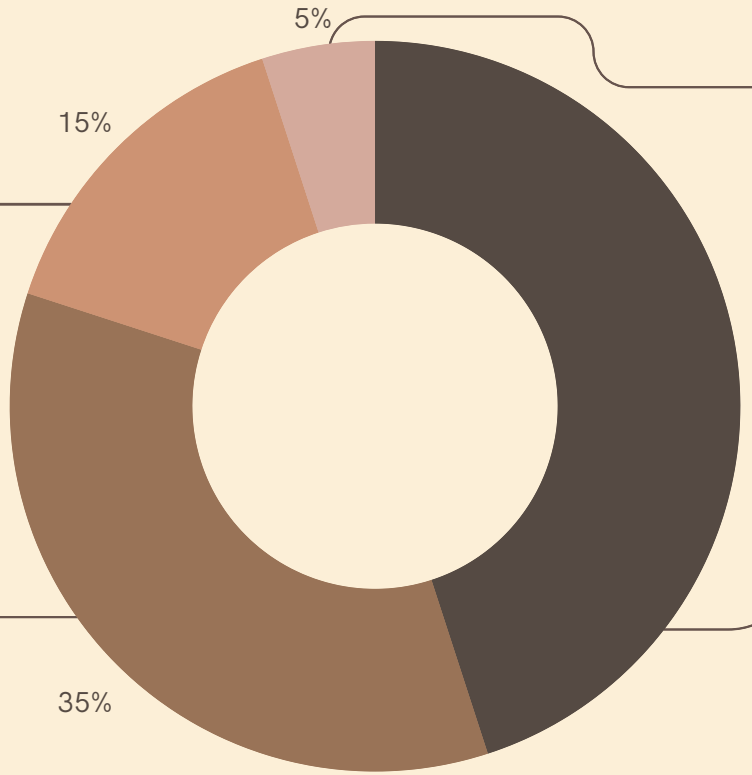
ROI Predictions

Driver of Savings	Evidence Base	Estimated Impact (5 Years)
Medicaid Billing & Reimbursements (Year 5 and on)	Medicaid reimbursement for telehealth is same as in-person services.[1] $7.94K benefit spending per Medicaid enrollee in Louisiana.[2]	≈ $10 M recaptured annually after transition.

[1] Louisiana Medicaid Program Chapter 5: Professional Services. (2020, July). https://www.lamedicaid.com/provweb1/Providermanuals/manuals/PS/PS_5.1_TeleMed_07-10-20.pdf

[2] Section 3: Program Enrollment and Spending-Medicaid Benefits MACStats Section 6 Section 3 Section 5 Section 2 Section 4 Section 1 MACStats Section 3 EXHIBIT 23. Medicaid Benefit Spending per Full-Year Equivalent Enrollee for Newly Eligible Adult and All Enrollees by State, FY 2023 State 1 All Medicaid enrollees Newly eligible adults 2 FYE enrollees Medicaid benefit spending Spending per FYE enrollee FYE enrollees Medicaid benefit spending Spending per FYE enrollee. (2024). https://www.macpac.gov/wp-content/uploads/2024/12/EXHIBIT-23.-Medicaid-Benefit-Spending-per-Full-Year-Equivalent-Enrollee-for-Newly-Eligible-Adult-and-All-Enrollees-by-State-FY-2023.pdf

The "Big Picture" Allocation



Program Administration and Evaluation ($3.65M)

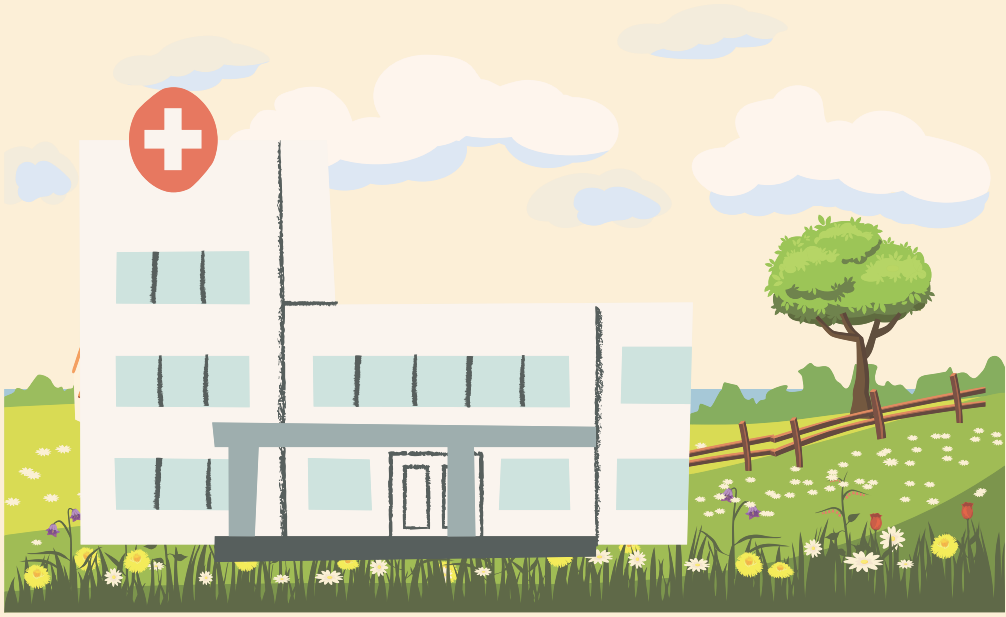
Telehealth Technology and Support ($10.95M)

Mobile Fleet and Operations ($32.5M)

Perinatal Navigator Workforce ($25.5M)

4. Connection to the Funding Source

- This plan directly utilizes the $70M Rural Health Transformation Fund to build a new, sustainable care model while preventing the net decline in rural services from impending Medicaid cuts.



Evaluation Metrics

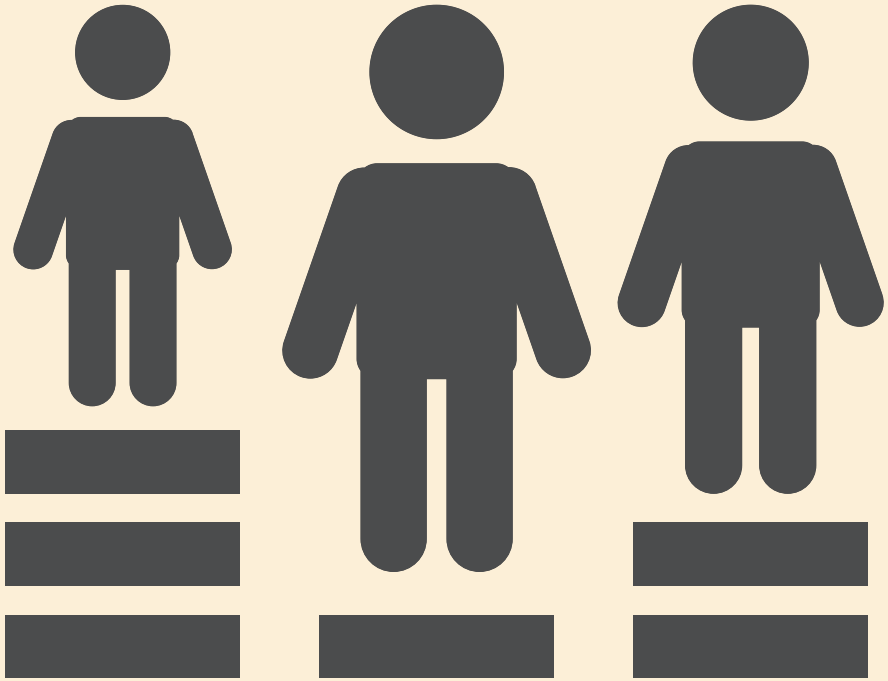
What does success looks like?

1. Effectiveness & Impact

- Primary Outcome (The Gold Standard):
  - ↓ Severe Maternal Morbidity (SMM) (a measurable proxy for mortality).

- Secondary Outcomes (Direct Drivers):
  - ↑ Adequate prenatal care (Kotelchuck Index)
  - ↑ Postpartum visit attendance (7–14 days)
  - ↓ Low-birth-weight rates
  - ↑ Early management of high-risk conditions

2. Equity



We will look at data for the following:

- Reduction in the Black-white disparity ratio for SMM.
- Percentage of program participants who are Black mothers.
- Comparison of outcomes (SMM, prenatal care) between participants and non-participants in the same parishes.

3. Feasibility & Output

To evaluate the feasibility, we will look at the following data:

- # of mothers enrolled in the LMHC program.
- # of clinical visits conducted on Mobile Pods.
- # of Perinatal Navigator patient encounters.
- # of telehealth specialist consultations completed.
- # of remote blood pressure monitors distributed and used.

4. Patient Experience & Quality

This measures the human side and quality of care.

- Patient Satisfaction Scores (e.g., % who agree "I felt heard and respected by my care team").[1]
- Perinatal Navigator trust score (e.g., % of patients who rate their navigator as "highly trustworthy").[2]
- Reported self-efficacy in managing their health and recognizing warning signs.[3]

[1]Notice of Funding Opportunity Rural Health Transformation Program.

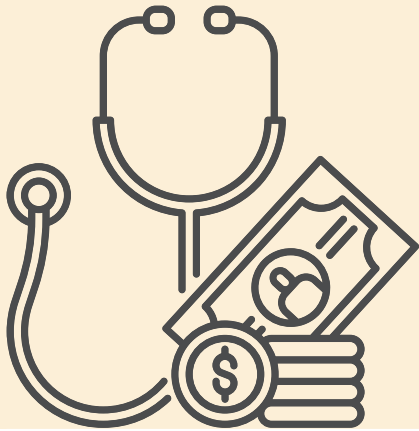
[2]"Rural Health Transformation (RHT) Program | CMS." Cms.gov, 2025, www.cms.gov/priorities/rural-health-transformation-rht-program/overview.

[3]"Rural Health Transformation Program | Louisiana Department of Health." La.gov, 2025, ldh.la.gov/page/rural-health-transformation-program.

5. Cost-Efficiency & Sustainability

These prove the financial argument for long-term funding.

- Cost per mother served.
- Medicaid billing from Navigator & telehealth services.
- ROI Calculation: Track rates of costly outcomes avoided and compare to program costs.
- Data-Driven Management: Real-time dashboard for continuous improvement and accountability

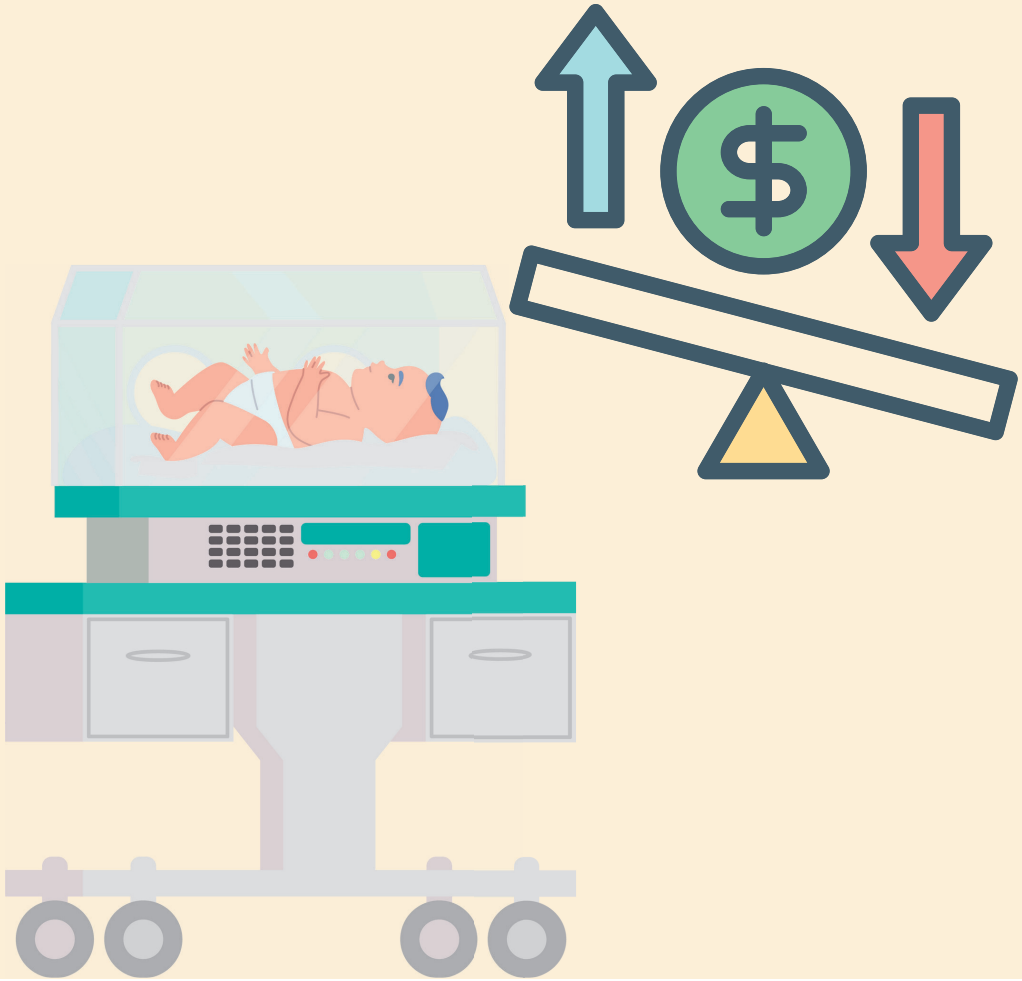


Trade-Offs & Rebuttals

Proposed Trade-Offs and Rebuttals

1. Trade-Off: High Upfront Costs

- **Trade-Off:** Requires significant upfront investment.
- **Rebuttal:**
  - A strategic investment with >$3 ROI per $1
  - Savings from fewer NICU stays, emergency transports, and complications far exceed initial costs.



Proposed Trade-Offs and Rebuttals

2. Trade-Off: Scalability and Geographic Reach

- **Trade-Off:** 5 pods can't reach every community daily.
- **Rebuttal:** Designed for strategic impact, not blanket coverage; we start with the 10 highest-need parishes, refine through rollout, and extend reach statewide through the Telehealth Bridge.

Proposed Trade-Offs and Rebuttals

3. Trade-Off: Sustainability Beyond the Grant

- Trade-Off: 5-year grant limits long-term funding.
- Rebuttal: Sustainability is built in from Day 1 with Medicaid billing codes and a state sustainability fund ensuring the Corps endures beyond Year 5.

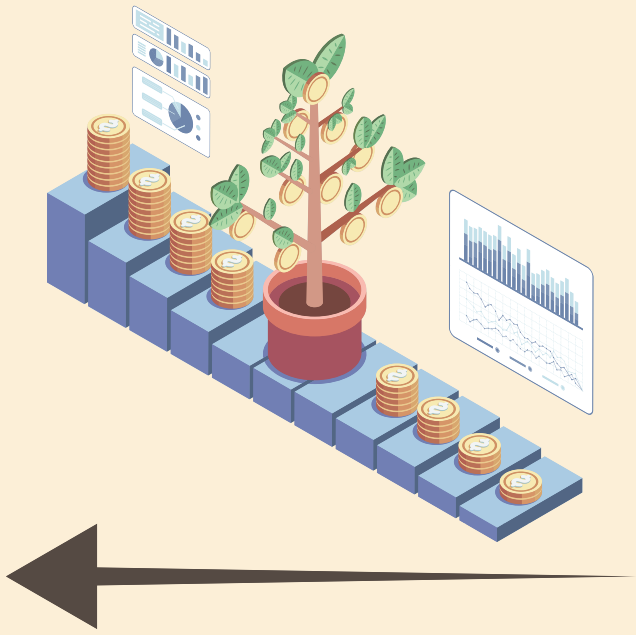
Addressing Equity Concerns Proactively

4. Trade-Off: Ensuring Inclusion for the Most Marginalized

- Trade-Off: The most isolated or distrustful populations (rural Black and Indigenous communities) may not be reached.
- Rebuttal:
  - Hiring Local: Perinatal Navigators from the communities they serve.
  - Strategic Partnerships: Black-led churches, community centers, Indigenous advocates.
  - Explicit Targeting: Metrics for Black & Indigenous mothers' participation and outcomes.

Foresight and Fairness: Addressing Key Challenges

- Trade-Off 2: Access Gaps
  - Rebuttal: Community-led model; local hires build trust and access



- Trade-Off 1: Significant Initial Investment
  - Rebuttal: Strategic investment with >3:1 ROI; The cost of inaction is far greater.[1]

- Trade-Off 3: Long-Term Financial Sustainability
  - Rebuttal: Sustainability fund built by Year 3 secure long-term viability.

[1]Henny, Chris, et al. "The Business Case for Telemedicine." International Maritime Health, vol. 64, no. 3, 2013, pp. 129-135, pubmed.ncbi.nlm.nih.gov/24072539/.

A Lifeline for Louisiana, A Model for the Nation

Analysis

- Healthier mothers and stronger babies
- $30 saved for every $1 invested
- A model for rural care nationwide

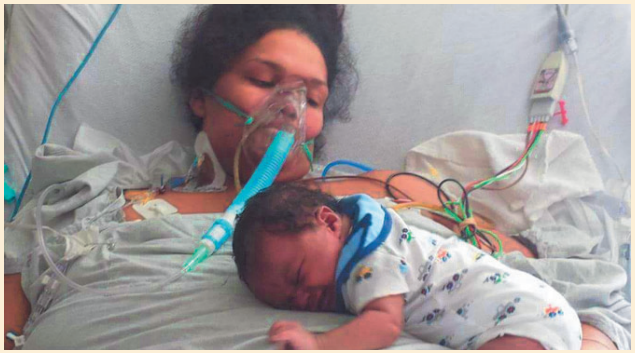
Problem

- Rural Louisiana = maternity deserts
- Black mothers face highest mortality
- Geography should never decide survival

Solution

- Mobile Pods bring prenatal care to rural mothers
- Perinatal Navigators guide families locally
- Virtual Hub links specialists statewide

The Crisis & Solution



- The Crisis:
  - Louisiana's rural mothers are dying from preventable causes, trapped by isolation and inequity.
- Our Solution:
  - The Louisiana Maternal Health Corps delivers quality, flexible care: mobile, community-powered, and tech-enabled.

Our Vision

LOUISIANA
MATERNAL
HEALTH CORPS

- Our Vision:
  - This is a sustainable investment in life, health, and equity. It’s a blueprint for turning today's crisis into tomorrow's national model.


A Lifeline for Louisiana’s Mothers

THANK YOU!