



Vermont Maternal Health Innovation Program Strategic Plan

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Overview of Maternal Health Workforce, Resources, and Access to Care



In Vermont, there are 10 rural community birthing hospitals and one tertiary medical center in the state's only urban county. One of the community hospitals closed its birth center, ending obstetrical services in November 2025, despite significant community pressure. There was an additional closing in 2019 of a rural community birth hospital as well. Due to low patient volume and the strain on rural hospitals, concerns about additional closures persist. In 2023, there were 5,063 babies born to Vermont residents. The crude birth rate in 2023 was 7.8 per 1,000 residents, a slight decrease from the 2022 rate. Approximately 12.8% of Vermont births are in neighboring New Hampshire. In 2025, the legislature passed new legislation expanding options for where Vermonters can give birth.

During the 2025-2026 legislative session, the General Assembly passed, and the Governor signed, [S.18](#), An Act Related to the Licensure of Free Standing Birth Centers. For the first time, these facilities will be allowed to operate in the state. It is not yet known how freestanding birth centers will impact hospital-owned birthing facilities, particularly in the nine remaining rural hospitals. The maternal health care system in Vermont has many strengths across the perinatal period, but there are differences geographically and demographically.

In 2022, 87.3% of pregnant women entered prenatal care during the first trimester ([2022 Vermont Maternal and Infant Health Annual Surveillance Report](#)), and 94% had a postpartum checkup 4-6 weeks after delivery ([PRAMS Phase 8 Report](#)). Despite these high rates, there are noteworthy variations based on educational attainment, private vs. public insurance, maternal age, and participation in WIC. For children born to women between the ages of 20-24, 77.8% had a postpartum visit (PPV), vs. 82.9% of women between the ages of 30-34. Those who have less than a high school education were less likely (67.4%) than those who graduated from college (81.2%) to have had a PPV. Other economic indicators, like the use of private (83.2%) vs. public (77.7%) insurance and participation in WIC (74.6% vs. non-participation 82.2%), also showed areas for improvement ([PRAMS Phase 8 Report](#)).

Vermont often exceeds the Healthy People 2030 target rate of 83.7% of very low birth weight infants being born in a hospital with a level III or higher NICU ([NCHS, 2024](#)). In 2023, 7.1% of Vermont resident births were low birth weight (less than 2,500 grams or 5 pounds, 8 ounces), and 0.9% were very low birth weight (less than 1,500 grams or 3 pounds, 5 ounces). The U.S. low birth weight rate for 2023 was 8.6% ([Vital Statistics Bulletin, 2023](#)).

Expansions to Vermont Medicaid over the last few years have bolstered services throughout the perinatal period. Vermont Medicaid covers pregnancy care up to 214% FPL and expanded Medicaid coverage for the full year postpartum starting in 2023. A new law signed in 2025 creates a roadmap for Medicaid coverage of doula services. The law also creates a certification program for all doulas through the Office of Professional Regulation and is tailored to address the needs of community-based doulas who serve lower-income and under-resourced populations. Vermont's HRSA grants, Maternal Mental Health and Substance Use Disorders

(MMHSUD) and Maternal Health Innovation (MHI), currently support doula services until Medicaid reimbursement is authorized, as well as training and readiness needs.

Despite these policy advancements, providers and community members during the strategic planning processes expressed deep concerns regarding policy uncertainty and pressures for defensive medicine stances. Including high liability and insurance pressures leading to defensive medicine, pressures on small providers, and overmedicalization, which are often not aligned with the needs of the family. Along with national policy shifts, which are creating more uncertainty.

Maternal Mental Health



Perinatal Mood and Anxiety Disorders (PMADs) are an ongoing concern. Mental health was the primary concern for participants of the 2025 Title V needs assessment who were pregnant or were parents of infants, exemplified by this quote: “...After I had my first child, I felt failed by our healthcare system as I struggled with postpartum anxiety and OCD for months before advocating for help for myself. If we had proper screening and better mental health preparedness for new moms, I am sure so many women would benefit...”

Infertility and/or the loss of a pregnancy were also noted as times when additional support from the healthcare system would be advantageous. Along the continuum of the perinatal period, 24% of people report feeling depressed before pregnancy, and only 18% receive care for their depression before becoming pregnant ([PRAMS, 2023](#)). During pregnancy, 23% of people report feeling depressed. And 13% of Vermonters report experiencing postpartum depression symptoms ([PRAMS, 2023](#)). While one in four Vermonters experiences a PMAD, fewer than half reported receiving treatment ([Platt, 2023](#)).

Since 2018, more than 90% of maternal mortality in Vermont has occurred among women with a diagnosis of a mental health disorder; most with multiple diagnoses. Additionally, since reviews began in 2012, 10% of deaths were identified as being caused by suicide ([MMRP Report, 2025](#)).

Building on Vermont’s previous PMADs efforts, HRSA’s Maternal Depression and Related Behavioral Disorders (MMHSUD) funded Perinatal Consultation, Access, Referral, Education, and Screening (CARES) promotes mental health and wellness for the perinatal population and their families and loved ones. This work also includes supporting the expansion of two community-based doula programs. The Vermont legislature recently signed bill S.53, which creates a voluntary certification process for community-based doulas and requires Vermont Medicaid to reimburse certified community-based doula services. FCH is working with the Office of Professional Regulation to prepare for the implementation of this bill.

In 2024, the Perinatal Psychiatric Consultation Service and the Child Psychiatry Access Program consultation services began serious discussions related to joint fiscal and

programmatic sustainability and discussed the potential alignment of both services. In 2025, the programs were joined and were renamed the Vermont Consultation and Psychiatry Access Program. Under the combined program, the perinatal service gained access to the liaison coordinators (LC), LICSW-trained clinicians who support practices in accessing resources and referrals for patients, including mental health clinicians with child and/or perinatal mental health expertise. With this added support, the program is increasing access for perinatal providers to community and national resources and services as they work with their patients.

Perinatal Substance Use



In the 2025 Title V Needs Assessment, providers identified several concerns regarding the nexus of pregnancy, substance use, and mental health. PRAMS data indicate one in 10 people smoke during pregnancy (2023). Vermonters who are under the age of 25, enrolled in Medicaid, or without a high school diploma are significantly more likely to smoke during pregnancy. Nurse home visitors, parent educators, and WIC staff regularly screen

pregnant women for tobacco use and refer them to the Quit Line resources and medical follow-up. Most (76%) of Vermonters who smoked during pregnancy received advice from a healthcare provider to quit, and 44% of people who smoked before pregnancy quit during pregnancy ([PRAMS, 2023](#)).

Alcohol is the number one substance used during pregnancy (12%) in Vermont. According to PRAMS, 70% of respondents report drinking in the months before becoming pregnant, and 18% report binge drinking (2023). Eighty-two percent of respondents are advised not to drink alcohol while pregnant. Vermonters who are 35 or older (16% vs. 3% under age 25), with private health insurance (14% vs. 9% of Medicaid users), or who have higher education (more than a high school education 14% vs. 9% those with a high school education) are significantly more likely to drink during pregnancy. Vermonters who are under 25 years old are significantly more likely to binge drink (22% vs. 11% among those who are 35 or older) ([PRAMS, 2023](#)).

Cannabis is the second most commonly used substance (10%) during pregnancy (PRAMS, 2024). Cannabis use before pregnancy has increased significantly from 13% in 2016, peaking at 22% in 2020, before slightly falling to 20% in 2022. Vermonters who are under the age of 25 (20% vs. 6% of those who are 35 or older), enrolled in Medicaid (22% vs. 3% with private insurance), or without a high school diploma (29% vs. 8% with more than a high school diploma) are significantly more likely to use cannabis during pregnancy ([PRAMS, 2023](#)).

Nearly half (45%) of maternal mortality in Vermont is caused by accidental overdose or endocarditis related to IV drug use. Additionally, substance use impacts decedents even when not a direct cause of death, with 59% of cases reviewed involving substance use and most of the accidental overdose deaths involving polysubstance use ([MMRP Report, 2025](#)).

FCH, its partner division, Substance Use Programs (DSU), the Perinatal Quality Collaborative (PQC-VT), and multiple community partners have been engaged in a two-year

technical assistance project on the intersection of perinatal substance use and child welfare, leading to important understanding and system changes. Additionally, the FCH division has utilized CDC/Overdose Data to Action funding to bring three community-based projects aimed at decreasing stigma for those struggling with perinatal substance use – a therapeutic storytelling training, peer recovery resources specifically for the perinatal period and embedded in clinical OB care, and a perinatal substance use educational series aimed at providers in the community setting. The PQC-VT is engaged in multiple quality improvement efforts in all of Vermont’s birthing facilities and with multiple community partners. The PQC-VT has two Alliance for Innovation in Maternal Health patient safety bundles in the maintenance phase and is currently implementing the substance use in pregnancy patient safety bundle. Additionally, the PQC-VT houses the Patient and Family Advisory Council (PFAC), a key project bringing patient voice to many maternal health projects across Vermont.

The Blueprint for Health is Vermont’s approach to patient-centered medical homes. The Blueprint provides technical assistance around healthcare quality (NCQA), as well as a financial mechanism to expand the healthcare team through a Community Health Team model. Based on a per-patient/per-month formula, additional staffing supports panel management and population health practices, care coordination, brief counseling, and referral to mental health and substance use specialists, condition-specific wellness, and more. The Blueprint also supports Vermont’s Hub & Spoke opioid use disorder treatment system. Through Blueprint’s Pregnancy Intention Initiative (FCH is on the advisory committee), specialty practices and Blueprint Patient Centered Medical Homes are providing enhanced health and psychosocial screening along with comprehensive family planning counseling.

Workforce



The makeup of the maternal health workforce and coordination between clinical providers and community-based supports were themes elevated during the strategic planning process. The workforce is largely homogeneous and does not fully reflect the families it serves. The families cannot all see themselves represented, and their cultural values are integral parts of day-to-day care, policy design, decision-making, and funding allocation. While not a unique challenge to the maternal healthcare system, the maternal health workforce is experiencing widespread burnout and staffing shortages, which are impacting access to and the quality of care provided. Both clinical and community-based service providers raised concerns and frustration over care silos, creating barriers for both providers and patients.

As of 2022, 64 (2%) of Vermont’s 3,112 physicians were OB/GYN providers, corresponding to 49.3 FTEs ([2022 Physician Census](#)). Additionally, two (<1%) of Vermont’s 402 Physician Assistants (PAs) were OB/GYN providers, corresponding to 1.5 FTEs ([2022 Physician Assistant Census](#)). Vermont echoes the national trend of physicians providing OB/GYN care

being concentrated primarily in urban centers ([Long et al. al, 2025](#)). Rural hospitals providing birth care in Vermont are especially vulnerable to turnover and vacancies. In some cases, even one obstetrical provider leaving a community hospital creates a crisis in care and limits access.

As of 2023, 88 (9%) of Vermont's 993 active Advanced Practice Registered Nurses (APRNs) worked in Primary Care Women's Health, corresponding to 62.7 FTEs ([2023 APRN Census](#)). Additionally, 413 (6%) of Vermont's 6,944 active Registered Nurses (RNs) primarily specialized in Women's Health, corresponding to 289.8 FTEs ([2023 RN Census](#)).

As of 2021, there were approximately 100 licensed Certified Nurse Midwives (CNMs) in Vermont, with 62 actively employed ([AHEC, 2021](#)). CNMs deliver at 10 Vermont hospitals and in one independent practice. In 2022, they delivered 27% of Vermont's infants, with most midwives practicing in rural counties ([Vital Statistics, 2022](#)).

Access to mental health and substance use supports varies across Vermont, with access in rural counties being more limited. Vermont has a mental health provider ratio of 180 residents per provider, compared to a U.S. ratio of 340:1 ([Mental Health Providers, 2025](#)). Windham County has the most providers with a ratio of 120:1, and Essex and Grand Isle counties have the lowest ratio, with a ratio of 1500:1 ([Psychologists Master's and Doctoral Census, 2024](#)). The number of psychologists in Vermont dropped from 378.1 in 2018 to 343.8 in 2024. Caledonia, Essex, Grand Isle, and Orleans counties have fewer than 20.0 FTE psychologists per 100,000 population. Perinatal-specific mental health supports remain even more limited, with capacity and training issues across the state.

According to the Licensed Alcohol and Drug Abuse Counselors (LADC) census, there are the equivalent of 222 full-time equivalents actively working in Vermont (FTEs per 100,000 population), with the highest rate, 54.6, in Lamoille County and the lowest, 0, in Essex County ([LADC Census, 2023](#)).

Access to Care



Nearly a third of pregnant Vermonters travel farther for obstetric care than what evidence-based guidelines recommend ([Fair, P., 1989](#)). In Vermont, the March of Dimes reports an average drive time of 22.1 minutes to the nearest birthing hospital, with 29.4% of women exceeding the 30-minute threshold under the current system of 11 birthing hospitals in the state ([March of Dimes, 2023](#)). Analyzing births only at rural community hospitals using the 2020-2024 Vermont Vital Statistics increases the average travel time to 37.4 minutes, with 33% of Vermonters exceeding the 30-minute guideline ([PQC-VT Data Brief on Understanding the Role of Local Maternity Care in Vermont, 2025](#)).

An evaluation of the Vermont healthcare system as part of Act 167 to address healthcare costs in Vermont has generated a proposal to reevaluate obstetric offerings in low-volume, rural hospitals. ([PQC-VT Data Brief on Understanding the Role of Local Maternity Care in Vermont, 2025](#)). If the recommendations to close birthing units in three rural community

hospitals are implemented, the average travel time to obstetric care could increase to 42.8 minutes, with 44.4% of birthing Vermonters exceeding the 30-minute threshold. One of the three hospitals recommended for closure is set to close its birth floor next month. Closure of birthing units will expand the range of maternity deserts, with the greatest impact seen in the Northeast Kingdom, the most rural region of the state. Additionally, these closures will impact low-income Vermonters disproportionately, with patients delivering at rural hospitals being more likely to have lower levels of education and higher rates of Medicaid coverage ([PQC-VT Data Brief on Understanding the Role of Local Maternity Care in Vermont, 2025](#)).

While not specific to those who are pregnant or birthing in Vermont, fewer than half of those diagnosed with a substance use disorder in Vermont begin treatment, and less than 20% continue treatment ([DSU Report](#), 2025). Barriers to accessing treatment and recovery resources in Vermont during the pregnancy and the postpartum periods are based on limited access in rural areas and a lack of specificity in care for this population. There are very few options for recovery residences in Vermont, especially those for women and even fewer for women who have children in their care. There are 16 certified recovery residences; seven serve women, and only three of these serve women with children. Additionally, one treatment center for pregnant or parenting women allows their young children to live with them while in treatment; this center is located in the state's only urban center. There are twelve peer recovery centers in Vermont, one in each Agency of Human Services region; however, only five have parenting-specific supports, and only one focuses some of its resources on the perinatal period and its specific needs.

Participants in our strategic planning process identified concerns that the quality of a birthing experience in Vermont now depends on many factors such as location, socioeconomic status, other community health factors (access to food, transportation, safety, financial stability, housing), and whether they feel safe accepting the services they are eligible for (for instance, fear of the child welfare system).

Participants shared that those with fewer resources may feel their voices aren't heard enough and therefore experience disempowerment, invalidation, or dismissal. People with economic means, people with existing knowledge of the health care system, and people who are English speakers or have a higher educational attainment may fare better because they can advocate for themselves, navigate the medical system better, have the time and capacity to independently research, and have access to more options.

During our strategic planning process, when participants shared about their experiences providing, coordinating, and receiving care in Vermont over the last several years, patterns and themes emerged.

These patterns and themes help us understand gaps in available care and barriers to accessing services and support, and how the system exacerbates rather than addresses existing variations in safety, support, and empowerment throughout pregnancy, birth, and postpartum experiences.

- **Gaps in behavioral health access (PMADs, SUD).** Vermont's maternal mortality is driven primarily by accidental drug overdose and, to a lesser extent, suicide ([MMRP Report](#), 2025). Our strategic planning process elevated several issues behind the

gaps in access to mental health and substance use services, including persistent stigma, the ability to understand needs at multiple junctures, lack of robust screening and referral options, a specialized workforce, capacity gaps, and siloed services and billing infrastructure preventing collaboration between providers.

- **Decreasing access to supports, services, and resources.** This includes awareness of what is available, affordability, physical accessibility to services in rural areas and for all, and availability of needed services. These are especially decreasing for those needing more extensive support.
- **Deep variations in access to care by race, income, location, and status.** Those experiencing poverty and rurality are disproportionately impacted by maternal mortality in Vermont. At the time of birth, 83% of decedents had Medicaid as primary insurance, 83% were utilizing the Women, Infants, and Children (WIC) program, and 90% of deaths occurred among residents of rural counties. Rural counties experience a maternal mortality rate three times higher than Vermont's metropolitan county ([MMRP Report](#), 2025). Participants in our strategic planning process felt that those who already have resources and knowledge of how to advocate and navigate a complex medical system have more positive birthing experiences. Increasing maternity deserts are also problematic. The uneven distribution of all birthing resources in the state is felt more by those who already experience higher rates of poor health outcomes and who have unmet needs.
- **Social media creates connections as well as anxiety.** Social media has two observable effects: one being that the use of social media creates connections through shared stories and increases access to information. On the other hand, social media use can cause anxiety (can intensify feelings of inadequacy, fear, and isolation).
- **Lack of peer, family, and community supports.** There has been a decline in community-based support and services. These supports are seen as essential to a proactive rather than reactive approach.
- **Underinvestment in community models that reflect community values.** Potential missed opportunities for strength, resiliency, support, and access.

Maternal Health Task Force



Mission: To reduce maternal mortality and severe maternal morbidity in Vermont by advancing effective, fair, and person-centered care addressing the full continuum of maternal health needs and supporting all families to be safe, supported, and empowered.

Vision: All people in Vermont receive fair access to respectful and high-quality care during pregnancy, birth, and postpartum periods so they are safe, supported, and empowered. Clinical and community providers are equipped, supported, and empowered to deliver compassionate and coordinated high-quality care within a system valuing collaboration, sustainability, and trust.

Guiding Principles: Several principles guide Vermont’s Maternal Health Strategic Plan as well as the larger body of work under MHI. These principles will serve as guideposts to ensure that processes reflect state values, resulting in actions that serve Vermont communities in accordance with the vision and mission.

- **Promoting Optimal Health:** Centering the needs of those who experience the greatest differences in health outcomes.
- **Fundamental need to partner:** Co-creating strategies with state agencies, healthcare providers, human service organizations, and families to succeed at our vision.
- **Collaboration:** Aligning and integrating efforts across sectors, including healthcare, behavioral health, social services, and community-based organizations.
- **Responsiveness:** Promoting trauma-informed care reflective of community values.
- **Data-Driven Action:** Grounding decisions in robust, community-informed, representative data and committing to ongoing learning and accountability.
- **Two-generation Framework:** Aligning with a two-generation framework, creating opportunities for, and addressing the needs of, both infants and their parents.

Maternal Health Taskforce Recruitment and Participants

To ensure broad and representative participation, the MHI team invited partners across Vermont to engage with the MHI work through multiple outreach strategies. All interested individuals and organizations were encouraged to complete an interest form to indicate their desired level of engagement. The forms were disseminated widely at each of the two virtual Kickoff meetings hosted in April and May, during which the community was briefed on the goals of the Maternal Health Innovation grant and the process through which the strategic plan would be developed. Over 120 community members, providers, and partners attended those virtual Kickoff meetings. Additionally, the form was distributed at the Maternal Health Summit, an in-person convening where community partners, providers, and other interested parties came together to discuss priorities within the maternal health system. Recruitment for core membership was open from spring through summer 2025. The interest form asked potential members to identify their organizational affiliation, role, populations served, and areas of expertise, as well as their preferred level of engagement in the work.

Vermont will intentionally increase participation of community members from populations most impacted by maternal mortality and severe maternal morbidity, including individuals with experience of substance use, mental health, and pregnancy loss, by recruiting directly from the PFAC, hosted and supported by the PQC-VT. The PFAC brings the perspectives of patients and families on issues impacting those in the pregnancy and postpartum period. Advisors share their lived experiences, providing feedback on policies, programs, and health

care delivery that directly affect families and the clinical teams supporting them. The PQC-VT creates a structured space for families to influence maternal health systems and engage in professional development opportunities. We will assess PFAC members' interest and engagement on the Task Force annually, ensuring a broad spectrum of voices inform the work, and that opportunities for engagement are continuously available.

Potential members of the MHTF were drawn from those who expressed interest in serving as a core partner. Following review of the responses, the MHI team identified and recruited additional participants to fill key gaps in representation, either by role (e.g., clinical specialty, community-based services) or by geography, to ensure balance across regions and populations. Final participation in the MHTF has not yet been determined; however, the group will include both those who expressed interest and strategically recruited partners to achieve comprehensive representation.

Roles that will be represented on the MHTF:

- FCH Central Office
- Doulas
- Nurses
- OB/GYN
- Peer Recovery/Substance Use Support
- WIC
- Neonatologist
- Perinatal Mental Health Provider
- VCHIP-PQC
- Local Health, FCHC
- Social Workers
- Parent Child Centers
- Division of Substance Use
- Human Trafficking Org
- Non-profit Executive Director
- Perinatal Mental Health Provider
- Midwives
- Patient and Family Advisory Committee (PFAC)
- Pediatrician
- Department of Children and Family- Family Services Division
- Pregnancy Intention Initiative
- Legislature
- Early Head Start

Maternal Health Task Force Structure

Meeting frequency: monthly meetings for the workgroups and quarterly meetings with the larger task force.

Planned Activities:

- Receive feedback and assist in finalizing the strategic plan
- Establish a governance mechanism within the grant
- Affirm oversight/management plan with key and accountable partners and provide technical assistance to support ongoing coordination
- Opportunity for more people to engage on specific topics in work groups described below

The MHTF will establish focused workgroups to advance specific priorities that have been endorsed by the field collectively and are aligned with the strategic plan. These include, but will not be limited to:

- Data and Evaluation – to align data collection, analysis, and interpretation of maternal health data to improve health outcomes and experiences
- Perinatal Quality – quality improvement topics in maternity care throughout the perinatal period
- Perinatal Substance Use - substance use in pregnancy and the year after birth, including alcohol, cannabis, illegal substances, and medication-assisted treatment
- Perinatal Mental Health – mental health conditions like depression and anxiety during pregnancy and after childbirth
- Community-Based Services – support for perinatal people, such as WIC, nurse home visiting, doulas, lactation consultants, and peer supports
- Policy – policies and legislation addressing health and well-being during pregnancy and the year after birth for all families

State Strategic Plan



During this strategic planning process, more than 120 people came together from all counties in Vermont – nurses, social workers, mental health clinicians, people prepared to speak from their own lived experiences, midwives, obstetrician-gynecologists, doulas, doctors, recovery coaches and peer support specialists, educators, administrators, and more – and agreed that the future we are working to create is one in which:

All Vermont families feel *safe, supported, and empowered* during their pregnancies, births, and throughout their postpartum experience.

Across diverse professional and personal perspectives, participants agreed that this future is one in which:

- Families would have a sense of empowerment and autonomy.
- Care would focus on the maternal-baby dyad (not system- or insurance-centered).
- Cultural traditions would be respected, affirmed, and incorporated. Language access would be well thought through in a way that enhances connection.
- There would be a sense of celebration, joy, and pride when people tell their birthing and postpartum stories, and a sense of connection through the experiences of grief, loss, and difficulty.
- Services would be universal and barrier-free, and families would know what resources and supports exist and how to easily access them.
- There would be a trusted, collaborative, connected, and psychologically safe relationship between the family and their care team.
- There would be a continuity of care, with postpartum support that is robust, trusted, and stems from the relationships and trust established previously.
- Care would be trauma-informed, compassionate, and judgment-free, so that families feel safe to disclose concerns.

Goals & Strategies for Statewide & Regional Impact

The strategic plan is designed to move beyond broad recommendations by translating each priority into a structured, measurable action plan. Each priority is accompanied by specific activities, performance measures that establish how progress will be assessed, implementation strategies that describe how the work will be accomplished, designated responsible entities that clarify accountability, and timelines that establish expectations for completion. Together, these components—Activity, Performance Measure, How, By Who, and By When—provide an actionable framework for implementation, monitoring, and evaluation. This structure enables partners to coordinate efforts, track progress, assess results, and adapt strategies over time, ensuring that the strategic plan serves as both a roadmap for collective action and an accountability tool for advancing maternal health in Vermont.

This strategic plan seeks to accomplish three goals:

1. **Improve access to care** that is comprehensive, high-quality, appropriate, and ongoing throughout the preconception, prenatal, labor and delivery, and postpartum periods.
2. **Enhance state maternal health surveillance and data capacity;** and
3. **Identify and implement innovative interventions** to improve outcomes for populations disproportionately impacted by maternal mortality and SMM.

We recommend implementing the following strategies to address the underlying causes of persistent challenges in ensuring safety, support, and empowerment across the perinatal and postpartum experiences of people in Vermont and measurably improve outcomes.

Goal 1: Improve access to care that is comprehensive, high-quality, appropriate, and ongoing throughout the preconception, prenatal, labor and delivery, and postpartum periods.

Strategy A: Create continuity of care for families throughout the perinatal period, supported by system integration, care coordination, and low-barrier services.

Domain 1. Enhancing care coordination and integration of services

Activity	Performance Measure	Who	When
1. Explore options for expanding care coordination services in obstetric (OB) offices.	# of advocacy and planning engagements focused on integration of maternal health care coordination services into system transformation efforts, including RHTP and Blueprint for Health	FCH/VDH Leadership with support from the MHI Team	Ongoing throughout the grant period
How: Engage state and healthcare system partners to identify opportunities to integrate or strengthen perinatal care coordination within existing and emerging care delivery and system transformation models.			
2. Support the integration of nurse home visiting and doula services across the continuum of care.	% increase in referrals to nurse home visiting and doula services	MHI/FCH in collaboration with FCH Home Visiting, Doula Program, and RPQCs	Annually throughout the grant period
How: Annually synthesize RPQC regional initiative data, CIS/FCH home visiting data, and Doula Program data to assess referral patterns, identify gaps, and monitor changes over time.			
3. Expand the Early Childhood Coordinated Intake and Referral (CIR) improvement project to include the perinatal period to integrate accessible referral pathways and networks.	Perinatal CIR Phase I assessment completed (Y/N); recommendations for integrating perinatal referral pathways into the statewide CIRS model developed (Y/N); # of maternal health partners engaged	FCH/MHI Team in partnership with Mathematica and maternal health system partners	Years 3-5
How: Extend CIRS under the umbrella contract to include a team to conduct the Phase I research for the perinatal period			

Domain 2. Expand perinatal community-based support

Activity	Performance Measure	Who	When
1. Assess and reduce barriers to prenatal education.	# of successful approaches implemented by the RPQCs and MHTF to increase access to prenatal education	MHTF (VDH) in collaboration with RPQC (VCHIP)	Ongoing throughout the grant period
How: Convene an MHTF sub-work group and leverage RPQC input to identify barriers to prenatal education and develop strategies to improve accessibility and reach.			
2. Explore expanding Medicaid eligibility to address benefit cliffs.	Analysis of Medicaid eligibility and potential benefit cliffs completed (Y/N); recommendations developed (Y/N)	MHTF (VDH), in collaboration with the OB Task Force and Medicaid Partners	By end of year 3
How: Partner with Medicaid and maternal health partners to examine eligibility thresholds, available perinatal services, and populations at risk of losing or being ineligible for needed supports.			
3. Explore and support community-based lactation care, including providing education for providers and community members about access to human donor milk.	# of strategies or initiatives supported through AHS funding streams, including RHTP, MHI, WIC, and SFVT	MHTF (VDH) in partnership with the Lactation Sub-workgroup	Ongoing throughout the grant period
How: Convene a lactation-focused MHTF sub-work group to identify barriers to community-based lactation care and donor milk access and advance opportunities for education, coordination, and investment.			
4. Distinguish and clarify community providers' roles in the perinatal space.	Perinatal provider ecosystem map developed (Y/N); # of provider types represented.	MHTF (VDH) and PQC (VCHIP), in collaboration with Maternal Health Partners	By end of year 3
How: Develop an ecosystem map describing the roles, services, scopes, and connections among community-based providers supporting families across the perinatal continuum.			
5. Assess and address barriers to licensing or credentialing for community-based care providers.	Perinatal community-based provider licensing and credentialing needs incorporated into AHS workforce development efforts (Y/N); # of identified barriers elevated for action	To be led by FCH/MHI Team, in collaboration with the OB Task Force, and MHTF (VDH).	Ongoing throughout the grant period
How: Engage community-based providers to identify licensing and credentialing barriers and elevate identified needs within state-level healthcare workforce development initiatives.			
6. Advance proposals for universal nurse home visiting and doula supports	# of funding or policy proposals developed or supported to expand access to nurse home visiting and doula services	To be led by the FCH/MHI Team, in collaboration with the MHTF (VDH), RPQC	Ongoing throughout the grant period

		(VCHIP), MMRP, and RHTP	
How: Identify funding and policy opportunities, develop and submit proposals, and advocate for inclusion of community-based nursing and doula services within broader maternal health and healthcare transformation initiatives.			

Strategy B: Expand workforce development efforts for the maternal health workforce to continue providing high-quality services.

Domain 1. Ensure access responsive to the community's needs and respectful maternity care.

Activity	Performance Measure	Who	When
1. Support training opportunities for trauma-informed and respectful maternity care that is responsive to the values of the community being served.	# of training opportunities supported; # of providers and partners participating	MHTF (VDH) in collaboration with AWHONN, RPQC (VCHIP)	Ongoing throughout the grant period
How: Engage community members and maternal health partners to identify training priorities and support development, adaptation, and delivery of trauma-informed and respectful maternity care training that incorporates community voices and values.			
2. Create recommendations to address gaps in access to interpretation services.	Recommendations to improve access to interpretation services developed (Y/N); # of system partners engaged in developing recommendations	MHTF (VDH), in collaboration with the OB Task Force	By end of year 3
How: Assess barriers to accessing interpretation services across perinatal settings and engage clinical, community, interpretation, and patient and family partners to identify feasible strategies for improving access and coordination.			

Domain 1. Enhance care coordination and integration of services

Activity	Performance Measure	How	By who	By when	What For	What programs, projects, and initiatives contribute to this?
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1. Explore options for expanding care coordination services in obstetric (OB) offices.	# of advocacy and planning engagements focused on integration of maternal health care coordination services into system transformation efforts, including RHTP and Blueprint for Health	Engage state and healthcare system partners to identify opportunities to integrate or strengthen perinatal care coordination within existing and emerging care delivery and system transformation models.	FCH/VDH Leadership with support from the MHI Team	Ongoing throughout the grant period	To identify sustainable opportunities to strengthen care coordination within OB settings and improve connections between clinical care and community-based maternal health services and supports.	CIRS Study, Closed loop referral, OB Taskforce
2. Support the integration of nurse home visiting and doula services across the continuum of care.	% increase in referral to nurse home visiting and doula services	Annually synthesize RPQC regional initiative data, CIS/FCH home visiting data, and Doula Program data to assess referral patterns, identify gaps, and	MHI/FCH Team in collaboration with CIS, FCH Home Visiting, Doula Program, and RPQCs	Annually throughout the grant period	To assess referral patterns as an indicator of integration of community-based supports across the continuum of perinatal care and identify opportunities to strengthen	Medicaid Reimbursement for Doula, Universal Home Visiting Study/Proposal, expanded eligibility to evidence based nurse home visiting, expansion of CIS responsiveness

		monitor changes over time.			n connections between clinical and community services.	e nurse home visiting for the full year year post partum
3. Expand the Early Childhood Coordinated Intake and Referral (CIR) improvement project to include the perinatal period to integrate accessible referral pathways and networks.	Perinatal CIR Phase I assessment completed (Y/N); recommendations for integrating perinatal referral pathways into the statewide CIR model developed (Y/N); # of maternal health partners engaged	Extend CIRS under the umbrella a contract to include a team to conduct the phase I research for the perinatal period	FCH/MHI Team in partnership with Mathematica and maternal health system partners	Initiate following completion of the existing CIRS contract; new performance measure selected in Year 3	To develop recommendations for a more coordinated perinatal system of care that strengthens transitions, referral pathways, and follow-up between clinical and community-based services.	Workgroup to inform outcomes for CIRS. Plug in the Referral Project?

Domain 2. Support and grow the maternal health workforce

Activity	Performance Measure	Who	When
1. Create data-driven recommendations to expand and retain the perinatal workforce.	Perinatal workforce recommendations developed (Y/N); # of recommendations advanced through statewide workforce development initiatives	MHTF (VDH), OB Task Force, FCH staff, and state workforce development partners	Recommendations developed by end of Year 3
How: Capitalizing on ongoing state investments in workforce development specifically supporting the perinatal workforce, such as loan forgiveness programs.			
2. Investigate reimbursement rates for perinatal providers, including OB practices and facilities, community-based service providers, substance use and mental health specialists,	Reimbursement landscape assessment completed (Y/N); # of recommendations developed and shared with relevant decision-makers	MHTF (VDH), OB Task Force, FCH staff, Medicaid, and relevant payer and	By end of Year 4

and recommend adjustments as needed.		provider partners	
How: Review existing reimbursement structures across perinatal provider types and engage Medicaid, commercial payers, healthcare systems, and community-based providers to identify reimbursement gaps and opportunities for improvement.			
3. Identify gaps and explore mechanisms to increase accessibility of professional development opportunities for the perinatal workforce continuum.	Professional development needs assessment completed (Y/N); # of strategies identified to improve access to training	MHTF (VDH), in collaboration with the perinatal partners	Initial assessment and recommendations by end of Year 3
How: Engage clinical and community-based perinatal providers to identify training needs, existing professional development opportunities, and barriers related to cost, geography, scheduling, and credentialing. Collaborate with educational and workforce development partners to identify opportunities to expand access.			
4. Understand and disseminate current best practices for clinic and inpatient caseload recommendations to increase patient satisfaction and reduce provider burnout.	Best-practice review completed (Y/N); recommendations disseminated to perinatal partners (Y/N)	MHTF (VDH), in collaboration with the perinatal partners	By end of Year 4
How: Review available evidence and professional guidelines on staffing, caseloads, and workload management across perinatal care settings. Engage clinical leaders and workforce partners to assess applicability to Vermont's healthcare delivery system and disseminate findings.			

Goal 2: Enhance state maternal health surveillance and data capacity.

Strategy A: Assess, improve, and sustain the maternal health data landscape by identifying indicators, addressing gaps, and supporting partners' data capacity for collection and evaluation.

Domain 1. Monitor new and ongoing programmatic initiatives and efforts to improve maternal health.

Activity	Performance Measure	Who	When
1. Monitor process and outcome measures of regional initiatives in partnership with the PQC-VT.	% of RPQCs with an approved evaluation plan	The FCH/MHI Evaluation team in partnership with the PQC team	Monitor progress continually with annual reports to the field.
How: By supporting regions to develop brief evaluation plans, identify performance measures, and report on process and outcomes data			

2. Assess changes in regional collaboration resulting from the implementation of the Regional PQC model.	% of RPQCs completing baseline and follow-up collaboration assessments; change in collaboration assessment scores	To be designed and implemented by the FCH/MHI team, supported by the PQC team	Baseline data will be collected in Year 3 and annually thereafter
How: Implement a collaboration assessment wherein FCHCs will identify the status of collaborative relationships and set strategic goals to improve coalition building within their region over the coming year.			
3. Ensure the MHI Evaluation Plan is leveraged as an accountability tool to show the outcomes and impact of grant activities.	Annual evaluation plan review completed (Y/N); % of identified performance measures with updated data	FCH/MHI Evaluation Team with the Data and Evaluation Workgroup and initiative leads	Ongoing throughout the grant period
How: Conduct an annual review of the Evaluation Plan, update measures and evaluation questions as initiatives evolve, and synthesize findings across MHI activities.			
4. Implement the Technical Assistance Model of evaluation to support individual initiatives to increase workforce capacity and ensure sustainability of data monitoring activities.	% of funded initiatives receiving evaluation TA; % with an evaluation plan and identified performance measures	FCH/MHI Evaluation Team in partnership with PQC-VT	Ongoing throughout the grant period
How: Provide individualized technical assistance, tools, templates, and coaching to help initiative partners develop feasible evaluation plans, collect and interpret data, and communicate findings.			
5. Assess the data sharing landscape across maternal health partners.	Data sharing inventory completed (Y/N); # of partners/data systems represented	FCH/MHI Evaluation Team with state agency, clinical, and community data partners	Complete initial landscape assessment in Year 3
How: Implement the developed data sharing inventory protocol to document existing data sharing agreements, data flows, barriers, and opportunities across maternal health partners.			
6. Increase data sharing across state agencies and community partners by providing technical assistance to organizations seeking to improve data sharing with partners.	# of organizations receiving data-sharing TA; # of new or strengthened data-sharing mechanisms/agreements	FCH/MHI Evaluation Team with relevant state data stewards and partner organizations	Beginning in Year 3 and ongoing thereafter
How: Provide technical assistance to partners to address identified data-sharing barriers and support development or improvement of agreements, processes, and data-use practices.			
7. Provide mechanisms for broader dissemination of findings across maternal health partners.	# of dissemination products and opportunities annually; # and type of partners reached	FCH/MHI Team in partnership with PQC-VT and communications partners	Ongoing through the grant period

How: Disseminate findings through annual reports, webinars, data briefs, presentations, the MHI webpage, MHTF/PQC forums, and other partner learning opportunities.

8. Leverage linkages between the early childhood data portal and the perinatal portal, which are under development.	# of shared or aligned indicators identified; recommendations for linkage developed (Y/N)	FCH/MHI Evaluation Team with early childhood and perinatal data partners	Identify alignment by end of Year 3
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How: Collaborate with portal developers and data stewards to identify shared indicators, definitions, data sources, and opportunities to connect perinatal and early childhood reporting.

9. Monitor ongoing needs within Vermont's maternal health landscape.	Maternal health landscape synthesis updated annually (Y/N); # of emerging priorities identified	FCH/MHI Evaluation Team with the MHTF Data and Evaluation Workgroup and PQC-VT	Review annually through September 2029.
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How: Routinely synthesize surveillance data, MMR findings, qualitative studies, regional data, partner feedback, and emerging assessments to identify changing needs and gaps.

10. Assess feasibility for universal doula and nurse home visiting services.	Feasibility assessment completed (Y/N); recommendations developed (Y/N)	FCH/MHI Team in partnership with FCH home visiting, doula, Medicaid partners	Complete assessment and recommendations by Year 3
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How: Analyze existing service capacity, utilization, geographic reach, workforce needs, financing, and implementation considerations and engage program, Medicaid, provider, and community partners.

11. Conduct assessments of priority populations to supplement state surveillance data.	# of assessments completed; # of priority populations engaged; findings and recommendations disseminated (Y/N)	FCH/MHI Evaluation Team in partnership with contractors, PQC-VT	Conduct assessment throughout the grant period
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How: Use qualitative and community-engaged methods, including interviews, focus groups, surveys, and participant panels, to examine experiences and needs that cannot be adequately understood through existing surveillance data.

Goal 3: Identify and implement innovative interventions to improve outcomes for populations disproportionately impacted by maternal mortality and SMM.

Strategy A: Regional PQCs will facilitate ongoing communication and partner convening across the state to support knowledge

dissemination, collaboration, and the adoption of innovative community and clinical approaches.

Domain 1. Support the development and infrastructure of the RPQCs and regional initiatives.

Activity	Performance Measure	Who	When
1. Integrate community-based services and peer networks into the maternal health system of care.	% of community providers and peer network representatives actively engaged in RPQC convenings.	VCHIP and supported by VDH District Offices.	Tracked quarterly throughout the grant period.
How: Promote RPQC meetings to a diverse audience and encourage regular attendance.			
2. Provide the infrastructure to regional PQCs to include training and administrative support for interventions that are sustainable, replicable, and scalable.	# by type of opportunities (FCHC leadership trainings, SPARKS calls, etc.) created for core project teams	VCHIP with support by partners and participants.	Tracked quarterly throughout the grant period.
How: Offer infrastructure and support to each RPQC, such as regular meeting times, facilitation support, and opportunities for learning and collaboration that engage diverse partners involved in the local maternal health system of care.			
3. Support planning and implementation of regional activities.	# of RPQC gatherings per year	VCHIP with support by partners and participants.	Tracked quarterly throughout the grant period.
How: Regularly engage RPQC project teams to support project implementation, data collection, and increase visibility.			
4. Support the development of sustainability plans for innovations.	% of RPQCs with a sustainability plan by year 5.	Regional Project Teams and supported by VCHIP.	Annually
How: Offer support to project teams to develop and submit sustainability plans detailing what is needed to continue, deepen, or adapt projects beyond the scope of the RQPC funding.			
5. Promote and highlight maternal health innovations and outcomes through approaches such as the annual summit and posting on the MHI webpage.	Develop a communication plan (Y/N)	VCHIP in partnership with VDH and supported by the MHTF.	Tracked quarterly throughout the grant period.
How: Identify opportunities for promotion, storytelling, and align regional innovations with statewide maternal health innovation plans. Support RQPC projects to tell the story of their innovation and impact in the maternal health system.			
6. Collaborate with the PQC-VT to produce and disseminate the	Developing a Perinatal Public Health Report represents the	FCH/MHI Team in partnership	Produced Annually

annual Perinatal Public Health Report.

maternal health landscape while highlighting MHI strategic priorities (Y/N)

with PQC-VT and VCHIP.

How: Collaborate with the PQC-VT on the Perinatal Public Health Report and provide MHI-specific data where necessary.

Innovations



Through collaboration among state agencies, healthcare systems, regional partners, and families, Vermont has and will continue to develop, implement, and evaluate innovative approaches that respond to local needs, demonstrate measurable impact, and inform sustainable improvements across the maternal health system.

Doula Projects: Limited access to birth support and perinatal-specific mental health resources in rural areas has been identified in multiple needs assessments and by participants in our strategic planning process. Our project subgrants to two community-based mental health agencies to serve as leaders and subject matter experts to grow and support doula capacity in Vermont. They support statewide doula systems-building efforts, including training, mentorship, coalition building, and working with the Office of Professional Regulation on doula certification and credentialing for Medicaid reimbursement. Funding also supports statewide doula coalition building.

Regional PQC Structure: To address the siloing of our maternal health systems and to increase the understanding of supportive services externally to the clinical care system, we are funding the central PQC-VT to create and maintain six regional PQCs (RPQCs) across the state. The RPQCs will draw together clinical and community care teams from a range of specialties in an organized and scaffolded structure. This RPQC approach will allow for bidirectional learning between the regions and the state. It will also create a collaborative space within regions to connect resources and better coordinate care. This funding will additionally support RPQC needs assessment, strategic planning, and selection and implementation of innovative programs, services, and training. RPQCs will be awarded funding individually to implement innovative community-specific projects and serve as an innovation hub to incubate and elevate sustainable and replicable interventions. These RPQCs will be able to respond to the changing maternal health landscape by maximizing existing, and sometimes underutilized, community-based supports.

Hypertension Telemonitoring: Through implementation of the Alliance for Innovation in Maternal Health hypertensive patient safety bundle, the PQC-VT has identified gaps in pregnant and postpartum hypertensive care. To address gaps in hypertensive monitoring in the spaces around the inpatient setting and to prevent rehospitalization and severe maternal morbidity, we are subcontracting with Central Vermont Home Health for a nurse-led intervention in the home for hypertension telemonitoring. This grant covers the fee for tablets/software/telephony for telemonitoring kits and nurse monitoring of hypertensive clients and will explore the adaptations needed to bill for home health services and expand this service to other home health agencies.

Donor Milk: Access to both human donor milk and lactation support resources is limited in Vermont, particularly in rural regions. Our MHI project is funding the Vermont Donor Milk Center to expand access to donor milk in the outpatient setting to two remote site depots, expanding access to families in need of donor milk via financial subsidy and addressing supplemental professional lactation support for clinicians and community-based providers supporting families in critically underserved areas in Vermont.

Farming Community Project: Vermont is primarily rural and has a strong agricultural base with many families living on small, independent farms across Vermont. Our project is funding the Bridges to Health program to increase their support for pregnant and postpartum women by training their Community Health Worker workforce and providing statewide coordination for Vermonters birthing in our farming communities. Additionally, helping to support and collaborate with existing doula and nurse home visiting services where available.

Perinatal Trauma-Informed Engagement and Support (P-TIES): Individuals experiencing high-risk pregnancies, traumatic birth, and pregnancy or infant loss often face complex clinical and emotional needs that require coordinated, trauma-informed care. P-TIES is a statewide initiative focused on improving care for individuals experiencing high-risk pregnancies, traumatic birth, and loss. This is a joint project with the FCH division staff and the University of Vermont College of Medicine. This project will first seek to understand patient and family experiences during inpatient care, traumatic birth, and loss; provider perspectives on clinical and emotional care delivery; and understand opportunities to strengthen trauma-informed, supportive services within clinical and community spaces. The next phase of this project will address the specific needs of these patients and identify targeted interventions to support patients and medical support providers across community and clinical settings.

Evaluation, Continuous Quality Improvement, and Action Plans



As community-led initiatives are implemented and the Maternal Health Strategic Plan is finalized, additional evaluation questions and performance measures will be incorporated iteratively to reflect emerging priorities, lessons learned, and evolving community needs. The evaluation plan will be revisited annually to assess progress, identify gaps, and ensure alignment with both regional and state priorities. The Data and Evaluation Committee will play a central role in maintaining this plan, guiding the integration of new measures, reviewing findings, and ensuring that evaluation remains responsive and useful for continuous quality improvement across all maternal health initiatives.

Evaluation questions were developed with input from MHI program staff to ensure they are specific, relevant, meaningful, and useful to program needs. The questions focus on: Process to understand how the program is implemented (e.g., tracking program events and activities at one or multiple points in time); outcome to understand what the program is doing to meet short- and long-term goals (e.g., comparing metrics across different time periods to identify meaningful changes); and impact to assess what happened as a result of the program and whether long-term goals were met (e.g., drawing conclusions about the overall impact of the program on the community).

Key measures of the MHI program goal:

Evaluation Question	Measures*
Program Requirement 1: Establish a state-focused Maternal Health Task Force (MHTF)	
EQ1P: How effectively were the steps for establishing the State-Focused MHTF executed?	Y/N - fair and inclusive MHTF charter developed? Y/N - fair and inclusive MHTF workgroup charters developed? Y/N - MHTF sustainability plan developed? #/% of planned meetings convened each year #/% of agenda items completed each year #/% of members attending all planned MHTF meetings #/% of key partners engaged in the strategic planning process #/% of strategic planning participants representing priority populations
EQ2O: Does the composition of the MHTF accurately reflect Vermont's Maternal Health system of care, to include prioritized populations and those with lived experience?	#/% of partner organizations with representative members in the MHTF #/% of filled compensated, lived experience positions in MHTF Y/N - membership representing priority populations on the MHTF #/% - survey or qualitative assessment response rate measuring engagement from MHTF members #/% of members satisfied with their experience on the MHTF
Program Requirement 2: Improve state-level maternal health data and surveillance	
EQ3O: Were inventory and mapping products useful in identifying barriers and opportunities to improve the MH data landscape?	Y/N - inventory review and data mapping completed? #/% of datasets with information related to priority populations (i.e., BIPOC, individuals w/ SUD, rural Vermonters, individuals w/ low SES) #/% of indicators for each core area of MHI work (i.e., regional PQCs, integration of clinical and community services, doula services) #/% of key partners reporting use and positive feedback about usefulness #/% of proposed recommendations approved as actionable by MHTF # of maternal health data products/reports released to the public each year
EQ4O: Were steps and recommendations to improve the MH data and	Y/N - indicator inventory approved by MHTF? Y/N - MHTF Data and Evaluation Workgroup charter developed? Y/N - MHTF Data and Evaluation Workgroup sustainability plan developed?

surveillance landscape accomplished?	#/% of partner organizations with representative members in the MHTF Data and Evaluation Workgroup #/% of workgroup participants representing priority populations #/% of recommendations implemented at the end of each year
Program Requirement 3: Promote and execute innovation in maternal health service delivery	
EQ5^o: Were programs/initiatives implemented or improved to be responsive and accessible for populations disproportionately impacted by mortality and SMM?	#/% of program participants rating services as positive and responsive/accessible to community needs % increase in programs/initiatives adapted to meet community needs, translated, and literacy-accessible materials for priority populations % increase in key partners providing feedback and content for materials supporting priority populations #/% of programs/grantees working on goals to serve impacted populations #/% of programs/grantees reporting progress in improving MH outcomes among impacted populations
EQ6^p: Were innovations and initiatives implemented sustainably to ensure long-term impact?	Y/N - Maternal Health Annual Report published? #/% of initiatives/activities that have a sustainability plan for continued funding, staffing, and resources #/% of initiatives/activities with commitment to continuation past the period of performance #/% of initiatives/activities with potential for replication and scale-up shared each year publicly
EQ7^o: Was there an increase in priority populations served because of grant activities?	#/% change in individuals from priority populations accessing services annually and overall # of doula training opportunities provided #/% change in individuals from priority populations trained as community-based doulas annually and overall
EQ8ⁱ: Were there any notable changes in maternal health data trends associated with the grant period?	% change in the prevalence of maternal mortality and/or severe maternal morbidities overall and disaggregated % change in program participant/patient satisfaction related to availability of culturally competent care overall and disaggregated % change in substance-related hospitalization/death associated with perinatal experiences overall and disaggregated % change in the referrals (e.g., PMADs, substance use treatment, and recovery) completed overall and disaggregated

* Comparisons between subsequent years or baseline/Year 5 will be made whenever possible with available Measure data. EQ^p=Process, EQ^o=Outcome, EQⁱ=Impact.

Conclusion: From Shared Vision to Collective Action

Vermont's Maternal Health Strategic Plan represents a shared commitment to building a more coordinated, accessible, and responsive maternal health system. Developed through statewide engagement with families, healthcare professionals, community organizations, and state partners, the plan reflects both the strengths of Vermont's existing maternal

health infrastructure and the opportunities to address persistent gaps in care. It establishes a common direction for improving maternal health outcomes while recognizing that meaningful systems change requires sustained collaboration, investment, and accountability.

The success of this plan will depend on translating its priorities into coordinated action at both the state and regional levels. The Maternal Health Task Force, Perinatal Quality Collaborative of Vermont, and Regional Perinatal Quality Collaboratives will play complementary roles in advancing shared priorities, strengthening clinical and community partnerships, and supporting locally responsive innovations. Continued investments in workforce development, care coordination, respectful and trauma-informed care, and maternal health data infrastructure will be essential to building a system that meets the different needs of Vermont families.

Importantly, this plan is intended to be a living framework rather than a static document. Ongoing evaluation, regional collaboration, community engagement, and the integration of emerging evidence will inform implementation and allow strategies to evolve as needs and opportunities change. Meaningful participation from families, particularly those disproportionately impacted by maternal mortality and morbidity, must remain central to decision-making and accountability. Our collective measure of success will be a maternal health system in which every Vermonter has access to the care, resources, relationships, and support they need to experience a healthy pregnancy, safe birth, and supported postpartum period.

Acknowledgements

The Vermont Department of Health, Division of Family and Child Health, extends its sincere appreciation to the many individuals, families, organizations, and partners who contributed to the development of Vermont's Maternal Health Strategic Plan. This plan reflects a collective commitment to strengthening Vermont's maternal health system through collaboration, shared learning, and the integration of clinical expertise, public health data, and community experience.

We are especially grateful to the people and families who shared their experiences, perspectives, and recommendations throughout the strategic planning process. Their contributions were essential to identifying gaps in care, understanding the experiences of populations disproportionately impacted by maternal mortality and morbidity, and establishing priorities that reflect the needs of Vermont families. We also honor and remember the families whose lives were lost due to pregnancy-related complications and maternal mortality. Their lives, families, and stories remind us of the urgency of this work and our collective responsibility to prevent avoidable deaths and ensure that every Vermonter has access to safe and respectful maternal healthcare.

We acknowledge the members of the Maternal Health Task Force, the Perinatal Quality Collaborative of Vermont, Regional Perinatal Quality Collaboratives, and the Patient and Family Advisory Committee for their leadership, expertise, and continued commitment to advancing maternal health. We also thank the healthcare professionals, community-based organizations, doulas, home visitors, public health practitioners, advocates, and state agency partners who participated in regional engagement activities, strategic planning meetings, and the statewide Maternal Health Summit.

Special appreciation is extended to the research and evaluation partners whose work strengthened the evidence informing this plan, including those who conducted studies examining the experiences of birthing Vermonters. Their contributions helped ensure that the strategic plan was informed by both population-level data and the experiences of individuals navigating Vermont's maternal health system.

Finally, we acknowledge the Health Resources and Services Administration (HRSA) for its support through the Maternal Health Innovation Program. This investment has provided Vermont with an opportunity to bring partners together, strengthen statewide and regional collaboration, and establish a shared vision for a more coordinated, accessible, and respectful maternal health system.

Glossary of Terms

AHS Vermont Agency of Human Services
AIM Alliance for Innovation on Maternal Health
CBO Community-Based Organization
CIR Coordinated Intake and Referral
CIS Children's Integrated Services
FCH Division of Family and Child Health
FCHC Family and Child Health Coordinator
MHI Maternal Health Innovation
MHTF Maternal Health Task Force
MMRP Maternal Mortality Review Panel
OB Obstetrics / Obstetric
PFAC Patient and Family Advisory Committee
PMAD Perinatal Mood and Anxiety Disorders
PQC Perinatal Quality Collaborative
PQC-VT Perinatal Quality Collaborative of Vermont
PRAMS Pregnancy Risk Assessment Monitoring System
RHTP Rural Health Transformation Program
RPQC Regional Perinatal Quality Collaborative
SMM Severe Maternal Morbidity
SUD Substance Use Disorder
TA Technical Assistance
UVM University of Vermont
VCHIP Vermont Child Health Improvement Program
VDH Vermont Department of Health
VUHDDS Vermont Uniform Hospital Discharge Data Set
WIC Special Supplemental Nutrition Program for Women, Infants, and Children