NORC at the University of Chicago

Report

Progress Towards Vitality: A 10-Year Retrospective Analysis of Systems Focused Efforts to Improve Maternal Health in Georgia

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Report Summary

Over the past decade, Georgia has made meaningful progress in improving maternal health through policy reforms and programmatic interventions. Key achievements include the extension of Medicaid postpartum coverage to 12 months and implementing the Alliance for Innovation in Maternal Health (AIM) safety bundles. Despite these successes, persistent challenges remain, including administrative errors, limited provider awareness of policy changes, workforce shortages, fragmented data systems, and funding challenges.

This retrospective analysis, conducted by NORC at the University of Chicago, commissioned by Georgia Health Initiative, reviewed a subset of 15 recommendations (approximately half of the recommendations identified) put forward by the Georgia Maternal Mortality Review Committee (MMRC) and the Georgia House Study Committee on Maternal Mortality. Through environmental scans and interviews with stakeholders, this report assesses the extent of recommendations' implementation, identifies barriers and facilitators, and highlights promising practices to inform future work to address maternal health needs in Georgia's broader maternal health ecosystem.

Key accomplishments reflect that notable progress has been made through the early adoption of AIM bundles, strong cross-sector collaboration, legislative support, and data-driven decision-making. Key lessons include the need for sustained investment, improved communication, integrated data systems, and culturally responsive, community-based care models. Looking ahead, Georgia can build on its success. With continued collaboration and strategic investment, the state can promote access to respectful, evidence-based, and affordable perinatal care, delivered with dignity and compassion.

Introduction

Background

In 2010, Amnesty International published a study that ranked Georgia 50th in maternal mortality in the United States.[1] As a result, Geogia state officials formed an advisory committee to determine a methodology for researching and identifying solutions for the high maternal mortality rate.[2] The committee held its first meeting in 2012, and in 2014, legislation was passed (SB 273) that safeguarded ongoing maternal mortality review in

Georgia and formally established the Maternal Mortality Review Committee (the MMRC). The MMRC is a multi-disciplinary committee made up of physicians, nurses, public health workers, epidemiologists, doulas and midwives, and individuals with lived experience.[3] The MMRC has completed reviews of maternal deaths in Georgia from 2012 to 2021.[4]

In 2019, a resolution was passed in Georgia (HR 589) which acknowledged that Georgia remained among the top ten states with the highest maternal death rate and that the MMRC reviewed three years of maternal death data in Georgia and found that 60% of those deaths were preventable. Based on this review, the MMRC recommended continued review of maternal deaths to develop strategies for systemic change to reduce and prevent maternal deaths in the state. The resolution therefore created the Georgia House Study Committee on Maternal Mortality (the Study Committee). This Study Committee was made up of seven members of the House of Representative and two members of the MMRC. The Study Committee convened five public meetings at the State Capitol in 2019, where they heard testimony from agencies and organizations with expertise in maternal health. The Study Committee's work culminated in a final report that summarized data trends and current initiatives, and nineteen recommendations for improving maternal health in Georgia.[5]

While several recommendations from the MMRC and the Study Committee have been implemented, to date there has been limited information on the full scope of their adoption, effectiveness, and opportunities for future improvement.

Commissioning this Research

Georgia Health Initiative® (the Initiative) is a non-partisan, non-profit private foundation working alongside forward-thinking partners and collaborators to develop and champion Georgia-specific solutions to some of the most challenging health issues. The Initiative understands that maternal and infant health are critical identifiers of the health and well-being for Georgia.

To support and strengthen maternal health systems in Georgia, the Initiative engaged over 50 multi-sectoral partners to better understand existing efforts and explore ways to enhance impact. This evolved into deeper conversations with key maternal health systems leaders who expressed a strong interest in examining the solutions that drive positive maternal health outcomes. These partners consistently highlighted the work of and the recommendations that emerged from the MMRC and the Study Committee. Partners reinforced that no more work was needed at present to *identify* new solutions. Instead, they stressed that what was critical was to assess which of the existing recommendations have already been implemented and how, including facilitators and barriers to success; which recommendations have yet to be implemented; and lessons learned that could emerge from this assessment to inform both the Initiative's work and that of Georgia's broader maternal health ecosystem.

To that end, the Initiative has contracted with NORC at the University of Chicago (NORC) to conduct a retrospective analysis of the past ten years of systems-focused recommendations and efforts aimed at improving maternal health outcomes in Georgia. The impetus for commissioning this research was informed by the Initiative's engagement with a multi-sector group of Georgia-based partner organization who jointly share a vision for improving maternal and child health within the state. This report presents the findings of NORC's retrospective analysis, offering insights into the extent of implementation, effectiveness, and areas for continued advancement of systems-focused maternal health efforts in Georgia.

Georgia's Maternal Health Landscape

Over the past decade, national and state-level events and policies have shaped maternal health in Georgia, offering context for both the changes and their underlying causes within broader social, political, and economic forces. Figure 1 below highlights the relevant events that occurred leading up to and during the last ten years.

Figure 1. Snapshot of Policy and Other Environmental Factors Shaping the Maternal Health Landscape in Georgia

2010

Amnesty International published a study that ranked Georgia 50th in maternal mortality in the United States. As a result, state officials formed an advisory committee to determine a methodology for researching and identifying solutions for the high maternal mortality rate.[6]

2012

In 2012, the maternal mortality advisory committee held an introductory meeting.

2014

In 2014, SB 273 was signed, which safeguarded ongoing maternal mortality review in Georgia and formally established the Georgia Maternal Mortality Review Committee (MMRC).[7]

2017

Georgia appropriated $100,000 to Department of Public Health (DPH)'s FY2018 budget to implement programs that address maternal mortality including the addition of nurse abstractors.

2018

The Georgia Perinatal Quality Improvement Collaborative (GaPQC) was established.

The GaPQC successfully began initiating and implementing AIM Bundles in rural hospitals.[8]

2019

Georgia passes $1.74 million in Maternal Health appropriation to DPH's FY2020 budget, including $200,000 for the MMRC, $1 million for Perinatal Mood and Anxiety Disorder screening and treatment in rural areas.[9]

Georgia passed HB 589, creating the House Study Committee on Maternal Mortality.[10]

In October 2019, HB 345 takes effect prohibiting restrictive practices such as strip searches and ankle shackling for pregnant/ immediate postpartum incarcerated women in state/county prisons.[11]

The Morehouse Center for Maternal Health Equity was established with $500,000 in funding.

Georgia legislature passes HB 481, banning abortions after detection of fetal cardiac activity and allowing alimony and child support from that point. The law, set to take effect in January 2020, was suspended due to litigation.

2020

On January 31, 2020, the Secretary of the Department of Health and Human Services (HHS) declared the 2019 Novel Coronavirus (2019-nCoV) outbreak a public health emergency.[12]

Effective, March 20, 2020, the Families First Coronavirus Response Act (FFCRA) established a continuous Medicaid enrollment safeguard that keeps people enrolled through the end of the COVID-19 public health emergency.[13]

2021

In July 2021, the Georgia legislature approves HB 1114, issuing guidance to Georgia Department of Community Health (DCH) to extend Medicaid Postpartum care from 60 days to 6 months.[14]

In May 2021, PEACE4Moms is established with funding from the Georgia Department of Public Health.[15]

2022

On June 24, 2022, the U.S. Supreme Court overturned *Roe v. Wade* in *Dobbs v. Jackson Women's Health*, ending the constitutional right to abortion until fetal viability.

On July 20, 2022, following the Supreme Court's ruling, the 11th Circuit Court of Appeals allowed HB 481 to take effect.

Georgia legislature passes SB496, which requires a medical examiner inquiry when a pregnant person dies and an inquest.[16]

2023

On March 31, 2023, the continuous enrollment condition for Medicaid ended. The Medicaid continuous enrollment provision, mandated by the FFCRA during the COVID-19 public health emergency, increased continuous Medicaid enrollment during the postpartum period.[17]

Over $1 million was appropriated for the remote fetal monitoring program.[18]

Georgia removed the 5-year waiting period for pregnant lawful permanent residents.

2024

Following media reporting in November 2024, which revealed information of two individuals whose deaths were determined to be preventable, the state of Georgia dismissed all members of the MMRC.[19]

The Maternal and Infant Health Commission was created.[20]

2025...

Georgia relaunched the MMRC with new members.

The Regional Perinatal Center Advisory Committee was created.[21]

Research Approach

NORC developed research questions in consultation with the Initiative to guide this work, which can be found in the Research Methodology Appendix. To answer the research questions, NORC conducted an environmental scan and stakeholder interviews to assess the implementation status of priority recommendations and to identify cross-cutting facilitators and barriers impacting these recommendations. Additional details on the research methodology are provided in the Research Methodology Appendix. Where deemed helpful to provide additional context and highlight the implications of recommendations, the research team has populated excerpts from stakeholder interviews throughout the report.

Priority Recommendations

As the first step in this work, NORC reviewed MMRC and Study Committee publications to extract maternal health recommendations issued over the past ten years. NORC identified over 30 recommendations and collaborated with the Initiative to identify 15 priority recommendations. The recommendations selected for further review were prioritized through consultation with stakeholders who possess significant expertise in maternal health systems. This group has been instrumental in deepening the Initiative's understanding of maternal health in Georgia and includes representatives from nonprofits, state agencies, academic institutions, professional organizations, and clinical and community service providers. Considerations for recommendations reviewed include initiatives designed to drive innovation, policy change, and systems transformation; feasibility of implementation, cost-effectiveness, and potential for scale or replication across different communities; and proven or promising evidence of effectiveness. The full list of recommendations from the MMRC and the Study Committee may be found in the Recommendations Appendix.

Findings

This report section is organized by the fifteen priority recommendations. For each recommendation, we provide a summary of implementation status, followed by a synthesis of findings from the environmental scan and stakeholder interviews, highlighting outcomes and, where applicable, lessons learned.

Recommendation 1. Extend Medicaid coverage for eligible pregnant women to one year postpartum.

Summary: This recommendation has been fully implemented. In 2021, Georgia was one of three states to increase Medicaid postpartum coverage beyond the federally required sixty days to six months, and in 2022, expanded it further to one year through a State Plan Amendment. While this policy change has been generally well received, its implementation has encountered challenges. Administrative errors and inconsistent communication have led to unintended disenrollment and gaps in provider awareness of patient coverage, highlighting the need for stronger oversight and more effective outreach.

Environmental Scan Findings. In 2021, Georgia increased coverage of Medicaid benefits to postpartum women beyond the Medicaid minimum. In 2022, State Bill (SB) 338, passed in both chambers and was signed by the governor,[22] which directed the Department of Community Health (DCH) to submit a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS).[23] CMS approved two SPAs to extend postpartum medical services to 12 months for low-income pregnant people enrolled in Medicaid and PeachCare

"We heard from a provider…that they were unaware that that had happened – [at the] end of 2024. So at least 2 years after it had happened."

for Kids®, effective November 1, 2022.[24] Despite this progress, administrative errors have resulted in inappropriate unenrollment among eligible postpartum women in Georgia.[25]

> **"I think there's a glitch in the system somewhere, because I have made calls for patients this year, where they got dropped. So, they show up to my clinic because a doctor who they saw won't see them, and I'm like 'that's not right because you have insurance for a year."**

Interview Findings. Stakeholders expressed support for the extension of Medicaid postpartum coverage but identified several implementation challenges. Communication efforts around the policy change have been inconsistent, with some stakeholders noting that many stakeholders remain unaware of the expanded coverage. Given that Medicaid beneficiaries rely heavily on state agencies to provide timely and accurate information, effective outreach and dissemination are critical. Some providers were unaware of the policy change, leading to underutilization of services and confusion about eligibility.

To address these gaps, advocacy organizations have stepped in to raise awareness, disseminate targeted updates, and promote utilization of the expanded services. These efforts aim to improve the flow of information from policymakers to health systems and beneficiaries.

Stakeholders also described incidents where individuals within the 12-month postpartum period were unenrolled, disrupting access to care and placing additional administrative burden on providers. One provider described the challenges this creates in clinical settings. These experiences align with environmental scan findings, suggesting a broader pattern of administrative and communication challenges.

Recommendation 2. Encourage and support the collection and analysis of pregnancy and postpartum data that can be used to inform and guide fiscal policy and program decisions at the state level.

Summary. This recommendation has been partially implemented. Georgia continues to collect pregnancy and postpartum data through systems such as the Pregnancy Risk Assessment Monitoring Systems (PRAMS), which inform maternal health programs and policies. However, recent changes to the MMRC, including limited transparency and establishing new members, have raised concerns about the consistency and utility of maternal health data for timely policy and fiscal decision-making.

Environmental Scan Findings. The MMRC completed reviews of maternal deaths from 2012 to 2021.[3] In 2024, Georgia dismissed all 32 members of its MMRC.[26] The MMRC was relaunched in March 2025, but state officials have not disclosed the names of the members. With the reestablished MMRC, it is unclear how data will be reviewed and what methodologies will be used.[27] Georgia also participates in the Centers for Disease Control and Prevention (CDC)-funded Pregnancy Risk Assessment Monitoring System (PRAMS) administered by the Georgia Department of Public Health (DPH), which supports the evaluation and planning of maternal health programs and policies.[28]

Interview Findings. Stakeholders agree that the data surrounding maternal mortality is lacking and lagging, often years behind once it is published to the public. Stakeholders also expressed concerns about limited transparency in the reestablished MMRC's membership and review process. Some stakeholders also questioned whether the current methodology for determining preventable deaths is as rigorous as was used by previous committees.

Recommendation 3. Georgia to continue to fund the Maternal Mortality Review Committee, Georgia Perinatal Quality Collaborative, and Maternal and Neonatal Center Designation Program.

Summary. This recommendation has been partially implemented. Georgia has made strategic investments in maternal health data infrastructure through initiatives such as the MMRC, Georgia Perinatal Quality Collaborative (GaPQC), and the Maternal and Neonatal Care Designation Program. However, stakeholders noted limited awareness of efforts to sustain funding for these programs.

Environmental Scan Findings. Over the past decade, Georgia has made strategic investments in maternal health, largely with support from federal funds, including maternal health quality improvement and oversight initiatives.[29] Since its establishment in 2014, the MMRC has completed reviews of maternal deaths from 2012 to 2021.[30] Prior to that, the Georgia Perinatal Quality Collaborative (GaPQC) was launched to implement strategies aimed at enhancing maternal and neonatal outcomes.[31] As of 2024, the CDC funds 36 state Perinatal Quality Collaboratives, including GaPQC.[32]

In 2017, Georgia became the thirteenth state to implement Alliance for Innovation in Maternal Health (AIM) bundles, supported by CDC funding. To further this effort, the Georgia General Assembly allocated $2 million in funding to help implement AIM bundles in rural hospitals.[33] (For additional information on the AIM bundle implementation, see Recommendation 4.) In 2018, House Bill (HB) 909 was enacted, establishing Georgia's Maternal and Neonatal Care Designation Program, which ensures appropriate levels of care for mothers and newborns.[34] Under this program, the Georgia DCH issues Certificates of Need for hospitals to provide care across four levels based on national clinical guidelines.[35]

Continued investment in the MMRC, GaPQC, and the Maternal and Neonatal Center Designation Program serve a critical role in identifying preventable causes of maternal mortality, promoting evidence-based clinical practices, and ensuring that birthing facilities meet high standards of care.

Interview Findings. While stakeholders were not aware of specific recommendations to sustain funding for key initiatives, they consistently emphasized the value of these programs. Many shared positive experiences participating in or collaborating with these efforts and highlighted their importance in improving maternal health outcomes across the state.

Recommendation 4. Implement the Alliance for Innovation in Maternal Health (AIM) bundles and other patient safety bundles in Georgia's birthing hospitals.

Summary. This recommendation has been fully implemented. Georgia has adopted multiple AIM bundles through the GaPQC, with strong participation from birthing hospitals and demonstrated improvements in maternal care practices. Implementation remains inconsistent across facilities, and stakeholders emphasized the need to expand AIM bundle adoption into community-based settings and ensure culturally responsive approaches.

Environmental Scan Findings. In 2017, the Georgia DPH applied to join the AIM, a national, data-driven quality improvement program that provides maternal patient safety bundles for hospitals to reduce maternal mortality and morbidity. In 2018, Georgia DPH and the GaPQC began inviting hospitals to implement AIM bundles.[36] GaPQC implemented the Obstetric Hemorrhage bundle in April 2018 and 45 of Georgia's 83 birthing hospitals currently participate.[37,38] GaPQC launched the Severe Hypertension bundle in June 2019 and there are currently 41 participating birthing hospitals.[39] In June 2022, GaPQC began implementing the AIM Cardiac Conditions in Obstetrical Care, making it the first state in the country to implement this bundle.[40]

Interview Findings. Stakeholders frequently cited the implementation and standardization of AIM bundles as a key strategy for improving maternal health. GaPQC was recognized for its leadership in promoting adoption of these patient safety bundles focused on obstetric hemorrhage and hypertension. Many birthing facilities exhibit

strong engagement through data reporting, training, and collaborative learning. However, the implementation of AIM bundles is inconsistent across hospital systems, largely due to differences in capacity and resources rather than the effectiveness of the bundles themselves. Stakeholders note a marked difference in outcomes between hospitals that have adopted AIM bundles and those that have not.

"I saw the difference between no AIM and AIM… the management of hemorrhage at the bedside with the AIM bundles implemented—we operated seamlessly between departments. We all understood because we had a shared language of what the process was and what role each of us played. It was night and day managing hemorrhage after those bundles were implemented."

In addition, stakeholders emphasized the importance of expanding AIM implementation beyond hospital settings. They advocated extending these safety bundles into community-based care settings, such as Federally Qualified Health Centers (FQHCs), community settings, and outpatient settings. To be effective, this community-centered approach also needs to integrate culturally responsive education, particularly to address the disparities faced by Black women, who are more likely to experience bias and discrimination in maternal healthcare.[41]

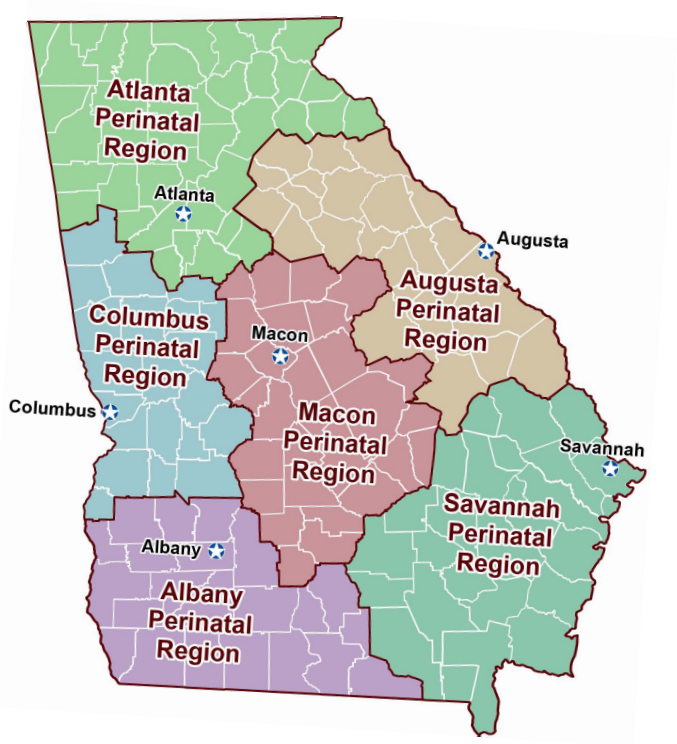
Recommendation 5. Promote the regional perinatal system for referral and treatment of high-risk pregnancies.

Summary. This recommendation has been partially implemented. Georgia established six Regional Perinatal Centers (RPCs) and continues to invest in regional coordination through updated guidelines and the creation for the Regional Perinatal Center Advisory Committee in 2025. However, stakeholders did not report direct engagement with RPCs, and highlighted the ongoing need for increased resources, particularly in rural areas.

Environmental Scan Findings. In 2009, Georgia divided the state into six perinatal regions, each with a Regional Perinatal Center (RPC): Albany, Atlanta, Augusta, Columbia, Macon, and Savannah. This initiative, funded by the Georgia DPH, coordinates access to needed maternal, fetal, neonatal, and infant care.[43] RPCs serve as a hub for coordinating and delivering maternal healthcare and filling gaps left by shuttered hospitals.[44] In 2017, the Georgia DPH updated the guidelines for perinatal level designations.[45] In 2025, Georgia HB 89 was passed, creating the Regional Perinatal Center Advisory Committee, which helps to ensure hospitals and doctors have the needed resources for caring for high-risk pregnancies and births.[46]

Interview Findings. Stakeholders highlighted the need for increased resources for rural areas, but did not report using the RPCs.

Georgia Regional Perinatal Center Regions[42]



Recommendation 6. Provide case management and care coordination for pregnant and postpartum women, particularly high-risk women.

Summary. This recommendation has been partially implemented. Georgia has taken steps to improve care coordination through initiatives such as the voluntary Medicaid Perinatal Case Management program and the establishment of the Regional Perinatal Center Advisory Committee. However, the absence of a standardized care coordination model, limited integration of health information systems, and inconsistent awareness of available resources continue to represent barriers for postpartum individuals navigating medical and social services.

Environmental Scan Findings. The need for a more integrated and equitable system is underscored by the absence of a standardized care coordination model across providers. The Georgia House Committee on Public and Community Health has acknowledged these gaps and established a Regional Perinatal Center Advisory Committee to improve coordination and referral pathways for high-risk pregnancies. [47] While some clinicians benefit from robust referral networks, others lack awareness of available resources or face barriers navigating the states' eligibility system, particularly when using online platforms. However, Georgia offers a voluntary Perinatal Case Management program for pregnant women enrolled in Medicaid, where case managers are assigned to help expectant mothers access tailored services for medical and social needs.[48] Additionally, while there is limited documentation on state integration of Electronic Health Records (EHRs) and Health Information Exchanges (HIEs) for maternal care coordination, Georgia has been working to improve interoperability through the Georgia Health Information Network (GaHIN), which facilitates health data sharing among providers.[49]

> **"I have patients who, if they do their application, if they find out that they're pregnant, try to do their eligibility online. It may or may not work. If you go in person, you get approval, presumptive approval right away, and you can go ahead and make your appointment, and they give you a temporary card. I've had to call the state".**

Interview Findings. Stakeholders agree there is a need for case management and care coordination for postpartum mothers to connect them to healthcare and social service resources. One stakeholder noted that they have had to support patients enrolling in social services such as WIC and even called the state when their eligibility was cancelled in error, underscoring the need for case management. Some stakeholders highlighted the home visiting pilot program as a success related to supporting patients beyond medical needs. To learn more about the home visiting pilot program, see Recommendation 12.

Recommendation 7. Improve strategies for identifying maternal deaths, including mandated autopsies for pregnancy-associated deaths.

Summary. This recommendation has been partially implemented. In 2022, Georgia mandated autopsies for pregnancy-associated deaths. However, full implementation has been hindered by a lack of dedicated funding for autopsies and ongoing logistical confusion regarding responsibility for conducting them.

Environmental Scan Findings. Effective July 1, 2022, Georgia enacted a law requiring medical examiners to investigate the deaths of individuals who are pregnant or die within one year postpartum. This aligns with MMRC recommendation to enhance surveillance and improve the accuracy of maternal mortality data. While the law aims to ensure comprehensive review of maternal deaths to identify preventable causes, it was implemented without dedicated funding or a system to track compliance, raising concerns about its effectiveness.[50]

In 2025, HB 89 was passed and simplified the process for investigating pregnancy-related deaths. The new law granted the MMRC access to mental health and pharmacy records, further supporting its data review efforts.[51]

Interview Findings. Stakeholders generally view the legislation as a positive step. However, they expressed concern over the lack of funding for autopsies, which often leaves families to bear the cost. One stakeholder noted that qualifying cases still go without state-mandated autopsies, with families paying out of pocket to determine the cause of death.

Additional challenges include logistical confusion within the Georgia Bureau of Investigation, including who is responsible for conducting autopsies and under what circumstances. These operational gaps have hindered the law's full execution and delayed its intended impact.

Stakeholders also highlighted a lack of clear communication, oversight, and evaluation mechanisms to monitor the implementation of laws, raising concerns about accountability and the ability to effectively learn from maternal death data.

Recommendation 8. Evaluate the effectiveness of and make updates to the death certificate to identify maternal mortality cases.

Summary. This recommendation has been partially implemented. Georgia requires reporting of maternal deaths through death certificates and has linked these with other vital records to improve surveillance. However, full implementation is limited by inconsistent use of the pregnancy checkbox, vague cause-of-death reporting, and unclear responsibilities for conducting autopsies.

Environmental Scan Findings. In Georgia, deaths are identified by the Georgia DPH using data from death certificates, as required by mandated reporting. Death certificates are linked with other vital records, including birth and fetal death certificates, to improve the quality and completeness of maternal mortality data.[52]

A significant advancement came with the amendment of Georgia Code 31-2A-16, which mandates investigations into maternal deaths. Under this law, all healthcare providers are legally required to report the death of a woman within one year of pregnancy regardless of cause using the State Electronic Notifiable Disease Surveillance System.[53] While this mandate was designed to hold providers accountable and improve maternal health data tracking, several challenges persist including inconsistent use of the pregnancy checkbox, vague or incomplete cause-of-death reporting, and unclear responsibilities regarding who conducts autopsies.[54]

Interview Findings. Stakeholders did not report any updates or share specific information related to the use of death certificates for identifying maternal mortality cases.

Recommendation 9. Fund a perinatal psychiatry inpatient program in a future legislative session.

Summary. This recommendation has not been implemented. However, the DPH-funded PEACE (Perinatal Psychiatry, Education, Access, and Community Engagement) for Moms is a perinatal psychiatry access program in the state that supports maternal mental health, particularly in rural communities. Stakeholders praised PEACE for Moms but noted limited awareness among providers and confusion around referral pathways and insurance coverage, especially for inpatient services.

Environmental Scan Findings. Currently, there is no established model for state-wide perinatal psychiatry inpatient programs. However, Georgia has established PEACE (Perinatal Psychiatry, Education, Access, and Community Engagement) - a Perinatal Psychiatry Access Program funded through the Georgia DPH and operated by Emory University School of Medicine.[55] Launched in 2021, this program aims to expand and build the capacity of healthcare providers to address perinatal mental health and substance use disorders. By offering access to

expert mental healthcare consultation and support, the program helps clinicians across Georgia better identify and manage perinatal mental health needs. The program helps address the gaps caused by a lack of access to medical, mental health, and postpartum care across the state.[56]

Interview Findings. Interviewed stakeholders spoke positively of PEACE for Moms. One stakeholder shared that the program enabled them to support a patient experiencing mental health challenges in a rural community. Several stakeholders noted the need to increase awareness of PEACE for Moms among providers. Clinicians reported confusion and a lack of clarity around referral pathways and insurance coverage, particularly when it comes to providing inpatient perinatal psychiatric care. As one stakeholder explained, *"What we're hearing from [providers] is okay, I'll screen. I'll do the coding, but I don't have a referral pathway. There's nowhere to send them, or their insurance isn't going to cover a specialist, or there isn't inpatient perinatal psychiatry oftentimes."* Although only a limited number of hospitals in Georgia offer inpatient psychiatric services, there is a broader network of organizations providing outpatient mental health support. The lack of clarity around referral pathways for perinatal psychiatry and insurance coverage underscores the need for a more coordinated and sufficiently funded system of care.

Georgia's PEACE for Moms (Perinatal Psychiatry, Education, Access, and Community Engagement) provides free consultative psychiatric services to healthcare professionals to help them address the mental health needs of pregnant and postpartum patients.

Stakeholders emphasized the value of collaborating with coalitions such as the Georgia Mental Health Policy Partnership, led by National Alliance for Mental Illness Georgia chapter, which has been instrumental in advancing legislation to support mental health integration within perinatal care. Such partnerships offer a strategic opportunity to engage clinicians and build a more robust, integrated perinatal mental health workforce.

Recommendation 10. Streamline the process for eligible pregnant women to enroll in the Women, Infants, and Children (WIC) program.

Summary. This recommendation has been partially implemented. While Georgia has made progress – such as transitioning to electronic benefits and installing self-service kiosks – stakeholders report that the online enrollment system remains unreliable. While the intent to streamline enrollment is evident, implementation is fragmented, and both execution and accessibility remain inconsistent.

Environmental Scan Findings. The Special Supplemental Nutrition program for Women, Infants, and Children (WIC) is a federally funded program, administered by states. WIC provides nutritional support and health referrals to pregnant and postpartum women, infants, and children.[58]

In Georgia, like many other states, there is a gap between WIC eligibility and actual enrollment. Although individuals enrolled in Medicaid, Supplemental Nutrition Assistance Program (SNAP), and the Temporary Assistance for Needy Family (TANF) are automatically eligible for WIC, many do not participate. For example, in 2023, 4 out of every 10 pregnant people with Medicaid in the U.S. were enrolled in WIC, highlighting a need for better integration across programs.[59]

In 2022, only 40.6% of eligible Georgians were enrolled in WIC, compared to the national average of 53.5%.[57]

In 2022, Georgia was the last state to transition from paper vouchers to electronic WIC benefits. This change has led to an 8% increase in enrollment over the past three years.[60]

In 2016, Georgia received $430,124 from the U.S. Department of Agriculture's (USDA) Food and Nutrition Service to help improve child retention in WIC. This funding supported a pilot partnership with Head Start and Early Head Start programs in three targeted health districts.[61] However, no evaluation or outcome data from this initiative could be identified, limiting insights into its effectiveness.

To improve access, the Georgia Department of Human Services partnered with the Georgia Public Library System in 2024 to install self-service kiosks in some public libraries. Funded by the USDA, these kiosks aim to expand access to the Georgia Gateway—the state's integrated benefits portal—particularly in rural areas with limited home internet connectivity.[62] Despite these efforts, the implementation of improving digital access and streamlining enrollment remains inconsistent. There is limited evidence of systematic monitoring and evaluation to assess the effectiveness of these initiatives, making it difficult to determine their long-term impact or scalability.

Interview Findings. Stakeholder interviews revealed persistent confusion and inconsistency in the implementation of WIC and Medicaid enrollment improvements, particularly for postpartum women. While in-person applications often result in presumptive eligibility and immediate issuance of temporary benefits, the online process through Georgia Gateway is frequently described as unreliable, and difficult to navigate. One stakeholder referred to the system as a "black hole" citing unresolved technical issues and a lack of communication or follow-up. These challenges are especially pronounced in rural healthcare settings, where digital access is limited and support resources are scarce.

Recommendation 11. Encourage the Georgia Department of Public Health to develop a model for county health departments that includes prenatal and postpartum onsite care as well as telehealth services.

Summary. This recommendation has been partially implemented. However, stakeholders described initiatives that utilize telehealth, such as remote fetal-medicine programs and the *Mom Heart Matters* program. While there is no formal statewide model systematically implemented across public health departments, stakeholders did identify promising practices emerging at the local level. These efforts suggest some progress through community-driven solutions, even in the absence of a formal statewide model.

Environmental Scan Findings. Counties play a critical role in improving maternal health outcomes, particularly through the integration of innovative care models.[63] In Georgia, 93 rural counties lack a hospital with a labor and delivery unit and two-thirds of rural births in Georgia occur outside of the mother's home county, underscoring the importance of telehealth services in rural areas.[64] The research team did not identify a state-developed model that can be implemented by county health departments for maternal health. However, CMS announced the fifteen states selected to participate in the Transforming Maternal Health (TMaH) Model. Georgia is not one of the participating states, but neighboring states such as Alabama and South Carolina are participants. The model will run for ten years and focuses on three pillars: access to care, infrastructure, and workforce capacity, quality improvement and safety, and whole-person care delivery. Although Georgia is not participating, the state and its counties may benefit from lessons learned once the model is underway.[65]

Interview Findings. Stakeholders did not identify any county-based models but highlighted the value of telehealth in enhancing prenatal and postpartum care. One promising example is a maternal-fetal medicine program in which providers specializing in maternal fetal medicine deliver high-risk obstetrics consultations, teleradiology ultrasounds, and provider training demonstrating how telemedicine can support county-level partnerships and infrastructure to improve care delivery.

Another stakeholder described *Mom Heart Matters* a program launched in February 2024 at the Liberty Regional Medical Center in Hinesville, Georgia designed to reduce the disproportionally high hypertension related morbidity and mortality rates among women of color. The program uses a web-based platform for real-time blood pressure monitoring, enabling timely clinical interventions, and incorporates mental health screening tools like the PHQ-9

and the Barkin Index of Maternal Functioning to support early detection of postpartum depression and promote personalized care.[66]

Recommendation 12. Continue to fund and support women's healthcare systems and workforce including doulas, home visit programs, medical education programs at the state medical schools, and expanding EMS to reduce the incidence of EMS delay.

Summary. This recommendation has been partially implemented. Georgia has taken meaningful steps to address maternal health workforce shortages through initiatives like the Healthy Babies Act, expansion of the maternal home visiting pilot, and tax incentives for rural providers. However, significant gaps remain with many counties still lacking obstetrics services, and efforts to expand the workforce through midwifery legislation have stalled.

Environmental Scan Findings. Georgia continues to face significant maternal health workforce shortages, with 35% of counties lacking an obstetric provider and 75% without a hospital offering obstetric or birthing services. The state has passed several bills aimed at strengthening the women's health workforce. One notable initiative is the 2023 Healthy Babies Act, which allocated $1.7 million to Georgia DPH to launch a pilot home visiting program to underserved individuals in rural counties.[67] This program deploys public health nurses and community health workers to assess maternal health between physicians' visits, and provide education and social support for mothers related to postpartum disorders, hypertension awareness, and other family planning resources. Although no formal evaluation has been conducted, the program has been expanded based on its initial success. The FY 2026 Georgia budget includes a $2.98 million increase to expand the pilot from 50 to 75 total counties and $778,239 increase to expand access to maternal fetal medicine by supporting cardiac obstetric care.

> **"Community-based doulas… not only for the informational, emotional, and physical support that they provide—but I would also say for the buffering that they can provide for when patients or clients encounter bias or discrimination… doulas can be that translator in the room, that extra voice of advocacy for mom, and the birthing partner as well."**

In 2024, HB 82 was signed, which makes rural providers eligible for a tax credit of up to $5,000 annually for up to five years, for each year a physician practices in a rural community.[68] However, not all legislative proposals to enhance the health workforce were passed into law. For instance, HB 684, which would have established a Certified Community Midwife Board to support licensure and regulation of midwives, aimed to address these gaps but ultimately failed to pass.[69]

Additionally, in 2019, the Morehouse School of Medicine Center for Maternal Health Equity was created, with funding from the Georgia state legislature to address the rates of maternal mortality and morbidities among Black women in the state.[70]

Despite these investments, access to care remains a challenge for Medicaid beneficiaries, as many providers in Georgia cite the low Medicaid reimbursement rates as a primary reason for not accepting Medicaid patients.[71]

Interview Findings. The importance of continued investment in the women's healthcare workforce was a recurring theme across interviews, with particular emphasis on programs that support the inclusion of doulas as part of community-based workforce development. Stakeholders highlighted the success of the maternal home visiting pilot program, noting its positive impact on maternal health in rural areas.

While doulas are not viewed as a universal solution to improving maternal outcomes, they are seen as a critical component of comprehensive care. One interviewee cited Wellstar Health System as a model for doula integration, describing a program that is run in-house, where *"you go to your prenatal visits and your doula is in the same place."* This underscores the need not only for funding doula services but also for embedding them within

broader, coordinated care systems. Integrating doulas into labor and delivery also presents an opportunity to enhance their financial stability and ensure fair compensation for their contributions.

Recommendation 13. Increase Medicaid provider reimbursement and coverage of psychotherapy services for adults.

Summary. This recommendation has not been implemented. However, Georgia has taken steps to strengthen the behavioral health system through the establishment of the Behavioral Health Reform and Innovation Commission and the passage of the Mental Health Parity Act. Stakeholders continue to advocate for increased Medicaid reimbursement for psychotherapy and improved provider awareness of existing mental health resources.

Environmental Scan Findings. Georgia has not made recent changes to the Medicaid coverage of psychotherapy for adults. However, in 2019, the state established the Behavioral Health Reform and Innovation Commission, comprised of 24 appointed members tasked with conducting a comprehensive review of Georgia's behavioral health system. The commission released its first report in 2020 which informed the passage of the Mental Health Parity Act. This legislation enacts several of the commission's recommendations and strengthens enforcement of federal mental health parity legislation.[72] Notably, the Act requires Medicaid plans to spend at least 85% of their revenue directly on services for members.[73]

Interview Findings. Stakeholders emphasized the need for increased reimbursement for psychotherapy for Medicaid. A frequently mentioned resource was the PEACE for Moms program (See Recommendation 9). Additionally, stakeholders agreed on the importance of enhancing provider awareness of existing mental health resources alongside improving Medicaid reimbursement rates for behavioral health providers.

Recommendation 14. The correctional system should ensure adequate medical care for pregnant and postpartum patients.

Summary. This recommendation has been partially implemented. Although Georgia passed a 2019 law banning the shackling of incarcerated pregnant women in later trimesters, lack of funding, stalled legislative efforts, and limited indications of changes signal that comprehensive maternal care in correctional settings remains insufficient.

Environmental Scan Findings. Each year, an estimated 50-100 women give birth while incarcerated in Georgia, yet current policies and practices fall short of ensuring adequate maternal care in correctional facilities. Although Georgia passed a 2019 law banning the shackling of pregnant women in their second and third trimesters, the lack of funding for training correctional officers and hospital staff has hindered its implementation.[74] Legislative efforts to expand protections, such as pregnancy testing at intake, delaying sentencing for postpartum women, and supporting breastfeeding have stalled or failed.[75] Like many states, Georgia does not allocate funds to educate correctional officers on caring for pregnant women, and correctional facilities lack the resources to adequately update hospital staff on the new laws, which limit their impact.[76]

Interview Findings. Stakeholders were largely unaware of any implemented changes related to this recommendation.

Recommendation 15. Ensure Adequate Medicaid Reimbursement to Allow Providers to Continue Offering Long-Acting Reversible Contraceptives (LARCs).

Summary. This recommendation has been partially implemented. In 2015, Georgia Medicaid introduced a policy to reimburse FQHCs and Rural Health Clinics (RHCs) for LARC devices and insertion services outside of the standard rate, effectively increasing reimbursement for these services. However, the stakeholders interviewed were unaware of ongoing efforts to further increase LARC reimbursement rates, suggesting increases in reimbursement have not been broadly implemented since the 2015 policy.

Environmental Scan Findings. Medicaid is the primary insurance option for about one third of low-income women of reproductive age. [77] In Georgia, a significant number of low-income individuals receive healthcare from FQHCs and RHCs. Per federal law, Medicaid reimburses these clinics using the Prospective Payment System (PPS) rates, which are minimum reimbursement rates for clinic visits for Medicaid fee-for-service (FFS) beneficiaries. The PPS rate does not include costs for long-acting reversible contraceptive (LARC) costs. Increased access to and use of effective contraception methods, such as LARCs, is important to improving maternal health outcomes. [78] LARCs include intrauterine devices (IUD) and the birth control implant. Increased use of highly effective contraceptive methods, such as LARCs, have been linked to reduced number of unplanned pregnancies and increased length of time between births, both of which have significant impacts on maternal health.[79]

In 2015, Georgia Medicaid, with authority from an approved Medicaid SPA, implemented a policy that reimburses FQHCs and RHCs for the cost of LARC devices outside of the PPS rate and provides separate FFS reimbursement to hospital-based providers in FQHC and RHC settings for LARC insertion.[80] This change aimed to incentivize providers to offer LARCs, since the previous utilization rate was low and the rate was considered insufficient to cover the cost of LARC services. Following this "unbundling" change, the LARC utilization rate increased from 1.2% of Medicaid enrolled women of reproductive age receiving LARCs at FQHCs or RHCs in 2015 to 1.7% in 2018. The LARC policy reform change was largely successful due to strong support from policy champions and key stakeholders. This reform was led by the Georgia Obstetrics and Gynecology (OB/GYN) Society with support from the Georgia DPH and the Association of State and Territorial Health Officials.[81]

Interview Findings. Interviewed stakeholders were not aware of policy or advocacy efforts aimed at increasing the LARC reimbursement rate.

Key Takeaways

Summary

The implementation status of each recommendation based on the research team's analysis and synthesis of available information is summarized below in Table 1.

Table 1. Implementation Status of Maternal Health Recommendations

#	Recommendation	Implementation Status
1	Extend Medicaid coverage for eligible pregnant women to one year postpartum.	Fully implemented
2	Encourage and support the collection and analysis of pregnancy and postpartum data that can be used to inform and guide fiscal policy and program decisions at the state level.	Partially implemented
3	Georgia to continue to fund the Maternal Mortality Review Committee, Georgia Perinatal Quality Collaborative, and Maternal and Neonatal Center Designation Program.	Partially implemented

#	Recommendation	Implementation Status
4	Implement the Alliance for Innovation in Maternal Health (AIM) bundles and other patient safety bundles in Georgia's birthing hospitals.	Fully implemented
5	Promote the regional perinatal system for referral and treatment of high-risk pregnancies.	Partially implemented
6	Provide case management and care coordination for pregnant and postpartum women, particularly high-risk women.	Partially implemented
7	Improve strategies for identifying maternal deaths, including mandated autopsies for pregnancy-associated deaths.	Partially implemented
8	Evaluate the effectiveness of and make updates to the death certificate to identify maternal mortality cases.	Partially implemented
9	Fund a perinatal psychiatry inpatient program in a future legislative session.	Not implemented
10	Streamline the process for eligible pregnant women to enroll in the Women, Infants, and Children (WIC) program.	Partially implemented
11	Encourage the Georgia Department of Public Health to develop a model for county health departments that includes prenatal and postpartum onsite care as well as telehealth services.	Partially implemented
12	Continue to fund and support women's healthcare systems and workforce including doulas, home visit programs, medical education programs at the state medical schools, and expanding EMS to reduce the incidence of EMS delay.	Partially implemented
13	Increase Medicaid provider reimbursement and coverage of psychotherapy services for adults.	Not implemented
14	The correctional system should ensure adequate medical care for pregnant and postpartum patients.	Partially implemented
15	Ensure Adequate Medicaid Reimbursement to Allow Providers to Continue Offering Long-Acting Reversible Contraceptives (LARCs).	Partially implemented

Accomplishments

Findings from this retrospective analysis show that Georgia has made significant strides in maternal health through targeted policy and system-level reforms.

Key accomplishments include:

- **Extended Medicaid postpartum coverage** for mothers from 60 days to 6 months and currently now at 12 months postpartum.
- **Implementation of the AIM safety bundle** in hospitals across the state, improving clinical practices and reducing preventable maternal complications.
- **Establishment of the Regional Perinatal Center Advisory Committee and Morehouse College of Medicine Center for Maternal Health Equity,** both supported by state funding.
- **Passage of legislation mandating autopsies for pregnancy-associated deaths**, enhancing data collection and accountability in maternal health reviews.
- **Protections for pregnant incarcerated women,** including banning the shackling of pregnant women in their second and third trimesters.

- **"Unbundling" reimbursement for LARCs** at FQHCs and RHCs, increasing access to effective contraception for Medicaid-enrolled women.
- **Support for incremental improvements to WIC benefits,** transitioning from paper vouchers to electronic benefits cards for a more convenient member experience.
- **Launch and expansion of the maternal home visiting pilot program,** providing critical support to families during pregnancy and early childhood.
- **Establishment of the Behavioral Health Reform and Innovation Commission** and the passage of the Georgia Mental Health Parity Act.

Lessons Learned

Through some of these efforts, particularly the early adoption of AIM bundles, Georgia has achieved notable progress in maternal health innovation. Much of the state's accomplishments can be attributed to several key facilitators:

- **Strong cross-sector collaboration** among stakeholders, advocates, healthcare providers, and policymakers, which enabled coordinated action and policy alignment.
- **Legislative advances and allocation of state resources**, which support the necessary infrastructure and funding to launch and sustain impactful initiatives.
- **Commitment to equity**, as demonstrated by the establishment of institutions like the Morehouse College of Medicine Center for Maternal Health Equity.
- **Data-driven decision-making**, including the use of maternal mortality review findings to inform policy and practice.

These facilitators were instrumental in driving the process Georgia has achieved over the past decade. However, alongside these successes, several persistent challenges emerged that hinder improvements in maternal health, which are discussed below.

- **Persistent workforce shortages**, particularly in rural communities, continue to challenge maternal health efforts. These shortages limit access to timely, high-quality maternal care and can compromise the sustainability of recent gains. Addressing this issue is a high priority. Promising innovations such as the PEACE for Moms program, which expands access to perinatal mental health consultation, and the remote fetal monitoring program, which enhances prenatal care delivery in underserved areas, demonstrate how technology and collaboration can help bridge workforce gaps.
- **Insufficient funding** remains a significant barrier to full implementation of maternal health initiatives in Georgia. While Georgia has made notable strides, limited financial resources have hindered the comprehensive execution of several key recommendations. For example, the partial implementation of mandated autopsies for pregnancy-related deaths illustrates how underfunding hinders the effectiveness of enacted policies. Moving forward, Georgia can prioritize sustained and strategic investment to ensure that maternal health reforms are fully realized and equitably delivered across the state.
- NORC came across several instances of **communication gaps** – between the state and healthcare providers, the state and the public (including those eligible for benefits and services), and between the MMRC and service providers. These gaps have hindered the effective dissemination of critical information, including implications of newly enacted legislation as well as updates on maternal health programs and benefits available to individuals. To address gaps, Georgia can invest in robust, targeted communication strategies that reach key audiences with timely, accessible, and actional information. Strengthening these channels is essential to ensure systems changes translate into real-world impact.
- Several interventions highlighted in this report **lacked built-in evaluation components to track their effectiveness and impact**. For policy and programmatic changes to maximize effectiveness and

scalability, they should be designed with sustainability and continuous improvement in mind. This includes incorporating robust evaluation frameworks from the outset to assess outcomes, identifying areas for refinement, and informing future expansion. Without evaluation, it becomes difficult to determine what works, for whom, and under what conditions.

Additional Considerations

These lessons learned can provide insight on how to improve maternal health vitality within the state. In addition, through environmental scan and key informant interviews with stakeholders, there emerged specific considerations that Georgia's leaders can activate to strengthen facilitators and/or to minimize barriers for successful implementation of identified strategies:

- **Expand culturally responsive perinatal education** throughout the continuum of education to equip current and future healthcare providers with the knowledge and skills needed to deliver equitable, effective, respectful, and culturally responsive care.
- **Enhance and integrate data systems** to reduce fragmentation and enable more comprehensive storytelling around care delivery and outcomes, particularly in community-based settings.
- **Strengthen collaboration among community-based providers,** including doulas, perinatal community health workers, and peer navigators to build a more cohesive and multidisciplinary maternal health workforce.
- **Adopt patient-centered, technology-enabled maternal care models**, to ensure more equitable, accessible, and coordinated care for pregnant and postpartum women, especially in underserved and rural communities.

Conclusion

Over the last ten years, Georgia has made significant progress in improving maternal health through a combination of policy reforms, innovative programs, and cross-sector collaboration. Key achievements, such as extending postpartum Medicaid coverage and implementing AIM safety bundles have positioned Georgia as making notable progress in areas of maternal health. Persistent challenges, however, underscore the need for continued investment and strategic planning. Stakeholder insights further emphasize the importance of culturally responsive education, integrated data systems, community-based collaboration, and technology-enabled care models.

One of Georgia's unique benefits is the existence of an already well-informed, comprehensive set of recommendations to improve maternal health that emerged from the work of both the MMRC and the Study Committee. Together, these recommendations offer a valuable and informative blueprint that maximizes the wide reach and ongoing progress of accomplishments already achieved, as well as how to initiate steps forward in implementing those recommendations that are yet to be fully realized in practice.

As Georgia looks to the next ten years, the path forward must be informed by the lessons of the past: prioritize sustainability, center equity, and foster collaboration. With intentional action and continued partnership, Georgia can continue to build a maternal health system that meets that needs of all Georgians.

Acknowledgements

The research team extends sincere gratitude to all the stakeholders who generously shared their time, insights, and experiences through interviews. Your contributions were invaluable in shaping the findings and recommendations of this report, and your continued commitment to improving maternal health in Georgia is deeply appreciated.

The team likewise extends its thanks to Georgia Health Initiative for commissioning this important research and for working alongside our team from ideation to publication of this report—all in service of its vision of a Georgia where all have the opportunity to attain their fullest potential for health.

Appendix

Research Methodology

This section details the research methodology, including research questions, comparative analysis, environmental scan, interviews, and analysis.

Research Questions

The following research questions were developed in consultation with the Initiative to facilitate this work:

1. Over the last ten years, which Georgia Maternal Mortality Review Committee (MMRC) and Georgia House of Representatives Study Committee on Maternal Health ("Study Committee") recommendations have been implemented?
    a. What mechanisms have been/are being used to monitor implementation of recommendations? Is there evidence of effectiveness?
    b. Was an appropriation tied to the recommendation implementation?
    c. How has the implementation of recommendations been shared with key stakeholders?
2. What other states and hospital systems have implemented similar recommendations to those of the MMRC and Committee?
    a. Has the implementation of similar recommendations in other states been evaluated? If yes, what were the findings?
3. What are the lessons learned and promising practices of the MMRC and Study Committee recommendations?
4. What are the underlying reasons or conditions that contribute to the delay in implementation of the remaining MMRC and Study Committee recommendations?

Comparative Analysis

The NORC team developed a data extraction tool in Microsoft excel to identify overlapping or related recommendations from several publications. In cases where recommendations were similar but not identical, they were consolidated to avoid duplication. The team extracted recommendations from the following sources:

- Maternal Mortality 2019-2021 Case Review
- Maternal Mortality Report and Fact Sheet 2018-2020
- Maternal Mortality Fact Sheet 2015-2017 Data
- Maternal Mortality Factsheet 2012-2016 Data
- Maternal Mortality 2014 Case Review
- Maternal Mortality 2013 Case Review
- Maternal Mortality 2012 Case Review
- Study Committee on Maternal Mortality Report (2019)

This process produced a master list of 34 recommendations to inform the environmental scan and stakeholder interviews. Below is the list of the 34 identified recommendations from the MMRC and Study Committee publications.

1. Extend Medicaid coverage for eligible pregnant women to one year postpartum.
2. Ensure adequate Medicaid reimbursement to allow providers to continue offering long-acting reversible contraceptives LARCs.
3. Fund a perinatal psychiatry inpatient program at the next legislative session.
4. Streamline the process for eligible pregnant women enrolled in the WIC Program.
5. Continue to fund the Maternal Mortality Review Committee, Georgia Perinatal Quality Collaborative, maternal and Neonatal Center Designation Program.
6. Encourage the Georgia Department of Public Health to develop a model for prenatal care county health departments that include prenatal and postpartum onsite care as well as telehealth services.
7. Implement the Alliance for Innovation in Maternal Health (AIM) bundle and other patient safety bundles in Georgia's birthing hospitals
8. Continue to fund and support women's health care systems and workforce including doulas, home visit programs, medical education programs at the state medical schools, and expanding emergency medical services to reduce the incidence of EMS delay.
9. Increase Medicaid coverage amounts for psychotherapy for adults.
10. Regulate laws for waiting period for firearm purchase and require physician evaluation prior to gun purchase for individuals with prior mental health hospitalization.
11. Conduct pre-pregnancy and contraception counseling and education.
12. Refer individuals to community-based services such as mental health and domestic violence services.
13. Educate and engage family members on topics such as postpartum depression, warning signs, and how to respond to life threatening situations post-partum.
14. Check blood pressure at 72 hours after discharge when patients have pre-eclampsia.
15. Provide case management and care coordination for pregnant and postpartum women, particularly high-risk patients.
16. Screen pregnant and postpartum women for mental health disorders and suicide risk.
17. Consult perinatal psychiatrists, closely monitor patients, and ensure access to mental health care for patients with mental health conditions.
18. Develop and implement institution-wide, survivor centered, trauma informed protocols for assessing and responding to intimate partner violence.
19. Provide health education to patients.

20. Providers should conduct a complete medical history including height, weight, pre-pregnancy weight, and body mass index (BMI).
21. Improve strategies for identifying maternal deaths, including mandated autopsy for pregnancy-associated deaths.
22. Evaluate the effectiveness of and make updates to the death certificate to identify maternal mortality cases.
23. Public health campaigns on various women's health topics including LARCs and perinatal mental health conditions
24. Provide health education in schools.
25. Communities should ensure access to culturally responsive services and support resources for survivors of intimate partner violence.
26. The correctional system should ensure adequate medical care for pregnant and postpartum patients.
27. Community based organizations and care settings should offer peer support groups for individuals with mental health conditions.
28. Expand telemedicine services and provide incentives for providing it.
29. Encourage hospitals and physicians to consider the use of FDA-regulated technology to monitor real time blood loss in deliveries to detect and avoid hemorrhages and encourage all hospitals to have a hemorrhaging bundle cart and explore ways to assist small hospitals with cost of training.
30. Encourage continued research on racial disparities, social determinants of health, and genetics to further understand and prevent maternal mortality.
31. Encourage hospitals and medical societies to provide training for physicians, nurses, or any healthcare personnel on racial sensitivity.
32. Support and encourage efforts to combat the obesity epidemic in Georgia, which contributes directly and indirectly to a broad range of co-morbid conditions that affect pregnancy outcomes, including hypertension and diabetes.
33. Encourage and support the collection and analysis of pregnancy and postpartum data that can be used to inform and guide fiscal policy and program decisions at the state level.
34. Promote regional perinatal system for referral and treatment of high-risk pregnancies.

Interviews

NORC conducted six virtual interviews with seven key stakeholders, identified in collaboration with the Initiative. Participating stakeholders comprised a diverse cohort of professionals with expertise in maternal health across the state of Georgia, including physicians, nurses, state legislators, government officials, and community advocates. Of the ten stakeholders contacted by the Initiative, seven participated. Table 1 contains information about each interview, including the role and position or the stakeholder and interview date.

Table 2. Interviewed Stakeholder Demographics

Interview #	Stakeholder Role/Position	Interview Date
1	Researcher, Healthcare provider	May 7, 2025
2	Legislator	June 2, 2025
3	State Agency Worker	May 21, 2025
4	State Agency Worker	May 21, 2025
5	Healthcare provider, Advocate	May 18, 2025
6	Advocate	June 5, 2025
7	Healthcare provider, Advocate	June 4, 2025

NORC scheduled and led the interviews, each of which included a trained lead interviewer and a notetaker. Prior to the interviews, stakeholders received a list of the fifteen priority recommendations to guide discussion. The interview guide and protocol were reviewed by the NORC Institutional Review Board (IRB), which determined the project qualified as Non-Human Subjects Research. Interview transcripts were imported into NVivo, a qualitative data analysis software, where the team developed a standardized codebook, completed coding, and summarized key themes and insights based on the coded data.

Environmental Scan

To support a retrospective analysis of maternal health efforts in Georgia, NORC conducted targeted searches of both gray and peer-reviewed literature. The search focused on materials published since January 1, 2015, that discuss the implementation, evaluation, and challenges of recommendations from Georgia's MMRC and the House Study Committee on Maternal Mortality. Searches were conducted using Google and key government and nonprofit websites, with specific search strings related to implementation, evaluation, funding, and barriers.

Only sources relevant to Georgia or comparable U.S. states were included, and results were screened for relevancy. Fifty sources were deemed relevant and saved to Zotero, reference management software, for further review. NORC used the following inclusion criteria:

- Published on or after January 1, 2015.
- Discusses implementation and successes (if applicable) of MMRC and House Study recommendations in Georgia or similar recommendations in other states.
- Addresses the underlying reasons for delays or lack of implementation of specific recommendations.

NORC conducted Google searches using the following search strings:

- (Georgia) AND (maternal mortality review committee) AND (recommendation) AND (implementation)
- (Georgia) AND (House of Representatives Committee on Maternal Health Study) AND (recommendation) AND (implementation)
- (Georgia) AND (maternal mortality review committee) AND (recommendation) AND (implementation) AND (evaluation)
- (Georgia) AND (House of Representatives Committee on Maternal Health Study) AND (recommendation) AND (implementation) AND (monitoring)
- (Georgia) AND (maternal mortality review committee AND (recommendation) AND (implementation) AND (appropriation)

- (Georgia) AND (maternal mortality review committee) AND (recommendation) AND (implementation) AND (partners)
- (Georgia) AND (maternal mortality review committee) AND (recommendation) AND (implementation) AND (stakeholders)
- (state) AND (maternal mortality review committee) AND (recommendation implementation)
- (state) AND (maternal mortality review committee) AND (recommendation) AND (evaluation)
- (Georgia) AND (maternal mortality review committee) AND (recommendation) AND (implementation) AND (lessons learned)
- (Georgia) AND (maternal mortality review committee) AND (recommendation) AND (implementation) AND (challenges)
- (Georgia) AND (maternal mortality review committee) AND (implementation delay)

The NORC team also searched (Georgia) AND (maternal health) on the following federal and state administrative office and research and advocacy organizations' websites:

- Federal and State Administrative Offices:
    - Centers for Disease Control and Prevention (CDC)
    - Centers for Medicare & Medicaid Services (CMS)
    - Georgia Department of Community Health (DCH)
    - Georgia Department of Public Health (DPH)
    - Health Resources and Services Administration (HRSA)
    - National Institutes of Health (NIH)
    - Office of the Assistant Secretary for Health (OASH) Office on Women's Health (OWH)
- Research and Advocacy Organizations:
    - American College of Obstetricians and Gynecologists
    - Black Mamas Matter Alliance
    - Center for Reproductive Rights
    - The Commonwealth Fund
    - Georgia Obstetrical and Gynecological Society
    - March of Dimes
    - Morehouse School of Medicine's Center for Maternal Health Equity
    - Healthy Mothers Healthy Babies Coalition of Georgia
    - National Health Law Program
    - National Partnership for Women & Families
    - KFF
    - Robert Wood Johnson Foundation
    - Urban Institute

Zotero searches were then imported into Covidence, a web-based software for streaming systematic reviews. In Covidence, NORC extracted key data from environmental scan documents to identify literature gaps and gather relevant content for the final report. Team members were assigned extractions using a standardized template aligned with the research questions and fifteen priority recommendations. NORC used data extracted from

Covidence to summarize findings in the report. Where gaps were identified, the team conducted targeted literature searches based on that recommendation. The following gaps were identified based on the general literature searches, resulting in additional targeted searches:

1. Limited Georgia-Specific Data: Many studies and reports provided national data, but there was a lack of detailed, Georgia-specific evidence on maternal health outcomes, workforce distribution, and program effectiveness.
2. Implementation and Impact of State Policies: While several policies have been enacted to improve maternal health, there was a lack of published evaluations or implementation studies assessing their real-world impact, barriers, and facilitators—particularly for initiatives like the AIM bundles or the Maternal and Neonatal Care Designation Program.
3. Stakeholder and Patient Perspectives: There was a noticeable gap in literature capturing the voices of patients, families, and frontline providers, particularly regarding their experiences with maternal health services, barriers to care, and perceptions of quality.
4. Health System Structure: The complexity of Georgia's health care system—marked by multiple funding sources, overlapping programs, and diverse administrative structures—posed significant challenges during the literature review. Maternal health data are often siloed across entities such as Medicaid, public health departments, hospital systems, and community-based organizations, each using different formats, timelines, and definitions. This fragmentation results in similar datasets being stored in various locations, making them difficult to locate, access, and synthesize for comprehensive analysis.

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