FACT SHEET

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Expand Access to Midwives for Virginia Moms

Problem: Currently, all midwives licensed in the state of Virginia (CNM/CM, CPM) are eligible for Medicaid reimbursement under Fee for Service Medicaid. However, the vast majority of Medicaid recipients are placed into Managed Care Organizations (MCOs), which offer more comprehensive wrap-around services. Contracting with individual MCO's is a major barrier for lower volume community practices. Most private midwifery practices do not accept Medicaid.

For the few midwifery practices that do accept Medicaid reimbursement under Fee For Service, the process for patients and providers is daunting. Patients must contact their individual MCO, have themselves removed from coverage and go back into Fee For Service Medicaid. This process can take months, requires a high level of health literacy and is resource heavy for patients, providers and the Virginia Department of Medical Assistance Services (DMAS).

Once removed from their MCO, patients lose the valuable services provided by their MCOs such as access to doulas, diapers, breast pump reimbursement, lactation and mental health services.

Research shows that integrating midwives into the maternity care system (including comprehensive insurance coverage) improves outcomes.[1] This is especially critical in rural areas experiencing obstetric service closures where a midwife might be the only option. Maternal mortality rates are higher in maternity care deserts.[2]

Policy solution: DMAS and the Virginia Department of Health (VDH) should convene a work group that brings stakeholders together to study barriers that prevent Virginia moms on Medicaid from accessing Cardinal Care with all midwives that are licensed by the state upon entry into care. VDH is included in the workgroup because midwives are a public health solution. **Include the voices of parents that struggle to access this care and midwives who serve impacted families in the work to expand coverage.**

Costs: None. Pregnant women are already covered by Cardinal Care. Integrating midwives lowers costs by improving outcomes and reducing cesarean section rates. This quality-improvement focused work should be a part of DMAS and VDH budget. Virginia's 2026 Budget must support a fully-functioning VDH and DMAS as integral to keep Virginia healthy.

Who benefits: When patients are unable to access care via their provider of choice and midwifery providers are unable to receive reimbursement due to credentialing and eligibility barriers, everyone loses. When midwives are able to receive reimbursement for services offered in the communities they live and serve, the midwifery workforce will grow.

[1] How Expanding the Role of Midwives in U.S. Health Care Could Help Address the Maternal Health Crisis, May 5, 2023. https://www.commonwealthfund.org/publications/issue-briefs/2023/may/expanding-role-midwives-address-maternal-health-crisis

[2] Atwani, Rula MD; Robbins, Lindsay MD, MPH; Saade, George MD; Kawakita, Tetsuya MD, MS. Association of Maternity Care Deserts With Maternal and Pregnancy-Related Mortality. Obstetrics & Gynecology 146(2):p 181-188, August 2025. | DOI: 10.1097/AOG.0000000000005976 https://journals.lww.com/greenjournal/fulltext/2025/08000/association_of_maternity_care_deserts_with.2.aspx

Kathryn Haines, Health Equity Manager, kathryn@virginiainterfaithcenter.org - Dec. 01, 2025

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Support Mom/Baby in Pregnancy with Substance Exposure

Problem: *Fear of a child protective services referral means Virginia moms do not seek prenatal care. This is a bill to encourage moms to enter prenatal care.*[1]*Early entry into prenatal care improves outcomes.*

Virginia's law currently implies child abuse when an infant is born affected by substance use or experiencing withdrawal symptoms. The language automatically links prenatal substance exposure with child abuse or neglect, even when the mother is engaged in medicated assisted treatment (MAT), or when the substance involved, such as cannabis, has been decriminalized. This punitive section of code refers solely to the child, ignoring the best practice method of supporting the mother/baby dyad. Substance use in the Virginia code does not have a uniform definition, which results in inconsistent implementation of this law. For example, community members report blanket cord-blood testing without informed consent, presumably due to the false belief that cord-blood testing is required to ensure compliance with the law. University of Virginia report on Charlottesville's Child Welfare System found that Black and multiracial children were overrepresented among referrals to CPS relative to the population[2].

The abuse/neglect classification discourages pregnant individuals from seeking prenatal care; treatment engagement reduces risk. Organizations like the American College of Obstetrics and Gynecology (ACOG) and the Centers for Disease Control (CDC) recommend avoiding labeling prenatal exposure as abuse/neglect by default and emphasize treatment access and family preservation. Public health experts and federal guidance (CAPTA) recommend a Plan of Safe Care approach, focusing on treatment and family support rather than punitive action.

Policy solution: Pass a bill that removes the automatic "abuse/neglect" label for all cases of prenatal substance exposure, requires full-informed consent for cord-blood testing, and considers the needs of the mother in addition to the child.

Costs: None. This code change should bring consistency to current implementation and end punitive referrals to CPS. Federal funding exists to support family-based care. Virginia should consider using Opiate Abatement funding to increase support for these services.

Who benefits: Amending this code section moves us closer to a code that reflects the worth and dignity of all persons. The absence of the mother in this code discounts the research that supporting the mother/baby dyad is evidence-based and best practice. When we explicitly work to support healthy moms and babies, we all benefit.

[1] https://www.pregnancyjusticeus.org/wp-content/uploads/2020/11/Understanding-CAPTA-and-State-Obligations_2020.pdf

[2] Charlottesville Child Welfare Study, 2018, Accessed Nov 2025 https://www.charlottesville.gov/DocumentCenter/View/817/Child-Welfare-Study-PDF

Kathryn Haines, Health Equity Manager, kathryn@virginiainterfaithcenter.org - Nov. 17, 2025

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Bias Reduction Training Licensing Criterion

Problem: Black women in Virginia continue to have two to three times higher rates of pregnancy-associated deaths compared with their white counterparts. In 2022, the rate was 138.1 for Black women and 50.6 for white women (per 100,000 live births).[1] **A recent look at Virginia data revealed that the infant death rate for *non-smoking* African-American mothers is three times the infant death rate for White American *smokers*.**[2] Virginia Pregnancy Risk Assessment Monitoring System (PRAMS) reported that 18% of women experienced discrimination or harassment as a result of their insurance or Medicaid status, 25% as a result of their race, ethnicity or culture, and 42% of women experienced discrimination or harassment due to their weight.[3] Studies show that when you control for education and income, racial disparities do not disappear, suggesting that bias plays a role. In one study, the wealthiest Black mothers had higher mortality rates than the poorest White mothers.[4]

Policy solution: To reduce the impact of bias in health care, Virginia must pass a bill to make evidence-based bias reduction training a criterion for licensing for health care professionals licensed by the Virginia Board of Medicine and the Board of Nursing. Bias can be both explicit (conscious) or implicit (unconscious). Unconscious bias is a bias (attitude or belief about a person or group that can affect judgement or behavior) that is present but not consciously held or recognized. It has long been identified as a factor contributing to lower health care quality for Black Americans. Numerous studies show implicit bias can impact patient safety and is directly correlated with lower quality of care.[5] High quality care is integral to improving maternal and infant mortality. The American Medical Association, the American Hospital Association, the Association of American Medical Colleges have urged the adoption of bias reduction training strategies such as unconscious bias and cultural competency. In recent longitudinal studies of bias reduction training, over 90% of healthcare providers reported that training: Improved their patient care. Enhanced patient encounters. Elevated the patient experience. Increased their confidence in caring for diverse populations.[6]

Costs: In 2024, the Department of Health Professions indicated that the Board of Medicine will need one new pay band 5 FTE at a cost of $140,750.

Who benefits: With passage of this bill, Virginia sends a strong message that VA Healthcare professionals are committed to equal treatment for all.

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[1] "2024 Virginia Maternal Morality Review Team Annual Report" Submitted February 20, 2025 to the Governor and the General Assembly per Code of Virginia, § 32.1-283.8.

[2] "Exploring Implicit Bias in Care Settings & the Respectful Maternal Care Model" Kenesha Barber, PhD and Lauren Kozlowski, MPH, MSW.

[3] Virginia PRAMS Facts-2021, https://www.vdh.virginia.gov/content/uploads/sites/67/2023/12/Virginia-PRAMS-Facts-2021.pdf

[4] National Bureau of Economic Research, Maternal and Infant Health Inequality: New Evidence from Linked Administrative Data, 2023. https://www.nber.org/system/files/working_papers/w30693/w30693.pdf

[5] Agency for Healthcare Research and Quality, (2024) Healthcare Worker Implicit Bias Training and Education, Rapid Review. https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/mhs-IV-rapid-response-implicit-bias.pdf

[6] "Learner-Reported Impact of the Dignity in Pregnancy & Childbirth Course: A Summary of Three Studies, Diversity Science Institute, 2024" https://www.humanitasinst.com/dipc-feedback

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Supporting Student Health and Achievement: RNs and APRNs

Problem: Despite the fact that every teacher knows that a sick child will struggle to learn, **the current lack of explicit state support for a Registered Nurse (RN) or an Advanced Practice Registered Nurse (APRN) in schools encourages the redirection of funding towards instruction and away from health.** To quote the former Surgeon General Joycelyn Elders, "You can't educate a child who isn't healthy, and you can't keep a child healthy who isn't educated." This is a bill to clarify that health, (physical and mental), and education go hand in hand and that certain licensed providers (RNs and APRNs) are critical to meet the current need.

The Virginia School Safety Audit Program[1] survey reveals mental health as a top concern for Virginia Schools. There is a youth mental health crisis and school nurses provide preventive help by recognizing early psychological distress.[2]

Today's school staff work with kids that have complex medical needs. An RN's scope of practice includes working to independently to assess, plan, and implement patient care. An RN can interpret medical records and write a plan of care for a health plan that is a part of a IEP/504. While few schools currently use APRNs, as more schools in health deserts build partnerships with local health care entities to create school-based health centers, it will be critical to expand access to a broader scope of care.

Policy solution: The At Risk Add On is an existing funding formula in the General Assembly budget designed to help the schools with the most need. The current formula does not explicitly address the physical and mental health of the student. To address this, pass a bill to add specific language about supporting a student's physical and mental health and add RNs/APRNs to the list of approved expenditures for the at-risk-add-on

Costs: None. This bill is permissive. Local school boards decide how to use their allotted funding. This gives explicit permission to use this funding to support school health.

Who benefits: Everyone. Access to providers that improve a student's physical and mental health and achievement will increase classroom and ultimately, community health. Our students are our future.

[1] https://www.dcjs.virginia.gov/virginia-center-school-and-campus-safety/virginia-school-safety-audit-program
[2] https://news.virginia.edu/content/theres-youth-mental-health-crisis-school-nurses-can-help

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Support paid sick days for all workers

Problem: Approximately 41 percent of private sector workers, **1.2 million workers in Virginia, have no paid sick days** or any paid time off (PTO). This creates a crisis for low-wage workers who must choose between taking a sick day for themselves or their children and getting paid. Workers who go to work sick endanger their co-workers, the public and the ability of the business to remain open.

Policy solution: Create a paid sick day standard to require all employers to provide five paid sick days (40 hours) each year for full-time workers that can be used for themselves or to care for sick children. Part-time employees could accrue fewer paid sick hours based on hours worked. PTO policies qualify as paid sick days.

Who benefits: Almost everyone benefits from a paid sick day standard, which is why 83 percent of Virginia registered voters support a policy proposal to provide paid sick days. Strong majorities of Democrats (96 percent, Independents (78 percent) and Republicans (72 percent) all support a paid sick day standard. Paid sick days help:

Workers and their families - When a worker takes 3.5 unpaid sick days, the average family loses a month's worth of groceries. Workers are forced to choose between feeding their families and caring for themselves or their children.

Schools - Parents who don't have paid sick days are more than twice as likely to send their children to school sick, than parents who have paid sick days. Sick children can't learn. Sick children spread germs to children and teachers.

Public health – Workers in low wage sectors are the least likely to have paid sick days. More than 80 percent of food industry workers and 75 percent of childcare workers have no paid sick days. More than half of all Norovirus outbreaks can be traced back to sick food service workers who were forced to choose between working sick and losing pay or their job. An October 2020 report in Health Affairs showed that the paid sick leave provision of the Families First Coronavirus Response Act (FFCRA) reduced the spread of coronavirus. Researchers called paid sick days "a highly effective tool to flatten the curve."

Businesses - Employers lose $160 billion annually in productivity due to "presenteeism" (the practice of coming to work despite illness or injury). Providing paid sick days results in reduced turnover – saving businesses money. The restaurant industry, which has a high turnover rate, found that implementing workplace benefits can reduce turnover by 50 percent.

People of color – In the US, about 38 percent of African Americans and 50 percent of Latinos do not have access to a single paid sick day. More than 25 percent of Latino households and 30 percent of African American households have no savings and cannot afford to take unpaid time off from work.

Can Virginia businesses afford paid sick days? Most Virginia businesses already provide paid sick days or PTO. The pandemic has made clear that businesses need a paid sick day policy. Fifteen states have already passed paid sick day standards and most of them rank higher than Virginia in overall health.

Sources: Family Values @ Work, National Partnership for Women & Families, United Health Foundation, U.S Bureau of Labor & Statistics, YouGov American poll

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November 2025

Support Paid Time to Care for All Workers

FACT SHEET

We all do better when everyone has the tools they need to be economically secure and have their hard work respected. Paid Sick Days (PSD) and Paid Family & Medical Leave (PFML) both ensure that hardworking people have paid time to care—**they're two sides of the same coin.**

	PAID SICK DAYS	PAID FAMILY & MEDICAL LEAVE
Why do we need paid time to care?	In Virginia, no one should have to choose between caring for themselves and a loved one or a paycheck.	
How are PSD and PFML different?	PSD is used when we need **hours or days** to care for ourselves or a loved one.	PFML is used when we need **weeks or months** to care for ourselves or a loved one.
When is it used?	PSD ensures working people have paid time to care for themselves or a loved one. It protects people from getting fired if, for example, a child gets sick during the middle of their shift. Examples include: → Picking your child up from the nurse's office → Recovering from the flu → Going to a medical appointment → Getting care and assistance after domestic assault, staking, or sexual assault	PFML covers longer term life events that affect all of us at some point. It allows people to keep getting their paycheck and protects them from getting fired if they need to take family or medical leave. Examples include: → Bonding with a newborn or adopted child → End-of-life support for a loved one → Caring for your aging parents or a loved one who is ill → Healing after an illness → Getting care and assistance after domestic assault, staking, or sexual assault
Why are they separate bills?	The underlying values are the same, but the mechanics are different.	
How much time to care is provided?	40 hours can be accrued per year and carried over.	Up to 12 weeks annually for medical or family leave.
How are they paid for?	PSD is a basic employment standard. Employees accrue hours that are paid by the employer.	PFML establishes a state-administered paid leave insurance program. Workers and employers contribute so everyone has guaranteed benefits.
How does paid time to care build a family-friendly economy that's good for business?	→ Supports a balanced economy that works for everyone, not just those that can afford it. → Ensures people have more time and money to invest in themselves and their families. → Helps level the playing field between small and large businesses while supporting work with dignity. → Allowing workers to access paid leave helps businesses keep the workplace healthier, reduces turnover, and improves productivity.	
How important is paid leave for Virginians' economic security?	→ Each year, Virginians are unable to take 339,000 leaves that they need and lose $1.4 billion in wages due to unpaid or partially paid leave, including $710 million lost by women. → When a worker takes 3.5 unpaid sick days, the average family loses a month's worth of groceries.	
How many other states have it?	18 states, 18 municipalities, and the District of Columbia	13 states and the District of Columbia

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HJ2/SJ2 Restoration of Voting Rights

Problem: When people are convicted for felonies in Virginia, they lose their right to vote while incarcerated. Once they have completed their sentence, the governor has sole authority to restore voting rights.

Policy solution: This bill proposes an amendment to the Virginia Constitution to restore a person's voting rights when they leave incarceration. In Virginia, a constitutional amendment needs to be passed by a simple majority in both chambers over two consecutive legislative sessions to be certified for the ballot.

Over the years, several states have made bipartisan efforts to reform their voting laws regarding felony disenfranchisement. Nebraska and Virginia have seen both Republican and Democratic lawmakers collaborate and pass legislation aimed at restoring voting rights to individuals with felony convictions.

Why is this important?

When a debt is paid, it's paid

- Every voice in our democracy deserves to be heard. That includes Virginians who have successfully served their time. They should be able to exercise their right to vote and be fully engaged citizens in their communities.
- The right to vote should be restored when a person returns to their community, to ensure that every voice is heard, and everyone has a chance to participate in our democracy.
- Permanently stripping away a person's right to vote extends a punishment far beyond what is just and reasonable — and prevents people from having a say in the future of their communities.

Virginians believe in second chances

- Virginians from all walks of life believe in second chances including law enforcement, faith-based groups, families, businesses, and a large majority of Virginians.
- Restoring the right to vote gives returning citizens a second chance at becoming invested members of their communities
- Restoring the right to vote recognizes our shared human dignity and acknowledges that people's contributions are greater than their mistakes.

People who vote are more engaged citizens

- Our democracy works best when it includes all of us.
- Providing returning citizens the chance to fully-engage with society by restoring the right to vote will reduce apathy and encourages people to work together to find solutions.

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Expediting Zoning For Affordable Housing

Problem: Virginia's affordable housing crisis is worsening every year. The Joint Legislative Audit and Review Commission (JLARC) reported in 2021 that approximately 905,000 households, nearly 29% of all households, were burdened by housing cost. Since then, the situation has grown more severe. The Virginia Housing Commission estimates the current statewide shortage at 187,000 units and projects that, without major policy changes, the gap could widen to 214,000 units within five years.

JLARC identified zoning and permitting delays as significant barriers to new housing production. These shortages affect every region of the state, driving up costs for both renters and prospective homeowners and making it harder for families, seniors, and essential workers to find a safe, stable, and affordable place to live.

Solution: Expediting affordable housing is a bill that would allow localities to adopt ordinances speeding up the approval process for increased density to build affordable housing. Under these ordinances, localities could approve projects through a streamlined administrative process, cutting red tape and decreasing uncertainty about development.

These ordinances would especially focus on projects with affordable housing, since so many families are paying too much for housing. In addition, the increased density is concentrated in areas the locality has already identified as being able to support additional units.

Beyond those limitations, this bill allows localities to craft the ordinance that makes sense in their context. Rural southern Virginia is facing different challenges than localities that border on DC, but all these places recognize the need for affordable housing development. The legislation allows cities, towns, and counties to incorporate zoning flexibility into these ordinances by permitting unique uses, and ensures accountability by reporting on how many units are approved and built under qualifying ordinances.

Localities adopting and successfully implementing these expedited ordinances would receive priority consideration for state infrastructure grants and loans, creating both incentives and capacity for faster, more efficient affordable housing development across the Commonwealth.

Background: Affordable Housing in Virginia code is based on the median income of a particular area. This means that housing classified as "affordable" includes people making up to the local average.

There is a history of zoning being used to amplify discrimination. Zoning played an important role in keeping people segregated by race and continues to segregate people by income. Even today, many neighborhoods that are zoned for single-family residential use are places that historically had race-restricted deeds. This bill allows an administrative process to cut through the discriminatory attitude and meet community needs.

Conclusion: By giving localities the tools to speed up approvals for multi-family affordable housing projects, Virginia can help close its housing gap more efficiently. This approach removes unnecessary delays while ensuring developments are well-located, connected to services, and meet high standards for accessibility and inclusion.

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Yes in God's Backyard (Faith and Housing)

Problem

There is a shortage of affordable homes in Virginia, both for rental and purchase. The Joint Legislative Audit and Review Commission (JLARC) released a report on affordable housing in 2021. The JLARC report highlights that over 900,000 households in Virginia are cost burdened by housing, and that the commonwealth has a shortage of over 200,000 homes. While needs are numerically concentrated in urban areas, the high cost of housing affects families in every part of Virginia.

At the same time, many faith communities understand that caring for neighbors is a part of their mission. Congregations own land in localities all over Virginia and are interested in supporting community members, and some are interested in developing affordable housing on their land. However, the process is made unnecessarily difficult because of the uncertainty and high cost of rezoning.

Background

There are already more than a dozen congregations in Virginia that have developed affordable housing on their property. **The process usually takes between 7 and 20 years**, and a significant part of that time is spent applying for Special Use Permits or zoning changes, along with convincing nearby residents that the development is good for the community. These projects range from a rural congregation building 12 small homes for halfway houses, to a large faith community in an urban area building more than 200 apartments. Communities have already seen the benefits of affordable housing built on faith land. Allowing other congregations to live their mission would benefit all Virginians.

Solution

This bill would streamline the permitting process for property tax-exempt nonprofits (most of which are faith communities) to build affordable multi-family housing on their land. **In response to an exclusionary attitude of "not in my backyard" (NIMBY), this policy can be thought of as a "Yes in God's backyard" (YIGBY) approach.**

Clergy and faith leaders hear about the need for affordable housing from their members and community, and many want to offer housing. Developing affordable housing allows congregations to provide resources to community members who are struggling, while putting faith into action.

Key provisions

- **Affordable Housing Requirements**:
  - Property must be owned by congregation or non-profit 5 years prior to application
  - At least 60% of homes must be affordable to residents making the area median income
  - Must remain affordable for at least 50 years
- **Design & Occupancy Provisions**:
  - Must comply with Virginia Fair Housing Act
  - Subject to local real estate tax
  - Height restricted to 3 stories or the height of the tallest building within 500 feet
  - Ground floor may contain child day care and worship space
  - Locality may require one parking spot per home
- **Delayed Effective Date**: September 1, 2026

COMMONWEALTH HOUSING COALITION

Yes In God's Backyard (YIGBY)

Sponsors:

Delegate Josh Cole

Senators McPike & Carroll-Foy

This legislation protects the right of faith institutions and certain property tax exempt non-profits to build income restricted, affordable homes on land they own. It also increases localities' power by creating a new administrative approval process under which review of these applications must take place.

By creating clear, objective standards and timelines for approval, this bill minimizes financial risk for both the property owner and builder. By eliminating risk, the bill incentivizes the creation of affordable homes.

Key Provisions

- **Affordable Housing Requirements**:
  - Property must be owned by congregation or tax-exempt non-profit 5 years prior to application
  - At least 60% of the new homes must be affordable to residents earning 100% of the area median income or less
  - Must remain affordable for at least 50 years
- **Design & Occupancy Provisions**:
  - Must comply with Virginia Fair Housing Law
  - Subject to local real estate tax
  - Height restricted to 3 stories or the height of the tallest building within 500 feet
  - Ground floor may contain child day care and worship space
  - May require one parking spot per home
- **Delayed Effective Date**: September 1, 2026

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