Community Health Association of Mountain/Plains States

# *PARTICIPANT HANDOUTS*
# The Role of Health Centers in Addressing Maternity Care Deserts

*Thank you for attending today's training. By doing so you are strengthening the ability of your community-based and patient-directed health center to deliver comprehensive, culturally competent, high-quality primary health care services. The CHAMPS 2023 Maternal Health Learning Series is a free series that was created in partnership with the HRSA Office of Intergovernmental and External Affairs (IEA) Region VIII Office.*

**Presented by:**
Elizabeth Cherot, MD, MBA, President and CEO, March of Dimes

**Target Audience:**
This series is intended for integrated clinical care teams that may include clinical leadership, clinicians, and clinical support staff at Region VIII (CO, MT, ND, SD, UT, WY) health centers.

**Event Overview:**
Dr. Cherot will discuss the March of Dimes' 85-year history of collaborations and partnerships with communities and patients. She will also discuss the 2022 edition of the March of Dimes Maternity Care Deserts Report, including the new sections on the role Community Health Centers and Family Physicians play in addressing the crisis.

**Learning Objectives:**
1. Describe the leading factors that influence maternal morbidity and mortality.
2. Describe the leading factors that influence infant mortality.
3. Discuss the key findings of the 2022 Maternity Care Desert Report
4. Identity at least one strategy to improve maternal and infant health outcomes.

**CHAMPS ARCHIVES**
This event will be archived online. This online version will be posted within two weeks of the live event and will be available for at least one year from the live presentation date. For information about all CHAMPS archives, please visit http://champsonline.org/events-trainings/distance-learning/online-archived-champs-distance-learning-events.

**CONTENTS**



**DESCRIPTION OF CHAMPS**
Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII (CO, MT, ND, SD, UT, and WY) federally-designated Community, Migrant, and Homeless Health Centers so they can better serve their patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, policy and funding communications, and the collection and dissemination of regional data. Staff and board members of CHAMPS Organizational Members receive targeted benefits in the areas

of business intelligence, networking and peer support, recognition and awards, recruitment and retention, training discounts and reimbursement, and more.

**For over 35 years, CHAMPS has been an essential resource for Community Health Center training and support!** Be sure to take advantage of CHAMPS' programs, products, resources, and other services. For more information about CHAMPS, please visit www.CHAMPSonline.org. The Happenings box on the lower left side of the CHAMPS home page highlights the newest CHAMPS offerings, while the CHAMPS Membership box on the lower right side of the page lists current benefits for CHAMPS Organizational Members.

**SPEAKER BIOGRAPHY**

Elizabeth K. Cherot, MD, MBA, FACOG is President and Chief Executive Officer at March of Dimes. Dr. Cherot joined March of Dimes in January 2023 as Senior Vice President and Chief Medical and Health Officer and moved to the position of President/CEO in July 2023. Since joining March of Dimes, she's successfully brought their critical mission to the forefront of both the political and media spaces to highlight the need for providing better outcomes to all moms and babies, regardless of their background. She's been working to expand March of Dimes' mission through vital initiatives, such as advancing doula work, expanding their Innovation Fund, and exploring new opportunities and partnerships for growth. Dr. Cherot brings to the role her inspiring vision and strategic guidance, commitment to health equity, and three decades of clinical expertise and deep knowledge of maternal and infant health. Dr. Cherot's passion to provide the best quality of care to all has been the hallmark of her remarkable career.

Dr. Cherot, a Fellow of the American College of Obstetricians and Gynecologists, has more than 21 years of experience managing numerous maternal and infant health initiatives. Most recently, she served as the Chief Medical Officer for Axia Women's Health, one of the largest fully integrated Women's Health Care Groups in the United States, where she oversaw over 2,500 colleagues, 500 providers, and 200 patient care center locations across 5 states. Dr. Cherot holds a medical degree from The University of Rochester School of Medicine and Dentistry along with an Executive Master's Degree in Business Administration and a Bachelor of Arts Degree from Johns Hopkins University. She also volunteers her time treating and providing patient care to women in a correctional facility in New Jersey.


# MARCH OF DIMES and Community Health Association of Mountain/Plains States (CHAMPS) 2023

HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES®

**Elizabeth Cherot, MD, MBA, FACOG**
**President and CEO**
**March of Dimes**

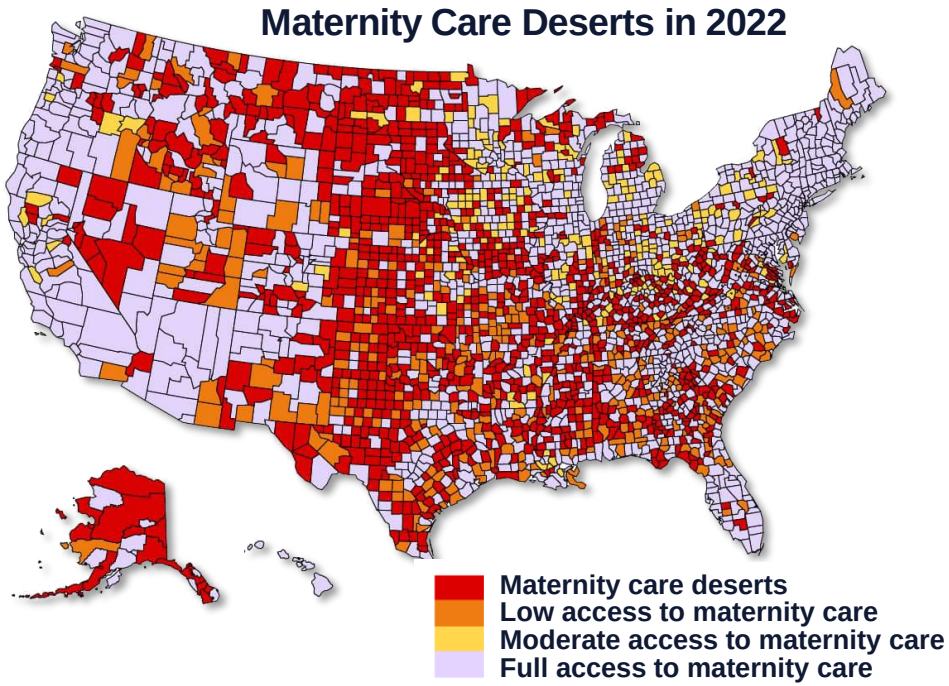
# MARCH OF DIMES LEADS THE FIGHT FOR THE HEALTH OF ALL MOMS AND BABIES.

WE IMAGINE A WORLD WHERE EVERY MOM AND BABY IS HEALTHY REGARDLESS OF WEALTH, RACE, GENDER, OR GEOGRAPHY.

YET TODAY IN THE U.S. FAR TOO MANY FACE BARRIERS TO A STRONG, HEALTHY BEGINNING...

## THE NEED

# The U.S. remains among the most dangerous developed nations for childbirth.




## 5.6 million women live in areas with low access to maternity care

**2 women**

will die from pregnancy-related causes today. And every day.

**2 babies**

die every hour in the U.S.

Pregnancy-related deaths have

**more than doubled**

over the past 30 years.

**2.2 million+ women**

live in maternity care deserts that have **NO** hospital offering obstetric care

**350,000+ babies**

are born to women living in counties with limited or no access to maternity care.

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## THE NEED

# The maternal and infant health crisis disproportionately affects Black and Brown women.

Pregnant Black women with one or more chronic health conditions are at a higher risk of preterm birth, with rates reaching 14% for preterm births and 47% having one or more chronic health conditions.

## There's a higher chance of maternal death or preterm birth based on race/ethnicity

Black women are **27% more likely** to experience severe pregnancy complications than White women.

Black babies are **2X more likely** to die before their first birthday than White babies.

Black women are **2.6X more likely** to die from pregnancy complications than White women.

Black women saw an **87% rate increase** in maternal mortality from 2018 to 2021.

Black and Brown women experience **significantly higher rates** of inadequate prenatal care at 21.9%, compared to the national average of 14.9%.

Black and Brown women are **62% more likely** to give birth prematurely compared to White women.

The preterm birth rates increase to **16.1%** for Black women living in maternity care deserts.

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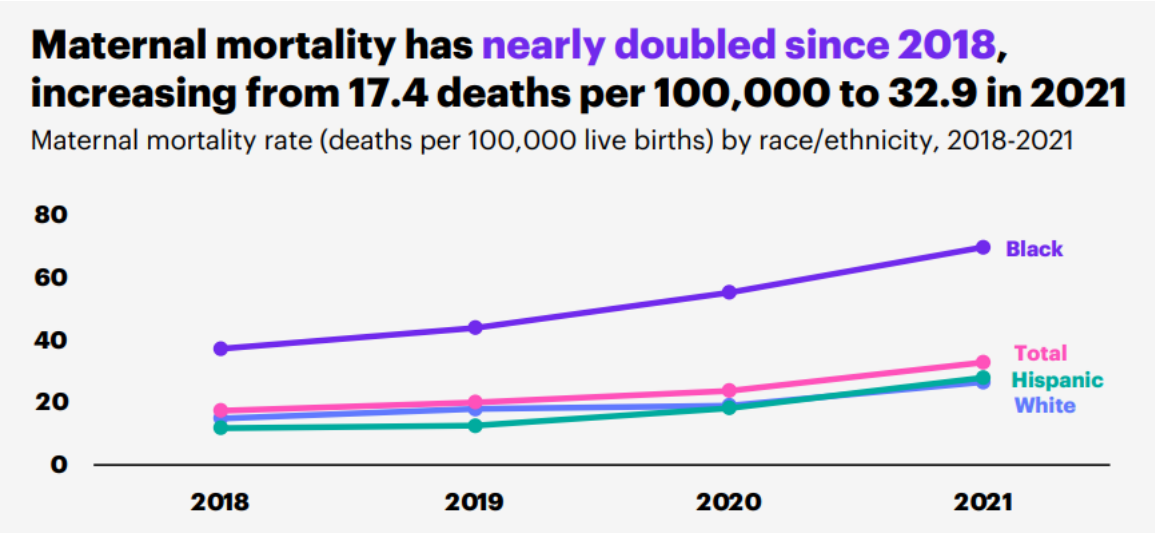
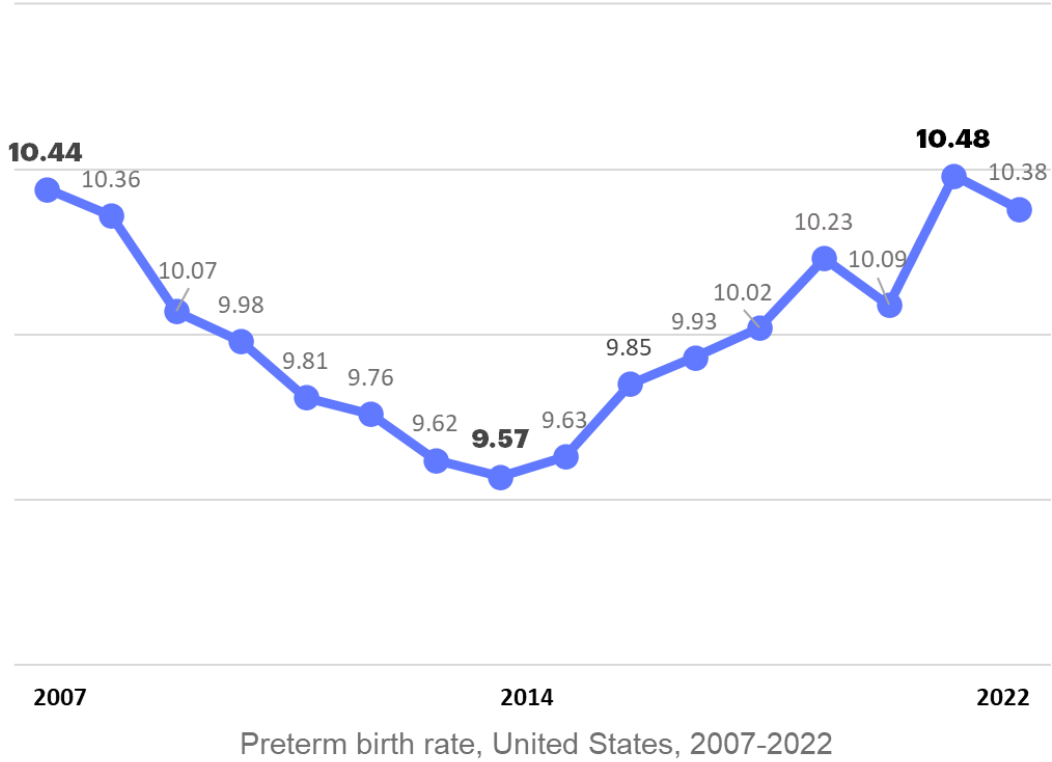
# Maternal mortality* in the U.S. has nearly doubled since 2018.




*Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, excluding those from accidental/incidental causes. (https://www.cdc.gov/nchs/maternal-mortality/evaluation.htm)

# The U.S. preterm birth rate decreased in 2022 by less than 1%.




Preterm birth rate, United States, 2007-2022

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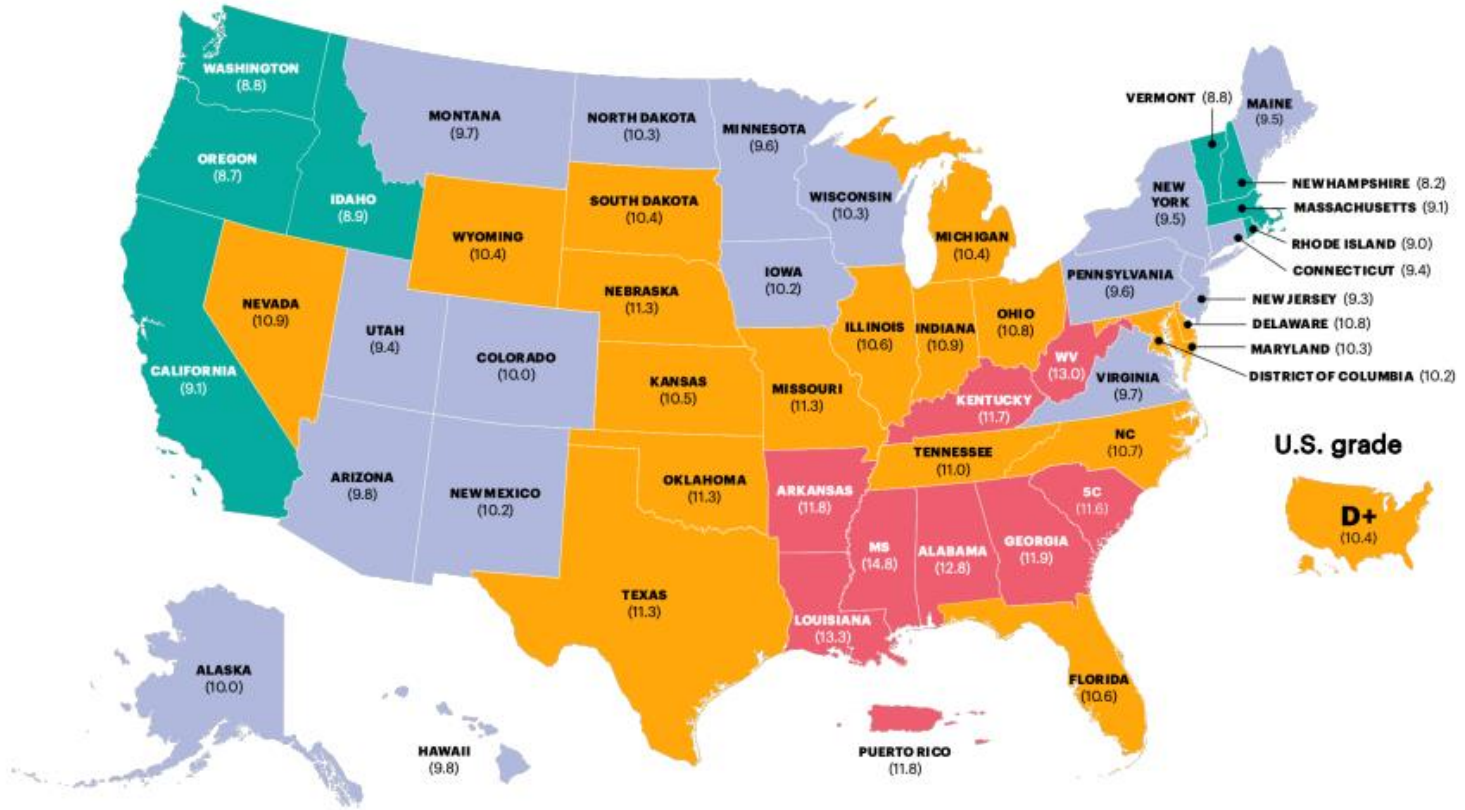
Premature/preterm is less than 37 weeks of gestation. Preterm birth rate is defined as the percentage of live births born preterm.
Source: National Center for Health Statistics, final natality data 2007- 2022.
Prepared by March of Dimes Perinatal Data Center, Oct 2023

# WHERE A MOM LIVES COULD DETERMINE IF HER BABY WILL BE BORN PRETERM.

## The preterm birth grade was D+ in 2022; the worst grades occurred in the southern region of the U.S.

Preterm birth rate (born before 37 weeks gestation) and grade by state, 2022




**GRADE AND PRETERM BIRTH RATE**

| A | A- | B+ | B | B- | C+ | C | C- | D+ | D | D- | F |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 7.7% or less | 7.8 to 8.1% | 8.2 to 8.5% | 8.6 to 8.9% | 9.0 to 9.2% | 9.3 to 9.6% | 9.7 to 10.0% | 10.1 to 10.3% | 10.4 to 10.7% | 10.8 to 11.1% | 11.2 to 11.4% | 11.5% or greater |

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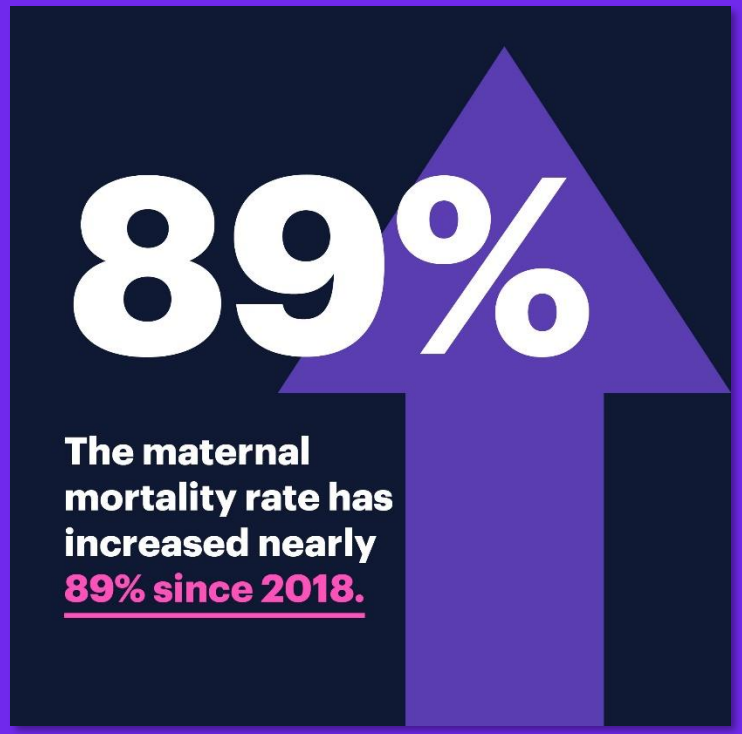
# CDC 2021 Maternal Mortality Report

**Released March 16, 2023**

- **1,205 deaths reported in 2021, reflecting an increase of nearly 89% in the maternal mortality rate since 2018.**
- **Black women are 2.6 times more likely to die than White women and 2.5 times more likely to die than Hispanic women.**



WHAT WE DO

# FIGHTING FOR THE HEALTH OF FAMILIES FOR 85 YEARS

**13**
**Nobel Prize winners since 1954**


**1938** — Founded by Franklin D. Roosevelt as NFIP

**1940** — Crowdfunding for polio

**1955** — The Salk vaccine (solving 20th century problem with 20th century tools)

**1958-59** — Announcement of new mission: birth defects prevention in 1958;

Virginia Apgar joins March of Dimes as first Medical Director in 1959

**1964** — First Volunteer Leadership Conference

**1976** — Publication of *Toward Improving Outcome of Pregnancy*

**1970s** — Shift to incorporate perinatal health

**1985** — Surfactant therapy to treat respiratory distress syndrome in preterm babies

**1998** — Folic Acid Campaign

**2007** — Universal newborn screening

**2012** — Healthy Babies are Worth the Wait™ 39 week campaign

**TODAY** — **Addressing health equity in the fight for healthy moms and strong babies**

# OUR GOALS

**END**
preventable maternal health risks and death

+

**END**
preventable preterm birth and infant death

**END**
the health equity gap

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## FOR HEALTHY MOMS AND STRONG BABIES

# LEADING FACTORS INFLUENCING MATERNAL AND INFANT HEALTH OUTCOMES

## Maternal morbidity and mortality

- Maternal Cardiovascular Health
- Maternal Mental Health and Chronic Stress

## Infant mortality

- Preterm Birth
- Birth Defects

## Health Equity

- Racism and Unequal Treatment
- Access to High Quality Healthcare
- Environmental Justice
- Lifelong Economic Security
- Safe and Connected Communities

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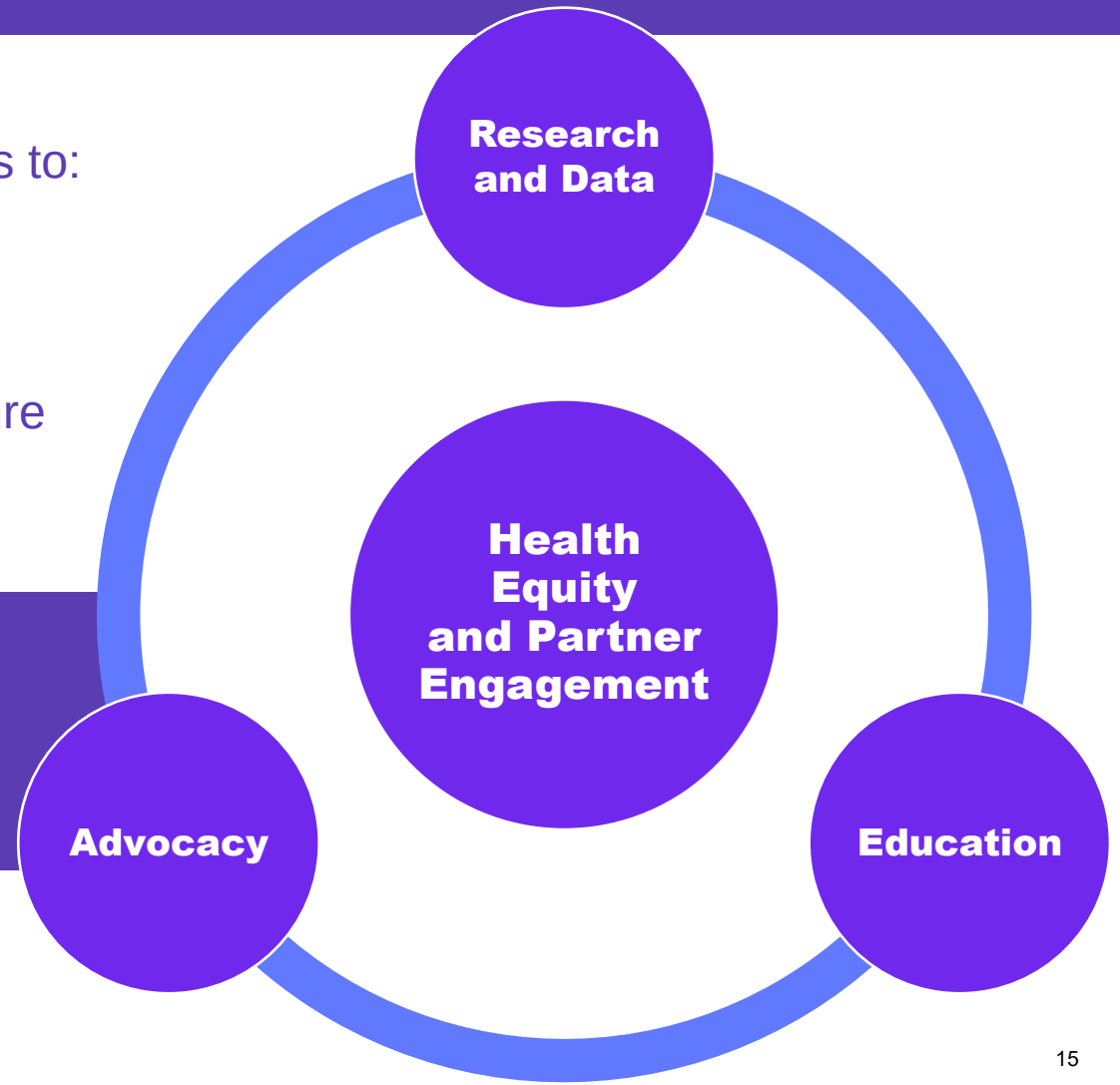
# CHANNELS THROUGH WHICH WE ADVANCE OUR STRATEGIC GOALS

**Leveraging the March of Dimes brand, reputation, and reach,** we channel our resources to:

- **EDUCATE** consumers and professionals,
- **ADVOCATE** for policy and systems change,
- **RESEARCH** and disseminate solutions, to ensure all moms and babies can be healthy regardless of wealth, race, gender, or geography.

**We are the convener of impact-driven partnerships through community engagement and thought leadership roles.**

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# EXAMPLES OF OUR WORK

## RESEARCH AND DATA

- Prematurity Research Centers
- Research Center for Advancing Maternal Health Equity
- Maternity Care Desert Report
- Annual Report Card

## PROGRAMS

- Supportive Pregnancy Care® Programs (group prenatal care)
- NICU Family Support®
- Mom & Baby Mobile Health Centers®

## ADVOCACY

We have shaped national and state policies, such as:

- Preemie Act
- Paid Medical and Family Leave
- Protections for Pregnant Workers

## EDUCATION

Accredited training and education for providers and families:

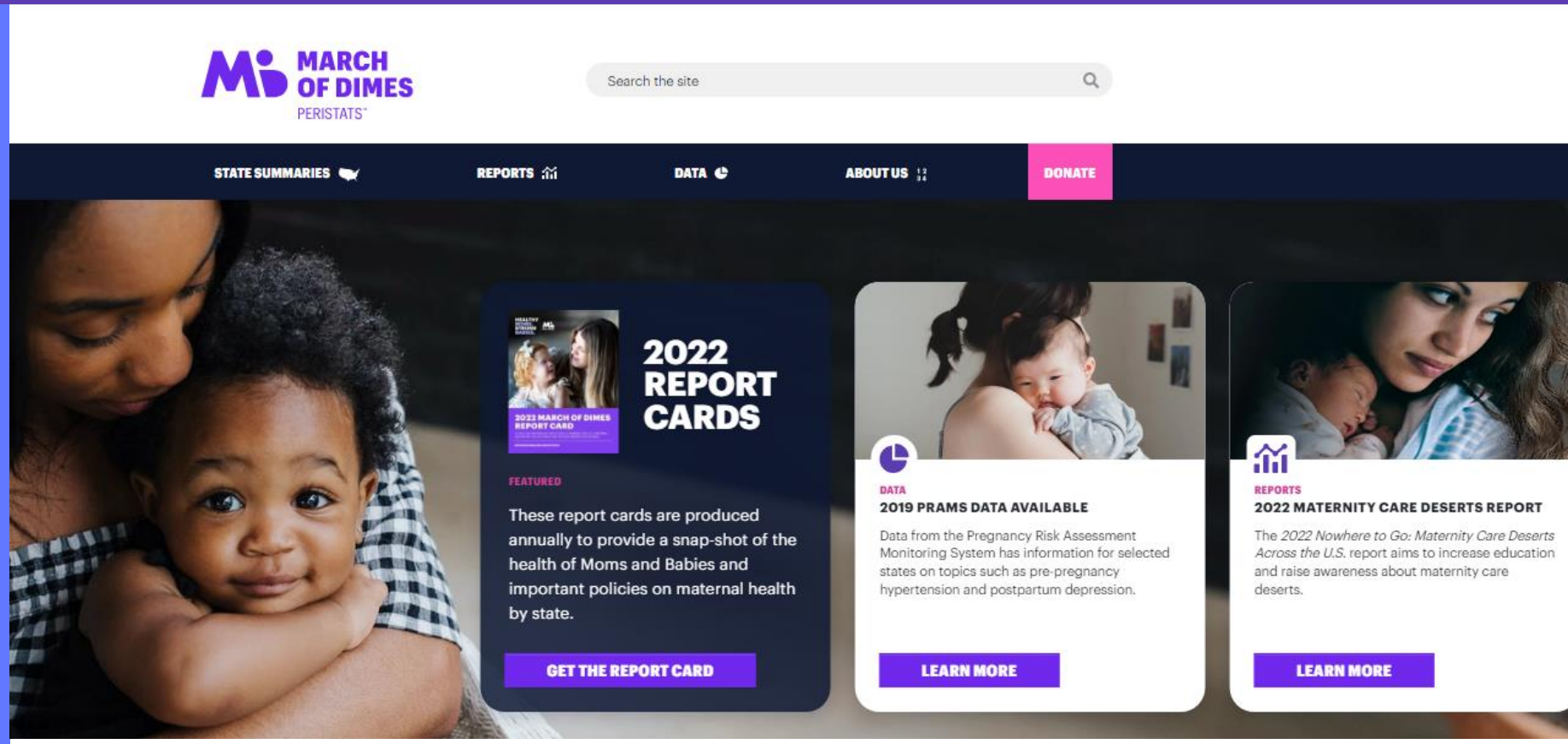
- Implicit Bias Training
- NICU Family Support®
- Consumer health education

## STRATEGIC PARTNERSHIPS

We leverage strategic, equity-focused partnerships with public and private organizations at local and national levels

# DATA: PERINATAL DATA CENTER

**PeriStats™** is the online database for perinatal statistics developed by the **March of Dimes Perinatal Data Center,** providing free access to maternal and infant health-related data at the U.S., state, county, and city level.




## MARCHOFDIMES.ORG/PERISTATS

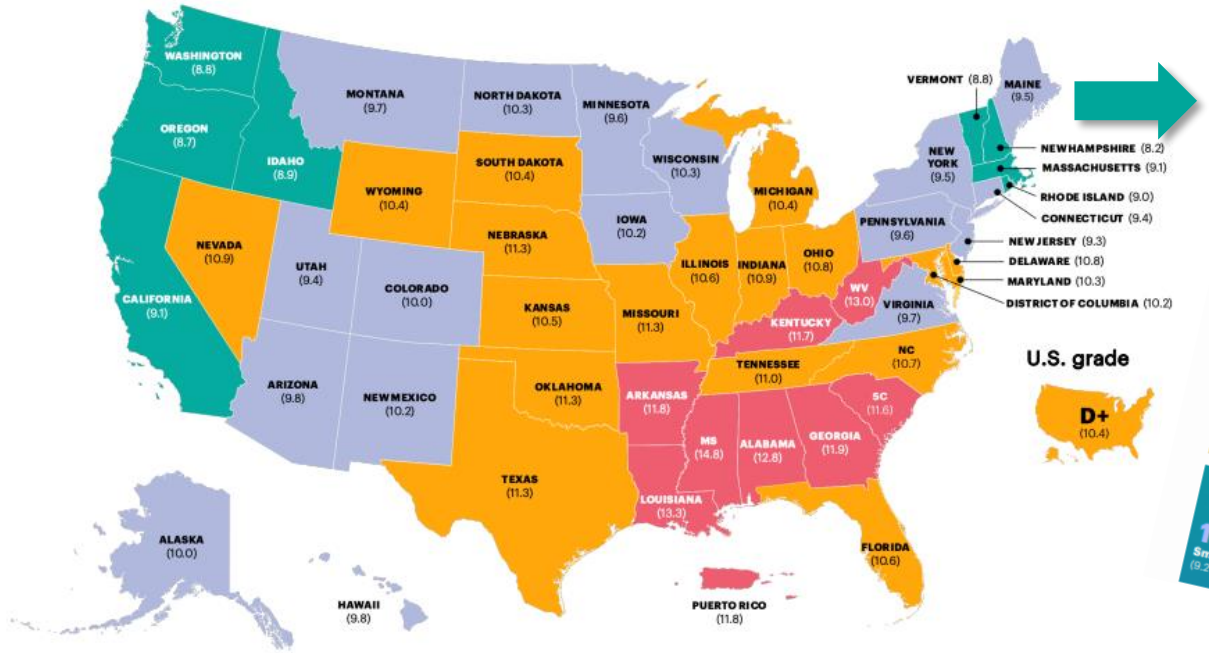
# 2023 REPORT CARD

# DATA: REPORT CARD

## UNITED STATES

**The preterm birth grade was D+ in 2022; the worst grades occurred in the southern region of the U.S.**

Preterm birth rate (born before 37 weeks gestation) and grade by state, 2022




**GRADE AND PRETERM BIRTH RATE**

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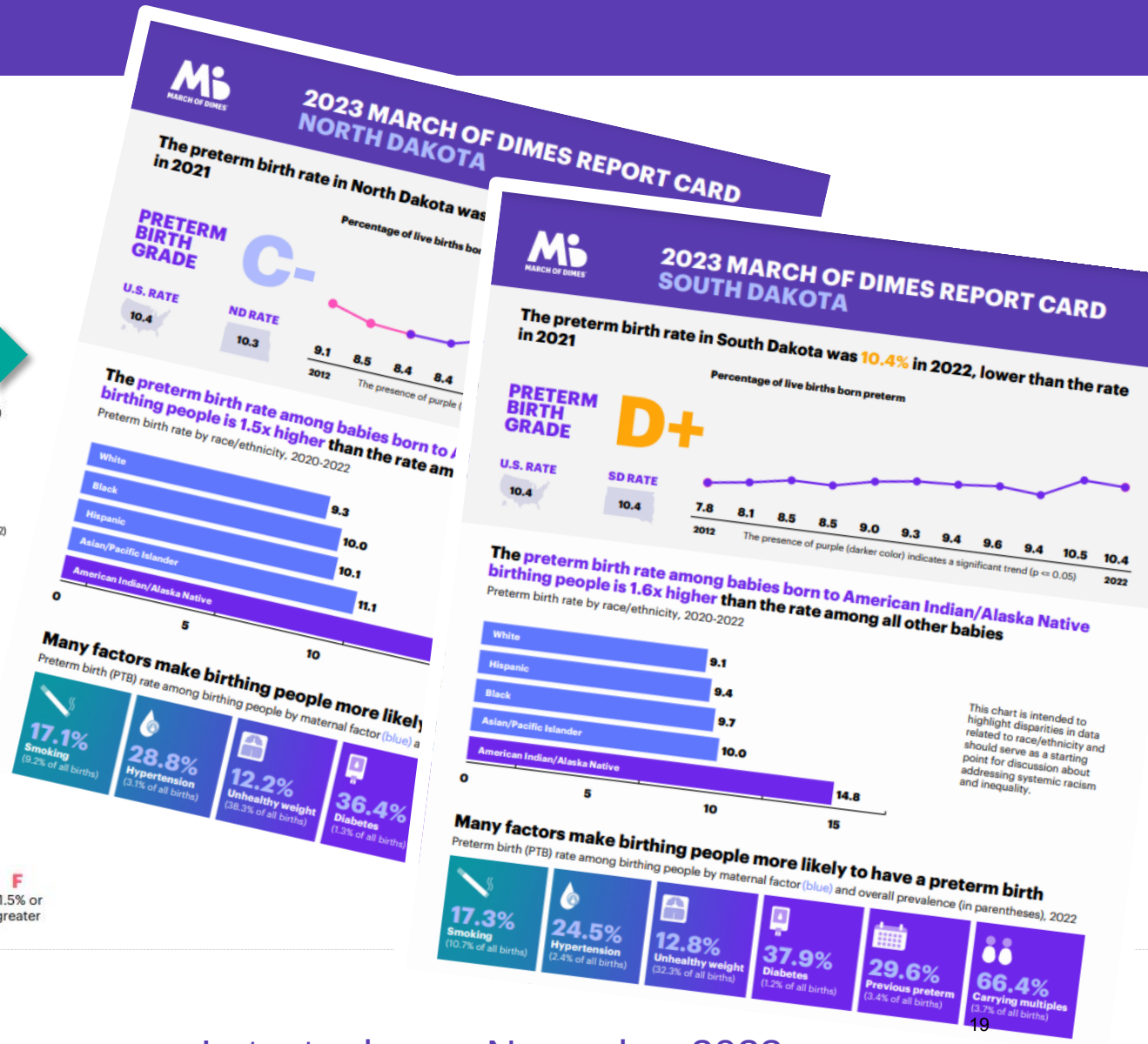


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Latest release: November 2023

# SUMMARY OF KEY FINDINGS IN 2023 REPORT CARD

## The U.S. earned a grade of D+ (10.4%)

- **This is a decline** from 10.5% on 2022 Report Card.
- **Preterm birth rates worsened** in 13 states and D.C.
- **Low-risk Cesarean birth rate was unchanged:** 26.3% in 2021 and 2022.
- **Infant mortality was unchanged** at 5.4 per 1,000 live births in 2021 and 2022.
- **Inadequate prenatal care increased** to 15.5% from 14.5% in 2021.

## Some states are enacting policy measures that improve health:

- **12 states** fully extended Medicaid in the past year.
- **44 states** have federally funded maternal mortality review committees.

# 2023 MARCH OF DIMES REPORT CARD, page 1&2

EMBARGOED UNTIL 11/08/2023

## 2023 MARCH OF DIMES REPORT CARD
## COLORADO

**The preterm birth rate in Colorado was 10.0% in 2022, higher than the rate in 2021**

PRETERM BIRTH GRADE: C

U.S. RATE: 10.4

CO RATE: 10.0%

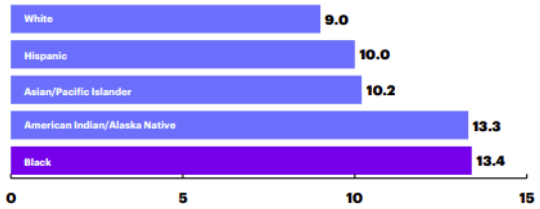
Percentage of live births born preterm

| 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|---|---|
| 8.9 | 8.6 | 8.4 | 8.7 | 8.9 | 8.8 | 9.2 | 9.6 | 9.1 | 9.7 | 10.0 |

Purple (darker) color shows a significant trend (p <= .05)

**The preterm birth rate among babies born to Black birthing people is 1.4x higher than the rate among all other babies**

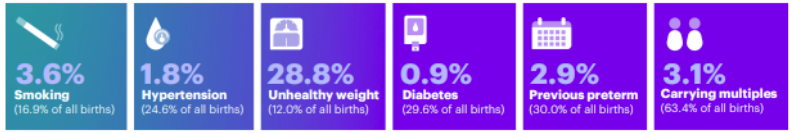
Preterm birth rate by race/ethnicity, 2020-2022




This chart is intended to highlight disparities in data related to race/ethnicity and should serve as a starting point for discussion about addressing systemic racism and inequality.

**Many factors make birthing people more likely to have a preterm birth**

Preterm birth (PTB) rate among birthing people by maternal factor (blue) and overall prevalence (in parentheses), 2022




**Note:** More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. U.S. PTB rates are as follows: smoking: 15%; hypertension: 23%; unhealthy weight: 12%; diabetes: 29%; previous preterm: 30%; carrying multiples: 62%.

**Source:** National Center for Health Statistics, 2012-2022 natality data.

THE 2023 MARCH OF DIMES REPORT CARD:
THE STATE OF MATERNAL AND INFANT HEALTH FOR AMERICAN FAMILIES

For the full report card visit www.marchofdimes.org/reportcard

For details on data sources and calculations, see Technical Notes: https://bit.ly/TechnicalNotes-ReportCard2023



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## COLORADO

**The infant mortality rate increased in the last decade; 314 died in Colorado in 2021**

INFANT MORTALITY RATE: 5.0

U.S. RATE: 5.4

Rate per 1,000 live births

| 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|---|---|---|
| 5.5 | 4.6 | 5.1 | 4.8 | 4.7 | 4.8 | 4.5 | 4.8 | 4.9 | 4.8 | 5.0 |

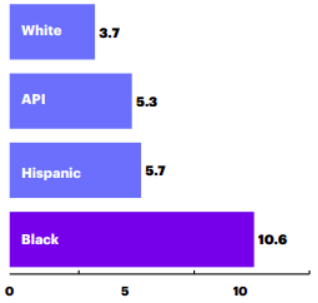
Purple (darker) color shows a significant trend (p <= .05)

**Source:** National Center for Health Statistics, Period Linked Birth/Infant Death data, 2011-2021.

**The infant mortality rate among babies born to Black birthing people is 2.1x the state rate**

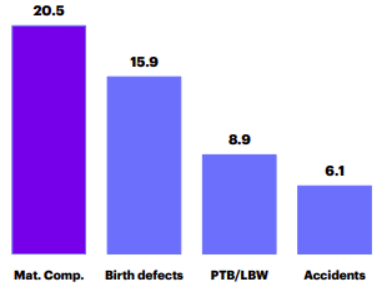
**Infant mortality rate per 1,000 live births**

Rate per 1,000 live births, 2019-2021




**Leading causes of infant death**

Percent of total deaths by primary cause, 2019-2021




**Notes:** API = Asian/Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death; Mat. Comp. = Maternal Complications

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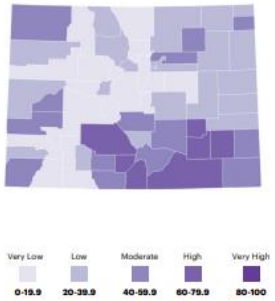
# 2023 MARCH OF DIMES REPORT CARD, page 3&4

**EMBARGOED UNTIL 11/08/2023**

## COLORADO

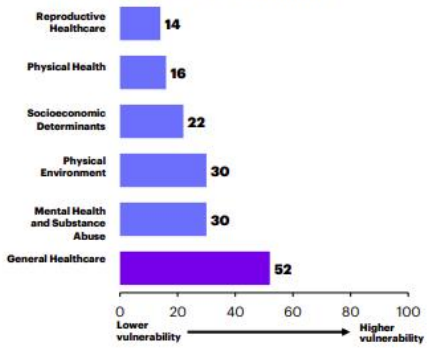
**Birthing people in Colorado have a very low vulnerability to poor outcomes and are most vulnerable due to general healthcare accessibility**

**MVI by county in Colorado**




**Factors related to maternal vulnerability**

Higher scores indicate higher vulnerability




**Notes:** The Maternity Vulnerability Index (MVI) is a tool used to understand where birthing people in each state may be more likely to have poor outcomes, including preterm birth and maternal death, due to clinical risk factors and other social, contextual, and environmental factors. Visit https://mvi.surgoventures.org/.

**Source:** Surgo Health, Maternal Vulnerability Index, 2023.

**The measures below are important indicators for how Colorado is supporting the health of birthing people**

**15.2** PER 100,000 BIRTHS (23.5)

**MATERNAL MORTALITY**

This shows the death rate of birthing people from complications of pregnancy or childbirth that occur during the pregnancy or within 6 weeks after the pregnancy ends.

**23.0** PERCENT (26.3)

**LOW-RISK CESAREAN BIRTH**

This shows Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

**13.5** PERCENT (15.5)

**INADEQUATE PRENATAL CARE**

Percent of birthing people who received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

**Source:** National Center for Health Statistics, Mortality data, 2018-2021. National Center for Health Statistics, Natality data, 2022.

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## ALABAMA

**Adoption of the following policies and sufficient funding in Alabama is critical to improve and sustain maternal and infant healthcare**

**MEDICAID EXTENSION**

State has extended coverage for women to one year postpartum.

**MEDICAID EXPANSION**

State has adopted this policy, which allows birthing people greater access to preventative care during pregnancy.

**PAID FAMILY LEAVE**

State has required employers to provide a paid option while out on parental leave.

**DOULA REIMBURSEMENT POLICY**

State Medicaid agency is actively reimbursing doula care.

**MATERNAL MORTALITY REVIEW COMMITTEE**

State has a federally funded MMRC committee, which is recognized as essential to understanding and addressing the causes of maternal death.

**FETAL AND INFANT MORTALITY REVIEW COMMITTEE**

State has a Fetal and Infant Mortality Review Committee to identify and review causes of death.

**PERINATAL QUALITY COLLABORATIVE**

State has a federally funded PQC to identify and improve quality care issues in maternal and infant healthcare.

Legend

- State has the indicated funding/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated funding/policy

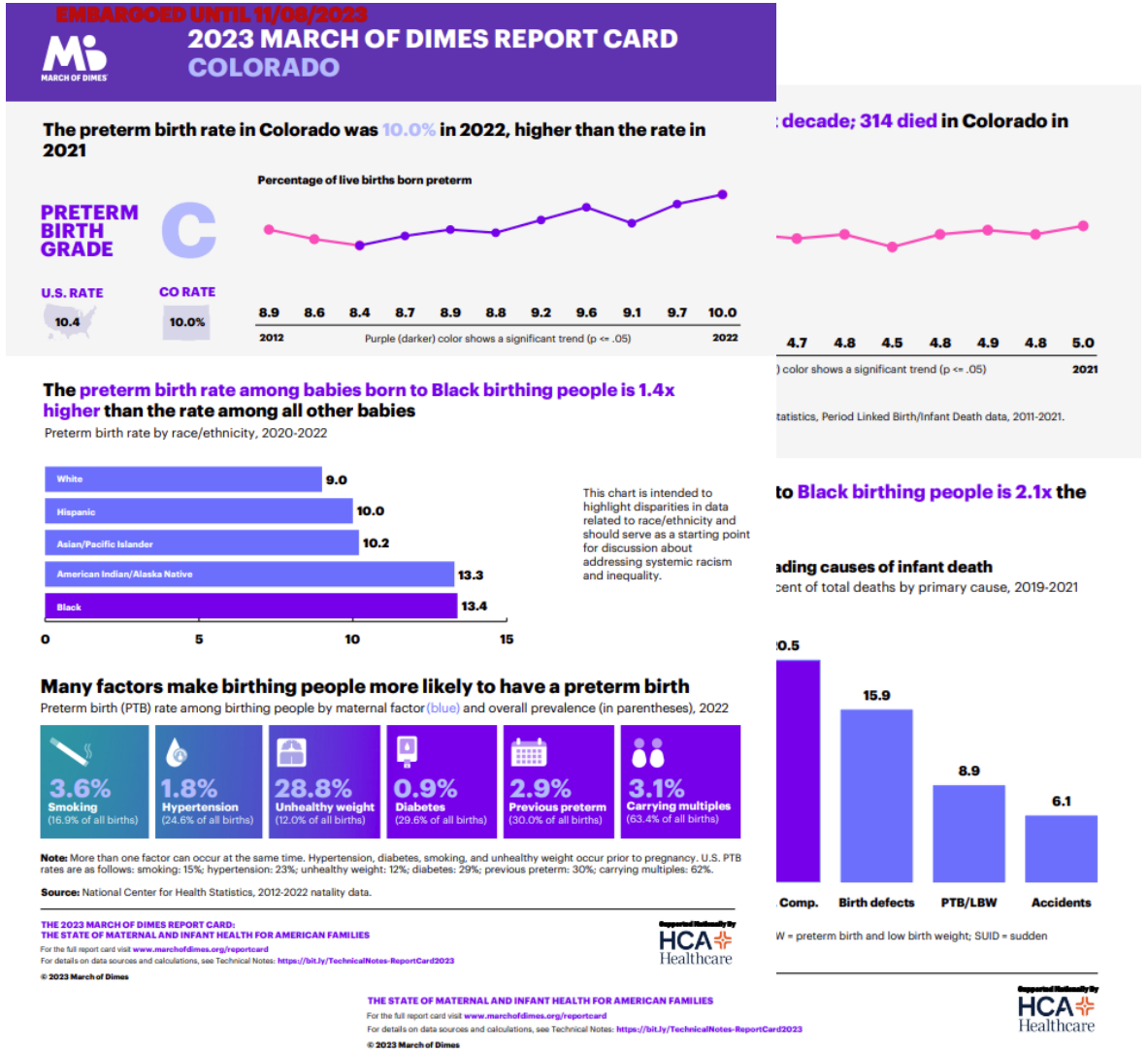
**OVER 380,000 BABIES WERE BORN PRETERM IN 2022. EVERY DATA POINT REPRESENTS A PERSON WITH A UNIQUE STORY; HERE'S JUST ONE.**

At 37 years old, Ashley Taylor got pregnant after her first round of IVF. The pregnancy went smoothly until, at 18 weeks, her water broke. She was put on bed rest in the hospital to help save the pregnancy. Ashley remained there for five weeks of excruciating back pain and uncertainty—until she went into labor. Julia was born at 23 weeks and six days, weighing 1 pound, 2.3 ounces. "I knew that I loved her more than anything from the very beginning when she came into this world and they asked me, 'What do you want to do?' And I said, 'Everything possible.' And now she's an amazing little girl with so much personality."

Far too many families are affected by prematurity. We advocate for policies outlined in this year's 2023 March of Dimes Report Card to prioritize the health of all families—especially moms and babies of color.

# INFANT OUTCOMES ON THE REPORT CARD

- Preterm birth and preterm birth grades (2022)
- Preterm birth rate by race and ethnicity (2020-2022)
- Preterm birth by related factors (2022)
- Infant mortality rates (2021)
- Infant mortality rates by race and ethnicity (2019-2021)
- Leading causes of infant death (2019-2021)

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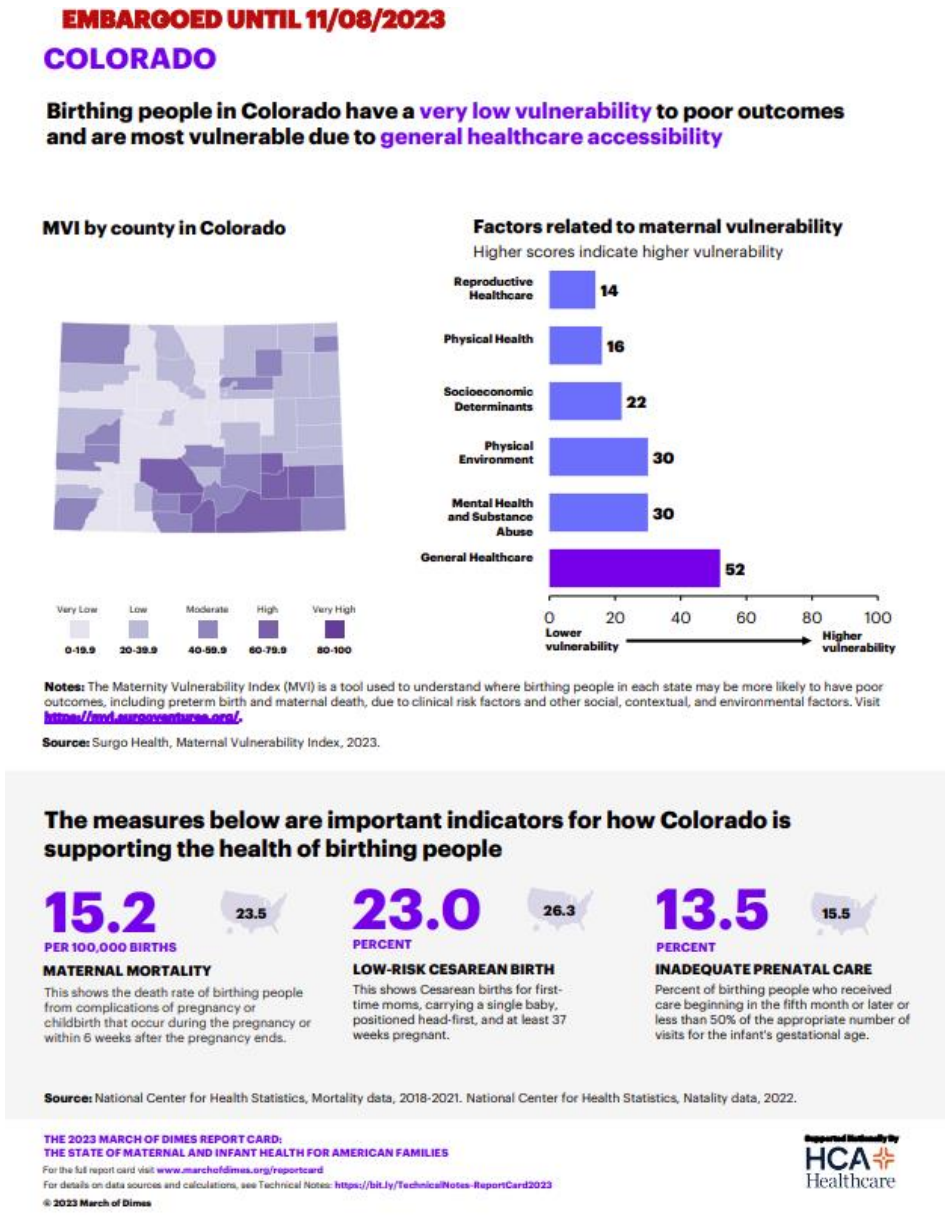
*Refers to the year of the data

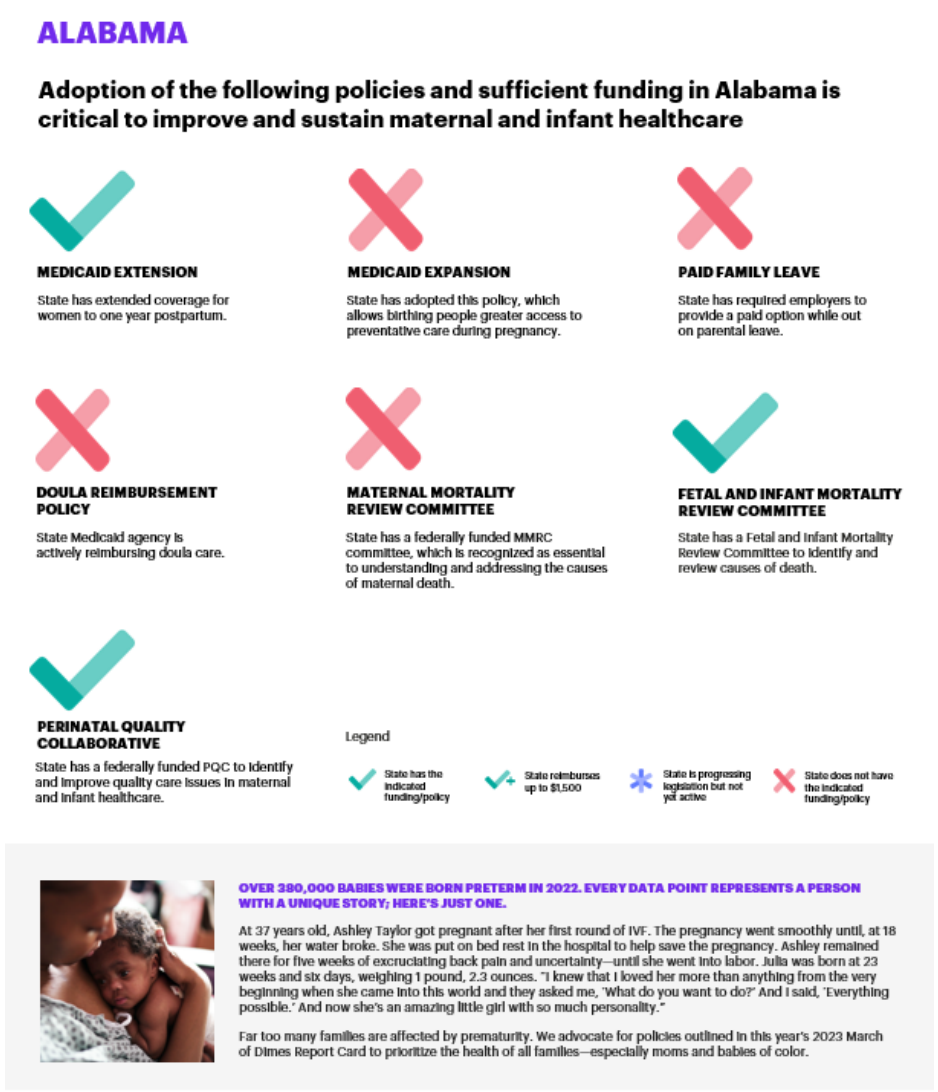
# MATERNAL HEALTH INDICATORS ON THE REPORT CARD

- Maternal Vulnerability Index (MVI) by county (2023)
- Factors related to maternal vulnerability (2023)
- Maternal mortality (2018-2021)
- Low-risk Cesarean birth rate (2022)
- Inadequate prenatal care (2022)



# STATE POLICIES ON THE REPORT CARD

- Policy Measures
  - Medicaid extension
  - Medicaid expansion
  - Paid Family Leave (new!)
  - Doula Medicaid Reimbursement
  - Maternal Mortality Review Committee
  - Fetal and Infant Mortality Review (new!)
  - Perinatal Quality Collaborative



## ALABAMA

**Adoption of the following policies and sufficient funding in Alabama is critical to improve and sustain maternal and infant healthcare**

**MEDICAID EXTENSION**
State has extended coverage for women to one year postpartum.

**MEDICAID EXPANSION**
State has adopted this policy, which allows birthing people greater access to preventative care during pregnancy.

**PAID FAMILY LEAVE**
State has required employers to provide a paid option while out on parental leave.

**DOULA REIMBURSEMENT POLICY**
State Medicaid agency is actively reimbursing doula care.

**MATERNAL MORTALITY REVIEW COMMITTEE**
State has a federally funded MMRC committee, which is recognized as essential to understanding and addressing the causes of maternal death.

**FETAL AND INFANT MORTALITY REVIEW COMMITTEE**
State has a Fetal and Infant Mortality Review Committee to identify and review causes of death.

**PERINATAL QUALITY COLLABORATIVE**
State has a federally funded PQC to identify and improve quality care issues in maternal and infant healthcare.

Legend
State has the indicated funding/policy
State reimburses up to $1,500
State is progressing legislation but not yet active
State does not have the indicated funding/policy



**OVER 380,000 BABIES WERE BORN PRETERM IN 2022. EVERY DATA POINT REPRESENTS A PERSON WITH A UNIQUE STORY; HERE'S JUST ONE.**

At 37 years old, Ashley Taylor got pregnant after her first round of IVF. The pregnancy went smoothly until, at 18 weeks, her water broke. She was put on bed rest in the hospital to help save the pregnancy. Ashley remained there for five weeks of excruciating back pain and uncertainty—until she went into labor. Julia was born at 23 weeks and six days, weighing 1 pound, 2.3 ounces. "I knew that I loved her more than anything from the very beginning when she came into this world and they asked me, 'What do you want to do?' And I said, 'Everything possible.' And now she's an amazing little girl with so much personality."

Far too many families are affected by prematurity. We advocate for policies outlined in this year's 2023 March of Dimes Report Card to prioritize the health of all families—especially moms and babies of color.

# Where You Live Matters:
# Maternity Care Deserts and the Crisis of Access and Equity

MARCH OF DIMES®

# DATA: MATERNITY CARE DESERT REPORT


**NOWHERE TO GO:**
**MATERNITY CARE DESERTS ACROSS THE U.S.**
2022 REPORT

▲ **2022 national report**

**2023 state-level reports coming in June** ▶

HEALTHY MOMS. STRONG BABIES.

## WHERE YOU LIVE MATTERS: MATERNITY CARE IN MONTANA

### INTRODUCTION

With over 3.5 million births in the United States annually, and rising rates of maternal mortality and morbidity, there is ample opportunity to improve maternal outcomes across the country.[1] More than 2 million women of childbearing age live in maternity care deserts, areas without access to birthing facilities or maternity care providers. Access to maternity care is essential for preventing poor health outcomes and eliminating health disparities. This report expands on the 2022 Nowhere to Go: Maternity Care Deserts Across the U.S. report[2] by taking a deeper dive into state level data and examining additional barriers that impact access to care. This data can be used to inform policies and practice recommendations in each state.

This report presents data on several important factors: levels of maternity care access and maternity care deserts by county; distance to birthing hospitals; availability of family planning services; community level factors associated with prenatal care usage as well as the burden and consequences of chronic health conditions across the state. While not an exhaustive list, each of these topics contribute to the complexity of maternity care access in each state. Working to improve access to maternity care by bringing awareness to maternity care deserts and other factors that limit access is one way in which March of Dimes strives to reduce preventable maternal mortality and morbidity for all pregnant people.

### KEY FINDINGS

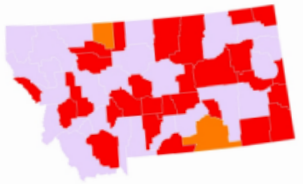
- In Montana, 50.0 percent of counties are defined as maternity care deserts compared to 32.6 percent in the U.S.
- 18.4 percent of women had no birthing hospital within 30 minutes compared to 9.7 percent in the U.S.
- Overall, women in Montana have a very low vulnerability to adverse outcomes due to the availability of reproductive healthcare services.
- 13.8 percent of birthing people received no or inadequate prenatal care, less than the U.S. rate of 14.8 percent.
- Women with chronic health conditions have a 71 percent increased likelihood of preterm birth compared to women with none.

### ACCESS TO MATERNITY CARE IN MONTANA

Access to care during pregnancy and around the time of birth is not consistently available across the country. Hospital closures and a shortage of providers are driving changes in maternity care access, especially within rural areas and among Black, Indigenous, and people of color (BIPOC).[3] The level of maternity care access within each county is classified across Montana by the availability of birthing facilities, maternity care providers, and the percent of uninsured women (see table). The map shows that in Montana, 50.0 percent of counties are defined as maternity care deserts compared to 32.6 percent of counties in the U.S. overall.

### FINDINGS

- In Montana, there was a 4% increase in the number of birthing hospitals between 2020 and 2019.
- In Montana, there were 961 babies born in maternity care deserts, 8.6% of all births.
- 56.5% of babies were born to women who live in rural counties, while 60.8% of maternity care providers practice in rural counties in Montana.




### DEFINITIONS OF MATERNITY CARE DESERT AND LEVEL OF MATERNITY CARE ACCESS

| Definitions | Maternity care deserts | Low access | Moderate access | Full access* |
|---|---|---|---|---|
| Hospitals and birth centers offering obstetric care | zero | <2 | <2 | ≥2 |
| Obstetric providers (obstetrician, family physician†, CNM/CM per 10,000 births) | zero | <60 | <60 | ≥60 |
| Proportion of women 18-64 without health insurance | any | ≥10% | <10% | any |

**Sources:** U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2022; American Board of Family Medicine, 2017-2020; National Center for Health Statistics, 2021 final natality data.
**Note:** CNM/CM = certified nurse midwives/certified midwives.
*A county is full access if it meets one or more of the criteria.
†Includes family physicians who provide obstetric care.

**WHERE YOU LIVE MATTERS: MATERNITY CARE DESERTS AND THE CRISIS OF ACCESS AND EQUITY**
March of Dimes recommends state policy actions that address access to care; see: https://marchofdimes.org/mcdr-mt
For details on data sources and calculations, see Technical Notes: https://www.marchofdimes.org/peristats/maternitycaretechnotes
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## UTAH

### DISTANCE TO MATERNITY CARE

The farther a woman travels to receive maternity care, the greater the risk of maternal morbidity and adverse infant outcomes, such as stillbirth and NICU admission.[4,5] Furthermore, longer travel distances to care can cause financial strain on families and increased prenatal stress and anxiety.[6] The distance a woman must travel to access care becomes a critical factor during pregnancy, at the time of birth, and in the case of emergencies. Nationwide closures of birthing hospitals have contributed to increased distance and travel time to care, especially in rural areas.[6]

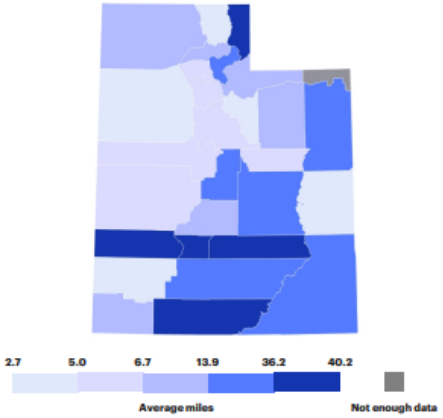
Mapping software was utilized to calculate distance, in miles and minutes, under normal traffic conditions and using real-world travel routes. The map indicates the average distance to the closest birthing hospital throughout Utah. Commonly used thresholds of 30- and 60-minute driving times were applied to measure the percent of birthing people with timely access to care.[4] This information can help identify areas where resources are needed to improve access to care. Overall, in the U.S. women travel 9.7 miles to their nearest birthing hospital.

### FINDINGS

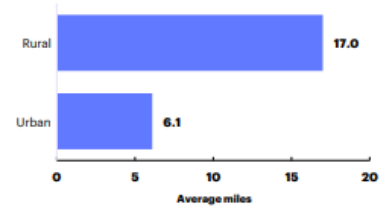
- In Utah, women travel 6.6 miles and 11.8 minutes, on average, to their nearest birthing hospital.
- Women living in counties with the highest travel times (top 20 percent) could travel up to 40.2 miles and 45.2 minutes, on average, to reach their nearest birthing hospital.
- Under normal traffic conditions, 0% of women live over 60 minutes from their nearest birthing hospital compared to 1.0% in the U.S.
- 2.5% of women in Utah had no birthing hospital within 30 minutes.
- In rural areas across Utah, 40.5% of women live over 30 minutes from a birthing hospital compared to 0.6% of women living in urban areas.
- Women living in maternity care deserts traveled 4.3 times farther than women living in areas with full access to maternity care in Utah.

*On average, women in Utah travel 6.6 miles to the nearest birthing hospital.*

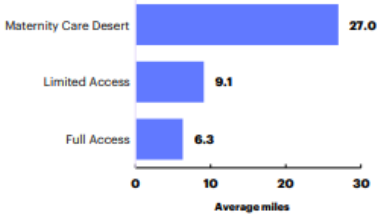
### DISTANCE TO BIRTHING HOSPITAL BY COUNTY




### DISTANCE TO CARE BY RURALITY




### DISTANCE TO CARE BY MATERNITY CARE ACCESS




**Sources:** Healthcare Cost and Utilization Project State Inpatient Database. Utah. Agency for Healthcare Research and Quality, 2020. Web. 1 Nov 2022. American Hospital Association, 2021; American Board of Family Medicine, 2017-2020; U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2022.

**WHERE YOU LIVE MATTERS: MATERNITY CARE DESERTS AND THE CRISIS OF ACCESS AND EQUITY**
March of Dimes recommends state policy actions that address access to care; see: https://marchofdimes.org/mcdr-ut
For details on data sources and calculations, see Technical Notes: https://www.marchofdimes.org/peristats/maternitycaretechnotes
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**Maternity care deserts** are counties where there's a lack of maternity care resources, where there are **no hospitals or birth centers offering obstetric care, and no obstetric providers.**

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# KEY FINDINGS OF THE 2022 REPORT

## More than 146,000 babies were born in maternity care deserts.

- **An additional 300,000 babies** were born in counties with limited maternity care access.
- **More than 2.2 million women** of childbearing age live in maternity care deserts.
- **4.7 million women** live in counties with limited maternity care access.

## 36% of all U.S. counties are designated as maternity care deserts.

- **Two in three maternity care deserts** are rural counties (61.5%).
- Counties with low access to telehealth were **30% more likely** to be maternity care deserts.
- **Five states** are actively reimbursing doula services on Medicaid plans and **seven states** are in the process of implementing **Medicaid doula benefits.*****
- **13 states** have approved legislation to **extend postpartum Medicaid coverage** to 12 months, as **11 states** have approved this legislation since the last report.**

# TRENDS IN MATERNITY CARE DESERTS

## Between the 2018 and 2022 Maternity Care Deserts Reports…

A total of **11%** of U.S. counties shifted in maternity care access classification.

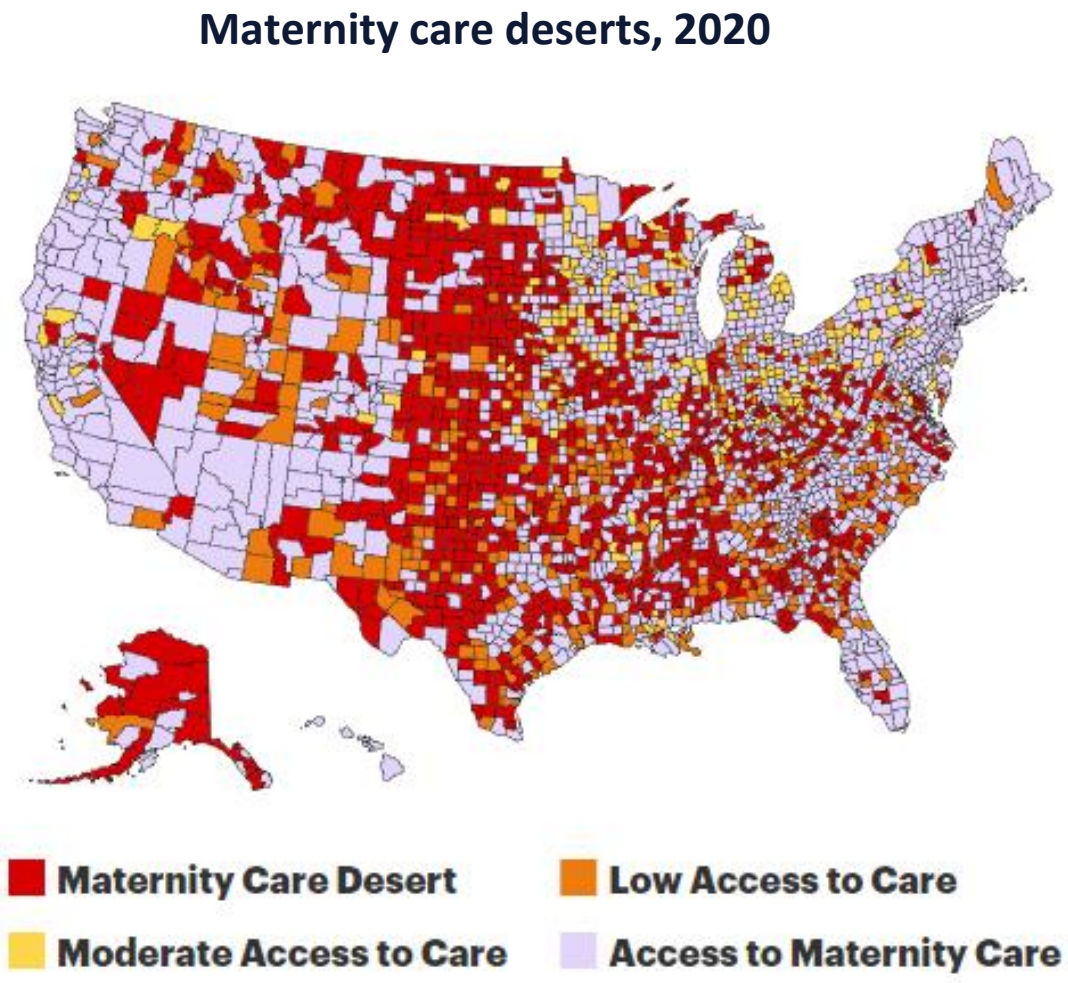
- **5%** (78) of counties have increased access.
- **6%** (83) show a decrease in access to care.
- **Changes in obstetric providers** affected the highest number of counties.
- **Hospital access** drove shifts in classification as 48 counties had decreased access to care while nine counties increased access to care.

## Between the 2020 and 2022 Maternity Care Deserts Reports…

A total of **8%** shifted maternity care classification.

- **5%** (153) of U.S. counties shifted to lower access in maternity care.
- **3%** (94) of counties shifted to higher access of care.
- **Shifts in the number of obstetric providers** was the primary driver for increases or decreases in access.
- **Hospitals limiting obstetric services** decreased access to care in 37 counties.

# ACCESS TO MATERNITY CARE




## Maternity Care Deserts

- **36 percent of all U.S. counties** are designated as maternity care deserts.
- More than **2.2 million women** of childbearing age live in maternity care deserts.
- In 2020**, more than 146,000 babies were born in maternity care deserts**.

## Limited Access to Care

- Over **2.8 million women of childbearing age and nearly 160,000 babies** were impacted by reduced access to maternity care.

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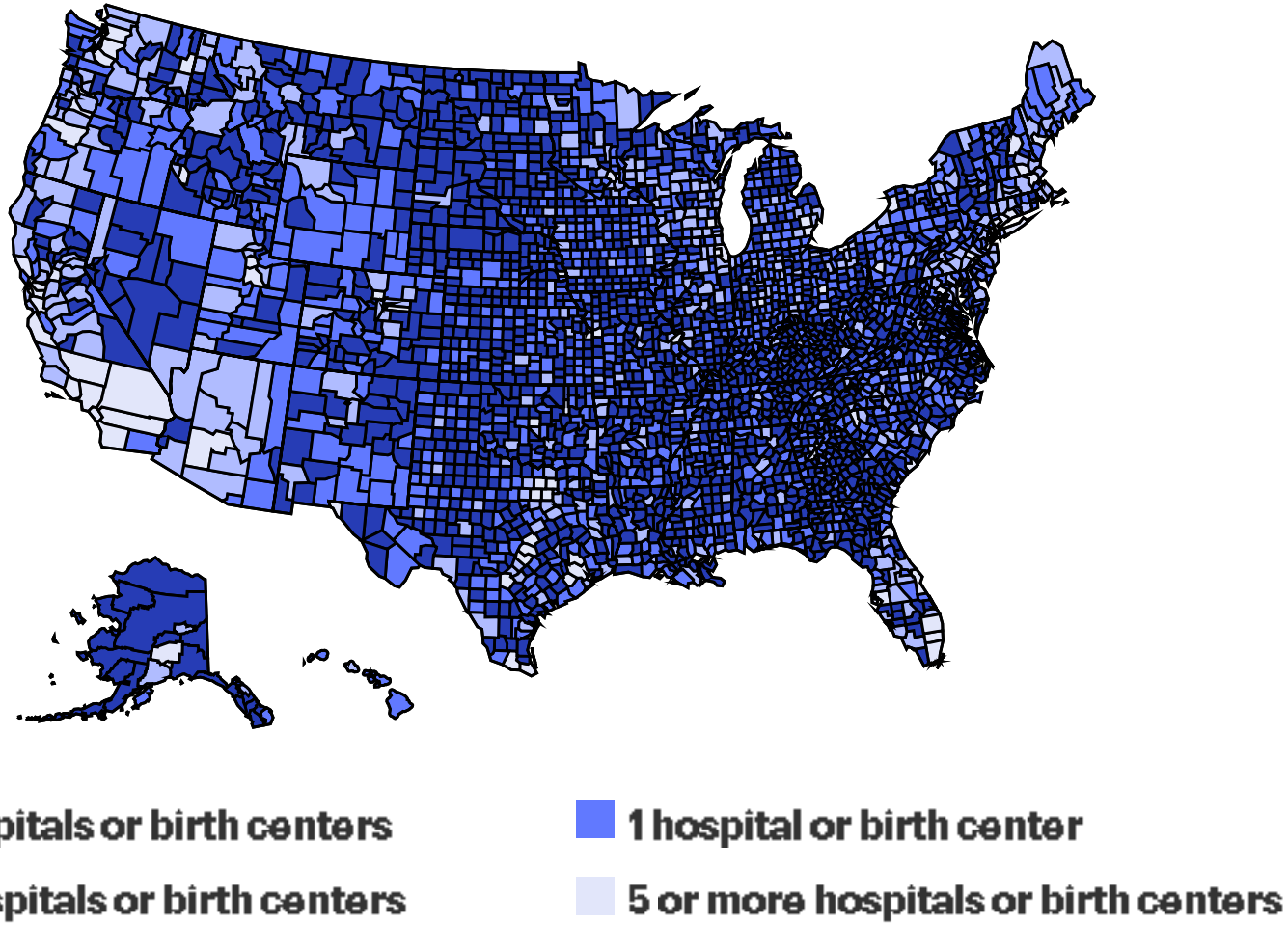
Source: Nowhere to go: Maternity Care Deserts across the U.S. March of Dimes, September 2022.

# HOSPITALS & BIRTH CENTERS

**Hospitals and/or birth centers offering obstetric care by county, 2019**

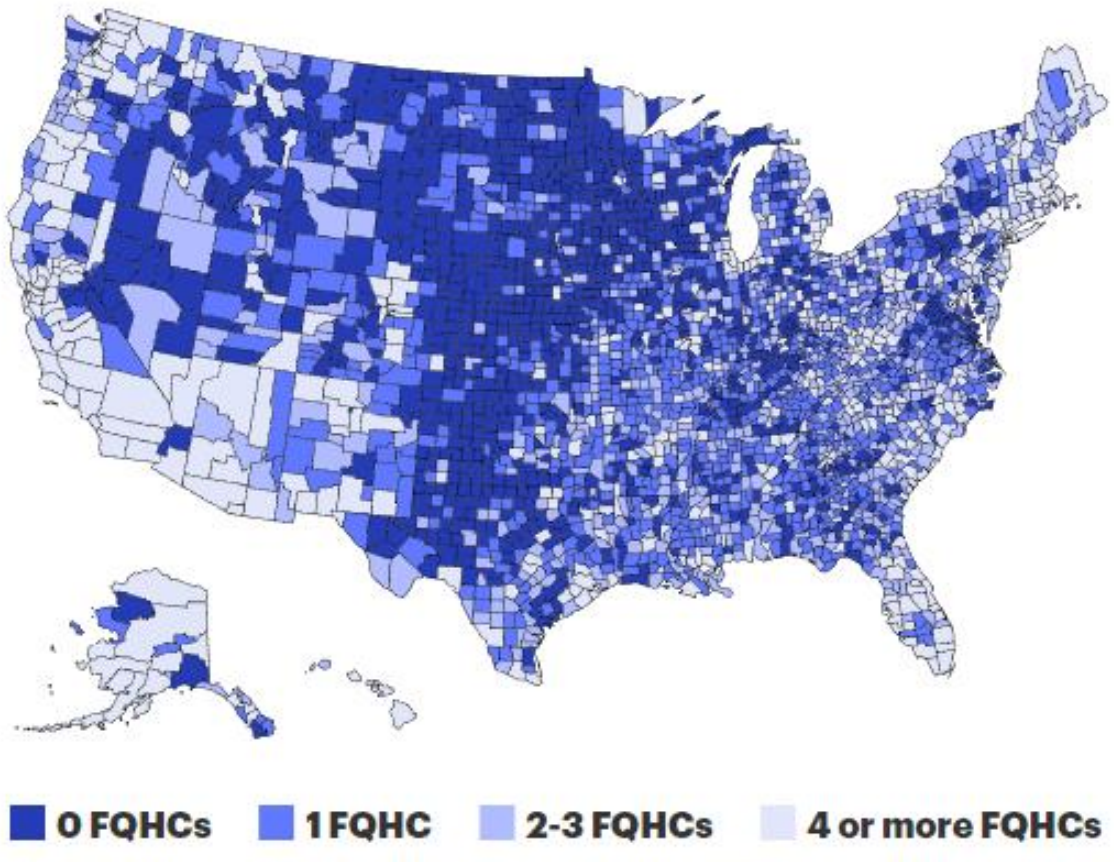



- In 2019, rural counties were less likely to have at least one OB hospital when compared to urban counties (25.9% vs. 52.4%).
- In one year**, 21 rural counties lost one or more OB hospital units**.
- **42.5% of counties** (1,337) had at least one hospital that provided obstetric services.

Source: Nowhere to go: Maternity Care Deserts across the U.S. March of Dimes, September 2022.

# FEDERALLY QUALIFIED HEALTH CENTERS

**Federally Qualified Health Centers (FQHC) by county, 2021**




- 8,104 FQHCs were identified as clinics that provide maternity care in the U.S.*
- 48% of rural counties don't have an FQHC
- At least 2.6 million Medicaid eligible women live in counties without an FQHC.
- 50.7% of counties with no FQHC are maternity care deserts.

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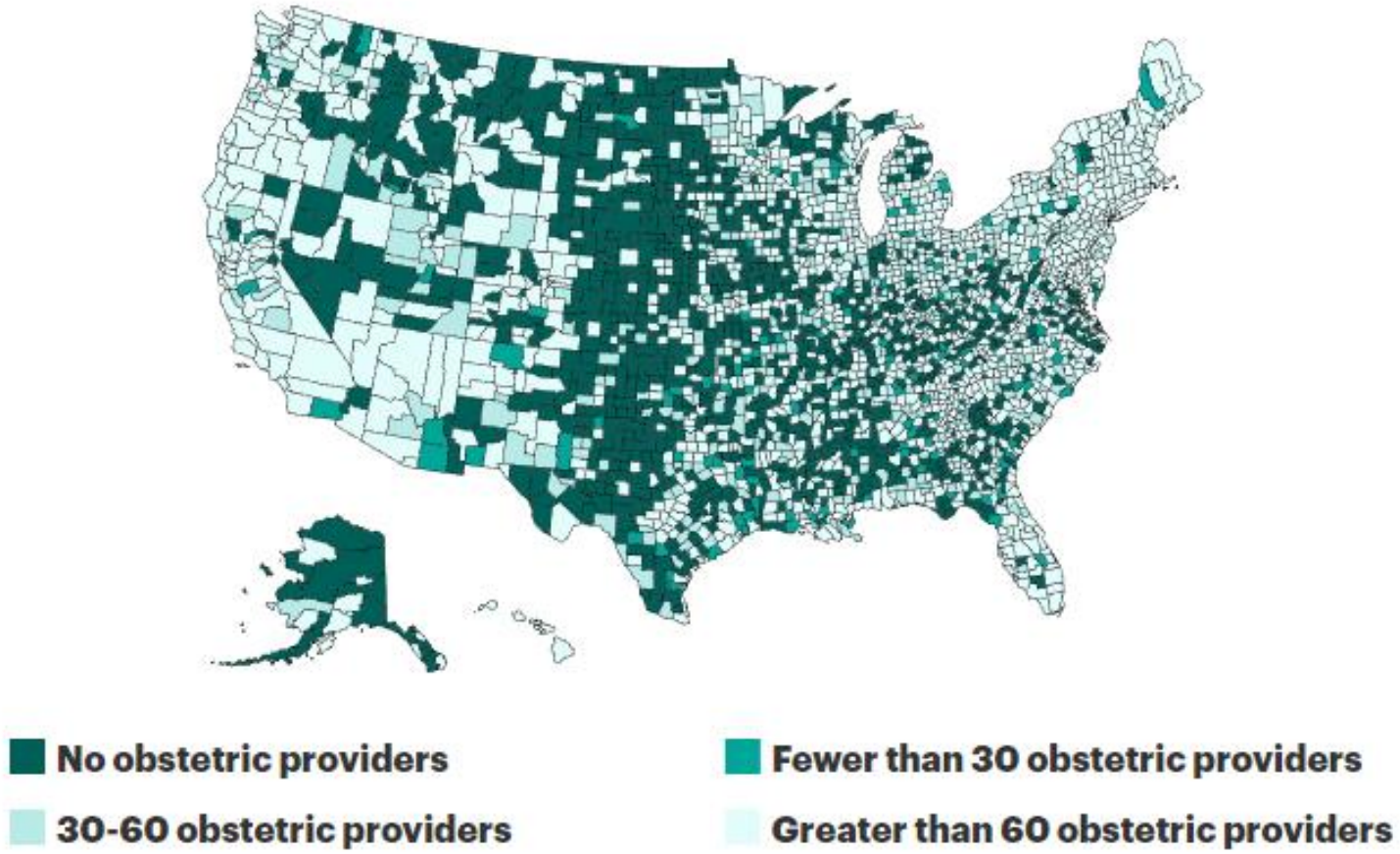
*As of December 2021

Source: Nowhere to go: Maternity Care Deserts across the U.S. March of Dimes, September 2022.

# PROVIDERS

**Distribution of obstetric providers per 10,000 births by county, 2019***




- Rural counties had nearly half as many obstetric providers compared to urban counties (26.7 vs. 58.0 per 10,000 births, respectively).
- 47.9% U.S counties did not have an OB and 55.1% do not have a CNM.
- 39.8% of counties lacked a single obstetrician or CNM.

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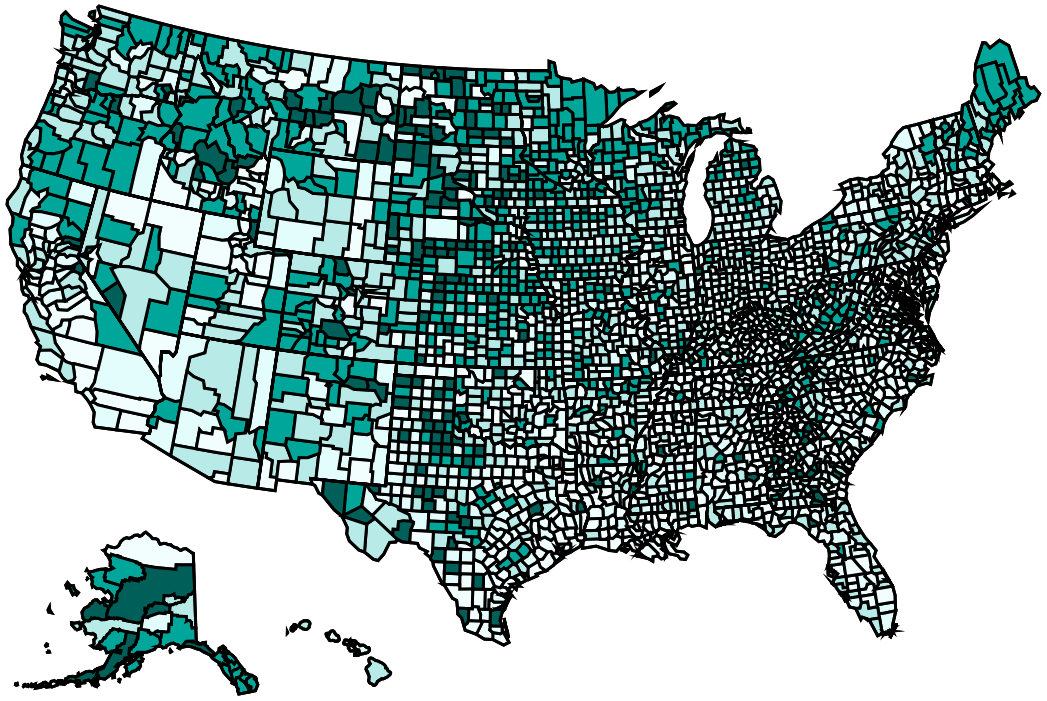
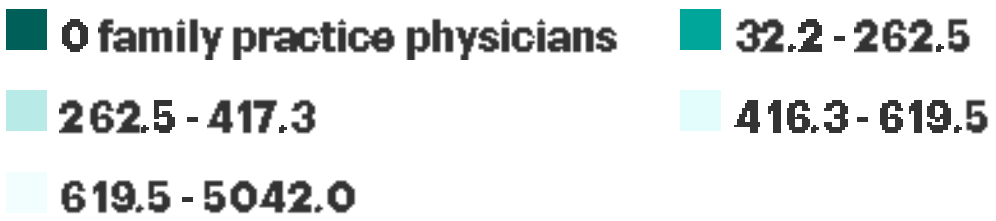
*includes obstetricians and certified nurse midwives (CNMs)
Source: Nowhere to go: Maternity Care Deserts across the U.S. March of Dimes, September 2022.

# FAMILY PHYSICIANS

**Distribution of women of childbearing age per family physicians by county, 2021**






- Only 6.5% of counties (204) do not have a family physician.
- Of counties without a family physician, 93.1% were maternity care deserts and four in five (82.4%) were rural.
- 6.1% of counties (193) do not have an obstetrician, CNM, or family physician.

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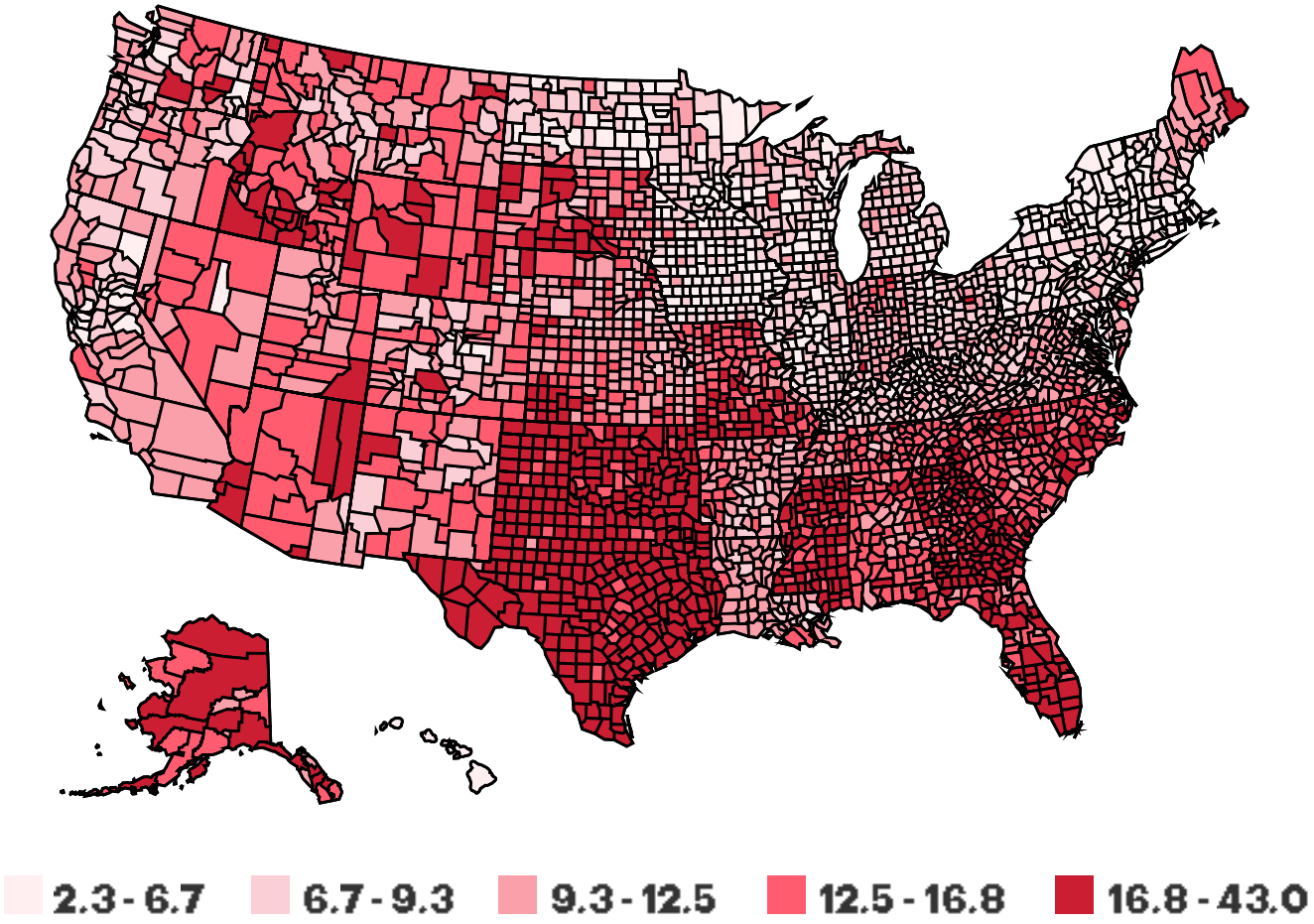
Source: Nowhere to go: Maternity Care Deserts across the U.S. March of Dimes, September 2022.

# ACCESS TO HEALTH INSURANCE

**Percentage of women without health insurance by county, 2019**




- Approximately 11% of women aged 19-64 are uninsured in the U.S.
- 48% of counties with full access to maternity care have a high proportion (≥ 10%) of women without health insurance.
- Over 55% (1,802) of all U.S. counties had a greater than 10% proportion of women without health insurance.

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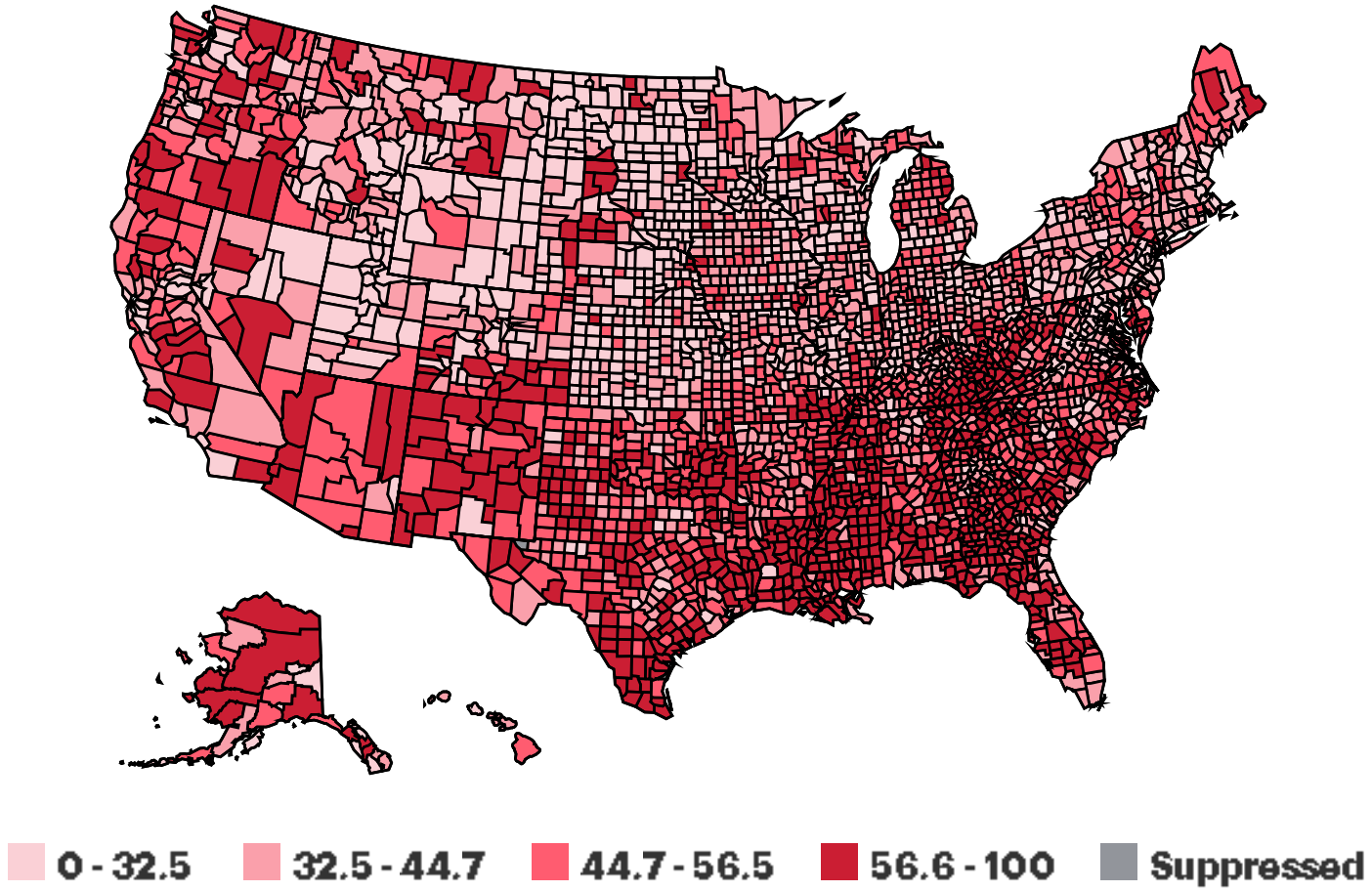
Source: Nowhere to go: Maternity Care Deserts across the U.S. March of Dimes, September 2022.

# BIRTHS COVERED BY MEDICAID

**Percentage of births covered by Medicaid, by county, 2020**




- Medicaid covered delivery care costs of more than 1.5 million pregnant women or 42% of births in the U.S.
- Nearly half of Medicaid-covered births are to Black, Hispanic or Native American birthing people.
- Health care providers are reimbursed less than private insurance, an issue especially pertinent in rural locations.

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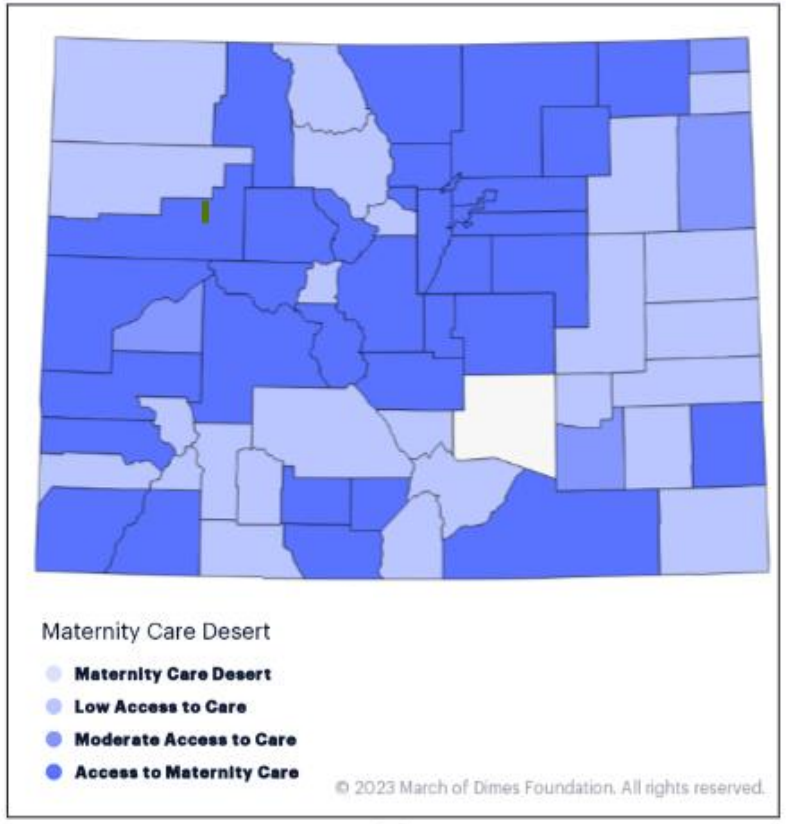
Source: Nowhere to go: Maternity Care Deserts across the U.S. March of Dimes, September 2022.

# State Profile: Colorado

## Access to Care in Colorado




| Maternal Vulnerability Index Score | Counties Designated as Maternity Care Deserts |
|---|---|
| 0 | 40% |

## Total Births in 2021: 62,949

| 14% | 30% | 35% | 15 | 74 | 22% |
|---|---|---|---|---|---|
| % BIPOC | % Hispanic | % of Births covered by Medicaid | Maternal Mortality Rate* | Severe Maternal Morbidity** | Low Risk Cesarean Births |

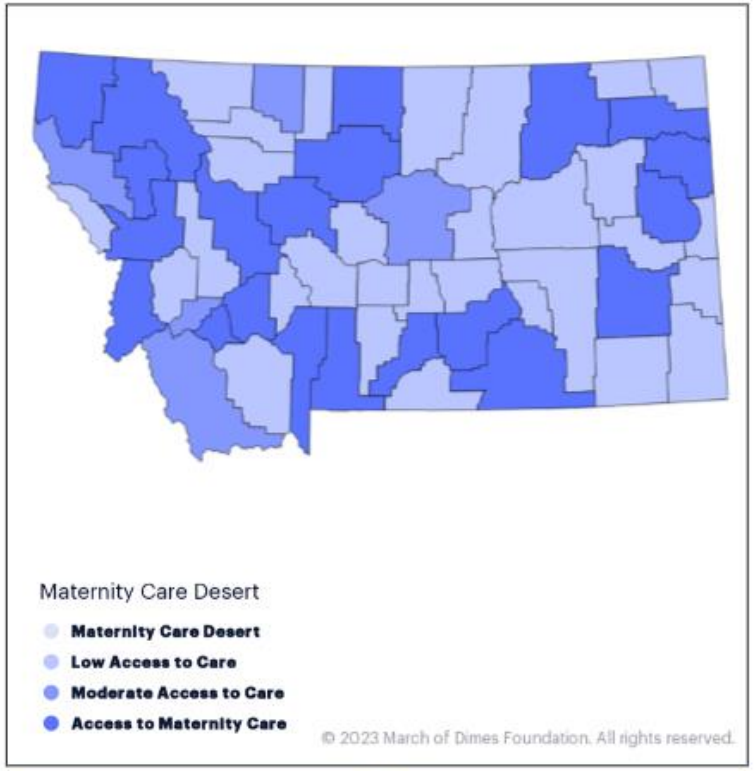
- Overall, women in Colorado have **low vulnerability to adverse outcomes** and are most vulnerable due to general healthcare accessibility.
- Non-Hispanic Black women and American Indian/Alaska Native women **were 2 and 3 times more likely to die during pregnancy or within one year postpartum** than compared to the overall population of Coloradans who gave birth in 2016 – 2020.
- The Colorado Maternal Mortality review committee found that **89% of pregnancy-related deaths were preventable.**

## Doula Legislation Status

Doula care included in state budget and legislation has been passed to support implementation work of doula care in Medicaid and ultimately private insurance

# State Profile: Montana

## Access to Care in Montana




| Maternal Vulnerability Index Score | Counties Designated as Maternity Care Deserts |
|---|---|
| 14 | 54% |

## Total Births in 2021: 11,231

| 14% | 6% | 37% | 29 | 38 | 22% |
|---|---|---|---|---|---|
| % BIPOC | % Hispanic | % of Births covered by Medicaid | Maternal Mortality Rate* | Severe Maternal Morbidity** | Low Risk Cesarean Births |

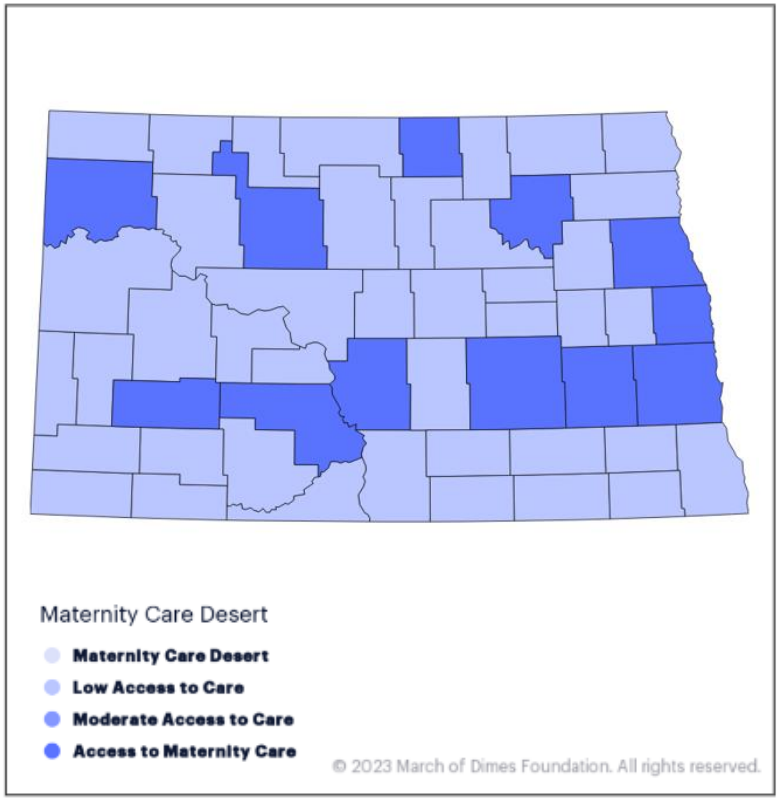
- Overall, women in Montana have **low vulnerability to adverse outcomes** and are most vulnerable due to general healthcare accessibility.
- **American Indian and Alaska Native women experienced SMM at a rate 68.8 per 10,000 hospitalizations** compared to 41.1 for white women during 2018 - 2020
- Hispanic women accounted for the **greatest percentage of low-risk cesarean births** at 28%, while American Indian and Alaska Native women recorded a rate of 21%

## Doula Legislation Status

No legislation passed. Medicaid managed care plan in the state is currently running a doula pilot program.

# State Profile: North Dakota

## Access to Care in North Dakota




| Maternal Vulnerability Index Score | Counties Designated as Maternity Care Deserts |
|---|---|
| 42 | 77% |

## Total Births in 2021: 10,112

| 20% | 7% | 23% | 24 | 57 | 19% |
|---|---|---|---|---|---|
| % BIPOC | % Hispanic | % of Births covered by Medicaid | Maternal Mortality Rate* | Severe Maternal Morbidity** | Low Risk Cesarean Births |

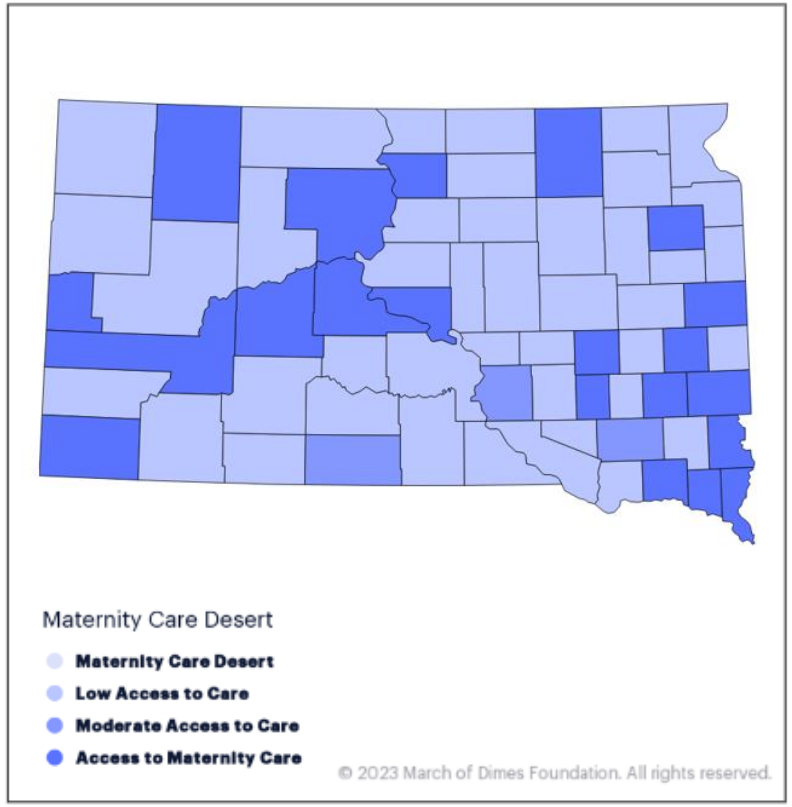
- Overall, women in North Dakota have **low vulnerability to adverse outcomes** due to the and are most vulnerable to due to general healthcare accessibility

## Doula Legislation Status

No legislation passed.

# State Profile: South Dakota

## Access to Care in South Dakota




| Maternal Vulnerability Index Score | Counties Designated as Maternity Care Deserts |
|---|---|
| 46 | 64% |

## Total Births in 2021: 11,369

| 24% | 6% | 28% | 29 | 45 | 18% |
|---|---|---|---|---|---|
| % BIPOC | % Hispanic | % of Births covered by Medicaid | Maternal Mortality Rate* | Severe Maternal Morbidity** | Low Risk Cesarean Births |

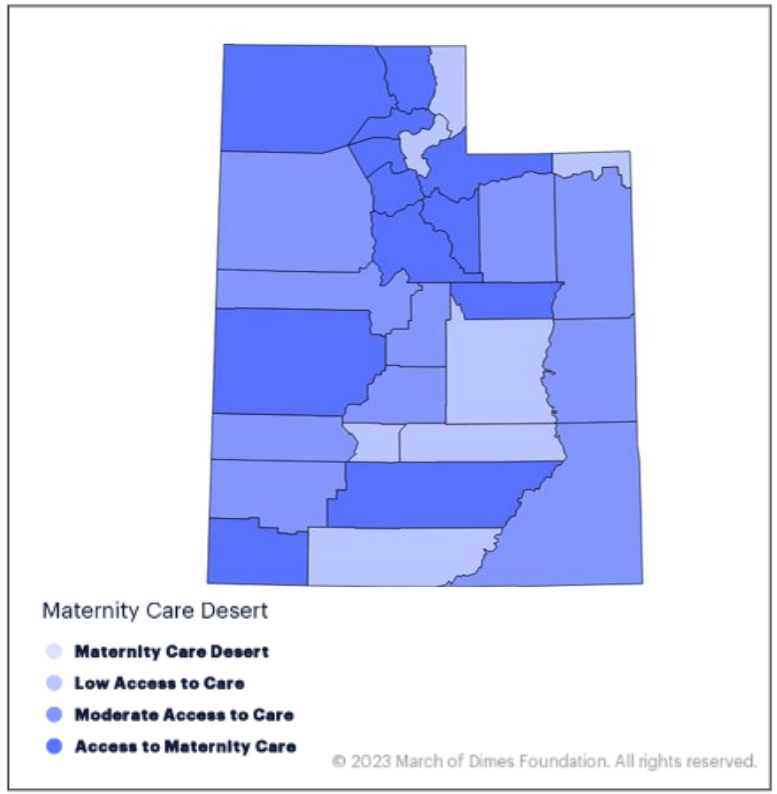
- Overall, women in South Dakota have **low vulnerability to adverse outcomes** due to the and are most vulnerable to due to general healthcare accessibility
- Rates of pregnancy – associated death among American Indians were **4 times higher** than among white women
- The South Dakota Maternal Mortality review committee found that **83% of pregnancy-related deaths** South Dakota **were preventable.**

## Doula Legislation Status

No legislation passed. Statewide non-profit called South Dakota Doulas has begun advocating for doula Medicaid legislation.

# State Profile: Utah

## Access to Care in Utah




| Maternal Vulnerability Index Score | Counties Designated as Maternity Care Deserts |
|---|---|
| 22 | 24% |

## Total Births in 2021: 46,712

| 10% | 18% | 21% | 16 | 58 | 20% |
|---|---|---|---|---|---|
| % BIPOC | % Hispanic | % of Births covered by Medicaid | Maternal Mortality Rate* | Severe Maternal Morbidity** | Low Risk Cesarean Births |

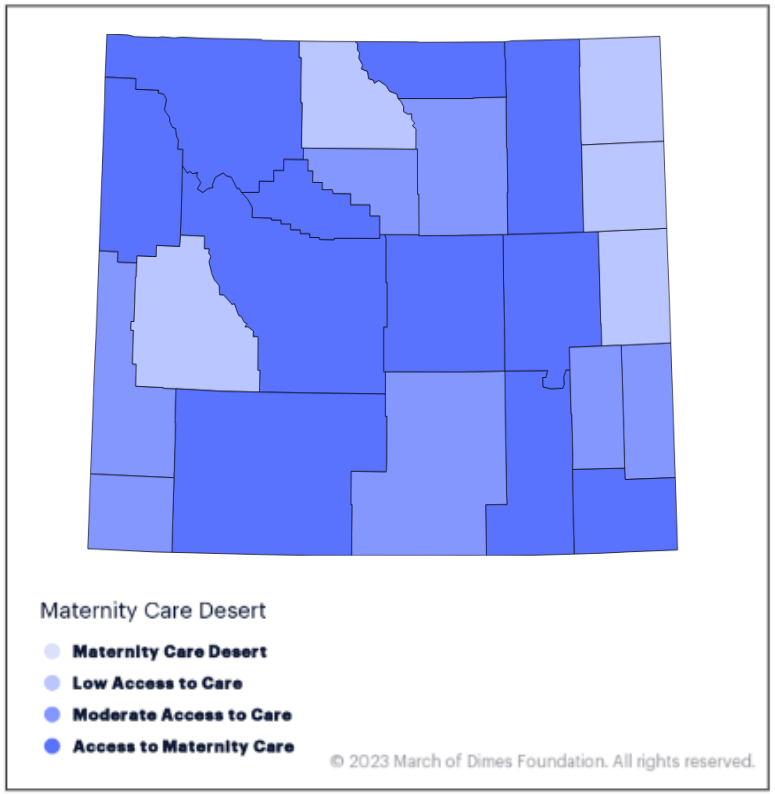
- Overall, women in Utah have a **moderate vulnerability to adverse outcomes** due to the and are most vulnerable to due to reproductive healthcare access.
- A majority of maternal deaths **(75%) were associated with a prior or current mental health condition**
- The Utah Maternal Mortality review committee found that **92% of pregnancy-related deaths** Utah **were preventable.**

## Doula Legislation Status

No legislation passed, however legislation has been introduced to expand access to doula care

# State Profile: Wyoming

## Access to Care in Wyoming




| Maternal Vulnerability Index Score | Counties Designated as Maternity Care Deserts |
|---|---|
| 20 | 22% |

## Total Births in 2021: 6,237

| 10% | 18% | 30% | Suppressed | 46 | 20% |
|---|---|---|---|---|---|
| % BIPOC | % Hispanic | % of Births covered by Medicaid | Maternal Mortality Rate* | Severe Maternal Morbidity** | Low Risk Cesarean Births |

- Overall, women in Wyoming have a low **vulnerability to adverse outcomes** due to the and are most vulnerable to due to general healthcare access.
- Among deaths which were determined to be pregnancy-related, **most deaths were caused by mental health conditions.**
- The Wyoming Maternal Mortality review committee found that **100% of pregnancy-related deaths** Wyoming **were preventable.**

## Doula Legislation Status

No legislation passed.

# MARCH OF DIMES SOLUTIONS

# FOCUSED ADVOCACY AND POLICY PRIORITIES

MARCH OF DIMES

## 2023-2024 POLICY PRIORITIES

March of Dimes leads the fight for the health of all moms and babies. We advocate for women, infants, children and families across a wide range of issues at the federal, state and local level. The diagram below outlines the highest priority issues March of Dimes will champion to improve health equity, reduce prematurity, prevent maternal mortality and make measurable strides for the health of every family.

### INCREASE ACCESS TO QUALITY HEALTH CARE

March of Dimes advocates for access to quality, high-value, private health insurance and public health coverage, as well as programs that provide integrated health care services.

**Medicaid postpartum extension**

**Access to midwives and doulas**

**Access to quality telehealth services**

### SUPPORT HEALTHY WOMEN AND BABIES

March of Dimes supports a broad range of policies and programs to promote health, improve health equity, prevent disease, further patient safety and prevent infant mortality. Advocating for a comprehensive national response to high maternal mortality and morbidity rates, especially among women of color who face health disparities.

**Access to mental health services**

**Workplace policies for families**

### IMPROVE RESEARCH AND SURVEILLANCE

March of Dimes advocates for innovative medical research and robust health surveillance programs, which are essential to discovering ways to prevent, diagnose and treat maternal and child health conditions, track occurrence and promote health equity.

**Maternal Mortality Review**

**Newborn screening modernization**

**Vaccination compliance**

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### INCREASE ACCESS TO QUALITY HEALTH CARE

- Expanding access to Medicaid, including extending coverage for mothers after childbirth to 12 months.
- Support expanded access to midwifery care for women who desire services, by further integrating midwives into maternity care, and promote full practice authority by removing restrictive laws and regulations.
- Advocate for Medicaid and private insurance coverage for doula care services.
- Increase access to quality telehealth services and technology to providers and pregnant women, especially for women living in maternity care deserts or with other obstacles to receiving care.
- Oppose harmful Medicaid block grant proposals, work requirements and other barriers to coverage.

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### SUPPORT HEALTHY WOMEN AND BABIES

- Support authentic and standardized implicit bias training for health care providers and staff, caring for women before, during and after pregnancy, as well as training accountability and governance policies to enhance broader goal of achieving equity for moms and babies.
- Support efforts that are critical to addressing and improving maternal mental health through; access to and insurance coverage, universal screening, referral and treatment coordination, consumer and provider education and surveillance and data collection.
- Advocating for policies and programs to prevent and treat substance use, including opioids and Neonatal Abstinence Syndrome (NAS) surveillance programs, with a focus on the safety and care of pregnant women and infants.
- Advancing policies to support mothers and reduce health disparities in the workplace such as parental leave, paid family leave, pregnancy accommodations, nondiscrimination and breastfeeding promotion.
- Promoting policies and practices that address social determinants (drivers) of health to help reduce health inequities related to housing, transportation, environmental health, food insecurity and access to nutritional foods.
- Ensuring coverage of immunizations and supporting efforts by federal agencies and Congress to address vaccine hesitancy and dispel misinformation about immunizations that endanger the public health.

### IMPROVE RESEARCH AND SURVEILLANCE

- Advancing legislation to enhance, standardize best practices and sustain Maternal Mortality Review Committees (MMRCs) and perinatal quality collaborative (PQCs) to further patient safety.
- Supporting federal and state legislation to protect and enhance newborn screening, ensure every state tests each newborn for all conditions on the Recommended Uniform Screening Panel (RUSP).
- Promoting surveillance, research and data collection on key maternal and child health priorities, including birth defects, preterm birth, health disparities, maternal depression and infant and maternal mortality.
- Supporting funding for the National Institutes of Health (NIH) and National Institute of Child Health and Human Development (NICHD) to continue maternal, child and infant health research and data collection.
- Encouraging Congress to invest more in the nation's public health infrastructure including the CDC, state, local, tribal and territorial core public health infrastructure to ensure we are prepared for the next public health emergency.
- Champion funding for pre-term birth research at Centers for Disease Control and Prevention (CDC).
- Promoting research to help pregnant and breastfeeding women and their health care providers know what medications are safe for them and their infants by advancing the recommendations of the Task Force on Research Specific to Pregnant Women and Lactating Women.

# ADVOCACY: #BLANKETCHANGE

**Our #BlanketChange advocacy agenda urges local, state, and federal policymakers to take action in these areas to support moms and babies:**

## Increase access to quality health care

- Medicaid postpartum extension
- Access to midwives and doulas
- Access to quality telehealth services

## Support healthy women and babies

- Access to mental health services
- Workplace policies for families

## Improve research and surveillance

- Maternal Mortality Review
- Newborn screening modernization
- Vaccination compliance

**BLANKETCHANGE.ORG**

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# LDA CAMPAIGN

**A comprehensive national campaign to increase equitable access to and utilization of low-dose aspirin among patients at risk of preeclampsia**

# What is Preeclampsia?

**Preeclampsia is defined as an elevated blood pressure after 20 weeks of pregnancy with clinical signs that one's brain, liver, and kidneys are not functioning properly.** The onset of preeclampsia can happen from the 20th week of pregnancy through six weeks postpartum.

- **Preeclampsia occurs in 5-8% of all pregnancies.**
- **According to the CDC, preeclampsia is the leading cause of maternal and fetal morbidity and mortality.**
- **Black women are 60% more likely to have preeclampsia than White women.**

**Risks of preeclampsia to the mother:** Maternal seizure, stroke, organ damage (particularly the kidney and liver), increase in chronic hypertension, life-long increase of cardiovascular and renal disease, and in extreme cases, maternal death.

**Risks of preeclampsia to the infant:** Insufficient blood flow through the placenta leading to low birth weight, premature birth, and in severe cases, stillbirth.

# LDA CAMPAIGN

## Low-Dose Aspirin daily has been associated with:

- Decreased risk of developing preeclampsia in the third trimester by approximately **20–30%**
- Decreased risk of preterm birth by **14%**
- Fetal growth restriction by **20%**

## Low-Dose Aspirin is recommended for certain high-risk individuals during pregnancy by:

- American College of Obstetrics and Gynecology
- Society for Maternal Fetal Medicine
- U.S. Preventative Services Task Force

# Benefits of low-dose aspirin

Low-dose aspirin has been shown to provide certain benefits in reducing the risk and severity of preeclampsia in pregnant individuals considered at high risk for the condition.

Some of these benefits include:

- **Reduced risk of preeclampsia**
- **Improved blood flow**
- **Potential reduction in preterm birth**
- **Lowered severity of preeclampsia**
- **Potential cardiovascular benefits for the mother**

# Barriers to utilization of low-dose aspirin

Several barriers may prevent high-risk patients from taking low-dose aspirin as a preventive measure against conditions like preeclampsia.

Addressing these barriers requires a multifaceted approach involving patient education, provider training and awareness, culturally competent care, and clear communication regarding the safety and benefits of low-dose aspirin in preventing preeclampsia.

Some of these barriers include:

- **Lack of awareness**
- **Healthcare provider awareness and prescribing practices**
- **Concerns about side effects**
- **Language and cultural barriers**
- **Complexity of regimen**

# ADVANCING ACCESS TO DOULA CARE

**Strengthening demand for utilization and systems integration of doula services**

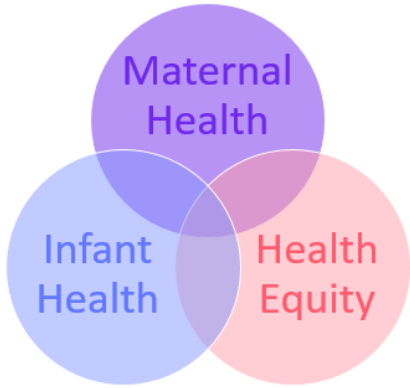
- Awareness of and demand for doula services
- Education of maternity care providers and administrators
- Organizational policies that promote sustainable doula integration

**Growth, diversification, and support of doula workforce**

- Awareness of and demand for doula training programs
- Accessibility of doula training programs
- Attrition prevention and continued support of the doula workforce

**Improvement of financial and operational efficiency**

- Affordability of doula services
- Ability of doulas to earn a living wage
- Support for doulas engaging in 3rd party payment and reimbursement models




**Through multi-year, cross-functional, aligned investments and efforts at the national and local levels:**

- **Consumer Education**
- **Advocacy**
- **Research**
- **Professional Education**
- **Partner & Community Engagement**

# MOM & BABY MOBILE HEALTH CENTERS®



- **IMPACT** – Mom & Baby Mobile Health Centers directly increase access to high-quality care to underserved communities and bring pregnancy care to the **patients who need it most**
- **VISIBILITY** – Mom & Baby Mobile Health Centers are a tangible and highly visible representation of March of Dimes delivering our mission in the communities we serve and are viewed as an effective and innovative approach to addressing the maternal and infant health crisis
- **THOUGHT LEADERSHIP** – Since 2007, March of Dimes Mom & Baby Mobile Health Centers have delivered care to **over ten thousand patients** who would have otherwise gone without quality healthcare.

# Call to Action

**We all have a role to play in addressing maternal health challenges in our local communities. This data is the catalyst to take action now to improve outcomes for all moms and babies.**

- You can do your part for maternal health in your local communities through ways such as education, advocacy, donation and partnership:
  - **Educate:** Learn more about the challenges facing your community and learn ways to get involved by visiting www.marchofdimes.org/mcdr
  - **Donate:** Individuals can help fund lifesaving research and community programs that keep families healthy and strong at marchofdimes.org/donate
  - **Activate:** Partner with March of Dimes to bring greater awareness and resources to fight the maternal and infant health crisis at marchofdimes.org/partner
  - **Share:** Use our social toolkit to share the Report Card and your state's information on social media—be sure to tag @marchofdimes and use #PrematurityAwarenessMonth and #WorldPrematurityDay.

- **Visit www.marchofdimes.org/mcdr to learn about the maternal health crisis and how you can help drive solutions.**

# THANK YOU

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