Maternity & Perinatal Care Deserts

September 11, 2024

KEY TAKEAWAYS

1. Texas continues to face a state-wide maternal morbidity and mortality crisis, which has resulted in part from the lack of geographical access to maternity and perinatal care.
2. Traveling further to attend healthcare appointments can make it difficult to receive adequate care, increasing the likelihood of adverse outcomes.
3. Several legislative actions in Texas have addressed the strain on rural hospitals and obstetric (OB) providers, and it is important to build on this work so that rural communities can maintain care.

Hospital Closures

Many publicly funded rural hospitals have struggled in recent years due to: 1) low, stagnant Medicaid and Medicare payments; 2) increased costs; 3) declining rural populations; 4) high rates of uninsurance; and 5) widespread healthcare staffing shortages.[1-3]

Rural Hospital Closures: Nationwide[4-6] and State[5-7]

192 hospitals have closed in the United States since 2005, and **267 OB units (25%)** closed between 2011 and 2021.

25 hospitals (14%) have closed in Texas since 2005, and **17 OB units** closed between 2011 and 2021.

Only **40%** of rural hospitals in Texas still have a labor and delivery unit.[8]

- Most hospital OB unit closures across the U.S. were among facilities serving mainly Black patients.[2]
- OB units are often the first to be shut down when hospitals are struggling to keep their doors open.[8]
  - Labor & delivery (L&D) are costly. In most cases, hospitals do not profit from these services — and may even lose money — since Medicaid does not reimburse their full cost.[1,3,9]

When patients are forced to travel outside of their communities to receive obstetric care, they are likely to return to that setting for future medical needs like primary care and pediatrics.

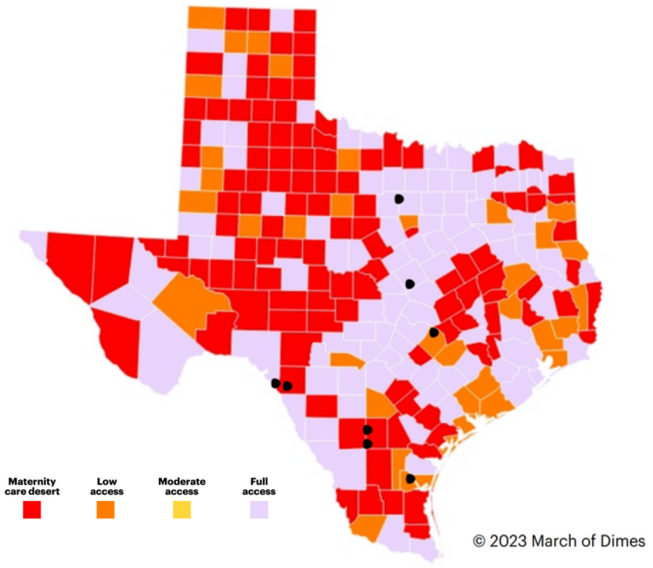
- With dwindling numbers of patients, rural facilities **struggle to cover costs** and a cycle develops:[1,8]

Rural hospitals can't offer **as competitive a salary** as urban hospitals. → **Recruiting and retaining staff** becomes an immense challenge. → Without enough staff, hospitals may need to redirect patients, further **reducing engagement and future public funding**.

Maternity Care Deserts

Less than half of Texas' rural hospitals have an L&D unit, contributing to the extent of maternity care deserts across the state.

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



51st In 2024, Texas ranked 51st out of 51 states, including D.C., in overall **health care access and insurance coverage**, and 49th in **health care quality** for women of childbearing age.[10]

47% 47% of **counties** in Texas were considered **maternity care deserts** in 2022, compared to **33%** in the U.S.[11]

68% Only 68% of **Texas mothers** met the recommendation in 2020 to enter **prenatal care during the first trimester**, which was a lower proportion than any other state.[12]

6 6 out of 8 **military bases** in Texas are located in **maternity care deserts or areas of low access**, and all 8 are in federally designated primary care shortage areas.[13]

4.5x Women living in maternity care deserts **travel** 4.5 times **farther** than women living in areas with full access to maternity care in Texas.[11]

Over 1 in 4 women in rural Texas:[11]

Live more than 30 minutes from the nearest birthing hospital

Travel an average of 70.5 miles to get to a birthing hospital

Implications

The statewide maternal morbidity and mortality crises are exacerbated when women are unable to receive adequate prenatal, L&D, and postpartum care.

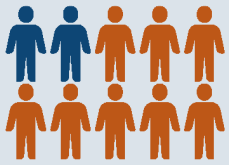
- Traveling farther for prenatal care can cause: (1) financial strain on families and (2) increased stress and anxiety. **These social and emotional risks can exacerbate clinical risks.**[11,18]
- During L&D, longer distances to delivery hospitals can delay medical attention or lead to riskier deliveries in non-hospital settings.[14]
  - Traveling farther during labor has been linked to increased risks of experiencing at least one **adverse maternal outcome**, including blood transfusion, unplanned operation, intensive care unit (ICU) admission, or perinatal mortality.[15-17]

States with the **highest obstetric unit closure rates** tend to have the **highest infant mortality rates**.[6]

- Unmonitored pregnancies have an increased risk of **adverse infant outcomes**, such as stillbirth, preterm birth, low birthweight, and Neonatal ICU (NICU) admission.[11,16]
- Rural counties see more births in emergency departments, more cesarean births, and a 9% greater probability of severe maternal morbidity.[14,17]

Rural OB unit closures negatively impact many rural residents, but the effects may be worse for racial and ethnic minority groups.[19]

Racial and ethnic minority groups make up 22% of the rural population.[19]



- Women of color are more likely to live in maternity care deserts.[20]
- American Indian/Alaska Native (AI/AN) women are disproportionately affected by maternal and infant mortality and maternity care access.[20]
  - AI/AN individuals are the only group with a higher population in rural rather than urban areas.[19]
  - The U.S. census tracts where the predominant race is AI/AN have the highest travel distances to the nearest OB facility.[21]
- Black and Hispanic women are less likely to initiate first trimester prenatal care.[22]
  - Location of care and insurance status are two main factors contributing to these disparities.

Recommendations

Short-term strategies for mitigating the impacts of maternity care deserts are available, but addressing the strain on rural hospitals and obstetric providers requires long-term solutions.

- Creation of a broader maternity care workforce through training and education can help fill in the gaps. [2,23]
  - Certified Nurse Midwives, Women's Health Nurse Practitioners, and doulas can provide support for uncomplicated pregnancies when obstetric care is inaccessible.
  - Alternative modalities for provision of care such as group prenatal care, telehealth, or home visiting programs like Nurse Family Partnership may also be suitable in some situations.
  - Family physicians already serving rural communities can also provide outpatient prenatal care and partner with an obstetrician for delivery.
- Reception of higher Medicaid reimbursements is critical for protecting hospitals in danger of closing or stopping obstetric services.[2,9]
  - Actions include preserving supplemental payments and maintaining the L&D add-on.
- Reduction of the number of uninsured Texans by investing in outreach to connect people to coverage can also help prevent closures. [7]

The Texas Legislature has previously taken actions that support rural maternity care providers and address maternal morbidity and mortality.

- In 2013, the 83rd Legislature established the Maternal Morbidity and Mortality Task Force to review cases of pregnancy-related death and make recommendations to prevent them.[24]
- In 2019, the 86th Legislature allotted extra Medicaid dollars for obstetric services.[8]
- In 2023, the 88th Legislature tripled the Medicaid L&D add-on payment from $500 to $1,500, dedicated $50 million for the Rural Hospital Stabilization Grant Program, and extended postpartum Medicaid coverage to 12 months.[7]

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Suggested Citation

Berns K, Zhang Y, Linton R, Menendez T, Handler K, Linan A, Flores-Thorpe S, Campos-Hernandez M, van den Berg AE, Briggs E, Ramsey P, Ramirez E, Hoelscher DM. UTHealth Houston School of Public Health in Austin, Michael & Susan Dell Center for Healthy Living. September 11, 2024. Maternity and Perinatal Care Deserts. A report of the Texas Research-to-Policy Collaboration Project.