HEALTHY MOMS. STRONG BABIES.

WHERE YOU LIVE MATTERS: MATERNITY CARE IN DISTRICT OF COLUMBIA

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; 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. While not an exhaustive list, each of these topics contribute to the complexity of maternity care access in each state and in the District of Columbia. 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

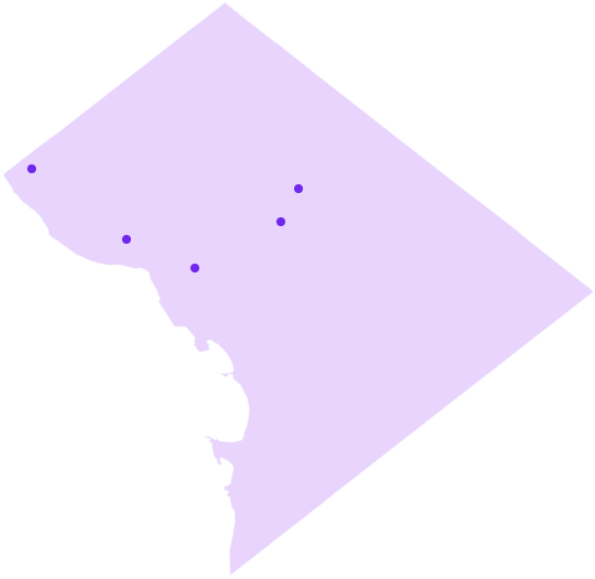
- In D.C., there was a 20 percent decrease in the number of birthing hospitals between 2020 and 2019.
- Black women in D.C. travel 1.9 times farther to reach their nearest birthing hospital compared to all other races.
- Overall, women in D.C. have a very low vulnerability to adverse outcomes due to the availability of reproductive healthcare services.
- 18.5 percent of birthing people received inadequate prenatal care, greater than the U.S. rate of 14.8 percent.
- Women with chronic health conditions have a 69 percent increased likelihood of preterm birth compared to women with none.

MATERNITY CARE ACCESS IN DISTICT OF COLUMBIA

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 in D.C. is classified by the availability of birthing facilities, maternity care providers, and the percent of uninsured women (see table). The map shows that D.C. is designated as having full access to maternity care, however, variations in access are prominent when examining the district by ward.

FINDINGS

- In D.C., there was a 20% decrease in the number of birthing hospitals between 2020 and 2019.
- In D.C., there was a 2.8% increase in the number of obstetric providers between 2020 and 2019.
- In D.C., 15% of obstetric providers are certified nurse midwives and 0.8% are family practice physicians who reported delivering babies.
- 3.7% of reproductive aged women were uninsured in D.C.



Maternity care desert | Low access | Moderate access | Full access | Hospital locations

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 1 or more of the criterion. †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-dc**

For details on data sources and calculations, see Technical Notes: **https://www.marchofdimes.org/peristats/maternitycaretechnotes**

DISTRICT OF COLUMBIA

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]

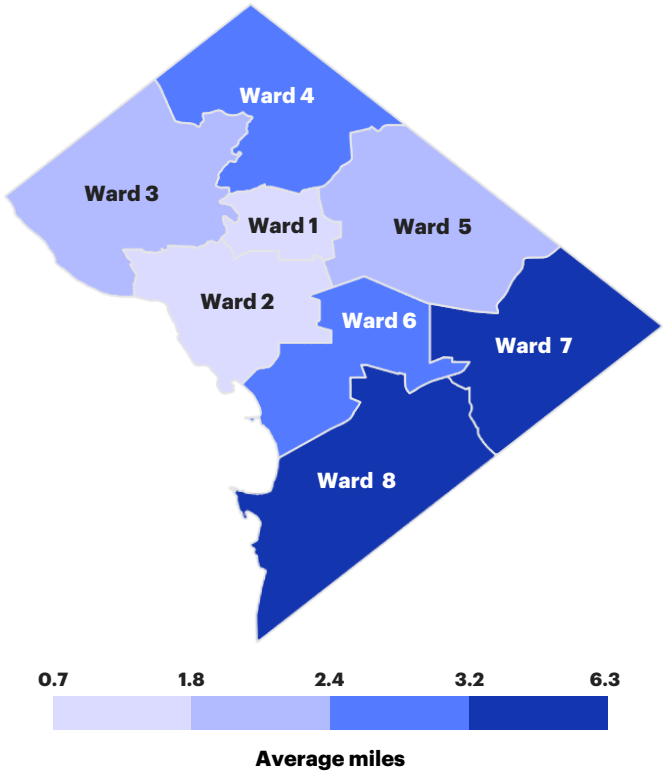
Mapping software was utilized to calculate distance, in miles and minutes, under normal traffic conditions and using real-world travel routes. To highlight differences across D.C., the map indicates the average distance to the closest birthing hospital by ward, which are administrative boundaries based on population distribution (see technical notes). 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

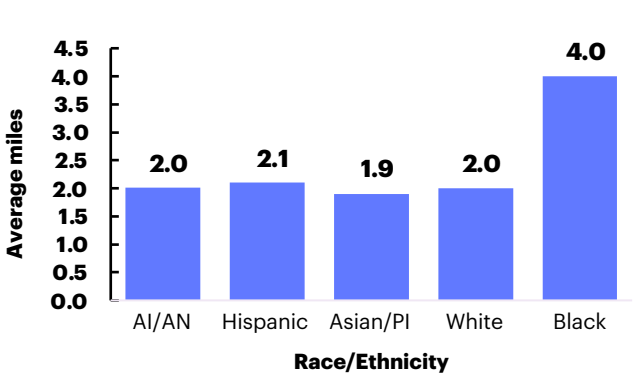
- In D.C., women travel 3.0 miles and 11.7 minutes, on average, to their nearest birthing hospital.
- Women living in wards with the highest travel times (top 25 percent) could travel up to 6.3 miles and 25.0 minutes, on average, to reach their nearest birthing hospital in D.C.
- Black women in D.C. travel 1.9 times farther to reach their nearest birthing hospital compared to all other races.
- Birthing people living in ward 8 travel 2.9 times farther than all other wards.
- In ward 8, 56.1% have access to a vehicle compared to 64.3% in D.C. and 91.7% percent in the US, indicating a heavier reliance on public transit resulting in potentially longer travel times.[7]
- Despite adjusting for distance traveled to care and maternal age, Black women were 2.1 times more likely to have a preterm birth when compared to White women in D.C.

On average, women in D.C. travel 3.0 miles to the nearest birthing hospital.

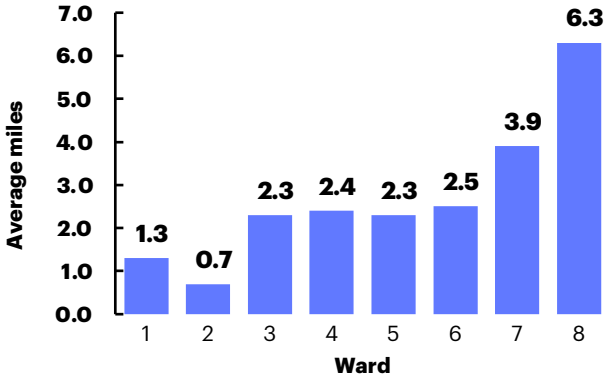
DISTANCE TO BIRTHING HOSPITAL BY WARD



DISTANCE TO CARE BY RACE/ETHNICITY



DISTANCE TO CARE BY WARD



Sources: Healthcare Cost and Utilization Project State Inpatient Database. Dist. of Columbia. 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.

Note: AI/AN=American Indian/Alaska Native. PI=Pacific Islander.

DISTRICT OF COLUMBIA

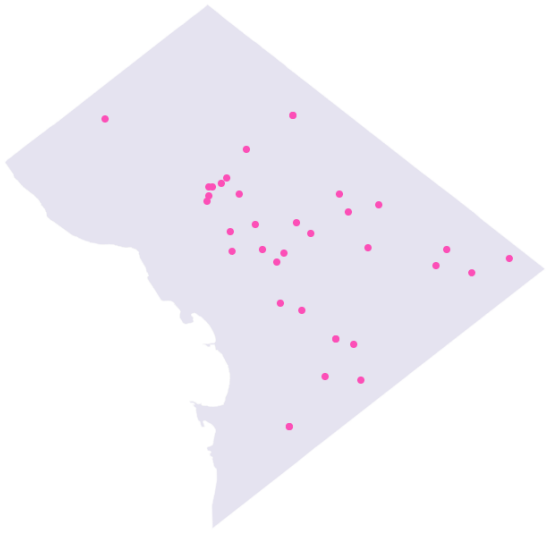
AVAILABILITY OF FAMILY PLANNING SERVICES

Access to family planning services allows for people to achieve their goals around having children, including the timing of and spacing between pregnancies.[8] An unexpected pregnancy or too little time between pregnancies can lead to serious health consequences, including preterm birth, depression, and anxiety.[9,10] Providing access to affordable contraceptives is a strategy to help people attain their family planning goals.[11] Title X clinics are federally funded healthcare sites that provide low-cost reproductive healthcare services including contraceptives, wellness exams, and breast and cervical cancer screenings.[12] The map displays Title X locations and areas where women are vulnerable to poor outcomes due to lack of access to reproductive health services. Risk data are derived from Surgo's U.S. Maternal Vulnerability Index (MVI), where a darker color indicates greater vulnerability.[13] Overall, women in D.C. have a very low vulnerability to adverse outcomes due to the availability of reproductive healthcare services.

FINDINGS

- There are 17.9 Title X clinics per 100,000 women in D.C. compared to 5.3 per 100,000 in the U.S. overall.
- On average, people living in D.C. travel 0.9 miles to reach their nearest Title X clinic, compared to the U.S. average of 9.4 miles.
- The teen birth rate for D.C. was 17.6 per 1,000 females aged 15-19 compared to the US rate of 16.7.

REPRODUCTIVE MATERNAL VULNERABILITY AND TITLE X CLINIC LOCATION



Sources: Surgo Maternal Vulnerability Index; U.S. Department of Health & Human Services, Office of Population Affairs. Title X Family Planning Directory (March 2023); United States Census Bureau. "S1301: Fertility." American Community Survey. 2017–2021. Web. 1 Nov 2022.

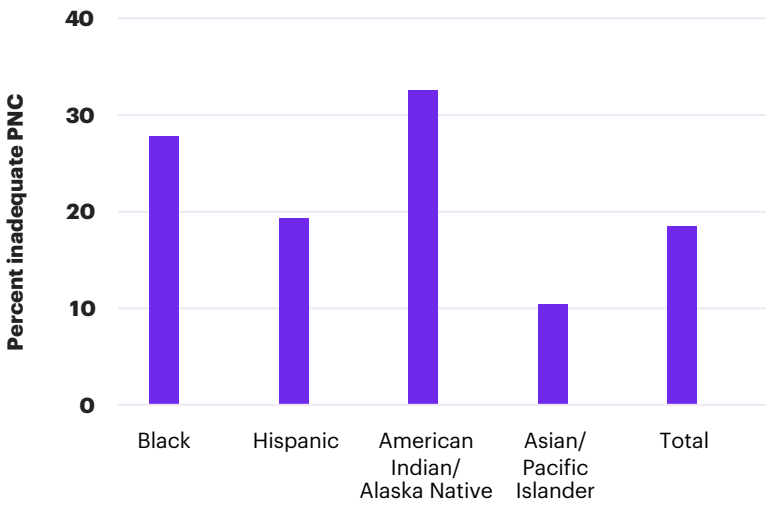
DISPARITIES IN PRENATAL CARE

Early and regular prenatal care (PNC) is an important strategy for reducing the risk of pregnancy complications and adverse birth outcomes.[14] Historically, BIPOC have lower rates of adequate PNC and may be less likely to receive services such as important health screenings and appropriate monitoring of baby's growth.[15,16] Community level factors, such as poverty, create barriers to accessing care that can worsen the disparity in PNC usage among BIPOC [17] The impact of poverty on PNC usage was assessed by examining the percent of women receiving inadequate PNC in areas of high and low poverty. In D.C., 18.5 percent of women received inadequate PNC compared to 14.8 percent in the U.S.

FINDINGS

- 2.8% of BIPOC did not receive PNC in D.C.
- BIPOC living in D.C. had a 384% increased likelihood of inadequate prenatal care when compared to White residents.
- The poverty rate for ward 7 and 8 is 25.0% and 28.7%, respectively and is over 2 times the poverty rate of ward 2, which is 12.3%.[7]

INADEQUATE PRENATAL CARE BY RACE/ETHNICITY



Source: National Center for Health Statistics, 2019-2021 final natality data.

Note: Inadequate PNC is defined as no prenatal care or care that began during or after the fifth month of pregnancy or that included less than half of the appropriate number of visits for the infant's gestational age.

DISTRICT OF COLUMBIA

CHRONIC HEALTH CONDITIONS AND PRETERM BIRTH

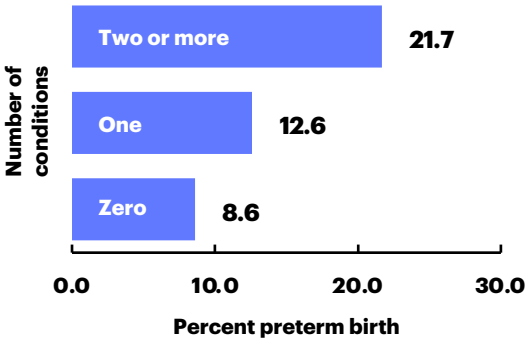
Having a chronic health condition before pregnancy increases the risk of pregnancy and postpartum complications. Preterm birth (PTB), a delivery before 37 weeks gestation, is one example of a complication that can lead to serious health impacts. The burden of chronic health conditions among birthing people is increasing across the U.S.[18,19] Access to healthcare before, during, and after pregnancy is important for appropriate management of chronic health conditions. At the time of birth, women with chronic conditions and their babies may need access to higher-level care, such as specialized providers, hospitals with the ability to perform a Cesarean birth, or hospitals with NICUs. Examining the chronic health burden (CHB) in D.C. and its relationship to adverse outcomes provides information needed to make important changes that can result in targeted resource allocation, prevention, and appropriate disease management.

The percent of birthing people in D.C. with one or more chronic conditions was calculated. The following conditions were included due to their availability in birth record data and established association with PTB: pre-pregnancy hypertension and diabetes, smoking, and being underweight or obese before pregnancy. The map describes the ward level rate of PTB where darker color indicates a higher rate of PTB. The national Healthy People 2030 (HP2030) target for PTB is 9.4 percent.[20] In D.C., the PTB rate was 10.1 percent, compared to 10.5 percent in the U.S. overall in 2021.

FINDINGS

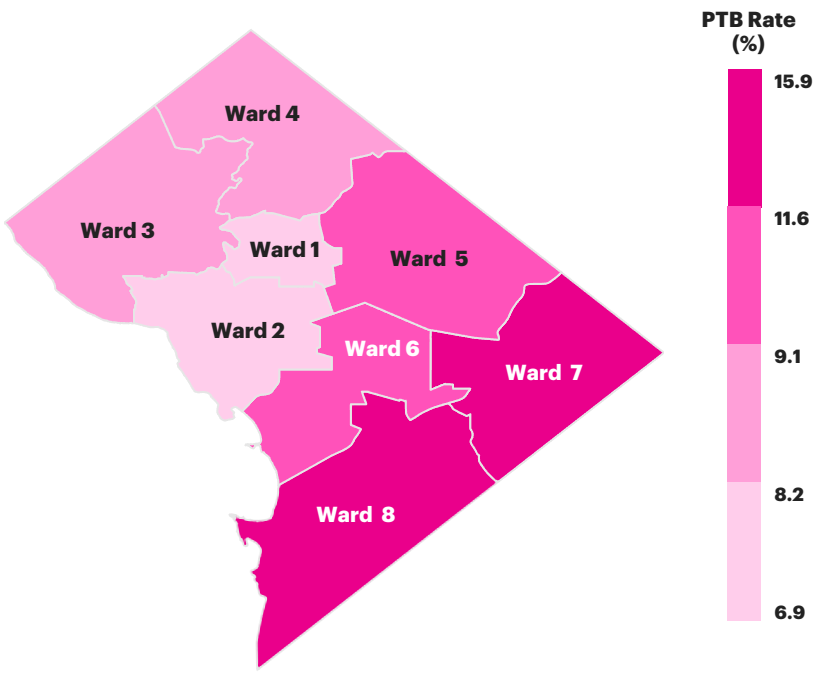
- In D.C., 29.7% of women had one or more chronic health conditions compared to 37.8% in the U.S. overall.
- Women with one or more chronic health conditions have a 69% increased likelihood of having a preterm birth compared to those without any chronic health conditions.
- 62.5% of wards in D.C. have a high rate of preterm birth, defined as higher than the HP2030 target of 9.4 percent.

PRETERM BIRTH BY NUMBER OF CHRONIC HEALTH CONDITIONS



Sources: National Center for Health Statistics, 2017-2021 final natality data. Healthcare Cost and Utilization Project State Inpatient Database. D.C. Agency for Healthcare Research and Quality, 2021. Web. 1 Nov 2022.

PRETERM BIRTH (PTB) BY WARD



Note: The burden of chronic health conditions is the percent of birthing people in each county with one or more chronic conditions. Data for counties with less than 10 preterm births or women with chronic health conditions are excluded from map.

SUMMARY

All women deserve healthcare which is safe, effective, timely, efficient and equitable. Consistent and equitable access to maternity care helps women maintain optimal health as well as reduce the risk of experiencing complications during pregnancy and the postpartum period. Several factors influence maternity care access for women across the U.S. By assessing distance to care and the availability of maternity care providers, hospitals and family planning services, this report provides insight into several physical components that affect a person's ability to receive care. In addition, examining community level factors associated with access to care and identifying vulnerable populations provides greater context around barriers to receiving appropriate care. Together this information can lead decision makers, public health professionals, clinicians and researchers to advocate for policies and resources that increase maternity care access across each state.

By addressing these factors, states may move closer to eliminating pregnancy-related deaths and complications. Telehealth, through various platforms, equips maternal health providers with the tools to better facilitate care before, during and after pregnancy and has been shown to not only increase access but also improves patient engagement and treatment.[21] March of Dimes fully supports Congress, governmental regulating agencies and states to act and make telehealth provisions balanced and permanent. Evidence-based telehealth services and other innovative solutions are explored in greater depth on page 5.

DISTRICT OF COLUMBIA

POLICY SOLUTIONS AND ACTIONS

March of Dimes has long supported policies that improve access to maternity care, including Medicaid expansion and extension, improved integration of the midwifery model of care, reimbursement for doula care, and increasing the availability of telehealth services across a range of healthcare specialties. Telehealth is healthcare delivered using technology to replace or enhance in-person care and can save lives by providing high-quality care for pregnant and postpartum people.[21] Women who are underserved, vulnerable to poor health outcomes, and have limited access to high-risk care can greatly benefit from telehealth.[21]

To address the limited access to maternity care in the U.S., states must adopt and support telehealth and other innovative practices to expand access and provide more options for healthcare delivery. The current state of telehealth policies and innovative solutions in D.C. aimed at improving maternal health outcomes is explored in this report. By highlighting innovative solutions implemented across states, policymakers and healthcare professionals can identify policies and programs that can improve health for pregnant people in D.C. and ensure they receive the support and care needed before, during, and after pregnancy.

TELEHEALTH LAW

Due to the COVID-19 Public Health Emergency (PHE), states expanded access to telehealth services. While many of the policies increased access to telehealth for maternity care services temporarily, many states permanently expanded telehealth services. This policy measure identifies whether D.C. has passed laws to permanently provide Medicaid telehealth coverage for maternity care services.[22, 23]

TELEHEALTH COVERAGE

Medicaid telehealth policies vary by state. States may cover all forms of telehealth services or restrict certain forms of telehealth services.[22] This policy measure identifies whether D.C. provides Medicaid reimbursement of the following telehealth services:

✓ Live video ✗ Remote patient monitoring ✓ Audio-only[22]

✓ Meets recommendations ✱ Progressing toward recommendations ✗ Needs improvement

POLICY AND PROGRAM INNOVATION

- District of Columbia offers Medicaid presumptive eligibility which provides immediate healthcare coverage for income-eligible pregnant people in D.C.[24]
- D.C. Healthcare Finance Department 2022 Maternal Health Projects were in the following three areas:
  - Coverage of doula services;
  - Expansion of postpartum coverage to one year; and
  - Extension of non-emergency medical transportation benefits to pregnant and postpartum Alliance beneficiaries. [25]

DISTRICT OF COLUMBIA

REFERENCES

[1] Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: Final Data for 2020. National Vital Statistics Reports. 2022;70(17). Accessed April 5, 2023. https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-17.pdf

[2] Brigance C, Ripley L, Jones E, et al. *Nowhere to Go: Maternity Care Deserts Across the U.S. (Report No. 3).* March of Dimes. 2022. Accessed April 5, 2023. https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx

[3] U.S. Government Accountability Office (GAO). Availability of Hospital-Based Obstetric Care in Rural Areas. October 2022. Accessed April 5, 2023. https://www.gao.gov/assets/gao-23-105515.pdf

[4] Roa L, Uribe-Leitz T, Fallah PN, et al. Travel Time to Access Obstetric and Neonatal Care in the United States. Obstetrics and Gynecology. 2020;136(3):610-612. doi:10.1097/AOG.0000000000004053

[5] Minion SC, Krans EE, Brooks MM, Mendez DD, Haggerty CL. Association of Driving Distance to Maternity Hospitals and Maternal and Perinatal Outcomes. Obstetrics and Gynecology. 2022;140(5):812-819. doi:10.1097/AOG.0000000000004960

[6] Kozhimannil KB, Hung P, Henning-Smith C, Casey MM, Prasad S. Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States. JAMA. 2018;319(12):1239. doi:10.1001/JAMA.29018.1830

[7] DC Office of Planning, State Data Center (SDC). 2017-2021 American Community Survey (ACS) Key Demographic Indicators. Accessed April 29, 2023. https://planning.dc.gov/sites/default/files/dc/sites/op/publication/attachments/Key%20Indicators%202017-2021.pdf

[8] World Health Organization (WHO). Family planning/contraception methods. Published November 9, 2020. Accessed April 9, 2023. https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception

[9] Kaiser Family Foundation. The U.S. Government and International Family Planning & Reproductive Health Efforts. Published November 11, 2021. Accessed April 3, 2023. https://www.kff.org/global-health-policy/fact-sheet/the-u-s-government-and-international-family-planning-reproductive-health-efforts/

[10] Napili A. Title X Family Planning Program. Published June 2022. Accessed April 3, 2023. https://crsreports.congress.gov/product/pdf/IF/IF10051#:~:text=What%20Is%20the%20Federal%20Funding,Rescue%20Plan%20Act%20(ARPA%2C%20P.L

[11] Centers for Disease Control and Prevention (CDC). Premature Birth. Published November 1, 2022. Accessed April 3, 2023. https://www.cdc.gov/reproductivehealth/features/premature-birth/index.html

[12] U.S. Department of Health & Human Services (HHS), Office of Population Affairs. Title X Service Grants. Accessed April 3, 2023. https://opa.hhs.gov/grant-programs/title-x-service-grants

[13] Valerio VC, Downey J, Sgaier SK, Callaghan WM, Hammer B, Smittenaar P. Black-White Disparities in Maternal Vulnerability and Adverse Pregnancy Outcomes: an Ecological Population Study in the United States, 2014-2018. Accessed April 3, 2023. *The Lancet Reg Health Am.* https://www.thelancet.com/journals/lanam/article/PIIS2667-193X%2823%2900030-3/fulltext

[14] Alexander GR, Kotelchuck M. Assessing the Role and Effectiveness of Prenatal Care: History, Challenges, and Directions for Future Research. Public Health Reports. 2001;116(4):306. doi:10.1016/S0033-3549(04)50052-3

[15] Hill L, Artiga S, Ranji U. Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them. Kaiser Family Foundation. Published November 1, 2022. Accessed April 3, 2023. https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/

[16] Howell EA. Reducing Disparities in Severe Maternal Morbidity and Mortality. Clin Obstet Gynecol. 2018;61(2):387. doi:10.1097/GRF.0000000000000349

[17] Bryant AS, Worjoloh A, Caughey AB, Washington AE. Racial/ethnic Disparities in Obstetric Outcomes and Care: Prevalence and Determinants. *Am J Obstet Gynecol*. 2010;202(4):335-343. doi:10.1016/J.AJOG.2009.10.864

[18] Blue Cross Blue Shield, The Health of America Report. *Trends in Pregnancy and Childbirth Complications in the U.S. 2020*. Accessed April 3,2023. https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/HoA_Maternal_Health.pdf

[19] Ananth CV, Duzyj CM, Yadava S, Schwebel M, Tita ATN, Joseph KS. Changes in the Prevalence of Chronic Hypertension in Pregnancy, United States, 1970 to 2010. Hypertension. 2019;74(5):1089-1095. doi:10.1161/HYPERTENSIONAHA.119.12968

[20] Healthy People 2030. Reduce preterm births — MICH-07. Office of Disease Prevention and Health Promotion, U.S. Dept. of Health and Human Services. Accessed April 3, 2023. https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-preterm-births-mich-07

[21] Brown HL, DeNicola N. Telehealth in Maternity Care. Obstet Gynecol Clin North Am. 2020;47(3):497-502. doi:10.1016/j.ogc.2020.05.003

[22] Health Resources & Services Administration (HRSA). Telehealth and High Risk Pregnancy. Published April 12, 2022. Accessed April 26, 2023. https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-maternal-health-services/telehealth-and-high-risk-pregnancy

[23] Center for Connected Health Policy (CCHP). State Telehealth Laws and Reimbursement Policies- Fall 2020 Summary Chart of Key Telehealth Policy Areas. Published October 2022. Accessed April 26, 2023. https://www.cchpca.org/2022/10/Fall2022_SummaryChart1.pdf

[24] Department of Health Care Finance - DHCF. Presumptive eligibility. Published 2023. Accessed May 4, 2023. https://dhcf.dc.gov/service/presumptive-eligibility

[25] Department of Health Care Finance - DHCF. Maternal Health Projects. Published October 4, 2022. Accessed May 4, 2023. https://dhcf.dc.gov/maternalhealthprojects

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