Dr. Amanda Williams
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Ellen Kelsay
That's Dr. Amanda Williams, Interim Chief Medical Officer at March of Dimes, the leading nonprofit organization dedicated to improving maternal and infant health. An expert on both maternal health and health equity, Dr. Williams brings 20 years of clinical experience as a practicing OB-GYN to her role of advancing the March of Dimes research, advocacy, education, and community programs. She also serves as a clinical innovation advisor with the California Maternal Quality Care Collaborative at Stanford University School of Medicine, where she's an adjunct faculty member in the Department of Obstetrics and Gynecology.

I'm Ellen Kelsay, and this is the Business Group on Health podcast, conversations with experts on the most relevant health and well-being issues facing employers.

Today, Dr. Williams and I talk about the March of Dimes' report, *Nowhere to Go: Maternity Care Deserts Across the US*, which details with shocking and sobering data, the maternity care crisis in the United States. In conversation, we talk about why this problem is getting worse, what the health consequences are, and what employers and others can do to ensure equitable access to maternity care across the U.S.

Dr. Williams, welcome. We're thrilled to have you with us today.

Dr. Amanda Williams
Thank you so much. I'm glad to be here.

Ellen Kelsay
Well, we've got a lot to talk about, and we want to dive right into the recent findings from March of Dimes' Maternity Care Desert Report. So, let's start right off the top. Could you define for our audience, what is a maternity care desert?

Dr. Amanda Williams
Sure. A maternity care desert is a county-level designation. That means that in that county, there's no hospital with maternity services, no licensed birth center, and no obstetric providers. That's no OB-GYN, no midwife, no family practice doc that does obstetrics. So, that means no place to have your baby, and nobody who's trained to take care of you.

Ellen Kelsay
And how prevalent are these in the United States?

Dr. Amanda Williams
The crazy part is that in our wealthy nation, 35% of all counties in the U.S. are designated maternity care deserts.

Ellen Kelsay
Unbelievable, 35% of counties in the entire country are maternity care deserts. Any other stats to illuminate that? I mean, that is sobering. Anything else you would say about how you all look at this data and determine that at the county-specific level.

Dr. Amanda Williams
Unfortunately, it's getting worse. So, this is 2% of U.S. counties additionally came on since our last report. And that's because over 100 maternity units closed. This is a real impactful problem and when, you know, a young couple gets married and says, maybe we'll have a family, the last thing they're thinking about is where I live an okay place to have a baby. And far too often, the answer is no.

Ellen Kelsay
You mentioned that some of these units are closing. What's driving this? Why is it getting worse in the United States?

Dr. Amanda Williams
Well, it's definitely multifactorial. There are two sides of it. There is the hospital side and then there is the staff side. On the hospital's side, labor and delivery units are very expensive. As you know, babies come any time of the day or night. That means that you've got to staff around the clock. You also have to staff like an emergency room, because there are triage or urgent visits that come through labor and delivery. There is the actual having a baby itself. There are the operating rooms and then there's postpartum rooms. So, there are lots of different kinds of units inside of a maternity unit in a hospital and it all has to be staffed 24-7. Then we have the perverse incentives of payment. And what I mean by that is far too often payment to the hospitals is associated with the work that is being done, that doesn't necessarily mean the outcome that is happening for the mom. For example, you may get paid more for a C-section when really that mom could have had a vaginal birth which would have been in her best interest. So, there are payment disincentives. Also, approximately half of the births in the United States are insured through Medicaid and Medicaid pays at a very low rate for maternity. There are all kinds of financial disincentives on the hospital side in addition to the staffing challenges. So, we're on the back end of a pandemic and so many people in nursing, physicians, came out of the workforce. As you can imagine, being an OB-GYN or perinatal nurse is not an easy job and when you have a pandemic on top of it, there are a lot of people who want a break. And then there are the legislative changes that are pressuring some folks to feel like they can't really practice good medicine anymore, so I'll retire early. Or for the youngsters, people in medical schools deciding, I'm not going to apply for a residency in an area where I feel like I can't practice fully. All of these issues are factors that are leading to an expansion of maternity care deserts.

Ellen Kelsay
Oh my gosh, there's so much to unpack there. Maybe let's start with the hospital closures. Are you seeing that become more of an issue in certain geographies? Is it more of a rural thing versus an urban thing? Any pockets of particular acuity there that you would call out from a hospital closure perspective?

Dr. Amanda Williams
It's actually happening all over the country. It's happening in urban areas. It's happening in rural areas. Over 100 hospitals have closed their maternity units in the last couple years. This is a really significant issue and the birthing centers are not making up for it and there aren't a whole lot of new hospitals opening because the old ones are closing. The areas that we see the most maternity care deserts are the Dakotas and many of them are in rural areas. But it's important to remember that urban neighborhoods, especially those that have been chronically underfunded, under-resourced, can have maternity care deserts as well.

Ellen Kelsay
Then from a staffing perspective, I noted with some interest the statistics around midwives and some challenges with getting midwives fully able to practice care at the level to which they've been trained and it seems really quite obviously that they could help address some of these provider shortfalls. Anything you would share there for the audience?

Dr. Amanda Williams
I think this is one of the most important elements of this discussion, because our lack of midwifery integration is one of the most critical factors that differentiate us from other wealthy nations. So, for example, in the UK, in France, in Sweden, you have midwives taking care of the majority of births. Whereas in the United States, midwives are only delivering approximately 10% of babies. We need the low-risk experts to be taking care of the low-risk births. In addition to expanding access, midwives also drive positive outcomes. We have great research out of Stanford, where I'm affiliated, that show that midwives decrease both preterm birth and decrease C-sections. So when we have midwives, and it doesn't even have to be a midwife delivering every birth, once there's a critical mass of midwife presence on a unit, it starts to influence the way that even the doctors are practicing to be a little bit more patient-centered, to be a little bit more patient, and then less running towards intervention. When we look at countries that have much lower maternal mortality rates than ours, one of the key differences is the integration of midwives.

Ellen Kelsay
We'll probably talk in a little bit, I will come back to this, but I want to get to some recommendations from a policy perspective, and I know perhaps that that might be one that you would suggest, so let's put a placeholder there for a minute. You did a really nice, although very sobering, overview of the findings in the Maternity Care Desert Report. Let's now talk about how does that impact women and children in pregnancy childbirth. What are the effects of these deserts for a woman wanting to become pregnant or who is pregnant, both from a prenatal all the way through delivery perspective? I'm sure there are many, so can you illuminate those for us?

Dr. Amanda Williams
The first thing that you point out is that this is not an abandoned desert. There are 2.3 million women in the United States who are living in these counties. It's not like it's just hayfields and roadrunners that are in the desert. These are places where real people live. And then what is the impact of living in a maternity care desert? If you live in a maternity care desert, you are more likely to have inadequate prenatal care. Now, that's not a surprise. If it isn't easy to get to, if it isn't easy to access, then you can imagine that those patients would be less likely to get their prenatal care. And we know that prenatal care is essential when it comes to diagnosing chronic conditions, making sure that all the labs are done, all the screening is done, decreases preterm birth rates. There's so many valuable aspects of prenatal care. When you live in a maternity care desert, you're less likely to have adequate prenatal care. In addition, and partially because of the lack of prenatal care, we know that there is an increased likelihood of having a preterm birth if you are living in a maternity care desert. These are serious things to be considered. And then finally, the length of time it takes to get to the hospital where you're going to deliver your baby is going to be significantly more if you're living in a maternity care desert and because people are having to cross county lines, sometimes that means that there are fewer or different resources available to them than the county in which they live. So there are actual real consequences. It's not just, okay, maybe I've got a little bit of a longer drive. There are real health consequences for mom and baby if someone is living in a maternity care desert.

Ellen Kelsay
I was so intrigued by the commentary around chronic conditions in the report, and you just mentioned it. Often, people living in these counties have poorer health outcomes to begin with, and many women, as we know, not just in maternity care deserts, often use their OB-GYN as their PCP. So you've got this compounding effect of maybe not having access to their OB-GYN to serve as their PCP and also having poorer health and chronic conditions to begin with, which just exacerbate the issues around prenatal care, poorer outcomes when it does come to birth. Anything more you would say there related to the chronic conditions than just general health to begin with of some of these individuals?

Dr. Amanda Williams
In general in America and all over, people are sicker going into pregnancy. There's been a marked increase in chronic conditions such as hypertension, diabetes, obesity, for patients going into their pregnancy. We know that chronic conditions are also more likely in maternity care deserts. You've got people who are sicker going into pregnancy and so who really need that support, and yet that support is not readily available to them. It's like we have less care for the people who need it most.

Ellen Kelsay
Let's start talking about what some of those perhaps positive things are. So we've illuminated the issue. It is getting worse. There are pretty sobering outcomes for pregnant people and families and infants related to these statistics. What are some things and solutions that you all advocate for, and specifically, are there things that you think employers and others in the health industry community can do to have more of a positive impact on these outcomes in the future?

Dr. Amanda Williams
Absolutely. I'll start with the things that we're working on. Our mom-baby mobile health centers, so our buses that are going out into many of these maternity care deserts are actually bringing care to the people. Now, there are only five of them in the U.S., but we've got another five that will hopefully be out in the next year or so. They are getting more popular. Instead of people coming to the hospital or to the office,

we are partnering with health care systems to bring care out to patients. Now, there also needs to be a leveraging of virtual care, and that's something that we're doing through a number of different partners, and we're certainly advocating from our legislative perspective to really encourage, and this is something that an employer can do as well, is to leverage online and virtual care resources for patients in particular who either have busy jobs or who live in areas where care is difficult to get. So, either bringing the care to the people in a bus or over their computer are two big areas where March of Dimes has been active. Going back to our advocacy work in our legislative agenda, we are advocating for telehealth. We're also advocating for expansion and continuation of Medicaid. There are still a few states where Medicaid stops abruptly after a baby is born, and what we're advocating for is for the entire year after birth and then to go above the poverty line for patients who are getting insured through Medicaid to make sure that they can go on to get care. We're also investing in some of those digital health technologies like the ones that I was speaking of before. We've invested recently in a company called Seven Starling, which is a way to access mental health care. Prenatal care is certainly a shortage, but mental health, especially mental health related to pregnancy and postpartum, are a major driver of maternal morbidity, mortality, and delayed return to work. And so having coverage and access to skilled maternity specific mental health support is really a top value for us, which is why we ended up investing in Seven Starling.

Ellen Kelsay
That's amazing. I think many of our listeners probably were not aware that March of Dimes is that involved in so many facets of your work. And the mental health connection is so vitally important, so I'm really glad you brought that example forward. You mentioned earlier in the conversation some of the payment challenges, too, and that you used the example of Cesarean when it wasn't needed. Other examples you would say that employers in particular, maybe from a payment model perspective, actions that you would urge them to consider if they're not already considering.

Dr. Amanda Williams
When we talk about value-based payment, what we mean is aligning health outcomes with payment. So, for example, if you're paying a certain amount for care during a pregnancy, there shouldn't be extra payment for a C-section when that person could have had a vaginal birth. We want to incentivize the health care providers or the plans that are providing care to give the best evidence-based care, which means keeping your C-section rate low, for example. We also want to incentivize things like mental health screening during pregnancy and postpartum. There are ways of incentivizing payment that really can make a difference. Additionally, we want to make sure that providers are being reimbursed at an acceptable rate. That's another big reason why so many providers have left the field, because the reimbursement for Medicaid is so low that they say it's not even worth it to try to do those births, and then their patients who need their help the most no longer can get access to that care. So certainly advocating for good reimbursement to the hospitals and to the providers, value-based care, especially around looking at pregnancy as a package, are all things we would hope that employers could advocate for. I would also add on to that doulas. We haven't talked much about doulas yet, but they are important bridge builders in this maternal health world and can really help in maternity care deserts. Often in maternity care deserts, there may not be any midwives or OB-GYNs, but there are community members. There may be community health workers. There may be doulas, and these can be important partners to help with education, to help with psychosocial support, so that even if someone has to go further or into foreign places for their obstetric care, at least they have this person to go with them and to escort them on their journey. Even when someone does have great access to care, doulas have also been shown to have the patient end up with a more positive birth experience, in addition to a decreased likelihood of C-section. So there are many positives that doulas can bring to the birth experience, and just now are we getting momentum across this country for adequate livable wage doula reimbursement, both on the Medicaid side and now commercial insurance is following, but that is a gap where employers can really make a big difference.

Ellen Kelsay
You just outlined so many great things, and I think we started at the top of the conversation outlining the magnitude of the issue and that it is getting worse, and that to many can seem very daunting and almost futile, but then hearing you speak about all of these things, they're very practical, reasonable things that are within reach, and I'll just recap some of them really quickly. Advocating for good and fair, reasonable reimbursement, supporting value-based models, deploying virtual care and other digital solutions, midwives, doulas, community health workers, the buses that you all are deploying and are expanding. You

said you've got five more coming. Those are really tangible, real things that can be done now. I appreciate you breaking those down, because it does make what can be a very overwhelming, daunting problem feel a little bit more real and tenable to address. Thank you for that.

Dr. Amanda Williams
Yes, and I would say that whenever we have big societal problems, people feel overwhelmed, but there actually are solutions. The question is, do we have the political will, the organizational will, to be able to put them into action? I had the privilege of working at the California Maternal Quality Care Collaborative based at Stanford, and this is our research. This is what we've been doing, and in California, we have moved forward with a lot of these different pieces of legislation and care delivery. There are models out there that can be replicated or tailored to your particular state or community. It's not like we don't know what the solutions are.

Ellen Kelsay
Great, great examples. Anything I didn't ask you about relative to the report or anything else that would be relevant to that that you'd like to share with the audience?

Dr. Amanda Williams
Yes, there are two other things I want to bring up. One is wraparound services. We can't forget that there's a lot that goes into a healthy pregnancy. Things like, we talked about mental health support, but doula services, nutrition, lactation, care coordination, support for social drivers of health such as housing, transportation, food adequacy, all of those things are part of a healthy pregnancy. If, for example, an employer is looking at a solution, whether that's a digital solution or whether it's working with community-based organizations, we need to think about that whole pregnancy experience. We need to think about whole person care that includes some of those wraparound solutions. So that's one. Then the other one is to remember that maternity care deserts, chronic conditions, these are not evenly distributed experiences across the United States. We know that the maternity care deserts, the majority of them are in rural communities, and we cannot forget about the patients there. We know that indigenous patients, black birthing people are all disproportionately represented in these groups, in addition to having a disproportionate burden of maternal morbidity and mortality. We need to think about where people live, who they are, and what barriers has our society put in the way that need to be overcome to be part of a healthy pregnancy experience.

Ellen Kelsay
Such an important point there with the, you know, certain populations and certain groups of people are impacted much more significantly than others in health, generally speaking, but certainly in maternal health. I'm really glad that you brought that one forward.

Well, Dr. Williams, as always, it's a pleasure. Thank you for joining us in conversation today and we look forward to amplifying your good work at March of Dimes with our audience. You gave us some really good tangible things for folks to think about and work on within their own organization. So again, grateful for your time. Thank you.

Dr. Amanda Williams
Thank you so much. It's an honor to speak with you.

Ellen Kelsay
I've been speaking with Dr. Amanda Williams about maternity care deserts in the United States and what employers and their partners can do to help alleviate the harmful effects of this worsening problem.

To access the March of Dimes' report, *Nowhere to Go: Maternity Care Deserts Across the US*, visit the March of Dimes website, https://www.marchofdimes.org/maternity-care-deserts-report.

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