HEALTHY MOMS. STRONG BABIES.

2021 MARCH OF DIMES REPORT CARD

A TIME FOR PARTNERSHIP AND ACTION: EXAMINING THE U.S. MATERNAL AND INFANT HEALTH CRISIS AND POLICIES NEEDED FOR CHANGE

MARCHOFDIMES.ORG/REPORTCARD

ON THE COVER

Alexandra and Edgar had twins born preterm at 30 weeks during the global pandemic. As if that wasn't scary enough, both parents contracted COVID-19 immediately after and were unable to see their babies for two weeks until they tested negative. "It's just not what you expected," Edgar said. "You're going home empty-handed and almost feel kicked out because you kind of want to stay there."

The twins had to spend 49 days in the NICU, and the entire experience was chaotic for Alexandra and Edgar—from having breastmilk delivered to the hospital to scheduling FaceTime calls with nurses to see their babies. But the confusion didn't end there. Once their babies were home, they realized there were many things that they still didn't know. Every time they went to the doctor, they had a new list of questions.

Far too many families are affected by preterm birth, which is hard enough without a global pandemic. That's why March of Dimes is advocating for policies outlined in this year's 2021 March of Dimes Report Card to prioritize the health of families—especially moms and babies of color.

HEALTHY MOMS. STRONG BABIES. | MARCH OF DIMES

MARCH OF DIMES REPORT CARD 2021 EXECUTIVE SUMMARY

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The March of Dimes Report Card showcases the state of maternal and infant health for the U.S., all states, Washington, D.C. and Puerto Rico. What began with a focus on preterm births has evolved into a Report Card that holds space for measures of both mom and baby and policy solutions that can improve their health. This year's report also features new data on low-risk cesarean birth, a social vulnerability measure, and doula and midwife legislation and policies. Today, the U.S. remains among the most dangerous of developed nations for childbirth, particularly for communities of color.

THE U.S. MATERNAL AND INFANT HEALTH CRISIS

The data show that the **U.S. preterm birth rate declined slightly for the first time in six years from 10.2 percent in 2019 to 10.1 percent in 2020—with the nation keeping its "C-" grade.** Yet, rates increased for Black and American Indian/Alaska Native women, who are 60 percent more likely to give birth preterm compared to White women. Thirty-three states, Washington D.C. and Puerto Rico experienced a decline in preterm birth rates, while 13 states saw an increase and four remained the same.

The latest data for infant mortality also show a slight decline from 5.7 deaths per 1,000 live births in 2018 to 5.6 deaths per 1,000 live births in 2019. Again, **disparities persist with Black and American Indian/Alaskan native babies being twice as likely as White babies to die before their first birthday.** Overall, 18 states had an improved infant mortality rate, 21 states stayed the same and 11 states worsened.

According to data from the CDC, **severe maternal morbidity (SMM) rates have doubled over the last two decades.** Each year, about 60,000 U.S. women experience morbidity due to pregnancy. A standardized definition of SMM, data collection and surveillance are needed, in addition to partnerships working to decrease these rates and disparity gaps. Additionally, **pregnancy-related death has more than doubled over the last 30 years,** with more than 700 women dying each year in the U.S.

This maternal and infant health crisis doesn't have one root cause, nor single solution. Beyond an individual's medical history, a complex web of factors impact the health of moms and babies. Policies that have systematically disadvantaged communities of color over centuries are resulting in persistent, inequitable poor maternal and infant health outcomes for communities of color.

ADVANCING CRITICAL POLICY ACTIONS FOR MOMS AND BABIES

The 2021 Report Card highlights policy actions, legislation and programs that can be adopted at the local, state and federal level to change the course of this crisis. We must start with the passage of the Black Maternal Health Momnibus Act of 2021 to improve health outcomes for moms of color and tackle long-standing disparities, in addition to the following policy priorities. (See Policy Action section of this report for details.)

- Increasing access to health care by extending Medicaid postpartum coverage. Only three states have approved waivers allowing for the postpartum extension of Medicaid and 12 states have not adopted Medicaid expansion.
- Funding Maternal Mortality Review Committees (MMRC) and Perinatal Quality Collaboratives (PQC). Although the majority of states have a PQC or an MMRC, they don't all have the same level of financial resources to operate. Only 38 states have an MMRC that reviews deaths up to a year after delivery, which is a critical time period.
- Expanding access to doula and midwifery support. In 2021, ten states passed legislation supporting reimbursement of doula care, making a total of 14 states. At this time, 34 states allow for the practice and licensing of direct-entry and certified nurse midwives.

March of Dimes and our partners advocate and lobby for these policies and programs through our #BlanketChange policy agenda. Learn how you can join us at BlanketChange.org. Only through this collaboration can we close the health equity gap and give every family the best possible start.

POLICY ACTIONS

HEALTHY MOMS. STRONG BABIES. | MARCH OF DIMES

MARCH OF DIMES REPORT CARD RECOMMENDED POLICY ACTIONS

March of Dimes 2021 Report Card monitors key indicators and policy actions to improve the health of moms and babies in the U.S. Health policy should be rooted in addressing disparities in maternal and infant health outcomes. Policymakers must take swift action to better serve the women and babies in our country. No single solution will improve maternal and child health however, key opportunities include:

EQUITY

ELIMINATE RACIAL DISPARITIES IN HEALTH OUTCOMES FOR MOMS AND BABIES

Black, American Indian and Alaska Native women and their babies consistently have worse health outcomes than their White peers. Implicit bias training for health care providers and increasing access to and coverage for doula services are among the many strategies to fight unacceptable disparities. Addressing determinants of health caused by social, environmental, and economic factors is another strategy to reduce disparities to improve health equity through engaging in health system reform.

More than 2.2 million women of childbearing age live in maternity care deserts.[1]

REMOVE BARRIERS TO OBTAINING QUALITY CARE IN UNDERSERVED AND RURAL COMMUNITIES

Each year in the U.S., approximately **150,000 babies** are born to moms living in maternity care deserts or communities without a hospital offering obstetric care and without any obstetric providers.[1] Women in these communities may have difficulty obtaining high-quality health care before, during and after pregnancy. Increasing access to inpatient obstetrical facilities and qualified obstetrical providers is critical to improving outcomes in these communities. Expanding access to midwifery care and further integrating midwives and their model of care into maternity care in all states can help improve access in under-resourced areas, reduce interventions that contribute to risk of maternal mortality and morbidity and improve the health of moms and babies.[1] Reimbursement for doula care is another way to help improve birth outcomes and reduce higher rates of maternal morbidity and mortality. As of now, only a few states cover doula services under the full range of private and public insurance programs, including Medicaid, the Children's Health Insurance Program (CHIP), TRICARE, and others. Payment levels should be sufficient to support the care provided. Efforts should be made to make the doula profession more accessible to people of diverse socio-economic and cultural backgrounds. Lastly, implementing perinatal regionalization would create a coordinated system of care within a geographic area that can help pregnant women to receive risk-appropriate care in a facility equipped with the proper resources and health care providers.

LEGEND

Women affected

Pregnant women affected

Baby affected

ACCESS

PROTECT COMPREHENSIVE HEALTH CARE COVERAGE FOR MOMS AND CHILDREN

Almost **90%** of U.S. women will give birth during their reproductive years.[2] All women need access to quality prenatal, labor and delivery, and postpartum services to help prevent and manage complications. It's imperative that health plans continue to offer the ten categories of Essential Health Benefits, required under the Affordable Care Act, including maternity and newborn care, well-woman and well-child preventive care, prescription drugs and mental health services, which are critical to the health of both mom and baby.[3] Lawmakers must also preserve existing consumer protections regarding pre-existing conditions and shield families from high premiums and out-of-pocket costs and lifetime or annual limits.

PROVIDE AFFORDABLE, QUALITY PUBLIC HEALTH INSURANCE PROGRAMS TO WOMEN BEFORE PREGNANCY, AN ESSENTIAL TIME TO INTERVENE TO ACHIEVE HEALTHY PREGNANCIES

Research shows that one of the best opportunities to achieve healthy pregnancies is to improve the health of women before they become pregnant. Medicaid expansion to cover individuals up to **138%** of the federal poverty level can play an essential role in improving maternal and infant health. A growing number of studies indicate that Medicaid expansion has reduced the rate of women of childbearing age who are uninsured, and improved health outcomes.

A pair of recent studies from Oregon State University found that Oregon's Medicaid expansion in 2014, one of the earliest states to adopt the policy, has led to increased prenatal care among low-income women, as well as improved health outcomes for newborn babies.[4,5] In the three years after the expansion, one study found that Oregon saw an almost two percentage point increase in first trimester prenatal care utilization, relative to 18% of the pre-expansion population who lacked any access to prenatal care in the earlier stages of pregnancy.[4] In the same period, the second study found, Medicaid expansion was associated with a 29% reduction in low birthweight among babies born to women on Medicaid, as well as a 23% reduction in preterm births.[5]

Other benefits of Medicaid extension have been seen throughout the U.S. A nationwide study found that among low-income women with a recent live birth, there were significant improvements in three preconception health indicators that were associated with Medicaid expansion: increased number of women who reported receiving preconception health counseling from a health care provider, an increased number of women reporting folic acid intake before pregnancy and increased use of effective contraception after pregnancy.[6]

Almost 1 in 4 moms who were insured by Medicaid for their delivery were uninsured two to six months after giving birth.[5]

EXTEND MEDICAID COVERAGE FOR POSTPARTUM MOMS

The latest data shows that one-third of all pregnancy-related deaths happen one week to one year after delivery.[8] In too many states, Medicaid maternity coverage ends 60 days after giving birth, ending access to care at a time when risks of maternal complications and death persist. Comprehensive health care coverage in Medicaid should be extended to at least 12 months postpartum through the option made available under the American Rescue Plan Act effective April 2022. It shouldn't be optional for states to ensure every mom gets the coverage they need to stay healthy — and alive — after their babies are born. Congress must take the next step and make one year of Medicaid coverage after birth a permanent, mandatory policy across the nation. The extension of postpartum coverage to 12 months needs to be enacted by Congress under Medicaid and CHIP on a mandatory and permanent basis for all state Medicaid programs.

ACCESS TO MIDWIFERY

Nationally, nearly 1 in 10 births is attended by a certified nurse midwife (9.4 percent) or other midwife (0.8 percent).[1] Efforts to further integrate health care professionals, such as midwives, into maternity care could help improve access to providers and quality of care. In a statement further reinforced by research, the American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse-Midwives supported that the highest quality of care for women occurs when physicians and midwives are working together to provide maternal healthcare.[9] March of Dimes encourages states to ensure that their laws foster access to midwifery care and also supports efforts to further integrate their model of care, with full autonomy, into maternity care in all states.

14 states have adopted legislation to support doula care.

ACCESS TO DOULA CARE SERVICES

Doulas are non-clinical professionals who provide physical, emotional and informational support to moms before, during and after childbirth, including continuous labor support.[10] They offer guidance and support around topics related to childbirth, breastfeeding, pregnancy health and newborn care. Supportive care during labor may include comfort measures, information and advocacy.[11] Women who utilize doula services tend to pay out of pocket and work in urban areas.[12,13] Access to doula care is further limited as services are not routinely covered by health insurance providers. This can leave those who may benefit the most from doula care with the least access to it—both financially and culturally.[14,15] Insurance coverage for doula support through Medicaid, CHIP, private insurance, and other programs may be a way to improve birth outcomes and close the gap in birth outcomes between Black and White women.[14] Just like midwives, doulas can practice in the homes of patients, which can have an impact for socially and economically vulnerable families.[16] Increasing access to doula care, especially in under-resourced communities, may improve birth outcomes, improve the experience of care and lower costs by reducing non-beneficial and unwanted medical interventions.[17,18,19]

IMPROVE MOM AND BABY HEALTH THROUGH EXPANSION OF GROUP PRENATAL CARE

Studies demonstrate that group prenatal care can provide health benefits for both moms and babies, such as reducing preterm birth.[20] Enhanced reimbursement models, including delivery and outcomes-based incentives, may encourage providers to offer it.

PROVIDE COVERAGE FOR EVIDENCE-BASED TELEHEALTH SERVICES FOR PREGNANT AND POSTPARTUM WOMEN AND SUPPORT ALIGNMENT OF TELEHEALTH REIMBURSEMENT APPROACHES ACROSS PAYERS

March of Dimes supports increasing access to telehealth services for pregnant and postpartum women. There is reason to focus specifically on telehealth in maternity care. Benefits of telehealth include efficiency and cost-effectiveness, increased access to care, reduction in patient travel and wait times, and increased patient satisfaction. In recent years, telehealth has been incorporated into many aspects of women's health care, including virtual patient consultation with specialists, remote observation of ultrasound recordings by maternal-fetal medicine experts, postpartum blood pressure monitoring using Wi-Fi connected devices and fertility tracking with patient-generated data.[21]

PREVENTION

ADVANCE OUR UNDERSTANDING OF MATERNAL DEATH

In order to implement strategies to prevent maternal death, we need to understand why moms are currently dying during and after pregnancy. Improving maternal mortality and morbidity data collection and surveillance will help us to establish baseline data, understand trends and monitor changes. Maternal Mortality Review Committees (MMRC) investigate every instance of maternal death in a state or community and make recommendations to stop future tragedies. We must continue to support the work of state MMRCs to collect robust and standardized data to inform local and national policies to address the nation's maternal mortality crisis. It is important to note that though the majority of states have an MMRC, they do not all have the same level of financial resources to operate. March of Dimes supports federal and state funding to each MMRC across the nation.

INCREASE INVESTMENTS IN VITAL PUBLIC HEALTH PROGRAMS TO PROMOTE HEALTHY MOMS AND STRONG BABIES COMMUNITIES

Population-level improvements in maternal and infant health rely on a robust public health infrastructure to detect contributors to poor health outcomes, identify opportunities to address those contributors and then mobilize providers, health systems, stakeholders and communities to take action. U.S. federal, state and local policy makers, public health officials, healthcare providers, hospitals and community-based organizations must support efforts to improve data on maternal and infant health and bolster programs focused on implementing strategies that have shown to keep moms and babies healthy.

CREATE PAID FAMILY LEAVE SYSTEMS

Paid family leave systems should strive to make benefits available to all workers while also distributing the responsibility for funding this system among employers. March of Dimes supports policies to create an affordable and self-sustaining national system to provide workers with up to 12 weeks of partial income through a family and medical leave insurance fund. The U.S. is the only industrialized nation that does not offer working parents paid time off to care for a new child or sick loved one. Access to paid family leave and sick day benefits supports parent-infant attachment, establishing an essential foundation for safe, stable, nurturing relationships and parenting practices that promote optimal infant health and development. These benefits include improved establishment and maintenance of breastfeeding and on-time routine childhood vaccinations. Paid leave also generates important maternal health outcomes, including association with reduced depressive symptoms.[22]

SUPPORT VACCINATIONS AS WELL AS BOOSTING VACCINE CONFIDENCE

Vaccines are considered one of the greatest public health successes in modern medicine. Immunizations play an especially critical role in the health of pregnant women and young children. It is estimated that from 1994 to 2016, the U.S. childhood immunization program prevented 381 million illnesses, 855,000 deaths, and $1.65 trillion in societal costs. Adult immunizations have similarly prevented millions of fatalities and illnesses from diseases like influenza and pneumococcal disease. The impact of COVID-19 on pregnant women is alarming. According to Centers for Disease Control and Prevention (CDC), pregnant women are at increased risk for severe illness and death from COVID-19 compared with nonpregnant women of reproductive age and are at risk for adverse pregnancy outcomes, such as preterm birth.[23] They have a greater likelihood of severe complications due to pregnancy. Results from a survey conducted soon after the COVID-19 vaccine became available in the U.S. showed that just over half of pregnant women would accept the vaccination while pregnant.[24] Among those who said they would decline vaccination; the most common primary concern was risk to the fetus or neonate regarding birth defects and other long-term effects to the baby" (45.8%).[24] The acceptance of the COVID-vaccine by pregnant women may have increased over time since the primary concern about vaccination was safety and more data about the vaccine has since been collected/published. Rates of acceptance of the COVID-19 vaccination during pregnancy may also have increased following the recommendations to vaccinate during pregnancy from the CDC and other leading professional health organizations such as the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM). Now more than ever, we as a country must prioritize efforts to boost confidence in COVID-19 vaccines not only to end the pandemic, but also build acceptance of the vaccines in every community, especially among pregnant women.

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2021 REPORT CARDS

HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

2021 MARCH OF DIMES REPORT CARD

The 2021 Report Card highlights the latest key indicators to describe and improve maternal and infant health in the U.S. It features grades for preterm birth and measures on infant mortality in addition to social drivers of health, low-risk Cesarean birth rates and inadequate access to prenatal care. Our Supplemental Report Card highlights the stark disparities across race/ethnicity within these factors.

With the onset of the COVID-19 pandemic, pre-existing health disparities have been magnified. Comprehensive data collection and analysis of these measures, and the resulting disparities, inform the development of policies and programs that move us closer to health equity. The Report Card looks at policies like Medicaid expansion and programs like Maternal Mortality Review Committees, that can help improve equitable maternal and infant health for families across the country.

UNITED STATES

Scan here for more data on the U.S.

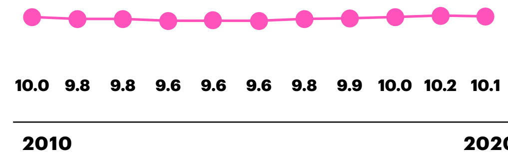
INFANT HEALTH

PRETERM BIRTH GRADE

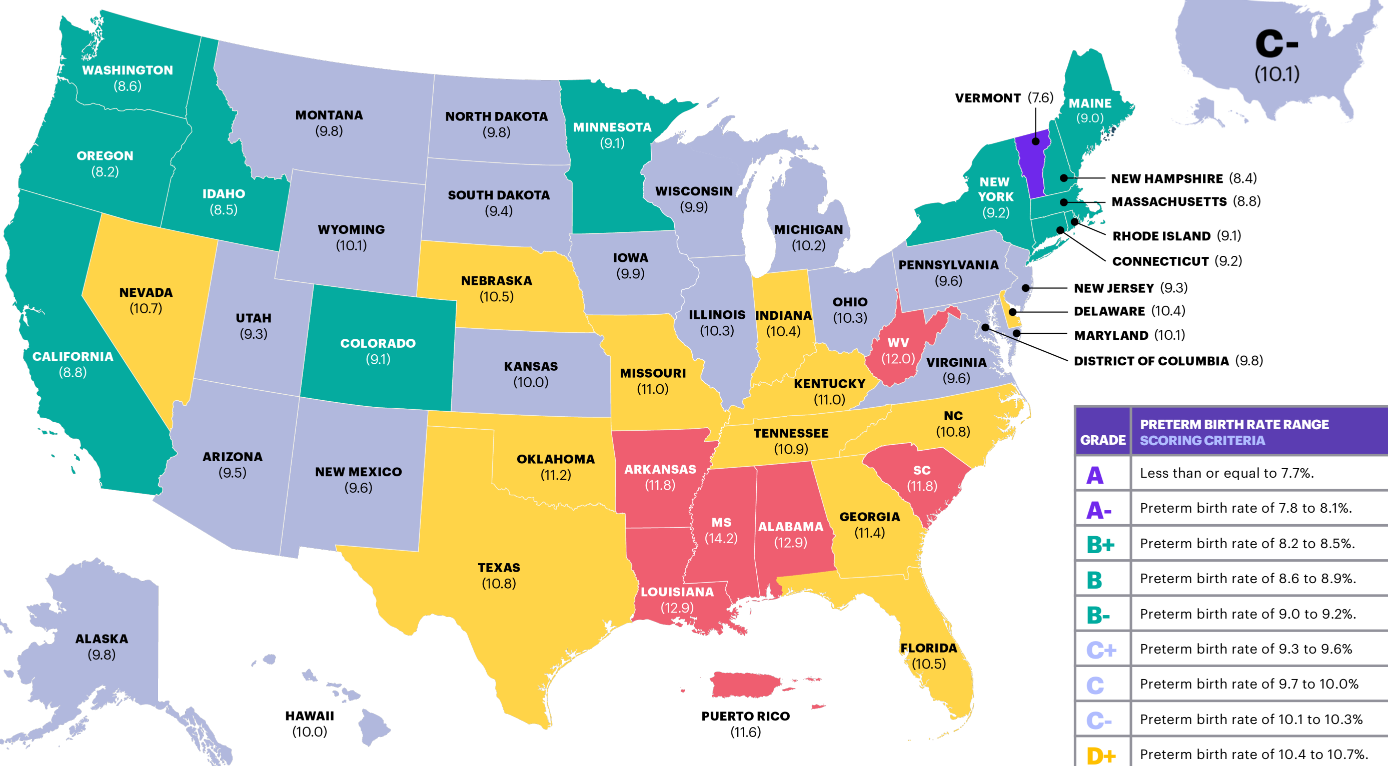
C-

PRETERM BIRTH RATE

10.1%



PRETERM BIRTH RATES AND GRADES BY STATE



GRADE	PRETERM BIRTH RATE RANGE SCORING CRITERIA
A	Less than or equal to 7.7%.
A-	Preterm birth rate of 7.8 to 8.1%.
B+	Preterm birth rate of 8.2 to 8.5%.
B	Preterm birth rate of 8.6 to 8.9%.
B-	Preterm birth rate of 9.0 to 9.2%.
C+	Preterm birth rate of 9.3 to 9.6%
C	Preterm birth rate of 9.7 to 10.0%
C-	Preterm birth rate of 10.1 to 10.3%
D+	Preterm birth rate of 10.4 to 10.7%.
D	Preterm birth rate of 10.8 to 11.1%.
D-	Preterm birth rate of 11.2 to 11.4%.
F	Preterm birth rate greater than or equal to 11.5%.

Puerto Rico is not included in the United States total.

Preterm is less than 37 completed weeks of gestation, based on obstetric estimate of gestational age.

Source: National Center for Health Statistics, 2020 final natality data.

Grades assigned by March of Dimes Perinatal Data Center.

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March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes, see **www.marchofdimes.org/reportcard**

For details on data sources and calculations, see Technical Notes. Scan the QR code to the right to access the full U.S. Report Card.

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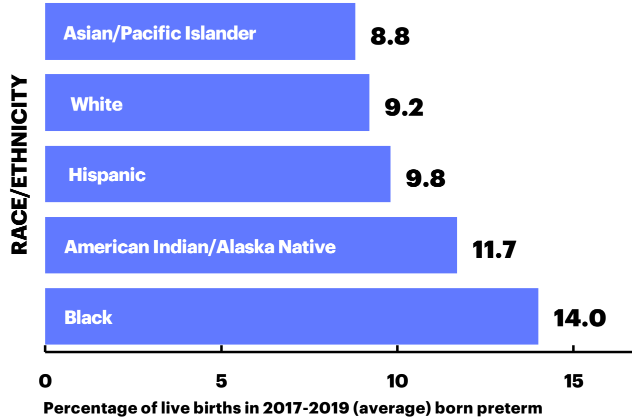
2021 MARCH OF DIMES REPORT CARD RACE & ETHNICITY IN THE U.S.

INFANT HEALTH

Aggregate 2017-2019 preterm birth rates are shown for each of the five bridged racial and ethnic groups. The racial/ethnic group with the highest rate is compared to the combined rate for all other racial/ethnic groups

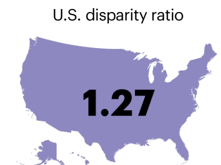


In the United States, the preterm birth rate among Black women is 51% higher than the rate among all other women.

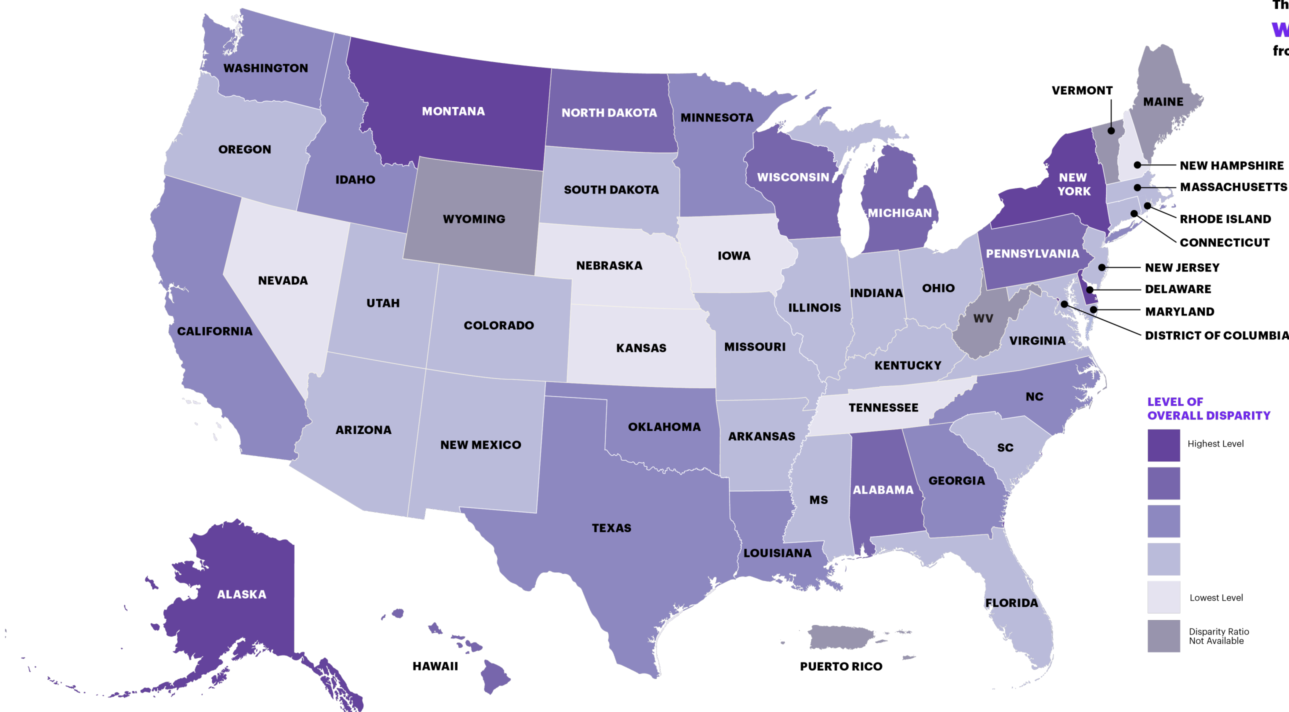
RACE & ETHNICITY DISPARITY BY STATE

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

U.S. disparity ratio



The U.S. Disparity Ratio has **worsened** from baseline



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2021 MARCH OF DIMES REPORT CARD
INFANT MORTALITY IN THE U.S.

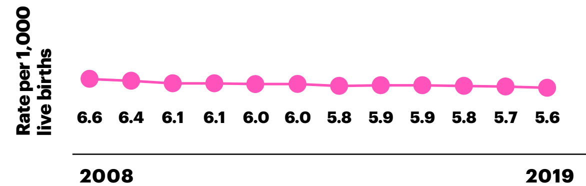
INFANT HEALTH

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

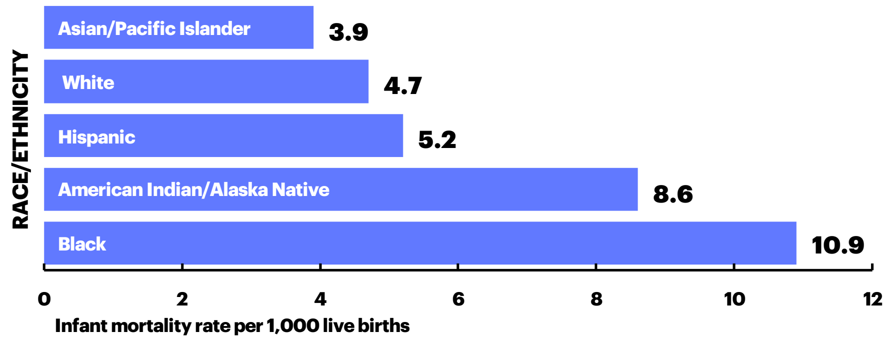
INFANT MORTALITY RATE

5.6

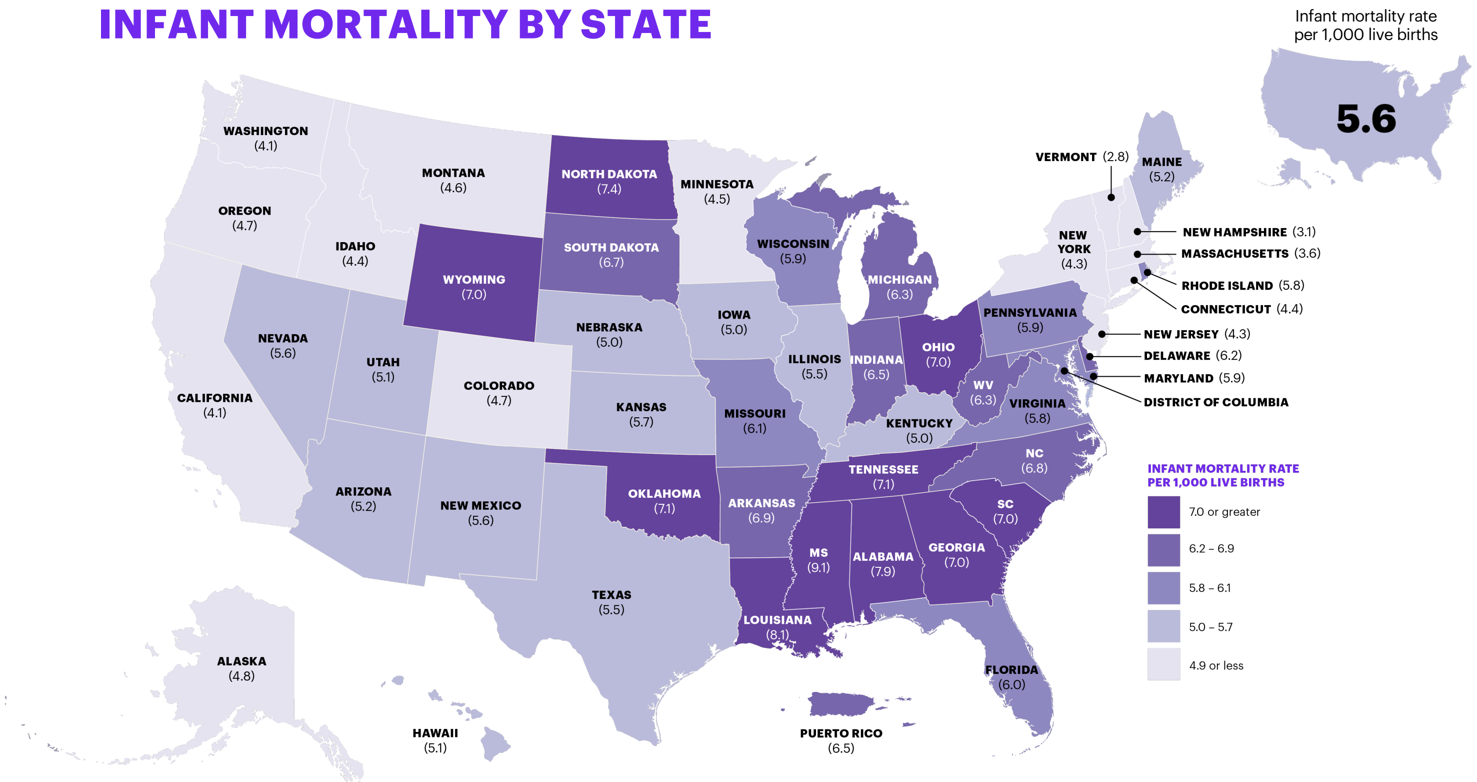


RATE BY RACE AND ETHNICITY

2018 infant mortality rates per 1,000 live births are shown for each of the bridged racial and ethnic groups. The highest rate of infant mortality are seen for non-Hispanic Black women.



INFANT MORTALITY BY STATE



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UNITED STATES

MATERNAL HEALTH

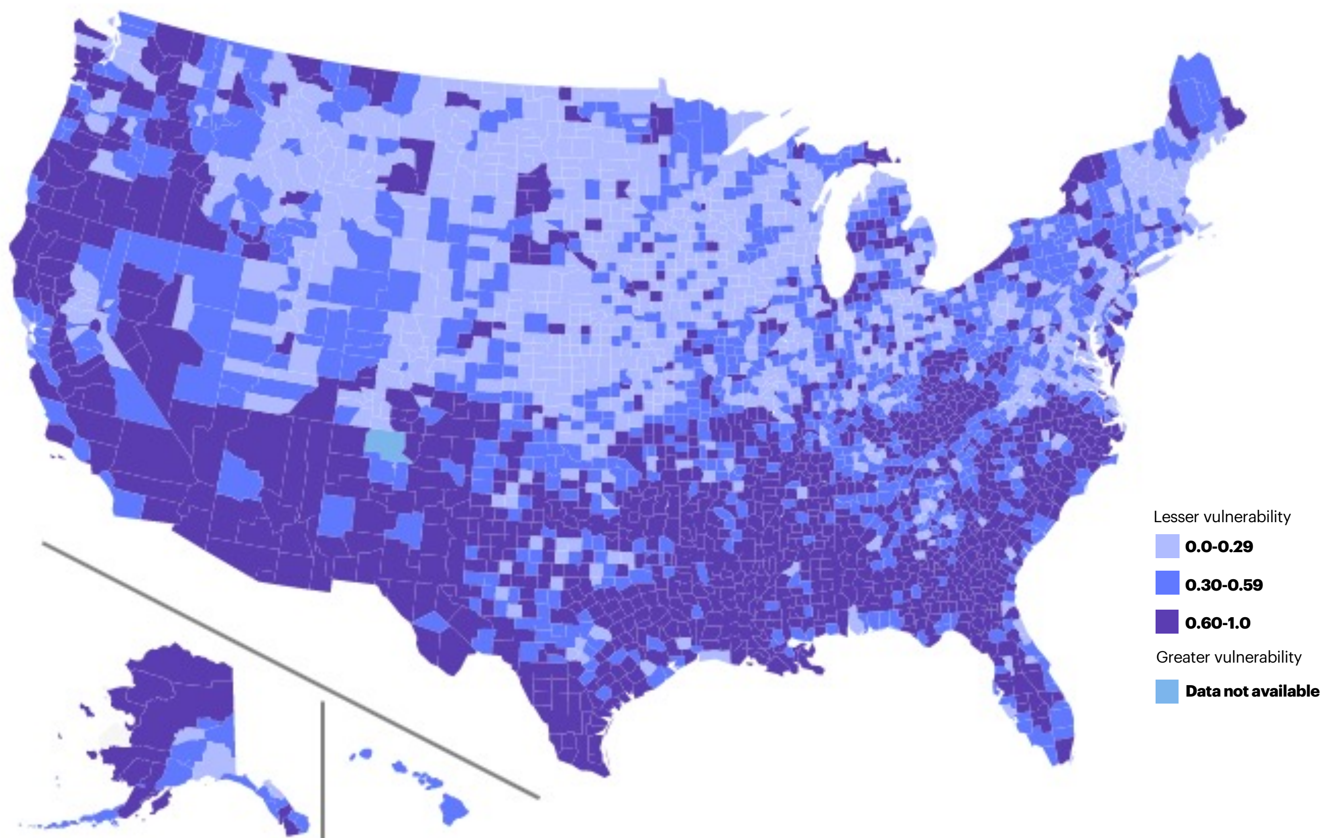
There is a critical connection between infant health, maternal health and the health of a family. All are dependent on their lived social context, the quality and accessibility of healthcare and the policies within a state. Each factor can provide insight into how a state serves its population.

SOCIAL VULNERABILITY INDEX

Where you live matters.

March of Dimes is offering the opportunity to examine social determinants of health at the county level using the Social Vulnerability Index (SVI). Socially vulnerable populations are at greater risk of experiencing poor health outcomes during a public health emergency. The same factors used in the index also contribute to poor maternal and infant health outcomes, including poor access to maternity care. The differences in counties are measured using 15 social factors, grouped into four areas including: socioeconomic status; household composition and disability; minority status and language; housing type and transportation. Each aspect of the index uses physical or social factors that help to estimate where poor health outcomes may be more prevalent.

The overall SVI for each county represents the amount of vulnerability relative to other counties in the state. The SVI measure is always a number between 0 and 1. A lower SVI indicates lesser vulnerability and a higher SVI indicates greater vulnerability.



CLINICAL MEASURES

Your healthcare matters.

Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

25.6

PERCENT

LOW-RISK CESAREAN BIRTH

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

14.9

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

A TIME FOR PARTNERSHIP AND ACTION:
EXAMINING THE U.S. MATERNAL AND INFANT HEALTH CRISIS AND POLICIES NEEDED FOR CHANGE

March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes, see **www.marchofdimes.org/reportcard**

For details on data sources and calculations, see Technical Notes. Scan the QR code to the right to access the full U.S. Report Card.

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UNITED STATES

MATERNAL HEALTH

ADOPTED in 39 STATES (INCLUDING D.C.)

MEDICAID EXPANSION

Medicaid expansion to cover individuals up to 138% of the federal poverty level can play an essential role in improving maternal and infant health. Medicaid expansion has reduced the rates of uninsured women of childbearing age. Increased access and utilization of health care are significantly associated with Medicaid expansion.[7]

RECENT ACTION in 19 STATES (INCLUDING D.C.) 3 STATES HAVE FULLY EXTENDED

RECENT ACTION ON MEDICAID EXTENSION

The adoption of this policy allows women to qualify for pregnancy-related Medicaid coverage for more than the standard 60 days after pregnancy for up to one year.[8] Extending this coverage typically requires both state legislation and an appropriation in addition to a Section 1115 waiver in order to receive federal match.[9] Three states have extended the full benefits of Medicaid extension at this time.

LEGISLATION IN 34 STATES

MIDWIFERY POLICY

Midwives are health care professionals that may be part of the birth care team or stand alone in providing prenatal, delivery and postpartum care. States that have policies to allow direct entry midwives and certified nurse midwives to practice may increase access to care, especially in under-resourced areas. Midwifery care can further reduce medical interventions that contribute to the risk of maternal mortality and morbidity in initial and subsequent pregnancies, lower costs, and potentially improve the health of mothers and babies.

14 STATES REIMBURSE DOULA CARE

DOULA LEGISLATION

Doulas are non-clinical professionals that emotionally and physically support women during the perinatal period, including birth and postpartum.[14] Increased access to doula care can help improve birth outcomes and reduce the higher rates of maternal morbidity and mortality among women of color in the United States. Doula support is not routinely covered by health insurance. Insurance coverage for doula support through Medicaid, the Children's Health Insurance Program, private insurance, and other programs may be a way to improve birth outcomes.

38 STATES (INCLUDING D.C.) REVIEW MATERNAL DEATHS UP TO ONE YEAR AFTER BIRTH

MATERNAL MORTALITY REVIEW COMMITTEE

These committees investigate deaths related to pregnancy to determine underlying causes of death and respond to improve conditions and practices. The committees can be made up of representatives from public health, nursing, maternal-fetal medicine, obstetrics and gynecology, midwifery, patient advocacy groups and community-based organizations.[10] States that have an MMRC are better equipped to prevent pregnancy-related deaths. States who review pregnancy-related deaths up to one year after pregnancy will best help us understand all the causes of pregnancy-related mortality.

45 STATES (INCLUDING D.C.) HAVE A PQC TO IMPROVE QUALITY OF CARE

PERINATAL QUALITY COLLABORATIVE

The PQC involves partnerships with families, key state agencies and organizations in order to identify and initiate programs or procedures that increase the quality of care in clinical settings. The work done by PQC's across the nation focus on a collaborative learning method between healthcare providers and the members of the PQC.[12]

March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes, see **www.marchofdimes.org/reportcard**

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HEALTHY MOMS. STRONG BABIES. | MARCH OF DIMES

100 U.S. CITIES WITH THE GREATEST NUMBER OF BIRTHS
2019 PRETERM BIRTH RATES AND GRADES

The 2021 U.S. March of Dimes Report Card assigns grades to the 100 cities with the greatest number of live births in 2019. Report Card grades are assigned by comparing the 2019 preterm birth rate in a city to the March of Dimes goal of 8.1 percent by 2020.

A

City	Rate
Irvine, CA	5.2
Ramapo, NY	5.2
Seattle, WA	6.9
Irving, TX	7.0

A-

City	Rate
Plano, TX	7.8

B+

City	Rate
Portland, OR	8.2
San Francisco, CA	8.5

B

City	Rate
San Diego, CA	8.6
Austin, TX	8.9
Mesa, AZ	8.9
Riverside, CA	8.9

B-

City	Rate
Modesto, CA	9.0
New York City, NY	9.1
Sacramento, CA	9.1
San Jose, CA	9.1
Raleigh, NC	9.2

C+

City	Rate
Denver, CO	9.3
Durham, NC	9.3
Long Beach, CA	9.3
Fontana, CA	9.4
Fort Wayne, IN	9.4
Oakland, CA	9.4
Los Angeles, CA	9.5
Salt Lake City, UT	9.5
Anaheim, CA	9.6
El Paso, TX	9.6
Stockton, CA	9.6

C

City	Rate
Aurora, CO	9.7
Garland, TX	9.7
Reno, NV	9.7
Santa Ana, CA	9.7
St Paul, MN	9.7
Anchorage, AK	9.8
Arlington, TX	9.8
Brookhaven, NY	9.8
Boston, MA	9.9
Chula Vista, CA	9.9
Glendale, AZ	9.9
Hempstead, NY	10.0
Phoenix, AZ	10.0

C-

City	Rate
Lincoln, NE	10.2
Bakersfield, CA	10.3
Tucson, AZ	10.3

D+

City	Rate
Dallas, TX	10.4
Des Moines, IA	10.4
District of Columbia	10.4
Fresno, CA	10.4
Minneapolis, MN	10.4
Kansas City, MO	10.5
Louisville, KY	10.5
Nashville-Davidson, TN	10.5
Tampa, FL	10.6
Albuquerque, NM	10.7
Jersey City, NJ	10.7
Miami, FL	10.7
Virginia Beach City, VA	10.7

D

City	Rate
Islip, NY	10.8
Honolulu, HI	10.9
Chicago, IL	11.0
Fort Worth, TX	11.0
Laredo, TX	11.0
Las Vegas, NV	11.0
Lexington-Fayette, KY	11.0
Charlotte, NC	11.1
Pittsburgh, PA	11.1
Wichita, KS	11.1

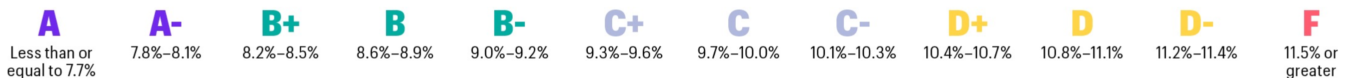
D-

City	Rate
Lubbock, TX	11.2
Orlando, FL	11.2
San Bernardino, CA	11.2
Colorado Springs, CO	11.3
Greensboro, NC	11.4
Philadelphia, PA	11.4

F

City	Rate
Brownsville, TX	11.5
Cincinnati, OH	11.5
Columbus, OH	11.6
Atlanta, GA	11.7
Corpus Christi, TX	11.7
Omaha, NE	11.7
Grand Rapids, MI	11.8
Fayetteville, NC	11.9
Houston, TX	11.9
Dayton, OH	12.1
Toledo, OH	12.2
San Antonio, TX	12.4
Buffalo, NY	12.5
Baton Rouge, LA	12.7
Memphis, TN	12.7
New Orleans, LA	12.7
Tulsa, OK	12.7
Newark, NJ	12.8
North Las Vegas, NV	12.8
St Louis City, MO	12.8
Winston-Salem, NC	12.9
Birmingham, AL	13.0
Rochester, NY	13.0
Norfolk City, VA	13.2
Oklahoma City, OK	13.3
Cleveland, OH	13.8
Milwaukee, WI	13.8
Detroit, MI	14.6

GRADE AND RANGE



Notes:

- Preterm is less than 37 weeks gestation based on obstetric estimate of gestational age.
- Cities represent those with the greatest number of live births out of all cities with a population of >100,000, as defined by the National Center for Health Statistics.
- *Data for Honolulu represent the combined city and county of Honolulu.
- See the U.S. 2021 March of Dimes Report Card for more information.

Source: National Center for Health Statistics, 2019 final natality data. **Prepared by:** March of Dimes Perinatal Data Center, 2021.

HEALTHY MOMS. STRONG BABIES. | MARCH OF DIMES

2021 MARCH OF DIMES REPORT CARD TECHNICAL NOTES

PRETERM BIRTH: DEFINITION AND SOURCE

Preterm birth is a birth with less than 37 weeks gestation based on the obstetric estimate of gestational age. Data used in this report card came from the National Center for Health Statistics (NCHS) natality files, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.[1] This national data source was used so that data are comparable for each state and jurisdiction-specific report card. Data provided on the report card may differ from data obtained directly from state or local health departments and vital statistics agencies due to timing of data submission and handling of missing data. The preterm birth rates shown at the top of report card was calculated from the NCHS 2020 final natality data. Preterm birth rates in the trend graph are from the NCHS 2010-2020 final natality data. County and city preterm birth rates are from the NCHS 2019 final natality data. Preterm birth rates for bridged racial and ethnic categories were calculated from NCHS 2017-2019 final natality data. Preterm birth rates were calculated as the number of premature births divided by the number of live births with known gestational age multiplied by 100.

GRADING METHODOLOGY

Expanded grade ranges were introduced in 2019. Grade ranges remain based on standard deviations of final 2014 state and District of Columbia preterm birth rates away from the March of Dimes goal of 8.1 percent by 2020. Grades were determined using the following scoring formula: (preterm birth rate of each jurisdiction – 8.1 percent) / standard deviation of final 2014 state and District of Columbia preterm birth rates. Each score within a grade was divided into thirds to create +/- intervals. The resulting scores were rounded to one decimal place and assigned a grade. See the table for details.

GRADE	PRETERM BIRTH RATE RANGE SCORING CRITERIA
A	Preterm birth rate less than or equal to 7.7%.
A-	Preterm birth rate of 7.8 to 8.1%.
B+	Preterm birth rate of 8.2 to 8.5%.
B	Preterm birth rate of 8.6 to 8.9%.
B-	Preterm birth rate of 9.0 to 9.2%.
C+	Preterm birth rate of 9.3 to 9.6%.
C	Preterm birth rate of 9.7 to 10.0%.
C-	Preterm birth rate of 10.1 to 10.3%.
D+	Preterm birth rate of 10.4 to 10.7%.
D	Preterm birth rate of 10.8 to 11.1%.
D-	Preterm birth rate of 11.2 to 11.4%.
F	Preterm birth rate greater than or equal to 11.5%.

INFANT MORTALITY RATE

Infant mortality rates were calculated using the NCHS 2019 period linked infant birth and infant death data. Infant mortality rates were calculated as the number of infant deaths divided by the number of live births multiplied by 1,000. Infant mortality rate in the trend graph are from the NCHS 2009-2019 period linked infant birth and infant death files.

PRETERM BIRTH BY RACE/ETHNICITY OF THE MOTHER

Mother's race and Hispanic ethnicity are reported separately on birth certificates. Rates for Hispanic women include all bridged racial categories (white, black, American Indian/Alaska Native and Asian/Pacific Islander). Rates for non-Hispanic women are classified according to race. The Asian/Pacific Islander category includes Native Hawaiian. To provide stable rates, racial and ethnic groups are shown on the report card if the group had 10 or more preterm births in each year from 2017-2019. To calculate preterm birth rates on the report card, three years of data were aggregated (2017-2019). Preterm birth rates for not stated/unknown race are not shown on the report card.

PRETERM BIRTH BY CITY

Report cards for states and jurisdictions, except District of Columbia, display the city with the greatest number of live births. Cities are not displayed for Delaware, Maine, Vermont, West Virginia and Wyoming due to limited availability of data. Grades were assigned based on the grading criteria described above. Change from previous year was calculated by comparing the 2019 city preterm birth rate to the 2018 rate.

PRETERM BIRTH DISPARITY MEASURES

The March of Dimes disparity ratio is based on Healthy People 2020 methodology and provides a measure of the differences, or disparities, in preterm birth rates across racial/ethnic groups within a geographic area.[2] The disparity ratio compares the racial/ethnic group with the lowest preterm birth rate (comparison group) to the average of the preterm birth rate for all other groups.

To calculate the disparity ratio, the 2017-2019 preterm birth rates for all groups (excluding the comparison group) were averaged and divided by the 2017-2019 comparison group preterm birth rate. The comparison group is the racial/ethnic group with the lowest six-year aggregate preterm birth rate (2010-2015) among groups that had 20 or more preterm births in each year from 2010-2015. A disparity ratio was calculated for U.S. states, the District of Columbia, and the total U.S. A disparity ratio was not calculated for Maine, Vermont, and West Virginia. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

A TIME FOR PARTNERSHIP AND ACTION:
EXAMINING THE U.S. MATERNAL AND INFANT HEALTH CRISIS AND POLICIES NEEDED FOR CHANGE

March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes, see **www.marchofdimes.org/reportcard**

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2021 MARCH OF DIMES REPORT CARD TECHNICAL NOTES

PRETERM BIRTH DISPARITY MEASURES

Progress toward eliminating racial and ethnic disparities was evaluated by comparing the 2017-2019 disparity ratio to a baseline (2010-2012) disparity ratio. Change between time periods was assessed for statistical significance at the 0.05 level using the approach recommended by Healthy People 2020.[2] If the disparity ratio significantly improved because the average preterm birth rate for all other groups got better, we displayed "Improved" on the report card. If the disparity ratio significantly worsened because the lowest group got better or the average of all other groups got worse, we displayed "Worsened" on the report card. If the disparity ratio did not significantly change, we displayed "No Improvement" on the report card.

The report card also provides the percent difference between the racial/ethnic group with the 2017-2019 highest preterm birth rate compared to the combined 2017-2019 preterm birth rate among women in all other racial/ethnic groups. This percent difference was calculated using only the racial/ethnic groups displayed on the state or jurisdiction-specific report card. This difference was calculated for each U.S. state with adequate numbers and the District of Columbia.

SOCIAL VULNERABILITY INDEX

March of Dimes recognizes the importance of certain risk factors that are associated with maternal and infant health outcomes. The social vulnerability index is calculated by the Center for Disease Control.[3] This index is comprised of fifteen variables from the American Community Survey (ACS), 2014-2018 and is represented at the county level. These variables are grouped into the following themes: socioeconomic, household composition/disability, minority status/language and housing type/ transportation. Socioeconomic includes poverty, unemployment, income and level of high school completion. Household composition and disability includes aged 65 or older, aged 17 or younger, disability and single-parent household. Minority status includes minority and speaks English "Less than well". Housing type and transportation includes multi-unit structures, mobile homes, crowding, no vehicle and group quarters.

MATERNAL AND CHILD HEALTH INDICATORS

LOW-RISK CESAREAN BIRTH RATES

A low-risk Cesarean birth occurs when a woman undergoes the surgical procedure if the baby is a single infant, is positioned head-first, the mother is full-term (at least 37 weeks), and has not given birth prior.[4] This is also referred to as a NTSV Caesarean birth. NTSV abbreviated to mean Nulliparous (or first-time mother), Term, Singleton, Vertex (head-first position).

Low-risk Cesarean birth rates were calculated using the NCHS 2019 final natality data.[1] Low-risk Cesarean birth rates were calculated as the number of Cesarean births that occurred to first-time mothers of a single infant, positioned headfirst with a gestational age of at least 37 weeks (NTSV) divided by the number of first-time mothers of a single infant, positioned headfirst with a gestational age of at least 37 weeks (NTSV) multiplied by 1,000.

INADEQUATE PRENATAL CARE

Adequacy of prenatal care is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into 1 of 4 categories (inadequate, intermediate, adequate and adequate plus) by combining information about the timing of prenatal care, the number of visits and the infant's gestational age.[5] Inadequate prenatal care is defined as a woman who received less than 50% of her expected visits. Inadequate prenatal care will be calculated using the NCHS 2019 final natality data.[1]

STATE LEVEL MATERNAL HEALTH POLICIES

MEDICAID EXPANSION

Medicaid expansion allows more people to be eligible for Medicaid coverage—it expands the cut-off for eligibility. Medicaid expansion status is provided from the Kaiser Family Foundation as adopted or not adopted.[6] Medicaid expansion has reduced the rates of uninsured. Increased access and utilization of health care are significantly associated with Medicaid expansion.[7]

MEDICAID EXTENSION

The adoption of this policy allows women to qualify for pregnancy-related Medicaid coverage for more than the standard 60 days after pregnancy for up one year.[8] Extending this coverage typically requires both state legislation and an appropriation in addition to a Section 1115 waiver in order to receive federal match.[9] Medicaid extension status is provided by Kaiser Family Foundation as adopted (having an approved 1115 waiver), waiver pending or planning or planning is occurring, or the state does not have the indicated organization/policy.[8]

MATERNAL MORTALITY REVIEW COMMITTEE (MMRC) — These committees investigate deaths related to pregnancy to determine underlying causes of death and respond to improve conditions and practices. The committees can be made up of representatives from public health, nursing, maternal-fetal medicine, obstetrics and gynecology, midwifery, patient advocacy groups and community-based organizations.[10] The measure is provided by the Guttmacher Institute and is categorized as: state has the indicated organization/policy, state has an MMRC but does not review deaths up to a year after pregnancy ends or state does not have the indicated organization/policy.[11]

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2021 MARCH OF DIMES REPORT CARD TECHNICAL NOTES

PERINATAL QUALITY COLLABORATIVE (PQC)

The PQC involves partnerships with families, key state agencies and organizations in order to identify and initiate programs or procedures that increase the quality of care in clinical settings. PQC's work focus on collaborative learning among healthcare providers and the PQC.[12] Data is provided by the Society of Maternal Fetal Medicine (SMFM) and the measure is reported as: state has the indicated organization/policy or the state does not have the indicated organization/policy.[13]

DOULA POLICY ON MEDICAID COVERAGE

Doulas are non-clinical professionals that emotionally and physically support women during the perinatal period, including birth and postpartum.[14] Doula policy status show states that have enacted bills relating to Medicaid coverage of doula care, or not. The measure is reported as: state has the indicated organization/policy or the state does not have the indicated organization/policy. Data is provided by the National Health Law Program under the Doula Medicaid Project.[15]

MIDWIFERY STATE LAWS

Midwives are health care professionals that may be part of the birth care team or stand alone in providing prenatal, delivery and postpartum care. Certified Nurse-Midwives (CNM) hold national certification and state licensure to practice in all 50 states. Measures depict states where both direct entry and nurse midwifery may practice and be licensed or where no licensure/practice is available/allowed. The measure is reported as: state has the indicated organization/policy or the state does not have the indicated organization/policy. Data is retrieved from the Midwife Alliance of North America.[16]

CALCULATIONS

All natality calculations were conducted by March of Dimes Perinatal Data Center.

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HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

2021 MARCH OF DIMES REPORT CARD

The 2021 Report Card highlights the latest key indicators to describe and improve maternal and infant health in the U.S. It features grades for preterm birth and measures on infant mortality in addition to social drivers of health, low-risk Cesarean births and inadequate prenatal care. Our Supplemental Report Card highlights the stark disparities across race and ethnicity within these factors.

With the onset of the COVID-19 pandemic, pre-existing health disparities have been magnified. Comprehensive data collection and analysis of these measures, and the resulting disparities, inform the development of policies and programs that move us closer to health equity. The Report Card looks at policies like Medicaid expansion and programs like Maternal Mortality Review Committees, that can help improve equitable maternal and infant health for families across the country.

ALABAMA

Scan here for more data on your state.

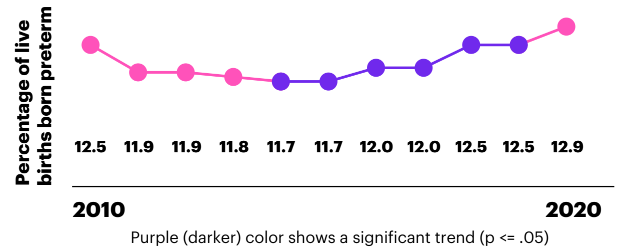
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

12.9%



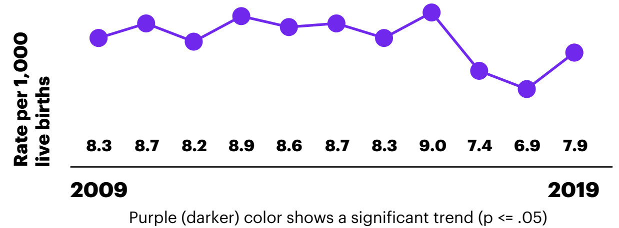
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

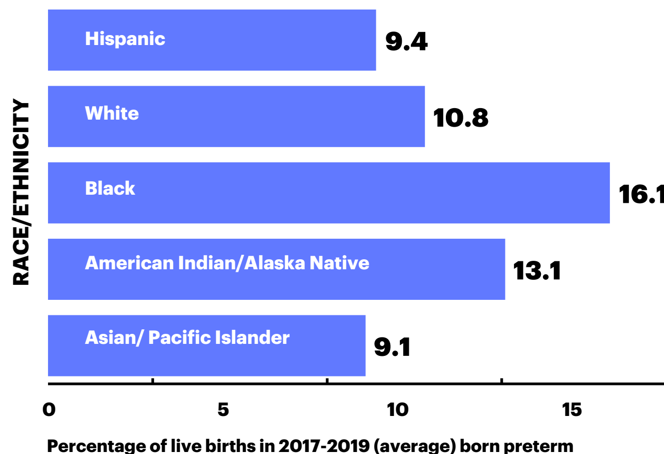
7.9



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

PRETERM BIRTH RATE BY RACE AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.



In Alabama, the preterm birth rate among Black women is 52% higher than the rate among all other women.

DISPARITY RATIO:

1.32

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Birmingham	F	13.0%	Improved

A TIME FOR PARTNERSHIP AND ACTION:
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March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes, see **www.marchofdimes.org/reportcard**

For details on data sources and calculations, see Technical Notes. Scan the QR code to the right to access the full U.S. Report Card.

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ALABAMA

MATERNAL HEALTH

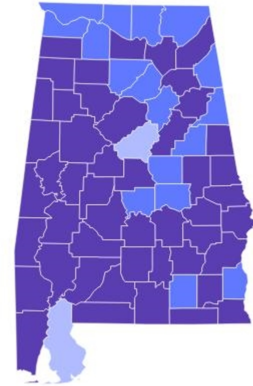
There is a critical connection between infant health, maternal health and the health of a family. All are dependent on their lived social context, the quality and accessibility of healthcare and the policies within a state. Each factor can provide insight into how a state serves its population.

SOCIAL VULNERABILITY INDEX

Where you live matters.

March of Dimes is offering the opportunity to examine social determinants of health at the county level using the Social Vulnerability Index (SVI). Socially vulnerable populations are at greater risk of experiencing poor health outcomes during a public health emergency. The same factors used in the index also contribute to poor maternal and infant health outcomes, including poor access to maternity care. The differences in counties are measured using 15 social factors, grouped into four areas including: socioeconomic status; household composition and disability; minority status and language; housing type and transportation. Each aspect of the index uses physical or social factors that help to estimate where poor health outcomes may be more prevalent.

The overall SVI for each county represents the amount of vulnerability relative to other counties in the state. The SVI measure is always a number between 0 and 1. A lower SVI indicates lesser vulnerability and a higher SVI indicates greater vulnerability.



CLINICAL MEASURES

Your healthcare matters.

Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

28.4 PERCENT

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.

18.8 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

The policies in your state matter. Adoption of the following policies and organizations can help improve maternal and infant health care.

MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

Allows the practice of direct entry midwives and certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend
- ✓ State has the indicated organization/policy
- ✗ State does not have the indicated organization/policy
- ✱ Waiver pending or planning is occurring
- ✱ Has an MMRC but does not review deaths up to a year after pregnancy ends

A TIME FOR PARTNERSHIP AND ACTION:
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ALASKA

Scan here for more data on your state.

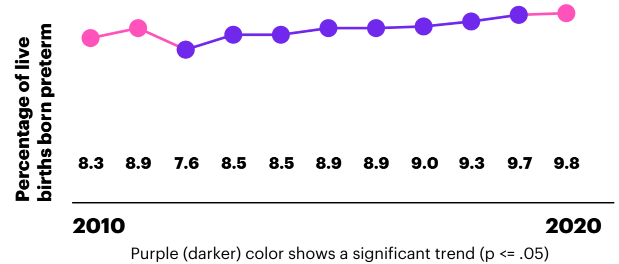
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.8%



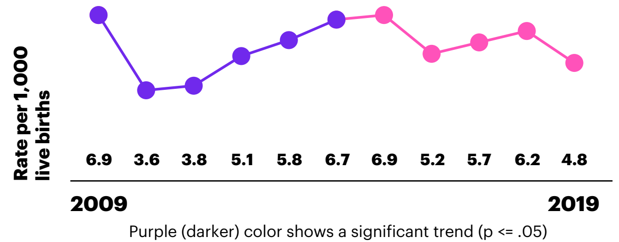
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

4.8



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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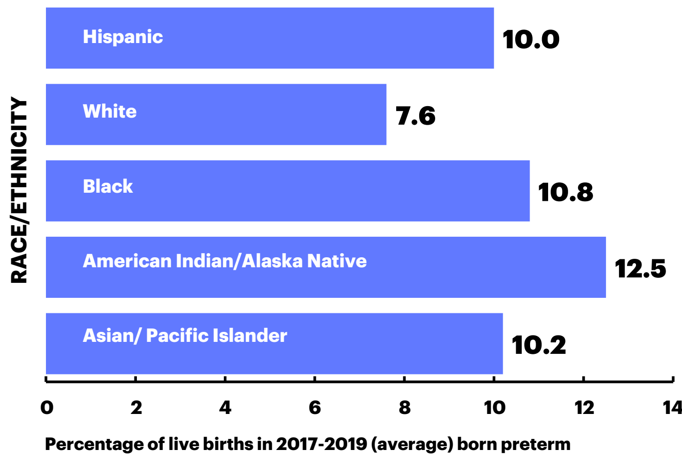

In Alaska, the preterm birth rate among American Indian/Alaska Native women is 49% higher than the rate among all other women.

DISPARITY RATIO:

1.42

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Anchorage	C	9.8%	No Change

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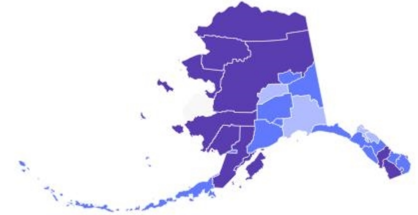

CLINICAL MEASURES

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Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

17.1 PERCENT

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.

16.1 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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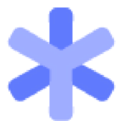

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ARIZONA

Scan here for more data on your state.

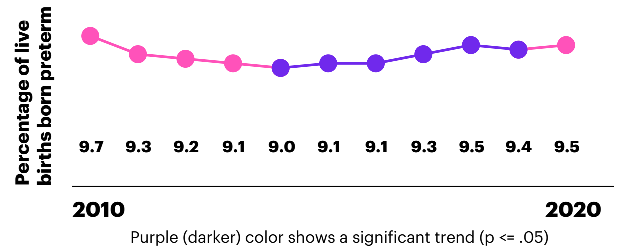
INFANT HEALTH

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.5%



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

INFANT MORTALITY

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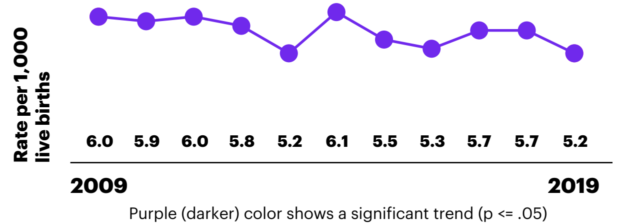
INFANT MORTALITY RATE

5.2



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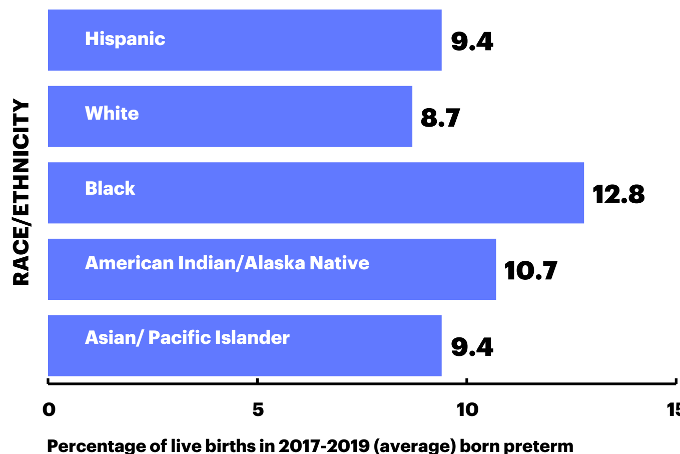

In Arizona, the preterm birth rate among Black women is 41% higher than the rate among all other women.

DISPARITY RATIO:

1.22

CHANGE FROM BASELINE:

Worsened

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Phoenix	C	10.0%	Worsened

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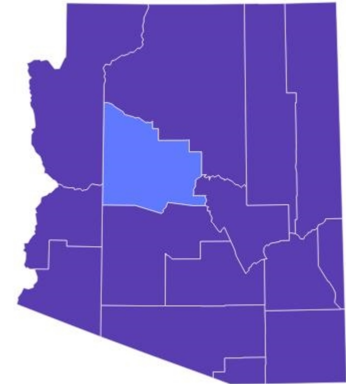

Lesser vulnerability Greater vulnerability

CLINICAL MEASURES

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21.9 PERCENT

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.

20.3 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend State has the indicated organization/policy State does not have the indicated organization/policy Waiver pending or planning is occurring Has an MMRC but does not review deaths up to a year after pregnancy ends

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ARKANSAS

Scan here for more data on your state.

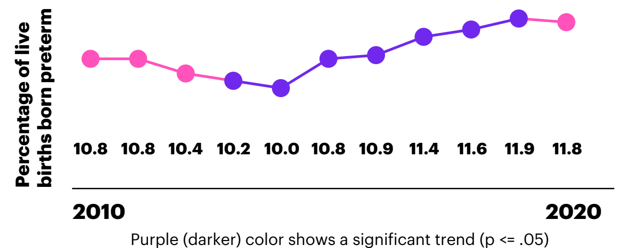
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

11.8%



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

INFANT MORTALITY

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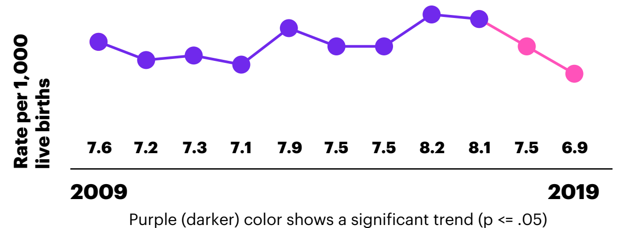
INFANT MORTALITY RATE

6.9



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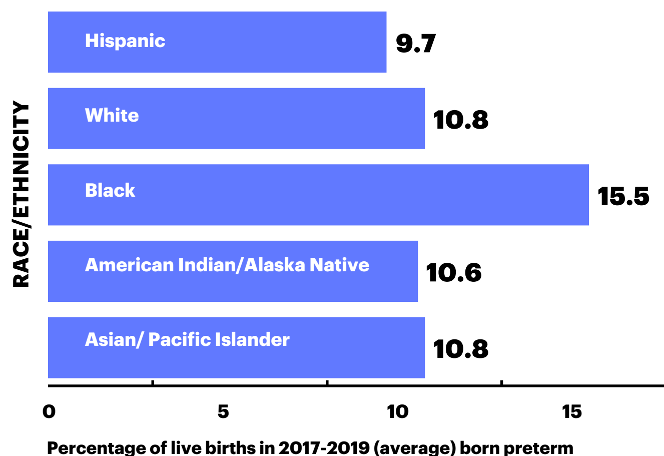

In Arkansas, the preterm birth rate among Black women is 46% higher than the rate among all other women.

DISPARITY RATIO:

1.23

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Little Rock	F	14.1%	Worsened

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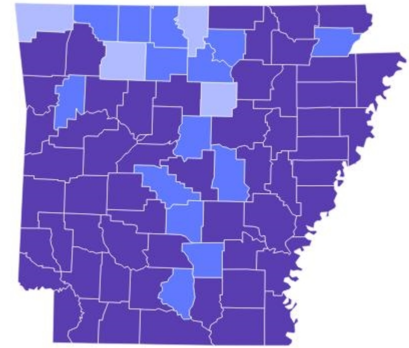

CLINICAL MEASURES

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27.7

PERCENT

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.

19.2

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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CALIFORNIA

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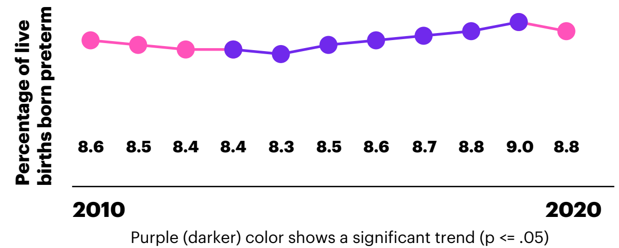
INFANT HEALTH

PRETERM BIRTH GRADE

B

PRETERM BIRTH RATE

8.8%



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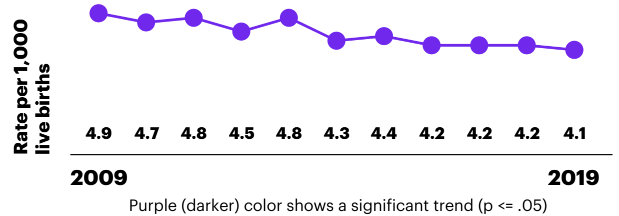
INFANT MORTALITY RATE

4.1



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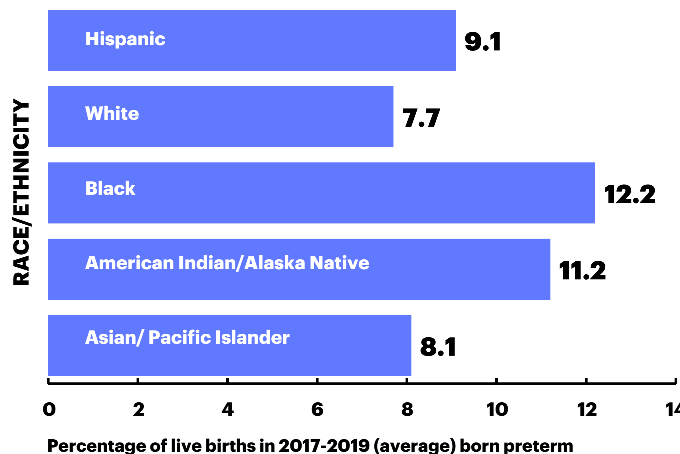

In California, the preterm birth rate among Black women is 44% higher than the rate among all other women.

DISPARITY RATIO:

1.31

CHANGE FROM BASELINE:

Worsened

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Los Angeles	C	9.5%	No Change

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Lesser vulnerability — Greater vulnerability

0.0-0.29 | 0.30-0.59 | 0.60-1.0

CLINICAL MEASURES

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23.8 PERCENT

LOW-RISK CESAREAN BIRTH

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9.0 PERCENT

INADEQUATE PRENATAL CARE

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COLORADO

Scan here for more data on your state.

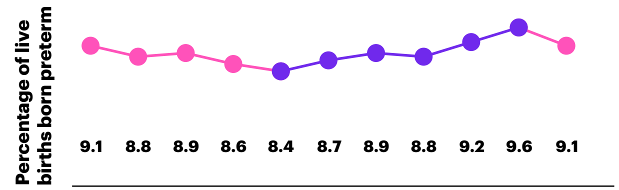
INFANT HEALTH

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.1%



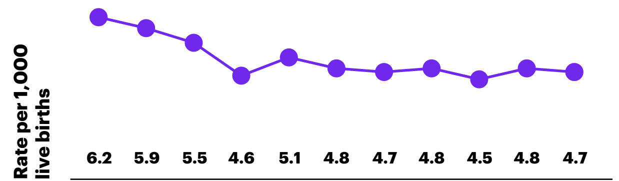
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

4.7



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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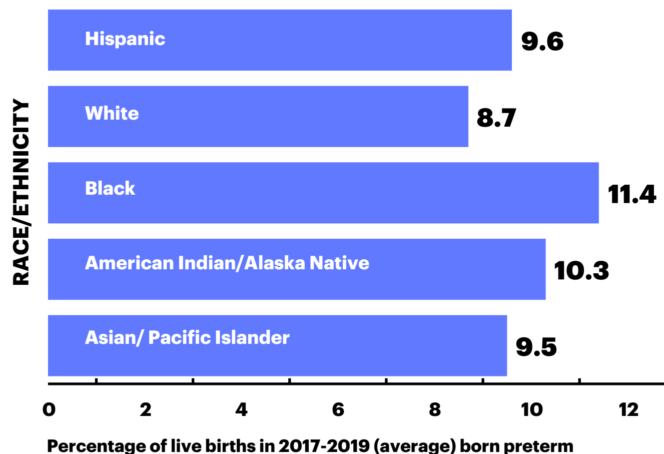

In Colorado, the preterm birth rate among Black women is 27% higher than the rate among all other women.

DISPARITY RATIO:

1.18

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Denver	C	9.3%	Worsened

A TIME FOR PARTNERSHIP AND ACTION:
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COLORADO

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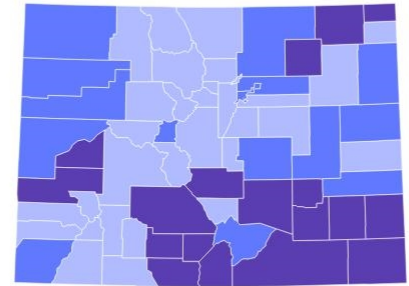

CLINICAL MEASURES

Your healthcare matters.

Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

21.4

PERCENT

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.

13.6

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

The policies in your state matter. Adoption of the following policies and organizations can help improve maternal and infant health care.

MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

Allows the practice of direct entry midwives and certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE

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PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend State has the indicated organization/policy; State does not have the indicated organization/policy; Waiver pending or planning is occurring; Has an MMRC but does not review deaths up to a year after pregnancy ends

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CONNECTICUT

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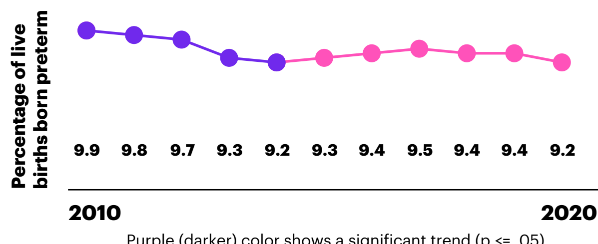
INFANT HEALTH

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.2%



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INFANT MORTALITY

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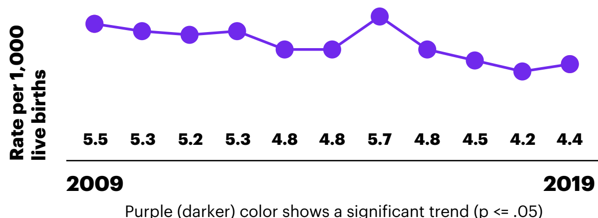
INFANT MORTALITY RATE

4.4



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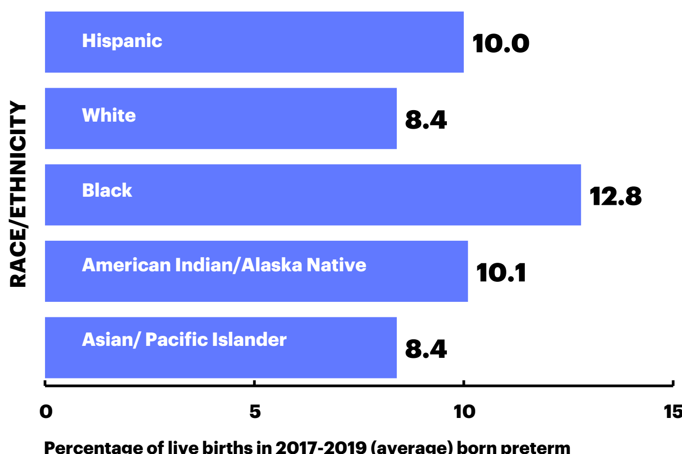

In Connecticut, the preterm birth rate among Black women is 44% higher than the rate among all other women.

DISPARITY RATIO:

1.24

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Bridgeport	D	10.5%	Improved

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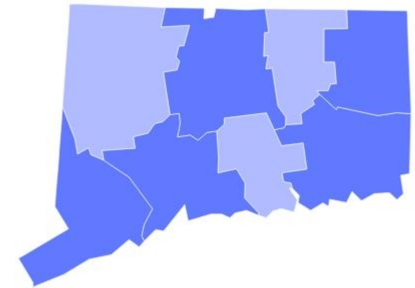

Lesser vulnerability Greater vulnerability

0.0-0.29 0.30-0.59 0.60-1.0

CLINICAL MEASURES

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28.9

PERCENT

LOW-RISK CESAREAN BIRTH

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8.9

PERCENT

INADEQUATE PRENATAL CARE

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MEDICAID EXTENSION

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DELAWARE

Scan here for more data on your state.

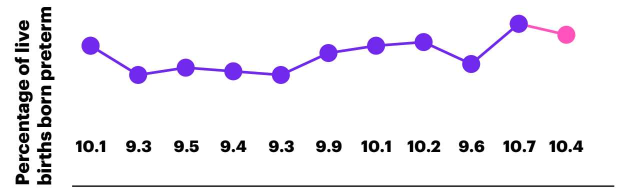
INFANT HEALTH

PRETERM BIRTH GRADE

D+

PRETERM BIRTH RATE

10.4%



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INFANT MORTALITY

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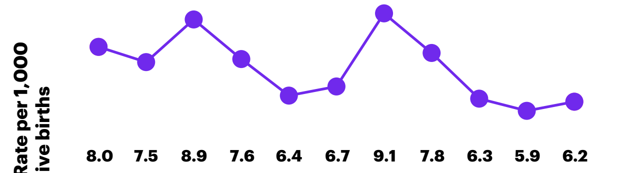
INFANT MORTALITY RATE

6.2



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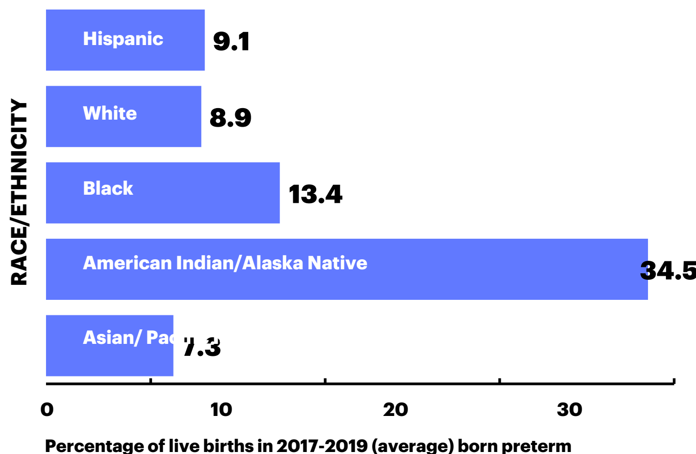

In Delaware, the preterm birth rate among Black women is 52% higher than the rate among all other women.

DISPARITY RATIO:

1.45

CHANGE FROM BASELINE:

No Improvement

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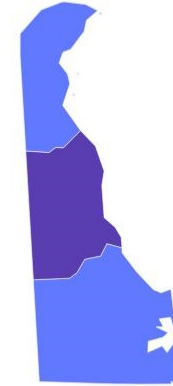

CLINICAL MEASURES

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24.4 PERCENT

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.

16.3 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

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DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend
- ✓ State has the indicated organization/policy
- ✗ State does not have the indicated organization/policy
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DISTRICT OF COLUMBIA

Scan here for more data on your state.

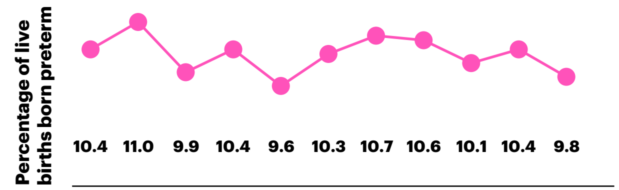
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.8%



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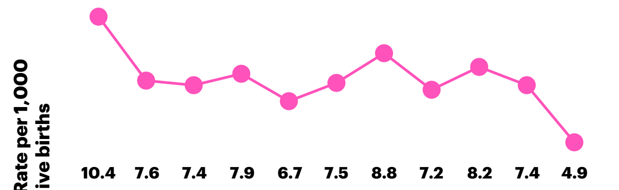
INFANT MORTALITY RATE

4.9



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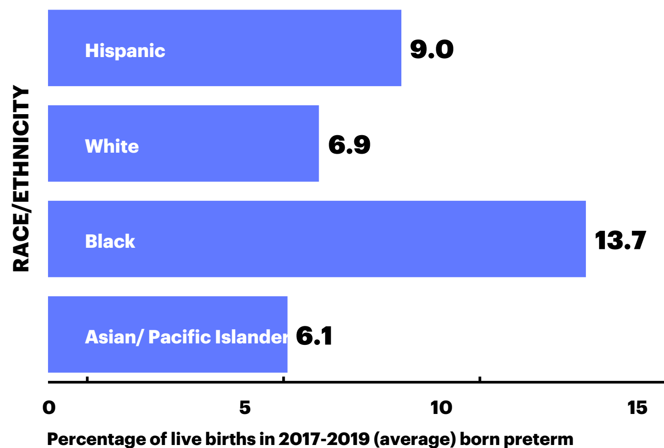

In District of Columbia, the preterm birth rate among Black women is 85% higher than the rate among all other women.

DISPARITY RATIO:

1.61

CHANGE FROM BASELINE:

No Improvement

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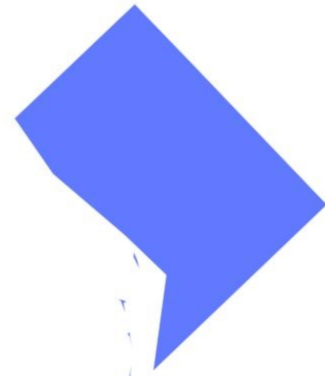

CLINICAL MEASURES

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28.0 PERCENT

LOW-RISK CESAREAN BIRTH

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17.5 PERCENT

INADEQUATE PRENATAL CARE

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FLORIDA

Scan here for more data on your state.

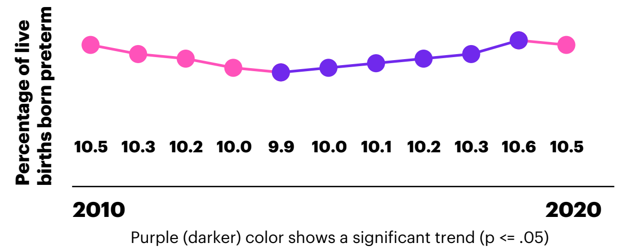
INFANT HEALTH

PRETERM BIRTH GRADE

D+

PRETERM BIRTH RATE

10.5%



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INFANT MORTALITY

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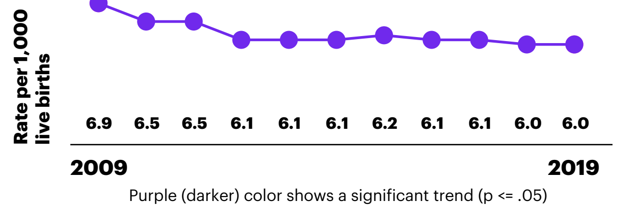
INFANT MORTALITY RATE

6.0



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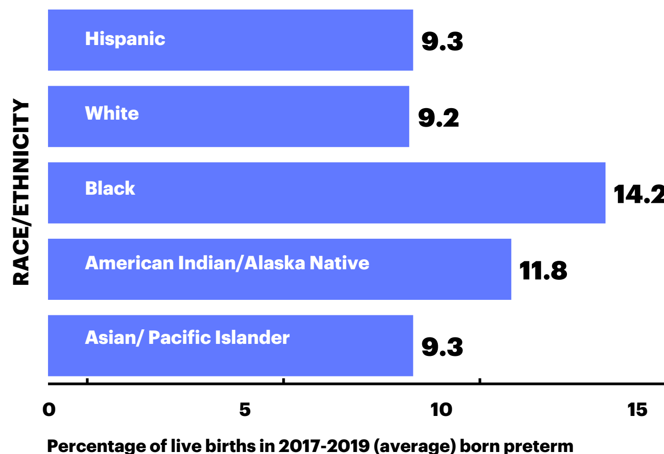
PRETERM BIRTH RATE BY RACE AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.



In Florida, the preterm birth rate among Black women is 53% higher than the rate among all other women.

DISPARITY RATIO:

1.18

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Orlando	D	11.2%	Worsened

A TIME FOR PARTNERSHIP AND ACTION:
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FLORIDA

MATERNAL HEALTH

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SOCIAL VULNERABILITY INDEX

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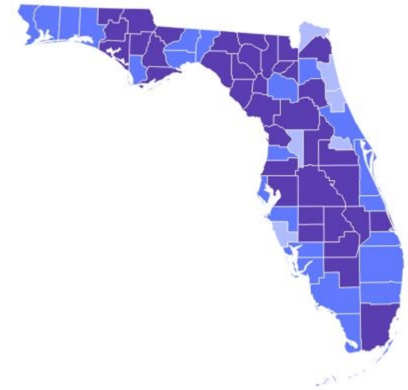

CLINICAL MEASURES

Your healthcare matters.

Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

29.6 PERCENT

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.

17.4 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

The policies in your state matter. Adoption of the following policies and organizations can help improve maternal and infant health care.

MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

Allows the practice of direct entry midwives and certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend

State has the indicated organization/policy

State does not have the indicated organization/policy

Waiver pending or planning is occurring

Has an MMRC but does not review deaths up to a year after pregnancy ends

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GEORGIA

Scan here for more data on your state.

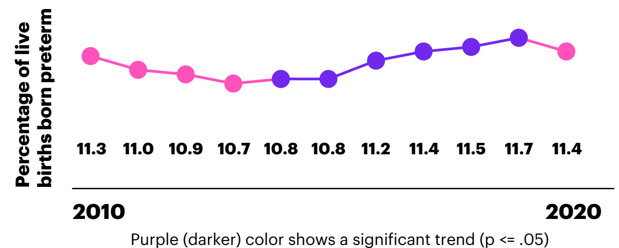
INFANT HEALTH

PRETERM BIRTH GRADE

D-

PRETERM BIRTH RATE

11.4%



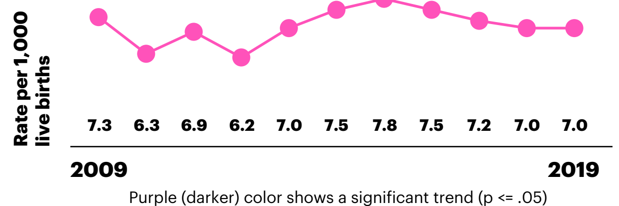
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

7.0



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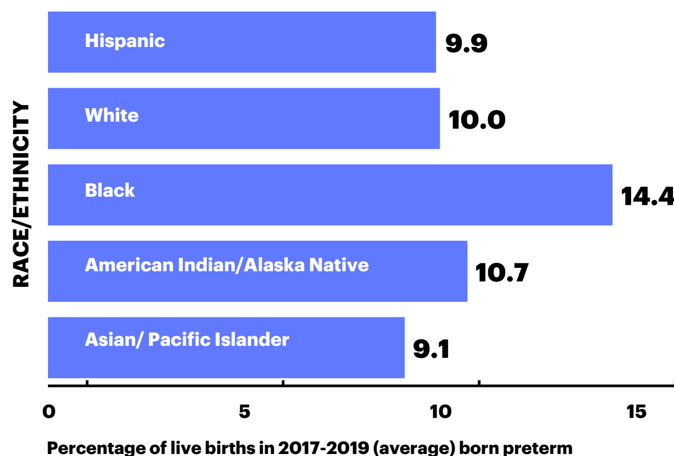

In Georgia, the preterm birth rate among Black women is 45% higher than the rate among all other women.

DISPARITY RATIO:

1.26

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Atlanta	F	11.7%	Worsened

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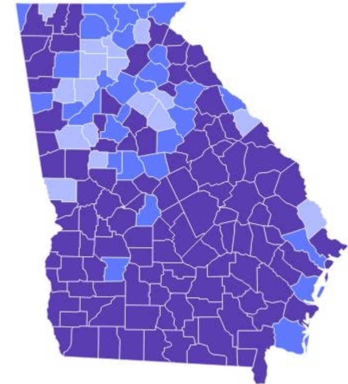

Lesser vulnerability — Greater vulnerability

0.0-0.29 | 0.30-0.59 | 0.60-1.0

CLINICAL MEASURES

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28.2

PERCENT

LOW-RISK CESAREAN BIRTH

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17.1

PERCENT

INADEQUATE PRENATAL CARE

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MIDWIFERY POLICY

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DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend
- ✓ State has the indicated organization/policy
- ✗ State does not have the indicated organization/policy
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HAWAII

Scan here for more data on your state.

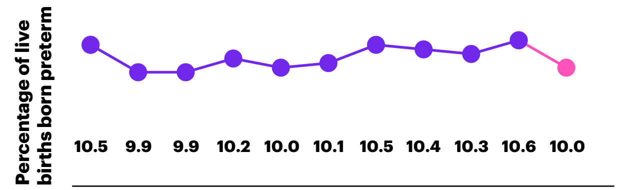
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

10.0%



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

INFANT MORTALITY

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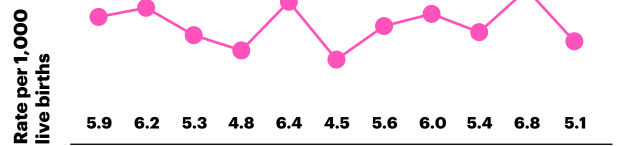
INFANT MORTALITY RATE

5.1



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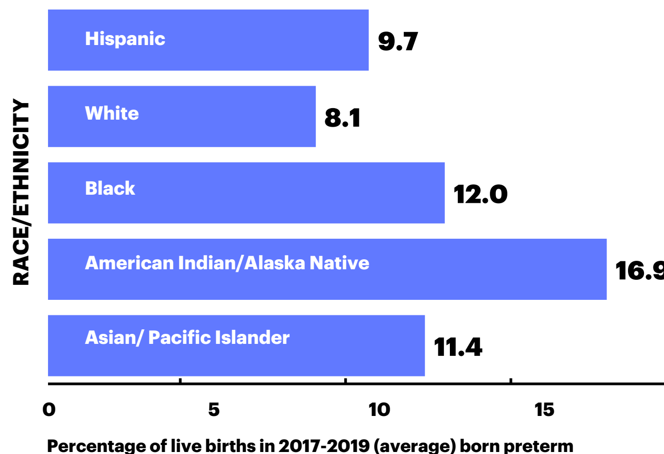

In Hawaii, the preterm birth rate among Black women is 17% higher than the rate among all other women.

DISPARITY RATIO:

1.36

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Honolulu	D	10.9%	Worsened

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HAWAII

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23.1 PERCENT

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.

20.4 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend State has the indicated organization/policy; State does not have the indicated organization/policy; Waiver pending or planning is occurring; Has an MMRC but does not review deaths up to a year after pregnancy ends

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IDAHO

Scan here for more data on your state.

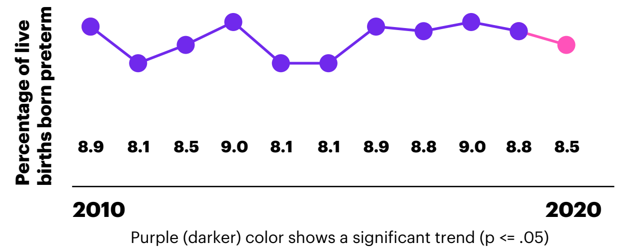
INFANT HEALTH

PRETERM BIRTH GRADE

B+

PRETERM BIRTH RATE

8.5%



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

INFANT MORTALITY

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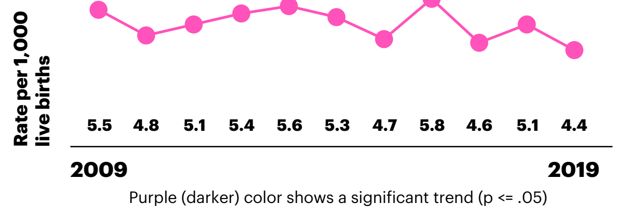
INFANT MORTALITY RATE

4.4



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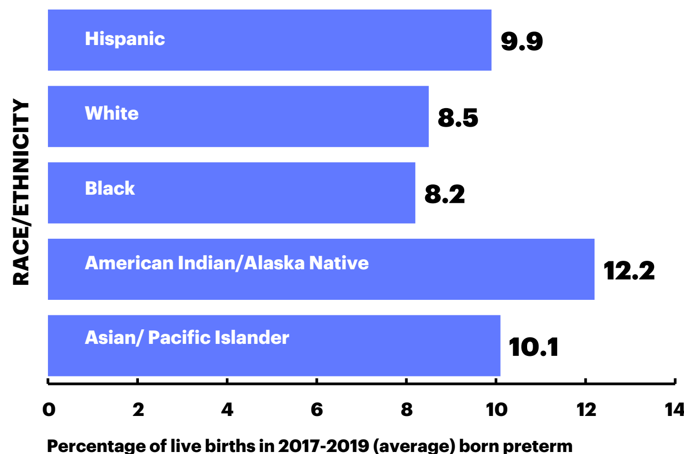

In Idaho, the preterm birth rate among American Indian/Alaska Native women is 39% higher than the rate among all other women.

DISPARITY RATIO:

1.26

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Boise City	A	8.1%	Improved

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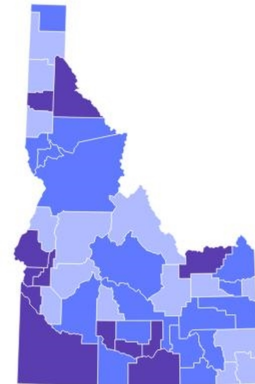

CLINICAL MEASURES

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19.0 PERCENT

LOW-RISK CESAREAN BIRTH

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9.8 PERCENT

INADEQUATE PRENATAL CARE

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ILLINOIS

Scan here for more data on your state.

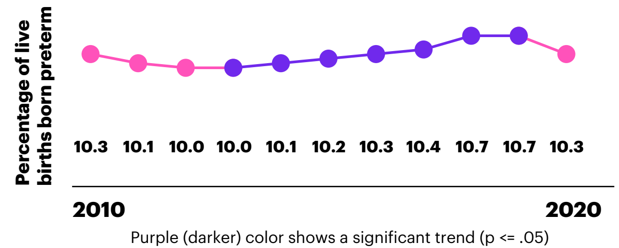
INFANT HEALTH

PRETERM BIRTH GRADE

C-

PRETERM BIRTH RATE

10.3%



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INFANT MORTALITY

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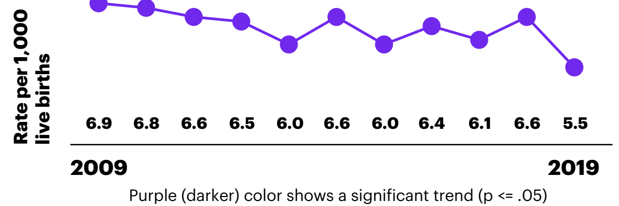
INFANT MORTALITY RATE

5.5



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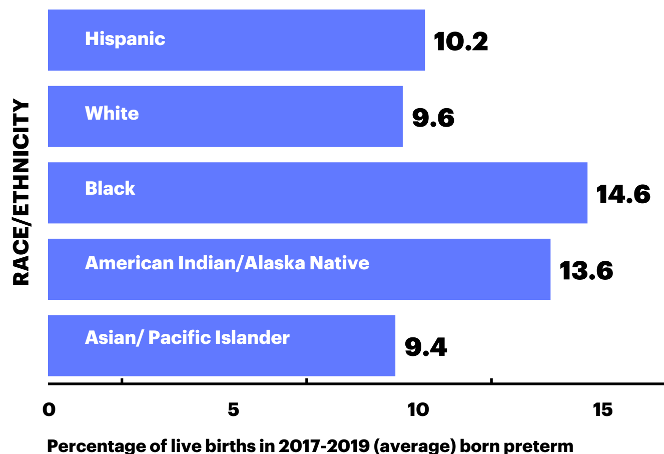

In Illinois, the preterm birth rate among Black women is 51% higher than the rate among all other women.

DISPARITY RATIO:

1.22

CHANGE FROM BASELINE:

Worsened

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Chicago	D	11.0%	Improved

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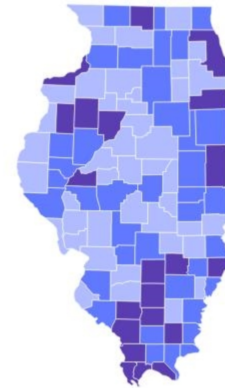

CLINICAL MEASURES

Your healthcare matters.

Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

24.7 PERCENT

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.

13.9 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

The policies in your state matter. Adoption of the following policies and organizations can help improve maternal and infant health care.

MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

Allows the practice of direct entry midwives and certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

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INDIANA

Scan here for more data on your state.

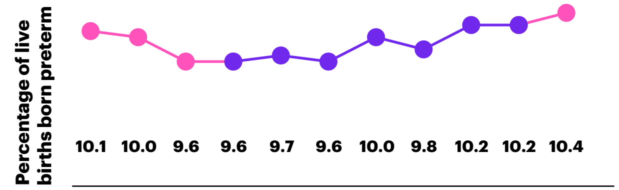
INFANT HEALTH

PRETERM BIRTH GRADE

D+

PRETERM BIRTH RATE

10.4%



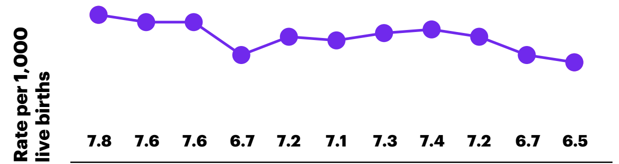
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

6.5



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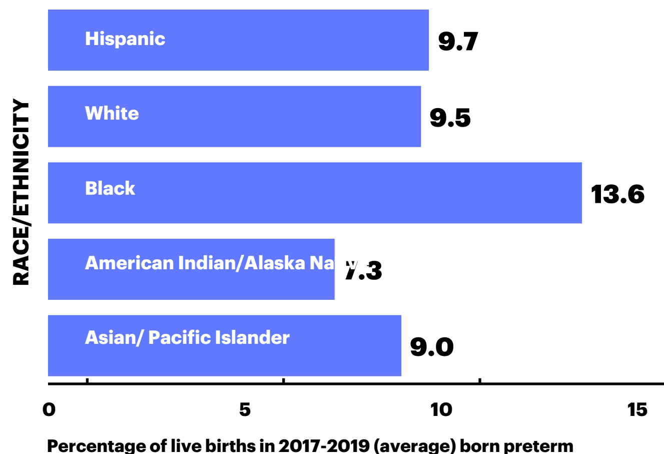
PRETERM BIRTH RATE BY RACE AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.



In Indiana, the preterm birth rate among Black women is 43% higher than the rate among all other women.

DISPARITY RATIO:

1.22

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Fort Wayne	C	9.4%	Improved

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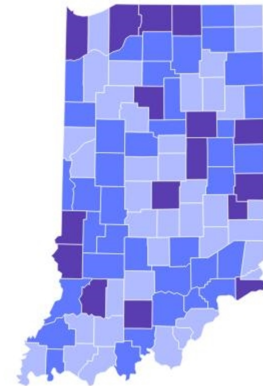

CLINICAL MEASURES

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23.0

PERCENT

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.

16.0

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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IOWA

Scan here for more data on your state.

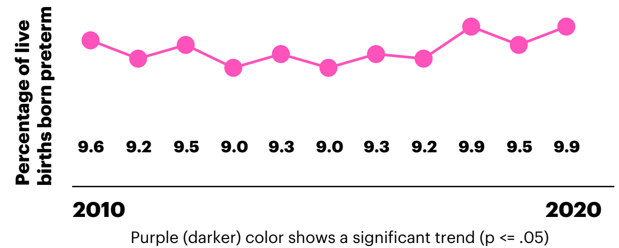
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.9%



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

INFANT MORTALITY

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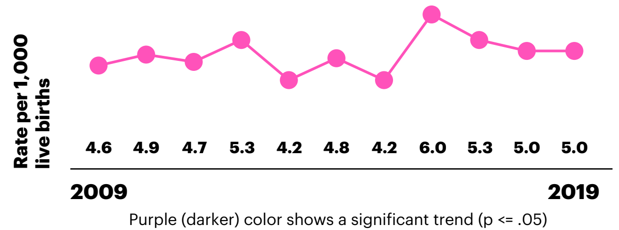
INFANT MORTALITY RATE

5.0



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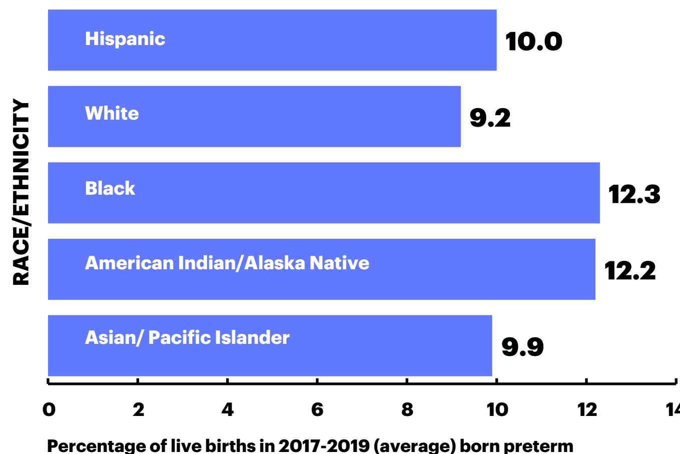

In Iowa, the preterm birth rate among Black women is 32% higher than the rate among all other women.

DISPARITY RATIO:

1.17

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Des Moines	D	10.4%	Improved

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IOWA

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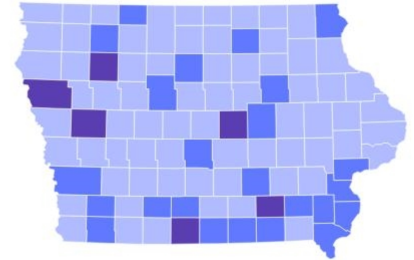

CLINICAL MEASURES

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23.6

PERCENT

LOW-RISK CESAREAN BIRTH

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10.6

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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KANSAS

Scan here for more data on your state.

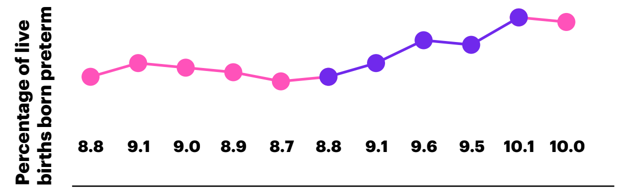
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

10.0%



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INFANT MORTALITY

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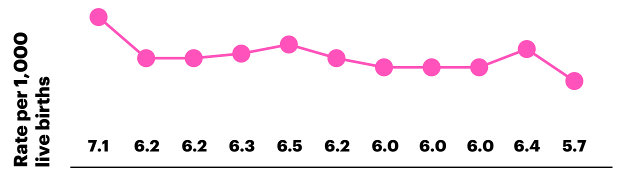
INFANT MORTALITY RATE

5.7



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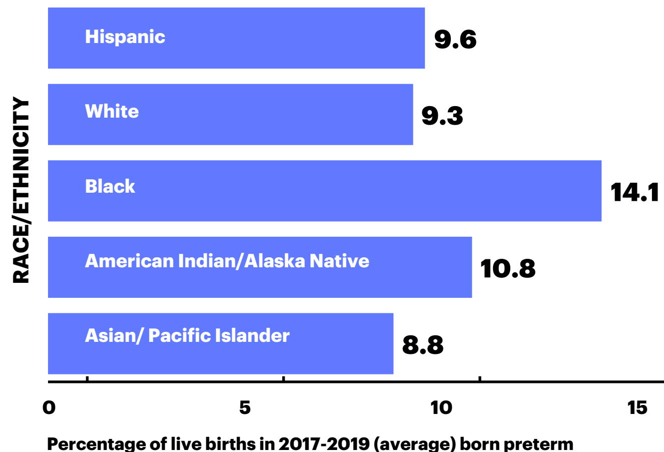

In Kansas, the preterm birth rate among Black women is 52% higher than the rate among all other women.

DISPARITY RATIO:

1.13

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Wichita	D	11.1%	Worsened

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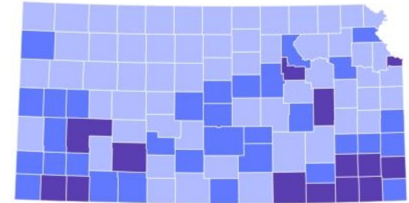

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24.3 PERCENT

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.

10.2 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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KENTUCKY

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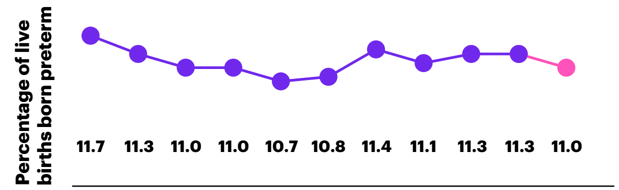
INFANT HEALTH

PRETERM BIRTH GRADE

D

PRETERM BIRTH RATE

11.0%



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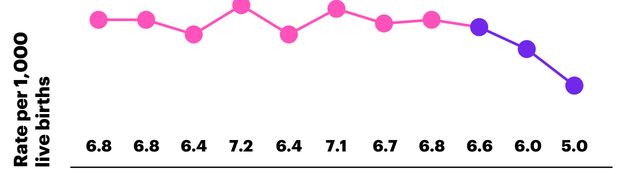
INFANT MORTALITY RATE

5.0



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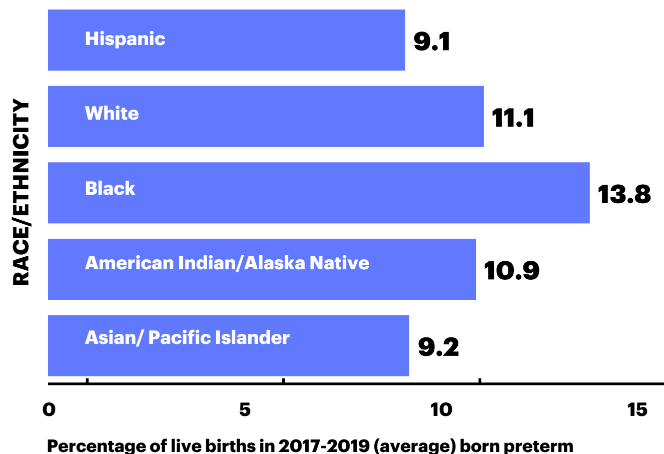

In Kentucky, the preterm birth rate among Black women is 25% higher than the rate among all other women.

DISPARITY RATIO:

1.24

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Louisville	D	10.5%	Improved

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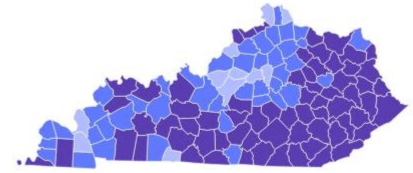

Lesser vulnerability | Greater vulnerability

CLINICAL MEASURES

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26.8

PERCENT

LOW-RISK CESAREAN BIRTH

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13.5

PERCENT

INADEQUATE PRENATAL CARE

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MIDWIFERY POLICY

Allows the practice of direct entry midwives and certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE

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These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend ✓ State has the indicated organization/policy ✗ State does not have the indicated organization/policy ✱ Waiver pending or planning is occurring ✱ Has an MMRC but does not review deaths up to a year after pregnancy ends

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LOUISIANA

Scan here for more data on your state.

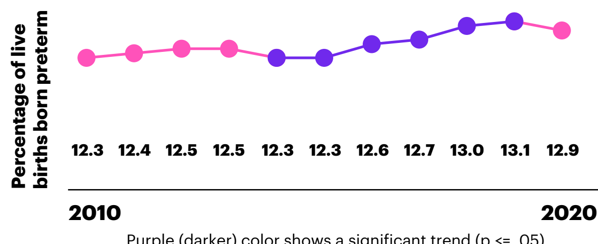
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

12.9%



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

INFANT MORTALITY

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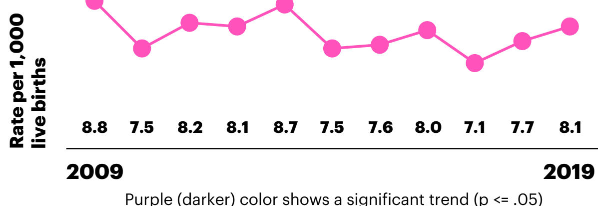
INFANT MORTALITY RATE

8.1



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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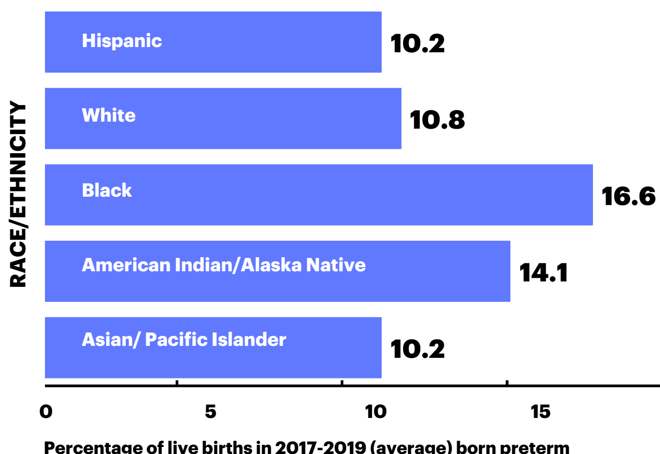

In Louisiana, the preterm birth rate among Black women is 55% higher than the rate among all other women.

DISPARITY RATIO:

1.26

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Baton Rouge	F	12.7%	Improved

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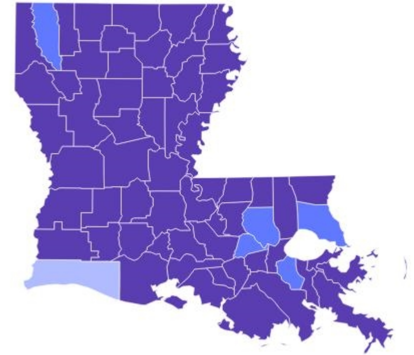

CLINICAL MEASURES

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28.5

PERCENT

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.

15.4

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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MAINE

Scan here for more data on your state.

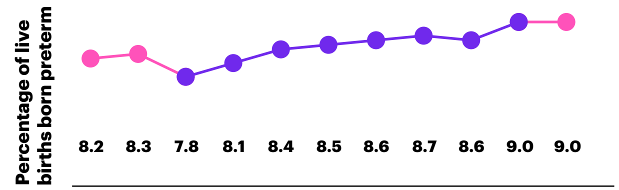
INFANT HEALTH

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.0%



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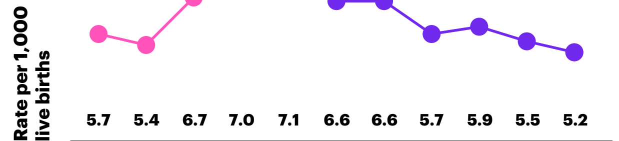
INFANT MORTALITY RATE

5.2



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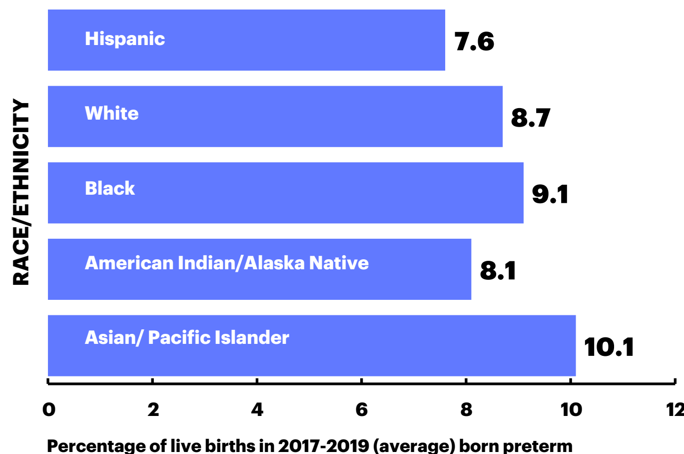

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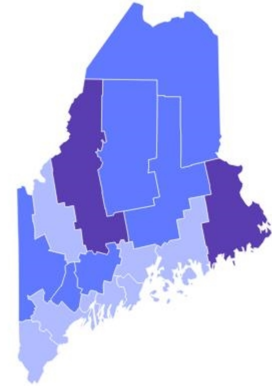

CLINICAL MEASURES

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25.3

PERCENT

LOW-RISK CESAREAN BIRTH

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9.0

PERCENT

INADEQUATE PRENATAL CARE

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MARYLAND

Scan here for more data on your state.

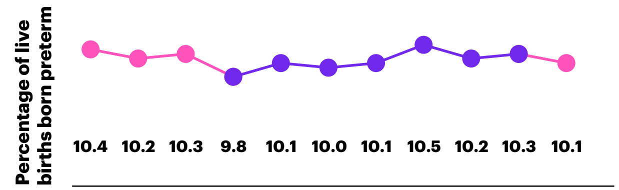
INFANT HEALTH

PRETERM BIRTH GRADE

C-

PRETERM BIRTH RATE

10.1%



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INFANT MORTALITY

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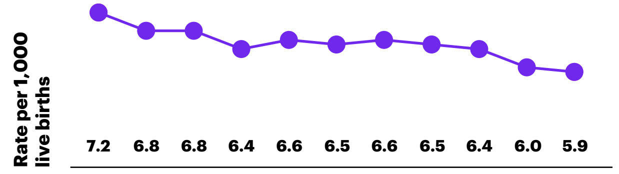
INFANT MORTALITY RATE

5.9



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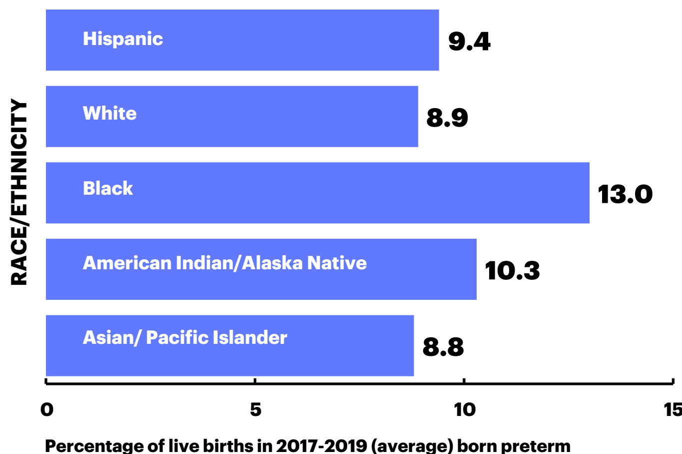

In Maryland, the preterm birth rate among Black women is 44% higher than the rate among all other women.

DISPARITY RATIO:

1.19

CHANGE FROM BASELINE:

No Improvement

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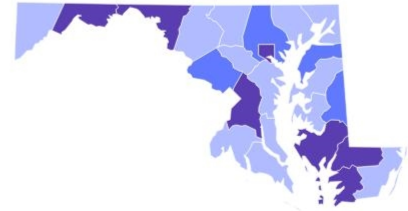

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27.6

PERCENT

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.

16.3

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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MASSACHUSETTS

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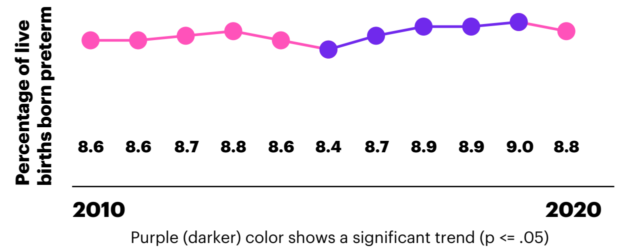
INFANT HEALTH

PRETERM BIRTH GRADE

B

PRETERM BIRTH RATE

8.8%



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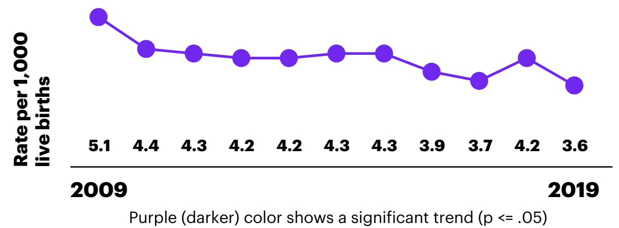
INFANT MORTALITY RATE

3.6



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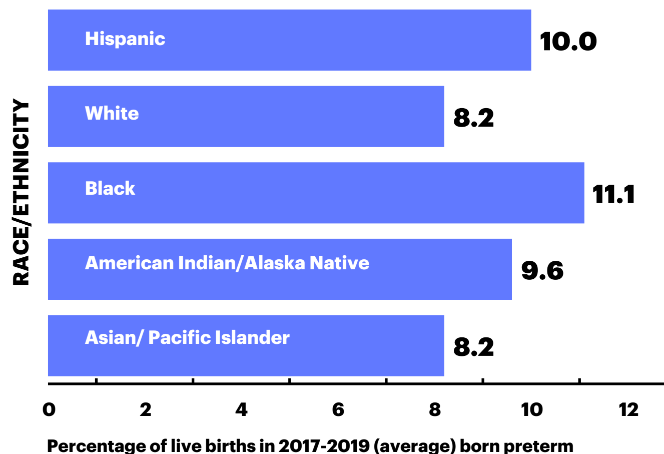

In Massachusetts, the preterm birth rate among Black women is 29% higher than the rate among all other women.

DISPARITY RATIO:

1.20

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Boston	C	9.9%	Improved

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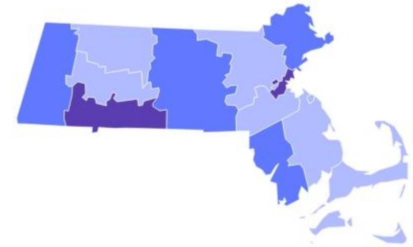

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24.8

PERCENT

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10.0

PERCENT

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MICHIGAN

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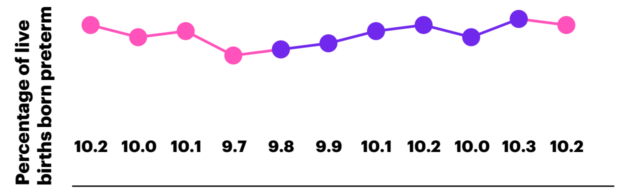
INFANT HEALTH

PRETERM BIRTH GRADE

C-

PRETERM BIRTH RATE

10.2%



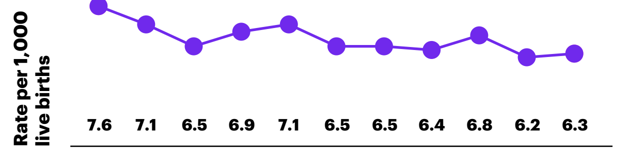
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

6.3



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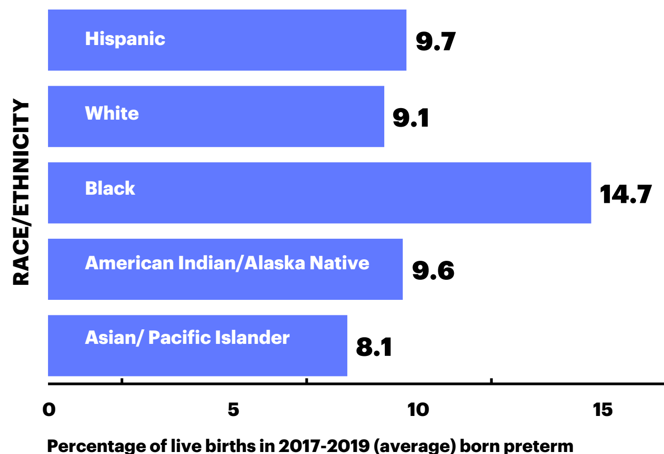
PRETERM BIRTH RATE BY RACE AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.



In Michigan, the preterm birth rate among Black women is 62% higher than the rate among all other women.

DISPARITY RATIO:

1.34

CHANGE FROM BASELINE:

Worsened

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Detroit	F	14.6%	Improved

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MICHIGAN

MATERNAL HEALTH

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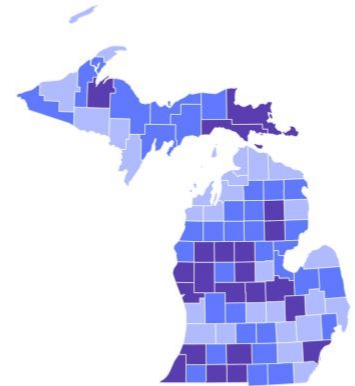

Lesser vulnerability — Greater vulnerability

0.0-0.29 | 0.30-0.59 | 0.60-1.0

CLINICAL MEASURES

Your healthcare matters.

Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

26.5 PERCENT

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.

12.5 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

The policies in your state matter. Adoption of the following policies and organizations can help improve maternal and infant health care.

MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

Allows the practice of direct entry midwives and certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend State has the indicated organization/policy | State does not have the indicated organization/policy | Waiver pending or planning is occurring | Has an MMRC but does not review deaths up to a year after pregnancy ends

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MINNESOTA

Scan here for more data on your state.

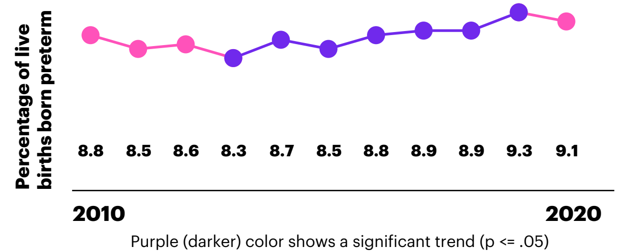
INFANT HEALTH

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.1%



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INFANT MORTALITY

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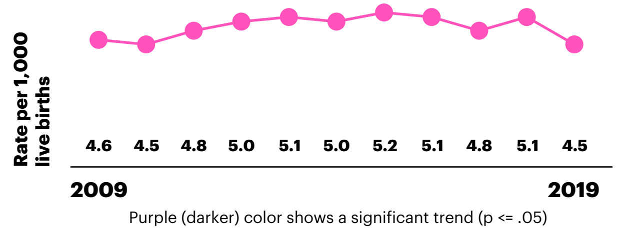
INFANT MORTALITY RATE

4.5



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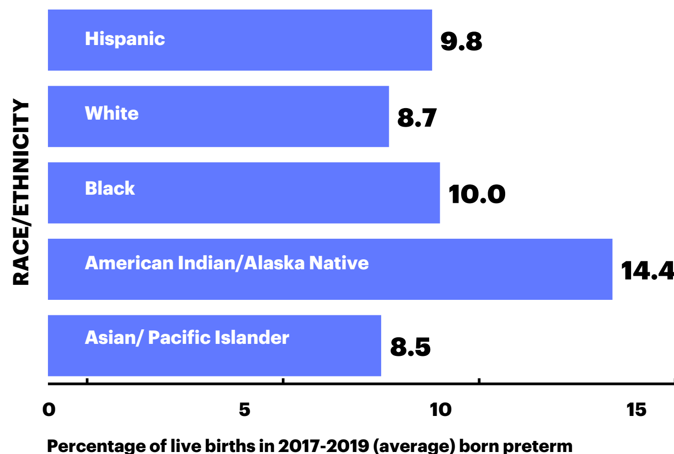

In Minnesota, the preterm birth rate among American Indian/Alaska Native women is 62% higher than the rate among all other women.

DISPARITY RATIO:

1.26

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Minneapolis	D	10.4%	Worsened

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MINNESOTA

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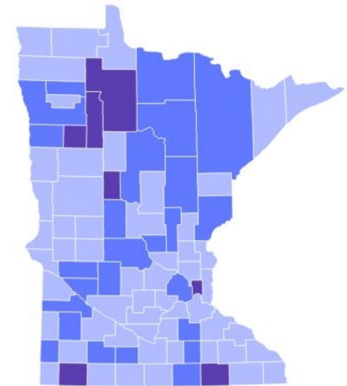

CLINICAL MEASURES

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23.8

PERCENT

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.

10.1

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

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DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend
- State has the indicated organization/policy
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MISSISSIPPI

Scan here for more data on your state.

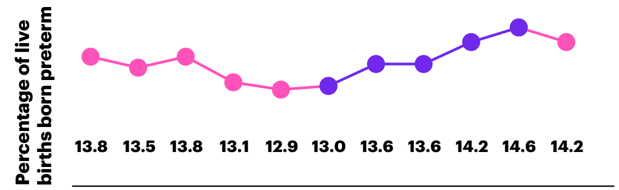
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

14.2%



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

INFANT MORTALITY

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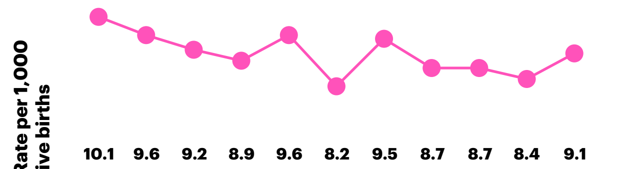
INFANT MORTALITY RATE

9.1



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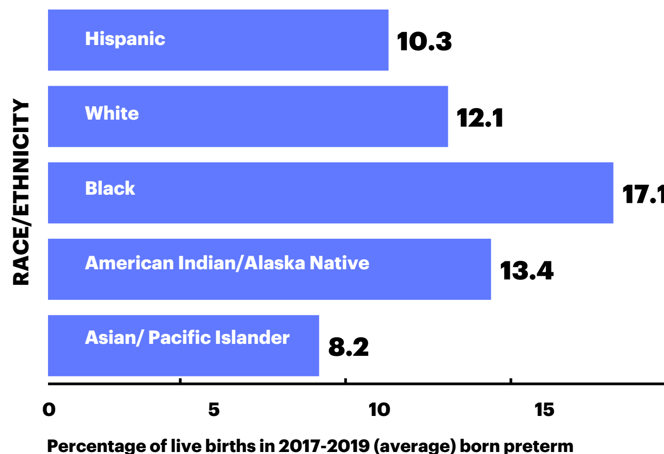

In Mississippi, the preterm birth rate among Black women is 44% higher than the rate among all other women.

DISPARITY RATIO:

1.24

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Jackson	F	19.6%	Worsened

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MISSISSIPPI

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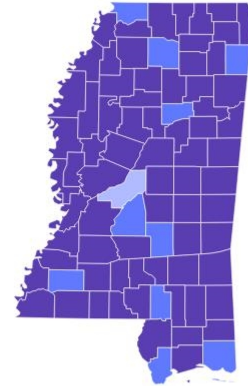

Lesser vulnerability | Greater vulnerability

0.0-0.29 **0.30-0.59** **0.60-1.0**

CLINICAL MEASURES

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30.7 PERCENT

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.

13.6 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

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MEDICAID EXTENSION

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MISSOURI

Scan here for more data on your state.

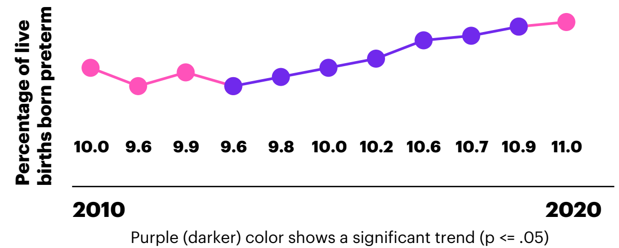
INFANT HEALTH

PRETERM BIRTH GRADE

D

PRETERM BIRTH RATE

11.0%



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INFANT MORTALITY

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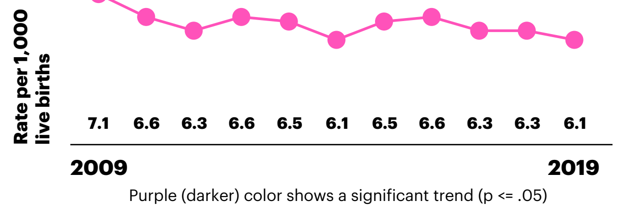
INFANT MORTALITY RATE

6.1



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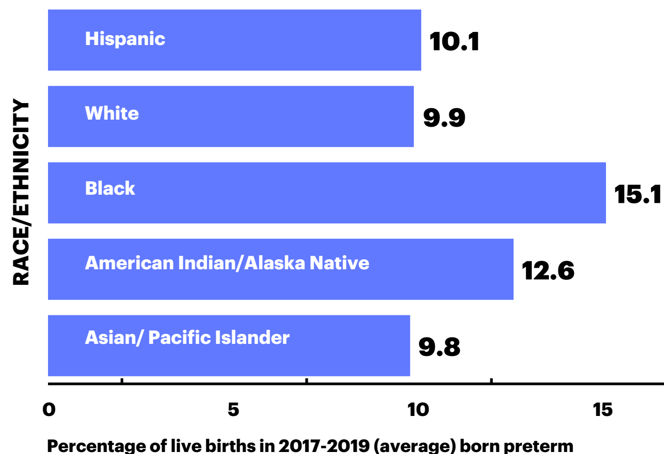

In Missouri, the preterm birth rate among Black women is 53% higher than the rate among all other women.

DISPARITY RATIO:

1.21

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Kansas City	D	10.5%	Improved

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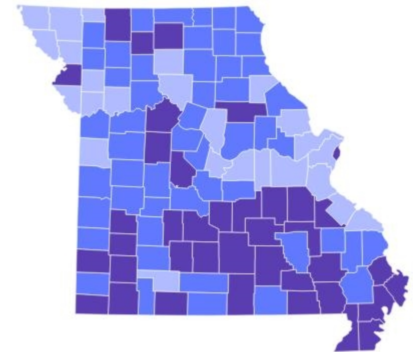

Lesser vulnerability Greater vulnerability

CLINICAL MEASURES

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23.9 PERCENT

LOW-RISK CESAREAN BIRTH

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15.6 PERCENT

INADEQUATE PRENATAL CARE

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MONTANA

Scan here for more data on your state.

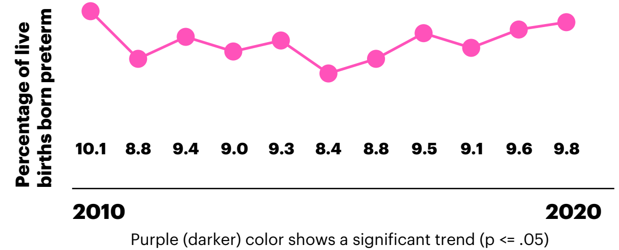
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.8%



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INFANT MORTALITY

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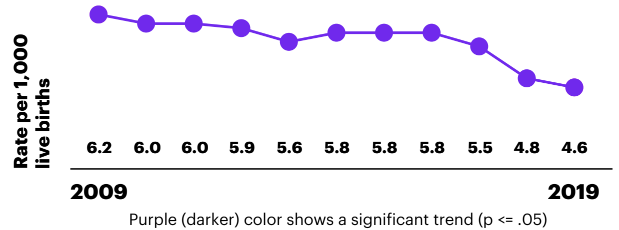
INFANT MORTALITY RATE

4.6



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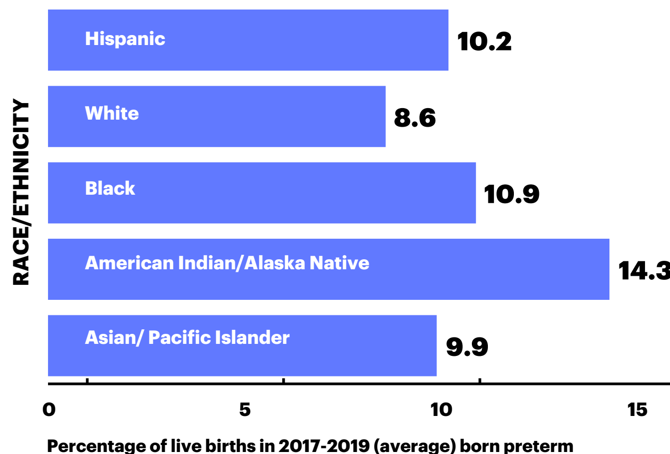

In Montana, the preterm birth rate among American Indian/Alaska Native women is 64% higher than the rate among all other women.

DISPARITY RATIO:

1.42

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Billings	B	9.0%	Improved

A TIME FOR PARTNERSHIP AND ACTION: EXAMINING THE U.S. MATERNAL AND INFANT HEALTH CRISIS AND POLICIES NEEDED FOR CHANGE

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MONTANA

MATERNAL HEALTH

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SOCIAL VULNERABILITY INDEX

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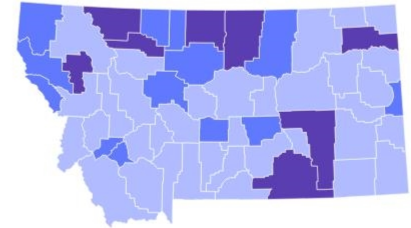

CLINICAL MEASURES

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23.2

PERCENT

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.

14.8

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

The policies in your state matter. Adoption of the following policies and organizations can help improve maternal and infant health care.

MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

Allows the practice of direct entry midwives and certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend
- ✓ State has the indicated organization/policy
- ✗ State does not have the indicated organization/policy
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MARCH OF DIMES

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NEBRASKA

Scan here for more data on your state.

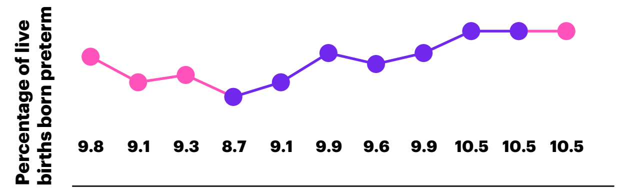
INFANT HEALTH

PRETERM BIRTH GRADE

D+

PRETERM BIRTH RATE

10.5%



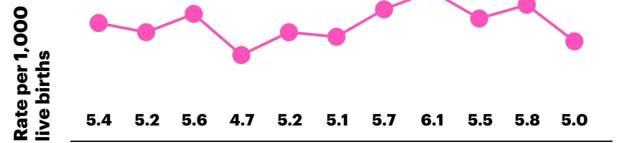
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

5.0



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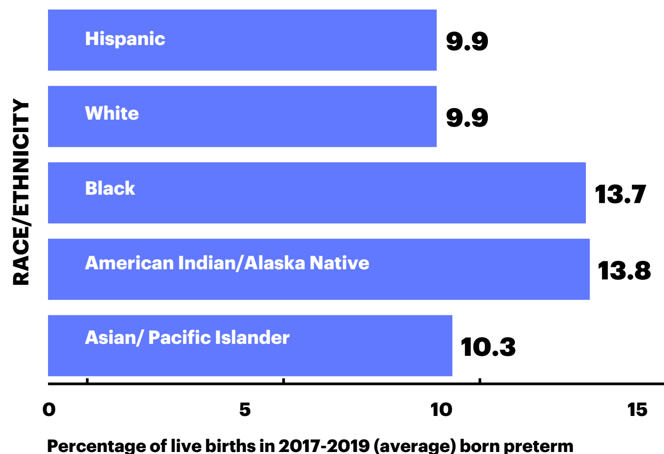

In Nebraska, the preterm birth rate among American Indian/Alaska Native women is 35% higher than the rate among all other women.

DISPARITY RATIO:

1.15

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Omaha	F	11.7%	No Change

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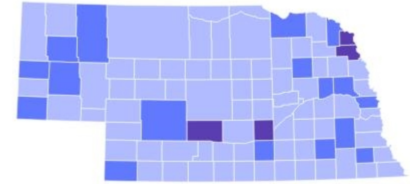

CLINICAL MEASURES

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21.2

PERCENT

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.

12.6

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

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NEVADA

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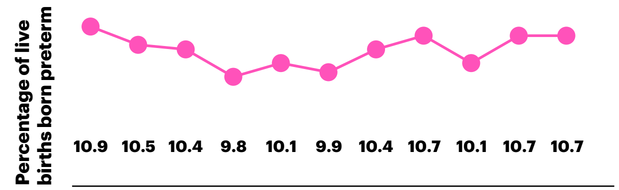
INFANT HEALTH

PRETERM BIRTH GRADE

D+

PRETERM BIRTH RATE

10.7%



2010 2020

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

INFANT MORTALITY

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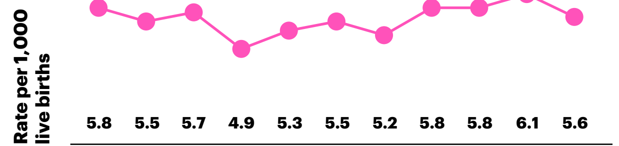
INFANT MORTALITY RATE

5.6



2009 2019

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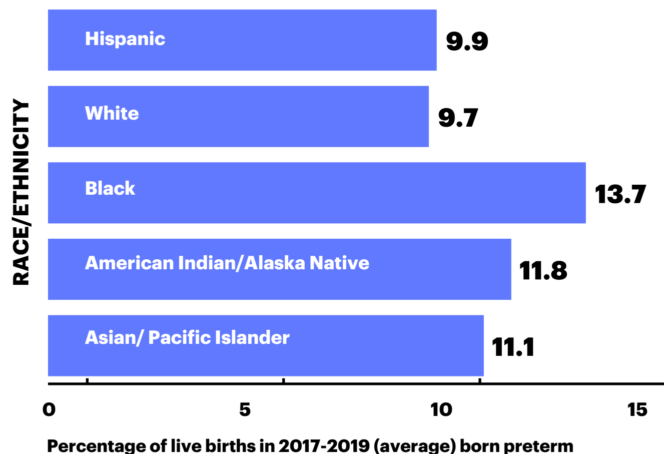

In Nevada, the preterm birth rate among Black women is 38% higher than the rate among all other women.

DISPARITY RATIO:

1.17

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Las Vegas	D	11.0%	Worsened

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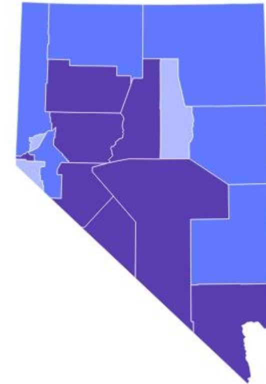

CLINICAL MEASURES

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26.8

PERCENT

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.

16.4

PERCENT

INADEQUATE PRENATAL CARE

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Legend
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NEW HAMPSHIRE

Scan here for more data on your state.

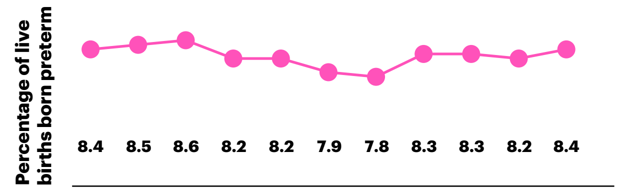
INFANT HEALTH

PRETERM BIRTH GRADE

B+

PRETERM BIRTH RATE

8.4%



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

INFANT MORTALITY

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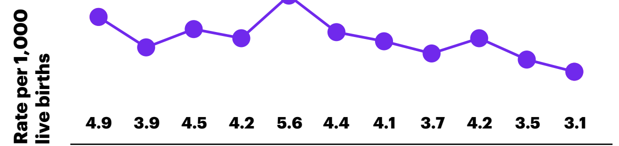
INFANT MORTALITY RATE

3.1



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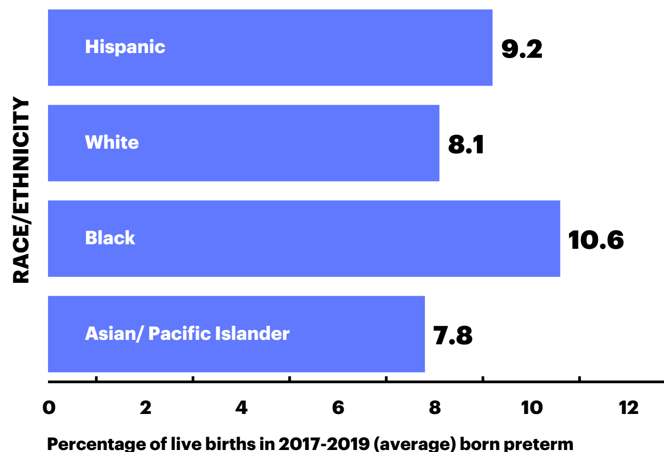

In New Hampshire, the preterm birth rate among Asian/Pacific Islander and Hispanic women is 14% higher than the rate among all other women.

DISPARITY RATIO:

1.11

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Manchester	B	8.6%	Improved

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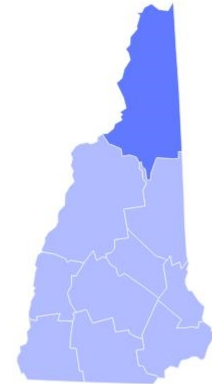

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26.0

PERCENT

LOW-RISK CESAREAN BIRTH

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8.3

PERCENT

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NEW JERSEY

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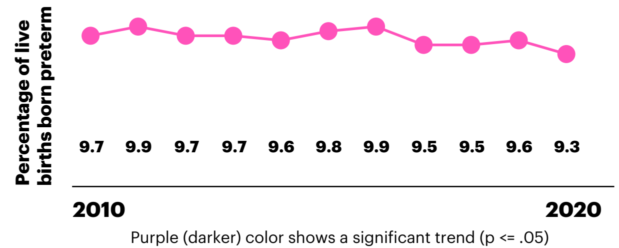
INFANT HEALTH

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.3%



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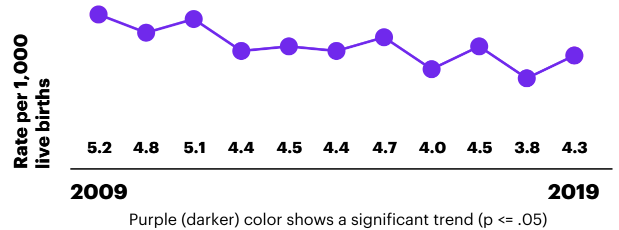
INFANT MORTALITY RATE

4.3



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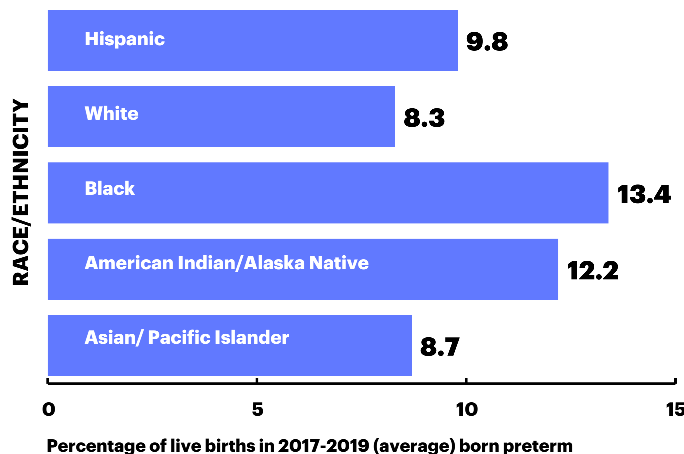

In New Jersey, the preterm birth rate among Black women is 51% higher than the rate among all other women.

DISPARITY RATIO:

1.21

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Jersey City	D	10.7%	Improved

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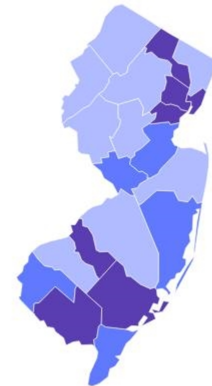

CLINICAL MEASURES

Your healthcare matters.

Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

26.7 PERCENT

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.

15.3 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

The policies in your state matter. Adoption of the following policies and organizations can help improve maternal and infant health care.

MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

Allows the practice of direct entry midwives and certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend State has the indicated organization/policy; State does not have the indicated organization/policy; Waiver pending or planning is occurring; Has an MMRC but does not review deaths up to a year after pregnancy ends

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NEW MEXICO

Scan here for more data on your state.

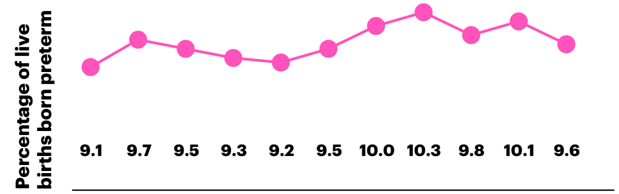
INFANT HEALTH

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.6%



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

INFANT MORTALITY

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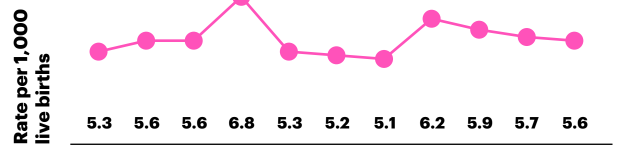
INFANT MORTALITY RATE

5.6



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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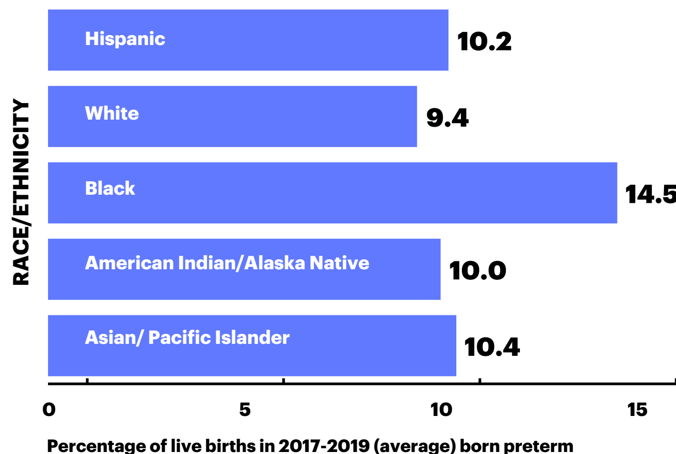

In New Mexico, the preterm birth rate among Black women is 45% higher than the rate among all other women.

DISPARITY RATIO:

1.20

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Albuquerque	D	10.7%	Improved

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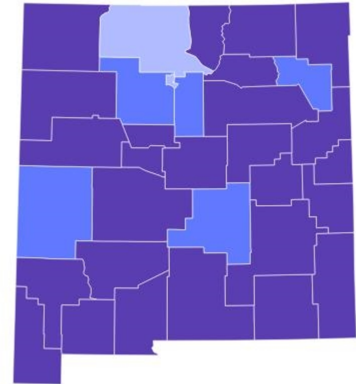

CLINICAL MEASURES

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21.3

PERCENT

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.

24.8

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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Passage of Medicaid coverage for doula care.

Legend
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NEW YORK

Scan here for more data on your state.

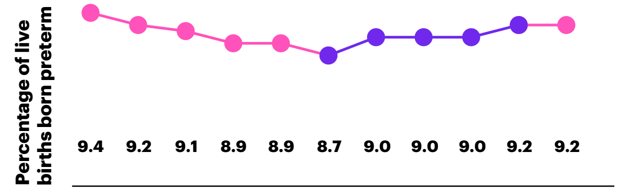
INFANT HEALTH

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.2%



2010 2020

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

INFANT MORTALITY

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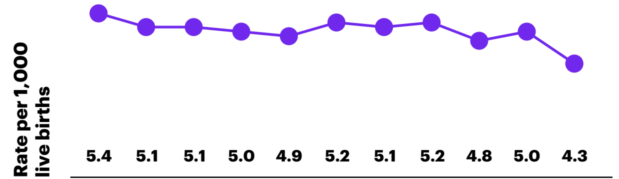
INFANT MORTALITY RATE

4.3



2009 2019

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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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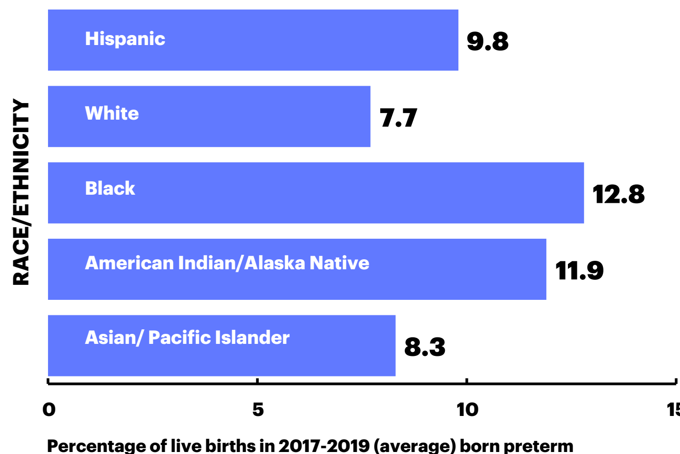

In New York, the preterm birth rate among Black women is 52% higher than the rate among all other women.

DISPARITY RATIO:

1.39

CHANGE FROM BASELINE:

Worsened

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
New York City	B	9.1%	Worsened

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NEW YORK

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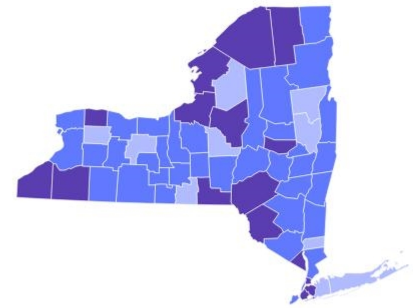

CLINICAL MEASURES

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28.1

PERCENT

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.

11.9

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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States who have adopted this policy allow women greater access to preventative care during pregnancy.

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Passage of Medicaid coverage for doula care.

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NORTH CAROLINA

Scan here for more data on your state.

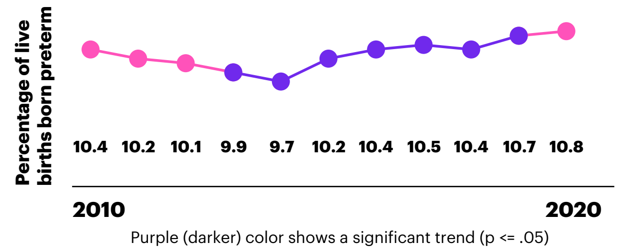
INFANT HEALTH

PRETERM BIRTH GRADE

D

PRETERM BIRTH RATE

10.8%



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

INFANT MORTALITY

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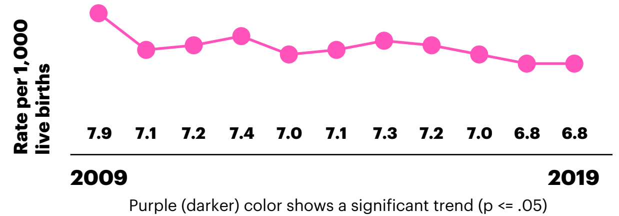
INFANT MORTALITY RATE

6.8



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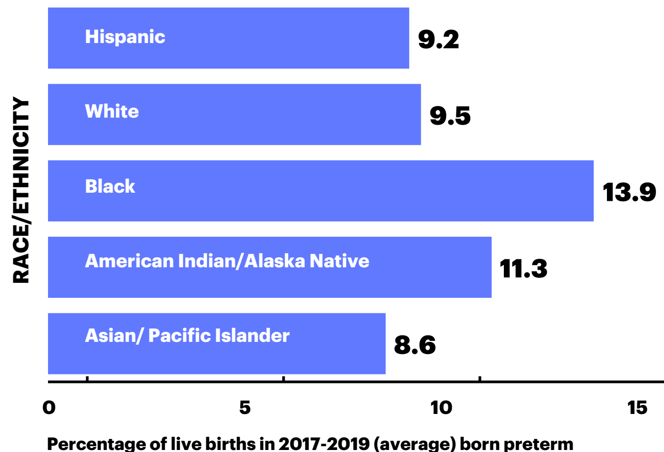

In North Carolina, the preterm birth rate among Black women is 48% higher than the rate among all other women.

DISPARITY RATIO:

1.28

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Charlotte	D	11.1%	Worsened

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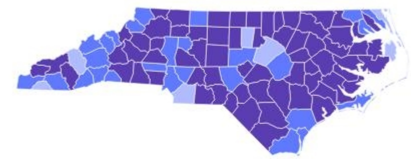

CLINICAL MEASURES

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22.5 PERCENT

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.

17.1 PERCENT

INADEQUATE PRENATAL CARE

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NORTH DAKOTA

Scan here for more data on your state.

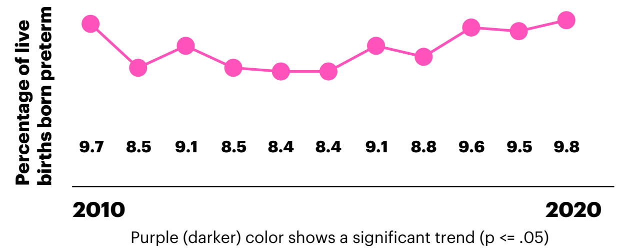
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.8%



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INFANT MORTALITY

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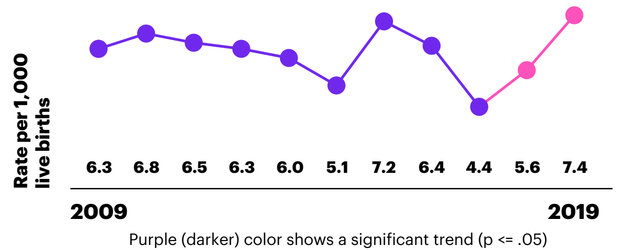
INFANT MORTALITY RATE

7.4



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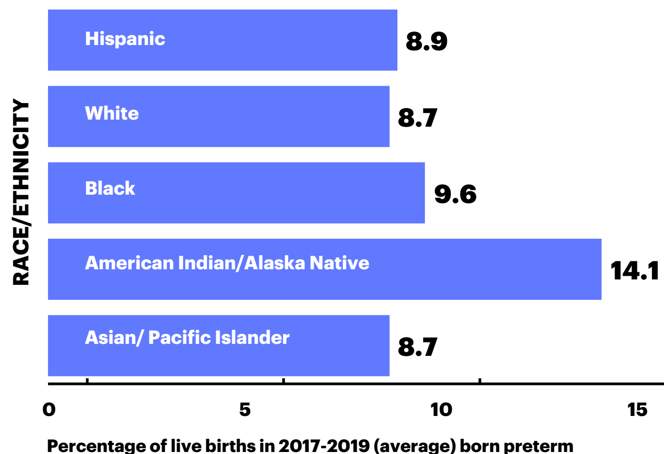

In North Dakota, the preterm birth rate among American Indian/Alaska Native women is 62% higher than the rate among all other women.

DISPARITY RATIO:

1.32

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Fargo	C	9.7%	Worsened

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NORTH DAKOTA

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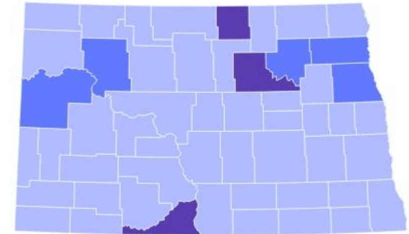

Lesser vulnerability Greater vulnerability

CLINICAL MEASURES

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18.4

PERCENT

LOW-RISK CESAREAN BIRTH

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14.3

PERCENT

INADEQUATE PRENATAL CARE

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States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

Allows the practice of direct entry midwives and certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend State has the indicated organization/policy; State does not have the indicated organization/policy; Waiver pending or planning is occurring; Has an MMRC but does not review deaths up to a year after pregnancy ends

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HEALTHY MOMS. STRONG BABIES. | MARCH OF DIMES

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OHIO

Scan here for more data on your state.

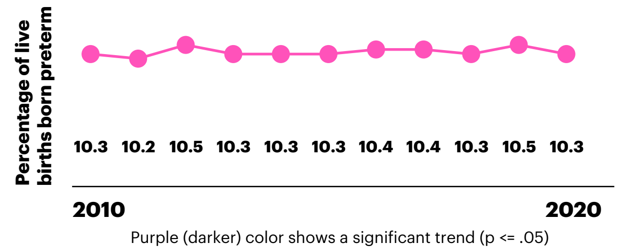
INFANT HEALTH

PRETERM BIRTH GRADE

C-

PRETERM BIRTH RATE

10.3%



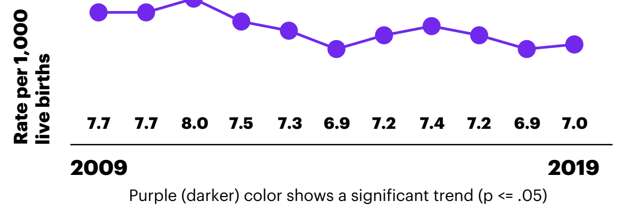
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

7.0



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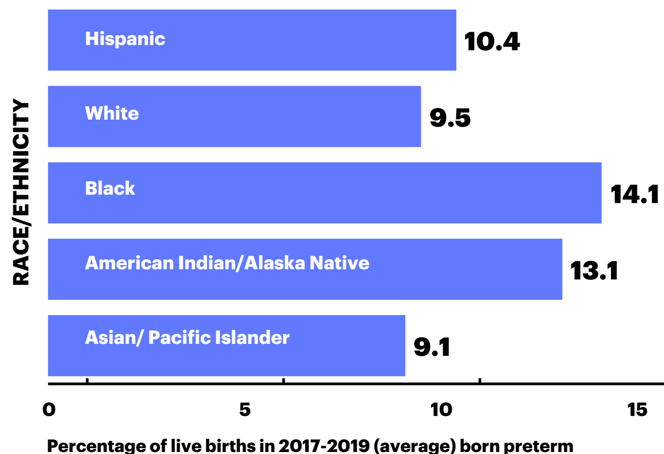

In Ohio, the preterm birth rate among Black women is 47% higher than the rate among all other women.

DISPARITY RATIO:

1.24

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Columbus	F	11.6%	No Change

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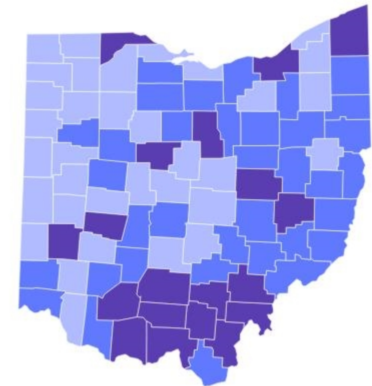

Lesser vulnerability Greater vulnerability

CLINICAL MEASURES

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25.6

PERCENT

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.

15.1

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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OKLAHOMA

Scan here for more data on your state.

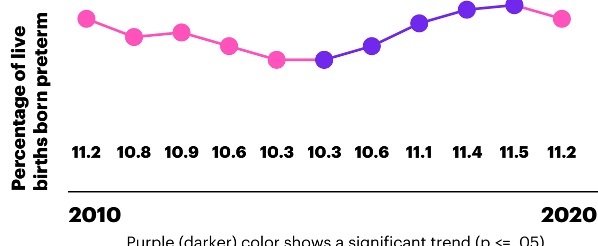
INFANT HEALTH

PRETERM BIRTH GRADE

D-

PRETERM BIRTH RATE

11.2%



INFANT MORTALITY

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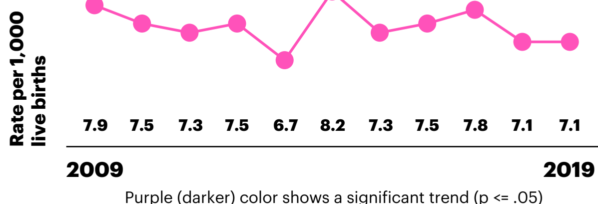
INFANT MORTALITY RATE

7.1



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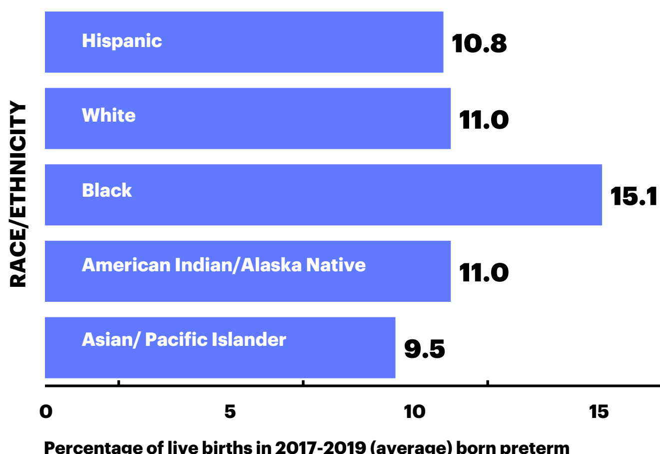

In Oklahoma, the preterm birth rate among Black women is 39% higher than the rate among all other women.

DISPARITY RATIO:

1.26

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Oklahoma City	F	13.3%	Worsened

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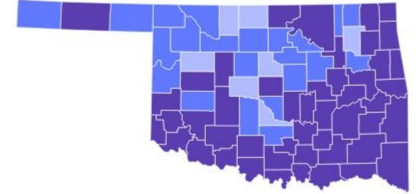

CLINICAL MEASURES

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24.5

PERCENT

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.

15.2

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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OREGON

Scan here for more data on your state.

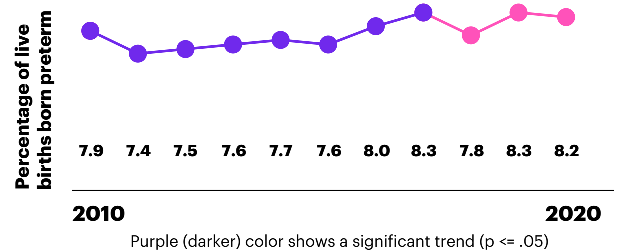
INFANT HEALTH

PRETERM BIRTH GRADE

B+

PRETERM BIRTH RATE

8.2%



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

INFANT MORTALITY

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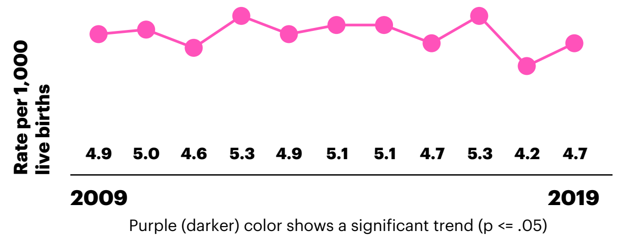
INFANT MORTALITY RATE

4.7



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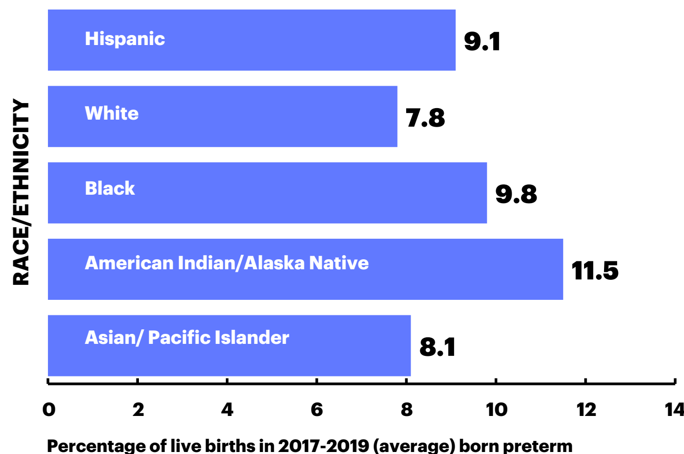

In Oregon, the preterm birth rate among American Indian/Alaska Native women is 42% higher than the rate among all other women.

DISPARITY RATIO:

1.24

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Portland	B	8.2%	Worsened

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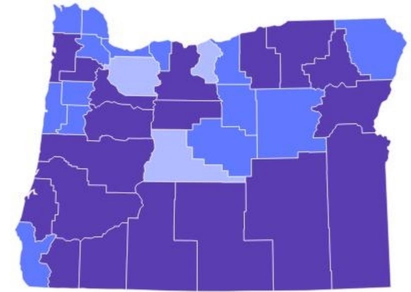

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23.4

PERCENT

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.

10.9

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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PENNSYLVANIA

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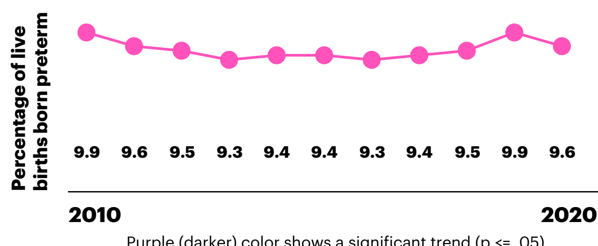
INFANT HEALTH

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.6%



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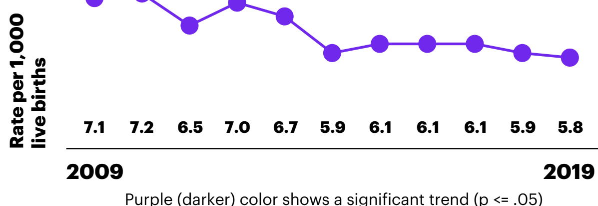
INFANT MORTALITY RATE

5.8



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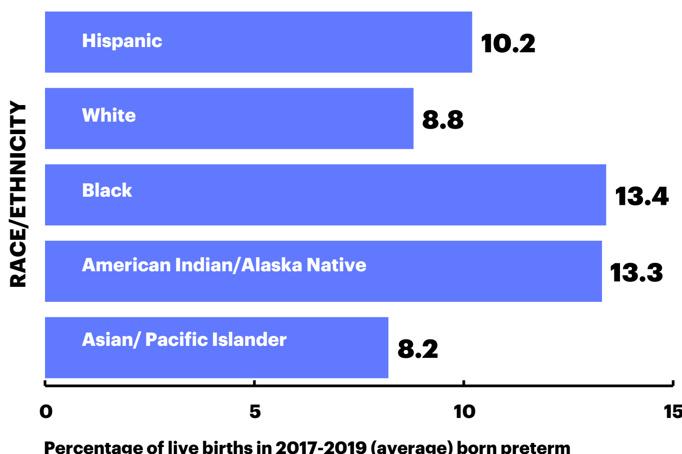

In Pennsylvania, the preterm birth rate among Black women is 51% higher than the rate among all other women.

DISPARITY RATIO:

1.32

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Philadelphia	D	11.4%	Worsened

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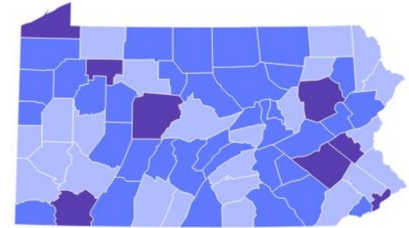

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25.2

PERCENT

LOW-RISK CESAREAN BIRTH

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15.0

PERCENT

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RHODE ISLAND

Scan here for more data on your state.

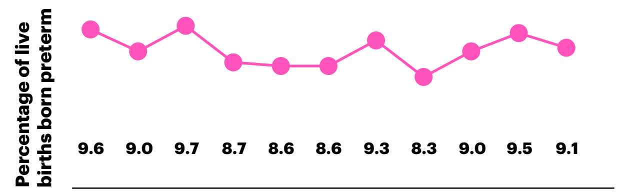
INFANT HEALTH

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.1%



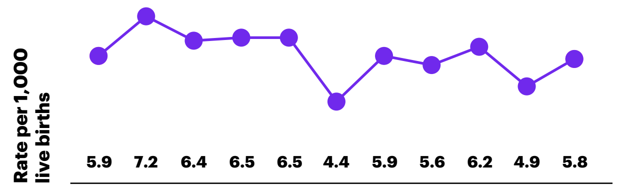
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

5.8



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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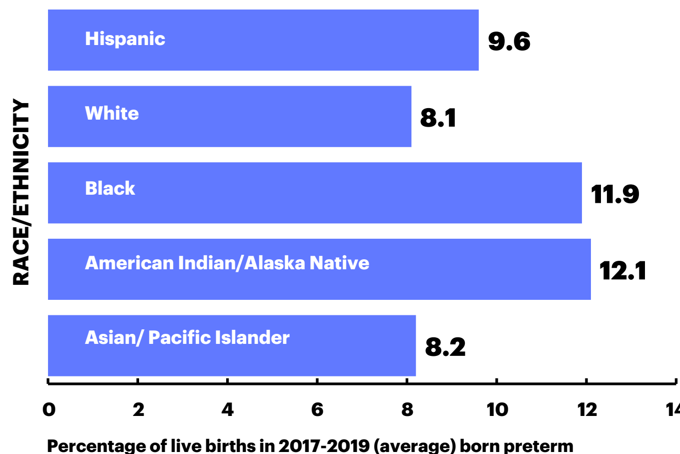

In Rhode Island, the preterm birth rate among Black women is 40% higher than the rate among all other women.

DISPARITY RATIO:

1.23

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Providence	C	10.1%	Worsened

A TIME FOR PARTNERSHIP AND ACTION:
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RHODE ISLAND

MATERNAL HEALTH

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The overall SVI for each county represents the amount of vulnerability relative to other counties in the state. The SVI measure is always a number between 0 and 1. A lower SVI indicates lesser vulnerability and a higher SVI indicates greater vulnerability.

Lesser vulnerability — Greater vulnerability

0.0-0.29 | 0.30-0.59 | 0.60-1.0

CLINICAL MEASURES

Your healthcare matters.

Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

27.7 PERCENT

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.

3.6 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

The policies in your state matter. Adoption of the following policies and organizations can help improve maternal and infant health care.

MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

Allows the practice of direct entry midwives and certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend State has the indicated organization/policy State does not have the indicated organization/policy Waiver pending or planning is occurring Has an MMRC but does not review deaths up to a year after pregnancy ends

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SOUTH CAROLINA

Scan here for more data on your state.

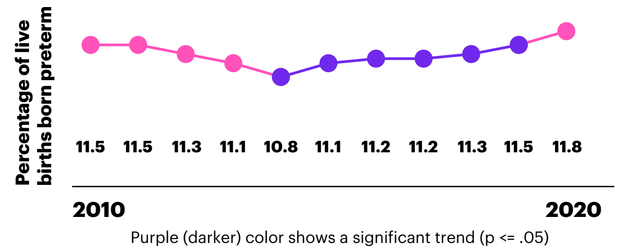
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

11.8%



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

INFANT MORTALITY

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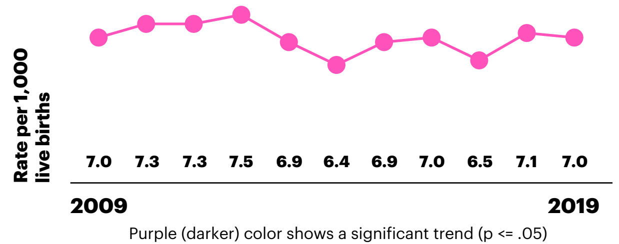
INFANT MORTALITY RATE

7.0



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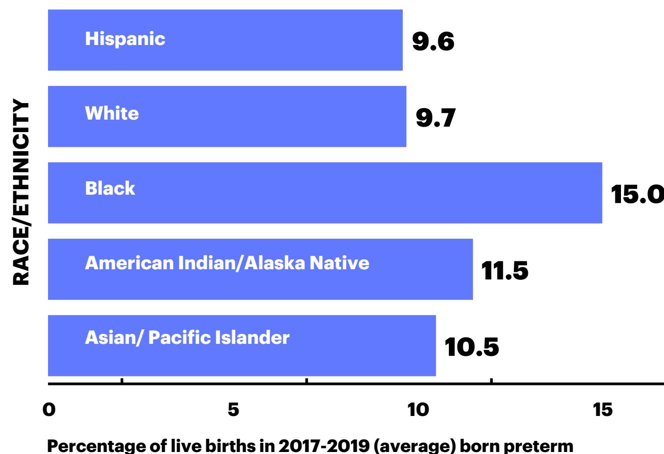

In South Carolina, the preterm birth rate among Black women is 55% higher than the rate among all other women.

DISPARITY RATIO:

1.22

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Columbia	F	11.9%	Improved

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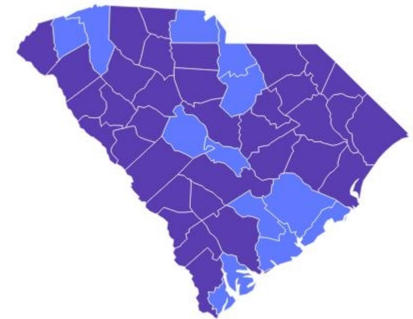

CLINICAL MEASURES

Your healthcare matters.

Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

26.9 PERCENT

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.

15.9 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

The policies in your state matter. Adoption of the following policies and organizations can help improve maternal and infant health care.

MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

Allows the practice of direct entry midwives and certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend State has the indicated organization/policy; State does not have the indicated organization/policy; Waiver pending or planning is occurring; Has an MMRC but does not review deaths up to a year after pregnancy ends

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SOUTH DAKOTA

Scan here for more data on your state.

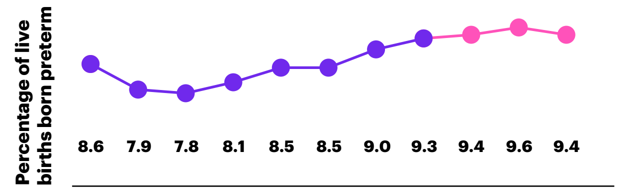
INFANT HEALTH

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.4%



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

INFANT MORTALITY

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INFANT MORTALITY RATE

6.7

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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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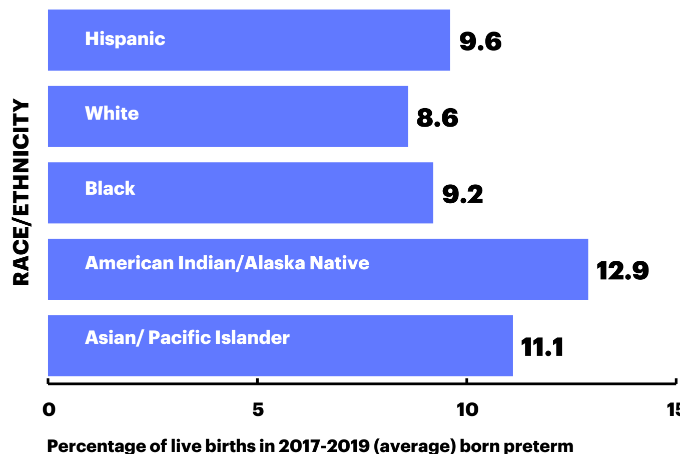

In South Dakota, the preterm birth rate among American Indian/Alaska Native women is 48% higher than the rate among all other women.

DISPARITY RATIO:

1.22

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Sioux Falls	B	9.2%	Improved

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SOUTH DAKOTA

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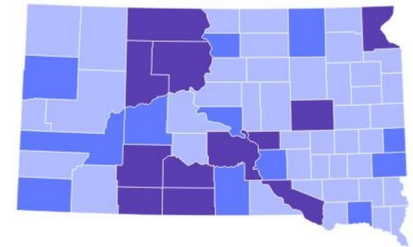

CLINICAL MEASURES

Your healthcare matters.

Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

19.1 PERCENT

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.

15.2 PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

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States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

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MIDWIFERY POLICY

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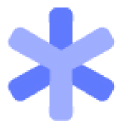

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

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TENNESSEE

Scan here for more data on your state.

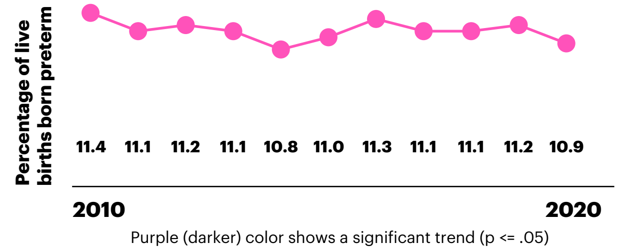
INFANT HEALTH

PRETERM BIRTH GRADE

D

PRETERM BIRTH RATE

10.9%



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

INFANT MORTALITY

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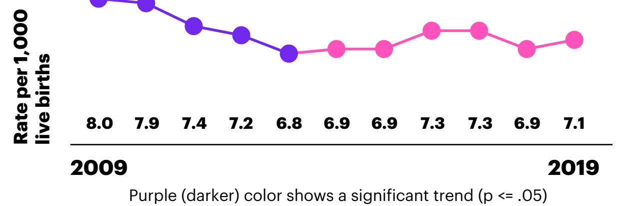
INFANT MORTALITY RATE

7.1



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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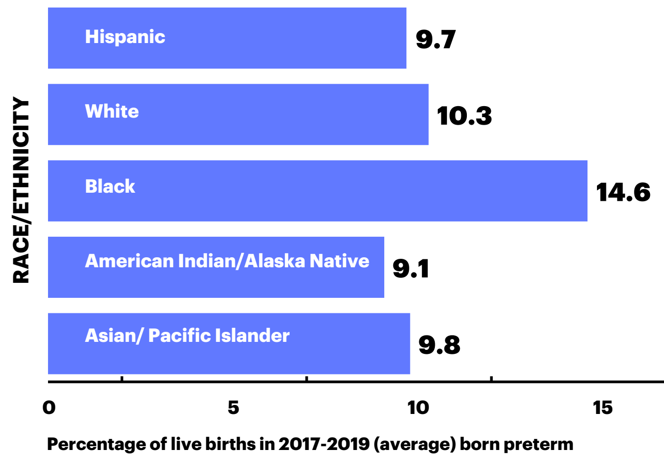

In Tennessee, the preterm birth rate among Black women is 43% higher than the rate among all other women.

DISPARITY RATIO:

1.17

CHANGE FROM BASELINE:

Improved

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Nashville-Davidson	D	10.5%	Worsened

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25.5

PERCENT

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.

16.0

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

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DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend
- State has the indicated organization/policy
- State does not have the indicated organization/policy
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TEXAS

Scan here for more data on your state.

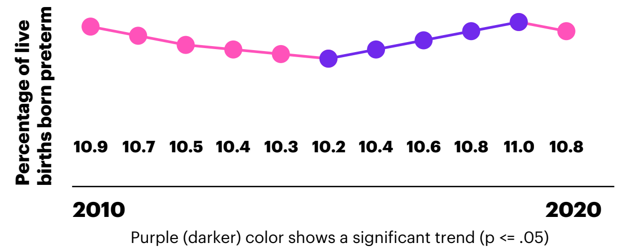
INFANT HEALTH

PRETERM BIRTH GRADE

D

PRETERM BIRTH RATE

10.8%



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

INFANT MORTALITY

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INFANT MORTALITY RATE

5.5

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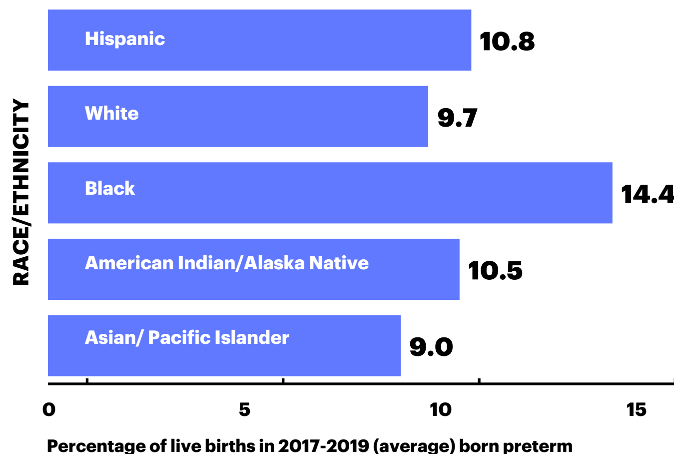

In Texas, the preterm birth rate among Black women is 41% higher than the rate among all other women.

DISPARITY RATIO:

1.26

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Houston	F	11.9%	No Change

A TIME FOR PARTNERSHIP AND ACTION:
EXAMINING THE U.S. MATERNAL AND INFANT HEALTH CRISIS AND POLICIES NEEDED FOR CHANGE

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TEXAS

MATERNAL HEALTH

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SOCIAL VULNERABILITY INDEX

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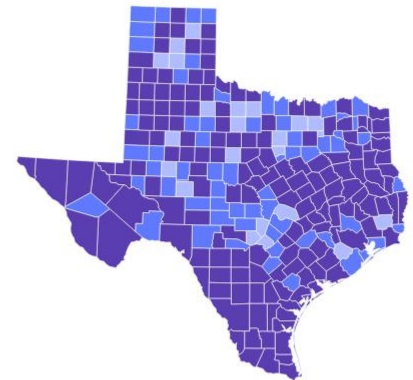

Lesser vulnerability   Greater vulnerability

CLINICAL MEASURES

Your healthcare matters.

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28.4

PERCENT

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.

20.4

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

The policies in your state matter. Adoption of the following policies and organizations can help improve maternal and infant health care.

MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

States have recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

Allows the practice of direct entry midwives and certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Passage of Medicaid coverage for doula care.

Legend
- State has the indicated organization/policy
- State does not have the indicated organization/policy
- Waiver pending or planning is occurring
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HEALTHY MOMS. STRONG BABIES. MARCH OF DIMES

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UTAH

Scan here for more data on your state.

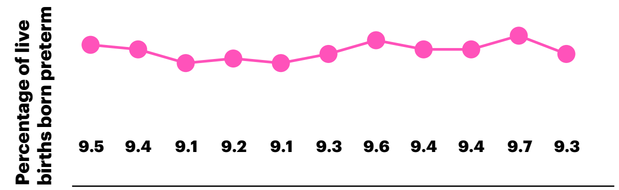
INFANT HEALTH

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.3%



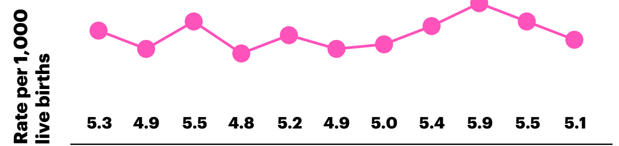
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

5.1



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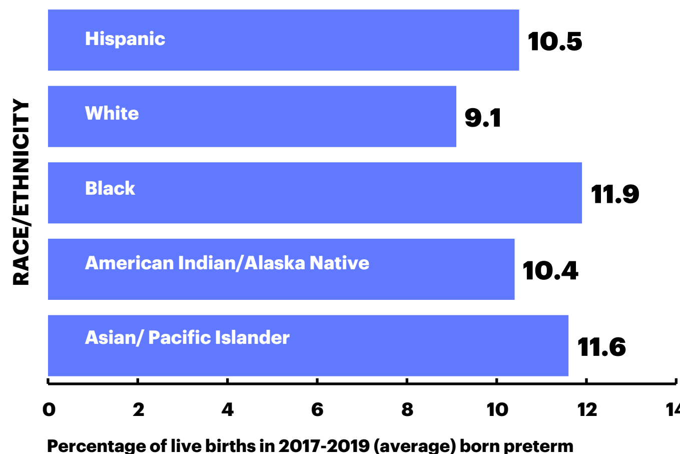

In Utah, the preterm birth rate among Black women is 25% higher than the rate among all other women.

DISPARITY RATIO:

1.22

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Salt Lake City	C	9.5%	Worsened

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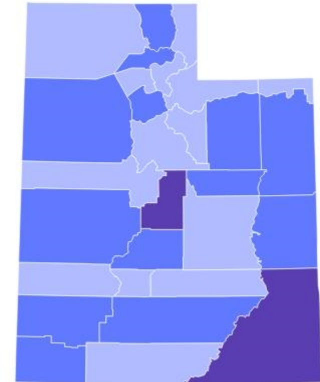

Lesser vulnerability   Greater vulnerability

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18.7

PERCENT

LOW-RISK CESAREAN BIRTH

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10.4

PERCENT

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VERMONT

Scan here for more data on your state.

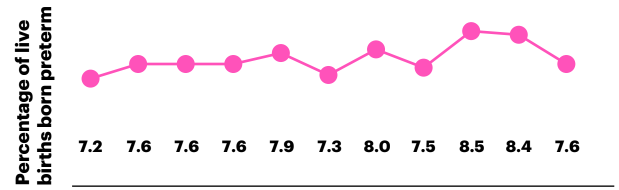
INFANT HEALTH

PRETERM BIRTH GRADE

A

PRETERM BIRTH RATE

7.6%



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INFANT MORTALITY

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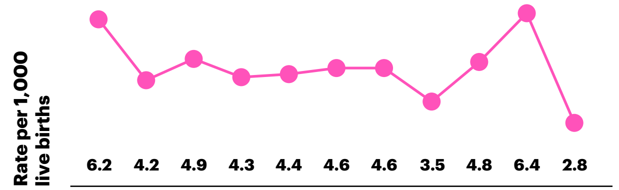
INFANT MORTALITY RATE

2.8



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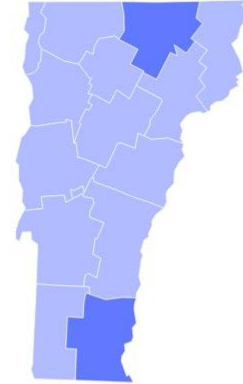

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20.8

PERCENT

LOW-RISK CESAREAN BIRTH

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5.4

PERCENT

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VIRGINIA

Scan here for more data on your state.

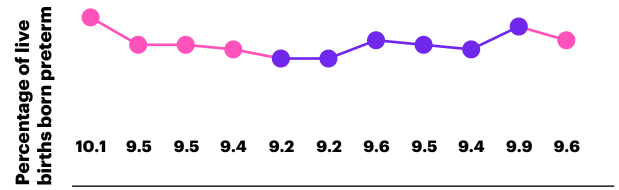
INFANT HEALTH

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.6%



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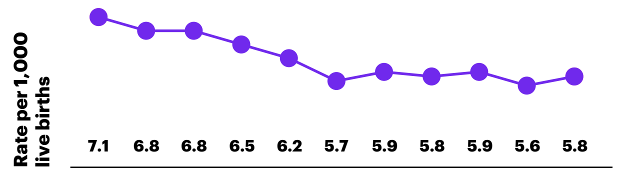
INFANT MORTALITY RATE

5.8



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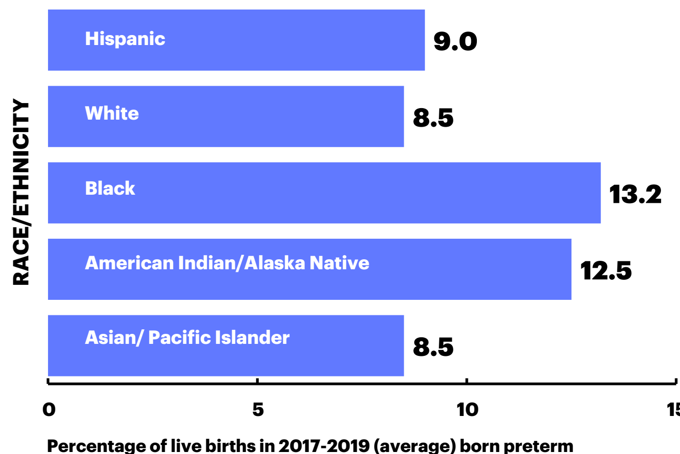

In Virginia, the preterm birth rate among Black women is 53% higher than the rate among all other women.

DISPARITY RATIO:

1.20

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Virginia Beach City	D	10.7%	Worsened

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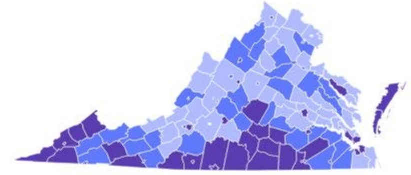

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26.2

PERCENT

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12.7

PERCENT

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WASHINGTON

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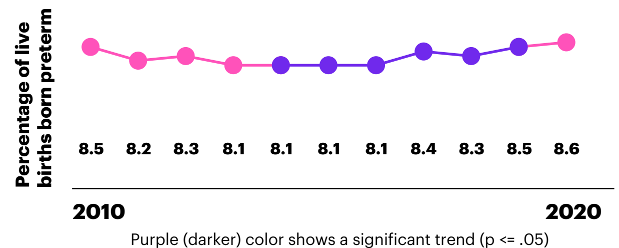
INFANT HEALTH

PRETERM BIRTH GRADE

B

PRETERM BIRTH RATE

8.6%



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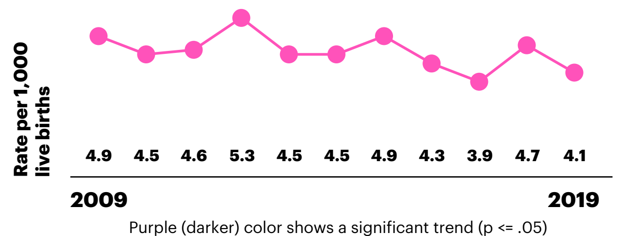
INFANT MORTALITY RATE

4.1



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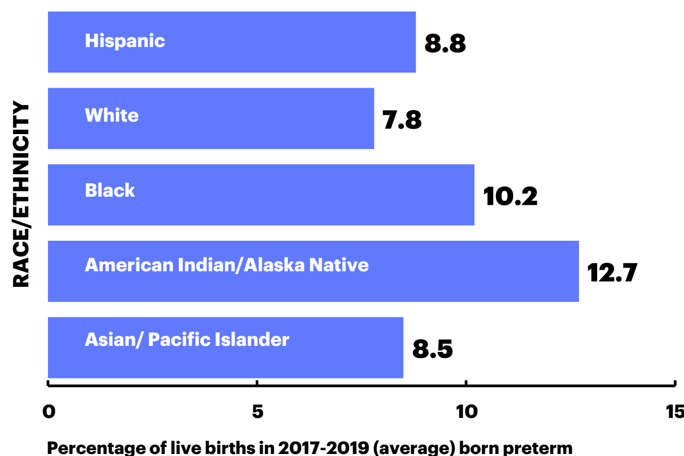

In Washington, the preterm birth rate among American Indian/Alaska Native women is 53% higher than the rate among all other women.

DISPARITY RATIO:

1.28

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Seattle	A	6.9%	Improved

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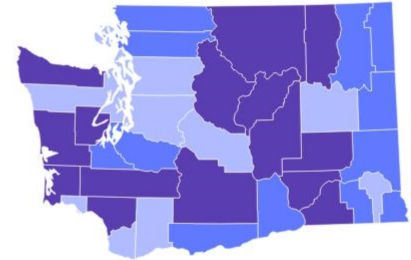

Lesser vulnerability Greater vulnerability

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13.1 PERCENT

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Passage of Medicaid coverage for doula care.

Legend State has the indicated organization/policy State does not have the indicated organization/policy Waiver pending or planning is occurring Has an MMRC but does not review deaths up to a year after pregnancy ends

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HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

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WEST VIRGINIA

Scan here for more data on your state.

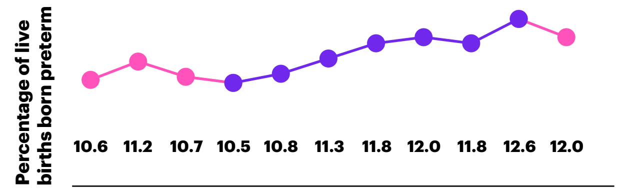
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

12.0%



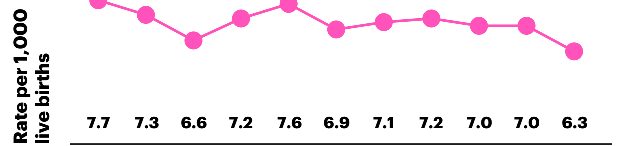
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

6.3



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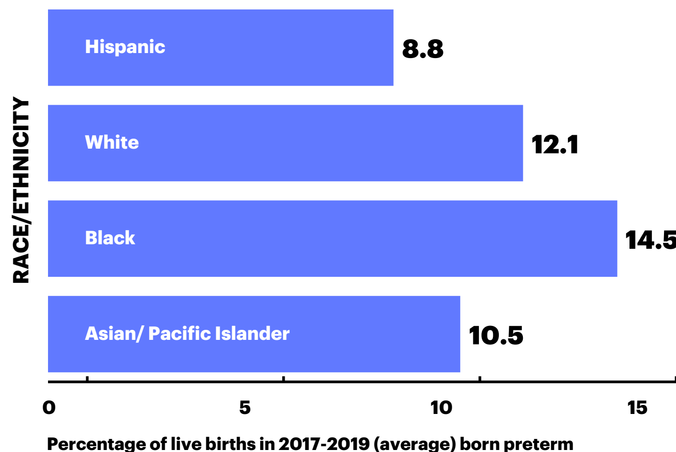

In West Virginia, the preterm birth rate among Black women is 20% higher than the rate among all other women.

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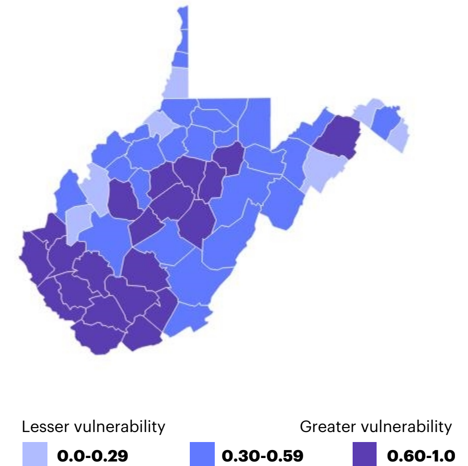

Lesser vulnerability — Greater vulnerability

0.0-0.29 | 0.30-0.59 | 0.60-1.0

CLINICAL MEASURES

Your healthcare matters.

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26.3

PERCENT

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.

14.0

PERCENT

INADEQUATE PRENATAL CARE

Percent of women 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.

POLICY MEASURES

The policies in your state matter. Adoption of the following policies and organizations can help improve maternal and infant health care.

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States who have adopted this policy allow women greater access to preventative care during pregnancy.

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WISCONSIN

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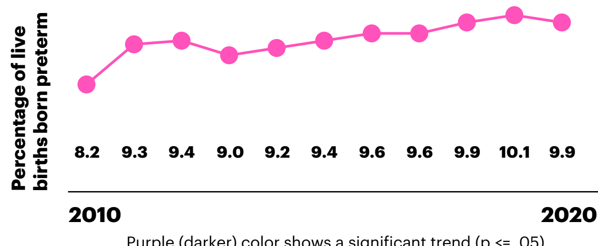
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.9%



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INFANT MORTALITY

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INFANT MORTALITY RATE

5.8

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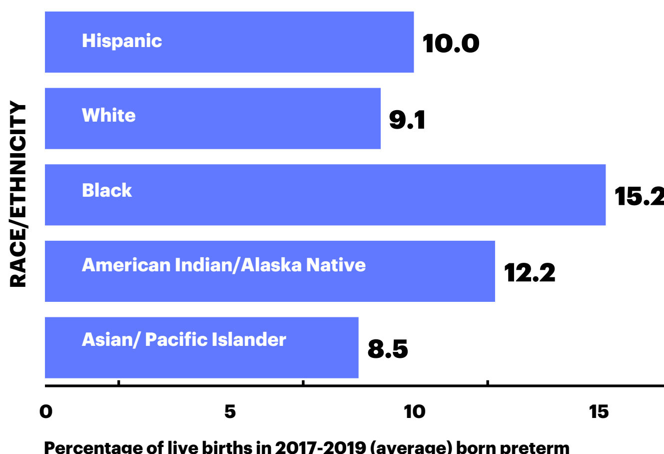

In Wisconsin, the preterm birth rate among Black women is 65% higher than the rate among all other women.

DISPARITY RATIO:

1.37

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Milwaukee	F	13.8%	Worsened

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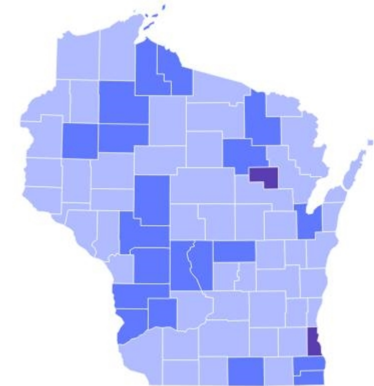

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21.6

PERCENT

LOW-RISK CESAREAN BIRTH

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10.5

PERCENT

INADEQUATE PRENATAL CARE

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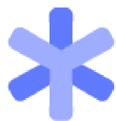

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WYOMING

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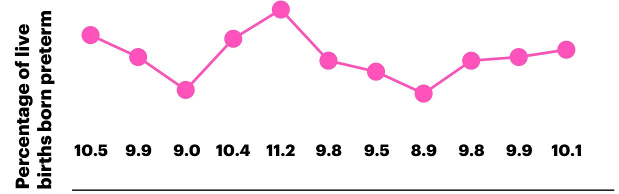
INFANT HEALTH

PRETERM BIRTH GRADE

C-

PRETERM BIRTH RATE

10.1%



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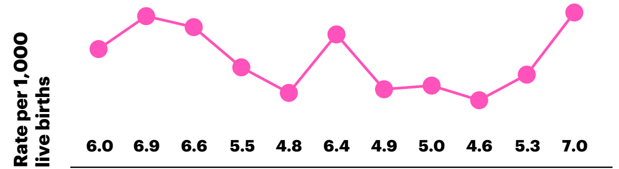
INFANT MORTALITY RATE

7.0



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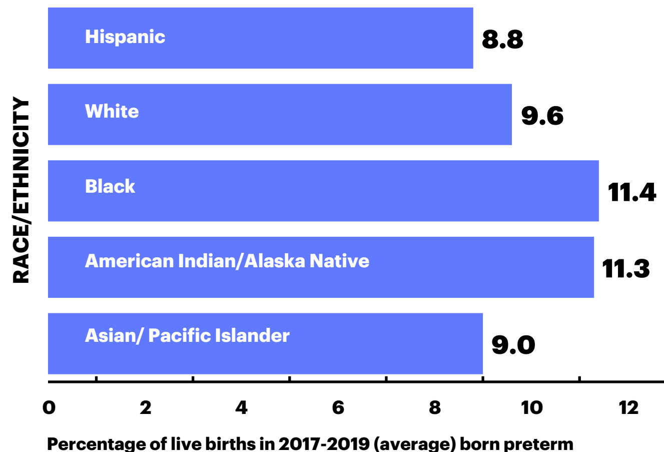

In Wyoming, the preterm birth rate among White women is 9% higher than the rate among all other women.

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WYOMING

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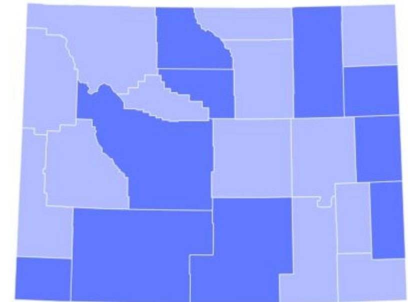

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20.7

PERCENT

LOW-RISK CESAREAN BIRTH

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14.3

PERCENT

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PUERTO RICO

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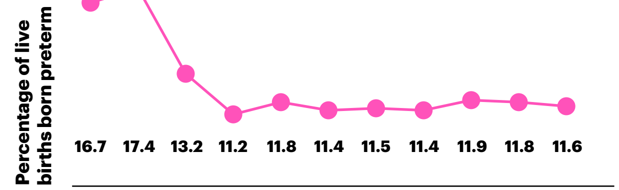
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

11.6%



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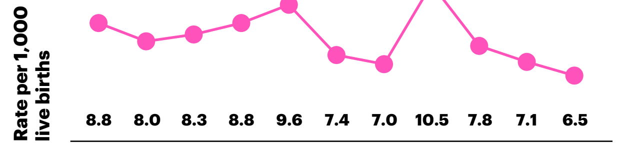
INFANT MORTALITY RATE

6.5



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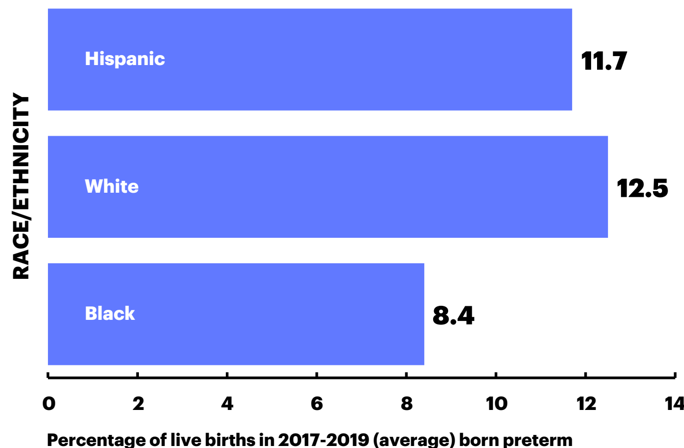

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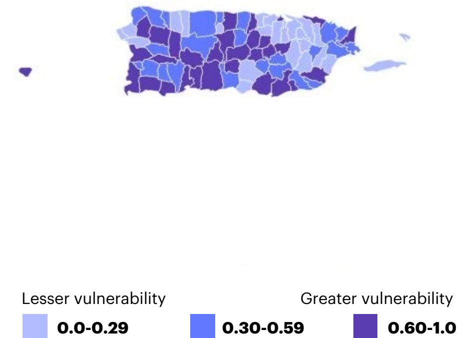

Lesser vulnerability | Greater vulnerability

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41.8

PERCENT

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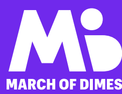

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