HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES®

2022 MARCH OF DIMES REPORT CARD

STARK AND UNACCEPTABLE DISPARITIES PERSIST ALONGSIDE
A TROUBLING RISE IN PRETERM BIRTH RATES

MARCHOFDIMES.ORG/REPORTCARD

ON THE COVER

Katie Wilton's pregnancy started off rough and only got worse. "This was not an enjoyable pregnancy from the beginning," she says. "Around six weeks gestation I was vomiting every day, and that continued until about 19 weeks." Then she hemorrhaged for the first time when she was 22 weeks pregnant, which was the beginning of a frustrating eight weeks of more hemorrhaging, weekly hospital visits and doctors not having answers.

After having two hemorrhages three days apart, Katie was brought into triage to be assessed—she was in preterm labor. Five days later Colette was born at 30 weeks, weighing just three pounds, one ounce. For the next 63 days, Katie spent 12 hours a day in the neonatal intensive care unit (NICU) by her daughter's side.

The number of women who experience pregnancy-related complications in the U.S. is steadily increasing, affecting at least 50,000 women each year. That's why March of Dimes is advocating for policies outlined in this year's 2022 March of Dimes Report Card to increase equitable access to care and improve the health of moms and babies across the country.

HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES REPORT CARD 2022 EXECUTIVE SUMMARY

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The 2022 March of Dimes Report Card presents the state of maternal and infant health in the United States (U.S.), Washington, D.C. and Puerto Rico. The report card indicates the maternal and infant health crisis is worsening for all families. It continues to examine mom and baby health and the supplemental report presents how states are progressing towards pregnancy and childbirth targets, using the U.S. Department of Health and Human Services Healthy People 2030 objectives. This year, the Report Card also includes a new section to describe March of Dimes organizational programmatic initiatives and advocacy efforts happening in each state to improve the health of moms, babies, and families.

THE U.S. MATERNAL AND INFANT HEALTH CRISIS

The U.S. preterm birth rate increased to 10.5 percent in 2021, representing an increase of four percent since 2020. This is the worst rate we have seen since 2007 and drops the U.S. Report Card grade from a C- to a D+. Overall, 45 states, Washington D.C. and Puerto Rico experienced an increase in preterm birth rates, while four states saw a decrease.

The latest data for infant mortality show a slight decline from 5.6 deaths per 1,000 live births in 2019 to 5.4 deaths per 1,000 live births in 2020. Overall, 30 states had an improved infant mortality rate, 13 states stayed the same and eight states worsened.

Our data reveals that racial differences in birth outcomes persist in the U.S. Infants born to Black and Native American moms are 62 percent more likely to be born preterm than those born to White women. Although babies born to Asian/Pacific Islander moms generally have the lowest rate of preterm birth, there was an eight percent increase observed from 8.7 percent in 2020 to 9.5 percent in 2021, the largest increase of all racial and ethnic groups. Black women are the most likely of any other racial/ethnic category to have a low-risk Cesarean birth, putting them at higher risk for future Cesarean births and related negative outcomes. The supplemental report card provides data by race and ethnicity to allow for further examination of these unacceptable disparities.

The maternal and infant health crisis does not have one root cause, nor a single solution. This year's report card includes the Maternal Vulnerability Index (MVI), which summarizes both where and why women are vulnerable to poor maternal outcomes. We know that healthy babies are more likely born to healthy moms in strong communities that provide support for women's health and policies that support access to quality health care.

ADVANCING CRITICAL POLICY ACTIONS FOR MOMS AND BABIES

March of Dimes is advocating for policies to prioritize the health of moms and babies.

- The Black Maternal Health Momnibus Act of 2021 can assist in filling gaps in existing legislation to improve maternal health outcomes and tackle long-standing racial and ethnic health care disparities.
- Congress should permanently extend Medicaid postpartum coverage to 12 months to ensure that all people across the nation have access to the essential care they need postpartum.
- States should adopt legislation to expand access to midwifery care and doula support. This is important to improve access to care and improve quality of care in under-resourced areas and among historically marginalized communities.
- States should fund Maternal Mortality Review Committees (MMRC) and Perinatal Quality Collaboratives (PQC) to identify and address emerging trends in adverse maternal and infant health outcomes.

March of Dimes continues to provide the most up-to-date data related to the U.S. maternal and child health crisis and advocate for policies that close the health equity gap. Visit BlanketChange.org to learn how you can join us in our efforts to give every family the best possible start.

POLICY ACTIONS

HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES REPORT CARD RECOMMENDED POLICY ACTIONS

March of Dimes 2022 Report Card monitors key indicators and policy actions to improve the health of moms and babies in the United States. 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 policy opportunities are highlighted below.

EQUITY

ELIMINATE RACIAL DISPARITIES IN HEALTH OUTCOMES FOR MOMS AND BABIES

Black and Native American 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 encounter difficulties in 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. 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, 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.**[7]

EXTEND MEDICAID COVERAGE FOR POSTPARTUM MOMS

The latest data shows that **53%** 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. 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 policy across the nation.

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.

8 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] 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 positively impact 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]

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. Benefits of telehealth include efficiency and cost-effectiveness, increased access to care, reduction in patient travel and wait times, and increased patient satisfaction. The COVID-19 public health emergency provisions required that Medicaid covered telehealth services for maternal care for 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.[20] We must ensure our moms and babies continue to have access to these services by making telehealth reimbursement policies permanent as the public health emergency ends.

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 IN 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 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.[21]

SUPPORT VACCINATIONS AND BOOST 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.[22] Adult immunizations have similarly prevented millions of fatalities and illnesses from diseases like influenza and pneumococcal disease. Maternal immunizations protect mothers and babies from deadly infectious diseases. Since newborns are too young to receive vaccinations, maternal immunizations provide critical protection for newborns.[23] The CDC's Advisory Committee on Immunization Practices recommend the flu, Tdap, and COVID-19 vaccines for pregnant people.[24] According to Centers for Disease Control and Prevention (CDC), pregnant women are at increased risk for severe illness and death from flu and COVID-19 compared with nonpregnant women of reproductive age. Pregnant people infected with COVID-19 and flu are at risk for adverse pregnancy outcomes, such as preterm birth.[25] Data shows that vaccination during pregnancy can protect babies younger than 6 months from hospitalization due to flu and COVID-19.[24] Racial, economic, and geographic disparities exist in the uptake of vaccines during pregnancy leaving the most vulnerable populations at risk.[26] Pregnant people need more safety and efficacy data on vaccines, more access to and receipt of vaccines, and improved implementation of vaccine programs.[23] Now more than ever, we as a country must prioritize efforts to boost confidence in vaccines, and build acceptance of the need to stay on schedule with routine vaccines, especially among pregnant women and children.

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2022 REPORT CARDS

HEALTHY MOMS. STRONG BABIES.

2022 MARCH OF DIMES REPORT CARD

The 2022 March of Dimes Report Card continues to elevate the latest data on infant and neonatal outcomes and maternal risk factors. We continue to provide updated measures on preterm birth, infant mortality, social drivers of health, rates of low-risk Cesarean births and inadequate prenatal care. This year we include an update to our social drivers of health by including the Maternal Vulnerability Index (MVI).

This year's report card highlights a worsening state of maternal and infant health with increases in preterm birth and low-risk Cesarean births. Additionally, the health equity gap continues to increase among these outcomes. Comprehensive data collection and analysis of these measures inform the development of policies and programs that move us closer to health equity. As in previous years, the Report Card presents policies and programs that can help improve equitable maternal and infant health outcomes for families across the country.

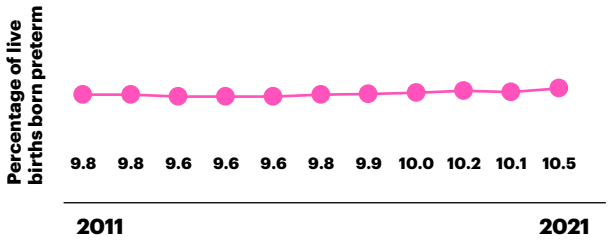
UNITED STATES

PRETERM BIRTH GRADE

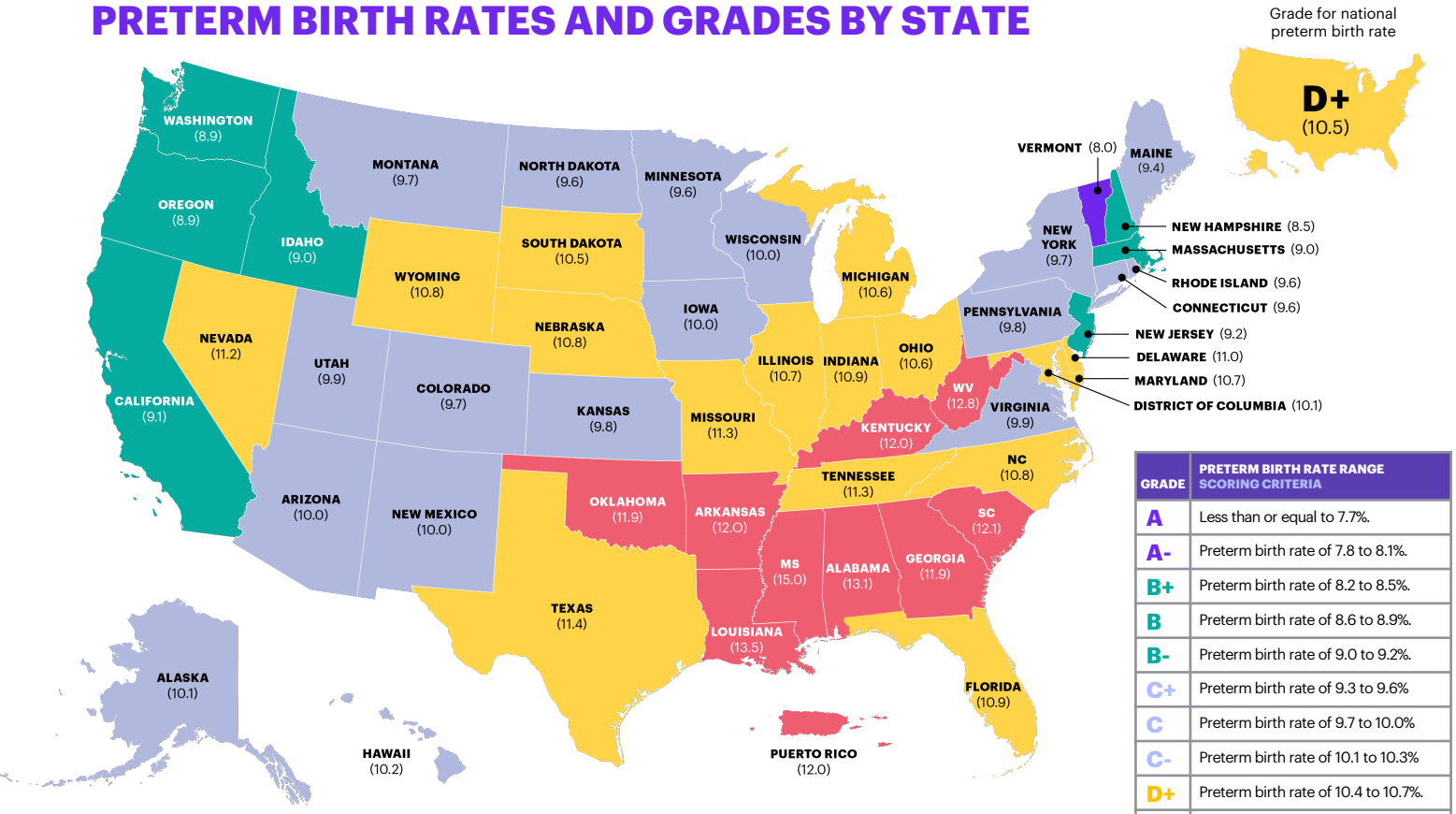
D+

PRETERM BIRTH RATE

10.5%



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%.

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

Grades assigned by March of Dimes Perinatal Data Center.

Puerto Rico is not included in the United States total.

Source: Preterm birth rates are from the National Center for Health Statistics, 2021 final natality data and U.S. Territories natality data.

THE 2022 MARCH OF DIMES REPORT CARD:
STARK AND UNACCEPTABLE DISPARITIES PERSIST ALONGSIDE A TROUBLING RISE IN PRETERM BIRTH RATES

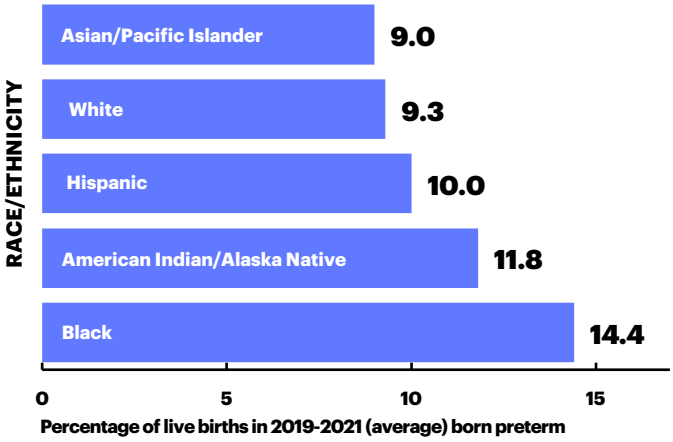
March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes, see **www.marchofdimes.org/reportcard**

For details on data sources and calculations, see Technical Notes: **https://bit.ly/ReportCardTechnicalNotes**

HEALTHY MOMS. STRONG BABIES.

2022 MARCH OF DIMES REPORT CARD
RACE & ETHNICITY IN THE U.S.

Aggregate 2019-2021 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 52% higher than the rate among all other women.

DISPARITY RATIO:

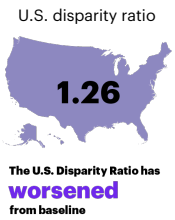
1.26

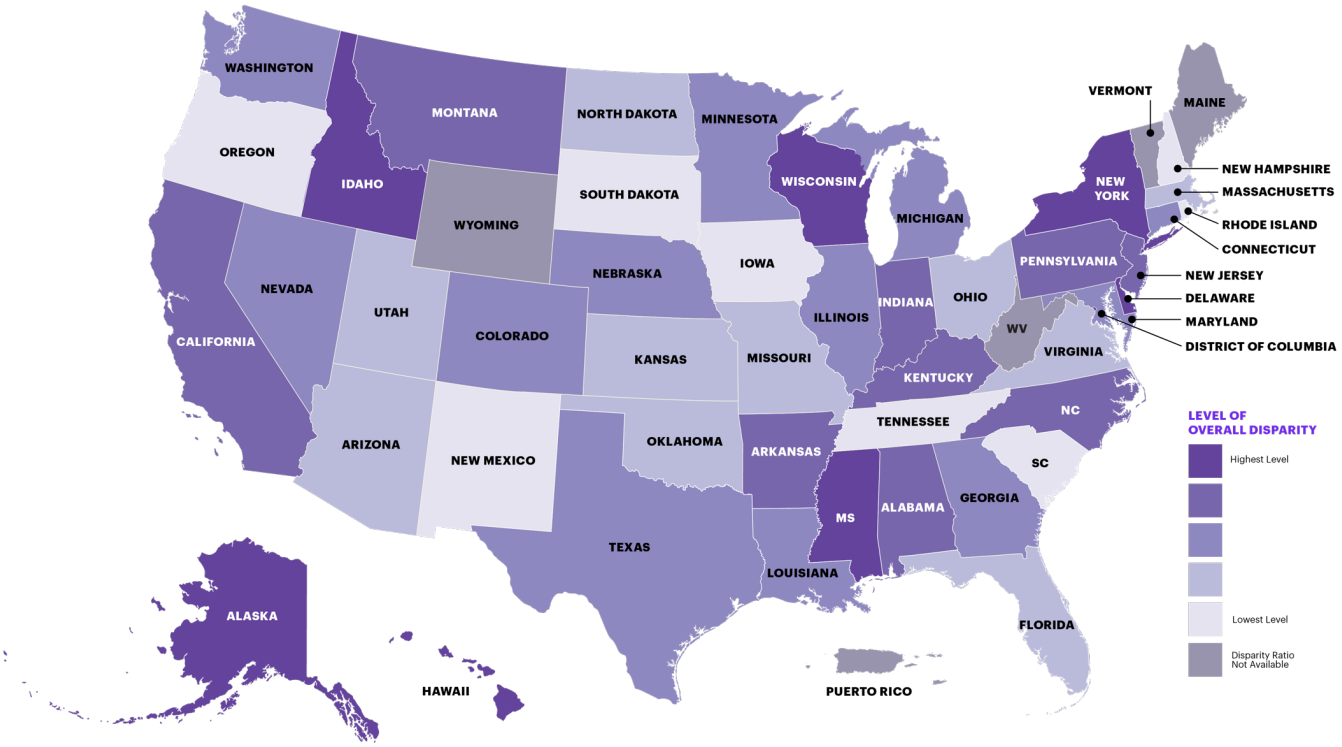
CHANGE FROM BASELINE:

Worsened

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.





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HEALTHY MOMS. STRONG BABIES.

2022 MARCH OF DIMES REPORT CARD
INFANT MORTALITY IN THE U.S.

INFANT MORTALITY

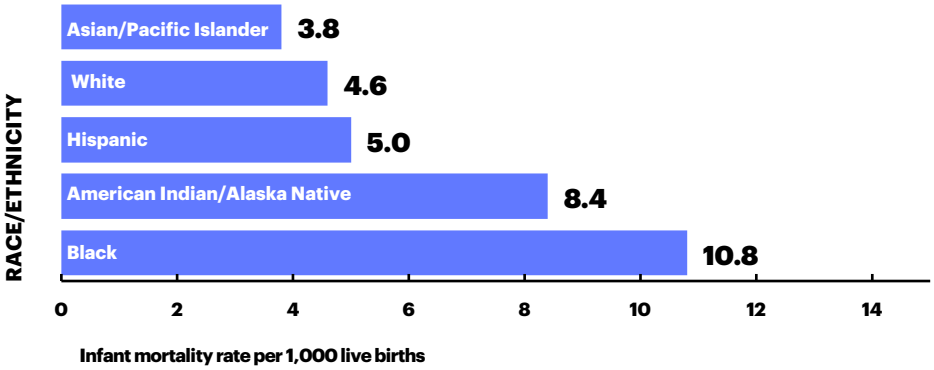
Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, preterm birth, low birth weight, maternal complications and sudden infant death syndrome (SIDS).

INFANT MORTALITY RATE

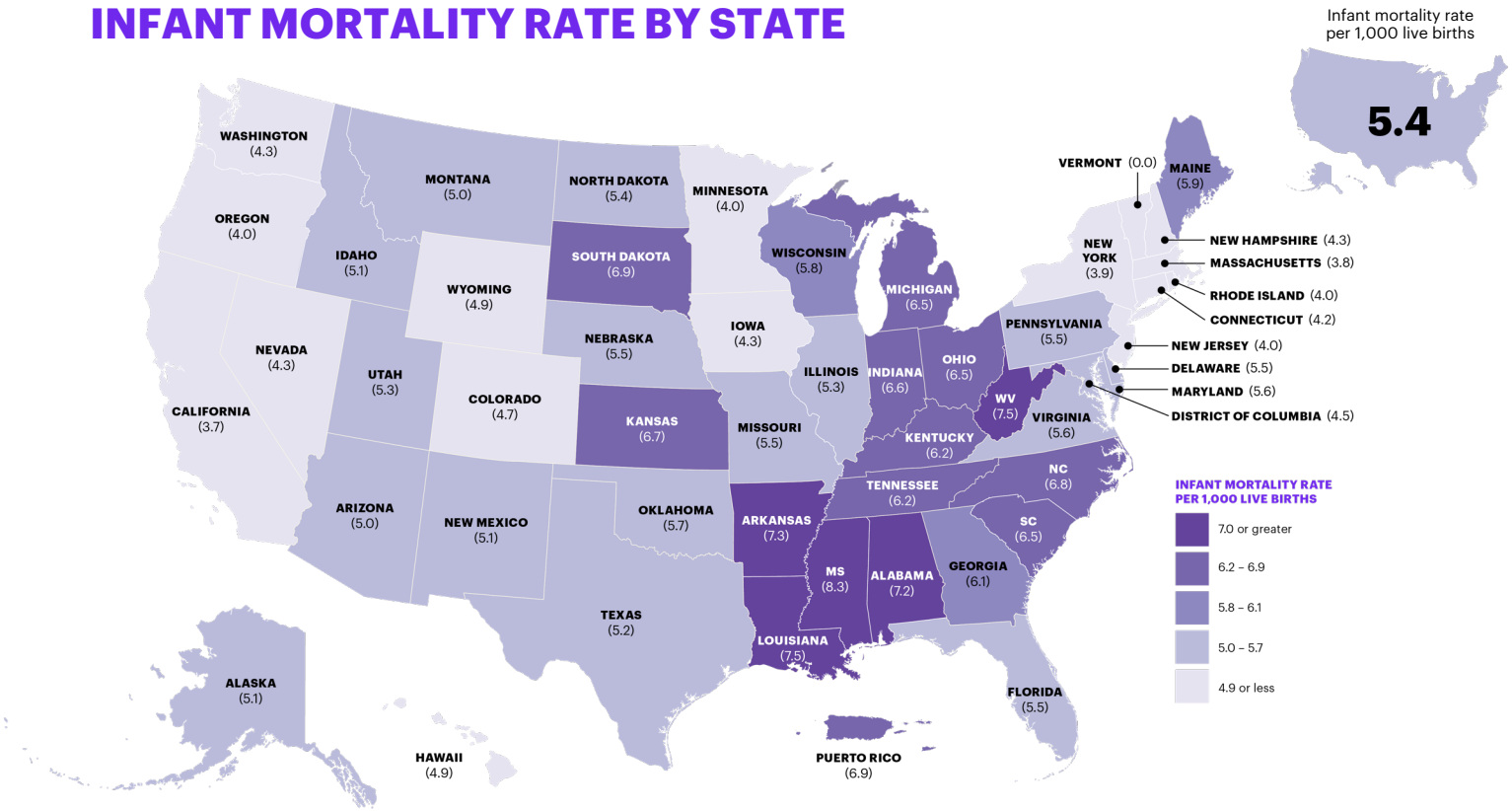
5.4

RATE BY RACE AND ETHNICITY

2017-2019 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 RATE 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.

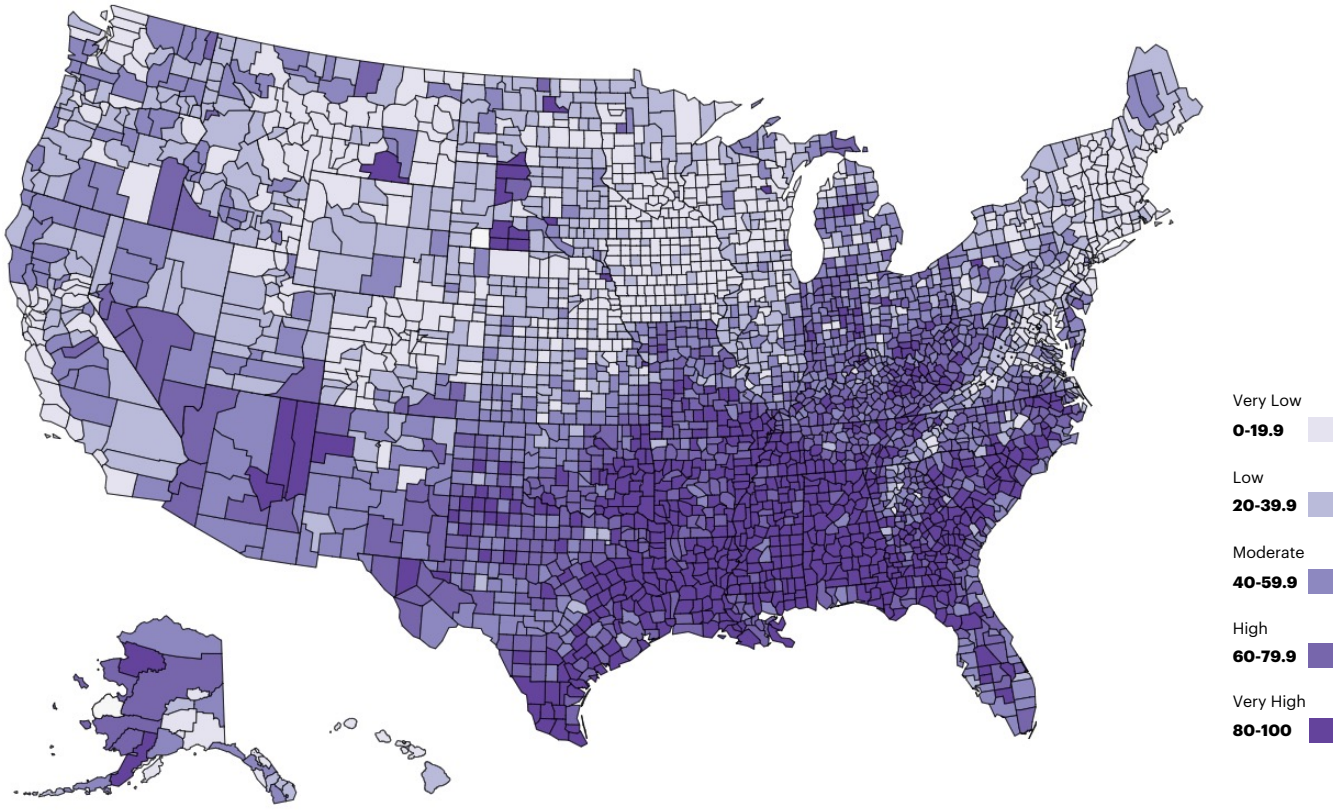
MATERNAL VULNERABILITY INDEX

Where you live matters.

March of Dimes, in partnership with Surgo Ventures, examines determinants of maternal health using the **Maternal Vulnerability Index (MVI)***. The MVI is the first county-level, national-scale tool to identify where and why moms in the U.S. are vulnerable to poor pregnancy outcomes and pregnancy-related deaths. The MVI includes not only widely known clinical risk factors, but also key social, contextual, and environmental factors that are essential influencers of health outcomes.

Differences in counties are measured using numerous factors broken into six themes: reproductive healthcare, physical health, mental health and substance abuse, general healthcare, socioeconomic determinants and physical environment. The MVI assigns a score of 0-100 to each geography, where a higher score indicates greater vulnerability to adverse maternal outcomes.

*Visit https://mvi.surgoventures.org/ for more information.



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.

26.3

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

14.5

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.

THE 2022 MARCH OF DIMES REPORT CARD:
STARK AND UNACCEPTABLE DISPARITIES PERSIST ALONGSIDE A TROUBLING RISE IN PRETERM BIRTH RATES

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: **https://bit.ly/ReportCardTechnicalNotes**

UNITED STATES

MATERNAL HEALTH

ADOPTED in 39 STATES (INCLUDING D.C.)

MEDICAID EXPANSION

States that adopt Medicaid expansion[7] enable all people in the state to qualify for Medicaid insurance benefits up to 138% of the federal poverty level thereby reducing the rates of uninsured pregnant individuals of childbearing age. Medicaid expansion plays an essential role in improving maternal and infant health. Increased access and utilization of health care are significantly associated with Medicaid expansion.[8]

RECENT ACTION in 10 STATES

26 STATES HAVE FULLY EXTENDED (INCLUDING D.C.)

RECENT ACTION ON MEDICAID EXTENSION

States that adopt Medicaid extension enable pregnant persons to qualify for medical-related Medicaid coverage for up to a year after the birth of their child. This policy extends the standard 60 days after pregnancy.[9] Extending this coverage typically requires both state legislation and an appropriation in addition to a Section 1115 waiver in order to receive federal match.[10]

37 STATES

REIMBURSE CERTIFIED NURSE MIDWIVES

MIDWIFERY POLICY

States that reimburse midwifery care on Medicaid insurance plans[18] at a high rate enable women to have increased access to midwifery care which can reduce the likelihood of 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. This is especially true in under-resourced areas. Midwives are health care professionals that may be part of the birth care team or stand alone in providing prenatal, delivery and postpartum care.

8 STATES REIMBURSE DOULA SUPPORT

DOULA LEGISLATION

States that reimburse doulas[17] enable women to have expanded access to doula support in their state and may be a way to improve birth outcomes. Doulas are non-clinical professionals that emotionally and physically support women during the perinatal period, including birth and postpartum.[16] Increased access to doula support 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.

40 STATES

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

MATERNAL MORTALITY REVIEW COMMITTEE (MMRC)

States that review pregnancy-associated deaths[12] up to one year after birth enable review committees to best understand all causes of pregnancy-associated mortality. MMRCs 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.[11] States that have an MMRC are better equipped to prevent pregnancy-related deaths.

47 STATES

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

PERINATAL QUALITY COLLABORATIVE (PQC)

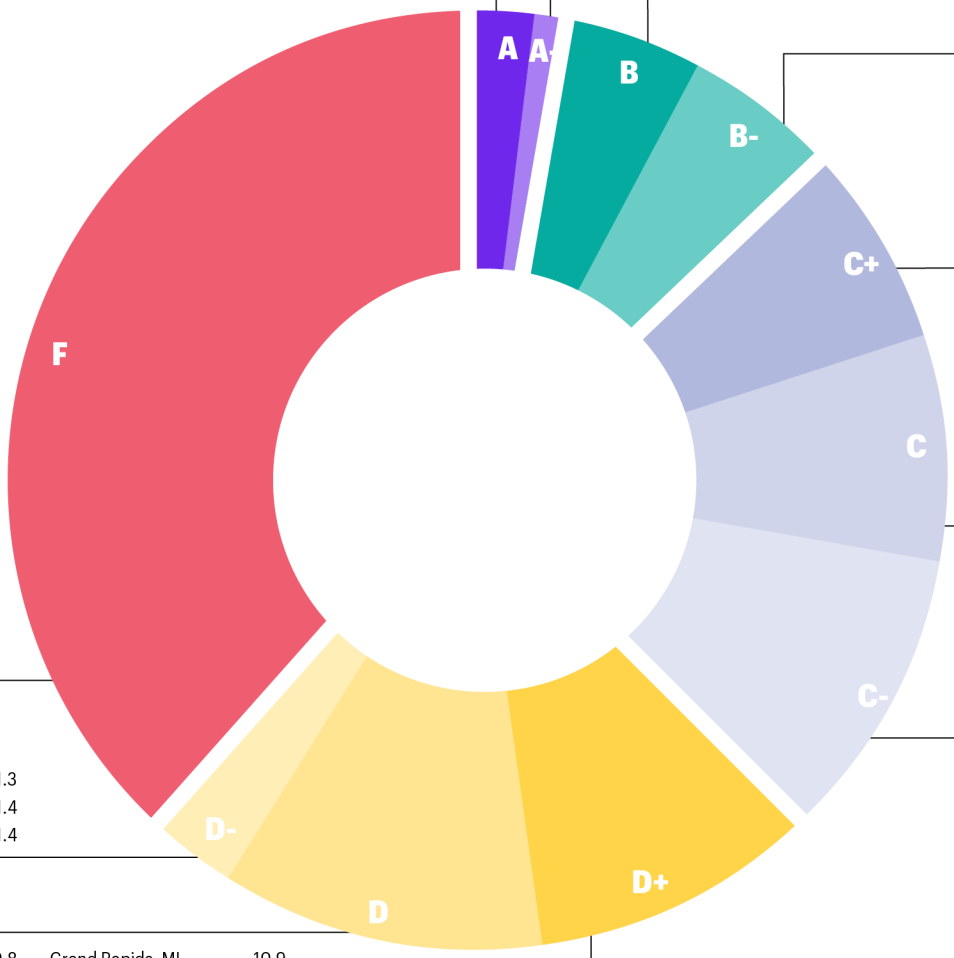
States that have an active PQC[15] enable collaborative work towards improving the quality of health care in clinical settings for moms and babies. Perinatal Quality Collaboratives are made up of state-level partnerships that come together to identify and initiate actions. The key to success is the variety of local stakeholders (including community and clinical perspectives) that work together for innovative solutions.[14]

*To access the full citation list, see our Technical Notes document below.

HEALTHY MOMS. STRONG BABIES.

100 U.S. CITIES WITH THE GREATEST NUMBER OF BIRTHS
2021 PRETERM BIRTH RATES AND GRADES

The 2022 U.S. March of Dimes Report Card assigns grades to the 100 cities with the greatest number of live births in 2021. Report Card grades are assigned by comparing the 2021 preterm birth rate in a city to the March of Dimes goal of 8.1 percent by 2020.



F			
Philadelphia, PA	11.5	Birmingham, AL	13.1
El Paso, TX	11.5	Brownsville, TX	13.1
Colorado Springs, CO	11.5	Toledo, OH	13.2
Fayetteville, NC	11.5	St. Louis, MO	14.1
Norfolk, VA	11.5	New Orleans, LA	14.4
Las Vegas, NV	11.6	Cleveland, OH	14.7
Louisville, KY	11.6	Detroit, MI	15.1
Fort Worth, TX	11.7		
Lubbock, TX	11.7		
Richmond, VA	11.7		
Atlanta, GA	11.8		
Greensboro, NC	11.8		
Indianapolis, IN	11.9		
Tulsa, OK	12.0		
Cincinnati, OH	12.1		
Newark, NJ	12.1		
San Antonio, TX	12.2		
Columbus, OH	12.2		
Milwaukee, WI	12.2		
North Las Vegas, NV	12.2		
Houston, TX	12.3		
Jacksonville, FL	12.3		
Baton Rouge, LA	12.3		
Oklahoma City, OK	12.4		
Omaha, NE	12.4		
Buffalo, NY	12.4		
Memphis, TN	12.8		
Dayton, OH	12.8		
Laredo, TX	12.9		
Rochester, NY	13.0		
Baltimore, MD	13.1		

A		A-	
Ramapo, NY	5.2	San Francisco, CA	8.1
Irvine, CA	7.7		

B		B-	
Seattle, WA	8.6	Portland, OR	9.0
San Diego, CA	8.7	Irving, TX	9.0
Oakland, CA	8.8	Austin, TX	9.2
Raleigh, NC	8.9	Boston, MA	9.2
Long Beach, CA	8.9	Modesto, CA	9.2

C+		C		C-	
Jersey City, NJ	9.4	San Jose, CA	9.7	Dallas, TX	10.1
Sacramento, CA	9.5	Brookhaven, NY	9.7	Washington, DC	10.1
Hempstead, NY	9.5	New York, NY	9.8	Tucson, AZ	10.1
Anaheim, CA	9.5	Miami, FL	9.8	Lincoln, NE	10.1
Los Angeles, CA	9.6	Bakersfield, CA	9.8	Honolulu, City & County, HI*	10.2
Denver, CO	9.6	Riverside, CA	9.8	Mesa, AZ	10.2
Albuquerque, NM	9.6	Reno, NV	9.8	Stockton, CA	10.2
		Anchorage, AK	10.0	Virginia Beach, VA	10.2
				Durham, NC	10.2
				Chula Vista, CA	10.3

D-			
Arlington, TX	11.3		
Tampa, FL	11.4		
Lexington-Fayette, KY	11.4		

D			
Orlando, FL	10.8	Grand Rapids, MI	10.9
Fresno, CA	10.8	Wichita, KS	11.0
Santa Ana, CA	10.8	Fort Wayne, IN	11.1
Chesapeake, VA	10.8	San Bernardino, CA	11.1
Nashville-Davidson, TN	10.9	Henderson, NV	11.1
Kansas City, MO	10.9		

D+			
Aurora, CO	10.4	Corpus Christi, TX	10.5
Islip, NY	10.4	Chicago, IL	10.6
Glendale, AZ	10.4	St. Paul, MN	10.6
Salt Lake City, UT	10.4	Phoenix, AZ	10.7
Charlotte, NC	10.5	Minneapolis, MN	10.7

GRADE AND RANGE

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

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.

Source: National Center for Health Statistics, 2021 final natality data. **Prepared by:** March of Dimes Perinatal Data Center, 2022.

HEALTHY MOMS. STRONG BABIES.

2022 MARCH OF DIMES REPORT CARD
TECHNICAL NOTES

PRETERM BIRTH RATE

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 2021 final natality data for all U.S. States and Washington D.C. Preterm birth rates in the trend graph are from the NCHS 2011-2021 final natality data. County and city preterm birth rates are from the NCHS 2021 final natality data for U.S. states and Washington D.C. Preterm birth rates for bridged racial and ethnic categories were calculated from NCHS 2019-2021 final natality data. All provided measures for Puerto Rico are calculated from the NCHS 2021 Territory final natality data, unless otherwise noted. 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. Joinpoint Trend Analysis Software[2] was utilized to assess significant trends in preterm birth.

INFANT MORTALITY RATE

Infant mortality rates were calculated using the NCHS 2020 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 2010-2020 period linked infant birth and infant death files. Joinpoint Trend Analysis Software[2] was utilized to assess significant trends in infant mortality.

PRETERM BIRTH 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%.

PRETERM BIRTH BY RACE/ETHNICITY OF THE MOTHER

Mother's race and Hispanic ethnicity are reported separately on the birth certificate. 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 2019-2021. To calculate preterm birth rates on the report card, three year data aggregates were used (2019-2021) for all states and D.C and for Puerto Rico (2018-2020). 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 2021 city preterm birth rate to the 2020 rate.

HEALTHY MOMS. STRONG BABIES.

2022 MARCH OF DIMES REPORT CARD
TECHNICAL NOTES

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 2019-2021 preterm birth rates for all groups (excluding the comparison group) were averaged and divided by the 2019-2021 comparison group preterm birth rate. The comparison group is the racial/ethnic group with the lowest six-year aggregate preterm birth rate (2012-2017) among groups that had 20 or more preterm births in each year from 2012-2017. 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, West Virginia, Wyoming and Puerto Rico. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

Progress toward eliminating racial and ethnic disparities was evaluated by comparing the 2019-2021 disparity ratio to a baseline (2012-2014) disparity ratio. Change between time periods was assessed for statistical significance at the 0.05 level using the approach recommended by Healthy People 2020.[3] 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 2019-2021 highest preterm birth rate compared to the combined 2019-2021 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.

MATERNAL VULNERABILITY INDEX

March of Dimes recognizes the importance of certain risk factors that are associated with maternal and infant health outcomes. March of Dimes, in partnership with Surgo Ventures, is offering the opportunity to examine determinants of maternal health at the county level using the Maternal Vulnerability Index (MVI)[4]. The MVI is the first county-level, national-scale, open-source tool to identify where and why mothers in the United States are vulnerable to poor pregnancy outcomes and pregnancy-related deaths. The MVI includes not only widely known clinical risk factors, but also key social, contextual, and environmental factors that are also essential influencers of outcomes.

Differences in counties are measured using numerous factors broken into six themes: reproductive healthcare, physical health, mental health and substance abuse, general healthcare, socioeconomic determinants and physical environment. The MVI assigns a score of 0-100 to each geography, where a higher score indicates greater vulnerability to adverse maternal outcomes. Learn more about the MVI methodology by visiting Surgo Ventures website. (Surgo Ventures - The US Maternal Vulnerability Index (MVI)).

MATERNAL 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.[5] This is also referred to as a NTSV Cesarean 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 2021 final natality data for the US states and Washington D.C. and the 2021 final territorial natality data for Puerto Rico.[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 100.

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.[6] Inadequate prenatal care is defined as a woman 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. Inadequate prenatal care will be calculated using the NCHS 2021 final natality data.[1]

HEALTHY MOMS. STRONG BABIES.

2022 MARCH OF DIMES REPORT CARD
TECHNICAL NOTES

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.[7] Medicaid expansion has reduced the rates of uninsured. Increased access and utilization of health care are significantly associated with Medicaid expansion.[8]

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.[9] Extending this coverage typically requires both state legislation and an appropriation in addition to a Section 1115 waiver in order to receive federal match.[10] Medicaid extension status is provided by the American College of Obstetricians and Gynecologists as adopted, waiver pending or planning or planning is occurring (ready to implement Section 1115 waiver or SPA option pending approval from CMS), or the state does not have the indicated organization/policy.[9]

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.[11] The measure is provided by the Guttmacher Institute[12] and the Louisiana, Wisconsin and Vermont Departments of Health[13] 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.

PERINATAL QUALITY COLLABORATIVE (PQC)

The PQC involves partnerships with families, key state agencies and organizations 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.[14] Data is provided by the National Institute for Children's Health Quality (NICHQ) and the measure is reported as: state has the indicated organization/policy or the state has the indicated organization/policy in progress.[15]

DOULA POLICY ON MEDICAID COVERAGE

Doulas are non-clinical professionals that emotionally and physically support women during the perinatal period, including birth and postpartum.[16] 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, state is in progress for having 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.[17]

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 Medicaid reimbursement rates for certified nurse-midwives are at or above 90% or below 90%. 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 American College of Nurse-Midwives.[18]

SUPPLEMENTAL REPORT CARD

HEALTHY PEOPLE 2030

National data-driven objectives from Healthy People 2030[19] were set by the U.S. Department of Health and Human Services with the goal of improving health and well being over the next decade. Several HP 2030 objectives are specific to the prevention of pregnancy complications and improvements to women's health before, during and after pregnancy. Progress towards the following objectives are shown on the supplemental report card:

Preterm births: see definition on page 1
Infant mortality: see definition on page 1
Low-risk Cesarean births: see definition on page 2

THE 2022 MARCH OF DIMES REPORT CARD:
STARK AND UNACCEPTABLE DISPARITIES PERSIST ALONGSIDE A TROUBLING RISE IN PRETERM BIRTH RATES

March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes.

HEALTHY MOMS. STRONG BABIES.

2022 MARCH OF DIMES REPORT CARD
TECHNICAL NOTES

SUPPLEMENTAL REPORT CARD (CONT.)

UNHEALTHY WEIGHT BEFORE PREGNANCY

Body mass index (BMI) is a measure of body fat based on height and weight that applies to adult men and women. BMI was calculated using NCHS 2021 final natality data for the US states and Washington D.C. and the 2020 final territorial natality data for Puerto Rico.[1] The percent of women with an unhealthy weight before pregnancy was calculated as the number of women with a BMI that is categorized as either underweight (BMI <18.5), overweight (BMI 25 to 29.9), or obese (30 or higher) divided by the number of women who had a live birth multiplied by 100. Note that the HP 2030 objective is "healthy weight before pregnancy"; unhealthy weight was used to better align with the other measures.

PRETERM BIRTH BY COUNTY

Supplemental report cards for states and jurisdictions, except District of Columbia, display the counties with the greatest number of live births. Grades were assigned based on the grading criteria described on page 1. Change from previous year was calculated by comparing the 2021 county preterm birth rate to the 2020 rate. For Puerto Rico, change from previous year was calculated by comparing 2020 municipality preterm birth rates to the 2019 rates.

LIVE BIRTHS AND PRETERM BIRTH BY RACE AND ETHNICITY OF THE MOTHER- EXPANDED

Mother's race and Hispanic ethnicity are reported separately on the birth certificate. Rates for Hispanic women include all expanded racial categories included on the birth certificate (White, Black, American Indian/Alaska Native, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, Hawaiian, Guamanian, Samoan, and other Pacific Islander) and are broken down based on the expanded Hispanic origin categories which include Mexican, Puerto Rican, Cuban, Dominican, Central or South American and Other Hispanic. Rates for non-Hispanic women are classified according to expanded race. For live births, any expanded race and Hispanic origin categories that accounted for less than 1% of live births in each state, were collapsed into the corresponding "other" category (other Hispanic, other Asian, other Pacific Islander). To provide stable preterm birth rates, racial and ethnic groups are shown on the report card if the group had 50 or more preterm births from 2019-2021. To calculate preterm birth rates on the report card, three years of data were aggregated (2019-2021). Number of live births and preterm birth rates for not stated/unknown race are not shown on the supplemental report card.

MARCH OF DIMES STATE IMPACT REPORT

ADVOCATES WHO RAISED THEIR VOICE

Through the March of Dimes, anyone who wants to join in the fight for the health of all birthing people, babies and their families can support our Office of Government Affairs by becoming an advocate. Advocates advance our efforts through supporting our work to influence legislation, policy and regulation at the federal and state level. The data are captured by the Office of Government Affairs are recorded in a database built into Capital Canary, a third-party software product. The numbers in these report show advocates who have signed up through August 31, 2022.

IMPLICIT BIAS TRAINING SEATS CONTRACTED

Through online and live training courses, March of Dimes provides peer-reviewed, clinically relevant Implicit Bias Training to eliminate maternal and infant health care inequities. The metric "Implicit Bias Trainings Seats Contracted" is captured internally and is the measure of how many seats are contracted to be received by partners that state. The reported numbers are based on contracts completed between January 1, 2022 and August 31, 2022.

PEOPLE SUPPORTED THROUGH OUR NICU INITIATIVES

Our NICU Initiatives educate and support families through evidence-based programs and a variety of both online and in person resources. The number pf families served is captured and reported directly from on-site staff members at our partner sites via a monthly survey of their on-going work. The reported numbers are based on surveys reported between January 1, 2022 and August 31, 2022.

PIECES OF STATE LEGISLATION SUPPORTED

March of Dimes Office of Government Affairs advocates for policy initiatives at a state level on a host of issues important to pregnant women, infants, children and families. The number collected represents the amount of Bills worked on at a state level by a March of Dimes Staff member and is reported directly by the staff member in a quarterly reporting survey. The reported numbers are based on surveys reported between January 1, 2022 and August 31, 2022.

CALCULATIONS

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

HEALTHY MOMS. STRONG BABIES.

2022 MARCH OF DIMES REPORT CARD
TECHNICAL NOTES

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[18] American College of Nurse-Midwives (ACNM). Reimbursement Equity. Accessed September 9, 2022. https://www.midwife.org/reimbursement-equity.

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HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

2022 MARCH OF DIMES REPORT CARD

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ALABAMA

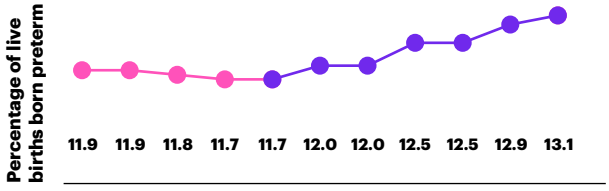
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

13.1%



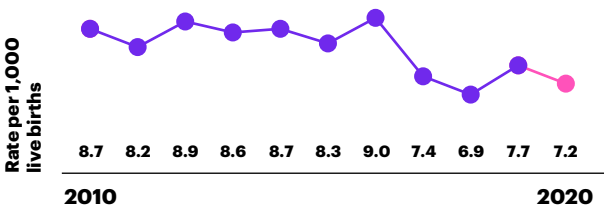
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

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

INFANT MORTALITY RATE

7.2



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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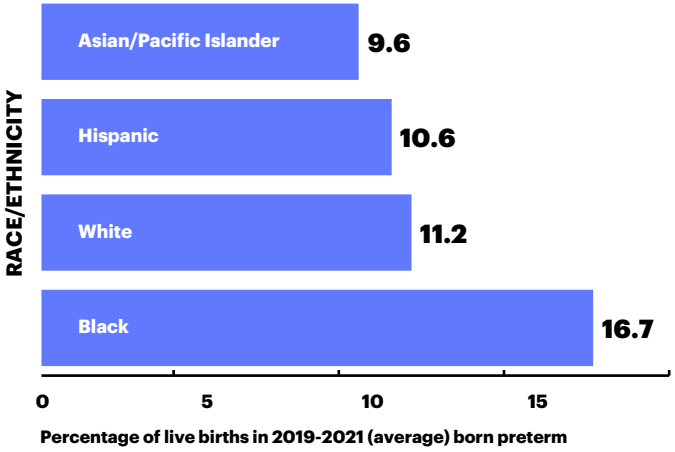

In Alabama, the preterm birth rate among Black women is 50% higher than the rate among all other women.

DISPARITY RATIO:

1.34

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Birmingham	F	13.1%	Worsened

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ALABAMA

MATERNAL HEALTH

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Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

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.

29.8

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

16.7

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

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

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

DOULA POLICY OR LEGISLATION

State has allowed for the passage of Medicaid coverage for doula care.

Legend

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ALASKA

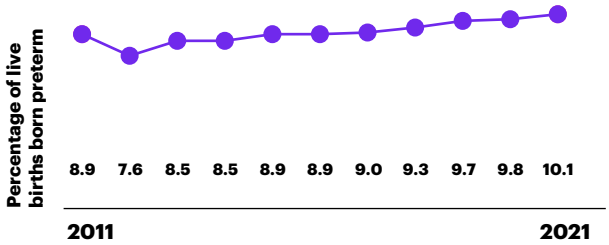
INFANT HEALTH

PRETERM BIRTH GRADE

C-

PRETERM BIRTH RATE

10.1%



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INFANT MORTALITY

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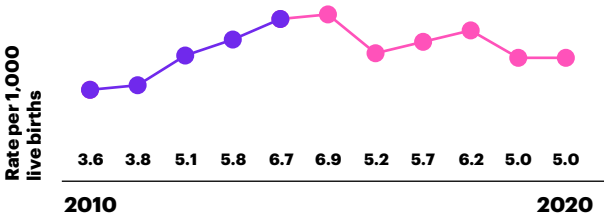
INFANT MORTALITY RATE

5.0



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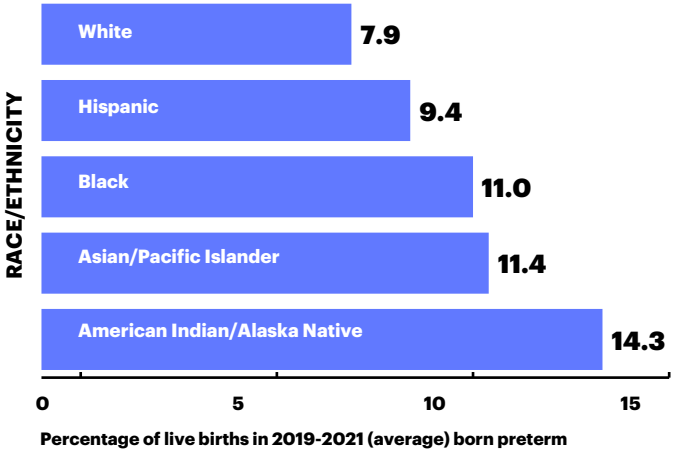

In Alaska, the preterm birth rate among American Indian/Alaska Native women is 66% higher than the rate among all other women.

DISPARITY RATIO:

1.46

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

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

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ALASKA

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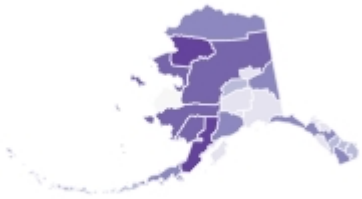

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

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.

19.9

PERCENT

26.3

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

18.5

PERCENT

14.5

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

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

PERINATAL QUALITY COLLABORATIVE (PQC)

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

DOULA POLICY OR LEGISLATION

State has allowed for the passage of Medicaid coverage for doula care.

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ARIZONA

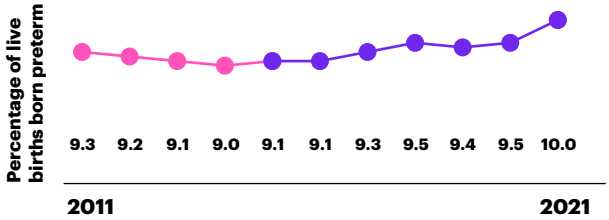
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

10.0%



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INFANT MORTALITY

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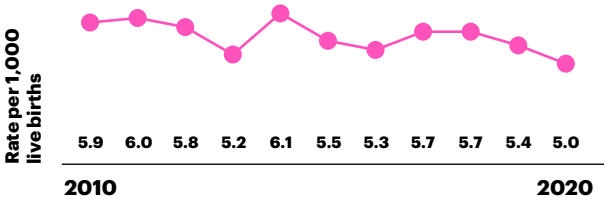
INFANT MORTALITY RATE

5.0



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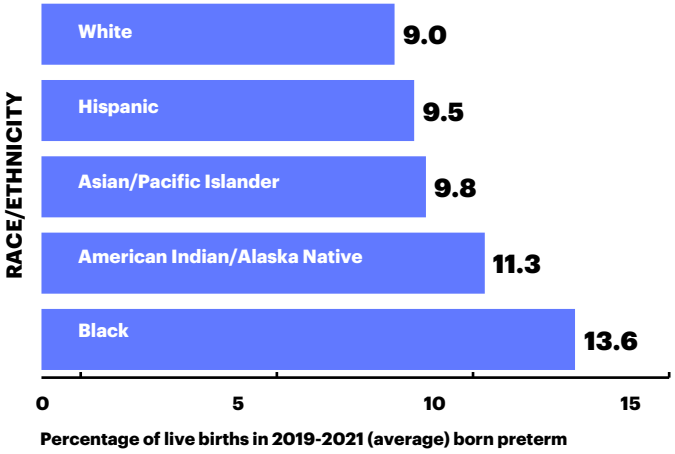

In Arizona, the preterm birth rate among Black women is 46% higher than the rate among all other women.

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
Phoenix	D+	10.7%	Worsened

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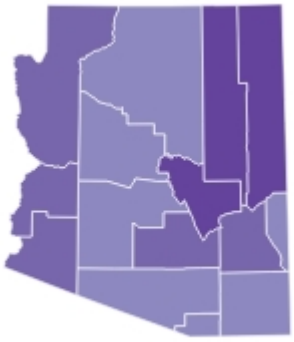

Very Low	Low	Moderate	High	Very High
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23.2

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

18.6

PERCENT

INADEQUATE PRENATAL CARE

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ARKANSAS

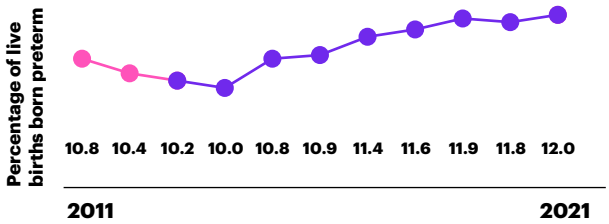
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

12.0%



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INFANT MORTALITY

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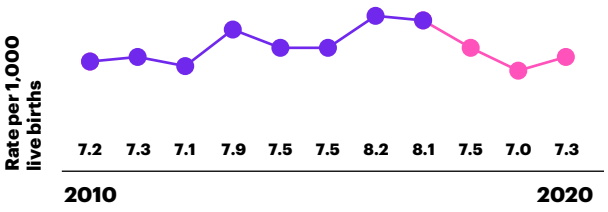
INFANT MORTALITY RATE

7.3



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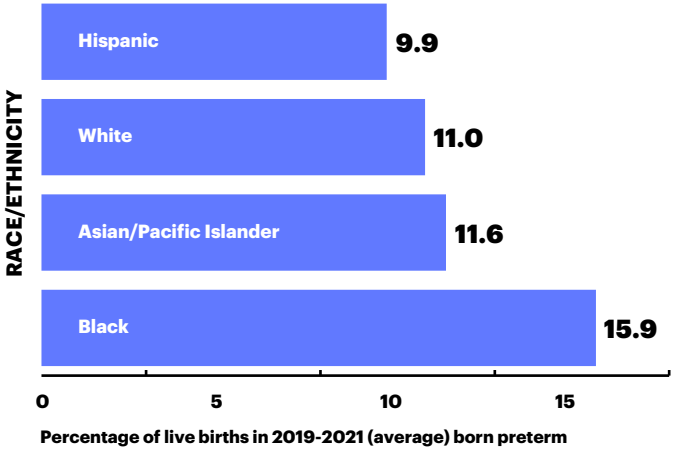

In Arkansas, the preterm birth rate among Black women is 46% higher than the rate among all other women.

DISPARITY RATIO:

1.29

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Little Rock	F	13.2%	Worsened

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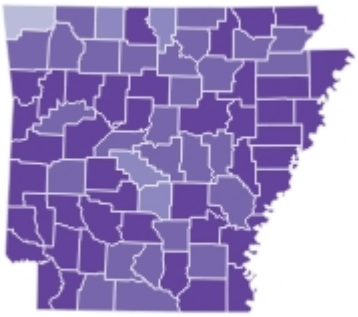

Very Low	Low	Moderate	High	Very High
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CLINICAL MEASURES

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.

28.0 PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

20.8 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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE (MMRC)

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

PERINATAL QUALITY COLLABORATIVE (PQC)

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

DOULA POLICY OR LEGISLATION

State has allowed for the 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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CALIFORNIA

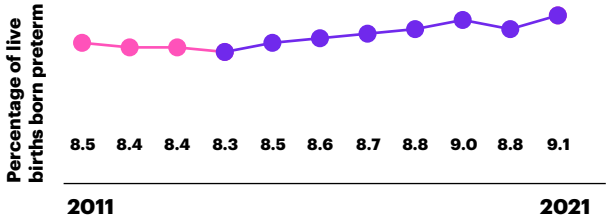
INFANT HEALTH

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.1%



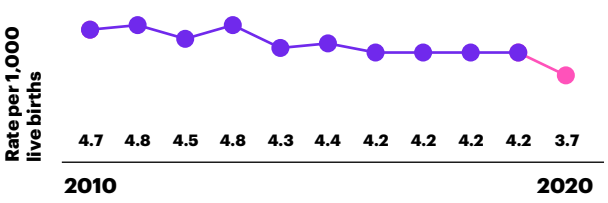
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

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

INFANT MORTALITY RATE

3.7



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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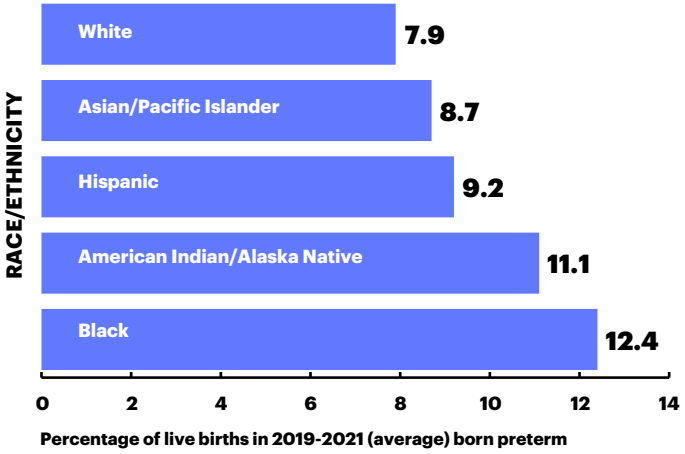

In California, the preterm birth rate among Black women is 43% higher than the rate among all other women.

DISPARITY RATIO:

1.31

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Los Angeles	C+	9.6%	Worsened

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Very Low	Low	Moderate	High	Very High
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CLINICAL MEASURES

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24.7

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

8.8

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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COLORADO

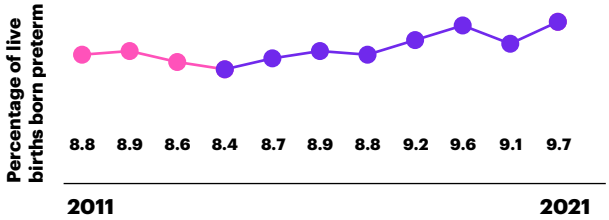
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.7%



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INFANT MORTALITY

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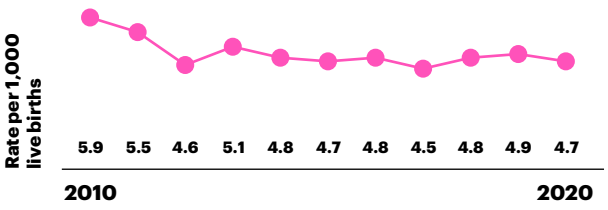
INFANT MORTALITY RATE

4.7



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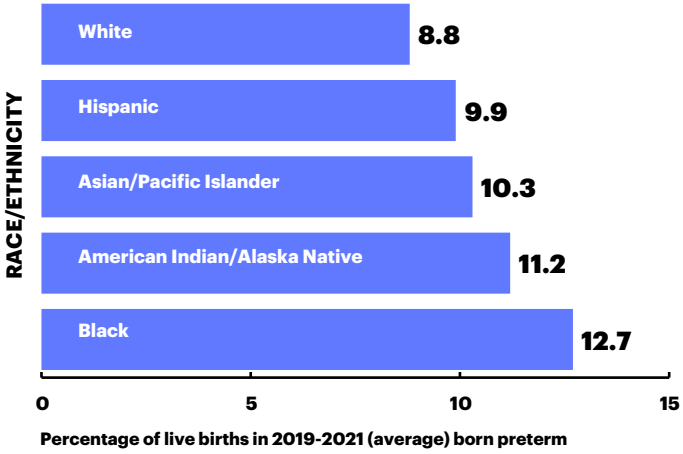

In Colorado, the preterm birth rate among Black women is 37% higher than the rate among all other women.

DISPARITY RATIO:

1.25

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Denver	C+	9.6%	Worsened

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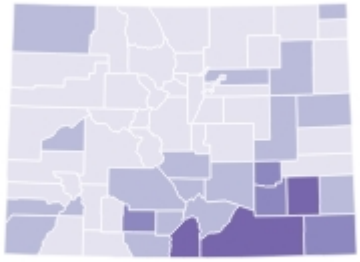

Very Low	Low	Moderate	High	Very High
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CLINICAL MEASURES

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22.3

PERCENT

26.3

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

12.9

PERCENT

14.5

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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CONNECTICUT

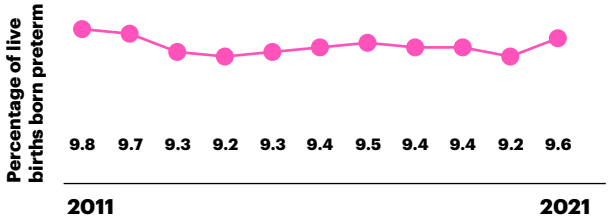
INFANT HEALTH

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.6%



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INFANT MORTALITY

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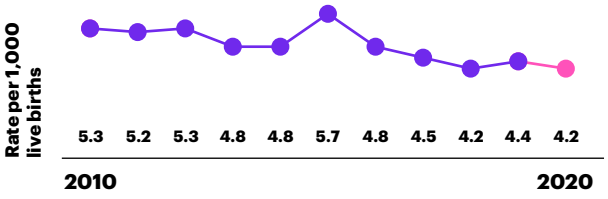
INFANT MORTALITY RATE

4.2



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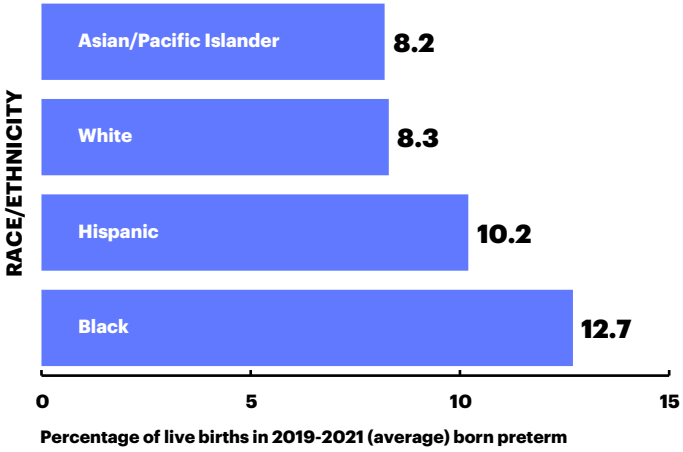

In Connecticut, the preterm birth rate among Black women is 43% higher than the rate among all other women.

DISPARITY RATIO:

1.27

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Bridgeport	D+	10.7%	Better

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28.9

PERCENT

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8.8

PERCENT

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MARCH OF DIMES

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DELAWARE

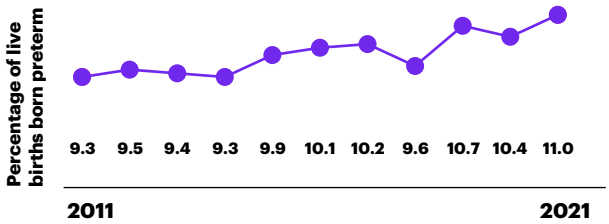
INFANT HEALTH

PRETERM BIRTH GRADE

D

PRETERM BIRTH RATE

11.0%



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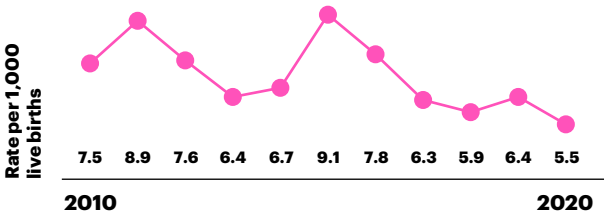
INFANT MORTALITY RATE

5.5



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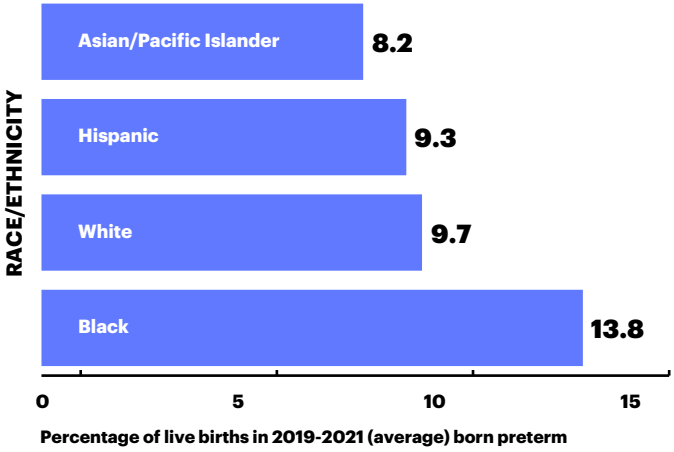

In Delaware, the preterm birth rate among Black women is 45% higher than the rate among all other women.

DISPARITY RATIO:

1.34

CHANGE FROM BASELINE:

No Improvement

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26.0

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE (MMRC)

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

PERINATAL QUALITY COLLABORATIVE (PQC)

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

DOULA POLICY OR LEGISLATION

State has allowed for the 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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HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

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DISTRICT OF COLUMBIA

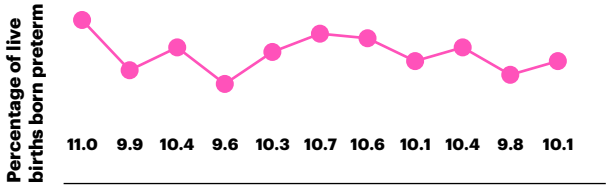
INFANT HEALTH

PRETERM BIRTH GRADE

C-

PRETERM BIRTH RATE

10.1%



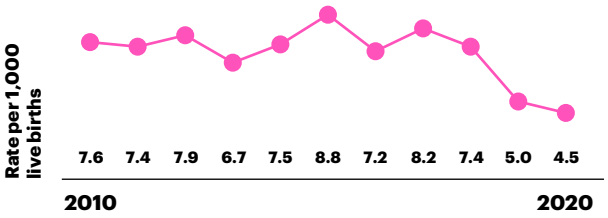
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

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

INFANT MORTALITY RATE

4.5



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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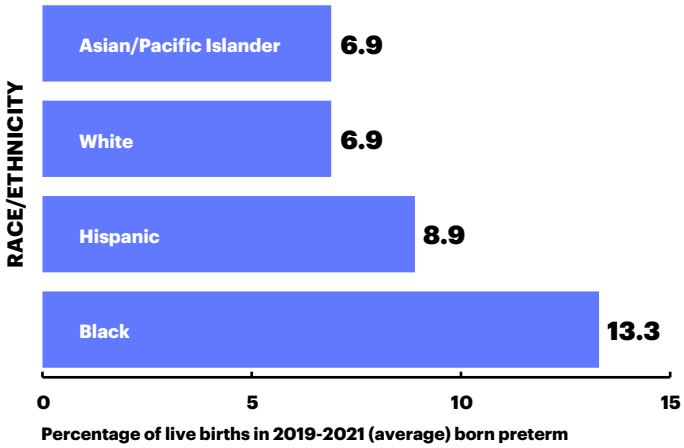

In District of Columbia, the preterm birth rate among Black women is 77% higher than the rate among all other women.

DISPARITY RATIO:

1.41

CHANGE FROM BASELINE:

No Improvement

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Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

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27.6

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

19.5

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.

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FLORIDA

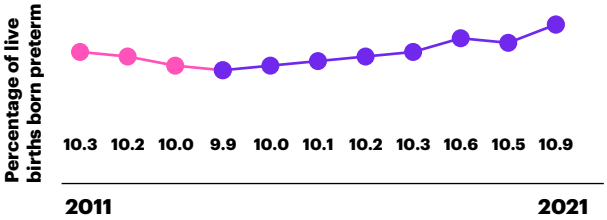
INFANT HEALTH

PRETERM BIRTH GRADE

D

PRETERM BIRTH RATE

10.9%



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INFANT MORTALITY

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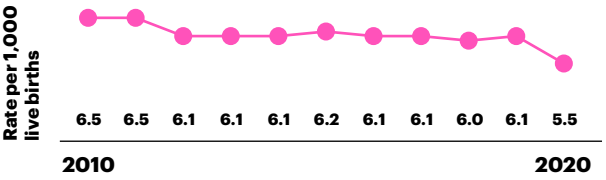
INFANT MORTALITY RATE

5.5



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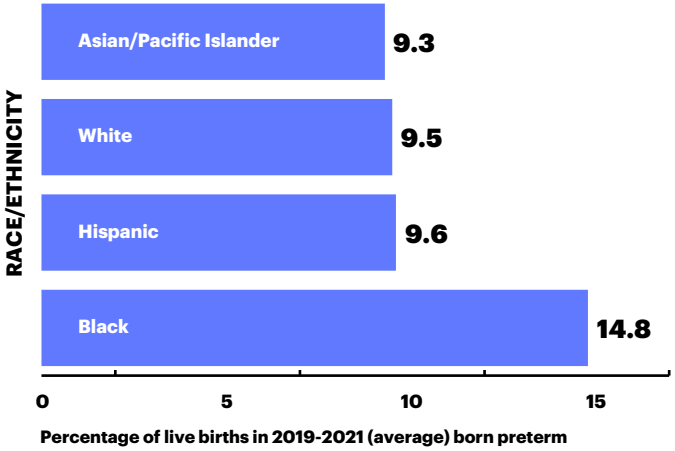

In Florida, the preterm birth rate among Black women is 56% higher than the rate among all other women.

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
Jacksonville	F	12.3%	Worsened

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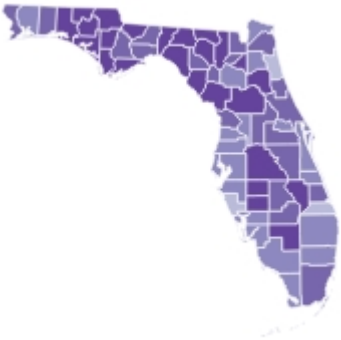

Very Low	Low	Moderate	High	Very High
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CLINICAL MEASURES

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28.9 PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

23.3 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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GEORGIA

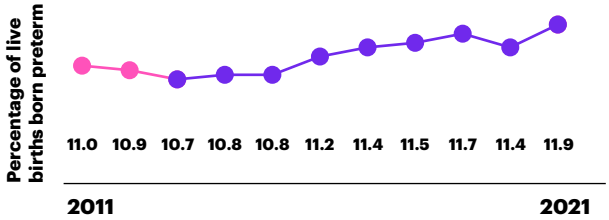
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

11.9%



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INFANT MORTALITY

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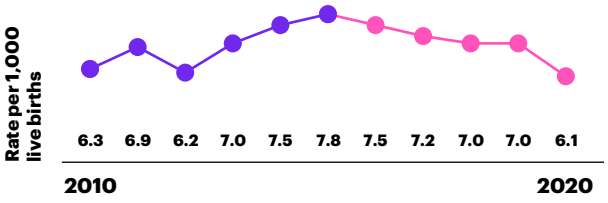
INFANT MORTALITY RATE

6.1



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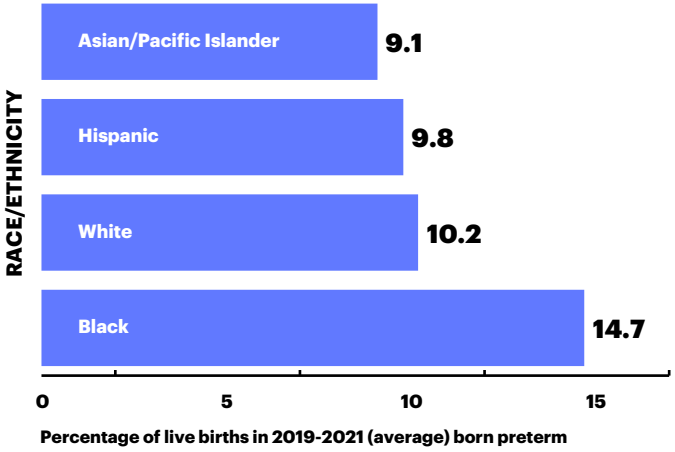

In Georgia, the preterm birth rate among Black women is 47% higher than the rate among all other women.

DISPARITY RATIO:

1.27

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Atlanta	F	11.8%	Worsened

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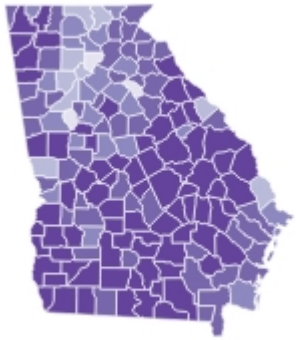

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28.8

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

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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HAWAII

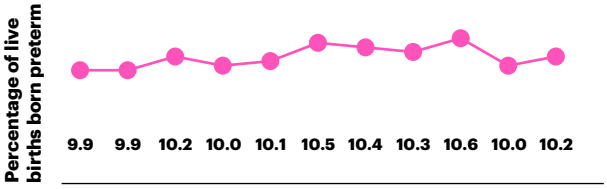
INFANT HEALTH

PRETERM BIRTH GRADE

C-

PRETERM BIRTH RATE

10.2%



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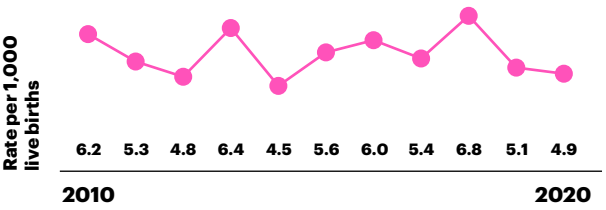
INFANT MORTALITY RATE

4.9



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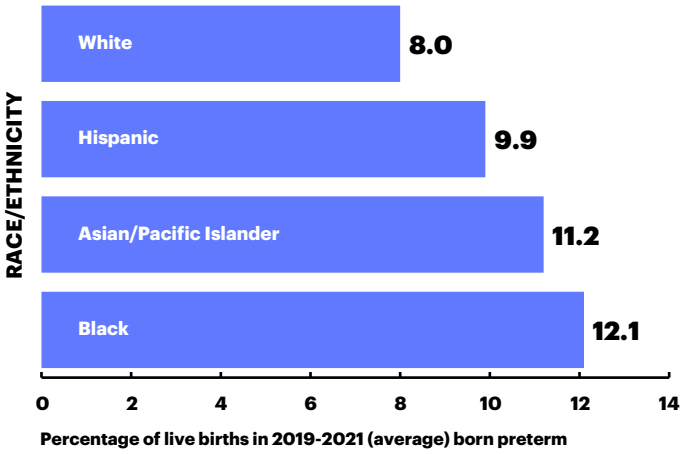

In Hawaii, the preterm birth rate among Black women is 20% higher than the rate among all other women.

DISPARITY RATIO:

1.39

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Honolulu	C-	10.2%	Same

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22.8

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

21.4

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

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

DOULA POLICY OR LEGISLATION

State has allowed for the passage of Medicaid coverage for doula care.

Legend

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IDAHO

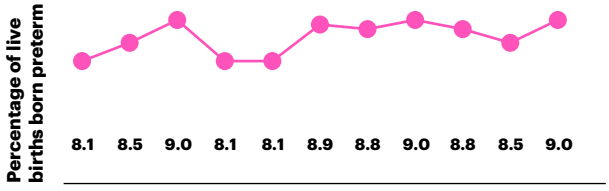
INFANT HEALTH

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.0%



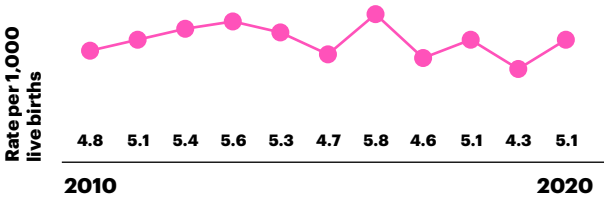
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

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

INFANT MORTALITY RATE

5.1



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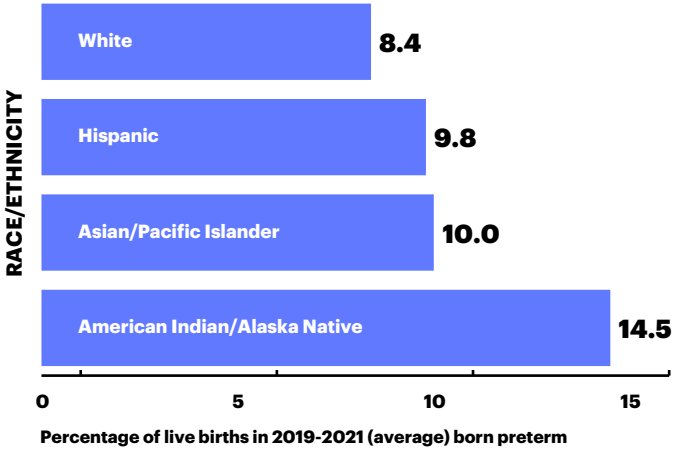

In Idaho, the preterm birth rate among American Indian/Alaska Native women is 67% higher than the rate among all other women.

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
Boise City	B+	8.3%	Worsened

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IDAHO

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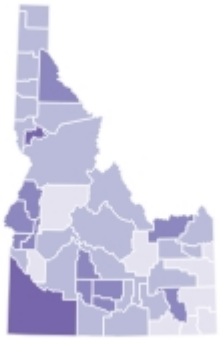

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

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19.0

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

9.7

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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ILLINOIS

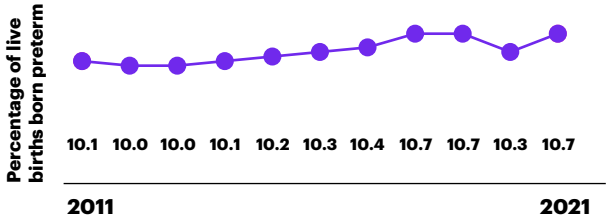
INFANT HEALTH

PRETERM BIRTH GRADE

D+

PRETERM BIRTH RATE

10.7%



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INFANT MORTALITY

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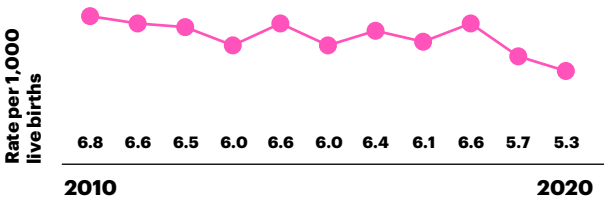
INFANT MORTALITY RATE

5.3



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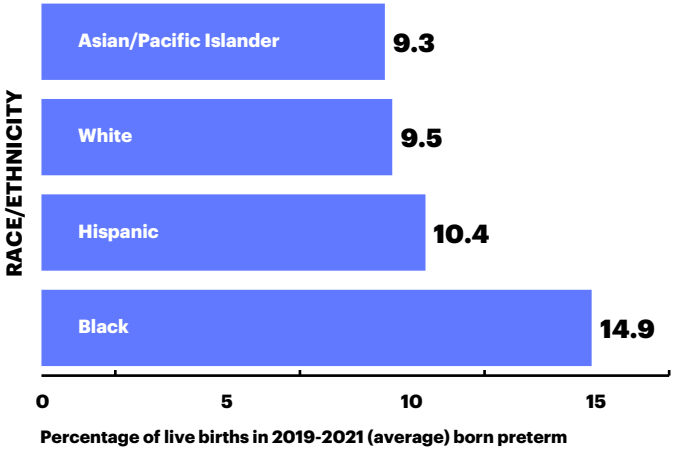

In Illinois, the preterm birth rate among Black women is 54% higher than the rate among all other women.

DISPARITY RATIO:

1.25

CHANGE FROM BASELINE:

Worsened

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Chicago	D+	10.6%	Same

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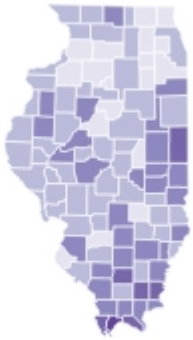

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

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25.3

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

13.0

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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MARCH OF DIMES

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INDIANA

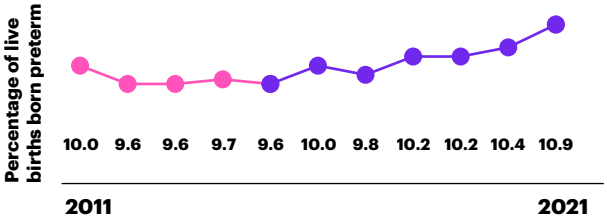
INFANT HEALTH

PRETERM BIRTH GRADE

D

PRETERM BIRTH RATE

10.9%



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INFANT MORTALITY

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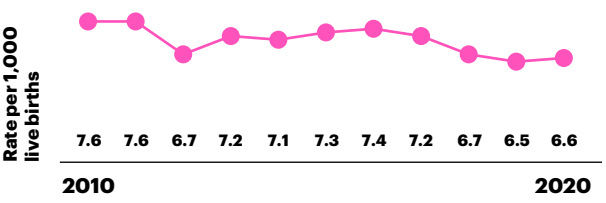
INFANT MORTALITY RATE

6.6



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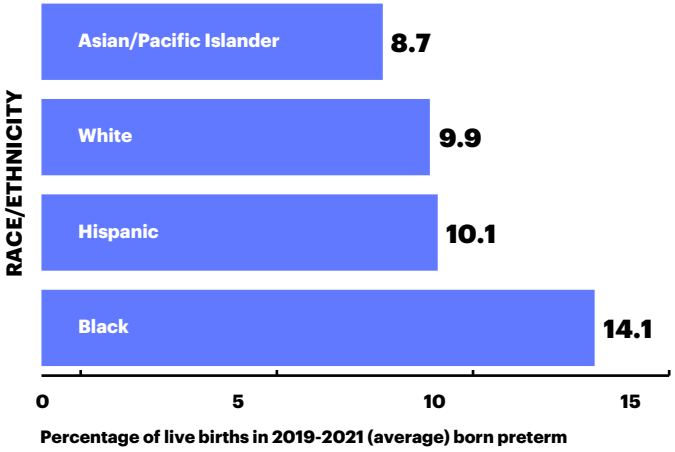

In Indiana, the preterm birth rate among Black women is 42% higher than the rate among all other women.

DISPARITY RATIO:

1.31

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Indianapolis	F	11.9%	Better

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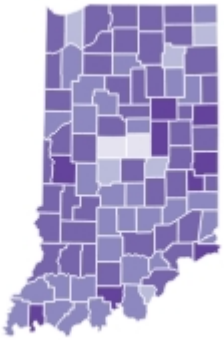

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24.4

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

14.6

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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IOWA

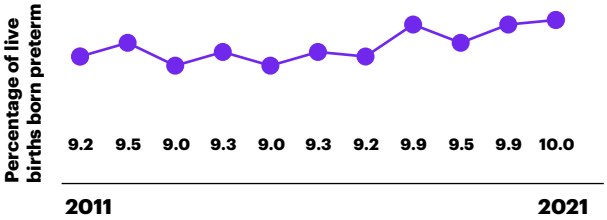
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

10.0%



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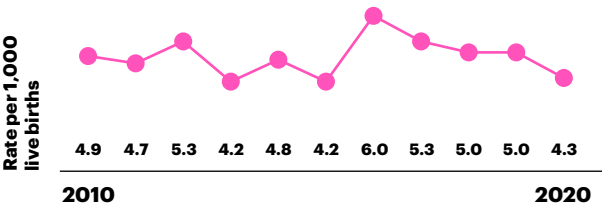
INFANT MORTALITY RATE

4.3



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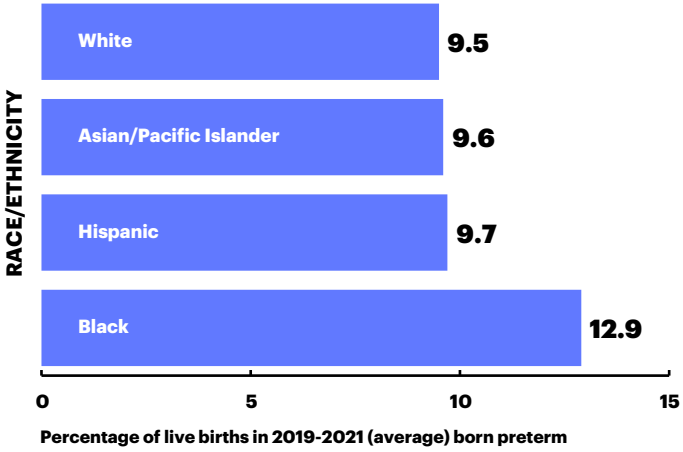

In Iowa, the preterm birth rate among Black women is 36% higher than the rate among all other women.

DISPARITY RATIO:

1.10

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Des Moines	D	10.8%	Worsened

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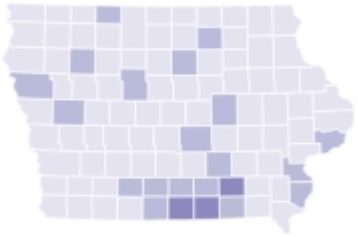

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

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23.5

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

10.3

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

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

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Legend

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KANSAS

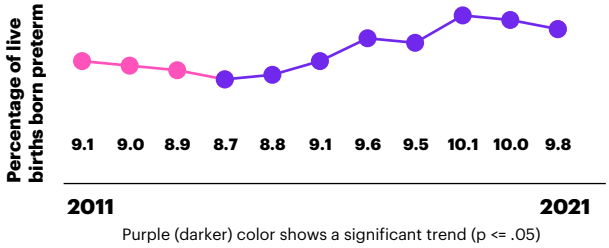
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.8%



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

INFANT MORTALITY

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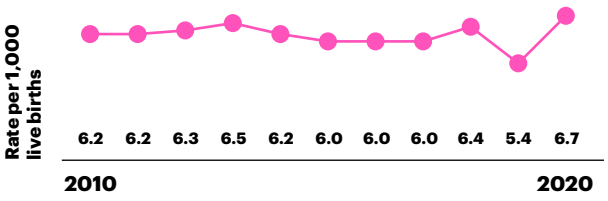
INFANT MORTALITY RATE

6.7



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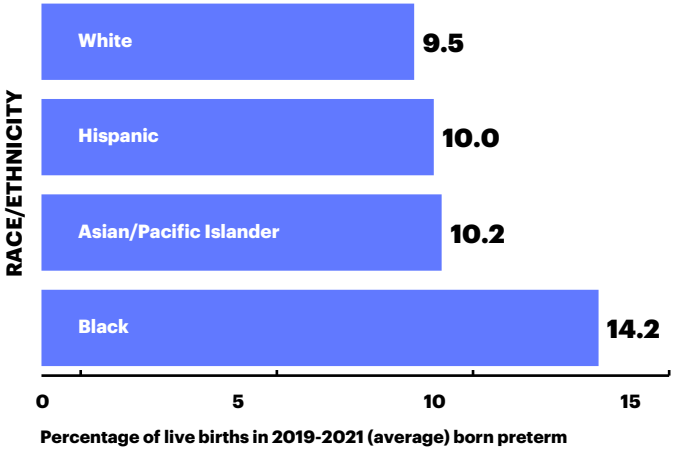

In Kansas, the preterm birth rate among Black women is 48% higher than the rate among all other women.

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
Wichita	D	11.0%	Worsened

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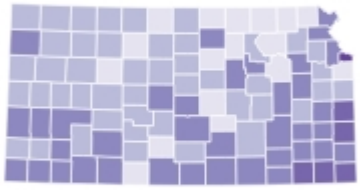

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23.9

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

9.4

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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KENTUCKY

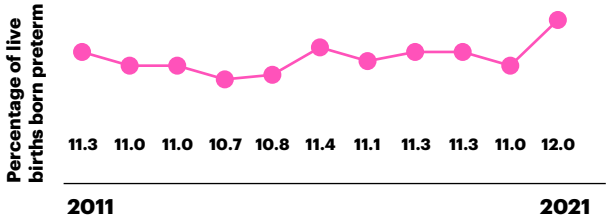
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

12.0%



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INFANT MORTALITY

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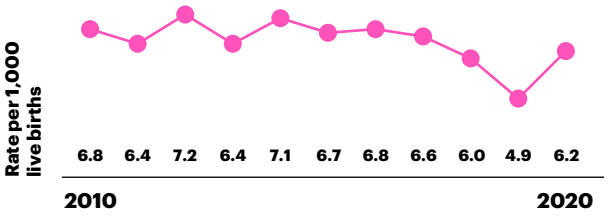
INFANT MORTALITY RATE

6.2



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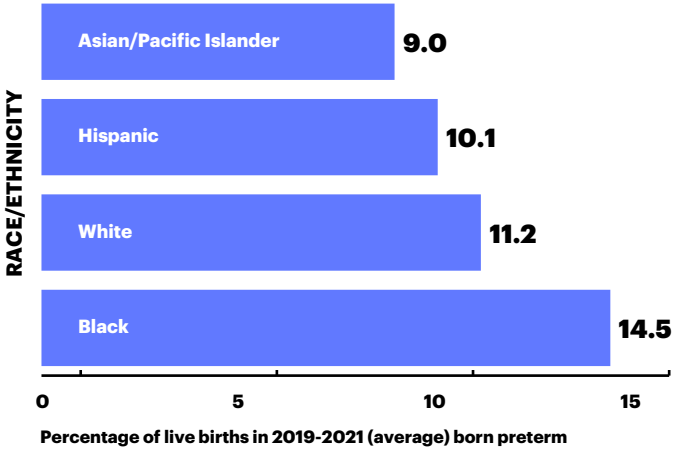

In Kentucky, the preterm birth rate among Black women is 31% higher than the rate among all other women.

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
Louisville	F	11.6%	Worsened

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27.4

PERCENT

26.3

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

14.2

PERCENT

14.5

INADEQUATE PRENATAL CARE

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LOUISIANA

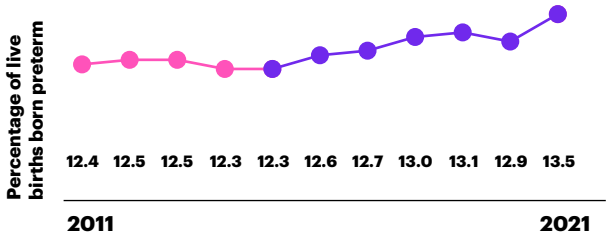
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

13.5%



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INFANT MORTALITY

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INFANT MORTALITY RATE

7.5

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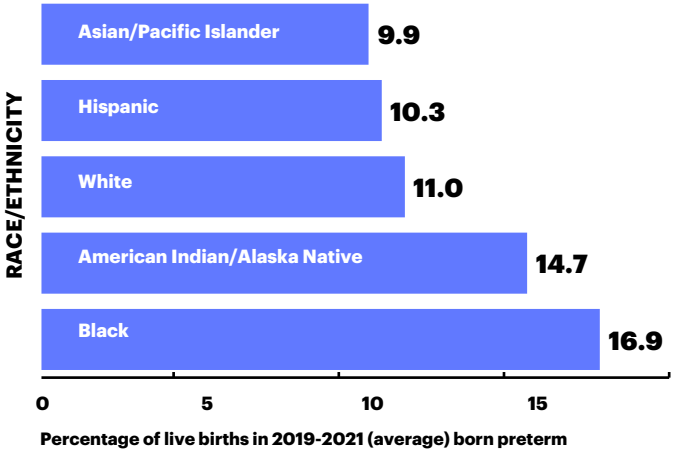

In Louisiana, the preterm birth rate among Black women is 55% higher than the rate among all other women.

DISPARITY RATIO:

1.28

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Baton Rouge	F	12.3%	Better

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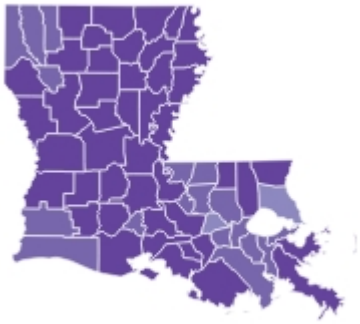

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29.8

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

16.5

PERCENT

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MAINE

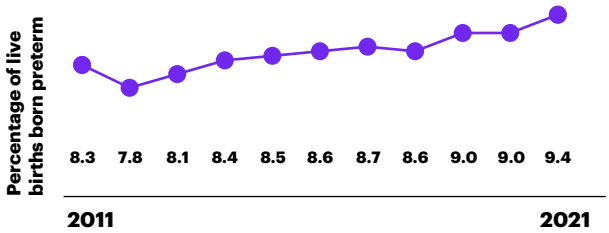
INFANT HEALTH

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.4%



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INFANT MORTALITY

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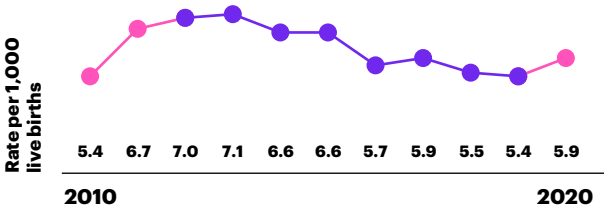
INFANT MORTALITY RATE

5.9



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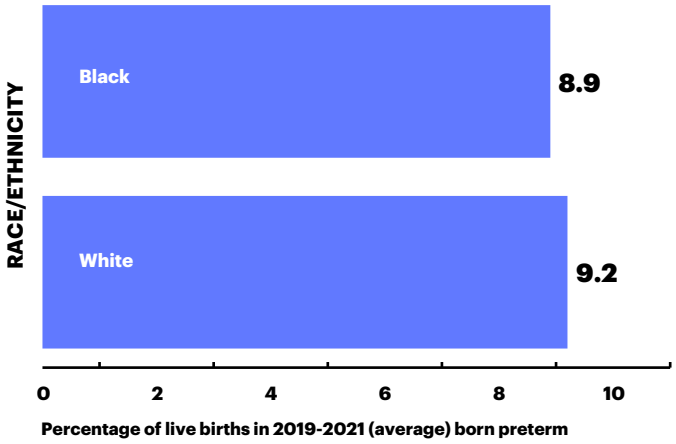

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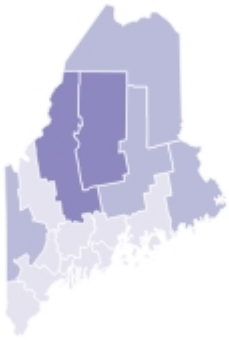

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

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.

25.3

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

8.9

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

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State has allowed for the passage of Medicaid coverage for doula care.

Legend

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MARYLAND

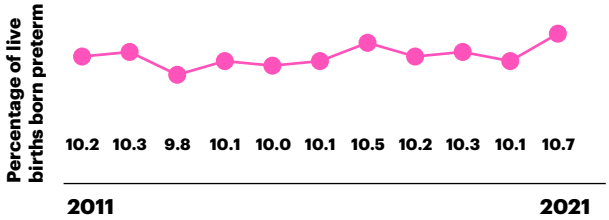
INFANT HEALTH

PRETERM BIRTH GRADE

D+

PRETERM BIRTH RATE

10.7%



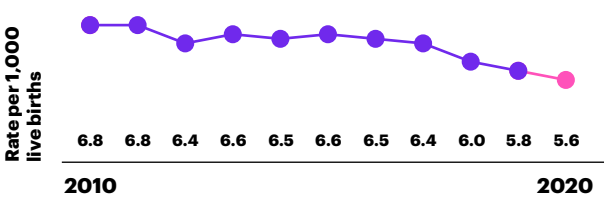
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

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

INFANT MORTALITY RATE

5.6



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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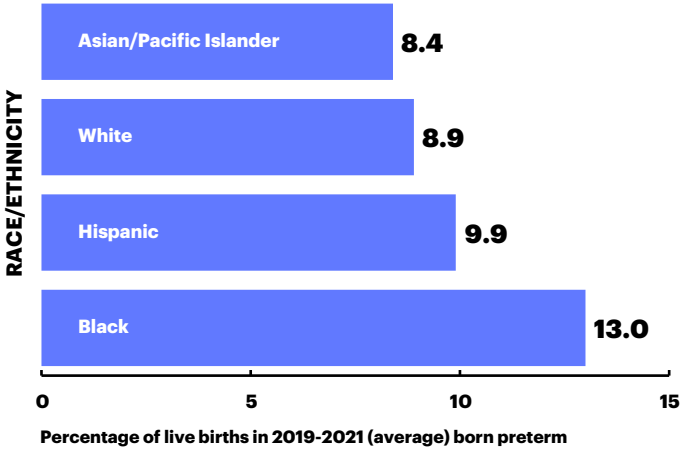

In Maryland, the preterm birth rate among Black women is 43% higher than the rate among all other women.

DISPARITY RATIO:

1.26

CHANGE FROM BASELINE:

Worsened

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Baltimore	F	13.1%	Same

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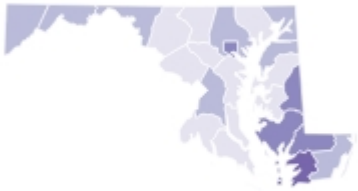

Very Low	Low	Moderate	High	Very High
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CLINICAL MEASURES

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29.3

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

15.6

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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MASSACHUSETTS

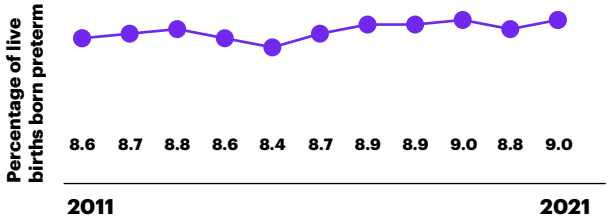
INFANT HEALTH

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.0%



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

INFANT MORTALITY

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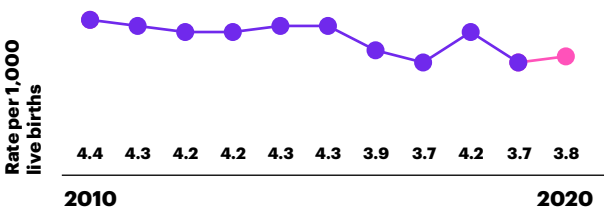
INFANT MORTALITY RATE

3.8



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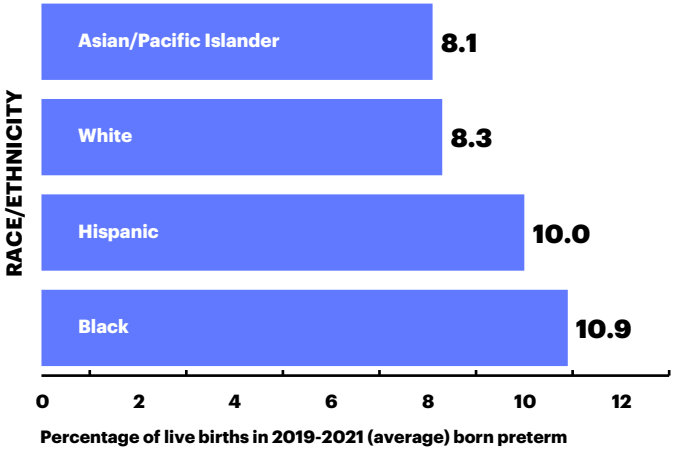

In Massachusetts, the preterm birth rate among Black women is 25% higher than the rate among all other women.

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
Boston	B-	9.2%	Worsened

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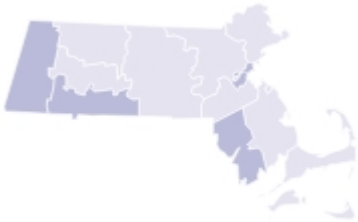

Very Low	Low	Moderate	High	Very High
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26.0

PERCENT

26.3

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

9.1

PERCENT

14.5

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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MICHIGAN

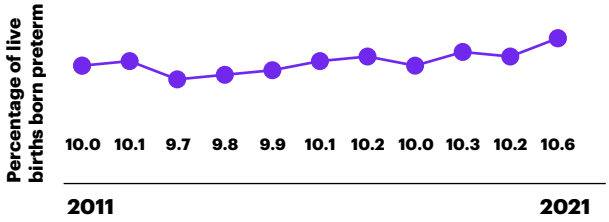
INFANT HEALTH

PRETERM BIRTH GRADE

D+

PRETERM BIRTH RATE

10.6%



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INFANT MORTALITY

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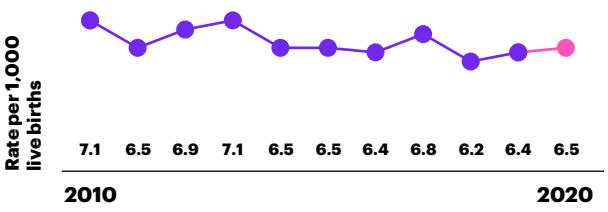
INFANT MORTALITY RATE

6.5



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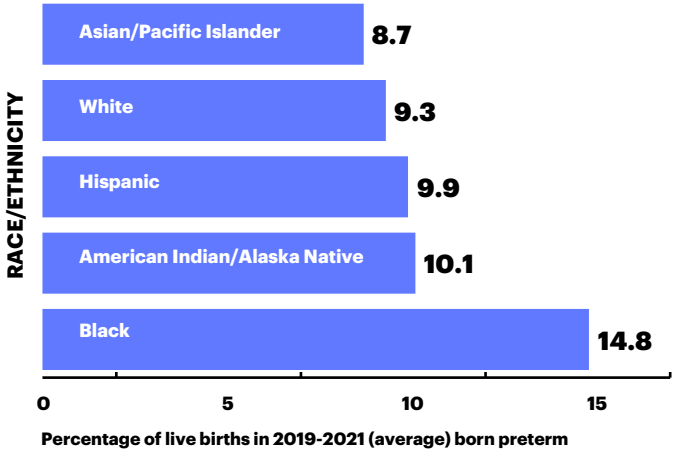

In Michigan, the preterm birth rate among Black women is 59% higher than the rate among all other women.

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
Detroit	F	15.1%	Worsened

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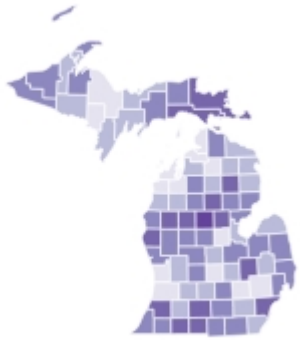

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28.1

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

13.1

PERCENT

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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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MINNESOTA

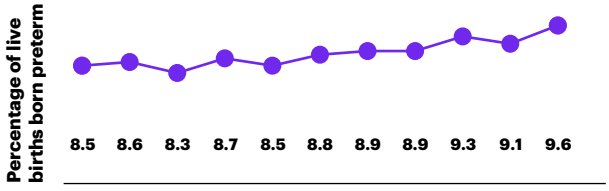
INFANT HEALTH

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.6%



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INFANT MORTALITY

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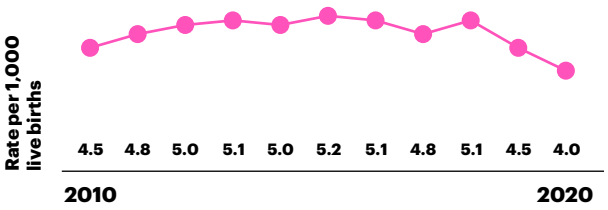
INFANT MORTALITY RATE

4.0



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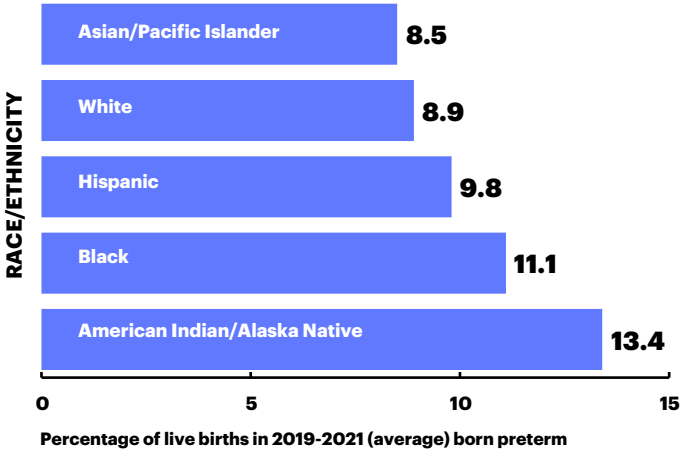

In Minnesota, the preterm birth rate among American Indian/Alaska Native women is 46% higher than the rate among all other women.

DISPARITY RATIO:

1.27

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Minneapolis	D+	10.7%	Worsened

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MINNESOTA

MATERNAL HEALTH

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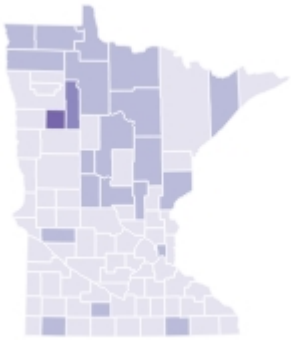

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

Your healthcare matters.

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25.5

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

9.6

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

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State has allowed for the passage of Medicaid coverage for doula care.

Legend

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MISSISSIPPI

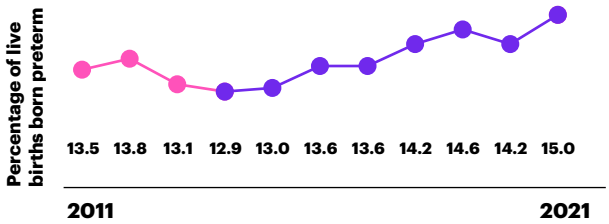
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

15.0%



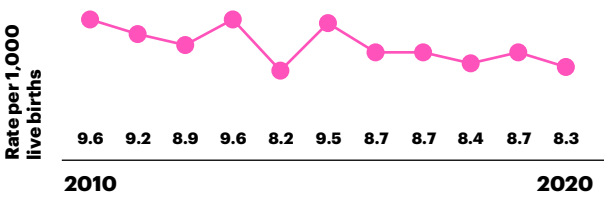
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

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

INFANT MORTALITY RATE

8.3



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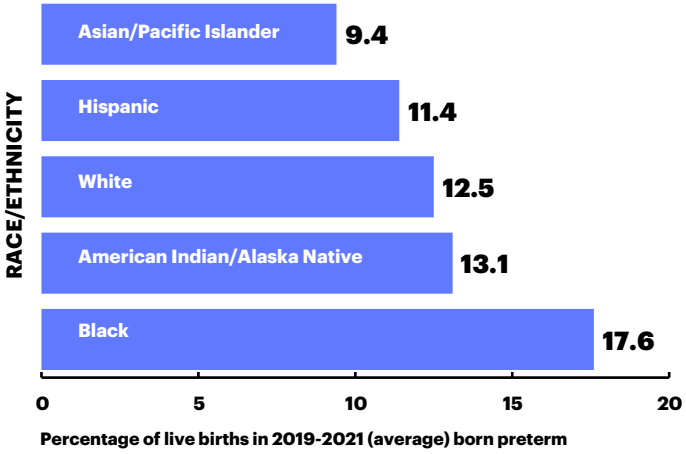

In Mississippi, the preterm birth rate among Black women is 43% higher than the rate among all other women.

DISPARITY RATIO:

1.45

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Jackson	F	18.1%	Worsened

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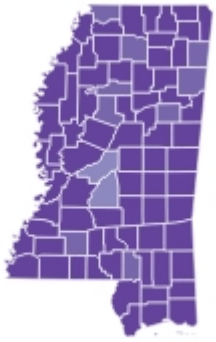

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

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31.2

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

13.7

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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MISSOURI

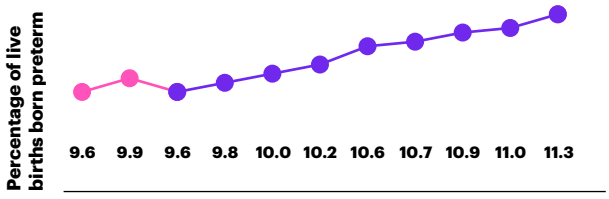
INFANT HEALTH

PRETERM BIRTH GRADE

D-

PRETERM BIRTH RATE

11.3%



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

INFANT MORTALITY

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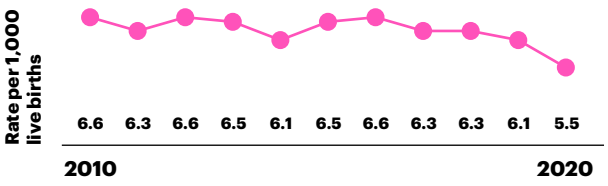
INFANT MORTALITY RATE

5.5



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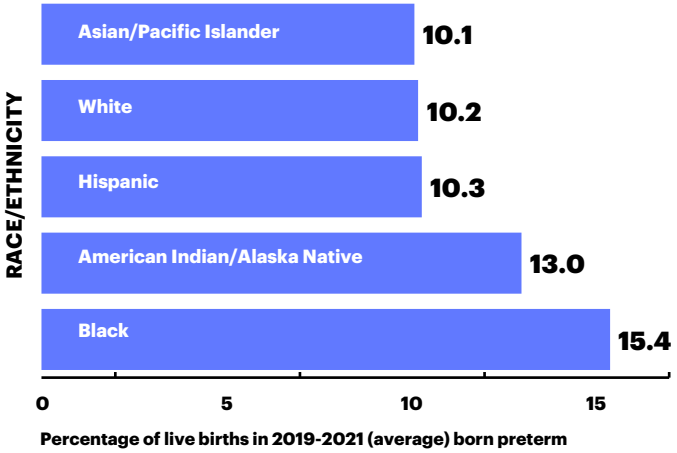

In Missouri, the preterm birth rate among Black women is 51% higher than the rate among all other women.

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
Kansas City	D	10.9%	Better

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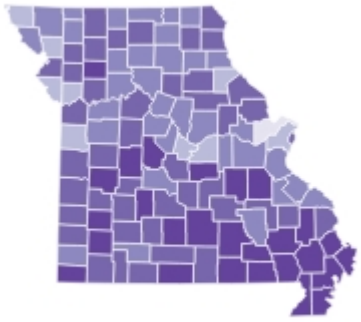

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

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24.3

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

14.3

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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MARCH OF DIMES

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MONTANA

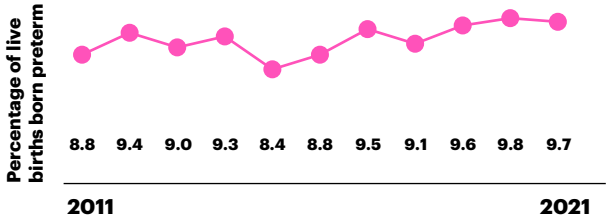
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.7%



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INFANT MORTALITY

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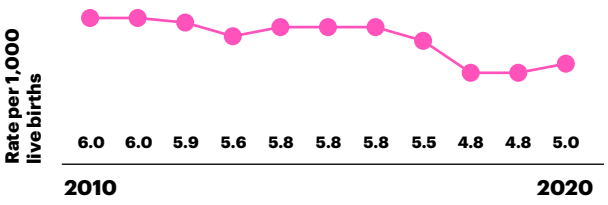
INFANT MORTALITY RATE

5.0



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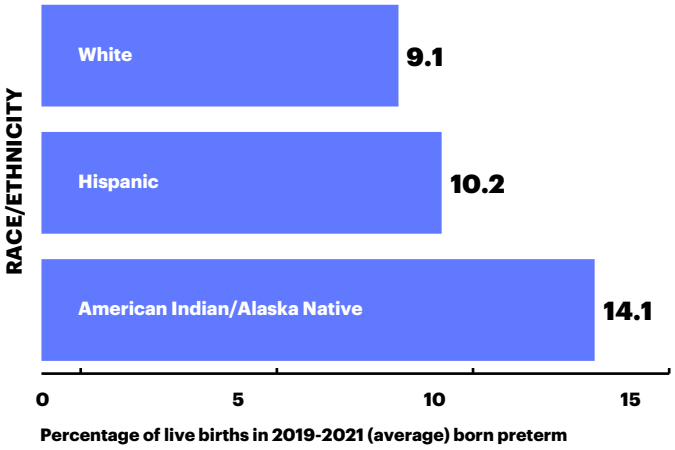

In Montana, the preterm birth rate among American Indian/Alaska Native women is 55% higher than the rate among all other women.

DISPARITY RATIO:

1.34

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Billings	A-	8.1%	Better

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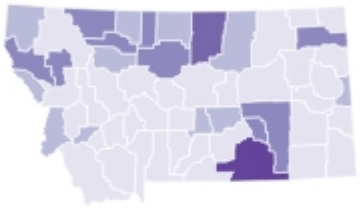

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22.1

PERCENT

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13.1

PERCENT

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NEBRASKA

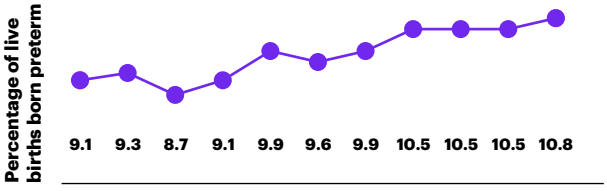
INFANT HEALTH

PRETERM BIRTH GRADE

D

PRETERM BIRTH RATE

10.8%



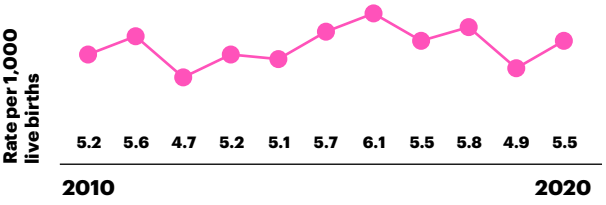
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

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

INFANT MORTALITY RATE

5.5



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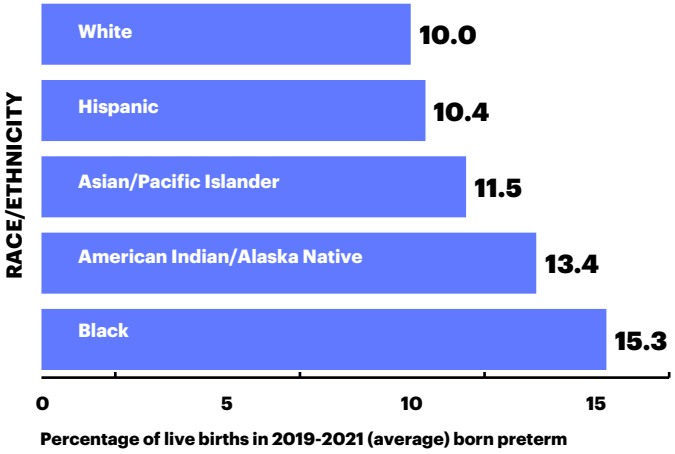
The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by 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. See Technical Notes for details.



In Nebraska, the preterm birth rate among Black women is 50% 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
Omaha	F	12.4%	Worsened

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NEBRASKA

MATERNAL HEALTH

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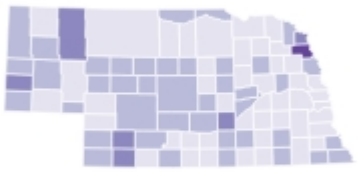

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

Your healthcare matters.

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22.3

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

12.3

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

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DOULA POLICY OR LEGISLATION

State has allowed for the passage of Medicaid coverage for doula care.

Legend

- State has the indicated organization/policy
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NEVADA

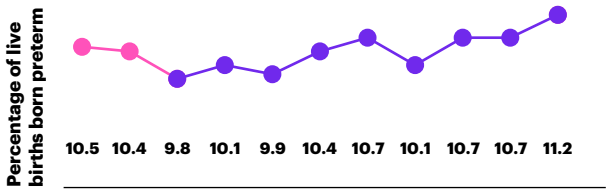
INFANT HEALTH

PRETERM BIRTH GRADE

D-

PRETERM BIRTH RATE

11.2%



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INFANT MORTALITY

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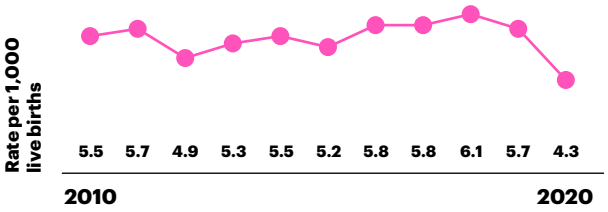
INFANT MORTALITY RATE

4.3



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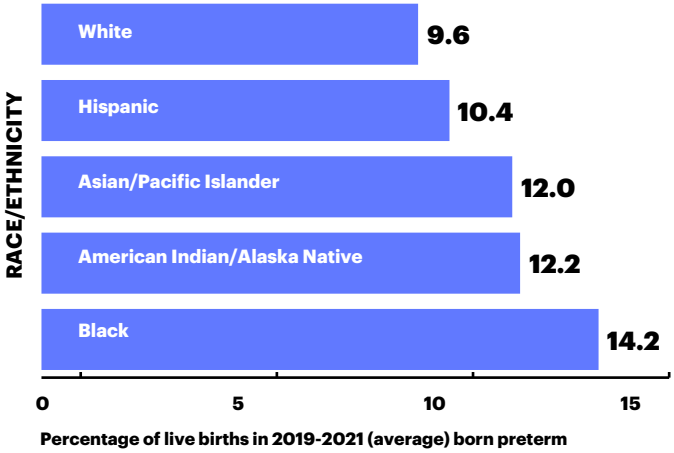

In Nevada, the preterm birth rate among Black women is 39% higher than the rate among all other women.

DISPARITY RATIO:

1.27

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Las Vegas	F	11.6%	Worsened

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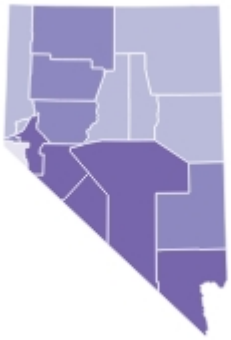

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

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26.6

PERCENT

26.3

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

15.0

PERCENT

14.5

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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State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

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HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

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NEW HAMPSHIRE

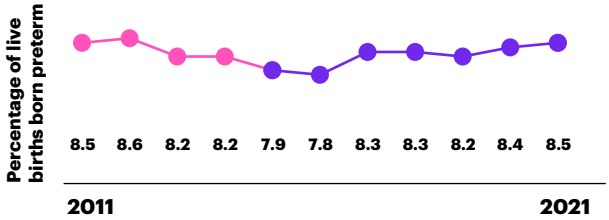
INFANT HEALTH

PRETERM BIRTH GRADE

B+

PRETERM BIRTH RATE

8.5%



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

INFANT MORTALITY

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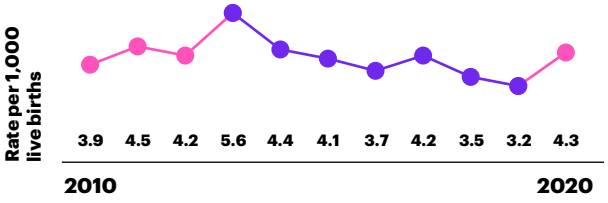
INFANT MORTALITY RATE

4.3



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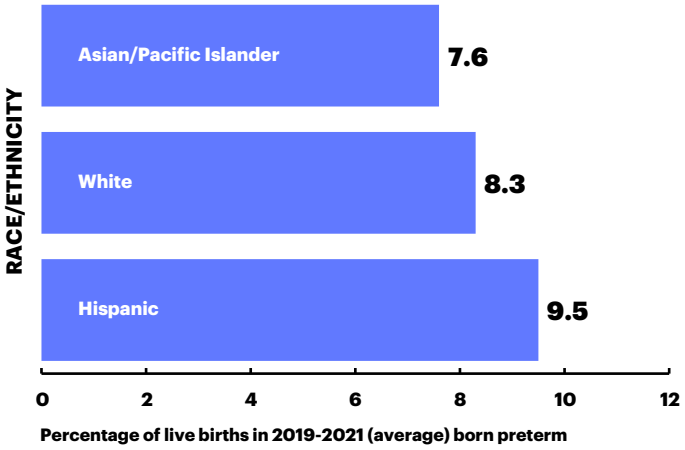

In New Hampshire, the preterm birth rate among Asian/Pacific Islander and Hispanic women is 16% higher than the rate among all other women.

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
Manchester	B	8.8%	Better

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28.5

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

9.4

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

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NEW JERSEY

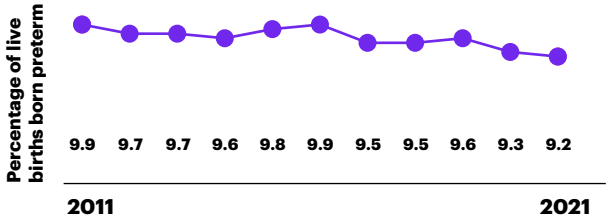
INFANT HEALTH

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.2%



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INFANT MORTALITY

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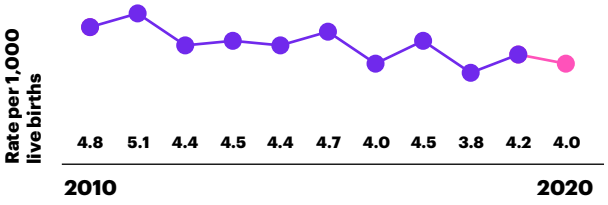
INFANT MORTALITY RATE

4.0



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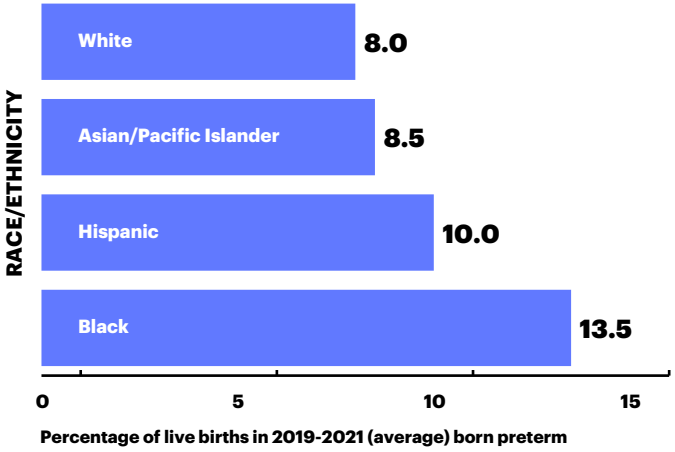

In New Jersey, the preterm birth rate among Black women is 55% higher than the rate among all other women.

DISPARITY RATIO:

1.33

CHANGE FROM BASELINE:

Worsened

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Newark	F	12.1%	Better

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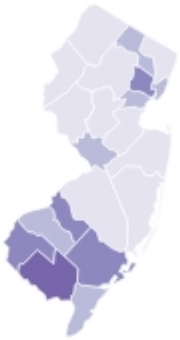

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PERCENT

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14.2

PERCENT

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NEW MEXICO

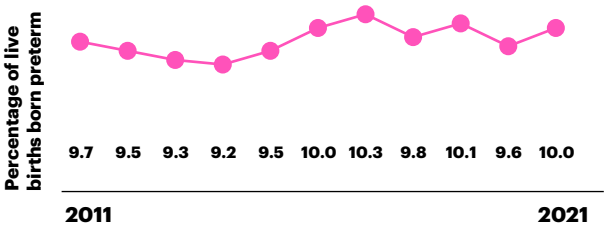
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

10.0%



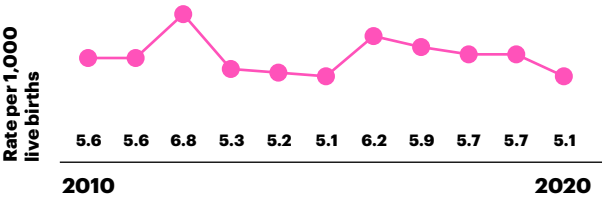
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

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

INFANT MORTALITY RATE

5.1



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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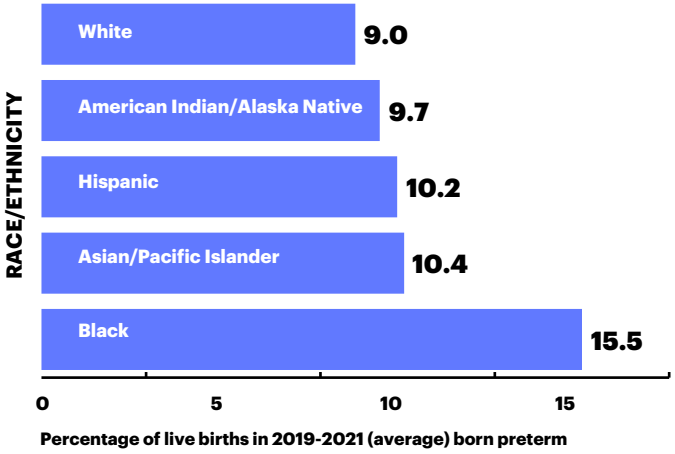

In New Mexico, the preterm birth rate among Black women is 58% higher than the rate among all other women.

DISPARITY RATIO:

1.16

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Albuquerque	C+	9.6%	Same

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NEW MEXICO

MATERNAL HEALTH

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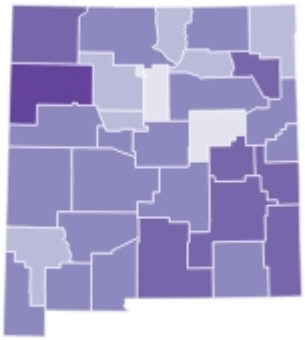

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

Your healthcare matters.

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22.3

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

21.4

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE (MMRC)

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DOULA POLICY OR LEGISLATION

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Legend

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NEW YORK

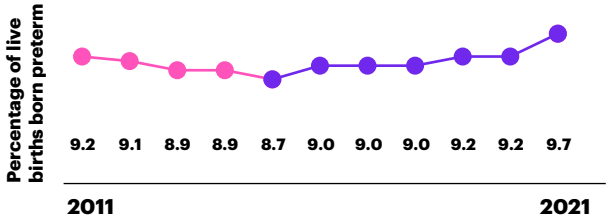
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.7%



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INFANT MORTALITY

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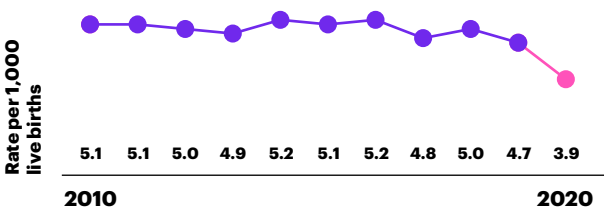
INFANT MORTALITY RATE

3.9



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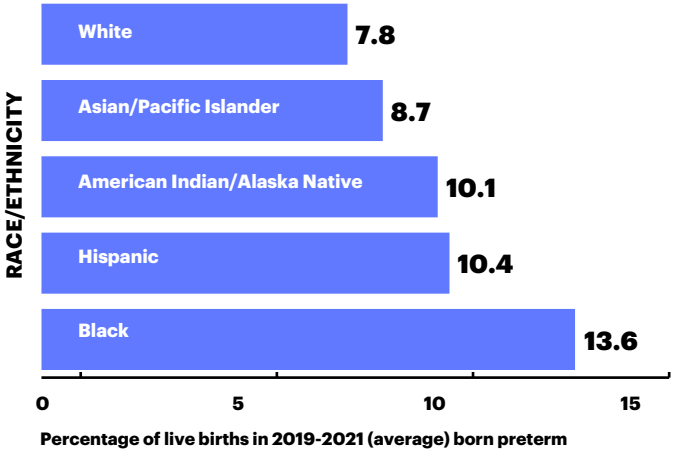

In New York, the preterm birth rate among Black women is 58% higher than the rate among all other women.

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
New York	C	9.8%	Worsened

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NEW YORK

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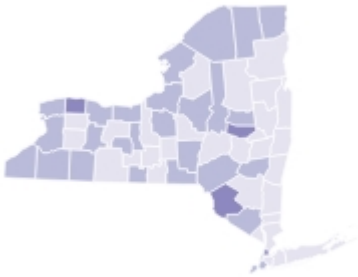

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

Your healthcare matters.

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29.8

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

12.7

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

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NORTH CAROLINA

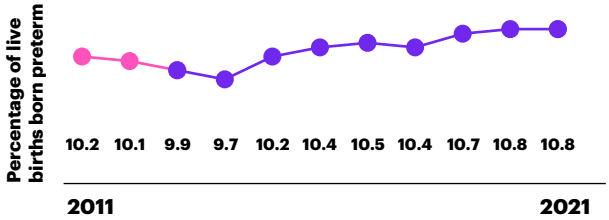
INFANT HEALTH

PRETERM BIRTH GRADE

D

PRETERM BIRTH RATE

10.8%



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INFANT MORTALITY

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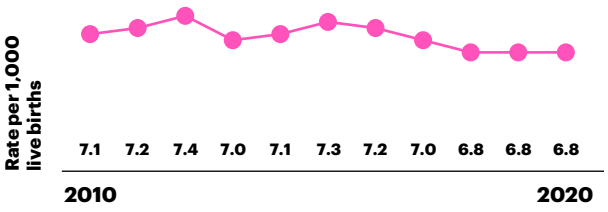
INFANT MORTALITY RATE

6.8



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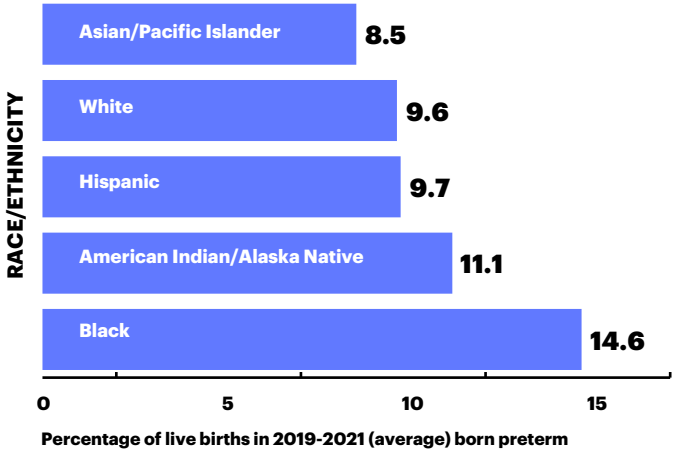

In North Carolina, the preterm birth rate among Black women is 52% higher than the rate among all other women.

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
Charlotte	D+	10.5%	Worsened

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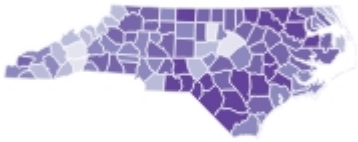

Very Low	Low	Moderate	High	Very High
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24.0

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

16.9

PERCENT

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MARCH OF DIMES

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NORTH DAKOTA

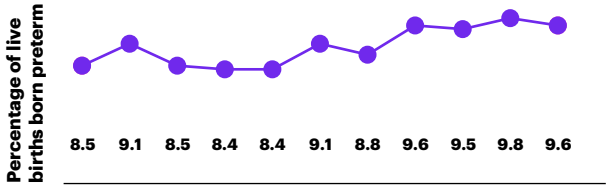
INFANT HEALTH

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.6%



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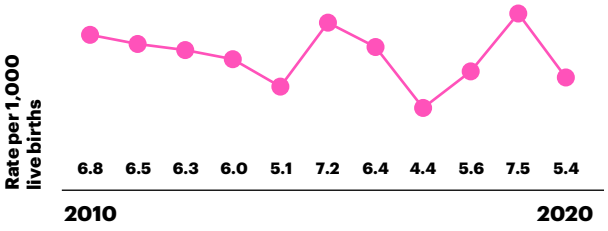
INFANT MORTALITY RATE

5.4



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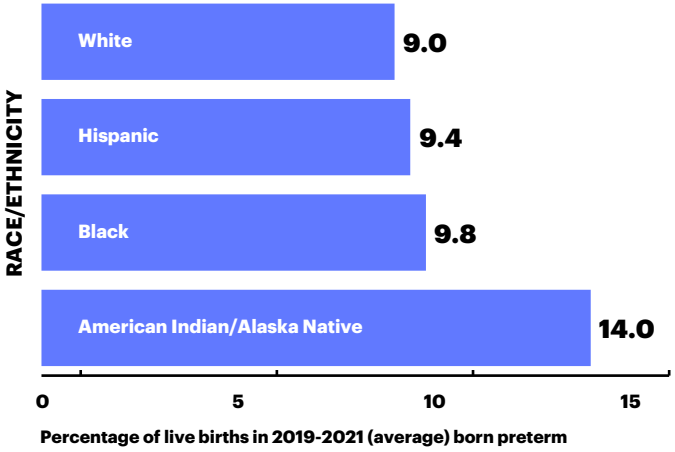

In North Dakota, the preterm birth rate among American Indian/Alaska Native women is 54% higher than the rate among all other women.

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
Fargo	C	9.8%	Better

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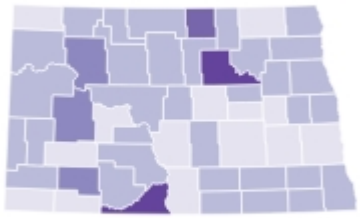

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20.1

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

12.9

PERCENT

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State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

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Legend

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OHIO

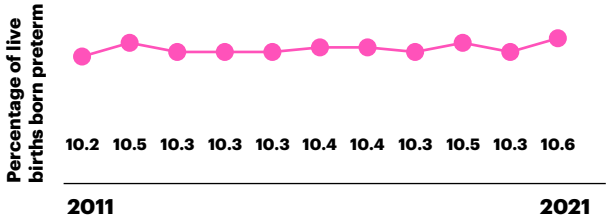
INFANT HEALTH

PRETERM BIRTH GRADE

D+

PRETERM BIRTH RATE

10.6%



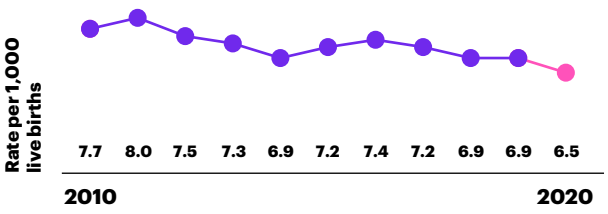
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

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

INFANT MORTALITY RATE

6.5



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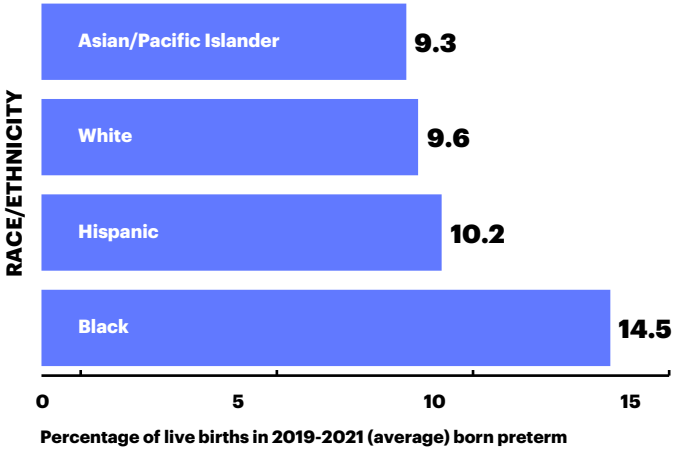

In Ohio, the preterm birth rate among Black women is 51% higher than the rate among all other women.

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
Columbus	F	12.2%	Worsened

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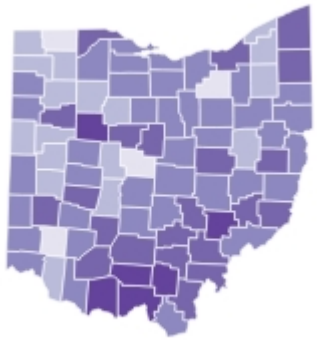

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

Your healthcare matters.

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26.0

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

13.8

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

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MARCH OF DIMES

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OKLAHOMA

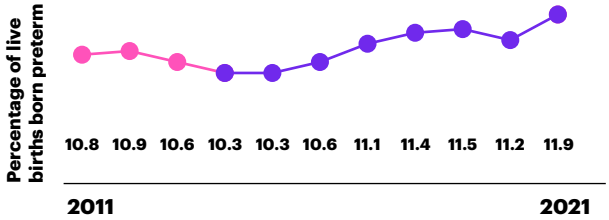
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

11.9%



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INFANT MORTALITY

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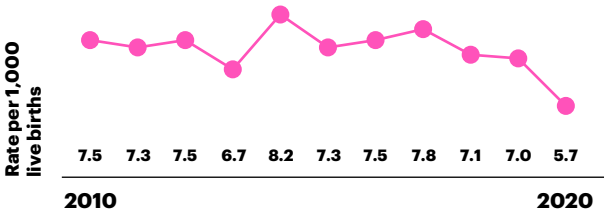
INFANT MORTALITY RATE

5.7



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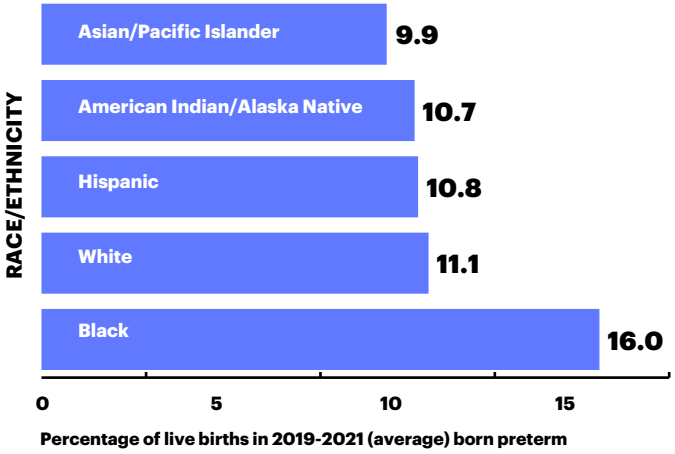

In Oklahoma, the preterm birth rate among Black women is 45% higher than the rate among all other women.

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
Oklahoma City	F	12.4%	Worsened

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OKLAHOMA

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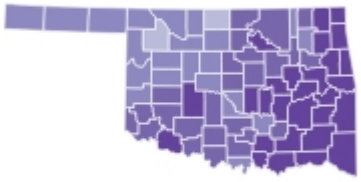

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

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24.4

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

14.2

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

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OREGON

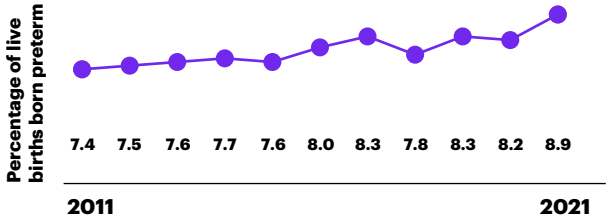
INFANT HEALTH

PRETERM BIRTH GRADE

B

PRETERM BIRTH RATE

8.9%



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INFANT MORTALITY

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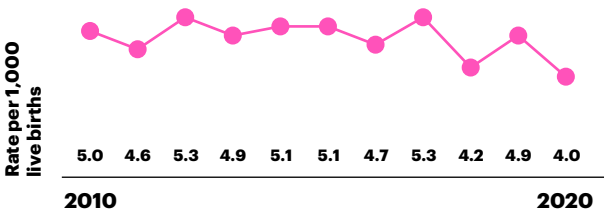
INFANT MORTALITY RATE

4.0



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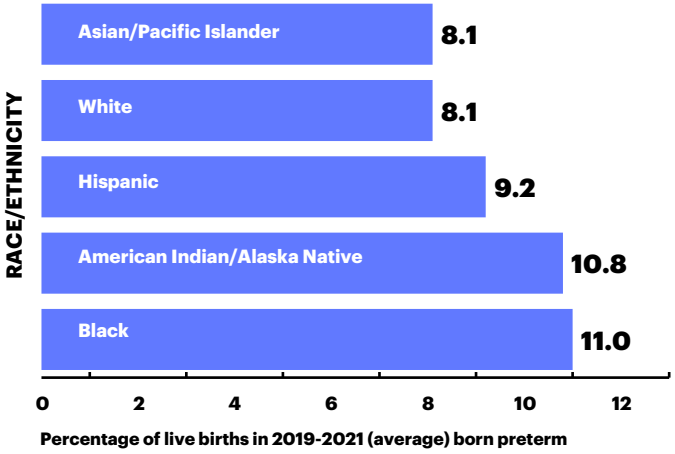

In Oregon, the preterm birth rate among Black women is 33% higher than the rate among all other women.

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
Portland	B-	9.0%	Worsened

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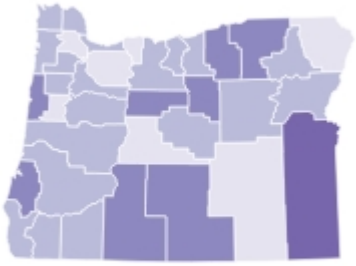

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25.0

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

10.3

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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PENNSYLVANIA

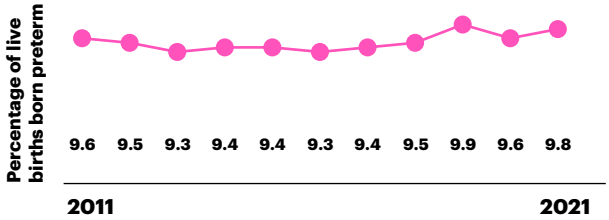
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.8%



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INFANT MORTALITY

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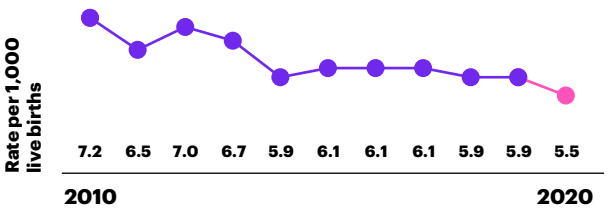
INFANT MORTALITY RATE

5.5



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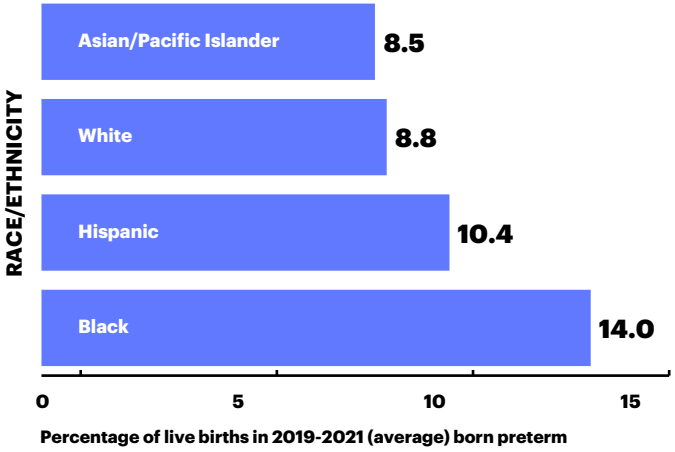

In Pennsylvania, the preterm birth rate among Black women is 56% higher than the rate among all other women.

DISPARITY RATIO:

1.30

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Philadelphia	F	11.5%	Worsened

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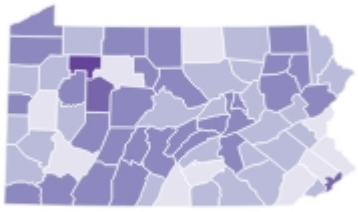

Very Low	Low	Moderate	High	Very High
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CLINICAL MEASURES

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25.3

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

15.5

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

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State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

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PERINATAL QUALITY COLLABORATIVE (PQC)

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DOULA POLICY OR LEGISLATION

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Legend

- ✓ State has the indicated organization/policy
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STARK AND UNACCEPTABLE DISPARITIES PERSIST ALONGSIDE A TROUBLING RISE IN PRETERM BIRTH RATES

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HEALTHY MOMS. STRONG BABIES.

MARCH OF DIMES

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RHODE ISLAND

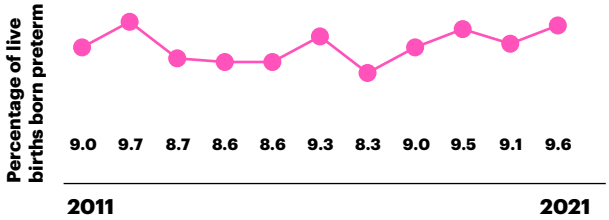
INFANT HEALTH

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.6%



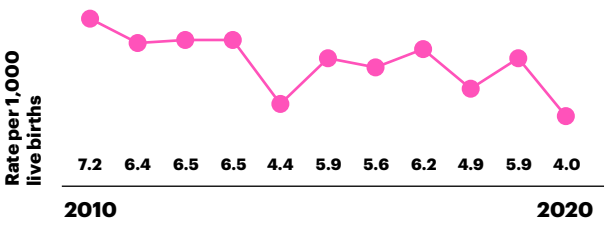
Purple (darker) color shows a significant trend (p <= .05)

INFANT MORTALITY

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

INFANT MORTALITY RATE

4.0



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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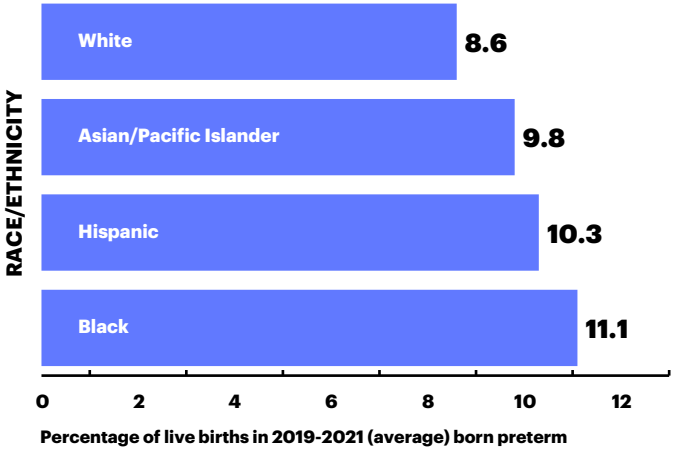

In Rhode Island, the preterm birth rate among Black women is 21% higher than the rate among all other women.

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
Providence	D-	11.2%	Worsened

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RHODE ISLAND

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Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

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.

29.0

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

5.0

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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SOUTH CAROLINA

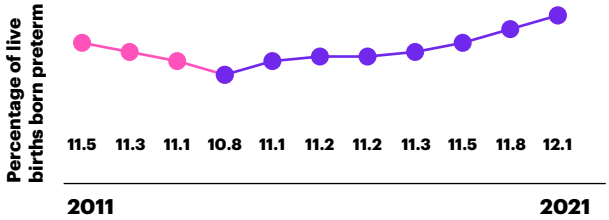
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

12.1%



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INFANT MORTALITY

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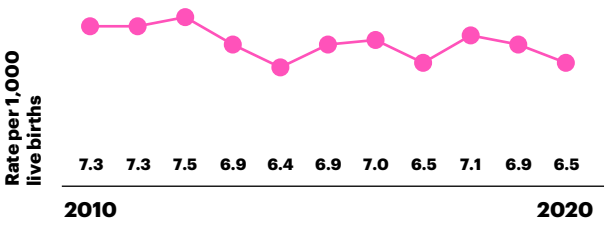
INFANT MORTALITY RATE

6.5



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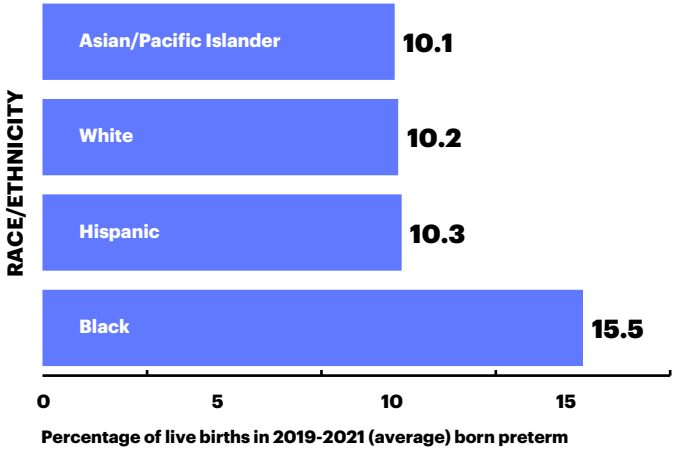

In South Carolina, the preterm birth rate among Black women is 52% higher than the rate among all other women.

DISPARITY RATIO:

1.19

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Columbia	D	10.8%	Better

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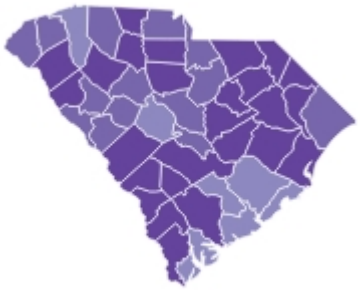

Very Low	Low	Moderate	High	Very High
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27.0

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

18.0

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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SOUTH DAKOTA

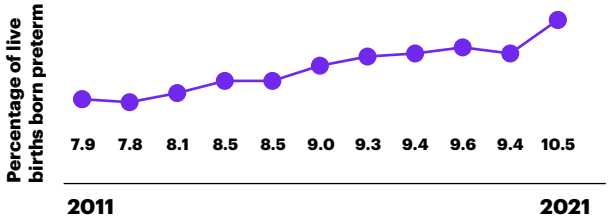
INFANT HEALTH

PRETERM BIRTH GRADE

D+

PRETERM BIRTH RATE

10.5%



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INFANT MORTALITY

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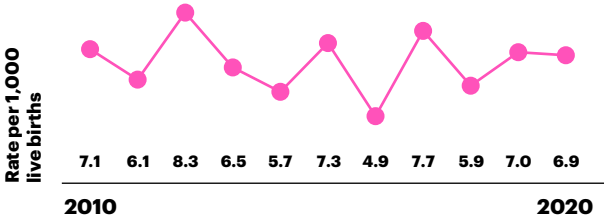
INFANT MORTALITY RATE

6.9



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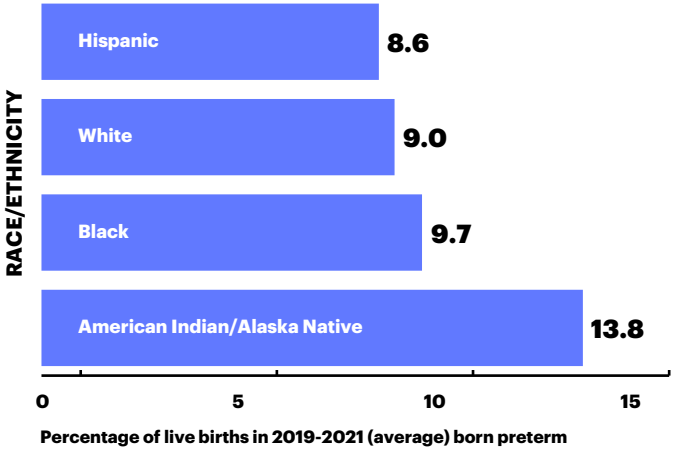

In South Dakota, the preterm birth rate among American Indian/Alaska Native women is 53% higher than the rate among all other women.

DISPARITY RATIO:

1.19

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Sioux Falls	C-	10.2%	Worsened

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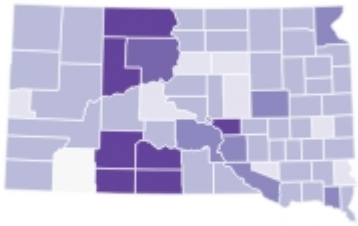

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18.2

PERCENT

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16.2

PERCENT

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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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TENNESSEE

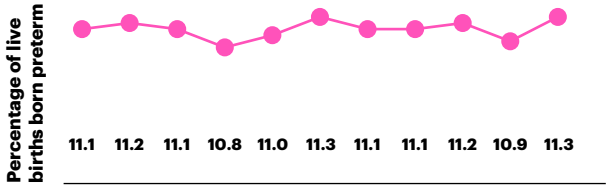
INFANT HEALTH

PRETERM BIRTH GRADE

D-

PRETERM BIRTH RATE

11.3%



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INFANT MORTALITY

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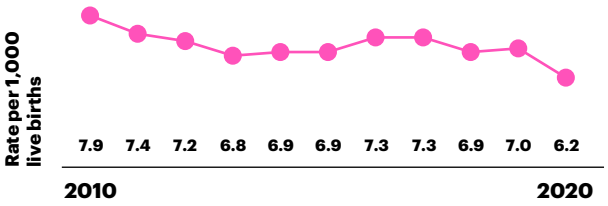
INFANT MORTALITY RATE

6.2



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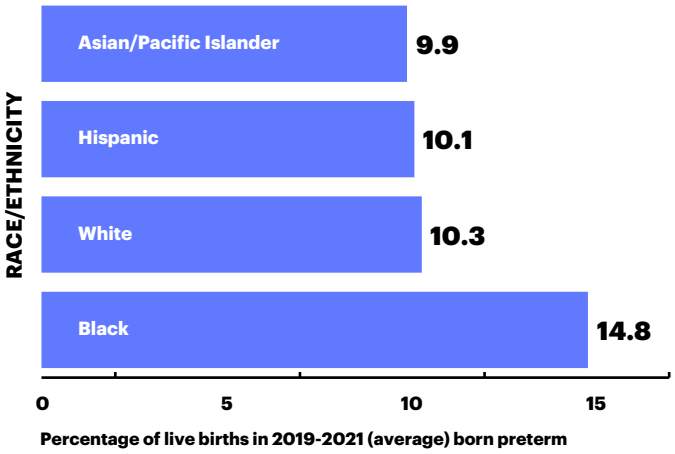

In Tennessee, the preterm birth rate among Black women is 45% higher than the rate among all other women.

DISPARITY RATIO:

1.19

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Nashville-Davidson, TN	D	10.9%	Worsened

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TENNESSEE

MATERNAL HEALTH

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Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

Your healthcare matters.

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26.6

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

17.1

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.

POLICY MEASURES

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

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

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DOULA POLICY OR LEGISLATION

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Legend

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TEXAS

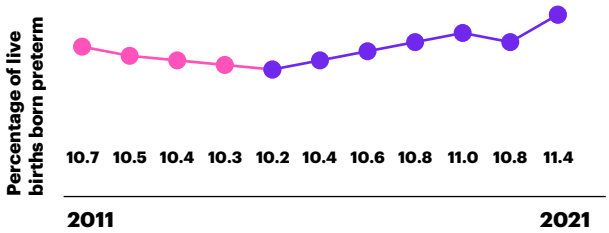
INFANT HEALTH

PRETERM BIRTH GRADE

D-

PRETERM BIRTH RATE

11.4%



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

INFANT MORTALITY

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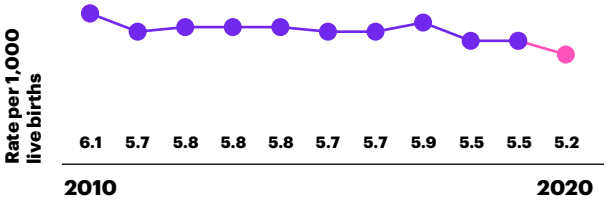
INFANT MORTALITY RATE

5.2



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PRETERM BIRTH RATE BY RACE AND ETHNICITY

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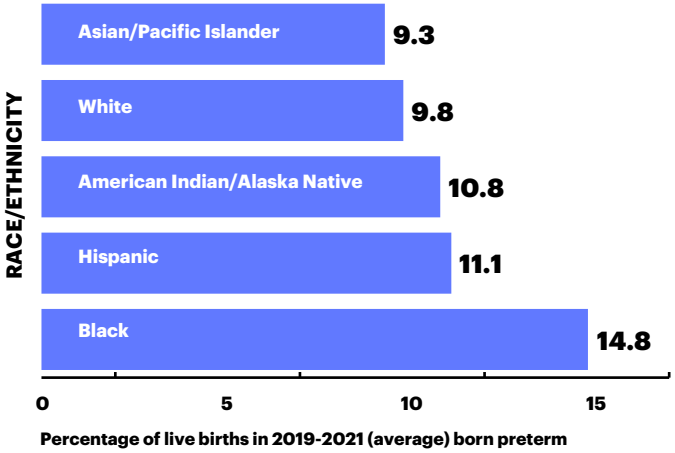

In Texas, the preterm birth rate among Black women is 41% higher than the rate among all other women.

DISPARITY RATIO:

1.25

CHANGE FROM BASELINE:

Worsened

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Houston	F	12.3%	Worsened

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28.3

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

19.8

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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MARCH OF DIMES

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UTAH

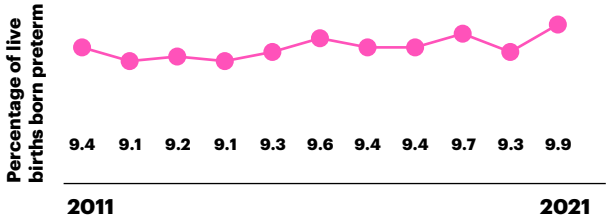
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.9%



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INFANT MORTALITY

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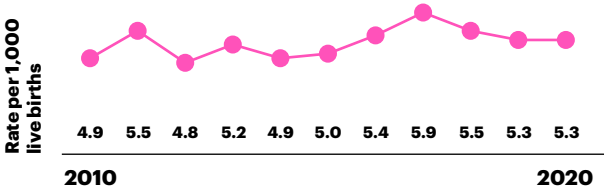
INFANT MORTALITY RATE

5.3



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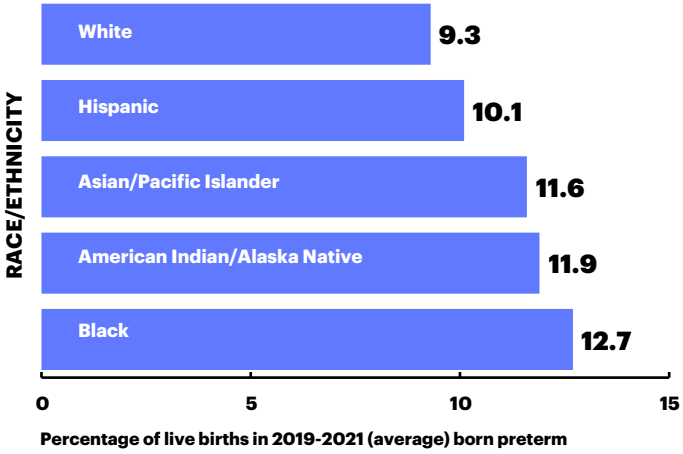

In Utah, the preterm birth rate among Black women is 32% higher than the rate among all other women.

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
Salt Lake City	D+	10.4%	Worsened

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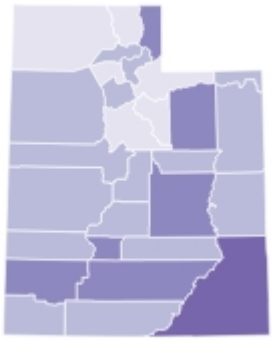

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19.4

PERCENT

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9.5

PERCENT

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VERMONT

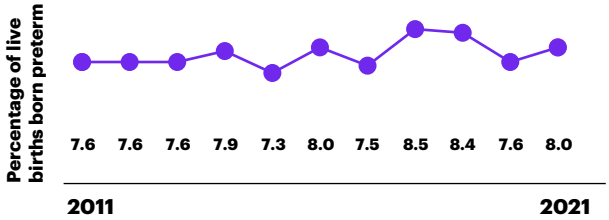
INFANT HEALTH

PRETERM BIRTH GRADE

A-

PRETERM BIRTH RATE

8.0%



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INFANT MORTALITY

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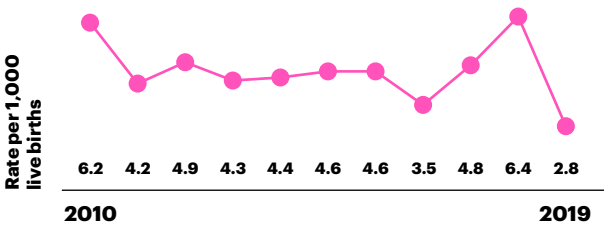
INFANT MORTALITY RATE

2.8



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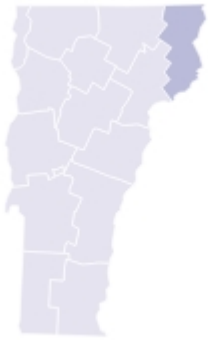

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VIRGINIA

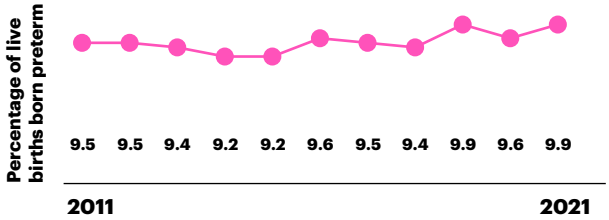
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.9%



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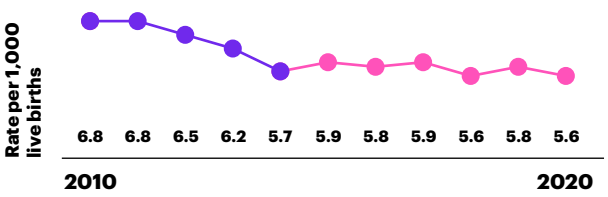

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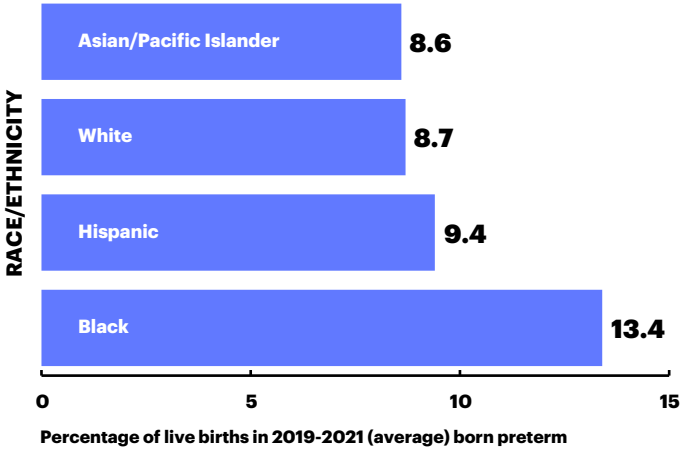

In Virginia, the preterm birth rate among Black women is 52% higher than the rate among all other women.

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
Virginia Beach	C-	10.2%	Worsened

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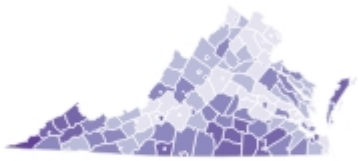

Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

CLINICAL MEASURES

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26.7

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

13.0

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

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DOULA POLICY OR LEGISLATION

State has allowed for the passage of Medicaid coverage for doula care.

Legend

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WASHINGTON

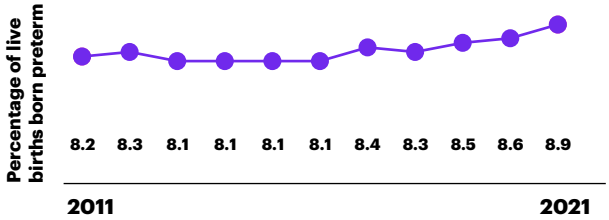
INFANT HEALTH

PRETERM BIRTH GRADE

B

PRETERM BIRTH RATE

8.9%



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

INFANT MORTALITY

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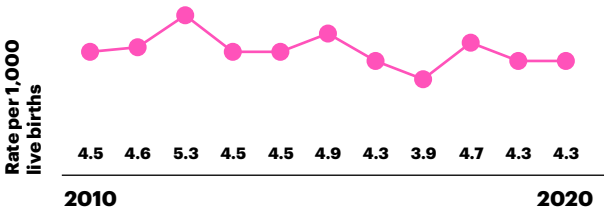
INFANT MORTALITY RATE

4.3



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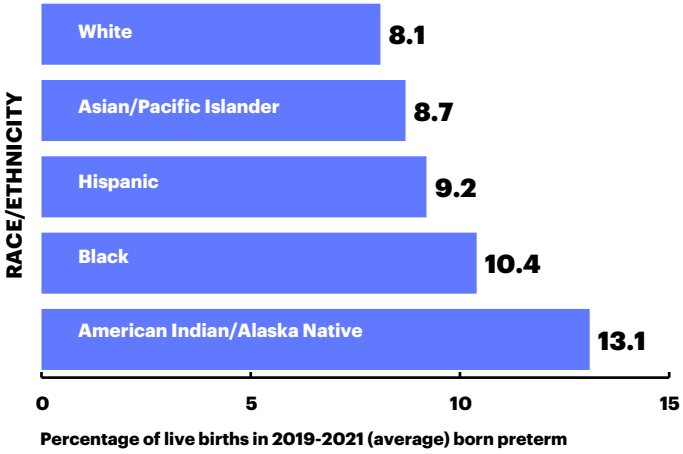

In Washington, the preterm birth rate among American Indian/Alaska Native women is 52% higher than the rate among all other women.

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	B	8.6%	Worsened

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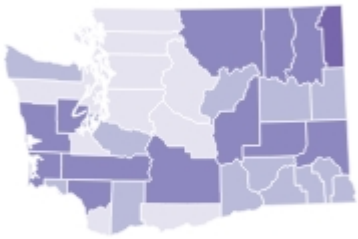

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24.4

PERCENT

26.3

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

14.9

PERCENT

14.5

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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WEST VIRGINIA

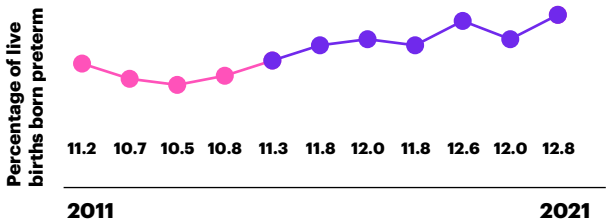
INFANT HEALTH

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

12.8%



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INFANT MORTALITY

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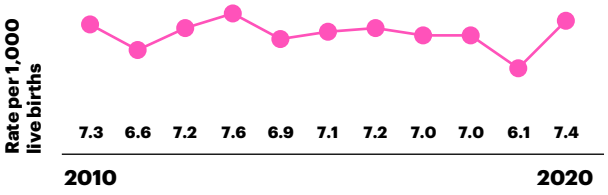
INFANT MORTALITY RATE

7.4



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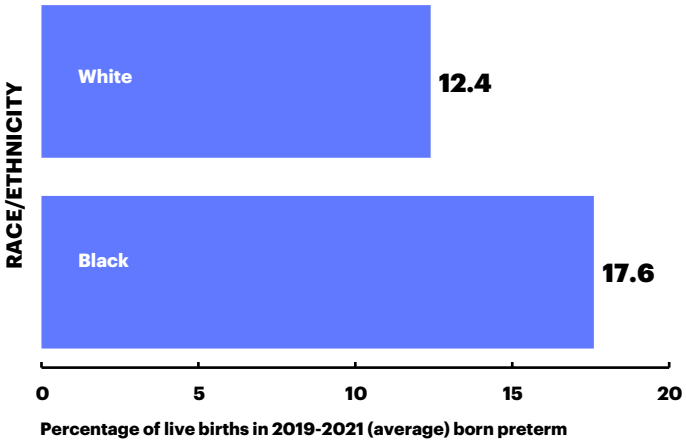

In West Virginia, the preterm birth rate among Black women is 42% higher than the rate among all other women.

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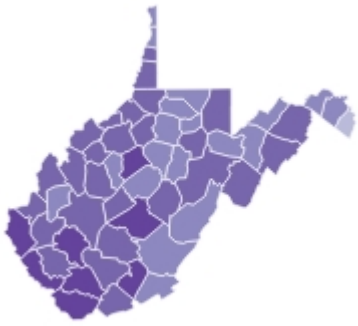

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14.5

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WISCONSIN

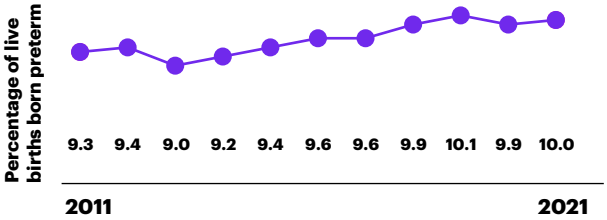
INFANT HEALTH

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

10.0%



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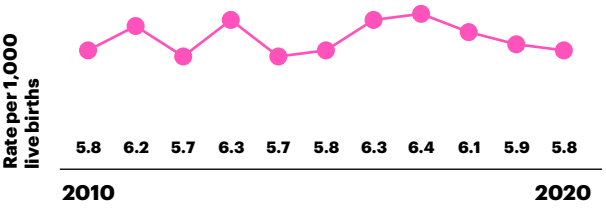
INFANT MORTALITY RATE

5.8



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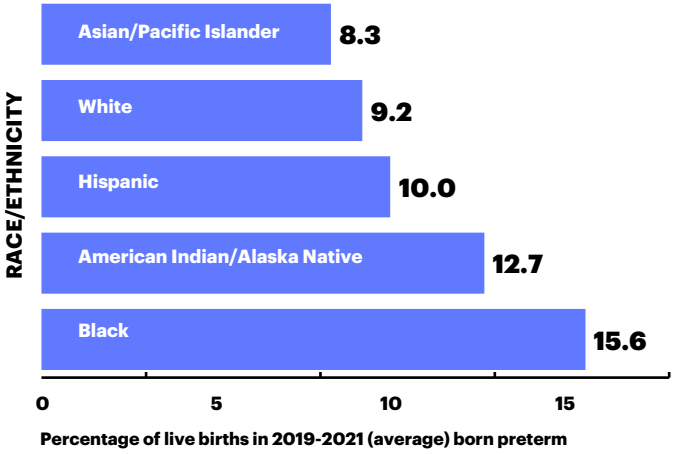

In Wisconsin, the preterm birth rate among Black women is 68% higher than the rate among all other women.

DISPARITY RATIO:

1.43

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Milwaukee	F	12.2%	Better

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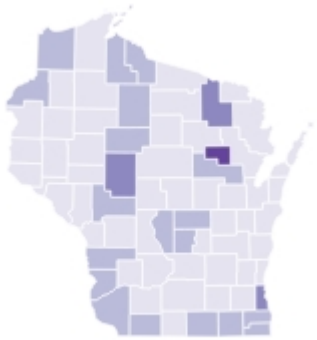

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PERCENT

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11.0

PERCENT

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WYOMING

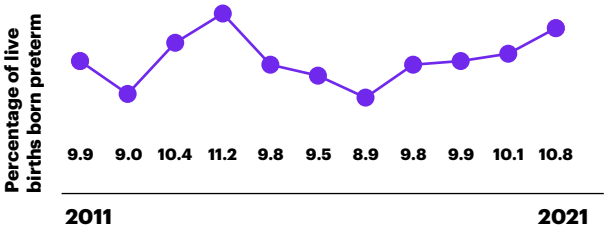
INFANT HEALTH

PRETERM BIRTH GRADE

D

PRETERM BIRTH RATE

10.8%



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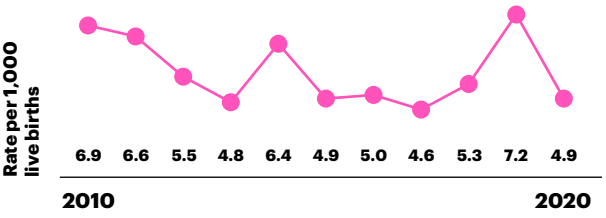
4.9



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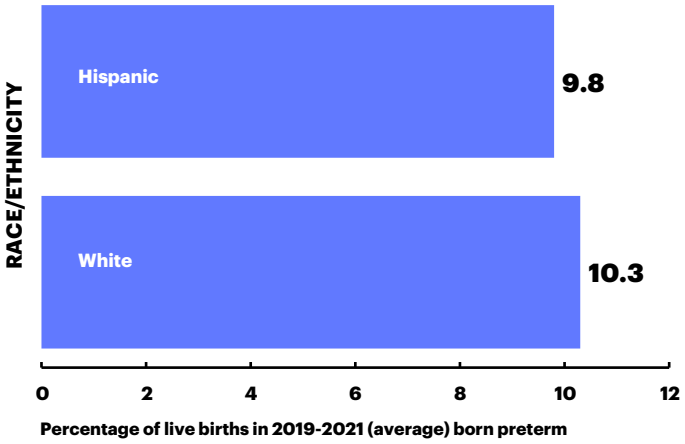

In Wyoming, the preterm birth rate among White women is 5% higher than the rate among all other women.

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STARK AND UNACCEPTABLE DISPARITIES PERSIST ALONGSIDE A TROUBLING RISE IN PRETERM BIRTH RATES

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WYOMING

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, among other factors.

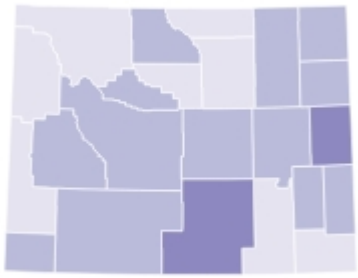
MATERNAL VULNERABILITY INDEX

Where you live matters.

March of Dimes, in partnership with Surgo Ventures, examines determinants of maternal health using the **Maternal Vulnerability Index (MVI)***. The MVI is the first county-level, national-scale tool to identify where and why moms in the U.S. are vulnerable to poor pregnancy outcomes and pregnancy-related deaths. The MVI includes not only widely known clinical risk factors, but also key social, contextual, and environmental factors that are essential influencers of health outcomes.

*Visit https://mvi.surgoventures.org/ for more information.

Differences in counties are measured using numerous factors broken into six themes: reproductive healthcare, physical health, mental health and substance abuse, general healthcare, socioeconomic determinants and physical environment. The MVI assigns a score of 0-100 to each geography, where a higher score indicates greater vulnerability to adverse maternal outcomes.



Very Low	Low	Moderate	High	Very High
0-19.9	20-39.9	40-59.9	60-79.9	80-100

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.

20.3

PERCENT

26.3

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

12.6

PERCENT

14.5

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

State policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MEDICAID EXPANSION

State has adopted this policy to allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

MIDWIFERY POLICY

State allows for Medicaid reimbursement at 90% and above for certified nurse midwives.

MATERNAL MORTALITY REVIEW COMMITTEE (MMRC)

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

PERINATAL QUALITY COLLABORATIVE (PQC)

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

DOULA POLICY OR LEGISLATION

State has allowed for the 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.

2022 MARCH OF DIMES REPORT CARD

The 2022 March of Dimes Report Card highlights the latest key indicators to describe and improve maternal and infant health. We continue to provide updated measures on preterm birth, infant mortality, low-risk Cesarean births and inadequate prenatal care. New this year is the inclusion of the Maternal Vulnerability Index (MVI), which provides county-level indicators of where women are most vulnerable to poor outcomes. Our Supplemental Report Card summarizes state-level progress towards selected Healthy People 2030 pregnancy and childbirth health objectives, outcomes by race/ethnicity and describes March of Dimes programmatic initiatives. We continue to monitor disparities in maternal and infant health. Comprehensive data collection and analysis of these measures inform the development of policies and programs that move us closer to health equity. The Report Card presents 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.

PUERTO RICO

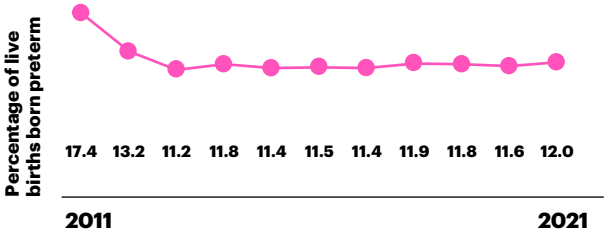
INFANT HEALTH

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, preterm birth, low birth weight, maternal complications and sudden infant death syndrome (SIDS).

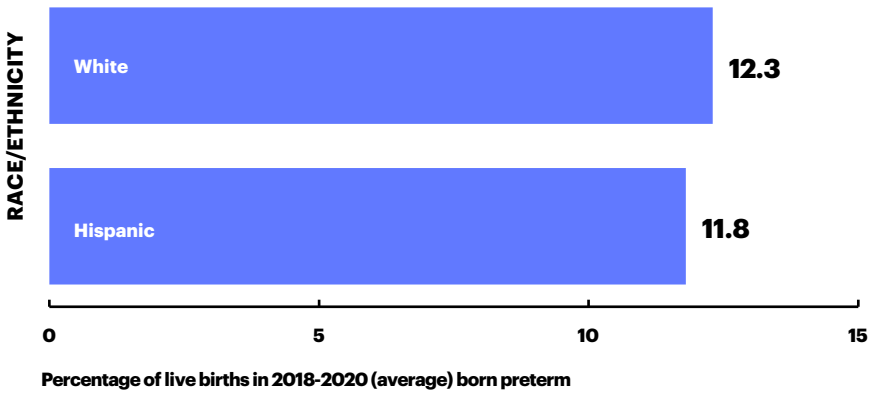
INFANT MORTALITY RATE

6.9

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

PRETERM BIRTH RATE BY RACE AND ETHNICITY

Many structural, systemic, and environmental factors influence the health of mothers and babies, especially for Black, Native American, and Hispanic people. This describes preterm birth by maternal race and ethnicity in Puerto Rico using race and ethnicity categories. By first understanding where differences exist, we can then move forward to advocate for changes towards health equity.



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PUERTO RICO

PRETERM BIRTH RATE BY MUNICIPALITY

MUNICIPALITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Bayamón	B-	9.1	Improved
Caguas	F	13.5	Worsened
Carolina	C+	9.3	Improved
Ponce	D-	11.2	Improved
San Juan	C-	10.1	Improved

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, among other factors.

CLINICAL MEASURE

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.

47.5

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

POLICY MEASURES

Policies matter. Adoption of the following policies and organizations can help improve maternal and infant healthcare.

MATERNAL MORTALITY REVIEW COMMITTEE (MMRC)

Territory has a MMRC, which is recognized as essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE (PQC)

Territory has a PQC to identify and improve quality care issues in maternal and infant healthcare.

DOULA POLICY OR LEGISLATION

Territory has allowed for the passage of Medicaid coverage for doula care.

Legend

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