UNIVERSITY OF KANSAS SCHOOL OF NURSING

Access to Maternity Care in Kansas

UNITED METHODIST HEALTH MINISTRY FUND

Acknowledgments

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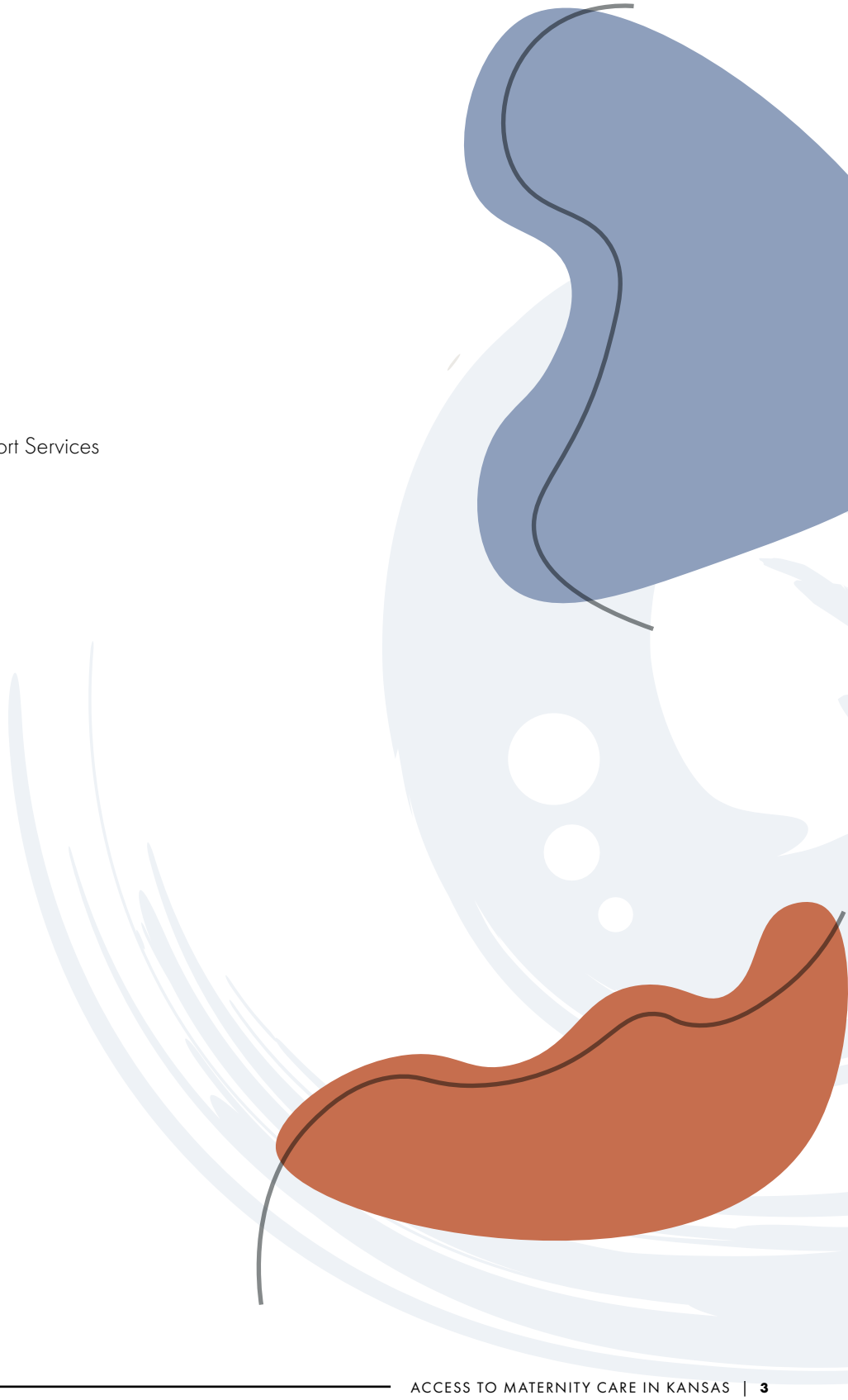


Executive Summary

OVERVIEW

Women in the United States who are pregnant, in labor, delivering a baby, or recovering from childbirth are twice as likely to be ill or die than they were 20 years ago.[1] This is known as maternal morbidity (illness) and mortality (death).

There is a direct correlation between the increase in maternal morbidity and mortality with the decrease in access to hospitals, doctors, nurses and other maternity care providers in rural areas. These differences exist across race, ethnicity, and geography and are multi-dimensional.

It takes a complex health care team and a network of community services to ensure comprehensive maternity care services. As critical access hospitals and clinics close or reduce their maternity care services, Kansas women must drive increasing distances to access basic care.

High-risk moms and babies may require medical appointments that necessitate traveling or relocating to metro areas like Wichita, Topeka, or Kansas City to access these maternal care services. Telemedicine can help with access to care. But when a mother or baby are moderate or high risk they need access to a team of well trained doctors, nurses and anesthesiologists with the right equipment at the right time in the right place. We must also keep in mind that any pregnant woman can become moderate or high risk at any point during the pregnancy or delivery.

Nationally, the 2024 report from the March of Dimes indicated that at least 35% of U.S. counties are defined as maternity care deserts[1], and the 2019 American Hospital Association Annual Survey found that 51% of rural hospitals in the U.S. did not provide maternity care.[2]

Maternity care deserts are not necessarily due to the absence of a hospital or clinic in the community. In many rural Kansas communities there are hospitals and/or clinics, but these facilities are not offering maternity care.

Kansas is not the only state facing these challenges. Six predominately rural states (North Dakota, Florida, Virginia, Alaska, Nevada and South Dakota) had no hospital-based obstetric services in more than two-thirds of their rural counties.[3]

This report describes the Kansas maternity care deserts, including the county-level information about the primary resources required to provide maternity care to Kansas mothers and babies.

Decreased access to maternity care harms Kansas communities by threatening the lives of mothers and babies. Over 46% of Kansas women live in a county without access to these maternity care services, and Kansas is second only to Texas in terms of the number of counties that are considered rural.[4]

These statistics indicate that the problem of access to maternity care and the number of hospitals at risk of closing is not new, but worsening.

Kansas must work to protect the services we do have and add structures to improve access to maternity care. Maps in this report illustrate the rural areas where investing in health care will save the lives of mothers and babies. Detailed information about the types of providers that are needed will help Kansans make better decisions so that communities thrive.

KEY FINDINGS

This report details the availability of low- to high-risk maternity services in Kansas, including the facilities and health care providers that are available in each county. It also provides insight into the significant challenges that a large number of Kansans face when attempting to access maternity care.

Disparities in maternal health outcomes exist for a complex variety of reasons including socioeconomic status, race/ethnicity, level of education, access to health care, and systemic racism. Additionally, structural racism, including implicit biases in the health care system, can significantly impact maternal health disparities. For example, Black Kansas mothers experience serious health complications during or after pregnancy and childbirth at a rate of 103.5 per 10,000 hospitalized deliveries, according to the Kansas Department of Health and Environment, which studied rates from 2016-2020. We acknowledge that these factors require further investigation, the purpose of this report is to provide an in-depth analysis of location of services in Kansas to capture access to services.

This report is based on data from 2022, 2023 and 2024. Since the data were gathered, additional facilities in western Kansas have either closed or paused both their outpatient (prenatal) and inpatient (labor and delivery) services, exacerbating the problems.

DISTANCE TO MATERNITY CARE

The growing maternity care desert is causing an increasing number of Kansans to travel up to 60 miles for low-risk prenatal/postpartum and labor and delivery care, particularly in the central and southwest corners of the state (see page 30).

INPATIENT MATERNITY SERVICES

59% of Kansans do not have local access to inpatient maternity care services (see page 27).

There is a higher proportional need for care in western Kansas. Two counties reflecting the highest relative need for maternal health care (Wallace county and Grant county) are on the western border of Kansas, with no health care system offering maternity care in either county. The approximate straight-line distance to inpatient maternity care for those residing in each county is 50 miles and 24 miles respectively (see page 33).

HIGH-RISK MATERNITY CARE SERVICES

The availability of services for women with high-risk pregnancies is extremely limited. Telehealth and teleradiology services provide an avenue for specialists in high-risk pregnancy to provide prenatal assessment. However, mothers needing to be delivered in hospitals with specially trained providers (both maternal and baby) must travel vast distances. Close to 30% of ZIP codes in Kansas are more than 100 miles away from tertiary, high-risk services (see page 34).

DISPARITIES IN ANESTHESISA SERVICES

There are 42 counties in Kansas without any documented anesthesia providers. The majority of the 42 counties are located on the western side of the state, with the growing maternity care desert (see page 43).

THE UNRECOGNIZED COSTS OF PROVIDING MATERNITY CARE

Maternity care requires a specially trained interdisciplinary team of multiple providers and nurses for 24/7/365 coverage of services. Meeting the need requires costly contracts that include coverage for anesthesia, nursing, respiratory therapy, radiology/sonography, and transport. The vast majority of rural hospitals are reimbursed through a Medicare-reimbursement model which does not reimburse the facilities for the high associated costs of providing maternity care. In Kansas, Medicare is primarily utilized by the over 65 population, not childbearing aged women.

Medicaid is the federal insurance coverage designated for those less than 65 that meet the requirements for assistance.

BETTER MATERNAL AND BABY OUTCOMES TAKE A VILLAGE

A safe and healthy pregnancy and delivery requires access to a variety of providers, facilities and specialists. The presence of a medical provider and a facility that can deliver a baby are only two parts of a multi-layer maternity care service system.

Not every mother needs every service, but they must have access to care when and where they need it, 24 hours a day, 7 days a week, 365 days a year, for optimal outcomes.

46% of Kansas women are in a maternal care desert.

HIGH-RISK DELIVERY CARE

The majority of Kansans live more than 30 miles from the nearest high-risk delivery facility. This distance is likely to be on unpaved, non-highway roads, which significantly increases the travel time and risk of a poor outcome. The roads may be unusable in poor weather conditions.

NEWBORN CARE

In Kansas there are approximately 4.1 family medicine physicians per 10,000 residents in rural counties compared to 3.9 physicians per 10,000 residents in urban counties, which is opposite the national data.

MATERNITY CARE

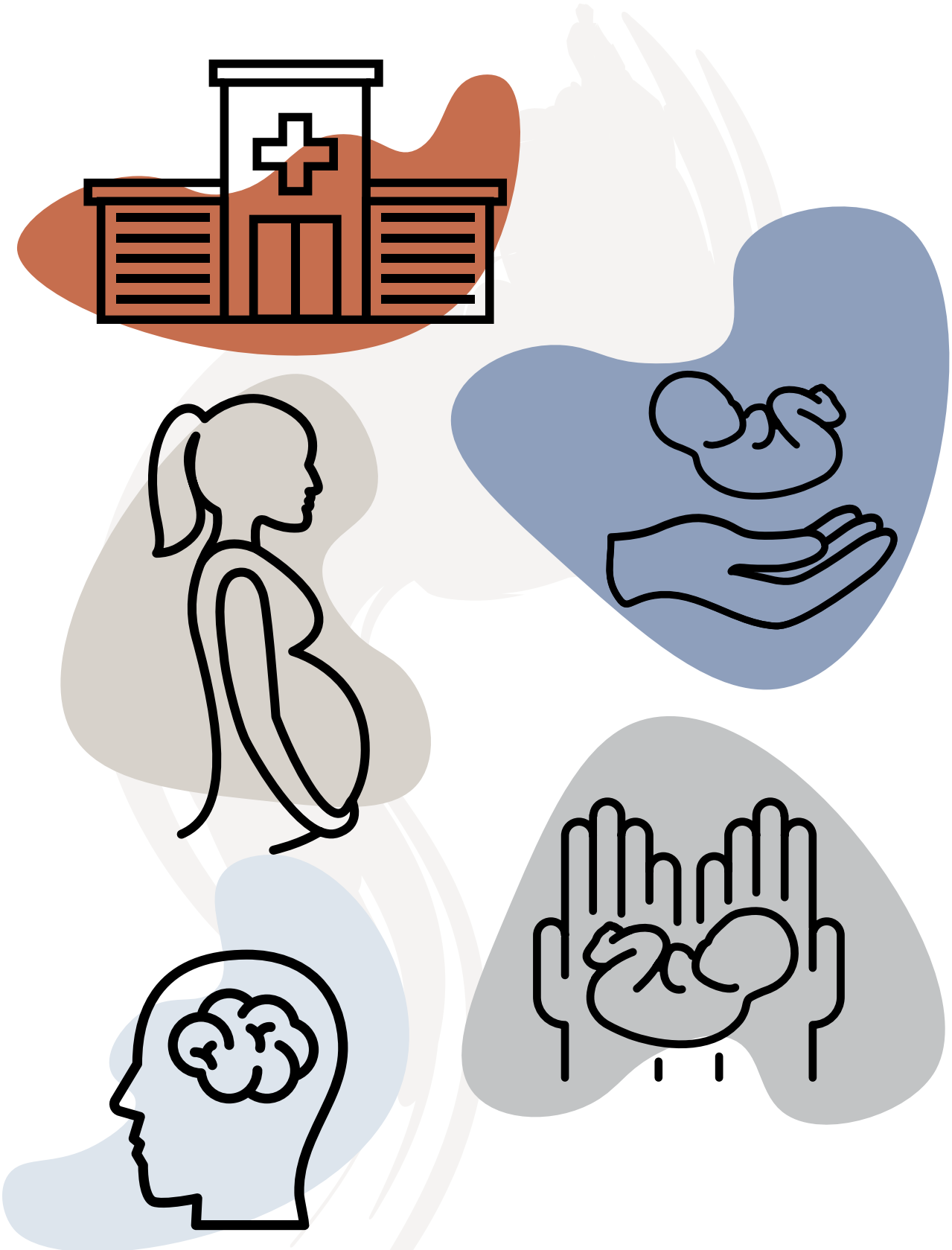
41% of Kansas counties do not have maternity care services.

SUPPORTIVE CARE

There are two reimbursable support services for women who are pregnant and postpartum in Kansas — **lactation support and doulas**.

MENTAL HEALTH CARE

Behavioral health access is **widespread and multi-layered** statewide.



Introduction

BACKGROUND

Across the United States, there is a growing disparity in access to maternity care services, as more and more hospitals and providers close service lines, creating what is now referred to as 'maternity care deserts.' It is projected that as many as two million women of childbearing age live in maternity care deserts[4], with up to 36% of all U.S. counties lacking a qualified 'childbirth' provider.[1]

Kansas has a higher percentage of counties reflected as maternity care deserts than the national average.[4]

Sadly, the number of hospitals closing is increasing specifically for inpatient maternity care services — also known as obstetrical or labor and delivery (L&D).[5] These closures are associated with inadequate prenatal care, increased preterm birth, low infant birth weight, more neonatal intensive care unit (NICU) admissions and greater maternal mortality (death).[6]

Providing comprehensive maternity health services requires a complex health care team and a network of community resources. This report details statewide, county-level data about the primary resources needed to provide maternity care (both outpatient and inpatient services) in Kansas.

Maternity health services, also known as perinatal health care, encompasses the care received during pregnancy, the management of labor and delivery, postpartum care, and neonatal care.[7] Providing responsive, quality perinatal care requires a broad range of resources and strategies that vary based on the capabilities of the health system and community.

The issue of geographical scarcity of maternity care services is not new. As early as 1985, a survey of small and rural California hospitals found that 64% planned to cut back or eliminate maternity care services.[8] And a 1993 report[9] showed two variables that significantly influenced the probability of the availability of maternity care services:

1. Births per 1,000 people increased the probability that a hospital offered maternity care by 11%.
2. The number of physicians per 10,000 people was positively correlated with the provision of maternity care. An increase of two physicians per 10,000 residents of a county raised the probability that its hospital offered maternity care services by 56%.

While many hospitals in Kansas have fewer than 25 beds, the bed size of the hospital had only a small, positive effect on the probability that maternity care services would be offered.

Certainly, the volume of births and the availability of providers are key to sustaining maternity care services. However, the requirements for inpatient maternity care (L&D) are complex and expensive.

Models of maternity care and delivery options vary but there are key elements that must be present regardless of whether a delivery takes place within a free-standing birthing center, a tertiary care hospital, a rural hospital, or at home.

- Providers trained in maternity care must be present. These individuals could be obstetricians, family medicine physicians, and/or midwives. Outpatient providers such as family nurse practitioners, or physician assistants are generally not credentialed to perform deliveries. Hospitalists may provide antepartum (pre-delivery) or postpartum assessments but are generally not credentialed to conduct routine deliveries.
- Registered nurses (RNs) with experience in obstetrical nursing care must be continuously available without interruption to provide care to a laboring mother. RNs must be able to stabilize and/or ensure the safe transfer of high-risk mothers and newborns, and they provide the initial postpartum assessment. Licensed practical nurses (LPNs) or Licensed vocational nurses (LVNs) cannot be the primary nurse assigned to a laboring mother. They cannot conduct the initial postpartum and/or newborn assessment requirements. The LPN and/or LVN may provide care to a stabilized newborn or a postpartum mother after an initial assessment has been completed and signed off by a RN. Labor support is understood as an ongoing process of nursing care that includes physical comfort, emotional support, instruction/information, and advocacy.[10]
- The role of a doula will be discussed, but not in the context of nursing care. Doulas are trained in childbirth and may be used for support and guidance during pregnancy, birth and postpartum.[11] However, they do not provide any level of medical or nursing care.
- All facilities offering maternity care must be able to provide for an operative delivery (cesarean delivery), including the surgical suite and equipment. Providers trained and qualified to perform a cesarean delivery, anesthesia and experienced registered nurses must be continuously available.
- Providers offering at-home delivery services must have access to safe and timely transport to a nearby hospital capable of performing an operative delivery.
- Anesthesia support must be available, as well as the equipment, facilities, and support personnel equal to that provided in the surgical department/suite.
- Implementing levels of maternity care requires regionalized, well-defined relationships among facilities. This model of maternity care delivery is dependent on the ability to transport patients (mother or baby) in a timely manner.

THIS REPORT

In an effort to define the issues surrounding the availability of maternity care in Kansas, this report outlines, by county and ZIP code when possible, the numbers of reproductive age women, the facilities offering prenatal care and/or inpatient maternity care, availability of referral/high-risk services, the providers accepting patients and offering prenatal and/or full perinatal services, nursing, anesthesia, behavioral health, lactation, and doula support services. The straight line distance to facilities offering delivery capability is provided. We also present considerations and brief narrative statements from Chief Executive Officers, Chief Medical Officers, and Chief Nursing Officers from facilities faced with the tough decision to stop or pause their maternity care services and those that pick up the volume of maternity care patients following closures.

BEHAVIORAL HEALTH

Optimal pregnancy and postpartum care require tailored attention to medical and behavioral health needs of each mother. Those with both low- and high-risk pregnancies can experience increased psychological distress before and after birth. Access to licensed behavioral health and substance abuse service providers varies widely across Kansas. We have provided the number of licensed providers by work location for psychiatry, clinical psychologists, family therapists and licensed social workers. In addition, we surveyed each health care system/facility as to their available behavioral and substance abuse resources, and we mapped the location of all the Certified Community Behavioral Health Clinics (CCBHCs) in the state.

SUPPORT SERVICES

The availability of supportive services and resources can make significant differences in maternal outcomes, particularly in areas with limited access. Every county in Kansas has a health department. The location and contact information for each health department is available in the Kansas Public Health Directory. Health departments can provide information about available programs for women, infants, and children such as WIC. Within this report, we have limited our discussion to two key maternal support areas that are reimbursable: 1) lactation support and 2) doula support.

LACTATION SUPPORT

Coverage of lactation support, counseling, and equipment for the duration of breastfeeding is a requirement under the Affordable Care Act (ACA). The support must be given by a trained provider during pregnancy and/or in the postpartum period. The ACA does not specify who is a trained provider. However, the Women's Preventive Services Initiative (WPSI) provides guidance that clinical lactation professionals providing clinical care include but are not limited to lactation consultants, nurse practitioners and physicians. Lactation personnel providing counseling, education or peer support include lactation counselors, breastfeeding educators, and peer supporters. Mothers who receive support are significantly more likely to successfully maintain breastfeeding for at least six months following birth.[12]

DOULA SUPPORT

Doula services were added to Kansas' Medicaid program (KanCare) effective July 1, 2024. The services of a doula are reimbursable prenatally, during labor and delivery (intrapartum) and postpartum (up to one year following delivery). Doula training varies; they can provide physical, emotional, and informational support, but cannot provide medical or nursing care. To receive reimbursement in the state of Kansas, a doula must be certified through a doula training organization or complete at least thirty hours of training through a nationally recognized program and have provided support at a minimum of three births.

COVERAGE FOR CARE

Most rural hospitals lose money delivering patient services in general. Birth is one of the most common reasons for health care use in the U.S. and one of the top costs for payers annually. Due to a difference in patient volumes, the same level of payment may adequately compensate a large urban hospital but won't cover the costs for a rural hospital to deliver the same health care services.[13] Having all the necessary services for maternity care available 24/7/365 when the volume of patients is very low is difficult to sustain, particularly for rural facilities with a reimbursement model based on Medicare coverage.

Many proposed solutions for rural hospitals are based on increasing Medicare or Medicaid payments or expanding Medicaid eligibility.[13] Medicaid is a major public source for coverage of health services provided to those who are pregnant, infants and children. In Kansas during 2022, 41% of mothers had Medicaid coverage at birth.[5] In 2021, a provision within the American Rescue Plan Act provided states with the option to extend Medicaid coverage for postpartum to 12 months. Kansas' state plan, which includes 12 months of coverage with no limits on benefits, was approved by the Centers for Medicare and Medicaid (CMS) on July 16, 2022. At many of the rural facilities in Kansas, our qualitative data reflect that about 7% of all patients

are covered by Medicaid. On pages 64-65, the percentage of births covered by Medicaid for each county in Kansas are provided. The lowest percentage is 9.09% and the highest is 58.51%.

At rural hospitals in the U.S., about half of all services are delivered to those with private insurance — both employer-sponsored and Medicare Advantage plans — or those with no insurance at all.[14]

TOPICS CONSIDERED OUTSIDE THE SCOPE OF THIS REPORT

Disparities in Kansas maternal health outcomes are driven by complex social, geographic, economic and racial factors; this report does not cover those topics. The report provides key information associated with the delivery of maternity care services across Kansas. The scope of this document:

- Is specific to prenatal, intrapartum and delivery and postpartum care. We do not address access to pre-conception counseling, infertility care or termination of pregnancy.
- Provides information related to the referral networks for high-risk patients and the availability of maternal-fetal medicine specialists. It does not include comprehensive information on the available services at the tertiary care facilities.
- Does not provide specific availability of services or birthing options (e.g. trial of labor after cesarean delivery). Services and options can change frequently based on provider and resource availability.
- Does not provide information about at-home birthing options.

FUTURE RESEARCH AND POLICY IMPLICATIONS

Access to maternity care services has been and continues to be dramatically impacted by the closure of maternity service lines and/or hospitals. Rural hospitals are at an increased risk of closure due to declining occupancy rates, high fixed costs and market pressures.[15]

Our findings point to additional stressors in obtaining and sustaining the qualified health care professionals needed to provide services for low-risk, healthy pregnancies, much less high-risk pregnancies. Careful consideration must be given to how scarce resources are maximized and protected. Moreover, decisions must be made with an understanding of the complexities of providing maternity care and meeting the standard of care.

We must expand research to learn how the reduction and closure of maternity care services in one area impacts the hospitals that pick up the additional care burden in another area, and how this changes the flow of health care delivery throughout Kansas.

Additional research is needed to understand how the distance to services may impact the standard of care, and how maternity care closures lead to changing perceptions about the quality of maternity care delivered in rural areas. The ability of the rural hospitals to sustain maternity care services has immense policy implications, particularly in terms of current reimbursement models.

Additional considerations are detailed on page 61.

DEFINITIONS

Anesthesiologist: A physician who specializes in anesthesia, sedation and pain management. Board certified anesthesiologists complete a residency and boards in anesthesiology.

Birth Center: A facility that exists within a health care system that provides a labor and childbirth experience in a family centered, home-like atmosphere, for healthy, low-risk mothers. Cesarean delivery is not offered at a birthing center.

Cesarean Birth: Delivery of the infant through an incision made in the abdomen and uterus.

Certified Midwife (CM): A person who has received relevant education as part of a midwifery program, but does not start with a nursing degree. They undergo the same certification process as a CNM. Note: There are non-certified midwives or lay midwives. They have not taken a certification exam and may not have attended formal training. Certified midwives are also called certified professional midwives.

Certified Nurse Anesthetist (CRNA): A registered nurse (RN) who obtains an advanced degree, either masters or doctoral-level education in anesthesia, sedation and pain management and passes a national certification examination for licensure.

Certified Nurse Midwife (CNM): Registered nurses who have graduated from an accredited midwifery education program and passed a national certification examination. A midwife manages the care of low-risk mother throughout pregnancy, childbirth and postpartum. In collaboration with obstetricians, CNM may care for mothers with medical or obstetrical complications.

Critical Access Hospitals: A licensure designation given to eligible rural hospitals by the Centers for Medicare and Medicaid Services (CMS) to reduce financial vulnerability and improve access to care. Multiple conditions must exist to obtain the designation, but one key element is 25 or fewer acute care inpatient beds.

Doula: A trained support professional who provides physical, emotional, and informational support before, during and following childbirth.

Family Medicine Physician: A physician who specializes in comprehensive health care for people of all ages. Board certified family medicine physicians complete a residency that includes specialized training in pediatrics, obstetrics and gynecology, internal medicine, psychiatry, neurology, surgery, and community medicine.

Federally Qualified Health Center (FQHC): Federally funded nonprofit health center or clinic that serves medically underserved areas and populations. They provide primary care services regardless of ability to pay.

Fetal Mortality: Fetal mortality is the spontaneous intrauterine death of a fetus at any time during pregnancy and reported per 1,000 live births. Fetal deaths after 20 weeks gestation are also referred to as stillbirths.

High-risk Pregnancy: A pregnancy in which the mother and/or the fetus has a higher-than-normal chance of experiencing complications.

Maternal Mortality: A death from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy. It is reported as a ratio of deaths per 100,000 live births for a specified year.

Morbidity: Morbidity refers to any physical or mental diseased state or condition. Entering pregnancy with a chronic medical disease such as hypertension or diabetes and/or anemia are examples of morbidity.

Neonatal and Infant Mortality: A neonatal death is an infant death that occurs in the first 28 days of life and is reported per 1,000 live births.

Neonatal Intensive Care Unit (NICU): An intensive care unit designed for newborns.

Neonatologist: A physician who specializes in caring for high-risk, complex newborn care, such as that of a premature newborn or congenital issues. Board certified neonatologists complete residency and boards in pediatrics and a fellowship and boards in neonatology.

Obstetrician/Gynecologist (OB/GYN): A physician who specializes in pregnancy and female reproductive health. An OB/GYN completes a residency and boards in OB/GYN.

Perinatal: Refers to pregnancy and the postpartum period, typically 12 weeks after birth.

Perinatologist: A physician who specializes in the health of the mother and fetus during pregnancy and shortly after birth; also referred to as a Maternal-Fetal Medicine (MFM) specialist. Board certified MFMs complete residency and boards in obstetrics and gynecology and a fellowship and boards in Maternal-Fetal Medicine.

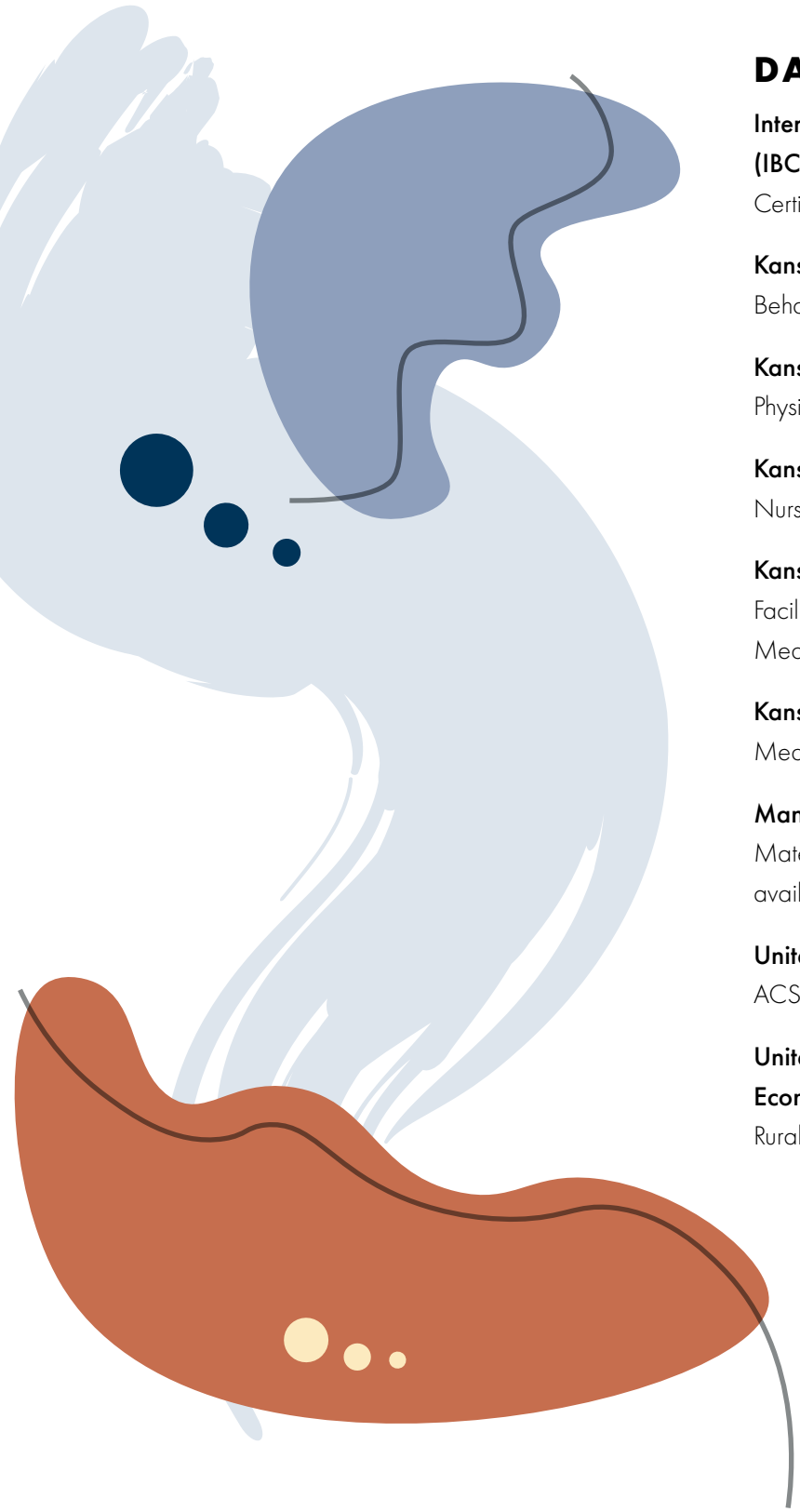
Postpartum: Period that begins immediately following childbirth, up to 12 weeks after birth.

Prenatal: The time before birth or during pregnancy.

Rural Health Clinics (RHC): Clinics providing outpatient care services in rural communities with a team approach to health care delivery. May be public, nonprofit, or for-profit health care facilities.

Tertiary Care: Specialized care in a hospital setting.

Vaginal Birth After Cesarean (VBAC): Giving birth vaginally after previously having a cesarean section.



DATA SOURCES

International Board of Lactation Consultant Examiners (IBCLE)
Certified IBCLCs by County (2024)

Kansas Behavioral Science Regulatory Board (KSBSRB)
Behavioral Health provider address, License Type, etc. (2024)

Kansas Board of Healing Arts (KSBHA)
Physician Address, Specialty, etc. (2024)

Kansas Board of Nursing (KSBN)
Nurse mailing address, License Type, etc. (2024)

Kansas Department of Health and Environment (KDHE)
Facility Licensure Data (2023)
Medicaid Births (2022)

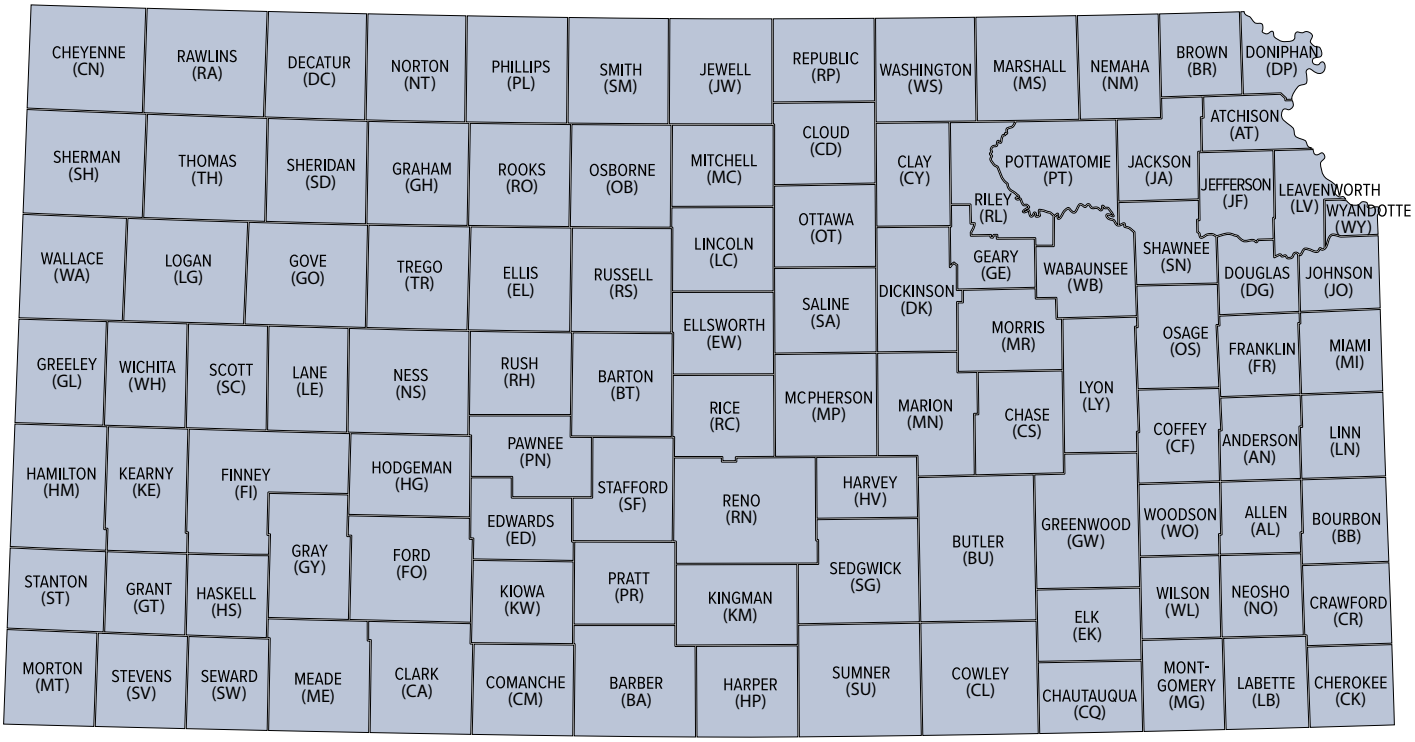
Kansas Health Institute (KHI)
Medicaid data (2024)

Manually Collected Maternity Care Data
Maternity Care and Behavioral Health related Services available (2023)

United States Census
ACS 5-Year Fertility Estimates by County (2022)

United States Department of Agriculture (USDA), Economic Research Service
Rural-Urban Continuum Codes (2024)

KANSAS COUNTIES



Maternity Care Need

Ideally, all individuals should be engaged within a health system providing maternal/women's health care before, during, and after pregnancy. The goal is to reduce the risk of adverse health effects for the woman, fetus, and newborn by optimizing health, and addressing modifiable risk factors.[16]

Obtaining early, regular maternity care is important for ensuring a healthy pregnancy. In Kansas, county health departments also offer a wide range of public health services, including some prenatal services. Core services include reproductive health that may include family planning, well-woman exams, and birth control services, as well as family support programs, including resources for new mothers and pregnant adolescents.

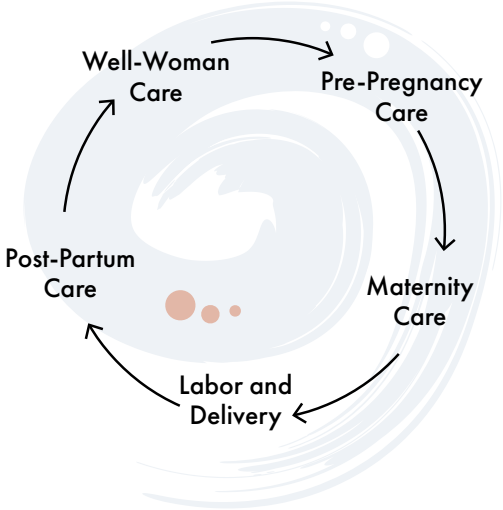
Notably, pregnancy is recognized as a window to future health, as conditions identified during pregnancy or unique to pregnancy can be associated with health complications later in life.[17] Postpartum care is therefore critical to address complications or medical issues that developed during pregnancy.

This continuum of women's health care that includes interpregnancy (the time between pregnancies) and well-woman care provides an opportunity to assess mental health and physical well-being. The continuum of care for women of reproductive age includes primary care providers, obstetrician-gynecologists, subspecialists, advanced practice professionals and mental health providers.

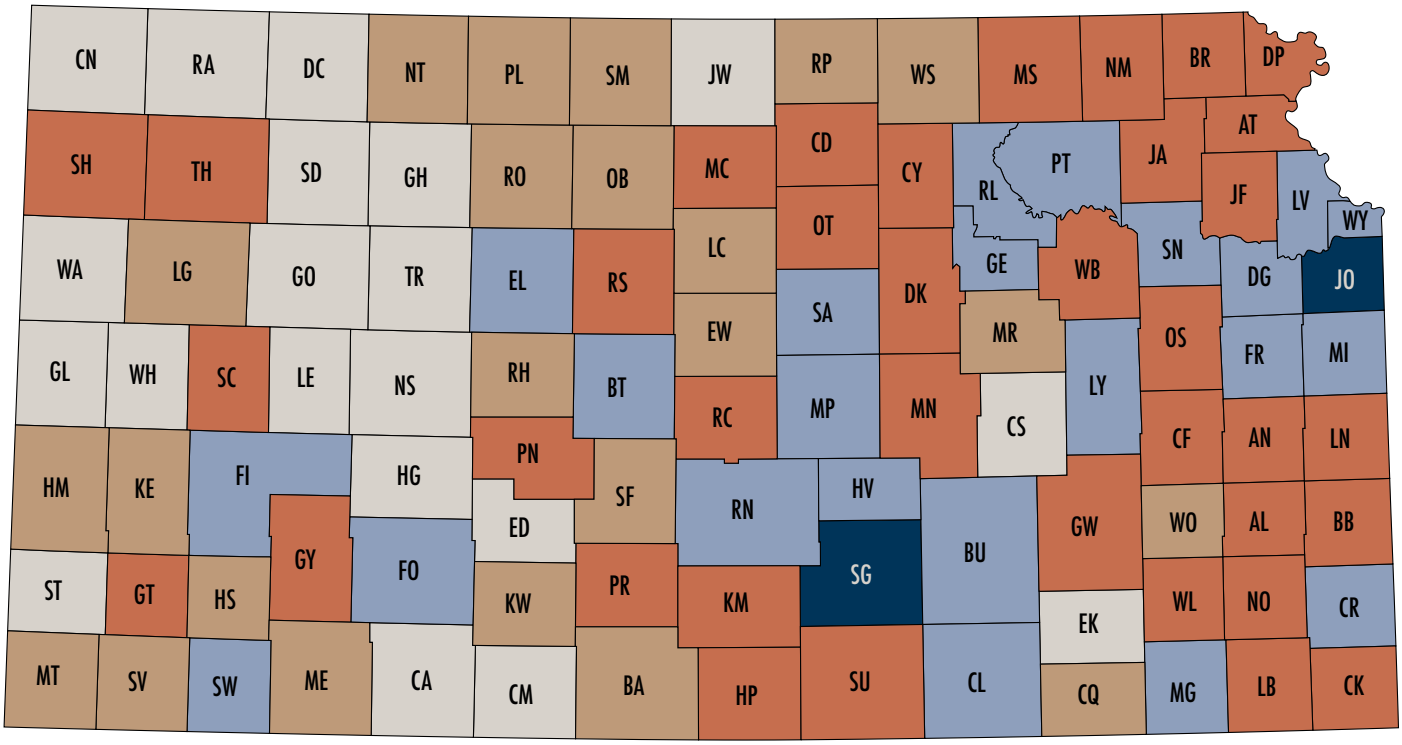
Within this section, the relative need for maternity care services is reflected through mapping of reproductive-aged women in all 105 counties of Kansas. To further highlight the need, a ratio of births to reproductive-age women was conducted to show where the greatest need for maternity care services exists. We then provide the availability of prenatal care and inpatient obstetrical care.

Access to the care in distance and availability of providers is mapped in the following section.

WELL MOTHER CYCLE OF CARE



REPRODUCTIVE AGED WOMEN BY COUNTY, 2022



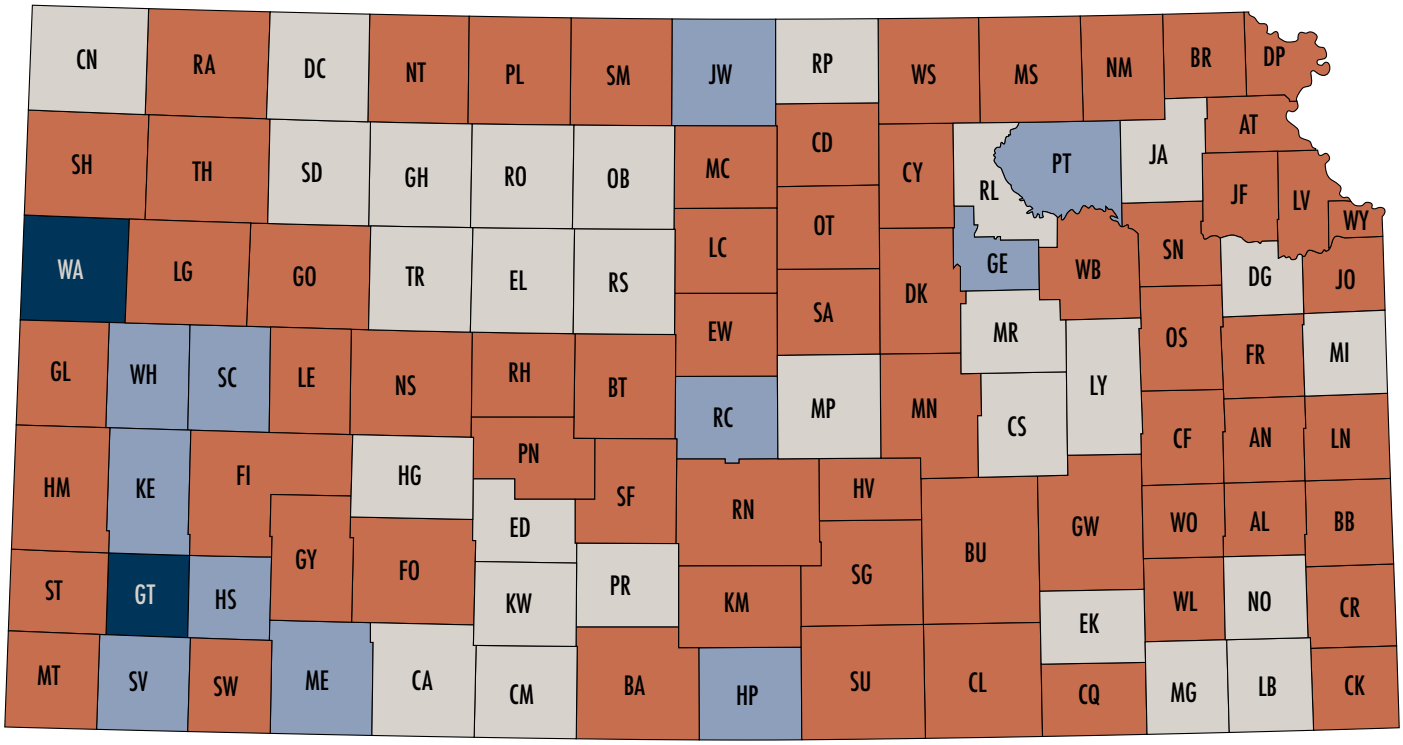
Population of Women of Reproductive Age (15-50) per County, 2022

0-499 | 500-999 | 1,000-4,999 | 5,000-49,999 | 50,000-150,000

U.S. census data were used to map the number of women of reproductive age across Kansas. Not surprisingly, the larger population centers reflect greater numbers of women of reproductive age. The map also reflects large populations of reproductive age women in the southeast corner of the state.

Additionally, note the fairly large numbers of reproductive aged women in some counties in northwest Kansas. This data is important when considering the availability of mother and baby health services for women who may become pregnant.

BIRTH RATES AMONG WOMEN OF REPRODUCTIVE AGE BY COUNTY, 2022



Live Births per 1,000 Residents of Reproductive Age (15-50), 2022

0-49 50-99 100-149 150-200

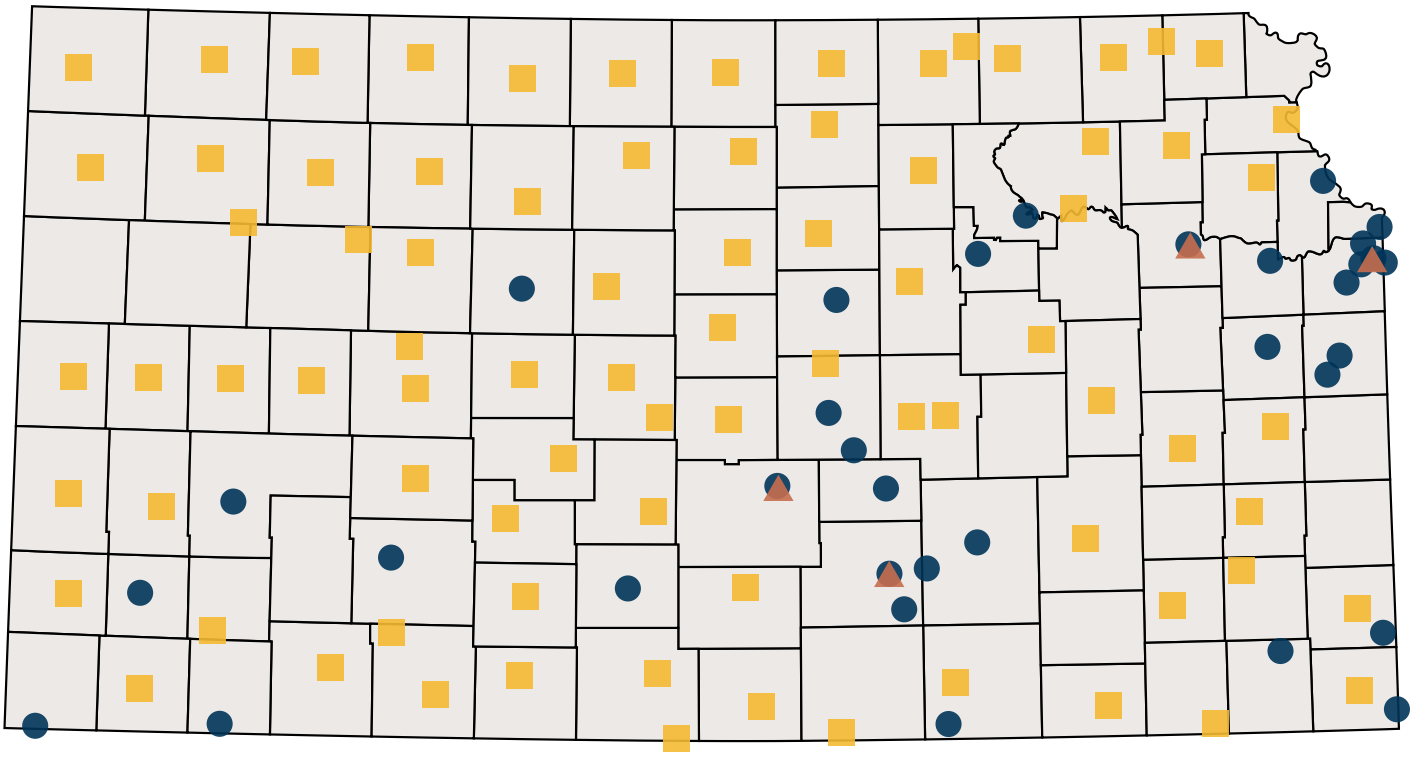
To evaluate the relative need for maternity care by county, we divided the number of live births by the number of women of childbearing age for each county to find the birth rate for each county. **The counties with the highest birth rates are the ones that are losing access to maternity care services.**

The western side of Kansas experiences higher live birth rates compared to urban areas. **While the median birthrate in urban counties is 61, rural counties have a significantly higher median of 67.** This is significant because when women can't access maternity care services, counties risk losing people to areas where care can easily be accessed.

The two counties with the largest ratio of births per reproductive age women are Wallace and Grant counties in western Kansas. The next pages will provide maps of the available outpatient and inpatient maternity care services and providers. Note the need for maternity care services in the southwest corner of Kansas.

Bedded Facilities

LICENSED FACILITIES WITH ACUTE CARE, INPATIENT BEDS, 2023

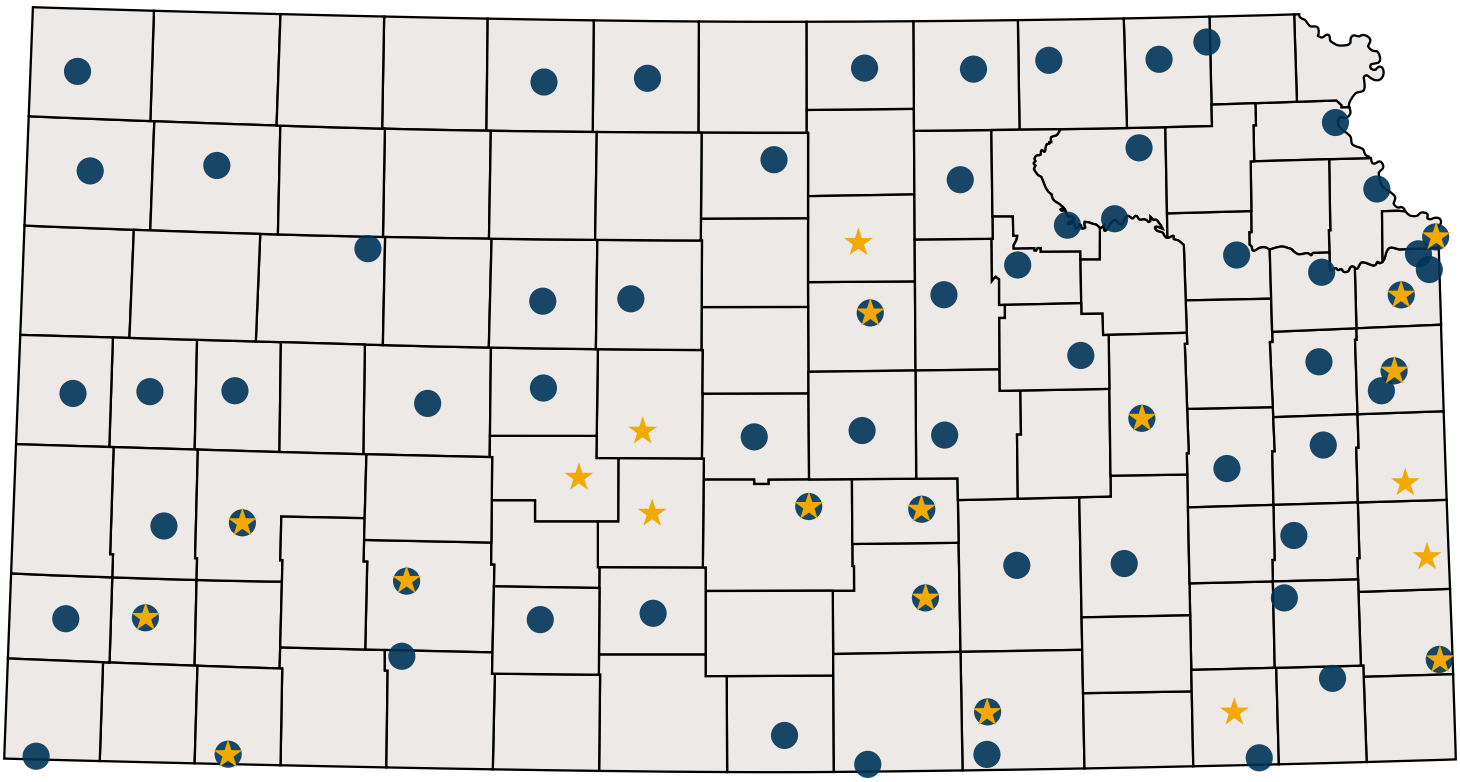


All hospitals (tertiary and rural), birthing centers and critical access hospitals with inpatient beds were included in this map. The majority of counties have some type of inpatient care capability, although not all facilities offer maternal health care, as will be noted in the upcoming maps. Each designation was based on facility licensure. The free-standing birthing centers are all co-located with hospitals that provide operative surgical (cesarean delivery) capabilities.

The data represent a preponderance of rural critical access hospitals which have limited resources.

The map does not include facilities licensed specifically for inpatient mental health, long-term care, or rehabilitative care.

FACILITIES OFFERING PRENATAL SERVICES, 2023



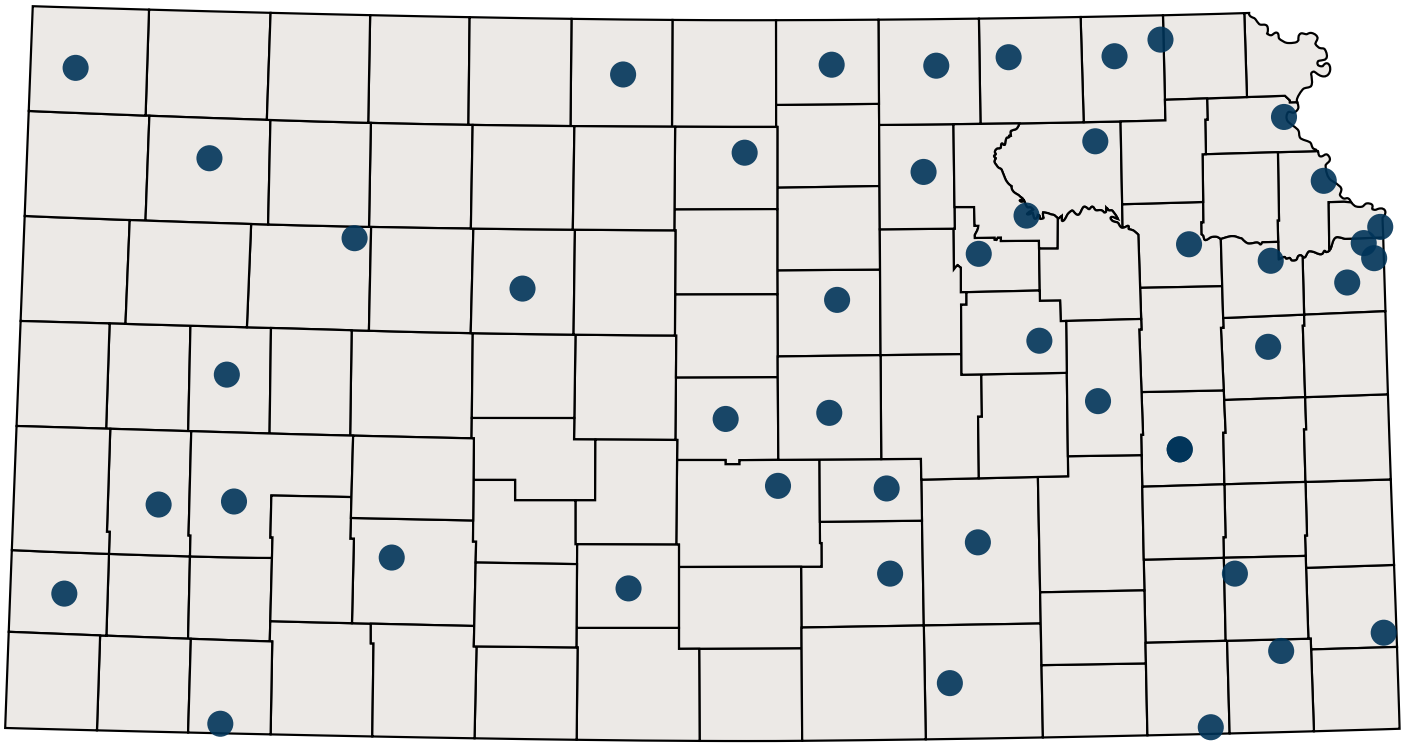
● Prenatal Services Facilities ★ Federally Qualified Health Centers

Prenatal care — the care that is delivered during pregnancy and prior to giving birth — is provided through a wide variety of outpatient avenues, such as county health clinics and federally qualified health centers (FQHCs). In rural communities, outpatient clinics are often co-located with the hospital. **The availability of prenatal services within a county does not guarantee inpatient obstetrical services.**

Forty-one percent of Kansas counties do not have prenatal care services. When there is a lack of prenatal care available, pregnant women enter into prenatal care later in their pregnancy and have fewer visits, which is associated with poor maternal and baby outcomes.

The majority of prenatal care services are for low-risk pregnancies.

FACILITIES OFFERING INPATIENT OBSTETRICAL SERVICES BY COUNTY, 2023



● Hospitals

Inpatient obstetrical services are defined as facilities offering inpatient labor and delivery or birthing services. Over half of all U.S. counties do not have inpatient obstetrical services. **In Kansas, 59% of counties do not have inpatient obstetrical services.**

Generally, preterm (premature) birth rates are higher in counties with limited or no obstetrical services. Many Kansas counties identified with the greatest need have no inpatient obstetrical services relative to the need for maternal care (see page 23).

Out-of-hospital births and preterm births increase in counties without delivery services, and studies reflect twice the rate of infant mortality (death) in counties without delivery services.[18]

This map reflects significant distances to low-risk inpatient obstetrical care for the western half of Kansas. The ability to take a regional approach to maternity care and coordinate higher levels of care becomes very difficult, if not impossible, given the sparse availability of maternity care services.

Distance to Care

In the 1970s regionalized, coordinated systems for maternity care were established. These systems were focused primarily on the newborn baby. Systems that focused on the mother's medical risk-based needs are less established across the United States.[19]

Regionalized maternity care — also known as a hub and spoke model — is intended to maintain or increase access to care. In this model, health care services are organized around a central facility (the hub) that coordinates with smaller, connected satellite facilities (the spokes). It develops, strengthens, and clearly defines the relationships among facilities within a region so that women with low- to moderate-risk pregnancies can stay in their local communities. It also ensures that the women who need high-risk pregnancy services can receive care in the facilities specifically prepared to provide the required specialized care.

The levels of maternity care range from Level I (Basic Care) to Level IV (Regional Perinatal Health Care Centers). Level IV centers maintain onsite medical and surgical care capabilities for the most complex maternal conditions and critically ill pregnant women and fetuses or neonates from pregnancy to postpartum care. They maintain a team of board certified maternal-fetal medicine (MFM) and neonatology experts who have full inpatient privileges and are readily available at all times for consultation and care management.

In comparison, a Level III Center has onsite medical and surgical ICUs that accept pregnant, postpartum and/or neonatal patients. The MFM or neonatologists may not be onsite but are available for consultation.

The maps within this section reflect the varying distances to care. Note, the distance to high-risk care on page 35 maps both Level III and Level IV Centers. There is only one location in the state of Kansas that has Level IV perinatal care capability: the Kansas City metro with a collaborative relationship between the University of Kansas Medical Center and Children's Mercy in Missouri.

It is important to recognize that the majority of births in the United States occur at hospitals designated as Level I Centers of care and birth centers. 59% of hospital births occur at hospitals where fewer than 1,000 newborns are delivered annually.[20] This underscores the importance of adequately staffed and equipped Level I and Level II hospitals with coordinated access to higher levels of care in the region.[19]

The following maps detail the distance to services for the various maternity care services and the availability of the wide variety of health care providers needed to ensure access to quality maternal health care.

Distance to care for each ZIP code was mapped using the straight-line distance from the center of the ZIP code to the nearest facility where maternity care services were available. It does not reflect the actual roads that a pregnant woman would travel to reach care.

DISTANCE TO PRENATAL SERVICES BY ZIP CODE, 2023

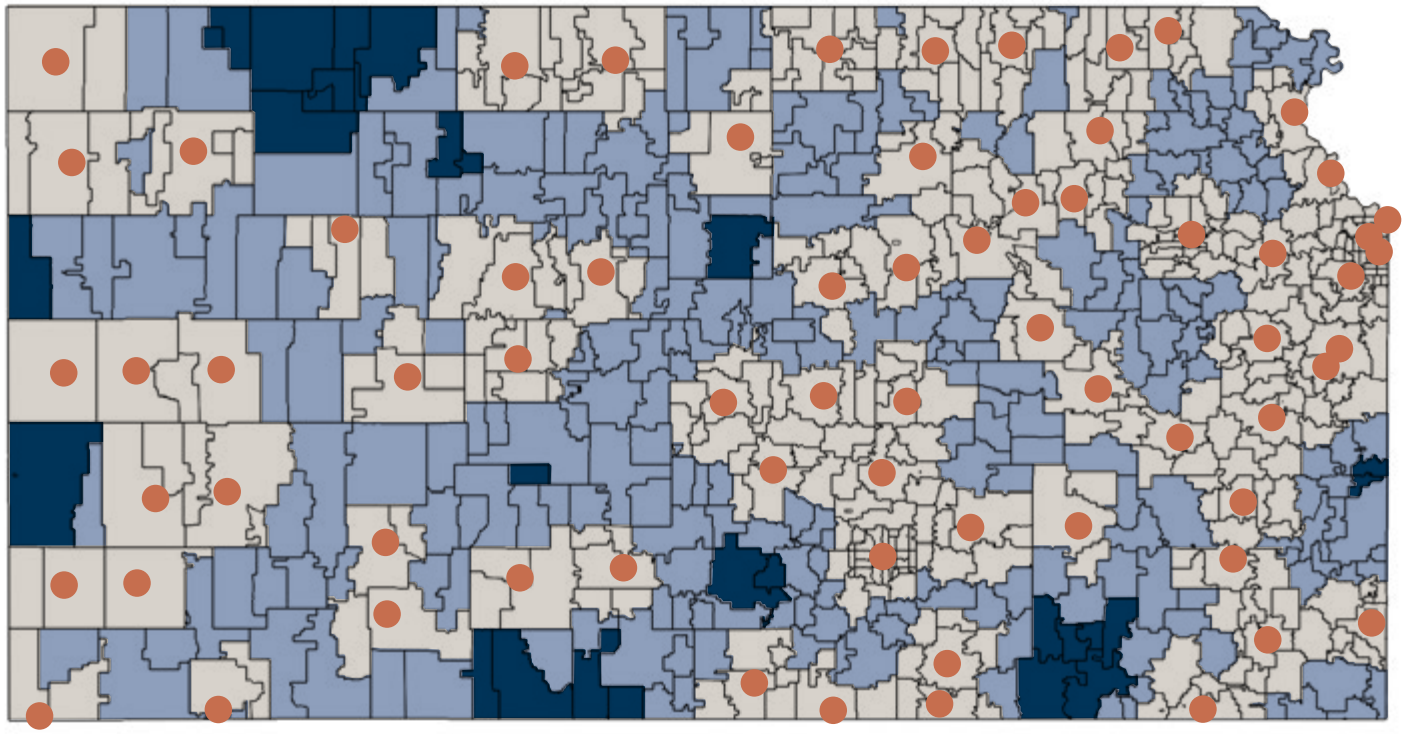
3.6% of ZIP codes in Kansas were farther than 30 miles away from the nearest facility offering prenatal services, while 35.8% of ZIP codes were farther than 15 miles from the nearest facility. The mean distance to the nearest facility was 13 miles.

TRAVEL TIME AND MISSED APPOINTMENTS

Longer travel distances to prenatal care can impact attendance at prenatal care visits, which ultimately negatively affects pregnancy outcomes.

A study in North Carolina found that over 56% of their sample traveled more than 30 minutes with a median travel time of 48.7 minutes. The study found that for every additional 10 minutes of travel time (>10 minutes), the mothers were significantly more likely to arrive late and cancel their appointments. Those who were publicly insured were 82% more likely to not show for appointments than those privately insured.[21]

These findings underscore the significance of travel distances for care. As noted above, the mean distance to travel for prenatal care in Kansas is approximately 15 miles.



Distance to Prenatal Services, 2023

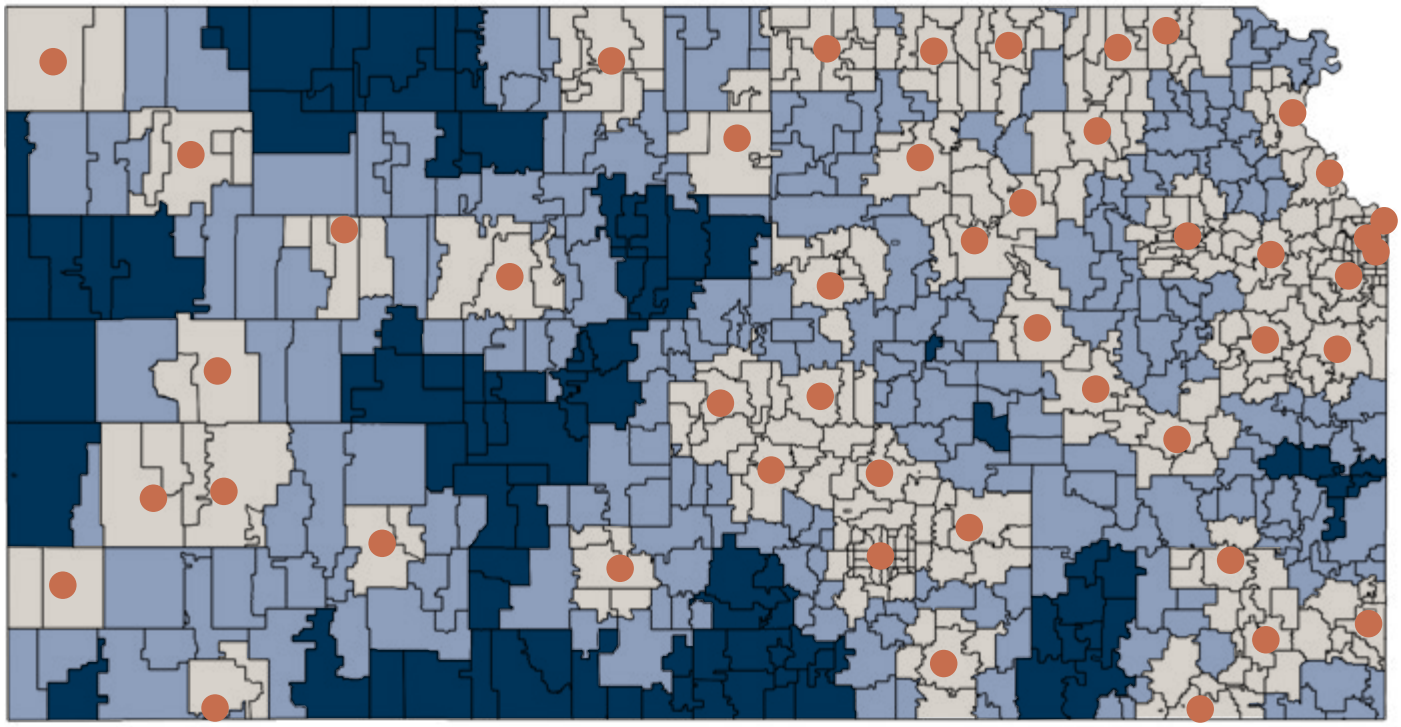
0-15 Miles | 15-30 Miles | 30-60 Miles | Prenatal Services

DISTANCE TO OBSTETRICAL AND DELIVERY SERVICES BY ZIP CODE, 2023

13% of ZIP codes in Kansas were farther than 30 miles away from the nearest facility offering delivery services, while 46% of ZIP codes were farther than 15 miles to the nearest facility offering delivery services. The mean distance to the nearest facility was 16 miles.

Closure of obstetrical services has increased travel times, especially in rural communities, which is associated with increased stress and preterm births. It increases unplanned out-of-hospital births.

The distance to delivery services is greater than that to prenatal care. **It is alarming that some laboring women in Kansas must travel 60 miles to arrive at a hospital providing delivery services.**



Distance to Delivery Services, 2023

0-15 Miles | 15-30 Miles | 30-60 Miles | Obstetrical and Delivery Services

DISTANCE TO HIGH-RISK MATERNITY OR NEONATAL SERVICES BY ZIP CODE, 2023

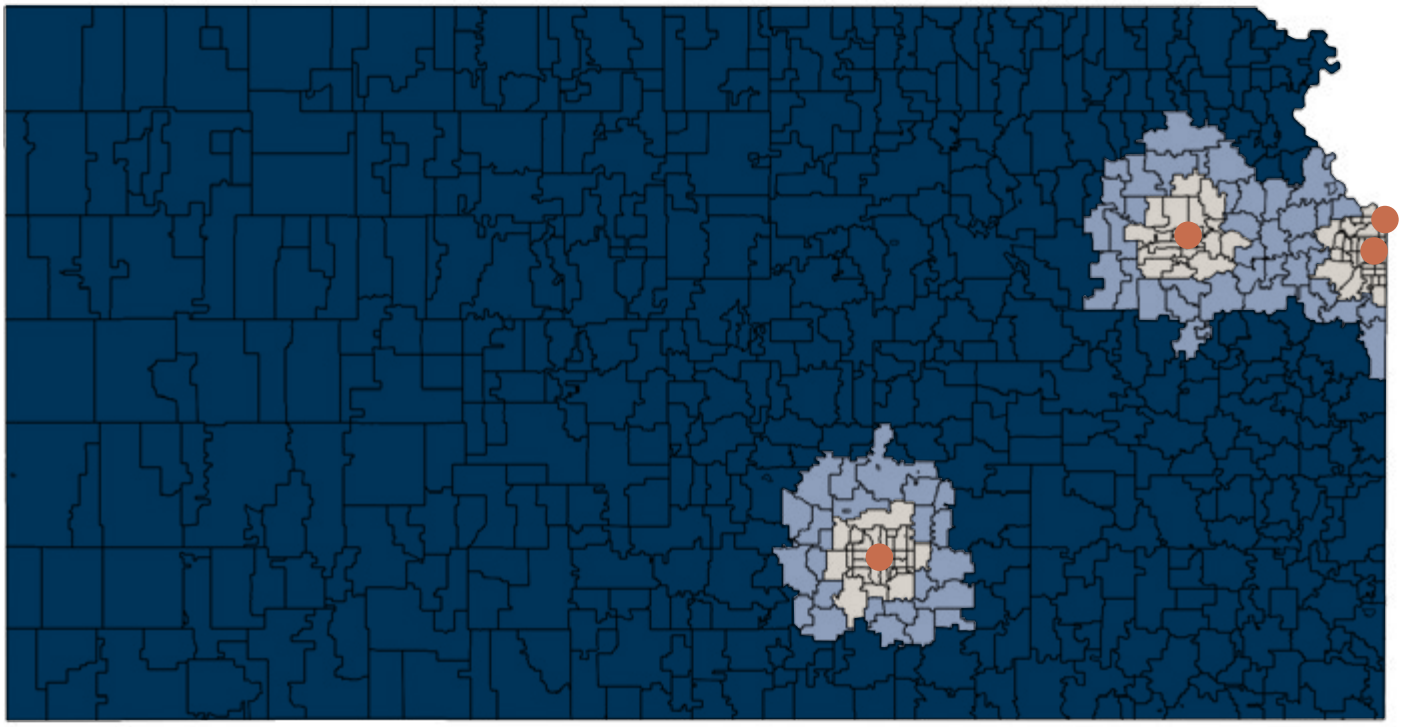
High-risk maternity or neonatal services were categorized by the presence of a maternal fetal medicine physician or a neonatologist.

Facilities able to handle high-risk pregnancies are concentrated in three main metropolitan centers in the state: Kansas City, Topeka, and Wichita. Seventy-five percent of ZIP codes in Kansas were farther than 30 miles away from the nearest facility offering high-risk delivery services, while 85% of ZIP codes were farther than 15 miles to the nearest facility offering high-risk delivery services. **The maximum mileage to access high-risk delivery services is 283 miles.**

While telehealth services can connect patients experiencing high-risk pregnancies to consultative care, frequent travel may still be required for ultrasounds and monitoring at a perinatal center of care, which could be required multiple times each week. Additionally, travel is still required to access high-risk delivery services.

Coordinating the care for the mother and baby requires a team of physicians and nurses familiar with the care of both low- and high-risk pregnancies. The team must be knowledgeable of regional maternal and neonatal transport capabilities. **Ensuring the right level of care is available at the right time requires significant planning and expertise.**

Note, that while there are three locations with maternal fetal medicine and neonatologist present, the levels of perinatal care are not equal. The University of Kansas Medical Center in conjunction with the Children's Mercy in Kansas City, MO is ***the only*** designated Level IV Regional Perinatal Center of Care. The other locations on the map are Level III Perinatal Centers of Care.



Distance to High-Risk Maternal or Neonatal Services, 2023

0-15 Miles | 15-30 Miles | >30 Miles | High-Risk Maternity or Neonatal Services

Maternity Care by Provider*

Maternal care refers to all aspects of prenatal, delivery, and postpartum care. At any of these timepoints, there may be specific requirements for providers able to care for those with low-, moderate-, and/or high-risk pregnancies.

Obstetricians, family medicine physicians and certified midwives (both nurse midwives and professional, non-nurse midwives) are all educated and trained to provide prenatal, delivery, and postpartum care for low-risk pregnancies. They are all educated and trained to assess and identify existing conditions or pregnancy-associated conditions that increase one's risk of becoming moderate- or high-risk pregnancies. Obstetricians can care for patients with moderate- to high-risk and in some cases, family medicine physicians may be able to care for patients with moderate- to high-risk through consultative collaborations and referrals.

Patients identified as high-risk generally require some evaluation and care from an obstetrician and/or a physician specialized in maternal-fetal medicine (perinatologist).

The levels of maternal care define basic care as low- to moderate-risk pregnancies. The providers at facilities providing Basic, Level I maternal care, must be able to detect, stabilize and initiate management of unanticipated maternal-fetal or neonatal problems that occur during the prenatal, delivery, or postpartum period until the patient can be transferred to a facility at which maternal specialty care can be provided.[19] Both obstetricians and family medicine physicians are trained to perform cesarean (surgical) delivery.

Obstetric care requires the availability of qualified providers and equipment to administer general and/or regional anesthesia (epidural, spinal, or combined spinal epidural). Anesthesiologists are board certified physicians in anesthesia and are qualified to manage anesthesia and analgesia requirements, as are certified nurse anesthetists (CRNAs). In addition to supporting pain management during labor, these individuals must be readily available if a cesarean (surgical) delivery is required at any time.

Registered nurses (RN) are another essential component to the maternity care team. The RN generally provides the immediate assessment of the patient upon arrival at the hospital. The RN is then responsible for care during labor and delivery and postpartum. The RN must have specialized training to assess, manage, and stabilize the mother and/or neonate as necessary.

Many maternal poor outcomes are a result of the lack of obstetric physicians (either obstetricians or family medicine physicians) and trained nurses attending the births.[22]

Pediatricians are another component of the maternal care team, as they are experts in providing care for infants and children. Neonatologists are experts in the care of newborns, particularly those requiring intensive care. Neonatology is a pediatric subspeciality.

The following pages map the availability of these maternity care team members in Kansas.

*This section includes mapping of the business addresses of licensed medical professionals and mailing addresses for the licensed nursing professionals. It does not include billing data of specialists providing telehealth services or locum tenens (a physician or advanced practice provider who temporarily fills in for another clinician when they are unavailable).

FAMILY MEDICINE PHYSICIANS BY COUNTY, 2023

In 2020, across the United States, there were approximately 5.1 family medicine physicians per 10,000 residents in rural areas compared to 8.0 in urban areas.[23]

In Kansas there are approximately 4.1 family medicine physicians per 10,000 residents in rural counties compared to 3.9 physicians per 10,000 residents in urban counties, which is opposite the national data.

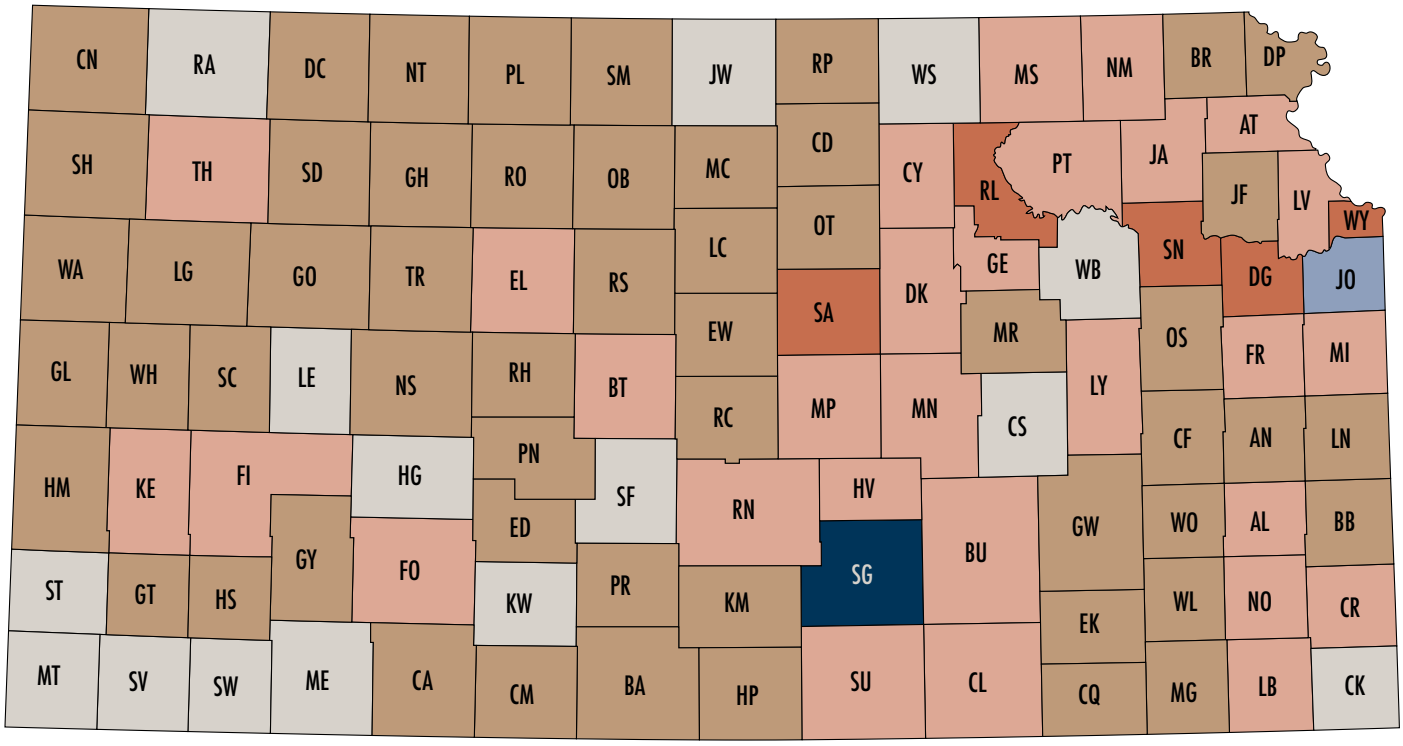
Efforts to stabilize rural hospital maternity services include recruiting and retaining family medicine physicians that want to provide maternity care. Various federal and state programs provide incentives for physicians choosing to practice in rural areas. These numbers reflect positive efforts to build a strong family medicine physician workforce in Kansas.

Family physicians are integral to providing prenatal, delivery and postpartum care services in rural communities. They are well prepared to provide care for births requiring cesarean delivery. The family physician also provides the care for the newborn. This is an important consideration when providing 24/7/365 requirements of routine and emergent maternity care. There must be provider coverage for both the mother and baby. It is estimated that family physicians comprise 20-23% of the physician delivery workforce.[24] Family physicians provide the majority of maternity care services and deliveries in U.S. rural hospitals, including cesarean deliveries.

The family medicine physician may be limited in the services they can provide, including delivery of babies, because of their location.

While these providers are fully trained and capable of providing delivery services, patients may require referrals to larger, urban facilities because of the limitations inherent to rural locations.

Even though there are a higher rate of family medicine physicians in rural Kansas, if a rural facility or hospital is not prepared to offer full maternity care, the family medicine physician cannot provide maternity care.



Licensed Family Medicine Physicians, 2023

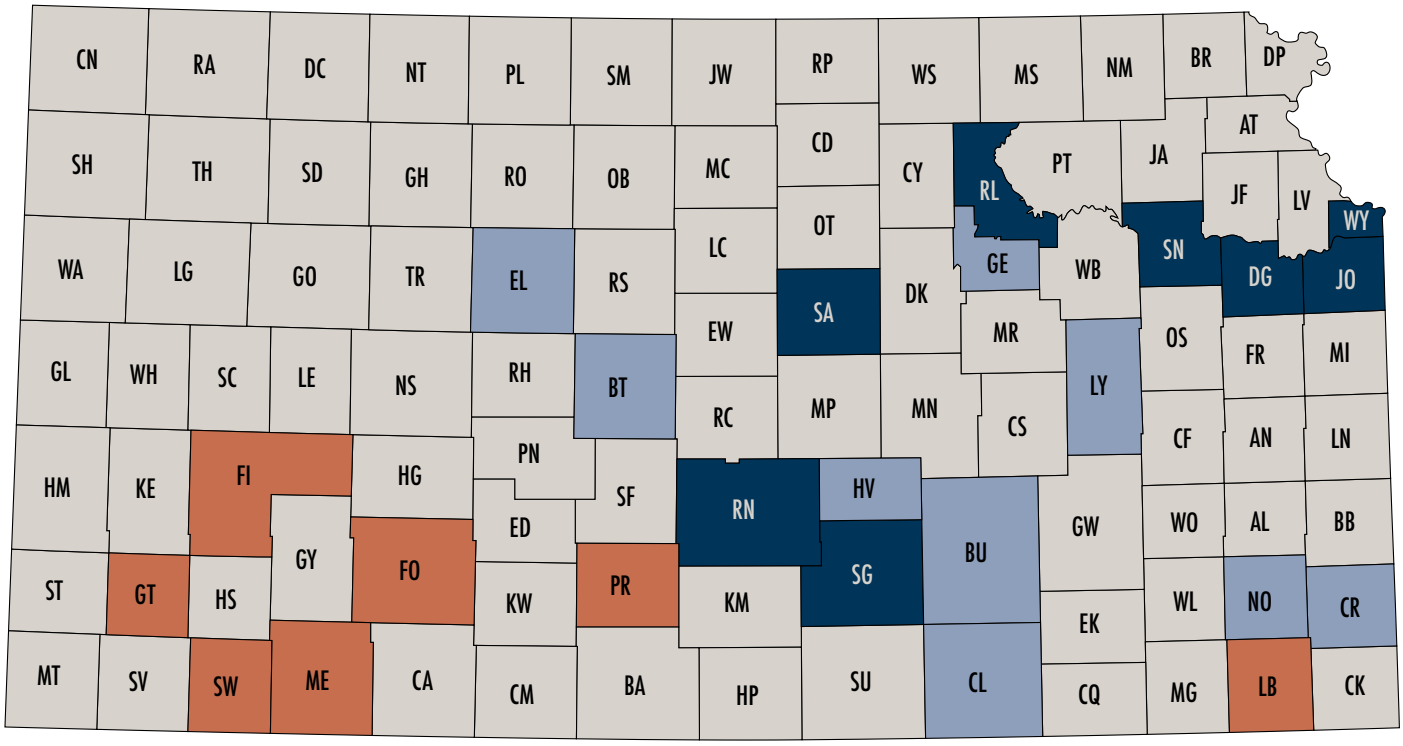
- 0 Providers
- 1-5 Providers
- 6-30 Providers
- 31-107 Providers
- 108-245 Providers
- 246-439 Providers

OB/GYN PHYSICIANS BY COUNTY, 2023

Establishing regional partnerships with hub-and-spoke models is one approach recommended for increasing the availability of maternity services.[18] Regionalization is intended to provide risk-appropriate care as needed. This model of care arranges services and resources into a network consisting of a central hub (the anchor) which offers a broad range of specialty services. Spokes, which offer limited services, can refer patients into the central hub. This approach requires the availability of regional centers with obstetricians or gynecologists (OB/GYN), pediatricians and nursing staff. Availability of OB/GYNs is key to this model for the referrals of moderate- and high-risk patients.

In addition to meeting the volume within their own communities, there must be sufficient resources at the hub to accommodate increased patient volume due to these referrals from the outlying spoke communities. The low numbers of OB/GYNs across Kansas jeopardizes the model upon which the rural hospitals rely.

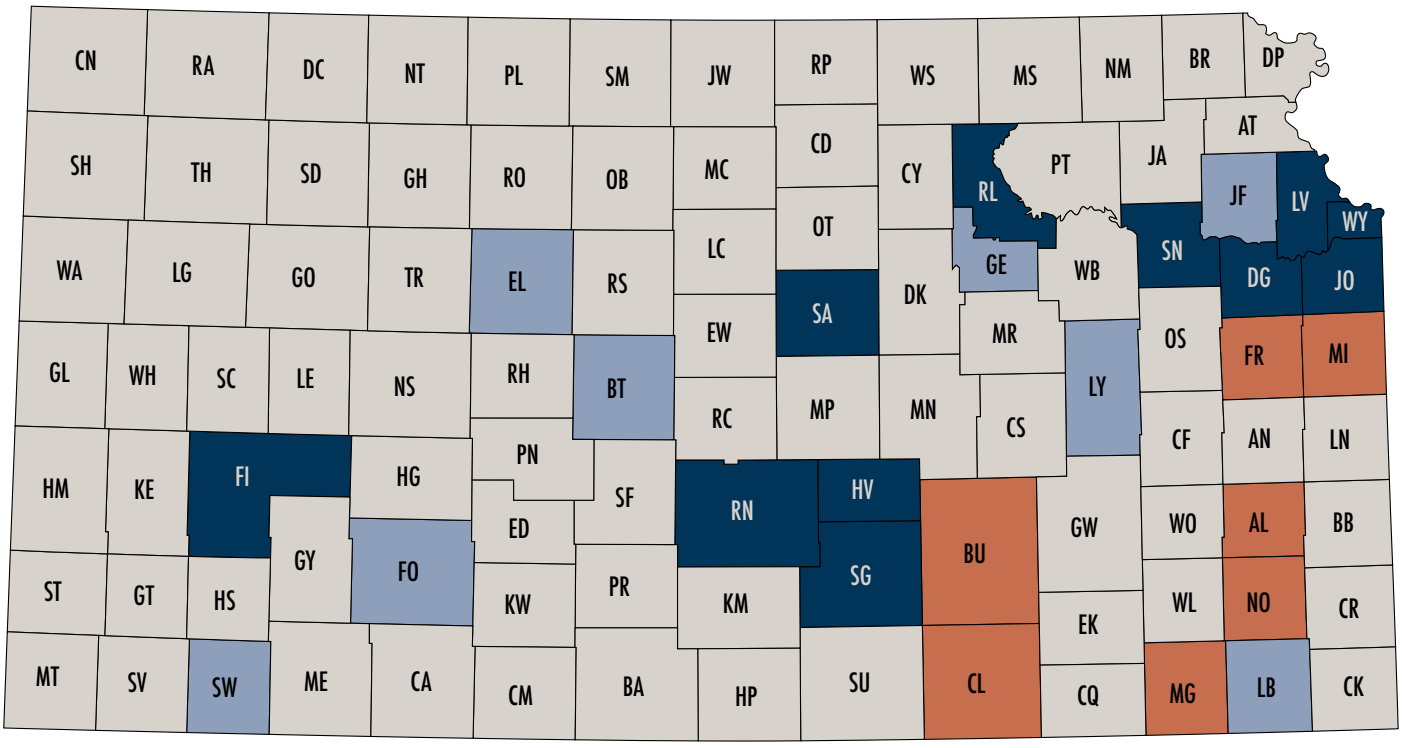
In Kansas, 61.4% of rural counties do not have an OB/GYN. This dire statistic supports the need for the hub-and-spoke model, but it provides little assurance that it is sustainable.



Licensed OB/GYNs, 2023

0 Providers | 1-2 Providers | 2-5 Providers | 5-82 Providers

PEDIATRICIANS BY COUNTY, 2023



Licensed Pediatric Physicians, 2023

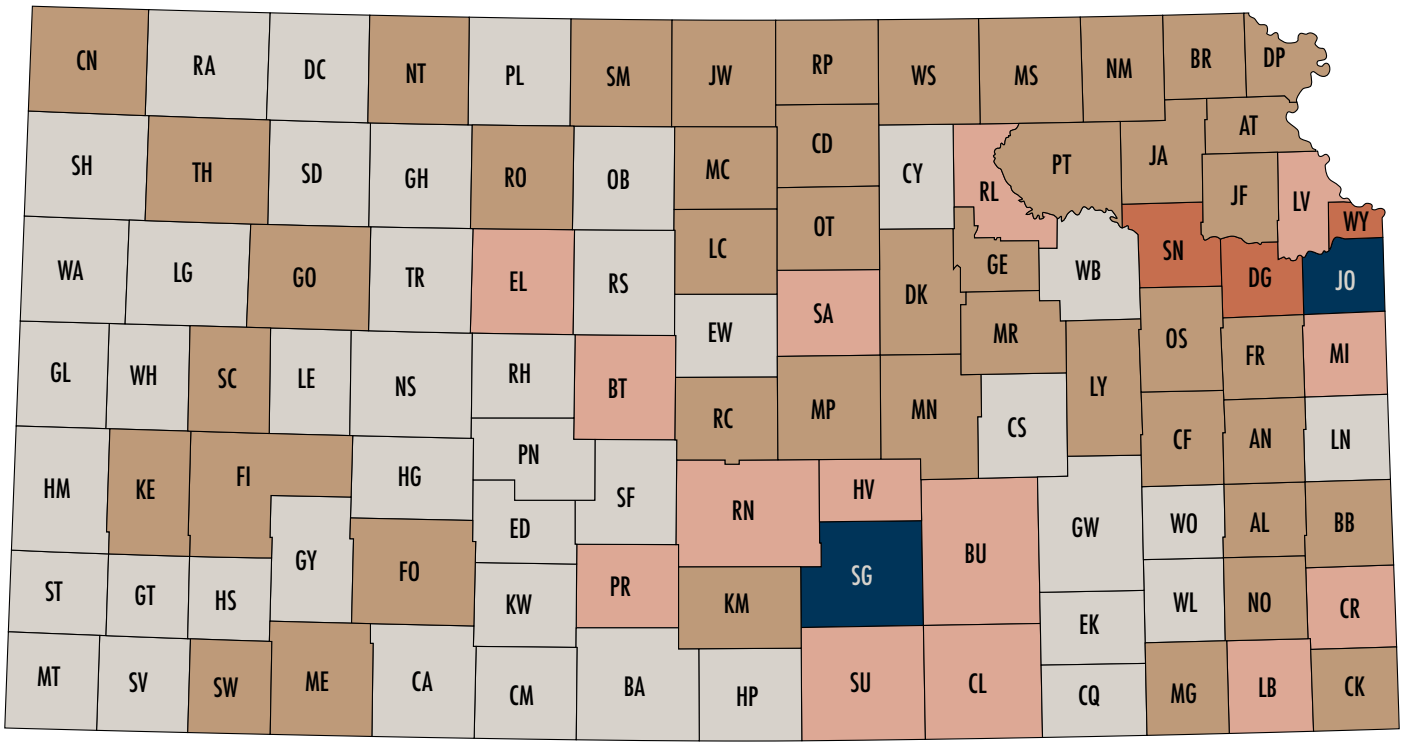
0 Providers | 1-2 Providers | 2-5 Providers | 5-107 Providers

The regional approach to rural health care requires geographic proximity to pediatricians. The United States is facing a shortage of pediatricians, particularly for inpatient care.[25] The shortage of pediatricians creates downstream issues for meeting the subspeciality requirements.

There are only 330 licensed pediatricians in Kansas and only 92% of pediatric residency slots were filled in 2024. In 2024, there were 3,139 pediatric residency slots provided, an increase of 93 from 2023, yet only 2,887 slots were filled. The fill rate for 2023 was 97.1%.[26] Having 'unmatched' residency slots raises challenges for meeting the workforce needs in the foreseeable future.

This map and the numbers reflect another dire statistic for meeting the regionalization, hub-and-spoke model.

ANESTHESIOLOGISTS & CRNAS BY COUNTY, 2023



Licensed Anesthesiologists & CRNAs, 2023

- 0 Providers
- 1 – 5 Providers
- 6 – 30 Providers
- 31-107 Providers
- 108-245 Providers
- 246-439 Providers

Anesthesia experts are an integral part of the maternity care team. These highly trained providers are skilled in airway management, patient stabilization, initiating blood transfusion protocols and managing the patient status during surgical procedures. These experts may be physicians or certified nurse anesthetists (CRNAs). Many of the Kansas counties are covered solely with CRNAs (43.8%). Only 16.2% of counties have both CRNA and anesthesiologists on staff. **Forty percent of counties have no anesthesia coverage and must utilize contracted coverage.**

The prevalence of chronic conditions and/or substance abuse in pregnancy continues to rise, so it takes an integrated team to ensure a safe delivery. Anesthesiology consultations and proactive, detailed plans of care throughout pregnancy are necessary for positive outcomes.

Additionally, incomplete or inappropriate anesthesia management was found to be significantly associated with maternal morbidity/mortality. **The presence of an anesthesia provider affords additional expertise in maternal plans of care decisions.**[27]

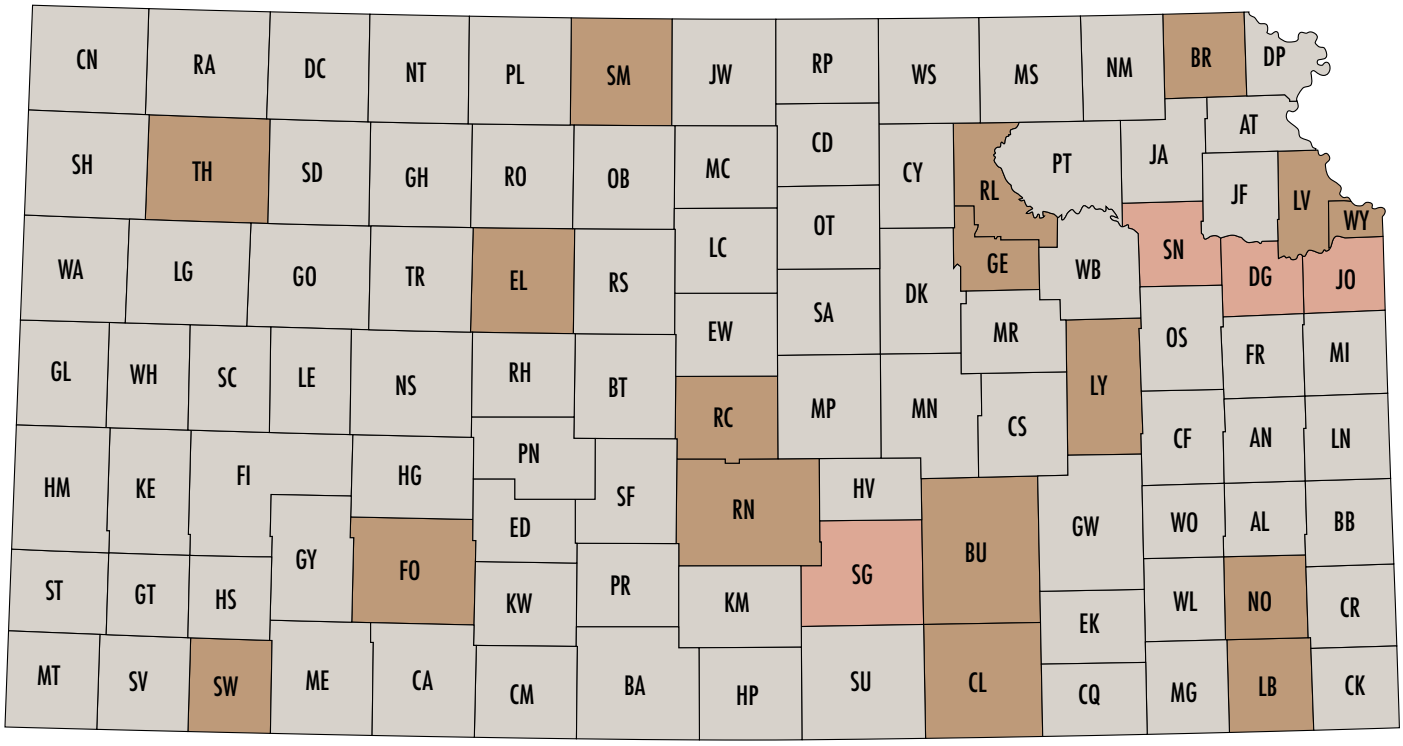
CERTIFIED NURSE MIDWIVES BY COUNTY, 2023

Kansas State Board of Nursing data indicates **there are 81 licensed certified nurse midwives (CNMs) in the state of Kansas.** Johnson County has the highest number of CNMs, with 30.

Kansas CNMs have full independent practice and prescriptive authority. In some counties, CNMs are not performing their full scope of practice, but only providing prenatal care. The CNMs are under-utilized advanced practice nurses who generally have years of obstetrical nursing experience. They are experts in pregnancy, childbirth, and postpartum care. CNMs are an important solution to the health care workforce shortage.

Note, in the U.S., the primary avenue for entry into the profession of midwifery is through nursing. There are certified professional midwives that enter the profession through non-nursing routes. In Kansas, the practice of midwifery is regulated through the State Board of Nursing. Therefore, in order to obtain authorization to engage in the independent practice of midwifery in Kansas, a CNM must be licensed to practice professional nursing under the Kansas nurse practice act and have successfully completed a course of study in nurse-midwifery approved by the board, and completed a national certification approved by the board.

There are non-certified, lay midwives practicing in Kansas. Lay midwives are not licensed or certified and therefore do not fall under the oversight of State licensure boards, so we were unable to account for these numbers.



Certified Nurse Midwives, 2023

0 Providers 1-5 Providers 6-30 Providers

REGISTERED NURSES BY COUNTY, 2024

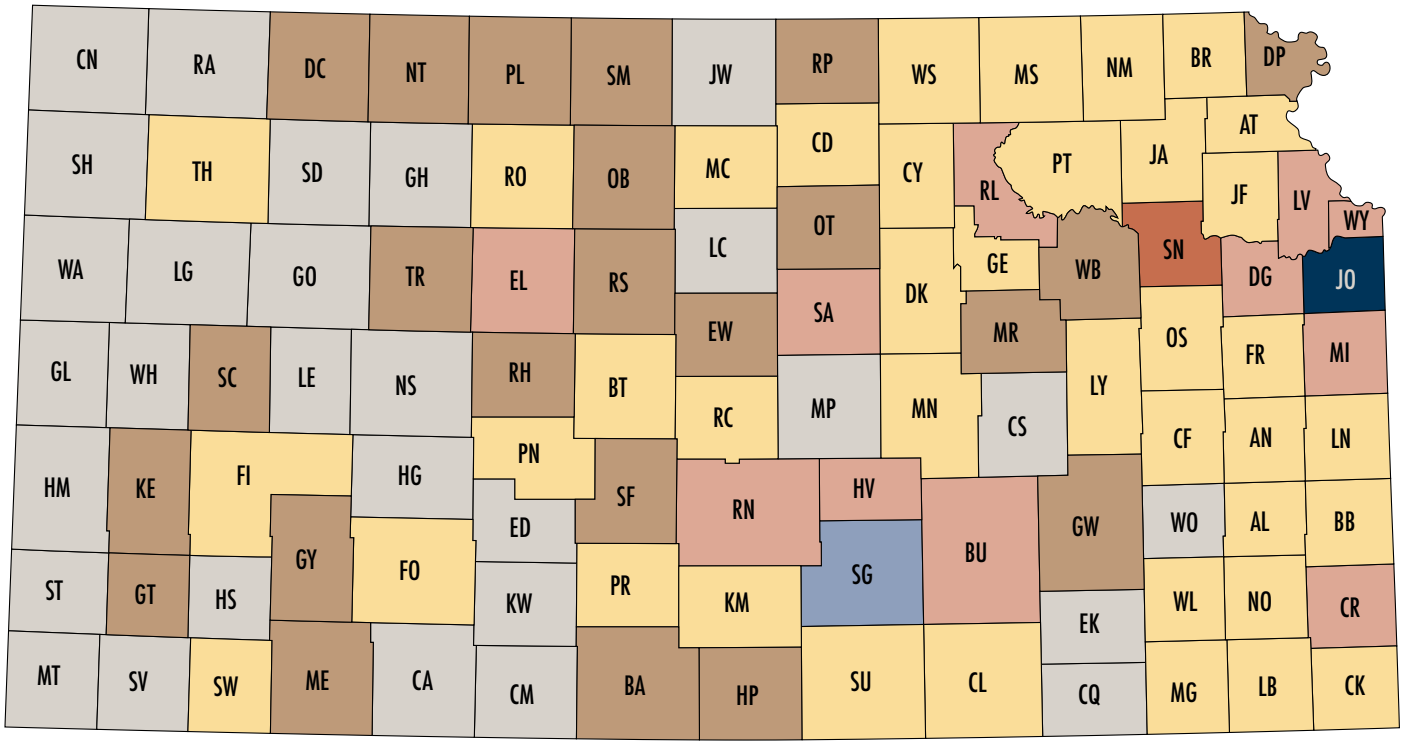
All hospitals are experiencing challenges with recruiting and retaining registered nurses (RNs), but the challenges for rural hospitals with maternity services are greater because of the need for the RNs to be experienced and confident in maternity care, in addition to all other areas of nursing care within the facility. Nurses spend more time with the patient than any other health care professional and are the primary caregivers in birth settings, community health centers, pediatric and neonatal special care units.[29]

Maternity care nursing is a specialized field that requires expertise in maternal-fetal assessment and care of the laboring and postpartum patient. Nurses responsible for inpatient maternity care must be familiar with all levels of low- to high-risk care and know how to initiate appropriate life-saving measures.

It is not unusual for the RN to be the highest licensed member of the health care team on site 24/7/365 in a rural facility. The initial assessment and determination of care is likely made by the RN.

RN staffing is a predictor of lower cesarean rates and the associated risks. However, facilities cannot easily plan for the number of RNs needed for deliveries on any given day because the number needed varies, depending on the amount of women who are in active labor.[28]

Despite the growing costs associated with recruiting and retaining experienced maternity care nurses, the specialized care provided by an RN is not directly included in reimbursement models.



Registered Nurses, 2024

20-49 50-99 100-499 500-1,999 2,000-4,999 5,000-9,999 10,0000+

Data from the Kansas State Board of Nursing was mapped for the number of RNs by county based on their home mailing addresses. Counties in which the number of RNs was below 20 were rounded to 20 to protect the privacy of individual nurses.

Maternal Mental Health & Support Services

Maternal mental health is a significant problem during pregnancy and the postpartum period. Nearly one in eight pregnant women develop prenatal anxiety, which is quite common and associated with poor outcomes, as well as postpartum depression, which is less common than prenatal anxiety.[30] Pregnancy anxiety and depressive symptoms increase the risk of low infant birthweight and preterm birth.[31] Postpartum depression is associated with maternal mortality, delayed child development and decreased quality of life.[32]

Mental health screenings, in addition to substance abuse, tobacco use, and alcohol misuse screenings, should take place throughout the perinatal period. For example, current clinical guidelines for the treatment of opioid use disorder (OUD) in pregnancy recommend medication for OUD (MOUD) rather than withdrawal. Kansas has eight Designated Women's Substance Abuse Treatment (DWSAT) programs.

Pregnant women are given priority status by federal mandate for admission to treatment. However, not all DWSAT programs are designated Opioid Treatment Programs (OTPs) where medication-based treatment is available. The nine accredited and certified OTPs in Kansas are limited geographically to Kansas City metro area, Lawrence, Topeka, and Wichita. While some medications for withdrawal can be administered by providers outside of the OTPs, there are broad regulatory requirements that may limit availability. Ultimately, provision of services for screening, treatment, recovery, and wrap-around care for mothers should be available.[33]

Behavioral health services encompass all aspects of prevention and intervention, including mental health and substance abuse disorders. Services are provided through a wide range of professionals such as psychiatrists, clinical psychologists and counselors, social workers, marriage and family therapists and addiction counselors.

In addition to behavioral health services, supportive care throughout the perinatal period is important to improved birth outcomes. The programs available to a mother and family vary by institution and community.

For this report we chose to examine the availability of behavioral health services in Kansas, and two important perinatal services that are reimbursable: lactation support and doula services.

We have mapped the facilities in Kansas that provide behavioral health services as well as the licensed behavioral health providers, including social workers, professional counselors, substance abuse counselors, marriage and family therapy counselors and psychiatrists.

SUPPORT SERVICES

According to the Kansas Breastfeeding Coalition's website, 80% of Kansas mothers initiate breastfeeding. All new health plans are required to cover comprehensive prenatal and postnatal lactation support and counseling, without cost sharing for as long as an individual is breastfeeding. We have provided information on the availability of support for initiating and sustaining lactation.

Beyond the immediate health care team, individuals may choose to have additional support provided by a doula during pregnancy, delivery and postpartum. Doulas are individuals trained to provide education, advocacy, and physical and emotional support during the pregnancy, delivery, and postpartum periods.[34] Effective July 1, 2024, multiple doula services are reimbursable through the Kansas Medicaid program.

We have mapped the locations of certified and/or trained doulas in Kansas based on the completion of either eight doula trainings plus the observation of three births OR the completion of 30 hours of education and the observation of three births. Of note, doulas are not licensed and are not intended to provide medical, nursing, or other clinical care.

FACILITIES OFFERING BEHAVIORAL HEALTH SERVICES BY COUNTY, 2023

We surveyed health care systems/facilities across Kansas to identify where expectant or new mothers could consistently access in-person behavioral health or mental health services. This map reflects locations offering these services and the locations of Certified Community Behavioral Health Clinics (CCBHCs).

In 2021, Kansas became the first state to pass legislation identifying the CCBHC as a solution to the mental health and substance use crisis. The legislation established Community Mental Health Centers (CMHCs) as the 'safety net' for Kansans with mental health needs and began transitioning the state's 26 CMHCs to CCBHCs.

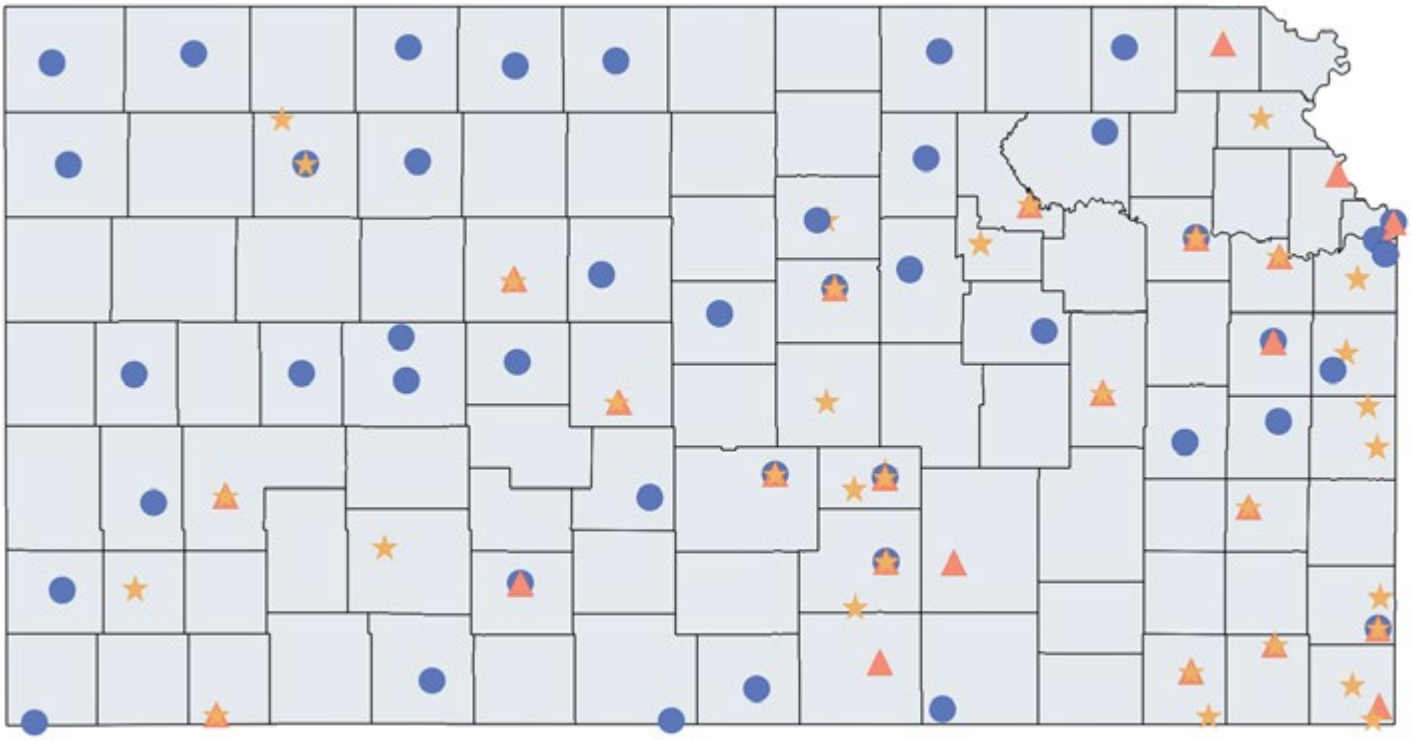
In 2024, Kansas was added along with 9 other states to the CCBHC Medicaid Demonstration program.[35] The mapping does not account for locations where a consultative appointment by a primary care provider is followed by a telehealth referral when necessary. Also, this map reflects the availability of services, not the type of provider. Page 53 provides details on the locations of specific mental and behavioral health providers.

In Kansas behavioral health access is widespread and multi-layered.

The importance of mental and behavioral health care to improved maternal and infant outcomes cannot be overstated. Importantly, in addition to health care experts in mental and behavioral health, peer mentored support programs have shown effectiveness in decreasing prenatal and postpartum anxiety and depression and improving outcomes.[36-37]

While many behavioral health centers, including FQHCs, may not provide services throughout the full pregnancy, they work closely with community partners to ensure the mother's care is well managed throughout the term of the pregnancy.

Additionally, prenatal and postpartum assessment of maternal mental health is critical and should be a component of the perinatal care continuum. As many as one third of women who deliver babies do not attend their postpartum appointment.[38] Every effort must be made to increase the number of mothers who receive their postpartum care follow-up visit. This visit provides an important opportunity to evaluate the new mother's mental health and the availability of support and resources.



- Facilities offering behavioral health or mental health care
- Certified Community Behavioral Health Clinics (CCBHCs)
- Federally Qualified Health Centers

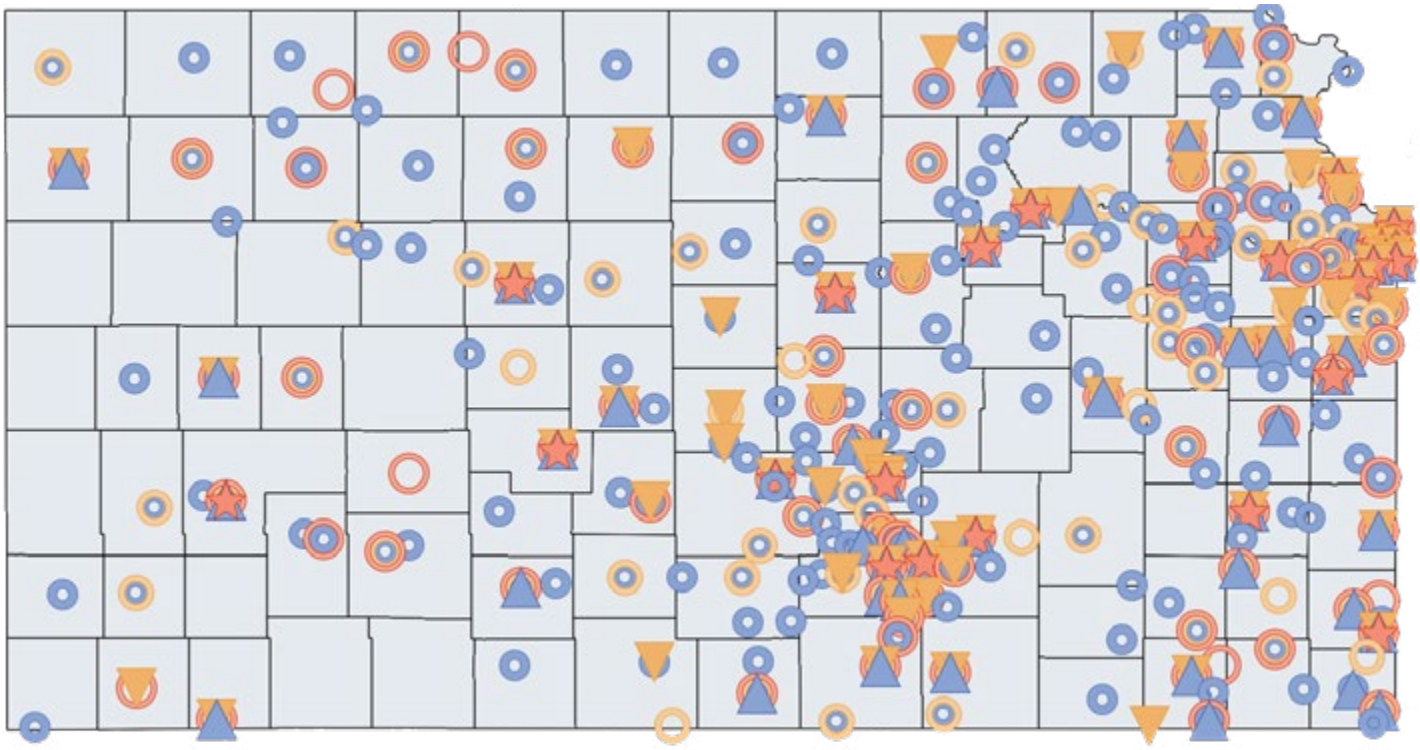
AVAILABILITY OF BEHAVIORAL HEALTH PROVIDERS, 2023

Behavioral health is a complex, multifactorial field featuring a combination of providers with varied specialties and training. Our data from 2023 reflects there were 5,388 licensed social workers, 1,302 professional counselors, 883 substance abuse counselors, 615 marriage and family therapists, 239 psychologists and 159 psychiatrists in Kansas (see chart). Mental health nurse practitioners are available to provide behavioral health to Kansans as well. However, they are not included in the map because they are not tracked separately from other types of advanced practice registered nurses.

In addition to the providers mapped within each county, Kansas Connecting Communities (kansasmch.org) offers a statewide perinatal psychiatric access program that provides consultations from an expert perinatal psychiatry team, resource, and referral support.

Beyond the professional mental health care team, pregnant and new mothers benefit from the help and support of other women, family, and friends during their transition from pregnancy to motherhood. Mothers can be encouraged through the perinatal process to build their support network. For the best outcomes, individualized woman- and family-centered care begins prenatally and requires collaboration between various health care entities and providers to meet the needs of the family.[39]

Provider Type	Number in Kansas
Licensed Social Workers	5,388
Professional Counselors	1,302
Substance Abuse Counselors	883
Marriage and Family Therapists	615
Psychologists	239
Psychiatrists	159



Licensed Behavioral Health Providers, 2023

- Social Workers
- Professional Counselors
- Substance Abuse Counselors
- Marriage and Family Therapy
- Clinical Psychologists
- Psychiatrists

CERTIFIED INTERNATIONAL BOARD-CERTIFIED LACTATION CONSULTANTS (IBCLCS)

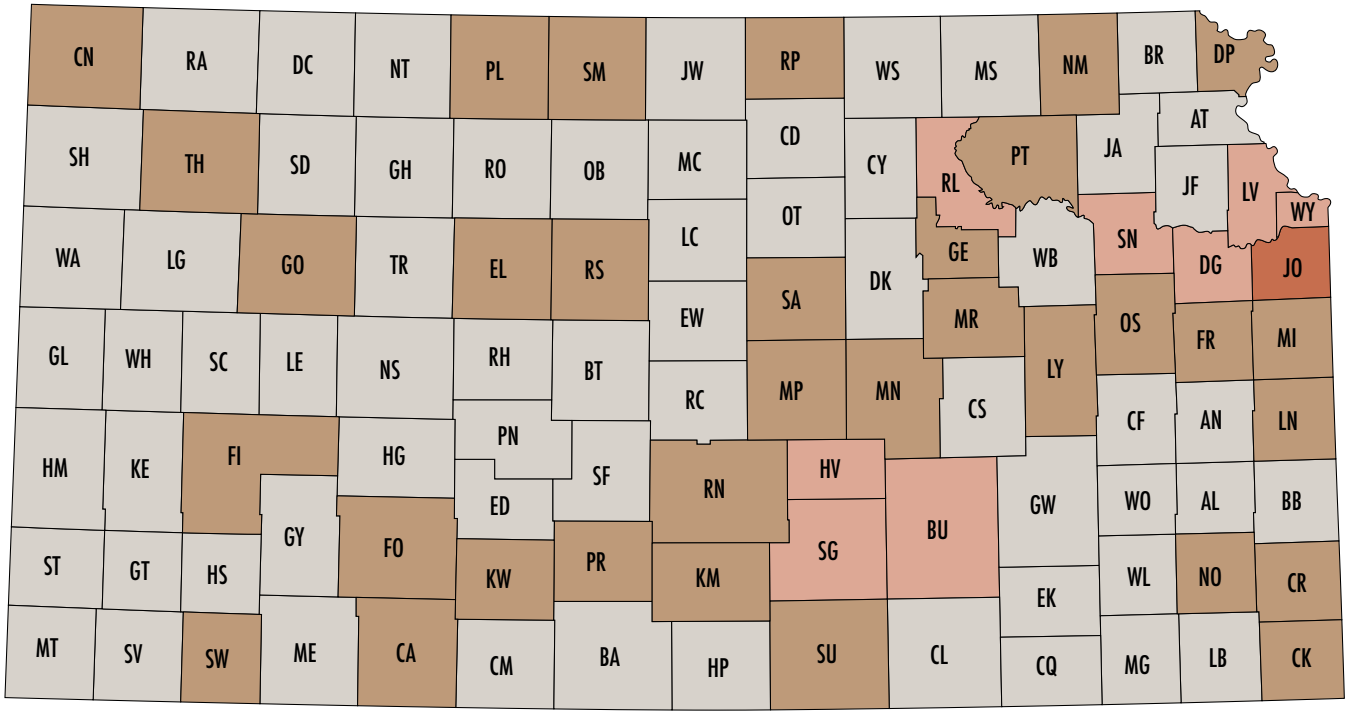
Breastfeeding provides positive health and well-being for both mother and baby. Breastfeeding supports the production of hormones that foster maternal-infant attachment, such as gaze, vocalization, positive affect, affectionate touch, and frequent checking of the infant. Moreover, elevated prolactin hormone levels are associated with decreased postpartum depression in the mother. The significance of breastfeeding to overall health and well-being cannot be overstated and therefore exclusive breastfeeding is recommended for the first six months of life, with continued breastfeeding with the introduction of foods during the infant's first year of life or longer.[40]

There is a worldwide recommendation for long-term breastfeeding, and 84.1% of U.S. women start with breastfeeding after giving birth. But of those women, 19.2% introduce formula within two days of birth and only 58.3% continue breastfeeding for six months.

Maternity care providers should be a resource for breastfeeding concerns, pain, milk supply, infections and maternal medication safety.[40] Embedding lactation professionals, such as International Board-Certified Lactation Consultants (IBCLCs) or other lactation providers should be considered, particularly given the coverage of lactation services included as preventive care within the Affordable Care Act.

Availability of IBCLCs in Kansas were compared and mapped. In addition to IBCLCs, there are also individuals certified as Lactation Counselors (CLCs). The services vary by location but range from prenatal support classes to tele-lactation.

In addition to lactation support, patients should be screened for Women, Infants, and Children (WIC) eligibility during prenatal care. This is an important way to provide breastfeeding and nutrition support to women and families and promote feeding goals.



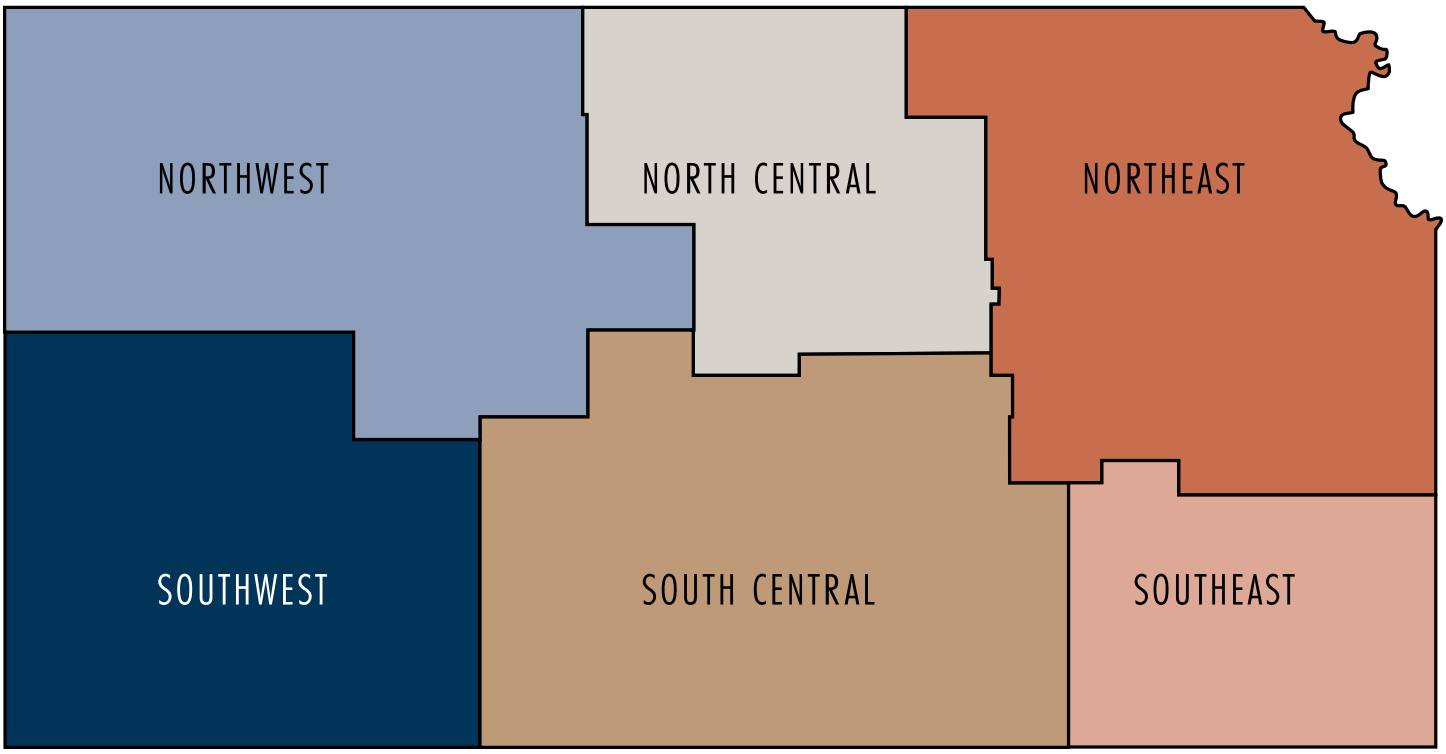
Certified International Board-Certified Lactation Consultants, 2023

0 Providers 1-5 Providers 6-30 Providers 31-107 Providers

LACTATION SUPPORT SERVICES

The map corresponds to the Kansas Hospital Association's regions, and the table represents the various lactation support services by facilities surveyed by United Methodist Health Ministry Fund in September 2024.

The data charted in the table reflects good coverage for lactation support services through prenatal, inpatient, and outpatient avenues for most regions in Kansas. Comprehensive support is seen with telelactation, walk-in clinics and courtesy postpartum calls. The survey indicated that the majority of lactation support was provided by RNs, who were certified lactation consultants within the health care systems. This approach and model of care provides the recommended continuum of support throughout the perinatal period.



LACTATION SUPPORT SERVICES

Region	Inpatient Care	Outpatient Visits	Prenatal Services	Prenatal Breastfeeding Classes	Telelactation Visits	Walk-in Clinic	Courtesy Postpartum Call
Northwest (N=3)	100%	100%	100%	100%	67%	33%	67%
North Central (N=4)	50%	100%	25%	25%	0%	0%	50%
Northeast (N=18)	94%	89%	61%	67%	17%	33%	50%
Southeast (N=2)	100%	60%	80%	40%	0%	0%	100%
South Central (N=7)	86%	57%	57%	43%	29%	14%	29%
Southwest (N=2)	100%	50%	100%	50%	0%	50	0%

Alt text: Based on survey data by United Methodist Health Ministry Fund, seven lactation services were charted. Three facilities in the Northwest region of Kansas reported: Inpatient Care (100%), Outpatient Visits (100%), Prenatal Services (100%), Prenatal Breastfeeding Classes (100%), Telelactation Visits (67%), Walk-in Clinic (33%), Courtesy Postpartum Call (67%). Four facilities in the North Central region of Kansas reported: Inpatient Care (50%), Outpatient Visits (100%), Prenatal Services (25%), Prenatal Breastfeeding Classes (25%), Telelactation Visits (0%), Walk-in Clinic (0%), Courtesy Postpartum Call (50%). Eighteen facilities in the Northeast region of Kansas reported: Inpatient Care (94%), Outpatient Visits (89%), Prenatal Services (61%), Prenatal Breastfeeding Classes (67%), Telelactation Visits (17%), Walk-in Clinic (33%), Courtesy Postpartum Call (50%). Two facilities in the Southeast region of Kansas reported: Inpatient Care (100%), Outpatient Visits (60%), Prenatal Services (80%), Prenatal Breastfeeding Classes (40%), Telelactation Visits (0%), Walk-in Clinic (0%), Courtesy Postpartum Call (100%). Seven facilities in the South Central region of Kansas reported: Inpatient Care (86%), Outpatient Visits (57%), Prenatal Services (57%), Prenatal Breastfeeding Classes (43%), Telelactation Visits (29%), Walk-in Clinic (14%), Courtesy Postpartum Call (29%). Two facilities in the Southwest region of Kansas reported: Inpatient Care (100%), Outpatient Visits (50%), Prenatal Services (100%), Prenatal Breastfeeding Classes (50%), Telelactation Visits (0%), Walk-in Clinic (50%), Courtesy Postpartum Call (0%).

DOULAS PER COUNTY, 2024

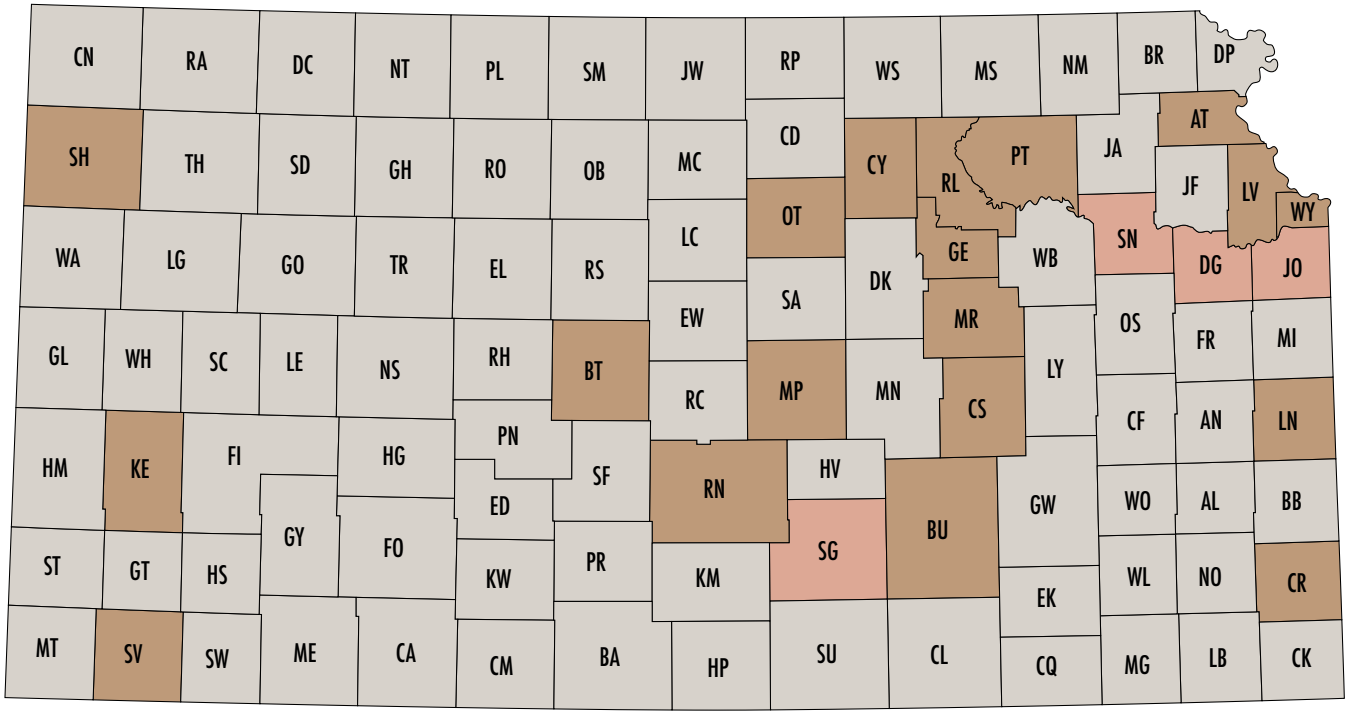
Evidence suggests that in addition to regular nursing care and support, continuous one-to-one physical and emotional support, such as that provided by a doula, is associated with improved outcomes for labor and postpartum outcomes.[41-42]

In September 2021, Health and Human Services (HHS) announced $350 million expansion for maternal health and the Centers for Medicare & Medicaid Services (CMS) funded increases focused on access to doula services, under 'community care provider' program strategies.[43]

The support and advocacy provided by a doula is now a reimbursable expense. The requirements vary across states. Reimbursement of doula services by Kansas' Medicaid program, KanCare, does not require a certified doula. It does require documentation of at least 30 hours of training (either eight doula trainings plus the observation of three births OR the completion of 30 hours of education and the observation of three births).

Data regarding the availability of doulas across the state is spread across several separate registries. The Kansas Department of Health and Environment has been engaged in an ongoing effort to compile this information. This map represents the best estimate of the number and availability of trained doulas.

Given the growing use of doulas, health care organizations, in conjunction with the obstetrical providers, may want to develop programs and policies to integrate trained support personnel into the birthing environment to provide continuous one-to-one emotional support to the laboring mother. Doulas are not to provide medical or nursing care. Therefore, the workforce requirements for nursing remain the same with a ratio of 1:1 continuous RN coverage during active labor.



Doulas per County, 2024

0 Providers 1-5 Providers 6-30 Providers

Coverage for Care

There are several options to cover the cost of a pregnancy and birth. Coverage for care can include direct payments (cash), private insurance, and public health insurance coverage, which is known as Medicaid in general and as KanCare in Kansas.

In 2021, a provision within the American Rescue Plan Act provided states with the option to extend Medicaid coverage for postpartum to 12 months. Kansas' state plan which includes 12 months of coverage with no limits on benefits, was approved by the Centers for Medicare and Medicaid (CMS) on July 16, 2022.[14]

Most rural hospitals lose money delivering patient services in general. Birth is one of the most common reasons for health care use in the U.S. and one of the top costs for payers annually. Due to a difference in patient volumes, the same level of payment may adequately compensate a large urban hospital but won't cover the costs for a rural hospital to deliver the same health care services.[13] Having all the necessary services for maternity care available 24/7/365 when the volume of patients is very low is difficult to sustain, particularly for rural facilities with a reimbursement model based on Medicare coverage.

Many proposed solutions for rural hospitals are based on increasing Medicare or Medicaid payments or expanding Medicaid eligibility.[13] Medicaid is a major public source for coverage of health services provided to those who are pregnant, infants and children. In Kansas during 2022, 41% of mothers had Medicaid coverage at birth.[14] At many of the rural facilities in Kansas, our qualitative data reflect that about 7% of all patients are covered by Medicaid.

In Kansas the Medicaid reimbursement rate for surgical or non-surgical delivery is approximately 70%, and only 61% for vaginal births after cesareans (VBAC), assuming a higher risk of complications for mother and baby.[44]

Medicaid programs in surrounding states offer reimbursement rates, as much as 2.2 times higher. Low reimbursement further impacts access to care in rural communities, where it is difficult to cover the overhead costs of providing maternity care.[44]

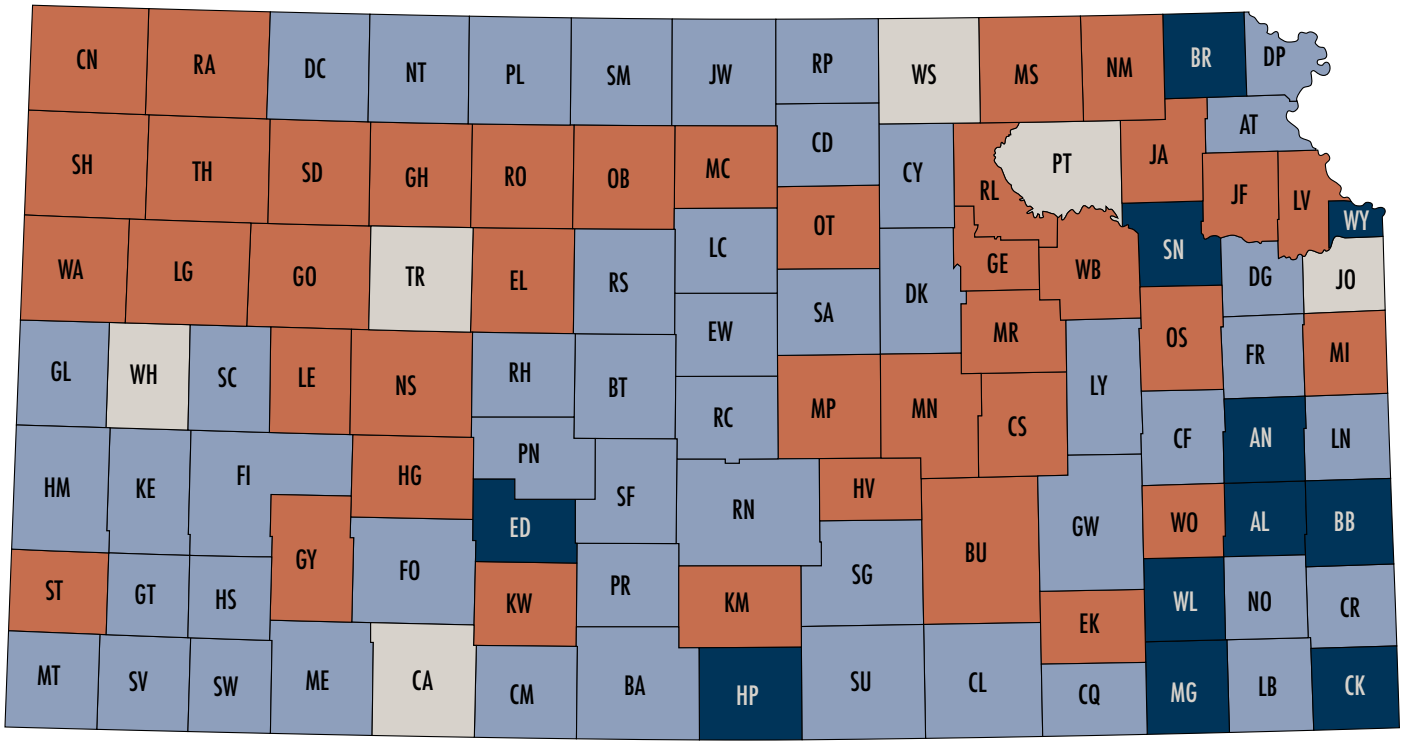
In this section we look at Medicaid coverage.

MEDICAID INSURANCE IN KANSAS, 2022

Public health insurance includes coverage provided through government-sponsored health programs which are funded at the federal, state, and/or local levels. Medicaid and Children's Health Insurance Program (CHIP) are administered by the state of Kansas through KanCare.

Pregnant women at 171% of the Federal Poverty Level, or an annual income of $47,453 or less for a family of four, are eligible for Medicaid coverage.[14] In July 2022, the Kansas Legislature passed Bill 267, extending postpartum coverage from 60 days to 12 months. The extension was approved by the Centers for Medicare and Medicaid. The extension includes access to health care and mental health services for pregnant and postpartum mothers as well as for children. The coverage for pregnant and postpartum women and children is currently fully funded through Medicaid and CHIP

The mapping of births with Medicaid coverage by county reflect the highest numbers in eastern Kansas, with percentages between 46-59%. Northwest Kansas has lower Medicaid numbers, but it also has some of the highest uninsured rates for the state. The percentages of births covered by Medicaid in Kansas for each county are detailed in the chart starting on page 64.



Percent of Live Births that are Medicaid Births, 2022

0-15% 15-30% 30-45% 45-60%

PERCENTAGE OF BIRTHS COVERED BY MEDICAID IN KANSAS

COUNTY	MEDICAID BIRTHS PER COUNTY
Allen	54.79%
Anderson	45.74%
Atchison	43.02%
Barber	38.30%
Barton	41.07%
Bourbon	47.37%
Brown	46.81%
Butler	27.62%
Chase	25.00%
Chautauqua	35.71%
Cherokee	53.26%
Cheyenne	15.62%
Clark	9.09%
Clay	34.57%
Cloud	37.14%
Coffey	34.12%
Comanche	30.00%
Cowley	44.59%
Crawford	44.70%
Decatur	33.33%
Dickinson	32.87%
Doniphan	35.82%
Douglas	31.36%
Edwards	47.83%
Elk	16.00%
Ellis	22.30%

COUNTY	MEDICAID BIRTHS PER COUNTY
Ellsworth	32.31%
Finney	42.63%
Ford	35.50%
Franklin	35.95%
Geary	16.26%
Gove	18.18%
Graham	24.00%
Grant	39.80%
Gray	20.99%
Greeley	35.71%
Greenwood	44.07%
Hamilton	40.00%
Harper	47.76%
Harvey	29.20%
Haskell	36.36%
Hodgeman	22.22%
Jackson	25.14%
Jefferson	22.83%
Jewell	34.38%
Johnson	13.22%
Kearny	35.09%
Kingman	25.33%
Kiowa	28.12%
Labette	43.03%
Lane	17.65%
Leavenworth	27.83%

COUNTY	MEDICAID BIRTHS PER COUNTY
Lincoln	31.25%
Linn	41.35%
Logan	28.57%
Lyon	30.81%
Marion	26.55%
Marshall	28.81%
McPherson	24.25%
Meade	35.56%
Miami	26.30%
Mitchell	19.12%
Montgomery	50.15%
Morris	28.95%
Morton	42.86%
Nemaha	15.97%
Neosho	37.10%
Ness	17.86%
Norton	31.25%
Osage	29.63%
Osborne	27.78%
Ottawa	29.09%
Pawnee	34.09%
Phillips	41.86%
Pottawatomie	14.32%
Pratt	34.51%
Rawlins	22.58%
Reno	41.93%

COUNTY	MEDICAID BIRTHS PER COUNTY
Republic	30.23%
Rice	35.83%
Riley	21.41%
Rooks	22.00%
Rush	35.71%
Russell	35.09%
Saline	41.98%
Scott	31.25%
Sedgwick	37.32%
Seward	36.98%
Shawnee	45.06%
Sheridan	15.79%
Sherman	27.12%
Smith	40.74%
Stafford	30.23%
Stanton	29.03%
Stevens	35.62%
Sumner	33.72%
Thomas	27.18%
Trego	12.5%
Wabaunsee	22.97%
Wallace	15.79%
Washington	13.89%
Wichita	14.29%
Wilson	58.51%
Woodson	28.12%
Wyandotte	47.12%

IN THEIR OWN WORDS

Finally, consider these quotes from chief executive officers, chief nursing officers, and providers from Kansas health care facilities that are considering closure of their maternity care programs, or have paused their programs, as well as those with potentially increased volumes secondary to nearby closures.

IN THEIR OWN WORDS

> We don't deliver **just our county.**
> We have surrounding counties, and it is more than six.

> [It] doesn't matter if you're doing 50 or 200 deliveries... you've **got to have the same resources.**

> OB is not a money maker for us. It's resource heavy. **We do this for the community.**

> Keeping anesthesia and well-trained nursing staff is **our biggest challenge** [to offering maternity care].

> We have been in the high fifties, low- to mid-sixties. Next year we will be **over one hundred [deliveries].**

> The cost [of maternity services] only goes up and the **reimbursement doesn't keep up.**

Considerations

MAXIMIZE MATERNITY CARE CAPABILITIES AND EXPERTISE THROUGH TELEHEALTH

Telehealth provides an excellent opportunity to expand and improve availability of health services to rural pregnant women. Telehealth is appropriate for appointments that concentrate on patient education or routine follow-up. Postpartum wellness checks could be conducted through telehealth with in-person follow-up as needed. This approach may promote better postpartum patient follow-up and opportunities to tailor services to individual needs.

PROMOTE COLLABORATIVE HEALTH NETWORKS THAT ENABLE COORDINATED REGIONAL SYSTEMS FOR MATERNITY CARE

Regionalization of maternity care requires collaborative efforts between the entire health care team and health systems. Culturally relevant care and transportation needs must be addressed. Plans to accommodate housing needs for those not requiring inpatient stays must be considered within the strategic planning and coordination. Obstetricians and gynecologists should consider partnering with family physicians, certified nurse midwives and certified midwives to provide consultation and training. Availability of specialists is key to regionalization of care. The numbers of obstetricians, pediatricians, neonatologists, and maternal-fetal medicine specialists requires monitoring and workforce considerations to maintain the necessary balance for services. Standardized processes and network-wide policies are also key to the success of regionalization.

NEW INNOVATIVE REIMBURSEMENT MODELS FOR MATERNITY CARE ARE NEEDED

Eighty-six percent of Kansas hospitals experienced a loss of services in 2023, 63% are at risk of closing and 32% are at risk of immediate closure.[45] Consider these numbers in light of the data presented on the availability of hospitals offering delivery services. Free standing birthing centers are struggling to stay open despite their popularity, due to the low reimbursement from Medicaid and private insurance companies.[46] Economy-wide inflation grew by 12.4% between 2021 and 2023, which was more than double the 5.2% growth in Medicare reimbursement for inpatient hospital care.[47] The American Hospital Association (AHA) is encouraging legislative approaches such as increasing reimbursement for maternity care services, reducing barriers to partnerships and innovative approaches to delivering care, and requiring Medicaid programs to cover telemedicine for maternity care.

ONGOING STAKEHOLDER ENGAGEMENT NEEDED

Everyone in Kansas must protect the maternity care services that we have. Additional engagement, collaboration and research are critical for making better decisions on behalf of Kansas mothers and babies. With scare resources, every policy decision has the potential to make lasting and positive change for all Kansans.

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