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Maternal Health in Utah: Risk Factors, Workforce Gaps, and Access to Care

Some Utahns face compounding challenges to accessing maternal health care, including long travel distances, limited provider availability, and higher prevalence of risk factors.

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Kem C. Gardner POLICY INSTITUTE
THE UNIVERSITY OF UTAH
DAVID ECCLES SCHOOL OF BUSINESS

10 YEARS OF IMPACT 2015-2025

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Maternal Health in Utah: Risk Factors, Workforce Gaps, and Access to Care

Analysis in Brief

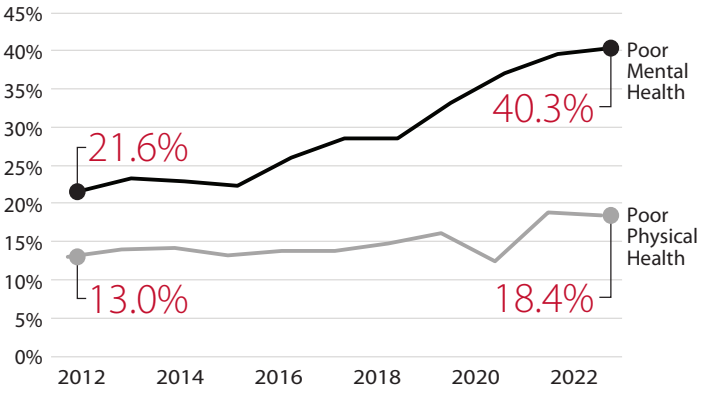
Understanding and addressing risk factors for poor maternal health, reducing gaps in access to care, and strengthening the maternal health workforce is key to improving health outcomes for women and children in Utah. A range of factors can influence poor maternal health outcomes experienced by women before, during, and after birth, including physical and mental health conditions, substance use, intimate partner violence, access to maternal health care, and social drivers of health (e.g., low income, unstable housing, and food insecurity). The share of Utah women experiencing risk factors for poor maternal health outcomes varies by population group, socioeconomic status, and where one lives in relation to maternal health care services and resources.

Unfortunately, Utah's maternal health workforce is also under-resourced. Some communities in the state currently experience a shortage of health care professionals providing maternal health care, and this gap is expected to grow over the coming decades.

Key Findings

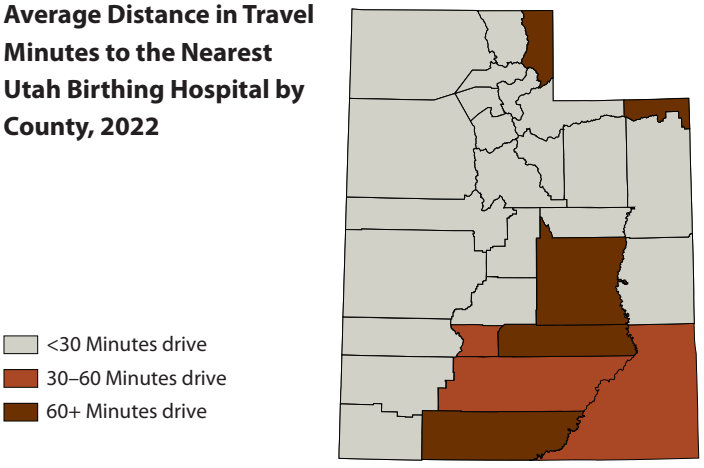
- **Maternal health outcomes** – Utah reports better maternal health outcomes compared to national estimates; however, poor maternal health outcomes are higher among Utah's racial and ethnic minority populations and women giving birth at later ages.
- **Contributing factors to maternal deaths** – Mental health, substance use disorders, and obesity are the most common contributing factors to maternal deaths in Utah. Access is another key contributing factor. More than 1 in 4 individuals who died during pregnancy or postpartum had at least one barrier to accessing health care.
- **Varying prevalence of risk factors for poor maternal health outcomes** – The prevalence of maternal health risk factors in Utah varies by geography and population group. Physical and mental health conditions, health care access barriers, and poverty are more prevalent among women living in Utah's rural counties and Utah's racial and ethnic minority women.
- **Increasing rates of poor health** – The prevalence of poor physical and mental health among Utah women of reproductive age is rising, with rates of poor mental health increasing by 18.7 percentage points in 10 years, putting more women at higher risk for pregnancy complications.
- **Access to birthing hospitals** – Seven of Utah's 29 counties do not have a birthing hospital. The average travel time to the nearest birthing hospital is over 60 minutes in five counties.
- **Maternal health workforce shortages** – Twenty-two of Utah's 29 counties are designated primary care workforce shortage areas. Over 77% of Utah's 2023 births occurred to mothers residing in these 22 counties.

Rates of Poor Physical and Mental Health Among Utah Women of Reproductive Age (18–44), 2012–2022



Note: "Poor mental and physical health" is defined as the percentage of women ages 18-44 who reported their mental or physical health was not good for 7 or more days in the past 30 days.
Source: Utah Department of Health and Human Services Behavioral Risk Factor Surveillance System, 2012-2022

Average Distance in Travel Minutes to the Nearest Utah Birthing Hospital by County, 2022



Note: Travel time is measured in minutes from the resident to the nearest birthing hospital, which is classified based on criteria from the AHA annual survey and the CMS POS files.
Source: Hospitals with obstetric units identified through 2022 AHA survey. Retrieved from Perinatal Data Center, March of Dimes, February 2025.

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Introduction

Utah's maternal health workforce is under-resourced. Some communities in the state currently experience a short supply of health care professionals providing maternal health care, and this gap is expected to grow over the coming decades. There is also a short supply of non-clinical professionals like doulas due to low reimbursement and a lack of health insurance coverage. Finally, limited providers specializing in maternal mental health and substance use treatment prevent individuals from accessing timely behavioral health care.

Methodology

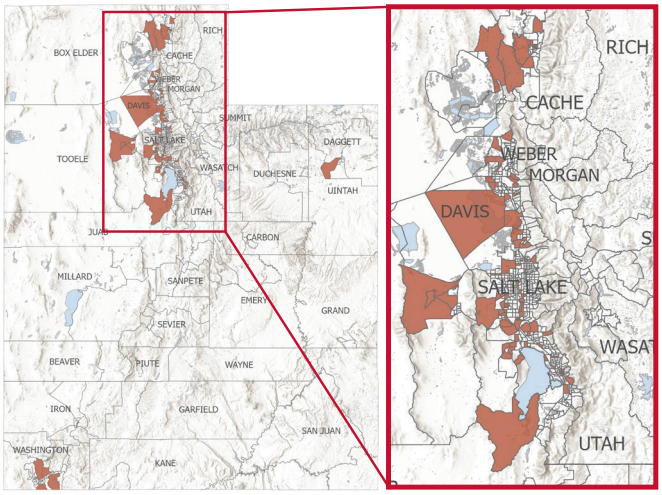
To better understand the potential demand for maternal health services in Utah, the Kem C. Gardner Policy Institute reviewed numerous data points and measures that reflect risk for poor maternal health outcomes. Where available, data were collected at the county level among women of reproductive age (15–44 years, 18–44 years, or 18–49 years, depending on the data source). These data highlight which populations and areas within the state may have higher relative risks for needing more maternal health services.

Utah's maternal health care workforce is also assessed at the county level using several data sources including the American Medical Association (AMA) Physician Masterfile, Centers for Medicare & Medicaid Services (CMS) Provider of Services (POS) file, March of Dime's Perinatal Data Center, Health Resources and Services Administration's (HRSA) Area Health Resources Files (AHRF) and workforce projections, and a review of Utah hospital websites (completed in April 2025).

The Gardner Institute also conducted 13 maternal health care stakeholder interviews with maternal health providers, health systems, clinics, training faculty, and state health department staff. These interviews provided insights into Utah's maternal health care landscape, challenges Utah families face in accessing quality care, barriers and opportunities to expanding maternal health care in areas with workforce shortages, and efforts to expand and improve maternal health care across the state (including physical and mental health care and substance use treatment).

Stories of Utah families experiencing challenges in accessing maternal health care were gathered through an additional 10 in-depth interviews with maternal health care providers, health department staff, and community-based organizations representing areas or population groups in the state with greater access barriers (including Utah's racial and ethnic minority populations and rural areas). Quotes and findings from these interviews are integrated into the body of the report.

Figure 1: Utah Census Tracts with More than 1,500 Women Residents of Reproductive Age (15–44 years), 2023



1,500+ women of reproductive age reside in census tract

Source: Census Bureau's American Community Survey, 2023

Table 1: Utah Births by Type of Birth Attendant, 2023

	Count of births	Percentage of births
Physician (M.D. or D.O.)	37,296	82.9%
Certified Nurse Midwife	5,833	13.0%
Other Midwives	1,717	3.8%
Other	111	0.3%
Total	44,992	100.0%

Source: Utah Birth Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

Utah Births

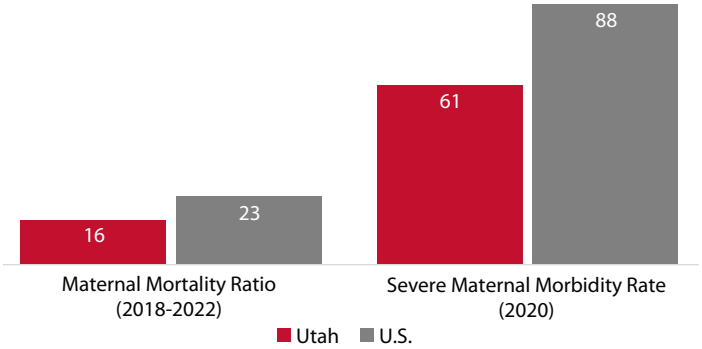
There were nearly 45,000 Utah births in 2023, with 58% to mothers residing in Salt Lake or Utah counties (the percent of births occurring in Salt Lake or Utah County increases to 63.8% when considering mothers traveling to these counties to deliver). Utah County reported the highest births per 1,000 population at 17.4, and Daggett County reported the lowest at 8.4.[1] Women of reproductive age (15–44 years) primarily live along Utah's Wasatch Front and in Washington County (Figure 1).

Over 95% of Utah births in 2023 occurred at a hospital.[2] Physicians (M.D. and D.O.) attended 82.9% of live births, certified nurse midwives attended 13%, and other midwives attended 3.8%[3] (Table 1).

Maternal Health Outcomes

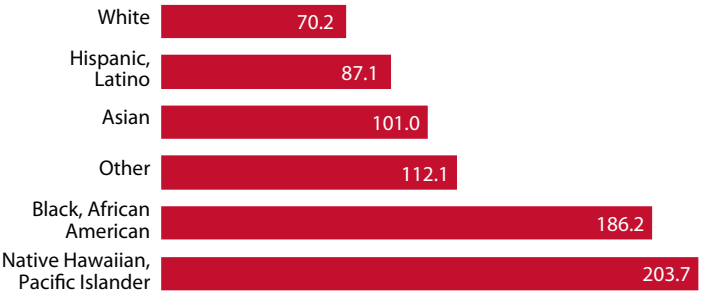
Utah reports better maternal health outcomes compared to national estimates (Figure 2). The ratio of maternal mortality[4] in Utah is 16 per 100,000 live births compared to 23 nationally. In terms of severe maternal morbidity (SMM), which is the rate of unexpected labor or delivery outcomes that have serious short- or long-term health impacts, Utah's rate is 61 per 10,000 delivery

Figure 2: Maternal Mortality Ratio and Severe Maternal Morbidity Rate in Utah and U.S., 2018–2022



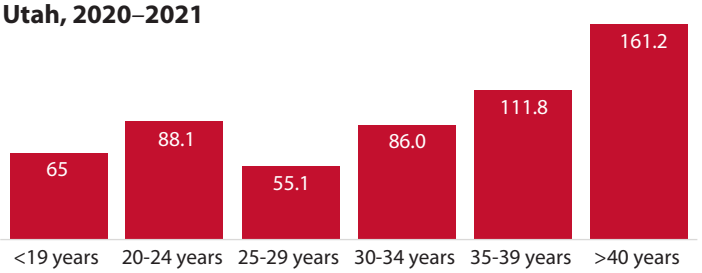
Note: Maternal mortality is defined differently depending on the surveillance system. The data source used to calculate maternal mortality in this figure defines maternal mortality as maternal deaths per 100,000 live births for the combined years 2018-2022. Maternal deaths are deaths among women while pregnant or within 42 days of termination of the pregnancy. Other data sources measure maternal deaths as a death during or within one year of pregnancy. The rate of severe maternal morbidity is per 10,000 delivery hospitalizations. SMM includes unexpected outcomes of labor or delivery that have serious short- or long-term health impacts. In most instances, these outcomes could have been avoided with timely, appropriate care.
Sources: Maternal mortality rates from the National Center for Health Statistics, National Vital Statistics System. Maternal Mortality by State, 2018-2022. Accessed from: https://www.cdc.gov/nchs/maternal-mortality/mmr-20182022-state-data.pdf. Severe maternal mortality from the Healthcare Cost and Utilization Project (HCUP) 2020

Figure 3: Severe Maternal Morbidity by Race/Ethnicity in Utah, 2020–2021



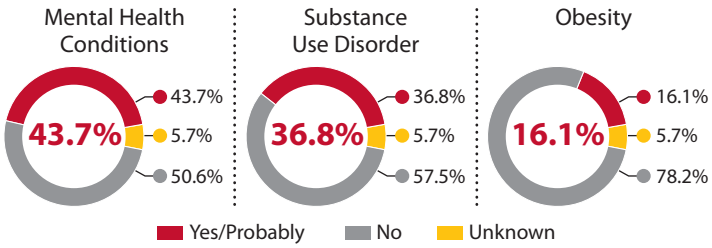
Note: SMM is unexpected outcomes of labor or delivery that have serious short- or long-term health impacts. In most instances, these outcomes could have been avoided with timely, appropriate care. Births that occur in freestanding birth centers and private homes are not included in the data. Race/ethnicity is self-reported during the intake/admission process. Anyone of any race can also have Hispanic/Latino ethnicity.
Sources: Utah Inpatient Hospital Discharge Data, Healthcare Information & Analysis Programs, Office of Research & Evaluation, Utah Department of Health and Human Services, 2020-2021

Figure 4: Severe Maternal Morbidity by Maternal Age in Utah, 2020–2021



Note: SMM is unexpected outcomes of labor or delivery that have serious short- or long-term health impacts. In most instances, these outcomes could have been avoided with timely, appropriate care. Births that occur in freestanding birth centers and private homes are not included in the data.
Sources: Utah Inpatient Hospital Discharge Data, Healthcare Information & Analysis Programs, Office of Research & Evaluation, Utah Department of Health and Human Services, 2020-2021

Figure 5: Common Factors Contributing to Maternal Deaths in Utah, 2017–2020



Note: Maternal deaths are pregnancy-associated deaths and measured as a death during or within one year of pregnancy for the combined years 2017-2020. This definition differs from the maternal mortality ratio in Figure 2, which calculates maternal deaths as a death during pregnancy or within 42 days of pregnancy termination for the combined years 2018-2022. The Utah Maternal Mortality Review Committee investigates each case of maternal mortality. During the review process, the Committee asks the following questions: 1. Did obesity contribute to this death? 2. Did substance use disorder contribute to this death? 3. Did mental health conditions contribute to this death? 4. Did discrimination contribute to this death?[5]
Source: Utah Department of Health and Human Services (2025), Maternal Mortality in Utah, 2017-2020

hospitalizations compared to 88 nationally (Figure 2). Poor maternal health outcomes are higher among Utah's racial and ethnic minority populations (Figure 3) and women giving birth at later ages (Figure 4).

Most cases of maternal deaths and morbidity can be avoided.[6,7] Recent estimates find 7 out of 10 maternal deaths[8] in Utah are preventable (71.3%, 2017–2020).[9,10] Mental health conditions, substance use disorders, and obesity are the most common contributing factors to maternal deaths (Figure 5).[11] Data also show more than 1 in 4 individuals who died during pregnancy or postpartum had at least one barrier to accessing health care (28.7%). The most common health care-related barriers are financial barriers (23.0%) and transportation barriers (14.9%).[12,13]

Risk Factors for Poor Maternal Health Outcomes

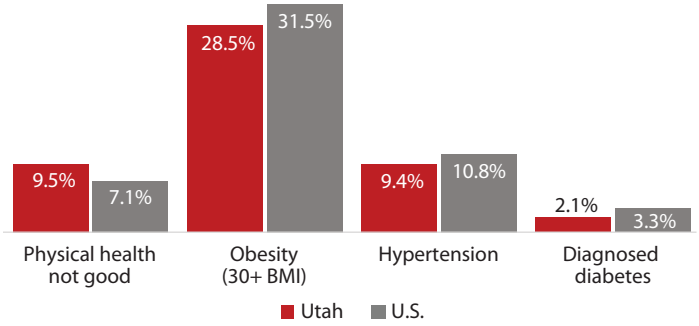
With over 70% of maternal deaths in Utah being preventable, understanding the risk factors for poor maternal health outcomes and gaps in accessing maternal health care is key to improving health outcomes for women and infants in Utah.

Maternal health refers to women's health and well-being during the pregnancy and postpartum periods (after childbirth).[14] A range of factors can influence poor maternal health outcomes, including physical and mental health conditions, substance use, intimate partner violence, access to maternal health care, and social drivers of health (e.g., low income, unstable housing, and food insecurity) experienced by women before, during, and after birth.

Physical Health Status

Poor physical health conditions increase the likelihood of complications both during pregnancy and postpartum.[15] Utah reports lower rates of most physical health conditions known to increase the risk for poor maternal health outcomes compared to national estimates (Figure 6).

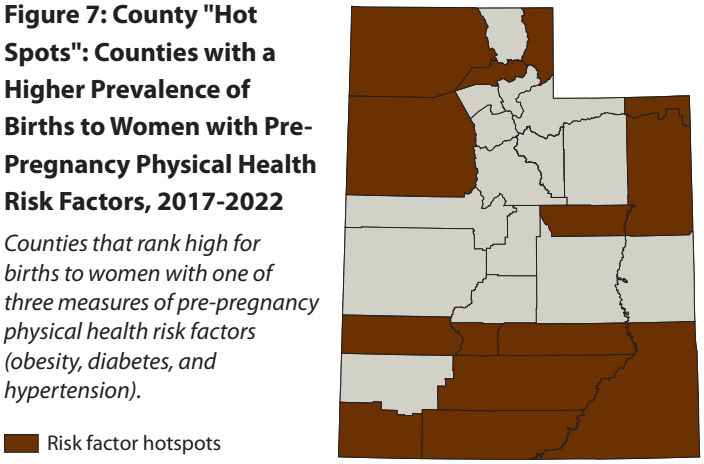
Figure 6: Select Measures of Physical Health Among Women Age 18–44 in Utah and U.S., 2020–2021



Note: "Physical health not good" is defined as the percentage of women ages 18-44 who reported their physical health was not good for 14 or more days in the past 30 days. Rates will differ from Figures 8-10 because of different source definitions (Figure 6 considers 14 or more poor health days, and Figures 8-10 consider 7 or more poor health days).
Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System, 2020-2021

Figure 7: County "Hot Spots": Counties with a Higher Prevalence of Births to Women with Pre-Pregnancy Physical Health Risk Factors, 2017-2022

Counties that rank high for births to women with one of three measures of pre-pregnancy physical health risk factors (obesity, diabetes, and hypertension).

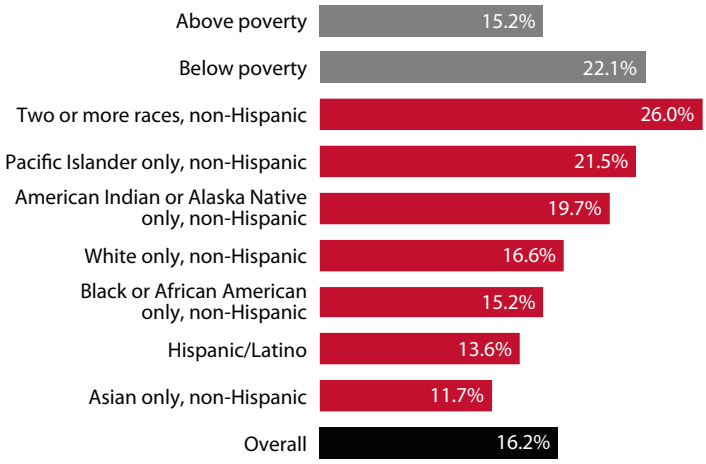


Note: Risk factor hot spots include counties that rank within the top quartile for prevalence of live births to women with one of three pre-pregnancy physical health risk factors (obesity, diabetes, and hypertension). Estimates are derived from the National Center for Health Statistics' Birth Files for 2017-2019 and 2020-2022 as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Urban and rural county classification is from the Utah Department of Health and Human Services' Indicator-Based Information System for Public Health (IBIS-PH). Figure 35 in the Appendix displays Utah's urban and rural county classification.
Source: Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau, 2017-2022. https://data.hrsa.gov/maps/mchb

That said, rates of pre-pregnancy risk factors (e.g., obesity, diabetes, and hypertension) are higher in Utah's rural counties (Figure 7). Over 19% of 2023 Utah births occurred in counties with a high prevalence of pre-pregnancy physical health risk factors. Sexually transmitted infections (STIs) are another pre-pregnancy risk factor, with rates highest among Wasatch Front counties and San Juan County.[16]

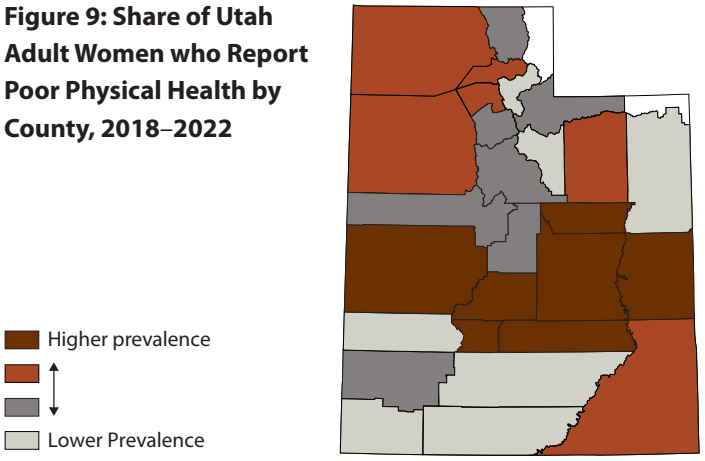
Rates of poor general physical health are higher for some Utah women in racial and ethnic minority populations and those with household incomes below the federal poverty level (Figure 8).[17] Rates of adult women reporting poor physical health also varies by Utah county with the highest prevalence in Piute (30.1%), Wayne (24.3%), Carbon (23.5%), Sevier (22.9%), and Emery (22.6%) counties (Figure 9).

Figure 8: Rates of Self-Reported Poor Physical Health Among Utah Women Age 18–44 by Race/Ethnicity and Poverty Status, 2018–2022



Note: Poverty is defined as 100% of the Federal Poverty Level (FPL). "Poor physical health" is defined as the percentage of women ages 18-44 who reported their physical health was not good for 7 or more days in the past 30 days. Rates will differ from Figure 6 because of different source definitions (Figure 6 considers 14 or more poor health days, and Figures 8-10 consider 7 or more poor health days).
Source: Utah Department of Health and Human Services Behavioral Risk Factor Surveillance System, 2018-2022

Figure 9: Share of Utah Adult Women who Report Poor Physical Health by County, 2018–2022

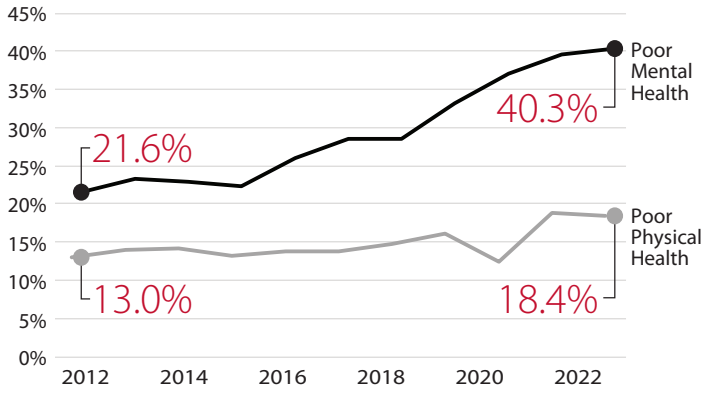


Note: All adult women age 18+. County share displayed by quartile. "Poor physical health" is defined as the percentage of Utah women who reported their physical health was not good for 7 or more days in the past 30 days. Rates will differ from Figure 6 because of different source definitions (Figure 6 considers 14 or more poor health days, and Figures 8-10 consider 7 or more poor health days). Urban and rural county classification is from the Utah Department of Health and Human Services' Indicator-Based Information System for Public Health (IBIS-PH). Figure 35 in the Appendix displays Utah's urban and rural county classification.
Source: Utah Department of Health and Human Services Behavioral Risk Factor Surveillance System, 2018-2022

Mental Health Status

Similar to poor physical health conditions, poor mental health conditions increase the likelihood of complications during pregnancy and postpartum and are a leading factor in maternal deaths in Utah.[18] The prevalence of poor physical and mental health among Utah women of reproductive age is rising, with rates of poor mental health increasing by 18.7 percentage points in 10 years, putting more women at higher risk for pregnancy complications (Figure 10).[19,20]

Figure 10: Rates of Poor Physical and Mental Health Among Utah Women Age 18–44, 2012–2022



Note: "Poor mental and physical health" is defined as the percentage of women ages 18-44 who reported their mental or physical health was not good for 7 or more days in the past 30 days. Rates of poor physical health will differ from Figure 6 because of different source definitions (Figure 6 considers 14 or more poor health days, and Figures 8-10 consider 7 or more poor health days).
Source: Utah Department of Health and Human Services Behavioral Risk Factor Surveillance System, 2012-2022

Rates of poor mental health conditions among Utah women are higher than the national average, with nearly 40% of Utah women of reproductive age having diagnosed depression (6th highest among states) and 1 in 6 experiencing postpartum depression symptoms (4th highest among reporting states) (Figure 11).[21] Data show that only 55% of Utah women with symptoms of anxiety or depression before, during, or after pregnancy report asking for help from a health care provider.[22]

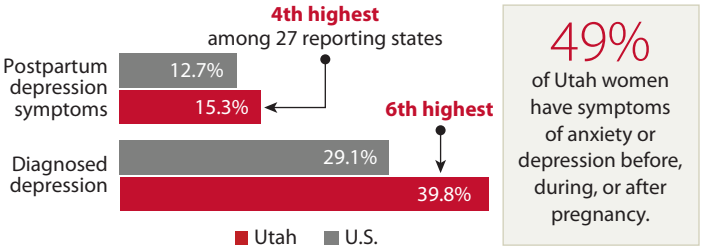
Poor mental health among Utah women varies by race and ethnicity, poverty status, and geography. Utah Black or African American women report the highest rates of poor mental health (45.9%) among population groups, and Utah women experiencing poverty report a significantly higher rate of poor mental health (43.4%) compared to Utah women not experiencing poverty (34.4%, Figure 12). Counties with over 30% of women experiencing poor mental health are all rural communities (Piute 41.8%, Grand 35.5%, Rich 32.9%, Emery 32.5%, and Sanpete County 30.6%) (Figure 13).[23]

Substance Use

Substance use disorder[24] is a major risk factor for maternal mortality and severe maternal morbidity.[25] Tobacco use in the months before and during pregnancy increases the risk of poor maternal and infant health outcomes.[26,27] Substance use can also reduce the likelihood that a pregnant woman will seek prenatal care.

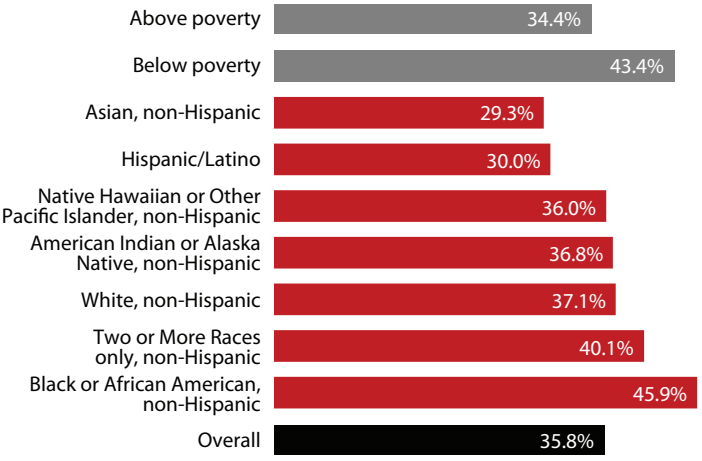
"I've had patients who come in with fetal demise who were using drugs and did not access any prenatal care. But it was not that access was not available… they did not take advantage of accessing care because of the substance use and the fear."

Figure 11: Depression Among Women Age 18–44 and Women Reporting Symptoms of Postpartum Depression in Utah and U.S., 2021–2022



Source: America's Health Rankings analysis of U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health, Pregnancy Risk Assessment Monitoring System (PRAMS), 2022. Rates of perinatal anxiety and depression from Pregnancy Risk Assessment and Monitoring System, 2020-2021.

Figure 12: Rates of Poor Mental Health Among Utah Women Age 18–44 by Race/Ethnicity and Poverty Status, 2018–2022



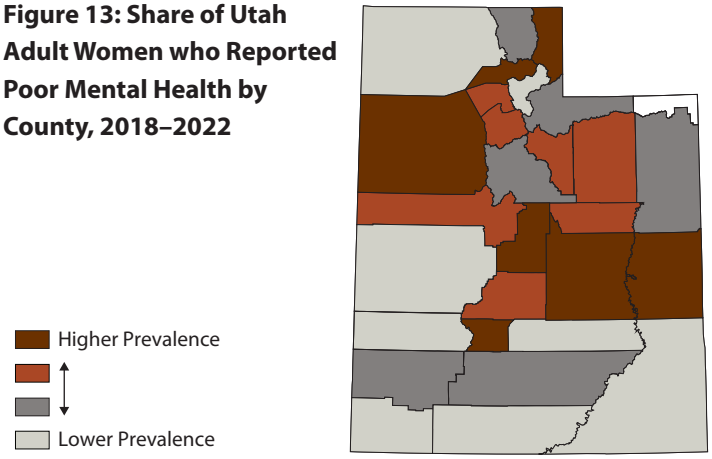
Note: Poverty is defined as 100% of the Federal Poverty Level (FPL). "Poor mental health" is defined as the percentage of women ages 18-44 who reported their mental health was not good for 7 or more days in the past 30 days.
Source: Utah Department of Health and Human Services Behavioral Risk Factor Surveillance System, 2018-2022

Rates of illicit drug use among Utah women of reproductive age are just above the national average (Figure 14). However, rates of smoking among women of reproductive age and smoking during pregnancy are lower in Utah than in the United States. Smoking among women of reproductive age is higher in Utah's rural counties (6.1% in urban vs. 8.9% in rural counties).[28]

Poverty

Poverty contributes to adverse maternal health outcomes and is associated with lower utilization of prenatal care as well as a greater likelihood of other risk factors. Women experiencing poverty are more likely to have more chronic conditions (such as obesity, hypertension, and depression), are more likely to experience chronic stress, and are more likely to smoke or experience substance use disorders.[29] Poverty also affects other social drivers of health that can increase the likelihood of poor

Figure 13: Share of Utah Adult Women who Reported Poor Mental Health by County, 2018–2022



Note: County share displayed by quartile. "Poor mental health" is defined as the percentage of Utah women who reported their mental health was not good for 7 or more days in the past 30 days. All adult women age 18+. Urban and rural county classification is from the Utah Department of Health and Human Services' Indicator-Based Information System for Public Health (IBIS-PH). Figure 35 in the Appendix displays Utah's urban and rural county classification.
Source: Utah Department of Health and Human Services Behavioral Risk Factor Surveillance System, 2018-2022

maternal health outcomes, including access to stable and quality housing, access to adequate and nutritious foods, and being able to afford health insurance.

"I hear time and time again, 'I made $18 too much for Medicaid, now what am I going to do [when I have a high-risk pregnancy and need to travel for care]?' And then, do they have a reliable vehicle? Can they take the time off work? Who watches their other kids? It's just this layered experience that just keeps building on cost and time and cost and time."

"It's just such a socioeconomic burden for these patients. I mean, most of them have Medicaid. Medicaid pays for the actual care they're getting at least, but it doesn't pay for … the economic burden of being away from their family and not being able to continue to make money, to do their job."

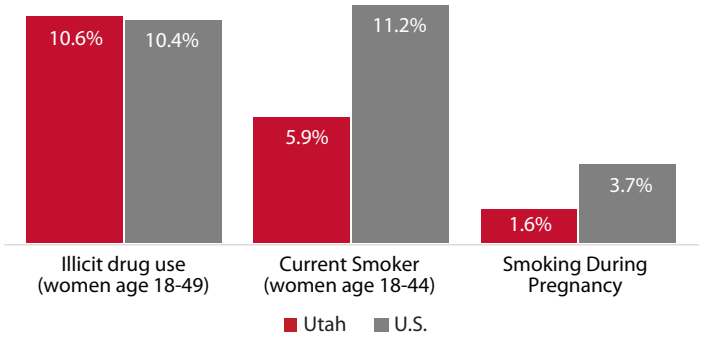
Roughly 1 in 3 Utah women of reproductive age report household incomes below 200% of the federal poverty level ($31,300 per year for a single person and $64,300 for a family of four in 2025).[30] Of those women, roughly 19% are uninsured and 55% reported cost as a barrier to care.[31]

Poverty rates are notably higher among women in racial and ethnic minority populations and those living in rural areas (Figures 15 and 16).[32] Over 40% of adult women fall below the 200% poverty threshold in 10 counties, with the highest rates observed in Piute County (65%) and San Juan County (60%).

Cost of Health Coverage and Care

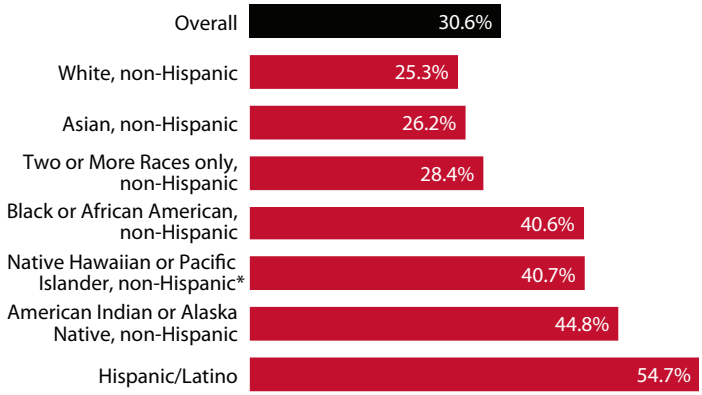
Women without health insurance often use fewer preventive services and postpone or forgo care.[33] Over 12% of Utah women did not have health insurance during the 12 months before pregnancy and over 16% of Utah women of reproductive age went without needed medical care due to cost.[34]

Figure 14: Illicit Drug Use and Smoking Rates Among Women of Reproductive Age in Utah and U.S., 2021–2022



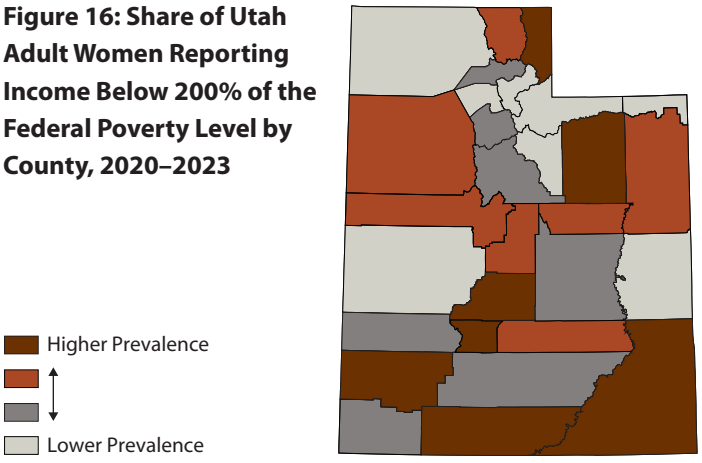
Note: Illicit drug use includes the misuse of prescription psychotherapeutics (pain relievers, tranquilizers, stimulants, or sedatives) or using cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year.
Sources: America's Health Rankings analysis of SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (2021-2022), CDC, Behavioral Risk Factor Surveillance System, 2022, and CDC WONDER, Natality Public Use Files, 2022

Figure 15: Share of Utah Women Age 18–49 Reporting Income Below 200% of the Federal Poverty Level by Race/Ethnicity, 2020–2023



Note: *Use caution in interpreting; the estimate has a coefficient of variation > 30% and is therefore deemed unreliable by Utah Department of Health and Human Services standards.
Source: Utah Department of Health and Human Services Behavioral Risk Factor Surveillance System, 2020-2023

Figure 16: Share of Utah Adult Women Reporting Income Below 200% of the Federal Poverty Level by County, 2020–2023



Note: All adult women age 18+. Urban and rural county classification is from the Utah Department of Health and Human Services' Indicator-Based Information System for Public Health (IBIS-PH). Figure 35 in the Appendix displays Utah's urban and rural county classification.
Source: Utah Department of Health and Human Services Behavioral Risk Factor Surveillance System, 2020-2023

1 in 3 Utahns with commercial health insurance in 2023 had high-deductible health plans (HDHP).[35] These plans have lower monthly premiums, but the higher deductibles require individuals and families to pay more out-of-pocket costs before their insurance plan begins to cover expenses. As such, they are often associated with lower rates of preventive care visits due to perceived costs.[36] Interviewees noted some pregnant women with HDHPs skip preventive visits and prescribed medication, as well as any necessary visits to manage high-risk pregnancies, often citing the cost associated with such care.

Women who access routine medical care before pregnancy are more likely to be healthier during pregnancy and have better birth outcomes.[37] For example, mothers who do not get enough health care during pregnancy have nearly three times higher risk of having a preterm birth.[38] Utah reports one of the lowest rates of women of reproductive age receiving an annual preventive medical visit (65.7% vs. 71.2% nationally),[39] and only 52% of Utah women had a regular health care checkup in the 12 months before pregnancy.[40]

Rates of health insurance coverage and access to care vary across Utah. Utah women in racial and ethnic minority populations are more likely to be uninsured and to go without needed medical care due to cost (Figures 17 and 18). Racially and ethnically diverse women in Utah also have more than double the uninsured rates of white women of reproductive age. Uninsured rates are also higher among women living in Utah's rural counties (Figure 19).

"While we do have Medicaid, we still have a lot of people that fall through [health insurance coverage] cracks that make just a little too much [income to qualify for Medicaid] and can't afford to purchase health insurance."

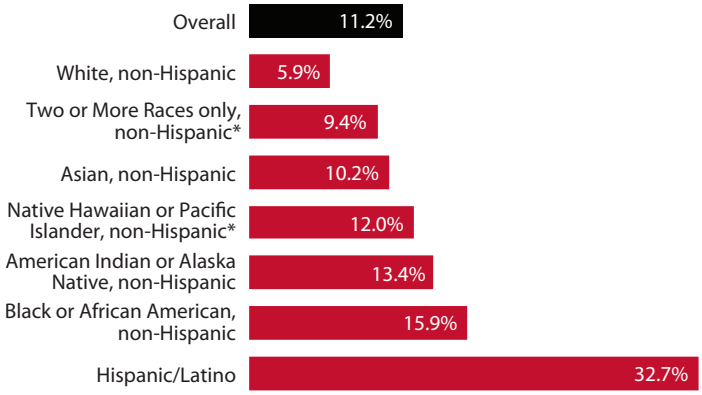
Utah Medicaid 12-Month Postpartum Coverage

Medicaid provides health insurance coverage to 9% of Utah women of reproductive age[46] and paid for 18% of Utah births in 2023.[47]

Federal law mandates that all states provide Medicaid coverage to pregnant women with incomes up to 138% of the federal poverty level (FPL) through 60 days postpartum.[48] Starting in 2024, postpartum women in Utah have access to 12 months of continuous Medicaid coverage, extending coverage through the postpartum period.

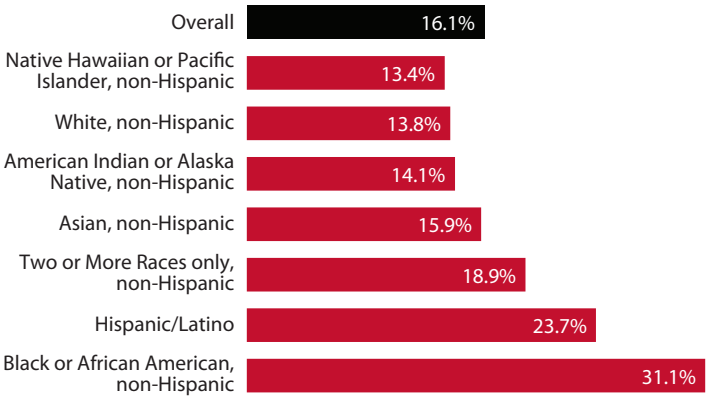
Interviewees reported limited awareness of the Medicaid postpartum coverage extension.[49] Additional outreach may be needed to educate both providers and enrollees about available services to improve access.

Figure 17: Uninsured Rates Among Utah Women Age 18–49 by Race/Ethnicity, 2020–2023



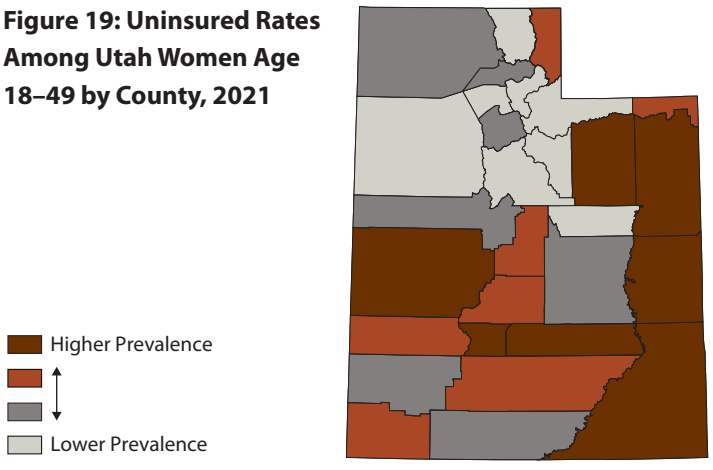
Note: *Use caution in interpreting; the estimate has a coefficient of variation > 30% and is therefore deemed unreliable by Utah Department of Health and Human Services standards.
Source: Utah Department of Health and Human Services Behavioral Risk Factor Surveillance System, 2020-2023

Figure 18: Cost as a Barrier to Care Among Utah Women Age 18–49 by Race/Ethnicity, 2020–2023



Source: Utah Department of Health and Human Services Behavioral Risk Factor Surveillance System, 2020-2023

Figure 19: Uninsured Rates Among Utah Women Age 18–49 by County, 2021



Note: County share displayed by quartile. Urban and rural county classification is from the Utah Department of Health and Human Services' Indicator-Based Information System for Public Health (IBIS-PH). Figure 35 in the Appendix displays Utah's urban and rural county classification.
Source: Small Area Health Insurance Estimates (SAHIE) program, 2021

Intimate Partner Violence

Intimate partner violence (IPV)[41] increases the risk of poor maternal and infant health outcomes. IPV during pregnancy is linked to maternal depression, anxiety, post-traumatic stress disorder (PTSD), and a higher risk of maternal death. It also increases the likelihood of preterm birth, low birth weight, and fetal injury.[42]

Women experiencing IPV during pregnancy are less likely to access prenatal care or are more likely to initiate care later than recommended. They also have higher rates of smoking, alcohol use, and substance use, and more often report inadequate weight gain, further increasing the risk of poor maternal and infant health outcomes.[43] Over 3% of Utah women experienced physical abuse during the 12 months before pregnancy in 2022,[44] and 2.2% experienced physical abuse during pregnancy.[45] This equates to between 1,000–1,500 Utah women reporting that they experienced violence before or during pregnancy.

Access to Maternal Health Care

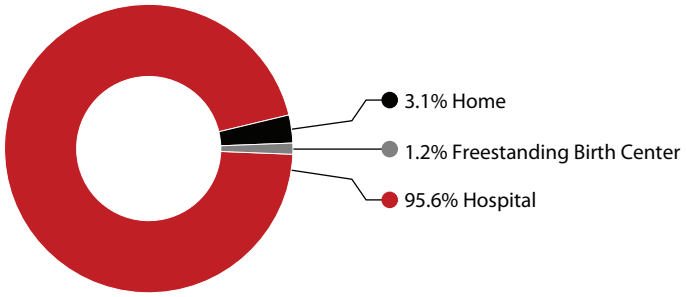
Examining the risk factors for poor maternal health outcomes helps describe the potential demand for maternal health services in Utah. Access to high-quality maternal health care is essential to help meet this demand. Maternal health care is defined as health care services provided to women during pregnancy, delivery, and postpartum.[50] A lack of access to maternal health care is influenced by many factors including:

- The absence of a hospital or obstetric department;
- Workforce supply;
- Availability of provider training or physician residency programs;
- State policy and scope of practice laws;
- Health facility policies;
- Reimbursement;
- Insurance status;
- Rural residence;
- Challenges navigating a complex health care system; and
- Access barriers stemming from social drivers of health (e.g., poverty, transportation, language barriers, and immigration status).[51,52]

Similar to the risk factors mentioned in the previous section, these access challenges can also contribute to poor maternal health outcomes including maternal mortality, severe maternal morbidity, increased risk for postpartum depression, as well as premature birth and infant low birth weight.[53]

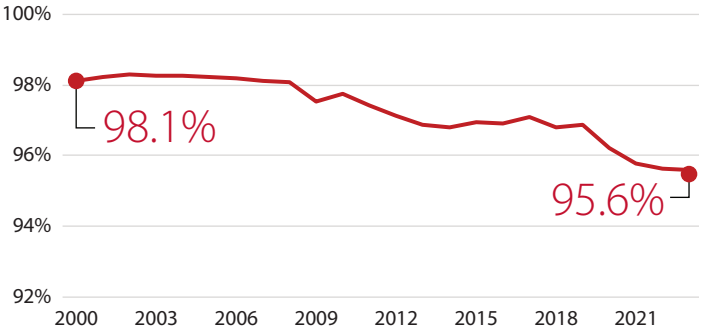
This section describes access to maternal health care services in Utah by examining hospital location and distance, the maternal health care workforce at the county level, and areas with high maternal health care workforce needs as defined by the Health Resources and Services Administration (HRSA) (see Maternity Care Target Area section).

Figure 20: Utah Birth Settings, 2023



Source: Utah Birth Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

Figure 21: Utah Hospital Births, 2000–2023



Source: Utah Birth Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

Obstetric care is health care provided before (preconception), during, and after (postpartum) pregnancy, including labor and delivery. Obstetric care focuses on supporting the health of the pregnant woman and their fetus(es)/newborn(s).[87]

Birthing hospitals, for purposes of this report, include hospitals reporting obstetric care, at least one obstetric care bed, or at least 10 births a year.

Hospitals

The vast majority of Utah births occurred in hospitals in 2023 (95.6%). Births also occurred at home and in birth centers (Figure 20). Utah's share of hospital births is lower than the national share (97.7%) and 5th lowest among all U.S. states. It has also been on a steady decline (Figure 21).[54]

The resources and services available across and even within different birth settings can vary substantially.[55] For example, birth centers have fewer resources than hospitals available for emergency procedures such as cesarean births or blood transfusions. Utah law also establishes what services can be performed by birth setting.

Hospitals generally provide the highest level of medical intervention for pregnant women and newborns among the different birth settings. However, there is wide variation in the types of providers and level of care and specialization offered

among Utah's hospitals. Factors such as a hospital's staffing, provider specializations, resources, and teleconsultation adoption lead to variations in the types of care a family can access during pregnancy, labor and delivery, and the postpartum period.[56] For example, while some hospitals can manage high-risk pregnancies, others may transfer high-risk patients to hospitals with higher levels of maternal care and specialists.[57]

Seven of Utah's 29 counties do not have a birthing hospital. These counties are primarily located in rural north and southeast Utah (Table 2). For purposes of this report, a birthing hospital includes hospitals reporting obstetric care, at least one obstetric care bed, or at least 10 births a year. Using this definition, roughly 6,700 Utah women of reproductive age live in counties without a birthing hospital (this is less than 1% of the total women of reproductive age).

In eight Utah counties, the average travel time to a birthing hospital is over 30 minutes. For five of these counties, the drive time is over 60 minutes (Kane, Wayne, Emery, Daggett, and Rich counties) (Figure 22).

"Rural access is really challenging. Being rural in Utah is different, you may be 4-5 hours from care here, [while in] other states you are 45 minutes."

Table 2: Average Distance in Miles and Minutes to Nearest Birthing Hospital for Utah Counties without a Birthing Hospital, 2022

County	Average Minutes	Average Miles
Kane	88.3	77.9
Wayne	86.4	68.4
Emery	76.7	51.2
Daggett	72.2	64.2
Rich	66.5	48.5
Piute	39.3	36.9
Morgan	24.3	20.1

Note: Travel time/distance is measured in minutes/miles from the resident to the nearest birthing hospital, which is classified based on criteria from the American Hospital Association (AHA) annual survey and the CMS POS files.
Source: Hospitals with obstetric units identified through 2022 AHA survey. Retrieved from Perinatal Data Center, March of Dimes, February 2025.

Scope of Practice

Scope of practice refers to the activities and procedures that a provider with a specific level of education, training, or competency is authorized to engage in as defined by state regulatory boards—typically with guidance or instruction from the state legislature. States set their own scope of practice standards, which may be informed by factors such as access to care, safety, professional competency, cost, and more.

A list of provider types providing maternal health care services in Utah and their scope of practice is in the Appendix.

Traveling long distances to care is a leading barrier to accessing maternal health services for Utah families. Interviews with maternal health care providers highlighted the multiple ways traveling for care burdens families such as paying for transportation, lost wages when missing work, and the need to arrange and pay for childcare. These barriers are especially challenging for low-income and rural Utah families.

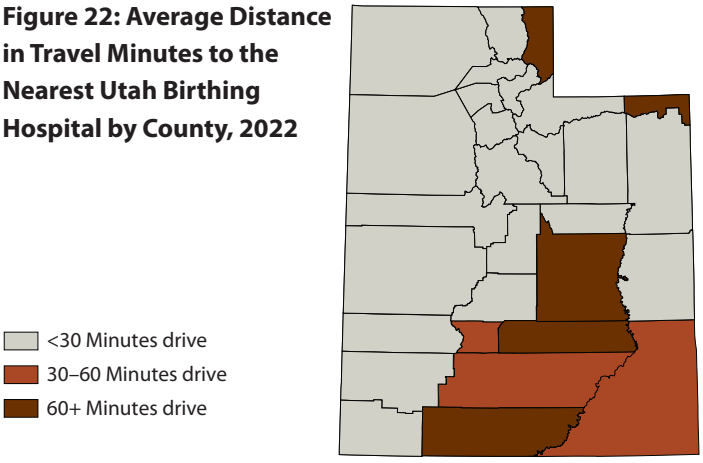
"It's not just the time it takes to travel, but the resources to travel, 'I don't have the gas money, I don't have a reliable car.' [Our patients] run into these barriers quite frequently."

"Traveling to urban areas is often required for complex conditions, creating a burden for families, especially if the family is low-income, lacks reliable transportation, or if the family needs childcare."

Maternal Health Care Workforce

Women receive care from a range of different providers during their pregnancy, postpartum, and when giving birth. These providers differ in how they are educated, trained, credentialed, and licensed (Appendix, Table 4) and each plays an important role in supporting access to comprehensive maternal health care and increasing birth experience choice for

Figure 22: Average Distance in Travel Minutes to the Nearest Utah Birthing Hospital by County, 2022



Note: Travel time is measured in minutes from the resident to the nearest birthing hospital, which is classified based on criteria from the AHA annual survey and the CMS POS files. Urban and rural county classification is from the Utah Department of Health and Human Services' Indicator-Based Information System for Public Health (IBIS-PH). Figure 35 in the Appendix displays Utah's urban and rural county classification.
Source: Hospitals with obstetric units identified through 2022 AHA survey. Retrieved from Perinatal Data Center, March of Dimes, February 2025.

Out-of-Hospital Births

To learn more about trends in planned out-of-hospital births in Utah and the associated maternal and infant outcomes, see the Utah Department of Health and Human Services 2024 report *Planned out-of-hospital births in Utah, 2016–2021: A descriptive review.*

Available at https://mihp.utah.gov/out-of-hospital-births

Utah families. As noted in the risk-factor section, behavioral health care and connecting families to social services are also essential to promoting healthy pregnancies and outcomes.[58]

Obstetricians (OB-GYNs), midwives (certified nurse midwives and other midwives), and family physicians provide the majority of maternal health care to women in Utah. An array of other providers support women during their pregnancy and postpartum period, including doulas, community health workers, behavioral health care providers, and home visiting professionals, among others.

Obstetricians

Obstetricians and gynecologists (OB-GYN) focus on the health of women before, during, and after their reproductive years, providing medical and surgical care to women throughout their lifespan. They are specialists with training and skills in pregnancy-related care for women (including preventive care and complex pregnancies and deliveries), the female reproductive system, and are surgically trained. They often collaborate with certified nurse midwives and family medicine physicians, providing consultation and surgical support during labor and delivery. Following medical school, OB-GYNs complete four years of an obstetrics and gynecology residency. Maternal fetal medicine (MFM) physicians are OB-GYNs with additional training and expertise to care for the highest-risk obstetric patients.[59]

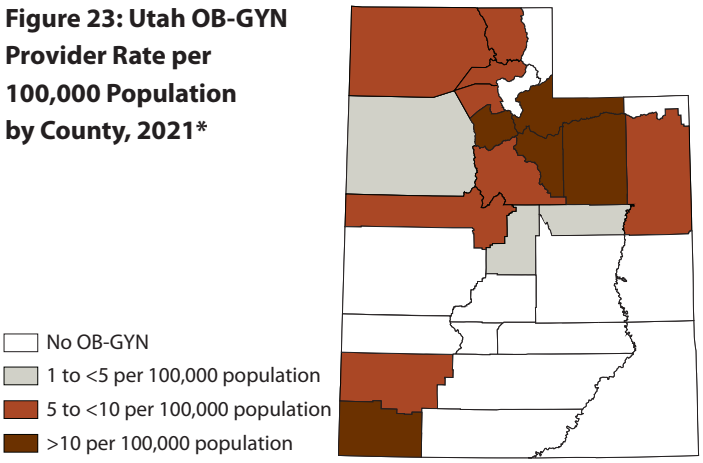
Access to OB-GYN services varies across Utah. Thirteen counties do not have a single OB-GYN (mostly Utah's rural central and southern counties) (Figure 23). Nearly 20,000 women of reproductive age live in those 13 counties (2.7% of the total women of reproductive age).

Recruiting OB-GYNs to rural communities can be a challenge and limit access to comprehensive maternal health care across the state. For example, interviewees noted that, ideally, every area should have two OB-GYNs given the daily on-call nature of the role, which can lead to high turnover rates. However, case volume in rural areas may not justify more than one OB-GYN, which impacts their work-life balance and hinders recruitment. Some interviewees also mentioned that current restrictions on pregnancy termination may have exacerbated this barrier.

"It is difficult to recruit and retain OBs in our area. The difficulty is that we are busy enough to need one OB but not too busy for two OBs. If you only have one, they get burnt out; there is no work-life balance. They are on call 24/7, 365 days a year."

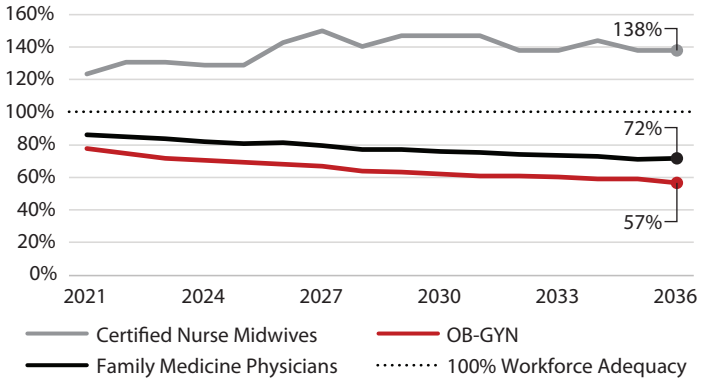
"We cannot recruit OBs to our area. Teleconsulting with specialists helps bridge this gap, as well as with mental health care services… We have had an OB job listing for over five years, but it is difficult to recruit to such a rural area."

Figure 23: Utah OB-GYN Provider Rate per 100,000 Population by County, 2021*



Note: Physicians with hospital affiliations outside of their primary practice location county are counted once in the data in the county of their primary practice location. For example, a physician with a primary practice location in Washington County with a hospital affiliation in Sanpete County is only counted as a provider in Washington County. Urban and rural county classification is from the Utah Department of Health and Human Services' Indicator-Based Information System for Public Health (IBIS-PH). Figure 35 in the Appendix displays Utah's urban and rural county classification.
*A review of input from informational interviews and hospital websites was conducted in April 2025 to confirm provider practice location.
Source: AMA Physician Masterfile 2021; Census County Pop. Estimates 2021. OB-GYN American Medical Association (AMA) Physician Masterfile and U.S. Census Bureau, via the Area Health Resources Files (AHRF).

Figure 24: Maternal Health Care Workforce Projected Adequacy in Utah, 2021–2036



Note: Projections are based on the Health Workforce Simulation Model (HWSM), an integrated microsimulation model that estimates the current and future supply of and demand for health care workers by occupation, geographic area, and year. The HWSM incorporates factors like the changing population size, demographics, and location of the population; new entrants and exiting providers in various occupations; and differing levels of access to care.
Source: Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections. Available at https://bhw.hrsa.gov/data-research/review-health-workforce-research

Workforce projections show Utah's OB-GYN provider adequacy rates reducing over time from 69% of demand in 2025 to 57% in 2036 (Figure 24).[60] These projections do not take into consideration the geographic distribution of the workforce across Utah communities. Based on the current supply and distribution of OB-GYNs within the state of Utah, it is expected that most rural counties will continue to experience provider shortages.

Projected Workforce Adequacy

The workforce adequacy rate is a measure that assesses whether the number of health care providers is sufficient to meet the needs of the population in a specific specialty or geographic area (state or national). Adequacy is calculated by dividing the projected supply of health care providers in a given year by the projected demand in the same year. Projections are based on population trends, health care utilization patterns, health care workforce demographics, and other factors.[61]

A workforce adequacy rate below 100% suggests that the supply of providers is projected to be insufficient to meet the demand, indicating a potential shortage. HRSA's projected workforce adequacy rate is calculated at the national and state levels and does not take into consideration the geographic distribution of providers within a state.

Midwives

Close to 17% of Utah births were attended by a midwife in 2023 (13% by certified nurse midwives, 3.8% by other midwives), which is higher than the national rate of 12.1% (2022) (Table 1).[62] Since 2009, the share of Utah births attended by a midwife has increased 8.2 percentage points (Figure 25). Midwives are trained health care professionals specializing in pregnancy, labor and delivery, and postpartum care, as well as in aspects of reproductive health. They utilize the midwifery model of care, which emphasizes patient education and psychosocial support.

Research shows midwife care is associated with improved birth outcomes for women and infants.[63] Increased integration of midwives into the maternal health workforce can help enhance access to maternal health providers and increase patient-provider choice.[64] Midwives practice in multiple birth settings such as hospitals, birth centers, clinics, or the patient's home. Training and licensing vary by type of midwife (Table 3).[65]

Certified nurse midwives (CNMs) are midwives with a nursing degree trained specifically to provide health care throughout pregnancy, labor and delivery, and postpartum.[66] CNMs deliver in hospitals, birth centers, clinics, or home settings.

Certified professional midwives (CPMs) are trained through midwifery schools and apprenticeships to provide health care throughout pregnancy and postpartum for low-risk pregnancies in out-of-hospital settings. CPMs can be licensed or unlicensed in Utah. CPMs deliver in birth centers and home settings.

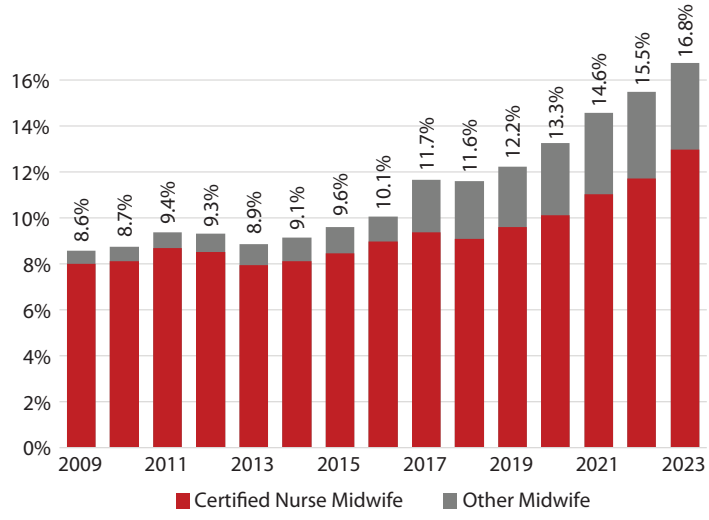
A licensed CPM (licensed direct entry midwife, LDEM) has limited prescribing authority and practices under specific limitations (e.g., they are not authorized to manage breech births or multiple births).

Unlicensed CPMs (unlicensed direct entry midwife, UDEM) are not held to license requirements and do not hold prescribing authority.

Utah's CNM provider ratio was 4.7 providers per 100,000 population from 2017-2022, which is above the national rate of 2.3.[67] However, 12 counties in Utah do not have a single CNM (Figure 26). These 12 counties are in rural areas with nearly 20,000 women of reproductive age (approximately 2.6% of Utah's total women of reproductive age).[68]

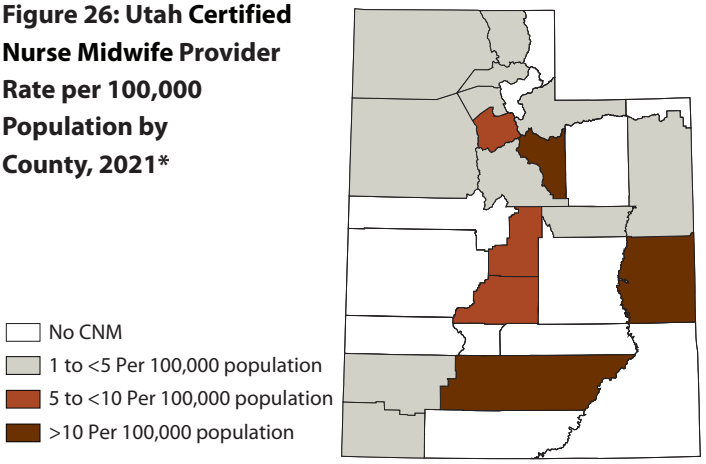
Workforce projections show CNM provider adequacy remaining above 120% through 2036 (Figure 24). Based on the current geographic distribution of CNMs across the state of Utah, however, rural counties are likely to continue to experience provider shortages.

Figure 25: Share of Utah Births Attended by a Midwife, 2009–2023



Source: Utah Birth Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

Figure 26: Utah Certified Nurse Midwife Provider Rate per 100,000 Population by County, 2021*



Note: Urban and rural county classification is from the Utah Department of Health and Human Services' Indicator-Based Information System for Public Health (IBIS-PH). Figure 35 in the Appendix displays Utah's urban and rural county classification.
* A review of input from informational interviews and hospital websites was conducted in April 2025 to confirm provider practice location.
Source: CNM 2021 Centers from Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) Downloadable File and 2020 Census County Characteristics File from the U.S Census Bureau, via the Area Health Resources Files (AHRF).

Table 3: Utah Midwives: Licensure, Education, Certifying Organization, and Prescribing Authority

	Certified Nurse Midwife (CNM)	Certified Professional Midwife (CPM)	Licensed Direct Entry Midwife (LDEM)	Unlicensed Direct Entry Midwife (UDEM)
Licensure and statute	Licensed Nurse-Midwife Practice Act	May or may not be licensed Direct Entry Midwife Act	Licensed Direct Entry Midwife Act	Not licensed Direct Entry Midwife Act
Education	Bachelor of Science in Nursing (BSN) and Masters or Doctor of Nursing Practice (DNP) in midwifery	No degree required. Documented: education skills exam, clinical experiences, written exam	Certified Professional Midwife credentialing, plus CPR/NRP, fetal monitoring, pharmacology	No requirements
Certifying organization	Must comply with American Midwifery Certification Board (AMCB) standards	Must comply with North American Registry of Midwives (NARM) standards	Must comply with National Association of Certified Professional Midwives (NACPM) standards and LDEM standards of practice	Voluntary adherence to Utah Midwives Organization (UMO) standards of practice
Prescriptive authority	Full prescriptive authority	Limited ability to obtain and administer, only if licensed	Limited ability to obtain and administer	May not give medication to patients except oxygen

Source: Utah Women and Newborn Quality Collaborative

According to interviews, the greatest barriers to expanding midwifery care in Utah include: (1) a lack of insurance coverage for midwifery services; (2) limited insurance reimbursement;[69] (3) restrictive hospital scope of practice policies; and (4) limited information or education on midwifery options in communities across Utah.

Family Physicians

Family physicians are a critical part of the maternal health care workforce, especially in rural and medically underserved communities where they are often the sole maternity care provider. They offer continuity of physical health care before, during, and after pregnancy, manage chronic conditions, address social care needs, and support smoother care transitions —a key to reducing maternal morbidity and mortality.[70,71] Many family physicians are also trained to address behavioral health conditions and substance use disorders.

Family physicians can choose to provide maternal health care, including prenatal care, to women with low-risk pregnancies, attend hospital deliveries, and consult with OB-GYNs for high-risk pregnancies, labor, and delivery. Family physicians receive 14 weeks of focused training in obstetrics during residency and can receive additional training in high-

Community Health Centers

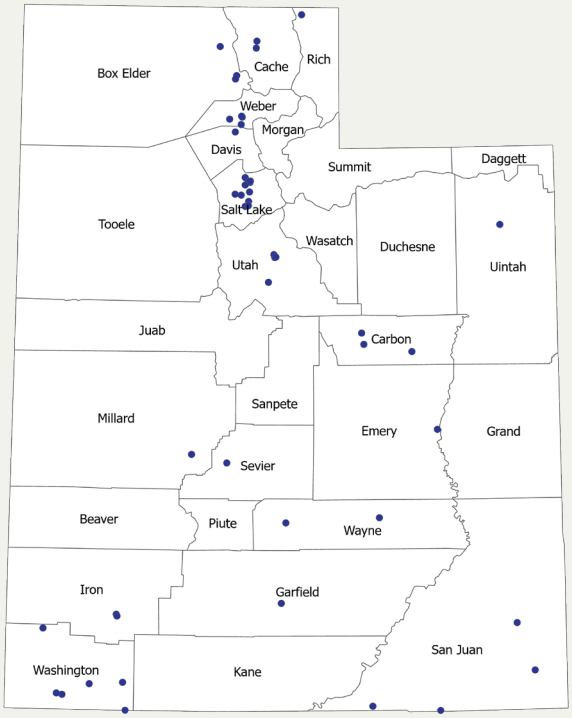
Community Health Centers (CHCs) are community-based clinics that provide health care to low-income and underserved populations on a sliding fee scale. CHCs increase access to comprehensive primary care (including dental, behavioral, and substance use disorder services), family planning, and contraception. Increased access to these services is associated with earlier initiation of prenatal care, use of contraception, and better management of chronic conditions, which reduces the risk of pregnancy complications.

Utah's 12 health center organizations operate 44 clinic sites in urban and rural communities across Utah (Figure 27). Utah CHCs served 140,000 patients in 2023. Nearly 86% of these patients have incomes below 200% of the federal poverty level and over 65% are uninsured or Medicaid beneficiaries.

CHCs provide access to comprehensive prenatal care directly or by referral. Many Utah CHCs provide care for families during the prenatal, delivery, and postpartum stages and co-manage substance use treatment during pregnancy for higher risk populations.

CHCs served nearly 4,700 prenatal patients in 2023. Of these patients, over 95% initiated prenatal care in the first trimester.

Figure 27: Utah's Community Health Centers, February 2025



Note: Not all community health centers provide prenatal or obstetric services.
Source: Association for Utah Community Health, February 2025

risk obstetrics and surgical deliveries such as cesarean sections. Family physicians often work in collaboration with nurse practitioners, physician assistants, CNMs, OB-GYNs, and behavioral health professionals to meet the maternal health needs of their communities.

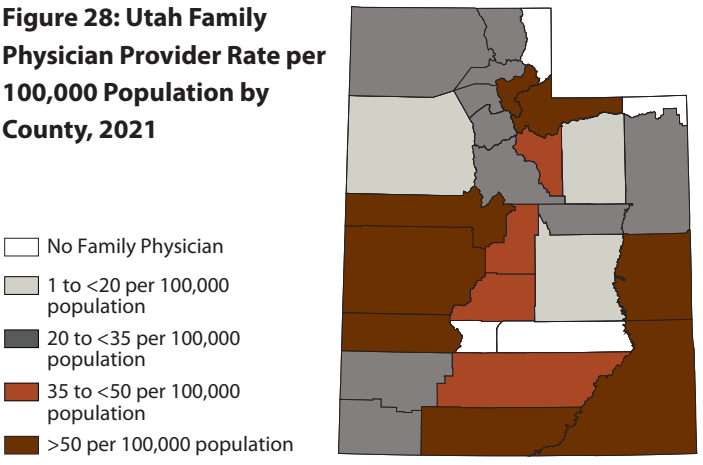
To increase access to comprehensive maternal health care in communities across Utah, the University of Utah's Family Medicine Obstetric Fellowship trains physicians in maternal health care, including labor and delivery. However, several interviewees noted that the low number of deliveries in rural communities can make it difficult for these fellows and other family physicians to maintain their skills.[72] Other barriers to providing comprehensive maternal health care include hospital privilege limitations, high medical liability premiums, and provider burnout.[73]

While 10 counties in Utah do not have an OB-GYN or CNM, only four counties lack a family physician (Figure 28). Over 1,200 women of reproductive age live in the four counties without a family physician, OB-GYN, or CNM. Workforce projections show Utah's family physician provider adequacy reducing over time from 81% of demand in 2025 to 72% in 2036 (Figure 24).

Other Maternal Health Clinical Providers

Physician assistants (PA) and nurse practitioners (NP) play an important role in providing care to obstetric patients in both outpatient and hospital settings with the supervision of a physician. Family physicians often work with PAs and NPs to improve access to health care services, particularly in rural communities.[74] Workforce projections show that the PA and NP workforce specializing in women's health is projected to increase over the next decade (Figure 29).

Figure 28: Utah Family Physician Provider Rate per 100,000 Population by County, 2021



Note: Family physician rate includes all family physicians and is not limited to family physicians reporting delivering babies. Urban and rural county classification is from the Utah Department of Health and Human Services' Indicator-Based Information System for Public Health (IBIS-PH). Figure 35 in the Appendix displays Utah's urban and rural county classification.
Source: AMA Physician Masterfile 2021; Census County Pop. Estimates 2021. American Medical Association (AMA) Physician Masterfile and U.S. Census Bureau, via the Area Health Resources Files (AHRF).

Expanding Access through Teleconsultation

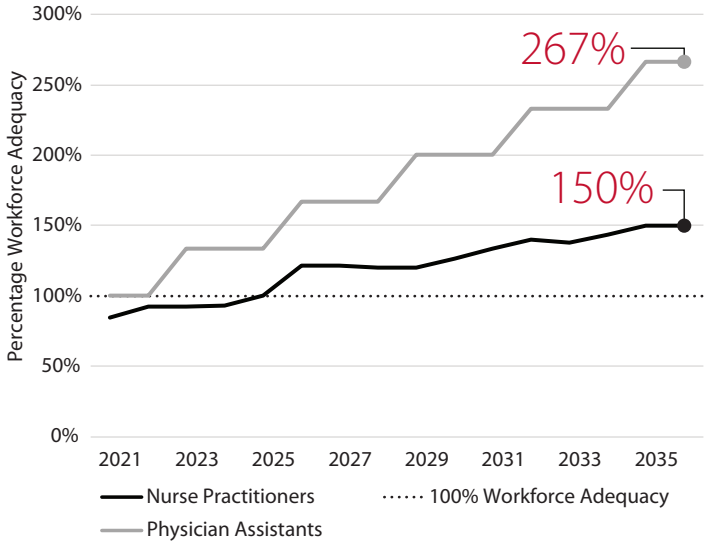
Some hospitals and clinics in Utah are expanding access to specialty care, including obstetric and behavioral health specialists, through teleconsultation. Interviewees described the role of teleconsultation in reducing barriers to needed specialty care (long travel distance, travel cost, childcare arrangements and cost, lost wages, etc.) as well as improving the management of pregnancy or postpartum complications.

"Without telehealth consultations, it would make it really difficult for us to do what we do. It helps us feel more comfortable to know we have support if things become complicated."

Maternal Support Providers

While obstetricians, family physicians, and midwives (CNMs and other midwives) provide the majority of maternal health care, other providers, including doulas, community health workers, behavioral health providers, and home visiting professionals, among others, play an important role in supporting the health and social needs of women, families, and infants.

Figure 29: Women's Health Nurse Practitioner and Physician Assistant Workforce Projected Adequacy in Utah, 2021–2036



Note: Nurse Practitioners and Physician Assistants are those specializing in women's health. Projections are based on the Health Workforce Simulation Model (HWSM), an integrated microsimulation model that estimates the current and future supply of and demand for health care workers by occupation, geographic area, and year. The HWSM incorporates factors like the changing population size, demographics, and location of the population; new entrants and exiting providers in various occupations; and differing levels of access to care.
Source: Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections. Available at https://bhw.hrsa.gov/data-research/review-health-workforce-research

Doulas

Doulas are non-clinical professionals who provide physical, emotional, and informational support to women before and during birth and postpartum. Doulas do not provide clinical support, but serve as a guide, advocate, and emotional support for women navigating the maternal health system and childbirth.[75]

Research shows doulas are associated with lower rates of maternal and infant health complications.[76] While important to the maternal health workforce, accurate and full data on the doula workforce is not available for the state of Utah.

According to interviews with providers, the primary challenges of expanding doula services in Utah include: (1) a lack of Medicaid coverage; (2) insufficient health insurance reimbursement; (3) a lack of education on the role of doulas and how to access doula services; and (4) the concentration of doulas in urban communities. During the 2025 Utah legislative general session, the legislature passed S.B. 284 requiring Utah Medicaid to apply to the Centers for Medicare & Medicaid Services (CMS) to cover doula services.

Community Health Workers

Community Health Workers (CHW) provide a variety of health education and support services. In terms of maternal health care, they educate families about breastfeeding and childcare, provide initial screenings for conditions such as postpartum depression, and connect families to health care and other social support. Research finds that leveraging CHWs for maternal health care is associated with improved screening rates and adherence to care plans.

The integration of CHWs in primary care is also shown to reduce hospital stays and improve access to preventive and social services.[77] Interviewees noted the importance of CHWs in educating Utah families on maternal health care services and connecting families to resources.

> *"I think community health workers are probably the single greatest tool to get past education barriers and understanding of what's out there. Most people just don't even know how to find services. And that's what a community health worker does, is go meet somebody where they're at and... help them get access to services."*

Mental Health Services

Utah has significant mental health provider shortages. Over 32% of Utah adults with diagnosed anxiety and/or depressive disorders report an unmet need for counseling or therapy, which is higher than the U.S. average of 25.5%.[78] Utah's rate of mental health providers is also lower than the U.S. average (365.2 per 100,000 population in Utah vs. 378.0 nationally).[79] While access to mental health providers and resources vary across Utah counties (Figure 30), nearly all counties are designated as a HRSA mental health care professional shortage area.[80]

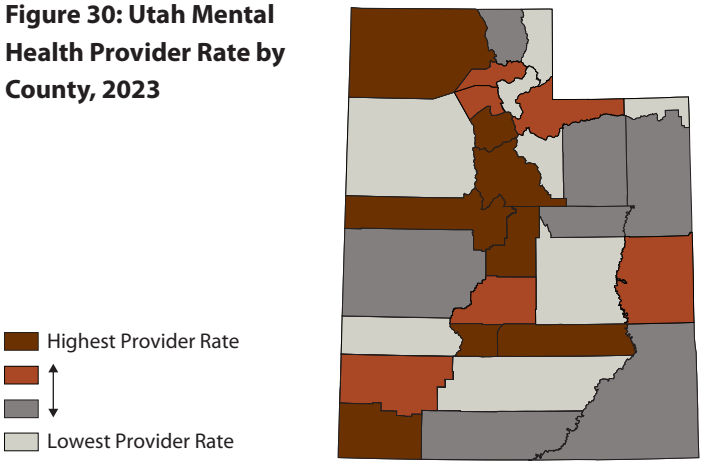
Utah Maternal Mental Health Referral Network

To improve access to perinatal mental health care specialists, the Utah Department of Health and Human Services created the Utah Maternal Mental Health Referral Network, an online directory of health care professionals and organizations with specialized training in perinatal mental health concerns. The network's resources are intended to help families with depression, anxiety, infertility, miscarriage, birth trauma, and other perinatal mental health concerns.[81]

The referral networks is available at https://maternalmentalhealth.dhhs.utah.gov/

The mental health provider shortage is a significant barrier for pregnant and postpartum women. Other barriers mentioned by interviewees include: (1) low or no provider reimbursement; (2) Utah's Medicaid behavioral health carve-out, which limits the ability of a Medicaid beneficiary who is pregnant to access mental health services through the same health care system that they are receiving maternal health services in; (3) limited referral networks or long wait times; (4) finding mental health providers with certification or training in perinatal mental health; (5) cost of care; and (6) social stigma, especially in Utah's rural communities and racially and ethnically diverse communities.[82]

Figure 30: Utah Mental Health Provider Rate by County, 2023



Note: Rate of mental health providers per 100,000 population. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care. Providers who transmit electronic health records are required to obtain an identification number, but some providers may not obtain a number. While providers have the option of deactivating their identification number, some mental health professionals included in this list may no longer be practicing or accepting new patients. This may result in an overestimate of active mental health professionals in some communities. It is also true that mental health providers may be registered with an address in one county, while practicing in another county.
Source: CMS National Provider Identification from County Health Rankings, 2023.

"It is difficult to get a mental health appointment in this state. Not a lot [of providers] accept insurance, and it is especially difficult for patients to get timely access to care. Waitlists are really long, and appointments can take 6-8 months to get."

"Fragmented systems make it difficult for patients to access mental health care. For those on Medicaid, the communication between the OB and the mental health care provider is limited by the carve-out. [OBs don't get notes so can't follow up with the patient]. There is a need for care coordinators to help Medicaid patients navigate the system."

Substance Use Disorder Resources

Substance use disorder is a leading cause of maternal deaths in Utah. Unfortunately, the accessibility of treatment for maternal substance use disorders is also a major challenge. According to interviews, barriers to services include: (1) limited availability of maternal health-focused substance use treatment and detox facilities; (2) limited health care provider training on maternal substance use disorders; and (3) social stigma.

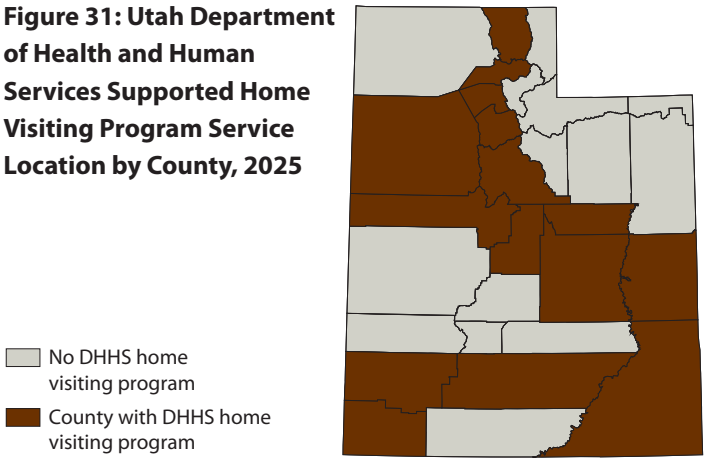
"Specifically for pregnant and postpartum people, they get an extra layer of stigma because it's 'You're just being selfish and… you don't care about your baby and if you just were less selfish… you'd be better. You wouldn't use drugs.' When in fact, it's a symptom of their disease that they're using while pregnant."

Home Visiting Programs

Utah's home visiting programs serve households at greater risk for poor maternal and infant health outcomes, including low-income households, racial and ethnic minority households, and young mothers.[83] Home visitors (i.e., a nurse, health, or social service professional) provide services to pregnant women and young families with children under six years of age who would like additional parenting knowledge (about nutrition, child development, home safety, etc.), skills, and support, including connections to community resources. Home visitors help address multiple maternal and infant health risks, including substance use disorders, parental mental health, housing and food insecurity, and unhealthy family relationships. Research finds home visiting not only improves maternal and infant health outcomes, but it reduces the likelihood of maternal mortality.[84,85]

Fourteen of Utah's 29 counties do not have a DHHS-supported home visiting program (Figure 31). Over 50,000 women of reproductive age live in those 14 counties, representing 7% of Utah's total population of women of reproductive age. More than 7% of births in 2023 occurred to women living in counties without a home visiting program.

Figure 31: Utah Department of Health and Human Services Supported Home Visiting Program Service Location by County, 2025



Source: Utah Department of Health and Human Services, Office of Early Childhood

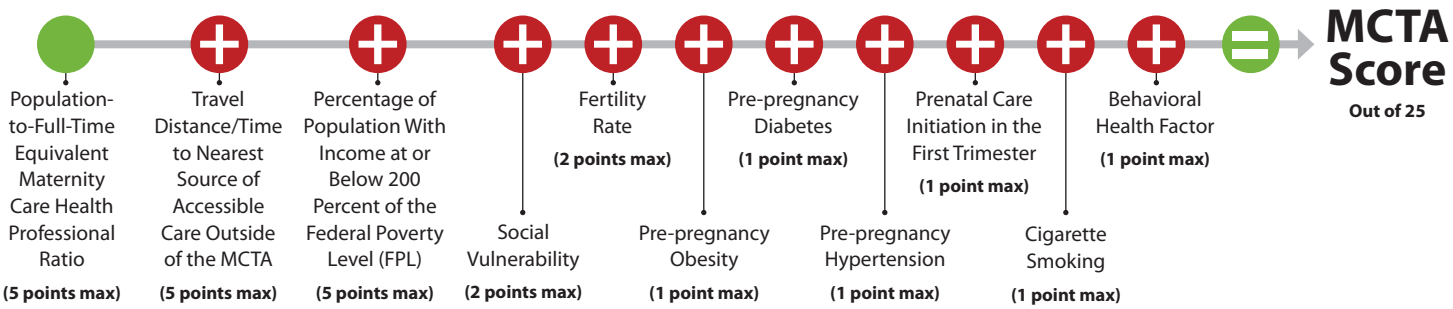
Federally Designated Maternity Care Target Areas (MCTA)

Maternity Care Target Areas (MCTAs) are existing Primary Care Health Professional Shortage Areas (HPSAs) identified by HRSA as having shortages of maternal health care professionals. Primary Care HPSAs are service areas or population groups that have been designated as having too few primary care providers to meet the needs of the population.[86]

A MCTA score is calculated for every HPSA to assess the level of need for maternal health care services based on multiple factors (Figure 32). The MCTA score is a composite measure of eleven weighted variables with scores ranging from 0 to 25. In addition to maternal health care provider-to-population ratios, MCTA scores measure distance to care, fertility rates, and risk factors for pregnancy and delivery-related complications. The higher the MCTA score, the greater the shortage of maternal health care professionals. The purpose of MCTAs is to pinpoint areas with the greatest need for maternal health care services and distribute maternal health care professionals within HPSAs.

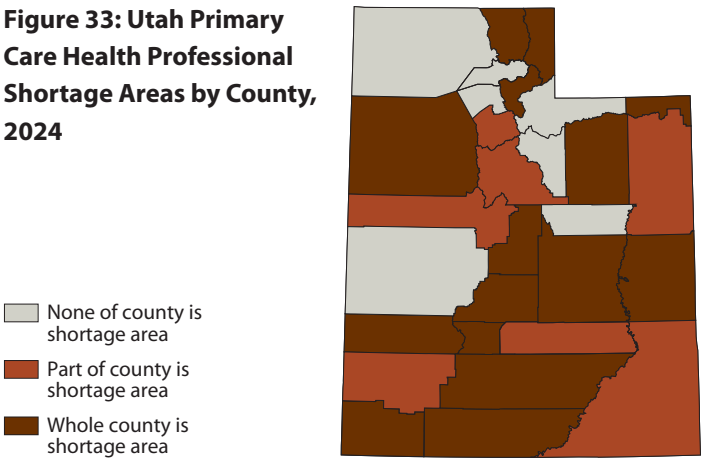
Twenty-two Utah counties have a Primary Care HPSA designation in 2024, with the whole county or part of the county designated as a shortage area (Figure 33). Over 565,000 women of reproductive age live in these 22 counties, approximately 77% of Utah's total women of reproductive age. Over 77% of Utah's 2023 births also occurred to mothers residing in these 22 counties. Figure 34 displays MCTA scores by Utah county.

Figure 32: Maternity Care Target Areas (MCTAs) Scoring



Source: Health Resources & Services Administration. Retrieved from: https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring#mcta-scoring

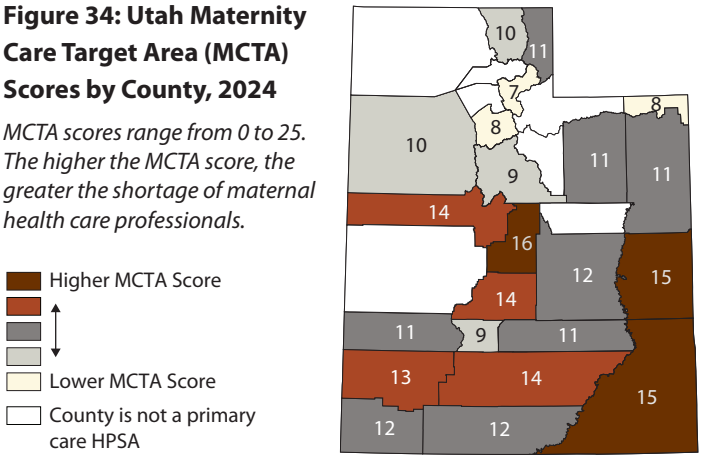
Figure 33: Utah Primary Care Health Professional Shortage Areas by County, 2024



Source: Health Resources & Services Administration, 2024. Retrieved from: https://data.hrsa.gov/data/download?hmpgtitle=hmpg-hrsa-data

Figure 34: Utah Maternity Care Target Area (MCTA) Scores by County, 2024

MCTA scores range from 0 to 25. The higher the MCTA score, the greater the shortage of maternal health care professionals.



Source: Health Resources & Services Administration, 2024. Retrieved from: https://data.hrsa.gov/data/download?hmpgtitle=hmpg-hrsa-data

Appendix

Table 4: Utah Maternal Health Providers' Scope of Practice

Provider	Description	Scope of Practice	Facilities	Licensure/ Certificate
Maternal Fetal Medicine Physician (MFM)	Physician specializing in highest risk obstetrics care	· Prenatal care · Labor and delivery, C-sections, operative vaginal deliveries, tubal ligations · High risk pregnancies · Postpartum care · Management of pregnancy complications	Hospitals Clinics	Licensed Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) specializing in both obstetrics and gynecology and with extra fellowship certification in MFM
Obstetrician/ Gynecologist (OB-GYN)	Physician specializing in obstetrics and gynecology	· Prenatal care · Labor and delivery, C-sections, operative vaginal deliveries, tubal ligations · High and low risk pregnancies · Postpartum care · Management of pregnancy complications · Family Planning · Surgical and non-surgical gynecological services	Hospitals Clinics	Licensed Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) specializing in both obstetrics and gynecology
Certified Nurse Midwife (CNM)	Advanced practice registered nurse who provides comprehensive prenatal, maternal health care, and child care to one year of age	· Prenatal care · Labor and delivery · Postpartum care · Family planning · Gynecological services	Hospitals Clinics Birth Centers	Licensed as Advanced Practice Registered Nurse (APRN) with specialization in midwifery
Licensed Direct Entry Midwife (LDEM)	Nationally certified professional who provides prenatal and postpartum care	· Prenatal care · Labor and delivery · Postpartum care · Limited prescriptive authority	Birth Centers Home Births	Licensed by Utah Division of Occupational and Professional Licensing (DOPL) as LDEM
Family Medicine Physician	Physician trained in care for all ages, including in maternal care and child care	· Prenatal care · Labor and delivery, C-sections, tubal ligations (depending on training) · High and low risk pregnancies · Postpartum care · Management of pregnancy complications in collaboration with MFM and OB-GYN · Family planning · Gynecological services	Hospitals Clinics	Licensed Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) with training in family medicine
Physician Assistant (PA)	Licensed medical professional who often works under the supervision of a physician, may be specialized in care for women or all ages, including child care	· Prenatal care (risk level depends on supervision and practice setting) · Postpartum care · Family planning · Gynecological services	Hospitals Clinics	Licensed Physician Assistant (PA), requires supervision of a physician
Nurse Practitioner (NP)	Advanced practice nurse who may be specialized in care for women or for all ages, including child care	· Prenatal care (risk level depends on supervision and practice setting) · Postpartum care · Family planning · Gynecological services	Hospitals Clinics	Licensed as Advanced Practice Registered Nurse (APRN), requires supervision of a physician
Doula	Trained professional providing physical, emotional, and informational support during pregnancy, labor, childbirth, and the postpartum period	· Birth coaching · Emotional and physical support · Postpartum recovery assistance	Hospitals Clinics Birth Centers Homes	No medical license required, training certification programs available
Community Health Worker (CHW)	Trained professional assisting with health education, social support, and navigating health care services	· Prenatal and postpartum education · Help with accessing maternal health care services · Social support related to housing, food security, and other determinants of health	Hospitals Clinics Birth Centers Homes	CHWs in Utah can complete training to become a State Certified Community Health Worker

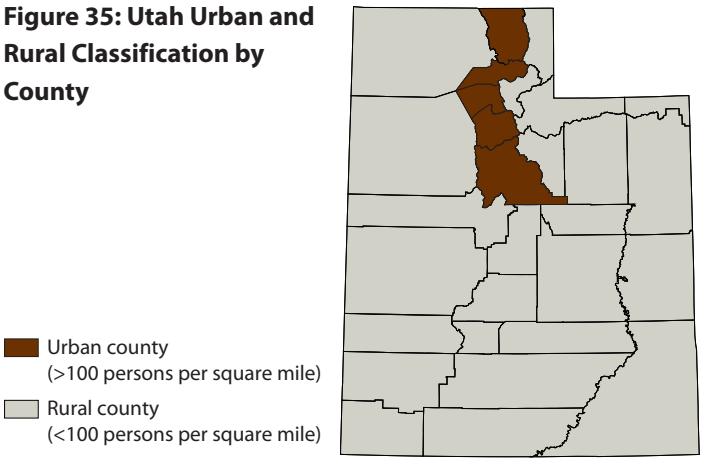
Sources: Midwives from Utah Women & Newborns Quality Collaborative, Midwives: Providers of Maternity and Newborn Care. Retrieved from: https://mihp.utah.gov/wp-content/uploads/Midwives-Infographic.pdf.

Urban and Rural Utah County Classification

The urban and rural county classification used in this report is from the Utah Department of Health and Human Services Indicator-Based Information System for Public Health (IBIS-PH), a website providing data on the health of Utahns and the Utah health care system.

This classification defines urban counties as those with more than 100 persons per square mile and rural counties as counties with fewer than 100 persons per square mile (Figure 35).

Figure 35: Utah Urban and Rural Classification by County



Source: County Classification, Utah Department of Health and Human Services Behavioral Risk Factor Surveillance System

Endnotes

1. Birth rate measured as a 5-year average (2019-2023). Utah Birth Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services. Utah Population Estimates Committee (UPEC) and the Governor's Office of Planning and Budget (GOPB) for years 1980-1999. For years 2000-2009 the population estimates are provided by the National Center for Health Statistics (NCHS) through a collaborative agreement with the U.S. Census Bureau. For years 2010 and later, the population estimates are provided by the Kem C. Gardner Policy Institute. Utah state and county annual population estimates are by single year of age and sex, IBIS Version 2023.
2. Utah Birth Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services. Retrieved August 19, 2024 from the Utah Department of Health and Human Services, Indicator-Based Information System for Public Health website: https://ibis.utah.gov/ibisph-view
3. Certified nurse midwives or licensed direct entry midwives
4. Maternal mortality is defined differently depending on the surveillance system. The data source used to calculate maternal mortality in this instance defines maternal mortality as maternal deaths per 100,000 live births. Maternal deaths are deaths among women while pregnant or within 42 days of termination of pregnancy. Other data sources measure maternal deaths as a death during or within one year of pregnancy, regardless of the cause of death. The Utah Department of Health and Human Services measures maternal deaths as those during or within one year of pregnancy and distinguishes between pregnancy-associated death and pregnancy-related death. Maternal deaths are also known as pregnancy-associated deaths. A pregnancy-related death is defined as the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. Pregnancy-related deaths are a subset of all pregnancy-associated (maternal) deaths.
5. Discrimination is based on the following definitions: Discrimination: treating someone less or more favorably based on the group, class or category they belong to resulting from biases, prejudices, and stereotyping. It can manifest as differences in care, clinical communication and shared decision-making (Hardeman, 2022). Interpersonal racism: discriminatory interactions between individuals based on differential assumptions about the abilities, motives, and intentions of others and resulting in differential actions toward others based on their race. It can be conscious as well as unconscious, and it includes acts of commission and acts of omission. It manifests as lack of respect, suspicion, devaluation, scapegoating, and dehumanization (Hardeman, 2022). Structural racism: the systems of power based on historical injustices and contemporary social factors that systematically disadvantage people of color and advantage white people through inequities in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc. (Hardeman, 2022).
6. The Commonwealth Fund. (2021). Severe Maternal Morbidity in the United States: A Primer. Retrieved from: https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/severe-maternal-morbidity-united-states-primer
7. Preventable refers to the degree to which a SMM event could have been avoided or its severity reduced with timely and appropriate actions by providers, systems, or the patient. This includes factors like improved care, better protocols, and recognizing and managing complications early. Preventable does not include SMM or maternal mortality due to an underlying health condition of the mother. Lawton, B., MacDonald, E. J., Brown, S. A., Wilson, L., Stanley, J., Tait, J. D., Dinsdale, R. A., Coles, C. L., & Geller, S. E. (2014). Preventability of severe acute maternal morbidity. American journal of obstetrics and gynecology, 210(6), 557.e1–557.e5576.
8. Rates of preventable deaths is measured among pregnancy-associated deaths which include maternal deaths during or within one year of pregnancy. Figure 2 measure maternal deaths as a death during pregnancy or within 42 days of the pregnancy termination.
9. Utah Department of Health and Human Services. (2025). Maternal Mortality in Utah, 2017-2020.
10. A death is considered preventable if the Maternal Mortality Review Committee determines there was at least some chance of the death being averted by one or more reasonable changes at the patient, provider, facility, systems, or community levels.
11. Share of maternal deaths by contributing factor is measured among pregnancy-associated deaths which include maternal deaths during or within one year of pregnancy. Figure 2 measure maternal deaths as a death during pregnancy or within 42 days of the pregnancy termination.
12. Utah Department of Health and Human Services. (2025). Maternal Mortality in Utah, 2017-2020.
13. Share of maternal deaths with a documented health care access issue is measured among pregnancy-associated deaths which include maternal deaths during or within one year of pregnancy. Figure 2 measure maternal deaths as a death during pregnancy or within 42 days of the pregnancy termination.

14. Centers for Disease Control and Prevention (CDC). Maternal Health. Available at: https://www.cdc.gov/cdi/indicator-definitions/maternal-health.html
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18. Differences in substance use disorder substate rates are for all adults. Brigance, C., Lucas R., Jones, E., Davis, A., Oinuma, M., Mishkin, K. and Henderson, Z. (2022). Nowhere to Go: Maternity Care Deserts Across the U.S. (Report No. 3). March of Dimes. https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx
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22. Health Status Report. (May 2025). Resources to improve perinatal mental health conditions. Utah Department of Health and Human Services.
23. Rates of poor mental health among women by county is an estimate of all adult women 18 years and over. Rates by women of reproductive age is not available due to data suppression because 1) the relative standard error is greater than 50% or the relative standard error can't be determined, 2) the observed number of events is very small and not appropriate for publication, or 3) it could be used to calculate the number in a cell that has been suppressed. Consider aggregating years to decrease the relative standard error and improve the reliability of the estimate.
24. The U.S. National Institute of Mental Health defines substance use disorder as a treatable mental disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. Symptoms can be moderate to severe, with addiction being the most severe form of SUD.
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40. Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System, 2021-2022.
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