

Center for Rural Pennsylvania

Public Hearing on Women's Health in Rural Pennsylvania

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Thank you for the opportunity to testify today. I am an epidemiologist at Penn State College of Medicine. My research examines how health systems, social conditions, and where people live shape health during pregnancy and the year after birth. I will begin with an overview of rural maternity care in Pennsylvania, then draw on two efforts: the Pennsylvania Maternal and Infant Health in a Pandemic (PA-MIPA) study, funded through Pennsylvania's Commonwealth Universal Research Enhancement (CURE) program, and the Central Pennsylvania Maternal Health Coalition, funded through the Pennsylvania Department of Health. These efforts represent an investment from the Commonwealth of Pennsylvania to bring together researchers, health systems, community organizations, and families to create partnerships that translate data, experience, and knowledge into meaningful improvement in maternal health and maternal health care.

Rural access in Pennsylvania

Rural Americans face many structural challenges in health and health care including longer distance to care, fewer specialists, and higher rates of chronic disease. Rural Americans in general die at higher rates than urban Americans from leading causes of death, including heart disease, cancer, and stroke. This trend persists across the lifespan for women living in rural communities: in preventive care, cancer screening, mental health, and heart health.¹

Pregnancy is one of the times these differences become most visible. It is often the time when a woman has the most contact with the health care system, and when gaps in access carry immediate consequences for both her and her baby. It is also a window into her future health. Complications such as high blood pressure and diabetes during pregnancy signal higher risks of heart disease and diabetes for decades afterward.^{2,3} For these reasons, I will focus today on care during pregnancy, at birth, and in the year after.

Nearly half of Pennsylvania's rural counties do not have a hospital with a labor and delivery unit: 23 of the state's 48 rural counties. Eight of these counties form a single connected region in the northern part of the state, meaning these women live in a place where there is no birthing hospital in their counties and their neighboring counties.⁴ About 106,000 Pennsylvania women of reproductive age live more than 30 minutes from the nearest hospital that delivers babies.⁵ For a woman in labor or facing an emergency, those minutes matter. The problem is growing. UPMC Cole in Coudersport stopped delivering babies in 2025, and Warren General Hospital did the same in January 2026.⁶

Nationally, rural women giving birth are more likely than urban women to suffer life-threatening complications, such as severe bleeding, stroke, or heart failure, or death. Their odds are 9% higher, even after accounting for differences in clinical and socioeconomic characteristics.⁷ When rural hospitals far from cities stopped delivering babies, the next year brought more babies born outside a hospital or in hospitals with no maternity unit, and more born too early.⁸

Pregnancy requires a sequence of care: timely prenatal visits, screening and treatment for complications, a safe place to give birth, and follow-up after delivery. Each step depends on the others. When care is far away, a family may have to arrange transportation, miss work, find childcare, and make that trip repeatedly. The same barriers remain after birth, when a parent needs care while also caring for a newborn. These practical burdens can contribute to fewer visits, later care, and more stress on the family.

A mother's risk does not end at discharge, and the postpartum period must be part of any rural maternal health strategy. In Pennsylvania, most deaths linked to pregnancy happen after the pregnancy ends. Of the 129 pregnancy-associated deaths in 2021, 31% occurred during pregnancy, 21% in the first six weeks after pregnancy ended, and 48% between six weeks and one year later.⁹ Some complications, including high blood pressure, infection, and depression, appear after delivery and others develop over the following months. Yet nationally, rural residents are less likely than urban residents to have a postpartum medical visit, even after accounting for sociodemographic and clinical differences.¹⁰ A policy focused only on prenatal appointments and delivery would miss the period when most deaths occur. Pennsylvania has already extended Medicaid postpartum coverage to 12 months.¹¹ That is an important foundation. Coverage helps only when a clinician is available, the handoff from obstetric care is clear, and someone notices when a patient falls out of care.

What our Pennsylvania data show

Our PA-MIPA study examines electronic health record data from four academic health systems (Penn State Health, Geisinger, Temple Health, and University of Pittsburgh Medical Center), covering pregnancies within these systems from 2019 to 2025. A sample of these patients is linked to longitudinal survey data from pregnancy to 12 months postpartum.¹² Because the data include patients from all counties in the state, with 36% of them living in rural counties and 11% in counties without a labor and delivery unit, and the data follow patients from pregnancy through the year after birth, we can ask questions about maternal health in Pennsylvania that other data sources cannot answer. In preliminary analyses, we have identified that important maternal health indicators differ by rurality. Our data show that rural women in Pennsylvania are more likely to have documented complications such as gestational diabetes and high blood pressure during pregnancy, and those without a depression history are more likely to have documented depression in the year after birth.

What we hear from communities

The Central Pennsylvania Maternal Health Coalition was established to implement the Maternal Mortality Review Committee recommendations in our region in order to eliminate preventable maternal mortality. The Coalition includes 26 members from 22 organizations across Berks, Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties. Members include representatives from health systems, home visiting programs, community-based organizations, doulas and community health workers, and people with lived experience.

Many of the services families need already exist in some form, but connecting families to them can be difficult. A clinician or other service provider may recognize that a new mother needs mental health care, home visiting, lactation support, transportation, or food assistance, but there is often no system in place to connect her to those services beyond a referral or phone number. She is then left to sort out eligibility, insurance, scheduling, and travel while recovering from birth and caring for a newborn. Each of those steps can involve a longer drive and fewer choices.

The Coalition's work has focused on laying groundwork to close that gap. We have mapped the maternal health resources available across our six counties and identified where services are missing. We have compiled training resources to help providers recognize and respond to families' needs, and we have developed resource materials for both patients and providers so that each knows what services exist and how to reach them.

Recommendations for the Commonwealth

Based on our research and our work with communities, I would highlight four opportunities for the Commonwealth.

First, protect access to maternal health care. Policies should support the sustainability of rural maternity care and help prevent avoidable closures or reductions in services. When closures or service reductions do occur, planning should include referral agreements, transport and transfer protocols, and readiness at the facilities that will receive patients. These efforts are particularly important in communities where the next hospital or appropriate level of care is far away.

Second, strengthen community health education and navigation. Pregnant and postpartum women and their families need clear, accessible information about where prenatal care, delivery services, emergency obstetric care, and postpartum follow-up are available. They also need education about warning signs, when to seek care, and how to navigate available services. This information should be culturally and linguistically appropriate and shared through trusted health care and community partners.

Third, strengthen navigation and coordination across maternal health care and services. Obstetricians are essential, but so are family physicians, pediatricians, midwives, behavioral health clinicians, home visitors, and community health workers, who often see families between major medical visits. Pennsylvania also has many strong maternal and child health programs, but they help only when families and providers can find and reach them. Navigation, referral systems, and shared information can turn a referral into actual care, and clear responsibility for follow-up helps ensure that a positive screen, an elevated blood pressure reading, or a missed appointment does not go unaddressed. Workforce policy should fund the time this coordination takes, not only the clinical visit itself.

Fourth, continue investing in Pennsylvania-specific maternal health data and research. To know how rural families are faring, Pennsylvania needs ongoing data on access, quality, and outcomes across pregnancy and the year after birth, from travel time and prenatal care to complications, mental health, and emergency care. PA-MIPA shows what becomes possible when the Commonwealth invests in research infrastructure. Research funding from the CURE program, supported by the Tobacco Settlement Fund, has brought major health systems together and created a large resource for understanding the health of pregnant and postpartum Pennsylvanians, one that can answer questions about our own communities that national data cannot. Pennsylvania should continue building ways for researchers and health systems to responsibly connect and analyze maternal health data while protecting patient privacy. That would let researchers, health systems, community organizations, and policymakers see where needs are greatest and whether new programs are improving outcomes.

Closing

Pennsylvania has extraordinary clinical expertise, public health programs, community organizations, and researchers working to improve maternal health. The lesson I take from this work is that no single intervention will close the rural gap and that rural populations across the state differ in their people, resources, health needs, and local circumstances. A delivery unit within reach matters, but so does what happens after discharge. Many rural women leave the hospital with conditions that need follow-up, and services help only when families can reach them and when someone is responsible for making sure they do.

Pennsylvania has already invested in many of these pieces, including extended postpartum Medicaid coverage, strong maternal and child health programs, and research infrastructure. The opportunity now is to connect them, so that every rural family knows where to get care during pregnancy, where to give birth safely, and who remains responsible for their care after they go home.

Thank you for the opportunity to share our work and for your attention to the health of Pennsylvania mothers, infants, and families. I would be glad to answer any questions.

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