

The County Maternal Health Landscape

Inequities, Barriers and Recommendations

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Introduction

Counties play a critical role in improving the health of pregnant and postpartum people. As owners and administrators of the local health and human services social net, county leaders recognize that rising instances of maternal health complications and deaths underscore the necessity for enhanced provision and accessibility of maternal health services. Further, disparities in maternal health experiences pose a serious equity issue that can be addressed through policies and programs that lead to strong birth outcomes.

To better understand the challenges and opportunities for county government in supporting pregnant and

postpartum people, the National Association of Counties Research Foundation (NACoRF) surveyed county officials on their role and authority in maternal health, gaps and barriers in maternal care systems and county-level solutions and priorities. This report highlights survey findings alongside focus group and interview responses to share the critical role of counties in serving pregnant and birthing residents. County leaders can use this information to guide development of comprehensive, accessible and equitable local maternal health care systems.



The Problem

The United States is facing a growing national crisis in maternal health as pregnant and postpartum people face worsening health outcomes and disparities continue to widen. We continue to have one of the highest maternal mortality ratios – the number of maternal deaths for every 100,000 live births – among

other high-income nations.¹ In the U.S., **700 mothers die each year** from complications during or after pregnancy and **4.7 million women live in counties with limited maternity care access.**² The national maternal mortality rate increased from 23.8 to 32.9 deaths per 100,000 live births between 2020 to 2021.³



In 2022, more than one in three (36 percent) of counties were classified as a maternity care desert.

Source: [March of Dimes](#)⁴

Note: A maternity care desert is a county where access to maternity health care services is limited or absent, either through lack of services or barriers to a woman's ability to access that care.⁵



Maternal health is vital for both the well-being of pregnant individuals and the health of their infants. For infants and children, maternal morbidity can increase risk of developing chronic health conditions, behavioral or developmental disorders or mental health challenges, all of which have future impacts on children. Providing safe and quality care can prevent adverse long-term outcomes.

The connection across maternal health and the health of infants, families and communities is visualized in the Birth Equity Ecosystem Map, created by The Association of Maternal and Child Health Programs' (AMCHP). The innermost layer of the map displays the interrelated health stages that impact individuals across the ecosystem. These stages exist in the intersections of social and economic supports, policies, clinical care and the physical environment. Centering a whole family ecosystem approach that recognizes and reflects the various systems that impact maternal, infant and child health will help counties improve equity and improve maternal health outcomes.

BIRTH EQUITY ECOSYSTEM MAP



Adverse birth outcomes and experiences have a direct impact on pregnant people. **Maternal death or mortality** is the loss of a pregnant person's life during the perinatal period – the period that includes the duration of pregnancy, childbirth and up to 42 days postpartum.⁸ It includes deaths caused by pregnancy-related complications or any aggravation of pre-existing conditions due to the physiological effects of pregnancy. Greater experiences of morbidity are associated with higher mortality rates, greater risk of unemployment, absenteeism, reduced productivity and greater costs.⁹

A maternal mortality rate is the measure of the frequency of occurrence of death, specifically the number of maternal deaths per 100,000 live births.⁶

Maternal morbidity is defined as any short- or long-term health problems that result from being pregnant and giving birth, or in other terms, the physical and psychological conditions resultant or aggravated by pregnancy.⁷

Maternal health is a particularly pressing issue for people of color and other historically marginalized populations, including pregnant people living in rural communities and those living with behavioral health conditions and other barriers. **In 2021, the maternal mortality rate for non-Hispanic Black women was 69.9 deaths per 100,000 live births, 2.6 times the rate for non-Hispanic White women.¹⁰ For American Indian/Alaskan Native women, the maternal mortality rate is 118.7 deaths per 100,000 live births, 4.5 times the rate for non-Hispanic White women.¹¹**

Many of the racial disparities in maternal health outcomes are driven by inequities in the social determinants of health (SDOH), including access to quality health care and education, social and community factors, economic stability and neighborhood and built

environment.¹² Understanding historical inequities like the generational trauma of enslavement, segregation, concentrated poverty, community disinvestment and persistent interpersonal racism is crucial to developing maternal health solutions that address SDOH.¹³

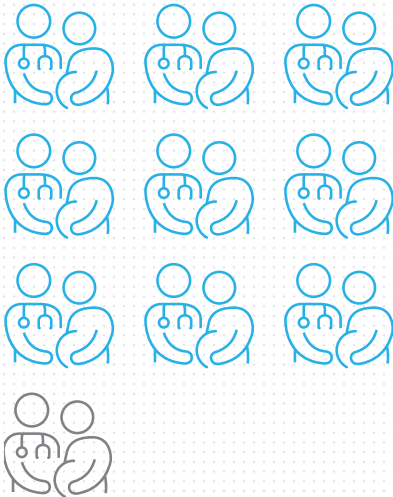


County Authority in Maternal Health

Counties provide comprehensive and equitable maternal health services to all residents. Counties invest annually \$100 billion into community health and hospitals, \$62.8 billion human services and education and support approximately 2,800 local health departments, which provide critical maternal health care services and resources.¹⁴

The National Association of Counties Research Foundation (NACoRF) surveyed counties from May to August 2023 to understand their role and authority. Of the 74 respondents, the majority were from urban or

suburban counties, with about one third representing rural counties. Common respondents included county commissioners, directors of public health, public health nurses and managers, human services coordinators/supervisors and maternal, child adolescent health coordinators. NACoRF then held two focus groups with six counties from across the U.S., selected from their survey responses, and three interviews with counties active in the maternal health space to dive further into their work and responses.



90 percent of respondents reported providing direct maternal health services or programs to residents.

Counties Fund and Administer Maternal Health Services

Counties support maternal health services through the blending and braiding of funding sources from all levels of government, as well as other grant programs and partners in maternal health.

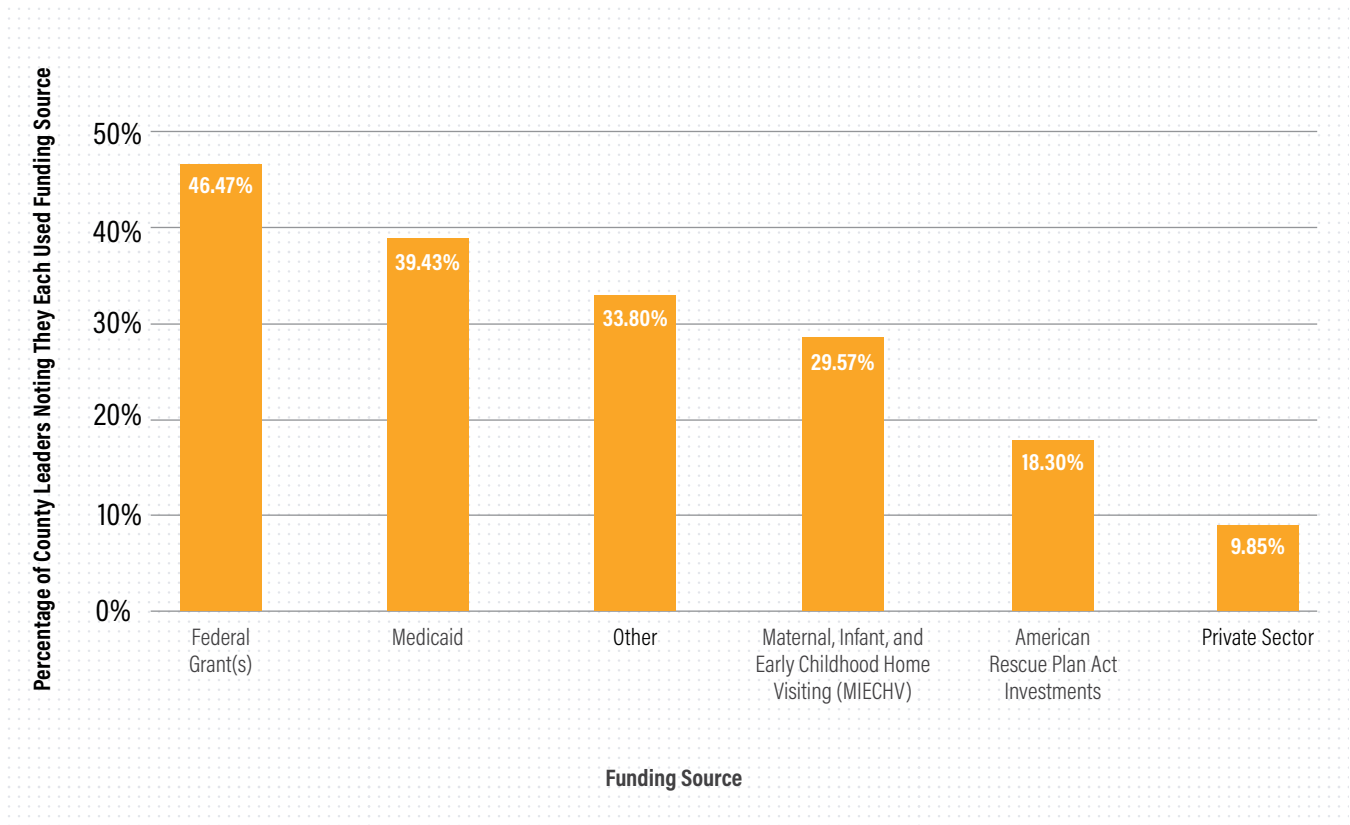
Counties assist in the administration of maternal health services in a variety of ways, including directly delivering services through county-based departments or agencies. While often serving as the initial point of contact for residents, counties then facilitate referrals to external partners and community-based providers. Counties work to expand options available to residents

by engaging with a variety of local partners such as community-based organizations, non-profits, universities and external health systems.

Maternal health services are provided from many different entities at the local level, but primarily through county public health departments (87 percent of respondents), local hospitals (45 percent), birthing centers (44 percent) and by contracting out to other organizations (36 percent). Respondents also noted human services departments, as well as behavioral health and child welfare agencies.

FIGURE 1. COUNTY FUNDING SOURCES USED TO PROVIDE MATERNAL HEALTH SERVICES

Note: Respondents could select all options that applied. "Other" sources included local levies (i.e., property or sales tax); state general funds, grants and Maternal Child Adolescent Health (MCAH) funds; Title V Maternal Child Health (MCH) Block Grants; non-profit funding and special hospital districts.



Types of Maternal Health Programs and Services

Counties across the country lead innovation in maternal health care service delivery and are expanding their reach beyond medical services to meet social needs of birthing people and include non-traditional methods and sources of maternal care.

Local government maternal health services are administered through county-based agencies and partnerships with other groups in the community. **A majority (64 percent) of respondents shared that they partner with community-based organizations,** with many noting how partnerships expand access to care and reach residents facing the greatest challenges.

Counties often partner with organizations that expand maternal health services for residents and address SDOH. For example, many counties are bolstering community health worker (CHW) programs that engage residents with strong community ties and lived experience to work on local health efforts. External partnerships allow counties to connect residents to additional and wraparound services.

Olmsted County, Minn. partners with [Family Service Rochester](#) (FSR), a non-profit organization that provides a wide range of services addressing mental health, child-wellbeing and family stability. Its Family Advocacy in Recovery and Restoration (FARR) program provides substance use recovery support for women who are pregnant and/or parenting, and the FATHER Project assists fathers in overcoming barriers that prevent them from supporting their children emotionally and economically. Olmsted County Public Health Services nurses participate in both programs to provide ongoing client education and make referrals to other services.

MATERNAL HEALTH SERVICES COMMONLY ADMINISTERED AT THE COUNTY LEVEL

- Nutrition education and WIC Services
- Family planning and parenting support
- Obstetrician/Gynecologist (OB/GYN)
- Breastfeeding support
- Prenatal care coordination
- Behavioral health resources
- Case management and referrals
- Doula services & public health nurses
- Nurse-family partnerships
- Home-visiting
- Community Health Workers (CHWs)

“The community was saying we need organizations that look like us, that understand us, that aren’t coming in telling us what to do, but partnering with us, understanding that we’re human beings with the human experience and we have value and voice. And so, you have partnerships with community-based organizations that already have a pulse on the community, already have trusted relationships with community members where people feel safe going.”

*— Hon. Erica Crawley, Commissioner
Franklin County, Ohio*

COMMON LOCAL PARTNERS IN MATERNAL HEALTH

- Non-profit organizations
- Federally Qualified Health Centers (FQHCs)
- Behavioral health organizations
- Recovery centers
- OB/GYNs and family medicine
- Parenting networks
- Birthing clinics
- Religious organizations and groups
- Social service organizations
- Food banks
- Local schools
- Family & maternal health resource centers
- WIC programs
- Health care systems

Counties Monitor Maternal Health Data

When a maternal death occurs, there is usually a specific position in the county that is required to make the final determination and finalize records. County respondents to the survey noted that this responsibility primarily falls upon the medical examiner (45 percent) or the coroner (33 percent). Others noted attending physicians, justices of the peace, a county health officer or the state government as alternative responsible parties for determining when a maternal death has occurred.

Maternal mortality data provides important information about the cause of death and other relevant factors about the person who passed. This data, often pulled from a death certificate, can be helpful to understand the broader health of a community to tailor interventions and drive policy efforts.¹⁵ Counties mainly access maternal mortality and morbidity data from state health departments and dashboards, though respondents noted local hospitals and local birth certificate reviews as other major data sources. For example, **Greene County, N.Y.** monitors birth certificates quarterly and convenes a meeting of local partners to review.

Livingston County, N.Y. gets data from reports and vital statistics through the health commerce system and retrieves data from [N.Y. State Community Health Indicator Reports](#). And **Olmsted County, Minn.** uses data from three state-level reports to get a fuller picture of maternal health – mortality, access to prenatal care and gestational diabetes.

Counties also collect data on a variety of other indicators to help gather information on key drivers of maternal health outcomes. Indicators such as the number of home-visits, uptake of breastfeeding, usage of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) are a part of the broader maternal health umbrella that addresses SDOH and can expand care touchpoints with new parents. Gathering data on these programs helps counties identify the geographic distribution of birthing people, understand whether they are getting the care they need and design interventions specifically addressing these gaps.

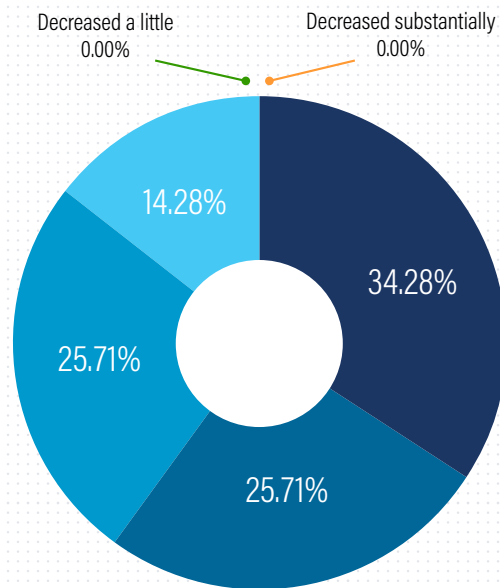
Persistent Maternal Health Disparities and County-Level Challenges

Local Maternal Health Disparities

Inequitable distribution of social and economic resources follows racial and geographic boundaries and leads to disparities in maternal health outcomes. Reflective of national trends, counties across the country report continued widening of maternal health inequities and disparities. When asked how they felt about the prevalence of maternal health disparities in their community over the last year (2022-23), a majority of survey respondents noted that disparities increased substantially (14 percent), increased a little (34 percent) or remained the same (26 percent). **No respondents noted any kind of decrease in disparities in the last year.**

Respondents were also asked which populations they observed to experience the greatest challenges with maternal health disparities. Over 40 percent of respondents reported pregnant people with behavioral health conditions, people of color and people experiencing homelessness have the greatest challenges within their communities. Following these groups, respondents reported people living in rural communities (31 percent), justice-involved people (18 percent) and refugees and immigrants (4 percent) also face substantial challenges to maternal health.

We asked counties: In the past year, has the prevalence of maternal health disparities increased, decreased or remained the same?



■ Increased substantially ■ Increased a little ■ Remained the same ■ Decreased a little ■ Decreased substantially ■ Unsure

Racial Disparities

Lack of perinatal health care access and workforce shortages – including lack of workforce diversity – are key contributors to poor maternal health outcomes. Specifically, Black and Hispanic women giving birth in U.S. hospitals report being more likely to experience mistreatment from their health care providers.¹⁶ Implicit racial bias among providers is associated with lower quality of care for patients, less use of services because of system mistrust and provider dismissal of legitimate symptoms. Birthing people of color also have inequitable access to culturally appropriate providers and respectful maternal care, a necessity for a population experiencing disproportionately high maternal death rates.¹⁷ Respondents from **Hennepin County, Minn., Franklin County, Ohio** and **Wayne County, Mich.** emphasized that patients continue to report persistent interpersonal racism in the maternal health setting by providers against their patients of color.

Participants also described challenges disproportionately affecting birthing people of color in their communities consistent with historic inequities. In **Franklin County**, Black mothers make up the largest share of homeless shelter residents. County leaders see this as a reflection of the wage gap and local housing inequity. Focus group participants from **Pierce County** reported similar trends disproportionately affecting Black mothers in the community who live under the effects of redlining that directly impact SDOH like food access, walkability and housing affordability.

Further, SDOH such as lack of stable and quality housing, economic instability and a lack of access to fresh and healthy foods all have detrimental impacts on maternal health. As noted previously, systemic racism and the continued effects of historic trauma, disinvestment and discrimination contribute to Black and Indigenous populations experiencing higher rates of maternal morbidity and mortality.



SPOTLIGHT BIRTH DETROIT



Photo of and provided by Leseliey Welch

Birth Detroit is an initiative led by former Detroit deputy director of public health, **Leseliey Welch**, alongside a team of midwives and birth justice advocates. The organization provides maternal care to people with low-risk pregnancies through **Birth Detroit Care** and is scheduled to open a birth center in 2024. As one of the United States' few Black-led or owned birth centers, Birth Detroit combats historic disinvestment in Black-led birthing. The organization advocates for midwifery expansion, because midwives have unique roles as specialists in the physiological reproductive life cycle with ties to the communities and cultures they serve. Additionally, Birth Detroit strives for a system of care rooted in values of safety, love, trust and justice, and where families can receive comprehensive, community-centered care on one care campus.

Birth Detroit Birth Center, the organization's forthcoming birth center, will be Detroit's first of its kind free-standing birth center and one of the first Black-led birth centers in the state of Michigan. Collaboration with the City of Detroit and Detroit Land Bank Authority was instrumental in securing the land used by Birth Detroit Care for the forthcoming birth center.

With the recent closure of Wayne State University's midwifery program, Birth Detroit's advocacy for midwifery training and education is a significant step forward amid local challenges to maternal health care workforce development. The federal Health Resources and Services Administration (HRSA) recently awarded the University of Michigan School of Nursing \$4 million dollars to partner with Birth Detroit to launch the **Michigan Maternity Care Traineeship Program** to support the financial and mentorship needs of midwifery students from underserved areas.

Welch also co-founded **Birth Center Equity (BCE)**, a national organization that's mission is to make birth centers a real option in every community by investing in Black, Indigenous, people of color-led birth centers. In addition to grant making and technical assistance, BCE is working to advance birth center sustainability through business development, integrated financial models and public-private partnerships like the new municipal birth center project being planned in collaboration with the Wayne County Department of Health, Human, and Veterans Services.

Geographic Disparities

Access to maternal health care inequitably affects birthing people living in rural areas, particularly in the southeast United States and neighborhoods experiencing deprivation (or a higher prevalence of adverse SDOH).¹⁸ Between 2004 and 2014, hospital-based obstetric services in rural U.S. counties declined from 54 to 45 percent coverage.¹⁹ **More than half (55 percent) of rural hospitals in the U.S. do not offer labor and delivery services; in 10 states, more than two-thirds of hospitals do not.**²⁰ As a result, individuals in rural areas often travel upwards of 30 minutes or more to reach an obstetric hospital. For example, **Del Norte County, Calif.** is a geographically isolated community with a majority of services housed in the county seat. As a result, the county has had to work to ensure mothers can afford and access transportation to services.

March of Dimes reports the proportion of women living in counties below the national median household income is twice as high for maternity care deserts as it is in full access counties (90.1 and 45.2 percent, respectively). **Consequently, women in rural areas are at higher risk for birthing complications and maternal mortality and morbidity compared to urban areas.**²¹

“In rural Idaho, we feel that there’s a difference, especially in initiating prenatal care. It takes longer for them to actually get into an appointment or to...travel the distance that they have [to reach prenatal care]. Transportation is a big issue for us. Broadband is a big issue for us. Housing is a big issue for us.”

— Carol Moehrle
Public Health Director (retired)
Nez Perce County, Idaho

Disparities in Other Populations

Across the focus group and interviews, participants reported the following other inequities and disparities observed within their counties:

- **Maternal Mental Health and Substance Use:** **Nez Perce County, Idaho; Pierce County, Wash.** and **Franklin County** reported a large share of maternal deaths among mothers struggling with mental illness and substance use disorder.
- **Quality and Access to Maternal Care for Medicaid Enrollees:**
 - **Del Norte County** experiences shortages of providers, especially those willing to accept Medicaid. Consequently, the county observes disparities in quality of maternal health services between mothers enrolled in Medicaid and those enrolled in private insurance.
 - Maternal health care providers in **Wayne County** note a trend where people who are underinsured may be deterred from accessing care due to high out-of-pocket costs. In turn, this affects local maternal health outcomes.
 - In **Jackson County, Mich.**, state Medicaid policy affects equitable access to culturally appropriate doula care. Current policies can pose occasional barriers to timely reimbursement from Medicaid Health Plans for services.

County Barriers to Providing Maternal Care

Local governments face substantial barriers to providing equitable and accessible maternal health care services to their residents. These barriers compound existing disparities and inequities and ultimately prevent pregnant people from receiving equitable maternal health care. A few notable barriers include a projected shortage of maternal health physicians and OB/GYNs by 2030, a lack of accurate and comprehensive maternal health data (especially data on maternal mental health and substance use), residual impacts of the COVID-19 pandemic and pervasive gaps related to provider access and insurance coverage among many others.²²

When asked what the primary factors were that contribute to maternal health disparities, survey respondents selected all that applied to their county and reported the biggest challenges to be:



Rural and Urban Counties Face Transportation Barriers to Maternal Health Services in Unique Ways

Other factors include limited health care options, mistrust in government, impacts of federal and state-level legislation and the underlying challenges with accessing SDOH. These factors were echoed by interview and focus group participants from **Nez Perce County**, a rural county with a population of roughly 43,000 people, and **Franklin County**, a large urban county, with a population of 1,326,000 people. Both counties expressed that birthing people in their communities face transportation and other structural barriers to accessing care.



NEZ PERCE COUNTY, IDAHO

RURAL COUNTY

In Nez Perce County, many families are unable to afford housing, increasing the number of people in tents and shelters. In addition, limited broadband and transportation make both in-person and distanced health access challenging.



FRANKLIN COUNTY, OHIO

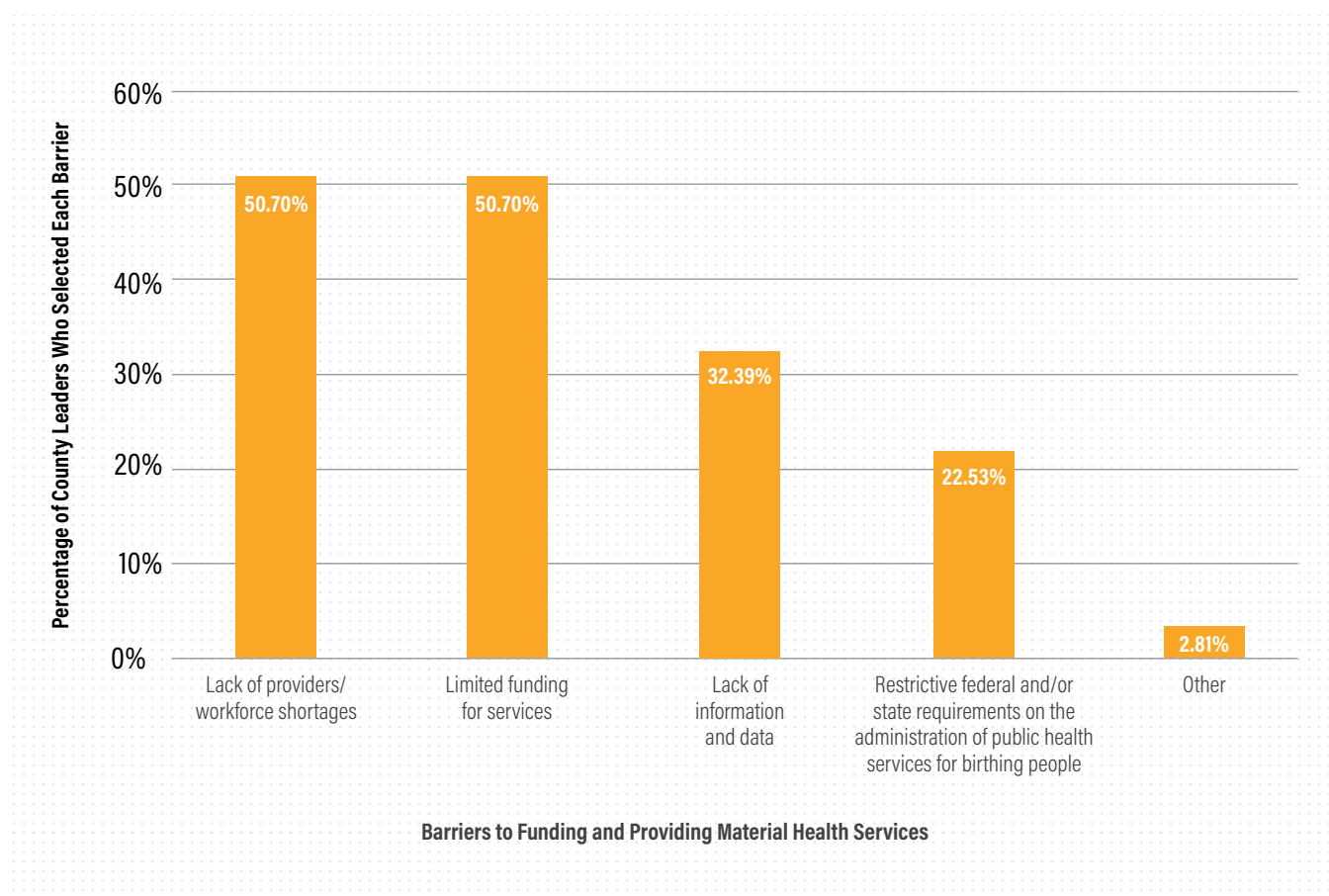
URBAN COUNTY

In Franklin County, interview participants noted the multi-layered transportation issues individuals face just to get to care facilities, as taking public transportation may require transferring from multiple buses over long distances. Franklin County participants also noted how people who already have children may have an even harder time getting to and from care, with the added task of finding child care or bringing children with them.

Figure 2 illustrates survey responses identifying major barriers to funding and providing maternal health services. This question, alongside conversations with local leaders, illuminated obstacles across four major categories:

- **Lack of maternal health infrastructure**
- **Lack of culturally competent care**
- **Limited funding for services, and**
- **Deficiencies in information and data.**

FIGURE 2. BARRIERS COUNTIES FACE IN FUNDING AND PROVIDING MATERNAL HEALTH SERVICES



Lack of Maternal Health Infrastructure

March of Dime's [2022 report on maternity care deserts](#) describes inequitable trends in maternal health care infrastructure decline across counties. Rural counties disproportionately meet the maternity care desert designation, with nearly two in three (61.5 percent) meeting the criteria.²³ This designation typically arrives with the loss of maternal health and obstetric care providers.

KEY DISCUSSION

Rural counties often experience the **“training ground”** phenomenon: providers come to gain a few years of intensive experience but then leave, adversely impacting the sustainability of a long-term maternal health workforce.

“We’re a geographically isolated, very rural community, very small. All of our providers are way underpaid and are having to see to very complex patients, so we tend to have very high rates of burnout. **We’ll have providers come in, stay very briefly, and then leave.** Or we’ll act sometimes as a training ground for people to come in and get experience and then leave after a couple of years to a place that pays more and doesn’t have as complex clients and structural and social issues to deal with.”

— Shelby Bodenstab, Director of Nursing
Del Norte County, Calif.

Limited funding can make replacement of vacant maternal health provider roles challenging, even among counties with successful retention.

“Just within our county alone within the last year and a half, **we’ve lost six of our OBGYNs....** Once we have staff for our maternal and infant health program, we’re able to retain – we have a pretty good staff retention rate – **it’s filling positions once they are vacant....** I’m really struggling right now to hire a social worker for our maternal infant health program. I’ve had the position open for a little over two months. Those are a little easier than our nursing positions **and it all aligns with funding and what we can offer.”**

— Ann McClure, Community Health Coordinator
Jackson County, Mich.

Recent developments in national and state maternal health policy have resulted in provider flight from states unfriendly to maternal health.

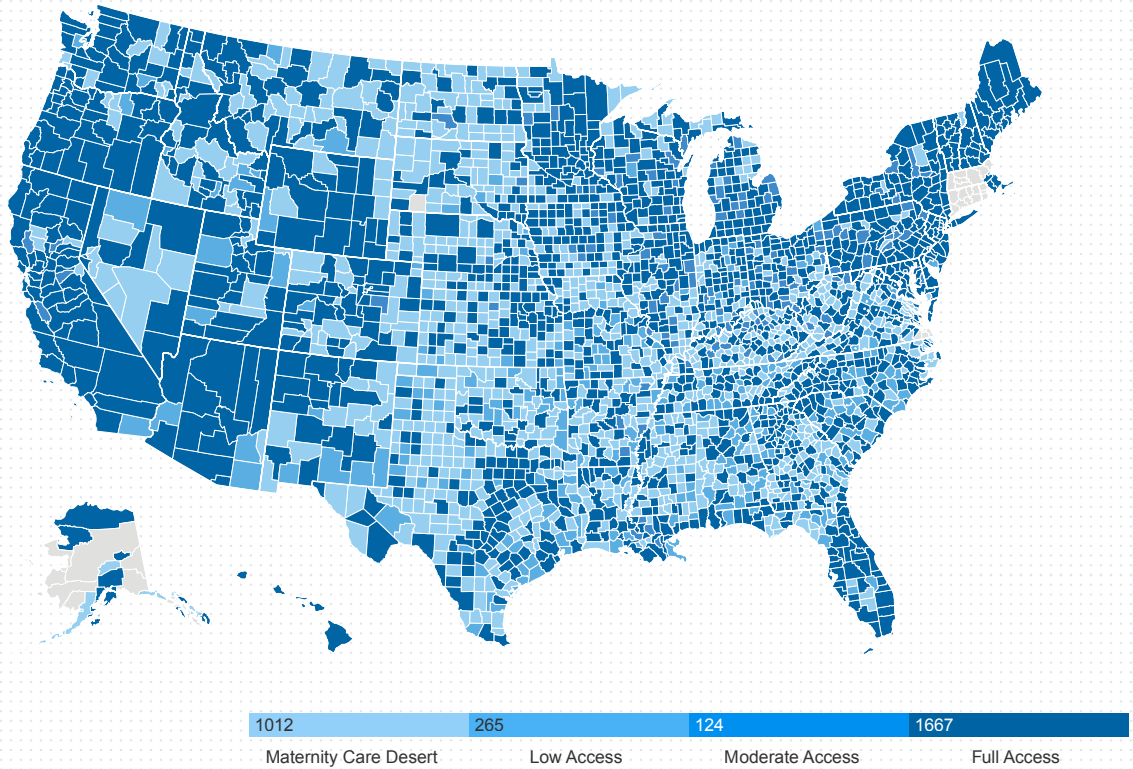
“With the legislative changes that have taken place in Idaho this last year especially, **we’ve had 20 OBGYN physicians leave Idaho.** Now, that doesn’t sound like many in big cities, but for Idaho that’s huge. We’ve also had three hospitals close their maternity wards because of this.”

— Carol Moehrle, Public Health Director (retired)
Nez Perce County, Idaho

PARTNERSHIP SPOTLIGHT

NACo partnered with March of Dimes to integrate data on [Maternity Care Access](#) (updated as of July 2023) in NACo's County Explorer tool.

2023 MATERNITY CARE ACCESS



Many county maternal health programs are looking at doula care as one of many strategies to alleviate adverse maternal health outcomes and inequities. Doulas specifically help address access to and initiation of services, creating nurturing and responsive child-parent relationships and improving birth outcomes and child development.²⁴ Doulas support the whole family with culturally-relevant knowledge and care, as well as empower birthing people, and especially birthing people of color.²⁵

With Medicaid covering 40 percent of all births across the U.S. and 60 percent of births among Black and American Indian/Alaskan Native birthing people, expansion to cover doula care is a crucial lever to

improve access and outcomes. Several states have expanded Medicaid to cover doula care as of October 2022, with others in process of implementing this expansion.²⁶

However, in some doula care-expansion states, counties still experience challenges to building doula care infrastructure. Participants from **Hennepin County** and **Jackson County** reported persistent billing barriers for doula services, which limits the number of doulas willing to provide Medicaid-funded services. In non-doula expansion states, county maternal health providers like **Pierce County** try to work with community partners who can sometimes fund doula services for low-income residents.

Accessing Culturally-competent Care

Culturally appropriate care is integral to a maternal health care infrastructure that serves all families. Shortages of culturally-appropriate providers challenge the expansion of equitable maternal health infrastructure. Participants from **Pierce County** and **Franklin County** reported shortages of race- and linguistically-aligned providers in their areas. In **Franklin County**, local Black doctors have wait lists for new clients because there are so few in the area. Both counties are home to significant immigrant populations with varying English ability, and providers that speak languages of these populations are in short supply.

With birthing people of color at higher risk of adverse maternal health outcomes, access to fully competent

care is a crucial resource. Across focus groups and interviews, two major themes that arose as barriers to culturally competent care were the **lack of accountability in health care and shortages in workforce diversity**.

Birthing people of color are more likely to face interpersonal racism from their providers, a trend leading to disparate outcomes.²⁷ Several participants highlighted the glaring need for accountability for racism by providers, citing a lack of a truly effective system. Notably, participants conveyed frustration over lack of recourse – it is unclear to whom providers are answerable.

“We see a lot of effects in the county from redlining, less access to resources in traditionally Black communities, grocery stores that are 10 percent higher cost and nowhere you can walk to get food, no affordable housing.”

— Emily Chandler, Black Infant Health Supervisor, Pierce County, Wash.



KEY DISCUSSION

<p>Insufficient anti-racism and inequity training</p>	<p>“There needs to be some accountability, so there has to be mandated racial equity training; all the things that people need in the health care system so that women are healthy pre- and post-[partum].”</p> <p>— Joy Bivens, Deputy County Administrator Franklin County, Ohio</p> <p>“Training and education are important because not everybody has the same level of understanding and knowledge, but training is pointless if there’s no accountability for the changes we’re expecting to see.”</p> <p>— Emily Chandler, Black Infant Health Supervisor, Pierce County, Wash.</p>
<p>Insufficient reporting systems</p>	<p>“We’ve had situations where it’s very clear that our clients are being mistreated due to the color of their skin, but when it comes to an investigation of the situation, there’s not a lot of proof that it is racially motivated, and the grievances just fall off and nothing really comes of it.”</p> <p>- Emily Chandler, Black Infant Health Supervisor Pierce County, Wash.</p>
<p>Lack of accountability data and “report cards”</p>	<p>“That’s why I liked the stronger language this [community] group had around some accountability and a report card. But that’s a challenge, and I don’t know who enforces that.”</p> <p>— Meredith O’Brien, Family Health Area Manager Hennepin County, Minn.</p>
<p>Lack of mechanisms of enforcement</p>	<p>“...Our insurance carriers in our state have said the only way to get to some of these physicians to change their behavior is to lower their payment.”</p> <p>— Survey respondent</p>

Building trust is crucial to delivering maternal care. Participants discussed how a shortage of diverse providers hamper full engagement in services for mothers from historically disadvantaged communities. In **Del Norte County** the relationship between providers and patients from Tribal communities is impacted by the historic and generational trauma inflicted upon Indigenous communities. Patients from Tribal communities generally do not have access to providers that share and reflect their identity and experiences.

Respondents from **Waukesha County, Wis.** reported a similar trend when working with undocumented

residents with lower English proficiency who often live in multigenerational homes. County providers often encounter perceptions among undocumented residents that government programs will separate their families. Culturally-appropriate care for these families includes interpreters or linguistically-aligned providers who are prepared to offer care to other family members during maternal health home visits. Respondents from **Pierce County** discussed how linguistically-aligned providers can be in short supply, making it harder to meet the cultural needs of populations with lower English proficiency.

“Something has to change, and it can’t just be training. You can’t just say ‘Oh we’re just going to have a provider go through training’ and it’s fine after that.....But until some real changes happen there, we’re going to struggle with poor birthing outcomes.”

— Meredith O’Brien, Family Health Area Manager, Hennepin County, Minn.





Funding Maternal Health Services

During the interviews and focus groups, participants alluded to **funding longevity, flexibility and specific programmatic guidelines** as primary contributors to the lack of adequate maternal health services.

For example, focus group participants from **Waukesha County** noted that when funding is short-lived, it can be difficult to attract talented individuals and retain them in the community. As such, they found long-term funding to be more conducive to sustaining providers in the community.

Del Norte County and **Waukesha County** shared that state funding is not always as flexible as needed,

particularly when modeled after a particular size of community. Specifically, when programs are modeled after denser, more resourced counties, those models can fall short in geographically larger counties with low-population density and fewer resources.

Similarly, respondents shared that overly specific programmatic guidelines can prove restrictive. For example, **Del Norte County** receives funds to provide some services that can only be offered on site, creating a barrier for those without access to reliable transportation.

“Sometimes funding will get pushed out and there will be really great criteria, but to expect the same thing from a health department with 20 people on staff as opposed to a health department that has over 200 people.... I think that has historically just been something that’s not done.”

— Shelby Bodenstab, Director of Nursing, Del Norte County, Calif.



Gaps in Maternal Health Information and Data

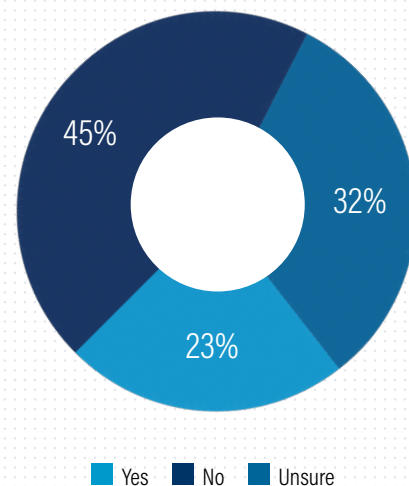
Pervasive gaps in maternal health data are a substantial barrier for counties. This includes **lack of county agency in data collection** and **specificity of data** needed to focus maternal health efforts.

Counties are often reliant on state and federal level entities for their maternal health data, meaning they often receive regional or broad datasets, rather than information specific to their county. Further, as a representative from **Del Norte County** noted, when receiving data from the state, smaller, more rural counties are often grouped with other counties into a region, making the data they receive less reliable and unrepresentative of their unique contexts. **Nez Perce County** has had similar experiences with unrepresentative state data and often relies on county-level data instead. These sentiments were reflected across respondents who noted a majority of their data come from state-level sources.

The avenues for maternal mortality data review are often housed at the state-level with varied county involvement. A major method for data analysis is through maternal mortality review committees (MMRCs). These committees are composed of health professionals and stakeholders charged with investigating and reviewing pregnancy-associated deaths.²⁸ MMRCs are also responsible for evaluating maternal health data and producing data-informed recommendations for interventions and policy change. Not all states have an MMRC, and participation in the MMRC varies by state. Less than a quarter of survey respondents indicated that they were part of the MMRC. Further, although MMRCs could serve as an opportunity for inclusion of historically underrepresented voices, many lack diverse representation those most affected, such as people of color and residents of rural counties.²⁹

Data collection at the local level can be a particularly huge lift for smaller communities and rural counties, as large-scale collection efforts can be costly and resource intensive. Some smaller counties with dispersed populations may not be able to gather large enough samples and must double-sample, further increasing cost. This in turn can impact the ability of counties to apply for grant opportunities and other programs, as they may not have the exact data to justify their application. Many counties, like **Waukesha County** noted infrastructure shortages of epidemiologists and other staff critical for local large-scale data collection. Further, more granular data can be difficult to acquire. Counties noted provider accountability and maternal mental health as areas with significant gaps in data specifically.

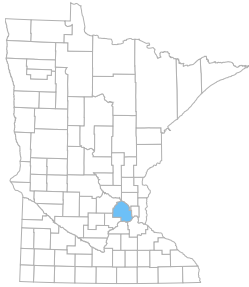
When asked if their county works with their state maternal mortality review committee, respondents replied:



Best Practice Approaches for Counties

Counties all across the country are actively innovating to reduce barriers to services for birthing people, improve access to equitable and culturally competent care and build out pipelines and plans to recruit and retain a diverse maternal care workforce. This section showcases examples of counties using their resources to improve the health and wellbeing of birthing people and their families.

Community Mapping and Creation of Strategic Plans



HENNEPIN COUNTY, MINN.

In 2022, Hennepin County partnered with four African American and American Indian led organizations to begin the community-led [Birth Justice Collaborative](#) to strategize maternal health solutions affecting birthing people in these populations. The effort revolves around community involvement and representation and is moving forward with five key strategies:

- Acknowledge and address impacts of racism
- Expand culturally-meaningful workforce pathways
- Advance and expand anti-bias accountability programs
- Invest in a network of trusted cultural providers and resources, and
- Advocate for and radically reform policy and payment.

These strategies directly address several barriers identified in this report, notably access to culturally appropriate care and workforce shortages of culturally appropriate providers. The Collaborative identified first-priority implementation initiatives including:

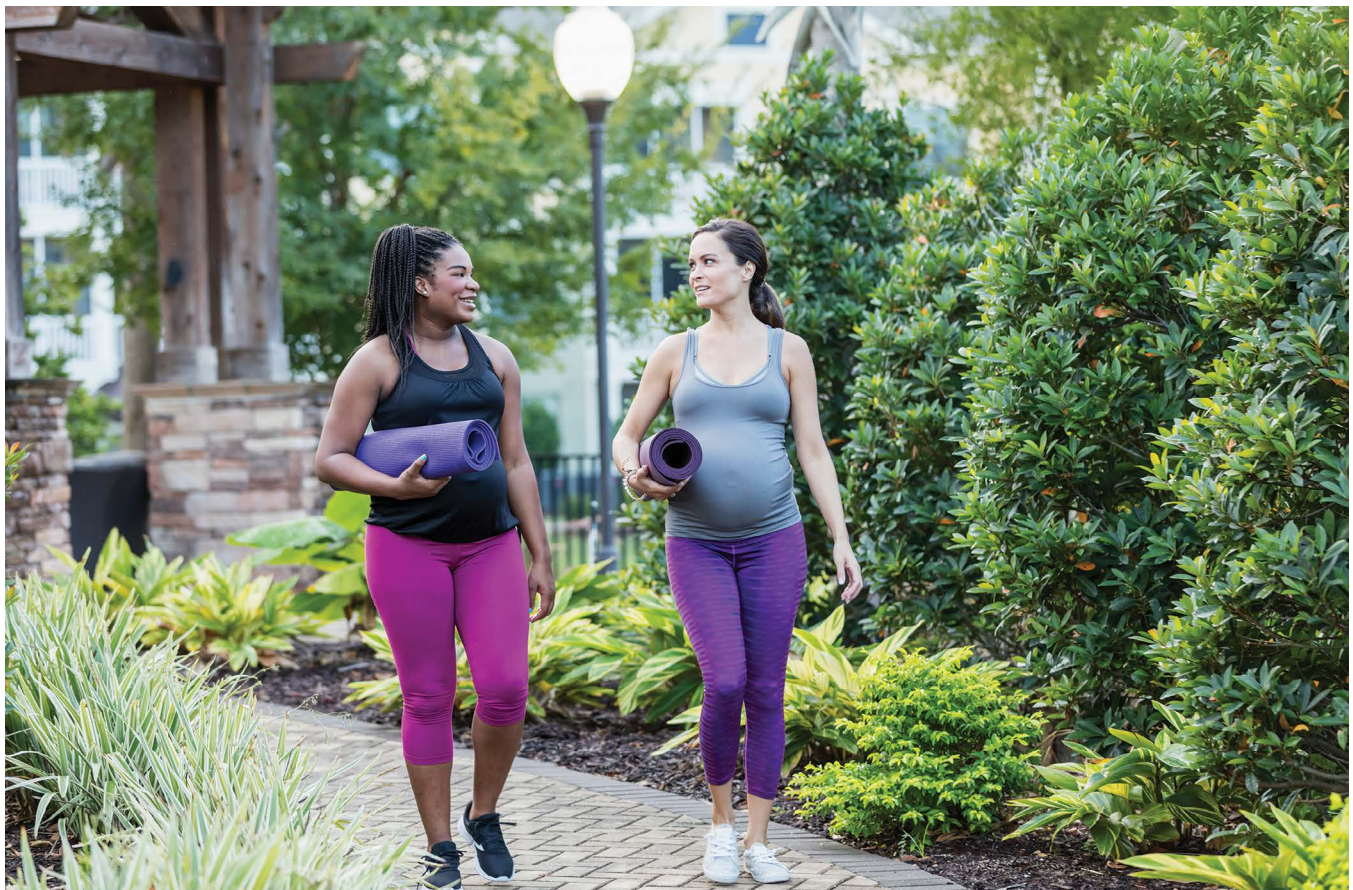
- Creating a year-one (of a child's life) support and cultural parenting pilot program
- Creating a cultural advocate and navigator pathway
- Establishing a community-credentialed provider network
- Creating culturally-responsive parenting resources to be community-based and embedded in health systems and clinics
- Designing and implementing an anti-bias report card program, and
- Collectively advocating for policy that advances all strategies.



FRANKLIN COUNTY, OHIO

In 2018, Franklin County leaders convened stakeholders to identify and support pathways to prosperity and address poverty in the county. The effort resulted in the [Blueprint for Reducing Poverty in Franklin County](#) report, which outlines trends in poverty across the county and serves as a long-term roadmap for interventions. The blueprint shows that areas with higher infant mortality are the same areas with higher poverty, a trend consistent with nationwide maternal health inequities.

Franklin County Board of Commissioners in partnership with Franklin County Public Health have created [Health Works Franklin County](#), as a “health in all policies” initiative. The partnership centers on the connections between social and economic drivers that impact health. The effort aims to support and advance the priorities of various community-based clinical and health initiatives by working in collaboration. In 2022, the partnership produced the 2023-2026 Community Health Improvement Plan, which included maternal and infant health and racial equity among its priorities, along with measurable indicators and strategies to improve related outcomes. Metrics are tracked on the [Franklin County Public Health Data Hub](#).



Uplifting Local Community Health Workers and the Trusted Advisor Model



JACKSON COUNTY, MICH.

Jackson County's Great Start Collaborative uses a [trusted advisor model](#) to connect harder-to-reach residents to services. Trusted advisors are known members from the community who perform field recruitment work and are commonly stationed at food banks, shelters and community events. They use portable devices to help service recipients through digital application processes in real time. Focus group participants shared that these trusted advisors have been a driving force in getting high-risk populations connected to services, particularly as it relates to maternal health services, and the local health department knows them as a resource for residents they serve.



PIERCE COUNTY, WASH.

The Tacoma-Pierce County Health Department relies on several innovative Nurse and Community Health Worker-based models to deliver maternal and child health care services. The [Nurse-Family Partnership](#) matches new mothers with personal nurses to help guide them through pregnancy. Black Infant Health provides Black parents with personalized pregnancy and parenting support from people who look like them. Black nurses and community health workers provide ongoing support such as health education, mentorship, emotional support, advocacy and linkages to maternal and child health care. Recently, the program received enough funding to shift some roles from volunteer to paid and increase client capacity by about 50 percent.



Workforce Solutions: Eliminating Barriers and Creating Pipelines



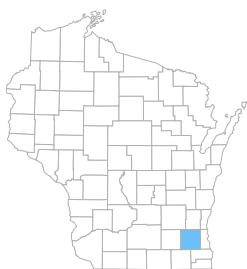
FRANKLIN COUNTY, OHIO

The Franklin County Department of Jobs and Family Services funds the [Community Health Worker Training Program](#), a partnership with the Ohio State University College of Nursing. The program places Community Health Workers on the front line to directly address health conditions, navigate health systems and reduce health disparities. The program is also looking to expand into a pathway that prepares women for nursing roles in Franklin County, emphasizing education access without debt, and addresses the county's barriers to accessible care and shortage of culturally appropriate providers.



DEL NORTE COUNTY, CALIF.

Using a state health equity grant, Del Norte County is looking into shifting from traditional education and professional experience requirements in their job descriptions to considering relevant lived experience for roles in maternal health. This strategy both expands the pool of potential applicants and helps diversify the county's maternal health workforce, providing multiple ways for applicants to qualify for positions, thereby expanding equitable care options for birthing people of color. Additionally, Del Norte County is working to create a pathway from the high school to the local community college to ensure those students can enter the workforce and work in their community, as well as think about how to increase Indigenous representation on staff, as the county is bracketed by multiple Tribal reservations.



WAUKESHA COUNTY, WIS.

Within the Waukesha County Health and Human Services Department, workgroups are tasked with looking at the different aspects of recruiting new staff, specifically at how to do so with an equity lens. These working groups discuss how to work with schools to get high schoolers exposed to job opportunities early, as well as ways to be flexible with benefits and consider how different cultures will value benefits.

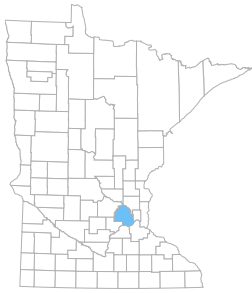
Strategic Investments and Partnerships



FRANKLIN COUNTY, OHIO

The Franklin County Board of Commissioners is funding more small community-based organizations and organizations led by people of color, responding to community calls for more involvement of organizations and partners that reflect their lived experiences. The Board of Commissioners has:

- Noted decreasing infant mortality among their maternal health priorities in the 2023-2026 Community Health Improvement Plan. One strategy focuses on collaboration between existing programs, agencies and initiatives serving birthing people in the county. Franklin County partners with Smart Columbus, a regional collaborative innovation lab focused on building sustainability, equity and economic prosperity, to complete this objective. Smart Columbus developed [CIE Columbus](#), a Community Information Exchange that uses a shared language, a resource database and integrated technologies to enable community partners to interact seamlessly, effectively a universal social services application.
- Invested \$15 million dollars in [Healthy Homes](#), a housing initiative led by Nationwide Children’s Hospital to build, rent and repair homes in two neighborhoods in the county with higher concentrations of blighted homes. This program focuses on housing as a determinant of health by offering services to residents living at or below 80 percent of area median income.
- Partnered with Franklin County Public Health, which entered an agreement with [Restoring Our Own Through Transformation \(ROOTT\)](#) to provide doula services to 50 birthing people. The department renewed the agreement for \$450,000 to provide birthing service to more people and provide wraparound services for birthing people and infants.
- Provided a grant to the African American Male Wellness Agency to train individuals who would like to become doulas and funds 12 community health worker positions with Franklin County Public Health.



HENNEPIN COUNTY, MINN.

The Hennepin County board of commissioners allocated \$10 million of ARPA funding to improve outcomes for Black and Indigenous birthing people, primarily focusing on expanding access to services and funding birthing centers and a FQHC's wraparound services and prenatal care.



Targeted Interventions for Underserved Communities and Culturally Relevant Care



SOLANO COUNTY, CALIF.

Solano County has engaged in a variety of efforts to expand culturally-relevant care and direct interventions towards communities most affected by historic inequities. They established [Solano HEALS](#), or Health Equity for All Lives in Solano, a community collaborative working to “promote health equity in births for Black babies and their families in Solano County.”³⁰ Further, Solano County has expanded its [Black Infant Health](#) program with home visiting, a Black Infant Health Community Advisory Board and included cultural humility and equity courses in their staff training.



PIERCE COUNTY, WASH.

Pierce County's [Black Infant Health \(BIH\)](#) program is a critical direct service and nurse-led community health worker model that provides services to families in the community. The program is intentionally community-driven and led by the people they serve. BIH focuses on community engagement, policy and advocacy in its work. Community health workers provide advocacy support, health education and promotion, postpartum visits and more to families. Community health workers follow the families through one year postpartum, ensuring access to maternal health services throughout the perinatal period. A [community advisory board](#) oversees the program work and helps to identify policy and system change initiatives that support Black familial health. Moving forward, BIH is working on developing an action collaborative network that will lead these identified policy changes in the county and develop new, innovative initiatives for Black maternal health.

Key Recommendations from County Leaders

Expand systems of maternal health accountability:

Anti-bias training can help reduce interpersonal racism and discrimination. County governments can incorporate competencies across certifying or employing entities (e.g., county agencies, hospitals, clinics, etc.) and require anti-racism or anti-bias training as part of medical professionals' Continuing Medical Education or other job requirements.

Improve county-representative maternal data:

Counties may advocate through local representatives or their state association of counties for more investment and capacity-building for local data collection that informs program and funding model design. Counties can also increase their presence in decision-making arenas, like state-level maternal mortality review committees, which can improve the representation, collaboration and utility of data reviews and recommendations.

Invest in partnerships and actions targeting social determinants of health:

County governments can invest in external organizations that provide services related to housing, food access, child care, maternal mental health and more. County leaders may work with their partners at the state level to improve systems affecting SDOH like paid family leave and postpartum Medicaid coverage expansion.

Develop mechanisms of common guidance: Counties can develop new or utilize existing blueprints, policy guides and best practice manuals – such as [Patient Safety Bundles](#) – to promote cross-sector alignment on local maternal health policy and intervention planning. Standard guidance documents for maternal health service navigation and data system connection will create more coordinated systems of intake and referral across agencies and departments.

Collaborate across county and maternal health field lines:

Cross-systems collaboration is an effective method to combat siloes across jurisdictions and expertise. As conveners, counties can prioritize a whole ecosystem approach that recognizes the maternal health system is one of many systems parents and families are interacting with in the first year of their child's life.

Create or strengthen partnerships with workforce development providers:

Counties can engage in cross-systems collaboration with local higher education, apprenticeship programs and Workforce Innovation and Opportunity Act-funded workforce development programs to fill critical gaps in the maternal health workforce. Partnerships can focus on programs that include professional upscaling for participants, improving workforce diversity and technology in maternal health.

Develop more equitable and representative program design and funding:

Counties can develop more inclusive programs and funding decision-making processes at the local level and work alongside state and federal funders to modify requirements to allow for more flexibility with unique county needs.

Foster an environment of greater intergovernmental coordination:

Counties can actively engage their state and federal partners regarding various pain points identified in the maternal health ecosystem to facilitate intentional initiatives responsive to unique county needs. Counties are important partners for state and federal governments in addressing the many systems influencing maternal health and trusted facilitators for program implementation in community.





County leaders across the country are prioritizing infants, toddlers and their families by investing in programs and changing policies to better meet the needs of families and communities. County leaders have a role to play in championing access to not only maternal and child health services, but also high-quality child care and economic supports that allow families to thrive. Learn more at www.countiesforkids.org.

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