



Seeing Through Barriers to Rural Maternity Care

Remote teleultrasound enables hospitals and health systems to expand access to high-quality prenatal and obstetrical care in underserved areas.

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Introduction

American medicine has never been better at seeing trouble in a pregnancy before it arrives. A fetal echocardiogram at 20 weeks can identify a heart defect that will need surgical intervention on the first day of life — giving a care team four months to prepare for it.

It has also gotten more challenging for a large share of American women to receive a scan like this. A third of U.S. counties have no birthing facility and no obstetric clinician. First-time mothers are older than they have been in modern record-keeping. High-risk pregnancies are climbing. And maternal mortality concentrates precisely where care is thinnest: in rural counties, where the pregnancy-related death rate runs roughly 50% above the national average.

The gap is not a gap in medical knowledge. It is a gap in geography. Hospitals and health systems are increasingly closing this gap with remote teleultrasound — sonographers scanning patients at rural sites while specialists read the images, guide the exam and counsel families from hundreds of miles away. Studies published in the past two years find real-time teleultrasound comparable to in-person ultrasound on image quality and diagnostic consistency.

This AHA Market Scan Trailblazers report examines the trends driving the service gap, the evidence behind teleultrasound and one health system putting it to work. ●



“We know that the later you start prenatal care or if no prenatal care is provided,, the chances of a negative outcome increase. If a patient only has to drive five miles versus 25 miles for an ultrasound, you have a better chance that your patients will show up for an appointment and consistently get the care they need.”

— KATHLEEN ELLIOTT —
 Marketing Director, GE HealthCare



Extending the reach of safe and effective prenatal care

The first use of ultrasound in obstetrics and gynecology dates back to 1958. The modern internet came along in 1983. The World Wide Web went public in 1991. Smartphones and tablets followed in 2007 and 2010, respectively. At the time, few could have predicted these technologies would one day converge to help address a pressing healthcare need: access to maternity and prenatal care in underserved and primarily rural areas of the country.

Those technologies have combined to support remote teleultrasound (TUS). Hospitals, health systems and medical practices use TUS to perform ultrasounds on pregnant women in remote care settings and transmit those images to off-site clinicians in real time to monitor the health status of moms-to-be and their fetuses.

That remote clinical capability has become critically more important from a maternal health, infant health and population health perspective because of four trends, most of which are driven by factors external to hospitals, health systems and medical practices.

I TREND 1 | MATERNAL AGE IS INCREASING.

The average age of first-time mothers is increasing, according to the National Center for Health Statistics (NCHS), which is part of the Centers for Disease Control and Prevention (CDC). Between 2016 and 2023, the average age of a first-time mother climbed from 26.6 years to 27.5 years.

In terms of location, it increased in large metropolitan areas from 27.6 years to 28.5 years. It also rose in noncore, rural areas, from 24.1 years to 24.8 years.

In addition, during the past few decades, women age 30 or older have accounted for a growing proportion of total births per year in the U.S. Between 1990 and 2023, the percentage of births in

which the mother was 30 or older increased from 30.2% to 51.4%, according to CDC figures. During the same period, the percentage of births to women ages 35 to 39 climbed from 7.6% to 16.8%. Advanced maternal age (35 and older) is associated with a higher risk of complications and certain health conditions, such as high blood pressure, pre-eclampsia and gestational diabetes, according to the Cleveland Clinic. Consequently, pregnant patients older than 35 may require more frequent prenatal visits and treatment by maternal-fetal medicine (MFM) specialists.

I TREND 2 | HIGH-RISK PREGNANCIES ARE INCREASING.

Maternal age and other factors, such as pre-existing health conditions, can contribute to high-risk pregnancies. A new study in The Lancet linked pregnant women with multiple long-term physical or mental health conditions with complications like hyperemesis, vomiting, miscarriage, gestational diabetes, gestational hypertension, obstetric cholestasis, pre-eclampsia, placental abruption, venous thromboembolism, antenatal anxiety and depression.

A 2024 report from the Cleveland Clinic estimates that 6% to 8% of all pregnancies in the U.S. each year are high-risk. A separate study published the same year in the open access journal Cureus suggests that the percentage could be many times higher.

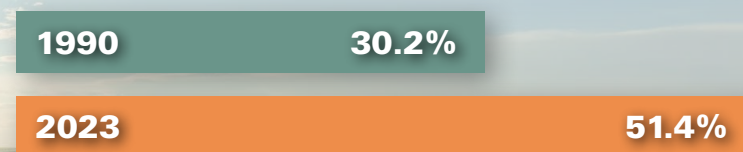
Regardless of the exact number, medical research indicates that the number of high-risk pregnancies is rising. The NCHS released a report this year that said cases of gestational hypertension rose 60% from 235,693 in 2016 to 377,267 in 2024. That is an average annual increase of 6% over that time period. The rate of gestational hypertension also jumped from 6%, or six cases per 100 live births, to 10.4%, or 10.4 cases per 100 live births. The highest rate was for mothers age 40 or older at 12.2%, or 12.2 cases per 100 live births, in 2024.

DATA POINTS

60%
Increase in cases of
gestational hypertension
between 2016 and 2024.

Source: "Trends and Characteristics in Gestational Hypertension: United States, 2016–2024." National Vital Statistics Reports, National Center for Health Statistics, U.S. Centers for Disease Control and Prevention, July 2026.

The increase in the percentage of births in which the **mother was 30 or older** between 1990 and 2023.



Source: Effects of Age-specific Fertility Trends on Overall Fertility Trends: United States, 1990–2023. Centers for Disease Control and Prevention. March 2025

| TREND 3 | MORTALITY RISK IS CONCENTRATED BY AGE.

Age and its associated risks also play a key role in maternal mortality rates. In 2024, 649 women died from maternal causes, according to a report released earlier this year by the NCHS. That is a maternal mortality rate of 17.9 deaths per 100,000 live births. But the rate was highest for women age 40 or older at 62.3 deaths per 100,000 live births in 2024.

| TREND 4 | LOCATION MATTERS.

Access to high-quality prenatal and obstetrical care around the country is vital for all pregnant patients to ensure the best possible outcomes. However, many women in large swaths of the U.S. lack or have limited access to those services.

In August, the patient advocacy group March of Dimes released its latest biennial "Nowhere to Go: Maternity Care Deserts Across the U.S." report. The 2026 report states that 34.6% of all counties in the U.S. are "maternity care deserts," meaning there is no birthing facility or obstetrical clinician there. Pregnant women in maternity deserts must drive an average of 42 minutes to get to a birthing hospital. That is three times the average for pregnant women in counties with full access to birthing hospitals.

A January 2025 commentary published in the Journal of the American Board of Family Medicine called maternity care deserts a key driver of the national maternal health crisis in the U.S.

The limited or lack of access to high-quality prenatal and obstetrical care is not lost on consumers. The patient advocacy group Healthy Moms, Healthy Babies America this year released the results of a poll of 1,001 registered U.S. voters on their awareness of maternal health challenges in the country. Some 60% said they were con-

cerned about the ability to access prenatal care during a pregnancy, and 58% said they were concerned about the ability to visit a healthcare provider after childbirth.

As a result of those maternity care deserts, where pregnant women live is highly correlated to maternal mortality. The CDC operates a Pregnancy Mortality Surveillance System that defines a pregnancy-related death as a death during or within one year of the end of pregnancy from any cause related to or aggravated by the pregnancy.

Overall, the pregnancy-related mortality rate was 18.4 per 100,000 live births in 2024 in the U.S. But the two highest rates that year occurred in "noncore" and "micropolitan" areas of the country, areas the CDC defines as rural. Pregnancy-related mortality rate was 28.0 per 100,000 live births in noncore markets and 23.3 in micropolitan markets.

Extending the reach of obstetrical care

The four trends converge to form one conclusion: Pregnant women and their unborn children need greater access to safe and effective obstetrical and prenatal care. However, a number of physical barriers inhibit access.

One way to address these barriers is through the use of TUS. The primary reason behind the adoption of this technology is expanding access to maternity care in areas with geographical limitations and where MFM specialists are concentrated in a specific location. While it is helpful for diagnostic purposes for patients experiencing high-risk pregnancies, it can also prove useful for routine scans and lower-risk cases. Trained sonographers at remote patient care sites perform ultrasounds on pregnant women under the in-person or virtual supervision of an MFM specialist and transmit those im-



DATA POINT

34.6%

Percentage of U.S. counties **without a birthing facility or obstetrics clinician** in 2026.

"Every effort should be made to advance telehealth maternal health services and perinatal regionalization." —"Maternity Care Deserts: Key Drivers of the National Maternal Health Crisis." Journal of the American Board of Family Medicine. January 2025.

ages to the offsite MFM or other obstetrical clinician to view in real time or assess after the images are transmitted.

Providers can perform the virtual diagnostic tests in different ways:

- **OPTION 1:** An onsite sonographer performs the ultrasound guided by an offsite MFM or obstetrical clinician who watches the procedure, views and interprets the images and consults with the sonographer and patient and/or family via a mobile device like an iPad.
- **OPTION 2:** An onsite sonographer performs the ultrasound guided by an offsite MFM or obstetrical clinician who watches the procedure and consults with the sonographer and patient and/or family via a mobile device but simultaneously views and interprets the images offsite on their own system as the ultrasound technology transmits the images to the offsite system.
- **OPTION 3:** An onsite sonographer performs the ultrasound guided by an offsite MFM or obstetrical clinician who watches the procedure and consults with the sonographer and patient and/or family via a mobile device but views and interprets the images offsite after the test and then communicates with the patient and/or family during a separate virtual visit.

In the January 2025 commentary for the Journal of the American Board of Family Medicine, three health services researchers affiliated with Brown University said TUS is one way to address maternity care deserts.

Is real-time TUS as effective as in-person ultrasound? The answer is yes, according to a study published last year in the Canadian Journal of Health Technologies.

“Real-time TUS was comparable to conventional in-person ultrasound for exam image quality and diagnostic consistency,” the researchers said.

A study published this year in PLOS Medicine supported that conclusion, especially for TUS in obstetrics.

“Image transfer was feasible for both synchronous and asynchronous teleultrasound transmission in a wide range of settings,” the researchers said, specifically citing the technology’s ability to improve access to care in rural areas.

The researchers said TUS worked best in obstetrics when the technology infrastructure was adequate. Adequacy included appropriate bandwidth and frame rate requirements, which the researchers said were “vital factors for sufficient image quality and minimizing transmission delays.”

In other words, users on both ends must have strong Wi-Fi and high-quality equipment.

Culture of care

A strong Wi-Fi signal and advanced, reliable technology are important. But they are not as important as culture when it comes to expanding access to safe and effective maternal care. In a recent interview with the McKinsey Institute for Economic Mobility, Joy Rhoden, the AHA’s senior vice president of Health Outcomes and Care Transformation, identified three critical success factors:

- **LEADERSHIP:** “There is a strong leadership commitment from both the clinical and administrative sides. When leaders clearly articulate that maternal health is a quality and safety priority — not a side initiative — it sets the tone from the very top.”
- **DATA:** “They demonstrate a willingness to look beyond national statistics and understand their own performance. Leading organizations should know their own story. What is the experience of moms coming into their hospitals? Then they can use those internal insights to design targeted interventions.”
- **HUMILITY:** “They approach the work with humility and person-centeredness. They understand that there are people behind that data. They are willing to move outside institutional walls, partner with communities, and deliver culturally responsive care.” ●



“Successful hospitals and health systems “are willing to move outside institutional walls, partner with communities, and deliver culturally responsive care.”

— JOY RHODEN —

American Hospital Association,
Senior Vice President, Health Outcomes and Care Transformation.

Benefits to patients, communities and providers

The powerful union of technology and culture to expand access to maternal care services through TUS generates a variety of administrative, clinical, financial and operational benefits for all of the parties connected by this virtual care, according to the literature reviewed and subject matter experts interviewed for this AHA Trailblazers report.

Topping the list are the clinical benefits to mothers and babies-to-be. Easy access to regular or as-needed ultrasounds ensures that the scans are done and reviewed promptly by MFMs or other obstetrical clinicians. Regular or as-needed monitoring gives MFMs and other obstetrical clinicians the opportunity to identify any medical issues and intervene early to achieve the best possible clinical outcome for both mom and baby.

The operational benefit for mothers and babies-to-be is access. TUS expands access to prenatal imaging by bringing ultrasound services closer to patients, reducing the transportation, scheduling, and geographic barriers that can delay or prevent care.

The administrative, clinical and operational benefits for hospitals, health systems and medical practices are early diagnoses and treatment, no gaps in care delivery and care coordination across the maternal care continuum. TUS eliminates the physical barrier that prevents providers from obtaining all three benefits. As for financial benefits, early diagnoses and treatment, seamless care delivery and care coordination across the maternal care continuum produce better outcomes for moms and babies. Better outcomes from prenatal care reduce the need for the utilization of high-intensity, specialty post-partum care. Better outcomes and preventing the need for high-intensity specialty care have substantial financial benefits for healthcare providers. ●

“There has to be a clinical champion. It’s typically a physician or department head who sees the big picture benefits of teleultrasound. Someone who believes in the power of teleultrasound. Those are the organizations that we’ve seen have the most success in the maternal care services space.”

— KATHLEEN ELLIOTT —
Marketing Director, GE HealthCareE

AHA INITIATIVE

AHA Better Health for Mothers and Babies Initiative

In 2019, the American Hospital Association launched its Better Health for Mothers and Babies Initiative to help hospitals and health systems address many of the trends and challenges identified in this report. The initiative offers users tools and resources in eight areas:

- 1 Improving quality outcomes
- 2 Maternal mental health
- 3 Person-centered care
- 4 Social drivers that influence pregnancy
- 5 Digital strategies
- 6 Interdisciplinary workforce
- 7 Rural maternity care
- 8 Infant health

Among the resources relevant to the topic of this report are a podcast on how Sanford Health Bemidji (Minnesota) uses telehealth to expand access to maternal care and a podcast on how San Luis Valley Hospital in Alamosa, Colorado, cross trains clinicians to maintain obstetrical care in rural areas. ●



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CASE STUDY Children's Hospital Colorado



Getting to the heart of the matter

Children's Hospital Colorado is a 632-bed children's hospital headquartered in Aurora, Colorado. All 17 of its locations — four inpatient campuses and 13 outpatient facilities — are physically located in Colorado. But its service area extends to six other states: Kansas, Montana, New Mexico, North Dakota, South Dakota and Wyoming. The majority of the hospital's unique patients — more than 300,000 in 2025 — come from Colorado, Montana, New Mexico and Wyoming.

Emily Bucholz, M.D., joined the staff of Children's in 2022 and is co-director of the fetal cardiology program in the hospital's Colorado Fetal Care Center. The center specializes in high-risk pregnancies with about 300 births per year. The center's ability to care for those high-risk moms and babies relies heavily on its maternal fetal telemedicine program.

The fetal cardiology team performs about 1,700 ultrasound diagnostic tests, on about 1,100 to 1,200 unique patients each year, specifically looking at images of a fetus's heart. Most of the procedures are done on an outpatient basis, and most of those are done via teleultrasound (TUS).

"If congenital heart disease isn't diagnosed before birth, a baby may be delivered at a hospital that doesn't have the specialized cardiac team, surgery, or other lifesaving

therapies available right away," Dr. Bucholz says. "For babies with the most critical heart defects, those first hours can matter enormously. They can become very sick very quickly, so knowing the diagnosis before delivery allows us to make sure they are born in the right place with the right team ready to act."

Children's offers TUS to expectant mothers through the mothers' local physicians primarily at three offsite,

DATA POINT

1,700

Number of ultrasounds performed by Children's Hospital Colorado per year, most of which are done on an outpatient basis and from remote sites via telehealth

Source: Children's Hospital Colorado

CASE STUDY Children's Hospital Colorado

off-campus outpatient locations: Grand Junction, Colorado; Sterling, Colorado; and Laramie, Wyoming.

The TUS workflows vary slightly at each of the three locations.

At the Grand Junction location, all scheduled procedures take place weekly on Wednesdays. Everything happens in real time. The onsite sonographer performs the ultrasound and then connects with Bucholz or another fetal cardiology specialist in Aurora. The specialist joins the visit virtually on an iPad with the patient and family, reviews the images in real time with the patient present and provides counseling about the findings and next steps.

"As I'm reviewing the ultrasound, I can point things out directly on the images so families can see exactly what I'm seeing," Dr. Bucholz says. "It makes it much easier to explain what we've found and talk through what it means."

At the Sterling and Laramie locations, the only part of the visit that is live is the post-ultrasound virtual visit with the patient and/or family members to discuss what the exam found. Onsite sonographers perform the scans and then send the images to the offsite specialists through an electronic imaging system in Aurora. The specialists review and interpret the findings and then conduct a telemedicine visit with the patient and/or family through the patient's online portal.

"One limitation is that we can't point things out directly on the ultrasound images in real time," Bucholz says. "But we can still use diagrams and other visuals during the telemedicine visit to walk families through what we found and help them understand the anatomy."

Children's also offers a second-opinion TUS service to

patients and providers in other states. Essentially, an out-of-state provider sends images to the specialists at Children's, and the specialists view and interpret the images. They meet and discuss the findings virtually with the patient and/or family to determine the best course of action based on the image results, including where to deliver the baby — at Children's or safely at another site.

"Fetal cardiologists are used to looking for subtle findings that may be less familiar to clinicians who don't see congenital heart disease as often," Bucholz says. "That additional expertise can be especially helpful when something on the ultrasound is difficult to interpret."

Regardless of the site, workflow or reason, offering TUS to patients in rural areas gives those patients access to high-risk fetal care. Access comes from flexible scheduling that meets their professional and personal needs and from short distances to care that do not require long car rides, air travel or overnight stays.

Access means better care as TUS eliminates delays in diagnoses and treatment, both of which can have a negative effect on clinical outcomes. Most fetal cardiology diagnoses occur between 20 and 24 weeks of gestation. That gives the care team 16 to 20 weeks to prepare for a high-risk delivery and life-saving newborn interventions.

"What we're doing remotely through teleultrasound is helping determine the safest plan for delivery and what level of care a baby may need immediately after birth," Bucholz says.

If other hospitals, health systems and medical practices want to follow Children's lead, Bucholz has three pieces of advice:



"What we're doing remotely through teleultrasound is triaging care for the delivery. Knowing the diagnosis before delivery allows us to make sure they are born in the right place with the right team ready to act."

— EMILY BUCHOLZ, M.D. —

Co-Director, Fetal Cardiology Program,
Colorado Fetal Care Center, Children's Hospital Colorado

CASE STUDY Children's Hospital Colorado

- **Invest in the people doing the scanning.** Hire local sonographers who have a passion to learn. Continuously train and educate them because they are responsible for performing the tests in remote settings. The quality of the program depends on their ability to consistently capture the images needed for an accurate diagnosis.
- **Build strong local partnerships.** Work closely with local obstetricians, MFMs, and other clinicians caring for pregnant patients in the community. Those relationships are what make it possible to identify patients who may benefit from fetal cardiac evaluation and connect them with specialty care, regardless of institutional affiliation.
- **Invest in the virtual interfaces between the offsite sonographers and the onsite specialists.** That means the best available technology, the best possible Internet connections and the best possible integrations. Combined, these efforts capture the best possible images and facilitate the best possible clinical workflows.

"The success of a telemedicine program ultimately depends on the quality of the images," Bucholz says. "If you can't trust what you're seeing, you can't make confident clinical decisions from it."

In the past two years (from September 1, 2024, to August 31, 2026), Children's has performed 359 telemedicine visits corresponding to 298 unique patients. Excluding genetic syndromes and twin pregnancies, there were 40 patients with significant fetal congenital heart disease, ranging from cardiac arrhythmias, coarctation of the aorta, pulmonary valve stenosis, atrioventricular canal defect, double outlet right ventricle, Ebstein's anomaly, cardiac mass, ventricular septal defects and tetralogy of Fallot. ●

INSIGHTS

Practical considerations

Hospitals, health systems and medical practices that hope to extend access to maternity care services in underserved areas via TUS will need to do much more than simply plugging in an ultrasound machine and turning on an iPad. There are a number of barriers other than physical ones they must address to execute a successful TUS program. Here is a brief checklist of practical considerations:

- **REIMBURSEMENT:** Who bills and who pays for the onsite procedures? Who bills and who pays for the offsite image reviews? Knowing these details ahead of time will eliminate implementation challenges.
- **MEDICAID TELEHEALTH POLICIES:** Each state sets its own rules for how telehealth is done, where telehealth is done, what services can be offered through telehealth and who can bill for telehealth. Providers who offer TUS in multiple states will need to comply with multiple policies.
- **STATE LICENSURE REQUIREMENTS:** Offsite MFM specialists and other obstetrical clinicians may need to be licensed not only in the states they practice in but also in the states where the onsite TUS procedures are performed.
- **BROADBAND:** Can the remote location support the capture and transmission of high-resolution ultrasound images to offsite MFMs and obstetrical clinicians hundreds of miles away? This capability is foundational.
- **SONOGRAPHER WORKFORCE:** TUS depends on the availability of qualified and properly trained sonographers at remote locations. Is there enough supply to meet the demand for these services at a remote location?
- **CAPITAL COSTS:** Setting up a TUS program to expand access to maternity care services in underserved areas will require a capital investment in equipment and an ongoing training and education budget to support local sonographers. ●

CONCLUSION

For hospitals, health systems and medical practices, expanding access to obstetrical and prenatal care via TUS appears to be a viable option for offering care in underserved areas. But even the best innovations require key performance indicators (KPIs) to track their impact.

Among the KPIs recommended by the literature reviewed and subject matter experts interviewed for this report are:

- **Number of remote sonographers trained to perform TUS.**
- **Time to competency for sonographers and radiology stenographers to perform TUS.**
- **Time to first prenatal visit pre- and post-TUS availability.**
- **Number and rate of missed prenatal visits.**
- **Ultrasound screening completion rates.**
- **Maternal and infant outcomes such as preterm birth, C-section rates, mortality and morbidity.**
- **Patient satisfaction scores.**
- **Provider net promoter scores.**

Hospitals, health systems and medical practices that adopt TUS to expand access to maternal care should see progress for all those KPIs and more. ●

The operational benefit for mothers and babies-to-be is access. TUS expands access to prenatal imaging by bringing ultrasound services closer to patients, reducing the transportation, scheduling, and geographic barriers that can delay or prevent care.

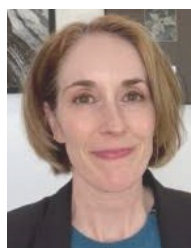


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Recommended reading list

The following source materials also provided insights for this Trailblazers report

- A Short History of Sonography in Obstetrics and Gynecology. Facts Views Vis Obgyn. 2013.
- Advanced Maternal Age. Cleveland Clinic. May 2025.
- Antenatal outcomes for women with multiple long-term conditions in pregnancy: a UK-wide retrospective cohort study. The Lancet. September 2026.
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