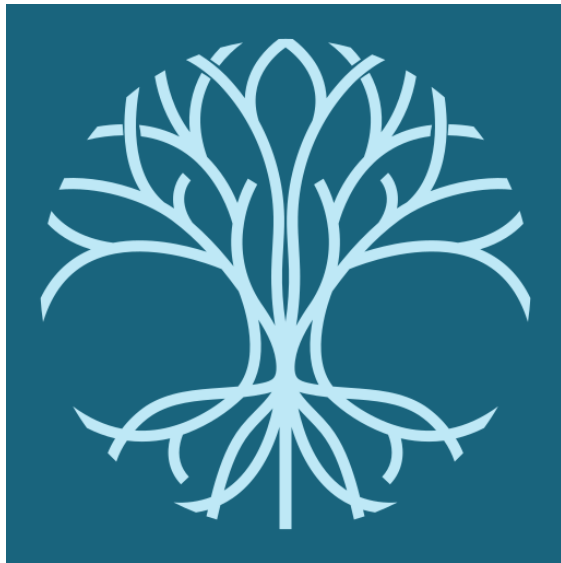


# Sustainable Rural Obstetrical Programs—Case studies of leadership, dedication and innovation



**In the United States, we have surpassed a critical threshold. Over half of our critical access hospitals no longer provide inpatient obstetrical services and 100 facilities have closed their inpatient obstetrical programs in the last 5 years.**

Workforce constraints, high fixed costs and low-volume lead many rural hospitals to examine their obstetrical services. They are asking whether these services are sustainable and safe. Over 130 hospitals reported that their obstetrical services lost money in 2024. Beyond the financial losses, the inability to safely staff in rural areas is a consistent theme. Many hospitals face the difficult decision of intermittently going on diversion due to staffing shortages against the

permanent closure of inpatient obstetrical services.

**Among these struggles, many have asked—where are the success stories? What does a sustainable rural obstetrical program look like?**

I had the unique opportunity to interview 7 amazing obstetrical leaders (nurses and physicians) across three rural hospitals in Minnesota, Vermont, and Maine. These multidisciplinary leadership teams are focused on their patients' needs, their communities and creating sustainable programs that will be their legacy for years to come. Their work prioritizes creating an obstetrical service that prioritizes clinical excellence for all patients, meeting patients needs, designing a place where people want to work, and long-term sustainable solutions.

## **Meeting patient's needs**

### **Providing great care**

Common themes were voiced on providing safe, consistent and patient-centered care. *“A nearby unit was intermittently closing due to significant staffing issues. This led to fragmented care with patients ending up unexpectedly in our obstetrical triage unit without records. Despite the difficulty in not having records, we focused on delivering great care...making sure they felt safe and taken care of. We are seeing a lot of late transfers to our hospital at the end of pregnancy from patients who realize that we*

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*are here, what we have to offer and that we will be here for them.”*

*“Fragmented and intermittent care is very difficult for patients. An obstetrical program close to us let patients know that they would have no access to epidural analgesia on nights or weekends. After that announcement, we noticed a big uptick in our volumes at our unit.”*

Prenatal care, postpartum and lactation support are close to home

To serve their communities, all units care for patients for their entire pregnancy, postpartum and breastfeeding journeys, even if they do not perform the deliveries. *“We take care of a high-risk patient population throughout their entire pregnancy and postpartum recovery. This often means that for delivery, pregnant patients will need to be transferred to a higher level of care for delivery. It certainly seems like we are seeing more obesity, more preeclampsia, and the problem list continues to grow. When mothers are transferred for delivery, we don’t get counted for the delivery volume, but we are here to support that mother and baby when they return to us, during the entire postpartum course, breastfeeding struggles. This effort goes*

**Simulation for High Acuity Low Occurrence Events (HALO events) such as neonatal resuscitations and postpartum hemorrhage at these three rural obstetrical facilities is not optional. It is a must.**

*uncounted, but is so important. Our program is here to support all the mothers in our community, not just the ones who deliver at our hospital.”*

Team care

A constant focus on being there for the other members of the team is a common thread. *“Our message is consistent. We are all in this together. We are all here to help. We care about you. This leads to the obstetrical teams being happy. This leads to being good place*

*to work. Patients feel this.*

*People feel this. It is important.”* One of the most important things that is done is modeling proactive communication across the whole healthcare team. This means constant contact *“with our anesthesia and pediatric colleagues about patient status and complexity, so*

*that when decisions get made for nonscheduled urgent cesarean deliveries, or other unexpected emergencies arise, everyone is aware and able to help.”*

Clinical Excellence in low-volume settings

**Simulation for High Acuity Low Occurrence Events (HALO events) such as neonatal resuscitations and postpartum hemorrhage at these three rural obstetrical facilities is not optional. It is a must.** All programs value

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multi-disciplinary team simulations. At one hospital, in-situ simulation training with the entire multidisciplinary team is performed every 2 months and has the complete support of both physician and nursing dyad on the obstetrical unit and the hospital leadership (CMO/CNO). This

results in a hospital-wide code drill that elicits the support of the emergency department and the hospitalist service for an all hands on deck reality. Being consistent and making this simulation training an important habit was key to making it something that is “*just what we do.*” Many new nurses report that

they don’t want to participate in the simulations because of not wanting to show their lack of knowledge or skills. “*I just don’t want to mess up.*” Consistent messaging from obstetrical unit leadership that simulation is exactly the right time to safely struggle has been critical. Each simulation reveals latent safety errors that the team works on and improves. One recent hospital-wide maternal code demonstrated that the adult code-cart was too far from the obstetrical unit. This led to working with pharmacy to stock appropriate 1<sup>st</sup> line ACLS medications in the unit pyxis and the obstetrical unit purchasing an AED device. A second code led to the

realization that many team members didn’t know where the neonatal code cart was located. Identifying and fixing these latent safety threats is a passion of the obstetrical leadership.

In another hospital, the entire hospital is dedicated to the obstetrical service. This is demonstrated in NRP certification being maintained not only by all pediatric providers, obstetricians, obstetrical nurses, but also by every respiratory therapist, nursing supervisor, emergency room nurse and emergency physician who work at the hospital.

**All units echo the same thing. Physician recruitment to rural obstetrical programs takes 2-3 years. New nurses take over a year to orient to specialty obstetrical and neonatal care. Hospitals and programs need to constantly be thinking ahead.**

## Designing a place where people want to work

One of the biggest challenges in a rural obstetrical unit is answering the question, “How do we plan for the future?” It is a challenge to know when stable and capable obstetrical providers are going to need a transition, an unexpected medical leave and to plan ahead for what that might look like.

**All units echo the same thing. Physician recruitment to rural obstetrical programs takes 2-3 years. New nurses take over a year to orient to specialty obstetrical and neonatal care. Midwifery programs take time to grow and nurture. Hospitals and**

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programs need to constantly be thinking ahead.

## Physicians

The obstetrical leaders on the unit are constantly evaluating options and concentrated on providing creative solutions and flexibility. *“There is no way we would be able to staff while expecting every physician to work as a 1.0 FTE. We are very creative to meet the needs of the physicians who want to work here. While we support a physician-based obstetrical coverage model, we have constantly looked at what it might look like to redesign our coverage to either an integrative midwifery service or the use of an office-based NP to meet our patient’s needs. We recognize that we may also partner with family medicine at some point in the future. Our biggest barrier with partnerships with family medicine is the enormous need the community currently has for primary care providers, so it is difficult for those individuals to concentrate on any obstetrical coverage obligations.”*

Not one of the three units have physicians providing more coverage for their units than every 4<sup>th</sup> weekend. *“You cannot live your life being on call all the time. You cannot recruit*

*physicians to a job that has Q2 call. And there is no way we could ask our physicians to be on every other weekend anymore. It is just not feasible to ask that of our physicians and their families.”* One unit reflected that by designing a program that is sustainable with Q4 call, they were meeting more gynecologic access (well-women exams, contraception, menopause support) needs of their community as well taking burden off of their primary care providers.

## Midwives

**The formation and integration of midwifery**

**services in rural obstetrics is critical to success.** One unit started an inpatient midwifery service 5 years ago which has been highly successful. The service made a strategic decision to add a collaborative midwifery care to their offerings. Partnering with the founding midwife, the physician leadership worked hard to get the care delivery model

correct and correctly sized. The midwifery service grew rapidly and now has 4 midwives who assist mothers in over 200 low-risk deliveries per year. The midwife-physician collaborative practice allows for physician management of high-risk medical conditions (such as hypertensive disorders during labor)

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while still allowing the patient's deliveries to be with their chosen midwifery provider. *"Close partnership and communication with the OB physicians and each midwife are key to success for this model."* By offering low intervention patient-centered care in the midwifery service, better outcomes have been seen across the unit. The same unit has seen a trial of labor after cesarean (TOLAC) success rate of 100% in the last three months. In addition, their physician-led service was able to decrease unnecessary cesarean birth in their practice with a normal term singleton vertex (NTSV) rate that is 22%--well below the national average. Not surprisingly, the midwifery-led service's NTSV rate is 15%. *"We collaborate together and learn from each other."*

## Nursing

**Nurse staffing has always been challenging, but has gotten acutely harder in the last 5 years. All three units have felt the retirement of strong and seasoned nurses with 30+ years of obstetrical experience.** The biggest gap is in the ability to recruit nurse to replace these years of compressed wisdom as there are no experienced obstetrical nurses to recruit. All units support and strive to maintain the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) 2022 staffing standards. All units value the nurse educator role to ensure those nurses in orientation are achieving competency. In all units, nurses train across all areas including

postpartum, normal new born support, neonatal resuscitation, and labor & delivery.

One unit has been successful at recruiting new grads. Orientation takes over 6 months and is a competency-based process. The obstetrical volume on the unit is such that nurses do not need to rotate through higher volume/acuity centers in order to achieve competency in orientation. The need for longer on-site orientation/mentorship was echoed throughout all programs. *"Rotating at larger facilities may be good to see something one time, but at that [high-acuity] hospital there is so much support. Here...it is just me. I have to know how to do everything in an emergency like restart a maternal IV and resuscitate a baby at the same time. In an emergency, I need to know where things are on my unit. I have to know how to do it at my hospital."*

At one hospital, being a highly specialized unit without a lot of nursing redundancy necessitated that the unit seek agency staffing to fill gaps in unexpected medical leaves and vacancies. *"The alternative would have been to make full-time nurses work overtime which is not sustainable or acceptable."*

At another unit, several experienced obstetrical nurses over the last 5 years retired and the vacancies were filled with new graduates. Because of low volumes, new nurses were mentored over a 12-month process which includes several certifications and educational modules in addition to a

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structured on-the-job orientation and mentoring program. The unit is able to staff 3 nurses per shift and has created a “primary” and “secondary” system for deliveries. Every shift has a nurse who can function as the primary nurse for any delivery or emergency. Primary nurses have at least 1 year experience as an obstetrical nurse on the unit and can respond as the lead nurse to any obstetrical emergency. Secondary nurses are in a competency-based orientation process. By design, secondary nurses spend more time on day shifts because the obstetrical triage volume is so much higher on these shifts, shortening the learning curve for these new graduates.

***“It is not hard to make people happy. You have to listen to what they want and make sure we all buy into the fact that we are on the same team and we need to work together. Doing this has made us successful.”***

## Long-term sustainable solutions

The obstetrical leadership at all three hospitals are fiercely dedicated to maintaining obstetrical services at their hospital and meeting the needs of their community. They meet regularly with hospital leadership to ensure alignment with the obstetrical program.

All three programs are constantly thinking about the future and keenly aware that all members of their team need to feel a supportive work environment. *“It is not hard to make people happy. You have to listen to*

*what they want and make sure we all buy into the fact that we are on the same team and we need to work together. Doing this has made us successful.”*

A big challenge in any of these units is asking people to do too much. *“At a small hospital, we all have many roles and wear many hats.*

*We cannot succeed with just one role. It is vitally important to understand how hard our team works to deliver great care. We have to support and protect them.”* As champions step forward to lead important obstetrical safety initiatives like TeamBirth™, Baby Café™, or Spinning Babies™, the biggest challenge is implementing

these programs without overburdening the staff leading them.

## Summary

Several common themes for these successful rural obstetrical programs are critical for their success: leadership, volume, flexibility and redundancy.

## Leadership

The leaders at these facilities are impressive. In talking with them, one can’t imagine interviewing with them for a position and not wanting to work there. Their enthusiasm is infectious and dedication is obvious. They set the standard of modeling teamwork and

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collaboration. They also ensure strong relationships with their entire hospital, not just their units, as evident by NRP certification of all emergency department staff or running hospital-wide maternal codes.

## Volume

While there is no magic number of annual deliveries that leads to a high-performing unit, all three obstetrical programs had maintained volumes above 200 births annually and successfully supported their communities through nearby unit closures. As nearby units had intermittent episodes of closure and diversion, *“we focused on delivering great care...making sure patients and families felt safe and taken care of every time.”*

## Flexibility and Redundancy

All three obstetrical units are thinking ahead. All units know that they can't stay open by expecting their people (physicians, midwives, nurses) to work unsustainable hours and more than full-time jobs. Over and over, the leaders reaffirmed that recruitment takes time and have successfully posted positions early to ensure enough redundancy in their programs for success. They see the advantage of succession planning to focus on recruitments that can expand services or compliment in areas not previously offered (e.g. menopause care or helping overworked primary care providers with annual wellness visits). In addition, they designed positions to

utilize people's skills. This could look like creating a part-time FTE for a physician, supporting a family medicine physician in obstetrics or sponsoring nurses to become fetal heart rate monitor instructors. Each unit is consistently look for win-win solutions rather than rigid rules in the workforce.

In summary, many rural obstetrical units are thinking long-term and are invested in designing units that meet their communities needs. The dedication of rural obstetrical teams to their communities is grounded in a deep love for the patients and families they serve. These are the heroes.



## **By Elisabeth Erekson, MD, MPH, FACOG**

Elisabeth Erekson is an experienced obstetric leader who believes that every mother matters. Her passion is to make rural health care better. She is the founder of Obstetric Consulting Solutions, LLC.

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