Rural Obstetrics Work Group Recommendations

A. Ensure the inclusion of obstetrics as a necessary service in health care delivery models such as Accountable Care Organizations. It is important to minimize variations in quality of care based on geography while recognizing that unique challenges exist for rural obstetric programs. [POLICY]

B. Educate rural providers and hospital staff about ways to better serve American Indian women. Statewide trainings in rural and urban underserved areas may be offered on traditional birth from an American Indian perspective. More could also be done to standardize the referral processes between clinics, hospitals, IHS facilities, human services, tribal nurses and doulas. [PATIENT/COMMUNITY]

C. Support a system for medical school admissions that considers rural provider perspectives and a prospective student’s inclination towards a rural obstetrics practice. Revisit the metrics used to choose and evaluate incoming medical students to ensure admissions processes do not discourage individuals with an interest in rural family medicine and obstetrics. [EDUCATION]

D. Provide more opportunities for rural family practice doctors to receive training in natural birthing and cesarean sections. Expand initial training in obstetrics for family medicine medical students through rural elective courses, residency and fellowship programs. Offer ongoing cesarean section training to rural family practice physicians through refresher courses or simulation technology. [EDUCATION]

E. Analyze and address the impact of newer federal work hour restrictions on medical residents. Residents are receiving less experience overall, especially in obstetrical and surgical training areas. This policy restriction may have unintended consequences and should be studied at the state level. [EDUCATION/POLICY]

F. Support an appropriate number of new medical graduates to meet future rural obstetric care needs. Minnesota is falling behind in the percentage of family practice physicians who are ready to practice in rural areas. A smaller percentage of these graduates are willing to include obstetrics in a rural practice. The number of Graduate Medical Education (GME) slots is not sufficient to meet current and projected workforce needs and should be increased. [EDUCATION]

G. Address ongoing challenges related to workforce shortages in rural obstetrics. The number of certified nurse-midwives (CNMs) being trained in Minnesota has remained relatively flat for 15 years. Affordable training programs for CNMs increase the potential for more female obstetric providers and add a wider range of birth options for rural women. State-level healthcare workforce planning should include periodic assessments of all primary obstetric providers in rural Minnesota. [EDUCATION]

H. Support rural obstetric team-based training that supplements labor and delivery skills. Continuing education issues are important for labor and delivery staff. Courses focused on high-risk pregnancies and emergency obstetric care for nurses, emergency room physicians and EMTs are needed. Reimbursement could be offered through Flex or other grant programs for training and curriculum development. [EDUCATION]

I. Support loan forgiveness programs for obstetric providers in small and isolated rural areas. Recent changes to state loan forgiveness programs include the level of rurality of a future practice location as a selection factor. State legislation to increase the number of loan forgiveness opportunities for physician and mid-level providers would help small and isolated rural hospitals maintain their obstetric practices. [WORKFORCE]
J. Address regulatory barriers to practice at federal, state and hospital levels for certified nurse-midwives (CNMs). Hospital bylaws determine the extent of CNM privileges and sometimes require a supervisory relationship between physicians and certified nurse midwives. Models demonstrating the best use of CNMs in rural obstetric practices need to be identified and reflected in policy. [WORKFORCE]

K. Educate rural providers and hospital staff about the role of doulas. Medical students are not exposed to doulas and may not understand their unique role during pregnancy and the birthing process. Doulas representing racial or ethnic minority populations can also educate rural obstetric providers and staff about culturally based beliefs regarding birth and related considerations for hospital settings. [WORKFORCE]

L. Expand awareness of the impact of local obstetric services on patient safety and quality. Lack of access to obstetric services may delay diagnosis or treatment for mothers and infants. This impacts patient safety and health outcomes, and may even result in otherwise preventable death. [HOSPITAL]

M. Promote a set of best practices for rural hospitals that encounter obstetric emergencies with limited obstetric staff or resources. When women are unable to travel to their chosen birth location and experience complications in labor, this can be a difficult situation for rural obstetric providers. A set of best practices may help providers offer the best care possible when faced with obstetric emergencies. An additional safety concern is the transport of women in labor. EMS and trauma system components of rural health systems may need patient transfer protocols or best practices to address this issue. [HOSPITAL]

N. Support improvements to Medicaid reimbursement for rural obstetrics. Analyze the impact of new legislation regarding Medicaid payments on Critical Access Hospitals. The Minnesota Department of Health, along with hospital and provider stakeholders, could advocate for improvements in Medicaid reimbursement for rural obstetric programs. [HOSPITAL]

O. Protect Minnesota's low-cost liability and malpractice insurance environment for obstetric providers. In many parts of the U.S., obstetric providers are leaving their practices due to high malpractice and liability costs. Minnesota has a relatively low-cost liability and malpractice environment that should be protected. [HOSPITAL]

P. Support collaborative efforts to maintain local obstetric services and share successful models. Collaborative practices can fill gaps in expertise and workforce that are common in rural areas. Mid-level and primary care practice can be integrated to maximize workforce capacities. Approaches that include providers sharing patients and call schedules could be considered. Neighboring hospitals may share surgical teams and obstetric call coverage. [COLLABORATION]

Q. Encourage collaboration between rural obstetric providers and public health nurses to maximize the use of local resources available to pregnant women and new parents. It is important for clinics, hospitals and local public health agencies to understand the resources available so pregnant women can be referred and access a range of support services from prenatal care to breastfeeding support. [COLLABORATION]

R. Develop and pilot a rural obstetrics telehealth program in Minnesota. Telehealth applications that are specifically tailored to rural obstetric practices are needed. This technology could support family practice physicians, providers in small or remote facilities, and solo or home-based obstetric providers. [COLLABORATION]