OB Task Force: Workforce Care Delivery and Operational Models — Meeting 1 Summary

Recording: November 13, 2026
Meeting focus: Care delivery and operational models for Vermont obstetric services
Note: The substantive task force discussion occurred during roughly the first hour. Later transcription appears to capture unrelated post-meeting/side conversation and is not summarized here.

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1. Concise 1-Minute Overview

The first meeting of the OB Task Force Care Delivery and Operational Models workgroup focused on identifying practical, high-impact opportunities to improve Vermont's maternity care system without duplicating the work of the related **finance** and **workforce** workgroups. Participants reviewed examples of care delivery models from other states and discussed how similar approaches may or may not fit Vermont's rural, low-volume, and workforce-constrained context.

Major themes included: maintaining safe local birth access; addressing call coverage and staffing burden; understanding where capacity exists or is constrained; preserving clinical competence in low-volume settings; improving use of midwives, nurses, pediatricians, behavioral health, home visiting, and community partners; and evaluating tailored prenatal/postpartum models, shared staffing, regional services, and specialty support.

The group did not select a final model. Instead, members agreed that the next step should be to use data on patient location, birth patterns, access, and capacity to narrow the workgroup's focus to **three to five concrete opportunities** for further structured work.

Attendance

Name	Affiliation
Julio Cespedes, Workgroup and Taskforce Chair	Agency of Human Services
Lauren MacAfee, Workgroup Chair	UVM, Vermont ACOG Chair
Shayla Livingston, Organizer	Vermont Department of Health
Katy Leffel, Organizer	Vermont Department of Health
Rick Hildebrant, Taskforce Chair	Vermont Department of Health
Jade Kaplan	Northeastern Vermont Regional Hospital
Katie Garland	Mathematica
Kristen Bigelow	BiState Primary Care Association

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Name	Affiliation
Rachel Garfield	VCHIP, UVM
Debra S. Beauchesne	North Country Hospital
James Trimarchi	Southeastern Vermont Medical Center
Peter J. Stuart MD	North Country Hospital
Mike Seaton	Porter Medical Center
Mindy Dame	Southeastern Vermont Medical Center
Chelsea Oclatis	Maitri Healthcare
Autumn Blais	Winston Prouty Center
Craig Jones	Agency of Human Services
Elizabeth A. Kyhill	Rutland Regional Medical Center
Julie Parker	Blueprint for Health
Sara A. Simeone	Gifford Medical Center
Devon Green	Vermont Association of Hospitals and Health Systems
Erinn Mandeville	Green Mountain Birth Center
Mary Kate Mohlman	BiState Primary Care Association
Laura Newell	Northeastern Vermont Regional Hospital
Aida Avdic, MD	Brattleboro Memorial Hospital
Whittney Barkhuff	UVM
Corina Tennant	Brattleboro Memorial Hospital
Maria Rossi	Washington County Mental Health
Allen Mead	UVM
Jade Kaplan	Northeastern Vermont Regional Hospital
Julie Tromblee	UVM
Marjorie C. Meyer	UVM

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2. Purpose of the Meeting

Need

The meeting was convened as part of Vermont's broader Obstetrical Task Force to address statewide challenges in obstetrical care, especially within hospital-based maternity services. Participants recognized that Vermont faces overlapping pressures related to:

- Rural geography and long travel distances
- Low and declining birth volumes in some areas
- Fragile call coverage and staffing models
- Financial sustainability of maternity services

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- Workforce shortages across OB, midwifery, nursing, pediatrics, anesthesia, sonography, and related services
- Need for specialty backup, neonatal stabilization, and safe transfer systems
- Maintaining local access while preserving quality and competence

Priorities

The workgroup was asked to focus specifically on **care delivery and operational models**, while recognizing connections to finance and workforce. Key priorities included:

- Understanding how prenatal, postpartum, inpatient, newborn, and specialty care are currently organized
- Identifying operational problems that the workgroup can realistically address
- Considering models that support care closer to home
- Exploring shared or regionalized staffing and service models
- Strengthening connections between hospitals, clinics, community supports, and specialty services
- Identifying opportunities that could have impact within one to three years

Charge of the Workgroup

The group's charge is to examine how maternity care is delivered across Vermont and identify practical opportunities for improvement. The goal of Meeting 1 was not to choose or approve an implementation model, but to build a shared foundation and begin identifying **three to five opportunities** for deeper exploration in future meetings.

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3. Meeting Themes

A. Care Delivery Models Reviewed

Julio Cespedes presented examples grouped into three broad categories.

1. Care Closer to Home

These models change where, when, and how prenatal and postpartum care are delivered.

Examples included:

- **Risk-stratified prenatal care:** Patients receive visit schedules tailored to clinical and social risk rather than a one-size-fits-all schedule.
- **Hybrid prenatal care:** Low-risk patients receive a mix of in-person and virtual visits, often with nursing follow-up and home monitoring.
- **Integrated behavioral health and community support:** Prenatal practices work closely with behavioral health, home health, designated agencies, and community health teams.
- **Group prenatal care:** Patients with similar due dates participate in structured group care, peer support, and education.

Participants noted that Vermont already has elements of these models through community health teams, home visiting, designated agencies, and local innovations.

2. Team and Organizational Models

These models change who delivers care or how organizations share responsibility.

Examples included:

- **Shared maternity workforce models:** Regional sharing of clinicians, nurses, sonographers, call coverage, training, or other scarce resources.
- **Hospital–FQHC or community practice partnerships:** Reorganizing clinical, administrative, or financial relationships to support maternity care.
- **Freestanding birth centers or hospital-linked birth center models:** Midwife-led birth settings with defined eligibility, consultation, and transfer pathways.

Participants also raised the concept of an **alongside midwifery unit**, where midwifery-led care occurs near or within a hospital rather than in a fully freestanding birth center.

3. Specialty and Newborn Support Models

These models connect local teams to services that cannot be duplicated everywhere.

Examples included:

- **Statewide or regional high-risk pregnancy/MFM support:** Remote consultation, ultrasound interpretation, protocols, and coordinated care plans.
- **Tele-neonatology or neonatal specialty support:** Real-time specialist support for local teams stabilizing newborns.

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Participants emphasized that tele-specialty support is valuable but does not replace the need for on-site nursing, OB, anesthesia, pediatric, or stabilization capacity.

B. Operational Problems Identified by Participants

Call Coverage and Fragile Staffing

Multiple participants identified call coverage, especially nights, weekends, vacations, and C-section coverage, as a major operational challenge. Peter Stuart noted that at North Country, prenatal care capacity exists, but maintaining safe and sustainable inpatient and call coverage is the looming issue.

Participants discussed whether shared regional staffing pools, easier credentialing, or cross-site privileging could help relieve pressure on smaller birth units.

Low Volume and Maintaining Competence

A major concern was that low birth volumes affect not only financial sustainability but also staff satisfaction and clinical competence. If births are diverted from small hospitals to other settings, local OBs, midwives, nurses, and pediatric teams may lose critical experience.

Participants stressed that rural hospitals must still be prepared for emergencies, including preterm deliveries when transport is delayed or unavailable due to weather, distance, helicopter availability, or ambulance limitations.

Pediatric and Neonatal Burden

Mike Seaton highlighted the often-overlooked impact on rural pediatricians. Stabilizing a premature or critically ill newborn may take a pediatrician out of clinic for six to eight hours, creating financial, workload, and liability disincentives. This issue affects whether pediatricians remain willing to participate in newborn coverage models.

Billing, Coding, and Revenue Capture

Billing and reimbursement emerged as important concerns, even though finance is a separate workgroup. Jade Kaplan raised concerns that unbundled prenatal care could reduce revenue if nurse-led visits cannot be billed appropriately. Lauren MacAfee noted that unbundling may also create opportunities to better capture the true complexity and time of labor, delivery, induction, and clinical care.

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There was discussion of preventive care protections under the Affordable Care Act and the use of pregnancy-related modifiers to prevent patient cost-sharing for prenatal/postpartum visits.

Patient Geography and Out-of-State Births

Corina Tennant raised the issue of Vermont patients, particularly in southeastern Vermont and Windsor County, giving birth out of state. Some out-of-state births are medically necessary, but others reflect geography, preference, or lack of nearby Vermont options. Participants discussed whether transportation support or local care models could help retain births within Vermont when appropriate.

Katy Leffel added that Vermont also receives births from neighboring states, especially New York, complicating interpretation of statewide birth patterns.

C. Community-Based and Non-Hospital Supports

Several participants emphasized the need to include partners beyond hospitals and OB practices.

Potential contributors include:

- Home visiting nurses
- Community health teams
- Designated agencies
- Certified Community Behavioral Health Clinics, or CCBHCs
- Doulas
- Social workers
- Behavioral health providers
- Substance use treatment supports
- Community-based midwifery practices
- Birth centers

Maria Rossi noted that Vermont's transition toward CCBHCs may create opportunities for greater integration of behavioral health and perinatal support, especially for patients with substance use histories or significant social needs.

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D. Midwifery and Birth Setting Considerations

Jade Kaplan and Erinn Mandeville emphasized the importance of understanding midwifery roles clearly. Certified nurse midwives are advanced practice registered nurses trained to provide prenatal care and conduct vaginal births. Participants discussed how midwifery-led care, continuity, relationship-based models, and appropriate risk escalation could contribute to Vermont's system.

Green Mountain Birth Center shared plans for a future birth center in Waterbury, current clinic services in Morrisville, prenatal/postpartum care, group education, and a future mobile clinic supported by grant funding.

Participants also discussed the need for respectful, smooth transfer processes from out-of-hospital to in-hospital birth when risk status changes.

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4. Key Takeaways

- The workgroup should focus on operational and care delivery solutions, while coordinating with finance and workforce groups.
- Call coverage, inpatient staffing, C-section readiness, and night/weekend/vacation coverage are major operational stress points.
- Vermont needs a clearer map of where maternity care capacity exists and where constraints are most severe.
- Low birth volume creates risks for competence, experience, satisfaction, and sustainability.
- Pediatric/newborn coverage must be included in any operational model.
- Tailored or hybrid prenatal care may improve capacity, but billing and safety standards need clarification.
- Shared staffing, regional credentialing, and cross-site support may be promising but require careful operational design.
- Community supports, including home visiting and behavioral health agencies, should be integrated into planning.
- The group should consider patient needs and geography first, then determine workforce and financing requirements.

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- Future work should narrow to a small number of concrete, testable opportunities.

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5. Task-Outs / Follow-Up Items

Agreed or Suggested Next Steps

- **Share meeting slides** with participants.
  Owner: Julio Cespedes / facilitation team.
- **Compile and share relevant data** on birth patterns, patient geography, access, and capacity.
  Owner: Katy Leffel and state/VDH partners, with Lauren MacAfee and Julio Cespedes.
- **Identify capacity opportunities and constraints** across regions, including prenatal, inpatient, newborn, and specialty support capacity.
  Owner: Workgroup/facilitation team; details to be determined.
- **Develop a short survey or input tool** to help frame the next meeting and prioritize discussion areas.
  Owner: Lauren MacAfee, Julio Cespedes, Katy Leffel.
- **Consider smaller breakout groups or subgroups** organized around major building blocks, such as:
  - Tailored local prenatal/postpartum care
  - Shared/regional maternity workforce and operations
  - Specialty, neonatal, and transfer support
    Owner: Facilitation team to consider for Meeting 2.
- **Invite or engage additional partners**, especially behavioral health, home visiting, designated agencies/CCBHCs, and possibly pediatric representatives.
  Owner: Facilitation team.
- **Coordinate with workforce and finance workgroups** on overlapping issues such as credentialing, call coverage, reimbursement, and sustainability.
  Owner: Task force leadership.

Items Needing Clarification or Future Discussion

- Which three to five opportunities should receive structured work?

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- What data best defines capacity and access gaps?
- How should Vermont balance local access with safe volume and competence?
- What role should midwifery-led care, alongside midwifery units, birth centers, and mobile clinics play?
- How can billing/coding support rather than undermine redesigned care models?
- How should pediatric and neonatal stabilization coverage be financed and operationalized?
- What model can support respectful, reliable transfer from out-of-hospital to hospital care?

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