OB Task Force: Workforce Workgroup Meeting 1

Meeting Date: November 12, 2026
Duration: 1 hour 32 minutes
Focus: Obstetric workforce challenges, care models, recruitment/retention, and possible statewide strategies for Vermont

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1. Concise 1-Minute Overview

The first OB Task Force Workforce Workgroup meeting focused on Vermont's strained and fragile obstetric workforce. Participants discussed shortages, burnout, recruitment and retention barriers, reimbursement challenges, uneven access to midwifery care, credentialing inefficiencies, nursing shortages, and the risks of consolidating or regionalizing birth services.

A major theme was that Vermont's OB workforce is deeply committed but overextended. Participants emphasized the need to better understand the current statewide workforce, including physicians, midwives, nurses, doulas, home health, mental health providers, birth centers, and other community-based supports.

The group also discussed the importance of preserving local access to low- and moderate-risk maternity care while ensuring strong referral and transfer pathways for high-risk care. Several participants advocated for strengthening midwifery-led care models, improving cross-hospital staffing options, reducing credentialing and enrollment barriers, and including patient and family perspectives in future planning.

The meeting closed with agreement that the next phase should include a current-state workforce assessment, education on existing care models, patient and provider needs assessment, and further exploration of shared staffing, reimbursement, nursing workforce, and barriers to practice.

Attendance

Name	Affiliation
Elizabeth A. Kyhill, Workgroup Chair	Rutland Regional Medical Center
Emily Zolten, Workgroup Chair	Porter Medical Center, ACNM-Vermont
Ilisa Stalberg, Organizer	Vermont Department of Health
Katy Leffel, Organizer	Vermont Department of Health
Shayla Livingston, Organizer	Vermont Department of Health
Rick Hildebrant, Taskforce Chair	Vermont Department of Health

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Name	Affiliation
Erin Just	Agency of Human Services
Julie Parker	Blueprint for Health
Sara Forward	VCHIP
Elisa Vandervort	UVM
Devon Green	Vermont Association of Hospitals and Health Systems
Erinn Mandeville	Green Mountain Birth Center
Laura Newell	Northeastern Vermont Regional Hospital
Katie Garland	Mathematica
Lou McLaren	Blue Cross Blue Shield Vermont
Chelsea Oclatis	Maitri Healthcare
Lexi Krupp	Vermont Medical Society
Jade Kaplan	Northeastern Vermont Regional Hospital
Tom Weigel, MD	Blue Cross Blue Shield Vermont
Sarah E. Decker, MD	Rutland Regional Medical Center
James Trimarchi	Southeastern Vermont Medical Center
Julie Tromblee	UVM Health
David Sanville	Brattleboro Memorial Hospital
Jun Chon MD	Porter Medical Center / Central Vermont Medical Center
Alicia Cooper	Department of Vermont Health Access
Maria Rossi	Washington County Mental Health, Doula Association of Vermont
Lydia S. Grondin	UVM Health
Craig Jones	Agency of Human Services
Allen Mead	UVM
Maddison McGuiness	Maitri Healthcare

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2. Purpose of the Meeting

The Workforce Workgroup was convened as one subgroup of the broader OB Task Force, alongside finance and operations-focused groups. The purpose of this meeting was to begin identifying workforce challenges and possible solutions related to obstetric and perinatal care in Vermont.

Participants acknowledged that workforce issues overlap heavily with finance and operations. However, this group's main focus is workforce capacity, staffing models, recruitment, retention, credentialing, care teams, and professional sustainability.

Chairs framed the conversation by noting that the group should be open to long-term, creative thinking, while also identifying practical strategies that could be pursued over the next **1 to 3 years**.

It was also emphasized that each subgroup should draw on the expertise of the people in the room. For this group, that includes experience with clinical practice, workforce design, credentialing, staffing, medical staff processes, hospital operations, community care, and payer issues.

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3. Major Meeting Themes

A. Vermont Has a Dedicated but Overstretched OB Workforce

Participants repeatedly described Vermont's OB workforce as highly committed but exhausted. Clinicians, nurses, and community providers are working hard to maintain services, often through unsustainable hours, multiple jobs, per diem work, or cross-site coverage.

Key concerns included:

- Burnout among physicians, midwives, nurses, and community providers.
- Difficulty recruiting and retaining clinicians.
- Competition among hospitals and practices for the same limited workforce.
- Vermont's high cost of living and lower salaries compared with other states.
- Reliance on locums or per diem arrangements.
- Strain on small and rural hospitals with low delivery volumes.

Several participants noted that while informal cross-coverage is already happening, it is not always organized, efficient, or sustainable.

B. Midwifery Care Must Be Understood as a Distinct Model

A portion of the meeting focused on the midwifery model of care. Participants emphasized that midwives should not simply be treated as physician extenders or inserted into traditional physician scheduling, call, or productivity models.

The midwifery model was described as:

- Relationship-based.
- High-touch and time-intensive.
- Focused on normal physiologic pregnancy, birth, postpartum care, and reproductive health.
- Centered on education, trust-building, and continuous support.
- Different from a rescue- or intervention-based medical model.

Participants noted that midwives often spend more time in prenatal visits and provide hands-on labor support. This care model can improve outcomes and is cost-effective for low- and moderate-risk patients. However, standard RVU-based productivity measures may undervalue this work because midwives often care for lower-acuity patients and spend more time on education and support.

The group also discussed unequal access to midwifery care across Vermont. Some hospitals have 24/7 midwifery coverage, while others have limited or no continuous midwifery presence. Several participants suggested that expanding access to 24/7 midwifery-led services, with OB backup, could improve sustainability and preserve local care.

C. Recruitment, Retention, and Compensation Are Closely Linked to Reimbursement

Although this was the Workforce Workgroup, reimbursement was a recurring issue. Participants emphasized that Vermont cannot recruit and retain a stable OB workforce without addressing compensation and payer structures.

Private practice representatives described difficulty competing with hospital systems for nurses, administrative staff, midwives, and physicians. They noted that independent practices may receive significantly lower reimbursement for the same services, making it difficult to offer competitive salaries.

Specific concerns included:

- Low Medicaid reimbursement.
- Lack of inflationary increases in Vermont Medicaid over several years.
- Commercial payers being unable to fully offset Medicaid shortfalls.
- Reimbursement disparities between hospital-based systems and independent practices.

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- Inability to recruit physicians when other states or hospitals offer much higher compensation.
- OB care being undervalued relative to other specialties.

Payer representatives acknowledged that reimbursement discussions are active but noted that commercial payers cannot fully close the gap created by Medicaid underpayment. Participants agreed this issue overlaps strongly with the Finance Workgroup.

D. Shared Workforce Models Could Help but Need Structure

Participants discussed whether Vermont could create a more formal shared workforce model for obstetric care. Informal sharing already occurs, with physicians and midwives working per diem at multiple hospitals and some providers traveling from out of state.

Ideas included:

- A statewide or regional OB/midwifery staffing pool.
- A Vermont-based OB hospitalist or perinatal workforce group.
- A registry of licensed and willing providers.
- Pre-negotiated rates.
- Streamlined credentialing and payer enrollment.
- Reduced reliance on expensive locums.

Participants saw potential in this idea, especially for smaller hospitals that need occasional coverage. However, they also identified challenges, including:

- Hospital-specific workflows, equipment, medications, and protocols.
- Different EMRs.
- Credentialing and enrollment delays.
- Malpractice coverage.
- Orientation needs.
- Risk of overworking already burned-out clinicians.

The group noted that shared staffing must be designed to support workforce sustainability, not simply stretch limited staff further.

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E. Credentialing, Enrollment, and Bylaws Are Barriers to Practice

Credentialing and payer enrollment were identified as significant obstacles to flexible workforce deployment. Participants discussed the difference between hospital credentialing and payer credentialing/enrollment. Even when a provider is already credentialed by a payer, each hospital or practice may still need to enroll or associate that provider with a new billing site.

These processes can take weeks and create administrative burden for providers and hospitals. Participants suggested exploring ways to streamline cross-site practice.

Related barriers included outdated hospital bylaws. Some participants noted that Vermont allows autonomous APRN practice and that certified nurse midwives should not be subject to outdated supervisory language. There was also discussion that APRNs and PAs now have admitting privileges under Vermont law, but implementation may vary across hospitals.

Potential areas for follow-up include:

- Standardizing credentialing processes where possible.
- Streamlining payer enrollment for providers working at multiple sites.
- Reviewing hospital bylaws for outdated supervisory language.
- Clarifying admitting privileges for APRNs and PAs.
- Identifying administrative practices that cause unnecessary delays.

F. Family Medicine OB May Be Part of the Solution, but Not a Complete Fix

The group discussed whether family medicine physicians with OB training could help address workforce shortages, especially in rural areas. Some participants noted that family medicine OB is common in other parts of the country and that some Vermont-trained family medicine residents interested in OB leave the state because they cannot find positions allowing them to practice obstetrics.

However, concerns were also raised:

- Family medicine is also under severe workforce pressure.
- Primary care redesign may increase demands on family medicine physicians.

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- If family physicians provide C-section coverage, OB backup may still be needed for GYN emergencies or complex cases.
- Training, experience, volume, outcomes, and credentialing standards would need to be clear.
- It can be difficult for a primary care practice if only one physician provides OB care and others do not.

The group did not reach consensus but agreed the topic deserves continued discussion, especially for rural or low-volume settings.

G. Nursing, Doulas, and Community-Based Supports Need More Attention

Participants noted that the discussion had focused heavily on physicians and midwives, but L&D nursing shortages are also a major workforce issue. Some hospitals may be adequately staffed with OB physicians but still struggle with inpatient nursing capacity.

Ideas raised included:

- Exploring new L&D nursing models.
- Considering whether doulas could extend support for laboring patients.
- Looking at whether L&D nurses could participate in ambulatory care to support retention.
- Including home health and community-based perinatal support workers.
- Integrating perinatal mental health into workforce planning.

One participant emphasized that hospital-based care is only one part of the system. What happens before and after hospitalization affects outcomes, and community providers are also stretched. She encouraged the group to include doulas, community mental health, home health, and other support systems in the workforce conversation.

H. Regionalization, Consolidation, and Local Access Are Central Questions

The group had a candid discussion about whether Vermont may need to consolidate births into fewer locations because of workforce shortages and low delivery volumes. Some participants raised consolidation as a difficult but necessary topic.

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Others strongly cautioned that removing local maternity services can create safety, access, and equity risks. Concerns included:

- Patients may not be able to travel for prenatal, delivery, or postpartum care.
- Low-income and higher-risk patients may be disproportionately affected.
- Local birth closures may create maternity care deserts.
- Travel barriers can worsen outcomes.
- Community-based low- and moderate-risk care is important for safety.

Participants discussed a possible hub-and-spoke model where low- and moderate-risk care remains local, high-risk care is regionalized, and smaller hospitals have strong consultation, referral, and transfer pathways with tertiary centers.

There was also discussion about volume and quality. Some participants questioned whether low birth volume affects skill maintenance. Others responded that available evidence does not establish a clear minimum number of births needed to maintain safe care, and that many small New England hospitals provide safe care with good outcomes.

I. Patient and Family Voice Should Guide the Work

Participants agreed that the group needs to better understand what patients and families want. Questions included:

- How far are patients willing or able to travel?
- What types of prenatal, birth, and postpartum care do patients value?
- Why do patients choose certain hospitals or practices?
- What local services are most important?
- What support do patients need from community-based providers?

Patient and family advisors have been invited into related work, and participants suggested using broader patient/family advisory groups to gather input on specific questions.

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4. Key Takeaways

- Vermont's OB workforce is committed but strained, burned out, and difficult to sustain.

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- Workforce solutions must include physicians, midwives, nurses, doulas, home health, mental health, community providers, and out-of-hospital care.
- Midwifery care should be preserved as a distinct model, not forced into physician productivity or scheduling structures.
- Reimbursement is a major driver of recruitment, retention, and workforce stability.
- Shared staffing models may help, but require credentialing, enrollment, orientation, and protocol solutions.
- Nursing workforce shortages need dedicated attention.
- Family medicine OB may help in some settings but is not a simple statewide fix.
- Local access to low- and moderate-risk maternity care remains a high priority.
- Any discussion of consolidation must consider equity, safety, travel, and community impact.
- Patient and provider needs assessments are needed before designing long-term solutions.

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5. Task-Outs and Follow-Up Items

1. Conduct a current-state workforce assessment

Map the existing OB/perinatal workforce across Vermont, including provider type, role, skill set, location, setting, and gaps. VDH has already done some mapping, so existing work should be reviewed.

2. Provide education on current care models

Future meetings should help participants understand hospital-based OB care, midwifery-led models, private practice, home birth, freestanding birth centers, community-based care, and transfer models.

3. Gather patient and family input

Use patient/family advisory groups to understand preferences, travel barriers, care priorities, and experiences with maternity care.

4. Assess provider and workforce needs

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Identify what physicians, midwives, nurses, doulas, home health, and community providers need to remain in the workforce.

5. Explore shared staffing models

Consider the feasibility of a statewide or regional OB/perinatal workforce pool with streamlined credentialing, enrollment, malpractice, orientation, and compensation structures.

6. Examine credentialing and bylaw barriers

Review hospital credentialing, payer enrollment, APRN/CNM autonomy, admitting privileges, and outdated supervisory language.

7. Focus on nursing workforce

Dedicate future discussion to L&D nursing shortages, retention, alternate staffing models, and the role of doulas or other supports.

8. Explore smooth transfer models

Review existing "Smooth Transitions" models that support safe transfers from out-of-hospital to hospital care.

9. Coordinate with Finance and Operations Workgroups

Reimbursement, locums, staffing models, and regionalization should be coordinated across all OB Task Force subgroups.

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