

Statewide Obstetrical Task Force Meeting Notes

September 24, 2026

Summary Notes

Purpose

- Ensuring pregnant and postpartum people can receive the right care, at the right time, as close to home as possible
- Vermont's challenge is not how to keep existing maternity service operating as it does today.
- Determine how the state can reorganize its existing system into a more coordinated statewide system
- A model variable by region but ensuring families have reliable access to high-quality care across the prenatal-to-postpartum continuum
- Hospitals and providers no longer have to solve statewide structural problems independently

Needs

1. Access and regionalization need to be redesigned together
2. Workforce is a fundamental structural challenge
3. Telehealth has potential, but the right use cases need to be defined
4. Vermont needs a more connected statewide care infrastructure
5. Maternal care needs to extend beyond the walls of the hospital
6. The system needs new operational models, not simply additional reimbursement
7. Preserve what is working while redesigning what is not

Potential Areas of Focus for Task Force Work

The discussion points toward four primary areas of work, with several cross-cutting topics:

Workgroup	Key Questions / Opportunities	Suggested attendance
Workforce	• Shared/regional staffing • Call models • Optimizing alternate providers – Nurse Practitioners, Family Practice, Midwives • Credentialing across facilities • Regional career pathways	• HR • CMOs, CNOs • Home health • Doulas • Provider Organizations
Care Delivery & Operational Models	• Which services should be local, regional, or statewide? • Alternative maternity models (telehealth, pre/post partum care, freestanding birth centers) • Partnering (FQHC, Home Health, consultation)	• Clinicians • Perinatal Quality Collaborative • Patient and Family Advisors • Home Health

Workgroup	Key Questions / Opportunities	Suggested attendance
Financing & Sustainability	• Financing shared infrastructure and staffing • FQHC partnership • Reimbursement • Standby payments	• Hospital CEOs and CFOs • Payors
HOLD for now Technology & Infrastructure	• Interoperable/shared EHRs • Patient information exchange • Transfer infrastructure • Transportation	• Hospital CIOs • Statewide information exchange
HOLD for now Community supports	• Hospital and community support integration	• Clinicians • Community partners

Purpose of the Task Force

Need. The meeting was framed around an urgent need to move Vermont’s maternal care system from a reactive approach—responding to individual hospital or birthing-unit crises—to a proactive statewide strategy. Participants acknowledged that Vermont continues to have strong maternal and newborn care quality, but the current delivery model is under increasing pressure from workforce shortages, rising costs, low and uneven birth volumes, hospital financial instability, rural geography, and recent loss of birthing services. Importantly, closure of a birthing unit can also destabilize prenatal, postpartum, newborn, lactation, and other related services in a community.

Priorities. The overarching priority is to protect access, quality, affordability, and long-term sustainability while ensuring pregnant and postpartum people can receive the right care, at the right time, as close to home as possible. The discussion emphasized looking beyond hospital-based delivery alone and considering the full continuum from prenatal care through birth and postpartum, including community-based providers and supports. A statewide model does not need to be identical in every region; different areas may require different configurations while maintaining equitable access and quality.

Charge of the Task Force. The Task Force was asked to approach the work as though Vermont were designing its maternal care system today “from scratch,” taking into account geography, workforce, birth volumes, technology, community resources, financing, and existing strengths. The State’s role is primarily to convene, provide data and resources, help remove barriers, and create opportunities for collaboration, rather than prescribe the final model. The Task Force is expected to identify and develop actionable solutions through smaller workgroups, informed by statewide data, clinical expertise, community perspectives, and patient/family experience.

Major Themes from the Discussion

1. Access and regionalization need to be redesigned together

Participants repeatedly returned to the tension between maintaining care close to home and creating a system that uses limited resources more efficiently. Vermont's historically local approach has important strengths, but participants described an unintended consequence: services and supports can vary considerably depending on where someone lives, creating fragmentation and inequity. Participants were interested in regionalization, but not if it simply means consolidating births farther away from families.

The discussion suggested a broader definition of regionalization: determining which services truly need to be local, which can be shared regionally, and which can be centralized statewide, while ensuring that every region has access to a comprehensive continuum of maternity services. Transportation and interfacility transfer capacity were identified as prerequisites for any model that asks patients to travel farther for some services. The chat also raised interest in better understanding out-of-state births, where Vermonters deliver, why they leave, and whether some births could be retained in-state. Cross-state partnerships and regional collaboration with neighboring states were also suggested.

A key principle was that people should be supported in the appropriate care setting without unnecessarily long travel, particularly for birth. Participants were clear that emergency departments should not become the default substitute for planned birthing services.

2. Workforce is a fundamental structural challenge

Workforce emerged as one of the clearest priorities. Participants discussed the expense and inefficiency of maintaining continuous OB call coverage at multiple low-volume sites and the difficulty individual organizations face recruiting and retaining enough clinicians and nurses.

Potential strategies included:

- Investing in family medicine with obstetrics as a way to simultaneously strengthen primary care and obstetric capacity.
- Developing regional or shared staffing/call models rather than expecting every hospital to independently maintain complete staffing.
- Reducing barriers to clinicians working at multiple hospitals, particularly credentialing and privileging.
- Exploring career models that allow clinicians to practice across multiple hospitals or regions.
- Mapping the existing workforce, including location, discipline, age, vacancies, recruitment times, retention, locum dependence, and nursing traveler use.
- Looking at workforce capacity structurally rather than hospital-by-hospital.

Participants emphasized that no single hospital or health system currently has the capacity to solve the statewide staffing problem alone.

Participants also indicated that many family medicine physicians are trained and interested in OB care but are constrained by current staffing and hiring models. Participants also suggested a statewide per diem provider pool and emphasized including pediatricians in workforce planning.

Workforce development was also raised as a pipeline issue, particularly the need for sustainable L&D student clinical experiences, onboarding, and specialty training.

3. Telehealth has potential, but the right use cases need to be defined

Telehealth was viewed as an important tool for reducing variability in access to specialty expertise, but participants distinguished between planned consultation and emergency response.

Current phone-based specialist consultation was described as highly valuable in emergency settings, where clinicians may not have time or available staff to establish a video connection. Participants noted that telehealth may be especially promising for preventive care, specialty consultation, ongoing condition management, and avoiding unnecessary transfers, rather than assuming video telehealth is always the best solution during an acute emergency.

Participants also raised the possibility of standardizing infrastructure so that telehealth does not require ad hoc setup or incompatible systems. Existing statewide consultation models—such as the perinatal psychiatric consultation service—were highlighted as examples of how a small number of specialized providers could serve clinicians statewide. Similar models could potentially support areas such as diabetes management or other specialized perinatal care.

The broader question is therefore not simply “Should Vermont use telehealth?” but which maternal-care functions can telehealth reliably support, what infrastructure is needed, and what statewide or regional model can sustain that capacity.

Conversation reinforced that emergency telehealth must be designed in advance with adequate equipment and workflows, particularly because OB and neonatal consultation may be needed simultaneously. Examples from other states included tele-NICU response systems, tele-rounding, remote postpartum blood-pressure monitoring, specialty telehealth, and standardized antenatal education.

4. Vermont needs a more connected statewide care infrastructure

Several operational barriers reflect a system in which hospitals and providers function as separate organizations rather than components of a connected maternity-care network.

Participants highlighted the need for:

- Shared or interoperable electronic health record infrastructure so information follows patients across organizations.
- More reliable interfacility transfer processes.
- Better coordination of maternal and neonatal transfers.
- Technology and workflow infrastructure that supports specialists working across multiple community hospitals.
- Transportation capacity that matches the expectations of a regionalized system.

These were described not as isolated technology projects but as core components of a more connected statewide healthcare system.

Comments from the chat emphasized that multiple EHR systems create barriers not only to information sharing, but also to moving staff between facilities because each system has different documentation and workflow requirements.

5. Maternal care needs to extend beyond the walls of the hospital

Participants strongly emphasized that maternity care cannot be redesigned only around labor and delivery. Prenatal and postpartum services, community mental health, home visiting, primary care, doulas, midwives, lactation, social supports, and other community-based services are essential parts of the system.

There was particular interest in partnerships between hospitals and community-based practices, including embedding or formally connecting community providers with hospital care and strengthening handoffs before hospitalization and after discharge.

This also raises a financing consideration: if the future system relies more heavily on community-based providers, payment and reimbursement models will need to support those providers rather than shifting responsibilities without corresponding resources.

The chat reinforced the importance of home visiting, doulas, recovery supports, mental health agencies, lactation, prenatal education, and stronger connections between maternity and primary care. Participants also suggested including the Department of Mental Health in future discussions.

6. The system needs new operational models, not simply additional reimbursement

Financing was acknowledged as essential, but participants repeatedly emphasized that reimbursement alone will not resolve the underlying problems. Workforce scarcity, low volumes, duplicative infrastructure, geography, and fragmented operations require structural redesign alongside financing reform.

Participants were interested in examining rural maternity models used elsewhere, including shared regional staffing, telehealth-supported specialty care, community-based maternity care, alternative birth settings, and other approaches. The group emphasized learning from other states while recognizing that models would need to be adapted to Vermont's geography and health system.

The chat also noted that Medicaid and other reimbursement structures should be examined to ensure OB and women's health services, as well as community-based services, are financially supported within any redesigned model.

7. Preserve what is working while redesigning what is not

The PQC presentation provided an important counterbalance to the conversation about instability: quality was not framed as the primary problem to solve. Vermont already has substantial clinical expertise, longstanding quality-improvement infrastructure, strong relationships between community hospitals and specialty providers, emergency consultation capacity, simulation and training, and high engagement in quality improvement.

The redesign therefore should not assume the current system is failing clinically. Rather, the challenge is to preserve Vermont's existing quality and local relationships while developing a more sustainable, equitable, and connected structure.

Priorities Communicated by Participants

Across the discussion, participants appeared to prioritize several principles for future work:

1. Protect geographic access while maintaining quality and safety. Regionalization should not inadvertently create long travel times or make services substantially less accessible for rural families.
2. Treat workforce as a statewide resource. Move away from every organization independently solving recruitment, credentialing, call, and staffing challenges.
3. Reduce geographic variability in services. Local flexibility should remain, but a person's ZIP code should not determine whether foundational maternity and postpartum supports are available.
4. Develop a connected continuum rather than focusing narrowly on delivery. Prenatal, birth, postpartum, newborn, behavioral health, and community supports should operate as parts of the same system.
5. Use technology strategically. Telehealth, shared EHRs, and other infrastructure should solve specific access and workforce problems rather than being treated as stand-alone innovations.
6. Build from existing strengths and infrastructure. The PQC, regional collaboratives, existing specialty consultation models, hospital-community partnerships, and other established forums should be leveraged rather than automatically creating new structures.

7. Use data to design the future model. Participants specifically requested better workforce mapping, recruitment/retention data, geographic service mapping, birth-location data, travel patterns, and information about successful rural operational models.
8. Move toward implementation rather than continuing indefinite planning. The meeting conveyed urgency and interest in identifying things Vermont can begin building now, particularly where Rural Health Transformation resources can support new capabilities and partnerships.

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Regionalization may be better treated as a cross-cutting design question rather than a stand-alone workgroup. One participant specifically noted that decisions about what services occur where will naturally emerge from workforce, operational-model, technology, and financing discussions.

Engagement in the chat raised several concrete questions for future work:

- Why do Vermonters give birth out of state, where do they go, and which of those births might reasonably be retained in Vermont?
- What services must exist locally, which can be regionalized, and which could be delivered through statewide specialty hubs or telehealth?
- What workforce configuration would make OB practice sustainable and attractive over the next 10–20 years?
- How can Vermont better integrate family medicine with OB and develop shared statewide staffing or per diem models?
- What clinical training and onboarding infrastructure is needed to build the next generation of OB, nursing, pediatric, and community-based workforce?
- Which maternity services could be standardized statewide, such as prenatal education, remote monitoring, or specialty consultation?
- What technology, EHR, transfer, credentialing, and licensure infrastructure would be required for clinicians to function as a regional or statewide workforce?
- How should payment models support hospital, primary care, and community-based maternity services?
- What are the broader community and demographic consequences of reduced maternity access?

Finally, participants recommended using existing meetings, networks, and structures wherever possible rather than automatically establishing additional workgroups. The conveners explicitly invited participants to identify existing forums where these conversations could be operationalized.

Overall Synthesis

The strongest message from the meeting was that Vermont's challenge is not simply how to keep every existing maternity service operating exactly as it does today. The Task Force is being asked to determine how the state can reorganize its existing clinical expertise, workforce, infrastructure, community supports, technology, and financing into a more coordinated statewide system. The desired endpoint is a model that can vary by region while still ensuring that families have reliable access to high-quality care across the prenatal-to-postpartum continuum, and that hospitals and providers no longer have to solve statewide structural problems independently.

Attendance: Present for 9/24/26 Meeting

Organization	Attendee
Agency of Human Services / Blueprint for Health	Julie Parker

Organization	Attendee
Agency of Human Services / Care Transformation	Katie Carrell
Agency of Human Services / Care Transformation	Erin Just
Agency of Human Services / Care Transformation	Craig Jones
Agency of Human Services / Health Reform	Julio Cespedes
American Nurses Association—Vermont	Betsy Hassan
Association of Women's Health, Obstetric and Neonatal Nurses	Kayla Panko
BiState Primary Care Association	Kristen Bigelow
BiState Primary Care Association	Mary Kate Mohlman
Blue Cross / Blue Shield	Tom Weigel
Blue Cross / Blue Shield	Lou McLaren
Brattleboro Memorial Hospital	Tony Blofson
Brattleboro Memorial Hospital	Corina Tenant
Central Vermont Medical Center	Terri Lynn Graham
Doula Association of Vermont	Maria Rossi
Gifford Medical Center	Sara A. Simeone
Gifford Medical Center	Michael Costa
Green Mountain Birth Center	Lindsay Lachant
North Country Hospital	Tracey Paul
North Country Hospital	Denise Carter
North Country Hospital	Deb Beauchesne
Northeastern Vermont Regional Hospital	Laura Newell
Northeastern Vermont Regional Hospital	Aimee Carew-Lyons
Northwestern Medical Center	Jonathan Billings
NYU Grossman School of Medicine	Renata Howland
Rutland Regional Medical Center	Sarah Decker
Rutland Regional Medical Center	Elizabeth Kyhill
Southeastern Vermont Medical Center	James Trimarchi
Southeastern Vermont Medical Center	Mindy Dame
Southeastern Vermont Medical Center	Kimberley Sampson
UVM / Dept of Obstetrics, Gynecology & Reproductive Sciences	Carole McBride
UVM Health	Julie Tromblee
UVM Health	Deirdre O'Reilly
Vermont Child Health Improvement Program	Breena Holmes
Vermont Child Health Improvement Program	Courtenay Devlin
Vermont Child Health Improvement Program	Jin Li Chan
Vermont Child Health Improvement Program	Julie Parent
Vermont Child Health Improvement Program	Sara Forward
VCHIP / Patient and Family Advisory Committee	Jin Li
Vermont Department of Health	Rick Hildebrant
Vermont Department of Health	Ilisa Stalberg
Vermont Department of Health	Katy Leffel
Vermont Department of Health	Shayla Livingston

Organization	Attendee
Vermont Department of Health	Michael Flaherty
Vermont Department of Health	Emily Smith
Vermont Medical Society	Lexi Krupp
Vermont Medical Society / AAP / AAFP	Stephanie Winters