NYS ASSOCIATION FOR RURAL HEALTH

ISSUE BRIEF

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Rewriting the Birth Plan: The Role of the Emergency Department and EMS After Rural Hospital Obstetric Unit Closures

Introduction

Labor by nature is unpredictable; even the most cohesive birth plans are subject to change without warning. Having access to appropriate and high-quality care is critical to good outcomes when even the best laid plans go awry.

Nationwide, over 50% of rural hospitals have faced obstetric unit closures since 2000, leaving pregnant patients reliant on the Emergency Department for many of their most emergent obstetric needs. The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to provide a medical screening examination and stabilizing treatment to any patient, including pregnant people, who presents at the emergency department with an emergency medical condition.[1] With this changing landscape, EDs may be the only place for laboring patients to have a chance at a safe birth; however many rural EDs are not designed to be equipped to handle complex prenatal, antenatal and perinatal conditions. To address this issue we recommend instituting an Obstetrics Ready ED certification, modeled from American College of Obstetrics and Gynecology (ACOG) obstetric emergencies in non-obstetric settings guidelines. Such a program in NYS would include training and reimbursement incentives for rural hospitals to increase their capacity for high quality obstetric emergency care in their EDs, much like the Geriatric Emergency Department Accreditation program developed by the American College of Emergency Physicians (ACEP).

Statement of the issue

In NYS, over the past 15 years more than 24 hospitals have closed their maternity wards, shifting the management of emergent and time-sensitive prepartum, antepartum, and postpartum needs to local emergency departments rather than specialized obstetric units.[2] To effectively manage the growing need for emergency department-based obstetric care in rural areas, rural ED providers need increased access to advanced obstetric care training, simulation opportunities, and EMS transport coordination.

Analysis of data about the issue

In the US, 54% of rural counties do not have hospital-based obstetric units. In a study of 4.9 million births in all 1086 rural counties in the US between 2004-2014, the loss of hospital-based obstetric services was associated with increased numbers of out-of-hospital and preterm births, and births in hospitals without obstetric units, when compared with counties with continual services.[4]

A survey of rural hospitals that did not offer obstetric services revealed that 28% reported having emergency room births in the past year, 32% experienced unanticipated adverse birth outcomes, and 22% faced delays in urgent transport for pregnant patients.[5] Fewer

than one-fifth of these hospitals had the capacity to perform surgery (16%), remove retained products of delivery (17%), and only 18% had a policy for emergency cesarean sections.[5] These data make clear that, even in counties without dedicated labor and delivery services, emergency departments are already caring for birthing patients—often without the necessary capabilities to manage obstetric emergencies safely.

A CDC maternal mortality review board found that over half of maternal deaths occur postpartum with the following breakdown: 1-6 days postpartum (19 percent), 7-42 days postpartum (21 percent), and 43-365 days postpartum (12 percent).[7] In the antenatal period, birthing parents are likely to seek care at their nearest hospital regardless of the presence or absence of Labor and Delivery services, further reinforcing the need for better rural ED preparedness for post-partum emergencies.

National, State, and Local Policies

In reviewing potential avenues to support an Obstetrics Ready ED accreditation program, the following were found to be relevant national and state-level policies and funding initiatives that address maternal health, obstetric readiness, and rural hospital capacity.

1. **National**
    a. Rural Maternity and Obstetrics Management Strategies (RMOMS) Program
        i. This HRSA program provides funding and technical assistance to grantees to collect data on rural hospital obstetric services and develop networks to coordinate the continuum of care throughout pregnancy and in the postpartum period.[10]
    b. Rural Obstetrics Readiness Act: S.380 — 119th Congress (2025-2026) Sen. Hassan, Margaret Wood [D-NH] (Introduced 02/04/2025)[9]
        i. This act would require HRSA to create a program for providing grants to certain hospitals or consortiums that include hospitals in rural areas or areas with maternal health care professional shortages for training, developing a workforce, and purchasing equipment relating to obstetric emergencies. In addition, the bill would require HRSA's Alliance for Innovation on Maternal Health Capacity program to provide grants for training on emergency obstetric services for practitioners in rural health care facilities without dedicated obstetric units. HRSA must also establish a pilot program to provide grants to government entities for developing or improving telehealth access programs to support urgent maternal health care in rural facilities without dedicated obstetric units.
2. **New York State**
    a. S7702 (companion A08207) Title: Establishes a state maternal health standards workgroup.[11]
        i. This statute authorizes the Department of Health to convene a multi-stakeholder workgroup to develop standards for maternal and birthing care focused on quality, cultural competency, patient support, and care consistency and to publish recommendations within a year. The bill

has passed both chambers and has returned to the Senate for final concurrence.

b. NYS Budgets: Safety Net Program 2026
    i. The current budget allocates $305 million to support investment in hospitals, including increases to hospital outpatient rates, support for new investments in hospital quality, continued support for the hospital maternal quality programs, and additional assistance to critical access and sole community hospitals.[12]
    ii. State level funding priority area in maternal health- provides an avenue to advocate for funding for the development and implementation of an Obstetrics Ready ED accreditation program.

Accreditation-Based Model: A Possible Solution

As we seek to encourage ED preparedness for obstetric emergencies, an existing accreditation-based program offers a useful model: the Geriatric Emergency Department Accreditation program. Through the American College of Emergency Physicians (ACEP), NYS hospitals have the opportunity to participate in a voluntary Geriatric Emergency Department Accreditation program which provides standards for three levels of certification (Bronze, Silver, Gold). The voluntary standards certify EDs that have instituted geriatric-specific initiatives to improve the care of older adults through screening guidelines, staff education, and enhancements to the physical ED environment.[6] This accreditation incentivizes hospitals to make improvements to enhance their reputation for quality care through measurable outcomes, though the program does not currently provide any supplemental reimbursement through Medicaid.

A similar accreditation for an Obstetrics Ready ED, with provisional reimbursement through NYS Medicaid for perinatal services, could increase rural hospitals without dedicated obstetrics units to develop and sustain the ability to provide high quality acute care in obstetric emergencies. A current ACOG initiative for the identification and management of obstetric emergencies in non-obstetric settings could provide the framework for standards of accreditation. ACOG's initiative provides the following screening algorithms and guidelines:[8]

- Emergency Departments- **Algorithms**
    - Cardiovascular Disease (CVD) in Pregnancy and Postpartum Algorithm
    - Acute Hypertension in Pregnancy and Postpartum Algorithm
    - Eclampsia Algorithm
- EMS- **Model Guidelines**
    - Postpartum Hemorrhage
    - Elevated Blood Pressure in Pregnancy and Postpartum
    - Eclampsia

The Alliance for Innovation on Maternal Health (AIM) is a federally supported, national quality improvement initiative led by ACOG in partnership with HRSA. AIM develops and disseminates standardized "safety bundles" and toolkits that provide evidence-based best practices to improve maternal outcomes and reduce preventable deaths. AIM has identified priority areas for obstetric emergency readiness in their toolkit. Focus areas include ED readiness, simulations, EMS transport coordination. Based on this toolkit, NYS specific recommendations for the development of an Obstetrics Ready ED include:

1. Emergency Department Readiness
    a. Training in Basic Life Support in Obstetrics (BLSO), Advanced Life Support in Obstetrics (ALSO), and Neonatal Resuscitation Program (NRP) for ED providers (nursing staff, midlevel providers, physicians).
2. Simulation
    a. In a study of ED providers surveyed across rural Minnesota; 79.7% indicated they need additional training or resources to handle emergency obstetric situations. 36% cited simulation training as an effective, needed resource to be better prepared in their hospitals for obstetric emergencies.[7]
    b. In NYS, this can be addressed through the creation of simulation training collaborative networks to connect rural critical access hospitals to larger, resource rich medical centers with dedicated simulation centers and staff, such as SUNY Upstate Medical University.
3. EMS
    a. 4% of birthing patients in NYS live over 30 minutes from a hospital with the majority of those patients living in rural counties.[2] This presents as a critical issue for the acuity of obstetric emergencies as EMS transport is a crucial link between patients and timely care.
    b. EMS transport services in NYS would benefit from the creation of a care process model to recognize obstetric patients in need of safe stabilization and transfer to a higher level of care.

NRHA, NYSARH Positions

NRHA has an advocacy priority area for maternal health in light of the rise in obstetric unit closures across the US with support for various congressional and HRSA initiatives.[13] 2024 NYSARH Policy Fellows Vuong Hoang, BS and Elizabeth Urbanski-Farrell, MBA, MS highlighted the perinatal health care crisis in rural NYS, noting the need for increased data analysis in the perinatal outcomes of rural birthing patients.[14]

Summary

Pregnancy, by nature, is unpredictable and complex and can be dangerous to pregnant patients and babies. Even if carefully established care pathways prescribe that pregnant patients who live in rural areas receive care at more distant birthing hospitals, these patients will inevitably seek local care for emergent obstetric needs as they arise. Obstetric emergencies can arise at any time: during the earliest pregnancy months, through the anticipated due date, and

throughout the postpartum period. As rural hospitals across NYS continue to lose dedicated obstetric units, birthing patients will present with increased frequency and acuity to rural EDs. ED and EMS providers need the training and support to recognize obstetric emergencies and provide the highest quality care to all obstetric patients regardless of location in NYS.

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Appendix A - Abbreviations and Acronyms

ACEP	American College of Emergency Physicians
ACOG	American College of Obstetrics and Gynecology
AIM	Alliance for Innovation on Maternal Health
ED	Emergency Department
FY	Fiscal Year
HRSA	Health Resources and Services Administration
NY	New York
NRHA	National Rural Health Association
NYSARH	New York State Association for Rural Health
NYS	New York State