NYS ASSOCIATION FOR RURAL HEALTH

POLICY BRIEF

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SUMMARY

- **Purpose:** To address the crisis of rural obstetric unit closures by ensuring New York Emergency Departments and Emergency Medical Services can provide safe, high-quality obstetric emergency care.
- **Issue:** Over half of rural counties nationwide—and 24 hospitals in NYS—have closed obstetric units, leaving EDs unequipped for obstetric emergencies.
- **Key Points:**
  - Closures drive rising maternal morbidity and mortality.
  - EDs lack capacity for complex interventions, requiring EMS stabilization and transfers.
  - Federal and state initiatives already support closing maternal care gaps.
- **Recommendation:** Establish an **Obstetrics Ready ED accreditation program** in NYS, modeled on existing accreditation frameworks, with integrated training, simulation, EMS coordination, and funding.

ISSUE

As rural hospitals across New York State (NYS) continue to lose dedicated obstetric units, birthing patients will present with increased frequency and acuity to rural Emergency Departments (EDs). ED and Emergency Medical System (EMS) providers need the training and support to provide the highest quality care to all obstetric patients, regardless of location in NYS.

BACKGROUND

Over the past 15 years, more than 24 obstetric units in New York State hospitals have closed, leaving many rural communities without dedicated obstetric care.[1] Nationally, 54% of rural counties lack hospital-based obstetric units, contributing to higher rates of preterm and out-of-hospital births[2]. While the Emergency Medical Treatment and Labor Act (EMTALA) requires EDs to stabilize laboring patients, many rural EDs lack the specialized obstetric training, advanced procedures, and consistent coordination with EMS required to ensure safe birthing outcomes.

CURRENT STATUS

Rural hospitals without obstetric units face severe capacity limitations with nearly one-third of rural hospitals nationally reporting unanticipated adverse birth outcomes and delays in urgent transfer.[3]

Stakeholders include the New York State Department of Health, rural critical access hospitals, EMS providers, the American College of Obstetricians and Gynecologists (ACOG), the American College of Emergency Physicians (ACEP).

CONSIDERATIONS

Loss of rural obstetric services correlates with worse birth outcomes, including increased maternal morbidity and mortality. Providers themselves recognize the gap: nearly 80% of rural ED clinicians report needing additional obstetric training, and more than one-third identify simulation as an actionable resource.

Public health data underscore the urgency of this issue. More than half of maternal deaths occur postpartum, a period when many laboring patients rely on local EDs rather than specialized centers. Community advocates and national organizations such as the NRHA and NYSARH have prioritized maternal health as a policy focus, while the public has expressed growing concern over maternal mortality disparities in rural and underserved regions.

POLICY LEVERS:

Existing Regulatory Levers & Impact

- ACOG Obstetric Emergencies in Non Obstetric Settings Initiative: Provides standards for recognizing and managing obstetric emergencies in non-obstetric settings, addressing a critical gap.
- ACEP Geriatric ED Accreditation: NY hospitals may earn Bronze, Silver, or Gold certification for implementing geriatric-specific initiatives (screening, staff training, ED environment upgrades). While not Medicaid-reimbursed, accreditation improves quality and reputation through measurable outcomes.

Potential Solution: A statewide **Obstetrics Ready ED accreditation program,** analogous to ACEP's Geriatric ED accreditation, could be created. Standards could include incorporating mandatory training, simulation collaboratives, and EMS process models. This leverages existing frameworks (GEDA, AIM, ACOG) and aligns with federal/state maternal health priorities.

Financial Impact:

- Training and simulation require upfront state investment but prevent costly maternal morbidity/mortality and reduce downstream health care expenditures.
- Medicaid reimbursement incentives can partially offset ED and EMS costs, supporting program sustainability.

POLICY RECOMMENDATIONS

a. NYSARH recommends a coordinated, actionable approach:
    i. Create an Obstetrics Ready ED Accreditation Program in New York State modeled with AIM Obstetric Emergency Readiness guidelines, with tiered certification and reimbursement incentives. Components of this program would include
        1. ED Provider Training through Basic and Advanced Life Support in Obstetrics (BLSO, ALSO) and Neonatal Resuscitation Programs (NRP).
        2. Development of Regional Simulation Networks linking rural hospitals to academic simulation centers (e.g., SUNY Upstate).

3. Strengthen EMS Protocols to ensure timely recognition, stabilization, and safe transfer of obstetric patients.
4. Integrate Federal and State Funding by aligning the Rural Obstetrics Readiness Act, RMOMS, and NYS Safety Net funds to sustain readiness initiatives.

Bottom Line: Obstetric emergencies cannot wait. As rural obstetric units continue to close, EDs and EMS must be prepared to serve as critical safety nets. NYS has the opportunity to lead nationally by implementing an Obstetrics Ready ED program protecting laboring patients, babies, and communities.

8. ATTACHMENTS

- Issue Brief

9. REFERENCES

1. March of Dimes. Maternity Care Deserts Report: New York. Published 2023. Accessed May 20, 2025. https://www.marchofdimes.org/peristats/reports/new-york/maternity-care-deserts
2. Kozhimannil KB, Hung P, Henning-Smith C, Casey MM, Prasad S. Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States. JAMA. 2018;319(12):1239–1247. doi:10.1001/jama.2018.1830
3. Kozhimannil KB, Interrante JD, Tuttle MS, Gilbertson M, Wharton KD. Local Capacity for Emergency Births in Rural Hospitals Without Obstetrics Services. J Rural Health. 2021;37(2):385-393. doi:10.1111/jrh.12539