The New York Times https://www.nytimes.com/2023/02/26/health/rural-hospitals-pregnancy-childbirth.html

Rural Hospitals Are Shuttering Their Maternity Units

Citing costs, many hospitals are closing labor and delivery wards, expanding so-called maternity care deserts.

By Roni Caryn Rabin

Feb. 26, 2023 7 MIN READ

TOPPENISH, Wash. — Three days before Christmas, the only hospital in this remote city on the Yakama Indian Reservation abruptly closed its maternity unit without consulting the community, the doctors who delivered babies there or even its own board.

At least 35 women were planning to give birth at Astria Toppenish Hospital in January alone, and the sudden closure — which violated the hospital's commitment to the state to maintain critical services in this rural area — threw their plans into disarray.

Victoria Barajas, 34, expecting her first child, scrambled to find a new doctor before her due date, Jan. 7. Jazzmin Maldonado, a 29-year-old schoolteacher due to give birth soon, wondered how she could make it to a distant hospital in time.

After an earlier miscarriage, doctors had placed a stitch in her cervix to prevent a second one, and the stitch would have to come out fast once labor began.

Astria Toppenish Hospital is one of a string of providers across the nation that have stopped providing labor and delivery care in an effort to control costs — even as maternal deaths increase at alarming rates in the United States, and as more women develop complications that can be life-threatening.

The closure in Toppenish mirrors national trends as financially strained hospitals come to a harsh conclusion: Childbirth doesn't pay, at least not in low-income communities.

From 2015 to 2019, there were at least 89 obstetric unit closures in rural hospitals across the country. By 2020, about half of rural community hospitals did not provide obstetrics care, according to the American Hospital Association.

In the past year, the closures appear to have accelerated, as hospitals from Maine to California have jettisoned maternity units, mostly in rural areas where the population has dwindled and the number of births has declined.

A study of hospital administrators carried out before the pandemic found that 20 percent of them said they did not expect to be providing labor and delivery services in five years' time.

Women in rural areas face a higher risk of pregnancy-related complications, according to a study by the Commonwealth Fund. Those living in so-called maternity care deserts are three times as likely to die during pregnancy and the critical year afterward as those who are closer to care, according to a study of mothers in Louisiana.

Ambulances aren't reliable in many rural areas like the Yakama reservation, which spreads over a million acres. There aren't many emergency vehicles, and the vast distances make for long waits. In the fall and winter, dense fog often blankets the roads, making driving treacherous.

Astria Toppenish Hospital in Washington is one of several providers across the United States that have stopped providing labor and delivery care to control costs as rates of maternal deaths increase at alarming rates. Ruth Fremson/The New York Times

Adriana Guel, 35, a mother of three, survived a rare life-threatening complication called an amniotic embolism during one of her deliveries and credited the hospital with saving her life. Ruth Fremson/The New York Times

In Toppenish, the frustration and fear erupted at a recent city council meeting, which drew such a large crowd that it spilled into the hallway outside the chambers. Astria, a health care system based in Washington State, had committed to keeping certain services, including labor and delivery, available for at least a decade after acquiring the hospital, residents noted.

Now the hospital said it could not afford to do so, and the state has taken no action. “There will be lives lost — people need to know that,” Leslie Swan, a Native American doula, said.

At the meeting and in interviews, many women said the doctors and labor and delivery nurses at Astria Toppenish Hospital had saved their lives. Adriana Guel, 35, a mother of three, survived a rare life-threatening complication called an amniotic embolism during one of her deliveries and credited the hospital with saving her life.

The mayor, Elpidia Saavedra, 47, had an obstetric emergency 10 years ago when an ectopic pregnancy ruptured. Semone Dittentholer, 39, said she almost died as a teenager, when she miscarried and lost massive amounts of blood.

“It’s a lifeline that we’ve had, and now that part of that lifeline is getting cut down,” said Ms. Dittentholer, who works on the reservation at the Ttawaxt Birth Justice Center, which offers support to pregnant women and to new mothers and has been providing space for a local obstetrician to see women once a week in order to ease access to care.

“It’s just another reminder of how scary it can be out here.”

A Downward Spiral

The United States is already the most dangerous developed country in the world for women to give birth, with a maternal mortality rate of 23.8 per 100,000 live births — or more than one death for every 5,000 live deliveries.

Recent figures show that the problems are particularly acute in minority communities and especially among Native American women, whose risk of dying of pregnancy-related complications is three times as high as that of white women. Their babies are almost twice as likely to die during the first year of life as white babies.

Women of color are more likely to live in maternity care deserts or in communities with limited access to care. According to the March of Dimes, the maternal health nonprofit, seven million women of childbearing age reside in counties where there is no hospital-based obstetric care, no birthing center, no obstetrician-gynecologist and no certified nurse midwife, or where those services are at least a 30-minute drive away.

The closure of an obstetrics unit often begins a downward health spiral in remote communities. Without ready access to obstetricians, prenatal care and critical postpartum checkups, risky complications become more likely.

But running a labor and delivery unit is expensive, said Katy Kozhimannil, director of the University of Minnesota Rural Health Research Center. The facility must be staffed 24 hours a day, seven days a week, with a team of specialized nurses and backup services, including pediatrics and anesthesia.

Elpidia Saavedra, the mayor of Toppenish, had an obstetric emergency 10 years ago when an ectopic pregnancy ruptured. Ruth Fremson/The New York Times

Hills outside of Toppenish. Ambulances aren't reliable in many rural areas like the Yakama reservation, which spreads over a million acres. In the fall and winter, dense fog often blankets the roads, making driving treacherous. Ruth Fremson/The New York Times

"You have to be ready to have a baby any time," Dr. Kozhimannil said.

Staffing shortages have driven costs up, and hospitals have been forced to bring in contract nurses, who can cost more than three times as much as a staff nurse. Labor and delivery nurses are in high demand, and pay for them can be even higher.

A vast majority of pregnant patients at Astria Toppenish had insurance coverage, but mostly Medicaid, which pays hospitals far less than private insurance plans do. Half of pregnant women in the United States are on Medicaid, and it pays poorly in all states.

In Washington State, Medicaid would pay $6,344 for a childbirth, about one-third of the $18,193 paid by private plans, according to an analysis by the Health Care Cost Institute that compared traditional fee-for-service rates paid by Medicaid with those paid by private plans.

In wealthier communities, private insurance helps offset low Medicaid payments to hospitals. But in rural areas where poverty is more entrenched, there are too few privately insured patients.

"Toppenish is the canary in the coal mine," said Cassie Sauer, president and chief executive of the Washington State Hospital Association, noting that many hospitals serving low-income communities in the state are in similar financial straits.

The administrator of Astria Toppenish, Cathy Bambrick, said the hospital had no cash reserves and the labor and delivery unit lost $3.2 million last year after a temporary Washington State initiative that paid enhanced Medicaid rates came to an end.

The cost of nursing spiked as the hospital turned to contract nurses, she said.

There was no money in the budget to replace an infant security system last year when it failed, she said. Recently, the ultrasound machine stopped working, and because the hospital could not afford a new one, Ms. Bambrick paid $50,000 for a refurbished machine.

Although Astria Toppenish serves a low-income population, Ms. Bambrick said, it does not qualify for any of the myriad government programs that help fund rural health services and hospitals in the state.

"We fall through the cracks," Ms. Bambrick said.

Cultural Awareness

Astria Toppenish's patients are a particularly vulnerable population that includes a large community of farm workers who toil in the Yakima Valley vineyards, orchards and hops fields.

So many children come from low-income homes that local schools provide free lunch. Patients often struggle to come up with gas money to go to doctor's appointments. Chronic diseases that complicate pregnancy — like diabetes, heart disease and substance abuse — are common.

The Yakima Valley Farm Workers Clinic in Toppenish. Ruth Fremson/The New York Times

Dr. Jordann Loehr, an obstetrician who works at the Yakima Valley Farm Workers Clinic. “They are poor in spite of working hard,” she said of its patients. Ruth Fremson/The New York Times

“They are poor in spite of working hard,” said Dr. Jordann Loehr, an obstetrician who works at the Yakima Valley Farm Workers Clinic.

Many women opted to give birth at Astria Toppenish because of its reputation for respecting patients’ wishes and for cultural sensitivity — including a labor room for Native American women that faces east, an ancestral practice, and permission for as many family friends and “aunties” in the delivery room as the mother wanted.

The nurses did not rush women in labor, and the unit had a cesarean section rate of 17 percent (way below the national average of 32 percent). They taught first-time mothers about infant care and breastfeeding — but also about how to use a papoose board safely, and why mothers shouldn’t overbundle a newborn, a common practice.

Nurses at the hospital introduced new mothers to ideas that contravened long-held beliefs.

“Our population generally has the cultural understanding that you don’t hold newborns — it makes them needy,” said Angi Scott, a labor and delivery nurse. “We tell them, ‘No, you can’t spoil a newborn. Babies who are held more in the first year of life grow up to be more self-assured. It’s important to hold your baby.’”

Many residents fear the obstetrics closure is a prelude to the hospital closing its doors altogether in a repeat of what happened in 2019, when the Astria Health system declared bankruptcy and later closed the largest of its three hospitals, a 150-bed facility in Yakima. Astria had purchased the hospital just two years earlier.

For now, the four obstetricians in town — all women — are digging in. Dr. Loehr has led a community drive to reestablish a maternity unit by creating a public hospital district, a special entity that would be governed and funded locally with taxes or levies.

Dr. Anita Showalter, another obstetrician, recently delivered Ms. Barajas’s baby, but at an Astria hospital farther away. She already had suffered one miscarriage, and Dr. Showalter stayed with her through 37 hours of labor. Baby Dylan was born on Jan. 15 at 1:52 a.m. “My heart is full,” Ms. Barajas said in a text.

Shayla Owen, 35, who lives in Goldendale, went into labor on the day before Valentine’s Day, and her husband drove her 70 miles over a desolate mountain pass to a hospital in Yakima. They were almost out of gas by the time they got there.

Baby Isaiah weighed 8 pounds 3 ounces, after 10 hours of labor. Ms. Owen said she had made the right call when she decided against trying a home birth.

“I hemorrhaged after the delivery,” she said. “So I was glad I was at a hospital.”

Shayla Owen with her son Israel. She went into labor the day before Valentine’s Day and nearly ran out of gas being driven the 70 miles to a hospital to give birth to Israel’s brother, Isaiah. Ruth Fremson/The New York Times