Ellen DaCorte
Somesville, Maine

May 15, 2025

Dear Honorable Members of the Committee on Health Coverage, Insurance and Financial Services,

My name is Ellen DaCorte and I am writing to provide follow-up testimony after submitting my initial testimony and listening to others speak both in support of and opposition to LD 1578 on May 7th. As a clinical RN lead in a rural OB unit facing closure, I would like to offer a perspective on a point that often comes up in discussions about provider and clinician competence in rural health care settings causing a medical service to be removed—particularly in obstetrics.

There is a tendency to focus on volume as a substitute for competence, especially in statements suggesting that clinicians must attend a certain number of deliveries to remain skilled. But the truth is, there is no universally accepted number that defines competency. The thresholds often referenced are arbitrary and not grounded in consistent evidence. Health care professionals maintain their skills through ongoing training, certifications, simulations, tenured experience, and collaborative practice—not just through sheer volume.

Hospitals, like any organization, need to assess their strengths, weaknesses, opportunities, and threats when evaluating a health service. That's an essential part of maintaining quality care. But when a significant challenge is identified—especially one that threatens the future of a critical service—it feels like the right time to ask for expert help. Just like a patient with a complicated medical issue sees their primary care provider first and is then referred to a specialist for expert help, hospitals, too, need access to external expertise. I see DHHS acting like that specialist—providing insight, resources, and guidance to help an organization recover, stabilize, or adapt, if possible. If we don't call in our experts when we're struggling, we risk missing opportunities to strengthen services and protect access.

I appreciate the complexity of rural health care through my lived work experience for the past 30 years. I would like to share an article that recognizes that severe maternal morbidity (SMM) can be increased in lower volume rural hospitals JAMA Health Forum 2023. However, there is a solution to this finding cited- improve quality improvement strategies for lower volume facilities in rural communities. The recommendation is not to remove the service, but to strengthen it.

Here in Maine, we are fortunate to have a strong network of support for pregnant individuals and newborns who are dedicated to improving outcomes for perinatal patients and their newborns. From DHHS and the Maternal and Child Health Team at the Maine CDC to PCQ4ME, the Perinatal Outreach Program, the Doula Coalition of Maine, RMOMS, and TMaH—these programs and many others are working hard to strengthen our communities to improve health outcomes for families across the state.

In addition, The Perinatal and Neonatal Level of Care Guideline Level of Care Guideline helps make sure pregnant people and newborns in Maine get the right care, in the right place, at the right time. It lets low-risk patients stay in their own communities if they choose, while making sure those with higher risks get the extra support they need. This guideline helps reduce health problems for both parents and babies, and we're fortunate to have it guiding care in Maine.

It's also important to recognize that most of what we do in rural perinatal health care is managing "the normal". We are trained for emergencies, but we spend most of our time caring for patients who do not experience an emergency complication.

To provide clarity, here is an example about stabilization of the newborn at birth. Intubation is not part of standard care for a newborn. Resuscitation of the Newborn The evidence suggests that:

- 0.5% of newborns require cardiopulmonary resuscitation (i.e. intubation)

Nurses and providers in rural areas are trained and certified in programs like NRP (Neonatal Resuscitation Program) and are also taught to use adjunct airway devices like LMAs, which are within the scope of nursing practice and are often effective alternatives to intubation.

Competency in rural health care isn't just about volume—it's about preparation, teamwork, and support. And when services are at risk, rather than questioning the abilities of those at the bedside, we should be asking how we can support them with training, partnerships, and expert guidance to continue delivering safe, local care. That is why I believe LD 1578 would be helpful.

Thank you for the opportunity to provide additional testimony. I continue to urge the committee to vote "ought to pass" on LD 1578.

With great appreciation and respect,

Ellen DaCorte, RN