GROW-WI
GATHERING THE RURAL OB WORKFORCE IN WI

Project ECHO®

Gathering the **R**ural **O**B **W**orkforce in **WI**
GROW-WI ECHO Program

How to Join:
https://iecho.org/public/program/PRGM17425658124325CC96FHKX3

For attendance purposes, please text the code BONDUZ to 608-260-7097.

Session Date: July 22, 2025
Facilitator: Allegra Ponshock, MD

	Topic	**Presenter**
Case Presentation	Postpartum Hemorrhage Management	Caitlin Hill, MD FM OB, Gundersen La Crosse Family Medicine Residency Faculty
Educational Presentation	Vaginal Breech Delivery	Dennis Hartung, MD, FACOG OB-Gyn, Western Wisconsin Health, Baldwin, WI

Agenda:

7:30 – 7:35 AM – Welcome and Introductions
-Text-in your attendance, even if you do not plan to claim Continuing Education credits.

7:35 – 8:00 AM – Case Presentation

8:00 – 8:30 AM – Educational Presentation

Continuing Education Credits:
To claim CE credit, **you must complete the evaluation form after each session**.
ICEP will email you a link to the evaluation form after texting in for attendance.

Interprofessional
Continuing Education Partnership
UNIVERSITY OF WISCONSIN-MADISON

GROW-WI ECHO (Gathering the Rural OB Workforce in WI)
2025-2026
Vaginal Breech Delivery
July 22, 2025
Dennis Hartung, MD, FACOG; Caitlin Hill, MD

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
MD/DO, RN, APRN, Physician Assistants, Certified Nurse Midwives, Students

Objectives:
1. Define key criteria for selecting candidates for planned and unplanned vaginal breech deliveries.
2. Explain step-by-step maneuvers used in breech deliveries, including indications, techniques, and potential complications.
3. Apply emergency management strategies for complications such as head entrapment, cord prolapse, or arrest of descent, including use of available rural resources and when to escalate or transfer care.
4. Outline safety and medico-legal considerations specific to vaginal breech delivery in low-resource or rural environments.

Policy on Disclosure
It is the policy of the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP) to identify, mitigate and disclose all relevant financial relationships with ineligible companies* held by the speakers/presenters, authors, planners, and other persons who may influence the content of this accredited continuing education (CE). In addition, speakers, presenters, and authors must disclose any planned discussion of unlabeled/unapproved uses of drugs or devices during their presentation. For this accredited continuing education activity, all relevant financial relationships have been mitigated and detailed disclosures are listed below.

** **Ineligible companies** are those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The ACCME does not consider providers of clinical service directly to patients to be ineligible companies.*

Name	Role	Financial Relationship Disclosures	Discussion of unlabeled/unapproved uses of drugs/devices in presentation	COI completion date
Dennis Hartung, MD	Presenter	No relevant financial relationships with ineligible companies to disclose.	No	6/23/2025
Caitlin Hill, MD	Presenter	No relevant financial relationships with ineligible companies to disclose.	No	7/3/2025
Jillian Landeck, MD	RSS Chair	No relevant financial relationships with ineligible companies to disclose.	NA	3/25/2025
Jenny White	RSS Coordinator	No relevant financial relationships with ineligible companies to disclose.	NA	3/27/2025
Korina Bauer, RN, CPM, LM	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/25/2025
Bonnie Brown, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/8/2025
Jensena Carlson, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/27/2025
Lee Dresang, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/17/2025
Rachel Hartline, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/15/2025
Ryan Luellwitz, DO	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/26/2025
Rebecca Pfaff, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/6/2025
Allegra Ponshock, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/29/2025
Ryan Spencer, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/31/2025
Shannan Stephens, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/10/2025

Accreditation Statement

In support of improving patient care, the University of Wisconsin–Madison ICEP is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

Credit Designation Statements

The University of Wisconsin-Madison ICEP designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1.0 ANCC contact hour(s).

The University of Wisconsin–Madison ICEP, as a member of the University Professional & Continuing Education Association (UPCEA), authorizes this program for 0.1 CEUs or 1.0 hour.

Welcome!

We will get started shortly.

Feel free to share your name, specialty/role, and practice location in the chat.

You can log your attendance by texting the code BONDUZ to 608-260-7097.

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American Nurses Credentialing Center (ANCC)

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1 ANCC contact hour.

Continuing Education Units

The University of Wisconsin–Madison ICEP, as a member of the University Professional & Continuing Education Association (UPCEA), authorizes this program for 0.1 continuing education units (CEUs) or 1 hour.

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Disclosures

Policy on Faculty and Sponsor Disclosure

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- The planning committee has no conflicts of interest to disclose.

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Attendance

- For attendance purposes please text the code BONDUZ to 608-260-7097
- Please text for attendance, **even if you are *not* claiming** continuing education (CE) credit.
- Email Jenny for instructions on creating ICEP account for attendance and CE.

Continuing Ed Credit

To receive continuing education credit:

1. Log your attendance (as above)
   - Create an ICEP account if you don't already have one.

2. Fill out the session evaluation form to receive credit – **REQUIRED for credit.**
   - A link to the evaluation will be sent after you text the code.

**Continuing Education Units with the Midwifery Education Accreditation Council are coming!

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Planning Team

Korina Bauer, RN, CPM, LM – WI Guild of Midwives, Iola, WI

Bonnie Brown, MD – UW DFMCH

Jensena Carlson, MD – UW DFMCH

Lee Dresang, MD – UW DFMCH

Rachel Hartline, MD* – Upland Hills Health, Dodgeville, WI

Jillian Landeck, MD* – UW DFMCH

Ryan Luellwitz, MD – UW OB GYN

Rebecca Pfaff, MD – Forks Community Hosp, Forks, WA

Allegra Ponshock, MD* – Mile Bluff Med Ctr, Mauston, WI

Ryan Spencer, MD – UW OB GYN

Shannan Stephens, MD – Gundersen OB GYN, La Crosse, WI

Jenny White* – UW DFMCH

* Core Facilitation Team

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Friendly Reminders

- Video appreciated
- Use chat function to ask questions or raise hand if able
- Mute microphone when not speaking
- Maintain confidentiality, no PHI
- Didactic will be recorded
- Mission is to empower those working in rural settings
- Our diversity of perspectives, specialties, practice scopes are our strength
- **"Coming together is a beginning. Keeping together is progress. Working together is success." -** Henry Ford

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Announcements

- Next Month:

Educational Topic: Critical Newborn Assessment

Katie Williams, MD, Center for Special Children, La Farge, WI

Case: Tiny Patient, Big Team: Coordinated Care in a Critical Access Hospital

Elizabeth Abbas, DO, FMOB, Founding Program Director - Developing Franklin Rural Family Medicine Residency Program

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Interested in sharing a case?

Email jennifer.white@fammed.wisc.edu

- Slide template shared, 10 min for details of case
- Priority to cases from rural and resource-limited settings
- No PHI
- Include on CV as a state presentation

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Rural OB Case Presentation

Caitlin Hill, MD
Family Medicine Faculty
FMOB fellowship trained
Emplify Health
7/21/2025

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Disclosures & Disclaimers

- No Disclosures

- PATIENT RELATIONSHIP DISCLAIMER
  - PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in a Project ECHO® setting.

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Disclosures & Disclaimers

- I trained in Baraboo from 2013-2016, with cesarean section training. This case is from my time in residency.
- Essential Health OB fellowship 2016-2017
- Practiced at an FQHC in Yakima, Washington with a rural residency
  - Surgical and High risk OB, inpatient medicine, clinic
- September 2024 I started at Emplify Health in La Crosse Serving as faculty in family medicine residency and the OB fellowship.

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Case Introduction

- 27 yo G1P0 at 37w3d GA admitted for induction of labor 2/2 preeclampsia with severe features (elevated BPs and headaches).
- Induction had been progressing slowly and then there was no progress so decision was made to move to cesarean section. I was called along with the c section team at this time (general surgeon, OR staff, CRNA).

- Primary question for discussion:Should there be restrictions for BMIs that deliver in rural settings?
- What do you do when management of a PPH has limited interventions?

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Obstetrical/Prenatal History:	Past Medical History:
G1P0 BMI 55 ASTHMA , mild persistent Remote hx of some elevated blood pressures Developed elevated BPs at 36 weeks but not severe range then developed symptoms	• Limited care prior to pregnancy

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Social History

- Lived with her parents
- Worked shift work at a local store
- No tobacco, alcohol, or other substance use

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Prenatal History

- Unplanned pregnancy, but excited
- FOB not involved, supported by parents
- Scans with normal growth, passed 1 hour GTT
- Was on ASA until 36 weeks due to Primigravida status, BMI, and remote hx of elevated blood pressures

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Exam:	Labs & Imaging:
BP: 145/90, HR 90, O2 99% RA, BMI 55 Heart: RRR, no murmurs Resp: CTAB FHT: 130s, moderate variability, no decelerations, accelerations present. Reassuring.	• Vertex • Hgb 11.9, Plt 220, AST and ALT and Ur PR: Cr ratio 0.35, A+, Ab neg. All others non-contributory

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Timeline/L&D details:

- Induction started around 24 hours prior to CS call.
- Around 8 PM the CS was called and the team was alerted to come in.
- Patient was continued on IV magnesium for Pree management
- CRNA unable to get spinal in- after 1 hour of attempting placement. Decision was made to move to CS under general anesthesia- team did ask if another CRNA could be called.
- Patient had one IV in the hand that was not really working and one large bore IV.
- Patient was prepped and then anesthesia started to intubate. While intubating she said she had secured it and to start- difficult intubation. Within 1-2 minutes it was clear patient was not correctly intubated- vitals became unstable. At that time we were down to the uterus so we continued the c/s to get baby out. Patient was bagged and masked while second CRNA was called.
- Once placenta was delivered uterine tone would not improve.
- Uterine incision was partially closed, but complete closure was delayed due to bleeding
  - What can we use for medications?
  - Do we have the right set up to help patient with a PPH?
- Called for ER doctor to come up to help to establish IV access as we felt like we were going to need blood
  - Multiple roles of RNs- Assisted with notifying team members needed, were more familiar with OB devices needed and could find for Surgery team, Assisted with IV placement attempts and ER doc needs, medications for hemorrhage.

Proposed diagnoses/management plan:

- Need more definitive airway and improved IV Access
  - Intubated by 2nd CRNA
  - Discussed IO vs Central line as we could not get another PIV
  - ER doctor placed central line
- We did not use methylergonovine due to Pree or carboprost due to lacking a definitive airway. Continued PIT. We did not do TXA (was not part of the algorithm at the time)
- We discussed Uterine balloon, but our surgeon had not placed one before, so asked for more guidance
- Called St. Mary's OB on call and they talked us through management and stabilization
- Uterine incision fully closed
- Uterine balloon for tapenade was placed- ***MAN would it have been awesome to have had a vacuum induced hemorrhage control device***
- Got 1 U of uncrossed blood and 2 U of matched blood
- Patient was taken out of OR and transferred to ICU to wait for transport as she needed higher staffing and level of care to support her than PACU middle of the night could offer
- Labs were monitored.
- Patient was able to discharge from St Mary's 4 days after admission.

Key learning points:

- ALSO/ ACLS key principals- Do we have the access we need
- Importance of clear communication
- USE of CUS words- had we all been vocal and used these then case may not have moved forward
- Discussion around safe BMI in hospital settings
- When do we call a second CRNA vs decide to do general
- Magnesium and general anesthesia and uterine atony risk
- Know process to access your tele health consults to assist in care

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Systems Issues/Area for Improvement:

OB committee worked on BMI restrictions for patients

BMI cut off now at this hospital

- 50 any time in pregnancy; 40 Anesthesia consult

- should this patient have been allowed to receive care and deliver locally.

- How do you maintain preparedness and skill when this patient presents in emergency and needs to be managed?

No need to delay closure of uterus when bleeding.

Hold mag if needed in cases like this or turn off if bleeding concerns.

Consider transition to alternative medications for pain control like propofol or midaz/ fentanyl to reduce impact of volatile anesthetics on uterine tone.

Protocol to have two large bore IVs when entering OR and not proceeding without

Standardized process for back up for CRNA/ use of alternative for difficult Airway

Confirm adequate airway prior to cut.

Interdisciplinary/interprofessional team successes or areas for improvement:

- We did a system debrief- CRNA staff, ER, OB, OR staff, general surgery, Consulting OB GYN team
  - New standards of care came out of this case
- We used good communication and exchange of options for caring for patient- what meds can we use, Uterine tamponade balloon, decision to call OB at St. Mary's

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Open Discussion

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