

# COLORADO RURAL PERINATAL CARE

## Hospital Labor and Delivery Case Study

### Summary of Interviews Integrated Across Five Rural Colorado Hospitals

Interviews conducted between September 2025 – March 2026

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## OVERVIEW OF FACILITIES AND CONTEXT

This summary synthesizes five rural Colorado hospital case studies examining the sustainability, closure, and persistence of labor and delivery (L&D) services in low-volume settings. These hospitals include critical access and small rural facilities serving geographically large and often isolated regions, with limited alternative access to maternity care. The interviews included both executive leadership from each of the hospitals and also a series of medical provider consultations from hospitals included in this study.

### 95 - 150 Births

Annual delivery range across studied rural facilities.

Annual deliveries across sites ranged from approximately 95 to 150 births, with several facilities consistently operating below 20-30 births per month—levels viewed by hospital leadership as unsustainable under current reimbursement and staffing models. Despite this, obstetric services were consistently described as essential, non-elective care requiring full readiness regardless of patient volume.

All hospitals operated within constrained workforce markets, Medicaid-heavy payer mixes, and increasingly fragile financial environments. Leaders emphasized that maintaining L&D services requires a continuous balancing of clinical readiness, workforce stability, and organizational solvency.

Providers emphasized that many rural obstetric closures are not inevitable outcomes of low volume alone, but are often shaped by leadership decisions, timing, and execution. Across interviews, clinicians described closures as potentially preventable with earlier intervention, stronger planning, and more effective alignment between leadership and care teams.



Community attachment to local maternity care was strong across all cases. In some instances, community response directly influenced or delayed closure decisions. However, these responses did not resolve the underlying structural challenges related to workforce availability and financial sustainability.

## WORKFORCE CONFIGURATION

Workforce fragility emerged as the most consistent and immediate driver of sustainability challenges across all five hospitals. Care models varied depending on local context and available clinicians, including OB/GYN-led models, family medicine physicians with obstetric training (FM-OB), and limited incorporation of midwifery. Regardless of model, all hospitals relied on lean clinical teams with little redundancy. Many facilities pursued FM-OB-based models to sustain services, often requiring full-scope practice, including cesarean delivery, without consistent OB/GYN backup.

*"Loss of even a single provider was sufficient to destabilize entire L&D programs."*

Loss of even a single provider was sufficient to destabilize entire L&D programs. Hospitals frequently relied on locum tenens providers or short-term coverage solutions, increasing costs and reducing continuity of care. A consistent pattern described by providers was the rapid onset of a "death spiral" dynamic, in which early signals of instability (e.g., rumors of closure, staffing concerns) can lead to staff departures, increased reliance on temporary providers, rising costs, and ultimately an inability to recruit or retain more permanent clinicians.



Clinicians described rural obstetric workforce models as functionally unsustainable without team-based redundancy, noting that safe coverage typically requires a minimum of 4–6 providers to support manageable call schedules, surgical assist, and neonatal care. Models relying on one or two clinicians, particularly without OB/GYN backup, were viewed as highly vulnerable to disruption.

To address these challenges, some hospitals have begun developing regional workforce approaches, including shared call pools, rotating physicians credentialed across multiple facilities, and coordinated “strike team” models. These efforts aim to create distributed coverage across independent hospitals, leveraging familiarity with local protocols and transfer systems. While promising, these models introduce significant operational complexity, particularly given variation in staffing structures, governance, and clinical resources across sites.

## **VOLUME AND CLINICAL SKILL MAINTENANCE**

Low and declining birth volumes were a defining feature across all hospitals. Most facilities operated below commonly referenced thresholds for sustaining clinical competency, particularly for low-frequency, high-risk events such as emergent cesarean delivery and obstetric emergencies.

Providers and administrators described persistent tension between preserving local access to care and ensuring clinical readiness. In environments where complex cases occur infrequently, maintaining procedural confidence and team coordination posed ongoing challenges. This contributed to heightened provider anxiety and concerns about long-term sustainability.

Providers emphasized that obstetric volume in rural communities is highly sensitive to external economic and social perceptual factors, including local economic shifts, availability of specific services (e.g., C-sections, VBAC), and community confidence. Even small changes, such as loss of a single long-term provider or rumors about program stability, can rapidly shift where patients choose to deliver.



Facility/Clinical maternal levels of care limitations were identified as a significant contributor to declining volume. In one setting, a substantial proportion of patients required services not available locally, including surgical delivery or higher-level neonatal care, further reducing the viability of maintaining L&D services.

## FINANCIAL ENVIRONMENT

All hospitals reported persistent operating losses associated with obstetric services. These losses were driven by a combination of Medicaid-dominant payer mixes, global maternity reimbursement structures, and the high fixed costs required to maintain continuous clinical readiness and medical liability.

Leaders consistently emphasized that obstetric services must be staffed as if an emergency could occur at any time, regardless of whether deliveries occur daily or monthly. This creates a fundamental mismatch between payment models tied to volume and the fixed costs of maintaining safe care.

Several hospitals faced significant financial distress, including risk of breaching bond covenants or sustaining large operating losses. While some organizations were able to partially offset obstetric losses through other service lines, such as surgical programs supporting anesthesia coverage, this was not universally feasible.

Providers reported that financial challenges were sometimes exacerbated by lack of transparency and operational breakdowns, including unclear accounting, inability to track service line performance, and, in some cases, failure to bill for services rendered. This limited clinicians' ability to engage in problem-solving and undermined trust in decision-making.

Financial sustainability was also highly sensitive to policy environments. Anticipated reductions in Medicaid reimbursement, along with broader federal and state fiscal pressures, were expected to significantly worsen operating margins within short timeframes. Leaders noted that financial viability could shift dramatically within six to twelve months based on policy changes alone.



At the same time, hospitals increasingly recognized the importance of evaluating the broader financial role of women's health services. Obstetric care was seen not only as a standalone service but as a driver of downstream utilization, including primary care, pediatrics, and other hospital services. Hospitals faced a persistent tension between the longer-term, downstream value of maintaining L&D services and the immediate financial pressures hospitals face in remaining financially viable. While broader obstetric services were often understood as important to long-term sustainability, near-term concerns related to operating losses and financial viability frequently limited hospitals' ability to sustain ongoing investment, framing closure decisions as difficult financial tradeoffs rather than assessments of clinical or community value.

Clinicians viewed obstetric services as being frequently undervalued within hospital financial strategy, viewed primarily as a cost center rather than as a driver of patient engagement, downstream service utilization, and long-term community trust.

## **KEY DECISION FACTORS INFLUENCING SUSTAINABILITY OR CLOSURE**

Across all cases, workforce instability was a primary trigger for decisions related to scaling back or closing L&D services. Even in hospitals with strong community support and committed leadership, the inability to maintain a stable and sufficient provider workforce created operational risk. Financial considerations were closely intertwined with workforce challenges. Hospital leaders weighed the ongoing losses against the need to preserve overall organizational solvency. In some cases, closure of L&D services was viewed as necessary to stabilize the hospital's broader financial position.

Safety and liability concerns were also central. Leaders expressed discomfort maintaining obstetric services without reliable specialty backup, particularly for emergent situations requiring cesarean delivery, hemorrhage management, or neonatal resuscitation.



Community response played an important but complex role. Strong public opposition to closures, including large-scale community engagement, influenced decision-making timelines and, in some cases, temporarily or permanently delayed closures. However, these responses did not resolve the underlying structural challenges related to workforce availability and financial sustainability.

Across interviews, providers described closure decision-making processes as involving limited collaboration and clinical input, which in some cases created a sense of abruptness and included minimal advance notice to both staff and the community. Providers noted that these dynamics often contributed to accelerated workforce loss and destabilized care delivery prior to closure.

Increasingly, hospitals are shifting from isolated decision-making toward exploration of regional, collaborative solutions, reflecting recognition that sustainability challenges extend beyond any single facility.

## **IMPLICATIONS FOR PATIENTS, COMMUNITIES, AND OPERATIONS**

Where L&D services were reduced or at risk, patients experienced increased travel distances for delivery, often ranging from 30 to 60 miles or more one way. These changes disrupted continuity of care and placed additional burdens on families, particularly in geographically isolated areas. Hospitals responded by strengthening transfer relationships, coordinating with EMS and air transport services, and investing in staff training to manage obstetric emergencies regardless of service status. Even in settings without active L&D units, emergency deliveries continued to occur, requiring ongoing preparedness.

Operationally, hospitals adapted through cross-training, simulation-based training, and expanded roles for clinical staff. These efforts were essential to maintaining safety but require ongoing investment in time and resources. Beyond clinical implications, L&D services were closely tied to community identity and trust. Maintaining local access to maternity care was seen as integral to broader community vitality and engagement with the healthcare system.



Providers expressed significant concern about the reliability of transport and emergency response systems, noting that many regions lack consistent, timely access to obstetric-capable transport. This often necessitated earlier transfers during pregnancy and created ongoing risk for patients presenting in active labor or emergency situations. However, these early transfers also served to decrease the number of local births.

## **CROSS-CUTTING THEMES AND EMERGING MODELS**

Several consistent themes emerged across all five hospitals: a fundamental mismatch between fixed readiness costs and low patient volume, workforce fragility, and the limitations of hospital-level solutions in addressing systemic challenges. A notable and evolving strategy is the development of regional collaboration models. These include shared workforce pools, cross-credentialing of providers across multiple hospitals, and coordinated call coverage designed to distribute staffing burden. Such models represent a shift from isolated operations toward distributed systems of care across independent hospitals.

While these approaches offer promise, they also require alignment across clinical protocols, credentialing processes, governance structures, and financial arrangements. Their long-term success will depend on supportive policy frameworks and sustained leadership for collaboration.

Clinicians emphasized that sustaining rural obstetric care requires more than structural solutions—it also depends on a distinct rural practice mindset, including willingness to maintain broad clinical scope, manage uncertainty, work within resource-constrained environments, and maintain some acceptance of risk inherent in the distance from a major medical center. Recruitment and retention are influenced as much by these cultural factors as by compensation or workload.

Simultaneously, hospitals are adapting internally through cross-trained staffing models, flexible workforce deployment, and partnerships with higher-volume centers to support training and competency.



## RECOMMENDATIONS FOR RURAL HOSPITALS AND STATE LEADERS

- **Infrastructure:** Recognize rural obstetric services as essential safety-net infrastructure, independent of patient volume.
- **Funding:** Implement payment models that include standby or readiness-based funding to account for fixed staffing requirements.
- **Workforce:** Support and formalize regional workforce models, including shared call pools and cross-credentialing across hospitals.
- **Pipelines:** Invest in training pipelines, clinical rotations, and partnerships with higher-volume centers to maintain workforce competency.
- **Analysis:** Conduct comprehensive financial analyses that account for the downstream value of maternity care across the broader health system.

## CONCLUSION

These findings demonstrate that rural obstetric service closures are not the result of isolated decisions or failures in care quality. Rather, they reflect a structural misalignment between workforce availability, patient volume, and reimbursement models. Providers stated that many closures seemed avoidable with different leadership, financial planning, and workforce strategies, reinforcing that current trends reflect system-level misalignment rather than inevitability.

Even in hospitals with strong leadership, deep community trust, and a commitment to high-quality care, the current system does not adequately support the fixed costs required to maintain safe obstetric services in low-volume settings. Without intentional policy, financial, and workforce alignment—particularly including regionalized approaches and readiness-based funding—rural maternity care access will continue to erode. At the same time, emerging collaborative models suggest that, with the right support, new pathways for sustainability are possible.

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