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.

95 - 150 Births

Annual delivery range across studied rural facilities.

Several facilities consistently operate below 20-30 births per month—levels viewed by leadership as unsustainable under current reimbursement models. Despite low volume, obstetric services are essential, non-elective care requiring full readiness 24/7.

All hospitals operated within constrained workforce markets and Medicaid-heavy payer mixes. Leaders emphasized that maintaining L&D services requires a continuous balancing of clinical readiness, workforce stability, and organizational solvency. Clinicians described closures as potentially preventable with earlier intervention and stronger alignment between leadership and care teams.

WORKFORCE CONFIGURATION

Workforce fragility emerged as the most consistent and immediate driver of sustainability challenges. Care models varied, including OB/GYN-led models and family medicine physicians with obstetric training (FM-OB). Regardless of the model, all relied on lean clinical teams with little redundancy.

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

A consistent pattern described by providers was the rapid onset of a “death spiral” dynamic: early signals of instability lead to staff departures, increased reliance on temporary locum providers, rising costs, and an inability to recruit or retain permanent clinicians.

Clinicians described rural obstetric workforce models as functionally unsustainable without team-based redundancy. Safe coverage typically requires 4–6 providers to support manageable call schedules and surgical backup. Models relying on one or two clinicians are highly vulnerable to disruption.

VOLUME AND CLINICAL SKILL MAINTENANCE

Most facilities operated below thresholds for sustaining clinical competency for high-risk events like emergent cesareans. Providers described a persistent tension between local access and procedural confidence. Obstetric volume is highly sensitive to external perceptions; rumors about program stability can rapidly shift where patients choose to deliver.

FINANCIAL ENVIRONMENT

All hospitals reported persistent operating losses. These were driven by:

- **Medicaid-Dominant Payer Mixes:** reimbursement structures often fail to cover the cost of care.
- **Fixed Readiness Costs:** Services must be staffed as if an emergency could occur at any time, creating a mismatch with volume-based payment models.
- **Operational Breakdowns:** Financial challenges were sometimes exacerbated by lack of transparency, unclear accounting, or failure to bill for services rendered.

Hospitals recognize women's health as a driver of downstream utilization (primary care, pediatrics). However, near-term financial pressures frequently frame closure as a necessary tradeoff for organizational survival.

KEY DECISION FACTORS INFLUENCING CLOSURE

Workforce instability was the primary trigger. Leaders weighed losses against organizational solvency and safety/liability concerns—particularly the risk of operating without reliable specialty backup for hemorrhage or neonatal resuscitation.

Community response played a complex role. Public opposition delayed some closures but did not alter structural constraints. Clinicians noted that decision-making often lacked collaboration, leading to abruptness and minimal advance notice to staff.

IMPLICATIONS FOR PATIENTS AND COMMUNITIES

Reduction in services increased travel distances by 30 to 60 miles, disrupting continuity and burdening families. Hospitals responded by strengthening transfer relationships and investing in staff training to manage emergency births that occur even after a unit closes.

Providers expressed concern about the reliability of transport systems, noting that many regions lack timely access to obstetric-capable transport.

RECOMMENDATIONS FOR RURAL HOSPITALS AND STATE LEADERS

- **Essential Infrastructure:** Recognize rural obstetric services as safety-net infrastructure independent of volume.
- **Readiness-Based Funding:** Implement payment models that include standby funding to account for fixed staffing requirements.
- **Regional Workforce Models:** Support shared call pools and cross-credentialing across systems.
- **Training Pipelines:** Invest in clinical rotations and partnerships with high-volume centers.
- **Downstream Value:** Conduct financial analyses that account for the value of maternity care across the broader health system.

CONCLUSION

Rural closures reflect a structural misalignment between workforce availability and reimbursement. Even with deep community trust, the current system does not adequately support the fixed costs of safe obstetric care in low-volume settings. Without intentional policy alignment and regionalized approaches, rural maternity care access will continue to erode.

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