Colorado Perinatal Care Access Study

Executive Summary

JUNE 2026

This report was developed by JSI with funding from the Colorado Department of Public Health & Environment and in accordance with Colorado House Bill 24-1262.

Acknowledgements

JSI Research & Training Institute, Inc. (JSI) appreciates the collaboration and thought partnership of several organizations that contributed to this study and report. These include our subcontractor, Elephant Circle, and our study advisors, the Colorado Hospital Association (CHA) and the Colorado Perinatal Care Quality Collaborative (CPCQC). This advisory role does not constitute a formal endorsement of the report's final findings, conclusions, or recommendations. We thank all individuals who contributed to the study, including patients, providers, and organizations impacted by a hospital labor and delivery unit or birth center closure. We are grateful to these contributors for sharing their experiences and ideas for improving access to perinatal care in Colorado.

Disclaimers

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Purpose

Perinatal care, defined as care during pregnancy, labor and delivery, and the postpartum period, is universally understood as important for maternal and infant health.

Colorado has been navigating a wave of birth facility closures that threaten access to perinatal care, particularly in rural areas. In accordance with House Bill 24-1262,[1] the Colorado Department of Public Health & Environment (CDPHE) contracted JSI Research & Training Institute, Inc. (JSI) to study the effects of birth facility closures, consolidations, and acquisitions. The study involved both primary and secondary data collection methods as well as advisory input from key experts. This approach surfaced evidence and promising approaches from literature, first-hand perspectives from affected patients and health care professionals, and important context and input from other stakeholders and experts. JSI conducted this study from November 2025 to March 2026. The complete report provides a summary of those findings and offers recommendations to address the negative effects of birth facility closures and strengthen Colorado's perinatal system of care.

Key Findings

Birth facilities in Colorado consist of hospital labor and delivery (L&D) units and freestanding birth centers. In 2025, Colorado had 55 birth facilities (50 hospital L&D units and five freestanding birth centers).[2] Birth centers[i] are state-licensed facilities that provide prenatal, intrapartum, and postpartum care to patients who are low-risk, as well as newborn care.

However, the majority of Colorado birth facilities, including all five birth centers, are located in the Denver Metro and Front Range regions, not in rural areas. Outside of the Front Range regions, birth facilities are sparsely distributed and generally limited to one or two hospital L&D units per county, which serve as regional hubs for larger geographic areas. Of rural hospitals in Colorado, only 17 of 43 have a hospital obstetrics department.[3]

Mirroring the national health ecosystem, Colorado is experiencing ongoing birth facility closures, a trend that further destabilizes the state's perinatal system of care. Since 2018, eight rural hospitals in Colorado have closed their L&D units. Since 2024 alone, five birth facilities have closed, including three freestanding birth centers and two rural hospital L&D units.[4] [5]

Birth facilities face a web of challenges that threaten viability and increase closure risk. These include financial strains, workforce shortages, and low birth volumes. The cost of operating a birth facility is a primary challenge, and the financial strain is particularly acute for rural hospitals.[6] Rural facilities commonly have low patient volumes, leaving them struggling to achieve reimbursement levels that could offset the high fixed costs of keeping providers available around-the-clock.[7]

[i] Note: Birth centers are not hospitals, attached to a hospital, or in a hospital.

"**All obstetric units in hospitals lose money, period.** Obstetric reimbursement just is not enough to pay for that kind of unit."

—Study participant, health care leader

Hospital L&D unit closures can be consequential for timely treatment of birth complications, including severe maternal morbidity (SMM). In the wake of a closure, patients may experience gaps in care and/or increased distance and travel time to care, which raises maternal and infant risk, including rates of preterm birth and unplanned out-of-hospital birth.[8 9 10] The American College of Obstetricians and Gynecologists (ACOG) describes SMM as unintended outcomes of labor and delivery that result in significant consequences to a woman's health, such as severe bleeding, kidney or heart failure, sepsis, and eclampsia.[11] Across Colorado, rural regions have some of the highest SMM rates when examined by where patients live.[12] SMM can have long-lasting physical and emotional impacts, including rehospitalization for a mental health concern.[13]

In addition to maternal and infant health, birth facility closures impact patients and families, staff and providers, the broader health system, and the local community and economy. Staff and providers at the closing facility suffer job loss while those in surrounding facilities face higher workloads, fueling the burnout and attrition cycle. A closure can destabilize the local economy by driving out health care professionals and families; people of reproductive age may opt to move into other communities.[14 15]

Colorado has several workforce assets and support services in the perinatal system of care that support access and serve as foundational building blocks to strengthen and expand access to care. These include a robust education and training pipeline for family medicine obstetrics physicians (FMOBs), a regulatory environment that has long supported independent midwifery, and statewide resources and support for families throughout pregnancy and the postpartum period (including home visiting programs, doulas, lactation supports, peer supports, and community health workers). The study identified other strategies to strengthen birth facility sustainability, as well as to mitigate the negative effects of birth facility closures.

Recommendations

These recommendations, based on study findings, offer strategies to foster resilience of the perinatal system of care and mitigate birth facility closures. See the full report for recommendation details and a scalable menu of possible action steps, from immediate refinement of existing regulations to broader systemic reforms requiring new legislative authority.

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1. Strengthen the Perinatal System of Care

- **1.1: Establish a formal designation process for Levels of Maternal Care.**
  The American College of Obstetricians and Gynecologists (ACOG) developed this framework

that stratifies birth facilities by acuity to promote collaboration among facilities and support the provision of risk-appropriate maternal care.[16]

- **1.2: Encourage regionalized transfer and consultation networks between low-acuity (Level I/II) rural hospitals and high-acuity (Level III/IV) regional perinatal centers.**
  Along with the Levels of Maternal Care, ACOG recommends a hub-and-spoke model in which low-acuity facilities "participate in a regional integrated delivery system with ready access to consultation and referral when needed, outreach education from regional perinatal centers, and regional analysis and evaluation of regional data."[17]

- **1.3: Standardize and fund perinatal emergency training, equipment, and transfer protocols.**
  Hospital L&D unit closures increase the risk of perinatal emergencies[18] and the need to transfer patients to other settings that may or may not be prepared to handle perinatal emergencies, such as general emergency departments.

- **1.4: Study and consider adopting a legislative and regulatory framework for standby perinatal units, modeled on California's Plumas Model.**
  The Plumas Model seeks to address the unsustainable around-the-clock fixed costs that rural hospital L&D units face. The primary feature of this model is a standby perinatal unit that is on call and available within 30 minutes but not staffed around-the-clock. California approved a five-year pilot in 2025.[19]

- **1.5: Strengthen and resource perinatal home visiting programs.**
  Home visiting programs are a proven strategy to improve maternal and infant outcomes (e.g., fewer emergency department visits, more prenatal care, lower substance use).[20]

2. Invest in the Perinatal Care Workforce

- **2.1: Invest in the hospital-based workforce with immediate, sustained, and long-term actions to stabilize and grow the rural perinatal workforce.**
  With a projected shortage of 140 obstetrician-gynecologists (OB-GYNs) in Colorado by 2038,[21] the state must prioritize workforce models that center providers with broader service capabilities. The state can help stabilize the rural perinatal workforce by shifting toward FMOB, certified nurse midwives (CNMs), and certified registered nurse anesthetists (CRNAs); these types of providers offer cost-efficient and flexible care capabilities across service lines, in addition to essential obstetric services.

- **2.2: Sustain clinical competence in low-volume hospital L&D units with cross-institutional clinical rotations and cased-based learning.**
  Maintaining clinical competency in low-volume L&D units is critical for workforce retention and patient safety. ACOG recommends rural health providers from low-volume facilities periodically rotate to higher-volume, regional facilities to support clinical experience and skill maintenance.[22]

- **2.3: Support the community midwifery workforce with targeted integration steps.**
  Colorado can build on prior efforts to bolster the midwifery pipeline and support patient choice through expanding access to certified professional midwives (CPMs). This could be achieved by creating a midwifery-led body to oversee or advise on midwifery regulations, providing consistent guidance on CPM malpractice insurance requirements, and removing state regulatory barriers that limit CPM scope-of-practice.

3. Structure Financing and Reimbursement to Support Rural Birth Facilities

- **3.1: Create supports to prevent further birth facility closures.**
  Preventing rural hospital L&D unit closures is critical to ensuring access to perinatal services in rural Colorado. [23] The state can take steps to create an early warning system that identifies rural hospital L&D units at risk of closure, provide financial support for these at-risk units, and continue to support and expand monitoring of outcomes related to closures.

- **3.2: Support more formalized regional collaboration and agreements between hospitals and other rural health providers.**
  Regional collaboration can support rural hospitals, including L&D units, with workforce solutions via resource and service sharing, care coordination, and improved efficiency.[24] [25] Improved regional collaboration might include new rural hospital collaborative agreements, expanded access to existing collaborative agreements, and regional shared workforce pools.

- **3.3: Implement a standby capacity payment to support Colorado's rural hospital L&D units.**
  Standby capacity, which refers to resources that are ready to use anytime, is a primary driver of hospital L&D unit closures.[26] The standby capacity of an L&D unit includes the readiness of providers and equipment to deliver a baby.

- **3.4: Support the rural perinatal workforce during the payment reform transition.**
  Starting in January 2027, significant billing changes will transition maternity care services from a bundled payment after delivery to per service reimbursement. It is important to monitor billing changes, including unintended revenue loss, to determine if additional advocacy or regulatory requirements are necessary.[27] Small and rural hospitals will also need technical assistance and education during payment reform.

Proposed Best Practice Guidelines for Birth Facility Closures

The guidelines below aim to mitigate the harm resulting from the closure of a local birth facility and support resulting transfers of care. Specifically, these guidelines focus on the importance of closure-related oversight and review, timely communication, and coordinated transfers of care.

1. CDPHE Oversight and Review

CDPHE is positioned to oversee, review, and support a birth facility closure process given its overarching role as a convener and coordinator and the role of CDPHE's Health Facilities and Emergency Medical Services Division (HFEMSD) in oversight and enforcement of all health facility closures, including hospitals and birth centers. The following guidelines aim to support regional perinatal care access at the health systems level.

- **1.1: Explore and conduct a community impact assessment, if needed.**
- **1.2: Support the closing facility in implementing best practice guidelines for a closure.**
- **1.3: Monitor the impacts of closures on perinatal care access and health outcomes.**
- **1.4: Monitor notification to the state when there are ownership transitions among facilities that provide perinatal care services and intervene, if needed.** Note: Legislative action is required to enact statutory authority for CDPHE to assess the impacts of a potential closure and to intervene.

2. Timely Notification and Supportive Communication

Clear and timely communication about a closure can support facilities, providers, and staff in providing patient-centered care. This includes planning for warm handoffs and emergency readiness, connecting patients to supportive resources, and giving patients sufficient time to identify and establish new care. These timely actions can mitigate patient stress, poorly coordinated care, and gaps in care.

- **2.1: Request that closing facilities provide notification of closure at least 90 days prior.**
- **2.2: Communicate quickly and transparently to closing facility providers and staff.**
- **2.3: Communicate directly with current patients.**
- **2.4: Communicate with the affected community.**

3. Coordinated Transfers of Care

Through proactive planning to transfer current patients to new care, closing facilities can support patients in receiving continuous, appropriate perinatal care.

- **3.1: Develop and implement a system-level transfer of care plan.**
- **3.2: Develop individual patient transfer of care plans.**
- **3.3: Develop an emergency response plan.**

Proposed Perinatal Care Access Outcome Categories

Timely data on perinatal care access and health outcomes is needed to assess the impact of recent birth facility closures and monitor facilities at risk of closing. It is recommended to track key measures at the most local level possible; specificity can help identify closure risk, emerging impacts and disparities, and opportunities for proactive intervention.

Level	Measures
Community	● Birth facility density ● Prenatal care demand met ● Maternity care access ● Maternal mortality rate ● Infant mortality rate ● Residence birth, not intended ● Emergency department deliveries ● Unemployment rate ● Population below federal poverty level
Provider	● Perinatal workforce capacity by provider type ● Medical attendant type at birth ● Obstetric emergencies ● Perinatal transfers
Clinical	● Late prenatal care ● Preterm birth ● Low birth weight ● Neonatal intensive care units (NICU) admissions ● Severe maternal morbidity (SMM)
Family	● Distance to birth facility ● Geographic determinants of access ● Travel costs and travel-related opportunity costs ● Prenatal/maternal stress level

Colorado Perinatal Care Access Study

Legislative Report

JUNE 2026

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I. Introduction

Perinatal care refers to health care during pregnancy, labor and delivery, and the postpartum period. Perinatal care is universally understood as important for achieving positive maternal and infant health outcomes. Typically, people have two choices for birth locations that provide perinatal care services: hospital labor and delivery (L&D) units and community-based, freestanding accredited birth centers.

Over the last few decades, the United States has experienced significant birth facility closures. Between 2010 and 2023, 641 hospital L&D units closed nationwide.[28] Since 2023, about two dozen freestanding birth centers have closed nationwide.

Colorado is navigating a wave of birth facility closures that mirrors the fragile national health ecosystem. Since 2018, eight rural hospitals in Colorado have closed their L&D units. Since 2024 alone, five birth facilities have closed, including three freestanding birth centers and two rural hospital L&D units.[29] [30]

In the wake of these closures, 40% of Colorado counties have been designated as maternity care deserts,[ii] a term to describe counties without access to birth facilities or obstetric providers,[31] and 98% of Coloradans live in an area with an inadequate supply of prenatal health care.[32] This shrinking access to safe, reliable perinatal care has an impact on women, infants, and their families; however, the extent and nature of this impact has not been well understood.

In 2024, Colorado House Bill 24-1262 authorized a study to investigate the effects of perinatal facility closures, consolidations, and acquisitions on maternal and infant health outcomes and experiences. CDPHE engaged JSI to conduct a study focusing on access to perinatal care in rural regions and the impacts of facility closures, consolidations, and acquisitions. To achieve its research goals, JSI used both primary and secondary data collection methods as well as advisory input from key experts. This approach surfaced evidence and promising approaches from the literature, first-hand perspectives from affected patients and health care professionals, and important context and input from other stakeholders and experts. JSI conducted this study from November 2025 to March 2026. The following table summarizes the study design and methods.

[ii] Note: Throughout the legislative report the terms maternity care deserts and maternity health professional shortage areas are used. When referring to national literature, the term maternity care deserts is used; when referring to specific strategies or action steps Colorado can take, the term maternity health professional shortage areas is used to align with concurrent efforts through the Colorado Office of Primary Care.

Table 1. Study Design and Methods.

Environmental scan	
Purpose	● Understand issues of perinatal care access in Colorado ● Contextualize the perinatal policy and system environment ● Identify promising approaches and models to improve perinatal care access
Qualitative study: Interviews (32) and focus groups (2)	
Purpose	● Understand issues of perinatal care access ● Understand the perinatal policy and systems environment ● Identify ideas to improve access to perinatal care and to mitigate the impacts of birth facility closures
Study participants	● Health care leaders and stakeholders (e.g., Colorado health care-related professional associations, health care quality and access organizations), n=7 ● Patients living in rural areas and/or whose perinatal care was affected by a recent closure, n=20 ● Perinatal health professionals serving rural areas and/or areas that experienced a recent closure (e.g., health system leadership, family medicine obstetrics physicians (FMOBs), registered nurses (RNs), certified professional midwives (CPMs), doulas, emergency medical services personnel, lactation consultants), n=17

See **Appendix I** for details on study methods, including sampling, recruitment, eligibility, and analysis.

This report summarizes study findings and recommendations. These include recommendations to strengthen Colorado's perinatal system of care, mitigate the effects of birth facility closures, ensure continuity of care during facility closures, and monitor perinatal care outcomes.

II. Key Findings on Perinatal Care Access and Birth Facility Closures in Colorado

This study explored rural perinatal care access and investigated the effects of birth facility closures, consolidations, and acquisitions in Colorado. The study revealed that disruptions to perinatal care have largely resulted from birth facility closures, not from consolidations or acquisitions. Consolidations and acquisitions have at times preceded closures; there is limited data on their occurrence and impact.

The study focused on access to birth facilities, including hospital L&D units and birth centers, particularly in rural areas. Most births in the state take place in the hospital; as a result, a hospital L&D unit closure can have wide-reaching impacts across a region. While representing a small percentage of the overall number of births in the state, community births (which include both birth center and home births attended by a midwife) comprise a growing percentage of births in Colorado, especially in areas impacted by recent hospital L&D unit closures.

Via interviews and focus groups, the study gathered perspectives from various stakeholders. These included health care leaders (e.g., health professional associations, health care quality and access organizations), hospital L&D unit providers (e.g., certified nurse midwives (CNMs), obstetrician-gynecologists (OB-GYNs), RNs, hospital leaders (e.g., chief executive officers), community birth providers and support personnel (e.g., certified professional midwives (CPMs), doulas, lactation consultants), and patients (both Medicaid and commercially insured) living in rural areas and/or who experienced a hospital L&D unit or birth center closure.

The findings that follow synthesize study participants' insights, experiences, and recommendations; expert guidance from study advisors Colorado Hospital Association (CHA), the Colorado Perinatal Care Quality Collaborative (CPCQC), and Elephant Circle; and the literature on perinatal access, birth facility closures, and related topics.

Key Finding Categories:

1. **Current State of Colorado Perinatal Care Access**
2. **Birth Facility Challenges and Closure Risk Factors**
3. **Impacts of Birth Facility Closures**
4. **Perinatal System of Care Assets and Innovations**
5. **Perinatal Care Access Strategies Proposed by Study Participants**

1. Current State of Colorado Perinatal Care Access

Perinatal Care and Birth Facility Access

Perinatal care refers to care to monitor patients during pregnancy and through the postpartum period. Perinatal care includes, but is not limited to, prenatal care (regular visits, tests, and other care during pregnancy to monitor the pregnant person and fetus), intrapartum care (medical and emotional support provided during labor and delivery), and postpartum care.

According to the state Health Professional Shortage Area (sHPSA) model for perinatal health, as of 2024, only 1.4% of Coloradans lived in an area with an adequate or surplus supply (≥ 100%) of prenatal health care. sHPSA models leverage clinician survey data and a comprehensive database of clinicians (the Colorado Health Systems Directory) to quantify the supply of perinatal health services. Demand for these services is based on the number of pregnancies per census block group available from the state's Vital Statistics Program. The most relatively well-supplied areas of the state include rural resort towns (especially those located along the I-70 corridor), northeastern Colorado, and the Denver metropolitan area. The southeastern quadrant of the state faces the highest shortages of perinatal health providers. In general, in central and southeastern Colorado, less than 20% of the demand for prenatal health care is met. CDPHE's State-Designated Health Professional Shortage Areas (sHPSAs) interactive map[33] provides data to examine geographic access by perinatal care demand met across regions of the state.

Birth facilities in Colorado consist of hospital L&D units and freestanding birth centers. In 2025, Colorado had 55 birth facilities (50 hospital L&D units and five freestanding birth centers).[34] Birth centers[iii] are state-licensed facilities that provide prenatal, intrapartum, and postpartum care to patients who are low-risk, as well as newborn care.

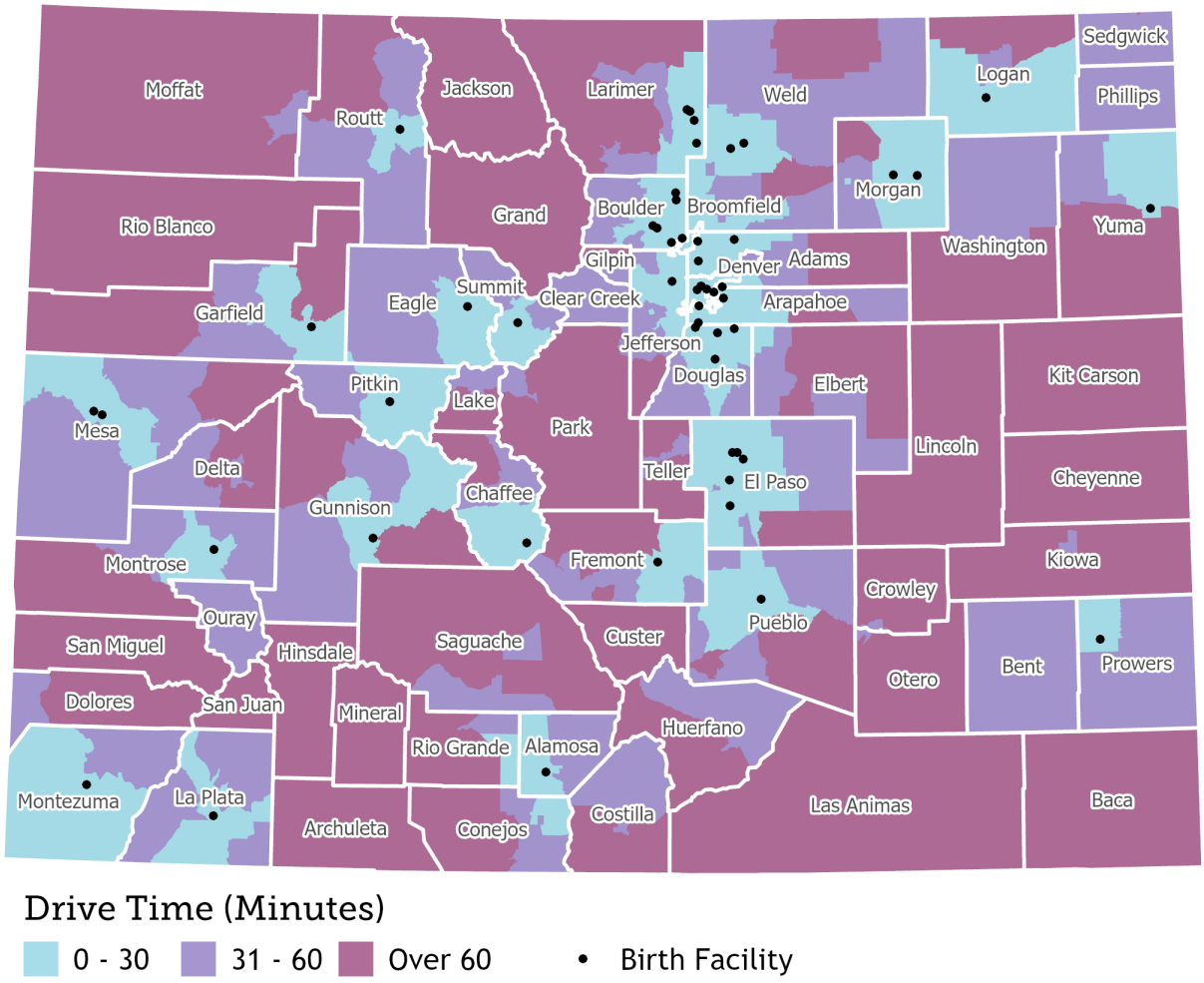
However, the majority of Colorado birth facilities, including all five birth centers, are located in the Denver Metro and Front Range regions, not in rural areas. Outside of the Front Range regions, birth facilities are sparsely distributed and generally limited to one or two hospital L&D units per county, which serve as regional hubs for larger geographic areas. Of rural hospitals in Colorado, only 17 of 43 have a hospital obstetrics department.[35] Since 2024 alone, five birth facilities have closed including three freestanding birth centers and two rural hospital L&D units.[36] Colorado's rural Eastern Plains and southern regions have the fewest birth facilities.[37] As of 2025, 50% of women in rural Colorado live over 30 minutes from the nearest birth facility (see **Figure 1**).[38]

Hospital L&D unit closures can be consequential for timely treatment of birth complications, including severe maternal morbidity (SMM). Following a closure, patients may experience gaps in care and/or increased distance and travel time to care, which raises maternal and infant risk, including rates of preterm birth and unplanned out-of-hospital birth.[39] [40] [41] The American College of Obstetricians and Gynecologists (ACOG) describes SMM as unintended outcomes of labor and delivery that result in significant consequences to a woman's health, such as severe bleeding, kidney or heart failure, sepsis, and eclampsia.[42] Across Colorado, rural regions have some of the highest SMM rates when examined by where patients live.[43] SMM can have long-lasting physical and emotional impacts, including rehospitalization for a mental health concern.[44]

While an analysis of health outcomes specifically linked to Colorado birth facility closures has not been conducted to date, Colorado Vital Statistics data could provide insight into the impact of closures on preterm birth and unplanned out-of-hospital birth. Higher travel distances and facility closures are also directly linked to higher prenatal stress and poor mental health outcomes.[45] Study participants most frequently cited distance to care, transportation, and travel time as barriers to accessing perinatal care and as contributors to worse health outcomes. Patients described these factors as stressors that shaped their decisions about where to seek care.

[iii] Note: Birth centers are not hospitals, attached to a hospital, or in a hospital.

Figure 1. Driving Time from Census Block Group Population Centers to the nearest Birth Facility in Colorado (2025)



Perinatal Care Workforce Access

There are several types of licensed and regulated perinatal providers authorized to provide care in Colorado. All of these provider types are regulated to practice in hospital, birth center, or home settings, with the exception of CPMs. In Colorado, CPMs practice exclusively in community settings (birth centers or home settings).

- **Certified Midwives (CMs)** provide low- to moderate-risk care and have prescriptive authority in some states, including Colorado. CMs have graduate-level education in midwifery but not a nursing degree.
- **Certified Nurse Midwives (CNMs)** provide low- to moderate-risk care and have prescriptive authority. They are advanced practice registered nurses (APRNs) with graduate-level education in midwifery.

- **Certified Professional Midwives (CPMs)** provide low-risk care in community settings. They have completed a formal midwifery education or apprenticeship program.[iv]
- **Doulas** provide physical, emotional, and informational (non-medical) support to people during pregnancy, birth, and postpartum. They have completed training and can receive certification.
- **Family Medicine Obstetrics Physicians (FMOBs)** provide comprehensive primary care throughout the life course. They are medical doctors with specialized education and training in family medicine, including prenatal care, normal vaginal births, postpartum care, and newborn care. They may have advanced training in surgical obstetric procedures, such as cesarean section, dilation and curettage, and tubal ligation.
- **Obstetrician-Gynecologists (OB-GYNs)** specialize in higher-risk care, including cesarean sections and other higher-risk surgical obstetric procedures. They are medical doctors with specialized education and training in obstetrics and gynecology.
- **Maternal-fetal medicine physicians (MFMs)** specialize in the diagnosis, treatment, and management of high-risk pregnancies and obstetric complications. They are OB-GYNs with advanced training in the medical and surgical complications of pregnancy.

Perinatal care workforce shortages persist across birth facilities in the U.S. and in Colorado, particularly in rural areas. Workforce shortages challenge recruitment and retention, creating a vicious cycle of burnout and attrition.[46] In interviews with health care providers serving in rural areas (e.g., FMOBs, RNs, doulas, and community providers such as CPMs), study participants described that without enough providers, call schedules become overly demanding for those working in both hospital and community settings. Doula and midwife study participants described feeling "maxed out" with patient loads and schedules. In interviews, health care providers serving in rural areas and/or who experienced a closure noted that the loss of even one provider impacts the capacity and stability of the birth facility.

In part because of physician shortages, midwifery is a significant source of perinatal services in rural areas in Colorado and nationwide.[47] While midwives currently attend less than 10% of all births in the U.S., they attend over 21% of deliveries in Colorado rural hospitals and 30% of deliveries in U.S. rural hospitals.[48] In Colorado, midwives attend on average about 15% of all births (CNMs attend 13% of births and CPMs attend 2%). There is variation across counties of midwife-attended births as some rural counties have much higher rates of midwife-attended births. For example, 28% of births in Delta County are attended by a midwife (CNMs attend 21% of births and CPMs attend 7%); 50% of births in Montrose County are attended by a midwife (CNMs attend 45% of births and CPMs attend 5%). On the other hand, some counties have lower rates of midwife-attended births. For example, 8% of births in Montezuma County are attended by a midwife (CNMs attend 3% of births and CPMs attend 5%).[49]

Financial Access

Affordability is a primary barrier to care for uninsured Coloradans and insured Coloradans with high premiums or deductibles.[50] While laws and regulations have expanded access to health

[iv] Note: Direct-entry midwives are educated in the discipline of midwifery through self-study, apprenticeship, or a midwifery school, rather than through prior nursing education. As of 2003, in Colorado, all direct-entry midwives must be CPMs. Therefore, Colorado statute and regulations pertaining to CPMs apply to direct-entry midwives.

insurance and coverage of perinatal care services, gaps in care persist. In 2024, about 5% of births in Colorado were uninsured and about 35% of births were covered by Medicaid.[51]

Patients who participated in the study cited the pros and cons of Medicaid insurance and accessing perinatal care. Medicaid provides insurance coverage for prenatal care, delivery, and 12 months of postpartum coverage.[52] Patients with Medicaid insurance who took part in the study described Medicaid as providing expansive perinatal care coverage for visits, prescriptions, and more. Some described limitations on choice in access to care given the challenges with finding a provider whom they preferred (e.g., type of provider, location, birth setting) and who accepted Medicaid insurance.

2. Birth Facility Challenges and Closure Risk Factors

Birth facilities face a web of challenges that threaten viability and increase closure risk.

Financial Pressures and Payer Mix

The cost of operating a birth facility is a primary challenge cited in the literature and by study participants. Executive leadership in rural Colorado hospitals discussed the persistent operating losses associated with obstetric services, driven primarily by high fixed overhead costs of an L&D unit (including labor, equipment, and liability), high Medicaid payer mixes, and global maternity reimbursement structures.[v]

This financial strain is particularly acute for rural hospitals. In rural hospitals, payer mix relies heavily on Medicaid. In 2024, 42% of births in rural Colorado were covered by Medicaid, compared to 34% in urban areas.[53] The literature indicates that Medicaid reimburses at lower rates than private insurers.[54] Furthermore, Medicaid underpays for the actual costs of services; for each $1 of cost to provide care, Medicaid reimburses $0.67.[55] Rural hospitals also tend to be low-volume settings, so rural hospitals may struggle to achieve a level of reimbursement that can offset fixed costs. Even though volume may be low, the nature of L&D services is such that providers and staff, including expensive specialized staff like anesthesiologists and surgically trained providers, need to be available around-the-clock.[56]

> "**All obstetric units in hospitals lose money, period.** Obstetric reimbursement just is not enough to pay for that kind of unit. And the more and more standards that arise, we have to meet those standards, yet the reimbursement either stays the same or goes lower."
>
> — Study participant, health care leader

Study participants noted that birth centers also face sustainability challenges, given high startup and overhead costs and low reimbursement. They cited onerous requirements and associated costs to establish a birth center as a licensed facility, thin margins because of their low-risk and low-intervention care model, and lower reimbursement due to some insurers paying less to birth centers than to health centers and hospitals for the same service.

[v] Note: Global maternity reimbursement structures will be ending on January 1, 2027, with changes being led by the American Medical Association.

Low Patient Volume

Low patient volume threatens birth facilities' financial viability.[57] While the literature does not define a threshold for financial sustainability, operational deficits for L&D are common. These can be reflected in days cash on hand, a key metric of liquidity and operational survival. When Arkansas Valley Regional Medical Center and Delta Health closed their L&D units in 2025, both had days cash on hand levels well below the state median of 153 days.[58]

According to the literature and study participants, low patient volumes also make it difficult for clinicians to gain experience and maintain their clinical competency. When a facility lacks the patient volume to regularly encounter a wide range of obstetric issues and complications, the resulting clinical safety concerns can contribute to a decision to close a birth facility.[59]

Workforce and Leadership Challenges

Workforce shortages threaten the sustainability of the workforce and, as a result, the sustainability of L&D units. Since L&D units rely on lean clinical teams, the loss of even a single provider can be destabilizing. To fill these workforce gaps, some hospitals rely on *locum tenens* (temporary travel providers). While this offers short-term workforce stability, it significantly increases operating costs and disrupts continuity-of-care. Furthermore, reliance on *locum tenens* can delay vital community referrals, as these providers are typically less familiar with local resources.

Health care leaders and providers who participated in the study noted that hospital leaders may opt to close an L&D unit to preserve the hospital's financial viability and, therefore, sustain access to the hospital's other service lines. Study participants cited the need for leadership to value and prioritize perinatal services as an essential service for a community and for leadership to "fight for it" when needed. They also cited the value of a supportive organizational culture and the recruitment and retention of mission-aligned staff as key contributors to sustainability. One health care leader described their experience achieving a sustainable staffing model in the rural community health center where they work (see **Case Study 1**).

Case Study 1: Achieving a Sustainable Staffing Model at a Colorado Community Health Center

- **Structure the staffing model to support cost efficiency and comprehensive care:** A midwife-led, physician-backed staffing model has allowed midwives to practice to their full scope, while also creating a "safety net" for higher-risk pregnancies and deliveries.
- **Take deliberate action to incentivize and retain staff:** The practice treats staff retention as a strategic priority built on competitive compensation, intergenerational mentorship (new graduates work with experienced midwives), and mission alignment (passion).
- **Employ a multidisciplinary team to address patients' wrap-around needs:** Such a team includes social workers, nurse case managers, and behavioral health practitioners.

3. Impacts of Birth Facility Closures

The closure of a birth facility triggers a cascade of consequences. Nationally, rural counties that experienced a birth facility closure and were not near urban areas have experienced a small increase in out-of-hospital births, a large increase in emergency department births, and a modest increase in

preterm births.[60] Analysis of the impact of birth facility closures in Colorado on these outcomes has not been conducted to date. Hospital L&D closures have additional effects on individuals during the perinatal period, as well as the perinatal workforce, the broader health system, and the community and local economy. Per the Colorado Hospital Association, hospitals navigate liability and risk-mitigation implications connected to L&D closures including transition planning and the operation of around-the-clock support or consultation lines. Birth facility closures increase both emergent and non-emergent transfers of care.

Impact on Patients and Families

A primary consequence of a closure is increased travel time and distance to access perinatal care.[61] Focus groups and interviews with patients (who live in a rural area and/or experienced a birth facility closure) and interviews with health care providers (serving in a rural area and/or experienced a birth facility closure) indicate that the leading consequence of birth facility closure was increased travel time to care. This can be exacerbated by inclement weather, concerns about laboring during a long drive, the costs and logistics of securing transportation, and the financial burdens of fuel, childcare, and lodging. In rural parts of the state, the closure of a single birth facility can result in significant increases in distance to L&D care. For example, if the hospital L&D unit in Prowers County were to close, many rural residents across the southeast region of the state would likely be facing 60+ miles to the nearest hospital with a L&D unit (see **Figure 1**).[62]

Patients who lose their birth facility to a closure often experience fragmented communication and continuity-of-care. They may also have difficulty identifying and establishing care with an available provider and have concerns around the quality of care they will receive with a new provider or facility.

Birth facility closures disrupt patient choice of birth setting and perinatal care provider. This choice is key to a patient's autonomy, sense of safety, and overall experience of care.[63] Removing this choice leads to frustration, uncertainty, and heightened stress. Downstream effects can include loss of choice in their birthing plan and lack of access to a specific, culturally matched provider.

Impact on Staff and Providers

A birth facility closure affects workers both within and outside the closing facility. Health care providers who experienced a closure or who work in rural areas shared that providers and staff at closing facilities face job loss, an emotional toll, and potentially longer commutes when they secure new employment. Providers who participated in the study described increased workloads among providers and staff at facilities that receive transferred patients. Interviews with health care leaders and with providers revealed that local emergency medical services and emergency department staff may not be prepared to handle obstetric emergencies without L&D support. Community-based providers, such as CPMs, may stop practicing in areas where distance to the nearest birthing facility makes emergency transfers potentially unsafe.

Impact on the Health System

The closure of a hospital L&D unit can result in an increased risk of emergency department births and preterm births.[64] Rural emergency departments are staffed by providers who do not regularly see patients in active labor and may not have ongoing training to safely deliver a baby.

Study participants noted that when hospital leadership views an L&D unit strictly as an isolated cost center, they may overlook the broader economic consequences of that unit's closure. Participants spoke about a hospital L&D unit closure that led community residents to sour on the entire hospital; rather than continue to access other available care in their community, they may instead seek services outside of their community. This can lead to community divestment in the local hospital and long-term financial losses across multiple service lines.

Local Economy and Community Impacts

Because people of reproductive age often consider access to local perinatal care when choosing where to live, they may opt for other communities with greater perinatal care access.[65] This finding is described as a "vicious cycle:" declining birth numbers contribute to obstetric unit closures and, in turn, the loss of such a unit can drive people out of the community and drive birth numbers even lower.[66] Pregnancy is also a sentinel event that drives future primary health care decisions for the household; for many families, perinatal services serve as the entry point for pediatrics, primary care, and urgent/emergency care services.

Study participants consider local access to perinatal care a vital safety net infrastructure that directly influences a community's economic vibrancy. In rural Colorado, health care is a top-five employer and a primary regional economic driver.[67] Because economic decline often precedes and predicts hospital closures,[68] worsening indicators, such as falling per capita income and rising unemployment, serve as early warning signals for at-risk facilities. When a closure causes community members to leave the community, the local economy destabilizes, putting more economic strain on those who remain and potentially discouraging new investment.

Additional Impacts

While the negative effects of facility closures are far-reaching, there are also potential positive impacts. For example, in the case of a facility proximate to a closure, patient volume could be consolidated to nearby sites, allowing providers to work at full capacity and better maintain their skills and clinical competency; ultimately, this can pave the way for improved quality of care and outcomes, especially in the most rural settings.[69] A closure can also reduce the financial strain of an unsustainable unit, allowing a hospital to provide essential services and improve quality of care in other areas of practice.

4. Perinatal System of Care Assets and Innovations

Colorado has several workforce assets and support services in the perinatal system of care that support access and serve as foundational building blocks to strengthen and expand access to care.

FMOB Workforce Model and Education Pipeline

Colorado has cultivated a robust education and training pipeline for family medicine obstetrics physicians (FMOBs) through the Rural Track Program at the University of Colorado (CU) Anschutz. Because FMOBs provide comprehensive primary care, including but not limited to perinatal care, they are the "Swiss Army knife of rural perinatal medicine." They can cover and share call schedules across many service lines (e.g., obstetrics, pediatrics, internal medicine). An FMOB model in an L&D unit offers cost efficiency and flexibility for a rural hospital.

Robust Midwifery Workforce and Pipeline

Colorado's regulatory environment has supported independent midwifery for over 30 years, including the practice of CPMs, CNMs, and, more recently, CMs. Colorado began licensing CMs in 2023, and CU Anschutz is launching a direct-entry Master of Science in Midwifery program in the fall of 2026. By not requiring a prior nursing degree, this program reduces barriers to entry for the perinatal workforce.

Perinatal Wrap-Around Support Services

Colorado has statewide resources and support for families throughout pregnancy and the postpartum period. This includes home visiting programs such as the Nurse-Family Partnership®, Parents as Teachers®, Family Connects, and Healthy Steps®, as well as a network of doulas, lactation counselors and consultants, peer supports, and community health workers who provide psychosocial and emotional support during the perinatal period. Rural areas (including in other states) tend to have fewer support services (e.g., doulas, lactation consultants) and would benefit from increased investment in this type of workforce.[70] [71] For example, the study revealed that only one doula serving the Western Slope in Colorado accepts Medicaid. Furthermore, patients who participated in the study indicated wanting more resources for lactation support and home visits, especially in the postpartum period.

5. Perinatal Care Access Strategies Proposed by Study Participants

Study participants described strategies to strengthen birth facility sustainability, as well as to mitigate the negative effects of birth facility closures.

Formalize Regional Collaborations and Transfer Protocols to Support Sustainability

Study participants generally endorsed regional collaboration as a strategy to support sustainability. Regionalized perinatal care increases access by strengthening relationships between facilities within a region.[72] This entails cross-facility support through shared workforce pools, training, and call coverage. By defining clear capabilities and transfer thresholds, low- to moderate-risk patients remain in their communities, while high-risk patients are directed to facilities with specialized care.

Adopting standardized transfer protocols between community birth providers and hospital systems ensures collaborative relationships and prevents delays when a higher level of care is required. By establishing transfer and consultation relationships with higher acuity facilities and specialty providers, community birth providers can continue to provide reliable care to patients. Aligning with the ACOG recommendations,[73] these partnerships use shared education and protocols to optimize safety and quality across a region.

Study participants spoke of the need for improved collaboration between obstetric practices and community midwives to support safe transfers. While community birth is a small share of the births in Colorado, several study participants working in the community birth space elevated the need for strengthening collaboration to support safe transfers. Liability concerns were cited as hindering collaboration between community midwives and hospitals, especially in the case of transferring care from the community setting to the hospital setting. However, study participants noted that these concerns could be alleviated with regular interprofessional engagement, such as an obstetric

hospitalist regularly meeting with community midwives to discuss their respective practices. One midwife who participated in the study described her positive hospital-community collaboration experience (see **Case Study 2**).

Case Study 2: Building Hospital-Community Birth Alliances to Support Transfer-of-Care

- **Start with informal relationships.** Rather than grounding relationships with community midwives in rigid and defensive legal contracts, the initiative began with informal, friendly conversations. Community midwives and hospital leadership met in a low-stakes environment to discuss general practice styles. These conversations evolved into stronger relationships and, ultimately, stronger transfer-of-care practices and warm handoffs.
- **Identify hospital-based champions.** Success was anchored by the director of maternal and child health and the lead obstetric hospitalist. These leaders signaled to the rest of the hospital-based care team that community midwives should be viewed as peers rather than outsiders, giving the institutional "permission" that the team needed to constructively facilitate transfers.
- **Frame transfers of care as collaborations rather than failures of community providers.** When a community birth requires a higher level of care, approach the transfer to a hospital as a collaborative effort. Emphasize the effort required of both the community and hospital providers to achieve the shared goals of high-quality care and patient safety.

Engage in Timely, Person-Centered Communication to Mitigate Closure Impact

When a birth facility plans to close, study participants identified the importance of timely and effective communication to patients, staff, and providers. Ample lead time helps patients and staff arrange alternative care. They also described the importance of a person-centered approach that includes notifying patients individually and providing a central communication line for emergent care needs. Additionally, they noted the importance of notifying the community's emergency medical services and hospital emergency department and other local providers and programs.

Ensure Care Coordination and Service Continuity to Mitigate Closure Impact

Study participants noted that closing facilities must prioritize a structured warm handoff, including support for relatively seamless transfer of medical records for current patients to the new facility or provider. They should also triage transitions of care based on gestational age. For example, to maintain care stability, closing facilities should, whenever possible, allow patients in their third trimester to continue care at their facility until delivery; those earlier in their pregnancy would transition to new providers.

Study participants suggested maintaining local prenatal and postpartum care services to support patients in receiving local continuous care during these periods (even if they would still need to travel a greater distance for L&D)**.** Additionally, connecting families to other local services and resources (e.g., transportation) supports access to care. Study participants emphasized postpartum home visits and integrated mental health support in particular as critical, but often fragmented, inaccessible, and unknown to patients. The postpartum period is a highly vulnerable time when patients risk "slipping through the cracks," which can lead to missed warning signs for severe complications.[74]

Strengthen Emergency Services to Mitigate Closure Impact

Birth facility closures shift the burden of obstetric emergencies to hospital emergency departments and emergency medical services in the impacted area. Study participants noted that, to ensure safety, local emergency medical services should focus on providing paramedics with specialized training in “birth in the field” and neonatal resuscitation. Educating local paramedics on community midwives’ scope of practice could also strengthen and streamline transfers from community settings to hospitals.

III. Recommendations to Increase Access to the Perinatal System of Care and Mitigate Birth Facility Closures

These recommendations, based on study findings, offer strategies to foster resilience of the perinatal system of care and mitigate birth facility closures. The foundation of sustainable change includes:

- **Building relationships, collaboration, and communication across sectors**
- **Employing a "whole of government" approach** that leverages leadership within the state health department, other state agencies, the Office of the Governor, and elected officials
- **Applying a systems thinking framework** that accounts for the interdependence of care networks to ensure policy changes in one area strengthen the entire perinatal system of care
- **Recognizing rural obstetric services as essential safety-net infrastructure**, independent of patient volume

The following recommendations provide a scalable menu of possible action steps. These range from immediate refinement of existing regulations to broader systemic reforms requiring new legislative authority. Maternity health professional shortages and L&D closures are most often a symptom of broader hospital financial and workforce instability, rather than solely a service-line issue. The qualitative study focused on the impacts of a birth facility closure on access to perinatal care and therefore, the recommendations center on improving access to birth facilities and perinatal care.

Because each action step comes with unique fiscal requirements and implementation timelines, this range of options allows for a flexible legislative response to evolving issues impacting rural hospital L&D units and rural hospitals more broadly. The feasibility and impact of these recommendations will depend on evolving realities and may be affected by further disruptions to rural hospital L&D units, external market shifts, and other unforeseen challenges. Lastly, additional strategies to address the hospital L&D closure crisis are likely to arise as a result of the diverse, adaptive approaches currently being pilot tested within Colorado and nationwide and are likely to provide an ongoing source of inspiration, correction, and recommendation.

The recommendations contained within this report are a product of JSI and should not be construed as recommendations or specific opinions of the CDPHE nor any other organizations or individuals named in the report.

1. Strengthen the Perinatal System of Care

Recommendation 1.1: Establish a formal designation process for Levels of Maternal Care.

Rationale: ACOG developed the Levels of Maternal Care, a framework to promote "collaboration among maternal facilities and health care providers so that women receive risk-appropriate maternal care, a key strategy to reducing maternal mortality and morbidity."[75] The levels include accredited

birthing centers, basic care (Level I), specialty care (Level II), subspecialty care (Level III), and regional perinatal health care centers (Level IV). Importantly, the goals include "allowing low-to moderate-risk women to stay in their communities and pregnant women with high-risk conditions to receive care in facilities that are prepared to provide the required level of specialized care."

Action Steps:

- **Assess the potential for a Colorado Levels of Maternal Care System.** Inform the assessment on findings from CPCQC's forthcoming analysis on implementation approaches in other states, costs, and the regulatory authority.
- **Update the CDPHE State Health Professional Shortage Areas (sHPSAs) map.** Update designation of hospital L&D units and birth centers to align with Levels of Maternal Care.

Recommendation 1.2: Encourage regionalized transfer and consultation networks between low-acuity (Level I/II) rural hospitals and high-acuity (Level III/IV) regional perinatal centers.

Rationale: Along with the Levels of Maternal Care, ACOG recommends a hub-and-spoke model in which low-acuity facilities "participate in a regional integrated delivery system with ready access to consultation and referral when needed, outreach education from regional perinatal centers, and regional analysis and evaluation of regional data."[76]

Formal networks help sustain low-acuity hospitals and prevent unit closures. They offer community providers, such as FMOBs, immediate specialist backup and remote consultation; support during high-risk emergencies; a pathway for strong care coordination; and shared cross-hospital infrastructure investments (e.g., telehealth, protocols, and quality improvement activities). Partnerships specifically between hospital L&D units and federally qualified health centers (FQHCs) can expand community services while saving hospitals millions of dollars via lower malpractice premiums and streamlined costs[77] (see the rural western Massachusetts example of an FQHC-hospital L&D unit partnership).[78]

Several states are using Rural Health Transformation Program[vi] resources to implement or expand collaborative arrangements. For example, California's proposed regional hub-and-spoke network would feature perinatal hospital hubs and spokes such as critical access hospitals, clinics, birth centers, and other providers.[79] CHA recommends any actions to support regionalization efforts should be voluntary and include liability, capacity, and funding considerations; they should also follow a multi-stakeholder process.

Action Steps:

- **Implement an around-the-clock statewide perinatal specialist hotline.** Make it accessible to hospital staff, emergency medical services personnel, and community birth providers. This will enable providers to consult real-time with high-acuity specialists (e.g., maternal fetal medicine, OB-GYN, or neonatologist) to support patient stabilization and transfers of care.

[vi] Note: Throughout the recommendations, examples of strategies from other states describe current Rural Health Transformation Program proposals. These examples are shared as potentially replicable models and early pilots that Colorado should monitor to address impact on perinatal care and access in rural areas.

- **Expand telehealth consultation infrastructure.** Provide tailored support and funding to rural hospitals to implement or upgrade telehealth capabilities, to facilitate virtual consults with regional specialists and allow for collaborative decision-making. Promote and encourage the use of PROSPER, a perinatal psychiatric expert consultation hotline intended to support clinicians caring for patients impacted by perinatal mental health and substance use.[80]
- **Establish interprofessional training frameworks.** Convene multidisciplinary personnel from lower- and higher-acuity centers for annual training on transfers and consultations, incorporating insights and feedback from patients who have experienced care gaps.
- **Fund pilot partnerships between FQHCs and rural hospitals.** Create a state grant to cover the initial legal and administrative costs of establishing shared-staffing agreements between FQHCs and rural hospitals in regions most impacted by birth facility closures (e.g., Southeast Colorado).
- **Provide facilities with optional shared credentialing support.** Support rural hospital L&D units with optional credentialing resources and support to help reduce administrative burden. Optional support allows for individual hospitals to continue to make decisions that reflect their staffing models and service considerations.

Recommendation 1.3: Standardize and fund perinatal emergency training, equipment, and transfer protocols.

Rationale: Hospital L&D unit closures increase the risks of perinatal emergencies and research has indicated that in the year after a unit closure, there is an increase in unplanned out-of-hospital births.[81] Additionally, study participants expressed concerns for other perinatal emergencies such as roadside deliveries and emergency department births. Demand for planned out-of-hospital births is also increasing, and ACOG estimates that 10–25% of such births will involve a transfer. As a result, there is a high need for both emergent transfers and non-emergent transfers.

Without advance planning, there are many hurdles to transfers across institutions, including poor communication and separate licensing, insurance, and regulatory structures. Given the risks to maternal and infant outcomes posed by situations in which a transfer is needed, ACOG has recommended mandating transfer protocols mutually agreed to by the out-of-hospital birth attendant and the hospital.[82] Some states also have efforts underway to prepare emergency departments to provide perinatal emergency care. For example, Georgia's Rural Health Transformation Program places obstetric carts with medications and supplies for hemorrhage management, neonatal resuscitation, and preeclampsia treatment in rural non-delivery emergency departments.[83] New York is using Rural Health Transformation Program resources to advance their "Rural Roots" workforce development model addressing maternal care in rural parts of New York through simulation-based obstetrics training for emergency medical technicians, nursing, and medical students.[84]

Certain hospital policies or practices may not be supportive of transfer of care protocols. For example, some hospitals and physicians may refuse to accept a patient transferred from a birth center without a consulting agreement in place. Study advisors reported a common misconception among hospitals that birth centers must be within 30 minutes of a hospital, though no statute or regulation dictates this. This misconception can lead hospitals to reject transfer of care protocols

from birth centers more than 30 minutes away and prevent birth centers from being fully integrated into the regional health care landscape.

Action Steps:

- **Promote the Colorado Safe Transfer Coalition's Consensus guidelines and implementation tools among community, hospital, and emergency medical services providers.**[85] These guidelines and resources aim to support collegial, collaborative transfers from community birth to hospital settings.
- **Support the regional alignment of hospital and birth center policies regarding safe transfer protocols.** According to study participants, aligning the travel-time threshold for transfer-of-care protocols between birth centers and hospitals would support continuous, timely care.
- **Codify the 2025 ACOG transfer protocols.**[86] Support hospitals in establishing formal, written transfer agreements with out-of-hospital birth attendants to ensure seamless bias-free transitions of care.
- **Update emergency medical services formulary and equipment.** Following an analysis of necessary supplies, update protocols to ensure emergency medical services systems carry essential medications (e.g., pitocin and/or medications to address hemorrhage needs) and equipment for safe transfer, drawing on the expertise of champions, such as members from the Colorado Safe Transfer Coalition (e.g., an emergency medical technician provider and/or midwife).
- **Fund equipment and medication procurement.** Provide funding for emergency medical services units to purchase necessary medication and equipment, and to conduct ongoing training.
- **Scale and fund high-fidelity simulation.** Fund a statewide obstetric simulation program to bring mobile simulation units and expert facilitators directly to rural hospitals with and without L&D units for high-fidelity emergency drills. Simulations could also be designed to include scenarios in which a community-based provider conducts an emergent transfer of care to a hospital.

Recommendation 1.4: Study and consider adopting a legislative and regulatory framework for standby perinatal units, modeled on California's Plumas Model.

Rationale: If hospital L&D units continue to close in Colorado, it will be necessary to provide rural communities in particular with local alternatives for safe, reliable perinatal care. California's pilot of the Plumas Model for rural communities, passed in 2025, specifically intends to preserve access to local prenatal care and reintroduce local L&D services for low-risk patients.[87] The model centers a freestanding birth center that provides prenatal care and handles low-risk births in the community, complemented by a hospital-based on-call standby perinatal care team, available within 30 minutes, but not staffed around-the-clock, to handle transfers of care when needed.[88] The on-call team is staffed by one CNM, one RN, and one physician (MD/DO). The perinatal care access landscape in Plumas County mirrors the landscape in much of rural Colorado, suggesting that a pilot of the Plumas Model in Colorado is worth exploring.

The framework uses a risk-appropriate care model that relies on triaging patients and, if needed, ensuring access to higher-acuity care. This entails leveraging relationships within a regional perinatal network to, for example, provide telehealth perinatal and neonatal consultations and refer patients to specialized providers.[89]

Action Steps:

- **Assess candidate hospitals for a pilot.** In partnership with stakeholders such as CHA and CPCQC, identify rural hospital L&D units that have closed within the last 5 years but have retained the infrastructure necessary to operate a standby perinatal unit. Prioritize communities where there are high numbers of home births attended by CPMs. Utilize the state-designated Health Professional Shortage Areas (sHPSAs) map as a resource in determining pilot sites as it provides a highly localized and data-driven framework to guide critical workforce infrastructure decisions. Unlike federal Maternity Care Target Areas (MCTAs), which are dependent on established Primary Care shortage designations, CDHPE's perinatal sHPSA models evaluate the entire state for shortages and consider a broader range of the maternal health workforce. This precision allows the state to efficiently allocate strategic workforce investments, such as the Colorado Health Service Corps physician loan repayment program, to the communities across the state facing the greatest maternal health needs.
- **Draft a Colorado Standby Perinatal Services Act.** Model the Colorado legislation after California's Senate Bill (SB) 669. Authorize a time-limited pilot with a midwifery-led birth center as the primary delivery site and a hospital-based on-call standby perinatal care team in the event of a transfer. Require data collection on safety, outcomes, and utilization, and feasibility of a Medicaid standby capacity payment.
- **Explore a collaboration agreement or Memorandum of Understanding with the Plumas Pilot.** Create partnerships with implementation partners in California, including the Department of Public Health and Plumas District Hospital, to learn real-time from their pilot and inform implementation and adaptation in Colorado. If any data (e.g., clinical, financial, survey, etc.) is exchanged, a data use agreement will be needed.

Recommendation 1.5: Strengthen and resource perinatal home visiting programs.

Rationale: Home visiting programs are a proven strategy to improve maternal and infant outcomes (e.g., fewer ED visits, more prenatal care, less substance use).[90] To increase perinatal care access in rural areas, since 2019 HRSA has funded the Rural Maternity and Obstetrics Management Strategies pilot program. Some states in the pilot cohort, like New Mexico, are integrating home visiting into their program.[91] Strengthening home visiting programs can help reduce the impacts of hospital L&D closures by serving as a critical connection to the health system through supporting screenings and referrals and care coordination.

Action Steps:

- **Expand care coordination capacity.** Provide additional funding to home-visiting programs to hire or expand navigation services, helping strengthen and/or rebuild connections between families and care systems.
- **Incentivize in-home screenings.** Equip and train home-visiting nurses to facilitate screenings and initial follow-up in the home. For remaining hospital L&D units, ensure all birthing hospitals have the equipment and training needed to conduct screenings.
- **Invest in telehealth infrastructure to support home visiting programs.** Apply for Rural Maternity and Obstetrics Management Strategies program funding, if future opportunities arise, to invest in infrastructure and coordination of care within a regionalized perinatal system of care. Otherwise,

consider Rural Health Transformation Program funds to invest in infrastructure to expand integration and connection of home visiting programs in the perinatal system of care.

2. Invest in the Perinatal Care Workforce

Recommendation 2.1: Invest in the hospital-based workforce with immediate, sustained, and long-term actions to stabilize and grow the rural perinatal workforce.

Rationale: Rural communities are trapped in a cycle of high turnover and staffing shortages, which threaten the viability of L&D units. With a projected shortage of 140 OB-GYNs in Colorado by 2038,[92] the state must prioritize workforce models that center providers with broader service capabilities. Facilities can remain clinically and operationally viable if they move from specialized services provided by OB-GYNs to FMOBs who can provide care across the lifespan. In addition, midwives can manage up to 80% of essential maternal care[93] and certified registered nurse anesthetists (CRNAs) can mitigate the costs of around-the-clock anesthesia coverage, yet they remain underutilized.

Growing the perinatal workforce includes both investing in the pipeline of new providers as well as removing obstacles for those already practicing. Opportunities to invest in the pipeline include building on existing FMOB and midwife training programs and offering financial incentives.

Strengthening the hospital-based workforce also relies on removing obstacles for those already practicing. According to study participants, some hospitals require APRN-physician collaborative agreements as a condition of APRNs to obtain hospital privileges. Under Colorado law, CNMs, CRNAs, and other APRNs may be licensed to practice independently within their defined scope and do not require physician oversight as a condition of licensure.

From the hospital perspective, collaborative agreements—when used—are generally intended to support clear, collegial care relationships rather than to impose supervision or limit APRN independence. As reflected in medical staff bylaws and credentialing processes, they may help outline expectations for communication, consultation, and escalation of care when clinical needs exceed a provider's scope or when complications arise. Hospitals use these governance structures to align provider roles with available resources, staffing models, and patient safety considerations.[94]

Study participants reported that because hospitals and physicians rarely sign off on collaborative agreements, this effectively prevents CNMs and CRNAs from practicing independently in those L&D units. This could be problematic in communities with a shortage of perinatal providers.

Action Steps:

- **Support and expand recruitment for the FMOB and midwifery pipelines.** Partner with the University of Colorado Anschutz and community colleges to recruit and train future FMOBs and midwives from rural areas and ensure local clinical placement. Additionally, consider direct scholarships and/or stipends for students in programs like the CU Anschutz College of Nursing and rural FMOB residency track who are committed to practicing in rural areas. This strategy is a long-term investment and does not address the immediacy of the workforce shortages. Consider opportunities for pre-licensure interprofessional training between obstetric providers.
- **Implement targeted financial incentives.** Develop salary supplements, personnel cost support (e.g., housing support, continued medical education), and/or enhanced loan repayment through the Colorado Health Service Corps to organizations that employ a diversified perinatal workforce (midwives, FMOBs, and CRNAs) in state-designated Health Professional Shortage Areas (sHPSAs).
- **Expand the Colorado Health Service Corps.** Expand eligibility to include CRNAs and CMs who commit to a minimum of three years of service in rural sHPSAs, which already includes FMOBs and CNMs. Note, this would help to more immediately address obstetrical workforce gaps.
- **Ensure rural provider representation to improve perinatal health.** Ensure rural providers, in particular FMOBs, have representation in the state's Maternal Mortality Review Committee to guarantee rural perspectives are included as rural regions of the state have the highest maternal mortality ratios.
- **Support doula workforce development**. Allocate permanent funding for the Doula Scholarships Program to cover training and certification costs for individuals from rural and marginalized communities, ensuring a diverse workforce that meets the requirements for Medicaid reimbursement.
- **Create spaces for interprofessional collaboration.** Spaces for connection, creating and supporting psychological safety proves valuable in building and maintaining rapport and trust between providers, especially in the context of systems for transfers of care. Bringing stakeholders together for ongoing conversation and collaboration is essential to continue to understand different perspectives, how the system is operating, and brainstorm solutions. CHA is well positioned to play this role as they have served as conveners previously.

Recommendation 2.2: Sustain clinical competence in low-volume hospital L&D units with cross-institutional clinical rotations and case-based learning.

Rationale: Maintaining clinical competency and confidence in low-volume L&D units is critical for workforce retention and patient safety. ACOG recommends rural providers from low-volume facilities periodically rotate to higher-volume facilities in the region to support clinical experience.[95] One rural hospital L&D unit in Colorado is already integrating clinical rotations within their (closed) system. Study advisors CPCQC and CHA recommend developing a clinical exchange program for hospitals. Note that, according to the Government Accountability Office, malpractice insurance limitations may prevent some providers from attending births in different facilities, including for training purposes.[96] CHA echoed similar concerns that liability and credentialing regulations would need to be taken into consideration.

Within the literature, models of clinical rotations exist within and between health systems which could be replicated in Colorado. For example, RWJBarnabas Health in West Orange, NJ supports obstetrical complication simulations in emergency departments in hospitals without L&D units.[97] The Minnesota Rural Obstetrics Simulation and Education Program launched in partnership with the Minnesota Department of Health and Community Memorial Hospital created the program to improve maternal and infant outcomes that includes portable, high-tech simulation equipment, scenario-based training modules, interdisciplinary team training, onsite and regional workshops, and more.[98] States such as Arizona have proposed utilizing Rural Health Transformation Program dollars to implement a similar shared staffing approach for providers working in rural areas.[99]

Action Steps:

- **Establish a statewide clinical exchange program.** Fund a program that allows rural providers to rotate through high-volume regional perinatal facilities to refresh high-acuity skills.
- **Resolve institutional and liability barriers.** Develop standardized inter-facility participation agreements that address malpractice insurance limitations for rotating providers and implement reciprocal credentialing to bypass lengthy vetting processes.
- **Promote and scale high-fidelity simulation.** Using the fund described in recommendation 1.4, bring mobile simulation units and expert facilitators directly to rural hospitals with and without L&D units for high-fidelity simulation drills, including but not limited to emergency drills, to support sustained clinical competence.
- **Integrate case-based learning.** Fund case-based learning, such as through the Extension for Community Health Outcomes Colorado to ensure rural providers have a permanent, state-supported platform for collaborative problem-solving and evidence-based learning on complex cases.

Recommendation 2.3: Support the community midwifery workforce with targeted integration steps.

Rationale: By supporting the midwifery workforce in providing care at the full scope of practice, Colorado can improve access to perinatal care in rural communities with L&D closures, offer some relief for persistent workforce shortages, and align workforce with research indicating that out-of-hospital births increased the year after an L&D closure.[100] Selected counties in the study revealed higher home birth rates attended by CPMs than the state as whole.[101] Additionally, both perinatal care providers and perinatal care patients who participated in the study expressed increased interest or demand for out-of-hospital birth services.

Study participants described state regulations that currently hinder the ability of midwives to provide care at the full scope of practice. State regulations that define the scope of practice for CPMs limit the clinical care they can provide, despite adequate education, training, and qualifications. For example, even though Colorado CPMs are qualified to manage postpartum hemorrhage with medicine, study participants cited that CPMs are prohibited from carrying tranexamic acid, a standard of care medication used to treat this condition. They are also trained to provide antibiotics and contraception but are prohibited from prescribing antibiotic treatment for urinary tract infections or prescribing contraception.

Study participants (e.g., providers serving in rural regions and/or providers who experienced a birth facility closure) noted in their experience that the Colorado Department of Regulatory Affairs (DORA) and the Colorado Department of Health Care Policy and Financing (HCPF) regulations (DORA, HCPF) were inconsistent regarding malpractice requirements for CPMs. Specifically, the study found that current regulations do not require CPMs to have malpractice insurance until it is "deemed affordable and accessible" by DORA though to become a Medicaid provider, HCPF requires CPMs to have malpractice insurance.

According to study participants, a key part of the effort to uplift the role of midwives would include changing oversight of midwife regulations from DORA to a midwife-led committee, advisory board, or a regulatory body that is well-positioned to advise on low-risk models of care. Other states are already taking this approach: For example, New Mexico has a midwifery advisory board within the state department of health that oversees midwives;[102] Washington has a midwifery advisory committee that advises the department of health;[103] and Oregon has a midwifery board that oversees CPMs and other midwives without a nursing degree (known as direct-entry midwives).[104]

A Perinatal Nurse Consultant at the Washington Department of Health shared that the state is taking steps to promote patient choice and reduce costs through the integration of licensed midwives (the equivalent of CPMs in Colorado). Washington Medicaid and private payers share information about licensed midwives as an option for birth after a pregnancy is confirmed. Washington's goal is to connect more people with low-risk pregnancies to licensed midwives if that is their preference. In 2014, Washington made data collection mandatory for licensed midwives as a condition for licensure renewal. This mechanism minimized data collection burden to licensed midwives and facilitates generation of data on planned home and birth center outcomes in a format consistent with hospital data.[105]

Action Steps:

- **Create a midwifery-led body to oversee or advise on midwifery regulations.** If possible, move toward a "Midwives Regulated by Midwives" model, consolidating the oversight of CNMs, CPMs, and CMs into a single governing body managed by experts within the midwifery model of care. Alternatively, create an advisory committee.
- **Align HCPF and DORA requirements regarding CPM malpractice insurance requirements.** Ensure CPMs are receiving consistent guidance regarding malpractice insurance across state agencies.
- **Remove state regulatory barriers that limit CPM scope-of-practice.** Update state statutes to allow CPMs to practice to the full extent of their training, including well-woman care and basic primary care (e.g. treating urinary tract infections). Washington passed Substitute Senate Bill 5765 in 2022 allowing licensed midwives (the equivalent of CPMs) to prescribe, obtain, and administer hormonal and non-hormonal family planning devices and implants; ongoing training is expected to receive this prescriptive authority.

3. Structure Financing and Reimbursement to Support Rural Birth Facilities

Recommendation 3.1: Create supports to prevent further birth facility closures and resources to monitor outcomes of closures.

Rationale: Preventing rural hospital L&D unit closures is critical to ensuring access to perinatal services in rural Colorado. While the literature does not have a specific methodology or exact number of births per year to identify an at-risk hospital L&D unit, there are some ranges in the literature. There is a lack of consensus of minimum number of deliveries per year that indicate clinical safety and financial viability. For example, one study reported hospital leadership noted needing to provide 200 births.[106] Whereas study advisors CPCQC and CHA shared in research they conducted with rural hospital L&D units, the units ranged from 95-150 births per year.

While there are current efforts underway to collect data monitoring the impacts of L&D closures, there are additional metrics specifically at the family level that could enhance existing data collection efforts. Ongoing collection of data in this area would necessitate renewed funding. The addition of new metrics would require an increase in funding.

Action Steps:

- **Create an early warning system.** Create an early warning system to identify at-risk rural hospital L&D units due to workforce, financial, and/or volume concerns. Future iterations of an early warning system should include accredited birth centers. Consider using the existing sHPSAs infrastructure that are updated annually to integrate current data from clinicians and localized pregnancy volume to identify areas with a shortage of perinatal healthcare providers. sHPSAs can be overlaid on the map with locations of all birth facilities, highlighting recently closed locations. This analysis and visualization tool provides foundational information for an early warning system. By identifying hospitals that operate within existing perinatal sHPSAs, the state can pinpoint geographically isolated facilities where local capacity is already strained. Because these communities lack alternative local capacity, any workforce or financial threat to these specific institutions would immediately eliminate regional access to care, serving as a core indicator that state intervention is needed.
- **Provide financial support for at-risk L&D units.** Allocate general funds for rural hospitals identified by the early warning system as having critically low liquidity with financial support and/or tailored technical assistance to work through workforce, financial, and/or volume concerns before any decisions are made for a hospital L&D unit.
- **Continue to support and expand monitoring for outcomes.** To monitor the outcomes related to closures, continued funding of existing datasets and programs is necessary. Additionally, new measures proposed (see V. Proposed Outcome Categories) will require the establishment of new resources.

Recommendation 3.2: Support more formalized regional collaboration and agreements between hospitals and other rural health providers.

Rationale: Regional collaboration can support rural hospitals, including L&D units, with workforce solutions via resource and service sharing, care coordination, and improved efficiency. Shared services can include legal, insurance, accounting, compliance, coding, peer-to-peer learning, clinical and non-clinical education, group purchasing, and more, according to the Rural Health Hub.[107] The Rural Wisconsin Health Cooperative is one of the country's earliest and successful models of a regional collaboration. Participants in this rural hospital network, which has existed for over 40 years, have shared clinical services, credentialing, quality improvement, and education.[108]

With the passage of SB23-298 and SB25-078, Colorado Revised Statutes 25.5-1-1001 and 25-3-304.5, rural hospitals are able to participate in voluntary, non-mandated collaboration. To date, 25 rural hospitals have been approved to participate in collaborative agreements under this law.[109] Voluntary, non-mandatory collaborative agreements support rural hospital sustainability by reducing costs and administrative burden, thereby strengthening hospital viability. Many rural hospitals still stand to benefit from participating in a collaborative agreement.

South Dakota is using their Rural Health Transformation Program funds to establish Regional Maternal and Infant Health Hubs that include clinical care and broader care coordination connecting rural sites (spokes) to larger facilities (hubs) after conducting a maternal health gap, policy, and funding analysis to identify service shortages, as well as workforce needs.[110]

Action Steps:

- **Promote rural hospital collaborative agreements.** Continue to support and promote the ability to allow rural hospitals to enter collaborative agreements that are voluntary and help to reduce cost and administrative burden. If resources are a barrier to establishing collaborative agreements, fund a third-party entity to take on the administrative burden of submission and/or to provide legal and financial consulting to help rural hospitals navigate the process.
- **Expand access to regional collaborative agreements for additional facilities.** Expand access to collaborative agreements in line with SB23-298 and SB25-078 to accredited birth centers.
- **Form regional shared workforce pools.** Allow independent rural hospitals and accredited birth centers to share clinicians and coordinate call coverage to maintain a safe coverage pool across multiple regional facilities, based on locally appropriate care models that reflect differences in volume, staffing, and clinical capacity as well as considerations for credentialing and privileging decisions.

Recommendation 3.3: Implement a standby capacity payment to support Colorado's rural hospital L&D units.

Rationale: Standby capacity refers to the capability of a birthing facility to support L&D at any time regardless of whether there is an actual delivery or C-section and includes the readiness of providers and equipment to deliver a baby. Standby capacity costs are fixed regardless of birth volume.

Standby capacity payments make up the difference between required costs to maintain safe and responsive operation and delivery.[111]

Action Steps:

- **Develop and implement a standby capacity payment for rural hospitals.** Ensure both the Department of Health Care Policy and Financing and private payers implement a fixed quarterly standby capacity payment to cover essential fixed costs of hospital L&D units. These payments should be weighted by a composite geographic risk score that accounts for both local workforce shortage and physical isolation (catchment size). Payments can be scaled based on (1) the relative Perinatal sHPSA shortage decile scores within a facility's catchment area and (2) the facility's catchment area travel threshold. Emphasis should be placed on facilities with a catchment area beyond a 37-mile (60 kilometers) travel threshold. Research shows that adverse health outcomes increase significantly beyond this distance.[112]

Recommendation 3.4: Support the rural perinatal workforce during the payment reform transition.

Rationale: Starting in January 2027, significant billing changes will transition maternity care services from a bundled payment after delivery to per service reimbursement. Led by the American Medical Association, maternity unbundling will "better reflect modern obstetric practice, enable accurate and transparent reporting across the full pregnancy spectrum, and create the data foundation necessary to better attribute maternal care and support the complexities of team-based care throughout a patient's journey."[113] The unbundling of maternity care will impact all payers. In addition to this, HPCF is launching a new, voluntary alternative payment model (APM) which is an evolution of an existing alternative payment model for maternity care which impacts Medicaid.

Action Steps:

- **Monitor the maternity unbundling and the alternative payment model.** Closely monitor these two major billing changes to determine if additional advocacy or regulatory requirements should be instituted, including monitoring for unintended revenue loss tied to volume volatility for low-volume hospitals during the transition.
- **Provide technical assistance to rural hospital L&D units.** Support small and rural hospital L&D units with technical assistance and education during payment reform.

IV. Proposed Best Practice Guidelines for Birth Facility Closures and Resulting Transfers of Care

The guidelines below aim to mitigate the harm resulting from the closure of a local birth facility and support resulting transfers of care. Specifically, these guidelines focus on the importance of closure-related oversight and review, timely communication, and coordinated transfers of care. They address:

- **Risks** that threaten to disrupt continuity of care, leading to adverse maternal and infant health outcomes
- **Opportunities** to prevent a facility closure and mitigate the effects of a closure
- **Process and other considerations for transfers of care** to ensure strong communication and care coordination and ultimately prevent gaps in care
- **The need to inform impacted communities** of an impending closure and support ongoing perinatal care access following a facility closure
- **The need to inform CDPHE** of an impending closure in order to secure CDPHE oversight, review, and support during and after a facility closure
- **The need for a clear and realistic closure timeline** that allows adequate time to notify patients, personnel, and other stakeholders and develop transfer of care plans
- **Potential resources needed** by facilities, providers, and families following a closure to ensure ongoing perinatal care access

These best practice guidelines are informed by the literature, feedback from perinatal access experts (including CPCQC, CHA, and ACOG), and input from study participants. While these guidelines represent the ideal action steps during a birth facility closure, they may need to be adapted to make them contextually relevant and operationally realistic.

1. CDPHE Oversight and Review

CDPHE is positioned to oversee, review, and support a facility closure process given its overarching role as a convener and coordinator and the role of CDPHE's Health Facilities and Emergency Medical Services Division (HFEMSD) in oversight and enforcement of all health facility closures, including hospitals and birth centers. The following guidelines aim to support regional perinatal care access at the health systems level.

Guideline 1.1: Explore and conduct a community impact assessment, if needed.

Currently, CDPHE does not have the authority to implement guideline 1.1. Legislative action is required to grant CDPHE the statutory authority necessary to assess the impacts of a potential closure and to intervene when appropriate.

- **Determine if a community impact assessment is needed**, in alignment with the National Academy for State Health Policy (NASHP) model legislation,[vii] which provides a policy framework to guide states as they address health care closures, consolidations and/or acquisitions of facilities or key service lines.[114] The assessment would review the impact of the potential closure on cost, quality, equity, and perinatal care access.
- **If an assessment is deemed necessary, conduct the review.** As part of this review, engage the closing facility and community to understand facility challenges and considerations, potential benefits and harms from closure, economic and community health considerations, and priorities and thoughts related to perinatal care access.
- **Intervene if a closure is deemed harmful to the public interest, in alignment with the National Academy for State Health Policy model legislation.** For example, use administrative authority to block the closure or place conditions on the closure. If a birth facility closure is deemed harmful to the public interest and the continued provision of essential L&D services is threatened, explore and determine the necessary supports to ensure financial and operational feasibility (e.g., financial support, workforce support), and safe, quality services.

Guideline 1.2: Support the closing facility in implementing best practice guidelines for a closure.

- **Ensure that closing facilities provide notice to stakeholders about an impending closure as specified in state law.** The HFEMSD is responsible for oversight and enforcement of federal and state statutes and regulations applicable to health care facilities and services in Colorado, including hospitals and birth centers.
- **Review and approve a closure plan for compliance with state law and best practice guidelines.** Provide technical assistance, as needed, to support the closing facility in complying with best practice guidelines to the extent feasible.
- **Support facilities with impending closure in communicating** with regional perinatal care facilities to establish transfer agreements and facilitate transfer of care for current patients and future perinatal patients.

[vii] Note: The National Academy for State Health Policy's model legislation on addressing transaction oversight, corporate practice of medicine, and transparency is designed as a framework and comprehensive approach to support states as they address health care closures, consolidations and/or acquisitions of health care facilities or key service lines. While the model legislation is not specific to birth facilities, it includes relevant elements regarding state oversight, assessment of potential impacts, notification timelines, and transparency.

Guideline 1.3: Monitor the impacts of closures on perinatal care access and health outcomes.

- **Prioritize monitoring perinatal care access and outcomes** in communities that experience birth facility closures (refer to Proposed Perinatal Care Access Outcome Categories).

Guideline 1.4: Monitor notification to the state when there are ownership transitions among facilities that provide perinatal care services and intervene, if needed.

The Code of Colorado Regulations requires that facilities providing perinatal care services notify HFEMSD of defined transitions in ownership. This aligns with NASHP model legislation to pave the way to address the influence of corporate and private equity in health care markets by ensuring transparency and knowledge of who will be able to make determinations about a facility's service line. Guideline 1.4, also aligned with NASHP model legislation, extends the State's role in ownership transitions in order to provide some guardrails to prevent decisions about the closure of essential perinatal service lines and/or facilities (see Oregon Health Market Oversight Program as an example regarding health care services generally).

Currently, CDPHE does not have the authority to implement guideline 1.4. Legislative action is required to enact statutory authority for CDPHE to assess the impacts of a potential closure and to intervene.

- **Consider setting conditions on a planned ownership transition that could threaten that birth facility's sustainability in a rural area.** For example, condition the ownership transition to require no changes to the specified service line for the next five years.

2. Timely Notification and Supportive Communication

Clear and timely communication about a closure can support facilities, providers, and staff to provide patient-centered care. This includes planning for warm handoffs and emergency readiness, connecting patients to supportive resources, and providing patients with sufficient time to identify and establish new care. Ultimately, these timely actions can mitigate patient stress, poorly coordinated care, and gaps in care.

Guideline 2.1: Request that closing facilities provide notification of closure at least 90 days prior.

Currently, CDPHE does not have the authority to implement guideline 2.1. Legislative action is required.

- **Revise the current state law to revoke the repeal date of July 1, 2027,** in order to maintain the requirement of providing notice to patients, staff, providers, the community, and the state at least 90 days before discontinuing services. A repeal would revert to a 30-day notice requirement for facilities discontinuing a service (e.g., a hospital closing its L&D unit) and a 10-day notice requirement when a facility fully closes (e.g., a freestanding birth center). These short notice requirements would threaten sufficient, clear, and timely notification of birth facility closures. Ensure state law includes a clause for exceptions when adhering to a 90-day notice timeline would compromise the quality and safety of services (e.g., insufficient workforce).
- **Encourage the continuation of services for all patients in the third trimester** and, if applicable, until they have reached six weeks postpartum or transferred care prior to reaching six weeks postpartum. If continuing services for patients in their third trimester is not possible, prioritize resources and support for their timely transfer to another provider and care coordination. Ensuring continuity-of-care during the third trimester is important for detection of high-risk health conditions, such as preeclampsia, gestational diabetes, and fetal growth issues.

Guideline 2.2: Communicate quickly and transparently to closing facility providers and staff.

- **Communicate transparently** with providers and staff about the reasons for closure.
- **Discuss and gather input** on strategies to prevent and/or mitigate impacts of a closure.
- **Engage providers and staff on workforce impacts** of an impending closure and opportunities for employment within the facility or broader health system.
- **Communicate about a final decision to close** at least 72 hours prior to announcing it to patients and the impacted community.

Guideline 2.3: Communicate directly with current patients.

- **Communicate with patients** about the closure via email, phone, mail, and/or in person during a visit.
- **Share key information with patients**, including reasons for the closure, timeline for the closure, impacts on care, transfer of care planning, **resources (e.g., information on other perinatal providers, birth facilities, and community supports),** and who they can contact with questions (e.g., patient navigator, care coordinator).

Guideline 2.4: Communicate with the affected community.

- **Provide a Frequently Asked Questions resource** addressing the factors contributing to the closure and anticipated impacts of the closure on local access to perinatal care, the local perinatal care workforce, and the health of the community.

3. Coordinated Transfers of Care

Through proactive planning to transfer current patients to new care, closing facilities can support patients in receiving continuous, appropriate perinatal care.

Guideline 3.1: Develop and implement a system-level transfer of care plan.

- **Develop a resource list of perinatal care facilities and programs in the region** to support providers and staff at the closing facility in connecting current patients with local resources. Colorado's Regional Health Connector Program may inform the development and dissemination of a resource list. Although Regional Health Connectors work at the system level rather than with patients and families, they aim to bridge connections and leverage community assets and resources to address community health needs. This includes serving as liaisons to physician offices, public health entities, and community organizations.
- **Inform operating perinatal care facilities and programs in the region** (e.g., hospitals, birth centers, health centers, midwifery practices, home visiting programs) about the upcoming facility closure, timeline, and volume of current patients impacted.
- **Coordinate with operating birth facilities and practices in the region to plan for a potential increase in volume.** It is recommended to plan for both the near term as current patients seek to transition care, and for the longer term to meet ongoing community needs for perinatal care.
- **Establish transfer agreements and referral processes** with other perinatal facilities, practices, and providers.
- **Provide talking points to support provider-patient communication** regarding the closure and transfers of care.
- **Convene the Colorado Safe Transfers Coalition**[115] **and community midwives in the area** to discuss closure implications on community births and safe transfers of care. Develop a protocol to transfer obstetric and neonatal emergencies from the community to the nearest hospital with risk-appropriate care.

Guideline 3.2: Develop individual patient transfer of care plans.

- **Perinatal providers and staff consult with each current perinatal patient** to develop a transfer of care plan considering their medical and health needs, and preferences for care.

- **Identify staff to provide current patients with transfer of care support** (e.g., care coordinator, care navigator). These staff will provide individual support to each patient, implement the patient's transfer of care plan, and ensure timely transfer of medical records.

Guideline 3.3: Develop an emergency response plan.

- **Develop a plan and conduct training, as needed, to ensure the emergency department of the facility with the closing L&D unit is prepared to manage potential obstetric and neonatal emergencies** (e.g., emergency room births). This includes having basic equipment available in the emergency room to support obstetric and neonatal care. This may be informed by the Colorado Perinatal Care Quality Collaborative's current **Maternal Quality and Safety Toolkit for Rural Hospitals** and their development of a curriculum for obstetric emergency response in the emergency department.
- **Inform local emergency medical services of the facility closure;** with support from the state, develop a plan with community providers for safe transfers when obstetric and neonatal emergencies warrant a higher level of care (i.e., transfer-of-care policies and procedures to regional receiving facilities).
- **Convene local emergency medical technicians to support training and preparedness for potential obstetric and neonatal emergencies.**

Supportive resources for implementing guidelines in this section include:

- The AIM Obstetric Emergency Readiness Resource Kit[116]
- The AIM Community Birth Transfer Resource Kit[117]

V. Proposed Perinatal System of Care Access Outcome Categories

Timely data on perinatal care access and health outcomes is needed to assess the impact of recent birth facility closures and monitor facilities at risk of closing. It is recommended to track key measures at the most local level possible (county, health statistic region, or state) and disaggregated by race, ethnicity, and insurance type. This level of specificity can help identify closure risk, emerging impacts and disparities, and opportunities for proactive intervention.

1. Outcome Category: Community Level Measures

When a birth facility closes, the immediate impact is increased travel time, which increases the risk of unplanned out-of-hospital births, emergency department deliveries, and poor maternal and infant outcomes.[118] [119] The proposed measures below can be used to track these adverse effects.

Table 3. Proposed Community Level Measures

Measure	Purpose	Currently Collected (Yes/No) and Source
Birth facility density (# hospital L&D units, # birth centers)	To quantify infrastructure loss and track geographic distribution of hospital L&D units and birth centers over time	Yes, CDPHE sHPSAs Interactive Map
Prenatal care demand met (%)[viii]	To evaluate the capacity of the localized workforce to provide perinatal care	Yes, CDPHE sHPSAs Interactive Map
Maternity care access	To monitor change in capacity and demand for perinatal services	Yes, CDPHE sHPSAs Interactive Map
Maternal mortality rate	To monitor the most severe outcomes resulting from a lack or loss of localized perinatal care and delayed emergency care	Yes, Colorado Maternal Mortality Review Committee data[ix]
Infant mortality rate	To serve as a sensitive indicator of overall community health and assess severe downstream effects of a closure	Yes, Colorado Vital Statistics
Residence birth, not intended	To monitor unintended out of birth facility births to understand the impact following a birth facility closure	Yes, Colorado Vital Statistics
Emergency department deliveries	To monitor change in births that occur in the emergency department to understand the	Yes, Hospital Discharge Data can be provided by

[viii] Note: Per CDPHE, future measures included in the sHPSAs may include percentage of postpartum care demand met and percentage of preconception care demand met. If/when these are added, it is recommended to add these as community measures.

[ix] Note: Given that this study prioritized access to perinatal care, claims data is not currently proposed as part of the Community Level Measure set. Further evaluation in the form of a cost-benefit analysis would likely include a claims analysis.

	impact following a birth facility closure	CHA
Unemployment rate	To monitor the broader economic health of a community, and determine the impact after a hospital L&D unit or birth center closure	Yes, Colorado Department of Labor and Employment or the Social Deprivation Index
Population below federal poverty level (%)	To monitor community health and identify populations most vulnerable to a resulting closure	Yes, Colorado Department of Local Affairs, State Demography Office (Colorado Demographic Profiles) or the Social Deprivation Index

2. Outcome Category: Provider Level Measures

At the provider level, assessing the risk and impact of closures requires a dual focus on birth facility financial resilience and perinatal workforce capacity. Birth facility closures are often preceded by a sharp decline in financial liquidity and workforce challenges. Following a closure, the remaining workforce and emergency departments may experience strain as they must manage unexpected obstetric emergencies.

Table 4. Proposed Community Level Measures

Measure	Purpose	Currently Collected (Yes/No) and Source
Perinatal workforce capacity by provider type	To monitor a lack or loss of workforce capacity and retention of the localized workforce post-closure	Yes, CDPHE sHPSAs Interactive Map[x]
Medical attendant type at birth	To monitor shifts in care models following the loss of services	Yes, Colorado Vital Statistics
Obstetric emergencies (#)	To quantify the downstream clinical burden placed on non-perinatal facilities	Yes, discharge data from CHA
Perinatal transfers (# or %)	To evaluate the safety and coordination of the regional safety net	Yes, Colorado Vital Statistics[xi]

[x] Note: The current sHPSAs map includes OB-GYNs, FMOBs, and CNMs but no other perinatal providers.

[xi] Note: Colorado birth certificate data includes transfers and whether the transfer was a planned home birth or birth center birth.

3. Outcome Category: Clinical Level Measures

The loss of localized perinatal services leads to worse maternal and infant health outcomes. Families in regions with the longest travel times to a hospital face life-threatening maternal complications at nearly double the state rate. Additionally, closures contribute to an increase in preterm births, low birth weights, and delayed prenatal care.

Table 5. Proposed Community Level Measures

Measure	Purpose	Currently Collected (Yes/No) and Source
Late prenatal care (%)	To monitor delays in receiving essential care	Yes, Colorado Vital Statistics*
Preterm birth	To assess the direct neonatal consequences of disrupted care	Yes, Colorado Vital Statistics*
Low birth weight	To assess downstream neonatal health impacts, particularly in rural areas where closures are associated with an increase in low-birth-weight infants	Yes, Colorado Vital Statistics*
Neonatal Intensive Care Unit (NICU) admissions	To assess the severity of neonatal complications that occur when localized care is lost	Yes, Colorado Vital Statistics*
Severe Maternal Morbidity (SMM)	To monitor life-threatening maternal complications	Yes, CHA provides hospital discharge data on SMM to CDPHE

* Included in birth certificate data and appears in Colorado Health Information Dataset.

4. Outcome Category: Family Level Measures

The loss of perinatal care imposes significant geographic, financial, and psychological burdens on families. The burden of a facility closure is measured not just in miles, but in the heightened anxiety of navigating further distances, mountain passes, and severe weather, as well as the economic impact of lost wages, travel expenses, and overall strain on household stability.

Table 6. Proposed Community Level Measures

Measure	Purpose	Currently Collected (Yes/No) and Source
Distance to birth facility (miles, travel time)	To assess the direct geographic burden placed on individuals and their families	No, could be added to the sHPSA map[xii]
Geographic determinants of access (e.g., mountain passes, weather, wildlife)	To contextualize the reality of post-closure travel, capturing how environmental hazards compound the logistical risks and unpredictability of traveling long distances	No, this would be a new measure[xiii]
Travel costs (e.g., gas, wear and tear), and travel-related opportunity costs (e.g., lost wages, added childcare)	To assess the hidden economic impact of geographic burden and closures on families	No, this would be a new measure
Prenatal/maternal stress level[xiv]	To assess the psychological toll of disrupted local care, increased travel times, and other stressors that arise post-closure	No, this would be a new measure

[xii] Note: This measure per CDPHE is a planned addition for the sHPSA map.
[xiii] Note: This measure is part of current sHPSA methodology except for seasonality and is something to explore in future updates.
[xiv] Note: Baby & You is a data source through CDPHE that monitors maternal mental health. Baby & You has an established process for creating supplements and additional questions, which could be leveraged to include questions about impacts of a facility closure. Either a supplement specific to birth facility closures (e.g., sent to a region that experienced a closure) could be created or Baby & You could provide guidance to a new data source integrating best practices and collaborative approaches used in the Baby & You survey.

VI. Conclusion

Insufficient access to perinatal care is a pressing issue in Colorado, particularly given recent birth facility closures and the ongoing threat of future closures. Since 2018, eight rural hospitals in Colorado have closed their L&D units. Since 2024 alone, five birth facilities have closed, including three freestanding birth centers and two rural hospital L&D units.[120] [121] Outside of the areas immediately impacted by closure, 98% of Colorado's population faces a shortage of perinatal providers.

The impacts of birth facility closures are greater in rural areas of Colorado, where families have far fewer options for safe, quality, timely perinatal care. For example, a birth facility closure in southeastern Colorado, which has few perinatal resources, would likely have a more significant impact on perinatal care access and health outcomes compared to a birth facility closure in Boulder or Douglas counties (see figure 1).[122]

This report provides a range of recommended action steps the state can take to strengthen Colorado's perinatal system of care and ensure access to safe, quality services.[123] The recommendations span three pillars: strengthening the perinatal system of care through standardized levels of care and regional networks; investing in the perinatal workforce, including FMOBs and midwives; and restructuring financing to support rural birth facilities at risk of closure.

The proposed best-practice guidelines in this report— informed by national and state experts and literature, local data, providers, and community members— offer the state and birth facilities a roadmap for navigating perinatal closures. The guidelines aim to support coordinated transfers of care for affected patients, timely communication with patients and other affected entities, and preparedness of emergency response teams to step in and handle obstetric and neonatal emergencies in the absence of nearby hospital L&D unit resources. **This report also proposes community, provider, clinical, and family outcome categories, many of which are already being collected, to monitor and identify areas for improvement of perinatal care access and the consequences of gaps.**

Going forward, the state must prioritize actions to improve perinatal care access following recent birth facility closures and to mitigate future closures. As birth facilities continue to close across the nation, new pilots, models, and promising approaches will emerge to address this challenge; it is important for the state to remain nimble and to consider if and how these novel ideas might be applied in Colorado. The state must also stay up to date on future iterations of the Rural Health Transformation Program and other federal funding opportunities to focus on perinatal care investments.

Appendix I: Study Methods

This report is grounded in findings from a mixed-methods study conducted between November 2025 and March 2026. To achieve its research goals, JSI used both primary and secondary data collection methods as well as advisory input from key experts. This approach surfaced evidence and promising approaches from the literature, first-hand perspectives from affected patients and health care professionals, and important context and input from other stakeholders and experts.

Study Advisor Input

From the study's outset through the development of this report, JSI engaged representatives from the CHA, CPCQC, and Elephant Circle (a Colorado organization dedicated to birth justice). These expert advisors:

- Provided input on areas of focus for the environmental scan and qualitative study
- Shared relevant resources and secondary data to review
- Connected JSI's study team with perinatal care stakeholders to inform the environmental scan and support qualitative study recruitment
- Provided input on recommendations to improve access and mitigate the impact of closures, best practice guidelines for navigating closures and transfers of care; and proposed outcome categories

Environmental Scan

The environmental scan involved both direct stakeholder engagement and a literature review, to understand perinatal care access issues in Colorado, contextualize the perinatal policy and system environment, and identify promising approaches and models to improve perinatal care access.

Stakeholder Context Interviews

JSI conducted context interviews with a variety of perinatal care stakeholders in Colorado to build understanding of the perinatal care access landscape. Stakeholders included representatives working in perinatal health within government, clinical, quality, advocacy and research settings and organizations.

Table A1: Participants in Stakeholder Context Interviews

Stakeholder
Maternal, Child & Reproductive Health Manager, Agricultural and Rural Program Administrator, and Manager of Substance Use Services and Supports for High-Risk Families, Colorado Behavioral Health Administration
Division for the Deaf, Hard of Hearing, and DeafBlind Coordinator, CDPHE
Health Access Branch Director, CDPHE
Program Coordinator, CDPHE Baby & You Program

Public Affairs and Communications Specialist, Health Facilities & Emergency Medical Services Division, CDPHE
Vice President, Data Analytics and Health Equity, Colorado Hospital Association
Executive Director, CPCQC
Director of Research and Education, Elephant Circle
Research and Policy Independent Consultant, Groundswell for Good
Reproductive Health Equity Team Lead, Colorado Department of Health Care Policy & Financing (HCPF)
Principal, Impact & Innovation, Increasing Contraceptive Access Initiative (ICAN)
Nurse Consultant, Invest in Kids
Director for Pregnancy, Infancy, and Early Childhood, Massachusetts Department of Public Health
Senior Director of Coverage, Cost and Value, National Academy for State Health Policy
Faculty, University of Colorado College of Nursing, Midwifery
Associate Dean of Clinical and Community Affairs, University of Colorado Anschutz, College of Nursing
Perinatal Nurse Consultant, Washington State Department of Health

Literature Review

JSI built upon an existing CDPHE literature review (*Summary of Existing Literature on Perinatal Health Care Practice Closures: Final Report*, 2025) to further describe the influencing factors and implications of closures, consolidations, and acquisitions. JSI used Google Scholar and Google search to identify additional literature, including peer-reviewed and grey literature, as well as publicly-available sources for data relating to closures, consolidation, and acquisitions and access to perinatal care. JSI also used a backward citation chaining to extend the literature review by searching for resources based on recommendations or information shared from study advisors and context interviewees.

Qualitative Study

Approach

CDPHE charged JSI with conducting a qualitative study to understand issues of perinatal care access and the policy and programmatic landscape. JSI engaged study advisors to provide input on the study focus and support study participant outreach and recruitment.

Research Questions

- What factors affect access to and experiences with perinatal care in priority regions and among priority groups in Colorado?
- How do people in priority regions or of priority groups experience access to perinatal care?
- What factors affect the accessibility of perinatal care?
- What are the economic impacts of closures, consolidations, or acquisitions within priority regions?
- What strategies, resources and/or innovations are implemented to support access to perinatal care within priority regions?

Methods

The qualitative study used two methods:

- **Semi-structured interviews** were designed to engage a purposive sample of patients and health care professionals to learn about their perspectives and/or experiences with perinatal care access in rural regions in Colorado and in communities with a birth facility closure.
- **Semi-structured focus groups** were conducted with a purposive sample of patients to learn about their experiences accessing perinatal care in a rural region and in a region that recently experienced a hospital obstetric unit closure. One focus group was conducted in-person and the other was conducted virtually.

Although recruitment efforts aimed to engage patients in English and Spanish, the response from individuals who preferred to take part in the study in Spanish was insufficient. All interviews and focus groups were conducted in English. Approval of the study protocol and procedures was granted by the JSI IRB (IRB# 25-26). This study was conducted between November 2025 and March 2026.

Geographic Areas of Focus Inclusion/Exclusion Criteria

The study prioritized learning about perinatal care access in three regions of the state, approved by CDPHE. The areas selected met one or more of the following criteria:

- Rural and/or frontier geography
- Communities with disparate challenges in accessing perinatal care
- Communities with disparate poor pregnancy and birth outcomes
- Recently experienced a birth facility closure

The areas included: Bent and Otero counties; Delta and Montrose counties; and Colorado's Southwest Region (Montezuma, La Plata, Archuleta, Dolores and/or San Juan counties).

Data Analysis

All interviews and focus groups were audio recorded and transcribed verbatim. Transcripts were deidentified and entered into Dedoose (i.e., qualitative data analysis software). Based on the interview and focus group guides, JSI created a deductive codebook, including parent and child codes, and modified it throughout the coding process. Study team members independently coded the transcripts, meeting regularly to discuss, iterate, and identify themes. All analyses used a team approach to limit personal biases, subjectivity, and preconceptions.

Semi-Structured Interviews

Study Participants

Based on input from study advisors and CDPHE, JSI prioritized interviews with four groups:

- Patients who, due to a birth center closure, experienced a disruption in perinatal care or a transfer of care
- Perinatal care providers/staff serving a rural or frontier county
- Perinatal care providers/staff who served in a region with a recent a birth facility closure
- Health care leaders/associations with regional or state perspective on perinatal care access and/or perinatal closures, consolidations, or acquisitions

As noted above, all patient interviewees experienced a disruption in perinatal care or a transfer of care due to a birth facility closure. Patient interviewees also met the following criteria:

- Pregnant or have given birth within the last five years (no earlier than December 1, 2020)
- Received care during pregnancy, L&D, and/or postpartum in Colorado
- 18-years-old or older
- Speak English or Spanish fluently*

*Based on recruitment responses, all interviews were conducted in English.

Table A2. Interview Participant Details by Segment

Segment	N=32	Description of Interviewees	Primary Counties Represented by Interviewees
Health care leaders	7	American Association of Birth Centers Colorado Chapter, Colorado Community Health Network, Colorado Hospital Association, Colorado Midwives Association, Colorado Nurse Midwives Association, Colorado Perinatal Care Quality Collaborative, Colorado Rural Health Center	Statewide
Health professionals: closure experience	8	Chief executive officers (hospital), certified professional midwives, family medicine physicians, perinatal RNs	Adams, Archuleta, Bent, Delta, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Otero, Pueblo
Health professionals: rural/frontier experience	9	Chief executive officers (hospital), chief nursing officer, senior medical director, certified professional midwives, doula, emergency medical technician, OB-GYN	Archuleta, Bent, Delta, Eagle, Elbert, El Paso, Garfield, La Plata, Larimer, Lincoln, Logan, Mesa, Montezuma, Montrose, Morgan, Otero, Pueblo, Teller, Weld

Patients impacted by a closure	8	Age range: 24–43 Birth history: ● Currently pregnant or gave birth in the last year (n=6) ● Gave birth 2 to 3 years ago (n=2) Race: ● Black or African American (n=3) ● White (n=4) Ethnicity: ● Hispanic or Latino (n=4) ● Not Hispanic or Latino (n=4) Health insurance: ● Medicaid (n=3) ● Private (n=4) ● Uninsured (n=1)	County of residence: ● Adams (n=1) ● Delta (n=3) ● Mesa (n=1) ● Otero (n=3)

Sampling Methods

Health care leaders and health professionals: The study employed purposive and snowball sampling to identify, select and recruit interviewees. The JSI team first worked with study advisors to prioritize initial interviews for each segment of health professionals. JSI also added to the sample of interviewees by asking interviewees for recommendations based on their understanding of the landscape, actors, and study purpose. JSI iteratively prioritized the final list of interviewees based on information and insights gathered, gaps in perspective, and interviewee recommendations for each interview group.

Patients: JSI relied on recruitment partners (e.g., state agencies and programs, community organizations, health providers and facilities, and study advisors) to disseminate information about the study, and used convenience sampling to achieve a large enough sample within the limited recruitment and data collection period.

Procedures

All interviews were virtual (Zoom) and conducted in English. Interviewers facilitated interviews using semi-structured interview guides tailored for each of the four groups of interviewees. JSI offered all interviewees a $75 Visa email gift card for their time and contributions.

Semi-Structured Focus Groups

Study Participants

JSI sought to gather input from patients across the three regions included in this study:

- **In-Person Focus Group:** Patients living in Otero or Bent counties
- **Virtual Focus Group:** Patients living in one of the five southwest counties (Archuleta, Dolores, La Plata, Montezuma, or San Juan)

All focus group participants experienced a disruption in perinatal care or a transfer of care due to a birth facility closure. Patients who participated in focus groups also met the following criteria:

- Pregnant or have given birth within the last five years (no earlier than December 1, 2020)
- Received care during pregnancy, L&D, and/or postpartum in Colorado
- 18-years-old or older
- Speak English or Spanish fluently*

* Based on recruitment responses, all interviews were conducted in English.

Table A3. Focus Group Participant Characteristics

	In-Person Focus Group	Virtual Focus Group	Total
Number of Participants	7	5	12
Recent Birth			
Currently pregnant or gave birth in past year	3	3	6
Gave birth 2 to 3 years ago	4	1	5
Gave birth 4-5 years ago	--	1	1
Mean Age (Range)	31 (28 - 35)	34 (24 - 38)	32 (24 - 38)
County of Residence			
Archuleta	--	2	2
La Plata	--	1	1
Montezuma	--	2	2
Otero	7	--	7
Racial Identity			
Asian	--	1	1
Black or African American	1	--	1
White	5	5	10
Prefer not to answer	1	--	1
Ethnic Identity			
Hispanic or Latino	2	--	2
Not Hispanic or Latino	4	5	9
Prefer not to answer	1	--	1
Health Insurance			
Public - Medicaid	4	1	5
Private	3	3	6
Prefer not to answer	--		1

Sampling Methods

Upon confirming general eligibility, JSI used purposive sampling to prioritize study participants whose characteristics represent the voices and experiences of those associated with disparate burden in perinatal access and outcomes, including Black, Indigenous, and People of Color and Medicaid insured patients. In addition to purposive sampling, convenience sampling was used to obtain sufficient participation. The study sample also includes individuals who are White and/or privately insured.

Procedures

Interviewers facilitated focus groups using two semi-structured focus group guides designed to elicit information about how patients experience access to perinatal care in Colorado. One guide included questions to explore impacts and experiences in relation to a recent birth facility closure. The other guide included questions to explore experiences accessing perinatal care within a rural/frontier region.

Focus groups were scheduled for 90 minutes. The in-person focus group was conducted in December 2025 in La Junta, CO, with patients living in Otero and Bent Counties. The virtual (Zoom) focus group was conducted in February 2026 with patients living in the southwest counties of Colorado. In-person participants received a $150 Visa email gift card; virtual participants received a $100 Visa email gift card.

Appendix II: Glossary

Abbreviation	Definition
ACOG	American College of Obstetricians and Gynecologists
APRN	Advanced Practice Registered Nurse
CDPHE	Colorado Department of Public Health & Environment
CHA	Colorado Hospital Association
CHQPR	Center for Healthcare Quality and Payment Reform
CM	Certified Midwife
CNM	Certified Nurse-Midwife
CPCQC	Colorado Perinatal Care Quality Collaborative
CPM	Certified Professional Midwife
CRNA	Certified Registered Nurse Anesthetist
DORA	Department of Regulatory Agencies (Colorado)
ED	Emergency department
EMS	Emergency medical services
EMT	Emergency medical technician
FMOB	Family Medicine Obstetrics
FQHC	Federally Qualified Health Center
HCPF	Health Care Policy and Financing (Colorado Department of)
HFEMSD	Health Facilities and Emergency Medical Services Division
HRSA	Health Resources and Services Administration
JSI	JSI Research & Training Institute, Inc.
L&D	Labor and Delivery Unit (Hospital-Based)
MFM	Maternal Fetal Medicine
MMRC	Maternal Mortality Review Committee
NICU	Neonatal Intensive Care Unit
OB-GYN	Obstetrician-Gynecologist
sHPSAs	State-Designated Health Professional Shortage Areas
SMM	Severe Maternal Morbidity
SB	Senate Bill

References

[1]Colorado General Assembly. (2024, June 4). HB24-1262 - Maternal Health Midwives. Colorado.gov; Colorado General Assembly. https://leg.colorado.gov/bills/hb24-1262

[2] Colorado Department of Public Health and Environment. State-Designated Health Professional Shortage Areas; and personal communication from Colorado Hospital Association on May 11, 2026.

[3] Colorado Rural Health Center, Snapshot of Rural Health 2026, https://coruralhealth.org/snapshot-of-rural-health

[4] CPCQC. (February 10, 2025). Press Release. https://cpcqc.org/colorado-perinatal-care-quality-collaborative-responds-to-the-closure-of-obstetric-services-at-arkansas-valley-regional-medical-center/

[5] CDPHE. State-Designated Health Professional Shortage Areas. https://experience.arcgis.com/experience/e8b28e7e4da443ce8607b7eb4a7892a9/page/Page?draft=true&org=CDPHE&views=%25-of-Demand-Met%2CPrenatal-Health-Shortage

[6] Kozhimannil, K.B., Interrante, J., Fritz, A., Sheffield, E., Carroll, C., & Handley, S. (2024). Information for Rural Stakeholders About Access to Maternity and Obstetric Care: A Community-Relevant Synthesis of Research Key Findings. The University of Minnesota Rural Health Research Center. https://rhrc.umn.edu/wp-content/uploads/2025/06/OB_Practical-Implications_2024_revised-June-2025.pdf

[7] Kozhimannil, K. B., Sheffield, E. C., & Interrante, J. D. (2026). Millions Of Women Don't Have Access To Maternity Care - And The Number Is Growing. Forefront Group. https://doi.org/10.1001/jama.2024.23010

[8] Kozhimannil, K.B. et al. (2026). Millions Of Women Don't Have Access.

[9] Deutchman, M., Macaluso, F., Bray, E., Evans, D., Boulger, J., Quinn, K., Pierce, C., Onello, E., Porter, J., Warren, W., Erickson, J. S., Bright, P., Maness, P., Luke, S., & James, K. A. (2021). The impact of family physicians in rural maternity care. Birth, 49(2), 220–232. https://doi.org/10.1111/birt.12591

[10] Kozhimannil,K.B. et al. (2024). Information for Rural Stakeholders.

[11] ACOG. (2016, September). Severe Maternal Morbidity: Screening and Review. Www.acog.org. https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2016/09/severe-maternal-morbidity-screening-and-review

[12] CPCQC. (December 2025). A Closer Look at Severe Maternal Morbidity in Colorado: Trends, Disparities, and Opportunities for Action. https://cpcqc.org/wp-content/uploads/2025/12/A-Closer-Look-at-Severe-Maternal-Morbidity-in-Colorado_-Trends-Disparities-and-Opportunities-for-Action.pdf

[13] Wolfson, C. L., Angelson, J. T., & Creanga, A. A. (2025). Is severe maternal morbidity a risk factor for postpartum hospitalization with mental health or substance use disorder diagnoses? Findings from a retrospective cohort study in Maryland: 2016–2019. Maternal Health Neonatology and Perinatology, 11(1). https://doi.org/10.1186/s40748-024-00198-0

[14] March of Dimes. (2022). Nowhere to Go: Maternity Care Deserts Across the U.S. 2022 Report. Marchofdimes.org https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf

[15] Leys, T. (2024, July 15) As a baby bust hits rural areas, hospital labor and delivery wards are closing down. NPR. https://www.npr.org/sections/shots-health-news/2024/07/12/nx-s1-5036878/rural-hospitals-labor-delivery-health-care-shortage-birth

[16] ACOG. (2019). Levels of Maternal Care. https://www.acog.org/programs/lomc

[17] ACOG. (2023, June). Practice Considerations for Rural and Low-Volume Obstetric Settings. https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/practice-considerations-for-rural-and-low-volume-obstetric-settings

[18] Kozhimannil et al. (2026). Millions Of Women Don't Have Access.

[19] Plumas District Hospital Community Center. (2024). The Plumas Model. Pdh.org. https://www.pdh.org/announcements/the-plumas-model-learn-and-take-action

[20] The Missouri Perinatal Quality Collaborative. (2025). The Power of Home Visiting: Supporting Families for a Stronger Future. Missouri PQC. https://mopqc.org/news/the-power-of-home-visiting-supporting-families-for-a-stronger-future/

[21] Health Resources and Services Administration (HRSA). 2025. Workforce projections: Projected supply and demand of healthcare workers through 2038. U.S. Department of Health and Human Services. https://data.hrsa.gov/topics/health-workforce/nchwa/workforce-projections

[22]ACOG. (2023, June). Practice Considerations for Rural and Low-Volume Obstetric Settings. https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/practice-considerations-for-rural-and-low-volume-obstetric-settings

[23] Kozhimannil, K. B., Interrante, J. D., Admon, L. K., & Basile Ibrahim, B. L. (2022). Rural Hospital Administrators' Beliefs About Safety, Financial Viability, and Community Need for Offering Obstetric Care. JAMA Health Forum, 3(3), e220204–e220204. https://doi.org/10.1001/jamahealthforum.2022.0204
[24] MacKinney, C., White, N., & Norell, B. (2023, April 19). Better Together: Rural Hospital High-Value Networks. The Rural Monitor. https://www.ruralhealthinfo.org/rural-monitor/rural-hospital-high-value-networks
[25] RWHC. (2022, May 11). RWHC One Pager. Rural Wisconsin Hospital Cooperative. https://www.rwhc.com/Portals/0/PDF/RWHC%20One%20Pager%205-11-22.pdf
[26] Center for Healthcare Quality and Payment Reform (CHQPR). (2026). Stopping the loss of rural maternity care. https://chqpr.org/downloads/Rural_Maternity_Care_Crisis.pdf
[27] AMA. (2026, April 24). CPT® 2027 Maternity Care Services code changes. American Medical Association. https://www.ama-assn.org/practice-management/cpt/cpt-2027-maternity-care-services-code-changes
[28] [28] Kozhimannil et al. (2026). Millions Of Women Don't Have Access.
[29] CPCQC. (February 10, 2025). Press Release. https://cpcqc.org/colorado-perinatal-care-quality-collaborative-responds-to-the-closure-of-obstetric-services-at-arkansas-valley-regional-medical-center/
[30] CDPHE. State-Designated Health Professional Shortage Areas. https://experience.arcgis.com/experience/e8b28e7e4da443ce8607b7eb4a7892a9/page/Page?draft=true&org=CDPHE&views=%25-of-Demand-Met%2CPrenatal-Health-Shortage
[31] Kozhimannil, K. B. (2023). Declining access to US maternity care is a systemic injustice. BMJ, p2038. https://doi.org/10.1136/bmj.p2038
[32] CDPHE. State-Designated Health Professional Shortage Areas. https://experience.arcgis.com/experience/e8b28e7e4da443ce8607b7eb4a7892a9/page/Page?draft=true&org=CDPHE&views=%25-of-Demand-Met%2CPrenatal-Health-Shortage
[33] CDPHE. State-Designated Health Professional Shortage Areas. https://experience.arcgis.com/experience/e8b28e7e4da443ce8607b7eb4a7892a9/page/Page?draft=true&org=CDPHE&views=%25-of-Demand-Met%2CPrenatal-Health-Shortage
[34] Colorado Department of Public Health and Environment. State-Designated Health Professional Shortage Areas; and personal communication from Colorado Hospital Association on May 11, 2026.
[35] Colorado Rural Health Center, Snapshot of Rural Health 2026, https://coruralhealth.org/snapshot-of-rural-health
[36] CDPHE. State-Designated Health Professional Shortage Areas. https://experience.arcgis.com/experience/e8b28e7e4da443ce8607b7eb4a7892a9/page/Page?draft=true&org=CDPHE&views=%25-of-Demand-Met%2CPrenatal-Health-Shortage
[37] CDPHE. State-Designated Health Professional Shortage Areas.
[38] Colorado Rural Health Center, Snapshot of Rural Health 2026, https://coruralhealth.org/snapshot-of-rural-health
[39] Kozhimannil, K.B. et al. (2026). Millions Of Women Don't Have Access.
[40] Deutchman, M., Macaluso, F., Bray, E., Evans, D., Boulger, J., Quinn, K., Pierce, C., Onello, E., Porter, J., Warren, W., Erickson, J. S., Bright, P., Maness, P., Luke, S., & James, K. A. (2021). The impact of family physicians in rural maternity care. Birth, 49(2), 220–232. https://doi.org/10.1111/birt.12591
[41] Kozhimannil,K.B. et al. (2024). Information for Rural Stakeholders.
[42] ACOG. (2016, September). Severe Maternal Morbidity: Screening and Review. Www.acog.org. https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2016/09/severe-maternal-morbidity-screening-and-review
[43] CPCQC. (December 2025). A Closer Look at Severe Maternal Morbidity in Colorado: Trends, Disparities, and Opportunities for Action. https://cpcqc.org/wp-content/uploads/2025/12/A-Closer-Look-at-Severe-Maternal-Morbidity-in-Colorado_-Trends-Disparities-and-Opportunities-for-Action.pdf
[44] Wolfson, C. L., Angelson, J. T., & Creanga, A. A. (2025). Is severe maternal morbidity a risk factor for postpartum hospitalization with mental health or substance use disorder diagnoses? Findings from a retrospective cohort study in Maryland: 2016–2019. Maternal Health Neonatology and Perinatology, 11(1). https://doi.org/10.1186/s40748-024-00198-0
[45] Woodward, R., Mazure, E. S., Belden, C. M., Denslow, S., Fromewick, J., Dixon, S., Gist, W., & Margaret Wolan Sullivan. (2023). Association of prenatal stress with distance to delivery for pregnant women in Western North Carolina. Midwifery, 118, 103573–103573. https://doi.org/10.1016/j.midw.2022.103573
[46] Busse, C.E., O'Hanlon, K., Kozhimannil, K.B., & Interrante, J.D. (2025). Financial challenges of providing obstetric services at rural US hospitals. The Journal of Rural Health, 41(4). https://doi.org/10.1111/jrh.70082
[47] Centers for Medicaid and Medicare (2019). Improving Access to Maternal Health Care in Rural Communities. https://www.cms.gov/about-cms/agency-information/omh/equity-initiatives/rural-health/09032019-maternal-health-care-in-rural-communities.pdf
[48] Colorado Rural Health Center. (2026). Snapshot of Rural Health in Colorado.

[49] Colorado Vital Statistics. 2024.

[50] Gunja, M. Z., Tikkanen, R., Seervai, S., Collins, R. (2018) What is the status of women's health and health care in the U.S. compared to other countries? The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2018/dec/womens-health-us-compared-ten-other-countries

[51] Colorado Vital Statistics Program, 2024.

[52] Ranji, U., Gomez, I., Salganicoff, A., et. al. Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey. KFF. May 19, 2022. https://www.kff.org/womens-health-policy/what-are-the-implications-of-the-dobbs-ruling-for-racial-disparities/

[53] Colorado Rural Health Center. (2026). Snapshot of Rural Health in Colorado.

[54] Mann, C., and Striar, (2022, August 17). How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost. Www.commonwealthfund.org; The Commonwealth Fund. https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact

[55] CHA. (2025). Colorado Hospital Industry Update Q3 2025 Financial and Utilization Trends. https://cha.com/wp-content/uploads/2026/01/Final-Q3-2025-Trends-External-1.pdf

[56] Bennett, K., Horstman, C., Lewis, C., & Shih, A. (2026). Why Rural Hospitals Are Facing a Funding Crisis — and How It Could Get Worse. Commonwealthfund.org. https://doi.org/10.26099/bywa-x418

[57] Kozhimannil, K.B. et al. (2026). Millions Of Women Don't Have Access.

[58] CE, B., K, O., KB, K., & JD, I. (2025). Financial challenges of providing obstetric services at rural US hospitals. The Journal of Rural Health, 41(4). https://doi.org/10.1111/jrh.70082

[59] Busse, C.E. et al. (2025). Financial challenges of providing obstetric services at rural US hospitals.

[60] Kozhimannil K.B. et al. (2024). Information for Rural Stakeholders.

[61] Kozhimannil, K. B., et al. (2024). Information for Rural Stakeholders.

[62] Colorado Rural Health Center. (2026). Snapshot of Rural Health in Colorado.

[63] Stoll, K., Vedam, S. V., Taiwo, T. K., Strauss, N., & Declercq, E. (2022). The Giving Voice to Mothers Study Report: Communities defining quality and safety in pregnancy and childbirth care. Birth Place Lab, University of British Columbia. https://www.birthplacelab.org/voices/

[64] Deutchman, M., Macaluso, F., Bray, E., Evans, D., Boulger, J., Quinn, K., Pierce, C., Onello, E., Porter, J., Warren, W., Erickson, J. S., Bright, P., Maness, P., Luke, S., & James, K. A. (2021). The impact of family physicians in rural maternity care. Birth, 49(2), 220–232. https://doi.org/10.1111/birt.12591

[65] March of Dimes. (2022). Nowhere to Go: Maternity Care Deserts Across the U.S. 2022 Report. Marchofdimes.org https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf

[66] Leys, T. (2024, July 15) As a baby bust hits rural areas, hospital labor and delivery wards are closing down. NPR. https://www.npr.org/sections/shots-health-news/2024/07/12/nx-s1-5036878/rural-hospitals-labor-delivery-health-care-shortage-birth

[67] Colorado Rural Health Center. (2026). Snapshot of Rural Health in Colorado.

[68] Chatterjee, P., Lin, Y., & Venkataramani, A. S. (2022). Changes in economic outcomes before and after rural hospital closures in the United States: A difference-in-differences study. Health Services Research, 57(5), 1020–1028. https://doi.org/10.1111/1475-6773.13988

[69] Durrance C, Guldi M, Schulkind L. The effect of rural hospital closures on maternal and infant health. Health Serv Res. 2024 Apr;59(2):e14248. https://doi.org/10.1111/1475-6773.14248

[70] Health Resources in Action. (2025, November 25). Improving Maternal Support by Expanding Doula Access in Rural Massachusetts: an HRiA Innovation Incubator Project - HRiA. HRiA. https://hria.org/rural-doulas-ii/

[71] Comstock, S., Lindsey, A., Narasimhan, S., López-Martinez, I., Jama, F., Williams, W., & Mosley, E. A. (2025). "I Live in a Doula Desert": A Community-Engaged Study of Doula Care in Rural Georgia. Women's Health Reports, 6(1), 624–631. https://doi.org/10.1089/whr.2025.0050

[72] ACOG. (2019). Levels of Maternal Care. www.acog.org. https://www.acog.org/programs/lomc

[73] ACOG. (2025). Transfer Protocols for Out-of-Hospital Birth. www.acog.org https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2025/transfer-protocols-for-out-of-hospital-birth

[74] Malhotra, R., Parikh, A., Sous, N., Thomas, P., Gittens-Williams, L., & Feurdean, M. (2025). Bridging the Postpartum Cliff—First Year Outcomes of a Postpartum Transition to Primary Care Clinic. Women's Health Reports, 6(1), 978–987. https://doi.org/10.1177/26884844251379414

[75] ACOG. (2019). Levels of Maternal Care. www.acog.org. https://www.acog.org/programs/lomc

[76] ACOG. (2023, June). Practice Considerations for Rural and Low-Volume Obstetric Settings. https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/practice-considerations-for-rural-and-low-volume-obstetric-settings
[77] Sullivan, E. E., Gilburg, M. L., McDonald, M., & Deutchman, M. (2025). Innovating for success: Strengthening rural maternity care and delivery programs. The Journal of Rural Health, 41(4). https://doi.org/10.1111/jrh.70099
[78] Sullivan, E., Anderson, B., & Deutchman, M. (2024). Rural Maternity Innovation Summit Site Report. https://www.ruralhealthinfo.org/topics/maternal-health/rural-maternity-summit/site-report-2024.pdf.
[79] State Health and Value Strategies. (2026, March 12). How States Are Using the RHTP to Advance Maternal Health. Shvs.org. https://shvs.org/how-states-are-using-the-rhtp-to-advance-maternal-health/
[80] Colorado PROSPER. (2026). Colorado PROSPER- Perinatal Mental Health & Substance Use Consulting + Access Program. Colorado PROSPER. https://www.coloradoprosper.org/
[81] Kozhimannil, K. B., et al. (2026). Millions Of Women Don't Have Access.
[82] ACOG. (2025). Transfer Protocols for Out-of-Hospital Birth.
[83] State Health and Value Strategies. (2026, March 12). How States Are Using the RHTP to Advance Maternal Health.
[84] CMS. (2022, November). Rural Health Transformation: 50-State Spotlights. Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/rural-health-transformation-50-state-spotlights.pdf
[85] CSTC. (2019). Consensus Transfer Guidelines from Planned Community Birth to Hospital. Colorado Safe Transfers Coalition. https://www.coloradosafetransferscoalition.com/
[86] ACOG. (2025). Transfer Protocols for Out-of-Hospital Birth.
[87] Plumas District Hospital Community Center. (2024). The Plumas Model. Pdh.org. https://www.pdh.org/announcements/the-plumas-model-learn-and-take-action
[88] The Plumas Sun. (2025, June). New bill would launch Plumas Model for birth services. The Plumas Sun. https://plumassun.org/2025/06/01/new-bill-would-launch-plumas-model-for-birth-services/
[89] Plumas District Hospital Community Center. (2024). The Plumas Model: Learn and Take Action. https://www.pdh.org/announcements/the-plumas-model-learn-and-take-action
[90] The Missouri Perinatal Quality Collaborative. (2025). The Power of Home Visiting: Supporting Families for a Stronger Future. Missouri PQC. https://mopqc.org/news/the-power-of-home-visiting-supporting-families-for-a-stronger-future/
[91] Hostetter, M., & Klein, S. (2021, September 30). Restoring Access to Maternity Care in Rural America | Commonwealth Fund. Www.commonwealthfund.org. https://www.commonwealthfund.org/publications/2021/sep/restoring-access-maternity-care-rural-america
[92] HRSA. (2025). Workforce projections: Projected supply and demand of healthcare workers through 2038. U.S. Department of Health and Human Services. https://data.hrsa.gov/topics/health-workforce/nchwa/workforce-projections
[93] Hostetter, M., & Klein, S. (2021, September 30). Restoring Access to Maternity Care in Rural America.
[94] Personal Communication with Colorado Hospital Association. June 2026.
[95]ACOG. (2023, June). Practice Considerations for Rural and Low-Volume Obstetric Settings.
[96] GAO. (2022, October 19). Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas. United States Government Accountability Office. https://www.gao.gov/products/gao-23-105515
[97] Falvey, A. (2026, March 4). 93 hospital and health system simulation and education programs to know | 2026. Becker's Healthcare Review. https://www.beckershospitalreview.com/hospital-management-administration/93-hospital-and-health-system-simulation-and-education-programs-to-know-2026/
[98] Community Memorial Hospital. (2025). MN Rural Obstetrics Simulation & Education Program. https://cloquethospital.com/ob-simulator-training-program/
[99] CMS. (2022, November). Rural Health Transformation: 50-State Spotlights.
[100] Kozhimannil K.B, Hung P, Henning-Smith C, Casey MM, Prasad S. Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States. JAMA. 2018;319(12):1239–1247. doi:10.1001/jama.2018.1830.
[101] Colorado Vital Statistics Program, 2024.
[102] New Mexico Department of Health. Maternal & Child Health. Www.nmhealth.org. https://www.nmhealth.org/about/phd/fhb/mch/
[103] Washington State Department of Health. (2026). Midwifery Advisory Committee. Washington State Department of Health. https://doh.wa.gov/licenses-permits-and-certificates/professions-new-renew-or-update/midwife/midwifery-advisory-committee
[104] Oregon Health Authority. (2026). Board of Direct Entry Midwifery. Oregon.gov; Board of Direct Entry Midwifery. https://www.oregon.gov/oha/ph/hlo/pages/board-direct-entry-midwifery.aspx

[105] Personal communication from Washington State Department of Health on May 11, 2026.
[106] Kozhimannil, K. B., Interrante, J. D., Admon, L. K., & Basile Ibrahim, B. L. (2022). Rural Hospital Administrators' Beliefs About Safety, Financial Viability, and Community Need for Offering Obstetric Care. JAMA Health Forum, 3(3), e220204–e220204. https://doi.org/10.1001/jamahealthforum.2022.0204
[107]MacKinney, C., White, N., & Norell, B. (2023, April 19). Better Together: Rural Hospital High-Value Networks. The Rural Monitor. https://www.ruralhealthinfo.org/rural-monitor/rural-hospital-high-value-networks
[108] RWHC. (2022, May 11). RWHC One Pager. Rural Wisconsin Hospital Cooperative. https://www.rwhc.com/Portals/0/PDF/RWHC%20One%20Pager%205-11-22.pdf
[109] Welch, C. (2024, February 28). First Collaboration Under New Law Approved for 25 Rural Colorado Hospitals | Colorado Hospital Association. Colorado Hospital Association. https://cha.com/first-collaboration-under-new-law-approved-for-25-rural-colorado-hospitals/
[110] State Health and Value Strategies. (2026, March 12). How States Are Using the RHTP to Advance Maternal Health. State Health and Value Strategies. https://shvs.org/how-states-are-using-the-rhtp-to-advance-maternal-health/
[111] Center for Healthcare Quality and Payment Reform (CHQPR). (2026). Stopping the loss of rural maternity care.
[112] CPCQC. (2024). New Report: Understanding Severe Maternal Morbidity in Colorado.
[113] AMA. (2026, April 24). CPT® 2027 Maternity Care Services code changes. American Medical Association. https://www.ama-assn.org/practice-management/cpt/cpt-2027-maternity-care-services-code-changes
[114] NASHP. (2021, November 13). Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency. NASHP. https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers/
[115] CSTC. (2019). Consensus Transfer Guidelines from Planned Community Birth to Hospital. Colorado Safe Transfers Coalition. https://www.coloradosafetransferscoalition.com/
[116] Alliance for Innovation on Maternal Health. (2024). AIM Obstetric Emergency Readiness Resource Kit. AIM. https://saferbirth.org/aim-obstetric-emergency-readiness-resource-kit/
[117] Alliance for Innovation on Maternal Health. (2024). Community Birth Transfer Resource Kit. AIM. https://saferbirth.org/community-birth-transfer-resource-kit/
[118] Deutchman, et al, 2021. The impact of family physicians in rural maternity care.
[119]GAO. (2022, October 19). Availability of Hospital-Based Obstetric Care in Rural Areas. Report to Congressional Committees. United States Government Accountability Office. https://www.gao.gov/products/gao-23-105515
[120] CPCQC. (February 10, 2025). CPCQC Responds to the Closure of OB Services at Arkansas Valley Regional Medical Center.
[121] CDPHE. State-Designated Health Professional Shortage Areas. https://experience.arcgis.com/experience/e8b28e7e4da443ce8607b7eb4a7892a9/page/Page?draft=true&org=CDPHE&views=%25-of-Demand-Met%2CPrenatal-Health-Shortage.
[122] Colorado Rural Health Center, Snapshot of Rural Health 2026
[123] Colorado Rural Health Center, Snapshot of Rural Health 2026