OREGON OFFICE of RURAL HEALTH
ORH
42nd Annual Oregon
Rural Health Conference
October 1- 3, 2025
OPPORTUNITY Just knock.
OHSU

Pathways to Sustainability for Rural Labor & Delivery

Jeff Sommer, MPP, Managing Director, Stroudwater

STROUDWATER

PATHWAYS TO SUSTAINABILITY FOR RURAL LABOR & DELIVERY

Jeff Sommer, MPP, Managing Director

WHAT TO KNOW:

Many mistakes are made around evaluating rural labor & delivery program sustainability

There are **opportunities to enhance the sustainability & improve evaluation** of these programs

Many of the lessons **learned today apply across other services & programs**

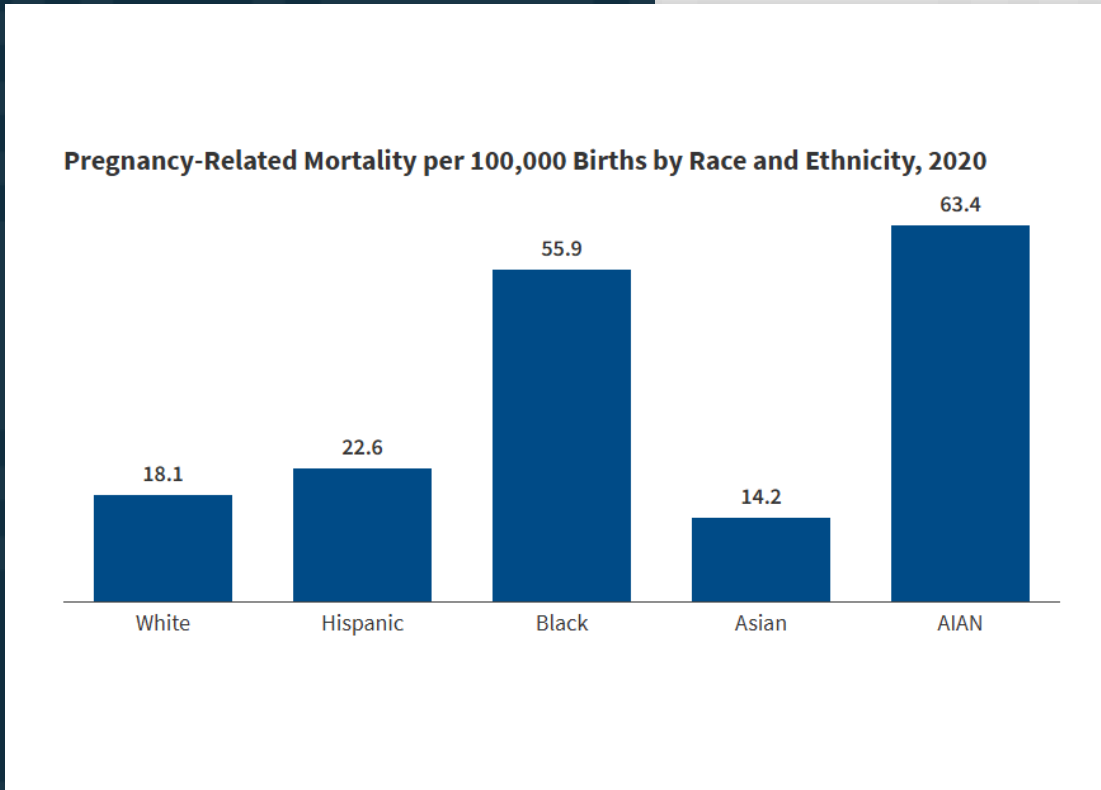
LANDSCAPE OF RURAL LABOR & DELIVERY

Over 500 hospitals have closed their labor and delivery departments since 2010...leaving most rural hospitals and more than a third of urban hospitals without obstetric care.

- The New York Times, 2024

SOURCE: Most Rural Hospitals Have Closed Their Maternity Wards, Study Finds, NYT
https://www.nytimes.com/2024/12/04/health/maternity-wards-closing.html

DISPARITIES IN HEALTH OUTCOMES

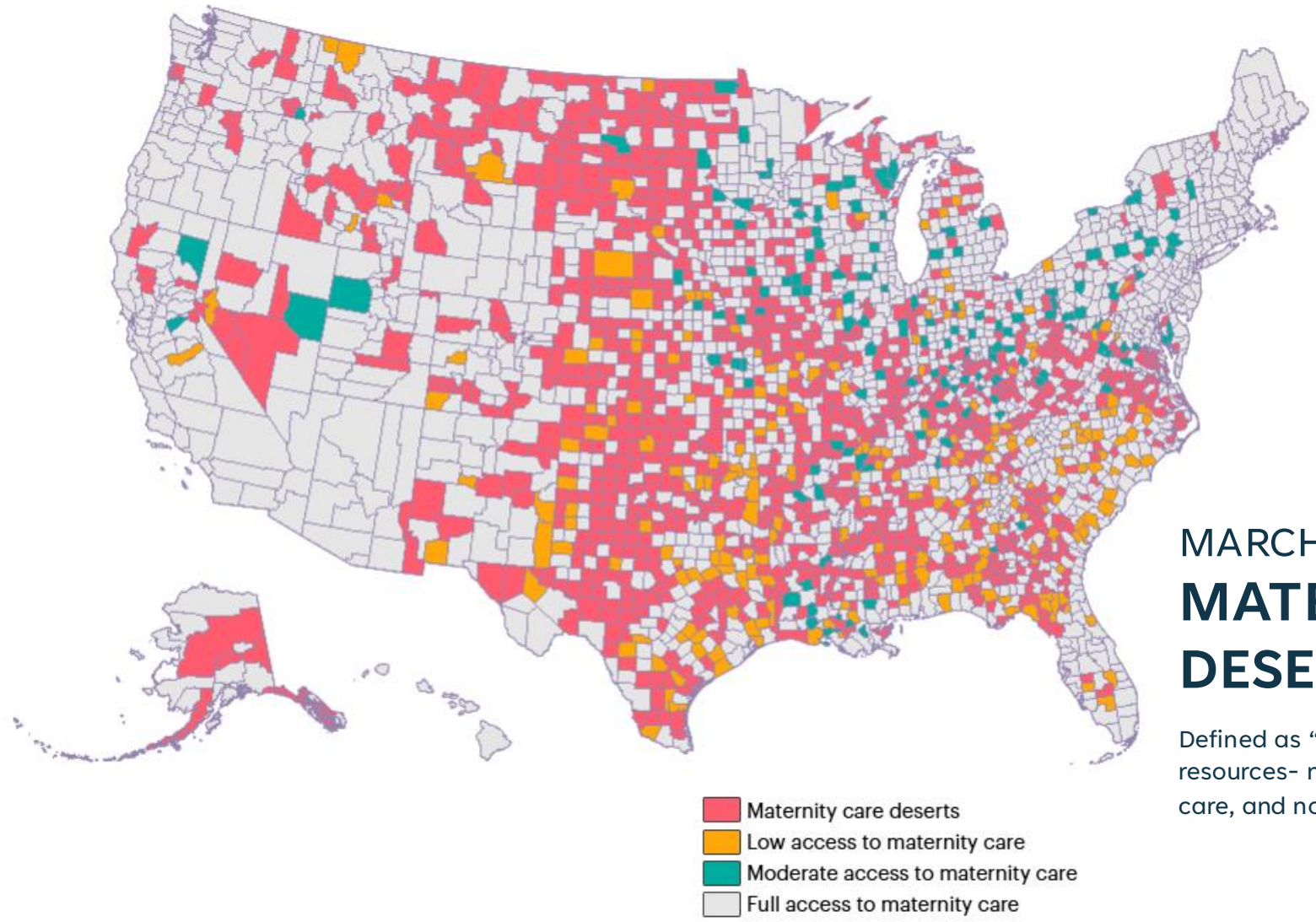


Data From KFF:

Pregnancy-related mortality rates among American Indian and Alaska Native (AIAN) and Black women **are over three times higher** than the rate for White women

- AIAN women: 63.4 per 100,000
- Black women: 55.9 per 100,000
- White women: 18.1 per 100,000

SOURCE: Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them, KFF
https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address them/#:~:text=Large%20racial%20disparities%20in%20maternal,those%20born%20to%20White%20people



MARCH OF DIMES

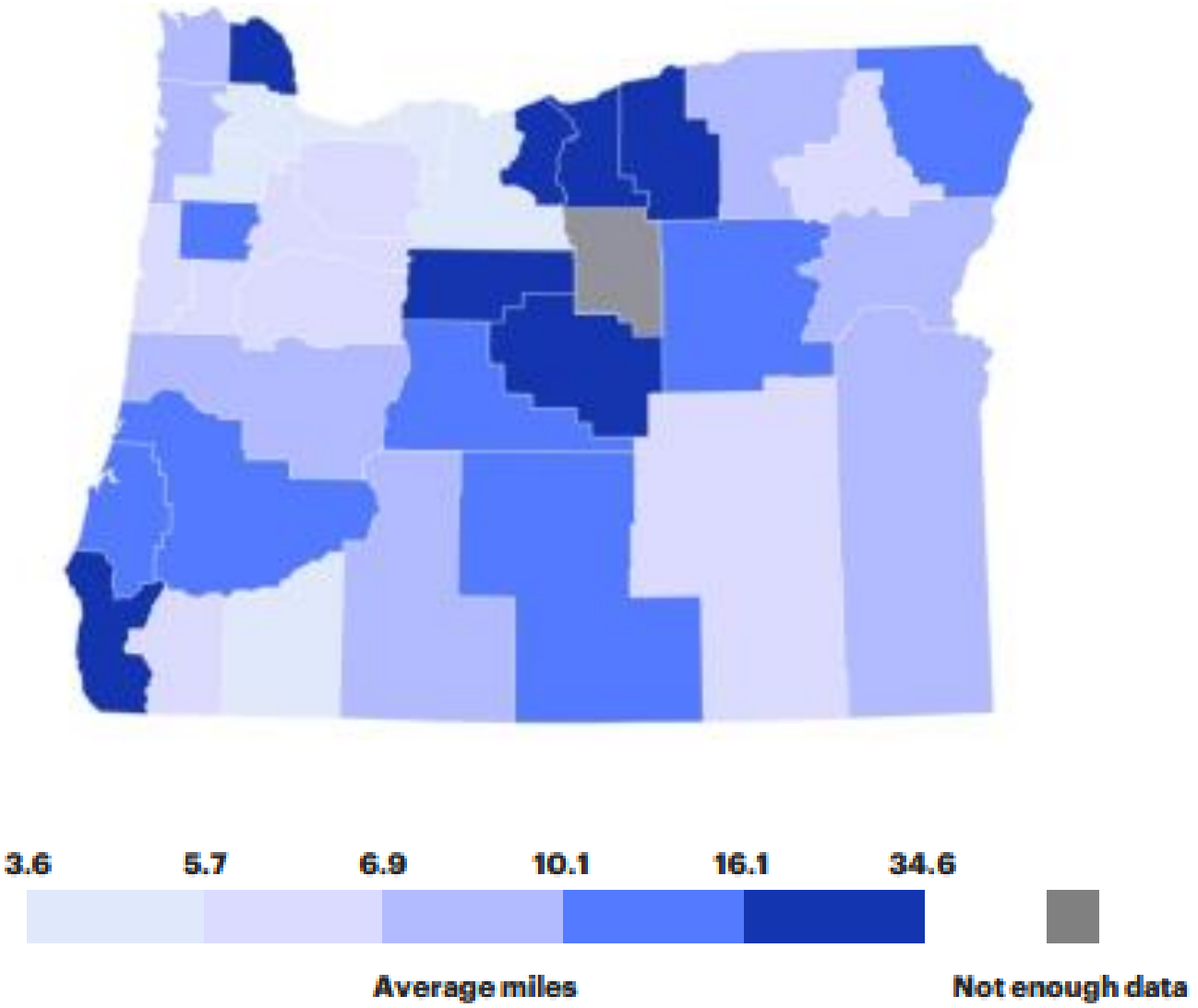
MATERNITY CARE DESERTS ACROSS THE US

Defined as “counties where there’s a lack of maternity care resources- no hospitals or birth centers offering obstetric care, and no obstetric providers.”

SOURCE: Nowhere to Go: Maternity Care Deserts Across the US, March of Dimes (2022-2023 data)
https://www.marchofdimes.org/maternity-care-deserts-report

MARCH OF DIMES

DISTANCE TO MATERNITY CARE IN OREGON



SOURCE: Where You Live Matters: Oregon, March of Dimes
https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Oregon.pdf

OREGON

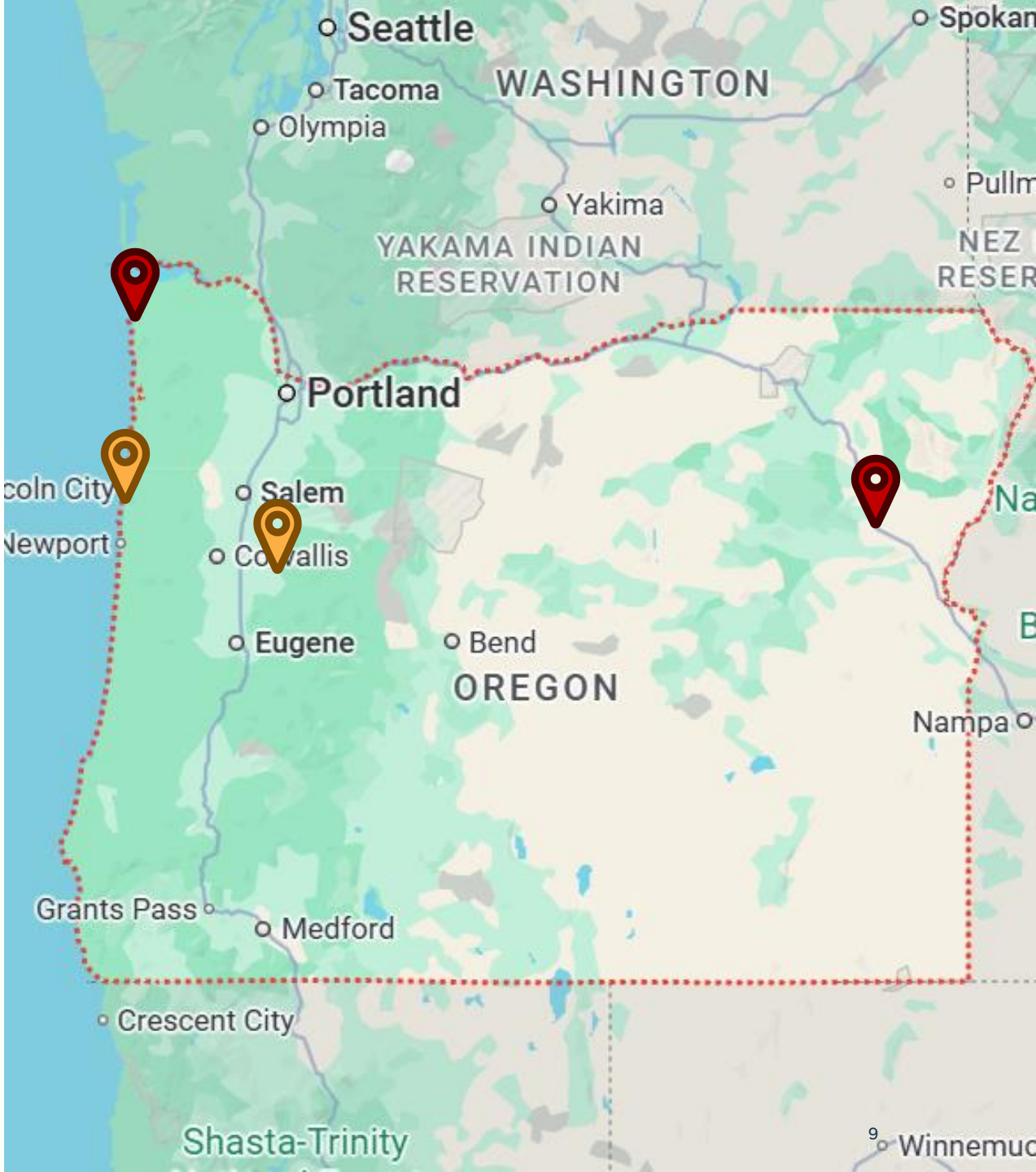
NOTABLE PROGRAMS

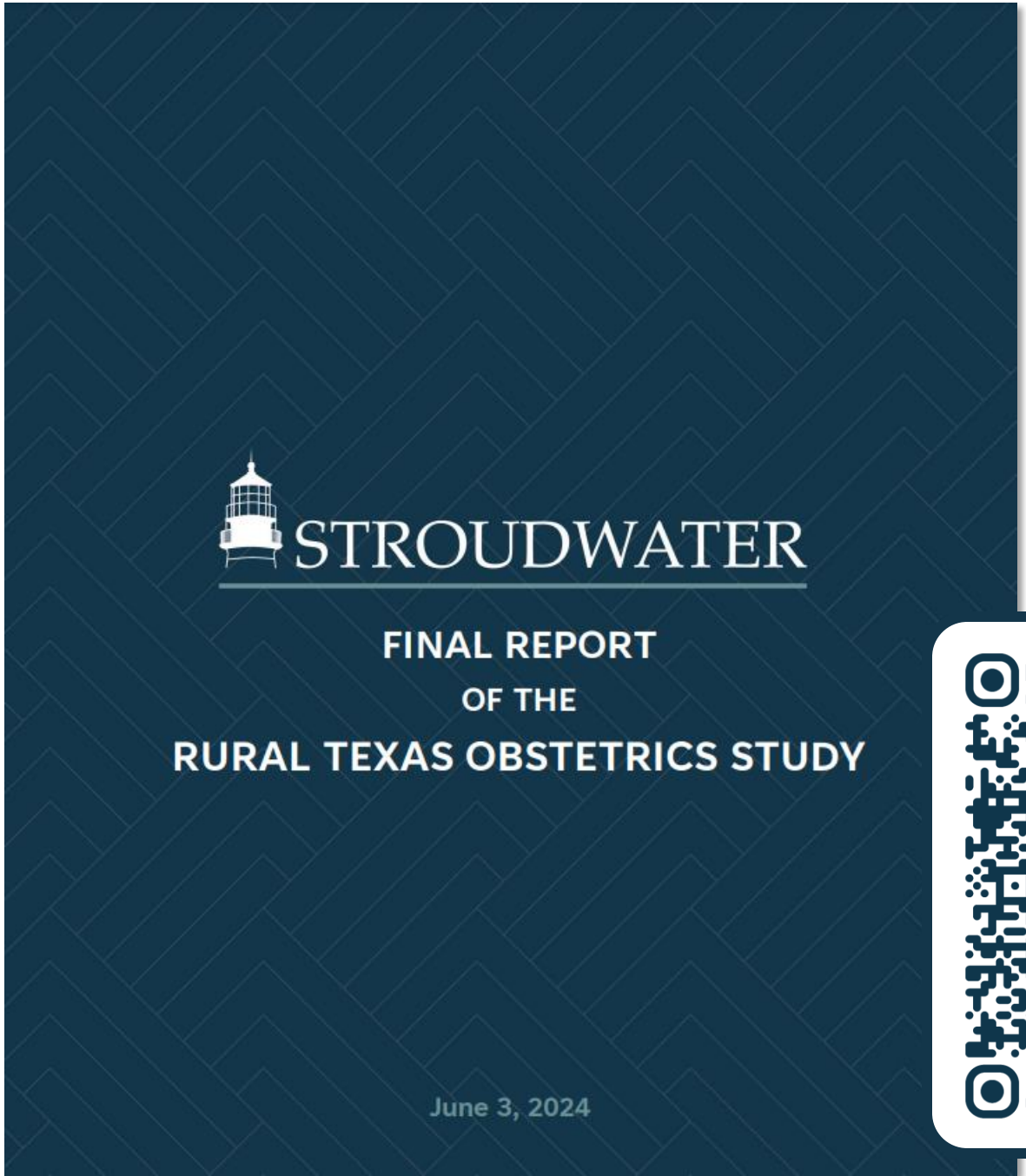
Recently Closed

- Saint Alphonsus Medical Center (2023)
- Providence Seaside Hospital (2025)

At Risk of Closure

- Samaritan Lebanon Community Hospital
- Samaritan North Lincoln Hospital





2024

RURAL TEXAS OBSTETRICS STUDY

2024

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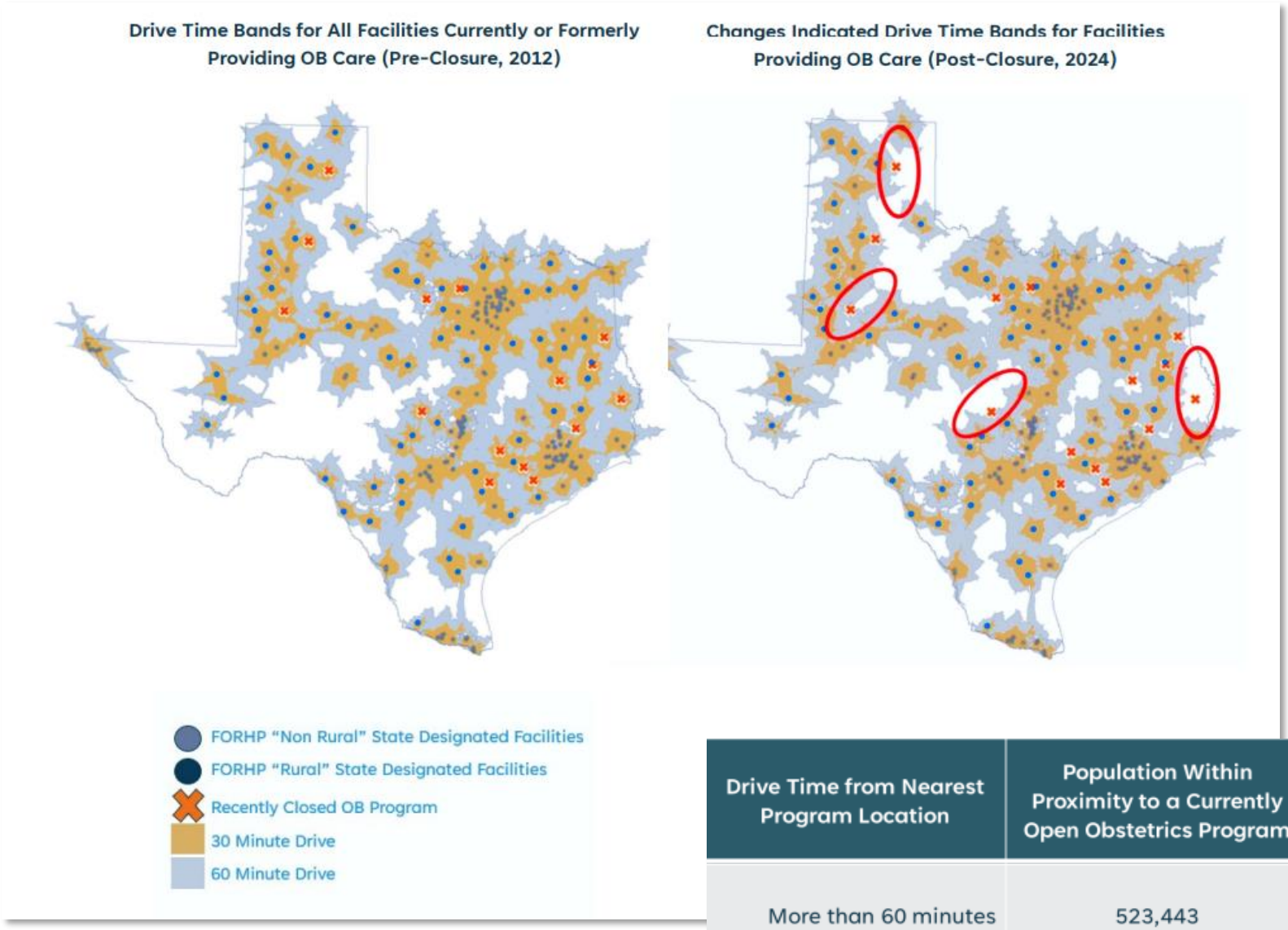

As a result of the closure of 15 labor and delivery programs between 2012 and 2024, **523,443 Texas residents now reside more than 60 minutes from the nearest labor and delivery program.**

Drive Time from Nearest Program Location	Population Within Proximity to a Currently Open Obstetrics Program	Population Within Proximity to an Open Obstetrics Program Prior to Closures (2012-2024)	Population Difference
More than 60 minutes	523,443	426,118	97,325

2024

RURAL TEXAS OBSTETRICS STUDY

Key Themes:

- Retention and recruitment of providers & staff
- Financial pressure & reimbursement
- Quality & service continuity

Key Indicators: Year Before Closure for Closed Texas Obstetrics Programs:

	For-Profit	Not-for-Profit	System	Independent
Profitability	1 of 3*	4 of 11	5 of 10*	0 of 4
Average Nursery Days	511	276	395	155
Average Inpatient Surgery Gross Charges	$5,540K	$860K	$2,220K	$979K
*Total is for hospitals where data was available				

RURAL MATERNITY
INNOVATION SUMMIT

Site Report

Abstract
This report summarizes the insights from six rural maternity programs, as presented at the March 2024 Rural Maternity Innovation Summit in Clifton, TX.

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2024

RURAL OBSTETRICS INNOVATION SUMMIT

CASE STUDY 01

LESSONS FROM THE ROAD

CASE STUDY 01

East Coast Critical Access Hospital

A partnership between a Critical Access Hospital (CAH) and a local Federally Qualified Health Centers (FQHC) created a sustainable obstetrics program.

- As a result of the partnership with the FQHC the local labor and delivery program has improved sustainability through:
  - Enhanced FQHC clinic visit payments for pre- and post-natal visits of Medicaid enrollees
  - Access to Section 330 Grant funds
  - Relief from medical malpractice insurance costs

CASE STUDY 01

Takeaways:

- Both Federally Qualified Health Centers (FQHCs) and independent Rural Health Clinics (RHCs) can play a critical part in creating a sustainable pre- and post-natal clinic business model.
- Depending on the state, independent RHC and FQHC clinic visits can be paid at 2-3 times the standard Medicaid clinic visit rate.
- In 2022, 41.3% of all deliveries nationally were covered by Medicaid, illustrating the potential significant benefits of independent RHC and FQHC payment rates to obstetrics programs.

CASE STUDY 02

LESSONS FROM THE ROAD

CASE STUDY 02

Western Critical Access Hospital

A hospital serving a significantly isolated population & performing over 400 deliveries annually (frequently sufficient volume for financial viability & key clinical competencies) decided to discontinue its obstetrics program.

Hospital leadership made the decision primarily based on identifying of a $3.0 million loss on OB services, which led to an under-investment in clinical staffing over a number of years.

However, the apparent loss on obstetrics services was primarily due to a misallocation of costs on the cost report. $6 million of obstetrics program costs were allocated to the labor & delivery ancillary department, which has no cost-based reimbursement.

CASE STUDY 02

Takeaways:

- Approximately 75% of inpatient costs for inpatient obstetrics care (when patients are not in active labor or delivery) should have been allocated to the medical-surgical cost center, which receives relatively high cost-based reimbursement.
- By properly reallocating these costs to the medical-surgical cost center, the hospital would have received incremental cost-based payments of $2.5 million, making up more than 80% of the loss on the OB program.
- This analysis did not include:
    - Potential impacts on spinoff ancillary services, which provides additional upside from retaining the program. Ultrasounds, lab work, and clinic visits are some direct spinoff benefits from a labor and delivery program.
    - Consideration of the loss in obstetric providers and the need to recruit.

CASE STUDY 03

LESSONS FROM THE ROAD

CASE STUDY 03

Southeastern Critical Access Hospital

A CAH in the southeast that performed 80 deliveries annually discontinued its obstetrics program because it only had one Family Practice (FP/OB) obstetrics provider who operated out of the CAH's provider-based Rural Health Clinic.

- The hospital had to call in additional providers approximately 60% of the time for obstetrics call coverage (no clinic visits included), and thus, 100% of call compensation was "professional" and not allowable for cost report purposes.
- The hospital also maintained 24/7 CRNA coverage solely due to the obstetrics program.
- The total cost to the hospital of obstetrics call compensation and the professional costs for anesthesia totaled roughly $800,000 annually.

The lack of RHC-based providers to limit call coverage costs, as well as the cost of maintaining CRNA coverage, were critical factors in program closure. Typically, three family practice obstetrics providers are needed to provide a long-term sustainable call schedule for a labor & delivery program.

CASE STUDY 03

Takeaways:

- The Rural Health Clinic is an important vehicle to offset the cost of FP/OP providers. Seeing patients in the RHC covers a significant portion of their costs.
    - Without this happening, the direct professional costs of providers without clinic volume offset become very expensive to the hospital.
- The FP/OB providers also expand general primary care capacity for the rural health system, which can also be a critical need.

CASE STUDY 04

LESSONS FROM THE ROAD

CASE STUDY 04

Southeastern Acute (PPS) Hospital

An acute-care hospital in the southeast maintained a successful obstetrics program. The hospital included obstetrics provider costs in its RHCs, offsetting a significant amount of call coverage costs.

The hospital's advisors had analyzed the program and recommended closing it.

However:

- The analysis had estimated obstetrics service line losses by including fixed costs of obstetrics-related services in the contribution margin analysis they had performed, which overstated the program's losses.
- This analysis did not account for the resulting impact on the Medicaid payer mix with the discontinuation of their obstetrics program, which would have reduced the hospital's disproportionate share percentage below 340B eligibility requirements.
- The loss of 340B program eligibility would **reduce the hospital's bottom line by $2.5 million annually**.

CASE STUDY 04

Takeaways:

- The original analysis by the advisors had not considered the impact on the hospitals disproportionate share % (DSH%) from discontinuing obstetrics services.
    - The effect of discontinuing obstetrics services would have **reduced the hospitals DSH% below 340B eligibility criteria**.
- Contribution margin analysis should only consider revenue less true variable expenses.
- A proper analysis of service line performance:
    - Should **not** include overhead costs
    - **Should** include “spinoff” effects from related ancillary services.

CLINICAL SUSTAINABILITY

CHALLENGES

- **Maintaining patient safety & competencies**
  - Low-volume facilities will have a harder time maintaining competencies: “If you don’t use it, you lose it”
  - This can increase the liability for facilities and staff
- **Changing best practices**
  - OB providers and staff may not always be aware of changes, or are less inclined to deviate practices from how they were trained
- **Utilizing resources & guidelines**
  - Facilities may not reference latest practice guidelines or maintain protocols and policies that adhere to changes in Conditions of Participation
  - Many rural facilities lack education and training resources and the funds to provide outside training

OPPORTUNITIES

- **Patient safety & competencies:**
  - Design orientation & ongoing programs
  - Simulation training
  - Partnerships
  - Internal training
  - Certification for staff
- **Best practices:**
  - Guidelines & policy development
  - Creating incentives
- **Utilizing resources:**
  - American College of Obstetricians and Gynecologists (ACOG)

WHAT TO TAKE AWAY

BETTER DECISIONS FOR

BETTER RURAL HEALTHCARE

OUR OBJECTIVE: Improve decisions about resource allocation and performance evaluation to enhance access to sustainable obstetrics care.

Value should include:

- Contribution margin from incremental referrals
- Incorporating ancillary spinoff volumes in program evaluation
- Collaboration opportunities with FQHCs

These decisions should be based upon:

- Variable/incremental costs (20%) not reallocated fixed costs (80%)
- Contribution margin: after variable costs are considered (80%)
- Cost-based payment (for CAHs) is unique and should inform management decisions

Access to unique rural-based programs; don't take conventional wisdom as definitive.

THANK YOU

SCAN TO VIEW FULL DOCUMENT:

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