The Robert Larner, M.D. College of Medicine | **Vermont Child Health Improvement Program**

Understanding the Role of Local Maternity Care in Vermont

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PERINATAL QUALITY COLLABORATIVE VERMONT

Key Findings

- Obstetric care received in Vermont's ten rural community hospitals meets safety and quality standards.
- Nearly one in three Vermont pregnant people travel further for their obstetric care than evidence-based guidelines recommend.
- Low-income, rural birthing Vermonters will be disproportionately impacted by the closure of hospital-based obstetric units.
- Freestanding birthing centers offer safe alternatives to maternity care but are not equivalent and work best in combination with hospital-based obstetric units.

For decades, Vermont's public health and obstetric care leaders have demonstrated strong commitment to maternal health and maternity care. Rural community hospital closures, driven in part by hospital budget concerns, are eliminating the ability of many people in rural areas to give birth close to where they live.[1] One in 12 women in the United States live in a maternity care desert, defined as a county with no obstetric providers or birthing facilities.[2] In Vermont, an independent consultant was hired in 2022 by the Green Mountain Care Board and Vermont legislature to evaluate the Vermont healthcare system as part of Act 167; their final report proposed the closure, consolidation, or reconfiguration of several low volume community hospital obstetric units.[3] Vermont has 11 birthing hospitals across the state; 10 of these are rural community hospitals including five critical access hospitals (CAHs) and five non-critical access hospitals (NCAHs). Rural community hospitals play a key role in serving residents where they live and supporting them in the years after birth. Obstetric care at rural community hospitals provides whole family, comprehensive community-based care for the pregnancy and the years after birth. This brief reviews what is known about Vermont's local maternity care and assesses evidence on the role of locally based obstetric care.

Hospital Designation

- **Critical Access Hospitals (CAHs):** Small, rural community hospitals with twenty-five or fewer beds. CAH is a federal designation given by the Centers for Medicare and Medicaid Services in order to provide essential services in rural communities.[4]
- **Non-Critical Access Hospitals (Non-CAHs):** Rural community hospitals that do not meet the specific criteria to be classified as CAHs.

Safety and Quality of Rural Obstetric Care

Analysis of quality data for Vermont rural community birthing hospitals shows they meet current quality standards. National data suggests that small rural hospitals generally have higher levels of maternal and neonatal morbidity and mortality[5,6]; however, Vermont-specific data consistently demonstrates high levels of care at community hospitals. In Vermont, more than half of births occur in small, rural community hospitals. Four out of the five CAHs have birthing volumes below the threshold of 240 per year quoted in state reports as an adequate number of deliveries to maintain skills.[3] Annual statistical reporting completed by the Perinatal Quality Collaborative Vermont (PQC-VT) demonstrates CAHs have high rates of adequate prenatal care utilization and lower rates of inductions and cesarean section deliveries than other hospitals (Table 1). Additionally, unexpected complications qualifying as severe maternal morbidity (SMM) events occur least frequently in Vermont's CAHs. While these quality outcomes may in part reflect a population of lower risk patients at these sites, they show that Vermont's CAHs meet quality standards for their current patient population.

Table 1: Obstetric Quality and Safety Metrics for Vermont Hospitals, 2020-2024.

Quality Measure 2020-2024	Critical Access Hospital	Non-Critical Access Hospital	Tertiary Care Center
Adequate Prenatal Care Utilization	74.3%	67.2%	68.2%
Induction of Labor	29.4%	37.8%	41.3%
Cesarean Deliveries	21.5%	28.5%	31.0%
Severe Maternal Morbidity*	0.7%	1.5%	1.9%

These data include all births occurring within Vermont hospitals, including out-of-state residents. This data excludes births to Vermont residents outside of Vermont. Adequate prenatal care utilization is defined using the Kotelchuck Index.[7] Severe maternal morbidity is a composite metric of 20 standardized diagnosis and procedure codes used to assess unexpected complications.[8]

Source: Data shown are from Vermont Vital Statistics 2020- 2024[9] and the Vermont Uniform Hospital Discharge Data 2022.[10]

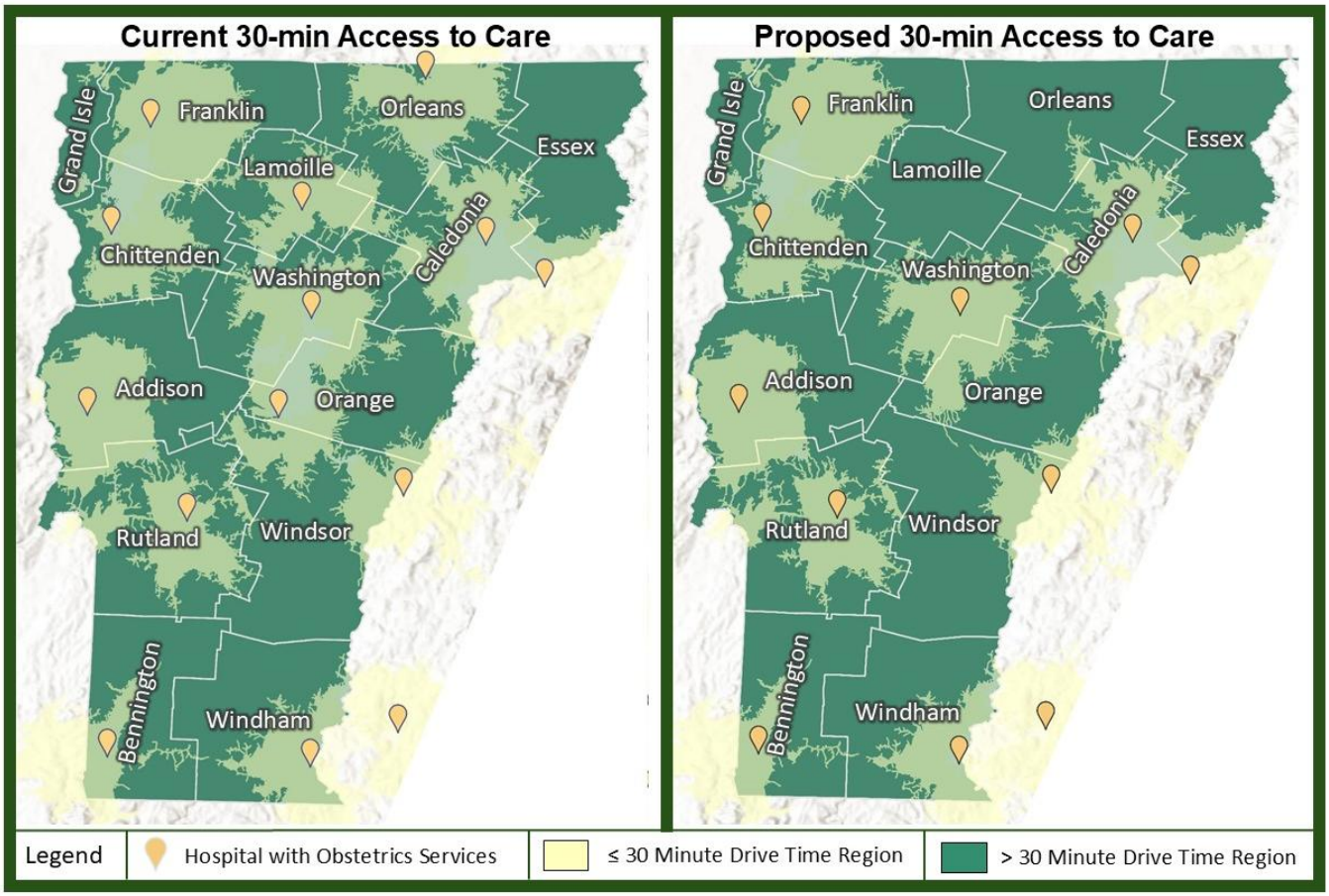
Vermont has a robust collaboration between community and tertiary care hospitals that provides support for quality local care. Through a collaborative relationship between rural community hospitals, University of Vermont Medical Center (UVMMC) and the PQC-VT, all rural community hospitals are able to access real-time consultation with maternal fetal medicine and neonatology specialists through a 24-hour telephonic and email wrap-around consultation service. Similar consultation services are offered by Dartmouth Health Medical Center (DHMC) to Vermont community hospitals bordering New Hampshire. This service allows community providers to receive specialist opinions, guides care, and may prevent unnecessary and expensive patient transport for higher-level care. Due to the coordination of care between UVMMC and rural community hospitals, 72 out of 93 late preterm infants born in 2024 were able to be cared for within their birthing facility.[10] In addition, the collaboration supported 17 maternal and 120 infant transfers between community and tertiary care facilities in 2024.[11]

Birthing hospitals statewide engage in ongoing quality improvement and skills development. The PQC-VT works with all Vermont birthing hospitals to support neonatal and obstetric preparedness through on-site skills training. From July 2024 to June 2025, healthcare professionals from nine rural community hospitals participated in 11 in-person Neonatal Simulation training sessions with 11 additional on-site obstetric drill training sessions. Annual PQC-VT statistical reporting and benchmarking conferences held with birthing hospitals in 2025 reached 131 healthcare professionals from all 10 of Vermont's rural community hospitals.

Local Maternity Care Access

Nearly one in three Vermont pregnant people travel further for their obstetric care than evidence-based guidelines recommend. Long driving distances to obstetric care are associated with worse maternal and infant outcomes.[5] The American College of Obstetricians and Gynecologists recommends all birthing people have access to obstetric care within one hour of travel time[12] and to be able to receive a cesarean section within 30 minutes when needed.[12, 13] Within Vermont, the March of Dimes reports an average drive time of 22.1 minutes to the nearest birthing hospital for Vermonters, with 29.4% of women exceeding the 30-minute threshold under the current structure of 11 birthing hospitals in the state.[14, 15] Evaluation of births occurring only at rural community hospitals using the 2020-2024 Vermont Vital Statistics expands average travel time to 37.4 minutes, with 33% of Vermonters exceeding the 30-minute guideline.[16]

Figure 1. Current and Proposed 30-minute Access to Care for Hospitals Offering Obstetrics Services in Vermont. Map of 30-minute drive-time regions within Vermont counties from currently open (July 2025) and remaining open Vermont and New Hampshire hospitals offering obstetrics and birthing services following proposed closures.



Methodology: 30-minute drive time maps were created in ArcGIS Pro version 3.5.2 using the Drive Time Analysis function coordinates of Vermont and New Hampshire hospitals. 30-minute drive time to the hospitals was used in accordance with the ACOG guideline to be within a 30-minute travel time to a hospital with obstetrics services for an emergency cesarean section.[11]

Reorganization of hospital-based birthing units as recommended in recent policy discussions would increase the number of pregnant Vermonters who exceed guidelines for access to care. Recent debate over healthcare costs and access in the state has generated proposals to reevaluate specific hospital service lines, including obstetric offerings. A report by the Oliver Wyman Group, termed the "Wyman Report," in August 2024 to the Green Mountain Care Board (GMCB) suggested Vermont overhaul its obstetric services with consolidations, reconfigurations, and closures in some areas, particularly in low-volume, rural hospitals.[3] If these recommendations were implemented, closing birthing units at Copley, Gifford, and North Country Hospitals, we estimate the average travel time to obstetric care would increase to 42.8 minutes, with 44.4% of birthing Vermonters exceeding the 30-minute threshold (Figure 1). Closure of birthing units will expand the range of maternity deserts, with the greatest impact seen in the Northeast Kingdom region of the state.

Low-income, rural birthing Vermonters will be disproportionately impacted by the closure of obstetric units. Patients who deliver at smaller rural community hospitals are more likely to have lower levels of education and higher rates of Medicaid coverage (a proxy for low income) than people who deliver at other hospitals (Table 2). These patients would be most affected by the closure of these hospitals, with the additional burden of further travel to seek a higher level of care. These findings echo similar national assessments.[17]

Table 2: Demographics of Birthing Population in Vermont, 2020-2024.

Demographics 2020-2024		Rural Community Hospital Births	Tertiary Care Center Births	Out of Hospital* Births	All Vermont Births**
	Total Live Births	12,885	10,736	797	24,430
Race and Ethnicity	**White, non-Hispanic**	92%	85%	92%	89%
	BIPOC	8%	15%	8%	11%
Education Level	**High School or Less**	36%	21%	21%	29%
	Some College or More	64%	79%	79%	71%
Insurance Status	**Private**	51%	68%	32%	58%
	Medicaid	46%	25%	33%	36%
	Other	4%	6%	35%	6%

Notes: **All Vermont births are defined as those occurring within Vermont, including to out-of-state residents. This data excludes births to Vermont residents outside of Vermont. *Out of hospital births are defined as planned and unplanned homebirths.
Source: Data shown are from Vermont Vital Statistics 2020- 2024

The safety of homebirth as an option for Vermonters is dependent on the ability to transfer to a higher level of care when clinically indicated. In Vermont, planned homebirths account for 3% of all births, the second highest rate in the nation. In the regions most impacted by potential obstetric unit closures, Lamoille, Orleans, and Orange Counties, the rate is 5%. From 2020 to 2024, 157 (21%) women attempting to homebirth were transferred to a hospital obstetric unit. An additional 68 infants born outside of hospitals were admitted.[16]

Role of Freestanding Birthing Centers

Freestanding birthing centers cannot replace hospital-based maternity care. Birthing centers offer midwifery-centered, safe alternatives to maternity care, but they are not equivalent in offerings and work best in combination with facilities offering higher levels of care.[18] A birthing center offers non-medicalized natural birth in a non-hospital environment but is not able to offer inductions of labor or pain relief and cannot meet the needs of patients who require cesarean deliveries or specialized care. As a result, birthing centers are appropriate only for low-risk patients. Additionally, 20-25% of low-risk deliveries result in unexpected clinical situations requiring cesarean sections; emergency departments and non-obstetric surgical teams are not adequately prepared to perform cesareans.[19]

Replacement of hospital-based obstetric care with freestanding birthing centers would lead thousands of patients to have to travel for care due to pregnancy-related risk or need for higher-level services. Using Vermont Vital Statistics data, we calculate that over 30% of Vermonters giving birth at the ten Vermont community hospitals between 2020 to 2024 would not have been eligible to give birth at a freestanding birthing center. Of those eligible, 16% would require extra consultation and could potentially be referred for higher levels of care, depending on their specific clinical considerations, including complications of pregnancy or prior cesarean. In addition, over 20% of eligible patients would require transport due to labor complication requiring operative or cesarean deliveries. The reasons for ineligibility and referral for specialized care are highlighted in the Appendix.

Birthing centers staff are not trained to offer induction or augmentation of labor or epidurals for pain management. These are medical interventions 70.2% of the eligible birthing population received in rural community hospital deliveries between 2020 to 2024. The inability for freestanding birthing centers to offer these services means patients will have to weigh concerns about travel time with availability of labor induction and pain management.

Implications for Policy and Practice

Healthcare policymakers and administrators are facing difficult decisions in the face of rising healthcare costs and access barriers in Vermont. Cutting relatively low-volume service lines, transitioning care to less expensive freestanding facilities, or consolidating patient care at tertiary care centers may provide logical solutions to financial stress. However, loss of hospital-based maternity care in local, rural communities will increase travel times to maternity care for thousands of Vermonters. For many patients, the replacement of hospital-based care with freestanding centers is not an option due to risk, and for others, such replacement may put them at risk of not receiving needed birth services. Ultimately, travel time, potential maternal and infant complications, increased wait times at remaining facilities, or difficulty in accessing care may lead to new costs in the system for hospitals and patients themselves.

Vermont is a small state with a statewide, collaborative system to support high quality perinatal care service delivery. This system also supports communities in other ways, including employment, connections to local services during pregnancy, and collaboration between perinatal and pediatric providers to provide ongoing care for the parent-child dyad. Our collaborative approach to perinatal care focuses on community connections before, during and after birth, supporting relationships and parent-child attachment. This approach has been a key component of Vermont's healthy outcomes and why our state ranks high among other states for family well-being. Closure of community hospital obstetric units disrupts the important role that local teams and community resources play in providing families with a healthy start.

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Appendix

Characteristics Affecting Eligibility to Deliver at a Freestanding Birthing Center in Vermont, 2020-2024.

Rural Community Hospital Birthing Population	N= 12,885	%
Characteristics Excluding Eligibility from a Birthing Center		
Chronic Hypertension	283	2.2
Diabetes	95	0.7
Obese (BMI>35)	2315	18.0
Preterm Birth	776	6.0
Multiple Gestation	103	0.8
Non-head down presentation	719	5.6
Multiple Cesarean Sections	393	3.1
Total with 1 or more of the above:	3915	30.4
Characteristics Requiring Extra Consideration in Eligibility (N=8971)		
1 prior cesarean	723	8.1
Gestational Diabetes	617	6.9
Pregnancy Associated Hypertension	653	7.3
History of Preterm Birth	179	2.0
Total with 1 or more of the above:	1418	15.8
Requiring Transport for Specialized Care		
Cesarean Delivery	1525	17.0
Operative Vaginal Delivery*	293	3.3
Total with 1 or more of the above:	1818	20.3
Additional Medical Technologies Not Available		
Induction	3,102	34.6
Augmentation	1,704	19.0
Epidural for pain management	4850	54.1
Total with 1 or more of the above:	6296	70.2

Notes: All deliveries occurring at Vermont Rural Community Hospitals (both CAH and non-CAHs) are included. This data excludes births to Vermont residents outside of Vermont.

* Operative vaginal delivery refers to a birth in which the clinician uses forceps or a vacuum device to aid vaginal delivery

Source: Data shown are from Vermont Vital Statistics 2020- 2024