STROUDWATER

PATHWAYS TO SUSTAINABILITY FOR RURAL LABOR & DELIVERY

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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**

POLL 1

What is the likelihood that the Labor and Delivery program at your hospital will be eliminated in the next 24 months?

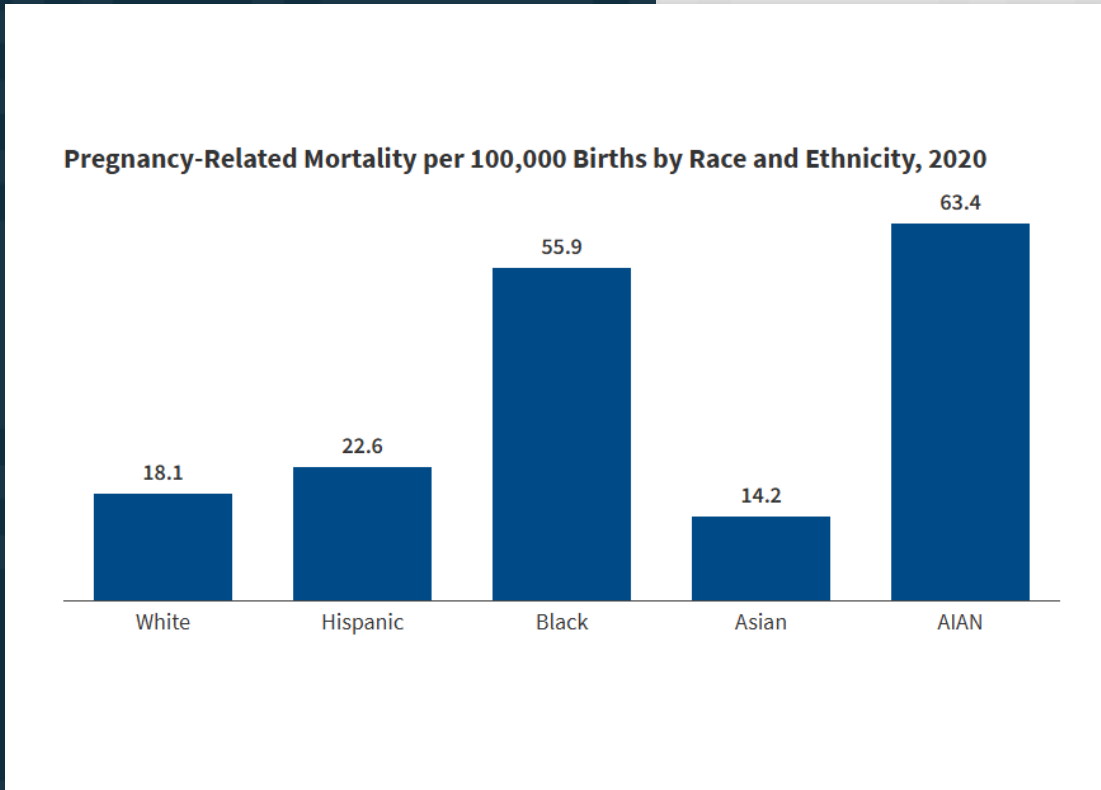
LANDSCAPE OF RURAL LABOR & DELIVERY

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

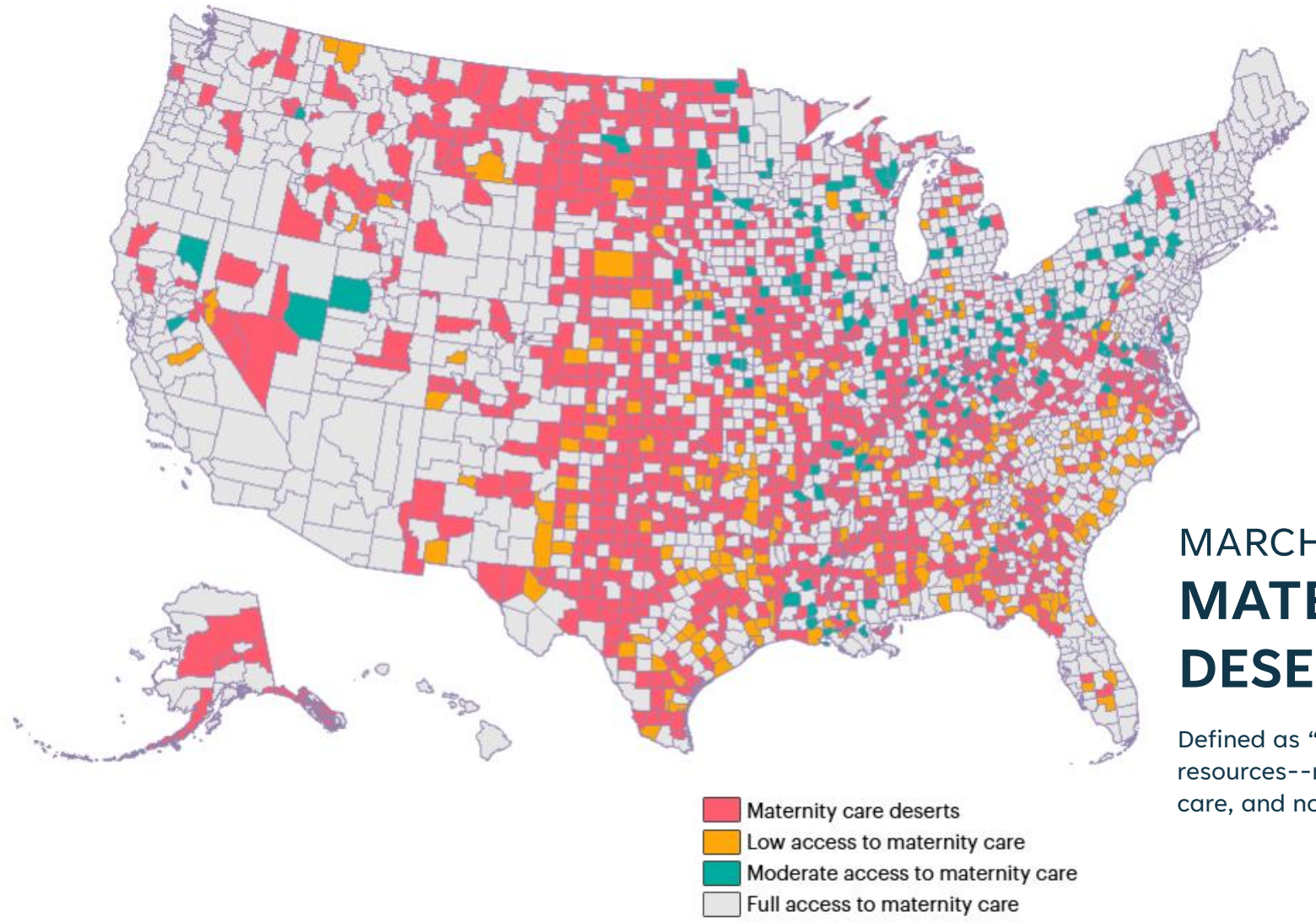


Data from KFF:

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

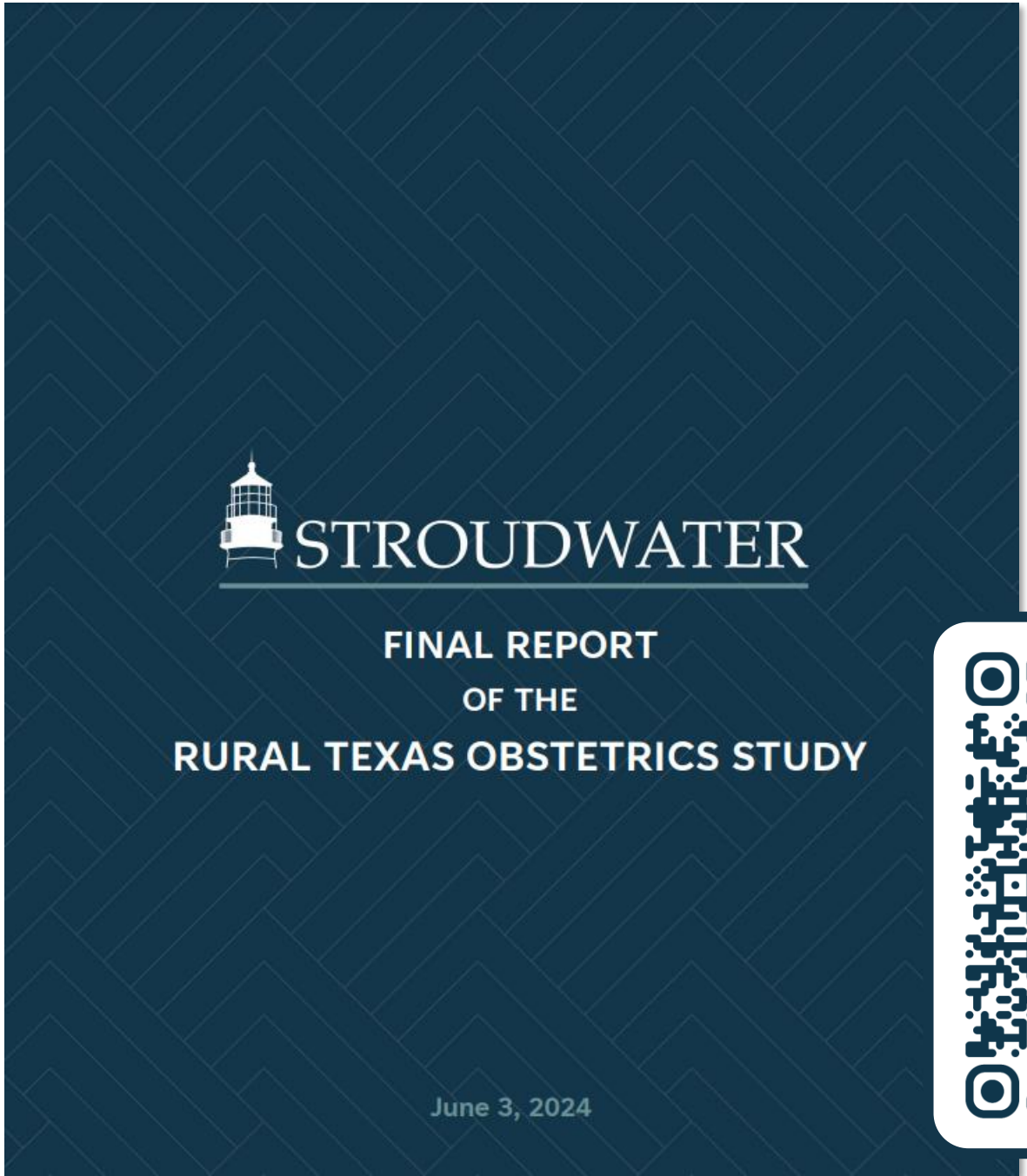


MARCH OF DIMES

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



2024

RURAL TEXAS OBSTETRICS STUDY

LESSONS FROM THE ROAD

POLL 2

If you have a Labor and Delivery program at your hospital, how accurately do you believe its performance is understood or evaluated?

CASE STUDY 01

Southern PPS Hospital

- A 49-bed PPS hospital maintained an OB program that did an average of 350 deliveries a year. The program consisted of:
  - A full-time employed OB-GYN who also performed GYN surgical procedures in addition to C-sections
  - A FP/OB in the community
  - Both providers shared responsibility & call for deliveries, keeping up with a high number of deliveries
  - OB/GYN clinic was not eligible to bill as RHC
- The hospital began to recruit a 2nd full-time OB-GYN—a local FQHC got involved and suggested an alternative plan:
  - The FQHC would employ the OB-GYN being recruited by the hospital
  - The FQHC would employ the hospital's current OB-GYN
  - Hospital pays call time beyond what is included in the provider contract with FQHC
  - All deliveries & surgeries would be taken to the hospital

CASE STUDY 01

- **The current situation:**
  - The FQHC continues to employ the providers
  - The deliveries & surgeries are performed at the hospital
  - The FQHC was able to obtain grant funding specific to women's services
- **Benefits for both parties:**
  - The solution helped take a clinic that was losing money off the books for the hospital, but kept the surgery revenue
  - FQHC can bill for OB services on a per-visit basis
  - FTCA covers malpractice insurance for providers employed by FQHCOB/GYN services continue to be provided in the community

CASE STUDY 01

Takeaways

- Both Federally Qualified Health Centers (FQHCs) and independent Rural Health Clinics (RHCs) can play a critical role 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 in an isolated population discontinued its obstetrics program
  - Nearest OB services are 90 miles away
- The decision was primarily based on a $3.0 million loss on OB services, which led to under-investment in clinical staffing over several years
- Subsequent review indicated that the loss on OB services was due to misallocation of costs on the cost report
  - A significant portion of OB program costs was allocated to the Labor & Delivery ancillary department, which has no cost-based reimbursement

CASE STUDY 02

Takeaways

- Approximately 75% of 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 higher 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 provide 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 key factors in the program's 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 essential vehicle for offsetting the cost of FP/OB providers. Seeing patients in the RHC covers a significant portion of their costs.
  - Without this happening, the direct professional costs of providers without a 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 hospital's disproportionate share % (DSH%) from discontinuing obstetrics services
  - The effect of discontinuing obstetrics services would have **reduced the hospital's DSH% below the 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 from practices as they were trained
- **Utilizing resources & guidelines**
  - Facilities may not reference the 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 and ongoing programs:**
  - Particularly for high-risk, low-volume cases
- **Simulation training:**
  - Sending staff to local institutions that have a simulation lab
  - Bringing a mobile simulation lab onsite at your facility
- **Partnerships:**
  - Partnering with larger, high-volume facilities to send providers and staff for hands-on training & shifts
- **Internal training:**
  - Some rural hospitals are having the ED & OB physicians help train the nursing staff
  - Holding mock drills for obstetrics emergencies, etc.
- **Certification for staff:**
  - Neonatal Resuscitation Program (NRP)
  - Promote the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) Fetal Heart Monitoring Program

OPPORTUNITIES (CONT.)

Best Practices:

- **Guideline & Policy Development**
  - Develop guidelines that are evidence-based, using resources available through AGOG and AWHONN
  - Ensure that policies & guidelines are reviewed & updated regularly
- **Creating Incentives**
  - Create a clinical lateral program for OB nurses so that they have additional incentives to grow their knowledge and competencies

Utilizing Resources:

- **American College of Obstetricians and Gynecologists (ACOG)**
  - ACOG developed an algorithm to help support the CMS final rule issued in November, designed to improve obstetrical outcomes

FROM THE FIELD

HAWAII

- After the CMS final rule was issued on November 27, 2024, facilities in Hawaii were left wondering how they were going to fulfill the education needs outlined by the final rule regarding obstetrical emergencies for CAHs without obstetrical services
- Kula and Lanai's system affiliate, Kaiser Permanente, has developed an entire program around OB emergencies that they were able to utilize to meet this requirement

NEW YORK

- Several facilities in New York have relied on simulation training, as well as outside education, to fulfill this requirement

POLL 3

What are the biggest challenges confronting your labor and delivery program?

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
- Opportunities to allocate costs

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.

QUESTIONS?

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THANK YOU

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