A new GMCB Public Comment has been received.

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Topic: Hospital Budget

Comment: I I am writing to provide public comment regarding the FY24 hospital budget deliberations.

I am the medical/site lead for a rural obstetric program.
Rural obstetric programs are closing around the country due to the costs involved in keeping them staffed.

I do not know much about hospital budgets, but I do know the following:
- staffing costs are going up
- births are going down
- patients are getting sicker and pregnancies are getting more complicated
- the United States is renowned for our abysmal maternal morbidity and mortality rates compared to countries of our wealth
- the JC has set measures and standards for things like reducing cesareans, and institutional readiness for complications such as obstetric hemorrhage and hypertension
- when a birth is low risk and none of this is needed, things may seem fine, but for a hospital birth, as opposed to a low risk home birth, it is expected that we can respond if things are not going fine
-often that means having resources “at the ready” even if they are not used or needed (in which case, as I understand it, they are not billed or reimbursed)

A not uncommon situation that I run into is that a labor is not going smoothly, and I am concerned that I may need to perform a cesarean. I call for the operating room to be ready, but I do not want to operate yet. I think she can deliver vaginally, but I am not certain. It may take 1-4 hours (or more) for the situation to play out. If it is a weekend or overnight, I call staff in from home so I can move quickly if needed, because I do not like playing a game of “chicken” with my patients. (The situational awareness needed in rural hospitals is very different from in a medical center which has the volume to support more staff in house 24/7) In the case of an operative vaginal birth or twins, I may even bring the patient into the OR to deliver with a “double set up” so I can convert to abdominal delivery even more quickly if needed.

In addition to myself and the labor nurse, I need:
- A pediatrician
- An anesthesiologist
- A scrub tech
- A circulating nurse
- A surgical assistant (which I probably don’t have, so it’s probably a general surgeon or another Obstetrician)

They all need to be paid for their time, often at overtime or traveler rates.
But we have only one of each, so the orthopedic surgeon, who theoretically has a case which would bring more revenue to the hospital, has to put their case on hold so everyone can stand by for this birth.

Most of the time, I can help the patient to have a safe vaginal birth.
At the end of the shift:
-Mom is healthy and not recovering from abdominal surgery
-Baby is healthy
-Staff go home and are paid (or looking for new jobs if they are not)

-The hospital is reimbursed at the lower vaginal birth DRG rate which does not account for all these surgical resources that were not used.
- The theoretical orthopedic case is delayed to the next day, probably with an extra unpaid hospital day, and causing some downstream mess in the next day's schedule for the OR, or for that surgeon.

No one says it out loud, but we would have made more money and used fewer resources (or for less time) if we had done a cesarean. I worry about not being able to sustain an OB practice, but I worry even more about keeping one going and not being able to keep it safe.

Thank you for your consideration.

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Post Comment: Yes