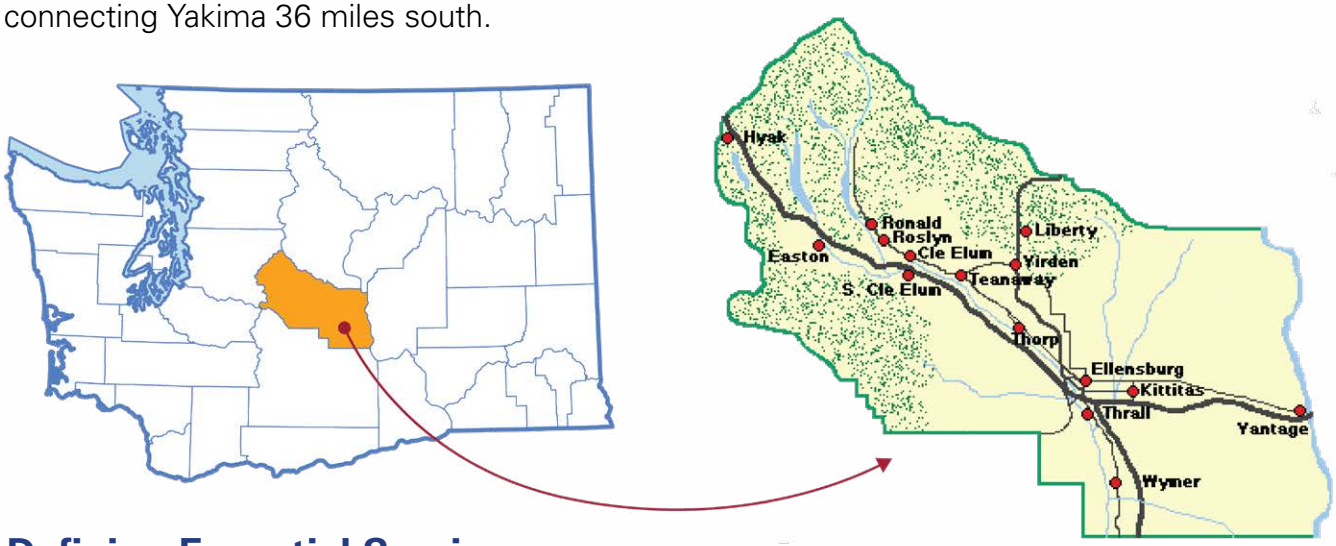
Meeting Essential Health Services And Reimagining Obstetrics In A Rural Community

Situated in Ellensburg in the heart of central Washington, Kittitas County Public Hospital District No. 1, also known as Kittitas Valley Healthcare (KVH), provides care to Kittitas County and surrounding areas. Kittitas County is 2,297 square miles and home to about 48,000 residents, growing fast at an average rate of 2.13% annually. Ellensburg is at the intersection of Interstate 90, which runs midway through the entire county connecting the major cities of Seattle, 110 miles west, and Spokane, 175 miles east, with I-82 connecting Yakima 36 miles south.



Defining Essential Services

KVH includes a 25-bed critical access hospital and provides care through clinics and specialty services in Upper and Lower Kittitas County. According to the 2021 Kittitas Community Health Assessment & Improvement Plan, the leading causes of hospitalization in the county are: 1) complications of pregnancy, childbirth and puerperium, and 2) certain conditions originating in the perinatal period. For young adults ages 18-24, the leading cause of hospitalization is complications of pregnancy, childbirth and puerperium, and for children 17 years of age or younger, it is certain conditions originating in the perinatal period.

Given the demand, it is clear that the core of essential services provided by KVH is women's health services, including obstetrics and gynecology (OBGYN). However, in 2023, all three full-time (FT) OB/GYNs gave notice of intent to leave the organization. KVH was in crisis. While OB services never paid for themselves, the board was committed to delivering babies for the community. With the loss of its FT OB/GYNs and the demand for a breadth of women's health services, KVH needed a fix.

The Market Drives the Need to Change

KVH delivers around 300 babies per year. Prior to 2022 and COVID-19, KVH provided maternity and gynecological care to the community through OB/GYNs. The original practice model involved employing three OB/GYNs and one certified nurse midwife (CNM).

But after providers left the practice, this traditional model was no longer viable. In addition to losing 24/7 OB call capacity, other types of services linked to OB/GYN care were compromised, such as GYN surgery and the capacity to perform routine, office-based gynecological procedures.

Nursing is a key component of the model. Nurses drive the service and are omnipresent. There are a minimum of two labor and delivery nurses 24/7 to staff a dedicated labor and delivery unit. To be effective, KVH must sustain an OB RN pool, CRNA capacity, cesarean section first assist capacity and acute newborn providers 24/7/365.

Innovative Model for Delivering Best Care in Rural OB

KVH had to think creatively about how to address this staffing concern. They had successfully worked with hospitalists and outsourced anesthesiology in the past. So, in 2023, leaders began to consider outsourcing obstetrics as an option. After considerable research and discussions with their clinical team, KVH engaged OB Hospitalist Group (OBHG), signaling a transition away from the OB/GYN employment model.

The new plan, launched in October 2023, includes securing three FT OB/GYNs who each work a five-day stretch of both clinic and OB call and then have 10 days off, returning after this 10-day break in service between rotations. The focus during clinic work is to restore capacity for all pregnant patients and routine gynecological care with procedures and surgeries.

Routine OB care is provided by an employed KVH family practice OB, a CNM and an advanced registered nurse practitioner. With the five-day rotations for OBHG OB/GYNs, many shifts cross over between weekends and the work week, providing some respite from 24/7 demands on weekends and holidays. Dedicated time for both clinic and OB call functions is scheduled whenever possible.

For KVH to break even on OB/GYN care, several strategies need to be implemented as they continually onboard OBHG. Based upon estimates, KVH needs to increase gynecological surgical volumes by 9.5 to a total of 10 cases per month, with an average reimbursement of $7,000 per case to break even and cover the cost of OB/GYN care in this community. This is only possible by using the OBHG model.

Now more than six months into the transition, it may take up to nine months for the new model to become fully staffed by OBHG providers. In the interim, KVH is building resources and increasing the frequency of teaching drills and simulation training with their teams (anesthesia, acute newborn and surgical assist) and solidifying referral networks and relationships between providers for both maternal fetal medicine and gynecological oncology.

Conclusion

KVH is optimistic that its new model will be fully staffed with OBHG providers on time, as planned. Presently, KVH employs a surgically trained family practice OB, but retains support from recently retired obstetricians. KVH partners with a teaching community health center and has sent FPs there to be surgically trained in performing c-sections, which helps to advance skills and supports overall recruitment.

KVH must maximize scheduling of gynecological clinic visits, surgeries and procedures by focusing OB/GYN expertise on GYN care in the clinic setting. They seek to restore GYN care for menopausal symptoms and concerns. KVH must continue work to secure maternal fetal medicine providers, so patients aren't forced to travel to either Seattle or the Tri-Cities for care, their current options.

Finally, KVH board and leadership will work with legislators and payers to secure and retain adequate reimbursement or funding to sustain comprehensive women's health care, including obstetrical and gynecologic care in the local community. Funding and reimbursement must keep pace with these local and national challenges.

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