Free White Paper—6 Questions Asked by an Actual Hospital Client with Answers

QUESTION #1

What has changed regionally or nationally regarding these OB hospitalist programs that we should know about? Issues such as recruiting/retention challenges, program model changes, contractual trends, salary trends, consolidation of the OBGYN Hospitalist "community", hospital/facility perceptions of the program's success, etc.

ANSWER

We have seen a lot of growth of OB hospitalist programs nationally. This reason is multifactorial, but the bottom line is that the OBGYN Hospitalist programs increase the quality and safety of care provided. To name a few reasons, the OBGYN hospitalist can attend precipitous deliveries, respond to an emergency such as cord prolapse or hemorrhage, provide immediate back-up for midwives and family practice, and enable more attempts at VBAC.

It is likely these programs soon will be the standard of care for hospitals delivering more than 1,000 babies a year. If a program is well designed and the providers are selectively chosen, physician recruitment and retention is not a common issue (unless it is already difficult to recruit to the hospital, i.e., not a desired location). Even though the concept of an OB Hospitalist program is similar, designing a program requires assessing the hospital's specific needs, resources, and service lines provided. Some hospitals elect to use an OB Hospitalist Management company, while other hospitals run the programs themselves. There are pros and cons to each. Salaries have trended similarly to the generalist OBGYN. SOGH will be surveying its members soon for the latest data. I am running that committee and will have this information before it is published.

QUESTION #2

We would like specific examples of programs where a Hospitalist functions as MFM extender. How does rounding work; billing options for same? Is there general resistance to this type of activity or do you "recruit for it"?

ANSWER

I have personal experience working as an MFM extender and I know many programs that operate this way successfully. Usually, the MFM rounds on their own patients but in many cases the patients are admitted by the OB hospitalist who rounds on them every day, and the MSM also rounds when necessary. Both physicians can charge for hospital visits the same day. The hospitalist rounds with the MFM so that the plan is clear. The Hospitalist is the "boots on the ground" and performs the necessary duties on Labor and Delivery. These duties include assessing the MFM's patient in triage, admitting their patients, plus performing vaginal deliveries and cesarean sections. The acceptance of high-risk transfer patients into the hospital differs. At some hospitals that MFM takes the phone call from the outlying physician but at others the OB hospitalist takes that call. Similarly, the admitting physician can be either the MFM or the OB hospitalist. At the Providence hospitals in Oregon, the MFMs round and then come back to the hospital for complex, high-risk patients, cesarean deliveries, and twin deliveries. The OB hospitalist does postpartum rounds and discharges the patients. The MFM is always available by

phone for any questions or consults. If the hospitalist does the delivery, they bill for it. The MFM bills for their daily rounds and deliveries they do. If the MFM does a delivery, but the hospitalist does the postpartum rounds and discharge, the bill is split.

This is just one example. Again, there is a lot of variation in how programs are designed. Perinatologists (MFM) are highly appreciative of these programs since it allows a better work/life balance for them. This also allows the MFM to stay highly productive in their office, seeing consults and doing complex ultrasounds. The MFM program at Providence was able to recruit two new MFMs from a University program in Seattle, partly because of the OB Hospitalist program in place.

QUESTION #3

What is variability in how shifts are managed; 12s vs 24s vs mixed, and pros and cons of each?

ANSWER

Again, this is something that we ask our members with the survey. There are 12-hour, 24-hour and mixed shifts at different programs. If a program has high volume and acuity, 12 hours is more common. There is no evidence showing any difference in outcomes between the two. If the hospitalist cannot at least take a couple of naps for an hour or two during the 24 hour shift, it may be better to go to 12s.

QUESTION #4

How common is itinerant activity, i.e., MDs wandering amongst more than one hospital just doing shifts? If this is common, how do you build in the engaged value-added quality effort that helps advance programs?

ANSWER

Ideally, you have a core group of obstetricians working on the Hospitalist team. The team of people on L&D is more effective if they know each other and the hospital system. OB Hospitalists quickly stand out as the leaders on Labor and Delivery, helping establish best practices protocols and even run simulations. At the minimum, there should be an obstetrician designated as the leader of the team who will interact with the other services and help establish protocols. The other services may include MFM, private OBGYN groups, midwives, Family Practice (FP) Physicians, OB or FP residents, nurses, administration, and the emergency department.

QUESTION #5

Do hospitalists ever participate (extra pay) in outpatient activities such as taking on some sporadic volume of routine prenatal care workload?

ANSWER

Yes, hospitalists do this type of work. The nature of shift work allows hospitalists to participate in other duties that are needed. This varies again, depending on the resources available, needs of the program, and the providers that are hired.

QUESTION #6

What are the characteristics of the best programs out there, and the worst?

ANSWER

Best programs

- Staffed by full time hospitalists with strong leadership
- Well-planned prior to implementation—this includes protocols integrating the hospitalist into the existing services, billing structure, and involvement of the current providers
- Hires obstetricians with the necessary characteristics: accessible, experienced, good communicator, service minded, team player, wants to improve safety and quality
- Each hospital and Labor & Delivery is different. Programs need to be designed to suit their needs

Worst programs

- Staffed by community providers working 1-2 shifts a month
- No clear leadership, etc.
- Basically the opposite of above

Although OBGYNs are trained well in their specialty, a full time hospitalist becomes adept at managing high risk situations that the community OB may see only once every 2-3 years. The hospitalist may manage the same problem many times in the same year, thus improving outcomes.