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Implementing a Laborist Model: Four Case Studies

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RESEARCH IN BRIEF

While laborists—as strictly defined—manage the inpatient care and delivery of newborns, many administrators employ a hybridized version of the laborist model to manage indigent patients, provide emergency care, and assist in providing back-up during delivery. In general, laborists work either 12- or 24-hour shifts, are mid-career physicians, and do not possess any special qualifications aside from a demonstrated interest in delivery. While in-house obstetricians/gynecologists (OB/GYNs) were initially resistant to laborists, the demonstrated benefits to patient care and both patient and physician satisfaction ultimately prove persuasive in garnering medical and nursing staff support. Nonetheless, administrators recommend that peers work extensively with all affected parties to explain the program and its intended benefits to secure early buy-in. This brief profiles the implementation and operation of the laborist model at four institutions.

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I. INTRODUCTION AND OBSERVATIONS

As originally defined, laborists are obstetrician/gynecologists (OB/GYNs) who provide specialized delivery services. Laborists benefit a number of hospital constituencies by providing physician-level care during delivery, thus relieving private-practice OB/GYNs of the burden of traveling to the hospital to manage inpatient care, which disrupts family and other work responsibilities. However, many OB/GYNs are resistant to the laborist model, as they perceive laborists as a threat to their existing practices. This strong opposition has precluded many administrators from adopting a full-scale laborist model.

Nonetheless, many programs that provided services similar to the laborist model exist. These programs are commonly distinguished as ‘OB hospitalist’ or hybridized laborist programs. In these models, participating physicians do not concentrate their care in delivery, but instead provide a range of services, such as general inpatient management, high-risk patient management, and OB-related emergency call response. Laborist-model physicians are generally experienced and board-certified but less interested in the responsibilities associated with private practice management; thus, laborists and OB hospitalists pose less of a threat to established OB/GYNs and are therefore a more acceptable alternative to hiring additional private-practice physicians.

Availability of residents, faculty generally negates possibility of AMC laborist program

Generally, the determining factor in the feasibility of the laborist model is the number of annual births at the hospital. With a large number of residents and faculty members, even academic medical centers (AMCs) with a large number of births may still possess an adequate number of physicians to accommodate the amount of care to be provided. Nonetheless, some of the most ardent supporters of the laborist model—including Dr. Louis Weinstein at Philadelphia, Pennsylvania-based Thomas Jefferson University Hospital and Dr. Debra Gussman at Neptune, New Jersey-based Jersey Shore University Medical Center—are AMC faculty members, and the possibility of a full-scale laborist model at these institutions therefore cannot be precluded.^{2,3}

The observations that follow are drawn from interviews with administrators at hospitals with laborist or hybridized-laborist programs.

Observation #1—OB hospitalist programs enable administrators to transition physicians to laborist care models.

None of the profiled institutions currently possess a full-scale laborist model. As interviewed administrators explain, it is at present extremely difficult to convince physicians that moving to laborist-based care creates benefits for patients, physicians, and administrators. Thus, initially instituting an OB hospitalist-based model may prove more palatable to private-practice physicians, as these programs provide additional relief to OB/GYNs and are therefore more likely to garner immediate support. Moreover, once the benefits of a model in which physicians provide specialized labor services are clear, private-practice physicians are perhaps more apt to consider transitioning to a full-scale laborist model. At the institution profiled in Section IV, for example, administrators seek to initiate conversations with physicians regarding an eventual transition to a full-scale laborist model. Private-practice physicians have not, however, indicated that they are amenable to such a change. Thus, while there are claims that laborist programs are in operation at many hospitals, research indicates that these programs are more likely to be OB hospitalist-based than laborist-based.

² Dover Women’s Health. “Meet Us.” (2007). www.doverwomenshealth.com/meetus.html (Accessed October 19, 2007).

³ Advisory Board interviews, October 2007.

Observation #2—Laborist programs staffed by various physician groups.

Physicians who become laborists and OB hospitalists—whether as a permanent career change or as a per diem rotation—are drawn from many areas and career paths. While all demonstrate an interest in delivery, staff at the program profiled in Section II are mid- to mid-to-late-career physicians, in contrast to laborists employed by the hospital profiled in Section IV, who are mostly in the initial stages of their careers. Moreover, administrators may choose to staff a program with the following groups

- ✓ Contracted physicians—institution profiled in Section IV
- ✓ Employed physicians—institution profiled in Section III
- ✓ Volunteer physicians—institution profiled in Section II

This staffing flexibility indicates the various ways in which administrators can deploy laborists and OB hospitalists to solve quality of care and physician relations challenges.

Observation #3—Laborists typically provide 24-hour, single-physician coverage.

Although the number of annual births at the profiled institutions vary, administrators at all profiled institutions have elected to staff one laborist for continuous coverage of designated units. Staffing levels are primarily based on devolved responsibilities, as calculated by indicators such as the annual number of births and OB-related emergencies. Yet while administrators at institutions with a high number of annual births could theoretically staff for additional laborists, the current staffing model remains in place. This may be one manifestation of the hesitation administrators face in implementing the model and the reluctance private-practice physicians feel toward laborists.

Observation #4—Laborists demonstrably improve patient throughput, outcomes, safety, and satisfaction.

Administrators at all of the profiled institutions have found that laborists improve multiple facets of care. For those physicians who are tasked with providing services to OB patients who present in the ED, administrators have found that laborists increase throughput, thereby increasing the quality of care for other ED patients. Moreover, emergency cases in the ED and in other units receive more timely care from laborists than from attending physicians; in such cases, the 20 additional minutes an attending physician needs to reach a patient negatively impacts a patient's outcome.

Moreover, the constant presence of laborists increases the confidence of both nurses and physicians. Administrators at the institution profiled in Section IV note that many nurses who leave the labor and delivery (L&D) unit often return, citing the ability to collaborate with laborists as one of the primary reasons for their decision. Finally, all interviewed administrators believe that their respective programs have positively influenced patient satisfaction. Most notably, administrators at the community hospital profiled in Section II cite their OB/GYN department's patient satisfaction scores as among the highest for the health system facilities the highest among that hospital's units.

Observation #5—While programs are financially unprofitable, administrators have partially funded laborists through cost savings in malpractice insurance.

In addition to physician dissatisfaction with ceding autonomy and authority to laborists, administrators' chief complaint with the laborist model is that it is unprofitable. However, at some facilities, at least a portion of these expenditures have been recouped through cost savings in malpractice insurance. At the health system profiled in Section III, the hospitals are self-insured, but administrators have not experienced an OB-related claim at the community hospital in almost two years. At the institution profiled in Section II, administrators have realized a six-figure cost savings in malpractice insurance as a result of the hospitalist model.

Thus, although implemented laborist programs are an undeniable expense, the decrease in insurance rates and the potential increase in referrals from community physicians pleased with the increased quality of care may aid administrators in persuading board members, physicians, and other parties of the model’s benefits.

The profiles below and on the following pages further detail variations of the laborist model at four institutions.

II. PROFILE: *Existing physicians volunteer for 12-hour shifts to provide OB hospitalist services*

As a major center for obstetrics and gynecologic medicine—including 2,000 annual births—administrators were among the first to consider and adopt a version of the laborist model. The 35-member OB/GYN medical staff not only felt overworked as a result of so many births, but many patient care requirements—such as a regulation mandating that physicians remain present during the first 30 minutes of an epidural anesthesia—further deteriorated job satisfaction. Thus, both administrators and physicians saw the laborist model as a means to reinvigorate the OB/GYN program. However, creating a full-fledged program was not an option, as OB/GYNs were wary of ceding authority and autonomy to laborists. Nonetheless, in 1999, administrators implemented a laborist model in which private-practice OB/GYNs volunteer to provide 24-hour, in-hospital coverage across 12-hour and 24-hour shifts. Since that time, the program’s founding purpose has shifted to caring for indigent patients, who present to the ED or an outpatient clinic, and who frequently have not had prenatal services. This responsibility constitutes a sizeable portion of the current laborist’s duties, although responding to emergency situations remains an essential service.

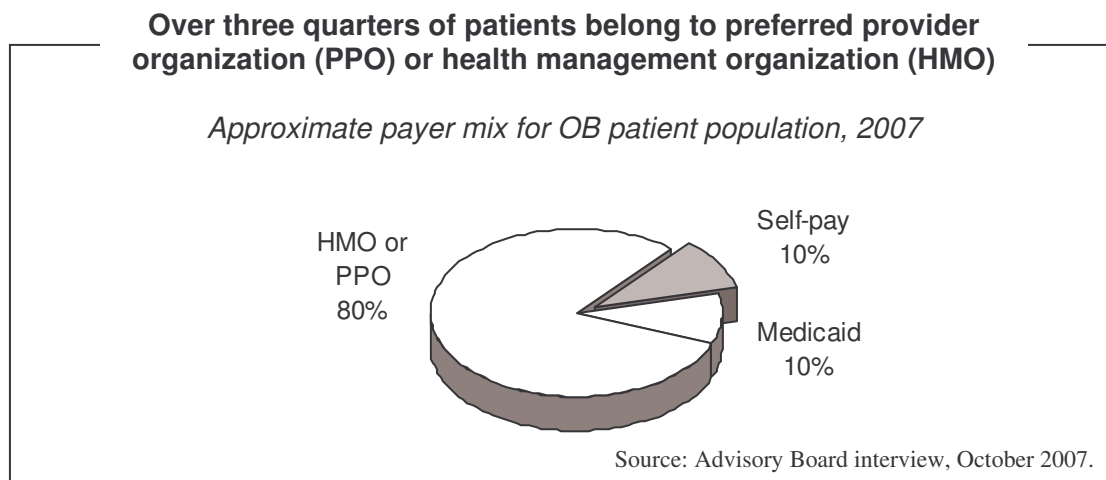
Institution type:	200-bed, not-for-profit community hospital located in the Midwest
Source:	Chair, obstetrics and gynecology (OB/GYN) department
Year laborist model implemented:	1999
Annual births:	Approximately 2,400
Laborist-specific volume:	Approximately 75 to 100
Program attributes:	<ul style="list-style-type: none"> • Laborists provide 24-hour emergency services • Scheduled as 6:30-to-6:30 shifts during weekdays, 24-hour weekend shifts • Volunteers drawn from hospital’s OB/GYNs
Impact on patients:	<ul style="list-style-type: none"> • ED throughput increased • Patient outcomes positively impacted • Patient safety positively impacted
Impact on physicians:	Physicians cite elimination of call, increased quality of care, and heightened job satisfaction as primary benefits
Drawbacks:	<ul style="list-style-type: none"> • Limited reimbursement for laborists • Represents significant hospital expense • Success dependent on voluntary nature

Approximately two thirds of OB/GYNs volunteer for laborist shifts

Under the current model, one laborist is in-house at all times. Laborists work 6:30-to-6:30 shifts during weekdays and 24-hour shifts during weekends. Especially due to the fact that the laborists are drawn from the private-practice ranks, administrators found little need to complicate the existing reporting structure; thus, laborists report directly to the department chair. Of the physicians who volunteer for the laborist shifts, many are mid-career, board-certified OB/GYNs. Administrators have noted that the younger physicians typically accept the longer, weekend shifts, while female physicians raising a family and senior attending physicians are less likely to volunteer. Moreover, as volunteering for laborists shifts is not viewed as a means to building a practice—as with call shifts—there is no obvious incentive for younger OB/GYNs to accept a majority of the laborist shifts.

Laborists primarily provide care for indigent patients

As noted previously, laborists' most valuable service is providing care to indigent patients. While this group constitutes less than five percent of annual births, and less than ten percent of expectant mothers have not received prenatal care, OB/GYNs were displeased with the high level of care they required. In addition to often being high-risk, less-affluent patients' limited ability to pay for services restricts the overall reimbursement physicians receive. The graph below provides the payer mix for the profiled hospital's service area.



Although administrators stress that the payer mix was not a factor influencing their decision to adopt the laborist model, one source of OB/GYN satisfaction with the program is that indigent patients are now under the care of specific clinicians, even if the individual filling this role varies from day to day. Moreover, administrators believe that the quality of care for this patient population has improved. Given that many indigent patients initially present to the ED, quality of care and throughput within the ED have improved as well, although data providing specific figures is unavailable.

Laborists' ability to provide timely emergency care further improves quality of care, OB/GYN satisfaction

Laborists have also improved quality of care in emergency medicine, where they are able to respond quickly to emergency situations. This service not only increases ED throughput by effectively adding staff physicians, but administrators also believe that patient outcomes have improved. For example, in the most extreme cases, a patient who presents in the ED with a condition requiring immediate attention must often wait 20 to 30 minutes while the attending OB/GYN is summoned. Laborists, on the other hand, are often able to provide care within 10 minutes. Thus, while there have been no quantitative studies measuring laborists' impact on quality of care, administrators strongly believe that many OB/GYN patients would experience less favorable outcomes were the laborist model not in operation.

Knowledge of laborist model increases patients' satisfaction with hospital care

Contrary to many reports that laborists would negatively impact patient satisfaction, administrators have found that the presence of these physicians increases patient satisfaction. In effect, patients view laborists as back-up for a patient's OB/GYN, should he or she be unable to reach the hospital in time for the delivery or require emergency assistance. For those cases in which a laborist has presided over delivery—usually arranged through a simple phone consultation between the private-practice OB/GYN and the laborist—administrators have not received negative feedback from patients.

Model mitigates malpractice insurance costs

The most significant quantifiable benefit of the laborist model to administrators is the reduction in malpractice insurance rates. Insurance representatives have explicitly noted their satisfaction with the addition of physicians within the L&D units, as well as the ability of laborists to respond to ED calls. Administrators have correspondingly realized a six-figure cost savings in insurance rates over the last year, which effectively funds a majority of the laborist program.

Funding, voluntary nature impede further expansion of laborist program

Nonetheless, the laborist program remains a significant expenditure for administrators and restricts its overall effectiveness and potential expansion. Administrators stress that OB/GYNs are uninterested in a true laborist program, in which participating physicians would fully concentrate on delivery. And while staff OB/GYNs were also initially resistant to the implemented program, they now acknowledge clear benefits for patients, administrators, and private-practice physicians. Administrators strongly recommend that those considering the laborist model provide ample time to meet with all hospital board members, community physicians, private-practice physicians, nursing staff, and other affected parties to explain the program and its intended effects in detail.

III. PROFILE: Success of model spurs implementation at second system facility

In August 2005, administrators at one of the health system’s community hospitals elected to implement a laborist model to achieve the following goals:

- Attend to indigent patients who present at the ED and who do not have an OB/GYN relationship
- Provide care for all patients on the L&D unit until the attending physician arrives
- Provide inpatient management of perinatal patients, consulting with the perinatologist when necessary
- Serve as clinical leaders on the unit by assisting nurses and staff

Furthermore, administrators were concerned about the difficulties perinatologists would face when asked to take call at two geographically disparate facilities. They believed that laborists would be able to support perinatologists such that job satisfaction and quality of care would not be compromised by the opening a new hospital within the health system.

The success of the laborist program spurred administrators to adopt it at a second system hospital, a teaching facility located in a more urban setting. In addition to the responsibilities described above, laborists are also asked to provide the following services:

- Lead continuing education (CE) case reviews
- Serve as a resource for residents and provide oversight on resident cases

In addition, laborists are also beginning to serve as assistants for Caesarian sections (C-sections), as it is more cost-effective for OB/GYNs to use the on-duty laborist than to coordinate with a fellow private-practice physician.

Institution type:	6-hospital, 1-000-bed, not-for-profit health system located in the Northwest
Source:	Clinical VP, women’s services
Year laborist model implemented:	2005 and 2006 (implemented at two system hospitals)
Annual births:	Approximately 1,800 at each facility
Laborist-specific volume:	Approximately 175 to 250
Program attributes:	<ul style="list-style-type: none"> • Four laborists on staff at each hospital • Provide surgery backup, emergency care, and indigent patient care services • Scheduled for 24-hour shifts
Impact on patients:	<ul style="list-style-type: none"> • ED throughput increased • Patient outcomes improved • Patient satisfaction increased
Impact on physicians:	<ul style="list-style-type: none"> • Physician satisfaction increased • Referrals from community physicians increased
Drawbacks:	<ul style="list-style-type: none"> • Billing issues remain unresolved • Paid leave difficult to schedule • Physician, nurse buy-in difficult to realize

Staff of 4 laborists provide 24-hour care at each hospital

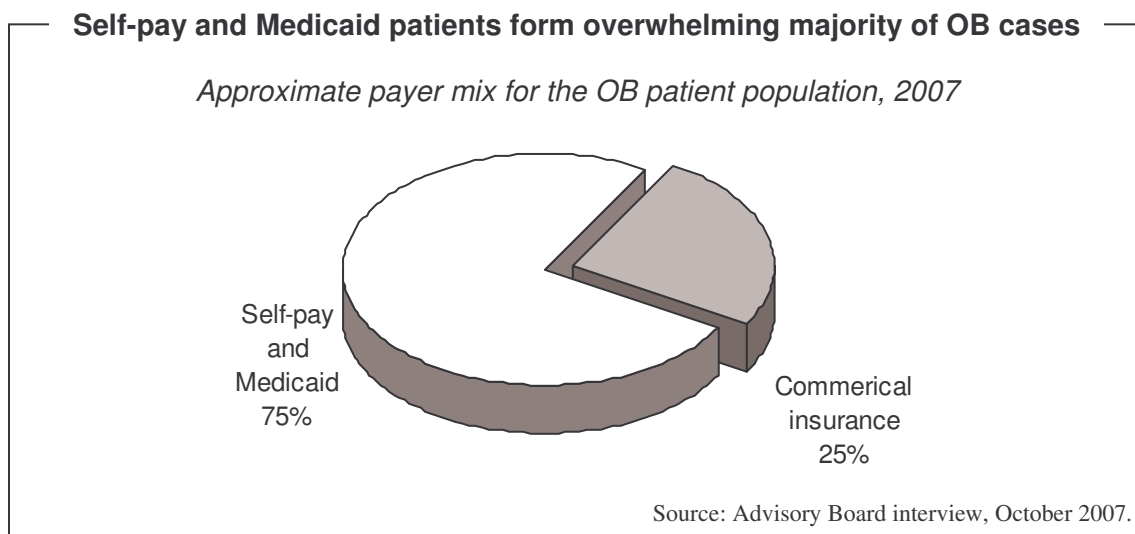
Given the responsibilities of the laborists, administrators determined the staffing model by reviewing the rate of deliveries and emergencies, both within the ED and the L&D unit. Under the current staffing model at each hospital, a staff of 4 laborists provide continuous coverage across a 24-hour shift. Administrators have experimented with a 12-hour shift model, but have found that physicians prefer to take fewer shifts rather than shorter ones. Shifts begin at 7:00 a.m. to cover the gap in coverage created by the departing attending physician.

With high level of responsibility, administrators sought experienced physicians

As administrators desired laborists to participate both in CE and resident cases, they sought physicians who not only possessed a demonstrated interest in delivery, but also a demonstrated interest in teaching and general clinical leadership. Despite these additional requirements, administrators did not experience any difficulties in recruiting for their employed laborist staffs. All staff members are mid- or mid-to-late-career physicians and do not possess any extraordinary qualifications, aside from those listed above and board certification.

Lack of emphasis on indigent-patient care led to decreased significance in planning

In contrast to the previously profiled institution, laborists are not specifically charged with caring for indigent patients. Thus, the payer mix—depicted below—was not influential in administrators' deliberations on the laborist model.



Benefits to private-practice physicians, patients abound

As the laborist programs have been in place since 2006 and 2005 at the teaching and community hospitals, respectively, administrators believe they are able to understand the initial effects of the model. For private-practice OB/GYNs, the benefits are manifold and include those listed on the following page.

- ❖ **Improved call coverage**—Administrators still maintain a call schedule for the OB/GYN department; however, the on-staff laborist takes 98 to 99 percent of the calls, effectively relieving community-based physicians from call coverage.
- ❖ **Increased referrals from family practice physicians**—Family practice (FP) physicians and nurse midwives who wish to gain admitting privileges are required to identify back-up OBs in case a patient presents with symptoms that are beyond the scope of the FP physician's or midwife's care. Community-based OB/GYNs are often hesitant to provide back-up due to increased liability, and FP physicians and midwives are hesitant to ask the OB to consult for fear of ruining an existing relationship. With the laborist model, the FP physicians and midwives can list the laborist as their back-up, which allows them to practice with no hesitation to consult, subsequently improving the quality of care.
- ❖ **Increased satisfaction**—Although physician satisfaction scores that assess the laborist program are currently unavailable, administrators have received positive anecdotal feedback from physicians. For example, after two years in operation, administrators believe that the laborist model has “bailed out” every physician at the community hospital at least once; these OB/GYNs in particular are strong supporters of the program.

For patients, the benefits of the laborist model center on improved quality of care, as indicated below.

- ❖ **High patient satisfaction**—Currently, the OB/GYN departments at both hospitals rank in the 99th percentile among health system facilities for patient satisfaction, and the community hospital's OB/GYN department has the best patient satisfaction score of any hospital department.
- ❖ **Increased safety and improved outcomes for high-risk patients**—Administrators have coordinated the work of perinatologists and laborists such that the former group may concentrate on creating care plans while the latter provides extensive inpatient care. At each facility, the laborist and perinatologist round together and meet frequently to discuss care coordination. Through this arrangement, administrators have increased the safety of transporting and caring for high-risk patients and have allowed perinatologists to provide call coverage at both facilities without increasing the size of the medical staff.

Lack of support, transparent billing protocols restrict program success

Although physicians and patients generally seem satisfied with the model, administrators and laborists, in contrast, face continuing difficulties. The two most significant barriers to the continued success of the program are outlined below.

- ❖ **Incomplete buy-in from nursing and medical staff**—Despite the benefits enumerated above, administrators still feel that the relationship between laborists and the rest of the hospital staff has not matured. In particular, they note that on occasion a laborist is available and willing to complete a delivery, but the private-practice physician refuses to agree. Incidents such as these speak to a continual mistrust of laborists when more complete collaboration would increase productivity—and most likely satisfaction—for both physicians.
- ❖ **Unresolved billing issues**—Laborists are often called to a delivery because although the OB/GYN has been called, he or she is still preparing for the delivery or en route. In these instances, the laborist provides services until the patient's OB/GYN arrives, but the hospital does not receive any reimbursement for the laborist's services. To improve the program's profitability, administrators would like to arrange a billing contract with the private-practice OB/GYNs so that coordination is increased; however, little progress has been made during initial negotiations.

In addition, laborists still encounter scheduling issues with administrative paid leave (APL), which they use to pursue continuing medical education (CME) coursework and other similar responsibilities.

Administrators recommend multiple meetings with affected parties to increase buy-in

While administrators are reluctant to characterize their implementation efforts as successful, they believe that their efforts to schedule multiple meetings with physicians to explain the laborist program were influential in limiting the resistance with which private-practice OB/GYNs met the proposed model. As at the previously profiled institution, administrators characterize opposition as inevitable, given that OB/GYNs will see laborists as a threat to their practices. However, a sustained and transparent effort to explain the model’s benefits to private-practice physicians may increase its rate of acceptance.

IV. PROFILE: OB hospitalist model created to facilitate care of indigent patients

As at the hospital profiled in Section II, administrators believed that providing dedicated coverage for both emergency cases and indigent patients would benefit patient and physicians, and therefore transitioned to a hybridized laborist model—which they refer to as an OB hospitalist model—in 2005 as the most effective means to achieving these aims.

Model implemented to provide indigent patients with timely care

Physicians had frequently approached administrators with complaints about call coverage and indigent patient care, particularly during office hours, at which time physicians preferred to be at their practices. Thus, hospitalists’ primary responsibility is in emergency and indigent care. However, hospitalists also fill the gaps in coverage left by night attending physicians. Traditionally, administrators employed moonlighters from local teaching hospitals to work from 6:00 p.m. to 6:00 a.m., leaving a coverage gap between the time the moonlighter left and the in-house OBs arrived, usually between 7:00 a.m. and 8:00 a.m.

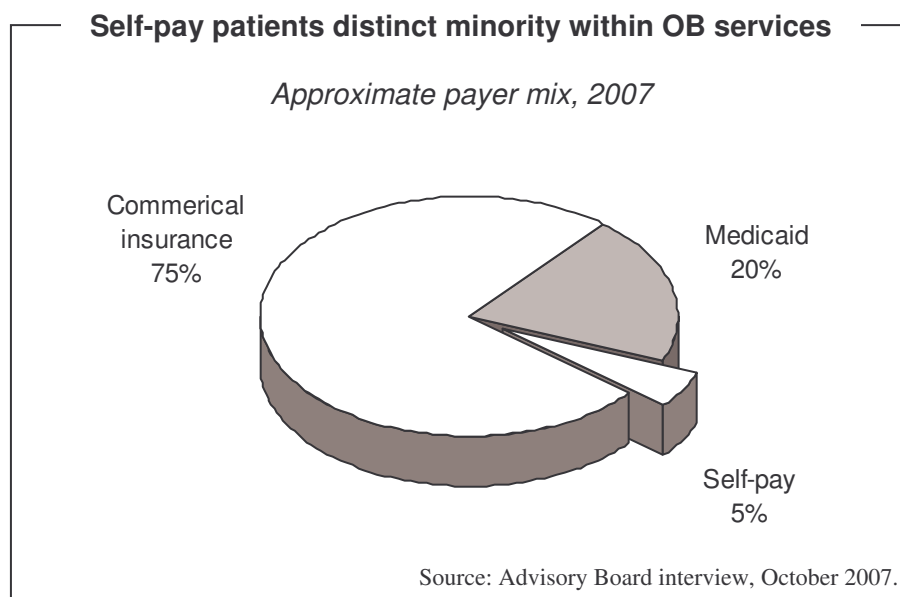
Institution type:	600-bed, not-for-profit teaching hospital located in the Southwest
Source:	Director, women’s services
Year laborist model implemented:	2005
Annual births:	Approximately 6,000
Laborist-specific volume:	Approximately 600
Program attributes:	<ul style="list-style-type: none"> • Contract with limited liability corporation (LLC) • Laborists primarily take emergency call and care for indigent patients • Shifts limited to less than 14 hours
Impact on patients:	<ul style="list-style-type: none"> • Anecdotal evidence suggests high level of satisfaction • Patient safety improved • Quality of care heightened
Impact on physicians:	<ul style="list-style-type: none"> • High level of satisfaction with emergency and indigent patient care
Drawbacks:	<ul style="list-style-type: none"> • Significant expense to hospital • Slightly strained relations with LLC due to limited profit potential

Administrators sought hospitalist group through request for proposal (RFP)

When administrators developed the hospitalist program, they decided to contract with a physician group or staffing company and therefore submitted an RFP. Although administrators wanted hospitalists to provide 24-hour care, they noted that proposals could not include shifts greater than 14 hours, as they believe longer shifts encourage physicians to be less active on the unit. Under the selected staffing model, 4 OB hospitalists provide approximately 80 percent of the coverage through 12-hour shifts, with the remaining time covered by designated per diem physicians. Hospitalists report directly to the department chair, although they are also responsible to administrators from the contracted company.

Payer mix not a direct factor determining adoption of hospitalist model

Despite the primary responsibility of caring for indigent patients, the payer mix—shown below—was not directly influential in administrators' deliberations on the hospitalist model.



Private-practice physicians satisfied with ability of hospitalists to take call, manage patients

Administrators note that physicians have generally responded positively to the hospitalists. Given that they perform two specific duties—in contrast, for example, to the hospitalists at the previously profiled institution, who have multiple responsibilities—the clear division of labor between physicians has produced more favorable relations. In particular, private-practice physicians are now unconcerned that hospitalists pose a threat to their practice. Moreover, community physicians who wish to admit or transfer a high-risk patient to the hospital are pleased with the model, as they are able to phone the hospitalist directly and negotiate the transfer.

Hospitalists improve nurse relations, increase retention

Integrating hospitalists into the medical staff has also improved nurse satisfaction and increased retention. Nursing staff administrators have found that nurses are pleased with the extra supervision and expertise they receive from hospitalists, and are therefore able to both advance their own clinical knowledge and work with increased confidence. Furthermore, select nurses who have left the OB/GYN department either for another hospital or another units have returned, citing the opportunity to work with the hospitalists as one of the primary reasons for their decision.

Patient satisfaction remains unmeasured, but administrators confident in improvement

Administrators have yet to quantify patient satisfaction, but believe that in general, patients are pleased with the new care model. In particular, indigent patients are satisfied with the increased emphasis and the coordination of care by hospitalists. Moreover, management of these patients by hospitalists increases throughput in the ED, indirectly increasing the quality of care for other ED patients.

As at other profiled institutions, medical staff have told administrators of numerous instances in which a hospitalist has provided timely care to a patient with an emergency condition, significantly improving that patient's outcome. Administrators have yet to experience a decline in malpractice insurance rates as a result, but based on the changes for similar programs, expect such a decrease in the coming months.

Physician resistance to full-scale laborist model bars development

Although all parties have reached a level of satisfaction with the laborist model in a short period of time, private-practice physicians are uninterested in increasing the number of laborists on staff or changing to a full-scale laborist model. Administrators believe that physicians fear a loss of patients and resultant financial decline should they agree to a more comprehensive laborist model. Thus, although some hospital staff and administrators believe a more-advanced model would be beneficial, discussions on this topic are not currently scheduled.

V. PROFILE: OB hospitalists contracted to assume delivery services from nurses

The profiled institution is one of the most recent to adopt a hybrid laborist model, as administrators initiated an OB hospitalist program in early 2007. The primary impetus for developing the program was the need for physician care during deliveries, as nurses were frequently compelled to oversee this service when the OB/GYN could not reach the patient in a timely fashion. However, administrators had also received complaints from physicians regarding call practices and therefore hoped that OB hospitalists would additionally be able to provide these services.

OB hospitalists provide care to various units during 8-hour, 16-hour shifts

Currently, six hospitalists have contracted with administrators to provide continual services. These services are arranged in shifts that ensure equal patient volumes, rather than hours: hospitalists thus work a 9:00 a.m to 5:00 p.m. shift or a 5:00 p.m. to 9:00 a.m. shift. Given the small program staff and high level of collaboration with both medical and nursing staff members, hospitalists report directly to the department chair, as at other profiled institutions.

Perinatologist selected hospitalists to increase likelihood of positive, collaborative relationship

Although administrators stipulated that hospitalists be board-certified OBs with established practices and sound reputations in the local medical community, one of the staff perinatologists was given the responsibility of selecting the six physicians. Administrators believed that this would facilitate a positive and collaborative relationship with the hospitalists; based on their experiences across this year, they recommend this practice to peers as a way to ensure buy-in from physicians and to increase generation of collaboration.

Institution type:	300-bed, for-profit teaching hospital located in the West
Source:	Director, women’s services
Year laborist model implemented:	2007
Annual births:	Approximately 2,000
Laborist-specific volume:	Approximately 120 to 150
Program attributes:	<ul style="list-style-type: none"> • Contract arrangement with administrators • Laborists provide delivery services and take ED call • Shift organized according to productivity, rather than number of hours
Impact on patients:	<ul style="list-style-type: none"> • Anecdotal evidence suggests high level of satisfaction • Patient safety improved • Quality of care heightened
Impact on physicians:	<ul style="list-style-type: none"> • Increased satisfaction among both perinatologists and private-practice OB/GYNs • Potential for increased revenues through indirect referrals • Serves as recruiting point for OB/GYNs
Drawbacks:	<ul style="list-style-type: none"> • Program is costly for smaller hospitals such as the profiled institution

Hospitalists serve as second assists in addition to primary responsibilities

Beyond the primary responsibilities for which they were hired, hospitalists perform the following services:

- ❖ Consult for community-based physicians on an as-needed basis
- ❖ Round on the L&D unit, antepartum unit, mother-baby unit, and in the ED
- ❖ Serve as the second assist on C-sections
- ❖ Work closely with perinatologists to generate and execute care plans

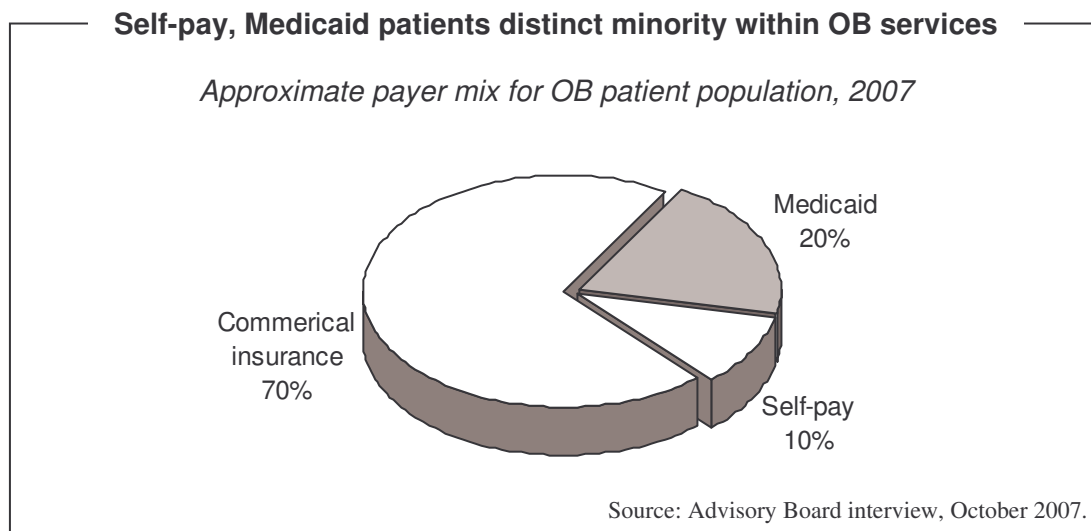
Thus, hospitalists work with perinatologists, nursing staff, and OB/GYNs on a daily basis, which has proven instrumental in developing trust among hospital staff members and garnering support for the hospitalist program.

Hospitalists do not perform deliveries for high-risk patients, those with pre-existing OB/GYN relationship

Hospitalists only consult with perinatologists and do not provide delivery services for high-risk patients. Should the patient of a community-based OB—whether high-risk or not—present to the hospital; administrators make every attempt to contact and receive permission from the attending OB before allowing the hospitalist to provide care. Administrators avoid having the hospitalists perform deliveries on these patients for reasons related to legality and competition.

Administrators did not consult payer mix when evaluating feasibility of hospitalist model

As hospitalists are not directly charged with providing care to patient populations with specific levels and types of insurance, administrators did not examine their payor mix when evaluating the hospital model, nor do they believe that these data were influential to physicians' support of the hospitalist program. The payer mix for OB services is detailed in the following chart:



Hospitalists' ability to take call, manage patients drives private-practice physicians' support

Despite assurances from administrators that hospitalists would not 'steal' patients from them and would restrict their services to inpatient management and emergency call, private-practice OB/GYNs were initially hesitant to collaborate with hospitalists, and administrators cite numerous instances in which hospitalists' responsibilities were effectively taken by private-practice physicians. However, as the relationship between hospitalists and perinatologists matured, the support of private-practice OB/GYNs gradually materialized, and currently, the OB hospitalists have strong support among medical and nursing staff members.

Program's manifold benefits drive high satisfaction among patients, nurses, physicians

Although the OB hospitalist program was established in early 2007, administrators believe the program to be successful, as indicated by the reasons provided below.

- ❖ ***Decrease in need of nurse delivery***—OB hospitalists have been successful in taking this responsibility from nurses, which has improved nurse and patient satisfaction and increased the quality of care, according to anecdotal evidence.
- ❖ ***Elimination of private-practice physician call coverage***—Hospitalists have also been able to respond to virtually all of the OB-related emergency calls, relieving private-practice OB/GYNs of this responsibility. As at previously profiled institutions, administrators believe that hospitalists' timely care has produced more favorable patient outcomes and satisfaction, although data buttressing this statement is unavailable.
- ❖ ***Increased enthusiasm from applying OBs***—In addition to the satisfaction among existing medical staff, those physicians applying for admitting privileges have often listed the opportunity to work with OB hospitalists as a reason for their application. This evidence demonstrates to administrators and fellow OB/GYNs that hospitalists have an estimable reputation within the local medical community and may also be an indirect referral source.
- ❖ ***Increased quality of care for high-risk patients***—The collaboration between perinatologists and OB hospitalists has improved the quality of patient care, as perinatologists can concentrate on formulating care plans while hospitalists concentrate on care provision.

Administrators have yet to receive the benefit of lower malpractice insurance rates due to increased quality of care, but they believe their efforts over the past year will yield this result in the coming months.

Sole drawback to program is significant hospital cost

At present, administrators are generally satisfied with the hospitalist model. However, they cite its significant cost as the one factor which may bar its expansion and continued success. While future cost savings in malpractice insurance may render the program financially viable, administrators are nonetheless concerned that unless the program garners strong physician and administrators support or reaches break-even profitability, its operation may be short-lived.

Research Methodology

During the course of research, Original Inquiry staff searched the following resources to identify pertinent information:

- Advisory Board's internal and online (www.advisory.com) research libraries
- Factiva™, a Dow Jones company
- Industry journals, including the following:
 - ✓ *Hospitals & Health Networks (HHN)* at www.hhnmag.com
 - ✓ *Journal of Reproductive Medicine* at www.reproductivemedicine.com
 - ✓ *Journal of the American Medical Association (JAMA)* at <http://jama.ama-assn.org>
 - ✓ *Medical Economics* at www.memag.com
 - ✓ *New England Journal of Medicine (NEJM)* at <http://content.nejm.org>
 - ✓ *Obstetric Anesthesia Digest* at www.obstetricanesthesia.com
 - ✓ *American Journal of Obstetrics & Gynecology (AJOG)* at <http://journals.elsevierhealth.com/periodicals/ymob>
- Internet, via search engines and multiple websites, including the following:
 - ✓ Association of Professors of Gynecology and Obstetrics (APGO) at www.apgo.org
 - ✓ Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) at www.awhonn.org
 - ✓ OB Laborist.org at www.oblaborist.org
 - ✓ OBGYN.net at <http://forums.obgyn.net>
 - ✓ PubMed at www.pubmed.gov
 - ✓ Society of Hospital Medicine at www.hospitalmedicine.org
 - ✓ *US News & World Report* at www.usnews.com
 - ✓ *USA Today* at www.usatoday.com
 - ✓ Various hospital and health system websites

Based on leads generated through the above resources, researchers contacted administrators overseeing laborist programs.

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