Ob.Gyn. News

www.obgynnews.com

VOL. 46, NO. 11 *The Leading Independent Newspaper for the Obstetrician/Gynecologist—Since 1966* NOVEMBER 2011

WHAT'S NEWS

Ob/Gyn Hospitalists Hold Inaugural Meeting

'Ob.gyn. hospitalists in this country are the wave of the future. There's no question about it.'

BY BRUCE JANCIN

FROM THE ANNUAL MEETING OF THE SOCIETY OF OB/GYN HOSPITALISTS

BOULDER, COLO. – A buzz of excitement – a sense of history in the making – was palpable as the newly incorporated Society of Ob/Gyn Hospitalists held its first-ever annual meeting here.

"We are all witnessing the birth of a new subspecialty," declared Dr. Brigid McCue, an ob.gyn. hospitalist at Jordan Hospital in Plymouth, Mass., and a member of the Society of Ob/Gyn Hospitalists (SOGH) steering committee.

Present at the birth were officials from both the American College of Obstetricians and Gynecologists (ACOG) and the Society of Hospital Medicine (SHM), two organizations interested in having close ties with the new medical society.

"ACOG recognizes this is the new paradigm of care," said Dr. J. Joshua Kopelman, chair of ACOG District VIII. "We absolutely want you to be people who provide input about what you do to all of the committees at the executive level of the college."

COURTESY IANTHE ANDRESS

Dr. Rob Olson said at present there are 143 ob.gyn. hospitalist groups spread throughout the country, typically with four to six hospitalists each.

"Ob.gyn. hospitalists in this country are the wave of the future. There's no question about it. The model has been going on for a long time in Great Britain, for example, where you have people whose practices are office-based, and you have people who work full time in the hospital and that's all they do. They've had to learn how to do patient handoffs between these two groups of physicians," he added.

Dr. Shaun Frost, president-elect of the SHM, observed that "it's kind of mind-boggling" to see the parallels between the birth of that organization and the SOGH. Both groups began with a small

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Proposed Gestational Diabetes Criteria Raise Questions, Concerns

'The impact of diagnosing nearly one-third of all pregnant women should be considered.'

BY MIRIAM E. TUCKER

FROM THE ANNUAL MEETING OF THE EUROPEAN ASSOCIATION FOR THE STUDY OF DIABETES

LISBON – Use of the recently proposed International Association of Diabetes and Pregnancy Study Group criteria for identifying women with gestational diabetes would increase the diagnosis by 240%, compared with the World Health Organization's criteria, according to the findings of a population-based multiethnic cohort study of 823 healthy pregnant women in Norway.

"Before endorsing the IADPSG criteria, the impact of diagnosing nearly one-third of all pregnant women should be considered," said Dr. Kjersti Morkrid of the department of endocrinology at Oslo University Hospital and the Institute of Clinical Medicine at the University of Oslo.

The IADPSG criteria were derived from an international workshop held in Pasadena, Calif., in which 225 conferees from 40 countries reviewed the results of the HAPO (Hyperglycemia and Adverse Pregnancy Outcome) study and other data suggesting that there is a risk for adverse fetal outcomes below current gestational diabetes mellitus (GDM) diagnostic thresholds. Indeed, currently used criteria were either chosen to identify women at risk for the later development of diabetes (Diabetes Care 2007;30:[Suppl. 2]:S251-60), or were derived from nonpregnant individuals (World Health Org. Tech. Rep. Ser. 1980;646:1-80) and were not primarily aimed at identifying pregnancies with increased risk for adverse perinatal outcome, the IADPSG authors noted (Diabetes Care 2010;33:676-91).

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Enhance Patient Safety in Hospital

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cadre of enthusiastic people full of outside-the-box ideas about how to improve patient care in the hospital.

Hospital medicine has experienced astronomical growth. The SHM consisted of 23 members in 1997, the year of its birth. Membership climbed to 800 just 2 years later, then to 3,200 in 2003, 6,300 in 2006, and now sits at about 12,000.

"I would anticipate that you're going to experience the same thing we did in terms of rapid and significant growth. Tighten your seat belts – it can be a wild ride sometimes, but I can tell you that for me, after 14 years, it has been nothing short of profoundly gratifying," said Dr. Frost, who is chief medical officer for the Northeast region of Cogent HMG Healthcare and an internist at the University of Minnesota, Minneapolis.

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DR. FROST

In an interview, meeting cochair Dr. Rob Olson said at present there are 143 ob.gyn. hospitalist groups spread throughout the country, typically with four to six hospitalists each. Most work 12-hour shifts, some 24-hour shifts.

"Right now hospitalists are doing a very small percentage of all deliveries, maybe 2%. I project in 5 years we'll be doing 20% or 25%," predicted Dr. Olson, an ob.gyn. hospitalist in Bellingham, Wash., and founder of www.obgynhospitalist.com.

The primary mission of ob.gyn. hospitalists is to enhance patient safety in the hospital, he explained. If an emergency requiring cesarean section occurs, the hospitalist can start the operation while the private obstetrician is en route, shifting to second assistant when the private physician arrives and takes over the procedure. Or if a woman who has been in labor for a few hours begins progressing rapidly at 2 a.m., the hospitalist can step in and do the delivery if the private physician can't get to the hospital promptly.

Hospitalists can also provide support when a midwife or family physician has a complicated delivery requiring a vacuum extraction, forceps, or a cesarean section.

"It's kind of like being a lifeguard, where you're sitting at the beach waiting for the problem," he said.

Ordinarily a hospitalist will never see a patient antepartum. The exception is the unassigned patient who may drop in to the hospital with no prenatal care, who then becomes the hospitalist's responsibility.

Hospitalists also support private physicians by letting them sign out patients as a convenience. "A private physician may say, 'I've got a big surgery tomorrow. Can you take care of all of my patients between midnight and 6 a.m. so I can sleep?' That's another way of utilizing us," Dr. Olson continued.

In the initial months following introduction of an ob.gyn. hospitalist program, however, patient sign-outs typically aren't a substantial part of the job. "At the beginning the private doctors are a little worried about it. They don't want to sign out. They're suspicious. They're afraid that they're going to give up not only their patients but their revenue. When they realize how helpful check outs are, though, then they sign out," he explained.

Some ob.gyn. hospitalists are laborists only and prefer it that way. Others also cover gynecologic cases in the emergency department. "I have diagnosed more horrific cancers in 18 months as a hospitalist than in 13 years of private practice," Dr. McCue said, adding that she feels good about covering gynecologic cases in the ER because it enables her to maintain some of her hard-earned gynecologic skills.

Several audience members voiced discomfort about leaving the labor and delivery area to take on emergency department gynecologic surgical cases because it distracts from the primary hospitalist focus of saving babies. Dr. McCue responded that the answer is to negotiate boundaries.

"What most of the hospitalist programs are coming to is making a deal with the privates," she explained. "You say, 'I am doing the vast majority of your nighttime work by covering the labor floor for you and covering the first calls for you. All that I ask is that you be available on an emergency basis for the ER overload that I can't handle. I am happy to get the ectopics and incompletes started for you, but if I call that's because I need you to be there to cover.' "

Conference attendees heard best-practice updates from authorities on obstetric triage and evidence-based cesarean section techniques. They also began planning SOGH's future course. Dr. Bob Fagnant circulated a rough draft of proposed core competencies defining what ob.gyn. hospitalists need to be able to do. (See box.)

The society will eventually have to formally settle on a group of core competencies, a program for attaining them, and a means of tracking them to attain subspecialty status from the American Board of Obstetrics and Gynecology. The board will want to see evidence that being an ob.gyn. hospitalist requires a special set of skills not taught to physicians who graduate residency as general ob.gyns., explained Dr. Fagnant, an ob.gyn. hospitalist at Intermountain Health Care in St. George, Utah, who is also vice chair of the ACOG Committee on Ambulatory Practice.

The SOGH leadership believes simulation training will play a key role in demonstrating ob.gyn. hospitalist competencies. Toward that end, SOGH's first annual meeting featured a half-day of participation in a three-station obstetrical emergency simulation workshop focused on management of obstetric hemorrhage, maneuvers and techniques to relieve shoulder dystocia, and operative deliveries.

Dr. Arthur Townsend, medical director of the ob.gyn. hospitalist program at Methodist Le-Bonheur Hospital in Germantown, Tenn., stressed that hospitalists are "perfectly positioned" to support the quality initiatives hospitals take on to improve outcomes, decrease liability, attract patients, and meet the requirements of outside national organizations that report on quality indicators, such as the National Perinatal Information Center/Quality Analytic Services.

A significant part of what he and his hospitalist colleagues do is gather statistics. These include hospital-wide cesarean rates, vaginal births after cesarean, incidence of episiotomy, third- and fourth-degree laceration rates, postpartum hemorrhage, vaginal deliveries with shoulder dystocia, and a host of others.

He and his fellow hospitalists also carefully track their own performance. They file a detailed online report at a secure website upon completing every shift. These shift reports are compiled into monthly reports totaling the number of deliveries the hospitalists have performed, assists provided at cesarean and vaginal deliveries, the emergencies hospitalists responded to, the number of gynecologic surgeries performed, unassigned patients they've seen, and nurse and physician satisfaction survey results. These reports go to the hospital CEO, the board of directors, and the hospital risk management and quality committees.

"We've got some data to show that we really make a difference. What we do in these reports is tell how we save people. Everyone wants to know how many patients we're saving," he explained.

The hospitalists track and submit individual physician-level statistics. When the data point to a problem physician – for example, an ob.gyn. who doesn't return phone calls from a nighttime nurse in timely fashion or who regularly scores poorly in patient satisfaction – Dr. Townsend leaves it to the hospital quality committee to do something about it. "I don't want to be the sheriff," he explained.

These data-filled reports document the progress the hospital has made in achieving safety. This in turn has led to a reduction in the cost of the hospital's risk insurance. Moreover, when Dr. Townsend made a presentation to the hospital's risk underwriter, the company was so favorably impressed by what ob.gyn. hospitalists do that it provided them with a $60,000 grant to purchase obstetrical emergency simulators.

Dr. Townsend asked audience members to think about which hospitalist quality measures they consider to be most important yet practical for hospitalist practices to routinely collect at the national level. This is an issue where SOGH would like to be able to provide recommendations.

Dr. Suneet P. Chauhan, a non-hospitalist guest speaker at the conference, recommended focusing initially on two key statistics where he believes ob.gyn. hospitalists could make an impact with maximum "wow" factor: time to cesarean section for nonreassuring fetal heart rate tracings, and time spent in obstetric triage for preterm labor.

"As everyone knows, in one-third of cases the decision-to-incision time in an emergency c-section is not met. The lawyers know that, too. You, more than any other person in the hospital, can decrease the decision-to-incision time," he told the hospitalists.

"You can also really help in obstetric triage. Triage is a very expensive place. In our hospital a patient could be there 3-6 hours before being seen. But if hospitalists routinely adopted the use of transvaginal cervical length measurement and/or fetal fibronectin, it would really shorten the stay at triage," predicted Dr. Chauhan, director of maternal-fetal medicine and professor of ob.gyn. at Eastern Virginia Medical School, Norfolk.

Dr. Frost, the SHM president-elect, shared five key lessons he believes to be essential in building a hospitalist medical society from scratch, based upon the SHM experience: focus keenly on quality improvement; seek to be recognized by external stakeholders as health care reform facilitators, not obstructionists; respect the power of 'branding" as hospitalists; define your members' uniqueness; and be an inclusive "big tent" organization rather than exclusive in terms of membership.

ACOG District VIII Chair Dr. Kopelman urged SOGH members to make their viewpoint heard at ACOG by becoming active at the section and district level, then applying for one of the roughly 50 new committee appointments made each year. Natural fits for SOGH members might be the Committee on Patient Safety and Quality Improvement, the Committee on Obstetric Practice, the Committee on Professional Liability, and the Council on Resident Education in Obstetrics and Gynecology. He also urged SOGH leaders to enroll in ACOG's Robert C. Cefalo National Leadership Institute.

SOGH leaders urged their members to seriously consider belonging to both ACOG and SHM, two organizations having the ear of health policy makers. ■

Rough Draft of Core Competencies

- Obstetric triage
- Emergency medical examination
- Outpatient prenatal care
- Management of labor
- Fetal heart rate interpretation
- Labor ultrasound
- Vaginal delivery and laceration repair
- Management of obstetric complications including eclampsia, shoulder dystocia, breech presentation, twins, and postpartum hemorrhage
- Operative deliveries
- Surgical skills entailed in tubal ligation, cesarean section, and immediate postpartum hemorrhage
- Gynecologic competencies including deep vein thrombosis prevention, diagnosis, and management; the gynecologic examination including the pelvic exam; and postoperative hemorrhage management.

Source: SOGH