Ob/Gyn Hospitalists Hold Inaugural Meeting

BY BRUCE JANCIN

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.”

“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 hand-offs between these two groups of physicians,” he added.

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

The impact of diagnosing nearly one-third of all pregnant women should be considered.9

Proposed Gestational Diabetes Criteria Raise Questions, Concerns

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 multi-ethnic 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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See Gestational Diabetes page 4
cader of enthusiastic people full of out- side-the-box ideas about how to improve patient care in the hospital.

Hospital medicine has experienced as- tronomical growth. The SHM consisted of 23 members in 1997, the year of its birth. Membership climbed to 800 just 2 years later, to 1,500 in 2001, 3,600 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.

In the initial months following introduc- tion of an ob.gyn. hospitalist group spread through- out 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. hospi- talists is to enhance patient safety in the hospital, he explained. If an emergency re- quiring cesarean section occurs, the hospi- talist can start the operation while the private obstetrician is en route, shifting to second assistant when the private physi- cian arrives and takes over the procedure. Or if a laboring patient 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 nuclei of a 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.

Certainly, 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 physi- cians by letting them sign out patients as a convenience. “A private physician may be taking care of all of my patients be- cause he wants the patient sign-outs typically aren’t a substantial part of the job. “At the begin- ning the private doctors are a little wor-

ried 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 them out,” he explained.

Some ob.gyn. hospitalists are laborists only and prefer that way because they cover gynecologic cases in the emergency de- partment. “I have diagnosed more horn- toria, vaginal births after cesarean, inci- dence of episiotomy, third- and fourth-de- gree laceration rates, postpartum hemor- rhage, vaginal deliveries with shoulder dystocia, and a host of others.

He and his fellow hospitalists also care- fully 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, assisted cesarean and vaginal de- liversies, the emergencies hospitalists re- sponded to, the number of gynecologic surgeries performed, unassigned patients they’ve seen, and nurse and physician satis- faction survey results. These reports go to the hospital CEO, the board of direc- tors, 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 pa- tients we’ve done saving,” he explained.

The hospitalists track and submit indi- vidual physician-level statistics. When the data point to a problem physician—for ex- ample, 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 management of obstetrical hemorrhage, vaginal deliveries with shoulder dystocia, and operative deliveries.

Dr. Arthur Townsend, medical director of the ob.gyn. hospitalist program at Methodist LeBonheur Hospital in Ger-

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mantown, Tenn., stressed that hospitalists are “perfectly positioned” to support the quality initiatives hospitals take on to im- prove outcomes, decrease liability, attract patients, and meet the requirements of payers and regulatory organizations, such as the Nation- al 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, inci- dence of episiotomy, third- and fourth-de- gree laceration rates, postpartum hemor- rhage, vaginal deliveries with shoulder dystocia, and a host of others.

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mand of the ob.gyn. hospitalist program at Southern OB-GYN Hospital in Nikolaevsk, Alaska, noted that hospitalists need to be able to do. (See box.)

Several audience members voiced discomfort about leaving the labor and delivery area to take on emergency department gyneco- logic surgical cases because it distracts from the very busy hospital focus of sav- ing babies. Dr. McCue responded that the answer is to negotiate boundaries.

“We must make the hospitalists program coming to is making a deal with the pri- vates,” 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 ba- sis for the EOR overload that I can’t handle. I am happy to get the ectopies and incom- pletes started for you, but if I call that’s be- cause I need you to be there to cover.”

Conference attendees heard best-prac- tice updates from authorities on obstetrical 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 hospitalists need to be able to do. (See box.)

The society will eventually have to for- mally settle on a group of core competen- cies, 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 be- ing an ob.gyn. hospitalist requires a spe- cial 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 simula- tion training will play a key role in demon- strating that ob.gyn. hospitalists can provide quality care. Toward that end, SOGH’s first annual meeting featured a half-day of participa- tion in a three-station obstetrical emer- gency simulation workshop focused on management of obstetric hemorrhage, management of newborn anomalies, and manage- ment of cesarean delivery, and 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 group 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 trans- vaginal cervical length measurement and/or fetal fibronectin, it would really shorten the stay at triage,” predicted Dr. Chauhan, director of maternal-fetal medi- cine 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 es- sential in building a hospitalist medical so- ciety from scratch, based upon the SHM experience: focus keenly on quality im- provement; seek to be recognized by ex- ternal stakeholders as health care reform facilitators, not obstructionists; respect the power of ‘branding’ as hospitalists; de- fine your members’ uniqueness; and be an inclusive “big tent” organization rather than exclusive in terms of membership.

ACOG District VIII Chair Dr. Kopel- man urged SOGH members to make their viewpoint heard at ACOG by be- coming 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 mem- bers 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 Ob- stetrics and Gynecology. He also urged SOGH leaders to enroll in ACOG’s Robert C. Cafola Medical School Network. SOGH leaders urged their members to take a serious look at belonging to both ACOG and SHM, two organizations hav- ing the ear of health policy makers.

Rough Draft of Core Competencies

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

Source: SOGH