# Business and Organizational Models of Obstetric and Gynecologic Hospitalist Groups

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**KEYWORDS**

- OB/GYN hospitalist programs • Patient safety • Program costs • Patient satisfaction
- Malpractice coverage

**KEY POINTS**

- Hospitalists have done well in patient satisfaction surveys, indicating a willingness among hospital administrators to provide subsidies for initiating obstetric and gynecologic (OB/GYN) hospitalist programs.
- Some hospitals have experienced indirect changes from OB/GYN hospitalist programs that have improved their bottom line.
- The principal hurdles or difficulties for OB/GYN hospitalist programs are funding, training, staffing, private physician acceptance, patient acceptance, and malpractice coverage.

## BUSINESS AND ORGANIZATIONAL MODELS OF OBSTETRIC AND GYNECOLOGIC HOSPITALIST GROUPS

The burgeoning growth of obstetric and gynecologic (OB/GYN) hospitalists throughout the United States over the past decade has led to a number of ways to approach how groups of OB/GYN hospitalists are organized. The organizational and business models do, however, depend on what one's perception of what an OB/GYN hospitalist is. A recent survey (Levine LD, Schulkin J, Mercer B, et al, American Journal of Perinatology, in press.) illustrates just how diverse is the idea of what

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defines an OB/GYN hospitalist. Among general OB/GYN physicians and Maternal Fetal Medicine (MFM) specialists, 68% defined an OB/GYN hospitalist or laborist as a member of a group providing 24/7 coverage on labor and delivery and not having a separate office practice, whereas 20% defined an OB/GYN hospitalist or laborist as having an office practice but covering either his or her own practice's patients in shifts on labor and delivery or covering unassigned and other physician's patients as well. Thus, the concept of an OB/GYN hospitalist or laborist is not only different in different practitioners' minds, but the organization of such different models can be very different from one program to another.

If we as a specialty are going to realize all the advantages of OB/GYN hospitalist practices, however, we must recognize that practitioners who do this as just 1 piece of their practice, within the context of a separate outpatient practice, are not really fulfilling the promise of what this new specialty can deliver in terms of patient safety, patient satisfaction, optimal communication among nurses and physicians, and the desires of obstetrician gynecologists to have a more balanced life style. Because those individuals with office practices who also do occasional dedicated labor and delivery coverage have their own business models (usually some variants of private group practice), the remainder of this article is devoted to how organizational and business models of OB/GYN hospitalists are structured for those physicians whose professional practice is devoted entirely to inpatient obstetrics with or without emergency room and/or inpatient gynecology coverage.

The business and organizational structures of OB/GYN hospitalists are not unlike those of other hospitalists, emergency room, anesthesia, and intensive care unit physicians, which have a substantially longer history. Like these other groups, there is a diversity within this new specialty of how they are structured and how they become financially solvent. The reasons for the differences in these organizational structures are multiple. First is the reason a hospital chooses to initiate an OB/GYN hospitalist group. The reasons for setting up such a new program often are multiple for any given hospital and may include the following:

- History of poor obstetric outcomes on the unit (with or without associated malpractice lawsuits) thought to be owing to physicians who are not immediately available or owing to poor nurse–physician communication aggravated by lack of availability
- The need to cover certified nurse midwife services and family practitioners who provide obstetric care
- Difficulty in providing care for obstetric emergency room or obstetric triage patients
- The need to provide in-house supervision for obstetric residents
- The need to provide services to "dropin" patients and unassigned patients as well as those who present in advanced labor or with critical needs
- The need to provide inpatient services for MFM physicians who often are busy with outpatient consultations and ultrasounds and may prefer not to take (or want to reduce) night call
- Individuals or groups of physician obstetric providers who need coverage assistance with their obstetric patients during busy office hours or on nights and weekends

A second and evolving reason for initiating an OB/GYN hospitalist program, especially among staff model programs such as Kaiser Permanente, is the desire for physician "tracking," where some physicians prefer office-only care, others gynecologic surgery, and still others labor and delivery and inpatient care. Some of this is driven