TEAMHealth

WHITE PAPER

The OB-ED: Redefining the Standard of Women's Care and Strengthening Hospital Finances

The OB-ED model fundamentally changes how hospitals care for expectant mothers in a way that improves patient satisfaction, enhances patient safety and quality of care, and increases hospital revenue.

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One of the most recent and innovative women's healthcare service offerings is the obstetrical emergency department, or OB-ED. The OB-ED redefines the standard of women's care in the hospital setting, promoting patient safety and enhancing satisfaction, improving quality, and reinforcing community provider relationships—all while embracing an entrepreneurial approach to strengthening hospital finances.

Defining the Need

As its name indicates, the OB-ED is an emergency department dedicated solely to pregnant women. Typically located in the labor and delivery unit, the OB-ED treats pregnant women who present to the hospital with obstetrical complaints such as abdominal pain or bleeding. Operating around the clock and staffed by board-certified physician specialists, the OB-ED ensures that expectant mothers receive timely, specialized care without the long wait times and anxiety often associated with current labor and delivery department protocols for treating pregnant women.

Typical hospital protocol dictates that women with an obstetrical complaint and who are at least 20

weeks pregnant bypass the emergency department and go to an obstetrical triage area located in the labor and delivery unit. These patients are typically monitored for several hours by a nurse while identifying an available physician. If a physician is unavailable to come into the hospital—particularly during nights and weekends or even during an ordinary day of heavily scheduled patients and surgeries—the nurse will speak with the physician over the phone to obtain treatment instructions. Under this protocol, patients often report low satisfaction rates due to the long wait times and/or the inability to see a physician. They are also more likely to return to the hospital within 24 hours and tend to have higher incidences of complications.

Hospitals also face financial hurdles with the obstetrical triage model. Because the service is considered "outpatient," the hospital can bill very little, if any, facility charges for these patient encounters, making it difficult to recover the cost of resources (e.g, nursing staff, fetal monitors, utilities, laundry, and supplies) used to provide the service. The emergency department is allowed to collect facility charges, so a woman who presents to the hospital in her 20th week of pregnancy poses a much different financial challenge for the hospital than if she had come in with the same complaint just one week earlier and was seen in the emergency department.

OB-ED Solution

With an OB-ED, every qualifying patient who presents at the hospital with an obstetrical complaint is seen in the OB-ED setting. In accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), each patient receives a medical screening exam by a qualified health professional in conjunction with the nursing assessment she would have received under the obstetrical triage protocol. However, unlike the triage environment, every patient in the OB-ED is also evaluated by a physician prior to discharge.

The positive impacts of implementing this model of care are numerous and significant, such as:

- Enhanced patient safety and quality care, including fewer complications and return visits
- Improved patient satisfaction
- Increased nursing staff satisfaction and retention
- Improved hospital finances

Safety and Quality

The OB-ED redefines the standard of women's care in the hospital setting. By eliminating "phone triage medicine" and ensuring that every patient is evaluated by a specialist in high-risk obstetrics and emergencies, patient safety is greatly improved. This is important for several reasons. Obviously, it increases the chances for positive outcomes and reduces the number of return visits to the hospital within 24 hours of discharge. It also lowers the number of patients who might otherwise be transferred to another facility for treatment of a high-risk condition, thereby allowing the hospital to capture the revenue associated with those patients.

Patient Satisfaction

With a dedicated physician staff, the OB-ED can typically assess, treat, and discharge obstetrical patients much faster than a general emergency department or obstetrical triage setting. Unlike the latter environment where wait times can be from four to six hours before seeing a physician and sometimes never seeing a physician, a normal OB-ED visit lasts less than two hours with little to no wait time on the front end. As most hospital leaders know, short wait times go a long way to achieving high levels of patient satisfaction. And, because a physician evaluates every patient, expectant mothers can leave the hospital with the peace of mind that comes with knowing their conditions are being expertly managed.

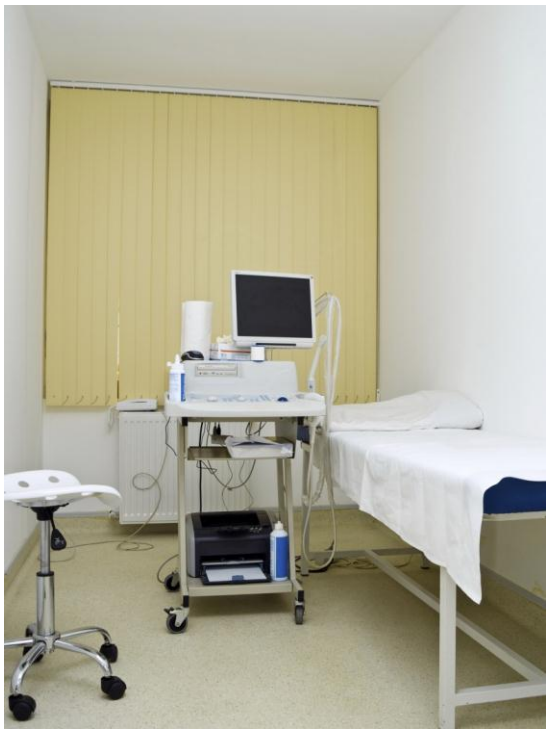
Because hospital reimbursement is now tied to patient satisfaction scores on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, these benefits can have an immediate positive financial impact if the patient must be admitted to the hospital, but are also important because they help generate repeat business for the hospital from mothers and their babies.

Nursing Staff Satisfaction

Hospitals with OB-EDs tend to have higher levels of job satisfaction among nurses and lower levels of nursing turnover. Unlike in an

obstetrical triage setting where nurses may manage a patient through a physician phone call and could feel that they are practicing at the very limits of their practice/license scope, the OB-ED nurse does not have to extend the limits of his or her professional duties. In addition, OB-ED nurses typically receive extra training in order to assist physicians with emergency cases, helping create a sense of being a valued team member and boosting satisfaction and retention.

Avoiding nursing turnover is important given that nurse resignations cost approximately 1.5 times that of a nurse's salary due to costs associated with recruitment, training, and overtime for nurses who must cover additional hours while the position is vacant.



Hospital Finances

The OB-ED allows hospitals to take an entrepreneurial approach to creating a positive financial impact for the hospital. With an OB-ED, hospitals can, and by law must, bill for patients in the same way as those treated in the main emergency department, meaning that as they would with general emergency department visits, hospitals can collect facility charges—charges that are lost in the obstetrical triage outpatient setting.

On average, facility charges are approximately $700 per patient. In some cases, depending on the OB-ED patient volume, this additional revenue can fully offset the costs associated with physician staffing and can even generate a profit.

An OB-ED requires little to no structural investment for the hospital. A Certificate of Need (CON) and up-front capital are not needed. An OB hospitalist partner should be able to convert a hospital's existing obstetrical triage area into an OB-ED at minimal to no additional cost, and as a plus—no additional nursing coverage should be needed.

Making it Work

Because an OB-ED requires around-the-clock physician coverage, physician staffing is the critical component to establish an OB-ED. Although some large academic medical centers fill this need with resident coverage, the most successful model for providing OB-ED physician coverage is through an OB hospitalist program.

With an OB hospitalist service, the hospital gets 24/7 staffing from an OB physician whose primary responsibility is the OB-ED but who also provides coverage for unassigned OB patients and as needed for call coverage in the main emergency department.

An OB hospitalist partner should know how to establish a successful OB-ED that will meet Centers for Medicare and Medicaid Services regulations as well as the standards of the department of health in the state where the hospital is located. The hospitalist will also be able to develop an implementation plan as well as an ongoing operations and business development plan for the OB-ED.

Depending on payer mix, in hospitals with approximately 1,500 deliveries per year, the facility revenue generated by the OB-ED can offset the cost of the OB hospitalist program. For hospitals with a delivery volume greater than 1,500, revenue from the OB-ED may cover more than the cost of the OB hospitalist program and thereby generate a profit. An added benefit is that satisfied patients who leave the OB-ED are more likely to return to the hospital again when they or their family need hospital or emergency care, providing repeat patient revenue.

Overcoming the Hurdles

Unfortunately, the implementation of an OB-ED and OB hospitalist program may not be met with fanfare at every hospital. For some facilities, bringing in an OB hospitalist to open an OB-ED

can raise alarm among community physicians who fear that they will be edged out of the hospital or have their patients “stolen” by the hospitalists. These providers may propose offering their own “laborist” or doctor-on-deck type of program, or they may threaten to take their patients elsewhere if the hospital moves forward with an outside hospitalist partner.

When facing a proposal from community OB/GYN physicians to provide OB-ED coverage, hospital executives must weigh several factors. Although a “homegrown” program may be associated with lower costs, it could also provide significantly lower value to the hospital. For example, the community physicians operating the OB-ED may:

- Have no prior expertise in creating an OB-ED service.
- Have no dedicated resources for capturing and maximizing facility and/or professional revenue.
- Provide reduced opportunities for the hospital to share in professional fee collections in order to offset program costs.
- Perceive the program as a competitive edge over other community providers and therefore the program may see limited utilization.

In fact, an OB-ED and OB hospitalist program offers benefits to all of the hospital’s existing OB/GYN providers and can help improve the facility’s relationship with those community physicians. For example, having 24/7 call coverage provided by the OB hospitalist means that these community physicians are less likely to be summoned to the hospital at a moment’s notice to deal with an emergency, which would promote a better work/life balance for those providers. Also, the fear of competition and patient poaching is eliminated because an effective OB hospitalist program restricts their providers from having a private practice within a certain radius of the hospital.

Attracting Physicians and Developing Business
Beyond providing a better work/life balance to community physicians, an OB hospitalist program and OB-ED can help hospitals recruit new obstetricians to their community and retain them. This is one of the primary reasons hospitals implement an OB hospitalist program in the first place.

The OB-ED is an excellent business development tool for hospitals that may have sufficient obstetricians but want to attract additional specialists and grow their women’s health service line. As an example, the hospital may want to expand its maternal fetal medicine practice. The specialty hospitalist vendor can help support the physicians necessary to develop individual service lines and grow women’s services overall, with the OB-ED as one important component of those offerings.

Conclusion

The OB-ED is an innovative model for providing emergency obstetrical care that redefines the standard of hospital-based women’s services. Creating an OB-ED in conjunction with adopting an OB hospitalist program can improve patient care, safety, and satisfaction while boosting hospital revenues and relationships with local providers.