OB-GYN PLAYBOOK

Supporting women’s healthcare across the United States
Executive Summary

The HCA Physician Services Group is fully dedicated to serving our communities with high-quality obstetrics and gynecology practices across the country. I firmly believe in carefully examining best-demonstrated practice models, so that we may continue to honor that commitment.

The OB-GYN Playbook serves as an overview of the organizational, structural, and functional attributes found in high-performing OB-GYN practices. It addresses operational, clinical and financial aspects of a practice, provides an overview with management hints and tips, and defines what excellence looks like in an OB-GYN practice.

What you will find is the best-demonstrated practices in obstetrics both inside and outside of HCA Physician Services Group.

We incorporated the evaluation of existing and new practices into this playbook, providing a framework from which to identify gaps between the current operating model and the operating model of the ideal practice.

This document highlights the key aspects of each practice component and is not intended to be an all-inclusive, detailed manual. We will update this playbook yearly to ensure it stays current and relevant.

I want to thank you, in advance, for taking time to reflect on the material contained within this resource.

Sincerely,

John Rebok
Vice President of Operations
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Purpose

The OB-GYN Playbook equips operational leaders with the fundamental tools needed to manage successful practices that exceed expectations with outstanding performance. The purpose of this playbook is to assist in driving out variation and standardizing excellence across Physician Services Group.

Using the Playbook

This playbook was created with the busy operator in mind. Each chapter begins with a brief overview, which outlines the key topics contained within and concludes with key takeaways to ensure the reader recognizes and can remember the most important elements of the section.

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Characteristics of a Successful Obstetrics Practice

Explore key elements of a high-performing OB-GYN practice.

Key Practice Elements

A high-performing OB-GYN practice consists of employed, boarded physicians supported by a team of advanced practice providers (APP) and professionals such as hospitalists, laborists, midwives, doulas, OB anesthesiologists, diabetes educators, and lactation consultants. Physicians should be privileged at local hospitals with high-quality labor and delivery units that offer:

• Separate birthing facilities from the main hospital
• Separate labor and delivery entrance
• A women’s triage department
  ○ And a separate triage area for >20 weeks pregnant patients
• Interior design that is conducive and supportive of labor, delivery and recovery
• Private rooms
• Sleeping arrangements for a mother’s support person
• Designated C-section surgical suites

Additionally, the following hospital-based programs and amenities can be key patient satisfiers:

• Breastfeeding support
• Couplet care
• Postpartum support
• Support for pregnancy loss
• Parenting classes
• Existence of a patient advisory council
• “Baby-friendly” certification
• Skin-to-skin contact program
• Online pre-registration
• Concierge for non-clinical services

According to the Advisory Board, technologies and procedures indicative of a high-performing OB-GYN practice are the offering of high-level ultrasound, elimination of elective inductions prior to 39 weeks, support for vaginal birth after caesarean, and a prioritization of multi-disciplinary care in obstetrics cases.

Learn more about the positive relationship between the physician and administrative leadership dyad and collaborative governance structure in a high-performing practice.

Practice Governance

These models are important for providing clear delineation of duties and decision-making and in guiding operations, growth, and culture.

Practice Governance Structure

In a small practice (15 providers or less), there should be a dedicated practice manager or administrator, and a designated physician leader.

Practice governance in larger practices (15+ providers) should be composed of two major components: the physician and administrative leadership dyad, and a collaborative practice governance structure.

Physician and administrative leadership dyads lead many successful large OB-GYN practices. Practice leaders manage the daily operations of the practice, with the strategic, financial, and other performance
metrics specified by the budget and appropriate policies and procedures. There should be a clear delineation of duties to avoid unnecessary conflict and confusion.

The second major component of the practice governance structure is the physician and administrator collaborative council. The council makes important decisions for the practice and guides its efficient operation, growth and culture. The council is composed of both physicians and administrators and is the hub of the dyadic decision model. The dyadic decision model is based on the belief that to effectively lead a clinical business, a combination of skills and talents of both clinical leaders and business leaders is required. The council meets regularly and is accountable for the practice’s key performance metrics and strategic plan.

Typically, the council is accountable for:

• Establishing the strategic direction of the practice by developing a plan that aligns the practice goals with those of the enterprise, division and/or host hospital(s) and ensuring performance to the strategic plan

• Establishing and adhering to a defined and openly transparent decision-making process

• Managing practice key performance metrics relative to financial planning, clinical quality, customer satisfaction, human resource management and operations performance

• Establishing practice performance standards concerning conduct, citizenship, service and compliance, and taking appropriate action where non-adherence occurs

• Establishing and enforcing practice policies that are consistent with all policies and procedures

• Practices may also appoint regular standing committees or ad hoc committees for specific purposes

Key Takeaways

• In a small practice (15 providers or less), there should be a capable practice manager/administrator and a designated physician leader

• A physician and administrative leadership dyad leads many successful large OB-GYN practices, with practice leaders managing the daily operations of the practice and the strategic, financial, and other performance metrics specified by the budget and appropriate policies and procedures

• The second major component of the practice governance structure is the physician and administrator collaborative council that makes important decisions for the practice and guides its efficient operation, growth and culture

The compact is a “two-way” provider and administrator tool that clearly articulates an agreed upon set of behavioral and performance rules that provide for explicit development and management of the practice culture. The compact typically addresses all aspects of the practice including clinical expectations, strategic and administrative expectations, as well as behavioral expectations. The purpose of the explicit delineation of expectations is to provide a clear operating framework from which to manage the practice, and to provide guidance to the provider and administrator recruitment teams. A satisfactory compact develops a shared sense of strategic imperatives, and helps the practice mold and manage its cultures. Outdated, unclear, or uncommunicated expectations diminish an organization’s ability to function smoothly and deliver optimal care.
Creating a Compact

Creating a compact is a collaborative effort between providers and the practice leadership. It is critical that all of the practice’s providers are involved in the process with physician leaders. The creation of the compact should take place through structured provider group conversations with significant pre-work to shape the sessions. All of the providers and the practice leadership should endorse the completed compact. Promote the compact vigorously in the practice, so it can become part of the practice language.

• Step 1: In order to create a compact, the practice must assemble an aligned provider and administrator leadership council that can effectively manage change

• Step 2: articulate the practice mission, vision and values

• Step 3: assess the practice culture by examining provider and administrator behavior as either enabling the group’s ability to achieve the shared vision, or as a barrier to success

• Step 4: identify behaviors and practices that are required to support the practice vision and the “gives” and “gets” required for both the administrators and providers to commit to the agreed upon compact

• Step 5: articulate the behaviors and practices that are supportive of achieving the practice vision and the series of “gives” and “gets” required

• The compact should be signed by all providers and by the organization’s non-physician leaders

• The compact should be included in the practice’s recruitment process for all new providers and administrative leadership

• Each provider and administrator should have an annual evaluation based on his or her responsibilities outlined in the compact

• The compact should be part of a formal “on-boarding” process for all providers and managers

• The compact and resulting culture should be widely accepted throughout the practice by all employees

Revising the Compact

The practice leadership, on a periodic basis, should review the compact. Updates to the compact should be focused and infrequent, but implemented as necessary to effectively manage the practice culture and be consistent with the realities of the enterprise.

It is critical that all providers be engaged in the process for the compact to be successful. The group must understand the strategic and business imperatives facing the practice specifically and healthcare globally. Providers must understand the vision and strategy so they can readjust their behavior and expectations based on the new realities of medicine. The journey is at least as important as the destination and multiple conversations are important to understand how the current status quo may hinder group performance. The use of an outside facilitator is strongly encouraged to help address difficult issues. Finally, leadership needs to be prepared for test cases that invariably arise. Others will observe how leadership manages providers who continue to operate outside compact expectations.

Key Takeaways

• The compact is the group culture

• Compact performance and compensation should be linked

• The compact needs to be a part of the practice language

• Compact expectations should guide behavior management

There are several levers for initiating the new compact:

• Review all policies to make sure they align with the new compact

• Align resources so both the group and providers can live up to their commitments in the compact

• Provide measures and ongoing feedback to providers regarding key measures in the compact

• Tie some portion of compensation to meeting the expectation in the new compact

• Acknowledge (non-financial) those who model the new expectations
The Provider’s Time

Consider the importance of effective provider time utilization and obtain efficiency recommendations for operators to consider implementing.

One of the most valuable assets of any practice is the provider’s time.

Providers include physicians and advanced APPs who are the core of the clinical team.

Effective Time Utilization

The provider’s time is the medical practice. It is the reason patients come to the practice and it generates the majority of the practice’s revenue. Optimize the provider’s time to provide maximum value to patients and ensure financial success.

A key concept to optimize the provider’s time is to ensure that everyone is working at the top of his or her license or certification. An APP, nurse, or MA should perform tasks that do not require a physician, and similarly APPs should not routinely perform tasks that are appropriate for a nurse or MA.
Lay out the practice intentionally to maximize efficiency. Large office space may look impressive, but it makes providers less efficient since there is more walking required than necessary. Physicians should operate in approximately 1,000 square feet apiece. The most efficient providers operate in a pod structure, typically with three exam rooms.

Equipment and supplies should be located as close as possible to where they are frequently utilized.

Using an electronic medical record (EMR) can make an office more efficient if deployed correctly. Efficiency will increase as technology becomes more powerful and mobile and as the interface becomes easier to use.

Key Takeaways

- Efficiently designed space is necessary for optimal time utilization
- Each team member should work at the top of his or her license
- Technology, including an EMR, can optimize time utilization

Staff should deploy other efficiency ideas such as:

- Use a call center text messaging system
- Keep equipment, supplies, and computers in the provider’s line of sight
- Co-locate processes and employees to save steps
- Use Wi-Fi wherever possible to streamline communications
- Find ways to eliminate redundancy

OBSTETRICS SCHEDULING

Review the unique circumstances in which obstetricians function and get recommendations on how to schedule physicians to create an efficient and supportive environment.

Obstetrics Scheduling Considerations

An obstetrician’s schedule has some unique considerations due to the unpredictability of obstetric events. The traditional model where each physician sees and delivers their own patients is becoming less acceptable to both patients and physicians. This older model creates enormous inefficiencies in the office since physicians leave for prolonged periods without warning. This results in unacceptable wait times, patient dissatisfaction, inefficient use of staff and potential for overtime, physician stress/dissatisfaction, and a heightened potential for burnout.

The ideal obstetric physician-staffing model includes a hospitalist who covers labor and delivery, thereby allowing physicians in the office to run on time. With that said, a hybrid between the traditional model and the aforementioned ideal model (using a full-time hospitalist who never comes to the office) can...
maximize physician and patient satisfaction. The hybrid model uses one or more of the physician group’s own physicians to act as a hospitalist one day per week, balancing the obstetrician’s desire to perform deliveries and serve in the hospital, the patient’s desire to be delivered by a physician with whom she is familiar and the realities of running the office efficiently. For groups with five or more obstetricians this model is easier, as one or more physicians can be assigned to a certain fixed day of the week. It may be helpful for each physician to keep the same day every week to allow the office schedule to be predictable. Scheduled deliveries may frequently be able to take place on the primary obstetrician’s hospital day to provide continuity for the patient. Some groups will continue the hospital day for 24 hours to include overnight call. Other groups may prefer a rotating call schedule that does not coincide with the hospital day. Groups with fewer than five physicians may consider providing hospital coverage for busier days of the week only.

Groups who use the hybrid model have reported significant improvements in physician, staff and patient satisfaction; no decrease in productivity; a reduction in overtime pay for clinic staff covering clinic days that are running late; and higher provider retention.

To ensure that patients are satisfied with the practice’s use of the hybrid model, the obstetrician should discuss the model during a new patient’s initial visit. A welcome letter to new pregnant patients that includes the practice’s care philosophy and information on the practice’s care delivery model is also recommended. A strategy for increasing efficiency and productivity is to encourage physicians to catch up on administrative duties during their day at the hospital. This allows the physician to focus on patients during their scheduled clinic days.

A typical office-scheduling template schedules patient appointments in 15-minute intervals with the ability to double book to allow approximately five patients per hour. Efficiency is maximized by having several appointment types (first pregnancy visit, established pregnancy visit, new gynecological visit, established gynecological visit, procedure visit, etc.) and distributing new patients evenly throughout the day. Consider seeing the majority of return obstetric patients in one or more concentrated half days a week as these are, in most cases, quick visits, which can be booked at up to eight per hour by utilizing medical assistants to have each patient ready to be seen expeditiously by the provider. Seeing a concentrated number of return obstetric patients in a clinical half day allows the staff to be in “obstetrics mode” and to follow a predictable and recurring pattern of patient care. For patient convenience, physicians may consider offering one early morning and one late afternoon obstetrics option weekly.

Patient and physician satisfaction may be improved by extending office hours to allow at least one provider to offer early or late appointments and appointments during the lunch hour. Opening the office on Saturday morning for at least one provider, especially one who is growing her/his practice, can also prove desirable both patient and provider. An independently credentialed APP may also run a Saturday clinic for urgent or low complexity visits with the support of a physician on call.

Physicians need dedicated time in their clinical schedule to do non-billable work including lab review, ultrasound review and billing, calling patients with test results, writing letters to referring physicians, completing medical records, sending congratulations cards to postpartum patients, practice development (such as visiting potential referring physician offices) and other administrative duties as assigned. A typical full time obstetrician should expect to spend approximately 40 hours per week in the office or hospital (excluding after hours call), which may include one full 8-10 hour day in the hospital serving as a hospitalist for the group, 26-28 hours of scheduled patient appointments, and up to six (6) hours of non-billable time for administrative work.

After-hours call is managed in many ways and may be shared between more than one group or managed by the individual group. A smaller group may find call volume allows enough rest to make working a full day post-call safe and manageable. Groups with high after-hours call volume, which precludes sleep, should consider limiting work post-call to half a day to limit potential for physician error and burnout. One physician may safely provide weekend coverage from Friday evening though Monday morning for a practice with fewer than five doctors, but larger groups should consider shortening weekend coverage to avoid physician burnout. Using APPs to take all after-hours calls first is another strategy to improve physician satisfaction and safety. In this scenario, the call schedule would always include an APP and a physician, with the APP fielding all calls first and forwarding on only those that require physician-level intervention, hospital admission, or delivery. The APP can also round on hospitalized patients for several hours on weekday and Saturday mornings (Sundays are generally more manageable since elective deliveries are rarely performed on Saturdays). APPs should be given the same scheduling considerations as a physician post-call.

Allowing providers to work a shortened day or have a day off post-call requires a physician leader to make the call schedule months in advance using a predetermined pattern to avoid staffing inefficiencies and patient reschedulings.

Key Takeaways

• An obstetrician’s schedule has some unique considerations due to the unpredictability of obstetric events
• The ideal obstetric physician staffing model includes a hospitalist who covers labor and delivery allowing physicians in the office to run on time
• The hybrid model uses one or more of the physician group’s own physicians to act as a hospitalist one day per week, balancing the obstetrician’s desire to perform deliveries and serve in the hospital, the patient’s desire to be delivered by a physician with whom she is familiar, and the realities of running the office efficiently
• Groups who use the hybrid model have reported significant improvements in physician, staff and patient satisfaction without decreased productivity; reduction in overtime pay for staff covering clinic days that are running late; and higher provider retention
• A typical office scheduling template places patient appointments in 15-minute intervals, with the ability to double book to allow approximately five patients per hour
• As staffing allows, patient and physician satisfaction may be greatly improved by extending office hours
• Dedicated time for non-billable work and time off post-call should be scheduled into the provider’s calendar
Non-Physician Staffing and Scheduling

Explore recommendations for staffing non-physician personnel to optimize the efficiency and effectiveness of the practice.

Staffing Considerations

OB-GYN practices employ clinical and non-clinical staff. While the non-clinical staff requirements may be similar to those in other specialties, clinical staffing does require some special considerations. Clinical staff includes a combination of medical assistants (MA), licensed nurses (RNs and/or LVNs), advanced practice providers (APPs), and ultrasound technicians. Each staff member should work at the top of their license.

MAs typically perform the following activities:

- Rooming patients
- Taking vital signs
- Dipping urine
• Recording weight, vital signs, and urine results in the prenatal flow sheet or electronic health record (EHR) visit template
• Asking basic intake questions and recording current complaints
• Updating the patient EHR medical history and verifying current demographics/contact information/email/medications/allergies/pharmacy information etc.
• Preparing predictable lab orders
• Stocking rooms
• Delivering normal lab results to patients through the portal
• Preparing and autoclaving instruments
• Downloading voicemail messages

Highly productive practices staffed by physicians with fully ramped practices typically have clinical MAs on the floor in a 2:1 ratio with a provider (MD or APP). One MA actively rooms patients and the other actively works with currently roomed patients. It is the MA’s responsibility to get information gathered and recorded prior to the provider seeing the patient. Practices should create standardized EHR visit templates to allow for convenient documentation of clinical services. Clinical staff should be assigned appropriate documentation responsibilities based on their clinical roles to allow the physicians adequate time for patient questions/engagement and throughput.

MAs should have several hours a week of scheduled non-clinical time to complete duties such as stocking rooms, downloading voicemail messages, sending normal lab results, preparing “goodie bags” for the first pregnancy visit, making courtesy calls to routine postpartum or post-op patients, and other similar assignments. For practices with several providers it may be beneficial to appoint a “lead MA” to be responsible for training, practice guidelines, and setting the standard for practice culture among the MA team members.

The typical functions of licensed nurses (RN and LVN) are in a back-office setting. They should communicate directly to patients by answering voicemails, emergency calls, calls from the hospital or other doctors’ offices; responding to patient emails or requests for clinical information through the portal; ordering and refilling prescriptions; and communicating with patients about abnormal results. A typical ratio of licensed nurse to MD is 1:2. The decision to use RNs vs. LVNs will vary depending on the practice size and preferences. A practice with several providers will benefit from assigning a clinical team leader/clinical manager, generally an RN, who will make the weekly staff clinical schedule, handle staff call-ins, coordinate training, assist with performance reviews, and assure adherence to practice culture and quality measures.

Nurse practitioners and/or physician assistants, otherwise known as APPs, play a vital role in the OB-GYN office. APPs are able to have their own schedule. This allows patients to schedule their visits with the APP directly rather than the MD for low-complexity and same-day visits. APPs should have several slots blocked daily for urgent/work-in visits. For normal-risk obstetric patients during the global obstetric period it is appropriate to use an APP to see patients for the first pregnancy visit, and for several subsequent routine prenatal visits. A common pattern is to alternate prenatal visits with the physician and the APP with a physician always being present in the office and available should the patient have physician-specific questions. Other visits appropriate for an APP are routine postpartum and post-operative visits, uncomplicated gynecological visits and procedures such as IUD placement, cervical cryotherapy, intrauterine insemination (if offered), and endometrial biopsies. APPs may also elect to obtain certification to perform colposcopies.

The APP is able to be the primary point of contact for all incoming labs and results for a particular physician and can triage results as needed. At the direction of the APP, an MA can manage and report normal results, and a licensed nurse can report abnormal results to the patient. The APP or physician should report clinically significant abnormal results to the patient. The APP can also be the primary point of contact for patient requests to communicate with a provider and hand off only those requests that are specifically appropriate for a physician.

The APP can round on uncomplicated postpartum and postoperative patients in the hospital each weekday morning with time commitment depending on practice volume. This frees the physician to perform higher-level duties in labor and delivery and encourages early discharge, which is a major satisfier for both the patient and hospital administration.

The ideal ratio of APP to physician will change as the practice matures. While two physicians with a growing practice may share a single APP, a physician with a full-time mature practice will require a dedicated APP. To provide the patient with a perception of continuity it is ideal for the physician and APP to work as a team long term so patients become comfortable and familiar with the APP and consider the APP to be one of their primary caregivers.

While midwives have traditionally kept their practices separate from physician practices, partly due to a perception of a cultural disconnect between different styles of pregnancy management, many physician offices are recognizing that midwives can fill an important role. Midwives can provide a unique service line that may be popular for a subset of low-risk patients preferring a more “natural” approach to pregnancy and delivery. Offering midwifery services can also be a significant source of revenue generation. Physician offices that employ midwives need to establish clear guidelines regarding which patients are appropriate for the midwifery service and which patients need to be transferred to the care of a physician. Since patients of the midwifery service would see only midwives for their prenatal care and delivery, the midwife group (although operating independent from the physician group) should adopt the physician group culture and adhere to all group policies and procedures. Patients admitted to the hospital under the midwife’s care should be transferred to the on-call physician for the group should complications occur during labor. Practice leaders should establish clear guidelines regarding indications for transfer. Since the midwife group is responsible for covering its own after-hours call, a minimum midwife group size of two is necessary to start a midwife practice in an existing physician group.

Ultrasound is a vital part of the OB-GYN office for both patient satisfaction and revenue generation. See chapter 14 for more information on ultrasound in the OB-GYN office.
Key Takeaways

- Clinical staff includes a combination of medical assistants (MA), licensed nurses (RN and/or LVN), advanced practice providers (APP), and ultrasound technicians
- Each staff member should work at the top of their license
- MAs are typically on the floor in a 2:1 ratio with a provider (MD or APP), with one MA actively rooming a patient and the other actively working with currently roomed patients
- For normal-risk obstetric patients during the global obstetric period it is appropriate to use an APP to see patients for the first pregnancy visit and for several subsequent routine prenatal visits
- The ideal ratio of APP to physician will change as the practice matures, but typically will be 1:2 or 1:1
- Midwives can provide a unique service line that may be popular for a subset of low-risk patients preferring a more “natural” approach to pregnancy and delivery
- Ultrasound is a vital part of the OB-GYN office for both patient satisfaction and revenue generation

07 Practice Culture and Experience

Determine how to establish practice culture and make connections between culture and patient experience.

When a practice’s culture and strategy work together they mutually reinforce each other. While this philosophy is simple, it is difficult to develop. Culture is an often misunderstood concept and its impact often discounted; however, a company’s culture is actually tangible. It is one of the most important drivers of growth and it has to be set, managed, and augmented to achieve long-term, sustainable success. There is more to a thriving practice than simply having good clinical outcomes and a healthy community. Long-term physician practice success is dependent on a positive and proactively nurtured culture.
Creating a Culture That Supports Success

Building a strong culture in a physician practice takes hard work and unwavering commitment. Below are some basic building blocks to consider when assessing a practice’s culture:

1. **Dynamic and engaged dyad leadership**
   
   There is a saying in the army, “Every unit is a direct reflection of the leadership it has been given.” Leadership fuels and inspires culture at every level of a business. Great leaders are effective communicators and motivators who share a clear vision, mission, values (compact), and goals with their teams. They create an environment for these factors to come alive. Exceptional leadership teams quickly address any action that harms or does not respect the culture of the organization.

2. **Living philosophy**
   
   It is one thing to have beliefs and values spelled out in a frame in your conference room. It is another thing to have genuine and memorable beliefs that drive an organization’s actions and decision-making. Discuss values with all potential candidates – physicians and staff – as part of the selection process to ensure that the practice attracts, selects, and retains individuals who contribute to the desired culture.

3. **Responsibility and accountability**
   
   Leaders immersed in fostering culture explain why they do what they do and then empower employees to act with integrity, personally contribute to maintaining the organization’s culture and are accountable and responsible to their organization.

4. **Patient first**
   
   Physicians in thriving cultures consistently ask patients for feedback and act to meet their needs.

**Things to remember when operationalizing culture:**

1. Employees are loyal to culture, not strategy, and to leaders that are loyal to them
2. Culture provides resilience in tough times
3. Culture is more efficient than strategy
4. Culture creates a competitive differentiation
5. Culture can spark industry-leading change
6. A complacent culture can blind an organization
7. Cultural miscues are more damaging than strategic mistakes
8. Strategies can be copied, but culture cannot
9. Culture provides greater discipline than disciplinary action
10. “Every organization has a culture. Unfortunately, many cultures, if not most, develop by happenstance…”

Key Factors in Defining and Managing the Practice Culture

- It is critical that everyone working at the practice engages in understanding and living the culture
- The practice must have a clear vision and mission that reinforces the culture
- Discuss culture at meetings, during interviews, at corrective actions and in everyday conversations
- The right culture impacts a practice’s ability to attract and retain patients
- Culture impacts every aspect of the practice

**Key Takeaways**

- Culture is created by what is allowed to occur within a practice
- Culture must be clearly communicated and should play into every decision and action that occurs within a practice
- Culture development needs to be a top priority for anyone in a leadership position
- A patient-centric culture is important for a successful practice

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Patient Experience in Obstetric Care

Discover recommendations for creating exceptional patient experiences at key points of a patient’s pregnancy.

Creating an Exceptional Patient Experience

The American College of Obstetrics and Gynecology (ACOG) publishes guidelines for recommended frequency of prenatal visits. The frequency of visits (average of 13 in a normal risk pregnancy) and the time sensitivity of several key visits present multiple opportunities for practices to make thoughtful decisions to minimize patient inconvenience and maximize patient satisfaction.

The first point of contact with the patient at the time of scheduling offers an important opportunity to educate the patient about the practice and ensure that the patient and practice are a good fit. Prior to the first pregnancy visit, the patient should be directed to information about the practice culture, use of APPs, what to expect at upcoming visits, modes of communication, hospital affiliations, and other important facts. A general obstetrician located in an
area with ready access to a maternal fetal medicine (MFM) group may consider training their schedulers to ask patients several “high-risk” questions prior to scheduling the first prenatal visit and consider referring truly high-risk patients to an MFM group rather than accepting them and transferring them later. A best-documented practice is to partner the patient with the appropriate physician from the start (even if that means referring them elsewhere prior to establishing a relationship).

A policy should be in place regarding acceptance of transfers. Schedulers should know not to schedule pregnant patients requesting to transfer in without physician approval. This policy should also address accepting patients late in pregnancy who have not had prenatal care or transferring into the practice during the late third trimester. It is important to set limits establishing when the practice will absorb this type of risk.

Once the patient has established a relationship with the practice, maximizing opportunities to create an exceptional patient experience should be the overarching practice goal. The first pregnancy visit is often scheduled with an APP and may take 30-60 minutes to allow for gathering a detailed history, performing a physical exam, providing education, conducting routine lab testing and bedside ultrasound, and creating the prenatal flow sheet. A key patient satisfier is meeting the patient and family in a comfortable office setting to gather basic information prior to moving to an exam room. Providers should consider holding off on any detailed discussion and education until after the bedside ultrasound determines that the pregnancy is viable. Clearly defining expectations and processes at the very first visit minimizes the possibility for future miscommunication or dissatisfaction. It is important to remember at all times that pregnancy can be an emotionally charged situation in which patients experience a sense of urgency. Clear, consistent communication is vital. It is important for patients to feel that the practice is accessible and available during this life event that can be wrought with anxiety.

Important opportunities to maximize patient satisfaction include:

- Having a lab draw station in the office or in the same building
- Reporting results to patients in a timely manner and clearly conveying expectations to the patient
- Providing a direct phone or email point of contact for questions
- Offering ultrasound within the office
- Scheduling ultrasound appointments and provider appointments back to back when possible

Practices should consider scheduling all of the patient’s routine prenatal visits at the second pregnancy visit, after confirming that the pregnancy is viable, in conjunction with a financial consultation as discussed in a later chapter. It is appropriate to schedule appointments for additional services such as genetic testing, trisomy screening, etc., at the patient’s request. While some of these appointments may be changed or edited in the future, scheduling all of the prenatal visits in the first trimester is beneficial for the following reasons:

- Avoids overbooking and managing unacceptable wait times later in the pregnancy
- Offers more appointment options
- Offers back to back ultrasound and provider visits
- Gives the practice a realistic picture of how much of the schedule is open for non-obstetric appointments
- Works around provider PTO and avoids reschedules
- Creates a perception that the practice has a clear vision of how to manage the pregnancy from beginning to end

At the time of gestational diabetes screening (24-28 weeks), providers should discuss issues such as hospital tour and registration, prenatal classes, choosing a pediatrician, and pertussis vaccination. This is also a time to check with your state’s requirements for additional third trimester testing for syphilis and HIV, as well as meeting other state requirements such as providing postpartum depression resources.

Once the final routine prenatal test is completed (usually a Group B strep culture at 35-37 weeks) it is helpful to give the patient a printed copy of her prenatal record to present to the hospital when she is admitted. It also allows any covering physician immediate access to the patient’s medical record when the EHR may not be readily accessible.

The most frequent patient complaint is excessive wait times in the vast majority of offices. While the hospitalist model significantly reduces these complaints, it is still vital to track and set goals for patient wait time and to deploy service recovery procedures when excessive wait time is unavoidable (for example offering the patient a snack or glass of water, validating parking, offering an alternate provider, or offering to reschedule).

It is important that a practice’s culture is supportive of effective communication between staff and providers, particularly as it relates to each patient’s specific circumstances. Keeping all staff “in the know” is a huge patient satisfier. Having a system that flags a patient’s EHR if a key event has occurred (such as pregnancy loss, if she is Rh negative, if she has twins, if the fetus has a concerning issue, or if she has recently been admitted to the hospital) ensures staff members can communicate with awareness. This communication should continue in the post-partum period and providers should be encouraged to include details (in a delivery-billing note or elsewhere) in the EHR with the baby’s name, weight, and other pertinent information that allows a staff member to initiate a conversation with a personal touch. Additional processes to consider are:

- Assigning a staff member (such as an MA) to call each post-partum patient within the first week of discharge from the hospital to check on her status
- Sending a personal “congratulations” card from the practice signed (not stamped) with a personal note by the primary physician
- Having the primary physician call the patient if she/he was not the delivering doctor

Direct communication from the primary physician indicating that she/he is aware of the details of the delivery is especially important when a hospitalist model is in place and ensures that the patient feels that she still has a primary doctor who is highly involved with her caregiving team. To meet these goals, an intra-office communication system using the EHR must be developed and adhered to and written policies and procedures regarding timely communication that includes all team members should be part of the practice culture.
Key Takeaways

- The first point of contact with the patient at the time of scheduling offers an important opportunity to educate the patient about the practice and ensure that the patient and practice are a good fit for each other.

- Once the patient has established a relationship with the practice, maximizing opportunities to create an exceptional patient experience should be the overarching practice goal.

- Important opportunities to maximize patient satisfaction include having a lab draw station in the office or in the same building, reporting results to patients in a timely manner, providing a direct phone or email point of contact for questions, offering ultrasound within the office, and scheduling ultrasound appointments and provider appointments back to back when possible.

- The most frequent patient complaint concerns wait time.

- It is important that a practice’s culture fosters effective communication between staff and providers, particularly as it relates to each patient’s specific circumstances.

Reputation Management, Patient Satisfaction, and Service Recovery

Review strategies for engaging with and marketing to patients in-person and online.

Patient Satisfaction and Service Recovery

One of the most unique aspects of an obstetrics practice is that the patient population is young, being in their late teens to early 40s. There is an inherent challenge in meeting the changing demands of this age group. Because most referrals to an obstetrics practice occur by word of mouth, it is vital that a practice has a customer service delivery program that includes establishing expectations of the staff, a survey/feedback mechanism, and a process for making changes based on patient feedback.

A standard healthcare staff-training program that has been widely adopted is called AIDET, which was developed by the Studer Group, a leading healthcare consultancy. AIDET stands for acknowledge, introduce, duration, experience, and thank you. This program aims to standardize messaging from staff to patients. Research conducted by the Studer Group has shown
that practices using AIDET experience reduced patient anxiety and increased compliance with clinical plans. Another important aspect of a patient service program is service recovery. Practice leaders should train every employee to recognize the need for service recovery and empower them to resolve any service issues immediately or to communicate with those who can resolve a misstep in patient service.

Patient feedback should be timely and consistent. Many practices offer patients the ability to complete patient satisfaction surveys online. This allows the practice to receive instant feedback and enables practice leaders to act expeditiously in addressing any issues. Great feedback systems also auto-post patient comments on public media platforms such as Google, HealthGrades, RateMD, Vitals, etc. Patient satisfaction should be part of the practice culture and feedback should be a standing agenda item at all staff and physician meetings.

Social Media and Public Information

The first step in effective practice marketing in the digital age is creating an easy-to-use, easy-to-find website that offers existing and potential patients all the information needed to learn about and engage with the practice. A great website is the entry point for many patients. A social media presence is also valuable for marketing or advertising the services provided by your OB-GYN practice.

Managing social media and public information requires both proactive and reactive strategies. From a proactive perspective, an excellent strategy is developing a strong online presence and reputation by asking satisfied customers to write a review or to “like” the practice on Facebook or on other social media sites. It is also important to monitor platforms by responding appropriately to comments, posting engaging information and positive patient videos or comments, as well as managing information accuracy.

Reputation management is a key part of any practice’s social media strategy. It is important to keep the following tips in mind when addressing the online conversation surrounding a practice and its physicians and providers:

1. Verify your information and make sure it is correct on your profiles so patients know they are viewing and reviewing the correct practice
2. Tell patients about your practice’s and physicians’ online presence
3. Develop a plan to ask for patient reviews and only ask patients to leave a review on one site, so they are not overwhelmed with options
4. Develop and execute an email marketing campaign
5. Create a friendly competition as this will encourage your entire office to work toward improving your online reputation
6. Don’t manufacture reviews

One challenge that OB-GYN practices face with regard to this new category of information is accuracy. It is common for public sites to post inaccurate physician and practice data including physician background, locations, and phone numbers.

Digital Marketing

Many practices implement a comprehensive digital marketing strategy to complement traditional marketing efforts. Pay-per-click (PPC) and search engine optimization (SEO) tactics provide direct links from potential patients to an obstetrician practice’s website.

PPC is an internet-marketing tool through which advertisers pay a fee each time one of their ads is clicked. Google AdWords is one of the most popular PPC tools online. Using Google AdWords, users start by creating an ad telling people what they offer and then choosing search terms that will make the ad show up in Google results. The final step is setting a daily budget, which dictates how much you would like to spend per click, per day. When people type in those search terms, the ad may appear above or next to Google’s results – the likelihood of appearance is directly related to the cost per click. The benefit to Google AdWords is that users only pay whenever someone interacts with the ad. PPC tactics can help patients find the practice online.

SEO is a process that works to increase the visibility of a website within search engine results; often referred to as earned or organic results. SEO considers how search engines work, what people search for and the words they use, and a target audience’s preferred search engines. Making a website SEO-friendly requires going through the website and creating unique and accurate page titles, improving site structure of URLs, making the site easier to navigate, writing appropriate anchor and heading text, and continually refreshing or adding new content. SEO can help make it easier for a patient to find the practice without any extra, episodic expense to the practice.

Targeted advertising is a type of advertising whereby advertisements are placed to reach consumers based on various traits such as demographics, psychographics, behavioral variables (such as product purchase history), and firmographics or other second-order activities which serve as a proxy for these traits. Many practices see positive results purchasing targeted ads from leading social and radio networks like Facebook, Twitter, Pandora, and Spotify.
Key Takeaways

- All staff should be trained on service recovery
- Staff should rapidly address negative feedback or issues identified within patient satisfaction surveys
- Websites should be easy to use and easy to find
- Managing social media and public information requires both proactive and reactive strategies
- Many practices implement a comprehensive digital marketing strategy to complement traditional marketing efforts
  - Pay-per-click (PPC) and search engine optimization (SEO) are examples

Ultrasound in the OB-GYN Office

Consider the importance of including ultrasound in OB-GYN offices.

Ultrasound Considerations

In-office ultrasound is an important part of the OB-GYN office, both for patient satisfaction and revenue generation. Ultrasound technologists should be certified by the American Registry of Diagnostic Medical Sonographers (ARDMS) and should have additional certification in both obstetrics/gynecology and physics. At least one technologist should have additional certification in nuchal translucency measurement, which can be obtained through either the Fetal Medicine Foundation (FMF) or the Nuchal Translucency Quality Review (NTQR) program. Additional training and experience in fetal cardiac and intracranial anatomy is also recommended, as well as annual continued education courses. In a larger group with three or more ultrasound technologists, practice leaders may consider appointing an ultrasound team leader to ensure quality, continued education, and adherence to practice culture.
Practices may combine the use of a smaller portable bedside ultrasound machine to be used by providers with use of one or more higher-level machines operated by a certified ultrasound technologist, the latter having capability for storage and recording, color flow Doppler, 3D, and other functions. Since a portable machine can be moved between rooms, consideration should be made to scheduling the first pregnancy visits during times when the APP or MD has access to a portable machine. Based on practice volume of obstetrics visits, a typical ratio of portable ultrasound machines to MD may be 1:3. A typical ratio of non-portable machine (and associated ultrasound technician) to MD may be 1:2. Prior to purchasing a portable ultrasound, it’s important to ask, “what is the purpose of this machine?” If it is only to confirm viability then it may be too limited of a study, and without some type of formal report and image storage capability, it is likely not a billable service.

Non-portable machines should be placed in a specialized room with no windows (or blacked out windows), a mounted flat screen TV in an appropriate location for the patient and family to view, a power table to allow height adjustment for operator comfort, additional seating for family members, and a documentation space for the technologist. A typical ultrasound room requires approximately 150 square feet (compared to 100 square feet in a typical exam room). Ultrasound machines generate a considerable amount of heat. It is important to ensure adequate ventilation to maintain a comfortable environment. Practices may consider having a separate sub-waiting area for ultrasound patients to improve patient satisfaction and maximize technologist time by making patients readily available. Since family members frequently attend obstetric ultrasound examinations, the sub-waiting area also avoids overflow in the main waiting room, and the size of the sub-waiting area needs to take this into account. There should be well-placed and visible signage outlining the practice’s policies regarding the use of recording devices to ensure HIPAA compliance. Please note that even the well-meaning recording of a woman’s ultrasound by a family member is, if then published, a violation of her HIPAA rights and should be discouraged.

Billable ultrasounds in every normal risk pregnancy can include the following (CPT codes in parentheses):

1. First pregnancy visit- bedside ultrasound performed by APP or MD with confirmed pregnancy (76801 or 76817)
   a. If ultrasound is being performed before pregnancy is confirmed it is billed under 76856 or 76830 as it is deemed a gynecological ultrasound
2. First trimester ultrasound at 8-13 weeks performed by technologist (76801)
3. Anatomy ultrasound at 19-22 weeks performed by technologist (76805)
   a. Please note that the use of 76811 should always be indication-driven and not used for routine pregnancy ultrasounds
4. Follow-up (growth) ultrasound at 34-36 weeks performed by technologist (76816)

Additional ultrasounds may be appropriate in certain patients including:

1. Nuchal translucency (NT) at 11-14 weeks performed by NT-certified technologist (76813) either alone or combined with bloodwork for prenatal screening; insurance coverage varies. These must also be a physician certified to interpret the images.
2. Biophysical profile (BPP) without non-stress test performed by technologist during the third trimester to assess fetal well-being may be performed weekly or twice weekly for certain diagnoses such as hypertension, diabetes, amniotic fluid abnormalities, fetal abnormalities or growth restriction (76819). The practice may also wish to offer non-stress testing (76819).

3. Follow-up ultrasound at any gestational age performed by technologist, at medically appropriate intervals following the anatomy scan, to assess fetal growth and well-being or re-assess anatomy (76816); may be combined with BPP or BPP without non-stress test.

4. Gender-reveal ultrasound is typically done at 15-17 weeks and performed by technologist, including recording and pictures, optional cash service.
   a. Please note that many organizations strongly discourage the provision of gender-reveal ultrasounds as an anatomy scan will be conducted traditionally at 28-32 weeks.
5. 3D ultrasound at 28-32 weeks performed by technologist, including recording and pictures, optional cash service.
   a. Please note that the ACOG Committee on Ethics discourages the use of nonmedical ultrasound stating that aesthetically pleasing images may provide a false reassurance of fetal health.
   b. Patients and their families must be informed that creating these images is not medically indicated and that the images are for novelty or keepsake purposes only.

Whatever the procedure, for compliant billing, there needs to be a capability for image storage and retrieval as well as report generation. Additionally, if a transvaginal approach is necessary, there are well-articulated guidelines regarding the necessity of high-level disinfection of transvaginal ultrasound probes. As much as possible, ultrasounds should be scheduled in conjunction with the provider visit (ultrasound first) for patient convenience and to allow the provider to discuss the status of fetal development with the patient shortly thereafter. This also allows the provider an opportunity to view and bill for the professional component of the ultrasound immediately and avoids the need for a separate point of contact to give the patient her results.

The appropriate scheduling template for ultrasound appointments will vary based on the ultrasound technician’s skill and experience, and whether the professional component (physician reading and signing off on the ultrasound) is performed simultaneously or at a later time. Since blocking a physician’s schedule to read ultrasounds at the patients’ bedside may be inefficient, a best-documented practice is to have physicians review their own patients’ ultrasounds during their assigned administrative time, or at the time of a same-day patient appointment. Please note that if the provider is not reviewing the images prior to discussing the results with the patient, the practice...
In-office ultrasound is an important part of the OB-GYN office, for quality of care, patient satisfaction, and revenue generation.

Ultrasound technologists should be certified by the American Registry of Diagnostic Medical Sonographers (ARDMS) and should have additional certification in both obstetrics/gynecology and physics.

At least one technician should have additional certification in nuchal translucency measurement, which can be obtained through either the Fetal Medicine Foundation (FMF) or the Nuchal Translucency Quality Review (NTQR) program.

A typical ultrasound room requires approximately 150 square feet (compared to 100 square feet in a typical exam room).

As much as possible, ultrasounds should be scheduled in conjunction with the provider visit (ultrasound first) for patient convenience and to allow the provider to discuss the status of fetal development with the patient shortly thereafter.

A typical full-time ultrasound technician may have up to 20 ultrasound appointments per day and up to 100 per week.

Key Takeaways

- In-office ultrasound is an important part of the OB-GYN office, for quality of care, patient satisfaction, and revenue generation.
- Ultrasound technologists should be certified by the American Registry of Diagnostic Medical Sonographers (ARDMS) and should have additional certification in both obstetrics/gynecology and physics.
- At least one technician should have additional certification in nuchal translucency measurement, which can be obtained through either the Fetal Medicine Foundation (FMF) or the Nuchal Translucency Quality Review (NTQR) program.
- A typical ultrasound room requires approximately 150 square feet (compared to 100 square feet in a typical exam room).
- As much as possible, ultrasounds should be scheduled in conjunction with the provider visit (ultrasound first) for patient convenience and to allow the provider to discuss the status of fetal development with the patient shortly thereafter.
- A typical full-time ultrasound technician may have up to 20 ultrasound appointments per day and up to 100 per week.
- When using transvaginal approach ultrasound probes, be sure to have in place well-monitored processes for high-level disinfection.

A typical ultrasound schedule using highly trained and experienced technicians will allow 30 minutes for anatomy and BPP ultrasounds, but other obstetric ultrasounds and most gynecologic ultrasounds can be performed at 20-minute intervals. A template may thus include set 30-minute slots for anatomy ultrasounds and/or BPP, with set hours scheduled at 20-minute intervals for other visit types. Another option is to book two 20-minute time slots for anatomy or BPP visits, allowing the technician some “catch up” time. The appropriate number of 20 vs. 30-40 minute time slots will vary by practice and should be constantly monitored and adjusted to ensure quality while maximizing productivity.

Using this model a typical full-time ultrasound technician may have up to 20 ultrasound appointments per day or 100 per week. A typical generalist OB-GYN practice maximizing use of ultrasound will generate 20-25 percent of their annual practice revenue from this service with an approximate split of one-third gynecology and two-thirds obstetrics.

Understand various models of physician compensation plans and what each one entails. The models are in three categories: productivity-based plans, base salary plus incentives, and fixed salary. Review part-time work, minimum work standards, and the time off policy.

Physician Compensation

Physician compensation plans vary among groups and are usually a function of the group’s culture. Most employed physicians’ compensation plans are driven by productivity or at a minimum are productivity related. Most productivity plans are based on wRVU, whether they convert on a 1:1 basis or have a threshold requirement or a percent of net professional revenue. The benefit of a wRVU system is that it is an external system annually established by Medicare and therefore correlates to the payment system. Additionally, there is no delay in capture of revenue for the provider, as compensation is based on when work is done not on when payment is received. The downside of a wRVU system is that the government does not always value CPTs fairly or value the effort and training required to perform a particular wRVU. The benefit of a percent of net professional revenue is that compensation can increase as payer contracts improve and may include payment for quality. The downsides of a percent of net
professional revenue are that compensation can decrease based on changing payer mix or rate reductions, and there is a lag time between service and payment that will affect provider revenue.

While productivity predominately drives compensation plans, it is important to align other incentives as well. Migration towards models compensating both clinical productivity and non-clinical metrics is evident. Non-clinical metrics can include clinical quality, citizenship or behavior, and operational goals such as timely discharge. It is anticipated this migration will continue and best practices will incorporate up to 20 percent in variable, goal-related physician compensation.

**Physician Compensation Plan Models**

<table>
<thead>
<tr>
<th>Description</th>
<th>Application Note</th>
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<tbody>
<tr>
<td><strong>Productivity-Based Plans</strong></td>
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<tr>
<td>Clinical work is valued at a per wRVU or a % of net revenue at an established conversion rate. The converted productivity units are either accumulated and distributed to physicians based on a predetermined formula or paid directly to the physician creating the productivity unit.</td>
<td></td>
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<tr>
<td><strong>Base Salary Plus Incentives</strong></td>
<td>As reimbursement continues to move toward a value basis, the &quot;base plus&quot; model continues to enjoy favor. Incentives, though initially a small component of total compensation, are rising each year with the expectation it will eventually approximate 20-30%. Physicians are paid a fixed base salary with various incentives for the achievement of quality, operations, and productivity goals. Typically, the base salary is anchored to a benchmarked scale or to a minimum productivity threshold.</td>
</tr>
<tr>
<td><strong>Fixed Salary</strong></td>
<td>Fixed salary compensation plans tend to be shorter in duration and appropriate for new physician hires during a probationary period (1-2 years) while they are growing their practice. Physicians are paid a fixed salary.</td>
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**Key Physician Compensation Program Considerations in OB-GYN**

Weekend, weekday, and holiday call responsibilities are generally required to participate fully in any physician compensation plan. Physicians who are allowed to be excused from call responsibilities are generally penalized 25 – 35 percent of their compensation.

Practices must determine whether physicians will be allowed to practice part time. Practices also must create a mechanism to request changes in status and a methodology to address compensation. In most practices, IF part-time physicians are allowed, they still must meet call requirements. Additionally, most part-time arrangements are for a certain time period with caveats that any change in status requires approval. Practices must also determine whether physicians will be allowed to perform gynecology services only. If some physicians are allowed to stop performing obstetrics, the practice must be prepared for the increase in call coverage for others.

Minimum work standards are typically established as a component of the compensation plan. Issues such as the number of days per workweek, call responsibilities, weekend and holiday rotations, and similar items are typically addressed in a work standard policy.

Physicians who are participating in call with their group need to have an arrangement for when a physician delivers a patient of a partner. These arrangements can be informal and just an expected responsibility or they can be complex to include internal payments among physicians for performing deliveries.

**Key Takeaways**

- Compensation plans should support the practice strategy and be in alignment with the practice’s strategic plan
- A portion of compensation should be variable dependent on achievement of goals
Identify key elements pertaining to gynecology.

Gynecology Considerations

While the primary goal of this playbook is to discuss issues unique to obstetrics, a brief mention of gynecology is warranted.

An office gynecology practice will function similarly to a primary care office with visits typically scheduled at 15-minute intervals and no more than two new patients per hour. With well-trained MAs preparing and updating the patient EHR record and a high volume of return well-woman exams (which are generally less time intensive), up to five patients per hour can manageably be seen.

Patient satisfaction is increased when providers meet new patients in a comfortable office setting prior to moving to an exam room. In a typical three-exam room setting, the physician office adds an additional point in the patient rooming flow, so seeing new patients in the physician office can be managed without
slowing down provider workflow. Office architecture ideally considers this and places provider offices within or adjacent to the patient exam rooms used by that provider. In a mixed obstetrics and gynecology practice, consideration may be made to assigning one “baby-free” exam room in each work area, to utilize for patients who have particular sensitivity or adversity to being surrounded by pregnant women, babies, and baby pictures (such as infertility patients, patients with recent pregnancy loss, or postmenopausal patients). Similar to the considerations discussed above for obstetrics, other patient satisfiers include having an on-site laboratory and ultrasound capability and the ability to accommodate same-day urgent visits (generally with an APP). Depending on a physician’s patient base and practice maturity, consider setting aside one or more days or half-days for gynecologic surgery to avoid patient reschedules and the potential for running late returning to the office.

Especially when mature physicians opt to limit or eliminate obstetrics, opportunities for revenue generation through the addition of aesthetic services may be considered, such as laser hair removal, skin treatments, Botox, and cosmetic labiaplasty or vaginoplasty. Adding this type of additional non-traditional service requires a significant investment in time and money for training and business development, and may not be cost effective in all practices.

Key Takeaways

- An office gynecology practice will function similarly to a primary care office, with visits typically scheduled at 15-minute intervals and no more than two new patients per hour

- Patient satisfaction and workflow efficiency can be enhanced in a variety of ways including seeing new patients in a physician office, assigning a “baby-free” exam room, on-site labs and ultrasound, and same day visits