Are There Alternatives To ED On-call Pay?

By Steven Nahm, for HealthLeaders News, Apr. 19, 2007

Physicians are increasingly less willing to serve on emergency department call panels. As a result, hospitals throughout the nation are reporting shortages of specialists to treat ED patients. According to a survey conducted by the American College of Emergency Physicians in 2005, nearly three-quarters (73 percent) of emergency department medical directors reported inadequate on-call specialist coverage, compared with two-thirds in 2004.

While there are a variety of reasons for the declining number of on-call clinicians, the primary ones are an aging physician workforce and attendant “lifestyle” concerns. In 1975, the American Medical Association reported just under half of physicians were older than 45. In 2005, that figure reached 61 percent. A 55-year-old physician may already have served on-call duty for 25 years, and it is natural to seek relief from that responsibility. Meanwhile, there are fewer young physicians who are willing to emulate the work patterns and accept the on-call responsibilities of their senior peers.

To ensure adequate coverage, many hospitals have worked out payment plans with physicians as an inducement to accept on-call duty. The arrangements must meet the rigor of fair market value and be unrelated to referrals. There are variations to the plans, but the typical arrangement will include payments to physicians via:

- A stipend paid per day of ED on-call
- Payment per service at Medicare rates (usually limited to indigent patients admitted via the ED)
- A combination of a stipend plus payment per service

While the payments help physicians cope monetarily with a rising tide of uninsured patients, as well as escalating medical liability insurance premiums, they do not address an underlying problem—alleviating physicians’ on-call burden in the ED. Thus, many physicians find the payments the equivalent of a short-term pain reliever, but not a cure.

ED on-call payments to physicians may be a necessary evil to deal with uninsured patients and malpractice risks, but there are numerous other options that may better address what most physicians want—less calls and fewer burdens when on call. They should also enhance continuity of care and overall patient safety.

Market-driven issues

Solutions and alternatives to a lack of ED on-call coverage are often market-specific. In some communities, the lack of specialty coverage may have less to do with lifestyle issues, and more with the cost associated with non-compensated care or malpractice risk. Where permissible under corporate practice of medicine laws, this has driven hospitals to employ physicians as a way to insulate them from these factors.
Other communities have taken a regional call panel approach to coverage, whereby a coordinated plan is agreed upon and hospitals take responsibility to ensure specific emergency services for given days or weeks. There are practical limitations to regional solutions due to competition among hospitals, anti-trust concerns, facility licensing requirements, and payer mix variances. Such regional call plans should be designed by, or with, EMS input and buttressed with transfer agreements.

One hospital’s solution
A definitive solution to the problem is elusive, but hospitals are investing in strategies they believe will bring relief. For example, at Providence St. Peter Hospital in Olympia, WA, management is instituting five major recommendations designed to help physicians cope with call responsibilities. “We surveyed our medical staff and found two-thirds of physicians thought ED call solution (on-call) is not about the money, but about lifestyle,” said Assistant Administrator Lori Van Zanten. “We had to find ways to bring relief from the burden of ED on-call. Physicians want their time back.”

Working with the medical staff, Providence St. Peter Hospital management formed a steering committee that included 15 physicians representing all specialties. The committee’s charge was to identify programs that could mitigate the ED on-call burden, while also improving service and quality. Hospital management and its board made a commitment to invest in the infrastructure of programs that met these criteria. Based on the committee’s recommendations, the hospital is now implementing the following programs:

- Hospitalist Services--The establishment of a hospitalist program for the admission of unassigned patients was the leading recommended solution. Hospitalists provide relief to physicians and surgeons when working under agreed upon rules of engagement. Hospitalists are also considered to produce a superior return on investment versus ED on-call payments.

- Nurse Practitioner Surgical Assistants--Providence is hiring highly skilled nurse practitioners who will assist with trauma surgery admissions and post-surgery care. They will also serve as the second assistant to the primary surgeon, reducing the need to call in a second surgeon.

- Dedicated On-Call OR--The hospital has designated a well equipped OR suite to be available for on-call surgery starting at 1 p.m. daily. The availability of the suite and staff permits a greater number of on-call surgeries to be performed during routine hours, as opposed to late evening “add-ons.”

- Pediatric Hospitalist Coverage (Newborn Nurse Practitioner Coverage)--The increased number of unassigned newborns at the hospital has stretched its pediatricians’ ability to provide inpatient care. Providence has instead hired pediatric hospitalist physicians and nurse practitioners to provide newborn care. This allows the community pediatricians to focus on their clinic patients during the day without frequent calls to come into the hospital to attend unassigned newborns. (The nurse practitioners are supervised and trained by the neonatal program).

Using technology to tackle ED on-call
Depending on the particular needs at a facility, investing in electronic health records and physician portals are also beneficial alternatives to ED on-call payments. Patient records can be accessed quickly and sometimes off-site, often allowing the physician to make rational medical decisions without coming to the hospital.
There are also other applications that expand the specialty coverage at a hospital, offering relief to overburdened clinicians or supplementing the lack of coverage. The most common of these applications include:

- **Teleradiology**—Radiology groups are purchasing after-hours interpretations from firms that have radiologists available to view digitized images at all hours, transmitted via the Internet. Hospitals often pay for this coverage, particularly in rural settings.

- **Electronic ICU**—To help reduce the ED on-call and general coverage burden on pulmonary and critical-care physicians, hospitals are purchasing specialized monitoring services. Critical-care physicians and nurses are linked via the internet and are provided real-time data and visual images of ICU patients. These clinicians remotely monitor patient status and provide phone guidance to the ICU staff. This remote ICU supervision has reportedly reduced clinical crises and helped lower the number of nursing calls to attending physicians.

- **Telehealth or Telediagnosis**—A growing trend is the visual and digital linkage with remote specialists from a hospital’s ED or patient floors. The specialists are often located at tertiary referral centers, and they aid local clinicians in patient assessments, diagnosing, and treatment decisions. A leader in this service is The Kansas University Center for TeleMedicine & TeleHealth of the Kansas University Medical Center. The U.S. Army is even extending this capability to the creation of a trauma pod, whereby surgery can be performed remotely.

**How to get there**

Informed, creative thinking with a problem solving mindset will help germinate effective strategies. Solutions are best generated through a working committee with medical staff input. This committee should make decisions based on objective data and work under a set of guiding principles and criteria. In addition, the number of physicians involved should be sufficient to ensure representation and input from all specialties.

The solution starts with a clear identification and ranking of the problems medical staff members have with ED on-call. This is accomplished through medical staff committees and one-on-one interviews and surveys. Understanding the magnitude of the ED on-call burden through data analysis of volume and payer mix is also necessary.

Educational sessions are held to arm participants with knowledge and data, who are then challenged to think creatively. Strategies are identified and their impact assessed and ranked against cost versus value criteria.

A hospital’s answer to ED on-call will reflect the nature of its community, state and federal laws, as well as its own situation. There may be multiple strategies employed and they may vary by specialty, but the objective is to devise a solution that all parties find is equitable, economically feasible, and truly addresses the issues confronting the hospital and its medical staff.

**Steven Nahm** is a vice president of The Camden Group, a hospital consulting firm in El Segundo, CA. He may be contacted at (310) 320-3990 or snahm@thecamdengroup.com.