

Innovative Solutions to On-Call ED Specialty Coverage

2005 Interim AMA Organized Medical Staff Section Assembly

Friday, November 4, 2005 from 4:15 to 5:45 pm

Wyndham Anatole Hotel, Dallas, Texas

Presented By Todd B. Taylor, MD, FACEP

PRESENTATION ABSTRACT

Increasingly, physician specialists are finding it difficult to fulfill the duties required of being on-call for hospital emergency departments (ED). These factors include EMTALA and other liability risks, lack of reimbursement, practice & lifestyle disruption, the chaotic ED environment, patients who are unable or unwilling to follow proscribed treatment plans, and less reliance upon hospitals for patient referrals. Despite this, and other changes in healthcare, many hospitals continue to rely upon "volunteerism" by the medical staff to provide vital and often life-saving specialty emergency care. To meet the federal EMTALA mandate, hospitals frequently find it necessary to require their medical staff to take ED specialty call. As a result, many physicians have reassessed their business practices and reduced the number of hospitals where they are on-staff or in some cases eliminated hospital practice altogether. This situation has resulted in discord between hospitals and the medical staff and left EDs with incomplete and inadequate specialty coverage.

With this backdrop of legal, regulatory, staffing, reimbursement, and delivery of service issues, this session with focus on the current state of on-call ED specialty coverage in America and explore promising innovative solutions. Workable, collaborative approaches that can serve as models for medical staffs and hospitals of all types will be discussed.

For a PDF of this handout or more information about this topic contact: ttaylor@acep.org

LEARNING OBJECTIVES

- 1) Identify the issues & challenges facing hospitals & medical staffs.
- 2) Learn three solutions being utilized in various hospitals settings.
- 3) Understand the risks & benefits of collaborative solutions.

ABOUT THE PRESENTER

Todd B. Taylor, MD, FACEP is Council Speaker (House of Delegates) for the American College of Emergency Physicians (ACEP). He received his Doctor of Medicine from Indiana University School of Medicine and completed a residency in Emergency Medicine at Mount Carmel Mercy Hospital in Detroit, Michigan. He is board certified by the American Board of Emergency Medicine and serves as a Fellow of the American College of Emergency Physicians. He is Affiliate Assistant Professor for the Arizona College of Osteopathic Medicine in Phoenix, Arizona and practices and teaches clinical emergency medicine at Banner Good Samaritan Medical Center, a 700-bed, level one trauma, and tertiary referral center.

For the past 12 years he has also served as Vice-President for Public Affairs for the Arizona College of Emergency Physicians. His volunteer activities have afforded him the opportunity to gain experience in ED Crowding & Ambulance Diversion, EMTALA, Healthcare Legislative & Regulatory Advocacy, Healthcare Policy, Managed Care Issues, Emergency Medicine Management, Coding, & Billing, and many other issues facing emergency medicine & healthcare.

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“We should start with what we have, not with what we lack”

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THE PROBLEM: Circular Responsibility for On-Call ED Specialty Coverage

- ⇒ Health plans say its medical staff problem - Medical staff say its a hospital problem - Hospitals say its a health plan problem - Emergency physicians are left responsible
- ⇒ Patients are the ones that suffer due to our inability/unwillingness to deal with the issues
- ⇒ Ultimately it's a patient (community) problem, but it is the responsibility of the entire healthcare system
- In 30 years we dramatically changed the way we fund healthcare, but have changed little how it is delivered.
- On-Call: High liability, inconvenient, disruptive to life & practice, inability of patients to follow prescribed care, low/no reimbursement – who would want this business?
- As on-call panels of hospitals erode, the American safety net goes with it.

SOLUTIONS: We have already tried all the things we wanted to do to solve it.

“Hospitals (& physicians) must decide what it is they wish to be to their community”

James Richardson, JD, General Counsel, University Medical Center, Tucson, Arizona

On-call ED specialty coverage solutions are 80% organizational & only 20% financial. However, both must be addressed in a fair and equitable way using sound business & managerial principles.

Non-Solutions

- EMTALA (& other regulatory mandates) may be part of the problem, but are not the solution.
- Malpractice liability may part of the problem, but liability reform is not the solution.
- Privilege Coverage: Mandating call by virtue of medical staff privileges (increasing a non-viable solution)
- Legislating on-call duty as condition of physician or hospital licensure (specialty hospitals)
- Ignoring it – Hoping it will go away

Contracting with Health Plans

- Hospitals that contract with specific health plans should include specialty coverage as part of the contracting process. It is irresponsible for health plans & hospitals to contract for delivery of services without assuring that appropriate providers will be readily available at that hospital.
- On-call physician services are now a commodity like any other hospital personnel expense (e.g. nursing, housekeeping, etc.) & these costs must be budgeted for & accounted for in contracting with health plans.
- Physicians should take on-call duties into account when dealing with & in contracting with health plans. (See “Potential Solutions to Managed Care Contracting Issues”)

Hospital Contracting with Providers for On-Call Specialty Services

- Direct contracting with providers or a group of providers at market rates
- Hire specialists as hospital employees (“university model”) – illegal in some states (“corporate practice of medicine”)
- On-Call Specialty Physician Management Company (e.g. Emergency & Acute Care Medical Corp - eacmc.com)
- On-Call Physicians “IPA” – Hospital or independent practice association that manages ED on-call services including practice management services such as scheduling, billing, compensation, etc.

Legislative/Regulatory Examples: [see Additional Reading & Resources]

- Arizona Access to Emergency Healthcare [AZ SB1286(1996)] – The “Imprudent Layperson” Standard for ER care
- Arizona DOI Network Adequacy Rule Making – Requires health plans to assure adequate physician coverage
- Liability & Reimbursement Reform: Access to Emergency Medical Services Act of 2005 (HR 3875)

Hospital & ED Specific Examples: [see Additional Reading & Resources]:

- Point of Service Revenue Capture Program (aka Turnstile ED & Charity Care Program)

Acute Care Specialists: “Taking the crumbs nobody wants & make them into lunch.”

- Burgeoning group of specialists interested in only doing acute care (traumatologist, intensivist, etc.)

Organizational:

- Hospital\medical staff perks for taking call:
 - ◆ Preferential scheduling for OR
 - ◆ Personal assistance when in the ED (to help deal with the inefficient unfamiliar chaotic environment)
 - ◆ Waive medical staff dues, free meals, better\valet parking, etc.
 - ◆ Cover liability for on-call duties
- Active involvement in local & regional healthcare community
 - ◆ Coordinate with EMS to direct specific maladies to hospitals with necessary services. Already common with major trauma, but increasingly necessary for stroke, neurosurgery, ophthalmology, hand surgery, etc.
 - ◆ Coordinated regional call coverage:
 - EX: Hand surgery coverage rotates between 3 hospitals a week at a time.
 - On-Call Resources Web Site – List each hospital's on-call daily resources. Allows for tracking & planning of regional specialty resources.
 - Establish & certify Centers of Excellence: e.g. stroke, cardiac, neurosurgery, etc.
 - ◆ State coordinated services linked to Medicaid &/or Workman's Comp.
 - EX: Regional Hand Injury Rehabilitation Program (see www.azcep.org/azcep/outline.doc)

Physician Supply Issues:

- Change how we train doctors, limit physician supply, retain physicians we do train
- Grants for training & provision of specialty care where shortages exist

Pearls & Pitfalls:

1. Active collaboration between hospital administration & medical staff via medical staff services is a must. When this breaks down, everyone is headed for difficult times.
2. The hospital has the EMTALA obligation to provide on-call physician services and must do so by any necessary means.
 - Ultimately, if the hospital cannot retain the cooperation of the medical staff to provide on-call for a particular service, it must eliminate that service for all patients (including elective cases).
 - EX: If the orthopedic surgeons refuse to provide a fair share of on-call coverage for the ED, the hospital may be forced to discontinue all orthopedic services (elective & emergency).
3. Hospital & medical staff should agree upon what services they intend to provide taking into account all regulatory requirements, necessary ancillary services, and equipment.
 - Corollary: Identify those services not available at all or during certain times, and devise a plan for how patients in need of such services will receive them when necessary (i.e. transfer where?)
4. Change the culture – STOP:
 - Health plan “stupid payment tricks”
 - Hospital stonewalling
 - Provider extortion
 - Managing by crisis
5. Cooperation, Organization, Innovation, More Cooperation . . .
 - Hospitals & medical staff that refuse to cooperate do so at their own peril & the peril of their patients.
6. Put some one in charge with the expertise, resources and authority to solve the issues.

EMTALA

[Excerpts from ACEP Comments to the EMTALA CMS Technical Advisory Group – Oct 2005]

“The on-call issue is complex, highly politically and economically charged, and EMTALA is only one reason driving the diminishing availability of on-call services by our nation's physician specialists. The uncompensated care burden, malpractice liability issues, decreased reimbursement from Medicare and Medicaid, difficulties obtaining payment from managed care entities, and lifestyle issues are more or equally compelling reasons physicians avoid ED on-call services.

“Physicians now recognize the onerous burdens and penalties of EMTALA. They can no longer define their practice to a local community, regional referral area, or limit the volume of cases they must accept. They have no choice over which patients they must accept and treat when on-call. As the neurosurgeons have learned, when on-call for one hospital they are literally on-call for the entire United States.

“In response, physicians have devised ways to avoid ED services. Many physicians have cut down the number of call days they provide hospitals. Physicians have also curtailed their hospital privileges to specifically minimize their exposure to ED patients and on-call duties.

“EMTALA was never intended to be a 'standard of care law'; nor supersede the state's purview regarding the quality of the care provided. Well meaning, but perhaps misguided, attempts by providers and regulators alike to use EMTALA to solve quality of care issues and longstanding deficiencies in the US health care system has led to frustration, confusion, undue liability exposure, and diminishing availability of access to emergency services, particularly on-call physician services. Primarily, EMTALA is intended to attach a duty that did not exist in common law - a duty for hospitals to uniformly examine (i.e. provide an 'appropriate' medical screening examination) all who present to the ED regardless of their financial status and to determine if an 'emergency medical condition' (EMC) exists, as defined by law. EMTALA is a limited purpose law; it was not drafted to solve all issues related to access to health care in the United States; and Congress did not intend EMTALA to govern all aspects of medical care provided in our nation's emergency departments (ED). EMTALA is law, not medicine.

“A new reality for the American healthcare system is that there will always be gaps in on-call coverage at the vast majority of hospitals in the U.S. This means that some patients will inevitably suffer adverse outcomes because of the delay in obtaining or the inability to obtain needed subspecialty services on an emergency basis. EMTALA cannot and was never designed to solve this resource shortage issue. The 'best meets needs standard', sanctioned as official policy by CMS, makes the provision of on-call physician services too complex, too variable, and has already spurred numerous lawsuits against the hospitals for failure to provide adequate on-call coverage of subspecialists.

“The statutory language should be interpreted to mean that hospitals are only required to maintain a list of those physicians who have voluntarily or contractually agreed to take call, so that the ED is prospectively aware of what on-call physician resources are available for any given day. The language of the statute says "to maintain a list of physicians who are on-call"; it doesn't say that the hospital must actually provide on-call physicians.

“ACEP recommends that hospitals simply be required to prospectively post a list of who is on-call so that the ED is aware at all times what services are immediately available and so that it can inform community EMS and when necessary make transfer arrangements with other hospitals with greater specialty service capacity.

“If CMS interprets the statutory language to mean that the hospitals must actually provide on-call physicians by forcing its medical staff to accept on-call responsibilities, then CMS is duty bound to tell hospitals exactly what level of on-call service it must provide to its ED, either based on the type of patients presenting to the ED and/or based on the capabilities of its medical staff. For CMS to say it will conduct a 'facts and circumstances analysis for each facility retrospectively at the time of a compliance investigation' is wholly inadequate because no hospital in the country will know what the law requires or what it must do in advance to attain compliance.

“ ‘That best meets the needs of the hospital's patients’, is an invitation to litigation and should be eliminated. It creates a slippery slope of near impossible compliance and unlimited, inconsistent retrospective enforcement and civil litigation. No hospital could possibly know in advance what it must do to ensure compliance with the law. No hospital can possibly provide on-call coverage that 'best meets the needs' of all of the hospital's ED patients. . .

CMS should, “Clarify that on-call physician follow-up care after an ED visit is not governed by EMTALA. Once the hospital ED determines that an EMC does not exist or stabilizes an EMC prior to discharge, the EMTALA duty ends.”

Summary of Pertinent EMTALA CMS Interpretive Guidelines Tag A404 - On Call Physicians - §489.20(r)(2) & §489.24(j)

§489.20 (r)(2)

A list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition

Section 1866 (a)(1) of the Act states, as a requirement for participation in the Medicare program, that hospitals must maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an EMC. The on call list identifies and ensures that the emergency department is prospectively aware of which physicians, including specialists and subspecialists are available to provide care.

A hospital can meet its responsibility to provide adequate medical personnel to meet its anticipated emergency needs by using on call physicians either to staff or to augment its emergency department, during which time the capability of its emergency department includes the services of its on call physicians.

CMS does not have requirements regarding how frequently on call physicians are expected to be available to provide on call coverage. Nor is there a pre-determined ratio CMS uses to identify how many days a hospital must provide medical staff on call coverage based on the number of physicians on staff for that particular specialty. In particular, CMS has no rule stating that whenever there are at least three physicians in a specialty, the hospital must provide 24 hour / 7 day coverage in that specialty. Generally, in determining EMTALA compliance, CMS will consider all relevant factors, including the number of physicians on staff, other demands on these physicians, the frequency with which the hospital's patient typically require services of on call physicians, and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on call physicians is unable to respond. On call coverage is a decision made by hospital administrators and the physicians who provide on call coverage for the hospital. Each hospital has the discretion to maintain the on call list in a manner that best meet the needs of the hospital's patients who are receiving services required under EMTALA in accordance with the resources available to the hospital, including the availability of on call physicians. The best practice for hospitals, which offer particular services to the public, is that those particular services should be available through on call coverage of the emergency department.

Physicians' group names are not acceptable for identifying the on call physician. Individual physician names are to be identified on the list.

§489.24(j)(1)

(j) Availability of on call physicians.

(1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians.

Hospitals have the ultimate responsibility for ensuring adequate on call coverage. Hospitals participating in the Medicare Program must maintain a list of physicians on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an EMC. Hospitals have an EMTALA obligation to provide on call coverage for patients in need of specialized treatment if the hospital has the capacity to treat the individual.

No physician is required to be on call at all times. On call coverage should be provided for within reason depending upon the number of physicians in a specialty. A determination about whether a hospital is in compliance with these regulations must be based on the facts in each individual case. The surveyor will consider all relevant factors including the number of physicians on staff, the number of physicians in a particular specialty, other demands on these physicians, the frequency with which the hospital's patients typically require services of on call physicians, vacations, conferences, days off and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on call physician is unable to respond.

If a staff physician is on call to provide emergency services or to consult with an emergency room physician in the area of his or her expertise, that physician would be considered to be available at the hospital. A determination as to whether the on call physician must physically assess the patient in the emergency department is the decision of the treating emergency physician. His or her ability and medical knowledge of managing that particular medical condition will determine whether the on call physician must come to the emergency department.

When a physician is on call for the hospital and seeing patients with scheduled appointments in his private office, it is generally not acceptable to refer emergency cases to his or her office for examination and treatment of an EMC. The physician must come to the hospital to examine the individual if requested by the treating emergency physician. If, however, if it is medically appropriate to do so, the treating emergency physician may send an individual needing the services of the on call physician to the physician's office if it is part of a hospital-owned facility (department of the hospital sharing the same Medicare provider number as the hospital) and on the hospital

Summary of Pertinent EMTALA CMS Interpretive Guidelines Continued

campus. In determining if a hospital has appropriately moved an individual from the hospital to the on call physician's office, surveyors may consider whether (1) all persons with the same medical condition are moved in such circumstances, regardless of their ability to pay for treatment; (2) there is bona fide medical reason to move the patient; and (3) appropriate medical personnel accompany the patient.

If a physician who is on call does not come to the hospital when called, but rather repeatedly or typically directs the patient to be transferred to another hospital where the physician can treat the individual, the physician may have violated EMTALA. Surveyors are to assess all facts of the case prior to making a recommendation to the RO as to whether the physician violated EMTALA. Surveyors are to consider the individual needs and the physician circumstances, which may have an impact upon the case. Each case is to be viewed on its own merit and specific facts.

For physicians taking call simultaneously at more than one hospital, the hospitals must have policies and procedures to follow when the on call physician is not available to respond because he has been called to the other hospital to evaluate an individual. Hospital policies may include, but are not limited to procedures for back up on call physicians, or the implementation of an appropriate EMTALA transfer according to 42 CFR §489.24(e). The policies and procedures a hospital adopts to meet its EMTALA obligation is at the hospital's discretion, as long as they meet the needs of the individuals who present for emergency care taking into account the capability of the hospital and the availability of on call physicians.

The decision as to whether the on call physician responds in person or directs a non-physician practitioner (physician assistant, nurse practitioner, orthopedic tech) as his or her representative to present to the dedicated ED is made by the responsible on call physician, based on the individual's medical need and the capabilities of the hospital and applicable State scope of practice laws, hospital bylaws, and rules and regulations. The on call physician is ultimately responsible for the individual regardless of who responds to the call.

[Telemedicine section redacted]

Physicians that refuse to be included on a hospital's on call list but take calls selectively for patients with whom they or a colleague at the hospital have established a doctor-patient relationship while at the same time refusing to see other patients (including those individuals whose ability to pay is questionable) may violate EMTALA. If a hospital permits physicians to selectively take call while the hospital's coverage for that particular service is not adequate, the hospital would be in violation of its EMTALA obligation by encouraging disparate treatment.

If a physician on call does not fulfill his obligation to the hospital, but the hospital arranges for another staff physician in that specialty to assess the individual, and no other EMTALA requirements are violated, then the hospital may not be in violation of the regulation. However, in this circumstance, the physician who has agreed to take call and does not come to the hospital when called may have violated the regulation.

CMS allows hospitals flexibility in the utilization of their medical personnel. Allowing exemptions from it call schedule for certain medical staff members (senior physicians) would not by itself violate EMTALA.

Surveyors are to review the hospital policies or medical staff bylaws with respect to response time of the on call physician. If a physician on the list is called by the hospital to provide emergency screening or treatment and either refuses or fails to arrive within the response time established by hospital policies or medical staff bylaws, the hospital and that physician may be in violation of EMTALA. Hospitals are responsible for ensuring that on call physicians respond within a reasonable period of time. The expected response time should be stated in minutes in the hospitals policies. Terms such as "reasonable" or "prompt" are not enforceable by the hospital and therefore inappropriate in defining physician's response time. Note the time of notification and the response (or transfer) time.

§489.24(j)(2)(i) (2) The hospital must have written policies and procedures in place—

(i) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and

The medical staff by-laws or policies and procedures must define the responsibility of the on call physicians to respond, examine and treat patients with an EMC.

Physicians, including specialists and subspecialists (e.g., neurologists) are not required to be on call at all times or required to be on call in their specialty for emergencies whenever they are visiting their own patients in the hospital. The hospital must have policies and procedures (including back-up call schedules or the implementation of an appropriate EMTALA transfer) to be followed when a particular specialty is not available or the on call physician cannot respond because of situations beyond his or her control. The hospital is ultimately responsible for providing adequate on call coverage to meet the needs of its patients.

ADDITIONAL READING & RESOURCES

- ACEP EMTALA Web Page: www.acep.org/webportal/PracticeResources/IssuesByCategory/EMTALA/default.htm
- Call Coverage Strategies: Securing Physician On-Call Cooperation Best Practices Implementation Kit. The Advisory Board Company. Jan 2003. The Watergate, 600 New Hampshire Ave., N.W., Washington, D.C. 20037
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<http://www.cmanet.org/member/upload/CMA%20On%20Call%20Survey%20Summary%20of%20Results.doc>
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- Ensuring Adequate On-Call Backup in the ED. ACEP, Dallas, TX.
Available at: <http://www.acep.org/webportal/PracticeResources/IssuesByCategory/Administration/NewsandPublicationsEnsuringAdequateOnCallBackupintheED.htm>
- Availability of On-Call Specialists. ACEP, Dallas, TX. - May 2005
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Summary available at: <http://www.azcep.org/azcep/sb1286.pdf>
- Arizona DOI Network Adequacy Rule Making. Title 20, Chapter 6, Article 19. "Health care services organizations oversight" – Available at: http://www.azsos.gov/public_services/Table_of_Contents.htm (pending final approval in Dec 2005. For summary e-mail: ttaylor@acep.org)
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American College of
Emergency Physicians®

Availability of On-Call Specialists

an Information Paper

*Developed by Members of the
Emergency Medicine Practice Committee*

May 2005

Mitigating the Crisis

Though there would likely be considerable debate about health care policies directed at providing care for every American at some level, all would likely agree that the safety net currently resides in our acute care hospitals. If asked, it is unlikely that any citizen would not be able to give “the emergency department (ED)” as the answer to where they would seek care if they needed it. The inconsistency of that care delivery to those without means of reimbursement led to a legislative solution in the form of the Emergency Medical Treatment and Active Labor Act (EMTALA). With the advent of EMTALA, all acute care hospitals were placed on notice that they would be expected to ensure that all patients would receive equivalent care for all services provided at that hospital regardless of their ability to pay. “Crisis” may often be overused, but it properly describes the concern about the ability of patients to access the level of care needed to meet their needs. As the call panels of hospitals erode, the safety net goes with it. In these circumstances, there is real discomfort that patients may not be able to access all types of needed care in a timely manner, if at all.

In order to effectively introduce solutions to the inability to cover hospital call, it is important to understand what factors have led to the current circumstances. The practice of medicine is dramatically different from a generation ago. The shift in both how physicians are perceived and their perception of their role in health care helps one understand why there is a current crisis.

Traditionally, the hospital was an essential part of a physician’s practice for nearly every specialty. They relied on the hospital mechanisms to build a practice, and for many specialties, the hospital was essential in providing care. Most physicians concentrated their education and work on the clinical practice of medicine, relegating the “business” to those who focused on the non-clinical issues. Clearly, this is not the current situation. With the advent of newer technologies and treatments, more medical care can be delivered in a less comprehensive setting. Adding to this is the sense by many physicians that they can deliver more efficient care in a more specialized setting. With all of these changes, many physicians, especially those in specialty care, no longer feel they need the hospital to build and maintain a practice. In fact, there is a sense that the attachment to the hospital detracts from their ability to maintain a successful practice.

Unfortunately, the legislative and regulatory activities to date have exacerbated this situation. Given the right incentives, it is highly likely that most physicians would provide their services on an urgent basis. The reality is that expenses are higher, especially with an escalating cost of liability insurance. At the same time, reimbursement is lower with increasing numbers of uninsured at the same time as reimbursement rates for those who have some form of payment are decreasing. Also, it is increasingly difficult to work through the maze of requirements to receive reimbursement that is due. The spin-off of an increasing burden of non-care related activity along with lower reimbursement is that physicians feel they have less time for patient care, especially those with an acute need.

Any attempts to address these concerns have been largely ineffectual from a public policy perspective. What has not been ignored is the continued attempt by policy makers to address all these issues without funding. Hospitals and ED s are bearing the burden of ensuring care for those unable to otherwise access care either due to an acute need or lack of funding. EMTALA demands that hospitals address access to all types of care despite a lack of resources and funding to do so.

Finally, the shift in focus of many physicians has had an impact. Work-life balance has become more of a driving factor. There are those who would suggest that years of observing the baby-boomer generation

work harder in the hope of more rewards have altered the approach of younger generations. Instead of working more to earn those rewards both financial and non-financial at work, there is a shift to tailoring the work environment to fit a desired lifestyle.

In spite of these significant barriers, the mandate to provide care remains both from a regulatory and a moral perspective. Following are some strategies for mitigating the crisis. As you progress, you will find that each section requires more time and often a broader group of constituents to introduce a strategy. The last two categories, legislative efforts and training issues, should be considered longer-term efforts, but may be more sustainable.

Mandatory On-call Requirements for Credentialing and Privileges

Mandating on-call services for all departments of the hospital is a primary method to successfully ensure adequate coverage for all types of medical and surgical procedures. The on-call responsibilities must be explicitly stated in the medical staff rules and regulations for hospital staff credentialing and privileges. They must apply to all physicians to ensure equity among house staff.

Advantages

Mandating on-call requirements for hospital staff credentialing and privileges allows hospitals to maintain their Medicare eligibility and successfully address quality of care issues related to ED coverage.

Requiring on-call coverage of all specialties will generate peer pressure among physicians that will discourage others from shirking call duties. This supports the belief of many physicians that it is the ethical responsibility of the medical staff to provide on-call services.

Disadvantages

Decreased physician satisfaction with mandated call policies and procedures leads to decreased retention. Physicians who do not wish to comply with the mandatory on-call requirements may choose to move their practice to competing hospitals or specialty hospitals where on-call requirements are minimal or nonexistent. This loss of physicians further increases the on-call burden for those physicians that remain. Factors found to influence physician defection are physician-hospital cooperation, hospital prestige, local competition, lack of tort reform and excessive call duty.

Mandatory call services do not always provide for timely care. While hospitals require call coverage from all departments the time-to-treat may vary and be as long as four hours for some specialists. In addition, it is difficult to enforce penalty systems for failure to respond to call in a timely fashion. Hospitals are struggling with an effective system to ensure a minimum time-to-treatment. Most administrators do not enforce penalties for untimely coverage because of the threat that these physicians may defect.

Although all hospital departments are required to provide on-call coverage, the frequency of call duty varies widely by specialty.

Best Practices

To successfully implement mandatory on-call policies and regulations for hospital staff credentialing, a number of best practices have been delineated.

- On-call requirements must be included in hospital bylaws and procedures.¹

- Hospital executive or administrative staff must be responsive to physician concerns regarding on-call policies and bylaws.¹
 - To ensure physician support for mandatory call, on-call physicians must be regularly educated about their obligations and individual responsibilities required by EMTALA.¹
 - Employing a dedicated liaison to concentrate on streamlining the on-call process, negotiate between medical staff and administration and ensure that physicians understand their duties under hospital policy will improve responsiveness.¹
- Physicians are allowed to participate in the strategic and operational decisions made regarding on-call requirements.
- Requirements for physician on-call policies and bylaws must be consistently implemented. Exemptions to call policies and bylaws will serve to undermine the hospital's ability to provide access to emergency services.¹
 - All physicians with hospital privileges must be required to serve on-call.
 - Sub-specialists must maintain the skills to serve call in his own general department to combat the shortage of specialists. If this strategy is adopted, there must clearly be some mechanism to ensure the skills in a non-specialty area meet the standard of care.
- Regular communication of hospital performance is reported to physicians. An on-call physician quality assurance program should be implemented as an ongoing process to assess compliance with mandatory on-call coverage.

Mitigate Burden of On-Call [Unscheduled/Unestablished Patient Care Responsibility]

An issue that is frequently raised by specialists is that the time they spend in the ED is inefficient, with many process and informational barriers to getting their evaluations done expediently. Utilization of strategies that maximize the time the specialist is in the ED, the operating room and the inpatient areas relates to call. The strategies presented here relate to mitigating that burden.

- Identify emergent vs. urgent request for specialist and time necessity of calls. Although there may be disagreement on this issue, it is important to try to reach a consensus on what consultations need their immediate attention and what can wait for another time or venue. This is not to suggest delay of necessary care, but that opportunities should be evaluated. For example, uncomplicated fractures could be discharged and be seen on a pooled basis the next day rather than calling the orthopedist with each case.
- Assign specialist an in-house customer service representative. This representative may be able to mediate some of the process issues that are frustrating to time-challenged individuals. The representative can also be a hospital-based interface to hospital administration.
- Clinical support staff specialist. Hospital based personnel can streamline the workload of an on-call physician. Examples would include:

Mid-level Provider (MLP) first responders

Programs of this nature have demonstrated a reduction in the physical presence of the on-call physician of as much as 80%. Their responsibilities might include:

- Taking first on-call contact for the specialist from the ED or IP
- Consulting, evaluating and preparing the patient for treatment, then presenting to the attending staff

- Cross-training in multiple areas to maximize their use. This might include trauma, orthopedics, neurosurgery, and ENT for example.

This program would require a performance improvement process to monitor efficiency and outcomes.

ED Dedicated Hospitalist

In this case, the hospitalist serves as an on-call physician for specialists. This would primarily be intended for medical specialties. In appropriate circumstances, the availability of the hospitalist could give a 12-hour window for the specialist to consult and personally see the patient. A newer trend is the presence of surgical hospitalists.

- **Malpractice Insurance Relief**
In this tactic, the on-call physician would receive affordable insurance from the hospital in return to serve on the hospital call panel. Advantages would include:
 - Reaching mutually aligned hospital/physician incentives
 - Hospital sponsored re-insurance²
 - Greater physician participation in risk management activities²
 - Guaranteed ED call coverage²
 - Stable premiums over time for the physicians²
 - 5-year contract with physicians not re-negotiated annually²
 - Might need to be pro-rated for less than full-time physicians.

Compensation

Hospitals that provide medical services are required under EMTALA to provide a panel of on-call physicians adequate to stabilize an emergency medical condition.³ While hospitals have a clear legal mandate to provide specialist coverage, individual physicians are bound solely by medical staff bylaws, hospital policy and a shared ethical responsibility to provide comprehensive healthcare.⁴ Increasingly, poor reimbursement for emergency patients is influencing physicians to reduce or eliminate time spent on-call. EMTALA does not offer funding for on-call physicians, despite the legal mandate it provides for specialist coverage.

Physician willingness to take call is influenced by poor or nonexistent reimbursement for medical services provided. Unfortunately, physicians may have trouble securing payment even from insured patients. A California Medical Association survey revealed that 80% of respondents had difficulty obtaining payment regardless of the type of insurance. Additionally, the survey reported that 42% of physicians received underpayment, 40% have reduced the time spent taking call and 20% had stopped taking call altogether.⁵ The type of insurance held by a patient frequently affects the willingness of consultants to respond for both initial and follow-up care.⁶ Physicians not contracting with a specific health plan may experience difficulty obtaining payment despite the health plan's requirement to pay for an emergency visit under the "prudent layperson" standard.⁷ Also, community medical providers may send uninsured patients to the emergency room for specialist care while keeping insured patients in their own network.

Hospitals can choose among several compensation strategies to encourage physicians to take call. Physician supply, market conditions, financial resources and hospital philosophy will influence the choice of compensation plan. A hospital may choose to compensate physicians with a stipend for all days on call, tier-based stipends, productivity-based compensation guarantees and a hybrid model.⁸⁻¹⁰ Some hospitals lack the financial resources to fund a stipend system. Also, physicians may demand increasing stipends which at some point the hospital cannot afford. Hospitals that lack funding for stipend programs can

create a cost savings program in which physicians and hospital administration reach a consensus to conserve resources and produce revenue for a stipend system.

In tier-based stipends, physicians receive a stipend for taking call beyond a threshold number of calls, which is less expensive for hospitals than providing a stipend for all days on call.^{8,11} The medical executive committee may choose to treat all specialties equally, with all physicians receiving the same stipend regardless of demand. However, different specialties can also be ranked according to the burden of call as determined by call frequency and intensity. Compensation for the different specialties will vary depending on the hospitals need for services, call intensity and physician supply. Specialties in high demand require individual negotiation and may demand the majority of the hospitals stipend budget. Other physicians in greater supply may be given smaller stipends or a greater number of uncompensated calls. Implementing a tier-based stipend system requires intensive data collection to determine the call burden for each specialty. Benefits to the hospital include avoiding time intensive negotiations with each specialty over stipend amounts and data to support decision making.

Productivity based compensation guarantees a fixed, negotiated payment per relative value unit (RVU) of service provided by on-call physicians to patients without an assigned physician.^{9,11} Payment is guaranteed regardless of the insurance status of the patient. Contracting physicians sign over the accounts receivable generated while on-call in exchange for regular payments. Insurance providers are billed for services rendered and the hospital is responsible for any shortfall between reimbursement and collections. Physicians benefit from guaranteed regular payments regardless of payer mix. Hospital research and forecasting is essential to determine a sustainable compensation rate. Negotiations with the medical staff are likely to be the most time consuming step in starting a productivity based compensation guarantee and enrollment in the program is voluntary.⁹ The greatest benefit accrues to physicians with the highest call intensity, the group also likely to be in greatest demand for on-call services.

Success of this model at Sharp Memorial Hospital led to the creation of the Emergency and Acute Care Medical Corporation (EACMC), which is known as the EA program.¹² EACMC works with hospital and medical staff to develop a mutually beneficial compensation plan and manages physician contracts, billing and collections. Since inception, EACMC has managed RVU based payment for on-call services for 22 California hospitals.

Productivity based payment guarantees have also been used in conjunction with stipends.^{10,11} Hospitals which have had experience with stipend programs may choose to continue paying some specialties stipends in combination with guaranteed payments based on productivity. Physicians receive a stipend for being on call which is only paid if they are not contacted. If physicians are contacted payment is made based on a RVU based productivity model. Physicians who are in less demand, internists for example, do not receive stipends but are guaranteed productivity based payment.¹⁰ Hospitals are able to maintain on-call rosters by paying for physician availability while total compensation costs are likely to be less than paying stipends alone.

Compensation arrangements between a hospital and physician groups need to be established with a formal legal contract. It is important to comply with anti kickback regulation because federal law prevents hospitals from paying physicians for patient referrals. Agreements need to comply with the personal services safe harbor to the anti kickback law.^{8,11} Interestingly, independent physicians who are not integrated economically cannot collude in negotiations with hospitals. For example, a group of neurologists refused to provide on-call coverage without an increase in compensation from the hospital.¹¹ The neurologists met to discuss fees and attempted to exert monopoly power in their negotiations with the hospital which is a clear anti-trust violation. Hospitals can complain to the federal trade commission but risk difficult relationships with physicians for years to come and further problems in securing on-call coverage.

Payment to physicians in the form of stipends or productivity based guarantees has been an invaluable tool in insuring specialty backup for emergency rooms. Physicians are facing increasing liability premiums and at the same time physician revenue has been flat or even decreasing. Some may look to on-call payment as a way to make up for lost revenue. Physicians value their time and want to be compensated fairly. However, doctors also feel a duty to their community and many will continue to volunteer for call despite today's challenging practice conditions.

Regional On-Call Pools

A somewhat new mitigation strategy is the development of regional call pools. This mechanism was proposed in the California Healthcare Foundation's Issue Brief, January 2005.⁷ While there are currently pools in existence, there is not yet clarity on their widespread use or success. These would likely only be possible in areas where there are dense populations with concentrations of physicians. An approach to this could be hospital based with the creation of regional competitive contracting. Hospitals in a given market would create a Group Purchasing Organization (GPO). This GPO would request proposals from contract groups to fill their call panels. It is clear to see why this might be beneficial to hospitals, but unclear as to how the specialists would perceive this. This strategy would also need to be closely reviewed for compliance with regulatory and legislative agendas.

Legislative/Regulatory Solutions

Legislative and/or regulatory initiatives addressing the on-call availability crisis are perhaps the most effective, albeit the most divisive ones. It is ironic that the need to contemplate such an approach lies, in part, on unintended consequences of a previous major regulatory initiative, namely EMTALA. Thus, before undertaking such initiatives, one has to consider that further regulation of the medical field might yield additional unexpected or undesirable consequences.

The current on-call system relies heavily on hospital medical staff by-laws requiring members to cover ED call. The options below explore ways to increase the pool of available on-call physicians or to decrease the burden of those taking call by decreasing liability and improving reimbursement.

- On-call requirement as a condition for participating in Medicare
One way to mitigate the ever dwindling number of on call physicians is to require all Medicare providers to participate in ED back-up call pools. By doing so, the burden of ED call will be more evenly shared by more providers thus improving patient access to specialized care in cases of emergency. There is the possibility that this approach might paradoxically lead to a decrease in the overall number of Medicare providers by discouraging participation in the program. This approach will also not significantly improve pediatric coverage.
- On-call requirement as a condition for licensing specialty hospitals
In certain markets, many physicians have chosen to practice in specialty hospitals that may not have a 24-hour ED or only have one that caters to specific presenting problems (ie, chest pain). This specialty migration has left certain hospitals without essential ED call coverage. By requiring physicians who practice at specialty hospitals to take ED call, specialists are still free to choose their preferred practice environment without sacrificing the health safety net provided by the ED. By requiring specialist to take ED call at general hospitals as well as at their own would likely require physicians to cover more than one hospital at a time, but would minimize patient transfers between facilities.

- On-call requirement for state licensing
By imposing a uniform on-call requirement for licensed physicians, state licensing boards could positively impact the number of physicians taking ED call. This requirement would level the playing field between general and specialty hospitals as far as specialty coverage is concerned. On the other hand, this requirement could easily discourage physician licensure in that particular state, if done in isolation.
- Professional Liability Relief for EMTALA mandated care
One of the reasons given by specialists as to why they shy away from ED call is the added liability, risk and cost of taking emergency cases. In fact, it is reported that insurers are now pricing professional liability insurance based on whether specialists take ED call or not. In fact, there are anecdotes of underwriters withholding coverage for specialists who do take ED unassigned patient call.

Shielding emergency medical care from lawsuits would likely encourage more physicians to remain on ED call panels. A concern related to full immunity from lawsuits would be that it is an invitation to abuse standards of care. Thus a review panel (or other such body) would have to be developed to distinguish frivolous lawsuits from those where clear negligence might exist.

- Universal Reimbursement for EMTALA mandated care
Another deterrent to providing ED call is the dismal reimbursement rate from uninsured/underinsured patients requiring emergency care. Ideally, uncompensated care rendered under EMTALA would be reimbursed at a reasonable level thus removing the financial strain it imposes on certain providers. This could possibly be addressed by including call coverage as a component of the expense calculation for the resource-based relative value scale (RBRVS). With the discussion on pay-for-performance for physicians, one of the indicators could also be a physician's inclusion on a hospital call panel. Clearly, any funding for these types of programs must be in addition to current fee schedules to have an impact. For this to be accomplished, the government would have to increase funding in the form of ever-unpopular taxes or fees. This may be difficult to accomplish given the current fiscal climate.

To be sure, most, if not all, of these options could be considered controversial or even inflammatory. Nonetheless, they should not be ignored. Hopefully, less drastic and more collegial solutions can be identified leaving the legislative/regulatory initiatives only as an option of last resort.

Physician Training

Many of the current strategies involve trying to create solutions around specialty areas where there are a small number of specialists. Call is finite. A physician for a given service must provide coverage for 24 hours a day. Mitigating that burden, and therefore the willingness of a given physician to take call voluntarily, is proportional to the frequency and work of a given call day. It follows that as the burden increases, more resources must be directed toward that service to ensure a call panel. For the long term, it is therefore important to review the training process especially in the context of these specialties to determine there are enough specialists being trained in these areas to provide an adequate network of care.

In addition, there is currently a great deal of discussion on the workload and work-life balance of residents and young physicians. It seems to follow that physicians who are trained in the 80-hour workweek era and who globally place a different emphasis on life outside of work will choose to practice differently. If that tendency continues, more physicians of all types will be needed just to keep a current

level of coverage. For that reason, long term strategies for creating a physician workforce that can provide a complete safety net must compensate for that change in practice.

In summary, the ability to provide the same standard of care to all patients regardless of place of presentation is in continued jeopardy. The causes of this have been elucidated and are symptomatic of the challenges to our system of health care provision and funding. Hospitals in all areas will be increasingly required to review potential strategies to mitigate this burden, as the regulatory mandate has been clearly placed on them. The approaches suggested in this article may serve as a starting point for these discussions.

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Ensuring Adequate On-Call Backup in the ED

Problems With On-Call Coverage Contribute to Treatment Delays and Rising Hospital Costs.

Under the Emergency Medical Treatment and Labor Act (EMTALA), a hospital that operates an emergency department is required to provide, within the specialty capability of its medical staff, an on-call panel of backup physicians in a manner that best meets the needs of its patients. However, physicians are only required to provide this coverage when they agree to serve on the emergency department call roster or when they are required to do so under the medical staff bylaws. While hospitals understand that they have an ethical and a legal responsibility to provide specialty coverage, the problem lies in getting physicians to agree, and in paying for those services.

Traditionally, medical staff have volunteered for call panels. However, as the number of uninsured, underinsured and out-of-plan patients in most EDs have increased, the ranks of call panel volunteers have thinned in the face of the financial and legal risks involved.

“The problem of on-call coverage has grown worse over time based on the growth and demand for emergency services and the accompanying lack of funding—just as ED overcrowding has grown,” said Loren Johnson, MD, President of Health Access Associates, Inc.; Director of Emergency Services, Sutter Davis Hospital, Davis, Calif.; and Chief Medical Officer, Sutter Emergency Medical Associates, Sacramento.

As with other EMTALA mandates, there are no provisions for funding on-call services. Physician participation is assumed as an ethical and legal duty. So the statute provides a healthcare safety net for the uninsured and underinsured without providing any funds to pay for those services. And this lack of funding has seriously damaged the backup infrastructure in the ED, so that these services, which were once provided willingly, have in many situations become scarce as well as costly.

“EMTALA is an unfunded mandate. And unfunded mandates don’t work very well because they tend to drive out service—if you don’t pay for something, it’s difficult to get someone to provide it,” Dr. Johnson said. In addition, the more time on-call physicians spend caring for unassigned ED patients, the less time they have available to spend caring for paying patients with whom they have established relationships.

Even when funds are available to pay for on-call physician services, collecting payments can still be a problem. The patients treated by an on-call physician may be covered by a number of different and unfamiliar insurance plans, which means that even those in large group practices may find it inefficient to bill for services. And when they do bill, payments may be denied or significantly reduced retrospectively because of the stringent utilization review processes practiced by many plans.

The other major factor affecting on-call services is malpractice. “ED backup is a high-risk, 24/7 service that is considered a high liability and, therefore, as the professional liability crisis deepens around the country, the call-panel infrastructure continues to erode,” Dr. Johnson said.

As the on-call problem continues to grow, it threatens adverse effects on patient care. Specialized treatment is sometimes not available because doctors won’t come in when called, won’t volunteer to be on-call in the first place, or simply are not available. And emergency physicians know all too well what delayed treatment can mean for patient outcomes.

“The on-call issue is the most critical issue affecting emergency care,” Dr. Johnson said. “Call panels are the weak link in the chain of survival, and it’s getting worse.”

The California Crisis

In 2001, the joint Emergency On-Call Task Force of the California Medical Association (CMA) and CAL-ACEP published a report concluding that many California hospitals do not have adequate backup for their EDs. The report included several recommendations for funding backup services. However there is little consensus in California, and many other states, on how to pay for these services, and none of the recommendations have

been adopted by the state legislature, said Dr. Johnson, who co-chaired the task force.

Then, in 2002, the California Senate Office of Research (SOR) published another report, "Stretched Thin: Growing Gaps in California's Emergency Room Backup System." At the top of the list of findings was this statement: "Problems with access to emergency room on-call services in many specialties in many areas of the state are adversely impacting the quality of patient care and forcing hospitals, physicians, patients and, in some cases, medical groups and health plans to incur significant costs." The SOR report further noted that problems with reimbursement are reducing the willingness of call panel specialists to provide on-call services.

And the problem is getting worse. In a recent statewide survey conducted by the CMA, 75 percent of hospitals responding to the survey reported that the issue of on-call coverage is either a very serious (33 percent) or a somewhat serious (42 percent) problem.

While California does have an EMS fund for uncompensated care, it covers just about 15 to 20 cents on the dollar, Dr. Johnson notes. "We have Proposition 67 on the November ballot. It would expand the scope of the California EMS fund by about \$250 million by means of a 3 percent surcharge on 911 calls. But the proposition is receiving significant opposition from the phone companies," said Dr. Johnson, who is chair of Californians for Proposition 67.

Mandated vs. Volunteer Coverage

On-call policies vary from hospital to hospital. Some hospitals have bylaws that require call panel participation as a condition of affiliation. Others rely on voluntary or paid voluntary arrangements.

Mandating that medical staff participate in on-call panels ensures coverage without adding costs for the hospital. The problem is that forcing physicians to provide ED backup as a condition of medical staff membership may create bitterness over the financial risks those physicians must assume. This can result in lowered morale, as well as resentment, and may lead to physicians resigning from hospitals that mandate call panel participation and choosing instead to practice at hospitals that don't have such mandates.

Some hospitals compensate physicians for on-call duty by offering annual stipends or per diem payments. These types of programs are intended to ensure physicians' voluntary participation on call panels. The problem is that stipends do not completely cover the physicians' cost of providing care, so they still face financial risks and are still under-reimbursed for caring for uninsured patients. Additionally, competition among specialties and hospitals can result in demands for larger and larger stipends, which add significant costs for the hospitals. Often, despite a hospital's costly investment in a stipend plan, call panels shrink and the remaining participating physicians face increasing financial risks.

Stipends can also provide an incentive for physicians to spend less time with patients because no matter how much care they provide, they are not paid any more.

"In order for on-call reimbursement programs to be successful, quality assurance and proper alignment of incentives have to be part of the plan. For example, it's better to consolidate resources toward the actual provision of service rather than to just provide stipends for being on call," Dr. Johnson said.

A Fee-for-Service Solution

Known as the EA program, Emergency and Acute Care Medical Corporation (EACMC), which is based in San Diego, California, designs and implements fee-for-service compensation agreements that improve call panel coverage. Founded in 1991, EACMC currently has programs in 47 hospitals in nine states, including 22 in California. The Clinical Advisory Board has recognized the EA solutions as a "best practice for ensuring adequate specialty ED call coverage."

EA programs compensate on-call specialists at a fixed rate per RVU (relative value unit) for treatment of unassigned patients. The dollar amount per RVU is negotiated between the hospital administration and the medical staff. It must be large enough to encourage physicians to participate on the ED call panel, but also economically feasible for the hospital.

"The RVU rate is determined by looking at both sides of the equation. On one side is the administration and its budgetary restraints; on the other side are the physicians, who basically have an amount they're willing to work for. We help them find common ground," said Art Gruen, MD, CEO of EACMC and Medical Director of the Emergency Department at Sharp Memorial Hospital in San Diego, which is the site of the first EA program.

“What we find works best is if the guaranteed set dollar amount per RVU of service is the same for all specialties across the board. This prevents any so-called sibling rivalry among specialists within a hospital. Under this plan, doctors will make more or less based on the procedures they perform. For instance, a neurosurgical procedure could have 30 RVUs, while a pediatric evaluation might have only three RVUs. So a difference in pay is inherently built in,” Dr. Gruen said.

“Frequently, the best solution we offer is a hybrid, which is a combination of stipends to pay doctors for their availability, plus the fee-for-service component, which guarantees payment for services provided. This gives them the best of both worlds,” Dr. Gruen said.

EA program participation is voluntary for members of the hospital medical staff, but guaranteeing reimbursement does encourage physicians to participate on ED backup panels. “The advantage of the EA program for on-call physicians is that they’re compensated for treating unassigned patients, guaranteed regular payments based on their RVUs of service, and they don’t have to do the coding, billing or collecting,” said Bradley Zlotnick, MD, Director of Strategic Development for EACMC.

Each participating physician receives a monthly explanation of benefits listing CPT codes for all of the patients they treated, the corresponding RVUs, and the amount the physician will be paid.

EACMC guides an EA steering committee, which includes members of the medical staff and administration, through the process of developing and implementing a site-specific EA plan, then maintains the program, billing and collections, and also generates detailed financial and utilization reports on program performance.

The hospital takes responsibility for the shortfall, which is the difference between what’s collected and what’s paid out to the doctors.

“But because of faster response times on the part of on-call physicians in EA plans, the average length of stay in the emergency department decreases, as does the average length of stay for those admitted to the hospital. So, the resulting cost savings partially offset the amount the hospital must pay to make up that shortfall,” Dr. Zlotnick said. “Moreover, EA accesses dollars previously left uncollected. These cost savings help offset hospital shortfall outlay. The shortfall may be considerably less than the hospital’s prior or proposed stipend expense.”

An Ethical Responsibility

In February 2000, ACEP’s Emergency Medicine Practice and Federal Government Affairs committees issued a policy statement regarding on-call coverage titled “Hospital, Medical Staff and Payer Responsibility for Emergency Department Patients.” The first statement in the policy is: “Hospitals and their medical staffs share an ethical responsibility for the provision of emergency care.” The policy statement also notes that “Physician services ... should be compensated in a fair and equitable manner.” And therein lies the problem. What should be the source of that compensation?

Hospitals and medical staffs do have an ethical and a legal obligation to provide on-call backup services for their emergency departments. But there is also a societal responsibility to provide payment for that medical care, notes Dr. Johnson.

“On-call coverage is still primarily covered by goodwill and many doctors still see it as an ethical obligation,” he said. “But the longer it takes to solve the reimbursement issues, the more that good will is eroded.”

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Abstract: The Shortage of On-Call Specialist Physician Coverage in U.S. Hospitals

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Research Objective: Anecdotal reports suggest that hospitals are losing the support of physician specialists to provide on-call coverage as a backup to physicians providing care to patients in emergency departments (ED) and in the hospital. The objective of this study was to measure the extent to which hospitals lack on-call coverage by specialists and to explore the factors that might be associated with on-call coverage shortages such as location, the community-level supply of specialists, the cost of professional liability insurance and the penetration of ambulatory-surgery centers (ASCs) and specialty hospitals.

Study Design: This was a national cross-sectional study in which we administered a standardized questionnaire to hospital ED directors asking them whether they have a problem with inadequate on-call coverage. For each of 11 specialties, respondents also reported 1) the percentage of days their hospitals had formal on-call coverage during a preceding three-month period and 2) the perceived degree of importance in having on-call coverage with respect to the needs of the patient population at their hospital. Data were also collected on payer mix for ED patients, community-level estimates of specialist supply, the cost of professional liability insurance and the penetration of ASCs and specialty hospitals.

Population Studied: Medical directors of emergency departments at acute-care general hospitals in the U.S. (N=4428). Specialty and federally-owned hospitals were excluded.

Principal Findings: Two-thirds [68% (95% CI, 66-70%)] of respondents reported that on-call coverage is inadequate to meet the needs of their patients. On-call coverage problems were reported in more often in urban [73% (95% CI 70-75%)] than rural [60% (95% CI, 57-64%)] hospitals and were similar in geographic regions of the country. The greatest shortage of specialists was in hand surgery: among hospitals where hand surgery coverage is perceived to be "very or extremely important for overall patient outcomes," 69% (95% CI, 65-72%) of hospitals has less than full-time coverage. Hospitals also have less than full-time coverage for plastic surgery (52%), neurosurgery (49%), ENT (44%), psychiatry (42%). On-call coverage shortages were related to the proportion of uninsured patients in the hospital ED, but not to the supply of specialists.

Conclusions: A large proportion of hospitals have unmet need for on-call specialist coverage based on ED directors' perceptions of coverage requirements. On-call coverage shortages are found for several specialties and in both urban and rural hospitals and in all regions of the country. The problem is related to the lack of health insurance and does not appear related to physician supply.

Implications for Policy, Delivery, or Practice: The shortage of on-call coverage is an emerging trend that threatens the integrity of the health care safety net, placing patients at potential risk for injury. This is one of the first studies at the national level demonstrating the scope of this problem. Until now, responsibility for adequate on-call staffing has rested with individual hospital administrators, but their efforts appear to be failing. Further study about the effect on patient outcomes warranted.

Primary Funding Source: Robert Wood Johnson Foundation

ON-CALL SPECIALIST COVERAGE IN U.S. EMERGENCY DEPARTMENTS

ACEP SURVEY OF EMERGENCY DEPARTMENT DIRECTORS

SEPTEMBER 2004



American College of
Emergency Physicians®

Executive Summary

The American College of Emergency Physicians' (ACEP) Emergency Medicine Foundation received a grant from The Robert Wood Johnson Foundation to survey medical directors of hospital emergency departments to assess the effects of current regulations and the practice climate on the availability of medical specialists who provide care in the nation's emergency departments. The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to medically screen every person who comes to an emergency department to determine whether an emergency medical condition exists, and if it does, to stabilize the patient. A patient may only be transferred to another hospital if — after all possible stabilizing efforts have been made — the patient's condition requires a "higher level of care" not available at the original hospital. EMTALA is essentially a non-discrimination law to ensure that every emergency patient is medically screened, regardless of ability to pay. Since its passage in 1986, EMTALA has been subject to regulatory and judicial interpretations that have expanded it into an extensive safety net program in the nation's emergency departments, which have more than 110 million visits annually. ¹

In November 2003, the Centers for Medicare & Medicaid Services (CMS) implemented revised regulations for hospitals and physicians to comply with EMTALA. The new regulations acknowledged the need to balance hospital and physician legal duties with the practical realities of today's crowded emergency departments and the concerns of on-call specialists and their practice demands. Specifically, while hospitals must continue to maintain a list of on-call physician specialists, physicians are permitted to be on call at more than one hospital at the same time and may limit the amounts of call time they are willing to take. While the EMTALA regulations took a more practical approach, recognizing physician specialists' time constraints and willingness to make additional on-call commitments, ACEP was concerned the rules would unwittingly make hospital and emergency physician services more difficult and compound an already growing problem in obtaining specialist care in a timely fashion. In addition to the recent regulatory changes, other factors — reduced payment to physicians by Medicare and other payors, the growing number of uninsured patients in America, and the increasing costs of medical liability insurance — may be affecting patients' access to timely specialty care in the nation's emergency departments.

This survey was designed to estimate, in the early months of the new regulations, the extent of problems related to on-call emergency department coverage by specialists. The survey asked emergency department medical directors whether they were experiencing problems with inadequate on-call coverage, given the needs of the patient populations at their hospitals. It asked about changes in the number of patient transfers to other hospitals and whether physicians and staff were experiencing significant increases in the time spent locating specialists willing to come to the emergency department.

The study findings, coupled with the growing demands for emergency services, show further strain on an already frayed system. Policymakers and physicians must work together to ensure that emergency care remains accessible to all. To that end, the new government-sponsored EMTALA Technical Advisory Group should include this issue in its deliberations.

Methods

Questionnaires were mailed to 4,444 emergency department medical directors between April 2004 and August 2004. This large sample comprises nearly every acute-care hospital in all 50 states and Washington, D.C. It excluded long-term hospitals (such as rehabilitation hospitals) and federal hospitals (e.g., Veterans Health Administration, Indian Health Service, military), as well as psychiatric, pediatric, and other specialty hospitals. Exclusions also were made in cases where one physician served concurrently as the medical director for two or more emergency departments. In these few cases (less than 1% of all emergency departments), ACEP mailed one questionnaire to the physician and addressed it to the larger hospital.

Survey recipients were given the option of completing the questionnaire on paper or by logging onto a Web site hosted by ACEP. Consent to participate was implied by the return or submission of a completed questionnaire. This study was approved by the Institutional Review Board at Johns Hopkins University. This survey will be repeated in spring 2005 to determine whether availability of on-call specialists has changed.

Results

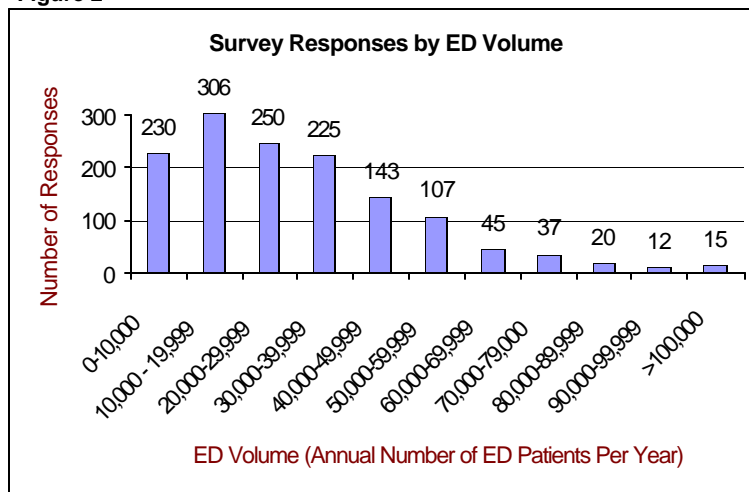
There were 1,427 of 4,444 (32%) surveys returned. The large majority of respondents were from non-teaching community hospitals (93%), while the remainder were from academic teaching hospitals (7%). The teaching/non-teaching distribution is representative of the country at large, but the responses were skewed toward a greater proportion of smaller and urban hospitals (see Figures 1 and 2). Nearly 75% of respondents were from not-for-profit hospitals, 6.5% were from public hospitals, and 19.4% were from for-profit hospitals. This distribution over-represents not-for-profit hospitals and significantly under-represents public hospitals. These differences between respondents and the larger population of all hospitals may reflect a response bias. Emergency department medical directors experiencing greater problems with on-call coverage may be more inclined to respond to the surveys. Emergency department medical directors at hospitals with no formal trauma-center designation comprised nearly two-thirds (63%) of the respondents, and one in five (21%) practiced at an advanced trauma center (level 1 or level 2). This proportion of level 1 and 2 trauma centers is higher in the sample than in the nation.

Figure 1

Hospital Characteristics Among Respondents		
	Total	Respondents
	4444	1427 (32%)
Hospital Type*		
Nonteaching	92.5%	93%
Academic/teaching	7.5%	7%
Hospital Ownership**		
Not-for-profit	61%	74.1%
For-profit	16%	19.4%
Public	23%	6.5%
Hospital Trauma Level		
Level 1 or Level 2	10%	21%
Level 3	6%	16%
Not a trauma center	84%	63%
Hospital Size		
≥100 inpatient beds	53%	23%
Urban		
Located in a metropolitan statistical area (MSA)	53%	63%

Source: * AAMC 2004 **AHA Hospital Statistics 2004

Figure 2



The available national data, however, is almost two years old, and the difference most likely reflects an ongoing trend among states and hospitals to designate additional hospitals as level 2 trauma centers.²

Two-thirds of emergency department medical directors reported inadequate on-call specialist coverage (see Figure 3). This problem appears to affect all U.S. geographic regions, although there is a statistically significant difference between hospitals in the North Central region (59% of respondents cite a problem) as compared with those in the South and Northeast (71% and 70% respectively). Among respondents, hospital size does not appear related to the perception of a problem, but a greater percentage of Emergency Department medical directors in urban hospitals (71%) versus rural hospitals (57%) indicated that on-call coverage was inadequate at their hospitals (see Figures 4 and 5).

Respondents were asked to select the top three (of ten) consequences of the shortages. They answered: risk of harm to patients who needed specialist care, delays in patient care, and an increase in the number of transfers of patients between emergency departments (see Figure 6). Other adverse effects included decreased efficiency of emergency physicians and staff, patient frustration due to poor service, increased wait times for patients to see a physician, and more crowded referral hospitals where patients were transferred.

Figure 3

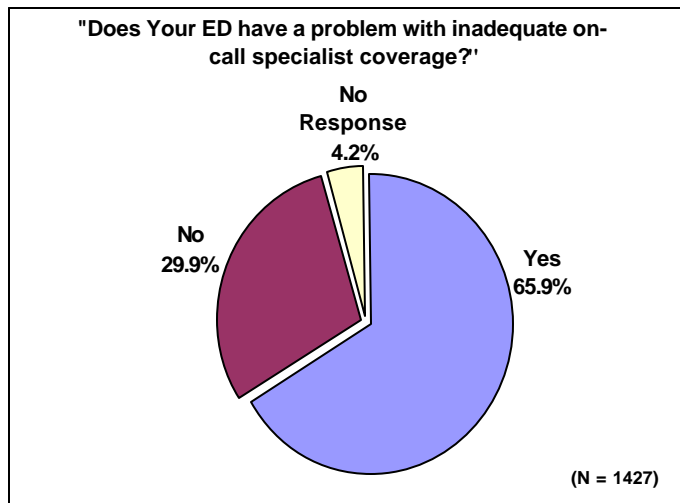


Figure 4

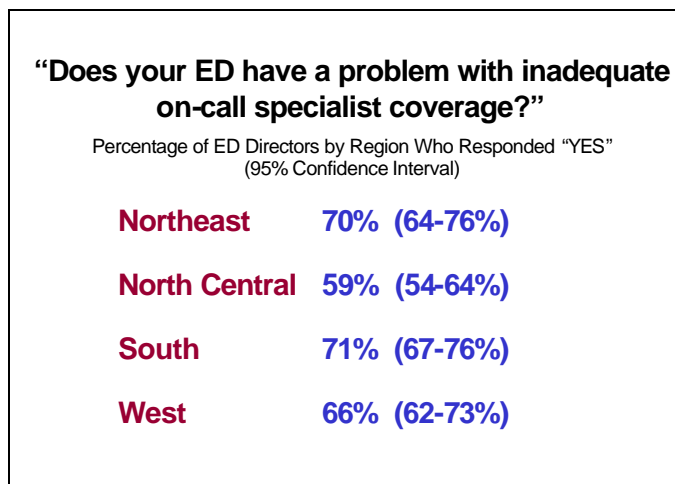


Figure 5

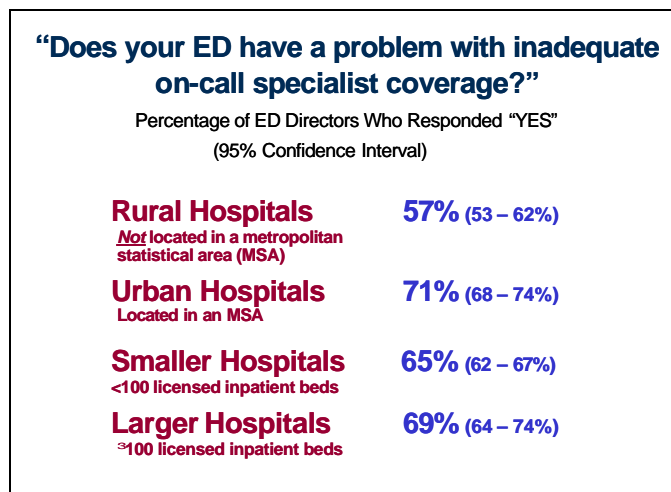


Figure 6



Survey respondents also were asked about other changes in their emergency departments in relation to the adequacy of on-call coverage by specialists. Seventeen percent noted that some specialists had already negotiated with their hospitals for fewer on-call coverage hours. Emergency physicians also say they spent more time seeking specialists to come to the hospital (see Figures 7 and 8).

A third of the respondents cited increasing levels of patients being transferred from one hospital to another (see Figure 9). More than one-quarter of the respondents said that a growing number of patients leave crowded emergency departments before being seen by a physician (see Figure 10).

When asked whether hospitals were providing incentives to specialists to take call, 8% said their hospitals were paying stipends, 15% were guaranteeing certain levels of payment for services, and 14% were providing some measure of medical liability coverage for on-call commitments (see Figures 11, 12, and 13).

Figure 7

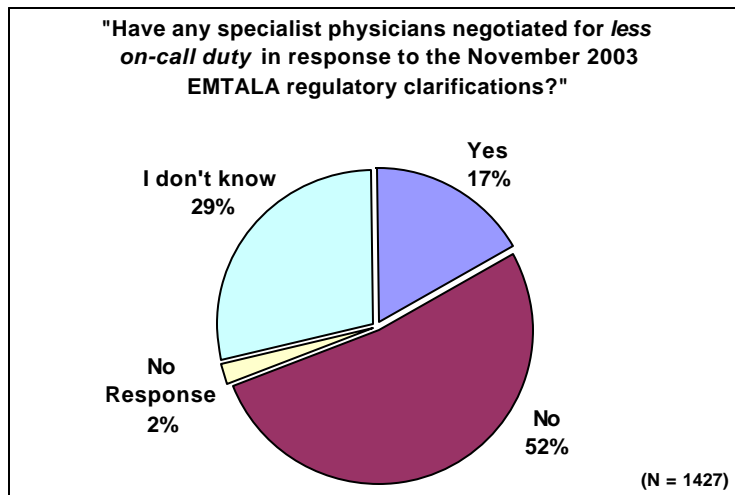


Figure 8

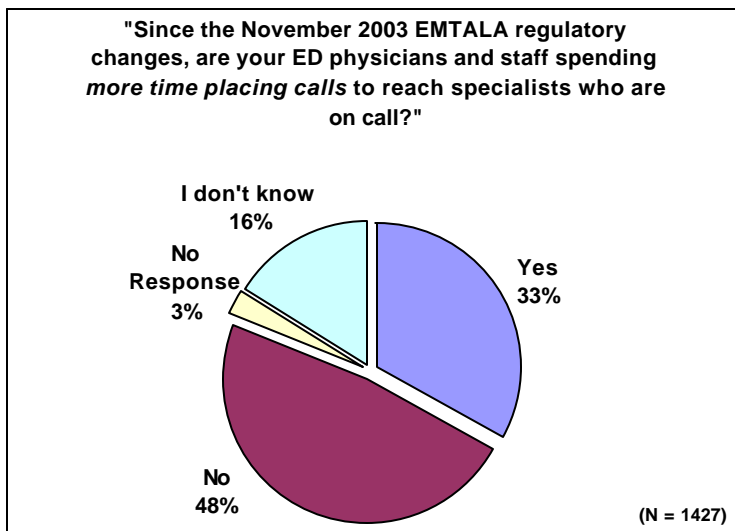


Figure 9

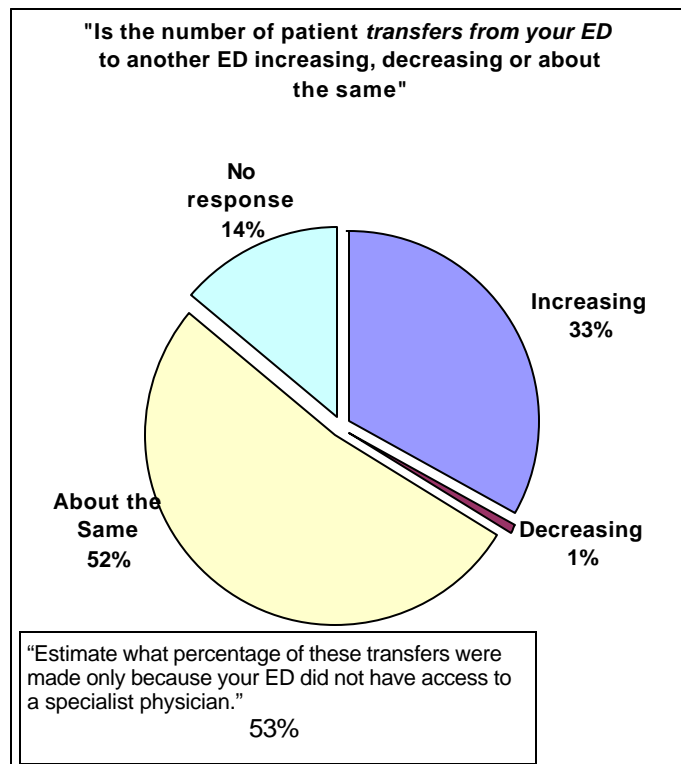
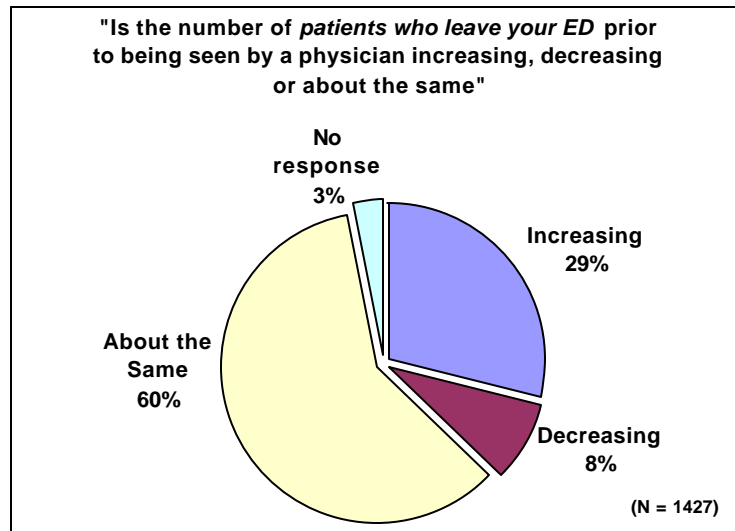


Figure 10



Conclusions

The decrease in the number of medical specialists willing to be on-call to the nation's emergency departments is a looming national health care crisis of supply and demand. While a large majority of specialists continue to take new patients and participate in the Medicare program, they are less willing to cover the nation's emergency departments. The survey findings reflect the extent of this dilemma, with two-thirds of emergency physician directors citing problems. At this time, access for patients who may need immediate emergency care is compromised, particularly in local areas such as Los Angeles and Tucson, where hospitals and trauma units are closing. This complex issue must be addressed in an equitable way that turns the tide on specialists departing from historical on-call commitments to cover emergency departments.

The results of this survey quantify one more aspect of an increasingly complex set of health system issues that affect availability of timely emergency care services all over the country. Responsibility for on-call coverage remains with the nation's hospitals, but, according to study findings, those efforts appear to be failing. The factors driving this worrisome problem — insurance coverage, funding, and liability concerns — must be addressed at the federal level.

Figure 11

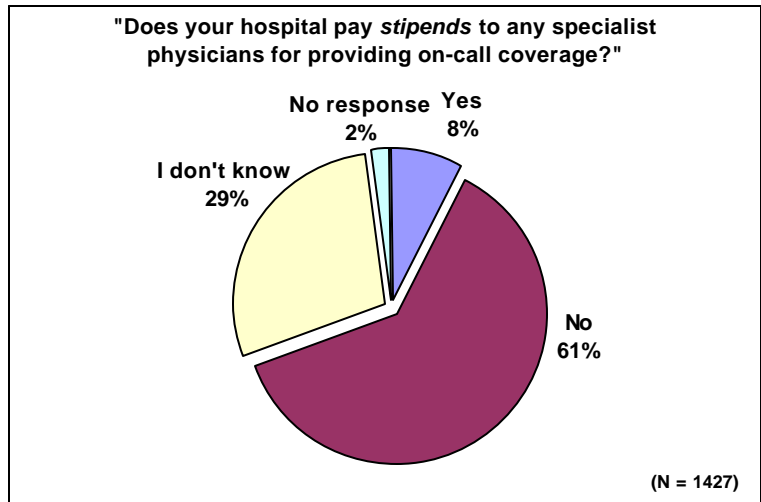
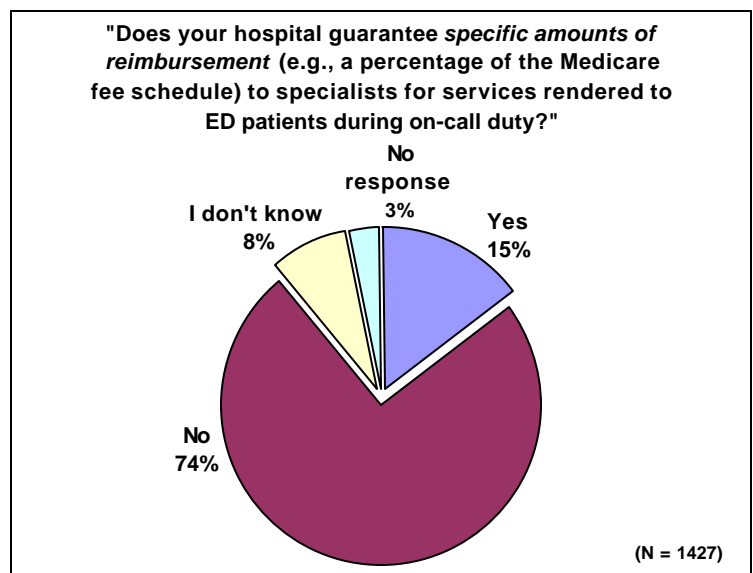


Figure 12



References

1. McCraig, LF, Burt, KW. National Hospital Ambulatory Medical Care Survey: 2002 Emergency Department Summary. NCHS/CDC. March, 2004.
2. MacKenzie EJ, Hoyt DB, Sacra JC, et al. National Inventory of Hospital Trauma Centers. JAMA. 2003 Mar 26;289(12):1515-22.

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Figure 13

