American College of Emergency Physicians®

Availability of On-Call Specialists

an Information Paper

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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 their 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:

    <u>Mid-level Provider (MLP) first responders</u>

    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-insurance[2]
  - Greater physician participation in risk management activities[2]
  - Guaranteed ED call coverage[2]
  - Stable premiums over time for the physicians[2]
  - 5-year contract with physicians not re-negotiated annually[2]
  - 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.

- <u>On-call requirement as a condition for participating in Medicare</u>
  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.

- <u>On-call requirement as a condition for licensing specialty hospitals</u>
  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 or 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 stating point for these discussions.

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