

## On Call In Crisis

### Problems Pervasive, Solutions Unique

By Jim Lott, HASC Executive Vice President

Emergency department (ED) on-call systems are on the brink of disaster. Spiraling downward nationally, they fare even worse in California. It's a simple problem of supply and demand (see Table 1). The underlying issues are far from

simple, however, and the solutions are not at all easy to come by. At stake are patient access to and quality of health care. As call panels deteriorate, hospital EDs also diminish as safety nets.

#### Table 1. Eye-Opening Statistics

##### Increasing Demand

###### *Nationally*

ED visits have increased 26 percent since 1993 to about 40 visits per 100 people.<sup>1</sup>

ED visits among Medicaid enrollees = 81 per 100 people; private insureds = 22 per 100.<sup>2</sup>

45 percent of hospitals reported in 2005 that patients leave crowded EDs before seeing a physician, compared to 29 percent in 2004.<sup>3</sup>

75 percent of hospitals reported "boarding" patients in the ED on a daily basis because inpatient beds were unavailable.<sup>4</sup>

###### *In California*

ED visits have increased more than 3 percent annually; visits increased 15 percent from 1998 to 2002 to 10.1 million annually.<sup>5</sup>

##### Decreasing Supply

###### *Nationally*

Surveys of ED medical directors show deterioration: two-thirds reported inadequate on-call coverage in 2004; three-fourths reported the same in 2005.<sup>6</sup>

###### *In California*

40 percent of physicians have curtailed or completely stopped taking call.<sup>7</sup>

Less than one-third of hospitals now mandate call as a condition of medical staff participation.<sup>8</sup>

##### Impact

###### *Nationally*

As of 2006, 24 percent of trauma centers and 13 percent of non-trauma centers had to shut down one or more services due to lack of physicians providing call.<sup>9</sup>

###### *In California*

Nearly 50 percent of hospitals pay specialists to be on call (compared to 42 percent in 2005, 18 percent in 2004).<sup>10</sup>

As of 2005, stipends to physicians cost California hospitals \$600 million annually—three times the cost of three years ago.<sup>11</sup>

### The Problems Hospital Issues

*EMTALA.* The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 and its updates, together with state licensing regulations, govern emergency coverage. Called the "anti-dumping" law, EMTALA was passed to ensure adequate emergency care

for patients regardless of ability to pay. It holds hospitals' feet to the fire, but neither funds this care nor mandates physician on-call coverage. EDs must provide date-specific lists of specialists taking call; if physicians choose to participate, then they must respond.<sup>12</sup> Medical staff bylaws

govern physician participation and what constitutes timely response.

In the 2003 EMTALA update, the Centers for Medicare & Medicaid Services (CMS) introduced or clarified some important rules in recognition of the growing problem of securing on-call

coverage. Specifically, CMS specified that on-call physicians need not be on-call at all times (and therefore, that hospitals not necessarily provide 24/7 on-call coverage) and that physicians can be on call at more than one institution.<sup>13</sup> CMS is trying to give hospitals leeway in how best to serve their communities. Nonetheless, as of 1999, on-call issues have been the second highest reason for EMTALA violation citations.<sup>14</sup>

Hope for some relief is in sight: Congress established a national EMTALA Technical Advisory Group (TAG) through the Medicare Modernization Act of 2003. TAG will make policy recommendations on EMTALA enforcement and on-call issues, due in August 2007.

*Multiple Call Panels.* Hospitals must now juggle a growing patchwork of multiple call panels, an outgrowth of managed care. Health plans now demand that managed-care medical groups and hospitals maintain lists of contracted physicians to serve their enrollees. These

*Alternative Care Settings and Lifestyle.* Physicians are no longer dependent on the hospital ED to build their practices.<sup>16</sup> Newer technology and treatments give physicians alternative and more efficient care settings. Private practice offices and freestanding specialty centers have more predictable payer mixes—and they don't receive uninsured trauma patients who may need surgery and extensive follow-up. Hospital call, particularly the middle-of-the-night cases, interferes with practice the following day. This is especially true for surgeons whose specialties require reliable application of critical skills. It provides an ethical challenge for surgeons who recognize that their skills for a scheduled case are not optimal as a consequence of stress and fatigue due to prior emergency care. And younger physicians of all specialties, as

lists are no guarantee of availability of call panel specialists in scarce specialties or where physicians are assigned to cover large geographic areas.

*Unassigned Patients.* Besides the well documented increase in ED visits, and increase among medically indigent (see Table 1), a new catch-all category of patients has emerged requiring its own call panel. "Unassigned" patients are those who enter the ED without a designated physician or medical group for backup coverage. Unassigned generally includes underinsured or uninsured / self-pay patients (maybe one-third pay their ED bills), those in Medicare or Medi-Cal who do not have a physician on staff, tourists or nonresidents, often trauma patients, and managed care enrollees without a physician on that hospital staff. This category accounts for, very conservatively, about 12 percent of ED visits nationwide, sometimes exceeding 25 percent.<sup>15</sup> These numbers understate the problem. For example, a regular patient of

### Physician Issues

well as aging physicians, want a balanced lifestyle-work style that prefers not to include ED coverage.

*Poor Reimbursement.* Coupled with declining Medicare, MediCal and contracted managed care reimbursement, physicians claim they receive inadequate or no reimbursement for unassigned patients. While many counties in California have multiple funding sources, they are difficult to access or have many hurdles to completion; they often are not worth the time and cost to pursue. Health plans appear to delay payments at best; some non-contracted physicians are not paid at all, not even at non-contracted rates, or are the victims of "down coding" for their services.<sup>17</sup>

*Physician Shortage?* A shortage of physicians in California is more an issue of distribution. Certain specialties like

a staff physician is still unassigned if the physician is not on call and the covering physician is unavailable or underqualified to provide critical care services. Reimbursement for care for the unassigned is rarely adequate.

*Mandatory vs. Voluntary Call Panels.* As physicians become increasingly disillusioned with ED call, hospitals grapple with the issue of coverage as a condition of medical staff privileges. Is going "voluntary" tantamount to no system? Will a mandatory system cause resignations and deter recruitment? These are questions for the hospital board and management and medical staff to work on jointly. The decision is not to be taken lightly and a plan must be in place before "mandatory" is abandoned—however it is defined in the medical staff bylaws. Moreover, mandatory assignment does not ensure compliance absent realistic enforcement and / or a culture that supports ED coverage.

neurosurgery face shortages, and the aging of the physician population, like so many other health care professions, is another factor. Recruitment, however, is tough. It used to be that you could entice people to California with the weather and lifestyle. Now the high cost of living and housing, city congestion, and managed care environment are severe deterrents.

*Legal Deterrents.* The rising cost of malpractice insurance is sometimes exacerbated by carriers that charge more to specialists who take ED call. And physicians perceive that ED patients are more non-compliant, difficult to contact for follow-up, and litigious than office patients with whom they have an established relationship. Further, physicians don't want to be involved in the real or perceived threat of EMTALA violations and penalties.<sup>18</sup>

## Solutions

Hospitals have been creative in trying to solve the problem of a frayed ED coverage problem. Each solution, even if temporary, seems to be unique and often borrows from several of the areas categorized below.

### Alleviating Mandatory Call

While less than a third of California hospitals have full-panel mandated ED coverage, more than 70 percent mandate some level of call as a condition of medical staff membership.<sup>19</sup> Mandatory call is successful if buoyed by strong administrative and medical staff support. But as physicians find call increasingly onerous, they are threatening to amend bylaws to make call voluntary. These systems are unstable, and hospitals and their boards should be sure an alternative plan is in place to ensure coverage before drastic steps are taken that might unravel the system.

*Back-Up Call System.* A pre-determined backup ladder call system should be developed if the established system is in danger of failing. The administration, chief of each service, and other medical staff leadership should become involved. This may result in verbal criticism and other more punitive measures if, for example, the on-call physician does not respond appropriately.

*ED Liaison.* Hospitals can employ or appoint a liaison to streamline the on-call process, help solve problems that arise, and work on communication issues. The goal would be to maximize the specialist's time in the ED, as well as the operating rooms and inpatient areas related to call.

*First Responders.* Hospitals can employ mid-level clinical staff or physician assistants (PAs) to assess ED patients before a specialist is called in and then coordinate care from admission to post-

discharge planning. PAs, in particular, are growing in numbers and use.<sup>20</sup> To be effective, however, at least three need to be assigned to each specialty, although cross-training and multiple specialty coverage are also possible. Hospitals pay their salaries and benefits; the medical staff and hospital jointly oversee credentialing and performance. Incorporation of PAs or general physicians into a specialty team structure may extend scarce surgeon resources while providing protocol-guided, specialty-level initial assessment and support.

*Malpractice Insurance Relief.* For some or all physician specialties, a hospital could purchase malpractice insurance, either in whole or above a threshold amount in return for guaranteed ED call coverage. Coordinated liability coverage for the physician and the hospital by the same carrier may enhance the efficiency of defense when needed.

### Compensation Models

Stipends—fees paid to physicians for being on call—have been escalating in California 10 to 25 percent annually over the last five years and are spreading to more and more specialties.<sup>21</sup> Stipends come off the bottom line, may prevent operational or capital improvements, and tend to cause relationship issues between hospitals and physicians. The issue is emotional: are physicians blackmailing hospitals or seeking fair compensation for work in light of decreasing reimbursement and increasing liability premiums? Other issues to consider are federal anti-kickback and Stark laws; they don't prohibit stipends but they must be fair market value and untainted by expected hospital referrals.<sup>22</sup>

*Stipend Types.* Knowing that stipends tend to grow in breadth and depth and might not be economically

sustainable over time, hospitals need to be cautious before going down this path. Do you pay stipends to all physicians or only those in short supply? Should you pay for "carrying the beeper" but not when physicians are actually called in? As a conservative start, could you pay stipends only beyond a threshold number of on-call days? For example, once a physician takes call beyond seven days a month, could you pay a daily stipend for the extra coverage to help offset "burnout"?

*Tiering.* Some hospitals have segmented their physician market based on need and / or supply.<sup>23</sup> For example, Tier 1 might be neurosurgeons and orthopedists who receive say, \$500 per day to carry the beeper. Tier 2 might be other surgical specialties who receive \$250 per beeper day. Tier 3 might include specialties that have enough physicians to share call and do not receive a stipend. Tiering can be based on other factors such as weekend and holiday call.

Stipends often revert to a different payment system when physicians actually treat ED patients. Either the physician bills as usual or the hospitals may set up a system for unassigned patients—groups included in this category can differ depending on the hospital's geographic region and payer mix. Hospitals have contracted with organizations that code, bill and collect on behalf of physicians.

Physician payment systems may also be tiered. Some specialties may receive 100 percent of Medicare RVUs; others in shorter supply may receive 120 percent, for example. Another option is to pay Medicare RVU rates only for unfunded or minimally funded patients.

These systems work best if there is heavy physician involvement in the system. Some hospitals have appointed a steering committee of various physician specialties, the ER medical director and

administrative staff. However managed, they seem to require continuous monitoring, negotiation and renegotiation.

**Contracted Coverage.** Hospitals can contract with an outside organization that can enlist any payment system from stipends, to tiering, to productivity models based on Medicare RVUs. The organization can do any or all of the following: recruit, credential, schedule, code, pay, monitor participating physicians, handle collections. An outside organization buffers hospitals from corporate practice and kickback issues.

One California hospital seems to have found success in contracting with a medical group to provide coverage. Founded by trauma surgeons, this multi-specialty group has a vested interest in making ED on-call coverage work (and the contract stipulates severe penalties for coverage problems). The group keeps it simple—it pays the same daily stipend to all for the burden of carrying the beeper and Medicare RVUs for actual care delivered. The hospital has a contracted and predictable year-to-year budget it pays to the medical group.

### Hospitalists

About half of California hospitals use hospitalists in one or more areas.<sup>24</sup> This approach is regarded as one of the most successful strategies for addressing ED on-call coverage. Hospitalists began with intensivists in the ICU, which happens to be the throttle point for ambulance diversions. Now hospitals are using internist hospitalists to cover unassigned ED patients, and coverage is spreading to OB, pediatrics, general surgery, and even neurology.

Other than ICU intensivists, coverage for other areas rarely starts as a 24/7 solution. An 8- or 12-hour program might be a starting point until the hospital needs and can afford full-time coverage.

The California ban on the corporate

practice of medicine is an issue that arises in connection with ED on-call coverage. Some argue that employed physicians would be more accountable to hospital issues, would enable hospitals to more easily pay their malpractice premiums as a benefit, and would free hospitals to recruit physicians without documenting demonstrated need. On the other hand, others argue that contracted physicians are highly motivated to keep their contracts year to year and are less inclined to check out at shift end. Some believe that contracted hospitalists, in particular, who are on the hospital premises for extended periods, have become more intensely involved in process improvements and quality-of-care issues.

### Regional Call Panels

The regional call panel models are more conceptual and experimental than fully implemented in California. There are major concerns and obstacles to avoid—EMTALA, antitrust, contracting arrangements with health plans, possible licensing conflicts, fee-splitting and kickback laws, and differing patient payer mixes among hospitals. Hence, several hospitals in several markets that began to explore the issue have abandoned plans over one or more of these concerns.

Nonetheless, several models bear consideration. In one, two or more hospitals, each contracts independently with a specialty group and pays a standby stipend.<sup>25</sup> The question is whether the contracted group has enough depth to cover the hospitals simultaneously. This method increases health care costs because two or more stipends are paid to the same group. But hospitals cannot set one price without risking antitrust violations.

Another option is for two or more hospitals in a geographic region to rotate call. Any of these arrangements require transfer agreements and careful coordina-

tion with paramedic and EMS personnel. Also, these arrangements limit patient access to care.<sup>26</sup>

A further option is regional competitive contracting, where two or more hospitals in a market create a group purchasing organization or a group practice organization to bid out and contract call-panel coverage for the community.

Hospitals that want to explore regional call panels are advised to start with just one high-demand, limited-supply specialty at a time.

### Legislative / Regulatory Relief

Besides broad health system reform, many piecemeal state or federal relief measures could be considered:

- Payment standards for all on-call physicians
- Eliminate restriction on corporate practice of medicine
- Increased funding for treatment of unassigned patients
- Reasonable health plan contracts and payments to non-contracted physicians
- Better dispute resolution between health plans and on-call physicians
- Improved liability protection
- State-sponsored malpractice fund for unassigned patients
- Established regions for emergency medical services
- Adjust Medicare RVUs to include the on-call factor
- Ensure funding for telemedicine services
- Remove barriers so that hospitals can share panels
- Tax credit for physicians on call or who take unassigned patients
- Mandated call
- Universal insurance coverage to eliminate the uncovered patient problem

For this year, hope centers on Proposition 86—the Tobacco Tax Act of 2006, which, if passed in November, would provide an estimated \$750 million

to California hospitals for emergency services. Proposition 86 also specifies that hospitals can work together, under public agency supervision, to develop

regional plans for providing emergency services to the poor and uninsured and to coordinate the availability of specialist physicians.

## Self-Assessment Guidelines

Obviously, hospitals need to find solutions to their own unique ED call-panel problems. They may start out as temporary or experimental; they most likely will be a combination of strategies. And the standard by which to judge the solution(s): Is it fair, equitable and economically sustainable?

They all need to start with a self-assessment, preferably on at least three fronts: interviews of physicians to find out their problems in taking call; review of all relevant medical staff and hospital policies and procedures; and data analysis of payer mix and physician reimbursement for call coverage. Hospitals can do this research themselves; however, they and the physicians may see more objectivity in work done by an outside firm.

After the data have been collected, then the questions begin:

### Medical staff policies and procedures

Medical staff bylaws and rules and regulations should clearly define obligations and responsibilities for coverage of emergency patients. Physicians assigned to emergency coverage, either through mandate or by voluntary status, should be evaluated by the hospital's performance improvement and peer review processes. Physicians should be assessed regarding the quality and efficiency of the emergency care they provide. Patterns of care based on these assessments should be considered in the medical staff's processes for the renewal of membership and emergency care privileges.

1. Are coverage conditions adequately explained?
2. Is timely response to call reasonably defined?
3. Are expectations for call clearly stated?
4. Are mechanisms stated for resolving conflict between emergency and on-call physicians?
5. Is a complaint resolution system in place?
6. Does a call ladder system need to be initiated and documented?

### Education Opportunities

1. EMTALA rules and interpretations
2. ED responsibilities
3. ED process changes to improve efficiency; opportunities for feedback

### Hospital Contracts

1. Can the hospital put more pressure on health plans for timely payments?
2. Are appropriate transfer agreements in place?
3. What areas might benefit from the services of a hospitalist?

### On-Call System & Roster

1. Is the roster posted in an accessible area?
2. Are procedures in place to ensure accuracy, timeliness, readability?
3. Can call be shared between services with clinical overlap?

4. Would PAs in certain clinical areas ease call burden?
5. Are systems in place to obtain continuous feedback from on-call physicians?
6. Are complaints handled expeditiously?
7. Would processes be enhanced by the appointment of an on-call liaison?

### Contacting Consultants

1. Is the paging system working during different shifts?
2. Should the emergency physicians carry pocket cards with each on-call physician's preferred method of contact according to different time frames? Does the card include secondary numbers?
3. Do we need periodic surveys to update?
4. Do the emergency physicians know the scope of practice for each on-call physician?

### Transfer Policies and Procedures

1. Is there an effective transfer mechanism for patients who need a higher level of care, for any reason?
2. Are the criteria for transfer approved by administration and the medical staff?
3. Are transferred patients reviewed regularly by the performance improvement and peer review processes?

## Conclusion

The ED on-call problem is a costly one among many: nurse staffing ratios, seismic upgrades, pandemic flu and bioterrorism preparedness, staffing shortages, declining reimbursements across the board, and hospital and ED closures. Overall ED use will

continue to grow. ED use by the elderly, who have the largest share of serious medical conditions, is about to soar as baby boomers reach Medicare age. Ambulance diversions due to crowded conditions reduce timely access to care for all. The ED on-call coverage issue is one to be addressed in the context of many issues.



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## References

1. Missouri Hospital Association. *Emergency Department On-Call Coverage: Issues and Solutions*. December 2005.
2. Ibid.
3. American College of Emergency Physicians. *On-Call Specialist Coverage in U.S. Emergency Departments: ACEP Survey of Emergency Department Directors*. September 2004 and April 2006.
4. Ibid.
5. California Hospital Association. *Background Paper: Emergency Department On-Call Physicians*. March 2006.
6. Ibid.
7. California Medical Association Center for Medical Policy and Economics. *CMA Survey: Payment for Emergency On-Call Services (summary)*. July 2000.
8. California HealthCare Foundation. *On-Call Physicians at California Emergency Departments: Problems and Potential Solutions*. January 2005.
9. Sullivan, Cotter and Associates, Inc. *2006 Physician On-Call Pay Survey Report*. July 2006.
10. San Jose Business Journal. *Rising fees for on-call specialists have hospitals seeing red*. October 2005.
11. Ibid.
12. Anthony L. Macasaet, et al: E-Medicine from WebMD. *The On-Call Physician*. April 2005.
13. Ibid.
14. Moy MM: *EMTALA and on-call physicians in: The EMTALA Answer Book*. Aspen Publishers. 1999.
15. California HealthCare Foundation. *On-Call Physicians at California Emergency Departments: Problems and Potential Solutions*. January 2005.
16. American College of Emergency Physicians. *Availability of On-Call Specialists: An Information Paper*. May 2005.
17. California HealthCare Foundation. *On-Call Physicians at California Emergency Departments: Problems and Potential Solutions*. January 2005.
18. Ibid.
19. Ibid.
20. Ibid.
21. San Jose Business Journal. *Rising fees for on-call specialists have hospitals seeing red*. October 2005.
22. American College of Emergency Physicians. *Availability of On-Call Specialists: An Information Paper*. May 2005.
23. California HealthCare Foundation. *On-Call Physicians at California Emergency Departments: Problems and Potential Solutions*. January 2005.
24. Ibid.
25. Ibid.
26. Ibid.

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