

BEST PRACTICES IN CONTRACTING FOR ED/TRAUMA CALL

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ABSTRACT

Recent polls find hospital physician leaders are having major problems maintaining ED call coverage, there is no consensus on whether to pay physicians for call, and that most feel that physicians refusing to care for uninsured patients is a major ethical problem (1). The basic issue is how to maintain call coverage, and the experience of trauma centers over the past 15 years provides excellent guidance on how to do it right – and wrong. A proactive leadership strategy is the key to an effective solution, which before payment, should address medical staff structures, hospital support, and emergency care operations.

1. THE ED CALL CRISIS HAS ARRIVED

Obtaining Emergency Department (ED) and trauma call coverage is a far-ranging and far-reaching problem that physician executives must confront constructively. The issue is of national importance and has increased urgency in regions where managed care penetration and the number of uninsured patients are highest.

Major factors eroding physician support for voluntary ED call include:

Call Conflicts With Private Practice

The unpredictable demands of ED call are frequently incompatible with private practice. No physician wants to neglect scheduled office patients or delay scheduled procedures. The economics of office practice preclude extended office hours.

Call Conflicts with Physician Lifestyle

Air Force Pilots Lifestyle

In 1994, the re-enlistment rate among air force pilots was 81%. By 1999, it had dropped to 30% primarily because the pilots wanted to spend more time with their families.

Since a fair amount of ED calls occur at night or weekends, physicians see the impact of ED call coverage as undesirable to their lifestyle and well-being. Physicians, along with Air Force pilots, are placing a higher emphasis on time with their families.

Increasing Burden of Uninsured Patients

The emergency department's share of uninsured patients is expanding along with the overall uninsured population.

Hospital & ED Capacity Constraints

Hospital and ED capacity has contracted for the last decade while the sheer volume of ED visits has increased 20% (2). In addition to increasing numbers of uninsured patients, recent studies demonstrate that insured patients are relying more on the ED because physician office appointments are increasingly harder to obtain.

EMTALA Inequities

The 1986 Emergency Medicine Transfer and Active Labor Act has created an unfunded mandate with harsh penalties for noncompliance by either the physician or the hospital, and the service pricing policies and exclusionary panels of many insurers add the risk of under-reimbursement to nonpayment.

Physician Shortages

Relative shortage in key specialties complicated by high demand reduces availability. Physician specialties most in demand often cover the gamut, but shortages in surgical subspecialties, dentistry, OFM, psychiatry and to a lesser degree some medical specialties (GI, Nephrology, and Pediatrics) are most common (3). Reductions in residency support due to hour limitations place the direct response burden back on the staff physician.

Trend to Outpatient Surgery/Specialty Hospitals

Specialty physicians are placing surgical suites in their offices and establishing specialty hospitals (heart, orthopedics, etc.), effectively severing their hospital ties and obligations. Other surgeons required for trauma call panels (i.e., plastic and oral surgeons) who rarely need the hospital's OR and find required trauma call onerous, can simply resign their hospital privileges with few adverse consequences.

Malpractice Turmoil

Episodic encounters with patients of high complexity who lack established relationships or assured follow-up present high-risk liability scenarios often coupled with no compensation to offset rising premiums.

As a result of these multiple factors, private practice physicians are increasingly rejecting the notion that emergency call is a community service and are demanding that it be voluntary and compensated. This essentially represents an economic shift, like the rising price of gas that must be dealt with as a new reality.

2. GENERAL PRINCIPLES FOR PROCEEDING

Lessons learned over the past decade in the more intense settings of trauma centers indicate that while there are no easy fixes, understanding the causes and potential solutions regarding ED call, coupled with a proactive and farsighted approach, will bring hospitals and their medical staffs to the best possible solution.

Creating the Proper Framework

Negotiation with one's own medical staff over call payments can become very divisive, and principles learned from addressing call issues in trauma centers include:

- Leadership is essential, and building an ad hoc leadership team to address this complex issue may be necessary.
- A well-defined process is essential. Benchmark institutional financial performance. Solicit physician input. Address non-financial issues. Float ideas and get feedback.
- Value, not cost, should be the major factor in determining payment. Quality care, service (interaction with staff, availability, and patient satisfaction) and service volume offer key metrics.
- Always take the long view and seek to resolve this issue for the next decade and not just the next year.
- Do not push physicians into forming a cartel.
- Adopt a systems perspective and try to fix the problem on the front end by addressing demand management through a strategic approach to primary care support and safety-net clinics.
- Evaluation of results will assure you are getting value for your investment, and that physician support for emergency call remains stable.

Do Not Neglect Operational Solutions

It is ironic that the very part of the hospital designed for speed and efficiency has now itself become a bottleneck with resultant delay, diversion and dissatisfaction, which extends to the many physician participants as well. For many physicians the contrast between their offices where they are most efficient and the ED environment of ambient delay is marked.

When patients present to the ED, they are likely to have high complexity illnesses associated with medical, surgical, psychiatric and drug related co-morbidities that require specialty consultation and referral in approximately 25% of cases. This requires both the responsiveness of a large and diverse medical staff and a strong operational system that makes their response as efficient as possible.

A focus on managerial and operational solutions will yield immense benefits because the basic processes that impact the hospital are very important to physicians as well. These include: Demand Management, Registration, Triage, Diagnostic testing, Social Service, In-patient Bed Control, Billing and Collections.

Placing the ED within the context of all other services will better show bottlenecks and vicious cycles. For example, the protracted laboratory and imaging test turn-around times in outpatient and inpatient venues feed a tendency to over-stage patients in the ED by getting all possible tests thereby overburdening staff and resources and distorting true demand. This instigates a strategy of making every request a stat request

Physician demands for emergency call payment are often accompanied with complaints about the support they receive once they arrive and include:

- Insufficient support in the emergency department, in terms of a lack of nursing staff, inconsistent support from emergency physicians, or the lack of needed equipment and supplies.
- Timely access to the OR for urgent/emergent patients they become responsible for while on call. Spending time trying to get an ED patient scheduled in the OR is very frustrating.
- Needless waiting for diagnostic test results from the lab or radiology.

A concerted effort to resolve hot-button issues will establish credibility and trust with call physicians. Steps that make call more palatable and less disruptive to physicians include:

- Use specialty defined protocols to call in a specialty only when needed
- Have patient ready when specialist arrives
- Nurse Practitioner or surgical tech support for basic evaluation and treatments
- OR block time for ED cases that came in the previous night

3. DEALING EFFECTIVELY WITH KEY ISSUES

Addressing the Medical Staff Structure

Medical staff organizations with their attendant departmentalization are generally fragile, complex structures, and often prove inadequate for constructively addressing emergency call issues. They were not designed for transactional purposes. With the exception of specific niche franchises such as ED physicians, anesthesia, NICU, or trauma care, medical staff physicians are poorly organized and represent a group of independent contractors often in competition with each other.

Avoid The Balkans of Hospital/Physician Relations

Where existing problems in hospital/physician relations are present, call issues are more likely to erupt, and the divisive process for dealing with them can further damage the collaboration upon which hospital relationships with their medical staffs are built. It is very important to not ignore a gathering storm, because rising frustrations and tensions make reasonable solutions even more elusive.

Paying private practice physicians for emergency call does not resolve the underlying problems. As we have noted, physicians still find it disruptive to their practices and lives, and often the next step is demand for additional payment. As this spreads from specialty to specialty, it becomes a very slippery slope.

Payment, which requires a new contractual relationship between a hospital and members of its medical staff, opens the door to new solutions, however. Hospitals have new choices in terms of the physicians they contract with, and the structure of the services provided. These opportunities should be fully considered, because payment systems tend to get set in stone once they are started.

Build and Offer A Franchise

The traditional model of active medical staff participating in ED/Trauma call is increasingly problematic, particularly in specialties heavily impacted by call. The flip side of this issue is that such specialties involve a large flow of professional fees, which are generally underestimated by physicians on call. Optimizing these fees with focused referrals and billing assistance builds the value of a franchise that can be offered to physicians interested in emergent care.

Seek Hospitalist Opportunities

Hospitalist programs have proven themselves in the effective management of “unassigned” ED patients, and this concept can be extended to major specialties, especially surgery and orthopedics. Hiring or contracting with physicians who focus on hospital-based patients, versus their own private practices, can benefit the patient, hospital and physicians, including those in these specialties who are then partially relieved of call responsibilities.

Other Structural Solutions

Other approaches that may work include:

- Tier coverage for specialties like Oral Surgery, perhaps by contracting with dentists
- Become involved in recruiting physicians for understaffed specialties.
- Consider approaches to channel uninsured patients to more cost-effective settings, such as Project Access.

4. ARRIVING AT FAIR COMPENSATION

There exist a wide variety of payment types that include flat rate per hour or day, response fees, stipends, and collection assistance. In this area information is power but do not mistake payment survey data for best practice. Payment rates are volatile and escalating. However, the process can be rationalized by tying market benchmarks to other specific factors:

- Volume of consultation
- Volume of emergent responses/surgeries
- Number of call days per month
- Proportion of uninsured patients
- In-house call versus on-call support
- Presence of a of residency or physician extender support

Factor in the franchise value of participation in that a hospital that can attract, filter and channel specific cases to a specialty is highly desirable. Not all ED patients lack resources; many in fact have insurance so collection and revenue cycle management assistance is an important offset to direct payments. Institutions often assist physicians by collecting receipts and providing additional payments to insure an average and equitable payment rate.

In dealing with physician leverage, institutional performance provides a clear constraint but Stark should be the ultimate backstop. Whether an employment or contracting relationship is pursued is always defined by the long-term strategy set out in the beginning of this process.

5. LOOKING TO THE FUTURE – THE EMERGENCY SURGERY HOSPITAL

The most recent trend, the ultimate model of a regional solution, is a hospital and medical staff that restructures itself to pursue emergency patients as a core business strategy. By attracting a critical mass of emergency patients, appropriate medical and hospital resources can be applied in a “super” hospitalist approach. A regional trauma center, a busy emergency department, and outreach to other emergency patients can generate the emergency patient volumes and resources necessary to support a dedicated medical staff structure.

This approach was first developed for neurosurgery in Orange County, California, where it has worked very well for over a decade. The combination of trauma cases, emergency neurosurgical cases and unassigned cases at these hospitals provides a sufficient patient base and referral stream to support the on-call neurosurgeons.

6. CONCLUSION

While physician response to patients in the emergency department can be an ethical issue, it is primarily an economic issue. Call provides value, and a critical mass of physicians is demanding relief or compensation. This issue will not go away, and the physician leaders who recognize this and take a constructive approach will find opportunities to strengthen their hospitals that their competitors will forgo.

(1) The Physician Executive, May-June 2005

(2) McCaig LF, Ly N. National hospital ambulatory medical care survey: 2000 emergency department summary. Advance data from vital statistics; no 326. Hyattsville, MD: national Center for Health Statistics. 2003.

(3) Rudkin SE, et al. "The State of ED On-Call Coverage in California", American Journal of Emergency Medicine (22) No 7, 2004. pp. 575-581.

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