Hospitalist Management Resources, LLC

Transitioning ED Call Panel Compensation Away From Stipends
Effective Strategies for Fair, Equitable and Sustainable ED and Trauma Call Compensation Solutions

Whitepaper
June 26, 2014

Hospital Administrators across the country are challenged by ever-increasing ED On-Call Stipends that cause lack of alignment between the Hospital and ED Call panel members. Is there a solution?

Yes!
This Whitepaper will describe your options to approaching this common challenge.

ED Call Stipend History:
In the past, one of the biggest issues challenging hospitals and healthcare systems was the growing unassigned, uninsured and underinsured patient population that stressed ED call panel members. Additionally, Hospitals desiring Trauma designation ran into resistance from their Medical Staff unless a compensation solution was implemented.

As a result of the increase in numbers of unassigned, uninsured, and underinsured patients, the burden of ED and Trauma Call on specialty call panels increased dramatically. Many call panel physicians were refusing to take call unless they received compensation—primarily because of the effect on their

private practices, and also because of an environment where reimbursement from federal and state payers continued to decrease.

To the on-call physicians, the ED Call issue is not only a matter of compensation, but of lifestyle quality. Call coverage interferes with their professional and personal lives. It disrupts family activities, affects social engagements, interferes with sleep and requires that physicians remain in close proximity to the hospital during call hours. A recent survey found that lifestyle issues were central in physicians' dissatisfaction with call. Ninety percent of the physicians surveyed indicated that they would not take more call for more money.[1] In many instances, the discussion was about payment, but the issue was lifestyle.

The simplest and most straightforward approach was to pay the physicians a daily per diem or 'stipend' to provide the ED and Trauma call coverage for their specialty. What seemed like a reasonable solution for the high volume and critical specialties has turned into an enormous expenditure that is expanding to all ED panel members, no matter how frequently they are called. What started out as a $400,000 to $600,000 line item expense for a hospital has grown to a $4 to $5 million line item, with no end in sight! These stipend expenses are inflating simultaneously as hospital revenues are declining with decreased volumes and reimbursements. It is critical for hospitals to look for an alternative to stipends to develop a more sustainable ED and Trauma Call compensation solution.

Strategy to Transition Away from Stipends

It is rare for an administrator to be successful in discontinuing stipend payments for ED Call without having another alternative. ED panel members are powerful, assertive and have become accustomed to the stipend payments and withdrawal is no easy task.

[1] "Night and Weekend Call: Tough but Manageable." *The Physician's Advisory, September 2000.*

What are the options for administrators to curb or eliminate the stipend payments? The solution starts with an understanding and is followed by a long-term strategy.

In order to develop a reasonable strategy, it is important that hospital leaders (including the Hospital Board of Directors) understand the way ED Call is affecting on-call physicians' lifestyles and incomes. For the physicians, it is not simply a compensation issue but quality of life issue due to the burden and irritants of being on call.

The following five steps briefly describe the process to determine a solution for your ED Call Panel Compensation issue.

1. Understand the Call Burden Data

The first step is to get the data to understand the burden of call.

The data will help you understand how to minimize the call burden by identifying the frequency, burden, and acuity of call by specialty. A professional physician coder should collect a study sample of approximately 300 unassigned patient medical records in a study period—this sample size has proven to be fairly representative of an annual patient population in an emergency department.

The sample should be drawn from a time frame for which hospital coders have completed medical record abstracts on the ED unassigned as well as Trauma patient population. The coding abstract should contain:

1) The name of all physicians on the case from admission to discharge
2) Insurance status and financial class of the patient
3) The DRG assigned
4) The inpatient length-of-stay
5) Diagnosis with ICD-9 codes
6) Total hospital charges per discharge
7) Discharge destination (home, SNF, another hospital, etc.)
8) Identify all physicians participating in the patients care and what CPT codes they generated.

Input this data into a computer and analyze the results.

2. Interview the Panel Members

The second step is to understand the burden of call for each sub specialty panel. Spend time listening to the concerns and issues of your Medical Staff panel members. Often, the burden of call is about the *irritants* of call. Responsiveness of the ED, ability to access the OR and assistance with the patient's social issues often make ED call worse than it should be. Lead by listening to capture the issues you are trying to solve. Often, the call burden exists because there is lack of adequate manpower to cover the ED, which can only be rectified by recruiting more specialists. Also, most Hospitalist Programs are now admitting the majority of the ED Unassigned Patients and calling consults as needed. If your Hospitalist Program is not providing this service, it will merit investigation.

3. Establish a Steering Committee

At the same time, an ED steering committee should be formed to evaluate the impact of ED call on the physicians' private lives and practices. The goal of the ED Steering Committee is to develop a fair and equitable solution for ED call. The payment for ED call should not be seen as something that is negotiated specialty by specialty, but seen as a Medical Staff issue that requires a solution that is fair and consistent for all members of the Medical Staff. Allowing a few specialties to 'drain the pool' with high stipends only creates resentment and fosters distrust between Administration and the Medical Staff. Conversely, openly sharing the call burden data and discussing options that treat all members fairly is the optimal solution.

4. A Wide Array of Solutions

The call burden data analysis, combined with in-depth physician interviews, will objectively define the burden of call by specialty and identify the major challenges expressed by ED call panel physicians. Reviewing these data will help the ED Steering Committee identify recommendations to ease the burden of call and reimburse ED call panel members in a fair and equitable manner.

Some of the following options, supported by a financial business plan, may be considered:

- Remove irritants of call; i.e., provide block scheduling in the OR for cases from the ED
- Improve the ED and how the ED physicians assess critical patient problems
- Develop an Internal Medicine hospitalist program that can admit a majority of the ED unassigned patients and request specialty consults
- Develop specialty hospitalist programs such as Surgicalists, Orthopaedic Hospitalists, Laborists and Intensivists
- Reassess/revise bylaws with respect to mandatory on-call without pay and/or voluntary call
- Pay for excess days of call (typically more than 7 days of call per month)
- Regionalize care by specialty among local hospitals with community call panels
- Hire mid-level provider first responders (physician assistants and nurse practitioners), especially for night call
- Develop co-management agreements that align incentives with the call panel members
- Implement an EMTALA Activation Fee to compensate for accepting out of area transfers
- Implement a Trauma Response Fee to compensate specialists for responding immediately to the ED for critically injured patients
- Incorporate minimum ED coverage requirements into physician employment contracts
- Implement telemedicine solutions
- Implement weekend moonlighter coverage
- Guarantee pay for work performed, which may include:
    - All ED patients
    - Uninsured and/or Underinsured patients only
    - Uninsured patients outside of the immediate service area
  - Option to fund the compensation program through a tax favored (deferred) mechanism
  - Develop a hybrid compensation model combining one or more solutions (including a hybrid stipend plus pay for productivity payments).

5. Transitioning away from Stipends

Through transparency of findings from data collection and interviews, the ED Steering Committee can work with Administration to develop compensation

options that will create more alignment between the Hospital and the Medical Staff ED panel members. The process must be grounded in data and not antidotal horror stories about ED call. Using the data, it will be important to break out the high volume ED panels from the less frequently called panels.

The high volume ED panels may be allowed to initially remain on the stipend solution while the low volume panels are transitioned to a new compensation solution.

One option for the low ED volume specialties is a solution that includes:

1. Pay for Productivity (chose between Unfunded Only, Unfunded and Medicaid and All Unassigned).
2. Pay an EMTALA (higher level of care) Response Fee to the Admitting/Receiving Panel Member.
3. Pay a Trauma Activation Fee to the specialist responding to a Trauma patient in the ED or immediately to surgery.
4. (Optional) Pay a flat On Call Stipend of $200 for each panel member for the inconvenience of carrying the beeper.
5. Utilize the Hospitalist Program to admit the majority of their ED patients and call for consultations.

This solution rewards response and creates more alignment with the hospital while still remaining within Fair Market Value.

Next, the high volume panels should be evaluated to determine whether sufficient volumes exist that would justify transitioning those panels to a sub specialty hospitalist program, often referred to as Surgicalist and Orthopaedic/Traumatologist Programs. Typically, these hospitalist programs can pencil when the stipends exceed $1,500 per day. The data collected combined with a business plan will determine when the transition should occur. Studies have now verified that Surgicalist and Orthopaedic Hospitalist Programs provide a return on investment similar to the Internal Medicine Hospitalist Programs. Often, the local surgeons can be incorporated into the Hospitalist Program staffing.

Summary

A clear and collaborative process with the medical staff will encourage an environment of trust and openness that will ultimately facilitate the development of a fair and equitable solution. Minimizing the burden of call and being fair and equitable to all on-call physicians will not only help align financial and clinical incentives for proper behavior patterns, but also make the ED and Trauma call more appealing. Transitioning the ED and Trauma call panels from stipends is a multi-step process, but can produce clinical as well as financial rewards for the Hospital. Finally, the data produced by following this disciplined process will help the hospital develop a financial business plan to address the short- and long-term needs of medical staff members taking call. Change is never easy, but delaying change can be even more painful. Now is the time to evaluate your ED and Trauma call panel compensation and develop long term solutions that are fair and equitable for the Medical Staff and financially sustainable for the Hospital. If a Hospital has not started paying for Call coverage, that is the ideal time to introduce the discipline described above and avoid stipends in the first place.

Contact HMR, LLC for a free one hour phone consultation to determine whether your Hospital is a candidate to transition from stipends to a more financially sustainable solution.

Martin Buser, M.P.H., FACHE
mbuser@hmrllc.com | 858.344.1060

Roger Heroux, M.H.A., Ph.D., FACHE
rheroux@hmrllc.com | 719.331.7119

Authors:
Martin Buser, M.P.H., FACHE and *Roger Heroux*, M.H.A., Ph.D., FACHE, founding partners of Hospitalist Management Resources, LLC and HMR ED Call Panel Solutions. Their firm specializes in developing solutions for ED call compensation that is fair and equitable while being financially sustainable for the Hospital. For more information please visit *www.hmrllc.com or contact them at mbuser@hmrllc.com or rheroux@hmrllc.com* .