



# Compensating Physicians for Emergency Department Call

*Presented to the 2007 ACHE Congress on Administration by*

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# Background

- **1918-ACS**

- Hospital Standardization Program states, “That physicians and surgeons privileged to practice in the hospital be organized as a definite group or staff defined as the group of doctors who practice in the hospital”
- Hospitals and medical staffs enjoyed a relatively symbiotic relationship where the hospital providing staff, facilities, and equipment; the medical staff providing oversight for quality and professional coverage for emergencies and consultation

# The Crunch

- Hospitals face decreasing physician coverage for critical services including ED call
- Many specialists are exploiting their upper hand as shortage of service providers intensifies, refusing responsibility — or demanding significant compensation — for medical staff duties once considered a condition for privileges

## Not an Easy Answer

- Increasing prevalence of subsidy programs outpaced only by increasing cost and complexity of methods
- Subsidy expenses proving difficult to contain as specialists demand ever-greater payment—giving rise to multi-million dollar programs

# Learning Objectives

- Establish a proactive and fair formula-based compensation methodology
- Move your unstable emergency department call arrangements into a proactive, method-based and data driven process

# A Change In Attitude

- **Past Emergency Department Protocols:**

- Failing to respond to emergency department or accept ED unconscionable resulting in strong negative response and possible sanctions from MEC.
- When patients admitted to ED, phone calls made to specialists responding as medical staff obligation.
- Specialists not worried about ability to pay, or spending night without compensation.

- **Current realities:**

- An ED without appropriate specialty coverage a liability and flawed business strategy.
- Mandating coverage through sanctions and disciplinary processes not a solution; only exacerbate it.
- Paying physicians to be available may be a positive business decision.
- Specialty physicians have a community obligation to participate on ED call panels, but not on pro bono basis.

## A Change In Attitude (continued):

- Problems resolved when both hospital and physicians agree on long-term plan to provide reasonable pay for reasonable call coverage.
- All parties should collaboratively to design, implement and administer a specialty physician call compensation program.

# Survey of Hospitals- Governance Institute 2004

- On-call coverage
  - 54% **do not** provide nor plan to provide payment or supplemental payment to physicians for on-call coverage
  - 42% reported that specialists have refused to provide on-call coverage
  - 46% who **do pay** for on-call coverage favor daily stipend as their method
    - Average stipend range: \$407–\$878
    - Highest daily stipend: \$2,000; Lowest: \$50
  - When on-call coverage is provided, it is in the following clinical service areas:
    - obstetrics
    - orthopedic surgery
    - pediatrics
    - internal medicine
    - urology
    - family medicine

## Survey of Hospitals- Governance Institute 2004 (continued)

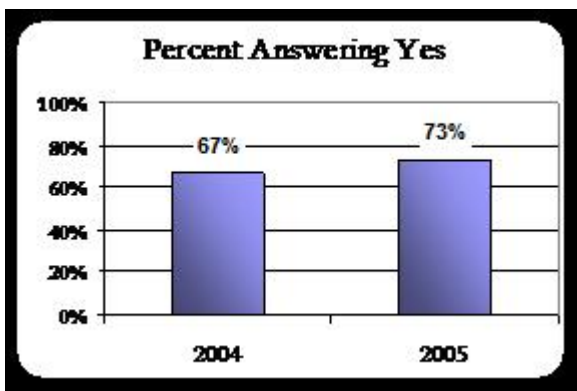
- External factors
  - Age Specific Requirements
    - 37% said the medical staff has an age-specific requirement for its members to take ED call;
    - 31% said physicians are required to take call for as long as they are on the medical staff.

# On-Call Specialist Coverage in U.S. Emergency Departments

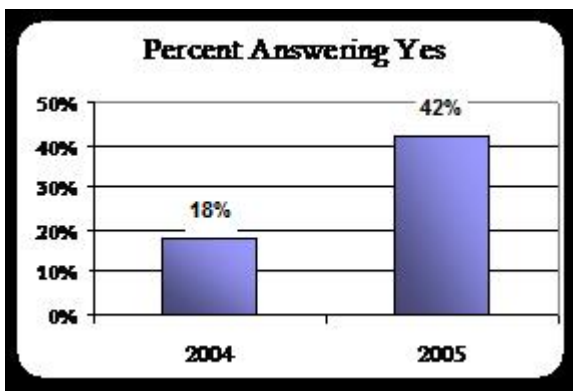
## • ACEP Survey of Emergency Department Directors in April 2006

1. Three-quarters of hospitals across the country had problems getting adequate call coverage.
2. 42% of specialists negotiated for less call, an increase of 2½ times over the previous year.
3. 36% of specialists received stipends for taking call, an increase of 4½ times over the previous year.

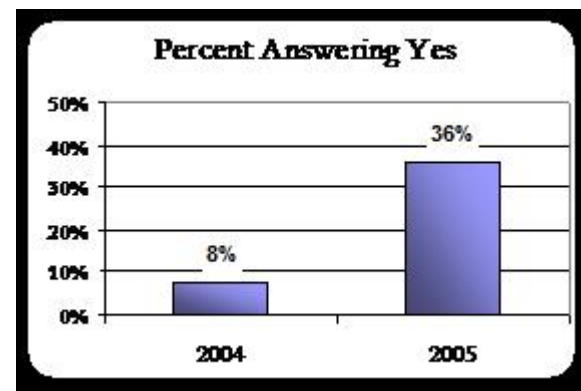
1. “Does your hospital have a problem with inadequate on-call coverage by specialty physicians?”



2. “Have any specialist physicians negotiated for less on-call duty in the past year?”



3. “Does your hospital pay stipends\* to any specialist physicians for providing on-call coverage?”



\*Stipends are defined as fees received for being on-call even when no patients are seen.

# Emergency Department Call Compensation Options

- Examples:
  - Shift on-call rate
  - Shift rate after minimum number of shifts covered
  - Fee schedule” for uninsured patients
  - Fee schedule for unassigned patients
  - Per admit + Fee schedule for uninsured patients

## Emergency Department Call Compensation Options (cont.)

- Examples:
  - Per encounter rate based on number of times called in
  - “Department Opt-Out” program; physicians pay a set fee to the department to opt-out of taking call - those physicians that take ED call, receive the payment from the department funded by those that opted out.
  - Hospitalist program covers ED call
  - Specialty / Department call pay for covering Emergency Department call



**Case Study**  
**Ashley Valley Medical Center:**  
**First Attempt at Resolution**

# Case Study:

## Ashley Valley Medical Center

- **Background**

- Small, rural hospital
  - 39 beds
  - 27 Physicians on Active Staff
- Hospital part of for-profit system
- Growing community
- Solid hospital earnings line, with marked improvement over a 5-year trend
- Increasing awareness of EMTALA among Medical Staff Members
- Hospital took conservative interpretation of Stark laws

## Case Study: Ashley Valley Medical Center

- Background (continued):
  - Medical Staff grew from 23 physicians to 27 in 4 year period
  - Physicians experiencing increased malpractice costs
  - Stable to decreasing physician reimbursement
  - Generalized breakdown of historic camaraderie among medical staff members
  - Growing misdirected anger at the hospital—easier than attacking physician peers
  - New, younger on staff physicians

## Case Study: Ashley Valley Medical Center

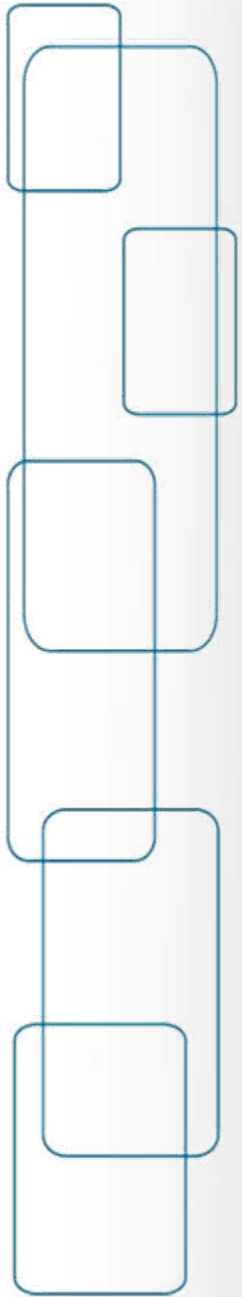
- Background (continued):
  - Female Family Practice physician announced she was no longer going to participate in call because it was too hard on her family (1 of 5 FPs).
  - Concern among Family Practice physicians of increasing call burden
  - No reference to hospital or medical staff bylaws relating to an emergency room call requirement
  - One (1) physician against hospital and the “tradition” of providing call services to the hospital for free.

## Case Study: Ashley Valley Medical Center

- First Attempt at Resolution:
  - Paid Internal Medicine physicians on staff (3) to take weekend call for the FPs. Pediatricians (3) agreed to take pediatric call on the weekends.
  - Recruited one (1) incremental family practice physician
  - Sort of worked for 2 years; but still some discontent, particularly by 2 Family Practice physicians
  - Physician relations continuing to deteriorate with hospital and among each other.
  - Growing outcry from medical staff for hospital to pay for call services that physicians provided—fueled by national trends.



# The Physicians' Perspective



# National Trends

- Mandatory call v. Voluntary call
  - Medical Society Resolutions prompting Bylaws changes
  - Leverage for Pay: Physicians want to feel valued

## National Trends (continued)

- Mandatory call v. Voluntary call
  - Medical Staff Obligations
  - Individual Obligation
  - Department Obligation

## National Trends (continued)

- *Physician Executive, May 2005*

### **Prediction:**

- In the future all hospitals will have to have a line item for ED Call Compensation

## Chief of Staff Boot Camp Input

- 4 Focus Groups were held during 2005 – 2006
  - Physician Focus Group Goal:
    - Define “Fair” Compensation across all medical specialties

# Chief of Staff Boot Camp Input: The Physicians' Response

- “Fair” Compensation Factors to include:
  - Average compensation per specialty, per geographic region
  - Malpractice rate per specialty, per geographic region
  - Frequency of calls made to the ED
  - Severity of Call
  - Payer Mix
  - Number of Phone Calls

# Chief of Staff Boot Camp Input: The Physicians' Response (continued)

- Elements of “Fair” Compensation Formula:
  - Work Factor
    - Actual work in ED
    - Lost work due to taking call
  - Lifestyle Factor
    - Pager stipend
    - Phone time



# **Ashley Valley Medical Center: Second Attempt at Resolution**

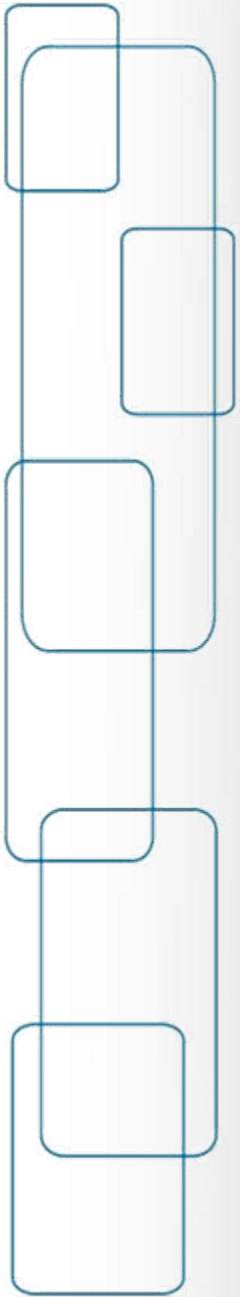


# Case Study:

## Ashley Valley Medical Center

- Hospital Goals:
  - Replace previous attempt with payment for call coverage with:
    - Physicians who were part of a specialty that provided 24/7 call
    - Specialties approved by the Board
  - Try to use this challenge as a means of improving relationships by working together to solve the problem
  - Use an established payment methodology determined and agreed upon ahead of time
  - Incorporated call and payment into Medical Staff Rules/Regs and Bylaws

# Working Together



# Getting Buy-in from the Medical Staff

- Initial Meeting Agenda
  - Hospital EMTALA Obligation
  - Medical Staff Options: Bylaws
  - Departmental Responsibility
  - Presentation of “Fair” Model

## Getting Buy-in from the Medical Staff (continued)

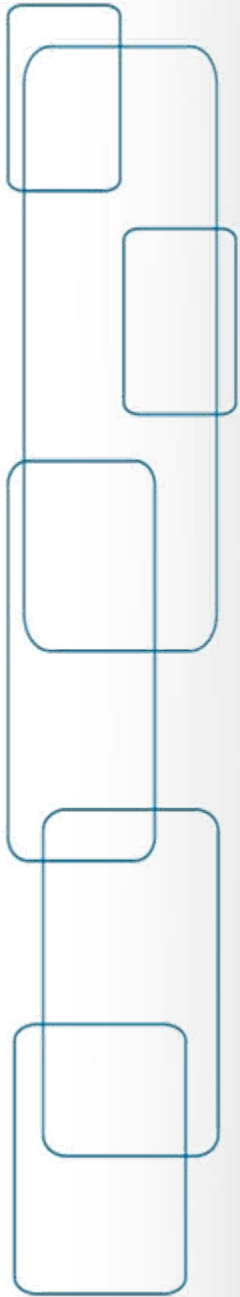
- Follow-up with Physician Leadership
  - Issues raised by Medical Staff: serve as mediator
  - Data-driven process
  - How much data to present to Medical Staff?

# Aligning the Hospital and Medical Staff

## Essential Elements:

- Find a Physician Champion: e.g. Dr. Rod Pollary at AVMC
- Share detailed data with CEO and Physician Champion
- Get physicians to think as a medical staff not as individuals: Bylaws, Rules and Regulations, Department (PAC) specific
- Physician mediator: the ethical and moral obligations of a medical staff
- Acknowledge physician concerns
- Physicians need to feel valued!
- Physician responsibility for accurate data collection along with hospital

# Creating the Formula



# Physician ED Call Process Components

- Process components:
  1. Meet with physicians in group(s) to discuss relevant issues.
  2. Meet with hospital management regarding current call arrangements.
  3. Collect Emergency Department data.
  4. Apply data to methodology and model.
  5. Present data driven model to hospital.
  6. Make adjustments to model per hospital input.
  7. Present model to physicians.
  8. Develop provider services agreements.

# Physician ED Call Objectives & Work Plan

- Physician ED Call Objective
  - To provide the Hospital / Medical center with a data-based compensation plan for the physicians taking Emergency Department call.
- Work Plan & Basic Outline
  - Collect Hospital / Medical Center specific data. The main data elements collected include:
    - Call schedule
    - Actual hours spent / worked in ED by physician
    - ED Payer mix by specialty
    - ED case severity (ED case mix index)
    - ED LOS
  - Basic Steps:
    - Calculate ED call compensation for each specialty taking call
    - Present draft compensation methodology and outcomes to Hospital / Medical Center, including physician leadership
    - Present compensation methodology to physicians

# Physician ED Call Methodology

- ED call compensation model consists of three key components:
    - PART 1: Benchmark Compensation Per Hour Adjusted for:
      - Specialty
      - Region
      - Increased Malpractice Risk in the ED
    - PART 2: Apply Four Components of Call to the Model:
      - Payment for
        - Uncompensated Time in ED.
        - Clinical Disruption.
        - Carrying Pager.
        - Phone Consults.
    - PART 3: Calculate ED Call Compensation for Each Specialty:
      - Per year\*
      - Per day on-call\*
- \*Annual percentage adjustment based on CPI

# Physician ED Call Model Example

## ED Call Compensation Model Example - by Specialty

	Internal Medicine	Obstetrics	Family Practice	Pediatrics	Total Primary Care	General Surgery	Orthopedic Surg	ENT	Total Specialists	Total
<b>1 Hours in ED Compensation</b>	\$ 11,868	\$ 15,334	\$ 9,043	\$ 8,561	<b>\$ 44,806</b>	\$ 9,005	\$ 1,757	\$ 3,244	<b>\$ 14,005</b>	<b>\$ 58,811</b>
<b>2 Lost Clinical Hours Compensation</b>	\$ 17,106	\$ 1,024	\$ 4,059	\$ 3,356	<b>\$ 25,544</b>	\$ 5,374	\$ 2,831	\$ 2,831	<b>\$ 11,037</b>	<b>\$ 36,581</b>
<b>3 Pager Compensation</b>	\$ 18,467	\$ 13,191	\$ 10,553	\$ 10,553	<b>\$ 52,763</b>	\$ 18,467	\$ 13,191	\$ 10,553	<b>\$ 42,210</b>	<b>\$ 94,973</b>
<b>4 Phone Consult Compensation</b>	\$ 6,281	\$ 3,141	\$ 5,025	\$ 3,141	<b>\$ 17,588</b>	\$ 1,841	\$ 1,841	\$ 368	<b>\$ 4,051</b>	<b>\$ 21,639</b>
<b>Total ED Call Compensation</b>	<b>\$ 53,722</b>	<b>\$ 32,690</b>	<b>\$ 28,679</b>	<b>\$ 25,610</b>	<b>\$ 140,701</b>	<b>\$ 34,687</b>	<b>\$ 19,620</b>	<b>\$ 16,996</b>	<b>\$ 71,303</b>	<b>\$ 212,004</b>

# Comparative Rates by Specialty at AVMC

- Internal Medicine- 100%
- OB/Gyn- 62%
- Family Practice- 54%
- Pediatrics- 48%
- General Surgery- 65%
- Orthopedics- 37%
- ENT- 32%

# Physician ED Call Anticipated Outcomes

- Hospital Savings from reduced call compensation
- Physicians across all specialties receive equitable ED call compensation from hospital.
- Hospital attains ongoing stable ED call coverage.
- Hospital avoids yearly ED call negotiations in the future.

# Potential Impact of Data-Driven Methodology

Typical Hospital Setting		Hospital Setting Using Data Driven Methodology	
Total Specialties Receiving Call	7	Total Specialties Receiving Call	7
Avg. Per Night Per Specialty ED Call Payment	\$ 750	Avg. Per Night Per Specialty ED Call Payment	\$ 150
Total Per Night Per Specialty ED Call Payment	\$ 5,250	Total Per Night Per Specialty ED Call Payment	\$ 1,050
Total Yearly ED Call Payment	<b>\$ 1,916,250</b>	Total Yearly ED Call Payment	<b>\$ 383,250</b>
		Potential Savings	<b>\$ 1,533,000</b>

Typical Hospital Setting		Hospital Setting Using Data Driven Methodology	
Total Yearly ED Call Payment	\$ 1,916,250	Total Yearly ED Call Payment	\$ 383,250
Implementation w/ No Escalation		Implementation w/ 3% Escalation	
Year 1	\$ -	Year 1	\$ 383,250
Year 2	\$ -	Year 2	\$ 394,748
Year 3	\$ 1,916,250	Year 3	\$ 406,590
Year 4	\$ 1,916,250	Year 4	\$ 418,788
Year 5	\$ 1,916,250	Year 5	\$ 431,351
Year 6	\$ 1,916,250	Year 6	\$ 444,292
Year 7	\$ 1,916,250	Year 7	\$ 457,621
Year 8	\$ 1,916,250	Year 8	\$ 471,349
Year 9	\$ 1,916,250	Year 9	\$ 485,490
Year 10	\$ 1,916,250	Year 10	\$ 500,054
10-Year Total	\$ 15,330,000	10-Year Total	\$ 4,393,532
		Potential Savings	<b>\$10,936,468</b>



# **Ashley Valley Medical Center: The End Result**

# Pitfalls

- Easy for physicians to get bogged down in the details of the formula
- Anti-kickback regulations increase difficulties in determining a good workload indicator for the formula
- Much of the formula had to be based on assumptions because there was just not data available through systems, and manual tracking was time intensive and only semi-accurate

## Bright Spots

- Have a physician mediator; not another administrative type
- Focus on data to remove emotion in this charged debate
- Some positive physician leaders emerged to broker a win/win solution
- Negative physician leaders became more isolated
- Call language was added to Bylaws and Rules & Regulations
- Physicians feel more valued for the vital service that they offer. It was as much about the recognition as the money

## What We Ended Up With

- Process outlined in Rules and Regs
- Requirement in the Bylaws
- Rate that varies by specialty and by week day verses weekend
- Payment only for specialties who provide 24/7 Call
- Specialties have to be approved by the Board (Mechanism for adding future specialties)

## What We Ended Up With (continued)

- Annual escalator in daily rate, and a stable call expense for budgets
- Annual review of “workload” to assess fairness of call payment distribution among specialties.
- Semi-functional mechanism for resolving physician call disputes.
- Diminished the power of Medical Staff members trying to make it an “us verses them” issue with the hospital.

## If I Had to Do it All Again...

- Limit number of physician leaders selected to review the details; not the whole group
- Involve ED physicians in the initial conversations; do not allow the debate to be physicians vs. hospital
- Acknowledge physicians for the time they are on call; do not take it for granted or focus on time not on call
- Base discussions on facts; begin gathering data now, at the beginning of the storm.

## If I Had to Do it All Again (continued)...

- Use a third party to help mediate, for example, a MD who understands administrative and financial realities
- Effectively articulate the real benefits physicians receive through ED call
- Utilize a formula to take into account significant factors for reimbursement and benefits already received; focus on deriving a data driven reimbursement amount.



## **Presenter Bios and Contact Information**



# Presenter Biographies

- Mr. Salmon is a former hospital administrator, both nationally and internationally, and former Vice President of Hospital Corporation of America. He is currently Chief Operating Officer of Phase 2 Consulting, a RehabCare Company, based in Salt Lake City. Phase 2 Consulting provides consulting services to numerous hospitals and health care organizations, helping them improve their bottom lines while delivering high quality care. Mr. Salmon helps hospitals and health systems develop dynamic, pragmatic strategic plans, and has special expertise in coaching physician leaders and hospital senior executives in collaborating effectively. He is Chairman of Miracor, a publicly held imaging company based in San Diego and a Fellow in the American College of Healthcare Executives.
- Dr. Reynolds, Senior Consultant, Phase 2 Consulting, is an executive coach and leadership development expert specializing in physician leadership. She is the President and CEO of The Institute for Medical Leadership, which provides leadership training and executive coaching to health care executives and physician leaders across the United States. She is a former emergency physician, CEO of an emergency medical center, White House advisor, and executive search consultant, who created a Physician Leadership Training Institute for the American Medical Association. Her clients include numerous hospitals and health systems, state and national medical societies, and academic medical centers.
- Si Hutt is the current Chief Executive Officer of Ashley Valley Medical Center, a 39-bed hospital in rural Utah, and has been in that position since 2001. For the previous 6 years, he worked as the Assistant and Associate Administrator with Ogden Regional Medical Center, a 239-bed hospital. Through-out his career, Si has focused on physician recruiting and relations, customer service, and process improvement. As an advocate for effective communication, Si has made numerous presentations to audiences ranging from junior high students to community groups to healthcare professionals about the successes and challenges within the healthcare industry at a local, state, and national level.

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