ED WATCH

CLINICAL INITIATIVES CENTER

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TO: Clinical Initiatives Center Members

FROM: Kyle Weston

DATE: May 2, 2000

CAUSE FOR CONCERN

ENSURING ADEQUATE AND TIMELY ON-CALL PHYSICIAN COVERAGE IN THE EMERGENCY DEPARTMENT

POINTS OF DISCUSSION

Introduction

Readily available physician consultation is essential to the effective practice of emergency medicine. Patients who present to the emergency department (ED) often require a level of care that can only be achieved through active collaboration between providers. This includes close clinical interactions between emergency physicians (EPs) and various specialists external to the ED. At times, however, this process breaks down. Namely, some ED consultants—including on-call specialists called in to treat specific problems, in-house physicians covering certain clinical services, and patients' own personal physicians—fail to respond to the ED in a timely manner when requested. To make matters worse, neither internal hospital administrators nor external regulatory authorities typically hold consultants accountable to any real degree for their inaction.

This *Watch* focuses primarily on problems associated with *backup or on-call physicians*—one particular group of consultants comprised principally of specialists and subspecialists responsible for providing timely expert care in the ED (see Definitional Note below). Backup physicians commonly treat unattended patients, both those who lack private physicians (the indigent, the uninsured) and those who arrive at the ED extremely sick or seriously injured (the semiurgent, the emergent). If patients have their own private physicians or belong to health maintenance organizations (HMOs) and their presenting condition is not life-threatening, ED staff usually first contact these individuals and organizations to arrange—whenever possible—for patients to receive in-network specialty care.

This *Watch* begins by reporting on cases involving recalcitrant on-call physicians who, by their inaction, adversely affected patient care. Then follows in-depth discussions on the four major barriers to timely consultant response in the ED, as well as commentary on the legal risks physicians and hospitals face due to insufficient on-call coverage. Next we profile five select strategies that address some of the challenges associated with on-call physicians. The briefing concludes with two appendixes: the first summarizes results from a statewide California survey that illustrates the magnitude of the ED backup physician problem, the second provides a sample medical staff policy one hospital instituted to specify on-call physician responsibilities in the ED.

Delayed consultant response to the ED is a difficult issue to disentangle, but one worthy of close examination. We hope that this briefing informs members about the complexity and importance of providing sufficient backup physician coverage in the ED. The *Watch* should also serve as a platform upon which productive discussions can ensue among all involved parties—ED staff, on-call physicians, and hospital administrators.

Definitional Note

Throughout this briefing, the terms "backup physician," "on-call physician," and "consultant" are used interchangeably to denote physicians—mostly specialists and subspecialists—who, by assignment, provide expert care in the ED.

Part I. A High-Profile Issue

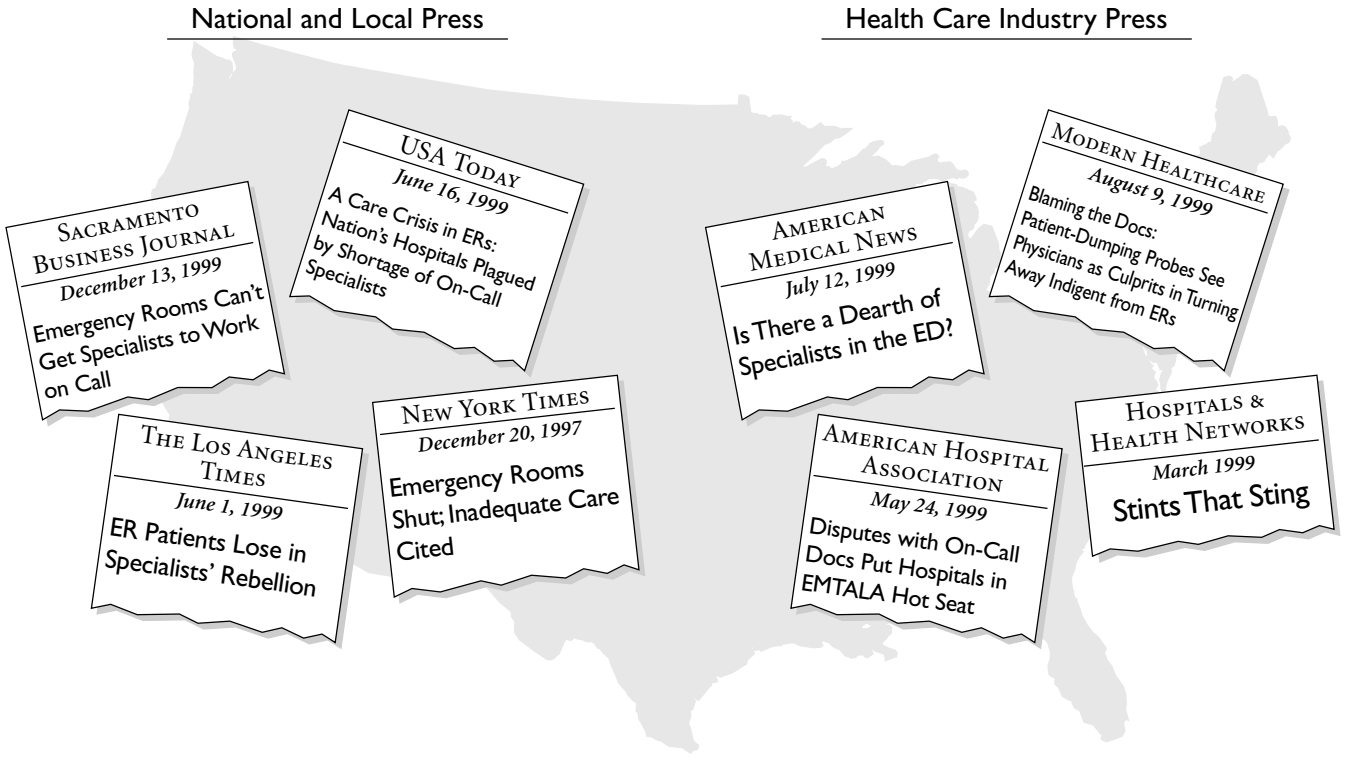
Grabbing National Headlines

A Problem at Large

Inadequate on-call physician coverage in the ED has exploded onto the national scene, hitting the front pages of both lay and health care press alike. The House of Delegates to the American Medical Association (AMA) recently asked its Board to look into the issue.[1] In California, where the issue has surfaced most visibly, 68 percent of 130 hospital administrators surveyed in late 1998 noted that lack of available backup physicians constituted a "serious" or "somewhat serious" problem.[2] Three large provider organizations there—the California Medical Association, the California Chapter of the American College of Emergency Physicians, and the California Healthcare Association—convened a special task force in an effort to identify potential solutions.[3] Providers on the East Coast have not fared well either. In late 1997, federal investigators temporarily shut down two EDs in New Jersey after discovering consultant response times exceeding 30 minutes, a violation of state health regulations.[4] And finally, the Department of Health and Human Services announced that hospital audits must now include a detailed survey of backup services available for emergency care.[5]

Catching Everyone's Attention

Insufficient On-Call Physician Availability Making Waves Nationwide



A Serious Concern

"The on-call issue is the biggest and most critical [issue affecting emergency care]…If you lose your on-call system, emergency departments will have to close."[6]

Loren Johnson, M.D.
Co-Chair of the California Emergency On-Call Task Force

Source: Clinical Initiatives Center research.

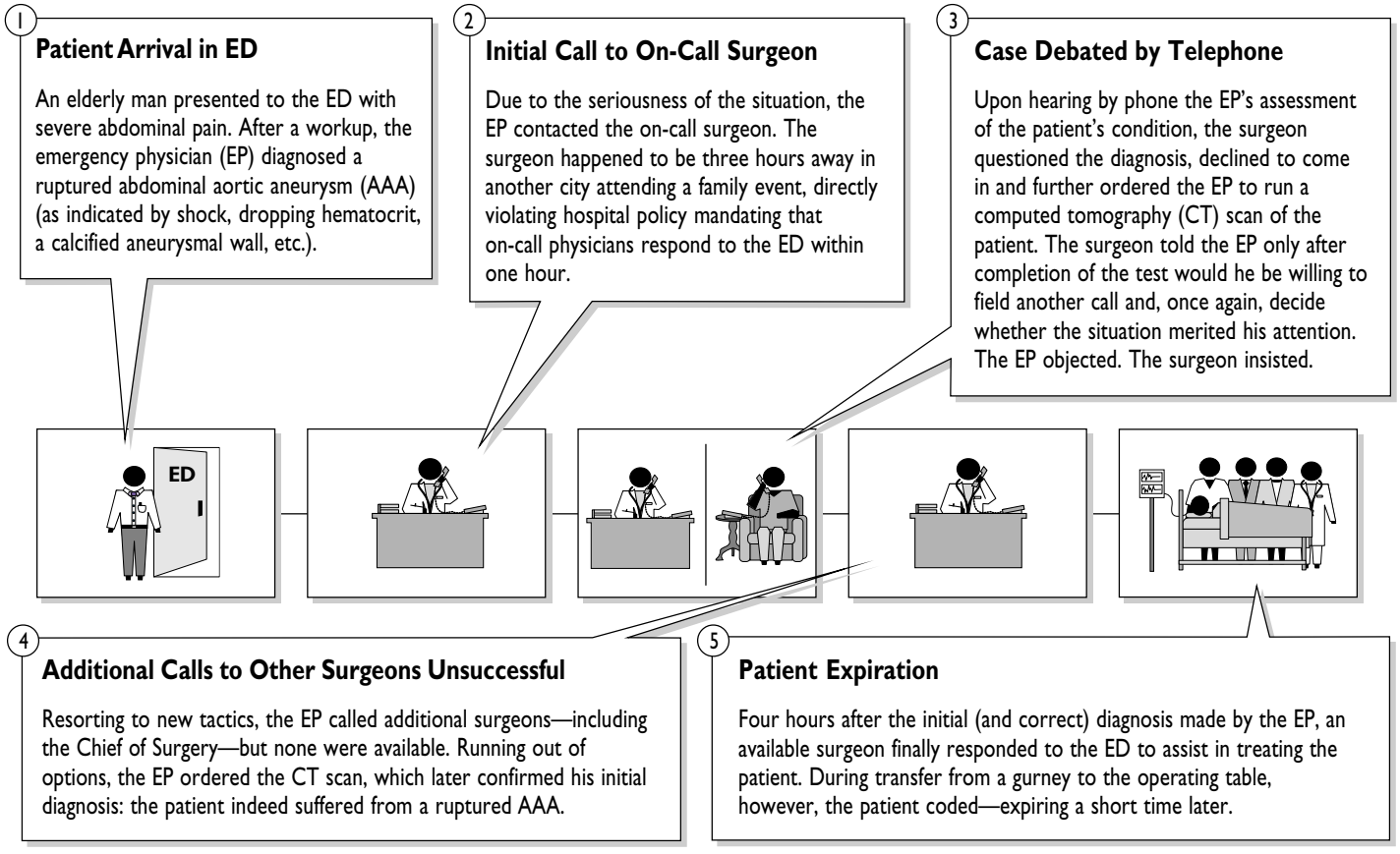
Resulting in Suboptimal Patient Care

When Patients Suffer

Patient care, unfortunately, deteriorates when backup physicians fail to respond quickly to the ED. Consider the following high-profile incident that transpired at one California hospital.[7] The case below illustrates rather egregious occurrences that have become all too common at hospitals today—occurrences that, at the extreme, can be life-threatening to patients and pose considerable legal risks to providers.[8] Bruce Sperlock, M.D., with the California Healthcare Association, described the on-call problem in the following terms: "the worrisome part for hospitals is that, ultimately, patient care is at risk—and that's something we all need to take very seriously."[9]

A Tragic Unfolding of Events, From Beginning to End

ED Patient Care Runs Afoul at One California Hospital Due to Unresponsive On-Call Surgeons



Physicians—Feelings of Helplessness; Patients—In Harm's Way

"There is nothing worse than being an ER physician and having a patient who is dying and clearly needs a consultant and you can't get one. You're left with a patient you feel helpless with."[10]

West Coast Emergency Physician

"It happens every day in California hospitals. I've had patients lose their limbs and lose their lives over failure to respond."[11]

California Emergency Physician

Source: Clinical Initiatives Center research.

Part II. Key Drivers of the Problem—Getting to the Crux of the Matter

An Essential Service

As noted earlier, readily available physician consultation is crucial to the practice of emergency medicine. In fact, various studies place the percentage of patients who eventually receive external physician consultation of some kind while in the ED at between 20 and 60 percent.[12]

That said, a number of barriers—key drivers of the problem—often prevent prompt consultant response to the ED. These include most prominently:

#1 Physician Inconvenience

#2 Financial Disincentives

#3 Insufficient Physician Supply

#4 Lack of Regulatory Oversight

Key Driver #1—Physician Inconvenience

Already Occupied and/or Unwilling

By definition, a call from the ED comes across to consultants frequently as an unwelcome event. The "ill-timed" call takes them away from some other activity—be it office or operating time during the day, family or sleep time during evenings, nights, and weekends, etc. Also, physicians who live significant distances from the hospital may resent the additional travel time required to attend to the ED. In short, many physicians often view being on call not just figuratively but literally a "nightmare job."

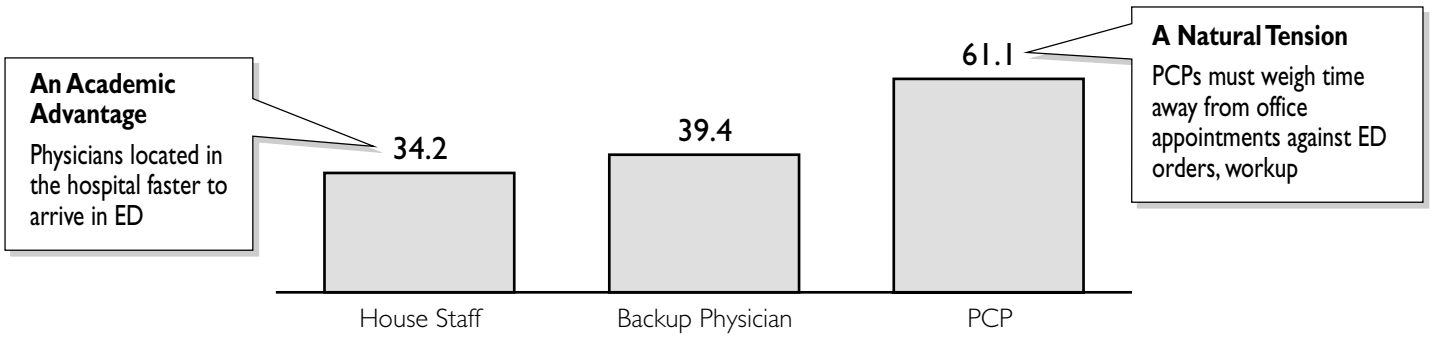
It comes as no surprise, then, that average response times to the ED for consultants who assume call responsibilities varies significantly and can be lengthy. Variation exists not just by type of consultants (house staff, backup physicians, attending PCPs) but also among individual consultants themselves. Some individual physicians, and some groups of physicians, simply respond to the ED more quickly than others, as depicted in the graphic below.

Some Speedier Than Others

Consultant Response Times to the ED Highly Variable

Variability by Type of Consultant

ED Call to Physician Arrival, Minutes (n=33 hospitals)



Source: Premier, Inc., Charlotte, N.C.; Clinical Initiatives Center interviews.

Variability by Individual Consultant

	Total (*n=21*)	The Speedy "Quick to Respond" (*n=7*)	The Tardy "Not in a Hurry" (*n=5*)
Number of Pages Required	1.5 +/– .04	1.2 +/– 0.2	1.9 +/– 0.2
Mean Time to Answer Page, Minutes	8.0 +/– 6.0	2.7 +/– 1.1	16.0 +/– 5.6
Mean Time from First Page to ED Arrival, Minutes	42 +/– 23	27 +/– 10	77 +/– 14
Mean Time from Answering Page to ED Arrival, Minutes	34 +/– 18	25 +/– 10	56 +/– 24

Note: Study authors defined a consultation as: "any instance in which a physician not based in the ED was contacted to assist in caring for a patient in the ED or to admit a patient." Authors defined a page as: "an attempt to contact a consultant by any means," including: a radio pager, overhead paging in the hospital, or a telephone call to office or home. Specialties included in the study: family practice, general internal medicine, and general surgery (most common), followed by pediatrics, obstetrics/gynecology, and orthopedics.

Source: Vosk A, "Response of Consultants to the Emergency Department: A Preliminary Report," *Annals of Emergency Medicine*, November 1998: 574–577.

Key Driver #2—Financial Disincentives

Inadequate Pay

Another major roadblock to prompt consultant response to the ED concerns reimbursement for care services rendered—or better put, lack thereof. For many hospitals, especially those located in inner-city areas, uninsured patients comprise a significant percentage of ED patients. The latest National Census Bureau figures put the total number of uninsured patients in the U.S. at almost 45 million, or roughly one out of every six individuals.[13] As a result, receiving inadequate pay commonly (and understandably) surfaces as a front-of-mind concern for many backup physicians every time ED providers request their presence. This concern can be widespread within certain specialties, like surgery and its subspecialties, where physicians spend extended periods of time treating patients only to later receive little to no pay. To be fair, a small number of physicians, usually recent medical school graduates, view taking calls as a potential source of income. For them, there exists the opportunity to build their practices by adding patients first encountered during on-call duties.

Fear of Denial

Beyond uninsured patients, some consultants fear that payment claims for treating managed care enrollees who present to the ED will be denied retrospectively due to stringent review processes practiced by health plans. Preliminary findings from the California provider task force examining the ED on-call issue support this contention. The group found concern over potential managed care claims denials to be one of the largest deterrents to timely on-call physician response to the ED, even greater than the perceived revenue loss from treating uninsured patients.[14] Additionally, one 1997 study, which surveyed over 2,000 physicians concerning medical management decision-making, revealed similarly interesting findings. On average across all specialties, physicians reported that 39 percent of all patient treatment decisions were subject to utilization review procedures employed by health plans.[15] Surgeons reported added scrutiny—43 percent of patient treatment decisions came under plan scrutiny.

Showing Some Resistance

In light of the above factors, it is not surprising that situations arise when consultants demand certain financial conditions be met prior to providing services in the ED. Some on-call physicians even go so far as to decline to respond to the ED at all. One California plastic surgeon expressed his frustration over the no-payment issue by penning the following in a letter to the *Los Angeles Times*:

Fair Pay for a Fair Day's Work

"…How often does a lawyer take on a case without a retainer?…Does the plumber leave a home where s/he has done work without expectation of being paid? How long would the *Times* continue to deliver after no payments [were] received?…"[16]

Specific cases that have caught the attention of local and national media include those summarized on the following page.

Backup Physicians Behaving Badly— Egregious Acts or Somewhat Excusable Behavior?

High-Profile Cases of Specialists Reluctant to Provide Care in the ED

Plastic Surgeon Requires Signed Promissory Note

The parents of one pediatric patient in the greater Los Angeles area had to offer $2,000 in cash to persuade a plastic surgeon to provide assistance in the ED. The plastic surgeon further required the patient's parents sign a promissory note—in advance of treatment—guaranteeing full payment.[17]

Plastic Surgeons Balk in Fear of Litigation

In New Jersey, plastic surgeons statewide refused to come to the ED to treat children with certain types of lacerations (mostly facial). To them, the risk of litigation and potential financial penalties associated with the procedure if misperformed far outweighed the nominal fee they would have received (around $50). As well, they viewed suturing of minor lacerations as elective procedures (not life or limb threatening), treatments driven more by patient and family convenience than actual clinical necessity.[18]

Orthopedists Demand Higher Fees

In San Mateo County, California, orthopedists resigned en masse from a large physician group, attributing their departure to "onerous" on-call duties that generated little pay. These physicians commented that they would only participate in ED on-call panels if guaranteed full fee reimbursement, as they had become discontented with discounted pay rates.[19]

Hospitals Pay Neurosurgeons More Money

In California, some hospitals in dire need of physician coverage have resorted to paying neurosurgeons up to $2,000 per day as a standby fee to be on-call, even though these physicians typically receive only two calls per month from the ED. Moreover, this amount comes on top of the approximately $22,000 average reimbursement for cases neurosurgeons initially assume while in the ED and then later treat in the inpatient setting.[20]

Key Driver #3—Insufficient Physician Supply

Shortages in Certain Specialties, Hospitals and Markets

Inadequate physician supply can also contribute to slow consultant response to the ED. In select markets, physician ranks may be stretched, thereby reducing the number of physicians available for backup physician pools. The graphic below conveys this point using physician supply data (by state) for general surgeons, neurosurgeons, orthopedic surgeons, and plastic surgeons—all specialists who frequently serve in on-call capacities.

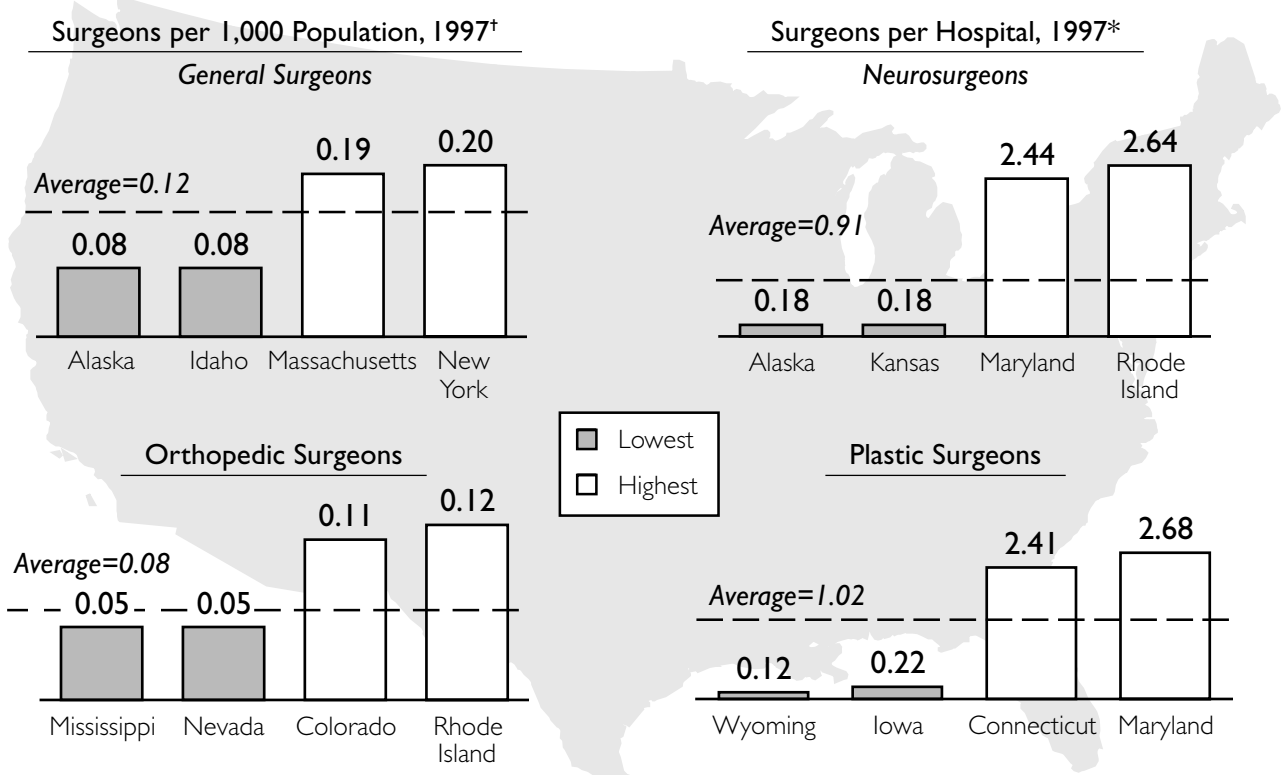
It is no surprise that states with large, urban cities tend to have a greater number of available surgeons than states with smaller, suburban and rural towns. In fact, Massachusetts and New York have more than twice the number of general surgeons per 1,000 population compared with smaller, more isolated states such as Alaska and Idaho. Likewise, the number of plastic surgeons in Maryland, calculated on a per hospital basis*, outnumber those in Wyoming by a factor of 22.

A similar distribution of consultant availability generally holds true according to institution type and organizational makeup. Academic medical centers, large health systems, and closed networks such as Kaiser typically have fewer backup physician problems. Respective to each, a greater abundance of specialists can be found in-house, in-system, or in-network. By contrast, community hospitals—especially those in outlying areas—more frequently encounter deficits in on-call physician availability. To offset this, many community hospitals sign transfer agreements with nearby facilities to take patients when necessary. Also, these institutions more commonly choose to pay specialists stipends or per diems for added on-call coverage (an issue discussed more fully in Part IV of this briefing).

The graphic below provides surgeon supply data for select states, illustrating how variable physician supply can be.

Stretched Thin

Supply of Surgeons Varies State to State, in Short Supply in Some Areas



Note: Average ratios were calculated using supply data from all 50 states. The District of Columbia was not included in this analysis for outlier reasons. Please see Appendix A for additional (survey) data on general consultant availability according to individual specialty.

* Clinical Initiatives Center staff derived the ratio of surgeons per hospital by taking the number of hospitals per state and dividing it by the number of surgeons per state.

† Clinical Initiatives Center staff derived the ratio of surgeons per 1,000 population by taking the number of surgeons per state and dividing it by number of persons per state.

Neurologists—Too Few and Overworked

"There are 14,000 active neurologists in the United States, and there are 730,000 strokes. There just isn't enough manpower, and [neurologists] aren't in the emergency department when they are needed. We're in the hospital 8 or 10 hours a day already. How can we do it all?"[21]

Thomas Brott, M.D. (Neurologist)
University of Cincinnati Medical Center

"They [neurologists] are always on call. They have no private lives at all."[22]

Bill Sandberg, Executive Director
Sacramento-El Dorado Medical Society

Source: *Physician Characteristics and Distribution in the US, 1997/1998 Edition,* Chicago: AMA; *American Hospital Statistics, 1997/1998 Edition,* Chicago: AHA; U.S. Census Bureau, http:/www.census.gov, accessed November 15, 1999; Clinical Initiatives Center analysis.

Undersized and Downsized

The second aspect of inadequate physician coverage in the ED centers on undersized and downsized physician specialty panels. Here, much of the fault rests squarely with insurers. Health plans determine the physician mix of their specialty panels, then assign patients to them. Hoping to spread the greatest number of enrollees across the fewest number of providers, these panels often fail to be of sufficient size and composition. To make matters worse, HMOs continue the practice of downsizing panels (economic deselection). In addition, health plan's own specialists, though available, at times will take longer or refuse outright to respond to an ED if the patient does not belong to "their network" of facilities. In short, plans rely—far too often—on non-contracted specialists to respond to their own members' emergency care needs, much to the detriment of both patients and providers.

Growing Subspecialization

One final trend in physician supply has further compounded the situation—increased subspecialization among consultants. This has led to greater malpractice concerns among consultants when treating certain types of ED patients. For instance, an orthopedic surgeon called to treat a pelvic injury may know more about knees; as a result, the surgeon may resist responding to the ED as she perceives the patient case falls outside her increasingly focused area of expertise.

Key Driver #4—Lack of Regulatory Oversight

Failure to Enforce at Many Levels

In addition to the three major obstacles already noted (matters of [in]convenience, financial disincentives, and inadequate physician supply), the final major barrier to timely on-call physician response to the ED concerns a general failure to adhere to regulations at all levels—federal, state, and institutional.

The federal Emergency Medical Treatment and Labor Act (EMTALA), referred to in industry parlance as the "anti-dumping" law, outlines how providers must screen, treat, and transfer ED patients regardless of their ability to pay.[23] On-call physicians who neglect their ED responsibilities can be prosecuted under this law. Some state health departments, too, have enacted their own rules regarding consultant coverage—New Jersey, for example, defines "timely response" as consultant arrival to the ED within 30 minutes of the initial call. Lastly, most hospitals lay out, in their bylaws, protocols overseeing relations between consultants and ED providers.

The problem, of course, has been a veritable lack of enforcement of these rules. Since the enactment of EMTALA—over a decade ago—the government reports that only 15 settlements with doctors have taken place, 13 of which occurred in the last four years.[24] Moreover, most hospitals rarely—if ever—penalize specialists when found delinquent in their on-call responsibilities. The reason? Specialists channel business and generate prestige for institutions.

These regulatory and enforcement issues, only touched upon here, are discussed in greater detail in the next section.

Part III. Legal Considerations

EMTALA Primer

Origin of the Law

The Emergency Medical Treatment and Labor Act (EMTALA) consists of federal legislation passed in 1986 as part of the larger Consolidated Omnibus Budget Reconciliation Act (COBRA). Put briefly, the law protects patients against care abuses in the ED at those hospitals participating in Medicare/Medicaid (a vast majority of institutions). Legislators drafted the law to remedy the situation of the late 1970s and early 1980s—a time when patients unable to pay for ED services (mostly the indigent) would be bumped around from facility to facility (literally dumped on ED doorsteps) until finally taken in. Such behavior, needless to say, resulted in numerous adverse patient outcomes, even the death of some patients. The good news, at least on this front, is that EMTALA has begun to take hold. In 1985 in Cook County, Illinois, 4,234 patient transfers occurred between hospitals. A decade later, in 1995, this number had dropped to 647—an astounding decrease of 85 percent.[25]

The Medical Screening Exam

Specifically, EMTALA mandates that all patients—regardless of financial coverage or social circumstance—who present to the ED (1) receive a medical screening exam (MSE), and (2) be medically stable prior to any interfacility transfer. Under this law, the sorting of patients conducted by nurses at triage does not qualify as a MSE; rather, a thorough medical evaluation must be completed in the back of the ED by a highly trained care professional. Exactly which provider a hospital has perform the MSE can vary, and is the subject of some debate in ED circles. Most hospitals require that the screening exam be performed by a physician. A small number of facilities allow advanced care professionals, such as nurse practitioners or physician assistants (not EMTs—too little training), to conduct the MSE. In these cases, hospitals first credential staff members and then clearly delineate their role in institutional bylaws. The American College of Emergency Physicians takes the stance that EPs, if available, should perform the MSE, as they have received the most training.

On-Call Services

With regard to on-call services, EMTALA mandates that every hospital provide backup physicians to assist EPs in determining—when requested—if an emergency condition exists or to help stabilize already emergent patients. All major specialties and subspecialties represented by the active medical staff must be included on the daily on-call list; furthermore, the list should be readily located in the medical staff office and posted in the ED at all times. Each clinical department usually creates its own call list, with physician shifts scheduled either on a weekly or monthly basis. As has been noted earlier, if a hospital lacks sufficient on-call coverage within a particular hospital service line for whatever reason (e.g., geographic location, absence of in-house specialists), the facility typically establishes patient transfer protocols with other hospitals that have access to a larger array of available specialists. These institutions may also choose to contract with specialty groups, paying physicians annual stipends or per diems to provide additional backup coverage in the ED. At times, these fees can become exorbitant, especially when hospital demand for certain specialists (e.g., neurosurgeons) in a given market outstrips existing physician supply.

Running into Legal Problems

On-call physicians violate EMTALA by not responding to EPs' requests for assistance. In so doing, they fail to aid in the examination and stabilization of patients as specified by the law. Still relatively unknown to many within the health care community, physician violations of EMTALA can carry over, in a legal sense, to hospitals. According to HCFA legal interpretations, hospitals act through their "agents." These agents include not just house physicians but also EPs and outside specialists who need not be formal employees of the hospital. As a result, if a backup physician causes a violation, and is found liable, so too can the hospital—regardless of the nature of the consultant's exact affiliation with hospital. Over one-half of EMTALA violations reported in 1998 in the state of California initially involved on-call physicians.[26]

The specific federal regulation governing backup physician coverage in the ED has been excerpted in the graphic that follows.

The Letter of the Law

HCFA Interpretive Guidelines for Consultant Coverage in the ED

Section A404 489.20(r)(2)

- The hospital agrees to provide a list of physicians who are on-call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition.
- The purpose of the on-call list is to ensure that the emergency department is prospectively aware of which physicians, including specialists and subspecialists, are available to provide treatment necessary to stabilize individuals with emergency medical conditions. If a hospital offers a service to the public, the service should be available through on-call coverage of the emergency department.

All hospital clinical service lines should be covered

- The medical staff bylaws or policies and procedures must define the responsibility of on-call physicians to respond, examine, and treat patients with emergency medical conditions.
- Physicians, including specialists and subspecialists (e.g., neurologists), are not required to be on call at all times. The hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control.
- Each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients.
- Physicians are not required to be on-call in their specialty or subspecialty for emergencies whenever they are visiting their own patients in a hospital.

Specific response times left up to discretion of hospital

- Review the hospital's policy with respect to response time of the on-call physician. Hospitals are responsible for ensuring that on-call physicians respond within a reasonable period of time. Note the time of notification and the response (or transfer) time.
- If a staff physician is on-call to provide emergency services or to consult with an emergency room physician is in the area of his or her expertise, that physician would be considered to be available at the hospital.
- Where a physician is on-call in an office it is not acceptable to refer emergency cases to their offices for examination and treatment. The physician must come to the hospital to examine the patient unless the physician is at a hospital-owned facility on contiguous land or on the hospital campus.
- If a physician demonstrates a pattern of not arriving at the hospital while on-call, but directs the patient to be transferred to another hospital where that physician can treat the patient, this may be a violation.

Not-so-veiled threat of possible legal action

Source: HCFA, Baltimore, Md.; Clinical Initiatives Center research.

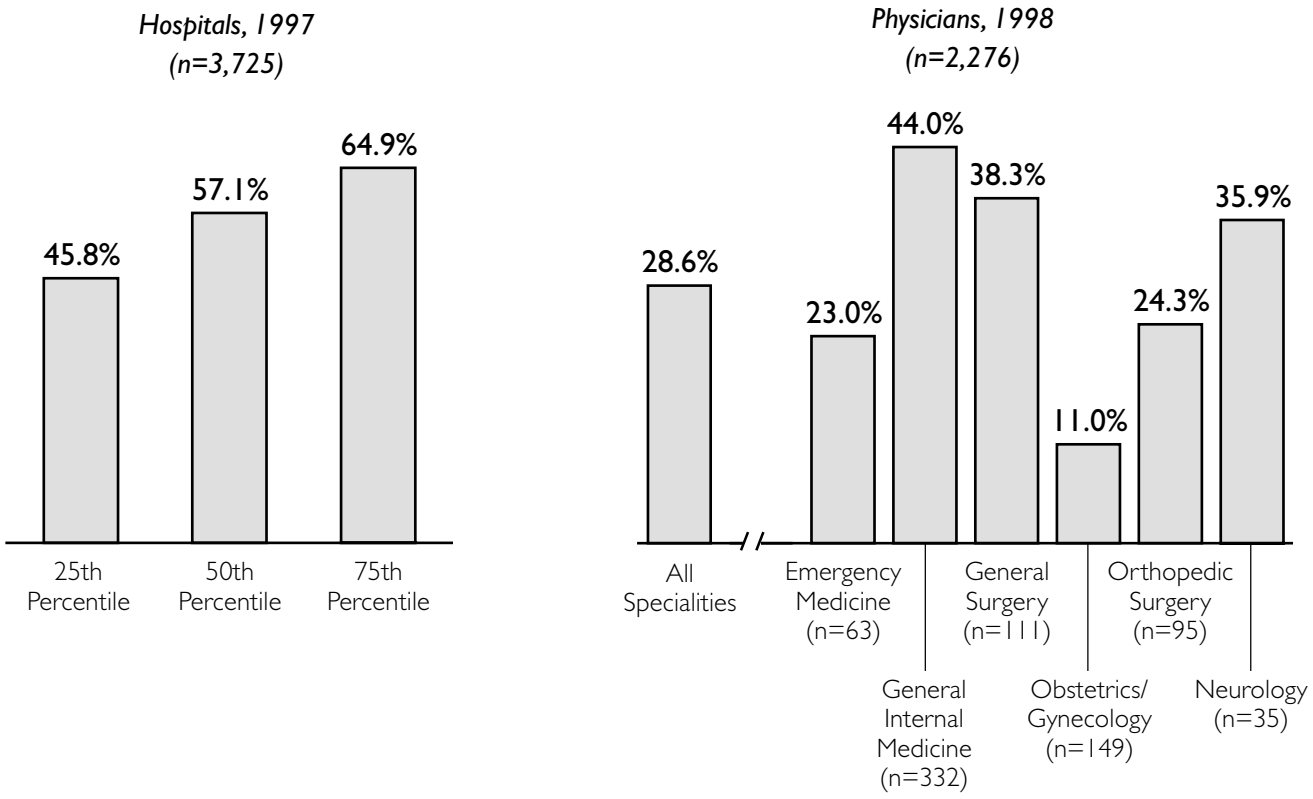
Financial Repercussions

Monetary penalties doled out by the government for violating EMTALA can be severe. Both physicians and hospitals risk fines of up to $50,000 per violation. Even worse, providers can be excluded from Medicare and Medicaid. Income lost here can quickly add up; payments from government programs, when combined, comprise a large portion of each group's revenues.

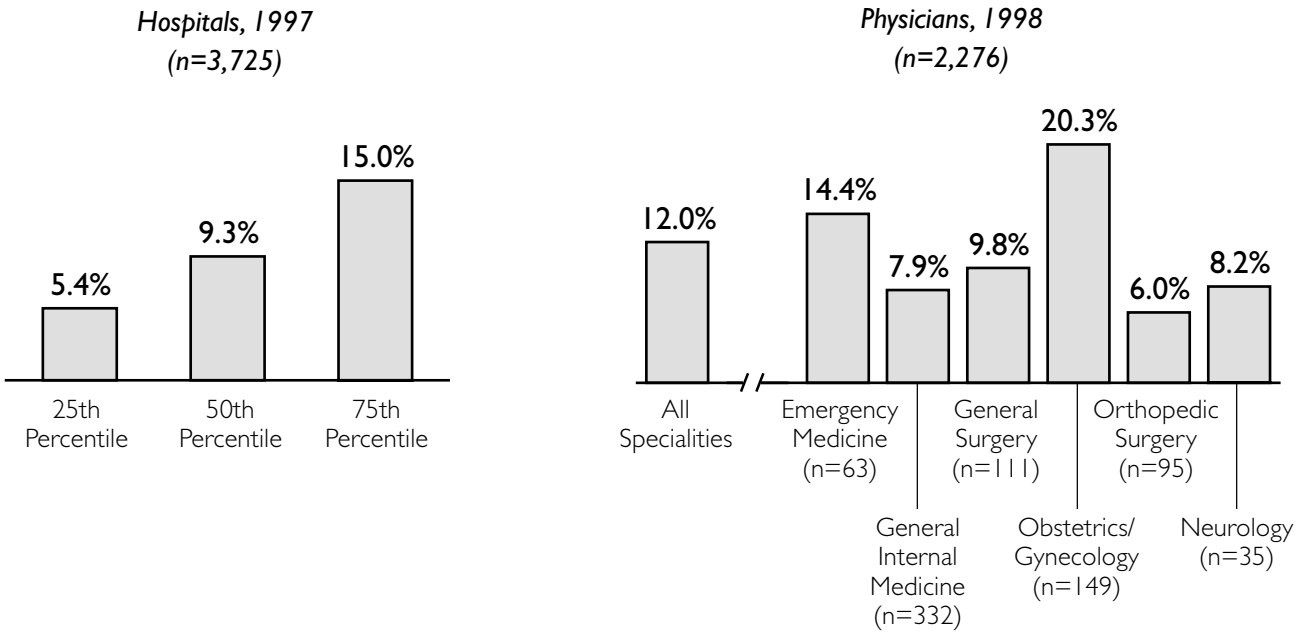
Getting Hit Where It Hurts Most

Hospitals and Physicians Risk Losing a Large Book of Business When Found in Violation of EMTALA

Percentage of Revenue from Medicare



Percentage of Revenue from Medicaid



Source: HCIA, Inc., and Deloite & Touche LLP, *The Comparative Performance of U.S. Hospitals: The Sourcebook*, 1999: 64–67, Baltimore, Md., Chicago, Ill.; *Physician Socioeconomic Statistics, 1999–2000 Edition,* Chicago: AMA: 97–100; *Physician Marketplace Statistics, 1997/1998 Edition*, Chicago: AMA: 106; Clinical Initiatives Center analysis.

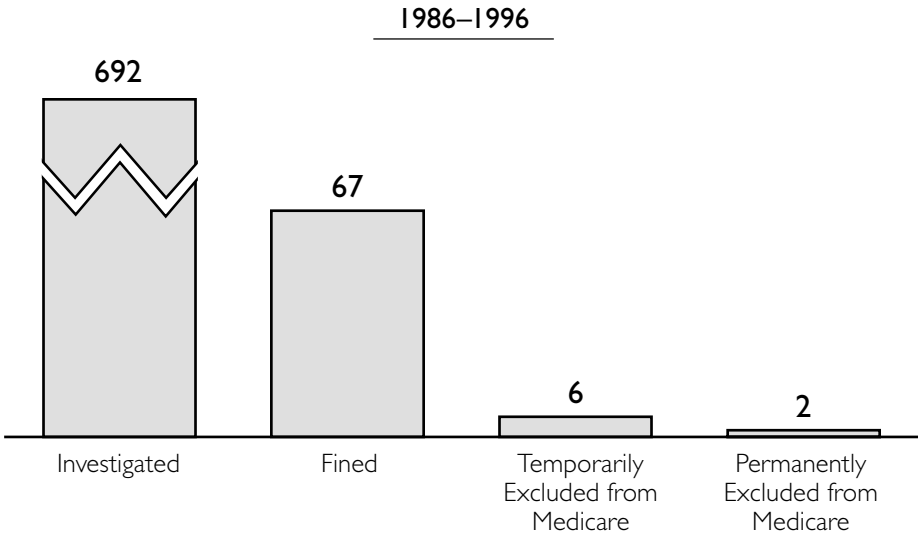
Enforcement Trends

A Dearth of Activity

EMTALA, while on the books since 1986, has proven difficult to interpret and enforce. Interpretation of the law has been complicated due to nationwide organizational changes in the health care delivery system and its financing, as well as specific reform within individual states. Governmental enforcement of the law, until recently, has been minimal due to traditionally few financial resources and staff to prosecute cases. In 1998, the consumer watchdog group Public Citizen, based in Washington, D.C., examined Department of Health and Human Services records.[27] The group found that more than 10 percent of all U.S. acute care facilities had been cited for patient-dumping between 1986 and 1996. However, only 67 hospitals, or less than 10 percent, eventually paid fines. Of these, only six hospitals lost Medicare privileges, four of which later had them reinstated.

Long an Empty Threat

EMTALA Investigations Historically Have Resulted in Few Fines, Almost No Exclusions



Source: "Patient-Dumping," *Hospitals & Health Networks*, February 5, 1999: 12.

Changing Times

The federal regulatory climate has begun to change. The government has started to hold both hospitals and physicians more accountable under EMTALA. With the passage of the 1996 Health Insurance Portability and Accountability Act, the number of staff lawyers at the Office of the Inspector General (OIG) increased threefold, from 6 to 18. Several of these lawyers now handle—exclusively—antidumping cases, significantly increasing the manpower available to prosecute cases.[28]

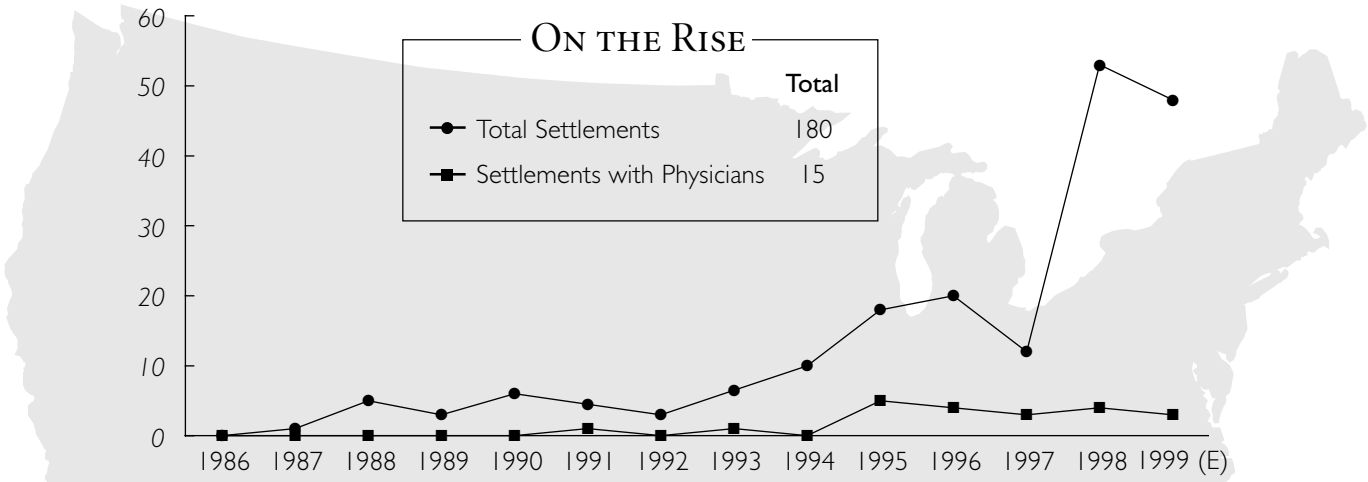
Most EMTALA violations prosecuted to date have entailed one of two scenarios: hospitals with inadequate on-call lists (too few available consultants from major hospital specialties and/or subspecialties); or EPs seeking preauthorization from health plans before examining and treating patients (failure to perform the MSE). In light of the recent announcement by United Healthcare (again, to do away with preauthorization requirements for the vast majority of patients), it is likely that the first scenario—EMTALA investigations of violations involving lack of backup physicians—will not only increase in the aggregate, but also face closer scrutiny in kind.

As depicted on the following page, in 1997 the government settled 13 patient dumping cases. A year later, the number jumped to 53. Midway through 1999 (as of June 30), the government reported 60 settlements. Moreover, the total settlement amount for all cases for the two-year period, 1997 and 1998, reached $2.3 million; compare this with $1.45 million for all cases settled from 1986 through 1996. The recent upward trend becomes quickly obvious. In fact, across April and May 1999 alone, nine hospitals settled patient dumping charges with the OIG.

EMTALA Investigations and Settlements Sweeping the Country

HCFA Now Taking a Hard Line with Providers

All Patient Dumping Settlements, January 1986 to June 1999



They Broke the Law and the Law Won

Recently Settled Hospital Patient Dumping Cases, April and May 1999

*Institutions**	*Settlement Amount*
260-bed Hospital, Northeast	$50,000
300-bed Hospital, Midwest	$50,000
40-bed Hospital, West Coast	$40,000
175-bed Hospital, Mid-Atlantic	$33,000
225-bed Hospital, Northeast	$20,000
30-bed Hospital, Northwest	$20,000
20-bed Hospital, Southwest	$14,500
85-bed Hospital, Midwest	$7,500
100-bed Hospital, Midwest	$6,000

Spanning the country: All types of hospitals—large and small, East to West—found in violation of EMTALA

* All hospitals settled without admitting any wrongdoing and entered community outreach agreements with the OIG. The agreements require them to actively advertise the availability of their EDs to all residents regardless of ability to pay.

Still Putting Up a Fight

EMTALA Cases Currently Under Administrative Litigation

Institution/Physician† (Disguised)	*Proposed Fine Amount*	*Proposed Length of Exclusion from Medicare/Medicaid*
100-bed Hospital, Mountain West	$25,000	None
380-bed Hospital, Midwest	$50,000	None
Emergency Physician, 350-bed Hospital, Southeast	$50,000	One year
On-call OB/GYN, 425-bed Hospital, Northeast	$50,000	One year
Emergency Physician, 300-bed Hospital, Southwest	$50,000	One year

† The hospitals where these physicians practiced have settled patient dumping charges with the OIG. The physicians have not.

Shots Fired 'Cross the Bow—And More Likely to Come

"Given that there's a law that hasn't been adequately enforced, it's laudable that they're now finally enforcing it. With 45 million Americans without health insurance, patient dumping is going to become a bigger issue."[29]

Sidney Wolfe, Consumer Health Advocate and
Co-Founder of Public Citizen Health Research Group,
a trade organization that tracks EMTALA enforcement

"Hospitals are getting it. But physicians haven't so far. We want them to get it; that's why we're turning up the heat. I think you'll start to see more cases against physicians."[30]

Jessica Bowman, Lawyer
Department of Health and Human Services,
Office of the Inspector General

Source: Taylor M, "Blaming the Docs: Patient-Dumping Probes See Physicians as Culprits in Turning Away the Indigent from ERs," *Modern Healthcare*, August 9, 1999: 36, 38; Clinical Initiatives Center research.

Part IV. Select Strategies

A Clouded Issue

While HCFA spells out hospitals' on-call responsibilities under EMTALA, in reality, the application and interpretation of the law often becomes less well defined when it plays out nationwide at hospitals. In fact, the specific makeup of ED backup physician panels can vary significantly from institution to institution. For instance, each hospital establishes its own rules regarding who gets assigned to the on-call list, how quickly consultants must respond to the ED, and whether taking ED call is a prerequisite for maintaining hospital privileges.

In the end, however, once physicians' names land on an on-call list, they should be held accountable for responding to the ED in a timely fashion. Holding consultants answerable for their actions—or more accurately, their inaction—has been shown, though, to be difficult given the multiple barriers discussed earlier in this briefing. This section profiles a number of strategies and incorporates learning from various institutions that have been successful in ensuring adequate and timely backup physician coverage in the ED.

By Law, by Ethics, and by Purse

To prevent the on-call problem from surfacing or intensifying, most hospitals pursue one of two primary strategies, or some combination of both. Approximately one-half of facilities mandate that their medical staff assume on-call responsibilities, making participation a condition for maintaining hospital admitting privileges.[31] Another four out of ten institutions pay backup physicians for on-call services.[32] These are not necessarily mutually exclusive endeavors; some facilities require participation from the medical staff but, at the same time, compensate physicians for providing on-call services.

Hospitals emphasizing the first approach (mandatory service) believe that it is the ethical responsibility of the medical staff, as physicians, to provide on-call services. They advance a patient care argument, emphasizing that adherence to EMTALA protects patient safety and rights. To do any less risks exposing not only physicians but also hospitals to sanctions and public scrutiny. In short, these hospitals attempt to appeal to physicians' sense of duty to patients. They also frequently—and, at times, quite forcibly—remind physicians of the various negative consequences associated with failure to perform this important function.

Hospitals in the second camp (paid service) choose to more fully recognize, as well as factor in, the current health care climate when making on-call decisions—a climate in which it has become increasingly difficult for many physicians to maintain their earnings. The prospect of providing ED care can be especially upsetting to specialists in a financial sense. They perceive services delivered there will likely go uncompensated: uninsured patients unable to pay and insurers unwilling to reimburse. Further, time spent in the ED risks lessening the amount of time devoted to (higher) paying patients with whom they already have established relationships.

Best Practices

This section details five strategies that address the backup physician problem. The first practice, mandatory on-call service, requires adoption of specific bylaws and necessitates significant up-front staff education. The next two practices detail payment methods for on-call services. All three practices preemptively reduce the risk of hospitals encountering resistance from backup physicians. The fourth practice, the "chain-of-command" call ladder, describes a fallback plan effectively deployed during times when on-call consultants fail to respond to the ED in a timely manner or at all. The final practice, an on-call physician quality assurance program, summarizes methods to monitor and ensure ongoing accountability among backup physician ranks.

Strategies to Ensure Timely Response of On-Call Consultants to the ED

I. Preemptive Measures

"Taking the Hard Line"

#1 Mandatory On-Call Service **B+**

"Paying for Services"

#2 Stipend and Per Diem On-Call Service **B–**

#3 Fee-for-Service Payment Guarantees **A–**

II. Fallback Plan

"Protecting Against Abuses"

#4 "Chain of Command" Call Ladder **A**

III. An Ongoing Process

"Holding the Gains"

#5 On-Call Physician Quality Assurance Program **A**

Clinical Initiatives Center Grading Scale

To assess the relative merits of practices for member consideration, the Clinical Initiatives Center assigned (admittedly subjective) grades based on case study data, available literature and extensive interviews.

A Strongly recommended for most members; highly effective practice for addressing the on-call consultant problem

B Recommended for most members; moderately effective practice for addressing the on-call consultant problem

Practice #1—Mandatory On-Call Service

Idea in Brief

Hospital mandates, by fiat, medical staff participation in on-call program; rather than having to rely solely on the "goodwill" of consultants to volunteer, practice ensures consultant coverage without adding costs.

Key Element #1—Bylaw Incorporation

The initial and most important step when implementing mandatory on-call service involves putting the policy in writing. Integrating on-call language into hospital medical staff bylaws, provisions, or general rules and regulations makes the process legally binding—part of a permanent record, so to speak. In addition, this helps prevent interdepartmental politics from interfering with the scheduling of on-call duties. No one medical specialty can claim another has received preferential treatment.

That said, most hospitals allow each department to handle the specifics of call-list generation—who gets assigned, the frequency of rotations, reasons for service exemptions, etc. For instance, one hospital interviewed during research, Ocean Hospital (a pseudonym), does not require physicians over the age of 63 to assume on-call duties, offered as an age-related benefit. Older physicians commonly feel that they have paid their dues to an institution; from their perspective, on-call duties offer few economic benefits and, in fact, can become substantial time burdens. Granting exceptions and allowing a degree of flexibility when mandating call service increases physician acceptance of the practice.

The graphic below shows the guideline employed by Rain Hospital (a pseudonym), a large West Coast teaching hospital. The document spells out appropriate interactions between the ED and on-call physicians, in this case mainly residents.

Getting Specific

Clinical Service Guideline Governing ED-Consultant Relations at Rain Hospital

Rain Hospital

The Emergency Department and the Clinical Service Chiefs will work together to ensure compliance with the following policies. The Emergency Department will make every effort to work cooperatively with the admitting and consulting residents from each Clinical Service. However, the Emergency Department attending has admitting privileges in concurrence with each Clinical Service and will make the final decision on all disputed placements (when a specific service attending is not physically present in the Emergency Department). The Clinical Service attending may personally examine and evaluate patients in the Emergency Department being considered for admission and make the admission or placement decision. The service assigned a patient will assume responsibility for patient care upon the patient's arrival to the unit.

Need for cross-departmental cooperation stated up front

It is policy that:

1. A representative from each Clinical Service will ensure that the results of the "consult and plan" for the patient will be communicated to the Emergency Department attending/resident before leaving the Emergency Department.
2. Each Clinical Service will respond to requests from the Emergency Department within the following time limits:
   - Immediate response for pages
   - Arrival in the Emergency Department within five minutes for emergent cases and 30 minutes for nonemergent cases.

   These response times apply under all circumstances including change of shift, rounds, and morning report.
3. The accuracy of the resident call schedule for each Clinical Service will be maintained. Changes to the call schedule will be communicated by the service department to the Emergency Department unit secretary.
4. The Clinical Service will ensure that residents assigned an admission will not delay the admission process. Specific points of care may be discussed briefly with the Emergency Department attending.
5. The Clinical Service will ensure that residents will maintain a professional demeanor at all times. Any displays of anger or demeaning behavior by either service will not be tolerated.
6. These policies will be incorporated into the standard orientation process for residents of each Clinical Service. Failure to comply with these policies will be reported and may result in disciplinary action

Minimum consultant turnaround times specified

Risk of disciplinary action due to noncompliance clearly noted

Key Element #2—Intensive Staff Education

In general, many EMTALA violations by on-call physicians can be traced back to a simple lack of knowledge. Consultants may not fully understand their responsibilities under the law, and in particular, the potential liabilities—in fines and exclusions from government programs—that accompany failure to provide adequate backup services in the ED. Nor, at times, do some consultants comprehend how quickly patient care can deteriorate due to a delayed response. In truth, most consultants usually have never received appropriate inservice training; instead, they possess only a vague understanding of the law obtained informally and infrequently by word-of-mouth.

To raise the level of awareness among the medical staff, and thereby lessen resistance to mandatory on-call participation, the medical director of the ED at Victorialand Hospital (a pseudonym) created an extensive presentation on EMTALA.[33] The slides described in detail how the federal law governed ED operations and the actions of the entire medical staff, highlighting potential liabilities resulting from violations. The medical director showed the presentation to individual hospital departments to spur discussion, eventually arriving at a shared understanding as to the importance of providing sufficient and timely backup physician coverage in the ED.

Once consultants begin to understand the scope of the law, interactions between EPs and consultants stand to improve. During actual calls, the content of EP–consultant conversations varies according to the nature of their relationship. Between associates or friends, it may suffice for the EP to simply state that the patient has a particular defined problem that warrants immediate action. On occasion, however, a more detailed informational exchange (full report) becomes necessary. On the next page are a collection of hints gathered from the research to improve ED–consultant conversation.

Closing the Divide

Guidelines for Effective Consultation

For Emergency Physicians

- When more than one type of consultant is needed, identify the primary or most important consultant and contact this physician first.
- Identify yourself and the hospital from which you are calling, as consultants may work out of several hospitals.
- If you place the call in the middle of the night, be sure that the consultant is awake.
- Provide the name, age, and sex of the patient.
- In brief fashion, tell the consultant the working diagnosis and what—in your clinical opinion—needs to be done.
  - Do not equivocate; state what is needed at the beginning.
  - Convey urgency, when warranted, and be sure it is understood.
- Be precise and pertinent. First state why you have requested the consultation, then provide the relevant supporting data. For example, a cardiologist called in to treat a chest pain patient will want to know results from any lab tests (e.g., arterial blood gas, hematocrit, electrolytes, etc.), findings from any x-ray studies, etc.
- Speak their language. For example, orthopedic surgeons will want to know:
  - Whether a wound is open versus closed
  - Neurovascular status of the patient
  - Appropriate fracture description (angles, lengths, or displacements)
- If therapy should be initiated in the ED, ask the consultant what he or she prefers.
- Be diplomatic:
  - Develop the ability to compromise appropriately
  - Handle disagreements privately and professionally
  - Delay prolonged discussion until after definitive patient care

For Consultants

- Determine the urgency of the consultation.
- Gather the history, physical, and appropriate ancillary information.
- Document information in an appropriate but brief fashion.
- List relevant recommendations—specific, prioritized to preserve vital functions, appropriate to available skills and equipment, and consistent with current standard of care.
- Provide contingency recommendations if original recommendations fail or the patient's condition worsens or improves.
- Address the specific problem for which you were called.
- Teach tactfully; provide brief, pertinent, and current references.
- Communicate personally with the primary physician, especially when recommendations may be considered crucial or controversial.
- Provide follow-up visits and recommendations dictated by the disease course, but be sure not to remove yourself prematurely from a patient's care.

In the Dark

"Historically, consultants' view[ed] EMTALA as being entirely an ED problem, and did not understand that it also applied to the…Personally, I am repeatedly surprised at how oblivious our colleagues can be on these issues. For some reason it isn't on their radar screens, and when they are made aware of the requirements, they are absolutely incredulous that there is such a law."[34]

Larry Mellick, M.D., Chair
Department of Emergency Medicine
Medical College of Georgia

Sources: Guertler AT, Cortazzo JM, Rice MM, "Referral and Consultation in Emergency Medicine Practice," *Academic Emergency Medicine*, 1994, 1: 565–571; Holliman JC, "The Art of Dealing with Consultants," *The Journal of Emergency Medicine*, 1992, 11: 633–640.

Cautionary Note #1—Specific or General Wording[35]

A considerable amount of controversy exists in the emergency care community concerning how specific hospitals should be when drafting language around consultant coverage in the ED. A hospital may choose to use vague words, such as a "reasonable" amount of time, when denoting how quickly on-call physicians should respond. Or a hospital may use specific time limits—e.g., as was the case at Rain Hospital, within five minutes for emergent cases and within 30 minutes for nonemergent cases.

Unless subject to specific state regulations, most risk management experts argue that an institution protects itself most by using nonspecific terms when developing policies overseeing on-call physician coverage in the ED. By putting into writing specific consultant turnaround times, hospitals risk setting themselves up for failure. Never will all on-call physicians across all situations be able to respond to the ED within specified times; too many extraneous factors may contribute to response delays (e.g., traffic, sickness, etc.) In addition if HCFA, during an investigation of a hospital, uncovers any incidents involving consultant response times that exceeded a specified time threshold, the hospital more easily becomes subject to federal sanctions, as it has violated its own internal rules and regulations.

Rain Hospital, after having carefully weighed such risks, nonetheless decided to hold consultants accountable for providing care to the ED within specific time frames. As an academic facility, Rain had the advantage of abundant in-house residents and medical school faculty. This helped to ensure adequate and timely consultant coverage.

Cautionary Note #2—Risk of Fight and/or Flight

While mandatory on-call coverage proves to be successful in most instances, especially when initiated in concert with intensive staff education, hospitals must nonetheless prepare themselves for drops in staff morale. Feelings of resentment among particular physicians or departments may surface. Relations can become quite contentious. At one California Hospital a dispute between the medical staff and administration concerning the scheduling of on-call services dragged on for more than a year before being resolved.[36] Consultants may also choose to restrict their medical practice to fewer hospitals within a system, thereby reducing their on-call burden but intensifying that of an unlucky hospital. Last, extreme dissatisfaction among consultant ranks sometimes leads to staff defections, especially when other hospitals in the community offer compensation (discussed in the next section) or have in place less strict rules governing on-call coverage.

Practice #2—Stipend and Per Diem On-Call Service

Idea in Brief

Hospital compensates physicians for call duty through annual stipends and/or daily per diems; practice increases staff participation in on-call program by rewarding physicians monetarily.

Paying consultants for call duty can be extremely effective stop-gap measure to address ED backup physician problems. In relatively quick fashion, facilities experiencing severe shortages in certain specialties can secure adequate backup physician coverage in the ED. In addition, paying physicians may lessen resistance at facilities that also mandate call duties. That said, careful consideration must be given when implementing the practice, as it can prove costly and often does not prove effective over the long term; the Clinical Initiatives Center recommends that members heed the key considerations and cautionary notes detailed below.

Key Consideration #1—Performing Cost/Benefit Analysis

Facilities employing stipend or per diem payment strategies for on-call services should be aware of inherent financial risks associated with these strategies. Once paid, consultants may infrequently be called in; as a result, the facility essentially has made a large, up-front investment only to realize a small, back-end return. Per diems can become especially costly to hospitals caught in such situations.

In some markets, consultants received daily standby fees on top of the annual stipends that had already been paid to them by hospitals (a "double whammy" of sorts). In other regions of the country, consultants requested and received hospital payment of their malpractice expenses and additional billing assistance (to improve physician charge capture). It has even been reported in the literature that a handful of hospitals, in dire need of additional coverage, paid consultants guaranteed rates—on par with inpatient fees paid by Medicare and indemnity insurers—for care services provided to ED patients regardless of care intensity.

Key Consideration #2—Calculating Payment Amounts

Establishing the price of annual stipends and daily per diems can be difficult. Center research reveals considerable differences concerning the amount hospitals pay backup physicians. Nationwide, annual stipends for on-call services range between $1,000 and $10,000.[37] Extreme variability also exists with regard to per diems. Center interviews and literature review indicate hospitals pay consultants between $100 and $2,000 for daily standby fees. Trauma surgeons, neurosurgeons, and obstetricians typically request higher per diem amounts.[38]

The Clinical Initiatives Center recommends each member consider various criteria when establishing payment amounts—whether annual stipends, per diems, or, if circumstances merit, use of both. Such criteria might include: current and future need for backup services, rates paid by other hospitals in the community, call intensity (by specialty), consultant participation in hospital committee work and community service, etc. Hospitals that outsource backup ED services to groups, roughly 4 of 10 institutions according to one survey of California providers[39], commonly stipulate specific criteria in contracts.

Cautionary Note #1—Beware the Domino-Effect

Once a hospital in a given market offers compensation for assuming on-call duties all surrounding hospitals in the area may be forced to follow suit. Even then, certain hospitals may witness defections of their staff to competing institutions offering higher compensation.

Cautionary Note #2—Beware Sibling Rivalry

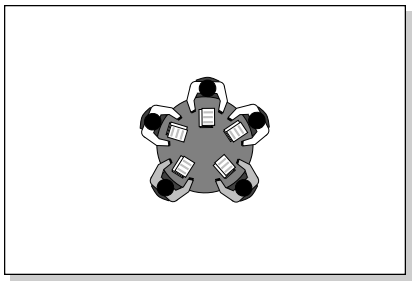
When implementing per diems or stipends, hospitals should spread payment amounts uniformly across physician ranks. This reduces the likelihood of interdepartmental tension and resentment. If the payment system is not delivered on a consistent basis, certain physicians and/or specialties may become disenfranchised, and, perceiving it as unfair, choose to take their business to another hospital.

Practice #3—Fee-for-Service Payment Guarantees

Idea in Brief

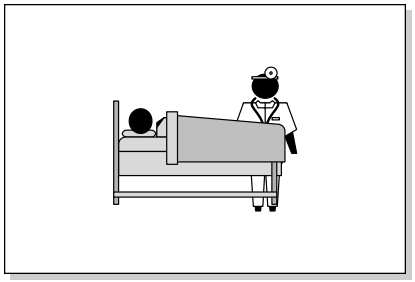
Hospital guarantees on-call physicians fixed payment per relative value unit (RVU) for care services rendered in the ED and entire hospital stay for select patients; practice spurs physician assumption of on-call responsibilities while protecting the hospital from unnecessary expense as payment tied to actual level of service provided in the ED.

Emergency and Acute Care Medical Corporation, based in La Jolla, California, created the fee-for-service payment guarantee concept as a creative and alternate solution that addresses the problem of insufficient backup coverage. The "Emergency Associates" (EA) program helps hospitals manage the economic risk of providing backup specialty services in the ED. Approximately 500 multispecialty physicians and three facilities in the San Diego and Sacramento areas currently participate in the EA program, which comprises four key elements, explained on the following page.



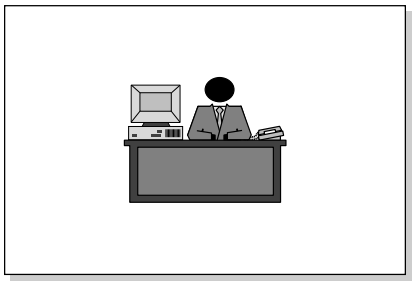
Key Element #1—Committees and Contract

A steering committee comprised of medical staff representatives and administrators creates policies related to the EA program. A coding committee devises policies related to the assignment of CPT codes. Upon completion of the aforementioned policy work, a formal contract is then signed between EA corporation (physician body) and the hospital.



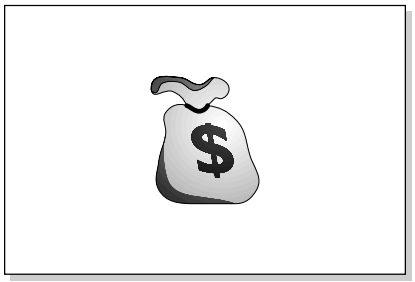
Key Element #2—Patient Designation

Emergency physicians designate which ED patients should be assigned EA status—most often patients without a physician, those who require on-site consultation and/or require admission to the hospital. In a trauma center, all patients could be classified as EA patients. The steering committee has the ultimate authority related to determining what criteria will govern patient eligibility under the EA program. The designation of EA patients is unrelated to their insurance status.



Key Element #3—Coding, Billing and Reimbursement

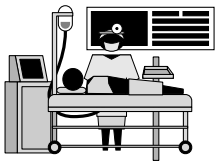
Under the EA system, the hospital typically employs its own coders who assign codes for physician services. A third-party billing agent performs the actual billing and collection of payments. Consultants then receive an explanation of benefits (EOB) that details the coding rationale and the amount to be paid for each code. Physicians have seven days to respond to the EOB, noting any discrepancies or complaints. If a consultant files a complaint, the coding committee has final say on the outcome of the dispute. Once the claim is accepted, the physician is paid approximately two months after performing the service, receiving a payment summary and check from the EA service.

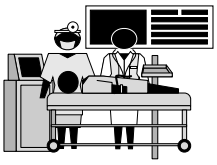


Key Element #4—Basis of Payment

Consultants who participate in the EA program receive a guaranteed payment on the basis of RVUs delivered. Most hospitals tie payment amounts to Medicare levels (current limiting charge for year 2000 is $36.61), where each CPT code (a physician procedure) has associated values (published annually in the Federal Register). Multiply the Medicare limiting charge by the RVUs associated with each CPT code and you arrive at the payment amount. For example, a physician attending to a patient requiring a consultation valued at 5.35 RVUs would receive approximately $196. (5.35 RVUs x $36.61≈$196.) The graphic on the following page illustrates the basis of payment calculation under the fee-for-service model for an EA patient requiring an appendectomy, and an EA patient requiring a craniotomy.

Getting Paid (Fairly) for a Job Well Done





	Appendectomy	Craniotomy
RVUs (measure of care intensity)	14.62	49.70
Medicare Reimbursement (for year 2000)	x $36.61	x $36.61
Total Amount Paid to Consultant	$535.24	$1,819.52

Source: Emergency and Acute Care Medical Corporation, La Jolla, California; Clinical Initiatives Center analysis.

The Emergency Associates Program—Fee-for-Service Payment Guarantees

Summary of Advantages and Disadvantages

Program Upside

- Participating physicians who provide services receive compensation consistent with the level of services delivered
- As patient volume and acuity fluctuates, so too does the cost of the program
- Participating physicians become more motivated to see patients in the ED
- The value to be paid to physicians per RVU can be easily determined (using Medicare rates as baseline to help determine a reasonable level of compensation)
- Physicians feel empowered as they participate in the creation and ongoing management of the program
- Extensive data can be gathered, collectively, regarding backup physician practices, better enabling sound business and clinical decisions

Program Downside

- Expense of the EA program can be larger than compared to paying stipends or purely mandating coverage (program costs run as high as $40,000 per month)
- Hospital maintains risk for patient volume, acuity, and payer mix
- Once initiated, the EA program may enjoy substantial popularity and thus be difficult to dismantle
- There is a risk of physicians overutilizing physician services to increase payments

For More Information

For additional information on the "Emergency Associates" concept, inquiries can be sent via e-mail to Kyle Weston at westonk@advisory.com, or feel free to contact Dr. Joseph Viglotti, Medical Director of the Emergency Department at Sharp Memorial Hospital, San Diego, California. Dr. Viglotti created the EA program and has extensive experience assisting clinicians, ED managers, and hospital administrators in developing compensation structures for on-call physicians.

Contact Information

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Emergency and Acute Care Medical Corporation
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858-454-8325
http://www.eacmc.com

Practice #4—"Chain-of-Command" Call Ladder

Idea in Brief

Hospital creates prearranged, backup call system to enable access to alternate specialists; practice authorizes EP to contact other physicians when the on-call consultant fails to respond to the ED in a timely manner (usually beyond 30 minutes).

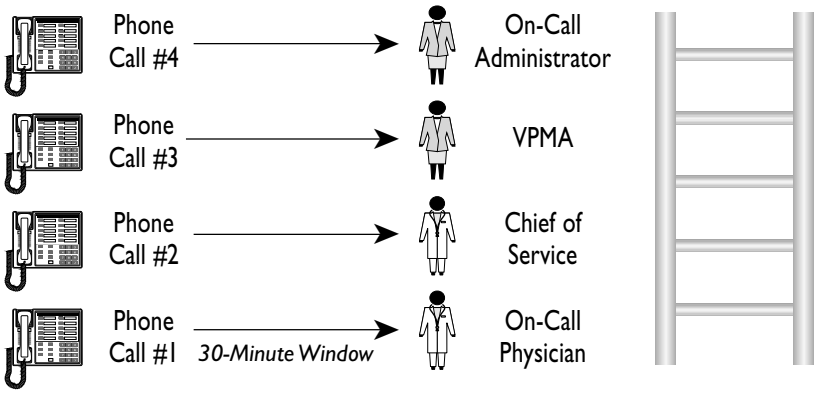
Two primary benefits of the practice: first, the strategy provides an immediate solution to outlier cases in which physicians respond to the ED too slowly or not at all; second, and perhaps more important, the threat of a call to the chief of service—or worse, VPMA or hospital administrator—motivates most physicians to speed up their response times to under 30 minutes. One hospital interviewed for this research resorted to calling the chief of a particular service line only once per month on average.

Climbing Up the Call Ladder (If Need Be)

Echo Hospital Reins in the Outliers

Call list should be:

- Checked for accuracy and updated regularly
- Spelled out in hospital and/or ED bylaws
- Easily located in ED



Source: Clinical Research Center research.

A Real Threat

"If the chairman won't back you up and the consultant you desperately need won't come in, your next step is to call the hospital administrator and tell them the following: 'I am packaging this patient up to transfer him to another hospital because he needs this service immediately and I can't obtain it here. Just so you know, this violates every federal regulation I am aware of, but if I don't do this, this patient may die.'"[40]

Emergency Physician

Practice #5—On-Call Physician Quality Assurance Program

Idea in Brief

To encourage greater adherence to call responsibilities, a handful of hospitals are starting to track and profile individual consultants on their responsiveness to the ED; as part of monitoring program, clinical departments receive detailed reports on individual consultant times, providing direct peer group comparisons.

This final practice summarizes methods to hardwire ongoing accountability among backup physician ranks. As shown earlier, wide variation exists regarding consultant response times to the ED. In the Vosk, et al. study, researchers studied 241 consultation requests of 21 physicians, and found wide variation in response times based on individual physician behavior patterns. Obviously, and as the data illustrated, there exists meaningful opportunity to improve matters. When implemented successfully, an on-call physician QA program can prove to be a highly effective strategy for speeding consultant response times. The practice plays both to physicians drive to match, even outperform, their peers as well as their fear of financial penalties that can be levied by HCFA if found in violation of EMTALA.

Basics of an On-Call Physician QA Program

Departmental Report Card

Specialty: General Surgery

Review Period: January 2000

Physician	*Personal Performance (minutes)*
Dr. Atlantis	27
Dr. Gillis	42
Dr. Goodwin	38
Dr. Knight	30
Dr. Lightner	33
Dr. Schow	24
Dr. Thomas	35

Peer Average
32.3 minutes

Target Performance
<30 minutes

Note: Clinical Initiatives Center hypothetical.

Implementation Tips

- Address vacation, holiday, and sick leave coverage for on-call physicians
- Address concerns for physicians with on-call schedules at multiple facilities
- Address issues surrounding office appointments during on-call schedule to provide assurance that scheduled appointments will not interfere with ED call
- Assign authority to develop and maintain call schedules
- Ensure that all medical staff understand EMTALA requirements through inservice programs
- Document request times for on-call physician assistance and log in the arrival time to the ED for all consultants
- Educate medical staff to recognize that EMTALA rules apply to the entire hospital, not just the ED
- Ensure that each specialty provides an on-call list (office telephone numbers, home telephone numbers, beepers, etc.)
- Evaluate consultant performance on established, objective criteria
- Maintain logs of on-call staff response times
- Maintain and report results of repeated failure of on-call physicians to attend to ED patients
- Monitor lack of hospital oversight of problem specialists
- Provide on-call performance reports to each department
- Report name and address of physician if consultant fails to respond to ED within specified time
- Supply outlier physicians—those with especially tardy response times—with pointed feedback and mentoring to bring performance back in line with that of peers

Source: "On-Call Consultants Present EMTALA Risks for the ED," *ED Management*, April 1998: 37–45.

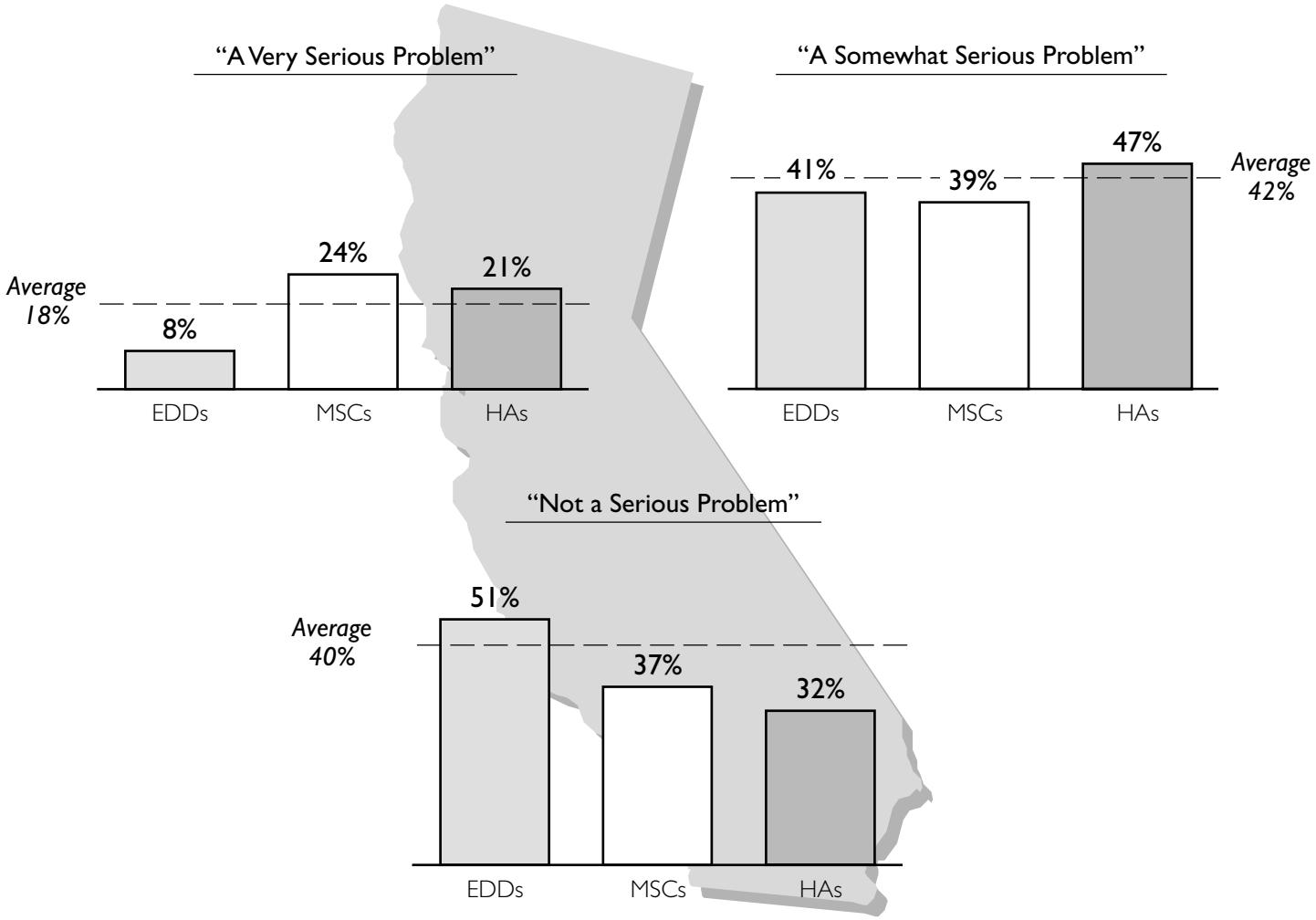
Appendix A-California On-Call Task Force Survey Results

A Word of Background

In late 1998, the California On-Call Task Force—comprised of members from the California American College of Emergency Physicians (ACEP) chapter, the California Medical Association, and the California Healthcare Association—surveyed hospitals statewide regarding on-call coverage problems. The group sent a four-page mailing to ED directors (EDDs), medical staff chiefs (MSCs), and hospital administrators (HAs) at all 420 California hospitals. Fifty-three percent of institutions responding were community hospitals with basic emergency services, and 25 percent community hospitals with tertiary care and specialized services. The specific breakout of survey respondents by position included 123 ED directors, 111 medical staff chiefs, 130 hospital administrators. The survey is the most extensive conducted to date, and captures the nature and extent of the on-call problem.

Inadequate On-Call Coverage a Statewide (and National) Problem

Of Serious Concern to Many…



Source: Emergency and Acute Care Medical Corporation, available at: http://www.eacmc.com/, accessed February 8, 2000.

…For Multiple Reasons

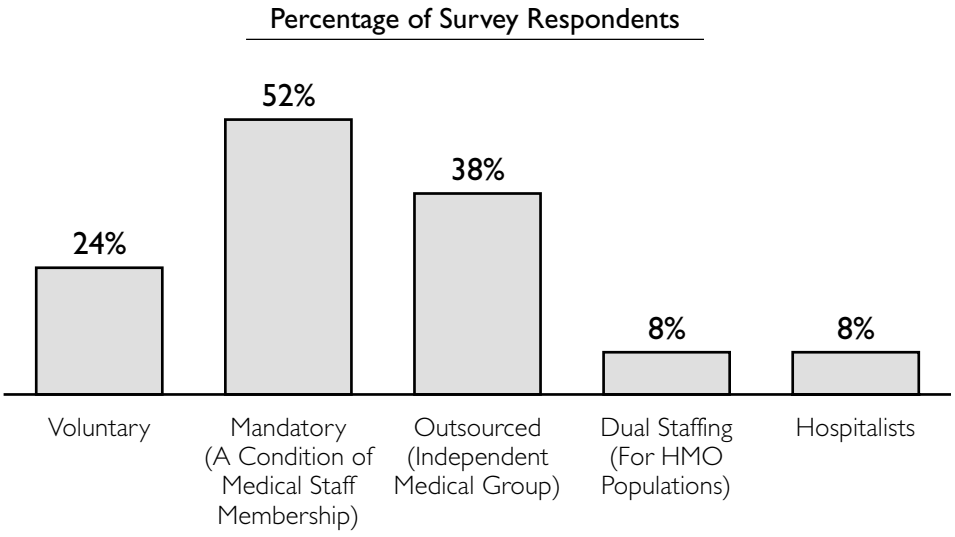
Common Reasons for Physician Resistance (Ranked in Order of Importance)*

1. *"It's Not My Responsibility"*—Physicians do not equate hospital privileges with a duty to assist their hospital in fulfilling its public service responsibilities.
2. *Little or No Pay*—Under managed care, a lack of adequate payment—or any payment at all—often exists for providing on-call services.
3. *Physician Resentment*—Physicians resent not being paid for ED call, especially when they compare their incomes with those of corporate executives.
4. *Unnecessary to Build Practice*—Physicians used to be more willing to make sacrifices to serve in the ED as a way of building their practices. With increased managed care penetration, serving in this capacity is not as vital to practice growth.
5. *Insufficient Number of Volunteers*—Approximately one-fourth of hospitals create ED on-call lists on a voluntary basis; as a result, an insufficient number of volunteers may choose to participate.
6. *Enforcement Difficulties*—Approximately one-half of hospitals mandate on-call coverage as a condition of medical staff membership; that said, these rules can be difficult to enforce.
7. *Physican/Hospital Affiliations*—Some physicians limit their medical staff affiliations to a select number of facilities, thereby reducing the number of available specialists at a particular hospital to take calls.
8. *Contractual Issues*—Specialists contracted through managed care organizations may not be available for ED consultations because such responsibility has not been specified in their contractual agreement.
9. *Effect of Depaneling*—Managed care has negatively impacted specialty availability in the ED in some areas, as many specialists have been deselected from managed care panels.
10. *Graying of the Medical Staff*—As the average age of medical staffs increases, on-call responsibilities become more burdensome.
11. *Changing Priorities*—Members of the medical staff may not be willing to spend as much time practicing as their predecessors, wishing to devote more time to their lives outside of work.
12. *Malpractice Concerns*—Strong perception among physicians that liability increases in the ED, lawsuits more commonly initiated by uninsured/indigent populations.
13. *"Grandfather Clauses"*—Certain hospitals exempt some groups of physicians from on-call services (age, revenue generators).
14. *Increasing Physician Specialization*—Physicians in general becoming increasing specialized, thereby limiting the number of cases to which they will respond (e.g., some orthopedic physicians will do knees only).

* The results listed came only from those institutions where survey respondents rated the on-call backup problem as a "very serious" or "somewhat serious" problem.

Source of On-Call Coverage

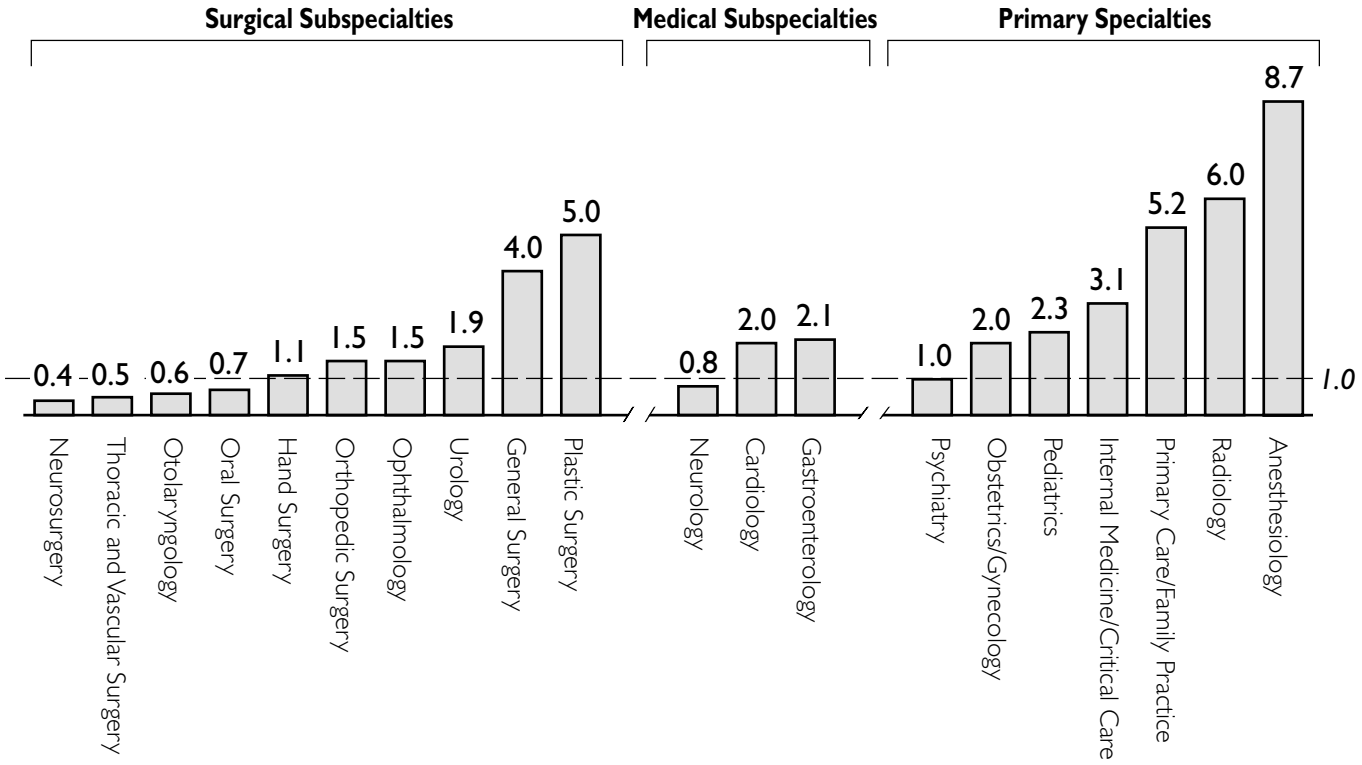
Q: How does your medical staff currently provide on-call backup coverage for the ED?



Note: Total exceeds 100 percent as individual hospitals often employ a variety of coverage arrangements.

Ranking of Specialties by Availability*

Q: If the problem of inadequate physician backup exists at your hospital's ED, which medical specialties are implicated?



* Survey respondents ranked specialties on adequacy of physicians on staff to provide backup services in the ED. Responses are expressed as a ratio of "yes" to "no" responses. Specialties with values "above the line" represent specialties where *sufficient* coverage was reported by survey respondents; specialties with values "below the line" represent specialties where *insufficient* coverage was reported.

Source: Johnson L, "Results of the On-Call Backup Survey: Searching for Solutions to a Serious Public Health Problem," *Lifeline: A Newsletter and Forum for the Emergency Physicians in California*, February 1999, available at: http://www.eacmc.com/program.html, accessed April 28, 2000.

Appendix B —Sample Hospital On-Call Physician Policy

Song Hospital

Policy & Procedure	Page 1 of 1 Policy ER.28
Subject: On-Call System	Effective Date 12/97
Dept: Emergency Department	Replaces Policy #ER.38 Dated 9/90

I. Policy

To provide 24-hour specialty coverage for consultation and referrals for emergency service patients

II. Procedure

A. On a monthly basis, each specialty department, division, or section will supply the Emergency Service with a monthly schedule designating the on-call specialist for emergency patients who need specialty consultation.

B. Once summoned by the ED, each physician should be available within the specified time frame meeting state regulations.

C. The rotation schedule may be on any basis that the specialty staff selects, as long as there is someone assigned for each specialty at all times.

D. A pediatrician will be required in the following situations:

1. Full-term newborn infants who present to the Emergency Department within the first six weeks of life.
2. Premature infants who presents to the Emergency Department within the first three months of life.
3. Seriously ill or otherwise compromised child under the age of 15.

E. If a specialist will be unavailable for either his private patients or for emergency consultation because of vacation, sickness, education, etc., he should notify the Medical Staff Office and Emergency Services and state who will be covering for him until he returns.

F. On-call lists for disaster drills for mass casualty situations will be kept current in the Emergency Room.

G. If unable to contact covering physician or specialist within specified time frame (1999—thirty [30] minutes).

- Notify department chairman for resolution and alternative physician assignment.
- If unable to reach or resolve with department chairman, contact nursing supervisor to involve administrator on-call.
- Contact Emergency Department Chairman.

Endnotes

1 Foubister V, "Is There a Dearth of Specialists in the ED?" *American Medical News*, July 12, 1999.

2 Appleby J, "Hospitals Plagued by On-Call Shortage," *USA Today*, June 16, 1999.

In light of these data (administrator concern over the on-call issue), it is not surprising that 10 percent of more than 500 hospital administrators surveyed in late 1999 commented that they would not go to their own ED to receive care if seriously injured. (Source: The Schumacher Group, an Emergency Medicine Management Firm based in Lafayette, Louisiana.)

3 Foubister V.

4 "On-Call Consultants Present EMTALA Risks for the ED," *ED Management*, April 1998: 37–47.

5 Robertson K, "Emergency Rooms Can't Get Specialists to Work On Call," *Sacramento Business Journal*, December 13, 1999.

6 Bernstein S, "ER Patients Lose in Specialists' Rebellion; Health: Some Doctors Fight Managed Care by Refusing to Come to Hospital When Called. Experts Say Problem Rampant," *Los Angeles Times*, June 1, 1999: A1.

7 Emergency Medicine Mailing List Serve (Emed-L), accessed June 26, 1999.

8 Other examples include:

- A young victim of a car wreck in California passes away after an ambulance takes her from one hospital to another, searching—to no avail—for an available neurosurgeon.
- A 13-year old girl in Mesa, Arizona, arrives to the ED with appendicitis. The on-call surgeon, without coming in, tells ED staff to send her to another hospital, where she later dies.
- A young boy with a piece of glass in his eye spends three hours in an ED while the EP begs an ophthalmologist to come in. Only after a call to an executive at the boy's insurance company does the physician respond. (Source: Appleby J)

9 Robertson K.

10 Appleby J.

11 Bernstein S.

12 Vosk A, "Response of Consultants to the Emergency Department: A Preliminary Report," *Annals of Emergency Medicine*, 1998, 5: 574–577; Guertler AT, Cortazzo JM, Rice MM, "Referral and Consultation in Emergency Medicine Practice," *Academic Emergency Medicine*, 1994: 1: 565–571; Cortazzo JM, Guertler AT, Rice MM, "Consultation and Referral Patterns from a Teaching Hospital Emergency Department," *American Journal of Emergency Medicine*, 1993, 5: 456–459.

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16 Vener J, "Re: ER Patients Lose in Specialists' Rebellion," [letter] *Los Angeles Times*, June 7, 1999: B4.

17 Bernstein S.

18 Bernstein S; "On-Call Consultants Present EMTALA Risks for the ED."

19 Bernstein S.

20 "On-Call Consultants Present EMTALA Risks for the ED."

21 Haney D, "Stroke Stopper Slow to Gain Acceptance, Neurologist Shortage Blamed," *The Record*, February 8, 1999: A07.

22 Robertson K.

[23] For additional information on EMTALA, please see the following articles: "It's Finally Here: Special Bulletin Clarifies EMTALA Regulations," *ED Management*, January 2000: 1–5; EMTALA Update: Understand This Confusing Law or Prep for Lawsuits, Penalties," *ED Legal Letter*, December 1999: 110–120.

[24] Taylor M, "Blaming the Docs: Patient-Dumping Probes See Physicians as Culprits in Turning Away the Indigent from ERs," *Modern Healthcare*, August 9, 1999: 36–37.

[25] Levine RG, et al., "Analysis of Federally Imposed Penalties for Violations of the Consolidated Omnibus Reconciliation Act," *Annals of Emergency Medicine*, July 1996: 45–50.

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[27] "Patient-Dumping," *Hospitals and Health Networks*, February 5, 1999: 12.

[28] Taylor M.

[29] Taylor M.

[30] Taylor M.

[31] Johnson L, "Results of the On-Call Backup Survey: Searching for Solutions to a Serious Public Health Problem," *Lifeline: A Newsletter and Forum for the Emergency Physicians in California*, February 1999, available at: http://www.eacmc.com/lifeline.html, accessed December 9, 1999.

[32] Johnson L.

[33] Clinical Initiatives Center interviews.

[34] "Educate On-Call Consultants About EMTALA," *ED Management*, July 1999: 79.

[35] Edelberg C, "Policy Must Protect ED Staff from On-Call Consultant Violations," *ED Management*, April 1998: 44–47.

[36] Clinical Initiatives Center research.

[37] Clinical Initiatives Center research and past Advisory Board research.

[38] Johnson L.

[39] Johnson L . Additional note: according to *Modern Healthcare* survey data, the top five ED contractors in 1998 were: EmCare Holdings (412 clients), Team Health (250 clients), MedAmerica (62 clients), California Emergency Physicians Group (47 clients), and the Schumacher Group (30 clients).

[40] "On-Call Consultants Present EMTALA Risks for the ED."