

On-Call Physicians at California Emergency Departments:

Problems and Potential Solutions

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the greatest difficulty with on-call coverage. Teaching hospitals, which have a pool of residents to provide coverage, and hospitals with standby emergency facilities that do not require full call panels reportedly have somewhat less difficulty.

This issue brief examines why the call-panel system is unstable, how emergency departments currently meet their call-panel needs, and ways the system could be improved. It is based on a 2003 white paper developed by The Performance Alliance in collaboration with the University of Southern California Center for Health Financing, Policy and Management, and funded by the California HealthCare Foundation. The authors sought answers to the following questions:

- What difficulties do physicians experience in taking call?
- Do the problems involving call panels vary by physician specialty, geographic area, or type of hospital?
- How do hospitals compensate physicians for taking call?
- How do managed care groups and health plans establish call panels?

Background

Demand for emergency services has continued to rise in recent years, even as a number of emergency departments (EDs) have closed their doors. Although capacity has expanded in many facilities, hospital EDs nevertheless face a variety of challenges, such as nurse staffing ratios and inpatient capacity constraints. Another significant issue is ensuring that EDs have an adequate panel of on-call physicians to handle a wide array of medical emergencies. The current callpanel system is often inefficient and unstable—a patchwork of approaches that, in addition to being costly, may compromise the quality of care for ED patients and the public.

A 2003 study by the California Healthcare Association found that 46 percent of hospital executives considered the lack of on-call physician backup a "serious" problem and that 78 percent thought the problem would become "very serious" within two years.¹ In contrast, just 18 percent of respondents to a 2000 survey by the California Medical Association characterized the situation as "very serious."² Urban and community hospitals with basic EDs and high numbers of uninsured patients typically have Are there best-practice approaches that EDs might adopt?

Findings suggest that while no single solution will fully resolve the many call-panel issues, a number of strategies would address one or more aspects of the problem. These strategies include:

- Legislative measures, such as payment standards for on-call physicians and elimination of restrictions on the corporate practice of medicine.
- Changes at the hospital level in medicalstaff assignment (instituting mandatory call, requiring physicians to provide services in their specialty), physician compensation (tier-based stipends, productivity-based guarantees), and delivery of services (hospitalists and physician assistants in the ED; regional doctor pools for high-demand, limited-supply services; transfer agreements between hospitals).
- Regional competitive contracting for on-call coverage.

Methodology

Researchers reviewed available literature and conducted nearly three dozen interviews with a cross-section of health-related organizations and individuals (see Appendix). Among these were hospital ED administrators, hospital executives, ED and other physician specialists and physician groups, managed care medical groups, and health care consultants and advisers.

Call Panel Issues

Emergency departments typically are staffed around-theclock by emergency physicians or, at standby facilities, by physicians who are available within 30 minutes or less. In some cases, an emergency practitioner may see a patient and then consult with a medical or surgical specialist about treatment, admission to the hospital, or follow-up care after discharge, or to relay information regarding a patient.^{3, 4}

To ensure access to specialty services, hospitals licensed to provide emergency services must maintain a roster of physicians available for on-call care or consultation, in accordance with state licensing regulations and the federal Emergency Medical Treatment and Active Labor Act (EMTALA), enacted in 1986. The responsibility for compliance rests solely with hospitals, not physicians, yet hospitals have little control over physicians and their willingness to take call. EMTALA makes no provision for reimbursing doctors or hospitals that provide mandated care, creating a serious dilemma and burden for hospitals.

The issue has grown in importance as visits to California's EDs increased 13.4 percent, to 10.1 million annually, between 1998 and 2001.⁵ Emergency care experts estimate one-fourth of all visits require the involvement of a consulting medical or surgical specialist—a total of more than 2.5 million potential consults each year.

In addition to increasing patient volume, hospitals must grapple with a growing patchwork of multiple call panels, a consequence of managed care. In the past, physicians provided on-call services as a way to build their practices or, if hospitals required it, to keep their medical staff privileges. But health plans now expect managed-care medical groups to maintain their own call lists of group or contracted physicians to serve their enrollees. Complicating the patchwork of on-call panels is the hospital's own panel for "unassigned" patients who enter the ED without a designated physician or medical group for backup coverage. This category generally includes underinsured or uninsured/self-pay patients (an estimated one-third of whom pay their ED bills), those in fee-for-service Medicare or Medi-Cal who do not have a regular physician, and tourists or nonresidents, even if they are covered by insurance. Trauma patients usually are "unassigned." Unassigned patients also may include managed care enrollees for whom no designated specialist is available and patients whose primary-care physician is not on the hospital staff.⁶

Depending on the type of hospital and its servicearea demographics, unassigned patients range from 5 percent to 25 percent of all ED patients; 12 percent is the estimated average.^{7, 8, 9, 10} Health care providers commonly view reimbursement for unassigned patients as insufficient at best.

As few as one-third of California hospitals may still mandate call-panel coverage as a condition of medical staff privileges. Requiring coverage can have the unintended consequence of prompting physicians to resign from the medical staff and work at a competing hospital, or simply to forgo medical-staff privileges at that facility.

Why Fewer Physicians Take Call

Fewer physicians are taking call for complex and often highly individual reasons, which fall into four categories: income and reimbursement; supply and demand; practice and lifestyle; and legal concerns.

1. Income and reimbursement. Inadequate or no reimbursement for unassigned patients is a major disincentive for on-call specialists, and the problem

appears to be worsening. Nearly eight in ten physicians have trouble obtaining payment for on-call services, four in ten have reduced their availability to take call, and two in ten have stopped taking call altogether.¹¹ Both the state and federal governments have scaled back Medi-Cal and Medicare reimbursements to health care providers in recent years.

Although there are funding sources to offset the cost of caring for unassigned patients, physicians report considerable problems collecting payment (Table 1). Forty-five of 58 counties have earmarked funds for emergency medical services (EMS), drawing from county indigent health programs and supplemental payment programs for hospitals. The latter include the SB 855 disproportionate share hospital funds, the SB 1255 hospital payment program, and the California Healthcare for Indigents Program. However, many specialists are unfamiliar with these funding sources and how to access them.¹²

 Table 1. Call Coverage Problems Deemed Related to

 Lack of Payment, Selected Specialties

Orthopedics	75%	Internal Medicine	27%
General Surgery	57	Trauma Surgery	24
Anesthesiology	47	Psychiatry	22
Plastic Surgery	45	Cardiology	22
ENT	44	Family Practice	22
OB/Gyn	39	Pulmonology	16
Neurology	34	Primary Care	16
Ophthalmology	33	Pediatrics	16
Gastroenterology	30	Radiology	15
Urology	29	Cardiovasc. Surg.	13

Source: California Healthcare Association, On-Call ED Physician Backup Survey, 2003.

Reimbursement rates often are so low that providers say efforts to collect them are not worth the time and administrative expense.¹³ For example, local EMS funds limit payments to 50 percent of physicians' reported losses (excluding co-pays, which can constitute 10 percent to 30 percent of fees) and require doctors to make three efforts to collect before they request reimbursement.¹⁴ Some physicians are resentful, frustrated, and simply unwilling to take call for little or no money, especially given the legal risks and other pressures they face.¹⁵

Standards that require health plans to pay for ED care if a "prudent layperson" deems the situation an emergency also are problematic. Such requirements can lead to conflict between a health plan and an on-call specialist who does not have a contract with that plan. These specialists may experience delays in receiving payment from the health plan, or may not be paid at all. Managed care groups counter that the specialists refuse to contract with them at reasonable rates and charge exorbitant fees.

Fifty-four percent of call specialists surveyed by the California Medical Association reported they receive no payment from health plans.¹⁶ Some oncall physicians cite instances in which health plans with inadequate specialist coverage sent patients to the emergency department and then refused to pay the non-contracted physicians' fees. Other specialists chafe at "downcoding" of their fees by health plans, resulting in lower payments, and at plans' "cherrypicking"—covering patients who pay but leaving uninsured patients for other providers. Some providers, such as urgent-care centers and community doctors, reportedly send uninsured patients to EDs where oncall specialists are expected to care for them without compensation and regardless of liability risks. *2. Supply and demand.* By some measures, California has an adequate supply of primary-care and specialty physicians. However, their geographic distribution creates local or regional shortages, particularly in rural and low-income areas, that can make it difficult to arrange on-call coverage. In other cases, the high cost of living in parts of California, low reimbursements, and a predominantly managed care environment impede recruitment. Some specialists, such as neurosurgeons, are in short supply. At California hospitals, orthopedists; plastic surgeons; neurologists; and ear, nose, and throat doctors are the most difficult to recruit for call panels.¹⁷

Shortages, however, aren't the only complication. Orthopedists, for example, may choose to work in private practice or at freestanding centers rather than hospitals. Neurosurgeons may not want to assume the cost and risk of treating trauma victims who need surgery and extensive follow-up care. Practicing in alternative settings eliminates specialists' need for hospital privileges and removes them from on-call obligations.

Meanwhile, the physician workforce—like society at large—is aging. Doctors are retiring or, as their frustration with medical practice grows, slowing down, relocating, or leaving practice altogether.¹⁸

To meet licensing and EMTALA requirements, multiple hospitals may share a limited pool of physicians from which they can draw. This creates an expectation for physicians to remain on-call even though most of them have privileges at more than one facility.

3. Practice and lifestyle. Physicians are feeling overworked, overwhelmed, and underappreciated.¹⁹

According to a 2001 survey by the California Medical Association, 75 percent had become less satisfied with medical practice in the previous five years, 43 percent planned to leave practice within three years, and 12 percent planned to reduce the amount of time they spent practicing medicine.²⁰

Taking call can have a significant negative impact on a physician's private practice. Being summoned into surgery at 3 a.m., for example, interferes with a doctor's office hours the next day, and being called during daylight hours may require a doctor to neglect office patients.

Finally, a growing number of physicians want to devote more time to family and personal interests, seek a more balanced lifestyle, or enjoy greater practice flexibility.

4. Legal concerns. Physicians also are reluctant to take call because of the real or implied threat of EMTALA, including its financial penalties; the rising cost of malpractice insurance, which is a disincentive to assume greater liability by treating unknown emergency patients; and the potential legal issues regarding patient abandonment if follow-up care does not occur. Physicians report that some emergency patients are not compliant or are difficult to contact regarding follow-up care.²¹

Physicians also report that unassigned patients tend to be more litigious than those treated in private practice. Key factors in this regard are the potential severity of unassigned patients' medical condition and outcome, and their lack of an established relationship with the on-call physician. The extent of legal immunity for ED and on-call physicians and the scope of civil liability are unclear.²² The skills and expertise of on-call specialists—and thus their liability risk—are important, too. Physicians who primarily treat adults, for example, may not feel adequately trained to handle pediatric emergencies.

How Hospitals Are Responding

Hospitals have used administrative and economic means, with varying degrees of success, to ensure the availability of on-call specialists. In its 2003 study, the California Healthcare Association found that:

- Seventy-eight percent of hospitals mandate some level of on-call coverage, which may apply to anything from full panel coverage to just one specialty. Only 17 percent say this works very well; 56 percent rate it as somewhat workable.
- Two-thirds use a voluntary system, but just 7 percent say this works very well; 51 percent report it is somewhat successful.
- Nearly half (46 percent) use hospitalists (hospital-based generalist physicians), regarded as the most successful approach. Among this group, 40 percent say the strategy works very well; 29 percent say it is somewhat successful.
- While 39 percent contract with a third party for call coverage, just 18 percent think this is very workable. About a third (36 percent) rate contracting as somewhat successful.
- Fourteen percent use some other approach.²³

To maintain their call rosters, many hospitals have had to accede to the demands of specialists by providing or guaranteeing compensation. The same CHA study showed that:

- Sixty-three percent of hospitals compensate oncall physicians with stipends.
- Nearly half rely on public, private, or patient payment.
- Thirty-nine percent pay a per-case amount to a guaranteed level.
- Eighteen percent use other mechanisms, such as a flat-fee or tiered payment system.

While on-call stipends and per-case payments may work well in the short run, health care providers

Table 2. Mean On-Call Compensation Paid by CA				
Hospitals, by Physician Specialty				

Specialty	Monthly Stipend	Weekend Stipend	Weekday Stipend
Anesthesiology	\$17,330	\$1,317	\$829
Cardiology	4,430	416	364
Cardiovasc. surgery	7,466	175	280
ENT	9,783	204	177
Gastroenterology	7,000	605	237
General surgery	9,863	625	464
Internal Medicine	9,851	658	445
Neurology	6,625	193	204
OB/Gyn	4,913	572	458
Ophthalmology	5,270	165	145
Orthopedics	10,430	651	442
Pediatrics	8,067	362	248
Plastic surgery	1,850	319	279
Primary care	21,000	638	447
Psychiatry	4,976	228	177
Pulmonology	4,575	820	455
Radiology	13,416	400	283
Trauma surgery	11,750	1,475	1,280
Urology	6,361	169	142

Source: California Healthcare Association, On-Call Physician Backup Survey, 2003.

Note: Three highest compensation amounts bolded in each category.

view this approach as a costly, rapidly spreading "virus." Table 2 provides a sample of on-call stipend compensation by physician specialty. Estimates suggest that stipends have climbed to \$300 million annually from \$200 million in 2000. In some instances, "these stipends represent legitimate compensation for disproportionately burdened specialists," says one physician. "However, in others, they drain resources away from other safety-net services and provoke similar demands by other members of the medical staff."²⁴

Although stipends are common, there is growing concern that, given their rapidly escalating cost, they are not economically sustainable.

Potential Solutions

Solutions to the call-panel problems are elusive. Among other complications, budget constraints limit the ability of state and local governments and most hospitals to establish or expand reimbursement for specialty call. Competing economic and political interests make it difficult to eliminate statutory or regulatory barriers.

Whether hospitals may legally share call panels is not clear under EMTALA. Recent regulations allow physicians to serve on more than one call panel if all hospitals are aware of the call schedule and are able to screen and stabilize emergency patients. EMTALA gives hospitals some discretion about how best to meet patients' needs. For example, it does not require that specialists be on call at all times nor does it stipulate how many physicians must take call and how often. However hospitals must have a transfer plan if services are unavailable.

Other obstacles include hospitals' antitrust concerns about pooling their resources, inflexible contracting arrangements between health plans and providers, licensing and regulatory restrictions or conflicts, and laws governing the corporate practice of medicine that restrict hospitals' ability to employ physicians for oncall coverage. There also are prohibitions against feesplitting and kickbacks to physicians from hospitals.

No single strategy will fully resolve on-call coverage problems, as they vary by region, specialty, and hospital. Potential solutions fall into three categories: legislative measures; changes in medical-staff assignment, physician compensation, and delivery of services; and regional competitive contracting for oncall coverage.

Legislative Measures

A key to legislative remedies is instilling the belief that emergency medical care is a basic public service, a responsibility which must be shared by all players. This assertion was among the policy principles proposed by the state Senate Office of Research and a multidisciplinary working group in 2003.²⁵ The group also called for:

- Increased funding to pay for treatment of unassigned patients and to compensate on-call physicians.
- Reasonable contracts between health plans and physicians that reflect the cost of providing services, plus a presumptive payment standard for non-contracted physicians.
- Better consumer protection in disputes between health plans and on-call doctors.
- Removal of legal and regulatory hurdles that prevent hospitals from sharing on-call resources.

- Further study of providing improved liability protection for on-call physicians.
- State monitoring of specialist gaps and problems of accessibility to on-call services.

Other proposals have ranged from market and reimbursement reform to broader health system reform. In terms of market reforms, repealing specific laws governing the corporate practice of medicine would enable hospitals to employ doctors for on-call duties. However, physician organizations strongly oppose easing these laws in California.

A recent example of a health systems reform involved a coalition including the California Healthcare Association, the California Medical Association, and the American College of Emergency Physicians of California, which sponsored an unsuccessful November 2004 ballot initiative that would have raised \$500 million to \$800 million a year for emergency care by boosting the state emergency 911 tax on long-distance phone calls. About 30 percent of the money raised would have gone to supplement payments to on-call physicians.

Another system reform option would be to establish a state-sponsored malpractice fund for physicians who treat unassigned patients, which could help shield specialists from liability. Proposed state legislation mandating that physicians take and answer ED call has not been successful.²⁶

Additional proposals include:

 Establishing a federal/state tax credit for physicians who take call and accept unassigned patients. Such a credit would avoid increasing the economic burden on hospitals.

- Using California's share of the Tobacco
 Settlement Fund to pay for on-call services for uninsured patients.
- Making managed care plans legally responsible for the cost of medically necessary and oncall services, with penalties imposed for late payment or nonpayment.²⁷
- Regionalizing emergency medical services to meet physician shortages, promote collaboration, and improve coordination.²⁸
- At the federal level, loosening EMTALA regulations, reimbursing hospitals for EMTALA-mandated services, and adjusting the Medicare resource-based relative value scale to include on-call coverage as a factor.²⁹

California hospital executives rate state-supported reimbursement for care of uninsured patients as the most useful legislative remedy, followed by mandatory physician coverage via state licensure or medical staff membership.³⁰

Hospital Strategies

At the hospital level, strategies that focus on medical staff, physician compensation, and delivery of services can help improve call coverage.

Hospital medical staff. Mandatory call for physicians has proven successful when it is paired with strong administrative support and medical staff leadership. Some hospitals have a committee or a physician liaison to address specialists' concerns, while others invoke mandatory call only if service cannot be provided on a voluntary basis. The CHA survey showed that 60 percent of hospital executives believe that mandatory call is a useful solution; 24 percent think it is somewhat useful.³¹ But physicians do not favor this strategy. A nationwide survey found that 48 percent of specialists and 36 percent of surgeons and other proceduralists would move some or all of their business if they had to take call.³² Moreover, physician organizations in California do not support across-the-board on-call mandates.

Physician compensation. For many physicians, taking call is not economical. They often have difficulty getting paid, reimbursements are low, and while on-call, they may lose money because they are unable to see patients in their offices.

Depending on a hospital's market, community demographics, physician supply, financial performance, and philosophy, several compensation strategies can provide economic incentive for physicians to take call. One is to allocate a portion of the hospital's annual budget for on-call compensation so that funds are always available.

Another is tier-based stipends—that is, compensating physicians for their "beeper weight," or standby availability. Physicians are paid for all on-call days or for the number of on-call days beyond an established threshold.³³ Under this approach, compensation varies according to a hospital's need for particular specialists, physician supply, the intensity of on-call service, and other factors. Tier 1 physicians, for example, are not compensated, as physician supply is adequate. Those in Tier 2, for which supply is moderate, are paid for a specified number of days per month. Tier 3 physicians receive the highest compensation because they are in short supply and their call burden is greater. An advantage of tier-based stipends is that they give hospitals better control over who receives what level of payment and for how many days. The responsibility for coverage shifts to physicians, who also bear the risk for patient volume, acuity, and mix. Among the disadvantages are the time it takes to set up the system, including gathering data and negotiating with physicians; the cost (paying physicians for all on-call days is about three times more expensive); and the difficulty of preventing costs from rising rapidly. Furthermore, tiered payments can create dissension among the medical staff, and they require continuous monitoring and renegotiation.

A third strategy that may be gaining momentum in California is the use of productivity-based guarantees. Hospitals contract with an outside organization to compensate doctors for unassigned patients at a fixed rate per relative value unit (RVU), or percentage of Medicare payments. The organization—rather than the hospital—recruits, credentials, schedules, pays, and monitors participating physicians, and handles collections. This buffer eliminates concerns about laws governing the corporate practice of medicine and kickbacks.

Under productivity-based guarantees, the hospital generally owns the accounts receivable and agrees to make up any shortfall between payment rates and collections. It is assessed a billing fee (about 12 percent) and a management fee (\$15,000 to 20,000 per year), and hires a coder and perhaps a part-time program manager. Physicians not only are shielded from financial and acuity risk, but receive regular payments. Specialists whose on-call work is highly intense, such as surgeons, like this arrangement because they view productivity-based guarantees as more equitable than stipends. However, such guarantees require continuous monitoring of RVU intensity.

Some hospitals combine compensation strategies to form hybrid models. They may offer stipends to oncall physicians for standby availability when they are not called to the ED and offer productivity-based payments based on RVUs when they are called. Rates may vary by specialty based on RVUs billed. Internists receive compensation only if they visit the ED; payment is based on Medicare rates and diagnosisrelated group weight.

Such hybrid programs require careful administrative tracking. The hospital assumes the financial risk of fluctuations in patient volume, acuity, and payer mix, so up-front planning is essential. On the other hand, the hospital owns the accounts receivable to offset physician payments. Physicians favor such programs because they recognize "beeper weight" and compensation levels can be negotiated according to scarcity and resource intensity.³⁴

For California hospitals, this approach—particularly performance-based guarantee models that provide flexibility and scalability—appears to be the best option.

Service delivery. Strategies that alter the delivery of oncall services range from using hospitalists, intensive care physicians, and physician assistants in the emergency department to coverage agreements between hospitals and regionalized pools for call services.

Hospitalists in the ED assess unassigned patients. They then either call in a specialist, if one is needed, or determine that specialty care can be deferred until the next day. Emergency physicians appreciate the availability of hospitalists as timesavers, while specialists value fewer calls and fewer unnecessary trips to the ED. However, because hospitalists see predominantly medical ED patients, subspecialty and some surgical coverage can remain difficult to secure.

Physician assistants (PAs) also have relieved doctors of some on-call responsibilities. A national survey by the American Academy of Physician Assistants found a 29 percent increase in their numbers in 2000-2001. Thirty-four percent of PAs took emergency department call, 46 percent performed surgery, 21 percent worked in surgery, and 9 percent worked in medical subspecialties.

One central California hospital uses physician assistants to respond to ED requests for unassigned patient consults in trauma, neurosurgery, and cardiovascular and orthopedic surgery. Both physicians and PAs are on call, although physicians remain responsible as agents of the hospital. As first responders, PAs assess patients and then, as needed, coordinate care from admission through post-discharge planning. Physicians and the hospital jointly oversee PA credentialing and performance.

Physician assistants build strong working relationships with physicians and can fully realize their potential as on-call surrogates within about six months. To be effective, they must provide 24-hour coverage, with at least three assigned to each specialty. Hospitals pay PAs' salaries and benefits; the cost varies according to the number of PAs employed and the number of specialties they cover.³⁵

Other hospitals are modifying the way they provide on-call care by sharing specialists informally; creating regional pools for high-demand, limited-supply services; or, under formal agreements, transferring stable patients to another local facility when a hospital cannot secure on-call services. These arrangements must heed state licensure requirements, EMTALA, and other regulations.

Two hospitals in the greater Los Angeles area share a large, local orthopedics group to provide call coverage. Each hospital contracts independently with the group and pays a standby stipend. There is no guarantee that the orthopedics group has sufficient depth to cover both hospitals simultaneously. Payment of two stipends for essentially the same coverage is a cost borne by the health care system—and one the hospitals cannot jointly address without running afoul of antitrust laws. This is not an efficient long-term solution.³⁶

Physicians are encouraging the formation of regional pools for high-demand, limited-supply services. In Southern California, neurosurgeons joined together and approached local hospitals about forging contracts for coverage at multiple facilities, and an eight-person urology group is sharing call coverage among three hospitals. The varying patient mix at these three hospitals eases the financial impact of uninsured patients.

Transfer agreements vary. An academic medical center or trauma facility with sufficient neurosurgery coverage, for example, might agree to accept stable transfers from another local facility that isn't able to secure neurosurgery call coverage. Or two hospitals might rotate call between them, so that a group of specialists takes call at one facility during certain hours and at the second facility during other hours. Such arrangements require transfer agreements and careful coordination with paramedic and EMS personnel. A distinct disadvantage of this approach is that it reduces patient access to care. The federal Centers for Medicare and Medicaid Services are easing the rules that govern simultaneous call and are clarifying what constitutes call coverage. This is opening market-driven opportunities for hospitals to explore formal or informal arrangements. For the most part, however, hospitals still handle callcoverage issues individually.

Regional Competitive Contracting

In studying on-call practices, the researchers fieldtested regional competitive contracting to see if it would be feasible in California. Under this model, two or more hospitals in a geographic market would create a group purchasing organization (GPO) to bid out and contract for call-panel coverage. Presumably, GPOs would have more clout than individual hospitals in negotiating for coverage, thus lowering costs.

GPOs would entertain proposals from qualified contractors. Depending on coverage needs, these might include an ED contracting group, a multi-specialty group practice, and a private enterprise. Regional competitive contracting might lure new market entrants or induce physicians to consider providing coverage in anticipation of compensation and higher patient volume, particularly in areas where physician supply or distribution is problematic.

Interviews with emergency medicine experts, hospital and physician organizations, managed care medical groups, specialists, health care executives, regulators, and consultants, among others, revealed wide conceptual support for this model. Regional competitive contracting could:

 Reduce the cost of on-call coverage and generate savings through improved care management.

- Promote partnerships among hospitals and physicians.
- Increase the efficiency, coordination, and integration of on-call services.
- Improve patient access and care by reducing diversions and transfers, and decrease inpatient lengths of stay.
- Expand market opportunities for practitioners or service suppliers.
- Ensure physician compensation for accepting unassigned patients.
- Spur competition.
- Stimulate innovation in the way call coverage is organized and delivered.

However, there also are potential drawbacks, including:

- Conflict at hospitals between the institutions and their medical staffs or key physicians.
- Antitrust concerns if the market is not appropriately defined and the GPO is incorrectly structured.
- Overextension of contracted specialists.
- Freezing out of managed care medical groups by contracted specialists who refuse to negotiate rates.
- Competitive disadvantage for small group practices unless they align.

Among the wild cards are whether market competition would increase or decrease the possibility that established physicians would view new recruits in the on-call system as a threat, and the administrative costs and bureaucracy associated with managing it.

Conclusions

Providing adequate on-call coverage is a serious challenge for many California hospitals. The current patchwork of call-panel arrangements is unwieldy and expensive, and may compromise the quality of care for emergency department patients.

However, several strategies could enable hospitals to stabilize and improve coverage, and save money in the process. The approaches that appear most successful are using hospitalists and physician assistants to ease the on-call load, developing a mix of stipends and performance-based guarantees for physician compensation, and pursuing regional competitive contracting by groups of hospitals. Hospital executives rate state-supported reimbursement for care of uninsured patients as the most useful legislative remedy, followed by mandatory physician coverage via state licensure or medical staff membership.

No single solution will guarantee stable and affordable call coverage, given that the problems vary by region, specialty, and hospital, and each strategy has disadvantages. But one thing is clear: In the absence of a major shift in state or federal policy, hospitals must take aggressive local action to resolve the crisis in oncall coverage.

APPENDIX: Interviewees

1. Anthony Abbate Regional Vice President (retired) Hospital Assoc. of Southern California Los Angeles, CA

2. John Armstrong Vice Pres., Supply Chain Management Scripps Health System San Diego, CA

3. Rick Bukata, M.D. Emergency Physician/Director San Gabriel Valley Medical Center San Gabriel, CA

4. Sandra Chester Chair, HASC EMS Committee CEO, Greater El Monte Hospital South El Monte, CA

5. Richard DeCarlo Vice President, Diagnostic Services Long Beach Memorial Medical Center Long Beach, CA

6. Brent Eastman, M.D. Chief Medical Officer Scripps Health System San Diego, CA

7. John Edelston Commissioner, LA Co. DHS EMS Commission and President, HealthPro Associates Westlake Village, CA

Dan Frank
 President
 CA. Hospitalists Network
 Anaheim, CA

9. Richard Frankenstein, M.D. Pulmonologist JCHAO Commissioner Speaker, House of Delegates California Medical Association Sacramento, CA 10. Dorel Harms Vice Pres. Quality and Professional Services California Hospital Association Sacramento, CA

11. Alan Heilpern, M.D. Emergency Physician/Director Horizon Health Services Saint John's Health Center Santa Monica, CA

12. Gerry Hinkley, Esq. Davis Wright Tremaine San Francisco, CA

13. Stacy Hrountas Vice President, Managed Care Sharp Health System San Diego, CA

14. Loren Johnson, M.D. Cal/ACEP Pres., Health Access Associates, Inc. Davis, CA

15. Wanda Jones
 President
 21st Century Health Institute
 San Francisco, CA

16. Patrick Kapsner President & CEO Bristol Park Medical Group Santa Ana , CA

17. Jeffrey Kaufman, M.D. Immediate Past President California Urological Association Former Chief of Staff—Western Medical Center, Anaheim Santa Ana, CA

18. Tim Korber, M.D. Emergency Physician/Director Anaheim Memorial Hospital Anaheim, CA

19. Frank Maas Administrative Director, Emergency Services UCLA Medical Center Los Angeles, CA 20. Mark A. Meyers President & CEO California Hospital Medical Center Los Angeles, CA

21. Michael Nelson, M.D. Chief Medical Officer Facey Medical Group Los Angeles, CA

22. Josie Rice Director, QA & Managed Care Facey Medical Group Los Angeles, CA

23. David Schriger, M.D. Emergency Physician, Researcher UCLA Medical Center Los Angeles, CA

24. Mark Schafer, M.D. Medical Director Bristol Park Medical Group Santa Ana, CA

25. Mindy Spiegel, M.D. EMS/Regulatory Consultant Los Angeles, CA

26. Susan Stone, M.D. Assoc. Director, Emergency Medicine Residency Program LAC + USC Medical Center Los Angeles, CA

27. Dennis W. Strum, Ph.D. Senior Vice President Citrus Valley Health Partners West Covina, CA

28. Raj Takhar Chief Executive Officer Gateway Medical Group Anaheim, CA

29. Kevin Thompson Chief Financial Officer Sharp Memorial Hospital San Diego, CA

30. Chris VanGorder President & CEO Scripps Health System San Diego, CA

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