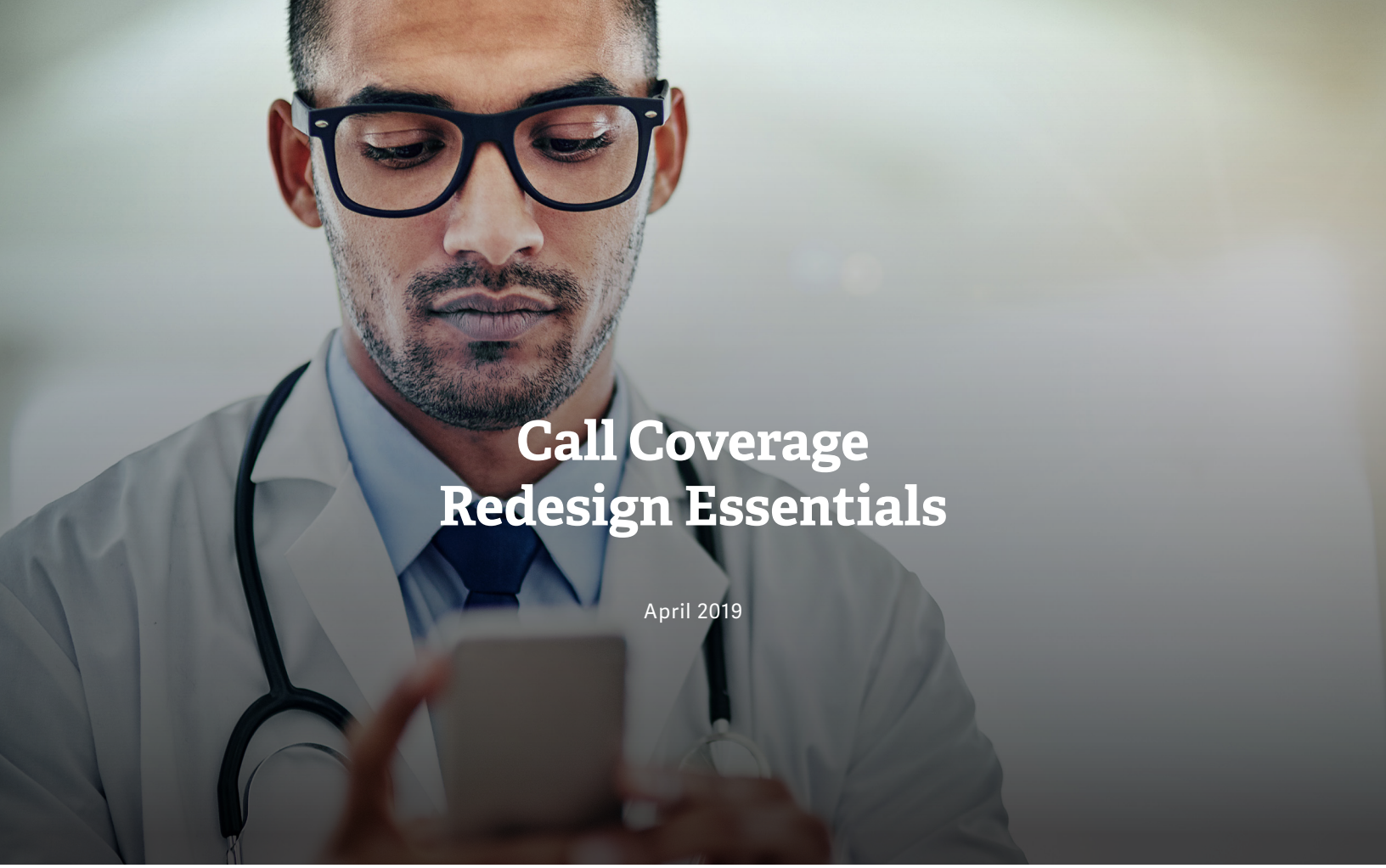

Call Coverage Redesign Essentials

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Within the last two years, hospital-based medicine reached its 20-year milestone as an acknowledged specialty, making it the perfect time for a look at how coverage was provided historically in hospitals, how it is provided in today's healthcare environment, and how things will change in tomorrow's value-based world. The market dynamics that shifted how call coverage is administered and compensated have left both physicians and hospitals unsatisfied with the new status quo. Now, an innovative approach to creating fair and sustainable call coverage arrangements is being employed.

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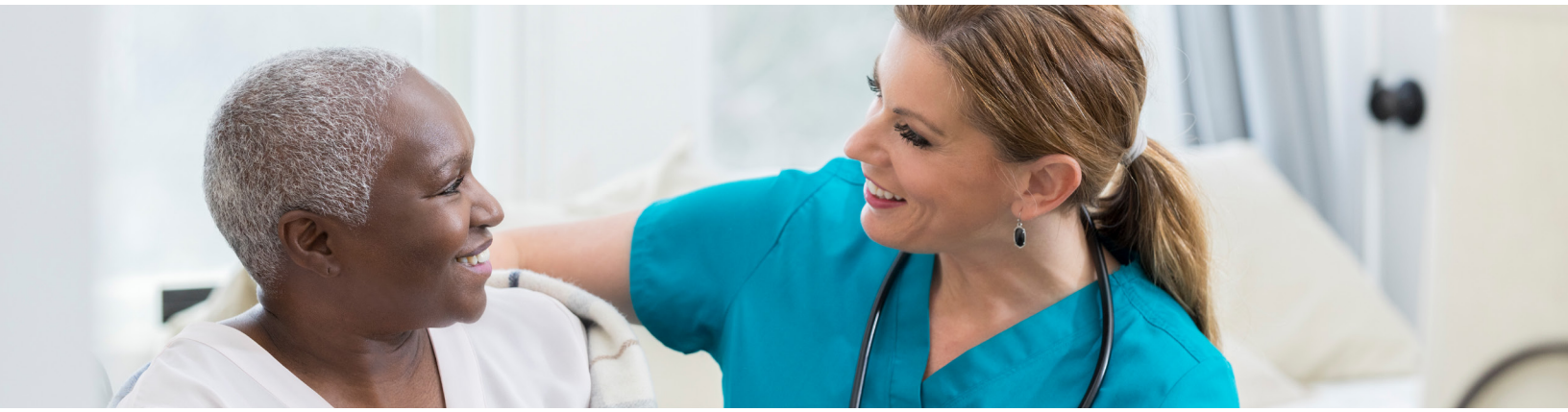
THE ORIGINS OF THE HOSPITALIST DESIGNATION IN THE CONTEXT OF CALL COVERAGE

Prior to the 1990s, most physicians, regardless of specialty, spent a portion of their time rounding in the hospital to not only care for their own hospitalized patients but also unassigned patients. However, the need for specialized hospital-based medicine became increasingly evident. The "hospitalist" designation was coined by UCSF [1] in August 1996 to describe primary care physicians dedicated to the practice of acute inpatient care. As the hospitalist specialty evolved, the rounding obligations of clinic-based primary care doctors were reduced, especially pertaining to the care of unassigned patients. Today, most clinic-based primary care physicians do not even round on their own hospitalized patients, leaving this work to the hospitalists.



Despite this new branch of medicine, the specialist call coverage paradigm, in which specialists respond to the hospital as needed, was left unchanged. Over the following decade, administrators increasingly found that specialists on their medical staff demanded compensation for providing coverage for unassigned hospital patients. Historically and today, most medical staff bylaws include an obligation for medical staff to be on call for their assigned patients. Thus, the coverage compensation actually relates only to the needs of unassigned patients. Nonetheless, doctors rarely differentiate between assigned versus unassigned hospital patients when describing the burden of call for which they require compensation. Indeed, in the same way that primary care hospitalists frequently attend to the needs of both assigned and unassigned patients, the covering specialists often find that this distinction is blurred, albeit to a lesser degree.

[1] Bai, N. (2016, August 15). The Hospitalist Turns 20: UCSF-Led Movement Has Revolutionized Inpatient Care. Retrieved October 25, 2018, from The University of San Francisco News Center.

CURRENT MODELS FOR CALL COVERAGE AND FINANCIAL IMPLICATIONS

The primary care hospitalist model is how most hospitals operate today—that is, a body of hospital-based physicians cover general hospital medicine. In an increasing number of instances, a pool of specialists provides call coverage for inpatients in need of specialty care. Specialty services have been secured through one-off coverage arrangements acquired over the course of many years or through traditional and synthetic employment arrangements.

The one-off nature of these compensation arrangements has often resulted in fragmentation, payment inequality across physicians, and a lack of clarity regarding the need for coverage of assigned patients. There can be a remarkably wide variation in pay for similar services within the same hospital or at peer hospitals in the same community. These differences are not only often seen as unfair but also carry substantial risk of variance to fair market value (FMV). The risk to FMV is common, because the standard prohibits the consideration of either party as being under compulsion to buy or sell. But what greater compulsion can there be than patient safety and/or program continuity depending on obtaining coverage from a limited number of overworked providers who are highly resistant to being stretched even further?

Consider also that a handful of specialists at hospitals still provide call coverage for unassigned patients without compensation. Thus, it is unsurprising that

this shrinking group is increasingly demanding call coverage pay or, at the very least, refusing to cover those unassigned hospital patients as a matter of fundamental fairness.

As the market dynamics take shape, many hospitals remain reliant on program structures or designs that were put in place many years ago. Whether these arrangements are either still years from expiration or are pending renewal and revision, the inequalities inherent in these coverage models are compelling many hospital administrators to seek ways to normalize their compensation arrangements. Ultimately, administrators must somehow establish a sustainable call coverage program, which frequently involves a great deal of innovation to ensure affordability, continuity, and stability of the medical staff so they can provide the requisite level of service and quality.

CALL COVERAGE REDESIGN ESSENTIALS

Administrators contemplating the restructuring or standardization of a call coverage program must consider four components in their prospective programs to align with today's market environment: call coverage burden, maximization of available physician resources, fair market compensation, and transparency with physicians.

Call Coverage Burden

Under any redesign initiative, a thorough understanding of the call coverage burden for each specialty is essential. Burden is the aggregate constraint due to taking call, which includes both active components (e.g., emergency procedures, patient consults) and passive components (e.g., carrying a beeper, maintaining a certain proximity to the hospital).

Understanding burden factors, both qualitatively and quantitatively, will provide the initial direction for any redesign efforts. A great place to start is to first assign each specialty a burden score or value, based on available information, then rank-order the specialties by their respective burden level. Comparing each specialty's level of call burden against its current annual spend will reveal which specialties are balanced and which present economic and/or retention risk for the organization. Generally, compensation should be commensurate with burden such that as burden increases, so does compensation, as demonstrated in **figure 1**.

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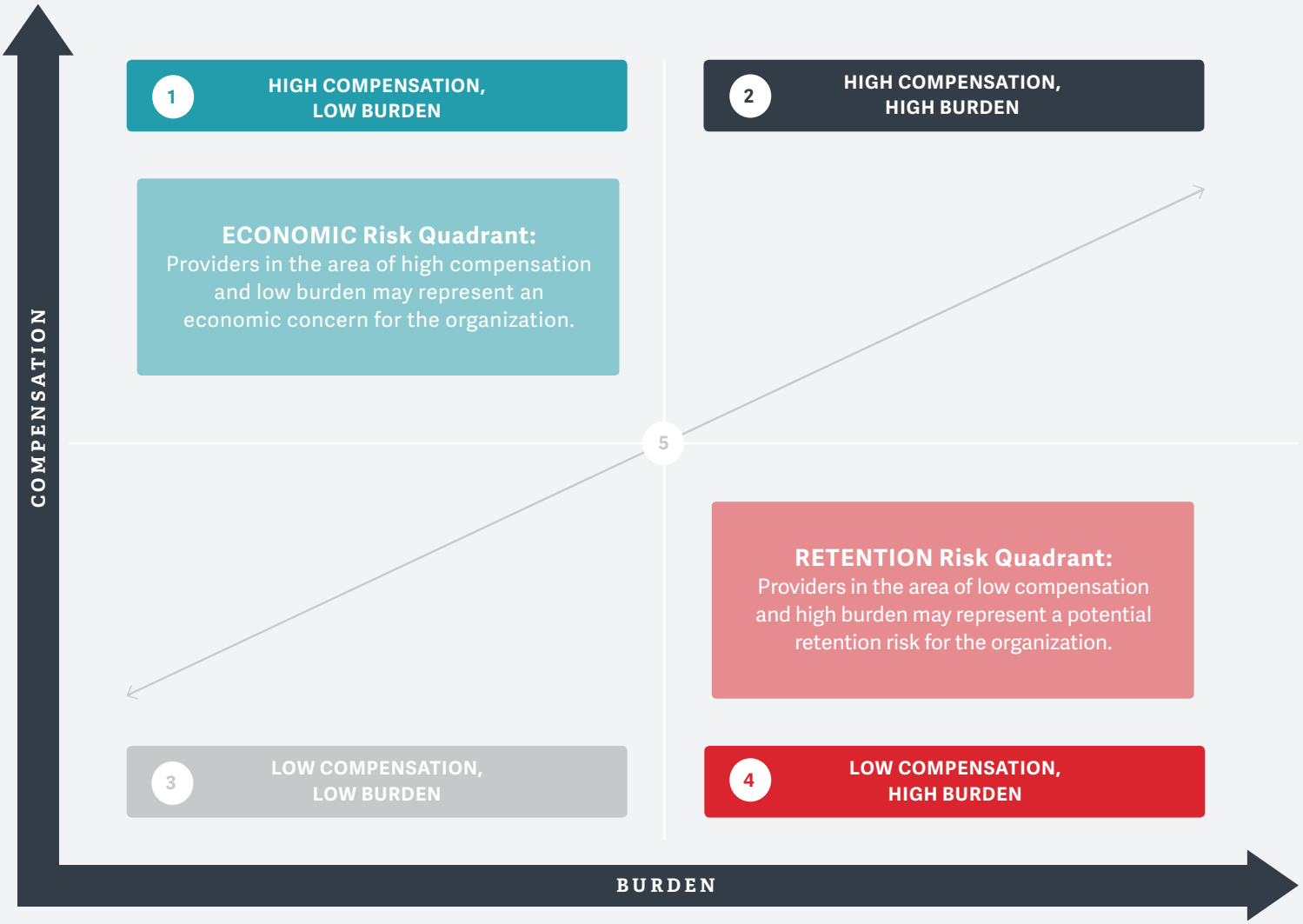
Figure 1 — Balancing Burden and Compensation



5 PROVIDERS WITHIN THE ARROW EXHIBIT BALANCED COMPENSATION AND BURDEN.

Call coverage burden should function as the primary factor in negotiations, not legacy contracts. Strategic or political considerations will serve as secondary considerations to call coverage planning efforts. Exploring innovative arrangements that extend beyond the traditional demand for more funding can often be the quickest route to a mutually beneficial arrangement.

Consider an innovative scenario in which pooling resources reduces burden across the organization. As demonstrated in **table 1**, partnering with sister hospitals to consolidate the call pools can limit the amount of burden on physicians and likely reduce the financial cost to the system.

Table 1 — Coverage Redesign Example

	FRAGMENTED COVERAGE MODEL			POOLED COVERAGE MODEL	VARIANCE
COMPONENT	HOSPITAL A	HOSPITAL B	TOTAL		
Hospital Coverage Days	365	365	730	730	0
Per Diem	$1,000	$1,000	$2,000	$1,500	-$500
Annual Spend	$365,000	$365,000	$730,000	$547,500	-$182,500
Rotating Providers	4	4	8	8	0
Annual Days Covered per Provider	91	91	91	46	-45
Annual Call Funding per Provider	$91,250	$91,250	$91,250	$68,438	-$22,812

WINS UNDER THE POOLED MODEL

- Both facilities maintain 24/7 coverage. Restricted versus unrestricted on-site requirements.
- Both hospitals realize significant changes in burden, including the following:
  - Coverage rotation is cut in half.
  - Active burden while on call increases (i.e., billable activity is increased, while passive, unbillable "beeper time" is reduced).

- Patients have access to a more reliable set of covering providers due to the increased panel size. Oftentimes a larger panel with multiple coverage sites includes a backup provider, which increases the reliability of coverage.
- Both hospitals realize a significant reduction in call spend (25% shared between the two hospitals).

LIMITATIONS UNDER THE POOLED MODEL

- This type of pooled coverage is dependent on specifications related to patient volume and the distance between the two facilities.
- Each physician's annual income from call coverage is reduced commensurate with the new number of coverage days.

Maximizing each call panel should be a priority when redesigning call coverage compensation. "

Maximization of Available Physician Resources

Call coverage is unusual in that there is an inverse relationship between the cost of coverage and the size of the resource pool. Specialties with more rotating physicians or other resources, such as PA support, often accept lower compensation due to the reduced rotation for each physician (i.e., reduced burden).

Maximizing each call panel should be a priority when redesigning call coverage compensation. Inconsistency when determining compensation is inefficient and can even become adversarial when comparisons are made between specialties at the same hospital or within the same specialty at sister hospitals.

Where possible, health systems should demand efficient use of call coverage dollars. If you are in a market with other affiliated hospitals, seek opportunities to regionalize coverage and pool resources. Even for specialties that are heavily burdened, there are still advantages to a regional approach to coverage.

Saturate your heaviest-burdened facility with specialty-specific resources. Explore the creation of a specialty hospitalist program or Center of Excellence. Busy specialties requesting additional payment could present an opportunity to invest in a service line in order to provide coverage for lower-burdened satellite facilities close to the site of the specialty program. This coverage may be offered through an advanced

practice provider who travels to the satellite facilities or the implementation of transfer protocols into the flagship site. Your affiliated satellite hospital can often satisfy coverage by relying on a prominent service line from the nearby flagship facility.

As a complement to restructuring compensation, implement a medical director for the specialty whose authority spans across all regional hospitals. This will provide a key first step in regionalizing and standardizing coverage. The medical director will be able to identify inequalities between hospitals beyond compensation and serve as a catalyst for further pooling resources in the future.

For hospitals without affiliated neighbors, this is an opportunity to innovate. An increasingly popular perspective is to view call coverage more like insurance, based on the unanticipated nature of need and less like a purchased service. By combining coverage with your unaffiliated neighbors, you can capitalize on scale, enhance coordination, and improve coverage.

INNOVATION IN ACTION: ORTHOPEDIC CALL COVERAGE

A recent orthopedic coverage example highlights the potential for innovative collaboration. A client was paying a market-competitive rate of $1,500 per diem for coverage. Hospital leadership learned that the physicians were also covering a neighboring unaffiliated hospital under a separate rate of $2,200 per diem. The physicians set their calendars to cover both facilities on the same day. This overlap had been occurring for over a year, indicating that the burden was low enough for the physicians to adequately cover both facilities.

Everything about this situation is correct, except for the fragmented economics. While the physicians had developed a regionalized model to cover both sites

Work collaboratively with a group of physicians, not only one-on-one, and be transparent with your goals and limitations."

and the hospitals were satisfied with their respective coverage, neither hospital was benefitting financially under this scenario. By simply issuing one very competitive per diem rate (e.g., $2,600), the hospitals could align their call coverage and ensure its success in the long term. Adding a specialty-specific regional medical director would increase coordination and allow the physicians to be transparent regarding their activities at the other facility.

WHAT DOES THIS MEAN FOR YOUR HOSPITAL?

If you have an affiliated hospital within reasonable distance, you must evaluate opportunities to pool resources for each specialty. Start with a task force of physicians, administrators, and analysts; frame out a template similar to **table 1**; and begin the process of maximizing your valuable resources.

For unaffiliated hospitals, step in front of your contemporaries and contact your neighboring hospitals. Discuss which physicians are already covering both sites. Look at opportunities to pool resources and add value to this difficult facet of acute care.

Fair Market Compensation

Like all physician compensation, call coverage compensation is required to be FMV for compliance with the IRS, Stark law, and the Anti-Kickback Statute. Ensuring compliance with these measures is required for your prospective call coverage compensation redesign initiative.

We often see health systems setting rates solely based on industry surveys and benchmarks, and while these may be directionally in line with the market, they often fail to capture key components of a hospital's specific call coverage situation. Unlike benchmarking total clinical compensation, which is a generally explicit measure, call coverage benchmarks often focus only on a per diem rate and fail to capture nuances in coverage arrangements, such as:

- Stipends for activation.
- Transfer incentives.
- Restricted versus unrestricted on-site requirements.
- Medical directorships.
- Collection of professional fees.
- Uncompensated care protocols.

With this in mind, you should secure an FMV opinion that considers call coverage burden; financial implications, such as payer mix; the supply of specialists in the market; and regulatory factors, such as EMTALA.

An FMV analysis that accounts for these factors will ensure your prospective compensation rates are competitive in the market, defensible with physicians, and compliant with state and federal regulations.

Transparency with Physicians

One critical strategy when considering a call coverage compensation redesign is engaging with your physician stakeholders. Invite representatives from several different specialties to be a part of a work group to evaluate redesign opportunities. Explain there are finite funds to allocate and the organization is seeking a more equitable and transparent way to distribute them.

Taking call is difficult, and many specialists are finding less value each year from inpatient services and their hospital affiliations. Therefore, engagement with physicians is critical to implementing a sustainable model and avoiding discontent or dissatisfaction. Work collaboratively with a group of physicians, not only one-on-one, and be transparent with your goals and limitations. Physicians still maintain a sense of commitment to community and will work with administration to achieve a collective goal.

PREPARING FOR TOMORROW'S VALUE-BASED COVERAGE MODELS

When evaluating your hospital's coverage, consider the breadth of call coverage agreement structures. If each specialty has a unique call coverage agreement and there are inconsistent methodologies or limited standardization across specialties, then it is highly recommended that you consider a restructure or redesign effort. Tomorrow's value-based coverage models will rely on equitable methodologies and won't support fragmentation or one-off arrangements.

A call coverage compensation model that is burden-based, resource efficient, and aligned with the market is key to securing long-term, viable coverage. Work collectively with your physicians and be transparent regarding your goals and needs regarding hospital coverage. The result will be a sustainable model that improves the value of your time and resource investment.

About **ECG**

ECG offers a broad range of strategic, financial, operational, and technology-related consulting services to healthcare providers. As a leader in the industry, ECG provides specialized expertise, such as strategic and business planning, specialty program development, and hospital-physician relationships, to community hospitals, academic medical centers, health systems, and medical groups. ECG's strength is built on approximately 215 healthcare professionals practicing in offices located in Atlanta, Boston, Chicago, Dallas, Minneapolis, San Diego, San Francisco, Seattle, St. Louis, and Washington, DC.

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