*Author: @JustinWampach*

# On- Call Schedule Management:

## *How to justify the cost...*

How does a modern hospital justify spending dollars to update an antiquated on-call management system from a 3-ring-binder to a web-based information management system? The same way everything else is done....justify the cost by showing one or all of the following, the ability to capture lost revenue, the ability to reduce risk and the ability to improve patient care.

In every hospital throughout the US and Canada there is a system for tracking and maintaining the on-call "roster" so that the Emergency Department (ED) know's who to call when they coverage from a specialty physician. Based on experience I can tell you that this is typically done using a 3-ring-binder. Yes I said 3-ring-binder. Again, based on experience here is the most common scenario that I hear almost every day.

## *History*

To refresh your memory, a specialty physicians office will create a monthly calendar (using Excel or Outlook) that shows who is "on-call" for their patients if they present to the ED. The specialty physicians office will fax the original calendar over to multiple areas of a hospital. On average every calendar will change several times throughout the month. Each change has to be re-documented and re-faxed over to the hospital. Not a big deal right?

On the hospital side, someone, perhaps the Medical Staff Office or the Telecom Department or even the ED will receive each of the schedules from each specialty physician offices. As a reference point, a medium sized hospital with 350 beds and 300 privileged physicians will have 19 specialty on-call schedules to manage. Each day someone in the hospital has to create a "daily on-call sheet" based on information from each 19 specialty physician offices and distribute throughout the hospital and medical community. Each time the schedule changes throughout the day this process must be repeated.

As you look to develop a strategy for purchasing an on-call management system, here are four buckets that I would use to illustrate areas of either cost savings, risk mitigation, physician satisfaction or increased patient care that will help you build the case for integration.

**4 Buckets to help you build your case.**

Bucket 1:
Finding the correct on-call physician is a clear patient quality of care issue.

Bucket 2:
Without access to accurate & timely information it takes staff longer to see patients and clear beds. Fewer patients seen is lost revenue.

# Bucket # 1

Door-to-balloon is a time measurement in emergency cardiac care (ECC), specifically in the treatment of ST segment elevation myocardial infarction (or STEMI). The interval starts with the patient's arrival in the emergency department, and ends when a catheter guidewire crosses the culprit lesion in the cardiac cath lab. Because of the adage that "time is muscle", meaning that delays in treating a myocardial infarction increase the likelihood and amount of cardiac muscle damage due to localised hypoxia, guidelines recommend a door-to-balloon interval of no more than 90 minutes. The inability for the ED staff to find the proper on-call physician due to poor information management is a contributing factor to an increase in lost door-to-balloon time. A facility that has a sophisticated on-call management system will virtually eliminate this factor. This is a clear patient quality of care issue. Although you may have to dig around to find relevant examples in your ED, they are out there, but not talked about.

# Bucket # 2

Left Without Being Seen (LWBS) is a health care term often used by emergency departments (ED) to designate a patient encounter that ended with the patient leaving the health care setting before the patient could be seen by a certified physician. Often the inclusion of this phrase in a medical record is the result of ED overcrowding (i.e. the patient could no longer wait in the ED to be seen by a physician, so they left without alerting a health care professional). Typically, those patients who leave an emergency department without being seen are not at an increased risk of death, and often do not require inpatient hospital admission. LWBS is both a patient care issue, and a lost revenue opportunity. One of the contributing factors to long wait times in an ED is trying to track down the on-call correct doctor. Each time the ED staff has to "hunt" for the correct physician, a certain amount of time is spent. When we multiply that time times the number of times this happens throughout a year, you can see that it adds up. While this time is adding up, new arrivals are getting restless in the waiting room. Without access to accurate information, it takes staff longer to see patients and clear beds. The longer it takes to clear a bed, the longer someone else has to wait and the less revenue is being generated by that bed.

Bucket 3:
EMTALA expressly holds hospitals liable for inaccurate on-call information.

Bucket 4:
On Call Management Systems decrease contention and increase physician satisfaction.

# Bucket # 3

Hospitals that participate in the Medicare and Medicaid programs must comply with various state and federal laws, including the Emergency Medical Treatment and Active Labor Act (EMTALA). Hospitals subject to EMTALA may incur liability for violations under its enforcement provisions. But did you know that on-call physicians at hospitals subject to EMTALA must also comply with the act to avoid liability?

EMTALA governs how and when a hospital can refuse to treat a patient and transfer unstable patients to another hospital. It requires hospitals to 'maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. The purpose of the on-call list is to identify and ensure that emergency departments are prospectively aware of those physicians, including specialists and sub specialists, who are available to provide care. By virtue of a hospital governing board's assignment of responsibilities, the hospital itself may be directly responsible for the actions of its medical staff, including on-call physicians. Moreover, EMTALA expressly holds hospitals liable for certain actions of on-call physicians.

The Office of Inspector General (OIG) may issue civil monetary penalties (CMPs) and exclude physicians from federal health care programs as well. CMPs range from up to $25,000 per violation for hospitals with fewer than 100 beds to $50,000 per violation for hospitals with 100 beds or over. Penalties are based on the size of the facility. The OIG can also assess up to $50,000 per violation for physicians who commit gross and flagrant violations.

If the on-call list is not accurate due to changes that are not being recorded properly, your organization may be in violation.

# Bucket # 4

Physician satisfaction regarding on-call is a major point of contention at most hospitals. Here is the reason, imagine that you area specialty physician such as a Neurologist or Cardiac Surgeon. After a long day of seeing patients, and performing procedures you finally end your day. In the middle of the night you receive a call from the ED stating that your being requested in the ED for a patient consult. You think to your self, I'm not on-call, I swapped with my partner weeks ago, why in the hell are you calling me. The reason is that the Hospital and particularly the ED does not have access to changes that are made in the paper system. Now, this does not happen every night, but it does occur often

enough that frustrates the heck out of the Doctors. Without an on-call management system, changes that are faxed over to the hospital need to be made to the correct paper schedule in the 3-ring binder and then communicated to each department. As you can imagine, this human process can and does fail. Although one wrong call in the middle of the night is not going to send a physician packing, but from a recruitment standpoint, it can be the straw that broke the camel's back.

## *Conclusion*

There are many more buckets that will show both hard and soft costs savings as well as other ways to reduce risk and improve patient care. These are the four to start with.

To learn more about Adjuvant's solution to on-call management, "Call Communicator" call us. Our solution puts the right providers in the right place at the right time.