

# Clinical CONNECTIONS

INFORMATION ON  
MEDICAL TRENDS  
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## ED Call: A Problem with a Solution

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**Nobody wants to be “on call.”** One of my partners once told me in disgust, “This call really gets in the way of my lifestyle!” Another doctor when asked about call quickly remarked, “You couldn’t pay me enough to take call!” However, people get sick and injured on weekends and so there will always be a need for healthcare during these times.

In the past, ED patients often comprised up to 20% of a specialists’ income, and it was a good source of new patients so ED call was desired. Medical groups would actually argue and protest over who got more call days not less. If you didn’t provide the ED physician with fast courteous service, you may not get any ED referrals and your practice would suffer financially. In that setting, it was easier to feel more professionally obligated to care for patients on nights and weekends. Personal time and a balanced life were not part of a physicians’ vocabulary.

However, times have changed. Physician employment, decreased reimbursement from ED patients, time expectations of the family, the onset of ambulatory surgical centers, and hospitalists have all affected the role of ED call in a physician’s professional and personal life. Per the EMTALA Part II Interpretive Guidelines of 3/21/2008, hospitals have the legal obligation to arrange physician coverage for their EDs; however, physicians who take call for their own patients or their group, but refuse to be “on call” for other patients may be violating EMTALA.

Every medical staff and hospital has a different culture, different staffs with different leaders, specialties and capabilities. As with any very contentious and complex problem, the best solution will have everyone feeling some discomfort. First, the majority of those making up the call coverage plan must agree that ED coverage is necessary to take care of the communities’ patients. This concept must be acknowledged, and accepted as the priority in all discussions concerning call. A group of doctors that represents all the major patient care groups should meet, form a Task Force, and discuss what the needs are for the specific patient population served by that particular medical staff and hospital. What individual doctors want, or what the hospital administration wants, should not be the primary focus of the discussion; rather, the focus should be centered on what is in the best interest of the community (i.e. under-served patients) and what does the law obligate the parties to undertake. Once the needs of the patients are understood and acknowledged, then ways to provide for these needs can begin.

Patient conditions that are managed by the medical staff during the day should always be attempted to be cared for during nights and weekends. This is a condition of participation for CMS.

- Medical conditions if left untreated that could lead to loss of life or limb can be designated as Level 1 concerns, in that they require 24/7 care.
- Level 2 concerns are those when gaps in care are not going to place the patients’ life or limbs in jeopardy.

Secondly, by using the “all relevant factors,” the physicians on the Call Task Force can begin to determine how much of the time the medical staff can and should cover the ED and how many gaps in local coverage there may be. The factors used are:

1. number of physicians in each specialty,
2. other demands on the physician’s time.
3. the work load for a specific specialty,
4. needed days off for the physicians, and
5. how difficult it is to get the patients to another facility.

Using this information with input from each of the departments or divisions of medical care, the physician Task Force should come up with recommendations to the MEC. They should also investigate ways to lessen the call burden, especially for those

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specialties that will be asked to do the most. Reviewing potential expanded but appropriate use of the hospitalists, ED physicians writing “bridge orders,” the use of mid-levels as physician extenders (not replacements), and creative scheduling to meet physician office or personal time, can all be used to make a situation work.

Efforts that decrease unnecessary phone calls from the ED or the floor nurses are important. Working with the inpatient nursing staff to vet calls through a nursing supervisor or charge nurse can make a substantial decrease in night calls. Carrying a pager versus being awakened several times are very different burdens.

After the doctors in each on-call service line have met, they should provide the MEC in writing their own call coverage availability, abilities and expectations. These factors should be reviewed yearly as there will be changes in the medical staffs’ availability for call coverage, and possibly new patient expectations. Therefore, it is better to have a “Call Policy” that is referenced in the Medical Staff Bylaws than to attempt to have the details written out in the Bylaws or Rules and Regulations.

New ED and hospitalist physicians, as well as nurses, will need to be educated on how the system of call works at your hospital.

Everyone involved in night and weekend work needs to be represented at these discussions. This process keeps the outcome of good patient care front and center. At the same time, it forces people to consider what is an acceptable workload for the physicians on the medical staff. Once the MEC has signed off on the plan, administration can meet with physician leaders and work through the plan.

Both hospitals and physicians know what resources they can bring to bear on this responsibility. The hospital should determine what the consequences will be if patients with problems related to a specific service line are going to be transferred. For instance, not having cardiology coverage on the weekends may cause certain medical and surgical patients to be transferred, not just new heart patients. It is only then that medical staff leaders and administration will know how to respond to physicians who cannot or will not take ED call.

The hospital has the legal responsibility to come up with a call schedule, but it is the physicians who provide the care. Therefore, we have an ethical responsibility to work among ourselves, and with the hospital, to assure reasonable medical care to the community during off hours. If we do not fulfill this mission, we as physicians will suffer along with our hospitals and our patients.

## ADVANCED CLINICAL ELECTRONIC SYSTEM (ACES) COMING TO YOUR HOSPITAL SOON

*The hospital where Dr. Swensson practices – Willamette Valley Medical Center in McMinnville, OR – was Capella’s first hospital to make the conversion to MEDITECH 6.0. Dr. David Siepmann, chair of the Physician Advisory Group, which has been providing direction for the overall process, is also affiliated with WVMC.*

The transformation to a fully electronic platform for your hospital is in full force. Conversion to an electronic platform has occurred over the past few years for many independent physician practices as well as in Capella’s employed physician offices. Now it is time for the hospitals themselves to convert all of their processes to an integrated electronic format. And, just as in physician offices, this transformation is not simply related to physician orders and documentation, but is a complete “rewiring” of the hospital. Therefore, although the doctors may only see what they have to touch, every department and staff member in the hospital has had to build and learn a new way of doing things.

“It’s important to remember that while physicians ultimately guide and deliver much of the care within the hospital, we are a part of a much larger transformation,” said Dr. Swensson. “Our healthcare system is being asked to do things that, without a robust and well-understood electronic system, we will not be able

to accomplish. The more you as a physician know and the more you are fully integrated with the hospital’s new Advanced Clinical Electronic System (ACES), which will be

MEDITECH 6.0 at most Capella hospitals, the more efficient you will be and the higher the quality of patient care will be.”

As part of this clinical transformation, Capella and your individual hospital have invested considerable resources in developing a set of evidence-based best practice order sets that will be used to help guide patient care. As with all reference materials, they provide a quick reference to the latest evidence-based thinking in the industry. These order sets will start with the ED/ER and the hospitalists, but other disciplines will be integrated over the next 12 to 18 months.

For the best order entry sets and other programs to be written, there must be knowledgeable input from physicians. “If you don’t learn everything you can about this new system, you will not be able to have a useful discussion with those who can assist. The most important thing that you can do to enhance the team work is learn as much about the system as possible.”

Not only should physicians do what is required within the training modules, but each one should consider spending more time with the program prior to it going live at their facility. “When your hospital goes into parallel testing, which is a simulated live environment, physicians should be there as much as possible to see how everything works together, or doesn’t work together,” Dr. Swensson said. “Many of the complaints and issues with MEDITECH 6.0 are due to physicians not spending enough time learning the system. That’s the only way we can make the transformation of healthcare from a fragmented system with interrupted service to one of patient management that is integrated on many different levels.”

For more information on your hospital’s conversion, see your CNO, IT Director or Physician Advisory Group representative.



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