Who's On Call?

Faced with decreasing emergency neurological services, some hospitals are spreading neurologists too thin. Their reaction hasn't always been kind.

By Paul Winnington, Editorial Director

It's been nearly eight years since the STOP Stroke Act—the bill that was supposed to herald a new era of emergency neurologic care by establishing and promoting stroke centers across the country—was introduced in the Senate. The fate of the legislation remains uncertain, and it's increasingly evident that the bill may have lost its relevance. Without the impetus of the bill, Stroke Centers have emerged nationwide, as have a plethora of logistical and financial challenges for all parties involved in providing care.

The Act's failure hasn't hindered government involvement, either. Recent Joint Commission action on core measures for CMS reporting will encourage wider growth of stroke centers. And there's no doubt that forthcoming initiatives from the Obama administration—including the push for increased use of technology in patient care—will translate to changes in acute stroke management.

Amidst these various changes and putative advancements, neurologists may be the ones left in the dust. They hear calls to provide the emergency neurological care necessary to allow interventional stroke therapy, while at the same time being offered disproportionate or no remuneration. Reaction to the current situation among specialists runs the gamut from those who want to mobilize for compensation for all call services to those who embrace the status quo. Many are somewhere in the middle, looking for creative solutions to the problem of emergency neurology care.

Is There a Doctor in the House?

Concerns about call coverage have existed for some time within neurology, but the dialogue has taken on new vigor recently. Some of the increased attention could relate to new Joint Commission approval of core measures for stroke for ORYX reporting, suggests David Likosky, MD, a neurohospitalist and president of Medical Staff at Evergreen Hospital Medical Center in Kirkland, WA. Hospitals that meet and report core measures stand to earn substantial reimbursements for stroke care services, while non-reporting hospitals would be exempt from such funding. That's a significant incentive for hospitals to offer emergency neurological services.

Neurologists, however, tend to see more disincentives to taking call than incentives. "A lot of physicians would rather just concentrate on office-based practice and not have to deal with the heavy load of on-call coverage," observes Josh Randall, Vice President for Business Development at NeuroCall, Inc. (neurocall.com), a provider of neurological telemedicine services.

Changing attitudes toward call coverage may mirror shifting attitudes and expectations regarding neurology practice, Dr. Likosky, chair of the AAN's newly formed Neurohospitalist Section, suggests. In the past physicians seemed to accept that taking call was simply a responsibility of a local specialist. Today's clinical neurologists face different practice and personal realities. "A lot has changed since then," Dr. Likosky says. Neurologists in the past practiced in a different healthcare economy. Now neurologists have increased financial pressures, insurance challenges, real or perceived malpractice concerns, declining reimbursements, and the like, and they need to dedicate more time than ever to the business of running their practices, Dr. Likosky points out.

Plus, he adds, until relatively recently, neurologists going into practice did not anticipate after-hours emergency call duty as a significant responsibility. An obstetrician going into practice 20 years ago, for example, would know that his/her career would require call. But until the dawn of tPA, there wasn't much need for neurologists to be available to emergency departments at all hours, Dr. Likosky observes.

Although Dr. Likosky suspects that many neurologists enjoy the inpatient care component of neurology practice, he notes that when hospital work begins to have a financial impact on the specialist's practice, the practice demands will likely win out.

Some neurologists have suggested that specialists deserve to be paid for taking call. Especially if the patient ends up receiving tPA, they argue, the neurologist deserves a portion of the hospital's reimbursement for the service. Compensation for call is the norm for some other specialties, and neurologists across the country do receive payment for taking call. But a number of those in the specialty are logging extra hours without remuneration.

Call coverage protocols are highly variable, acknowledges Dr. Likosky, "many hospitals pay neurologists in one way or another," whether through establishing medical directorships, offering per call stipends, or some other incentive. The Medical Group Management Association (MGMA) noted in a recent survey report that while on-call services have historically been "sporadically compensated," the organization has seen more hospitals offering compensation and compensation levels are rising.

Still, there is great variability nationwide. This is not surprising, since physician reimbursement for clinical practice varies nationwide, as well, Dr. Likosky points out. "Neurologists practicing in two different states can have vastly different incomes, even if their practices are very similar," he notes. Even government reimbursement rates for E/M services vary regionally. Local workforce issues come into play.

The same MGMA report says that 38 percent of providers receive no additional compensation for on-call coverage. Among physicians working for hospital-owned group practices, 30 percent of providers report no additional compensation for taking call, while 42 percent of those in non-hospital-owned practice report no additional payment for call.

In further support of on-call compensation, the Office of the Inspector General for Health and Human Services determined just last month that it is not a violation of anti-kickback rules for an unnamed hospital to reimburse physicians for on-call services. Although the OIG stresses that its decision refers only to the hospital that petitioned for clarification on the issue, other physicians seeking reimbursement will likely cite the Opinion (No. 09-05).

Stipends no doubt attract and retain on-call physicians, but these and other forms of monetary reimbursement for taking call aren't likely to keep growing in the current healthcare economy. In fact, they may become scarce, as the healthcare system overall grapples with high and growing costs of care.

He supports neurologists receiving reimbursement for their time and expertise, but Dr. Likosky also recognizes the needs of hospitals to rein in costs. "Should hospitals have to shoulder that burden or should it come out of the whole healthcare system?" he asks.

To pay specialists for call coverage in many cases simply is not cost effective for hospitals, Mr. Randall points out. "Based on current reimbursement levels, paying a neurologist would leave the hospital in the red," he says. For their part, "A lot of times doctors are happy with income from office-based clinical practice," he observes. Therefore, financial incentives to take call may not appeal to them.

Finally, it's important to note that the desire to avoid call isn't just about money. Receiving emergency calls at odd hours can significantly hinder a physician's lifestyle, and call responsibilities can limit one's ability to travel and make other plans.

Call for Change

When it comes to reimbursement for call coverage, discrepancies aren't limited to the needs and desires of hospitals versus those of neurologists. There are conflicts in philosophy between various members of the specialty. The AAN has issued a brief statement on the issue, saying that the Academy, "believes that patients and communities will have better access to emergency neurologist services for stroke and other illnesses when neurologists are reimbursed to be on call."

Some in the specialty have called for stronger statements in support of compensation and even urge a unified effort to demand payment for all who take call. There are even those who encourage work stoppages and other measures to obtain payment.

In the Words of the OIG

The OIG Advisory Opinion No. 09-05 regarding compensation for call coverage reads in part:

…We are aware that hospitals increasingly are compensating physicians for on-call coverage for hospital emergency rooms. We are mindful that legitimate reasons exist for such arrangements in many circumstances, including: compliance with EMTALA obligations; scarcity of certain physicians within a hospital's service area; or access to sufficient and proximate trauma services for local patients. Simply put, depending on market conditions, it may be difficult for hospitals to sustain necessary on-call physician services without providing compensation for on-call coverage.

…The Hospital reports that most physicians dislike the duty of performing on-call coverage for its Emergency Department because telephone calls requesting the physician to respond to the Emergency Department come at all hours, disrupting their professional and personal lives. In addition, the on-call obligation creates additional medical liability for care rendered to persons with whom there is often no previously established patient-physician relationship, increasing the risk of claims of medical malpractice.

Yet others in the specialty take a different tack, holding to the notion that call is a duty of the community specialist: Call duty represents a burden on neurologists, but it's an unfortunate element of the occupation.

Still others are trying to identify alternatives to the traditional call model that may diminish or eliminate demands on community neurologists and perhaps reimburse any call duty that is required. Among options to potentially mitigate the demands of call duty while ensuring patient access to top-quality care are the expansion of telemedicine and the emergence of neurohospitalists. While each approach has potential benefits for local communities, hospitals, and neurologists, multiple factors will determine whether or not each option is appropriate in a given situation.

Telemedicine. By now, telemedicine is an established practice in the US and around the world. A decade ago, researchers showed in *Stroke* (1999;30:2141-2145) that the NIH stroke scale "remains a swift and reliable clinical instrument when used over interactive video." Compared to bedside assessments, remote assessments took about three minutes longer, on average, but scores from each method were strongly correlated. Ten of 12 items offered excellent or good agreement. Subsequent studies confirmed that "remote examination of acute stroke patients with a computer-based telesupport system is feasible and reliable when applied in the emergency room; interrater agreement was good to excellent in all items" (*Stroke* 2003;34:2842-2846) and established a benefit from telemedical stroke care in rural areas (*Stroke* 2003; 34:2951-2957).

Yet wide expansion of telemedicine into neurology is relatively recent. Only last month, the American Stroke Association/American Heart Association published a comprehensive evidence-based review and statement regarding use of telemedicine (*Stroke* 2009;40). Importantly, teleneurology is not only a solution for rural areas or regions with few or no neurologists, although this is an important aspect of the practice, Mr. Randall says. In fact, he says, telemedicine can be an option "even in larger urban areas where hospitals may have a neurologist on staff but just don't have the manpower needed for sufficient round the clock coverage."

NeuroCall began with a neurologist who was taking hospital call. Ricardo Garcia-Rivera, MD lived a 40-minute drive away from the Florida hospital where he took call. By the time some patients reached the hospital and underwent initial evaluation, they were already close to the three-hour time limit then in place for tPA. Adding the time it took for Dr. Garcia-Rivera to arrive on-site, review radiology, and assess the patient nearly guaranteed that the patient would be beyond the treatment window. Even now that tPA is indicated up to 4.5 hours after the start of an ischemic event, it's easy to see how some individuals who are otherwise candidates for therapy may miss the treatment opportunity due to logistical constraints.

That's why Dr. Garcia-Rivera convinced the hospital's CEO to install dedicated DSL lines in ICU rooms and to invest in a camera-cart-system. Once the technology was in place, within 10 minutes of a patient arriving at the hospital, Dr. Garcia-Rivera could begin to remotely view radiology, assess the patient, and administer the stroke scale and make a decision regarding intervention. "The ER doctor or the ARNP at the hospital became Dr. Garcia-Rivera's hands, but he was able to assess the patient just as he would in person," Mr. Randall says.

"The system started saving lives because of the fact that he could cut out one-and-a-half to two hours of travel time." Based on his experience, Dr. Garcia-Rivera founded NeuroCall, which is now partnered with Global Media to offer services nation- and world-wide.

Here's how NeuroCall works (other companies offer similar services, though specifics may vary). Hospitals contract with the company for installation of the telecommunications equipment and technical support and to provide physician access. The company then contracts with and pays neurologists licensed to practice in the respective state to be on-call for the hospital. If necessary, multiple neurologists can conference to review a case. When a patient arrives at the ER, the physician is "called" and he or she logs on to complete the remote assessment.

Physicians can also contract with NeuroCall for its services. "One of our markets is neurologists who simply don't want to take call at hospitals or who don't want to take call on weekends or may want to take a vacation," Mr. Randall says. And, of course, the company actively recruits neurologists to be digitally "on call."

Companies that offer off-site call coverage via telemedicine don't compete with local specialists or hospitals. "We don't deal with third-party reimbursement at all. We are paid by the hospital based on monthly stroke volume," Mr. Randall explains, noting that charges may range from $3,000 to $18,000 monthly. Additional hospital billings made possible by the availability of an on-call neurologist could off-set these fees, since patients who otherwise might have been routed to a different hospital with an interventional program can now be evaluated and treated.

Interest in teleneurology has been growing for some time, but the practice may be at a critical tipping point. "Telemedicine more and more is being part of the solution to coverage," Dr. Likosky notes, "that solution just makes sense."

"It's not like this is some idea that popped up a few months ago where people aren't that sure about it. It's been a long time now," Mr. Randall says, adding that an increasingly tech-savvy society is also ready to accept telemedicine. "Society is much more susceptible to the acceptance of this modern yet practical solution and recognizes in many instances it's either this or nothing." The fact that President Obama has not only endorsed but encouraged the adoption of telemedicine doesn't hurt, either.

Neurohospitalists. A neurohospitalist is a neurologist employed full-time to provide specialty emergency services to a hospital. He or she may be employed by either the hospital or a practice(s). In instances where a practice or group of practices employ the neurohospitalist, the practice employees may still share evening and weekend call, but they benefit from having daytime coverage by the neurohospitalist, thus minimizing the impact of call responsibilities on the day-to-day operations of the practice.

Some question the economic feasibility of hiring a neurohospitalist. Dr. Likosky says the proposition may be unexpectedly affordable in many instances. "It takes a surprisingly small number of beds at a hospital to warrant a hospitalist or a full-time on-call neurologist," he says.

The neurohospitalist model is still nascent—the American Academy of Neurology officially launched its Neurohospitalist Section at this year's Annual Meeting in Seattle. There are very few fellowships currently available in the US, Dr. Likosky acknowledges, but he encourages young neurologists with an interest in hospital care to consider the option. He says the neurohospitalist role is suited to "someone who enjoys the hospital work and likes to focus their attention primarily in the inpatient realm."

Given that any board-certified neurologist is able to take hospital call, any BC neurologist technically could become a neurohospitalist. But, Dr. Likosky says, certain experience and expertise may be particularly appropriate for a neurohospitalist. For example, expertise in internal medicine or critical care is beneficial in stroke care. Knowledge of hospital administration or systems work could be helpful in the hospital setting.

Those interested in pursuing a career as a neurohospitalist or in potentially hiring a neurohospitalist can find more information at the AAN website (aan.com) within the Neurohospitalist section pages. Among resources available there are information on scope of practice and best practice models.

Heeding the Call

Clinical neurologists have numerous options when it comes to on-call service. Some simply opt out, maintaining their regular practice and avoiding the hassles of taking call. Others want to serve their community hospitals but seek to earn a fair reimbursement for their time and expertise (many just want to offset the revenues lost to practice due to emergency services). Still others seek to implement creative alternatives in their communities. Whatever approach one takes, Dr. Likosky encourages a cooperative interaction between parties. Based on personal experience, he observes, "The more the conversations can be collegial and less adversarial with each hospital the better they seem to go."

Neurologists need not navigate these waters alone. As Dr. Likosky points out, "Some national specialty organizations have taken on the issue of compensation, and it led to changes for those specialists." These organizations may be willing to share relevant tips and resources with neurologists seeking to promote a change. **PN**