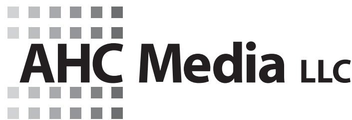
The monthly update on Emergency Department Management



Specialist hospitalists: Could they be the answer to the challenge of call panels?

Proponents: EDs benefit, hospitals increase bottom lines

Since the hospitalist concept was introduced several years ago, proponents have lauded its potential advantages: all-day availability, greater familiarity with the hospital environment, improved clinical expertise through greater experience, increased incentives to reduce lengths of stay, and freeing up physicians with outside practices. It was perhaps inevitable that the hospitalist would be looked to as a potential solution to one of the most challenging problems in emergency medicine today: finding specialists to take call.

In theory, it makes sense. After all, two of the greatest impediments to specialists taking call revolve around financial and lifestyle considerations. Because hospitalists by definition are on-site 24/7, the lifestyle issue becomes moot. Also, because they are being paid for the time they spend in the hospital, there is no need for a stipend or other remuneration for being "on call."

Emergency medicine experts agree that, on many levels, this is a viable option. They note, however, that the hospitalist model may not fill the bill for any and all specialty needs an ED manager might have.

"The use of hospitalists has helped mitigate the specialty on-call issues, but they are not the solution," asserts **Todd B. Taylor**, MD, FACEP, a veteran emergency physician who resides in Nashville, TN. "They can do a certain number of specialty

Executive Summary

Having your hospital hire specialist hospitalists can provide much-needed relief for EDs that can't fill their call panels. However, be aware of the limitations of such a strategy:

- Only specialties that are needed on a regular basis, i.e., general surgeons or orthopedists, will make economic sense.
- There may be some patient resistance to unfamiliar physicians in sensitive areas such as obstetrics and gynecology.
- A surgical hospitalist may not have the intimate knowledge of a patient that their regular surgeon would have.

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procedures, but not the full spectrum of specialty care, so you still must rely on other specialists to do that."

Paul Kivela, MD, MBA, FACEP, managing partner and attending physician at Queen of the Valley Hospital in Napa, CA, agrees. "All else being even, I think it's a very viable solution, but you have to look at things specialty by specialty to see if makes sense," he says. For example, he points out, if you need a gastroenterologist only once a month or so, it does not make sense to have a gastroenterologist on your staff full time. "It presents particular challenges with rural facilities," Kivela adds.

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Benefits undeniable

Kivela and Taylor agree that having specialist hospitalists on staff offers significant advantages.

"The most important thing is reliability," says Kivela, whose ED is served by internal medicine hospitalists. "I think the predictability of having someone on call and knowing there is one just number to call is a very good thing."

In fact, he says, he doesn't even have to page his hospitalists any more. "They have cell phones, so there is no delay. I get them in 60 seconds," Kivela says.

The biggest benefit is coordination of care, Taylor says. "And just like when some physicians first began to perform only emergency medicine, they get better and better at what they do and begin to advance to subspecialties," he says.

As a staffing model it makes sense, says Taylor, recalling an experience he had about nine years ago at a hospital in Arizona. "We had a serious problem getting on-call general surgeons, so one of the trauma surgeons and I cooked up a solution," he recalls. "We had a surgery residency, so we created what was essentially a 'surgicalist' program, where the surgeons in the hospital became supervising attendings for the residents."

The residents gained great experience and improved training, he says, and "we became the first hospital in the region where general surgeons could be on staff and not be required to take any call." The hospital became a big draw for area surgeons, he says.

David Joyce is president and CEO of Morrisville, NC-based Delphi Healthcare Partners, which is a staffing company for hospitalists — primarily orthopedists, general surgeons, and OB/GYNs. "It's great for patients because the specialist is immediately available," he reports. "They are not a half-hour or two hours away."

The hospitalists see primarily uninsured or unassigned patients, although they also will see insured patients when the need arises. "Not only are they seen faster, but the patients get better care since they are our exclusive patients," Joyce notes, "and patient satisfaction is typically very high."

Be aware of downside

ED managers considering asking their administrators to bring on specialist hospitalists also should be aware of some of the potential drawbacks, Kivela warns.

"When you interface with a hospitalist, you are sometimes not talking to the person who knows that

patient intimately already," he explains. "For example, there may be a surgeon who has previously operated on that patient but they are not on call, and they may know something explicit about the individual patient that you can't glean from medical records."

There could be particular problems with hospitalist OB/GYNs, he continues. "I have heard from numerous people that there is something intimate about deliveries and surgery, and patients want the person they have already established relationships with," Kivela says. "A delivery is not the same as taking out an appendix."

Psychiatric hospitalists might not be needed because care can be provided remotely, he says. "What happens is, you would have a computer station in the ED hooked up [to a psychiatrist in a remote location] via a secure Internet connection and talk in real time," explains Kivela, adding that his wife, who is a practicing psychiatrist, and he have worked out protocols for such a program.

Certain things work better when you have residents in your facility, Taylor says.

"That's why referral hospitals have been more successful at doing this," he says. "Having said that, many hospitals have been very successful having people there 24/7 with appropriate compensation."

Because the hospitalists "are already bought and paid for," Taylor says, hospitals have found several different ways to use them and maximize their value. "One group I know contracted with an internal medicine teaching program to serve as attending supervision physicians at night to alleviate the need for their own teaching staff to be on call as much," he notes.

Joyce asserts that having specialist hospitalists take ED call also can benefit the hospital's bottom line. The way the program is typically set up, his company adds up all the costs — compensation, benefits, malpractice, etc., — designates one doctor as group medical director, adds in a management fee, and bills the hospital.

"It does not come out of the ED budget," he says. "Just based on the professional fees that we charge, the programs do not pay for themselves; but because we free up 'orthopods' and general surgeons and obstetricians to do more procedures, the hospital will benefit tremendously."

He cites the experience of one hospital in Charleston, WV, where a general surgery program was instituted. The facility originally had eight general surgeons, but four left town; of the four who remained, two opted out of ED call. "We put in a program where two surgeons would take all the calls," says Joyce. "The hospital told us the four who remained in town all did more general surgery. At the end of one year, that hospital put $1.6 million in the bank." ■

Disaster surge fails to fluster ED staff

Things were a little slower than normal on Tuesday evening, March 25, in the ED at Caritas Norwood (MA) Hospital. That all changed in an instant when 48 patients arrived — 33 in a single busload — who were victims of a commuter train wreck in nearby Canton. All of the patients arrived between 6 and 6:30 p.m.

Kathy Merrigan, MSN, RN, ED manager, says the department's thorough disaster planning, the facility's "Code D" disaster response plan, and outstanding support from staff — some of whom came in to work without even being called — all contributed to a successful response.

The department swung into action almost immediately, she recalls.

"I was home eating dinner with the TV on when one of my kids saw on the local news that there had been a train collision in the next town over," Merrigan says. "Five minutes later I got beeped."

David Geller, MD, director of pre-hospital services, had a similar experience. "I was out shopping in Wal-Mart when I got a cell phone call from the chief of pathology," he recalls.

This notification system was part of the Code D plan, says Merrigan. "The disaster call list was activated, and some nurses who were on the floors came down initially on their own or were asked to do so by their nursing supervisor, which pooled extra resources for us," she recalls. "I also had three staff members come in on their own who had seen the news, as well as several nurses who work in the hospital but not the ED."

Geller says, "One of the nice things about being in a community hospital is that you live and work in the

Executive Summary

Advance preparation can make a big difference in how your department responds to emergencies, as demonstrated by the ED at Caritas Norwood (MA) Hospital in the wake of a recent train wreck. Here are some actions taken in advance that help facilitate a successful response:

- Their disaster plan included the immediate availability of nurses who were working on other floors.
- A day surgery area had been designated to handle patient overflow and provided 20 additional beds.
- A designated conference room for family members helped make them comfortable while keeping them out of the hectic ED area.

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