Dealing with constant call is the bane of many small physician groups. But with the right planning, even solo physicians can share call just like their big-practice peers. Here’s how.

Doctors with a calling to heal have mixed feelings about patients calling them weeknights and weekends.

On one hand, dealing with an after-hours emergency can make them feel like a real doctor, strengthening their bond with patients. On the other hand, taking calls 24-7 can erode their identity as a spouse, a parent, or a human being who’d like to watch a movie without having to leave in the middle.

Doctors in medium and large groups have ready-made partners for sharing call coverage, but what about soloists or members of tiny practices? For them, phone fear looms so large that they often decide to recruit a partner or join a large group, says practice management consultant Judy Bee. But these doctors overlook a traditional and much simpler solution to their quandary — forming a call coverage group with outside clinicians.

“It never occurs to them to seek out other soloists with the same problem,” says Bee. “Or if they do, they come up with goofy ideas why call sharing won’t work. They overestimate how difficult it is.”

In fact, patient call — whether you share it or take it all yourself — has gotten easier with the rise of hospitalists who relieve off-duty doctors of the burden of admitting patients to the hospital and seeing them at bedside (taking emergency-department call is another story entirely). The load will become even lighter as doctors increasingly switch to interoperable electronic health record systems that put clinical information galore at their fingertips about a new patient. However, you don’t need high-tech tools to make call sharing work for you right now. We’ll spell out common-sense steps for assembling and managing a cadre of outside call partners that will let you watch a movie right through to the closing credits.

**Your call coverage lineup**

Ideally, you and your call partners should have privileges at the same hospitals, experts say. After all, if you can’t admit another doctor’s patient to the facility that your colleague ordinarily uses, but instead must admit to your hospital, nobody’s bound to be happy. And if the patient can’t receive the services he needs at your hospital, you create an opening for a malpractice suit.

For the sake of patient care and risk management, you and your call partners also should belong to the same specialty, again, in an ideal world. In small-town America where some specialties may be in short supply, however, necessity may dictate a mixture. Internist and infectious disease specialist Robert Bode of Richmond, Ind., recalls how in the late 1980s, his call group included the town’s only pulmonologist and the only cardiologist. While the internists welcomed their help, they also knew that without giving these two specialists call relief, the community might eventually lose them to burnout, recalls Bode. Since then, more cardiologists and pulmonologists have moved into Richmond, allowing them to form their own coverage units. Tip: If your group does include some odd ducks, reach an understanding, as Bode’s group did. When a patient requires a certain specialist’s services — say, an emergency cardiac catheterization — the specialist will come to the rescue even if he’s off duty.

In larger cities swarming with doctors, you can afford not only to stay within your specialty, but also choose peers who provide the same services to the same sort of patients. “An orthopedic hand surgeon will struggle covering for a general orthopedist,” explains Bee. “Some pediatricians don’t want to see newborns, or adolescents.”

When the pool of available doctors is deep enough, you can fish for call partners who match up in other ways, like treatment philosophy, bedside manner, or prescribing habits. “Never cover with someone who writes meds without seeing the patient, or writes too many narcotic prescriptions,” says family practice physician Steven Kamajian in Montrose, Calif.
How many call partners do you need? Five is the golden number for doctors who want a nightly rotation Monday through Friday, with a separate rotation for weekends. Going higher than five means even fewer hours tethered to your phone, but there’s a price to pay. Because you’re entrusted with a larger volume of patients, you could be eaten alive with the medical problems of total strangers. That’s a big reason why solo family practice physician Robert Eidus in Cranford, N.J., scaled back from five partners to one. “It’s easier to care for patients you know,” he says.

The fine art of scheduling

Like the choice of partners, the design of your call schedule is ... your call. While some doctors prefer a daily rotation during the work week, others, like solo family practice physician Jitendra Patel in Portsmouth, Ohio, take call for their own patients Monday through Friday and share coverage on weekends. “This way we provide continuity of care most of the time,” Patel says about his three-member coverage group.

Your call group will operate more smoothly if you keep your schedule as simple as possible. Make it Byzantine, and you’ll suffer breakdowns, says Jennifer Schulz, vice president of an answering service called Answer Midwest. “Groups create problems for themselves with too many rules — this doctor is scheduled only for patient call, not hospital call; this doctor is only taking calls from the hospital ICU; this doctor is not on call except for this list of patients.” The solution? Take all phone calls on your shift.

The task of compiling and managing the schedule often falls to one practice’s office manager. That’s fine, provided this employee has enough clout to get every doctor’s cooperation, says Bee. However, if one doctor shirks his obligations, it may take a fellow doctor to shape him up.

Accordingly, many doctors function as call-calendar czar, sometimes rotating the responsibility annually. In the six-member call group of gastroenterologist Gregory Smith in Athens, Ga., doctors meet every three or four months over dinner to map out their schedule. Even so, doctors invariably need administrative help; not only for creating the calendar but also distributing it to call partners, the answering service, and hospitals — not just once, but every time it changes.

In the fall, you’ll need to poll members about dates they want off in the coming year for vacations, wedding anniversaries, and such. Then draft a schedule that attempts to honor all requests and circulate it for approval. Be extra careful about everyone taking their turn covering major holidays, cautions Bode. “You don’t want somebody assigned Thanksgiving two years running,” says Bode, whose group tracks holiday duty for that very reason. “Treat all physicians fairly. There are no senior or junior members of a call group.”

Computerization can reduce the hassle of creating and sharing a calendar. Google the phrase “call schedule” and you’ll dredge up a batch of commercial software programs for this task, designed to incorporate whatever rules you care to add about coverage assignments. Some are Web-based programs you can access from a smart phone. But why spend the money? Set up a free online calendar from Google or Yahoo that your call group collectively views and edits. And check with your answering service for high-tech help. Answer Midwest, for example, recently introduced an online calendar for its clients.

Digitization, though, is no substitute for the human touch when it comes to managing the calendar. A doctor who’s constantly trying to back out of his assigned call slots — “Such and such came in town and I need to spend time with him,” — is courting expulsion from the group, especially if he doesn’t bother lining up substitutes beforehand. However, the most stable groups eschew legalism and quickly grant each other favors when they’re not demanded. In Patel’s group, for example, weekend call starts at noon on Friday, but the doctor on duty may handle another doctor’s patient at 11:45 a.m. if that doctor has to rush out the door to catch a plane. “We don’t nitpick,” says Patel.

Making it work

The real focus of call coverage isn’t the calendar; it’s the patient with a fever at 11 p.m. To handle such problems as a team, you need good communication habits.

Of utmost importance is the sign-out of hospitalized patients (assuming you don’t use hospitalists) to the covering doctor by the colleague going off duty. Members of Patel’s group sign out by recording basics like the patient’s condition, treatment regimens, pending test results, complications to watch for, and a likely discharge date if all goes according to plan. That way, covering doctors know exactly what to expect and what to do. Bee puts it more bluntly: “Don’t dump.”

The same thoroughness applies to how the covering doctor passes the baton back to the hospitalized patient’s doctor. Patel writes a note reporting new developments, medications prescribed, and anything else his colleagues would want to know. The members of Smith’s coverage group trust
each other so much that an on-call doctor sometimes orders a procedure that the patient’s doctor will perform a few days later. “Clinically we function like a group practice,” says Smith. Good hand-offs also are important when on-call doctors field phone calls that lead to a prescription or a hospital admission. Covering doctors invariably report admissions to the patient’s doctor the following day by phone, e-mail, or fax. Some groups are more relaxed about prescriptions and let the patient make the notification.

As with scheduling, information technology — in the form of EHRs — promises to streamline how call groups share clinical data. In the Indiana Health Information Exchange, a network that connects 39 hospitals and 10,000 physicians, on-call providers have electronic access to radiology and lab results and provider notes from other practices when they can establish that they have a therapeutic relationship with the patient, says IHIE spokesperson Lori LeRoy. Don’t belong to a health information exchange? You still may be able to give call partners remote access to your EHR as guest users, and vice versa. However, check with the vendor to see if your software license permits this.

Such cooperation, digital and otherwise, assumes a high level of trust and collegiality. Call-group relationships shatter when one member denigrates the medical wisdom of another, or attempts to steal his patients. But when goodwill, respect, and selflessness prevail, call groups can experience a wonderful camaraderie, not to mention regular breathers from answering the phone at midnight. It’s easy to forgive Patel’s hyperbole when he says, “We feel we have the best on-call group in the nation.”

**Cover charges — no, not for a nightclub**

Covering for another doctor is unpaid work when it’s only phone care. However, a call at 10 p.m., may lead to a hospital visit, or a home visit. Then you’re talking billable service. Getting paid for it usually doesn’t pose a problem, but there may be a few complications to navigate, especially when you’re subbing for a doctor in another practice.

Covering doctors generally can bill for services rendered to another doctor’s patient. That’s fairly easy when all call partners contract with the same commercial insurer as network providers in a preferred provider organization. Some insurers, in fact, may require your partners to belong to the network, says practice management consultant Dave Scroggins. That spares the patient from owing more to an out-of-network provider (who might want to avoid balance-billing to keep the patient and his regular doctor happy).

Billing as a substitute doctor is also possible when you treat each other’s Medicare patients. However, Medicare allows you to reverse the process, so that the patient’s regular doctor can bill for a covering doctor’s services. All you do is submit the claim with the Q5 modifier for reciprocal billing. Check with your commercial carriers to see if they offer reciprocal billing as well, and how they want it coded.

Things get trickier when one member of a call group has capitated patients. His partners ordinarily can’t submit a fee-for-service bill for services rendered. Solution? The doctor taking capitation can pay the covering doctor according to the Medicare fee schedule, suggests Bee.

OB/GYNs face a payment wrinkle when a doctor on call delivers a baby. One way to iron that out, suggests Scroggins, is for the patient’s regular doctor to forgo the customary global fee and instead bill for care before and after delivery while the covering doctor bills for baby-catching. Or, the regular doctor can collect the entire global fee, and pay the covering doctor a negotiated delivery fee. In light of complex patient-care scenarios and insurance-contract restrictions, a covering doctor can expect to get shorted occasionally. But over time, the inequities even out among call partners. So don’t argue about a few dollars here and there. Preserving group unity is more important.

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