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News in Review

March 27, 2003
Vol. 1, Issue 2

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Following the lead of many U.S. corporations, hospitals are increasingly using executive coaches to help physician leaders transition to executive roles. Such programs are especially attractive for doctors lacking significant administrative experience. In an interview with the *Watch*, Maryanne Peabody, vice president of the executive-coaching service Stybel Peabody Lincolnshire, said coaching can help physicians develop requisite management skills. In many situations, coaching also boosts executive productivity and offers a significant return on investment.

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In response to a nationwide anesthesiologist shortage, an increasing number of hospitals are experimenting with anesthesiology staffing models, often hiring certified registered nurse anesthetists in growing proportions to contracted physicians. Many health officials support state decisions allowing CRNAs to administer anesthesia without physician supervision. However, increased CRNA use, as illustrated in several anesthesiology staffing models, remains controversial among physicians and patient-safety advocates.

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PHYSICIAN LEADERSHIP

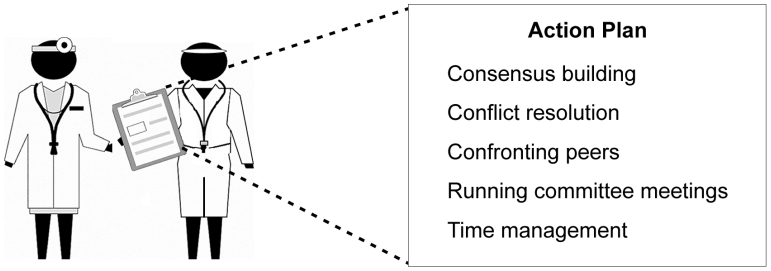
Executive training: Coaches may ease physicians' transition to top posts

Following the lead of many major U.S. corporations, hospitals are increasingly using executive coaches to help physician leaders transition from clinical duties to executive roles. In particular, executive-coaching programs are especially attractive for physicians who lack significant health care administration experience. In an interview with the *Watch* (3/19/03), Maryanne Peabody, vice president of the Boston-based executive-coaching service Stybel Peabody Lincolnshire, said good coaching can help physicians—who are often accustomed to working as solo practitioners—develop requisite management skills, such as consensus building and conflict resolution. In many situations, coaching also boosts executive productivity and offers a significant return on investment (Vincola, HR.com, 1/12/01; Fisher, *Fortune*, 2/19/01).

Coaching builds management skills necessary for executive suite

Physicians who become department heads, staff directors, or senior administrators may find themselves "outside of their circle of influence and outside of their comfort zone" (Healthcare Dynamics, Inc., website, accessed 3/18/03). As a result, senior officials often suggest the use of executive coaches to help physician leaders adjust to their new roles and develop management skills (*Watch* interview, 3/19/03). Such training has proven relevant across the health care industry; for example, Dr. Alan Adler, a former medical director at the New Jersey-based HMO Horizon/Mercy, followed his CEO's suggestion to meet with a coach after learning that his executive position introduced challenges that his "medical training had left [him] unsuited to respond to" (Adler, *Managed Care*, December 2001).

Coaching builds physicians' management skills



Source: Adler, *Managed Care*, December 2001; *Watch* interview, 3/19/03; Healthcare Dynamics, Inc., website, accessed 3/18/03.

Training length, cost varies to meet executive needs

According to Healthcare Dynamics, Inc., an executive-coaching firm, coaching duration depends on "the problem(s) to be corrected and the commitment of the executive" (Healthcare Dynamics, Inc., website, accessed 3/18/03). A typical coaching engagement consists of biweekly, hourlong meetings for three to six months and is often extended to monthly meetings for one year. Peabody cautions that an engagement should last for at least three months to ensure "sustainable results" (*Watch* interview, 3/19/03). Coaching costs also vary, Peabody notes, and some coaches charge up to "$2,000 a month or $20,000 a year." However, a survey of 10 coaches in the United States and Canada found that more modest fees range from $150 to $1,000 an hour, with the most common charges falling between $300 and $500 an hour (Churchill, HR.com, 1/29/01).

Studies find coaching boosts productivity, offers significant ROI

Hospitals, as opposed to physicians, frequently pay executive-coaching costs and often justify coaching program expenses by citing an increase in manager productivity subsequent to personalized training. According to an International Personnel Management Association study of 31 managers who underwent a "conventional" management training program followed by eight weeks of one-on-one executive coaching, manager productivity increased 22% after traditional training and 88% after individual coaching (HR.com, 1/12/01). Moreover, in a survey of 100 managers who received executive coaching from Manchester, Inc., a coaching vendor, respondents estimated a monetary return of more than $100,000 from their coaching experience, or more than six times the cost of the coaching program itself (Fisher, *Fortune*, 2/19/01; Advantage Coaching and Training website, accessed 3/18/03).

Physician commitment determines coaching results

While many hospitals have utilized successful coaching programs, analysts caution that clinical executives should not view coaches as a cure-all for administrative shortcomings, which sometimes result from underlying psychological issues (*Harvard Business Review*, June 2002). "I think it's important to understand that this is not therapy," Peabody says (*Watch* interview, 3/19/03). In addition, some coaches may gain too much influence with the person they are training, and a new executive may feel compelled to use ineffective strategies, particularly if a higher manager recommended the coach (*Harvard Business Review*, June 2002). To avoid this pitfall, Peabody says it is important to "ensure that a person feels comfortable with a coach" (*Watch* interview, 3/19/03). Furthermore, coaching will not produce desired results unless a physician has the right attitude. "They have to be committed, otherwise it's a waste of time and effort," Peabody notes. She finds that new clinical leaders are receptive to coaching when they are "in a position that means something to them, and they want to stay there."

PHYSICIAN LEADERSHIP

On Our Watch

Physician appointed head of Tenet California

Tenet Healthcare recently named Dr. Stephen Newman, a pediatric gastroenterologist, as CEO of the company's 40-hospital California division (Tenet release, 3/17/03). A "seasoned health care executive" since 1990, Newman taught and practiced medicine for 12 years before entering administration. He most recently served as senior vice president of Tenet's Gulf States Region, a division of nine acute hospitals in Alabama, Louisiana, and Mississippi. Newman's background as a physician will bring "unique insights into the needs of physicians, nurses, and other clinical personnel" to the position, W. Randolph Smith, president of Tenet's Western division, said. Newman's promotion to the newly-created California CEO position is part of a recent management overhaul in response to government probes of Tenet's Medicare reimbursements, the *Los Angeles Times* reports (Peltz, 3/18/03).

INPATIENT SPECIALISTS

Anesthesiology: Shortage leads hospitals to experiment with CRNA staffing

In response to escalating labor costs resulting in part from a nationwide anesthesiologist shortage, an increasing number of hospitals are experimenting with anesthesiology staffing models, often hiring certified registered nurse anesthetists (CRNAs) and anesthesiology assistants in growing proportions to contracted physicians. Given a nationwide projected shortage of up to 4,500 anesthesiologists by 2005, hospitals particularly strapped for staff soon may have to consider canceling elective surgeries, decreasing operating-room use, or increasing elective-surgery wait times (*Mayo Clinic Proceedings*, 10/1/01).

Faced with these prospects, many health officials support statewide decisions allowing CRNAs to administer anesthesia without physician supervision, especially in rural areas where staffing problems are most acute. However, increased CRNA use, as illustrated in several anesthesiology staffing models, remains controversial among many physicians and patient-safety advocates.

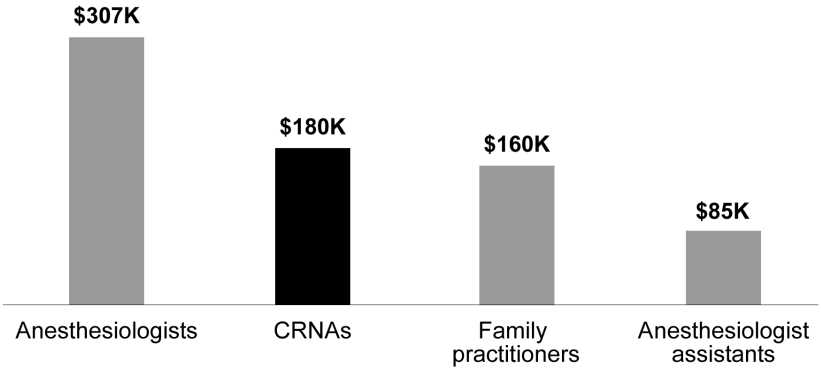
State-by-state expansion of CRNA responsibilities results in 'turf war'

According to CMS regulations finalized in November 2001, state governors have the right—only after conferring with their state's Board of Medicine and Nursing—to disregard the federal requirement that anesthesiologists must supervise CRNAs in all Medicare- and Medicaid-participating hospitals, critical access hospitals, and ambulatory surgical centers (*AHA News Now*, 7/5/01). Thus far, Iowa, Nebraska, Idaho, Minnesota, New Hampshire, and New Mexico have opted out of the requirement, and the issue is under debate in Colorado (*Pittsburgh Post-Gazette*, 3/11/03). The ruling has pitted CRNAs and anesthesiologists against each other in "a battle for control" (McClurg, *Birmingham Business Journal*, 5/14/01). Anesthesiologists argue that the ruling effectively diminishes care quality because CRNAs receive insufficient training for independent practice. The American Association of Nurse Anesthetists counters that care quality is not the central issue; rather, AANA President Larry Hornsby contends that anesthesiologists "fear a loss of control in the marketplace and a loss of status."

Rising physician salaries make CRNAs an attractive alternative

Recruiting challenges have forced hospitals to dramatically increase compensation for anesthesiologists and, to a lesser degree, CRNAs. While the top CRNA salaries rival and sometimes surpass the average pay for family practice physicians, nurse anesthetists still cost hospitals significantly less than anesthesiologists.

Top CRNA salaries surpass average PCP salaries



Source: *MGMA Physician Compensation and Production Survey*, December 2002; Godinez, *Dallas Morning News*, 5/29/02; *Palm Beach Post*, 3/16/02.

According to the AANA, there are currently 27,000 CRNAs providing care to more than 65% of all patients undergoing medical procedures requiring anesthesia. Additionally, CRNAs are the "sole anesthesia provider" at 70% of rural hospitals (AANA website, accessed 3/20/03). While average CRNA salaries are much lower than anesthesiologists, many rural hospitals have felt compelled to offer job sharing and flex-time as recruiting incentives. Such tactics have led to "almost half" of the nation's CRNAs working half-time or on a contract basis, making their labor more scarce and more expensive (Godinez, *Dallas Morning News*, 5/29/02).

Hospitals experiment with staffing ratios to maximize efficiency

As states ease physician-supervision regulations and allow CRNAs to become increasingly autonomous, hospitals have been able to experiment successfully with CRNA-to-anesthesiologist ratios to a greater extent than before. For example, a Kaiser Permanente Medical Centers study of operating room staffing and productivity at 42 Kaiser facilities found that anesthesia-care-team productivity increased when hospitals allowed CRNAs to exercise "expanded practice" and when one anesthesiologist supervised CRNAs in four operating rooms (AANA website, accessed 3/20/03). As a result of the study, Southern California Kaiser hospitals employ an average of 0.4 anesthesiologists for each full-time CRNA, while non-Kaiser California hospitals employ 2.6 anesthesiologists for each CRNA. Kaiser officials warn, however, that any expansion of CRNA responsibilities should be accompanied with appropriate education (Kaiser Permanente website, accessed 3/24/03).

Previous benchmarking models have suggested hospitals use anesthesiologists to treat only the sickest patients, while using CRNAs with limited physician supervision to treat healthy and medium-risk patients (Bierstein, *American Society of Anesthesiologists Newsletter*, March 1997). However, such practices are controversial as they contradict American Society of Anesthesiologist guidelines and may be "inconsistent" with Medicare billing requirements.

INPATIENT SPECIALISTS

On Our Watch

Proposed Medicare rules eliminate anesthesiologists for some procedures

Proposed Medicare changes that prohibit anesthesiologists' presence during certain invasive procedures such as colon cancer screenings increase patients' mortality risk, according to a group of Las Vegas surgeons (Babula, *Las Vegas Review-Journal*, 3/24/03). The changes, which would eliminate anesthesia services that CMS officials contend are "not necessary for the average patient" during certain procedures, are designed to reduce Medicare costs by cutting "unnecessary medical procedures." The rules would apply only to patients in Medicare's Western region, which includes Alaska, Arizona, Hawaii, Nevada, and Oregon; physicians and patients "successfully thwarted" a similar proposal for Eastern-region states. Nevada gastroenterologists say the rules are "absurd" and "dangerous" because they would require physicians to sedate patients themselves and monitor vital signs while performing a colonoscopy. Gastroenterologist Dr. Laura Gitlin, who feels "it's not safe" to sedate her own patients, plans to ask patients to pay the $150 needed for traditional anesthesia services during screening procedures. The rules are currently in draft phase and open for public comment until April 15.

Radiologist recruiting challenges could result in increased pay

A recently released survey from recruiting firm Merritt, Hawkins and Associates indicates that radiologists are among the most difficult physician specialists to recruit (Hawkins, Auntminnie.com, 2/25/03). Overall, 92% of the 280 hospital CEOs surveyed indicated that recruiting radiologists was "somewhat difficult" or "very difficult." According to Joseph Hawkins, the company's CEO, the firm received more search assignments for radiologists than for any other specialist in 2002. Hawkins notes that the "net result" of this recruiting challenge is likely to be rising compensation levels and increased incentives from hospitals looking for radiologists. In a clear illustration of this trend, a recent *Physician Compensation Report* (March 2003) notes that radiologists' starting salaries have risen 15% to 25% in the past two years.

PATIENT SAFETY

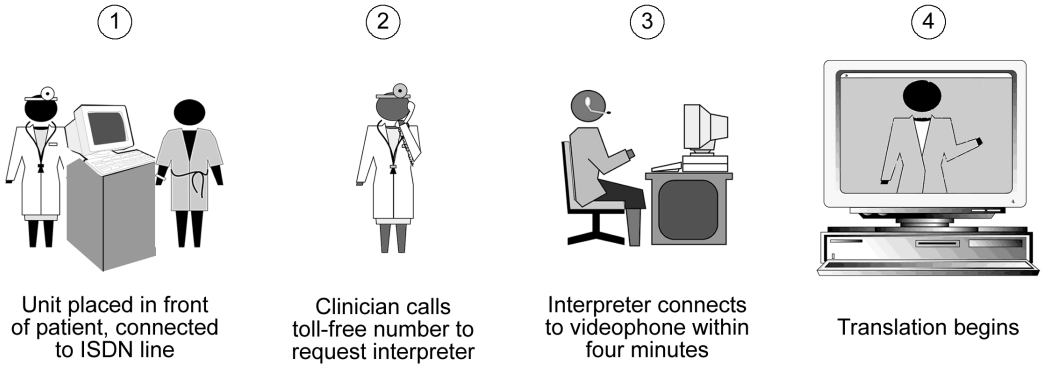
Care access: Video translation aids foreign, hearing-impaired patients

To comply with laws requiring interpretive services for hearing-impaired or non-English-speaking patients, some medical centers are going beyond traditional onsite and telephone interpreters by purchasing video translation services (Tran, *Boston Globe*, 8/27/02). Although implementing videoconferencing technology can be costly, such systems allow more precise patient-provider communication and could help increase patient volume at hospitals willing to invest in the services. In addition, Connie Camelo, director of interpreter services at University of Massachusetts Memorial Health Care, told the *Watch* (3/19/03) that video translation can increase physician satisfaction by obviating the delay associated with interpreters commuting to the hospital.

Video translation services at a glance

In February, UMass Memorial began supplementing its onsite translation services with Deaf-Talk, a Pittsburgh, Penn.-based subscription service that offers video access to interpreters in 19 languages—including American Sign Language—24 hours a day (*Watch* interview, 3/19/03; 3/20/03). According to Camelo, technical and telecommunications staff installed the necessary ISDN lines in about three months. Staff training modules on the videoconference units, which consist of a television monitor, camera, microphone, keyboard, and data compression/decompression unit, take only 15 minutes (*Watch* interview, 3/19/03; Deaf-Talk website, accessed 3/17/03). The technology allows staff to connect patients in a hospital's ED, outpatient clinics, or maternity, neonatal, or surgical wards to an interpreter within three to four minutes. The health system rents one video unit per hospital to respond to about 50,000 annual translations.

Video translation connects clinicians to interpreters



Source: Deaf-Talk website, accessed 3/17/03.

Visual cues, rapid connectivity best telephone, onsite translation

Unlike phone-based translation services, video translation provides participants with the ability to respond to visual cues, a key element for both sign- and foreign-language interpretation. Video images offer patients "a more personal" interaction than listening to telephone interpreters, Camelo says, and enable physicians to explain diagnoses and recommended treatments using gestures (*Watch* interview, 3/19/03; Spice, *Pittsburgh Post-Gazette*, 1/30/03). Moreover, instant video connections save time in emergency situations—deaf ED patients often wait five to six hours for onsite sign-language interpreters, who are in short supply (Cooney, Worcester *Telegram & Gazette*, 3/3/03).

Video translation impacts the bottom line

Camelo says that hospitals considering video translation services should weigh an increased financial burden against possible improvements in patient satisfaction. UMass Memorial rents video units through Deaf-Talk for $400 a month and pays $3 a minute for actual translation time (*Watch* interview, 3/19/03). Telephone interpretation services provided by CyraCom International cost $2.65 per minute of translation and $9.95 a month to rent a specialized, two-receiver phone (Hospital Association of Southern California website, accessed 3/20/03), while onsite interpreters automatically charge for a two-hour session (*Watch* interview, 3/19/03). According to Deaf-Talk President Bob Fisher, "hospitals that need interpretation services at least four or five times a month can usually save money" with videoconferencing systems compared with onsite services (Deaf-Talk website, accessed 3/17/03). Camelo says it is "too soon to tell" whether UMass Memorial has saved money with video translation but expects the system to attract more patients to the hospital.

Decreased waiting time pleases physicians

In addition to pleasing patients, Camelo notes that the video system has led to improved physician satisfaction (*Watch* interview, 3/19/03). While physicians, who were not involved in the implementation process, were "hesitant [about the system] at first," Camelo says "virtually all the feedback...has been positive" since the program's initiation. Doctors appreciate the decreased waiting time for translation services and "not having to cancel or reschedule appointments because an interpreter didn't show up." The system's success has led Camelo to consider expanding access; she expects to add an additional video translation unit at each hospital within the next year.

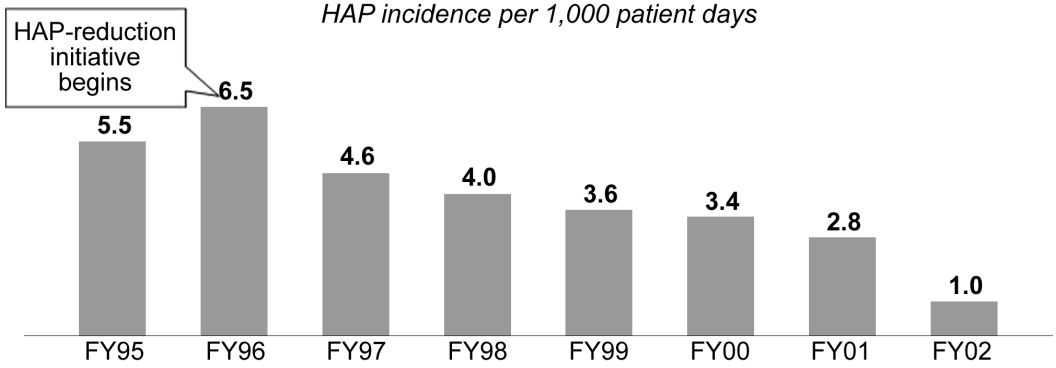
PATIENT SAFETY

Nosocomial infection: Protocols reduce hospital pneumonia rates by 85%

Proving that clinical quality improvement requires sustained clinician buy-in, St. Luke's Episcopal Health System in Houston has reduced its incidence of hospital-acquired pneumonia (HAP) by 85% since 1997 by using a set of protocols developed and refined as new information—and feedback from staff—emerged. Administrators initially convened a multidisciplinary collaborative practice team in 1996 to address HAP incidence and to develop infection-reduction protocols for caregivers; seven years later, the original protocols—aimed at one particular patient population—have evolved into institutionwide processes targeting all high-risk patients.

HAP incidence decreases as protocols are implemented

HAP incidence per 1,000 patient days



Source: Houston et al., *Quality Management in Health Care*, January 2003; *Watch* interview, 3/11/03.

HAP risk-scoring tool developed for cardiovascular ICU

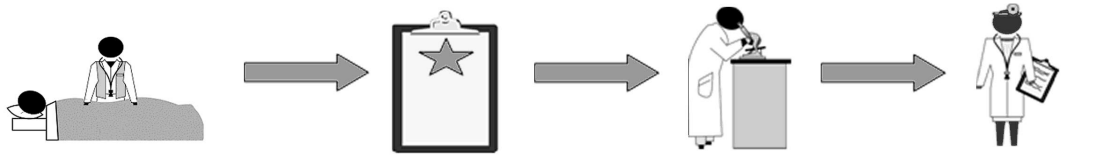
St. Luke's initially focused HAP-reduction efforts on cardiovascular surgery patients in the ICU, primarily because these patients account for more than 60% of the hospital's HAP cases (Houston et al., *Quality Management in Health Care*, January 2003). Beginning in 1997, administrators implemented several action plans designed to either prevent HAP infection or identify and treat high-risk HAP patients. A hospitalwide staff initiative to increase handwashing compliance represented one of the primary HAP prevention strategies, as literature has shown the practice to significantly reduce disease transmission.

Officials also introduced a HAP risk-scoring tool that nurses in the cardiovascular ICU completed for each patient on a daily basis. The tool required nurses to check and assign acuity-based point values to each patient as determined by various risk factors, including length of intubation, renal failure, and intra-aortic balloon pump insertion. Susan Houston, the assistant vice president of clinical management and outcomes research at St. Luke's, told the *Watch* (3/11/03) that completing these risk assessments took approximately 15 to 20 minutes per patient per day—a time-consuming activity that isolated only a few patients at risk for HAP. Ultimately, the risk-scoring tool proved too time intensive, and officials implemented a simplified risk-assessment protocol.

Simplified "high-risk" scoring tool leads to refined physician notification

In the second iteration of the program, St. Luke's officials instituted hospitalwide HAP "high-risk protocols" for all patients ventilated more than 24 hours, due to evidence suggesting that such ventilation lengths greatly increase HAP susceptibility.

Staff feedback spurs development of protocols for high-risk patients



Nurse follows high-risk protocol:
1. Obtain sputum sample
2. Order "pneumonia protocol" sputum culture
3. Order chest X-ray
4. Order complete blood count with machine differential

RN places sticker on patients' medical charts to indicate high-risk-protocol compliance

Lab performs sputum gram stain

Physician reviews test results and initiates antibiotic therapy as needed

Source: *Watch* interview, 3/11/03.

Lab results for high-risk patients determined appropriate physician intervention (*Quality Management in Health Care*, January 2003). If the gram stain was positive for gram-negative rods, physicians were advised to administer 2 g ceftazidime every eight hours. If the gram stain was positive for gram-positive cocci, physicians were advised to administer 1 g vancomyacin every 12 hours or 600 mg every 12 hours if the patient was reintubated. In addition, the protocol suggested physicians should reassess antibiotic therapy every 72 hours.

Expanded protocol emerges from literature reviews

St. Luke's augmented its HAP-reduction program in 1999 by mandating the pre- and post-operative administration of Peridex—an oral mouth rinse that the hospital found to decrease respiratory-tract bacteria more than other oral rinses, such as Listerine, Scope, or Cepacol—to ventilated patients. The protocol, implemented after literature reviews indicated the use of Peridex for reducing upper-respiratory-tract bacteria, requires pre-operative patients to rinse daily with Peridex and post-operative patients to rinse twice daily for as long as they are ventilated (*Quality Management in Health Care*, January 2003).

Continued protocol compliance challenges officials

Hospital administrators noted "major obstacles" in maintaining clinical-staff involvement in the various HAP-reduction protocols and said that informing front-line staff that "their efforts [were] truly making a difference" was a key component of success. Sustaining protocol enthusiasm was achieved via committee reports, nurse manager support, posters, and a team excellence award for compliance. Houston added that the process continues to evolve as administrators consider installing video cameras to monitor handwashing compliance and review compliance rates for other mandated protocols (*Watch* interview, 3/11/03). Anecdotally, she noted that some clinical staff, particularly nurses, have expressed little opposition to video surveillance as they feel video cameras will simply reinforce compliance.

PATIENT SAFETY

On Our Watch

FDA releases details, benefits of drug-barcode rule

The FDA on March 13 formally proposed a rule requiring barcodes on most drugs and blood products as part of a plan to reduce hospital medication errors (HHS release, 3/13/03). The proposed rule would require barcodes on most prescription drugs—including biological products and vaccines but excluding physician samples—and on any over-the-counter drugs "commonly used in hospitals and dispensed in a hospital pursuant to an order." Each barcode would contain the medication's National Drug Code number, strength, and dosage form (FDA fact sheet, 3/13/03). The FDA also is considering including drug lot numbers and expiration dates in barcodes. The agency estimates the barcodes will assist clinical staff in intercepting 50% more potential drug dispensing and administration errors, reduce total adverse drug events by 413,000 over 20 years, and decrease costs associated with patients' pain, suffering, and hospital-stay extensions by $41 billion over 20 years. The *New York Times* (Strugatch, 3/23/03) reports that while the rule is expected to increase patient safety, it is "not as broad as it could have been," in part because it allows physicians to continue writing paper, rather than computerized, prescriptions. The rule was published March 14 in the Federal Register and will be finalized after a 90-day public comment period.

UMC's (Ariz.) CPOE system significantly reduces pediatric medical errors

University Medical Center in Tucson, Ariz., achieved a 95% reduction in medical errors and greatly improved clinical-staff efficiency just 14 months after installing a new CPOE system in three pediatric units, the *Arizona Daily Star* reports (Erikson, 3/9/03). UMC installed Eclipsys Corp.'s $10 million Sunrise Clinical Manager system as part of an ongoing five-year, $25 million effort to upgrade facility technology. While the hospital documented 63 medical errors in 2002, medical staff have reported only three errors since CPOE implementation. In addition, administrators note that the system has improved clinical throughput and led to improved medical-staff interactions. For example, the technology allows in-house residents and offsite attending physicians to simultaneously review patients' charts and lab results, allowing for rapid assessment of patient needs. According to CPOE project managers at the hospital, clinical staff members have "for the most part been enthusiastic" about using the system, a factor contributing greatly to overall program success.

JOURNAL HIGHLIGHTS

On Our Watch

Delays in transfer to ICU increase inpatient mortality, costs

Inpatients who experience ICU-transfer delays have increased mortality and morbidity and higher total hospital costs, according to findings in the February *Journal of General Internal Medicine* (Young et al., February 2003). In a study involving 91 non-cardiac inpatients who met physiologic criteria indicating ICU care, researchers found that those who had to wait four or more hours before transfer—"slow transfer"—had a significantly higher risk of in-hospital mortality than those transferred sooner (41% vs. 11%; relative risk = 3.5). Slow-transfer patients also had higher scores on the APACHE II illness severity scale (21.7 vs. 16.2; $p = 0.002$) and higher median total hospital costs ($34,000 vs. $21,000; $p = 0.01$). Moreover, slow-transfer patients were less likely to have a "bedside physician evaluation" within the first three hours of meeting ICU criteria (23% vs. 83%; $p = 0.001$). Based on these findings, researchers suggest that improving physician communication and promoting timely evaluation of inpatients may lower mortality rates.

MEDICAL STAFF AFFAIRS

On Our Watch

ED call-coverage pay growing, yet remains infrequent

Two recent surveys indicate that while more medical groups are compensating their physicians for ED call coverage duties, payment for such services is still "not the norm" (*Physician Compensation Report*, March 2003). According to a Medical Group Management Association (MGMA) survey involving 280 physician groups—generally "single-specialty practices of no more than 25 physicians"—the number of respondents offering call-coverage pay doubled from 13% in 1999 to 26% in 2002. In a Sullivan, Cotter & Associates (SCA) survey involving larger, multispecialty groups, the number of respondents offering such pay rose from 19% in 2001 to 28% in 2002. While many of the groups surveyed said on-call pay is built into physician salaries, some groups report providing physicians "production pay" for work performed while on call. Analysts attribute the increase in compensation in part to a growing number of hospitals who pay groups to provide on-call physicians. MGMA reports that call-coverage compensation varies drastically from "$10 an hour for employed physicians to $1,250 per shift" when hospitals pay. The SCA survey suggests that hourly rates range from $50 to $75, depending on specialty.

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