

Nocturnal Economics

Weigh tradeoffs with dedicated night coverage vs. night-call service



In my previous column, I reviewed different strategies for providing hospitalist practice night coverage based on the size of the group (February 2008, p. 61). I suggested that dedicated nocturnists are a valuable though expensive asset that any practice larger than about six to eight full-time equivalents (FTE) should consider.

This month, I offer additional thoughts about compensation for nocturnists. I'll demonstrate why adding dedicated night coverage—in which the doctor working at night doesn't work during the daytime hours the day before or after the night shift—may not increase practice workload significantly.

What follows is adapted from a new book I co-wrote with Joe Miller, senior vice president of SHM, and Win Whitcomb, MD, a hospitalist at Mercy Medical Center in Springfield, Mass., and co-founder of SHM.¹

A traditional system of night call (such as pager call from home while also working days) is usually cheaper than dedicated night shifts. And while there are many benefits to having dedicated night shifts, increased patient capacity may not be one of them.

Compensation

If all hospitalists provide an equal amount of night coverage in rotation (e.g., each member of a four-person group works 61 nights annually), it's not necessary to adjust the compensation scheme to reflect night work. A night-shift differential in this situation will not influence a doctor's annual income relative to that of his partner hospitalists.

However, if the hospitalist program seeks more flexibility, it may be advisable to pay more for a night of work than a day of work. Under this scheme, hospitalists may trade day and night work among themselves, leading to enhanced satisfaction. For example, Dr. McCartney is willing to work some of Dr. Lennon's nights because of the income benefit. Dr. Lennon may or may not work some of Dr. McCartney's days in return.

If the practice has one or more dedicated nocturnists, they will need to realize some benefit to working only nights. This benefit can take many forms:

- The night hospitalist works less often than day doctors (e.g., day doctors work 220 days annually, night doctors work 182);
- The night hospitalist has a lighter patient load (e.g., a night hospitalist in a small practice typically sleeps three to six hours per night shift while the day doctors typically

work a busy eight-to-12-hour shift);

- The night doctor earns more than the day doctors; or
- The night doctor has a higher priority in time-off scheduling.

It is common to combine these benefits. For example a night hospitalist might work less often than day doctors, have a lighter patient load, and earn the same annual income. Anecdotal experience shows that having more income or fewer workdays than day doctors is valued more than a reduced patient load.

For most practices, compensating hospitalists based significantly or entirely on their production can be a good idea but might be problematic for a night doctor. It could lead the night doctor to encourage marginal admissions, some of whom would need to be discharged by the daytime hospitalists hours later. In effect, the night hospitalist could say: "I'll admit anyone I can get my hands on because my income will increase. I'll leave it for the day doctors to sort out what to do with all these patients tomorrow."

An Example

A traditional system of night call (such as pager call from home while also working days) is usually cheaper than dedicated night shifts. And while there are many benefits to having dedicated night shifts, increased patient capacity may not be one of them. Consider the following example:

- On any given day, a five-FTE hospitalist practice has three doctors working, one of whom will be on-call that night by pager;
- That will mean 219 worked days per year for each doctor, one-third of which (73) will be on-call. Each hospitalist gets 146 days off per year;
- The practice decides to switch to dedicated night shifts in which the

doctors do not work the day before or after a night shift. The practice wants to retain the 146 days off for each hospitalist. This new coverage arrangement is equivalent to adding 365 shifts annually (one for each night); and

- This will require an additional 1.67 FTE hospitalists (1.67 hospitalists at 219 shifts/year=365).

In this example, by switching from on-call coverage to on-site coverage, the practice increased from five FTEs to 6.67 FTEs. If the daytime work was already enough to keep all three doctors busy, adding 1.67 FTEs for dedicated night shifts may not increase practice productivity or revenue significantly. The practice looks much less productive per FTE (6.67 FTEs are now seeing the volume previously handled by five FTEs) and much costlier.

Changing from traditional night call to dedicated night coverage can be expensive because it may require adding staff yet doesn't usually increase practice capacity significantly. But it offers other benefits such as those listed in Table 1 (below). Some practices find they must provide dedicated night coverage to recruit hospitalists. Other institutions choose to support it believing it leads to more timely, efficient, higher-quality care. **TH**

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Reference

1. Miller J, Nelson J, Whitcomb W. *Hospitalists: A Guide to Building and Sustaining a Successful Program*. Chicago:Health Administration Press;2007:149-150.

POTENTIAL BENEFITS OF DEDICATED NIGHT COVERAGE

- Enhanced career satisfaction and longevity for hospitalists (less burnout);
- Improved hospitalist recruiting;
- Potential to implement other night initiatives, such as hospitalists serving on code response or rapid response teams;
- Improved quality of care through elimination of the need for the admission of patients to be admitted by the emergency physician (or hospitalist by phone without being seen) with long delays until seen in person by the hospitalist;
- Modest improvement in revenue possible by billing admissions prior to midnight rather than the next day; and
- Improved night nurse satisfaction because they have access to an awake doctor who expects to be working rather than having to page and wake up a doctor who is trying to sleep.