Call RVUs: One Way to Make Call More Equitable

By acknowledging that not all call is created equal, one group has made its call schedule less contentious.

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It's probably safe to say that few physicians actually enjoy call. It can cause more dissention among physicians than money. And for family physicians, it can be even more intense, given that access is a hallmark of primary care. Call can also be more complicated for family physicians because we "do it all" – caring for adults, children, infants, pregnant women, trauma patients, etc. When sharing call with physicians of other specialties, the family doctor can often handle every problem that arises, but other specialties can't always return the favor. For family practice groups in which some physicians do deliveries, call coverage can get even trickier. Then, there's the issue of nurse practitioners, nurse midwives and physician assistants who have to be backed up. Throw in physicians who work only part time, and it's hard to come up with a call system that works and feels right to everyone involved.

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In a recent survey, 90 percent of physicians said they would not take more call for more money. On a 5-point difficulty scale, with 3 being defined as "an acceptable but fairly demanding part of the job," primary care physicians ranked night call a 2.29 and weekend call a 3.07. The primary care physicians surveyed

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CME Covered in *FPM* Quiz

FPM Tool inside

ILLUSTRATION BY LINDA HELTON

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With full-time, part-time, OB and non-OB physicians practicing within one group, it can be difficult to craft a call system that works for everyone.

The exact call scheme a practice uses is not as important as the fact that its physicians feel the system is fair and administered properly.

Call RVUs (relative value units) have helped the author's group distribute call more equitably.

The group arbitrarily defined a weeknight of call for its general inpatient service as 1.0 RVU and asked physicians to vote on RVUs for all other after-hours activities.

thought call was worth about $226 on weekdays and $862 for a 48-hour weekend.[1,2]

Building a call system that works

There are many ways groups can arrange call. Some of the most common models are listed below. While practice management experts could certainly debate the pros and cons of each model, it's helpful to recognize that the exact call scheme is not really that important. What is important is that all the physicians participating feel that the system is fair and administered properly.

At the University of North Carolina at Chapel Hill, the Department of Family Medicine has a very complex set of call parameters for faculty clinicians. A few clinicians take no call at all (and get paid less than the rest of us). There are always two faculty on call simultaneously: one for maternity and newborn care and one for all other inpatient care. Some clinicians take call on both schedules; some take call on only one. Some do a lot of weekends; some do more weekdays.

Like many groups, we struggled with developing a system that distributed call fairly while allowing for personal workstyle differences. The solution we finally discovered was to develop a "call RVU" system. For those who are not familiar with an RVU system, it stands for "relative value units" and is used by Medicare and other third-party payers to determine the comparative worth of physician services based on the amount of resources involved in furnishing each service. For example, a level-I, established-patient office visit has total RVUs of 0.56, while a level-IV, established-patient office visit has total RVUs of 2.18.

To develop RVUs for call coverage, we began by sending out a call ballot to all clinicians in our group who take call. On this ballot, we arbitrarily defined a weeknight of call for the general inpatient service as 1.0 RVU. We then had clinicians vote on the RVUs for other after-hours activities, such as weeknight and weekend maternity and newborn call, weekend inpatient call, nurse midwife backup, evening supervision of a

KEY POINTS

- Call coverage can cause more dissention among physicians than money.
- To make call more equitable, the author's practice assigned "relative value units" to each type of call.
- Physicians may not take the same number of call days, but the RVU system ensures overall equity.

A VARIETY OF CALL SCHEMES

There are an endless variety of call systems that physician groups can employ. Below are some of the options, any of which could be made equitable using the "call RVU" approach described in the article.

Call options:

- Each physician takes call every nth day, regardless of weekends.
- Each physician takes call every nth weeknight plus every nth weekend.
- Each physician takes call for an entire week every nth week.
- Each physician covers his or her own call during the week but takes weekend call every nth weekend.

Variations:

- Each physician rounds on his or her own patients on the weekend unless out of town; the physician on call covers only new admissions.
- Each physician takes after-hours phone calls from his or her patients, while hospitalist physicians handle all after-hours inpatient care.
- A contracted nurse call service handles after-hours calls using protocols and forwards only problem phone calls to the physicians.
- A resident service handles all phone calls and hospital care under physician supervision.

For obstetrics:

- Each physician does obstetrics and takes call for both OB and non-OB care using one of the above schemes.
- Physicians who do obstetrics participate in a separate OB call schedule.
- Physicians who do obstetrics participate in both OB and non-OB call schedules, preferably on the same day.
- Physicians who do obstetrics cover their own OB patients and participate in the group's regular call schedule.

A SAMPLE SPREADSHEET

The spreadsheet shown here is modeled after the one used in the author's practice to calculate physicians' call relative value units (RVUs) and distribute call more equitably. For the sake of simplification, some items from the practice's actual spreadsheet have been deleted, such as RVUs for nurse midwife backup and supervision of a free health clinic. In addition, the physicians' actual call assignments have been replaced with fictitious data.

The spreadsheet calculates physicians' total call RVUs by multiplying the raw number of calls by the accompanying RVU. Total call RVUs are then adjusted by the physician's full-time equivalent (FTE) status. For example, for "Dr. A," the calculation would be as follows: (8 shifts x 6.34 RVUs) + (2 days x 1.0 RVU) = 53 total RVUs; 53 total call RVUs/.80 FTE = 66 adjusted call RVUs.

Physicians may download a copy of the spreadsheet to adapt for use in their own practices. Simply visit the online version of this article at www.aafp.org/fpm.

Call Distribution Spreadsheet

		Inpatient attending call			OB/newborn call			Call RVUs	
		Sat, Sun, Mon and Thu call	Wed or Tue call	Fri call w/ Sat a.m. clinic	Thu, Fri and Sun call	Sat call	Mon, Tue or Wed call	Total	Adjusted by % FTE
	RVUs	6.34	1.0	1.73	4.54	2.21	1.0		
CLINICIANS	% FTE*	# of 1-week rotations	# of days	# of Fri/Sat a.m. shifts	# of 1-week rotations	# of Sat shifts	# of days		
Dr A	80%	8	2					53	66
Dr B	100%	4	25	9				66	66
Dr C	100%	7	16	4				67	67
Dr D	100%	9		6				67	67
Dr E	75%		35	9				51	67
Dr F	75%	7		3				50	66
Dr G	100%	5	20	8				66	66
Dr H	50%	3	6	5				34	67
Dr J	50%	3		8				33	66
Dr K	100%				8	11	19	80	80
Dr L	100%				7	12	22	80	80
Dr M	100%	2			5	4	36	80	80
Dr N	80%				7	5	22	65	81
Dr O	100%	4			8	2	14	80	80
Dr P	100%				6	7	37	80	80
Dr Q	100%				11	11	6	80	80
TOTAL	1410%	52	104	52	52	52	156	Avg non-OB	66.5
Needed		52	104	52	52	52	156	Avg OB	80.2
Difference		0	0	0	0	0	0		

*FTE = "Full-time equivalent"

NOTE: Total RVUS for each shift are based on the following:	
For inpatient attending	For OB/newborn care:
Sat or Sun = 2.17 RVUs/day	Sat or Sun = 2.21 RVUs/day
Fri w/ Sat AM clinic = 1.73 RVUs	Fri = 1.32 RVUs
Mon, Tue, Wed or Thu = 1 RVU/day	Mon, Tue, Wed or Thu = 1 RVU/day

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When assigning call for the coming year, the group uses a spreadsheet to calculate physicians' call RVUs and adjust the schedule until it is fair.

Although the clinicians may end up with different distributions among the various kinds of call, their total call RVUs are equitable.

Physicians who provide obstetric services have unavoidably higher call RVUs than the physicians who do not provide obstetric services.

Involving physicians in the development of their own call RVUs gives them a greater sense of control and ownership over the system.

free clinic run by medical students, etc. Then, we averaged the ballots and came up with RVUs for each type of call. (See the box below for the RVUs our practice uses.)

How we use call RVUs

Before the start of each academic year, we use a basic computer spreadsheet to distribute call for faculty clinicians. (See a sample on page 33.) Faculty names are listed in rows and types of call are listed in columns. As we input the number of call shifts for each physician under each call type, the spreadsheet automatically figures the total call RVUs for each physician. It does this by multiplying the raw number of calls a clinician has in each category by the appropriate call RVU. Call assignments are then adjusted until the total call RVUs for each clinician are essentially equal for the year. The spreadsheet even makes adjustments for physicians who do not work full time to ensure that they receive the appropriate amount of call. Each clinician may end up with a different distribution among the various kinds of call, but their total call RVUs are equitable. Our staff scheduler manages the spreadsheet and ensures that each clinician takes the correct amount and type of call as specified in the spreadsheet.

The fact that one clinician may not take Friday night call for religious reasons is not an issue.

This system has helped us make sense out of a complex call system. The fact that one clinician may not take Friday night call for religious reasons, for example, is not an issue. By taking more weeknight call, which has a lower RVU value, he can still carry his equal share of call RVUs for the year. In the same way, it is OK that some clinicians do more weekend call (inherent in doing a two-week stint as inpatient attending) because they will have to do almost no weeknight call.

One inequity we have not been able to correct entirely involves our clinicians who take maternity and newborn call. As a group, these physicians have higher call RVUs than the clinicians not doing obstetrics, but it is by their choice. In many cases, those clinicians doing obstetrics also want to participate in inpatient attending, which raises their RVUs, and we do not want to discourage this. Ultimately, we may offer a maternity and newborn call bonus to reward these physicians for their additional effort.

Getting docs on board

Physician buy-in is always important in a medical group, particularly when you're dealing with contentious issues such as call coverage. Because our clinicians took part in developing the group's call RVUs, they have a greater sense of control and ownership over the new system. It is their system, not one imposed on them.

Overall, physician acceptance of the call RVU system has been very good. It gives physicians credit for the work they do and a choice about how they want to accomplish their fair share. It provides objectivity to a potentially emotional issue. And it is a relatively simple solution that physician groups of all shapes and sizes can implement. FPM

Send comments to fpmedit@aafp.org.

WHAT'S A DAY OF CALL WORTH TO YOU?

The physicians in the author's practice voted to use the following call "relative value units," which are plugged into a spreadsheet that enables the practice to distribute call equitably.

For inpatient attending:
Sat or Sun = 2.17 RVUs/day
Fri w/ Sat a.m. clinic = 1.73 RVUs
Mon-Thu = 1 RVU/day

For OB/newborn care:
Sat or Sun = 2.21 RVUs/day
Fri = 1.32 RVUs
Mon-Thu = 1 RVU/day

For backup of nurse midwife:
Mon-Thu = 0.71 RVU/day

For supervision of free health clinic:
Weekends = 0.43 RVU/day

1. Night and weekend call: tough but manageable. *The Physician's Advisory*. Conshohocken, Pa: Advisory Publications; September 2000:4-6.

2. How much is call coverage worth? *The Physician's Advisory*. Conshohocken, Pa: Advisory Publications; October 2000:4-5.