

## What to Do When Your Contract Is Threatened

### *An Information Paper*

One of the most unsettling times in any emergency physician's life is when the hospital, in which s/he has invested considerable personal and professional time and attention,<sup>1</sup> indicates it is going to put the emergency department (ED) contract out to bid. This situation has the potential to put the physician's entire life in disarray. The purpose of this paper is to assist emergency physicians in negotiating the treacherous waters involved when a contract is under threat of not being renewed. Many of the actions outlined particularly in the early and intermediate stages can be used proactively to foster communication with stakeholders and prevent minor issues from becoming a threat to the contract.

The paper is divided into sections around timing, specifically:

- Early (Stage I) - when you become aware the hospital is considering putting the contract out for bid;
- Intermediate (Stage II) - when the hospital has put the contract out to bid, but your group is still an active player;
- Late (Stage III) - when the contract has been awarded to an alternate provider group and you are looking to either make a last-ditch effort or work on a smooth transition.

Obviously, these situations are influenced by specific local issues, personalities, and history and these issues will be determining factors in whether or not your group retains its hospital contract.

Fundamental to this concept is that emergency physicians are typically contract doctors, like radiology, anesthesiology, and pathology. Contractual relationships between hospitals and doctors are increasing as hospitals are forced to work to gain efficiencies that positively impact the bottom line. Increases in hospital costs and unfunded patients place financial pressures on the entire healthcare system. Hospital administrators want and need more from ED groups as these challenges are addressed. The number of contract physicians working in "their" hospitals will increase dramatically as hospitalists, critical care, obstetrical, and surgical providers contract with hospitals. As a result, emergency physicians must strive to work cooperatively. Hospital and emergency physician incentives and goals need to be aligned wherever possible. There are numerous examples where a long-term ED group was viewed as expendable and the hospital elected to terminate a contract for tactical or financial reasons.

### **EARLY (STAGE 1) - Hospital Voices Concern, But Has Not Bid Contract**

#### **Determine Hospital's Issues**

In the earliest stages of a threat to an ED contract, whether a large contracting group or a small one-hospital group holds the contract, the first signs of an upcoming ED group change can come in a variety of ways. One way is hearing comments from administration such as "if you value your contract," "we can always find another group," etc. Other signals are rumors out in the community that the hospital may be looking for another group, or noticing outside people assessing the ED

Be alert for the foundation being laid for termination. It can involve “heightened criticism.” The administrator(s) may seem a little more standoffish and less likely to visit or give compliments. Additionally, watch out when the administration is asking the group for unusual, unrealistic, or unattainable demands outside the scope of the contract. Although any and all of these may not lead to a contract termination, none are false alarms. It is better to always be prepared and on the alert. This is the time to be sure that the group has a handle on the numbers that the hospital generally wants assessed:

- Turn-around times
- Patients leaving without being seen
- Patients leaving against medical advice
- Overall numbers of patients being seen
- Patient satisfaction scores and patient complaints
- Medical staff complaints
- Nursing staff complaints

Individual physician numbers in these categories are not as important as the overall numbers. The most important statistics are ones that either show an overall trend of improvement, or that the numbers are within the goals that have been set by the hospital. Do not be ignorant of this information. If the numbers might be seen as unacceptable by the administration, this is the time to immediately have a written action plan. It is fine to have an explanation of less than acceptable numbers, but this will sound defensive even when it is the reality. A defensive posture is never good. A strong proactive position is always better—excuses should be minimized.

The explanation must be accompanied by a written action plan for improvement. Even if the plan seems self evident, put it in writing (ie, the ED had a shortage of nurses and the numbers will improve when more nurses are hired). The administration might still portray less than stellar numbers as the fault of the group unless the “obvious” reason is provided when statistics are shown.

By far the most vulnerable time for the ED contract to be threatened is when administration changes. A change in the ownership of a hospital generally means new administration, either immediately or within the next few months. Frequently the ownership does not change, but the administrator/CEO does. The new administrator/CEO will come with past experiences and may have a different agenda than the previous administrator/CEO. Do not underestimate this individual. Administrators strive to make great financial strides, and some of these may include changes in the ED group contract.

In some hospitals, changes in the nursing administrator or nursing director of the ED can threaten a contract. It is imperative if changes in administration occur physicians in the group should immediately meet with new administrators, whether inviting them to lunch or dinner away from the facility or setting up a specific meeting, where common ground can be found, and a working relationship initiated. Loyalty is a virtue but complaining about administrative changes is counter productive. A contract group that is perceived as a threat to the new administrator is another reason for an ED group change.

### **Ask for a Meeting with the Hospital**

The best time to ask for a meeting with the hospital administration is before there is any threat to the contract, but no later than at the earliest indication of a potential threat to the ED contract. The meeting should include the CEO or administrator, the chief financial officer and any other executive who was involved with signing the contract with the group. If the hospital has a medical administrator or VP of medical affairs, invite them. The key is having all the stakeholders to the ED contract in the same room for constructive dialogue. Key officers of the ED group should try to be present, along with the medical director and assistant medical director, and individual members of the group who may have a close

association with the administrator or who are perceived by administration as an asset to the hospital. Go to the meeting with copies of statistics and written plans for improvement and for action in hand.

One goal of the meeting would be to establish where the hospital is in its decision process about bidding out the ED contract. Someone in the group should be taking notes. Try to address issues at this time while the group can be more proactive since the group has called for the meeting. Try to get the administration to commit to an action plan before taking further steps to look for a new group.

At the meeting, the group needs to be flexible and willing to make changes to meet the hospital's perceived needs, even if the group does not think the changes will work. This is the time to be creative and work with administration to align goals and incentives, to educate the administrator about what can and cannot be done due to medical reasons and what is medically ethical. If administration demands that one or more physicians be taken off the schedule, be prepared to counter those demands with a plan. For each physician in the group, try to have a positive point or area of expertise they contribute to the hospital. One physician may have the best turn-around times, one may generate the least number of complaints, one may be the liaison with EMS and has smoothed over many problems, one may give monthly in-services to the nursing staff, and one may have the best medical record documentation. Find out the specific problem that administration has with a particular physician, inform administration of the positive aspects of that physician, then propose that a plan be made to correct that problem to the satisfaction of administration within a certain time frame, such as 60-90 days. You must be objective and back up your assertions with a plan. During this meeting, point out that it is hard on the hospital medical and nursing staff to change ED groups, and that you are willing and able to work through the issues to prevent a change from being necessary.

### **Rally Support for Yourselves**

This is the time to rally support for the ED group. While a good ED group will establish early in its tenure its value to the medical staff <sup>1</sup>(just like any good medical staff member), self promotion cannot be underestimated. The administration needs to keep the physicians who are admitting paying patients to the hospital happy (revenue stream). The physicians who admit the most patients (elective surgical patients bring in the most money) and those who are the most vocal should be approached first. Other key physicians on staff should also be approached in a subtle manner. One method is to go through the staff roster and assign emergency physicians to speak with particular staff physicians, giving preference to personal requests due to friendships or good rapport. The medical staff advises hospital leaders on the sources of clinical services provided by contractual arrangements and it is important to have feedback from those involved. Be sure to cover all the physicians on the medical executive committee as they will have input into this process. The emergency physicians should report on their contacts with particular attention to conversations with staff physicians who seem displeased or may have an allegiance to another emergency physician or group.

The manner in which to approach other physicians for support will vary according to the relationship between that emergency physician and the staff physician. As a general rule, in order to be subtle, the emergency physician can ask if the staff physician believes that the emergency physicians are being fair with that individual when the staff physician is on call, if the physician is satisfied with the amount of information being given about the patient, and if the staff physician is satisfied with how the emergency physicians are treating the patients in the ED. The emergency physician can probably ask in general terms if the staff physician would be supportive if administration ever tries to change to another group, or how can support be improved at this time. If the emergency physicians have not been following the call schedule properly or not documenting well when a different physician has been requested by the patient, be prepared to hear negative comments. Quickly follow up on any complaints about a particular case or about perceived favoritism that the staff physician offers. The group does not want smoldering problems (that are often inaccurate) to suddenly arise when administration voices concerns about the emergency

group to other physicians. Take the time to keep a written record of any complaints and the outcome so that this record can be produced if the staff physician still complains or forgets to correct misconceptions that have been voiced to administration.

Support from the nursing staff is critical. In some areas, the nursing shortage is so severe that nurses are more valuable to the hospital than the emergency physicians. Being polite, while not being condescending, is of utmost importance when interacting with the nursing staff. And nurses will generally be supportive of physicians who are kind and respectful to them and their patients, because nurses see their primary role as being patient advocates. Remember that most nurses have worked in several EDs and many nurses have second jobs in other EDs. If nurses have poor experiences with emergency physicians at another facility, this information will be helpful to the administration if it's a group the hospital is considering to compete for the contract. That information can be great news for the current group. On the other hand, if the nurses have had better encounters with another physician group elsewhere, they will bring back information that could be harmful to the current group.

Know who is on the Board of Trustees of the hospital. Many of these Board members may not be physicians. If any of the emergency physicians know one or more of the lay members of the Board, a positive relationship may squelch early threats to the contract. Generally, the CEO or administrator answers directly to the Board. Be aware that a contract threat will sometimes originate from the Board simply because a member has a relationship with an outside emergency physician. The current group must have an advocate on the Board to counteract that possibility. It is also important to be aware of all the physicians who are on the Board and maintain good relationships with these invaluable colleagues. Be sure to know who the partners of these physician board members are, since a poor relationship with a partner could ruin an otherwise supportive association. Knowing a member of the Board can be invaluable in alerting the group about dissatisfaction with the ED contract so that the problem can be addressed immediately.

Rallying support includes support among all the emergency physicians including physicians who work part-time. Partners of the group may assume support that is not there. If a significant number of the emergency physicians are not supportive, it will be almost impossible to retain the contract once administration decides to consider a change. Assess the group for the possibility of one or more "moles" who are actually working to get the contract changed. This circumstance is less likely to occur if the physicians feel they are being treated and paid fairly and they are an integral part of the group.

The early phases of a potential contract threat will be the only realistic chance that the group has of gaining the full support of the emergency physicians. Once the contract has been put out for bid, the emergency physicians who are less supportive often become skeptical of continued employment and leave for other work, thus making the current contract group increasingly unstable and less likely to retain the contract. Emergency physicians who have been asking to participate in the group to be shown the books and billings, allowed to buy into the group as an eventual owner, or to be given the right to due process, will not believe the owners who suddenly offer these options. If changes need to be made in order to gain the support of the emergency physicians, these changes must be made immediately in the early threat phase. Otherwise, it will probably be too late to be effective.

### **Don't Allow New Issues to Arise**

Now is not the time to have problems arise -when the hospital administration is considering changing the emergency group contract. This is not the time to have poor coverage in the ED. The officers or those who do not work as many shifts may need to be more visible, not only to cover holes in the schedule but to be sure that all the new physicians and nursing staff know the emergency physician group. Someone needs to be available if the department gets busier than usual so that administration does not hear

complaints about how no one in the group would come in to help. This is not a good time for administration to hear more than the expected number of complaints from patients, physicians, or nurses.

Stay away from gossip. All emergency physicians should be on guard against making comments that could be taken out of context. The group must constantly be aware of their actions and comments around the ED staff, peers, and other associates. Many issues arising from ED performance and complaints come from group members who are complaining about each other. These casual comments can be overheard and used against the group.

Address all clinical and behavioral issues immediately. A fairly common occurrence can be taken completely out of context if administration is trying to find reasons to change the contract, or if one or more people in the department are themselves working against the group. If nurses and other personnel are complaining that a physician is ordering inappropriate tests or medications, immediately review the charts in a formal (written) fashion and address those complaints (or arrange for re-education of the physician if they are actually correct). Do not ignore any complaints of sexual harassment or other types of inappropriate behavior. Look at these issues with an open mind. The accused may be innocent, but also may be guilty, in which case the physician may have to be temporarily taken off the schedule until correction of the behavior can occur or may need to be permanently removed for egregious behavioral problems.

In these early stages of a threatened group contract, encourage ancillary staff to the emergency group to be on their best behavior as well. This would include staff who bill for insurance and whoever answers the phone for the contract group. Their pleasant and professional attitude can go a long way in pleasing administration, whereas unprofessional or rude behavior could swing the decision against the current emergency group.

### **Group Meeting**

When you first learn of a significant threat to your group's contract, informing your group is imperative. A face-to-face meeting is optimal to properly inform the members. This subject is too critical to be relegated to e-mail. If your group is large and geographically spread out, then a conference call would be the next best choice. The timing of this meeting should be ASAP, as the risks of the rumor mill increase exponentially, and the potential damage done by ill-informed and angry members is very real.

Once the time of the meeting is set, it must be determined who is in charge, as well as who will be talking with hospital management. Most groups usually have a good sense of who would be the best spokesperson, usually one in a leadership position such as the president, chairman, or member of the board of directors. Ideally, this individual (or individuals) will possess the necessary negotiating skills, have substantial experience with the group and administration, and not be viewed as a key adversary by the hospital administration.

Next, the group needs to do a deep self-examination of the major issues at hand that lead to the contract being at-risk in the first place. The group must identify not only the major issues from the hospital's perspective (which may or may not be valid) but also potential shortcomings of the group itself, where they are not perceived to be meeting the hospital's needs. Although it may be very difficult, the group needs to face the reality that they may not have been as effective as they have perceived, or perhaps they were performing well, but were less effective at communicating their strong points and achievements to the hospital administration.

The group leader needs to be skilled in discussing this information with group members, so as not to create panic. On the other hand, one needs to be realistic in allowing physicians to explore their options. This will be determined largely by the unique size and nature of the group, the hospital organization,

geographic location, and the local healthcare economic circumstances. If the group leader seems to be the problem, the others must delicately work to replace him/her with a more effective leader.

Once the group identifies the major issues(s) and their main spokesperson(s), the group needs to formulate a strategy to address the issues and to attempt to counteract the threat. The strategy will inevitably be very specific to the unique situation of the group and the hospital administration. The group members need to be absolutely clear what they are to say concerning the contract situation, taking legal advice from their attorney into consideration. In many, perhaps most, settings it may be best to say “no comment” and let their group spokesperson do the talking. The group also needs to be clear on whether they discuss any issues with the medical staff or the hospital ED staff at all. While doing anything to garner support for the group is constructive, a misdirected or inappropriate comment may cause great harm and must be avoided at all costs.

### **Contractual Issues**

In addition to informing each group member of the issues and ground rules, the group’s contract with the hospital needs to be reviewed closely to make sure the group is in compliance with the contract. The contract may have clauses that benefit the group. You should obviously use these to your advantage.

A formal legal opinion from the group’s corporate attorney or other expert in hospital contract law should be sought. Getting a formal opinion on your legal options from a legal perspective is essential in finalizing the group’s strategy. For example, you may have a 90-day out clause that buys you some time to remedy the factors that lead the hospital to reconsider your group in the first place. Any delay or time in your favor should be used to your advantage to address and formulate solutions to the hospital’s perception of the group’s shortcomings. If the contract has a “without cause” termination agreement, you may have no legal grounds to prevent the hospital from releasing you, but you should still utilize all the other strategies to try to salvage the contract.

Once you have determined the key issues, a formal meeting with the hospital administration is necessary (see section II above). Unfortunately, the hospital is probably in a more favorable negotiating position when it comes to addressing these key issues. You need to clearly identify the key issues or problems from the hospital’s perspective. At this time, you need to demonstrate to the hospital exactly why continuation of your contract is of mutual benefit, and why termination would be detrimental to their institution’s mission and goals. You must also make it clear to the hospital the downside of contracting with a new group. Have an action plan and be prepared to present it. Be proactive. Do not make excuses.

This may be your chance to educate the hospital administration concerning what unique qualities your group brings to their organization, and why an outside entity would be a step backward. If the issues are financial, you must have a strategy to meet the hospital’s perceived needs, such as your group going to independent billing and elimination of a hospital subsidy. If the issues are personnel, detail your groups plan to address these issues.

While not necessarily part of the early deliberations, your group may discuss the presence of a restrictive covenant in the individual physician employment contracts. Along with a legal opinion from your attorney, your group should begin formulating a strategy to determine how a non-compete clause potentially could be used to deter the hospital from dismissing the entire group. This is not something that would likely come up in early negotiations but may be used in a more desperate situation (see below).

## **INTERMEDIATE (STAGE II) - Hospital Puts Contract Out to Bid**

### **Develop Overall Strategy**

At this point, your earlier efforts have failed. It may have been because you did not take the initial threat seriously, or it may be that despite your best efforts, the contract has now been put out to bid. If you have not addressed the early steps, it is not too late to review them, but you cannot delay. At this point, you must understand that it is not in your best interest to think you have an advantage relative to other groups - and you may have damaged relationships that cause you to be at a significant disadvantage. You must prepare for this challenge in many ways as if this is your initial contact with the hospital.

### ***Review your contract***

First, you must bid as if it were an initial contract negotiation. You do have an inside track in many cases because you have access to all the data to understand the true financial picture. Other groups will be given access to the information the hospital has regarding the demographics of your patient population but generally will not have access to the professional data unless the hospital does the billing (or you have given it to them). You need to carefully review that information to determine if the compensation, staffing, and provider mix are appropriate for your current practice environment. For example, changing your compensation system to a productivity-based system may drive behaviors that lead to positive results. Assessing the ability of mid-level providers to provide an additional level of service may be beneficial. You may find that your physician staffing is either falling above or below standards for the volume and acuity of the patients you see. Note that decreasing coverage is much more difficult to explain (to administration and to your doctors) at this time.

The goals in this stage are obviously to provide the best coverage to meet any published benchmarks with an efficient turnaround time, and to make sure your compensation package is competitive for the market. The caveats are that you cannot sacrifice so much that you do not have a viable contract in a few months. Although every hospital is looking for a contract that requires no subsidy, that does not always mean you have to submit the lowest bid. It does mean that you need to be prepared to support your bid with some form of objective data that states why you are recommending certain concepts.

### ***Analyze your practice***

Every group has strengths and weaknesses. Do SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis on your group. You need to understand where you are in order to specifically address these areas. Certainly, by this point you should have met with key members of the administrative team, hospital medical staff leadership, and other thought leaders. By being the incumbent group, this is also an area where you should have some leverage. By knowing how decisions are made in your hospital, you should reach out to those decision-makers with which you have good relationships. Your message to them should not be what a bad hand you are being dealt, but a message that you truly value your contract and you wish to improve what needs improvement. If you have not done so in the early stages, solicit their perceptions of what the strengths, weaknesses and opportunities of your group are.

Remember also that you may not always agree, but you cannot become argumentative or defensive if you are to retain the contract. Members of your group must understand you are addressing perceptions and an action plan must be developed quickly to address those perceptions. The action plan should not only discuss how you will approach the weaknesses, but how you will reemphasize the strengths.

It may be necessary to go outside the group for this analysis. In many cases, it is difficult for the incumbent group to critically analyze your practice without rationalizing some of the weaknesses. An outside expert may be able to better draw on additional experiences to provide a more robust analysis and action plan.

### ***Herd those cats***

Physicians are notoriously independent thinkers who often have difficulty with a group mentality (a cohesive group mentality is paramount when your contract is threatened). We are trained to think of the issue in front of us with our being the “captain of the ship.” In many cases, this concept may have led to difficulties with the contract. With the contract out to bid, it is absolutely imperative that the group becomes united in approach and resolve. There must be consistent communication about the strategies for approaching the contract. Controversies that arise will be viewed unfavorably in terms of the contract decision. After all, if you can’t “control” your group when the contract is threatened, you certainly cannot be expected to provide a consistent approach when the contract is on solid footing.

The leadership of the contract, whether partners or individuals, must have clear communication with each physician to deliver that message. The expectations for behavior and performance must be clearly articulated and agreed upon, with clear communication about the next steps if they are not followed. A rogue physician can have a detrimental effect on the entire group. It may be necessary to remove personnel who are not in compliance with standards of performance as related to the group or as viewed by the hospital. In doing so, it must be clear that the method for making that decision is appropriate and understandable to the rest of the group. You are creating a standard for all interested parties that will be established for future decisions of this type.

### **Consider Other Alternatives to Your Practice Model**

This approach becomes more difficult to many groups the longer they have held the contract but is often the area in which the hospital is looking to improve performance.

- **Management Services** – Depending on the size of a group, the ability of physicians to develop expertise in non-clinical areas related to emergency medicine is increasingly difficult. We cannot all be experts in human resources, corporate compliance, reimbursement, risk management, and other ED services to name a few. Engaging a practice management services group to provide that expertise demonstrates the resolve of the group to establish the best practices in these areas. Establishing this relationship allows the group to maintain the autonomy over the contract while “outsourcing” many of the management needs of the group.
- **Added Services** – The traditional ED has provided emergency care to patients who present. As the reality of ED practice has changed, many EDs have added services to both meet the needs of the ED and establish their ability to serve as a partner with the hospital. Establishing clinical decision units is one way of addressing reality while creating a win-win for the group and the hospital. Establishing a chest pain unit or observation unit often creates more efficient care delivery for patients who might be in the ED for an extended time. Before doing so, a clear analysis of how to maximize this service is essential.
- **Hospitalist Services** – In some institutions, the transition from ED to inpatient care is problematic with disagreements between ED and inpatient physicians creating delays in care and animosity between the two groups. In most hospitals, the inpatient physician is often viewed by the administration as the relationship that must be maintained. The inpatient physicians are often viewed as “bringing” their patients into the hospital, and therefore provide the financial reward the hospital needs to drive business. In addition, they are often viewed as the subject matter experts when it comes to clinical decisions.

Putting that interface under a single management structure changes much of that dynamic. Having the ED group partner with or employ hospitalists creates allies in the continuum of care and often addresses hospital concerns about inpatient efficiency and quality. As more services become less

dependent on the hospital for their profitability, the ED may play an increasingly central role in assisting in the establishment of such services and relationships.

## **LATE (STAGE III) - It Appears the Contract Will Be Lost**

### **Steps to Take Once It Appears the Contract Will Be Lost**

There may still be time to salvage the situation. You may want to contact your local medical society or ACEP for support as you work with the hospital administration.

First and foremost, maintain a professional demeanor in your interactions with the hospital. Let the hospital know that you are still willing to work with them while you inform them of possible issues that may arise during a transition. There are many reasons for this approach. First, while you may know the contract will not be renewed with your group, you may not know whom the new group contract holder will be. You or other members of your current group may wish to remain at the hospital and work for the new contract holder. If so, you will want both those who stay and those that leave to have good evaluations provided by the hospital. There may also be positions in administration or in hospital affiliated areas such as employee health, infection control, information services or occupational medicine that you may be able to transition into and thus want the hospital to have a high opinion of you. While you may ultimately decide to leave, you want any potential new group who might contact the hospital (since your group will be gone) to get a good evaluation of your work while in your current position.

Second, there may still be possible outside influences that may save your contract. The hospital Board may not approve the change. If a large national group is awarded the contract, your medical staff may be mobilized more to fight for your group. Remember that administrators change, hospitals are sold, and groups cycle. When this occurs, the contract may again go out to bid allowing your group another chance. Burning your bridges may prevent you from taking advantage of these opportunities in the near future. Bitterness and obstructing the transition may backfire if any of these possibilities exist.

If it is still clear that the hospital will not renew your contract, your next step would be to once again have your group review the ED contract with the hospital administration. If you had negotiators representing the group, this is a good time (if you can get the hospital administration to agree) for everyone in the group to be present at the discussion so the negotiators are not accused of “not doing a good enough job.” It will also make the hospital administrators look at every member of the group and try to explain why a change is being made.

At this time, your group needs to meet with the hospital administration to explore what is needed for a smooth transition. You may be able to convince the hospital to require any new group to keep current members if necessary while they look for another position. If members of the current group leave before the contract with the hospital expires, you need to have discussions about filling the shifts that become uncovered. You must anticipate that staffing will become unreliable as physicians leave for new jobs.

This may also represent an opportunity for you and other members of your group to relocate. Have you always wanted to live near the beach? Those of us in emergency medicine are always sympathetic to those who have lost their contracts. Use this to your advantage. Contacts that you have developed through ACEP, by attending CME courses, medical school and residency should be explored.

Even if one is in a small group, a “do not compete” clause (designed to make it more difficult for the hospital to change contract holders) may exist. If such a clause exists,<sup>2</sup> the group should now meet together to determine if the clause will be enforced.

### **Meeting with New Contract Holder**

At the earliest possible date, members of your group should meet with the new contract holder. You will need to explore many issues with them. Will they contract with current members of your group and if so, which ones? (Assuming you release the members from any “do not competes” that might exist). Will they hire any of your current support staff (secretaries, billers, coders, etc)? What will they pay and what benefits will they offer? Can you work together to look at the potential for employment of current clinical and non-clinical staff and the purchase of assets of the practice? This is where accounts receivable will need to be addressed. They may be sold (often at a discount) or the group may need to remain in business for a few months after the contract expires to collect them. Could your group possibly be merged into their group? You have nothing to lose at this point by asking and you may be surprised at the response.

### **Final Steps**

The final steps to closing down your contract involve malpractice and other legal steps to dissolve the group. Your lawyer will need to review many things such as your pension plan, possible expenses, contacting the state if your group is incorporated, finalizing your tax returns and other IRS matters, etc. Make sure the attorney reviews your malpractice coverage both for the group members and the group itself, so you are covered for any suits that may arise once the group is dissolved. You must also be sure that any pending suits are being accounted for.

## **LAST GASPS**

### **Playing Hardball**

The strategies that might be employed in this section come at a high price. They involve actively and publicly opposing your hospital administration. They should generally be considered as last ditch, desperation measures and only after legal review and counsel. However, they may, on occasion, be effective and the subsequent issue will become, even if you keep the contract, can you repair the relationships with the hospital administration sufficiently that they are not looking for another time and place to get rid of your group?

These strategies can be employed anywhere in the process, but as desperate measures would seem to be best left for desperate times, including after contract changes in the hopes that the contract can actually be salvaged. This has in fact happened at several places.

### **Media**

It is most important to frame your media discussion in terms of a “patient and community needs” perspective. A description of effectively using the media is beyond this paper, but in general you can try to interest local media reporters on the upcoming change and emphasize local community loyalties.

It is extremely effective if the nurses are solidly in your corner and are willing to go to the media in support. Nurses are viewed as trustworthy, and the community and media will play off of a public declaration by the nurses in support of your group. Direct nursing appeals to the hospital’s administration may also be very effective.

### **Use of Non-Compete Clauses**

This is not a discussion of the pros and cons of having non-competes in your contract; however, if they are in your contracts, this is the time to make use of them.<sup>2</sup> You may use them to inform the hospital administration that a certain list of physicians will no longer be able to work at that facility. You may use it to inform the physicians they should not be discussing or negotiating with a new group about conditions of working. The general effort in this regard should be to make the administration aware that the local pool of physicians may not be available to staff the new contract.

### **Open Appeals to Medical Staff**

Another high-risk effort may be to send an open letter to all of the physicians on the medical staff explaining your side of the issue or use local meetings of your regional medical society to do the same. Again, the emphasis should be on quality emergency care and patient satisfaction and local vs. outside, and on. You might ask for a hearing before the hospital's Medical Executive Committee. In addition, you could ask for an open meeting with the administration and the hospital's medical staff to discuss this issue. Be aware that physicians do not like to get in the midst of these types of issues and just asking may have a negative response.

### **Using National ACEP and Other National Organizations as Facilitators**

In some situations, it may be advisable to seek assistance from national leaders to solicit support to address issues of fairness, provide input on the use of media coverage, and provide information regarding other recourses to help work through the issues between the hospital administration and the group. Try having some outside emergency medicine experts frame the discussion. It may be possible to smooth over some of the issues between the group and the administration and salvage the contract. Mediation involves compromise and you as the group **MUST** be willing to compromise and address the administration's concerns if you wish to keep the contract. If you choose this route, you must be willing to listen as well as talk and be prepared for changes.

It should be emphasized that all of the above are high-risk measures. Various risks exist. Sound legal counsel must be sought and followed. Risks include litigation based on tortious interference with a contract and other legal theories. Open appeals to the medical staff may boomerang in that if there have been medical staff issues, the forum may turn around and become a lambasting of the current group in a public forum by all the medical staff rather than a defense to the administration. Lastly, using the media is problematic in that the focus of the story may change from support for your group to people writing in and/or the hospital explaining all the issues they have had with the current physicians. Furthermore, your local hospital is likely to be a big local buyer of ads and media space and it may defer to the hospital and go out of their way to present their side of the issue.

Thus the "hard ball strategies" are truly desperation measures and even if you are successful in the long term, your relationships with administration may be so fractured that you may never form an effective working team. In that case, eventually either the physicians decide to leave because of the adverse conditions or the hospital administration pushes the group out more successfully in a later contract bid.

If all your physicians are solidly committed to the group, you have a great deal of leverage. Again, this is a high-risk strategy. The clear downside is that everyone may be forced to leave his or her job. If the other sites you staff are local, you have even more credibility.

## **CONCLUSION**

Going through a contract renegotiation with a hospital that is dissatisfied is an extremely stressful event. Even with the best of planning, you may not be able to keep your contract. Hopefully this paper has provided you with the tools you need to succeed.

Created by members of the Emergency Medicine Practice Committee, April 2006  
Reviewed by the Board of Directors, April 2006

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