



Starting a Democratic Emergency Department Group

an Information Paper

*Developed by Members of the
Emergency Medicine Practice Committee*

June 2001

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The Emergency Medicine Practice Committee prepared this information paper as an educational tool. The object is to inform the emergency physician about starting a democratic emergency department group. This material should not be construed as legal advice or be used as a generic model to develop a contract. If legal advice or other expert assistance is required, the services of a competent legal professional should be obtained.

Introduction: Philosophy of the Democratic ED Group

The definition of democracy is government by the people with the majority ruling. In a democratic emergency department (ED) group, emergency physicians (EPs) ensure that their rights and responsibilities are recognized and respected. The American College of Emergency Physicians (ACEP) policy statement, “Emergency Physician Rights and Responsibilities,” establishes general democratic principles that apply to all EPs regardless of group organizational structure. In a truly democratic ED group, each full-time physician member has an equal voice and vote, and the majority vote rules. Operationally, most democratic ED groups conduct business as a representative republic. In this model, the physician members elect a board of directors or an individual with decision-making authority. This provides efficiency of decision-making and allows the physician group to defer most operational decisions to those with superior expertise.

In addition to the advantage of equitable business practices, a democratically organized physician group shares the profits earned by the group. The group can adopt policies regarding due process, restrictive contractual covenants, and profit distribution to outgoing members. Conversely, the individual members of a democratically organized group share the financial risk of group failure. Single-hospital groups lack the economies of scale afforded to larger physician organizations. This may lead to higher relative costs for malpractice insurance, coding, billing and reimbursement, recruiting, and administrative costs such as accounting services, legal services, and office expenses. In a democratic group, the physicians are entrepreneurs, whether as employees or independent contractors.

A cohesive democratic group is good for patient care and for the hospital. Any ED group that maintains a good relationship with the hospital staff and administration is less likely to be displaced by another group of ED physicians. The other hospital physicians will view the EPs as peers because the EPs have an interest in developing and maintaining a profitable practice. Involvement in hospital affairs and accessibility to the hospital administrators helps the ED group communicate its vital role in the hospital’s success through efficient, expert ED patient care and through hospital admissions. There are many advantages to being an active member of a democratic ED group.

The physicians in a democratic group must be willing to accept the responsibilities of having an equal voice and vote. Organizing and maintaining a democratic group is labor-intensive and is further discussed in the sections that follow. The physicians may decide to fund the start-up costs with their own money or obtain credit lines using their personal credit guarantees. In starting the group, the members must determine the appropriate allocation and compensation for group administration. Responsibilities of membership in a democratic group include active involvement on hospital staff committees, participation in hospital politics and staff meetings, and participation in ED nursing and staff education. Participation in county and state medical society affairs further increases the visibility of the group. The physicians must commit to professional and compassionate interaction with patients and their families and significant others. The group members must abide by rules of professional conduct during any public function or event, since the community will judge the group by the actions of individual members.

Some responsibilities are surprisingly difficult to handle with a democratic group. Planning in advance of these difficult tasks is essential. If a particular physician proves to be a problem and threatens the security

of the contract, it is difficult for the other group members, who are equal partners of the offending physician, to effectively counsel the physician or, alternatively, to vote the offending physician out of the group. Choosing the group of physicians with whom to start a democratic ED group can be difficult, in light of differences between individual personalities, practice styles, training, experience, and egos.

Democratically organized ED groups must decide how to distribute profits, generally through stock, stock options, or profit sharing. Alternatives include: equal division of shares; shares purchase options; awarding shares based upon years and hours of service, including time involved in administrative duties; and, phased-in share distribution following a defined trial period with the group. However, the democratic ED group philosophy depends upon equity. This equity should afford each physician in good standing the opportunity for full partnership and an equal vote in group operational decisions.

Hospital Selection and General Negotiations

Hospital Selection

Occasionally hospitals publicly announce their intent to entertain proposals for ED physician staffing. Alternatively, the democratic ED group may have a geographic preference and must contact the various hospital CEOs in their area to gauge interest. Inquiries by qualified ED groups sometimes are invited to present a proposal to a hospital's decision-making authority. The group must select representation and prepare for the presentation. Such a presentation generally includes: qualifications and experience of the group members; advantages that the group brings to the hospital; the group's philosophies on matters of hospital and administrative affairs. Most administrators or decision-making bodies also expect the group to exhibit knowledge regarding the hospital's current internal and external environment.

When offered the opportunity to contract with a hospital for emergency physician staffing, the group must consider a number of vital features of the hospital and its medical staff. These considerations include: patient payer mix; history of ED collections; the potential need for a hospital subsidy to support physician compensation; medical staff awareness of and compliance with regulations such as EMTALA; and, medical staff expectations such as admission orders, elective admission ED evaluations, ED to ED transfers, and interpersonal interaction regarding ED patients. Meetings with the hospital chief of staff and other departmental leaders are essential prior to making a decision. The group must gauge the hospital CEO's level of support for the ED. The CEO is ultimately responsible for adequate ED staffing, ED equipment, and ED physical plant quality. The CEO must understand or, at a minimum, be open to the need for efficient laboratory and radiographic services, state-of-the-art equipment and monitoring devices, and adequate ED on-call staffing. Finally, the group should investigate why the current ED group failed or discontinued services. These preliminary investigations not only aid in the decision to accept or decline the hospital's offer, but also begin to create important relationships with the medical staff and administration.

In today's current budget-cutting environment the principle focus of most hospitals, regardless of business model (for profit, not for profit, government-sponsored) is financial survival. The inquiring ED group should review the hospital's mission statement and statement of values and determine the hospital's commitment to these statements. The hospital's short and long-range plans may include projects that potentially detract from the goals and mission of the ED, such as large capital projects that ignore immediate ED financial needs or plans to build extended-hour urgent care clinics. The group also should conduct a limited evaluation of the status of the hospital's competitors.

General Negotiations with the Hospital

The principle interest of the hospital from a democratic ED group is full-time emergency coverage. Most hospitals have a regulatory obligation to provide ED physician coverage twenty-four hours a day, 365 days per year. The medical staff bylaws or the hospital's rules and regulations determine the physician credentials required to work in the ED. Many hospital administrators are unaware that residency programs for emergency medicine exist. In addition to the hospital's primary objective of continuous ED physician staffing, there are significant secondary interests. Volume growth, revenue growth, patient and physician staff satisfaction, and ED physician support of projects such as fast tracks and observation units are important concerns for all hospitals and their administrators. The negotiation process must address these issues.

Provided that the group's due diligence indicates that the hospital is an attractive candidate, the group must market their ability to provide the hospital superior service. The financial viability of the group is vital both to the group and to the hospital. Based upon the physician reimbursement model of the proposed contract (hospital employee, independent contractor with or without internal billing functions, etc.) the group must use revenue and cost projections to demonstrate sound fiscal health. Also, these projections may demonstrate the need for a financial subsidy to the group from the hospital in order to maintain fair and reasonable compensation for the ED physicians. Excluding government-funded facilities, such subsidy arrangements are less acceptable to hospitals today than in the past. The tough financial situation thrust upon the nation's hospitals by managed care and cuts in federal funding lead hospital leaders to expect ED physician groups to accept more financial risk and to fail or succeed on their own.

Hospital CEOs and their designees tend to be savvy negotiators. The group's first opportunity to present their case must include a sound business strategy for success. Items to address include:

1. Start up costs (if you are not a hospital employee)—cost projections for accountants; billing, coding, and collections; planning for 6-9 months of physician compensation costs prior to a steady revenue stream.
2. Billing, collecting, and coding strategies—this is important for all types of groups, especially if one is a hospital employee or receiving a guarantee (see section on Coding, Billing and Reimbursement for Services).
3. Physician reimbursement—strongly consider an incentive based system that rewards the ED physicians for speed and efficiency, proper documentation, patient satisfaction, and evidence-based practice.
4. Other practice costs—recruiting, scheduling, medical directorship reimbursement, QA, patient/staff complaint management, performance improvement programs, review of proper documentation, coding and reimbursement, medico-legal, physician benefits and malpractice insurance costs.

The group must demonstrate its interest in successful business practice and collaboration with the hospital to achieve mutual goals, such as efficient patient throughput, patient satisfaction, and excellent patient outcomes. The group should maintain objectivity regarding potentially polarizing issues, such as diagnostic study overutilization and unfair expectations for detailed order writing or inpatient responsibilities. Emphasize the commitment of the group members to involvement in hospital and community affairs, continuing medical education, and open access to the hospital leaders. Explain the importance of mutual success to the individual ED physician, who shares in the profitability of the group.

Contract Issues

A democratic ED group encounters three main types of contracts. This includes contracts between: the physicians and the democratic group; the group and the hospital(s); and, the group and third party payers. This section references information which is described in more detail in the ACEP publication, Before You Sign: Contract Basics for the Emergency Physician. Also, ACEP has a policy statement addressing EP contractual relationships¹ that applies to the information that follows.

The following principles should be followed, when applicable, within all three contract types. 1) The interests of patients are best served when EPs practice in a fair, equitable, and supportive environment. 2) Quality patient care is best promoted within a framework of fair and appropriate contractual relationships among various involved parties. 3) Business relationships that include EPs are best defined within a written contract. When providing services as an employee or contracting physician, the EP contracting entity may assign such rights, within the limits of federal and state law. In such cases, the EP should retain the right to review what is billed and collected for his or her service on his or her behalf. In addition, the EP should be knowledgeable about state regulations regarding fraud and abuse and reassignment issues. 5) It is the right of an EP contracting entity to make an independent decision regarding all contractual arrangements that involve third party payers and to be represented by legal counsel. 6) Quality medical care is provided by EPs organized under a wide variety of group configurations and with varying methods of compensation. 7) EPs under contract to a hospital or other health care facility should have the same right to qualify for and maintain medical staff membership and privileges as any other member of the medical staff. This right includes privileges to vote, serve on committees, and hold office, and the right to due process in the same general manner prescribed in the medical staff bylaws for other members of the medical staff. 8) EP contracting entities should enter into a written contract with a hospital or health care facility only after understanding all elements of the contract, including such important elements as: covered services; administrative fees (if any) paid to a management firm; accessibility to patients; hospital or health care facility obligations; compensation and billing; indemnity; non-compete covenants (if applicable); termination; and dispute resolution. 9) In those situations in which a corporate entity is the primary party in a contractual relationship for provision of emergency medical services, any issue pertaining to medical care must be reviewed and affirmed by a licensed EP. 10) The EP is individually responsible for the ethical provision of medical care within the physician-patient relationship, regardless of financial or contractual relationships.

In a contract, both parties have rights and obligations. The contracting process is a process of both parties agreeing to terms and should reflect the needs and interests of both parties. Usually a contract is a lengthy document that is written to include all possible terms and conditions and is used to prevent possible problems. Generally, the party that writes the contract will be at an advantage, because the other party must negotiate from a defensive position to exclude parts that are not in their best interest. Conversely, there is inherent negotiating advantage in allowing the other party to open the negotiation process, since certain unexpected, and advantageous, provisions may be offered. For physicians contracting together to form an equitable group, no adversarial position exists. Nonetheless, the process of writing a contract between physician group members can be thought provoking, as it allows the physicians to see the process from both sides. Furthermore, this contract likely will apply to some degree to the hiring of future physician group members. Whereas the physicians may have elected not to include “non-compete” clauses in their own contracts, they now face the prospect of constructing language to protect the group from internal contract competition from new group members. The issue of due process for termination from the group must also be contractually addressed, and this may raise issues with the contract between the group and the hospital if the hospital refuses to honor such language. Negotiating skills are extremely important and legal counsel is mandatory to protect the interests of the group.

Contracts Between Physicians and the Democratic Group

In starting a democratic group, the physicians may decide that the bylaws of the group address all issues that should be in writing. In fact, in certain states, an oral agreement (hand-shake agreement) is considered as binding as a written contract. If all the physicians forming the democratic group are in agreement as to their obligations to the group and, conversely, the group to them as individuals, then a written contract may not be necessary initially. Future physicians may even join the group without a written contract if they are comfortable with the philosophy and bylaws of the group.

The remaining discussion under this heading contains elements that the group may decide to include in the contract between the group and an individual physician member. Most contracts articulate the requirement that the physician will maintain an active license to practice in the state, an unrestricted DEA number, and active medical staff privileges, even though this would generally be a pre-existing hospital credentialing requirement. The contract may address board certification requirements and may exclude certain board certifications. Other prerequisites, such as years of ED experience, patient volume minimums for the candidates' previous ED experience, and type of residency training may be specified in these contracts. The contract may address requirements for physician candidates to be certified in ATLS, ACLS, and PALS.

Some contracts include language that will allow the use of qualified assistants and substitutes, as long as the contractor ensures that the providers comply with all provisions of the agreement. The contractor is then responsible for paying the substitutes and may be responsible for notifying the group of the substitution within a particular time frame.

The group may decide to list contractual responsibilities of the group to the physician, such as supplying backup coverage in case of unforeseen illness or accident to the physician, the provision of data to the physician regarding patient turn-around times, and feedback regarding patient and staff complaints. The contract may list responsibilities of the physician to the group, such as clinical hours expectations, administrative duties, committee meetings obligations, CME requirements, timely medical record completion, and other physician duties such as in-house emergencies, hospital employee physical examinations, EMS telemetry coverage, and fast track or observation unit coverage.

The contract may include number of hours or shifts guaranteed by the group to the physician or language restricting the physician from clinical work outside the group contract, although such a restriction may not apply to the independent contractor physician.

Specific figures may be included within the compensation and benefits section of the contract, or the language may refer in more general terms to methods of compensation and benefit calculation. Contractual compensation options that may be addressed include salary, fee for service based upon billed or collected amounts, hourly pay, guarantee base, percentage of gross or net receipts, bonuses, and distribution of overage or profits based upon shares or other performance criteria. The contract language may specify sign-on bonuses, moving expenses, health insurance, disability insurance, life insurance, dental insurance, workman's compensation insurance, unemployment insurance, pension plan, vacation pay, time allowed off (compensated or not) for sick time, personal time, maternity/paternity leave, military leave, CME attendance, leave of absence or sabbaticals. Other benefits may be included, such as license fees, professional fees, CME expenses, journal subscriptions, medical supplies and equipment, textbooks, parking expenses, meals, laboratory coats and cleaning, uniforms (scrubs), pager, cell phone, or vehicle/transportation expenses.

The contract may contain language referring to nondiscrimination in treatment of patients, ethical treatment of patients, and compliance with federal, state, and local laws, including the Emergency

Medical Treatment and Labor Act (EMTALA). Other contractual compliance issues may include: confidentiality; required reporting of communicable diseases; child or elder abuse cases; domestic violence reporting obligations; reporting of chemically impaired drivers and epileptic patients; testing and disclosure of HIV-related information; compliance with living wills and advance directives; adherence to OSHA and CLIA laws; prohibition of patient referral kickbacks and fee splitting (Medicare fraud and abuse laws); the state's age of majority; civil involuntary commitment; control testing for drugs and alcohol with disclosure of results; reporting to the trauma registry; reporting of illegal drug overdoses to the department of health; and reporting of suicide attempts.

Malpractice insurance issues must be addressed in this contract if the group purchases malpractice insurance on behalf of the individual physicians. The physician may agree to purchase his or her own insurance or the group may provide the coverage. The limits of coverage must be specified, as well as whether the policy is claims-made (and, subsequently who will purchase the "tail") or occurrence. Language in the contract may require the physician to notify the group of any threatened or pending malpractice action, and how the notification is to be made (in writing, within a certain number of days). The contract may contain hold harmless and indemnification language in case the physician is sued for malpractice. However, despite a hold-harmless clause, the group may still be successfully included in a malpractice suit, particularly if the group pays for the malpractice coverage and if the physician is an employee. To indemnify means to reimburse or to directly pay for loss or damage. This may not only include malpractice cases, but also general uninsured losses (such as judgments for sexual harassment), and other possible liabilities (such as IRS tax assessments and penalties). The group is more likely to include indemnification language with physicians if the hospital has insisted on indemnification provisions in the contract with the group. This is a method to transfer the risk of the group to the individual physician. It is unlikely that the malpractice insurance policy will cover indemnification losses.

The contract should contain a provision for physician due process for purposes of termination from the group. The group also must negotiate due process provisions in its contact with the hospital. Termination *with cause* is proper, with the criteria for termination delineated in the contract (such as loss of medical license or DEA certificate, suspension or loss of medical staff privileges, disqualification from participating in Medicare or Medicaid, formal conviction or indictment for a felony crime, inability to obtain malpractice coverage, and breach of confidentiality terms). The contract must define whether the termination is immediate under certain circumstances, or whether a certain number of days notification (and pay) is required before termination occurs. Termination *without cause* may well be in the contract between the group and the hospital, and sometimes the group contract with physicians will mirror the hospital contract. Certainly individual physicians will likely raise objections to this provision, because the termination may be based on incomplete or inaccurate information that the physician does not control.

As mentioned earlier, the group may wish to include restrictive covenants and non-compete clauses, but the individual physicians may be opposed to such contractual language. Forming a democratic group gives the physicians the unique opportunity to decide for themselves what is best for the group and the individual physician. An example of a restrictive covenant is: "Physician agrees that he/she will not, directly or indirectly, contract to provide the same or similar services envisioned by this Agreement to any Hospital(s) served by the ED Contract Group or those that might contract with the ED Contract Group or those to whom physician was introduced by the ED Contract Group. This covenant will apply as long as the Agreement is in effect and for a period of eighteen (18) months following the effective date of its termination." An example of a non-compete clause is: "During the term of the ED Contract Group's agreement with Hospital or any hospital at which services will, in the future be, provided by the ED Contract Group, Physician covenants and agrees not to engage in any action or course of conduct which is detrimental to or inconsistent with the interests of the ED Contract Group in retaining the right to provide services to the Hospital under the aforementioned agreement or any hospital at which services will, in the future be, provided by the ED Contract Group." Note that restrictive covenants and non-compete clauses

are difficult to enforce, more so in some states than in others, depending upon state law and judicial interpretation, and that a purchase of the covenant or clause can be made. For example, a hospital that wishes to retain a physician who has a restrictive covenant with the group that is being terminated can offer a sum of money to the outgoing group to purchase the covenant. This arrangement allows the physician to continue to work at the hospital without breach of contract.

The group should realize that a non-compete provision could actually help the group keep its contract with the hospital. The medical staff generally desires continuity in the ED, and a hospital will be less likely to terminate a group if the hospital cannot retain at least some of the group's physicians. Not only is administration unwilling to upset the medical staff, but with an enforced non-compete provision, the hospital would have to find an entirely new outside group to take over the department.

Additional language in the contract may include confidentiality provisions, including a description of what is considered confidential (employee/employer relationships, trade secrets, concepts or treatments, improvements and inventions), and what penalties (e.g., termination) will occur if confidentiality is breached. Also, the length of time that the confidentiality agreement is in effect should be explicitly stated. The contract should specify billing arrangements for patient care and specify that the individual physician is responsible for accurate billings and should have the opportunity to review billings made in their name.²

The provision for negotiating managed care contracts may need to be included in this contract. If the physician's compensation is based on a percentage of charges or collections, and the group purposefully or inadvertently negotiates a significantly lower reimbursement in a managed care contract, then this could significantly decrease the physician's income. The physician may wish to set a limit to the percentage discount that can be arranged by the group acting as the physician's authorized contracting agent. Of course, in a democratic group, the individual physician is likely to be part of the authorized contracting agent, and thus has more control over these circumstances.

The contract for a democratic group should specify how a physician becomes a partner, when the physician gains a vote in the organization as a member, the terms and cost for any buy-in provision, how shares are distributed, and other pertinent information. This portion of the contract may refer to the bylaws of the democratic group.

The term of the contract should be specified, or it may be ongoing unless terminated for some reason, as noted in the discussion above regarding termination with cause and termination without cause provisions. If the term of the contract is to be renewed or renegotiated, the contract should specify the time frame and whether the contract will renew automatically ("evergreen") unless intent not to renew or to renegotiate is given with advance (30 to 90 days) notice.

Contract Between the Democratic Group and the Hospital

When possible, it is better for the group to draft the contract between the group and the hospital. This approach potentially usurps initial attempts by the hospital to include clauses that are disadvantageous to the physician group. The group should have an experienced contract attorney review, if not draft, the contract. The hospital certainly retains legal counsel for this purpose. Expert legal advice ensures that each party is fully apprised of their respective contractual duties and expectations.

The hospital may request a copy of the contract between the contracting physician group and its individual partners or contracting physicians. The hospital may elect not to contract with a particular group due to provisions in the group-physician contract. Also, the hospital may request modifications to the group-physician contract in order to comply with hospital bylaws. In the case of bylaws mandates for

individual physician rights to due process and fair hearing, this alignment of contract language is beneficial to the contracting ED group. Conversely, the hospital may attempt to require provisions in the physician-group contract that are disadvantageous to the democratic group, such as “clean sweep” provisions (see below), or termination *without cause* provisions.

Financial agreements are an important part of the democratic group’s contract with the hospital. The contract should precisely reflect the group’s understanding of any financial help that it will receive, such as a subsidy, and should delineate clearly the timing of subsidy payments. If the group expects monthly payments, this must be stipulated. Otherwise, the hospital may elect to make subsidy payments at the end of their fiscal year, thus depriving the group of important funding during the start-up phase of the group. Please refer to the “finances” section, which discusses one strategy for front-end subsidy payment. If a loan is offered by the hospital, loan repayment and interest calculations must be clear and subject to review by the group’s tax consultant. Loan agreements can defer principle amounts as payable only if requested by the group. Such loan terms can be advantageous to a neophyte group facing the uncertainty of short-term revenue streams, which are dependent upon the billing and collections process. Specific contractual language is crucial to avoid conflicts in case of hospital leadership changes.

The contract should stipulate whether the physician group is expected to perform duties outside of the ED, such as in-house codes or other emergencies, death pronouncement of inpatients, performance of employee physical exams, fast track or observation unit coverage, or comprehensive assessment of inpatients requiring restraints or seclusion. If such services are required, the contract should specify the method and amount of reimbursement, if any, for these services. The hospital may also specify administrative expectations of the group, such as chairpersonship of department meetings and participation in hospital committee meetings or the medical executive committee. The contract should address physician expectations regarding quality assurance/improvement programs or other profiles such as departmental or physician turn-around-times and utilization of laboratory and radiology services.

Responsibilities of the hospital may be delineated, such as provision of a fully staffed ED with necessary equipment in working order, in addition to an accurate on-call physician schedule. The contract may specify the provision of a sleep room for the EP and whether meals are provided for the EP while on duty. As noted in the section addressing contracts between the physician and the democratic group, the hospital contract may contain language referring to nondiscrimination in treatment of patients, ethical treatment of patients, and compliance with federal, state, and local laws, including EMTALA. Other federal/regulatory issues may include: confidentiality, required reporting of communicable diseases, child or elder abuse cases, state-specific domestic violence reporting requirements, chemically impaired drivers and epileptic patients, testing and disclosure of HIV-related information, established living wills and advance directives, adherence to Occupational Safety and Health Administration (OSHA) and Clinical Laboratory Improvement Amendments (CLIA) laws, prohibition of patient kickback referrals and fee splitting (Medicare fraud and abuse laws), mandated age of majority, civil involuntary commitment regulations, control testing for drugs and alcohol with disclosure of results, trauma registry reporting requirements, reporting requirements for illegal drug overdoses to the department of health, and reporting requirements for suicide attempts.

Many hospital contracts allow termination *without cause* of the group with 30 to 90 days notice. If the “without cause” clause remains in the contract, then the hospital maintains powerful leverage over the group through the implicit threat of termination. The “without cause” provision weakens the right of the group to challenge the hospital’s decision to terminate the contract for no cause. Such termination decisions may be made with incomplete or inaccurate information or may have no basis other than a personal one. For example, a hospital may decide to transfer the ED contract to a relative or business ally. The hospital may legitimately argue that the group should not expect a contractual right to terminate their responsibility to supply ED physician services to the hospital *without cause* if the group is unwilling to

accept a reciprocal *without cause* agreement. A termination *with cause* provision is reasonable, preferably with a delineation of the reasons for termination in the contract.

Many hospital contracts contain a restrictive covenant stating that the group cannot contract with another hospital within a certain number of miles of the hospital during the contract and for a certain time period (often two years) following termination of the contract. Such restrictive covenants are not advantageous to the group. The group needs to consider what would happen if the hospital files bankruptcy or otherwise breaches its subsidy or salary agreements with the group. The group may not terminate the contract or ignore the restrictive covenant if the hospital files bankruptcy, because Section 365(e) of the Bankruptcy Code specifically prohibits termination of a contract due to one party's filing of a bankruptcy. However, a geographic restrictive covenant may be contingent upon a hospital's continued presence in a geographic market. An experienced contract attorney is invaluable in the articulation of these delicate contract issues.

A "clean sweep" provision in the contract between the group and the hospital requires the physician to relinquish medical staff membership and privileges (without the right to a medical staff hearing) if the group's professional relationship at a hospital is terminated. The hospital will likely favor this provision because it makes it difficult for a terminated group to create problems for the hospital by competing with a successor group (for instance, if the terminated group physicians negotiate a deal with many of the staff's physicians to manage their private patients who come to the ED). The "clean sweep" provision also makes it difficult for the individual terminated physician to create problems, depending upon the contract provisions between an individual physician and the group. If that contract contains a termination without cause provision and the group subsequently terminates a physician, the terminated physician is entitled to a medical staff fair hearing unless a "clean sweep" provision exists in the hospital-group contract. Thus, the "clean sweep" provision potentially protects the group from the retaliatory actions of a disgruntled former physician employee.

The group may prefer a contractual provision regarding the right to sell the contract or otherwise facilitate a change in group ownership. The hospital may agree to this provision with their prior approval of the change.

The contract may contain provisions for participation in those managed care plans with which the hospital contracts. Such agreements carry the implicit or explicit agreement that the physician group accepts the managed care plan's professional fee schedule as offered by the managed care plan. Without proper language to protect the group, the hospital exercises full control of fee schedule negotiations, which may include capitation fee arrangements with less than equitable capitation fee splits between the hospital and physician group. The hospital may agree to managed care plan discounts that are unacceptable to the group.

The hospital contract may specify the amount of malpractice coverage that the EPs must carry, particularly if the amount is more than that required by the medical staff bylaws. The group must be informed of the medical staff bylaws requirements prior to negotiating a higher requisite amount of malpractice insurance coverage for the group.

Concurrently, the hospital contract may require indemnification against any actions, such as malpractice or non-medically related judgments (sexual harassment, tax assessments), involving the physicians or group. If this provision is present, the hospital should reciprocally indemnify the physician and group against actions involving the hospital or hospital employees. The hospital may insist on a "hold-harmless" agreement. This provision may not protect the hospital in the case of a suit against the physician, because the patient often perceives the physician as an extension of the hospital, since the patient seeking emergency care generally chooses a hospital ED and not a specific physician. The patient retains a right to sue the hospital despite contractual agreements between the hospital and physician.

The term of the contract should be specified. Often ED contracts renew annually, but longer contracts are negotiable (two to five years unless terminated for other reasons). The contract also should specify if renewal is automatic (“evergreen”) unless a defined advance notice of intent not to renew is provided. The automatic renewal may not be desirable if either side could benefit from renegotiation before renewal. For example, the hospital may wish to decrease the subsidy over time, or the group believes that they need to renegotiate subsidy or benefit amounts. If renewal is not automatic, ensure that a defined notice is provided so that the group will not suddenly find themselves without a contract if they ignore the date of contract expiration.

Contracts Between the Democratic Group and Third Party Payers

The term “managed care” encompasses a wide variety of health care entities and delivery systems, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), physician hospital organizations (PHOs), integrated delivery systems (IDSs), independent practice associations (IPAs), management service organizations (MSOs), and physician practice management companies (PPMCs). A contract between a democratic ED group and a third party payer often involves a managed care entity.

ACEP published a textbook on managed care which discusses various methods of physician reimbursement used by managed care organizations (MCOs), such as discounted fee-for-service and capitation. Contracts between physician groups and MCOs must supply detailed information regarding the method and formula for professional fee reimbursement. An MCO generally expects a discount for care rendered to its covered lives in exchange for designation of the physician group as preferred providers. This professional fee discount is packaged in different ways, including discounted fee-for-service, reduced flat fee per patient, reduced fee schedules, capitated arrangements and global payments. In return the MCO offers additional volume to the ED as a designated in-network emergency facility for its members. Depending upon the negotiating strength of the democratic group (in other words, if the hospital is not forcing the group to accept the managed care contract as written), the group can consider making the percentage discount contingent upon, or relative to, the growth in volume over a designated period of time. The group may successfully limit the discount by asserting that the EPs have a higher cost of business due to indigent care and the stand-by costs associated with providing emergency care access to the MCOs members 24 hours a day, including holidays.

State laws may specify timeliness of payment, or so-called “prompt pay,” and other regulatory aspects of dealing with managed care plans. Enforcement of federal and state MCO mandates generally falls to the state’s Department of Insurance and Attorney General. Knowledge of the state laws by the group and its contract attorney is integral to the development of contract language consistent with state laws and regulations. For example, over 30 states have the “prudent layperson” definition of an emergency medical condition as part of state regulation or state law. In these states, the contract should not limit coverage of ED visits to anything less than the prudent layperson standard. The contract should stipulate the responsibility and breadth of the medical screening process, which includes the use of ancillary and diagnostic studies available to hospital inpatients, and the EMTALA mandate forbidding any delay of medical screening to obtain financial patient information. The MCO may request consultation with a plan representative for post-stabilization services, in which case the group should construct detailed post-stabilization contract provisions to include: 24-hour availability of an MCO-associated, qualified physician for post-stabilization consultation; maximum response time following initial ED contact of 30 minutes, after which approval for post-stabilization services is guaranteed; a provision providing authority to the treating ED physician to usurp the telephone consultant’s decision in case of disagreement between the two; and a provision protecting the patient’s right to participate in all post-stabilization care decisions.

Some state laws and regulations prohibit “gag” rules, which attempt to restrict physician disclosure to patients regarding treatment options not provided or approved by the managed care plan. However, some employer-sponsored plans are protected from state jurisdiction, so groups should not accept “gag” rules or other unfair restrictions in their contracts with MCOs.

Participation agreements or contracts with third party payers should be between the group and the third party payer rather than with individual physicians. The group should make the third party payer aware that some of the physicians in the group may be participants with the managed care plan in another setting or in another ED not associated with the group. Under these circumstances, the group’s agreement will supersede any other agreement with an individual physician and the third party payer.

It is important to include language within the contract that prohibits the transfer or assignment of the contract’s provisions to any other managed care plan without specific written consent of the group. Managed care plans may acquire another plan or make some other arrangement with another plan with which the group has a different arrangement or perhaps a higher discounted rate for services. If the plan can identify an alternative pre-existing arrangement between the MCO and a group member that is financially more advantageous to the plan, the MCO may attempt to force acceptance of the lower-cost arrangement upon the group. The contract should include language to prohibit this practice. Furthermore, it is advantageous to the group to include language that prohibits disclosure of the terms of the contract to any other third party without written consent of the group.

The contract between the democratic group and third party payers should contain language regarding due process. Managed care organizations can seek to release a physician or group for a variety of reasons, such as over-utilization of services, poor quality of care, and excessive patient complaints. Without a due process provision in the contract, decertification or deselection can occur without significant explanation or without physician right to appeal. Information used against the physician in such cases may be statistically invalid or unsubstantiated. Although some state laws address this issue, the group is smart to address this contractually.

As noted in the discussions above with respect to contracts between the democratic group and physicians or hospitals, a termination *with cause* provision may be fair, preferably with a delineation of the reasons for termination within the contract. The group must retain the right to terminate a contract with the managed care plan (usually with a designated number of days notice) in cases such as nonpayment or late payment, for reasons of potential compromise in patient care, or for a breach in the contract agreements. However, a termination *without cause* provision should be avoided.

The contract likely will contain hold-harmless and indemnification language to indemnify the managed care entity or its employees from any lawsuits involving the physician. Legal counsel generally advises physicians and groups not to sign hold-harmless and indemnification clauses in contracts with third party payers. Also, most malpractice plans will not cover any indemnification settlements.

The term of the contract should be specified unless termination on either side occurs sooner for other reasons. The contract should also specify if renewal is automatic unless intent not to renew is provided with a designated time frame. The automatic renewal may not be desirable if either side could benefit from renegotiation before renewal. Beware of contract provisions that allow unilateral amendments, such as changing the reimbursement rates or applying alternative fee arrangements without written approval of the group. The contract should provide the group with the right to reject an alternative fee arrangement without terminating the group’s right to provide services to existing patients or groups under the contract. The pre-contract stage offers the group the best opportunity for protection from future bankruptcy of the third party payer. The group and its attorney should consider the effect of bankruptcy on restrictive covenants, termination provisions, collateralization, and other contractual issues. As mentioned in the

discussion regarding contracts between the group and hospital, it is important to specify the circumstances under which a restrictive covenant becomes null and void, including third party payer bankruptcy or failure to pay. The contract should contain language that provides the group with the right to terminate the contract, with notice, for breach of provisions in the contract, so that the group can terminate for non-payment. Without such language, the group may be forced to continue to provide services without payment if bankruptcy is filed, per Section 365(e) of the Bankruptcy Code, which specifically prohibits termination of a contract due to one party's filing of a bankruptcy. Of course, the EPs must provide emergency medical screening and stabilization to everyone presenting to the ED, pursuant to EMTALA. Without detailed contract language outlining the group's right to terminate the contract for breach of provisions, the group can be prohibited from balance billing the patients of a bankrupt MCO.

Finances

There are several ways to finance the start-up of a democratic ED group, and a combination of these methods may be required. Under certain circumstances, financial issues may represent the most formidable barrier to starting a group.

According to a major company ED physician recruiting firm, a new ED group should project a start-up practice expense of \$10,000 per 1000 annual patient visits. Thus a relatively small hospital ED that treats 12,000 patients annually, needs access to approximately \$120,000 to cover practice expenses pending significant revenue flow from patient billing and collections. A 50,000 annual patient visits contract requires approximately \$500,000. Bear in mind that these are, at best, very rough estimates. A small business consultant or experienced CPA can provide more accurate projections based upon the facility's historical financial data, patient demographics, and estimations of future ED census growth or declines. Please refer to the section on "Compensation" regarding various start-up and ongoing practice expenses.

Generally speaking, revenue from patient accounts receivable begins to flow approximately 4 to 9 months following initiation of billing. Receipt of billed revenue during the first few months of operation is dependant upon establishment of provider numbers, efficient hospital processing of charts to facilitate receipt of pertinent medical record data to the physician billing operation, and the ability of the billing operation to gear up for the task. If these items are in place, a neophyte group may recognize as much as 10% of billed revenue within the first month. ED physician staffing for a new hospital entails more financial uncertainty, since the group has no idea how many patients will arrive on day 1 or day 31. The accounts receivable is the amount of money that is billed for services rendered by the group, but is not yet received. The accounts receivable as a percentage of billings is high during the start-up phase and is expected to shrink over time. Unless specific negotiations occur, an incoming group will not receive revenue generated under the prior group's provider numbers. On occasion the hospital assumes the accounts receivable of the previous group as reimbursement for debt owed the hospital by the prior group, such as for start-up loans.

One method to finance start-up costs is through a subsidy. The group may be able to negotiate a subsidy from the hospital in the form of a lump sum to cover projected start-up costs or as a monthly stipend that reduces over time. As noted above, the group must project financial needs for the ensuing 4 to 9 months when negotiating a subsidy. Unfortunately, the new democratic group may be competing for the contract against an established group that does not require a subsidy. If two competing groups each require a subsidy, the negotiation with the hospital becomes particularly challenging if the groups are blinded to their opponent's offer in a "lowest bid" race. If faced with this situation, the group must emphasize its strengths in regards to quality patient care, focus on patient and staff satisfaction, dedication to efficient patient care systems, and willingness to secure alternative means of funding, if necessary and plausible. In the end, the group must remain realistic about the ability to generate sufficient physician earnings from the contract and must walk away if a subsidy is required, but not offered. The group may consider

offering a potential “win-win” situation for the group and hospital by accepting a sequential subsidy that falls over time contingent upon improved patient satisfaction and subsequent census growth, improved physician documentation (which positively impacts hospital reimbursement under the Ambulatory Patient Classification [APC] system), and increased ED procedures due to the expertise of the incoming group. Please refer to the section on “Contracts” regarding the hospital provision of a temporary or ongoing subsidy. Bear in mind that start-up financial projections must include not only historical data but also solid projections regarding future patient census and demographic changes, since these factors may produce major discrepancies between past and future collections. Most billing companies will look at several random and separate weeks of accounts and estimate what they can expect to bill and collect, and they will usually perform this service free of charge, in the hopes of winning the billing contract. A billing company may inflate projected collections in order to secure business. Conversely, the billing company may underestimate the expected accounts receivable, either to impress a new client when actual collections are higher or to gain from a bonus program in their contract.

If the hospital offers a partial subsidy, request prepayment to avoid the need for additional start-up funding. If the hospital agrees to a monthly subsidy amount, the hospital may be willing to pay the first year’s amount as a lump sum payment to the group, which helps offset start-up expenses. If the hospital is concerned about the time value of money and the subsequent loss of interest revenue through front-end, lump sum payment, the group may counteroffer to accept the lump sum amount minus the potential interest income amount based upon a standard market interest figure, such as the LIBOR rate of interest published daily in the Wall Street Journal.

Most new groups require an established line of credit to cover ongoing, short-term expenses that are not reimbursed by subsidy. One potential source for this loan is the hospital, since it has an inherent interest in the success of the group. This loan method removes duplication of effort, since the hospital generally is aware of the group’s financial position at this juncture and requires less additional personal financial information than a lending institution, such as a bank.

If the hospital is unable or unwilling to loan the money, then the group must approach a professional lending institution. At this point, the group must prepare a business plan, probably with the help of a CPA or small business consultant. Most banks consider loans for a well-organized physician group to be relatively low risk. However, it is unlikely that the bank will lend the money directly to a new group, because the group lacks credit history. Often each physician member must apply for the loan or line of credit, and each member likely will be held jointly and severally liable for the total loan amount. If one or more of the physicians has a poor credit history, then it may be prudent not to include that physician or those physicians in the loan application, realizing that this may cause resentment on the part of the other physicians who are placing their personal guarantees on the line to start the democratic group. Some compromise may be necessary, such as awarding extra shares to those applying for the loan, providing those physicians with a pre-determined bonus when the credit line is no longer needed, or providing more unpaid administrative duties to those who cannot assist with the loan.

Since this is a democratic group, the members may elect to apply for a smaller loan or line of credit and compensate by working a certain number of shifts for less pay or without pay, until such time as the revenue stream begins. A related option is to work initially for shares rather than cash money. However, if the members elect to use this option to help reserve cash on the front end, then a limit should be set for the number of shares that can be acquired through this method. Another method to conserve cash on the front end is to establish a graduated pay scale that increases over the start-up period, such that the physician eventually is compensated for underpaid clinical work performed early in the contract period. The group should confer with their CPA or tax attorney regarding tax implications of substituting shares for cash and that other creative ways of reducing the group’s initial financial burden comply with state regulations for corporations and employees or independent subcontractors.

Recruiting for a Democratic Group

Recruiting can be a very time consuming and expensive proposition for any democratic group. There are several ways to approach recruiting from doing it completely on your own to retaining a firm for an exclusive search. To determine which alternative is best for your group four questions must be answered.

1. How quickly do you need a physician for your group?
2. What time of year are you beginning your recruitment?
3. How much money are you willing to spend on recruiters?
4. How much time is your group willing to spend screening applicants?

The least expensive, but most labor intensive, approach is to have your group recruit its own new physicians. This recruitment technique requires advertising through journals, the Internet, medical newspapers, and notification of residency programs of job opportunity. Finding potential EPs through print advertising requires a minimum of three months due to publication lead times. Internet advertising has not yet proven itself as an effective means of recruiting. Residency programs sometimes limit access to their residents-in-training. A thorough background screen and extensive reference check must be completed for each EP applying for a position. Evaluating potential candidates prior to a site visit is the most important, cost effective, labor-intensive segment of the recruiting process. When done correctly site visits are offered to physicians who appear to be a good match for the group and are genuinely interested in the position. Democratic groups using this approach must supply travel arrangements and expense reimbursement for interviewing candidates. Site visit interviews allow the candidate to evaluate the job and the community. The democratic group should use this time to reinforce their decision that the applicant physician is a good fit for the group. This recruiting method is best suited for those groups that are willing and able to properly screen applicants and recruit proactively. Recruiting activities for graduating residents should begin 10-12 months prior to the June month of residency completion.

The most expensive recruiting approach is retention of a search firm. The cost for most retained searches is \$20,000-\$30,000, or more, per position. However, a retained search can be very beneficial to a group not willing to spend the time and effort identifying and screening potential candidates. Professional recruiters should know the strengths and weaknesses of your available position. The candidates' credentials and references are screened, and the candidate is evaluated relative to potential fit with the group. This "prescreening" process allows the democratic group to spend their time considering only candidates that appear to meet their needs. Successful recruiting generally occurs more quickly through a recruiting firm, since recruiters generally have a number of candidate physicians in queue at any given time. Although this approach saves time and effort, the group maintains the ultimate responsibility of proper hiring decisions.

One additional recruiting option is the use of non-retained recruiters. These recruiting groups generally charge approximately \$15,000-\$20,000+ per successfully placed candidate. The use of multiple non-retained recruiting firms provides exposure to the most potential candidates in the shortest period of time. However, these recruiters usually do not screen applicants as thoroughly as a retained search firm. The group must dedicate more time for pre-interview screening.

As a group assesses their recruiting needs, it must honestly answer the four questions stated previously. The answers provide the necessary framework for planning and initiating successful recruiting efforts.

Coding, Billing, and Reimbursement For Emergency Services

Emergency department professional services typically consist of low dollar, high volume claims. The key to successful reimbursement is complete documentation coupled with proper translation into the appropriate level of care designation. This generally leads to submission of a “clean claim” to the proper insurance carrier under the correct provider number. The group must first decide who will perform coding and billing services on behalf of the group: the group itself (unusual in today’s environment); the hospital; a third party professional billing and coding organization; or, a hybrid of these methods. The complicated and confusing environment of insurance company, MCO, and legal/regulatory requirements makes it difficult, if not impossible, for a group to effectively perform its own billing and collection without employed billing and coding specialists. Hospital billing departments have a long history of inefficient (with protracted accounts receivables periods) and ineffective practices relative to emergency physician professional fee reimbursement. Most ED groups contract with a third party to perform billing and collection services. For the purposes of this discussion, we will assume that the physician group contracts with a coding and billing organization or hires in-house personnel to perform coding, billing, and collection services. It is extremely important to remember that, regardless of who performs coding and billing on behalf of the physician group, the individual physician ultimately is responsible for claims submitted under his or her provider number.

Coding

Coding to the proper level of care for all billable services consists of a number of key components. Coding must be consistent with the nature of the presenting problem and compliant with HCFA Documentation Guidelines for Evaluation and Management (E/M) services. Accurate and complete charting, as discussed in a later section entitled, “Emergency Department Charting Methods,” is essential. Physician education regarding the components of E/M services and HCFA requirements is requisite. Another critical component of successful coding is the submission to the coder of the full chart including the physician documentation, nurse’s notes, EKG and radiographic interpretation reports, and the physician order sheet. ED groups often rely upon the hospital to provide copies of these documents. The group must establish a solid professional relationship with hospital staff members responsible for this duty. Omission of any supporting documentation can lead to a substantial reduction in reimbursement amount. Some groups elect to hire clerical staff to facilitate this transfer of information to this billing entity.

Select a coding company that has expertise in ED coding, obtains periodic external reviews of coding compliance, and has a comprehensive compliance program that is in accordance with the recommendations of the US Office of the Inspector General (OIG). The group should examine the results of external reviews and compliance programs. Communication between the billing company and the group is imperative, particularly regarding the group’s method of interpretation of, and potential billing for, electrocardiographic and radiographic studies. The group should expect monthly reports demonstrating the number of claims that are downcoded due to insufficient documentation and the subsequent revenue loss per physician. If trends emerge that identify certain physicians as consistently poor documenters, this physician profiling data may be used to educate these physicians and, potentially, to reduce income or bonuses to the physician as a penalty.

Billing and Reimbursement

The first challenge that a newly established group faces in the billing and reimbursement arena is obtaining new federal provider numbers. Whether the group elects to do this themselves or to defer this duty to the group’s billing company, it is the most important first step. The failure to promptly obtain these numbers can result in months of delay in receiving payments. This becomes more crucial if federal

payers comprise a relatively large portion of the group's payer mix. Obtaining provider numbers from the Medicare and Medicaid programs typically requires several weeks to several months. The group must apply for provider numbers at the earliest possible moment, preferably well in advance of initiating services. Simultaneous with the submission of provider number applications, the group also should complete electronic billing, electronic payment and electronic remittance advice forms. One should not assume that the application is in process despite having confirmation that the intermediary is in receipt of the application. The first follow-up call should be placed at the 2-week mark. Applications sometimes are lost or misplaced and must be resubmitted with an original signature from the physician.

The second important step is selection of a billing company. Prior experience with ED billing in a particular state is preferable, and experience in the group's particular market is helpful. The group should expect a very high percentage of "clean claims" with initial claim submission. Achieving success in this regard is multi-factorial. The hospital must provide accurate patient demographic information, which sometimes is not properly updated at the time of ED service. Insurance verification prior to submission is necessary in markets where there is a high penetration of managed care, particularly HMOs. The group should find a billing company that is willing and able to devote the resources necessary to verify information, either electronically or through on-site physical presence.

The group should interview 2 to 3 candidate billing firms prior to selecting one. Due diligence in the selection of a firm includes: review of the company's financial position and statements; the company's written compliance plan demonstrating compliance with state regulatory standards and the federal OIG recommendations; the firm's method of monitoring for discrepancies between expected reimbursement and reimbursement paid; the firm's system for resubmitting underpaid or unpaid claims; the firm's understanding of federal and state legislation and regulation regarding the prudent layperson standard for an emergency medical condition; the company's appeals process; the firm's balance billing process; the firm's use of technology such as electronic billing and the procedure for reconciliation of rejected reports; the firm's method of protecting filing deadlines in the event provider numbers are not issued in a timely manner; the company's bad debt collection process; and, the firm's compliance monitoring process.

Most billing companies successfully collect claims for patients with accurate demographic information who are insured by a reputable carrier. To ensure collection of more challenging claims, the billing company must run monthly extracts to identify those carriers not compliant with the group's fee schedules. Monthly extracts also identify carriers that are inappropriately denying claims. Claims delineated by the extracted data are resubmitted to a designated provider representative the respective payer institution (not to the original claim submission address). Over thirty states have prudent layperson emergency medical condition laws or regulations which ban emergency services denials based upon ICD-9 codes. Insurance claims should be followed up either electronically or through a telephone call within 60 days of nonpayment. The billing company should balance bill the patient no later than 60 days following non-payment (unless this practice is specifically prohibited by the carrier or MCO). A less aggressive approach involves contacting the patient to request their assistance in facilitating payment by their carrier. The top 12 to 15 carriers typically account for approximately 80 to 90 percent of outstanding accounts receivable, excluding self-pay patients. The billing company selected should have established relationships with these top carriers in the group's market or, alternatively, be willing to devote the time and resources to quickly develop those relationships. Collecting these dollars makes the difference in the group's ability to recruit, retain, and appropriately compensate top quality emergency physicians.

The group should clearly communicate expectations on performance goals, service levels and monthly reporting requirements. The group or their designee should meet and interview the person who will function as the group's account manager. References must be checked to confirm the firm's track record of cash collections versus expected collections. The group should review background information and

credentials of key personnel. Immediate outsourcing of self-pay accounts to collection agencies is a consideration.

After contracting with a billing company, the group must monitor performance closely. Metrics to follow include: average charges per visit versus expected charges per visit; average collections per visit versus expected collections per visit; ongoing review of patient demographics and payer mix; and month-end reports to include accounts receivable aging by payer and credit balance reports. The group should ensure that commercial carrier classifications are detailed at a level that allows you to determine if you have specific payer problems. Monitoring of these aging accounts helps to determine if accounts are aging past industry averages. The accounts receivable should be calculated in days by payer type based upon the last 90 days to evaluate collection performance. An office manager or business manager, if the group elects to employ one, can be a valuable assistant to the group in these matters. Carriers often will respond more favorably to the medical group than to the billing company, so a group designee must be available to assist in these issues. If the group identifies performance issues, these must be communicated openly to the billing company in writing and on a timely basis. In this circumstance, the group should require the company to prepare an action plan, inclusive of timelines and specific staff accountability, to resolve the issues. The group should compliment the billing company when its performance warrants.

Physician Compensation (Clinical, Administrative, Deferred, and Shareholders)

Compensation for Clinical Duties

In forming a democratic ED group, the physicians must opt for employee or independent contractor status. A related consideration is Medicare's stipulation that it must pay directly to the individual physician unless the physician is an employee, in which case the reimbursement can be paid to the group (employer). The physician remains responsible for billings under his or her provider number regardless of the reimbursement arrangement, and the physician should have access to their individual billing and collection records. If the group acts as an employer of the physicians, the company (employer) can use a single provider number. This prevents submission to other facilities that an individual physician has worked. Another consideration is the option of employee benefits, such as health insurance and pension plans, under an employer-employee model. Such plans also are available to independent contractors through independent arrangements, and these arrangements are not subject to some of the restrictions imposed by state and federal laws upon employers providing benefits for employees. If the physicians opt for employee status, the group, as opposed to the individual physicians, pays an additional 5% in matching FICA taxes. Furthermore, the group may be held jointly liable in malpractice cases for the actions of an employed physician. The independent contractor offers less exposure, not complete immunity from malpractice action, in this regard.

The Internal Revenue Service (IRS) does not hold a group responsible for withholding taxes from an independent contractor physician. The IRS applies multiple criteria to determine that a physician meets the definition of an independent contractor. If these criteria are violated, the group can be held liable for any unpaid taxes, and possibly additional penalties, on behalf of the physician. Consultation with a qualified CPA or small business consultant is essential to determine the group's preferred business model.

In the absence of a hospital subsidy, failure to project accurately the first year revenue and expenses can be detrimental to the group. As discussed in a previous section, the group must either compensate physicians during the first 4 to 6 months on par with net income projections, with the inherent risk to diminishing compensation over time should projections fail to be accurate, or to under-compensate during the early months with the possibility of bonus income or increased hourly compensation. The clinical physician compensation may be based upon an hourly set amount, a fluctuating amount based upon defined criteria (see below), or can be based upon a percentage of gross or net billings, with that

percentage based upon predetermined criteria (see below). Finally, a combination of these methods may be used.

The group needs a reasonable projection of expected revenue, as discussed in the previous “Finances” section. To this estimate, the group may add any available subsidy, followed by subtraction of projected malpractice insurance costs, billing and collections expenses, legal and professional fees (i.e., CPA, contract attorney, small business consultant), employee benefit costs (i.e., health, disability, dental, life insurance, pension/retirement plan), administrative costs (see below), and other operating expenses (i.e., interest on loans, office rent and utilities, non-physician personnel salaries and benefits, phones, pagers, recruiting fees for physicians). The group may incur administrative expenses such as limited office space, clerical assistance, or a practice business manager. Employee-employer models must subtract projected federal and state business taxes. The difference between these estimated revenue and expense figures provides a projected net income, which serves as the basis for physician compensation calculations. The group may elect to under-compensate clinical duties in the start-up phase in order to protect against projection error and, in the best-case scenario, to create reserve cash.

Another method for calculating clinical compensation is to calculate the expected monthly income [based on relative value unit (RVU)] data provided by the billing company) and subtract malpractice costs, billing costs, and fixed expenses such as office space. Fifty percent of this figure may be applied to direct physician compensation. The remaining 50% each month is used to pay monthly deductibles on items such as health, disability, dental, and life insurance policies. One-half of the remainder is paid as bonus compensation to the physicians, monthly or quarterly. The remaining half is held to cover for unforeseen expenses. At the end of the fiscal year, the remaining funds can be distributed. The group may prefer, in consultation with their accountant, to time disbursements before calendar year end if this offers a tax advantage. This method of compensation provides a financial cushion in case ED volume falls unexpectedly or revenue projections suffer due to managed care influence or other negative forces. The group should decide in advance if differences in pay or future distributions are based upon defined criteria, such as patient turn-around-times, documentation completeness and accuracy, number of procedures performed, number of patients seen, responsiveness to patient/staff/administration complaints, attendance at meetings, resource-based value units/hour (such as RVU), or commendations. The group also must address overtime issues, such as payment for work beyond a scheduled shifts end. The group may choose to reimburse group members to serve as a designated back-up physician to the ED. Solid physician selection and recruiting should produce a group of motivated, collaborative physicians who approach such issues fairly and equitably.

Compensation for Administrative Duties

Administrative demands vary relative to the size and number of hospital contracts the ED group maintains. Administrative effort on behalf of the group is required to select a billing company or design a billing system, arrange for malpractice insurance, investigate health, disability, dental, and/or life insurance options, investigate pension and retirement plan options, arrange for an attorney to incorporate the group, and to negotiate with the hospital and with managed care plans. If all members divide these tasks equitably, initial administrative compensation may consist of “sweat” equity alone. Some members of the group may be more qualified or experienced in these matters than others, so the group must decide how to fairly compensate administrative hours if they are not shared equally.

The group must properly reimburse medical director activities. This may consist of hourly compensation commiserate with clinical activity or a percentage of group net income. These methods tend to peg the amount of medical director reimbursement to the patient volume of the ED, since higher volume facilities generally require heavier administrative demands. If an assistant medical director is desired, the designated amount of medical director compensation generally is divided between the medical director

and assistant director, in a ratio of approximately 2:1. Alternatively, a group simply may designate a specific amount for medical director compensation.

The neophyte group may lack the cash to fund administrative duties at the outset. Options in this circumstance include: deferral of administrative pay, plus interest, until cash becomes available; distribution of administrative activities among the group members, without compensation, until such time that cash is available to fund a medical director position; or, allocation of equity shares in return for administrative duties. If the group chooses the latter option, the group must decide if group decision-making is based upon the one person-one vote principle or upon votes/share. An inherent danger in the vote/share method of decision-making is the potential for unequal group control and subsequent loss of the democratic group model.

Deferred Compensation for Outgoing Members

The democratic ED group may elect to offer a deferred compensation plan, with eligibility contingent upon number of years with the group. The group's business consultant, attorney or CPA can assist with state-specific regulations in this regard.

Deferred compensation plans are designed to reward a physician for service over time when the physician faces retirement, health issues, career changes, or otherwise leaves the group in good standing. Deferred compensation provides the physician a return on his or her time investment by transferring a portion of the contract market value to the departing physician. Qualification for deferred compensation often requires 10—20 years of full-time service to a group. Although various methods are used to calculate deferred compensation amounts, one such calculation is based upon net receipts for each year of eligibility. The first year of deferred compensation is valued at 10% of net receipts. The second eligible year's value is calculated from 10% of year two's net receipts plus 20% of this figure: [(Net Receipts x 0.01) x 0.20]. For year three of eligibility, the calculation is 10% of year three's net receipts plus 30 % of this figure: [(Net Receipts x 0.01) x 0.30]. The formula graduates over time at an additional 10% for each year of eligibility (e.g., the years of service beyond 10-20 years, whatever is designated by the group). For departing, long-term employees a group that is financially successful, the payout may occur over 3-7 years to avoid depletion of the group's fiscal reserves.

Shareholders

The group can decide, perhaps assisted by an attorney or CPA, whether shares should be awarded to group members in single digit designations (for example, one share per year worked, to a maximum of 5 shares, with an extra share for ten or fifteen years) or in multiple digit designations (for example, 5000 shares to start, with an additional 5000 shares after two years, and so on).

Of utmost importance when founding a democratic ED group is the decision, as discussed previously, to base decision-making upon the one person-one vote principle or upon votes/share. A truly democratic group allocates an equal vote to each member, even if shares are not equal. The group needs to decide whether or not to set a limit on the number of shares an individual physician can acquire.

Most groups require a physician to compile a minimum number of hours prior to offering shareholder status. The group must decide if physicians become shareholders immediately or following a trial or buy-in period. Most groups institute a buy-in period of approximately two years. All criteria that lead to partnership should be in writing, particularly if partnership is not automatic at the end of the buy-in period. Written guidelines should state whether the new partner must pay for eligible shares at the end of the buy-in period, and these guidelines should describe the calculation used to determine the cost of shares. Some democratic groups count the work performed during the buy-in period toward the purchase

of shares by allocating to the new shareholder a quantity of shares identical to that awarded to the existing shareholders during the buy-in period. The group also must choose a method to reward a member or members who identify a new contract or other source of revenue for the group.

Generally, distributions of overage or profit are based upon a physician's quantity of shares. Therefore, if the contract is sold or terminated, the net proceeds from the sale plus the remaining accounts receivable, which may be protracted over many months, are distributed based on share quantity.

Emergency Department Charting Methods

Emergency department charts are legal documents that document a patient's visit. Other physicians (primary care providers, consultants, and ED physician colleagues), third party payers, coders, and ED administrators rely upon ED documentation to perform their respective duties. ED medical directors use ED records for ED performance improvement initiatives and quality assurance. Academicians use this information for clinical research. The ED physician record became fundamental to hospital reimbursement with the advent of ambulatory procedure codes (APCs). Because the ED chart is vital to so many crucial functions, documentation must be legible, complete, and accurate. The ED physician prefers charting methods that facilitate, not detract from, patient care. This section discusses various ED documentation methods. The individual ED group's choice of a charting method depends upon individual needs, hospital and group infrastructure, and resources.

Traditionally, the handwritten chart is used for documentation throughout hospitals. Handwritten charts are inexpensive and can be accessed immediately after completion. As an additional convenience, these charts can be completed at bedside. Handwritten charts often are illegible or incomplete,³ and are rapidly falling out of favor due to federal documentation regulations, reimbursement issues, and medico-legal concerns.

A second common method of ED physician documentation is voice dictation with transcription. Compared to hand written charts, dictated charts are more complete and legible.^{3,4} In a study comparing dictated charts to handwritten charts, dictated charts were preferred over handwritten charts by physicians, and the charts were completed more quickly.⁵ There are some negatives to dictated charts. Dictation incurs higher costs, may not reliably fulfill all HCFA documentation requirements. Dictation, as it currently exists, is not available at bedside and requires variable transcription turnaround time. Hospitals that provide dictation services to emergency physicians often seek to transfer the cost of documentation to the physician group.

Recently, template charting became a popular method of ED physician documentation. Some template systems apply a general, all-purpose template that can be used for any patient, while other systems employ a symptom or problem-oriented multiple template system. These paper-based charting systems appear to improve completeness of documentation^{6,7,8} and billing,⁸ allowing more time for physician-patient interaction.⁶ Template systems are substantially less expensive than dictation with transcription but are more costly than handwritten charts (which generally are provided by the hospital at no cost to the physician group). The template chart is available immediately after completion and can be completed at bedside. In a study comparing templates and handwritten charts, physicians preferred the template.⁸ The template format has an additional advantage as a proactive risk management tool. Through its preformatted structure, templates prompt the physician to address pertinent negatives and high-risk diagnoses. The downside of templates is that the charts are handwritten and not in traditional narrative; this makes them more difficult for others to read and interpret. Subtleties of individual patient presentation and interaction are more difficult to communicate with a template compared to dictation.

Computer based charting programs offer another charting method—the most common being voice recognition software programs. Some voice recognition programs are free form dictation, while others contain templates that prompt the physician to fill in blanks for specific complaints. To their advantage, these programs produce a medical record in the traditional narrative format. The charts are immediately available. They are electronic; thus, the information can be integrated into other electronic portions of the medical record, tracking systems, discharge instructions, and prescriptions. Because the chart is part of a searchable database, the computerized chart facilitates performance improvement and research projects. Some programs, by searching the database, can identify the CPT and ICD-9 codes in the chart. Current weaknesses of computer-based charting systems include technological limitations of voice recognition software. Inaccurate voice translation requires the editor, often the physician, to correct mistakes by keystroke, stylus, or mouse. Some charting services suggest hiring a clerical worker to proofread charts. This produces completion delays and new costs. Currently, voice recognition systems are difficult to use at bedside due to the background noise inherent to EDs. As with traditional dictation systems in patient care areas, patient confidentiality is an issue.

Computerized templates with touch screens are an evolving ED documentation strategy. Touch screen documentation systems, combined with handwriting recognition software may allow high technology, discrete bedside ED documentation in the near future.

Finally, some ED groups use scribes for charting. Scribes are personnel who accompany the physician into the patient's room and take notes during the encounter. These individuals receive a short course of training, often by the physician group, regarding medical jargon and other necessary skills. Some groups expand the scribes' duties to include other physician support services such as collecting lab and radiological data or constructing discharge instructions. Unfortunately, many groups recognize a high turnover rate of trained scribes, since they often are students awaiting admission to medical school or completion of health care related programs. Scribes are expensive, and their work requires review by the physician prior to signature; however, many physicians feel far more efficient and effective with a scribe. These physicians argue that scribes offset their cost through increased productivity. Productivity gains may include: reduced malpractice risk through impeccable documentation; decreased downcodes due to incomplete documentation, and increasing physician productivity by transferring physician attention and time to patient interaction. One might counter these arguments by suggesting that similar gains are available through the use of efficient, accurate template or user-friendly computer-based systems.

Emergency Department Management

In many groups, the medical director handles the managing aspects of the ED through a combination of clinical shift and administrative duties. Some groups distribute the medical director administrative duties amongst their partners. Regardless of how the administrative work is distributed, time spent on required administrative duties should be compensated fairly (please refer to the subsection, "Compensation for Administrative Duties.")

Other sections of this information paper discuss the various aspects of ED management including performance improvement, patient satisfaction, physician recruiting, and physician management. This section discusses other aspects of ED management that neophyte democratic groups should address.

Benchmarking

Often, as part of the agreement between the group and the hospital, the two parties work together to set achievable goals for the ED. Often this is accomplished through benchmarks. Benchmarking is an industry term used to describe the ranges of best practices or best efficiencies. Benchmarks are tools that aid in setting goals and should not be used as absolute hurdles or metrics. Also, benchmark data may vary

relative to its geographic scope—local, regional, or national. Benchmarking must account for, or at a minimum recognize, differences between hospital type or size, data collection methods and standardization, and geographic variations in practice style or methods. Some commonly benchmarked data items include:

1. Left without being seen/AMA rate
2. Patient flow times--
 - a. ED arrival to triage
 - b. Triage to room arrival
 - c. Triage to registration
 - d. Room arrival to MD evaluation
 - e. MD evaluation to disposition
 - f. Discharge order to patient discharge
 - g. Admission order to ED departure
3. Ancillary test efficiency
 - a. Lab ordered to lab arrival of specimen
 - b. Lab ordered to lab completion
 - c. X-ray ordered to completion
 - d. ECG ordered to ECG completion
4. Physician efficiency
 - a. Resource utilization (e.g. number of labs/X-rays/CTs ordered)
 - b. Patients seen per hour
 - c. RVUs per hour (adjusts for patient volume and acuity)
5. Other staff efficiency
 - a. Staff hours per unit of service
 - b. Staff to patient ratios
6. Admission rate
7. Patient satisfaction

Traditional collection of the data from the group's hospital is through chart review. Computerized medical record software or patient tracking systems can generate this information more easily and efficiently. Through awareness of benchmarks and their applications, the ED group can negotiate with the hospital for a reasonable set of goals to optimize the physician practice, hospital efficiency, and patient satisfaction.

Patient Flow

There are various means of tracking ED patient flow. A simple, traditional approach is through use of an ED “grease board,” or with a large board and erasable pen. On this board one can locate all of the ED patients and additional information, which may include: time of arrival, name or initials, age, chief complaint, disposition, and a place for the physician to “sign up” for the patient. Larger, segmented EDs may require 2 to 3 patient boards. Patient confidentiality issues prompted many EDs to abandon the use of patient boards or, at a minimum, to greatly limit the information provided on them.

Some EDs are segregated into patient care pods, with designated nurses and physicians assigned to care for the patients in a particular area, or pod. The limited number of patients in each pod generally precludes the need for a patient board.

An alternative patient tracking system, the computerized ED tracking system, is growing in popularity. These systems function as a virtual patient “grease” board. Some systems simultaneously track ancillary tests and create printable discharge instructions and prescriptions. Advantages of computerized patient tracking systems include: confidential tracking of all patients in the ED (including triaged patients);

simplified collection of benchmark and quality assurance (QA) data; efficiency notification of diagnostic study completion; and, legible, neat discharge instructions prescriptions. The disadvantages of computerized patient tracking systems include the expense of purchase and maintenance and the requisite, albeit short, learning curve essential for their effective use.

For discharge instructions, many EDs use a preprinted general form with some common instruction options that can be designated by circling an instruction or checking a box. Some groups generate customized discharge instruction sheets for certain disease entities or problems that briefly explain the disease or problem and provide specific instructions (e.g., head injury, wound care, gastroenteritis). If the group does not wish to create their own discharge instructions, it can purchase them through private companies or physician organizations (e.g., ACEP state chapters).

ED Policy Manual

Every ED should have a policy manual that is easily accessible to staff for reference. This manual should contain copies of pertinent ED policies. This includes policies on subjects such as EMTALA, the hospital disaster plan, chemical/toxic exposure management, on-call physician responsibilities, sexual assault management, domestic assault management, and suspected child abuse management. The ED policy manual also may contain patient care pathways and ED triage protocols.

Patient Care Pathways

Many hospitals assign multi-specialty, multi-professional committees to design care pathways for guidance in patient care. These pathways expedite care and offer additional benchmarks to assess quality and expediency of care. Common patient care pathways that are initiated in the ED include those for acute myocardial infarction, stroke, asthma, congestive heart failure, community-acquired pneumonia, and diabetic ketoacidosis. The policy manual should articulate that these pathways provide patient care suggestions, but do not dictate care for individual patients or replace attending physician judgment.

Similarly, many groups use symptom-based triage protocols that facilitate the initiation of patient care by nursing staff. These protocols may be as simple as ordering a radiograph for a suspected fracture, or may initiate a more complex evaluation, such as for suspected ischemic chest pain. Triage protocols can expedite patient care by reducing the elapsed time to initiation of diagnostic testing or treatment. These protocols should be designated as suggestions, but not as specific patient management requirements.

Hospital Interactions

The EPs interact with nearly all departments of the hospital. As a result, the democratic physician group must be involved in their hospital, beyond simple shift work; including active participation on hospital committees. This involvement is especially important for those committees that commonly address ED issues, including the medical executive committee, medical staff quality improvement committee, ambulatory care committee, trauma committee, ad hoc committees for patient care pathways, and pharmacy and therapeutics committees. The medical director or a group representative must attend these meetings to speak for the ED physicians and to demonstrate the group's commitment to the medical staff and hospital.

Direct staff relations are very important as well. The ED group's most pivotal relationships are with the director of emergency nursing, nursing staff, and ancillary ED staff such as ED technicians, laboratory technicians, radiology technicians, respiratory therapists, housekeeping personnel, and ED registration personnel. When appropriate, the ED group must involve these team members in ED improvement processes and programs. Some groups develop funds to purchase flowers, cards, or other items

demonstrating appreciation for the work and support of other physicians, nurses, clerks, and ancillary staff members. Many groups use such funds to finance an annual party for all those intimately involved with the ED. The democratic group should encourage their physicians to participate in simple activities such as eating lunch at the medical staff lounge, attending general medical staff meetings, and attending community fund raising events. These gestures lead to a more amicable and productive relationship with those involved in the everyday functioning and success of a democratic group.

Finally, the democratic group should understand how to market itself. From meeting or exceeding predetermined benchmarks or sponsoring a morale-building party, the democratic ED group must represent itself in a manner that builds confidence in and respect for the group. This fosters a long and productive relationship with the hospital and its staff. Involvement in organized medicine adds prestige to the group and brings in new ideas and connections through which the group may continue to grow and develop. Community activities such as volunteering as medical backup at an athletic event, speaking to the media on public health issues, and the word of mouth reputation of the group create additional value to the democratic group's practice.

Physician Group Compliance

In 1995, HCFA produced a set of documentation guidelines intended to support the level of service charged to the federal government by physicians. Over the last several years, the federal government increased investigations targeting physician fraud and abuse, including inappropriate coding and billing practices. These investigations triggered many prosecutions and hefty fines for health care providers, including physician groups and individual physicians. In order to assist physicians in avoiding fraud and abuse investigation, the federal government suggested that physicians and physician groups develop written compliance plans, followed by implementation of these plans into active programs. Recently, the OIG outlined its expectations of small physician groups, which includes many ED democratic groups, for compliance. This document is available on the OIG website or from a regional HCFA office. These OIG guidelines detail how a group should design their compliance plan. These guidelines outline such steps as an initial audit to assess risk, ongoing physician education, and continuing audits. Every democratic group should construct and implement a compliance plan for their organization. Any compliance activity performed (such as physician education) should be documented and include physician signatures, if appropriate. Finally, the group should confirm that other entities with which it interacts, such as the hospital and its billing company, have a complementary compliance program in place.

Physician Scheduling

The EP must staff the ED 24 hours a day, seven days a week. This includes nights, holidays, and weekends, which traditionally are the less desirable shifts. Many shift structures exist. One equitable method is division of shifts equally among the group members. The downside to this method is that those physicians with more administrative duties and fewer clinical hours receive proportionately more of the undesirable shifts. Another equitable way to distribute shifts is to calculate the percentage of total ED clinical hours provided by the individual physician, followed by assignment of that physician an identical percentage of night, weekend, and holiday hours. Some groups offer higher compensation to physicians willing to work predominantly night or weekend shifts, thus significantly lowering the number of undesirable shifts remaining for the group.

The group must decide how far in advance the schedule is announced. Common methods include announcement of the schedule monthly, on or before the 10th day of the preceding month, and creation of 3 to 6 month schedules. A more extended schedule allows the group members to plan other activities well in advance. The disadvantage is decreased flexibility, such as when an event comes up unexpectedly. The advantage to the individual physicians of scheduling monthly is increased flexibility, with little lead-

time, for specific off-day requests. This creates more difficulty for the scheduler. Often groups develop guidelines and limitations for schedule requests in order to facilitate schedule completion. Another disadvantage is that the requesting physician cannot commit to more distant activities until the monthly schedule is completed. In response, physicians often form pacts to trade shifts between months, in advance of schedule announcement, in order to secure time during a particular month for personal activities.

Often one physician within the group is designated to manage the schedule and is compensated by the group for this activity. Rotation of the scheduling responsibility between group members allows each member to experience the difficulties of producing the schedule and may lead to more reasonable schedule requests by the group members in the future. Other groups hire a nurse, another person with experience with shift-work, or any other qualified individual to arrange the schedule, although a physician designee likely should be involved to settle disputes or manage problems. The scheduling can be performed manually or with computer software programs. Many believe the latter speeds the completion of the scheduling task. The group must address back-up ED physician coverage, should the need arise due to unforeseen illness or ED patient overload.

Continuous Quality Improvement/Quality Assurance

Democratic groups must address many non-clinical responsibilities in order to maintain their viability. Three extremely important non-financial areas include:

1. Customer/patient satisfaction
2. Continuous quality improvement/ Quality assurance
3. Malpractice risk management

One hundred percent participation in all three of these areas is required by the members of a successful democratic group in order to sustain a long-term, mutually beneficial relationship with a hospital.

Customer satisfaction must be a primary focus of the democratic ED group. The group must realize that their customer base includes their patients, medical staff, and hospital administrators. Clinical competence is a fundamental expectation of the hospital administration and medical staff. To promote a long-term relationship with the hospital, the EPs must exceed the fundamental expectations of the hospital by dutifully serving their recognized customer groups. Any concern or observation by a customer is valid, until proven otherwise, and must be addressed expediently.

Strategies to improve patient satisfaction include but are not limited to:

- 1) Exhibit common courtesy--introducing oneself to patient and family, shaking hands, sitting during interview, smiling, and expressing concern and empathy for the patient.
- 2) See patients as soon as possible.
- 3) Inform patients of expected delays while treating them as quickly as their clinical condition allows.
- 4) Explain lab and test results, treatment plans, and potential problems that can occur following discharge.
- 5) Be certain that all questions and concerns of the patient and their family are acknowledged and addressed prior to discharge.
- 6) Provide accurate, simplified billing for the services provided.

Excellent medical staff relations should be a common goal for the democratic group. The medical staff needs to have confidence in the quality of care provided by the EPs. The EPs should serve the medical staff by competently, conscientiously, and efficiently providing emergency care for their patients. Emergency physicians should promote continuous quality improvement, or performance improvement initiatives. Not only is the hospital required by the JCAHO to conduct this activity, but also this enables the EPs to objectively and proactively assess the quality of care delivered. By addressing patient

satisfaction and quality of care issues in an ongoing manner, the ED group demonstrates commitment to each of its customers.

Emergency physician groups that devote attention to patient satisfaction and quality of care issues simultaneously reduce the group's medical malpractice risk. Patients who are happy with the care they receive are less likely to pursue legal action despite a less than ideal outcome. Meticulous medical records further reduce medical malpractice risk. A strong democratic group must be able to critically evaluate the quality and legibility of the medical record their physicians provide to the medical staff and their billing company. Collaboration with the hospital on ED medical record issues and needs protects both the hospital and the physician should a medical malpractice issue arise. Once a legal procedure has commenced, the medical record will only be useful if it is complete, accurate, and legible.

Successful democratic ED groups engage their members in the pursuit of customer satisfaction for their patients, medical staff, and administrators. When the needs of patients and medical staff are addressed proactively, complaints directed to hospital administration fall precipitously. By reducing the "headaches" caused by the ED and being an integral part of customer relations initiatives promoted by the hospital, the EP group is perceived as a pivotal part of the hospital's global business strategy. This win-win mentality leads to long-term benefits for the patients, hospital, and the democratic ED group.

Human Resources

The democratic ED physician group must have a clear understanding of the mechanisms for dismissal, including due process rights extended to individual members of the group who face issues that threaten their ongoing relationship with the group or the hospital. A clear, well-articulated process for physician remediation and dismissal is essential to avoid confusion and frustration for each party when issues of substandard performance or unacceptable conduct arise. This section discusses some of the issues that a neophyte group must address. Groups that devote time and attention to these issues early in their group's existence are rewarded with diminished complexities, misunderstandings, and legal issues in the future, should termination issues arise.

There are several situations which, when they occur, often lead to immediate dismissal from the group. A new group should clearly delineate these criteria. These criteria can include, but are not limited to:

- 1) Loss of license to practice medicine.
- 2) Felony conviction.
- 3) Loss of prescriptive authority (DEA license).
- 4) Loss of hospital privileges.
- 5) Inability to maintain malpractice coverage to practice medicine.
- 6) Doctor's breach of provisions in their contract with the group.

More complex issues involve due process and appropriate documentation for less egregious, but clearly unacceptable actions or behaviors by a physician. By developing clear policies to address such circumstances, the group is empowered to deal with issues regarding physician performance head on, often resulting in modified behavior or practice patterns on the part of the offending physician. Examples of applicable issues include, but are not limited to:

- 1) Drug and alcohol addiction.
- 2) Chronic tardiness to scheduled shifts or meetings.
- 3) Inappropriate behaviors (sexual harassment, physical or verbal abuse of staff).
- 4) Poor patient/customer interactions.
- 5) Quality of care issues.
- 6) Lack of participation in assigned non-clinical activities of the group.
- 7) Failure to see a fair share of patients during clinical shifts.

- 8) Failure to provide expedient patient care due to lack of focus or distraction with non-patient care activities.

Once a behavior that needs improvement is identified, the physician in a democratic group should understand the subsequent process for remediation, which encourages correction of this behavior. The physician also should understand the consequences of failure to modify unacceptable practice patterns or behavior. The policy should treat every physician in the group equally in regards to the process for behavior modification. Counseling of an individual physician should be documented in writing and kept in the physician's confidential personnel file. Failure of the offending physician to adequately respond to modification attempts should prompt either an additional, final meeting to openly discuss the prospect of termination for continued failure to comply, or immediate termination, depending upon the circumstances. The desired goal of the process should be correction of the inappropriate behavior or unacceptable practice pattern. Fortunately, this goal is achieved through organized counseling for the majority of physicians.

A longstanding, successful democratic group faces many human resource challenges during the life of the group. By planning for potential human resource issues before they arise, the group is prepared for these challenges when they occur.

Business Management Skills and Training

The practice of medicine is becoming increasingly complicated with federal and managed care rules, increasing patient expectations, and limitations on resources. The term "business management" has different connotations dependent upon a group's size. Large groups may employ a third party company or in house individual to manage the business of the ED group, thus limiting the direct input required from individual physicians. Smaller groups (10 or less physicians) may not have the financial capital to designate for professional business management. In this case, the group designates a physician or physicians to manage the business affairs of the group. Reimbursement models for clinical and administrative duties are discussed in the preceding section titled, "Physician Compensation." Given that the group's existence is tied to its financial success, even small groups should consider hiring a full or part-time business professional to ensure that the economics of the group are never neglected.

For any ED group there are four key business issues that must be considered.

1. Group-physician relationship:

The individual physician has goals and needs in addition to practicing the art of medicine. If a physician feels no respect from his colleagues and does not feel valued, there is little future in the relationship. There must be a positive quality to the individual physician's job. This may be forged through group or individual activities such as group outings with families or community projects. Other options may include providing physicians with a particular area of interest or expertise a project that may benefit the group. For example, a physician with an interest in cardiology may develop a new way to market the ED practice by reviewing an aspect of the practice and using the medical literature and local expertise to improve patient care through a chest pain patient care pathway.

2. Hospital-group dynamics:

The relationship between the hospital and group is an ongoing dynamic. Physicians may be employed as independent contractors, as a private group, or as a staff physician. The hospital's primary interests are high-quality, cost-effective care and satisfied patients. This leads to growth in the hospital's patient base, increased hospital admissions due to growth in the ED census, and physician staff that are pleased with the hospital ED. The physician's interests generally are a quality, stimulating work environment and the opportunity to provide quality emergency care with fair reimbursement. The hospital and group are tied together by the nature of the practice setting. If

- the hospital and group envision themselves as partners, the dynamic tends to be less adversarial and mutually beneficial. Recent financial strains on hospitals produced by falling managed care reimbursement and the funding cuts of the Balanced Budget Act diminish the hospital's interest in "propping up" the ED through subsidies or low interest loans. Therefore, the group must strongly consider hiring a business manager to effectively manage the financial aspects of the group.
3. Customer Satisfaction:
- As discussed in the preceding section titled, "Continuous Quality Improvement/Quality Assurance," customer satisfaction is a key ingredient to ED group success. Traditionally, health care enterprises lag behind other service sector businesses in their attention to customer satisfaction. Patients who do not feel respected and cared for they will take their "business" elsewhere. Although it's difficult to accept during a busy shift, the democratic ED group member's income ultimately is tied to patient volume, acuity, payer mix, and satisfaction. Patient satisfaction leads to both return business and word of mouth advertising. Some studies have examined use of the ED to assist with immunization programs and after-hours primary care. This model appears to succeed in rural areas, where the department's marginal costs may make it a cost-effective area for medical care when primary doctors' offices are closed. Efforts to market the ED through advertising must be coupled with sincere efforts by the hospital and ED group to provide the highest quality ED care for customers recruited through these advertising campaigns.

4. Practice Profiling:
- In recent years some groups and hospitals began to analyze the physicians' practice parameters in an effort to streamline patient care and reduce costs. If the goal of this exercise is to improve patient care and cost-effectiveness, then the physicians view the results in a more positive light. The health care system of the future will require EPs to conserve scarce resources. By optimizing physician education regarding evidence-based practice and appropriate documentation, the group improves its quality of care and financial potential. Collaboration with the physicians of the group during the development and implementation of practice profiling tools dissipates the historical fear and paranoia associated with profile results. The group must respond to developments in health care through proactive measures to practice emergency medicine cost-effectively. The current medical system is adjusting over time to decreasing payments (Balanced Budget Act of 1997), unfunded federal mandates (i.e. EMTALA), an aging population, increased bureaucratic regulation and litigation, and increased patient expectations. ED physician groups must create and implement performance metrics, such as practice profiling measures, to position themselves as participants in the changes that will affect them.

Business school seminars, health care symposia, fellowships, and masters programs are available to physicians seeking to improve their business skills and acumen. Some medical schools offer MD/MBA combined degree programs. ACEP addresses the business aspects of emergency medicine practice through a number of venues, including the ACEP Scientific Assembly, the ACEP annual Leadership and Legislative Issues Conference, and ACEP-sponsored or supported publications.

Entry and Exit Strategies

Entry Strategies and Partnership Tracks

As discussed in the preceding section titled, "Physician Compensation," a democratic ED group may base profit sharing and voting authority upon the number of shares a group member holds or upon the one person—one vote principle. Graded, or graduated stockholder or partnership status may be acquired based upon years of service to the group, as previously described. To remain democratic, a group should have clearly established criteria for granting shares and voting authority. These criteria should be equitable and equally accessible to all members of the group in good standing. Democratic groups cannot retain fairness if a small minority of group members holds the majority of shares. The group should establish a

predetermined limit of shares that may be allocated based upon seniority status with the group. In a democratic group, partnership tracks, with gradual achievement of an equity position for new group members, are reasonable, since new recruits do not incur the financial risk and cost of start-up. More specifically, the rationale for a buy-in period or a gradual accumulation of shareholder or partnership status for a new group member is:

- The establishment and development of a group, its reputation (which enables the contract acquisition), its assets (offices, management or billing company, etc.) and any reserve or invested capital are valuable, earned assets. The new recruit did not personally invest (time or money) or incur the financial risk associated with the accumulation of these assets. These assets should be quantified and their value available to the new group member.
- The new recruit's income for the first 12 to 24 months of work is provided and/or supported by the revenue generated by the preexisting group members. The group's cash reserves and income continue to provide the financial support for group expenses or deferred compensation arrangements, as discussed in the preceding section titled, "Physician Compensation."

General guidelines for partnership tracks within democratic groups include:

1. A clear and reasonable timeline with clear-cut performance parameters and review periods, including:
 - a. A clear job description with predefined rights and responsibilities.
 - b. A predefined and fair process that reviews and determines the progress of a prospective partner through the "track."
 - c. A predefined process providing periodic and written reports on the prospective partner's performance.
 - d. Predefined, written, and fair mediation, due process and arbitration processes.
2. The bylaws should clearly delineate the minimum average number of hours per month that are expected for one to be eligible for the partnership track. The group must predetermine and clearly outline the period of time over which these clinical hours are performed in order to qualify for partnership. Democratic groups should not limit partnership eligibility to clinical hour requirements alone. If agreed upon by group members and articulated in the group's bylaws, service to the organization through administration, leadership activity, and non-clinical productivity should be considered criteria for partnership status and deferred compensation eligibility.
3. Entry strategies and partnership tracks should be equitable and apply to all current and future physicians in that group.

Exit Strategies

As discussed in the preceding section titled, "Physician Compensation," exit strategies, or deferred compensation plans are a means to equitably compensate a physician for the value added to the group through the physician's dedication and service to the group. Physician founders of the group created ongoing value through the energy and entrepreneurial spirit required to envision, plan, organize, and found an ED group. The physician founder(s) initiated business opportunity and income for the physicians by marketing their group and convincing hospital administrators and senior medical staff members to contract with the group to care for their ED patients. Furthermore, personal financial investment often is required at start-up either to fund the start-up costs of the group or to convince lending institutions of the founder's commitment to success. Sometimes the founding physician(s) performs clinical and administrative duties for little or no reimbursement during the start-up of a new, single-hospital ED contract. Deferred compensation plans partially reimburse outgoing or retiring founding physician members for the effort, expertise, and personal risk associated with these activities.

Physicians with years of service to a group, who also meet the group's predetermined criteria for partnership status, may receive deferred compensation revenue as part of the group's accepted partnership benefit. If a new recruit physician accepts an initial compensation reduction as recompense for the lag time associated with billings accounts receivable, this physician deserves a reciprocal deferred compensation agreement to account for revenue received by the group from his or her billings following departure from the group.

To be consistent with democratic ED group philosophy, an exit strategy should meet the following criteria:

1. It must be coupled with an equitable entry strategy as discussed above.
2. A democratic group should maintain a predefined, written mediation and arbitration process that addresses disputes pertaining to the value of an exiting physician's deferred compensation agreement.
3. The details of this process should be predefined and articulated in the group's bylaws and should apply to all current and future group physicians.
4. Safeguards in the democratic group's bylaws should protect the majority from the disputed sale of the group's contract(s) by a minority of group members, regardless of stock distribution among the members.

Governance and Bylaws

The development of comprehensive bylaws for the democratic ED group is essential. The democratic philosophy of a group is established only when its bylaws provide a predefined governance system that meets certain standards. Various adaptations of democratic ED standards are necessary to accommodate groups of different sizes. Suggestions for democratic ED group standards of governance include:

1. Bylaws should define a mechanism to elect all group officers. This includes the Board of Directors, the President and/or Chair of the Board, and the executive and administrative leadership for the medical group. Bylaws must define pre-established terms for all of the officers' positions. If the group is small, this directive may be limited to the assignment of administrative leadership and responsibilities within the group.
2. Bylaws must define a pre-established job description, authority, review process and a set of responsibilities for each of the leadership positions.
3. Bylaws should define a pre-established system to appoint local and regional medical directors, as applicable based upon the size of the physician group and/or ED(s).
4. All physicians in good standing should be eligible to vote and to hold any of the leadership positions.
5. Nominating committees may be useful to identify prospective candidates for leadership positions. Nonetheless, any physician group member should be eligible for any of the leadership positions.
6. The voting mechanism should allow all physicians to participate in the election process, including the use of electronic or mailed-in ballots when applicable. The ability to vote should not be limited by arbitrary restrictions such as a requirement to attend a specific meeting.
7. Bylaws must predefine the minimum percentage of votes required to change the group bylaws, the compensation plan, and the group structure.
8. Bylaws should predefine what constitutes the majority that would be required for elections and for bylaw changes.
9. Bylaws should specify minimum voting requirements for physician group members. The group may choose to encourage participation in elections by tying certain physician compensation to reasonable participation.
10. Bylaws should stipulate the amount of group financial resources available to fund the elected leadership and medical director positions.

11. The distribution of votes among group members should be predetermined in the group's bylaws. As discussed in the preceding section titled, "Physician Compensation," the group may establish voting rights based upon the one share-one vote model or the one person-one vote model. However, under the one share-one vote model, groups that grow over time may lose the majority decision control that is integral to the democratic ED group philosophy. Other factors that the group may wish to consider pursuant to vote distribution include: the number of hours worked – clinically and administratively; years of group membership; and, the value added to the group through the personal investment of time, expertise, or finances.
12. Bylaws should establish a clear and reasonable maximum number of votes per partner.
13. Bylaws should predefine the mechanism for entry and exit from the group.
14. Bylaws should establish safeguards against block or cumulative voting practices.
15. Elections and voting should be confidential and conducive to freedom of choice and expression.

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Prepared by the Emergency Medicine Practice Committee
Developed by the Subcommittee on Starting a Democratic ED Group
April 2001

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