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ADVANCING EMERGENCY CARE

Obtaining, Maintaining, and Retaining an Emergency Department Contract

an Information Paper

Developed by Members of the
Emergency Medicine Practice Committee

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Introduction

The practice of emergency medicine is an art, a science, and a business. The value of an emergency physician (EP) group is not limited to the provision of quality care for patients. As practitioners of a hospital-based specialty, EP groups must concern themselves with the issues and needs of the hospital and medical staff. Successful EP groups develop mutual trust and satisfaction with their hospital administrators and medical staffs. Contracts between the EP members of a group and between the group and a hospital are integral to this trust and satisfaction.

The goal of this information paper is to discuss issues that EP groups should address in their relationships with hospitals and medical staffs. The discussion focuses on several important issues and is not intended to address all of the issues specific to a particular emergency department (ED) group or hospital contract. Careful attention to these key issues helps a dedicated group of emergency physicians obtain, maintain, and retain a contract with a hospital.

Patient Services

Successful EP groups focus on satisfying the practice's primary customers: patients who seek emergency care. A satisfied customer base strengthens the EP group's relationship with individual patients, the community, the medical staff, and the hospital. A talented, cohesive, and dedicated EP group heightens a community's confidence in the hospital and strengthens the emergency department's position within the hospital.

The clinical diversity and service expectations of patients seeking emergency care is great. Patient presentations range from severely ill or injured patients requiring immediate intervention to patients with low acuity problems utilizing ED services due to access or convenience issues. The common denominator of these presentations is that all ED patients maintain high expectations for the ED's performance. Patient satisfaction generally is a function of three variables: service, quality of care, and cost. Patients weigh the relative importance of these variables in assessing the perceived value of services provided. Consumer surveying organizations, such as the Gallup organization, use correlation variable analysis to rank the relative power of various ED patient "satisfiers." Such correlation variable analysis tends to rank factors such as speed of service, ED efficiency, and sense of urgency above such variables as quality of the physician and nursing care. When patients receive ED care, quality and cleanliness are baseline expectations. The failure to meet these expectations leads to profound dissatisfaction, but the provision of quality care and cleanliness has little impact on creating a very satisfied customer. The very satisfied customer results from provision not only of minimal ED requirements, but also through speed of service and a sense of caring and concern from ED staff. The EP group must acknowledge and act upon these principles of ED patient satisfaction to maximize their potential as a group.

A successful ED practice should consider a number of variables related to customer satisfaction. These variables include:

- Accurate identification of customers
- Physician group member and institutional commitment to patient satisfaction
- Integration of physician group and institutional goals relative to patient satisfaction
- Attention to operational issues impacting patient satisfaction

- The value of formal customer service training
- Patient and medical staff complaint management
- Patient satisfaction measurement
- A commitment to ongoing assessment of patient satisfaction initiatives

The term “customer satisfaction” extends beyond the actual patient to include other individuals involved in the patient’s ED experience. Attention to the satisfaction of family members, friends, and other caregivers is pivotal. Hard-line ED policies that seek to exclude significant others from participation in the patient’s ED care result in dissatisfied ED customers. Only those patient attendees who appear to be potential detractors from the patient’s care should be excluded from the patient care area. Failure to achieve the confidence of the patient’s significant others can influence an otherwise gratified patient to feel dissatisfied.

The institution must share the EP group’s commitment to customer satisfaction. Physician and nursing leadership must integrate customer satisfaction efforts to produce an environment that underscores its importance. Joint initiatives between the physician group and the facility lead to unified emphasis on patient satisfaction between the physicians, nurses, and other ED staff. These joint initiatives can include formal customer satisfaction training, coordinated patient complaint management programs, and regularly scheduled forums to discuss specific cases involving dissatisfied and very satisfied customers.

Participation in formal customer service training demonstrates a commitment to patient satisfaction. The integrated nature of ED care requires the training of all individuals involved in the ED care of patients. This list of personnel includes physicians, nurses, registration personnel, technicians, unit secretarial staff or coordinators, patient care representatives, caseworkers, volunteers, and any other staff that have direct contact with ED patients and their families or friends. Topics addressed during customer service training include the following: customer identification, communication approaches, promptness of care issues, and “real time” complaint management. Most quality customer service training programs include scripted responses to common patient interaction scenarios. Role-playing exercises are a customary and useful component of this training.

A structured complaint management program is crucial to the achievement of superior patient satisfaction. Program components include complaint prevention, optimal management and resolution of complaints, complaint categorization and analysis, compliment tracking and feedback, and integration of patient complaint and risk management initiatives. Complaint management programs should identify processes and issues that tend to result in complaints. These problems consequently can be remedied. Patient satisfaction survey tools assist in the identification of satisfaction issues. Focus groups are a more advanced method of identifying important satisfaction issues. Survey score trends are an important staff feedback mechanism.

Emergency department operations must facilitate the efficiency that patients desire. Operational improvements in the ED focus on increases in service quality and efficiency. Operational efficiency serves the common goals of ensuring high quality care, decreasing waiting times, improving the patient’s experience and interaction with the ED staff, and ultimately, increasing satisfaction. Inefficient ED patient care systems increase patient load in the waiting area and influence patients to leave prior to triage evaluation or completion of ED care. ED operational improvements that enhance patient care efficiency and patient satisfaction include expanded triage capacity, rapid triage-bedside registration programs, standing triage orders, point-of-care

diagnostic testing, expanded x-ray technician staffing, ED patient tracking systems, and streamlined ED patient admission systems.

The acquisition, maintenance, and retention of an emergency services agreement are necessarily associated with the satisfaction of key customers. The primary customer in emergency medicine is the patient. Continuous improvement and attention to patient satisfaction strengthens the foundation of an emergency group's relationship with its other customers: the community, the medical staff, the hospital administration, and the hospital board.

Medical Staff Relations

A hospital medical staff's perception of its EP group considerably influences its success or failure. Whether through committee meeting discussions, discussions with the hospital administration, or physician lounge conversations, the medical staff's impression of EP group performance matters. The hospital administration justifiably recognizes the impact of hospital admissions on the fiscal success of the organization. Consequently, the contentment of inpatient medical staff with the performance of the EP group is essential.

Although a hospital medical staff generally includes a few antagonistic, ill-disposed members, most medical staffs and their leaders share a common goal with the EP group: quality medical care. The EP group should develop consistency relative to patient management of common patient presentations and communication practices with medical staff members. Evidence-based emergency medicine practice can supplant many disagreements over proper patient management. A standing invitation for medical staff members to attend a portion of the EP group general business meeting can dissipate negative feelings and lead to productive discussions. Open communication between the EP group and the medical staff pleases the hospital administration by diminishing their role as mediator.

Medical staff and hospital committee participation by EP group members is pivotal to the maintenance and retention of an emergency services contract. While some EP groups elect to reimburse members of their group in exchange for committee participation, most groups consider some level of participation in medical staff and hospital affairs a requisite part of medical staff membership. Participation by EP group members in committee work serves the dual purpose of broadening the medical staff's understanding of emergency medicine practice and providing the EP a view from the medical staff's perspective.

The ED medical director and other EP group leaders must be visible and capable representatives to the medical staff regarding ED issues. Much the same as cardiologist and radiologist leaders are held accountable for operations in the cardiac care unit and radiology department, respectively, the EP group leadership must intimately involve themselves in the successful operation of the ED. It is shortsighted and ineffective for EP group leadership to defer issues of ED management to hospital nursing leadership. This principle is particularly applicable to the mandates of the Emergency Medical Treatment and Labor Act (EMTALA), which often are poorly understood by hospital medical staff members. EP group leaders also must develop and maintain effective systems of communication with medical staff members regarding the ED care of their patients. This communication may include the timely transmission of ED physician documentation to the appropriate staff physician following a patient ED visit or attendance by an EP group leader at general business meetings of other departments.

The ED medical director should lobby to obtain membership on the hospital medical executive committee, if not preexistent, to gain a direct forum with the other medical staff leaders. When

EP group leaders obtain chief of staff designation, board of trustees membership, medical executive committee membership, or other leadership positions within the hospital, the EP group often benefits through concession of EP remediation or termination decisions to the EP group leadership. Moreover, EP groups that sustain hospital leadership positions are much less likely to face administrative actions that threaten the longevity of the EP group contract with the hospital.

Intra-group Function

A clear understanding of the relationships between the physicians in a contract group is paramount to successful long-term viability. The following need to be clearly defined early in the process of group formation:

1. Group legal structure. Most potential groups will organize under some sort of corporate structure, either a Subchapter S, a C Corporation, a professional corporation (P.C.), or a limited liability company (LLC). The articles of incorporation and associated bylaws (or operating agreement) define the ownership and governance structure, leadership, compensation arrangements, admission of new members, retirement, resignation, termination, duties of members, and other policies, procedures, and related matters.

2. Group ownership. The ownership of the group is a critical issue that must be defined in the documents of incorporation. All physician members of the original group may be equal stockowners. Alternative arrangements may grant stock ownership differentially to founding or senior members. Larger groups may institute incentive reimbursement plans or salary arrangements commensurate with the EP group's financial performance.

3. New group members. There must be a clearly defined mechanism for new members to be admitted to the group. Some groups define a period of service prior to admission. There may be other criteria as well as a requirement for a financial buy in. The admission of new group members to the ownership group has the potential for litigation in the future if not clearly defined and enforced.

4. Leaving the group. A mechanism for resignation, retirement, or death of a group member should be defined clearly in the group bylaws. Such arrangements will include valuation of stock at the time of the member's departure and how the departing member's shares will be redeemed. Some groups will require advance written notice prior to a voluntary resignation, typically 90 or 120 days.

5. Involuntary departure. A written procedure for the involuntary termination of a group member is very important. Most group bylaws will include items such as loss of medical license, loss of hospital privileges, conviction of a felony, and personal bankruptcy of a member as being grounds for involuntary termination. Other provisions may address impairment due to chemical dependency and issues related to clinical performance and medical competency. Other factors that may result in termination can be loosely defined as citizenship matters: participation in group and hospital business, patient and staff complaints, hospital administration complaints, and ability to work smoothly with nursing and other staff members. Procedures for addressing these latter issues should be in place and should remediation fail, a process for terminating the relationship must be defined. Poor performance by the group as a whole can lead to loss of the group's contract with the hospital.

6. Disability and illness. Group bylaws should address the issue of prolonged absence from work by a member due to illness or injury, including psychiatric illness. At times a member may have an impairment that allows limited duties only. A written policy should address these matters.

7. Group leadership. Leadership of the group can be assumed by one individual or divided among several or all members. There must be a clear delineation of duties and responsibilities. These areas of responsibility should include medical directorship, quality assurance (QA) and performance improvement (PI) activities, patient and staff complaint management, and group fiscal management. While billing and related administrative issues generally are handled by either an outside vendor or a group administrator, physician oversight of the process is essential, since the physicians ultimately are responsible for any claims for reimbursement submitted on behalf of the group. Group leadership positions may be designated through group elections or appointment by group ownership.

8. Employment contract. In addition to the articles of incorporation and by-laws (or operating agreement), most groups execute a specific employment contract between each physician provider and the group. Such a contract defines terms of employment, wages and benefits, termination procedures, and grievance procedures.

9. Conflict resolution. There are many daily issues and conflicts among members of a group. It can be comparable to a marriage with multiple partners. There is no substitute for good legal advice and accounting services to define the basic rules of group operation and structure. In the end, the quality of the relationship between members is dependent upon the honor and communication skills of the people involved.

The EP group leadership should consider development and implementation of a physician performance assessment tool that seeks to objectively rate physician performance based upon predefined metrics. Such metrics can include: quality of care as determined by random chart reviews, performance improvement project outcomes, and patient outcomes analysis; responsiveness to patient, staff, and administration complaints; attendance at regularly scheduled EP group business meetings; participation in hospital and medical staff affairs; promptness and reliability relative to scheduled clinical shifts; and, other appropriate metrics as defined by group leadership. Formal periodic performance assessment tools assist the group by predefining group expectations and providing a more objective means for physician promotion and termination decisions.

Risk Management

Risk management in emergency medicine is not an isolated event but rather a continuum of endeavors directed toward preventing and mitigating a variety of legal risks. Emergency physicians must effectively and efficiently manage these risks in a clinical environment in which a bad outcome is often inherent, and in a legal environment in which physician actions are frequently, tediously, and sometimes publicly scrutinized. Hospital regulatory requirements often focus on the actions of EPs and place them at further risk of liability. Every emergency medicine practice must have an organized plan to address these challenges if it is to be successful in obtaining, maintaining, and retaining an emergency services agreement.

A formal risk management plan consists of a group of planned activities. Strictly speaking, these activities are designed to ensure quality patient care and protect EP group financial assets. Other, less tangible assets also are at risk from adverse legal actions against an EP group member, including the reputation of the EP group within the community and the institution. Moreover,

such legal action can negatively impact the relationship of the EP group with its customers: the patients; the medical staff; and, the hospital administration. Consequently, the goals of risk management programs go beyond the protection of patients and financial assets to preserve the reputation of the group and its individual physicians. By extension, successful risk management plans are integral to the retention of an emergency services contract.

Risk management program components optimally include, but are not limited to, the following activities:

- Pre-employment screening and credentialing
- Orientation
- Complaint management (including coordination with billing activities)
- High-risk presentation educational activities
- Customer service training
- Education and training in the EMTALA and other regulatory compliance concerns
- QA/PI program activities
- Claims management
- Risk management site assessments
- ED policy maintenance
- Payer relationship management
- Coding and billing compliance plan

A review of the bulleted items above illustrates the diverse nature of a comprehensive risk management program. While the group must designate individuals within the group to manage individual components of the program, it is imperative that all members of the practice understand risk management principles and participate in the EP group's risk management initiative.

The plan begins with the appropriate screening of potential clinical employees. Background reviews, inquiries to the National Practitioner Data Bank (NPDB), and confirmation of training and licensure should be routine. Once hired, a formal orientation and at least several "orientation shifts" are appropriate.

Patient and staff complaints often signal areas of risk as well. Consequently, the careful and appropriate application of complaint management techniques can mitigate the risk associated with a complaint through intervention prior to a claim being filed. The timely receipt of patient and staff complaints by the designated EP group member requires communication and coordination with hospital billing and administrative personnel and the physician billing service. Patients are more likely to pursue legal action if they perceive that their complaint is ignored, so an efficient response mechanism is required. This can include an initial contact with the complainant with the promise of a detailed investigation and follow-up communication. Communication with complainants by telephone, e-mail, or letter is acceptable, but written documentation of complaint response and outcome is necessary. If the complaint originated with a member of the administration or medical staff, that individual should be copied on the complaint response and outcome in order to promulgate the ED's commitment to patient satisfaction. The ED physician involved should, at a minimum, be aware of the complaint and, ideally, should be directly involved in its resolution. This physician involvement is more likely to modify the physician's approach or behavior in the future, if appropriate.

All physicians and supporting practitioners should participate in several educational activities directed toward limiting risk. Participation in structured educational programs (internal or

external) focused on high-risk presentations, as determined by closed claim data, is essential. A separate customer-service training program complements this education. Additionally, EMTALA education and training reduces the risk of regulatory penalties associated with patient triage, screening, referral, and transfer. Physician orientation relative to emergency medical services (EMS) medical direction activities should be documented. EP group members should receive appropriate education in other areas of regulatory compliance, including but not limited to: the Americans with Disabilities Act, OSHA blood borne pathogen standards, and the reimbursement and supervision requirements for teaching physician and resident services, if applicable. The physician practice should strive to integrate this training with similar training provided to all ED staff. By leading risk management training efforts and championing the inclusion of the other members of the patient care team, the group members can demonstrate institutional leadership in the area of risk management.

Quality assurance (QA) initiatives, such as focused high-risk or random chart audits, assist in identifying potential areas of risk and providing feedback to physicians. Structured and consistent management of these and other QA programs (such as x-ray interpretation procedures, lab culture follow-up processes, and electrocardiogram interpretation discrepancy systems) should be routine. Performance improvement (PI) projects can provide focus on certain high-risk patient management and documentation issues, such as the absence of a foreign body in wounds or the timely administration of thrombolytic agents in appropriate patients.

The careful management of a relationship with a high quality, reputable, and supportive malpractice insurance carrier is fundamental to risk management in emergency medicine. Appropriately structured and priced malpractice coverage is the most fundamental goal of this relationship. However, many aspects of claims management (case recognition, insurer notification, claim defense, settlement approaches) also are critical. Many malpractice insurers assist in claims prevention by offering programs such as risk management site assessments and risk related educational activities for clinicians.

Properly managed EDs maintain departmental policies addressing a broad range of issues. These issues include, but are not limited to: sedation procedures, language and interpretive services, transfer procedures, triage and medical screening procedures, patients' rights, EMTALA and other regulatory compliance procedures, chemical decontamination procedure, domestic abuse policies, and sexual assault policies. EP participation in the development of and compliance with departmental policies is imperative to their accuracy and success.

Managed care organizations (MCOs), indemnity insurance organizations, and other payers often misunderstand ED regulatory obligations, such as EMTALA medical screening requirements. Moreover, these payer entities often are unaware of or simply ignore federal and state legislative requirements pertaining to reimbursement for emergency care. Likewise, ED physicians sometimes are slow to recognize and assume cost-efficient treatment options based upon generally accepted evidence based medical literature. Consequently, the EP group, and their patients, benefit through frequent communication with payer entities. It is beneficial to designate a group member with knowledge and expertise in regulatory and legislative issues to serve as liaison to the group's most prominent payers. If the group has no such member, involvement in ACEP locally and nationally is an effective means of gaining knowledge in these pivotal areas. The group should work closely with its billing agent to confirm compliance with all applicable documentation, coding, and reimbursement regulations.

An ED group's reputation for the provision of high quality care is essential in facilitating the acquisition, maintenance, and retention of an emergency services agreement. Patient, community,

medical staff, and administration relationships are strengthened through well-structured and carefully implemented risk management programs. Consequently, a comprehensive risk management program not only protects the financial assets of the practice and its members, but also preserves its relationships and reputation within the hospital and community.

Focus Projects for the Emergency Department

Hospital administrators sometimes identify desired focus issues or projects to be addressed by the ED. These projects often target an area that, in the opinion of the administration, needs improvements. Focus projects may seek to establish new "service lines" or case management pathways for specific illnesses. Common examples include: alternative delivery systems such as "fast tracks," chest pain centers, and observation units; "stroke centers," and, programs that guarantee ED evaluation or management within a certain time frame. The genesis of such projects frequently involves efforts to market the hospital to its community. The maintenance and retention of an ED contract requires the active and enthusiastic involvement of the EP group in the feasibility analysis and, when appropriate, the implementation of hospital-ED focus projects.

Focus projects may or may not be advantageous for the ED group. Projects such as rapid triage-bedside registration can improve patient care by reducing the number of patients who leave the ED prior to triage or medical screening completion. However, a hospital guarantee of emergency services within a defined time frame fails to recognize the unpredictable nature of providing emergency services to fluctuating patient volumes and acuities. The EP group can suffer financially if a new operational system requires the unjustified addition of physician hours or requires discounted professional services fees. ED management of chest pain patients through alternative delivery systems can be highly efficient, but restrictions on reimbursement for observation services by governmental and other payers can adversely affect ED physician and hospital collections.

An EP group that is trying to obtain or retain a contract must understand the fiscal impact on physician salaries that a particular project will have. Professional accounting services are invaluable in these circumstances. Detailed financial projections based upon expected patient volume and reimbursement changes could influence the EP group's decision to endorse a project and the hospital's desire to proceed with plans.

The level of EP leadership involvement in hospital affairs and leadership is integral to the group's ability to properly influence project decisions that directly impact the ED and the EPs. Detached EP group leadership can lead to the forceful implementation of undesirable focus projects. Conversely, the engaged EP physician leader is highly likely to be involved in preliminary hospital discussions regarding ED focus projects and is positioned to diplomatically intercept disadvantageous plans.

Hospital/Emergency Physician Group Contracting

Hospital and EP group relationships involve a variety of contractual issues. A number of ACEP publications and products address contractual issues in detail, including *Contract Issues for the Emergency Physician* and *Before You Sign: Contract Basics for the Emergency Physician* (please refer to the attached reference section). The ACEP information paper "Starting a Democratic Emergency Department Group" includes discussions of contractual issues between EPs and their group, the EP group and the hospital, and the EP group and third-party payers.

When negotiating a contract with a prospective EP group, hospital administrators and medical staff leaders often consider the clinical expertise of the individual EP a baseline expectation. Therefore, EP groups that offer expertise or interest in other value-added services often negotiate at an advantage relative to other interested EP groups. EP group expertise or experience in billing and reimbursement, patient and staff satisfaction, QA/PI initiatives, hospital medical staff or specialty society leadership, and risk management offer an attractive advantage to the hospital. The technicalities of successful contract negotiation itself are complex and beyond the scope of this paper. While there are many books and references on negotiating techniques, the book *Getting to Yes: Negotiating Agreement Without Giving In*, by Fisher and Ury, is a recognized resource on the topic.

Coercive Contracting

On occasion, an EP group falls victim to disadvantageous contract agreements, often referred to as coercive contracting. One example is the contractual acceptance by the EP group of heavily discounted professional services fees, which extend to the EP group by virtue of exclusive contract agreements between hospitals and third party payers. While this circumstance certainly is not unique to EPs, this practice is addressed in the ACEP policy statement "Emergency Physician Rights and Responsibilities." The pertinent excerpt from this policy states:

> Emergency physicians, both independent contractors and physician employees, shall be represented in the contract negotiation process between hospitals and those payers providing reimbursement for emergency services. Emergency physicians are entitled to fair rights and reimbursement pursuant to such contract agreements.

Other potentially disadvantageous contract provisions include: unrealistic and unprofitable physician staffing demands; requirements to perform unreimbursed and nontraditional hospital services such as free employee screening physicals or free employee emergency care; unrealistic involvement in hospital or nursing administrative duties; and requirements to staff hospital patient care areas outside of the ED. Consultation and advice from an experienced health care attorney can help determine the legality and advisability of entering into such contractual agreements.

In seeking to establish and maintain a contractual relationship with a facility, it is important for EPs to understand and identify their potential customers and, when reasonable, meet their needs. Patients, the medical staff, the hospital administration, the nursing staff, EMS providers, and the community each maintain their own set of prioritized needs. Insightful EP leaders will identify these needs and implement clinical, administrative, and business processes to reasonably fulfill them within the parameters of expert emergency medical practice.

In summary, the identification of customers and their needs, a strong service orientation, and the establishment of open communication in the negotiation process contribute to the successful acquisition and retention of an emergency services agreement. Ultimately, the quality and depth of the relationship between the EP group, the hospital administration, and the other key customers such as the medical staff are the foundation of EP group success. When problematic contractual or operational issues arise, the maturity and health of these relationships can determine the outcome.

Please refer to the attached list of ACEP/EMRA Contract Products for additional information on EP contractual issues.

Conclusion

Emergency physician groups that seek to obtain, maintain, and retain an emergency services contract with a hospital must recognize and devote attention to issues beyond the provision of high-quality emergency care. The long-term success of an EP group is dependant upon its ability to address the interests and concerns of the patients, the hospital medical staff, the hospital administration, and the community. Focus on these interests and concerns often can enhance the EP group's opportunity to provide its patients the very best emergency medical care.

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John H. Proctor, MD, MBA, FACEP, Chair, Emergency Medicine Practice Committee
Mark D. Tripp, MD, FACEP
Patrick N. Connell, MD FACEP
Howard Z. Davis, MD, FACEP
Paul W. Kolodzik, MD, FACEP
Daniel L. Platter, MD
Timothy Seay, MD, FACEP

ACEP/EMRA Contract Products

Publications

1. *Contract Issues for Emergency Physicians* (2000)
   Joseph P. Wood, MD, JD (editor) ~ published by EMRA

2. *Before You Sign: Contract Basics for the Emergency Physician* (1996)
   David Kalifon and Daniel J. Sullivan (authors)

3. *Managed Care in Emergency Medicine: Understanding the New Economics and Opportunities* (1995)
   Marty Karpiel (author)

Related ACEP Policy Statements

1. *Emergency Physician Rights and Responsibilities* (July 2001)

2. *Managed Health Care Organizations and Emergency Care* (July 2000)

3. *Agreements Restricting the Practice of Emergency Medicine* (June 2000)

4. *Emergency Physician Contractual Relationships* (March 1999)

5. *Economic Credentialing* (September 1997)

6. *Code of Ethics for Emergency Physicians* (June 1997)

7. *Compensation Arrangements for Emergency Physicians* (June 1997)

Educational Offerings

1. How to Evaluate a New Job and Negotiate a Contract
   David T. Overton, MD, MBA, FACEP (faculty)
   Scientific Assembly 2001

2. Capitation and Negotiating Managed Care Contracts
   Thom A. Mayer, MD, FACEP (faculty)
   Scientific Assembly 2000

3. Negotiating for What You Want
   Robert W. Strauss, Jr., MD, FACEP (faculty)
   EM Connection 2000

4. Capitation: Mastering It May Be a Key to Survival
   Thom Mayer, MD, FACEP (faculty)
   Scientific Assembly 1999

ACEP/EMRA Contract Products

Educational Offerings (*continued*)

5. Risk Contracting: Turning Risk to Reward
   Ken DeHart, MD, FACEP (faculty)
   EM Connection 1999

6. Get (and Keep) That Contract
   John Shufeldt, Jr., MD, FACEP
   EM Connection 1999

7. Capitation: Mastering It May Be a Key to Survival
   Keith Ghezzi, MD, FACEP and Thom Mayer, MD, FACEP (faculty)
   Scientific Assembly 1998

8. Preserving Your Contract
   Greg Henry, MD, FACEP and Dighton Packard, MD, FACEP (faculty)
   Management Academy 1998

9. Negotiating and Implementing Managed Care Contracts
   Marc Weiner, FACHE and James Augustine, MD, FACEP (faculty)
   Management Academy 1998

10. Risk Contracting and Capitation
    James Augustine, MD, FACEP (faculty)
    Management Academy 1998

Other Resources

1. Starting a Democratic Emergency Department Group
   Developed by the Emergency Medicine Practice Committee, 2001

2. The Exclusive Contract in Emergency Medicine – It's Use and Abuse
   Article by Michael T. Rapp, MD; ACEP News, October 2000

3. In Transition: More on Democratic Groups
   Article by Cherri Hobgood, MD; ACEP News, May 2000

4. In Transition: Your Cards and Letters
   Article by Cherri Hobgood, MD; ACEP News, April 2000

5. In Transition: Democratic Groups – What you Need to Know Before Signing the Dotted Line
   Article by Cherri Hobgood, MD; ACEP News, March 2000

6. In Transition: Contracts - Watch Out for These Red Flags
   Article by Cherri Hobgood, MD; ACEP News, February 2000

7. Restrictive Covenants a Continuing Source of Controversy
   ACEP News, June 1999

ACEP/EMRA Contract Products

Other Resources (*continued*)

8. Emergency Physicians' Checklist for Evaluating Managed Care Plans
   Developed by the Emergency Medicine Practice Committee, 1997

9. ACEP Model Emergency Physician Services Agreement with Managed Care Organizations
   Developed by the Emergency Medicine Practice Committee, 1997

10. Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships
    Developed by the Emergency Medicine Practice Committee, 1997

11. ED Group Structure-Contracts and Contract Analysis-Contract Negotiations
    Presented by Dr. Ron Hellstern at the EMF/ACEP Teaching Fellowship, 1997

12. Model State Legislation on Non-Compete Clauses 1996

13. Restrictive Covenants in Emergency Medicine White Paper to Council 1995

14. Recommendations from Contract Task Force June 1994

15. Contract Resource File
    Emergency Medicine Practice Department (available on ACEP website)

Non-ACEP offerings

Getting to Yes: Negotiating Agreement Without Giving In (1991)
Roger Fisher, William Ury, and Bruce Patton (editor) ~ published by Penguin USA

Emergency Department Management: Principles & Applications
Saluzzo, Mayer, Strauss, & Kidd ~ published by Mosby