

# **Emergency Department Physician Group Staffing Contract Transition**

## ***An Information Paper***

### **Contract Transitions Affect Patients, Communities and Hospital Staff**

The mission of the American College of Emergency Physicians (ACEP) is to promote the highest quality of emergency care and to be the leading advocate for emergency physicians, their patients, and the public. Within this mission, ACEP seeks to serve the best interests of all parties and provide resources for ACEP members on how best to interact and collaborate with other stakeholders. It is important that these efforts not stop at the walls of the clinical arena, but rather include emergency medicine (EM) negotiations and business contracts. Although some contract transitions are smooth and amicable, others are contentious and require the College and its members to consider the interests of all involved and understand ethical obligations. When difficulties and conflicts arise, emergency physicians should look to ACEP for guidance. By creating these guidelines and ideals related to contract or staffing transition, ACEP can help guide physicians through the process in a more beneficial manner for all involved. Contract transitions can be difficult and confusing, and this document helps to answer questions, set expectations, and guide members through the transition process from start to finish.

### **Contract Transitions Affect Academic and Research Sectors**

While emergency physicians based at traditional academic medical centers directly affiliated with medical schools tend to be at less risk for contract transition, they are not immune. Academic faculty with responsibility for supervision and teaching of residents have unique responsibilities as outlined by the Liaison Committee for Medical Education (LCME) and/or the Accreditation Council for Graduate Medical Education (ACGME) for educational programs to remain in good standing, which must be strongly considered during times of contract renegotiation or transition. Faculty involved in medical student education fall under the purview of the LCME, which among other accreditation standards, require that they have appropriate knowledge of specialty content, teaching assessment skills, program educational learning objectives, and supervision standards (LCME Standards 4 and 9).

### **Contract Transitions Affect Residents in Training Programs**

Contract transitions involving EM residency training programs are complicated. The ACGME institutional requirements state that a sponsoring institution must have a Designated Institutional Official (DIO) who, in collaboration with the Institutional Graduate Medical Education Committee (GMEC), must oversee all ACGME-accredited programs at the institution. The DIO needs to be involved in any contract transition. Less well defined, but no less important, are the logistical and emotional impact transitions may have on the residents.

If the contract transition involves bringing on a new program director and other new faculty, these physicians must meet certain minimum criteria to qualify, and the program director must be approved by the ACGME for the residency program to remain in good standing. If a program loses its accreditation, residents may be required to transfer to a different program to complete their residency. But this assumes open positions are even available in one of the most competitive specialties in the United States. This may also require relocation (eg, selling a home), significant financial burden, and perhaps a gap in training. There are also troublesome implications for the hospital and affiliated academic institutions with regard to recruitment for other residency disciplines and future ACGME accreditation. Additional considerations may be necessary, depending on the characteristics of the training programs, including existence of fellowship training. Even under the best of circumstances, there is always a loss of talent, institutional knowledge, and standing within the EM academic community. When changing a contract would cause

negative effects to faculty physicians in a training program, administration should strive to avoid making the change, if at all possible.

## **ED Physician Staffing Contract Considerations**

The fundamental purpose of a contract is to specify rights and obligations of the parties through common understanding. Various contract types and relationships exist in emergency medicine. This section focuses on exclusive service contracts to provide emergency services. Such contracts typically exist between a hospital and a group of physicians who intend to provide coordinated emergency services for a hospital ED. If the hospital directly employs the physician, an exclusive services contract usually is not necessary.

Typically, a contract is written after the ED physician group has been selected. That selection process may take many forms, including an open “Request for Proposal” (RFP), selection based on a prior relationship (eg, a new ED within a system choosing an existing system provider), a personal relationship with the hospital CEO, etc. A full discussion of the reasons for and implications of the selection process is beyond the scope of this document.

While one would hope and anticipate that the parties will maintain a good relationship, share a common understanding and be respectful of each other, the contract serves to delineate that understanding. The process of writing a contract helps to achieve a common understanding to avoid future conflicts and disputes. If a dispute occurs, the contract will be employed by the parties, and, if necessary, the courts or arbitrators to determine the rights and responsibilities of each of the parties.

A contract is a legal document and binds the parties to certain obligations. It is imperative that independent attorneys for each party, who are experts in contracts with knowledge of healthcare law, are involved in writing and reviewing the contract. The contract should detail all aspects of the relationship. Perhaps most importantly, the contract must anticipate an end to the relationship and specify how it will occur. It is critical that the emergency physician group completely understands and agrees to abide by the terms of the contract. There are many important elements of an exclusive services contract and, in this document, we will focus on the termination of a contract and transition to the next services provider.<sup>1</sup>

Contracts must have specific language addressing the duration of the contract, ie, generally, a contract will be for a specified period of time (ie, the “term”). A contract may have language indicating it will continue under the same terms after expiry while the parties negotiate a new contract or automatically renew, unless due notice has been given by either party. Nevertheless, all parties should consider requiring notification within a specified time frame if one party does not intend to renew the contract. A 90-day notice is the most frequently cited standard in the industry and should be considered a minimum. Some contracts have as long as a 12-month notice requirement. Regardless, each party should assure the amount of time is sufficient to allow for an orderly transition should either decide to terminate the relationship. To that point, the requirement to continue the contract should extend for a minimum of 90 days from the point at which either party decides not to move forward with a new contract.

Additionally, the contract should contain provisions to terminate the contract at any time with proper notice. Early termination is usually divided into two categories: “without cause” and “with cause”. “Without cause” allows either party to end a contract without a stated reason. In this instance, there must be notice delivered within a specified timeframe to the other party. As noted above, the amount of time for notice varies, and the typical 90 days may not be sufficient, especially if the other party did not have advance knowledge of the impending notice. Six months may be more reasonable, but regardless, should be defined in the contract. “With cause” termination means that one party ends the contract because the other party is not fulfilling its requirements under the contract. In this case, the amount of notice is usually shorter, often 30 days. Some contracts specify that a contract can be terminated with little to no notice if

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<sup>1</sup> For more information refer to [Emergency Department Management by Strauss and Mayer](#), available in the ACEP Bookstore.

there are safety, fraud or criminal allegations. Shorter notice may be adequate in “with cause” cases, as the terminating party will have advance knowledge of the deficiencies and can plan for orderly transition accordingly. The contract must specify what types of conditions allow for “with cause” termination and the necessary notice required. Generally, prior to exercising a “with cause” termination, the party must be given an opportunity to remedy its alleged failures. This is often a formal written notice with a demand to start performing as the contract specifies and a specific timetable for compliance. All of these terms, time periods, methods for notification, and reasons for termination must be clearly specified in a contract.

The contract should have clear language detailing the rights and responsibilities of the party after the decision to terminate is made. Typically, both parties have the same obligations and rights until the termination date. Contracts should specify an orderly transition, and both parties should agree to work collaboratively towards that future transition. Whether there are certain ethical obligations on all parties (beyond the contract) is perhaps debatable, but continuity of patient care, patient safety and community safety, and any medical student/resident vital patient care or educational programs should be paramount. There are certain rights and obligations that must continue after termination. For example, sharing billing information, HIPAA compliance, and addressing final payments and/or accounts receivable should be specified in the contract.

Staff privileges are generally terminated upon loss of the group contract. It should be clear that loss of staff privileges solely due to contract termination is not disciplinary and thus not reportable to the medical board, national practitioner data bank, and other similar parties. For more information, refer to ACEP’s policy statement and PREP on contractual relationships.<sup>2</sup>

### **Physician Non-Compete Clause (Restrictive Covenant) in Exclusive Services Contracts**

The hospital and/or the group may seek non-compete clauses. The American Medical Association (AMA) has a position against non-compete clauses. Non-compete clauses may be legally prohibited depending on various state laws and the particular arrangement (contractor, employee, or partner) the physician has with the entity paying the physician. From the physician’s perspective, to the extent the clause is enforceable, a non-compete clause could prevent the physician from working within a defined geographic area at any facility (eg, another hospital ED, a free-standing emergency department, an urgent care or other setting) or with another physician group while providing services at the same hospital and for a period of time after leaving the contracted hospital (voluntarily or due to termination).

A non-compete provision may also be used to preclude the physician from continuing services at the hospital (or geographic area) after an exclusive services contract transitions to a new group. In the latter case, the group views the non-compete as protecting its investment in recruiting and training the physician. Because an individual physician often has no control or influence over whether or not a contract transitions, non-competes of this nature are unfair to physicians and not in the emergency physician’s interest. Furthermore, a non-compete may lead to disruption in emergency care and educational continuity at a hospital. It should be a goal to keep as many of the current group as possible to ease the disruption of changing contract groups.

It is a common argument that emergency physicians (and other hospital-based physicians) are fundamentally different than primary care and specialists with offices in the community because emergency physicians and hospital-based physicians do not control referral patterns at the hospital. Nevertheless, this issue is frequently a contractual point of contention between EM physician groups and hospitals, with each side being on differing sides depending on the situation. When considering non-

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<sup>2</sup> “Emergency Physician Contractual Relationships” policy statement - <https://www.acep.org/emergency-physician-contractual-relationships.pdf>  
“Emergency Physician Contractual Relationships” PREP - <https://www.acep.org/emergency-physician-contractual-relationships-prep.pdf>

compete clauses in the exclusive services contracts, both parties should consider the impact on the community and individual physicians upon contract termination.

At the very least, individual emergency physicians should be aware of non-compete or similar restrictive clauses in the exclusive services contract. ACEP policy states:

- Emergency physicians employed or contracted should be informed of any provisions in the employment contract or the contracting vendor's contract with the hospital concerning termination of a physician's ability to practice at that site. This includes any knowledge by the contracting vendor of substantial risk of hospital contract instability.
- The emergency physician should have the right to review the parts of the contracting entities' contract with the hospital that deal with the term and termination of the emergency physician contract.<sup>3</sup>

### **Contract Health and Maintenance**

As evidenced by the RAND Report, "The Evolving Role of Emergency Departments in the United States," a well-functioning ED has become a critical element of a high-performing health care delivery system. For a private emergency physician group, contract security is intimately connected with an ability to help the health system's care for patients. Successful groups have a strong understanding of their customers. This includes patients and their families. There are many other stakeholders who must be considered secondary customers, including:

- ED team (nurses, technicians, ancillary personnel, trauma team, etc.)
- Larger impact on all hospital departments and personnel (eg, potential disruption of longstanding interpersonal relationships)
- Hospital committees, task forces, and related operational groups (eg, committee membership, chairs, and unique expertise of current ED physicians)
- Academic programs and faculty, including ED and other specialties, plus various other training programs, eg, BLS\ACLS\APLS\ATLS
- EMS and other pre-hospital providers
- Medical staff, particularly hospitalists, trauma, radiology, lab, and on-call specialists
- Local and regional transfer facilities, eg, both incoming and outgoing transfer agreements and referral patterns
- Primary care community, including incoming and outgoing referrals
- Hospital administration, particularly risk management, finance, registration, IT\health information management, bed placement, public relations, long-range planning, disaster management, surge management, etc.
- Various vendors, eg, EMR\HIS, uniforms, supplies (eg, use patterns may change), equipment\technology (eg, bedside lab and ultrasound, communications, etc.)
- The general community and local, regional and national employers
- Various governmental (eg, State Department of Health) and political (eg, state legislators) entities
- Local and national news media
- Volunteer and charitable organizations

While not all-inclusive, this list shows just how important the ED and its physician staff are to the overall functioning and well-being of the hospital. Working relationships, as noted above, can take years to develop and mature. Often, it is not until days to weeks after a group transition that both simple (eg,

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<sup>3</sup> "Emergency Physician Contractual Relationships" policy statement - <https://www.acep.org/emergency-physician-contractual-relationships.pdf>

management of the bedside ultrasound program) and complex (eg, EMTALA and transfer processes) operational processes are found to be lacking.

The contract must have a strong foundation, based upon a cohesive well-functioning team of emergency physicians and advanced practice providers (APPs) offering good clinical care and service to patients and families. Beyond this, active involvement in virtually every aspect of the hospital and even into the local medical community is imperative. In addition, community involvement and outreach is highly desirable. All of these activities are fundamental to maintaining an ED contract. Three critical stakeholders include:

***The Medical Staff:*** Beyond good clinical care and patient satisfaction, an effective ED physician group manages well the expectations and satisfaction of the medical staff, especially those taking ED call. Being proactive and forging strong relationships with the medical staff through active involvement in both formal and informal medical staff activities is required. Emergency physicians need to be considered leaders, colleagues, friends and vital members of the medical community.

ED leadership should take an active role in welcoming new medical staff members, introducing them to ED colleagues, and being familiar with their names and background. For new ED providers, orientation should include introduction to the key service members, eg, hospitalists, radiologists, surgeons and intensivists.

All group members should be expected to serve on hospital committees and take part in medical staff functions. Group leaders should seek out roles such as chief/president of the medical staff and committee chairs, and be active participants in clinical programs and process improvement projects.

Emergency physicians must be actively involved in ED on-call coverage solutions and EMTALA transfer coordination between the medical staff and local hospitals. These activities may take many different forms and are two of the most challenging aspects of managing the ED. Next to clinical care, failure to manage these aspects are two of the most common reasons for loss of an ED contract.

***The Primary Care Community:*** Accountable Care Organizations (ACOs) and other alternative payment methods have tied hospital financial health to the strength of primary care providers (PCPs). As payments shift, so do referral patterns. There is also a risk of hospitals become insular, with the burgeoning of multiple hospital-based providers, such as general and specialty hospitalists. Remaining engaged with PCPs for both patient care guidance and availability of follow-up is critical and challenging. A successful group establishes strong relationships with this group through the encouragement of communication and in-person interaction with various PCP groups to develop strong working relationships.

***Hospital Administration:*** As hospital-based physicians, the goal of the ED group is to help make hospital administration leaders successful. By developing strong relationships built on mutual respect and trust, the hospital leaders will seek out and value advice on issues that impact the ED, resulting in mutually beneficial outcomes. While contract negotiations may at times seem adversarial, never lose sight that everyone is on the same team. Find creative ways to resolve conflicts toward the mutual benefit of all.

Hospital administrators may not realize how important these relationships with stakeholders are and how many years are involved in establishing and solidifying these relationships. It is helpful for the emergency physician group to educate the administration, especially new administration, about this aspect and the impact changing a contract would have. Special recognition and respect should be held for an emergency group that has held the contract for many years, because relationships with the medical staff are likely to be deep and long-standing. The medical staff tends to be more entrenched in the system than the administration, and the medical staff should be treated with respect. Administrators may underestimate the loyalty of the medical staff to their fellow staff members and may not realize how disruptive a contract change can be.

Successful contract maintenance is an ongoing activity, and the process of a successful contract begins the moment it is renewed. If a group finds itself at odds leading up to contract negotiation and renewal, they should stop, step back, and reevaluate their priorities and look for root causes of the discord. These issues must be resolved before proceeding with the contract. Remember, the contract merely outlines responsibilities of both parties. It is not designed to resolve conflict.<sup>4</sup>

## **Coordinated Contract Transition**

Healthcare in America is changing at an accelerating rate. Yet, many of the methods of delivering healthcare have changed little. Nevertheless, economic and other factors may eventually force change. When a contract transition is anticipated, a careful transition plan must be outlined, and accommodation made to prevent interruption in patient care. This is challenging under any circumstance and especially if the parties are at odds with regard to the transition. As noted above, there are a number of stakeholders and considerations that must be addressed.

A well-defined transition plan is critically important and can be divided into four phases:

### **Preparation Phase**

Timing of the transition must be long enough to allow for smooth transfer of responsibilities, yet brief enough to allow for orderly transition, including personnel changes, if necessary. As noted previously, a minimum of 90 days should be allowed for the contract to continue when it has been decided that one party does not intend to renew the contract. Current physicians must be given adequate time to consider offers from the incoming group (if permissible) or seek new employment elsewhere. A wholesale replacement of physicians can be very disruptive, but there may not be another option. Doing so requires extra attention and perhaps “double staffing” for a period of time. Regardless, the incoming group must be prepared to fully staff the ED as soon as the transition is announced. No one should count on the “good will” of the “ousted” physicians, who rightly may seek other employment immediately. Much of the effort in this situation must be focused on avoiding any interruption in patient care. Significant financial inducement may be necessary to achieve this objective.

**Communication Plan:** This should include a description of how internal communications and communications with external stakeholders will occur. Prior to any public announcement, certain key stakeholders should be advised, and their counsel elicited. Among others, this may include the chief of staff, hospitalist leaders, key hospital departmental heads, local EMS leaders, and any vendors with contracts or relationships with the prior group. As noted previously, if this involves any academic programs (even beyond EM), special attention must be paid to ACGME and other logistical notifications and requirements. Within 48 hours of the execution of a new group contract, communications should be delivered to the medical staff, ED team, and hospital-wide. Spokespersons from the new group should be onsite to answer questions and to meet with various departments. Note, this may require presence during off-hours due to the 24/7/365 nature of acute hospital care. There will undoubtedly be many questions and possibly fears related to the transition which can be allayed with a good communication plan. The outgoing group should communicate with its staff at an appropriate time, which may precede the above. A professional tone in this communication will set the stage for a smooth transition. Questions to be addressed may include:

- 1) Will current staff have employment opportunities with the outgoing group elsewhere?
- 2) Will the incoming group be retaining any of the current providers or will non-competes prevent this?

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<sup>4</sup> For further information related to maintaining a contract, the reader is advised to reference ACEP’s information paper “Obtaining, Maintaining, and Retaining an Emergency Department Contract” at <https://www.acep.org/obtaining-maintaining-retaining-an-emergency-department-contract>

- 3) Will there be impact on benefits, such as health, life or disability insurance and pension plans?
- 4) What will be the status of malpractice insurance and tail coverage?
- 5) What are the logistics and timing of the transition? And particularly, what happens to members of the outgoing group who had joined the group with the promise of partnership and were just about to become partners? (Did the contract the physicians had with the group address this possible scenario?)
- 6) If an academic institution, what will be the impact on the residencies?

**Leadership Plan:** This should describe roles and responsibilities of key leaders, including a transition manager, medical director, as well as billing personnel, revenue cycle management and human resources staff. If the medical director and other clinical leadership will change, efforts should be made to overlap the incoming and outgoing medical directors. This may include a stipend for the outgoing director in recognition of the value, importance, and discomfort involved in training a replacement.

If possible, the new medical director should be in place shortly after contract execution or two months prior to the start date. This will help ensure continuity of critical departmental elements, such as complaint management, clinical care review, and the integration into the hospital culture.

Transition planning meetings with the ED nurse leadership and various department heads, such as radiology, lab, surgery/trauma, hospitalists and other hospital-based physicians, are critical to ensuring patient safety in a coordinated transition. These meetings ensure open lines of communication and allow for prompt identification of problem areas that may need attention.

**Knowledge Capture:** The ED may have ongoing projects and processes which require a transfer of knowledge to ensure continuity. In addition, there are always unique aspects to every ED that simply take time to learn. Efforts to capture these elements and commit them to writing to orient the new physicians are worthwhile.

**Staffing and Recruiting:** Shortly after contract execution, representatives from the new group should reach out to current emergency physicians and APPs to provide details of the transition, addressing the following questions:

- 1) Which, if any, current staff will be asked to remain?
- 2) What is the application process and timeline?
- 3) What will be the new compensation and benefit package?

An early goal of the transition must be a clear assessment of recruiting needs to replace current and potential future vacant positions. Even with a mutually agreeable transition, attrition is to be expected before and within 6-12 months of the new contract. The largest pool of newly available emergency physicians occurs each June, as senior residents complete their training, and most graduating residents will commit to a new position 3-6 months prior to graduation. This should be considered when planning the timing of the contract transition, to give adequate time to recruit new hires.

Hiring bonuses and “incentive pay” to garner local qualified physicians to staff the ED while a more permanent staff is being established should be anticipated and funding budgeted.

**Credentialing & State Licensure:** If new providers are expected to be hired, a clear understanding of the hospital’s credentialing timeline must be considered. The ability to obtain expedited (emergency) medical staff privileges is key. Without this option, the credentialing process can often take 90 to 120 days. The hospital should consider providing extra support for credentialing if the number of new providers will be large.

State licensure is much more problematic. Some states have an expedited and/or transitional licensure process, although usually only for physicians already licensed in another state. Nevertheless, that process may take 2 to 6 months depending on several factors. Hiring staff to manage these processes should be considered if a large number of new providers are anticipated.

***Orientation and Onboarding:*** Adequate time and resources must be devoted to training new providers on use of the EMR and on departmental orientation. This will generally include 1-2 days of training and orientation (depending on several factors), followed by at least 2-3 shifts where new providers are considered extra staff. Efforts should also be made to introduce the new providers and new group to the existing medical staff.

***Revenue Cycle Management:*** Most emergency physician groups have robust coding\billing operations and have sufficient capital necessary to front startup expenses while accounts receivables mature. But these are certainly considerations a hospital should ask the new group leadership about during contract negotiations. ED documentation transfer may require assistance of information technology (IT) and medical records, so be sure they have sufficient resources. The contract should delineate responsibilities for various aspects of coding, billing and collections, as well as any requirements with regard to health plan contracting. Other more nuanced issues (such as billing for ECG and radiology initial interpretation) may need to be addressed.

***Academic Training Programs:*** If the hospital in question involves an EM residency, the incoming group must work closely with the ACGME to ensure stability and continued accreditation. ACGME requirements have already been noted, but even without an EM residency, there may be other residencies or fellowships that require EM experience or a relationship with a medical school for training of medical students or nurses. Losing ACGME accreditation for the EM residency can affect other affiliated residency accreditation at the hospital, as well as hamper the ability of other hospital residencies to recruit quality applicants.

***Emergency Medical Services (Pre-Hospital):*** Many EMS agencies depend on EMS medical directors who are part of a hospital-based emergency physician group. The incoming group must meet with these local EMS agencies to determine if new EMS medical directors will be needed.

### **Start Up Phase**

***Prior to Transition (Days 90 to 0):*** Once knowledge of the transition is known, there may be rapid attrition of staff, and measures may need to be taken to maintain adequate staffing.

***Early Transition (Days 1-7):*** The new group may need to staff more than normal in recognition of a significant drop in productivity associated with using an unfamiliar EMR and working in a new environment, preferably with IT support available 24 hours a day in the ED.

***Mid-Transition (Days 7-28):*** Excess coverage can be tapered, as most new physicians and other providers will have completed their orientation and first shifts. However, special attention should be paid to patient and staff feedback, as these may be early indications of elements that are or are not working and can be addressed at this time.

***Late Transition (Days 28-90):*** Staffing levels should return to normal, and leadership quality teams should gather initial quality data to quickly identify opportunities for improvement. Ongoing feedback from physicians and nurses is critical to assess and recognize successes and identify weaknesses to be remedied.

### **Integration Phase**

This phase has significant overlap with its two adjacent phases but is worth considering here in isolation.

**Communication:** Efforts should focus on developing clear, bidirectional communication with nursing staff, ED physicians, administration, the hospital medical staff, and the greater medical community.

**Leadership:** A permanent ED physician director and other group leadership should be in place and in the process of integrating into the hospital organizational structure.

**Staffing and Recruiting:** Permanent ED physician staff and APPs should be in place or contracted with a start date.

**Revenue Cycle Management:** Cash flow will significantly improve as accounts receivable begin to mature.

**Quality Data and Results Review:** Sufficient data is likely available for leadership to assess compliance with ongoing quality and process improvement initiatives. Careful consideration should be undertaken to compare performance to the period before the new contract.

### **Evaluation and Feedback Phase**

Most focused professional practice evaluations (FPPE) advise provider performance reviews at 90 to 180-day marks. The medical director should consider “360-degree reviews” for emergency physicians and APPs. This can also be an excellent way to survey providers to gauge levels of engagement and to uncover any areas of stress or risk. Open collaborative discussions with hospital and medical staff leadership should focus on areas that are working well and on areas that have opportunities for improvement.

Special attention should be paid to patient satisfaction surveys. This should include the national surveys (eg, Press-Ganey and Picker), as well as local surveys undertaken in support of specific initiatives.

Development of new quality initiatives should be crafted by multi-disciplinary teams anchored by emergency physicians, emergency nurses and members of the hospital administrative team.

### **Difficult Transitions**

Difficult (or dysfunctional) transitions can occur for many reasons, but are usually due to poor planning, a lack of resources, or rushed transition. However, upon occasion, they result from either a hospital (administration) that is being unreasonable or a physician group that becomes vindictive over losing the contract, or both.

From a professional, practical, and even ethical standpoint, it is important to recognize when a contract transition is inevitable that cooperation is needed to assure a coordinated transition. “Fighting to the bitter end” leads to a multitude of unproductive behaviors and does not serve anyone’s interest, least of all the patients and other staff. To be clear, once a physician group puts a hospital in a difficult position by threatening or implying they will not cooperate with an inevitable transition, the war has already been lost. This is not to say that either side should not exercise their legal rights and power of persuasion, but at some point, both parties need to recognize the relationship cannot be salvaged.

On the other side, hospitals need to respect and treat the physicians with dignity. There are times when a contract transition truly is a “business decision.” But this does not give the hospital a right to disparage the physician group. There may be times when it is in the best interest of the hospital to extend a contract or offer a “transitional” short term, more lucrative contract to avoid a disaster.

Finally, emergency physician groups should consider declining certain contract offers that do not follow best practices outlined in this paper. Put another way, emergency physician groups should not “enable” a hospital by agreeing to participate in a limited notice uncoordinated hostile contract transition.

Historically, there are instances where these scenarios have occurred to some degree. The “handover” for example, is likely to be more difficult to occur on New Year’s Eve for multiple reasons, even if the date is because it is the last day of the contract. It is strongly recommended to set the contract renewal\ cancellation date at a slower time of year.

While there are always at least two sides to every story, and while there may be fundamental disagreements, one should respect decisions made by others. It is important not to let frustration and anger seep into the ED, its staff, and patients. Preparing the ED for the success of the next group is the right thing to do, while at the same time taking care of the professional, business, and personal needs of exiting physician colleagues.

Finally, there are some guiding principles for both hospital administration and physician leadership that may avert disruptive transitions:

- Open, face to face, proactive communication, especially with regard to outstanding issues
- Honest discussion of concerns, issues, problems
- Realism in approach to resolution of concerns
- Understanding and respect for the terms and conditions of the contract
- Respectful dialogue
- Recognition of longevity and loyalty to the organization
- Understanding of what each side can and cannot change
- Desire to preserve reputation regardless of outcome
- Creating ability for graceful exit

### **Considerations Specific to Physicians During Contract Transitions**

This section has been added to address issues of contract transitions that individual emergency physicians may need to recognize and consider during a contract transition. Circumstances may differ if the physician has financial ownership in the contract versus a non-equity member of the group. As noted, the need for a contract transition can be avoided with good communication with administration and addressing problems as they arise. Hospital administration needs to realize that there is inherent value in having experienced (ie, aware of hospital culture, proficient use of the EMR, rapport with the medical staff, nurses and other personnel, etc.), well-qualified emergency physicians staffing the ED. However, certain contract transitions may be unavoidable, such as a hospital system acquisition in which the contracted “system” ED group manages all of the EDs.

No matter how smooth or difficult the transition is, losing a contract is unsettling and difficult and may come as a complete surprise to many of the physicians involved. Many emergency physicians are not aware or privy to the hospital contract details or negotiations. Distress and even panic can set in quickly if the future is suddenly uncertain with regard to income and providing for themselves and/or family. It is helpful if physicians can be informed of the contract termination early and notified if there will be an opportunity to work with the new group. Open communication can offer some assurance and avoid a mass exodus of providers. Also, potential new hires and physicians working toward partnership should be informed of any likely or ongoing transition immediately, in case they need to postpone major decisions.

Upon being informed of the contract termination, physicians may wish to consider consulting legal counsel. There may be contractual rights and responsibilities of which they are not aware, such as bonuses due or deferred compensation and how accounts receivable will be distributed after the termination date. This is particularly important for those with an equity or ownership in the group. There may be contractual obligations that preclude leaving before the contract is expired. If the physician has been covered by a “claims-made” malpractice insurance policy (the most common), then purchase of an “extended reporting period,” often referred to as “tail coverage,” may be necessary if not provided by the

group. An “occurrence” policy does not require “tail coverage.” Another reason for legal counsel is that a restrictive covenant may not be enforceable if the contract has been terminated due to a material breach by either of the parties involved. Other important information may not be known to the physician.

Consideration also should be made regarding consulting a financial or benefits advisor and obtaining information that pertains to health insurance, life insurance, disability insurance, and retirement accounts (IRA, SEP IRA, 401(k) plans). It may be less expensive to transition the current policies or plans than to obtain new ones.

If the physician can join the incoming contract holder, it is important to find out what changes will occur, such as compensation and benefit packages. The reason for the transition is important to know (for example, administration desires improvements, such as faster throughput, higher patient experience survey scores, or improved documentation, of which the emergency physician may not approve). Other changes must be considered, such as the incoming group plans to save costs by decreasing coverage; or conversely, plans to increase coverage by request of the hospital, which may impact compensation.

Lastly, when a contract transition is unavoidable, it is best to help make it as smooth as possible. It may be impossible to resist being upset, and in certain circumstances, legal action may be warranted. But bringing this anger and frustration to work is not helpful. Anything derogatory you may say can place you in legal jeopardy, so anything said in a public forum is best undertaken under the advice of legal counsel.

This information paper is intended as a resource of best practices for contract transitions and should not replace professional and legal advice pertaining to individual situations.

***Created by members of the Contract Transitions Task Force, April 2018***

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