

# **THE BUSINESS OF EMERGENCY MEDICINE ... MADE EASY!**

**Sponsored by AAEM Services, the management education division of AAEM**

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## **Disclaimer**

The views presented in this course and syllabus represent those of the lecturers. The information is presented in a generalized manner and may not be applicable to your specific situation. Also, in many cases, one method of tackling a problem is demonstrated when many others (perhaps better alternatives for your situation) exist. Thus, it is important to consult your attorney, accountant or practice management service before implementing the concepts relayed in this course.

## **Goal**

This course is designed to introduce emergency physicians with no formal business education to running the business of emergency medicine. The title “The Business of Emergency Medicine Made Easy” is not meant to be demeaning. Instead, the course will convince anyone with the aptitude to become an emergency physician that, by comparison, running the business of emergency medicine is relatively simple. With off-the-shelf software and a little help from key business associates, we can run an emergency medicine business and create a win-win-win situation for the hospital, patients, and EPs. By eliminating an unnecessary profit stream as exists with CMGs, we can attract and retain better, brighter EPs.

AAEM’s Certificate of Compliance on “Fairness in the Workplace” defines the boundaries within which independent groups should practice in order to be considered truly fair. Attesting to the following eight principles allows a group the privilege of advertising itself as AAEM-endorsed:

- Access to predefined due process after a provisional period up to one year
- Detail of professional charges/collections provided to EPs
- Predefined and reasonable pathway to full and equal partnership within three years
- Partners provided the total charges/collections for the group and distribution of all group income including all management and operational expenses

- All EPs provided details of the governance process including the method of selecting partners and officers, appointing medical directors and revising the bylaws
- No post-contractual restrictive covenants (i.e., non-compete clauses)
- Group, or its controlling entity, wholly owned by practicing physicians
- All full partners will maintain AAEM membership and subject to its code of ethics and sanctions therein

It is the intent of this course to be exceedingly user friendly by avoiding accounting terminology. We want physicians to leave with a general understanding of what is involved in launching a new group and a feeling that they can succeed with no formal business training. In other words, "The Business of emergency medicine made easy."

## **Business Plan – Revenue**

### **Introduction**

The terms “pro forma” or “business plan” refer to the development of financial assumptions that reconciles all significant expenses with expected collections based on forecasted conditions. To move the possibility of group formation forward it is necessary to construct an accurate business plan. In its simplest form, the business plan reconciles all components of expense with those of revenue. This section covers the main considerations regarding the key aspects of expense and revenue as they pertain to typical physician group practices.

### **Accounts Receivable**

The primary revenue stream is from reimbursement of professional charges. The coding/billing/collecting company (CBCC) you choose will take responsibility for estimating your collections for business plan development. Once the practice is off and running, the CBCC must make sure you get paid adequately, regularly, and on time.

The total expected revenue anchors the business plan. Remember that the collections component of this number is an educated guess – still, a guess. It is true that most emergency physicians are goal-seekers. Nonetheless, in designing or approving a

business plan cast a discerning eye on revenue and become absolutely sure that you are no overestimating collections. Engage a trusted CBCC and not one that makes unrealistic promises to attract you as a new client. Develop the best, the most likely, and the worst-case scenarios. You will unlikely be disappointed if you devise your business plan nearer the worst case with regard to collections.

Expect a several month ramp up regarding collections until a steady state is achieved. Many payers take over a few months to pay and certainly after the treating physicians are credentialed and the group has contracted with the payer. Given a few months head start for credentialing, expect a linear increase from 0% to 100% over 6 months. The group will require a minimum of three months of revenues as part of a start up loan (see Figure 1), unless salary deferral is preferred. The total loan will needed will also need to include first installments (about 35%) of professional liability, workman's comp, and Directors & Officers (D&O) insurances, as well as attorney, accountant and CBCC, start-up fees.

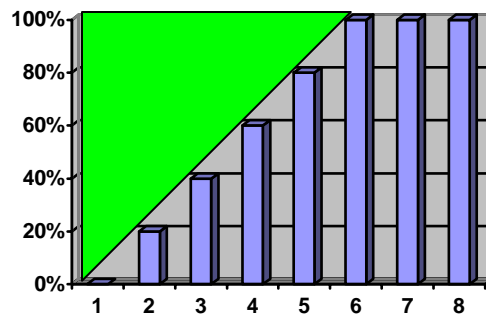


Figure 1 – the columns represent collections by months in business and the triangle represents the loan amount needed to cover salaries.

### Practice Support Stipend

When fair salaries plus business expenses exceed the reimbursement capabilities of the payer mix, the hospital must kick in a practice support payment so that the group can survive. This generally occurs when the rate of Medicaid plus uninsured cases exceeds one-third of cases. Even when the payer mix is better, low volume hospitals may need to subsidize 24/7 staffing of emergency physicians. Finally, most hospitals pay the group a

stipend for medical services that directly benefit hospital operations such as those performed by the chairperson, medical director, EMS director, and education director.

A practice support stipend demonstrates that a hospital is committed to providing the community and the other medical staff with qualified emergency physicians regardless of its circumstances. The indirect, of course, is great as many (often most) admissions originate from the emergency department and other hospital services are “advertised” when patients and their family/friends regularly appreciate excellent care.

Assuming the going rate for emergency physicians in a certain geographic is \$150 per hour (including the value of benefits) and the number of patients per physician per hour (PPH) is 2.2, and all practice expenses amount to \$30 per patient, then the collection rate must be  $(150/2.2+30)$  \$98 per patient. If the average collections for uninsured and Medicaid patients is \$38 and for the rest is \$128, then the break even point is when there are 33% uninsured and Medicaid patients combined. If there are actually 50% uninsured and Medicaid patients, then there is a deficit of \$15 per patient. If the ED experiences 50,000 ED visits, then the necessary practice support is \$750,000.

As you can see, it is not difficult to estimate any necessary practice support. The real question is what hospital administrators consider reasonable. Take a principled, facts-based approach. Assume qualified emergency physicians will be adequately staffed (AAEM position statements support this basic premise). Next, your CBCC can develop a revenue estimate. The going rate for qualified emergency physicians in a particular geographic area is common knowledge among emergency physicians. Use local advertisements or the most recent Daniel Stern & Associates salary survey to convince disbelievers. If a practice support stipend is approved, the group is usually required to open their books periodically to hospital administration so that the CEO can demonstrate fiduciary due diligence and compliance with the Stark (fair market cost) requirements.

## **Startup Loan**

As previously mentioned, after a group acquires a contract, it will take several months to mature the steady stream of collections necessary to make the payroll. In addition, many significant startup costs will be incurred early on such as attorney's fees and an initial malpractice insurance payment.

A business plan will estimate the amount needed for a startup loan. If incumbent emergency physicians are being offered the contract (e.g., converting from employed to independent) the hospital may front the loan and secure it with the future accounts receivable. Alternatively, the group will need to shop for a bank loan and risk personal assets as collateral though, assuming an accurate business plan, the personal risk is low.

When a group receives a stipend due to a challenging payer mix, the hospital will generally demand periodic financial audits to be sure the arrangement is fair. One indirect indicator that the group could tolerate a lower stipend is when a hospital-provided loan is paid back faster than the loan agreement requires.

## **Business Plan – Expenses**

### **Salaries**

The greatest single expense for a physician group is salary. What emergency physicians are paid for professional services varies widely from group to group. To determine the minimally acceptable salary for the business plan, a long discussion with group members is necessary. Too high a figure (whereby a hospital stipend becomes necessary or inflated) may result in loss of the contract to a CMG that can find physicians to accept a lower rate. Too low a figure may encourage attrition, difficulty recruiting, and failure to maintain the contract.

Become aware of what local groups are paying emergency physicians in your area. Consider those hospitals that represent competitive situations. In order to compare 'apples' to 'apples,' convert the value of any benefits into an enhanced hourly rate). Include undesirable shift differentials, overtime, holiday pay, emergency staffing

bonuses, incentive bonuses or any other add on you may be considering. For instance, a group paying \$120 per hour and offering five weeks of paid time off, a \$5,000 CME stipend, medical/dental insurance, and a matching pension may be financially equivalent to a group paying \$150 per hour with none of these benefits. Based on this information, determine your group salary expectations.

In addition to the average hourly pay rate, the amount of paid hours per day is integral in determining the salary expense. Average hourly rate divided by PPH and multiplied by annual volume quickly determines the clinical salary expense. For instance in a 50,000 visit ED with a pay rate of \$150 per hour and an average of 2.2 patients per physician per hour (PPH), the annual salary cost is \$3.4 M or \$68 per patient. By contrast in a single-coverage, 12,000 visit ED, maintaining \$68 per patient for salary means the hourly pay rate must be \$93. This is because the night physician experiences 1.2 PPH. In this low-volume ED, to maintain salary at \$150 per hour, \$110 per patient must be realized.

Often, you will be competing against large, national CMGs for the contract. In some respects, by eliminating an expense line item for “corporate profit,” you will always be more competitive. Once you know the minimum it will take to staff the ED with qualified physicians (and midlevel providers where applicable), you will have a firm foundation for developing your business plan. Hopefully, you will be able to appreciate more revenue and return it to the practicing physician.

Your competitors for the contract may be willing to take a loss during the first contract cycle hoping to turn a profit in subsequent years by leveraging their “home court advantage.” Once chummy with the administration they are better able to encourage a higher stipend. Also, unfair contract clauses can facilitate this goal. Restrictive covenants make it difficult for a CEO to lose the CMG and keep the practitioners. The CMG may under staff to increase profit and can and summarily terminate any complainers that signed away their due process rights.

In formulating the business plan, it is important to realize that the employer must match the FICA portion of an employee's taxes. Plan on about \$9,000 per fulltime position..<sup>a</sup>

### **Physician Administration**

The amount of administrative time required in running a top-notch emergency department is significant. Physician administration involves oversight and improvement of emergency department and pre-hospital operations, hospital-wide committee work, maintaining excellent medical staff and CEO relations, and assuring high quality educational offerings. In my opinion, the number of physician administrative hours required weekly for proper departmental administration can be roughly estimated by dividing the annual emergency department visits by 1,000. This formula is based on the assumption that 10% of all physician hours are required for proper administration and 90% for clinical work. The formula,  $\text{annual volume}/10^b/2.2^c/46^d$ , is approximated by dividing the annual visits by 1,000. Through my personal experience and discussions with Chairs and Medical Directors in our field, administrative time and cost requirements are commonly under estimated. Job security and professional satisfaction of all group members depends on hiring talented physician administrators and allowing them ample time to continually improve professional services and interpersonal relationships.

### **Professional Liability Insurance**

Of non-salary costs, the largest item by far is professional liability insurance. Beginning in 2001, groups experienced much higher rates, tougher underwriting criteria, and a reduction in insurers. Emergency medicine is an expensive specialty to insure due to round-the-clock staffing, overcrowding, and the diminishing availability of consultants. In addition, physician credentials and adequacy of staffing is inconsistent from hospital to hospital.

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<sup>a</sup> In 2004, the employee and employer portions of FICA are each calculated at 6.2% times income, up to a maximum income of \$87,900, plus 1.45% of all wages. Thus, an employee making \$250,000 costs his employer \$9075 ( $\$87,900 \times 0.062 + \$250,000 \times 0.0145$ ) in FICA.

<sup>a</sup> derived from an administration:clinical hours ratio of 1:10

<sup>b</sup> national PPH average

<sup>c</sup> worked weeks per year

“Claims-made” coverage extends for a specified period, usually one-year increments. The rate usually ratchets up until a mature rate is achieved after 3-4 years though some products require a mature rate immediately. “Tail” coverage provides retrospective malpractice insurance after a claims-made policy ends and is necessary to protect personal assets should the contract terminate. The cost of tail insurance is about twice the prior year “claims-made” premium and a provision for paying it should be incorporated into the business plan. The Office of the Inspector General (OIG) is supportive of hospitals funding the liability coverage – i.e., a safe harbor with regard to anti-kickback (Stark II) statutes.<sup>a</sup>

New groups are advised to seek a knowledgeable insurance broker early in their development to get an accurate cost estimate and to begin the onerous process of credentialing. Because of its expertise in emergency medicine, MGIS, a professional liability insurance brokerage entered into a business agreement with AAEM Services. The chief contact, David Hambright, can be reached at (866) 457-4204.

### **Coding, Billing, and Collecting Company (CBCC)**

Careful consideration must be given to the company that will code your charts and collect from your patients. Find a company that knows emergency medicine and the payers in your region, keeps up with and adheres to the latest coding regulations, can rapidly credential new physicians with all the payers, and offers regular feedback on ways to improve documentation.

The group that promises the highest revenue as they may simply be trying to woo your business and might put you at risk with up-coding. Call other ED directors in your region and get recommendations on a CBCC that will give you an accurate collection estimate.

The price to code and bill a chart set at a flat rate creates no up coding incentives to the company you choose. Some recommend using a different company for collections and

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<sup>a</sup> See <http://oig.hhs.gov/fraud/docs/alertsandbulletins/MalpracticeProgram.pdf>

paying this portion on a percentage basis. Expect to pay between \$6 and \$10 per case for coding, billing and collecting depending on the region.

### **Attorney and Accountant**

Consulting attorneys and accountants is part and parcel of developing a new group, forming a corporation, negotiating a contract with the hospital, creating employment agreements, seeking a lender, setting up a bookkeeping system, and a myriad of other business details. It is important to find individuals that you trust and that have experience in physician group development.

Expect to pay a minimum of \$25,000 and a maximum of \$50,000 for the first year of a new group for legal and accounting assistance. Subsequent years may be more like \$5,000 to \$10,000 assuming there are no contract disputes, business law suits, or government audits. Unless you have a unique relationship with a particular firm, a retainer will be necessary before significant work begins.

### **Documentation costs**

Typically the costs related to emergency physician documentation are met by the hospital and the range per patient is from under \$1 for templates to about \$6 for outsourced transcription. In some cases though, especially when negotiating a lucrative contract, the group may consider offering to relieve the hospital of this burden.

### **Cash Reserves**

Cash reserves represent the financial cushion necessary to conduct business. It absorbs the cyclic variations collections and expenses. Since this money becomes liquid only upon dissolution of the group, it must be considered a startup expense. A good estimate is 50% of the payroll costs.

### **Miscellaneous**

- Loan interest and payback
- Workers compensation insurance

- Contributions to various hospital fund raisers
- Directors and Officers insurance
- FICA
- Recruiting

**Unforeseen Costs**

As Gilda Radner lamented, “It’s always something.” Fore planning for the unexpected epitomizes the clinical practice of emergency medicine and it must be considered in our business practices. It’s impossible to tell you what this expense will be or it would otherwise be categorized. Perhaps a contract dispute leads to unanticipated legal costs. Perhaps the hospital assumes you understood that the director office required a lease cost. Regardless, plan on a \$25,000 surprise (or two) and you won’t be sorry.

<b>Wages</b>	<b>Calculation</b>
<i>ED staffing</i>	<i>hours per day * average hourly rate</i>
<i>Overtime</i>	<i>if allowed</i>
<i>Holiday/Call-in Premium</i>	<i>if allowed</i>
<i>Incentive Program</i>	<i>if allowed</i>
<i>Physician administration</i>	<i>estimate by dividing above subtotal by 9 (9:1 ratio)</i>
<b>Other Practice Expenses</b>	<b>Estimates</b>
<i>Malpractice (claims made)</i>	<i>consult broker for annual premiums estimate</i>
<i>Malpractice (tail)</i>	<i>multiple above by 2 and divide by contract length</i>
<i>Coding/Billing/Collecting</i>	<i>\$6-10 per patient and varies by region</i>
<i>Legal/Accounting</i>	<i>start-up \$25-50K; thereafter \$5-10K/year</i>
<i>Miscellaneous/Unforeseen</i>	<i>allow \$50-100K</i>

Figure 2 – Example of the major expenses in a simple business plan

## **Negotiation Tactics**

Negotiating with the hospital to become the exclusive provider of emergency services is a delicate task. If you are the incumbent group (e.g., hospital wants to move from employing physicians to partnering with a group) and you are well liked by administration and the medical staff, then you are likely to get the contract if you make reasonable requests. Often times, for a variety of reasons, a hospital will want to terminate the contract with one group and consider others. When this is going on, the first task at hand is determining why the transition is taking place. Perhaps the former group could not meet achievable satisfaction goals because of understaffing. Perhaps the former group was doing a great job and the CEO wanted to cut the practice support payment.

During the negotiation process, learn as much as possible about the hospital's needs and goals. Be honest and decent. Negotiation is all about posturing so never overreact to an offer or issue. If a request seems unrealistic, a pre-existing, amicable relationship sets a great stage for correcting misperceptions.

A successful businessperson never displays anger during intense negotiations. Of course, it is hard not to reciprocate when confronted with anger. Here's an approach that will improve one's effectiveness.

By listening more and talking less, you will learn the other position fully and be given far more attention when you do speak. Taking things personally causes us to respond angrily reliably and this worsens the situation. Instead, respond as you would to someone that really needs your help and direction. In business matter, focus on what you bring to the table and redirect financial disputes to discussions on fair market rates.

Make fair and accurate appraisals of every situation. Don't jump to conclusions nor let personal biases interfere with understanding the issue from the other person's perspective. If you want to "bring someone along" on an issue, connect

first and try to change misperceptions later. Demonstrating that you are genuinely interested in someone else's concerns and gets that person to open up.

Paraphrasing what you heard demonstrates that you have paid attention and are trying hard to understand their views.

Once you understand their position, state yours. While maintaining respect for their position, defend yours. Be neither aggressive nor passive – a challenging balance. Stay focused on relevant facts and strive for compromise. The goal is to turn a transactional interaction (my way) into a transformational interaction (our way).

If the hospital is considering a “national staffing company,” you might remind the decision makers that the corporate practice of medicine is banned, or restricted, in most states. This legal doctrine is founded upon the principles that lay organizations can neither employ physicians nor share in professional fees. In addition, AAEM is concerned that certain corporate employment arrangements involve prohibited fee-splitting activities under current state and federal statutes.

A locally based group structured as a true partnership offers several advantages for hospital and community. Emergency physician stakeholders typically become ingrained in the fabric of the hospital and are more likely to make career-long commitments. Personal concern in the success of the practice drives physicians to serve patients in an exemplary manner.

CMG contracts are often amenable to legal dismantlement. When the hospital CEO pushes for change, non-interference clauses are muted. Also, non-competition clauses are often unenforceable as many states side with a person trying to make a living.

CMGs that make lofty promises to land contracts. They guarantee excellent retention of the current physicians (unless administration wants someone removed). If you do not make it absolutely clear that the current talent will not work for an unfair CMG (and

mean it), the cycle may continue. By utilizing a proven management services organization, you will convince hospital administration that your business will succeed.

Once awarded the contract, the rest is surprisingly easy. Despite the requisite trepidations, emergency medicine is a relatively low-risk endeavor. There is no significant equipment to buy, space to lease, or office staff to hire. Billing companies are readily available to optimize your managed care contracts and bring in revenue. Your local bank will certainly extend a start-up loan. Experienced attorneys and accountants can incorporate your group, write and review contracts, and design benefits programs. User-friendly computer programs and web-based services make bookkeeping and payroll a snap.

## **Preparation**

### **Setting up a corporation**

In setting up a professional corporation, it is important to determine what type of entity (i.e., C corporation, S corporation, or LLP) will best meet the group's business, legal, and tax goals and this is a question for an accountant or attorney. Beside personal asset protection, a corporation facilitates benefits such as a defined pension plan.

A corporation is recognized as a separate legal entity, distinct from its owners, and is liable for debts, obligations, and liabilities, including income taxes. This arrangement limits shareholder liability regarding any debts and obligations of the corporation, thus protecting personal assets. This assumes that the corporation was properly setup and rules are followed.

Directors must observe legal formalities. Annual meetings must be held, meeting minutes taken, Officers appointed, and shares issued. When these requirements are ignored, shareholders may be held personally liable should the IRS "pierce the corporate veil."

Shareholders own the corporation and elect a Board of Directors responsible for corporate management and policy decisions. Officers (e.g., President, Vice-President,

Secretary, and Treasurer) are elected by the Board and conduct day-to-day operations. Shareholders may be required to approve the actions of the Board when Bylaw amendment, mergers or dissolution is planned.

A corporation will be taxed on any fiscal year end profits and when these are paid out as shareholder dividends, they are taxed again. In practice, such double taxation rarely occurs since owner-employees are typically paid salaries and fringe benefits that fully consume any profit.

### **Staffing – Qualifications and PPH**

Nothing is more dangerous to the community and a group's longevity than being a cheapskate when it comes to emergency department staffing. Quality and perceived compassion require time and pleased patients elevate the hospital's reputation and drives future business.

Productivity correlates with reduced waiting times and this leads to increased patient (and administrator) satisfaction. However, in order to preserve quality, an average load of 2.5 patients per physician per hour (PPH) should not be exceeded.<sup>a</sup> This benchmark is upheld by AAEM and allows an emergency physician to achieve the depth of data acquisition and time for decision making necessary to consistently provide excellent medical care and patient satisfaction. Many believe a rate of 2.2 PPH allows for the optimal balance of professional and patient satisfaction.

If you know the annual volume of the ED, assuming it is a relatively typical setting, the number of staffing hours can be backed out. Calculate the PPH through an average day in one-hour blocks. As a rule, single covered EDs should have annual volumes not exceeding 18,000, since half of the patients usually arrive in the busiest ten hours. EDs with minor care or pediatric care areas effectively "condense" higher acuity cases in the main ED, where the maximal main area PPH may appropriately drop below 2.0. A good MLP (NP, PA, senior emergency medicine resident) will extend a seasoned EP by 50%.

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<sup>a</sup> Graff LG, Wolf S, Dinwoodie R et al: Emergency physician workload: a time study. *Ann Emerg Med* 1993; 22(7) 1156-1163.

In other words, the two-person team can safely see (meaning the EP prospectively supervises each case) up to 3.75 PPH.

Independent emergency medicine groups may self-impose high PPH levels to maximize compensation. This becomes harmful to job security when important findings are missed and negative comments like "the doctor barely saw me" become prevalent.

Given a fixed cost to staff an emergency department, patient volume per physician per hour worked (PPH) is directly proportional to salary. For example, let's assume a high-volume, high-acuity emergency department has a PPH of 2.2. Basic algebra proves that increasing it to 3.3 results in either a 50% increase in salary or a 33% reduction in shifts. For those that like tangible examples, getting paid \$150/hour with a PPH of 3.3 is equivalent to getting paid \$100/hour with a PPH of 2.2. Conversely, if you work 24 hours a week with a PPH of 3.3, you must work 36 hours a week with a PPH of 2.2 to maintain the same salary.

While physicians can be incented to increase productivity, this effort should be tempered by quality and satisfaction standards. CMGs may financially reward a PPH increase from 2.2 to 3.3, by splitting the excess profit with the EP. While the physician expends more stress and risk, the CMG simply carries a heavier sack to the bank. CMGs are not the only force encouraging excessive PPH levels. Financially motivated democratic groups sometimes hold off as long as physically (and mentally) possible before increasing coverage.

### **Payee Credentialing and Contracting**

The credentialing process can be quite cumbersome as there are many payees with which to contend. This work is usually spearheaded by your CBCC. It is important to realize professional services are held until the payer recognizes a new provider and group.

Managed care and PHO contracting are crucial and something your CBCC, attorney, and accountant should help you optimize.

## **Running the Business**

### **Payroll – Incentives, differentials, etc.**

Many groups run their payroll on a monthly basis. Bonuses often correlate with fiscal year end. Ending the fiscal year on October 31<sup>st</sup> avoids the end of a quarter, separates the fiscal and calendar year-ends, and achieves a nice time for bonuses to be distributed (just before the holidays).

### **Bookkeeping**

With a short tutorial, one can master an off-the-shelf program such as QuickBooks Pro. This program makes an easy and enjoyable job of organizing revenue and expenses and creating reports. With little prior computers or accounting experience one can keep careful books. A means of data backup is essential to prevent a real nightmare should your computer fail. These systems allow an easy way to send your accountant periodic updates for review and tax preparation.

### **Lockbox**

A lockbox is a banking service that reduces receivables processing time by directing payments to a unique Post Office box that is emptied, counted, verified and processed each business day. This service reduces the cost of hiring an assistant to process payments and provides better audit control by separating the billing and receiving transactions. The cost of providing a lockbox will be an important determinate in which bank is chosen by the corporation.

### **Business manager**

While it is good to master the business of emergency medicine yourself, you can soon become consumed with mundane tasks that can be delegated to a business manager. Hire an intelligent, reliable, and trustworthy person. AAEM Services recommends temporary practice management services until an effective manager is hired and trained.

### **Medical and Dental Insurance**

Many groups offer group medical and dental insurance. While an expensive endeavor, this makes the group more attractive to potential recruits, and is less expensive in the aggregate. Other groups require physicians to fund their own family medical/dental insurance plan. The later option allows those with spousal coverage to enjoy a higher salary but those with pre-existing conditions (and no spousal coverage) to pay high prices. New groups often have trouble affording group coverage. An alternative solution is to provide a method for reimbursing medical expenses with pre-tax dollars by designing a medical reimbursement plan. Your accountant and legal counsel can determine whether or not this is feasible given your corporate structure.

### **Pension options**

Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) increased the maximum elective deferral limit of 403(b) and 401(k) plans in a stepwise manner over several years (2004 \$13,000; 2005 \$14,000; 2006 \$15,000). Company sponsored plans can be designed to allow an additional source of retirement savings, up to \$40,000.

Groups can purchase and self-administrate prototype retirement plans that are flexible and IRS-approved. One such vendor can be found at [www.NPIN.com](http://www.NPIN.com). This can be set up such that participants can self-direct their investment portfolio according to options made available through the plan's designated investment service.

### **Life and Disability Insurance**

Consideration should be given to group life and disability plans, which are more cost-effective than individual policies.

### **Job Security**

#### **Inter-hospital Relationships**

Realize that we maintain our contracts at the pleasure of the hospital leaders and we earn their respect through opportunities to display our reasonableness and our patient-centered

efforts to improve quality, satisfaction, and efficiency. Our patients, nurses, and medical staff colleagues are the eyes and ears of hospital administration. Dole out praise constantly and constructive criticism when it's warranted. And, since medicine is an ever-changing art and science, stay atop of the literature.

When the issue of salary comes up because a fair stipend is being determined, maintain objectivity by sharing regional job ads and emergency medicine salary surveys (e.g., that published by Daniel Stern & Associates).

Make sure your department head is considered an asset to administration regarding knowledge, commitment, and forward thinking. Promote a senior emergency physician for a medical staff officer position. Group members should join and serve well on hospital committees. To further solidify your covenant, contribute generously to hospital charities and attend the social functions.

Make stronger ties and grow deeper roots in your community. Your hospital board and administration are intensely concerned with community perception and you can work to improve the hospital's image. Establish yourself as a public educator and an advocate for excellent health care.

With the current national nursing shortage, many hospitals have an easier time recruiting physicians than nurses. To maintain excellent nurse-physician relationships, recommend and attend open discussions. One arrogant or rude emergency physician is too many.

### **Quality and Satisfaction Measurement**

High quality care is non-negotiable. The department and hospital leadership must create an environment that allows one to deliver proper and timely medical care in an atmosphere of empathy and respect. The department head must formulate an immediate and effective action plan to handle any outliers.

A sensible *indirect* marker for quality is patient *perception* of quality – i.e., patient satisfaction with the emergency physician. This outcome correlates with empathy (e.g., concern about pain), interest (e.g., spending enough time), and ability (e.g., no subsequent revision in treatment plan). Many hospitals farm out satisfaction measurement to companies that rely on the completion of evaluation forms. Depending on survey return rates and the extent of subsequent analyses, such programs may or may not provide meaningful information specific to individual physicians.

An effective opportunity to measure satisfaction is via telephone callbacks. This practice has the added benefit of assuring the patient's well being and may even become part of the defense against future lawsuits. When a patient (or parent) is reached, documentation will exist that either that the patient's condition improved or that s/he was directed to return. A non-medical person with good interpersonal and problem-solving skills can perform callbacks as long as requests for medical advice are properly forwarded. The kind act of checking in on a patient alone improves satisfaction. Imagine, a day after seeing you, your patient hears "the doctor asked me to call to see how you are doing."

For some, there is an inverse correlation between productivity and satisfaction. *Hand-holders* (higher satisfaction/lower productivity) are those patients adore despite long waits. *Meat-movers* (higher productivity/lower satisfaction) keep the nurses running and the waiting room empty. Productivity and satisfaction are symbiotic efforts. Increasing productivity increases satisfaction because there is less waiting. Less waiting decreases the rate of those leaving before seeing a physician and this cultivates higher productivity. Incentive programs should cull *superstars*, those that do well in both areas.

The department head should not assume that poor scorers are unable to improve. With motivation, experience, and facilitation some rise from the bottom to the top. In addition, leaders must appreciate that a continuum of performance always exists. Finally, no matter how well an incentive system is designed to be fair, it will be regularly criticized whenever an abusive patient grumbles despite proper, timely, and compassionate care.

### **Operational efficiency**

It is very important to aggressively seek and implement quality-preserving practices that improve time and cost efficiencies. It behooves the medical director to become intimately involved in all aspects of patient flow in order to assure an efficient and safe system. This includes triage, registration, laboratory and radiology procedures, information systems, and the on-call system.

Many innovations are well suited for our practice. For instance, portable fluoroscopy units are being used to assess extremity trauma. Inexpensive handheld ultrasound devices offer similar efficiencies. Both require intellectual adaptation and a shift in responsibility from radiologists to emergency physicians. The reward of making such transitions comes from the professional satisfaction of mastering a new skill and managing patients more expeditiously.

Often, private physicians use the ED to extend their practice. In fact, the ED is a more efficient site to refer unscheduled problems even if they do not meet criteria for life or limb threatening problems. The marginal cost for us to care for one more patient on any given day is exceedingly low. In addition, when clear-cut admissions are sent to the ED, we are able to expedite the initial testing and treatment and, often, shorten the length of stay as a result. We can also make a better determination as to the most appropriate level of care. It is unfortunate that some emergency physician criticize patient referrals from private physicians.

### **AAEM's Principles and Resources**

AAEM's *Blueprint for Securing Emergency Medicine's Future* requires full control of the practice of emergency medicine as a necessary condition of accepting the responsibility for emergency patient care. To this end, emergency physicians should form democratic groups, bid for contracts, and share the pitfalls of unfair contracts with hospital staff and community members.

The first three principles in the *Blueprint* read:

- The ideal practice situation in Emergency Medicine affords each physician an equitable ownership stake in the practice. Such ownership entails substantive responsibility to the practice beyond clinical services.
- Emergency physicians should have control over their professional fees. It is they who earn them by toiling at the bedside.
- The role of Emergency Medicine management companies should be to help physicians manage their practice. The practice should be owned and controlled by the physicians and not by a management company.

By reiterating AAEM's Certificate of Compliance on "Fairness in the Workplace," we are reminded why emergency physicians are more motivated when working for a group abiding by these eight principles:

- Access to predefined due process after a provisional period up to one year
- Detail of professional charges/collections provided to EPs
- Predefined and reasonable pathway to full and equal partnership within three years
- Partners provided the total charges/collections for the group and distribution of all group income including all management and operational expenses
- All EPs provided details of the governance process including the method of selecting partners and officers, appointing medical directors and revising the bylaws
- No post-contractual restrictive covenants (i.e., non-compete clauses)
- Group, or its controlling entity, wholly owned by practicing physicians
- All full partners will maintain AAEM membership and subject to its code of ethics and sanctions therein

AAEM Services is the management education subsidiary of AAEM with a chief mission of providing management education and materials to AAEM members. AAEM Services will also provide information regarding qualified management services that may be able to assist our members. These vendors will contract directly with emergency physicians and assist in setting up and running successful, fair, independent practices. The following requests are most common:

- Business plan development

- Contract and negotiation coaching
- Education on business principles
- Choosing strategic alliances (insurance brokers, coding/billing/collecting companies, attorneys, and accountants)

Our practice consultants can confidentially review your particular situation and make recommendations to help you secure an independent practice. You will sharpen your competitive edge by utilizing a management services organization with a national scope and the endorsement of AAEM. You can reach AAEM Services at (800) 884-AAEM or [info@AAEM.org](mailto:info@AAEM.org).