

American College of Emergency Physicians

EMS Medical Director Contracts Evaluation Toolkit

Information Paper

Developed by the ACEP EMS Committee

April 2016

EMS Medical Director Contracts Evaluation Toolkit

Preamble

The goal of this document is to provide the physician with a basic foundation to “ask the right questions” when considering a new or existing relationship with an Emergency Medical Services (EMS) agency in the role of Medical Director. While the original resolution that began this project was centered on evaluation of the contractual relationships and implications of these relationships under Stark Law and Federal Anti-Kickback Regulations, the authors felt that it was important to provide a more general guideline by which a physician can develop a better understanding of contractual relationships between EMS agencies and the Medical Director. The specifics of how contracts function under Stark and Anti-Kickback regulations are a constantly changing and fairly technical aspect of contract law. The authors felt this particular evaluation was best left to attorneys with expertise in Anti-Kickback Regulations.

This document is not designed as professional legal advice. It is not intended to be a substitute for the services of an attorney and is not intended to be a comprehensive review. We strongly recommend that physicians have employment/contractor agreements reviewed by a licensed professional that is well versed in the local, state and federal laws and the professional standards that govern both the practice of EMS and the practice of medicine within a given jurisdiction. Much of the information in this paper comes from the collective experience of the authors across many agencies and years of EMS experience. It is recommended that EMS physicians should always seek professional legal advice before entering into a formal contract.

Introduction

The landscape of EMS is changing. With the creation of board certification of EMS, physicians practicing EMS medicine are beginning to understand and assert that EMS is no longer a side job that one engages in to serve the community and collect a small stipend. EMS is now a real profession, which just as the profession of emergency medicine, deserves to be protected and adequately compensated.

As EMS physicians enter into the market to seek jobs it will be necessary to consider implications of contract negotiations. EMS physicians who do not adequately prepare for and anticipate contract details risk not only financial loss, but also significant undue legal exposure.

Understanding that we are in the birth of this new sub-specialty of emergency medicine, and that there is quite a bit of variance in EMS systems and medical director relationships within a given EMS system, it would be impossible to script a standard EMS medical director contract for reference by EMS physicians. Thus, the purpose of this document is

to help physicians consider all the possible pitfalls that could be encountered in the contract negotiation process. Certainly, the list of questions that are explored in this document is not all-inclusive. Yet this list should be a good springboard for the development of a successful contract that benefits both the physician and the jurisdiction. Finally, as stated above in the Preamble, physicians are counseled to seek legal advice and contract review from an attorney in the negotiation process.

Questions that should be addressed:

1. *Employment type (independent contractor versus jurisdictional employee, academic buy-out, etc.)*

Do you fully understand the type of employment arrangement you are entering?

How will you receive compensation? (see #2)

Will you receive a w-2, a 1099 or some other document/benefit at the end of the year?

Will you be responsible for your own taxes or will the company/organization be withholding taxes?

If you are in a clinical offset arrangement, is the offset a fair compensation for your time? How will additional time requirements be handled? Who will handle this, and how often will this portion of the contract be revisited?

Discussion:

There are several different types of employment arrangements for an EMS Medical Director each with advantages and disadvantages. The three most common arrangements are that of employee (W-2), contractor (1099) or direct clinical buy-out. There are important implications of each type of arrangement and it behooves a physician to have a detailed understanding of the advantages and disadvantages of the job being offered. Each arrangement has specific obligations on the part of the contractor and the employer and the differences can have significant impact from the standpoint of tax liability, overall compensation, PTO calculations, vacation, sick time, and family/medical leave.

2. *Compensation rate and calculation: Several questions surround this topic for EMS medical directors.*

What is the rate being paid?

Is it a fixed rate per month/year or is it hourly?

Will you be required to report your hours? Activities? Ride time?

Is there a scheduled adjustment of compensation annually? On-demand? Never?

Will you be doing both direct and indirect medical oversight? How are the various hours accounted for in the terms of the contract?

What expectation will you have to work during off hours?

Will you be on call? Who provides backup and whose responsibility is it to make these arrangements?

Is there non-monetary compensation (license fees, pagers, mobile phones, light packages and radios for vehicles, insurance, benefits, sprint vehicles, medical equipment, travel/CME expenses, etc.)?

Does all compensation, when added, provide fair market value for your hours?

If you are providing pro-bono or charity work for the EMS agency, does the agency need to have a formal charitable structure in order to allow this?

Discussion:

Generally, EMS agencies are moving to a place where they recognize that the services of a physician medical director are essential for delivery of quality pre-hospital health care. The medical director's services should be a budgeted and expected cost of running a modern EMS agency. The EMS physician is a critical part of the EMS agency and should be paid fairly for the time, risk, and expertise required. By the same token, the EMS agency needs to be getting good value for its money and it is the responsibility of the medical director to stay engaged with the agency in the capacity outlined in the contract. This is likely the area that will involve the most significant negotiation.

3. Credentials required to do the job:

Does the organization require board certification in Emergency Medicine? EMS Subspecialty Boards? If not, why not?

Do they require the medical director to have/maintain PALS, ACLS, ATLS, etc.? Do you need to be an instructor for these courses?

Will you be responsible for producing and/or delivering educational content to the EMS providers only? Students? Orientees?

Are you required to live within the service area?

Will you drive your own or company vehicles? Do you have to gain additional training to drive agency vehicles? Do you need to carry extra insurance (at whose cost)? Change your driver's license type?

4. Conflict of interest/Stark/Anti-Kickback:

Does any portion of the medical director's job description involve directing patients to or away from a facility where you are employed?

If so, could anything in this arrangement be interpreted as a "quid pro quo" for directing patients to specific facilities?

Are there clear referral/patient destination rules that guide destination regardless of medical director outside employment?

Do you have relationships with vendors who will sell products to your agency, and will your role allow selection of one vendor over another for various products?

Have you clarified and disclosed these relationships and removed yourself from purchasing decisions if they involve a product from a company you consult with outside of your EMS role? (This is particularly important in municipal agencies with public RFP processes).

5. Responsibilities for supervision, education, QA/QI, protocol design and implementation:

How current are the protocols, how often are they reviewed and what is the process for changing/updating/adding?

How is the QA/QI process designed? Is this agency-specific or designed to meet the requirements of an outside entity? What is your role in the QI process? Do you have full unrestricted, and independent, access to all EMS charts without having to ask permission from someone to send you a chart to review?

Is the QI culture "just" or is it oppressive? What influence do you have in setting the tone of the QI process?

Do you have the authority to restrict or rescind an EMS provider's privileges?

How are new employees cleared to work alone?

What is the quantity of chart review? Who is responsible?

How do issues get to the medical director's desk?

Are there ongoing research/pilot programs within the agency? Is this expected? What reviews are required to participate in research (IRB? Etc.)?

Is the medical director expected to speak/present outside of the agency? Who handles cost/expenses for this?

Discussion:

It is important under this bullet to familiarize yourself with the legal concept of “negligent supervision”. In the case of a bad outcome for a patient within the service, there will be a close examination of the people and protocols responsible for education, training and supervision of a provider to ensure that there was the necessary training and experience to follow the protocols as approved by the medical director. In an EMS model where the medical director has final authority for education/training and protocols, he or she should also be the final authority in releasing a provider into the field or removing a provider from the field. The QA/QI process should be in place and the person/people responsible should be delineated clearly. Additionally, a process for communication of incidents reportable to the medical director should be available. Presenting at regional or national meetings or major protocol revisions/updates require significant commitments of time and energy separate from the usual “EMS time”. If there is an expectation of this type of activity in your EMS contract, there should be reflection of the time/expense involved.

6. *Chain of command:*

Who do you report to?

Who reports to you?

Is there a direct line of command or are you a consultant to someone within a separate chain?

Are there any issues that involve patient care that will bypass you in your current position in the chain of command (for example, return-to-duty decisions)? If yes, are you comfortable with this?

Are you considered only as a content expert advisor to the agency administration or do you have a role in operations?

7. *Hire/fire/credentialing authority:*

Will you have the authority to approve/disapprove hiring decisions?

Will you have authority to approve release of a medic from probation? Can you extend field-training time?

How is remediation handled?

Do you have authority to pull an EMS provider off patient care immediately? What is the expected process that follows and who is involved?

Who is the ultimate decision maker about who practices under your supervision?

Does your malpractice insurance provide you civil protection (administrative liability) for these types of decisions?

8. *Field responsibilities:*

Will your job be strictly supervisory or involve direct patient care/contact?

Will you carry medications that are outside the scope of your medics, but within your scope? How will these be supplied, inventoried and charted?

Will you ride with patients that have received advanced care from you? Is this legally permissible in your jurisdiction?

Will the agency restock your supplies/drugs?

Will you be expected to generate patient records? Do you have the ability to complete patient care records for direct patient encounters?

Does the agency have its own State Controlled Substance License and DEA number or will they be operating/ordering under a number assigned to you? Do you need to acquire an independent number under your name for your medical director activities?

What are the implications for other DEA numbers you hold in this regard?

What is the process for ordering/shipping/inventory/dispensing/wasting/disposing of controlled substances?

9. *Malpractice insurance (clinical and administrative):*

Who is responsible for obtaining and maintaining malpractice insurance for the medical director?

Is the coverage specific to EMS?

Are you covered for clinical patient care, care supervision and administrative responsibilities/issues?

What are the policy limits?

What type of policy is this (occurrence or claims-made)?

Who will handle the tail in the event of termination by either party?

What is the jurisdiction for claims? Are there any cases for precedent?

Discussion:

If you plan to run calls with the providers, you need to have a malpractice policy that covers you for both clinical care and for administrative duties. Many malpractice policies that cover the practice of Emergency Medicine within an ED will not cover patient care in the field. In most states, operating under the auspices of an EMS agency will not allow you to be considered under any relevant Good Samaritan laws, if they exist. Nor will most generic medical malpractice policies cover the multitude of issues that may arise in the supervisory context of an EMS agency. Termination of a paramedic's clinical privileges may result in a lawsuit or a long legal fight with an individual or a union. Harassment, discriminatory hiring/promotion practices, HIPAA violations, computer security breaches, personnel actions are all potential land mines where you do not want to be paying for an attorney or a settlement/decision out of pocket. Ensure that you are covered before you touch a patient or show up on a scene. Don't assume. The policy limits for clinical care should be the same as your standard (in the ED) clinical malpractice (this is state/jurisdiction/precedent dependent).

10. Union issues/municipal employment:

Are you eligible for membership in the union by virtue of your employment status in the organization?

Is union membership required?

Is there anyone who provides care under your supervision who is not under your authority (i.e. do you credential the Chief as a paramedic and do you have the authority to limit his/her privileges without losing your job)?

How powerful is the union (if there is one) and what is your status with them?

Are you appointed or employed? Eligible for retirement? Pension?

If you are practicing with a university/government employer in the ED, does this arrangement with the EMS agency change/conflict with that contract?

11. Termination cause and non-cause for both sides:

Is the notice term defined?

Type of notice?

Are the reasons for "for cause" termination defined? Is there an open-ended qualifier like "but not limited to" or "etc." in the contract?

If "for cause" termination is in the contract related to criminal activity is the triggering event for cause accusation, arrest or conviction?

12. Roles and Responsibilities for maintaining PHI and HIPAA compliance:

Will you have access to PHI outside the workplace?

Will a computer be provided to you or will you be expected to provide your own?

Is there a Bring Your Own Device (BYOD) policy and what are the requirements?

What are the tracking, security and reporting process in the event of a breach?

Discussion:

This is particularly important for chart review, exchange and follow up on patients and communication with providers in the field through various devices/media. There should be a clear policy in place and any BYOD (Bring your own device) policies should be reviewed prior to signing.

Conclusion:

With the large variance in EMS medical director positions, the environment of EMS contract negotiations can be quite complex and onerous. It is the hope of the authors of this document that the questions that are outlined above do not scare future medical directors away from the profession of EMS medicine. EMS medicine is exciting and a great way to contribute to the emergency health care system.

Yet, medical directors can get into significant trouble if implications of contracts are not fully explored before signing on the bottom line. Hopefully this list of questions will serve as a living document as EMS systems are surely strengthened by the involvement of medical directors in the EMS system. Ultimately, the job is to protect the patient population in the out-of-hospital environment, and medical directors are more likely to be successful in the role if they have adequate compensation and legal protection, which starts with a carefully developed contract.