



EMPAC RRG RENEWAL PROFILE SHEET

I. ED GROUP

- A. Group Address
B. City State Zip Code Phone
C. Key Contact Title
D. Group Website
E. Medical Director Phone Email

II. PHYSICIAN INFORMATION

Have any members of the group been recently re-certified in Emergency Medicine or other professional specialty? yes no

- 1. If yes, date and place of completion
Secondary specialty(s)? % of practice Board certified? yes no
2. If yes, date and place of completion
Secondary specialty(s)? % of practice Board certified? yes no
3. If yes, date and place of completion
Secondary specialty(s)? % of practice Board certified? yes no

What % of the group have current ACLS, ATLS, or PALS certification? ACLS ATLS PALS

III. PRACTICE HISTORY

- Do any providers practice outside this ED? yes no
If yes, do you have separate professional liability insurance for this exposure? yes no

IV. COVERAGE BEING APPLIED FOR

- A. Are you, as of this date, aware of any claims against the group that have not been reported to your present or prior insurer(s)? If yes, please describe on separate sheet yes no
B. Are you, as of this date, aware of any conduct, circumstances or incidents that occurred during the periods of coverage listed below that could reasonably be expected to result in a claim, and that have not been reported to your present or prior insurer(s)? If yes, please describe on separate sheet yes no

V. ATTESTATIONS

If you answer YES to any of the following questions, please give full details in the Remarks section. Include dates and copies of any related documents.

- A. Is anyone in the group currently being treated for alcoholism, narcotics addiction or mental illness or are/were in a physician health or diversion program not previously reported? yes no
If yes, attach a copy of documentation from a physician health or diversion program or a letter of release from the treating physician.
B. Have you become aware of any health problem, illness, or physical condition that impairs or could impair your group's or an individual's ability to safely practice emergency medicine? yes no

- C. Has any physician within the group ever undergone a CMS investigation for an alleged violation of EMTALA?
yes ___ no ___
- D. Has any physician within the group been fined as a result of a CMS investigation resulting from an alleged violation of EMTALA?
yes ___ no ___
- E. Has the group or any member ever had professional liability insurance declined, non-renewed, cancelled or restricted, or had an involuntary deductible and/or surcharge assessed since your last application?
yes ___ no ___
- F. Has any group member been investigated by any State Licensing Board, Narcotics Board, DEA or other governmental or regulatory agency or have had license to practice or narcotics license ever been denied, revoked, suspended or limited in any way since your last application?
yes ___ no ___
- G. Has any hospital restricted or revoked privileges or invoked probation for any group member for any cause other than incomplete charts since your last application?
yes ___ no ___
- H. Has any group member ever been indicted for or convicted of a crime other than minor traffic violations since your last application?
yes ___ no ___
- I. Has any group member been suspended, restricted or put on probation by any governmental health program (e.g. Medicare or Medicaid) since your last application?
yes ___ no ___
- J. Has any group member been involved in a malpractice claim, suit or incident that might give rise to a claim in the period since you have provided information to us on this subject. Or are you currently involved in medical malpractice litigation?
yes ___ no ___

If yes, please provide complete details on the Claim Information Form. Complete a separate form for each claim.

VI. SENTINEL EVENTS:

Are there any cases, issues, complaints that you (*or your group*) are concerned about but, as of this renewal, have *not* resulted in being named as a defendant in a case or lawsuit? yes ___ no ___

If yes, please explain on separate sheet of paper and attach in front of this page.

VII. PHYSICIAN ROSTER

Please list all active and terminated (along with termination dates) physicians and health care extenders. Provide names on separate sheet and attach in front of this page. FT = Full Time; PT = Part Time

A. Total Number in Group _____ Physicians(FT/PT) _____ PAs(FT/PT) _____ NPs(FT/PT) _____
Other(FT/PT) _____

Change from prior year

Total Number in Group: _____ Physicians(FT/PT) _____ PAs(FT/PT) _____ NPs(FT/PT) _____
Other(FT/PT) _____

Explain these Differences _____

B. Please itemize your visits from last year and provide expected visits for this year.

	Total Urgent Care patient visits	Total Emergency patient visits	Total Pediatric patient visits	Total patient visits
Prior Year				
Current Year				

Change in % or total OPV from year prior _____

C. What percent of your emergency room patients have been admitted to the hospital during the prior year? _____
What is the change from the prior year? _____

EMPAC

risk retention group

VIII. FACILITY CONTRACTS

Total Number of Contracts: _____

Have any of the contracts for these facilities changed from the prior year? yes ___ no ___

If yes, please attach a copy of contract for each facility where you are providing ED services that has changed.

A. Name of Approved Medical Facility _____
 Address _____
 City _____ State _____ Zip Code _____
 Contact Person _____ Phone _____

B. Please list additional approved Medical Facility(ies) on a separate sheet of paper if new from last renewal.

IX. PREVIOUS INSURANCE

Has there been any change, from your last submission, to currently valued Loss Runs from prior carriers?

<u>Carrier Name</u>	<u>Policy From</u>	<u>Period To</u>	<u>Limits of Liability</u>	<u>Claims-Made/ Occurrence</u>	<u>Tail Coverage Purchased?</u>

X. GROUP PRACTICE RISK MANAGEMENT

A. Do you have a formal, written risk management protocol? yes ___ no ___

If yes, attach a copy of the Table of Contents of existing risk management protocol.

B. Has EMPAC's contractor QRM or other risk management group provided input for the group's Risk Program. yes ___ no ___

If yes, please provide a separate sheet summarizing recommendations and action undertaken to address input.

C. Is compliance with the protocol mandatory for all physicians? yes ___ no ___

	<u>Yes</u>	<u>No</u>	<u>Mandatory</u>	<u>Optional</u>
1. Triage Policy	___	___	___	___
2. Medical Screening Exam	___	___	___	___
3. Transfer (COBRA)/EMTALA	___	___	___	___
4. Clinical Protocols	___	___	___	___
5. Chest Pain and/or Thrombolytic	___	___	___	___
6. Stroke/Thrombolytic	___	___	___	___
7. Discharge Activities	___	___	___	___
8. Pt Complaint Follow Up	___	___	___	___

9. List and provide all CME certificates completed during the prior year and specify those which are state mandated CMEs on a separate sheet.

Minimum number of hours of CME required per year by your state _____

10. Are Patient Satisfaction Surveys utilized? yes ___ no ___

If yes, please attach a sample copy of the most recent survey results for your group.

Average score? Facility A _____ Facility B _____ Facility C _____
 Facility A Facility B Facility C

What is your average door to doctor time? _____
 What is your average length of stay in the ED for non-admitted patients? _____
 What is your average length of stay in the ED for admitted patients? _____

